THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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

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

v.

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

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

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HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Orangeburg	CareSouth–Homecare Professionals–Cola	210	14332	68.25
Orangeburg	Edisto Health District Home Health	1354	56291	41.57
Orangeburg	Home Care of Regional Medical Center	7	136	19.43
Orangeburg	Olsten Health Services	260	8276	31.83
Orangeburg	VNA of Greater Bamberg, Inc.	346	22255	64.32
Pickens	Appalachia II Home Health	1058	63869	60.37
Pickens	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Pickens	Clemson Area Retirement Center HHA	Licensed 11/6/98		
Pickens	(Coram Home Care of South Carolina)	52	896	17.23
Pickens	Greenville Hospital System HHA	112	2942	26.27
Pickens	Interim Healthcare of Greenville	677	24930	36.82
Pickens	Matria Healthcare–Piedmont	14	28	2.00
Pickens	Oconee Memorial Hospital HHA	Licensed 7/28/99		
Pickens	(Plan Home Health Care/Greenville)	114	7579	66.48
Pickens	(Professional Home Nursing, Inc.)	Merged with Coram		
Pickens	St. Francis Hospital Home Care	102	6558	64.29
Richland	CarePro Home Health	64	2422	37.84
Richland	CareSouth–Homecare Professionals–Cola	264	11791	44.66
Richland	Carolina Home Health Care, Inc.	1346	32682	24.28
Richland	Palmetto Health HomeCare	1914	95625	49.96
Richland	Home Health of South Carolina, Inc.–Midlands	0	0	0
Richland	(Interim HealthCare of Columbia)	435	14019	32.23
Richland	Lowman Home Health (restricted)	0	0	0
Richland	Matria Healthcare–Midlands	137	205	1.50
Richland	Olsten Health Services	332	5159	15.54
Richland	Palmetto Home Health Services	737	24857	33.73
Richland	Tri–County Home Health Care	727	29321	40.33
Saluda	Health Related Home Care, Inc.	53	1489	28.09
Saluda	HomeCare of HospiceCare of Piedmont (term)	0	0	0
Saluda	Self Memorial Hospital VNA	54	525	9.72
Saluda	Tri–County Home Health Care	62	1927	31.08
Saluda	Upper Savannah Home Health	255	9146	35.87
Spartanburg	Appalachia III Home Health	1882	72877	38.72
Spartanburg	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Spartanburg	(Coram Home Care of South Carolina)	150	4631	30.87
Spartanburg	Interim Healthcare of Greenville	1394	69190	49.63
Spartanburg	Matria Healthcare–Piedmont	22	44	2.00
Spartanburg	Spartanburg Reg Med Ctr Home Care	2719	62907	23.14
Spartanburg	St. Francis Hospital Home Care	111	3251	29.29
Sumter	CareSouth Homecare Professionals–Cola	Licensed 9/8/99		
Sumter	(Home Health Services of Carolinas Hospital)	81	10155	125.37
Sumter	Tri–County Home Health Care	691	30786	44.55
Sumter	Tuomey Regional Home Health	386	14982	38.81
Sumter	Wateree Home Health Services	761	37186	48.86
Union	Appalachia III Home Health	679	26367	38.83
Union	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Union	(Coram Home Care of South Carolina)	12	152	12.67

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Union	Total Care, Inc	162	9413	58.10
Williamsburg	CareSouth Home Care Professionals–Gtown	30	1101	36.70
Williamsburg	Home Health Services of Carolinas Hosp (term)	Formerly Home Health of Williamsbur		
Williamsburg	(Home Health of Williamsburg (term))	1	122	122.00
Williamsburg	Total Care, Inc–Coastal	159	11873	74.67
Williamsburg	Waccamaw Home Care Services	658	26182	39.79
Williamsburg	Winyah Home Health Care	221	9084	41.10
York	Catawba Home Health	1294	60006	46.37
York	Home Health of South Carolina, Inc.	780	62804	80.52
York	Interim Healthcare/Rock Hill	595	36621	61.55
York	Matria Healthcare–Piedmont	2	4	2.00
York	Total Care, Inc	338	20357	60.23
York	(Community Home Care) (term)	58	1616	27.86
TOTAL		88711	4055843	45.72

E. Subacute Care:

Subacute care (also known as transitional care, among other names) is a niche of the health care industry which is receiving interest from hospitals, nursing homes, managed care organizations, and both the federal and state governments. It is envisioned as being the area of patient care that lies somewhere between inpatient hospitalization and long-term-care services. Subacute care can be loosely defined as being for patients who are stabilized and no longer require the technology and equipment provided early in the acute episode of illness or injury, however, they still require 24-hour professional care. Potential candidates include accident and stroke victims, ventilator-dependent patients, AIDS and cancer patients - mostly staying 3 to 30 days, sometimes as long as 90 days. Some reports claim that up to 40 percent of patients in acute medical, surgical, or rehabilitation hospitals can be treated in subacute settings.

Currently, there are no industry-wide standards of care or program design, no distinct bed licensure or reimbursement for subacute care, and no regulation of such care. No studies have yet demonstrated superior patient outcomes from and cost-effectiveness of subacute care, although research is continuing. Subacute care does not qualify for Medicare reimbursement as a separate medical sub-specialty.

However, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now accredits subacute care facilities. The JCAHO used the nursing home standards developed by the Health Care Financing Administration (HCFA) as a starting point, then revised approximately one-third of the conditions of participation. These revisions were primarily made to reflect the generally shorter stays and higher staffing qualifications for subacute care {such as earlier comprehensive assessment of a resident's condition and more extensive requirements for medical equipment and physical plant capacity}. The JCAHO anticipates that their pre-survey application process will provide data to build a profile of the subacute field, including demographic profiles, lengths of stay, payment source, and where patients came from and went afterwards.

Nationally, units have been established in both hospitals and nursing homes. There is disagreement between advocates as to whether the establishment of such units is done in the interest of patient care or in the interest of maximizing reimbursement. There is also disagreement as to whether hospitals or nursing homes are the proper loci for these units.

In South Carolina, there are no licensing standards for subacute facilities. It appears that these patients can be cared for in nursing home beds. However, it must be recognized that the level of care required for these patients is more intense than that provided by traditional nursing homes.

F. Other Services For The Elderly

1. Hospices

Hospice means a centrally administrated, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family, including but not limited to home, outpatient and inpatient services provided directly or through written agreement. Terminally ill means a medical prognosis that the individual's estimated life expectancy is less than a year.

A hospice must be primarily engaged in providing the care and services for the purposes described above. It must:

a. Make these services available as needed on a twenty-four (24) hour basis;
b. Provide these services in a manner consistent with acceptable standards of practice;
c. Provide these services to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness; and
d. Not discontinue or diminish care provided to an individual because of that individual's inability to pay for that care.

The hospice must provide for the continuity of care, whether furnished in the home, on an outpatient basis, or in an inpatient setting.

The following services must be routinely provided directly by hospice employees or volunteers:

a. Coordination of services provided by or arranged for by the hospice;
b. Maintenance of records;
c. Coordination of orientation, education and training of providers in the hospice concept;
d. Bereavement counseling and follow-up; and
e. Recruitment, selection, training and monitoring of volunteers.

The following services must be provided either directly by the hospice or through legally binding arrangements made by the hospice;

a. Nursing by or under the supervision of a registered nurse;
b. Medical social services;
c. Spiritual care by or under the supervision of clergy;
d. Home health aide;
e. Homemaker;
f. Physical therapy;
g. Provision of medical supplies; and

h. Short-term inpatient care for pain control, symptom management or respite purposes.

Hospices must not discriminate based on age, sex, race, color, religion, source of payment, or location of patient, in the acceptance of or the provision of goods and services to patients or potential patients.

A Certificate of Need is **not** required for the establishment of a hospice program; however, hospices must be licensed by the Division of Health Licensing.

There are forty (40) licensed hospices with at least one licensed hospice serving every county in the state. For a list of hospices or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

2. Day Care Facilities for Adults

A Day Care Facility for Adults means a facility, for adults eighteen (18) years of age or older, which offers in a group setting a program of individual and group activities and therapies. The program is directed toward providing community-based day care services for those adults in need of a supportive setting, thereby preventing unnecessary institutionalization. The program shall provide a minimum of four (4) and a maximum of fourteen (14) hours of operation a day. A Certificate of Need is **not** required for the establishment of a Day Care Facility for Adults; however, they must be licensed by the Division of Health Licensing.

There are eighty-two (82) licensed Day Care Facilities for Adults with 2,541 participants. The number of licensed participants (slots) by county follows. For a list of licensed facilities or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

COUNTY	SLOTS	COUNTY	SLOTS	COUNTY	SLOTS
Abbeville		Dillon	50	Marion	80
Aiken	40	Dorchester	41	Marlboro	
Allendale		Edgefield	10	McCormick	
Anderson	73	Fairfield		Newberry	44
Bamberg		Florence	138	Oconee	50
Barnwell	22	Georgetown	108	Orangeburg	36
Beaufort	7	Greenville	90	Pickens	30
Berkeley	41	Greenwood	60	Richland	366
Calhoun		Hampton		Saluda	26
Charleston	205	Horry	105	Spartanburg	62
Cherokee	60	Jasper	27	Sumter	52
Chester	45	Kershaw	20	Union	
Chesterfield	20	Lancaster	36	Williamsburg	20
Clarendon		Laurens	40	York	140
Colleton	7	Lee	15		
Darlington	72	Lexington	303		

3. Community Residential Care Facilities

A Community Residential Care Facility is a facility which offers room and board and which provides a degree of personal assistance for a period of time in excess of twenty-four consecutive hours for two or more persons, eighteen years old or older, unrelated to the operator within the third degree of consanguinity. Included in this definition is any facility (other than a health care facility), which offers or represents to the public that it offers a beneficial or protected environment specifically for the mentally ill or drug addicted or alcoholic, or provides or purports to provide any specific procedure or process for the cure or improvement of that disease or condition. A Certificate of Need is **not** required for the construction of a Community Residential Care Facility; however, they must be licensed by the Division of Health Licensing.

There are 549 licensed Community Residential Care Facilities with 14,979 beds as of October 1, 1999. The number of beds by county follows. For a list of licensed facilities or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

COUNTY	BEDS	COUNTY	BEDS	COUNTY	BEDS
Abbeville	43	Dillon	166	Marion	17
Aiken	545	Dorchester	235	Marlboro	89
Allendale	15	Edgefield	47	McCormick	40
Anderson	514	Fairfield	126	Newberry	105
Bamberg	72	Florence	846	Oconee	198
Barnwell	35	Georgetown	229	Orangeburg	371
Beaufort	388	Greenville	1268	Pickens	591
Berkeley	218	Greenwood	295	Richland	1370
Calhoun	15	Hampton	68	Saluda	89
Charleston	1791	Horry	498	Spartanburg	1196
Cherokee	124	Jasper	8	Sumter	494
Chester	144	Kershaw	142	Union	78
Chesterfield	296	Lancaster	93	Williamsburg	64
Clarendon	108	Laurens	501	York	850
Colleton	69	Lee	98		
Darlington	158	Lexington	894		

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RESIDENTIAL CARE BEDS AS OF OCTOBER, 1999

COUNTY	1999 65+ POP	RESIDENTIAL BEDS	65+ BEDS/M
ABBEVILLE	3.300	43	13.03
AIKEN	19.500	545	27.95
ALLENDALE	1.900	15	7.89
ANDERSON	22.900	514	22.45
BAMBERG	2.400	72	30.00
BARNWELL	2.600	35	13.46
BEAUFORT	14.100	388	27.52
BERKELEY	10.000	218	21.80
CALHOUN	1.700	15	8.82
CHARLESTON	35.900	1791	49.89
CHEROKEE	6.700	124	18.51
CHESTER	5.500	144	26.18
CHESTERFIELD	6.700	296	44.18
CLARENDON	4.500	108	24.00
COLLETON	4.900	69	14.08
DARLINGTON	8.700	158	18.16
DILLON	3.300	166	50.30
DORCHESTER	8.400	235	27.98
EDGEFIELD	2.200	47	21.36
FAIRFIELD	3.700	126	34.05
FLORENCE	14.600	846	57.95
GEORGETOWN	6.200	229	36.94
GREENVILLE	45.700	1268	27.75
GREENWOOD	8.600	295	34.30
HAMPTON	3.100	68	21.94
HORRY	28.000	498	17.79
JASPER	1.700	8	4.71
KERSHAW	6.500	142	21.85
LANCASTER	7.300	93	12.74
LAURENS	10.100	501	49.60
LEE	2.300	98	42.61
LEXINGTON	19.500	894	45.85
MARION	4.800	17	3.54
MARLBORO	3.700	89	24.05
MCCORMICK	1.300	40	30.77
NEWBERRY	5.600	105	18.75
OCONEE	9.000	198	22.00
ORANGEBURG	10.700	371	34.67
PICKENS	12.300	591	48.05
RICHLAND	30.100	1370	45.51
SALUDA	2.700	89	32.96
SPARTANBURG	34.000	1196	35.18
SUMTER	11.100	494	44.50
UNION	4.900	78	15.92
WILLIAMSBURG	3.900	64	16.41
YORK	17.600	850	48.30
	474.2	15601	32.90

The 1999 population is for the over age sixty-five only.
The 65+ beds per M is the number of residential care beds per thousand population.

G. Alzheimer's Disease

Alzheimer's Disease is a degenerative, fatal neurological disease that progressively robs people of their ability to function, both physically and mentally. It affects the cells of the brain producing a diminished capacity to think, remember, reason or understand. In advanced stages of the disease, individuals are unable to perform even the simplest of daily activities. It accounts for approximately 65% of all dementias. References are made to ADRD (Alzheimer's disease and related disorders) which would include Multi-Infarct dementia, Parkinson's disease with dementia, Huntington's chorea, Creutzfeldt-Jakob disease, Pick's disease, normal pressure hydrocephalus and other dementias.

The prevalence of ADRD increases with age. It is estimated that 5-10% of the population age 65 or over have ADRD and over 30% of those age 85 or over have ADRD. This equates to approximately 51,000 people in South Carolina. The population age 65 and over is the fastest growing population segment and also the group at greatest risk for ADRD. Both the person afflicted with the disease and the caregiver are victims of the disease. Informal caregiving (unpaid care by family and friends) accounts for approximately 80% of all care provided. Alzheimer's disease has become the "Gray Plague of the 21st Century." The South Carolina Blue Ribbon Task Force on ADRD has made specific recommendations on this disease. For more information, contact the Alzheimer's Resource Coordination Center, Office of the Governor, Division on Aging, 202 Arbor Lake Drive, Suite 301, Columbia, SC 29223.

The following recommendations are based on this report:

a. Expand outreach methods of identifying and obtaining information from ADRD individuals and their families and caregivers in order to understand and meet their needs;
b. Direct collected client information to the Alzheimer's Registry and report service and training needs to the Alzheimer's Resource Coordination Center;
c. Promote accessible home and community respite care;
d. Provide ADRD education and training opportunities for health care professionals, adult care managers and home service workers;
e. Work with the Governor's Office, Division on Aging, to enhance the content of certified nurse aide and home health aide/ homemaker training to include current information on ADRD and the special needs of caregivers.

To respond to the growing needs of this population and to promote policies which allow greater flexibility for individual choice, it is critical to invest both in lower cost, lower technology home and community based services, as well as institutional care.

ADRD individuals are likely consumers of long term care services, as the disease process can last from 2 to 20 years, with the average

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length of 7 years duration. As the disease progresses, the burden of care rises for the caregiver, both in terms of physical care and the subsequent emotional stress of caregiving for a quasi- or totally dependent person. There are increasing cases of premature placement of the person with dementia into institutional care when the primary caregiver is no longer able to cope with the caregiving demands.

Institutional care is now, and will always be an essential part of the continuum of long term care. However, the cost to the Medicaid program for institutional services is currently more than twice the cost of long term care services delivered in a home or community based setting. Unfortunately, there are long waiting lists for institutional care as well as for home and community services, such as personal care aides and adult day care, which provide support and respite for caregivers.

To address this, the South Carolina Blue Ribbon Task Force in 1993 recommended the promotion of a comprehensive service system, with emphasis on community services in the least restrictive environment, meeting individual needs and maximizing independence.

The Governor's Office, Division on Aging, through its Alzheimer's Resource Coordination Center, legislated in 1994, will be working in collaboration with the South Carolina Department of Health and Environmental Control and other key human service agencies to determine systemic needs, coordinate information and program development, and promote more effective service delivery for both community and institutional care settings.

H. PEOPLE WITH HIV/AIDS:

Nursing homes and people with AIDS: A February, 1991, report entitled, "South Carolina's Plan to Provide Services for People with HIV/AIDS," discusses long-term care facilities and people with AIDS. This report does not recommend additional nursing home beds strictly for HIV/AIDS patients. It does state that access and funding for long-term care of these persons has been a problem. This report makes the following recommendations:

(a) Training and educational interventions regarding HIV infection should be directed to boards of directors of long term care facilities, administrators, and the staffs of long term care facilities;
(b) Mechanisms should be developed to protect long term care facilities against major financial losses as a result of having cared for patients with HIV/AIDS;
(c) Long term care facilities should be encouraged to develop and implement a full range of policies and procedures to care for patients with HIV/AIDS.

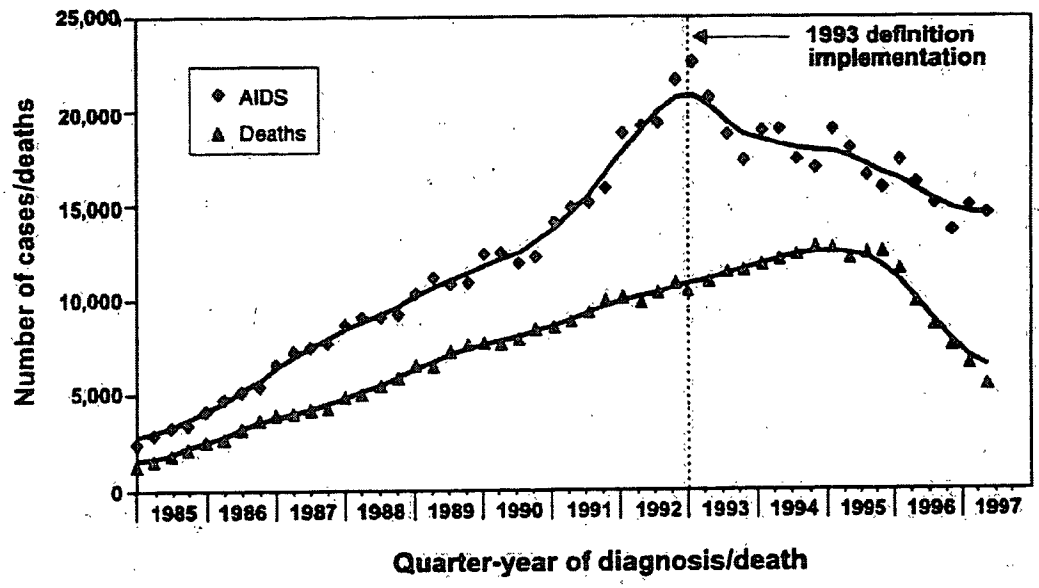
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HIV/AIDS

National Data -

Acquired immunodeficiency syndrome (AIDS) is a specific group of diseases or conditions which are indicative of severe immunosuppression related to infection with the human immunodeficiency virus (HIV). Estimated incidence of AIDS and deaths of persons with AIDS, adjusted for delays in reporting by quarter of diagnosis/death, United States, January 1985 through June 1997. The top curve represents the number of cases diagnosed with AIDS using the 1993 definition criteria after adjustments for reporting delays. It represents the distribution of all cases diagnosed with AIDS and illustrates the distorting effect of the change in the case definition. The recent trend in AIDS incidence is no longer affected by the change in the case definition but is affected by HIV treatments, largely beginning in 1996, as is the bottom curve which represents the reported number of deaths of persons with AIDS using the 1993 case definition after adjustments for reporting delays. It shows the continued decline in deaths of persons with AIDS. (Graph by Debra L. Hanson, MS)



Data Source: HIV/AIDS Surveillance Report, CDC

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RECORD 003440

AIDS cases and annual rates per 100,000 population, by state, reported in 1996 and 1997; and cumulative totals, by state and age group, through December 1997, United States

State of residence	1996		1997		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Alabama	607	14.2	570	13.2	4,774	63	4,837
Alaska	36	6.0	52	8.5	407	5	412
Arizona	589	13.3	448	9.8	5,447	21	5,468
Arkansas	267	10.7	242	9.6	2,356	35	2,391
California	9,508	29.8	7,029	21.8	104,201	555	104,756
Colorado	518	13.6	380	9.8	6,103	27	6,130
Connecticut	1,110	34.0	1,222	37.4	9,566	172	9,738
Delaware	285	39.4	231	31.8	1,995	15	2,010
District of Columbia	1,256	233.3	998	188.7	10,255	154	10,409
Florida	7,293	50.6	6,098	41.8	63,617	1,289	64,906
Georgia	2,420	33.0	1,722	23.0	18,555	179	18,734
Hawaii	199	16.8	94	7.9	2,074	14	2,088
Idaho	38	3.2	52	4.3	415	2	417
Illinois	2,193	18.5	1,842	15.5	20,165	233	20,398
Indiana	590	10.1	523	8.9	4,904	34	4,938
Iowa	110	3.9	101	3.5	1,066	9	1,075
Kansas	230	8.9	159	6.1	1,978	10	1,988
Kentucky	401	10.3	361	9.2	2,562	21	2,583
Louisiana	1,463	33.7	1,094	25.1	10,096	112	10,208
Maine	50	4.0	51	4.1	797	9	806
Maryland	2,245	44.4	1,875	36.8	16,864	274	17,138
Massachusetts	1,303	21.4	863	14.1	12,714	198	12,912
Michigan	961	9.9	882	9.0	9,164	94	9,258
Minnesota	304	6.5	214	4.6	3,187	21	3,208
Mississippi	450	16.6	347	12.7	3,160	47	3,207
Missouri	853	15.9	577	10.7	7,773	54	7,827
Montana	34	3.9	41	4.7	265	3	268
Nebraska	99	6.0	91	5.5	870	9	879
Nevada	428	26.6	592	35.3	3,632	25	3,657
New Hampshire	93	8.0	55	4.7	759	8	767
New Jersey	3,580	44.7	3,226	40.1	35,417	693	36,110
New Mexico	208	12.0	169	9.8	1,607	5	1,612
New York	12,364	68.2	13,189	72.7	118,042	2,061	120,103
North Carolina	896	12.3	850	11.4	8,057	109	8,166
North Dakota	12	1.9	13	2.0	90	—	90
Ohio	1,156	10.4	848	7.6	9,453	112	9,565
Oklahoma	272	8.3	283	8.5	2,987	26	3,013
Oregon	460	14.4	305	9.4	4,147	16	4,163
Pennsylvania	2,340	19.4	1,912	15.9	19,058	265	19,323
Rhode Island	177	17.9	152	15.4	1,722	18	1,740
South Carolina	853	23.0	779	20.7	6,956	71	7,027
South Dakota	14	1.9	11	1.5	125	4	129
Tennessee	821	15.5	784	14.8	6,265	46	6,311
Texas	4,799	25.1	4,718	24.3	44,164	337	44,501
Utah	194	9.6	152	7.4	1,513	21	1,534
Vermont	25	4.3	29	4.9	325	3	328
Virginia	1,195	17.9	1,175	17.4	10,116	155	10,271
Washington	799	14.5	641	11.4	8,194	32	8,226
West Virginia	121	6.6	130	7.2	866	8	874
Wisconsin	271	5.3	255	4.9	3,009	25	3,034
Wyoming	7	1.5	16	3.3	155	2	157
Subtotal	**66,497**	**25.1**	**56,443**	**21.8**	**611,989**	**7,701**	**619,690**
U.S. dependencies, possessions, and associated nations							
Guam	4	2.8	2	1.4	19	—	19
Pacific Islands, U.S.	1	0.3	1	0.3	4	—	4
Puerto Rico	2,241	59.2	2,040	53.3	20,241	370	20,611
Virgin Islands, U.S.	18	17.2	99	93.9	363	14	377
Total[1]	**68,808**	**25.5**	**58,634**	**22.3**	**633,000**	**8,086**	**641,086**

[1]U.S. totals presented in this report include data from the United States (50 states and the District of Columbia), and from U.S. dependencies, possessions, and independent nations in free association with the United States. See Technical Notes. Totals include 385 persons whose state of residence is unknown.

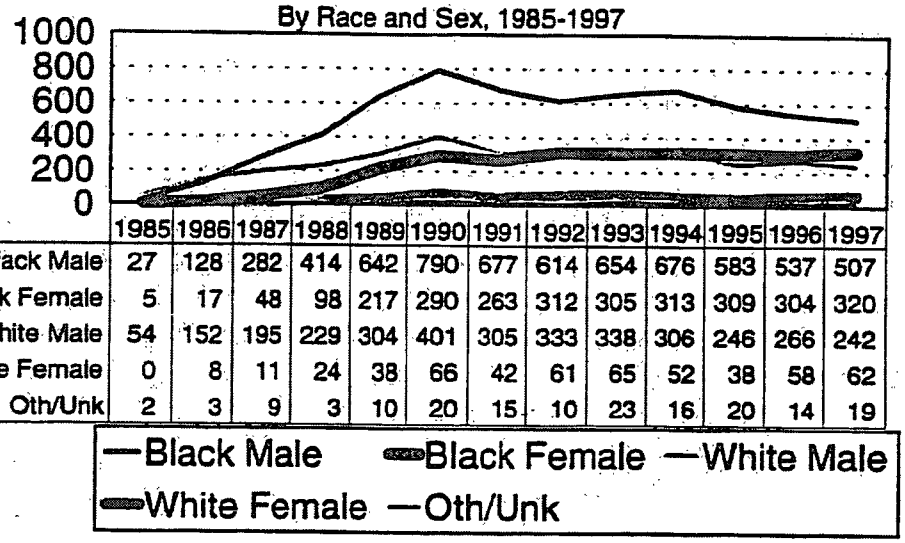
Data Source: HIV/AIDS Surveillance Report, CDC

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RECORD 003441

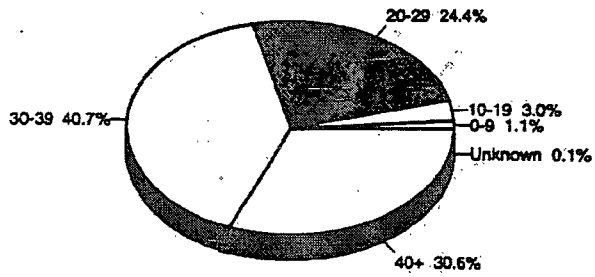
Reported Cases of HIV* in South Carolina
By Year of Report

The below reflects the number of new cases diagnosed or reported in South Carolina each year. New cases appear to be stabilizing/slightly declining during the past five (5) years.

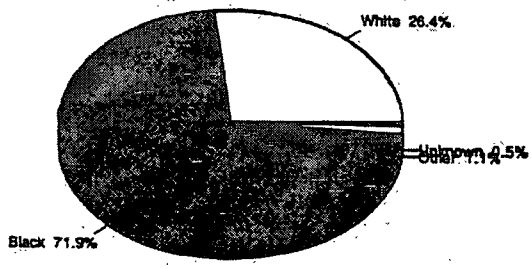


	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Black Male	27	128	282	414	642	790	677	614	654	676	583	537	507
Black Female	5	17	48	98	217	290	263	312	305	313	309	304	320
White Male	54	152	195	229	304	401	305	333	338	306	246	266	242
White Female	0	8	11	24	38	66	42	61	65	52	38	58	62
Oth/Unk	2	3	9	3	10	20	15	10	23	16	20	14	19

By Age Group,
1997 Cases



By Race,
1997 Cases



*** AIDS cases are included in counts of HIV cases.**

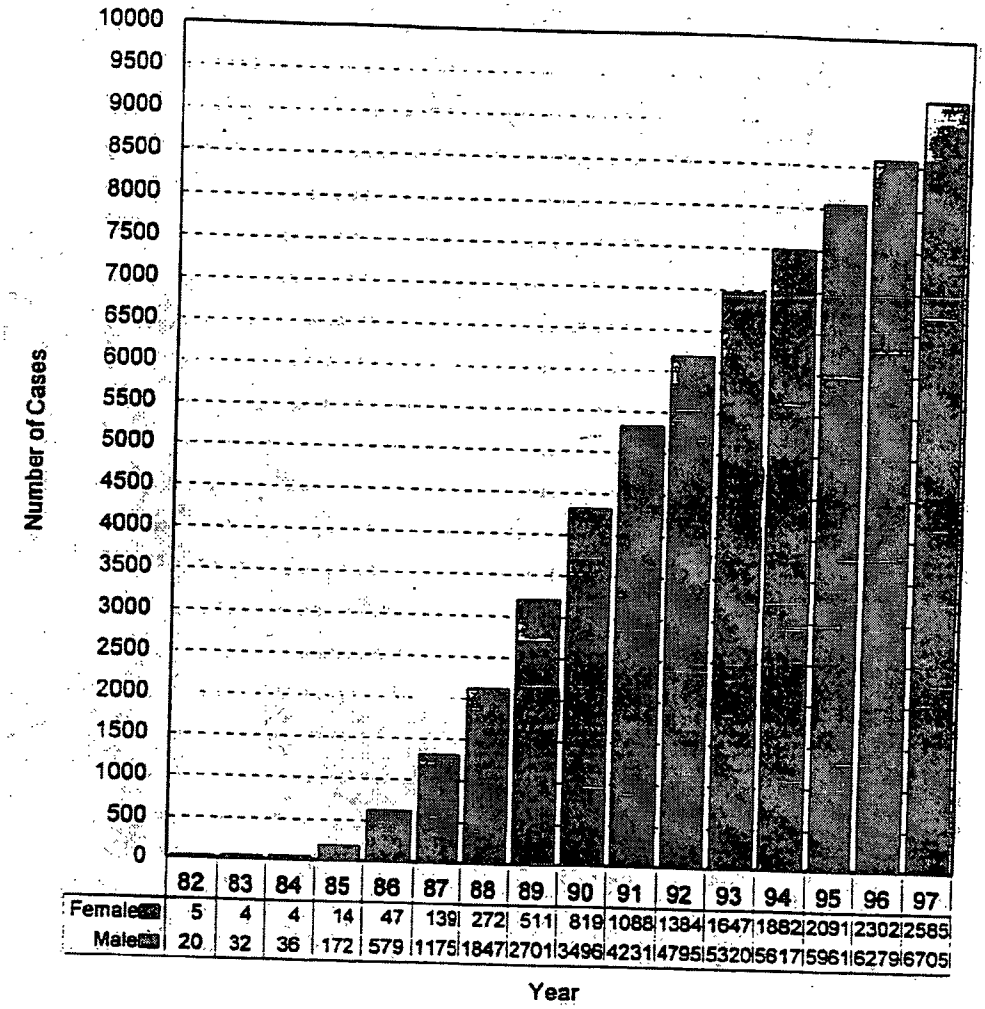
Data Source: SCDHEC STD/HIV Program

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RECORD 003442

HIV Prevalence: Number of Cases Alive With HIV at the End of Each Year by Sex

South Carolina, Through 1997



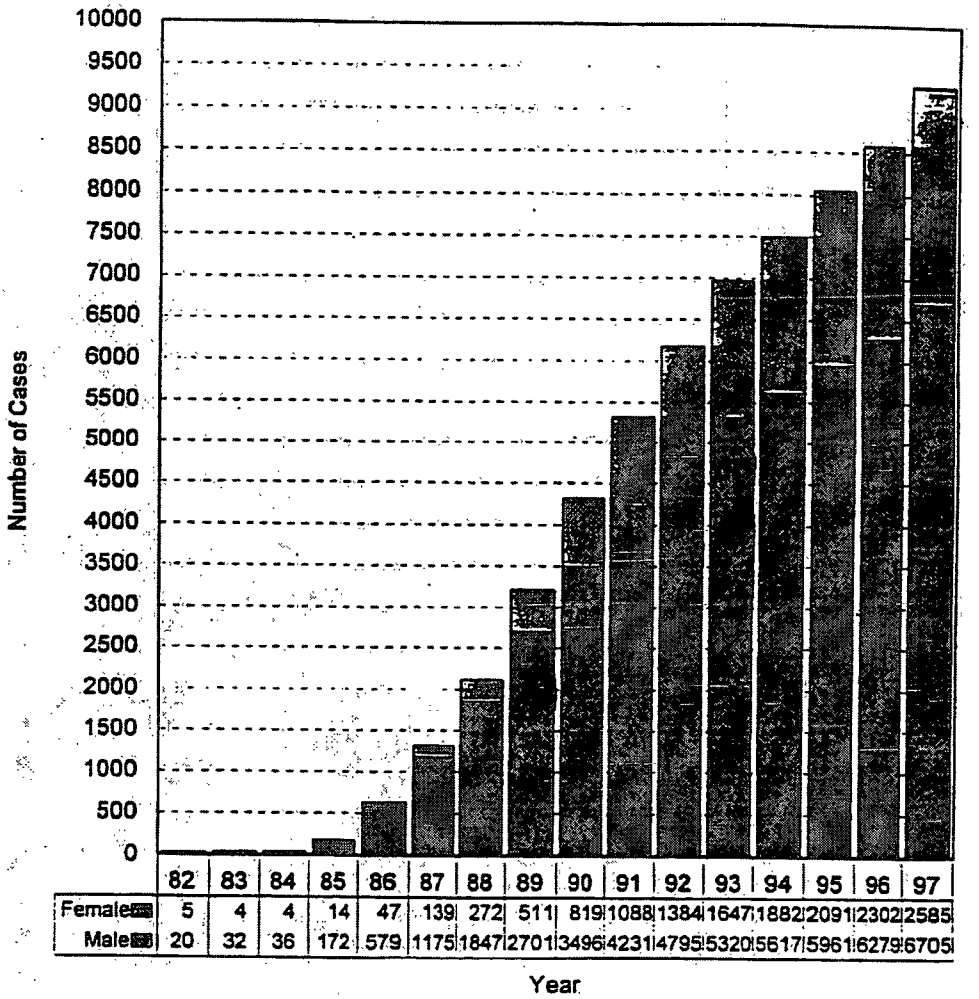
	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97
Female	5	4	4	14	47	139	272	511	819	1088	1384	1647	1882	2091	2302	2565
Male	20	32	36	172	579	1175	1847	2701	3496	4231	4795	5320	5617	5961	6279	6705

While the overall number of newly diagnosed HIV/AIDS cases is leveling/declining, the number of people *living* with HIV infection is growing. These numbers in part reflect the success many people have had with the new highly active drug therapies.

Source: SC DHEC, STD/HIV Surveillance Program
Note: HIV cases include AIDS cases.

HIV Prevalence: Number of Cases Alive With HIV at the End of Each Year by Sex

South Carolina, Through 1997



	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97
Female	5	4	4	14	47	139	272	511	819	1088	1384	1647	1882	2091	2302	2585
Male	20	32	36	172	579	1175	1847	2701	3496	4231	4795	5320	5617	5961	6279	6705

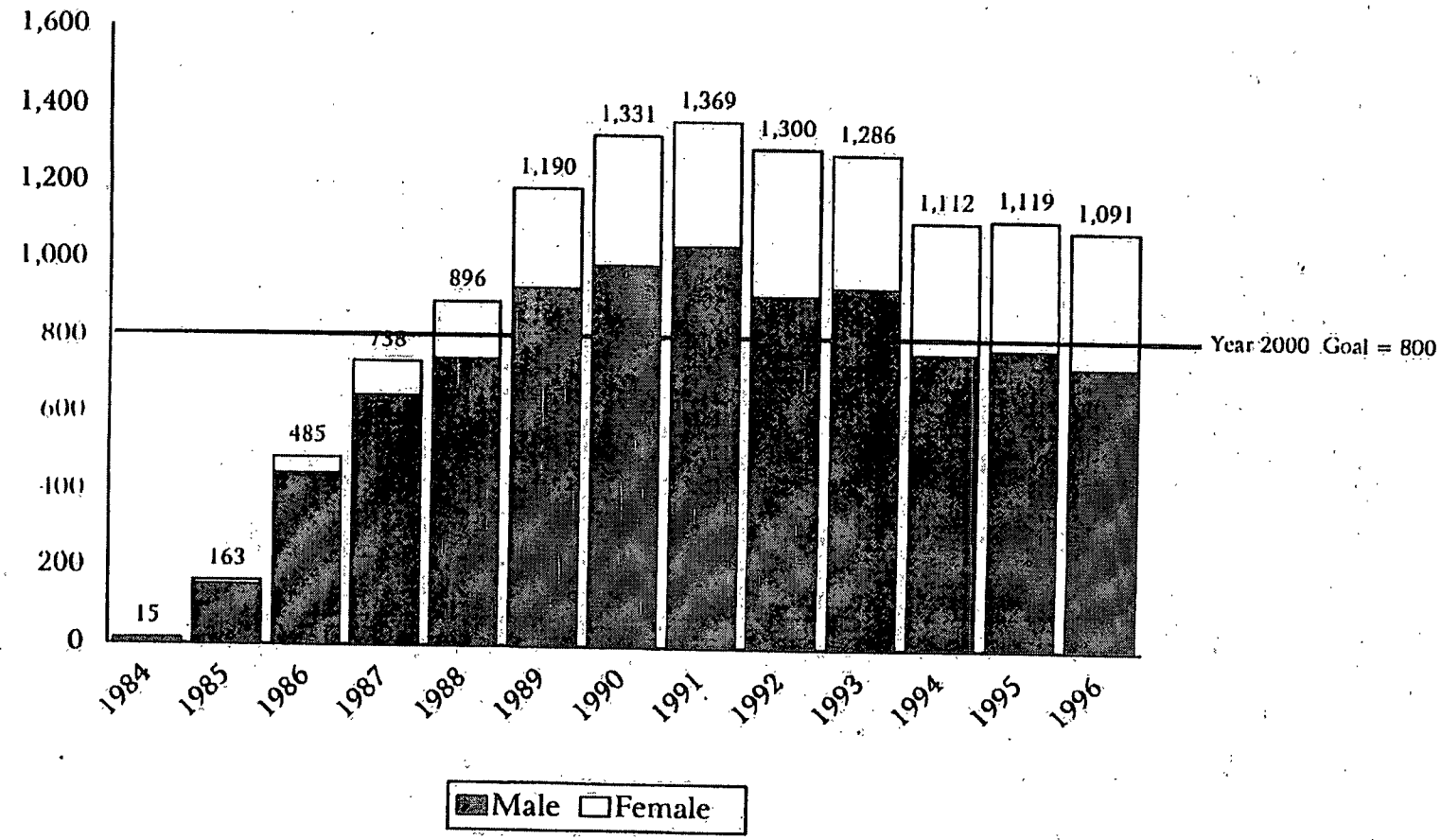
While the overall number of newly diagnosed HIV/AIDS cases is leveling/declining, the number of people *living* with HIV infection is growing. These numbers in part reflect the success many people have had with the new highly active drug therapies.

Source: SC DHEC, STD/HIV Surveillance Program
Note: HIV cases include AIDS cases.

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RECORD 003444

Number of HIV Infections by Year of Diagnosis and Sex
South Carolina



Source: HIV/AIDS Reporting System, TGS, SCDHEC

RECORD 003445

PET-EX004.0215

7. RURAL HEALTH CARE

OVERVIEW

South Carolina is a small state, the 40th in size with the 25th largest population. Of the 46 counties in the state, the following 16 are classified as urban: Aiken, Anderson, Berkeley, Charleston, Cherokee, Dorchester, Edgefield, Florence, Greenville, Horry, Lexington, Pickens, Richland, Spartanburg, Sumter and York. The remaining counties are classified as rural. The percent of South Carolina residents living in rural areas has steadily decreased over time. In 1960, 41.2% of the population lived in urban areas, while 58.8% lived in rural areas. By 1990, 54.6% were living in urban areas, while only 45.4% lived in rural areas. Seven counties lost population between the 1980 and 1990 Censuses. Rural counties in general have a lower population density {population per square mile of land} than urban counties.

In addition to the low population density, there is often a lack of employment in rural areas, leading to an emigration of the younger population in search of employment in larger communities. In 1995, the overall unemployment rate in South Carolina was 5.1%; 5 rural counties had unemployment rates greater than 10% while only 4 had rates lower than the state average. As a result, rural counties tend to have a higher percentage of elderly residents. In 1990, 12.6% of the U.S. population was age 65 and over. South Carolina's rate was 11.4%. However, 23 counties in South Carolina had percentages higher than the national average and 19 were rural counties. Newberry County had the highest rate at 15.4%, followed by Saluda at 14.4%. At the other end of the scale, Berkeley, Dorchester, Lexington, Richland and Sumter Counties all had rates less than 10%. The elderly utilize approximately 3 times as many health services per illness than does the younger population.

Residents of rural counties tend to have fewer years of education. Between 15-20% of rural residents have less than a 9th grade education and fewer attend college than urban residents. This is correlated with income. Persons in South Carolina with a Bachelors Degree average twice as much average annual earnings compared to people with less than a 9th grade education, while the ratio for those holding Professional or Doctorate Degrees is approximately 4:1. A greater percentage of rural residents are employed in agriculture, forestry and fishing, which tend to be low-paying professions. Many workers in these jobs also do not have health insurance.

Rural hospitals tend to be smaller than urban hospitals. Of the 30 rural hospitals in South Carolina, 5 have fewer than 50 licensed beds, 13 have between 50-99 beds, 9 between 100-149, and only 3 have more than 150 beds. Diagnostic and therapeutic technology are generally less available than at urban hospitals. For example, only 19 rural hospitals have Magnetic Resonance Imaging (MRI) services available, and almost all of these rely on mobile services which are present 1-2 days per week. Only 8 offer cardiac catheterizations, 3 have Linear Accelerators for cancer treatment, and none perform open heart surgery.

Rural counties generally have fewer physicians and other health care professionals, such as Nurse Practitioners and Phyisicans Assistants. The table on the following page lists the number of physicians practicing in rural counties in South Carolina. Recruitment of staff is often difficult because of the limited availability of resources and lower reimbursements.. The federal government

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RECORD 003446

designates underserved areas as Health Professional Shortage Areas (HPSA's). The following rural counties are currently designated as underserved:

ENTIRE COUNTY

Abbeville	Colleton	Lee
Allendale	Dillon	McCormick
Bamberg	Edgefield	Marlboro
Barnwell	Fairfield	Oconee
Calhoun	Hampton	Saluda
Chester	Jasper	Williamsburg
Clarendon		

PARTIAL COUNTY

Beaufort	Lancaster	Orangeburg
Chesterfield	Marion	Union
Darlington		

Rural hospitals typically have a higher Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. The Prospective Payment System (PPS) automatically assumes that hospitals in rural areas will not experience the labor costs for health personnel services as urban hospitals do. Therefore, the wage index component of the formula for each Diagnostic Related Group (DRG) has a smaller wage allowance for rural hospitals.

Overall, rural hospitals have smaller markets from which to attract patients, a limited local tax base, their utilization of inpatient services continues to decrease, while their patient mix is increasingly composed of the elderly, who are covered by Medicare. The lack of specialized personnel and the inability to obtain new technologies prevent rural hospitals from providing specialized services which might increase their revenue. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

In January, 1998, the Governor appointed an 18-member Health Care Advisory Committee to make recommendations to improve access to care for underserved rural areas of the state. The following 12 counties were identified as the most medically underserved: Allendale, Bamberg, Calhoun, Clarendon, Dillon, Fairfield, Hampton, Jasper, Lee, Marion, Marlboro, McCormick and Williamsburg. Among the committee's recommendations are the following:

1) Develop and submit a planning grant to the Robert Wood Johnson Southern Rural Access Program to improve access to care for Marlboro and Dillon Counties;

2) Explore the inclusion of the Volunteers in Medicine concept in the Low Country Network;

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RECORD 003447

3) Provide cultural competence training for health care providers and integrate into studentexperiences;

4) Explore the use of volunteers in locum tenens programs as preceptors to advanced local practitioners and students in training;

5) Increase the number of minority practitioners in primary care practices in rural settings; and

6) Establish a funding strategy for incentives for rural providers to work with students and participate in community projects.

CRITICAL ACCESS HOSPITALS

The federal Balanced Budget Act of 1997 created the "Medicare Rural Hospital Flexibility Program, which allows states the option of designating Critical Access Hospitals (CAH's). Participating facilities are allowed to function as facilities eligible for Medicare Part A, cost-based reimbursement, without having to meet all of the staffing criteria for full-service acute care hospitals. These rural hospitals provide outpatient and short-term inpatient hospital care on an urgent or emergency basis, then release patients or transfer them to a full-service hospital. These limited service hospitals are intended to provide essential health services to rural communities; because of the special allowances for staffing and reimbursement, converting a struggling rural hospital to a CAH can allow a community to maintain local health access which would otherwise be lost.

There are a number of criteria which must be met in order for a facility to qualify as a CAH:

1) It must be an existing Public or Not-for-Profit facility in a rural county. The program does not allow the construction of new facilities; for-profit hospitals and those located in urban counties are ineligible;

2) The facility must be part of a rural health network with at least 1 full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or be certified by the State as being a necessary provider of health care services to residents of the area;

4) The maximum number of licensed beds is 15, unless the hospital participates in the Swing-Bed Program. In this case, the facility may be licensed for up to 25 inpatient beds, but no more than 15 can be used at any one time for acute care;

5) Required services include: inpatient care, emergency care, laboratory and pharmacy;

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RECORD 003448

6) Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes;

7) The medical staff must consist of at least 1 physician. Staffing must include nursing on a 24-hour basis; other staffing can be flexible. Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists can provide inpatient care without their supervising physician(s) being on-site.

8) Patient length of stay is limited to no more than 96 hours (4 days), except under emergency conditions.

The impact of the Critical Access Hospital Program in South Carolina would essentially be a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH would not require a change in the licensing of an existng hospital. However, a hospital may be required to de-license a number of beds in order to meet the program's 15/25 bed requirement.

Based on their Average Daily Census (ADC), the following hospitals in South Carolina could potentially participate in the CAH program:

Hospital	# Acute Beds	# Swing Beds	1995 ADC	1996 ADC	1997 ADC
Abbeville Memorial	52	24	11.2	12.2	10.6
Allendale County	36	18	10.4	7.0	6.5
Barnwell County	53	22	8.8	10.1	15.0
Fairfield County	33	6	12.7	13.9	11.3
Hampton Regional	68	10	7.6	8.2	5.8
Low Country General	31	0	10.5	8.7	7.7

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 the number of licensed beds in order to meet the criteria for a CAH. Should a hospital later desire to revert back 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.

PET-EX004.0219

RECORD 003449

TOTAL NUMBER OF PHYSICIANS (FULL AND PART TIME) WORKING IN EACH COUNTY.
THE COMBINED HOURS WORKED ARE EXPRESSED AS FULL TIME EQUIVALENTS,
BASED ON A FORTY HOUR WORK WEEK.
SOUTH CAROLINA 1998

COUNTY	PHYSICIANS	FULL-TIME EQIVALENT
T O T A L	8672	6189.5
ABBEVILLE	37	25.2
AIKEN	146	131.9
ALLENDALE	16	11.9
ANDERSON	300	233.7
BAMBERG	33	20.0
BARNWELL	27	15.3
BEAUFORT	213	168.9
BERKELEY	49	36.8
CALHOUN	1	1.0
CHARLESTON	1868	1109.8
CHEROKEE	57	45.8
CHESTER	25	22.1
CHESTERFIELD	46	35.4
CLARENDON	30	24.3
COLLETON	64	43.4
DARLINGTON	86	68.1
DILLON	27	23.3
DORCHESTER	94	69.8
EDGEFIELD	17	10.5
FAIRFIELD	14	11.4
FLORENCE	378	313.9
GEORGETOWN	106	78.5
GREENVILLE	1102	795.8
GREENWOOD	190	147.6
HAMPTON	26	13.0
HORRY	360	288.2
JASPER	23	19.3
KERSHAW	74	50.5
LANCASTER	94	68.4
LAURENS	77	49.9
LEE	11	7.4
LEXINGTON	288	216.7
MCCORMICK	5	2.7
MARION	56	42.0
MARLBORO	38	26.8
NEWBERRY	58	37.2
OCONEE	89	71.5
ORANGEBURG	153	126.9
PICKENS	136	104.3
RICHLAND	1290	860.1
SALUDA	8	7.2
SPARTANBURG	517	395.9
SUMTER	124	112.5
UNION	43	29.1
WILLIAMSBURG	21	16.9
YORK	255	198.6

THIS INFORMATION IS FROM THE SOUTH CAROLINA BOARD OF EXAMINERS
RELICENSURE FILE 1998. HOURS WORKED IN EACH COUNTY ARE REPORTED
BY THE INDIVIDUAL PHYSICIAN.

PET-EX004.0220

RECORD 003450

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

Inventory of Hospital Services
Regional Need and Narrative
Regional Summary and Program
Inventory of Inpatient Facilities
Inventory of Emergency Facilities and Trauma Centers

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes which occurred since the previous plan are explained by a footnote. The number of beds existing and needed are summarized by region. The inventory of beds and facilities was current as of November 1, 1998.

PET-EX004.0221

RECORD 003451

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	MEDICAL/SURGICAL	PEDIATRIC	PSYCHIATRIC	OBSTETRIC	REHABILITATION	REHABILITATION	ALCOHOL/DRUG	ALCOHOL/DRUG	MEDICAL/SURGICAL	MEDICAL/SURGICAL	INTENSIVE CARE	CORONARY CARE	NEONATAL	INTERMEDIATE	BURN	CARDIAC CATH	OPEN HEART	ORGAN TRANSPLANT	AMBULATORY SURGICAL

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	EMERGENCY DEPT	ORGANIZED OUTPAT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THER	RADIOACTIVE IMPLANTS	THER RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
ABBEVILLE COUNTY MEMORIAL HOSP	X	X			X	X							X			X		X
AIKEN REGIONAL MED. CENTERS	X	X	X	X	X	X		X	X	X	X	X	X			X		X
ALLEN BENNETT MEMORIAL HOSPITAL	X	X			X	X						X			X			X
ALLENDALE COUNTY HOSPITAL	X					X						X			X			X
ANDERSON AREA MEDICAL CENTER	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X
ANMED-WELLSPRING		X											X	X	X	X	X	X
B J WORKMAN MEMORIAL HOSPITAL	X	X				X						X			X			
BAMBERG COUNTY MEMORIAL HOSPITAL	X				X	X						X			X			X
BARNWELL COUNTY HOSPITAL	X	X			X	X						X			X			X
BEAUFORT MEMORIAL HOSPITAL	X	X	X		X	X	X					X	X	X	X		X	X
BON SECOURS, ST. FRANCIS XAVIER	X	X	X		X	X				X		X	X	X	X	X		X
BYERLY HOSPITAL	X				X	X	X					X			X			X
CANNON MEMORIAL HOSPITAL	X	X			X	X			X						X			X
CAROLINAS HOSP SYSTEM-KINGSTREE	X	X			X	X	X								X			X
CAROLINAS HOSP SYSTEM-LAKE CITY	X	X			X	X	X					X			X			X
CAROLINAS HOSPITAL SYSTEM	X	X	X	X	X	X	X								X			X
CHARLESTON MEMORIAL HOSPITAL	X					X			X	X		X	X	X	X	X	X	X
CHARTER CHARLESTON BEHAVIORAL HLT		X										X			X			X
CHARTER GREENVILLE BEHAV HLTH		X											X	X				X
CHARTER RIVERS BEHAVIORAL HLTH		X											X					X
CHESTER COUNTY HOSPITAL	X	X			X	X							X					X
CHESTERFIELD GENERAL HOSP	X	X			X	X						X		X	X	X	X	X
CHESTNUT HILL PSYCHIATRIC HOSP		X										X				X		X
CLARENDON MEMORIAL HOSPITAL	X	X			X	X							X		X			X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003453
PET-EX004.0223

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	MEDICAL SURGICAL	PEDIATRIC	PSYCHIATRIC	OBSTETRIC	REHABILITATION	REHABILITATION	ALLERGY	ALLERGY	MEDICAL ONCOLOGY	CONVALESCENT	NEONATAL INTENSIVE CARE	INTERMEDIATE CARE	BURN CARE	CARDIAC CATHETERIZATION	OPEN HEART SURGERY	ORGAN TRANSPLANT	AMBULATORY SURGICAL
COASTAL CAROLINA HOSPITAL			X					X	X									
COLLETON MEDICAL CENTER	X	X		X	X	X				X								X
CONWAY HOSPITAL INC	X	X		X	X	X				X				X				
E A RONDEAU INST. GENERAL HOSP	X	X			X	X								X				
EAST COOPER REGIONAL MED CTR	X	X		X	X	X				X	X							X
EDGEFIELD COUNTY HOSPITAL	X	X			X	X												X
FAIRFIELD MEMORIAL HOSPITAL	X																	X
G WERBER BRYAN PSYCHIATRIC HOSP			X															
GEORGETOWN COUNTY MEMORIAL HOSP	X	X	X	X	X	X	X	X		X	X		X					X
GRAND STRAND MEDICAL CENTER	X	X		X	X					X	X			X		X		X
GREENVILLE GENERAL HOSPITAL																		
GREENVILLE MEMORIAL MED. CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X
HAMPTON REGIONAL MEDICAL CENTER	X	X																X
HEALTHSOUTH REHAB HOSP CHARLESTON						X	X											
HEALTHSOUTH REHAB HOSP COLUMBIA						X	X											
HEALTHSOUTH REHAB HOSP FLORENCE						X	X											
HILLCREST HOSPITAL	X	X				X	X				X	X						X
HILTON HEAD HOSPITAL	X	X	X	X	X	X	X				X	X			X			X
HOPE HOSPITAL	X																	
J.F. BYRNES CTR. FOR GER. MED.	X		X					X										X
KERSHAW COUNTY MEDICAL CENTER	X	X	X	X	X	X	X				X	X						X
LAURENS COUNTY HOSPITAL	X	X		X							X	X						X
LEXINGTON MEDICAL CENTER	X	X		X	X	X					X	X			X			X
LORIS COMMUNITY HOSPITAL	X	X		X		X					X	X						X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003454

PET-EX004.0224

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																												
	EMERGENCY DEPT	ORGANIZED OUTPATIENT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THER	RADIOACTIVE IMPLANTS	THERAPEUTIC RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
COASTAL CAROLINA HOSPITAL	X	X	X	X	X	X							X	X				X
COLLETON MEDICAL CENTER	X		X	X	X	X	X					X		X	X	X	X	X
CONWAY HOSPITAL INC		X										X			X	X		X
E A RONDEAU INST. GENERAL HOSP			X												X	X		X
EAST COOPER REGIONAL MED CTR	X	X			X	X	X					X	X	X	X	X	X	X
EDGEFIELD COUNTY HOSPITAL	X													X	X	X	X	X
FAIRFIELD MEMORIAL HOSPITAL	X	X			X	X						X		X	X	X	X	X
G WERBER BRYAN PSYCHIATRIC HOSP													X					X
GEORGETOWN COUNTY MEMORIAL HOSP	X	X	X		X	X						X	X	X	X	X	X	X
GRAND STRAND MEDICAL CENTER	X	X	X	X	X	X	X					X			X	X		X
GREENVILLE GENERAL HOSPITAL												X						
GREENVILLE MEMORIAL MED. CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HAMPTON REGIONAL MEDICAL CENTER	X	X	X	X	X	X						X			X	X		X
HEALTHSOUTH REHAB HOSP CHARLESTON			X											X	X	X	X	X
HEALTHSOUTH REHAB HOSP COLUMBIA			X											X	X	X	X	X
HEALTHSOUTH REHAB HOSP FLORENCE			X											X	X	X	X	X
HILLCREST HOSPITAL	X	X			X	X						X		X	X	X	X	X
HILTON HEAD HOSPITAL	X	X			X	X						X	X		X	X		X
HOPE HOSPITAL												X	X	X	X	X	X	X
J.F. BYRNES CTR. FOR GER. MED.,	X	X			X							X	X					
KERSHAW COUNTY MEDICAL CENTER	X	X	X		X	X						X			X	X		X
LAURENS COUNTY HOSPITAL	X	X		X	X	X	X			X		X		X	X	X	X	X
LEXINGTON MEDICAL CENTER	X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X
LORIS COMMUNITY HOSPITAL	X	X			X	X						X		X	X	X	X	X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003455
PET-EX004.0225

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	MEDICAL ICAL	PEDIATRIC	PSYCHIATRIC	OBSTETRICS	RESPIRATORY THERAPY	RESPIRATORY CARE	ALLERGY TESTING	ALLERGY IMMUNOTHERAPY	MEDICAL SURGICAL	CORONARY CARE	NEONATAL INTENSIVE CARE	INTERMEDIATE CARE	BURN CARE	CARDIAC CATHETERIZATION	OPEN HEART SURGERY	ORGAN TRANSPLANT	AMBULATORY SURGERY
LOW COUNTRY GENERAL HOSPITAL	X	X		X	X													X
MARION COUNTY MEDICAL CENTER	X	X		X	X				X	X								X
MARLBORO PARK HOSPITAL	X	X	X	X		X			X	X								X
MARY BLACK MEMORIAL HOSPITAL	X	X		X	X	X			X	X		X						X
MCLEOD REGIONAL MED. CTR.	X	X	X	X	X	X	X	X	X	X	X			X	X			X
MONCRIEF ARMY COMMUNITY HOSPITAL	X	X	X						X	X								X
MUSC MEDICAL CENTER	X	X	X	X	X	X			X	X	X		X	X	X	X	X	X
NAVAL HOSPITAL BEAUFORT	X	X		X						X								X
NAVAL HOSPITAL CHARLESTON	X		X			X												X
NEWBERRY COUNTY MEMORIAL HOSPITAL	X	X		X		X				X	X							X
NORTH GREENVILLE HOSPITAL	X																	
OCONEE MEMORIAL HOSPITAL	X	X		X						X	X							X
PALMETTO BAPTIST COLUMBIA	X	X	X	X	X	X	X	X	X	X	X			X				X
PALMETTO BAPTIST EASLEY	X	X		X	X	X				X	X							X
PALMETTO RICHLAND MEMORIAL HOSP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PATRICK B HARRIS PSYCHIATRIC HOSP			X						X									
PIEDMONT MED CTR-ROCK HILL	X	X	X	X					X	X	X			X				X
PROVIDENCE HOSPITAL	X					X				X	X				X	X		X
RALPH HENRY JOHNSON VETERANS MED.	X		X		X				X	X	X				X	X	X	
REGIONAL MED CTR, OBURG/CAL	X	X	X	X	X	X	X				X			X				X
ROPER HOSPITAL NORTH, INC	X	X			X	X	X	X	X		X		X					X
ROPER HOSPITAL, INC.	X	X		X	X	X	X			X	X			X		X	X	X
SAINT EUGENE COMMUNITY HOSPITAL	X	X		X	X	X				X	X			X				X
SAINT FRANCIS HOSPITAL, INC.	X	X			X	X				X	X					X		X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003456

PET-EX004.0226

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																												
	EMERGENCY DEPT	ORGANIZED OUTPATIENT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THERAPY	RADIOISOTOPE FACILITY	THERAPEUTIC RADIOLOGY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
LOW COUNTRY GENERAL HOSPITAL	X				X							X			X	X		X
MARION COUNTY MEDICAL CENTER	X	X			X	X	X					X			X	X		X
MARLBORO PARK HOSPITAL	X			X	X	X						X	X		X	X		X
MARY BLACK MEMORIAL HOSPITAL	X	X			X	X	X					X		X	X	X		X
MCLEOD REGIONAL MED. CTR.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MONCRIEF ARMY COMMUNITY HOSPITAL	X	X			X	X	X					X	X	X	X	X		X
MUSC MEDICAL CENTER		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
NAVAL HOSPITAL BEAUFORT	X		X			X						X	X	X	X	X	X	X
NAVAL HOSPITAL CHARLESTON	X				X	X	X					X	X		X	X		X
NEWBERRY COUNTY MEMORIAL HOSPITAL	X				X	X							X					
NORTH GREENVILLE HOSPITAL	X	X			X	X						X			X	X		X
OCONEE MEMORIAL HOSPITAL	X	X			X	X												
PALMETTO BAPTIST COLUMBIA	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PALMETTO BAPTIST EASLEY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PALMETTO RICHLAND MEMORIAL HOSP	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
PATRICK B HARRIS PSYCHIATRIC HOSP													X	X	X	X	X	X
PIEDMONT MED CTR-ROCK HILL	X	X	X		X	X	X						X					X
PROVIDENCE HOSPITAL	X	X	X		X	X	X					X	X	X	X	X	X	X
RALPH HENRY JOHNSON VETERANS MED.	X	X	X		X	X	X					X	X		X	X		X
REGIONAL MED CTR, OBURG/CAL	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ROPER HOSPITAL NORTH, INC	X	X			X	X						X	X		X	X	X	X
ROPER HOSPITAL, INC.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SAINT EUGENE COMMUNITY HOSPITAL	X	X			X	X						X						
SAINT FRANCIS HOSPITAL, INC.	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X

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RECORD 003457

PET-EX004.0227

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	MEDICAL/SURGICAL	PEDIATRIC	PSYCHIATRIC	OBSTETRIC	REHABILITATION	REHABILITATION	ALCOHOL/DRUG	ALCOHOL/DRUG	MEDICAL/SURGICAL	MEDICAL/SURGICAL	MEDICAL/SURGICAL	CORONARY	NEONATAL	INTERMEDIATE	BURN	CARDIAC	OPEN HEART	CARDIAC	OPEN HEART	AMBULATORY

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1997
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																												
	EMERGENCY DEPT	ORGANIZED OUTPATIENT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THER	RADIOACTIVE IMPLANTS	THERAPEUTIC RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
SC CAROLINA STATE HOSPITAL													X					X
SC VOC REHAB EVALUATION CTR																		
SELF MEMORIAL HOSPITAL	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X		X
SHRINERS HOSPITAL FOR CHILDREN		X										X	X	X	X	X		X
SPARTANBURG HOSP. FOR RESTORATIVE												X		X	X	X		X
SPARTANBURG REGIONAL MEDICAL CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
SPRINGS MEMORIAL HOSPITAL	X	X	X			X	X					X	X	X	X	X	X	X
ST FRANCIS WOMEN'S & FAMILY HOSP.	X	X				X	X					X		X	X	X		X
SUMMERVILLE MEDICAL CENTER	X	X				X	X					X		X	X	X		X
TRIDENT MEDICAL CENTER	X	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X
TUOMEY REGIONAL MEDICAL CTR	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X
UPSTATE CAROLINA MEDICAL CTR	X	X				X	X					X		X	X	X	X	X
WALLACE THOMSON HOSPITAL	X	X				X	X			X	X	X		X	X	X	X	X
WHITTEN CENTER INFIRMARY																		
WILLIAM J B DORN V A HOSPITAL	X	X	X		X	X						X	X	X	X	X	X	X
WILLIAM J MCCORD ADOLESCENT TREAT																		
WILLIAM S HALL PSYCHIATRIC INSTIT		X																
WILSON MEDICAL CENTER	X	X			X	X	X					X						X
WOMEN'S CTR OF CAROLINAS HOSP.		X				X						X		X	X	X	X	X
20TH MEDICAL GROUP (ACC)	X	X			X	X						X	X		X			X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003459

PET-EX004.0229

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR:1999

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds.

2. All changes affecting the Statewide Health Facilities have been fully annotated in the inventory.

RECORD 003460

PET-EX004.0230

REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:									
	ALLENDALE CORRECTIONAL INF		ALLENDALE	FAIRFAX	ST	10	10			
XYZ	MEDICAL UNIVERSITY HOSPITAL	1	CHARLESTON	CHARLESTON	ST	242	242		8927	59617
	TURBEVILLE CORRECTIONAL INF		CLARENDON	TURBEVILLE	ST	8	8			
	LIEBER OP CLINIC & INF		DORCHESTER	RIDGEVILLE	ST	10	10			
YZ	PEE DEE REG CTR INF		FLORENCE	FLORENCE	ST	6	6			
	PERRY CORRECTIONAL INF		GREENVILLE	PELZER	ST	20	20			
X	SHRINERS HOSPITAL CHILDREN	29	GREENVILLE	GREENVILLE	NPA	50	50		1047	7698
	RIDGELAND CORRECTIONAL INF		JASPER	RIDGELAND	ST	8	8			
XYZ	WHITTEN CTR INFIRMARY		LAURENS	CLINTON	ST	26	26		312	4753
	LEE CORRECTIONAL INS INF		LEE	BISHOPVILLE	ST	20	20			
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		295	5780
	EVANS CORRECTIONAL INF		MARLBORO	BENNETTSVILLE	ST	10	10			
	MCCORMICK OP CLINIC & INF		MCCORMICK	MCCORMICK	ST	10	10			
	COLUMBIA CARE CENTER	27	RICHLAND	COLUMBIA	PROP	326	326			
XYZ	JF BYRNES CTR FOR GERIATRIC MED, ED & RESEARCH	3	RICHLAND	COLUMBIA	ST	(66)	(208)		687	15798
YZ	E A RONDEAU MIDLANDS CTR		RICHLAND	COLUMBIA	ST	34	34		345	3432
	KIRKLAND CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	24	24			
	WOMEN'S CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	10	(10)			
	WILLOW LANE INF		RICHLAND	COLUMBIA	ST	8	8			
	CHILDREN'S HABILIATION CTR		SPARTANBURG	SPARTANBURG	ST	22	22		237	337
	TOTAL					874	864		11850	97415

RECORD 003461

PET-EX004.0231

REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	MENTAL HOSPITALS:									
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30 ANDERSON	ANDERSON	ST		162	162		2464	37601
XYZ	CRAFTS-FARROW STATE HOSPITAL	2 RICHLAND	COLUMBIA	ST		(117)	(129)	63 c		
	GILLIAM MENTAL HLTH CTR	RICHLAND	COLUMBIA	ST		87	87			
XYZ	SC STATE HOSPITAL	3 RICHLAND	COLUMBIA	ST		446	501	264 abc	275	127750
XYZ	G WERBER BRYAN PSYCHIATRIC HOSPITAL	RICHLAND	COLUMBIA	ST		288	305		4567	72560
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITUTE	4 RICHLAND	COLUMBIA	ST		215	251		1055	66396
	TOTAL					1198	1306	327	8361	304307
	RESIDENTAL TREATMENT FAC FOR CHILDREN & ADOLESCENTS:									
XYZ	DIRECTIONS WS HALL	5 RICHLAND	COLUMBIA	ST		55	37		31	1794
XY	SOUTHBRIDGE RESIDENTAL TREATMENT FACILITY	26 RICHLAND	COLUMBIA	ST		40	40			
	TOTAL					95	77		31	1794
	DRUG AND ALCOHOL IPATIENT TREATMENT:									
	EARL E. MORRIS ADA TRT CTR	RICHLAND	COLUMBIA	ST		183	183		2674	50699
	CRAFTS FARROW	2 RICHLAND	COLUMBIA	ST		(30)	(61)			
	HOMESVIEW ALCOHOLIC CTR	GREENVILLE	GREENVILLE	ST		36	36		380	8928
	PALMETTO CTR	FLORENCE	FLORENCE	ST		48	48		552	11815
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30 ANDERSON	ANDERSON	ST		44	44		427	6587
	TOTAL					311	311	0	4033	78029

RECORD 003462

PET-EX004.0232

REGION:STATEWIDE

						INPATIENT INVENTORY		OCT.1,1996-SEPT.30,1997		
					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	LONG TERM FACILITIES:									
Y	RM CAMPBELL VA NURS HM	6 ANDERSON	ANDERSON	ST		220	220		68	77724
YN	PRESTON HEALTH CENTER	7 BEAUFORT	HILTON HEAD	PROP		8	8			
Y	FRASER HEALTH CTR	BEAUFORT	HILTON HEAD	PROP		14	14			
Y	BISHOP GADSDEN EPISCOPAL HLTH CARE CTR	8 CHARLESTON	CHARLESTON	NPA		(20)	(20)			
N	BETHEA BAPTIST HM	9 DARLINGTON	DARLINGTON	NPA		62	62			
N	PRESBYTERIAN HM OF SC SUMMERVILLE	DORCHESTER	SUMMERVILLE	NPA		90	90		125	40627
N	PRESBYTERIAN HM OF SC FLORENCE	10 FLORENCE	FLORENCE	NPA		44	44		31	14450
N	METHODIST MANOR OF THE PEE DEE	11 FLORENCE	FLORENCE	NPA		22	22		13	7679
N	ROLLING GREEN VILLAGE HEALTH CARE FACILITY	GREENVILLE	GREENVILLE	NPA		44	44		32	15263
N	PRESBYTERIAN HM OF SC CLINTON	LAURENS	CLINTON	NPA		66	66		45	20943
N	MARTHA FRANK BAPTIST HM	LAURENS	LAURENS	NPA		44	44			
N	SC EPISCOPAL HM STILL HOPES	14 LEXINGTON	W COLUMBIA	NPA		42	42			
N	LAUREL CREST NURS HM	12 LEXINGTON	W COLUMBIA	NPA		12	12		14	2747
N	PRESBYTERIAN HM OF SC COLUMBIA	13 LEXINGTON	W COLUMBIA	NPA		44	44		70	14106
N	CLEMSON AREA RET CTR	15 PICKENS	CLEMSON	NPA		22	22			
APP	FOTHILLSPRESBYTERIAN HOME HEALTH CARE CENTER	28 PICKENS	EASLEY	NPA			18			
YZN	CM TUCKER JR /DOWDY GARDNER NURS CTR FEWELL & STONE PAVILIONS	23 RICHLAND	COLUMBIA	ST		252	252	229 d	155	235533
YZN	CM TUCKER JR /DOWDY GARDNER NURS CTR RODDY PAVILION	23 RICHLAND	COLUMBIA	ST		308	308			

RECORD 003463

PET-EX004.0233

REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
YZN	DOWDY GARDNER FARMER BLDG	18 RICHLAND	COLUMBIA		ST	162	198			
N	LOWMAN HOME-WC BOLICK	16 RICHLAND	WHITEROCK		NPA	47	47			
N	SKYLYN HEALTH CENTER	SPARTANBURG	SPARTANBURG		PROP	11	11			
N	CARTER NURSING CTR	17 SUMTER	SUMTER		PROP	44	44		25	3700
	TOTAL					1558	1612		578	432772
	LICENSED FACILITIES FOR HABILITATION:									
Z	WARE SHOALS HAB CTR I	ABBEVILLE	WARE SHOALS		ST	8	8		0	2920
Z	WARE SHOALS HAB CTR II	ABBEVILLE	WARE SHOALS		ST	8	8		0	2920
	ABBEVILLE CO	TOTAL				16	16		0	5840
Z	DUPONT I&II HABILITATION CTR	AIKEN	AIKEN		ST	16	16		0	5781
Z	LAURENS STREET ICF/MR	AIKEN	AIKEN		ST	8	8		0	2912
Z	LINDER STREET ICR/MR	AIKEN	AIKEN		ST	8	8		0	2920
Z	RUDNICK COMM RES	AIKEN	NORTH		ST	8	8		0	2873
Z	SANDERS COMM RES	AIKEN	NORTH		ST	8	8		0	2905
	AIKEN CO	TOTAL				48	48		0	17391
Z	ANDERSON HAB CTR	ANDERSON	ANDERSON		ST	8	8		0	2918
Z	BELTON HAB CTR	ANDERSON	BELTON		NPA	8	8		0	2878
Z	HONEA PATH HAB CTR	ANDERSON	BELTON		NPA	8	8		0	2866
	ANDERSON CO	TOTAL				24	24		0	8662
Z	HAMPTON ST COMM RES	BAMBERG	DENMARK		ST	8	8		0	2920
Z	ZEIGLER ST COMM RES	BAMBERG	BAMBERG		ST	8	8		0	2853
	BAMBERG CO	TOTAL				16	16		0	5773
Z	ACADEMY ST COMM RES	BARNWELL	BARNWELL		NPA	8	8		0	2882
Z	BLACK'S DRIVE COMM RES	BARNWELL	BARNWELL		NPA	8	8		0	2882
Z	HARLEY RD COMM RES	BARNWELL	BARNWELL		NPA	8	8		0	2882
Z	LEMON PARK COMM RES	BARNWELL	BARNWELL		NPA	8	8		0	2920
	BARNWELL CO	TOTAL				32	32		0	11566
Z	PORT ROYAL COMM RES	BEAUFORT	PORT ROYAL		ST	16	16		0	5811

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					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997	
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	BEAUFORT CO	TOTAL			16	16			5811
Z	CONIFER I&II COMM RES	BERKELEY	MONCKS CORNER	ST	16	16		0	5775
Z	DEHAY COMM RES	BERKELEY	MONCKS CORNER	ST	8	8		0	2877
	BERKELEY CO	TOTAL			24	24		0	8652
Z	FLORENCE GRESSETTE RES	CALHOUN	ST MATTHEWS	NPA	8	8		0	2897
Z	WYLIE-BRUNSON RES	CALHOUN	ST MATTHEWS	NPA	8	8		0	2897
	CALHOUN CO	TOTAL		0	16	16		0	5794
Z	CAMP ROAD COMM RES	CHARLESTON	CHARLESTON	ST	8	8		0	2748
Z	DILLS BLUFF COMM RES	CHARLESTON	CHARLESTON	ST	8	8		0	2772
Z	FARMINGTON COMM RES	CHARLESTON	CHARLESTON	ST	8	8		0	2725
Z	SECESSIONVILLE COMM RES	CHARLESTON	CHARLESTON	ST	8	8		0	2916
	CHARLESTON CO	TOTAL			32	32		0	11161
Z	JC FORT COMM RES #1	CHEROKEE	GAFFNEY	NPA	8	8		0	2830
Z	JC FORT COMM RES #2	CHEROKEE	GAFFNEY	NPA	8	8		0	2904
	CHEROKEE CO	TOTAL			16	16		0	5734
Z	CHARLES INGRAM, SR COMM RES	CHESTERFIELD	CHERAW	ST	8	8		0	2908
Z	CHESTERFIELD COMM RES	CHESTERFIELD	CHESTERFIELD	ST	8	8		0	2915
Z	PAGELAND COMM RES	CHESTERFIELD	PAGELAND	ST	8	8		0	2857
	CHESTERFIELD CO	TOTAL			24	24		0	8680
Z	VANGUARD COMM RES 1& 2	CLARENDON	MANNING	NPA	16	16		0	5838
	CLARENDON CO	TOTAL			16	16		0	5838
Z	JOSIE DRIVE COMM RES	COLLETON	WALTERBORO	ST	8	8		0	2914
Z	FOREST CIRCLE COMM RES	COLLETON	WALTERBORO	ST	8	8		0	2908
	COLLETON CO	TOTAL			16	16		0	5822
Z	JM REAGAN COMM RES	DARLINGTON	HARTSVILLE	NPA	8	8		0	2893
Z	THAD E SALEEBY DEVL CTR	DARLINGTON	HARTSVILLE	ST	96	128		0	35885
Z	WW BOWEN COMM RES	DARLINGTON	HARTSVILLE	NPA	8	8		0	2893
	DARLINGTON CO	TOTAL			112	144		0	41671
Z	DILLON COMM RES	DILLON	DILLON	ST	8	8		0	2890
	DILLON CO	TOTAL			8	8		0	2890
Z	COASTAL CTR -HIGHLAND	DORCHESTER	LADSON	ST	192	192		0	68855

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				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	& HILLSIDE								
Z	COASTAL CTR HIGHLANDS 510	DORCHESTER	LADSON	ST	18	18		0	8288
YZ	COASTAL CTR LIVE OAK VLG	DORCHESTER	SUMMERVILLE	ST	50	50		0	17599
Z	PARSONS GRP HM 1&2	DORCHESTER	SUMMERVILLE	NPA	16	16		0	5825
	DORCHESTER CO	TOTAL			276	276		0	100567
Z	EDGEFIELD COMM RES	EDGEFIELD	EDGEFIELD	ST	8	8		0	2920
	EDGEFIELD CO	TOTAL			8	8		0	2920
Z	RC BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
Z	SL BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
	FAIRFIELD CO	TOTAL			16	16		0	5840
Z	ACLINE PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	CAROLINA PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	COIT ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2919
Z	CEDARS, THE	FLORENCE	PAMPLICO	ST	8	8		0	2920
Z	FLORENCE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2557
Z	GRAHAM ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	MAGNOLIA PLACE	FLORENCE	OLANTA	ST	8	8		0	2920
Z	MULBERRY PARK 301-307	FLORENCE	FLORENCE	ST	85	112		0	34243
Z	THE OAKS	FLORENCE	TIMMONSVILLE	ST	8	8		0	2597
Z	PALMETTO PLACE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	1424
Z	PECAN LN 201-205	FLORENCE	FLORENCE	ST	120	132		0	34555
	FLORENCE CO	TOTAL			277	316		0	92895
Z	JESSAMINE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2715
Z	MARYVILLE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2909
	GEORGETOWN CO				16	16		0	5624
Z	CIVITAN COMM RES	GREENVILLE	GREENVILLE	NPA	8	8		0	2919
Z	FOUNTAIN INN COMM RES	GREENVILLE	FOUNTAIN INN	NPA	12	12		0	4258
Z	HUGHES STREET RES	GREENVILLE	FOUNTAIN INN	NPA	8	8		0	2889
Z	MARIAN PARKINS COMM RES I & II	GREENVILLE	GREENVILLE	ST	16	16		0	5831
Z	RIDGE RD RES	20 GREENVILLE	GREENVILLE	NPA	12	12		0	4380
Z	TRAVELERS REST RES	GREENVILLE	TRAVELERS REST	NPA	8	8		0	2779
	GREENVILLE CO	TOTAL			64	64		0	23056
Z	HENRY & FREIDA BONDS C RES	GREENWOOD	GREENWOOD	NPA	8	8		0	2920
Z	MARION P CARNELL HAB CTR	GREENWOOD	WARE SHOALS	ST	8	8		0	2920
Z	DR PB PRITCHARD,JR RES	GREENWOOD	GREENWOOD	ST	12	12		0	4337
Z	JF BURTON COMM RES	GREENWOOD	GREENWOOD	ST	8	8		0	2819
	GREENWOOD CO	TOTAL			36	36		0	12996

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REGION:STATEWIDE

INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	VARNVILLE COMM RES	HAMPTON	VARNVILLE	ST		8	8		0	2912
	HAMPTON CO	TOTAL				8	8		0	2912
Z	HORRY CO COMM RES	HORRY	CONWAY	ST		8	8		0	2893
Z	THE L EARGLE COMM RES	HORRY	CONWAY	ST		8	8		0	2877
	HORRY CO	TOTAL				16	16		0	5770
Z	CAMDEN I GRP HM	KERSHAW	CAMDEN	NPA		8	8		0	2912
Z	CAMDEN II GRP HM	KERSHAW	CAMDEN	NPA		8	8		0	2913
	KERSHAW CO	TOTAL				16	16		0	5825
Z	NJ MCCONNELL HM	LANCASTER	LANCASTER	ST		8	8		0	2873
Z	TOM MANGUM HM	LANCASTER	LANCASTER	ST		8	8		0	2886
	LANCASTER CO	TOTAL				16	16		0	5759
Z	CLINTON MANOR COMM RES	LAURENS	CLINTON	CO		8	8		0	2863
Z	DAVIDSON ST COMM RES	LAURENS	CLINTON	CO		8	8		0	2920
Z	MILL ST COMM RES	LAURENS	CLINTON	CO		8	8		0	2920
Z	S HARPER ST COMM RES	LAURENS	CLINTON	ST		8	8		0	2879
Z	SULLIVAN ST COMM RES	LAURENS	LAURENS	CO		8	8		0	2876
Z	OAKGROVE COMM RES	LAURENS	CLINTON	ST		8	8		0	2818
YZ	WHITTEN CTR CTL SQ 201-205	LAURENS	CLINTON	ST		143	143		0	
Z	WHITTEN CTR CAMPUS UNITS 101-110	LAURENS	CLINTON	ST		180	180		0	
Z	WHITTEN CTR WEBB 401-404 21	LAURENS	CLINTON	ST		156	174		0	
Z	WHITTEN CTR SUBER 301-303 22	LAURENS	CLINTON	ST		68	136		0	
	WHITTEN CTR TOTAL:								0	202945
	LAURENS CO	TOTAL				595	681		0	220221
Z	MCLEOD GRP HM 1 & II	LEE	BISHOPVILLE	NPA		16	16		0	5676
	LEE CO	TOTAL				16	16		0	5676
Z	B SMITH RD GRP HM	LEXINGTON	LEXINGTON	NPA		8	8		0	2920
Z	BATESBURG GROUP HM	LEXINGTON	BATESBURG	NPA		8	8		0	2920
Z	CLUSTER OF LEXINGTON A	LEXINGTON	LEXINGTON	NPA		8	8		0	17517
Z	CLUSTER OF LEXINGTON B	LEXINGTON	LEXINGTON	NPA		8	8			
Z	CLUSTER OF LEXINGTON C	LEXINGTON	LEXINGTON	NPA		8	8			
Z	CLUSTER OF LEXINGTON D	LEXINGTON	LEXINGTON	NPA		8	8			
Z	CLUSTER OF LEXINGTON E	LEXINGTON	LEXINGTON	NPA		8	8			
Z	CLUSTER OF LEXINGTON F	LEXINGTON	LEXINGTON	NPA		8	8			
Z	EAST HARTLEY HAB CTR	LEXINGTON	BATESBURG	NPA		4	4		0	1083
Z	HENDRIX ST GRP HM	LEXINGTON	LEXINGTON	NPA		8	8		0	2920
Z	KITTY WAKE HAB CTR	LEXINGTON	LEXINGTON	NPA		4	4		0	1083
Z	LEANING PINES TRAIL ICF/MR	LEXINGTON	LEXINGTON	NPA		4	4		0	1083
Z	NAZARETH ROAD COMM RES	LEXINGTON	LEXINGTON	NPA		8	8		0	2920

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	PEACHTREE HAB CTR	LEXINGTON	BATESBURG	NPA	4	4		0	1082
Z	WIRE RD I&II	LEXINGTON	GILBERT	NPA	16	16		0	5840
	LEXINGTON CO	TOTAL			112	112		0	39368
Z	JENNINGS MCABEE COMM	MCCORMICK	MCCORMICK	ST	8	8		0	2920
	MCCORMICK CO	TOTAL			8	8		0	2920
Z	ES HUNTER COMM RES	NEWBERRY	NEWBERRY	NPA	12	12		0	4172
Z	HA MCCULLOUGH COMM RES	NEWBERRY	NEWBERRY	NPA	12	12		0	4162
	NEWBERRY CO	TOTAL			24	24		0	8334
Z	OCONEE COMM RES#1	OCONEE	SENECA	ST	16	16		0	5810
Z	OCONEE COMM RES #2	OCONEE	SENECA	ST	8	8		0	2920
	OCONEE CO	TOTAL			24	24		0	8730
Z	NANCE COMM RES	ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	KINGS COMM RES	ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	SIFLY ST COMM RES	ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
Z	WANNAMAKER ST COMM RES	ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
	ORANGEBURG CO	TOTAL			32	32		0	11680
Z	EASLEY COMM RES I&II	PICKENS	EASLEY	ST	16	16		0	5715
	PICKENS CO	TOTAL			16	16		0	5715
Z	ARCHIE DRIVE GRP HM	RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	BAY SPRINGS HAB CTR	RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	CARTER ST GRP HM	RICHLAND	COLUMBIA	NPA	8	8		0	2920
YZN	CRAFTS-FARROW ST HOSP ICF/MR BLDG 16	RICHLAND	COLUMBIA	ST	80	80		0	36496
Z	FIRST MIDLANDS ICF-MR	25 RICHLAND	COLUMBIA	ST	344	344		0	43955
Z	HORRELL HILL COMM RES	RICHLAND	EASTEROVER	NPA	8	8		0	2920
Z	IDA LANE I&II COMM RES	RICHLAND	COLUMBIA	NPA	16	16		0	5839
Z	KENSINGTON GRP HM 1	RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	KENSINGTON GRP HM 2	RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	NORTH PINES COMM RES	RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	PINE LAKE ICF-MR	RICHLAND	COLUMBIA	NPA	44	44		0	16060
Z	RABBIT RUN	RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	SECOND MIDLANDS	RICHLAND	COLUMBIA	ST	20	20		0	21203
Z	SUNVIEW CIRCLE HAB CTR	RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	WILSON BLVD COMM RES I&II	RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	WOODLAWN AV GRP HM	RICHLAND	COLUMBIA	NPA	8	8		0	2917
	RICHLAND CO	TOTAL			584	584		0	152750

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REGION:STATEWIDE

INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	BENCHMARK-SPGT	SPARTANBURG	SPARTANBURG	NPA	12	12		0	4351
Z	BENCHMARK HM-COWPENS	SPARTANBURG	COWPENS	NPA	12	12		0	4378
Z	LANDRUM COMM RES I&II	SPARTANBURG	LANDRUM	ST	16	16		0	5597
Z	JD FERGUSON COMM RES I&II	SPARTANBURG	SPARTANBURG	ST	8	16		0	5613
Z	SPARTANBURG COMM RES I&II	SPARTANBURG	SPARTANBURG	NPA	16	16		0	5713
	SPARTANBURG CO	TOTAL			64	72		0	25652
Z	ATKINSON W&E GRP HM	SUMTER	SUMTER	NPA	18	18		0	6486
Z	THOMAS DR COMM RES	SUMTER	SUMTER	ST	8	8		0	2885
	SUMTER CO	TOTAL			26	26		0	9371
Z	WEST MAIN ST COMM RES	UNION	UNION	ST	8	8		0	2798
	UNION CO	TOTAL			8	8		0	2798
Z	BIRD ST HAB CTR I&II	YORK	ROCK HILL	ST	16	16		0	5693
	YORK CO	TOTAL			16	16		0	5693
	TOTAL				2578	2743		0	947283

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FOOTNOTES

REGION: STATEWIDE FY 99 PLAN

CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved
NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. Beds, admissions, and patient days allocated based on patient origin.
2. Licensed beds reduced from 629 to 519, 2/1/94. Licensed beds increased from 519 to 549 with closure of 30 licensed D&A beds, 3/1/95. Licensed beds reduced from 549 to 300, 3/1/96. Facility closed 6/30/96.
3. Licensed beds reduced from 450 to 350 3/1/95. Licensed beds increased from 350 to 400, 3/1/96. Licensed beds increased by 15 from 400 to 415, 11/18/97. Licensed beds at JF Byrnes closed & State licensed for 446 beds(424 psy & 22 instit general inf), 7/8/99.
4. Licensed beds reduced from 233 to 220, 9/11/94. Licensed beds increased from 220 to 236, 3/1/95. Temporary licensure of 18 acute beds to adol/child residential care beds, E-95-130, 11/22/95. Licensed beds increased from 236 to 239, 3/1/96. Conversion of 24 psy beds to 24 adolescent res care beds for 215 psy & 55 arc beds, 11/8/96. Licensed beds decreased from 239 to 215,3/14/97. Licensed beds at Hall increased from 215 to 232, 2/9/99 before the the exemption was issued. E=99-25 to increase licensed beds from 215 to 232 & to reduce licensed beds from 55 to 37 at Directions, 4/21/99. Beds at Hall to increase from 232 to 235, 7/28/99 e-99-43. Licensed beds at Hall to increase by 16 from 235 to 251, 8/12/99 e-99-48.
5. Exemption to add a 13 bed RTF for Children and Adolescents with a 13 bed reduction in psy beds, 6/10/93. Licensed for 13 RTF beds, 3/11/94. Licensed beds increased from 13 to 31 by E-95-130 on 12/15/95.Exp to increase beds from 31 to 55, 11/8/96. See #4. Licensed beds increased from 31 to 55, 3/14/97.
6. Licensed beds increased from 88 to 132, 10/12/92. Licensed beds increased from 132 to 176, 7/7/93. Licensed beds increased from 176 to 220, 1/3/94. E-99-25 to increase the licensed beds at Hall from 215 to 232 & reduce the licensed beds at Directions from 55 to 37, 4/21/99. See fn#4.
7. CON issued for 44 dual beds (36 community and 8 restricted), 8/28/89. Facility licensed for 36 comm and 8 restricted beds with name change from Cypress of Hilton Head, 4/7/92.
8. CON issued for 20 dual facility which does not provide a community service, 2/27/89. Facility licensed for 20

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beds, 4/29/92. CON issued to convert 20 non-comm beds to comm for a total of 44 beds, 6/7/94. Licensed for 44 comm beds, 10/8/94.

9. CON issued to convert 6 non-comm beds to comm for a total of 62 non-comm & 26 comm, 10/11/94. Licensed for 62 non-comm and 26 comm, 1/1/95.
10. CON issued for 19 additional non-community LTC beds for a total of 44 beds, 12/16/92. Licensed for 44 beds, 4/20/94.
11. CON issued for 22 bed restricted nurs hm, 8/4/92. Facility licensed for 22 beds, 9/23/92. Con issued for 10 add non-comm beds for a total of 32, sc99-07 2/16/99.
12. CON issued for 12 beds restricted nurs. hm., 2/10/93. Licensed 9/16/94.
13. CON issued for 22 additional restricted beds for a total of 44, 1/8/93. Licensed beds increased from 22 to 44, 1/14/94.
14. Approved to convert 8 non-comm beds to comm for a total of 36 non-comm & 8 comm, 10/18/94. Licensed for 36 non-comm and 8 comm, 12/1/94. CON for 22 addditional non-comm beds for a total of 58 non-comm & 8 comm, 12/19/95. Licensed for 58 non-comm beds & 8 comm beds, 3/17/97. Facility licensed for 46 institutional & 20 comm nurs hm beds, 1/1/99. Facility non-comm beds reduced from 46 to 44, e-99-41, 7/15/99.
15. CON issued for 8 non-com beds & the conversion of 14 comm to non-comm for a total of 52 beds (30 comm & 22 non-comm), 8/9/94. Licensed for 30 comm and 22 non-comm, 2/20/95.
16. CON issued for 47 restricted beds and 85 replacement beds, 4/27/90. Licensed for 47 beds, 3/31/93.
17. CON issued for 22 restricted beds, 5/19/93. Licensed for 22 nurs hm beds, 5/11/94. CON issued for 22 additional restricted beds for a total of 44 nurs hm beds, 6/7/96. Licensed for 44 nurs beds, 6/1/97.
18. Beds reduced from 176 to 132, 2/1/95. Exp to transfer 32 beds from D&G Rock Hill 10/7/96. Facility licensed for 162 beds, 11/6/96. Reduced the survey beds at DG Farmer by 44 from 198 to 146 & licensed for 132, e-99-56, 10/1/99.
19. CON issued 3/14/94. Licensed 5/17/95.
20. Licensed beds changed from 16 to 12, 10/1/96.
21. Beds reduced from 174 to 168, 8/1/95
22. Beds reduced from 136 to 117, 8/1/95.
23. Beds increased from 440 to 572, 7/18/95. Licensed as two facilities one for 264 & the other for 308, 7/1/97. Facility beds reduced by 12 from 264 to 252, 5/18/98.
24. No footnote 24.
25. Licensed beds increased from 332 to 344, 6/1/96.
26. Exemption for a 40 bed rtf, 2/9/98. Facility licensed for 40 rtf beds, 2/11/98.
27. Facility licensed as a 326 Institutional General Inf., 9/2/98.
28. Con issued for 18 bed non community nurs home, 1/25/99 SC-99-03,.
29. Exp #e99-09 to reduce beds from 60 to 50, 3/11/98. Facility licensed for 50 beds, 3/1/99.
30. Licensed beds changed for psy from 184 to 162 and D&A from 22 to 44, 2/3/99.

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REGION NARRATIVE

REGION: I FISCAL YEAR:1999

1. Unusual Characteristics: There are no unusual characteristics such as military bases with associated dependents, nor barriers to transportation and communications in this region.

2. General Hospitals: W.J. Barge Hospital is a restricted use facility. There is no need for additional hospital beds in this region.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in five facilities in this region and long term psychiatric beds available at Chestnut Hill in Greenville County. There is no need for additional psychiatric beds in this region.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There is a need for inpatient treatment beds in the Spartanburg, Cherokee, and Union Counties area.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES			NUMBER OF BEDS	
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
HOSPITALS:					
ANDERSON	1	0	322	495	-173
CHEROKEE	1	0	62	125	-63
GREENVILLE	6	0	928	1015	-87
OCONEE	1	0	119	160	-41
PICKENS	2	0	94	151	-57
SPARTANBURG	4	0	572	848	-276
UNION	2	1	75	157	-82
TOTALS:	17	1	2172	2951	-779
LTC:					
ANDERSON	6	2	901	794	107
CHEROKEE	2	0	265	217	48
GREENVILLE	17	5	1825	1701	124
OCONEE	2	0	355	211	144
PICKENS	7	4	495	424	71
SPARTANBURG	13	1	1365	1198	167
UNION	2	0	195	196	-1
TOTALS:	49	12	5401	4741	661

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REGION:I

						INPATIENT INVENTORY				OCT.1,1996-SEPT.30,1997		
					CON-	LICENSED	SURVEY	NONCON		ADMIS	PATIENT	% OCCU
	HOSPITALS:											
XYZ	ANDERSON AREA MEDICAL CTR	28	ANDERSON	ANDERSON	NPA	495	495			16742	89464	47.0%
	ANDERSON CO.		TOTAL			495	495			16742	89464	47.0%
XYZ	UPSTATE CAROLINA MED CTR		CHEROKEE	GAFFNEY	PROP	125	125			3323	15178	33.3%
	CHEROKEE CO.		TOTAL			125	125			3323	15178	33.3%
XYZ	ALLEN BENNETT MEM	1	GREENVILLE	GREER	NPA	58	58			2970	12836	60.6%
XYZ	GREENVILLE GEN.	29	GREENVILLE	GREENVILLE	NPA	(75)	(75)			0	0	0.0%
XYZ	GREENVILLE MEM.MEDICAL CTR.	1	GREENVILLE	GREENVILLE	NPA	628	628			29481	167232	73.0%
XYZ	HILLCREST		GREENVILLE	SIMPSONVILLE	NPA	56	56			1174	5865	28.7%
XYZ	NORTH GREENVILLE	2	GREENVILLE	TRAVELERS REST	NPA	5	5			0	0	0.0%
	(W.J. BARGE)	3	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(90)	(3)	c	(1402)	(3087)	
XYZ	SAINT FRANCIS HOSP.	21	GREENVILLE	GREENVILLE	NPA	206	206			8788	52298	65.7%
XYZ	SAINT FRANCIS WOMAN'S AND FAMILY HOSPITAL	21	GREENVILLE	GREENVILLE	NPA	62	62			3036	7901	43.3%
	GREENVILLE CO.		TOTAL			1015	1015			45448	246132	61.9%
XYZ	OCONEE MEM		OCONEE	SENECA	NPA	160	160			6658	28626	49.0%
	OCONEE CO.					160	160			6658	28626	49.0%
XYZ	PALMETTO BAPTIST MED CTR-EASLEY	17	PICKENS	EASLEY	NPA	96	96			3878	17013	48.6%
XYZ	CANNON MEM.		PICKENS	PICKENS	NPA	55	55			1040	5039	25.1%
	PICKENS CO.		TOTAL			151	151			4918	22052	40.0%
XYZ	B.J. WORKMAN MEM.		SPARTANBURG	WOODRUFF	CO	43	43			765	3254	20.7%
XYZ	SPGT HOSP RESTORATIVE CARE	4	SPARTANBURG	SPARTANBURG	CO	97	97			228	6262	17.7%
XYZ	MARY BLACK MEM.	22	SPARTANBURG	SPARTANBURG	PROP	176	176			7044	32370	45.1%
XYZ	SPARTANBURG REG. MED.CTR.		SPARTANBURG	SPARTANBURG	CO	532	532			21624	108840	56.1%
	SPARTANBURG CO.		TOTAL			848	848			29661	150726	47.5%
	HOPE HOSP.		UNION	LOCKHART	CO	16	14	7	cd	134	946	16.2%
XYZ	WALLACE THOMSON		UNION	UNION	DIST	143	143	6	c	3695	18009	34.5%
	UNION CO.		TOTAL			159	167	13		3829	18955	32.7%
	TOTAL					2953	2951	13		110579	571133	50.9%
	MENTAL FACILITIES:											
XYZ	ANDERSON AREA MEDICAL CTR		ANDERSON	ANDERSON	NPA	38	38			695	6044	43.6%
	ANDERSON CO.		TOTAL			38	38			695	6044	43.6%
YZ	CHARTER GREENVILLE BEHAVIORAL HEALTH SYSTEM	5	GREENVILLE	GREENVILLE	PROP	45	53			1619	13429	81.8%
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6	GREENVILLE	TRAVELERS REST	PROP	44	44			198	3582	
XYZ	GREENVILLE MEM.MEDICAL CTR.	2	GREENVILLE	GREENVILLE	NPA	72	72			1656	14067	53.5%
	GREENVILLE CO.		TOTAL			161	169			3373	31078	72.8%

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REGION:I

INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
XYZ	MARY BLACK MEM.	22 SPARTANBURG	SPARTANBURG	PROP		15	15				
XYZ	SPARTANBURG REG. MED. CTR.	SPARTANBURG	SPARTANBURG	CO		56	56		1154	9084	
	SPARTANBURG CO.	TOTAL				71	71		1154	9084	
	TOTAL					270	278		5222	46206	
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:										
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6 GREENVILLE	TRAVELERS REST	PROP		44	44				0.0%
YZ	MARSHALL I. PICKENS CHILDREN'S PROGRAM	7 GREENVILLE	GREENVILLE	NPA		22	22		40	6757	84.1%
	GREENVILLE CO.	TOTAL				66	66		40	6757	28.0%
	DRUG AND ALCOHOL INPATIENT TREATMENT:										
YZ	ANMED-WELLSPRING	ANDERSON	WILLIAMSON	NPA		27	27		383	2673	27.1%
YZ	CHARTER HOSP. GREENVILLE	5 GREENVILLE	GREENVILLE	PROP		21	13		489	3857	50.3%
	GREENVILLE MEM.MEDICAL CTR.	2 GREENVILLE	GREENVILLE	NPA		18	(18)		327	1233	18.8%
	GREENVILLE CO.	TOTAL				66	40		1199	7763	32.2%
	REHABILITATION FACILITIES:										
XYZ	GREENVILLE GEN.	29 GREENVILLE	GREENVILLE	NPA		(14)	(11)				0.0%
XYZ	GREENVILLE MEM.MEDICAL CTR.	8 GREENVILLE	GREENVILLE	NPA		53	53		668	13187	72.3%
XYZ	SAINT FRANCIS HOSP.	GREENVILLE	GREENVILLE	NPA		19	19		424	5347	77.1%
	GREENVILLE CO.	TOTAL				72	72		1092	18534	61.2%
XYZ	MARY BLACK MEM.HOSP	SPARTANBURG	SPARTANBURG	PROP		18	18		303	5343	81.3%
	SPARTANBURG CO					18	18		303	5343	81.3%
	LONG TERM CARE FACILITIES:										
APP	ANDERSON MED CTR SUBACTUE	28 ANDERSON	ANDERSON	NPA		27	27				
YZ	ANDERSON PLACE	ANDERSON	ANDERSON	PROP		44	44		37	11555	71.9%
YZ	BROOKSIDE NURSING CTR	ANDERSON	ANDERSON	PROP		88	88	19 c	123	31142	97.0%
YZ	ELLENBURG NURS CTR	9 ANDERSON	ANDERSON	PROP		181	181		119	64637	97.8%
YZ	CALLIE & JOHN RAINEY HOSPICE HOUSE	18 ANDERSON	ANDERSON	NPA		16	16				
YZ	NHC HEALTHCARE ANDERSON	ANDERSON	ANDERSON	PROP		290	290		310	104163	98.4%
	(NHC HEALTHCARE EDGEBROOK)	25 ANDERSON	ANDERSON	PROP			(112)				
YZ	RIVERSIDE NURSING CTR	ANDERSON	ANDERSON	PROP		88	88		107	31242	97.3%
ZI	WILLOW CREEK NURS CTR	10 ANDERSON	IVA	PROP		60	60	(16) cd	82	20440	93.3%
	ANDERSON CO	TOTAL				767	794	19	778	263179	94.0%
YZ	BROOKVIEW HLTHCARE CTR	CHEROKEE	GAFFNEY	PROP		132	132		98	45476	94.4%
YZ	CHEROKEE CO. LTC	11 CHEROKEE	GAFFNEY	CO		85	85		47	30966	99.8%

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REGION:I

					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	CHEROKEE CO	TOTAL			217	217		145	76444	96.5%
Z	ALLEN BENNETT NURS HM 1	GREENVILLE	GREER	NPA	10	10		183	2783	76.2%
YZ	BRIARWOOD NURSING CTR	GREENVILLE	SIMPSONVILLE	PROP	42	39		12	14114	92.1%
CON	BRIGHTON GARDENS 27	GREENVILLE	GREENVILLE	PROP		45				
CON	(BROOKSTONE TERRACE NURS HM) 12	GREENVILLE	GREENVILLE	PROP		(44)				
Z	FOUNTAIN INN NURS HM	GREENVILLE	FOUNTAIN INN	PROP	44	44	26 cd	13	15813	98.5%
YZ	GRADY H HIPP NURS CTR	GREENVILLE	GREENVILLE	CO	112	112		56	40827	99.4%
CON	NHC CENTER OF MAUDLIN 13	GREENVILLE	MAULDIN	PROP	120	120				
YZ	GREENVILLE NURSING CTR	GREENVILLE	GREENVILLE	PROP	79	79	18 d	43	28313	98.2%
NHM	GREENVILLE MEM CTR 1 SUBACUTE UNIT	GREENVILLE	GREENVILLE	NPA	48	48		746	12378	70.7%
YZ	MAGNOLIA MANOR-GREENVILLE 23	GREENVILLE	GREENVILLE	PROP	88	88	25 d	132	46026	97.8%
YZ	MAGNOLIA PLACE-GREENVILLE 23	GREENVILLE	GREENVILLE	PROP	120	120				
Y	NHC CENTER GREENVILLE	GREENVILLE	GREER	PROP	176	176		149	63475	98.8%
YZ	OAKMONT EAST NURS CTR	GREENVILLE	GREENVILLE	PROP	132	132		157	45834	95.1%
Z	OAKMONT WEST	GREENVILLE	GREENVILLE	PROP	125	125		109	43128	94.5%
Z	PIEDMONT LUTHERAN HOME	GREENVILLE	GREER	PROP	132	132		78	39816	82.6%
YZ	ROGER HUNTINGTON NURS CTR	GREENVILLE	GREENVILLE	NPA	88	88	12 c	85	31810	99.0%
YZ	ST FRANCIS TRANSITIONAL CARE TRANSITONAL CARE UNIT	GREENVILLE	GREENVILLE	NPA	32	32		768	10668	91.3%
YZ	SUMMIT PLACE	GREENVILLE	SIMPSONVILLE	PROP	132	132		109	45484	94.4%
Z	STROUD NURS HOME	GREENVILLE	MARIETTA	NPA	44	44	1 c	24	15133	94.2%
YZ	WESTSIDE NURS CTR	GREENVILLE	GREENVILLE	PROP	132	132		112	46311	96.1%
	GREENVILLE CO	TOTAL			1656	1698	82	2776	501713	94.3%
YZ	LILA DOYLE NURS CARE	OCONEE	SENECA	CO	79	79		231	27015	93.7%
YZ	MARINER HLTH CARE OF SENECA	OCONEE	SENECA	PROP	132	132		132	46720	97.0%
	OCONEE CO	TOTAL			211	211		363	73735	95.7%
Z	BLUE RIDGE NURS CTR	PICKENS	EASLEY	PROP	66	66	33 d	32	23726	98.5%
Y	CLEMSON AREA RET CTR 14	PICKENS	CLEMSON	PROP	30	30		40	17558	92.5%
NHM	COUNTRYSIDE CARE CTR	PICKENS	EASLEY	PROP	44	44		48	11008	68.5%
YZ	EASLEY NURS CTR	PICKENS	EASLEY	PROP	103	100	50 d	77	35918	95.5%
Z	HARVEY'S NURSING HOME 24	PICKENS	SIX MILE	PROP	44	41	27 cd	37	14377	98.5%
YZ	LAUREL HILL	PICKENS	PICKENS	PROP	80	80		67	28591	97.9%
Z	ROSEMOND NURSING CTR 20	PICKENS	PICKENS	PROP	44	44	22 d	16	15929	99.2%
Y	PALMETTO MEDICAL CTR-EASLEY 17 TRANSITIONAL CARE FACILITY	PICKENS	EASLEY	NPA	13	13		204	2096	44.2%
	PICKENS CO	TOTAL			424	418	132	521	149203	92.5%
Z	CAMP CARE	SPARTANBURG	INMAN	PROP	88	88		40	31679	98.8%
YZ	(SPGT HOSP RESTORATIVE CARE SNF) 4	SPARTANBURG	SPARTANBURG	CO	11	(11)				
Z	GOLDEN AGES-INMAN	SPARTANBURG	INMAN	PROP	44	44		9	15914	99.1%
YZ	INMAN HEALTHCARE	SPARTANBURG	INMAN	PROP	40	35		16	14401	98.6%
YZ	MAGNOLIA MANOR/INMAN	SPARTANBURG	INMAN	PROP	176	176		91	63342	98.6%
YZ	MAGNOLIA MANOR-SPGT	SPARTANBURG	SPARTANBURG	PROP	95	89	62 ad	62	34129	98.4%
YZ	MAGNOLIA PLACE-SPGT	SPARTANBURG	SPARTANBURG	PROP	88	88		67	31560	98.2%
CON	MARY BLACK MEM HOSP-SNF 22	SPARTANBURG	SPARTANBURG	PROP	20	20		316	3967	81.7%
YZ	MOUNTAINVIEW NURS HM	SPARTANBURG	SPARTANBURG	CO	132	132		36	48083	99.8%
YZ	SKYLYN PLACE HEALTH CTR 15	SPARTANBURG	SPARTANBURG	PROP	33	33		188	13984	87.1%
APP	SPARTANBURG REG MED CTR-SNF 4	SPARTANBURG	SPARTANBURG	CO		26				
YZ	VALLEY FALLS TERRACE	SPARTANBURG	SPARTANBURG	PROP	88	88		27	32025	99.7%
YZ	WHITE OAK MANOR-SPARTANBURG	SPARTANBURG	SPARTANBURG	PROP	192	192		123	69054	98.5%
Y	WHITE OAK ESTATES	SPARTANBURG	SPARTANBURG	PROP	88	88		107	31491	98.0%
YZ	WOODRUFF HLTH CARE CTR	SPARTANBURG	WOODRUFF	PROP	88	88		29	32012	99.7%

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REGION:I

					INPATIENT INVENTORY				OCT.1,1996-SEPT.30,1997		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	SPARTANBURG CO	TOTAL			1183	1187	62	1109	421631	98.2%
YZD	ELLEN SAGAR	16 UNION	UNION	CO	108	108		143	36916	102.2%
YZD	OAKMONT OF UNION	UNION	UNION	PROP	88	88		110	30597	95.3%
	UNION CO	TOTAL			196	196		253	67513	98.9%
	TOTAL				4654	4721	295	5946	1553418	95.6%

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CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued to convert 17 general beds to 13 LTC beds at Allen Bennett Mem., to convert 34 general beds to 32 LTC beds and add 16 LTC beds in the Rehab Unit, resulting in 53 general beds & 13 LTC beds at Allen Bennett and 628 general beds, 72 psych., 50 rehab., 18 substance abuse an 48 LTC beds at Greenville Mem., 9/23/94. Greenville Mem licensed for 48 Nur Hm and Gen Mem licensed reduced from 662 to 628; 10/31/95. CON for Allen Bennett modified to conversion of 12 hosp beds to 10 nurs hm beds, 9/21/95. Allen Bennett licensed for 10 nurs hm & 58 general beds, 1/2/96.
2. Facility is licensed for 53 beds (5 acute, 48 inpatient treatment beds). CON issued to delicense 30 inpatient treatment beds from NGH, 18 psy beds from GMEM and transfer 18 inpat beds from NGH to GMEM resulting in 5 acute beds at NGH and 72 psy, 18 inpat treat beds to GMEM with 16 RT beds for children at MIP, 4/25/94. Facility licensed for only 5 general beds, 6/9/94. 18 inpat treatment beds closed by e-99-59, 10/22/99.
3. Facility use restricted to students.
4. Name changed from Doctors Mem., 10/1/95. Con issued to transfer the 11 nurs hm beds plus additional 15 new non-medicaid beds for a 26 nurs hm beds at Spart Reg Med Ctr, 8/28/98.
5. CON issued to convert 14 inpat treatment beds to 14 crisis beds resulting in 21 inpat treat beds, 25 psy beds and 14 crisis beds (psy), 3/28/94. Facility licensed for 21 treatment beds, 3/29/94. Licensed for 45 psy(31 psy & 14 crisis beds) and 21 d&a beds, 5/10/95. Con issued to convert 8 of the 21 D&A beds to psy for a total of 53 psy (39 psy & 14 crisis beds) & 13 D&A beds, 07/14/99.
6. Facility is licensed for 44 long term care psychiatric beds and 44 RTC beds.
7. CON issued for 16 RTF beds, 1/10/92. Facility licensed for 16 RTF beds, 4/1/93. CON issue for 6 additional beds for a total of 22 rtf beds, 10/16/95. Facility licensed for 22 rtf beds, 10/22/95.

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8. Exemption for relocation of the inpatient component of the Pain Therapy Center at Greenville General to Greenville Mem., 5/12/94. The licensed 14 rehab beds at Greenville Gen. are restricted to Pain Therapy only by CON SC F-749 issued 11/7/84. Con issued to transfer 3 rehab beds from general to Memorial resulting in 11 rehab at general & 53 rehab beds at memorial, 4/13/98. GMH licensed for 53 rehab beds, 2/2/99.
9. CON issued to convert 5 private beds to semi for total of 181 beds, 3/19/93. Licensed for 181 beds 4/20/93.
10. CON issued for a 34 bed addition for a total of 60 beds, 4/12/93. Name changed from Golden Acres Nurs Fac.
11. CON issued for 32 dual Medicaid beds 6/15/90. Facility licensed for 76 beds, 1/25/93. CON issued for 9 additional non-Medicaid beds for a total of 85 beds, 9/12/94. Facility licensed for 85 beds, 8/16/94.
12. CON issued for 44 non-Medicaid LTC beds 5/13/94. Void 5/10/95.
13. CON issued for 81 non-medicaid LTC beds, 3/8/95. CON issued to increase LTC beds by 39 for a total of 120 non-medicaid beds & name change from Greenville HealthCare Ctr, 2/9/96. Facility licensed for 120 beds 10/20/97.
14. CON issued for 8 non-community beds, with conversion of 14 community beds to non-comm with a total of 52 beds (30 community and 22 non-comm), 8/9/94. Facility licensed for 52 beds (30 comm & 22 non-comm), 2/20/95.
15. Facility licensed for 44 bed (33 comm. and 11 non-comm beds), 8/1/90. Additon of 4 private rooms without any change of licensed beds (11 non-comm & 33 comm) of 44, exmpt # E-96-02, 1/10/96.
16. CON issued for 11 additional beds for a total of 106, 9/28/95.Facility licensed beds increased by 4 from 95 to 99 beds 10/1/96. Licensed beds increased by 7 from 99 to 106, 2/12/97. CON for 2 addtional beds for a total of 108, 8/1/97. Licensed beds increased from 106 to 108,8/26/97.
17. CON issued for conversion of 13 hosp beds to 13 nurs hm beds, 9/25/95. Facility licensed hosp beds reduced from 109 to 96 with 13 nurs hm beds licensed, 3/20/96.
18. CON issued for 16 nurs hm beds, 9/22/95. facility licensed for 16 nurs hm beds, 7/15/98.
19. App to added an ER , mobile MRI & add 12 general beds to SF Women's Hosp for a total of 62 general beds at SF Woman's Hosp & 206 general beds at SF Hosp, 12/14/95.
20. Formerly Jonathan's Nursing Ctr.
21. CON issued to expanded SFW w/ addition of a er, expansion of surgery, ect & the transfer of 12 general beds from SFH to SFW for 62 general beds & SFH w/ 206 general, 19 rehab & 32 nurs hm bds; provision of mobile MRI services at both hospitals, 2/21/96. SFH licensed beds decreased by 12 from 218 to 206 & SFWF increased by 12 from 50 to 62, 9/30/97.
22. CON issued to convert 10 general beds to 20 nursing home beds for a total of 198 general beds , 18 rehab & 20 nurs hm beds, 8/26/96. Facility licensed general beds reduced from 208 to 198 & licensed for 20 nurs hm beds, 1/31/97.CON issued to convert 22 general beds to 15 psy with 176 general 18 rehab & 20 nurs hm beds,1/27/97. Facility licensed for the 15 psy beds & a reduction of general beds from 198 to 176,6/18/97.
23. CON to transfer 41 beds from the licensed 129 resulting in 88 at Magnolia Manor & construtión of a new facility Magnolia Place for 88 beds (41+47 non-medicaid beds), 12/2/96. Con issued for additional 32 beds non-medicaid beds

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at Magnolia Place for a total of 120 nurs hm beds,10/27/97. Magnolia Place licensed for 60 beds & the 41 transfered beds will be phased in from 6/1 to 6/10, 5/26/98. Magnolia Manor reduced 129 licensed beds to 88, 7/28/98.Magnolia Place licensed beds increased by from 60 to 120 beds, 07/28/98.

24. CON issued to increase licensed nurs hm beds from 40 to 44 & survey beds from 37 to 41, 2/24/97. Facility licensed for 44 beds, 11/5/98.
25. Con issued for construction of a 112 non-medicaid nurs hm, 9/29/97.
26. App for conversion of 30 general beds to 30 nurs hm beds for a total of 492 general acute, 38 psy & 30 nurs hm beds, 10/20/97. CON voided 3/26/99.
27. Con to construct a 45 nOn-medicaid beds, 12/29/97.
28. Con issued to convert 27 general beds to 27 nurs hm beds resulting in 495 general, 38 psy & 27 nurs hm beds, 05/01/98. Facility licensed for 12 nurs hm beds and the hospital licensed beds reduced by 12 from 522 to 510, 9/29/98. Licensed nurs hm beds increased by 15 to 27 & hospital beds reduced from 510 to 495, 12/18/98.
29. Exempt to close & demolition Greenville Gen with a permanent reduction of 75 general , 11 rehab & trasfer of 3 rehab beds to Greenville Mem for a total of 53 rehab beds, 3/30/98. Building demolished , 1/14/99.
30.

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INVENTORY OF EMERGENCY FACILITIES

FY 1999 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1997 ER VISITS
REGION I:	EMERGENCY FACILITIES			
II	ANDERSON AREA MED CTR	ANDERSON	ANDERSON	56865
III	UPSTATE CAROLINA M CTR	CHEROKEE	GAFFNEY	18034
I	GREENVILLE MEM HOSP	GREENVILLE	GREENVILLE	72199
II	ST FRANCIS COMM HOSP	GREENVILLE	GREENVILLE	20525
II	ST FRANCIS WOMENS & FAMILY HOSP	GREENVILLE	GREENVILLE	7885
(*)	WJ BARGE	GREENVILLE	GREENVILLE	6474
II	ALLEN BENNETT MEM HOSP	GREENVILLE	GREER	22335
II	HILLCREST HOSP	GREENVILLE	SIMPSONVILLE	17067
III	OCONEE MEM HOSP	OCONEE	SENECA	29964
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	21306
III	CANNON MEM HOSP	PICKENS	PICKENS	10545
III	MARY BLACK MEM HOSP	SPARTANBURG	SPARTANBURG	23799
I	SPARTANBURG REG MED CTR	SPARTANBURG	SPARTANBURG	70796
III	BJ WORKMAN MEMHOSP	SPARTANBURG	WOODRUFF	5880
III	WALLACE THOMSON HOSP	UNION	UNION	14227
TOTALS				397901

(*) Met insufficient criteria to be classified.

REGION I:	TRAUMA CENTERS		
II	ANDERSON AREA MED CTR	ANDERSON	ANDERSON
I	GREENVILLE MEM HOSP	GREENVILLE	GREENVILLE
III	ALLEN BENNETT MEM HOSP	GREENVILLE	GREER
I	SPARTANBURG REG MED CTR	SPARTANBURG	SPARTANBURG

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REGION NARRATIVE

REGION: II FISCAL YEAR:1999

1. Unusual Characteristics: This region has an estimated military population of 10,500 assigned to Fort Jackson. A 450 bed military hospital provides health care services for the military and dependents residing in this region. All of these beds are not in use. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation and communications. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 95% of the Richland County population plus 45% of the population of Lexington County. For Lexington County, 55% of the Lexington County population plus 5% of the Richland County population is used. The bed needs are developed separately with a separate need indicated for each county.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in five facilities and two Federal facilities in this region.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There are inpatient treatment beds in the three different service areas of this region.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES		NUMBER OF BEDS		
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
II					
HOSPITALS:					
ABBEVILLE	1	0	16	52	-36
CHESTER	1	0	66	82	-16
EDGEFIELD	1	0	14	40	-26
FAIRFIELD	1	0	18	33	-15
GREENWOOD	1	0	184	334	-150
KERSHAW	1	0	78	121	-43
LANCASTER	1	0	94	135	-41
LAURENS	1	0	79	76	3
LEXINGTON	1	0	252	292	-40
NEWBERRY	1	0	40	90	-50
RICHLAND	5	0	1062	1270	-208
YORK	2	0	230	248	-18
TOTALS:	17	0	2133	2773	-640
LTC:					
ABBEVILLE	1	0	129	116	13
CHESTER	1	0	211	100	111
EDGEFIELD	1	0	100	88	12
FAIRFIELD	2	1	148	262	-114
GREENWOOD	3	0	335	369	-34
KERSHAW	2	0	265	236	29
LANCASTER	3	0	300	310	-10
LAURENS	2	0	386	365	21
LEXINGTON	6	0	780	744	36
MCCORMICK	1	0	47	120	-73
NEWBERRY	2	0	248	276	-28
RICHLAND	11	3	1190	1088	102
SALUDA	1	0	105	176	-71
YORK	6	0	718	648	70
TOTALS:	42	4	4962	4898	394

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REGION:II

					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	HOSPITALS:									
YZ	ABBEVILLE CO. MEM.	18 ABBEVILLE	ABBEVILLE	CO	52	52		1336	3873	20.4%
	ABBEVILLE CO.	TOTAL			52	52		1336	3873	20.4%
XYZ	CHESTER CO. HOSP.	CHESTER	CHESTER	DIST	82	82		3066	16257	54.3%
	CHESTER CO.	TOTAL			82	82		3066	16257	54.3%
XYZ	EDGEFIELD CO. HOSP.	EDGEFIELD	EDGEFIELD	CO	40	40		878	3317	22.7%
	EDGEFIELD CO.	TOTAL			40	40		878	3317	22.7%
XYZ	FAIRFIELD MEM.	FAIRFIELD	WINNSBORO	NPA	33	33		860	4119	34.2%
	FAIRFIELD CO.	TOTAL			33	33		860	4119	34.2%
XYZ	SELF MEM.	27 GREENWOOD	GREENWOOD	NPA	334	334		9989	53191	40.4%
	GREENWOOD CO.	TOTAL			334	334		9989	53191	40.4%
XYZ	KERSHAW CO. MED.CTR.	KERSHAW	CAMDEN	CO	121	121		4473	19641	44.5%
	KERSHAW CO.	TOTAL			121	121		4473	19641	44.5%
XYZ	SPRINGS MEM HOSPITAL	21 LANCASTER	LANCASTER	NPA	135	135		4746	25453	48.8%
	LANCASTER CO.	TOTAL			135	135		4746	25453	48.8%
XYZ	LAURENS CO. HOSP.	36 LAURENS	LAURENS	DIST	90	76		3848	19360	58.9%
	LAURENS CO.	TOTAL			90	76		3848	19360	58.9%
XYZ	LEXINGTON MED CTR	LEXINGTON	WEST COLUMBIA	CO	292	292		13016	60796	57.0%
	LEXINGTON CO.	TOTAL			292	292		13016	60796	57.0%
XYZ	NEWBERRY CO. MEM.	31 NEWBERRY	NEWBERRY	CO	102	90		2039	9805	26.3%
	NEWBERRY CO.	TOTAL			102	90		2039	9805	26.3%
XYZ	PALMETTO BAPTIST MED. CTR. OF COLA	1 RICHLAND	COLUMBIA	NPA	363	363		16322	69892	48.1%
XYZ	PROVIDENCE HOSPITAL	23 RICHLAND	COLUMBIA	PROP	205	247		10291	62020	71.1%
XYZ	PROVIDENCE HOSPITAL NE	26 RICHLAND	COLUMBIA	PROP	34	48				
CON	INTERMEDICAL HOSP OF SC	1 RICHLAND	COLUMBIA	NPA	35	35				
XYZ	PALMETTO RICHLAND MEM. HOSP.	15 RICHLAND	COLUMBIA	CO	579	579		25561	163542	72.7%
X	W J B DORN VA	2 RICHLAND	COLUMBIA	FED		(400)		(4543)	(63783)	
X	MONCRIEF ARMY H	2 RICHLAND	COLUMBIA	FED		(49)		(2049)	(6685)	
	RICHLAND CO	TOTAL			1216	1270		52174	285454	64.2%
XYZ	PIEDMONT MED. CTR.	YORK	ROCK HILL	PROP	248	248		11250	54739	60.5%
	YORK CO	TOTAL			248	248		11250	54739	60.5%
	TOTAL				2746	2773		107875	556005	54.8%

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REGION:II

						INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	MENTAL FACILITIES:										
YZ	CHARTER RIVERS	3 LEXINGTON	WEST COLUMBIA	PROP		39	39		981	9030	63.4%
	LEXINGTON CO.	TOTAL				39	39		981	9030	63.4%
XYZ	SELF MEM.	GREENWOOD	GREENWOOD	NPA		36	36		623	5673	43.2%
	GREENWOOD CO.	TOTAL				36	36		823	5673	43.2%
XYZ	PALMETTO BAPTIST MED. CTR. COLA.	RICHLAND	COLUMBIA	NPA		104	104		1576	11925	31.4%
XYZ	PALMETTO RICHLAND MEM. HOSP.	4 RICHLAND	COLUMBIA	CO		60	60		1431	17871	81.6%
X	MONCRIEF ARMY H	2 RICHLAND	COLUMBIA	FED			(20)		(397)	(2902)	
X	W J B DORN VA	2 RICHLAND	COLUMBIA	FED			(60)		(835)	(18241)	
	RICHLAND CO	TOTAL				164	164		3007	29796	49.8%
XYZ	PIEDMONT MED. CTR.	19 YORK	ROCK HILL	PROP		20	20		619	3637	49.8%
	YORK CO	TOTAL				20	20		619	3637	49.8%
	TOTAL					259	259		5130	48136	50.9%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:										
	CHARTER RIVERS	5 LEXINGTON	WEST COLUMBIA	PROP		14	14		30	4124	80.7%
	NEW HOPE MIDLANDS	6 LEXINGTON	WEST COLUMBIA	PROP		54	54		99	17679	89.7%
	LEXINGTON CO	TOTAL				68	68		129	21803	87.8%
	YORK PLACE	YORK	YORK	PROP		40	40		23	9712	66.5%
	YORK CO	TOTAL				40	40		23	9712	66.5%
	TOTAL					108	108				
	DRUG AND ALCOHOL INPATIENT TREATMENT:										
	CHARTER RIVERS	5 LEXINGTON	WEST COLUMBIA	PROP		27	27		350	1723	17.5%
	SPRINGS MEM HOSPITAL	LANCASTER	LANCASTER	NPA		45	45		608	6754	41.1%
	FAIRFIELD MEM.	FAIRFIELD	WINNSBORO	NPA		17	17		23	146	2.4%
	PALMETTO RICHLAND SPRINGS	RICHLAND	COLUMBIA	CO		10	10		336	2776	76.1%
	SELF MEM. HOSP.	GREENWOOD	GREENWOOD	NPA		24	24		101	2048	23.4%
	TOTAL					123	123		1418	13447	30.0%
	REHABILITATION FACILITIES:										
YZ	HEALTHSOUTH REHABILITATION HOSPITAL OF COLA.	29 RICHLAND	COLUMBIA	PROP		89	77		1243	26216	80.7%
	RICHLAND CO	TOTAL				89	77		1243	26216	80.7%

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REGION:II

						INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
	PIEDMONT HEALTHSOUTH REHABLITATION HOSPITAL	29	YORK	ROCK HILL	CON-PROP	LICENSED	SURVEY 20	NONCON	ADMIS	PATIENT	% OCCU
	YORK CO		TOTAL			0	20				
	LONG TERM CARE FACILITIES:										
YZ	ABBEVILLE NURS HM		ABBEVILLE	ABBEVILLE	PROP	94	94		29	33488	97.6%
Z	DUE WEST RET CTR-HEALTH CARE CTR	30	ABBEVILLE	DUE WEST	NPA	22	22				
	ABBEVILLE CO		TOTAL			116	116		29	33488	97.6%
YZ	CHESTER CO NURS CTR		CHESTER	CHESTER	CO	100	100		88	35995	98.6%
	CHESTER CO		TOTAL			100	100		88	35995	98.6%
Z	EDGEFIELD HLTH CARE CTR		EDGEFIELD	EDGEFIELD	PROP	88	88		28	31144	97.0%
	EDGEFIELD CO		TOTAL			88	88		28	31144	97.0%
Z	FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	104	36 C	46	39451	96.6%
Z	TANGLEWOOD HEALTH CARE CTR		FAIRFIELD	RIDGEWAY	PROP	150	150		110	54020	98.7%
	FAIRFIELD CO		TOTAL			262	254	36	156	93471	97.7%
YZ	MAGNOLIA MANOR-GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88		51	31613	98.4%
YZ	HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102		102	35866	96.3%
YZ	NHC HEALTHCARE- GREENWOOD	8	GREENWOOD	GREENWOOD	PROP	152	152		186	51608	93.0%
YZ	TRANSITIONAL CARE OF SELF MEM HOSP	27	GREENWOOD	GREENWOOD	NPA	27	27				
	GREENWOOD CO		TOTAL			369	369		339	119087	95.4%
YX	A SAM KARESH LTC		KERSHAW	CAMDEN	CO	88	88		37	31760	98.9%
Y	SPRINGDALE HEALTHCARE CTR	7	KERSHAW	CAMDEN	PROP	148	148		420	51100	94.6%
	KERSHAW CO		TOTAL			236	236		457	82860	96.2%
YX	CENTRAL CAROLINAS REHAB COMPLEX		LANCASTER	LANCASTER	PROP	22	22		256	4469	55.7%
YZ	LANCASTER CONVL CTR	24	LANCASTER	LANCASTER	NPA	142	142		54	39628	98.7%
YZ	TRANSITIONAL CARE UNIT-SPRINGS MEM	21	LANCASTER	LANCASTER	NPA	14	14		152	1843	82.8%
YZ	WHITE OAK MANOR-LANCASTER		LANCASTER	LANCASTER	NPA	132	132		49	47730	99.1%
	LANCASTER CO		TOTAL			310	310		511	93670	95.0%
CON	LAURENS CO HOSP/SNF	36	LAURENS	LAURENS	DIST		14				
YZ	NHC HEALTHCARE LAURENS		LAURENS	LAURENS	PROP	176	176		135	61822	96.2%
NHM	MARTHA FRANK BAP RET CTR	9	LAURENS	LAURENS	NPA	44	44		191	26847	83.6%
YZ	NHC HEALTHCARE CLINTON		LAURENS	CLINTON	PROP	131	131		152	46091	96.4%
	LAURENS CO		TOTAL			351	365		478	134760	93.5%
YZ	BRIAN CTR-ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120		142	41344	94.4%
YZ	LEXINGTON MED CTR EXTENDED CARE	10	LEXINGTON	LEXINGTON	NPA	352	352		327	117295	91.3%
YZ	MANOR CARE HLTH SERVICES W COLA	11	LEXINGTON	W.COLUMBIA	PROP	132	132		147	32155	73.4%
NHM	NHC HEALTHCARE LEXINGTON	12	LEXINGTON	W.COLUMBIA	PROP	120	120		227	29883	93.0%
NHM	SC EPISCOPAL HM @ STILL HOPES	13	LEXINGTON	W.COLUMBIA	NPA	20	20		43	16190	79.3%

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REGION:II

					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	LEXINGTON CO TOTAL				744	744	0	886	236887	88.2%
YZD	MCCORMICK NURS CTR	25 MCCORMICK	MCCORMICK	CO	120	120		38	31682	98.6%
	MCCORMICK CO TOTAL				120	120		38	31682	98.6%
YZ	J F HAWKINS NURS HM	20 NEWBERRY	NEWBERRY	CO	98	118		52	33340	98.4%
Y	NEWBERRY CO MEM HOSP-SNF	31 NEWBERRY	NEWBERRY	CO	12	12				
YZ	WHITE OAK MANOR-NEWBERRY	28 NEWBERRY	NEWBERRY	PROP	146	146		52	45711	99.4%
	NEWBERRY CO				256	276		104	79051	99.0%
Y	BENZIE T. RICE NURSING FACILITY	34 RICHLAND	COLUMBIA	NPA		20				
YZ	CENTRAL CAROLINA HLTH & REHAB	37 RICHLAND	COLUMBIA	PROP	257	260	146 cd	392	89527	95.4%
YZ	LIFE CARE CTR OF COLA	17 RICHLAND	COLUMBIA	PROP	140	140		240	45709	94.9%
YZ	LOWMAN HOME NURSING CTR	RICHLAND	WHITEROCK	NPA	129	129		165	60284	93.8%
YZ	MAGNOLIA MANOR-COLA	RICHLAND	COLUMBIA	PROP	88	88		68	29266	91.1%
Y	MANORCARE HLTH SERVICES COLA	14 RICHLAND	COLUMBIA	PROP	132	132		218	33869	72.5%
Y	NHC CTR OF COLUMBIA	16 RICHLAND	COLUMBIA	PROP	120	120		82	3890	21.3%
Y	PROVIDENCE HOSP-TCU	23 RICHLAND	COLUMBIA	NPA	(19)	(19)		359	5005	72.2%
Y	PROVIDENCE HOSP NE-TCU	26 RICHLAND	COLUMBIA	PROP	18	18				
CON	PALMETTO BAPTIST MED CTR	1 RICHLAND	COLUMBIA	NPA	22	22		438	5908	73.6%
NHM	RIDGE VIEW MANOR	32 RICHLAND	HOPKINS	PROP		30				
YZ	(STANTON PINES NURSING HOME)	32 RICHLAND	HOPKINS	PROP	26	(21)	11 cd	40	6318	66.6%
FED	WHITE OAK MANOR-COLUMBIA	RICHLAND	COLUMBIA	PROP	120	120		159	43157	98.5%
	W J B DORN VA	RICHLAND	COLUMBIA	FED		(150)		(75)	(30892)	
	RICHLAND CO TOTAL				1033	1050	157	2161	322933	86.9%
YZ	SALUDA NURS CTR	SALUDA	SALUDA	CO	176	176		115	63217	98.4%
	SALUDA CO TOTAL				176	176		115	63217	98.4%
CON	CAROLINA VILLAGE HLTH CARE CTR	33 YORK	ROCK HILL	PROP		40				
NHM	EBENEZER NURS HM	YORK	ROCK HILL	PROP	44	44		106	15006	93.4%
YZ	MAGNOLIA MANOR -ROCK HILL	YORK	ROCK HILL	PROP	106	106		72	37822	97.8%
YZ	BEVERLY HEALTH CARE-ROCK HILL	YORK	ROCK HILL	PROP	132	132		388	43957	91.2%
APP	PIEDMONT HEALTHSOUTH REHABILITATION HOSPITAL	29 YORK	ROCK HILL	PROP		20				
YZ	WHITE OAK MANOR-ROCK HILL	YORK	ROCK HILL	PROP	141	141		63	50887	98.9%
NHM	WESTMINSTER TOWERS	35 YORK	ROCK HILL	PROP	44	66		95	15089	94.0%
YZ	WHITE OAK MANOR-YORK	22 YORK	YORK	NPA	99	99		21	24066	99.9%
	YORK CO TOTAL				566	648		745	186827	96.0%
	TOTAL				4727	4852	193	6097	1513370	92.8%

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FOOTNOTES

REGION II FY99 PLAN

CON-Certificate of Need
UC-Under Contract
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved
NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued to transfer 35 general beds BMCC to est a 35 beds long term acute care hosp InterMedical Hosp of SC resulting in 363 general acute care, 104 psy 22 nursing hm & 35 longterm acute beds, 9/2/97. InterMedical licensed for 35 long term care acute beds & Palmetto Baptist MCC licensed gen beds reduced from 398 to 363, 10/21/98.
2. Bed use restricted. Beds reported by facility.
3. CON issued to convert 5 D&A beds to 5 Psy. beds for 41 D&A beds and 39 Psy. beds, 5/10/93. Facility licensed on same date as CON, 5/10/94.
4. CON issued for 23 crisis-stab beds for a total of 60 psy(37 & 23 crisis) beds,12/22/94. Licensed per con, 2/1/95. CON issued to construct/renovate & create a 20 bed non licensed observation unit adjacent to the ER, 12/11/98.
5. CON issued for 14 RTF beds by converting 14 inpat treat beds with a total of 39 psy., 27 inpat. treat and 14 RTF beds, 11/4/93. Licensed for 14 RTF beds, 9/21/94.
6. Facility licensed for 30 RTF beds 1/13/93. CON issued to add 14 RFT beds with a total of 44 RFT beds, 11/2/93. CON issued to add 10 RTF beds with a total of 54 RTF beds, 4/26/94. Facility licensed, for 54 beds, 4/8/95.
7. CON for 23 additional non-Medicaid LTC beds for a total of 148 beds, 5/19/93. Licensed for 148 LTC beds, 9/20/94.
8. Formerly Greenwood Health Care.
9. CON issued to construct a 44 community non-Medicaid bed addition, 8/31/94. Licensed for 2 comm beds & 44 non-comm beds, 7/3/95. Licensed comm beds increased from 2 to 44, 2/5/96.
10. CON issued for 185 replacement facility, 10/10/94. CON for 35 additional non-Medicaid beds for a total of 220, 11/38/94. Licensed beds increased from 185 to 220, 8/29/96. Licensed combined for Rikard (132 beds) & Kiesler/Holstedt (220 beds) for 352, 10/1/97.

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11. CON issued for 12 non-medicaid nurs beds for total of 132 beds, 1/20/95. Facility licensed for addtional 12 beds for 132 nurs hm beds, 3/1/97.
12. CON issued for 83 beds, 7/06/90. Facility licensed 3/9/94. CON issued for 5 additional beds for a total of 88, 5/16/94. Facility licensed for 88 beds, 10/19/94. Con issued for 23 addtional beds for a total of 111, 9/9/96. CON issued for 9 additional beds for a total of 120,3/21/97. Facility licensed beds increased by 32 from 88 to 120, 8/25/98.
13. Approved to convert 8 non-community beds to community beds for 36 non-community and 8 community beds, 10/18/94. Licensed per con, 12/1/94. con issued to convert 12 institutional beds to 12 comm for a total 46 institutional beds & 20 comm beds, 12/22/97. Facility licensed for 46 institutional & 20 comm nurs hm beds, 1/1/99. Facility licensed non-comm beds reduced by 4 to 42 non-comm & 20 comm, e-90-41, 7/15/99.
14. CON issued for 14 additional non-Medicaid beds for a total of 132, 10/24/94. Facility licensed beds increased by 14 from 118 to 132 nurs hm beds, 1/14/97.
15. CON issued for purchase of a Gamma Knife, 3/18/97. NA-99-97 for renovation of the 11th floor for the addition of 26 general beds with no change it the licensed bed capacity, 11/18/99.
16. CON issued to NHC Ctr. of Columbia for a 132 bed non-Medicaid nursing home, 6/6/94. CON reduced from 132 to 120, 5/5/95. Facility licensed for 120 nurs hm beds & name changed, 5/2/97.
17. CON issued 132 dual beds (80 Medicaid), 12/20/91. Facility licensed for 132 beds, 6/27/94. CON issued for 8 additional non-medicaid beds for a total of 140 (80 medicaid) nurs hm beds, 4/24/97. Facility licensed beds increased by 8 from 132 to 140, 6/23/98.
18. Close ob service of 8 beds 9/8/95.
19. CON issued for relocation of the 20 psy beds to a new building & converting the semi-private rooms on the old psy floor to private with no change in licensed beds, 2/5/96.
20. CON issued to add 20 non-medicaid beds for a total of 98 nurs hm beds, 6/7/96. Facility licensed for 98 nur hm beds, 1/3/97. CON issued for 20 non-medicaid beds for a total of 118, 7/7/97.
21. CON issued for conversion of 14 general beds to 14 nurs hm beds for a total of 135 general beds , 45 D&A beds & 14 nurs hm beds, 9/16/96. Facility licensed for 14 nurs hm beds & 135 general beds,4/25/97.
22. CON issued for 33 additional non-medicaid nurs hm beds for a total of 99 nurs hm beds, 9/30/96. Facility licensed beds increased by 33 for 99 nurs hm beds, 9/23/97.
23. Con for for renovation & construction to include the addition of 19 nurs hm beds resulting in 239 general & 19 nurs hm beds, 10/07/96. Licensed for 19 nurs hm beds, 12/4/96. Exempt #E99-12 to permanent close 19 bed nurs hm, 3/15/99. The licensed 19 nurs hm beds at Providence closed, 4/5/99. See fn #26.
24. App for 10 additional non-medicaid beds & 22 replacement beds to increase from 110 to 120 nurs hm beds, 10/2/96.

RECORD 003489

PET-EX004.0259

Facility licensed beds increased from 110 to 120,11/12/97. CON issued to add 22 non-medicaid beds fo a total of 142 nurs hm beds, 1/26/99. Facility licensed for 142 nurs beds,6/15/99.

25. CON issued for 32 additional medicaid beds for a total of 120 beds, 11/25/96. Facility licensed for 120 beds, 2/13/98.
26. CON issued for construction of a new 46 general hosp & 18 non-medicaid nurs beds by the transfer of 46 general beds from Providence resulting in 193 general beds ,19 nurs beds at Cola Providence & 46 general ,18 nurs hm beds at Cola Providence NE, 2/14/97. Providence NE licensed for 34 gen beds & 18 nurs beds, 3/23/99. Providence Hosp licensed beds reduced by 34 from 239 to 205, 5/28/99. Con issued for 54 additional general beds for a total of 247 general beds, SC-99-41 11/2/99.
27. App for conversion of 38 general beds to nurs hm beds for a capacity of 323 licensed general(326 survey), 36 psy, 24 sub abuse beds & 38 nurs hm beds, 2/20/97. Appealed. Court order compromise for 27 nurs hm beds & 334 licensed beds (made survey & licensed beds the same by reducing survey by 4 beds), con issued 7/29/97. Facility licensed beds reduced from 361 to 334 general beds & 27 nurs hm beds licensed, 1/1//99.
28. Con to add 20 non-medicaid beds for total of 146 nurs hm beds, 6/13/97. Facility licensed increased from 126 to 146, 5/1/98.
29. App for a 20 beds rehab hosp & 20 nurs hm beds (non-medicaid) with a reduction of 12 rehab beds from Hlth South Cola from 89 to 77 rehab beds, 5/27/97.
30. CON issued for a 22 bed non-medicaid nurs hm, 9/10/97. Facility licensed for 22 nurs hm beds, 6/11/99.
31. App to convert 12 acute care beds to 12 non-medicaid nurs hm beds resulting in 90 acute care & 12 nurs hm beds, 9/2/97. Licensed for 12 nurs hm beds, 2/19/99.
32. Con issued to constructed a new facility to replace 26 licensed beds at Stanton Pines & 21 survey with 11cd beds plus 4 additional non-medicaid beds for a total of 30 nurs hm beds, 12/01/97.
33. Con issued for a 40 bed non-medicaid nurs hm, 9//98.
34. CON issued for 20 non-medicaid nurs hm beds, 1/4/99. Facility licensed for 20 nurs hm beds, 3/29/99.
35. CON issued for an add 22 non-medcaid nurs beds for a total of 66 nurs beds, 1/5/99.
36. CON issued to convert 14 acute beds to 14 nurs hm beds resulting in 76 acute beds & 14 nurs hm beds, sc-99-08 2/25/99.

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37. Name changed from Brian Ctr-Forest Hill.

RECORD 003490

PET-EX004.0260

INVENTORY OF EMERGENCY FACILITIES

FY 1999 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1997 ER VISITS
REGION II:	EMERGENCY FACILITIES			
III	ABBEVILLE CO MEM HOSP	ABBEVILLE	ABBEVILLE	11886
II	CHESTER CO HOSP	CHESTER	CHESTER	15802
III	EDGEFIELD CO HOSP	EDGEFIELD	EDGEFIELD	5120
III	FAIRFIELD CO HOSP	FAIRFIELD	FAIRFIELD	12484
II	SELF MEM HOSP	GREENWOOD	GREENWOOD	38807
III	KERSHAW CO MEM HOSP	KERSHAW	CAMDEN	21767
II	SPTINGS MEMORIAL HOSP	LANCASTER	LANCASTER	20732
II	LAURENS COUNTY HOSP	LAURENS	LAURENS	21812
II	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	57941
III	NEWBERRY CO MEM HOSP	NEWBERRY	NEWBERRY	11805
II	PALMETTO BAPTIST MED CTR-COLA	RICHLAND	COLUMBIA	41422
II	PROVIDENCE HOSPITAL	RICHLAND	COLUMBIA	18939
I	PALMETTO RICHLAND MEM HOSP	RICHLAND	COLUMBIA	76753
II	PIEDMONT MED CTR	YORK	ROCK HILL	37445
TOTALS				392715
REGION II:	TRAUMA CENTERS			
III	SELF MEM HOSP	GREENWOOD		
III	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	
I	PALMETTO RICHLAND MEM HOSP	RICHLAND	COLUMBIA	
III	PALMETTO BAPTIST MED CTR-COLA	RICHLAND	COLUMBIA	

PET-EX004.0261

RECORD 003491

REGION NARRATIVE

REGION: III FISCAL YEAR:1999

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." Shaw Air Force Base near Sumter has an estimated military population of 9,800. A 65 bed hospital provides health care services for the military and dependents residing in this region. The inland waterway is a barrier to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in four facilities in this region. There is a small need for a few additional psychiatric beds in this region.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. To make these services more accessible, there is some need in the Chesterfield, Dillon, and Marlboro area and the Sumter, Lee, Clarendon area.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES		NUMBER OF BEDS		
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
III					
HOSPITALS:					
CHESTERFIELD	1	0	28	59	-31
CLARENDON	1	0	47	56	-9
DARLINGTON	2	0	92	166	-74
DILLON	1	0	67	79	-12
FLORENCE	5	0	643	694	-51
GEORGETOWN	1	0	126	142	-16
HORRY	3	0	364	437	-73
MARION	2	0	131	124	7
MARLBORO	1	0	40	94	-54
SUMTER	2	0	201	229	-28
WILLIAMSBURG	1	0	21	78	-57
TOTALS:	20	0	1760	2158	-398
LTC:					
CHESTERFIELD	3	0	261	211	50
CLARENDON	2	1	176	152	24
DARLINGTON	4	0	366	350	16
DILLON	2	1	144	208	-64
FLORENCE	8	1	573	795	-222
GEORGETOWN	2	0	269	242	27
HORRY	9	0	1166	694	472
LEE	1	0	78	120	-42
MARION	3	1	191	190	1
MARLBORO	2	1	148	118	30
SUMTER	4	1	452	428	24
WILLIAMSBURG	2	1	148	176	-28
TOTALS:	42	7	3972	3684	644

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RECORD 003493

REGION:III

						INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	HOSPITALS:										
XYZ	CHESTERFIELD GENERAL	27	CHESTERFIELD	CHERAW	PROP	59	59		2023	7904	36.7%
	CHESTERFIELD CO.		TOTAL			59	59		2023	7904	36.7%
XY	CLARENDON MEM.		CLARENDON	MANNING	CO	56	56		2117	12101	59.2%
	CLARENDON CO.		TOTAL			56	56		2117	12101	59.2%
XYZ	CAROLINA PINES REG MED CTR	24	DARLINGTON	HARTSVILLE	NPA	116	116		4414	19086	45.1%
XYZ	WILSON MEDICAL CTR		DARLINGTON	DARLINGTON	NPA	50	50		1001	4807	26.3%
	DARLINGTON CO.		TOTAL			166	166		5415	23893	39.4%
XYZ	SAINT EUGENE MEDICAL CENTER	23	DILLON	DILLON	NPA	79	79		4362	16524	57.3%
	DILLON CO.		TOTAL			79	79		4362	16524	57.3%
XYZ	CAROLINAS HOSP SYS	1	FLORENCE	FLORENCE	PROP	290	290		11548	60099	56.8%
XYZ	CAROLINAS HOSP SYS LAKE CITY		FLORENCE	LOWER FLORENCE	DIST	48	48		1074	3135	17.9%
XYZ	MCLEOD REG MED CTR	2	FLORENCE	FLORENCE	NPA	336	336		15937	102307	94.7%
YZ	WOMEN'S CENTER CAROLINA HOSP SYS		FLORENCE	FLORENCE	PROP	20	20		1402	3052	41.8%
	FLORENCE CO.		TOTAL			694	694		29961	188593	70.6%
XYZ	GEORGETOWN CO. MEM.	35	GEORGETOWN	GEORGETOWN	NPA	142	102		7032	32434	62.6%
APP	WACCAMAW NECK HOSP	35	GEORGETOWN	MURRELLS INLET	NPA		40				
	GEORGETOWN CO.		TOTAL			142	142		7032	32434	62.6%
XYZ	CONWAY HOSP. INC.		HORRY	CONWAY	NPA	160	160		7714	31622	54.1%
XYZ	GRAND STRAND REG MED CTR	19	HORRY	MYRTLE BEACH	PROP	172	172		9568	37028	59.0%
XYZ	LORIS COMM. HOSP.	3	HORRY	LORIS	DIST	105	105		3531	15148	39.5%
	HORRY CO.		TOTAL			437	437		20813	83798	52.5%
APP	MARION CO MEDICAL CTR	13	MARION	MARION	DIST	124	124		6847	32238	71.2%
XYZ	(MARION CO. MEM.)		MARION	MARION	DIST	(82)	(82)				
XYZ	(MULLINS HOSP.)		MARION	MULLINS	DIST	(80)	(80)				
	MARION CO.		TOTAL			124	124		6847	32238	71.2%
	MARLBORO PARK	27	MARLBORO	BENNETTSVILLE	PROP	94	94		2083	9219	26.9%
	MARLBORO CO.		TOTAL			94	94		2083	9219	26.9%
X	SHAW AFB	5	SUMTER	SUMTER	FED		(21)		(1256)	(2577)	
XYZ	TUOMEY REG MED CTR	20	SUMTER	SUMTER	NPA	229	229		7253	48313	55.4%
	SUMTER CO.		TOTAL			229	229		7253	48313	55.4%
XYZ	CAROLINAS HOSP SYSTEM KINGSTREE		WILLIAMSBURG	KINGSTREE	CO	78	78		1583	5556	19.5%
	WILLIAMSBURG CO.		TOTAL			78	78		1583	5556	19.5%
	TOTAL					2158	2158		89489	438573	56.7%

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REGION:III

					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
	MENTAL FACILITIES:									
XYZ	MCLEOD REG.	FLORENCE	FLORENCE	NPA	35	35		895	4996	39.1%
	FLORENCE CO.	TOTAL			35	35		895	4996	39.1%
YZ	CHARTER SANDS BEHAVIORAL HLTH SYS 6	HORRY	CONWAY	PROP	45	45		587	6522	39.7%
	HORRY CO.	TOTAL			45	45		587	6522	39.7%
XYZ	MARLBORO PARK 27	MARLBORO	BENNETSVILLE	PROP	8	8		37	362	12.4%
	MARLBORO CO.	TOTAL			8	8		37	362	12.4%
XYZ	TUOMEY REG MED CTR	SUMTER	SUMTER	NPA	19	19		385	4146	59.8%
	SUMTER CO.	TOTAL			19	19		385	4146	59.8%
	TOTAL				107	107		1904	16026	41.0%
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:									
YZ	CHARTER SANDS BEHAVIORAL HLTH SYS 6	HORRY	CONWAY	PROP	15	15		15	5010	76.3%
	HORRY CO.	TOTAL			15	15		15	5010	76.3%
	DRUG AND ALCOHOL INPATIENT TREATMENT:									
	CAROLINAS HOSP SYS 7	FLORENCE	FLORENCE	PROP	4	4				
	CAROLINAS HOSP SYS 7	FLORENCE	FLORENCE	PROP	42	42		634	3433	20.4%
	CHARTER SANDS BEHAVIORAL HLTH SYS 6	HORRY	CONWAY	PROP	15	15		157	1347	24.6%
	TOTAL				61	61		791	4780	21.5%
	REHABILITATION FACILITIES:									
YZ	HEALTH-SOUTH REHABILITATION HOSPITAL OF FLORENCE	FLORENCE	FLORENCE		88	88		1116	23659	73.7%
	CAROLINAS HOSP SYS	FLORENCE	FLORENCE	NPA	24	24		413	4806	54.9%
	FLORENCE CO.	TOTAL			112	112		1529	28465	69.6%
	LONG TERM FACILITIES:									
YZ	CHERAW HEALTHCARE	CHESTERFIELD	CHERAW	PROP	100	99		48	35717	97.9%
Z	CHESTERFIELD GEN HOSP SNF	CHESTERFIELD	CHERAW	PROP	7	7		169	1413	55.3%
YZ	CHESTERFIELD CONVL CTR 15	CHESTERFIELD	CHERAW	PROP	104	104		55	35715	96.4%
	CHESTERFIELD CO	TOTAL			211	210		272	72845	95.7%
YX	LAKE MARION NURSING FAC	CLARENDON	SUMMERTON	PROP	88	88		55	31336	97.6%
YX	WINDSOR MANOR	CLARENDON	MANNING	PROP	64	43	26 cd	13	23236	99.5%

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REGION:III — INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

					CON-	LICENSED	SURVEY	NONCON		ADMIS	PATIENT	% OCCU
	CLARENDON CO	TOTAL				152	131	28		68	54572	98.4%
YZ	BETHEA BAPTIST HOME	8 DARLINGTON	DARLINGTON	NPA		26	26			57	21221	66.1%
YZ	MEDFORD PLACE	9 DARLINGTON	DARLINGTON	PROP		88	88			95	31530	98.2%
YZ	MORRELL MEM CONV CTR	28 DARLINGTON	HARTSVILLE	PROP		148	148			90	48351	97.3%
YZ	OAKHAVEN CONV CTR	21 DARLINGTON	DARLINGTON	PROP		88	88			49	33239	94.9%
	DARLINGTON CO	TOTAL				350	350			291	134341	90.2%
YZ	BEVERLY HEALTHCARE THE PINES	DILLON	DILLON	PROP		84	84			102	29971	97.8%
YZ	SUNNY ACRES , INC	DILLON	FORK	PROP		111	108	58	cd	43	39804	98.2%
YZ	ST EUGENE MED CTR-SNF	23 DILLON	DILLON	NPA		13	13			112	959	20.2%
	DILLON CO	TOTAL				208	203	58		257	70734	93.2%
YZ	CAROLINAS HOSP SYS TRANSITIONAL CARE UNIT	1 FLORENCE	FLORENCE	PROP		44	44			669	14514	90.4%
YZ	COMMANDER HLTH CARE	FLORENCE	FLORENCE	PROP		163	152			67	59004	99.2%
YZ	FAITH HEALTHCARE CTR	FLORENCE	FLORENCE	PROP		104	93			142	34859	91.8%
Z	FLORENCE CONV CTR	FLORENCE	FLORENCE	PROP		88	88	44	d	59	31020	96.6%
YZ	HERITAGE HM OF FLORENCE	34 FLORENCE	FLORENCE	PROP		132	132			44	31948	99.5%
YZ	HONORAGE HM OF FLORENCE	FLORENCE	FLORENCE	PROP		88	88			39	31890	99.3%
YZ	LAKE CITY/SCRANTON HLTH CARE CTR	FLORENCE	SCRANTON	PROP		88	88			99	31562	98.3%
YZ	SOUTHLAND HLTH CARE CTR	FLORENCE	FLORENCE	PROP		88	88	(42)	cd	40	31668	98.6%
	FLORENCE CO	TOTAL				795	773	44		1159	286463	97.2%
APP	GEORGETOWN MEM HOSP SNF	35 GEORGETOWN	GEORGETOWN	NPA			10					
YZ	PRINCE GEORGE HLTHCARE CENTER	10 GEORGETOWN	GEORGETOWN	PROP		148	148			368	46901	86.8%
YZ	WINYAH EXTENDED CARE CTR	GEORGETOWN	GEORGETOWN	PROP		84	84			57	28344	92.4%
	GEORGETOWN CO	TOTAL				232	242			425	75245	88.9%
NH	(COMPASS TRANSITIONAL CARE)	6 HORRY	CONWAY	PROP		(20)	(20)			351	5991	82.1%
Y	COVENANT TOWERS	HORRY	MYRTLE BEACH	PROP		30	30			31	8242	75.3%
YZ	CONWAY NURS CTR	HORRY	CONWAY	PROP		190	190			194	65927	95.1%
Y	GRAND STRAND HLTH CARE	31 HORRY	CONWAY	PROP		88	88			44	32120	100.0%
NH	GRAND STRAND REG /ECU	19 HORRY	MYRTLE BEACH	PROP		18	18			386	3386	51.5%
YZ	KINGSTON NURS CTR	HORRY	CONWAY	PROP		88	88			324	29496	91.8%
YZ	LORIS EXTENDED CARE CTR	HORRY	LORIS	DIST		88	88			33	31958	99.5%
YZ	MYRTLE BEACH MANOR	12 HORRY	MYRTLE BEACH	PROP		104	104			167	34360	90.5%
Y	NHC-GARDEN CITY	HORRY	MYRTLE BEACH	PROP		88	88			164	30280	94.3%
	HORRY CO	TOTAL				694	694			1694	241760	92.8%
YZ	MCCOY MEM. NURS. CTR.	25 LEE	BISHOPVILLE	PROP		120	120			75	31891	99.3%
	LEE CO.	TOTAL				120	120			75	31891	99.3%
APP	MULLONS NURSING CTR	30 MARION	MARION	NPA		92	102					
YZ	(ENGLISH PARK NURSING CT)	MARION	MARION	NPA		(44)	(44)			15	15975	99.5%
YZ	(JENKINS NURS HM)	MARION	MARION	PROP		(56)	(56)			15	21038	99.4%
YZ	MARION NURSING CTR	14 MARION	MARION	PROP		88	88	1	c	63	31156	97.0%
	MARION CO	TOTAL				180	190	1		93	68169	98.3%
YZ	DUNDEE NURS HM	MARLBORO	BENNETTSVILLE	PROP		111	111	(24)	(a)	71	38481	95.0%
Y	MARLBORO PARK HOSP SNF	MARLBORO	BENNETTSVILLE	PROP		7	7			104	1239	48.5%

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REGION:III

INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

						CON-	LICENSED	SURVEY	NONCON		ADMIS	PATIENT	% OCCU
	MARLBORO CO		TOTAL				118	118			175	39720	92.2%
YZ	HOPEWELL HLTH CARE CTR		SUMTER	SUMTER		PROP	96	96	(48)	cd	53	34140	97.4%
YZ	MARINER HLTH CARE SUMTER-EAST	33	SUMTER	SUMTER		PROP	176	176			120	30613	95.3%
YZ	(MARINER HLTH CARE SUMTER-WEST)	33	SUMTER	SUMTER		PROP	(88)	(88)			66	30400	94.6%
YZ	NHC HEALTHCARE SUMTER	26	SUMTER	SUMTER		PROP	123	138			74	43983	98.7%
Y	TUOMEY HOSP-SNF	17	SUMTER	SUMTER		NPA	18	18			332	4701	71.6%
	SUMTER CO		TOTAL				413	428	0		645	143837	95.6%
YZ	KINGSTREE NURS FAC	32	WILLIAMSBURG	KINGSTREE		PROP	70	88	(45)	d	27	25059	98.1%
YZ	RE MCNAIR NURS CTR		WILLIAMSBURG	CADES		PROP	88	88			27	25059	78.0%
	WILLIAMSBURG CO		TOTAL				158	176	0		54	50118	86.9%
	TOTAL						3631	3635	129		5208	1249695	94.1%

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FOOTNOTES

REGION III	FY99 PLAN
CON-Certificate of Need	NPA-Non Profit
UC-Under Construction	ST-State
X-JCAH Accredited	CO-County
Y-Medicare	PROP-Proprietary
Z-Medicaid	N-Nursing Home
APP-Approved	SW-Statewide Facility

1. CON issued to replace & relocate the existing 290 acute care bed on the site with the 20 bed women's Ctr and with the 24 rehab, 44 nurs hm & the 46 d&a (42 inpat & 4 med detox) beds at their current site, 2/27/96. Con issued for conversion of 28 general beds to 28 nurs hm plus the existing 44 nurs beds for 72 nurs hm beds, 262 general beds, 46 d&a, 24 rehab, 12/09/97. Facility licensed for 290 general beds & the 28 additional nurs hm beds are being completed, 11/13/98. CON for additional 28 nurs hm beds expired and 28 acute beds added back to the 262 for 290 general beds, 12/9/98.
2. CON issued for 40 additional general beds for a total of 336,10/21/97. CON issued for construction of a three story additional known as McLeod Day Hosp with two story day hosp, 89 holding & recovery beds, a GI lab with 5 procedure rooms, and a Child Life Activity Ctr, 12/5/97. Licensed beds increased from 296 to 336, 12/1/97.
3. Exemption for use of 12 general beds for DMH patients w/o any licensure change, 1/9/95.
4. Exemption for permanent reduction of 35 general beds, 4/27/94. Facility closed 7/21/94. CON issued for ambulatory surgery ctr., 5/8/95.
5. Bed use restricted.
6. CON issued to convert 20 inpatient sub abuse beds to nurs hm beds resulting in licensed beds as 15 inpatient sub abuse beds, 45 psy (17 adolescent, 18 adult, 10 state contract beds), 18 RTF beds and 20 nurs hm beds. Facilty licensed per CON, 7/5/94. Nurs hm closed, 6/30/98. Exemption issued for Charter Conway to purchase the facility, 9/21/98.
7. Facility is licensed for 42 inpatient treatment beds (12 adolescent and 30 adult) and for 4 public detox beds for a total of 46 D&A beds.
8. Facility licensed for 20 comm beds and 68 non-comm beds. CON issued for 6 additional comm. beds for a total of 26 comm. beds and 62 non-comm beds, 10/11/94. licensed per CON, 1/1/95.

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9. CON issued for 5 non-medicaid beds for a total of 88, 2/21/95. Facility licensed beds increased from 83 to 88, 9/29/95.
10. CON for 16 additional non-medicaid beds for a total of 148 LTC beds, 5/20/93. Facility licensed beds increased from 132 to 148, 10/13/94.
11. CON issued for 22 non-medicaid beds, 4/17/95. CON voided, 10/18/95.
12. CON issued 6 additional non-medicaid beds for a total of 85, 7/11/94. Licensed for 85 beds, 9/1/94. CON issued for 19 additional beds for a total of 104, 10/17/95.
13. CON issued for a 124 replacement hospital, 7/6/95. Facility licensed for 124 general beds, 6/17/97.
14. App name changed from Marion Co Convl Ctr & change of lease 9/25/95.
15. CON for 16 additional non-medicaid beds for a total of 104, 11/14/95. Facility licensed for 104 nurs hm beds, 11/27/96.
16. CON issued for 35 replacement beds with increase of survey from 86 to 96 & the reduction of non-conforming from 48 to 0, 12/19/95.
17. CON issued for conversion of 18 general beds to nurs hm beds with 229 general , 19 psy & 18 nurs hm beds, 12/18/95. Licensed for 18 nurs hm beds, 229 general, & 19 psy beds 2/7/96.
18. CON for conversion of 14 general beds to 14 nurs hm beds with 78 general & 14 nurs hm beds, 12/29/95.
19. CON to construct an 18 hospital base nurs hm beds unit, 1/30/96. Also, to temporarily licensed 10 general beds as 10 nurs hm beds (for appox. 10 months), the 10 beds were licensed as nurs hm beds & the general beds are temporarily reduced from 172 to 162, 3/1/96. Licensed nurs beds increased by 10 for 18 and licensed general beds licensed back to 172 from the temp 162, 9/16/97.
20. CON issued to convert 18 hosp beds to 18 nurs hm beds for 229 general beds, 19,psy beds & 18 nure hm beds, 12/18/95. Licensed for 18 nurs hm, 229 general & 19 psy beds, 2/7/96.
21. Con issued for 8 non-medicaid beds for a total of 96 LTC beds, 3/19/96. Facility licensed beds increased by 4 from 88 to 92, 4/26/96. CON voided for additional 4 beds, 9/30/96. Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds incrased from 144 to 148, 12/10/97.
22. Con issued for 3 non-medicaid beds for a total of 123 ltc beds, 3/25/96.
23. Con issued for converting 14 general beds to nurs hm beds for 78 general beds & 14 nurs hm beds, 12/29/95. Con changed to reflect 79 general & 13 nurs hm beds, 7/24/96. Facility licensed for 79 general & 13 nurs hm beds, 8/14/96.
24. CON issued for 116 general beds replacement hospital, 8/15/96. Name changed from Byerly Hospital, 5/1/99.
25. CON for the adddition of 32 medicaid beds for a total of 120 nurs hm beds, 11/25/96. Facility licensed for 120 beds, 9/26/97.
26. CON issued to add 3 nurs hm beds to increase from 120 to 123, 3/28/96. Licensed for 123 nurs hm beds, 1/16/97. Con

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issued for 15 non-medicaid nurs beds for a total of 138,10/20/98.

27. CON issued for transfer of 7 psy beds from Chesterfield plus 1 additional psy bed for 8 psy beds at Marlboro Park & 94 general with the transfer of 7 general beds from Marlboro to Chesterfield going from 52 general to 59, resulting in 94 general, 8 psy beds at Marlboro Park & 59general beds at Chesterfield, 2/6/97. Marlboro licensed for 94 gen & 8 psy beds with Chesterfield licensed for 59 gen beds, 4/26/97.
28. CON issued for 8 non-medicaid beds for a total of 140 nurs hm beds, 2/10/97. Facility licensed beds increased by 8 from 132 to 140,3/31/97. Con issued for 4 add nurs hm beds for a total of 144, 9/1597. Facility licensed beds increased by 4 to 144, 9/25/97.Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds reduced from 92 to 88, 12/10/97.
29. APP for 32 additional non medicaid beds for a total of 120, 9/12/97.
30. Exmp renovated vacated Mullins Hosp to replace English park & Jenkins Nursing Hm without a change of licensed beds, 9/22/97. Facility licensed for 92 nurs hm beds, 9/15/98.
31. CON issued for 32 additional non-medicaid nurs hm beds for a total of 120, 9/30/97. Con voided for 32 additional nurs hm beds reduce back to 88 beds,3/31/99.
32. Con SC 97-66 issued for 88 replacement facility 70 existing licensed beds (65 surveyed with 45 d) plus 18 new non-medicaid beds, 11/24/97.
33. Exmp to merge Mariner Hlth Ctr Sumter-East & West, 9/3/98. Facilities licensed as one with 176 nurs beds, 9/3/98.
34. Con # SC-97-32 issued for replacement of 44 nurs hm beds, 7/14/97. Pursuant to the 1998 medicaid proviso the 44 replacement beds will still licensed & medicaid certified for a total of 132, 9/98. Facility licensed beds increased by 44 from 88 to 132, 12/8/98.
35. App to transfer 40 acute beds from Georgetown Mem to construct a new 40 hosp and add a 10 bed nurs hm to Georgetown mem resulting in 102 acute & 10 nurs hm at Georgetown Mem, 3/26/99.

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PET-EX004.0270

INVENTORY OF EMERGENCY FACILITIES

FY 1999 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1997 ER VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GEN HOSP	CHESTERFIELD	CHERAW	11408
III	CLARENDON MEM HOSP	CLARENDON	MANNING	16554
III	WILSON MEDICAL CTR	DARLINGTON	DARLINGTON	8913
III	BYERLY HOSP	DARLINGTON	HARTSVILLE	17539
III	ST EUGENE REG MED CTR	DILLON	DILLON	15453
III	CAROLINAS HOSPITAL SYS	FLORENCE	FLORENCE	26080
II	MCLEOD REG MED CTR	FLORENCE	FLORENCE	49884
III	CAROLINAS HOSPITAL SYS LAKE CITY	FLORENCE	LAKE CITY	17821
II	GEORGETOWN MEM HOSP	GEORGETOWN	GEORGETOWN	26846
II	CONWAY HOSP INC	HORRY	CONWAY	35931
III	LORIS COMM HOSP	HORRY	LORIS	16206
II	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH	40994
III	MARION CO MED CTR	MARION	MARION	22554
III	MARLBORO PARK HOSP	MARLBORO	BENNETTSVILLE	13184
II	TUOMEY REG MED CTR	SUMTER	SUMTER	36067
III	CAROLINAS HOSPITAL SYS KINGSTREE	WILLIAMSBURG	KINGSTREE	10151
TOTALS				365585

REGION III:	TRAUMA CENTERS		
III	CAROLINAS HOSP SYSTEM	FLORENCE	FLORENCE
III	MCLEOD REG MED CTR	FLORENCE	FLORENCE
III	GEORGETOWN MEM HOSP	GEORGETOWN	GEORGETOWN
III	CONWAY HOSP INC	HORRY	CONWAY
III	LORIS COMM HOSP	HORRY	LORIS
III	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH

REGION NARRATIVE

REGION: IV FISCAL YEAR:1999

1. Unusual Characteristics: This region has a military presence in Charleston. A 290 bed naval hospital provides health care services for the military and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with an estimated military population of 10,000. A 290 naval hospital provides health care to the military and dependents. There are no barriers to communications in this region. The sea islands, rivers and sounds are barriers to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. Medical University was partially assigned to the Statewide area based on patient origin data. By mutual agreement, Berkeley and Dorchester County hospitals were closed upon the opening of Trident Regional Medical Center. After a review of patient origin information, the population used to calculate beds for Berkeley and Dorchester Counties is 70% of Berkeley, 85% of Dorchester and 10% of Charleston County with the facilities predominately serving Charleston County using the other 30% of Berkeley, 15% of Dorchester and 90% of Charleston Counties population.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in seven facilities and two Federal facilities in this region. There is a small need for additional psychiatric beds in the Beaufort, Jasper, Colleton, and Hampton area.

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5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There is a need for additional inpatient treatment beds in the Beaufort, Hampton, Colleton, and Jasper area. The William J. McCord Adolescent Treatment Center in Orangeburg County serves adolescents exclusively from throughout the state and was licensed in October, 1993. Therefore, the minimum use rate was utilized to determine the need for 4 additional beds for adults in the Orangeburg area.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES			NUMBER OF BEDS	
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
IV					
HOSPITALS:					
AIKEN	1	0	183	178	5
ALLENDALE	1	0	10	36	-26
BAMBERG	1	0	27	59	-32
BARNWELL	1	0	22	53	-31
BEAUFORT	2	0	147	174	-27
BERKELEY/DORCHS	1	0	286	325	-39
CHARLESTON	7	1	801	1153	-352
COLLETON	1	0	103	116	-13
HAMPTON	1	0	9	68	-59
JASPER	1	0	12	31	-19
ORANGEBURG/CALH	1	0	200	261	-61
TOTALS:	18	1	1800	2454	-654
LTC:					
AIKEN	6	1	780	718	62
ALLENDALE	1	0	82	44	38
BAMBERG	1	0	94	88	6
BARNWELL	3	1	101	169	-68
BEAUFORT	7	0	601	482	119
BERKELEY	3	0	413	316	97
CALHOUN	1	0	70	120	-50
CHARLESTON	12	0	1439	1342	97
COLLETON	2	0	195	175	20
DORCHESTER	4	0	332	284	48
HAMPTON	1	0	117	104	13
JASPER	1	0	103	88	15
ORANGEBURG	4	1	442	416	26
TOTALS:	46	3	4769	4346	541

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REGION:IV

INPATIENT INVENTORY — OCT.1,1996-SEPT.30,1997

	HOSPITALS:				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT	% OCCU
YZ	ALLENDALE CO.HOSP.	1 ALLENDALE	FAIRFAX	CO		36	36		720	2363	18.0%
	ALLENDALE CO.	TOTAL				36	36		720	2363	18.0%
XYZ	BAMBERG CO. MEM.	BAMBERG	BAMBERG	CO		59	59		1289	6763	31.4%
	BAMBERG CO.	TOTAL				59	59		1289	6763	31.4%
YZ	BARNWELL CO. HOSP.	BARNWELL	BARNWELL	CO		53	53		906	5458	28.2%
	BARNWELL CO.	TOTAL				53	53		906	5458	28.2%
X	NAVAL HOSP	2 BEAUFORT	BEAUFORT	FED			(64)		(1438)	(4326)	
XYZ	BEAUFORT CO. MEM.	45 BEAUFORT	BEAUFORT	CO		106	106		5851	23478	60.7%
XYZ	HILTON HEAD MED CTR & CLINICS	27 BEAUFORT	HILTON HEAD	NPA		64	68		3705	12989	52.3%
	BEAUFORT CO.	TOTAL				170	174		9556	36467	57.4%
XYZ	(BON-SECOURS ST. FRANCIS)	6 CHARLESTON	CHARLESTON	NPA		(362)	(375)				
XYZ	BON-SECOURS ST. FRANCIS	6 CHARLESTON	CHARLESTON	NPA		141	141		5248	25257	37.0%
XYZ	CHARLESTON MEM. HOSP.	43 CHARLESTON	CHARLESTON	CO		98	98				
CON	(CHARLESTON LTC HOSP.)	3 CHARLESTON	CHARLESTON	CO			(26)		1285	14728	25.7%
YZ	EAST COOPER REG MED CTR	4 CHARLESTON	MT PLEASANT	PROP		100	100				
XYZ	(MEDICAL UNIVERSITY HOSP.)	CHARLESTON	CHARLESTON	ST		(466)	(466)		3834	14898	40.8%
XYZ	MEDICAL UNIVERSITY HOSP.	5 CHARLESTON	CHARLESTON	ST		224	224		(20726)	(114649)	
XYZ	ROPER HOSP.	3 CHARLESTON	CHARLESTON	NPA		414	414		11833	55032	67.3%
YZ	ROPER HOSPITAL NORTH	3 CHARLESTON	N CHARLESTON	NPA		60	60		15183	89809	59.4%
YZ	SPECIALITY HOSPITAL OF SC	43 CHARLESTON	CHARLESTON	PROP		59	59		1263	6887	31.4%
XYZ	TRIDENT MED CTR.	7 CHARLESTON	CHARLESTON	PROP		251	251				
X	NAVAL REG.HOSP.	2 CHARLESTON	CHARLESTON	FED			(32)		12157	57287	62.2%
X	RALPH H JOHNSON VETERANS MEDICAL CTR	2 CHARLESTON	CHARLESTON	FED			(197)		(1326)	(4669)	
		TOTAL				1347	1347	0	(4317)	(28127)	
XYZ	COLLETON MED CTR	29 COLLETON	WALTERBORO	PROP		116	116		50803	263898	51.9%
	COLLETON CO.	TOTAL				116	116		3808	25107	59.3%
XYZ	SUMMERVILLE MED CTR	8 DORCHESTER	SUMMERVILLE	PROP		74	74		3808	25107	59.3%
	DORCHESTER CO.	TOTAL				74	74		2811	11092	40.6%
YZ	HAMPTON REG MED CTR	HAMPTON	VARNVILLE	CO		68	68		2811	11092	40.6%
	HAMPTON CO.	TOTAL				68	68		511	2119	8.5%
YZ	LOW COUNTRY GENERAL HOSP	42 JASPER	RIDGELAND	PROP		31	31		511	2119	8.5%
	JASPER CO.	TOTAL				31	31		662	2827	25.0%
XYZ	REGIONAL MEDICAL CENTER OF ORANGEBURG-CALHOUN	9 ORANGEBURG 41	ORANGEBURG	CO		271	271		9700	53361	53.9%
	ORANGEBURG CO.	TOTAL				271	271		9700	53361	53.9%
XYZ	AIKEN REG.MED. CTR.	AIKEN	AIKEN	PROP		178	178		9670	43606	67.1%

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					CON-	LICENSED	SURVEY	NONCON		ADMIS	PATIENT	% OCCU
	AIKEN CO.		TOTAL			178	178			9670	43606	67.1%
	TOTAL					2403	2407	0	0	90436	453061	
	MENTAL FACILITIES:											
XYZ	BEAUFORT MEM HOSP	10	BEAUFORT	BEAUFORT	CO	20	20			373	3265	24.8%
						20	20			373	3265	24.8%
XYZ	CHARLESTON MEM. HOSP.	33	CHARLESTON	CHARLESTON	CO	15	15			210	1503	27.5%
XYZ	MEDICAL UNIVERSITY HOSP.	12	CHARLESTON	CHARLESTON	ST	82	82			2254	16415	51.5%
XY	CHARTER CHARLESTON	11	CHARLESTON	CHARLESTON	PROP	60	60			622	5613	25.6%
XYZ	TRIDENT MED CTR		CHARLESTON	CHARLESTON	PROP	20	20			714	3920	53.7%
X	RALPH H JOHNSON VETERANS MEDICAL CTR		CHARLESTON	CHARLESTON	FED		(36)			(597)	(3907)	
	CHARLESTON CO.		TOTAL			177	177			3800	26451	40.9%
	RMC ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15			459	3710	67.8%
	ORANGEBURG CO.		TOTAL			15	15			459	3710	67.8%
XYZ	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	29	29			628	5167	48.8%
	AIKEN CO.		TOTAL			29	29			628	5167	48.8%
	TOTAL					241	241			4887	35328	37.7%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:											
	CHARTER ADOLESCENT RESIDENTIAL TREATMENT CTR/CHARLESTON		CHARLESTON	CHARLESTON	PROP	32	32			75	7516	64.3%
	NEW HOPE SUMMERVILLE	13	SUMMERVILLE	DORCHESTER	PROP	52	52			31	17405	91.7%
	CHARLESTON CO.		TOTAL			84	84			106	24921	81.3%
	REHABILITATION FACILITIES:											
XYZ	MEDICAL UNIVERSITY HOSP.	14	CHARLESTON	CHARLESTON	ST	25	25			342	7528	82.5%
XYZ	ROPER HOSP.	3	CHARLESTON	CHARLESTON	NPA	39	39			696	11807	82.9%
XYZ	HEALTHSOUTH CHARLESTON	15	CHARLESTON	CHARLESTON	PROP	39	39			569	11058	84.2%
	CHARLESTON CO.		TOTAL			103	103			1607	30393	83.3%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	18	18			173	983	15.0%
	ROPER HOSPITAL NORTH		CHARLESTON	N CHARLESTON	NPA	44	44			452	6269	39.0%
	CHARTER CHARLESTON	11	CHARLESTON	N CHARLESTON	PROP	10	10			168	1166	31.9%
	MUSC MEDICAL CTR	16	CHARLESTON	CHARLESTON	ST	23	23			643	3447	41.1%
	VETERANS ADMINSTRATION		CHARLESTON	CHARLESTON	FED	(30)	(30)					

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REGION:IV

					INPATIENT INVENTORY			OCT.1,1996-SEPT.30,1997		
	WJ MCCORD ADOLESCENT TREATMENT CTR	ORANGEBURG	ORANGEBURG	CON-CO	LICENSED 15	SURVEY 15	NONCON	ADMIS 127	PATIENT 3117	% OCCU 56.9%
	TOTAL				110	110		1583	14982	
	LONG TERM FACILITIES:									
YZ	JOHN E HARTER N HM	ALLENDALE	FAIRFAX	CO	44	44		18	15633	97.3%
	ALLENDALE CO TOTAL				44	44		18	15633	97.3%
YZ	BAMBERG CO MEM NURS CTR 31	BAMBERG	BAMBERG	CO	88	88		18	16005	99.7%
	BAMBERG CO TOTAL				88	88		18	16005	99.7%
YZ	BARNWELL CO NURS HM	BARNWELL	BARNWELL	CO	40	40		10	14467	99.1%
Z	MEADOWBROOK HEALTHCARE CTR	BARNWELL	BLACKVILLE	PROP	85	85	85 a	47	30094	97.0%
YZ	SILVER SPRINGS HEALTHCARE CTR	BARNWELL	WILLISTON	PROP	44	44		15	15764	98.2%
	BARNWELL CO TOTAL				169	169	85	72	60325	97.8%
Y	BEAUFORT CO MEM HOSP 10	BEAUFORT	BEAUFORT	CO	44	44		514	7453	46.4%
	SUBACUTE SKILLED CARE PROGRAM	BEAUFORT	BEAUFORT	PROP	192	192		202	65773	93.9%
YZ	BAYVIEW NURS CTR	BEAUFORT	HILTON HEAD	PROP	88	88		63	29182	90.9%
Y	LIFE CARE CENTER OF HILTON HEAD 40	BEAUFORT	HILTON HEAD	PROP	30	30		58	14454	90.0%
Y	FRASER HEALTH CTR	(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
SW	(FRASER HEALTH CTR)	BEAUFORT	HILTON HEAD	NPA	15	15		311	2864	52.3%
Y	HILTON HEAD HOSP NURS HM 27	BEAUFORT	HILTON HEAD	PROP	69	69		88	13867	86.3%
Y	PRESTON HEALTH CARE CTR 32	(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				
SW	(PRESTON HEALTH CARE CTR)	BEAUFORT	HILTON HEAD	PROP	44	44		31	2112	20.7%
NHM	BROAD CREEK 17									
	BEAUFORT CO TOTAL				482	482		1267	135705	81.7%
YZ	HEARTLAND HLTH CARE CTR	BERKELEY	HANAHAN	PROP	96	96		227	24138	68.9%
YZ	LAKE MOULTRIE NURSING HOME 18	BERKELEY	ST STEPHENS	PROP	88	88		48	30790	633.3%
YZ	MAGNOLIA MANOR-MOCKS CORNER	BERKELEY	MONCKS CORNER	PROP	132	132		95	46258	96.0%
	BERKELEY CO TOTAL				316	316		370	101186	114.9%
YZ	CALHOUN CONV CTR 34	CALHOUN	ST. MATTHEWS	PROP	120	120		28	32010	99.7%
	CALHOUN CO TOTAL				120	120		28	32010	99.7%
YZ	ASHLEY CROSSING REHAB & NURS CTR	CHARLESTON	CHARLESTON	NPA	132	132		711	41083	86.3%
Y	BISHOP GADSDEN EPISCOPAL HM 19	CHARLESTON	CHARLESTON	NPA	53	53		17	16187	99.2%
APP	CHARLESTON LIVING CENTER 44	CHARLESTON	CHARLESTON	NPA		60				
YZ	CHARLESTON NURS CTR	CHARLESTON	MT. PLEASANT	PROP	132	132		139	46304	96.1%
APP	FRANKE NURSING HOME 30	CHARLESTON	CHARLESTON	NPA		24				
	(FRANKE NURSING HOME) 30	CHARLESTON	CHARLESTON	NPA		(20)				
YZ	GRACE HALL- REHABILITATION 38	CHARLESTON	MT. PLEASANT	PROP	42	42				
YZ	HERMINA TRAEYE 20	CHARLESTON	CHARLESTON	NPA	132	132		47	44920	93.2%
YZ	INTEGRATED HLTH SERVICES	CHARLESTON	CHARLESTON	PROP	160	160		334	54621	93.5%
	CHARLESTON /DRIFTWOOD									
NHM	LIFE CARE CTR/CHARLESTON 21	CHARLESTON	N CHARLESTON	PROP	148	148		96	26848	83.0%
YZ	MANOR CARE HEALTH 37	CHARLESTON	CHARLESTON	NPA	82	82		134	35276	73.4%

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						CON-	LICENSED	SURVEY	NONCON		ADMIS	PATIENT	% OCCU
CON	SERVICES-CHARLESTON (NHC CHARLESTON)	39	CHARLESTON	CHARLESTON	PROP			(120)					
YZ	SANDPIPER CONV CTR TRIDENT SKILLED		CHARLESTON	MT. PLEASANT	PROP		176	176			155	61839	96.3%
Y	TRIDENT SKILLL NURS CTR	8	CHARLESTON	CHARLESTON	PROP		25	25			453	5004	58.1%
YZ	WHITE OAK MANOR-CHARLESTON		CHARLESTON	CHARLESTON	PROP		176	176			204	53942	84.0%
	CHARLESTON CO		TOTAL				1258	1342			2290	385824	88.4%
YZ	COLLETON REG HOSP NURS HM		COLLETON	WALTERBORO	PROP		15	15			195	3020	55.2%
YZ	OAKWOOD HLTH CARE CTR	22	COLLETON	WALTERBORO	PROP		132	160			124	46866	97.3%
	COLLETON CO		TOTAL				147	175			319	49886	93.0%
YZ	HALLMARK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP		88	88			148	29004	90.3%
YZ	OAKBROOK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP		88	88			132	29930	93.2%
	ST GEORGE HLTH CARE CTR		DORCHESTER	ST. GEORGE	PROP		88	88			120	30138	93.8%
YZ	SUMMERVILLE MED CTR-SNF	8	DORCHESTER	SUMMERVILLE	PROP		20	20			228	2534	49.6%
	DORCHESTER CO		TOTAL				284	284			628	91606	90.3%
Z	HARPER NURSING CTR	35	HAMPTON	ESTILL	CO		104	104			56	31105	96.8%
	HAMPTON CO		TOTAL				104	104			56	31106	96.8%
YZ	RIDGELAND NURSING CTR		JASPER	RIDGELAND	PROP		88	88			29	32076	99.9%
	JASPER CO		TOTAL				88	88			29	32076	99.9%
YZ	EDISTO CONV CTR		ORANGEBURG	ORANGEBURG	PROP		113	113			57	40354	97.8%
YZ	JOLLEY ACRES HLTHCARE CTR	23	ORANGEBURG	ORANGEBURG	PROP		60	60			131	19974	91.2%
YZ	ORANGEBURG NURS HM		ORANGEBURG	ORANGEBURG	PROP		88	88			43	31106	96.8%
YZ	THE METHODIST OAKS	24	ORANGEBURG	ORANGEBURG	NPA		155	155			259	49477	77.0%
	(REG MED CTR ORANGEBURG/CALHOUN SNF)	41	ORANGEBURG	ORANGEBURG	NPA			(10)					
	ORANGEBURG CO		TOTAL				416	416			490	140911	88.3%
YZ	ANNE MARIA REHAB & NURS CTR	25	AIKEN	N. AUGUSTA	PROP		132	132			313	47032	97.6%
YZ	BEVERLY HLTH & REHAB CTR-AIKEN	28	AIKEN	AIKEN	PROP		86	86			60	29515	94.0%
YZ	CARRIAGE HILLS PLANTATION REHAB CTR	36	AIKEN	AIKEN	PROP		57	60					
YZ	MATTIE CHAFEE HALL HLTH C		AIKEN	AIKEN	PROP		176	176			148	62408	97.1%
Z	(NEW ELLETON NURSING CTR)	36	AIKEN	NEW ELLENTON	PROP		(26)	(22)	(12)	scd	41	8878	93.6%
YZ	NHC HEALTHCARE N. AUGUSTA	26	AIKEN	N. AUGUSTA	PROP		132	132			163	46134	95.8%
YZ	PEPPER HILL NURS CTR		AIKEN	AIKEN	PROP		132	132			264	45600	94.6%
	AIKEN CO		TOTAL				715	718	0		979	239587	96.0%
	TOTAL						4231	4346	85		6664	1331839	92.2%

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CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued for renovation and construction with a 4 bed reduction from 40 general beds to 36 general beds, 2/8/92. Facility licensed for 36 general beds, 5/1/94.
2. Bed use restricted. Beds as reported by facility.
3. CON to construct a new 100 bed hospital Baker-North by replacing 60 beds from Baker Hosp and the relocation of 40 beds from Roper Hospital. The bed capacities would be 44 D&A beds at Baker, 100 general beds at Baker-North and 381 general plus 28 rehab beds at Roper 09/07/93. CON issued for 11 additional rehab beds and a reduction of 7 general beds resulting in 374 general and 29 rehab beds, 7/13/94. CON rescinded for replacement of Baker, 3/9/95. Roper licensed for 414 general & 39 rehab beds,5/11/95. CON issue for transferring 26 acute beds from Roper North to establish Charleston LTC Hosp as a 26 beds long term acute hosp; resulting in Roper North 34 bed acute, 44 bed substance abuse & Charleston LTC as 26 long term acute beds, 4/15/96. Con rescinded fo 26 long term acute beds, 8/29/97.
4. CON issued for renovation and expansion of the outpatient capacity of OR area from 5 OR rooms and 2 endoscopy rooms to 8 OR rooms and 2 endos rooms, 5/13/93.
5. Total general beds, admissions, and patient days are allocated by patient origin to the Trident area and SW.
6. CON issued to construct a new 198 general bed hospital, west of the Ashley, to replace the existing licensed 362 general bed hospital, 12/7/92. Facility licensed for 141 general beds,12/16/96.
7. CON issued for expansion of ancillary areas and addition of 34 general beds, 7/1/87. Facility licensed for 280 general and 20 psy beds, 2/5/88. CON issued to relocate 39 general beds for construction of Summerville Medical Center licensed for 80 general beds, 8/13/93. CON issued for Trident Reg Med Ctr to provide ambulatory surgery within the hospital, 12/28/95. CON to convert 10 general beds to nurs hm for a total of 251 general ,25 nurs hm &

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20 psy, 10/15/96. See Footnote #8. Facility licensed for 251 general , 20 psy & 25 nurs hm beds, 2/21/97.

8. CON issued to construct a 56 bed specialty hospital to include 20 psychiatric beds which would be transferred from TRMC and 36 rehab beds, 12/10/92. Authorization for temporary licensure of 20 general beds as 20 rehab beds as Trident Neurosciences Ctr. in Summerville Med. Ctr., 11/19/93. Licensed general beds still licensed at Trident Reg but to be licensed at Summerville, total 241 general, 20 psy and 15 nursing hm., 6/6/94. Trident skilled nur ctr. licensed for 15 LTC beds, 7/6/94. Neuroscience 36 rehab; Summerville Med. Ctr. 80 general beds, 9/7/94. Trident Neuro licensed for 36 rehab beds (which removes the 20 temp rehab beds from Summerville), 9/24/94. Con issued for 14 nurs hm beds and 80 general beds, 10/17/94. Cola Summerville SNF licensed for 14 beds 11/1/94. Con Trident for 10 addtional nurs hm beds for a total of 25 nurs hm, 251 general & 20 psy, 10/15/96. Con for Summerville to convert 6 general beds to nurs hm for 74 general & 20, 10/08/96. Fcaility licensed for 74 general & 20 nurs hm beds, 2/20/97.
9. Provision of temporary detox for the Tri-county Commission of D&A, 8/31/94.
10. CON issued for 72 non-Medicaid nurs hm beds, 8/15/90. Licensed for 20 psych. beds, 7/18/94. Facility licensed for 44 LTC beds, 10/3/94.
11. CON issued for closure of Fenwick with the transfer of 8 psy & 10 d&a beds resulting in 78 psy & 10 d&a beds, 4/21/95. Charter licensed for 60 psy &10 d&a beds with partial fulfillment of the above con, 5/24/95. Since the facility did not fullfill rest of the con by 5/24/96 by licensing the additional 18 psy beds; these beds will be removed from the survey beds resuling in a 60 bed capicity at the facility, 7/2/97.
12. CON issued for 15 crisis stab beds to the existing 67 psy beds, 8/12/94. Facility licensed for 82 psy beds (67 & 15 crisis beds), 6/15/95.
13. CON issued for 52 RTC beds, 6/1/92. Licensed for 52 RTC beds, 1/26/93.
14. CON issued for 11 additional rehab beds with total of 25 beds, 11/19/91. Facility licensed for 25 rehab beds, 12/1/94.
15. Licensed for 36 rehab bes,9/7/94. Formerly Trident Neuroscience. Con issued for 3 additional rehab beds for a total of 39, 10/26/98. Facility licensed for 39 rehab beds, 11/23/98.
16. CON issued for 23 D&A beds for research with funding from a federal grant and the beds will not be counted against the area, 10/2/92. Facility licensed for 23 D&A beds, 3/23/95.
17. CON issued for 44 non-Medicaid Nursing Home beds, 2/5/92. Facility licensed for 44 beds with name change from Sea Pines, 2/10/97.
18. CON issued for 88 dual beds (74 Medicaid), 10/29/91. Faility licensed for 22 beds, 4/13/95. Formerly, St. Stephens. Licensed beds increased from 22 to 44, 6/26/95. Licensed beds increased from 44 to 66, 9/18/95. Licensed beds increased from 66 to 76, 12/11/95. Licensed beds from 76 to 88, 1/29/96.

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19. CON issued to convert 20 restricted beds to comm. for a total of 44 nursing hm beds, 6/7/94. Facility licensed for 44 comm beds, 10/18/94. CON issued for 10 addtional non-medicaid for a total of 54 beds,3/12/97. Facility licensed for 45 beds, 5/6/97. Licensed beds increased by 8 from 45 to 53,9/22/98. Licensed beds to stay at 53 with with the reduction of the 8 additional beds to 7, 7/7/99.
20. CON issued for an additional 44 dual beds (40 Medicaid) with an increased from 88 to 132 beds, 12/11/89. Facility licensed for 132 beds, 6/2/95.
21. CON issued for 88 non-Medicaid beds, 8/6/91. Facility licensed, 11/22/93. Name changed from Elmwood Plantation. P CON issued for 60 non-medicaid for a total of 148, 5/19/97. Facility licensed for 60 additional beds for a total of 148, 1/27/99.
22. CON issued for 28 additional non-Medicaid beds for a total of 160 LTC beds, 4/13/93.
23. CON for 17 additional non-Medicaid beds for a total of 60 LTC beds, 5/19/93. Licensed for 60 LTC beds, 9/30/94.
24. CON issued for replacement of 132 existing beds and the addition of 44 non-Medicaid beds for a total of 176 beds, 7/11/94. Facility licensed beds increased from 132 to 176, 5/10/96. Exemption issued for conversion of 21 nurs hm beds to 20 rcf beds for a total of 155 nurs hm & 64 crf beds, 9/22/98. Facility licensed for 155 nurs hm beds,9/24/98.
25. CON issued for 3 additional beds for a total of 132, 10/19/94. Licensed beds increased from 129 to 132, 6/6/95.
26. CON issued for 82 dual beds, 1/23/90. CON issued for 6 additional beds total of 88, 9/10/90. Facility licensed for 44, 12/6/91. Licensed beds increased from 44 to 88, 3/23/92. CON issued for 44 additional beds for a total of 132 LTC beds, 12/16/92. Facility licensed for 132 LTC beds, 8/16/94.
27. CON issued to convert 4 acute beds plus 11 new nurs hm beds for a total of 15 nurs hm beds & 64 general acute beds, 8/29/95. Licensed for 15 nurs hm beds & 64 hosp beds, 12/19/95. Con for 4 additional general beds for a total of 68 gen beds,6/27/97.
28. Name changed from Aiken Nurs Hm, 10/1/95.
29. Exemption to upfit existing shell space for a operating room to an endoscopic procedure room, 9/18/95.
30. Con issued for 44 nurs hm ,without medicaid, with 24 community beds & 20 restricted beds, 9/16/98.
31. CON for 44 additional non-medicaid beds for a total of 88 beds, 11/17/95. Licensed beds increased from 44 to 88, 10/15/98.
32. CON issued for 33 additional non-medicaid beds for a total of 69 comm & 8 non-comm, 12/19/95.Facility licensed for 69 comm & 8 noncomm beds, 5/1/97. Facility will temporarily close nursing unit, 11/18/97.
33. Temporary use of psy beds as detox without change of licensure, 8/21/96.
34. CON for 32 additional medicaid beds for a total of 120, 11/19/96. Facility licensed for 120 beds, 2/1/98.
35. CON for 16 additional medicaid beds for a total of 104 nurs beds, 11/25/96. Facility licensed beds increased by 16

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from 88 to 104, 2/19/99.

36. CON issued for replacement facility with 31 non-medicaid additional beds for a total of 57 nurs hm beds, 8/7/96. Name changed and licensed for 57 nurs beds, 7/8/98. CON 99-35 issued for 3 non-medicaid beds for a total of 60, 10/11/99.

37. Exmpt to reduce 4 beds & relocate 19 nurs beds to add 23 res beds for total licensure of 128 nurs hm beds & 40 res beds, 2/20/97. Licensed nurs hm beds reduced from 132 to 128, 5/9/97. Exemption to close 46 nurs hm beds for a total of 82 nurs hm beds, 10/15/98. Facility licensed for 82 beds, 10/15/98.
38. CON issued for 42 non-medicaid nurs hm, 12/1/97. Facility licensed for 42 nurs beds, 6/11/99.
39. APP for a 120 non-medicaid nurs hm, 6/24/97.Appealed. CON issued for the 120 non-medcaid nurs hm beds, 8/17/98.
40. Fomerly Health Care Of Hilton Head, 6/1/97.
41. Con issued to convert 10 general beds to nurs hm for 261 general, 15 psy & 10 nurs hm beds, 12/8/97. Con voided to convert 10 hosp beds to nurs hm, 11/24/98. CON voided 12/9/99.
42. Con issued to relocate & replace the existing 31 bed hospital, 2/23/98. Discontinued OB services, 4/8/98.
43. Con issued to transfer 59 beds from Charleston Mem to establish Speciality Hosp of SC a 59 long term acute care hospital, 8/4/98. Specialty Hosp of SC licensed for 37 of the 59 Ltc acute beds & Charleston Mem licensed gen acute beds reduced from 157 to 120,12/2/98. Specialty Hosp of SC licensed beds increased by 12 rom 37 to 59 & Charleston Mem reduced from 120 general to 98 general & 15 psy, 7/4/99.
44. Con issued for 60 nurs hm non-medicaid beds, 9/16/98.
45. NA-99-54 build out the hospital's 5th for the addition of 12 non-licensed observation beds, 7/7/99.

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INVENTORY OF EMERGENCY FACILITIES

FY 1999 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1997 ER VISITS
REGION IV:	EMERGENCY FACILITIES			
II	AIKEN REG MED CTR	AIKEN	AIKEN	49073
IV	ALLENDALE CO HOSP	ALLENDALE	FAIRFAX	8365
III	BAMBERG CO MEM HOSP	BAMBERG	BAMBERG	10143
III	BARNWELL CO HOSP	BARNWELL	BARNWELL	10948
III	BEAUFORT CO MEM HOSP	BEAUFORT	BEAUFORT	21692
II	HILTON HEAD HOSP	BEAUFORT	HILTON HEAD	15398
II	ROPER HOSP NORTH	CHARLESTON	CHARLESTON	16522
II	CHARLESTON MEM HOSP	CHARLESTON	CHARLESTON	32208
II	EAST COOPER REG MED CTR	CHARLESTON	MT PLEASANT	13062
II	TRIDENT MED CTR	CHARLESTON	CHARLESTON	32552
II	ROPER HOSP	CHARLESTON	CHARLESTON	40088
II	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON	13913
(*)	MUSC MEDICAL CTR	CHARLESTON	CHARLESTON	18599
III	COLLETON MED CTR	COLLETON	WALTERBORO	18238
II	SUMMERVILLE MED CTR	DORCHESTER	SUMMERVILLE	25285
III	HAMPTON REG MED CTR	HAMPTON	VARNVILLE	6883
III	LOW COUNTRY GEN HOSP	JASPER	RIDGELAND	6117
II	RMC ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG	32187
TOTALS				371273

(*) Met insufficient criteria to be classified.

REGION IV:	TRAUMA CENTERS		
III	AIKEN REG MED CTR	AIKEN	AIKEN
III	BEAUFORT CO MEM HOSP	BEAUFORT	BEAUFORT
I	MUSC MEDICAL CTR	CHARLESTON	CHARLESTON
III	EAST COOPER COMM HOSP	CHARLESTON	MT PLEASANT
III	ROPER HOSP	CHARLESTON	CHARLESTON
III	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON
III	TRIDENT MED CTR	CHARLESTON	CHARLESTON
III	HILTON HEAD HOSP	BEAUFORT	HILTON HEAD
III	ORANGEBURG-CALHOUN REG	ORANGEBURG	ORANGEBURG

South Carolina Health Plan



SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Petitioner's Trial Exhibit 005

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2001 South Carolina Health Plan

South Carolina State Health Planning Committee

South Carolina Department of Health and Environmental Control

Effective June 15, 2001 for all sections except for converting hospital based nursing home beds to acute care beds and PET scanners, which were effective September 15, 2001 and mobile cardiac catheterization section which was effective October 12, 2001.

South Carolina State Health Planning Committee
As of 11/1/2001

Member	Representing	Term expires
Gerald A. Wilson, M.D. Chairman	Provider	6/30/02
Langdon A. Hartsock, M.D.	Provider	6/30/04
Bradley W. Moorhouse	Provider	6/30/02
Frederick D. Hobby	Provider	6/30/04
Nicki S. Davis	Finance/Business	6/30/04
James E. Armbruster	Finance/Insurance	6/30/04
Angela H. McCrae	Finance/Business	6/30/06
Samuel A. Williams	Finance/Insurance	6/30/06
Edward D. Tinsley, III	Consumer	6/30/02
Oscar J. Harm, III, Ph.D.	Consumer	6/30/06
William Patrick Flack	Consumer	6/30/04
Billy R. Oswald	Consumer	6/30/04
Nancy V. Coombs	Ex Officio	(Consumer Affairs)
Larry Chewning, D.M.D.	DHEC Board	6/30/03

All correspondence should be addressed to: State Health Planning Committee, Division of Planning and Certification of Need, 2600 Bull Street, Columbia, South Carolina 29201. 803-545-4200

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CHAPTER I

INTRODUCTION

Legal Basis

Purpose

Relationship with Other Agencies

Standards of Construction and Equipment

Standards for Maintenance and Operation

State Certification of Need and Health Facility Licensure Act

Indigent Care Policy

Relative Importance of Project Review Criteria

Existing Resources and Capacity

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CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is conscious that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

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E. Standards of Construction and Equipment:

Construction of health care facilities will comply with the Standards for Licensing as promulgated by the S.C. Department of Health and Environmental Control.

F. Standards for Maintenance and Operation:

1. Pursuant to the "State Certification of Need and Health Facility Licensure Act," the South Carolina Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of hospitals and other health care facilities in South Carolina. The Division of Health Licensing within DHEC is responsible for licensing Hospitals, Nursing Homes, Intermediate Care Facilities for the Mentally Retarded, Ambulatory Surgical Centers, Home Health Agencies, Hospices, Community Residential Care Facilities, End Stage Renal Dialysis facilities, Psychiatric Hospitals, Substance Abuse Treatment Facilities (inpatient and outpatient), Halfway Houses, Detoxification Centers, Residential Treatment Centers for Children and Adolescents, Adult Day Care Facilities, Chiropractic Inpatient Facilities, Hearing Aid Dealers and Fitters, Lay Midwives, Birthing Centers and Health Maintenance Organizations.

2. Health Officers in local county health departments and various Bureaus of DHEC provide health care facilities with professional consultation, e.g., medical, laboratory, nursing, dietary, home visitation, x-ray, et cetera.

3. The Office of Environmental Quality Control, DHEC, must approve all water supply and sewage disposal systems.

G. State Certification of Need and Health Facility Licensure Act:

1. The purpose of the State Certification of Need and Health Facility Licensure Act as amended is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

2. This law requires:

   (1) the issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;

   (2) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;

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(3) preparation and publication of a State Health Plan, with the advice of the health planning committee; and

(4) the licensure of facilities rendering medical, nursing and other health care.

3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.

4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet at www.scdhec.net.

H. Indigent Care Policy:

The following indigent care policy shall apply to all Certificate of Need applications which have a capital cost associated with a health service or beds; the establishment or expansion of a home health agency; or change of ownership or controlling interest in a health care facility or home health agency. Certificate of Need applications will be reviewed with particular emphasis on the Department's accessibility criteria. Applications which fail to address this issue in enough specificity, or which fail to reflect an adequate commitment to meeting this identified community need will be denied by Department staff subject to review on appeal by the Board of Health and Environmental Control.

The South Carolina Board of Health and Environmental Control is particularly concerned about the problems of accessibility and indigent care in South Carolina health care facilities. It is in the interest of the Board to assure all citizens of this state equal access to our health care facilities including those who are not fortunate enough to be able to pay for their health care services. For this reason, the Board has adopted the following policy:

> "It shall be the policy of the S.C. Board of Health and Environmental Control to require all applicants for Certification of Need to address in detail their plan of access to care for the indigent population in their application. This plan must separately identify bad debt and contractual adjustments from any indigent care as addressed in their plan for provision of indigent care. Applications which fail to address this issue adequately and clearly or which fail to reflect an adequate commitment to meeting this identified community need shall be denied by the staff subject to review on appeal by the Board."

For the purpose of this policy, the following definitions are adopted:

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1. Indigent Care - That medical care (measured in dollars) provided to an individual who has been determined to be unable to pay for this care prior to admission in non-emergency situations, and as soon as possible but before the discharge in emergency situations and for which only one billing has occurred and no other efforts have been undertaken to collect such debt. Indigent care does not include debt; contractual adjustments; or care which is reimbursed by a governmental program (Medicare, Medicaid, County indigent care program), church, or philanthropic organizations.

2. Revenue - When indigent care is expressed as a percentage of revenue, gross operating revenues should be used. Gross operating revenues are total charges prior to reduction due to contractual adjustments, discounts, bad debts or similar revenue adjustments.

3. Department - The South Carolina Department of Health and Environmental Control.

4. Health Care Facility or facility - Those "health care facilities" as defined in the State Certification of Need and Health Facility Licensure Act, Section 44-7-130 (10).

5. Home Health Agency or agency - Those "home health agencies" as defined in the Licensure of Home Health Agencies Act Section 44-69-20 (4).

The provisions of this policy will apply to all health care facilities and home health agencies that apply to the Department for a Certificate of Need. When an application is submitted, the applicant shall submit as part of the application, an indigent care plan addressing all of the elements of the Board's policy. The plan will describe how the health care facility or home health agency will address indigent care. It shall include at a minimum, the following:

1. The existing and proposed admission and treatment policies of the facility or agency with regard to race, sex, creed, national origin, and ability to pay.

2. The proposed admission and treatment policies of the facility or agency with respect to admission and care of indigent patients including those patients unable to pay at the time of admission and those whose benefits expire while in the care of the facility or agency.

3. In existing facilities or agencies, provide the amount, in terms of dollars and percent of gross revenues, that the facility or agency provided in indigent care during the past three fiscal years. NOTE: Indigent care is defined in H-1.

4. Provide the proposed amount of indigent care the facility or agency projects to provide during the existing fiscal year and next fiscal year. This projection shouldbe expressed in both dollars and a percent of gross revenues.

5. A discussion of why the above figures are adequate or inadequate for the needs of the

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community; the need of indigent care within the proposed service area; and any solutions, remedial plans or proposals by the facility or agency to better address the indigent care problems in the service area. Include any initiatives or undertakings the facility or agency has begun to address the indigent care problems in the proposed service area.

6. Describe any Board or Advisory Board established to implement or control the Indigent program at the facility or agency. Include the Board's functions, responsibilities and limitations.

I. Relative Importance of Project Review Criteria:

In accordance with the latest revisions to the Certification of Need and Health Facility Licensure Act, a general statement has been added to each section of Chapter II stating the project review criteria considered to be the most important in reviewing certificate of need applications for each type of facility, service, and equipment. These criteria are not listed in order of importance, but sequentially as found in Chapter 8 of Regulation No. 61-15, Certification of Need for Health Facilities and Services. In addition, a finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse affects caused by the duplication of any existing facility, service or equipment.

J. Existing Resources and Capacity:

To preclude unnecessary duplication, the existing resources and capacity of all services and facilities will be considered prior to the approval of any Certificate of Need application.

CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

- Inventory Regions and Service Areas
- Exceptions to Service Area Standards
- Identification of Inventory Regions
- Estimated State Civilian Population
- Patient Statistics
- Facility Information and Plan Cut-Off Date
- Categories of Facilities and Services
  - General Medical Facilities and Services
    - General Hospitals
    - General Hospital-Bed Supply
    - General Hospital-Occupancy Rate
    - Obstetrical and Neonatal Services
      - Obstetrical Services
      - Neonatal Services
    - Pediatric Inpatient Services
    - Cardiovascular and Associated Heart Disease
      - Cardiac Catheterization
      - Open Heart Surgery
    - Cancer
      - Linear Accelerators
      - Gamma Knife
    - Diagnostic Imaging
      - Magnetic Resonance Imaging
      - Positron Emission Tomography
      - CT Scanner Utilization
    - End-Stage Renal Disease
    - Lithotriptors
    - Outpatient Facilities
      - Ambulatory Surgical Facilities
      - Emergency Hospital Services
      - Trauma Referral System
  - Community Psychiatric Beds
  - Residential Treatment Facilities for Children and Adolescents
  - Alcohol and Drug Abuse Facilities
  - Rehabilitation Facilities
  - Long-Term Care Facilities and Services
    - Nursing Homes
    - Medicaid Nursing Home Permits
    - Mental Retardation Facilities
    - Retirement Community: Nursing Home Units
    - Swing Beds
    - Home Health Agencies
    - Subacute Care
    - Other Services for the Elderly
  - Alzheimer's Disease
  - People with HIV/AIDS
  - Rural Health Care
  - Long-Term Care Hospitals

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CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration. The Health Service Area (HSA) designations previously used are no longer applicable and have been replaced.

The needs for hospitals, nursing homes, and home health services are projected by county. The needs for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents are based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The needs for most services (cardiac catheterization, open heart surgery, etc.) are based upon the service standard, which is a combination of utilization criteria and travel time requirements. Each service standard constitutes the service area for that particular service.

Any service area may cross multiple administrative, geographic, trade and/or political boundaries. It is recognized that due to factors which may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the state. Therefore, service areas may specifically cross inventory regions and/or state boundaries. The need for a service is analyzed by an assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan and applicable statutes and regulations.

B. Exceptions to Service Area Standards:

It must be recognized that the health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, we are seeing a number of health care facilities consolidating and establishing provider networks in order to better compete for contracts within the new environment. This is particularly important for the smaller, more rural, facilities which run the risk of being bypassed by insurers and health care purchasers looking for the availability of comprehensive health care services for their subscribers.

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes desire to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as being two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds,

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equipment or services. There may be certain instances where 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; however, such transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. 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 services may be approved only if there is no overall increase in the number or amount of such services;

(2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;

(3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

(4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impacts must be detailed along with the perceived benefits of the proposal;

(5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;

(6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;

(7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

Region	Counties
I	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and Union.
II	Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda and York.
III	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg.

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IV Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg.

D. Estimated State Civilian Population:

This Plan has been developed using the estimated civilian population of 3,868,100 for 1999 and projected population of 4,130,600 for 2005 where these projections were required for calculations. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 1999 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

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 October 1, 2001.

G. Categories of Facilities and Services:

1. General Medical Facilities and Services

(A) General Hospitals

(1) Definitions:

(a) A "hospital" means a facility organized and administered to provide overnight medical or surgical care 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.

(b) "Hospital beds" 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.

(2) Bed Capacity is as follows:

(a) For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds

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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.

Adequate square footage is defined as:

100 square feet in single rooms;
80 square feet per bed or pediatric crib in multi-bed rooms;
40 square feet per bassinet in pediatric nurseries.

In measuring the square footage of patient rooms for the purpose of determining bed capacity, only the net usable space in the room was considered. Space in toilet rooms, wash rooms, closets, vestibules, and corridors were not included.

(b) For facilities constructed under the Certificate of Need program, bed capacity will be as stated in the certificate, regardless of oversize room construction.

(c) For Areas Included:

1. Bed space in all nursing units, including: (1) intensive care unit and (2) minimal or self-care units.
2. Isolation units.
3. Pediatric units, including: (1) pediatric bassinets and (2) incubators located in the pediatric department.
4. Observation units equipped and staffed for overnight use.
5. All space designated for inpatient bed care even if currently closed or assigned to easily convertible, non-patient uses such as administration offices or storage.
6. Space in areas originally designed as solaria, waiting rooms, offices, conference rooms and classrooms which have necessary fixed equipment and are accessible to a nurses' station exclusively staffed for inpatient care.
7. Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

(d) For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.

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7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.
8. Corridors.
9. Solaria, waiting rooms and such which are not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) {an area which is finished except for movable equipment shall not be considered unfinished space}.
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are a separate category of bed utilizing the same criteria outlined for general acute beds.

(3) Inventory:

(a) All licensed general hospitals, as well as Federal facilities, are included in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days listed for the general hospital category does not include days of care rendered in psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventory.

(b) Total capacity by survey refers to a total designed capacity or maximum number of beds which 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, such as:

1. Fire-resistivity of each building.
2. Fire and other safety factors of each building.
3. Design and structural factors affecting the function of nursing units.
4. Design and structural factors affecting the function of service departments.

(4) Narrative: General Hospital Beds

The General Acute Hospital bed need methodology is based on analyses including historical utilization; nationally recognized bed need methodologies; and consideration of the physical characteristics of hospitals in the State. Based upon these analyses, a variable occupancy rate methodology was developed, as follows:

0-174 bed rural hospital with less than 4,000 admissions, 70%;
0-174 bed urban hospital or rural with greater than 4,000 admissions, 75%;
175-349 beds, 75%; and
350+ beds, 80%.

The population and associated utilization has been 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

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over, recognizing that different population groups have different utilization rates. In some areas, different age groups were used based on the data available from the facility.

It should be noted that, throughout the Plan where the term "hospital bed need" is specified, these figures are actually based upon demand or utilization data for the general acute hospitals. Use of these planning factors is not intended to stem initiative or to suggest that facilities cannot operate at more efficient levels than used in the calculations without additional beds.

The methodology for calculating bed need follows:

(a) 1. Multiply the current facility use rate by age cohort by the projected population by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort;

2. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.70/.75/.80) to determine the number of beds needed to meet the area's need.

(b) The number of additional beds needed or excess beds is obtained by subtracting the number of existing beds from the bed need.

(c) The policy for allocation of hospital beds considers the county(ies) as the basic unit for planning. Institutions are listed for the purpose of applying the variable occupancy rates so that total county needs can be developed. Should there be a need shown for additional beds for an individual hospital, then up to 50 additional beds above this need may be approved for a cost-effective addition, provided the hospital can document and demonstrate the need for additional beds.

(d) In some areas of South Carolina, there is a considerable influx of tourists who are 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 the Department may approve some additional beds at the existing hospital based on further analysis.

(e) Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital. The impacted hospital must document this increase in demand and explain why additional beds are needed to accommodate the care of patients previously served at a Federal facility. Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.

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(f) Because of the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

1. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert these nursing home beds to acute care hospital beds only within the hospital provided the hospital can document an actual need for these additional acute care beds. This will be based on actual utilization using current information. A Certificate of Need is required for this conversion.

2. Existing general hospitals that have inpatient psychiatric or substance abuse beds may be allowed to convert these specialty beds to acute care hospital beds regardless of the projected need for general acute care hospital beds, provided a Certificate of Need is received.

(g) 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 following criteria:

1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

2. Such transfers may cross county lines; however, the applicants must document with patient origin data the historical utilization of the receiving facility by residents of the county giving up beds;

3. Should the response to Criterion 2. fail to show a historical precedence of residents of the county transferring the beds utilizing the receiving facility, the applicants must document why it is in the best interest of these residents to transfer the beds to a facility with no historical affinity for them;

4. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impacts must be detailed along with the perceived benefits of such an agreement;

5. The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

6. The facility giving up the beds may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

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7. A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of beds must be included in the Certificate of Need application;

8. Each facility giving up beds must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

(h) Factors to be considered regarding modernization of facilities should include:

1. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
2. The ability to update medical technology within the existing plant.
3. Existence of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) deficiencies or "grandfathered" licensure deficiencies.
4. Cost efficiency of the existing physical plant versus plant revision, etc.

(i) Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on health delivery and status within the service area.

(B) General Hospital - Bed Supply:

Existing beds are based upon survey capacity. Projected beds were based on the methodology outlined in this Chapter.

BEDS/1000 POPULATION	
Existing Beds/1999 Population:	2.66
Projected Beds/2005 Population:	1.99
Existing Beds/2005 Population:	2.49

(C) General Hospital - Occupancy Rate:

There should be an average annual occupancy rate of at least 75% for all nonfederal, short-stay hospital beds considered together except under extraordinary circumstances. Conditions which may justify an adjustment to this standard include:

1) Seasonal population fluctuation - In some areas, the influx of people for vacation or other purposes may require a greater supply of hospital beds than would otherwise be needed.

2) Rural areas - Lower annual occupancy rates are usually required by small hospitals to maintain empty beds to accommodate normal fluctuations of admissions (hospitals with less than 4,000 admissions/year are included in this group).

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The above conditions were either factored into the bed need methodology or there was no justification for an adjustment to the bed supply.

The actual statewide occupancy rate for nonfederal short-stay acute hospitals, based on average licensed beds for FY 1999 was 57.1%. The following pages depict the calculation of hospital bed need as described earlier.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Cost Containment; and
g. Adverse Effects on Other Facilities.

General hospital beds are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and current utilization and population growth are factored into the methodology for determining general hospital beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for these beds.

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FY 2005 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON AREA MEDICAL CTR	<18	38740	40180	4347	12.35				
	18-64	98860	103720	40137	115.37				
	+65	22900	24000	47998	137.82				
	TOTAL	160500	167900	92482	265.54	0.80	332	495	-163
ANDERSON CO.	TOTAL						332	495	-163
UPSTATE CAROLINA MED CTR	<18	12080	12640	844	2.46				
	18-64	29820	31260	6826	19.61				
	+65	6700	7100	7670	22.27				
CHEROKEE CO.	TOTAL	48600	51200	15340	44.33	0.70	63	125	-62
ALLEN BENNETT MEM	<18	86860	91520	171	0.50				
	18-64	222740	236780	5244	15.27				
	+65	45700	48400	8874	25.75				
	TOTAL	355300	376700	14290	41.52	0.70	60	58	2
GREENVILLE MEM MED CTR	<18	86860	91520	13799	39.83				
	18-64	222740	236780	93370	271.93				
	+65	45700	48400	72044	209.04				
	TOTAL	355300	376700	179213	520.81	0.80	651	710	-59
HILLCREST	<18	86860	91520	105	0.30				
	18-64	222740	236780	3173	9.24				
	+65	45700	48400	4816	13.97				
	TOTAL	355300	376700	8094	23.52	0.70	34	43	-9
NORTH GREENVILLE	<18	86860	91520	0	0.00				
	18-64	222740	236780	0	0.00				
	+65	45700	48400	0	0.00				
	TOTAL	355300	376700	0	0.00	0.70	0	0	0
SAINT FRANCIS HOSPITAL	<64	309600	328300	15295	44.44				
	+65	45700	48400	38020	110.32				
	TOTAL	355300	376700	53315	154.75	0.75	207	206	1
ST.FRANCIS WOMAN'S & FAMILY HOSP	<64	309600	328300	9151	26.59				
	+65	45700	48400	2970	8.62				
	TOTAL	355300	376700	12121	35.20	0.75	47	62	-15
GREENVILLE CO	TOTAL						999	1079	-80
OCONEE MEM	<18	14800	16080	843	2.51				
	18-64	41500	45520	14324	43.04				
	+65	9000	9700	18537	54.74				
OCONEE CO	TOTAL	65300	71300	33703	100.29	0.75	134	160	-26

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FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
CANNON MEM.	<18	23980	25980	70	0.21				
	18-64	74040	82020	2140	6.50				
	+65	12300	13600	4122	12.49				
	TOTAL	110300	121600	6332	19.19	0.70	27	55	-28
PALMETTO BAPTIST MED CTR EASLEY	<18	23980	25980	657	1.95				
	18-64	74040	82020	8027	24.36				
	+65	12300	13600	9075	27.49				
	TOTAL	110300	121600	17759	53.80	0.75	72	96	-24
PICKENS CO	TOTAL						99	151	-52
B.J. WORKMAN MEM.	<18	58720	62580	95	0.28				
	18-64	158280	169520	1002	2.94				
	+65	34000	36600	1702	5.02				
	TOTAL	251000	268700	2799	8.24	0.70	12	43	-31
SPGT HOSP RESTORATIVE CARE	<18	58720	62580	0	0.00				
	18-64	158280	169520	5013	14.71				
	+65	34000	36600	6538	19.28				
	TOTAL	251000	268700	11551	33.99	0.75	45	97	-52
MARY BLACK MEM.	<18	58720	62580	1686	4.92				
	18-64	158280	169520	11007	32.30				
	+65	34000	36600	10728	31.63				
	TOTAL	251000	268700	23420	68.86	0.75	92	176	-84
SPARTANBURG REG. MED.CTR.	<18	58720	62580	4995	14.59				
	18-64	158280	169520	51279	150.47				
	+65	34000	36600	45672	134.70				
	TOTAL	251000	268700	101946	299.75	0.80	375	532	-157
SPARTANBURG CO	TOTAL						524	848	-324
HOPE HOSP.	<18	7200	7200	0	0.00				
	18-64	18200	18500	722	2.01				
	+65	4900	5000	8	0.02				
	TOTAL	30300	30700	728	2.03	0.70	3	14	-11
WALLACE THOMSON	<18	7200	7200	965	2.65				
	18-64	18200	18500	8121	22.62				
	+65	4900	5000	9844	27.52				
	TOTAL	30300	30700	18930	52.78	0.70	75	143	-68
UNION CO	TOTAL						78	157	-79
REGION I	TOTAL						2229	3015	-786

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FY 2005 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ABBEVILLE CO. MEM.	<18	6140	6560	206	0.60				
	18-64	14960	16640	1760	5.36				
	+65	3300	3400	3195	9.02				
ABBEVILLE CO.	TOTAL	24400	26600	5161	14.99	0.70	21	52	-31
CHESTER CO. HOSP.	<18	9680	10820	1228	3.76				
	18-64	18420	19080	5094	14.46				
	+65	5500	5500	6608	18.10				
CHESTER CO.	TOTAL	33600	35400	12928	36.31	0.70	52	82	-30
EDGEFIELD CO.HOSP.	<18	5300	6000	173	0.54				
	18-64	12300	13800	1038	3.19				
	+65	2200	2600	1687	6.11				
EDGEFIELD CO.	TOTAL	19800	22400	3098	9.84	0.70	14	40	-26
FAIRFIELD MEM	<18	5560	5720	195	0.55				
	18-64	14340	14480	1654	4.58				
	+65	3700	3900	2492	7.20				
FAIRFIELD CO.	TOTAL	23600	24100	4341	12.32	0.70	18	33	-15
SELF MEM.HOSP.	<18	15460	16320	2037	5.89				
	18-64	39540	41780	22456	65.01				
	+65	8600	8700	25188	69.81				
GREENWOOD CO.	TOTAL	63600	66800	49681	140.71	0.75	188	334	-146
KERSHAW CO.MEM HOSP	<18	12300	13380	1611	4.80				
	18-64	30100	32820	7566	22.46				
	+65	6500	7000	12016	35.45				
KERSHAW CO.	TOTAL	48900	53000	21193	62.72	0.75	84	121	-37
SPRINGS MEM	<18	13580	13880	1786	5.00				
	18-64	36120	37220	13338	37.66				
	+65	7300	7900	12780	37.89				
LANCASTER CO.	TOTAL	57000	59000	27904	80.55	0.75	107	135	-28
LAURENS CO HOSP	<18	15540	15820	609	1.70				
	18-64	37860	39180	7611	21.41				
	+65	10100	10300	10896	30.44				
LAURENS CO.	TOTAL	63300	65300	19016	53.55	0.70	77	76	1
LEXINGTON MED CTR	<18	31061	34575	2109	6.43				
	18-64	86659	96805	32457	99.33				
	+65	12230	13630	33478	102.22				
LEXINGTON CO.	TOTAL	129950	145010	68044	207.99	0.75	277	292	-15
NEWBERRY CO. MEM.	<18	8960	9060	282	0.78				
	18-64	21140	21340	3298	9.12				

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FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
NEWBERRY CO.	+65	5600	5600	6475	17.74				
	TOTAL	35700	36000	10055	27.84	0.70	39	90	-51
PALMETTO BAPTIST MED CTR COLA & INTERMEDICAL HOSP OF SC	<18	90359	95525	2496	7.23				
	18-64	260321	276195	36630	106.48				
	+65	37370	39970	34281	100.48				
	TOTAL	388050	411690	73407	214.16	0.80	268	398	-130
PROVIDENCE HOSPITAL AND PROVIDENCE HOSPITAL NE #1	<18	90359	95525	66	0.19				
	18-64	260321	276195	27388	79.55				
	+65	37370	39970	38354	112.39				
	TOTAL	388050	411690	65788	192.13	0.75	256	293	-37
PALMETTO RICHLAND MEM HOSPITAL	<18	90359	95525	20006	57.94				
	18-64	260321	276195	87718	254.98				
	+65	37370	39970	45706	133.93				
	TOTAL	388050	411690	153430	446.86	0.80	559	579	-20
RICHLAND CO.	TOTAL						1083	1270	-187
PIEDMONT MED. CTR.	<18	36600	41240	3163	9.73				
	18-64	103800	117460	26979	83.64				
	+65	17600	19600	30496	93.05				
	TOTAL	158000	178300	60628	186.42	0.75	249	248	1
YORK CO.	TOTAL						249	248	1
REGION II	TOTAL						2209	2773	-564
CHESTERFIELD GENERAL	<18	8600	8700	766	2.07				
	18-64	24800	25100	3814	10.58				
	+65	6700	6700	2644	7.24				
CHESTERFIELD CO.	TOTAL	40300	40500	7224	17.82	0.70	25	59	-34
CLARENDON MEM. HOSP.	<18	7820	8440	797	2.36				
	18-64	16280	20160	5701	17.23				
	+65	4500	4600	5580	15.63				
CLARENDON CO.	TOTAL	30600	33200	12078	35.21	0.70	50	56	-6
CAROLINA PINES REG HOSPITAL	<18	16280	17100	1935	5.57				
	18-64	41020	42700	11418	32.56				
	+65	8700	8600	10837	29.35				
	TOTAL	66000	68400	24190	67.48	0.75	90	116	-26

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FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
WILSON MEDICAL CTR	<18	16280	17100	27	0.08				
	18-64	41020	42700	1723	4.91				
	+65	8700	8600	2726	7.38				
	TOTAL	66000	68400	4476	12.37	0.70	18	50	-32
DARLINGTON CO.	TOTAL						108	166	-58
SAINT EUGENE MEDICAL CENTER	<18	8740	8640	1753	4.75				
	18-64	18360	18460	6294	17.34				
	+65	3300	4000	5548	18.42				
DILLON CO.	TOTAL	30400	31100	13593	40.50	0.70	58	79	-21
CAROLINAS HOSP SYS &	<18	32880	33200	2268	6.27				
WOMEN'S CENTER OF THE	18-64	78120	80300	26715	75.23				
CAROLINAS HOSP. SYS. #1	+65	14600	15000	34024	95.77				
	TOTAL	125600	128500	63007	177.28	0.75	236	282	-46
CAROLINAS HOSP SYS LAKE CITY	<18	32880	33200	295	0.82				
	18-64	78120	80300	2717	7.65				
	+65	14600	15000	3396	9.56				
	TOTAL	125600	128500	6408	17.96	0.70	26	48	-22
MCLEOD REG MED CTR	<18	32880	33200	8759	24.23				
	18-64	78120	80300	52243	147.13				
	+65	14600	15000	43275	121.81				
	TOTAL	125600	128500	104277	293.17	0.75	391	336	55
FLORENCE CO.	TOTAL						853	666	-13
GEORGETOWN CO. MEM. AND	<18	14600	15520	1933	5.63				
WACCAMAW NECK	18-64	32500	35180	16498	48.93				
	+65	6200	6800	17358	52.16				
GEORGETOWN CO.	TOTAL	53300	57500	35790	106.72	0.75	143	142	1
CONWAY HOSP. INC.	<18	38460	43700	2878	8.96				
	18-64	109840	125700	16037	50.28				
	+65	28000	33000	18467	59.63				
	TOTAL	176300	202400	37382	118.87	0.75	159	160	-1
GRAND STRAND REG MED CTR	<18	38460	43700	753	2.34				
	18-64	109840	125700	18326	57.46				
	+65	28000	33000	22719	73.36				
	TOTAL	176300	202400	41798	133.16	0.75	178	219	-41
LORIS COMM. HOSP.	<18	38460	43700	865	2.69				
	18-64	109840	125700	8303	26.03				
	+65	28000	33000	9242	29.84				
	TOTAL	176300	202400	18410	58.57	0.70	84	105	-21

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FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
HORRY CO.	TOTAL						421	484	-63
MARION CO MEDICAL CTR	<18	10080	10020	1366	3.72				
	18-64	20920	20980	16032	44.05				
	+65	4800	4700	15122	40.57				
	TOTAL	35800	35700	32520	88.34	0.70	126	124	2
MARION CO.	TOTAL						126	124	2
MARLBORO PARK	<18	8120	8420	491	1.39				
	18-64	18880	19980	4240	12.29				
	+65	3700	3800	4527	12.74				
MARLBORO CO.	TOTAL	30700	32200	9258	26.43	0.70	38	94	-56
TUOMEY	<18	32080	33400	3137	8.95				
	18-64	67320	70300	26465	75.72				
	+65	11100	12500	27435	84.84				
SUMTER CO.	TOTAL	110500	116200	57037	169.31	0.75	226	229	-3
WILLIAMSBURG REGIONAL HOSP	<18	10280	10280	323	0.88				
	18-64	22620	23220	2158	6.07				
	+65	3900	3800	3095	8.26				
WILLIAMSBURG CO.	TOTAL	36800	37300	5576	15.22	0.70	22	78	-56
REGION III	TOTAL						1870	2177	-307
ALLENDALE CO HOSP	<18	3280	3600	182	0.65				
	18-64	6720	7100	857	2.48				
	+65	1900	2100	681	2.08				
ALLENDALE CO.	TOTAL	11900	12800	1720	5.09	0.70	7	36	-29
BAMBERG CO. MEM.	<18	4740	4440	247	0.63				
	18-64	10260	10060	2718	7.30				
	+65	2400	2400	3072	8.42				
BAMBERG CO.	TOTAL	17400	16900	6035	16.35	0.70	23	59	-36
BARNWELL CO. HOSP	<18	6220	6520	273	0.78				
	18-64	13780	14980	1734	5.16				
	+65	2600	2600	2394	6.56				
BARNWELL CO.	TOTAL	22600	24100	4401	12.51	0.70	18	53	-35
BEAUFORT CO. MEM.	<18	24660	27640	1779	5.49				
	18-64	63940	73260	16217	50.91				

RECORD 003541
PMC.2013.SHP.0028
PET-EX005.0028

FY 2005 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
	+65	14100	16500	11652	37.36				
	TOTAL	102600	117400	29648	93.75	0.75	125	130	-5
HILTON HEAD MEDICAL CTR & CLINICS	<18	24580	27840	207	0.64				
	18-64	63940	73260	5468	17.16				
	+65	14100	16500	10262	32.90				
	TOTAL	102600	117400	15935	50.70	0.70	72	93	-21
BEAUFORT CO.	TOTAL						197	223	-26
TRIDENT MED CTR	<18	50726	54686	2517	7.44				
AND	18-64	123524	133844	39813	117.60				
SUMMERVILLE MED CTR	+65	16310	17890	31987	96.13				
	TOTAL	190560	206430	74117	221.16	0.75	295	345	-50
BERKELEY/DORCHESTER COS.	TOTAL						295	345	-50
ROPER HOSP NORTH #2	<18	90554	94124	33	0.09				
DATA , BEDS AND BED NEEDS ARE	18-64	221896	232636	2205	6.33				
WITH BON SECOURS ST. FRANCIS	+65	37990	40210	3221	9.34				
	TOTAL	350440	366970	5459	15.77	0.75			
CHARLESTON MEMORIAL &	<18	90554	94124	2	0.01				
SPECIALITY HOSPITAL OF SC	18-64	221896	232636	14399	41.38				
	+65	37990	40210	5477	15.88				
	TOTAL	350440	366970	19878	57.25	0.75	76	157	-81
MEDICAL UNIVERSITY HOSP.	<18	141280	148820	11400	32.90				
	18-64	345420	366480	34844	101.28				
	+65	54300	58100	12219	35.82				
	TOTAL	541000	573400	58463	170.00	0.80	213	221	-8
ROPER HOSP.	<18	90554	94124	1450	4.13				
	18-64	221896	232636	39531	113.55				
	+65	37990	40210	55479	160.88				
	TOTAL	350440	366970	96460	278.55	0.80	348	414	-66
BON SECOURS	<18	90554	94124	779	2.22				
ST. FRANCIS XAVIER	18-64	221896	232636	21706	62.35				
	+65	37990	40210	18495	53.63				
	TOTAL	350440	366970	40980	118.20	0.75	158	201	-43
EAST COOPER REG MED CTR.	<18	90554	94124	112	0.32				
	18-64	221896	232636	8673	24.91				
	+65	37990	40210	7246	21.01				
	TOTAL	350440	366970	16031	46.24	0.75	62	100	-38

RECORD 003542
PMC.2013.SHP.0029
PET-EX005.0029

FY 2005 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1999 POP	2005 POP	99 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
CHARLESTON CO.	TOTAL						857	1093	-236
COLLETON MED CTR	<18	9680	11000	816	2.64				
	18-64	23620	25700	10145	30.24				
	+65	4900	5200	14529	42.24				
COLLETON CO.	TOTAL	38200	41900	25490	75.03	0.70	108	116	-8
HAMPTON REG MED CTR	<18	5660	5720	79	0.22				
	18-64	11240	11480	965	2.70				
	+65	3100	3000	2119	5.62				
HAMPTON CO.	TOTAL	20000	20200	3163	8.54	0.70	12	68	-56
LOW COUNTRY GEN HOSP	<18	5600	5600	61	0.17				
	18-64	10100	11500	1030	3.21				
	+65	1700	1700	1659	4.55				
JASPER CO.	TOTAL	17400	18800	2750	7.93	0.70	11	31	-20
RMC ORANGEBURG-CALHOUN	<18	24780	25380	3188	8.95				
	18-64	54120	56320	27548	78.54				
	+65	10700	11000	33032	93.04				
ORANGEBURG CO.	TOTAL	89600	92700	63768	180.52	0.75	241	247	-6
AIKEN REG.MED. CTR.	<18	37080	40200	1556	4.62				
	18-64	88420	95300	22748	68.73				
	+65	19500	21500	21466	64.84				
AIKEN CO.	TOTAL	143000	157000	45770	138.19	0.75	184	178	6
REGION IV	TOTAL						1953	2449	-496

#1 DATA & BED NEEDS FOR COMBINED HOSPITALS.
#2 DATA , BEDS AND BED NEEDS FROM ROPER NORTH TRANSFERRED TO ST. FRANCIS PER CON SC-01-37, 8/10/01.

RECORD 003543
PMC.2013.SHP.0030
PET-EX005.0030

% OCCUPANCY RATE

	1996	1997	1998	1999
REGION I	50.1	52.0	53.6	53.9
ANDERSON AREA MED CTR	47.5	47.0	47.4	50.8
UPSTATE CAROLINA MED C	34.6	33.3	33.0	33.6
ALLEN BENNETT MEM	67.1	60.6	67.0	67.5
GREENVILLE MEM MED CTR	71.4	73.0	75.4	78.2
HILLCREST	31.0	28.7	32.1	39.6
NORTH GREENVILLE	0.0	0.0	0.0	0.0
ST FRANCIS COMM	67.4	65.7	74.1	70.9
ST FRANCIS WOMEN"S & FAMILY	36.1	43.3	47.7	53.6
OCONEE MEM	45.8	49.0	53.2	57.7
CANNON MEM	28.7	26.1	25.6	31.5
PALMETTO BAPTIST M C EASLEY	47.2	48.6	42.1	50.7
BJ WORKMAN MEM	20.9	20.7	20.7	17.8
MARY BLACK MEM	50.7	46.1	49.5	36.5
SPGT HOSP RESTORATIVE C	7.4	17.7	17.1	3.3
SPARTANBURG REG MED CTR	50.7	56.1	54.2	52.5
HOPE	16.7	16.2	14.7	12.5
WALLACE THOMSON	33.3	34.5	37.8	38.3

	1996	1997	1998	1999
REGION III	52.8	56.7	59.3	60.1
CHESTERFIELD GEN	25.1	36.7	31.5	33.5
CLARENDON MEM	55.3	59.2	56.0	59.1
(BYERLY)	38.8	45.1	52.1	
CAROLINA PINESREG MED CTR				57.1
WILSON CLINIC	26.8	26.3	27.1	24.5
ST. EUGENE REG MED CTR	44.3	57.3	49.9	47.1
CAROLINAS HOSPITAL SYS	55.6	56.8	52.5	55.4
CAROLINAS HOSP LAKE CITY	21.6	17.9	19.2	36.6
MCLEOD REG MED CTR	89.9	94.7	89.4	85.0
WOMEN'S CTR/CAROLINAS	34.3	41.8	65.2	60.4
GEORGETOWN CO MEM	57.4	62.6	64.1	69.1
CONWAY HOSP	55.9	54.1	60.2	64.0
GRAND STRAND REG	57.2	59.0	63.0	66.6
LORIS COMM	36.2	39.5	42.1	48.0
MARION CO MED CTR	38.9	71.2	66.5	71.9
(MULLINS)	62.2			
MARLBORO PARK	23.9	26.9	25.6	27.0
TUOMEY	57.2	55.4	60.1	68.2
CAROLINAS HOSP KINGSTREE	17.8	19.5	17.9	19.6

% OCCUPANCY RATE

	1996	1997	1998	1999
REGION II	54.2	54.8	55.0	56.7
ABBEVILLE CO	23.4	20.4	23.4	27.2
CHESTER CO	54.0	54.3	48.4	43.2
EDGEFIELD CO	23.5	22.7	18.8	21.2
FAIRFIELD MEM	42.1	34.2	31.4	36.0
GELF MEM	45.6	40.4	40.6	37.7
KERSHAW CO MEM	44.9	44.5	46.2	48.0
SPRINGS MEM	46.9	48.8	53.2	56.6
LAURENS COUNTY HOSP	66.5	58.9	69.6	57.9
LEXINGTON MED CTR	54.7	57.0	59.1	63.8
NEWBERRY CO MEM	28.1	26.3	25.7	27.0
INTERMEDICAL HOSPITAL OF SC				14.8
PALMETTO BAPTIST MED CTR COLA	50.8	48.1	49.2	53.8
PROVIDENCE HOSPITAL	67.6	71.1	72.8	78.0
PROVIDENCE HOSPITAL NE				32.5
PALMETTO RICHLAND MEM	66.3	72.7	68.9	72.8
PIEDMONT MED CTR	58.5	60.5	64.6	67.0

	1996	1997	1998	1999
REGION IV	49.0	52.4	55.3	57.1
ALLENDALE CO	19.3	18.0	16.6	13.1
BAMBERG CO MEM	33.7	31.4	27.5	28.0
BARNWELL CO	19.1	28.2	22.5	22.7
BEAUFORT CO MEM	56.3	60.7	68.3	76.6
HILTON HEAD	46.5	52.3	68.1	68.2
ROPER HOSP NORTH	60.4	31.4	30.3	24.9
CHARLESTON MEM	29.1	25.7	26.8	34.0
EAST COOPER REG MED CTR	37.0	40.8	40.6	43.9
MEDICAL UNIVERSITY	64.9	67.3	68.8	72.5
TRIDENT MED CTR	62.4	62.2	60.1	66.0
SPECIALTY HOSPITAL OF SC				24.6
SUMMERVILLE MED CTR	48.5	40.6	40.7	50.4
ROPER	60.4	59.4	62.8	64.0
BON SECOURS ST FRANCIS	23.6	37.0	56.9	69.0
COLLETON MED CTR	49.7	59.3	54.9	60.2
HAMPTON REG MED CTR	12.1	8.5	9.0	12.7
LOW COUNTRY	28.1	25.0	25.3	23.3
RMC ORANGEBURG/CALHOUN	52.9	53.9	58.1	64.5
AIKEN REG MED CTR	65.8	67.1	68.4	70.4

RECORD 003544
PMC.2013.SHP.0031
PET-EX005.0031

(D) Obstetrical and Neonatal Services

Obstetrical Services

Advances in obstetrical and newborn intensive care offer the promise of a lower perinatal mortality and an 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 constitute a small percentage of the total annual deliveries, but these patients require a high degree of specialized care.

Infant mortality is the death rate for babies from birth until their first birthday. South Carolina's infant mortality rate has declined faster than it has for the nation as a whole. For 1996-1998, South Carolina's infant mortality rate was 9.1 per thousand infant births with a goal of 7.0 per thousand infant births.

Neonatal mortality is the death rate for infants up to 28 days old. For 1996-1998, South Carolina's neonatal mortality rate for all races was 6.3 neonatal deaths per 1,000 live births with a goal of 4.5 neonatal deaths per 1,000 live births.

The Trends of Infant Mortality Rates and Neonatal Mortality Rates follow:

PMC.2013.SHP.0032

PET-EX005.0032

RECORD 003545

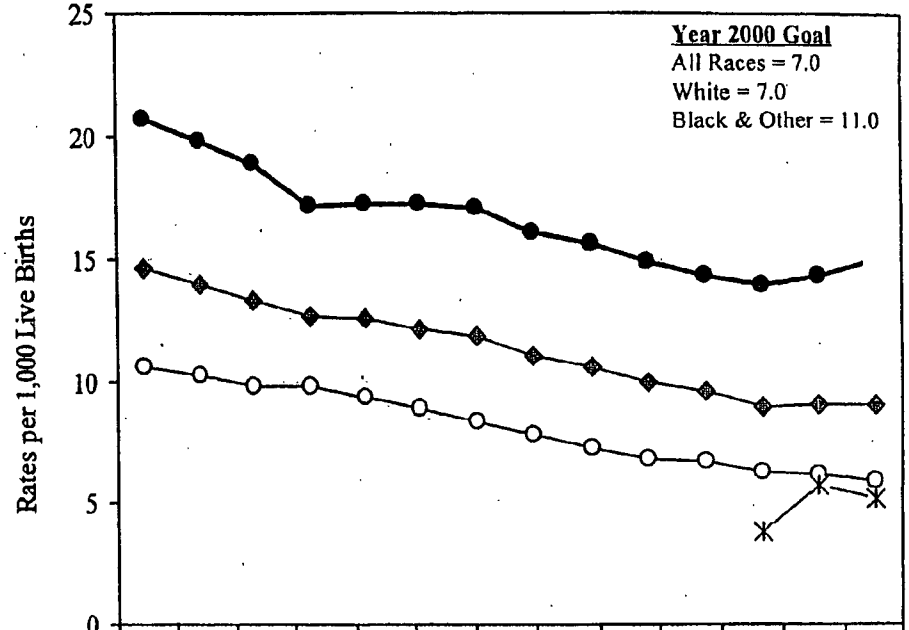
Three Year Infant Mortality Rates

State of South Carolina

- Infant deaths in SC among all races have seen a 38.0% decline from a rate of 14.6 per 1,000 live births in 1983-85 to 9.1 in 1996-98. The longstanding declining trend stabilized in 1995-97. As a result, it appears that SC will not reach the US Healthy People Year 2000 objective of 7.0 infant deaths per 1,000 live births among all races.

- Infant deaths, when revlewed by race/ethnicity reveal differences. The death rate for white infants declined by 44.0% from 10.6 deaths per 1,000 live births in 1983-85 to 5.9 in 1996-98; this decline resembles the state's downward trend for all races. Death rates for Black and Others declined by 30.0% from 20.7 in 1983-85 to 14.4 in 1993-95, and increased from 14.0 in 1994-96 to 15.0 in 1996-98 for Blacks. Death rates for the subgroup, 'Other' climbed by 33.0% from 3.8 in 1994-96 to 5.7 in 1995-97 and then dropped to 5.2 in 1996-98. The fluctuation among Other infants may be a phenomenon of the small number of deaths involved.

- SC Whites have already reached the race specific Healthy People Year 2000 objective of 7.0 infant deaths per 1,000 live births. However, the Year 2000 objective of 11.0 deaths for Black and Others appears out of reach for SC.



	83-85	84-86	85-87	86-88	87-89	88-90	89-91	91-93	92-94	93-95	94-96	95-97	96-98
All Races	14.6	14	13.4	12.7	12.6	12.2	11.9	10.6	10	9.6	9	9.1	9.1
White	10.6	10.3	9.8	9.8	9.4	8.9	8.4	7.3	6.8	6.7	6.3	6.2	5.9
Black	20.7	19.8	18.9	17.2	17.3	17.3	17.1	15.6	14.9	14.4	14	14.4	15
Other											3.8	5.7	5.2

Note: The trend line labeled Black and Others, represents Black & Others from 1983-85 to 1993-95. However, in 1994-96, Other races were analyzed separately and the trend line at this point represents only Blacks. Please see the new and separate line reflecting the new population subgroup - "Others" beginning in 1994-96.

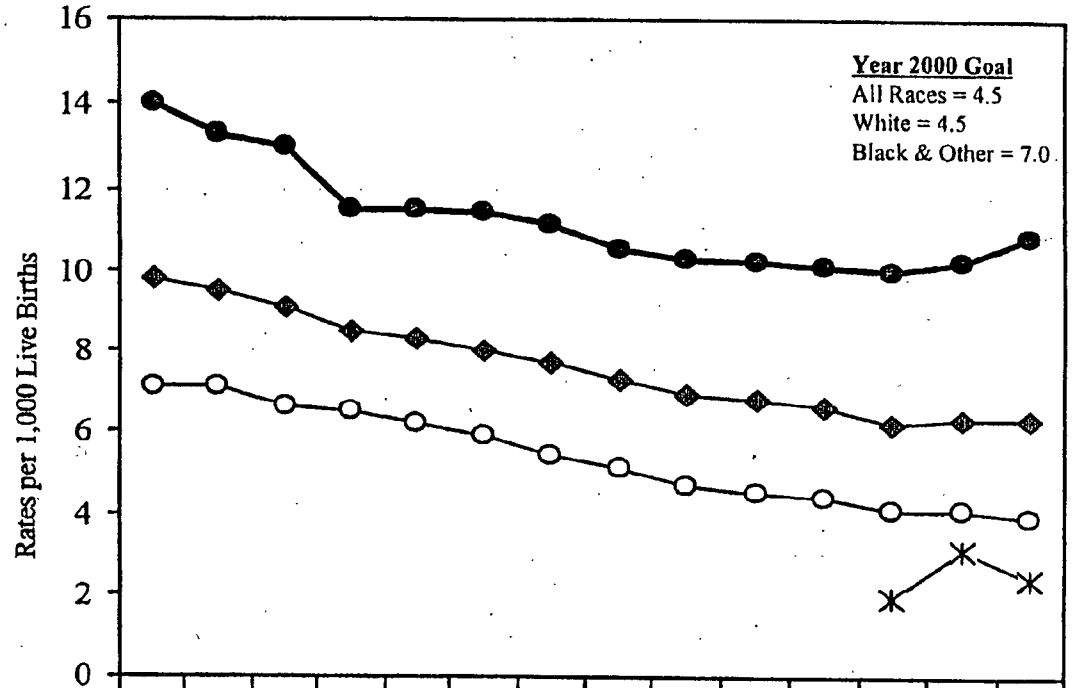
RECORD 003546
PMC.2013.SHP.0033
PET-EX005.0033

Three Year Neonatal Mortality Rates

State of South Carolina

- Neonatal deaths among South Carolinians have decreased by 36.0% from 9.8 in 1983-85 to 6.3 in 1996-98.

- Neonatal deaths for Black and Others have declined by 28.0% from 14.0 deaths per 1,000 live births in 1983-85 to 10.2 deaths in 1993-95. The death rates for Whites have dropped by 45.0% from 7.1 in 1983-85 to 3.9 in 1996-98. However, since 1995-1997 death rates have increased slightly for Blacks while decreasing for the two other subgroups: Whites and Other races.



	83-85	84-86	85-87	86-88	87-89	88-90	89-91	90-92	91-93	92-94	93-95	94-96	95-97	96-98
All Races	9.8	9.5	9.1	8.5	8.3	8	7.7	7.3	6.9	6.8	6.6	6.2	6.3	6.3
White	7.1	7.1	6.6	6.5	6.2	5.9	5.4	5.1	4.7	4.5	4.4	4.1	4.1	3.9
Black	14	13.3	13	11.5	11.5	11.4	11.1	10.5	10.3	10.2	10.1	10	10.2	10.8
Other												1.9	3.1	2.4

Note: The trend line labeled Black and Others, represents Black & Others from 1983-85 to 1993-95. However, In 1994-96, Other aces were analyzed separately and the trend line at this point represents only Blacks. Please see the new and separate line reflecting the new population subgroup, "Others" beginning In 1994--96.

RECORD 003547
PMC.2013.SHP.0034
PET-EX005.0034

Infant Mortality National Ranking by Rates[1]
United States, 1998
(Residence Data)

1	District of Columbia	12.5
2	Alabama	10.2
3	Mississippi	10.1
4.5	Delaware	9.6
4.5	South Carolina	9.6
6	North Carolina	9.3
7.5	South Dakota	9.1
7.5	Louisiana	9.1
9	Arkansas	8.9
10	North Dakota	8.6
11.5	Georgia	8.5
11.5	Oklahoma	8.5
13	Illinois	8.4
14	Maryland	8.3
15.5	Michigan	8.2
15.5	Tennessee	8.2
17.5	Ohio	8.0
17.5	West Virginia	8.0
19.5	Missouri	7.7
19.5	Virginia	7.7
21	Indiana	7.6
22.5	Kentucky	7.5
22.5	Arizona	7.5
24	Montana	7.4
25	Nebraska	7.3
28	Wisconsin	7.2
28	Florida	7.2
28	Idaho	7.2
28	Wyoming	7.2
28	New Mexico	7.2
31	Pennsylvania	7.1
34	Vermont	7.0
34	Rhode Island	7.0
34	Connecticut	7.0
34	Kansas	7.0
34	Nevada	7.0
37	Hawaii	6.9
38	Colorado	6.7
39	Iowa	6.6
40.5	New Jersey	6.4
40.5	Texas	6.4
42.5	Maine	6.3
42.5	New York	6.3
44.5	Minnesota	5.9
44.5	Alaska	5.9
46	California	5.8
47	Washington	5.7
48	Utah	5.6
49	Oregon	5.4
50	Massachusetts	5.1
51	New Hampshire	4.4

[1] Rates per 1,000 live births

Prepared by:
Division of Biostatistics
Office of Public Health Statistics and Information Services
South Carolina Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201

PMC.2013.SHP.0035

PET-EX005.0035

RECORD 003548

Neonatal Mortality National Ranking by Rates[1]
United States, 1998
(Residence Data)

1	District of Columbia	7.2
2	Delaware	6.9
3.5	South Carolina	6.7
3.5	Alabama	6.7
5	North Carolina	6.4
6.5	Maryland	6.2
6.5	Mississippi	6.2
8	Louisiana	5.9
9.5	Vermont	5.8
9.5	Georgia	5.8
11.5	Illinois	5.6
11.5	Tennessee	5.6
13	Arkansas	5.5
15.5	Ohio	5.4
15.5	North Dakota	5.4
15.5	Virginia	5.4
15.5	Oklahoma	5.4
18	Michigan	5.3
19.5	Rhode Island	5.2
19.5	Indiana	5.2
22	Connecticut	5.1
22	Wisconsin	5.1
22	Hawaii	5.1
24	Pennsylvania	5.0
25.5	Missouri	4.9
25.5	Kentucky	4.9
28	Nebraska	4.8
28	Florida	4.8
28	Arizona	4.8
32	Iowa	4.6
32	South Dakota	4.6
32	Kansas	4.6
32	West Virginia	4.6
32	Idaho	4.6
36	New York	4.5
36	New Jersey	4.5
36	Wyoming	4.5
38.5	Colorado	4.4
38.5	New Mexico	4.4
40.5	Maine	4.2
40.5	Montana	4.2
42.5	Minnesota	4.0
42.5	Texas	4.0
44	Massachusetts	3.9
45	California	3.8
46.5	Utah	3.6
46.5	Washington	3.6
48	Nevada	3.5
49	New Hampshire	3.4
50	Oregon	3.2
51	Alaska	2.9

[1] Rates per 1,000 live births

Prepared by:
Division of Biostatistics
Office of Public Health Statistics and Information Services
South Carolina Department of Health and Environmental Control
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PMC.2013.SHP.0036

PET-EX005.0036

RECORD 003549

THE PROPOSED REVISION OF REGULATION 61-16, STANDARDS FOR LICENSING HOSPITALS AND INSTITUTIONAL GENERAL INFIRMARIES, HAS BEEN APPROVED BY THE BOARD OF HEALTH AND ENVIRONMENTAL CONTROL AND IS CURRENTLY UNDER REVIEW BY THE GENERAL ASSEMBLY. The following is a description of the five levels of perinatal services as outlined in the proposed regulation. No Certificate of Need will be approved for a Level IIE service until these regulations become effective.

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 this level 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 shall be designated by DHEC's Division of Licensing as a Level I, II, IIE (Enhanced), or III Perinatal Hospital or RPC (Regional Perinatal Center) and the hospital shall request such designation by letter to the Department. The determination shall be made by the Department based upon a hospital's ability to meet regulatory requirements to be determined by a special inspection by the Department following the initial request for designation and as an integral part of subsequent license renewal procedures. This should ensure that patients are treated in the hospital best suited to handle their expected problems. 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 following definitions apply:

A. Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital shall have the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2000 grams. When it is anticipated or determined that these criteria will not or have not been met, consultation and a plan of care shall be initiated and mutually agreed upon with the RPC. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. Management shall include emergency resuscitation and/or stabilization for both maternal and neonatal patients in preparation for transfer/transport for more specialized services. This description does not constitute Certificate of Need review criteria.

B. Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1500 grams. A board-eligible pediatrician shall be in the hospital or on site within 30 minutes, 24 hours a day. The hospital shall have at least a written consultative agreement with a board eligible neonatologist. Neonates shall be without acute distress or complex management requirements and shall not be in need of ventilatory support for more than six cumulative hours. Neonates shall not require high-frequency ventilation support. When it is anticipated or determined that these criteria will not or have not been met, a plan of care will be developed in consultation with the RPC and documented in the patient's medical record. The hospitals shall manage no less than an average of 500 deliveries annually, calculated over the previous three years. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Level II hospital shall not admit outborn neonates into its nursery without prior concurrence with the RPC. This description does not constitute Certificate of Need review criteria.

PMC.2013.SHP.0037

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C. Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may be only located in areas of the state which are no closer than 60 miles from a South Carolina Regional Perinatal Center. This level of neonatal care includes the management of neonates who are at least 30 weeks gestation with an anticipated birthweight of at least 1250 grams, as determined by estimations based upon best professional judgement, ultrasound, and/or other available medical technology and instruments. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. Neonates shall not be in need of ventilatory support for more than 24 cumulative hours. When it is anticipated or determined that any of the preceding criteria relating to gestation, weight, and length of ventilatory support will not be or have not been met, the neonate may remain at the Level IIE facility, pursuant to a plan of care developed in consultation with and agreed to by the RPC. Such plan of care shall be documented in the patient's medical record. Neonates shall not require high-frequency ventilation support. These hospitals shall manage no less than an average of 1200 deliveries annually, calculated over the previous three years. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Level IIE hospital shall not admit outborn neonates into its nursery without prior concurrence with the RPC. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services. Level IIE hospitals must have an adequate number of neonatal bassinets to provide care for these neonates and the number of bassinets will be justified by the hospital in the Certificate of Need application. Because these hospitals already have neonatal bassinets, the number of bassinets will not be counted against the needs projected in the following sections of this Plan. Once utilization information is obtained, the projections may be revised.

D. Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, provides all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified maternal-fetal medicine specialist (perinatologist) shall be available for supervision and consultation, 24 hours a day. In addition to the Level II and IIE capabilities, Level III hospitals shall have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. Hospitals with Level III designation shall manage no less than 1500 deliveries annually, calculated over the previous three years, or at least an average of 125 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. The establishment of a Level III service requires Certificate of Need review.

E. Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to Level I, II, IIE, and III hospitals in the region. The RPC shall manage no less than an average of 2000 deliveries annually, calculated over the previous three years, or at least an average of 250 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. Personnel qualified to manage obstetric or neonatal emergencies shall be in-house. A board-certified maternal-fetal medicine specialist (perinatologist) shall be in the hospital or on site within 30 minutes for supervision and consultation, 24 hours a day. The RPC

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shall participate in residency programs for obstetrics, pediatrics, and/or family practice. Continuing education and outreach education programs shall be available to all referring hospitals, and physician-to-physician consultation shall be available 24 hours a day. The RPC shall provide a perinatal transport system that operates 24 hours a day, seven days a week, and return transports neonates to lower level perinatal hospitals when the neonates' condition and care requirements are within the capability of those hospitals. No more than one Regional Perinatal Center will be approved in each perinatal region. Regional Perinatal Centers must meet the criteria and standards required in the hospital licensing regulations. The establishment of a Regional Perinatal Center requires Certificate of Need review.

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Existing facilities will be monitored to determine if expansion, reduction, or addition of obstetrical services is appropriate. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services where appropriate. Additional beds for obstetrical services will not be approved unless other hospital beds are converted to obstetrical beds or a need is indicated in the Plan for additional hospital beds.

Desired occupancy rates are 65% for Level I and 75% for Levels II, IIE, III and RPCs.

Facilities providing obstetrical services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

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:

a. Need;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

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

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The following hospitals have requested a Perinatal Capability Review and been designated as a Level II, Level IIE, Level III or RPC facility:

REGIONAL PERINATAL CENTERS

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
Medical University of South Carolina Medical Center
Palmetto Richland Memorial Hospital
Self Memorial Hospital
Spartanburg Regional Medical Center

SUBSPECIALITY PERINATAL CENTER (LEVEL III HOSPITAL)

Palmetto Baptist Medical Center at Columbia

ENHANCED PERINATAL CENTER (LEVEL II ENHANCED CARE HOSPITALS)

None at present

SPECIALITY PERINATAL CENTERS (LEVEL II HOSPITALS)

Aiken Regional Medical Centers
Anderson Area Medical Center
Palmetto Baptist Medical Center - Easley
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital, Inc.
East Cooper Regional Medical Center
Georgetown County Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital, Inc.
Piedmont Medical Center
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital, Inc.
Saint Eugene Community Hospital
Saint Francis Women's and Family Hospital
Springs Memorial Hospital
Trident Regional Medical Center
Tuomey Regional Medical Center
Women's Center of Carolinas Hospital System

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FY99 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEM. MED. CTR.	5081	44	4836	10177	63.4%
PALMETTO RICHLAND MEM. HOSP.	3242	57	6534	14172	68.1%
PALMETTO BAPTIST MED. CTR. COLA.	3105	56	4984	12188	59.6%
SPARTANBURG REG. MED.CTR.	2518	44	3059	7963	49.6%
LEXINGTON MED. CTR.	2314	35			0.0%
TRIDENT MED. CTR.	2070	20	2239	5285	72.4%
MCLEOD REG. MED. CTR.	1977	24	2291	5635	64.3%
ANDERSON AREA MED CTR	1904	22	1700	4660	58.0%
MEDICAL UNIVERSITY HOSP.	1881	34			0.0%
ST. FRANCIS WOMEN'S & FAMILY HOSP	1757	24	2148	4937	56.4%
BEAUFORT CO. MEM.	1608	20	1796	4203	57.6%
PIEDMONT MED. CTR.	1502	38	2600	7193	51.9%
SELF MEM. HOSP.	1499	34	2460	6150	49.6%
RMC ORANGEBURG-CALHOUN	1491	27	2119	2104	21.3%
EAST COOPER REG MED CTR	1374	27	1739	3935	39.9%
BON SECOURS' ST. FRANCIS	1236	12	1150	2608	59.5%
ROPER HOSP.	1228	11	1439	2915	72.6%
TUOMEY REG MED CTR	1220	20	1494	3619	49.6%
WOMEN'S CTR /CAROLINAS	1202	20	1510	4407	60.4%
CONWAY HOSP. INC.	1063	27	2272	6750	68.5%
AIKEN REG.MED. CTR.	1039	18	1659	4383	66.7%
MARY BLACK MEM.	984	21	1220	2971	38.8%
GRAND STRAND REG MED CTR	826	19	1254	2958	42.7%
GEORGETOWN CO. MEM.	774	14	737	3333	65.2%
SPRINGS MEMORIAL HOSP	668	7	862	1951	76.4%
BAPTIST MED CTR EASLEY	649	14	695	2089	40.9%
OCONEE MEM.	623				
CAROLINA PINES REG MED CTR	570	11	560	2272	56.6%
SUMMERVILLE MED CTR	564	4	578	1260	86.3%
MARION CO. MEM.	494				
LAURENS CO. HOSP.	411	8			
CLARENDON MEM.	403	8	403	910	31.2%
COLLETON REG MED CTR	396	5	364	853	46.7%
LORIS COMM. HOSP.	393	8	507	1170	40.1%
ALLEN BENNETT MEM	380	5	385	770	42.2%
HILTON HEAD HOSP.	380	8	432	908	31.1%
ABBEVILLE CO. MEM.	363	8	241	514	17.6%
KERSHAW CO.	352	10	472	1060	29.0%
SAINT EUGENE MEDICAL CTR	311	11	447	1075	26.8%
UPSTATE CAROLINA MED CTR	296	15	454	1018	18.6%
NEWBERRY CO. MEM.	260	12	379	736	16.8%
CHESTERFIELD GENERAL	258	6	427	1046	47.8%
CHESTER CO.	217	5	318	900	49.3%
MARLBORO PARK	202				
CAROLINAS HOSP SYS KINGSTREE	199	4	256	556	38.1%
WALLACE THOMSON	178				
ALLENDALE CO.	139				
PROVIDENCE HOSP NE	113	6	122	269	12.3%
BAMBERG CO. MEM.	97				
W.J. BARGE FAMILY HOSP	65				

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Neonatal Services:

Neonatal services are highly specialized and 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 regionalized basis, fostering the location of these specialized units in medical centers, which have the necessary staff, equipment, and consultative services and facilities. Referral networks should be established to facilitate the transfer infants requiring this level of services from other facilities.

(a) Neonatal services should be planned on a regional basis with linkages with obstetrical services.

(b) Only Level III and RPCs neonatal units contain both intensive and intermediate care bassinets.

According to American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, the following ratios are suggested for predicting the number and type of neonatal bassinets:

1 per 1,000 of the projected # births in year Z =
projected neonatal intensive care bassinets.

3-4 per 1,000 of the projected # births in year Z =
projected neonatal intermediate care bassinets.

The above ratios were based on 80 low-birth weight (LBW) {2500 grams} births per 1,000 births. As indicated below, in 1999 South Carolina had 98.6 LBW births per 1,000 births, with a white rate of 72.3 and a nonwhite rate of 144.3 per 1,000. Because South Carolina has a significant higher number of LBW infants per 1,000 births, an alternative method was selected for determining the need for intensive care bassinets in RPCs.

1999	TOTAL	WHITE	NONWHITE
All Births	54,706	34,683	20,004
<2,500 Grams	5,393	2,506	2,887
Rate/1,000	98.6	72.3	144.3

Based on the above information and adjusting for the incidence of LBW births, South Carolina would need the following ratio of intensive care bassinets:

$$\frac{98.6}{80} = 1.24 \text{ bassinets}$$

1.24 per 1,000 projected births in year Z =
projected neonatal intensive care bassinets

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The intermediate care bassinets are derived by multiplying the intensive care factor by 4.

4.96 per 1,000 projected births in year Z =
projected neonatal intermediate care bassinets

When the race variance and incidence of LBW births are factored in the intensive care ratios are:
White = $\frac{72.3}{80} = 0.91$ Nonwhite = $\frac{144.3}{80} = 1.80$

The intermediate care ratios are:
White = 0.91 x 4.96 = 4.51
Non-white = 1.80 x 4.96 = 8.93

The actual births in South Carolina have been:

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
58,454	57,509	56,094	53,765	51,895	50,913	51,105	52,205	53,833	54,706

The projected births have been:

1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
53,840	51,680	51,660	51,460	51,280	51,860	52,440	52,800	53,460	54,200

As noted above, both actual births and projected births have been declining or remaining relatively constant except for the last three years when they have increased.

The following projected need for neonatal intensive care bassinets is based on the actual utilization of the bassinets in Level III Hospitals and the Regional Perinatal Centers based on a planning factor of 70% occupancy. There is no need for additional Level III hospitals or RPCs, and any facility not meeting the licensing criteria should not be categorized as such.

Perinatal Region With Facility	Intensive Care Patient Days	Bassinets Needed at 70% Occupancy	Existing Bassinets
Greenville Memorial	3908	16	12
Spartanburg Regional	2106	9	10
Self Memorial	628	3	7
Palmetto Richland & Baptist	8888	35	25
McLeod Regional	4368	18	12
MUSC Medical Center	4556	18	16

Note: S.C. presently has 1.5 neonatal intensive care bassinets and 5.2 neonatal intermediate care bassinets per 1,000 births.

A neonatal unit should have an average annual occupancy rate of 70%. Facilities providing neonatal services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

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Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Anderson, Greenville, Oconee, Pickens		
Palmetto Baptist Med Ctr Easley	0	2
Greenville Memorial Med Ctr	12	29
Anderson Area Medical Ctr	0	7
St. Francis Women's & Fam Hosp	0	10
SUBTOTAL	12	48
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Med Ctr	10	15
Mary Black Memorial Hospital	0	8
SUBTOTAL	10	23
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda		
Self Memorial Hospital	7	11
SUBTOTAL	7	11
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Lee Kershaw, Lancaster, Orangeburg, York, Lexington, Newberry, Richland, Sumter		
Palmetto Richland Memorial	21	38
Palmetto Baptist Columbia	4	16
Lexington Medical Ctr.	0	20
Piedmont Medical Ctr.	0	8
Springs Memorial Hospital	0	4
Aiken Regional Med. Ctr.	0	8
Reg Med Ctr Orangeburg-Calhoun	0	3
Tuomey Regional Med Ctr	0	8
SUBTOTAL	25	105
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Reg. Med. Ctr.	0	2
Saint Eugene Community	0	2
Marion County Medical Ctr	0	2
McLeod Regional Medical Ctr	12	28
Conway Hospital	0	6
Grand Strand Regional	0	3
Women's Ctr. of Carolinas	0	7
SUBTOTAL	12	50

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Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	3
Georgetown County Memorial	0	5
MUSC Medical Center	16	22
East Cooper Reg Med Ctr	0	6
Bon Secours-St. Francis Xavier	0	4
Trident Medical Center	0	5
Roper Hospital	0	5
SUBTOTAL	16	50
TOTAL	82	285

NOTE: The occupancy rate includes both intensive and intermediate care patient days. Some of the RPCs have a higher utilization in the intensive care bassinets than reflected by the total occupancy. Some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero.

The existing bassinets in the preceding table and the table below are based on the number stated on the hospital license or approved under the Certificate of Need program.

The following estimates of need for intermediate neonatal bassinets are derived from the preceding methodology:

Perinatal Region	INTERMEDIATE BASSINETS Existing	Need	To Be Added
Greenville	48	53	5
Spartanburg	23	28	5
Greenwood	11	17	6
Richland	105	117	12
Florence	50	51	1
Charleston	50	72	22
TOTAL	287	338	51

Based on the above information, it appears that the number of intermediate care bassinets should be increased in every perinatal region of the state. The number of intermediate care bassinets should be increased in Level II and Level IIE facilities so babies could 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. In order 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. It appears that if more back transfers to the Level II and/or Level IIE facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

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It should be noted that some RPC 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. The Medical University may require additional bassinets since babies with congenital heart disease are referred there. The Medical University will document the need for any additional bassinets. The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

Relative Importance of Project Review Criteria

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

a. Need;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. In addition, most of the hospitals offering this service provide specialized transportation vehicles. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is no justification for additional Level III hospitals or Regional Perinatal Centers; however, there may be a need for additional intensive care neonatal bassinets in the existing Regional Perinatal Centers providing the need is indicated in this Plan. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service. The need for bassinets in Level IIE hospitals has not been determined, but will be justified by the individual hospital seeking this level of service.

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The following chart indicates the utilization of neonatal special care units by facility. Some facilities are not using any of the intermediate care bassinets. The data are from the Joint Annual Reports of Hospitals-1999. In some cases the utilization data were prorated between intensive care and intermediate care bassinets based on reported information. This utilization information supports the projected need.

NEONATAL UTILIZATION FROM 1999 JARS

HOSPITAL	ICU Bassinets	ICU P.D.'s	ICU ADC	Intermediate Bassinets	Intermediate P.D.'s	Intermed ADC	Total Bassinets	Total P.D.'s	Total ADC	Total Occupancy
Anderson Area Med Ctr				7	965	2.6	7	965	2.6	37.8%
Greenville Memorial	12	3908	10.7	29	8569	23.5	41	12477	34.2	83.4%
St. Francis Women's				10	1162	3.2	10	1162	3.2	31.8%
Palmetto Baptist-Easley				2	0	0	2	0	0	0.0%
REGION SUBTOTAL	12	3908	10.7	48	10696	29.3	60	14604	40.0	66.7%
Spartanburg Regional	10	2106	5.8	15	4041	11.1	25	6147	16.8	67.4%
Mary Black Memorial				8	978	2.7	8	978	2.7	33.5%
REGION SUBTOTAL	10	2106	5.8	23	5019	13.8	33	7125	19.5	59.2%
Self Memorial	7	628	1.7	11	2220	6.1	18	2848	7.8	43.3%
REGION SUBTOTAL	7	628	1.7	11	2220	6.1	18	2848	7.8	43.3%
Palmetto Richland Mem	21	7842	21.5	38	9097	24.9	59	16939	46.4	78.7%
Lexington Medical Center				20	2271	6.2	20	2271	6.2	31.1%
Piedmont Medical Center				8	1321	3.6	8	1321	3.6	45.2%
Springs Memorial Hosp				4	0	0	4	0	0	0.0%
Palmetto Baptist Med Ctr	4	1046	2.9	16	4182	11.5	20	5228	14.3	71.6%
Tuomey Regional				8	0	0.0	8	0	0.0	0.0%
Reg Med Ctr Orangeburg				3	442	1.2	3	442	1.2	40.4%
Aiken Regional Med Ctr				8	977	2.7	8	977	2.7	33.5%
REGION SUBTOTAL	25	8888	24.4	105	18290	50.1	130	27178	74.5	57.3%
Women's Ctr of Carolinas				7	1180	3.2	7	1180	3.2	46.2%
McLeod Regional	12		0.0	28		0.0	40	8372	22.9	57.3%
St. Eugene Community				2	70	0.2	2	70	0.2	9.6%
Marion Co Medical Ctr				2	0	0	2	0	0	0.0%
Grand Strand Regional				3	75	0.2	3	75	0.2	6.8%
Conway Hospital				7	589	1.6	7	589	1.6	23.1%
REGION SUBTOTAL	12	0	0.0	49	1914	3.6	61	1914	5.2	8.6%
Georgetown Co Memorial				5	0	0	5	0	0	0.0%
MUSC Medical Center	16	4395	12.0	22	6043	16.6	38	10438	28.6	75.3%
Roper Hospital				5	819	2.2	5	819	2.2	44.9%
East Cooper Reg Med Ctr				6	205	0.6	6	205	0.6	9.4%
Trident Reg Med Center				5	578	1.6	5	578	1.6	31.7%
Bon Secours-St. Francis				4	159	0.4	4	159	0.4	10.9%
Beaufort Memorial Hosp				3	126	0.3	3	126	0.3	11.5%
SUBTOTAL	16	4395	12.0	50	7930	21.4	66	12325	33.8	51.2%
GRAND TOTAL	82	19925	54.6	286	46069	124.3	368	65994	180.8	49.1%

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KESSNER INDEX and ADEQUATE PRENATAL CARE

The Kessner Index provides a measure of percentage of pregnant women in a defined population who adequately participated in prenatal care. A high percentage of women with inadequate to intermediate prenatal care may have an adverse effect on several of the regionalization indicators related to birthweight distribution, risk appropriate referral and mortality impact. The following tables indicate the percentage of live births by adequacy of prenatal care form 1983 to 1998. The percentage of whites with adequate prenatal care has increased from 66.4% to 79.7% over this period. The percentage of non-whites with adequate prenatal care has increased from 42.4% to 62.7% over this same period.

The following tables indicate the adequacy of prenatal care by level of care at birth by hospital for 1998. For example, of the Level III hospitals, Medical University Hospital had 17.1% of births from mothers that received inadequate prenatal care and Palmetto Baptist Medical Center-Columbia had 0.9%.

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Percentage of Live Births by Adequacy of Prenatal Care
(Kessner Index)

Statewide – white

Kessner	1983	1985	1987	1989	1991	1993	1994	1995	1996	1997	1998
Adequate	66.4	68.7	65.9	68.1	70.6	73.9	76.2	77.6	78.5	79.4	79.7
Intermediate	26.5	24.6	25.7	24.2	22.4	20.4	18.6	17.8	16.9	15.7	15.8
Inadequate	7.1	6.6	8.4	7.7	7.1	5.6	5.2	4.6	4.6	4.9	4.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Statewide – Black and Other

Kessner	1983	1985	1987	1989	1991	1993	1994	1995	1996	1997	1998
Adequate	42.4	44.1	40.6	40.6	44.1	48.9	53.7	57.1	58.6	59.7	62.7
Intermediate	39.9	37.5	38.0	38.3	37.2	34.8	31.9	30.1	29.2	28.6	25.5
Inadequate	17.8	18.4	21.3	21.2	18.7	16.3	14.4	12.8	12.2	13.8	11.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: S.C. Perinatal Regionalization Surveillance 1999

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ADEQUACY OF PRENATAL CARE (KESSNER)
BY LEVEL OF CARE AT BIRTH, RACE, AND HOSPITAL OF DELIVERY

LEVEL OF CARE = LEVEL 1 RACE = ALL RACES

HOSPITAL OF DELIVERY	PERCENT INADEQ. CARE	PERCENT INTERMED CARE	PERCENT ADEQUATE CARE	PERCENT UNKNOWN CARE	TOTAL LIVE BIRTHS	BIRTHS W/ INADEQ. CARE	BIRTHS W/ INTERMED CARE	BIRTHS W/ ADEQUATE CARE	BIRTHS W/ UNKNOWN CARE
OCONEE MEM. HOSPITAL	1.96	10.97	84.94	2.13	611	12	67	519	13
HILTON HEAD HOSPITAL	2.26	4.76	88.97	4.01	399	9	19	355	16
SUMMERVILLE MEDICAL CENTER	2.56	5.51	91.93	0.00	508	13	28	467	0
ALLEN BENNETT MEM. HOSP	3.13	12.22	83.52	1.14	352	11	43	294	4
UPSTATE CAROLINA MED.CTR	3.78	13.75	80.76	1.72	291	11	40	235	5
KERSHAW CTY. MEMORIAL	4.12	18.24	75.59	2.08	340	14	62	257	7
BAMBERG MEMORIAL HOSP	4.55	20.91	74.55	0.00	110	5	23	82	0
BYERLY HOSPITAL	5.86	16.12	67.40	10.62	546	32	88	368	58
MARLBORO PARK HOSPITAL	5.91	15.76	73.40	4.93	203	12	32	149	10
ABBEVILLE CTY. MEMORIAL	6.52	15.22	78.26	0.00	184	12	28	144	0
COLLETON REGIONAL HOSP	6.58	22.19	71.23	0.00	365	24	81	260	0
LAURENS CTY. HOSPITAL	6.94	25.36	66.75	0.96	418	29	106	279	4
WALLACE THOMSON HOSP	7.39	27.27	63.64	1.70	176	13	48	112	3
CLARENDON MEM. HOSPITAL	8.63	30.36	59.23	1.79	336	29	102	199	6
LORIS COMM. HOSPITAL	9.63	24.69	62.96	2.72	405	39	100	255	11
NEWBERRY CTY. MEM.HOSP	10.11	28.16	58.84	2.89	277	28	78	163	8
CHESTERFIELD GEN. HOSP	11.19	27.61	48.88	12.31	268	30	74	131	33
CHESTER CTY. HOSPITAL	12.94	25.87	60.70	0.50	201	26	52	122	1
CAR. HOSP SYS-KINGSTREE	16.27	38.76	38.76	6.22	209	34	81	81	13
ALLENDALE CTY. HOSPITAL	20.23	41.04	38.73	0.00	173	35	71	67	0
WJ BARGE MEM. HOSPITAL	100.00	0.00	0.00	0.00	1	1	0	0	0

Source: South Carolina Perinatal Regionalization Surveillance 1999

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ADEQUACY OF PRENATAL CARE (KESSNER)
BY LEVEL OF CARE AT BIRTH, RACE, AND HOSPITAL OF DELIVERY

LEVEL OF CARE = LEVEL 2 RACE = ALL RACES

HOSPITAL OF DELIVERY	PERCENT INADEQ. CARE	PERCENT INTERMED CARE	PERCENT ADEQUATE CARE	PERCENT UNKNOWN CARE	TOTAL LIVE BIRTHS	BIRTHS W/ INADEQ. CARE	BIRTHS W/ INTERMED CARE	BIRTHS W/ ADEQUATE CARE	BIRTHS W/ UNKNOWN CARE
AMI EAST COOPER HOSPITAL	1.36	21.61	60.62	16.42	1328	18	287	805	218
ST FRANCIS XAVIER	1.49	8.29	88.44	1.77	1073	16	89	949	19
TRIDENT REGIONAL MED CTR	1.56	4.03	94.41	0.00	1985	31	80	1874	0
ST FRANCIS WOMENS HOSPITAL	1.64	19.12	78.56	0.66	1825	30	349	1434	12
BAPTIST MEDICAL CTR - EASLEY	2.05	16.42	76.90	2.63	684	14	126	526	18
ROPER HOSPITAL	3.27	15.08	79.51	2.13	1313	43	198	1044	28
MARY BLACK MEMORIAL HOSP	3.35	21.91	72.33	2.41	954	32	209	690	23
ELLIOTT WHITE SPRINGS	3.59	15.17	81.08	0.16	613	22	93	497	1
ANDERSON AREA MED CTR	3.64	8.07	88.23	0.05	1895	69	153	1672	1
WOMENS CTR OF CAROLINAS HOSP	4.09	17.83	75.89	2.18	1099	45	196	834	24
MARION MEMORIAL HOSPITAL	5.29	16.82	75.99	1.89	529	28	89	402	10
LEXINGTON MEDICAL CENTER	6.18	16.16	77.62	0.04	2283	141	369	1772	1
GRAND STRAND HOSPITAL	7.47	15.47	76.41	0.66	763	57	118	583	5
CONWAY HOSPITAL	8.75	22.17	68.32	0.76	1051	92	233	718	8
PIEDMONT MEDICAL CENTER	9.29	29.70	60.72	0.29	1357	126	403	824	4
REGIONAL MED CTR -ORANGEBURG	9.45	19.62	70.89	0.14	1429	135	279	1013	2
GEORGETOWN MEM HOSPITAL	11.89	31.22	56.22	0.68	740	88	231	416	5
HCA AIKEN REGIONAL MED CTR	12.03	22.42	49.95	15.59	1097	132	246	548	171
TUOMEY REG MED CTR	12.83	25.42	59.65	2.00	1353	175	344	807	27
ST EUGENE HOSPITAL	13.08	30.84	49.53	6.54	321	42	99	159	21
BEAUFORT MEMORIAL HOSPITAL	16.40	28.61	54.18	0.81	1482	243	424	803	12

Source: South Carolina Perinatal Regionalization Surveillance 1999

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ADEQUACY OF PRENATAL CARE (KESSNER)
BY LEVEL OF CARE AT BIRTH, RACE, AND HOSPITAL OF DELIVERY

LEVEL OF CARE = LEVEL 3 RACE = ALL RACES

HOSPITAL OF DELIVERY	PERCENT INADEQ. CARE	PERCENT INTERMED CARE	PERCENT ADEQUATE CARE	PERCENT UNKNOWN CARE	TOTAL LIVE BIRTHS	BIRTHS W/ INADEQ. CARE	BIRTHS W/ INTERMED CARE	BIRTHS W/ ADEQUATE CARE	BIRTHS W/ UNKNOWN CARE
PALMETTO BAPTIST MED CTR	0.92	8.01	90.98	0.09	3258	30	261	2964	3
SPARTANBURG REG MED CTR	4.88	25.05	70.03	0.04	2539	124	636	1778	1
GREENVILLE HOSPITAL SYSTEM	6.35	21.62	64.26	7.56	4860	310	1065	3136	369
MCLEOD REGIONAL MED CTR	6.82	19.94	66.27	6.97	2096	143	418	1389	146
SELF MEMORIAL HOSPITAL	7.37	17.97	69.76	4.89	1614	119	290	1126	79
PALMETTO RICHLAND MEM HOSP	15.82	27.84	55.72	0.62	3243	513	903	1807	20
MEDICAL UNIVERISTY HOSPITAL	17.06	18.38	63.67	0.90	1888	322	347	1202	17

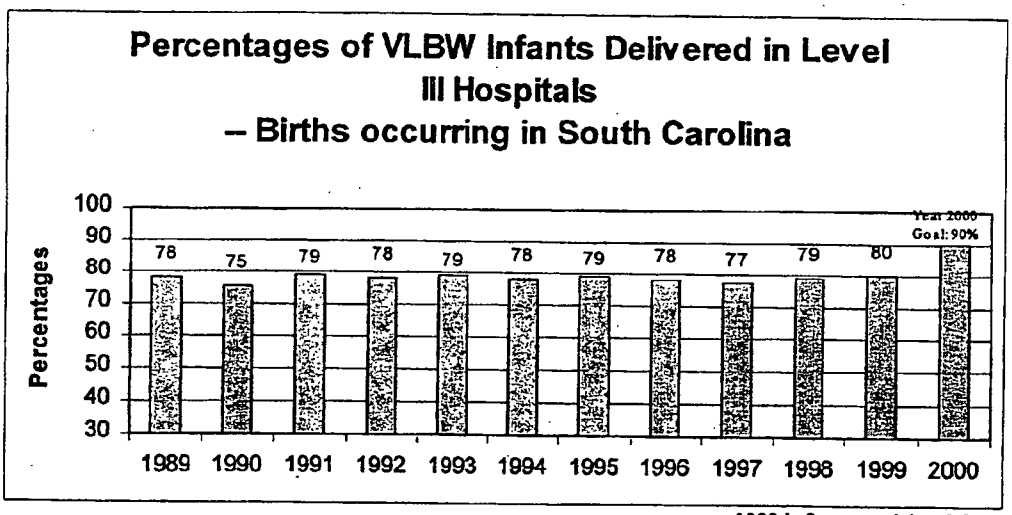
Source: South Carolina Perinatal Regionalization Surveillence 1999

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90% of VLBW Infants in Level III Hospitals: Will We Reach the Healthy People 2000 Goal?

South Carolina's Progress Toward Year 2000 Goal

The Healthy People Year 2000 goal, a national consensus of health leaders, is to have at least 90% of the very low birthweight (VLBW) births delivered in Leel III hospitals. In South Carolina, the annual percentages of VLBW births in Level III hospitals steadily increased between 1983 and 1989, but experienced a sharp decline in 1990. Since then, the percentages have been between 78% and 79% making no progress toward the year 2000 Goal.



1999 is from provisional data

Why is the issue important?

- In South Carolina and the united states, neonatal mortality is significantly lower in very low birthweight infants (500-1,499 gram) born at Level III hospitals with neonatal intensive care units compared with those born at community hospitals.
- Cost of hospitalization and length of hospital stay for very low birthweight infants transferred in-utero tended to be less compared with those transferred after births to Level III hospitals.
- Very low birthweight infants account for nearly 40% of infant deaths in South Carolina in recent years.
- Number of VLBW births steadily increased in some Level II hospitals in recent years. Some Level II hospitals delivered 4-6 times the number of VLBW infants as other Level II hospitals with similar delivery volumes.
- Findings from the 1991 South Carolina Study of Very Low Birthweight Births indicated that many of the VLBW deliveries in Level I and Level II hospitals may have been preventable.

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(E) Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants.

It is recognized that children have special problems which need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care, but rather, beds for children should be consolidated and distributed in such a manner as to ensure accessibility throughout an area. The need for pediatric beds is calculated under general hospital beds.

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for this service:

a. Need;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service.

CHILDREN WITH CHRONIC CONDITIONS

According to national studies, approximately 20% of children grows up with some chronic condition that impairs their abilities and about 4% grows up with two or more. Chronic conditions such as asthma, sickle cell, diabetes, spina bifida or cystic fibrosis affect children emotionally, physically and developmentally.

Asthma is one of the leading chronic conditions of children. The hospitalization rate for asthma in South Carolina has been increasing over the past ten years. The hospitalization rate for **sickle cell** disease in SC has also been increasing. **Diabetes, spina bifida** and **cystic fibrosis** are also leading chronic conditions; however, the hospitalization rate has remained steady or declined slightly for these conditions over the past ten years.

The following table indicates the hospitalization rate for chronic conditions in South Carolina over the past twelve years:

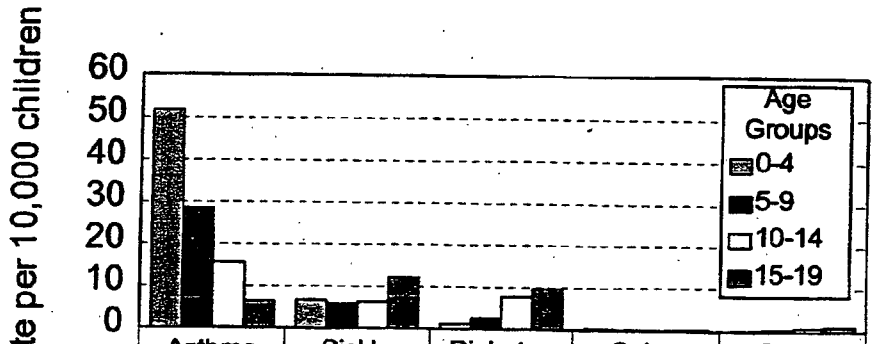
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Hospitalization Rate for Chronic Conditions

Children (0 - 19), South Carolina, 1999



	Asthma	Sickle Cell	Diabetes	Spina Bifida	Cystic Fibrosis
0-4	51.6	6.6	1.3	0.3	0.1
5-9	28.5	5.9	2.5	0.1	0.4
10-14	15.6	6.4	7.8	0.1	0.8
15-19	6.4	12	9.6	0.3	1.2

Data source: Hospital Discharge Survey, SC Budget and Control Board, Office of Research and Statistics

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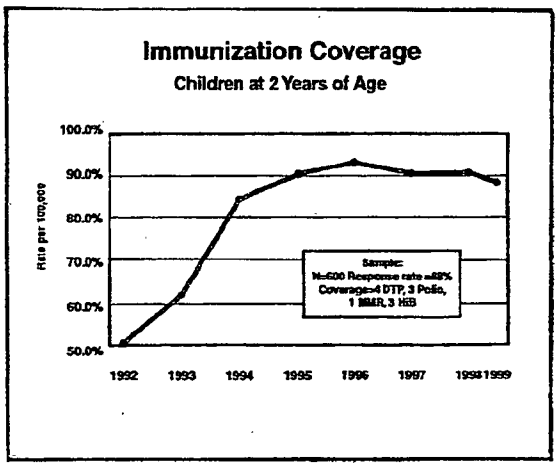
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CHILDHOOD IMMUMNIZATION RATE

State Data –

Immunization is the most powerful and cost-effective method of preventing serious childhood infections. The percentage of 2 year olds in South Carolina receiving a complete set of standard immunizations rose from 62 percent to 93 percent between 1993 and 1996. Most serious vaccine preventable childhood infections will die out spontaneously in a population that is over 90 percent resistant. The slight decline in the 1999 point estimate of vaccination coverage does not represent a significant change from previous years. The plateau of 89.0 to 91.9 percent point estimates of vaccination coverage for the past five years demonstrates the difficulty in improving immunization rates. The new State Immunization Information System (SIIS) allows privates physicians' offices and DHEC clinics to track a child's previous immunizations. Full SIIS implementation will help to sustain high levels of vaccination coverage and identify new and more focused efforts need to be implemented to raise vaccination coverage levels above the 90 percent plateau.



Data Source: SCDHEC Immunization Program, State Survey

National Data –

The National Immunization Survey (NIS) provides ongoing national estimates of vaccination coverage among children aged 19-35 months based on data for the most recent 21 months for each of the 50 states. For this reporting period (January - December 1999), NIS included children born February 1996 – May 1998. This report indicates that vaccination coverage among U.S. children aged 19 – 35 months were at or near record high levels.

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The following table is the estimated vaccination coverage with the 4:3:1:3* series among children aged 19 – 35 months by state. National Immunization Survey, United States, 1999 (Children in this survey period were born during February 1996 – May 1998).

Alabama	78.4%	Montana	82.5%
Alaska	85.2%	Nebraska	81.8%
Arizona	72.4%	Nevada	73.1%
Arkansas	77.1%	New Hampshire	84.5%
California	75.3%	New Jersey	80.8%
Colorado	75.8%	New Mexico	73.0%
Connecticut	85.9%	New York	81.0%
Delaware	78.2%	North Carolina	81.8%
Florida	80.3%	North Dakota	80.4%
Georgia	81.9%	Ohio	78.1%
Hawaii	81.6%	Oklahoma	72.9%
Idaho	69.4%	Oregon	72.3%
Illinois	77.4%	Pennsylvania	86.0%
Indiana	74.3%	Rhode Island	87.4%
Iowa	83.4%	South Carolina	80.6%
Kansas	78.9%	South Dakota	81.7%
Kentucky	87.6%	Tennessee	77.7%
Louisiana	76.8%	Texas	72.4%
Maine	82.9%	Utah	80.2%
Maryland	79.4%	Vermont	90.5%
Massachusetts	85.2%	Virginia	80.3%
Michigan	74.4%	Washington	74.9%
Minnesota	85.2%	West Virginia	81.0%
Mississippi	81.7%	Wisconsin	84.5%
Missouri	75.0%	Wyoming	82.8%
	Overall **78.4%**		

- Four doses of any diptheria and tetan us toxoids and pertussis vaccine, three doses of poliovirus vaccine, one dose of MCV, and three doses of *Haemophilusinfluenzae* type b vaccine.

Data Source: National Immunization Survey

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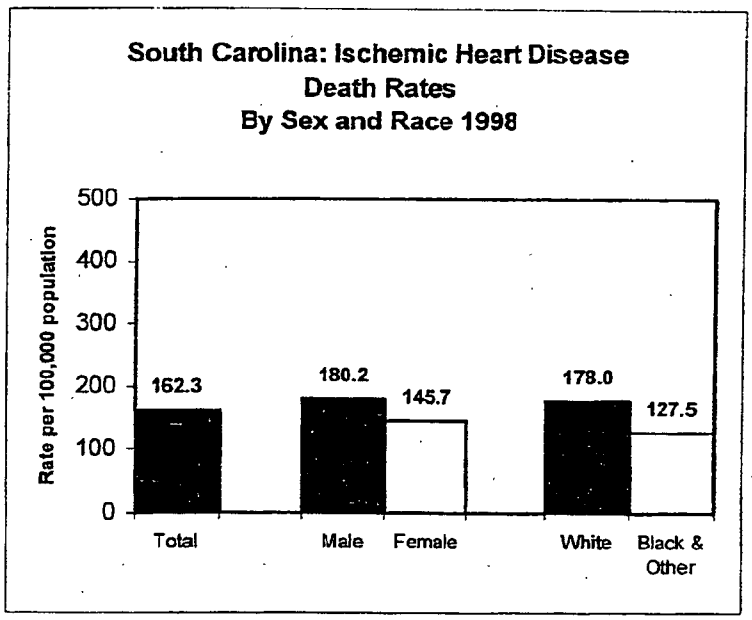
(F) CARDIOVASCULAR, CEREBROVASCULAR AND ASSOCIATED HEART DISEASE

OVERVIEW

There are over 20 identified cardiovascular diseases, the most common of which are arteriosclerosis {hardening of the arteries}, myocardial infarction {heart attack} and cerebrovascular disease {strokes}. Cardiovascular diseases are the leading cause of death among both men and women of all racial and ethnic groups, accounting for more than 40% of all deaths in the United States. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country.

The heart requires oxygen and nutrients supplied through the coronary arteries in order to function. If the blood supply becomes inadequate, the result is ischemia; if it persists, the result is infarction, or death of heart muscle {myocardium}. In its extreme form, ischemic heart disease results in a heart attack and is responsible for more than 20% of all deaths in the United States each year. South Carolina has the seventh highest mortality rate due to ischemic heart disease. The highest death rate per 100,000 population is found among white males; white females have the lowest rate.

The usual cause of a heart attack is arteriosclerosis, the accumulation of fat-filled cells {plaque} on the inner walls of blood vessels. These plaque narrow the blood flow through the coronary arteries and reduce blood flow to the heart muscle. Should a plaque crack or rupture, a blood clot {thrombus} forms on top of the plaque in order to repair the damage. However, if the blood clot is big enough to block all blood flow through the artery, the myocardium will not receive the oxygen needed and the muscle cells die. If blood flow is not quickly restored to the dying heart muscle, the victim will die. Approximately one-third of all heart attacks are fatal; survivors may develop congestive heart failure or other health problems.



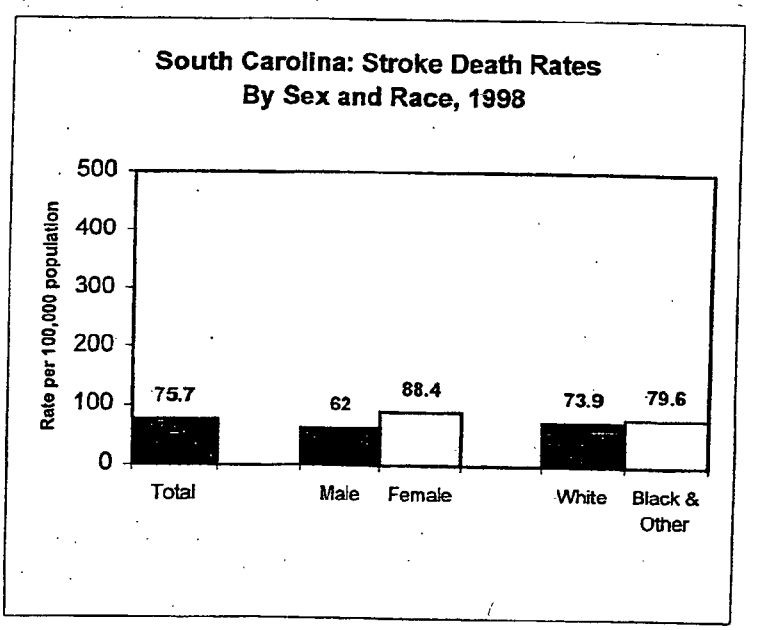
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A cerebrovascular accident, or stroke, occurs when a blood vessel bringing oxygen and nutrients to the brain bursts or is clogged by a blood clot. As in a heart attack, part of the brain is deprived of the blood flow it needs. Nerve cells in the affected area cannot function and die within minutes. When these nerve cells are not functioning, the part of the body controlled by these cells cannot function either. Since dead brain cells cannot be replaced, a stroke often results in permanent damage.

Stroke is the third leading cause of death both nationally and in South Carolina. Approximately 150,000 Americans die annually of strokes and another 500,000 suffer non-fatal strokes. South Carolina has the highest rate in the country. Nine of the 12 states with the highest stroke mortality rates are located in the Southeast, an area known as the "stroke belt."



There are a number of modifiable risk factors for both heart attacks and strokes. Cigarette smoking is estimated to account for 21% of all coronary artery disease deaths. Women smokers who use oral contraceptives are up to 39 times more likely to have a heart attack and 22 times more likely to have a stroke than women who neither smoke nor take birth-control pills. Quitting smoking can reduce the risk of heart disease by 50-70% after 5 years.

High blood pressure, or hypertension, means that the force of blood pushing against blood vessel walls is consistently above the normal range. The top, systolic number is the pressure when the heart beats; the bottom, diastolic pressure is the pressure when the heart is at rest. High blood pressure is a consistently elevated pressure of 140+ systolic and/or 90+ diastolic. The risk of coronary heart disease is 2-4 times higher and the risk of stroke is 4-6 times higher for people with high blood

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pressure. However, each reduction of 1 mm/Hg in diastolic pressure reduces the risk by 2-3 percent. High blood pressure is more prevalent among women than men and higher for blacks than whites. Approximately 24.7% of the population in South Carolina has high blood pressure.

Over half of Americans have blood cholesterol values of 200 mg/dL and higher; approximately 22% have levels of 240 or above. High blood cholesterol increases the risk of heart disease by a factor of 2.4. Lowering total serum cholesterol by 1% is estimated to reduce heart disease risk by 2-3%. In 1996, 21.4% of survey respondents in South Carolina reported being told they had high blood cholesterol levels.

More than a quarter of all Americans age 18 and older report no leisure-time physical activity; for South Carolina, the number was 29.7%. Physical inactivity is the leading risk factor for heart disease, accounting for approximately 37% of coronary artery disease deaths each year. Having a physically active lifestyle reduces the risk of heart attack by 35-55%.

South Carolina has the highest percentage of overweight adults in the country, at 34.4% of the population. People who are seriously overweight are 3 times as likely to have coronary artery disease. Maintaining ideal body weight can reduce the risk of coronary artery disease by 35-55%.

More than 80% of people with diabetes die from some form of heart or blood-vessel disease. People with diabetes are 2-4 times more likely to have heart disease and 5 times more likely to have strokes than those without diabetes. Diabetics are also at increased risk for blindness, kidney failure and lower extremity amputation. South Carolina has the 4th highest diabetes death rate in the country.

While these risk factors can increase the chances of developing cardiovascular disease, there are also several factors which can decrease the risks. Aspirin inhibits the formation of blood clots in the coronary arteries, preventing heart attacks. Many physicians recommend low-dose aspirin as a primary prevention measure for men over 50, postmenopausal women and younger people at risk. Postmenopausal women who choose Estrogen Replacement Therapy {ERT} reduce the risk of heart disease by about 44%, while also protecting against osteoporosis. However, the estrogen should be taken with a synthetic form of progesterone to reduce the risk of endometrial cancer. Finally, studies have indicated that drinking the equivalent of 1 beer, glass of wine or mixed drink per day reduces the risk of heart disease. However, heavy drinking increases the risk of heart disease, so some physicians are cautious about recommending consumption of alcohol as a preventive measure.

Over the past 25 years, the death rates from heart disease and stroke have decreased by 49% and 58% respectively. In the 1950's only about 33% of heart attack victims who reached a hospital survived; now approximately 90% live. Part of these reductions are due to improvements in the lifestyle factors mentioned above. Increased emphasis has been placed on high blood pressure and cholesterol screening, detection and management. Cigarette smoking rates have also decreased.

Electron Beam Computer Tomography (EBCT) is a technology which shows promise for predicting the likelihood of a heart attack. Also known as "Ultrafast CT," it is a non-invasive scanner which produces cross-sectional pictures depicting the presence amount of calcium in the coronary arteries. Calcium is an indicator of atherosclerosis; plaque rupture is the major mechanism for sudden coronary

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death. EBCT may be used for examining emergency room patients reporting chest pain. If the scan shows no calcification, patients are at low risk of having a heart attack. It may also be used for early detection of coronary artery disease of asymptomatic persons, especially those with multiple risk factors such as family history, hypertension, diabetes, etc. The scanners cost approximately $1.8 million; the test costs $425-475, but it is not yet covered by most insurance companies.

The other cause for the decreased death rates is improvements in treatment. The amount of heart muscle that is damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive. Ambulances and Emergency Rooms are better equipped to treat these victims. Doctors are now able to limit heart damage through medications such as aspirin, nitroglycerin, beta-adrenergic blocking agents (beta blockers), and heparin (blood thinner). The development of drugs which can dissolve blood clots and stop heart attacks has been a medical breakthrough. Drugs such as t-PA and streptokinase are often successful if administered within 6 hours of the onset of heart attack symptoms, although they do have a risk of bleeding complications. In addition, restoring blood flow to the dying heart muscle (reperfusion) by breaking up the blood clot through angioplasty or by grafting blood vessels from other body parts to construct a detour around the blockage have greatly improved survival rates.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. Cardiac catheterization is the standard method for detecting and determining the severity of coronary artery disease. During this test, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The tube is manipulated by the physician to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of radioactive dye allow blockages or area of weakness to appear on x-rays. In addition, other diagnostic and therapeutic procedures such as coronary angioplasty, myocardial biopsy, electrophysiology studies, thromobolytic therapy, and insertion of pacemakers may be performed. Diagnostic catheterizations take approximately 1-1/2 hours to perform while therapeutic catheterizations average 3 hours.

Percutaneous Transluminal Coronary Angioplasty (PTCA), is the most common therapeutic procedure. A catheter tipped with a balloon is inserted into a blood vessel, guided to the site of the constriction in the vessel, then inflated to flatten plaque against the artery wall and widen the narrowed artery. PTCA may delay or eliminate the need for surgery for many patients with coronary artery disease. Although the success rate for single-lesion dilation is 90-95%, the mortality rate is about 1% and for approximately 1-4% of PTCA's performed, severe complications set in during the procedure requiring open heart surgery. In addition, between 30-50% of patients initially successfully treated with PTCA experience re-narrowing within 3-6 months, requiring repeat PTCA treatment or open heart surgery. Because of the risk of arterial damage and resulting need for immediate open heart surgery, PTCA is contraindicated for institutions without a cardiac surgery program.

Another common therapeutic intervention is the coronary stent. An expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Stenting has been successful in 95-98% of patients, with emergency bypass surgery being required for fewer than 1%. There are also suggestions that the re-stenosis rate for coronary stenting may be lower than that after PTCA. However, there is a risk of

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blood clots, which form in 1-2% of patients, which can cause a heart attack. After coronary stenting, all patients must use a combination of blood-thinning medicines for approximately 8 weeks.

Open heart surgery refers to an operation performed on the heart or intrathoracic great vessels which requires the temporary use of a heart-lung bypass machine to perform the normal functions of the heart and lungs during surgery. While it can be used to correct congenital heart defects and defects in the heart valves, it is most commonly used to treat ischemic heart disease. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases. The saphenous vein from the leg or the internal mammary artery from the chest is extracted from the patient and grafted to bypass a constricted section of 1 or more of the coronary arteries. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. While mortality rates have declined significantly since its introduction, CABG still carries significant risks. Standard CABG surgery requires sawing through the breastbone and prying open the ribcage, resulting in a 1 week hospital stay and up to 2 months recuperation.

A new generation of open heart surgery techniques have been developed and are now in use. Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) surgery features a 3-4 inch incision and a stabilizer foot, allowing single- or double-artery bypass to be performed while the heart is still beating. The Octopus method also allows single- or double-artery bypasses with the heart still beating, through the use of suction wands which stabilize the heart. The Port-Access method relies on small incision ports to perform repairs, while the heart-lung machine is attached through the groin. While these methods offer pluses such as smaller incisions, less bleeding and faster recovery, their long-term effectiveness is not known at this time.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs represent a less efficient use of an expensive resource and often reflects unnecessary duplication of services in an area. This may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year {diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0}. For pediatric catheterization laboratories, a minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to increase in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year; at least 75 should be open heart surgery.

STATUS OF SOUTH CAROLINA PROVIDERS

1. CARDIAC CATHETERIZATIONS

The Certificate of Need standards for cardiac catheterization laboratories require a minimum of 600 cardiac equivalents annually within 3 years of initiation of service. In 1999, there were 25 hospitals

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approved to provide cardiac catheterization services in fixed laboratories in South Carolina, although only 23 programs were operational. Of these, 19 were exceeding the minimum of 600 equivalents per lab. St. Francis Hospital exceeded this requirement for their first cath lab; they recently opened a second lab, which has not yet met this standard but is still within the time frame considered following initiation of services. Self Memorial received a CON for a second lab in 1999. Mary Black Memorial converted from a mobile lab to a fixed lab in 1998. Georgetown Regional converted from a mobile to a fixed cath lab in 1996; utilization has steadily increased each year. Conway Hospital and Palmetto Baptist Easley received CONs in 1999 for diagnostic cath labs. There were also mobile cath labs at Springs Memorial and Carolina Pines Regional Medical Center.

There are currently 15 open heart surgery programs approved for the general public in South Carolina, although 2 programs are not yet operational and 2 other programs have only recently initiated services. The Veterans Administration (VA) Hospital in Charleston also performs open heart surgery. These are the only facilities approved to perform therapeutic catheterizations. The standard for these programs is that they should be performing a minimum of 300 therapeutic caths annually within 3 years of initiation of service. All of the 11 operational programs performed at least the minimum number.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The recommended standard requires a minimum of 600 cardiac equivalents per year {a pediatric catheterization is weighted as 2.0 equivalents}. MUSC has consistently exceeded this requirement.

There is a lack of available data to measure the quality of care provided by the facilities offering cardiac catheterization services in South Carolina. The best approximation can be made by comparing the utilization of these facilities with national and state standards. In general, the providers of cardiac catheterization are adequately in compliance with these standards. The number of cardiac equivalents per cath lab is higher than ever, despite the increasing number of labs. In 1999, 19 of the 23 facilities who have been offering cardiac catheterizations for more than 3 years provided more than the minimum standard of 600 diagnostic equivalents per laboratory. Every established facility providing therapeutic catheterizations exceeded the minimum requirement of 300 procedures annually by the third year of operation.

2. OPEN HEART SURGERY

The number of open heart surgeries performed in South Carolina has almost doubled in the time period of 1989-1999, from 3,221 in 1989 to 6,341 in 1999. Prior to 1995, there were 8 facilities providing open heart surgery in South Carolina. Since that time, Grand Strand Regional initiated services in 1995 and Aiken Regional began their program in 1996. These programs have now been in operation for at least 3 years. Also, Piedmont Regional began providing open heart in 1997, and Carolinas Regional and St. Francis in 1999. In addition, Anderson Area and Self Memorial have received CON approval but have yet to begin performing open heart surgery. Because these 5 facilities have not completed 3 years of operation, it is not possible to evaluate their performance compared to the Certificate of Need and literature standards. Therefore, this analysis will focus on the 10 established programs in South Carolina.

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In spite of the increased number of open heart surgeries performed, additional capacity remains in most programs in the state. The 10 established programs had a total of 24 open heart surgery suites in operation in 1999. With a stated capacity of 500 procedures per suite, the statewide capacity was 12,000 cases. A total of 6,070 open heart surgeries were actually performed in these suites, giving an average utilization rate of 50.6%. The state average was 252.9 procedures per suite.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within 3 years of initiation of service. It should be emphasized that this minimum volume for clinical proficiency should not be interpreted as an optimal level of operation. An annual caseload of 200 cases amounts to less than 5 procedures per week and clearly does not fully utilize the resources required to staff a cardiac surgery program.

Studies indicate that hospitals that perform a minimum of 350 cases annually tend to have better outcomes than those that perform fewer cases. In 1999, 7 of the 10 established programs performed more than 350 total cases; Greenville Memorial and Providence Hospital both performed over 1,000 open heart surgeries. Grand Strand performed 316; Trident Regional performed 172, and Aiken performed 115 open heart surgeries in 1999.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 1999, 184 pediatric open heart surgeries were performed there.

The Certificate of Need standards for Cardiac Catheterization and Open Heart Surgery follow.

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Certificate of Need Standards for Cardiac Catheterization

DEFINITIONS

"Capacity" means the number of cardiac catheterizations that can be accommodated in a cardiac catheterization laboratory in one year.

"Cardiac Catheterization" is an invasive medical procedure performed within a cardiac catheterization laboratory and used as a diagnostic or therapeutic tool for heart and circulatory conditions. A thin, flexible catheter is inserted into a blood vessel; subsequently, the free end of the catheter is manipulated by the physician to travel along the course of the blood vessel into the chambers or vessels of the heart. During a cardiac catheterization, blood pressure, oxygen content and flow measurements, injection of x-ray dyes, coronary angioplasty, myocardial biopsy, electrophysiology procedures, thrombolytic therapy, insertion of pacemakers, and other diagnostic and therapeutic techniques may be performed.

"Cardiac Catheterization Laboratory" refers to a room or suite of rooms in a hospital, a mobile unit on the campus of a hospital, or a freestanding cardiac catheterization facility which has the equipment, staff and support services to function as an integrated unit for the purposes of performing cardiac catheterization procedures for a single patient at a given time and which is used to perform cardiac catheterization procedures.

"Cardiac Catheterization Procedure" means an angiographic or physiologic study performed within a cardiac catheterization laboratory. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed.

"Coronary stents" are metallic wire tubes that are implanted at the site of a narrowing in a coronary artery to keep the vessel open. They consist of an expandable metal coil or framework that buttresses the wall of the coronary artery.

"Diagnostic Catheterization" refers to a cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization
37.22 Left Heart Cardiac Catheterization
37.23 Combined Right and Left Heart Cardiac Catheterization

"Diagnostic Catheterization Laboratory" means a dedicated room or suite of rooms in which only diagnostic catheterizations are performed.

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"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. Diagnostic catheterizations are weighted as 1.0 equivalents, while therapeutic and pediatric catheterizations are weighted as 2.0 equivalents.

"Percutaneous Transluminal Coronary Angioplasty (PTCA)" refers to a therapeutic procedure in which a catheter tipped with a balloon is inserted into a blood vessel, guided to the site of the constriction in the vessel, then inflated to flatten plaque against the artery wall and widen the narrowed artery.

"Therapeutic catheterization" refers to a cardiac catheterization during which, in addition to any or all of the procedures listed above under Diagnostic Catheterizations, any or all of the following interventional procedures are performed: Percutaneous Transluminal Coronary Angioplasty (PTCA); Thrombolytic Agent Infusion; Directional Coronary Atherectomy (DCA); Coronary Stent Implants and Cardiac Valvuloplasty. The following ICD-9-CM Codes refer to therapeutic catheterizations:

35.96 Percutaneous Valvuloplasty
36.01 Single Vessel PTCA Without Mention of Thrombolytic Agent
36.02 Single Vessel PTCA With Thrombolytic Agent
36.05 Multiple Vessel PTCA Performed During the Same Operation, With or Without Mention of Thrombolytic Agent

"Thrombolytic agent infusion" refers to the administration of a drug, such as Streptokinase or Tissue Plasminogen Activator (TPA), to break up a blood clot that obstructs a blood vessel of the heart.

STANDARDS

(1) The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Diagnostic catheterizations (ICD-9-CM Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Codes 35.96, 36.01, 36.02, and 36.05) and pediatric catheterizations shall be weighted as 2.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

(2) The service area for a diagnostic catheterization laboratory is defined as all facilities within 45 minutes one way automobile travel time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes one way automobile travel time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

(3) New diagnostic cardiac catheterization services, including mobile, shall be approved only if all existing labs in the service area have performed at a combined use rate of 80% (960 equivalents per laboratory) for the most recent year;

(4) An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of

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services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

(5) An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 120 diagnostic equivalents annually for each day of the week that the mobile lab would be located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of 240 equivalents at the applicant's facility by the end of the third year of operation). In addition:

A. the applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 600 diagnostic equivalents per year;

B. the applicant must include vendor documentation of the complication rate of the mobile units operated by the vendor; and

C. if an application for a mobile lab is approved and the applicant subsequently desires to change vendors, the Department must approve such change in order to insure that appropriate minimum utilization can be documented.

(6) Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 600 procedures per year on the additional equipment within three years of its implementation.

(7) Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PTCA and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is considered to be an absolute contraindication for PTCA, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart, or abnormalities in the heart structure, shall not be allowed to perform PTCA and other therapeutic procedures.

(8) New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. all existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations and performed at a combined use rate of 80 percent in the most recent year (i.e. 960 equivalents per laboratory); and

B. an applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of

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services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

(9) Expansion of an existing comprehensive cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. This figure of 600 equivalents may be comprised by a combination of diagnostic and therapeutic procedures.

(10) New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

A. all existing facilities have performed at a combined use rate of 80% of capacity for the most recent year; and

B. an applicant must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services.

(11) Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation.

(12) Documentation of need for the proposed service:

A. the applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

B. the applicant shall project the utilization of the service and the effect of its projected utilization on other cardiac catheterization services within its service area, to include:

1. the number of patients of the applicant hospital who were referred to other cardiac catheterization services in the preceding 3 years and the number of those patients who could have been served by the proposed service;

2. the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

3. existing and projected patient origin information and referral patterns for each cardiac catheterization service serving patients from the area proposed to be served shall be provided.

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(13) Both fixed and mobile diagnostic cardiac catheterization laboratories must provide a written agreement with at least one hospital providing open heart surgery, which states specified arrangements for referral and transfer of patients, to include:

A. criteria for referral of patients on both a routine basis and an emergency back-up basis;

B. regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

C. acceptability of diagnostic results from the cardiac catheterization service to the receiving surgical service to the greatest extent possible to prevent duplication of services; and

D. development of linkages with the receiving institution's peer review mechanism.

(14) The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk. For diagnostic catheterization laboratories, this description of patient selection criteria shall include referral arrangements for high-risk patients. For comprehensive laboratories, these high-risk procedures should only be performed with open heart surgery back-up. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

(15) Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

SCOPE OF SERVICES

The following services should be available in both adult and pediatric catheterization laboratories:

(1) Each cardiac catheterization lab should be competent to provide a range of angiographic (angiocardiography, coronary arteriography, pulmonary arteriography), hemodynamic, and physiologic (cardiac output measurement, intracardiac pressure, etc.) studies. These facilities should be available in one laboratory so that the patient need not be moved during a procedure.

(2) The lab should have the capability of immediate endocardiac catheter pacemaking in cardiac arrest, a crash cart, and defibrillator.

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(3) A full range of non-invasive cardiac/circulatory diagnostic support services, such as the following, should be available within the hospital:

a. Nuclear Cardiology
b. Echocardiography
c. Pulmonary Function Testing
d. Exercise Testing
e. Electrocardiography
f. Cardiac Chest X-ray and Cardiac Fluoroscopy
g. Clinical Pathology and Blood Chemistry Analysis
h. Phonocardiography
i. Coronary Care Units (CCUs)
j. Medical Telemetry/Progressive Care

(4) Each applicant shall document plans for providing cardiac rehabilitation services to its patients, or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Cardiac catheterization studies for elective cases should be available at least 40 hours a week. All catheterization laboratories should have the capacity for rapid mobilization of the study team for emergency procedures 24 hours a day, 7 days a week.

All facilities offering cardiac catheterization services should meet full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or if the facility is not JCAHO accredited, then they must meet certification and/or licensure standards.

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:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Staff Resources; and
i. Adverse Effects on Other Facilities.

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic

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catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

(2) Significant cardiac catheterization capacity exists in most areas of the State; and

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures are recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

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

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CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY98 ADULTS: DIAG	FY98 ADULTS: THERP	FY98 PEDS TOTAL	FY99 ADULTS: DIAG	FY99 ADULTS: THERP	FY99 PEDS TOTAL	FY00 ADULTS: DIAG	FY00 ADULTS: THERP	FY00 PEDS TOTAL
I										
ANDERSON AREA MED CTR #16	3	2626		2626	2625		2625	2408		2408
GREENVILLE MEM MED CTR #6	7	4192	1665	6057	4388	2140	6528	4489	2039	6528
MARY BLACK MEM #8	1	92		92	64		64	506		506
OCONEE MEM HOSP #5	1	686		686	644		644	689		689
PALMETTO BAPTIST MED CTR-EASLEY #13	1						0	256		256
SPARTANBURG REG MED CTR	3	2758	495	3253	2994	711	3705	3086	857	3952
ST FRANCIS COMM #9	2	657		657	899	31	930	1312	326	1638
TOTAL AREA I		11111	2350	13471	11614	2882	14496	12753	3222	15975
II										
PALMETTO BAPTIST MED CTR-COLA	1	445		445	651		651	830		830
SPRINGS MEM #20	1	252		252	393		393	406		406
LEXINGTON MED CTR #18	1									
PROVIDENCE HOSPITAL	5	3541	1384	4925	3449	1642	5091	3730	1884	5614
PIEDMONT MEDICAL CTR	2	2172	718	2890	2297	825	3122	2216	633	2849
PALMETTO RICHLAND MEM HOSP #17	4	1284	557	1841	1353	653	2006	1580	615	2196
SELF MEM HOSP #15	2	462		462	500		500	512		512
SOUTH CAROLINA HEART CENTER #1	2			0			0			0
TOTAL AREA II		8156	2659	10815	8643	3120	11763	9274	3132	12406
III										
CAROLINA PINES REG MED CTR #12	1	7		7	20		20	166		166
CAROLINAS HOSP SYS #2	2	1167		1167	1122		1122	1136		1136
CONWAY HOSP #14	1	425		425	419		419	461		461
GEORGETOWN MEM HOSP #6	1	357		357	468		468	477		477
GRAND STRAND REG MED CTR #7	2	821	446	1267	1253	576	1829	1060	670	1730
MCLEOD REG MED CTR #10	4	3476	1224	4700	3292	1108	4400	3089	727	3816
TUOMEY	1	685		685	875		875	985		985
TOTAL AREA III		6938	1670	8608	7449	1684	9133	7394	1397	8791

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CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY98 ADULTS: DIAG	FY98 ADULTS: THERP	FY98 ADULTS: TOTAL	FY98 PEDS	FY99 ADULTS: DIAG	FY99 ADULTS: THERP	FY99 ADULTS: TOTAL	FY99 PEDS	FY00 ADULTS: DIAG	FY00 ADULTS: THERP	FY00 ADULTS: TOTAL	FY00 PEDS
II:													
IV													
BEAUFORT MEMORIAL HOSP #21	1												
HILTON HEAD HOSP #3	1	720	(136)	720		913	(155)	913		874	(193)	874	
MEDICAL UNIV HOSP #18	5	2111	568	2679	652	2173	560	2733	985	1831	691	2522	964
ROPER HOSP #11	3	2978	815	3793		2224	759	2983		2760	793	3553	
TRIDENT MED CTR	2	1208	457	1663		1326	437	1763		1532	487	2019	
BON SECOURS ST. FRANCIS XAVIER	1	1962		1962		121		121		304		304	
RMC ORANGEBURG-CALHOUN	1	713		713		763		763		974		974	
AIKEN REG MED CTR	1	1539	1635	3174		1097	415	1512		1097	399	1496	
TOTAL AREA IV		11229	3475	14704		8617	2171	10788		9372	2370	11742	
TOTAL		37434	10164	47598		38323	9857	48180		38793	10121	48914	

#1 DOCTORS OFFICE NOT A LICENSED AMBULATORY SURGERY CTR
#2 CON FOR 2ND CATH, 7/23/96
#3 CON 4/20/95 DATA FOR 96 CHANGED ON 97 JAR
APPROVED TO PROVIDE THERAPEUTIC CATHS, 4/3/01
#4 CON FOR FIX TO REPLACE MOBILE 1/26/96
#5 CON FOR COMBINATION LAB 1/23/96
#6 CON FOR 6TH CATH, 3/6/97. CON ISSUED FOR 7TH CATH, 11/30/99. CON TO REPLACE AN EXISTING CATH & MAINTAINING 7 CATHS WITH 5 AT GMH AND 2 AT MEM MEDICAL OFFICE,7/3//00.
#7 CON ISSUED FOR 2ND CATH, 8/26/97.
#8 CON ISSUED REPLACE MOBILE W/ FIXED,3/10/98
#9 CON ISSUED FOR 2ND CATH,9/10/97.
#10 CON FOR 4ND CATH, 7/23/98.
#11 CON FOR 3TH CATH, 6/13/97.
#12 EXEMPT 4/21/97.FOR MOBILE. CON FOR FIXED TO REPLACE MOBILE 6/20/01.
#13 CON ISSUED FOR FIXED CATH, 6/15/99.
#14 CON TO REPLACE MOBILE W/ FIXED,6/21/99
#15 CON FOR 2ND CATH, 9/2/99.
#16 CON FOR 3RD CATH W/ THERA, 11/2/98.
#17 CON FOR 4TH CATH, 11/05/99.
#18 CON ISSUED TO REPLACE ADULT CATH WITH AN ADULT/PEDIATRIC CATH, 12/28/99 ,SC-99-50. HAS 3 ADULTS & 1 PED CATH. CON ISSUED FOR 2 ADDITIONAL ADULT CATHS FOR 5 ADULT & 1 PED SC-01-13 3/12/01
#19 CON ISSUED FOR FIXED CATH, 1/30/01 SC-01-05.
#20 CON TO REPLACE MOBILE W/ FIXED CATH, 07/12/01
#21 APP FOR DIAGNOSTIC CATH, 8/28/01.

RECORD 003586
PMC.2013.SHP.0073
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Certificate of Need Standards for Open Heart Surgery

DEFINITIONS

"Capacity" means the number of open heart surgery procedures that can be accommodated in an open heart surgery unit in one year.

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes:

35.10 Open heart valvuloplasty, without replacement, unspecified valve
35.11 Open heart valvuloplasty of aortic valve without replacement
35.12 Open heart valvuloplasty of mitral valve without replacement
35.13 Open heart valvuloplasty of pulmonary valve without replacement
35.14 Open heart valvuloplasty of tricuspid valve without replacement
35.20 Replacement of unspecified heart valve
35.21 Replacement of aortic valve with tissue graft
35.22 Other replacement of aortic valve
35.23 Replacement of mitral valve with tissue graft
35.24 Other replacement of mitral valve
35.25 Replacement of pulmonary valve with tissue graft
35.26 Other replacement of pulmonary valve
35.27 Replacement of tricuspid valve with tissue graft
35.28 Other replacement of tricuspid valve
35.31 Operations on papillary muscle
35.32 Operations on chordae tendineae
35.33 Annuloplasty
35.34 Infundibulectomy
35.35 Operations on trabeculae carnae cordis
35.39 Operations on other structures adjacent to valves of heart
35.41 Enlargement of existing atrial septal defect
35.42 Creation of septal defect in heart
35.50 Repair of unspecified septal defect of heart with prosthesis
35.51 Repair of atrial septal defect with prosthesis, open technique
35.53 Repair of ventricular septal defect with prosthesis
35.54 Repair of endocardial defect with prosthesis
35.60 Repair of unspecified septal defect with tissue graft
35.61 Repair of atrial septal defect with tissue graft
35.62 Repair of ventricular septal defect with tissue graft
35.63 Repair of endocardial cushion defect with tissue graft
35.70 Other and unspecified repair of unspecified septal defect of heart
35.71 Other and unspecified repair of atrial septal defect
35.72 Other and unspecified repair of ventricular septal defect
35.73 Other and unspecified repair of endocardial cushion defect
35.81 Total repair of tetralogy of Fallot

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35.82 Total repair of total anomalous pulmonary venuos connection
35.83 Total repair of truncus arteriosus
35.84 Total repair of transposition of great vessels, not elsewhere classified
35.91 Interatrial transposition of venous return
35.92 Creation of conduit between right ventricle and pulmonary artery
35.93 Creation of conduit between left ventricle and aorta
35.94 Creation of conduit between atrium and pulmonary artery
35.95 Revision of corrective procedure on heart
35.98 Other operations on septa of heart
35.99 Other operations on valves of heart
36.03 Open chest coronary artery angioplasty
36.09 Other removal of coronary artery obstruction
36.10 Aortocoronary bypass for heart revascularization, not otherwise specified
36.11 Aortocoronary bypass of one coronary artery
36.12 Aortocoronary bypass of two coronary arteries
36.13 Aortocoronary bypass of three coronary arteries
36.14 Aortocoronary bypass of four or more coronary arteries
36.15 Single internal mammary-coronary artery bypass
36.16 Double internal mammary-coronary artery bypass
36.19 Other bypass anastomosis for heart revascularization
36.2 Heart revascularization by arterial implant
36.91 Repair of aneurysm of coronary vessel
36.99 Other operations on vessel of heart
37.10 Incision of heart, not otherwise specified
37.11 Cardiotomy
37.32 Excision of aneurysm of heart
37.33 Excision or destruction of other lesion or tissue of heart

An "Open Heart Surgery Unit" is an operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.

"Open Heart Surgical Procedure" means an operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.

"Open Heart Surgical Program" means the combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including:

(1) repair/replacement of heart valves
(2) repair of congenital defects
(3) cardiac revascularization
(4) repair/reconstruction of intrathoracic vessels

PMC.2013.SHP.0075

PET-EX005.0075

RECORD 003588

(5) treatment of cardiac traumas.

In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.

STANDARDS

The standards for open heart surgery in South Carolina are as follows:

(1) The establishment or addition of an open heart surgery unit requires Certificate of Need review, as this is considered a substantial expansion of a health service.

(2) Comprehensive cardiac catheterization laboratories shall only be located in hospitals which provide open heart surgery. The lack of a formal cardiac surgical program within the institution is considered to be an absolute contraindication for therapeutic catheterizations, due to the risk of arterial damage and subsequent need for emergency bypass surgery.

(3) The capacity of an open heart surgery program is determined to be 500 open heart procedures per year for the initial open heart surgery unit and each additional dedicated open heart surgery unit (i.e. each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

(4) There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit, within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

(5) New open heart surgery services shall be approved only if the following conditions are met:

A. Each existing unit in the service area (defined as all facilities within 60 minutes one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

1. There are no open heart surgery programs located in the same county as the applicant; and

2. The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic equivalents in the previous year of operation.

PMC.2013.SHP.0076

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B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery procedures annually per open heart surgery unit, within three years after initiation. The standard for pediatric open heart surgery shall be 100 procedures annually per open heart surgery unit within three years after initiation:

1. using a standard of every four (4) diagnostic cardiac catheterizations performed generating one (1) open heart surgery, the applicant must demonstrate that the facility performs sufficient diagnostic cardiac catheterizations to generate the minimum volume of open heart surgeries.

2. the applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which open heart surgery is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

3. an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services shall include:

   a. the number of patients of the applicant hospital who were referred to other open heart surgery services in the preceding 3 years and the number of these patients who could have been served by the proposed service;

   b. the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

   c. existing and projected patient origin information and referral patterns for each open heart surgery service serving patients from the area proposed to be served shall be provided.

(6) No new open heart surgery programs shall be approved if the new program will cause the annual caseload of other programs within the proposed service area to drop below 350 adult procedures or 130 pediatric procedures per open heart surgery unit.

(7) Expansion of an existing open heart surgery service shall only be approved if the service has operated at a minimum use rate of 70 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year in the new open heart surgery unit. The applicant shall document the other service providers, if any, from which these additional patients will be drawn.

(8) The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the

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American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

(9) Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

(10) The open heart surgery service will have the capability for emergency coronary artery surgery, including:

A. sufficient personnel and facilities available to conduct the coronary artery surgery on an immediate, emergency basis, 24 hours a day, 7 days a week;

B. location of the cardiac catheterization laboratory(ies) in which therapeutic catheterizations will be performed near the open heart surgery operating rooms; and

C. a predetermined protocol adopted by the cardiac catheterization service governing the provision of PTCA and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

SCOPE OF SERVICES

Within the hospital, a range of non-invasive cardiac and circulatory diagnostic services, including the following, should be available:

(1) services for hematology and coagulation disorders;
(2) electrocardiography, including exercise stress testing;
(3) diagnostic radiology;
(4) clinical pathology services which include blood chemistry and blood gas analysis;
(5) nuclear medicine services which include nuclear cardiology;
(6) echocardiography;
(7) pulmonary function testing;
(8) microbiology studies;
(9) Coronary Care Units (CCU's);
(10) medical telemetry/progressive care; and
(11) perfusion.

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Backup physician personnel in the following specialties should be available in emergency situations:

(1) Cardiology;
(2) Anesthesiology;
(3) Pathology;
(4) Thoracic Surgery; and
(5) Radiology.

Each applicant shall document plans for providing cardiac rehabilitation services to its patients, or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Adult open heart surgery services should be available within 60 minutes one way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks.

All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements, and should meet the full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), if the facility is JCAHO accredited.

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:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

The Department makes the following findings:

(1) Open heart surgery services are available within sixty (60) minutes travel time for the majority of residents of South Carolina;

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(2) Based upon the standards cited above, most of the open heart surgery providers are currently utilizing less than the functional capability (i.e. 70% of maximum capacity) of their existing surgical suites;

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures is recommended per year in order to develop and maintain physician and staff competency in performing these procedures; and

(4) Increasing geographic access may create lower volumes in existing programs causing a potential reduction in quality and efficiency, exacerbate existing problems regarding the availability of nursing staff and other personnel, and not necessarily reduce waiting time since other factors (such as the referring physician's preference) would still need to be addressed.

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

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REGION/FACILITY	# OPEN HEART UNITS	FY97 ADULTS	FY97 PEDS	FY98 ADULTS	FY98 PEDS	FY99 ADULTS	FY99 PEDS	FY00 ADULTS
I								
ANDERSON AREA MED CTR #7	2							
GREENVILLE MEM MED CTR	5	1404		1463		1333		1379
ST FRANCIS HOSPITAL #4	2					49		221
SPARTANBURG REG MED CTR	2	493		503		516		599
II								
PIEDMONT MED CTR #2	2			188		222		248
PROVIDENCE HOSPITAL	4	1065		1136		1107		1057
PALMETTO RICHLAND MEM HOSP	2	414		464		458		486
SELF MEMORIAL HOSPITAL #6	2							
III								
CAROLINAS HOSPITAL SYSTEM #5	2							86
MCLEOD REG MED CTR #6	3	608		765		769		608
GRAND STRAND REG MED CTR #1	2	201		231		316		278
IV								
AIKEN REG MED CTR #3	1	142		144		115		113
HILTON HEAD HOSP #8	1							
MEDICAL UNIV HOSP	3	464	171	460	159	628	184	465
ROPER HOSP	2	665		491		656		650
TRIDENT REG MED CTR	1	206		147		172		283
VA(CHARLESTON)	1							
		5662		5992		6341		

#1 CON ISSUED 2/7/94.
#2 CON 10/24/95.
#3 CON ISSUED 12/1/95
#4 CON 9/10/97
#5 CON7/23/98 BUT EFFECTIVE 11/1/98
#5 CON7/23/98 BUT EFFECTIVE 11/1/98
#6 CON 9/2 /99
#7 CON ISSUED 11/2 /99
#8 APP 4/3/01

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(G) Cancer

OVERVIEW

Cancer is a group of many related diseases. All forms of cancer involve out-of-control growth and spread of abnormal cells. Normal cells of most tissues only divide to replace dying cells or to repair injuries. However, cancer cells continue to grow and divide, and can spread to other parts of the body. These cells accumulate and form tumors which invade and destroy normal tissue. Cells can break away from tumors through the blood stream or lymph system and form tumors in other parts of the body, a process known as "metastasis."

Causal factors for cancer are both external (chemicals, radiation, viruses, etc.) and internal (hormones, immune conditions, inherited mutations, etc.). These factors may work together or in sequence to initiate and then promote carcinogenesis (production of cancer). It is possible for 10 or more years to pass between exposures or mutations and recognizable cancer. Over their entire lifetimes, American men have a 1:2 risk of developing cancer while U.S. women have a 1:3 risk.

Cancer is classified by the part of the body in which it began, and by its appearance under a microscope. When cancer metastasises it is still named after the part of the body where it began. For example, lung cancer which spreads to the brain is still referred to as lung cancer. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment.

Cancer is the second leading cause of death in the United States, accounting for approximately 25% of all deaths. It is estimated that there will be 1,228,600 new cases of cancer diagnosed in the US in 1998, and 564,800 people will die of cancer. Among the most prevalent are the following:

Cancer	New Cases	Deaths
Reproductive Organs	274,000	66,900
Digestive System	227,700	69,400
Respiratory System	187,900	97,200
Urinary System	86,300	24,700
Lymphoma	62,500	26,300
Skin, Excludes Basal/Squamous	53,100	9,200
Oral	30,300	8,000
Leukemia	28,700	21,600
Endocrine System	18,800	2,000
Brain	17,400	13,300
Multiple Myeloma	13,800	11,300
Soft Tissue, Includes Heart	7,000	4,300
Bones and Joints	2,400	1,400
Eye and Orbit	2,100	300
Others	36,300	35,700

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The 10 most frequent cancer sites for men and women are as follows:

	Sites		Deaths	
	Men	Women	Men	Women
1.	Prostate	Breast	Lung	Lung
2.	Lung	Lung	Prostate	Breast
3.	Colon/Rectum	Colon/Rectum	Colon/Rectum	Colon/Rectum
4.	Urinary Bladder	Endometrium	Pancreas	Pancreas
5.	Non-Hodgkin's Lymphoma	Ovary	Non-Hodgkin's Lymphoma	Ovary
6.	Skin Melanoma	Non-Hodgkin's Lymphoma	Leukemia	Non-Hodgkin's Lymphoma
7.	Oral Cavity	Skin Melanoma	Esophagus	Leukemia
8.	Kidney	Urinary Bladder	Urinary Bladder	Endometrium
9.	Leukemia	Pancreas	Stomach	Liver
10.	Stomach	Cervix	Liver	Stomach

The 10 leading causes of death by race in 1994 were:

	White	African-American	Hispanic
1.	Lung	Lung	Lung
2.	Colon/Rectum	Colon/Rectum	Colon/Rectum
3.	Female Breast	Prostate	Female Breast
4.	Prostate	Female Breast	Prostate
5.	Pancreas	Pancreas	Pancreas
6.	Non-Hodgkin's Lymphoma	Stomach	Stomach
7.	Leukemia	Esophagus	Non-Hodgkin's Lymphoma
8.	Ovary	Leukemia	Leukemia
9.	Brain	Liver	Liver
10.	Stomach	Non-Hodgkin's Lymphoma	Ovary

It is estimated that there were 17,600 new cases of cancer diagnosed in South Carolina for 1998 and 8,100 cancer deaths. The highest number of new cases were expected to be prostate (3,000 cases), lung (2,600), breast (2,500), and colon/rectal (2,000). The highest expected causes of mortality are: lung (2,100 deaths), colon/rectal (900), breast (600), and prostate (500). The projected mortality rate of 179 deaths/100,000 population was the 16th highest rate in the country.

Screening and self examinations can result in the detection of cancers at earlier stages. The earlier the cancer is identified and treated, the greater the likelihood of successful treatment. The survival

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rate is much higher for cancers treated "in situ" (non-invasive earliest stage) that those that have metastasized to other locations. The overall relative 5-year survival rate, adjusted for normal life expectancy, is approximately 58%. This means almost 6 of 10 people diagnosed with cancer are still alive 5 years later, whether in remission, disease-free or still undergoing treatment. The table on the following page shows the 5-Year Survival Rate of Cancer by Location.

Methods of reducing risk for cancer include avoiding smoking, exercising regularly, moderating use of alcohol and following a healthy diet. The American Cancer Society recommends a cancer-related checkup every 3 years for people age 20-40 and annual checkups for those over 40. Such examinations could include checking for cancers of the thyroid, oral cavity, skin, lymph nodes, testes and ovaries. They also recommend special tests for certain cancer sites:

Breast

---- Self-exam monthly, for women age 20 and over;
---- Clinical physical exam for women aged 20-40, every 3 years, over 40, every year; and
---- Mammography for women age 40 and over, every year.

Colon/Rectal

Beginning at age 50, either:

---- Yearly fecal occult blood test plus flexible sigmoidoscopy and digital rectal exam every 5 years;
---- Colonoscopy and digital rectal exam every 10 years; or
---- Double-contrast barium enema and digital rectal exam every 5-10 year.

Cervical

---- Pap test and pelvic examination for women who are or have been sexually active or have reached age 18, every year; after 3 or more consecutive satisfactory normal annual exams, the Pap test may be performed less frequently at the discretion of the physician.

Prostate

---- Both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually, beginning at age 50, to men who have at least a 10-year life expectancy; and to younger men who are at high risk.

Different types of cancers vary in their rates of growth, patterns of spread, and responses to different types of treatment. The choice of treatment may also vary depending on the stage of the tumor at the time it is discovered. Treatment options may include:

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Immunotherapy

The use of treatments that promote or support the body's immune system response to the cancer.

Hormone Therapy

Treatment with hormones, drugs that interfere with hormone production or hormone action, or surgical removal of hormone-producing glands to kill cancer cells or slow their growth.

Surgery

The oldest form of treatment for cancer and the one which still offers the greatest chance for cure for many types of cancer. About 60% of people with cancer will have some type of surgery during the course of their treatment. Types of surgery include:

1. Preventive or Prophylactic - surgery performed to remove a growth that is not presently malignant but is likely to become malignant if left untreated. Preventive surgery is sometimes used to remove an organ when people have an inherited condition that makes development of a cancer likely.

2. Diagnostic - surgery is used to obtain a tissue sample for laboratory testing. The technique to be used is determined by the type, size, location and growth characteristics of the suspected tumor.

3. Curative - the removal of a tumor when the tumor appears to be localized and there is hope of taking out all of the cancerous tissue.

4. Palliative - performed as a treatment of complications of advanced disease and is not intended to cure cancer. If the metastatic cancer does not respond to radiation or chemotherapy, palliative surgery can relieve these symptoms and improve the patient's quality of life.

5. Supportive - used to help with other types of treatment, such as implanting vascular access ports under the skin to assist with chemotherapy treatments.

A number of surgical techniques are used in the diagnosis and treatment of cancer. A procedure to remove all or part of a tumor for diagnostic purposes is called a "biopsy." Excisional biopsies involve removal of an entire tumor under anesthesia. However, a number of minimally invasive procedures can be performed with a thin needle or an endoscope (flexible lighted tube). Lasers are often used to vaporize cancers of the cervix, larynx and skin. Cryosurgery uses liquid nitrogen to freeze and kill abnormal cells. High frequency electrical currents are used to treat some mouth and skin cancers. Mohs' surgery is a technique to remove cancerous tissue by shaving off one layer at a time. This technique is used when the extent of the cancer is not known or when the maximum amount of healthy skin around the tumor needs to be preserved.

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Chemotherapy

Chemotherapy is the use of medicines/drugs to treat cancer. It can destroy cancer cells which have metastasized to parts of the body away from the primary tumor. About 50 anti-cancer drugs are currently in use. While a single drug can be used to treat cancer, generally anti-cancer drugs are more powerful when used in combination with other drugs, known as combination chemotherapy. This strategy allows drugs with different actions to work together to kill more cancer cells and reduces the chances of developing resistance to a single medication. Drugs may also be used to block the effects of hormones or boost the body's natural defenses against cancer.

Radiation Therapy

Radiation therapy is also known as radiotherapy, x-ray therapy, supervoltage therapy, and irradiation. It involves the use of a stream of high-energy particles or waves, such as x-rays, gamma rays, and alpha and beta particles, to destroy or damage cancer cells. The radiation causes breakdowns in one or both of the DNA strands, preventing cell division. Radiation treatments can be used alone or in combination with surgery, chemotherapy or biologic therapy. For example, radiation may be used before surgery to shrink a tumor to make it easier to remove, or after surgery to stop the growth of any cancer cells that remain.

Radiation therapy is one of the most common treatments for cancer and is used in more than half of all cancer cases. It is the primary treatment for many kinds of cancer in almost any part of the body, such as head and neck tumors, early stage Hodgkin's disease, non-Hodgkin's lymphomas, and certain cancers of the lung, breast, cervix, prostate, testes, bladder, thyroid, and brain. Properly used, radiation therapy is also a superb palliative agent with a high likelihood of success and easily controlled or avoided morbidity.

Internal radiation therapy uses a radioactive pellet that is sealed in an implant, which is placed directly into or near the tumor. Another form uses unsealed doses which are taken orally or by injection. External radiation requires a machine that directs high-energy rays at the cancer and some normal surrounding tissue. These are usually performed on an outpatient basis. The total prescribed tumor-lethal dosage is divided into smaller doses called fractions, which are administered 5 days a week for 5-8 weeks, with weekend rest breaks to allow normal cells to recover. External radiation treatment sessions generally last about 15 minutes. There are 2 pieces of radiation therapy equipment reviewed under the Certificate of Need Program in South Carolina. They are:

1. LINEAR ACCELERATORS

Minimal equipment requirements for a linear accelerator include:

a. At least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;

b. Access to an electron beam source or a low energy X-ray unit;

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c. appropriate brachytherapy equipment and sources for intracavitary and interstitial treatment;

d. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;

e. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

f. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);

g. field-shaping capability; and

h. access to CT scanning capability.

A realistic load for a megavoltage unit is 5,600 treatments per year. This measurement is based upon an average of 22 patients treated per day, 5 days per week, 51 weeks per year, allowing time for scheduled maintenance, portal filming, field checks, etc.

2. GAMMA KNIFE

Stereotactic radiosurgery is an evolving technique by which intracranial lesions are treated with high dose, high energy photons. The term was coined in 1951 to describe the use of a single dose of precisely directed ionizing radiation for the non-invasive destruction of intracranial tissues or lesions that may be inaccessible or unsuitable for open surgery. The first gamma unit was developed in 1968.

This non-invasive procedure uses narrow bands of radiant energy which are directed at the treatment target in the head. Computers and computerized tomography (CT), radiography, magnetic resonance imaging (MRI) and angiography are used to create a 3-D map of the brain and to precisely locate the tumor. The procedure may be performed using the "Gamma Knife," a spherically arranged array of multiple Cobalt 60 sources converging on a defined intracranial lesion, or using a modified linear accelerator with which multiple treatment arcs of x-ray beams target an intracranial abnormality. Both methods produce an intense, well-defined radiation dose within the lesion with a rapid dose "fall-off" outside the defined target volume, thus sparing normal adjacent tissue from high dose radiation effects. An advantage of the gamma knife is that multiple isocenters can be used to treat irregularly shaped tumors.

The radiation damages the genetic code of the tumor, preventing it from replicating and causing it to slowly shrink. Patients routinely use only a local anesthesia with a mild sedative while undergoing the procedure. Current uses of this technology include: malignant brain tumors; recurrent brain tumors; meningiomas; orbital tumors; arteriovenous malformations (AVM's); acoustic neuromas, and other cranial nerve neuromas; metastatic tumors to the brain; pituitary tumors and brain stem tumors.

A gamma knife consists of a large 20 ton shield surrounding a circular or hemispheric array of 201 cobalt-60 beam channels, resembling a giant hair dryer. Other components include the radiation unit;

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individual collimator helmets of four different beam diameters {4, 8, 14 and 18 mm used to create different diameter fields at the focal point}; the patient couch; the computer console; and the treatment planning computer system. There are currently approximately 40 gamma knifes in use in the United States.

Generally, a patient will arrive early in the morning of the date of the procedure and can often be discharged that evening. The entire procedure takes about three to four hours, depending on complexity. First, a rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging {CT, MRI and/or angiography}, which allows the treatment team to accurately determine the position of the target. The computer system is then used to develop a treatment plan which specifies how to position the patient for treatment, the focal point(s) for the treatment arcs, the paths the radiation beams will follow for each arc, the number of arcs, and the dose delivered from each arc. When the plan is ready and has been tested using a steel ball as a dummy target, the patient is positioned for treatment with the head frame affixed to the couch. Once the couch and machinery are positioned properly, the treatment is delivered. The patient is freed from the couch and the frame is removed; the patient then is held for observation for several hours or overnight.

While the gamma knife has a high success rate for certain types of tumors and avoids the complication risks of traditional neurosurgery, there are also some concerns regarding this technology. Because the procedure appears relatively benign compared to conventional brain surgery, there is the temptation to use the equipment inappropriately. In reality, not many tumors qualify for gamma knife radiosurgery; most tumors and AVM's are too large to be safely treated this way and require conventional surgery. The targets must be small and far enough away from vital structures. Attempting to treat too large an area can result in damage to healthy tissue, leading to neurological damage. Most gamma knife users limit use to lesions with a mean spherical diameter of less than 35 mm and located at least 5 mm from the optical structures. While 40,000 cases of brain tumors are diagnosed annually in the United States, one expert estimated that the greater New York City area would only generate 300 gamma knife cases a year.

The gamma knife is bloodless and the procedure is performed under local, rather than general, anesthesia, which reduces the risks of nosocomial infections and reactions to anesthesia. However, there are still some risks and side effects associated with this technology. Immediate side effects are seizures or nausea and vomiting, experienced by 3-16 percent of patients. About 18 percent of patients develop new neurological deficits within months after treatment, most of which are treated with steroids. Patients with brain metastases and certain gliomas face a risk of later re-operations for radionecrosis. Other factors affecting a patient's suitability for the procedure include the person's age, general health, and the previous record of surgeries and radiation treatments.

Another concern is the cost of the unit. A gamma knife costs approximately $3.5 million with installation costs of another $.5 million, plus a further $.5 million every 4-5 years to replenish the cobalt 60. As a result of the high costs and limited uses of the machine, average charges exceed $20,000, excluding physician's fees. However, this must be balanced against the overall charges for conventional neurosurgery. Experts estimate that a minimum caseload of 150 cases per year is needed for the unit to be financially viable. A less expensive alternative is to modify a standard linear

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accelerator {at a cost of about $300,000 above the initial cost of the machine} to allow it to perform radiosurgery; similar results are reported for these two technologies.

STATUS OF SOUTH CAROLINA PROVIDERS

1. LINEAR ACCELERATORS

There are currently 24 facilities either operating or approved for a total of 44linear accelerators in South Carolina. This analysis will focus on the 38 accelerators that were in operation during 1999. The capacity of a linear accelerator is stated as 7,000 treatments per year, and a realistic load is 5,600 treatments per year (80% of capacity). For 1999, the 38 existing accelerators averaged 5,845 treatments per unit (83.5% of overall capacity). The utilization for each provider per linear accelerator was:

Provider	# Accelerators	Treatments/ Accelerator
Greenville Radiation Care	1	13,652
Trident Regional	1	10,289
Rock Hill Radiation	1	9,986
Lexington Med. Ctr.	1	8,446
Palmetto Baptist	2	7,751
Roper Hospital	2	7,406
Beaufort-Hilton Head	1	6,925
Myrtle Beach Radiation	2	6,699
Anderson Area Med. Ctr.	2	6,560
Greenville Memorial Hosp.	3	6,071
Self Memorial	1	5,794
RMC-Orangeburg/Calhoun	1	5,759
Spartanburg Regional	3	5,206
MUSC	3	4,695
Aiken Regional	1	4,692
Palmetto Richland Memorial	4	4,572
Tuomey Regional	2	4,554
McLeod Regional	4	4,497
Carolinas Hosp. Sys.	1	2,958
Cancer Ctr. Carolinas Eastside	1	2,532
Eastside Cancer Ctr.	1	938 {Partial Year}

2. GAMMA KNIFES

Palmetto Richland Memorial received a CON for a gamma knife on March 18, 1997. A total of 97 patients received a gamma knife treatment in 1999.

The Certificate of Need standards for linear accelerators and gamma knifes follow.

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Certificate of Need Standards for Linear Accelerators

STANDARDS

(1) The planning capacity of a megavoltage therapy unit shall be 7,000 treatments per year.

(2) There are 13 service areas established for megavoltage therapy units. These service areas are defined on the chart following this section.

(3) New megavoltage therapy services shall only be approved if the following conditions are met:

A. all existing units in the service area have performed at a combined use rate of 80 percent of capacity {5,600 treatments per unit} for the year immediately preceding the filing of the applicant's CON application; and

B. an applicant must project that the proposed service will perform a minimum of 3,500 treatments annually within three years of initiation of services, without reducing the utilization of existing megavoltage therapy machines in the service area below the 80 percent threshold.

(4) Expansion of an existing megavoltage therapy service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for the past two years {5,600 treatments per unit} and can project a minimum of 3,500 treatments per year on the additional equipment within three years of its implementation.

(5) Documentation of need for the proposed service:

A. the applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which megavoltage therapy is appropriate within the proposed service area, to include the number of potential patients for these procedures; and

B. the applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

(6) The replacement of an existing Cobalt 60 unit with a linear accelerator does not constitute additional megavoltage therapy equipment; however, the purchase of the linear accelerator does require Certificate of Need review. Any replaced equipment should be totally decommissioned within 30 days of the start of the replacement equipment.

(7) The applicant must affirm the following:

A. that all treatments provided will be under the control of a board certified or board eligible radiation oncologist;

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B. that the applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

C. that the applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

D. that the applicant will have access to a custom block design and cutting system; and

E. that the institution shall operate its own tumor registry or actively participate in a central tumor registry.

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 these services:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

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

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MEGAVOLTAGE VISITS

REGION	#UNITS	FY1996	FY1997	FY1998	FY1999	FY2000
I						
ANDERSON AREA MED CTR #5						
COBALT 60	1	3559	3493	764	0	
LINEAR ACCELERATOR	2	8971	9210	11735	13120	12770
EASTSIDE CANCER TREATMENT CTR #3						
LINEAR ACCELERATOR	1				938	1852
CANCER CENTERS OF THE CAROLINAS #4						
EASTSIDE						
LINEAR ACCELERATOR	1				2532	9329
GREENVILLE MEM MED CTR:						
LINEAR ACCELERATORS	3	21638	22646	20287	18212	14314
GREENVILLE RADIATION CARE						
LINEAR ACCELERATOR	1	7276	5300	9243	13652	9688
CANCER CTRS OF THE CAROLINAS #10	1					
OCONEE COUNTY						
SPARTANBURG REG MED CTR:						
LINEAR ACCELERATORS	3	14501	15477	13992	15618	15604
II						
PALMETTO BAPTIST MED CTR COLA:						
LINEAR ACCELERATORS	2	11003	12107	12280	15501	12755
LEXINGTON MED CTR: #7						
LINEAR ACCELERATOR	2	5344	5608	7399	8446	8746
PALMETTO RICHLAND MEMORIAL HOSP:						
LINEAR ACCELERATORS	4	15778	18026	18662	18289	26856
GAMMA KNIFE	1				97	96
SELF MEMORIAL:						
LINEAR ACCELERATOR	1	5285	5079	6141	5794	5520
ROCK HILL RADIATION THERAPY CT:						
LINEAR ACCELERATOR #1	2	7877	8807	8741	9986	9082
III						
CAROLINAS HOSP SYS #2	1				2958	7111
MCLEOD REGIONAL:						
LINEAR ACCELERATORS	4	16686	20753	19968	17987	18242
MYRTLE BEACH RADIATION:						
THERAPY CENTER						
LINEAR ACCELERATORS	2	11822	13082	12100	13397	14270

MEGAVOLTAGE VISITS

REGION	# UNITS	FY1996	FY1997	FY1998	FY1999	FY2000
TUOMEY LINEAR ACCELERATOR	2	8292	8727	8467	9107	10598
GEORGETOWN MEM HOSP #8	1					
IV						
MEDICAL UNIVERSITY: #10 LINEAR ACCELERATORS	3	14579	12932	13773	14085	15632
ROPER: LINEAR ACCELERATOR	2	11917	11216	12597	14812	14126
TRIDENT MED CTR: #6 LINEAR ACCELERATOR	2	7655	9246	9306	9969	10971
REG MED CTR ORANGEBURG/CALHOUN LINEAR ACCELERATOR	1	5444	5078	6474	5759	6022
BEAUFORT/HILTON HEAD RADIATION ONCOLOGY CTR LINEAR ACCELERATOR	1	4683	5083	6218	6925	7502
BEAUFORT MEMORIAL HOSPITAL #11	1					
AIKEN REG MED CTR	1	3381	3984	4635	4692	4729

#1 CON ISSUED FOR 2ND LA 7/27/98
#2 CON ISSUED FOR LA, 4/7/97.
#3 CON ISSUED 3/6/98.
#4 CON ISSUED 3/6/98.
#5 CON FOR 2nd LA 6/2/97.
#6 CON FOR 2nd LA 6/1/99.
#7 CON TO REPLACE EXISTING LA 6/14/99.
AND 2ND LA, 11/12/99.
#8 CON ISSUED 3/15/01
#9 CON FOR LA, 2/28/00
#10 CON TO REPLACE EXISTING LA 8/14/00
#11 APP FOR LA, 10/22/01

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RECORD 003606

LINEAR ACCELERATORS

SERVICE AREAS	1999 POPULATION	# OF LIN. ACC.	POP/ LIN. ACC.	TOTAL AREA TREATMENTS	TREATMENTS/ LIN. ACC.	PLANNING AREA CAPACITY
ANDERSON,OCONEE	225,800	3	75,267	13,120	4,373	21,000
GREENVILLE,PICKENS	465,600	6	77,600	35,334	5,889	42,000
CHEROKEE,SPARTANBURG UNION	329,900	3	109,967	15,618	5,206	21,000
CHESTER,LANCASTER,YORK	248,600	2	124,300	9,986	4,993	14,000
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	198,000	1	198,000	5,794	5,794	7,000
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	590,500	8	73,813	42,236	5,280	56,000
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	328,800	5	65,760	20,945	4,189	35,000
CLARENDON,LEE,SUMTER	161,400	2	80,700	9,107	4,554	14,000
GEORGETOWN,HORRY WILLIAMSBURG	266,400	3	88,800	13,397	4,466	21,000
BAMBERG,CALHOUN ORANGEBURG	120,700	1	120,700	5,759	5,759	7,000
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	190,100	2	95,050	6,925	3,463	14,000
BERKELEY,CHARLESTON DORCHESTER	541,000	7	77,286	39,186	5,598	49,000
AIKEN,BARNWELL	165,600	1	165,600	4,692	4,692	7,000
STATE TOTAL	3,832,400	44	87,100	222,099	5,048	308,000

PMC.2013.SHP.0094

PET-EX005.0094

RECORD 003607

Certificate of Need Standards for Gamma Knifes

STANDARDS

(1) The capacity of a gamma knife unit is 500 procedures annually. This is based on an average of two procedures per day times 250 days a year.

(2) Because of the limited number of eligible cases and necessary referrals in order to generate sufficient utilization of this technology, the entire State of South Carolina is designated as the appropriate service area.

(3) Any proposal to offer gamma knife services shall be required to demonstrate in detail why the gamma knife should be obtained, rather than make the less costly modifications necessary to enable the same procedures to be performed using a linear accelerator.

(4) New gamma knife services shall only be approved if the following conditions are met:

A. all existing units have performed at a combined use rate of 80 percent of capacity for the most recent year; and

B. an applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of services, without reducing the utilization of existing gamma knifes below the 80 percent threshold.

(5) Expansion of a existing gamma knife service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

(6) Documentation of need for the proposed service:

A. the applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which gamma knife treatment is appropriate, to include the number of potential patients for these procedures;

B. the applicant shall project the utilization of the service, to include:

1. the number of patients of the applicant who were referred to other gamma knife providers in the preceding three years and the number of those patients who could have been served by the proposed service;

2. existing and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances; and

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PET-EX005.0095

RECORD 003608

3. documentation of the type and estimated number of procedures performed in the facility that the gamma knife will replace or complement.

(7) The applicant must document that protocols will be established to assure that all clinical gamma knife procedures performed are medically necessary and that alternative treatment modalities have been considered.

(8) The applicant must affirm the following:

A. that the operation of the gamma knife will be overseen by a board certified neurosurgeon trained in stereotactic and radiosurgery;

B. that all treatments provided will be under the control of a radiation oncologist with training in radiation surgery;

C. that the applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

D. that dosimetry and calibration equipment and a computer with the appropriate software for performing gamma knife surgical procedures will be available;

E. that the applicant has access to a full range of diagnostic technology, including CT, MRI and angiograpy; and

F. that the institution shall operate its own tumor registry or actively participate in a central tumor registry.

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 these services:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

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

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(H) Diagnostic Imaging

1. Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging (MRI) uses radio waves, high magnetic fields and a powerful computer to create diagnostic images useful for detecting disease states. Organ systems suitable for MRI examination include: brain, respiratory, circulatory, cardiac, breast, abdomen, kidney and pelvis, musculoskeletal, and blood vessels. MRI produces spatial resolution and tissue contrast without the use of ionizing radiation, such as X-rays, or iodinated compound injections.

Within a strong external magnetic field, protons (nuclei of hydrogen atoms) align in either a low or high energy state. Radio waves released from the body become the magnetic resonance image. Spatial information is obtained by superimposing small gradients within the external magnetic field. The result is a two-dimensional picture with great tissue contrast, clarity and potential to characterize tissue as diseased or not diseased.

Due to the high sensitivity of the images produced, and the relative safety of the procedure, MRI has replaced CT and angiography as a diagnostic tool for many diagnoses and greatly enhances diagnosis in other cases. MRI may eliminate the need for other examinations, such as biopsies and exploratory surgery, in addition to reducing risk and discomfort to the patient.

Capital costs for a fixed MRI unit; depending upon the type of magnet, range from approximately $500,000 to $1,500,000. Special shielding may be required to prevent the magnet from interfering with other electrical equipment and/or to prevent radiofrequency interference from outside sources. MRI is contraindicated for patients with metal surgical implants and pacemakers, or who are on life support equipment. In addition, some patients physically do not fit into an MRI unit and others experience a claustrophobic reaction to the confined space of an MRI. A new generation of MRI's with a "open" design has been developed to alleviate these concerns.

A table follows listing the facilities that have either received Certificate of Need approval or have been exempted from review for MRI units. Utilization data are from the Joint Annual Reports. This information is current as of October 1, 2001.

Certificate of Need Standards for Magnetic Resonance Imaging (MRI)

STANDARDS

(1) The applicant must document that a minimum of 1,500 scans can be performed annually by the end of the third year of operation. This documentation must include proposed utilization by both patient diagnostic category and number of patients to be examined.

(2) The utilization of existing resources must be considered prior to the approval of additional equipment.

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(3) In order to promote cost effectiveness, and provide the latest diagnostic technological capabilities, facilities should consider the use of shared mobile MRI units. Because a shared mobile unit would only operate on a part-time basis, it would not be expected to operate at the same volume as a fixed unit.

(4) The applicant agrees in writing to provide to the Department utilization data on the operation of the MRI service.

(5) Each hospital should have at least one MRI unit in-house for diagnosis of emergency patients, inpatients and outpatients, provided the hospital can demonstrate sufficient volume and staffing capabilities.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Operating Budget;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

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

PMC.2013.SHP.0098

PET-EX005.0098

RECORD 003611

MRI SCANS

COUNTY	FACILITY	TYPE	FY98 CON SCANS	FY99 CON SCANS	FY00 CON SCANS
ABBEVILLE	ABBEVILLE CO MEM HOSP	MOBILE	200	372	439
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	638	336	237
AIKEN	AIKEN REG MED CTR	MOBILE	2164	3465	3038
AIKEN	CAROLINA ORTHOPAEDIC ASSOC	FIXED		0	1272
AIKEN	IMAGING CTR OF AIKEN	FIXED		176	781
AIKEN	SOUTHERN NEUROLOGICAL INST	FIXED	1723	1477	1453
ANDERSON	ANDERSON AREA MED CTR	3 FIXED	5020	5947	7346
ANDERSON	ANDERSON RADIOLOGY	FIXED	1634	2479	3500
ANDERSON	(HEALTH SOUTH DIAGNOSTIC CTR OF ANDERSON)	(FIXED)	CLOSED		
BEAUFORT	BEAUFORT MEM HOSP	FIXED	2738	3325	4043
BEAUFORT	HEALTH SOUTH DIAGNOSTIC CTR OF HILTON HEAD	FIXED	2210	2585	1850
BEAUFORT	LOWCOUNTY MEDICAL GROUP MRI	FIXED		0	148
BEAUFORT	LOWCOUNTY MEDICAL GROUP PORT ROYAL	FIXED	758	810	849
BEAUFORT	MRI AT BELFAIR	FIXED			
BEAUFORT	NEUROLOGICAL INST HILTON HEAD	FIXED			319
BEAUFORT	BEAUFORT OPEN MRI	FIXED			
BEAUFORT	SOUTHERN MRI, LLC	2FIXED		1243	2845
CLARENDON	CLARENDON MEM HOSP	MOBILE	642	534	680
CHARLESTON	ROPER HOSP	FIXED	3636	4584	4692
CHARLESTON	ROPER DIAGNOSTIC CTR-FARMFIELD	FIXED	925	1228	1283
CHARLESTON	MEDICAL UNIVERSITY HOSP	3 FIXED	6870	8170	8321
CHARLESTON	MEDICAL UNIVERSITY HOSP	(PED FIXED)			
CHARLESTON	UMA AMBULATORY CARE FAC	FIXED			
CHARLESTON	TRIDENT MEDICAL CTR	FIXED	5439	3283	6552
CHARLESTON	TRIDENT MEDICAL ARTS MRI	FIXED		1746	ABOVE
CHARLESTON	EAST COOPER REG MED CTR	MOBILE	220	144	0
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	MOBILE	1199	1497	1638
CHARLESTON	DISC IMAGING	2 FIXED	5938	5275	6834
CHARLESTON	(HEALTH SOUTH DIAGNOSTIC CTR OF CHARLESTON)	(FIXED)	483	CLOSED	
CHARLESTON	CHARLESTON PHYSICIANS IMAGING CTR	FIXED	267	923	1428
CHARLESTON	SC DIAGNOSTIC IMAGING	MOBILE	3196	3419	3860
CHARLESTON	FARMFIELD DIAGNOSTIC IMAGING	FIXED			
CHEROKEE	UPSTATE CAROLINA MED CTR	MOBILE	526	678	1033
CHESTERFIELD	CHESTERFIELD GEN HOSP	MOBILE	503	452	417
COLLETON	COLLETON REG HOSP	FIXED	1118	1213	1603
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	1527	1920	1844
DARLINGTON	WILSON MED CTR	MOBILE	196	195	176
DILLON	ST. EUGENE MED CTR	MOBILE	485	502	554
DORCHESTER	SUMMERVILLE MEDICAL CENTER	FIXED		1428	2232
FLORENCE	CAROLINAS HSP SYS	FIXED	3285	3044	2401
FLORENCE	MCLEOD REG MED CTR	2 FIXED	5068	5184	5192
FLORENCE	(FLORENCE MED IMAGING)	(FIXED)	1190	1205	751
FLORENCE	CAROLINAS HSP SYS LAKE CITY	MOBILE	255	347	308
FLORENCE	DEMICHELE & EVANS NEUROLOGICAL	MOBILE			1149
FLORENCE	INMED DIAGNOSTIC SERVICES	FIXED	122	778	1287
FLORENCE	OPEN MRI & IMAGING OF FLORENCE	FIXED		1250	2919
GEORGETOWN	GEORGETOWN MEM HOSP	FIXED	1720	2202	3194
GREENVILLE	ST. FRANCIS HOSP	FIXED	1952	1844	2627
GREENVILLE	ST. FRANCIS WOMAN'S & FAMILY HOSP	MOBILE	314	624	441
GREENVILLE	ALLEN BENNETT HOSP	MOBILE			
GREENVILLE	HILLCREST HOSP	MOBILE	13	21	362
GREENVILLE	GREENVILLE MEM HOSP	3 FIXED & MOBILE	6946	7635	7372
GREENVILLE	HEALTH SOUTH DIAGNOSTIC CTR OF GREENVILLE	FIXED	5116	5319	6288
GREENVILLE	HEALTH SOUTH DIAGNOSTIC CTR OF SIMPSONVILLE	FIXED			
GREENVILLE	G'VLLE PHYSICIANS IMAGING CTR	2 FIXED	1897	2700	3477
GREENVILLE	GHS/EASTSIDE ACS	MOBILE	1801	1938	1709

PMC.2013.SHP.0099

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RECORD 003612

MRI SCANS

COUNTY	FACILITY	TYPE	FY98 CON SCANS	FY99 CON SCANS	FY00 CON SCANS
GREENVILLE	OAKWOOD ORTHOPAEDIC CLINIC	MOBILE			296
GREENVILLE	PIEDMONT ORTHOPAEDICS	FIXED			
GREENVILLE	GREENVILLE RADIOLOGY, PA	FIXED			
GREENVILLE	GREENVILLE RADIOLOGY, PA	MOBILE			
GREENVILLE	NUEROLOGY ASSOC. OF GREENVILLE	MOBILE			
GREENVILLE	SE NUEROSURGICAL & SPINE INSTITUTE	MOBILE		162	930
GREENVILLE	OPEN MRI OF SIMPSONVILLE	FIXED			
GREENWOOD	LAKELANDS ORTHOPAEDICS CLINIC	MOBILE		310	633
GREENWOOD	SELF MEM HOSP	FIXED	3910	4576	3932
HAMPTON	HAMPTON REG MED CTR	MOBILE	218	123	0
HORRY	CONWAY HOSP	FIXED	1540	2006	2661
HORRY	GRAND STRAND REG MED CTR	FIXED	3655	4033	2530
(HORRY)	(GRAND STRAND REG MED CTR)	(MOBILE)			
HORRY	MYRTLE BEACH MRI	FIXED	371	322	285
HORRY	LORIS COMM HOSP	MOBILE	985	1230	1465
HORRY	OPEN MRI OF MYTRLE BEACH	FIXED		1087	2770
HORRY	GRAND STRAND IMAGING	FIXED			261
HORRY	(PREFERRED IMAGING)	FIXED	1349	1003	CLOSED
HORRY	SOUTH STRAND AMB CARE CTR	FIXED		144	680
HORRY	SEACOAST MED CTR	FIXED			
HORRY	STRAND REG SPECIALTY ASSOC, LLC	MOBILE			1559
KERSHAW	KERSHAW CO MEM HOSP	FIXED	591	649	669
LANCASTER	SPRINGS MEMORIAL HOSP	FIXED	1022	1146	1161
LAURENS	LAURENS CO HOSP	MOBILE	737	937	843
LAURENS	LAURENS CO ORTHOPAEDICS ASSOC	FIXED			672
LEXINGTON	LEXINGTON MED CTR	2 FIXED	2716	3495	4266
LEXINGTON	LEXINGTON OPEN MRI	FIXED	2292	3838	4094
MARION	MARION CO MEDICAL CTR	MOBILE	623	996	1201
MARLBORO	MARLBORO PARK	MOBILE	312	302	253
NEWBERRY	NEWBERRY CO MEM HOSP	MOBILE			
OCONEE	OCONEE MEM HOSP	FIXED	2455	2557	2197
OCONEE	MOUNTAINVIEW RADIOLOGY,PA	FIXED		544	2166
ORANGEBURG	(OPEN MRI & IMAGING ORANGEBURG)	(FIXED)			
ORANGEBURG	RMC ORANGEBURG/CALHOUN	FIXED	3346	3807	3499
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	FIXED.		380	1385
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	MOBILE	697	1328	1805
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	FIXED			
PICKENS	CANNON MEM HOSP	MOBILE	29	0	0
RICHLAND	PALMETTO RICHLAND MEM HOSP	2 FIXED	4363	4715	5002
RICHLAND	PALMETTO BAPTIST MED CTR-COLA	FIXED	4323	3853	3506
RICHLAND	HEALTH SOUTH DIAGNOSTIC CTR	FIXED	1081	1263	1041
RICHLAND	PALMETTO IMAGING	2 FIXED	4367	4023	5506
RICHLAND	PROVIDENCE HOSPITAL	FIXED		842	1596
RICHLAND	MIDLANDS ORTHOPAEDICS	FIXED	1300	1317	1935
RICHLAND	INMED DIAGNOSTIC SERVICES	2 FIXED	154	671	1621
RICHLAND	IMAGECARE	FIXED			
RICHLAND	CAROLINA MED IMAGING	FIXED			
SPARTANBURG	SPARTANBURG REG MED CTR	3 FIXED	7639	8869	8031
SPARTANBURG	MARY BLACK MEM HOSP	2 FIXED	1903	2055	2568
SPARTANBURG	PIEDMONT IMAGING, INC #1	FIXED	1133	2263	3400
SPARTANBURG	ORTHOPEDIC SPECIALTIES OF SPTB	FIXED			
SUMTER	TUOMEY OUTPATIENT IMAGING CTR	FIXED			
SUMTER	TUOMEY	FIXED	1946	3053	3342
UNION	WALLACE THOMSON HOSP	FIXED	574	735	939
WILLIAMSBURG	WILLIAMSBURG REGIONAL HOSP	MOBILE	114	104	58
YORK	PIEDMONT MED CTR	FIXED & MOBILE	4950	5890	6744
YORK	PIEMONT HEALTHCARE SYSTEM	FIXED			
YORK	MRI CHARLOTTE	FIXED	1489	1582	1593
YORK	OLD POINTE DIAGNOSTIC CTR	FIXED			236

1 REPLACE 1.0MRI W/1.0MRI & TEMP USE MOBILE
E-99-51, 8/26/99.

PMC.2013.SHP.0100

PET-EX005.0100

RECORD 003613

2. Positron Emission Tomography (PET)

Positron Emission Tomography (PET) captures images of cellular activity, or metabolism, by tracking the movement of radioactive tracers throughout the body. Unlike CT and MRI, which depict form (tissue and bones), PET allows the study of metabolic processes such as oxygen consumption, and utilization of glucose and fatty acids. It is quantitative and very sensitive, so only tracer amounts of isotopes are needed. PET was initially used primarily for research purposes, but has recently been approved for additional clinical applications.

PET was developed in the 1970's and clinical use initially focused on studies of cerebral function and detection and assessment of coronary artery disease. Recent PET development has centered on oncology, which is now estimated to constitute 48% of clinical applications. Because tumors metabolize glucose faster than healthy tissue, physicians are now able to track their growth by using PET to measure their metabolism of a glucose-based tracer. No other technology is capable of performing this test. This glucose test was primarily used for brain tumors, but the development of "whole body" scanners now allows testing in other areas of the body. The Health Care Financing Administration (HCFA) has recently expanded the coverage of PET for Medicare patients with lung, colorectal, head and neck and esophageal cancers, and melanomas, as well as for additional neurological and heart disease uses.

PET compliments the information obtained from CT and MRI scans. A research project at the University of Pittsburg to develop a combined CT-PET scanner has produced good early results in evaluating pancreatic cancer, but is still several years away from Food and Drug Administration (FDA) approval. PET scanners cost approximately $800,000. Capital costs are approximately $500,000 and annual operating costs are approximately $1,500,000. Costs for establishment of a program have decreased because the host facility no longer has to build a cyclotron to generate the radioisotopes needed for PET operation. The Institute for Clinical PET projects operating efficiency for a PET as being 6 scans per day. The following PET scanners have been approved:

Facility	County	Date
Carolinas Clinical PET Institute	Greenville	1/26/01
Palmetto Baptist Medical Center	Richland	3/16/00
Grand Strand Medical Center (mobile – 2 days/week)	Horry	5/8/01
Charleston Radiologists (mobile – 1 day/week)	Charleston	3/21/01
Roper Hospital	Charleston	7/12/00

Certificate of Need Standards for Positron Emission Tomography (PET)

STANDARDS

(1) Each of the four planning regions has been approved for a PET scanner service and not all of them are operational to date. An additional full-time PET scanner may be approved in each

PMC.2013.SHP.0101

PET-EX005.0101

RECORD 003614

region based on patient origin and market share information and physician/patient referrals. Full-time is defined as a PET scanner that provides services 5 days per week.

(2) The applicant must document that it provides a full range of diagnostic modalities including, but not limited to radiography, computed tomography and/or magnetic resonance imaging, ultrasound and nuclear medicine, and provides a range of comprehensive medical services which would justify the need for such specialized technology.

(3) Applicants proposing new PET services must project at a minimum 750 PET clinical procedures per year (3 clinical procedures/day x 250 working days), The projection of need must include proposed utilization by both patient category and number of patients to be examined.

(4) After the approval of 2 full-time PET scanners in a planning region, additional full-time PET scanners will be considered after evaluating the utilization of the approved PET scanners and considering demographic patterns, patient origin and market share information, and physician/patient referrals. The existing PET scanners should be performing at 1,250 clinical procedures (5 clinical procedures x 250 days) per PET unit per year. Prior to the approval of additional PET services, the impact on existing PET services will be evaluated and considered in the review of a CON.

(5) The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

(6) The applicant agrees in writing to provide to the Department utilization data on the operation of the PET service.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability; {continued}
e. Operating Budget;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

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

CT SCANS

REGION/COUNTY	FACILITY	TYPE	NUMBER	FY99 NUMBER OF PROCEDURES
I				
ANDERSON	ANDERSON MED CTR	FIXED	3	19870
ANDERSON	ANMED	FIXED	1	
CHEROKEE	UPSTATE CAROLINA	FIXED	1	
GREENVILLE	GREENVILLE MEM HOSP	FIXED	3	18106
GREENVILLE	ALLEN BENNETT MEM	FIXED	1	2400
GREENVILLE	HILLCREST HOSP	FIXED	1	2245
GREENVILLE	ST FRANCIS HOSP	FIXED &	1	6101
		MOBILE	1	
GREENVILLE	ST FRANCIS WOMAN' S& FAMILY HOSP	FIXED	1	2788
GREENVILLE	OUTPATIENT DIAG CTR	FIXED	1	
GREENVILLE	GREENVILLE PHYSICIAN IMAGING	FIXED	1	
SPARTANBURG	BJ WORKMAN HOSP	FIXED	1	571
SPARTANBURG	SPARTANBURG REG MED CTR	FIXED	2	15330
SPARTANBURG	MARY BLACK MEM	FIXED	1	4681
OCONEE	OCONEE MEM	FIXED	1	6822
OCONEE	MOUNTAINVIEW RADIOLOGY, PA	FIXED	1	
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	FIXED	1	4227
PICKENS	CANNON MEM	FIXED	1	891
UNION	WALLACE THOMSON	MOBILE	1	4056
II				
ABBEVILLE	ABBEVILLE CO MEM	MOBILE	1	1058
CHESTER	CHESTER CO	MOBILE	1	3234
EDGEFIELD	EDGEFIELD CO HOSP	FIXED	1	354
FAIRFIELD	FAIRFIELD MEM	MOBILE	1	799
GREENWOOD	SELF MEM	FIXED	2	10802
KERSHAW	KERSHAW CO MEM	FIXED	1	
LANCASTER	SPRINGS MEMORIAL HOSP	MOBILE	1	4044
LAURENS	LAURENS COUNTY HOSP	FIXED	1	2558
LEXINGTON	LEXINGTON MED CTR	FIXED	3	20325
LEXINGTON	LEXINGTON OPEN MRI	FIXED	1	
LEXINGTON	LEXINGTON MED CTR-IRMO	FIXED		
NEWBERRY	NEWBERRY CO MEM	FIXED	1	1664
RICHLAND	IMAGETRUST COLA, INC	FIXED		
RICHLAND	PALMETTO BAPTIST MED CTR-COLA	FIXED	3	20794
RICHLAND	PROVIDENCE HOSPITAL	FIXED	1	9254
RICHLAND	PROVIDENCE HOSPITAL NE	FIXED	1	1105
RICHLAND	PALMETTO RICHLAND MEM HOSP	FIXED	5	21376
YORK	PIEDMONT MED CTR	FIXED	1	10977
III				
CHESTERFIELD	CHESTERFIELD GENERAL	FIXED	1	2282
CLARENDON	CLARENDON MEMHOSP	FIXED	1	1485
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	1	8564
DARLINGTON	WILSON CLINIC AND HOSP	FIXED	1	1288
DILLON	ST EUGENE MEDICAL CTR	FIXED	1	2352
FLORENCE	CAROLINAS HOSP SYS	FIXED	1	10052
FLORENCE	CAROLINAS HOSP SYS LAKE CITY	MOBILE	1	1172
FLORENCE	MCLEOD REG MED CTR	FIXED	2	19378
GEORGETOWN	GEORGETOWN CO MEM	FIXED	1	8095
HORRY	CONWAY	FIXED	1	7136
HORRY	GRAND STRAND REG MED CTR	FIXED	1	11660
HORRY	LORIS COMM	FIXED	1	3693
MARION	MARION CO MED CTR	FIXED	1	3556

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RECORD 003616

CT SCANS

REGION/COUNTY	FACILITY	TYPE	NUMBER	FY99 NUMBER OF PROCEDURES
MARLBORO	MARLBORO PARK	FIXED	1	1235
SUMTER	TUOMEY OUTPATIENT IMAGING CTR	FIXED	1	
SUMTER	TUOMEY REG MED CTR	FIXED	1	7984
WILLIAMSBURG	CAROLINAS HOSP KINGSTREE	MOBILE	1	946
IV				
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	1	
AIKEN	AIKEN REG MED CTR	FIXED & MOBILE	1 1	7901
AIKEN	IMAGING CTR OF AIKEN	FIXED	1	
ALLENDALE	ALLENDALE CO HOSP	MOBILE	1	482
BAMBERG	BAMBERG CO MEM HOSP	MOBILE	1	1059
BARNWELL	BARNWELL CO HOSP	FIXED	1	1045
BEAUFORT	BEAUFORT MEM	FIXED	1	5028
BEAUFORT	HILTON HEAD	FIXED	1	4518
BEAUFORT	BEAUFORT MEDICAL PLAZA	FIXED	1	
CHARLESTON	ROPER NORTH HOSPITAL	FIXED	1	2108
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	FIXED	1	6304
CHARLESTON	EAST COOPER REG MED CTR	FIXED	1	2649
CHARLESTON	MEDICAL UNIVERSITY	FIXED	3	18111
CHARLESTON	UMA AMBULATORY CARE FAC	FIXED	1	
CHARLESTON	TRIDENT MED CTR	FIXED	2	10956
CHARLESTON	ROPER HOSPITAL	FIXED	2	15490
CHARLESTON	TRICOUNTY RADIOLOGY ASSOC.	FIXED	1	
COLLETON	COLLETON MED CTR	MOBILE	1	2985
DORCHESTER	SUMMERVILLE MED CTR	FIXED	1	4088
HAMPTON	HAMPTON REG MED CTR	FIXED	1	678
JASPER	LOW COUNTRY GEN HOSP	MOBILE	1	
ORANGEBURG	ADVANGE DIAGNOSTIC IMAGING	FIXED	1	
ORANGEBURG	RMC ORANGEBURG-CALHOUN	FIXED	1	8521

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RECORD 003617

(I) End Stage Renal Disease

Dialysis services do not require Certificate of Need Review.

END STAGE RENAL DISEASE FACILITIES

FACILITY	COUNTY	# OF STATIONS	FOOTNOTES
I			
ANDERSON DIALYSIS CLINIC, INC.	ANDERSON	47	
DCI GAFFNEY	CHEROKEE	16	#15
FMC SIMPSONVILLE DIALYSIS	GREENVILLE	10	#38
GREENVILLE DIALYSIS CENTER, INC.	GREENVILLE	39	
GREER KIDNEY CENTER, INC.	GREENVILLE	27	
TWIN OAKS DIALYSIS CENTER	GREENVILLE	31	
UPSTATE DIALYSIS CENTER	GREENVILLE	52	
OCONEE DIALYSIS CLINIC, INC.	OCONEE	14	
EASLEY DIALYSIS CENTER	PICKENS	28	
DCI EAST SPARTANBURG	SPARTANBURG	32	
DCI LANDRUM	SPARTANBURG	13	
DCI SPARTANBURG	SPARTANBURG	43	#18
DCI WEST SPARTANBURG	SPARTANBURG	25	
DCI UNION	UNION	15	#16
II			
(GAMBRO HEALTHCARE - ABBEVILLE)	ABBEVILLE	0	#10
TRI-COUNTY DIALYSIS CENTER	CHESTER	12	
GAMBRO HEALTHCARE - EDGEFIELD	EDGEFIELD	14	#9
FAIRFIELD COUNTY DIALYSIS CENTER	FAIRFIELD	16	#36
GAMBRO HEALTHCARE - WINNSBORO	FAIRFIELD	16	#5
GAMBRO HEALTHCARE - GREENWOOD	GREENWOOD	25	#7
CAMDEN DIALYSIS CENTER	KERSHAW	21	
GAMBRO HEALTHCARE - LANCASTER SC	LANCASTER	17	#34
LAURENS COUNTY DIALYSIS CENTER, INC.	LAURENS	27	
PALMETTO KIDNEY CENTER	LAURENS	21	#40
LEXINGTON DIALYSIS CENTER	LEXINGTON	21	#26
WEST COLUMBIA DIALYSIS CENTER	LEXINGTON	20	#25
NEWBERRY DIALYSIS CENTER	NEWBERRY	16	#23
BROAD RIVER DIALYSIS CENTER	RICHLAND	12	#2
COLUMBIA DIALYSIS CENTER	RICHLAND	30	#30
GAMBRO HEALTHCARE-COLUMBIA CENTRAL	RICHLAND	18	
IRMO DIALYSIS CENTER	RICHLAND	21	#39
LOWER RICHLAND DIALYSIS CENTER	RICHLAND	20	#3
MEADOWLAKE DIALYSIS CENTER	RICHLAND	21	#17
MIDTOWN DIALYSIS CENTER	RICHLAND	25	#12
SOUTH COLUMBIA DIALYSIS CENTER	RICHLAND	15	
ROCK HILL DIALYSIS CENTER, INC.	YORK	37	

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END STAGE RENAL DISEASE FACILITIES

FACILITY	COUNTY	# OF STATIONS	FOOTNOTES
III			
CHESTERFIELD COUNTY DIALYSIS CENTER	CHESTERFIELD	11	
MANNING DIALYSIS CENTER	CLARENDON	20	
FMC LAKE MARION DIALYSIS CENTER	CLARENDON	13	#19
DARLINGTON DIALYSIS CENTER	DARLINGTON	30	
DILLON DIALYSIS CENTER	DILLON	16	
FLORENCE DIALYSIS CENTER	FLORENCE	55	
FMC FLORENCE HOME DIALYSIS CENTER	FLORENCE	2	#21
FMC PEE DEE DIALYSIS SERVICES	FLORENCE	11	#24
FMC DIALYSIS SERVICES-GEORGETOWN	GEORGETOWN	28	
FMC DIALYSIS SERVICES-MURRELLS INLET	GEORGETOWN	12	#13
CONWAY DIALYSIS CENTER	HORRY	15	
FMC DIALYSIS SERVICES-MYRTLE BEACH	HORRY	12	
FMC DIALYSIS SERVICES-N. MYRTLE BEACH	HORRY	15	#1
LORIS DIALYSIS CENTER	HORRY	11	#27
LEE COUNTY DIALYSIS CENTER	LEE	11	
MARION DIALYSIS CENTER	MARION	20	#28
BENNETTSVILLE DIALYSIS CENTER	MARLBORO	16	#33
SUMTER DIALYSIS CENTER	SUMTER	54	
FMC DIALYSIS SERVICES-ANDREWS	WILLIAMSBURG	12	#37
KINGSTREE DIALYSIS CENTER, INC.	WILLIAMSBURG	33	
IV			
FMC-NORTH AUGUSTA	AIKEN	15	#41
GAMBRO HEALTHCARE - AIKEN	AIKEN	14	
GAMBRO HEALTHCARE - NORTH AUGUSTA	AIKEN	16	#32
GAMBRO HEALTHCARE - ALLENDALE COUNTY	ALLENDALE	10	
GAMBRO HEALTHCARE - BAMBERG	BAMBERG	10	
GAMBRO HEALTHCARE - BARNWELL	BARNWELL	16	#12
DIALYSIS SERVICE GROUP - HILTON HEAD	BEAUFORT	10	#31
FMC DIALYSIS SVCS-LOW COUNTRY DIALYSIS	BEAUFORT	22	
GAMBRO HEALTHCARE - MONCKS CORNER	BERKELEY	22	
GAMBRO HEALTHCARE - ST. MATTHEWS	CALHOUN	12	#8
CHARLESTON RENAL CARE	CHARLESTON	17	#42
DCI AZALEA PLACE	CHARLESTON	20	
DCI CHARLESTON	CHARLESTON	20	
DCI EAST OF THE COOPER	CHARLESTON	13	
DCI JAMES ISLAND	CHARLESTON	16	#14
DCI MAGNOLIA COURT	CHARLESTON	16	
DCI WEST OF THE ASHLEY	CHARLESTON	23	
GAMBRO HEALTHCARE - CHARLESTON	CHARLESTON	28	
GAMBRO HEALTHCARE - CHARLESTON WEST	CHARLESTON	26	#22

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RECORD 003619

END STAGE RENAL DISEASE FACILITIES

FACILITY	COUNTY	# OF STATIONS	FOOTNOTES
HAMPTON REG MED CTR DIALYSIS CENTER	HAMPTON	13	
FMC DIALYSIS SERVICIES-THE MARSHLANDS	JASPER	17	#11
GAMBRO HEALTHCARE - ORANGEBURG	ORANGEBURG	21	#29
GAMBRO HEALTHCARE - SO ORANGEBURG	ORANGEBURG	21	#30
GAMBRO HEALTHCARE - SANTEE	ORANGEBURG	14	

FOOTNOTES:

#1 Licensed 2/22/99 for 15 stations.
#2 Located at SC Department of Corrections.
#3 Licensed increased from 17 to 20, 11/1/99.
#4 Not certified for outpatient;provides home training & outpatient.
#5 License increased from 10 to 16, 2/1/99.
#6 Licensed stations increased from 14 to 16, 4/16/99.
#7 License increased from 16 to 25, 2/2/99.
#8 Licensed for 12 stations, 3/10/99.
#9 License increased form 7 to 14, 9/10/99.
#10 License increased from 8 to 16, 2/26/99. Facility closed 2/1/01.
#11 License increased from 8 to 17 stations, 8/11/99
#12 License increased from 20 to 25 on 2/16/99.
#13 Licensed 6/10/99.
#14 Licensed for 16 stations, 2/26/99.
#15 CON issued 4/13/98 to add 4 stations for a total of 16 stations.
#16 CON issued 4/13/98 to add 5 stations for a total of 15 stations.
#17 Licensed for 21 ESRD stations 2/4/2000.
#18 License increased from 26 to 43 ESRD stations, 7/19/99.
#19 Facility licensed 2/10/00 for 13 stations.
#20 License increased from 28 to 30 stations, 1/26/00.
#21 Licensed for 2 stations, 3/10/2000.
#22 License increased from 14 to 26, 3/2/2000.
#23 License increased from 12 to 16, 4/18/2000.
#24 Facility licensed 5/11/00 for 10 stations; license increased to 11 stations, 6/1/2001.
#25 License increased from 15 to 20, 7/27/2000.
#26 License increased from 15 to 21, 8/16/2000.
#27 License increased from 9 to 11, 7/24/2000.
#28 License increased from 16 to 20, 9/11/2000.
#29 License increased from 20 to 21, 9/26/2000.
#30 License increased from 20 to 21, 9/26/2000.
#31 Name and ownership changed, 10/1/2000; formerly Gambro Healthcare Hilton Head.
#32 License increased from 13 to 16, 12/21/2000.
#33 License decreased from 20 to 16, 1/5/2001.
#34 License increased from 13 to 17, 1/25/2001.
#35 License increased from 14 to 25, 3/31/2001.
#36 Licensed for 16 stations, 5/9/2001.
#37 Licensed for 12 stations, 5/11/2001.
#38 Licensed for 10 stations, 6/19/2001.
#39 Licensed for 21 stations, 7/5/2001.
#40 Licensed for 21 stations, 1/3/2001.
#41 Licensed for 15 stations, 8/31/2001.
#42 Licensed for 17 stations, 9/10/2001.

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LITHOTRIPTORS 2001 HEALTH PLAN

COUNTY	FACILITY	TYPE	CON DATE/ PROCEDURES
AIKEN	AIKEN REGIONAL MED. CTR.	MOBILE	116
ANDERSON	ANDERSON AREA MED. CTR.	MOBILE	153
BEAUFORT	BEAUFORT MEMORIAL	MOBILE	30
BEAUFORT	HILTON HEAD HOSPITAL	MOBILE	51
CHARLESTON	EAST COOPER REGIONAL	MOBILE	59
CHARLESTON	ROPER HOSPITAL	MOBILE	170
CHARLESTON	ST. FRANCIS XAVIER	MOBILE	3
CHARLESTON	TRIDENT REGIONAL	MOBILE	264
CHESTERFIELD	CHESTERFIELD GENERAL	MOBILE	33
COLLETON	COLLETON REGIONAL	MOBILE	0
DARLINGTON	CAROLINA PINES	MOBILE	26
DILLON	ST. EUGENE COMMUNITY	MOBILE	49
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE	57
FLORENCE	CAROLINAS - LAKE CITY	MOBILE	0
FLORENCE	MCLEOD REGIONAL MED. CTR.	MOBILE	227
GEORGETOWN	GEORGETOWN MEMORIAL	MOBILE	38
GREENVILLE	ALLEN BENNETT	MOBILE	2/24/2000
GREENVILLE	ST. FRANCIS HOSPITAL	MOBILE	624
GREENWOOD	SELF MEMORIAL	MOBILE	98
HORRY	CONWAY HOSPITAL	MOBILE	181
HORRY	GRAND STRAND REGIONAL	MOBILE	114
HORRY	LORIS HOSPITAL	MOBILE	76
KERSHAW	KERSHAW MEMORIAL	MOBILE	41
LANCASTER	SPRINGS MEMORIAL	MOBILE	99
LAURENS	LAURENS REGIONAL	MOBILE	7
LEXINGTON	UROLOGY SURGERY CENTER	MOBILE	8/12/1999
MARION	MARION MEMORIAL	MOBILE	61
OCONEE	OCONEE MEMORIAL HOSPITAL	MOBILE	5
ORANGEBURG	RMC-ORANGEBURG/CALHOUN	MOBILE	64
PICKENS	BAPTIST MED. CTR. - EASLEY	MOBILE	24
PICKENS	CANNON MEMORIAL HOSPITAL	MOBILE	5
RICHLAND	BAPTIST MED. CTR.-COLUMBIA	FIXED	437
SPARTANBURG	MARY BLACK MEMORIAL	MOBILE	223
SPARTANBURG	SPARTANBURG REGIONAL	FIXED	166
SPARTANBURG	UROLOGY CTR SPARTANBURG	MOBILE	1/7/2000
SUMTER	TOUMEY REGIONAL	MOBILE	3/14/2000
WILLIAMSBURG	WILLIAMSBURG MEMORIAL	MOBILE	0
YORK	PIEDMONT MED. CTR.	MOBILE	127
		TOTAL	3,628

(K) Outpatient Facilities

Outpatient facility means a facility located in or apart from a hospital, providing community service for the diagnosis and treatment of ambulatory patients: (1) which is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery (or dentistry in the case of dental diagnosis or treatment); or (3) which offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services.

Hospital-based outpatient departments vary in scope from a full range of services at the larger hospitals to the basic medical specialties of the smaller hospitals. All are expected to offer, at least, diagnostic laboratory, radiology, and clinical referral services. These departments are excluded from the inventory in Section III. The inventory also excludes: (1) the offices of private physicians and dentists whether for individual or group practice; and (2) industrial clinics and first aid centers for employees only and similar facilities not providing a community service.

(1) Ambulatory Surgical Facility

An Ambulatory Surgical Facility is a distinct entity that is equipped and operated exclusively for the purpose of performing surgical procedures for which patients are scheduled to arrive, receive surgery, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff. This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care providers. In addition to ambulatory surgical centers, most hospitals provide surgical services on an ambulatory (outpatient) basis. Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in either a hospital or a freestanding ambulatory surgery center.

In 1999, a total of 306,520 outpatient surgeries were performed in either a freestanding surgical center or a hospital in South Carolina, amounting to 66.9% of all surgeries. Not all ambulatory surgical units perform all procedures, nor is every patient a suitable candidate for an outpatient procedure. The table on the following page shows the trend in number and percentage of ambulatory and inpatient surgeries performed in the state.

Prior to the approval of additional ambulatory surgical facilities or the addition of operating rooms/endoscopy suites to existing ambulatory surgical facilities, the following criteria must be satisfied:

1. The applicant must define the proposed service area and/or provide patient origin information on the current facility.

2. The applicant must document a need for the expansion of or the addition of an ambulatory surgical facility. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

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3. There must be support from the physicians in the area to be served. An application for an Ambulatory Surgery Center must contain letters of support from physicians other than those affiliated with the proposed facility stating that they will either refer to or use the center.

4. The applicant must discuss the impact that the proposed ambulatory surgical facility or expansion will have upon the existing service providers.

5. The applicant must document where the potential patients for the facility will come from and where they are currently being served.

6. All new Certificate of Need approvals by the Department will not restrict the specialties of ambulatory surgery centers. Ambulatory surgery centers may be open to all surgical specialties or provide services to a single specialty, depending on their capabilities. For an ambulatory surgery center approved to only perform endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

7. All proposed ambulatory surgical facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

8. Before a new Ambulatory Surgery Center can be approved, all existing ASC's in the county must have been licensed and operational for one year to allow for a determination of the utilization of ASC's. Endoscopy-only ASC's are only considered to impact other Endoscopy-only facilities.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements, and should meet the full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations, if the facility is JCAHO accredited. Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most of the residents of South Carolina. Most ambulatory surgical services operate five days a week, with elective surgery being scheduled several days in advance.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and

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j. Adverse Effects on Other Facilities.

There has been a substantial increase in the past five years in both the number and percentage of ambulatory surgeries performed and the number of ambulatory surgery centers approved and licensed. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, there is now concern that, particularly in the case of specialty facilities, ambulatory surgery centers are being proposed as a method of increasing reimbursement for procedures currently being performed in physician's offices (through the "facility fee" built into the reimbursement mechanisms). The Department will continue to evaluate applications for ambulatory surgery centers on their individual merit. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 1999):

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RECORD 003624

AMBULATORY SURGERY CENTERS

Facility	County	# of ORs	# of Endos	Total # of Suites	1999 Total Operations	Footnote
Region I:						
AnMed Outpatient Surg. Ctr.	Anderson	5	4	9	7,221	*1*
Bearwood ASC	Anderson	1		1	246	
Medicus Surgery Center	Anderson	3		3	4,835	
Carolina Orthopaedic Surgery	Greenville	2		2	—	*2*
Cross Creek Surgery Center	Greenville	4		4	6,200	
Greenville Endoscopy Center	Greenville		3	3	3,260	
GHS – Eastside ASC	Greenville	6		6	1,107	*3*
HealthSouth SC Greenville	Greenville	4		4	3,650	
Jervey Eye Center	Greenville	2		2	2,705	*4*
Patewood Ambulatory Surgery	Greenville	2		2	702	*5*
Blue Ridge Medical Specialties {pain management only}	Oconee	2		2	—	*6*
Blue Ridge Surgery Center {orthopaedic surgery only}	Oconee	2		2	—	*7*
Amb Surg Ctr - Spartanburg	Spartanburg	7		7	—	*8*
Spartanburg Urology Surgicenter	Spartanburg	2		2	1,866	*9*
Region II:						
Greenwood Endoscopy Center	Greenwood		2	2	4,337	
Surgery Ctr. at Self Mem Hosp	Greenwood	5		5	—	*10*
Outpt SC Lex Med Ctr - Irmo	Lexington	4		4	2,631	*11*
Outpt SC Lex Med Ctr - Lexington	Lexington	3	1	4	—	*12*
South Carolina Endoscopy Ctr {endoscopic procedures only}	Lexington		4	4	4,956	*13*
Urology Surgery Center	Lexington	2		2	348	*14*
Columbia Amb Surg Ctr	Richland	2		2	638	*15*

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RECORD 003625

Facility	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Footnote
Columbia Eye Surgery Center (eye surgery only)	Richland	4		4	2,533	*16*
Columbia GI Endoscopy Ctr.	Richland		2	2	4,721	
Huff and Milne Eye Surgery	Richland	2		2	—	*17*
Palmetto Surgery Center	Richland	4		4	—	*18*
Providence Hosp Surg Ctr	Richland	4		4	4,488	
South Carolina Med Endoscopy Ctr {endoscopic procedures only}	Richland		2	2	161	*19*
Carolina Surgical Center	York	4		4	4,033	
Region III:						
Darlington Endoscopy Center {endoscopic procedures only}	Darlington		2	2	—	*20*
Carolina Eye Surg & Laser Ctr.	Florence	2		2	—	*21*
McLeod Amb Surg Ctr	Florence	2		2	1,311	*22*
Physicians Surgery Center	Florence	4	2	6	—	*23*
Bay Microsurgical Unit	Georgetown	1		1	1,817	
Waccamaw Neck S D Surgery	Georgetown	3		3	—	*24*
Carolina Regional Surg Ctr	Horry	2		2	3,245	*25*
Coastal Car Ctr Urology& Surg	Horry	2		2	—	*26*
Comm Med Ctr - South Strand	Horry	2	1	3	—	*27*
Ocean Amb Surg Ctr	Horry	2		2	—	*28*
Parkway Surgery Ctr	Horry	2		2	—	*29*
Seacoast Med Ctr Amb Surg	Horry	3		3	—	*30*
Strand GI Endoscopy {endoscopic procedures only}	Horry		2	2	—	*31*
Doctor's Outpt Surgical Clinic	Marlboro	2		2	—	*32*
Region IV:						
Carolina Amb Surg Ctr	Aiken	1		1	182	

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RECORD 003626

Facility	County	# of ORs	Endos	of Suites	Operations	Footnote
Hilton Head Med. Ctr. & Clinics	Beaufort	2		2	1,288	*33*
Laser and Skin Surgery Center	Beaufort	2		2	—	*34*
Surgery Center of Beaufort	Beaufort	3	2	5	—	*35*
Roper Berkeley Amb Surg	Berkeley	3		3	—	*36*
Charleston Plastic Surg Ctr	Charleston	2		2	474	*37*
ENT Surgery Center	Charleston	1	1	2	—	*38*
HealthSouth Surg Ctr Charleston	Charleston	4		4	2,625	
Roper W. Ashley Surg Center	Charleston	4		4	3,370	
Trident Eye Surgery Center (eye surgery only)	Charleston	2		2	1,544	
Trident Surgery Center	Charleston	4		4	5,592	
Colleton Ambulatory Care	Colleton	2	1	3	1,403	
Edisto Surgery Center	Orangeburg	4		4	—	*39*

FOOTNOTES:

— Facility not licensed during reporting period.
1 CON issued 7/13/01 for a 4th endoscopy suite.
2 CON issued 9/19/01.
3 CON issued 1/26/98; licensed 5/20/99.
4 CON issued 10/21/97; licensed 3/1/99.
5 Formerly Same Day Surgery East.
6 CON issued 1/8/01.
7 CON issued 1/8/01.
8 CON issued 10/10/00.
9 CON issued 10/9/00 to become an unrestricted surgery center.
10 CON issued 5/01/00.
11 CON issued 10/18/99 for a 4thOR; licensed 4/13/01.
12 CON issued 2/3/99 for 3 OR's and 1 Endoscopy suite; licensed 8/21/01.
13 CON issued 11/3/00 for a 4th Endoscopy suite; licensed 2/13/01.
14 CON issued 10/27/98; licensed 9/17/99.
15 Formerly Columbia Ambulatory Plastic Surgery Center.
16 CON issued 9/18/00 to add 2 additional OR's for a total of 4.
17 CON issued 9/25/01 to establish an ASC within Palmetto Surgery Center.
18 CON issued 8/27/98; licensed 2/15/00.
19 CON issued 9/1/98; licensed 8/9/99.
20 CON issued 10/29/99.
21 CON issued 2/20/01.
22 CON issued 9/14/01 for 3 additional OR's; formerly Pee Dee ASC.
23 CON issued 8/27/01.

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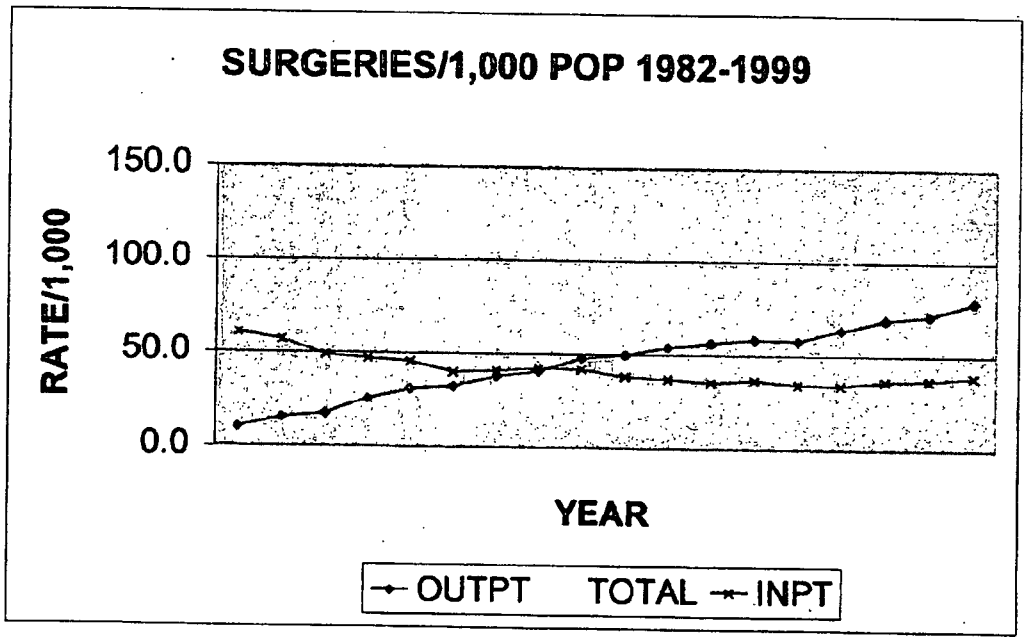
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24 CON issued 8/15/97; licensed 10/31/00; formerly Palmetto Same Day Surgery.
25 CON issued 8/24/00 to relocate the facility.
26 CON issued 5/29/01.
27 CON issued 7/21/97; licensed 10/28/99; formerly South Strand.
28 CON issued 4/27/00; licensed 10/8/01.
29 CON issued 4/11/00, licensed 10/16/01; formerly Grand Strand Urology Ctr
30 CON issued 7/28/98; licensed 9/15/00; formerly North Myrtle Beach Day Hospital.
31 CON issued 7/24/00.
32 CON approved 12/17/98; under appeal.
33 CON issued 2/2/98; licensed 2/9/99; formerly Bluffton/Okatie Ambulatory Surg Ctr.
34 CON issued 10/219/99; licensed 9/13/01.
35 CON issued 11/19/98, for 3 ORs and 2 Endoscopy suites; licensed 6/21/00.
36 CON issued 2/1/00.
37 2nd OR licensed 6/19/99.
38 CON issued 3/8/00 for 1 OR and 1 Endoscopy suite.
39 CON denied 7/2/98; Board approved 11/12/98; appealed.

S.C. SURGERIES PER 1,000 POPULATION
OUTPATIENT, INPATIENT AND TOTAL
1982-1999

YEAR	OUTPT	INPT	TOTAL	OUTPAT % OF TOTAL
1982	10.3	60.7	71.0	14.5%
1983	15.8	57.1	72.9	21.7%
1984	17.6	49.0	66.6	26.4%
1985	26.0	47.3	73.3	35.5%
1986	30.9	45.6	76.5	40.4%
1987	32.4	39.9	72.3	44.8%
1988	37.9	40.7	78.6	48.2%
1989	40.7	42.3	83.0	49.0%
1990	47.8	41.9	89.7	53.3%
1991	49.8	38.4	88.2	56.5%
1992	53.9	37.1	91.0	59.2%
1993	56.7	35.5	92.2	61.5%
1994	58.5	36.9	95.4	61.3%
1995	58.0	34.7	92.7	62.6%
1996	63.9	34.4	98.3	65.1%
1997	69.5	36.6	106.1	65.5%
1998	71.9	37.2	109.1	65.9%
1999	79.2	39.1	118.4	66.9%



PMC.2013.SHP.0116

PET-EX005.0116

(2) Emergency Hospital Services

All hospital emergency departments are sub-categorized into four levels of service from I to IV, with I being the highest level of care. These categories are based on modified JCAHO standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one way travel time.

Level I offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecologic, pediatric, and anesthesia services. Other specialty consultation is available within approximately 30 minutes, initial consultation through two-way voice communication is acceptable.

Level II offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. The hospital's scope of services include in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another organization when needed.

Level III offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

Level IV offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.

A Certificate of Need is required to establish a freestanding emergency service {also referred to as an off-campus emergency service}. CON criteria for development of freestanding emergency services are as follows:

1. All off-campus emergency services must be an extension of an existing hospital's emergency service. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

2. Regulation No. 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

3. The proposed freestanding emergency service must be located no closer than 30 miles from an existing hospital emergency department or off-campus emergency service.

PMC.2013.SHP.0117

PET-EX005.0117

RECORD 003630

4. An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems which the off-campus emergency service cannot handle.

5. The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.

(3) Trauma Referral System

The Division of Emergency Medical Services, DHEC, has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become designated. The following is a brief description of the criteria for each of the three levels of Trauma Centers:

Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general, neurologic and orthopaedic surgery capability in-house at all times. This level is also required to have anesthesia in-house at all times. Medical and other specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior surgical residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public.

Level II: This trauma center has extensive capability and meets the needs of most trauma victims. It is required to have general, neurologic and orthopaedic surgery available when the patient arrives. Anesthesiology is also required to be available when the patient arrives. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The major difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call but with the clear commitment to be in the Emergency Department when the patient arrives.

Level III: These hospitals are committed to caring for the trauma patient. These facilities have the capability to perform major resuscitation when necessary. These hospitals are required to have general surgery, anesthesia, and internal medicine on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader. All of the other specialties are on-call and must come in when needed.

PMC.2013.SHP.0118

PET-EX005.0118

RECORD 003631

3. There must be support from the physicians in the area to be served. An application for an Ambulatory Surgery Center must contain letters of support from physicians other than those affiliated with the proposed facility stating that they will use the center.

4. The applicant must discuss the impact that the proposed ambulatory surgical facility or expansion will have upon the existing service providers.

5. The applicant must document where the potential patients for the facility will come from and where they are currently being served.

6. All new Certificate of Need approvals by the Department will not restrict the specialties of ambulatory surgery centers. Ambulatory surgery centers may be open to all surgical specialties or provide services to a single specialty, depending on their capabilities. For an ambulatory surgery center approved to only perform endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

7. All proposed ambulatory surgical facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

8. Before an expansion or new Ambulatory Surgery Center can be approved, all existing ASC's in the county must have been licensed and operational for one year to allow for a determination of the utilization of ASC's.

Facilities providing ambulatory surgery services must conform with local, state, and federal regulatory requirements, and should meet the full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations, if the facility is JCAHO accredited. Ambulatory surgical services are generally available within 30 minutes one way automobile travel time of most of the residents of South Carolina. Most ambulatory surgical services operate five days a week, with elective surgery being scheduled several days in advance.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

PMC.2013.SHP.0119

PET-EX005.0119

RECORD 003632

2. Community Psychiatric Beds

OVERVIEW

Inpatient psychiatric services are those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Such services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals. Psychiatric services are provided on both a short-term (average length of stay of less than 30 days for adults and 60 days for children) and long-term (average length of stay greater than 30 days for adults and 60 days for children) basis. These lengths of stay should not be considered as rigid since different therapies and clientele may require different lengths of stay and still be considered acute care. Variations may occur in the individual's response to therapy, the reaction to medication, the therapeutic relationship, and emergent symptoms that were not evident upon admission. Therefore, it is important to allow flexibility in determining what constitutes short and long-term lengths of stay.

An occupancy factor of 80% was used to calculate short-term projected bed needs. A minimum use rate of 75% of the overall state use rate was used to project bed needs in areas not now having short-term psychiatric units and related utilization data. Need projections were developed based on psychiatric service areas, which were derived after analysis of patient origin data from the Hospital Discharge Data System. The following pages depict the calculations described above. This information is current as of October 1, 2001.

Special units for children and adolescents and geriatric patients have been developed throughout the state. If any additional beds are approved, they must come from the overall psychiatric bed component shown as needed. These specialty psychiatric services should be identifiable units with sufficient space to have available areas for sleeping, dining, education, recreation, occupational therapy and offices of evaluation and therapy. The unit should be staffed with an appropriate multi-disciplinary care team of psychiatrists, psychologists, social workers, nurses, occupation therapists, recreational therapists, and psychiatric technicians. Other consultants should be available as needed.

The policy for the allocation of short-term psychiatric beds will consider the service area the basic unit for planning and issuance of Certificates of Need. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

STATE MENTAL HEALTH FACILITIES

(1) Psychiatric Hospital Beds

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum.

PMC.2013.SHP.0120

PET-EX005.0120

RECORD 003633

Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital compliment is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, they are exempt from Certificate of Need review.

(2) Local Inpatient Crisis Stabilization Beds:

These facilities provide short-term emergency stabilization of psychiatric patients. Such care may be provided in units of general hospitals, preferably under the care of the medical staff of the local community mental health center. However, the development of crisis residential services (therapeutic foster homes and crisis placement within community care homes) is intended to prevent unnecessary hospital admissions. Trained supervision is available on a one-to-one basis while the client is in the home.

Should the Department of Mental Health wish to contract with a hospital which proposes to provide crisis stabilization services, the following standards will apply. If the hospital proposes to provide this care in existing acute care or psychiatric beds, then this action will not require Certificate of Need review. However, an exemption request which includes a written memorandum of agreement with the local community mental health center must be filed. Should the hospital propose to license additional psychiatric beds in order to fulfill the contract, then the procedure listed below must be followed by the applicant:

(a) The applicant for a Certificate of Need must negotiate a written memorandum of agreement with the local community mental health center, stating that these beds are specifically for local inpatient crisis stabilization beds. The memorandum will be submitted through the State Department of Mental Health and be included in the Certificate of Need application. This memorandum must address the following:

1. the patient population;
2. the financial strategy;
3. joint screening and discharge planning strategies.

(b) An applicant must specifically delineate these beds in the application and not mix them with other psychiatric beds.

(c) Should the memorandum of agreement with the Department of Mental Health be broken or fail to be renewed, the license for the designated psychiatric beds will be revoked.

Persons interested in other crisis residential services should contact the Department of Mental Health directly.

PMC.2013.SHP.0121

PET-EX005.0121

RECORD 003634

(3) Long-Term Care Needs

The following nursing homes are operated by the Department of Mental Health:

C.M. Tucker, Jr./Dowdy Gardner	560 beds
Richard Campbell Veteran's Center	220 beds
TOTAL	780 beds

Based upon on-going patient analysis by DMH, consideration should be given to converting psychiatric hospital beds to other levels of care in order to accommodate the level of functioning of the patients if alternative community-based resources are not available. DMH will justify any changes in bed or service categories. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for these services.

PMC.2013.SHP.0122

PET-EX005.0122

RECORD 003635

PSYCHIATRIC BED UTILIZATION, 1999

COUNTY	FACILITY	1999 AVERAGE LICENSED BEDS	1999 OCC. RATE	
AIKEN	AURORA PAVILION	29	51.9%	
ANDERSON	ANDERSON MEMORIAL	38	46.2%	
BEAUFORT	BEAUFORT MEMORIAL	20	28.2%	
CHARLESTON	CHARLESTON MEMORIAL	15	0.0%	
CHARLESTON	MEDICAL UNIVERSITY	82	61.1%	
CHARLESTON	PAL LOWCNTRY BEHAV HLTH	60	35.5%	1
CHARLESTON	TRIDENT REGIONAL	20	51.7%	
FLORENCE	MCLEOD REGIONAL	35	44.8%	
GREENVILLE	CAROLINA CTR BEHAV HLTH	45	74.4%	### 2
GREENVILLE	GREENVILLE MEMORIAL	72	59.5%	
GREENWOOD	SELF MEMORIAL	36	37.2%	
HORRY	CHARTER-SANDS	45	41.6%	3
LEXINGTON	THREE RIVERS BEHAV HLTH	39	67.0%	### 4
MARLBORO	MARLBORO PARK HOSP.	8	56.2%	
ORANGEBURG	RMC-ORGBURG/CALHOUN	15	48.8%	
RICHLAND	PALM. BAPTIST - COLUMBIA	104	33.4%	
RICHLAND	PALM.RICHLAND MEMORIAL	60	74.5%	
SPARTANBURG	SPARTANBURG REGIONAL	56	75.8%	
SUMTER	TOUMEY REGIONAL	19	42.0%	
YORK	PIEDMONT MEDICAL CTR.	20	55.7%	
	TOTAL	**818**	**51.7%**	

TOTAL REFLECTS UTILIZATION OF DUAL-DIAGNOSIS SWING BEDS

1 FORMERLY CHARTER-CHARLESTON
2 FORMERLY CHARTER-GREENVILLE
3 FACILITY DE-LICENSED 5/18/00
4 FORMERLY CHARTER RIVERS HOSPITAL

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	1999 POP	2005 POP	99 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	<65	193900	205500	5534	16.07				
	+65	31900	33700	878	2.54				
	TOTAL	225800	239200	6412	18.61	0.70	27	38	-11
GREENVILLE,PICKENS	<65	407600	436300	22306	65.42				
	+65	58000	62000	5547	16.25				
	TOTAL	465600	498300	27853	81.68	0.70	131	116	15
CHEROKEE,SPARTANBURG UNION	<65	284300	301900	3045	8.86				
	+65	45600	48700	6980	20.42				
	TOTAL	329900	350600	10025	29.28	0.70	42	71	-29
CHESTER,LANCASTER,YORK	<65	218200	239700	3116	9.38				
	+65	30400	33000	952	2.83				
	TOTAL	248600	272700	4068	12.21	0.70	17	20	-3
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	169800	180500	3701	10.78				
	+65	28200	29200	1185	3.36				
	TOTAL	198000	209700	4886	14.14	0.70	20	36	-16
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	560800	599200	24478	71.66				
	+65	65400	70100	8951	26.29				
	TOTAL	626200	669300	33429	97.94	0.70	153	203	-50
DARLINGTON,FLORENCE MARION	<65	171400	204300	4690	15.32				
	+65	28100	28300	1037	2.86				
	TOTAL	199500	232600	5727	18.18	0.70	26	35	-9
CHESTERFIELD,DILLON MARLBORO	<65	63400	89300	337	1.30				
	+65	13700	14500	1304	3.78				
	TOTAL	77100	103800	1641	5.08	0.70	7	8	-1
CLARENDON,LEE,SUMTER	<65	143500	149300	2455	7.00				
	+65	17900	19100	458	1.34				
	TOTAL	161400	168400	2913	8.34	0.70	12	19	-7

RECORD 003637
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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	1999 POP	2005 POP	99 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
GEORGETOWN,HORRY WILLIAMSBURG	<65	228300	253600	75%	17.23				
	+65	38100	43600	STATE USE	6.99				
	TOTAL	266400	297200	RATE	24.22	0.70	35		35
BAMBERG,CALHOUN ORANGEBURG	<65	105900	108000	1913	5.35				
	+65	14800	15200	760	2.14				
	TOTAL	120700	123200	2673	7.48	0.70	11	15	-4
ALLENDALE,BEAUFORT COLLETON,HAMPTON, JASPER	<65	164400	182600	1681	5.12				
	+65	25700	28500	374	1.14				
	TOTAL	190100	211100	2055	6.25	0.70	12	20	-8
BERKELEY,CHARLESTON DORCHESTER	<65	486700	515300	25832	74.93				
	+65	54300	58100	4019	11.78				
	TOTAL	541000	573400	29851	86.71	0.70	139	157	-18
AIKEN,BARNWELL	<65	143500	157000	3934	11.79				
	+65	22100	24100	1562	4.67				
	TOTAL	165600	181100	5496	16.47	0.70	24	29	-5
STATE TOTAL							656	767	-111
STATE MIMIMUM USE RATE	<65	3113400	3368900	103022.088	0.0330899	0.02			
	+65	436100	464500	34006.912	0.0779796	0.06			
	TOTAL	3549500	3833400	137029	0.0386052	0.03			

RECORD 003638
PMC.2013.SHP.0125
PET-EX005.0125

3. Residential Treatment Facilities for Children and Adolescents

OVERVIEW

"Residential treatment facilities for children and adolescents" means a facility operated for the assessment, diagnosis, treatment, and care by two or more persons of children and adolescents in need of mental health treatment. "Children and adolescents in need of mental health treatment in a residential treatment facility" means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgement including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

These facilities provide medium to long-term care (6 months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are current licensed or approved as Residential Treatment Facilities:

Facility	Beds	FY 1999 Occ. Rate	
Directions {DMH, Columbia}	37	63.8%	*1*
Marshall Pickens Hospital {Greenville}	22	87.1%	
New Hope-Charleston {Summerville}	52	94.4%	
New Hope-Midlands {West Columbia}	54	85.4%	
Palmetto Low Country Behavioral Health {Charleston}	32	93.5%	*2*
Palmetto Pee Dee Behavioral Health{Florence}	59	87.4%	*3*
Southbridge {Columbia}	40 (0)	91.8%	*4*
Springbrook Behavioral Ctr. {Travelers Rest}	68	36.0%	*5*
Three Rivers Behavioral Care {West Columbia}	14	94.7%	*6*
York Place {York}	40	70.2%	
TOTAL	418 (378)		

1 License decreased from 55 beds to 37 beds 4/21/99.
2 Formerly Charter Academy of Charleston.
3 Facility relocated from Conway to Florence 7/18/00; new location licensed 9/29/00. Name changed from Charter Sands of Conway. CON issued 4/19/01 to add 41 additional RTF beds. Utilization data are for 1998.
4 Facility closed 6/15/01.
5 Formerly Chestnut Hill. CON issued 6/12/01 to convert 24 long-term psychiatric beds to RTF beds. Facility licensed for 68 RTF beds on 8/28/01.
6 Formerly Charter Rivers Hospital.

PMC.2013.SHP.0126

PET-EX005.0126

RECORD 003639

Certificate of Need Standards for Residential Treatment Facilities

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;
2. Individual treatment plans to assess the problems and determine specific patient goals;
3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;
4. Nursing services, as required;
5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;
6. Recreational facilities with an organized youth development program;
7. A special education program with a minimum program defined by the South Carolina Department of Education; and
8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

Each facility shall have a written plan for cooperation with other public and private organizations, such as schools, social service agencies, etc., to ensure that each child under its care will receive comprehensive treatment. In addition, each facility shall have a written transfer agreement with one or more hospitals for the transfer of emergency cases when such hospitalization becomes necessary.

A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Continuum of Care for Emotionally Disturbed Children, the SC Department of Social Services and the SC Department of Mental Health. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the agencies mentioned above.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 6 years of age would be candidates for this type of care, the bed need will be based on the population age 6-21. The projected bed needs by service area are as follows:

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RECORD 003640

Inventory Region I Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, Union.

Facilities:		
	Marshall Pickens	22 beds
	Springbrook Behavioral	68 beds
	Total	90 beds

2005 Population Age 6-21:	232,640	
41.4 Beds/100,000 Population:	x .000414	
	97	beds
	- 90	beds
Need Shown:	7	beds

Inventory Region II Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, York.

Facilities:		
	Charter Rivers	14 beds
	New Hope Midlands	54 beds
	York Place	40 beds
	Total	108 beds

2005 Population Age 6-21:	280,660	
41.4 Beds/100,000 Population:	x .000414	
	117	beds
	- 108	beds
Need Shown:	9	beds

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:		
	Pal. Pee Dee Behav. Hlth.	59 beds
	Total	59 beds

2005 Population Age 6-21:	180,420	
41.4 Beds/100,000 Population:	x .000414	
	75	beds
	- 59	beds
Need Shown:	16	beds

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RECORD 003641

Inventory Region IV Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg.

Facilities:	New Hope Charleston	52 beds
	Pal. Low Cnty Behav. Hlth.	32 beds
	Total	84 beds

2005 Population Age 6-21:	254,940	
41.4 Beds/100,000 Population:	x .000414	
	106	beds
	- 84	beds
Need Shown:	22	beds

The projected need for additional RTF beds is based upon the number of clients of the Department of Mental Health, Department of Social Services, and the Continuum of Care for Emotionally Disturbed Children who are currently being served, waiting for service, and/or who could be appropriately placed in these facilities. Additionally, it allows for sufficient beds to be available to meet the needs of private pay and other non-governmental clients. Applicants must document sources for patient referral. The Directions program (and the Southbridge program before closing) primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

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:

a. Compliance with the Need Outlined in this Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Record of the Applicant;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within seventy-five (75) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PMC.2013.SHP.0129

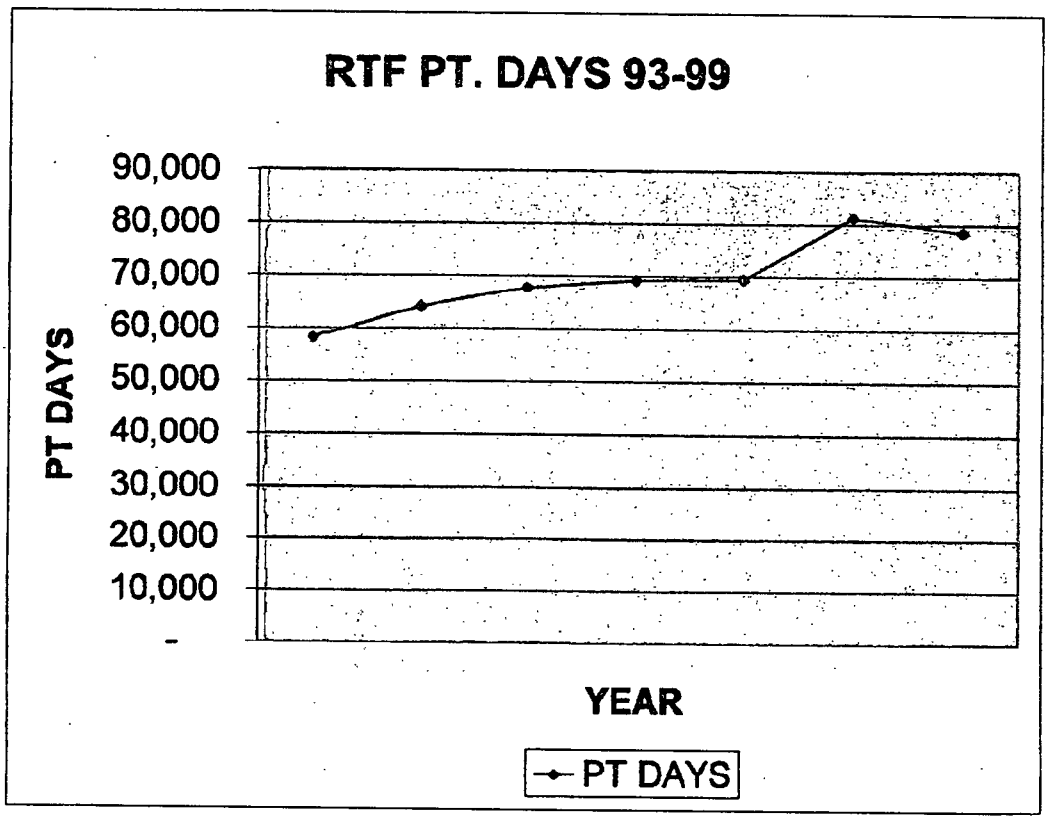
PET-EX005.0129

RECORD 003642

RTF UTILIZATION 1993-1999

DOES NOT INCLUDE DMH PROGRAMS

YEAR	PATIENT DAYS
1993	58,147
1994	64,147
1995	67,734
1996	69,235
1997	69,381
1998	81,250
1999	78,533



PMC.2013.SHP.0130

PET-EX005.0130

4. Alcohol and Drug Abuse Facilities

There are six distinct providers of substance abuse treatment in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services; and narcotic treatment programs. These are defined as follows:

(1) Outpatient Facilities

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment and referral, individual and group counseling, family counseling, case management and crisis management services. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 54 licensed outpatient facilities for chemically dependent or addicted persons in South Carolina.

CERTIFICATE OF NEED REQUIREMENTS

Certificate of Need is not required for outpatient facilities described above.

(2) Social Detoxification Facilities

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides education and referral. A social detoxification facility provides 24-hour-a-day observation of the client until discharge.

Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized medical provider. Social detoxification facilities provide, at a minimum, the following services:

(a) Screening and intake provided by staff/volunteers specially trained to monitor the client's physical condition;

(b) Development of an individual treatment plan for supervised withdrawal;

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(c) Continuing observation of each patient's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action;

(d) Room, dietary service, and other care and supervision necessary for the maintenance of the client;

(e) Counseling designed to motivate patients to continue in the treatment process.

INVENTORY

Facility	Beds
Shoreline Behavioral Health Services (Horry County)	5
Spring Branch Residential Treatment Ctr. (Marion County)	6
Westview Behavioral Health Services (Newberry County)	3
Spartanburg Alcohol and Drug Abuse Commission-Detox Prog.	15
Freedom House (Sumter County)	6
TOTAL	35

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a social detoxification center.

(3) Freestanding Medical Detoxification Facilities

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse and referral. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized medical provider.

Medical detoxification services should provide at a minimum the following treatment and support services:

(a) Intake medical examination and screening by a physician or other authorized medical provider to determine need for medical services or referral for serious medical complications;

(b) Continuing observation of each client's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action. Each client's general condition shall be monitored and his/her vital signs taken at a frequency as determined by the facility, but not less than 3 times during the first 72 hours of admission to the facility;

(c) Medication as appropriate to assist in the withdrawal process;

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(d) A plan for supervised withdrawal, to be implemented upon admission;

(e) Room, dietary service, and other care and supervision necessary for the health and safety of the client;

(f) Counseling designed to motivate patients to continue in the treatment process and referral to the appropriate treatment modality.

INVENTORY

Facility	Beds	1999 Occupancy
Carolinas Hospital System (Florence County)	4	39.9%
Charleston Center Subactute Detox. Program	16	53.9%
Greenville Detoxification Center	27	42.3%
Lexington/Richland A.D.A.C. Detox. Unit	16	80.5%
Keystone Detoxification Center (York County)	12	31.7%
TOTAL	75	51.1%

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for freestanding medical detoxification beds. The 1999 utilization rates are used to project the need for services in 2005. An occupancy factor of 70% was used in the calculations. The greater of the service area's actual utilization or 100% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Freestanding detoxification centers should be available within 60 minutes one-way automobile travel time for 90% of the service area's population. Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed: however, the bed need projections refer to two distinct treatment modes which cannot be commingled.

Since 1987, courts in South Carolina have had the authority to order individuals involuntarily into addiction treatment. Because of this law, the number of detoxification beds shown as needed in this Plan may need to be increased. If an applicant can document an increased need and if either the

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DETOXIFICATION BED NEED

SERVICE AREA	1999 POP	2005 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	181,500	192,600	0	3.01	0.80	4	0	4
GREENVILLE,PICKENS	374,400	402,100	4,167	12.26	0.80	15	27	-12
CHEROKEE,SPARTANBURG UNION	265,100	282,200	0	4.40	0.80	6	0	6
CHESTER,LANCASTER,YORK	199,000	218,100	1,389	4.17	0.80	5	12	-7
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	156,600	166,200	0	2.59	0.80	3	0	3
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	504,600	539,900	4,700	8.43	0.80	11	16	-5
DARLINGTON,FLORENCE MARION	178,300	182,600	582	2.85	0.80	4	4	0
CHESTERFIELD,DILLON MARLBORO	80,000	82,300	0	1.28	0.80	2	0	2
CLARENDON,LEE,SUMTER	123,800	129,500	0	2.02	0.80	3	0	3
GEORGETOWN,HORRY WILLIAMSBURG	213,800	239,400	0	3.74	0.80	5	0	5
BAMBERG,CALHOUN ORANGEBURG	93,500	95,900	0	1.50	0.80	2	0	2
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	150,500	167,800	0	2.62	0.80	3	0	3
BERKELEY,CHARLESTON DORCHESTER	423,300	450,200	3,147	9.17	0.80	11	16	-5
AIKEN,BARNWELL	129,800	142,600	0	2.23	0.80	3	0	3
STATE TOTAL	3,074,200	3,291,400	13,985	60.27		77	75	2
MINIMUM USE RATE	0.005697							

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South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) or the South Carolina Department of Mental Health (DMH) submits a letter of support for additional detoxification beds beyond those shown as needed in the Plan, then additional detoxification beds could be approved.

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 Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 5 freestanding medical detoxification facilities in the state operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Services are accessible within sixty (60) minutes travel time for the majority of state residents. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(4) Residential Treatment Program Facilities

A 24-hour facility offering an organized service in a residential setting which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living.

Residential treatment programs utilize a multi-disciplinary staff whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs shall provide or make available the following:

(a) Room and board including shared responsibility by clients for daily operations of the facility, e.g. cooking, cleaning, and maintenance of house rules as appropriate to the level of residential treatment provided;

(b) Specialized professional consultation, supervision and direct affiliation with other levels of treatment;

(c) Physician and nursing care and observation based on clinical judgment if appropriate to the level of treatment;

(d) Arrangements for appropriate laboratory and toxicology tests as needed;

(e) Availability of a physician 24 hours a day by telephone;

(f) Multidisciplinary team of appropriately trained clinicians is able to assess and treat adult alcohol and/or other drug dependent patients and obtain and interpret information regarding the needs of these clients. Such clinicians must be knowledgeable of the biological and psychological dimensions of alcohol and/or other drug dependence;

(g) Licensed or certified addictions clinicians to provide a planned regimen of professionally directed, evaluation, care and treatment services for addicted persons and their families to include individual, group, and/or family counseling directed toward specific client goals indicated in his/her individual treatment plan;

(h) Health education services;

(i) Educational guidance and educational program referral when indicated;

(j) Vocational counseling for any client when indicated. For those not employed, staff shall facilitate the client's pursuit of job placement, as appropriate;

(k) Work activity participation by clients provided such activities are an integral part of the rehabilitation process and clients are made aware of the necessity of their participation in such activities, such activities are not a substitute for staff;

(l) Leisure time activities, including recreational activities;

(m) Planned clinical program activities designed to enhance the client's understanding of addiction;

(n) Multi-disciplinary individualized assessments and treatment are provided;

(o) Family and significant other services;

(p) Living skills training, as needed.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a Residential Treatment Program. However, an exemption

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request is required prior to the establishment of such a program.

(5) Inpatient Treatment Facilities

A short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients as needed in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital.

Inpatient treatment services should provide at a minimum the following:

(a) An ability to attend to and document any physical or behavioral condition requiring immediate attention. Documentation of consultative and contractual services should be available to demonstrate the facility's ability to attend to physical and behavioral problems needing immediate attention.

(b) An individual treatment plan prepared and maintained on a current basis for each patient.

(c) Counseling services, including group, family, and/or individual, on a regular planned basis in keeping with the specific needs of the patient.

(d) A structured alcohol and other drug abuse education program.

(e) A structured recreational program, including recreational activities.

(f) Dietary service, room and board, and other care and supervision necessary for the health and safety of the patient.

(g) Discharge planning including a final assessment of the patient's condition and development of an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

All organizations providing inpatient alcohol and drug abuse treatment services should have written policies and procedures to provide for referring patients who cannot be served or who require immediate treatment that cannot be provided by the facility. In addition, the organization should adopt and have in force written policies requiring all patients, families, guardians, etc. be appropriately informed of:

(a) Any rules or regulations regarding patient behavior;

(b) Providers' responsibilities for the care and comfort of the patients; and

(c) Estimates of average charges including room rates and charges for different services and billing procedures prior to rendering services.

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INVENTORY

Facility	Beds	1999 Occupancy	
Aiken Regional Medical Center	18	11.9%	
AnMed-Wellspring (Anderson County)	27	7.1%	
Carolina Center Behav. Health (Greenville County)	13	50.3%	*1*
Carolinas Hospital System (Florence County)	42 (18)	8.6%	*2*
Charter Sands (Horry County)	15 (0)	24.6%	*3*
Fairfield Memorial Hospital	17	0.0%	
Holmesview Center (Greenville County)	40	80.1%	*4*
Marshall Pickens (Greenville County)	18 (0)	0.0%	*5*
McCord Adolescent (Orangeburg County)	15	79.3%	*4*
Medical University (Charleston County)	23	76.8%	
Morris Village (Richland County)	173	74.5%	*4*
Palmetto Center (Florence County)	48	63.9%	*4*
Palmetto Lowcountry Behav. Health (Charleston County)	10	36.6%	*6*
Palmetto Richland Springs (Richland County)	10	84.2%	
Roper North (Charleston County)	44	12.6%	
Self Memorial (Greenwood County)	24	0.0%	
Springs Memorial (Lancaster County)	45	35.4%	
Three Rivers Behav. Health (Lexington County)	27	17.5%	*7*
TOTAL	333 (276)	21.9%	

1 Formerly Charter-Greenville; partial year of data.
2 Licensed beds decreased from 42 to 18, effective 1/27/99.
3 Formerly Coastal Carolina Hospital; facility closed 5/8/00.
4 Statewide Facility, Not Included in Bed Need Calculations.
5 Approval granted 10/22/99 to permanently close the 18 beds at Marshall Pickens.
6 Formerly Charter-Charleston.
7 Formerly Charter Rivers Hospital.

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for inpatient treatment beds. The 1999 utilization rates are used to project the need for services in 2005. An occupancy factor of 80% was used in the calculations. The greater of the service area's actual utilization or 75% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Inpatient treatment centers should be available within 60 minutes one-way automobile travel time for 90% of the service area's population. Morris Village,

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INPATIENT BED NEED

SERVICE AREA	1999 POP	2005 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	181,500	192,600	695	2.02	0.80	3	27	-24
GREENVILLE,PICKENS	374,400	402,100	2,360	6.94	0.80	9	13	-4
CHEROKEE,SPARTANBURG UNION	265,100	282,200	0	6.14	0.80	8	0	8
CHESTER,LANCASTER,YORK	199,000	218,100	5,819	17.47	0.80	22	45	-23
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	156,600	166,200	0	3.62	0.80	5	24	-19
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	504,600	539,900	5,187	15.21	0.80	19	54	-35
DARLINGTON,FLORENCE MARION	178,300	182,600	1,326	3.72	0.80	5	18	-13
CHESTERFIELD,DILLON MARLBORO	80,000	82,300	0	1.79	0.80	2	0	2
CLARENDON,LEE,SUMTER	123,800	129,500	0	2.82	0.80	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	213,800	239,400	0	5.21	0.80	7	0	7
BAMBERG,CALHOUN ORANGEBURG	93,500	95,900	0	2.09	0.80	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	150,500	167,800	0	3.65	0.80	5	0	5
BERKELEY,CHARLESTON DORCHESTER	423,300	450,200	7,558	22.02	0.80	28	77	-49
AIKEN,BARNWELL	129,800	142,600	783	3.10	0.80	4	18	-14
STATE TOTAL	3,074,200	3,291,400	23,728	95.81		124	276	-152

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Holmesview, McCord Adolescent and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed, but the bed need projections refer to two distinct treatment modes which cannot be commingled.

Additional inpatient treatment beds could be considered for the service area only if the following criteria are met:

(a) The service area shows a need for additional beds;

(b) The applicant demonstrates an unserved demand for the proposed service area; and

(c) The utilization of treatment facilities in the contiguous service areas should be considered prior to approval of additional beds. This should include occupancy rates, patient origin, scope of services offered, and patient mix.

It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

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 Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 12 inpatient treatment facilities in the state. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will

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be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(6) Narcotic Treatment Programs

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin, or any derivative or synthetic drug of that group. Opioid Maintenance Therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and non-pharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and LAAM (levo-alpha-acetylmethadol) to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client's needs. Adjunctive non-pharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider.

Narcotic treatment programs have the following characteristics:

(a) Linkage with or access to psychological, medical and psychiatric consultation;

(b) Linkage with or access to emergency medical and psychiatric affiliations with more intensive levels of care, as needed;

(c) Linkage with or access to evaluation and ongoing primary medical care;

(d) Ability to conduct or arrange for appropriate laboratory and toxicology tests; and

(e) Availability of physicians to evaluate, prescribe, and monitor use of methadone or LAAM, and of nurses and pharmacists to dispense and administer methadone or LAAM.

(f) An interdisciplinary team of appropriately trained and credentialed addiction professionals, including a medical director, counselors, and the medical staff delineated below;

(g) Licensed medical, nursing, or pharmacy staff, who are available to administer medications in accordance with the physicians's prescription or orders. The intensity of nursing care is appropriate to the services provided by an outpatient treatment program that uses methadone or LAAM; and

(h) A physician, who is available during medication dispensing and clinic operating hours, either in person or by telephone.

(i) Interdisciplinary individualized assessment and treatment;

(j) Assessing, prescribing, administering, reassessing and regulating dose levels appropriate to the individual; supervising detoxification from opiates, methadone or LAAM; overseeing and

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facilitating access to appropriate treatment, including medication for other physical and mental health disorders;

(k) Monitored urine testing;

(l) Counseling services;

(m) Case management; and

(n) Psychoeducation, including HIV/AIDS and other health education services.

INVENTORY

Facility	Location	Clients or CON
Center for Behavioral Health South Carolina	North Charleston	233
Charleston Center	Charleston	197
Columbia Metro Treatment Center, Inc.	West Columbia	207
Greenville Metro Treatment Center, Inc.	Greenville	252
Piedmont Treatment Center, Inc.	Greenville	325
Southwest Carolina Treatment Ctr.	Anderson	10/22/01
York County Treatment Center, Inc.	Fort Mill	193

The table on the following page indicates the number of clients as of December 31, 1999, by county/state of residence being served by methadone centers, and the number of emergency room visits for opiod and cocaine dependence for calendar year 1999.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is required for a methadone treatment facility. A Certificate of Need for a methadone treatment facility will not be approved until licensure standards for these facilities are promulgated by the Department, in accordance with the Administrative Procedures Act. The licensure standards will include standards for the location of these facilities within the community. Once these licensure standards are promulgated, the Department will review applications for these facilities under Regulation No. 61-15, Certification of Need for Health Facilities and Services.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

This section will not be developed until after licensure standards for these facilities are promulgated by the Department.

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METHADONE CLIENTS SERVED BY COUNTY AND
EMERGENCY ROOM VISITS FOR OPOID DEPENDENCE
BY COUNTY OF RESIDENCE OF CLIENTS

COUNTY	Methadone Centers	Emergency Room Visits
Abbeville		1
Aiken		6
Allendale		0
Anderson	35	3
Bamberg		0
Barnwell		1
Beaufort	4	5
Berkeley	28	2
Calhoun	3	0
Charleston	338	17
Cherokee		0
Chester	4	0
Chesterfield	2	0
Clarendon		0
Colleton	6	0
Darlington		1
Dillon		0
Dorchester	15	0
Edgefield		0
Fairfield	2	0
Florence	24	4
Georgetown	10	1
Greenville	194	9
Greenwood	10	1
Hampton		0
Horry	15	8
Jasper	2	0
Kershaw	10	3
Lancaster	30	2
Laurens	20	0
Lee		0
Lexington	69	7
McCormick		0
Marion		0
Marlboro	3	1
Newberry	7	1
Oconee	4	4
Orangeburg	8	1
Pickens	30	1
Richland	77	14
Saluda	2	0
Spartanburg	100	9
Sumter	9	1
Union	8	1
Williamsburg	3	0
York	69	4
NC	207	
GA	12	
Other states	72	6
Unknown	5	
TOTAL	1432	114

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5. Rehabilitation Facilities

OVERVIEW

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision of (1) medical evaluation and services and (2) psychological, social, and/or vocational evaluation and services. The current concept of a rehabilitation facility is one in which the disabled person is assisted through an integrated program conducted by a team of specialized personnel representing several professional disciplines, under the direction of a person licensed to practice medicine or surgery in the State.

According to the American Medical Association (AMA), rehabilitation services are most effective when delivered in comprehensive medical rehabilitation units or centers located in either short-stay hospitals or freestanding facilities, where inpatients with severe disabilities receive medical, nursing, restorative and personal adjustment services in an integrated rehabilitation program. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with such physical impairments as stroke, spinal cord injury, head injury, multiple sclerosis and other neuromuscular diseases, arthritis, chronic pain, amputations, hip and pelvis fractures, and childhood birth defects and injuries are typical clients.

Patients requiring this level of care should be able, based on interdisciplinary evaluation, to participat fully in the therapies, practice sessions, and other activities provided and to benefit from such therapies. Along with the capacity to endure the intensity of service offered, the individual must be emotionally ready to participate in and accept the treatment plan developed for his/her rehabilitation.

Rehabilitation facilities should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. It may be beneficial to utilize the services of, or effect a cooperative plan with, present medical and vocational centers when establishing a rehabilitation facility. Where separate freestanding facilities are established, the employees representing the professional fields mentioned above should be provided on a full-time basis.

Physical rehabilitation services which involve a single service such as physical therapy, occupational therapy, speech therapy, or recreation therapy, and outpatient rehabilitation services without the involvement of a formal interdisciplinary program, are provided by most general hospitals, nursing homes, home health agencies, and outpatient rehabilitation centers.

In addition, several hospitals have received approval to consolidate their therapy services into a single unit to improve the coordination of rehabilitative care for acute patients in their facilities. While these facilities provide a more coordinated and possible higher degree of care than in hospitals with indecent single services, these hospitals are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan. The consolidation of rehabilitative therapies is intended to improve the quality of care for patients currently being treated in the facility.

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is not intended to allow hospitals to market themselves or advertise as offering comprehensive rehabilitation. Hospitals, which have received permission to consolidate their rehabilitation services into a distinct unit, include Colleton Regional Hospital and Tourney Hospital.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	1999 Occupancy	
I	Roger C. Peace	Greenville	53	75.5%	*1*
I	St. Francis	Greenville	19	82.5%	
I	Mary Black	Spartanburg	18	94.6%	
II	HealthSouth	Richland	96	82.1%	*2, 3*
II	Piedmont Med. Ctr.	York	20	—	*2*
III	HealthSouth	Florence	88	81.5%	
III	Carolinas Hospital	Florence	24	71.0%	
III	Waccamaw Neck	Georgetown	19	—	*4*
IV	Beaufort Memorial	Beaufort	14	—	*5*
IV	HealthSouth	Charleston	42	88.5%	*6*
IV	M.U.S.C.	Charleston	25	83.3%	
IV	Roper Hospital	Charleston	39	83.7%	
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	—	*7*
		Total	481		

1 CON issued 4/23/98 to transfer 3 beds from Greenville General to Roger C. Peace. The remaining 11 beds at Greenville General were de-licensed 1/14/99.

2 CON issued 5/27/97 to establish a 20 bed unit at Piedmont Medical Center by transferring 12 beds from HealthSouth-Columbia and adding 8 additional beds.

3 CON issued 9/25/00 to replace 12 beds transferred to Piedmont Medical Center and add 7 additional beds for a total of 96 beds; licensed for 89 beds 10/12/00.

4 CON issued 5/26/00 to create a 19 bed rehabilitation unit at Waccamaw Neck Hospital.

5 CON issued 12/12/00 for a 14 bed rehabilitation unit, licensed 8/28/01.

6 CON issued 10/26/98 to add 3 additional beds, from 36 to 39 beds; licensed 11/23/98. CON issued 6/8/00 to add 3 additional beds, from 39 to 42 beds.

7 CON issued 4/4/00 for a 24 bed rehabilitation unit.

STATEWIDE PROGRAMS

S.C. Vocational Rehabilitation Center, in West Columbia, has 30 beds. This facility is operated by the S.C. Vocational Rehabilitation Department to serve the vocational training needs of the disabled, and should be expanded to 44 beds to better enable VRD to served their statewide client caseload.

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CERTIFICATE OF NEED STANDARDS FOR REHABILITATION

DEFINITIONS

"Disabled person" is an individual who has a physical or mental condition which, to a material degree, limits, or if not corrected, will probably result in limiting, the individual's performance or activities to the extent of constituting a substantial physical, mental, or vocational handicap.

"Medical service" means a service under the direct personal supervision of a medical director, varied and extensive availability of specialized medical consultants, and other evaluation and therapy services suitable to the needs of the disabled persons to be served.

"Psychological service" means evaluation and services by a qualified psychologist in amounts and variety appropriate to the needs of the disabled persons to be served.

"Social service" means evaluation and services by a qualified social worker in amounts and variety appropriate to the needs of the patients to be served.

"Vocational service" means a variety of vocational services appropriate to the program and persons to be served, such as pre-vocational exploration, work evaluation, and vocational training.

STANDARDS

The need for rehabilitation beds is calculated based on 12 service areas as defined on the following page. An occupancy factor of 70% was used to calculate projected bed needs. The greater of the service area's actual utilization or the statewide use rate was used to project bed needs. This information is current as of October 1, 2001.

Due to the low utilization of existing hospital beds, consideration should be given to the conversion of existing beds to rehabilitation beds rather than to the construction of new facilities and/or beds.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

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Rehabilitation facilities are now located throughout the state and are available within approximately ninety (90) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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REHABILITATION BED NEED

SERVICE AREA	1999 POP	2005 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCES
ANDERSON, OCONEE	225,800	239,200	0	19.89	0.70	28	0	28
GREENVILLE, PICKENS	465,600	498,300	19,992	58.62	0.70	84	72	12
CHEROKEE, SPARTANBURG, UNION	329,900	350,600	6,213	18.09	0.70	26	18	8
CHESTER, LANCASTER, YORK	248,600	272,700	0	22.67	0.70	32	20	12
ABBEVILLE, EDGEFIELD, GREENWOOD, LAURENS, MCCORMICK, SALUDA	198,000	209,700	0	17.43	0.70	25	0	25
FAIRFIELD, LEXINGTON, NEWBERRY, RICHLAND	577,300	616,300	26,673	78.01	0.70	111	96	15
CHESTERFIELD,DARLINGTON, DILLON, FLORENCE, MARION, MARLBORO, WILLIAMSBURG	365,600	373,700	32,399	90.73	0.70	130	112	18
CLARENDON, KERSHAW, LEE, SUMTER	210,300	221,400	0	18.41	0.70	26	0	26
GEORGETOWN, HORRY	229,600	259,900	0	21.61	0.70	31	19	12
AIKEN,ALLENDALE,BAMBERG, BARNWELL, CALHOUN, ORANGEBURG	298,200	317,100	0	26.36	0.70	38	24	
BEAUFORT, COLLETON, HAMPTON, JASPER	178,200	198,300	0	16.49	0.70	24	14	10
BERKELEY, CHARLESTON, DORCHESTER	541,000	573,400	32,097	93.20	0.70	133	106	27
STATE TOTAL	3,868,100	4,130,600	117,374	481.52		688	481	207
STATE USE RATE	0.0303441							

6. Long Term Care Facilities and Services

A. Nursing Homes:

Nursing homes provide inpatient care for convalescent or chronic disease patients who require nursing care and related medical services, in which such nursing care and medical services are prescribed by, or are performed under the general direction, of persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. For more specific detail, refer to the Department's Standards for Licensing Nursing Homes.

For existing licensed nursing homes, bed capacity is considered to be the number of licensed beds or the number of beds approved under the Certificate of Need program regardless of oversize room construction. The number of beds counted in any patient room is the maximum number for which adequate square footage is available. These minimums are: 100 square feet in single rooms; and 80 square feet per bed in multi-bed rooms. Only the net usable space in the room is considered. Space in the toilet rooms, wash rooms, closets, vestibules, and corridors is not counted.

The following items should be noted regarding the inventory of long-term care facilities:

(1) Restricted usage facilities (federal and institutional) are counted as statewide facilities and not counted in the region located.

(2) Patient days and admissions are as reported by the nursing home.

(3) Existing beds are counted based upon the greater of licensed or survey capacity. Survey beds refer to the capacity; the survey beds do not exceed the licensed beds unless a Certificate of Need has been issued for an increase in the number of beds. The footnotes in the inventory explain any changes. Community residential care beds are not included.

(4) The beds included in the inventory have been classified for planning purposes as conforming or nonconforming. This classification is based on U.S. Public Health Service standards of plant evaluation and an actual on-site survey of each facility and updated as changed by construction and/or modernization.

(5) The standards used in this survey are basically the same for general hospitals and nursing homes. Such standards include:

(a) Fire-resistivity of each building;
(b) Fire and other safety factors of each building;
(c) Bed capacity and evaluation of nursing units, including:

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(1) Availability of nurses' call system;
(2) Adequacy of bed space;
(3) Patient rooms; grade level or above;
(4) Availability of outside windows in patient rooms;
(5) Availability of direct access to a corridor for each patient room;
(6) A minimum corridor width of eight (8) feet;
(7) Availability of a nurses' station within 120 feet of each patient room unless the alternative standard of 150 feet has been approved;
(8) Adequate toilet, bedpan, bath or handwashing facilities in each patient unit; and
(9) Maximum capacity of four (4) beds per patient room.

(d) Design and structural factors affecting the function of service departments, including:

(1) Dietary department;
(2) Dining, recreation and day room space;
(3) Rehabilitation services (for facilities in excess of 100 beds only)
(4) Laundry and linen department.

The nursing home bed need methodology developed and used in the Plan is derived from a factor of 39.33 beds per thousand population age 65 and over by county. This factor was selected after detailed analysis of the method outlined in the Public Health Service health grants manual 23-2 as amended; the South Carolina Projected Use Rate method, previously approved by the Department of Health, Education, and Welfare (HEW); and several other methodologies. These beds are generally used by the (noninstitutional) population age 65+. In an effort to give more equitable distribution of beds throughout the State, these needs are developed by county.

This methodology factored in the utilization from the South Carolina Community Long Term Care Project (CLTC) regarding client utilization of nursing homes. This project provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing home placement under the Medicaid program.

Therefore, the ratio of 39 beds/1000 population age 65 and over was selected as the appropriate number of nursing home beds for 2003. There are currently 298 additional nursing home beds approved and either under construction or development.

A two-year projection, through 2003, of the nursing home bed need for the general (noninstitutional) population is used for the following reasons:

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(1) There is a shortage of Title XIX (Medicaid) funding in the state. Approximately 67% of all patients in nursing homes are financed by Medicaid.

(2) The state has limited resources to invest in meeting the long-term care needs of its population. The Long Term Care Committee of the Human Services Coordinating Council recommends that services toward home and community care should be stressed as an alternative to institutionalization.

(3) The CLTC program is operational with both Medicaid and Medicare waivers for a client assessment program to help people with disabilities find the right type of long-term care by expanding community-based services. These services include:

a. Medical Day Care
b. Personal Care
c. Respite Care
d. Home Delivered Meals
e. Transportation
f. Medical Social Services
g. Expanded Therapies
h. Mental Health Counseling

(4) Nursing homes can be developed and constructed in two years. A shorter planning horizon may lessen the potential for an over built situation in nursing home beds as alternatives are developed and funded.

There are no longer separate Federal and State standards for skilled nursing and intermediate care beds; therefore, the beds have been combined under nursing home beds.

The long-term care analyses and factor development was accomplished with the assistance of representatives of various agencies and organizations associated with long-term care.

Since the vast majority of patients utilizing nursing homes are 65 years of age or older, only this segment of the population is used in the projection of need for the general public. However, all patient days, including the under 65 population, were used to develop the bed need factor used in these methodologies.

The number of beds needed to be constructed is obtained by subtracting the number of existing beds (greater of license or survey capacity) from the bed need. In order to provide a more equitable distribution of nursing home beds throughout the State, the following policies will apply:

(1) Additional beds may be approved in counties with a positive bed need up to the need indicated.

(2) When a county has more beds than the projected need (i.e. excess beds), additional beds will not be approved.

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(3) An exception to numbers (1) and (2) above can be made for an individual nursing home to add some additional nursing home beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing home may add up to 16 additional beds to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing home must document how these additional beds will make a more economical unit(s). In no case will more than 16 additional beds be approved for a specific facility unless there is a need in the particular county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand age 65 and over by county. The number of additional nursing home beds shown as needed in a county has been adjusted for some counties based on patient origin information to allow enough nursing home beds in the county to serve the patients from the county currently residing in nursing home beds. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county. This map was current as of September 30, 2000.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating certificate of need applications for these beds or facilities:

a. Need;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing homes are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing home is located in every county, there is no justification for approving additional nursing homes or beds which are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since approximately 67% of all nursing home patients are paid for by the Medicaid Program. This Plan projects the need for nursing home beds by county. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

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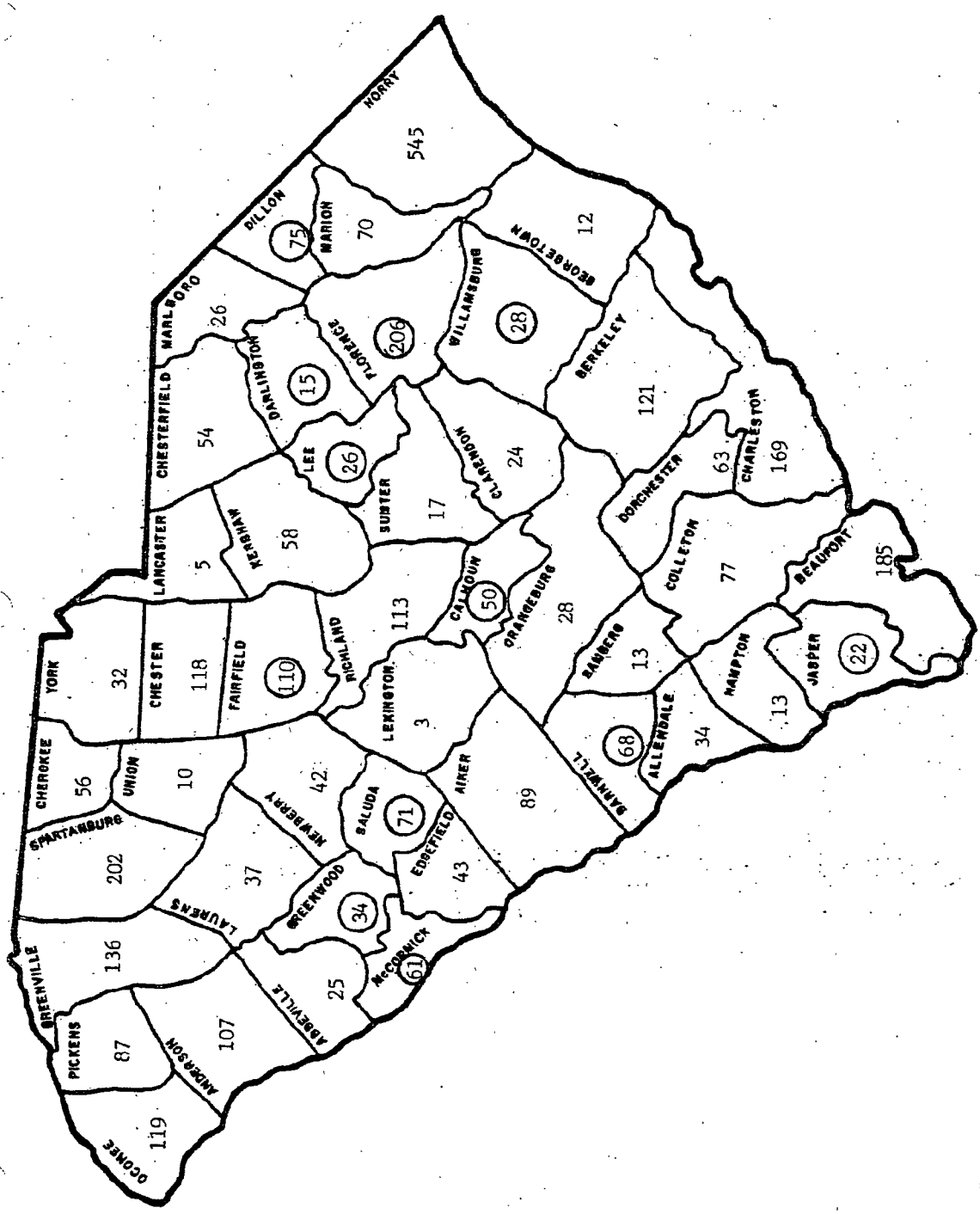
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LONG TERM CARE BED NEED		2003 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	TO BE ADDED/OR EXCESS
	ANDERSON	23.500	917	810	107
	CHEROKEE	7.000	273	217	56
	GREENVILLE	47.900	1868	1732	136
	OCONEE	9.500	371	252	119
	PICKENS	13.100	511	424	87
	SPARTANBURG	36.100	1408	1206	202
	UNION	5.000	206	196	10
REGION I	TOTAL	142.100	5554	4837	717
	ABBEVILLE	3.300	141	116	25
	CHESTER	5.600	218	100	118
	EDGEFIELD	2.400	131	88	43
	FAIRFIELD	3.900	152	262	-110
	GREENWOOD	8.600	335	369	-34
	KERSHAW	6.900	294	236	58
	LANCASTER	7.500	293	288	5
	LAURENS	10.300	402	365	37
	LEXINGTON	21.200	827	824	3
	MCCORMICK	1.500	59	120	-61
	NEWBERRY	5.600	318	276	42
	RICHLAND	30.800	1201	1088	113
	SALUDA	2.700	105	176	-71
	YORK	19.100	745	713	32
REGION II	TOTAL	129.400	5221	5021	476
	CHESTERFIELD	6.800	265	211	54
	CLARENDON	4.400	176	152	24
	DARLINGTON	9.000	351	366	-15
	DILLON	3.400	133	208	-75
	FLORENCE	15.100	589	795	-206
	GEORGETOWN	6.500	254	242	12
	HORRY	31.300	1221	676	545
	LEE	2.400	94	120	-26
	MARION	4.700	250	180	70
	MARLBORO	3.700	144	118	26
	SUMTER	11.400	445	428	17
	WILLIAMSBURG	3.800	148	176	-28
REGION III	TOTAL	102.500	4070	3672	748
	AIKEN	20.700	807	718	89
	ALLENDALE	2.000	78	44	34
	BAMBERG	2.400	101	88	13
	BARNWELL	2.600	101	169	-68
	BEAUFORT	15.800	616	431	185
	BERKELEY	11.200	437	316	121
	CALHOUN	1.800	70	120	-50
	CHARLESTON	37.400	1459	1290	169
	COLLETON	4.900	224	147	77
	DORCHESTER	8.900	347	284	63
	HAMPTON	3.000	117	104	13
	JASPER	1.700	66	88	-22
	ORANGEBURG	10.700	444	416	28
REGION IV	TOTAL	123.100	4867	4215	792
GRAND TOTAL		497.100	19712	17745	2733

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COUNTY	2003 POP	NURSING BEDS	BEDS/M	RANK
CHESTER	5.600	100	17.86	1
HORRY	31.300	676	21.60	2
ALLENDALE	2.000	44	22.00	3
OCONEE	9.500	252	26.53	4
BEAUFORT	15.800	431	27.28	5
BERKELEY	11.200	316	28.21	6
COLLETON	4.900	147	30.00	7
CHEROKEE	7.000	217	31.00	8
CHESTERFIELD	6.800	211	31.03	9
MARLBORO	3.700	118	31.89	10
DORCHESTER	8.900	284	31.91	11
PICKENS	13.100	424	32.37	12
SPARTANBURG	36.100	1206	33.41	13
KERSHAW	6.900	236	34.20	14
ANDERSON	23.500	810	34.47	15
CHARLESTON	37.400	1290	34.49	16
CLARENDON	4.400	152	34.55	17
HAMPTON	3.000	104	34.67	18
AIKEN	20.700	718	34.69	19
ABBEVILLE	3.300	116	35.15	20
RICHLAND	30.800	1088	35.32	21
LAURENS	10.300	365	35.44	22
GREENVILLE	47.900	1732	36.16	23
BAMBERG	2.400	88	36.67	24
EDGEFIELD	2.400	88	36.67	25
GEORGETOWN	6.500	242	37.23	26
YORK	19.100	713	37.33	27
SUMTER	11.400	428	37.54	28
MARION	4.700	180	38.30	29
LANCASTER	7.500	288	38.40	30
LEXINGTON	21.200	824	38.87	31
ORANGEBURG	10.700	416	38.88	32
UNION	5.000	196	39.20	33
DARLINGTON	9.000	366	40.67	34
GREENWOOD	8.600	369	42.91	35
WILLIAMSBURG	3.800	176	46.32	36
NEWBERRY	5.600	276	49.29	37
LEE	2.400	120	50.00	38
JASPER	1.700	88	51.76	39
FLORENCE	15.100	795	52.65	40
DILLON	3.400	208	61.18	41
BARNWELL	2.600	169	65.00	42
SALUDA	2.700	176	65.19	43
CALHOUN	1.800	120	66.67	44
FAIRFIELD	3.900	262	67.18	45
MCCORMICK	1.500	120	80.00	46
	497.100	17785	35.78	

Medicaid Nursing Home Permits

Beginning July 1, 1988, nursing homes which wish to continue to serve Medicaid patients must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing home may provide, and the nursing home must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

MEDICAID PATIENT DAYS AND MEDICAID BEDS REQUESTED AND AUTHORIZED

YEAR	# DAYS REQUESTED	BEDS	# DAYS AUTHORIZED	BEDS	# DAYS DIFFERENCE
1988-1989	3,032,839	8309	2,971,811	8142	61,028
1989-1990	3,644,248	9984	3,644,248	9984	0
1990-1991	3,709,814	10163	3,659,965	10028	49,849
1991-1992	3,856,833	10567	3,659,965	10028	196,868
1992-1993	3,976,576	10895	3,806,382	10429	170,194
1993-1994	4,012,359	10993	3,856,382	10566	155,977
1994-1995	4,023,690	11024	3,892,882	10665	130,808
1995-1996	3,969,681	10876	3,892,882	10665	76,799
1996-1997	4,072,519	11158	4,002,382	10965	70,137
1997-1998	4,119,753	11287	4,097,282	11225	22,471
1998-1999	4,265,182	11685	4,265,182	11685	0
1999-2000	4,367,134	11965	4,341,832	11895	25,302
2000-2001	4,420,522	12111	4,378,332	11995	42,190
2001-2002	4,473,170	12255	4,378,332	11995	94,838

NOTES: 36,500 patient days = 100 beds

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Mental Retardation Facilities

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed. Based on the known numbers of individuals in service systems as well as improved public awareness and acceptance of issues associated with mental retardation, it is believed that there are no significant numbers of citizens with mental retardation or related disabilities currently unrecognized.

The South Carolina Department of Disabilities and Special Needs is reducing the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds are being developed for those persons from the regional centers and those on the residential services waiting list. Community beds will be distributed over the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs will enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in.

Any certificate of need for mental retardation beds should not be approved unless it is supported by the South Carolina Department of Disabilities and Special Needs.

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B. Institutional Nursing Home (Retirement Community Nursing Home)

An institutional nursing home means a nursing home (established within the jurisdiction of a larger nonmedical institution) which maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program which has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

(1) The nursing home must be a part of and located on the campus of the retirement community.

(2) It must restrict admissions to campus residents.

(3) The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home" and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, the generally accepted ratio of nursing home beds to retirement beds is 1:4. This ratio appears to be high for newly established retirement centers as the new residents are not in need of nursing home care until several years later.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing Home Beds (restricted beds) are used solely by the residents of the retirement community, there is no justification for approving these types of nursing homes unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing beds or facilities.

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C. Swing Beds:

To participate in the Swing Bed Program, a Certificate of Need is not required in South Carolina. However, the hospital must be certified. The swing beds concept refers to beds in a hospital which alternate between hospital and long-term care and are occupied by long-term care patients for periods of a few days to several weeks. This concept does not refer to hospital beds being designated as nursing home beds and does not necessarily involve moving beds or patients into separate areas of the hospital.

Swing beds can be the link between inpatient acute care and home and community-based services, in a continuum of care for those patients requiring long-term care. Although the goal is to return patients to the community, this is not always possible. Should a return to the community not be possible, the swing bed hospital assists the patient and family with nursing home placement. The swing bed program improves the coordination of long-term care services within the community.

Section 1883 of the Omnibus Budget Reconciliation Act of 1987 amendments permit payment under Medicaid or Medicare for extended care services to any hospital that meet the following requirements:

-- Has a Medicare provider agreement;
-- Has fewer than 100 certified beds, excluding newborn, ICU/CCU beds, beds in certified "distinct part" SNFs and NFs, and beds in PPS-excluded distinct part psychiatric and rehabilitation units;
-- Is located in a rural (non-urbanized) region;
-- Has been granted a Certificate of Need for the provision of extended care services, if required by the State;
-- Does not have in effect a 24-hour nursing waiver;
-- Has not had a swing-bed approval that was terminated within the last two years; and
-- Meets the Skilled Nursing Facility (SNF) Conditions of Participation on resident rights, specialized rehabilitation services, dental services, social services, resident activities, discharge planning, admission, transfer and discharge rights and resident behavior and facility practices.

The Code of Federal Regulations (CFR) section 42 Subpart A, section 482.66 details other specific requirements.

In addition, hospitals that have 50-99 beds and meet the above criteria must also meet the following criteria for approval:

1. The hospital must identify and enter into a transfer agreement with all of the Medicare SNFs in the geographic region. The SNF will notify the hospital when a post-hospital SNF care bed becomes available and the date it becomes available;

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2. The hospital agrees to transfer the patient to the SNF within 5 work days (excluding weekends and holidays) of the availability date unless the patient's physician certifies that the transfer is not medically appropriate;

3. If beds are available in more than one SNF, the patient will choose the SNF to which he or she will transfer. The transfer must occur, however, within 5 work days from the day the first bed becomes available.

The following hospitals in South Carolina either meet the swing bed eligibility requirements or participate in the swing bed program:

Hospital	Swing Beds	Admissions	Patient Days	Average Census
Abbeville Co. Mem. **	18	22	213	0.6
Allendale Co. **	18	65	5133	14.1
Bamberg Co. Mem. **	24	118	2747	7.5
Barnwell Co. **	24	169	2543	7.0
Beaufort Co. Mem.	--			
B.J. Workman **	21	41	7990	21.9
Cannon Memorial **	25	36	341	9.5
Carolinas-Kingstree **	39	63	884	2.4
Carolinas-Lake City **	23	108	2907	7.9
Chester County	--			
Chesterfield Gen.	--			
Clarendon Memorial	--			
Edgefield Co. **	19	31	6099	16.7
Fairfield Memorial **	15	3	100	0.3
Hampton Regional **	10	52	1455	4.0
Hilton Head	--			
Laurens County	--			
Loris Comm.	--			
Low Country	--			
Marlboro Park	--			
Newberry Co. Mem.	--			
Saint Eugene Med. Ctr.	--			
Wallace Thompson **	12	117	2581	7.1
Wilson Medical Ctr **	24	164	7193	19.7
TOTALS	276	989	40186	110.1

** Participates in the swing bed program.

The number of swing beds listed above is the number that the hospital reported. In 1999, there were 13 hospitals participating in the swing bed program with 989 admissions and 40,186 patient days for an average length of stay of 40.6 days. The average number of patients per day in swing beds was 110.

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D. Home Health Agencies

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (c) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services, home health aide services and other therapeutic services; (c) any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing care facility, or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot be readily made available to the individual in his home, or which are furnished at such facility while the patient is there to receive such items or services, but not including transportation of the individual in connection with any such items or services.

1. Skilled Nursing services are services given in accordance with a physician's orders which require the competencies of a registered nurse and include such duties as: (a) evaluates and regularly reevaluates the nursing needs of the patient; (b) initiates the plan of treatment and coordinates the services for the patient; (c) administrators medications and treatments as prescribed by the physician; (d) provides nursing services, treatments, and diagnostic and preventive services; (e) initiates preventive and rehabilitation nursing procedures as appropriate for the patient's care and safety; (f) observes signs and symptoms, records and reports to the physician reactions to treatment, including drugs, and changes in the patient's physical and emotional condition; (g) teaches, supervises, and counsels the patient and family members regarding the nursing care needs and other related problems of the patient at home; (h) prepares clinical and progress notes; (i) supervises and trains other nursing service personnel.

2. a) The speech therapist cooperates in the evaluation of patients with speech, hearing or language disorders; on basis of orders by the physician, who indicates anticipated goals and is responsible for general medical direction of such services as part of the total care of the patient, determines and recommends appropriate speech and hearing services; provides rehabilitation services for speech, hearing and language disorders; records and reports to the physician the patients reaction to treatment and

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any changes in the patient's condition; instructs other health team personnel and family members in methods of assisting the patient to improve and correct speech, hearing and language disabilities.

b) Physical therapists assist the physician in his evaluation of patients by applying muscle, nerve, joint, and functional ability tests; treat patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means, such as exercise, massage, heat, water, light, and electricity; arrange for the provision on an outpatient basis of the above services which involve the use of equipment which cannot be made readily available in the patient's home; observes, records and reports to the physician the patient's reaction to treatment and any changes in the patient's condition; instructs patients in care and use of wheelchairs, braces, crutches, canes, and prosthetic and orthotic devices; instructs other health team personnel and family members in certain phases of physical therapy with which they may work with the patient; and instructs the family on patient's total physical therapy program.

c) The occupational therapist assists the physician in his evaluation of the patient's level of function by applying diagnostic procedures; guides the patient in his use of therapeutic, creative and self-care activities for the purpose of improving function; observes, records, and reports to the physician the patient's reaction to treatment and any changes in the patient's condition; and instructs other health team personnel and family members in certain phases of occupational therapy in which they may work with the patient;

3. Home health aides are under the supervision of a registered nurse. They provide personal care services for the patient such as helping the patient with bath, care of mouth, skin and hair; helping patient to bathroom or in using bed pan; helping patient in and out of bed, assisting with ambulation; helping patient with prescribed exercises which the patient and home health aide have been taught by appropriate professional personnel; assisting with medications, ordinarily self-administered, that have been specifically ordered by a physician; perform such incidental household services as are essential to the patient's health care at home; report to the registered nurse supervisor changes in the patient's condition or family situation; and completes appropriate records.

4. Medical social workers assist the physician and other members of the health team in understanding the significant social and emotional factors relating to the patient's health problems; assess the social and emotional factors in order to estimate the patient's capacity and potential to cope with problems of daily living; helps the patient and family to understand, accept, and follow medical recommendations and provides services planned to restore the patient to optimum social and health adjustment, assists patients and families with personal and environmental

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difficulties which predispose toward illness or interfere with obtaining maximum benefits from medical care; and utilize resources, such as family and community agencies, to assist patient to resume life in the community or to learn to live with his disability.

The average mix of home health visits by type of service during FY 1999 for the home health agencies in South Carolina were:

Total Visits	2,472,078
Nursing visits	45.0%
Home health aide visits	25.1%
Physical therapy visits	19.3%
Medical social worker visits	2.6%
Speech therapy visits	2.7%
Occupational therapy visits	4.5%
Other	0.8%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Some of the reasons for the increased demand through 1997 for home health services include: the Prospective Payment System, which encourages hospitals to reduce the average length of stay for most Medicare patients; changes in employee benefit plans which include economic incentives for home care; a greater awareness of community-based services such as home health, home-delivered meals, and adult day care; managed care and increased physician acceptance. The utilization of home health services has decreased since 1997 primarily due to the Balanced Budget Act of 1997 which cut reimbursement and the number of allowable visits.

Of the current patients receiving home health services, approximately 31% are less than age 65 and 69% are age 65 and over. There are currently 87 approved home health agencies in South Carolina. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Applications for home health agencies must comply with the following standards:

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

3. There should be documentation from physicians and discharge planners in the proposed service area substantiating the need and

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support for an additional home health agency. These need and support letters must be on letterhead and define which practice and specialty or facility the physician/discharge planner represents as well as the county from which their patient base will be drawn. They must clearly state the number of additional patients that will be referred to a new home health agency and why another home health agency is needed. The physician or discharge planner must also personally sign these letters. If there are problems with the existing agencies serving the area, the physicians and discharge planners should state the reasons.

4. The attached table indicates the counties where one additional home health agency could be approved or an existing home health agency expanded. This table is based on the number of persons served per thousand population and the projected maximum number of agencies needed per county based on the projected population (see following table). Counties that indicate a need based on the projected population and which are below 75% of the state average of people served per thousand population could accommodate one additional agency in order to assist the residents of the county in receiving services. Only these counties will be approved for an additional service. NO ADDITIONAL AGENCY WILL BE APPROVED IN THESE COUNTIES UNTIL THE APPROVED AGENCIES HAVE BEEN LICENSED AND A YEAR OF UTILIZATION DATA ARE AVAILABLE AND HAS BEEN INCORPORATED INTO THE METHODOLOGY.

MAXIMUM AGENCIES PER THOUSAND POPULATION

<30k pop. = 2 HHA's
30-50k pop. = 3 HHA's
50-75k pop. = 4 HHA's
75-125k pop. = 5 HHA's
125-175k pop. = 6 HHA's
175-225k pop. = 7 HHA's
225-275k pop. = 8 HHA's
275-325k pop. = 9 HHA's
>325k pop. = 10 HHA's

5. The applicant should have a track record of providing indigent care or a documented proposed plan for serving these patients. The applicant must provide for the past three years, the number of indigent people served, the number of indigent visits provided, the dollar amount of these services and the percentage of gross revenue devoted to indigent care. This does not include bad debt or contractual adjustments. The application must also include a pro-forma budget which contains both the dollar amount and percentage of gross revenue proposed for indigent care for the first three years of operation.

6. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of

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prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state where it operates. If licensed in another state, the name, address, and telephone number of the licensing agency and a contact person at the State Agency must be provided.

7. The applicant must document that they can serve at least 50 patients annually in each county for which they are licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to less than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county.

8. Because of the limited number of patients that would require Home Uterine Activity Monitoring and administration of tocolytic therapy that requires obstetrical staff expertise and 24 hour fetal monitoring, an exception to the above criteria may be made for a Certificate of Need for only this restricted service. Only one Certificate of Need application will be required for a home health agency that proposes to provide this specialized service for the 25 counties that currently do not have this service. The applicant must document that no other provider offers this service in the counties and that the agency will only provide services to obstetrical patients. The license for the agency will be restricted to serving obstetrical patients only.

If the license is terminated, another agency will be approved only if the methodology indicates a need for another agency.

Continuing Care Retirement Community Home Health Agencies

A licensed continuing care retirement community which also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

a. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;
b. The continuing care retirement community maintains a current license and meets applicable home health agency licensing standards;
c. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base

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contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on nonfacility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, the utilization is not counted as serving the community.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating Certificate of Need applications for this service:

a. Need;
b. Acceptability;
c. Distribution (Accessibility);
d. Medically Underserved Groups;
e. Record of the Applicant; and
f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing service.

The home health agency inventory follows. The persons served and visits are based on Home Health Agency Reports. The "cut-off" date for inclusion in the inventory was October 1, 2001.

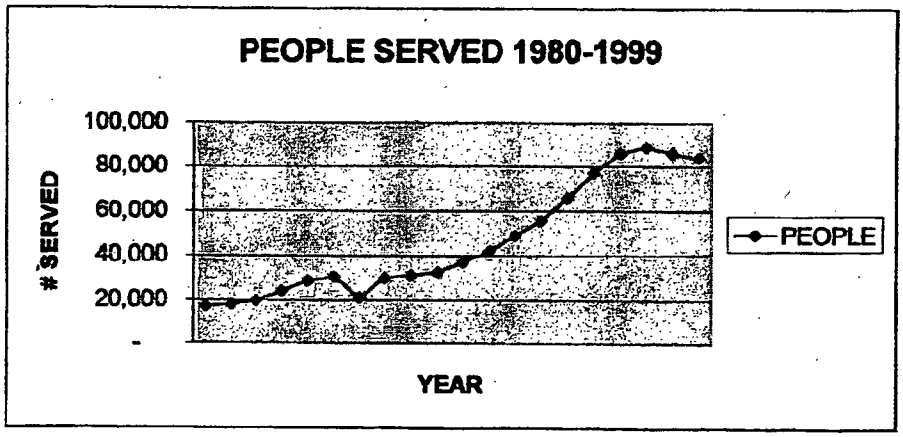
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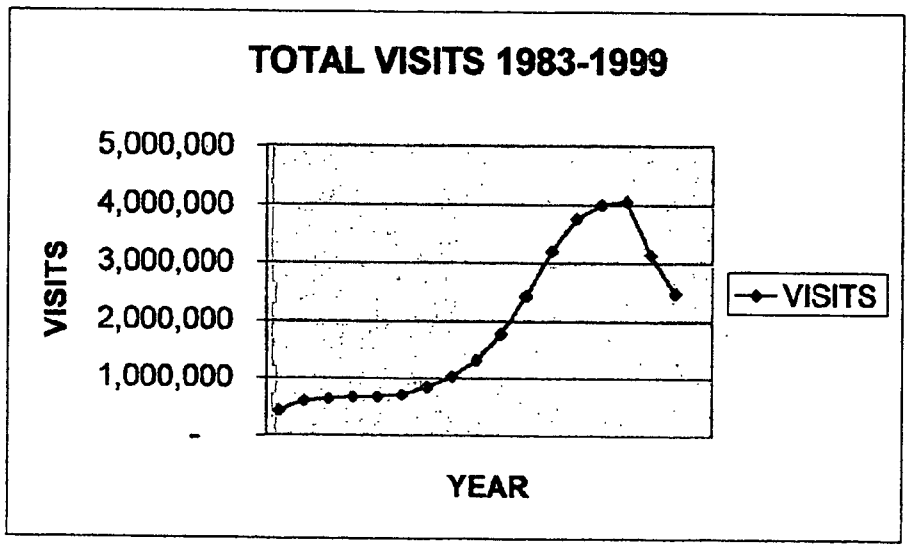
HOME HEALTH UTILIZATION, 1980-1999

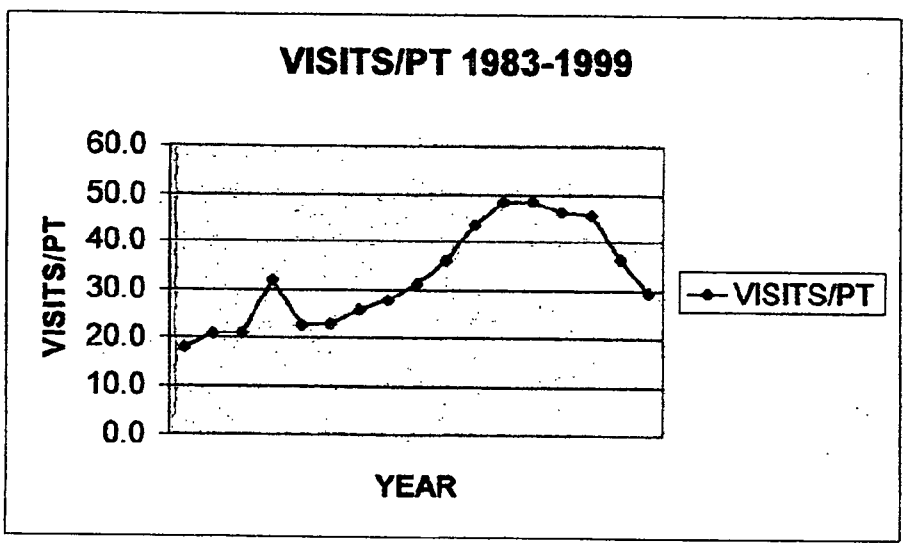
YEAR	PEOPLE SERVED	TOTAL VISITS	VISITS/ PATIENT
1980	17,120	———	———
1981	18,021	———	———
1982	19,751	———	———
1983	24,013	427,759	17.8
1984	28,511	590,657	20.7
1985	30,360	631,498	20.8
1986	21,012	672,361	32.0
1987	30,004	673,346	22.4
1988	31,230	710,756	22.8
1989	32,727	843,514	25.8
1990	36,827	1,024,177	27.8
1991	41,912	1,307,371	31.2
1992	49,035	1,767,825	36.1
1993	55,551	2,417,241	43.5
1994	65,754	3,192,689	48.6
1995	77,214	3,755,027	48.6
1996	86,070	3,995,110	46.4
1997	88,711	4,055,843	45.7
1998	86,123	3,131,997	36.4
1999	83,969	2,472,078	29.4



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HOME HEALTH AGENCIES

COUNTY OF RESIDENCE	1999 TOTAL PATIENTS	1999 POP. (000s)	PERSONS SERVED/ 1000 POP	BELOW STATE AVG.	NEW AGENCY /P 1/1/99	# OF EXIST. HHAs	NEW HHA CAN BE APPROVED
Abbeville	698	24.40	28.61	—	—	4	—
Aiken	2,373	143.00	16.59	—	—	5	—
Allendale	241	11.90	20.25	—	—	3	—
Anderson	3,159	160.50	19.68	—	—	6	—
Bamberg	444	17.40	25.52	—	—	2	—
Barnwell	420	22.60	18.58	—	—	3	—
Beaufort	2,049	102.60	19.97	—	—	6	—
Berkeley	1,668	148.60	11.22	YES	—	7	—
Calhoun	329	13.70	24.01	—	—	5	—
Charleston	7,618	303.60	25.09	—	—	9	—
Cherokee	1,140	48.60	23.46	—	—	4	—
Chester	716	33.60	21.31	—	—	3	—
Chesterfield	934	40.30	23.18	—	—	3	—
Clarendon	766	30.60	25.03	—	—	2	—
Colleton	936	38.20	24.50	—	—	6	—
Darlington	1,351	66.00	20.47	—	—	4	—
Dillon	687	30.40	22.60	—	—	4	—
Dorchester	1,388	88.80	15.63	YES	—	7	—
Edgefield	447	19.80	22.58	—	—	4	—
Fairfield	561	23.60	23.77	—	—	3	—
Florence	3,511	125.60	27.95	—	—	4	—
Georgetown	1,472	53.30	27.62	—	—	6	—
Greenville	8,034	355.30	22.61	—	—	7	—
Greenwood	1,206	63.60	18.96	—	—	5	—
Hampton	467	20.00	23.35	—	—	4	—
Horry	5,988	176.30	33.96	—	—	6	—
Jasper	563	17.40	32.36	—	—	5	—
Kershaw	1,271	48.90	25.99	—	—	3	—
Lancaster	1,287	57.00	22.58	—	—	2	—
Laurens	1,315	63.30	20.77	—	—	6	—
Lee	437	20.30	21.53	—	—	4	—
Lexington	3,738	208.10	17.96	—	—	7	—
McCormick	186	9.70	19.18	—	—	3	—
Marion	856	35.80	23.91	—	—	3	—
Marlboro	768	30.70	25.02	—	—	4	—
Newberry	621	35.70	17.39	—	—	3	—
Oconee	1,503	65.30	23.02	—	—	4	—
Orangeburg	2,024	89.60	22.59	—	—	5	—
Pickens	2,022	110.30	18.33	—	—	6	—
Richland	5,679	309.90	18.33	—	—	8	—
Saluda	340	17.20	19.77	—		4	—
Spartanburg	5,492	251.00	21.88	—	—	5	—
Sumter	1,760	110.50	15.93	YES	—	4	YES
Union	1,061	30.30	35.02	—	—	2	—
Williamsburg	904	36.80	24.57	—	—	4	—
York	2,856	158.00	18.08	—	—	4	—
TOTALS	83,286	3,868.10	21.53			208	

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HOME HEALTH AGENCIES INVENTORY-1999 DATA

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Alliance Home Care 3/	Horry	621	9371	15.1
Amedisys Home Health Inc. of S.C. 29/	Berkeley, Charleston & Dorchester	--	---	---
ANMED Home Health Agency	Anderson	1557	45561	29.3
Appalachia I Home Health Care Services	Anderson & Oconee	1055	25828	24.5
Appalachia II Home Health Services	Greenville & Pickens	2242	53495	23.9
Appalachia III Home Health Services	Spartanburg, Union & Cherokee	2231	50451	22.6
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	148	4384	29.6
Bethea Home Health 5/	Darlington (may serve retirement community only)	0	0	--
Care One Home Health Services	Beaufort, Hampton, & Jasper	1402	28190	20.1
CarePro Home Health 7/	Richland	222	14044	63.3
CareSouth Homecare Professionals, A Winyah Company-Georgetown	Georgetown & Williamsburg	111	1219	11.0
CareSouth Homecare Professionals, A Winyah Company-Columbia 22/ 18/	Lexington, Richland, Orangeburg, Calhoun, Newberry, Lee, Sumter & Edgefield	831	36330	43.7
Carolina Home Health Care 19/	Richland & Lexington	1706	43296	25.4
Carolina Home Health Care-Greenville 8/	Anderson, Oconee, Greenville, Pickens, Cherokee, Spartanburg Laurens & Union	340	8639	25.4 (may only serve patients in Union County whose initial diagnosis require IV therapy services and/or h

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uterine activity monitoring)

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Catawba Home Health Services	Chester, York & Lancaster	1721	39534	23.0
Chesterfield General Home Health	Chesterfield	156	7900	50.6
Chesterfield Visiting Nurses Services	Darlington,Marlboro & Chesterfield	298	11124	37.3
Choice Health Care Services	Colleton	89	2802	31.5
Clarendon Memorial Home Health 12/	Clarendon	210	5960	28.4
Clemson Area Retirement Center HHA	Pickens (may serve retirement community only)	36	847	23.5
(Coastal Rivers Home Health of Low Country General Hospital) 4/	Jasper	61	4440	72.8
Cypress Club Home Health Agency	Beaufort (may serve retirement community only)	43	676	15.7
(Edgefield County Hospital Home Health Services) 22/	Edgefield	103	5153	50.0
Edisto Health District Home Health Services	Bamberg, Calhoun & Orangeburg	1570	58243	37.1
Fairfield Home Health Services	Fairfield	201	6445	32.1
Florence Visiting Nurses Services	Florence, Lee, Dillon & Marion	503	24382	48.5
(Foothills Home Care) 23/	Oconee (may serve terminally ill patients only)	0	0	0.0
Franke Home Health 10/	Charleston (may serve retirement center residents only)	--	---	---
Franklin C. Fetter Home Health Agency	Charleston	8	175	21.9

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Facility	Counties Served	Number of Persons Served	Visits	Visi per Patient
(Gentiva Health Services) 24/	Fairfield, Kershaw, Richland, Newberry, Lexington, Calhoun, & Orangeburg	1115	21108	18.9
Greenville Hospital System HHA	Greenville & Pickens	2069	59972	29.0
(HealthCalls Professional Home Health Services) 29/	Berkeley, Charleston & Dorchester	404	15649	38.7
Health Related Home Care, Inc.	Abbeville, Laurens, Greenwood, Saluda & McCormick	992	19910	20.1
Hitchcock Rehabilitation Center, Inc.-HHA	Aiken	828	14434	17.4
HomeCare of HospiceCare of the Piedmont	Abbeville, Greenwood, Laurens, McCormick, & Saluda	32 (may serve terminally ill patients only)	622	19.4
Home Care of Lancaster	Lancaster	551	13195	23.9
Home Care of the Regional Medical Center	Calhoun & Orangeburg	90	2238	24.9
Home Health of S.C., Inc. - Lowcountry	Berkeley & Dorchester	439	17428	39.7
Home Health of S.C., Inc. - Midlands	Lexington & Richland	774	29883	38.6
Home Health of South Carolina, Inc.	York	1118	58094	52.0
Home Health Services of Carolinas Hospital System 16/	Darlington, Dillon, Florence, (Sumter, Lee,) Marlboro & Williamsburg	2415 (may serve terminally ill patients only in Williamsburg County)	51180	21.2
Hospice Care of the Low Country Home Health	Beaufort & Jasper	72 (may serve terminally ill patients only)	1679	23.3
Hospice of Charleston HHA	Charleston, Berkeley & Dorchester	111	2491	22.4

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Incare Home Health, Inc.	Horry & Georgetown	3592	70202	19.5
(Interim HealthCare of the Eastern Carolinas) 1/	Horry	—	---	---
Interim Healthcare of the Grand Strand, LLC A Winyah Company 1/	Horry	374	9150	24.5
(Interim HealthCare of Greater Charleston) 26/	Charleston, Jasper, Dorchester, Berkeley, Colleton, Beaufort, & Hampton	2250	54750	24.3
Interim HealthCare of Greenville	Anderson, Pickens, Spartanburg, Oconee, Greenville & Cherokee	6539	216025	33.0
Interim HealthCare, Rock Hill	York	640	24052	37.6
Island Health Care, Inc.	Beaufort	779	24934	32.0
Kershaw County Medical Center Home Health	Kershaw	689	25216	36.6
Liberty Home Care- Bennettsville 11/	Marlboro	166	15137	91.2
Liberty Home Care- Myrtle Beach 15/	Horry	227	7849	34.6
Low Country Home Health Services	Beaufort, Jasper, Colleton & Hampton	994	24814	25.0
Lower Savannah Home Health Services	Aiken, Allendale & Barnwell	875	23610	27.0
Lowman Home Health	Richland (may serve retirement community only)	44	1498	34.0
Matria Healthcare- Midlands	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	156	156 (may serve obstetrical patients only)	1.0

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Matria Healthcare-Piedmont	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg & York	157	157 (may serve obstetrical patients only)	1.0
McLeod Home Health	Florence, Dillon Darlington, Marion, & Lee	1790	65417	36.5
(Medshares Home Care of Coastal Carolina) 14/	Berkeley, Charleston Dorchester	--	---	---
Medshares Home Care of Southeastern South Carolina, Inc. 13/	Allendale, Berkeley Charleston, Colleton, Dorchester, Georgetown	817	33437	40.9
(Mercy Home Care) 27/	Horry (may serve terminally ill patients only)	46	713	15.5
NHC HomeCare - Aiken	Aiken	161	5344	33.2
NHC HomeCare-Greenwood	Greenwood	108	4686	43
NHC HomeCare-Laurens 20/	Laurens and Greenville	325	8620	26.5
Neighbors Care Home Health Agency	Chester	387	11867	30.7
Oconee Memorial Hospital HHA 6/	Anderson, Oconee & Pickens	26	216	8.3
Palmetto Health HomeCare 17/	Richland, Lexington/Bamberg	2867	79403 (may serve terminally ill patients only in Bamberg County)	27.7
Palmetto Home Health Services	Fairfield, Richland Lexington & Newberry	1818	35961	19.8
Pee Dee District Home Health Services	Dillon, Florence, Marion, Darlington, Marlboro, Chesterfield	2938	68075	23.2
PHC Home Health	Charleston	496	15334	30.9
Plan Home Health Care of Greenville 6/	Abbeville, Laurens, Greenville, (Oconee), Greenwood, (Anderson),	1050	18990	18.1

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
	& (Pickens)			
(Quality Home Health, Inc.) 28/	Beaufort	243	15440	63.5
(Roper Home Health Care) 21/	Charleston, Berkeley, & Dorchester	2722	72471	26.6
Roper-St. Francis Home Health Care 21/	Charleston, Berkeley, & Dorchester	--	---	---
Sea Island Home Health	Charleston & Colleton	332	13625	41.0
Self Memorial Hospital VNA	Abbeville, Laurens, Greenwood, Saluda & McCormick	683	10357	15.2
Spartanburg Regional Med. Center Home Health Services	Spartanburg	2465	60576	24.6
St. Francis Hospital HomeCare	Anderson, Pickens, Greenville, & Spartanburg	2499	137047	54.8
(St. Francis Xavier Home Health Care) 21/	Charleston, Berkeley & Dorchester	2346	54209	23.1
St. Joseph Home Health Care Services	Aiken, Edgefield & Barnwell	670	12440	18.6
Total Care, Inc.	York, Cherokee, Chester, & Union	1125	51110	45.4
Total Care, Inc.- Coastal	Georgetown, Horry, Williamsburg	828	51258	61.9
Tri-County Home Health Care & Services	Saluda, Richland, Lexington, & Sumter	2409	81975	34.0
Trident Home Health Services	Charleston, Berkeley, & Dorchester	1463	30026	20.5
Tuomey Home Health	Lee, Clarendon & Sumter	531 (may serve terminally ill patients only in Lee and Clarendon Counties)	13636	25.7
University Home Health -North Augusta 25/	Aiken & Edgefield	690	24786	35.9

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Upper Savannah Home Health Services	Abbeville, Laurens, Edgefield, Saluda, Greenwood & McCormick	1336	33071	24.8
(Upstate Carolina 9/ Home Health Care)	Cherokee	—	---	---
Village Home Health 2/	Greenville (may only serve residents of Rolling Green Village)	16	385	24.1
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Orangeburg, Hampton, & Colleton	732	22475	30.7
Waccamaw Home Health Services	Georgetown, Horry & Williamsburg	1882	44672	23.7
Wateree District Home Health Services	Clarendon, Lee, Kershaw & Sumter	1994	72291	36.3
Winyah Home Health Care Piedmont, LLC 24/	Fairfield, Kershaw, Richland, Newberry, Lexington, Calhoun, & Orangeburg	---	----	-
Winyah Home Health Care 26/	Georgetown, Beaufort, Williamsburg, Jasper, Charleston, Berkeley, Dorchester, Colleton, Hampton	657	24859	37.8

NOTES:

1/ Name and ownership changed, 11/4/99, now Interim Healthcare of the Grand Strand, L.L.C.

2/ Licensed to serve Rolling Green Village only, 10/21/99. Partial year of data.

3/ CON issued 1/9/98. Licensed as Alliance Home Care, 11/17/98; formerly called Loris-Conway Home Health Care.

4/ Name changed 6/1/98, formerly Medi Home Health of Low Country General Hospital. Closed 6/12/2001.

5/ Licensed to serve residents of Bethea Baptist Retirement Community campus only, 7/25/97. No patients seen during 1999.

6/ CON issued 7/9/99 to Oconee Memorial Hospital to purchase Anderson, Oconee and Pickens Counties service areas from Plan Home Health Care of Greenville. License changes effective 7/28/99.

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7/ CON issued 10/18/96. Licensed 1/7/97. Name changed 7/21/97, formerly Medi-Force Home Health. Name changed 3/12/98, formerly Health Force Home Health Care. Purchased by Advantage Health Systems, Inc., October 1998, and licensed 10/29/98.

8/ CON issued 9/22/94, to Caremark, Inc., to serve Anderson, Cherokee, Pickens, Oconee, Greenville, Spartanburg, and Union counties for patients whose initial diagnosis requires intravenous therapy services and/or home uterine activity monitoring. Licensed 1/19/95. Name changed 4/1/95, from Caremark, Inc. to Coram Alternate Site Services, Inc. Professional Home Nursing, Inc. merged with Coram, 1/17/96, and name changed to Coram Home Health Care of South Carolina, Inc. The service to Union County is now restricted to serving patients whose initial diagnosis requires intravenous therapy services and/or home uterine activity monitoring. Other counties are full service. Change in ownership and name, formerly Coram Home Care of South Carolina, Inc., 1/15/99.

9/ Formerly Karing Professional Nursing Care. CON issued to Upstate Carolina Medical Center to purchase, 5/17/95. Licensed 5/31/95. Facility closed when purchased by Interim HealthCare of Greenville, 3/1/99.

10/ Exempt from CON to serve residents of The Franke Home campus only, 8/14/00. Licensed 8/30/00.

11/ Ownership and name changed 12/31/98, formerly Comprehensive Home Health Care-Bennettsville.

12/ Clarendon Total Care licensed 2/1/97 for Clarendon County. Name changed 5/19/99, formerly Clarendon Total Care.

13/ Name changed 2/13/95; formerly Doctor's Home Health. CON issued 1/9/96, to serve Allendale County; licensed 1/29/96. Name changed 7/1/96, formerly Abbey Home Health Services. CON issued 3/3/97, to Columbia Trident to purchase Doctor's Home Health; licensed 3/14/97, and name changed to Columbia Homecare Doctors. Columbia Homecare Doctor's purchased by Medshares Home Care, Inc. and name changed to Medshares Home Care of Southeastern South Carolina, Inc., 9/1/98. Medshares Home Care of Coastal Carolina merged 4/1/99.

14/ Formerly Coastal Carolina Home Health. Columbia Homecare, Coastal Carolina purchased by Medshares, Inc. and name changed to Medshares Home Care of Coastal South Carolina, Inc., 9/1/98. Agency closed 4/1/99, when merged with Medshares Home Care of Southeastern South Carolina.

15/ Name changed 12/1/97, formerly Comprehensive Home Health Care I, Inc. Name changed 12/31/98, formerly Comprehensive Home Health Care-Myrtle Beach.

16/ CON issued 5/8/96 to serve Lee County; Name changed 4/1/96, formerly Interim Health Care/Florence. Licensed 6/20/96. Agency purchased Home Health of Williamsburg, 8/98. Agency sold Lee and Sumter Counties to CareSouth Homecare Professionals, A Winyah Company-Columbia, 9/8/99.

17/ Name changed 8/28/98, formerly Home Care Resources.

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18/ Name and ownership changed, 9/15/95, formerly Healthmaster Home Health Care, Inc.-Lexington Division. Name changed 10/28/98, formerly CareSouth-Lexington. Agency purchased Lee and Sumter Counties from Home Health of Carolinas Hospital System, licensed 9/8/99.

19/ Carolina Home Health Care, Inc. purchased by Capital CareResources of South Carolina, Inc., November 16, 1998.

20/ NHC HomeCare-Greenville closed 2/1/99 and Greenville County added to NHC HomeCare-Laurens.

21/ Consolidation of Roper Home Health Care and St. Francis Xavier Home Health Care went into effect on December 31, 1999. The remaining agency (Roper Home Health Care) is now known as Roper-St. Francis Home Health Care.

22/ Purchase of assets of Edgefield County Hospital Home Health for Edgefield County by CareSouth Homecare Professionals, A Winyah Company-Columbia, 4/4/00. Edgefield County added to license, 5/1/00.

23/ Agency closed 7/28/99, when Oconee Memorial Home Health Agency licensed.

24/ Name changed 4/24/00, formerly Olsten Health Services. Name changed to Winyah Home Health Care Piedmont, LLC, 4/23/2001; formerly Gentiva Health Services.

25/ Name changed 11/1/00, formerly Caresouth of University Hospital-North Augusta.

26/ Winyah Home Health Care purchased Interim HealthCare of Greater Charleston and incorporated license into Winyah Home Health Care license, 12/1/2000. Data listed by Winyah is only for Georgetown and Williamsburg Counties. Interim HealthCare of Greater Charleston data is reflected under Interim.

27/ Agency closed 4/19/2001.

28/ Agency closed 1/31/01.

29/ Formerly HealthCalls Professional Home Health Services, name and ownership changed, 9/13/01.

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Abbeville	Health Related Home Care, Inc.	461	9984	21.7
Abbeville	HomeCare of HospiceCare of Piedmont (te	4	91	22.8
Abbeville	Plan Home Health Care/Greenville	31	186	6.0
Abbeville	Self Memorial Hospital VNA	53	680	12.8
Abbeville	Upper Savannah Home Health	153	5216	34.1
Aiken	Hitchcock Rehabilitation Center HHA	828	14434	17.4
Aiken	Lower Savannah Home Health Services	357	10907	30.6
Aiken	Matria Healthcare-Midlands	4	4	1.0
Aiken	NHC Home Care - Aiken	161	5344	33.2
Aiken	St. Joseph Home Health Care	534	9909	18.6
Aiken	University Home Health-North Augusta	493	16540	33.5
Allendale	Lower Savannah Home Health Services	213	5328	25.0
Allendale	Medshares Home Care of Southeastern SC	1	39	39.0
Allendale	VNA of Greater Bamberg, Inc.	27	914	33.9
Anderson	AnMed Home Health Agency	1557	45561	29.3
Anderson	Appalachia I Home Health	527	12438	23.6
Anderson	Carolina Home Health Care-Greenville	0	0	0.0
Anderson	(Coram Home Care of South Carolina)	0	0	0.0
Anderson	Interim Healthcare of Greenville	912	27289	29.9
Anderson	Matria Healthcare-Piedmont	8	8	1.0
Anderson	Oconee Memorial Hospital HHA	0	0	0.0
Anderson	(Plan Home Health Care/Greenville)	22	462	21.0
Anderson	St. Francis Hospital Home Care	141	8939	63.4
Bamberg	Edisto Health District Home Health	300	11315	37.7
Bamberg	Palmetto Health HomeCare (terminal)	2	58	29.0
Bamberg	VNA of Greater Bamberg, Inc.	144	4593	31.9
Barnwell	Lower Savannah Home Health Services	305	7375	24.2
Barnwell	St. Joseph Home Health Care	83	1798	21.7
Barnwell	VNA of Greater Bamberg, Inc.	32	922	28.8
Beaufort	Beaufort-Jasper Home Health Agency	116	3909	33.7
Beaufort	CareOne Home Health Services	464	19611	42.3
Beaufort	Hospice Care of Low Country (term)	58	1417	24.4
Beaufort	(Interim Healthcare of Greater Charleston)	192	4948	25.8
Beaufort	Island Health Care, Inc.	779	24934	32.0

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Beaufort	Low Country Home Health Services	255	6881	27.0
Beaufort	Matria Healthcare-Midlands	2	2	1.0
Beaufort	(Quality Home Health, Inc.)	243	15440	63.5
Beaufort	The Cypress Club Home Health Agency (re	43	676	15.7
Beaufort	Winyah Home Health Care	0	0	0.0
Berkeley	Amedisys Home Health Inc. of S.C.	0	0	0.0
Berkeley	(HealthCalls Professional Home Health Ser	73	3022	41.4
Berkeley	Home Health of S. C., Inc.-Lowcountry	192	7277	37.9
Berkeley	Hospice of Charleston HHA	17	374	22.0
Berkeley	(Interim Healthcare of Greater Charleston)	142	3002	21.1
Berkeley	Matria Healthcare-Midlands	8	8	1.0
Berkeley	(Medshares Home Care of Coastal SC)	0	0	0.0
Berkeley	Medshares Home Care of Southeastern SC	140	6835	48.8
Berkeley	(Roper Home Health Care)	385	10288	26.7
Berkeley	Roper-St. Francis Home Health Care			
Berkeley	(St. Francis Xavier Home Health)	415	8444	20.3
Berkeley	Trident Home Health Services	304	6258	20.6
Berkeley	Winyah Home Health Care	0	0	0.0
Calhoun	CareSouth-Homecare Professionals-Cola	37	1934	52.3
Calhoun	Edisto Health District Home Health	186	6457	34.7
Calhoun	(Gentiva Health Services)	61	900	14.8
Calhoun	Home Care of Regional Medical Center	12	671	55.9
Calhoun	VNA of Greater Bamberg, Inc.	33	1101	33.4
Calhoun	Winyah Home Health Care-Piedmont	0	0	0.0
Charleston	Amedisys Home Health Inc. of S.C.	0	0	0.0
Charleston	Franke Home Health (retirement only)	Exempt 8/14/00		
Charleston	Franklin C. Fetter Home Health	8	175	21.9
Charleston	(HealthCalls Professional Home Health Ser	280	10980	39.2
Charleston	Hospice of Charleston HHA	75	1694	22.6
Charleston	(Interim Healthcare of Greater Charleston)	1524	29681	19.5
Charleston	Matria Healthcare-Midlands	8	8	1.0
Charleston	(Medshares Home Care of Coastal SC)	0	0	0.0
Charleston	Medshares Home Care of Southeastern SC	329	11661	35.4
Charleston	PHC Home Health	496	15334	30.9
Charleston	(Roper Home Health Care)	2177	58963	27.1

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Charleston	Roper-St. Francis Home Health Care			
Charleston	Sea Island Home Health	311	12511	40.2
Charleston	(St. Francis Xavier Home Health)	1699	40605	23.9
Charleston	Trident Home Health Services	719	13622	18.9
Charleston	Winyah Home Health Care	0	0	0.0
Cherokee	Appalachia III Home Health	481	11360	23.6
Cherokee	Carolina Home Health Care-Greenville	17	346	20.4
Cherokee	(Coram Home Care of South Carolina)	0	0	0.0
Cherokee	Interim Healthcare of Greenville	512	21712	42.4
Cherokee	Matria Healthcare-Piedmont	5	5	1.0
Cherokee	Total Care, Inc	130	8798	67.7
Cherokee	(Upstate Carolina Home Health Care)	0	0	0.0
Chester	Catawba Home Health	272	5171	19.0
Chester	Neighbors Care Home Health Agency	387	11867	30.7
Chester	Total Care, Inc	57	2038	35.8
Chesterfield	Chesterfield General Hospital HHA	156	7900	50.6
Chesterfield	Chesterfield VNS	199	7060	35.5
Chesterfield	Pee Dee District Home Health Services	579	10616	18.3
Chesterfield	Matria Healthcare-Piedmont	1	1	1.0
Clarendon	Clarendon Memorial Home Health	210	5960	28.4
Clarendon	Tuomey Regional Home Health (term)	22	136	6.2
Clarendon	Wateree Home Health Services	556	15102	27.2
Colleton	Choice Healthcare Services	89	2802	31.5
Colleton	(Interim Healthcare of Greater Charleston)	215	9983	46.4
Colleton	Low Country Home Health Services	328	9083	27.7
Colleton	Matria Healthcare-Midlands	2	2	1.0
Colleton	Medshares Home Care of Southeastern SC	222	10612	47.8
Colleton	Sea Island Home Health	21	1114	53.0
Colleton	VNA of Greater Bamberg, Inc.	61	1574	25.8
Colleton	Winyah Home Health Care	0	0	0.0
Darlington	Bethea Home Health (retirement area)	0	0	0.0
Darlington	Chesterfield VNS	71	2812	39.6
Darlington	Home Health Services of Carolinas Hospita	484	11316	23.4
Darlington	McLeod Home Health	412	18361	44.6
Darlington	Pee Dee District Home Health Services	384	7643	19.9

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Dillon	Florence VNS	48	2187	45.6
Dillon	Home Health Services of Carolinas Hospita	34	692	20.4
Dillon	McLeod Home Health	132	9350	70.8
Dillon	Pee Dee District Home Health Services	473	12144	25.7
Dorchester	Amedisys Home Health Inc. of S.C.	0	0	0.0
Dorchester	(HealthCalls Professional Home Health Ser	51	1647	32.3
Dorchester	Home Health of S. C., Inc.-Lowcountry	247	10151	41.1
Dorchester	Hospice of Charleston HHA	19	423	22.3
Dorchester	(Interim Healthcare of Greater Charleston)	114	4162	36.5
Dorchester	Matria Healthcare-Midlands	12	12	1.0
Dorchester	(Medshares Home Care of Coastal SC)	0	0	0.0
Dorchester	Medshares Home Care of Southeastern SC	125	4290	34.3
Dorchester	(Roper Home Health Care)	160	3220	20.1
Dorchester	Roper-St. Francis Home Health Care			
Dorchester	(St. Francis Xavier Home Health)	232	5160	22.2
Dorchester	Trident Home Health Services	440	10146	23.1
Dorchester	Winyah Home Health Care	0	0	0.0
Edgefield	CareSouth Homecare Professionals, Colum	0	0	0.0
Edgefield	(Edgefield County Hospital HHA)	103	5153	50.0
Edgefield	St. Joseph Home Health Care	53	733	13.8
Edgefield	Upper Savannah Home Health	94	1924	20.5
Edgefield	University Home Health-North Augusta	197	8246	41.9
Fairfield	Fairfield Home Health Services	201	6445	32.1
Fairfield	(Gentiva Health Services)	27	450	16.7
Fairfield	Matria Healthcare-Midlands	1	1	1.0
Fairfield	Palmetto Home Health Services	333	7461	22.4
Fairfield	Winyah Home Health Care-Piedmont	0	0	0.0
Florence	Florence VNS	285	15175	53.2
Florence	(Home Care of the Pee Dee (term))	0	0	0.0
Florence	Home Health Services of Carolinas Hospita	1676	33275	19.9
Florence	McLeod Home Health	940	25350	27.0
Florence	Pee Dee District Home Health Services	610	14510	23.8
Georgetown	CareSouth Home Care Professionals-Gtown	65	780	12.0
Georgetown	Incare Home Health	669	12981	19.4
Georgetown	Matria Healthcare-Midlands	0	0	0.0

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Georgetown	Medshares Home Care of Southeastern SC	0	0	0.0
Georgetown	Total Care, Inc - Coastal	75	3214	42.9
Georgetown	Waccamaw Home Care Services	212	4104	19.4
Georgetown	Winyah Home Health Care	451	17205	38.1
Greenville	Appalachia II Home Health	1261	21004	16.7
Greenville	Carolina Home Health Care-Greenville	156	3885	24.9
Greenville	(Coram Home Care of South Carolina)	0	0	0.0
Greenville	Greenville Hospital System HHA	1917	55566	29.0
Greenville	Interim Healthcare of Greenville	2066	65554	31.7
Greenville	Matria Healthcare-Piedmont	102	102	1.0
Greenville	NHC HomeCare-Laurens	44	1167	26.5
Greenville	Plan Home Health Care/Greenville	620	11730	18.9
Greenville	St. Francis Hospital Home Care	1970	107911	54.8
Greenville	Village Home Health, Inc.(retire only)	16	385	24.1
Greenwood	Health Related Home Care, Inc.	344	6560	19.1
Greenwood	HomeCare of HospiceCare of Piedmont (te	21	451	21.5
Greenwood	NHC Homecare-Greenwood	108	4686	43.4
Greenwood	Plan Home Health Care/Greenville	48	960	20.0
Greenwood	Self Memorial Hospital VNA	486	7723	15.9
Greenwood	Upper Savannah Home Health	220	6822	31.0
Hampton	CareOne Home Health Services	105	1825	17.4
Hampton	(Interim Healthcare of Greater Charleston)	28	1847	66.0
Hampton	Low Country Home Health Services	309	5818	18.8
Hampton	VNA of Greater Bamberg, Inc.	25	621	24.8
Hampton	Winyah Home Health Care	0	0	0.0
Horry	Alliance Home Care	621	9371	15.1
Horry	Incare Home Health	2923	57521	19.7
Horry	(Interim Healthcare of the Eastern Carolina	0	0	0.0
Horry	Interim Healthcare of the Grand Strand	374	9150	24.5
Horry	Liberty Home Care-Myrtle Beach	227	7849	34.6
Horry	Mercy Home Care (terminal)	46	713	15.5
Horry	Total Care, Inc - Coastal	650	37012	56.9
Horry	Waccamaw Home Care Services	1193	30790	25.8
Jasper	Beaufort-Jasper Home Health Agency	32	475	14.8
Jasper	CareOne Home Health Services	333	6754	20.3

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Jasper	Coastal Rivers Home Health of Low Count	61	4440	72.8
Jasper	Hospice Care of Low Country (term)	14	262	18.7
Jasper	(Interim Healthcare of Greater Charleston)	35	1127	32.2
Jasper	Low Country Home Health Services	102	3032	29.7
Jasper	Winyah Home Health Care	0	0	0.0
Kershaw	Kershaw Co. Medical Center Home Health	689	25216	36.6
Kershaw	(Gentiva Health Services)	17	288	16.9
Kershaw	Matria Healthcare-Midlands	10	10	1.0
Kershaw	Wateree Home Health Services	565	31335	55.5
Kershaw	Winyah Home Health Care-Piedmont	0	0	0.0
Lancaster	Catawba Home Health	736	14460	19.6
Lancaster	Home Care of Lancaster	551	13195	23.9
Lancaster	Matria Healthcare-Midlands	1	1	1.0
Laurens	Carolina Home Health Care-Greenville	27	1037	38.4
Laurens	(Coram Home Care of South Carolina)	0	0	0.0
Laurens	Health Related Home Care, Inc.	110	1774	16.1
Laurens	HomeCare of HospiceCare of Piedmont (te	3	36	12.0
Laurens	National Home Care of Laurens	281	7453	26.5
Laurens	Plan Home Health Care/Greenville	275	4515	16.4
Laurens	Self Memorial Hospital VNA	92	1355	14.7
Laurens	Upper Savannah Home Health	530	10412	19.6
Lee	CareSouth Homecare Professionals-Cola	12	336	28.0
Lee	Florence VNS	35	1435	41.0
Lee	(Home Health Services of Carolinas Hospit	23	237	10.3
Lee	McLeod Home Health	75	1702	22.7
Lee	Tuomey Regional Home Health (term)	0	0	0.0
Lee	Wateree Home Health Services	315	9297	29.5
Lexington	CareSouth-Homecare Professionals-Cola	119	5586	46.9
Lexington	Carolina Home Health Care, Inc.	996	26409	26.5
Lexington	(Gentiva Health Services)	73	1628	22.3
Lexington	Home Health of South Carolina, Inc.-Midla	468	17519	37.4
Lexington	Matria Healthcare-Midlands	41	41	1.0
Lexington	Palmetto Health HomeCare	628	17121	27.3
Lexington	Palmetto Home Health Services	411	7487	18.2
Lexington	Tri-County Home Health Care	1043	35483	34.0

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Lexington	Winyah Home Health Care-Piedmont	0	0	0.0
Marion	Florence VNS	135	5585	41.4
Marion	McLeod Home Health	231	10654	46.1
Marion	Pee Dee District Home Health Services	490	14631	29.9
Marlboro	Chesterfield VNS	28	1252	44.7
Marlboro	Home Health Services of Carolinas Hospita	172	5420	31.5
Marlboro	Liberty Home Care-Bennettsville	166	15137	91.2
Marlboro	Pee Dee District Home Health Services	402	8531	21.2
McCormick	Health Related Home Care	39	1021	26.2
McCormick	HomeCare of HospiceCare of Piedmont (te	2	26	13.0
McCormick	Self Memorial Hospital VNA	34	417	12.3
McCormick	Upper Savannah Home Health	113	2725	24.1
Newberry	CareSouth-Homecare Professionals-Cola	98	3851	39.3
Newberry	(Gentiva Health Services)	12	125	10.4
Newberry	Matria Healthcare-Midlands	8	8	1.0
Newberry	Palmetto Home Health Services	511	10054	19.7
Newberry	Winyah Home Health Care-Piedmont	0	0	0.0
Oconee	Appalachia I Home Health	528	13390	25.4
Oconee	Carolina Home Health Care-Greenville	27	605	22.4
Oconee	(Coram Home Care of South Carolina)	0	0	0.0
Oconee	(Foothills Home Care) (term)	0	0	0.0
Oconee	Interim Healthcare of Greenville	903	26785	29.7
Oconee	Matria Healthcare-Piedmont	0	0	0.0
Oconee	Oconee Memorial Hospital HHA	24	211	8.8
Oconee	(Plan Home Health Care/Greenville)	21	378	18.0
Orangeburg	CareSouth-Homecare Professionals-Cola	207	10255	49.5
Orangeburg	Edisto Health District Home Health	1084	40471	37.3
Orangeburg	(Gentiva Health Services)	245	6032	24.6
Orangeburg	Home Care of Regional Medical Center	78	1567	20.1
Orangeburg	VNA of Greater Bamberg, Inc.	410	12750	31.1
Orangeburg	Winyah Home Health Care-Piedmont	0	0	0.0
Pickens	Appalachia II Home Health	981	32491	33.1
Pickens	Carolina Home Health Care-Greenville	17	605	35.6
Pickens	Clemson Area Retirement Center HHA (res	36	847	23.5
Pickens	(Coram Home Care of South Carolina)	0	0	0.0

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Pickens	Greenville Hospital System HHA	152	4406	29.0
Pickens	Interim Healthcare of Greenville	674	21663	32.1
Pickens	Matria Healthcare-Piedmont	22	22	1.0
Pickens	Oconee Memorial Hospital HHA	2	5	2.5
Pickens	(Plan Home Health Care/Greenville)	33	759	23.0
Pickens	St. Francis Hospital Home Care	163	7280	44.7
Richland	CarePro Home Health	222	14055	63.3
Richland	CareSouth-Homecare Professionals-Cola	355	14254	40.2
Richland	Carolina Home Health Care, Inc.	705	16882	23.9
Richland	(Gentiva Health Services)	673	11552	17.2
Richland	Home Health of South Carolina, Inc.-Midla	306	12364	40.4
Richland	Lowman Home Health (restricted)	44	1498	34.0
Richland	Matria Healthcare-Midlands	59	59	1.0
Richland	Palmetto Health HomeCare	2237	62224	27.8
Richland	Palmetto Home Health Services	563	10959	19.5
Richland	Tri-County Home Health Care	618	21031	34.0
Richland	Winyah Home Health Care-Piedmont	0	0	0.0
Saluda	Health Related Home Care, Inc.	38	571	15.0
Saluda	HomeCare of HospiceCare of Piedmont (te	2	18	9.0
Saluda	Self Memorial Hospital VNA	18	182	10.1
Saluda	Tri-County Home Health Care	58	1977	34.1
Saluda	Upper Savannah Home Health	226	5972	26.4
Spartanburg	Appalachia III Home Health	1242	27810	22.4
Spartanburg	Carolina Home Health Care-Greenville	88	2160	24.5
Spartanburg	(Coram Home Care of South Carolina)	0	0	0.0
Spartanburg	Interim Healthcare of Greenville	1472	53022	36.0
Spartanburg	Matria Healthcare-Piedmont	19	19	1.0
Spartanburg	Spartanburg Reg Med Ctr Home Care	2465	60576	24.6
Spartanburg	St. Francis Hospital Home Care	225	12917	57.4
Sumter	CareSouth Homecare Professionals-Cola	3	114	38.0
Sumter	(Home Health Services of Carolinas Hospit	26	240	9.2
Sumter	Tri-County Home Health Care	690	23484	34.0
Sumter	Tuomey Regional Home Health	509	13500	26.5
Sumter	Wateree Home Health Services	558	16557	29.7
Union	Appalachia III Home Health	508	11281	22.2

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HOME HEALTH AGENCIES INVENTORY 1999 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Union	Carolina Home Health Care-Greenville	8	1	0.1
Union	(Coram Home Care of South Carolina)	0	0	0.0
Union	Total Care, Inc	553	23786	43.0
Williamsburg	CareSouth Home Care Professionals-Gtown	46	439	9.5
Williamsburg	Home Health Services of Carolinas Hosp (t	0	0	0.0
Williamsburg	Total Care, Inc-Coastal	175	14243	81.4
Williamsburg	Waccamaw Home Care Services	477	9778	20.5
Williamsburg	Winyah Home Health Care	206	7654	37.2
York	Catawba Home Health	713	19903	27.9
York	Home Health of South Carolina, Inc.	1118	58094	52.0
York	Interim Healthcare/Rock Hill	640	24052	37.6
York	Matria Healthcare-Piedmont	0	0	0.0
York	Total Care, Inc	385	16488	42.8
TOTAL		83969	2472078	29.4

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F. Other Services For The Elderly

1. Hospices

Hospice means a centrally administrated, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family, including but not limited to home, outpatient and inpatient services provided directly or through written agreement. Terminally ill means a medical prognosis that the individual's estimated life expectancy is less than a year.

A hospice must be primarily engaged in providing the care and services for the purposes described above. It must:

a. Make these services available as needed on a twenty-four (24) hour basis;
b. Provide these services in a manner consistent with acceptable standards of practice;
c. Provide these services to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness; and
d. Not discontinue or diminish care provided to an individual because of that individual's inability to pay for that care.

The hospice must provide for the continuity of care, whether furnished in the home, on an outpatient basis, or in an inpatient setting.

The following services must be routinely provided directly by hospice employees or volunteers:

a. Coordination of services provided by or arranged for by the hospice;
b. Maintenance of records;
c. Coordination of orientation, education and training of providers in the hospice concept;
d. Bereavement counseling and follow-up; and
e. Recruitment, selection, training and monitoring of volunteers.

The following services must be provided either directly by the hospice or through legally binding arrangements made by the hospice;

a. Nursing by or under the supervision of a registered nurse;
b. Medical social services;
c. Spiritual care by or under the supervision of clergy;
d. Home health aide;
e. Homemaker;
f. Physical therapy;
g. Provision of medical supplies; and

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h. Short-term inpatient care for pain control, symptom management or respite purposes.

Hospices must not discriminate based on age, sex, race, color, religion, source of payment, or location of patient, in the acceptance of or the provision of goods and services to patients or potential patients.

A Certificate of Need is **not** required for the establishment of a hospice program; however, hospices must be licensed by the Division of Health Licensing.

There are forty-four (44) licensed hospices with at least one licensed hospice serving every county in the state. For a list of hospices or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

2. Day Care Facilities for Adults

A Day Care Facility for Adults means a facility, for adults eighteen (18) years of age or older, which offers in a group setting a program of individual and group activities and therapies. The program is directed toward providing community-based day care services for those adults in need of a supportive setting, thereby preventing unnecessary institutionalization. The program shall provide a minimum of four (4) and a maximum of fourteen (14) hours of operation a day. A Certificate of Need is **not** required for the establishment of a Day Care Facility for Adults; however, they must be licensed by the Division of Health Licensing.

As of October 1, 2001, there are 102 licensed Day Care Facilities for Adults with 3,386 participants. The number of licensed participants (slots) by county follows. For a list of licensed facilities or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

COUNTY	SLOTS	COUNTY	SLOTS	COUNTY	SLOTS
Abbeville		Dillon	38	Marion	122
Aiken	52	Dorchester	77	Marlboro	12
Allendale	38	Edgefield	10	McCormick	
Anderson	90	Fairfield	98	Newberry	15
Bamberg		Florence	256	Oconee	50
Barnwell	22	Georgetown	102	Orangeburg	100
Beaufort	9	Greenville	202	Pickens	42
Berkeley	122	Greenwood	60	Richland	391
Calhoun		Hampton		Saluda	26
Charleston	176	Horry	134	Spartanburg	79
Cherokee	60	Jasper	48	Sumter	52
Chester	45	Kershaw	20	Union	32
Chesterfield	20	Lancaster	36	Williamsburg	32
Clarendon	112	Laurens	40	York	169
Colleton	44	Lee	15		
Darlington	60	Lexington	278		

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3. Community Residential Care Facilities

A Community Residential Care Facility is a facility which offers room and board and which provides a degree of personal assistance for a period of time in excess of twenty-four consecutive hours for two or more persons, eighteen years old or older, unrelated to the operator within the third degree of consanguinity. Included in this definition is any facility (other than a health care facility), which offers or represents to the public that it offers a beneficial or protected environment specifically for the mentally ill or drug addicted or alcoholic, or provides or purports to provide any specific procedure or process for the cure or improvement of that disease or condition. A Certificate of Need is not required for the construction of a Community Residential Care Facility; however, they must be licensed by the Division of Health Licensing.

There are 543 licensed Community Residential Care Facilities with 17,680 beds as of October 1, 2001. The number of beds by county follows. For a list of licensed facilities or to obtain licensing information, contact the Division of Health Licensing, DHEC, 2600 Bull Street, Columbia, SC 29201.

COUNTY	BEDS	COUNTY	BEDS	COUNTY	BEDS
Abbeville	43	Dillon	166	Marion	88
Aiken	622	Dorchester	295	Marlboro	89
Allendale	20	Edgefield	74	McCormick	40
Anderson	660	Fairfield	25	Newberry	80
Bamberg	72	Florence	885	Oconee	257
Barnwell	40	Georgetown	251	Orangeburg	432
Beaufort	621	Greenville	1935	Pickens	560
Berkeley	228	Greenwood	370	Richland	1328
Calhoun	18	Hampton	66	Saluda	89
Charleston	1886	Horry	770	Spartanburg	1440
Cherokee	184	Jasper	0	Sumter	476
Chester	144	Kershaw	161	Union	64
Chesterfield	196	Lancaster	158	Williamsburg	64
Clarendon	118	Laurens	503	York	794
Colleton	49	Lee	102		
Darlington	149	Lexington	1068		

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RESIDENTIAL CARE BEDS AS OF OCTOBER, 2001

COUNTY	2000 65+ POP	RESIDENTIAL BEDS	65+ BEDS/M
ABBEVILLE	3.300	43	13.03
AIKEN	19.700	622	31.57
ALLENDALE	2.000	20	10.00
ANDERSON	23.100	660	28.57
BAMBERG	2.400	72	30.00
BARNWELL	2.600	40	15.38
BEAUFORT	14.600	621	42.53
BERKELEY	10.300	228	22.14
CALHOUN	1.800	18	10.00
CHARLESTON	36.900	1886	51.11
CHEROKEE	6.800	184	27.06
CHESTER	5.600	144	25.71
CHESTERFIELD	6.700	196	29.25
CLARENDON	4.400	118	26.82
COLLETON	4.900	49	10.00
DARLINGTON	9.000	149	16.56
DILLON	3.400	166	48.82
DORCHESTER	8.600	295	34.30
EDGEFIELD	2.400	74	30.83
FAIRFIELD	3.800	25	6.58
FLORENCE	15.000	885	59.00
GEORGETOWN	6.300	251	39.84
GREENVILLE	46.500	1935	41.61
GREENWOOD	8.600	370	43.02
HAMPTON	3.000	66	22.00
HORRY	29.100	770	26.46
JASPER	1.700	0	0.00
KERSHAW	6.600	161	24.39
LANCASTER	7.400	158	21.35
LAURENS	10.100	503	49.80
LEE	2.400	102	42.50
LEXINGTON	20.000	1068	53.40
MARION	4.700	88	18.72
MARLBORO	3.700	89	24.05
MCCORMICK	1.500	40	26.67
NEWBERRY	5.400	80	14.81
OCONEE	9.100	257	28.24
ORANGEBURG	10.600	432	40.75
PICKENS	12.600	560	44.44
RICHLAND	30.300	1328	43.83
SALUDA	2.700	89	32.96
SPARTANBURG	34.700	1440	41.50
SUMTER	11.200	476	42.50
UNION	5.000	64	12.80
WILLIAMSBURG	3.800	64	16.84
YORK	18.200	794	43.63
	482.5	17680	36.64

The 2000 population is for the over age sixty-five only.
The 65+ beds per M is the number of residential care beds per thousand population.

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G. Alzheimer's Disease

Alzheimer's Disease is a degenerative, fatal neurological disease that progressively robs people of their ability to function, both physically and mentally. It affects the cells of the brain producing a diminished capacity to think, remember, reason or understand. In advanced stages of the disease, individuals are unable to perform even the simplest of daily activities. It accounts for approximately 65% of all dementias. References are made to ADRD (Alzheimer's disease and related disorders) which would include Multi-Infarct dementia, Parkinson's disease with dementia, Huntington's chorea, Creutzfeldt-Jakob disease, Pick's disease, normal pressure hydrocephalus and other dementias.

The prevalence of ADRD increases with age. It is estimated that 5-10% of the population age 65 or over have ADRD and over 30% of those age 85 or over have ADRD. This equates to approximately 62,000 people in South Carolina. The population age 65 and over is the fastest growing population segment and also the group at greatest risk for ADRD. Both the person afflicted with the disease and the caregiver are victims of the disease. Informal caregiving (unpaid care by family and friends) accounts for approximately 80% of all care provided. Alzheimer's disease has become the "Gray Plague of the 21st Century." The South Carolina Blue Ribbon Task Force on ADRD has made specific recommendations on this disease. For more information, contact the Department of Health and Human Services (DHHS), Bureau of Senior Services, P.O. Box 8206, Columbia, SC 29202.

The following recommendations are based on this report:

a. Expand outreach methods of identifying and obtaining information from ADRD individuals and their families and caregivers in order to understand and meet their needs;
b. Direct collected client information to the Alzheimer's Registry and report service and training needs to the Alzheimer's Resource Coordination Center;
c. Promote accessible home and community respite care;
d. Provide ADRD education and training opportunities for health care professionals, adult care managers and home service workers;
e. Work with the DHHS Bureau of Senior Services, to enhance the content of certified nurse aide and home health aide/ homemaker training to include current information on ADRD and the special needs of caregivers.

To respond to the growing needs of this population and to promote policies which allow greater flexibility for individual choice, it is critical to invest both in lower cost, lower technology home and community based services, as well as institutional care.

ADRD individuals are likely consumers of long term care services, as the disease process can last from 2 to 20 years, with the average

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length of 7 years duration. As the disease progresses, the burden of care rises for the caregiver, both in terms of physical care and the subsequent emotional stress of caregiving for a quasi- or totally dependent person. There are increasing cases of premature placement of the person with dementia into institutional care when the primary caregiver is no longer able to cope with the caregiving demands.

Institutional care is now, and will always be an essential part of the continuum of long term care. However, the cost to the Medicaid program for institutional services is currently more than twice the cost of long term care services delivered in a home or community based setting. Unfortunately, there are long waiting lists for institutional care as well as for home and community services, such as personal care aides and adult day care, which provide support and respite for caregivers.

To address this, the South Carolina Blue Ribbon Task Force in 1993 recommended the promotion of a comprehensive service system, with emphasis on community services in the least restrictive environment, meeting individual needs and maximizing independence.

The DHHS Bureau of Senior Services, through its Alzheimer's Resource Coordination Center, legislated in 1994, will be working in collaboration with the South Carolina Department of Health and Environmental Control and other key human service agencies to determine systemic needs, coordinate information and program development, and promote more effective service delivery for both community and institutional care settings.

H. PEOPLE WITH HIV/AIDS:

A Long Term Care Committee Report from 1996-1997 discussed persons with HIV disease and contained the following information:

1. There are barriers to maintaining persons with HIV disease in their community at a reasonable cost.
   a. There is a lack of both formal and informal supports for this population. In the latter stages of the disease, persons often have complex medical needs in addition to requiring assistance with activities of daily living.
   b. There is a lack of housing options for these persons if they do not have their own residence. The stigma associated with HIV disease may limit housing options.
   c. Caregiver burnout is often a contributing factor to being able to maintain a person with HIV disease in the community.
   d. Primarily rural areas of South Carolina lack health care providers trained in or willing to care for someone with HIV disease which limits options for home care.

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2. There are also barriers to meeting the needs of persons with HIV disease in an out-of-home setting in the community or in an institution such as a nursing care facility.
   a. There are few community settings or alternatives available to these persons.
   b. Other than hospitals, nursing homes, mental institutions or residential care facilities, there are no other institutional alternatives available.
3. The following barriers were cited concerning the availability and accessibility to nursing care facilities.
   a. The lack of available staff trained and/or willing to care for persons with HIV disease.
   b. Nursing facility operators have identified the high cost of care and the lack of financial incentives or suitable reimbursement methodologies.
   c. There is a fear of "mixing" a primarily geriatric population with other patients with HIV disease. Infection control is a concern along with the lack of age-appropriate activities for HIV patients.
   d. There may not be a large enough population of HIV patients to warrant the feasibility or investment to provide care to HIV patients.
   e. Persons with HIV disease have traditionally been resistant to institutional care and fear being "warehoused" until their death.

Recommendations as options for providing cost effective care for persons with HIV disease requiring out-of-home placement.

1. Options should be explored for recruiting trained volunteers to provide care in their homes for persons with HIV disease.
2. The benefits of an HIV designated hospice facility should be considered for South Carolina.
3. Hospitals should be encouraged to provide in-facility care to HIV patients with sub-acute care needs, as is currently done with swing bed or administrative days programs under Medicare and Medicaid.
4. Consideration should be given to piloting an HIV unit in an existing nursing care facility or hospital.

The need for HIV specific nursing home or hospital beds would have to come from the need for nursing home or hospital beds that is already projected.

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7. Rural Health Care

OVERVIEW

South Carolina is a small state, the 40th in size with the 25th largest population. Of the 46 counties in the state, the following 16 are classified as urban: Aiken, Anderson, Berkeley, Charleston, Cherokee, Dorchester, Edgefield, Florence, Greenville, Horry, Lexington, Pickens, Richland, Spartanburg, Sumter and York. The remaining counties are classified as rural. The percent of South Carolina residents living in rural areas has steadily decreased over time. In 1960, 41.2% of the population lived in urban areas, while 58.8% lived in rural areas. By 1990, 54.6% were living in urban areas, while only 45.4% lived in rural areas. Seven counties lost population between the 1980 and 1990 Censuses. Rural counties in general have a lower population density {population per square mile of land} than urban counties.

In addition to the low population density, there is often a lack of employment in rural areas, leading to an emigration of the younger population in search of employment in larger communities. In 1995, the overall unemployment rate in South Carolina was 5.1%; 5 rural counties had unemployment rates greater than 10% while only 4 had rates lower than the state average. As a result, rural counties tend to have a higher percentage of elderly residents. In 1990, 12.6% of the U.S. population was age 65 and over, the South Carolina rate was 11.4%. However, 23 counties in South Carolina had percentages higher than the national average and 19 were rural counties. Newberry County had the highest rate at 15.4%, followed by Saluda at 14.4%. At the other end of the scale, Berkeley, Dorchester, Lexington, Richland and Sumter Counties all had rates less than 10%. The elderly utilize approximately 3 times as many health services per illness than does the younger population.

Residents of rural counties tend to have fewer years of education. Between 15-20% of rural residents have less than a 9th grade education and fewer attend college than urban residents. This is correlated with income. Persons in South Carolina with a Bachelors Degree average twice as much average annual earnings compared to people with less than a 9th grade education, while the ratio for those holding Professional or Doctorate Degrees is approximately 4:1. A greater percentage of rural residents are employed in agriculture, forestry and fishing, which tend to be low-paying professions. Many workers in these jobs also do not have health insurance.

Rural hospitals tend to be smaller than urban hospitals. Of the 30 rural hospitals in South Carolina, 5 have fewer than 50 licensed beds, 13 have between 50-99 beds, 9 are between 100-149 beds, and only 3 have more than 150 beds. Diagnostic and therapeutic technology is generally less available than at urban hospitals. For example, only 19 rural hospitals have Magnetic Resonance Imaging (MRI) services available, and almost all of these rely on mobile services that are present 1-2 days per week. Only 7 offer cardiac catheterizations, 3 have Linear Accelerators for cancer treatment, and none perform open-heart surgery.

Rural counties generally have fewer physicians and other health care professionals, such as Nurse Practitioners and Physician's Assistants. The table on the following page lists the number of physicians practicing in rural counties in South Carolina. Recruitment of staff is often difficult because of the limited availability of resources and lower reimbursements. The federal government

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designates underserved areas as Health Professional Shortage Areas (HPSA's). The following rural counties are currently designated as underserved:

ENTIRE COUNTY

Abbeville	Chester	Fairfield	McCormick
Allendale	Clarendon	Hampton	Oconee
Bamberg	Colleton	Jasper	Saluda
Barnwell	Dillon	Lee	Williamsburg
Calhoun	Edgefield	Marlboro	

PARTIAL COUNTY

Beaufort	Darlington	Marion	Union
Chesterfield	Lancaster	Orangeburg	

Rural hospitals typically have a higher Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. The Prospective Payment System (PPS) automatically assumes that hospitals in rural areas will not experience the labor costs for health personnel services as urban hospitals do. Therefore, the wage index component of the formula for each Diagnostic Related Group (DRG) has a smaller wage allowance for rural hospitals.

Overall, rural hospitals have smaller markets from which to attract patients, a limited local tax base, their utilization of inpatient services continues to decrease, while their patient mix is increasingly composed of the elderly, who are covered by Medicare. The lack of specialized personnel and the inability to obtain new technologies prevent rural hospitals from providing specialized services which might increase their revenue. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

In January, 1998, the Governor appointed an 18-member Health Care Advisory Committee to make recommendations to improve access to care for underserved rural areas of the state. The following 12 counties were identified as the most medically underserved: Allendale, Bamberg, Calhoun, Clarendon, Dillon, Fairfield, Hampton, Jasper, Lee, Marion, Marlboro, McCormick and Williamsburg. Among the committee's recommendations were the following:

1) Develop and submit a planning grant to the Robert Wood Johnson Southern Rural Access Program to improve access to care for Marlboro and Dillon Counties;

2) Explore the inclusion of the Volunteers in Medicine concept in the Low Country Network;

3) Provide cultural competence training for health care providers and integrate into student experiences;

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4) Explore the use of volunteers in locum tenens programs as preceptors to advanced local practitioners and students in training;

5) Increase the number of minority practitioners in primary care practices in rural settings; and

6) Establish a funding strategy for incentives for rural providers to work with students and participate in community projects.

CRITICAL ACCESS HOSPITALS

The federal Balanced Budget Act of 1997 created the "Medicare Rural Hospital Flexibility Program, which allows states the option of designating Critical Access Hospitals (CAH's). Participating facilities are allowed to function as facilities eligible for Medicare Part A, cost-based reimbursement, without having to meet all of the staffing criteria for full-service acute care hospitals. These rural hospitals provide outpatient and short-term inpatient hospital care on an urgent or emergency basis, then release patients or transfer them to a full-service hospital. These limited service hospitals are intended to provide essential health services to rural communities; because of the special allowances for staffing and reimbursement, converting a struggling rural hospital to a CAH can allow a community to maintain local health access which would otherwise be lost.

There are a number of criteria which must be met in order for a facility to qualify as a CAH:

1) It must be an existing Public or Not-for-Profit facility in a rural county. The program does not allow the construction of new facilities; for-profit hospitals and those located in urban counties are ineligible;

2) The facility must be part of a rural health network with at least 1 full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or be certified by the State as being a necessary provider of health care services to residents of the area;

4) The maximum number of licensed beds is 15, unless the hospital participates in the Swing-Bed Program. In this case, the facility may be licensed for up to 25 inpatient beds, but no more than 15 can be used at any one time for acute care;

5) Required services include: inpatient care, emergency care, laboratory and pharmacy;

6) Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes;

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7) The medical staff must consist of at least 1 physician. Staffing must include nursing on a 24-hour basis; other staffing can be flexible. Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists can provide inpatient care without their supervising physician(s) being on-site.

8) Patient length of stay is limited to no more than 96 hours (4 days), except under emergency conditions.

The impact of the Critical Access Hospital Program in South Carolina would essentially be a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH would not require a change in the licensing of an existng hospital. However, a hospital may be required to de-license a number of beds in order to meet the program's 15/25 bed requirement.

Based on their Average Daily Census (ADC), the following hospitals in South Carolina could potentially participate in the CAH program:

Hospital	# Acute Beds	# Swing Beds	1997 ADC	1998 ADC	1999 ADC
Abbeville Memorial	52	24	10.6	12.2	14.1
Allendale County	36	18	6.5	6.0	4.7
Barnwell County	53	22	15.0	12.0	12.1
Fairfield County	33	6	11.3	10.4	11.9
Hampton Regional	68	10	5.8	6.1	8.7
Low Country General	31	0	7.7	7.8	7.2

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 the number of licensed beds in order to meet the criteria for a CAH. Should a hospital later desire to revert back 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.

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8. Long-Term Care Hospitals

Section 42 Code of Federal Regulations 412.23(e) defines the requirements for a Long Term Care (LTC) Hospital. Long term care hospitals provide diagnostic and medical treatment or rehabilitation to patients with chronic diseases or complex medical conditions with an average stay of 25 days or longer. Due to their extended illnesses, these patients would have exhausted their DRG benefits and would be considered outlier cases. Although these patients are no longer in need of general acute care, they still require extensive lengths of stay in a setting which can provide highly skilled nursing, therapy, and medical treatment. The LTC hospital provides a level of care designed to minimize secondary medical conditions prior to discharge to nursing facilities, outpatient rehabilitation, or home health services. Long term care hospitals are exempt from the Prospective Payment System (PPS) and are reimbursed based on allowable costs. They must have a Medicare provider agreement to participate as a hospital and must maintain a minimum 25-day average length of stay.

Examples of the type of conditions that fall into this category are strokes, cardiac care, HIV, ventilator dependency, general debilitation, wound care, respiratory infections, and post-surgical care. These patients are medically complex, often requiring life support and/or extended ICU care. Required intensive support services may include invasive monitoring, cardiac telemetry, transfusion therapy, dialysis, central line placement, nutritional support, hemodynamic monitoring, and ancillary support services. Targeted physician specialties include: Internal Medicine, Physical Medicine, Orthopedic Surgery, Pulmonology, Radiology, Nephrology, Oncology, and Gastroenterology.

A LTC hospital may either be a freestanding facility, or may occupy space in a building also being used by another hospital or in one or more buildings located on the same campus as buildings being used by another hospital {"the host facility"}. By locating within an existing hospital, they avoid the construction costs of a new facility while optimizing use of underutilized space in the host facility. Hospitals must meet additional Federal criteria in order to qualify as a LTC Hospital located in a building used by another hospital {"hospital-within-a-hospital"}:

1) The new hospital must have a governing board, which is distinct and separate from the governing body of the host hospital. In addition, the new board cannot be under the control of the host hospital or any entity that controls the host hospital.

2) The LTC hospital must have a separate CEO and administrative structure with no contract or affiliation with the host facility.

3) The hospital must have a separate Chief of Staff who reports directly to the governing board and is responsible for all medical staff activities. The Chief of Staff cannot be under contract with the host hospital or an affiliated organization.

4) There must be a separate and distinct medical staff directly to the governing board.

In addition, the LTC Hospital must demonstrate that it is organizationally and functionally separate from the host facility. This can be met in any of three ways:

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1) The Basic Hospital Services Rule – The LTC hospital performs basic hospital functions such as Quality Assurance, Medical Staff, Nursing Services, Medical Records, Pharmacy, Radiology, Lab, Utilization Review, and Infection Control through its own employees or via contracts with entities other than the host hospital or a third entity controlling both facilities. The LTC hospital can only contract with the host hospital for food and dietary services, maintenance, housekeeping, and other services necessary to maintain a clean and safe physical environment.

2) The 15 % Rule – The cost of the services provided by the host hospital or controlling entity do not exceed 15% of the LTC hospital's total inpatient operating costs {as defined in the federal regulations}.

3) The 75% Rule – At least 75% of the inpatient population of the LTC hospital were referred there from a source other than another hospital occupying space in the same building or on the same campus.

There are currently four LTC hospitals in South Carolina:

1) Spartanburg Hospital for Restorative Care, a freestanding facility affiliated with Spartanburg Regional Medical Center, has 97 beds with a 1999 occupancy rate of 3.3%.

2) InterMedical Hospital of South Carolina, located within Palmetto Baptist Medical Center in Columbia, is licensed for 35 beds with a 1999 occupancy rate of 14.8%.

3) A CON was issued on 1/20/00 to establish Nextcare Specialty Hospital, a 28 bed facility affiliated with Carolinas Hospital System in Florence.

4) Specialty Hospital of South Carolina, a 59 bed facility within Charleston Memorial Hospital, had a 1999 occupancy rate of 24.6%

STANDARDS

1) An application for a Long Term Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

2) Long Term Care Hospital beds will not be considered as a separate category for licensing or planning purposes. All LTC beds remain part of the inventory of general acute care hospital beds.

3) Approval will only be given for the conversion of existing licensed general acute care beds to LTC beds. Projects which involve the construction of new health care facilities will not be approved.

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

Inventory of Hospital Services
Regional Need and Narrative
Regional Summary and Program
Inventory of Inpatient Facilities
Inventory of Emergency Facilities and Trauma Centers

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes which occurred since the previous plan are explained by a footnote. The number of beds existing and needed are summarized by region. The inventory of beds and facilities was current as of October 1, 2001.

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SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	MEDICAL	PEDIATRIC	PSYCHIATRIC	OBSTETRIC	REHABILITATION	REHABILITATION	ALLERGY	ALLERGY	MEDICAL	CORONARY	NEONATAL	INTERMEDIATE	BURN CARE	CARDIAC	OPEN HEART	ORGAN TRANSPLANT	AMBULATORY
	SURGICAL	ACUTE	ACUTE				CHEMICAL DEPENDENCY	CHEMICAL DEPENDENCY	SURGICAL								
	ACUTE								ACUTE								
ABBEVILLE COUNTY MEMORIAL HOSP	X			X	X	X			X	X							X
AIKEN REGIONAL MED. CENTERS	X	X	X	X	X	X		X	X	X	X			X	X	X	X
ALLEN BENNETT MEMORIAL HOSPITAL	X	X		X	X	X			X	X	X						X
ALLENDALE COUNTY HOSPITAL	X	X		X													X
ANDERSON AREA MEDICAL CENTER	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X
ANMED-WELLSPRING							X	X									
B J WORKMAN MEMORIAL HOSPITAL	X					X	X										X
BAMBERG COUNTY MEMORIAL HOSPITAL	X	X		X			X										X
BARNWELL COUNTY HOSPITAL	X	X	X		X				X								X
BEAUFORT MEMORIAL HOSPITAL	X	X	X	X		X			X			X					X
BON SECOURS, ST. FRANCIS XAVIER	X	X	X	X		X	X	X	X	X	X		X	X			X
CANNON MEMORIAL HOSPITAL	X	X							X	X							X
CAROLINA PINES REGIONAL MED CTR	X	X		X		X			X	X							X
CAROLINAS HOSPITAL SYSTEM	X	X			X	X	X	X	X	X	X			X			X
CHARLESTON MEMORIAL HOSPITAL	X								X	X							
CHARTER FENWICK HALL BEHAV HL																	
CHARTER GREENVILLE BEHAV HLTH			X				X	X									
CHARTER RIVERS BEHAVIORAL HLTH			X				X	X									
CHESTER COUNTY HOSPITAL	X	X		X		X			X	X							X
CHESTERFIELD GENERAL HOSP	X	X		X	X				X	X							X
CLARENDON MEMORIAL HOSPITAL	X	X		X		X			X	X							X
COLLETON MEDICAL CENTER	X	X		X	X	X											X
CONWAY HOSPITAL INC	X	X		X	X	X			X	X			X	X			X
EARL E. MORRIS, JR., ADA TRT CTR							X	X									

* SERVICE AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003715
PMC.2013.SHP.0202
PET-EX005.0202

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	EMERGENCY DEPT	ORGANIZED OUTPAT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THER	RADIOACTIVE IMPLANTS	THERAPEUTIC RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
ABBEVILLE COUNTY MEMORIAL HOSP	X	X			X	X								X		X			X
AIKEN REGIONAL MED. CENTERS	X	X	X	X	X	X		X	X	X	X	X	X	X		X			X
ALLEN BENNETT MEMORIAL HOSPITAL	X	X		X	X	X						X			X	X	X		X
ALLENDALE COUNTY HOSPITAL	X					X						X			X	X	X	X	X
ANDERSON AREA MEDICAL CENTER	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ANMED-WELLSPRING		X						X	X	X	X								
B J WORKMAN MEMORIAL HOSPITAL	X	X			X											X	X		
BAMBERG COUNTY MEMORIAL HOSPITAL	X		X		X	X						X			X	X	X	X	X
BARNWELL COUNTY HOSPITAL	X	X			X	X						X		X	X	X	X	X	X
BEAUFORT MEMORIAL HOSPITAL	X	X	X		X	X	X					X	X	X	X	X	X		X
BON SECOURS, ST. FRANCIS XAVIER	X	X	X		X	X				X		X	X	X	X	X	X	X	X
CANNON MEMORIAL HOSPITAL	X	X			X	X									X	X	X		X
CAROLINA PINES REGIONAL MED CTR	X				X	X	X					X			X	X	X		X
CAROLINAS HOSPITAL SYSTEM	X	X	X	X	X	X	X		X	X		X		X	X	X	X	X	X
CHARLESTON MEMORIAL HOSPITAL	X			X		X						X			X	X	X		X
CHARTER FENWICK HALL BEHAV HL																			
CHARTER GREENVILLE BEHAV HLTH		X											X						X
CHARTER RIVERS BEHAVIORAL HLTH		X											X						X
CHESTER COUNTY HOSPITAL	X	X			X	X						X	X	X	X	X	X	X	X
CHESTERFIELD GENERAL HOSP	X	X			X	X						X					X		X
CLARENDON MEMORIAL HOSPITAL	X	X			X	X						X	X	X	X	X	X		X
COLLETON MEDICAL CENTER	X	X	X		X	X						X				X	X	X	X
CONWAY HOSPITAL INC	X		X	X	X	X	X					X			X	X	X		X
EARL E. MORRIS, JR., ADA TRT CTR													X						X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003716
PMC.2013.SHP.0203
PET-EX005.0203

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	MEDICAL SURGICAL ACUTE	PEDIATRIC ACUTE	PSYCHIATRIC ACUTE	OBSTETRICS	REHABILITATION INPATIENT	REHABILITATION OUTPATIENT	ALC CHEM DEPENDENCY INPATIENT	ALC CHEM DEPENDENCY OUTPATIENT	MED SURG INTENSIVE CARE	CORONARY INTENSIVE CARE	NEONATAL INTENSIVE CARE	INTERMEDIATE CARE NURSERY	BURN CARE	CARDIAC CATH LAB	OPEN HEART SURGERY	ORGAN TRANSPLANT	AMBULATORY SURGERY
EAST COOPER REGIONAL MED CTR	X	X		X	X	X			X	X					X		X
EDGEFIELD COUNTY HOSPITAL	X	X			X	X											X
FAIRFIELD MEMORIAL HOSPITAL	X																X
G WERBER BRYAN PSYCHIATRIC HOSP			X														
GEORGETOWN COUNTY MEMORIAL HOSP	X	X	X	X	X	X	X		X	X			X	X			X
GRAND STRAND REGIONAL MED CTR	X	X		X	X				X	X		X		X	X		X
GREENVILLE MEMORIAL MED. CTR	X	X	X	X	X	X		X	X	X	X		X	X			X
HAMPTON REGIONAL MEDICAL CENTER	X	X															X
HEALTHSOUTH REHAB HOSP CHARLESTON					X	X											
HEALTHSOUTH REHAB HOSP COLUMBIA					X	X											
HEALTHSOUTH REHAB HOSP FLORENCE					X	X											
HILLCREST HOSPITAL	X	X			X	X			X								X
HILTON HEAD MEDICAL CTR & CLINS	X	X	X	X	X	X			X	X				X			X
HOPE HOSPITAL	X																
INTERMEDICAL HOSPITAL OF SC	X																
KERSHAW COUNTY MEDICAL CENTER	X	X		X	X	X			X	X							X
LAURENS COUNTY HOSPITAL	X	X		X					X	X							X
LEXINGTON MEDICAL CENTER	X	X		X	X	X			X	X	X	X					X
LORIS COMMUNITY HOSPITAL	X	X		X	X				X	X							X
LOW COUNTRY GENERAL HOSPITAL	X	X				X											
MARION COUNTY MEDICAL CENTER	X	X		X	X				X	X							X
MARLBORO PARK HOSPITAL	X	X	X	X		X			X	X						X	X
MARY BLACK MEMORIAL HOSPITAL	X	X		X	X	X			X	X		X		X			X
MCLEOD REGIONAL MED. CTR.	X	X	X	X	X	X	X	X	X	X	X			X	X		X

* SERVICE AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003717
PMC.2013.SHP.0204
PET-EX005.0204

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	EMERGENCY DEPT	ORGANIZED OUTPATIENT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THERAPY	RADIOACTIVE IMPLANTS	THERAPEUTIC RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC INPATIENT SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPECIAL PATHOLOGY	SOCIAL WORK SERVICES
EAST COOPER REGIONAL MED CTR	X	X			X	X	X					X	X	X	X	X	X	X	X
EDGEFIELD COUNTY HOSPITAL	X				X	X	X					X			X	X	X		
FAIRFIELD MEMORIAL HOSPITAL	X	X			X	X						X			X	X	X		
G WERBER BRYAN PSYCHIATRIC HOSP													X						X
GEORGETOWN COUNTY MEMORIAL HOSP	X	X	X		X	X	X		X			X	X	X	X	X	X	X	X
GRAND STRAND REGIONAL MED CTR	X	X	X	X	X	X	X		X			X			X	X	X		X
GREENVILLE MEMORIAL MED. CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HAMPTON REGIONAL MEDICAL CENTER	X	X	X			X	X					X			X	X	X	X	X
HEALTHSOUTH REHAB HOSP CHARLESTON		X													X	X	X	X	X
HEALTHSOUTH REHAB HOSP COLUMBIA		X													X	X	X	X	X
HEALTHSOUTH REHAB HOSP FLORENCE		X													X	X	X	X	X
HILLCREST HOSPITAL	X	X			X	X	X					X			X	X	X	X	X
HILTON HEAD MEDICAL CTR & CLINS	X	X			X	X						X	X	X	X	X	X	X	X
HOPE HOSPITAL																			
INTERMEDICAL HOSPITAL OF SC			X																X
KERSHAW COUNTY MEDICAL CENTER	X	X			X	X						X			X	X	X	X	X
LAURENS COUNTY HOSPITAL	X	X		X	X	X	X					X	X			X	X	X	X
LEXINGTON MEDICAL CENTER	X	X	X		X	X	X	X	X	X	X	X			X	X	X	X	X
LORIS COMMUNITY HOSPITAL	X	X			X	X						X			X	X	X	X	X
LOW COUNTRY GENERAL HOSPITAL	X					X						X				X	X		X
MARION COUNTY MEDICAL CENTER	X	X			X	X	X					X			X	X	X	X	X
MARLBORO PARK HOSPITAL	X			X	X	X						X	X			X	X	X	X
MARY BLACK MEMORIAL HOSPITAL	X	X			X	X	X					X	X		X	X	X	X	X
MCLEOD REGIONAL MED. CTR.	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003718
PMC.2013.SHP.0205
PET-EX005.0205

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	MEDICAL SURGICAL ACUTE	PEDIATRIC ACUTE	PSYCHIATRIC ACUTE	OBSTETRICS	REHABILITATION INPATIENT	REHABILITATION OUTPATIENT	ALC DEPENDENCY INPAT	ALC CHEM DEPENDENCY OUTPAT	MED SURG INTENSIVE CARE	CORONARY INTENSIVE CARE	NEONATAL INTENSIVE CARE	INTERMEDIATE CARE NURSERY	BURN CARE	CARDIAC CATH LAB	OPEN HEART SURGERY	ORGAN TRANSPLANT	AMBULATORY SURGERY
MONCRIEF ARMY COMMUNITY HOSPITAL	X	X	X		X				X								X
MUSC MEDICAL CENTER	X	X	X	X	X	X	X	X	X	X	X		X			X	X
NAVAL HOSPITAL CHARLESTON	X	X	X	X		X											X
NEWBERRY COUNTY MEMORIAL HOSPITAL	X	X		X	X	X			X	X							X
NORTH GREENVILLE HOSPITAL	X																X
OCONEE MEMORIAL HOSPITAL	X	X		X		X		X	X	X				X			X
PALMETTO BAPTIST MED CTR COLUMBIA	X	X	X	X	X	X	X		X	X	X						X
PALMETTO BAPTIST MED CTR EASLEY	X	X		X	X	X			X	X							X
PALMETTO RICHLAND MEMORIAL HOSP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PATRICK B HARRIS PSYCHIATRIC HOSP			X				X										
PIEDMONT MEDICAL CENTER	X	X	X	X			X	X	X	X	X			X	X		X
PROVIDENCE HOSPITAL	X					X			X	X							X
PROVIDENCE HOSPITAL NORTHEAST	X	X		X		X			X								X
REGIONAL MED CTR, OBURG/CAL	X	X	X	X	X	X	X		X	X							X
ROPER HOSPITAL NORTH, INC	X				X	X	X	X	X		X						X
ROPER HOSPITAL, INC.	X	X		X	X	X			X	X							X
SC VOC REHAB EVALUATION CTR																	
SELF MEMORIAL HOSPITAL	X	X	X	X		X	X	X	X	X	X						X
SHRINERS HOSPITAL FOR CHILDREN		X			X	X											
SPARTANBURG REGIONAL MEDICAL CTR	X	X	X	X	X	X			X	X	X						X
SPECIALTY HOSPITAL OF S.C.	X																
SPRINGBROOK BEHAVIORAL HLTHCARE			X														
SPRINGS MEMORIAL HOSPITAL	X	X		X	X	X	X	X	X								X
ST FRANCIS WOMEN'S & FAMILY HOSP.	X	X		X	X				X		X	X					X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003719
PMC.2013.SHP.0206
PET-EX005.0206

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																								
	EMERGENCY DEPT	ORGANIZED OUTPAT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THER	RADIOACTIVE IMPLANTS	THER RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES
MONCRIEF ARMY COMMUNITY HOSPITAL					X	X	X					X	X					
MUSC MEDICAL CENTER	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
NAVAL HOSPITAL CHARLESTON					X	X	X					X	X	X	X	X		
NEWBERRY COUNTY MEMORIAL HOSPITAL	X				X	X						X	X	X	X	X	X	X
NORTH GREENVILLE HOSPITAL	X	X																X
OCONEE MEMORIAL HOSPITAL	X	X			X	X						X	X	X	X	X	X	X
PALMETTO BAPTIST MED CTR COLUMBIA	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PALMETTO BAPTIST MED CTR EASLEY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PALMETTO RICHLAND MEMORIAL HOSP	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
PATRICK B HARRIS PSYCHIATRIC HOSP													X					X
PIEDMONT MEDICAL CENTER	X	X	X		X	X	X					X	X	X	X	X	X	X
PROVIDENCE HOSPITAL	X	X	X		X	X	X					X	X	X	X	X	X	X
PROVIDENCE HOSPITAL NORTHEAST	X	X			X	X							X	X	X	X	X	X
REGIONAL MED CTR, OBURG/CAL	X	X	X		X	X	X			X	X	X	X	X	X	X	X	X
ROPER HOSPITAL NORTH, INC	X				X	X							X	X	X	X	X	
ROPER HOSPITAL, INC.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SC VOC REHAB EVALUATION CTR														X	X			
SELF MEMORIAL HOSPITAL	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X
SHRINERS HOSPITAL FOR CHILDREN	X	X																
SPARTANBURG REGIONAL MEDICAL CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SPECIALTY HOSPITAL OF S.C.																		
SPRINGBROOK BEHAVIORAL HLTHCARE	X	X																
SPRINGS MEMORIAL HOSPITAL	X	X	X		X	X				X		X	X	X	X	X		
ST FRANCIS WOMEN'S & FAMILY HOSP.	X	X		X	X	X	X					X			X	X		

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RECORD 003720
PMC.2013.SHP.0207
PET-EX005.0207

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																						
	MEDICAL SURGICAL ACUTE	PEDIATRIC ACUTE	PSYCHIATRIC ACUTE	OBSTETRICS	REHABILITATION INPATIENT	REHABILITATION OUTPATIENT	ALC	ALC CHEM DEPENDENCY INPAT	ALC CHEM DEPENDENCY OUTPAT	MED SURG INTENSIVE CARE	CORONARY INTENSIVE CARE	NEONATAL INTENSIVE CARE	INTERMEDIATE CARE NURSERY	BURN CARE	CARDIAC CATH LAB	OPEN HEART SURGERY	ORGAN TRANSPLANT	AMBULATORY SURGERY
ST. EUGENE MEDICAL CENTER	X	X		X	X	X				X	X							X
ST. FRANCIS HOSPITAL, INC	X	X			X	X				X	X				X	X		X
SUMMERVILLE MEDICAL CENTER	X	X		X		X				X	X							X
TRIDENT MEDICAL CENTER	X	X	X	X	X	X	X			X	X		X		X	X		X
TUOMEY REGIONAL MEDICAL CTR	X	X	X	X	X		X			X	X							X
UPSTATE CAROLINA MEDICAL CTR	X	X		X	X	X												X
WALLACE THOMSON HOSPITAL	X	X		X						X								X
WHITTEN CENTER INFIRMARY	X																	
WILLIAM J B DORN V A HOSPITAL	X		X		X	X	X		X	X	X				X			X
WILLIAM J MCCORD ADOLESCENT TREAT								X	X									
WILLIAM S HALL PSYCHIATRIC INSTIT			X															
WILSON MEDICAL CENTER	X	X				X												X
WOMEN'S CTR OF CAROLINAS HOSP.				X		X						X						X

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003721
PMC.2013.SHP.0208
PET-EX005.0208

SERVICES AVAILABLE* IN SOUTH CAROLINA AS OF SEPTEMBER 30, 1999
SOURCE: JOINT ANNUAL REPORT OF HOSPITALS

HOSPITAL	SERVICE																							
	EMERGENCY DEPT	ORGANIZED OUTPATIENT SERVICES	HEMODIALYSIS	LITHOTRIPSY	CT SCANNER	DIAGNOSTIC ULTRASOUND	MAGNETIC RESONANCE IMAGING	MEGAVOLTAGE RADIATION THERAPY	RADIOACTIVE IMPLANTS	THERAPEUTIC RADIOISOTOPE FACILITY	X RAY RADIATION THERAPY	BLOOD BANK	PSYCHIATRIC SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	RESPIRATORY THERAPY	SPEECH PATHOLOGY	SOCIAL WORK SERVICES					
ST. EUGENE MEDICAL CENTER	X	X			X	X						X		X	X	X		X					
ST. FRANCIS HOSPITAL, INC	X	X	X	X	X	X	X		X					X	X	X	X	X					
SUMMERVILLE MEDICAL CENTER	X	X			X	X	X					X		X	X	X	X	X					
TRIDENT MEDICAL CENTER	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X					
TUOMEY REGIONAL MEDICAL CTR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
UPSTATE CAROLINA MEDICAL CTR	X	X			X	X						X				X		X					
WALLACE THOMSON HOSPITAL	X	X			X	X			X	X		X				X		X					
WHITTEN CENTER INFIRMARY														X	X		X						
WILLIAM J B DORN V A HOSPITAL	X	X	X		X	X	X					X	X	X	X	X		X					
WILLIAM J MCCORD ADOLESCENT TREAT													X										
WILLIAM S HALL PSYCHIATRIC INSTIT		X																X					
WILSON MEDICAL CENTER	X	X			X	X	X					X		X	X	X	X	X					
WOMEN'S CTR OF CAROLINAS HOSP.		X				X						X				X		X					

* SERVICES AVAILABLE IN HOSPITAL ONLY. SERVICES PROVIDED THROUGH CONTRACTS NOT INCLUDED.

RECORD 003722
PMC.2013.SHP.0209
PET-EX005.0209

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE

FISCAL YEAR:2001

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds.

2. All changes affecting the Statewide Health Facilities have been fully annotated in the inventory.

RECORD 003723

PMC.2013.SHP.0210

PET-EX005.0210

REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:									
	ALLENDALE CORRECTIONAL INF		ALLENDALE	FAIRFAX	ST	10	10			
XYZ	MEDICAL UNIVERSITY HOSPITAL	1	CHARLESTON	CHARLESTON	ST	242	242		10031	64876
	TURBEVILLE CORRECTIONAL INF		CLARENDON	TURBEVILLE	ST	8	8			
	LIEBER OP CLINIC & INF		DORCHESTER	RIDGEVILLE	ST	10	10			
YZ	PEE DEE REG CTR INF		FLORENCE	FLORENCE	ST	6	6			
	PERRY CORRECTIONAL INF		GREENVILLE	PELZER	ST	(20)	(20)			
X	SHRINERS HOSPITAL CHILDREN	29	GREENVILLE	GREENVILLE	NPA	50	50		305	1607
	RIDGELAND CORRECTIONAL INF		JASPER	RIDGELAND	ST	8	8			
XYZ	WHITTEN CTR INFIRMARY		LAURENS	CLINTON	ST	26	26		209	4425
	LEE CORRECTIONAL INS INF		LEE	BISHOPVILLE	ST	20	20			
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		274	3266
	EVANS CORRECTIONAL INF		MARLBORO	BENNETTSVILLE	ST	10	10			
	MCCORMICK OP CLINIC & INF		MCCORMICK	MCCORMICK	ST	10	10			
	COLUMBIA CARE CENTER	27	RICHLAND	COLUMBIA	PROP	326	326			
XYZ	JF BYRNES CTR FOR GERIATRIC MED, ED & RESEARCH		RICHLAND	COLUMBIA	ST	(66)	(208)			
YZ	(E A RONDEAU MIDLANDS CTR)	31	RICHLAND	COLUMBIA	ST	(34)	(34)		345	3432
	KIRKLAND CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	24	24			
	WOMEN'S CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	10	(10)			
	WILLOW LANE INF		RICHLAND	COLUMBIA	ST	8	8			
	CHILDREN'S HABILIATION CTR		SPARTANBURG	SPARTANBURG	ST	22	22		244	292
	TOTAL					800	790		11408	77898

MENTAL HOSPITALS:

RECORD 003724
PMC.2013.SHP.0211
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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30 ANDERSON	ANDERSON	ST	162	162		2451	33516
XYZ	CRAFTS-FARROW STATE HOSPITAL	2 RICHLAND	COLUMBIA	ST	(117)	(129)	63 c		
	GILLIAM MENTAL HLTH CTR	RICHLAND	COLUMBIA	ST	87	87			
XYZ	SC STATE HOSPITAL	3 RICHLAND	COLUMBIA	ST	346	501	264 abc	307	121703
XYZ	G WERBER BRYAN PSYCHIATRIC HOSPITAL	RICHLAND	COLUMBIA	ST	288	305		5471	80450
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITUTE	4 RICHLAND	COLUMBIA	ST	285	285		1124	59212
	TOTAL				1168	1340	327	9353	294881
	RESIDENTAL TREATMENT FAC FOR CHILDREN & ADOLESCENTS:								
XYZ	DIRECTIONS WS HALL	5 RICHLAND	COLUMBIA	ST	37	37		41	9873
XY	SOUTHBRIDGE RESIDENTAL TREATMENT FACILITY	26 RICHLAND	COLUMBIA	ST	(40)	(40)			
	TOTAL				37	37		41	9873
	DRUG AND ALCOHOL IPATIENT TREATMENT:								
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30 ANDERSON	ANDERSON	ST	44	44		921	12396
	PALMETTO CTR	FLORENCE	FLORENCE	ST	48	48		506	11200
	HOMESVIEW ALCOHOLIC CTR	GREENVILLE	GREENVILLE	ST	36	36		489	11691
XYZ	WM J MCCORD ADOLESCENT TREAT	ORANGEBURG	ORANGEBURG	ST	16	16		159	4339
XYZ	EARL E. MORRIS ADA TREATMENT CTI	32 RICHLAND	COLUMBIA	ST	174	174		2130	47063
	TOTAL				317	317	0	4205	86689

G TERM FACILITIES:

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Y	RM CAMPBELL VA NURS HM	6 ANDERSON	ANDERSON	ST	220	220		92	77489
YN	PRESTON HEALTH CENTER	7 BEAUFORT	HILTON HEAD	PROP	8	8			
Y	FRASER HEALTH CTR	BEAUFORT	HILTON HEAD	PROP	14	14			
Y	BISHOP GADSDEN EPISCOPAL HLTH CARE CTR	8 CHARLESTON	CHARLESTON	NPA	9	9			
N	THE FRANKE HEALTH CARE CTR	CHARLESTON	MT PLEASANT	NPA	20	20			
N	BETHEA BAPTIST HM	9 DARLINGTON	DARLINGTON	NPA	52	52			
N	PRESBYTERIAN HM OF SC SUMMERVILLE	DORCHESTER	SUMMERVILLE	NPA	90	90		112	27280
N	PRESBYTERIAN HM OF SC FLORENCE	10 FLORENCE	FLORENCE	NPA	44	44		43	14291
N	METHODIST MANOR OF THE PEE DEE	11 FLORENCE	FLORENCE	NPA	32	32		17	7641
N	ROLLING GREEN VILLAGE HEALTH CARE FACILITY	GREENVILLE	GREENVILLE	NPA	44	44		32	13974
N	PRESBYTERIAN HM OF SC CLINTON	LAURENS	CLINTON	NPA	66	66		23	20724
N	MARTHA FRANK BAPTIST HM	LAURENS	LAURENS	NPA	44	44			
N	SC EPISCOPAL HM STILL HOPES	14 LEXINGTON	W COLUMBIA	NPA	42	42			
N	LAUREL CREST NURS HM	12 LEXINGTON	W COLUMBIA	NPA	12	12		10	3468
N	PRESBYTERIAN HM OF SC COLUMBIA	13 LEXINGTON	W COLUMBIA	NPA	44	44		53	15089
N	CLEMSON AREA RET CTR	15 PICKENS	CLEMSON	NPA	22	22			
APP	FOOTHILLS PRESBYTERIAN HOME HE/ CARE CENTER	28 PICKENS	EASLEY	NPA	18	18			
YZN	CM TUCKER JR /DOWDY GARDNER NURS CTR FEWELL & STONE PAVILIONS	23 RICHLAND	COLUMBIA	ST	252	252	229 d	34	82798
YZN	CM TUCKER JR /DOWDY GARDNER NURS CTR RODDY PAVILION	23 RICHLAND	COLUMBIA	ST	308	308		60	90362
YZN	(DOWDY GARDNER FARMER BLDG)	18 RICHLAND	COLUMBIA	ST	(132)	(132)		33	44623

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REGION:STATEWIDE

					INPATIENT INVENTORY		OCT.1,1998-SEPT.30,1999		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
N	LOWMAN HOME-WC BOLICK	16 RICHLAND	WHITEROCK	NPA	47	47			
N	WJB DORN VETERANS NURSING	RICHLAND	COLUMBIA	FED	150	150		142	29118
N	SKYLYN HEALTH CENTER	SPARTANBURG	SPARTANBURG	PROP	11	11			
N	CARTER NURSING CTR	17 SUMTER	SUMTER	PROP	44	44		25	11189
	TOTAL				1593	1593		676	438046
	LICENSED FACILITIES FOR HABILITATION:								
Z	WARE SHOALS HAB CTR I	ABBEVILLE	WARE SHOALS	ST	8	8		0	2920
Z	WARE SHOALS HAB CTR II	ABBEVILLE	WARE SHOALS	ST	8	8		0	2920
	ABBEVILLE CO	TOTAL			16	16		0	5840
Z	DUPONT I&II HABILITATION CTR	AIKEN	AIKEN	ST	16	16		0	5781
Z	LAURENS STREET ICF/MR	AIKEN	AIKEN	ST	8	8		0	2912
Z	LINDER STREET ICR/MR	AIKEN	AIKEN	ST	8	8		0	2920
Z	RUDNICK COMM RES	AIKEN	NORTH	ST	8	8		0	2873
Z	SANDERS COMM RES	AIKEN	NORTH	ST	8	8		0	2905
	AIKEN CO	TOTAL			48	48		0	17391
Z	ANDERSON HAB CTR	ANDERSON	ANDERSON	ST	8	8		0	2918
Z	BELTON HAB CTR	ANDERSON	BELTON	NPA	8	8		0	2878
Z	HONEA PATH HAB CTR	ANDERSON	BELTON	NPA	8	8		0	2866
	ANDERSON CO	TOTAL			24	24		0	8662
Z	HAMPTON ST COMM RES	BAMBERG	DENMARK	ST	8	8		0	2920
Z	ZEIGLER ST COMM RES	BAMBERG	BAMBERG	ST	8	8		0	2853
	BAMBERG CO	TOTAL			16	16		0	5773
Z	ACADEMY ST COMM RES	BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	BLACK'S DRIVE COMM RES	BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	HARLEY RD COMM RES	BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	LEMON PARK COMM RES	BARNWELL	BARNWELL	NPA	8	8		0	2920
	BARNWELL CO	TOTAL			32	32		0	11566
Z	PORT ROYAL COMM RES	BEAUFORT	PORT ROYAL	ST	16	16		0	5811

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	BEAUFORT CO	TOTAL				16	16			5811
Z	CONIFER I&II COMM RES	BERKELEY	MONCKS CORNER	ST		16	16		0	5775
Z	DEHAY COMM RES	BERKELEY	MONCKS CORNER	ST		8	8		0	2877
	BERKELEY CO	TOTAL				24	24		0	8652
Z	FLORENCE GRESSETTE RES	CALHOUN	ST MATTHEWS	NPA		8	8		0	2897
Z	WYLIE-BRUNSON RES	CALHOUN	ST MATTHEWS	NPA		8	8		0	2897
	CALHOUN CO	TOTAL			0	16	16		0	5794
Z	CAMP ROAD COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2748
Z	DILLS BLUFF COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2772
Z	FARMINGTON COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2725
Z	SECESSIONVILLE COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2916
	CHARLESTON CO	TOTAL				32	32		0	11161
Z	JC FORT COMM RES #1	CHEROKEE	GAFFNEY	NPA		8	8		0	2830
Z	JC FORT COMM RES #2	CHEROKEE	GAFFNEY	NPA		8	8		0	2904
	CHEROKEE CO	TOTAL				16	16		0	5734
Z	CHARLES INGRAM, SR COMM RES	CHESTERFIELD	CHERAW	ST		8	8		0	2908
Z	CHESTERFIELD COMM RES	CHESTERFIELD	CHESTERFIELD	ST		8	8		0	2915
Z	PAGELAND COMM RES	CHESTERFIELD	PAGELAND	ST		8	8		0	2857
	CHESTERFIELD CO	TOTAL				24	24		0	8680
Z	VANGUARD COMM RES 1& 2	CLARENDON	MANNING	NPA		16	16		0	5838
	CLARENDON CO	TOTAL				16	16		0	5838
Z	JOSIE DRIVE COMM RES	COLLETON	WALTERBORO	ST		8	8		0	2914
Z	FOREST CIRCLE COMM RES	COLLETON	WALTERBORO	ST		8	8		0	2908
	COLLETON CO	TOTAL				16	16		0	5822
Z	JM REAGAN COMM RES	DARLINGTON	HARTSVILLE	NPA		8	8		0	2893
Z	THAD E SALEEBY DEVL CTR	DARLINGTON	HARTSVILLE	ST		96	128		0	35885
Z	WW BOWEN COMM RES	DARLINGTON	HARTSVILLE	NPA		8	8		0	2893
	DARLINGTON CO	TOTAL				112	144		0	41671
Z	DILLON COMM RES	DILLON	DILLON	ST		8	8		0	2890
	DILLON CO	TOTAL				8	8		0	2890
Z	COASTAL CTR -HIGHLAND	DORCHESTER	LADSON	ST		188	188		0	68855

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

	& HILLSIDE			CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	COASTAL CTR HIGHLANDS 510	DORCHESTER	LADSON	ST	18	18		0	8288
YZ	COASTAL CTR LIVE OAK VLG	DORCHESTER	SUMMERVILLE	ST	50	50		0	17599
Z	PARSONS GRP HM 1&2	DORCHESTER	SUMMERVILLE	NPA	16	16		0	5825
	DORCHESTER CO	TOTAL			272	272		0	100567
Z	EDGEFIELD COMM RES	EDGEFIELD	EDGEFIELD	ST	8	8		0	2920
	EDGEFIELD CO	TOTAL			8	8		0	2920
Z	RC BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
Z	SL BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
	FAIRFIELD CO	TOTAL			16	16		0	5840
Z	ACLINE PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	CAROLINA PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	COIT ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2919
Z	CEDARS, THE	FLORENCE	PAMPLICO	ST	8	8		0	2920
Z	FLORENCE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2557
Z	GRAHAM ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	MAGNOLIA PLACE	FLORENCE	OLANTA	ST	8	8		0	2920
Z	MULBERRY PARK 301-307	FLORENCE	FLORENCE	ST	85	112		0	34243
Z	THE OAKS	FLORENCE	TIMMONSVILLE	ST	8	8		0	2697
Z	PALMETTO PLACE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	1424
Z	PECAN LN 201-205	FLORENCE	FLORENCE	ST	120	132		0	34555
	FLORENCE CO	TOTAL			277	316		0	92895
Z	JESSAMINE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2715
Z	MARYVILLE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2909
	GEORGETOWN CO				16	16		0	5624
Z	CIVITAN COMM RES	GREENVILLE	GREENVILLE	NPA	8	8		0	2919
Z	FOUNTAIN INN COMM RES	GREENVILLE	FOUNTAIN INN	NPA	12	12		0	4258
Z	HUGHES STREET RES	GREENVILLE	FOUNTAIN INN	NPA	8	8		0	2889
Z	MARIAN PARKINS COMM RES I & II	GREENVILLE	GREENVILLE	ST	16	16		0	5831
Z	RIDGE RD RES	20 GREENVILLE	GREENVILLE	NPA	12	12		0	4380
Z	TRAVELERS REST RES	GREENVILLE	TRAVELERS REST	NPA	8	8		0	2779
	GREENVILLE CO	TOTAL			64	64		0	23056
Z	HENRY & FREIDA BONDS C RES	GREENWOOD	GREENWOOD	NPA	8	8		0	2920
Z	MARION P CARNELL HAB CTR	GREENWOOD	WARE SHOALS	ST	8	8		0	2920
Z	DR PB PRITCHARD,JR RES	GREENWOOD	GREENWOOD	ST	12	12		0	4337
Z	JF BURTON COMM RES	GREENWOOD	GREENWOOD	ST	8	8		0	2819
	GREENWOOD CO	TOTAL			36	36		0	12996

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	HORRY CO COMM RES		HORRY	CONWAY	ST	8	8		0	2893
Z	THE L EARGLE COMM RES		HORRY	CONWAY	ST	8	8		0	2877
	HORRY CO		TOTAL			16	16		0	5770
Z	CAMDEN I GRP HM		KERSHAW	CAMDEN	NPA	8	8		0	2912
Z	CAMDEN II GRP HM		KERSHAW	CAMDEN	NPA	8	8		0	2913
	KERSHAW CO		TOTAL			16	16		0	5825
Z	NJ MCCONNELL HM		LANCASTER	LANCASTER	ST	8	8		0	2873
Z	TOM MANGUM HM		LANCASTER	LANCASTER	ST	8	8		0	2886
	LANCASTER CO		TOTAL			16	16		0	5759
Z	CLINTON MANOR COMM RES		LAURENS	CLINTON	CO	8	8		0	2863
Z	DAVIDSON ST COMM RES		LAURENS	CLINTON	CO	8	8		0	2920
Z	MILL ST COMM RES		LAURENS	CLINTON	CO	8	8		0	2920
Z	S HARPER ST COMM RES		LAURENS	CLINTON	ST	8	8		0	2879
Z	SULLIVAN ST COMM RES		LAURENS	LAURENS	CO	8	8		0	2876
Z	OAKGROVE COMM RES		LAURENS	CLINTON	ST	8	8		0	2818
YZ	WHITTEN CTR CTL SQ 201-205		LAURENS	CLINTON	ST	143	143		0	
Z	WHITTEN CTR CAMPUS UNITS 101-110		LAURENS	CLINTON	ST	180	180		0	
Z	WHITTEN CTR WEBB 401-404	21	LAURENS	CLINTON	ST	156	174		0	
Z	WHITTEN CTR SUBER 301-303	22	LAURENS	CLINTON	ST	68	136		0	
	WHITTEN CTR TOTAL:								0	202945
	LAURENS CO		TOTAL			595	681		0	220221
Z	MCLEOD GRP HM 1 & II		LEE	BISHOPVILLE	NPA	16	16		0	5676
	LEE CO		TOTAL			16	16		0	5676
Z	B SMITH RD GRP HM		LEXINGTON	LEXINGTON	NPA	8	8		0	2920
Z	BATESBURG GROUP HM		LEXINGTON	BATESBURG	NPA	8	8		0	2920
Z	CLUSTER OF LEXINGTON A		LEXINGTON	LEXINGTON	NPA	8	8		0	17517
Z	CLUSTER OF LEXINGTON B		LEXINGTON	LEXINGTON	NPA	8	8			
Z	CLUSTER OF LEXINGTON C		LEXINGTON	LEXINGTON	NPA	8	8			
Z	CLUSTER OF LEXINGTON D		LEXINGTON	LEXINGTON	NPA	8	8			
Z	CLUSTER OF LEXINGTON E		LEXINGTON	LEXINGTON	NPA	8	8			
Z	CLUSTER OF LEXINGTON F		LEXINGTON	LEXINGTON	NPA	8	8			
Z	EAST HARTLEY HAB CTR		LEXINGTON	BATESBURG	NPA	4	4		0	1083
Z	HENDRIX ST GRP HM		LEXINGTON	LEXINGTON	NPA	8	8		0	2920
Z	KITTY WAKE HAB CTR		LEXINGTON	LEXINGTON	NPA	4	4		0	1083
Z	LEANING PINES TRAIL ICF/MR		LEXINGTON	LEXINGTON	NPA	4	4		0	1083
Z	NAZARETH ROAD COMM RES		LEXINGTON	LEXINGTON	NPA	8	8		0	2920
Z	PEACHTREE HAB CTR		LEXINGTON	BATESBURG	NPA	4	4		0	1082
Z	WIRE RD I&II		LEXINGTON	GILBERT	NPA	16	16		0	5840
	LEXINGTON CO		TOTAL			112	112		0	39368

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REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	JENNINGS MCABEE COMM		MCCORMICK	MCCORMICK	ST	8	8		0	2920
	MCCORMICK CO		TOTAL			8	8		0	2920
Z	ES HUNTER COMM RES		NEWBERRY	NEWBERRY	NPA	12	12		0	4172
Z	HA MCCULLOUGH COMM RES		NEWBERRY	NEWBERRY	NPA	12	12		0	4162
	NEWBERRY CO		TOTAL			24	24		0	8334
Z	OCONEE COMM RES#1		OCONEE	SENECA	ST	16	16		0	5810
Z	OCONEE COMM RES #2		OCONEE	SENECA	ST	8	8		0	2920
	OCONEE CO		TOTAL			24	24		0	8730
Z	NANCE COMM RES		ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	KINGS COMM RES		ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	SIFLY ST COMM RES		ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
Z	WANNAMAKER ST COMM RES		ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
	ORANGEBURG CO		TOTAL			32	32		0	11680
N	EASLEY COMM RES I&II		PICKENS	EASLEY	ST	16	16		0	5715
	PICKENS CO		TOTAL			16	16		0	5715
Z	ARCHIE DRIVE GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	BAY SPRINGS HAB CTR		RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	CARTER ST GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2920
YZN	CRAFTS-FARROW ST HOSP ICF/MR BLDG 16		RICHLAND	COLUMBIA	ST	80	80		0	36496
Z	FIRST MIDLANDS ICF-MR	25	RICHLAND	COLUMBIA	ST	344	344		0	43955
Z	HORRELL HILL COMM RES		RICHLAND	EASTEROVER	NPA	8	8		0	2920
Z	IDA LANE I&II COMM RES		RICHLAND	COLUMBIA	NPA	16	16		0	5839
Z	KENSINGTON GRP HM 1		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	KENSINGTON GRP HM 2		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	NORTH PINES COMM RES		RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	PINE LAKE ICF-MR		RICHLAND	COLUMBIA	NPA	44	44		0	16060
Z	RABBIT RUN		RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	SUNVIEW CIRCLE HAB CTR		RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	WILSON BLVD COMM RES I&II		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	WOODLAWN AV GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2917
	RICHLAND CO		TOTAL			564	564		0	131547
Z	BENCHMARK-SPGT		SPARTANBURG	SPARTANBURG	NPA	12	12		0	4351
Z	BENCHMARK HM-COWPENS		SPARTANBURG	COWPENS	NPA	12	12		0	4378
Z	LANDRUM COMM RES I&II		SPARTANBURG	LANDRUM	ST	16	16		0	5597
Z	JD FERGUSON COMM RES I&II		SPARTANBURG	SPARTANBURG	ST	8	16		0	5613
	SPARTANBURG CO		TOTAL			48	56		0	19939

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				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	ATKINSON W&E GRP HM	SUMTER	SUMTER	NPA	18	18		0	6486
Z	THOMAS DR COMM RES	SUMTER	SUMTER	ST	8	8		0	2885
	SUMTER CO	TOTAL			26	26		0	9371
Z	WEST MAIN ST COMM RES	UNION	UNION	ST	8	8		0	2798
	UNION CO	TOTAL			8	8		0	2798
Z	BIRD ST HAB CTR I&II	YORK	ROCK HILL	ST	16	16		0	5693
	YORK CO	TOTAL			16	16		0	5693
	TOTAL				2638	2703		0	920367

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FOOTNOTES

__REGION: STATEWIDE

FY2001 PLAN

CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. Beds, admissions, and patient days allocated based on patient origin.
2. Licensed beds reduced from 629 to 519, 2/1/94. Licensed beds increased from 519 to 549 with closure of 30 licensed D&A beds, 3/1/95. Licensed beds reduced from 549 to 300, 3/1/96. Facility closed 6/30/96.
3. Licensed beds reduced from 450 to 350 3/1/95. Licensed beds increased from 350 to 400, 3/1/96. Licensed beds increased by 15 from 400 to 415, 11/18/97. Licensed beds at JF Byrnes closed & State licensed for 446 beds(424 psy & 22 instit general inf), 7/8/99. Licensed beds reduced from 446 to 346, 11/22/00.
4. Licensed beds increased from 220 to 236, 3/1/95. Temporary licensure of 18 acute beds to adol/child residential care beds, E-95-130, 11/22/95. Licensed beds increased from 236 to 239, 3/1/96. Conversion of 24 psy beds to 24 adolescent res care beds for 215 psy & 55 arc beds, 11/8/96. Licensed beds decreased from 239 to 215,3/14/97. Licensed beds at Hall increased from 215 to 232, 2/9/99 before the the exemption was issued. E=99-25 to increase licensed beds from 215 to 232 & to reduce licensed beds from 55 to 37 at Directions, 4/21/99. Beds at Hall to increase from 232 to 235, 7/28/99 e-99-43. Licensed beds at Hall to increase by 16 from 235 to 251, 8/12/99 e-99-48. Licensed beds increased from 232 to 235 12/8/99. Licensed beds increased from 235 to 272, 11/22/00. Licensed beds increased from 272 to 285, 8/14/01.
5. Exemption to add a 13 bed RTF for Children and Adolescents with a 13 bed reduction in psy beds, 6/10/93. Licensed for 13 RTF beds, 3/11/94. Licensed beds increased from 13 to 31 by E-95-130 on 12/15/95.Exp to increase beds from 31 to 55, 11/8/96. See #4. Licensed beds increased from 31 to 55, 3/14/97. Licensed beds decreased from 55 to 37 4/21/99.
6. Licensed beds increased from 88 to 132, 10/12/92. Licensed beds increased from 132 to 176, 7/7/93. Licensed beds increased from 176 to 220, 1/3/94.
7. CON issued for 44 dual beds (36 community and 8 restricted), 8/28/89. Facility licensed for 36 comm and 8 restricted beds with name change from Cypress of Hilton Head, 4/7/92.
8. Con issued for 9 non-comm resulting in 53 comm & 9 non-comm beds , 12/19/00 sc-00-65.
9. CON issued to convert 6 non-comm beds to comm for a total of 62 non-comm & 26 comm, 10/11/94. Licensed for 62 non-comm and 26 comm, 1/1/95.
10. CON issued for 19 additional non-community LTC beds for a total of 44 beds, 12/16/92. Licensed for 44 beds, 4/20/94. Con issued to convert 10 non-comm beds to comm. Beds for a total of 52 non-comm & 36 comm ,3/13/00.

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Facility licensed for 36 comm & 52 Inst. Beds , 6/29/00.

11. CON issued for 22 bed restricted nurs hm, 8/4/92. Facility licensed for 22 beds, 9/23/92. Con issued for 10 add non-comm beds for a total of 32, sc99-07 2/16/99. Facility licensed for 32 beds , 12/30/99.
12. CON issued for 12 beds restricted nurs. hm., 2/10/93. Licensed 9/16/94.
13. CON issued for 22 additional restricted beds for a total of 44, 1/8/93. Licensed beds increased from 22 to 44, 1/14/94.
14. Approved to convert 8 non-comm beds to comm for a total of 36 non-comm & 8 comm, 10/18/94. Licensed for 36 non-comm and 8 comm, 12/1/94. CON for 22 addditional non-comm beds for a total of 58 non-comm & 8 comm, 12/19/95.Licensed for 58 non-comm beds & 8 comm beds, 3/17/97. Facility licensed for 46 institutional & 20 comm nurs hm beds,1/1/99. Facility non-comm beds reduced from 46 to 42 ,e-99-41,7/15/99. Facility licensed for 42 non-comm & 20 comm, 7/16/99.
15. CON issued for 8 non-com beds & the conversion of 14 comm to non-comm for a total of 52 beds (30 comm & 22 non-comm), 8/9/94. Licensed for 30 comm and 22 non-comm, 2/20/95.
16. CON issued for 47 restricted beds and 85 replacement beds, 4/27/90. Licensed for 47 beds, 3/31/93.
17. CON issued for 22 restricted beds, 5/19/93. Licensed for 22 nurs hm beds, 5/11/94. CON issued for 22 additional restricted beds for a total of 44 nurs hm beds, 6/7/96. Licensed for 44 nurs beds, 6/1/97.
18. Beds reduced from 176 to 132, 2/1/95. Exp to transfer 32 beds from D&G Rock Hill 10/7/96. Facility licensed for 162 beds, 11/6/96. Reduced the survey beds at DG Farmer by 44 from 198 to 146 & licensed for 132, e-99-56, 10/1/99. Facility closed 2/17/00.
19. CON issued 3/14/94. Licensed 5/17/95.
20. Licensed beds changed from 16 to 12, 10/1/96.
21. Beds reduced from 174 to 168 and from 168 to 156.
22. Facility licensed for 68 beds.
23. Beds increased from 440 to 572, 7/18/95. Licensed as two facilities one for 264 & the other for 308, 7/1/97. Facility beds reduced by 12 from 264 to 252, 5/18/98.
24. No footnote 24.
25. Licensed beds increased from 332 to 344, 6/1/96. Transfer of 20 beds from 2nd Midlands to 1st Midlands with a bed increase from 344 to 364 and closure of 2nd Midlands 10/31/00 e-00-67. 2nd midlands closed 5/16/01 , but did not transfer the 20 beds.
26. Exemption for a 40 bed rtf, 2/9/98. Facility licensed for 40 rtf beds, 2/11/98. Facility closed.
27. Facility licensed as a 326 Institutional General Inf., 9/2/98.
28. Con issued for 18 bed non community nurs home, 1/25/99 SC-99-03,. Facility licensed for 18 beds, 10/20/00.
29. Exp #e99-09 to reduce beds from 60 to 50,3/11/98. Facility licensed for 50 beds, 3/1/99.
30. Licensed beds changed for psy from 184 to 162 and D&A from 22 to 44, 2/3/99.
31. Facility closed 12/1/99.
32. E-01-27 to permanent reduction of 9 d&a beds from 183 to 174, 5/21/01. Facility licensed reduced from 183 to 174 6/1/01.

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PET-EX005.0221

REGION NARRATIVE

REGION: I

FISCAL YEAR:2001

1. Unusual Characteristics: There are no unusual characteristics such as military bases with associated dependents, nor barriers to transportation and communications in this region.

2. General Hospitals: W.J. Barge Hospital is a restricted use facility.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards. There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in five facilities in this region and long term psychiatric beds available at Springbrook Behavioral Healthcare System, formerly Chestnut Hill, in Greenville County. There is a small need for additional psychiatric beds in this region.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There is a need for inpatient treatment beds in the Spartanburg, Cherokee, and Union Counties area.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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PET-EX005.0222

AREA SUMMARY

REGION	NUMBER OF FACILITIES			NUMBER OF BEDS	
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
I					
HOSPITALS:					
ANDERSON	1	0	332	495	-163
CHEROKEE	1	0	63	125	-62
GREENVILLE	6	0	999	1079	-80
OCONEE	1	0	134	160	-26
PICKENS	2	0	99	151	-52
SPARTANBURG	4	0	524	848	-324
UNION	2	1	78	157	-79
TOTALS:	17	1	2229	3015	-786
LTC:					
ANDERSON	6	2	917	810	107
CHEROKEE	2	0	273	217	56
GREENVILLE	17	5	1868	1732	136
OCONEE	2	0	371	252	119
PICKENS	7	4	511	424	87
SPARTANBURG	13	1	1408	1206	202
UNION	2	0	206	196	10
TOTALS:	49	12	5554	4837	717

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RECORD 003736

REGION:I — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCONFORMING	ADMISSIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	ANDERSON AREA MEDICAL CTR	28	ANDERSON	ANDERSON	NPA	495	495		18495	92482	498.6	50.8%
	ANDERSON CO.		TOTAL			495	495		18495	92482	498.6	50.8%
XYZ	UPSTATE CAROLINA MED CTR		CHEROKEE	GAFFNEY	PROP	125	125		3761	16340	125	33.6%
	CHEROKEE CO.		TOTAL			125	125		3761	16340	125	33.6%
XYZ	ALLEN BENNETT MEM	1	GREENVILLE	GREER	NPA	58	58		2903	14290	58	67.5%
XYZ	GREENVILLE GEN.	29	GREENVILLE	GREENVILLE	NPA	(75)	(75)		0	0		
XYZ	GREENVILLE MEM.MEDICAL CTR.	1	GREENVILLE	GREENVILLE	NPA	628	710		32256	179214	628	78.2%
XYZ	HILLCREST	1	GREENVILLE	SIMPSONVILLE	NPA	56	43		1729	8094	56	39.6%
XYZ	(NORTH GREENVILLE)	2	GREENVILLE	TRAVELERS REST	NPA	(5)	(5)		0	0	5	0.0%
	(W.J. BARGE)	3	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(90)	(3) c	(1402)	(3087)		
XYZ	SAINT FRANCIS HOSP.	21	GREENVILLE	GREENVILLE	NPA	206	206		3830	53315	206	70.9%
XYZ	SAINT FRANCIS WOMAN'S AND FAMILY HOSPITAL	21	GREENVILLE	GREENVILLE	NPA	62	62		4176	12121	62	53.6%
	GREENVILLE CO.		TOTAL			1010	1079		44894	267034	1015	72.1%
XYZ	OCONEE MEM		OCONEE	SENECA	NPA	160	160		7510	33703	160	57.7%
	OCONEE CO.					160	160		7510	33703	160	57.7%
XYZ	PALMETTO BAPTIST MED CTR-EASLEY	17	PICKENS	EASLEY	NPA	96	96		4267	17759	98	50.7%
XYZ	CANNON MEM.		PICKENS	PICKENS	NPA	55	55		1229	6332	55	31.5%
	PICKENS CO.		TOTAL			151	151		5496	24091	151	43.7%
XYZ	B.J. WORKMAN MEM.		SPARTANBURG	WOODRUFF	CO	43	43		1210	2799	43	17.8%
XYZ	SPGT HOSP RESTORATIVE CARE	4	SPARTANBURG	SPARTANBURG	CO	97	97		365	11551	97	32.6%
XYZ	MARY BLACK MEM.	22	SPARTANBURG	SPARTANBURG	PROP	176	176		6126	23420	178	36.5%
XYZ	SPARTANBURG REG. MED.CTR.	30	SPARTANBURG	SPARTANBURG	CO	532	532		21311	101946	532	52.5%
	SPARTANBURG CO.		TOTAL			848	848		29012	139716	848	45.1%
	HOPE HOSP.		UNION	LOCKHART	CO	16	14	7 cd	116	728	16	12.5%
XYZ	WALLACE THOMSON		UNION	UNION	DIST	143	143	6 c	4095	18930	143	36.3%
	UNION CO.		TOTAL			159	157	13	4211	19658	159	33.9%
	TOTAL					2948	3015	13	113379	592024	2956.6	54.9%
	MENTAL FACILITIES:											
XYZ	ANDERSON AREA MEDICAL CTR		ANDERSON	ANDERSON	NPA	38	38		613	6412	38	46.2%
	ANDERSON CO.		TOTAL			38	38		613	6412	38	46.2%
YZ	THE CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	53	53		1501	12219	45	74.4%
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6	GREENVILLE	TRAVELERS REST	PROP	20	20		180	3160		
XYZ	GREENVILLE MEM.MEDICAL CTR.	2	GREENVILLE	GREENVILLE	NPA	72	63		1805	15649	72	59.5%
	GREENVILLE CO.		TOTAL			145	136		3486	31028	117	72.7%
XYZ	MARY BLACK MEM.	22	SPARTANBURG	SPARTANBURG	PROP	15	15		318	2955	15	54.0%
XYZ	SPARTANBURG REG. MED. CTR.		SPARTANBURG	SPARTANBURG	CO	56	56		838	7070	56	34.6%

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REGION I — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	SPARTANBURG CO.		TOTAL			71	71		1156	10025	71	38.7%
	TOTAL					254	245		5255	47465	226	57.5%
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:											
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6	GREENVILLE	TRAVELERS REST	PROP	44	68		24	6776	44	36.0%
YZ	MARSHALL I. PICKENS CHILDREN'S PROGRAM	7	GREENVILLE	GREENVILLE	NPA	22	22		35	6998	22	87.1%
	GREENVILLE CO.		TOTAL			66	90		59	12774	66	53.0%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
YZ	ANMED-WELLSPRING		ANDERSON	WILLIAMSON	NPA	27	27		276	695	27	7.1%
YZ	THE CAROLINA CENTER FOR BEHAVIORAL HEALTH	6	GREENVILLE	GREENVILLE	PROP	13	13		335	2360	21	30.8%
	GREENVILLE MEM.MEDICAL CTR.	2	GREENVILLE	GREENVILLE	NPA	(18)	(18)					
	GREENVILLE CO.		TOTAL			40	40		611	3055	48	17.4%
	REHABILITATION FACILITIES:											
XYZ	GREENVILLE GEN.	29	GREENVILLE	GREENVILLE	NPA	(14)	(11)				14	0.0%
XYZ	GREENVILLE MEM.MEDICAL CTR.	8	GREENVILLE	GREENVILLE	NPA	53	53		667	14288	51.8	75.5%
XYZ	SAINT FRANCIS HOSP.		GREENVILLE	GREENVILLE	NPA	19	19		565	6724	19	82.5%
	GREENVILLE CO.		TOTAL			72	72		1232	19992	84.8	64.6%
XYZ	MARY BLACK MEM HOSP		SPARTANBURG	SPARTANBURG	PROP	18	18		345	6213	18	94.6%
	SPARTANBURG CO					18	18		345	6213	18	94.6%
	LONG TERM CARE FACILITIES:											
APP	ANDERSON MED CTR SUBACTUE	28	ANDERSON	ANDERSON	NPA	27	27		413	4576	23.8	52.7%
YZ	ANDERSON PLACE		ANDERSON	ANDERSON	PROP	44	44		50	10450	44	65.1%
YZ	BROOKSIDE NURSING CTR		ANDERSON	ANDERSON	PROP	88	88	19 o	98	31427	88	97.8%
YZ	ELLENBURG NURS CTR	9	ANDERSON	ANDERSON	PROP	181	181		147	63537	181	96.2%
YZ	CALLIE & JOHN RAINEY HOSPICE HOUSE	18	ANDERSON	ANDERSON	NPA	16	32		185	3809	16	65.2%
YZ	NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290		419	103993	290	98.2%
	(NHC HEALTHCARE EDGEBROOK)	26	ANDERSON	ANDERSON	PROP		(112)					
YZ	RIVERSIDE NURSING CTR		ANDERSON	ANDERSON	PROP	88	88		100	31841	88	99.1%
ZI	WILLOW CREEK NURS CTR	10	ANDERSON	IVA	PROP	60	60	(16) cd	161	19715	60	90.0%
	ANDERSON CO		TOTAL			794	810	19	1563	269348	790.8	93.3%
YZ	BROOKVIEW HLTHCARE CTR		CHEROKEE	GAFFNEY	PROP	132	132		133	45594	132	94.6%
YZ	CHEROKEE CO. LTC	11	CHEROKEE	GAFFNEY	CO	85	85		44	30979	85	99.9%
	CHEROKEE CO		TOTAL			217	217		177	76573	217	96.7%
Z	ALLEN BENNETT NURS HM	1	GREENVILLE	GREER	NPA	10	10		187	2980	10	81.6%
YZ	BRIARWOOD NURSING CTR		GREENVILLE	SIMPSONVILLE	PROP	42	39		35	13710	42	89.4%
NHM	BRIGHTON GARDENS	27	GREENVILLE	GREENVILLE	PROP	45	45					
CON	(BROOKSTONE TERRACE NURS HM)	12	GREENVILLE	GREENVILLE	PROP		(44)					

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REGION I — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
Z	FOUNTAIN INN NURS HM		GREENVILLE	FOUNTAIN INN	PROP	44	44	26 cd	15	15931	44	99.2%
YZ	LAUREL BAYE HEALTHCARE OF GREENVILI	33	GREENVILLE	GREENVILLE	CO	112	132		76	38994	112	95.4%
YZ	GREENVILLE NURSING CTR		GREENVILLE	GREENVILLE	PROP	79	79	18 d	23	28470	79	98.7%
NHM	GREENVILLE MEM CTR	1	GREENVILLE	GREENVILLE	NPA	48	48		832	10812	48	61.7%
	SUBACUTE UNIT											
YZ	MAGNOLIA MANOR-GREENVILLE	23	GREENVILLE	GREENVILLE	PROP	99	99	25 d	63	31481	88	98.0%
YZ	MAGNOLIA PLACE-GREENVILLE	23	GREENVILLE	GREENVILLE	PROP	120	120		132	33204	120	75.8%
Y	NHC CENTER GREENVILLE		GREENVILLE	GREER	PROP	176	176		190	61649	176	96.0%
YZ	NHC CENTER OF MAUDLIN	13	GREENVILLE	MAULDIN	PROP	120	120		149	40394	120	92.2%
YZ	OAKMONT EAST NURS CTR		GREENVILLE	GREENVILLE	PROP	132	132		161	46263	132	96.0%
Z	OAKMONT WEST		GREENVILLE	GREENVILLE	PROP	125	125		145	41963	125	92.0%
Z	PIEDMONT NURSING AND REHAB		GREENVILLE	GREER	PROP	132	132		104	43647	132	90.6%
YZ	ROGER HUNTINGTON NURS CTR		GREENVILLE	GREENVILLE	NPA	88	88	12 c	80	31752	88	98.9%
YZ	ST FRANCIS TRANSITIONAL CARE		GREENVILLE	GREENVILLE	NPA	32	32		633	10090	32	86.4%
	TRANSITONAL CARE UNIT											
YZ	SUMMIT PLACE		GREENVILLE	SIMPSONVILLE	PROP	132	132		177	45633	132	94.7%
Z	STROUD NURS HOME		GREENVILLE	MARIETTA	NPA	44	44	1 c	9	15958	44	99.4%
YZ	WESTSIDE NURS CTR		GREENVILLE	GREENVILLE	PROP	132	132		117	46974	132	97.5%
	GREENVILLE CO		TOTAL			1712	1729	82	3128	559905	1656	92.6%
YZ	LILA DOYLE NURS CARE	32	OCONEE	SENECA	CO	79	120		271	26421	79	91.6%
YZ	MARINER HLTH CARE OF SENECA		OCONEE	SENECA	PROP	132	132		131	47850	132	99.3%
	OCONEE CO		TOTAL			211	252		402	74271	211	96.4%
Z	BLUE RIDGE NURS CTR		PICKENS	EASLEY	PROP	66	66	33 d	32	23436	66	97.3%
Y	CLEMSON AREA RET CTR	14	PICKENS	CLEMSON	PROP	30	30		31	17182	52	90.5%
NHM	COUNTRYSIDE CARE CTR	34	PICKENS	EASLEY	PROP	44	44		73	15055	44	93.7%
YZ	EASLEY NURS CTR		PICKENS	EASLEY	PROP	103	100	50 d	177	36595	103	97.3%
Z	HARVEY'S NURSING HOME	24	PICKENS	SIX MILE	PROP	44	41	27 cd	62	14172	40	97.1%
YZ	LAUREL HILL		PICKENS	PICKENS	PROP	80	80		85	28645	80	98.1%
Z	ROSEMOND NURSING CTR	20	PICKENS	PICKENS	PROP	44	44	22 d	18	15257	44	95.0%
Y	PALMETTO MEDICAL CTR-EASLEY	17	PICKENS	EASLEY	NPA	13	13		186	1676	13	35.3%
	TRANSITIONAL CARE FACILITY											
	PICKENS CO		TOTAL			424	418	132	663	152018	442	94.2%
Z	CAMP CARE		SPARTANBURG	INMAN	PROP	88	88		47	31577	88	98.3%
YZ	SPGT HOSP RESTORATIVE CARE SNF	4	SPARTANBURG	SPARTANBURG	CO	11	11					
Z	GOLDEN AGES-INMAN		SPARTANBURG	INMAN	PROP	44	44		23	15877	44	98.9%
YZ	INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	35		13	15022	40	102.9%
YZ	MAGNOLIA MANOR/INMAN		SPARTANBURG	INMAN	PROP	176	176		122	62132	176	96.7%
YZ	MAGNOLIA MANOR-SPGT		SPARTANBURG	SPARTANBURG	PROP	95	89	62 ad	76	32425	95	93.5%
YZ	MAGNOLIA PLACE-SPGT		SPARTANBURG	SPARTANBURG	PROP	88	88		89	30208	88	94.0%
NHN	MARY BLACK MEM HOSP-SNF	22	SPARTANBURG	SPARTANBURG	PROP	(20)	(20)		89	902	20	12.4%
YZ	MOUNTAINVIEW NURS HM		SPARTANBURG	SPARTANBURG	CO	132	132		49	47996	132	99.6%
CON	ROSECREST NURSING CENTER	31	SPARTANBURG	INMAN	NPA		43					
YZ	SKYLYN PLACE HEALTH CTR	15	SPARTANBURG	SPARTANBURG	PROP	33	33		66	13661	44	85.1%
YZ	VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88		43	31864	88	99.2%
YZ	WHITE OAK MANOR-SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192		180	68211	192	97.3%
Y	WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88		105	31241	88	97.3%
YZ	WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88		22	31474	88	98.0%
	SPARTANBURG CO		TOTAL			1163	1195	62	914	412590	1183	95.6%
YZD	ELLEN SAGAR	16	UNION	UNION	CO	108	108		143	39153	99	108.4%
YZD	OAKMONT OF UNION		UNION	UNION	PROP	88	88		110	30879	88	96.1%
	UNION CO		TOTAL			196	196		253	70032	187	102.6%
	TOTAL					4717	4817	295	7100	1614737	4666.8	94.4%

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PMC.2013.SHP.0226
PET-EX005.0226

FOOTNOTES

__REGION: I
1.

FY2001 PLAN

CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued to convert 17 general beds to 13 LTC beds at Allen Bennett Mem., to convert 34 general beds to 32 LTC beds and add 16 LTC beds in the Rehab Unit, resulting in 53 general beds & 13 LTC beds at Allen Bennett and 628 general beds, 72 psych., 50 rehab., 18 substance abuse an 48 LTC beds at Greenville Mem., 9/23/94. Greenville Mem licensed for 48 Nur Hm and Gen Mem licensed reduced from 662 to 628, 10/31/95. CON for Allen Bennett modified to conversion of 12 hosp beds to 10 nurs hm beds, 9/21/95. Allen Bennett licensed for 10 nurs hm & 56 general beds, 1/2/96. Con issued to transfer 13 beds from Hill Crest to GM resulting in 43 at Hill Crest & 641 at GM, 7/3/2000 SC-00-35. Con issued to transfer 5 general acute beds from NG to GM resulting in 646 general acute beds at GM and) acute beds at NG with the closure of the facility. SC-01-09 2/20/01. Con issued for adding 55 new acute beds & converting 9 psy beds for a total of 710 general & 63 psy beds, SC-01-57 10/10/01.
2. Facility is licensed for 53 beds (5 acute, 48 inpatient treatment beds). CON issued to delicense 30 inpatient treatment beds from NGH, 18 psy beds from GMEM and transfer 18 inpat beds from NGH to GMEM resulting in 5 acute beds at NGH and 72 psy, 18 inpat treat beds to GMEM with 16 RT beds for children at MIP, 4/25/94. Facility licensed for only 5 general beds, 6/9/94. 18 inpat treatment beds closed by e-99-59, 10/22/99. 18 bed inpat treatment closed 1/1/00. Con issued to transfer 5 general acute care beds from NG to GM for 646 beds at GM and 0 beds at NG, SC-01-09 2/20/01. App for adding 55 new acute beds & converting 9 psy beds for a total of 710 general & 63 psy beds, 9/25/01.
3. Facility use restricted to students.
4. Name changed from Doctors Mem., 10/1/95. Con issued to transfer the 11 nurs hm beds plus additional 15 new non-medicaid beds for a 26 nurs hm beds at Spart Reg Med Ctr, 8/28/98. Con voided, 1/24/00.
5. CON issued to convert 14 inpat treatment beds to 14 crisis beds resulting in 21 inpat treat beds, 25 psy beds and 14 crisis beds (psy), 3/28/94. Facility licensed for 21 treatment beds, 3/29/94. Licensed for 45 psy(31 psy & 14 crisis beds) and 21 d&a beds, 5/10/95. Con issued to convert 8 of the 21 D&A beds to psy for a total of 53 psy (39 psy & 14 crisis beds) & 13 D&A beds, 07/14/99. Facility licensed for 13 D&A & 53 psy beds , 8/18/00.
6. Facility is licensed for 44 long term care psychiatric beds and 44 RTC beds. Con issued to reduce 24 long term psy beds from 44 to 20 and add 24 RFT beds from 44 ro 68 RFT and 20 Long Term Psy beds, 6/12/01 Facility licensed for 68 RFT and 20 LTC Psy, 8/10/01.

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7. CON issued for 16 RTF beds, 1/10/92. Facility licensed for 16 RTF beds, 4/1/93. CON issue for 6 additional beds for a total of 22 rtf beds, 10/16/95. Facility licensed for 22 rtf beds, 10/22/95.
8. Exemption for relocation of the inpatient component of the Pain Therapy Center at Greenville General to Greenville mem., 5/12/94. The licensed 14 rehab beds at Greenville Gen. are restricted to Pain Therapy only by CON SC F-749 issued 11/7/84. Con issued to transfer 3 rehab beds from general to Memorial resulting in 11 rehab at general & 53 rehab beds at memorial,4/13/98. GMH licensed for 53 rehab beds, 2/2/99.
9. CON issued to convert 5 private beds to semi for total of 181 beds, 3/19/93. Licensed for 181 beds 4/20/93.
10. CON issued for a 34 bed addition for a total of 60 beds, 4/12/93. Name changed from Golden Acres Nurs Fac.
11. CON issued for 32 dual Medicaid beds 6/15/90. Facility licensed for 76 beds, 1/25/93. CON issued for 9 additional non-Medicaid beds for a total of 85 beds, 9/12/94. Facility licensed for 85 beds, 8/16/94.
12. CON issued for 44 non-Medicaid LTC beds 5/13/94. Void 5/10/95.
13. CON issued for 81 non-medicaid LTC beds, 3/8/95. CON issued to increase LTC beds by 39 for a total of 120 non-medicaid beds & name change from Greenville HealthCare Ctr, 2/9/96. Facility licensed for 120 beds 10/20/97.
14. CON issued for 8 non-community beds, with conversion of 14 community beds to non-comm with a total of 52 beds (30 community and 22 non-comm), 8/9/94. Facility licensed for 52 beds (30 comm & 22 non-comm), 2/20/95.
15. Facility licensed for 44 bed (33 comm. and 11 non-comm beds), 8/1/90. Additon of 4 private rooms without any change of licensed beds (11 non-comm & 33 comm) of 44, exmpt # E-96-02, 1/10/96.
16. CON issued for 11 additional beds for a total of 106, 9/28/95.Facility licensed beds increased by 4 from 95 to 99 beds 10/1/96. Licensed beds increased by 7 from 99 to 106, 2/12/97. CON for 2 addtional beds for a total of 108, 8/1/97. Licensed beds increased from 106 to 108,8/26/97.
17. CON issued for conversion of 13 hosp beds to 13 nurs hm beds, 9/25/95. Facility licensed hosp beds reduced from 109 to 96 with 13 nurs hm beds licensed, 3/20/96.
18. CON issued for 16 nurs hm beds, 9/22/95. facility licensed for 16 nurs hm beds, 7/15/98. Con issued for 16 additional non-medicaid beds for a total of 32. SC-01-12 2/20/01.
19. App to added an ER , mobile MRI & add 12 general beds to SF Women's Hosp for a total of 62 general beds at SF Woman's Hosp & 206 general beds at SF Hosp, 12/14/95.
20. Formerly Jonathan's Nursing Ctr.
21. CON issued to expanded SFW w/ addition of a er, expansion of surgery, ect & the transfer of 12 general beds from SFH to SFW for 62 general beds & SFH w/ 206 general, 19 rehab & 32 nurs hm bds; provision of mobile MRI services at both hospitals, 2/21/96. SFH licensed beds decreased by 12 from 218 to 206 & SFWF increased by 12 from 50 to 62, 9/30/97.
22. CON issued to convert 10 general beds to 20 nursing home beds for a total of 198 general beds , 18 rehab & 20 nurs hm beds, 8/26/96. Facility licensed general beds reduced from 208 to 198 & licensed for 20 nurs hm beds, 1/31/97.CON issued to convert 22 general beds to 15 psy with 176 general 18 rehab & 20 nurs hm beds,1/27/97. Facility licensed for the 15 psy beds & a reduction of general beds from 198 to 176,6/18/97. Exemption issued to close the 20 bed nurs hm , NA-00-23 4/03/00. Nurs hm closed 4/25/00.
23. CON to transfer 41 beds from the licensed 129 resulting in 88 at Magnolia Manor & construction of a new acility Magnolia Place for 88 beds (41+47 non-medicaid beds), 12/2/96. Con issued for additional 32 beds non-medicaid beds at Magnolia Place for a total of 120 nurs hm beds,10/27/97. Magnolia Place licensed for 60 beds & the 41

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transferred beds will be phased in from 6/1 to 6/10, 5/26/98. Magnolia Manor reduced 129 licensed beds to 88, 7/28/98.Magnolia Place licensed beds increased by from 60 to 120 beds, 07/28/98. Magnolia Manor Greenville Con issued for 11 additional non-medicaid beds for a total of 99 nurs hm beds, 1/31/00 SC-00-04. Magnolia Manor licensed for 99 beds, 9/25/00.

24. CON issued to increase licensed nurs hm beds from 40 to 44 & survey beds from 37 to 41, 2/24/97. Facility licensed for 44 beds, 11/5/98.
25. Con issued for construction of a 112 non-medicaid nurs hm, 9/29/97.
26. App for conversion of 30 general beds to 30 nurs hm beds for a total of 492 general acute, 38 psy & 30 nurs hm beds, 10/20/97. CON voided 3/26/99.
27. Con to construct a 45 non-medicaid beds, 12/29/97. Facility licensed for 45 beds, 2/3/00.
28. Con issued to convert 27 general beds to 27 nurs hm beds resulting in 495 general, 38 psy & 27 nurs hm beds, 05/01/98. Facility licensed for 12 nurs hm beds and the hospital licensed beds reduced by 12 from 522 to 510, 9/29/98. Licensed nurs hm beds increased by 15 to 27 & hospital beds reduced from 510 to 495, 12/18/98.
29. Exempt to close & demolition Greenville Gen with a permanent reduction of 75 general , 11 rehab & trasfer of 3 rehab beds to Greenville Mem for a total of 53 rehab beds, 3/30/98. Building demolished , 1/14/99.
30. Exemption to temporary transfer of 18 ltc acute beds from Spgt Restorative for a total of 36 ltc acute beds at Spgt Gen and must revert back to Sgpt Res Care by 5/31/2002 na-00-42.
31. Con issued for a 43 non medicaid nursing home, 7/31/00 SC-00-39.
32. Con issued for add 41 nurs hm beds (25 medicaid & 16 non-medicaid) for a total of 120 , 08/04/00 Sc-00-40.
33. Con issued for 20 add beds for a total of 132 name changed from Grady Hippe , 8/25/00 Sc-00-43.
34. E-01-20 issued for permanent reduction of nurs hm beds by 28 from 44 to 16 will apply upon licensure change. E-01-20 is voided, 10/4/01.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1999 ER VISITS
REGION I:	EMERGENCY FACILITIES			
II	ANDERSON AREA MED CTR	ANDERSON	ANDERSON	57499
III	UPSTATE CAROLINA M CTR	CHEROKEE	GAFFNEY	20531
III	NORTH GREENVILLE HOSP	GREENVILLE	TRAVELERS REST	16495
I	GREENVILLE MEM HOSP	GREENVILLE	GREENVILLE	84876
II	ST FRANCIS COMM HOSP	GREENVILLE	GREENVILLE	27351
II	ST FRANCIS WOMENS & FAMILY HOSP	GREENVILLE	GREENVILLE	16167
(*)	WJ BARGE	GREENVILLE	GREENVILLE	6474
II	ALLEN BENNETT MEM HOSP	GREENVILLE	GREER	24078
II	HILLCREST HOSP	GREENVILLE	SIMPSONVILLE	21756
III	OCONEE MEM HOSP	OCONEE	SENECA	35348
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	25892
III	CANNON MEM HOSP	PICKENS	PICKENS	12215
III	MARY BLACK MEM HOSP	SPARTANBURG	SPARTANBURG	23285
I	SPARTANBURG REG MED CTR	SPARTANBURG	SPARTANBURG	80047
III	BJ WORKMAN MEMHOSP	SPARTANBURG	WOODRUFF	6434
III	WALLACE THOMSON HOSP	UNION	UNION	14605
TOTALS				473053

(*) Met insufficient criteria to be classified.

REGION I:	TRAUMA CENTERS		
II	ANDERSON AREA MED CTR	ANDERSON	ANDERSON
I	GREENVILLE MEM HOSP	GREENVILLE	GREENVILLE
III	ALLEN BENNETT MEM HOSP	GREENVILLE	GREER
I	SPARTANBURG REG MED CTR	SPARTANBURG	SPARTANBURG

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REGION NARRATIVE

REGION: II FISCAL YEAR:2001

1. Unusual Characteristics: This region has an estimated military population of 10,500 assigned to Fort Jackson. A 450 bed military hospital provides health care services for the military and dependents residing in this region. All of these beds are not in use. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation and communications. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 95% of the Richland County population plus 45% of the population of Lexington County. For Lexington County, 55% of the Lexington County population plus 5% of the Richland County population is used. The bed needs are developed separately with a separate need indicated for each county.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards. There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in five facilities and two Federal facilities in this region.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There are inpatient treatment beds in the three different service areas of this region.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES		NUMBER OF BEDS		
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
II					
HOSPITALS:					
ABBEVILLE	1	0	21	52	-31
CHESTER	1	0	52	82	-30
EDGEFIELD	1	0	14	40	-26
FAIRFIELD	1	0	18	33	-15
GREENWOOD	1	0	188	334	-146
KERSHAW	1	0	84	121	-37
LANCASTER	1	0	107	135	-28
LAURENS	1	0	77	76	1
LEXINGTON	1	0	277	292	-15
NEWBERRY	1	0	39	90	-51
RICHLAND	5	0	1083	1270	-187
YORK	2	0	249	248	1
TOTALS:	17	0	2209	2773	-564
LTC:					
ABBEVILLE	1	0	141	116	25
CHESTER	1	0	218	100	118
EDGEFIELD	1	0	131	88	43
FAIRFIELD	2	1	152	262	-110
GREENWOOD	3	0	335	369	-34
KERSHAW	2	0	294	236	58
LANCASTER	3	0	293	288	5
LAURENS	2	0	402	365	37
LEXINGTON	6	0	827	824	3
MCCORMICK	1	0	59	120	-61
NEWBERRY	2	0	318	276	42
RICHLAND	11	3	1201	1088	113
SALUDA	1	0	105	176	-71
YORK	6	0	745	713	32
TOTALS:	42	4	5221	5021	476

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REGION:II — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
YZ	ABBEVILLE CO. MEM.	18	ABBEVILLE	ABBEVILLE	CO	52	52		1386	5161	52	27.2%
	ABBEVILLE CO.		TOTAL			52	52		1386	5161	52	27.2%
XYZ	CHESTER CO. HOSP.		CHESTER	CHESTER	DIST	82	82		3243	12928	82	43.2%
	CHESTER CO.		TOTAL			82	82		3243	12928	82	43.2%
XYZ	EDGEFIELD CO. HOSP.		EDGEFIELD	EDGEFIELD	CO	40	40		880	3098	40	21.2%
	EDGEFIELD CO.		TOTAL			40	40		880	3098	40	21.2%
XYZ	FAIRFIELD MEM.		FAIRFIELD	WINNSBORO	NPA	33	33		973	4341	33	36.0%
	FAIRFIELD CO.		TOTAL			33	33		973	4341	33	36.0%
XYZ	SELF MEM.	27	GREENWOOD	GREENWOOD	NPA	334	334		10312	49681	361	37.7%
	GREENWOOD CO.		TOTAL			334	334		10312	49681	361	37.7%
XYZ	KERSHAW CO. MED.CTR.		KERSHAW	CAMDEN	CO	121	121		4442	21193	121	48.0%
	KERSHAW CO.		TOTAL			121	121		4442	21193	121	48.0%
XYZ	SPRINGS MEM HOSPITAL	21	LANCASTER	LANCASTER	NPA	135	135		6821	27904	135	56.6%
	LANCASTER CO.		TOTAL			135	135		6821	27904	135	56.6%
XYZ	LAURENS CO. HOSP.	36	LAURENS	LAURENS	DIST	76	76		3724	19016	90	57.9%
	LAURENS CO.		TOTAL			76	76		3724	19016	90	57.9%
XYZ	LEXINGTON MED CTR		LEXINGTON	WEST COLUMBIA	CO	292	292		14673	68045	292	63.8%
	LEXINGTON CO.		TOTAL			292	292		14673	68045	292	63.8%
XYZ	NEWBERRY CO. MEM.	31	NEWBERRY	NEWBERRY	CO	102	90		2350	10055	102	27.0%
	NEWBERRY CO.		TOTAL			102	90		2350	10055	102	27.0%
XYZ	PALMETTO BAPTIST MED. CTR. OF COLA	1	RICHLAND	COLUMBIA	NPA	363	363		16052	71623	364.9	49.3%
XYZ	PROVIDENCE HOSPITAL	23	RICHLAND	COLUMBIA	PROP	228	247		11280	62684	219.8	78.0%
XYZ	PROVIDENCE HOSPITAL NE	28	RICHLAND	COLUMBIA	PROP	46	46		713	3204	27.01	32.5%
Y	INTERMEDICAL HOSP OF SC	1	RICHLAND	COLUMBIA	NPA	35	35		63	1784	33.08	14.8%
XYZ	PALMETTO RICHLAND MEM. HOSP.	15	RICHLAND	COLUMBIA	CO	579	579		28145	153892	579	72.8%
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(400)		(3683)	(44232)		
X	MONCRIEF ARMY H	2	RICHLAND	COLUMBIA	FED		(63)		(1037)	(4856)		
	RICHLAND CO		TOTAL			1251	1270		56253	293087	1163.7	89.0%
XYZ	PIEDMONT MED. CTR.		YORK	ROCK HILL	PROP	248	248		13044	60628	248	67.0%
	YORK CO		TOTAL			248	248		13044	60628	248	67.0%
	TOTAL					2766	2773		118101	575137	2719.7	57.9%
	MENTAL FACILITIES:											
YZ	CHARTER RIVERS	3	LEXINGTON	WEST COLUMBIA	PROP	39	39		1135	9532	39	67.0%

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REGION:II

INPATIENT INVENTORY OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	LEXINGTON CO.		TOTAL			39	39		1135	9532	39	67.0%
XYZ	SELF MEM.		GREENWOOD	GREENWOOD	NPA	36	36		499	4886	36	37.2%
	GREENWOOD CO.		TOTAL			36	36		499	4886	36	37.2%
XYZ	PALMETTO BAPTIST MED. CTR. COLA.		RICHLAND	COLUMBIA	NPA	104	104		1553	12676	104	33.4%
XYZ	PALMETTO RICHLAND MEM. HOSP.	4	RICHLAND	COLUMBIA	CO	60	60		1347	16311	60	74.5%
X	MONCRIEF ARMY H	2	RICHLAND	COLUMBIA	FED		(20)		(377)	(3020)		
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(60)		(492)	(3743)		
	RICHLAND CO		TOTAL			164	164		2900	28987	164	48.4%
XYZ	PIEDMONT MED. CTR.	19	YORK	ROCK HILL	PROP	20	20		532	4068	20	55.7%
	YORK CO		TOTAL			20	20		532	4068	20	55.7%
	TOTAL					259	259		5066	47473	259	50.2%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:											
	CHARTER RIVERS	5	LEXINGTON	WEST COLUMBIA	PROP	14	14		15	4837	14	94.7%
	NEW HOPE MIDLANDS	6	LEXINGTON	WEST COLUMBIA	PROP	54	54		82	16837	54	85.4%
	LEXINGTON CO		TOTAL			68	68		97	21674	68	87.3%
	YORK PLACE		YORK	YORK	PROP	40	40		28	10250	40	70.2%
	YORK CO		TOTAL			40	40		28	10250	40	70.2%
	TOTAL					108	108		125	31924	108	81.0%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	CHARTER RIVERS	5	LEXINGTON	WEST COLUMBIA	PROP	27	27		448	2116	27	21.5%
	SPRINGS MEM HOSPITAL		LANCASTER	LANCASTER	NPA	45	45		692	5819	45	35.4%
	FAIRFIELD MEM.		FAIRFIELD	WINNSBORO	NPA	17	17		0	0	17	0.0%
	PALMETTO RICHLAND SPRINGS		RICHLAND	COLUMBIA	CO	10	10		354	3072	10	84.2%
	SELF MEM. HOSP.		GREENWOOD	GREENWOOD	NPA	24	24		0	0	24	0.0%
	TOTAL					123	123		1494	11007	123	24.5%
	REHABILITATION FACILITIES:											
YZ	HEALTHSOUTH REHABILITATION HOSPITAL OF COLA	29	RICHLAND	COLUMBIA	PROP	89	96		1391	26673	89	82.1%
	RICHLAND CO		TOTAL			89	96		1391	26673	89	82.1%
	HEALTHSOUTH REHABLITATION HOSPITAL	29	YORK	ROCK HILL	PROP	20	20					
	YORK CO		TOTAL			20	20					
	LONG TERM CARE FACILITIES:											

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REGION:II — INPATIENT INVENTORY — OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	ABBEVILLE NURS HM		ABBEVILLE	ABBEVILLE	PROP	94	94		32	33097	94	96.5%
Z	CARLISLE NURSING CTR	30	ABBEVILLE	DUE WEST	NPA	22	22		14	1026	22	12.8%
	ABBEVILLE CO		TOTAL			116	116		46	34123	116	80.6%
YZ	CHESTER CO NURS CTR		CHESTER	CHESTER	CO	100	100		97	35924	100	98.4%
	CHESTER CO		TOTAL			100	100		97	35924	100	98.4%
Z	EDGEFIELD HLTH CARE CTR		EDGEFIELD	EDGEFIELD	PROP	88	88		43	31129	88	96.9%
	EDGEFIELD CO		TOTAL			88	88		43	31129	88	96.9%
Z	FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	104	36 C	84	39030	112	95.5%
Z	RIDGEWAY HEALTH & REHABILITATION CTR		FAIRFIELD	RIDGEWAY	PROP	150	150		87	51593	150	94.2%
	FAIRFIELD CO		TOTAL			262	254	36	171	90623	262	94.8%
YZ	HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102		73	33992	102	91.3%
YZ	MAGNOLIA MANOR-GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88		54	31505	88	98.1%
YZ	NHC HEALTHCARE- GREENWOOD	8	GREENWOOD	GREENWOOD	PROP	152	152		200	51932	152	93.6%
YZ	TRANSITIONAL CARE OF SELF MEM HOSP	27	GREENWOOD	GREENWOOD	NPA	27	27		267	3045	20.2	41.3%
	GREENWOOD CO		TOTAL			369	369		594	120474	362.2	91.1%
YX	A SAM KARESH LTC		KERSHAW	CAMDEN	CO	88	88		38	31938	88	99.4%
Y	SPRINGDALE HEALTHCARE CTR	7	KERSHAW	CAMDEN	PROP	148	148		379	47552	148	88.0%
	KERSHAW CO		TOTAL			236	236		417	79490	236	92.3%
YX	CENTRAL CAROLINAS REHAB COMPLEX	29	LANCASTER	LANCASTER	PROP	(22)	(22)		216	3665	22	45.5%
YZ	LANCASTER CONVL CTR	24	LANCASTER	LANCASTER	NPA	142	142		90	43936	126.5	95.2%
YZ	TRANSITIONAL CARE UNIT-SPRINGS MEM	21	LANCASTER	LANCASTER	NPA	14	14		323	3716	14	72.7%
YZ	WHITE OAK MANOR-LANCASTER		LANCASTER	LANCASTER	NPA	132	132		50	47202	132	98.0%
	LANCASTER CO		TOTAL			266	266		679	98509	294.5	91.6%
NHM	LAURENS CO HOSP/SNF	36	LAURENS	LAURENS	DIST	14	14					
YZ	NHC HEALTHCARE LAURENS		LAURENS	LAURENS	PROP	176	176		215	60702	176	94.5%
NHM	MARTHA FRANK BAP RET CTR	9	LAURENS	LAURENS	NPA	44	44		138	29043	88	90.4%
YZ	NHC HEALTHCARE CLINTON		LAURENS	CLINTON	PROP	131	131		187	46129	131	96.5%
	LAURENS CO		TOTAL			365	365		540	135874	395	94.2%
APP	AGAPE NURSING AND REHABILIATION	40	LEXINGTON	W.COLUMBIA	PROP		44					
YZ	BRIAN CTR-ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120		110	40602	120	92.7%
YZ	LEXINGTON MED CTR EXTENDED CARE	10	LEXINGTON	LEXINGTON	NPA	352	388		441	124649	352	97.0%
YZ	MANOR CARE HLTH SERVICES W COLA	11	LEXINGTON	W.COLUMBIA	PROP	132	132		349	38213	132	79.3%
NHM	NHC HEALTHCARE LEXINGTON	12	LEXINGTON	W.COLUMBIA	PROP	120	120		273	40418	120	92.3%
NHM	SC EPISCOPAL HM @ STILL HOPES	13	LEXINGTON	W.COLUMBIA	NPA	20	20		48	20351	65.2	85.5%
	LEXINGTON CO		TOTAL			744	780	0	1221	264233	769.2	91.7%
YZD	MCCORMICK NURS CTR	25	MCCORMICK	MCCORMICK	CO	120	120		75	42672	120	97.4%
	MCCORMICK CO		TOTAL			120	120		75	42672	120	97.4%
YZ	J F HAWKINS NURS HM	20	NEWBERRY	NEWBERRY	CO	118	118		34	35770	98	100.0%
Y	NEWBERRY CO MEM HOSP-TRANSITIONAL	31	NEWBERRY	NEWBERRY	CO	12	12		49	581	7.3	21.8%
YZ	WHITE OAK MANOR-NEWBERRY	28	NEWBERRY	NEWBERRY	PROP	146	146		135	51640	146	96.9%

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REGION:II

INPATIENT INVENTORY OCT.1,1998-SEPT.30,1999

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	NEWBERRY CO					276	276		218	87991	251.3	95.9%
Y	BENZIE T. RICE NURSING FACILITY	34	RICHLAND	COLUMBIA	NPA	20	20		17	1553	10.2	41.7%
y	BERNADIN HOSPICE HOUSE	39	RICHLAND	COLUMBIA	NPA	12	12					
YZ	CENTRAL CAROLINA HLTH & REHAB	37	RICHLAND	COLUMBIA	PROP	257	250	146 od	387	89670	257	95.6%
YZ	LIFE CARE CTR OF COLA	17	RICHLAND	COLUMBIA	PROP	140	140		202	48414	140	94.7%
YZ	LOWMAN HOME NURSING CTR		RICHLAND	WHITEROCK	NPA	129	129		199	58906	176	91.7%
YZ	MAGNOLIA MANOR-COLA		RICHLAND	COLUMBIA	PROP	88	88		110	30960	88	96.4%
YZ	MANORCARE HLTH SERVICES COLA	14	RICHLAND	COLUMBIA	PROP	132	132		109	40416	132	83.9%
Y	NHC HEALTHCARE PARKLAND	16	RICHLAND	COLUMBIA	PROP	120	120		165	39706	120	90.7%
Y	PROVIDENCE HOSP-TCU	23	RICHLAND	COLUMBIA	NPA	(19)	(19)		115	1489	4.84	84.3%
Y	PROVIDENCE HOSP NE-TCU	26	RICHLAND	COLUMBIA	PROP	18	18		291	3977	14	77.8%
Y	PALMETTO BAPTIST MED CTR	1	RICHLAND	COLUMBIA	NPA	22	22		478	5347	22	66.6%
NHM	RIDGEVIEW MANOR	32	RICHLAND	HOPKINS	PROP	30	30		26	7300	26	76.9%
YZ	WHITE OAK MANOR-COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120		144	43065	120	98.3%
FED	W J B DORN VA		RICHLAND	COLUMBIA	FED		(160)		(76)	(30892)		
	RICHLAND CO		TOTAL			1069	1062	146	2243	370803	1110.04	91.5%
YZ	SALUDA NURS CTR		SALUDA	SALUDA	CO	176	176		173	62242	176	96.9%
	SALUDA CO		TOTAL			176	176		173	62242	176	96.9%
NHM	CAROLINA VILLAGE HLTH CARE CTR	33	YORK	ROCK HILL	PROP	40	40					
NHM	EBENEZER NURS HM	38	YORK	ROCK HILL	PROP	44	99		104	14870	44	92.6%
YZ	MAGNOLIA MANOR -ROCK HILL		YORK	ROCK HILL	PROP	106	106		74	37212	106	96.2%
YZ	BEVERLY HEALTH CARE-ROCK HILL		YORK	ROCK HILL	PROP	132	132		312	44742	132	92.9%
YZ	HEALTHSOUTH REHABLITATION HOSP (SNF	29	YORK	ROCK HILL	PROP	20	20					
YZ	WHITE OAK MANOR-ROCK HILL		YORK	ROCK HILL	PROP	141	141		117	50968	141	99.0%
NHM	WESTMINSTER TOWERS	35	YORK	ROCK HILL	PROP	66	66		151	13802	44	85.9%
YZ	WHITE OAK MANOR-YORK	22	YORK	YORK	NPA	109	109		32	36012	99	99.7%
	YORK CO		TOTAL			658	713		790	197606	566	95.7%
	TOTAL					4845	4921	182	7232	1609021	4746.24	92.9%

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FOOTNOTES

__REGION II

FY2001 PLAN

CON-Certificate of Need
UC-Under Contract
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued to transfer 35 general beds BMCC to est a 35 beds long term acute care hosp InterMedical Hosp of SC resulting in 363 general acute care, 104 psy 22 nursing hm & 35 longterm acute beds, 9/2/97. InterMedical licensed for 35 long term care acute beds & Palmetto Baptist MCC licensed gen beds reduced from 398 to 363, 10/21/98.
2. Bed use restricted. Beds reported by facility.
3. CON issued to convert 5 D&A beds to 5 Psy. beds for 41 D&A beds and 39 Psy. beds, 5/10/93. Facility licensed on same date as CON, 5/10/94.
4. CON issued for 23 crisis stab beds for a total of 60 psy(37 & 23 crisis) beds,12/22/94. Licensed per con, 2/1/95. CON issued to construct/renovate & create a 20 bed non licensed observation unit adjacent to the ER, 12/11/98.
5. CON issued for 14 RTF beds by converting 14 inpat treat beds with a total of 39 psy., 27 inpat. treat and 14 RTF beds, 11/4/93. Licensed for 14 RTF beds, 9/21/94.
6. Facility licensed for 30 RTF beds 1/13/93. CON issued to add 14 RFT beds with a total of 44 RFT beds, 11/2/93. CON issued to add 10 RTF beds with a total of 54 RTF beds, 4/26/94. Facility licensed, for 54 beds, 4/8/95.
7. CON for 23 additional non-Medicaid LTC beds for a total of 148 beds, 5/19/93. Licensed for 148 LTC beds, 9/20/94.
8. Formerly Greenwood Health Care.
9. CON issued to construct a 44 community non-Medicaid bed addition, 8/31/94. Licensed for 2 comm beds & 44 non-comm beds, 7/3/95. Licensed comm beds increased from 2 to 44, 2/5/96.
10. CON issued for 185 replacement facility, 10/10/94. CON for 35 additional non-Medicaid beds for a total of 220, 11/38/94. Licensed beds increased from 185 to 220, 8/29/96. Licensed combined for Rikard (132 beds) & Kiesler/Holstedt (220 beds) for 352, 10/1/97 and Facility licensed as Lexington Med Ctr Extended Care. Con issued for 36 non-medicaid beds for a total of 388,SC-00-12 2/29/00.
11. CON issued for 12 non-medicaid nurs beds for total of 132 beds, 1/20/95. Facility licensed for addtional 12 beds for 132 nurs hm beds, 3/1/97.
12. CON issued for 83 beds, 7/06/90. Facility licensed 3/9/94. CON issued for 5 additional beds for a total of 88, 5/16/94. Facility licensed for 88 beds, 10/19/94. Con issued for 23 addtional beds for a total of 111, 9/9/96. CON issued for 9 additional beds for a total of 120,3/21/97. Facility licensed beds increased by 32 from 88 to 120, 8/25/98.

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13. Approved to convert 8 non-community beds to community beds for 36 non-community and 8 community beds, 10/18/94. Licensed per con, 12/1/94. con issued to convert 12 institutional beds to 12 comm for a total 46 institutional beds & 20 comm beds, 12/22/97. Facility licensed for 46 institutional & 20 comm nurs hm beds, 1/1/99. Facility licensed non-comm beds reduced by 4 to 42 non-comm & 20 comm, e-90-41, 7/15/99. Facility licensed for 42 non-comm & 20 comm, 7/16/99.
14. CON issued for 14 additional non-Medicaid beds for a total of 132, 10/24/94. Facility licensed beds increased by 14 from 118 to 132 nurs hm beds, 1/14/97.
15. CON issued for purchase of a Gamma Knife, 3/18/97. NA-99-97 for renovation of the 11th floor for the addition of 26 general beds with no change it the licensed bed capacity, 11/18/99.
16. CON issued to NHC Ctr. of Columbia for a 132 bed non-Medicaid nursing home, 6/6/94. CON reduced from 132 to 120, 5/5/95. Facility licensed for 120 nurs hm beds & name changed, 5/2/97.
17. CON issued 132 dual beds (80 Medicaid), 12/20/91. Facility licensed for 132 beds, 6/27/94. CON issued for 8 additional non-medicaid beds for a total of 140 (80 medicaid) nurs hm beds, 4/24/97. Facility licensed beds increased by 8 from 132 to 140, 6/23/98.
18. Close ob service of 8 beds 9/8/95.
19. CON issued for relocation of the 20 psy beds to a new building & converting the semi-private rooms on the old psy floor to private with no change in licensed beds, 2/5/96.
20. CON issued to add 20 non-medicaid beds for a total of 98 nurs hm beds, 6/7/96. Facility licensed for 98 nur hm beds, 1/3/97. CON issued for 20 non-medicaid beds for a total of 118, 7/7/97. Facility licensed increased from 98 to 118 , 9/6/00.
21. CON issued for conversion of 14 general beds to 14 nurs hm beds for a total of 135 general beds , 45 D&A beds & 14 nurs hm beds, 9/16/96. Facility licensed for 14 nurs hm beds & 135 general beds ,4/25/97.
22. CON issued for 33 additional non-medicaid nurs hm beds for a total of 99 nurs hm beds, 9/30/96. Facility licensed beds increased by 33 for 99 nurs hm beds, 9/23/97. Con issued for 10 add non-medicaid beds ,SC-00-10 2/23/00. License beds increased by 10 from 99 to 109 , 6/8/00.
23. Con for for renovation & construction to include the addition of 19 nurs hm beds resulting in 239 general & 19 nurs hm beds, 10/07/96. Licensed for 19 nurs hm beds, 12/4/96. Exempt #E99-12 to permanent close 19 bed nurs hm, 3/15/99. The licensed 19 nurs hm beds at Providence closed, 4/5/99. See fn #26.
24. App for 10 additional non-medicaid beds & 22 replacement beds to increase from 110 to 120 nurs hm beds, 10/2/96. Facility licensed beds increased from 110 to 120,11/12/97. CON issued to add 22 non-medicaid beds for a total of 142 nurs hm beds, 1/26/99. Facility licensed for 142 nurs beds,6/15/99.
25. CON issued for 32 additional medicaid beds for a total of 120 beds, 11/25/96. Facility licensed for 120 beds, 2/13/98.
26. CON issued for construction of a new 46 general hosp & 18 non-medicaid nurs beds by the transfer of 46 general beds from Providence resulting in 193 general beds ,19 nurs beds at Cola Providence & 46 general ,18 nurs hm beds at Cola Providence NE, 2/14/97. Providence NE licensed for 34 gen beds & 18 nurs beds, 3/23/99. Providence Hosp licensed beds reduced by 34 from 239 to 205, 5/28/99. Con issued for 54 additional general beds for a total of 247 general beds, SC-99-41 11/2/99. Providence NE licensed beds increased from 34 to 46, 12/15/99. Licensed general

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beds at Providence increased by 23 from 205 to 228, 12/15/99.

27. App for conversion of 38 general beds to nurs hm beds for a capacity of 323 licensed general(326 survey), 36 psy, 24 sub abuse beds & 38 nurs hm beds, 2/20/97. Appealed. Court order compromise for 27 nurs hm beds & 334 licensed beds (made survey & licensed beds the same by reducing survey by 4 beds), con issued 7/29/97. Facility licensed beds reduced from 361 to 334 general beds & 27 nurs hm beds licensed, 1/1//99. Con issued for 10 additional critical beds w/o change of licensed bed capacity , 2/2/01 sc-01-07.
28. Con to add 20 non-medicaid beds for total of 146 nurs hm beds, 6/13/97. Facility licensed increased from 126 to 146, 5/1/98.
29. Con issued for a 20 beds rehab hosp & 20 nurs hm beds (non-medicaid) with a reduction of 12 rehab beds from Hlth South Cola from 89 to 77 rehab beds, 5/27/97. Licensed for 20 rehab beds & 20 nurs hm beds, 4/28/00. Facility closed in Lancaster for 22 nurs beds , 4/30/00. Health South Cola beds reduced from 89 to 77 4/28/00. Hlth South Con issued for Cola to added 19 rehab beds for a total of 96, 9/25/00 SC-00-47. Health South Cola licensed beds increased by 12 from 77 to 89 10/10/00.
30. CON issued for a 22 bed non-medicaid nurs hm, 9/10/97. Facility licensed for 22 nurs hm beds, 6/11/99.
31. App to convert 12 acute care beds to 12 non-medicaid nurs hm beds resulting in 90 acute care & 12 nurs hm beds, 9/2/97. Licensed for 12 nurs hm beds and 90 hospital beds, 2/19/99.
32. Con issued to constructed a new facility to replace 26 licensed beds at Stanton Pines & 21 survey with 11cd beds plus 4 additional non-medicaid beds for a total of 30 nurs hm beds, 12/01/97. Name changed to Ridgeview Manor. Facility licensed beds increased by 4 from 26 to 30 , 4/17/00.
33. Con issued for a 40 bed non-medicaid nurs hm, 9//98. Licensed for 40 beds, 1/24/01.
34. CON issued for 20 non-medicaid nurs hm beds, 1/4/99. Facility licensed for 20 nurs hm beds, 3/29/99.
35. CON issued for an add 22 non-medcaid nurs beds for a total of 66 nurs beds, 1/5/99. Licensed beds increased from 44 to 66, 8/6/01.
36. CON issued to convert 14 acute beds to 14 nurs hm beds resulting in 76 acute beds & 14 nurs hm beds, sc-99-08 2/25/99.Facility licensed for 76 hospital beds & 14 nurs beds, 3/31/00.
37. Name changed from Brian Ctr-Forest Hill.
38. Con issued for 55 add non-medicaid beds for a total of 99, SC-00-08 2/1/2000.
39. Con issued for 12 non-medicaid nurs beds , 3/9/98. Facility licensed 4/18/00.
40. Con issued for 44 non-medicaid nurs beds , SC-01-55 10/9/01.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1999 E VISITS
REGION II:	EMERGENCY FACILITIES			
III	ABBEVILLE CO MEM HOSP	ABBEVILLE	ABBEVILLE	10825
II	CHESTER CO HOSP	CHESTER	CHESTER	15806
III	EDGEFIELD CO HOSP	EDGEFIELD	EDGEFIELD	6088
III	FAIRFIELD CO HOSP	FAIRFIELD	FAIRFIELD	13788
II	SELF MEM HOSP	GREENWOOD	GREENWOOD	34507
III	KERSHAW CO MEM HOSP	KERSHAW	CAMDEN	21851
II	SPTINGS MEMORIAL HOSP	LANCASTER	LANCASTER	26692
II	LAURENS COUNTY HOSP	LAURENS	LAURENS	24224
II	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	69481
III	NEWBERRY CO MEM HOSP	NEWBERRY	NEWBERRY	12791
II	PALMETTO BAPTIST MED CTR-COLA	RICHLAND	COLUMBIA	39624
II	PROVIDENCE HOSPITAL	RICHLAND	COLUMBIA	18794
II	PROVIDENCE HOSPITAL NE	RICHLAND	COLUMBIA	9856
I	PALMETTO RICHLAND MEM HOSP	RICHLAND	COLUMBIA	73612
II	PIEDMONT MED CTR	YORK	ROCK HILL	46931
TOTALS				424870
REGION II:	TRAUMA CENTERS			
III	SELF MEM HOSP	GREENWOOD		
III	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	
I	PALMETTO RICHLAND MEM HOSP	RICHLAND	COLUMBIA	7878
III	PALMETTO BAPTIST MED CTR-COLA	RICHLAND	COLUMBIA	

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REGION NARRATIVE

REGION: III FISCAL YEAR:2001

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." Shaw Air Force Base near Sumter has an estimated military population of 9,800. A 65 bed hospital provides health care services for the military and dependents residing in this region. The inland waterway is a barrier to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards. There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in four facilities in this region. There is a need for additional psychiatric beds in the Horry, Georgetown and Williamsburg Counties area.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. To make these services more accessible, there is some need in this region.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES		NUMBER OF BEDS		
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
III					
HOSPITALS:					
CHESTERFIELD	1	0	25	59	-34
CLARENDON	1	0	50	56	-6
DARLINGTON	2	0	108	166	-58
DILLON	1	0	58	79	-21
FLORENCE	5	0	653	666	-13
GEORGETOWN	1	0	143	142	1
HORRY	3	0	421	484	-63
MARION	2	0	126	124	2
MARLBORO	1	0	38	94	-56
SUMTER	2	0	226	229	-3
WILLIAMSBURG	1	0	22	78	-56
TOTALS:	20	0	1870	2177	-307
LTC:					
CHESTERFIELD	3	0	265	211	54
CLARENDON	2	1	176	152	24
DARLINGTON	4	0	351	366	-15
DILLON	2	1	133	208	-75
FLORENCE	8	1	589	795	-206
GEORGETOWN	2	0	254	242	12
HORRY	9	0	1221	676	545
LEE	1	0	94	120	-26
MARION	3	1	250	180	70
MARLBORO	2	1	144	118	26
SUMTER	4	1	445	428	17
WILLIAMSBURG	2	1	148	176	-28
TOTALS:	42	7	4070	3672	748

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	CHESTERFIELD GENERAL	27	CHESTERFIELD	CHERAW	PROP	59	59		2195	7224	59	33.5%
	CHESTERFIELD CO.		TOTAL			59	59		2195	7224	59	33.5%
XY	CLARENDON MEM.		CLARENDON	MANNING	CO	56	56		2213	12078	56	59.1%
	CLARENDON CO.		TOTAL			56	56		2213	12078	56	59.1%
XYZ	CAROLINA PINES REG MED CTR	24	DARLINGTON	HARTSVILLE	NPA	116	116		5773	24190	116	57.1%
XYZ	WILSON MEDICAL CTR	36	DARLINGTON	DARLINGTON	NPA	49	49		938	4476	50	24.5%
	DARLINGTON CO.		TOTAL			165	165		6711	28666	166	47.3%
XYZ	SAINT EUGENE MEDICAL CENTER	23	DILLON	DILLON	NPA	79	79		3820	13693	79	47.1%
	DILLON CO.		TOTAL			79	79		3820	13693	79	47.1%
XYZ	CAROLINAS HOSP SYS	1	FLORENCE	FLORENCE	PROP	282	282		11413	56601	290	55.4%
XYZ	CAROLINAS HOSP SYS LAKE CITY		FLORENCE	LOWER FLORENCE	DIST	48	48		1243	6407	48	36.6%
XYZ	MCLEOD REG MED CTR	2	FLORENCE	FLORENCE	NPA	336	336		21791	104278	336	85.0%
APP	NEXTCARE SPECIALTY HOSP OF SC	1	FLORENCE	FLORENCE	PROP	26	26					
YZ	WOMEN'S CENTER CAROLINA HOSP SYS		FLORENCE	FLORENCE	PROP	20	20		1510	4407	20	60.4%
	FLORENCE CO.		TOTAL			694	694		35957	173693	694	68.6%
XYZ	GEORGETOWN CO. MEM.	35	GEORGETOWN	GEORGETOWN	NPA	142	102		7951	35790	142	69.1%
APP	WACCAMAW NECK HOSP	35	GEORGETOWN	MURRELLS INLET	NPA		40					
	GEORGETOWN CO.		TOTAL			142	142		7951	35790	142	69.1%
XYZ	CONWAY HOSP. INC.		HORRY	CONWAY	NPA	160	160		9153	37382	160	64.0%
XYZ	GRAND STRAND REG MED CTR	19	HORRY	MYRTLE BEACH	PROP	210	219		10886	41840	172	66.6%
XYZ	LORIS COMM. HOSP.	3	HORRY	LORIS	DIST	105	105		4409	18410	105	48.0%
	HORRY CO.		TOTAL			475	484		24450	97632	437	61.2%
XYZ	MARION CO MEDICAL CTR	13	MARION	MARION	DIST	124	124		7582	32520	124	71.9%
	MARION CO.		TOTAL			124	124		7582	32520	124	71.9%
	MARLBORO PARK	27	MARLBORO	BENNETTSVILLE	PROP	94	94		2086	9257	94	27.0%
	MARLBORO CO.		TOTAL			94	94		2086	9257	94	27.0%
X	SHAW AFB	5	SUMTER	SUMTER	FED		(21)		(1255)	(2577)		
XYZ	TUOMEY REG MED CTR	20	SUMTER	SUMTER	NPA	229	229		10121	57037	229	68.2%
	SUMTER CO.		TOTAL			229	229		10121	57037	229	68.2%
XYZ	WILLIAMSBURG REGIONAL HOSP		WILLIAMSBURG	KINGSTREE	CO	78	78		1345	5576	78	19.6%
	WILLIAMSBURG CO.		TOTAL			78	78		1345	5576	78	19.6%
	TOTAL					2195	2204		104431	473066	2156	60.1%
	MENTAL FACILITIES:											
XYZ	MCLEOD REG.		FLORENCE	FLORENCE	NPA	35	35		931	5727	35	44.8%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	FLORENCE CO.		TOTAL			35	35		931	5727	35	44.8%
YZ	(CHARTER SANDS BEHAVIORAL HLTH SYS)	6	HORRY	CONWAY	PROP	(45)	(45)					
	HORRY CO.		TOTAL			(45)	(45)					
XYZ	MARLBORO PARK	27	MARLBORO	BENNETSVILLE	PROP	8	8		156	1641	8	56.2%
	MARLBORO CO.		TOTAL			8	8		156	1641	8	56.2%
XYZ	TUOMEY REG MED CTR		SUMTER	SUMTER	NPA	19	19		401	2913	19	42.0%
	SUMTER CO.		TOTAL			19	19		401	2913	19	42.0%
	TOTAL					62	62		1488	10261	62	45.4%
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:											
YZ	PALMETTO PEE DEE RTC	6	FLORENCE	FLORENCE	PROP	18	59		15	5010	18	76.3%
	FLORENCE CO.		TOTAL			18	59		15	5010	18	76.3%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	CAROLINAS HOSP SYS -CEDAR TOWERS	7	FLORENCE	FLORENCE	PROP	4	4					
	CAROLINAS HOSP SYS -CEDAR TOWERS	7	FLORENCE	FLORENCE	PROP	18	18		379	1908	46	11.4%
	(CHARTER SANDS BEHAVIORAL HLTH SYS)	6	HORRY	CONWAY	PROP							
	TOTAL					22	22		379	1908	46	11.4%
	REHABILITATION FACILITIES:											
YZ	HEALTH-SOUTH REHABILITATION HOSPITAL OF FLORENCE		FLORENCE	FLORENCE		88	88		1282	26180	88	81.6%
	CAROLINAS HOSP SYS -CEDAR TOWERS		FLORENCE	FLORENCE	NPA	24	24		535	6219	24	71.0%
	FLORENCE CO.		TOTAL			112	112		1817	32399	112	79.3%
APP	WACCAMAW NECK HOSP	35	GEORGETOWN	MURRELLS INLET	NPA		19					
	GEORGETOWN		TOTAL				19					
	LONG TERM FACILITIES:											
YZ	CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	100	99		35	36109	100	98.9%
Z	CHESTERFIELD GEN HOSP SNF		CHESTERFIELD	CHERAW	PROP	7	7		120	1218	7	47.7%
YZ	CHESTERFIELD CONVL CTR	15	CHESTERFIELD	CHERAW	PROP	104	104		38	37414	104	98.6%
	CHESTERFIELD CO		TOTAL			211	210		193	74741	211	97.0%
YX	LAKE MARION NURSING FAC		CLARENDON	SUMMERTON	PROP	88	88		53	31070	88	96.7%
YX	WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	26 cd	32	22160	64	94.9%
	CLARENDON CO		TOTAL			152	131	26	85	53230	152	95.9%
YZ	P[illegible]EA BAPTIST HOME	8	DARLINGTON	DARLINGTON	NPA	[illegible]	36		45	16664	88	51.9%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	MEDFORD PLACE	9	DARLINGTON	DARLINGTON	PROP	88	88		104	30082	88	93.7%
YZ	MORRELL MEM CONV CTR	28	DARLINGTON	HARTSVILLE	PROP	154	154		75	52303	148	96.8%
YZ	OAKHAVEN CONV CTR	21	DARLINGTON	DARLINGTON	PROP	88	88		38	31695	88	99.3%
	DARLINGTON CO		TOTAL			366	366		262	130944	412	87.1%
YZ	BEVERLY HEALTHCARE THE PINES		DILLON	DILLON	PROP	84	84		94	30569	84	99.7%
YZ	SUNNY ACRES , INC		DILLON	FORK	PROP	111	106	56 cd	39	40180	111	99.2%
YZ	ST EUGENE MED CTR-SNF	23	DILLON	DILLON	NPA	13	13		128	937	13	19.7%
	DILLON CO		TOTAL			208	203	56	261	71686	208	94.4%
YZ	CAROLINAS HOSP SYS TRANSITIONAL CARE UNIT	1	FLORENCE	FLORENCE	PROP	44	44		473	9532	44	59.4%
YZ	COMMANDER HLTH CARE		FLORENCE	FLORENCE	PROP	163	152		105	58285	163	98.0%
YZ	FAITH HEALTHCARE CTR		FLORENCE	FLORENCE	PROP	104	93		101	33945	104	89.4%
Z	CLARKE NURSING CENTER	38	FLORENCE	FLORENCE	PROP	88	88	44 d	47	31734	88	98.8%
YZ	HERITAGE HM OF FLORENCE	34	FLORENCE	FLORENCE	PROP	132	132		86	36585	123 8	81.0%
YZ	HONORAGE HM OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88		44	31425	88	97.8%
YZ	LAKE CITY/SCRANTON HLTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88		59	30412	88	94.7%
YZ	SOUTHLAND HLTH CARE CTR		FLORENCE	FLORENCE	PROP	88	88	(42) cd	45	32034	88	99.7%
	FLORENCE CO		TOTAL			795	773	44	961	263952	786.8	91.9%
APP	GEORGETOWN MEM HOSP SNF	35	GEORGETOWN	GEORGETOWN	NPA		10					
YZ	PRINCE GEORGE HLTHCARE CENTER	10	GEORGETOWN	GEORGETOWN	PROP	148	148		227	49646	148	91.9%
YZ	WINYAH EXTENDED CARE CTR		GEORGETOWN	GEORGETOWN	PROP	84	84		71	27954	84	91.2%
	GEORGETOWN CO		TOTAL			232	242		298	77600	232	91.6%
NH	(COMPASS TRANSITIONAL CARE)	6	HORRY	CONWAY	PROP	(20)	(20)					
Y	COVENANT TOWERS		HORRY	MYRTLE BEACH	PROP	30	30		43	8691	30	79.4%
YZ	CONWAY NURS CTR		HORRY	CONWAY	PROP	190	190		222	64859	190	93.5%
Y	GRAND STRAND HLTH CARE	31	HORRY	CONWAY	PROP	88	88		39	31849	88	99.2%
NH	(GRAND STRAND REG /ECU)	19	HORRY	MYRTLE BEACH	PROP	(18)	(18)		619	5134	18	78.1%
YZ	KINGSTON NURS CTR		HORRY	CONWAY	PROP	88	88		460	28674	88	89.3%
YZ	LORIS EXTENDED CARE CTR	37	HORRY	LORIS	DIST	88	88		80	31323	88	97.5%
YZ	MYRTLE BEACH MANOR	12	HORRY	MYRTLE BEACH	PROP	104	104		198	34022	104	89.6%
Y	NHC HEALTHCARE GARDEN CITY		HORRY	MYRTLE BEACH	PROP	88	88		239	30693	88	95.6%
	HORRY CO		TOTAL			676	676		1900	235245	694	92.9%
YZ	MCCOY MEM. NURS. CTR.	25	LEE	BISHOPVILLE	PROP	120	120		80	43534	120	99.4%
	LEE CO.		TOTAL			120	120		80	43534	120	99.4%
YZ	MULLONS NURSING CTR	30	MARION	MARION	NPA	92	92		30	33350	92	99.3%
YZ	MARION NURSING CTR	14	MARION	MARION	PROP	88	88	1 c	68	31487	88	98.0%
	MARION CO		TOTAL			180	180	1	98	64837	180	98.7%
YZ	DUNDEE NURS HM		MARLBORO	BENNETTSVILLE	PROP	111	111	(24) (a)	55	38735	111	95.6%
Y	MARLBORO PARK HOSP SNF		MARLBORO	BENNETTSVILLE	PROP	7	7		119	1822	7	71.3%
	MARLBORO CO		TOTAL			118	118		174	40557	118	94.2%
YZ	HOPEWELL HLTH CARE CTR		SUMTER	SUMTER	PROP	96	96	(48) cd	58	30778	96	87.8%
YZ	MARINER HLTH CARE SUMTER-EAST	33	SUMTER	SUMTER	PROP	176	176		241	61372	176	95.5%
YZ	NHC HEALTHCARE SUMTER	26	SUMTER	SUMTER	PROP	138	138		71	44386	123	98.9%
Y	TUOMEY HOSP-SNF	17	SUMTER	SUMTER	NPA	18	18		365	5364	18	81.6%
	SUMTER CO		TOTAL			428	428	0	755	141800	413	94.1%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	KINGSTREE NURS FAC	32	WILLIAMSBURG	KINGSTREE	PROP	88	88	(45) d	72	23898	70	93.5%
YZ	RE MCNAIR NURS CTR		WILLIAMSBURG	CADES	PROP	88	88		44	31391	88	97.7%
	WILLIAMSBURG CO		TOTAL			176	176	0	116	55289	158	95.9%
	TOTAL					3662	3623	129	5183	1253515	3684.8	93.2%

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FOOTNOTES

__REGION III

FY2001 PLAN

CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued to replace & relocate the existing 290 acute care bed on the site with the 20 bed women's Ctr and with the 24 rehab, 44 nurs hm & the 46 d&a (42 inpat & 4 med detox) beds at their current site, 2/27/96. Con issued for conversion of 28 general beds to 28 nurs hm plus the existing 44 nurs beds for 72 nurs hm beds, 262 general beds, 46 d&a, 24 rehab, 12/09/97. Facility licensed for 290 general beds & the 28 additional nurs hm beds are being completed, 11/13/98. CON for additional 28 nurs hm beds expired and 28 acute beds added back to the 262 for 290 general beds, 12/9/98. Con issued to transfer 28 general beds to establish a 28 bed ltc acute hosp, SC-00-03 1/20/2000. NextCare licensed for 28 ltc acute beds and Carolinas Hosp licensed for 262, 7/17/01
2. CON issued for 40 additional general beds for a total of 336,10/21/97. CON issued for construction of a three story additional known as McLeod Day Hosp with two story day hosp, 89 holding & recovery beds, a GI lab with 5 procedure rooms, and a Child Life Activity Ctr, 12/5/97. Licensed beds increased from 296 to 336, 12/1/97. NA-00-21 issued for a ten beds non-licensed observation unit on the 1st floor , 3/31/00.
3. Exemption for use of 12 general beds for DMH patients w/o any licensure change, 1/9/95.
4. Exemption for permanent reduction of 35 general beds, 4/27/94. Facility closed 7/21/94. CON issued for ambulatory surgery ctr., 5/8/95.
5. Bed use restricted.
6. CON issued to convert 20 inpatient sub abuse beds to nurs hm beds resulting in licensed beds as 15 inpatient sub abuse beds, 45 psy (17 adolescent, 18 adult, 10 state contract beds), 18 RTF beds and 20 nurs hm beds. Facilty licensed per CON, 7/5/94. Nurs hm closed, 6/30/98. Exemption issued for Charter Conway to purchase the facility, 9/21/98. 18 RFT beds closed in Horry & move to Florence , 3/14/00. Approved for 41 additional beds for a total of 59 beds, 4/19/01.
7. Facility is licensed for 42 inpatient treatment beds (12 adolescent and 30 adult) and for 4 public detox beds for a total of 46 D&A beds. Exemption E-00-06 to reduce the inpat beds from 42 to 18 & licensed the same day, 1/27/99.
8. Facility licensed for 20 comm beds and 68 non-comm beds. CON issued for 6 additional comm. beds for a total of 26 comm. beds and 62 non-comm beds, 10/11/94. licensed per CON, 1/1/95. Con issued to convert 10 non-comm beds to 10 comm for a total of 52 non-comm & 36 comm, 3/13/00. Facility for 52 & 36 , 6/29/00.

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9. CON issued for 5 non-medicaid beds for a total of 88, 2/21/95. Facility licensed beds increased from 83 to 88, 9/29/95.
10. CON for 16 additional non-medicaid beds for a total of 148 LTC beds, 5/20/93. Facility licensed beds increased from 132 to 148, 10/13/94.
11. CON issued for 22 non-medicaid beds, 4/17/95. CON voided, 10/18/95.
12. CON issued 6 additional non-medicaid beds for a total of 85, 7/11/94. Licensed for 85 beds, 9/1/94. CON issued for 19 additional beds for a total of 104, 10/17/95.
13. CON issued for a 124 replacement hospital, 7/6/95. Facility licensed for 124 general beds,6/17/97.
14. App name changed from Marion Co Convl Ctr & change of lease 9/25/95.
15. CON for 16 additional non-medicaid beds for a total of 104, 11/14/95. Facility licensed for 104 nurs hm beds, 11/27/96.
16. CON issued for 35 replacement beds with increase of survey from 86 to 96 & the reduction of non-conforming from 48 to 0, 12/19/95.
17. CON issued for conversion of 18 general beds to nurs hm beds with 229 general , 19 psy & 18 nurs hm beds, 12/18/95. Licensed for 18 nurs hm beds, 229 general, & 19 psy beds 2/7/96.
18. CON for conversion of 14 general beds to 14 nurs hm beds with 78 general & 14 nurs hm beds, 12/29/95.
19. CON to construct an 18 hospital base nurs hm beds unit, 1/30/96. Also, to temporarily licensed 10 general beds as 10 nurs hm beds (for appox. 10 months), the 10 beds were licensed as nurs hm beds & the general beds are temporarily reduced from 172 to 162, 3/1/96. Licensed nurs beds increased by 10 for 18 and licensed general beds licensed back to 172 from the temp 162, 9/16/97. Con issued for 47 additional beds with 18 coming the closing of the 18 bed nurs hm for a total of 219 general beds, 10/30/2000 sc-00-52. General beds increased by 18 from 172 to 190 with the delicensing of the 18 bed nurs hm 1/16/01.Licensed general beds increased by 20 from 190 to 210 , 4/4/01
20. CON issued to convert 18 hosp beds to 18 nurs hm beds for 229 general beds, 19,psy beds & 18 nure hm beds, 12/18/95. Licensed for 18 nurs hm, 229 general & 19 psy beds, 2/7/96.
21. Con issued for 8 non-medicaid beds for a total of 96 LTC beds, 3/19/96. Facility licensed beds increased by 4 from 88 to 92, 4/26/96. CON voided for additional 4 beds, 9/30/96. Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds incrased from 144 to 148, 12/10/97.
22. Con issued for 3 non-medicaid beds for a total of 123 1TC beds, 3/25/96.
23. Con issued for converting 14 general beds to nurs hm beds for 78 general beds & 14 nurs hm beds, 12/29/95. Con changed to reflect 79 general & 13 nurs hm beds, 7/24/96. Facility licensed for 79 general & 13 nurs hm beds, 8/14/96.
24. CON issued for 116 general beds replacement hospital, 8/15/96. Name changed from Byerly Hospital, 5/1/99.
25. CON for the adddition of 32 medicaid beds for a total of 120 nurs hm beds, 11/25/96. Facility licensed for 120 beds, 9/26/97.
26. CON issued to add 3 nurs hm beds to increase from 120 to 123,3/28/96. Licensed for 123 nurs hm beds, 1/16/97. Con issued for 15 non-medicaid nurs beds for a total of 138,10/20/98. Facility licensed for 15 additional beds for a total of 138, 3/9/00.

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27. CON issued for transfer of 7 psy beds from Chesterfield plus 1 additional psy bed for 8 psy beds at Marlboro Park & 94 general with the transfer of 7 general beds from Marlboro to Chesterfield going from 52 general to 59, resulting in 94 general, 8 psy beds at Marlboro Park & 59general beds at Chesterfield, 2/6/97. Marlboro licensed for 94 gen & 8 psy beds with Chesterfield licensed for 59 gen beds, 4/26/97.
28. CON issued for 8 non-medicaid beds for a total of 140 nurs hm beds, 2/10/97. Facility licensed beds increased by 8 from 132 to 140,3/31/97. Con issued for 4 add nurs hm beds for a total of 144, 9/1597. Facility licensed beds increased by 4 to 144, 9/25/97.Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds reduced from 92 to 88, 12/10/97. Con issued to Morrell for 6 add nurs beds for a total of 154 , 4/13/00. Facility licensed beds increased by 6 from 148 to 154 , 6/1/00.
29. APP for 32 additional non medicaid beds for a total of 120, 9/12/97.
30. Exmp renovated vacated Mullins Hosp to replace English park & Jenkins Nursing Hm without a change of licensed beds, 9/22/97. Facility licensed for 92 nurs hm beds, 9/15/98. Existing beds reduced from 102 to 92 since over one year since the initial license of 92 beds, 11/20/00.
31. CON issued for 32 additional non-medicaid nurs hm beds for a total of 120, 9/30/97. Con voided for 32 additional nurs hm beds reduce back to 88 beds, 3/31/99.
32. Con SC 97-66 issued for 88 replacement facility 70 existing licensed beds (65 surveyed with 45 d) plus 18 new non-medicaid beds, 11/24/97. New facility licensed or 88 beds , 6/8/00.
33. Exmp to merge Mariner Hlth Ctr Sumter-East & West, 9/3/98. Facilities licensed as one with 176 nurs beds, 9/3/98.
34. Con # SC-97-32 issued for replacement of 44 nurs hm beds, 7/14/97. Pursuant to the 1998 medicaid proviso the 44 replacement beds will still licensed & medicaid certified for a total of 132, 9/98. Facility licensed beds increased by 44 from 88 to 132, 12/8/98.
35. Con issued to transfer 40 acute beds from Georgetown Mem to construct a new 40 hosp and add a 10 bed nurs hm to Georgetown mem resulting in 102 acute & 10 nurs hm at Georgetown Mem, SC-00-07 2/7/00. App to add 19 beds comprehensive rehab unit , 5/26/00 SC-00-27.
36. Exemption to reduce beds by 1 from 50 to 49, 4/20/00. Facility licensed for 49 general beds, 5/15/00.
37. Con issued for 44 additional nurs beds (25 medicaid) for a total of 132 nurs beds, 9/15/00.SC-00-45 Con voided for additional 44 nurs hm beds,8/02/01.
38. Formerly Florence Convl ctr.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1999 VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GEN HOSP	CHESTERFIELD	CHERAW	12303
III	CLARENDON MEM HOSP	CLARENDON	MANNING	18524
III	WILSON MEDICAL CTR	DARLINGTON	DARLINGTON	10106
III	CAROLINA PINES REG MED CTR	DARLINGTON	HARTSVILLE	20418
III	ST EUGENE REG MED CTR	DILLON	DILLON	18782
III	CAROLINAS HOSPITAL SYS	FLORENCE	FLORENCE	23941
II	MCLEOD REG MED CTR	FLORENCE	FLORENCE	50790
III	CAROLINAS HOSPITAL SYS LAKE CITY	FLORENCE	LAKE CITY	18569
II	GEORGETOWN MEM HOSP	GEORGETOWN	GEORGETOWN	30393
II	CONWAY HOSP INC	HORRY	CONWAY	31911
III	LORIS COMM HOSP	HORRY	LORIS	18809
II	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH	44297
III	MARION CO MED CTR	MARION	MARION	22383
III	MARLBORO PARK HOSP	MARLBORO	BENNETTSVILLE	14812
II	TUOMEY REG MED CTR	SUMTER	SUMTER	41472
III	CAROLINAS HOSPITAL SYS KINGSTREE	WILLIAMSBURG	KINGSTREE	14248
TOTALS				391758

REGION III:	TRAUMA CENTERS		
III	CAROLINAS HOSP SYSTEM	FLORENCE	FLORENCE
III	MCLEOD REG MED CTR	FLORENCE	FLORENCE
III	GEORGETOWN MEM HOSP	GEORGETOWN	GEORGETOWN
III	CONWAY HOSP INC	HORRY	CONWAY
III	LORIS COMM HOSP	HORRY	LORIS
III	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH

REGION NARRATIVE

REGION: IV FISCAL YEAR:2001

1. Unusual Characteristics: This region has a military presence in Charleston. A 290 bed naval hospital provides health care services for the military and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with an estimated military population of 10,000. A 290 naval hospital provides health care to the military and dependents. All of these beds are not in use. There are no barriers to communications in this region. The sea islands, rivers and sounds are barriers to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. Medical University was partially assigned to the Statewide area based on patient origin data. By mutual agreement, Berkeley and Dorchester County hospitals were closed upon the opening of Trident Regional Medical Center. After a review of patient origin information, the population used to calculate beds for Berkeley and Dorchester Counties is 60% of Berkeley, 80% of Dorchester and 10% of Charleston County with the facilities predominately serving Charleston County using the other 40% of Berkeley, 20% of Dorchester and 90% of Charleston Counties population.

3. Nursing Homes: The number of facilities to be added is not projected but should be based on economical units due the staffing requirements in the licensing standards. There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in seven facilities and two Federal facilities in this region.

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5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There is a need for additional inpatient treatment beds in the Beaufort, Hampton, Colleton, and Jasper area. The William J. McCord Adolescent Treatment Center in Orangeburg County serves adolescents exclusively from throughout the state and was licensed in October 1993. There is a small need for additional inpatient treatment beds in this region.

6. Rehabilitation Facilities: See Chapter II for discussion and calculations.

7. Calculations of need are shown in Chapter II.

8. All changes affecting the health facilities in this region have been fully annotated in the inventory.

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AREA SUMMARY

REGION	NUMBER OF FACILITIES		NUMBER OF BEDS		
	TOTAL EXISTING	TO BE MODERNIZED	TOTAL NEEDED	TOTAL EXISTING	TO BE ADDED
IV					
HOSPITALS:					
AIKEN	1	0	184	178	6
ALLENDALE	1	0	7	36	-29
BAMBERG	1	0	23	59	-36
BARNWELL	1	0	18	53	-35
BEAUFORT	2	0	197	223	-26
BERKELEY/DORCHS	1	0	295	345	-50
CHARLESTON	7	1	857	1093	-236
COLLETON	1	0	108	116	-8
HAMPTON	1	0	12	68	-56
JASPER	1	0	11	31	-20
ORANGEBURG/CALH	1	0	241	247	-6
TOTALS:	18	1	1953	2449	-496
LTC:					
AIKEN	6	1	807	718	89
ALLENDALE	1	0	78	44	34
BAMBERG	1	0	101	88	13
BARNWELL	3	1	101	169	-68
BEAUFORT	7	0	616	431	185
BERKELEY	3	0	437	316	121
CALHOUN	1	0	70	120	-50
CHARLESTON	12	0	1459	1290	169
COLLETON	2	0	224	147	77
DORCHESTER	4	0	347	284	63
HAMPTON	1	0	117	104	13
JASPER	1	0	66	88	-22
ORANGEBURG	4	1	444	416	28
TOTALS:	46	3	4867	4215	792

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
YZ	ALLENDALE CO.HOSP.	1	ALLENDALE	FAIRFAX	CO	36	36		549	1720	36	13.1%
	ALLENDALE CO.		TOTAL			36	36		549	1720	36	13.1%
XYZ	BAMBERG CO. MEM.		BAMBERG	BAMBERG	CO	59	59		1465	6035	59	28.0%
	BAMBERG CO.		TOTAL			59	59		1465	6035	59	28.0%
YZ	BARNWELL CO. HOSP.		BARNWELL	BARNWELL	CO	53	53		868	4400	53	22.7%
	BARNWELL CO.		TOTAL			53	53		868	4400	53	22.7%
X	NAVAL HOSP	2	BEAUFORT	BEAUFORT	FED		(64)		(1438)	(4325)		
XYZ	BEAUFORT CO. MEM.	44	BEAUFORT	BEAUFORT	CO	130	130		7747	29648	106	76.6%
XYZ	HILTON HEAD MED CTR & CLINICS	27	BEAUFORT	HILTON HEAD	NPA	85	93		4281	15935	64	68.2%
	BEAUFORT CO.		TOTAL			215	223		12028	45583	170	73.5%
XYZ	BON-SECOURS ST. FRANCIS	6	CHARLESTON	CHARLESTON	NPA	141	201		7683	35521	141	69.0%
XYZ	CHARLESTON MEM. HOSP.	43	CHARLESTON	CHARLESTON	CO	98	98		1185	16845	135.6	34.0%
YZ	EAST COOPER REG MED CTR	4	CHARLESTON	MT PLEASANT	PROP	100	100		4440	16032	100	43.9%
XYZ	(MEDICAL UNIVERSITY HOSP.)		CHARLESTON	CHARLESTON	ST	(466)	(466)		(22796)	(123339)		
XYZ	MEDICAL UNIVERSITY HOSP.	5	CHARLESTON	CHARLESTON	ST	224	224		12765	58463	221	72.5%
XYZ	ROPER HOSP.		CHARLESTON	CHARLESTON	NPA	414	414		15952	96654	414	64.0%
YZ	ROPER HOSPITAL NORTH	6	CHARLESTON	N CHARLESTON	NPA	60	(60)		1101	5459	60	24.9%
YZ	SPECIALITY HOSPITAL OF SC	43	CHARLESTON	CHARLESTON	PROP	59	59					
XYZ	TRIDENT MED CTR.	7	CHARLESTON	CHARLESTON	PROP	251	271		13395	60425	251	66.0%
X	NAVAL REG.HOSP.	2	CHARLESTON	CHARLESTON	FED		(15)		(183)	(641)		
X	RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(197)		(3475)	(22192)		
			TOTAL			1347	1367	0	56521	289399	1322.6	59.9%
XYZ	COLLETON MED CTR	29	COLLETON	WALTERBORO	PROP	116	116		4767	25490	116	60.2%
	COLLETON CO.		TOTAL			116	116		4767	25490	116	60.2%
XYZ	SUMMERVILLE MED CTR	8	DORCHESTER	SUMMERVILLE	PROP	74	74		3456	13618	74	50.4%
	DORCHESTER CO.		TOTAL			74	74		3456	13618	74.8	49.9%
YZ	HAMPTON REG MED CTR		HAMPTON	VARNVILLE	CO	68	68		738	3163	68	12.7%
	HAMPTON CO.		TOTAL			68	68		738	3163	68	12.7%
YZ	LOW COUNTRY GENERAL HOSP	42	JASPER	RIDGELAND	PROP	31	31		536	2641	31	23.3%
	JASPER CO.		TOTAL			31	31		536	2641	31	23.3%
XYZ	REGIONAL MEDICAL CENTER OF ORANGEBURG-CALHOUN	9 41	ORANGEBURG	ORANGEBURG	CO	271	247		10370	63768	271	64.5%
	ORANGEBURG CO.		TOTAL			271	247		10370	63768	271	64.5%
XYZ	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	178	178		10120	45770	178	70.4%
	AIKEN CO.		TOTAL			178	178		10120	45770	178	70.4%
	TOTAL					2448	2452	0 0	101418	501587	2379.4	57.8%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	MENTAL FACILITIES:											
XYZ	BEAUFORT MEM HOSP	10	BEAUFORT	BEAUFORT	CO	20	20		351	2055	20	28.2%
	BEAUFORT CO.		TOTAL			20	20		351	2055	20	28.2%
XYZ	CHARLESTON MEM. HOSP.	33	CHARLESTON	CHARLESTON	CO	15	15				15	0.0%
XYZ	MEDICAL UNIVERSITY HOSP.	12	CHARLESTON	CHARLESTON	ST	82	82		2532	18300	82	61.1%
XY	PALMETTO LOWCOUNTY BEHAVIORAL HLT	11	CHARLESTON	CHARLESTON	PROP	60	60		1037	7779	60	35.5%
XYZ	TRIDENT MED CTR		CHARLESTON	CHARLESTON	PROP	20	(20)		617	3772	20	51.7%
X	RALPH H JOHNSON VETERANS MEDICAL CTR		CHARLESTON	CHARLESTON	FED		(36)		(599)	(4244)		
	CHARLESTON CO.		TOTAL			177	157		4186	29851	177	46.2%
	RMC ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15		371	2673	15	48.8%
	ORANGEBURG CO.		TOTAL			15	15		371	2673	15	48.8%
XYZ	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	29	29		759	5496	29	51.9%
	AIKEN CO.		TOTAL			29	29		759	5496	29	51.9%
	TOTAL					241	221		5316	38020	241	43.2%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:											
	PALMETTO LOWCOUNTY BEHAVIORAL HLTH RTC		CHARLESTON	CHARLESTON	PROP	32	32		67	10916	32	93.5%
	NEW HOPE SUMMERVILLE	13	SUMMERVILLE	DORCHESTER	PROP	52	52		30	17909	52	94.4%
	CHARLESTON CO.		TOTAL			84	84		97	28825	84	94.0%
	REHABILITATION FACILITIES:											
CON	BEAUFORT MEM HOSP	44	BEAUFORT	BEAUFORT	CO	14	14					
	BEAUFORT CO.		TOTAL				14					
XYZ	MEDICAL UNIVERSITY HOSP.	14	CHARLESTON	CHARLESTON	ST	25	25		398	7598	25	83.3%
XYZ	ROPER HOSP.	3	CHARLESTON	CHARLESTON	NPA	39	39		849	11910	39	83.7%
XYZ	HEALTHSOUTH CHARLESTON	15	CHARLESTON	CHARLESTON	PROP	42	42		633	12589	36	95.8%
	CHARLESTON CO.		TOTAL			106	106		1880	32097	100	87.9%
CON	RMC ORANGEBURG-CALHOUN	41	ORANGEBURG	ORANGEBURG	CO		24					
	ORANGEBURG CO.		TOTAL			0	24					
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	18	18		180	783	18	11.9%
	ROPER HOSPITAL NORTH		CHARLESTON	N CHARLESTON	NPA	44	44		381	2017	44	12.6%
	PALMETTO LOWCOUNTY BEHAVIORAL HLT	11	CHARLESTON	N CHARLESTON	PROP	10	10		198	1337	10	36.6%
	MUSC MEDICAL CTR	16	CHARLESTON	CHARLESTON	ST	23	23		642	4204	23	50.1%
	TOTAL					95	95		1399	8341	95	24.1%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	LONG TERM FACILITIES:											
YZ	JOHN E HARTER N HM		ALLENDALE	FAIRFAX	CO	44	44		13	15760	44	98.1%
	ALLENDALE CO		TOTAL			44	44		13	15760	44	98.1%
YZ	BAMBERG CO MEM NURS CTR	31	BAMBERG	BAMBERG	CO	88	88		55	30767	86.31	97.7%
	BAMBERG CO		TOTAL			88	88		55	30767	86.31	97.7%
YZ	BARNWELL CO NURS HM	47	BARNWELL	BARNWELL	CO	40	40		8	14367	40	98.4%
Z	LAUREL BAYE HEALTHCARE CTR OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	85 a	70	29055	85	93.7%
YZ	LAUREL BAYE HEALTHCARE OF WILLISTOI	46	BARNWELL	WILLISTON	PROP	44	44		19	15700	44	97.6%
	BARNWELL CO		TOTAL			169	169	85	97	59122	169	95.8%
Y	BEAUFORT CO MEM HOSP TRANSITIONAL CARE UNIT	10	BEAUFORT	BEAUFORT	CO	18	18		634	7791	44	48.5%
YZ	BAYVIEW NURS CTR	45	BEAUFORT	BEAUFORT	PROP	182	182		287	63339	192	90.4%
Y	LIFE CARE CENTER OF HILTON HEAD	40	BEAUFORT	HILTON HEAD	PROP	88	88		56	28913	88	90.0%
Y	FRASER HEALTH CTR		BEAUFORT	HILTON HEAD	PROP	30	30		83	12947	44	80.6%
SW	(FRASER HEALTH CTR)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				(14)	
Y	HILTON HEAD HOSP NURS HM	27	BEAUFORT	HILTON HEAD	NPA	(15)	(15)		273	2490	15	45.5%
Y	PRESTON HEALTH CARE CTR	32	BEAUFORT	HILTON HEAD	PROP	69	69		67	16057	77	57.1%
SW	(PRESTON HEALTH CARE CTR)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				(8)	
NHM	BROAD CREEK	17	BEAUFORT	HILTON HEAD	PROP	44	44		124	9652	44	60.1%
	BEAUFORT CO		TOTAL			431	431		1524	141189	504	76.7%
YZ	HEARTLAND HLTH CARE CTR		BERKELEY	HANAHAN	PROP	96	96		307	30017	96	85.7%
YZ	LAKE MOULTRIE NURSING HOME	18	BERKELEY	ST STEPHENS	PROP	88	88		48	30312	88	94.4%
YZ	MAGNOLIA MANOR-MOCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132		93	46824	132	98.8%
	BERKELEY CO		TOTAL			316	316		448	106953	316	92.7%
YZ	CALHOUN CONV CTR	34	CALHOUN	ST. MATTHEWS	PROP	120	120		65	42841	120	97.6%
	CALHOUN CO		TOTAL			120	120		65	42841	120	97.8%
YZ	ASHLEY CROSSING REHAB & NURS CTR		CHARLESTON	CHARLESTON	NPA	132	132		497	38408	132	79.7%
Y	BISHOP GADSDEN EPISCOPAL HM	19	CHARLESTON	CHARLESTON	NPA	53	61		47	18637	53	96.3%
	(BISHOP GADSDEN EPISCOPAL HM)		CHARLESTON	CHARLESTON	NPA		(9)					
YZ	CHARLESTON NURS CTR		CHARLESTON	MT. PLEASANT	PROP	132	132		105	45648	132	94.7%
NHM	FRANKE NURSING HOME	30	CHARLESTON	CHARLESTON	NPA	24	24					
	(FRANKE NURSING HOME)	30	CHARLESTON	CHARLESTON	NPA	(20)	(20)					
YZ	GRACE HALL- REHABILITATION	38	CHARLESTON	MT. PLEASANT	PROP	42	42		19	978	12.9	20.8%
YZ	HERMINA TRAEYE NURSING CTR	20	CHARLESTON	CHARLESTON	NPA	132	132		80	47258	132	98.1%
YZ	INTEGRATED HLTH SERVICES		CHARLESTON	CHARLESTON	PROP	160	160		326	49919	160	85.5%
	CHARLESTON /DRIFTWOOD											
NHM	LIFE CARE CTR/CHARLESTON	21	CHARLESTON	N CHARLESTON	PROP	148	148		185	34845	128.6	74.2%
YZ	HEARTHLAND OF WEST ASHLEY	37	CHARLESTON	CHARLESTON	NPA	82	82		146	23435	83.8	78.6%
	REHABILITATION AND NURSING CTR											
CON	(NHC CHARLESTON)	39	CHARLESTON	CHARLESTON	PROP		(120)					
YZ	SANDPIPER CONV CTR		CHARLESTON	MT. PLEASANT	PROP	176	176		208	61436	176	95.6%
Y	TRIDENT SKILLL NURS CTR	8	CHARLESTON	CHARLESTON	PROP	26	26		453	5813	26	63.7%
YZ	WHITE OAK MANOR-CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176		93	61497	176	95.7%
	CHARLESTON CO		TOTAL			1282	1290		2139	387874	1211.3	87.7%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	COLLETON REG HOSP NURS HM		COLLETON	WALTERBORO	PROP	15	15		197	3068	15	56.0%
YZ	OAKWOOD HLTH CARE CTR	22	COLLETON	WALTERBORO	PROP	132	132		97	45454	132	94.3%
	COLLETON CO		TOTAL			147	147		294	48522	147	90.4%
YZ	HALLMARK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		126	29542	88	92.0%
YZ	OAKBROOK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		105	29984	88	93.3%
	ST GEORGE HLTH CARE CTR		DORCHESTER	ST. GEORGE	PROP	88	88		67	29708	88	92.5%
YZ	SUMMERVILLE MED CTR-SNF	8	DORCHESTER	SUMMERVILLE	PROP	20	20		231	2295	20	31.4%
	DORCHESTER CO		TOTAL			284	284		529	91529	284	88.3%
Z	HARPER NURSING CTR	35	HAMPTON	ESTILL	CO	104	104		77	30795	88	95.9%
	HAMPTON CO		TOTAL			104	104		77	30795	88	95.9%
YZ	RIDGELAND NURSING CTR		JASPER	RIDGELAND	PROP	88	88		61	30795	88	95.9%
	JASPER CO		TOTAL			88	88		61	30795	88	95.9%
YZ	EDISTO CONV CTR		ORANGEBURG	ORANGEBURG	PROP	113	113		63	39061	113	94.7%
YZ	JOLLEY ACRES HLTHCARE CTR	23	ORANGEBURG	ORANGEBURG	PROP	60	60		89	19485	60	89.0%
YZ	ORANGEBURG NURS HM		ORANGEBURG	ORANGEBURG	PROP	88	88		60	31343	88	97.6%
YZ	THE METHODIST OAKS	24	ORANGEBURG	ORANGEBURG	NPA	155	155		262	47645	155	84.2%
	(REG MED CTR ORANGEBURG/CALHOUN SNF)	41	ORANGEBURG	ORANGEBURG	NPA		(10)					
	ORANGEBURG CO		TOTAL			416	416		474	137534	416	90.6%
YZ	ANNE MARIA REHAB & NURS CTR	25	AIKEN	N. AUGUSTA	PROP	132	132		241	46376	132	96.3%
YZ	AZALEA WOODS	28	AIKEN	AIKEN	PROP	86	86		73	29878	86	95.2%
YZ	CARRIAGE HILLS PLANTATION REHAB CTR	36	AIKEN	AIKEN	PROP	60	60		190	16900	57	78.4%
YZ	MATTIE CHAFEE HALL HLTH C		AIKEN	AIKEN	PROP	176	176		160	62333	176	97.0%
YZ	NHC HEALTHCARE N. AUGUSTA	26	AIKEN	N. AUGUSTA	PROP	132	132		155	45174	132	93.8%
YZ	PEPPER HILL NURS CTR		AIKEN	AIKEN	PROP	132	132		199	44700	132	92.8%
	AIKEN CO		TOTAL			718	718	0	1018	244361	715	93.6%
	TOTAL					4207	4215	85	6784	1368042	4186.61	89.5%

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FOOTNOTES

_REGION: IV

FY2001 PLAN

CON-Certificate of Need
UC-Under Construction
X-JCAH Accredited
Y-Medicare
Z-Medicaid
APP-Approved

NPA-Non Profit
ST-State
CO-County
PROP-Proprietary
N-Nursing Home
SW-Statewide Facility

1. CON issued for renovation and construction with a 4 bed reduction from 40 general beds to 36 general beds, 2/8/92. Facility licensed for 36 general beds, 5/1/94.
2. Bed use restricted. Beds as reported by facility.
3. CON to construct a new 100 bed hospital Baker-North by replacing 60 beds from Baker Hosp and the relocation of 40 beds from Roper Hospital. The bed capacities would be 44 D&A beds at Baker, 100 general beds at Baker-North and 381 general plus 28 rehab beds at Roper 09/07/93. CON issued for 11 additional rehab beds and a reduction of 7 general beds resulting in 374 general and 29 rehab beds, 7/13/94. CON rescinded for replacement of Baker, 3/9/95. Roper licensed for 414 general & 39 rehab beds,5/11/95. CON issue for transferring 26 acute beds from Roper North to establish Charleston LTC Hosp as a 26 beds long term acute hosp; resulting in Roper North 34 bed acute, 44 bed substance abuse & Charleston LTC as 26 long term acute beds, 4/15/96. Con rescinded fo 26 long term acute beds, 8/29/97.
4. CON issued for renovation and expansion of the outpatient capacity of OR area from 5 OR rooms and 2 endoscopy rooms to 8 OR rooms and 2 endos rooms, 5/13/93.
5. Total general beds, admissions, and patient days are allocated by patient origin to the Trident area and SW.
6. CON issued to construct a new 198 general bed hospital, west of the Ashley, to replace the existing licensed 362 general bed hospital, 12/7/92. Facility licensed for 141 general beds,12/16/96. Con issued to transfer 60 hosp beds from Roper North to Bon Secours St Francis for a total of 201 general beds & 44 D&A at Roper N, 8/10/2001 sc-01-37.
7. CON issued for expansion of ancillary areas and addition of 34 general beds, 7/1/87. Facility licensed for 280 general and 20 psy beds, 2/5/88. CON issued to relocate 39 general beds for construction of Summerville Medical Center licensed for 80 general beds, 8/13/93. CON issued for Trident Reg Med Ctr to provide ambulatory surgery within the hospital, 12/28/95. CON to convert 10 general beds to nurs hm for a total of 251 general ,25 nurs hm & 20 psy, 10/15/96. See Footnote #8. Facility licensed for 251 general , 20 psy & 25 nurs hm beds, 2/21/97. Con issued to convert 20 psy to 20 general acute for 271 general , sc-01-58, 10/10/01.
8. CON issued to construct a 56 bed specialty hospital to include 20 psychiatric beds which would be transferred from TRMC and 36 rehab beds, 12/10/92. Authorization for temporary licensure of 20 general beds as 20 rehab beds as Trident Neurosciences Ctr. in Summerville Med. Ctr., 11/19/93. Licensed general beds still licensed at Trident Reg but to be licensed at Summerville, total 241 general, 20 psy and 15 nursing hm., 6/6/94. Trident skilled nur ctr.

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licensed for 15 LTC beds, 7/6/94. Neuroscience 36 rehab; Summerville Med. Ctr. 80 general beds, 9/7/94. Trident Neuro licensed for 36 rehab beds (which removes the 20 temp rehab beds from Summerville), 9/24/94. Con issued for 14 nurs hm beds and 80 general beds, 10/17/94. Cola Summerville SNF licensed for 14 beds 11/1/94. Con Trident for 10 addtional nurs hm beds for a total of 25 nurs hm, 251 general & 20 psy, 10/15/96. Con for Summerville to convert 6 general beds to nurs hm for 74 general & 20, 10/08/96. Fcaility licensed for 74 general & 20 nurs hm beds, 2/20/97.

9. Provision of temporary detox for the Tri-county Commission of D&A, 8/31/94.
10. CON issued for 72 non-Medicaid nurs hm beds, 8/15/90. Licensed for 20 psych. beds, 7/18/94. Facility licensed for 44 LTC beds, 10/3/94. LTC beds reduced from 44 to 18, 8/28/01. See footnote #44.
11. CON issued for closure of Fenwick with the transfer of 8 psy & 10 d&a beds resulting in 78 psy & 10 d&a beds, 4/21/95. Charter licensed for 60 psy &10 d&a beds with partial fulfillment of the above con, 5/24/95. Since the facility did not fullfill rest of the con by 5/24/96 by licensing the additional 18 psy beds; these beds will be removed from the survey beds resuling in a 60 bed capicity at the facility, 7/2/97.
12. CON issued for 15 crisis stab beds to the existing 67 psy beds, 8/12/94. Facility licensed for 82 psy beds (67 & 15 crisis beds), 6/15/95.
13. CON issued for 52 RTC beds, 6/1/92. Licensed for 52 RTC beds, 1/26/93.
14. CON issued for 11 additional rehab beds with total of 25 beds, 11/19/91. Facility licensed for 25 rehab beds, 12/1/94. Temporarily closure of the Rehab unit 9/1/00.
15. Licensed for 36 rehab bes,9/7/94. Formerly Trident Neuroscience. Con issued for 3 additional rehab beds for a total of 39, 10/26/98. Facility licensed for 39 rehab beds, 11/23/98. Con issued for 3 add rehab beds for a total of 42, 4/10/2000 SC-00-19. Facility licensed beds increased by 3 form 39 to 42 rehab beds, 6/8/00.
16. CON issued for 23 D&A beds for research with funding from a federal grant and the beds will not be counted against the area, 10/2/92. Facility licensed for 23 D&A beds, 3/23/95.
17. CON issued for 44 non-Medicaid Nursing Home beds, 2/5/92. Facility licensed for 44 beds with name change from Sea Pines, 2/10/97.
18. CON issued for 88 dual beds (74 Medicaid), 10/29/91. Faility licensed for 22 beds, 4/13/95. Formerly, St. Stephens. Licensed beds increased from 22 to 44, 6/26/95. Licensed beds increased from 44 to 66, 9/18/95. Licensed beds increased from 66 to 76, 12/11/95. Licensed beds from 76 to 88, 1/29/96.
19. CON issued to convert 20 restricted beds to comm. for a total of 44 nursing hm beds, 6/7/94. Facility licensed for 44 comm beds, 10/18/94. CON issued for 10 addtional non-medicaid for a total of 54 beds,3/12/97. Facility licensed for 45 beds, 5/6/97. Licensed beds increased by 8 from 45 to 53,9/22/98. Licensed beds to stay at 53 with with the reduction of the 8 additional beds to 7, 7/7/99. Con issued for 9 non-comm beds for a total of 53 comm & p non-comm beds, 02/19/00 sc-00-65. Con issued for 8 non-medicaid beds from 53 to 61 comm & 9 non-comm beds, SC-01-44, 9/14/01 8/28/01.
20. CON issued for an additional 44 dual beds (40 Medicaid) with an increased from 88 to 132 beds, 12/11/89. Facility licensed for 132 beds, 6/2/95.
21. CON issued for 88 non-Medicaid beds, 8/6/91. Facility licensed, 11/22/93. Name changed from Elmwood Plantation. P CON issued for 60 non-medicaid for a total of 148, 5/19/97. Facility licensed for 60 additional beds for a total of 148, 1/27/99.

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22. CON issued for 28 additional non-Medicaid beds for a total of 160 LTC beds, 4/13/93. Con voided 10/15/93.
23. CON for 17 additional non-Medicaid beds for a total of 60 LTC beds, 5/19/93. Licensed for 60 LTC beds, 9/30/94.
24. CON issued for replacement of 132 existing beds and the addition of 44 non-Medicaid beds for a total of 176 beds, 7/11/94. Facility licensed beds increased from 132 to 176, 5/10/96. Exemption issued for conversion of 21 nurs hm beds to 20 rcf beds for a total of 155 nurs hm & 64 crf beds, 9/22/98. Facility licensed for 155 nurs hm beds,9/24/98. E-01-48 Permanent reduction of 23 nurs hm beds from 155 to 132 , 10/2/01.The beds will be removed upon licensing of the reduction.
25. CON issued for 3 additional beds for a total of 132, 10/19/94. Licensed beds increased from 129 to 132, 6/6/95.
26. CON issued for 82 dual beds, 1/23/90. CON issued for 6 additional beds total of 88, 9/10/90. Facility licensed for 44, 12/6/91. Licensed beds increased from 44 to 88, 3/23/92. CON issued for 44 additional beds for a total of 132 LTC beds, 12/16/92. Facility licensed for 132 LTC beds, 8/16/94.
27. CON issued to convert 4 acute beds plus 11 new nurs hm beds for a total of 15 nurs hm beds & 64 general acute beds, 8/29/95. Licensed for 15 nurs hm beds & 64 hosp beds, 12/19/95. Con for 4 additional general beds for a total of 68 gen beds,6/27/97. Closed 15 bed nurs hm, 1/7/2000. Con issue for additional 25 general beds for a total of 93 general beds, 1/16/00 sc-00-57. Facility licensed beds increased form 64 to 68, 11/1/00. Licensed increased from by 17 from 68 to 85, 2/21/01.
28. Name changed from Beverly Health & Rehab Ctr 9/1/00.
29. Exemption to upfit existing shell space for a operating room to an endoscopic procedure room, 9/18/95.
30. Con issued for 44 nurs hm ,without medicaid, with 24 community beds & 20 restricted beds, 9/16/98. Facility licensed 7/19/2000.
31. CON for 44 additional non-medicaid beds for a total of 88 beds, 11/17/95. Licensed beds increased from 44 to 88, 10/15/98.
32. CON issued for 33 additional non-medicaid beds for a total of 69 comm & 8 non-comm, 12/19/95.Facility licensed for 69 comm & 8 noncomm beds, 5/1/97. Facility will temporarily close nursing unit, 11/18/97.
33. Temporary use of psy beds as detox without change of licensure, 8/21/96.
34. CON for 32 additional medicaid beds for a total of 120, 11/19/96. Facility licensed for 120 beds, 2/1/98.
35. CON for 16 additional medicaid beds for a total of 104 nurs beds, 11/25/96. Facility licensed beds increased by 16 from 88 to 104, 2/19/99.
36. CON issued for replacement facility with 31 non-medicaid additional beds for a total of 57 nurs hm beds, 8/7/96. Name changed and licensed for 57 nurs beds, 7/8/98. CON 99-35 issued for 3 non-medicaid beds for a total of 60, 10/11/99. Facility licensed for 3 additional beds for a total of 60, 3/7/00.
37. Exmpt to reduce 4 beds & relocate 19 nurs beds to add 23 res beds for total licensure of 128 nurs hm beds & 40 res beds, 2/20/97. Licensed nurs hm beds reduced from 132 to 128, 5/9/97. Exemption to close 46 nurs hm beds for a total of 82 nurs hm beds, 10/15/98. Facility licensed for 82 beds, 10/15/98.
38. CON issued for 42 non-medicaid nurs hm, 12/1/97. Facility licensed for 42 nurs beds, 6/11/99.
39. APP for a 120 non-medicaid nurs hm, 6/24/97.Appealed. CON issued for the 120 non-medcaid nurs hm beds, 8/17/98.
40. Fomerly Health Care Of Hilton Head, 6/1/97.
41. Con issued to convert 10 general beds to nurs hm for 261 general, 15 psy & 10 nurs hm beds, 12/8/97. Con voided to convert 10 hosp beds to nurs hm, 11/24/98. CON voided 12/9/99. App for conversion of 24 general beds to 24 rehab

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with the reduction of 32 licensed general beds for 239 general 24 rehab & 15 psy, 4/4/2000 SC-00-18. Con issued for major renovation to retain 8 beds lost in the rehab con, 11/27/00 sc-00-60

42. Con issued to relocate & replace the existing 31 bed hospital, 2/23/98. Discontinued OB services, 4/8/98. CON voided 2/23/00. E-01-10 change of ownership change name of the facility to Jasper County Hosp. , 3/6/01.
43. Con issued to transfer 59 beds from Charleston Mem to establish Speciality Hosp of SC a 59 long term acute care hospital, 8/4/98. Specialty Hosp of SC licensed for 37 of the 59 Ltc acute beds & Charleston Mem licensed gen acute beds reduced from 157 to 120,12/2/98. Specialty Hosp of SC licensed beds increased by 12 rom 37 to 59 & Charleston Mem reduced from 120 general to 98 general & 15 psy, 7/4/99.
44. NA-99-54 build out the hospital's 5th for the addition of 12 non-licensed observation beds, 7/7/99. Con issued for 24 additional general beds for a total of 130 general beds, 11/17/00. Con issued to convert 14 of the 44 nurs hm beds to 14 rehab beds and to delicense 12 nurs beds resulting in 18 nurs beds & 14 rehab beds , 12/12/00 SC-00-62. Licensed general beds increased by 4 from 106 to 110, 4/3/01. Licensed gen beds increased by 11 from 110 to 121 , 4/19/01. licensed beds increased from 121 to 130 , 7/6/2001. Facility licensed nursing home beds reduced from 44 to 18, 8/28/2001. Facility licensed for 14 rehab beds, 9/5/01.
45. Exemption issued to permanently reduce licensed beds by 10 from 192 to 182, e-00-77 , 12/1/00. Licensed beds reduced from 192 to 182 , 12/01/00.
46. Formerly Silver Springs HealthCare Ctr.
47. Con issued to replace the existing 40 bed facility, 7/13/2001 sc-01-30.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	1999 VISITS
REGION IV:	EMERGENCY FACILITIES			
II	AIKEN REG MED CTR	AIKEN	AIKEN	52063
IV	ALLENDALE CO HOSP	ALLENDALE	FAIRFAX	8703
III	BAMBERG CO MEM HOSP	BAMBERG	BAMBERG	9559
III	BARNWELL CO HOSP	BARNWELL	BARNWELL	11493
III	BEAUFORT CO MEM HOSP	BEAUFORT	BEAUFORT	24326
II	HILTON HEAD HOSP	BEAUFORT	HILTON HEAD	17274
II	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON	25552
II	CHARLESTON MEM HOSP	CHARLESTON	CHARLESTON	29187
II	EAST COOPER REG MED CTR	CHARLESTON	MT PLEASANT	14808
II	TRIDENT MED CTR	CHARLESTON	CHARLESTON	36239
II	ROPER HOSP	CHARLESTON	CHARLESTON	68070
II	ROPER HOSP NORTH	CHARLESTON	CHARLESTON	17616
(*)	MUSC MEDICAL CTR	CHARLESTON	CHARLESTON	24693
III	COLLETON MED CTR	COLLETON	WALTERBORO	21001
II	SUMMERVILLE MED CTR	DORCHESTER	SUMMERVILLE	25429
III	HAMPTON REG MED CTR	HAMPTON	VARNVILLE	7639
III	LOW COUNTRY GEN HOSP	JASPER	RIDGELAND	7743
II	RMC ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG	41574
TOTALS				442969

(*) Met insufficient criteria to be classified.

REGION IV:	TRAUMA CENTERS		
III	AIKEN REG MED CTR	AIKEN	AIKEN
III	BEAUFORT CO MEM HOSP	BEAUFORT	BEAUFORT
I	MUSC MEDICAL CTR	CHARLESTON	CHARLESTON
III	EAST COOPER COMM HOSP	CHARLESTON	MT PLEASANT
III	ROPER HOSP	CHARLESTON	CHARLESTON
III	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON
III	TRIDENT MED CTR	CHARLESTON	CHARLESTON
III	HILTON HEAD HOSP	BEAUFORT	HILTON HEAD
III	ORANGEBURG-CALHOUN REG	ORANGEBURG	ORANGEBURG

Total Cost: $1,595.00 Total Run: 200 Unit Cost: $7.97



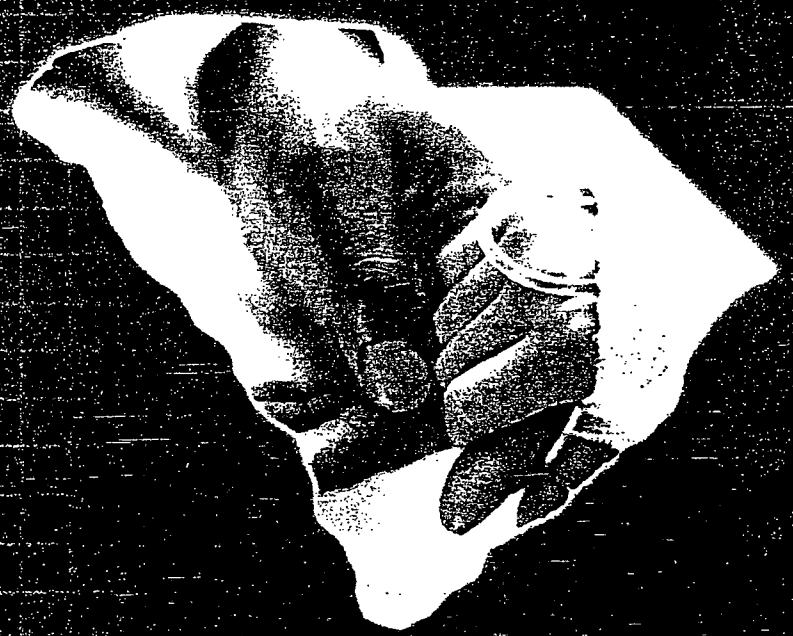
South Carolina Department of Health
and Environmental Control

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PET-EX005.0264

2003 South Carolina Health Plan



South Carolina Health Planning Committee

South Carolina Department of Health and Environmental Control

Petitioner's Trial Exhibit 006

PMC.2013.SHP.0265

PET-EX006

2003 South Carolina Health Plan

South Carolina State Health Planning Committee

South Carolina Department of Health and Environmental Control

Effective June 13, 2003

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South Carolina State Health Planning Committee

Member	Representing	Term expires
Gerald A. Wilson, M.D. Chairman	Provider	6/30/06
Langdon A. Hartsock, M.D.	Provider	6/30/04
Susan A. Lake	Provider	6/30/06
Frederick D. Hobby	Provider	6/30/04
Nicki S. Davis	Finance/Business	6/30/04
James E. Armbruster	Finance/Insurance	6/30/04
Angela H. McCrae	Finance/Business	6/30/06
Samuel A. Williams	Finance/Insurance	6/30/06
Edward D. Tinsley, III	Consumer	6/30/06
Oscar J. Harm, III, Ph.D.	Consumer	6/30/06
William Patrick Flack	Consumer	6/30/04
Billy R. Oswald	Consumer	6/30/04
Elliott Elam, Jr.	Ex Officio	(Consumer Affairs)
Larry Chewning, D.M.D.	DHEC Board	6/30/03

All correspondence should be addressed to: State Health Planning Committee, Division of Planning and Certification of Need, S.C. DHEC, 2600 Bull Street, Columbia, South Carolina 29201.

TEL: 803-545-4200 FAX: 803-545-4579

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CHAPTER I

INTRODUCTION

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Standards of Construction and Equipment

Standards for Maintenance and Operation

State Certification of Need and Health Facility Licensure Act

Indigent Care Policy

Relative Importance of Project Review Criteria

Existing Resources and Capacity

Interpretation of the Plan

Quality of Care

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CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is conscious that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

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E. Standards of Construction and Equipment:

Construction of health care facilities will comply with the Standards for Licensing as promulgated by the S.C. Department of Health and Environmental Control.

F. Standards for Maintenance and Operation:

1. Pursuant to the "State Certification of Need and Health Facility Licensure Act," the South Carolina Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina. The Division of Health Licensing within DHEC is responsible for licensing Hospitals, Nursing Homes, Intermediate Care Facilities for the Mentally Retarded, Ambulatory Surgical Facilities, Home Health Agencies, Hospice Programs and Facilities, Community Residential Care Facilities, Renal Dialysis Facilities, Psychiatric Hospitals, Psychoactive Substance Abuse Treatment Facilities, Residential Treatment Programs, Detoxification Facilities, Residential Treatment Centers for Children and Adolescents, Abortion Clinics, Day Care Facilities for Adults, Chiropractic Inpatient Facilities, Hearing Aid Specialists, Licensed Midwives, Birthing Centers, and Body Piercing Facilities.

2. Health Officers in local county health departments and various Bureaus of DHEC provide health care facilities with professional consultation, e.g., medical, laboratory, nursing, dietary, home visitation, x-ray, et cetera.

3. The Office of Environmental Quality Control, DHEC, must approve all water supply and sewage disposal systems.

G. State Certification of Need and Health Facility Licensure Act:

1. The purpose of the State Certification of Need and Health Facility Licensure Act as amended is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

2. This law requires the:

   (1) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;

   (2) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;

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(3) preparation and publication of a State Health Plan, with the advice of the health planning committee; and

(4) licensure of facilities rendering medical, nursing and other health care.

3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.

4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet through www.scdhec.net.

H. Indigent Care Policy:

The following indigent care policy shall apply to all Certificate of Need applications which have a capital cost associated with a health service or beds; the establishment or expansion of a home health agency; or change of ownership or controlling interest in a health care facility or home health agency. Certificate of Need applications will be reviewed with particular emphasis on the Department's accessibility criteria. Applications which fail to address this issue in enough specificity, or which fail to reflect an adequate commitment to meeting this identified community need will be denied by Department staff subject to review on appeal by the Board of Health and Environmental Control.

The South Carolina Board of Health and Environmental Control is particularly concerned about the problems of accessibility and indigent care in South Carolina health care facilities. It is in the interest of the Board to assure all citizens of this state equal access to our health care facilities including those who are not fortunate enough to be able to pay for their health care services. For this reason, the Board has adopted the following policy:

> "It shall be the policy of the S.C. Board of Health and Environmental Control to require all applicants for Certification of Need to address in detail their plan of access to care for the indigent population in their application. This plan must separately identify bad debt and contractual adjustments from any indigent care as addressed in their plan for provision of indigent care. Applications which fail to address this issue adequately and clearly or which fail to reflect an adequate commitment to meeting this identified community need shall be denied by the staff subject to review on appeal by the Board."

For the purpose of this policy, the following definitions are adopted:

1. Indigent Care - That medical care (measured in dollars) provided to an individual who has been determined to be unable to pay for this care prior to admission in non-

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emergency situations, and as soon as possible but before the discharge in emergency situations and for which only one billing has occurred and no other efforts have been undertaken to collect such debt. Indigent care does not include debt; contractual adjustments; or care that is reimbursed by a governmental program (Medicare, Medicaid, County indigent care program), church, or philanthropic organizations.

2. Revenue - When indigent care is expressed as a percentage of revenue, gross operating revenues should be used. Gross operating revenues are total charges prior to reduction due to contractual adjustments, discounts, bad debts or similar revenue adjustments.

3. Department - The South Carolina Department of Health and Environmental Control.

4. Health Care Facility or facility - Those "health care facilities" as defined in the State Certification of Need and Health Facility Licensure Act, Section 44-7-130 (10).

5. Home Health Agency or agency - Those "home health agencies" as defined in the Licensure of Home Health Agencies Act Section 44-69-20 (4).

The provisions of this policy will apply to all health care facilities and home health agencies that apply to the Department for a Certificate of Need. When an application is submitted, the applicant shall submit as part of the application, an indigent care plan addressing all of the elements of the Board's policy. The plan will describe how the health care facility or home health agency will address indigent care. It shall include at a minimum, the following:

1. The existing and proposed admission and treatment policies of the facility or agency with regard to race, sex, creed, national origin, and ability to pay.

2. The proposed admission and treatment policies of the facility or agency with respect to admission and care of indigent patients including those patients unable to pay at the time of admission and those whose benefits expire while in the care of the facility or agency.

3. In existing facilities or agencies, provide the amount, in terms of dollars and percent of gross revenues, that the facility or agency provided in indigent care during the past three fiscal years. NOTE: Indigent care is defined in H-1.

4. Provide the proposed amount of indigent care the facility or agency projects to provide during the existing fiscal year and next fiscal year. This projection should be expressed in both dollars and a percent of gross revenues.

5. A discussion of why the above figures are adequate or inadequate for the needs of the community; the need of indigent care within the proposed service area; and any solutions, remedial plans or proposals by the facility or agency to better address the indigent care problems in the service area. Include any initiatives or undertakings the

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facility or agency has begun to address the indigent care problems in the proposed service area.

6. Describe any Board or Advisory Board established to implement or control the Indigent program at the facility or agency. Include the Board's functions, responsibilities and limitations.

I. Relative Importance of Project Review Criteria:

In accordance with the latest revisions to the Certification of Need and Health Facility Licensure Act, a general statement has been added to each section of Chapter II stating the project review criteria considered to be the most important in reviewing certificate of need applications for each type of facility, service, and equipment. These criteria are not listed in order of importance, but sequentially as found in Chapter 8 of Regulation No. 61-15, Certification of Need for Health Facilities and Services. In addition, a finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse affects caused by the duplication of any existing facility, service or equipment.

J. Existing Resources and Capacity:

To preclude unnecessary duplication, the existing resources and capacity of all services and facilities will be considered prior to the approval of any Certificate of Need application.

K. Interpretation of the Plan:

The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole.

L. Quality of Care:

There is both local and national concern regarding the quality of health care services, particularly in relation to patient safety. In 2003, the Joint Commission on Accreditation of Health Care Organizations (JACHO) began surveying accredited facilities for compliance with recommendations for improving the accuracy of patient identification; improving the effectiveness of communication among caregivers; improving the safety of using high-alert medications; eliminating wrong-site, wrong-patient, wrong-procedure surgeries; improving the safety of using infusion pumps; and improving the effectiveness of clinical alarm systems. Other organizations, such as the Leapfrog Group, a business consortium of Fortune 500 companies, are also focusing on hospital safety.

The Department of Health and Environmental Control shares this concern. Therefore, it is the policy of the Department that all Certificate of Need applications must address the policies and procedures taken to assure the quality of care provided by the applicant.

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CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

- Inventory Regions and Service Areas
- Exceptions to Service Area Standards
- Identification of Inventory Regions
- Estimated State Civilian Population
- Patient Statistics
- Facility Information and Plan Cut-Off Date
- Categories of Facilities and Services
  - General Medical Facilities and Services
    - General Hospitals
    - General Hospital-Bed Supply
    - General Hospital-Occupancy Rate
    - Obstetrical and Neonatal Services
      - Obstetrical Services
      - Neonatal Services
    - Pediatric Inpatient Services
    - Cardiovascular and Associated Heart Disease
      - Cardiac Catheterization
      - Open Heart Surgery
    - Cancer
      - Linear Accelerators
      - Gamma Knife
    - Diagnostic Imaging
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    - Outpatient Facilities
      - Ambulatory Surgical Facility
      - Emergency Hospital Services
      - Trauma Referral System
  - Community Psychiatric Beds
  - Residential Treatment Facilities for Children and Adolescents
  - Alcohol and Drug Abuse Facilities
  - Rehabilitation Facilities
  - Long-Term Care Facilities and Services
    - Nursing Homes
    - Medicaid Nursing Home Permits
    - Mental Retardation Facilities
    - Retirement Community: Nursing Home Units
    - Hospice Facilities and Hospice Programs
    - Swing Beds
    - Home Health Agencies
    - Other Services for the Elderly
  - Critical Access Hospitals
  - Long-Term Care Hospitals

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CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration. The Health Service Area (HSA) designations previously used are no longer applicable and have been replaced.

The needs for hospital beds are based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The needs for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents are based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The needs for most services (cardiac catheterization, open heart surgery, etc.) are based upon the service standard, which is a combination of utilization criteria and travel time requirements. Each service standard constitutes the service area for that particular service.

Any service area may cross multiple administrative, geographic, trade and/or political boundaries. It is recognized that due to factors which may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the state. Therefore, service areas may specifically cross inventory regions and/or state boundaries. The need for a service is analyzed by an assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan and applicable statutes and regulations.

B. Exceptions to Service Area Standards:

It must be recognized that the health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, we are seeing a number of health care facilities consolidating and establishing provider networks in order to better compete for contracts within the new environment. This is particularly important for the smaller, more rural, facilities that run the risk of being bypassed by insurers and health care purchasers looking for the availability of comprehensive health care services for their subscribers.

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes desire to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as being two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds,

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equipment or services. There may be certain instances where 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; however, such transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. 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 services may be approved only if there is no overall increase in the number or amount of such services;

(2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;

(3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

(4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impacts must be detailed along with the perceived benefits of the proposal;

(5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;

(6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;

(7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

Region	Counties
I	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and Union.
II	Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda and York.
III	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg.

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IV Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg.

D. Estimated State Civilian Population:

This Plan has been developed using the estimated civilian population of 4,053,340 for 2001 and projected population of 4,355,080 for 2008 where these projections were required for calculations. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2001 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

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 July 1, 2003.

G. Categories of Facilities and Services:

1. General Medical Facilities and Services

(A) General Hospitals

(1) Definitions:

(a) A "hospital" means a facility organized and administered to provide overnight medical or surgical care 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.

(b) "Hospital beds" 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.

(2) Bed Capacity is as follows:

(a) 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

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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.

Adequate square footage is defined as:

100 square feet in single rooms;
80 square feet per bed or pediatric crib in multi-bed rooms;
40 square feet per bassinet in pediatric nurseries.

In measuring the square footage of patient rooms for the purpose of determining bed capacity, only the net usable space in the room was considered. Space in toilet rooms, washrooms, closets, vestibules, and corridors were not included.

(b) For facilities constructed under the Certificate of Need program, bed capacity will be as stated in the certificate, regardless of oversize room construction.

(c) For Areas Included:

1. Bed space in all nursing units, including: (1) intensive care unit and (2) minimal or self-care units.
2. Isolation units.
3. Pediatric units, including: (1) pediatric bassinets and (2) incubators located in the pediatric department.
4. Observation units equipped and staffed for overnight use.
5. All space designated for inpatient bed care even if currently closed or assigned to easily convertible, non-patient uses such as administration offices or storage.
6. Space in areas originally designed as solaria, waiting rooms, offices, conference rooms and classrooms that have necessary fixed equipment and are accessible to a nurses' station exclusively staffed for inpatient care.
7. Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

(d) For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.

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8. Corridors.
9. Solaria, waiting rooms and such which are not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) {an area that is finished except for movable equipment shall not be considered unfinished space}.
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are a separate category of bed utilizing the same criteria outlined for general acute beds.

(3) Inventory:

(a) All licensed general hospitals, as well as Federal facilities, are included in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days listed for the general hospital category does not include days of care rendered in psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventory.

(b) 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, such as:

1. Fire-resistivity of each building.
2. Fire and other safety factors of each building.
3. Design and structural factors affecting the function of nursing units.
4. Design and structural factors affecting the function of service departments.

(4) Narrative: General Hospital Beds

The General Acute Hospital bed need methodology is based on analyses including historical utilization; nationally recognized bed need methodologies; and consideration of the physical characteristics of hospitals in the State. Based upon these analyses, a variable occupancy rate methodology was developed, as follows:

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 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, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

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It should be noted that, throughout the Plan where the term "hospital bed need" is specified, these figures are actually based upon demand or utilization data for the general acute hospitals. Use of these planning factors is not intended to stem initiative or to suggest that facilities cannot operate at more efficient levels than used in the calculations without additional beds.

The methodology for calculating bed needs is as follows:

(a) Calculations of bed need are made for individual facilities.

(b) 1. Multiply the current facility use rate by age cohort by the projected population by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

2. 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 area's need.

(c) The number of additional beds needed or excess beds is obtained by subtracting the number of existing beds from the bed need.

(d) Should there be a need shown for additional beds for a hospital, then an increase may be approved. In order to provide for a cost-effective addition, up to the greater of 50 beds or the actual projected number of additional beds may be approved, provided the hospital can document and demonstrate the need for additional beds.

(e) In some areas of South Carolina, there is a considerable influx of tourists who are 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 the Department may approve some additional beds at the existing hospital based on further analysis.

(f) Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital. The impacted hospital must document this increase in demand and explain why additional beds are needed to accommodate the care of patients previously served at a Federal facility. Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.

(g) Because of the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

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1. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert these nursing home beds to acute care hospital beds only within the hospital provided the hospital can document an actual need for these additional acute care beds. This will be based on actual utilization using current information. A CON is required for this conversion.

2. Existing general hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert these specialty beds to acute care hospital beds regardless of the projected need for general acute care hospital beds, provided a Certificate of Need is received.

(h) 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 following criteria:

1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

2. Such transfers may cross county lines; however, the applicants must document with patient origin data the historical utilization of the receiving facility by residents of the county giving up beds;

3. Should the response to Criterion 2. fail to show a historical precedence of residents of the county transferring the beds utilizing the receiving facility, the applicants must document why it is in the best interest of these residents to transfer the beds to a facility with no historical affinity for them;

4. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impacts must be detailed along with the perceived benefits of such an agreement;

5. The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

6. The facility giving up the beds may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

7. A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of beds must be included in the Certificate of Need application;

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8. Each facility giving up beds must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

(i) Factors to be considered regarding modernization of facilities should include:

1. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
2. The ability to update medical technology within the existing plant.
3. Existence of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) deficiencies or "grandfathered" licensure deficiencies.
4. Cost efficiency of the existing physical plant versus plant revision, etc.

(j) Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on health delivery and status within the service area.

The following pages depict the calculation of hospital bed need as described earlier.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Cost Containment; and
g. Adverse Effects on Other Facilities.

General hospital beds are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and current utilization and population growth are factored into the methodology for determining general hospital beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for these beds.

PMC.2013.SHP.0284

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FY 2008 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2001 POP	2008 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANDERSON CO.									
ANDERSON AREA MEDICAL CTR & WOMEN AND CHILDREN'S HOSPITAL #3	<18	40890	42580	3683	10.51				
	18-64	103390	109630	41085	119.35				
	+65	22760	24840	49680	148.55				
	TOTAL	167040	177050	94448	278.41	0.75	372	495	-123
CHEROKEE CO.									
UPSTATE CAROLINA MED CTR	<18	13710	14550	1033	3.00				
	18-64	32760	35180	6916	20.35				
	+65	6520	6880	7698	22.26				
	TOTAL	52990	56610	15647	45.61	0.65	70	125	-55
GREENVILLE CO:									
ALLEN BENNETT MEM	<18	94560	98820	166	0.47				
	18-64	243680	264740	6308	18.76				
	+65	44740	48160	8581	25.31				
	TOTAL	383180	411720	15054	44.54	0.65			
GREENVILLE MEM MED CTR	<18	94560	98820	17017	48.72				
	18-64	243680	264740	97989	291.43				
	+65	44740	48160	71996	212.33				
	TOTAL	383180	411720	187002	552.48	0.75			
ALLEN BENNETT MEM AND #4 GREENVILLE MEM MED CTR AND GREENVILL HOSP SYS- PATEWOOD	TOTAL						806	840	-34
HILLCREST	<18	94560	98820	98	0.28				
	18-64	243680	264740	3651	10.86				
	+65	44740	48160	5177	15.27				
	TOTAL	383180	411720	8926	26.41	0.65	41	43	-2
SAINT FRANCIS HOSPITAL	<64	338440	363560	23227	68.36				
	+65	44740	48160	32958	97.20				
	TOTAL	383180	411720	56185	165.56	0.70			
ST.FRANCIS WOMAN'S & FAMILY HOSP	<64	338440	363560	9648	28.39				
	+65	44740	48160	3885	11.46				
	TOTAL	383180	411720	13533	39.85	0.65			
SAINT FRANCIS HOSPITAL AND #4 ST.FRANCIS WOMAN'S & FAMILY HOSP	TOTAL						299	319	-20

RECORD 003798
PMC.2013.SHP.0285
PET-EX006.0021

TY/CO	CAT	POP	POP	2001 DAYS	P ADC	% OCCU	BED NEED	EXIST BEDS	T ADDED/OR (EXCESS)
OCONEE CO									
OCONEE MEM									
	<18	15140	15780	992	2.83				
	18-64	41330	44280	13628	40.00				
	+65	10690	13590	17371	60.50				
	TOTAL	67160	73650	31990	103.33	0.65	159	160	-1
PICKENS CO									
CANNON MEM.									
	<18	27160	28870	75	0.22				
	18-64	72470	80630	1959	5.97				
	+65	12790	14360	4226	13.00				
	TOTAL	112420	123860	6260	19.19	0.65	30	55	-25
PALMETTO BAPTIST MED CTR EASLEY	<18	27160	28870	626	1.82				
	18-64	72470	80630	8211	25.03				
	+65	12790	14360	9051	27.84				
	TOTAL	112420	123860	17888	54.69	0.65	84	96	-12
SPARTANBURG CO									
B.J. WORKMAN MEM.									
	<18	63840	66990	91	0.26				
	18-64	160830	174060	871	2.58				
	+65	31890	34240	1786	5.25				
	TOTAL	256560	275290	2748	8.10	0.65	12	43	-31
SPGT HOSP RESTORATIVE CARE	<18	63840	66990	0	0.00				
	18-64	160830	174060	6161	18.27				
	+65	31890	34240	15921	46.83				
	TOTAL	256560	275290	22082	65.10	0.65	100	97	3
MARY BLACK MEM.	<18	63840	66990	1358	3.90				
	18-64	160830	174060	12459	36.94				
	+65	31890	34240	12303	36.19				
	TOTAL	256560	275290	26120	77.04	0.70	110	176	-66
SPARTANBURG REG. MED.CTR.	<18	63840	66990	4589	13.19				
	18-64	160830	174060	52723	156.33				
	+65	31890	34240	54828	160.69				
	TOTAL	256560	275290	111939	330.21	0.75	440	532	-92
UNION CO									
HOPE HOSP.									
	<18	7090	7040	7	0.02				
	18-64	18050	17640	794	2.13				
	+65	4710	4930	7	0.02				
	TOTAL	29850	29610	808	2.17	0.65	3	14	-11
WALLACE THOMSON	<18	7090	7040	620	1.69				
	18-64	18050	17640	7133	19.10				
	+65	4710	4930	8992	25.78				
	TOTAL	29850	29610	16744	46.57	0.65	72	143	-71

RECORD 003799
PMC.2013.SHP.0286
PET-EX006.0022

FACILITY/COUNTY	AGE CAT	2001 POP	2008 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION II									
ABBEVILLE CO.									
ABBEVILLE CO. MEM.	<18	6650	6750	1003	2.79				
	18-64	15790	16450	1755	5.01				
	+65	3840	4020	2703	7.75				
	TOTAL	26280	27220	5460	15.55	0.65	24	52	-28
CHESTER CO.									
CHESTER CO. HOSP.	<18	9090	8990	944	2.56				
	18-64	20810	21550	5383	15.27				
	+65	4320	4600	6965	20.32				
	TOTAL	34220	35140	13292	38.15	0.65	59	82	-23
EDGEFIELD CO.									
EDGEFIELD CO.HOSP.	<18	5950	5820	293	0.79				
	18-64	16090	17730	1172	3.54				
	+65	2710	3040	2109	6.48				
	TOTAL	24750	26590	3574	10.81	0.65	17	40	-23
FAIRFIELD CO.									
FAIRFIELD MEM	<18	6130	6200	204	0.57				
	18-64	14390	15340	1690	4.94				
	+65	3070	3190	2188	6.23				
	TOTAL	23590	24730	4082	11.73	0.65	18	33	-15
GREENWOOD CO									
SELF MEM.HOSP.	<18	17160	17790	2714	7.70				
	18-64	40440	42930	26478	77.01				
	+65	9070	9400	31123	88.37				
	TOTAL	66690	70120	60315	173.08	0.70	247	334	-87
KERSHAW CO									
KERSHAW CO.MEM HOSP	<18	13660	14050	1815	5.11				
	18-64	32720	35840	8230	24.70				
	+65	6850	7570	14820	44.87				
	TOTAL	53230	57460	24865	74.68	0.65	115	121	-6
LANCASTER CO									
SPRINGS MEM	<18	15540	15490	1823	4.98				
	18-64	38530	39960	19937	56.65				
	+65	7370	7700	16216	46.42				
	TOTAL	61440	63150	37976	108.04	0.65	166	145	21
LAURENS CO									

RECORD 003800
PMC.2013.SHP.0287
PET-EX006.0023

FACILITY/COUNTY	AGE CAT	2001 POP	2006 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDED/OR (EXCESS)
LAURENS CO HOSP	<18	17690	17720	481	1.27				
	18-64	43290	47420	6674	20.03				
	+65	9250	10310	10614	32.41				
	TOTAL	70230	75450	17749	53.71	0.65	83	76	7
LEXINGTON CO									
LEXINGTON MED CTR	<18	34920	36557	2749	7.88				
	18-64	87899	98205	37644	115.23				
	+65	14001	16885	35964	118.83				
	TOTAL	136820	151647	76357	241.94	0.70	346	292	54
NEWBERRY CO									
NEWBERRY CO. MEM.	<18	8820	8970	393	1.10				
	18-64	22200	23470	3686	10.68				
	+65	5350	5590	6827	19.54				
	TOTAL	36370	38030	10906	31.31	0.65	48	90	-42
RICHLAND CO									
PALMETTO HEALTH BAPTIST &	<18	102180	105274	2297	6.48				
	18-64	263172	283586	37868	111.80				
	+65	40119	44415	33940	102.94				
	TOTAL	405471	433275	74105	221.22	0.75	295	351	-56
PROVIDENCE HOSPITAL	<18	102180	105274	64	0.18				
	18-64	263172	283586	25456	75.15				
	+65	40119	44415	38441	116.60				
	TOTAL	405471	433275	63961	191.93	0.70	274	247	27
PROVIDENCE HOSPITAL NE	<18	102180	105274	100	0.28				
	18-64	263172	283586	4926	14.54				
	+65	40119	44415	7414	22.49				
	TOTAL	405471	433275	12440	37.31	0.65	57	46	11
PALMETTO HEALTH RICHLAND	<18	102180	105274	23054	65.07				
	18-64	263172	283586	81417	240.36				
	+65	40119	44415	41438	125.69				
	TOTAL	405471	433275	145909	431.12	0.75	575	579	-4
INTERMEDICAL HOSP OF SC	<18	102180	105274	0	0.00				
	18-64	263172	283586	3600	10.63				
	+65	40119	44415	5727	17.37				
	TOTAL	405471	433275	9327	28.00	0.65	43	47	-4
YORK CO									
PIEDMONT MED. CTR.	<18	43670	45490	2361	6.74				
	18-64	106140	120910	28388	86.60				
	+65	17350	19910	28270	86.88				
	TOTAL	167180	186310	59019	184.22	0.70	263	268	-5

RECORD 003801
PMC.2013.SHP.0288
PET-EX006.0024

FY 2006 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2001 POP	2006 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION III									
CHESTERFIELD CO									
CHESTERFIELD GENERAL	<18	11290	11170	443	1.20				
	18-64	26430	27270	2844	8.04				
	+65	5120	5370	2120	6.09				
	TOTAL	42840	43810	5407	14.13	0.65	22	59	-37
CLARENDON CO									
CLARENDON MEM. HOSP.	<18	8340	7870	726	1.88				
	18-64	19720	20460	6820	19.67				
	+65	4650	5770	6057	20.59				
	TOTAL	32710	34100	13703	42.14	0.65	65	56	9
DARLINGTON CO									
CAROLINA PINES REG HOSPITAL	<18	17700	17670	2591	7.09				
	18-64	41600	42370	13425	37.46				
	+65	8160	8690	11550	33.70				
	TOTAL	67460	68730	27566	78.25	0.65	120	116	4
WILSON MEDICAL CTR	<18	17700	17670	4	0.01				
	18-64	41600	42370	1667	4.65				
	+65	8160	8690	1993	5.81				
	TOTAL	67460	68730	3664	10.48	0.65	16	50	-34
DILLON CO									
SAINT EUGENE MEDICAL CENTER	<18	8760	8210	1514	3.89				
	18-64	18340	18520	5905	16.34				
	+65	3520	3460	5198	14.00				
	TOTAL	30620	30190	12617	34.22	0.65	53	79	-26
FLORENCE CO									
CAROLINAS HOSP SYS & WOMEN'S CENTER OF THE CAROLINAS HOSP. SYS. #1	<18	32670	32710	1540	4.22				
	18-64	79010	83740	26548	77.09				
	+65	14950	16350	33509	100.40				
	TOTAL	126630	132800	61597	181.72	0.70	260	282	-22
CAROLINAS HOSP SYS LAKE CITY	<18	32670	32710	143	0.39				
	18-64	79010	83740	1840	5.34				
	+65	14950	16350	1787	5.35				
	TOTAL	126630	132800	3770	10.83	0.65	17	48	-31
MCLEOD REG MED CTR	<18	32670	32710	8397	23.03				
	18-64	79010	83740	58782	170.69				
	+65	14950	16350	46299	138.73				
	TOTAL	126630	132800	113478	332.45	0.70	475	338	139

RECORD 003802
PMC.2013.SHP.0289
PET-EX006.0025

FY 2008 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2001 POP	2008 PDP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	TO BE EXIST BEDS	ADDED/OR (EXCESS)
REGENCY HOSPITAL OF SC	<18	32870	32710		0.00				
	18-64	79010	83740		0.00				
	+65	14950	16350		0.00				
	TOTAL	126830	132800	261	0.75	0.65	1	28	-27
GEORGETOWN CO									
GEORGETOWN CO. MEM. AND WACCAMAW NECK	<18	13730	12910	1720	4.43				
	18-64	33910	36120	16871	54.49				
	+65	8670	11350	21566	77.35				
	TOTAL	56310	60380	41957	136.27	0.70	195	185	10
HORRY CO									
CONWAY HOSP. INC.	<18	42260	43250	2514	7.05				
	18-64	127510	146530	16452	51.80				
	+65	30710	40000	18005	64.25				
	TOTAL	200480	229780	36971	123.10	0.65	190	160	30
GRAND STRAND REG MED CTR	<18	42260	43250	839	2.35				
	18-64	127510	146530	20382	64.17				
	+65	30710	40000	28130	100.38				
	TOTAL	200480	229780	49351	166.91	0.70	238	219	19
LORIS COMM. HOSP.	<18	42260	43250	965	2.71				
	18-64	127510	146530	10403	32.75				
	+65	30710	40000	10081	35.97				
	TOTAL	200480	229780	21449	71.43	0.65	110	105	5
MARION CO									
MARION CO MEDICAL CTR	<18	9850	9330	1681	4.45				
	18-64	21840	22490	14504	41.30				
	+65	4250	4430	16683	47.64				
	TOTAL	35540	36250	32868	93.39	0.65	144	124	20
MARLBORO CO									
MARLBORO PARK	<18	7440	7190	493	1.31				
	18-64	17810	17250	3064	8.13				
	+65	3470	3280	3018	7.82				
	TOTAL	28720	27720	6575	17.25	0.65	27	94	-67
SUMTER CO									
TUOMEY	<18	29710	30940	2888	8.24				
	18-64	64380	69480	26501	78.36				
	+65	12030	14080	27237	87.34				
	TOTAL	106120	114500	56626	173.94	0.70	249	248	1
WILLIAMSBURG CO									
WILLIAMSBURG REGIONAL HOSP	<18	10440	9670	69	0.18				

RECORD 003803
PMC.2013.SHP.0290
PET-EX006.0026

	AGE CAT	2001 POP	2006 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
	18-64	21860	22100	950	2.63				
	+65	4890	5120	1628	4.67				
	TOTAL	37190	36890	2647	7.48	0.65	12	78	-66
REGION IV									
ALLENDALE CO									
ALLENDALE CO HOSP	<18	3000	3050	117	0.33				
	18-64	6900	7180	928	2.65				
	+65	1450	1690	897	2.86				
	TOTAL	11350	11920	1942	5.84	0.65	9	25	-16
BAMBERG CO.									
BAMBERG CO. MEM.	<18	4330	3970	157	0.39				
	18-64	9980	9710	2815	7.50				
	+65	2270	2220	2832	7.59				
	TOTAL	16580	15900	5804	15.49	0.65	24	59	-35
BARNWELL CO.									
BARNWELL CO. HOSP	<18	6490	6180	349	0.91				
	18-64	14190	15430	2002	5.98				
	+65	2990	3330	3370	10.28				
	TOTAL	23670	24940	5721	17.16	0.65	26	53	-27
BEAUFORT CO.									
BEAUFORT CO. MEM.	<18	28980	28050	1669	4.48				
	18-64	74480	84600	19928	62.02				
	+65	19860	28340	15913	62.21				
	TOTAL	123320	140990	37530	128.71	0.65	199	130	69
HILTON HEAD MEDICAL REG MED CTR	<18	28980	28050	225	0.60				
	18-64	74480	84600	7492	23.32				
	+65	19860	28340	12697	49.64				
	TOTAL	123320	140990	20414	73.55	0.65	113	93	20
BERKELEY/DORCHESTER CHARLESTON COS.									
TRIDENT MED CTR AND SUMMERVILLE MED CTR	<18	143580	143400	2806	7.68				
	18-64	353660	383560	42709	126.90				
	+65	58640	73200	42183	144.27				
	TOTAL	555880	600160	87698	278.85	0.75	372	351	21
SPECIALITY HOSPITAL OF SC	<18	143580	143400	0	0.00				
	18-64	353660	383560	2470	7.34				
	+65	58640	73200	5959	20.38				
	TOTAL	555880	600160	8429	27.72	0.65	43	59	-16
CHARLESTON MEMORIAL	<18	143580	143400		0.00				

RECORD 003804
PMC.2013.SHP.0291
PET-EX006.0027

FY 2008 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2001 POP	2008 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
	18-64	353660	383560	3845	11.42				
	+65	58640	73200	427	1.46				
	TOTAL	555880	600160	4272	12.89	0.65	20	98	-78
MEDICAL UNIVERSITY HOSP.									
	<18	143580	143400	24536	67.14				
	18-64	353660	383560	71635	212.85				
	+65	58640	73200	27125	92.77				
	TOTAL	555880	600160	123296	372.76	0.75	498	466	32
ROPER HOSP.									
	<18	143580	143400	1628	4.45				
	18-64	353660	383560	40117	119.20				
	+65	58640	73200	54000	184.68				
	TOTAL	555880	600160	95745	308.34	0.75	411	414	-3
BON SECOURS ST. FRANCIS XAVIER #2									
	<18	143580	143400	657	1.80				
	18-64	353660	383560	20808	61.83				
	+65	58640	73200	17211	58.86				
	TOTAL	555880	600160	38676	122.49	0.70	175	201	-26
EAST COOPER REG MED CTR.									
	<18	143580	143400	193	0.53				
	18-64	353660	383560	9831	28.62				
	+65	58640	73200	7687	26.29				
	TOTAL	555880	600160	17511	55.43	0.65	85	100	-15
COLLETON CO.									
COLLETON MED CTR									
	<18	10430	10640	708	1.98				
	18-64	23200	24610	12484	36.58				
	+65	4950	5450	16321	49.23				
	TOTAL	38580	40900	29513	87.79	0.65	136	131	5
HAMPTON CO.									
HAMPTON REG MED CTR									
	<18	5780	5550	96	0.25				
	18-64	13040	13910	1872	5.47				
	+65	2600	2880	2608	7.91				
	TOTAL	21420	22340	4578	13.64	0.65	21	68	-47
JASPER CO.									
LOW COUNTRY GEN HOSP									
	<18	5480	5140	61	0.16				
	18-64	13030	14540	1030	3.15				
	+65	2300	2670	1659	5.28				
	TOTAL	20810	22350	2750	8.58	0.65	13	31	-18
ORANGEBURG CO.									
RMC ORANGEBURG-CALHOUN									
	<18	24170	23820	2439	6.59				
	18-64	55700	58470	26832	77.17				
	+65	12230	13560	28807	87.51				
ORANGEBURG CO.	TOTAL	92100	95850	58078	171.26	0.70	245	247	-2

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FACILITY/COUNTY	AGE CAT	2001 POP	2008 POP	2001 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
				FY 2008 HOSPITAL NEED					
AIKEN CO.									
AIKEN REG.MED. CTR.									
	<18	37230	37770	1197	3.33				
	18-64	68920	100180	23065	71.19				
	+65	18690	21990	21776	70.19				
	TOTAL	144840	159940	46038	144.72	0.65	223	183	40

#1 DATA & BED NEEDS FOR COMBINED HOSPITALS.
#2 DATA , BEDS AND BED NEEDS FROM ROPER NORTH TRANSFERRED TO ST. FRANCIS PER CON SC-01-37, 8/10/01.
#3 CON ISSUED TO TRANSFER 72 BEDS FOR NEW HOSPITAL.
#4 BED NEEDS ARE COMBINED FOR THESE HOSPITALS; SINCE, ADDITIONAL BEDS WERE APPROVED FOR TRANSFER AMONG THESE HOSPITALS. 6/30/03

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PMC.2013.SHP.0293
PET-EX006.0029

% OCCUPANCY RATE

	1998	1999	2000	2001
REGION I	53.6	53.9	56.8	58.3
ANDERSON AREA MED CTR	47.4	50.8	51.7	52.3
UPSTATE CAROLINA MED C	33.0	33.8	32.5	34.3
ALLEN BENNETT MEM	67.0	67.5	67.0	71.1
GREENVILLE MEM MED CTR	75.4	78.2	78.8	81.8
HILLCREST (NORTH GREENVILLE)	32.1	39.6	37.2	43.7
ST FRANCIS HOSPITAL	0.0	0.0		
ST FRANCIS WOMEN"S & FAMILY	74.1	70.9	82.0	74.7
OCONEE MEM	47.7	53.8	64.1	59.8
CANNON MEM	53.2	57.7	58.4	54.8
PALMETTO BAPTIST M C EASLEY	25.6	31.5	28.2	31.2
BJ WORKMAN MEM	42.1	50.7	47.0	51.1
MARY BLACK MEM	20.7	17.6	16.8	17.5
SPGT HOSP RESTORATIVE C	49.5	38.5	36.3	40.7
SPARTANBURG REG MED CTR	17.1	3.3	47.2	62.4
HOPE	54.2	52.5	54.2	62.4
WALLACE THOMSON	14.7	12.5	8.0	13.8
	37.8	36.3	37.0	32.1

% OCCUPANCY RATE

	1998	1999	2000	2001
REGION II	55.0	56.7	59.2	61.2
ABBEVILLE CO	23.4	27.2	24.5	24.0
CHESTER CO	46.4	43.2	46.8	44.4
EDGEFIELD CO	18.8	21.2	23.7	24.5
FAIRFIELD MEM	31.4	36.0	36.8	33.9
SELF REGIONAL	40.6	37.7	45.8	49.5
KERSHAW CO MEM	46.2	48.0	51.2	56.3
SPRINGS MEM	53.2	56.6	76.0	77.1
LAURENS COUNTY HOSP	59.6	57.9	51.0	64.0
LEXINGTON MED CTR	59.1	63.8	68.3	71.6
NEWBERRY CO MEM	25.7	27.0	26.0	29.3
INTERMEDICAL HOSPITAL OF SC		14.8	38.7	72.3
PALMETTO HEALTH BAPTIST	49.2	53.8	53.0	55.9
PROVIDENCE HOSPITAL	72.8	78.0	74.9	76.9
PROVIDENCE HOSPITAL NE		32.5	57.1	74.1
PALMETTO HEALTH RICHLAND	68.9	72.8	70.9	69.0
PIEDMONT MED CTR	64.6	67.0	66.6	65.2

	1998	1999	2000	2001
REGION III	59.3	60.1	62.1	64.0
CHESTERFIELD GEN	31.5	33.5	33.2	25.1
CLARENDON MEM	55.0	59.1	65.5	67.0
(BYERLY)	52.1			
CAROLINA PINESREG MED CTR		57.1	61.9	65.1
WILSON CLINIC	27.1	24.5	20.5	20.5
ST. EUGENE REG MED CTR	49.9	47.1	36.8	43.8
CAROLINAS HOSPITAL SYS	52.5	55.4	60.7	60.3
CAROLINAS HOSP LAKE CITY	19.2	36.8	28.8	21.5
MCLEOD REG MED CTR	88.4	85.0	86.6	92.5
WOMEN'S CTR/CAROLINAS	65.2	60.4	44.8	53.2
REGENCY HOSPITAL OF SC				12.8
GEORGETOWN MEM	64.1	69.1	71.7	81.0
CONWAY HOSP	60.2	64.0	64.8	63.3
GRAND STRAND REG	63.0	66.6	74.9	78.6
LORIS COMM	42.1	48.0	53.8	56.0
MARION CO MED CTR (MULLINS)	66.5	71.9	74.7	90.6
MARLBORO PARK	25.6	27.0	28.5	19.2
TUOMEY	60.1	68.2	70.1	67.7
WILLIAMSBURG REGIONAL	17.9	19.6	14.6	9.3

	1998	1999	2000	2001
REGION IV	55.3	57.1	59.3	60.8
ALLENDALE CO	16.6	13.1	14.8	14.8
BAMBERG CO MEM	27.5	28.0	28.4	27.0
BARNWELL CO	22.5	22.7	33.1	29.6
BEAUFORT MEM	69.3	76.6	83.4	80.3
HILTON HEAD	68.1	68.2	83.1	78.8
ROPER HOSP NORTH	30.3	24.9	25.0	7.0
CHARLESTON MEM	26.8	34.0	19.2	11.9
EAST COOPER REG MED CTR	40.6	43.9	44.1	48.0
MEDICAL UNIVERSITY	68.8	72.5	69.3	72.5
TRIDENT MED CTR	60.1	66.0	71.5	77.6
KINDRED-HOSP CHARLESTON		24.6	32.5	39.1
SUMMERVILLE MED CTR	40.7	50.4	57.5	61.4
ROPER	62.8	64.0	62.6	63.4
BON SECOURS ST FRANCIS X	56.9	69.0	73.0	72.2
COLLETON MED CTR	54.9	60.2	59.1	69.7
HAMPTON REG MED CTR	9.0	12.7	17.4	16.4
LOW COUNTRY	25.3	23.3	0 0	0.0
RMC ORANGEBURG/CALHOUN	58.1	64.5	63.3	58.7
AIKEN REG MED CTR	68.4	70.4	69.7	70.9

Occupancy rates are based on general acute care beds and exclude psychiatric beds.

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PET-EX006.0030

(B) Obstetrical and Neonatal Services

Obstetrical Services

Advances in obstetrical and newborn intensive care offer the promise of a lower perinatal mortality and an 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 constitute a small percentage of the total annual deliveries, but these patients require a high degree of specialized care.

Infant mortality is the death rate for babies from birth until their first birthday. South Carolina's infant mortality rate has declined faster than it has for the nation as a whole. For 2000, South Carolina's infant mortality rate was 8.7 per thousand infant births with a Healthy People 2010 objective for the nation of no more than 4.5 per thousand infant deaths per thousand live births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2000, South Carolina's neonatal mortality rate for all races was 9.9 neonatal deaths per 1,000 live births with a Healthy People 2010 objective for the nation of 2.9 neonatal deaths per 1,000 live births.

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PET-EX006.0031

RECORD 003808

The following is a description of the five levels of perinatal services as outlined in Regulation Number 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

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 shall be designated by DHEC's Division of Licensing as a Level I, II, IIE (Enhanced), or III Perinatal Hospital or RPC (Regional Perinatal Center) and the hospital shall request such designation by letter to the Department. The determination shall be made by the Department based upon a hospital's ability to meet regulatory requirements to be determined by a special inspection by the Department following the initial request for designation and as an integral part of subsequent license renewal procedures. Each Level I, II, IIE and III hospital shall maintain and document a relationship with its designated RPC for consultation, transport and continuing education. All patients shall be transferred to the appropriate RPC when medically appropriate, if beds are available. This agreement/relationship shall include the ability to share data, as appropriate, related to these functions. This should ensure that patients are treated in the hospital best suited to handle their expected problems. 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 following definitions apply:

A. Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital shall have the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2000 grams. When it is anticipated or determined that these criteria will not or have not been met, consultation and a plan of care shall be initiated and mutually agreed upon with the RPC. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. Management shall include emergency resuscitation and/or stabilization for both maternal and neonatal patients in preparation for transfer/transport for more specialized services. Hospitals at this level shall not provide care or services which are designated only for higher level hospitals. This description does not constitute Certificate of Need review criteria.

B. Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1500 grams. A board-eligible pediatrician shall be in the hospital or on site within 30 minutes, 24 hours a day. The hospital shall have at least a written consultative agreement with a board eligible neonatologist. Neonates shall be without acute distress or complex management requirements and shall not be in need of ventilatory support for more than six cumulative hours. Neonates shall not require high-frequency ventilation support. When it is anticipated or determined that these criteria will not or have not been met, a plan of care will be developed in consultation with the RPC and documented in the patient's medical record. These hospitals shall manage no less than an average of 500 deliveries annually, calculated over the previous three years. This calculation shall include the number of

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maternal transfers made prior to delivery to higher level perinatal hospitals. A Level II hospital shall not admit outborn neonates into its nursery without prior concurrence with the RPC. Hospitals at this level shall not provide care or services which are designated only for higher level hospitals. This description does not constitute Certificate of Need review criteria.

C. Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may be located only in areas of the state which are no closer than 60 miles from a South Carolina Regional Perinatal Center. This level of neonatal care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1250 grams, as determined by estimations based upon best professional judgement, ultrasound, and/or other available medical technology and instruments. A board-eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. Neonates shall not be in need of ventilatory support for more than 24 cumulative hours. When it is anticipated or determined that any of the preceding criteria relating to gestation, weight, and length of ventilatory support will not be or have not been met, the neonate may remain at the Level IIE facility, pursuant to a plan of care developed in consultation with and agreement to by the RPC. Such plan of care shall be documented in the patient's medical record. Neonates shall not require high-frequency ventilation support. These hospitals shall manage no less than an average of 1200 deliveries annually, calculated over the previous three years. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Level IIE hospital shall not admit outborn neonates into its nursery without prior concurrence with the RPC. Hospitals at this level shall not provide care or services which are designated only for higher level hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services. Level IIE hospitals must have an adequate number of neonatal bassinets to provide care for these neonates and the number of bassinets will be justified by the hospital in the Certificate of Need application. Because these hospitals already have neonatal bassinets, the number of bassinets will not be counted against the needs projected in the following sections of this Plan. Once utilization information is obtained, the projections may be revised.

D. Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, provides all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified maternal-fetal medicine specialist (perinatologist) shall be available for supervision and consultation, 24 hours a day. In addition to the Level II and IIE capabilities, Level III hospitals shall have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. Hospitals with Level III designation shall manage no less than an average of 1500 deliveries annually, calculated over the previous three years, or at least an average of 125 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. Hospitals at this level shall not provide additional care or services designated only for RPCs. The establishment of a Level III service requires Certificate of Need review.

E. Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall

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provide consultative, outreach, and support services to Level I, II, IIE, and III hospitals in the region. The RPC shall manage no less than an average of 2000 deliveries annually, calculated over the previous three years, or at least an average of 250 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. Personnel qualified to manage obstetric or neonatal emergencies shall be in-house. A board-certified maternal-fetal medicine specialist (perinatologist) shall be in the hospital or on site within 30 minutes for supervision and consultation, 24 hours a day. The RPC shall participate in residency programs for obstetrics, pediatrics, and/or family practice. Continuing education and outreach education programs shall be available to all referring hospitals, and physician-to-physician consultation shall be available 24 hours a day. The RPC shall provide a perinatal transport system that operates 24 hours a day, seven days a week, and return transports neonates to lower level perinatal hospitals when the neonates' condition and care requirements are within the capability of those hospitals. No more than one Regional Perinatal Center will be approved in each perinatal region. Regional Perinatal Centers must meet the criteria and standards required in the hospital licensing regulations. The establishment of a Regional Perinatal Center requires Certificate of Need review.

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Existing facilities will be monitored to determine if expansion, reduction, or addition of obstetrical services is appropriate. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services where appropriate. Additional beds for obstetrical services will not be approved unless other hospital beds are converted to obstetrical beds or a need is indicated in the Plan for additional hospital beds.

Desired occupancy rates are 65% for Level I and 75% for Levels II, IIE, III and RPCs.

Facilities providing obstetrical services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

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:

a. Need;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

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

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The following hospitals have requested a Perinatal Capability Review and been designated as a Level II, Level IIE, Level III or RPC facility:

REGIONAL PERINATAL CENTERS

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
Medical University of South Carolina Medical Center
Palmetto Richland Memorial Hospital
Spartanburg Regional Medical Center

SUBSPECIALITY PERINATAL CENTER (LEVEL III HOSPITAL)

Palmetto Baptist Medical Center at Columbia
Self Memorial Hospital

ENHANCED PERINATAL CENTER (LEVEL II ENHANCED CARE HOSPITALS)

Piedmont Medical Center

SPECIALITY PERINATAL CENTERS (LEVEL II HOSPITALS)

Aiken Regional Medical Centers
Anderson Area Medical Center
Palmetto Baptist Medical Center - Easley
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital, Inc.
East Cooper Regional Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital, Inc.
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital, Inc.
Saint Francis Women's and Family Hospital
Springs Memorial Hospital
Trident Regional Medical Center
Tuomey Regional Medical Center
Women's Center of Carolinas Hospital System

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RECORD 003812

FY01 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEM. MED. CTR.	5259	66	6654	18926	78.6%
PALMETTO HEALTH RICHLAND	2382	45	5728	13808	84.1%
PALMETTO HEALTH BAPTIST	3558	56	4923	13025	63.7%
SPARTANBURG REG. MED.CTR.	2428	44	3263	8214	51.1%
LEXINGTON MED. CTR.	2523	35	2670	5472	42.8%
TRIDENT MED. CTR.	2036	26	2466	5658	59.6%
MCLEOD REG. MED. CTR.	2153	20	2471	5951	81.5%
ANDERSON AREA MED CTR	1912	22	1551	4444	55.3%
MEDICAL UNIVERSITY HOSP.	1982	34			0.0%
ST. FRANCIS WOMEN'S & FAMILY HOSP	1667	24	1772	4315	49.3%
BEAUFORT CO. MEM.	1803	20	1969	4784	65.5%
PIEDMONT MED. CTR.	1615	38	2846	7672	55.3%
SELF MEM. HOSP.	1650	34	2645	7135	57.5%
RMC ORANGEBURG-CALHOUN	1360	27	2095	5148	52.2%
EAST COOPER REG MED CTR	1394	27	1746	3881	39.4%
BON SECOURS' ST. FRANCIS	1301	12	1581	3206	73.2%
ROPER HOSP.	1162	11			0.0%
TUOMEY	1142	20	1930	4876	66.8%
WOMEN'S CTR /CAROLINAS	1050	20	1321	3887	53.2%
CONWAY HOSP. INC.	1118	16	1251	4073	69.7%
AIKEN REG.MED. CTR.	1031	18	1629	4362	66.4%
MARY BLACK MEM.	1306	21	1538	6698	87.4%
GRAND STRAND REG MED CTR	967	19	1386	3266	47.1%
GEORGETOWN CO. MEM.	697	14	873	3840	75.1%
SPRINGS MEMORIAL HOSP	684	7	1006	2456	96.1%
BAPTIST MED CTR EASLEY	600	14	889	2132	41.7%
OCONEE MEM.	611				
CAROLINA PINES REG MED CTR	690	11	545	2316	57.7%
SUMMERVILLE MED CTR	738	5	869	1850	101.4%
MARION CO. MEM.	632				
LAURENS CO. HOSP.	356	8	319		
CLARENDON MEM.	601	8	601	1172	40.1%
COLLETON REG MED CTR	437	5	327	688	37.7%
LORIS COMM. HOSP.	418	8	610	1545	52.9%
ALLEN BENNETT MEM	389	5	398	857	47.0%
HILTON HEAD HOSP.	467	4	528	1184	81.1%
ABBEVILLE CO. MEM.	186	8	209	404	13.8%
KERSHAW CO.	416	10	657	1589	43.5%
SAINT EUGENE MEDICAL CTR	258	11	362	739	18.4%
UPSTATE CAROLINA MED CTR	367	15	521	1253	22.9%
NEWBERRY CO. MEM.	317	12	457	866	19.8%
CHESTERFIELD GENERAL	222	6			0.0%
CHESTER CO.	146	5	226	897	49.2%
MARLBORO PARK	183				
WALLACE THOMSON	124				
ALLENDALE CO.	113				
PROVIDENCE HOSP NE	287	6	456	1051	48.0%
BAMBERG CO. MEM.	112				
W.J. BARGE FAMILY HOSP	65				

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RECORD 003813

Neonatal Services:

Neonatal services are highly specialized and 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 regionalized basis, fostering the location of these specialized units in medical centers, which have the necessary staff, equipment, and consultative services and facilities. Referral networks should be established to facilitate the transfer infants requiring this level of services from other facilities.

(a) Neonatal services should be planned on a regional basis with linkages with obstetrical services.

(b) Only Level III and RPCs neonatal units contain both intensive and intermediate care bassinets.

According to American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, the following ratios are suggested for predicting the number and type of neonatal bassinets:

1 per 1,000 of the projected # births in year Z =
projected neonatal intensive care bassinets.

3-4 per 1,000 of the projected # births in year Z =
projected neonatal intermediate care bassinets.

The above ratios were based on 80 low-birth weight (LBW) {2500 grams} births per 1,000 births. As indicated below, in 2000 South Carolina had 96.7 LBW births per 1,000 births, with a white rate of 72.2 and a nonwhite rate of 138.1 per 1,000. Because South Carolina has a significant higher number of LBW infants per 1,000 births, an alternative method was selected for determining the need for intensive care bassinets in RPCs.

2000	TOTAL	WHITE	NONWHITE
All Births	55,964	35,146	20,803
<2,500 Grams	5,412	2,539	2,872
Rate/1,000	96.7	72.2	138.1

Based on the above information and adjusting for the incidence of LBW births, South Carolina would need the following ratio of intensive care bassinets:

$$\frac{96.7}{80} = 1.21 \text{ bassinets}$$

1.21 per 1,000 projected births in year Z =
projected neonatal intensive care bassinets

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RECORD 003814

The intermediate care bassinets are derived by multiplying the intensive care factor by 4.

4.84 per 1,000 projected births in year Z =
projected neonatal intermediate care bassinets

When the race variance and incidence of LBW births are factored in the intensive care ratios are:
White = $\frac{72.2}{80} = 0.90$ Nonwhite = $\frac{138.1}{80} = 1.73$

The intermediate care ratios are:
White = 0.90 x 4.84 = 4.36
Non-white = 1.73 x 4.84 = 8.37

The actual births in South Carolina have been:

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
57,509	56,094	53,765	51,895	50,913	51,105	52,205	53,833	54,706	55,964

The projected births have been:

1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
51,460	51,280	51,860	52,440	52,800	53,330	53,440	53,490	53,500	53,560

The following projected need for neonatal intensive care bassinets is based on the actual number of 2000 births by race and the need projected at 65% occupancy rate using the incidence of low-birth weight babies by Perinatal Center. The planning factor of 65% occupancy will allow for a potential increase in births and the small number of bassinets. There is no need for additional Level III hospitals or RPCs, and any facility not meeting the licensing criteria should not be categorized as such.

Perinatal Region With Facility	Bassinets Needed at 65% Occupancy	Existing Bassinets
Greenville Memorial	15	12
Spartanburg Regional	9	10
Self Memorial	5	7
Palmetto Richland & Baptist	33	35
McLeod Regional	14	12
MUSC Medical Center	21	16

Note: S.C. presently has 1.5 neonatal intensive care bassinets and 5.1 neonatal intermediate care bassinets per 1,000 births.

A neonatal unit should have an average annual occupancy rate of 65%. Facilities providing neonatal services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

PMC.2013.SHP.0302

PET-EX006.0038

RECORD 003815

Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Anderson, Greenville, Oconee, Pickens		
Palmetto Baptist Med Ctr Easley	0	2
Greenville Memorial Med Ctr	12	34
Anderson Area Medical Ctr	0	7
St. Francis Women's & Fam Hosp	0	10
SUBTOTAL	12	53
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Med Ctr	10	15
Mary Black Memorial Hospital	0	8
SUBTOTAL	10	23
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda		
Self Memorial Hospital	7	11
SUBTOTAL	7	11
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Lee Kershaw, Lancaster, Orangeburg, York, Lexington, Newberry, Richland, Sumter		
Palmetto Richland Memorial	27	38
Palmetto Baptist Columbia	8	16
Lexington Medical Ctr.	0	20
Piedmont Medical Ctr.	0	12 *
Springs Memorial Hospital	0	4
Aiken Regional Med. Ctr.	0	8
Reg Med Ctr Orangeburg-Calhoun	0	3
Tuomey Regional Med Ctr	0	8
SUBTOTAL	35	109
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Reg. Med. Ctr.	0	4
Marion County Medical Ctr	0	2
McLeod Regional Medical Ctr	12	28
Conway Hospital	0	6
Grand Strand Regional	0	3
Women's Ctr. of Carolinas	0	7
SUBTOTAL	12	50

* CON issued for Level IIE 9/18/2002; licensed 1/28/2003.

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RECORD 003816

Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	3
Georgetown County Memorial	0	5
MUSC Medical Center	16	46
East Cooper Reg Med Ctr	0	6
Bon Secours-St. Francis Xavier	0	4
Trident Medical Center	0	5
Roper Hospital	0	5
SUBTOTAL	16	74
TOTAL	92	320

NOTE: The occupancy rate includes both intensive and intermediate care patient days. Some of the RPCs have a higher utilization in the intensive care bassinets than reflected by the total occupancy. Some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero.

The existing bassinets in the preceding table and the table below are based on the number stated on the hospital license or approved under the Certificate of Need program.

The following estimates of need for intermediate neonatal bassinets are derived from the preceding methodology:

Perinatal Region	INTERMEDIATE BASSINETS Existing	Need	To Be Added
Greenville	53	55	2
Spartanburg	23	34	11
Greenwood	11	23	12
Richland	109	142	33
Florence	50	63	13
Charleston	74	88	14
TOTAL	320	405	85

Based on the above information, it appears that the number of intermediate care bassinets should be increased in every perinatal region of the state. The number of intermediate care bassinets should be increased in Level II and Level IIE facilities so babies could 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. In order 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. It appears that if more back transfers to the Level II and/or Level IIE facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

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PET-EX006.0040

RECORD 003817

It should be noted that some RPC and Level III 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. The Medical University may require additional bassinets since babies with congenital heart disease are referred there. The Medical University will document the need for any additional bassinets. The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

Relative Importance of Project Review Criteria

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

a. Need;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. In addition, most of the hospitals offering this service provide specialized transportation vehicles. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is no justification for additional Level III hospitals or Regional Perinatal Centers; however; there may be a need for additional intensive care neonatal bassinets in the existing Regional Perinatal Centers providing the need is indicated in this Plan. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service. The need for bassinets in Level IIE hospitals has not been determined, but will be justified by the individual hospital seeking this level of service.

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The following chart indicates the utilization of neonatal special care units by facility. Some facilities are not using any of the intermediate care bassinets. This information is from the Joint Annual Reports of Hospitals-2001. This utilization information supports the projected need.

NEONATAL UTILIZATION FROM 2001 JARS

HOSPITAL	ICU Bassinets	ICU P.D.'s	ICU ADC	Intermediate Bassinets	Intermediate P.D.'s	Intermed ADC	Total Bassinets	Total P.D.'s	Total ADC	Total Occupancy
Anderson Area Med Ctr				7	1115	3.1	7	1115	3.1	43.6%
Greenville Memorial	12	3515	9.6	29	8856	24.3	41	12371	33.9	82.7%
St. Francis Women's				10	962	2.6	10	962	2.6	26.4%
Palmetto Baptist-Easley				2	0	0	2	0	0	0.0%
REGION SUBTOTAL	12	3515	9.6	48	10933	30.0	60	14448	39.6	66.0%
Spartanburg Regional	10	2203	6.0	15	4442	12.2	25	6645	18.2	72.8%
Mary Black Memorial				8	1216	3.3	8	1216	3.3	41.6%
REGION SUBTOTAL	10	2203	6.0	23	5658	15.5	33	7861	21.5	65.3%
Self Memorial	7	614	1.7	11	2578	7.1	18	3192	8.7	48.6%
REGION SUBTOTAL	7	614	1.7	11	2578	7.1	18	3192	8.7	48.6%
Palmetto Richland Mem	21	7374	20.2	38	9786	26.8	59	17160	47.0	79.7%
Lexington Medical Center				20	2665	7.3	20	2665	7.3	36.5%
Piedmont Medical Center				8	1359	3.7	8	1359	3.7	46.5%
Springs Memorial Hosp				4	0	0	4	0	0	0.0%
Palmetto Baptist Med Ctr	4			16		*	20	5496	15.1	75.3%
Tuomey Regional				8	0	0.0	8	0	0.0	0.0%
Reg Med Ctr Orangeburg				3	338	0.9	3	338	0.9	30.9%
Aiken Regional Med Ctr				8	745	2.0	8	745	2.0	25.5%
REGION SUBTOTAL	25	7374	20.2	105	14893	40.8	130	22267	61.0	46.9%
Women's Ctr of Carolinas				7	965	2.6	7	965	2.6	37.8%
McLeod Regional	12			28		*	40	9859	27.0	67.5%
Carolina Pines				4	105	0.3	4	105	0.3	
St. Eugene Community				2	56	0.2	2	56	0.2	7.7%
Marion Co Medical Ctr				2	0	0	2	0	0	0.0%
Grand Strand Regional				3	6	0.0	3	6	0.0	0.5%
Conway Hospital				6	426	1.2	6	426	1.2	19.5%
REGION SUBTOTAL	12	0	0.0	52	1558	3.1	64	1558	4.3	6.7%
Georgetown Co Memorial				5	275	0.8	5	275	0.8	15.1%
MUSC Medical Center	16	4800	13.2	46	11321	31.0	62	16121	44.2	71.2%
Roper Hospital				5	735	2.0	5	735	2.0	40.3%
East Cooper Reg Med Ctr				6	0	0.0	6	0	0.0	0.0%
Trident Reg Med Center				5	525	1.4	5	525	1.4	28.8%
Bon Secours-St. Francis				4	78	0.2	4	78	0.2	5.3%
Beaufort Memorial Hosp				3	88	0.2	3	88	0.2	8.0%
SUBTOTAL	16	4800	13.2	74	13022	35.4	90	17822	48.8	54.3%
GRAND TOTAL	82	18506	50.7	313	48642	131.9	395	67148	184.0	46.6%

* Hospital did not separate data by intensive and intermediate care

Palmetto Richland added 6 ICU bassinets and Palmetto Baptist added 4 ICU bassinets in 2002 which are not reflected above.

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PET-EX006.0042

RECORD 003819

(C) Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants.

It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care, but rather, beds for children should be consolidated and distributed in such a manner as to ensure accessibility throughout an area. The need for pediatric beds is calculated under general hospital beds.

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for this service:

a. Need;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service.

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PET-EX006.0043

RECORD 003820

(D) Cardiovascular, Cerebrovascular and Associated Heart Disease

OVERVIEW

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. The heart requires oxygen and nutrients supplied through the coronary arteries in order to function. If the blood supply becomes inadequate, it can result in infarction, or death of the heart muscle {myocardium}.

The usual cause of a heart attack is arteriosclerosis, the accumulation of fat-filled cells {plaque} on the inner walls of blood vessels. Plaque narrows the blood flow through the coronary arteries and reduces blood flow to the heart muscle. Should a plaque crack or rupture, a blood clot {thrombus} forms on top of the plaque in order to repair the damage. However, if the blood clot is big enough to block all blood flow through the artery, the myocardium will not receive the oxygen needed and the muscle cells die. If blood flow is not quickly restored to the dying heart muscle, the victim will die. The amount of heart muscle that is damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive. Approximately 1/3 of all heart attacks are fatal; survivors may develop congestive heart failure or other problems.

Ambulances and Emergency Rooms are better equipped to treat these victims. Doctors are now able to limit heart damage through medications such as aspirin, nitroglycerin, beta-adrenergic blocking agents (beta blockers), and heparin (blood thinner). Drugs such as t-PA and streptokinase, which can dissolve blood clots and stop heart attacks, are often successful if administered within 6 hours of the onset of heart attack symptoms, although they do have a risk of bleeding complications. In addition, restoring blood flow to the dying heart muscle (reperfusion) by breaking up the blood clot through angioplasty or by grafting blood vessels from other body parts to construct a detour around the blockage have greatly improved survival rates.

Electron Beam Computer Tomography (EBCT) is a promising technology for predicting the likelihood of a heart attack. It is a non-invasive scanner that produces cross-sectional pictures depicting the presence amount of calcium in the coronary arteries. Calcium is an indicator of atherosclerosis; plaque rupture is the major mechanism for sudden coronary death. EBCT may be used for examining emergency room patients reporting chest pain. If the scan shows no calcification, patients are at low risk of having a heart attack. It may also be used for early detection of coronary artery disease of asymptomatic persons. The scanners cost approximately $1.8 million. The test costs $425-475, but most insurance companies do not yet cover it.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. Cardiac catheterization is the standard method for detecting and determining the severity of coronary artery disease. A thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of radioactive dye allow blockages or area of weakness to appear on x-rays. In addition, other diagnostic and therapeutic procedures such as coronary angioplasty, myocardial biopsy, electrophysiology studies, thrombolytic

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PET-EX006.0044

RECORD 003821

therapy, and insertion of pacemakers may be performed. Diagnostic catheterizations take approximately 1-1/2 hours to perform while therapeutic catheterizations average 3 hours.

Percutaneous Transluminal Coronary Angioplasty (PTCA) is the most common therapeutic procedure. A catheter tipped with a balloon is inserted into a blood vessel, guided to the site of the constriction in the vessel, then inflated to flatten plaque against the artery wall and widen the narrowed artery. Although the success rate for single-lesion dilation is 90-95%, the mortality rate is about 1% and severe complications requiring open heart surgery occur in 1-4%. In addition, nearly 20% of patients initially successfully treated experience re-narrowing within 3-6 months, requiring open heart surgery. Because of the risk of arterial damage and resulting need for immediate open heart surgery, PTCA is contraindicated for institutions without a cardiac surgery program.

Another common therapeutic intervention is the coronary stent, often used in conjunction with a PTCA. An expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Stenting is successful in 95-98% of patients, with emergency bypass surgery required for less than 1%. The re-stenosis rate for coronary stenting may be lower, although it occurs in approximately 16% of patients. In addition, there is a risk of blood clots, which form in 1-2% of patients, which can cause a heart attack. After coronary stenting, patients must use a combination of blood-thinning medicines.

The FDA is currently reviewing a drug-eluting stent, which is coated with an anti-rejection drug. Clinical trials have indicated that this stent reduces restenosis by 75% compared with conventional stents. The Centers for Medicare and Medicaid Services (CMS) began reimbursing hospitals for the device on April 1, 2003. It is anticipated that this new technology will capture the majority of the stent market within 2 years of introduction. It has also been postulated that the development of drug-eluting stents will reduce the number of coronary bypass surgeries performed.

Open heart surgery refers to an operation performed on the heart or intrathoracic great vessels which requires the temporary use of a heart-lung bypass machine to perform the normal functions of the heart and lungs during surgery. While it can be used to correct congenital heart defects and defects in the heart valves, it is most commonly used to treat ischemic heart disease. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases. The saphenous vein from the leg or the internal mammary artery from the chest is extracted from the patient and grafted to bypass a constricted section of 1 or more of the coronary arteries. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. While mortality rates have declined significantly since its introduction, CABG still carries significant risks. Standard CABG surgery requires sawing through the breastbone and prying open the ribcage, resulting in a 1-week hospital stay and up to 2 months recuperation.

A new generation of open heart surgery techniques have been developed and are now in use. The Off-Bypass CABG with a smaller incision is performed on a beating heart and is designed to avoid a coronary artery bypass. Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) surgery features a 3-4 inch incision and a stabilizer foot, allowing single- or double-artery bypass to be performed while the heart is still beating. The Port-Access method is video-assisted and relies on small incision ports to perform repairs on a stopped heart, while the heart-lung machine is attached

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small incision ports to perform repairs on a stopped heart, while the heart-lung machine is attached through the groin. While these methods offer pluses such as smaller incisions, less bleeding and faster recovery, their long-term effectiveness is not yet known.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs are a less efficient use of an expensive resource and often reflect unnecessary duplication of services in an area. This may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year {diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0}. For pediatric catheterization laboratories, a minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to increase in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year; at least 75 of which should be open heart surgery.

STATUS OF SOUTH CAROLINA PROVIDERS

1. CARDIAC CATHETERIZATIONS

The Certificate of Need standards for cardiac catheterization laboratories require a minimum of 600 cardiac equivalents annually within 3 years of initiation of service. There are 29 hospitals approved to provide cardiac catheterization services in fixed laboratories in South Carolina, although 7 programs had been in operation for less than 3 years in 2001. Of the other 22 programs, 20 exceeded the minimum of 600 equivalents per lab. Bon Secours St. Francis Xavier fell below the minimum. Self Memorial began operating a second cath lab in 2001, which affected its calculation. Colleton Medical Center received a CON on 4/15/03 to establish a mobile cardiac catheterization service 1 day per week.

There are currently 16 open heart surgery programs approved for the general public in South Carolina, as well as the Veterans Administration (VA) Hospital in Charleston. These are the only facilities approved to perform therapeutic catheterizations. They should be performing a minimum of 300 therapeutic caths annually within 3 years of initiation of service. Of the 14 programs operational in 2001, 12 performed at least the minimum number of therapeutic caths. Anderson Area Medical Center was in its first year of operation and Carolinas Health System was in its second year of operation.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The recommended standard requires a minimum of 600 cardiac equivalents per year {a pediatric catheterization is weighted as 2.0 equivalents}. MUSC has consistently exceeded this requirement.

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There is a lack of available data to measure the quality of care provided by the facilities offering cardiac catheterization services in South Carolina. Comparing the utilization of these facilities with national and state standards can make an approximation of quality. In general, the providers of cardiac catheterization are in compliance with these standards. In 2001, 20 of the 22 facilities that have been offering cardiac caths for more than 3 years provided more than the minimum standard of 600 diagnostic equivalents per lab. Every established facility providing therapeutic catheterizations exceeded the minimum requirement of 300 procedures annually by the third year of operation.

2. OPEN HEART SURGERY

The number of open heart surgeries performed in South Carolina has doubled from 3,221 in 1989 to 6,372 in 2001. Prior to 1999, there were 11 facilities providing open heart surgery in South Carolina. St. Francis Hospital began offering open heart surgery in 1999, Carolinas Regional in 2000, and Anderson Area in 2001. In addition, Self Memorial and Hilton Head Hospital received CON approval but had not yet begun operation. Because these 5 facilities had not completed 3 full years of operation, it is not possible to evaluate their performance compared to the Certificate of Need and literature standards. Therefore, this analysis will focus on the 11 programs fully operational in 2001.

In spite of the increased number of open heart surgeries performed, unused capacity remains in all programs in the state. The established programs had a total of 27 open heart surgery suites in operation in 2001. With a capacity of 500 surgeries per suite, the statewide capacity was 13,500 surgeries. A total of 5,932 open heart surgeries were actually performed in these suites, giving an average utilization rate of 43.9%. The state average was 219.7 surgeries per suite.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within 3 years of initiation of service. It should be emphasized that this minimum volume for clinical proficiency should not be interpreted as an optimal level of operation. An annual caseload of 200 cases amounts to less than 5 procedures per week and clearly does not fully utilize the resources required to staff a cardiac surgery program.

Studies indicate that hospitals that perform a minimum of 350 cases annually tend to have better outcomes than those that perform fewer cases. In 2001, 8 of the 11 established programs performed more than 350 total surgeries; Greenville Memorial performed over 1,000. Trident Regional performed 310, Piedmont Regional performed 257, and Aiken performed 125 surgeries in 2001.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2001, 249 pediatric open heart surgeries were performed there.

The Certificate of Need standards for Cardiac Catheterization and Open Heart Surgery follow.

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PET-EX006.0047

RECORD 003824

Certificate of Need Standards for Cardiac Catheterization

DEFINITIONS

"Capacity" means the number of cardiac catheterizations that can be accommodated in a cardiac catheterization laboratory in one year.

"Cardiac Catheterization" is an invasive medical procedure performed within a cardiac catheterization laboratory and used as a diagnostic or therapeutic tool for heart and circulatory conditions. A thin, flexible catheter is inserted into a blood vessel; subsequently, the free end of the catheter is manipulated by the physician to travel along the course of the blood vessel into the chambers or vessels of the heart. During a cardiac catheterization, blood pressure, oxygen content and flow measurements, injection of x-ray dyes, coronary angioplasty, myocardial biopsy, electrophysiology procedures, thrombolytic therapy, insertion of pacemakers, and other diagnostic and therapeutic techniques may be performed.

"Cardiac Catheterization Laboratory" refers to a room or suite of rooms in a hospital, a mobile unit on the campus of a hospital, or a freestanding cardiac catheterization facility which has the equipment, staff and support services to function as an integrated unit for the purposes of performing cardiac catheterization procedures for a single patient at a given time and which is used to perform cardiac catheterization procedures.

"Cardiac Catheterization Procedure" means an angiographic or physiologic study performed within a cardiac catheterization laboratory. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed.

"Coronary stents" are metallic wire tubes that are implanted at the site of a narrowing in a coronary artery to keep the vessel open. They consist of an expandable metal coil or framework that buttresses the wall of the coronary artery.

"Diagnostic Catheterization" refers to a cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization
37.22 Left Heart Cardiac Catheterization
37.23 Combined Right and Left Heart Cardiac Catheterization

"Diagnostic Catheterization Laboratory" means a dedicated room or suite of rooms in which only diagnostic catheterizations are performed.

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"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. Diagnostic catheterizations are weighted as 1.0 equivalents, while therapeutic and pediatric catheterizations are weighted as 2.0 equivalents.

"Percutaneous Transluminal Coronary Angioplasty (PTCA)" refers to a therapeutic procedure in which a catheter tipped with a balloon is inserted into a blood vessel, guided to the site of the constriction in the vessel, then inflated to flatten plaque against the artery wall and widen the narrowed artery.

"Therapeutic catheterization" refers to a cardiac catheterization during which, in addition to any or all of the procedures listed above under Diagnostic Catheterizations, any or all of the following interventional procedures are performed: Percutaneous Transluminal Coronary Angioplasty (PTCA); Thrombolytic Agent Infusion; Directional Coronary Atherectomy (DCA); Coronary Stent Implants and Cardiac Valvuloplasty. The following ICD-9-CM Codes refer to therapeutic catheterizations:

35.96 Percutaneous Valvuloplasty
36.01 Atherectomy, Coronary, PTCA, Single Vessel, Without Mention of Thrombolytic Agent
36.02 Atherectomy, Coronary, PTCA, Single Vessel, With Thrombolytic Agent
36.05 Atherectomy, Coronary, PTCA, Multiple Vessel, With or Without Thrombolytic Agent
36.06 Insertion of Coronary Artery Stent(s)
36.07 Insertion of Drug Eluding Coronary Artery Stent(s)

"Thrombolytic agent infusion" refers to the administration of a drug, such as Streptokinase or Tissue Plasminogen Activator (TPA), to break up a blood clot that obstructs a blood vessel of the heart.

STANDARDS

(1) The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Diagnostic catheterizations (ICD-9-CM Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Codes 35.96, 36.01, 36.02, 36.05, 36.06, and 36.07) and pediatric catheterizations shall be weighted as 2.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

(2) The service area for a diagnostic catheterization laboratory is defined as all facilities within 45 minutes one way automobile travel time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes one way automobile travel time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

(3) New diagnostic cardiac catheterization services, including mobile, shall be approved only if all existing labs in the service area have performed at a combined use rate of 80% (960 equivalents per laboratory) for the most recent year;

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RECORD 003826

(4) An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

(5) An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 120 diagnostic equivalents annually for each day of the week that the mobile lab would be located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of 240 equivalents at the applicant's facility by the end of the third year of operation). In addition:

A. the applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 600 diagnostic equivalents per year;

B. the applicant must include vendor documentation of the complication rate of the mobile units operated by the vendor; and

C. if an application for a mobile lab is approved and the applicant subsequently desires to change vendors, the Department must approve such change in order to insure that appropriate minimum utilization can be documented.

(6) Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 600 procedures per year on the additional equipment within three years of its implementation.

(7) Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PTCA and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is considered to be an absolute contraindication for PTCA, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart, or abnormalities in the heart structure, shall not be allowed to perform PTCA and other therapeutic procedures.

(8) New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. all existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations and performed at a combined use rate of 80 percent in the most recent year (i.e. 960 equivalents per laboratory); and

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PET-EX006.0050

RECORD 003827

B. an applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

(9) Expansion of an existing comprehensive cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. This figure of 600 equivalents may be comprised by a combination of diagnostic and therapeutic procedures.

(10) New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

A. all existing facilities have performed at a combined use rate of 80% of capacity for the most recent year; and

B. an applicant must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services.

(11) Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation.

(12) Documentation of need for the proposed service:

A. the applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

B. the applicant shall project the utilization of the service and the effect of its projected utilization on other cardiac catheterization services within its service area, to include:

1. the number of patients of the applicant hospital who were referred to other cardiac catheterization services in the preceding 3 years and the number of those patients who could have been served by the proposed service;

2. the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

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3. existing and projected patient origin information and referral patterns for each cardiac catheterization service serving patients from the area proposed to be served shall be provided.

(13) Both fixed and mobile diagnostic cardiac catheterization laboratories must provide a written agreement with at least one hospital providing open heart surgery, which states specified arrangements for referral and transfer of patients, to include:

A. criteria for referral of patients on both a routine basis and an emergency back-up basis;

B. regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

C. acceptability of diagnostic results from the cardiac catheterization service to the receiving surgical service to the greatest extent possible to prevent duplication of services; and

D. development of linkages with the receiving institution's peer review mechanism.

(14) The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk. For diagnostic catheterization laboratories, this description of patient selection criteria shall include referral arrangements for high-risk patients. For comprehensive laboratories, these high-risk procedures should only be performed with open heart surgery back-up. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

(15) Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

SCOPE OF SERVICES

The following services should be available in both adult and pediatric catheterization laboratories:

(1) Each cardiac catheterization lab should be competent to provide a range of angiographic (angiocardiography, coronary arteriography, pulmonary arteriography), hemodynamic, and physiologic (cardiac output measurement, intracardiac pressure, etc.) studies. These facilities

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should be available in one laboratory so that the patient need not be moved during a procedure.

(2) The lab should have the capability of immediate endocardiac catheter pacemaking in cardiac arrest, a crash cart, and defibrillator.

(3) A full range of non-invasive cardiac/circulatory diagnostic support services, such as the following, should be available within the hospital:

a. Nuclear Cardiology
b. Echocardiography
c. Pulmonary Function Testing
d. Exercise Testing
e. Electrocardiography
f. Cardiac Chest X-ray and Cardiac Fluoroscopy
g. Clinical Pathology and Blood Chemistry Analysis
h. Phonocardiography
i. Coronary Care Units (CCUs)
j. Medical Telemetry/Progressive Care

(4) Each applicant shall document plans for providing cardiac rehabilitation services to its patients, or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Cardiac catheterization studies for elective cases should be available at least 40 hours a week. All catheterization laboratories should have the capacity for rapid mobilization of the study team for emergency procedures 24 hours a day, 7 days a week.

All facilities offering cardiac catheterization services should meet full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or if the facility is not JCAHO accredited, then they must meet certification and/or licensure standards.

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:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;

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h. Staff Resources; and
i. Adverse Effects on Other Facilities.

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

(2) Significant cardiac catheterization capacity exists in most areas of the State; and

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures are recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

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

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CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY99 ADULTS: DIAG	FY99 ADULTS: THERP	FY99 PEDS TOTAL	FY00 ADULTS: DIAG	FY00 ADULTS: THERP	FY00 PEDS TOTAL	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 PEDS TOTAL
I										
ANDERSON AREA MED CTR #16	3	2825		2825	2406		2406	2692	129	2821
GREENVILLE MEM MED CTR #6	7	4388	2140	6528	4489	2039	6528	4580	2225	6805
MARY BLACK MEM #8	1	64		64	606		606	305		305
OCONEE MEM HOSP #5	1	644		644	689		689	786		786
PALMETTO BAPTIST MED CTR-EASLEY #13	1			0	256		256	418		418
SPARTANBURG REG MED CTR #22	4	2994	711	3705	3095	857	3952	3030	678	3708
ST FRANCIS COMM #9	2	899	31	930	1312	326	1638	1167	438	1605
TOTAL AREA I		11614	2882	14496	12753	3222	15975			16448
II										
PALMETTO HEALTH BAPTIST	1	651		651	830		830	658		658
SPRINGS MEM #20	1	393		393	406		406	565		565
LEXINGTON MED CTR #19	1									
PROVIDENCE HOSPITAL #23	6	3449	1642	5091	3730	1884	5614	3846	2195	6041
PIEDMONT MEDICAL CTR	2	2297	825	3122	2216	633	2849	2581	639	3220
PALMETTO HEALTH RICHLAND #17	4	1353	653	2006	1580	616	2195	1783	674	2457
SELF MEM HOSP #15	2	500		500	512		512	600		600
SOUTH CAROLINA HEART CENTER #1	2			0			0			0
TOTAL AREA II		8643	3120	11763	9274	3132	12406			13541
III										
CAROLINA PINES REG MED CTR #12	1	20		20	166		166	177		177
CAROLINAS HOSP SYS #2	2	1122		1122	1136		1136	1305		1305
CONWAY HOSP #14	1	419		419	481		481	584		584
GEORGETOWN MEM HOSP #4	1	466		466	477		477	610		610
GRAND STRAND REG MED CTR #7	2	1253	576	1829	1060	670	1730	1113	932	2045
MCLEOD REG MED CTR #10	4	3292	1108	4400	3089	727	3816	3304	753	4057
TUOMEY	1	875		875	985		985	727		727
TOTAL AREA III		7449	1684	9133	7394	1397	8791			9505

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	ADULT # CATH LABS	FY02 ADULTS: DIAG	FY02 ADULTS: THERP	FY02 ADULTS: TOTAL	FY02 PEDS	FY00 ADULTS: DIAG	FY00 ADULTS: THERP	FY00 ADULTS: TOTAL	FY00 PEDS	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 ADULTS: TOTAL	FY01 PEDS
IV													
BEAUFORT MEMORIAL HOSP #21	1												
HILTON HEAD REG MED CTR #3	2	913	(155)	813		874	(193)	874		1044	128	1172	
MEDICAL UNIV HOSP #18	5	2173	560	2733	985	1831	691	2522	984	1551	583	2134	970
ROPER HOSP #11	3	2224	759	2983		2760	793	3553		2625	644	3269	
TRIDENT MED CTR	2	1326	437	1763		1532	487	2019		1691	569	2260	
BON SECOURS ST. FRANCIS XAVIER	1	121		121		304		304		190		190	
COLLETON MEDICAL CTR #24	MOBILE												
RMC ORANGEBURG-CALHOUN	1	763		763		722		722		813		813	
AIKEN REG MED CTR	1	1097	415	1512		1097	399	1496		860	506	1366	
TOTAL AREA IV		8617	2171	10788		9120	2370	11490		8774	2430	11204	
TOTAL		38323	9857	48180		38541	10121	48662				50898	

#1 DOCTORS OFFICE NOT A LICENSED AMBULATORY SURGERY CTR
#2 CON FOR 2ND CATH, 7/23/98
#3 CON 4/20/95 DATA FOR 96 CHANGED ON 97 JAR CON FOR 2ND CATH SC-01-66 11/13/01 AND CON ISSUED FOR THERAPEUTIC CATH PROGRAM 7/15/02 SC-02-41
#4 CON FOR FIX TO REPLACE MOBILE 1/26/98
#5 CON FOR COMBINATION LAB 1/23/96
#6 CON FOR 6TH CATH, 3/6/97. CON ISSUED FOR 7TH CATH, 11/30/99. CON TO REPLACE AN EXISTING CATH & MAINTAINING 7 CATHS WITH 5 AT GMH AND 2 AT MEM MEDICAL OFFICE,7/3//00.
#7 CON ISSUED FOR 2ND CATH, 8/26/97.
#8 CON ISSUED REPLACE MOBILE W/ FIXED,3/10/98
#9 CON ISSUED FOR 2ND CATH,8/10/97.
#10 CON FOR 4ND CATH, 7/23/98.
#11 CON FOR 3TH CATH, 6/13/97.
#12 EXEMPT 4/21/97 FOR MOBILE. CON FOR FIXED TO REPLACE MOBILE 6/20/01. UTILIZE FIXED 4/12/02.
#13 CON ISSUED FOR FIXED CATH, 8/15/99.
#14 CON TO REPLACE MOBILE W/ FIXED,6/21/99
#15 CON FOR 2ND CATH, 9/2/99.
#16 CON FOR 3RD CATH W/ THERA, 11/2/99.
#17 CON FOR 4TH CATH, 11/08/99.
#18 CON ISSUED TO REPLACE ADULT CATH WITH AN ADULT/PEDIATRIC CATH, 12/28/99 ,SC-99-50. HAS 3 ADULTS & 1 PED CATH. CON ISSUED FOR 2 ADDITIONAL ADULT CATHS FOR 5 ADULT & 1 PED SC-01-13 3/12/01
#19 CON ISSUED FOR FIXED CATH, 1/30/01 SC-01-05.
#20 CON TO REPLACE MOBILE W/ FIXED CATH, 07/12/01
#21 CON FOR DIAGNOSTIC CATH, 6/6/02.
#22 CON FOR 4TH CATH, 11/13/01.
#23 CON FOR 6TH CATH, 03/19/02 SC-02-19.
#24 CON FOR MOBILE 1 DAY P/WK , 4/15/03 SC-03-15

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Certificate of Need Standards for Open Heart Surgery

DEFINITIONS

"Capacity" means the number of open heart surgery procedures that can be accommodated in an open heart surgery unit in one year.

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes:

35.10 Open heart valvuloplasty, without replacement, unspecified valve
35.11 Open heart valvuloplasty of aortic valve without replacement
35.12 Open heart valvuloplasty of mitral valve without replacement
35.13 Open heart valvuloplasty of pulmonary valve without replacement
35.14 Open heart valvuloplasty of tricuspid valve without replacement
35.20 Replacement of unspecified heart valve
35.21 Replacement of aortic valve with tissue graft
35.22 Other replacement of aortic valve
35.23 Replacement of mitral valve with tissue graft
35.24 Other replacement of mitral valve
35.25 Replacement of pulmonary valve with tissue graft
35.26 Other replacement of pulmonary valve
35.27 Replacement of tricuspid valve with tissue graft
35.28 Other replacement of tricuspid valve
35.31 Operations on papillary muscle
35.32 Operations on chordae tendineae
35.33 Annuloplasty
35.34 Infundibulectomy
35.35 Operations on trabeculae carnae cordis
35.39 Operations on other structures adjacent to valves of heart
35.41 Enlargement of existing atrial septal defect
35.42 Creation of septal defect in heart
35.50 Repair of unspecified septal defect of heart with prosthesis
35.51 Repair of atrial septal defect with prosthesis, open technique
35.53 Repair of ventricular septal defect with prosthesis
35.54 Repair of endocardial defect with prosthesis
35.60 Repair of unspecified septal defect with tissue graft
35.61 Repair of atrial septal defect with tissue graft
35.62 Repair of ventricular septal defect with tissue graft
35.63 Repair of endocardial cushion defect with tissue graft
35.70 Other and unspecified repair of unspecified septal defect of heart
35.71 Other and unspecified repair of atrial septal defect
35.72 Other and unspecified repair of ventricular septal defect
35.73 Other and unspecified repair of endocardial cushion defect
35.81 Total repair of tetralogy of Fallot

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35.82 Total repair of total anomalous pulmonary venuos connection
35.83 Total repair of truncus arteriosus
35.84 Total repair of transposition of great vessels, not elsewhere classified
35.91 Interatrial transposition of venous return
35.92 Creation of conduit between right ventricle and pulmonary artery
35.93 Creation of conduit between left ventricle and aorta
35.94 Creation of conduit between atrium and pulmonary artery
35.95 Revision of corrective procedure on heart
35.98 Other operations on septa of heart
35.99 Other operations on valves of heart
36.03 Open chest coronary artery angioplasty
36.09 Other removal of coronary artery obstruction
36.10 Aortocoronary bypass for heart revascularization, not otherwise specified
36.11 Aortocoronary bypass of one coronary artery
36.12 Aortocoronary bypass of two coronary arteries
36.13 Aortocoronary bypass of three coronary arteries
36.14 Aortocoronary bypass of four or more coronary arteries
36.15 Single internal mammary-coronary artery bypass
36.16 Double internal mammary-coronary artery bypass
36.19 Other bypass anastomosis for heart revascularization
36.2 Heart revascularization by arterial implant
36.91 Repair of aneurysm of coronary vessel
36.99 Other operations on vessel of heart
37.10 Incision of heart, not otherwise specified
37.11 Cardiotomy
37.32 Excision of aneurysm of heart
37.33 Excision or destruction of other lesion or tissue of heart

An "Open Heart Surgery Unit" is an operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.

"Open Heart Surgical Procedure" means an operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.

"Open Heart Surgical Program" means the combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including:

(1) repair/replacement of heart valves
(2) repair of congenital defects
(3) cardiac revascularization
(4) repair/reconstruction of intrathoracic vessels

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(5) treatment of cardiac traumas.

In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.

STANDARDS

The standards for open heart surgery in South Carolina are as follows:

(1) The establishment or addition of an open heart surgery unit requires Certificate of Need review, as this is considered a substantial expansion of a health service.

(2) Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is considered to be an absolute contraindication for therapeutic catheterizations, due to the risk of arterial damage and subsequent need for emergency bypass surgery.

(3) The capacity of an open heart surgery program is determined to be 500 open heart procedures per year for the initial open heart surgery unit and each additional dedicated open heart surgery unit (i.e. each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

(4) There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit, within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

(5) New open heart surgery services shall be approved only if the following conditions are met:

A. Each existing unit in the service area (defined as all facilities within 60 minutes one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

1. There are no open heart surgery programs located in the same county as the applicant; and

2. The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic equivalents in the previous year of operation.

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B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery procedures annually per open heart surgery unit, within three years after initiation (the standard for pediatric open heart surgery shall be 100 procedures annually per open heart surgery unit within three years after initiation):

1. using a standard of every four (4) diagnostic cardiac catheterizations performed generating one (1) open heart surgery, the applicant must demonstrate that the facility performs sufficient diagnostic cardiac catheterizations to generate the minimum volume of open heart surgeries.

2. the applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which open heart surgery is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

3. the applicant shall provide an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services, including:

   a. the number of patients of the applicant hospital who were referred to other open heart surgery services in the preceding 3 years and the number of these patients who could have been served by the proposed service;

   b. the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

   c. the existing and projected patient origin information and referral patterns for each open heart surgery service serving patients from the area proposed to be served shall be provided.

(6) No new open heart surgery programs shall be approved if the new program will cause the annual caseload of other programs within the proposed service area to drop below 350 adult procedures or 130 pediatric procedures per open heart surgery unit.

(7) Expansion of an existing open heart surgery service shall only be approved if the service has operated at a minimum use rate of 70 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year in the new open heart surgery unit. The applicant shall document the other service providers, if any, from which these additional patients will be drawn.

(8) The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the

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American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

(9) Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

(10) The open heart surgery service will have the capability for emergency coronary artery surgery, including:

A. sufficient personnel and facilities available to conduct the coronary artery surgery on an immediate, emergency basis, 24 hours a day, 7 days a week;

B. location of the cardiac catheterization laboratory(ies) in which therapeutic catheterizations will be performed near the open heart surgery operating rooms; and

C. a predetermined protocol adopted by the cardiac catheterization service governing the provision of PTCA and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

SCOPE OF SERVICES

Within the hospital, a range of non-invasive cardiac and circulatory diagnostic services, including the following, should be available:

(1) services for hematology and coagulation disorders;
(2) electrocardiography, including exercise stress testing;
(3) diagnostic radiology;
(4) clinical pathology services which include blood chemistry and blood gas analysis;
(5) nuclear medicine services which include nuclear cardiology;
(6) echocardiography;
(7) pulmonary function testing;
(8) microbiology studies;
(9) Coronary Care Units (CCU's);
(10) medical telemetry/progressive care; and
(11) perfusion.

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Backup physician personnel in the following specialties should be available in emergency situations:

(1) Cardiology;
(2) Anesthesiology;
(3) Pathology;
(4) Thoracic Surgery; and
(5) Radiology.

Each applicant shall document plans for providing cardiac rehabilitation services to its patients, or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Adult open heart surgery services should be available within 60 minutes one way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks.

All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements, and should meet the full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), if the facility is JCAHO accredited.

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:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

The Department makes the following findings:

(1) Open heart surgery services are available within sixty (60) minutes travel time for the majority of residents of South Carolina;

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(2) Based upon the standards cited above, most of the open heart surgery providers are currently utilizing less than the functional capability (i.e. 70% of maximum capacity) of their existing surgical suites;

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures is recommended per year in order to develop and maintain physician and staff competency in performing these procedures; and

(4) Increasing geographic access may create lower volumes in existing programs causing a potential reduction in quality and efficiency, exacerbate existing problems regarding the availability of nursing staff and other personnel, and not necessarily reduce waiting time since other factors (such as the referring physician's preference) would still need to be addressed.

(5) Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. As components of the Certificate of Need program, the Department is charged with guiding the establishment of health facilities and services which will best serve public needs and ensure that high quality services are provided in health facilities in this State.

Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflect an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

Therefore, the Department staff is directed to evaluate low-volume open heart surgery providers to monitor their progress and recommend to the State Health Planning Committee any changes deemed necessary by staff.

(6) The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

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

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REGION/FACILITY	# OPEN HEART UNITS	FY99 ADULTS	FY99 PEDS	FY00 ADULTS	FY00 PEDS	FY01 ADULTS	FY01 PEDS
I							
ANDERSON AREA MED CTR #7	2					94	
GREENVILLE MEM MED CTR	5	1333		1379		1147	
ST FRANCIS HOSPITAL #4	2	49		221		224	
SPARTANBURG REG MED CTR	2	516		599		626	
II							
PIEDMONT MED CTR #2	2	222		248		257	
PROVIDENCE HOSPITAL	4	1107		1057		970	
PALMETTO HEALTH RICHLAND	2	458		486		443	
SELF MEMORIAL HOSPITAL #6	2						
III							
CAROLINAS HOSPITAL SYSTEM #5	2			86		122	
MCLEOD REG MED CTR #6	3	769		608		495	
GRAND STRAND REG MED CTR #1	2	316		278		358	
IV							
AIKEN REG MED CTR #3	1	115		113		125	
HILTON HEAD REG MED CTR #8	1						
MEDICAL UNIV HOSP	3	628	184	465	186	634	249
ROPER HOSP	2	656		650		567	
TRIDENT REG MED CTR	1	172		283		310	
VA(CHARLESTON)	1						
		6341					

#1 CON ISSUED 2/7/94.
#2 CON 10/24/95.
#3 CON ISSUED 12/1/95
#4 CON 9/10/97
#5 CONT/23/98 BUT EFFECTIVE 11/1/98
#6 CON 9/2 /99
#7 CON ISSUED 11/2 /99
#8 CON 7/15/02

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(E) Cancer

OVERVIEW

Cancer is a group of many related diseases. All forms of cancer involve out-of-control growth and spread of abnormal cells. Normal cells of most tissues only divide to replace dying cells or to repair injuries. However, cancer cells continue to grow and divide, and can spread to other parts of the body. These cells accumulate and form tumors that invade and destroy normal tissue. Cells can break away from tumors through the blood stream or lymph system and form tumors in other parts of the body, a process known as "metastasis." Cancer is classified by the part of the body in which it began, and by its appearance under a microscope. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment.

Cancer is the second leading cause of death, both nationally and South Carolina, accounting for approximately 22% of all deaths. It is estimated that there will be 17,375 new cases of cancer diagnosed in South Carolina in 2002 and 7,730 cancer deaths. The most common types of cancer deaths are lung, colon/rectum, breast, and prostate.

Screening and self-examinations can result in the detection of cancers at earlier stages. The earlier the cancer is identified and treated, the greater the likelihood of successful treatment. The survival rate is much higher for cancers treated "in situ" (non-invasive earliest stage) that those that have metastasized to other locations. The overall relative 5-year survival rate, adjusted for normal life expectancy, is approximately 58%.

Radiation therapy is one of the most common treatments for cancer and is used in more than half of all cancer cases. It involves the use of a stream of high-energy particles or waves, such as x-rays, gamma rays, and alpha and beta particles, to destroy or damage cancer cells. The radiation causes breakdowns in one or both of the DNA strands, preventing cell division. Radiation treatments can be used alone or in combination with surgery or chemotherapy. For example, radiation may be used before surgery to shrink a tumor to make it easier to remove, or after surgery to stop the growth of any cancer cells that remain.

It is the primary treatment for many kinds of cancer in almost any part of the body. Internal radiation therapy uses a radioactive pellet that is sealed in an implant, which is placed directly into or near the tumor. Another form uses unsealed doses that are taken orally or by injection. External radiation requires a machine that directs high-energy rays at the cancer and some normal surrounding tissue.

There are 2 pieces of radiation therapy equipment reviewed under the Certificate of Need Program in South Carolina. They are:

1. LINEAR ACCELERATORS

The linear accelerator uses microwave technology to accelerate electrons and then allows these electrons to collide with a heavy metal target. As a result of these collisions, high energy x-rays are scattered from the target. The accelerator must sit in a room with lead and concrete walls to keep the rays from escaping. A portion of these x-rays is collected to form a beam that matches the size and

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shape of the patient's tumor. The patient lies on a movable couch. Radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry and moving the couch.

Linear accelerator treatments are usually performed on an outpatient basis. The total prescribed tumor-lethal dosage is divided into smaller doses called fractions, which are administered 5 days a week for 2-8 weeks, with weekend rest breaks to allow normal cells to recover. These sessions generally last about 15 minutes.

Minimal equipment requirements for a linear accelerator include:

a. At least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;

b. Access to an electron beam source or a low energy X-ray unit;

c. appropriate brachytherapy equipment and sources for intracavitary and interstitial treatment;

d. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;

e. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

f. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);

g. field-shaping capability; and

h. access to CT scanning capability.

A realistic load for a megavoltage unit is 5,600 treatments per year. This measurement is based upon an average of 22 patients treated per day, 5 days per week, 51 weeks per year, allowing time for scheduled maintenance, portal filming, field checks, etc.

2. GAMMA KNIFE

Stereotactic radiosurgery is an evolving technique of using radiant energy to treat brain tumors. The radiation damages the genetic code of the tumor, preventing it from replicating and causing it to slowly shrink. Patients routinely use only a local anesthesia with a mild sedative while undergoing the procedure. The gamma knife consists of a large 20 ton shield surrounding a circular or hemispheric array of 201 cobalt-60 beam channels, resembling a giant hair dryer.

The entire procedure takes about 3-4 hours, depending on complexity. First, a rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then

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sent for imaging, to accurately determine the position of the target. The computer system then develops a treatment plan to position the patient for treatment and the paths and doses of radiation. When the plan is ready, the patient is positioned for treatment with the head affixed to the couch, and the treatment is delivered.

The gamma knife has a high success rate for certain types of tumors and avoids the complication risks of traditional neurosurgery. However, not many tumors qualify for gamma knife radiosurgery; most are too large to be safely treated this way and require conventional surgery. The targets must be small and far enough away from vital structures to avoid damaging healthy tissue.

A gamma knife costs approximately $3.5 million with installation costs of another $0.5 million, plus a further $0.5 million every 4-5 years to replenish the cobalt-60. As a result of the high costs and limited uses of the machine, average charges exceed $20,000, excluding physician's fees. However, this must be balanced against the overall charges for conventional neurosurgery. Experts estimate that a minimum caseload of 150 cases per year is needed for the unit to be financially viable. A less expensive alternative is to modify a standard linear accelerator {at a cost of about $300,000 above the initial cost of the machine} to allow it to perform radiosurgery; similar results are reported for these two technologies.

STATUS OF SOUTH CAROLINA PROVIDERS

1. LINEAR ACCELERATORS

There are currently 24 facilities either operating or approved for a total of 45 linear accelerators in South Carolina. This analysis will focus on the 40 accelerators that were in operation during 2001. The capacity of a linear accelerator is stated as 7,000 treatments per year, and a realistic load is 5,600 treatments per year (80% of capacity). For 2001, the 40 existing accelerators averaged 5,732 treatments per unit (81.9% of overall capacity). The utilization for each provider per linear accelerator was:

Provider	# Accelerators	Treatments/ Accelerator
Cancer Ctr. Carolinas Eastside	1	9,863
Cancer Center Carolinas	1	9,007
Carolinas Hospital System	1	8,519
Myrtle Beach Radiation	2	7,519
Palmetto Baptist	2	7,371
Roper Hospital	2	7,230
Beaufort-Hilton Head	1	7,049
Anderson Area Med. Ctr.	2	6,440
Greenville Memorial Hospital	3	6,353
Trident Regional	2	6,032
Self Memorial	1	5,911
Rock Hill Radiation	2	5,841
Spartanburg Regional	3	5,549

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RMC-Orangeburg/Calhoun	1	5,522
Lexington Medical Ctr.	2	4,639
McLeod Regional	4	4,600
Tuomey Regional	2	4,218
MUSC	3	4,161
Aiken Regional	1	3,921
Palmetto Richland Memorial	4	3,579

2. GAMMA KNIFES

Palmetto Richland Memorial is the only hospital to operate a gamma knife in South Carolina. A total of 128 patients received gamma knife treatment in 2001.

The Certificate of Need standards for linear accelerators and gamma knifes follow.

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Certificate of Need Standards for Linear Accelerators

STANDARDS

(1) The planning capacity of a megavoltage therapy unit shall be 7,000 treatments per year.

(2) There are 13 service areas established for megavoltage therapy units. These service areas are defined on the chart following this section.

(3) New megavoltage therapy services shall only be approved if the following conditions are met:

A. all existing units in the service area have performed at a combined use rate of 80 percent of capacity {5,600 treatments per unit} for the year immediately preceding the filing of the applicant's CON application; and

B. an applicant must project that the proposed service will perform a minimum of 3,500 treatments annually within three years of initiation of services, without reducing the utilization of existing megavoltage therapy machines in the service area below the 80 percent threshold.

(4) Expansion of an existing megavoltage therapy service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for the past two years {5,600 treatments per unit} and can project a minimum of 3,500 treatments per year on the additional equipment within three years of its implementation.

(5) Documentation of need for the proposed service:

A. the applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which megavoltage therapy is appropriate within the proposed service area, to include the number of potential patients for these procedures; and

B. the applicant shall project the utilization of the service and document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

(6) The replacement of an existing Cobalt 60 unit with a linear accelerator does not constitute additional megavoltage therapy equipment; however, the purchase of the linear accelerator does require Certificate of Need review. Any replaced equipment should be totally decommissioned within 30 days of the start of the replacement equipment.

(7) The applicant must affirm the following:

A. that all treatments provided will be under the control of a board certified or board eligible radiation oncologist;

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B. that the applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

C. that the applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

D. that the applicant will have access to a custom block design and cutting system; and

E. that the institution shall operate its own tumor registry or actively participate in a central tumor registry.

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 these services:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

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

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY1998	FY1999	FY2000	FY2001
I					
ANDERSON CO:					
ANDERSON AREA MED CTR #5					
(COBALT 60)	1	764	0		
LINEAR ACCELERATOR #13	2	11735	13120	12770	12880
GREENVILLE CO:					
(EASTSIDE CANCER TREATMENT CTR #3)					
(LINEAR ACCELERATOR)	(1)		938	1852	
CANCER CENTERS OF THE CAROLINAS #4					
EASTSIDE					
LINEAR ACCELERATOR	1		2532	9329	9863
GREENVILLE MEM MED CTR:					
LINEAR ACCELERATORS	3	20287	18212	14314	19058
CANCER CENTERS OF THE CAROLINAS					
LINEAR ACCELERATOR	1	9243	13652	9688	9007
CHEROKEE CO:					
GIBBS REGIONAL CANCER CTR	1				
SATELLITE #14					
OCONEE CO:					
CANCER CTRS OF THE CAROLINAS #10	1				
OCONEE COUNTY					
SPARTANBURG CO:					
SPARTANBURG REG MED CTR:					
LINEAR ACCELERATORS	3	13992	15618	15604	16646
II					
LEXINGTON CO:					
LEXINGTON MED CTR: #7					
LINEAR ACCELERATOR	2	7399	8446	8746	9278
RICHLAND CO:					
PALMETTO HEALTH BAPTIST :					
LINEAR ACCELERATORS	2	12280	15501	12755	14742
PALMETTO HEALTH RICHLAND :					
LINEAR ACCELERATORS	4	18662	14415	13008	16842
GAMMA KNIFE	1		97	96	128
GREENWOOD CO:					
SELF MEMORIAL: #12					

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY1998	FY1999	FY2000	FY2001
LINEAR ACCELERATOR	2	6141	5794	5520	5911
YORK CO:					
ROCK HILL RADIATION THERAPY CT: LINEAR ACCELERATOR #1	2	8741	9986	9082	11682
III					
FLORENCE CO:					
CAROLINAS HOSP SYS #2	1		2958	7111	8519
MCLEOD REGIONAL: LINEAR ACCELERATORS	4	19968	17987	18242	18398
HORRY CO:					
MYRTLE BEACH RADIATION: THERAPY CENTER LINEAR ACCELERATORS	2	12100	13397	14270	15037
SUMTER:					
TUOMEY LINEAR ACCELERATOR	2	8467	9107	10598	8435
GEORGETOWN CO:					
GEORGETOWN MEM HOSP #8	1				
IV					
CHARLESTON CO:					
MEDICAL UNIVERSITY: #10 LINEAR ACCELERATORS	3	13773	14085	15632	12484
ROPER: LINEAR ACCELERATOR	2	12597	14812	14126	14460
TRIDENT MED CTR: #6 LINEAR ACCELERATOR	2	9306	9969	10971	12063
ORANGEBURG CO:					
REG MED CTR ORANGEBURG/CALHOUN LINEAR ACCELERATOR	1	6474	5759	6022	5522
BEAUFORT CO:					
BEAUFORT/HILTON HEAD RADIATION ONCOLOGY CTR LINEAR ACCELERATOR	1	6218	6925	7502	7049

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY1998	FY1999	FY2000	FY2001
BEAUFORT MEMORIAL HOSPITAL #11	1				
AIKEN CO:					
AIKEN REG MED CTR	1	4635	4692	4729	3921

#1 CON ISSUED FOR 2ND LA 7/27/98
#2 CON ISSUED FOR LA , 4/7/97.
#3 CON ISSUED 3/6/98. CLOSED 8/00.
#4 CON ISSUED 3/6/98.
#5 CON FOR 2nd LA 6/2/97.
#6 CON FOR 2nd LA 6/1/99.
#7 CON TO REPLACE EXISTING LA 6/14/99.
AND 2ND LA , 11/12/99.
#8 CON ISSUED 3/15/01
#9 CON FOR LA , 2/28/00
#10 CON TO MOVE & REPLACE EXISTING LA
TO MT PLEASANT 7/08/03 SC-03-38 .
#11 CON SC-03-24 4/29/03
#12 CON FOR 2nd LA , 2/11/02 SC-02-14
#13 REPLACE ONE LA , 5/22/02: CON SC-03-07
TO MOVE THE 2 LAS FROM HOSP TO
OP TREAMENT CTR ON CAMPUS & REPLACE
1 LA , 2/12/03.
#14 APPROVED FOR 1LA 3/31/03. APPEALED

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LINEAR ACCELERATORS

SERVICE AREAS	2001 POPULATION	# OF LIN. ACC.	POP/ LIN. ACC.	TOTAL AREA TREATMENTS	TREATMENTS/ LIN. ACC.	PLANNING AREA CAPACITY
ANDERSON,OCONEE	234,200	3	78,067	12,880	4,293	21,000
GREENVILLE,PICKENS	495,600	5	99,120	37,928	7,586	35,000
CHEROKEE,SPARTANBURG UNION	339,400	4	84,850	16,646	4,162	28,000
CHESTER,LANCASTER,YORK	262,820	2	131,410	11,682	5,841	14,000
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	217,220	2	108,610	5,911	2,956	14,000
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	655,480	8	81,935	38,334	4,792	56,000
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	331,810	5	66,362	26,917	5,383	35,000
CLARENDON,LEE,SUMTER	159,030	2	79,515	8,435	4,218	14,000
GEORGETOWN,HORRY WILLIAMSBURG	293,980	3	97,993	15,037	5,012	21,000
BAMBERG,CALHOUN ORANGEBURG	123,930	1	123,930	5,522	5,522	7,000
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	215,480	2	107,740	7,049	3,525	14,000
BERKELEY,CHARLESTON DORCHESTER	555,880	7	79,411	39,007	5,572	49,000
AIKEN,BARNWELL	168,510	1	168,510	3,921	3,921	7,000
STATE TOTAL	4,053,340	45	90,074	229,269	5,095	315,000

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Certificate of Need Standards for Gamma Knifes

STANDARDS

(1) The capacity of a gamma knife unit is 500 procedures annually. This is based on an average of two procedures per day times 250 days a year.

(2) Because of the limited number of eligible cases and necessary referrals in order to generate sufficient utilization of this technology, the entire State of South Carolina is designated as the appropriate service area.

(3) Any proposal to offer gamma knife services shall be required to demonstrate in detail why the gamma knife should be obtained, rather than make the less costly modifications necessary to enable the same procedures to be performed using a linear accelerator.

(4) New gamma knife services shall only be approved if the following conditions are met:

A. all existing units have performed at a combined use rate of 80 percent of capacity for the most recent year; and

B. an applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of services, without reducing the utilization of existing gamma knifes below the 80 percent threshold.

(5) Expansion of a existing gamma knife service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

(6) Documentation of need for the proposed service;

A. the applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which gamma knife treatment is appropriate, to include the number of potential patients for these procedures;

B. the applicant shall project the utilization of the service, to include:

1. the number of patients of the applicant who were referred to other gamma knife providers in the preceding three years and the number of those patients who could have been served by the proposed service;

2. existing and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances; and

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3. documentation of the type and estimated number of procedures performed in the facility that the gamma knife will replace or complement.

(7) The applicant must document that protocols will be established to assure that all clinical gamma knife procedures performed are medically necessary and that alternative treatment modalities have been considered.

(8) The applicant must affirm the following:

A. that the operation of the gamma knife will be overseen by a board certified neurosurgeon trained in stereotactic and radiosurgery;

B. that all treatments provided will be under the control of a radiation oncologist with training in radiation surgery;

C. that the applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

D. that dosimetry and calibration equipment and a computer with the appropriate software for performing gamma knife surgical procedures will be available;

E. that the applicant has access to a full range of diagnostic technology, including CT, MRI and angiograpy; and

F. that the institution shall operate its own tumor registry or actively participate in a central tumor registry.

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 these services:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

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

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(F) Diagnostic Imaging

1. Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging (MRI) uses radio waves, high magnetic fields and a powerful computer to create diagnostic images useful for detecting disease states. MRI produces spatial resolution and tissue contrast without the use of ionizing radiation, such as X-rays, or iodinated compound injections.

Within a strong external magnetic field, protons align in either a low or high-energy state. Radio waves released from the body become the magnetic resonance image. Spatial information is obtained by superimposing small gradients within the external magnetic field. The result is a two-dimensional picture with great tissue contrast, clarity and potential to characterize tissue as diseased or not diseased.

Due to the high sensitivity of the images produced, and the relative safety of the procedure, MRI has supplemented CT and angiography as a diagnostic tool for many diagnoses and greatly enhances diagnosis in other cases. MRI may eliminate the need for other examinations, such as biopsies and exploratory surgery, in addition to reducing risk and discomfort to the patient.

Capital costs for a fixed MRI unit; depending upon the type of magnet, range from approximately $500,000 to $2,500,000. Special radiofrequency shielding may be required to prevent the magnet from interfering with other electrical equipment and/or to prevent radio frequency interference from outside sources. MRI is contraindicated for patients with metal surgical implants and pacemakers, or who are on life support equipment. A new generation of MRI's with a "open" design has been developed to alleviate the concerns of patients who physically do not fit into an MRI unit and those who experience a claustrophobic reaction to the confined space of a regular MRI.

The following table lists the facilities that have either received Certificate of Need approval or have been exempted from review for MRI units. Utilization data are from the Joint Annual Reports.

Certificate of Need Standards for Magnetic Resonance Imaging (MRI)

STANDARDS

(1) Each hospital should have at least one MRI unit available for diagnosis of emergency patients, inpatients and outpatients.

(2) In order to promote cost-effectiveness, the use of shared mobile MRI units should be considered.

(3) The applicant agrees in writing to provide to the Department utilization data on the operation of the MRI service.

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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:

a. Community Need Documentation;
b. Distribution (Accessibility);
c. Acceptability; and
d. Cost Containment.

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

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MRI SCANS

COUNTY	FACILITY	TYPE	FY00 CON SCANS	FY01 CON SCANS
ABBEVILLE	ABBEVILLE CO MEM HOSP	MOBILE	439	517
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	237	
AIKEN	AIKEN REG MED CTR	FIXED	3038	2421
AIKEN	CAROLINA ORTHOPAEDIC ASSOC	2 FIXED	1272	1253
AIKEN	IMAGING CTR OF AIKEN	FIXED	761	1832
AIKEN	SOUTHERN NEUROLOGICAL INST	FIXED	1453	1631
ANDERSON	ANDERSON AREA MED CTR	3 FIXED	7346	7396
ANDERSON	ANDERSON RADIOLOGY	FIXED	3500	3551
ANDERSON	(HEALTH SOUTH DIAGNOSTIC CTR OF ANDERSON)	(FIXED)		
BEAUFORT	BEAUFORT MEM HOSP	FIXED & TEMP MOBILE	4043	4197
BEAUFORT	HILTON HEAD REGIONAL MEDICAL CTR	FIXED		
BEAUFORT	BEAUFORT ORTHOPEDIC SERVICES	MOBILE		
BEAUFORT	HEALTH SOUTH DIAGNOSTIC CTR OF HILTON HEAD	FIXED	1850	3219
(BEAUFORT)	(LOWCOUNTY MEDICAL GROUP MRI)	FIXED	148	
BEAUFORT	LOWCOUNTY MEDICAL GROUP PORT ROYAL	FIXED	849	1221
BEAUFORT	MRI AT BELFAIR	FIXED		
BEAUFORT	NEUROLOGICAL INST HILTON HEAD	FIXED	319	400
BEAUFORT	BEAUFORT OPEN MRI	FIXED		
BEAUFORT	SOUTHERN MRI, LLC	2FIXED	2715	2756
CHARLESTON	ROPER HOSP	FIXED	4692	5471
CHARLESTON	ROPER DIAGNOSTIC CTR-FARMFIELD	FIXED	1283	1627
CHARLESTON	MEDICAL UNIVERSITY HOSP	3 FIXED	8321	7166
CHARLESTON	UMA AMBULATORY CARE FAC	FIXED		
CHARLESTON	TRIDENT MEDICAL CTR	FIXED	6552	8559
CHARLESTON	TRIDENT MEDICAL ARTS MRI	2 FIXED	ABOVE	
CHARLESTON	EAST COOPER REG MED CTR	MOBILE	0	0
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	FIXED	1638	1784
CHARLESTON	DISC IMAGING	2 FIXED	6834	6017
CHARLESTON	(HEALTH SOUTH DIAGNOSTIC CTR OF CHARLESTON)	(FIXED)		
CHARLESTON	FARMFIELD DIAGNOSTIC IMAGING	FIXED		
CHARLESTON	CHARLESTON PHYSICIANS IMAGING CTR	FIXED	1428	2135
CHARLESTON	SC DIAGNOSTIC IMAGING	MOBILE	3862	6037
CHARLESTON	TRICOM DIAGNOSTIC IMAGING	FIXED		
CHARLESTON	WEST ASHLEY DIAGNOSTIC IMAGING	FIXED		
CHARLESTON	PHYSICIAN OWNED DIAGNOSTIC CTR	MOBILE		
CLARENDON	CLARENDON MEM HOSP	MOBILE	680	758
CHEROKEE	UPSTATE CAROLINA MED CTR	FIXED	1033	976
CHESTER	CHESTER CO HOSP	MOBILE		384
CHESTERFIELD	CHESTERFIELD GEN HOSP	MOBILE	417	452
COLLETON	COLLETON REG HOSP	FIXED	1603	1972
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	1844	1910
DARLINGTON	WILSON MED CTR	MOBILE	176	192
DILLON	ST. EUGENE MED CTR	FIXED	553	691
DORCHESTER	SUMMERVILLE MEDICAL CENTER	FIXED	2232	2020
FLORENCE	CAROLINAS HSP SYS	FIXED	2401	2446
FLORENCE	MCLEOD REG MED CTR	2 FIXED	5192	5829
FLORENCE	(FLORENCE MED IMAGING)	(FIXED)	751	
FLORENCE	CAROLINAS HSP SYS LAKE CITY	MOBILE	308	222
FLORENCE	DEMICHELE & EVANS NEUROLOGICAL	MOBILE	1149	1313
FLORENCE	INMED DIAGNOSTIC SERVICES	FIXED	1287	2213
FLORENCE	OPEN MRI & IMAGING OF FLORENCE	FIXED	2919	3734
GEORGETOWN	GEORGETOWN MEM HOSP	FIXED	3378	3905
GEORGETOWN	WACCAMAW COMM HOSP	FIXED		
GREENVILLE	ST. FRANCIS HOSP	FIXED	2627	2354
GREENVILLE	ST. FRANCIS WOMAN'S & FAMILY HOSP	MOBILE	441	868
GREENVILLE	ALLEN BENNETT HOSP	MOBILE		
GREENVILLE	HILLCREST HOSP	MOBILE	362	537
GREENVILLE	GREENVILLE MEM HOSP	3 FIXED & MOBILE	7372	6662
GREENVILLE	AXIS MEDICAL IMAGING	MOBILE		
GREENVILLE	CAROLINA ORTHAPAEDIC CTR	FIXED		
GREENVILLE	CAROLINA HEALTH IMAGING	FIXED		

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MRI SCANS

COUNTY	FACILITY	TYPE	FY00 CON SCANS	FY01 CON SCANS
GREENVILLE	HEALTH SOUTH DIAGNOSTIC CTR OF GREENVILLE	FIXED	6288	6468
GREENVILLE	G'VLLE PHYSICIANS IMAGING CTR	2 FIXED	3477	3371
GREENVILLE	GHS/EASTSIDE ACS	MOBILE	1709	1803
GREENVILLE	GREENVILLE RADIOLOGY, PA	FIXED		
GREENVILLE	GREENVILLE RADIOLOGY, PA	MOBILE		1187
GREENVILLE	NUEROLOGY ASSOC. OF GREENVILLE	MOBILE		113
GREENVILLE	OAKWOOD ORTHOPAEDIC CLINIC	MOBILE	296	408
GREENVILLE	OPEN MRI OF SIMPSONVILLE	FIXED		299
GREENVILLE	PIEDMONT ORTHOPAEDICS	FIXED		766
GREENVILLE	SE NUEROSURGICAL & SPINE INSTITUTE	MOBILE	930	839
GREENWOOD	LAKELANDS ORTHOPAEDICS CLINIC	MOBILE	633	697
GREENWOOD	SELF MEM HOSP	2 FIXED	3932	4297
GREENWOOD	SELF MEM HOSP	MOBILE		
HAMPTON	HAMPTON REG MED CTR	MOBILE	0	16
HORRY	CONWAY HOSP	FIXED	2661	3239
HORRY	GRAND STRAND REG MED CTR	FIXED	2532	3574
(HORRY)	(GRAND STRAND REG MED CTR)	(MOBILE)		
HORRY	LORIS COMM HOSP	MOBILE	1465	1503
HORRY	COASTAL ORTHOPAEDIC ASSOC	FIXED		
HORRY	MYRTLE BEACH MRI	FIXED	285	237
HORRY	OPEN MRI OF MYTRLE BEACH	FIXED	2770	2755
HORRY				
HORRY	GRAND STRAND IMAGING	FIXED	261	554
HORRY	(PREFERRED IMAGING)	FIXED	CLOSED	
HORRY	STRAND ORTHOPAEDIC CONSULTANTS	MOBILE		
HORRY	SOUTH STRAND AMB CARE CTR	FIXED	680	1558
HORRY	SEACOAST MED CTR	FIXED		265
(HORRY)	(STRAND REG SPECIALTY ASSOC, LLC)	(MOBILE)	1559	2863
HORRY	OCEAN MRI, LLC	FIXED		
KERSHAW	KERSHAW CO MEM HOSP	FIXED	669	958
LANCASTER	SPRINGS MEMORIAL HOSP	FIXED	1161	2173
LANCASTER	LANCASTER IMAGING CTR	FIXED		
LAURENS	LAURENS CO HOSP	MOBILE	843	435
LAURENS	LAURENS CO ORTHOPAEDICS ASSOC	FIXED	672	1580
LEXINGTON	LEXINGTON MED CTR	2 FIXED	4266	4795
LEXINGTON	LEXINGTON OPEN MRI	FIXED	4094	4299
LEXINGTON	LEXINGTON MED CTR-IRMO			
LEXINGTON	LEXINGTON MED CTR-LEXINGTON			
MARION	MARION CO MEDICAL CTR	MOBILE	1201	1392
MARLBORO	MARLBORO PARK	MOBILE	253	248
MARLBORO	IMAGING CTR OF MARLBORO CO	FIXED		
NEWBERRY	NEWBERRY CO MEM HOSP	MOBILE		
OCONEE	OCONEE MEM HOSP	FIXED	2197	2594
OCONEE	MOUNTAINVIEW RADIOLOGY,PA	FIXED	2166	3351
ORANGEBURG	(OPEN MRI & IMAGING ORANGEBURG)	(FIXED)		
ORANGEBURG	RMC ORANGEBURG/CALHOUN	FIXED	3499	3274
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	FIXED & MOBILE	1385	1466
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	MOBILE	1805	1876
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	FIXED		
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	MOBILE	0	0
PICKENS	CANNON MEM HOSP	2 FIXED	5002	4822
RICHLAND	PALMETTO HEALTH RICHLAND	FIXED	3506	3341
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	1041	843
RICHLAND	HEALTH SOUTH DIAGNOSTIC CTR	FIXED		
RICHLAND	PALMETTO HEALTH ALLIANCE DIAG CTR	FIXED		
RICHLAND	COLA NEUROSURGICAL ASSOC	2 FIXED	5506	5921
RICHLAND	PALMETTO IMAGING	FIXED	1596	1872
RICHLAND	PROVIDENCE HOSPITAL	FIXED	1935	3000
RICHLAND	MIDLANDS ORTHOPAEDICS	2 FIXED	1621	4052
RICHLAND	INMED DIAGNOSTIC SERVICES	FIXED		
RICHLAND	IMAGECARE	FIXED		321
RICHLAND	CAROLINA MED IMAGING	FIXED		
RICHLAND	COLA NUEROSURGICAL ASSOC	3 FIXED	8031	8285
SPARTANBURG	SPARTANBURG REG MED CTR	2 FIXED	2568	2881
SPARTANBURG	MARY BLACK MEM HOSP	FIXED	3400	4747
SPARTANBURG	PIEDMONT IMAGING, INC #1			

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RECORD 003857

MRI SCANS

COUNTY	FACILITY	TYPE	FY00 CON SCANS	FY01 CON SCANS
SPARTANBURG	ORTHOPEDIC SPECIALTIES OF SPTB	FIXED		586
SPARTANBURG	ORTHOPEDIC ASSOCIATES,PA	MOBILE		
SPARTANBURG	UPSTATE MRI & IMAGING CTR	FIXED		
SUMTER	TUOMEY OUTPATIENT IMAGING CTR	FIXED		
SUMTER	TUOMEY	FIXED	3342	4017
UNION	WALLACE THOMSON HOSP	FIXED	939	1088
WILLIAMSBURG	WILLIAMSBURG REGIONAL HOSP	MOBILE	58	0
YORK	PIEDMONT MED CTR	FIXED & MOBILE	6744	6746
YORK	PIEMONT HEALTHCARE SYSTEM	FIXED		
	CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES	FIXED		
YORK	OPEN MRI CAROLINAS	FIXED	1593	880
YORK	OLD POINTE DIAGNOSTIC CTR	FIXED	236	1575
			1.359E+09	1.553E+09

PMC.2013.SHP.0345

PET-EX006.0081

RECORD 003858

2. Positron Emission Tomography (PET)

Positron Emission Tomography (PET) captures images of cellular metabolism by tracking the movement of radioactive tracers throughout the body. Unlike CT and MRI, which depict form (tissue and bones), PET allows the study of metabolic processes such as oxygen consumption, and utilization of glucose and fatty acids. It is quantitative and very sensitive, so only tracer amounts of isotopes are needed. PET compliments the information obtained from CT and MRI scans; there are also combined PET/CT scanners now available.

PET was developed in the 1970's and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent PET development has centered on oncology, which is now estimated to constitute half of all of clinical applications. The Center for Medicare and Medicaid Services (CMS) has recently expanded the coverage of PET for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers, and melanomas, as well as for additional neurological and heart disease uses

PET scanners cost approximately $800,000. Capital costs are approximately $500,000 and annual operating costs are approximately $1,500,000. Costs for establishment of a program have decreased because the host facility no longer has to build a cyclotron to generate the radioisotopes needed for PET operation. The Academy of Molecular Imaging projects operating efficiency for a PET as being 6 scans per day.

The following PET scanners have been approved:

Facility	County	Scans/ CON Date
Region I:		
Carolinas Clinical PET Institute	Greenville	255 *1*
Anderson Area Med. Ctr. (mobile – 2 days/week)	Anderson	5/30/02 *2*
Spartanburg Reg. Med. Ctr. (mobile – 3 days/week)	Spartanburg	5/30/02 *2*
Region II:		
Lexington Medical Center (mobile – 3 days/week)	Lexington	7/19/02
Palmetto Baptist Medical Center	Richland	503 *3*
Piedmont Medical Center (mobile – 2 days/week)	York	7/19/02
Region III:		
Conway Hospital (mobile – 2 days/week)	Horry	6/24/03 *4*
Grand Strand Medical Center (mobile – 2 days/week)	Horry	5/8/01
McLeod Regional Medical Center	Florence	5/6/02

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PET-EX006.0082

RECORD 003859

Region IV:

Charleston Radiologists (mobile – 1 day/week)	Charleston	125	*5*
Roper Hospital	Charleston	535	*6*

1 Scans performed between 9/1/01 – 12/31/01.
2 Mobile unit is shared between Anderson Area Med. Ctr. and Spartanburg Reg. Med. Ctr.
3 Scans performed between 4/10/01 – 9/30/01.
4 CON issued 7/11/03.
5 Scans performed between 6/7/01 – 12/31/01; exemption from CON issued 3/21/01.
6 Scans performed between 5/2/01 – 12/31/01.

Certificate of Need Standards for Positron Emission Tomography (PET)

STANDARDS

(1) Each of the four planning regions has been approved for at least 1 full-time PET scanner service and not all of them are operational to date. Full-time is defined as a PET scanner that provides services 5 days per week. A maximum of 2 full-time PET scanners may be approved in each region based on patient origin and market share information and physician/patient referrals. Shared mobile services will be calculated based on the number of days of operation per week at each participating facility. Any PET scanner services that have been exempted from CON review will not be counted as fulfilling a portion of this projected need.

(2) The applicant must document that it provides a full range of diagnostic modalities including, but not limited to radiography, computed tomography and/or magnetic resonance imaging, ultrasound and nuclear medicine, and provides a range of comprehensive medical services which would justify the need for such specialized technology.

(3) Applicants proposing new PET services must project at a minimum 750 PET clinical procedures per year (3 clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined.

(4) After the approval of 2 full-time PET scanners in a planning region, additional full-time PET scanners will be considered after evaluating the utilization of the approved PET scanners and considering demographic patterns, patient origin and market share information, and physician/patient referrals. The existing PET scanners should be performing at 1,250 clinical procedures (5 clinical procedures x 250 days) per PET unit per year. Prior to the approval of additional PET services, the impact on existing PET services will be evaluated and considered in the review of a CON.

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PET-EX006.0083

RECORD 003860

(2) Emergency Hospital Services

All hospital emergency departments are sub-categorized into four levels of service from I to IV, with I being the highest level of care. These categories are based on modified JCAHO standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one-way travel time.

Level I offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecologic, pediatric, and anesthesia services. Other specialty consultation is available within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

Level II offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another organization when needed.

Level III offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

Level IV offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.

A Certificate of Need is required to establish a freestanding emergency service {also referred to as an off-campus emergency service}. The CON criteria are as follows:

1. All off-campus emergency services must be an extension of an existing hospital's emergency service. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

2. Regulation No. 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

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PET-EX006.0084

RECORD 003861

35 CON approved 9/11/02.

36 CON issued 10/219/99; licensed 9/13/01.

37 CON approved 12/17/02.

38 CON issued 2/1/00; licensed 2/14/02.

39 Approved 8/8/01; under appeal.

40 Approved 12/11/01; under appeal.

41 Approved 8/8/01; under appeal.

42 CON issued 3/8/00 for 1 OR and 1 Endo suite; licensed 12/18/02

43 License converted from eye surgery only to multi-specialty 11/20/02.

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PET-EX006.0085

RECORD 003862

Trident Surgery Center	Charleston	4		4	6,042
Colleton Ambulatory Care	Colleton	2	1	3	1,707

FOOTNOTES:

—Facility not licensed during reporting period.

1 CON issued 7/13/01 to add 4th Endoscopy suite; licensed 2/14/03.

2 CON issued 7/8/03.

3 CON issued 9/19/01; licensed 9/4/02.

4 CON issued 5/13/02 to add 2 OR's for a total of 6 OR's and 2 Endo Suites.

5 CON issued 2/12/03.

6 CON issued 1/8/01; licensed 9/12/02.

7 CON issued 1/8/01; facility licensed 8/21/02.

8 CON issued 10/10/00; licensed 4/21/02.

9 CON issued 10/9/00 to become an unrestricted surgery center.

10 CON issued 5/01/00; licensed 5/03/01.

11 CON issued 10/18/99 for a 4th OR; licensed 4/13/01.

12 CON issued 2/3/99 for 3 OR's and 1 Endoscopy suite; licensed 8/21/01.

13 CON issued 11/3/00 for a 4th Endoscopy suite; licensed 2/13/01.

14 CON issued 9/18/00 to add 2 OR's for a total of 4; 4 OR's licensed 7/24/02.

15 CON issued 1/18/02 to expand from 2 to 4 Endoscopy suites.

16 CON issued 9/25/01 to establish an ASC w/in Palmetto Surgery Ctr; licensed 3/12/03.

17 CON issued 1/7/02.

18 CON issued 2/11/02.

19 CON issued 1/7/02; licensed 5/20/03.

20 CON issued 10/29/99; licensed 4/13/01.

21 CON issued 9/10/02.

22 CON issued 2/20/01, licensed 3/6/03; formerly Carolina Eye Surgery & Laser Center.

23 CON issued 9/14/01 to add 3 additional OR's for a total of 5.

24 CON issued 8/27/01.

25 CON issued 8/12/02.

26 CON issued 11/25/02 to relocate the facility.

27 CON issued 3/26/02.

28 CON issued 8/24/00 to relocate the facility; formerly Carolina Regional Surgery Center.

29 CON issued 4/27/00; licensed 10/8/01.

30 CON issued 4/11/00, licensed 10/16/01; formerly Grand Strand Urology Ctr.

31 CON issued 5/29/01; licensed 1/14/03. Formerly Coastal Carolina Ctr Urology & Surgery.

32 CON issued 7/24/00, licensed 11/05/01.

33 CON approved 12/17/98; under appeal.

34 CON approved 9/11/02.

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PET-EX006.0086

RECORD 003863

Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	1,882	
Strand GI Endoscopy Center	Horry		2	2	327	*32*
Doctor's Outpt Surgical Clinic	Marlboro	2		2	----	*33*
Sumter Urological Surgery Ctr.	Sumter	2		2	----	*34*
Tuomey Outpatient Surgery Center	Sumter	4		4	----	*35*
Region IV:						
Carolina Ambulatory Surgery Ctr	Aiken	1		1	111	
Hilton Head Med. Ctr. & Clinics ASC	Beaufort	2	1	3	1,288	
Laser and Skin Surgery Center	Beaufort	2		2	266	*36*
Outpatient Surg. Ctr. Hilton Head	Beaufort	2	2	4	----	*37*
Surgery Center of Beaufort	Beaufort	3	2	5	3,508	
Roper Berkeley Ambulatory Surgery	Berkeley	3		3	----	*38*
Charleston Endoscopy Center	Charleston		4	4	----	*39*
Charleston Plastic Surgery Ctr	Charleston	2		2	674	
Health First	Charleston	2		2	----	*40*
HealthSouth Surgery Ctr Charleston	Charleston	4		4	3,330	
Palmetto Digestive Disease Endo. Ctr.	Charleston		2	2	----	*41*
Roper W. Ashley Surgery Center	Charleston	4		4	5,170	
Surgery Center of Charleston	Charleston	1	1	2	----	*42*
Trident Eye Surgery Center	Charleston	2		2	1,544	*43*

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PET-EX006.0087

RECORD 003864

Palmetto Health NW ASC	Richland	4		4	—	*18*
Palmetto Surgery Center	Richland	4		4	4,610	
Providence Hosp Surgery Ctr	Richland	4		4	4,709	
South Carolina Med Endoscopy Ctr.	Richland		2	2	161	
South Carolina Endoscopy Ctr-NorthEast	Richland		5	5	—	*19*
Carolina Surgical Center	York	4		4	4,312	
Region III:						
Darlington Endoscopy Center	Darlington		2	2	—	*20*
Dillon Family Medicine Endoscopy Ctr.	Dillon		1	1	—	*21*
Florence Surgery & Laser Center	Florence	2		2	—	*22*
McLeod Amb Surgery Ctr	Florence	5		5	1,256	*23*
Physicians Surgery Center	Florence	4	2	6	—	*24*
Atlantic Surgery Center	Georgetown	2		2	—	*25*
Bay Microsurgical Unit	Georgetown	1		1	2,887	
Waccamaw Same Day Surgery Ctr.	Georgetown	2	1	3	486	*26*
Carolina Bone and Joint Surgery Ctr.	Horry	2		2	—	*27*
Community Med Ctr - South Strand	Horry	2	1	3	2,624	
Carolina Regional Surgery Ctr	Horry	2		2	4,649	*28*
Ocean Ambulatory Surgery Ctr	Horry	2		2	72	*29*
Parkway Surgery Ctr	Horry	2		2	—	*30*
Rivertown Surgery Center	Horry	2		2	—	*31*

HealthSouth Surg Ctr - Greenville	Greenville	4		4	4,716	
Jervey Eye Center	Greenville	2		2	3,324	
Patewood Ambulatory Surgery	Greenville	2		2	1,107	
Upstate Endoscopy Center	Greenville		3	3	—	*5*
Blue Ridge Surgery Center	Oconee	2		2	—	*6*
Upstate Pain Mgt. & Surgery Ctr.	Oconee	2		2	—	*7*
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7		7	—	*8*
Spartanburg Urology Surgicenter	Spartanburg	2		2	1,891	*9*
Region II:						
Greenwood Endoscopy Center	Greenwood		2	2	4,643	
Surgery Ctr. of Self Memorial Hospital	Greenwood	5		5	2,104	*10*
Outpt Surg Ctr Lexington Med Ctr - Irmo	Lexington	4		4	3,633	*11*
Outpt Surg Ctr Lex Med Ctr - Lexington	Lexington	3	1	4	548	*12*
South Carolina Endoscopy Ctr	Lexington		4	4	10,051	*13*
Urology Surgery Center	Lexington	2		2	1,589	
Columbia Ambulatory Surgery Center	Richland	2		2	685	
Columbia Eye Surgery Center (Eye Surgery Only)	Richland	4		4	3,519	*14*
Columbia GI Endoscopy Ctr.	Richland		4	4	6,266	*15*
Huff and Milne Eye Surgery	Richland	2		2	—	*16*
Lake Murray Endoscopy Ctr.	Richland		2	2	—	*17*

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PET-EX006.0089

RECORD 003866

d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

There has been a substantial increase in the past decade in both the number and percentage of ambulatory surgeries performed and the number of ambulatory surgery centers approved and licensed. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, there is now concern that, particularly in the case of specialty facilities, ambulatory surgery centers are being proposed as a method of increasing reimbursement for procedures currently being performed in physician's offices (through the "facility fee" built into the reimbursement mechanisms). The Department will continue to evaluate applications for ambulatory surgery centers on their individual merit. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 2001):

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Footnote
Region I:						
AnMed Health Outpatient Surgery Ctr.	Anderson	5	4	9	9,192	1
Bearwood ASC	Anderson	1		1	162	
Medicus Surgery Center	Anderson	3		3	5,320	
Upstate Endoscopy Center	Anderson		2	2	—	2
Center for Special Surgery, The	Greenville	2		2	—	3
Cross Creek Surgery Center	Greenville	4		4	4,736	
Greenville Endoscopy Center	Greenville			3	4,965	
GHS Outpt. Surg. Ctr. – Patewood	Greenville	6	2	8	6,120	4

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PET-EX006.0090

RECORD 003867

3. There must be support from the physicians in the area to be served. An application for an Ambulatory Surgery Center must contain letters of support from physicians other than those affiliated with the proposed facility stating that they will either refer to or use the center.

4. The applicant must discuss the impact that the proposed ambulatory surgical facility or expansion will have upon the existing service providers.

5. The applicant must document where the potential patients for the facility will come from and where they are currently being served.

6. All new Certificate of Need approvals by the Department will not restrict the specialties of ambulatory surgery centers. Ambulatory surgery centers may be open to all surgical specialties or provide services to a single specialty, depending on their capabilities. For an ambulatory surgery center approved to only perform endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

7. All proposed ambulatory surgical facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

8. Before a new Ambulatory Surgery Center can be approved, all existing ASC's in the county must have been licensed and operational for one year to allow for a determination of the utilization of ASC's. For purposes of this Standard, endoscopy suites are considered separately from other operating rooms. Endoscopy-only ASC's do not impact other ASC's. Before additional licensed endoscopy suites can be added in a county, all ASC's with licensed endoscopy suites must have been licensed and operational for one year to allow for a determination of the utilization of the endoscopy providers.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements, and should meet the full accreditation standards for the Joint Commission on Accreditation of Healthcare Organizations, if the facility is JCAHO accredited. Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most of the residents of South Carolina. Most ambulatory surgical services operate five days a week, with elective surgery being scheduled several days in advance.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);

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PET-EX006.0091

RECORD 003868

(G) Outpatient Facilities

Outpatient facility means a facility located in or apart from a hospital, providing community service for the diagnosis and treatment of ambulatory patients: (1) which is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery (or dentistry in the case of dental diagnosis or treatment); or (3) which offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services.

Hospital-based outpatient departments vary in scope from a full range of services at the larger hospitals to the basic medical specialties of the smaller hospitals. All are expected to offer, at least, diagnostic laboratory, radiology, and clinical referral services. These departments are excluded from the inventory in Section III. The inventory also excludes: (1) the offices of private physicians and dentists whether for individual or group practice; and (2) industrial clinics and first aid centers for employees only and similar facilities not providing a community service.

(1) Ambulatory Surgical Facility

An Ambulatory Surgical Facility is a distinct entity that is equipped and operated exclusively for the purpose of performing surgical procedures for which patients are scheduled to arrive, receive surgery, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff. This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care providers. In addition to ambulatory surgical centers, most hospitals provide surgical services on an ambulatory (outpatient) basis. Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in either a hospital or a freestanding ambulatory surgery center.

In 2001, a total of 282,746 outpatient surgeries were performed in either a freestanding surgical center or a hospital in South Carolina, amounting to 66.3% of all surgeries. Not all ambulatory surgical units perform all procedures, nor is every patient a suitable candidate for an outpatient procedure.

Prior to the approval of additional ambulatory surgical facilities or the addition of operating rooms/endoscopy suites to existing ambulatory surgical facilities, the following criteria must be satisfied:

1. The applicant must define the proposed service area and/or provide patient origin information on the current facility.

2. The applicant must document a need for the expansion of or the addition of an ambulatory surgical facility. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

PMC.2013.SHP.0356

PET-EX006.0092

RECORD 003869

(5) The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

(6) The applicant agrees in writing to provide to the Department utilization data on the operation of the PET service.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Operating Budget;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

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

PMC.2013.SHP.0357

PET-EX006.0093

RECORD 003870

3. The proposed freestanding emergency service must be located no closer than 30 miles from an existing hospital emergency department or off-campus emergency service.

4. An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.

5. The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.

(3) Trauma Referral System

The Division of Emergency Medical Services, DHEC, has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers:

Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I trauma center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This trauma center has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patent arrives. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The major difference between Level I and Level II facilities is that the major surgical specialties are allowed to be on-call but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

PMC.2013.SHP.0358

PET-EX006.0094

RECORD 003871

Level III: These hospitals are committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

PMC.2013.SHP.0359

PET-EX006.0095

RECORD 003872

2. Community Psychiatric Beds

OVERVIEW

Inpatient psychiatric services are those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Such services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals. Psychiatric services are provided on both a short-term (average length of stay of less than 30 days for adults and 60 days for children) and long-term (average length of stay greater than 30 days for adults and 60 days for children) basis. These lengths of stay should not be considered as rigid since different therapies and clientele may require different lengths of stay and still be considered acute care. Variations may occur in the individual's response to therapy, the reaction to medication, the therapeutic relationship, and emergent symptoms that were not evident upon admission. Therefore, it is important to allow flexibility in determining what constitutes short and long-term lengths of stay.

An occupancy factor of 70% was used to calculate short-term projected bed needs. A minimum use rate of 75% of the overall state use rate was used to project bed needs in areas not now having short-term psychiatric units and related utilization data. Need projections were developed based on psychiatric service areas, which were derived after analysis of patient origin data from the Hospital Discharge Data System. The following pages depict the calculations described above.

Special units for children and adolescents and geriatric patients have been developed throughout the state. If any additional beds are approved, they must come from the overall psychiatric bed component shown as needed. These specialty psychiatric services should be identifiable units with sufficient space to have available areas for sleeping, dining, education, recreation, occupational therapy and offices of evaluation and therapy. The unit should be staffed with an appropriate multi-disciplinary care team of psychiatrists, psychologists, social workers, nurses, occupation therapists, recreational therapists, and psychiatric technicians. Other consultants should be available as needed.

The policy for the allocation of short-term psychiatric beds will consider the service area the basic unit for planning and issuance of Certificates of Need. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

STATE MENTAL HEALTH FACILITIES

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital compliment is maintained or reduced. As long as the Department of Mental Health does not add

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any additional beds over the 3,720 beds that were in existence on July 1, 1988, they are exempt from Certificate of Need review.

Based upon on-going patient analysis by DMH, consideration should be given to converting psychiatric hospital beds to other levels of care in order to accommodate the level of functioning of the patients if alternative community-based resources are not available. DMH will justify any changes in bed or service categories. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for these services.

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PSYCHIATRIC BED UTILIZATION

COUNTY	FACILITY	2001 AVERAGE LICENSED BEDS		2001 OCC. RATE	
AIKEN	AURORA PAVILION	29		57.8%	
ANDERSON	ANDERSON MEMORIAL	38		27.2%	
BEAUFORT	BEAUFORT MEMORIAL	20		54.2%	
CHARLESTON	CHARLESTON MEMORIAL	15		0.0%	
CHARLESTON	MEDICAL UNIVERSITY	82		66.7%	
CHARLESTON	PAL LOWCNTRY BEHAV HLTH	60		68.5%	
CHARLESTON	TRIDENT REGIONAL	20	(0)	36.3%	*1*
FLORENCE	MCLEOD REGIONAL	35		50.6%	
GREENVILLE	CAROLINA CTR BEHAV HLTH	53		70.4%	#
GREENVILLE	GREENVILLE MEMORIAL	72	(63)	64.3%	*2*
GREENWOOD	SELF MEMORIAL	36		41.0%	
HORRY	LIGHTHOUSE - CONWAY	—	(8)	—	*3*
LEXINGTON	THREE RIVERS BEHAV HLTH	39		69.7%	#
MARLBORO	MARLBORO PARK HOSP.	8		51.1%	
ORANGEBURG	RMC-ORGBURG/CALHOUN	15		34.7%	
RICHLAND	PALM. BAPTIST - COLUMBIA	104		58.9%	
RICHLAND	PALM.RICHLAND MEMORIAL	60		58.7%	
SPARTANBURG	MARY BLACK MEMORIAL	15		49.3%	
SPARTANBURG	SPARTANBURG REGIONAL	56		35.8%	
SUMTER	TUOMEY REGIONAL	19	(0)	35.7%	*4*
YORK	PIEDMONT MEDICAL CTR.	20		49.3%	
	TOTAL	796	756	53.3%	

\# TOTAL REFLECTS UTILIZATION OF DUAL-DIAGNOSIS SWING BEDS
1 DELICENSED 12/6/01
2 DELICENSED 9 BEDS 9/25/01
3 CON ISSUED FOR 8 BEDS 11/25/02, LICENSED 6/3/03.
4 DELICENSED 9/10/02

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2001 POP	2008 POP	2001 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	<65	200750	212270	2995	8.68				
	+65	33450	38430	782	2.46				
	TOTAL	234200	250700	3777	11.14	0.70	16	38	-22
GREENVILLE,PICKENS	<65	438070	473060	22532	66.66				
	+65	57530	62520	3591	10.69				
	TOTAL	495600	535580	26123	77.35	0.70	125	114	11
CHEROKEE,SPARTANBURG UNION	<65	296280	315460	5103	14.89				
	+65	43120	46050	5926	17.34				
	TOTAL	339400	361510	11029	32.22	0.70	46	71	-25
CHESTER,LANCASTER,YORK	<65	233780	252390	2341	6.92				
	+65	29040	32210	1261	3.83				
	TOTAL	262820	284600	3602	10.76	0.70	15	20	-5
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	187790	197620	3437	9.91				
	+65	29430	38250	1949	6.94				
	TOTAL	217220	235870	5386	16.85	0.70	24	36	-12
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	588090	627490	38630	112.93				
	+65	69390	77650	6710	20.57				
	TOTAL	657480	705140	45340	133.50	0.70	204	203	1
DARLINGTON,FLORENCE MARION	<65	202270	208310	5464	15.42				
	+65	27360	29470	1001	2.95				
	TOTAL	229630	237780	6465	18.37	0.70	26	35	-9
CHESTERFIELD,DILLON MARLBORO	<65	90070	89610	422	1.15				
	+65	12110	12110	1070	2.93				
	TOTAL	102180	101720	1492	4.08	0.70	6	8	-2
CLARENDON,LEE,SUMTER	<65	139820	146760	2134	6.14				
	+65	19210	22660	342	1.11				
	TOTAL	159030	169420	2476	7.24	0.70	10		10

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PSYCHIATRIC BEDS NEED

SERVICE AREA	AGE CAT	2001 POP	2008 POP	2001 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
GEORGETOWN,HORRY WILLIAMSBURG	<65	249610	270580	75%	20.98				
	+65	44270	56470	STATE USE	7.83				
	TOTAL	293880	327050	RATE	28.81	0.70	41	8	33
BAMBERG,CALHOUN ORANGEBURG	<65	107350	109670	1278	3.58				
	+65	16580	18130	621	1.86				
	TOTAL	123930	127800	1899	5.44	0.70	8	15	-7
ALLENDALE,BEAUFORT COLLETON,HAMPTON, JASPER	<65	184320	197470	3198	9.39				
	+65	31160	41030	760	2.74				
	TOTAL	215480	238500	3958	12.13	0.70	20	20	0
BERKELEY,CHARLESTON DORCHESTER	<65	497240	526960	32826	95.31				
	+65	58640	58100	4767	12.94				
	TOTAL	555880	585060	37593	108.25	0.70	170	157	13
AIKEN,BARNWELL	<65	146830	159560	4604	13.71				
	+65	21680	25320	1515	4.85				
	TOTAL	168510	184880	6119	18.39	0.70	26	29	-3
STATE TOTAL							737	754	-17
STATE MIMIMUM USE RATE	<65	3312660	3516630	124964	0.0377232	0.03			
	+65	448700	501930	30295	0.0675173	0.05			
	TOTAL	3761360	4018560	155259	0.0412774	0.03			

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3. Residential Treatment Facilities for Children and Adolescents

OVERVIEW

"Residential treatment facilities for children and adolescents" means a facility operated for the assessment, diagnosis, treatment, and care by two or more persons of children and adolescents in need of mental health treatment. "Children and adolescents in need of mental health treatment in a residential treatment facility" means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgement including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

These facilities provide medium to long-term care (6 months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are current licensed or approved as Residential Treatment Facilities:

Facility	Beds	FY 2001 Occ. Rate	
Directions {DMH, Columbia}	37	68.1%	
Lighthouse Care Center {Conway}	16	--	*1*
Marshall Pickens Hospital {Greenville}	22	99.6%	
New Hope-Charleston {Summerville}	60 (52)	94.5%	*2*
New Hope-Midlands {West Columbia}	54	65.8%	
Palmetto Low Country Behavioral Health {Charleston}	32	89.0%	
Palmetto Pee Dee Behavioral Health {Florence}	59 (18)	90.1%	*3*
Southbridge {Columbia}	0 (40)	—	*4*
Springbrook Behavioral Ctr. {Travelers Rest}	68	66.4%	*5*
Three Rivers Behavioral Care {West Columbia}	18 (14)	39.6%	*6*
York Place {York}	40	81.5%	
TOTAL	406 (393)		

1 CON issued 11/25/02.

2 CON issued 10/8/02 for 8 additional RTF beds.

3 Facility relocated from Conway to Florence 7/18/00; new location licensed 9/29/00. Name changed from Charter Sands of Conway. CON issued 4/19/01 to add 41 additional beds.

4 Facility closed 6/15/01.

5 Formerly Chestnut Hill. CON issued 6/12/01 to convert 24 long-term psychiatric beds to RTF beds. Facility licensed for 68 RTF beds on 8/28/01.

6 CON issued 5/13/02 to add 4 additional RTF beds.

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RECORD 003878

Certificate of Need Standards for Residential Treatment Facilities

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;
2. Individual treatment plans to assess the problems and determine specific patient goals;
3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;
4. Nursing services, as required;
5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;
6. Recreational facilities with an organized youth development program;
7. A special education program with a minimum program defined by the South Carolina Department of Education; and
8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

Each facility shall have a written plan for cooperation with other public and private organizations, such as schools, social service agencies, etc., to ensure that each child under its care will receive comprehensive treatment. In addition, each facility shall have a written transfer agreement with one or more hospitals for the transfer of emergency cases when such hospitalization becomes necessary.

A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Continuum of Care for Emotionally Disturbed Children, the SC Department of Social Services and the SC Department of Mental Health. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the agencies mentioned above.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 6 years of age would be candidates for this type of care, the bed need will be based on the population age 6-21. The projected bed needs by service area are as follows:

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Inventory Region I Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, Union.

Facilities:		
	Marshall Pickens	22 beds
	Springbrook Behavioral	68 beds
	Total	90 beds

2008 Population Age 6-21:	252,204	
41.4 Beds/100,000 Population:	x .000414	
	104	beds
	- 90	beds
Need Shown:	14	beds

Inventory Region II Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, York.

Facilities:		
	Charter Rivers	18 beds
	New Hope Midlands	54 beds
	York Place	40 beds
	Total	112 beds

2008 Population Age 6-21:	276,114	
41.4 Beds/100,000 Population:	x .000414	
	114	beds
	- 112	beds
Need Shown:	2	beds

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:		
	Lighthouse Care Center	16 beds
	Palmetto Pee Dee Behav. Health	59 beds
	Total	75 beds

2008 Population Age 6-21:	176,508	
41.4 Beds/100,000 Population:	x .000414	
	73	beds
	- 75	beds
Need Shown:	(2)	beds

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Inventory Region IV Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg.

Facilities:	New Hope Charleston	60 beds
	Palmetto Low Country Behav. Hlth.	32 beds
	Total	92 beds

2008 Population Age 6-21:	250,058	
41.4 Beds/100,000 Population:	x .000414	
	104	beds
	- 92	beds
Need Shown:	12	beds

The projected need for additional RTF beds is based upon the number of clients of the Department of Mental Health, Department of Social Services, and the Continuum of Care for Emotionally Disturbed Children who are currently being served, waiting for service, and/or who could be appropriately placed in these facilities. Additionally, it allows for sufficient beds to be available to meet the needs of private pay and other non-governmental clients. Applicants must document sources for patient referral. The Directions program (and the Southbridge program before closing) primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

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:

a. Compliance with the Need Outlined in this Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Record of the Applicant;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within seventy-five (75) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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4. Alcohol and Drug Abuse Facilities

There are six distinct providers of substance abuse treatment in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

(1) Outpatient Facilities

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment and referral, individual and group counseling, family counseling, case management and crisis management services. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 55 licensed outpatient facilities for chemically dependent or addicted persons in South Carolina, with a total of 74 locations.

CERTIFICATE OF NEED REQUIREMENTS

Certificate of Need is not required for outpatient facilities described above.

(2) Social Detoxification Facilities

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides education and referral. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized medical provider. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a social detoxification center.

(3) Freestanding Medical Detoxification Facilities

A short-term residential facility, separated from an inpatient treatment facility, providing for

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medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse and referral. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized medical provider. The services provided by these facilities are described in Section 3101 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

INVENTORY

Facility	Beds	2001 Occupancy
Carolinas Hospital System (Florence County)	4	29%
Charleston Center Subactute Detox. Program	16	55%
Greenville Detoxification Center	27	49%
Lexington/Richland A.D.A.C. Detox. Unit	16	87%
Keystone Detoxification Center (York County)	12	72%
TOTAL	75	61.1%

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for freestanding medical detoxification beds. The 2001 utilization rates are used to project the need for services in 2008. An occupancy factor of 70% was used in the calculations. The greater of the service areas' actual utilization or 100% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Freestanding detoxification centers should be available within 60 minutes one-way automobile travel time for 90% of the service area's population. Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed: however, the bed need projections refer to two distinct treatment modes which cannot be commingled.

Since 1987, courts in South Carolina have had the authority to order individuals involuntarily into addiction treatment. Because of this law, the number of detoxification beds shown as needed in this Plan may need to be increased. If an applicant can document an increased need and if either the

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RECORD 003883

DETOXIFICATION BED NEED — 2003 PLAN

SERVICE AREA	2001 POP	2008 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	187,220	202,560	0	3.62	0.70	5	0	5
GREENVILLE,PICKENS	395,950	432,470	4,841	14.49	0.70	21	27	-6
CHEROKEE,SPARTANBURG UNION	262,180	289,010	0	5.16	0.70	7	0	7
CHESTER,LANCASTER,YORK	206,020	227,900	3,152	9.55	0.70	14	12	2
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	172,720	186,320	0	3.33	0.70	5	0	5
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	520,400	568,320	5,101	10.15	0.70	15	16	-1
DARLINGTON,FLORENCE MARION	179,870	188,930	425	3.37	0.70	5	4	1
CHESTERFIELD,DILLON MARLBORO	79,280	79,900	0	1.43	0.70	2	0	2
CLARENDON,LEE,SUMTER	123,380	133,250	0	2.38	0.70	3	0	3
GEORGETOWN,HORRY WILLIAMSBURG	238,990	273,110	0	4.88	0.70	7	0	7
BAMBERG,CALHOUN ORANGEBURG	98,100	102,750	0	1.84	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	171,240	195,800	0	3.50	0.70	5	0	5
BERKELEY,CHARLESTON DORCHESTER	438,570	484,050	3,237	9.79	0.70	14	16	-2
AIKEN,BARNWELL	132,200	149,180	0	2.66	0.70	4	0	4
STATE TOTAL	3,206,120	3,513,550	16,756	76.15		110	75	35
MINIMUM USE RATE	0.0065197							

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South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) or the South Carolina Department of Mental Health (DMH) submits a letter of support for additional detoxification beds beyond those shown as needed in the Plan, then additional detoxification beds could be approved.

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 Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 5 freestanding medical detoxification facilities in the state operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Services are accessible within sixty (60) minutes travel time for the majority of state residents. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(4) Residential Treatment Program Facilities

A 24-hour facility offering an organized service in a residential setting which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs shall provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a Residential Treatment Program. However, an exemption request is required prior to the establishment of such a program.

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RECORD 003885

(5) Inpatient Treatment Facilities

A short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries; contact the Division of Health Licensing at (803) 545-4370 for further information.

Facility	Beds	2001 Occupancy	
Aiken Regional Medical Center	18	12.1%	
AnMed-Wellspring (Anderson County)	27	8.5%	
Carolina Center Behav. Health (Greenville County)	13	52.3%	
Carolinas Hospital System (Florence County)	18	29.1%	
Fairfield Memorial Hospital	17	0.0%	
Holmesview Center (Greenville County)	40	64.9%	*1*
McCord Adolescent (Orangeburg County)	15	56.9%	*1*
Medical University (Charleston County)	23	50.1%	
Morris Village (Richland County)	173	82.3%	*1*
Palmetto Center (Florence County)	48	71.5%	*1*
Palmetto Lowcountry Behav. Health (Charleston County)	10	41.5%	
Palmetto Richland Springs (Richland County)	10	97.4%	
Roper North (Charleston County)	44 (0)	0.0%	*2*
Self Memorial (Greenwood County)	24	0.0%	
Springs Memorial (Lancaster County)	45 (35)	25.5%	*3*
Three Rivers Behav. Health (Lexington County)	27	20.1%	
TOTAL	276 (222)	23.2%	

1 Statewide Facility, Not Included in Bed Need Calculations.
2 Facility de-licensed 4/4/02.
3 CON issued 4/15/03 to convert 10 inpatient substance abuse beds to general acute.

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for inpatient treatment beds. The 2001 utilization rates are used to project the need for services in 2008. An 70% occupancy factor was used in the calculations. The greater of the service areas' actual utilization or 75% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

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For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Inpatient treatment centers should be available within 60 minutes one-way automobile travel time for 90% of the service areas' population. Morris Village, Holmesview, McCord Adolescent and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

Additional inpatient treatment beds could be considered for the service area only if the following criteria are met:

(a) The service area shows a need for additional beds;

(b) The applicant demonstrates an un-served demand for the proposed service area; and

(c) The utilization of treatment facilities in the contiguous service areas should be considered prior to approval of additional beds. This should include occupancy rates, patient origin, scope of services offered, and patient mix.

It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

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 Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 11 inpatient treatment facilities in the state, not including state-operated facilties. There is a projected need for additional beds in some service areas. Services are accessible within

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INPATIENT BED NEED

2003 PLAN

SERVICE AREA	2001 POP	2008 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	187,220	202,560	833	2.47	0.70	4	27	-23
GREENVILLE,PICKENS	395,950	432,470	2,481	7.42	0.70	11	13	-2
CHEROKEE,SPARTANBURG UNION	262,180	289,010	0	5.47	0.70	8	0	8
CHESTER,LANCASTER,YORK	206,020	227,900	4,189	12.70	0.70	18	35	-17
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	172,720	186,320	0	3.52	0.70	5	24	-19
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	520,400	568,320	5,532	16.55	0.70	24	54	-30
DARLINGTON,FLORENCE MARION	179,870	188,930	1,914	5.51	0.70	8	18	-10
CHESTERFIELD,DILLON MARLBORO	79,280	79,900	0	1.51	0.70	2	0	2
CLARENDON,LEE,SUMTER	123,380	133,250	0	2.52	0.70	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	238,990	273,110	0	5.17	0.70	7	0	7
BAMBERG,CALHOUN ORANGEBURG	98,100	102,750	0	1.94	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	171,240	195,800	0	3.70	0.70	5	0	5
BERKELEY,CHARLESTON DORCHESTER	438,570	484,050	5,717	17.29	0.70	25	33	-8
AIKEN,BARNWELL	132,200	149,180	795	2.82	0.70	4	18	-14
STATE TOTAL	3,206,120	3,513,550	21,461	88.59		128	222	-94
MINIMUM USE RATE	0.0069049							

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sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(6) Narcotic Treatment Programs

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and LAAM (levo-alpha-acetylmethadol) to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client□s needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider.

Narcotic treatment programs are described in Section 3200 of Regulation Number 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

INVENTORY

Facility	County	Clients During Year
Center for Behavioral Health South Carolina	Charleston	311
Center for Hope of Myrtle Beach	Horry	CON 12/6/02
Charleston Center	Charleston	269
Columbia Metro Treatment Center	Lexington	195
Greenville Metro Treatment Center	Greenville	364
Piedmont Treatment Center	Greenville	410
Southwest Carolina Treatment Center	Anderson	Lic. 2/25/02
Spartanburg Treatment Associates	Spartanburg	Lic. 11/21/02
Starting Point, LLC	Richland	Lic. 2/12/03
York County Treatment Center, Inc.	York	254

A Certificate of Need is required for a methadone treatment facility. The licensure standards include standards for the location of these facilities within the community. A narcotic treatment program shall not operate within 500 feet of: a church, a public or private of elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district or the property line of a lot devoted to residential use.

Because clients must usually attend a Methadone Treatment Center 6 days per week to receive their dose of methadone, these centers should be located throughout the state. Until these clinics are developed throughout the state, additional Methadone Treatment Centers are not needed in counties

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where an existing clinic exists, but should be developed in counties where none exists to improve accessibility.

The following table indicates that there were 1,460 clients served by Methadone Treatment Centers as of December 31, 2001 by county/state of residence and that there were 791 visits to Emergency Rooms for opoid dependent patients for calendar year 2001. The Methadone Treatment centers served a total of 1,803 clients during 2001. There were an additional 2,376 patients seen in emergency departments for other drug dependency.

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:

a. Compliance with this Plan;
b. Distribution (Accessibility);
c. Record of the Applicant;
d. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility may outweigh the adverse effects of the duplication of this existing service.

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COUNTY	Clients at Methadone Centers	Opiod Dependent Emergency Room Visits	Other Drug Dependent ER Visits
Abbeville		10	11
Aiken	1	17	40
Allendale		0	2
Anderson	31	29	111
Bamberg	1	1	6
Barnwell		3	8
Beaufort		14	61
Berkeley	43	18	82
Calhoun	3	1	12
Charleston	233	116	307
Cherokee	15	8	23
Chester	3	1	15
Chesterfield	1	8	20
Clarendon		2	6
Colleton	16	4	19
Darlington	3	11	47
Dillon		9	12
Dorchester	108	20	51
Edgefield		0	1
Fairfield	3	0	47
Florence	22	72	91
Georgetown	11	18	26
Greenville	314	55	202
Greenwood		7	91
Hampton		2	7
Horry	24	82	139
Jasper	2	4	7
Kershaw	10	7	28
Lancaster	43	12	43
Laurens	43	10	22
Lee		1	7
Lexington	58	29	99
McCormick		1	5
Marion		3	2
Marlboro		3	13
Newberry	4	10	19
Oconee	1	20	36
Orangeburg	6	5	63
Pickens	3	17	22
Richland	97	37	303
Saluda	1	3	7
Spartanburg	147	52	76
Sumter	4	3	26
Union	1	5	30
Williamsburg	2	9	17
York	36	16	53
NC	127		
GA	8		
Other states	29	36	61
Unknown	6		
TOTAL	1460	791	2376

Clients at Methadone Centers denote the number of clients as of December 31, 2001
Opiod dependent emergency room visits are patients seen in emergency departments by county of residence for 2001.
Other drug dependent emergency room visits are patients seen in emergency departments by county of residence that had a diagnosis of drugs other than opiods or were not specified.

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5. Rehabilitation Facilities

OVERVIEW

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision of (1) medical evaluation and services and (2) psychological, social, and/or vocational evaluation and services. The current concept of a rehabilitation facility is one in which the disabled person is assisted through an integrated program conducted by a team of specialized personnel representing several professional disciplines, under the direction of a person licensed to practice medicine or surgery in the State.

According to the American Medical Association (AMA), rehabilitation services are most effective when delivered in comprehensive medical rehabilitation units or centers located in either short-stay hospitals or freestanding facilities, where inpatients with severe disabilities receive medical, nursing, restorative and personal adjustment services in an integrated rehabilitation program. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with such physical impairments as stroke, spinal cord injury, head injury, multiple sclerosis and other neuromuscular diseases, arthritis, chronic pain, amputations, hip and pelvis fractures, and childhood birth defects and injuries are typical clients.

Patients requiring this level of care should be able based on interdisciplinary evaluation, to participate fully in the therapies, practice sessions, and other activities provided and to benefit from such therapies. Along with the capacity to endure the intensity of service offered, the individual must be emotionally ready to participate in and accept the treatment plan developed for his/her rehabilitation.

Rehabilitation facilities should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. It may be beneficial to utilize the services of, or affect a cooperative plan with, present medical and vocational centers when establishing a rehabilitation facility. Where separate freestanding facilities are established, the employees representing the professional fields mentioned above should be provided on a full-time basis.

Physical rehabilitation services which involve a single service such as physical therapy, occupational therapy, speech therapy, or recreation therapy, and outpatient rehabilitation services without the involvement of a formal interdisciplinary program, are provided by most general hospitals, nursing homes, home health agencies, and outpatient rehabilitation centers.

In addition, several hospitals have received approval to consolidate their therapy services into a single unit to improve the coordination of rehabilitative care for acute patients in their facilities. While these facilities provide a more coordinated and possible higher degree of care than in hospitals with indecent single services, these hospitals are not considered to be providing comprehensive

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physical rehabilitation services as defined in this section of the Plan. The consolidation of rehabilitative therapies is intended to improve the quality of care for patients currently being treated in the facility; it is not intended to allow hospitals to market themselves or advertise as offering comprehensive rehabilitation. Hospitals, which have received permission to consolidate their rehabilitation services into a distinct unit, include Colleton Regional Hospital and Tourney Hospital.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2001 Occupancy
I	HealthSouth	Anderson	28	--- *1*
I	Roger C. Peace	Greenville	53	81.9%
I	St. Francis	Greenville	19	88.8%
I	Mary Black	Spartanburg	18	70.0%
II	HealthSouth Columbia	Richland	111 (96)	87.6% *2*
II	HealthSouth Rock Hill	York	32 (20)	86.6% *3*
III	HealthSouth Florence	Florence	88	89.1%
III	Carolinas Hospital	Florence	42 (24)	80.6% *4*
III	Waccamaw Neck	Georgetown	29 (19)	--- *5*
IV	Beaufort Memorial	Beaufort	14	--- *6*
IV	HealthSouth	Charleston	42	87.9%
IV	M.U.S.C.	Charleston	25	9.8%
IV	Roper Hospital	Charleston	39	81.1%
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	--- *7*
IV	Low Country General	Jasper	10	--- *8*
		Total	574 (519)	

1 CON issued 1/25/02 to build a rehabilitation hospital with 28 rehabilitation beds.
2 CON issued 10/10/02 to add 15 beds for a total of 111 rehabilitation beds.
3 CON issued 2/28/02 for 12 additional beds; licensed 4/1/02.
4 CON issued 4/15/03 to add 18 beds for a total of 42 beds; licensed 6/27/03.
5 CON issued 5/26/00 to create a 19-bed rehabilitation unit; CON issued 2/11/02 for an additional 10 beds.
6 CON issued 12/12/00 for a 14-bed rehabilitation unit, licensed 8/28/01.
7 CON issued 4/4/00 for a 24-bed rehabilitation unit.
8 CON issued 3/28/02 for the addition of 10 rehabilitation beds.

STATEWIDE PROGRAMS

S.C. Vocational Rehabilitation Center, in West Columbia, has 30 beds. This facility is operated by the S.C. Vocational Rehabilitation Department to serve the vocational training needs of the disabled, and should be expanded to 44 beds to better enable VRD to served their statewide client caseload.

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CERTIFICATE OF NEED STANDARDS FOR REHABILITATION

DEFINITIONS

"Disabled person" is an individual who has a physical or mental condition which, to a material degree, limits, or if not corrected, will probably result in limiting, the individual's performance or activities to the extent of constituting a substantial physical, mental, or vocational handicap.

"Medical service" means a service under the direct personal supervision of a medical director, varied and extensive availability of specialized medical consultants, and other evaluation and therapy services suitable to the needs of the disabled persons to be served.

"Psychological service" means evaluation and services by a qualified psychologist in amounts and variety appropriate to the needs of the disabled persons to be served.

"Social service" means evaluation and services by a qualified social worker in amounts and variety appropriate to the needs of the patients to be served.

"Vocational service" means a variety of vocational services appropriate to the program and persons to be served, such as pre-vocational exploration, work evaluation, and vocational training.

STANDARDS

The need for rehabilitation beds is calculated based on 12 service areas as defined on the following page. An occupancy factor of 70% was used to calculate projected bed needs. The greater of the service area's actual utilization or the statewide use rate was used to project bed needs.

Due to the low utilization of existing hospital beds, consideration should be given to the conversion of existing beds to rehabilitation beds rather than to the construction of new facilities and/or beds.

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:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

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Rehabilitation facilities are now located throughout the state and are available within approximately ninety (90) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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REHABILITATION BED NEED

SERVICE AREA	2001 POP	2008 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON, OCONEE	234,200	250,700	0	20.84	0.70	30	28	2
GREENVILLE, PICKENS	495,600	535,580	21,997	65.13	0.70	93	72	21
CHEROKEE, SPARTANBURG, UNION	339,400	361,510	4,598	13.42	0.70	19	18	1
CHESTER, LANCASTER, YORK	262,820	284,600	6,322	23.65	0.70	34	32	2
ABBEVILLE, EDGEFIELD, GREENWOOD, LAURENS, MCCORMICK, SALUDA	217,220	230,240	0	19.14	0.70	27	0	27
FAIRFIELD, LEXINGTON, NEWBERRY, RICHLAND	602,250	647,680	28,467	83.87	0.70	120	111	9
CHESTERFIELD,DARLINGTON, DILLON, FLORENCE, MARION, MARLBORO, WILLIAMSBURG	369,000	375,760	35,668	99.51	0.70	142	130	12
CLARENDON, KERSHAW, LEE, SUMTER	212,260	226,880	0	18.86	0.70	27	0	27
GEORGETOWN, HORRY	256,790	290,160	0	24.12	0.70	34	29	5
AIKEN,ALLENDALE,BAMBERG, BARNWELL, CALHOUN, ORANGEBURG	303,790	324,600	0	26.98	0.70	39	24	15
BEAUFORT, COLLETON, HAMPTON, JASPER	204,130	226,580	0	18.83	0.70	27	24	3
BERKELEY, CHARLESTON, DORCHESTER	555,880	600,160	25,915	76.66	0.70	110	106	4
STATE TOTAL	4,053,340	4,354,450	122,967	491.01		702	574	128
STATE USE RATE	0.0303372							

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6. Long Term Care Facilities and Services

A. Nursing Homes:

Nursing homes provide inpatient care for convalescent or chronic disease patients who require nursing care and related medical services, in which such nursing care and medical services are prescribed by, or are performed under the general direction, of persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.net the licensing list of nursing homes contains the facilities that have Alzheimer's units. For more specific detail about nursing homes, refer to the Department's Standards for Licensing Nursing Homes.

For existing licensed nursing homes, bed capacity is considered to be the number of licensed beds or the number of beds approved under the Certificate of Need program regardless of oversize room construction. The number of beds counted in any patient room is the maximum number for which adequate square footage is available. These minimums are: 100 square feet in single rooms; and 80 square feet per bed in multi-bed rooms. Only the net usable space in the room is considered. Space in the toilet rooms, wash rooms, closets, vestibules, and corridors is not counted.

The following items should be noted regarding the inventory of long-term care facilities:

(1) Restricted usage facilities (federal and institutional) are counted as statewide facilities and not counted in the region located.

(2) Patient days and admissions are as reported by the nursing home.

(3) Existing beds are counted based upon the greater of licensed or survey capacity. Survey beds refer to the capacity; the survey beds do not exceed the licensed beds unless a Certificate of Need has been issued for an increase in the number of beds. The footnotes in the inventory explain any changes.

(4) The beds included in the inventory have been classified for planning purposes as conforming or nonconforming. This classification is based on U.S. Public Health Service standards of plant evaluation and an actual on-site survey of each facility and updated as changed by construction and/or modernization.

(5) The standards used in this survey are basically the same for general hospitals and nursing homes. Such standards include:

(a) Fire-resistivity of each building;
(b) Fire and other safety factors of each building;
(c) Bed capacity and evaluation of nursing units, including:

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(1) Availability of nurses' call system;
(2) Adequacy of bed space;
(3) Patient rooms; grade level or above;
(4) Availability of outside windows in patient rooms;
(5) Availability of direct access to a corridor for each patient room;
(6) A minimum corridor width of eight (8) feet;
(7) Availability of a nurses' station within 120 feet of each patient room unless the alternative standard of 150 feet has been approved;
(8) Adequate toilet, bedpan, bath or handwashing facilities in each patient unit; and
(9) Maximum capacity of four (4) beds per patient room.

(d) Design and structural factors affecting the function of service departments, including:

(1) Dietary department;
(2) Dining, recreation and day room space;
(3) Rehabilitation services (for facilities in excess of 100 beds only)
(4) Laundry and linen department.

The nursing home bed need methodology developed and used in the Plan is derived from a factor of 39.33 beds per thousand population age 65 and over by county. This factor was selected after detailed analysis of the method outlined in the Public Health Service health grants manual 23-2 as amended; the South Carolina Projected Use Rate method, previously approved by the Department of Health, Education, and Welfare (HEW); and several other methodologies. These beds are generally used by the (noninstitutional) population age 65+. In an effort to give more equitable distribution of beds throughout the State, these needs are developed by county.

This methodology factored in the utilization from the South Carolina Community Long Term Care Project (CLTC) regarding client utilization of nursing homes. This project provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing home placement under the Medicaid program.

Therefore, the ratio of 39 beds/1000 population age 65 and over was selected as the appropriate number of nursing home beds for 2005.

A two-year projection, through 2005, of the nursing home bed need for the general (noninstitutional) population is used for the following reasons:

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(1) There is a shortage of Title XIX (Medicaid) funding in the state. Approximately 67% of all patients in nursing homes are financed by Medicaid.

(2) The state has limited resources to invest in meeting the long-term care needs of its population. The Long Term Care Committee of the Human Services Coordinating Council recommends that services toward home and community care should be stressed as an alternative to institutionalization.

(3) The CLTC program is operational with both Medicaid and Medicare waivers for a client assessment program to help people with disabilities find the right type of long-term care by expanding community-based services. These services include:

a. Medical Day Care
b. Personal Care
c. Respite Care
d. Home Delivered Meals
e. Transportation
f. Medical Social Services
g. Expanded Therapies
h. Mental Health Counseling

(4) Nursing homes can be developed and constructed in two years. A shorter planning horizon may lessen the potential for an over built situation in nursing home beds as alternatives are developed and funded.

There are no longer separate Federal and State standards for skilled nursing and intermediate care beds; therefore, the beds have been combined under nursing home beds.

The long-term care analyses and factor development was accomplished with the assistance of representatives of various agencies and organizations associated with long-term care.

Since the vast majority of patients utilizing nursing homes are 65 years of age or older, only this segment of the population is used in the projection of need for the general public. However, all patient days, including the under 65 population, were used to develop the bed need factor used in these methodologies.

The number of beds needed to be constructed is obtained by subtracting the number of existing beds (greater of license or survey capacity) from the bed need. In order to provide a more equitable distribution of nursing home beds throughout the State, the following policies will apply:

(1) Additional beds may be approved in counties with a positive bed need up to the need indicated.

(2) When a county has more beds than the projected need (i.e. excess beds), additional beds will not be approved.

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(3) An exception to numbers (1) and (2) above can be made for an individual nursing home to add some additional nursing home beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing home may add up to 16 additional beds to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing home must document how these additional beds will make a more economical unit(s). In no case will more than 16 additional beds be approved for a specific facility unless there is a need in the particular county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand age 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating certificate of need applications for these beds or facilities:

a. Need;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing homes are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing home is located in every county, there is no justification for approving additional nursing homes or beds which are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since approximately 67% of all nursing home patients are paid for by the Medicaid Program. This Plan projects the need for nursing home beds by county. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

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LONG TERM CARE BED NEED		2005 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	TO BE ADDED/OR EXCESS
	ANDERSON	23.320	909	775	134
	CHEROKEE	6.510	254	217	37
	GREENVILLE	45.440	1772	1694	78
	OCONEE	12.150	474	252	222
	PICKENS	13.490	526	424	102
	SPARTANBURG	32.350	1262	1227	35
	UNION	4.840	189	201	-12
REGION I	TOTAL	138.100	5386	4790	608
	ABBEVILLE	3.850	150	116	34
	CHESTER	4.270	167	100	67
	EDGEFIELD	2.770	108	120	-12
	FAIRFIELD	3.020	118	262	-144
	GREENWOOD	9.040	353	369	-16
	KERSHAW	7.000	273	236	37
	LANCASTER	7.280	284	288	-4
	LAURENS	9.580	374	365	9
	LEXINGTON	24.910	971	824	147
	MCCORMICK	2.200	86	120	-34
	NEWBERRY	5.320	207	276	-69
	RICHLAND	31.820	1241	1135	106
	SALUDA	2.920	114	176	-62
	YORK	18.420	718	701	17
REGION II	TOTAL	132.400	5164	5088	417
	CHESTERFIELD	5.040	197	204	-7
	CLARENDON	5.120	200	152	48
	DARLINGTON	8.190	319	366	-47
	DILLON	3.400	133	195	-62
	FLORENCE	15.440	602	777	-175
	GEORGETOWN	9.840	384	249	135
	HORRY	35.400	1381	676	705
	LEE	2.620	102	120	-18
	MARION	4.100	160	180	-20
	MARLBORO	3.170	124	111	13
	SUMTER	13.170	514	428	86
	WILLIAMSBURG	4.930	192	176	16
REGION III	TOTAL	110.420	4308	3634	1003
	AIKEN	20.230	789	718	71
	ALLENDALE	1.560	61	44	17
	BAMBERG	2.120	83	88	-5
	BARNWELL	3.120	122	169	-47
	BEAUFORT	24.050	938	408	530
	BERKELEY	14.970	584	325	259
	CALHOUN	2.100	82	120	-38
	CHARLESTON	39.420	1537	1290	247
	COLLETON	5.020	196	147	49
	DORCHESTER	11.290	440	278	162
	HAMPTON	2.600	101	104	-3
	JASPER	2.390	93	88	5
	ORANGEBURG	12.780	498	393	105
REGION IV	TOTAL	141.650	5524	4172	1445
GRAND TOTAL		522.570	20382	17684	3473

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COUNTY	2005 POP	NURSING BEDS	BEDS/M	RANK
BEAUFORT	24.050	408	16.96	1
HORRY	35.400	676	19.10	2
OCONEE	12.150	252	20.74	3
BERKELEY	14.970	325	21.71	4
CHESTER	4.270	100	23.42	5
DORCHESTER	11.290	278	24.62	6
GEORGETOWN	9.840	249	25.30	7
ALLENDALE	1.560	44	28.21	8
COLLETON	5.020	147	29.28	9
CLARENDON	5.120	152	29.69	10
ABBEVILLE	3.850	116	30.13	11
ORANGEBURG	12.780	393	30.75	12
PICKENS	13.490	424	31.43	13
SUMTER	13.170	428	32.50	14
CHARLESTON	39.420	1290	32.72	15
LEXINGTON	24.910	824	33.08	16
ANDERSON	23.320	775	33.23	17
CHEROKEE	6.510	217	33.33	18
KERSHAW	7.000	236	33.71	19
MARLBORO	3.170	111	35.02	20
AIKEN	20.230	718	35.49	21
RICHLAND	31.820	1135	35.67	22
WILLIAMSBURG	4.930	176	35.70	23
JASPER	2.390	88	36.82	24
GREENVILLE	45.440	1694	37.28	25
SPARTANBURG	32.350	1227	37.93	26
YORK	18.420	701	38.06	27
LAURENS	9.580	365	38.10	28
LANCASTER	7.280	288	39.56	29
HAMPTON	2.600	104	40.00	30
CHESTERFIELD	5.040	204	40.48	31
GREENWOOD	9.040	369	40.82	32
BAMBERG	2.120	88	41.51	33
UNION	4.840	201	41.53	34
EDGEFIELD	2.770	120	43.32	35
MARION	4.100	180	43.90	36
DARLINGTON	8.190	366	44.69	37
LEE	2.620	120	45.80	38
FLORENCE	15.440	777	50.32	39
NEWBERRY	5.320	276	51.88	40
BARNWELL	3.120	169	54.17	41
MCCORMICK	2.200	120	54.55	42
CALHOUN	2.100	120	57.14	43
DILLON	3.400	195	57.35	44
SALUDA	2.920	176	60.27	45
FAIRFIELD	3.020	262	86.75	46
	522.570	17684	33.84	

Medicaid Nursing Home Permits

Beginning July 1, 1988, nursing homes which wish to continue to serve Medicaid patients must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing home may provide, and the nursing home must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

MEDICAID PATIENT DAYS AND MEDICAID BEDS REQUESTED AND AUTHORIZED

YEAR	# DAYS REQUESTED	BEDS	# DAYS AUTHORIZED	BEDS	# DAYS DIFFERENCE
1988-1989	3,032,839	8309	2,971,811	8142	61,028
1989-1990	3,644,248	9984	3,644,248	9984	0
1990-1991	3,709,814	10163	3,659,965	10028	49,849
1991-1992	3,856,833	10567	3,659,965	10028	196,868
1992-1993	3,976,576	10895	3,806,382	10429	170,194
1993-1994	4,012,359	10993	3,856,382	10566	155,977
1994-1995	4,023,690	11024	3,892,882	10665	130,808
1995-1996	3,969,681	10876	3,892,882	10665	76,799
1996-1997	4,072,519	11158	4,002,382	10965	70,137
1997-1998	4,119,753	11287	4,097,282	11225	22,471
1998-1999	4,265,182	11685	4,265,182	11685	0
1999-2000	4,367,134	11965	4,341,832	11895	25,302
2000-2001	4,420,522	12111	4,378,332	11995	42,190
2001-2002	4,473,170	12255	4,275,998	11715	197,172
2002-2003	4,340,158	11891	4,205,553	11522	134,605

NOTES: 36,500 patient days = 100 beds

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Mental Retardation Facilities

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed. Based on the known numbers of individuals in service systems as well as improved public awareness and acceptance of issues associated with mental retardation, it is believed that there are no significant numbers of citizens with mental retardation or related disabilities currently unrecognized.

The South Carolina Department of Disabilities and Special Needs is reducing the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds are being developed for those persons from the regional centers and those on the residential services waiting list. Community beds will be distributed over the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs will enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in.

Any certificate of need for mental retardation beds should not be approved unless it is supported by the South Carolina Department of Disabilities and Special Needs.

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B. Institutional Nursing Home (Retirement Community Nursing Home)

An institutional nursing home means a nursing home (established within the jurisdiction of a larger non-medical institution) which maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program which has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

(1) The nursing home must be a part of and located on the campus of the retirement community.

(2) It must restrict admissions to campus residents.

(3) The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home" and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, the generally accepted ratio of nursing home beds to retirement beds is 1:4. This ratio appears to be high for newly established retirement centers as the new residents are not in need of nursing home care until several years later.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing Home Beds (restricted beds) are used solely by the residents of the retirement community, there is no justification for approving these types of nursing homes unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing beds or facilities.

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C. Hospice Facilities and Hospice Programs

Hospice means a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including but not limited to home, outpatient and inpatient services provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

A Hospice Facility means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is required for an Inpatient Hospice Facility. A Certificate of Need is not required for the establishment of a Hospice Program; an inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program. An inpatient Hospice Facility must document the need for the facility and justify the number of inpatient beds that are being requested. The proposed facility must consider the impact on other existing inpatient hospice facilities.

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. State Health Plan standards;
2. Distribution (Accessibility);
3. Community Need Documentation;
4. Acceptability;
5. Financial feasibility, and
6. Staff Resources

The only existing inpatient hospice facilities is:
Callie and John Rainey Hospice House in Anderson with 32 beds.

There are forty-eight (48) licensed Hospice Programs with at least one licensed hospice serving every county in the state. Additional information may be found at www.scdhec.net under health regulations.

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D. Swing Beds:

To participate in the Swing Bed Program, a Certificate of Need is not required in South Carolina. However, the hospital must be certified. The swing beds concept refers to beds in a hospital which alternate between hospital and long-term care and are occupied by long-term care patients for periods of a few days to several weeks. This concept does not refer to hospital beds being designated as nursing home beds and does not necessarily involve moving beds or patients into separate areas of the hospital.

Swing beds can be the link between inpatient acute care and home and community-based services, in a continuum of care for those patients requiring long-term care. Although the goal is to return patients to the community, this is not always possible. Should a return to the community not be possible, the swing bed hospital assists the patient and family with nursing home placement. The swing bed program improves the coordination of long-term care services within the community.

Section 1883 of the Omnibus Budget Reconciliation Act of 1987 amendments permit payment under Medicaid or Medicare for extended care services to any hospital that meet the following requirements:

-- Has a Medicare provider agreement;
-- Has fewer than 100 certified beds, excluding newborn, ICU/CCU beds, beds in certified "distinct part" SNFs and NFs, and beds in PPS-excluded distinct part psychiatric and rehabilitation units;
-- Is located in a rural (non-urbanized) region;
-- Has been granted a Certificate of Need for the provision of extended care services, if required by the State;
-- Does not have in effect a 24-hour nursing waiver;
-- Has not had a swing-bed approval that was terminated within the last two years; and
-- Meets the Skilled Nursing Facility (SNF) Conditions of Participation on resident rights, specialized rehabilitation services, dental services, social services, resident activities, discharge planning, admission, transfer and discharge rights and resident behavior and facility practices. The Code of Federal Regulations (CFR) section 42 Subpart A, section 482.66 details other specific requirements.

In addition, hospitals that have 50-99 beds and meet the above criteria must also meet the following criteria for approval:

1. The hospital must identify and enter into a transfer agreement with all of the Medicare SNFs in the geographic region. The SNF will notify the hospital when a post-hospital SNF care bed becomes available and the date it becomes available;

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2. The hospital agrees to transfer the patient to the SNF within 5 work days (excluding weekends and holidays) of the availability date unless the patient's physician certifies that the transfer is not medically appropriate;

3. If beds are available in more than one SNF, the patient will choose the SNF to which he or she will transfer. The transfer must occur, however, within 5 work days from the day the first bed becomes available.

The following hospitals in South Carolina either meet the swing bed eligibility requirements or participate in the swing bed program:

Hospital	Swing Beds	Admissions	Patient Days	Average Census
Abbeville Co. Mem. **	18	14	69	0.2
Allendale Co. **	18	32	4521	12.4
Bamberg Co. Mem. **	24	409	1984	5.4
Barnwell Co. **	24	22	300	0.8
Beaufort Co. Mem.	--			
B.J. Workman **	21	45	7663	21.0
Cannon Memorial 1/	25	48	300	0.8
Carolinas-Kingstree **	39	21	1592	4.4
Carolinas-Lake City **	23	51	1304	3.6
Chester County	--			
Chesterfield Gen.	--			
Clarendon Memorial	--			
Edgefield Co. **	19	58	4922	13.5
Fairfield Memorial **	15			
Hampton Regional **	10	49	553	1.5
Hilton Head	--			
Laurens County	--			
Loris Comm.	--			
Low Country	--			
Marlboro Park 3/ **	--			
Newberry Co. Mem.	--			
Saint Eugene Med. Ctr.	--			
Wallace Thompson 2/	12	5	48	0.1
Wilson Medical Ctr **	24	176	5785	10.4
TOTALS	276	930	29041	79.6

** Participates in the swing bed program.
1/ Discontinued swing bed program 10/1/2002.
2/ Discontinued swing bed program 1/1/2003.
3/ Approved for swing bed program 5/1/2002.

The number of swing beds listed above is the number that the hospital reported. In 2001, there were 13 hospitals participating in the swing bed program with 930 admissions and 29,041 patient days for an average length of stay of 31.2 days. The average number of patients per day in swing beds was 80.

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E. Home Health Agencies

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan, and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

The average mix of home health visits by type of service during FY 2001 for the home health agencies in South Carolina were:

Total Visits	1,426,895
Nursing visits	45.8%
Home health aide visits	15.5%
Physical therapy visits	27.4%
Medical social worker visits	1.8%
Speech therapy visits	3.2%
Occupational therapy visits	5.9%
Other	0.4%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Some of the reasons for the increased demand through 1997 for home health services include: the Prospective Payment System, which encourages hospitals to reduce the average length of stay for most Medicare patients; changes in employee benefit plans which include economic incentives for home care; a greater awareness of community-based services such as home health, home-delivered meals, and adult day care; managed care and increased physician acceptance. The utilization of home health services has decreased since 1997 primarily due to the Balanced Budget Act

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of 1997, which cut reimbursement and the number of allowable visits.

Of the current patients receiving home health services, approximately 40% are less than age 65 and 60% are age 65 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

STANDARDS:

Applications for home health agencies must comply with the following standards:

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

3. There should be documentation from physicians and discharge planners in the proposed service area substantiating the need and support for an additional home health agency. These need and support letters must be on letterhead and define which practice and specialty or facility the physician/discharge planner represents as well as the county from which their patient base will be drawn. They must clearly state the number of additional patients that will be referred to a new home health agency and why another home health agency is needed. The physician or discharge planner must also personally sign these letters. If there are problems with the existing agencies serving the area, the physicians and discharge planners should state the reasons.

4. The attached table indicates the counties where one additional home health agency could be approved or an existing home health agency expanded. This table is based on the number of persons served per thousand population and the projected maximum number of agencies needed per county based on the projected population (see following table). Counties that are below 75% of the state average of patients served per thousand population and have less than the maximum number of agencies based on the projected population could accommodate one additional agency in order to assist the residents of the county in receiving services. Only these counties will be approved for an additional service. NO ADDITIONAL AGENCY WILL BE APPROVED IN THESE COUNTIES UNTIL THE APPROVED AGENCIES HAVE BEEN LICENSED AND A YEAR OF UTILIZATION DATA ARE AVAILABLE AND HAS BEEN INCORPORATED INTO THE METHODOLOGY.

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MAXIMUM AGENCIES PER THOUSAND POPULATION

<30k pop. = 2 HHA's
30-50k pop. = 3 HHA's
50-75k pop. = 4 HHA's
75-125k pop. = 5 HHA's
125-175k pop. = 6 HHA's
175-225k pop. = 7 HHA's
225-275k pop. = 8 HHA's
275-325k pop. = 9 HHA's
>325k pop. = 10 HHA's

5. The applicant should have a track record of providing indigent care or a documented proposed plan for serving these patients. The applicant must provide for the past three years, the number of indigent people served, the number of indigent visits provided, the dollar amount of these services and the percentage of gross revenue devoted to indigent care. This does not include bad debt or contractual adjustments. The application must also include a pro-forma budget that contains both the dollar amount and percentage of gross revenue proposed for indigent care for the first three years of operation.

6. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state where it operates. If licensed in another state, the name, address, and telephone number of the licensing agency and a contact person at the State Agency must be provided.

7. The applicant must document that they can serve at least 50 patients annually in each county for which they are licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to less than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county.

8. Because of the limited number of patients that would require Home Uterine Activity Monitoring and administration of tocolytic therapy that requires obstetrical staff expertise and 24 hour fetal monitoring, an exception to the above criteria may be made for a Certificate of Need for only this restricted service. Only one Certificate of Need application will be required for a home health agency that proposes to provide this specialized service for the 25 counties that currently do not have this service. The applicant must document that no other provider offers this service in the counties and that the agency will only provide services to obstetrical patients. The license for the agency will be restricted to serving obstetrical patients only.

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If the license is terminated, another agency will be approved only if the methodology indicates a need for another agency.

Continuing Care Retirement Community Home Health Agencies

A licensed continuing care retirement community which also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

a. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;
b. The continuing care retirement community maintains a current license and meets applicable home health agency licensing standards;
c. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on nonfacility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, the utilization is not counted as serving the community.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating Certificate of Need applications for this service:

a. Need;
b. Acceptability;
c. Distribution (Accessibility);
d. Medically Underserved Groups;
e. Record of the Applicant; and
f. Financial Feasibility.

-ecause home health agencies provide services in every county and there are at least two providers per county, there is no justification -or approving additional agencies beyond those shown as needed in this lan. The benefits of improved accessibility do not outweigh the

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adverse affects caused by the duplication of any existing service.

The home health agency inventory follows. The persons served and visits are based on Home Health Agency Reports. The "cut-off" date for inclusion in the inventory was July 1, 2003.

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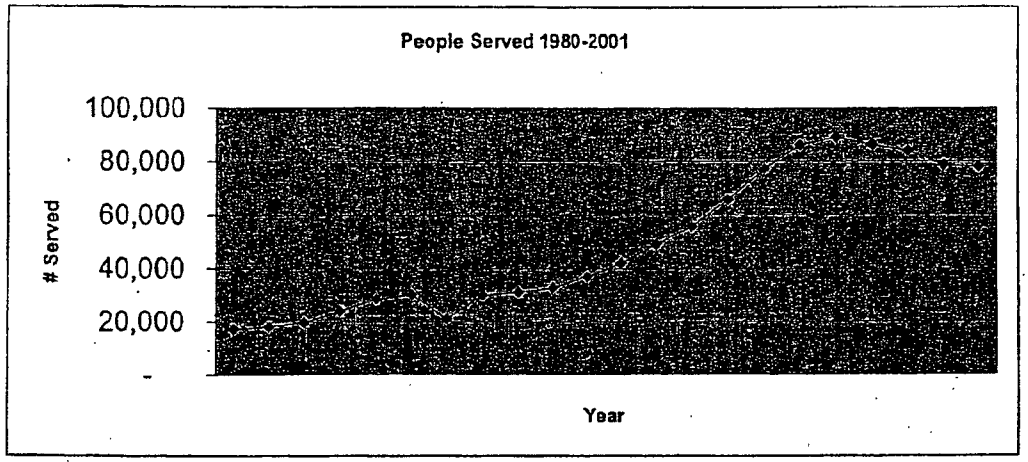
HOME HEALTH UTILIZATION, 1980-2001

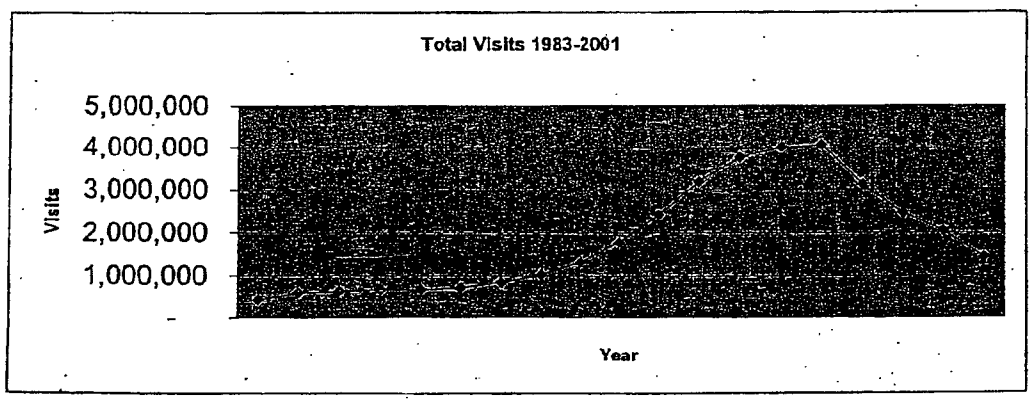
YEAR	PEOPLE SERVED	TOTAL VISITS	VISITS/ PATIENT
1980	17,120	-------	------
1981	18,021	-------	------
1982	19,751	-------	------
1983	24,013	427,759	17.8
1984	28,511	590,657	20.7
1985	30,360	631,498	20.8
1986	21,012	672,361	32.0
1987	30,004	673,346	22.4
1988	31,230	710,756	22.8
1989	32,727	843,514	25.8
1990	36,827	1,024,177	27.8
1991	41,912	1,307,371	31.2
1992	49,035	1,767,825	36.1
1993	55,551	2,417,241	43.5
1994	65,754	3,192,689	48.6
1995	77,214	3,755,027	48.6
1996	86,070	3,995,110	46.4
1997	88,711	4,055,843	45.7
1998	86,123	3,131,997	36.4
1999	83,969	2,472,078	29.4
2000	78,542	2,041,754	26.0
2001	77,869	1,427,436	18.3

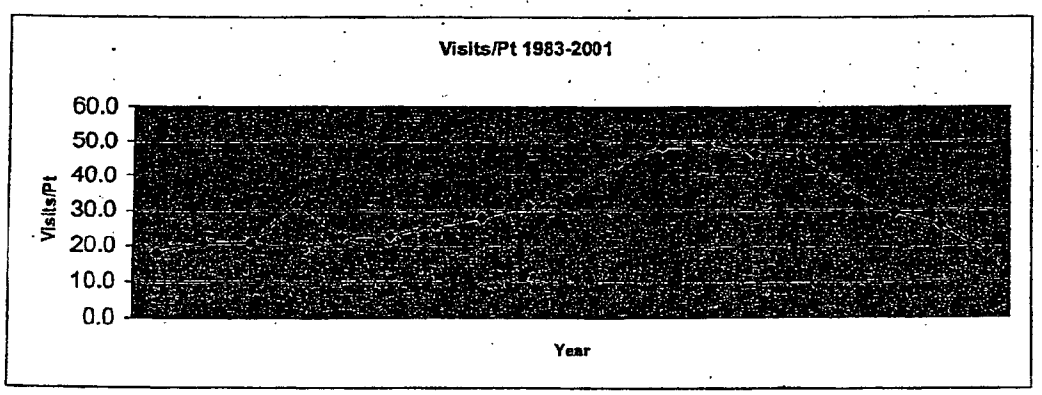
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