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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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

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

v.

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

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

RECORD ON APPEAL - VOLUME VII OF XVII

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- Select and script citizen spokespersons for presentations at *Ft Mill Times* forum and DHEC project review. Cover these topics:
  - structure of community advisory boards for hospital and 24/7 clinic;
  - position on charity care;
  - community benefits in general;
  - remind that Tenet gets dollars to pay taxes from the patients it serves;
  - Disproportionate share - public funds
  - not offering a satellite hospital but a community hospital;
  - don't over-emphasize Huntersville/Matthews community hospitals as a "cookie-cutter" or package that we're selling…

- Revisit communities and promote benefits such as 24/7 in York with mailings and ads to support in Clover, Lake Wylie, etc.
- Update York County info on Presbyterian/Novant websites.

3) Position Presbyterian favorably in the news media.

- Feed information about support letters and excerpts from community impact study to use in opinion-editorials.
- Coordinate letters-to-the-editor campaign.
- Place stories with local media as well as *Charlotte Observer* and *The State*.
- Assess impact of Hugh McColl's TV spot; do we use TV?

4) Influence legislative and congressional delegations and other elected officials to understand public sentiment for Presbyterian.

- Determine status of visits to General Assembly and DHEC board; make appointments and follow through (new letters from Spratt, Norman, etc?).
- Coordinate campaign to send letters from citizens and physicians.
- Make presentation to York City Council on urgent care facility (drawings, etc).
- Strengthen SC ties by aligning with Palmetto Health/USC School of Medicine.
- Identify Presbyterian board's ties in SC and assign Carl to make strategic contacts.

IMMEDIATE NEEDS:

- Updated list of letters; copies of letters from physicians and politicians, etc;
- Time with legal team to get schedule/timelines for all processes in play;
- Weekly status meetings
- Meetings for Carl with Nicole Bell of *Observer* and Julie Graham of *The Herald* so they will know him before public hearing
- Good community opportunities for Carl to make a "stump" speech

# # #

RECYCLED PAPER
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Patient Testimonials
Piedmont Medical Center
June 2011

Art Towns

My name is Art Towns and I'm from York County. Piedmont Medical Center saved my life. June 11, 2009 I showed up dead with a cardiac arrest. My heart stopped three times on the way here. They shocked me 16 times, worked on me for nearly 80 minutes trying to get a heartbeat that would sustain my life. I believe beyond a shadow of a doubt that if Piedmont wasn't here I'd be dead. The staff was excellent. They treated me no so much as a patient but as a human being. I thought the level of care was great. If they can get me through what I went through, then they can get anybody through anything, I think. There were a lot of miracles that happened and the doctors all made the right calls at the right time and I would judge Piedmont Medical Center second to none. I mean, I walked in here dead and came out alive. Piedmont saved my life.

Kathy Bigham

I'm Kathy Bigham from York County. Piedmont Medical Center has just such a huge broad impact on our community. They are sponsors for many of the events in the community, many of our organizations. But they also provide a lot of leadership in our community on our boards and committees and throughout the county. In the fall of 2004, my husband, Larry, experienced a very unusual situation where he was on the phone with me actually and his speech became interrupted. And in his case, minutes did matter because he was experiencing a minor stroke. And the doctors there worked as a team to find out what was actually going. And

they were very diligent in their testing and because of that they found his problem. You know, Piedmont Medical Center is a true comprehensive medical center and a lot of times as a community, we don't realize that until we need them, but when you need them, you realize how valuable they are.

Mike Smith

I am Mike Smith and I'm from York County. Our community needs Piedmont. Personally, I have been a patient at Piedmont. I have had surgery at Piedmont. My wife has had surgery at Piedmont. Both of my children were born at Piedmont and I've never seen any quality of care that has been better. All of the schools in the county all have certified athletic trainers and the sports medicine staffs at these schools all use Piedmont Medical Center. They refer the families to the Piedmont Medical Center because of the fact that they are local and the quality of care, and the physicians who have privileges there are wonderful physicians as well. And we are able to have conversations with them on a professional level that is a benefit to our athletes. **[Note: One of the four York County school districts now uses a healthcare system other than Piedmont.]**

Amy Faulkenberry

I am Amy Faulkenberry from York County. Piedmont is much more than just a hospital that York County depends on. They are a huge partner in this community. I actually had both of our boys, now ages 3 and 7, at Piedmont and had a wonderful experience both times. You are nervous, excited, you know, just the anticipation of it all, and I think the staff there completely

gets that. I mean, there is just a certain piece of mind that they provide especially to that first-time mother I don't know that you get anywhere else.

Butch Brendell

I am Butch Brendell from York County, South Carolina. Piedmont Medical Center, they were all about getting it right. I have been to Piedmont twice in emergency situations. First time when I had a stroke while I was driving on Interstate 77. Then I had a second episode here this year and about 10:00 or 10:30 I told my wife to call the ambulance because it felt like two or three elephants and everybody else in Rock Hill sitting on my chest. But my enzyme tests were normal, my EKG was still normal, and my blood pressure was normal. They kept after it, and they kept after it, and they said, well, I tell you what, what do you think if we just put you in cardiac rehab and watch you for a little while. And then within a few minutes after going into cardiac rehab they came in and said you are having a heart attack; the doctor is on the way. If they had sent me home, the least that would have happened is that I would have been back. The worst that could have happened I might not be sitting here talking to you today. I can't imagine you could get any better quality. Well, like I tell people, Piedmont Medical Center saved my life twice. I mean that's all the quality I need. It was there; I got the best.

###

RECYCLED PAPER
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Transcript of the Testimony of
CMHA, ET AL V. SCDHEC, ET AL

Date: September 9, 2009

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Condensed Transcript and Word Index

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1 last sentence on that page.
2 MR. WESTBROOK: And Dan, if you would highlight that
3 for us, pull it out. That's good. Yeah, there
4 you go.
5 Q: And Ms. Fechtel, that sentence reads, "The
6 benefits of improved accessibility will be
7 equally weighted with the adverse effects of
8 duplication in evaluating Certificate of Need
9 applications for these beds"; is that correct?
10 A: Yes.
11 Q: So the State Health Plan has an adverse impact
12 requirement as well; is that correct?
13 A: Yes.
14 Q: And, in fact, that Plan requires DHEC to give
15 equal consideration to both accessibility and
16 adverse impact; does it not?
17 A: Yes.
18 Q: Okay. Let's go back to your summary sheets now,
19 and I want to go to Bates page 895 of your
20 summary sheets. Do you have those?
21 A: Which of the --
22 Q: I'm sorry of the four, the summary sheets, yeah.
23 MR. WESTBROOK: And Dan, if you could call out that
24 second paragraph, please.
25 Q: This is the one we discussed yesterday, Ms.

1 facilities, she was really looking at that as
2 being a negative on the existing facility in
3 the area, which was Piedmont, and thinking that
4 really was a low rank because didn't see it as
5 having a real significant adverse impact. But
6 looking at the standard in the Plan, yeah, I
7 think it -- thinks changed. It probably should
8 have been there together both under number two.
9 But that was just -- I think what happened, it
10 wasn't an intended error, but I thin the Plan
11 changed and based on history, memory, that's
12 why that wasn't caught.
13 Q: Thank you. Now, let me see if I understand.
14 What I think you just, what you just said, and
15 you correct me if I'm wrong, is that under the
16 Plan, Ms. Fechtel should have ranked
17 accessibility and adverse impact equally; is
18 that right?
19 A: Based on this language, and it -- it would be
20 less argument if it were. Yes, I mean, based
21 on what the Plan says, and the Plan is very
22 important in the decision making process, I
23 agree. But here again, I think the reason that
24 got changed, it was thinking in the past where
25 most of the Plan used to say one outweighed the

Exhibit I

Angel MedFlight
Carrying out an air ambulancemission (medical flight)
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category: hospital industry

Are nonprofit hospitals truly not for profit?: Tax breaks rankle some critics, who ask: "What are you giving the community?" [The Orlando Sentinel, Fla.]

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JUL 31

Aug. 01When Florida Hospital and United Healthcare started their public wrangling over a new contract this summer, each side pointed to the other company's profits.

Both companies are health-care behemoths. Minnesota-based United Healthcare is the largest health insurer in the United States, with profits of $3.8 billion in 2009. Adventist Health System, which operates Florida Hospital system, is the largest nonprofit Protestant health-care provider in the nation, operating 37 hospitals in 12 states and generating $363 million in profit in 2009.

But in the high-dollar world of health care, what does it mean to be a nonprofit hospital that makes big profits?

"If you go back 100 years, these were charity hospitals. They took care of the poor," said Frank Sloan, a professor of health-care economics at Duke University. "But as health care has grown, they've become commercial. Now these nonprofits are in a big business."

Today's nonprofit hospitals which make up slightly more than half of the nation's 5,000 community hospitals are trying to juggle the demands of making money with being a charitable organization.

"You're supposed to show a good bottom line, but at the same time you're supposed to show that you lost tons of money by giving charity care," said Jessica Berg, a law professor at Case Western University who has studied the nonprofit-hospital system and its tax structure. "We're used to thinking of churches and religious organizations as nonprofits whoever thinks of a for-profit church?"

For legislators across the country, there's growing tension that massive nonprofit-hospital organizations don't pay any taxes.

"The question is: What is the nonprofit doing that for-profits are not? We're giving them a huge tax benefit," Berg said. "So what's the trade-off? You're not paying taxes, so what are you giving the community?"

Charity care

For nonprofit hospitals, much of the community benefit is measured in two ways: through charity care and "community-benefit programs," which can range from health fairs to glaucoma screening. At Florida Hospital, those programs also include a diabetes-prevention program among Hispanics in east Orange County and a congestive- heart-failure clinic for those with

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Medicaid or no insurance.
Charity care the free care that hospitals provide to those with no insurance or the amount of a bill they write off because the patient is unable to pay has come under more fire from legislators across the country as questions arise about how much the hospitals are writing off.
In 2008, in documents provided to the state of Florida, Florida Hospital reported spending $442 million or 7 percent of its patient revenues on charity care. Its competitor, nonprofit Orlando Health, spent $213 million or 4 percent of its patient revenues on charity care.
Florida Hospital accepts more Medicaid patients than any hospital system in the state except Jackson Memorial in Miami, said Richard Morrison, Florida Hospital's regional vice president for governmental relations.
Yet the amount of charity care the hospitals are providing is unclear, said Becky Cherney of the Florida Health Care Coalition. If the hospital performs an appendectomy on an uninsured person, she said, hospital officials may write off the "full price" of the care at $11,000, but insurance companies, which negotiate rates, pay about half that. So what's the real cost to the hospital?
"When they do their charity care, they take the whole $11,000," Cherney said.
And everybody in the business, said Berg, "knows that that's a make-believe number."
Hospitals on a spree
Though for-profit hospitals send their profits back to shareholders, nonprofit hospitals can pump those profits into community-health programs, charity care and financing new technology and buildings.
The hospital system has invested in liver- and heart-transplant programs, which are not moneymakers, Morrison said. And, to support the new University of Central Florida medical school, Florida Hospital has expanded the number of medical residents it accepts at its cost.
"You put money into services that the community needs, but that are not necessarily something you would invest in ordinarily," Morrison said.
In the past decade, Central Florida's two competing nonprofit-hospital systems have been on a building spree, trying to gain market dominance.
Florida Hospital has increased the size of several of its existing hospitals for example, the recent 300-bed expansion at Florida Hospital Orlando and expanded its reach into other counties with its network of 18 hospitals. In June, Florida Hospital executives signed a five-year operating agreement with Bert Fish Medical Center in New Smyrna Beach with an option to buy the hospital. In the Tampa area, Florida Hospital is negotiating to buy three hospitals and a long-term-care center.
Orlando Health operates six hospitals and partially owns two more, one in Osceola County and another in Lake County.
"These are turf wars," Cherney said. "We have two competing systems, so they both want to be sure they're in the right place. And Florida Hospital is very aggressive about the turf war."
The problem, she said, is that nonprofits such as Florida Hospital and Orlando Health also are buying doctors' practices and lab services, squeezing out competition.
"They're not just buying hospitals," Cherney said. "They're buying doctors' practices that operate in these hospitals and then that's a true monopoly."
Hospitals in such an arms race "probably overbuild, over-technologize, and quality often will go down," said Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance.
Once they invest in expensive technology like robotic surgery systems or MRIs, hospitals have to use the machines frequently or raise rates.

"Unless you use it all the time, you're going to have to charge more for it," Anderson said.

Customer satisfaction

In recent years as local nonprofit hospitals have expanded, their new wings look less like old-fashioned hospitals and more like high-end hotels. That may rankle critics, but experts say that hospitals even nonprofits are competing for customers.

"From an economic point of view, they're doing exactly what they should be doing," said Anderson at Johns Hopkins. "The flat-screen TVs and fancy buildings attract patients. And since the patient doesn't really have to pay more for the flat-screen TVs" because the rates have been negotiated "they are going to go to them."

And, because Medicare scores hospitals in part on patient satisfaction, a hospital with the latest amenities may come out ahead.

"Nobody wants to be sick and stuck in a tiny little room and people don't like sharing rooms, either," said Florida Hospital's Morrison. "So the standards for room size have changed over the years."

That conflicts, however, with the old-fashioned notion of nonprofits, Berg said.

"We're a very torn society when we think about health care," she said. "We don't like to accept that it's a business, but we fundamentally insist that it's a business model."

Linda Shrieves can be reached at lshrieves@orlandosentinel.com or 407-420-5433.

More on local hospitals, health care

Florida Hospital doctor's success is model for prostate-cancer surgery

PBS documentary 'The Adventists' will feature Florida Hospital

3-D is a star in robotic surgery

Orlando hospitals give resort treatment to maternity rooms, services

Orlando VA hospital will be national hub for medical simulation training

In 'medical city,' eating, shopping options remain scant

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A WHITE PAPER PRESENTED BY NATIONAL CITY

The Tax Status of Not-for-Profit Hospitals Under Siege & The Financial Implications of Recent Attacks

In a growing wave of litigation and scrutiny, critics charge that modern not-for-profit hospitals and healthcare systems fail to qualify for charitable status under state and federal laws.

Keith Anderson
Partner
Gardner, Carton & Douglas

George Gevas
Senior Vice President / Regional Manager
National City

A battle is brewing over the legal status of not-for-profit hospitals and healthcare systems. The opening salvo was fired in the summer of 2004 when plaintiffs' attorneys, led by The Scruggs Law Firm of tobacco litigation fame, filed federal class-action lawsuits in eight states against roughly a dozen not-for-profit hospital systems.

The suits alleged that the not-for-profit institutions had violated their "explicit or implicit contract" with the federal government to serve uninsured patients, in return for significant tax breaks. These not-for-profits, the suits claimed, had charged uninsured patients "premium" rates even though insurers, HMOs and government programs paid steeply discounted rates. Some suits also cited aggressive billing and collection tactics, including placing liens on homes and assessing interest, fines and legal fees.

In the wake of this litigation, other parties across the country quickly stepped up their scrutiny of not-for-profit healthcare organizations. Community advocates, state and municipal tax commissions, and state attorneys general all began asking one central question: Are charitable hospitals living up to their stated mission of providing charitable care to all who need and apply for it?

"It is a multi-faceted onslaught that has been occurring over the last 18 to 24 months," says Keith Anderson, a partner in the Chicago law office of Gardner, Carton & Douglas, a firm whose practice focuses on business, transactional and regulatory matters for not-for-profit and for-profit healthcare entities. "What we've begun to see is a focus on the obligations of not-for-profits, and what they need to give back to the community in exchange for the tax breaks they receive."

National City

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JOINT-B-PMC-001.0851

RECORD 002956

The Background On a Hot Issue

Historically, there has been little dispute that not-for-profit hospitals qualify for charitable tax exemption. Typically, hospitals are exempted from federal income tax if they qualify as charitable organizations under section 501(c)(3) of the Internal Revenue Code and provide care to all patients in need – regardless of their ability to pay. Likewise, the interest on tax-exempt bonds used to finance not-for-profit hospitals and health systems is not taxable to the bondholder. On the state level, hospital corporations must meet the obligations of their state's not-for-profit corporation acts and, in some respects, their state constitutions.

Of course, exceptions have occurred. During tight economic times, taxing authorities – notably, in Pennsylvania, Utah and Texas – sought new sources of revenue and developed bright-line exemption tests. In several cases, hospitals lost their property tax exemption, for example, when it was determined that they:

1. Served primarily paying patients;
2. Charged services to all patients able to pay;
3. Verified patients' financial ability to pay.

"That kind of scrutiny is, in part, what we are seeing now," says George Gevas, Senior Vice President and Regional Manager of Corporate Banking, National City. "Critics charge that modern not-for-profit hospitals and health systems fail to qualify for charitable status because they do not dispense charity to all who need and apply for it, and that they seem more focused on their balance sheet and financial stability."

Recent actions against not-for-profit hospitals:

- Federal and state class action lawsuits
- Challenges to state property tax exemptions
- Attorneys general investigations
- IRS investigations and audits
- Congressional investigation
- Proposed state legislation

Property Tax Exemptions Take a Hit

The 2004 federal lawsuits appear to have piqued the interest of municipal and state taxing authorities, which began questioning the exemption of not-for-profit hospitals from property taxes in several notable cases:

Illinois – Provena Covenant Medical Center in Urbana became the first not-for-profit hospital in the state to ever be denied property tax exemption, in part because of its overly aggressive attempts to collect money from poor and uninsured patients. The Illinois Department of Revenue agreed with the assessment of the Champaign County Board of Review, which found that the hospital didn't prove that the property was being used in a charitable manner. The loss of its property tax exemption could cost the hospital $1 million a year.

Status: Provena has appealed the decision and is currently awaiting a final ruling from the Illinois Department of Revenue.

Illinois – Likewise, in 2004, the Champaign tax board recommended that the state deny charitable exempt status for the Carle Foundation Hospital, Urbana's other main hospital. The recommendation was based on claims that less than .5 percent of its assets and/or revenue were devoted to charity care.

Status: Carle Foundation appealed this recommendation with the Illinois Department of Revenue. A decision is pending, depending on the outcome of the Provena case.

Ohio – In September 2004, the Ohio Tax Commissioner recommended against charitable tax exemption for a family health and surgery center of an academic medical center. Among the factors cited were that less than 2 percent of charitable care was provided to indigent persons or those who could not afford the full cost of care. It was claimed that the property was primarily used to generate revenue.

Status: The case was dismissed because property taxes, assessments, penalties and interest sought to be exempted had not been paid in full. But the case was recently re-filed and remains pending.

Attorneys General Cite Consumer Fraud

Attorneys general in several states have also weighed in, claiming that not-for-profit hospitals are running afoul of contract law by unfairly pricing and billing their services.

In Minnesota, for example, the attorney general's office took the view that a two-tier pricing policy existed in that state. The tier one cited was that insured patients were receiving a discount negotiated by their insurance companies or managed care plans. The second tier cited was that in not having access to those same discounts, uninsured patients were being charged full prices. The AG's office made it very clear that it would begin lawsuits unless hospitals were willing to abandon that practice.

To date, more than 60 Minnesota hospitals have signed a settlement arrangement and have effectively agreed not to charge uninsured patients who earn less than $125,000 per year anything greater than what they charge their biggest insurance payer. "The bottom line is that AGs are comparing notes and considering whether not-for-profit hospitals and systems are delivering on their missions and community commitments," says Anderson. "The Minnesota approach has begun to be widely accepted and endorsed by a number of attorneys general around the country."

What Triggers Trouble?

Common themes running through these cases include:

- Substantial profits, but a small percentage of those profits spent on charity care
- Grants and contributions are a low percentage of gross revenue
- Extensive screening to qualify for financial assistance programs
- Failure to advertise charity and financial assistance

Billing Practices Get Blasted

In addition to coming after their exemptions from state property taxes, state attorneys general have also turned their attention to what they claim are not-for-profits' heavy-handed billing and collection practices. News accounts of elderly persons losing their homes and retirement savings to hospital garnishment actions or liens have only fanned the flames.

"The AGs and revenue authorities have taken the position that billing every admitted patient constitutes evidence of a non-charitable hospital," says Anderson. "So, if an organization's approach to charity care is that everyone is going to get a bill and, once they get the bill, they can come in to talk about potential charity care, the hospital is placing itself at risk of scrutiny."

IRS Eyes Executive Compensation

A number of hospitals and health systems have also received letters over the past year from the IRS requesting documentation on executive compensation and benefits, deferred compensation plans, and executive contracts. In some circumstances, these soft audits have led to full-blown IRS audits and scrutiny of the entire not-for-profit operation. In addition, there appears to be increased interest by the IRS in joint ventures between not-for-profit hospitals and for-profit or private individuals, including physicians.

What Charity Care Is...and Is Not

So, just exactly how much charity care is enough? "That's a big part of the challenge," says Anderson. "There really are no standards for measuring charity care."

Some state revenue departments have taken the position that charity care is the only factor in a not-for-profit's exemption analysis. For example, unreimbursed Medicare or Medicaid costs have been deemed irrelevant to the qualification for charitable property tax exemption. In addition, health education activities – health fairs, lecture series and screenings – have been viewed simply as marketing and public relations expenditures, not evidence of providing charity care.

"The AGs and revenue authorities have taken the position that billing every admitted patient constitutes evidence of a non-charitable hospital. So, if an organization's approach to charity care is that everyone is going to get a bill and, once they get the bill, they can come in to talk about potential charity care, the hospital is placing itself at risk of scrutiny."

- Keith Anderson
Gardner, Carton & Douglas

State Legislators Weigh In

As the battle wages on, several states are contemplating legislation that provides more definite requirements for not-for-profit hospitals.

- Among other things, the Tax-Exempt Hospital Responsibility Act ("TEHRA") proposed by the Illinois Attorney General would require all tax-exempt hospitals to provide uncompensated care equal to at least 8 percent of their total operating costs, and file an annual charity care report with the AG.

- The Hospital Fair Billing and Collection Practices Act ("HFBCPA") would require all Illinois hospitals to refrain from aggressive and harassing collection measures, including refraining from billing patients during the 60-day period post-discharge.

- Ohio's legislature has had hearings into whether not-for-profit hospitals are meeting their duty to provide charitable care and has explored having hospitals make Payments in Lieu of Taxes ("PILOTS").

In addition, Congress has indicated its intent to reform tax-exempt organization laws that have not been modified since 1969. These reforms are likely to focus on transparency, board governance, charity care policies, community benefit standards, and billing or debt-collection activities. U.S. Sen. Chuck Grassley (R-Iowa), Chairman of the Senate Finance Committee, recently stated that he will propose new reforms for tax-exempt organizations, including hospitals, later this year.

NFP Litigation – The Numbers

Efforts to consolidate the more than 75 federal class action lawsuits that were filed during the first wave of litigation were quickly rejected. Twenty-nine federal cases have been dismissed in whole or in part for a variety of reasons, including the conclusion by some federal courts that a private citizen did not have a right to bring a case to enforce the 501(c)(3) section against another private citizen or public not-for-profit hospital.

Many of the plaintiffs then dismissed their federal cases in order to preserve their claims and to refile their cases at the state level. A number of those cases are still pending. Some have been dismissed. Some discovery is being permitted in others.

Federal Cases

- [illegible] Motion to Dismiss
- [illegible] Dismissed by Plaintiffs
- [illegible] Remanded to State Court
- [illegible] Undecided
- [illegible] On Appeal

State Cases

- [illegible] Decisions
- [illegible] Dismissed on Motion to Dismiss
- [illegible] Dismissed on Merits
- [illegible] Dismissed with Leave to Amend
- [illegible] Denying, in Whole or in Part, Motions to Dismiss

Potential Financial Implications

The financial implications of a hospital losing its not-for-profit status under state and/or federal law are substantial.

A hospital or health system that is suddenly faced with a multi-million dollar tax bill must obviously divert funds away from providing health care services. "That could have a direct negative impact on access to, and the quality of, healthcare in a community," Anderson says. "That's a big concern because, in many communities, the not-for-profit hospitals are the safety nets. There are very few hospitals today that are county tax-funded."

A hospital that loses its 501(c)(3) status could also face serious challenges with regard to any tax-free bonds it issued. "Those bonds would become subject to federal income tax that may be retroactive to the date of issuance," says Gevas of National City. Cross default clauses in the financial documents could also trigger default of other tax-free bonds the hospital issued.

"If the bonds were to become included in gross income, they could be accelerated pursuant to the terms of the trust indenture, or they could be put back by the bondholders to the remarketing agent," Gevas says. Then there is the issue of future bond issues. "It is going to be a lot more expensive, borrowing on a taxable basis, for a hospital to put up a new cancer center, expand a campus or add new equipment," says Gevas. "It really is a substantial tax liability on income of the hospital, which could have a material adverse effect on the financial condition of the hospital."

Fund-raising could also be impacted if a hospital loses its not-for-profit status. "Those individuals and institutions that are giving to a hospital are deducting the contributions from their taxes," says Anderson. "The philanthropic support may be impaired if the organization loses its tax-exempt status."

The Bottom Line

Unfortunately, the issue of how hospitals treat the uninsured is likely to continue drawing attention, especially as people experience the high price of health care themselves and become more sensitized to the issue. "It's not something that will simply go away," says Gevas. "Not-for-profit hospitals need to make sure that they are not only providing charity care but also documenting it and communicating those efforts."

"Not-for-profit hospitals need to make sure that they are not only providing charity care but also documenting it and communicating those efforts."

- George Gevas
National City

Action Steps

In light of the heightened scrutiny, not-for-profit healthcare organizations would be well advised to thoroughly evaluate their charity care policies and debt-collection activities.

Step 1: Evaluate Your Charity Care Policies

"Not-for-profit healthcare organizations need to seriously look at their charity care policies – when they advise patients of the policy and how they make charity care available," Anderson says. "It really becomes a question of, 'Are you operating in a way that makes you susceptible to scrutiny?'"

Questions to ask include:

- Has your governing board established a written charity care policy with clear guidelines for determining which patients qualify for charity care?
- Is this policy consistently applied?
- Does your organization have a policy for offering discounts or reduced-fee services to uninsured patients who do not qualify for charity care?
- Does your hospital effectively communicate its charity care and discount policies?
- Is the amount of charity care provided by your hospital responsive to the needs of your community? Is it consistent with that provided by other hospitals in your area?

Step 2: Evaluate Your Billing Policies

The American Hospital Association (AHA) has encouraged hospitals to adopt voluntary reforms concerning billing and collection. "In evaluating billing and collection policies and procedures, it's important to make your charity care policies known and publicized upfront," Anderson says. "Prior to discharge, a patient should be clearly advised of what options are available in terms of charity care, discounts and installment payment mechanisms."

Questions to ask include:

- Has your staff been educated on the hospital's charity care, financial assistance, and billing and collection policies and procedures?
- Are uninsured patients provided (and informed of) a 60-day stand-still period following discharge, during which time they can apply for charity care?
- For uninsured patients who do not qualify for charity care, do you offer a patient-friendly billing process and the opportunity to enter into a reasonable payment plan?
- If your hospital is under an agreement with a debt collection agency, does the agreement permit you to dictate the debt collection practices?
- Before any legal action is pursued, does your board get involved and approve any post judgment collection efforts?

About The Experts

Keith Anderson is a partner in the Chicago law office of Gardner, Carton & Douglas. His practice focuses on business, transactional and regulatory matters for not-for-profit and for-profit healthcare entities. Keith is regularly involved in negotiating and structuring health industry mergers, acquisitions and joint ventures, and physician hospital initiatives. Keith graduated from George Washington University, J.D., 1982, and DePauw University, B.A. 1979.

George Gevas is a Senior Vice President and Regional Manager of Corporate Banking at National City. George has been lending and providing banking services to the healthcare industry for 25 years, including large and community hospital systems, ambulatory surgery centers; physician practices and senior living facilities. George received his BSBA from Miami University, MBA from Capital University and is a graduate of the Stonier Graduate School of Banking.

About National City

National City Corporation (NYSE: NCC), headquartered in Cleveland, Ohio, is one of the nation's largest financial holding companies. The company operates through an extensive banking network primarily in Ohio, Illinois, Indiana, Kentucky, Michigan, Missouri and Pennsylvania, and also serves customers in selected markets nationally. Its core businesses include commercial and retail banking, mortgage financing and servicing, consumer finance and asset management.

At National City, we offer a range of products and services that make your financial issues easier to manage, and positive results easier to obtain. We pride ourselves on being the best financial institution for corporate banking, and a leader in financial services and banking technology. Our goal is to develop long-lasting, high-quality business relationships based on communication, interaction, knowledge, trust and most important, results. For more information on National City, visit www.NationalCity.com.

About National City Webcasts

Information in this White Paper is extracted from a January, 2006 Webcast entitled "Financial Implications of Recent Attacks on Not-For-Profit Hospital Status." A transcript of this Webcast and/or the slides reviewing the Webcast may be accessed at http://www.nationalcityseminars.com; click on "Archived Webcasts". National City also sponsors a series of Webcasts conducted by Richard J. DeKaser, Senior Vice President and Chief Economist, National City. DeKaser discusses economic trends and provides analysis. For more information on these and other Webcasts, visit www.nationalcityseminars.com.

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National City

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PIEDMONT

Piedmont						
FYE 5/31	2009	2008	2007	2006	2005	2004
.E STATEMENT ($000s)						
Total Gross Patient Service Revenue	571,514	554,430	552,993	551,353	510923	539131
Deductions from Revenue:						
Free care valued at charges	20,574	18,326	19,142	22,018	14776	18212
Provision for Bad Debt	26,292	24,981	25,635	19,194	25640	22406
Contractual adjustments	292,703	274,287	280,036	293,210	273256	291147
Net Patient Serv Revenue	231,945	236,836	228,180	216931	197251	207366
Other Operating Revenue	3,334	2,580	2,835	1,873	1567	1862
Total Operating Revenue	235,279	239,416	231,015	218,804	198,818	209,228
OPERATING EXPENSES						
Depreciaton						
Interest						
Supplies	34,410	34,668	35,824	32,313	29,779	29,703
Other operating expenses						
Total operating expenses	215,063	216,677	223,897	201,959	186121	185645
Operating Income -pretax	20,216	22,739	7,118	16,845	12,697	23,583
Taxes:						
Fed income	6,340	7,150	1,671	5,201	3926	7563
State income and franchise	996	1,112	330	834	652	1169
Property Tax	2,011	2,220	2,255	1,894	1390	1885
Bus Lic tax (put into op exp)	175	179	181	367	299	295
Indigent care tax (put into op exp)	7,602	7,373	11,843	1,919	1949	1847
Total taxes excl bus and indigent	9,347	10,482	4,256	7,929	5,968	10,617
After tax income	10,869	12,257	2,862	8,916	6,729	12,966
tax income	10,869	12,257	2,862	8,916	6,729	12,966
Markup	2.6729	2.5707	2.4825	2.7393	2.7535	2.9141
Estimated Medicaid Shortfall	1,537	4,975	9,409	10,209	8347	6351
Free care at cost	7,697	7,129	7,711	8,038	5,366	6,250
Total CB at cost	9,234	12,104	17,120	18,247	13,713	12,601
Estimated Taxes:						
Federal effective rate	0.3299	0.3306	0.2462	0.3248	0.3259	0.3374
State effective rate	**0.0493**	**0.0489**	**0.0464**	**0.0495**	**0.0514**	**0.0496**
Property Tax Rate						
Assessed Value						
Sales Tax Rate						
Estimated Value of Tax Exemption:						
Federal Income Tax	6,340	7,150	1,671	5,201	3,926	7,563
State Income Tax	996	1,112	330	834	652	1,169
Sales Tax	3,230	3,259	2,842	2,735	2,316	2,281
Property Tax	2,011	2,220	2,255	1,894	1,390	1,885
Total Value of taxes paid	12,577	13,741	7,098	10,664	8,284	12,898
CB as % TOR	3.92%	5.06%	7.41%	8.34%	6.90%	6.02%
TE as % TOR	5.35%	5.74%	3.07%	4.87%	4.17%	6.16%
Net benefit as % TOR	**9.27%**	**10.79%**	**10.48%**	**13.21%**	**11.06%**	**12.19%**

PIEDMONT MEDICAL CENTER 2009

	A	B	NOTES
		2009	
1.	**Piedmont**		
2.	**FYE 5/31**		
3.			
4.	INCOME STATEMENT **($000s)**		
5.	Total Gross Patient Service Revenue	571,514	2009 Annual Report, p. 7
6.	Deductions from Revenue:		
7.	Free care valued at charges	20,574	2009 Annual Report, p. 7
8.	Provision for Bad Debt	26,292	2009 Annual Report, p. 7
9.	Contractual adjustments	292,703	2009 Annual Report, p. 7 (281,596 + 11,107)
10.	Net Patient Serv Revenue	231,945	B5 – B7 – B8 – B9
11.	Other Operating Revenue	3,334	2009 Annual Report, p. 7
12.	Total Operating Revenue	235,279	B10 + B11
13.	OPERATING EXPENSES		
14.			
15.	Interest		
16.	Supplies	34,410	B18 x 16%
17.	Other operating expenses		
18.	Total operating expenses	215,063	2009 Annual Report, p. 7 (207,286 + 175 + 7,602)
19.	Operating Income -pretax	20,216	B12 – B18
20.			
21.	Taxes:		
22.	Fed income	6,340	2009 Annual Report, p. 7
23.	State income and franchise	996	2009 Annual Report, p. 7 (906 + 90)
24.	Property Tax	2,011	2009 Annual Report, p. 7
25.	Bus Lic Tax (put into op. exp.)	175	2009 Annual Report, p. 7
26.	Indigent Care Tax (put into op. exp.)	7,602	2009 Annual Report, p. 7
27.	Total Taxes Excl. Bus. And Indigent	9,347	B22 + B23 + B24
28.	After Tax Income	10,869	2009 Annual Report, p. 7
29.			
30.			
31.			
32.			
33.			
34.	Markup	2.6729	(B5 + B11)/B18
35.	Estimated Medicaid Shortfall	1,537	Medicaid spreadsheet from Piedmont (1,238 + 299)
36.	Free care at cost	7,697	B7/B34
37.	Total CB at cost	9,234	B35 + B36
38.			
39.	Estimated Taxes:		
40.	Federal effective rate	.3299	B22 / (B19 – B23)
41.	State effective rate	.0493	B23/B19

Annual Financial Statement FY '09 - Ending May 31, 2009

Funds Available	2009 (000s)
Piedmont Medical Center received:	
For inpatient services	$332,485
For outpatient services	$239,028
Total revenue	$571,514
In Addition, the Medical Center Received,	
From Cafeteria Activity	
From Other Non-Patient Activity	$3,334
Total Non-Patient Revenue	$3,334
Piedmont did not receive full payment for services:	
From Government and Third-Party Payors	$281,596
From Those Unwilling to Pay	$26,292
From Those Unable to Pay	$20,574
From Compact with Uninsured Total	$11,107
Revenue Not Received	***$339,569***
Total Funds Available	$235,278
FUNDS APPLIED	
Piedmont Medical Center Applied Funds:	
To Pay Full- and Part-Time Employees	$68,310
To Provide Employee Benefits	$15,278
To Purchase Supplies, Utilities, Insurance and Other Expenses	$97,094[1]
To Pay Depreciation and Amortization	$10,316
To Pay Interest on Debt	$16,287
Total Expenses	***$207,286***
Pre-Tax Income	$27,993
Federal Inc Taxes	$6,340
State Inc Taxes	$906
State Franchise Taxes	$90
Property Taxes	$2,011
Business License Taxes	$175
Indigent Care Taxes	$7,602
Total Tax Expense	***$17,124***
After Tax Income	**$10,869**
Capital Expenditures	***$10,089***

(1) This amount includes corporate overhead.

PIEDMONT MEDICAL CENTER 2009

	A	B	NOTES
		2009	
42.			
43.	Property Tax Rate		
44.	Assessed Value		
45.			
46.			
47.	Sales Tax Rate:		
48.	**NOT IN $000s BELOW**		
49.	Estimated Value of Tax Exemption:		
50.	Federal Income Tax	6,340,000	B22
51.	State Income Tax	996,000	B23
52.	Sales Tax	3,230,000	Medicaid spreadsheet from Piedmont
53.	Property Tax	2,011,000	B24
54.	Total Value of Tax Paid	12,577,000	B50 + B51 + B52 + B53
55.			
56.	CB as % TOR	3.92%	B37/B12
57.	Tax Paid as % TOR	5.35%	B54/B12
58.	Net benefit as % TOR	9.27%	B56 + B57

CALEND/ /EAR 2009

SRG 8	SRG 8 Description	Total Charges	Estimated Net Revenue	Total Varial Cost	Gross Margin	Total Fixed Cost	Hospital Overhead Cost	Profit/Loss	Profit/ Per Case
None	None Indicated		5,516.09		5,516.09			5,516.09	
05	Charity	21,082,087.20	919,555.72	3,624,843.67	(2,705,287.95)	449,580.67	2,569,224.61	(5,724,093.23)	(3,331.84)
70	Commercial/Other	9,079,146.18	3,125,389.92	1,575,122.82	1,550,267.10	246,480.40	1,125,162.80	178,623.90	45.22
80	Managed Care	160,995,742.13	109,904,935.95	26,228,235.82	83,676,700.13	3,766,074.40	18,459,515.36	61,451,110.37	1,265.00
50	Medicaid	46,397,270.67	15,282,363.43	8,865,303.97	6,417,059.46	1,100,477.58	6,554,125.80	(1,237,543.92)	(109.65)
55	Medicaid Managed Care	32,825,785.79	11,361,085.05	6,283,183.46	5,077,901.59	837,277.62	4,539,716.75	(299,092.78)	(21.37)
40	Medicare	241,550,489.57	71,278,320.69	44,372,066.03	26,906,254.66	5,656,443.88	28,549,392.83	(7,299,582.05)	(182.29)
45	Medicare Managed Care	41,768,627.55	12,308,515.10	7,659,804.72	4,648,710.38	965,461.62	4,826,815.32	(1,143,566.56)	(167.70)
65	Self Pay/Uninsured	34,710,851.14	19,895,150.21	5,975,003.02	13,920,147.19	956,750.98	4,441,884.48	8,521,511.73	381.00
Total:		**588,410,000.23**	**244,080,832.16**	**104,583,563.51**	**139,497,268.65**	**13,978,547.15**	**71,065,837.95**	**54,452,883.55**	

Report Criteria Summary:

Report Type:	SRG
Facilities:	PMC
Date Type:	Admit
Date Range:	Year
Date Selection:	2009
SRG Type:	SRG 8
Patient Classification:	All
Physician Type:	Admitting
Cost View:	Summary
Run Date:	11/22/2010

Sales Tax	
Supplies:	3,064,270.41
Other:	165,851.96
Total:	3,230,122.37

Medicaid Spreadsheet

RECORD 002970

Pied.Supp-COV 0817

JOINT-B-PMC-001.0865

ahd.com

Financial - Carolinas Medical Center

Charlotte, NC 28203

See column headings for cost reporting periods. / Definitions

Balance Sheet

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Amended	Reopened
Assets					
Current Assets	$428,413,621	$462,897,276	$714,205,355	$504,755,907	$337,071,918
Fixed Assets	$395,068,179	$405,334,219	$193,217,668	$188,881,922	$170,033,302
Other Assets	$1,286,760,650	$973,717,525	$1,121,000,601	$1,098,154,968	$1,015,336,578
Total Assets	**$2,110,242,450**	**$1,841,949,020**	**$2,028,423,624**	**$1,791,792,797**	**$1,522,441,798**
Liabilities and Fund Balances					
Current Liabilities	$73,134,288	$60,577,641	$59,804,510	$74,153,342	$119,537,731
Long-Term Liabilities	$4,186,092	$11,991,067	$11,254,832	$12,129,285	$11,880,844
Total Liabilities	**$77,320,380**	**$72,568,708**	**$71,059,342**	**$86,282,627**	**$131,418,575**
Total Fund Balances	$2,032,922,070	$1,769,380,312	$1,974,367,222	$1,705,510,170	$1,391,023,223
Total Liabilities & Fund Balances	**$2,110,242,450**	**$1,841,949,020**	**$2,045,426,564**	**$1,791,792,797**	**$1,522,441,798**

Income Statement

Data are annualized for periods other than twelve months.

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005

Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Amended	Reopened
Inpatient Revenue	$1,800,047,225	$1,605,204,537	$1,439,196,118	$1,318,394,312	$1,194,926,092
Outpatient Revenue	$1,141,978,100	$991,654,818	$894,120,728	$701,198,632	$584,292,350
Total Patient Revenue	$2,942,025,325	$2,596,859,355	$2,333,316,846	$2,019,592,944	$1,779,218,442
Contractual Allowance (Discounts)	$1,789,553,187	$1,502,252,015	$1,314,191,735	$1,079,787,124	$906,216,113
Net Patient Revenues	$1,152,472,138	$1,094,607,340	$1,019,125,111	$939,805,820	$873,002,329
Total Operating Expense[1]	$1,301,830,962	$1,166,936,317	$1,006,615,535	$928,910,239	$881,959,477
Operating Income	**$-149,358,824**	**$-72,328,977**	**$12,509,576**	**$10,895,581**	**$-8,957,148**
Other Income (Contributions, Bequests, etc.)	$67,022,702	$71,878,742	$63,319,626	$77,694,627	$61,514,505
Income from Investments	$200,750,062	$-269,283,235	$129,501,941	$165,026,006	$90,605,817
Governmental Appropriations	$0	$0	$0	$0	$0
Miscellaneous Non-Patient Revenue	$126,998,611	$139,411,601	$122,800,992	$115,398,421	$67,824,204
Total Non-Patient Revenue	$394,771,375	$-57,992,892	$315,622,559	$358,119,054	$219,944,526
Total Other Expenses	$0	$0	$0	$5	$0
Net Income or (Loss)	**$245,412,551**	**$-130,321,869**	**$328,132,135**	**$369,014,630**	**$210,987,378**
[1] Depreciation Expense (included above)	$46,892,656	$44,004,241	$34,564,408	$32,384,504	$28,136,149

Please note:
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Uncompensated Care

This hospital's most recent cost reporting period is for the period ending 12/31/2009

	Revenue	Estimated Cost

Medicaid	$213,108,821	$174,050,490
State Children's Health Insurance Program (SCHIP)	$4,021,876	$3,784,119
State and local indigent care programs	$14,588,641	$0
TOTAL Governmental Programs	**$231,719,338**	**$177,834,609**
Other uncompensated care	$25,385,019	$61,385,882
Restricted grants	$0	N/A
Unrestricted grants	$0	N/A

		imposed on business activity within the Metropolitan Commuter Transportation District.
North Carolina	6.9%	The franchise tax rate is $1.50 per $1,000 and is applied to the greatest of three different tax bases, with a minimum of $35.
North Dakota	2.6% > $0 4.1 > 3K 5.8 > 8K 6.4 > 20K 6.5 > 30K	7% for financial institutions, with a minimum of $50. Corporations making a water's-edge election must pay an additional 3.5% tax.
Ohio	0.26% > $0	A tax on gross receipts, the commercial activity tax (CAT), was instituted in 2005. It will be phased in through 2010 while the corporate franchise tax (Ohio's corporate net income tax) is phased out. From April 2008 through March 2009, the CAT rate is 0.208%. Beginning April 1, 2009 the CAT rate is fully phased in and equals 0.26%. For tax year 2009 companies owe 20% of Corporate Franchise Tax liability. For Tax Year 2010 and thereafter the Corporate Franchise Tax is fully phased out.
Oklahoma	6.0%	Additional franchise tax of $1.25 for each $1,000 of capital invested or used in Oklahoma.
gon.	6.6%	Minimum tax $10. Financial Institutions are subject to the income tax. The top income tax rate (7.9% on income over $250,000) applies to tax years beginning on or after January 1, 2009, and before January 1, 2011.
Pennsylvania	9.99%	Imposes a capital stock and foreign franchise tax of 0.189% on taxable income over $125K. Bank and Trust Company Shares Tax is 1.25%.
Rhode Island	9.0%	Greater of 9% of net income apportioned to Rhode Island or a franchise tax on authorized capital stock at the rate of $2.50 for each $10,000.00 or fractional part thereof (minimum of $500).
South Carolina	5.0%	4.5% for banks; 6% for savings and loans.
South Dakota	None	Banks pay 6% on net income. Minimum tax is $200 per location.
Tennessee	6.5%	Franchise tax of 0.25% of the greater of net worth or real and tangible property (minimum $100)
exas	None	Texas has a 1% franchise tax which is a gross receipts tax paid by most taxable entities. Qualified

Real Estate Lookup

Print

Close

Parcel Information

Parcel ID	Account	Parent	Previous
15301124	EXEMPT		15301124

Owner(s)

Owner Name	Mailing Address	City/State
CHARLOTTE MECKLENBURG HOSPITAL AUTHORITY	PO BOX 32861	CHARLOTTE NC 28232

Legal Information

Legal	Municipality	Annexed	Special District	Fire District	Acreage
P1401-53	CHARLOTTE			CITY OF CHARLOTTE	40.41

Total Parcel Assessment & Exemptions

Building	Land	Features	Total	Exemption	Year Approved	Review Date	Amount
372408196	52803900	5310000	430522096	HOSPITAL			430522096

Sales Information

Land Use

Use	Units	Type	Neighborhood	Assessment
8500	40.41	AC	OF02	52803900

Building Information

Bldg	Description	Type	Year Built	Property Location
1	MEMORIAL HOSPITAL Office	HOSPITAL	1939	1000 BLYTHE BV CHARLOTTE
2	Office	HOSPITAL	1964	1000 BLYTHE BV CHARLOTTE
3	Office	HOSPITAL	1964	1000 BLYTHE BV CHARLOTTE
4	Office	HOSPITAL	1962	1000 BLYTHE BV CHARLOTTE
5	Office	HOSPITAL	1975	1000 BLYTHE BV CHARLOTTE
6	Office	HOSPITAL	1965	1000 BLYTHE BV CHARLOTTE
7	Warehouse	WAREHOUSE	1962	1000 BLYTHE BV CHARLOTTE
8	Office	HOSPITAL	1975	1000 BLYTHE BV CHARLOTTE
9	HEART INSTITUTE Office	HOSPITAL	1986	1000 BLYTHE BV CHARLOTTE
10	LOADING DOCK 2003 ADDN Office	HOSPITAL	2003	1112 BLYTHE BV CHARLOTTE
11	LEVINE CHILDREN CTR Office	HOSPITAL	2004	1100 BLYTHE BV CHARLOTTE
12	MACHINE SHOP Office	HOSPITAL	2004	1000 BLYTHE BV CHARLOTTE
13	ICU tower expansion Office	HOSPITAL	2005	1000 BLYTHE BV CHARLOTTE
14	Office	HOSPITAL	2005	1000 BLYTHE BV CHARLOTTE
15	PARKING DECK Warehouse	PKG GARAGE	2000	1000 BLYTHE BV CHARLOTTE

Bldg	Story	Units	Total SqFt	Heated	Foundation	Ext. Wall	Grade	Value
1	>= 2.5 STY	1	1671814	1623883	HIGH RISE	PRECAST PANL -	VERY GOOD 03	176435296
2	1 STORY	1	73020	73020	HIGH RISE	PRECAST PANL -	VERY GOOD 03	7815800
3	>= 2.5 STY	1	46080	40464	SLAB-COM	PRECAST PANL -	GOOD 04	3668600
4	2.0 STORY	1	14400	14400	SLAB-COM	PRECAST PANL -	VERY GOOD 03	1526200
5	1 STORY	1	57754	55600	SLAB-COM	PRECAST PANL -	GOOD 04	5028200
6	2.0 STORY	1	78095	77535	SLAB-COM	FACE BRICK -	GOOD 04	6997300
7	1 STORY	1	3400	3400	SLAB-COM	PRECAST PANL -	GOOD 03	129300
8	1 STORY	1	76250	67849	SLAB-HEAVY	PRECAST PANL -	GOOD 04	6213900
9	>= 2.5 STY	1	69350	69350	HIGH RISE	PRECAST PANL -	VERY GOOD 03	7055700
10	1 STORY	1	11222	11222	SLAB-COM	PRECAST PANL -	VERY GOOD 03	1414100
11	>= 2.5 STY		255024	254184	CRAWL SPACE	PRECAST PANL -	CUSTOM 06	56910400
12	1 STORY		57932	57596	SLAB-STRUCT	FACE BRICK -	VERY GOOD 03	8462800
13	>= 2.5 STY		198305	198305	HIGH RISE	PRECAST PANL -	CUSTOM 06	48187300
14	>= 2.5 STY		30791	30791	HIGH RISE	PRECAST PANL -	CUSTOM 06	7373700
15	>= 2.5 STY		692412	692412	SLAB-HEAVY	PRECAST PANL -	EXCELLENT 03	35189600

Bldg	Heat	Fuel	FirePlace	AC	Fixtures	Bedrooms	Full Baths	3/4 Baths	1/2 Baths
1	AIR-DUCTED	GAS		AC-CENTRAL	2911	0	0		972
2	AIR-DUCTED	ELECTRIC		AC-CENTRAL	70	0	0		0
3	AIR-DUCTED	ELECTRIC		AC-CENTRAL	56	0	0		0

State Sales Tax Rates
January 1, 2008

State	Tax Rates	Exceptions: Food	Exceptions: Prescription Drugs	Exceptions: Non-prescription Drugs
ALABAMA	4		*	
ALASKA	none			
ARIZONA	5.6	*	*	
ARKANSAS	6	3% (4)	*	
CALIFORNIA (3)	7.25 (2)	*	*	
COLORADO	2.9	*	*	
CONNECTICUT	6	*	*	*
DELAWARE	none			
FLORIDA	6	*	*	*
GEORGIA	4	* (4)	*	
HAWAII	4		*	
IDAHO	6		*	
ILLINOIS	6.25	1%	1%	1%
INDIANA	6	*	*	
IOWA	5	*	*	
KANSAS	5.3		*	
KENTUCKY	6	*	*	
LOUISIANA	4	* (4)	*	
MAINE	5	*	*	
MARYLAND (5)	6	*	*	*
MASSACHUSETTS	5	*	*	
MICHIGAN	6	*	*	
MINNESOTA	6.5	*	*	*
MISSISSIPPI	7		*	
MISSOURI	4.225	1.225%	*	
MONTANA	none			
NEBRASKA	5.5	*	*	
NEVADA	6.5	*	*	
NEW HAMPSHIRE	none			
NEW JERSEY	7	*	*	*
NEW MEXICO	5	*	*	
NEW YORK	4	*	*	*
NORTH CAROLINA (6)	4.25	* (4)	*	
NORTH DAKOTA	5	*	*	
OHIO	5.5	*	*	
OKLAHOMA	4.5		*	
OREGON	none			
PENNSYLVANIA	6	*	*	*
RHODE ISLAND	7	*	*	*
SOUTH CAROLINA	6	*	*	
SOUTH DAKOTA	4		*	
TENNESSEE	7	5.5%	*	
TEXAS	6.25	*	*	*
UTAH	4.85	1.75% (4)	*	

Couches and washes 2.5%
meat, bakery, mtgs
auto . 5 to 5
public transportation

EXHIBIT
5 Kane
12.20.09

Piedmont.Kane.0789

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Carolinas Medical Center	2009	2008	2007	2006	2005	2004
FYE 12/31						
INCOME STATEMENT ($000s)						
Total Gross Patient Service Revenue	2,942,025	2,596,859	2,333,317	2019593	1779218	1587182
Deductions from Revenue:						
Free care valued at charges						
Provision for Bad Debt						
Contractual adjustments	1,789,553	1,502,252	1,314,192	1079787	906216	806485
Net Patient Serv Revenue	1152472	1,094,607	1019125	939806	873002	780697
Other Operating Revenue	126,999	139,412	122,801	115398	67824	61201
Total Operating Revenue	1279471	1234019	1141926	1055204	940826	841898
OPERATING EXPENSES						
Depreciation and amortization						
Interest						
Supplies	208293	186710	161059	148626	141113	127307
Other operating expenses						
Total operating expenses	1,301,831	1,166,936	1,006,616	928910	881959	795667
Operating Income	-22360	67083	135310	126294	58867	46231
NONOPERATING REVENUE						
Interest and Dividend						
Realized Gains/losses on sales of securities						
Permanently impaired security writedowns						
Total investment income	200,750	(269,283)	129,502	165026	90606	100925
Gains/losses on asset sales/equity investments						
Permanently impaired writedowns of nonsecurity assets						
Other nonoperating revenues (gifts, bequests	67,023	71,879	63,320	77695	61515	64383
Total nonoperating revenue	267773	-197404	192822	242721	152121	165308
Excess of revenue over expenses	245413	-130321	328132	369015	210988	211539
OTHER GAINS (LOSSES) DUE TO:						
Extraordinary Gains (Losses)	0	0	0	0	0	0
Total Surplus/Deficit	245413	-130321	328132	369015	210988	211539
Markup	2.3575	2.3448	2.4400	2.2984	2.0942	2.0717
Estimated Medicaid Shortfall	0	0	6,832	22,345	26878	16,985
Free care at cost	61,386	68,743	66,474	58,397	51557	44,884
Total CB at cost	61,386	68,743	73,306	80,742	78,435	61,869
Estimated Taxes:						
Federal effective rate	0.3299	0.3306	0.2462	0.3248	0.3259	0.3374
State statutory rate	0.069	0.069	0.069	0.069	0.069	0.069
Property Tax Rate	1.2973	1.2973	1.2973	1.2973	1.2973	1.2973
Assessed Value	430,522,096	353673596	353673596	353673596	353673596	353673596
Sales Tax Rate:	0.0725	0.0725	0.0725	0.0725	0.0725	0.0725
Estimated Value of Tax Exemption:						
Federal Income Tax	75,367	0	75,203	111,599	64,025	66,453
State Income Tax	16,933	0	22,641	25,462	14,558	14,596
Sales Tax	15,101	13,536	11,677	10,775	10,231	9,230
Property Tax	5,585	4,588	4,588	4,588	4,588	4,588
Total Value of Tax Exemption	112,987	18,125	114,109	152,425	93,402	94,867
CB as % TOR	4.80%	5.57%	6.42%	7.65%	8.34%	7.35%
TE as % TOR	8.83%	1.47%	9.99%	14.45%	9.93%	11.27%
Net Benefit as % TOR	-4.03%	4.10%	-3.57%	-6.79%	-1.59%	-3.92%

Carolinas MC

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RECORD 002978

CAROLINAS MEDICAL CENTER 2009

	A	B	NOTES
		2009	
1.	**Carolinas Medical Center**		
2.	**FYE 12/31**		
3.			
4.	INCOME STATEMENT **($000s)**		
5.	Total Gross Patient Service Revenue	2,942,025	Cost Report (ahd.com)
6.	Deductions from Revenue:		
7.	Free care valued at charges		
8.	Provision for Bad Debt		
9.	Contractual adjustments	1,789,553	Cost Report
10.	Net Patient Serv Revenue	1,152,472	Cost Report
11.	Other Operating Revenue	126,999	Cost Report
12.	Total Operating Revenue	1,279,471	B10 + B11
13.	OPERATING EXPENSES		
14.			
15.	Interest		
16.	Supplies	208,293	B18 x 16%
17.	Other operating expenses		
18.	Total operating expenses	1,301,831	Cost Report
19.	Operating Income	(22,360)	B12 – B18
20.	NONOPERATING REVENUE		
21.	Interest and Dividend		
22.	Realized Gains/losses on sales of securities		
23.	Permanently impaired security writedowns		
24.	Total investment income	200,750	Cost Report
25.	Gains/losses on asset sales/equity investments		
26.	Permanently impaired writedowns of nonsecurity assets		
27.	Other nonoperating revenues (gifts, bequests, gov't appropriations)	67,023	Cost Report
28.	Total nonoperating revenue	267,773	B24 + B27
29.	Excess of revenue over expenses	245,413	B19 + B28
30.	OTHER GAINS (LOSSES) DUE TO:		
31.	Extraordinary Gains (Losses)		
32.			
33.	Total Surplus/Deficit	245,413	B29
34.			
35.	Markup	2.3575	(B5 + B11) / B18
36.	Estimated Medicaid Shortfall	0	Cost Report: Medicaid revenue ($213M) exceeds cost ($174M)
37.	Free care at cost	61,386	Cost Report

CAROLINAS MEDICAL CENTER 2009

	A	B	NOTES
		2009	
38.	Total CB at cost	61,386	B36 + B37
39.			
40.	Estimated Taxes:		
41.	Federal effective rate	0.3299	Piedmont 2009 spreadsheet B40
42.	State effective rate	0.069	Taxfoundation.org (Bates Piedmont.Kane.0794)
43.			
44.	Property Tax Rate	1.2973	Phone conf. with Mecklenburg Cty. Tax Assessor Office
45.	**NOT IN $000s BELOW** Assessed Value	430,522,096	Mecklenburg Cty. Real Estate Lookup website
46.			
47.			
48.	Sales Tax Rate:	.0725	State Sales Tax website and note re: phone conf. with Mecklenburg Cty Tax Assessor Office (Bates Piedmont.Kane.0789)
49.			
50.	Estimated Value of Tax Exemption:		
51.	Federal Income Tax	75,367,000	(B33 – B52) x B41
52.	State Income Tax	16,933,000	B33 x B42
53.	Sales Tax	15,101,000	B48 x B16
54.	Property Tax	5,585,000	B44 x (B45/100)
55.	Total Value of Tax Exemption	112,987,000	B51 + B52 + B53 + B54
56.			
57.	CB as % TOR	4.80%	B38/B12
58.	TE as % TOR	8.83%	B55/B12
59.	Net Benefit as % TOR	-4.03%	B57 – B58

CMC-Mercy and Pineville (Pineveill is a campus of Mercy) so MCR is combined Mercy-Pineville						
FYE	2009	2008	2007	2006	2005	2004
E STATEMENT ($000s)						
ross Patient Service Revenue	824,041	709,450	622,747	578,005	537,028	486,372
Deductions from Revenue:						
Free care valued at charges						
Provision for Bad Debt						
Contractual adjustments	511,986	420,413	364,369	335,750	305,304	268,685
Net Patient Serv Revenue	312,055	289,037	258,378	242,255	231,724	217,687
Other Operating Revenue	27,894	(8,265)	9,560	14,247	9,270	11,568
Total Operating Revenue	339,949	280,772	267,938	256,502	240,994	229,255
OPERATING EXPENSES						
Depreciation and amortization						
Interest						
Supplies	41,232	37,385	31,759	28,788	28,418	25,730
Other operating expenses						
Total operating expenses	257,703	233,659	198,492	179,927	177,615	160,813
Operating Income	82,246	47,113	69,446	76,575	63,379	68,442
NONOPERATING REVENUE						
Interest and Dividend						
Realized Gains/losses on sales of securities						
Permanently impaired security writedowns						
Total investment income	19,926	28,422	46,047	36,498	23,346	12,531
Gains/losses on asset sales/equity investments						
Permanently impaired writedowns of nonsecurity assets						
Other nonoperating revenues (gifts, bequests	11	5	8	(11)	20	26
Total nonoperating revenue	19,937	28,427	46,055	36,487	23,366	12,557
Excess of revenue over expenses	102,183	75,540	115,501	113,062	86,745	80,999
OTHER GAINS (LOSSES) DUE TO:						
Extraordinary Gains (Losses)	0	0	0	0	0	0
Total Surplus/Deficit	102,183	75,540	115,501	113,062	86,745	80,999
Markup	3.3059	3.0009	3.1856	3.2916	3.0757	3.0964
stimated Medicaid Shortfall	1,761	3,845	1,357	3,845	5,940	307
are at cost	12,908	14,735	13,033	11,090	10,138	7,025
CB at cost	14,669	18,580	14,390	14,935	16,078	7,332
Estimated Taxes:						
Federal effective rate	0.3299	0.3306	0.2462	0.3248	0.3259	0.3374
State statutory rate	0.0690	0.0690	0.0690	0.0690	0.0690	0.0690
Property Tax Rate	1.2973	1.2973	1.2973	1.2973	1.2973	1.2973
Assessed Value	108,287,300	89168900	89168900	89168900	89168900	89168900
Sales Tax Rate:	0.0725	0.0725	0.0725	0.0725	0.0725	0.0725
Estimated Value of Tax Exemption: (not in 000)						
Federal Income Tax	31,381	23,251	26,471	34,193	26,323	25,445
State Income Tax	7,051	5,212	7,970	7,801	5,985	5,569
Sales Tax	2,989	2,710	2,303	2,087	2,060	1,865
Property Tax	1,405	1,157	1,157	1,157	1,157	1,157
Total Value of Tax Exemption	42,826	32,330	37,900	45,238	35,526	34,056
CB as % TOR	4.32%	6.62%	5.37%	5.82%	6.67%	3.20%
TE as % TOR	12.60%	11.51%	14.15%	17.64%	14.74%	14.86%
Net Benefit as % TOR	-8.28%	-4.90%	-8.77%	-11.81%	-8.07%	-11.66%

CMC-MERCY/PINEVILLE 2009

	A	B	NOTES
		2009	
1.	**CMC-Mercy/Pineville**		
2.			
3.			
4.	INCOME STATEMENT **($000s)**		
5.	Total Gross Patient Service Revenue	824,041	Cost Report (ahd.com)
6.	Deductions from Revenue:		
7.	Free care valued at charges		
8.	Provision for Bad Debt		
9.	Contractual adjustments	511,986	Cost Report
10.	Net Patient Service Revenue	312,055	Cost Report
11.	Other Operating Revenue	27,894	Cost Report
12.	Total Operating Revenue	339,949	B10 + B11
13.	OPERATING EXPENSES		
14.			
15.	Interest		
16.	Supplies	41,232	B18 x 16%
17.	Other operating expenses		
18.	Total operating expenses	257,703	Cost Report
19.	Operating Income	82,246	B12 – B18
20.	NONOPERATING REVENUE		
21.	Interest and Dividend		
22.	Realized Gains/losses on sales of securities		
23.	Permanently impaired security writedowns		
24.	Total investment income	19,926	Cost Report
25.	Gains/losses on asset sales/equity investments		
26.	Permanently impaired writedowns of nonsecurity assets		
27.	Other nonoperating revenues (gifts, bequests, gov't appropriations)	11	Cost Report
28.	Total non-operating revenue	19,937	B22 + B23 + B24 + B25 + B26 + B27
29.	Excess of revenue over expenses	102,183	B19 + B28
30.	OTHER GAINS (LOSSES) DUE TO:		
31.	Extraordinary Gains (Losses)		
32.			
33.	Total Surplus/Deficit	102,183	B29
34.			
35.	Markup	3.3059	(B5 + B11)/B18
36.	Estimated Medicaid Shortfall	1,761	Cost Report (19,818,785-18,058,448)
37.	Free care at cost	12,908	Cost Report

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CMC-MERCY/PINEVILLE 2009

	A	B	NOTES
		2009	
38.	Total CB at cost	14,669	B36 + B37
39.			
40.	Estimated Taxes:		
41.	Federal effective rate	0.3299	Piedmont 2009 spreadsheet B41
42.	State effective rate	0.0690	Taxfoundation.org (Bates Piedmont.Kane.0794)
43.			
44.	Property Tax Rate	1.2973	Phone conf. with Mecklenburg Cty. Tax Assessor Office
45.	**NOT IN $000s BELOW** Assessed Value	 108,287,300	 Mecklenburg Cty. Real Estate Lookup website
46.			
47.			
48.	Sales Tax Rate:	0.0725	State Sales Tax website and note re: phone conf. with Mecklenburg Cty. Tax Assessor Office (Bates Piedmont.Kane.0789)
49.			
50.	Estimated Value of Tax Exemption:		
51.	Federal Income Tax	31,381,000	(B33 – B52) x B41
52.	State Income Tax	7,051,000	B42 x B33
53.	Sales Tax	2,989,000	B48 X B16
54.	Property Tax	1,405,000	B44 x (B45/100)
55.	Total Value of Tax Exemption	42,826,000	B51 + B52 + B53 + B54
56.			
57.	CB as % TOR	4.32%	B38/B12
58.	TE as % TOR	12.60%	B55/B12
59.	Net Benefit as % TOR	-8.28%	B57 – B58

Total Patient Revenue	$824,041,342	$709,449,527	$622,746,797	$578,005,529	$537,028,923
Contractual Allowance (Discounts)	$511,985,905	$420,412,992	$364,369,128	$335,749,721	$305,303,859
Net Patient Revenues	$312,055,437	$289,036,535	$258,377,669	$242,255,808	$231,725,064
Total Operating Expense[1]	$257,349,702	$233,649,999	$198,493,189	$179,927,036	$177,614,815
Operating Income	**$54,705,735**	**$55,386,536**	**$59,884,480**	**$62,328,772**	**$54,110,249**
Other Income (Contributions, Bequests, etc.)	$11,371	$4,649	$8,360	$35,160	$29,323
Income from Investments	$19,925,824	$28,421,576	$46,047,395	$36,497,861	$23,346,067
Governmental Appropriations	$0	$0	$0	$0	$0
Miscellaneous Non-Patient Revenue	$27,893,781	$-8,265,034	$9,559,959	$14,247,147	$9,269,656
Total Non-Patient Revenue	$47,830,976	$20,161,191	$55,615,714	$50,780,168	$32,645,046
Total Other Expenses	$352,588	$9,090	$0	$45,825	$8,595
Net Income or (Loss)	**$102,184,123**	**$75,538,637**	**$115,500,194**	**$113,063,115**	**$86,746,700**
[1] Depreciation Expense (included above)	$11,663,259	$10,767,654	$9,872,614	$8,504,839	$10,144,926

Please note:
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Uncompensated Care

This hospital's most recent cost reporting period is for the period ending 12/31/2009

	Revenue	Estimated Cost
Medicaid	$18,058,448	$19,818,785
State Children's Health Insurance Program (SCHIP)	$228,535	$345,361
State and local indigent care programs	$674,119	$0
TOTAL Governmental Programs	**$18,961,102**	**$20,164,146**
Other uncompensated care	$2,018,095	$12,908,035
Restricted grants	$0	N/A

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Financial - Carolinas Medical Center - Mercy
Charlotte, NC 28207

See column headings for cost reporting periods. / Definitions

Balance Sheet

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Settled Without Audit	Reopened
Assets					
Current Assets	$713,140,754	$650,095,336	$564,928,977	$471,528,551	$391,647,608
Fixed Assets	$90,774,196	$93,955,369	$83,892,335	$70,986,915	$58,494,888
Other Assets	$72,034,223	$58,884,474	$80,895,427	$75,590,635	$67,309,522
Total Assets	**$875,949,173**	**$802,935,179**	**$729,716,739**	**$618,106,101**	**$517,452,018**
Liabilities and Fund Balances					
Current Liabilities	$2,397,692	$3,517,509	$5,060,120	$5,740,261	$14,650,734
Long-Term Liabilities	$458,016	$277,952	$0	$0	$0
Total Liabilities	**$2,855,708**	**$3,795,461**	**$5,060,120**	**$5,740,261**	**$14,650,734**
Total Fund Balances	$873,093,465	$799,139,718	$724,656,619	$612,365,840	$502,801,284
Total Liabilities & Fund Balances	**$875,949,173**	**$802,935,179**	**$729,716,739**	**$618,106,101**	**$517,452,018**

Income Statement

Data are annualized for periods other than twelve months.

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	As Submitted	Settled Without Audit	Reopened
Inpatient Revenue	$367,543,230	$320,735,938	$275,179,564	$269,555,695	$271,482,953
Outpatient Revenue	$456,498,112	$388,713,589	$347,567,233	$308,449,834	$265,545,970

Pied.Supp-CON
0830

JOINT-B-PMC-001.0881

RECORD 002986

		imposed on business activity within the Metropolitan Commuter Transportation District.
North Carolina	6.9%	The franchise tax rate is $1.50 per $1,000 and is applied to the greatest of three different tax bases, with a minimum of $35.
North Dakota	2.6% > $0 4.1 > 3K 5.6 > 8K 6.4 > 20K 6.5 > 30K	7% for financial institutions, with a minimum of $50. Corporations making a water's-edge election must pay an additional 3.5% tax.
Ohio	0.26% > $0	A tax on gross receipts, the commercial activity tax (CAT), was instituted in 2005. It will be phased in through 2010 while the corporate franchise tax (Ohio's corporate net income tax) is phased out. From April 2008 through March 2009, the CAT rate is 0.208%. Beginning April 1, 2009 the CAT rate is fully phased in and equals 0.26%. For tax year 2009 companies owe 20% of Corporate Franchise Tax liability. For Tax Year 2010 and thereafter the Corporate Franchise Tax is fully phased out.
Oklahoma	6.0%	Additional franchise tax of $1.25 for each $1,000 of capital invested or used in Oklahoma.
gon.	6.6%	Minimum tax $10. Financial institutions are subject to the income tax. The top income tax rate (7.9% on income over $250,000) applies to tax years beginning on or after January 1, 2009, and before January 1, 2011.
Pennsylvania	9.99%	Imposes a capital stock and foreign franchise tax of 0.189% on taxable income over $125K. Bank and Trust Company Shares Tax is 1.25%.
Rhode Island	9.0%	Greater of 9% of net income apportioned to Rhode Island or a franchise tax on authorized capital stock at the rate of $2.50 for each $10,000.00 or fractional part thereof (minimum of $500).
South Carolina	5.0%	4.5% for banks; 6% for savings and loans.
South Dakota	None	Banks pay 6% on net income. Minimum tax is $200 per location.
Tennessee	6.5%	Franchise tax of 0.25% of the greater of net worth or real and tangible property (minimum $100)
exas	None	Texas has a 1% franchise tax which is a gross receipts tax paid by most taxable entities. Qualified

Real Estate Lookup

Print

Close

Parcel Information

Parcel ID	Account	Parent	Previous
12708602	EXEMPT		12708602

Owner(s)

Owner Name	Mailing Address	City/State
MERCY HOSPITAL INC	2000 E 5TH ST	CHARLOTTE NC 28204

Legal Information

Legal	Municipality	Annexed	Special District	Fire District	Acreage
N	CHARLOTTE			CITY OF CHARLOTTE	13.91

Total Parcel Assessment & Exemptions

Building	Land	Features	Total	Exemption	Year Approved	Review Date	Amount
78959100	29084100	244100	108287300	HOSPITAL		1/1/2014 12:00:00 AM	108287300

Sales Information

Sale	Price	Stamps	Qualify	V/I	DeedBook	Type	Legal Ref.	Grantor.
Jan 1 1975	0			IMP	02213 - 205	WARRANTY D	02213-205	

Land Use

Use	Units	Type	Neighborhood	Assessment
8500	605919.63	SF	OF02	29084100

Building Information

Bldg	Description	Type	Year Built	Property Location
1	MERCY HOSPITAL Office	HOSPITAL	1915	2001 VAIL AV CHARLOTTE
2	Mercy Hospital Warehouse	WAREHOUSE	1952	2001 VAIL AV CHARLOTTE
3	Mercy Hospital Office	HOSPITAL	1958	2001 VAIL AV CHARLOTTE
4	Mercy Hospital Warehouse	WAREHOUSE	1947	2001 VAIL AV CHARLOTTE
5	Mercy Hospital Office	HOSPITAL	1981	2001 VAIL AV CHARLOTTE
6	Mercy Hospital Warehouse	PKG GARAGE	1981	2001 VAIL AV CHARLOTTE
7	MERCY MED PLAZE Office	HOSPITAL	2007	2001 VAIL AV CHARLOTTE
8	CENTRL ENERGY PLNT Office	HOSPITAL	2007	2001 VAIL AV CHARLOTTE
9	MERCY MED. PLZ PKGING Warehouse	PKG GARAGE	2007	2001 VAIL AV CHARLOTTE
10	VAIL PKING DECK Warehouse	PKG GARAGE	2007	2001 VAIL AV CHARLOTTE

Bldg	Story	Units	Total SqFt	Heated	Foundation	Ext. Wall	Grade	Value
1	>= 2.5 STY	1	326384	326384	HIGH RISE	FACE BRICK -	GOOD 03	32607600
2	1 STORY	1	2073	504	SLAB-PLFM HT	WOOD ON SHTG - FACE BRICK	AVERAGE 03	25700
3	SPLIT LEVEL	1	15076	15076	HIGH RISE	FACE BRICK -	GOOD 04	1560400
4	1 STORY	1	3726	3726	SLAB-PLFM HT	PRECAST PANL -	AVERAGE 03	109800
5	1 STORY	1	52331	50311	HIGH RISE	FACE BRICK -	VERY GOOD 02	5425800
6	>= 2.5 STY	1	169520	169520	HIGH RISE	EXT PLYWOOD -	AVERAGE 03	3282400
7	>= 2.5 STY		151830	151830	HIGH RISE	FACE BRICK - STONE	GOOD 03	22384000
8	1 STORY		10113	10113	SLAB-COM		GOOD 03	1417500
9	>= 2.5 STY		107684	107684	SLAB-HEAVY	RNFR CONC -	GOOD 03	4384000
10	>= 2.5 STY		182416	182416	HIGH RISE	RNFR CONC -	GOOD 03	7761900

Bldg	Heat	Fuel	FirePlace	AC	Fixtures	Bedrooms	Full Baths	3/4 Baths	1/2 Baths
1	AIR-DUCTED	GAS		AC-CENTRAL	107	0	0		0
2	AIR-NO-DUCT	GAS		AC-NONE		0	0		0
3	HEAT PUMP	ELECTRIC		AC-CENTRAL	60	0	0		0
4	AIR-NO-DUCT	GAS		AC-NONE	4	0	0		0
5	AIR-DUCTED	GAS		AC-CENTRAL	45	0	0		0
6	HEAT - NONE	NONE		AC-NONE		0	0		0
7	AIR-DUCTED	GAS		AC-CENTRAL			6		12
8	AC-PCKD ROOF	ELECTRIC		AC-CENTRAL					
9	HEAT - NONE	NONE							
10	HEAT - NONE	NONE							

Pied.Supp-CON 0833

State Sales Tax Rates
January 1, 2008

State	Tax Rates	Exemptions: Food	Exemptions: Prescription Drugs	Exemptions: Non-prescription Drugs
ALABAMA	4		*	
ALASKA	none			
ARIZONA	5.6	*	*	
ARKANSAS	6	3% (4)	*	
CALIFORNIA (3)	7.25 (2)	*	*	
COLORADO	2.9	*	*	
CONNECTICUT	6	*	*	*
DELAWARE	none			
FLORIDA	6	*	*	*
GEORGIA	4	* (4)	*	
HAWAII	4		*	
IDAHO	6		*	
ILLINOIS	6.25	1%	1%	1%
INDIANA	6	*	*	
IOWA	5	*	*	
KANSAS	5.3		*	
KENTUCKY	6	*	*	
LOUISIANA	4	* (4)	*	
MAINE	5	*	*	
MARYLAND (5)	6	*	*	*
MASSACHUSETTS	5	*	*	
MICHIGAN	6	*	*	
MINNESOTA	6.5	*	*	*
MISSISSIPPI	7		*	
MISSOURI	4.225	1.225%	*	
MONTANA	none			
NEBRASKA	5.5	*	*	
NEVADA	6.5	*	*	
NEW HAMPSHIRE	none			
NEW JERSEY	7	*	*	*
NEW MEXICO	5	*	*	
NEW YORK	4	*	*	*
NORTH CAROLINA (6)	4.25	* (4)	*	
NORTH DAKOTA	5	*	*	
OHIO	5.5	*	*	
OKLAHOMA	4.5		*	
OREGON	none			
PENNSYLVANIA	6	*	*	*
RHODE ISLAND	7	*	*	*
SOUTH CAROLINA	6	*	*	
SOUTH DAKOTA	4		*	
TENNESSEE	7	5.5%	*	
TEXAS	6.25	*	*	*
UTAH	4.65	1.75% (4)	*	

Counties add another 2.5%
Mecklenburg, on top adds .5% for public transportation

EXHIBIT
5 Kane
12.20.09 SB

Piedmont.Kane.0789

Pied.Supp-CON 0834

JOINT-B-PMC-001.0884

RECORD 002989

Presbyterian-Charlotte						
FYE				thousands of dollars		
	2009	2008	2007	2006	2005	2004
IE STATEMENT ($000s)						
Gross Patient Service Revenue	1,326,650	1,181,019	1,106,781	1,018,040	930,335	883,798
Deductions from Revenue:						
Free Care at cost			21,510	0	0	2,450
Provision for Bad Debt						23,290
Contractual adjustments	767,668	680,429	624,149	574,855	512,236	484,686
Net Patient Serv Revenue	558,982	500,590	482,632	443,185	418,099	399,112
Other Operating Revenue	11,056	12,085	10,497	6,878	4,685	4,528
Total Operating Revenue	570,038	512,675	493,129	450,063	422,784	403,640
OPERATING EXPENSES						
Depreciation and amortization				18,642	18,251	18,000
Interest						
Supplies	82,827	79,369	77,809	72,560	70,276	63,936
Other operating expenses						
Total operating expenses	517,671	496,058	486,304	453,500	439,225	399,602
Operating Income	52,367	16,617	6,825	(3,437)	(16,441)	4,038
NONOPERATING REVENUE						
Interest and Dividend						
Realized Gains/losses on sales of securities						
Permanently impaired security writedowns						
Total investment income	71	(32)	27,175	152	140	206
Gains/losses on asset sales/equity investments						
Permanently impaired writedowns of nonsecurity assets						
Other nonoperating revenues (gifts, bequests	1,117	2,028	2,030	1,923	1,659	1,243
Total nonoperating revenue	1,188	1,996	29,205	2,075	1,799	1,449
Excess of revenue over expenses	53,555	18,613	36,030	(1,362)	(14,642)	5,487
OTHER GAINS (LOSSES) DUE TO:						
Extraordinary Gains (Losses)	0	0	0	0	0	0
Total Surplus/Deficit	53,555	18,613	36,030	(1,362)	(14,642)	5,487
p	2.5841	2.4052	2.2975	2.2600	2.1288	2.2230
pital Share of Medicaid shortfall, at cost	20,977	22,047	16,682	14013	11428	5400
Hospital Share of Charity Care	27,745	22,605	21,510	16693	14869	10892
Total CB at cost	48,722	44,652	38,192	30,706	26,297	16,292
Estimated Taxes:						
Federal effective rate	0.3299	0.3306	0.2462	0.3248	0.3259	0.3374
State statutory rate	0.0690	0.0690	0.0690	0.0690	0.0690	0.0690
Property Tax Rate	1.2973	1.2973	1.2973	1.2973	1.2973	1.2973
Assessed Value	182,633,800	105361900	105361900	105361900	105361900	105361900
Sales Tax Rate:	0.0725	0.0725	0.0725	0.0725	0.0725	0.0725
Estimated Value of Tax Exemption:						
Federal Income Tax	16,447	5,729	8,257	0	0	1,724
State Income Tax	3,695	1,284	2,486	0	0	379
Sales Tax	6,005	5,754	5,641	5,261	5,095	4,635
Property Tax	2,369	1,367	1,367	1,367	1,367	1,367
Total Value of Tax Exemption	28,517	14,134	17,752	6,627	6,462	8,105
CB as % TOR	8.55%	8.71%	7.74%	6.82%	6.22%	4.04%
TE as % TOR	5.00%	2.76%	3.60%	1.47%	1.53%	2.01%
Net CB as % TOR	3.54%	5.95%	4.15%	5.35%	4.69%	2.03%

Presbyterian

PRESBYTERIAN HOSPITAL 2009

	A	B	NOTES
		2009	
1.	**Presbyterian Hospital**		
2.			
3.			
4.	INCOME STATEMENT **($000s)**		
5.	Total Gross Patient Service Revenue	1,326,650	Cost Report (ahd.com)
6.	Deductions from Revenue:		
7.	Free Care at cost		
8.	Provision for Bad Debt		
9.	Contractual adjustments	767,668	Cost Report
10.	Net Patient Serv Revenue	558,982	Cost Report
11.	Other Operating Revenue	11,056	Cost Report
12.	Total Operating Revenue	570,038	B10 + B11
13.	OPERATING EXPENSES		
14.			
15.	Interest		
16.	Supplies	82,827	B18 x 16%
17.	Other operating expenses		
18.	Total operating expenses	517,671	Cost Report
19.	Operating Income	52,367	B12 – B18
20.	NONOPERATING REVENUE		
21.	Interest and Dividend		
22.	Realized Gains/losses on sales of securities		
23.	Permanently impaired security writedowns		
24.	Total investment income	71	Cost Report
25.	Gains/losses on asset sales/equity investments		
26.	Permanently impaired writedowns of nonsecurity assets		
27.	Other nonoperating revenues (gifts, bequests, gov't appropriations)	810	Cost Report
28.	Total nonoperating revenue	881	B24 + B27
29.	Excess of revenue over expenses	53,248	B19 + B28
30.	OTHER GAINS (LOSSES) DUE TO:		
31.	Extraordinary Gains (Losses)	0	
32.			
33.	Total Surplus/Deficit	53,248	B29
34.			
35.	Markup	2.5841	(B5 + B11) / B18
36.	Medicaid shortfall at cost	20,977	Cost Report (60,934,440-39,956,702)

PRESBYTERIAN HOSPITAL 2009

	A	B	NOTES
		2009	
37.	Free Care at Cost	27,745	Cost Report
38.	Total CB at cost	48,722	B36 + B37
39.			
40.	Estimated Taxes:		
41.	Federal effective rate	0.3299	Piedmont 2009 spreadsheet B41
42.	State effective rate	0.0690	Taxfoundation.org (Bates Piedmont.Kane.0794)
43.			
44.	Property Tax Rate	1.2973	Phone conf. with Mecklenburg Cty. Tax Assessor Office
45.	**NOT IN $000s BELOW** Assessed Value	182,633,800	Mecklenburg Cty. Real Estate Lookup website
46.			
47.			
48.	Sales Tax Rate:	.0725	State Sales Tax website and note re: phone conf. with Mecklenburg Cty. Tax Assessor Office (Piedmont.Kane.0789)
49.			
50.	Estimated Value of Tax Exemption:		
51.	Federal Income Tax	16,347,000	(B33 – B52) x B41
52.	State Income Tax	3,674,000	B29 X B42
53.	Sales Tax	6,005,000	B48 X B16
54.	Property Tax	2,369,000	B44 x (B45 / 100)
55.	Total Value of Tax Exemption	28,395,000	B51 + B52 + B53 + B54
56.			
57.	CB as % TOR	8.55%	B38 / B12
58.	TE as % TOR	4.98%	B55 / B12
59.	Net Benefit as % TOR	3.57%	B57 – B58

ahd.com

Financial - March 18, 2011

Presbyterian Hospital
Charlotte, NC 28204
Medicare Provider Number: 340053

See column headings for cost reporting periods. / Definitions

Balance Sheet

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	Amended	Settled Without Audit	Reopened
Assets					
Current Assets	$91,346,953	$78,140,322	$74,713,010	$69,776,098	$68,109,326
Fixed Assets	$217,457,665	$183,085,955	$164,182,638	$162,947,372	$164,919,321
Other Assets	$57,649,019	$2,200,370	$21,957,191	$8,667,712	$5,589,149
Total Assets	**$366,453,637**	**$263,426,647**	**$260,852,839**	**$241,391,182**	**$238,617,796**
Liabilities and Fund Balances					
Current Liabilities	$-66,671,185	$-36,756,272	$-29,351,864	$33,165,528	$26,234,754
Long-Term Liabilities	$12,443,742	$13,735,874	$13,670,539	$173,167,772	$171,238,266
Total Liabilities	**$-54,227,443**	**$-23,020,398**	**$-15,681,325**	**$206,333,300**	**$197,473,020**
Total Fund Balances	$420,681,080	$286,447,045	$276,534,164	$35,057,882	$41,144,776
Total Liabilities & Fund Balances	**$366,453,637**	**$263,426,647**	**$260,852,839**	**$241,391,182**	**$238,617,796**

Income Statement

Data are annualized for periods other than twelve months.

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	Amended	Settled Without Audit	Reopened
Inpatient Revenue	$819,782,656	$756,682,860	$718,274,475	$658,397,073	$572,368,449
Outpatient					

Pied.Supp-CON 238

JOINT-B-PMC-001.0889

RECORD 002994

Revenue	$506,867,149	$424,335,965	$388,506,690	$359,643,400	$357,966,951
Total Patient Revenue	$1,326,649,805	$1,181,018,825	$1,106,781,165	$1,018,040,473	$930,335,400
Contractual Allowance (Discounts)	$767,667,686	$680,428,749	$624,148,993	$574,854,772	$512,235,559
Net Patient Revenues	$558,982,119	$500,590,076	$482,632,172	$443,185,701	$418,099,841
Total Operating Expense[1]	$517,671,339	$496,057,932	$486,303,728	$453,499,754	$439,225,207
Operating Income	**$41,310,780**	**$4,532,144**	**$-3,671,556**	**$-10,314,053**	**$-21,125,366**
Other Income (Contributions, Bequests, etc.)	$810,317	$1,750,499	$1,787,496	$1,694,549	$1,442,742
Income from Investments	$71,130	$-32,493	$27,174,692	$151,684	$139,992
Governmental Appropriations	$307,020	$277,743	$242,318	$227,743	$216,067
Miscellaneous Non-Patient Revenue	$11,056,331	$12,085,283	$10,497,143	$6,877,752	$4,684,892
Total Non-Patient Revenue	$12,244,798	$14,081,032	$39,701,649	$8,951,728	$6,483,693
Total Other Expenses	$0	$0	$0	$0	$0
Net Income or (Loss)	**$53,555,578**	**$18,613,176**	**$36,030,093**	**$-1,362,325**	**$-14,641,673**
[1] Depreciation Expense (included above)	$17,694,935	$17,103,207	$18,710,414	$18,641,698	$18,251,035

Please note:
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Uncompensated Care

This hospital's most recent cost reporting period is for the period ending 12/31/2009

	Revenue	Estimated Cost
Medicaid	$39,956,702	$60,934,440
State Children's Health Insurance Program (SCHIP)	$0	$0
State and local indigent care programs	$0	$0
TOTAL Governmental Programs	**$39,956,702**	**$60,934,440**
Other uncompensated care	$0	$27,745,276
Restricted grants	$0	N/A

		imposed on business activity within the Metropolitan Commuter Transportation District.
North Carolina	8.9%	The franchise tax rate is $1.50 per $1,000 and is applied to the greatest of three different tax bases, with a minimum of $35.
North Dakota	2.6% > $0 4.1 > 3K 5.6 > 8K 6.4 > 20K 6.5 > 30K	7% for financial institutions, with a minimum of $50. Corporations making a water's-edge election must pay an additional 3.5% tax.
Ohio	0.26% > $0	A tax on gross receipts, the commercial activity tax (CAT), was instituted in 2005. It will be phased in through 2010 while the corporate franchise tax (Ohio's corporate net income tax) is phased out. From April 2008 through March 2009, the CAT rate is 0.208%. Beginning April 1, 2009 the CAT rate is fully phased in and equals 0.26%. For tax year 2009 companies owe 20% of Corporate Franchise Tax liability. For Tax Year 2010 and thereafter the Corporate Franchise Tax is fully phased out.
Oklahoma	6.0%	Additional franchise tax of $1.25 for each $1,000 of capital invested or used in Oklahoma.
gon-	6.6% [redacted]	Minimum tax $10. Financial institutions are subject to the income tax. The top income tax rate (7.9% on income over $250,000) applies to tax years beginning on or after January 1, 2009, and before January 1, 2011.
Pennsylvania	9.99%	Imposes a capital stock and foreign franchise tax of 0.189% on taxable income over $125K. Bank and Trust Company Shares Tax is 1.25%.
Rhode Island	9.0%	Greater of 9% of net income apportioned to Rhode Island or a franchise tax on authorized capital stock at the rate of $2.50 for each $10,000.00 or fractional part thereof (minimum of $500).
South Carolina	5.0%	4.5% for banks; 6% for savings and loans.
South Dakota	None	Banks pay 6% on net income. Minimum tax is $200 per location.
Tennessee	6.5%	Franchise tax of 0.25% of the greater of net worth or real and tangible property (minimum $100)
Texas	None	Texas has a 1% franchise tax which is a gross receipts tax paid by most taxable entities. Qualified

Real Estate Lookup

Print

Close

Parcel Information

Parcel ID	Account	Parent	Previous
12703801	EXEMPT		

Owner(s)

Owner Name	Mailing Address	City/State
NOVANT HEALTH INC	2085 FRONTIS PLAZA BLVD	WINSTON-SALEM NC 27103
ATTN: TAX DEPARTMENT	2085 FRONTIS PLAZA BLVD	WINSTON-SALEM NC 27103

Legal Information

Legal	Municipality	Annexed	Special District	Fire District	Acreage
NA	CHARLOTTE			CITY OF CHARLOTTE	17.51

Total Parcel Assessment & Exemptions

Building	Land	Features	Total	Exemption	Year Approved	Review Date	Amount
145844300	36611300	178200	182633800	HOSPITAL	1995	1/1/2015 12:00:00 AM	182633800

Sales Information

Sale	Price	Stamps	Qualify	V/I	DeedBook	Type	Legal Ref.	Grantor
Oct 26 1990	0			IMP	06384 - 038	DEED STAMPS	06384-038	

Land Use

Use	Units	Type	Neighborhood	Assessment
O400	762735.63	SF	OF02	36611300

Building Information

Bldg	Description	Type	Year Built	Property Location
1	PRESBYTERIAN HOSPITAL Office	HOSPITAL	1941	200 HAWTHORNE LN CHARLOTTE
2	Office	HOSPITAL	1952	200 HAWTHORNE LN CHARLOTTE
3	Office	HOSPITAL	1960	200 HAWTHORNE LN CHARLOTTE
4	Office	HOSPITAL	1958	200 HAWTHORNE LN CHARLOTTE
5	Office	HOSPITAL	1968	200 HAWTHORNE LN CHARLOTTE
6	Office	HOSPITAL	1968	200 HAWTHORNE LN CHARLOTTE
7	Office	OFFICE	1921	220 HAWTHORNE LN CHARLOTTE
8	Office	HOSPITAL	1975	200 HAWTHORNE LN CHARLOTTE
9	Warehouse	LIGHT MFG	1975	200 HAWTHORNE LN CHARLOTTE
10	Warehouse	PKG GARAGE	1975	200 HAWTHORNE LN CHARLOTTE
11	Office	HOSPITAL	1976	200 HAWTHORNE LN CHARLOTTE
12	Office	HOSPITAL	1979	200 HAWTHORNE LN CHARLOTTE
13	Office	HOSPITAL	1982	200 HAWTHORNE LN CHARLOTTE
14	PARKING DECK Warehouse	PKG GARAGE	1987	200 HAWTHORNE LN CHARLOTTE
15	MRI 2003 ADDN Office	HOSPITAL	2003	200 HAWTHORNE LN CHARLOTTE
16	2008 F wing expansion Office	HOSPITAL	2009	200 HAWTHORNE LN CHARLOTTE
17	PRES. HOSP. G WING Office	HOSPITAL	2009	200 HAWTHORNE LN CHARLOTTE

Bldg	Story	Units	Total SqFt	Heated	Foundation	Ext. Wall	Grade	Value
1	1 STORY	1	170496	147760	HIGH RISE	FACE BRICK -	GOOD 02	13345800
2	>= 2.5 STY		51679	50664	HIGH RISE	FACE BRICK -	GOOD 02	6355300
3	2.0 STORY		43572	42852	SLAB-STRUCT	FACE BRICK -	GOOD 02	3423300
4	1 STORY		22418	20748	HIGH RISE	FACE BRICK -	GOOD 02	1710600
5	1 STORY		87695	87695	HIGH RISE	FACE BRICK -	GOOD 02	7978400
6	2.0 STORY		10296	10296	SLAB-COM	FACE BRICK -	GOOD 02	958200
7	2.0 STORY		13525	8543	CRAWL SPACE	FACE BRICK -	GOOD 02	783200
8	1 STORY		259850	204855	HIGH RISE	FACE BRICK -	VERY GOOD 01	29264900
9	1 STORY		19831	16151	HIGH RISE	FACE BRICK -	GOOD 02	1235000
10	2.0 STORY		139382	139382	HIGH RISE	PRECAST PANL -	AVERAGE 04	2970000
11	>= 2.5 STY		60376	57048	HIGH RISE	FACE BRICK -	GOOD 02	5401400
12	>= 2.5 STY		48952	45164	SLAB-STRUCT	FACE BRICK -	VERY GOOD 01	4327100
13	>= 2.5 STY		95786	95786	HIGH RISE	FACE BRICK -	GOOD 02	9304300
14	>= 2.5 STY		313908	313908	HIGH RISE	PRECAST PANL -	GOOD 03	7806300

State Sales Tax Rates
January 1, 2008

State	Tax Rates	Exemptions: Food	Exemptions: Prescription Drugs	Exemptions: Non-prescription Drugs
ALABAMA	4		*	
ALASKA	none			
ARIZONA	5.6	*	*	
ARKANSAS	6	3% (4)	*	
CALIFORNIA (3)	7.25 (2)	*	*	
COLORADO	2.9	*	*	
CONNECTICUT	6	*	*	*
DELAWARE	none			
FLORIDA	6	*	*	*
GEORGIA	4	* (4)	*	
HAWAII	4		*	
IDAHO	6		*	
ILLINOIS	6.25	1%	1%	1%
INDIANA	6	*	*	
IOWA	5	*	*	
KANSAS	5.3		*	
KENTUCKY	6	*	*	
LOUISIANA	4	* (4)	*	
MAINE	5	*	*	
MARYLAND (5)	6	*	*	*
MASSACHUSETTS	5	*	*	
MICHIGAN	6	*	*	
MINNESOTA	6.5	*	*	*
MISSISSIPPI	7		*	
MISSOURI	4.225	1.225%	*	
MONTANA	none			
NEBRASKA	5.5	*	*	
NEVADA	6.5	*	*	
NEW HAMPSHIRE	none			
NEW JERSEY	7	*	*	*
NEW MEXICO	5	*	*	
NEW YORK	4	*	*	*
NORTH CAROLINA (6)	4.25	* (4)	*	
NORTH DAKOTA	5	*	*	
OHIO	5.5	*	*	
OKLAHOMA	4.5		*	
OREGON	none			
PENNSYLVANIA	6	*	*	*
RHODE ISLAND	7	*	*	*
SOUTH CAROLINA	6	*	*	
SOUTH DAKOTA	4		*	
TENNESSEE	7	5.5%	*	
TEXAS	6.25	*	*	*
UTAH	4.65	1.75% (4)	*	

Couches and clothes 2.53
meat, bakery, m toys
auto . 5 & 6.5
public transportation

EXHIBIT
5 Kane
12.20.09

Piedmont Kane 0780

Pied.Supp-CON 842

JOINT-B-PMC-001.0893

Presbyterian-Matthews						
FYE	2009	2008	2007	2006	2005	2004
[illegible]E STATEMENT ($000s)						
[illegible]ss Patient Service Revenue	349,220	315,793	258,987	226,874	192,011	160,447
Deductions from Revenue:						
Free care valued at charges						
Provision for Bad Debt						
Contractual adjustments	193,110	174,876	134,092	119,730	104,625	87,027
Net Patient Serv Revenue	156,110	140,917	124,895	107,144	87,386	73,420
Other Operating Revenue	337	42	81	63	31	32
Total Operating Revenue	156,447	140,959	124,976	107,207	87,417	73,452
OPERATING EXPENSES						
Depreciation and amortization				4,546	4,628	4,543
Interest						
Supplies	19,142	17,176	15,704	13,888	11,324	10,094
Other operating expenses						
Total operating expenses	119,640	107,348	98,147	86,803	70,778	63,089
Operating Income	36,807	33,611	26,829	20,404	16,639	10,363
NONOPERATING REVENUE						
Interest and Dividend						
Realized Gains/losses on sales of securities						
Permanently impaired security writedowns						
Total investment income	18	12	11	8	34	36
Gains/losses on asset sales/equity investments						
Permanently impaired writedowns of nonsecurity assets						
Other nonoperating revenues (gifts, bequests		0		0	0	0
Total nonoperating revenue	18	12	11	8	34	36
Excess of revenue over expenses	36,825	33,623	26,840	20,412	16,673	10,399
OTHER GAINS (LOSSES) DUE TO:						
[illegible]ordinary Gains (Losses)	0	0	0	0	0	0
[illegible]Surplus/Deficit	36,825	33,623	26,840	20,412	16,673	10,399
Markup	2.9217	2.9422	2.6396	2.6144	2.7133	2.5437
Hospital Share of Medicaid shortfall, at cost	2,306	3,023	2,845	2,085	1,535	1,214
Free care at cost	8,869	7,098	1,333	2,159	2,051	1,816
Total CB at cost	11,175	10,121	4,178	4,244	3,586	3,030
Estimated Taxes:						
Federal Rate	0.3299	0.3306	0.2462	0.3248	0.3259	0.3374
State statutory rate	0.0690	0.0690	0.0690	0.0690	0.0690	0.0690
Property Tax Rate	1.1712	1.1712	1.1712	1.1712	1.1712	1.1712
Assessed Value	55,369,700	37052300	37052300	37052300	37052300	37052300
Sales Tax Rate:	0.0725	0.0725	0.0725	0.0725	0.0725	0.0725
Estimated Value of Tax Exemption:						
Federal Income Tax	11,309	10,349	6,151	6,173	5,059	3,267
State Income Tax	2,541	2,320	1,852	1,408	1,150	718
Sales Tax	1,388	1,245	1,139	1,007	821	732
Property Tax	649	434	434	434	434	434
Total Value of Tax Exemption	15,887	14,348	9,576	9,022	7,465	5,150
CB as % TOR	7.14%	7.18%	3.34%	3.96%	4.10%	4.12%
TE as % TOR	10.15%	10.18%	7.66%	8.42%	8.54%	7.01%
Net Benefit as % TOR	-3.01%	-3.00%	-4.32%	-4.46%	-4.44%	-2.89%

	2007	2006	2005	2004
System Unpaid MCD Cost				
	45,578	33472	26882	22370.56
System Net Patient Service Revenues				
	2001095	1720195	2E+06	1353293
Matthews				
PCT NPSR	0.0624133	0.062286	0.0571	0.054253
PCT MCD	2844.6747	2084.8357	1534.5	1213.666

Pres-Matt

Pied.Supp-CO 0843

JOINT-B-PMC-001.0895

RECORD 003000

PRESBYTERIAN-MATTHEWS 2009

	A	B	NOTES
		2009	
1.	**Presbyterian-Matthews**		
2.			
3.			
4.	INCOME STATEMENT **($000s)**		
5.	Total Gross Patient Service Revenue	349,220	Cost Report (ahd.com)
6.	Deductions from Revenue:		
7.	Free care valued at charges		
8.	Provision for Bad Debt		
9.	Contractual adjustments	193,110	Cost Report
10.	Net Patient Serv Revenue	156,110	Cost Report
11.	Other Operating Revenue	337	Cost Report
12.	Total Operating Revenue	156,447	B10 + B11
13.	OPERATING EXPENSES		
14.			
15.	Interest		
16.	Supplies	19,142	B18 x 16%
17.	Other operating expenses		
18.	Total operating expenses	119,640	Cost Report
19.	Operating Income; Misc. non-pt. rev.	36,807	B12 – B18
20.	NONOPERATING REVENUE		
21.	Interest and Dividend		
22.	Realized Gains/losses on sales of securities		
23.	Permanently impaired security writedowns		
24.	Total investment income	18	Cost Report
25.	Gains/losses on asset sales/equity investments		
26.	Permanently impaired writedowns of nonsecurity assets		
27.	Other non-operating revenues (gifts, bequests		
28.	Total non-operating revenue	18	B24
29.	Excess of revenue over expenses	36,825	B19 + B28
30.	OTHER GAINS (LOSSES) DUE TO:		
31.	Extraordinary Gains (Losses)		
32.			
33.	Total Surplus/Deficit	36,825	B29
34.			
35.	Markup	2.9217	(B5 + B11)/B18
36.	Medicaid shortfall at cost	2,306	Cost Report (7,734,976-5,428,657)
37.	Free care at cost	8,869	Cost Report

Pied.Supp-CON 0344

JOINT-B-PMC-001.0896

RECORD 003001

PRESBYTERIAN-MATTHEWS 2009

	A	B	NOTES
		2009	
38.	Total CB at cost	11,175	B36 + B37
39.			
40.	Estimated Taxes:		
41.	Federal Rate	0.3299	Piedmont 2009 spreadsheet B41
42.	State effective rate	0.0690	Taxfoundation.org (Bates Piedmont.Kane.0794)
43.			
44.	Property Tax Rate	1.1712	Phone conf. with Mecklenburg Cty. Tax Assessor Office
45.	**NOT IN $000s BELOW** Assessed Value	55,389,700	Mecklenburg Cty. Real Estate Lookup website
46.			
47.			
48.	Sales Tax Rate:	.0725	State Sales Tax website and note re: phone conf. with Mecklenburg County Tax Assessor Office (Piedmont.Kane.0789)
49.			
50.	Estimated Value of Tax Exemption:		
51.	Federal Income Tax	11,309,000	(B33 – B52) x B41
52.	State Income Tax	2,541,000	B42 x B33
53.	Sales Tax	1,388,000	B48 x B16
54.	Property Tax	649,000	B44 x (B45/100)
55.	Total Value of Tax Exemption	15,887,000	B51 + B52 + B53 + B54
56.			
57.	CB as % TOR	7.14%	B38/B12
58.	TE as % TOR	10.15%	B55/B12
59.	Net Benefit as % TOR	-3.01%	B57 – B58

ahd.com

Financial - March 18, 2011

Presbyterian Hospital Matthews

Matthews, NC 28105
Medicare Provider Number: 340171

See column headings for cost reporting periods. / Definitions

Balance Sheet

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	Amended	Reopened	Reopened
Assets					
Current Assets	$23,419,542	$22,188,637	$21,768,627	$16,542,146	$14,955,773
Fixed Assets	$47,046,492	$46,836,142	$42,135,429	$42,054,112	$34,462,090
Other Assets	$0	$0	$3,504,079	$45,683	$7,581,220
Total Assets	**$70,466,034**	**$69,024,779**	**$67,408,135**	**$58,641,941**	**$56,999,083**
Liabilities and Fund Balances					
Current Liabilities	$-115,471,043	$-80,093,264	$-48,887,519	$-30,787,778	$5,570,212
Long-Term Liabilities	$547,885	$635,294	$0	$-3,688	$39,199,145
Total Liabilities	**$-114,923,158**	**$-79,457,970**	**$-48,887,519**	**$-30,791,466**	**$44,769,357**
Total Fund Balances	$185,389,192	$148,482,749	$116,295,654	$89,433,407	$12,229,726
Total Liabilities & Fund Balances	**$70,466,034**	**$69,024,779**	**$67,408,135**	**$58,641,941**	**$56,999,083**

Income Statement

Data are annualized for periods other than twelve months.

Period ending date	12/31/2009	12/31/2008	12/31/2007	12/31/2006	12/31/2005
Number of months in period	12	12	12	12	12
Cost report status	As Submitted	As Submitted	Amended	Reopened	Reopened
Inpatient Revenue	$154,288,644	$132,397,941	$105,487,860	$91,650,229	$74,487,240
Outpatient Revenue	$194,931,277	$183,395,437	$153,499,172	$135,223,915	$117,523,597
Total Patient Revenue	$349,219,921	$315,793,378	$258,987,032	$226,874,144	$192,010,837
Contractual Allowance (Discounts)	$193,109,505	$174,876,021	$134,091,892	$119,730,085	$104,624,644
Net Patient Revenues	$156,110,416	$140,917,357	$124,895,140	$107,144,059	$87,386,193
Total Operating Expense[1]	$119,639,642	$107,348,265	$98,147,382	$86,802,703	$70,778,144
Operating Income	**$36,470,774**	**$33,569,092**	**$26,747,758**	**$20,341,356**	**$16,608,049**

Other Income (Contributions, Bequests, etc.)	$0	$0	$22,076	$0	$0
Income from Investments	$17,903	$12,089	$11,388	$8,167	$33,507
Governmental Appropriations	$0	$0	$0	$0	$0
Miscellaneous Non-Patient Revenue	$337,338	$41,552	$81,025	$62,856	$30,554
Total Non-Patient Revenue	$355,241	$53,641	$114,489	$71,023	$64,061
Total Other Expenses	$0	$0	$0	$0	$0
Net Income or (Loss)	**$36,826,015**	**$33,622,733**	**$26,862,247**	**$20,412,379**	**$16,672,110**

[1] Depreciation Expense (included above)	$5,012,302	$3,685,492	$5,248,161	$4,545,665	$4,628,352

Please note:
Hospitals receiving 100% Federal prospective payment for capital were not required to complete Parts III - IV of Worksheet A-7 for cost reports beginning on or after October 1, 2001 and ending before February 29, 2004. All other hospitals must complete Parts III and IV for all cost reporting periods ending on or after April 30, 2005. This worksheet is the source of interest, depreciation, and amortization expense.

Uncompensated Care

This hospital's most recent cost reporting period is for the period ending 12/31/2009

	Revenue	Estimated Cost
Medicaid	$5,428,657	$7,734,976
State Children's Health Insurance Program (SCHIP)	$0	$0
State and local indigent care programs	$0	$0
TOTAL Governmental Programs	**$5,428,657**	**$7,734,976**
Other uncompensated care	$0	$8,868,905
Restricted grants	$0	N/A
Unrestricted grants	$0	N/A

		imposed on business activity within the Metropolitan Commuter Transportation District.
North Carolina	6.9%	The franchise tax rate is $1.50 per $1,000 and is applied to the greatest of three different tax bases, with a minimum of $35.
North Dakota	2.6% > $0 4.1 > 3K 5.6 > 8K 6.4 > 20K 6.5 > 30K	7% for financial institutions, with a minimum of $50. Corporations making a water's-edge election must pay an additional 3.5% tax.
Ohio	0.26% > $0	A tax on gross receipts, the commercial activity tax (CAT), was instituted in 2005. It will be phased in through 2010 while the corporate franchise tax (Ohio's corporate net income tax) is phased out. From April 2008 through March 2009, the CAT rate is 0.208%. Beginning April 1, 2009 the CAT rate is fully phased in and equals 0.26%. For tax year 2008 companies owe 20% of Corporate Franchise Tax liability. For Tax Year 2010 and thereafter the Corporate Franchise Tax is fully phased out.
Oklahoma	6.0%	Additional franchise tax of $1.25 for each $1,000 of capital invested or used in Oklahoma.
gon.	6.6%	Minimum tax $10. Financial institutions are subject to the income tax. The top income tax rate (7.9% on income over $250,000) applies to tax years beginning on or after January 1, 2009, and before January 1, 2011.
Pennsylvania	9.99%	Imposes a capital stock and foreign franchise tax of 0.189% on taxable income over $125K. Bank and Trust Company Shares Tax is 1.25%.
Rhode Island	9.0%	Greater of 9% of net income apportioned to Rhode Island or a franchise tax on authorized capital stock at the rate of $2.50 for each $10,000.00 or fractional part thereof (minimum of $500).
South Carolina	5.0%	4.5% for banks; 6% for savings and loans.
South Dakota	None	Banks pay 6% on net income. Minimum tax is $200 per location.
Tennessee	6.5%	Franchise tax of 0.25% of the greater of net worth or real and tangible property (minimum $100)
Texas	None	Texas has a 1% franchise tax which is a gross receipts tax paid by most taxable entities. Qualified

Real Estate Lookup

Print

Close

Parcel Information

Parcel ID	Account	Parent	Previous
19329115	EXEMPT		

Owner(s)

Owner Name	Mailing Address	City/State
NOVANT HEALTH INC	PO BOX 33549	CHARLOTTE NC 28233
ATTN: PROPERTY MANAGEMENT	PO BOX 33549	CHARLOTTE NC 28233

Legal Information

Legal	Municipality	Annexed	Special District	Fire District	Acreage
70% EXEMPT MEDICAL OFFICE BLDG ON CD #2 ONLY MATTHEWS				FIRE SERVICE E MATTHEWS / MORNING STAR	42.13

Total Parcel Assessment & Exemptions

Building	Land	Features	Total	Exemption	Year Approved	Review Date	Amount
42099400	12846300	444000	55389700	HOSPITAL	1997	1/1/2013 12:00:00 AM	55389700

Sales Information

Sale	Price	Stamps	Qualify	V/I	DeedBook	Type	Legal Ref.	Grantor
Aug 16 1989	0			VAC	06088 - 949		06088-949	

Land Use

Use	Units	Type	Neighborhood	Assessment
O400	42.13	AC	OF11	12846300

Building Information

Bldg	Description	Type	Year Built	Property Location
1	MATTHEWS PRES. HOSP Office	HOSPITAL	1999	1450 MATTHEWS TOWNSHIP PY MATTHEWS
2	MATTHEWS MED. BLDG. Office	MEDICAL	1999	1500 MATTHEWS TOWNSHIP PY MATTHEWS
3	2003 MRI ADDN MATT PRES Office	HOSPITAL	2003	1500 MATTHEWS TOWNSHIP PY MATTHEWS
4	PRES HOSP EMERGENCY ADD Office	HOSPITAL	2004	1500 MATTHEWS TOWNSHIP PY MATTHEWS

Bldg	Story	Units	Total SqFt	Heated	Foundation	Ext. Wall	Grade	Value
1	>= 2.5 STY	1	261375	257975	SLAB-RES	JUMBO/COM BR - FACE BRICK	AVERAGE 03	24481700
2	>= 2.5 STY	1	143725	142825	SLAB-RES	JUMBO/COM BR - FACE BRICK	VERY GOOD 03	15062200
3	1 STORY	1	3740	3668	SLAB-COM	JUMBO/COM BR - FACE BRICK	AVERAGE 03	431500
4	1 STORY		17028	13788	SLAB-HEAVY	FACE BRICK -	VERY GOOD 03	2124000

Bldg	Heat	Fuel	FirePlace	AC	Fixtures	Bedrooms	Full Baths	3/4 Baths	1/2 Baths
1	AIR-DUCTED	GAS		AC-CENTRAL	423	0	0		168
2	AIR-DUCTED	GAS		AC-CENTRAL	169	0	0		64
3	AIR-DUCTED	GAS		AIR-DUCTED	4	0	2		
4	AC-CHLD WAT	GAS		AIR-DUCTED					

Sub Areas

Bldg	Description	Size
1	BASE (FIRST FLOOR)	51595
1	UPPER STORY - FINISHED	51595
1	UPPER STORY - FINISHED	51595
1	UPPER STORY - FINISHED	51595
1	UPPER STORY - FINISHED	51595
1	CANOPY	2500
1	CANOPY	900
2	BASE (FIRST FLOOR)	38719
2	UPPER STORY - FINISHED	34702
2	UPPER STORY - FINISHED	34702
2	UPPER STORY - FINISHED	34702
2	CANOPY	900
3	BASE (FIRST FLOOR)	3668
3	PORCH - OPEN - FINISHED	72
4	BASE (FIRST FLOOR)	13788

State Sales Tax Rates
January 1, 2008

		Exemptions		
States	Tax Rates	Food	Prescription Drugs	Non-prescription Drugs
ALABAMA	4		■	
ALASKA	none			
ARIZONA	5.6	■	■	
ARKANSAS	6	3% (4)	■	
CALIFORNIA (3)	7.25 (2)	■	■	
COLORADO	2.9	■	■	
CONNECTICUT	6	■	■	■
DELAWARE	none			
FLORIDA	6	■	■	■
GEORGIA	4	■ (4)	■	
HAWAII	4		■	
IDAHO	6		■	
ILLINOIS	6.25	1%	1%	1%
INDIANA	6	■	■	
IOWA	5	■	■	
KANSAS	5.3		■	
KENTUCKY	6	■	■	
LOUISIANA	4	■ (4)	■	
MAINE	5	■	■	
MARYLAND (5)	6	■	■	■
MASSACHUSETTS	5	■	■	
MICHIGAN	6	■	■	
MINNESOTA	6.5	■	■	■
MISSISSIPPI	7		■	
MISSOURI	4.225	1.225%	■	
MONTANA	none			
NEBRASKA	5.5	■	■	
NEVADA	6.5	■	■	
NEW HAMPSHIRE	none			
NEW JERSEY	7	■	■	■
NEW MEXICO	5	■	■	
NEW YORK	4	■	■	■
NORTH CAROLINA (6)	4.25	■ (6)	■	
NORTH DAKOTA	5	■	■	
OHIO	5.5	■	■	
OKLAHOMA	4.5		■	
OREGON	none			
PENNSYLVANIA	6	■	■	■
RHODE ISLAND	7	■	■	■
SOUTH CAROLINA	6	■	■	
SOUTH DAKOTA	4		■	
TENNESSEE	7	5.5%	■	
TEXAS	6.25	■	■	■
UTAH	4.65	1.75% (4)	■	

Counties add extra 2.5% Mecklenburg, on top extra .5 of 1% prescription

EXHIBIT
5 Kane
4.20.09

Piedmont.Kane.0789

Pied.Supp-CON 0850

JOINT-B-PMC-001.0902

LEVITT

healthcare
affiliates

August 18, 2011

Ms. Beverly Brandt
Chief
Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

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

Dear Ms. Brandt:

The following is clarifying information on the above referenced project.

1. Names of 45 physicians who provided letters of support for Piedmont (page 9, July 11 response).

Response: **Attachment 1** provides a list and the Bates page for each letter. Also provided is a copy of the letter.

2. Summary of capital projects and improvements for Piedmont Medical Center over the past 10 years.

Response: **Attachment 2** provides the capital projects for Piedmont Medical Center and affiliates from 2001 through 2010. For the 10-year period, total expenditures were over $143,000,000.

3. Explanation for the decline of endoscopy outpatient operations at Piedmont from 5,813 in 2009 to 2,316 in 2010 as per the 2010 JAR, and any operational or financial ramifications from this decline.

Response: Piedmont Medical Center experienced a dramatic decline in endoscopy utilization from 2009 to 2010 due to the opening of a freestanding physician owned endoscopy center, York County Endoscopy Center (YCEC). In 2007, Piedmont opposed YCEC's CON application due to the negative impact expected by the center; however, the project was approved. As projected in 2007, the opening of the new center has had a dramatic negative impact on the endoscopy services at PMC. From CY 2009 to 2010,

1778 Emory Ridge Drive, Atlanta, GA 30329
(p) 404.315.9011 (f) 404.315.1071

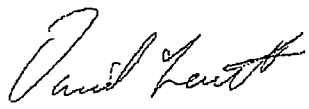
9 River Place, Beaufort, SC 29906
(p) 843.379.9372 (f) 843.379.9373

cell 404.964.2658
david.levitt@comcast.net

outpatient endoscopy volume declined over 60 percent and outpatient endoscopy revenue decreased by approximately $5.4 million. The resulting negative impact on a contribution margin basis (net revenue less variable expenses) totals over $3.4 million. AS volume decreased, capacity was reduced by closing one of the endoscopy suites and clinical staff was reduced. The negative impact has continued into the current fiscal year, with volumes remaining significantly reduced from 2009 and consistent with 2010 experience.

If you have any additional questions, please do not hesitate to contact me at 843-379-9372. I look forward to working with you as this project continues.

Sincerely,



David S. Levitt
Managing Principal

ATTACHMENT 1

PHYSICIAN LETTERS OF SUPPORT

Independent York County Physicians Letters of Support for PMC

Physician	Bates ID
Adlakha, Arun, MD, F.C.C.P.	Pied.MD.LTR.0054-.0055
Alleyne, William F., MD, F.C.C.P.	Pied.MD.LTR.0015
Cowan, Michael A., MD	Pied.MD.LTR.0060-.0061
Culp, Max A., MD	Pied.MD.LTR.0049
Curtis, Ken, DC, DIBCN	Pied.MD.LTR.0046
DiOrio, Christopher, MD	Pied.MD.LTR.0003
Edgerton, T. Arthur, MD	Pied.MD.LTR.0069-.0070
Espinal, Alex, MD	Pied.MD.LTR.0018
Fleischer, Thomas G., MD	Pied.MD.LTR.0021 - .0022
Gor, Asutosh, MD	Pied.MD.LTR.0016
Heinig, Michael, MD	Pied.MD.LTR.0051 - 0052
Hicklin, Harry E. III, MD	Pied.MD.LTR.0075 - .0076
Hoitink, John C., Dr.	Pied.MD.LTR.0064
Hooten, Mark, MD	Pied.MD.LTR.0083
Johnson, Ronald	Pied.MD.LTR.0030
Kessler, Chad, MD	Pied.MD.LTR.0032
Lehman, William L. Jr., MD	Pied.MD.LTR.0050
Livingston, W.D. Jr., MD	Pied.MD.LTR.0039
Lupo, Susan E. MD	Pied.MD.LTR.0073
Magura, Christian, MD	Pied.MD.LTR.0027
Martin, Robert, MD	Pied.MD.LTR.0013
Matthews, Curtis J., MD	Pied.MD.LTR.0025
McCarthy, William G., MD	Pied.MD.LTR.0017
McClelland, Robert, MD	Pied.MD.LTR.0074
Patel, Kashyap, MD	Pied.MD.LTR.0048
Patel, Vasant B., MD	Pied.MD.LTR.0034-.0035
Paxtor, Carlos, MD	Pied.MD.LTR.0072
Pennington, Larry H., MD	Pied.MD.LTR.0053
Powell, E. Neal, MD	Pied.MD.LTR.0033
Randall, Robert Jr., MD	Pied.MD.LTR.0036
Richter, Richard L., MD	Pied.MD.LTR.0026
Robinson, Joe C., MD	Pied.MD.LTR.0068
Shah, Jay K., MD	Pied.MD.LTR.0065-.0066
Singh, Pradeep, MD	Pied.MD.LTR.0062-.0063
Singhi, Sushil K., MD	Pied.MD.LTR.0028-.0029
Taormina, Martin V., MD	Pied.MD.LTR.0042-.0043
Taylor, R. Norman, MD	Pied.MD.LTR.0044
Walker, Robert, MD	Pied.MD.LTR.0071
Welsh, James D., MD	Pied.MD.LTR.0047

Wilson, Robert, MD	Pied.MD.LTR.0031
Zdeneck, Joseph	Pied.MD.LTR.0004
Carlisle, Joseph, DMD	00361 (2005 DHEC Review)
Nicolson, Douglas, DO	000073 (2005 DHEC Review)
Risser, Marjorie, DMD	000807 (2005 DHEC Review)
Simpson, Thomas H., MD	000809 (2005 DHEC Review)

ATTACHMENT 2

CAPITAL PROJECTS FOR PIEDMONT MEDICAL CENTER AND AFFILIATES
FROM 2001 THROUGH 2010

Piedmont Medical Center and Affiliates
2001 - 2010 Capital and Major Operating Leases
Listed by Calendar Year

Category Description	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Grand Total
Piedmont Medical Center and MSOs											
BUILDINGS - HOSPITAL	3,497,481	25,795,541	8,762,824	1,239,786	1,672,256	1,017,952	1,480,831	296,310	1,618,106	8,676	$ 45,389,743
BUILDINGS - OTHER	22,482	8,018	926					12,460	213		$ 44,099
COMPUTER PROGRAMS, SW, PC LIC	255,017	81,647	272,260	571,633	163,050	253,846	1,710,129	390,713	797,107	1,050,362	$ 5,545,764
EQUIPMENT AUTOMOTIVE	17,079		27,607	104,160	97,513	458,909	157,183	268,996	3,795	276,943	$ 1,412,185
EQUIPMENT FIXED EQUIPMENT	14,393	75,103	173,446	(31,214)	967	15,787	228,159	1,178,903	64,988	355,712	$ 2,076,244
EQUIPMENT MAJOR MOV-15 YRS	1,230,369	3,001,427	2,398,795	1,166,379	1,520,414	1,434,302	2,255,407	1,480,964	251,877	658,911	$ 15,398,844
EQUIPMENT MAJOR MOV-7 YRS	5,811,707	4,178,553	2,588,722	1,373,688	2,812,481	8,846,145	7,891,731	2,944,670	2,829,334	5,752,427	$ 45,029,458
EQUIPMENT MINOR MOVAB							13,893		4,224		$ 18,116
INTANGIBLES SW DVL LIC 15YRS	33,471			749,649				222,908	5,390	220,084	$ 1,231,502
LAND NOT HELD 4 EXPANS-HSP FAC		511,887	853,260		1,011,059	9,666,580					$ 12,042,786
LAND/EXPANS				774,017							$ 774,017
LAND/IMPROV OTHER		100,594		2,084			119			13,750	$ 116,547
LAND/IMPROV PARKING LOT			9,718						916,098		$ 925,816
LEASEHOLD/IMP LEASEHOLD IMPROV			12,687				55,496		17,300		$ 85,483
Asset Ledger Capital - Hospital & MSOs	10,882,000	33,752,770	15,100,245	5,950,161	7,277,740	21,693,521	13,792,947	6,795,923	6,508,430	8,336,866	$ 130,090,603
Operating Lease - Cath Lab			212,450	456,001	841,065	1,112,673	1,242,069	1,243,317	1,251,138	414,239	$ 6,772,951
Operating Lease - Pyxis		186,069	191,476	186,949	186,159	282,550	437,458	389,157	443,241	446,473	$ 2,749,531
Cath Lab and Pyxis Operating Leases	-	186,069	403,926	642,950	1,027,223	1,395,222	1,679,526	1,632,474	1,694,379	860,711	$ 9,522,482
Carolina Surgical Center											
BUILDINGS HOSP BLDGS		3,612	2,647				698,845				$ 705,104
EQUIPMENT FIXED EQUIPMENT		9,092			67,747		8,450	20,017	2,006		$ 107,312
EQUIPMENT MAJOR MOV-15 YRS	4,628	459,927	62,929	1,456	8,460	3,341	41,728	914	46,659	19,275	$ 649,317
EQUIPMENT MAJOR MOV-7 YRS	23,803	1,004,940	154,900	23,008	356,852	20,148	54,645	34,588	85,606	427,292	$ 2,185,781
COMPUTER PRG SW PC LIC 3,5,10							22,484		3,852		$ 26,336
Total Fixed Asset Ledger Capital - CSC	28,431	1,477,570	220,476	24,464	433,060	23,488	826,153	55,519	138,123	446,567	3,673,851
Grand Total	$ 10,910,430	$ 35,416,409	$ 15,724,648	$ 6,617,576	$ 8,738,023	$ 23,112,232	$ 16,298,626	$ 8,483,916	$ 8,340,932	$ 9,644,144	$ 143,286,937

8/18/2011

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

Certified Mail 91 7199 9991 7030 0505 8631

September 9, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

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

Dear Mr. Miller:

It is the decision of this Department that the Certificate of Need application submitted by Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center for the construction of a one hundred (100) bed general acute care hospital in York County, South Carolina, be denied. The Department has decided to grant the competing Certificate of Need application submitted by Carolinas Medical Center – Fort Mill for the construction of a sixy-four (64) bed general acute care hospital in York County on the basis that it most fully complies with the requirements, goals, and purposes of Certificate of Need Program, the South Carolina Health Plan, Project Review Criteria, and Regulation 61-15, "Certification of Need for Health Facilities and Services."

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

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

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

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

00944

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

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

2. The Department is concerned with the declining utilization at Piedmont Medical Center, the heavy dependence of recapturing significant lost market share which would require a significant reversal of market trend, the impact of redirecting existing patients away from Piedmont Medical Center, the substantial cost of the project, and the ability to finance the project.

3. The Carolinas Medical Center – Fort Mill proposed project adequately demonstrated that its current significant level of market share and utilization will be sufficient to justify the implementation of the project, appears to be financially feasible and proposes to shift current market share to a facility in South Carolina, resulting in less adverse impact to existing facilities.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,

Beverly Brandt

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

Enclosures: Project Review Criteria Analysis
Notice of Appeals Procedure

cc: Ashley Biggers, Esquire, Chief Counsel for DHEC Health Regulation
Ariail B. Kirk, Esquire, McNair Law Firm, P.A.
Ms. Barbara L. Freedy, Director, Certificate of Need, Novant
Doug Muller, Esquire, Moore & Van Allen
Del Murphy, Vice President, Carolinas HealthCare System
Stuart M. Andrews, Jr., Esquire, Nelson Mullins
David Levitt, Levitt Healthcare Affiliates

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

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

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

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

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

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

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

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

January 7, 2011

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

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

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

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

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

Note that the purpose of "this article," Article 3. State Certification of Need and Health Facility Licensure Act, and the CON program as a whole is "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State."

Background Information

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

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

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

Written Findings

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

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

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

00948

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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S.C. DEPT OF HEALTH
& ENVIRONMENTAL CONTROL

2011 SEP 23 AM 9:47

OFFICE OF THE COMMISSIONER
CHIEF OF STAFF
CLERK OF SCDHEC BOARD

Nelson Mullins

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September 23, 2011

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HEALTH FACILITIES AND
SERVICES DEVELOPMENT

Hand Delivered
Lisa Lucas Longshore
Clerk of the Board
Department of Health and
Environmental Control
Office of the Commissioner
2600 Bull Street
Columbia, SC 29201

RE: Carolinas Medical Center-Fort Mill
Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court
Our File No. 05946/01509

Dear Ms. Longshore:

Pursuant to section 44-1-60 of the SC Code of Laws, I am writing on behalf Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center (Piedmont) to request final review of the September 9, 2011 decisions by the Department staff to award a certificate of need (CON) to Carolinas Healthcare System for the construction of a 64-bed general acute hospital in York County, and to deny Piedmont's CON application to construct a 100-bed general acute care hospital in York County.

The grounds on which this request is based include all issues presented to or considered by the Department staff since the order of the Honorable Carolyn C. Matthews issued on December 9, 2009 remanding this matter to the Department. More specifically, Piedmont's application, not the application of Carolinas Medical Center-Fort Mill, instead of the application filed by Piedmont, most fully complies with the requirements, goals, and purposes of the Certificate of Need and Health Facilities Act, the State Health Plan, the project review criteria, and other applicable CON regulations. The staff decisions to approve Carolinas' application and to deny Piedmont's are not supported by the reliable, probative, and substantial evidence based on the whole record before the Department.

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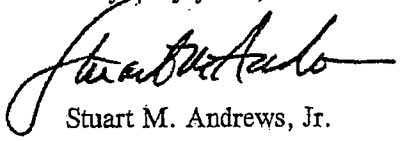
11-RFR-47
21301

Piedmont asks that the Board reverse the staff decision to approve the Carolinas Medical Center-Fort Mill application and, instead, to deny that application and to approve Piedmont's application to construct a 100-bed hospital in York County.

We have enclosed a check made payable to the Department for the filing fee and a copy of the staff's decisions for your convenience. Thank you for your assistance.

Very truly yours,



Stuart M. Andrews, Jr.

SMA:cks
Enclosures
cc: Ashley C. Biggers, Esq.
Douglas M. Muller, Esq.

00958

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

Certified Mail 91 7199 9991 7030 0505 8631

September 9, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

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

Dear Mr. Miller:

It is the decision of this Department that the Certificate of Need application submitted by Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center for the construction of a one hundred (100) bed general acute care hospital in York County, South Carolina, be denied. The Department has decided to grant the competing Certificate of Need application submitted by Carolinas Medical Center – Fort Mill for the construction of a sixy-four (64) bed general acute care hospital in York County on the basis that it most fully complies with the requirements, goals, and purposes of Certificate of Need Program, the South Carolina Health Plan, Project Review Criteria, and Regulation 61-15, "Certification of Need for Health Facilities and Services."

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

- "determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department</u>' as required by S.C. Code Ann. § 44-7-210(C)" (emphasis in original);
- "be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1"; and
- "be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof."

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

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

2. The Department is concerned with the declining utilization at Piedmont Medical Center, the heavy dependence of recapturing significant lost market share which would require a significant reversal of market trend, the impact of redirecting existing patients away from Piedmont Medical Center, the substantial cost of the project, and the ability to finance the project.

3. The Carolinas Medical Center – Fort Mill proposed project adequately demonstrated that its current significant level of market share and utilization will be sufficient to justify the implementation of the project, appears to be financially feasible and proposes to shift current market share to a facility in South Carolina, resulting in less adverse impact to existing facilities.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,

Beverly Brandt

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

Enclosures: Project Review Criteria Analysis
Notice of Appeals Procedure

cc: Ashley Biggers, Esquire, Chief Counsel for DHEC Health Regulation
Ariail B. Kirk, Esquire, McNair Law Firm, P.A.
Ms. Barbara L. Freedy, Director, Certificate of Need, Novant
Doug Muller, Esquire, Moore & Van Allen
Del Murphy, Vice President, Carolinas HealthCare System
Stuart M. Andrews, Jr., Esquire, Nelson Mullins
David Levitt, Levitt Healthcare Affiliates

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

Certified Mail 91 7199 9991 7030 0505 8624

September 9, 2011

Ms. Barbara L. Freedy, Director
Certificate of Need
Novant Health, Inc.
2085 Frontis Plaza Boulevard
Winston-Salem, NC 27103

Re: Presbyterian Hospital York, LLC d/b/a Presbyterian Hospital Fort Mill ("Presbyterian")
Fort Mill, South Carolina
As Per December 9, 2009 Order from Judge Matthews, Administrative Law Court

Dear Ms. Freedy:

It is the decision of this Department that the Certificate of Need application submitted by Presbyterian Hospital York, LLC d/b/a Presbyterian Hospital Fort Mill for the construction of a sixty-four (64) general acute care hospital in York County, South Carolina be denied. The Department has decided to grant the competing Certificate of Need application submitted by Carolinas Medical Center – Fort Mill on the basis that it most fully complies with the requirements, goals, and purposes of Certificate of Need Program, the South Carolina Health Plan, Project Review Criteria, and Regulation 61-15, "Certification of Need for Health Facilities and Services."

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

- "determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department'</u> as required by S.C. Code Ann. § 44-7-210(C)" (emphasis in original);
- "be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1"; and
- "be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof."

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

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

2. The Department is concerned with fact that it would be difficult for Presbyterian to meet proposed utilization projections, and if they are not met, this will affect the financial viability of the project. Presbyterian will also have to capture a high level of market share that is held by other providers, resulting in adverse impact to these providers, primarily Piedmont Medical Center.

3. The Carolinas Medical Center – Fort Mill proposed project adequately demonstrated that its current significant level of market share and utilization will be sufficient to justify the implementation of the project, appears to be financially feasible and proposes to shift current market share to a facility in South Carolina, resulting in less adverse impact to existing facilities.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,

Beverly Brandt

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

Enclosures: Project Review Criteria Analysis
Notice of Appeals Procedure

cc: Ashley Biggers, Esquire, Chief Counsel for DHEC Health Regulation
Ariail B. Kirk, Esquire, McNair Law Firm, P.A.
Doug Muller, Esquire, Moore & Van Allen
Del Murphy, Vice President, Carolinas HealthCare System
Stuart M. Andrews, Jr., Esquire, Nelson Mullins
Charles Miller, President and CEO, Piedmont Medical Center
David Levitt, Levitt Healthcare Affiliates

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

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

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

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

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

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

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

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

January 7, 2011

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

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

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

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

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

Note that the purpose of "this article," Article 3. State Certification of Need and Health Facility Licensure Act, and the CON program as a whole is "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State."

Background Information

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

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

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

Written Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2004 - 2005

South Carolina Health Plan

CHS
TRIAL EXHIBIT
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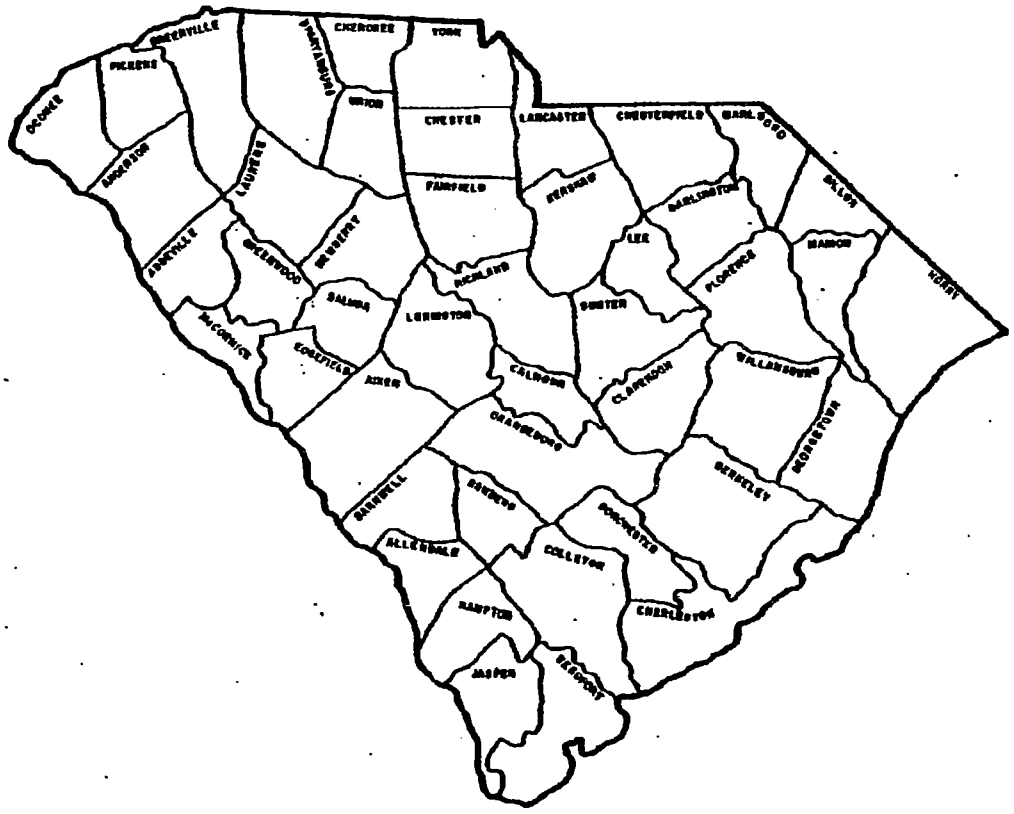
PMC.2013.SHP.0484

2004-2005
South Carolina Health Plan



South Carolina State Health Planning Committee

South Carolina Department of Health and Environmental Control

Effective October 15, 2004 for all but the Open Heart Surgery Section on page II-48, Section (5)A items 1 and 2 and the Ambulatory Surgery Facility Section
The above two sections became effective on January 14, 2005

PMC.2013.SHP.0485

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
Vacant	Consumer	6/30/04
Billy R. Oswald	Consumer	6/30/04
Elliott Elam, Jr.	Ex Officio DHEC Board	(Consumer Affairs)

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CHAPTER I

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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. Safety of Patient Care:

There is both local and national concern regarding the quality of health care services, particularly in relation to patient safety. The Joint Commission on Accreditation of Health Care Organizations (JCAHCO) identified the following 2004 Patient Safety Goals for surveyed facilities: improve the accuracy of patient identification; improve the effectiveness of communication among caregivers; improve the safety of using high-alert medications; eliminating wrong-site, wrong-patient, wrong-procedure surgery; improve the safety of using infusion pumps; improve the effectiveness of clinical alarm systems; and reduce the risk of health care-acquired infections. Not all of the goals or measurements of compliance are appropriate for all organizations. Other organizations, such as the Leapfrog Group, a business consortium of Fortune 500 companies, are also focusing on health care 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 patient safety 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
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    - 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 4,136,020 for 2003 and projected population of 4,446,400 for 2010 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 2003 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 January14, 2005.

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:

TRANSFERS

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.

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY		AGE CAT	2003 POP	2010 POP	2003 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	#1	<18	41,470	42,810	3,000	8.51				
		18-64	105,050	111,950	42,097	122.47				
		+65	23,060	25,620	45,734	140.30				
		TOTAL	169,580	180,280	90,923	271.27	0.75	362	495	-133
CHEROKEE CO.										
UPSTATE CAROLINA MEDICAL CTR		<18	13,980	14,770	1,151	3.33				
		18-64	33,380	35,960	7,241	21.37				
		+65	6,620	7,120	7,577	22.67				
		TOTAL	53,980	57,850	15,985	47.37	0.65	73	125	-52
GREENVILLE CO.										
ALLEN BENNETT MEMORIAL		<18	95,940	99,860	141	0.40				
		18-64	249,390	271,400	6,726	20.05				
		+65	45,090	49,950	6,851	26.95				
		TOTAL	390,420	421,210	13,719	47.41	0.65			
GREENVILLE MEMORIAL MED CTR		<18	95,940	99,860	15,612	44.52				
		18-64	249,390	271,400	103,985	309.74				
		+65	45,090	49,950	73,240	222.29				
		TOTAL	390,420	421,210	192,736	576.54	0.78			
ALLEN BENNETT MEM & GREENVILLE MEM MED CTR AND GREENVILL HOSP SYS-PATEWOOD	#2	TOTAL						642	640	2
HILLCREST		<18	95,940	99,860	54.	0.15				
		18-64	249,390	271,400	4,442	13.24				
		+65	45,090	49,950	6,259	19.00				
		TOTAL	390,420	421,210	10,755	32.39	0.65	50	43	7
NORTH GREENVILLE LTAC	#3	<18	95,940	99,860	-	0.00				
		18-64	249,390	271,400	70	0.21				
		+65	45,090	49,950	163	0.49				
		TOTAL	390,420	421,210	233	0.70	0.65	1	45	-44
SAINT FRANCIS HOSPITAL		<64	345,330	371,260	24,841	73.17				
		+65	45,090	49,950	25,241	76.61				
		TOTAL	390,420	421,210	50,082	149.77	0.70			
ST FRANCIS WOMAN'S & FAMILY HOSP		<64	345,330	371,260	6,819	20.08				
		+65	45,090	49,950	6,915	20.89				
		TOTAL	390,420	421,210	13,721	41.07	0.65			

PMC.2013.SHP.0504

FY 2010 HOSPITAL NEED

FACILITY/COUNTY		AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
SAINT FRANCIS HOSPITAL & ST FRANCIS WOMAN'S & FAMILY HOSP	#4	TOTAL						278	319	-41
REGENCY HOSPITAL GREENVILLE	#5	<18	95,940	99,860	-	0.00				
		18-64	249,390	271,400	-	0.00				
		+65	45,090	49,950	-	0.00				
		TOTAL	390,420	421,210	-	0.00		0	32	-32
OCONEE CO										
OCONEE MEMORIAL		<18	15,360	15,610	855	2.42				
		18-64	42,240	45,020	13,968	40.79				
		+65	11,410	14,830	18,011	62.84				
		TOTAL	69,030	75,460	32,867	106.05	0.65	163	160	3
PICKENS CO										
CANNON MEMORIAL		<18	27,690	29,360	75	0.22				
		18-64	74,910	82,880	1,544	4.68				
		+65	13,150	14,910	4,184	12.94				
		TOTAL	115,750	127,150	5,764	17.84	0.65	27	55	-28
PALMETTO BAPTIST MED CTR EASLEY		<18	27,690	29,360	746	2.16				
		18-64	74,910	82,880	8,920	27.04				
		+65	13,150	14,910	8,956	27.83				
		TOTAL	115,750	127,150	18,623	57.03	0.65	88	109	-21
SPARTANBURG CO										
B.J. WORKMAN MEMORIAL		<18	65,080	67,440	77	0.22				
		18-64	164,700	177,670	957	2.86				
		+65	32,130	35,490	1,601	4.86				
		TOTAL	261,910	280,600	2,642	7.92	0.65	12	43	-31
SPART HOSP RESTORATIVE CARE		<18	65,080	67,440	-	0.00				
		18-64	164,700	177,670	5,513	16.29				
		+65	32,130	35,490	17,082	51.69				
		TOTAL	261,910	280,600	22,595	67.99	0.65	105	97	8
MARY BLACK MEMORIAL		<18	65,080	67,440	1,472	4.18				
		18-64	164,700	177,670	11,454	33.85				
		+65	32,130	35,490	11,601	35.11				
		TOTAL	261,910	280,600	24,527	73.14	0.70	104	176	-72
SPARTANBURG REGIONAL MED CTR		<18	65,080	67,440	4,683	13.86				
		18-64	164,700	177,670	63,861	188.74				
		+65	32,130	35,490	56,222	170.14				
		TOTAL	261,910	280,600	124,217	372.75	0.75	497	532	-35
UNION CO										

PMC.2013.SHP.0505

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
WALLACE THOMSON	<18	7,080	6,990	738	1.99				
	18-64	17,880	17,440	6,272	16.75				
	+65	4,770	5,000	10,560	30.33				
	TOTAL	29,750.	29,430	17,570	49.07	0.65	75	143	-68
REGION II									
ABBEVILLE CO.									
ABBEVILLE CO. MEMORIAL	<18	6,700	6,750	186	0.51				
	18-64	15,940	16,710	1,651	4.74				
	+65	3,840	4,190	2,209	6.60				
	TOTAL	26,480	27,650	4,046	11.86	0.65	18	25	-7
CHESTER CO.									
CHESTER CO. HOSPITAL	<18	9,080	8,910	620	1.67				
	18-64	21,060	21,770	4,133	11.70				
	+65	4,290	4,820	4,640	14.25				
	TOTAL	34,430	35,500	9,393	27.65	0.65	43	82	-39
EDGEFIELD CO.									
EDGEFIELD CO. HOSPITAL #6	<18	5,880	5,840	140	0.38				
	18-64	16,510	18,360	837	2.55				
	+65	2,730	3,200	2,069	6.64				
	TOTAL	25,120	27,400	3,042	9.57	0.65	15	25	-10
FAIRFIELD CO.									
FAIRFIELD MEMORIAL #7	<18	6,170	6,160	88	0.19				
	18-64	14,700	15,440	1,459	4.20				
	+65	3,050	3,300	2,224	6.59				
	TOTAL	23,920	24,900	3,751	10.98	0.65	17	25	-8
GREENWOOD CO									
SELF MEMORIAL HOSPITAL	<18	17,400	17,920	2,129	6.01				
	18-64	41,180	43,630	27,682	80.33				
	+65	9,070	9,620	32,629	94.82				
	TOTAL	67,660	71,170	62,628	181.16	0.70	259	334	-75
KERSHAW CO									
KERSHAW CO. MEMORIAL HOSPITAL 8	<18	13,760	14,180	1,489	4.20				
	18-64	33,550	38,810	8,775	26.38				
	+65	6,920	7,920	12,647	39.66				
	TOTAL	54,230	58,910	22,911	70.24	0.65	108	121	-13
LANCASTER CO									

PMC.2013.SHP.0506

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
SPRINGS MEMORIAL	<18	15,530	15,450	2,114	5.76				
	18-64	38,610	40,540	20,293	55.08				
	+65	7,350	7,970	15,027	47.61				
	TOTAL	61,690	63,960	38,434	111.45	0.65	171	168	3
LAURENS CO									
LAURENS CO. HOSPITAL	<18	17,690	17,720	405	1.11				
	18-64	44,430	48,750	6,333	19.04				
	+65	9,420	10,770	9,443	29.58				
	TOTAL	71,540	77,240	16,197	49.73	0.65	77	76	1
LEXINGTON CO									
LEXINGTON MEDICAL CENTER	<18	35,450	36,961	2,103	6.01				
	18-64	90,687	101,337	42,652	130.58				
	+65	14,653	17,919	39,371	131.91				
	TOTAL	140,790	156,217	84,126	268.49	0.70	384	346	38
NEWBERRY CO									
NEWBERRY CO. MEMORIAL	<18	8,880	8,980	298	0.83				
	18-64	22,640	23,760	4,385	12.61				
	+65	5,330	5,780	7,232	21.49				
	TOTAL	36,850	38,620	11,915	34.92	0.65	54	90	-36
RICHLAND CO									
PALMETTO HEALTH BAPTIST	<18	103,241	105,950	1,919	5.40				
	18-64	268,753	289,794	38,987	115.12				
	+65	40,798	46,361	32,916	102.48				
	TOTAL	412,792	442,105	73,802	222.99	0.75	297	363	-66
PROVIDENCE HOSPITAL	<18	103,241	105,950	70	0.20				
	18-64	268,753	289,794	29,667	87.64				
	+65	40,798	46,361	39,905	124.24				
	TOTAL	412,792	442,105	69,642	212.08	0.70	303	258	45
PROVIDENCE HOSPITAL NORTHEAST	<18	103,241	105,950	74	0.21				
	18-64	268,753	289,794	6,726	19.87				
	+65	40,798	46,361	5,576	17.36				
	TOTAL	412,792	442,105	12,363	37.43	0.65	58	46	12
PALMETTO HEALTH RICHLAND	<18	103,241	105,950	21,430	60.26				
	18-64	268,753	289,794	78,907	233.11				
	+65	40,798	46,361	41,582	129.46				
	TOTAL	412,792	442,105	141,919	422.82	0.75	564	579	-15
INTERMEDICAL HOSPITAL OF SC	<18	103,241	105,950	-	0.00				
	>18	309,551	336,155	9,038	26.89				
	TOTAL	412,792	442,105	9,038	26.89	0.65	41	35	6

PMC.2013.SHP.0507

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
YORK CO									
PIEDMONT MEDICAL CENTER	<18	44,300	45,910	2,937	8.34				
	18-64	110,120	125,480	38,863	115.08				
	+65	17,670	20,910	33,632	109.04				
	TOTAL	172,090	192,300	73,432	232.48	0.70	332	268	64
REGION III									
CHESTERFIELD CO									
CHESTERFIELD GENERAL	<18	11,270	11,080	785	2.11				
	18-64	28,820	27,570	4,519	12.82				
	+65	5,050	5,620	2,096	6.39				
	TOTAL	42,940	44,270	7,408	19.21	0.65	30	59	-29
CLARENDON CO									
CLARENDON MEMORIAL HOSPITAL	<18	8,180	7,770	578	1.50				
	18-64	19,940	20,670	6,624	18.81				
	+65	4,900	5,210	5,367	18.64				
	TOTAL	33,020	34,650	12,569	38.95	0.65	60	56	4
DARLINGTON CO									
CAROLINA PINES REGIONAL HOSPITAL	<18	17,780	17,560	2,444	6.61				
	18-64	41,750	42,690	15,857	44.42				
	+65	8,200	9,000	13,036	39.20				
	TOTAL	67,730	69,250	31,337	90.23	0.65	139	166	-27
WILSON MEDICAL CENTER	<18	17,780	17,560	3	0.01				
	18-64	41,750	42,690	1,111	3.11				
	+65	8,200	9,000	1,974	6.94				
	TOTAL	67,730	69,250	3,085	9.06	0.65	14	49	-35
DILLON CO									
SAINT EUGENE MEDICAL CENTER	<18	8,590	8,090	1,436	3.71				
	18-64	18,360	18,670	6,628	18.47				
	+65	3,490	3,530	5,758	15.96				
	TOTAL	30,440	30,290	13,809	38.13	0.65	59	79	-20
FLORENCE CO									
CAROLINAS HOSP SYS & WOMEN'S CENTER OF THE CAROLINAS HOSP. SYS. #8	<18	32,740	32,610	1,877	5.12				
	18-64	80,440	84,930	35,123	110.28				
	+65	15,190	16,930	39,618	121.59				
	TOTAL	128,370	134,470	75,244	236.99	0.70	339	282	57
CAROLINAS HOSPITAL SYSTEM LAKE CITY	<18	32,740	32,610	103	0.28				
	18-64	80,440	84,930	1,547	4.47				
	+65	15,190	16,930	2,151	6.57				
	TOTAL	128,370	134,470	3,801	10.91	0.65	17	48	-31

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
MCLEOD REGIONAL MEDICAL CTR	<18	32,740	32,610	8,001	21.83				
	18-64	80,440	84,930	60,116	173.89				
	+65	15,190	16,930	43,115	131.66				
	TOTAL	128,370	134,470	111,121	327.38	0.70	468	453	15
REGENCY HOSPITAL OF SC	<18	32,740	32,610		0.00				
	18-64	80,440	84,930		0.00				
	+65	15,190	16,930		0.00				
	TOTAL	128,370	134,470	9,251	25.55	0.65	41	28	13
GEORGETOWN CO									
GEORGETOWN CO. MEMORIAL	<18	13,510	12,660	2,269	5.83				
	18-64	34,530	36,770	15,743	45.93				
	+65	9,280	12,320	17,481	63.58				
	TOTAL	57,320	61,750	35,458	115.34	0.65		131	
WACCAMAW COMMUNITY HOSPITAL	<18	13,510	12,660	122	0.31				
	18-64	34,530	36,770	3,872	11.30				
	+65	9,280	12,320	7,131	25.94				
	TOTAL	57,320	61,750	11,125	37.56	0.65		82	
GEORGETOWN CO. MEMORIAL & WACCAMAW COMMUNITY HOSP #9	TOTAL				152.88	0.65	236	213	23
HORRY CO									
CONWAY HOSPITAL	<18	42,520	43,600	2,313	6.50				
	18-64	132,550	152,460	15,242	46.03				
	+65	33,090	43,000	16,501	58.75				
	TOTAL	208,160	239,060	34,022	113.28	0.65	175	160	15
GRAND STRAND REGIONAL MED CTR	<18	42,520	43,600	1,095	3.08				
	18-64	132,550	152,460	21,296	67.11				
	+65	33,090	43,000	27,416	97.61				
	TOTAL	208,160	239,060	49,757	167.79	0.70	240	219	21
LORIS COMMUNITY HOSPITAL	<18	42,520	43,600	731	2.05				
	18-64	132,550	152,460	8,582	27.04				
	+65	33,090	43,000	9,929	35.35				
	TOTAL	208,160	239,060	19,242	64.45	0.65	99	105	-6
MARION CO									
MARION CO MEDICAL CENTER	<18	9,590	9,200	1,321	3.47				
	18-64	21,940	22,560	16,716	47.09				
	+65	4,190	4,610	16,716	50.39				
	TOTAL	35,720	36,370	34,763	100.95	0.65	155	124	31
MARLBORO CO									

PMC.2013.SHP.0509

FY 2010 HOSPITAL NEED

FACILITY/COUNTY		AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
MARLBORO PARK		<18	7,400	7,070	716	1.87				
		18-64	17,660	17,030	4,641	12.27				
		+65	3,320	3,340	650	1.79				
		TOTAL	28,370	27,440	6,020	15.93	0.65	25	94	-69
SUMTER CO										
TUOMEY		<18	30,250	31,020	2,095	5.89				
		18-64	66,240	70,420	30,012	87.41				
		+65	12,630	14,680	29,458	93.81				
		TOTAL	109,120	116,120	61,627	187.11	0.70	268	248	20
WILLIAMSBURG CO										
WILLIAMSBURG REG HOSPITAL	#10	<18	10,230	9,410	199	0.50				
		18-64	21,930	22,150	2,330	6.45				
		+65	4,890	5,300	2,707	8.04				
		TOTAL	37,050	36,860	5,236	14.99	0.65	23	25	-2
REGION IV										
AIKEN CO.										
AIKEN REGIONAL MEDICAL CTR.		<18	37,520	37,750	897	2.47				
		18-64	92,370	103,080	22,519	68.85				
		+65	19,460	23,110	21,442	69.76				
		TOTAL	149,350	163,940	44,858	141.09	0.65	217	183	34
ALLENDALE CO.										
ALLENDALE CO. HOSPITAL		<18	3,030	3,030	110	0.30				
		18-64	7,050	7,170	827	2.30				
		+65	1,500	1,750	860	3.07				
		TOTAL	11,580	11,950	1,897	5.67	0.65	9	25	-16
BAMBERG CO.										
BAMBERG CO. MEMORIAL		<18	4,210	3,850	98	0.25				
		18-64	9,910	9,560	2,961	7.83				
		+65	2,200	2,340	2,712	7.90				
		TOTAL	16,320	15,750	5,771	15.97	0.65	25	59	-34
BARNWELL CO.										
BARNWELL CO. HOSPITAL		<18	6,390	8,080	411	1.07				
		18-64	14,540	15,820	2,166	6.46				
		+65	3,050	3,490	2,758	8.62				
		TOTAL	23,990	25,400	5,335	16.15	0.65	25	53	-28
BEAUFORT CO.										
BEAUFORT CO. MEMORIAL		<18	28,750	27,740	1,852	4.90				
		18-64	77,320	87,650	20,329	63.14				

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
	+65	22,010	31,030	17,954	69.35				
	TOTAL	128,080	146,420	40,255	137.38	0.65	212	195	17
HILTON HEAD REGIONAL MEDICAL CTR	<18	28,750	27,740	352	0.93				
	18-64	77,320	87,650	8,491	26.37				
	+65	22,010	31,030	14,613	56.44				
	TOTAL	128,080	146,420	23,456	83.74	0.65	129	93	36
BERKELEY/CHARLESTON/DORCHESTER COS									
TRIDENT MEDICAL CENTER	<18	143,710	143,140	2,449	8.68				
	18-64	363,720	390,100	36,966	114.60				
	+65	62,130	78,300	32,807	113.27				
	TOTAL	569,560	611,540	74,225	234.48	0.75	313	271	42
SUMMERVILLE MEDICAL CENTER	0-64	507,430	533,240	11,491	33.08				
	+65	62,130	78,300	9,201	31.77				
	TOTAL	569,560	611,540	20,617	64.85	0.65	100	80	20
KINDRED HOSPITAL CHARLESTON	<18	143,710	143,140		0.00				
	18-64	363,720	390,100	3,533	10.38				
	+65	62,130	78,300	8,442	29.15				
	TOTAL	569,560	611,540	11,975	39.53	0.65	61	59	2
CHARLESTON MEMORIAL #11	<18	143,710	143,140	7	0.02				
	18-64	363,720	390,100	4,342	12.76				
	+65	62,130	78,300	499	1.72				
	TOTAL	569,560	611,540	4,890	14.50	0.65			
MEDICAL UNIVERSITY HOSPITAL #11	<18	143,710	143,140	23,201	63.31				
	18-64	363,720	390,100	75,653	225.24				
	+65	62,130	78,300	28,328	97.61				
	TOTAL	569,560	611,540	126,182	386.35	0.75	538	604	-66
ROPER HOSPITAL	<18	143,710	143,140	1,122	3.06				
	18-64	363,720	390,100	38,144	112.08				
	+65	62,130	78,300	54,224	187.22				
	TOTAL	569,560	611,540	93,489	302.37	0.75	403	414	-11
BON SECOURS ST FRANCIS XAVIER	<18	143,710	143,140	656	1.79				
	18-64	363,720	390,100	20,331	59.74				
	+65	62,130	78,300	17,631	60.86				
	TOTAL	569,560	611,540	38,678	122.41	0.70	175	141	34
EAST COOPER REG MED CTR.	<18	143,710	143,140	166	0.45				
	18-64	363,720	390,100	12,022	35.33				
	+65	62,130	78,300	8,611	29.73				
	TOTAL	569,560	611,540	20,800	65.51	0.65	101	100	1
COLLETON CO.									

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
COLLETON MEDICAL CENTER	<18	10,520	10,690	626	1.74				
	18-64	23,760	25,190	11,429	33.20				
	+65	4,990	5,730	15,157	47.68				
	TOTAL	39,270	41,610	27,211	82.62	0.65	126	131	-3
HAMPTON CO.									
HAMPTON REGIONAL MEDICAL CTR	<18	5,740	5,490	65	0.17				
	18-64	13,340	14,170	1,616	4.71				
	+65	2,590	3,030	1,940	5.22				
	TOTAL	21,670	22,690	3,627	11.10	0.65	17	68	-51
JASPER CO.									
COASTAL CAROLINA MEDICAL CENTER	<18	5,350	5,050	-	0.00				
	18-64	13,410	15,120	-	0.00				
	+65	2,330	2,830	-	0.00				
	TOTAL	21,090	23,000	-	0.00	0.65	0	31	-31
ORANGEBURG CO.									
REG MED CTR ORANGEBURG-CALHOUN	<18	24,070	23,740	2,065	5.68				
	18-64	58,610	59,080	22,016	64.68				
	+65	12,530	14,060	24,488	75.22				
ORANGEBURG CO.	TOTAL	93,210	96,880	49,169	145.48	0.70	208	247	-39

#1 CON ISSUED TO TRANSFER 72 BEDS FOR NEW HOSPITAL.
#2 BED NEEDS ARE COMBINED FOR THESE HOSPITALS; SINCE, ADDITIONAL BEDS WERE APPROVED FOR TRANSFER AMONG THESE HOSPITALS. 6/30/03
#3 CON ISSUED TO CONVERT N GREENVILLE TO A 45 BED LTC HOSPITAL 4/15/03.
#4 BED NEEDS ARE COMBINED FOR THESE HOSPITALS, SINCE ADDITIONAL BEDS WERE APPROVED FOR TRANSFER AMONG THESE HOSPITALS. 6/30/03
#5 CON ISSUED FOR 32 BED LTACH 5/22/04 SC-04-26
#6 THE HOSPITAL DELICENSED FROM 40 TO 25 BEDS ON 8/31/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#7 THE HOSPITAL DELICENSED FROM 50 TO 25 BEDS ON 8/23/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#8 DATA AND BED NEEDS ARE COMBINED.
#9 NEEDS ARE COMBINED SINCE CON SC-03-86 TRANSFER 14 BEDS FROM GM TO WACCAMAW. 11/10/03. AND WACCAMAW ADDED 28 BEDS 4/12/04 SC-04-20.
#10 THE HOSPITAL DELICENSED FROM 75 TO 25 BEDS ON 9/20/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#11 CON ISSUED TO COMBINE THESE TWO FACILITIES SC-09-60 10/14/03.

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SOUTH CAROLINA GENERAL ACUTE BEDS

% OCCUPANCY RATE

	2001	2002	2003
REGION I	58.3	58.7	59.4
ANDERSON AREA MED CTR	52.3	52.8	50.3
UPSTATE CAROLINA MED CTR	34.3	31.7	35.0
ALLEN BENNETT MEMORIAL	71.1	71.3	74.3
GREENVILLE MEM MED CTR	81.8	81.5	83.5
NORTH GREENVILLE LTAC	–	–	13.0
HILLCREST HOSPITAL	43.7	52.7	55.7
ST FRANCIS HOSPITAL	74.7	73.7	66.6
ST FRANCIS WOMEN'S & FAMILY	59.8	58.4	60.6
OCONEE MEMORIAL	54.8	52.2	56.3
CANNON MEMORIAL	31.2	27.8	28.8
PALMETTO BAPTIST M C EASLEY	51.1	52.8	53.1
BJ WORKMAN MEMORIAL	17.5	18.0	16.8
MARY BLACK MEMORIAL	40.7	40.7	38.2
SPART HOSP RESTORATIVE CARE	62.4	40.7	63.8
SPARTANBURG REG MED CTR	62.4	65.6	64.5
HOPE HOSPITAL	13.8	11.5	0.0
WALLACE THOMSON	32.1	32.2	33.7

	2001	2002	2003
REGION II	61.2	63.0	64.8
ABBEVILLE COUNTY	24.0	25.0	21.3
CHESTER REGIONAL MED CTR	44.4	37.3	31.4
EDGEFIELD COUNTY	24.5	19.9	20.8
FAIRFIELD MEMORIAL	33.9	36.4	31.1
SELF REGIONAL MED CTR	49.5	48.5	51.4
KERSHAW COUNTY MEMORIAL	56.3	53.3	51.9
SPRINGS MEMORIAL	77.1	67.6	78.0
LAURENS COUNTY HOSPITAL	64.0	61.4	58.4
LEXINGTON MEDICAL CTR	71.6	75.2	78.9
NEWBERRY CO MEMORIAL	29.3	34.0	36.3
INTERMEDICAL HOSPITAL OF SC	72.3	78.5	70.7
PALMETTO HEALTH BAPTIST	55.9	52.7	55.7
PROVIDENCE HOSPITAL	76.9	79.0	83.7
PROVIDENCE HOSPITAL NE	74.1	82.6	73.6
PALMETTO HEALTH RICHLAND	69.0	68.6	67.2
PIEDMONT MEDICAL CTR	65.2	71.6	75.1

	2001	2002	2003
REGION III	64.0	63.3	63.5
CHESTERFIELD GENERAL	25.1	31.1	34.4
CLARENDON MEMORIAL	67.0	69.5	61.5
CAROLINA PINES REG MED CTR	65.1	69.4	74.0
WILSON CLINIC	20.5	19.7	17.2
ST. EUGENE REGIONAL MED CTR	43.8	48.2	47.9
CAROLINAS HOSPITAL SYSTEM	60.3	68.3	75.6
CAROLINAS HOSP LAKE CITY	21.5	19.9	21.7
MCLEOD REGIONAL MED CTR	92.5	92.0	90.6
WOMEN'S CTR/CAROLINAS	53.2	37.1	40.9
REGENCY HOSPITAL OF SC	12.8	78.6	90.5
GEORGETOWN MEMORIAL	81.0	81.1	68.4
WACCAMAW COMMUNITY	–	–	78.6
CONWAY HOSPITAL	63.3	57.3	58.3
GRAND STRAND REGIONAL	78.6	64.3	62.2
LORIS COMMUNITY	56.0	49.9	50.2
MARION COUNTY MED CTR	90.6	69.4	76.8
MARLBORO PARK	19.2	21.7	17.5
TUOMEY	67.7	70.7	68.1
WILLIAMSBURG REGIONAL	9.3	19.6	18.4

	2001	2002	2003
REGION IV	60.8	62.9	62.2
AIKEN REGIONAL MED CTR	70.9	71.1	69.0
ALLENDALE COUNTY	14.8	21.0	20.8
BAMBERG CO MEMORIAL	27.0	25.2	26.8
BARNWELL COUNTY	28.6	27.9	27.6
BEAUFORT MEMORIAL	89.3	94.7	84.8
HILTON HEAD	78.8	60.6	69.1
CHARLESTON MEMORIAL	11.9	12.3	13.7
EAST COOPER REG MED CTR	48.0	48.8	57.0
MEDICAL UNIVERSITY	72.5	72.2	75.4
TRIDENT MEDICAL CTR	77.6	82.4	76.9
KINDRED-HOSP CHARLESTON	39.1	50.9	55.6
SUMMERVILLE MED CTR	61.4	69.3	74.5
ROPER	63.4	63.9	61.9
BON SECOURS ST FRANCIS X	72.2	75.7	75.0
COLLETON MEDICAL CTR	69.7	61.6	64.3
HAMPTON REGIONAL MED CTR	18.4	13.2	14.6
LOW COUNTRY	0.0	0.0	0.0
RMC ORANGEBURG/CALHOUN	58.7	58.9	54.5

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(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 2002, South Carolina's infant mortality rate was 9.3 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 2002, South Carolina's neonatal mortality rate for all races was 6.4 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.

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

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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 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

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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 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 obstetrical 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.

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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 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
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.
Palmetto Baptist Medical Center - Easley
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital, Inc.
Saint Francis Women's and Family Hospital
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Women's Center of Carolinas Hospital System

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RECORD 003078

FY03 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEM. MED. CTR.	5208	65	6026	16382	69.0%
PALMETTO HEALTH BAPTIST	3705	61	5895	15224	68.4%
LEXINGTON MED. CTR.	2576	35	2769	6501	50.9%
SPARTANBURG REG. MED.CTR.	2506	43	3122	8738	55.7%
PIEDMONT MED. CTR.	2088	19	2239	5695	82.1%
MCLEOD REG. MED. CTR.	2058	20	2686	5777	79.1%
TRIDENT MED. CTR.	2035	25	2495	5947	65.2%
PALMETTO HEALTH RICHLAND	1967	59	5181	9980	46.3%
BEAUFORT MEMORIAL	1814	20	1968	4664	63.9%
MEDICAL UNIVERSITY HOSP.	1803	34			0.0%
ST. FRANCIS WOMEN'S & FAMILY HOSP	1780	24	1962	5113	58.4%
ANDERSON AREA MED CTR	1755	22	1447	3934	49.0%
EAST COOPER REG MED CTR	1539	27	1676	4839	49.1%
SELF MEM. HOSP.	1456	37	2569	6882	51.0%
BON SECOURS' ST. FRANCIS XAVIER	1429	12			0.0%
RMC ORANGEBURG-CALHOUN	1329	27	1885	4758	48.3%
TUOMEY	1153	20	813	4821	66.0%
CONWAY HOSP. INC.	1132	16	1481	3666	62.8%
MARY BLACK MEM.	1114	21	1377	3495	45.6%
WOMEN'S CTR /CAROLINAS	1072	20	1141	2984	40.9%
GRAND STRAND REG MED CTR	931	19	1311	3126	45.1%
ROPER HOSP.	875	11			0.0%
AIKEN REG.MED. CTR.	852	18	1584	4452	67.8%
SUMMERVILLE MED CTR	791	12	794	1684	38.4%
SPRINGS MEMORIAL HOSP	693	7	928	2145	84.0%
CAROLINA PINES REG MED CTR	625	11	712	2820	70.2%
CLARENDON MEM.	563	8	599	1282	43.9%
MARION CO. MEM.	563				
PALMETTO BAPTIST MED CTR EASLEY	547	14	920	2163	42.3%
GEORGETOWN CO. MEM.	527	14	840	2786	54.5%
PROVIDENCE HOSP NE	520	6	602	1347	61.5%
HILTON HEAD REG MED CTR	510	7	587	1385	54.2%
OCONEE MEM.	506	16	1092	3423	58.6%
COLLETON REG MED CTR	419	6	449	1056	48.7%
ALLEN BENNETT MEM	393	5	411	966	52.9%
LAURENS CO. HOSP.	391	8	391	778	26.6%
KERSHAW CO. MED CTR	383	10	597	1497	41.0%
LORIS COMM. HOSP.	382	8	580	1322	45.3%
UPSTATE CAROLINA MED CTR	352	15	546	1278	23.3%
NEWBERRY CO. MEM.	294	12	425	801	18.3%
WACCAMAW COMM HOSPITAL	271	5	379	1248	68.4%
SAINT EUGENE MEDICAL CTR	256	10	421	1078	29.5%
MARLBORO PARK	189				
WALLACE THOMSON	135	4	217	590	40.4%
ABBEVILLE CO. MEM.	131	8	170	499	17.1%
CHESTERFIELD GENERAL	120	7	153	559	21.9%
BAMBERG CO. MEM.	99				
ALLENDALE CO.	97				
WILLIAMSBURG REG HOSP	66	6	86	178	8.1%
CHESTER CO.	18	5	0	68	3.7%

PMC.2013.SHP.0518

RECORD 003079

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 2003 South Carolina had 100.7 LBW births per 1,000 births, with a white rate of 76.1 and a nonwhite rate of 146.3 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.

2003	TOTAL	WHITE	NONWHITE
All Births	55,452	36,001	19,451
<2,500 Grams	5,586	2,739	2,846
Rate/1,000	100.7	76.1	146.3

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

$$\frac{100.7}{80} = 1.26 \text{ bassinets}$$

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

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

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

PMC.2013.SHP.0519

RECORD 003080

When the race variance and incidence of LBW births are factored in the intensive care ratios are:

$$\text{White} = \frac{76.1}{80} = 0.95 \qquad \text{Nonwhite} = \frac{146.3}{80} = 1.83$$

The intermediate care ratios are:

White = 0.95 x 5.04 = 4.79
Non-white = 1.83 x 5.04 = 9.22

The actual births in South Carolina have been:

1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
51,907	50,913	51,105	52,205	53,833	54,706	55,964	55,748	54,453	55,461

The projected births have been:

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
51,860	53,120	53,210	53,330	53,440	53,490	53,500	53,560	53,600	53,670

The following projected need for neonatal intensive care bassinets is based on the actual number of 2003 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 & Self Memorial	27	19
Spartanburg Regional	13	10
Palmetto Richland & Baptist	39	31
McLeod Regional	24	12
MUSC Medical Center	25	16
TOTAL	128	88

Note: S.C. presently has 1.6 neonatal intensive care bassinets and 5.9 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.

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RECORD 003081

Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Anderson, Greenville, Oconee, Pickens, Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda		
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
Self Memorial Hospital	7	11
SUBTOTAL	19	64
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Med Ctr	10	15
Mary Black Memorial Hospital	0	8
SUBTOTAL	10	23
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Lee Kershaw, Lancaster, Orangeburg, York, Lexington, Newberry, Richland, Sumter		
Palmetto Richland Memorial	27	40
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	0	8
SUBTOTAL	31	107
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	11
SUBTOTAL	12	54

* CON issued for Level IIE 9/18/2002; licensed 1/28/2003.

PMC.2013.SHP.0521

RECORD 003082

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
Summerville Medical Center	0	3
Trident Medical Center	0	5
Roper Hospital	0	5
SUBTOTAL	16	78
TOTAL	88	326

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	64	72	8
Spartanburg	23	30	7
Richland	107	123	16
Florence	54	52	(2)
Charleston	78	84	6
TOTAL	326	361	35

Based on the above information, it appears that the number of intermediate care bassinets should be added in some areas. The intermediate care bassinets should be better utilized 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 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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RECORD 003084

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-2003. This utilization information supports the projected need.

NEONATAL UTILIZATION FROM 2003 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	794	2.2	7	794	2.2	31.1%
Greenville Memorial	12	5748	15.7	34	7876	21.6	46	13624	37.3	81.1%
St. Francis Women's				10	1215	3.3	10	1215	3.3	33.3%
Palmetto Baptist-Easley				2	0	0	2	0	0	0.0%
REGION SUBTOTAL	12	5748	15.7	53	9885	27.1	65	15633	42.8	65.9%
Spartanburg Regional	10	2864	7.8	15	5309	14.5	25	8173	22.4	89.6%
Mary Black Memorial				8	967	2.6	8	967	2.6	33.1%
REGION SUBTOTAL	10	2864	7.8	23	6276	17.2	33	9140	25.0	75.9%
Self Memorial	7	446	1.2	11	2015	5.5	18	2461	6.7	37.5%
REGION SUBTOTAL	7	446	1.2	11	2015	5.5	18	2461	6.7	37.5%
Palmetto Richland Mem	21	7661	21.0	40	9005	24.7	61	16666	45.7	74.9%
Lexington Medical Center				20	2209	6.1	20	2209	6.1	30.3%
Piedmont Medical Center				8	1070	2.9	8	1070	2.9	36.6%
Springs Memorial Hosp				4	0	0	4	0	0	0.0%
Palmetto Baptist Med Ctr	4 *	*		16 *	*		20	7013	19.2	96.1%
Tuomey Regional				8	0	0.0	8	0	0.0	0.0%
Reg Med.Ctr Orangeburg				3	438	1.2	3	438	1.2	40.0%
Aiken Regional Med Ctr				8	541	1.5	8	541	1.5	18.5%
REGION SUBTOTAL	25	7661	21.0	107	13263	36.3	132	20924	57.3	43.4%
Women's Ctr of Carolinas				11	853	2.3	11	853	2.3	21.2%
McLeod Regional	12	5322	14.6	28	4935	13.5	40	10257	28.1	70.3%
Carolina Pines				4	0	0.0	4	0	0.0	0.0%
Marion Co Medical Ctr				2	0	0	2	0	0	0.0%
Grand Strand Regional				3	24	0.1	3	24	0.1	2.2%
Conway Hospital				6	621	1.7	6	621	1.7	28.4%
REGION SUBTOTAL	12	5322	14.6	54	6433	15.9	66	11755	32.2	48.8%
Georgetown Co Memorial				5	273	0.7	5	273	0.7	15.0%
MUSC Medical Center	16	5655	15.5	46	11654	31.9	62	17309	47.4	76.5%
Roper Hospital				5	259	0.7	5	259	0.7	14.2%
East Cooper Reg Med Ctr				6	0	0.0	6	0	0.0	0.0%
Trident Reg Med Center				5	745	2.0	5	745	2.0	40.8%
Bon Secours-St. Francis				4	222	0.6	4	222	0.6	15.2%
Summerville Med. Ctr.				3	0	0.0	3	0	0.0	0.0%
Beaufort Memorial Hosp				3	70	0.2	3	70	0.2	6.4%
SUBTOTAL	16	5655	15.5	77	13223	36.0	93	18878	51.7	55.6%
GRAND TOTAL	82	27696	75.9	325	51095	138.1	407	78791	215.9	53.0%

* Hospital did not separate data by intensive and intermediate care
Palmetto Richland added 6 ICU bassinets in 2002 which are not reflected above.

(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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RECORD 003086

(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.

CT Angiography is another promising tool that may eventually become a substitute for diagnostic cardiac catheterizations. The 16-slice CT, introduced in 2002, offers image resolution and speed that allows it to capture the small anatomy of a beating heart. The procedure takes approximately 15 minutes to perform. It costs about $3,000 but is rarely reimbursed at this point. A 32-slice machine is currently under development that will further enhance the available imaging. The machine costs $1.2 million. About 2,500 16-slice CTs have been sold worldwide, with approximately 600 dedicated to cardiac imaging.

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RECORD 003087

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 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 Coronary Intervention (PCI) is a therapeutic catheterization procedure used in treating occluded or partially occluded coronary arteries. Treatment of an occluded vessel is accomplished by inserting a catheter with a balloon or a stent into the blood vessel and guided to the site of the constriction in the vessel. Because of the risk of arterial damage and resulting need for immediate open heart surgery, elective PCI is contraindicated for institutions without an on-site open heart surgery program. Hospitals without an open heart surgery program shall be allowed to provide emergent PCIs ("Primary PCIs") only if they comply with all sections of Standard (8) of the Standards for Cardiac Catheterization.

Percutaneous Transluminal Coronary Angioplasty (PTCA) is the most common PCI. Percutaneous Transluminal Coronary Angioplasty (PTCA) is the most common therapeutic procedure. A balloon is 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.

Another common therapeutic intervention is the coronary stent, often used in conjunction with a PTCA. When using a 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 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.

In April 2003, the Centers for Medicare and Medicaid Services (CMS) began reimbursing hospitals for the Cypher drug-eluting stent that is coated with an anti-rejection drug. Clinical trials indicated that this stent reduces restenosis by 75% compared with conventional stents. However, there have also been reports of higher than expected complication rates, possibly due to inappropriate utilization. In March 2004, the Food and Drug Administration (FDA) approved the Taxus drug-eluting stent. It is anticipated that these stents will capture the majority of the stent market within the next few years, and may reduce the number of coronary bypass surgeries performed.

Open heart surgery refers to an operation performed on the heart or intrathoracic great vessels which

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requires the temporary use of a heart-lung bypass machine to perform the normal functions of the heart and lungs during surgery. 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. Mortality rates have declined significantly since its introduction, but CABG still carries significant risks. 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 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 appear 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 require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 32 hospitals approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Of these, 24 programs exceeded the minimum of 600 equivalents per lab. Bon Secours St. Francis Xavier, Oconee Memorial Hospital, and Mary Black Memorial Hospital fell below the minimum. Carolina Pines Regional received a CON to replace their mobile lab with a fixed lab. Beaufort Memorial Hospital received a CON to establish a diagnostic lab on 6/6/02. Colleton Medical Center received a

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CON on 4/15/03 to establish a mobile cardiac catheterization service 1 day per week. Loris Community Hospital received a CON on 6/2/04 and Kershaw County Medical Center received a CON on 6/11/04 to establish fixed cardiac catheterization labs.

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. All of the programs that had been operational for 3 full years performed the minimum number of therapeutic caths in 2003.

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. 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 2003, 24 of the 27 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 decreased from 6,279 in 2002 to 5,952 in 2003. There are 16 approved open heart surgery programs in South Carolina. Self Memorial and Anderson Area began in 2001, and Hilton Head Hospital began operation in 2002. Because these 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.

The established programs had a total of 31 open heart surgery suites in operation in 2003. With a capacity of 500 surgeries per suite, the statewide capacity was 15,500 surgeries. A total of 5,486 open heart surgeries were performed in these suites, giving an average utilization rate of 35.4%. The state average was 177.0 surgeries per suite. Unused capacity remains in all programs in the state.

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 2003, 8 of the 13 established programs performed more than 350 total surgeries; Trident Regional performed 304, Piedmont Regional performed 232, St. Francis performed 182, Aiken performed 128, and Carolinas Hospital System performed 87.

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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 2003, 238 pediatric open heart surgeries were performed there.

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

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RECORD 003091

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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RECORD 003092

"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 Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation.

"Therapeutic catheterization" refers to a PCI or 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: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; 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 Eluting 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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(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, PCI 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 a contraindication for PCI, 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 PCI and other therapeutic procedures, unless they comply with all sections of standard 8.

(8) The provision of emergency PCI (Primary PCI) at a hospital without an on-site comprehensive catheterization laboratory and an open heart surgery program requires a Certificate of Need. This application shall be approved only if all of the following criteria are met:

A. Therapeutic catheterizations must be limited to Percutaneous Coronary Interventions (PCIs) performed only in emergent circumstances (Primary PCIs).

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RECORD 003094

B. The applicant has a diagnostic catheterization laboratory that has performed a minimum of 600 diagnostic catheterizations for the most recent year of data.

C. The hospital must acquire an intra-aortic balloon pump (IABP) dedicated solely to this purpose.

D. The chief executive officer of the hospital must sign an affidavit assuring that the criteria listed below are and will continue to be met at all times.

E. An application shall be approved only if it is consistent with the criteria from the 2001 American College of Cardiology/American Heart Association Percutaneous Coronary Intervention Guidelines (Smith et al., ACC/AHA Guidelines for Percutaneous Coronary Intervention ((Revision of the 1993 PTCA Guidelines) JACC Vol. 37, No. 8, June 15, 2001:2239i-lxvi). The complete guidelines can be found at: www.acc.org/clinical/guidelines/percutaneous/percutaneous_IV.htm

1. Criteria for the Performance of Emergency (Primary) PCI

a. The physicians must be experienced interventionalists who regularly perform elective intervention at a surgical center (75 cases/year). The institution must perform a minimum of 36 primary PCI procedures per year.

b. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule.

c. The catheterization laboratory itself must be well-equipped, with optimal imaging systems, resuscitative equipment, intra-aortic balloon pump (IABP) support, and must be well-stocked with a broad array of interventional equipment.

d. The cardiac care unit nurses must be adept in hemodynamic monitoring and IABP management.

e. The hospital administration must fully support the program and enable the fulfillment of the above institutional requirements.

f. There must be formalized written protocols in place for immediate (within 1 hour) and efficient transfer of patients to the nearest cardiac surgical facility which are reviewed/tested on a regular (quarterly) basis.

g. Primary (emergency) intervention must be performed routinely as the treatment of choice around the clock for a large proportion of patients with acute myocardial infarction (AMI), to ensure streamlined care paths and increased case volumes.

h. Case selection for the performance of primary (emergency) angioplasty must be rigorous. Criteria for the types of lesions appropriate for primary (emergency) angioplasty and for the selection for transfer for emergent aortocoronary bypass surgery are shown in Section E.2.

i. There must be an ongoing program of outcomes analysis and formalized periodic case review. Institutions should participate in a 3- to 6-month-period of implementation during which time development of a formalized primary PCI program is instituted that includes establishing standards, training staff, detailed logistic development, and creation of a quality assessment and error management system.

2. Patient Selection Guidelines

a. Avoid intervention in hemodynamically stable patients with:

1) Significant (60%) stenosis of an unprotected left main (LM) coronary artery upstream from an acute occlusion in the left coronary system that might be disrupted by the angioplasty catheter
2) Extremely long or angulated infarct-related lesions with TIMI grade 3 flow
3) Infarct-related lesions with TIMI grade 3 flow in stable patients with 3-vessel disease
4) Infarct-related lesions of small or secondary vessels
5) Lesions in other than the infarct artery

b. Transfer for emergent aortocoronary bypass surgery patients with:

1) High-grade residual left main or multivessel coronary disease and clinical or hemodynamic instability
2) After angioplasty or occluded vessels
3) Preferably with intra-aortic balloon pump support

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

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

(10) 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.

(11) 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.

(12) 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.

(13) 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;

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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.

(14) 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.

(15) 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.

(16) 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.

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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.

(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;

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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 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 not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PMC.2013.SHP.0539

RECORD 003100

CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 PEDS TOTAL	FY02 ADULTS: DIAG	FY02 ADULTS: THERP	FY02 PEDS TOTAL	FY03 ADULTS: DIAG	FY03 ADULTS: THERP	FY03 PEDS TOTAL
I										
ANDERSON AREA MEDICAL CTR #1	3	2090	137	2227	2075	610	2685	1838	711	2549
GREENVILLE MEMORIAL MED CTR #2	7	4580	2225	6805	5374	1999	7373	5916	2137	8053
MARY BLACK MEMORIAL	1	305		305	225		225	128		128
OCONEE MEMORIAL HOSPITAL	1	786		786	764		764	672		672
PALMETTO BAPTIST MED CTR-EASLEY	1	418		418	656		656	672		672
SPARTANBURG REG MED CTR #3	4	3030	678	3708	2713	568	3281	2669	695	3364
ST FRANCIS COMMUNITY HOSPITAL	2	1167	438	1605	1166	327	1493	1435	483	1918
TOTAL AREA I		12376	3478	15854	12974	3504	16478	13252	3996	17248
II										
KERSHAW COUNTY MEDICAL CTR #4	1									
LEXINGTON MEDICAL CENTER #5	1				870		870	1114		1114
PALMETTO HEALTH BAPTIST	1	858		858	660		660	712		712
PALMETTO HEALTH RICHLAND MEMORIAL	4	1783	674	2457	1723	665	2388	1723	686	2409
PIEDMONT MEDICAL CENTER #6	3	2581	639	3220	3053	928	3981	2676	1007	3683
PROVIDENCE HOSPITAL #7	6	3846	2195	6041	3746	2306	6052	3798	2875	6673
SELF MEMORIAL HOSPITAL	2	600		600	1056	35	1091	1223	184	1407
SOUTH CAROLINA HEART CENTER #8	2			0			0			0
SPRINGS MEMORIAL HOSPITAL #9	1	565		565	755		755	691		691
TOTAL AREA II		10033	3508	12978	11883	3934	15042	12139	4752	16000
III										
CAROLINA PINES REGIONAL MED CTR #10	1	177		177	431		431	477		477
CAROLINAS HOSPITAL SYSTEM	2	1305		1305	955	156	1112	964	161	1125
CONWAY HOSPITAL	1	584		584	857		857	768		768
GEORGETOWN MEMORIAL HOSPITAL #11	1	610	19	629	804	29	833	672	33	705
GRAND STRAND REGIONAL MED CTR	2	1113	932	2045	1132	1078	2210	1029	1034	2063
LORIS COMMUNITY HOSPITAL #12	1									
MCLEOD REGIONAL MEDICAL CTR	4	3304	753	4057	3247	867	4114	3130	841	3971
TUOMEY HOSPITAL	1	727		727	754		754	685		685
TOTAL AREA III		7820	1704	9524	7981	2130	10111	7726	2069	9795

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RECORD 003101

CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 ADULTS: TOTAL	FY01 PEDS	FY02 ADULTS: DIAG	FY02 ADULTS: THERP	FY02 ADULTS: TOTAL	FY02 PEDS	FY03 ADULTS: DIAG	FY03 ADULTS: THERP	FY03 ADULTS: TOTAL	FY03 PEDS
III													
IV													
AIKEN REGIONAL MEDICAL CTR	1	860	506	1366		1233	375	1608		1147	323	1470	
BEAUFORT MEMORIAL HOSPITAL #13	1									82		82	
BON SECOURS ST. FRANCIS XAVIER	1	160		160		189		189		165		165	
COLLETON MEDICAL CENTER #14	MOBILE												
HILTON HEAD REGIONAL MED CTR #15	2	1044	128	1172		1015	123	1138		784	361	1145	
MEDICAL UNIVERSITY HOSPITAL #16	6	1551	583	2134	970	1517	610	2127	992	1962	610	2572	1349
RMC ORANGEBURG-CALHOUN	1	813		813		968		968		774		774	
ROPER HOSPITAL	3	2625	644	3269		2600	659	3259		2824	792	3616	
TRIDENT MEDICAL CENTER	2	1691	569	2260		1865	601	2466		1210	544	1754	
TOTAL AREA IV		8774	2430	9649		8385	2368	9956		8968	2630	9881	
TOTAL		39903	11120	46002		42203	11936	51587		42065	13447	52904	

#1 CON FOR 3RD CATH W/ THERAPEUTIC, 11/2/89.
#2 CON TO REPLACE AN EXISTING CATH LAB AND MAINTAINING 7 CATHS WITH 5 AT GMH AND 2 AT MEMORIAL MEDICAL OFFICE, 7/3/00.
#3 CON FOR 4TH CATH LAB, 11/13/01.
#4 CON ISSUED 6/11/19/04.
#5 CON ISSUED FOR FIXED CATH, 1/30/01 SC-01-05.
#6 CON FOR 3RD CATH AND REPLACEMENT OF THE 2 EXISTING CATHS 11/4/03 SC-03-84.
#7 CON FOR 6TH CATH, 03/18/03 SC-02-19.
#8 DOCTORS OFFICE, NOT A LICENSED ASF.
#9 CON TO REPLACE MOBILE W/ FIXED CATH, 07/12/01.
#10 CON FOR FIXED TO REPLACE MOBILE 6/20/01; BEGAN FIXED 4/12/02.
#11 FACILITY IS NOT APPROVED TO DO ANGIOPLASTY.
#12 CON ISSUED 6/2/04.
#13 CON FOR DIAGNOSTIC CATH LAB, 6/6/02.
#14 CON FOR MOBILE 1 DAY/WK, 4/15/03 SC-03-13.
#15 CON FOR 2ND CATH SC-01-56 11/13/01 AND CON ISSUED FOR THERAPEUTIC CATH PROGRAM 7/15/02 SC-02-41.
#16 CON ISSUED FOR 2 ADDITIONAL ADULT CATH LABS FOR A TOTAL OF 5 ADULT & 1 PED, SC-01-13 3/12/01.

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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.0543

RECORD 003104

(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.

PMC.2013.SHP.0545

RECORD 003106

(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 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);

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RECORD 003107

(10) medical telemetry/progressive care; and
(11) perfusion.

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;

(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 not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PMC.2013.SHP.0548

RECORD 003109

REGION/FACILITY	# OPEN HEART UNITS	FY00 ADULTS	FY00 PEDS	FY01 ADULTS	FY01 PEDS	FY02 ADULTS	FY02 PEDS	FY03 ADULTS	FY03 PEDS
I									
ANDERSON AREA MED CTR	2			94		312		243	
GREENVILLE MEM MED CTR #1	4	1379		1147		936		844	
ST FRANCIS HOSPITAL	2	221		224		164		182	
SPARTANBURG REG MED CTR	2	599		626		567		546	
II									
PIEDMONT MEDICAL CTR	2	248		257		232		232	
PROVIDENCE HOSPITAL	4	1057		970		949		969	
PALMETTO HEALTH RICHLAND	2	486		443		499		425	
SELF MEMORIAL HOSPITAL	2					140		132	
III									
CAROLINAS HOSPITAL SYSTEM	2	86		122		139		87	
MCLEOD REGIONAL MED CTR	3	608		495		495		359	
GRAND STRAND REG MED CTR	2	278		358		401		432	
IV									
AIKEN REGIONAL MED CTR	1	113		125		128		142	
HILTON HEAD REG MED CTR #2	1							91	
MEDICAL UNIVERSITY HOSP	3	465	186	634	249	447	223	497	238
ROPER HOSPITAL	2	650		567		533		467	
TRIDENT REGIONAL MED CTR	1	283		310		317		304	
VA HOSP (CHARLESTON)	1								
				6372		6279		5952	

#1 # Labs decreased from 5 to 4, 2003.
#2 CON 7/15/02.

(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 Ametastasis. 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 were 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) than 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. The average treatment time for linear accelerator treatment can be longer because of highly specialized radiation therapy techniques such as total body irradiation, Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiosurgery, or for treating children. A facility providing such specialized treatment may not be able to average treating as many patients per day because of the longer treatment time per patient. Therefore, a lower measurement of functional capacity may be appropriate for such a facility.

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

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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 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 42 accelerators that were in operation during 2003. 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 2003, the 42 existing accelerators averaged 5,713 treatments per unit (81.6% of overall capacity). The utilization for each provider per linear accelerator was:

Provider	# Accelerators	Treatments/ Accelerator
Cancer Ctr. Carolinas Eastside	1	9,687
Carolina Regional Radiation	2	8,813
Palmetto Baptist	2 (0)	8,595 *1*
Carolinas Hospital System	1	7,863
Lexington Medical Ctr.	2	7,513
Anderson Area Med. Ctr.	2	6,864
RMC-Orangeburg/Calhoun	1	6,849

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Roper Hospital	2	6,119
Cancer Center Carolinas	1	6,092
Trident Regional	2	6,080
Spartanburg Regional	3	5,870
Rock Hill Radiation	2	5,784
Greenville Memorial Hospital	3	5,437
Beaufort-Hilton Head	1	5,410
Aiken Regional	1	5,044
MUSC	3	4,443
Tuomey Regional	2	4,432
McLeod Regional	4	4,281
Palmetto Richland Memorial	4	3,605
Self Memorial	2	3,499 *2*

1 CON issued 11/12/03 to replace and relocate the 2 Linear Accelerators at Palmetto Baptist to South Carolina Oncology Associates.
2 CON issued 2/11/02 for a 2nd Linear Accelerator.

2. GAMMA KNIFES

Palmetto Richland Memorial is the only hospital to operate a gamma knife in South Carolina. A total of 170 patients received gamma knife treatment in 2003.

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

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY2001	FY2002	FY2003
I				
ANDERSON CO:				
ANDERSON AREA MEDICAL CTR LINEAR ACCELERATOR #1	2	12880	12937	13728
GREENVILLE CO:				
CANCER CENTERS OF THE CAROLINAS EASTSIDE LINEAR ACCELERATOR	1	9863	8343	9687
GREENVILLE MEMORIAL MEDICAL CTR LINEAR ACCELERATORS	3	19058	13074	16312
CANCER CENTERS OF THE CAROLINAS LINEAR ACCELERATOR	1	9007	6245	6092
CHEROKEE CO:				
GIBBS REGIONAL CANCER CENTER SATELLITE #2	1			
OCONEE CO:				
CANCER CENTERS OF THE CAROLINAS OCONEE COUNTY	1			4790
SPARTANBURG CO:				
SPARTANBURG REGIONAL MED CTR LINEAR ACCELERATORS	3	16646	18552	17611
II				
LEXINGTON CO:				
LEXINGTON MEDICAL CENTER LINEAR ACCELERATOR	2	9278	11810	15026
RICHLAND CO:				
PALMETTO HEALTH BAPTIST #3 LINEAR ACCELERATORS	(2)	14742	14888	17190
PALMETTO HEALTH RICHLAND LINEAR ACCELERATORS	4	16842	17937	14419
GAMMA KNIFE	1	128	102	170
NEWCO #3 LINEAR ACCELERATORS	2			
GREENWOOD CO:				
SELF MEMORIAL #4 LINEAR ACCELERATOR	2	5911	6344	6998

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY2001	FY2002	FY2003
YORK CO:				
ROCK HILL RADIATION THERAPY CENTER LINEAR ACCELERATOR	2	11682	11125	11568
III				
FLORENCE CO:				
CAROLINAS HOSPITAL SYSTEM	1	6519	7197	7863
MCLEOD REGIONAL LINEAR ACCELERATORS	4	18398	17601	17124
HORRY CO:				
CAROLINA REGIONAL RADIATION CENTER LINEAR ACCELERATORS	2	15037	15408	17626
SUMTER:				
TUOMEY LINEAR ACCELERATOR	2	8435	8402	8864
GEORGETOWN CO:				
GEORGETOWN MEMORIAL HOSP #5	1			
IV				
CHARLESTON CO:				
MEDICAL UNIVERSITY #6 LINEAR ACCELERATORS	3	12484	14949	13328
ROPER HOSPITAL LINEAR ACCELERATOR	2	15325	12545	12237
TRIDENT MEDICAL CENTER LINEAR ACCELERATOR	2	12063	13001	12160
ORANGEBURG CO:				
REG MED CTR ORANGEBURG/CALHOUN LINEAR ACCELERATOR	1	5522	7185	6849
BEAUFORT CO:				
BEAUFORT/HILTON HEAD RADIATION ONCOLOGY CENTER LINEAR ACCELERATOR	1	7049	6518	5410
BEAUFORT MEMORIAL HOSPITAL #7	1			

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY2001	FY2002	FY2003
AIKEN CO:				
AIKEN REGIONAL MEDICAL CTR	1	3921	4719	5044

#1 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.
#2 APPROVED FOR 1LA 3/31/03. APPEALED
#3 APPROVED TO TRANSFER & REPLACE 2 LAS FROM BAPTIST & TO TRANSFER OWNERSHIP OF 4 LAS FROM PAL RICHLAND 11/12/03 SC-03-68.
#4 CON FOR 2nd LA , 2/11/02 SC-02-14
#5 CON ISSUED 3/15/01
#6 CON TO MOVE & REPLACE EXISTING LA TO MT PLEASANT 7/08/03 SC-03-38
#7 CON SC-03-24 4/29/03

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LINEAR ACCELERATORS

2004 Plan

SERVICE AREAS	2003 POPULATION	# OF LIN. ACC.	POP/ LIN. ACC.	TOTAL AREA TREATMENTS	TREATMENTS/ LIN. ACC.	PLANNING AREA CAPACITY
ANDERSON,OCONEE	238,610	3	79,537	18,518	6,173	21,000
GREENVILLE,PICKENS	506,170	5	101,234	32,091	6,418	35,000
CHEROKEE,SPARTANBURG UNION	345,550	4	86,388	17,611	4,403	28,000
CHESTER,LANCASTER,YORK	268,410	2	134,205	11,568	5,784	14,000
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	220,490	2	110,245	6,998	3,499	14,000
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	668,580	8	83,573	46,635	5,829	56,000
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	333,570	5	66,714	24,987	4,997	35,000
CLARENDON,LEE,SUMTER	162,560	2	81,280	8,864	4,432	14,000
GEORGETOWN,HORRY WILLIAMSBURG	302,530	3	100,843	17,626	5,875	21,000
BAMBERG,CALHOUN ORANGEBURG	124,960	1	124,960	6,849	6,849	7,000
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	221,690	2	110,845	5,410	2,705	14,000
BERKELEY,CHARLESTON DORCHESTER	569,560	7	81,366	37,725	5,389	49,000
AIKEN,BARNWELL	173,340	1	173,340	5,044	5,044	7,000
STATE TOTAL	4,136,020	45	91,912	239,926	5,332	315,000

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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 as shown on the preceding chart.

(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.

Even individual or average

(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.

Bias — Adverse impact not at issue

(5) 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 applicant must affirm the following:

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

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.

The average treatment time for linear accelerator treatment at some facilities may be longer because of highly specialized radiation therapy techniques such as total body irradiation, Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiosurgery, and the treatment of children. Since the use of 7,000 treatments per machine may not accurately reflect the actual capacity of the service, a facility may require an additional linear accelerator to provide these specialized treatments. The facility must document the need for the additional equipment.

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 not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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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) The applicant shall project the utilization of the service, to include:

A. 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;

B. current 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

C. 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 not outweigh 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 MRIs with an 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.

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	FY02 CON SCANS	FY03 CON SCANS
ABBEVILLE	ABBEVILLE CO MEM HOSP	MOBILE	507	563
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	closed 1/02	
AIKEN	AIKEN NEUROSCIENCES, PC	FIXED	1516	1575
AIKEN	AIKEN REG MED CTR	FIXED	2240	2415
AIKEN	CAROLINA MUSCULOSKELETAL ASSOC	2 FIXED	1159	2082
AIKEN	IMAGING CTR OF AIKEN #2	FIXED	2138	0
ALLENDALE	ALLENDALE CO HOSPITAL	MOBILE		0
ANDERSON	ANDERSON AREA MED CTR	3 FIXED	8182	7951
ANDERSON	ANDERSON DIAGNOSTIC IMAGING	FIXED & MOBILE	3281	3093
ANDERSON	BLUE RIDGE ORTHOPEDIC ASSOC	FIXED		
BAMBERG	BAMBERG CO MEM HOSPITAL	MOBILE		0
BARNWELL	BARNWELL CO HOSPITAL	MOBILE		0
BEAUFORT	BEAUFORT MEM HOSP	FIXED & MOBILE	3599	2787
BEAUFORT	BEAUFORT IMAGING CENTER	FIXED	1130	1570
BEAUFORT	BEAUFORT ORTHOPEDIC &SPORTS MED	MOBILE	159	112
BEAUFORT	HEALTHSOUTH DIAG CTR HILTON HEAD	FIXED	2413	1240
BEAUFORT	HILTON HEAD REGIONAL MEDICAL CTR	FIXED	363	522
BEAUFORT	LOWCOUNTY MEDICAL GROUP PORT ROYAL	FIXED & TEMP MOBILE	1438	1684
BEAUFORT	MRI AT BELFAIR	FIXED	1256	2367
BEAUFORT	NEUROLOGICAL INSTITUTE HILTON HEAD	FIXED	357	350
BEAUFORT	SOUTHERN MRI -HILTON HEAD	FIXED	1698	1486
BEAUFORT	SOUTHERN MRI, LLC	2FIXED	2662	1177
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	FIXED	1950	2655
CHARLESTON	CHARLESTON PHYSICIANS IMAGING CTR	FIXED	2410	1963
CHARLESTON	DISC RADIOLOGISTS	MOBILE		2635
CHARLESTON	EAST COOPER DIAGNOSTIC IMAGING	MOBILE	1639	507
CHARLESTON	FARMFIELD DIAGNOSTIC IMAGING	FIXED	2839	
CHARLESTON	MEDICAL RESOURCES, INC -EAST COAST	MOBILE		0
CHARLESTON	MEDICAL RESOURCES, INC -FAMILY CHIRO	MOBILE		0
CHARLESTON	MEDICAL UNIVERSITY HOSP	3 FIXED	7714	8826
CHARLESTON	ORTHOPAEDIC SPECIALISTS CHARLESTON	MOBILE		0
CHARLESTON	ROPER DIAGNOSTIC CTR-FARMFIELD #3	FIXED	2038	
CHARLESTON	ROPER HOSPITAL	FIXED	5814	6055
CHARLESTON	SOUTHEASTERN SPINE INSTITUTE	FIXED		0
CHARLESTON	TRICOM DIAGNOSTIC IMAGING	FIXED	2061	6813
CHARLESTON	TRIDENT MEDICAL ARTS MRI	2 FIXED		
CHARLESTON	TRIDENT MEDICAL CTR	FIXED	10193	10481
CHARLESTON	UMA AMBULATORY CARE FACILITY	FIXED		
CHARLESTON	UNIVERSITY MEDICAL ASSOCIATES	FIXED		
CHARLESTON	WEST ASHLEY DIAGNOSTIC IMAGING #1	FIXED	735 see note	
CHEROKEE	UPSTATE CAROLINA MED CTR	FIXED	1295	1322
CHESTER	CHESTER CO HOSP	MOBILE	344	359
CHESTERFIELD	CHESTERFIELD GEN HOSP	MOBILE	282	147
CLARENDON	CLARENDON MEM HOSP	MOBILE	988	897
CLARENDON	MANNING DIAGNOSTICS	MOBILE		0
COLLETON	COLLETON REG HOSP	FIXED	1955	2180
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	2036	2143
DARLINGTON	WILSON MED CTR	MOBILE	59	0
DILLON	ACCIDENT AND INJURY CLINIC	MOBILE		0
DILLON	ST. EUGENE MED CTR	FIXED	781	1123
DORCHESTER	SUMMERVILLE MEDICAL CENTER	2 FIXED	1845	1360
FLORENCE	ACCIDENT AND INJURY CLINIC	MOBILE		0
FLORENCE	CAROLINAS HSP SYS	FIXED	2709	3258
FLORENCE	CAROLINAS HSP SYS LAKE CITY	MOBILE	312	396
FLORENCE	COMPREHENSIVE NEUROLOGICAL IMAGING	MOBILE	106	284
FLORENCE	INMED DIAGNOSTIC SERVICES	FIXED	3025	2137
FLORENCE	MCLEOD REG MED CTR	3 FIXED	6812	7194
FLORENCE	OPEN MRI & IMAGING OF FLORENCE	FIXED	4395	4109
GEORGETOWN	GEORGETOWN MEM HOSP	FIXED	3330	2318
GEORGETOWN	WACCAMAW COMM HOSP	FIXED		640
GREENVILLE	ALLEN BENNETT HOSP	MOBILE	853	1122

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MRI SCANS

COUNTY	FACILITY	TYPE	FY02 CON SCANS	FY03 CON SCANS
GREENVILLE	CAROLINA ORTHAPEDIC CTR	FIXED	31	437
GREENVILLE	DIAGNOSTIC CENTERS OF CAROLINAS	MOBILE		0
GREENVILLE	GHS/EASTSIDE ACS	MOBILE		
GREENVILLE	GREENVILLE MEM HOSP	3 FIXED &	6082	7343
GREENVILLE	GREENVILLE PHYSICIANS IMAGING CTR	2 FIXED	2252	1750
GREENVILLE	GREENVILLE RADIOLOGY, PA	FIXED	2722	3666
GREENVILLE	HEALTHSOUTH DIAG CTR GREENVILLE	FIXED	5532	5045
GREENVILLE	HILLCREST HOSP	MOBILE	937	917
GREENVILLE	NEUROLOGY ASSOC OF GREENVILLE	MOBILE	625	559
GREENVILLE	OAKWOOD ORTHOPEDIC CLINIC	MOBILE	425	507
GREENVILLE	OPEN MRI OF SIMPSONVILLE	FIXED	2017	2478
GREENVILLE	OPEN MRI SIMPSONVILLE, LLC	MOBILE		2478
GREENVILLE	PIEDMONT ORTHOPAEDICS	FIXED	1413	1338
GREENVILLE	SE NUEROSURGICAL & SPINE INSTITUTE #4	MOBILE	906 see note	
GREENVILLE	ST. FRANCIS HOSPITAL	2 FIXED	2135	2150
GREENVILLE	ST. FRANCIS WOMAN'S & FAMILY HOSP	FIXED	1073	1044
GREENVILLE	THE FAMILY PRACTICE	MOBILE		0
GREENWOOD	LAKELANDS ORTHOPAEDIC CLINIC	MOBILE	691	654
GREENWOOD	PIEDMONT NEUROLOGY ASSOCIATES	MOBILE		
GREENWOOD	SELF MEM HOSP	2 FIXED	4950	5193
HAMPTON	HAMPTON REG MED CTR	MOBILE	0	0
HORRY	COASTAL ORTHOPAEDIC ASSOC	FIXED	539	201
HORRY	CONWAY HOSP	FIXED	3190	3627
HORRY	GRAND STRAND REG MED CTR	FIXED	4136	3704
HORRY	INMED DIAGNOSTIC SERVICES	FIXED		738
HORRY	LORIS COMM HOSP	FIXED	2090	2517
HORRY	MYRTLE BEACH MRI	FIXED	closed 7/03	
HORRY	LONG BAY DIAGNOSTIC IMAGING	FIXED	3084	3768
HORRY	LONG BAY DIAGNOSTIC IMAGING	MOBILE		
HORRY	SEACOAST MED CTR #5	FIXED	1231 see note	
HORRY	SOUTH STRAND AMB CARE CTR	FIXED	1649 closed 5/04	
HORRY	STRAND REG SPECIALTY ASSOC, LLC	FIXED	2763	2340
KERSHAW	KERSHAW CO MEM HOSP	FIXED	1299	1491
LANCASTER	LANCASTER IMAGING CTR	FIXED		
LANCASTER	SPRINGS MEMORIAL HOSP	FIXED	1988	1895
LAURENS	LAURENS CO HOSP	MOBILE	426	354
LAURENS	LAURENS CO ORTHOPEDIC ASSOC	FIXED	1650	1540
LEXINGTON	CAROLINA NEURO SPECIALISTS	MOBILE		0
LEXINGTON	LEXINGTON MED CTR	2 FIXED	4926	6796
LEXINGTON	LEXINGTON MED CTR-IRMO #6	FIXED	see note	
LEXINGTON	LEXINGTON MED CTR-LEXINGTON #6	FIXED	see note	
LEXINGTON	LEXINGTON OPEN MRI	FIXED	4327	4319
MARION	MARION CO MEDICAL CTR	MOBILE	1487	1575
MARLBORO	MARLBORO PARK	MOBILE	258	268
NEWBERRY	NEWBERRY CO MEM HOSP	MOBILE		504
OCONEE	BLUE RIDGE ORTHOPEDIC ASSOC	FIXED	122	678
OCONEE	MOUNTAINVIEW RADIOLOGY,PA	FIXED	2382	2097
OCONEE	OCONEE MEM HOSP	FIXED	2667	2815
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	FIXED	1403	1254
ORANGEBURG	RMC ORANGEBURG/CALHOUN	FIXED	3370	3989
ORANGEBURG	SANTHILL DIAGNOSTICS	MOBILE		0
PICKENS	CANNON MEM HOSP.	MOBILE	0	0
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	FIXED	2496	2712
RICHLAND	CAROLINA MED IMAGING	FIXED	1415	1267
RICHLAND	COLUMBIA NUEROSURGICAL ASSOC	FIXED		1297
RICHLAND	HEALTH SOUTH DIAGNOSTIC CTR	FIXED	854	111
RICHLAND	IMAGECARE	FIXED	275	1944
RICHLAND	INMED DIAGNOSTIC SERVICES	2 FIXED	4365	4019
RICHLAND	MIDLANDS ORTHOPAEDICS	FIXED	3085	428
RICHLAND	MRI OF THE CAROLINAS	2 FIXED		
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	3623	3557
RICHLAND	PALMETTO HEALTH RICHLAND	2 FIXED	5352	5768
(RICHLAND)	(PALMETTO HEALTH ALLIANCE DIAG CTR)	(FIXED)		
RICHLAND	PALMETTO IMAGING	FIXED	5175	4405

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MRI SCANS

COUNTY	FACILITY	TYPE	FY02 CON SCANS	FY03 CON SCANS
RICHLAND	PROVIDENCE HOSPITAL	FIXED	1900	1840
SPARTANBURG	CAROLINA HEALTH IMAGING	FIXED		285
SPARTANBURG	MARY BLACK MEM HOSP	2 FIXED	3694	4469
SPARTANBURG	ORTHOPEDIC ASSOCIATES,PA	MOBILE	193	1570
SPARTANBURG	ORTHOPEDIC SPECIALTIES OF SPART	FIXED	1150	1035
SPARTANBURG	PIEDMONT IMAGING CENTER	FIXED		0
SPARTANBURG	PIEDMONT IMAGING, INC #1	FIXED	4985	3655
SPARTANBURG	SPARTANBURG REG MED CTR	3 FIXED	10243	10364
SUMTER	TUOMEY	FIXED	4582	5208
SUMTER	TUOMEY OUTPATIENT IMAGING CTR #7	FIXED		
UNION	WALLACE THOMSON HOSP	FIXED	1228	1206
WILLIAMSBURG	WILLIAMSBURG REGIONAL HOSP	MOBILE	138	165
YORK	CAROLINA ORTHOPEDIC SURG ASSOC	FIXED	492	2294
YORK	METROLINA NEURODIAGNOSTICS CENTER	FIXED	1164	816
YORK	CAROLINAS DIAGNOSTIC IMAGING	FIXED	2354	2591
YORK	PIEDMONT MED CTR	FIXED & MOBILE	5274	6097

#1 Tricounty Radiology Associates includes West Ashley Diagnostic Imaging data.
#2 Purchased by Aiken Regional Medical Center
#3 Reported as part of Roper Hospital, formerly Farmfield Diagnostic Imaging
#4 Reported as part of Greenville Memorial
#5 Reported under Loris Hospital
#6 Reported under Lexington Medical Center
#7 Reported under Tuomey Hospital

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2. Positron Emission Tomography (PET) and PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. It allows the study of metabolic processes such as oxygen consumption, and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only tracer amounts of isotopes are needed.

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, and neurological applications such as epilepsy, Alzheimer's and Parkinson's Diseases. 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; melanomas; certain thyroid diseases; neurological; and heart disease uses. The process takes around 45 minutes to an hour to perform.

Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus an additional $800,000 in yearly staff and operational costs. The average time to perform a PET scan is approximately one hour. The Medicare reimbursement rate is currently $1,450 for the PET scan and $325 for the isotopes, although CMS is considering reducing these rates. According to a study commissioned by the Academy of Molecular Imaging, a facility must perform approximately 3 scans/day to break-even. The current national average is 2.63 scans/day, although there are a number of new facilities offering PET services.

Computerized Tomography (CT) uses x-ray beams and digital processing to produce cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. However, even a slight change in the patient's body position between the 2 scans can lead to a misinterpretation of the images. Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. These new generation of machines currently cost anywhere from $2.0-2.7 million. It is expected that PET/CT imaging will eventually replace stand-alone PET imaging for most uses.

Because of the on-going development of this technology, it is anticipated that PET and PET/CT will become a standard diagnostic modality in the fields of cardiology, oncology and neurology. Due to the current cost of this technology and the uses approved for reimbursement, it is more appropriate that this technology be available for health care facilities providing specialized therapeutic services such as open heart surgery and radiation oncology. Note: in the Certificate of Need standards cited below, the terms PET and PET/CT are interchanged. The Department does not differentiate between these modalities in defining these standards. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger CON review, although it could still be reviewable because of equipment cost.

The following PET scanners are operational or have been approved in South Carolina:

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POSITRON EMISSION TOMOGRAPHY (PET) SCANNER

COUNTY	FACILITY	SCANNERS	FY01 SCANS	FY02 SCANS	FY03 SCANS	CON/DATE
ANDERSON	ANDERSON AREA MEDICAL CTR	MOBILE FOR 2 DAYS		13	171	CON 5/30/02
GREENVILLE	THE CAROLINAS CLINICAL PET INST	FIXED	255	1,058	1,464	CON 1/26/2001
SPARTANBURG	SPARTANBURG REG MED CTR	MOBILE FOR 3 DAYS		229	535	CON 5/30/02

LEXINGTON	LEXINGTON MEDICAL CENTER	MOBILE FOR 3 DAYS		25	407	CON 7/19/02
RICHLAND	PALMETTO BAPTIST MED CTR	FIXED	507	1,386	1,325	CON 3/30/2000
YORK	PIEDMONT MEDICAL CENTER	MOBILE FOR 2 DAYS			123	CON 7/19/02

FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE FOR 1/2 DAY				CON 3/5/04
FLORENCE	MCLEOD REGIONAL MEDICAL CTR	FIXED			45	CON 5/06/02
HORRY	GRAND STRAND REG MED CTR	MOBILE FOR 2 DAYS	4	357	571	CON 5/8/01
HORRY	CONWAY HOSPITAL	MOBILE FOR 2 DAYS				CON 7/11/03
SUMTER	TUOMEY	MOBILE FOR 1/2 DAY				CON 3/5/04

AIKEN	AIKEN REGIONAL	MOBILE FOR 1 DAY				CON 8/18/04
BEAUFORT	BEAUFORT IMAGING	MOBILE FOR 2 DAYS				APPROVAL APPEALED
CHARLESTON	ROPER HOSPITAL	FIXED	535	1,048	1,373	CON 7/12/2000
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE FOR 1 DAY	125	238	293	NA 3/31/2001
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE FOR 2 DAYS				CON 8/25/03
TOTAL			1,426	4,352	6,277	

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Certificate of Need Standards for Positron Emission Tomography (PET)

STANDARDS

(1) Hospitals that provide specialized therapeutic services (open heart surgery and/or radiation therapy) should have either fixed or mobile PET services for the diagnosis of both inpatients and outpatients. Other hospitals must document that they provide a sufficient range of comprehensive medical services that would justify the need for PET services. Applicants for a freestanding PET service not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

(2) Full-time PET scanner service is defined as having PET scanner services available 5 days per week. Fixed PET scanners are considered to be in operation 5 days per week. Capacity is considered to be 1,500 procedures annually. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

(3) Applicants proposing new fixed 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, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (5 clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

(4) In order to promote cost-effectiveness, the use of shared mobile PET units should be considered. Applicants for a shared mobile scanner must project an annual minimum of 3 clinical procedures/day times the number of days/week the scanner is operational at the facility by the end of the third full year of service.

(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;

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c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

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

(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 a minimum of diagnostic laboratory, radiology, and clinical referral services.

(1) Ambulatory Surgical Facility (ASF)

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 facilities, 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 2003, a total of 296,769 outpatient surgeries were performed in either an ASF or a hospital in South Carolina, amounting to 66.9% of all surgeries. Not all ambulatory surgical units perform all procedures, nor are every patient a suitable candidate for an outpatient procedure.

The Draft 2004 South Carolina Health Plan proposed a moratorium on the review of CON applications for both the expansion of existing ASF's and the establishment of new ASF's. After reviewing all of the public comments received on this issue, the Department has determined not to initiate a moratorium. The Department still intends to study the impact of ASF's on the health care delivery system in South Carolina in order to develop revised standards and criteria to be incorporated in the next edition of the Plan. The Department will accept studies from health care facilities, physicians, and other interested parties during the coming year and determine what criteria to incorporate for the CON review criteria.

Prior to the approval of additional Ambulatory Surgical Facilities or the addition of operating rooms/endoscopy suites to existing ASF's, the following criteria must be addressed:

1. The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

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2. The applicant must identify the physicians who are affiliated or have an ownership interest in the proposed facility by medical specialty. These physicians must identify where they currently perform their surgeries and whether they anticipate making any changes in staff privileges or coverage should the application be approved.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the need for the expansion of or the addition of an ASF, based on the most current utilization data available. This need documentation must include the projected number of surgeries to be performed by medical specialty. 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.

5. An application for a new ASF must contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility. These letters should indicate their intent to utilize the facility and/or refer patients to the facility. They should state the number of surgeries they anticipate performing or the number of patients they anticipate referring to the facility per year. If the physicians do not intend to utilize or refer patients to the facility, they should state why they believe the existing resources are not adequate to meet the needs of the community and why a need exists for the project.

6. The applicant must document the potential impact that the proposed new ASF or expansion will have upon the existing service providers and referral patterns.

7. All new Certificate of Need approvals by the Department will not restrict the specialties of Ambulatory Surgery Facilities. However, it is the position of the Department that Ambulatory Surgery Facilities open to and equipped for all surgical specialties will better serve the community than those targeted towards a single specialty or group of practitioners. For an ASF approved to only perform endoscopic procedures, another CON would be required before the center could provide other surgical specialties. For an ASF approved for a single specialty, another CON is required before the facility can provide other surgical specialties.

8. All proposed Ambulatory Surgical Facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

9. Before an application for a new Ambulatory Surgery Facility can be accepted for filing, all existing ASF's in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization. For purposes of this standard, endoscopy suites are considered separately

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from other operating rooms. Endoscopy-only ASF's do not impact other ASF's. Before additional licensed endoscopy suites can be added in a county, all ASF's with licensed endoscopy suites must have had these suites licensed and operational for one year to allow for a determination of the utilization of the endoscopy providers.

10. In no case can more than one new ASF in a county be approved at a single time. The approval of a new ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements, and must commit to seek accreditation from a nationally recognized organization such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF). Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most of the residents of South Carolina. Most ASF's 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. Adverse Effects on Other Facilities.
c. Community Need Documentation;
d. Distribution (Accessibility);
e. Financial Feasibility;
f. Cost Containment;
g. Projected Revenues;
h. Projected Expenses;
i. Ability of the Applicant to Complete the Project; and
j. Staff Resources.

There has been a substantial increase in the past decade in both the number and percentage of ambulatory surgeries performed and the number of ASF's 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 serious concern that ASF's 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, to the detriment of hospitals' ability to provide the range of services needed. The benefits of improved accessibility are to be balanced with the adverse effects 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 2003):

2003 ASF Utilization — Updated 12/14/04

Name of Facility	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Outpatient Surgery Ctr.	Anderson	5	4	9	4,173	6,133	10,306	835	1,582	1
Bearwood Ambulatory Surgery Center	Anderson	1		1	159		159	159		
Medicus Surgery Center	Anderson	3		3	4,739		4,739	1,580		
Upstate Endoscopy Center	Anderson		2	2	—					2
Center for Special Surgery, The	Greenville	2		2	614		614	307		3
Cross Creek Surgery Center	Greenville	4		4	4,941		4,941	1,235		
Endoscopy Center of the Upstate	Greenville		3	3	—					4
Greenville Endoscopy Center	Greenville		3	3		6,148	6,148		2,049	
GHS Outpt. Surg. Ctr. – Patewood	Greenville	6	2	8	4,339	2,691	7,030	1,085	1,346	5
HealthSouth Surg Center - Greenville	Greenville	4		4	4,108		4,108	1,027		
Jervey Eye Center	Greenville	3		3	3,982		3,982	1,991		6
Patewood Surgery Center	Greenville	2		2	1,633		1,633	817		7
Physicians Surgery Ctr - St. Francis	Greenville	4			—					8
Blue Ridge Surgery Center	Oconee	2		2	1,133		1,133	567		9
Upstate Pain Mgt. & Surgery Center	Oconee	2		2	751		751	376		10
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,384	515	7,899	1,055	258	11
Spartanburg Urology Surgicenter	Spartanburg	2		2	2,334		2,334	1,167		

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Center at Pelham	Spartanburg	4	2	6	----					12
Westside Eye Center	Spartanburg	2		2	----					13
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		5,904	5,904		2,952	14
Surgery Ctr. of Self Memorial Hospital	Greenwood	5		5	4,616		4,616	923		
Columbia Ambulatory Surgery Center	Lexington	2		2	983		983	492		
Midlands Endoscopy Center	Lexington		2	2	----					15
Outpt Surg Ctr Lexington Med Ctr - Irmo	Lexington	4		4	2,052		2,052	513		
Outpt Surg Ctr Lex Med Ctr - Lexington	Lexington	3	1	4	1,493	1,566	3,059	498	1,566	
South Carolina Endoscopy Center	Lexington		4	4		9,668	9,668		2,417	
Urology Surgery Center	Lexington	2		2	1,204		1,204	602		
Columbia Eye Surgery Center (Eye Surgery Only)	Richland	4		4	4,404		4,404	1,101		16
Columbia GI Endoscopy Center	Richland		4	4		6,522	6,522		1,792	17
Huff and Milne Eye Surgery	Richland	(2)		(2)	----					18
Lake Murray Endoscopy Center	Richland		2	2		157	157		79	19
Palmetto Surgery Center	Richland	4		4	5,600		5,600	1,400		

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Parkridge Surgery Center	Richland	4		4	12		12	3		20
Providence Hospital Surgery Center	Richland	4		4	1,874			469		
South Carolina Med Endoscopy Ctr.	Richland		4	4		3,500	3,500		1,750	21
South Carolina Endoscopy Ctr-NorthEast	Richland		5	5		1,605	1,605		521	22
Carolina Surgical Center	York	4		4	4,988			1,247		
Region III:										
Darlington Endoscopy Center	Darlington		2	2		836	836		418	
Florence Surgery & Laser Center	Florence	2		2	1,490		1,490	745		23
McLeod Ambulatory Surgery Center	Florence	2		2	1,320		1,320	660		
Physicians Surgical Center of Florence	Florence	4	2	6	—					24
Atlantic Surgery Center	Georgetown	2		2	—					25
Bay Microsurgical Unit	Georgetown	1		1	2,958		2,958	2,958		
Waccamaw Same Day Surgery Ctr.	Georgetown	(2)	(1)	(3)	59		59	30		26
Carolina Bone and Joint Surgery Ctr.	Horry	2		2	31		31	16		27
Community Medical Ctr - South Strand	Horry	(2)	(1)	(3)	2,355	954	3,309	1,178	954	28
Grande Dunes Surgery Center	Horry	2		2	4,578		4,578	2,289		29
Ocean Ambulatory Surgery Center	Horry	2		2	1,969		1,969	985		30
Parkway Surgery Center	Horry	2		2	1,687		1,687	844		31

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Rivertown Surgery Center	Horry	2		2	544		544	283		32
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	2,590		2,590	1,295		33
Strand GI Endoscopy Center	Horry		2	2		3,136	3,136		1,568	
Tuomey Outpatient Surgery Center	Sumter	(4)		(4)	—					34
Wesmark Ambulatory Surgery Facility	Sumter	2		2	—					35
Region IV:										
Ambulatory Surgery Center of Aiken	Aiken	4	1	5	—					36
Carolina Ambulatory Surgery Center	Aiken	1		1	—					37
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,293	1,011	2,304	647	1,011	38
Laser and Skin Surgery Center	Beaufort	2		2	347		347	174		
Outpatient Surgery Ctr. Hilton Head	Beaufort	2	2	4	—					39
Surgery Center of Beaufort	Beaufort	3	2	5	3,327	864	4,191	1,109	432	
Roper Berkeley Ambulatory Surgery	Berkeley	3		3	457		457	152		
Charleston Endoscopy Center	Charleston		4	4	—					40
Charleston Plastic Surgery Center	Charleston	2		2	578		578	289		41
Health First	Charleston	2		2	—					42

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
HealthSouth Surgery Ctr Charleston	Charleston	4	1	5	4,638		4,638	1,160	0	
Palmetto Endoscopy Center	Charleston		2	2	—					*43*
Roper West Ashley Surgery Center	Charleston	4		4	5,642		5,642	1,411		
Surgery Center of Charleston	Charleston	1	1	2	1,198	461	1,659	1,198	461	*44*
Trident Eye Surgery Center	Charleston	2		2	2,237		2,237	1,119		*45*
Trident Surgery Center	Charleston	4		4	6,014		6,014	1,504		
Colleton Ambulatory Surgery Center	Colleton	2	1	3	1,094	937	2,031	547	937	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	—					*46*
Summerville Surgery Center	Dorchester	2		2	—					*47*
TOTALS		154	65	215	113,920	52,608	166,528	917	1,163	

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2004 Plan ASF Footnotes

—	No data available for facility during reporting period.
1	CON issued 7/13/01 to add 4th Endoscopy suite; licensed 2/14/03; 3 ORs to be transferred to AnMed Women and Children's Center 10/5/04 with no change in license.
2	CON issued 7/8/03; licensed 6/4/04.
3	CON issued 9/19/01; licensed 9/4/02.
4	CON issued 2/12/03; licensed 7/26/04.
5	CON issued 5/13/02 to add 2 OR's for a total of 6 OR's and 2 Endo Suites; licensed 4/19/04.
6	CON issued 12/22/03 to add a 3rd OR; licensed for 3 OR's 8/30/04.
7	CON issued 11/12/03 to relocate facility; CON issued 3/12/04 to add 2 OR's for a total of 4. Both CONs voided 8/11/04.
8	CON issued 12/14/04.
9	CON issued 1/8/01; licensed 9/12/02.
10	CON issued 1/8/01; facility licensed 8/21/02.
11	CON issued 10/10/00; licensed 4/21/02.
12	CON issued 12/5/03; licensed 12/21/04.
13	CON issued 12/15/03. Licensed 8/3/04; formerly Eastside Eye Center West.
14	CON issued 8/25/03 to relocate the facility and add 2 Endo suites for a total of 4. Licensed for 4 Endo suites 8/5/04.
15	CON issued per ALJ Order 7/16/04.
16	CON issued 9/18/00 to add 2 OR's for a total of 4; 4 OR's licensed 7/24/02.
17	CON issued 1/18/02 to expand from 2 to 4 Endoscopy suites; licensed 10/24/03.
18	CON issued 9/25/01; licensed 3/12/03; closed 2/20/04.
19	CON issued 1/7/02; licensed 10/22/03.
20	CON issued 2/11/02; licensed 11/28/03; formerly Palmetto Health NorthWest ASC.
21	CON approved to expand from 2 to 4 Endoscopy suites 9/19/03; under appeal.
22	CON issued 1/7/02; licensed 5/20/03.
23	CON issued 2/20/01, licensed 3/6/03; formerly Carolina Eye Surgery & Laser Center.
24	CON issued 8/27/01; licensed 8/20/04; formerly Physicians Surgery Center.
25	CON issued 8/12/02; licensed 7/6/04.
26	Delicensed 7/31/03.
27	CON issued 3/26/02; licensed 11/26/03.
28	Facility closed 5/15/04.
29	CON issued 8/24/00 to relocate the facility; formerly Carolina Regional Surgery Center.
30	Temporarily closed due to fire, 7/21/04.
31	Formerly Grand Strand Urology Center.
32	Licensed 1/14/03. Formerly Coastal Carolina Ctr Urology & Surgery.
33	CON issued 1/13/04 to convert an endoscopy suite to a 3rd OR; licensed 3/22/04.
34	Not licensed; merged into hospital.
35	CON issued 9/11/02; licensed 3/21/04. Formerly Sumter Urological Surgery Center.
36	CON approved 11/10/03.
37	Surgery center acquired by CASC Acquisitions and licensed 3/30/04.
38	CON issued 6/8/04 to convert procedure room to an endoscopy suite; licensed 8/12/04.
39	CON issued 2/21/03.
40	CON issued 10/20/03; licensed 1/22/04.
41	CON issued for Roper Hospital to purchase the facility 11/5/04.
42	CON issued 1/16/04.
43	CON issued 9/25/03; licensed 6/8/04.
44	CON issued 3/8/00 for 1 OR and 1 Endo suite; licensed 12/18/02
45	License converted from eye surgery only to multi-specialty 11/20/02.
46	CON issued 6/28/04.
47	CON issued 6/28/04.

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(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}. 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.

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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 patient arrives. Anesthesiology 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 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.

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.

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RECORD 003142

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 65% 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

(A) 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. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and

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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.

(B) 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 that 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 that 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, the applicant must follow the following procedure:

(1) 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:

a. patient population;
b. financial strategy;
c. joint screening and discharge planning strategies.

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

(3) 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.

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.

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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. 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

2004 PLAN

COUNTY	FACILITY	BEDS	2003 OCC. RATE	
AIKEN	AURORA PAVILION	29	67.9%	
ANDERSON	ANDERSON MEMORIAL	38	32.6%	
BEAUFORT	BEAUFORT MEMORIAL	20	41.5%	*1*
CHARLESTON	CHARLESTON MEMORIAL	0	0.0%	*2*
CHARLESTON	MEDICAL UNIVERSITY SC	82	69.9%	
CHARLESTON	PAL LOWCOUNTRY BEHAV HEALTH	70	67.0%	*3*
DARLINGTON	WILSON MED CENTER	23	0.0%	*4*
FLORENCE	MCLEOD REGIONAL	0	40.4%	*4*
GREENVILLE	CAROLINA CTR BEHAV. HEALTH	64	78.7%	*5*
GREENVILLE	GREENVILLE MEMORIAL	63	59.1%	*6*
GREENVILLE	SPRINGBROOK	15	30.2%	
GREENWOOD	SELF MEMORIAL	36	45.2%	
HORRY	LIGHTHOUSE - CONWAY	28	35.8%	*7*
LEXINGTON	THREE RIVERS BEHAV HEALTH	39	96.1%	*8*
MARLBORO	MARLBORO PARK HOSPITAL	8	50.9%	
ORANGEBURG	RMC-ORANGEBURG/CALHOUN	15	41.7%	
RICHLAND	PALMETTO BAPTIST - COLUMBIA	104	60.5%	
RICHLAND	PALMETTO RICHLAND MEMORIAL	60	46.0%	
SPARTANBURG	MARY BLACK MEMORIAL	15	72.5%	
SPARTANBURG	SPARTANBURG REGIONAL	56	35.6%	
YORK	PIEDMONT MEDICAL CENTER	20	32.3%	
	TOTAL	785	56.9%	

1 CON ISSUED 6/8/04 TO CONVERT 6 PSYCH BEDS TO GENERAL ACUTE FOR A TOTAL OF 14 PSYCH BEDS.

2 CON ISSUED 10/4/03 TO CONVERT 15 PSYCH BEDS TO GENERAL ACUTE & CLOSE PROGRAM.

3 CON ISSUED 10/18/04 TO ADD 10 PSYCH BEDS FOR A TOTAL OF 70.

4 CON ISSUED 1/20/04 TO CONVERT 12 PSYCH BEDS AT MCLEOD TO GENERAL ACUTE AND TRANSFER THE REMAINING 23 PSYCH BEDS TO WILSON MED CENTER.

5 CON ISSUED 10/11/04 TO ADD 11 PSYCH BEDS FOR A TOTAL OF 64.

6 CON ISSUED 8/25/03 TO CONVERT 17 PSYCH BEDS TO GENERAL ACUTE FOR A TOTAL OF 46.

7 CON ISSUED FOR 8 BEDS 11/25/02, LICENSED 6/3/03. CON ISSUED FOR 20 ADDITIONAL BEDS 12/31/03, LICENSED FOR 28 BEDS 1/22/04.

8 TOTAL REFLECTS UTILIZATION OF DUAL-DIAGNOSIS SWING BEDS.

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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2003 POP	2010 POP	2003 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	<65	204140	215390	3692	10.67				
	+65	34470	40350	833	2.67				
	TOTAL	238610	255740	4526	13.34	0.65	21	38	-17
GREENVILLE,PICKENS	<65	447930	483500	28901	79.55				
	+65	58240	64860	4122	12.58				
	TOTAL	506170	548360	31023	92.13	0.65	142	125	17
CHEROKEE,SPARTANBURG UNION	<65	302130	320270	5826	16.92				
	+65	43420	47610	5418	16.28				
	TOTAL	345550	367880	11244	33.20	0.65	51	71	-20
CHESTER,LANCASTER,YORK	<65	238900	258060	2058	6.09	1.04 / .65 = 11			
	+65	29510	33700	302	0.94				
	TOTAL	268410	291760	2360	7.04	0.65	11	20	-9
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	190590	200730	3622	10.45				
	+65	29900	34090	2316	7.23				
	TOTAL	220490	234820	5938	17.69	0.65	27	36	-9
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	597830	639470	42845	125.56				
	+65	70750	81280	8574	26.99				
	TOTAL	668580	720750	51419	152.55	0.65	235	203	32
DARLINGTON,FLORENCE MARION	<65	204240	209550	4830	13.58				
	+65	27580	30540	332	1.01				
	TOTAL	231820	240090	5162	14.58	0.65	22	23	-1
CHESTERFIELD,DILLON MARLBORO	<65	89890	89510	330	0.90				
	+65	11860	12490	1155	3.33				
	TOTAL	101750	102000	1485	4.23	0.65	7	8	-1
CLARENDON,LEE,SUMTER	<65	142440	147940	75%	12.32				
	+65	20120	23870	STATE USE	3.37				
	TOTAL	162560	171810	RATE	15.69	0.65	24	0	24

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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2003 POP	2010 POP	2003 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
GEORGETOWN,HORRY	<65	255270	277050	75%	23.07				
WILLIAMSBURG	+65	47260	60620	STATE USE	8.55				
	TOTAL	302530	337670	RATE	31.62	0.65	49	28	21
BAMBERG,CALHOUN	<65	108120	110090	1612	4.50				
ORANGEBURG	+65	16840	18880	672	2.06				
	TOTAL	124960	128970	2284	6.56	0.65	10	15	-5
ALLENDALE,BEAUFORT	<65	188270	201300	2826	8.28				
COLLETON,HAMPTON,	+65	33420	44370	200	0.73				
JASPER	TOTAL	221690	245670	3026	9.01	0.65	14	14	0
BERKELEY,CHARLESTON	<65	507430	533240	30482	87.76				
DORCHESTER	+65	62130	78300	5120	17.68				
	TOTAL	569560	611540	35602	105.44	0.65	162	152	10
AIKEN,BARNWELL	<65	150820	162740	6006	17.76				
	+65	22520	26600	1186	3.84				
	TOTAL	173340	189340	7192	21.52	0.65	33	29	4
STATE TOTAL							808	762	46
STATE MIMIMUM USE RATE	<65	3230290	3423850	131030.75	0.0405632	0.03			
	+65	440640	513070	30230	0.0686048	0.05			
	TOTAL	3670930	3936920	161260.75	0.0439291	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 currently licensed or approved as Residential Treatment Facilities:

Facility	Beds	FY 2003 Occ. Rate	
Directions (DMH, Columbia)	37	53.7%	
Lighthouse Care Center (Conway)	16	69.0%	*1*
Marshall Pickens Hospital (Greenville)	22	98.2%	
New Hope-Charleston (Summerville)	60	92.1%	*2*
New Hope-Midlands (West Columbia)	59	83.3%	*3*
Palmetto Low Country Behavioral Health (Charleston)	32	5.0%	
Palmetto Pee Dee Behavioral Health (Florence)	59	68.8%	*4*
Springbrook Behavioral Ctr. (Travelers Rest)	68	81.0%	
Three Rivers Behavioral Care (West Columbia)	20	96.2%	*5*
York Place (York)	40	62.3%	
TOTAL	413		

1 CON issued 11/25/02; licensed 4/29/03.
2 CON issued 10/8/02 for 8 additional beds for a total of 60; additional beds licensed 9/9/04.
3 CON issued 11/13/01 to add 5 beds for a total of 59; licensed for 59 beds 1/22/03.
4 CON issued 4/19/01 to add 41 beds for a total of 59; additional beds licensed 1/30/03.
5 CON issued 5/13/02 to add 4 beds for a total of 18 beds; licensed 12/6/02; CON issued 4/12/04 to add 2 additional beds for a total of 20 beds; additional beds licensed 6/24/04.

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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

2010 Population Age 6-21:	260,640	
41.4 Beds/100,000 Population:	x .000414	
	108	beds
	- 90	beds
Need Shown:	18	beds

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

Facilities:		
	Three Rivers	20 beds
	New Hope Midlands	59 beds
	York Place	40 beds
	Total	119 beds

2010 Population Age 6-21:	284,070	
41.4 Beds/100,000 Population:	x .000414	
	118	beds
	- 119	beds
Need Shown:	(1)	bed

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:		
	Lighthouse Care Center	16 beds
	Pal. Pee Dee Behav. Hlth.	59 beds
	Total	75 beds

2010 Population Age 6-21:	178,120	
41.4 Beds/100,000 Population:	x .000414	
	74	beds
	- 75	beds
Need Shown:	(1)	bed

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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
	Pal. Low Cnty Behav. Hlth.	32 beds
	Total	92 beds

2010 Population Age 6-21:	249,580	
41.4 Beds/100,000 Population:	x .000414	
	103	beds
	- 92	beds
Need Shown:	11	beds

The projected need for additional RTF beds is based upon the number of clients of the Department of Mental Health (DMH), Department of Social Services (DSS), 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 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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RECORD 003152

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 63 licensed outpatient facilities for chemically dependent or addicted persons in South Carolina, with a total of 85 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 N/A

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
Carolinas Hospital System (Florence County)	4
Charleston Center Subactute Detoxification Program	16
Greenville Detoxification Center	27
Lexington/Richland A.D.A.C. Detoxification Unit	16
Keystone Detoxification Center (York County)	10
TOTAL	73

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for freestanding medical detoxification beds. The 2003 utilization rates are used to project the need for services in 2010. 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 003154

DETOXIFICATION BED NEED

2004 PLAN

SERVICE AREA	2003 POP	2010 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	191,190	207,420	0	4.00	0.70	6	0	6
GREENVILLE,PICKENS	405,400	444,340	4,841	14.54	0.70	21	27	-6
CHEROKEE,SPARTANBURG UNION	273,970	295,300	0	5.70	0.70	8	0	8
CHESTER,LANCASTER,YORK	211,570	235,160	3,152	9.60	0.70	14	10	4
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	176,150	191,030	0	3.68	0.70	5	0	5
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	532,870	583,620	5,101	11.26	0.70	16	16	0
DARLINGTON,FLORENCE MARION	182,180	191,720	425	3.70	0.70	5	4	1
CHESTERFIELD,DILLON MARLBORO	79,130	80,530	0	1.55	0.70	2	0	2
CLARENDON,LEE,SUMTER	126,680	135,590	0	2.62	0.70	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	247,910	283,950	0	5.48	0.70	8	0	8
BAMBERG,CALHOUN ORANGEBURG	99,370	104,130	0	2.01	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	177,920	203,370	0	3.92	0.70	6	0	6
BERKELEY,CHARLESTON DORCHESTER	452,960	495,230	3,237	9.55	0.70	14	16	-2
AIKEN,BARNWELL	137,130	153,940	0	2.97	0.70	4	0	4
STATE TOTAL	3,294,430	3,605,330	16,756	80.58		116	73	43

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 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.

PMC.2013.SHP.0595

RECORD 003156

Fred's impression is that these beds can be used for [illegible] but only if primary diagnosis is alcohol/drug admit

Inpatient Treatment Facilities

This is 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	2003 Occupancy	
Aiken Regional Medical Center	18	12.1%	
AnMed-Wellspring (Anderson County)	27	8.5%	
Carolina Center Behavioral Health (Greenville County)	13	52.3%	
Carolinas Hospital System (Florence County)	18	29.1%	
Fairfield Memorial Hospital	0	0.0%	*1*
Holmesview Center (Greenville County)	40	64.9%	*2*
McCord Adolescent (Orangeburg County)	15	56.9%	*2*
Medical University (Charleston County)	23	50.1%	
Morris Village (Richland County)	173	82.3%	*2*
Palmetto Center (Florence County)	48	71.5%	*2*
Palmetto Lowcountry Behav. Health (Charleston County)	10	41.5%	
Palmetto Richland Springs (Richland County)	10	97.4%	
Self Memorial (Greenwood County)	24	0.0%	
Springs Memorial (Lancaster County)	12	25.5%	*3*
Three Rivers Behavioral Health (Lexington County)	27	20.1%	
TOTAL (DOES NOT INCLUDE STATEWIDE BEDS)	182	23.2%	

1 CON issued 11/12/03 to convert the 17 substance abuse beds to general acute.

2 Statewide Facility, Not Included in Bed Need Calculations.

3 Facility was licensed for 45 substance abuse beds. CON issued 4/15/03 to convert 10 substance abuse beds to general acute; CON issued 11/20/03 to convert 23 substance abuse beds to general acute, for a total of 12 beds; licensed for 12 beds 7/19/04.

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for inpatient treatment beds. The 2003 utilization rates are used to project the need for services in 2010. A 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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RECORD 003157

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

PMC.2013.SHP.0597

RECORD 003158

INPATIENT BED NEED

2004 PLAN

SERVICE AREA	2003 POP	2010 POP	PAT DAYS	PROJ ADC	% OCCUP	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	191,190	207,420	1,207	3.59	0.70	5	27	-22
GREENVILLE,PICKENS	405,400	444,340	889	2.67	0.70	4	13	-9
CHEROKEE,SPARTANBURG UNION	273,970	295,300	0	6.01	0.70	9	0	9
CHESTER,LANCASTER,YORK	211,570	235,160	1,977	6.02	0.70	9	12	-3
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	176,150	191,030	0	3.89	0.70	6	24	-18
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	532,870	583,620	6,338	19.02	0.70	27	37	-10
DARLINGTON,FLORENCE MARION	182,180	191,720	2,198	6.34	0.70	9	18	-9
CHESTERFIELD,DILLON MARLBORO	79,130	80,530	0	1.64	0.70	2	0	2
CLARENDON,LEE,SUMTER	126,680	135,590	0	2.76	0.70	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	247,910	283,950	0	5.78	0.70	8	0	8
BAMBERG,CALHOUN ORANGEBURG	99,370	104,130	0	2.12	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	177,920	203,370	0	4.14	0.70	6	0	6
BERKELEY,CHARLESTON DORCHESTER	452,960	495,230	7,204	21.58	0.70	31	33	-2
AIKEN,BARNWELL	137,130	153,940	1,128	3.47	0.70	5	18	-13
STATE TOTAL	3,294,430	3,605,330	20,941	89.02		128	182	-54
MINIMUM USE RATE	0.0074319							

(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	COUNTY	2003 CLIENTS during year
Center for Behavioral Health South Carolina	Charleston	290
Center of Hope of Myrtle Beach, LLC	Horry	Licensed 12/10/03
Columbia Metro Treatment Center, Inc.	Lexington	222
Charleston Center	Charleston	349
Gaffney Treatment Associates	Cherokee	CON issued 1/12/05
Greenville Metro Treatment Center, Inc.	Greenville	332
Piedmont Treatment Center, Inc.	Greenville	485
Recovery Concepts	Jasper	Approved 8/31/04
Southwest Carolina Treatment Center	Anderson	224
Spartanburg Treatment Associates	Spartanburg	437
Starting Point, LLC	Richland	358
Starting Point of Florence	Florence	CON issued 1/19/05
York County Treatment Center, Inc.	York	239

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 where an existing clinic exists, but should be developed in counties where none exists to improve accessibility.

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RECORD 003160

The following table indicates that there were 2,219 clients being served at Methadone Treatment Centers as of December 31, 2003. In addition, there were 2,936 clients served by Methadone Treatment Centers during the year 2003 and there were 1,136 visits to Emergency Rooms for opioid dependent patients for calendar year 2003. There were an additional 2,718 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.

METHADONE CLIENTS AT CENTERS AND USE OF EMERGENCY ROOMS

COUNTY	Clients at Methadone Centers 12/31/2003	2003 Opioid Dependent Emergency Room Visits	2003 Other Drug Dependent ER Visits
Abbeville	3	7	26
Aiken		19	48
Allendale		0	1
Anderson	109	63	158
Bamberg		2	7
Barnwell		4	8
Beaufort	4	29	75
Berkeley	33	29	78
Calhoun	1	1	7
Charleston	340	133	314
Cherokee	35	21	62
Chester	7	1	21
Chesterfield	3	4	23
Clarendon	2	1	5
Colleton	22	9	9
Darlington	14	38	68
Dillon		7	10
Dorchester	25	25	53
Edgefield		1	0
Fairfield	11	0	22
Florence	76	81	132
Georgetown	21	19	34
Greenville	355	58	179
Greenwood	4	22	113
Hampton		3	14
Horry	25	80	139
Jasper		7	9
Kershaw	21	16	36
Lancaster	41	9	57
Laurens	40	13	30
Lee		1	10
Lexington	104	44	108
McCormick		0	9
Marion	3	7	11
Marlboro		2	6
Newberry	7	7	14
Oconee	24	36	80
Orangeburg	11	17	38
Pickens	49	30	48
Richland	176	71	219
Saluda		1	4
Spartanburg	439	122	188
Sumter	5	14	47
Union	8	7	35
Williamsburg	2	4	19
York	74	19	45
NC	88		
GA	31		
Other states	6	52	99
Unknown			
TOTAL	2219	1136	2718

Clients at Methadone Centers denote the number of clients as of December 31, 2003.
Opiod dependent emergency room visits are patients seen in emergency departments by county of residence for 2003.
Other drug dependent emergency room visits are patients seen in emergency departments by county of residence that had a diagnosis of drugs other than opioids or were not specified.

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RECORD 003162

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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RECORD 003163

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 and Tourney Hospital.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2003 Occupancy
I	HealthSouth	Anderson	30	79.0% *1*
I	Roger C. Peace	Greenville	53	82.6%
I	St. Francis	Greenville	19	83.6%
I	Mary Black	Spartanburg	18	88.2%
II	HealthSouth Columbia	Richland	96	76.6% *2*
II	HealthSouth Rock Hill	York	34	90.7% *3*
III	HealthSouth Florence	Florence	88	79.8%
III	Carolinas Hospital	Florence	42	99.5% *4*
III	Waccamaw Community	Georgetown	24	67.5% *5*
III.	Georgetown Memorial	Georgetown	10	— *5*
IV	Beaufort Memorial	Beaufort	0	86.4% *6*
IV	HealthSouth Charleston	Charleston	46	94.5% *7*
IV	Medical University	Charleston	0	— *8*
IV	Roper Hospital	Charleston	39	78.3%
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	84.0%
IV	Low Country General	Jasper	10	— *9*
		Total	533	

1 CON issued 1/25/02 to build a rehabilitation hospital with 28 beds; licensed 12/20/02. CON issued 2/18/04 to convert 2 nursing home beds to rehab beds, for a total of 30 rehab beds; licensed for 30 beds 7/2/04.

2 CON issued 10/10/02 to add 15 beds for a total of 111 rehabilitation beds, voided 10/8/04.

3 CON issued 12/3/03 to convert 2 nursing home beds to rehab for a total of 34 rehab beds; licensed for 34 beds 4/1/04.

4 CON issued 4/15/03 to add 18 beds for a total of 42 beds; licensed for 42 beds 6/27/03.

5 CON issued 5/26/00 to create a 19-bed rehabilitation unit at Waccamaw; CON issued 2/11/02 for an additional 10 beds; 29 rehab beds licensed 10/21/02. CON issued 8/19/04 to create a 10 bed unit at Georgetown by adding 5 new beds and transferring 5 licensed beds from Waccamaw.

6 CON issued 6/8/04 to convert the 14 rehabilitation beds to general acute.

7 CON issued 12/15/03 to add 4 additional beds for a total of 46; licensed for 46 beds 6/3/04.

8 CON issued 10/14/03 to convert the 25 rehabilitation beds to general acute beds.

9 CON issued 3/28/02 for a 10 bed rehabilitation unit.

PMC.2013.SHP.0603

RECORD 003164

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.

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. For service areas without existing licensed beds, the statewide average 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);

PMC.2013.SHP.0604

RECORD 003165

d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

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.

REHABILITATION BED NEED

2004 PLAN

SERVICE AREA	2003 POP	2010 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED.	EXIST BEDS	ADDITION (EXCESS)
ANDERSON, OCONEE	238,610	255,740	8,070	25.84	0.70	37	30	7
GREENVILLE, PICKENS	506,170	548,360	22,549	66.93	0.70	96	72	24
CHEROKEE, SPARTANBURG, UNION	345,550	367,880	5,804	37.17	0.70	53	18	35
CHESTER, LANCASTER, YORK	268,410	291,760	10,588	31.53	0.70	45	34	11
ABBEVILLE, EDGEFIELD, GREENWOOD, LAURENS, MCCORMICK, SALUDA	220,490	234,820	0	23.73	0.70	34	0	34
FAIRFIELD, LEXINGTON, NEWBERRY, RICHLAND	614,350	661,840	26,824	79.17	0.70	113	96	17
CHESTERFIELD,DARLINGTON, DILLON, FLORENCE, MARION, MARLBORO, WILLIAMSBURG	370,620	378,950	34,352	96.23	0.70	137	130	7
CLARENDON, KERSHAW, LEE, SUMTER	216,790	230,720	0	23.31	0.70	33	0	33
GEORGETOWN, HORRY	265,480	300,810	6,923	30.39	0.70	43	34	9
AIKEN,ALLENDALE,BAMBERG, BARNWELL, CALHOUN, ORANGEBURG	309,880	330,260	7,360	33.37	0.70	48	24	24
BEAUFORT, COLLETON, HAMPTON, JASPER	210,110	233,720	4,417	23.61	0.70	34	10	24
BERKELEY, CHARLESTON, DORCHESTER	569,560	611,540	25,644	75.44	0.70	108	85	23
STATE TOTAL	4,136,020	4,446,400	152,531	546.72		781	533	248
STATE USE RATE	0.0368787							

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.gov the licensing list of nursing homes also denotes 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, washrooms, 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:

PMC.2013.SHP.0607

RECORD 003168

(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 non-institutional 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 2007.

A two-year projection, through 2007, of the nursing home bed need for the general (non-institutional) population is used for the following reasons:

PMC.2013.SHP.0608

RECORD 003169

(1) There is a shortage of Title XIX (Medicaid) funding in the state. Approximately 70% 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.

PMC.2013.SHP.0609

RECORD 003170

(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 70% 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.

PMC.2013.SHP.0610

RECORD 003171

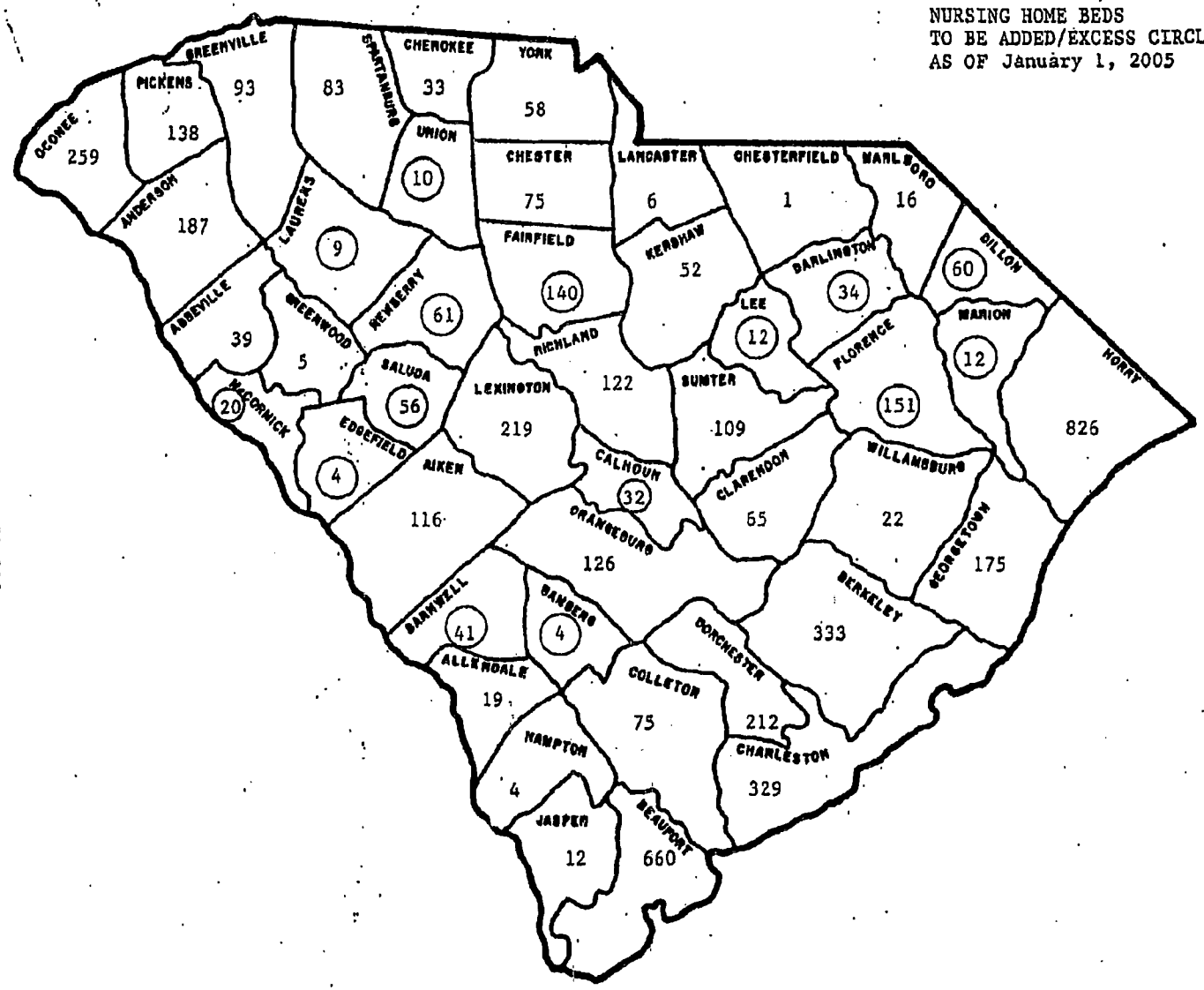
LONG TERM CARE BED NEED

		2007 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	TO BE ADDED/OR EXCESS
	ANDERSON	24.320	948	761	187
	CHEROKEE	6.730	262	229	33
	GREENVILLE	47.250	1843	1750	93
	OCONEE	13.100	511	252	259
	PICKENS	14.070	549	411	138
	SPARTANBURG	33.600	1310	1227	83
	UNION	4.910	191	201	-10
REGION I	TOTAL	143.980	5614	4831	793
	ABBEVILLE	3.980	155	116	39
	CHESTER	4.480	175	100	75
	EDGEFIELD	2.970	116	120	-4
	FAIRFIELD	3.130	122	262	-140
	GREENWOOD	9.280	362	357	5
	KERSHAW	7.380	288	236	52
	LANCASTER	7.540	294	288	6
	LAURENS	10.070	393	402	-9
	LEXINGTON	26.750	1043	824	219
	MCCORMICK	2.560	100	120	-20
	NEWBERRY	5.510	215	276	-61
	RICHLAND	33.040	1289	1167	122
	SALUDA	3.070	120	176	-56
	YORK	19.420	757	699	58
REGION II	TOTAL	139.180	5429	5143	576
	CHESTERFIELD	5.250	205	204	1
	CLARENDON	5.570	217	152	65
	DARLINGTON	8.510	332	366	-34
	DILLON	3.470	135	195	-60
	FLORENCE	16.040	626	777	-151
	GEORGETOWN	10.870	424	249	175
	HORRY	38.520	1502	676	826
	LEE	2.770	108	120	-12
	MARION	4.320	168	180	-12
	MARLBORO	3.230	126	110	16
	SUMTER	13.780	537	428	109
	WILLIAMSBURG	5.080	198	176	22
REGION III	TOTAL	117.410	4578	3633	1214
	AIKEN	21.390	834	718	116
	ALLENDALE	1.620	63	44	19
	BAMBERG	2.160	84	88	-4
	BARNWELL	3.280	128	169	-41
	BEAUFORT	26.930	1050	390	660
	BERKELEY	16.860	658	325	333
	CALHOUN	2.260	88	120	-32
	CHARLESTON	41.280	1610	1281	329
	COLLETON	5.320	207	132	75
	DORCHESTER	12.560	490	278	212
	HAMPTON	2.760	108	104	4
	JASPER	2.570	100	88	12
	ORANGEBURG	13.320	519	393	126
REGION IV	TOTAL	152.310	5939	4130	1886
GRAND TOTAL		552.880	21560	17737	4469

PMC.2013.SHP.0611

RECORD 003172

NURSING HOME BEDS
TO BE ADDED/EXCESS CIRCLED
AS OF January 1, 2005



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COUNTY	2007 POP	NURSING BEDS	BEDS/M	RANK
BEAUFORT	26.930	390	14.48	1
HORRY	38.520	676	17.55	2
OCONEE	13.100	252	19.24	3
BERKELEY	16.860	325	19.28	4
DORCHESTER	12.560	278	22.13	5
CHESTER	4.480	100	22.32	6
GEORGETOWN	10.870	249	22.91	7
COLLETON	5.320	132	24.81	8
ALLENDALE	1.620	44	27.16	9
CLARENDON	5.570	152	27.29	10
ABBEVILLE	3.980	116	29.15	11
PICKENS	14.070	411	29.21	12
ORANGEBURG	13.320	393	29.50	13
LEXINGTON	26.750	824	30.80	14
CHARLESTON	41.280	1281	31.03	15
SUMTER	13.780	428	31.06	16
ANDERSON	24.320	761	31.29	17
KERSHAW	7.380	236	31.98	18
AIKEN	21.390	718	33.57	19
CHEROKEE	6.730	229	34.03	20
MARLBORO	3.230	110	34.06	21
JASPER	2.570	88	34.24	22
WILLIAMSBURG	5.080	176	34.65	23
RICHLAND	33.040	1167	35.32	24
YORK	19.420	699	35.99	25
SPARTANBURG	33.600	1227	36.52	26
GREENVILLE	47.250	1750	37.04	27
HAMPTON	2.760	104	37.68	28
LANCASTER	7.540	288	38.20	29
GREENWOOD	9.280	357	38.47	30
CHESTERFIELD	5.250	204	38.86	31
LAURENS	10.070	402	39.92	32
EDGEFIELD	2.970	120	40.40	33
BAMBERG	2.160	88	40.74	34
UNION	4.910	201	40.94	35
MARION	4.320	180	41.67	36
DARLINGTON	8.510	366	43.01	37
LEE	2.770	120	43.32	38
MCCORMICK	2.560	120	46.88	39
FLORENCE	16.040	777	48.44	40
NEWBERRY	5.510	276	50.09	41
BARNWELL	3.280	169	51.52	42
CALHOUN	2.260	120	53.10	43
DILLON	3.470	195	56.20	44
SALUDA	3.070	176	57.33	45
FAIRFIELD	3.130	262	83.71	46
	552.880	17737	32.08	

PMC.2013.SHP.0613

RECORD 003174

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
2003-2004	4,304,160	11792	4,205,553	11522	98,607
2004-2005	4,294,977	11767	4,205,553	11522	89,424

NOTES: 36,500 patient days = 100 beds

PMC.2013.SHP.0614

RECORD 003175

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.

PMC.2013.SHP.0615

RECORD 003176

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 licensed inpatient hospice facility is:
Callie and John Rainey Hospice House in Anderson with 32 beds.

PMC.2013.SHP.0616

RECORD 003177

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 that 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 Adistinct 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;

PMC.2013.SHP.0617

RECORD 003178

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 2003 for the home health agencies in South Carolina were:

Total Visits	1,235,335
Nursing visits	45.8%
Home health aide visits	12.3%
Physical therapy visits	32.2%
Medical social worker visits	1.7%
Speech therapy visits	1.9%
Occupational therapy visits	6.0%
Other	0.1%

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

PMC.2013.SHP.0618

RECORD 003179

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.

PMC.2013.SHP.0619

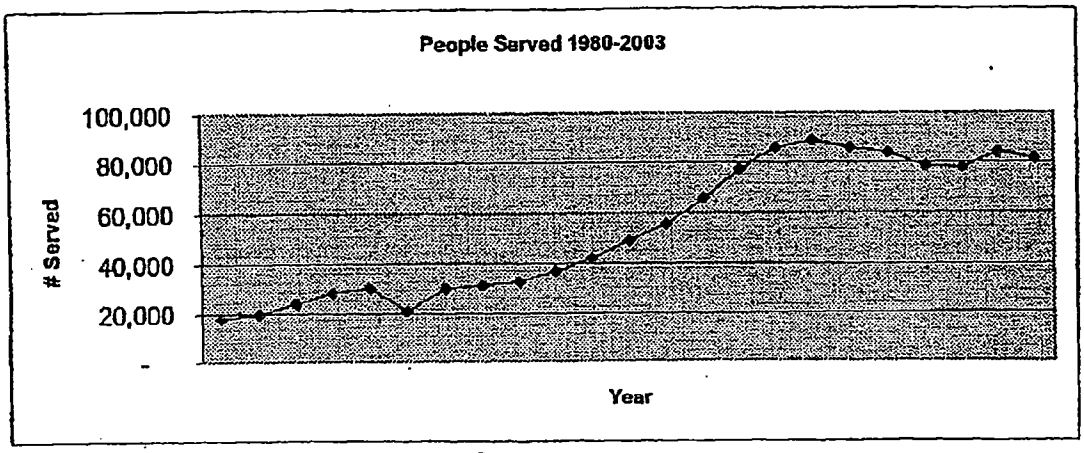
RECORD 003180

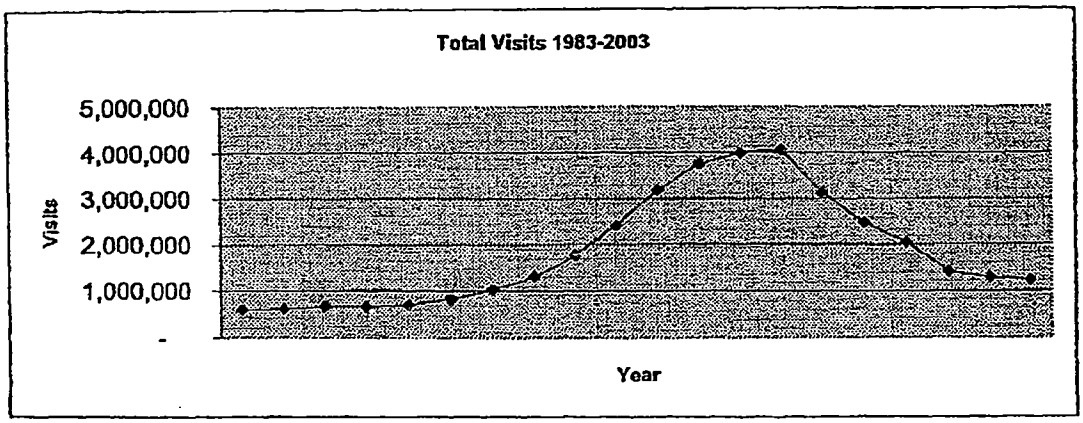
adverse affects caused by the duplication of any existing service.

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 January 14, 2005.

PMC.2013.SHP.0620

RECORD 003181


People Served 1980-2003
100,000
80,000
60,000
40,000
20,000
-
Served
Year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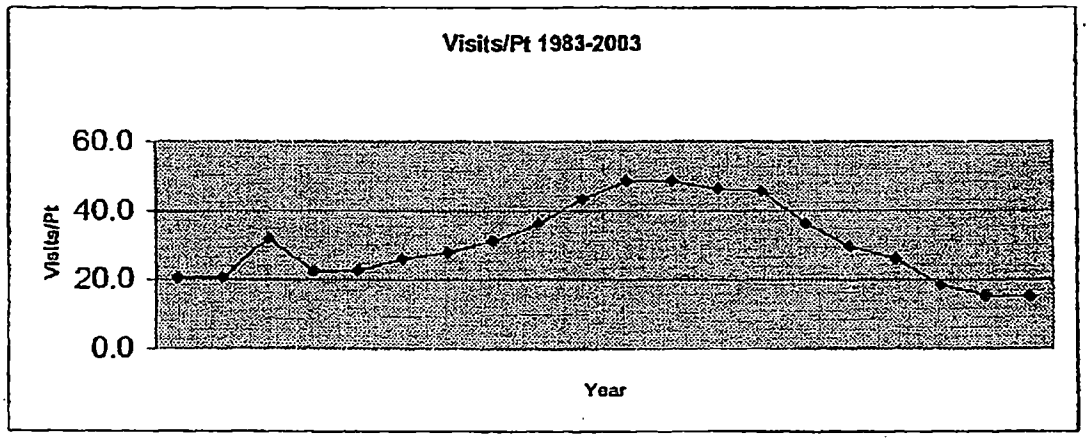
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
Visits
Year


Visits/Pt 1983-2003
60.0
40.0
20.0
0.0
Visits/Pt
Year

HOME HEALTH AGENCIES INVENTORY-2003 DATA

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Alliance Home Care	Horry	1275	16901	13.3
Amedisys Home Health Inc. of S.C.	Berkeley, Charleston & Dorchester	1086	20459	18.8
ANMED Home Health Agency	Anderson	1058	20623	19.5
Appalachia I Home Health Care Services	Anderson & Oconee	1212	9772	8.1
Appalachia II Home Health Services	Greenville & Pickens	1475	12245	8.3
Appalachia III Home Health Services	Spartanburg, Union & Cherokee	3295	29537	9.0
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	120	774	6.5
Bethea Home Health	Darlington (may serve retirement community only)	31	16091	519.1
Care One Home Health Services	Beaufort, Hampton, & Jasper	604	9781	16.2
CarePro Home Health 1/	Richland & Sumter	497	11094	22.3
Caring Neighbors Home Health 3/	Fairfield	276	5272	19.1
Carolina Home Health Care	Richland & Lexington	955	14485	15.2
Carolina Home Health 2/ Care-Greenville	Anderson, Oconee, Greenville, Pickens, Cherokee, Spartanburg Laurens & Union	535	9819	18.4 (may only serve patients in Union County whose initial diagnosis requires IV therapy services and/or home uterine activity monitoring)
Catawba Home Health Services	Chester, York & Lancaster	1094	8667	7.9
Chesterfield Visiting Nurses Services	Darlington, Marlboro & Chesterfield	510	14731	28.9

PMC.2013.SHP.0622

RECORD 003183

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Home Health of S.C., Inc. - Midlands	Lexington & Richland	899	12197	13.6
Home Health of South Carolina, Inc.	York	1007	15075	15.0
Home Health Services of Carolinas Hospital System	Darlington, Dillon, Florence, Marlboro & Williamsburg	1272	27736 (may serve terminally ill patients only in Williamsburg County)	21.8
Home Health Services of Self Regional Healthcare	Abbeville, Laurens, Greenwood, Saluda Mccormick	1182	19946	16.8
Hospice Care of the Low Country Home Health	Beaufort & Jasper	69 (may serve terminally ill patients only)	2521	36.5
Hospice of Charleston HHA	Charleston, Berkeley & Dorchester	83	1413	17.0
Incare Home Health, Inc.	Horry & Georgetown	1541	34202	22.2
Interim HealthCare of Greenville	Anderson, Pickens, Spartanburg, Oconee, Greenville & Cherokee	6600	112888	17.1
Interim HealthCare, Rock Hill	York	965	17057	17.7
Intrepid USA Healthcare Services 8/	Allendale, Berkeley Charleston, Colleton, Dorchester, Georgetown	823	14116	17.2
Island Health Care, Inc.	Beaufort	1338	16542	12.4
Kershaw County Medical Center Home Health	Kershaw	718	13849	19.3
Liberty Home Care-Bennettsville	Marlboro	193	3440	17.8
Liberty Home Care-Myrtle Beach	Horry	294	4096	13.9
Low Country Home Health Services	Beaufort, Jasper, Colleton & Hampton	1034	8209	7.9

PMC.2013.SHP.0623

RECORD 003184

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Pee Dee District Home Health Services	Dillon, Florence, Marion, Darlington, Marlboro, Chesterfield	3649	34397	9.4
PHC Home Health	Charleston	641	9536	14.9
Roper-St. Francis Home Health Care	Charleston, Berkeley, & Dorchester	2644	52356	19.8
Sea Island Home Health	Charleston & Colleton	79	2609	33.0
Spartanburg Regional Med. Center Home Health Services	Spartanburg	1861	29601	15.9
St. Francis Hospital HomeCare	Anderson, Pickens, Greenville, & Spartanburg	1884	21838	11.6
St. Joseph Home Health Care Services	Aiken, Edgefield & Barnwell	368	5167	14.0
The Seabrook Wellness and Home Health Care	Beaufort (may only serve residents of The Seabrook of Hilton Head)	38	2193	57.7
Total Care of North 7/ Carolina-Rock Hill	York, Cherokee, Chester, & Union	1428	18024	12.6
Total Care, Inc.- Coastal	Georgetown, Horry, Williamsburg	1237	17140	13.9
Tri-County Home Health Care & Services	Saluda, Richland, Lexington, & Sumter	2734	47227	17.3
Trident Home Health Services	Charleston, Berkeley, & Dorchester	1184	14171	12.0
Tuomey Home Health	Lee, Clarendon & Sumter	804 (may serve terminally ill patients only in Lee and Clarendon Counties)	13063	16.2
University Home Health -North Augusta	Aiken & Edgefield	716	13694	19.1
Upper Savannah Home Health Services	Abbeville, Laurens, Edgefield, Saluda, Greenwood & McCormick	1067	6767	6.3

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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.

3/ Name changed 10/16/02, formerly Fairfield Home Health Services.

4/ Agency closed, 8/5/03.

5/ Agency closed, 4/16/03.

6/ CON issued 2/14/03 to expand services for OB patients only to Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Orangeburg, Saluda, Sumter, Union and Williamsburg Counties. Licensed 3/28/03.

7/ Name changed 2/3/04, formerly Total Care, Inc.

8/ Name changed 7/1/03, formerly Medshares Home Care of Southeastern South Carolina, Inc.

9/ Name changed 9/1/04, formerly Interim of Coastal Carolina.

10/ Name changed when Lower Savannah Home Health Services and Edisto Health District Home Health Services merged, 9/20/04.

11/ Facility closed 10/1/04.

12/ Name changed 11/1/04, formerly CareSouth HomeCare Professionals, A Winyah Company-Georgetown.

13/ Name changed 11/1/04, formerly CareSouth HomeCare Professionals, A Winyah Company-Columbia.

14/ Name changed 12/1/04, formerly Interim Health Care of the Low Country.

15/ Name changed 11/4/04, formerly Interim Health Care of the Grand Strand, LLC A Winyah Company.

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RECORD 003186

HOME HEALTH AGENCIES INVENTORY 2003 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Beaufort	The Seabrook Wellness and Home Health (	38	2193	57.7
Berkeley	Amedisys Home Health Inc. of SC	277	4558	16.5
Berkeley	Home Health of S. C., Inc.-Lowcountry	240	2559	10.7
Berkeley	Hospice of Charleston HHA	14	144	10.3
Berkeley	Winyah Home HealthCare Coastal Carolin:	505	4469	8.8
Berkeley	Matria Healthcare-Midlands	12	25	2.1
Berkeley	Intrepid USA Healthcare Services	144	2885	20.0
Berkeley	Roper-St. Francis Home Health Care	386	6290	16.3
Berkeley	Trident Home Health Services	93	996	10.7
Calhoun	Winyah Home Health Care - Midlands	0	0	0.0
Calhoun	Edisto Savannah Home Health Agency	162	1566	9.7
Calhoun	Home Care of Regional Medical Center	21	562	26.8
Calhoun	Matria Healthcare-Piedmont	3	6	2.0
Calhoun	VNA of Greater Bamberg, Inc.	33	1448	43.9
Calhoun	Winyah Home Health Care-Piedmont	2	20	10.0
Charleston	Amedisys Home Health Inc. of SC	622	11953	19.2
Charleston	(Franke Home Health (retirement only))	0	0	0.0
Charleston	Franklin C. Fetter Home Health	102	4574	44.8
Charleston	Hospice of Charleston HHA	54	991	18.4
Charleston	Winyah Home HealthCare Coastal Carolin:	2028	18189	9.0
Charleston	Matria Healthcare-Midlands	34	73	2.1
Charleston	Intrepid USA Healthcare Services	252	3545	14.1
Charleston	PHC Home Health	641	9536	14.9
Charleston	Roper-St. Francis Home Health Care	2076	43478	20.9
Charleston	Sea Island Home Health	79	2609	33.0
Charleston	Trident Home Health Services	945	11293	12.0
Cherokee	Appalachia III Home Health	792	8134	10.3
Cherokee	Carolina Home Health Care-Greenville	1	3	3.0
Cherokee	Interim Healthcare of Greenville	481	10913	22.7
Cherokee	Matria Healthcare-Piedmont	19	35	1.8
Cherokee	Total Care of North Carolina-Rock Hill	157	2478	15.8
Chester	Catawba Home Health	88	669	7.6
Chester	Matria Healthcare-Piedmont	1	2	2.0
Chester	Neighbors Care Home Health Agency	415	7879	19.0
Chester	Total Care of North Carolina-Rock Hill	172	1800	10.5
Chesterfield	Chesterfield VNS	400	11069	27.7
Chesterfield	Matria Healthcare-Piedmont	11	19	1.7
Chesterfield	Pee Dee District Home Health Services	1052	7519	7.1
Clarendon	Clarendon Memorial Home Health	167	2658	15.9
Clarendon	Matria Healthcare-Piedmont	1	1	1.0

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HOME HEALTH AGENCIES INVENTORY 2003 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Florence	McLeod Home Health	977	14708	15.1
Florence	Pee Dee District Home Health Services	535	5917	11.1
Georgetown	Winyah Home Health Care - Georgetown	28	415	14.8
Georgetown	Incare Home Health	291	7379	25.4
Georgetown	Matria Healthcare-Midlands	3	4	1.3
Georgetown	Intrepid USA Healthcare Services	0	0	0.0
Georgetown	Total Care, Inc - Coastal	135	1941	14.4
Georgetown	Waccamaw Home Care Services	337	3115	9.2
Georgetown	Winyah Home Health Care	531	6389	12.0
Greenville	Appalachia II Home Health	423	2609	6.2
Greenville	Carolina Home Health Care-Greenville	305	5848	19.2
Greenville	Greenville Hospital System HHA	2142	35406	16.5
Greenville	Interim Healthcare of Greenville	2389	37998	15.9
Greenville	Matria Healthcare-Piedmont	70	179	2.6
Greenville	NHC HomeCare-Laurens	151	2484	16.5
Greenville	St. Francis Hospital Home Care	1312	15940	12.1
Greenville	Winyah Home Health Care-Upper State	0	0	0.0
Greenwood	Health Related Home Care, Inc.	227	7311	32.2
Greenwood	HomeCare of HospiceCare of Piedmont (te	12	177	14.8
Greenwood	Home Health Services of Self Regional He:	809	14107	17.4
Greenwood	Matria Healthcare-Piedmont	13	23	1.8
Greenwood	NHC Homecare-Greenwood	183	5920	32.3
Greenwood	Upper Savannah Home Health	169	1198	7.1
Greenwood	Winyah Home Health Care-Upper State	0	0	0.0
Hampton	CareOne Home Health Services	69	1031	14.9
Hampton	Winyah Home HealthCare Coastal Carolin:	97	931	9.6
Hampton	Low Country Home Health Services	349	2665	7.6
Hampton	Matria Healthcare-Piedmont	1	1	1.0
Hampton	VNA of Greater Bamberg, Inc.	7	170	24.3
Horry	Alliance Home Care	1275	16901	13.3
Horry	Incare Home Health	1250	26823	21.5
Horry	Winyah Home Health Care of Grand Stran	388	5334	13.7
Horry	Liberty Home Care-Myrtle Beach	294	4096	13.9
Horry	Matria Healthcare-Piedmont	12	19	1.6
Horry	Total Care, Inc - Coastal	866	11508	13.3
Horry	Waccamaw Home Care Services	986	10332	10.5
Jasper	Beaufort-Jasper Home Health Agency	33	180	5.5
Jasper	CareOne Home Health Services	150	2492	16.6
Jasper	Hospice Care of Low Country (term)	8	391	48.9
Jasper	Winyah Home Health Care of Beaufort	61	988	16.2

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HOME HEALTH AGENCIES INVENTORY 2003 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
McCormick	Health Related Home Care	37	1379	37.3
McCormick	HomeCare of HospiceCare of Piedmont (te	1	17	17.0
McCormick	Home Health Services of Self Regional He:	68	1126	16.6
McCormick	Matria Healthcare-Piedmont	0	0	0.0
McCormick	Upper Savannah Home Health	97	698	7.2
Newberry	Winyah Home Health Care-Midlands	212	2669	12.6
Newberry	Matria Healthcare-Midlands	8	19	2.4
Newberry	Palmetto Home Health Services	583	4554	7.8
Newberry	Winyah Home Health Care-Piedmont	39	546	14.0
Oconee	Appalachia I Home Health	475	4300	9.1
Oconee	Carolina Home Health Care-Greenville	8	69	8.6
Oconee	Interim Healthcare of Greenville	733	14508	19.8
Oconee	Matria Healthcare-Piedmont	11	34	3.1
Oconee	Oconee Memorial Hospital HHA	510	9878	19.4
Orangeburg	Winyah Home Health Care - Midlands	515	9517	18.5
Orangeburg	Edisto Savannah Home Health Agency	880	10923	12.4
Orangeburg	Home Care of Regional Medical Center	335	6466	19.3
Orangeburg	Matria Healthcare-Piedmont	7	12	1.7
Orangeburg	VNA of Greater Bamberg, Inc.	300	14230	47.4
Orangeburg	Winyah Home Health Care-Piedmont	19	255	13.4
Pickens	Appalachia II Home Health	1052	9636	9.2
Pickens	Carolina Home Health Care-Greenville	53	1188	22.4
Pickens	Clemson Area Retirement Center HHA (re:	18	1527	84.8
Pickens	Greenville Hospital System HHA	227	4060	17.9
Pickens	Interim Healthcare of Greenville	627	11806	18.8
Pickens	Matria Healthcare-Piedmont	9	18	2.0
Pickens	Oconee Memorial Hospital HHA	111	1384	12.5
Pickens	St. Francis Hospital Home Care	197	1863	9.5
Richland	CarePro Home Health	497	11094	22.3
Richland	Winyah Home Health Care - Midlands	845	10979	13.0
Richland	Carolina Home Health Care, Inc.	470	7282	15.5
Richland	Home Health of South Carolina, Inc.-Midl:	467	5988	12.8
Richland	(Lowman Home Health (restricted))	0	0	0.0
Richland	Matria Healthcare-Midlands	94	211	2.2
Richland	Palmetto Health HomeCare	1749	35656	20.4
Richland	Palmetto Home Health Services	341	2312	6.8
Richland	Tri-County Home Health Care	796	13542	17.0
Richland	Winyah Home Health Care-Piedmont	33	437	13.2
Saluda	Health Related Home Care, Inc.	34	1074	31.6
Saluda	HomeCare of HospiceCare of Piedmont (te	3	44	14.7

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RECORD 003189

F. Other Services For The Elderly

1. 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 January 1, 2005, there were 99 licensed Day Care Facilities for Adults with 3,414 participants. Additional information may be found at www.scdhec.gov under health regulations.

2. 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.

As of January 1, 2005, there were 500 licensed Community Residential Care Facilities with 16,474 beds. Additional information may be found at www.scdhec.gov under health regulations.

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RECORD 003190

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 25, which can be operated as any combination of acute or Swing-Beds;

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;

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) The annual average length of stay must be less than 96 hours (4 days).

The state legislature approved an amendment to Article 7, Chapter 6, Title 44, amending the definition of "rural" for hospitals located in Metropolitan Statistical Area (MSA) Counties. Specifically, a hospital located in an urban area (MSA county) can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

1) It is enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients;

2) It provides emergency health care services to indigent patients;

3) It maintains a 24-hour emergency room;

4) It staffs 50 or fewer acute care beds; and

5) It is located in a county with 25% or more rural residents, as defined by the most recent Census.

As of May 2004, 893 hospitals nationwide had been approved for CAH status. The impact of the Critical Access Hospital Program in South Carolina would 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 existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25 bed requirement.

The following facilities in South Carolina have either been approved as a CAH or have received exemptions to de-license beds to reach the 25 bed maximum allowed under the CAH program:

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RECORD 003191

8. Long-Term Care Hospitals

Long Term Care (LTC) 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. 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. As of May 2004, there were 318 long-term care hospitals nationwide.

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, and hemodynamic monitoring.

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:

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

PMC.2013.SHP.0631

RECORD 003192

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

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 January 14, 2005.

PMC.2013.SHP.0632

RECORD 003193

REGION: STATEWIDE — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:									
	THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38			
	LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10			
X	SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50		959	5849
	LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20			
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30			
	COLUMBIA CARE CENTER		RICHLAND	COLUMBIA	PROP	140	140		170	25508
	KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24			
	WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8			
	CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22		174	199
	TOTAL					304	304		1303	31556
	MENTAL HOSPITALS:									
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSP		ANDERSON	ANDERSON	ST	206	206		1806	47189
XYZ	COLUMBIA CARE CENTER		RICHLAND	COLUMBIA	PROP	178	178		363	52621
	GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87			
XYZ	SC STATE HOSPITAL	1	RICHLAND	COLUMBIA	ST	150	501	264 abc	107	25614
XYZ	G WERBER BRYAN PSYCHIATRIC HOSP		RICHLAND	COLUMBIA	ST	288	305		1821	72641
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITI	2	RICHLAND	COLUMBIA	ST	89	89		389	22525
	TOTAL					998	1366	264	4476	220590
	RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:									
XYZ	DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37		37	7258
	TOTAL					37	37		37	7258

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REGION: STATEWIDE — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

				CON-ST	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
YZN	CM TUCKER JR NURS CTR-RODDEY	RICHLAND	COLUMBIA		308	308	154 d	18	80818
N	LOWMAN HOME - WC BOLICK	RICHLAND	WHITEROCK	NPA	47	47		40	16508
N	WJB DORN VETERANS NURSING	RICHLAND	COLUMBIA	FED	94	150		248	33307
N	SKYLYN HEALTH CENTER	SPARTANBURG	SPARTANBURG	PROP	11	11		22	3043
N	CARTER NURSING CENTER	SUMTER	SUMTER	NPA	44	44		33	14964
	TOTAL				1496	1552		1088	425205

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Z	DR DON LESTER PEOPLES COMM RES	ABBEVILLE	WARE SHOALS	ST	8	8			
Z	WARE SHOALS HAB CTR I	ABBEVILLE	WARE SHOALS	ST	8	8			
	ABBEVILLE CO	TOTAL			16	16			
Z	DUPONT I HABILITATION CTR	AIKEN	AIKEN	ST	8	8			
Z	DUPONT II HABILITATION CTR	AIKEN	AIKEN	ST	8	8			
Z	LAURENS STREET ICF/MR	AIKEN	AIKEN	ST	8	8			
Z	LINDEN STREET ICR/MR	AIKEN	AIKEN	ST	8	8			
Z	RUDNICK HABILITATION CTR	AIKEN	AIKEN	ST	8	8			
Z	SANDERS HABILITATION CTR	AIKEN	AIKEN	ST	8	8			
	AIKEN CO	TOTAL			48	48			
Z	ANDERSON HABILITATION CTR	ANDERSON	ANDERSON	ST	8	8			
Z	BELTON HABILITATION CTR	ANDERSON	BELTON	ST	8	8			
Z	HONEA PATH HABILITATION CTR	ANDERSON	HONEA PATH	ST	8	8			
	ANDERSON CO	TOTAL			24	24			
Z	ACADEMY STREET COMMUNITY RES	BARNWELL	WILLISTON	NPA	8	8			
Z	BLACK'S DRIVE COMMUNITY RES	BARNWELL	WILLISTON	NPA	8	8			
Z	HARLEY RD COMMUNITY RES	BARNWELL	WILLISTON	NPA	8	8			
Z	LEMON PARK COMMUNITY RES	BARNWELL	BARNWELL	NPA	8	8			
	BARNWELL CO	TOTAL			32	32			
Z	CONIFER I COMMUNITY RESIDENCE	BERKELEY	MONCKS CORNER	ST	8	8			
Z	CONIFER II COMMUNITY RESIDENCE	BERKELEY	MONCKS CORNER	ST	8	8			
	BERKELEY CO	TOTAL			16	16			
Z	FLORENCE GRESSETTE RESIDENCE	CALHOUN	ST MATTHEWS	NPA	8	8			
Z	WYLIE-BRUNSON RESIDENCE	CALHOUN	ST MATTHEWS	NPA	8	8			
	CALHOUN CO	TOTAL		0	16	16			

PMC.2013.SHP.0634

REGION: STATEWIDE — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	FLORENCE CO	TOTAL			253	253			
Z	JESSAMINE COMMUNITY RESIDENCE	GEORGETOWN	GEORGETOWN	ST	8	8			
Z	MARYVILLE COMMUNITY RESIDENCE	GEORGETOWN	GEORGETOWN	ST	8	8			
	GEORGETOWN CO				16	16			
Z	CIVITAN COMMUNITY RESIDENCE	GREENVILLE	GREENVILLE	ST	8	8			
Z	FOUNTAIN INN COMMUNITY RESIDENCE	GREENVILLE	FOUNTAIN INN	NPA	12	12			
Z	HUGHES STREET COMMUNITY RES	GREENVILLE	FOUNTAIN INN	NPA	8	8			
Z	MARIAN PARKINS COMMUNITY RES I	GREENVILLE	GREENVILLE	ST	8	8			
Z	MARIAN PARKINS COMMUNITY RES II	GREENVILLE	GREENVILLE	ST	8	8			
Z	RIDGE ROAD RESIDENCE	GREENVILLE	GREENVILLE	ST	12	12			
Z	TRAVELERS REST COMMUNITY RES	GREENVILLE	TRAVELERS REST	NPA	8	8			
	GREENVILLE CO	TOTAL			64	64			
Z	HENRY & FREIDA BONDS HAB CTR	GREENWOOD	GREENWOOD	ST	8	8			
Z	MARION P CARNELL HAB CTR	GREENWOOD	WARE SHOALS	ST	8	8			
Z	J. FELTON BURTON COMMUNITY RES	GREENWOOD	GREENWOOD	ST	8	8			
	GREENWOOD CO	TOTAL			24	24			
Z	HORRY CO LADIES COMMUNITY RES	HORRY	CONWAY	ST	8	8			
Z	THE LOIS EARGLE HOME	HORRY	CONWAY	ST	8	8			
	HORRY CO	TOTAL			16	16			
Z	CAMDEN I GROUP HOME	KERSHAW	CAMDEN	NPA	8	8			
Z	CAMDEN II GROUP HOME	KERSHAW	CAMDEN	NPA	8	8			
	KERSHAW CO	TOTAL			16	16			
Z	NANCY J MCCONNELL COMMUNITY RES	LANCASTER	LANCASTER	ST	8	8			
Z	TOM MANGUM COMMUNITY RESIDENCE	LANCASTER	LANCASTER	ST	8	8			
	LANCASTER CO	TOTAL			16	16			
Z	CLINTON MANOR COMMUNITY RES	LAURENS	CLINTON	NPA	8	8			
Z	DAVIDSON STREET COMMUNITY RES	LAURENS	CLINTON	CO	8	8			
Z	MILL STREET COMMUNITY RESIDENCE	LAURENS	CLINTON	CO	8	8			
Z	SOUTH HARPER ST HABILITATION CTR	LAURENS	CLINTON	ST	8	8			
Z	SULLIVAN STREET COMMUNITY RES	LAURENS	LAURENS	NPA	8	8			
Z	OAK GROVE COMMUNITY RESIDENCE	LAURENS	LAURENS	ST	8	8			
YZ	WHITTEN CTR CTL SQ 201,204,205,207,209	LAURENS	CLINTON	ST	143	143			
Z	WHITTEN CENTER CAMPUS AREA 101-110	LAURENS	CLINTON	ST	152	152			
Z	WHITTEN CENTER WEBB UNIT 403	LAURENS	CLINTON	ST	60	60			
Z	WHITTEN CENTER SUBER UNITS 301-303	LAURENS	CLINTON	ST	68	68			
	LAURENS CO	TOTAL			471	471			
Z	MCLEOD I GROUP HOME	LEE	BISHOPVILLE	NPA	8	8			
Z	MCLEOD II GROUP HOME	LEE	BISHOPVILLE	NPA	8	8			

PMC.2013.SHP.0635

REGION: STATEWIDE — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	RABBIT RUN COMMUNITY RESIDENCE	RICHLAND	HOPKINS	NPA	8	8			
Z	WOODLAWN GROUP HOME	RICHLAND	COLUMBIA	NPA	8	8			
	RICHLAND CO	TOTAL			424	424			
Z	BENCHMARK HOMES-SPARTANBURG	SPARTANBURG	SPARTANBURG	ST	12	12			
Z	BENCHMARK HOMES-COWPENS	SPARTANBURG	COWPENS	ST	12	12			
Z	LANDRUM COMMUNITY RESIDENCE I	SPARTANBURG	LANDRUM	ST	8	8			
Z	LANDRUM COMMUNITY RESIDENCE II	SPARTANBURG	LANDRUM	ST	8	8			
	SPARTANBURG CO	TOTAL			40	40			
Z	ATKINSON EAST COMMUNITY RESIDENCE	SUMTER	SUMTER	NPA	9	9			
Z	ATKINSON WEST COMMUNITY RESIDENCE	SUMTER	SUMTER	NPA	9	9			
Z	THOMAS DRIVE COMMUNITY RESIDENCE	SUMTER	SUMTER	ST	8	8			
	SUMTER CO	TOTAL			26	26			
Z	WEST MAIN STREET COMMUNITY RES	UNION	UNION	ST	8	8			
	UNION CO	TOTAL			8	8			
Z	BIRD STREET HABILITATION CENTER	7 YORK	ROCK HILL	ST	8	8			
Z	BIRD STREET HABILITATION CENTER	7 YORK	ROCK HILL	ST	8	8			
	YORK CO	TOTAL			16	16			
	TOTAL				2184	2184			

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REGION NARRATIVE

REGION: I FISCAL YEAR: 2004

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: 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 six facilities in this region and long term psychiatric beds available at Springbrook Behavioral Healthcare System in Greenville County. There is a 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: There is a need for additional rehabilitation beds in this region.

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REGION: I

INPATIENT INVENTORY — OCT.1.2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING		ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	HOSPITALS:												
XYZ	ANDERSON AREA MEDICAL CENTER		ANDERSON	ANDERSON	NPA	495	423			17,876	80,923	495	50.3%
CON	WOMEN & CHILDREN'S HOSPITAL	13	ANDERSON	ANDERSON	NPA		72						
	ANDERSON COUNTY		TOTAL			495	495			17,876	80,923	495	50.3%
XYZ	UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125			4,453	15,986	125	35.0%
	CHEROKEE COUNTY		TOTAL			125	125			4,453	15,986	125	35.0%
XYZ	ALLEN BENNETT MEMORIAL	1	GREENVILLE	GREER	NPA	58	58			3,424	15,719	58	74.3%
APP	GRENVILLE HOSPITAL SYSTEM - PATEWOOD	1	GREENVILLE	GREENVILLE	NPA		72						
XYZ	GREENVILLE MEMORIAL MEDICAL CENTER	1	GREENVILLE	GREENVILLE	NPA	710	710			35,035	192,736	632.3	83.5%
XYZ	HILLCREST	1	GREENVILLE	SIMPSONVILLE	NPA	43	43			2,211	10,795	52.9	55.7%
XYZ	NORTH GREENVILLE LTC ACUTE CARE HOSP	1	GREENVILLE	TRAVELERS REST	NPA	45	45			13	233	4.9	13.0%
	(W.J. BARGE)	2	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(80)	(3)	c	(1231)	(2955)		
XYZ	REGENCY HOSPITAL OF GREENVILLE	15	GREENVILLE	GREENVILLE	NPA	32	32						
XYZ	SAINT FRANCIS HOSPITAL	7	GREENVILLE	GREENVILLE	NPA	206	228			8,792	50,082	206	66.6%
XYZ	SAINT FRANCIS WOMAN'S & FAMILY HOSPITAL	7	GREENVILLE	GREENVILLE	NPA	62	83			4,518	13,721	62	60.6%
	GREENVILLE COUNTY		TOTAL			1,156	1,279			53,993	283,246	1,016.1	76.4%
XYZ	OCONEE MEMORIAL HOSPITAL		OCONEE	SENECA	NPA	160	160			7,776	32,867	160	56.3%
	OCONEE COUNTY					160	160			7,776	32,867	160	56.3%
XYZ	PALMETTO BAPTIST MED CTR - EASLEY	6	PICKENS	EASLEY	NPA	109	109			5,087	18,623	96	53.1%
XYZ	CANNON MEMORIAL		PICKENS	PICKENS	NPA	55	55			1,356	5,784	55	28.8%
	PICKENS COUNTY		TOTAL			164	164			6,443	24,407	151	44.3%
XYZ	B.J. WORKMAN MEMORIAL		SPARTANBURG	WOODRUFF	CO	43	43			991	2,642	43	16.8%
XYZ	MARY BLACK MEMORIAL		SPARTANBURG	SPARTANBURG	PROP	176	176			6,236	24,527	176	38.2%
XYZ	SPARTANBURG HOSP RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97			883	22,595	97	63.8%
XYZ	SPARTANBURG REGIONAL MEDICAL CTR.		SPARTANBURG	SPARTANBURG	CO	532	532			21,272	125,217	532	64.5%
	SPARTANBURG COUNTY		TOTAL			848	848			29,382	174,981	848	56.8%
	HOPE HOSPITAL	16	UNION	LOCKHART	CO	(0)	(0)	7	cd	-	-	16	0.0%
XYZ	WALLACE THOMSON		UNION	UNION	DIST	143	143	6	c	3,929	17,570	143	33.7%
	UNION COUNTY		TOTAL			143	143	13		3,929	17,570	159	30.3%
	TOTAL					3,091	3,214	13		123,852	639,979	2,954.1	59.4%
	MENTAL FACILITIES:												
XYZ	ANDERSON AREA MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38			699	4,525	38	32.6%
	ANDERSON COUNTY		TOTAL			38	38			699	4,525	38	32.6%
YZ	CAROLINA CENTER FOR BEHAVIORAL HEALTH	4	GREENVILLE	GREENVILLE	PROP	63	64			1,713	15,228	53	78.7%
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE	5	GREENVILLE	TRAVELERS REST	PROP	5	5			169	2,201		
	SYSTEM (LTC PSYCHIATRIC)												
YZ	SPRINGBROOK BEHAV. HEALTHCARE SYSTEM	5	GREENVILLE	TRAVELERS REST	PROP	15	15						
XYZ	GREENVILLE MEMORIAL MEDICAL CTR.	1	GREENVILLE	GREENVILLE	NPA	63	46			1,551	13,594	63	59.1%
	GREENVILLE COUNTY		TOTAL			136	130			3,463	31,023	116	73.3%
XYZ	MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15			321	3,968	15	72.5%
XYZ	SPARTANBURG REGIONAL MEDICAL CTR.		SPARTANBURG	SPARTANBURG	CO	56	56			786	7,276	56	35.5%

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RECORD 003199

REGION: I — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	ANDERSON COUNTY		TOTAL			761	761	19	1,344	268,313	763	96.3%
YZ	BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132		128	46,789	132	97.1%
YZ	CHEROKEE COUNTY LTC	19	CHEROKEE	GAFFNEY	CO	85	97		36	30,958	85	99.8%
	CHEROKEE COUNTY		TOTAL			217	229		164	77,747	217	98.2%
Z	ALLEN BENNETT NURSING HOME	1	GREENVILLE	GREER	NPA	10	10		239	3,365	10	92.2%
YZ	BRIARWOOD NURSING CENTER		GREENVILLE	SIMPSONVILLE	PROP	42	39		30	12,803	42	83.5%
NHM	BRIGHTON GARDENS		GREENVILLE	GREENVILLE	PROP	45	45		110	14,483	45	88.2%
Z	FOUNTAIN INN NURSING HOME		GREENVILLE	FOUNTAIN INN	PROP	44	44	26 cd	19	16,347	44	95.6%
YZ	LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	CO	132	132		304	44,262	132	91.9%
YZ	GREENVILLE NURSING CENTER		GREENVILLE	GREENVILLE	PROP	79	79	18 d	88	22,995	79	79.7%
NHM	GREENVILLE MEM CTR SUBACUTE UNIT	1	GREENVILLE	GREENVILLE	NPA	18	(3)		-	-	3	0.0%
YZ	NORTH GREENVILLE	1	GREENVILLE	TRAVELERS REST	NPA	(27)	(27)		210	4,035	14.9	74.2%
YZ	MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	25 d	76	35,176	99	97.3%
YZ	MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120		139	42,650	120	97.4%
Y	NHC CENTER GREENVILLE		GREENVILLE	GREER	PROP	176	176		319	60,701	176	94.5%
YZ	NHC CENTER OF MAULDIN		GREENVILLE	MAULDIN	PROP	120	120		185	42,198	120	96.3%
YZ	OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132		207	46,649	132	96.8%
Z	OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125		154	44,021	125	96.5%
Z	PIEDMONT NURSING AND REHABILITATION		GREENVILLE	GREER	PROP	132	132		110	46,651	132	97.2%
YZ	ROGER HUNTINGTON NURSING CTR	14	GREENVILLE	GREENVILLE	NPA	88	176	(12) c	68	31,014	88	96.6%
NHM	ROLLING GREEN VILLAGE HEALTH CARE FAC	11	GREENVILLE	GREENVILLE	NPA	10	10		17	3,160	10	87.1%
SW	(ROLLING GREEN VILLAGE HEALTH CARE FAC)		GREENVILLE	GREENVILLE	NPA	(34)	(34)				(34)	
YZ	ST FRANCIS TRANSITIONAL CARE UNIT	15	GREENVILLE	GREENVILLE	NPA	32	(32)		409	9,251	32	79.2%
YZ	SUMMIT PLACE		GREENVILLE	SIMPSONVILLE	PROP	132	132		137	46,610	132	96.7%
Z	STROUD NURSING HOME		GREENVILLE	MARIETTA	NPA	44	44	1 c	13	15,673	44	97.6%
YZ	WESTSIDE NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132		143	48,653	132	96.8%
	GREENVILLE COUNTY		TOTAL			1,712	1,747	70	2,868	587,917	1,711.9	94.1%
YZ	LILA DOYLE NURSING CARE	10	OCONEE	SENECA	CO	120	120		251	27,612	79	95.8%
YZ	MARINER HEALTH CARE OF SENECA		OCONEE	SENECA	PROP	132	132		258	44,531	132	92.4%
	OCONEE COUNTY		TOTAL			252	252		509	72,143	211	93.7%
Z	BLUE RIDGE NURSING CENTER		PICKENS	EASLEY	PROP	66	66	33 d	62	23,609	66	98.0%
Y	CLEMSON AREA RETIREMENT CENTER HEALTH		PICKENS	CLEMSON	PROP	30	30		36	8,019	30	73.2%
SW	(CLEMSON AREA RETIREMENT CENTER HEALTH)		PICKENS	CLEMSON	PROP	(22)	(22)				(22)	
NHM	COUNTRYSIDE CARE CENTER		PICKENS	EASLEY	PROP	44	44		44	9,932	44	61.8%
YZ	EASLEY NURSING CENTER		PICKENS	EASLEY	PROP	103	100	50 d	214	36,022	103	95.8%
Z	HARVEY'S NURSING HOME		PICKENS	SIX MILE	PROP	44	41	27 cd	23	15,721	44	97.9%
YZ	LAUREL HILL		PICKENS	PICKENS	PROP	80	80		47	26,706	80	98.3%
Z	ROSEMOND NURSING CTR		PICKENS	PICKENS	PROP	44	44	22 d	29	15,527	44	98.7%
Y	PALMETTO MED CTR-EASLEY TRANS CARE UNI'	6	PICKENS	EASLEY	NPA	(13)	(13)		-	-	0	
	PICKENS COUNTY		TOTAL			411	405	132	445	137,535	411	91.7%
Z	CAMP CARE		SPARTANBURG	INMAN	PROP	88	88		47	31,389	88	97.7%
YZ	(SPARTANBURG HOSP RESTORATIVE CARE SNI	3	SPARTANBURG	SPARTANBURG	CO	(11)	(11)					
Z	GOLDEN AGE-INMAN		SPARTANBURG	INMAN	PROP	44	44		31	16,007	44	93.4%
YZ	INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	35		22	14,522	40	99.5%
YZ	MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176		175	62,741	176	97.7%
YZ	MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	95	69	62 cd	168	32,519	95	93.8%
YZ	MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88		88	31,705	88	98.7%
YZ	MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132		42	47,624	132	98.8%
NHN	ROSECREST NURSING CENTER	9	SPARTANBURG	INMAN	NPA	75	75		216	15,874	63.2	68.8%
YZ	SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33		85	9,128	33	75.8%
SW	(SKYLYN HEALTH CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)				(11)	
YZ	VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88		72	31,483	88	98.0%
YZ	WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192		210	68,254	192	97.4%
Y	WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88		108	31,423	88	97.8%
YZ	WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88		35	31,842	88	89.1%

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RECORD 003200

FOOTNOTES

2004 PLAN

REGION I

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 transfer 13 beds from Hillcrest to GM resulting in 43 at Hillcrest & 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 0 acute beds at NG with the closure of the acute facility & the transfer of 28 nursing home beds to NG with 20 at GM & 28 at GM, SC-01-09 2/20/01. CON issued to add 55 new acute beds & convert 9 psych beds at GM for a total of 710 general & 63 psych beds, SC-01-57 10/10/01. NG licensed for 27 nursing beds and GM licensed nursing home beds reduced from 48 to 21 licensed and 20 survey beds 3/14/02. The nursing beds at NG reduced from 28 survey beds to 27 and the 1 bed added back to GM for 21 existing. CON issued for 45 bed LTC Acute Hosp at NG by converting the 27 nursing beds & moving 18 nursing beds from GM, leaving 3 nursing home beds at GM 4/15/03 SC-03-17. GM nursing home beds reduced from 21 to 3, 8/27/03. GM licensed general beds increased from 628 to 646, Hillcrest licensed beds decreased by 13 from 56 to 43 & NG licensed beds decreased from 5 to 0 to fulfill CONs SC-00-35 & SC-01-09 6/04/03. CON issued 8/25/03 for a 72 bed general acute hospital by transferring the 52 beds to be added from Allen Bennett with the reduction of 17 psych beds from Memorial and the transfer of the 3 nursing beds from GM, SC-03-46. This results in a new 72 bed licensed acute hospital, & GM with 710 general, 53 rehab, 46 psych beds and 0 licensed nursing beds. GM licensed general beds increased from 646 to 710 & licensed psych beds reduced from 72 to 63, 1/1/04. CON issued 4/21/04 to temporarily transfer 18 approved nursing home beds from Roger Huntington to GM, SC-04-21; licensed 10/26/04.
2. Facility use restricted to students.
3. Nursing home unit at Spartanburg Restorative de-licensed and closed 8/31/02.
4. CON issued to add 11 psych beds for a total of 64 psych and 13 substance abuse beds10/11/04 SC-04-46.
5. CON issued to reduce 24 long term psych beds from 44 to 20 and add 24 RFT beds from 44 to 68 RFT and 20 Long Term Psych beds, 6/12/01. Facility licensed for 68 RFT and 20 LTC Psych, 8/10/01. CON issued to convert 15 ltc psych beds to 15 acute psych beds & 5 ltc psych beds, 2/19/03, SC-03-12. Facility licensed for 5 ltc psych & 15 psych, 3/10/03.
6. CON issued to convert 13 nursing home beds to general for 109 general beds, 3/9/04 SC-04-13. Licensed for 109 general beds & Transitional Care Unit de-licensed 9/7/04.
7. CON issued to add 20 general beds to SF's 206 general beds for a total of 226, & 31 to SFW&F's 62 general beds for a total of 93, 8/25/03 SC-03-47.
8. E-02-15 issued 3/20/02 to permanently reduce the 27 nursing beds by 15 to 12 nursing beds. Licensed beds reduced to 12, 7/11/02. E-02-67 issued for permanent reduction of the 12 nursing home beds; de-licensed 12/24/02.
9. CON issued for 32 additional nursing home beds (non-Medicaid) for a total 75, 1/16/02 SC-02-80. Licensed beds increased 2/13/03.
10. CON issued for an additional 41 nursing home beds (25 Medicaid & 16 non-Medicaid) for a total of 120, 08/04/00, SC-00-40; licensed 4/15/03.

PMC.2013.SHP.0640

RECORD 003201

INVENTORY OF EMERGENCY FACILITIES 2004 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2003 ER VISITS
REGION I:	EMERGENCY FACILITIES			
II	ANDERSON AREA MEDICAL CENTER	ANDERSON	ANDERSON	64,197
III	UPSTATE CAROLINA MEDICAL CENTER	CHEROKEE	GAFFNEY	24,847
III	NORTH GREENVILLE HOSPITAL	GREENVILLE	TRAVELERS REST	19,373
I	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE	81,050
II	ST FRANCIS HOSPITAL	GREENVILLE	GREENVILLE	28,337
II	ST FRANCIS WOMENS & FAMILY HOSP	GREENVILLE	GREENVILLE	21,316
(*)	WJ BARGE	GREENVILLE	GREENVILLE	7,431
II	ALLEN BENNETT MEMORIAL HOSPITAL	GREENVILLE	GREER	24,659
II	HILLCREST HOSPITAL	GREENVILLE	SIMPSONVILLE	23,672
III	OCONEE MEMORIAL HOSPITAL	OCONEE	SENECA	34,363
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	30,454
III	CANNON MEMORIAL HOSPITAL	PICKENS	PICKENS	15,456
III	MARY BLACK MEMORIAL HOSPITAL	SPARTANBURG	SPARTANBURG	25,466
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG	81,337
III	BJ WORKMAN MEMORIAL HOSPITAL	SPARTANBURG	WOODRUFF	9,446
III	WALLACE THOMSON HOSPITAL	UNION	UNION	15,742
			TOTAL	507,146

(*) Met insufficient criteria to be classified.

REGION I:	TRAUMA CENTERS		
II	ANDERSON AREA MEDICAL CENTER	ANDERSON	ANDERSON
I	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE
III	ALLEN BENNETT MEMORIAL HOSPITAL	GREENVILLE	GREER
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG

PMC.2013.SHP.0641

RECORD 003202

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	18	25	-7
CHESTER	1	0	43	82	-39
EDGEFIELD	1	0	15	25	-10
FAIRFIELD	1	0	17	25	-8
GREENWOOD	1	0	259	334	-75
KERSHAW	1	0	108	121	-13
LANCASTER	1	0	171	168	3
LAURENS	1	0	77	76	1
LEXINGTON	1	0	384	346	38
NEWBERRY	1	0	54	90	-36
RICHLAND	5	0	1263	1281	-18
YORK	2	0	332	268	64
TOTALS:	17	0	2741	2841	-100
LTC:					
ABBEVILLE	2	0	155	116	39
CHESTER	1	0	175	100	75
EDGEFIELD	1	0	116	120	-4
FAIRFIELD	2	1	122	262	-140
GREENWOOD	4	0	362	357	5
KERSHAW	2	0	288	236	52
LANCASTER	3	0	294	288	6
LAURENS	4	0	393	402	-9
LEXINGTON	6	0	1043	824	219
MCCORMICK	1	0	100	120	-20
NEWBERRY	2	0	215	276	-61
RICHLAND	12	3	1289	1167	122
SALUDA	1	0	120	176	-56
YORK	8	0	757	699	58
TOTALS:	49	4	5429	5143	286

PMC.2013.SHP.0642

RECORD 003203

REGION: II — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	GREENWOOD COUNTY		TOTAL			36	36		636	5,938	36	45.2%
YZ	THREE RIVERS BEHAVIORAL CARE		LEXINGTON	WEST COLUMBIA	PROP	39	39		1,490	13,675	39	96.1%
	LEXINGTON COUNTY		TOTAL			39	39		1,490	13,675	39	96.1%
XYZ	PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	104	104		2,537	22,975	104	60.5%
XYZ	PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60		1,837	14,769	60	67.4%
X	MONCRIEF ARMY HOSPITAL	2	RICHLAND	COLUMBIA	FED		(20)		(377)	(3020)		
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(60)		(515)	(4245)		
	RICHLAND COUNTY		TOTAL			164	164		4,374	37,744	164	63.1%
XYZ	PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20		362	2,360	20	32.3%
	YORK COUNTY		TOTAL			20	20		362	2,360	20	32.3%
	TOTAL					259	259		6,862	59,717	259	63.2%
	RESIDENTIAL TRATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
	THREE RIVERS BEHAVIORAL CARE	3	LEXINGTON	WEST COLUMBIA	PROP	20	20		20	6,321	18	96.2%
	NEW HOPE MIDLANDS	4	LEXINGTON	WEST COLUMBIA	PROP	59	59		45	17,929	59	83.3%
	YORK PLACE		YORK	YORK	PROP	40	40		36	9,115	40	62.4%
	TOTAL					119	119		101	33,365	117	78.1%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	THREE RIVERS BEHAVIORAL CARE		LEXINGTON	WEST COLUMBIA	PROP	27	27		427	2,840	27	28.8%
	SPRINGS MEMORIAL HOSPITAL	9	LANCASTER	LANCASTER	NPA	12	12		437	1,977	45	12.0%
	FAIRFIELD MEMORIAL HOSPITAL	21	FAIRFIELD	WINNSBORO	NPA	(17)	(17)		-	-	17	0.0%
	PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10		388	3,498	10	95.8%
	SELF MEMORIAL HOSPITAL		GREENWOOD	GREENWOOD	NPA	24	24		-	-	24	0.0%
	TOTAL					73	73		1,252	8,315	123	18.5%
	REHABILITATION FACILITIES:											
YZ	HEALTHSOUTH REHAB. HOSP. COLUMBIA	11	RICHLAND	COLUMBIA	PROP	96	96		1,602	26,824	96	76.6%
	RICHLAND COUNTY		TOTAL			96	96		1,602	26,824	96	76.6%
	HEALTHSOUTH REHAB. HOSP. ROCK HILL	16	YORK	ROCK HILL	PROP	34	34		663	10,588	32	90.7%
	YORK COUNTY		TOTAL			34	34		663	10,588	32	90.7%
	TOTAL					130	130		2,265	37,412	128	80.1%
	INPATIENT HOSPICE FACILITIES:											
CON	HOSPICE HOUSE HOSPICECARE PIEDMONT	24	GREENWOOD	GREENWOOD	NPA	-	15					
CON	PORTSBRIDGE INPATIENT HOSPICE	26	RICHLAND	COLUMBIA	PROP		12					
APP	HOSPICE AND COMMUNITY CARE	23	YORK	ROCK HILL	NPA	-	16					

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RECORD 003204

REGION: II

INPATIENT INVENTORY OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
YZ	WHITE OAK MANOR - NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146		142	52,618	146	98.7%
	NEWBERRY COUNTY					276	276		418	97,737	276	97.0%
Y	RICE NURSING FACILITY	13	RICHLAND	COLUMBIA	NPA	32	32		76	10,914	32	93.4%
y	(BERNADIN HOSPICE HOUSE)	15	RICHLAND	COLUMBIA	NPA	(12)						
YZ	CAROLINA HEALTH & REHAB	29	RICHLAND	COLUMBIA	PROP	257	250	146 cd	317	87,191	257	92.9%
YZ	LIFE CARE CENTER OF COLUMBIA	7	RICHLAND	COLUMBIA	PROP	179	179		310	96,317	152.7	101.0%
YZ	LOWMAN HOME NURSING CENTER		RICHLAND	WHITEROCK	NPA	129	129		108	45,319	129	96.2%
SW	(LOWMAN HOME NURSING CENTER)		RICHLAND	WHITEROCK	NPA	(47)	(47)				(47)	
YZ	MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88		221	30,641	88	95.4%
YZ	HEARTLAND COLUMBIA REHAB & NURSING CTR		RICHLAND	COLUMBIA	PROP	132	132		328	41,356	132	85.8%
Y	NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	120	120		141	42,267	120	96.5%
Y	PROVIDENCE HOSPITAL NE - TRANS CARE UNIT		RICHLAND	COLUMBIA	PROP	18	18		398	5,298	18	80.5%
Y	PALMETTO BAPTIST MEDICAL CENTER		RICHLAND	COLUMBIA	NPA	22	22		682	6,324	22	78.8%
YZ	RIDGEVIEW MANOR	12	RICHLAND	HOPKINS	PROP	38	38		40	10,767	30	88.5%
YZ	WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120		73	42,825	120	97.8%
YZ	WILDEWOOD DOWNS NURSING CENTER	27	RICHLAND	COLUMBIA	PROP		32					
FED	W J B DORN VA		RICHLAND	COLUMBIA	FED		(160)		(248)	(33307)		
	RICHLAND COUNTY		TOTAL			1,135	1,160	146	2,674	378,259	1100.7	94.4%
YZ	SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176		151	62,088	176	96.7%
	SALUDA COUNTY		TOTAL			176	176		151	62,088	176	96.7%
NHM	CAROLINA VILLAGE HEALTH CARE CENTER		YORK	ROCK HILL	PROP	40	40		79	10,825	40	74.2%
NHM	EBENEZER SENIOR SERVICES	14	YORK	ROCK HILL	PROP	99	99		220	22,709	80.8	77.0%
YZ	MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106		103	37,395	106	96.7%
YZ	ROCK HILL HEALTHCARE		YORK	ROCK HILL	PROP	132	132		198	46,720	132	97.0%
YZ	HEALTHSOUTH REHABILITATION HOSP (SNF)	18	YORK	ROCK HILL	PROP	6	6		287	4,298	14	84.1%
NHM	WESTMINSTER HEALTH & REHABILITATION		YORK	ROCK HILL	PROP	66	66		195	20,211	66	83.8%
YZ	WHITE OAK MANOR - ROCK HILL		YORK	ROCK HILL	PROP	141	141		106	51,007	141	99.1%
YZ	WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109		61	39,327	109	98.8%
	YORK COUNTY		TOTAL			699	699		1,248	232,494	688.8	92.5%
	TOTAL					5,123	5,128	182	8,551	1,724,354	4883.9	96.7%

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convert 2 nursing beds to 2 rehab beds for a total of 34 rehab beds & 6 nursing beds, 12/3/03, SC-03-74. Licensed for 34 rehab & 6 nursing beds 4/1/04.

19. CON issued to add 20 general beds for a total of 268 general & 20 psych beds, 6/12/02 SC-02-37. License increased by 8 beds from 248 to 256, 11/27/02. Licensed beds increased by 12 from 256 to 268 12/19/02.
20. Facility discontinued provision of OB services 11/30/02. Name changed 10/7/04, formerly Chester County Hospital and Nursing Center, Inc.
21. CON issued for conversion & closure of 17 A&D beds to general for a total of 50 general beds, 11/12/03 SC- 03-70. Facility licensed for 50 general beds, 2/10/04. Exemption issued 5/14/04 E-04-27 to de-license 25 beds for a total of 25 beds in order to qualify as a Critical Access Hospital; licensed for 25 beds 8/23/04.
22. CON issued to add 54 additional general beds for a total of 346, 12/29/03 SC-03-77; licensed beds increased from 292 to 319 on 10/11/04.
23. Approved for construction of a 16 bed hospice, under appeal.
24. CON issued for construction of a 15 bed hospice 3/9/04 SC-04-15.
25. Permanent reduction of 12 licensed beds for a total of 90, 7/7/04 E-04-39.
26. Exemption issued 8/20/04 to de-license 15 beds from 40 for a total of 25 beds in order to qualify as a Critical Access Hospital; licensed for 25 beds 8/31/04.
27. CON issued 10/18/04 for a 32-bed nursing home that does not participate in the Medicaid program, SC-04-50.
28. CON issued 1/19/05 for a 12 bed inpatient hospice.
29. Name changed 12/17/04, formerly Central Carolina Health and Rehabilitation Center.

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RECORD 003206

REGION NARRATIVE

REGION: III FISCAL YEAR: 2004

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." Shaw Air Force Base near Sumter has a military hospital to provide health care services for the active duty 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: 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 three facilities in this region. There is a need for additional psychiatric beds in the this 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: There is a need for additional rehabilitation beds in this region.

PMC.2013.SHP.0646

REGION: III — INPATIENT INVENTORY — OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	CHESTERFIELD GENERAL		CHESTERFIELD	CHERAW	PROP	59	59		2,263	7,408	59	34.4%
	CHESTERFIELD COUNTY		TOTAL			59	59		2,263	7,408	59	34.4%
XY	CLARENDON MEMORIAL		CLARENDON	MANNING	CO	56	56		2,643	12,569	56	61.5%
	CLARENDON COUNTY		TOTAL			56	56		2,643	12,569	56	61.5%
XYZ	CAROLINA PINES REGIONAL MEDICAL CTR	16	DARLINGTON	HARTSVILLE	NPA	116	166		7,913	31,337	116	74.0%
XYZ	WILSON MEDICAL CENTER		DARLINGTON	DARLINGTON	NPA	49	49		748	3,085	49	17.2%
	DARLINGTON COUNTY		TOTAL			165	215		8,661	34,422	165	57.2%
XYZ	SAINT EUGENE MEDICAL CENTER	7	DILLON	DILLON	NPA	79	79		4,063	13,809	79	47.9%
	DILLON COUNTY		TOTAL			79	79		4,063	13,809	79	47.9%
XYZ	CAROLINAS HOSPITAL SYSTEM	1	FLORENCE	FLORENCE	PROP	262	282		13,674	72,260	282	75.6%
XYZ	CAROLINAS HOSPITAL SYSTEM LAKE CITY		FLORENCE	LOWER FLORENCE	DIST	48	48		923	3,801	48	21.7%
XYZ	MCLEOD REGIONAL MEDICAL CENTER	2	FLORENCE	FLORENCE	NPA	336	453		23,453	111,121	336	90.6%
YZ	REGENCY HOSPITAL OF SC	1	FLORENCE	FLORENCE	PROP	28	28		342	9,251	28	90.5%
YZ	WOMEN'S CENTER CAROLINA HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20		1,141	2,984	20	40.9%
	FLORENCE COUNTY		TOTAL			694	811		39,533	199,417	694	78.7%
XYZ	GEORGETOWN MEMORIAL HOSPITAL	8	GEORGETOWN	GEORGETOWN	NPA	131	131		7,452	35,458	142	68.4%
XYZ	WACCAMAW COMMUNITY HOSPITAL	8	GEORGETOWN	MURRELLS INLET	NPA	82	82		2,992	11,125	38.6	78.6%
	GEORGETOWN COUNTY		TOTAL			213	213		10,444	46,583	180.6	70.6%
XYZ	CONWAY HOSPITAL		HORRY	CONWAY	NPA	160	160		9,047	34,022	160	58.3%
XYZ	GRAND STRAND REGIONAL MEDICAL CENTER	5	HORRY	MYRTLE BEACH	PROP	219	219		11,032	49,757	219	62.2%
XYZ	LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105		4,405	19,242	105	50.2%
	HORRY COUNTY		TOTAL			484	484		24,484	103,021	484	58.3%
XYZ	MARION COUNTY MEDICAL CENTER		MARION	MARION	DIST	124	124		7,695	34,753	124	76.8%
	MARION COUNTY		TOTAL			124	124		7,695	34,753	124	76.8%
	MARLBORO PARK		MARLBORO	BENNETTSVILLE	PROP	94	94		1,825	6,020	94	17.5%
	MARLBORO COUNTY		TOTAL			94	94		1,825	6,020	94	17.5%
X	SHAW AFB	3	SUMTER	SUMTER	FED		(11)		(429)	(951)		
XYZ	TUOMEY	6	SUMTER	SUMTER	NPA	248	248		7,267	61,627	248	68.1%
	SUMTER COUNTY		TOTAL			248	248		7,267	61,627	248	68.1%
XYZ	WILLIAMSBURG REGIONAL HOSPITAL	17	WILLIAMSBURG	KINGSTREE	CO	25	25		1,351	5,236	78	18.4%
	WILLIAMSBURG COUNTY		TOTAL			25	25		1,351	5,236	78	18.4%
	TOTAL					2,241	2,408		110,229	524,885	2261.6	63.6%
	MENTAL FACILITIES:											
CON	WILSON MEDICAL CENTER	2	DARLINGTON	DARLINGTON			23					

PMC.2013.SHP.0647

REGION: III

INPATIENT INVENTORY OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	LONG TERM FACILITIES:											
YZ	CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	100	99		36	35,660	100	97.5%
Z	(CHESTERFIELD GENERAL HOSPITAL SNF)	11	CHESTERFIELD	CHERAW	PROP	(7)	(7)					
YZ	CHESTERFIELD CONVALESCENT CTR		CHESTERFIELD	CHERAW	PROP	104	104		42	37,308	104	98.3%
	CHESTERFIELD COUNTY		TOTAL			204	203		78	72,988	204	98.0%
YX	LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88		44	31,162	88	97.0%
YX	WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	26 cd	39	22,503	64	96.3%
	CLARENDON COUNTY		TOTAL			152	131	26	83	53,665	152	96.7%
YZ	BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	36	36		39	6,543	36	49.8%
SW	(BETHEA BAPTIST HOME)		DARLINGTON	DARLINGTON	NPA	(52)	(52)				(52)	
YZ	MEDFORD PLACE		DARLINGTON	DARLINGTON	PROP	88	88		92	31,541	88	98.2%
YZ	MORRELL MEMORIAL CONVALESCENT CTR		DARLINGTON	HARTSVILLE	PROP	154	154		99	55,290	154	98.4%
YZ	OAKHAVEN CONVALESCENT CTR		DARLINGTON	DARLINGTON	PROP	88	88		81	31,378	88	97.7%
	DARLINGTON COUNTY		TOTAL			366	366		291	124,753	366	93.4%
YZ	THE PINES	18	DILLON	DILLON	PROP	84	84		49	29,622	84	97.3%
YZ	SUNNY ACRES		DILLON	FORK	PROP	111	108	58 cd	43	39,720	111	98.0%
YZ	(ST EUGENE MEDICAL CENTER - SNF)	7	DILLON	DILLON	NPA	(13)	(13)					
	DILLON COUNTY		TOTAL			195	190	58	92	69,342	195	97.7%
YZ	CAROLINAS HOSP SYSTEM TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	26	26		383	4,699	44	29.3%
YZ	COMMANDER HEALTH CARE		FLORENCE	FLORENCE	PROP	163	152		83	58,769	163	98.8%
YZ	FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	93		128	36,040	104	94.9%
Z	COOKE ASSOCCIATES OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88	44 d	34	28,940	88	90.1%
YZ	HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132		50	47,871	132	99.4%
YZ	HONORAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88		85	31,389	88	97.7%
YZ	LAKE CITY/SCRANTON HEALTH CARE CENTER		FLORENCE	SCRANTON	PROP	88	88		40	30,392	88	94.6%
YZ	SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	(42) cd	41	31,705	88	98.7%
	FLORENCE COUNTY		TOTAL			777	755	44	844	259,795	795	93.0%
	(GEORGETOWN MEMORIAL HOSPITAL SNF)	8	(GEORGETOWN)	(GEORGETOWN)	NPA		(10)					
CON	LAKES AT LITCHFIELD SKILLED NURSING CTR	9	GEORGETOWN	PAWLEYS ISLAND	PROP	17	17		43	1,678	17	27.0%
	(LAKES AT LITCHFIELD SKILLED NURSING CTR)	9	(GEORGETOWN)	(PAWLEYS ISLAND	(PROP	(7)	(7)					
YZ	PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148		524	52,030	148	96.3%
YZ	WINYAH EXTENDED CARE CENTER		GEORGETOWN	GEORGETOWN	PROP	84	84		88	25,381	84	82.8%
	GEORGETOWN COUNTY		TOTAL			249	249		655	79,089	232	93.4%
Y	COVENANT TOWERS		HORRY	MYRTLE BEACH	PROP	30	30		43	7,551	30	68.0%
YZ	CONWAY NURSING CENTER		HORRY	CONWAY	PROP	190	190		148	63,419	190	91.4%
Y	GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88		145	31,226	88	97.2%
NH	(GRAND STRAND REGIONAL EXTEND CARE UNI	5	HORRY	MYRTLE BEACH	PROP	(18)	(18)		613	5,116	18	77.9%
YZ	KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88		398	29,688	88	92.4%
YZ	LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88		149	29,940	88	93.2%
YZ	MYRTLE BEACH MANOR		HORRY	MYRTLE BEACH	PROP	104	104		342	28,532	104	77.8%
Y	NHC HEALTHCARE GARDEN CITY		HORRY	MYRTLE BEACH	PROP	88	88		294	30,317	88	94.4%
	HORRY COUNTY		TOTAL			676	676		2,130	226,790	694	89.5%
YZ	MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120		105	41,621	120	95.0%
	LEE COUNTY		TOTAL			120	120		105	41,621	120	95.0%
YZ	MARION NURSING CENTER		MARION	MARION	PROP	88	88	1 c	52	31,269	88	97.4%
YZ	MULLINS NURSING CENTER		MARION	MARION	NPA	92	92		29	33,366	92	99.4%

PMC.2013.SHP.0648

RECORD 003209

FOOTNOTES 2004 PLAN

REGION III

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 transfer 28 general beds to establish a 28 bed LT acute care hosp, SC-00-03 1/20/2000. NextCare licensed for 28 LT acute care beds and Carolinas Hospital licensed for 262, 7/17/01. NextCare changed name to Regency Hospital. CON issued for construction of a 4 floor addition with 98 observation beds with no change of licensed capacity, 2/20/04 SC-04-10.
2. CON issued for 105 new general beds to increase from 336 to 441 general beds 9/22/03 SC-03-53. CON issued to convert 12 psych beds to general for 453 general & transfer 23 psych beds to Wilson Med Center 1/20/04 SC-04-04.
3. Bed use restricted.
4. Exemption issued for Charter Conway to purchase the facility, 9/21/98. 18 RTF beds closed in Horry County & moved to Florence, 3/14/00. Approved for 41 additional beds for a total of 59 beds, 4/19/01. Licensed for 59 beds 4/29/02.
5. CON issued for 47 additional beds, with 18 coming from the closing of the 18 bed nursing home, for a total of 219 general beds 10/30/2000 SC-00-52. General beds increased by 18 from 172 to 190 with the de-licensing of the 18 bed nursing home 1/16/01. Licensed general beds increased from 190 to 210, 4/4/01. Licensed general beds increased from 210 to 218 10/30/01 and increased from 218 to 219 4/30/02.
6. CON issued to convert 19 psych beds to general for 248 general & 18 nursing home beds, 6/12/02 SC-02-35. Facility licensed for 248 general beds and psych beds de-licensed 9/10/02.
7. Facility closed the 13 nursing home beds 2/25/02.
8. CON issued to transfer 40 acute beds from Georgetown Memorial to construct a new 40 hosp and add a 10 bed nursing home, resulting in 102 acute & 10 nursing home beds at Georgetown Mem, SC-00-07 2/7/00. CON issued to add 19 bed rehab unit at Waccamaw, 5/26/00 SC-00-27. CON issued for 43 general beds & delete the 10 bed nursing home for a total of 145 general beds, SC-02-07, 1/9/02. CON issued for 10 additional rehab beds for a total of 29 rehab beds, 2/11/02 SC-02-15. Waccamaw Comm Hosp licensed for 40 general beds & 29 rehab beds, 10/21/02. Transfer 14 general beds from Georgetown to Waccamaw for 131 general at Georgetown & 54 general at Waccamaw, 11/10/03 SC-03-65. Waccamaw CON to add 28 acute beds for a total of 82 general & 29 rehab beds, 4/12/04 SC-04-20. CON issued to establish a 10 bed rehab unit at Georgetown by adding 5 new beds and transferring 5 rehab beds from Waccamaw, for a total licensed capacity of 82 acute beds and 24 rehab beds at Waccamaw and 131 acute beds and 10 rehab beds at Georgetown, 8/19/04 SC-04-44. Licensed general beds decreased from 142 to 131 at Georgetown and increased from 40 to 54 at Waccamaw, 8/16/04. Licensed beds at Waccamaw increased from 54 to 82 beds, 11/1/04.
9. CON issued to construct a 24 bed nursing home with 17 community beds and 7 institutional beds SC-01-72 11/13/01. Facility licensed 12/03/02.
10. Facility closed 04/8/02.

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RECORD 003210

INVENTORY OF EMERGENCY FACILITIES 2004 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2003 ER VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GENERAL HOSPITAL	CHESTERFIELD	CHERAW	15,416
III	CLARENDON MEMORIAL HOSPITAL	CLARENDON	MANNING	21,342
III	WILSON MEDICAL CENTER	DARLINGTON	DARLINGTON	CLOSED
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE	27,896
III	ST EUGENE REGIONAL MED CTR	DILLON	DILLON	22,861
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE	34,971
II	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE	58,983
III	CAROLINAS HOSPITAL SYSTEM LAKE C	FLORENCE	LAKE CITY	18,536
II	GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	GEORGETOWN	27,758
II	WACCAMAW COMMUNITY HOSPITAL	GEORGETOWN	MURRELLS INLET	11,797
II	CONWAY HOSPITAL	HORRY	CONWAY	30,821
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS	31,245
II	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH	56,176
III	MARION COUNTY MEDICAL CENTER	MARION	MARION	23,545
III	MARLBORO PARK HOSPITAL	MARLBORO	BENNETTSVILLE	14,137
II	TUOMEY	SUMTER	SUMTER	46,836
III	WILLIAMSBURG REGIONAL	WILLIAMSBURG	KINGSTREE	13,093
			TOTAL	455,413

REGION III:	TRAUMA CENTERS		
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE
II	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE
III	CONWAY HOSPITAL	HORRY	CONWAY
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS
III	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH
III	MARION COUNTY MEDICAL CENTER	MARION	MARION

PMC.2013.SHP.0650

RECORD 003211

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	217	183	34
ALLENDALE	1	0	9	25	-16
BAMBERG	1	0	25	59	-34
BARNWELL	1	0	25	53	-28
BEAUFORT	2	0	341	288	53
BERKLY/DORCH/ CHARLESTON	7	1	1689	1669	20
COLLETON	1	0	128	131	-3
HAMPTON	1	0	17	68	-51
JASPER	1	0	0	31	-31
ORANGEBG/CALHN	1	0	208	247	-39
TOTALS:	17	1	2659	2754	-95
LTC:					
AIKEN	6	1	834	718	116
ALLENDALE	1	0	63	44	19
BAMBERG	1	0	84	88	-4
BARNWELL	3	1	128	169	-41
BEAUFORT	6	0	1050	390	660
BERKELEY	3	0	658	325	333
CALHOUN	1	0	88	120	-32
CHARLESTON	12	0	1610	1281	329
COLLETON	1	0	207	132	75
DORCHESTER	4	0	490	278	212
HAMPTON	1	0	108	104	4
JASPER	1	0	100	88	12
ORANGEBURG	4	1	519	393	126
TOTALS:	44	3	5939	4130	1809

PMC.2013.SHP.0651

RECORD 003212

REGION: IV

INPATIENT INVENTORY OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	AIKEN COUNTY		TOTAL			29	29		1,144	7,192	29	67.9%
XYZ	BEAUFORT MEMORIAL HOSPITAL	15	BEAUFORT	BEAUFORT	CO	20	14		608	3,026	20	41.5%
	BEAUFORT COUNTY		TOTAL			20	14		608	3,026	20	41.5%
XYZ	CHARLESTON MEMORIAL HOSPITAL	13	CHARLESTON	CHARLESTON	CO	15	(15)				15	0.0%
XYZ	MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82		2,576	20,923	82	69.9%
XY	PALMETTO LOWCOUNTY BEHAVIORAL HEALTH	7	CHARLESTON	CHARLESTON	PROP	60	70		1,912	14,679	60	67.0%
XYZ	TRIDENT MEDICAL CENTER	5	CHARLESTON	CHARLESTON	PROP	(20)	(20)					
X	RALPH H JOHNSON VETERANS MEDICAL CTR		CHARLESTON	CHARLESTON	FED		(35)		(599)	(4244)		
	CHARLESTON COUNTY		TOTAL			157	152		4,488	35,602	157	62.1%
	REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15		360	2,284	15	41.7%
	ORANGEBURG COUNTY		TOTAL			15	15		360	2,284	15	41.7%
	TOTAL					221	210		5,992	45,078	221	55.9%
	RESIDENTIAL TRATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
	PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32		2	583	32	5.0%
	NEW HOPE SUMMERVILLE	6	SUMMERVILLE	DORCHESTER	PROP	60	60		23	17,491	52	92.2%
	TOTAL					92	92		25	18,074	84	58.9%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18		218	1,128	18	17.2%
	(ROPER HOSPITAL NORTH)	19	CHARLESTON	N CHARLESTON	NPA	(44)	(44)					
	PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10		304	1,787	10	49.0%
	MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23		999	5,417	23	64.5%
	TOTAL					51	51		1,521	8,332	51	44.8%
	REHABILITATION FACILITIES:											
XYZ	BEAUFORT MEMORIAL HOSPITAL	15	BEAUFORT	BEAUFORT	CO	14	(14)		330	4,417	14	86.4%
	BEAUFORT COUNTY		TOTAL			14	-		330	4,417	14	86.4%
XYZ	MEDICAL UNIVERSITY HOSPITAL	9	CHARLESTON	CHARLESTON	ST	25	(25)					
XYZ	ROPER HOSPITAL		CHARLESTON	CHARLESTON	NPA	39	39		1,099	11,150	39	78.3%
XYZ	HEALTHSOUTH CHARLESTON	10	CHARLESTON	CHARLESTON	PROP	46	46		858	14,494	42	94.5%
	CHARLESTON COUNTY		TOTAL			110	85		1,957	25,644	81	86.7%
APP	COASTAL CAROLINA MEDICAL CENTER	14	JASPER	RIDGELAND	PROP		10					
	JASPER COUNTY		TOTAL				10					
CON	REGIONAL MED CTR ORANGEBURG-CALHOUN	26	ORANGEBURG	ORANGEBURG	CO	24	24		442	7,360	24	84.0%
	ORANGEBURG COUNTY		TOTAL			24	24		442	7,360	24	84.0%

PMC.2013.SHP.0652

REGION: IV

INPATIENT INVENTORY

OCT.1,2002-SEPT.30,2003

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
YZ	HERMINA TRAEYE NURSING CENTER		CHARLESTON	CHARLESTON	NPA	132	132		70	44,132	132	91.6%
YZ	DRIFTWOOD REHAB. & NURSING CENTER		CHARLESTON	CHARLESTON	PROP	160	160		369	54,512	160	93.3%
NHM	LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148		519	52,386	148	97.0%
YZ	HEARTHLAND WEST ASHLEY REHAB & NURS CT	28	CHARLESTON	CHARLESTON	NPA	82	99		241	28,150	82	94.1%
YZ	SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176		245	60,104	176	93.6%
Y	TRIDENT SKILLED NURSING CENTER	8	CHARLESTON	CHARLESTON	PROP	25	25		473	5,181	25	56.8%
CON	TRINITY MISSION HEALTH & REHAB CHARLESTC	22	CHARLESTON	CHARLESTON	PROP	132	132					
YZ	WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176		118	60,588	176	94.3%
	CHARLESTON COUNTY		TOTAL			1,264	1,281		2,436	385,320	1150	91.8%
YZ	(COLLETON REGIONAL HOSP NURSING HOME)	12	COLLETON	WALTERBORO	PROP	(15)	(15)		119	2,255	15	41.2%
YZ	OAKWOOD HEALTH CARE CTR		COLLETON	WALTERBORO	PROP	132	132		197	44,614	132	92.6%
	COLLETON COUNTY		TOTAL			132	132		316	46,869	147	87.4%
YZ	HALLMARK HEALTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		186	32,120	88	100.0%
YZ	OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88		101	30,343	88	94.5%
	ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	86	88		60	30,524	88	95.0%
YZ	SUMMERVILLE MED - SKILLED NURSING CARE C	8	DORCHESTER	SUMMERVILLE	PROP	14	14		307	3,642	20	49.9%
	DORCHESTER COUNTY		TOTAL			276	278		654	96,629	284	93.2%
Z	HARPER NURSING CENTER		HAMPTON	ESTILL	CO	104	104		133	29,073	104	76.6%
	HAMPTON COUNTY		TOTAL			104	104		133	29,073	104	76.6%
YZ	RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88		45	29,698	88	92.5%
	JASPER COUNTY		TOTAL			88	88		45	29,698	88	92.6%
YZ	LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113		146	33,335	113	80.8%
YZ	JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60		96	18,603	60	84.9%
YZ	ORANGEBURG NURSING HOME		ORANGEBURG	ORANGEBURG	PROP	88	88		84	30,559	88	95.1%
YZ	THE METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132		232	38,954	132	76.7%
	ORANGEBURG COUNTY		TOTAL			393	393		558	119,451	393	83.3%
	TOTAL					4,113	4,130	85	7,124	1,318,914	4032.8	89.7%

PMC.2013.SHP.0653

RECORD 003214

17. CON issued to replace the existing 40 bed facility, 7/13/2001 SC-01-30.
18. Facility closed 132 nursing home 2/8/02.
19. Facility closed 44 A&D beds, 4/5/02.
20. Permanent reduction of 11 community nursing home beds, resulting in 14 institutional and 19 community beds, E-02-56 9/4/02. Licensed for 33 beds, 14 institutional & 19 community 4/21/03.
21. CON issued for 9 non-Medicaid beds for a total of 105, SC-02-73 12/20/02. Licensed for 105 beds 1/8/04.
22. CON issued for 132 non-Medicaid beds, SC-03-25 5/13/03. Facility licensed for 44 beds 1/29/04. Licensed for 132 beds 4/21/04.
23. CON issued for 5 additional general acute beds for a total of 183, SC-03-37 6/13/03.
24. CON issued for 20 bed inpatient Hospice SC-03-51 9/12/03.
25. CON issued 5/12/04 to convert 17 CRCF beds to non-Medicaid nursing beds for a total of 99 nursing home beds SC-04-27.
26. Licensed general beds decreased from 271 to 247 when licensed for 24 rehabilitation beds.
27. Licensed beds decreased from 132 to 126, 12/30/04.

PMC.2013.SHP.0654

RECORD 003215

Printed – JANUARY, 2005

Total Printing Cost $ 846.00
Total Number of Documents Printed – 500
Cost Per Unit $ 1.692

Criterion	DHEC	Dan Sullivan	David Levitt	Dawn Carter	Notes:
Rank 2					
2a-Community Need Documentation	Equally met	Agrees	Agrees	Equally met	
2b-Population projections	Equally met	Agrees	Agrees	Equally met	
2c-Service to meet need	Equally met	Agrees	Disagrees; PMC best met	PMC not met	100 beds; occupancy; volume/share capture
2d-Reduction, elimination or relocation of services	Concerned re PMC	Disagrees; equally met	Disagrees; equally met	PMC not met	Present population
2e-Current or projected utilization justified	CHS best met	Disagrees; equally met	Disagrees; equally met	PMC not met	100 bed occupancy
3a-Duplication and modernization	PMC did not justify	Disagrees; PMC met	Disagrees; PMC met	PMC not met	Duplication
3b-Located to serve medically underserved	Equally met	Disagrees; CHS least met	Disagrees; CHS least met	PMC not met	Unnecessary duplication
3c-Location allows for timely delivery of support services	Equally met	Agrees	Agrees	Equally met	
3d-No restriction on admissions	Equally met	Agrees	Disagrees; PMC best met	Equally met	
3e-Documentation of access means	Equally met	Agrees	Agrees	Equally met	
3f-Access to medically underserved	CHS/Presby equally met	Disagrees; equally met	Disagrees; equally met	CHS best met	
3g-Provisions for access regardless of ability to pay	CHS/Presby equally met	Disagrees; equally met; should have added 3h	Disagrees; equally met; should have added 3h	CHS best met	
22-Distribution	CHS best met	Disagrees	Disagrees	PMC not met	Geographic accessibility
Rank 3					
6a-Charges	Equally met	Agrees	Agrees	Equally met	
6b-Projected Utilization/Expenses	CHS best met	Disagrees; equally met	Disagrees; equally met	PMC not met	Utilization
7-Consistent with similar facilities	Equally met	Agrees	Agrees	Equally met	
9-Net Income	CHS best met	Disagrees; equally met	Disagrees; equally met	PMC not met	Utilization
15-Financial feasibility	CHS best met	Disagrees; equally met	Disagrees; equally met	PMC not met	Utilization
16a-Cost containment	CHS best met	Disagrees; equally met	Disagrees; equally met	Equally met	
16b-Lease alternatives	NA	NA	NA	NA	
16c-Impact on costs	Equally met	Agrees	Disagrees; PMC best met	Equally met	
17-Efficiency	PMC least met	Disagrees; PMC best met	Disagrees; PMC best met	CHS best met	
Rank 4					
13a-Record of the applicant	Equally met	Agrees	Agrees	Equally met	
13b-Ability to obtain financing	CHS best met	Disagrees; equally met	Disagrees; equally met	Equally met	
13d-Record of compliance	Equally met	Agrees	Agrees	Equally met	
4a-Acceptability	Equally met	Agrees	Agrees	Equally met	
4b-Opposition	Noted letters			CHS best met	Share capture
4c-Transfer agreements				Equally met	
23a-Adverse impact on existing facilities	CHS best met	Disagrees; PMC best met	Disagrees; PMC best met	CHS best met	Not adverse; not impacted; impact analysis flawed
23b-Adverse impact on staffing	Equally met	Disagrees; PMC best met	Disagrees; PMC best met	Equally met	

CHS
TRIAL EXHIBIT
32

S-CHS-9844

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
Attorneys and Counselors at Law
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Tel: 803.799.2000 Fax: 803.255.5164
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Stuart M. Andrews, Jr.
Tel: 803.255.9461
Fax: 803.255.5506
stuart.andrews@nelsonmullins.com

November 15, 2011

Via Hand Delivery
The Honorable Jana E. Shealy
Clerk, South Carolina Administrative Law Court
1205 Pendleton Street
Columbia, SC 29201

FILED
NOV 15 2011
SC ADMIN. LAW COURT

RE: Request for Contested Case Hearing
Our File No. 05946/01513

Dear Ms. Shealy:

I am writing on behalf of Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center, d/b/a Fort Mill Medical Center ("Piedmont"). Pursuant to Rule 11 of the South Carolina Rules of Procedure for the Administrative Law Court, Piedmont requests a contested case hearing to challenge two decisions by the South Carolina Department of Health and Environmental Control ("DHEC"):

1) DHEC's September 9, 2011 decision to deny Piedmont's CON application to construct a 100-bed hospital in Fort Mill (enclosed as Exh. 1); and

2) DHEC's September 9, 2011 decision to approve the CON application of Carolinas Healthcare System ("Carolinas") to construct a 64-bed hospital in Fort Mill (enclosed as Exh. 2).

In a letter dated October 17, 2011, the South Carolina Department of Health and Environmental Control notified Piedmont of its decision not to conduct a Final Review Conference on these decisions (enclosed as Exh. 3).

Piedmont respectfully requests the Administrative Law Court to reverse both decisions by approving Piedmont's application and denying Carolinas'.

I have enclosed two checks, each in the amount of $500.00, for the applicable filing fees in this matter.

Very truly yours,

Stuart M. Andrews, Jr.

SMA:dmc
Enclosures

cc: Lisa L. Longshore
Ashley C. Biggers, Esq.
Doug M. Muller, Esq.
M. Elizabeth Crum, Esq.

CERTIFICATE OF SERVICE

I, the undersigned administrative assistant of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center d/b/a Fort Mill Medical Center do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by delivering to the following address(es):

Pleadings: **REQUEST FOR CONTESTED CASE HEARING**

Counsel Served:

Via E-Mail and U.S. Mail
M. Elizabeth Crum, Esq.
Kelly M. Jolley, Esq.
Pamela A. Baker, Esq.
McNair Law Firm, P.A.
1301 Gervais Street, 17th Floor
Post Office Box 11390
Columbia, SC 29211

Via E-Mail and U.S. Mail
Douglas M. Muller, Esq.
Trudy H. Robertson, Esq.
Robert E. Sumner IV, Esq.
Moore & Van Allen PLLC
40 Calhoun Street, Ste. 300
Charleston, SC 29401

Via E-Mail and U.S. Mail
Ashley C. Biggers, Esq.
Bureau of Health Facilities & Services Development
South Carolina Department of Health and Environment Control
2600 Bull Street
Columbia, SC 29201

FILED
NOV 15 2011
SC ADMIN. LAW COURT

Dianne M. Cahill
Dianne M. Cahill
Administrative Assistant

November 15, 2011

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

Certified Mail 91 7199 9991 7030 0505 8631

September 9, 2011

Mr. Charles Miller, President and CEO
Piedmont Medical Center
222 South Herlong Avenue
Rock Hill, SC 29732

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

Dear Mr. Miller:

It is the decision of this Department that the Certificate of Need application submitted by Amisub of South Carolina, Inc. d/b/a Fort Mill Medical Center for the construction of a one hundred (100) bed general acute care hospital in York County, South Carolina, be denied. The Department has decided to grant the competing Certificate of Need application submitted by Carolinas Medical Center – Fort Mill for the construction of a sixy-four (64) bed general acute care hospital in York County on the basis that it most fully complies with the requirements, goals, and purposes of Certificate of Need Program, the South Carolina Health Plan, Project Review Criteria, and Regulation 61-15, "Certification of Need for Health Facilities and Services."

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

- "determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department'</u> as required by S.C. Code Ann. § 44-7-210(C)" (emphasis in original);
- "be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1"; and
- "be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof."

Exh. 1

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

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

2. The Department is concerned with the declining utilization at Piedmont Medical Center, the heavy dependence of recapturing significant lost market share which would require a significant reversal of market trend, the impact of redirecting existing patients away from Piedmont Medical Center, the substantial cost of the project, and the ability to finance the project.

3. The Carolinas Medical Center – Fort Mill proposed project adequately demonstrated that its current significant level of market share and utilization will be sufficient to justify the implementation of the project, appears to be financially feasible and proposes to shift current market share to a facility in South Carolina, resulting in less adverse impact to existing facilities.

A copy of the Notice of Appeals Procedure is enclosed for your convenience. If you have any questions, please feel free to contact us at (803) 545-4200.

Sincerely,

Beverly Brandt

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

Enclosures: Project Review Criteria Analysis
Notice of Appeals Procedure

cc: Ashley Biggers, Esquire, Chief Counsel for DHEC Health Regulation
Ariail B. Kirk, Esquire, McNair Law Firm, P.A.
Ms. Barbara L. Freedy, Director, Certificate of Need, Novant
Doug Muller, Esquire, Moore & Van Allen
Del Murphy, Vice President, Carolinas HealthCare System
Stuart M. Andrews, Jr., Esquire, Nelson Mullins
David Levitt, Levitt Healthcare Affiliates

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment

CERTIFIED MAIL 91 7199 9991 7030 0505 8648

September 9, 2011

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

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

Dear Mr. Murphy:

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

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

- "determine 'which of the applicants, if any, <u>most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department'</u> as required by S.C. Code Ann. § 44-7-210(C)" (emphasis in original);
- "be made based upon the fact that each of the parties is in equal compliance with 24A S.C. Code Reg. 61-15 § 802.1"; and
- "be accompanied by written findings as to each applicant's compliance with the relevant Project Review Criteria and which party best meets each project review criterion and the basis thereof."

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

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

Exh. 2

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

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

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

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

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

Sincerely,

Beverly Brandt

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

Enclosures: Project Review Criteria Analysis
Notice of Appeal Procedure

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

BOARD:
Allen Amsler
Chairman

Mark S. Lutz
Vice Chairman

Steven G. Kisner
Secretary

C. Earl Hunter, Commissioner
Promoting and protecting the health of the public and the environment

BOARD:
R. Kenyon Wells
L. Clarence Batts, Jr.
Ann B. Kirol, DDS
John O. Hutto, Sr., MD

S.C. Board of Health and Environmental Control; Telephone (803) 898-3309 Fax: (803) 898-3393

October 17, 2011

U.S. Mail - CERTIFIED – Return Receipt

91 7108 2133 3937 3695 9401

Stuart M. Andrews, Jr., Esq.
Nelson Mullins Riley & Scarborough, LLP
Post Office Box 11070
Columbia, SC 29211

91 7108 2133 3937 3695 9418

M. Elizabeth Crum, Esq.
McNair Law Firm, P.A.
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Columbia, South Carolina 29211

91 7108 2133 3937 3695 9425

Douglas M. Muller, Esq.
Moore & Van Allen, PLLC
PO Box 22828
Charleston, SC 29413

Via Interagency Mail Delivery
Ashley C. Biggers, Esq.
SCDHEC – Office of General Counsel
2600 Bull Street
Columbia, SC 29201

RE: ***Docket No. 11-RFR-47*** *– Decision dated September 9, 2011, to issue a Certificate of Need to Carolinas Healthcare System for the construction of a 64-bed general acute hospital in York County.*

Docket No. 11-RFR-48 *– Decision dated September 9, 2011, to deny a Certificate of Need to Piedmont Medical Center for the construction of a 100-bed general acute care hospital in York County.*

Docket No. 11-RFR-49 *-- Decision dated September 9, 2011, to deny a Certificate of Need to Presbyterian Hospital York, LLC for the construction of a 64-bed general acute care hospital in York County.*

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
2600 Bull Street • Columbia, SC 29201 • Phone: (803) 898-3432 • www.scdhec.gov

Exh. 3

The S.C. Board of Health and Environmental Control decided on October 13, 2011, not to conduct a Final Review Conference on the above-referenced matter.

S.C. Code Section 44-1-60 provides that if the Board declines in writing to schedule a final review conference, the staff decision becomes the final agency decision, and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court (ALC) within thirty calendar days after notice is mailed to the applicant, permittee, licensee, and affected person that the Board declined to hold a final review conference.

A request for a contested case hearing before the Administrative Law Court must be filed within the time allowed and in accordance with the Rules of the ALC, including payment of the ALC's filing fee, at the following address:

Clerk's Office
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

The ALC's Notice of Request for Contested Case Hearing form and the Rules of the ALC can be found at the ALC's website: http://www.scalc.net. Further information on filing a request for a contested case hearing before the ALC may be obtained by calling the Clerk's Office at the Administrative Law Court (803-734-0550).

If a party files a request for a contested case hearing with the ALC, the party must serve a copy of the request on DHEC and any other parties at the same time the request is filed with the ALC. A copy of the request for a contested case hearing must be delivered or mailed to DHEC at the address at the top of this memorandum.

Sincerely,

Lisa Lucas Longshore

Lisa Lucas Longshore
Clerk

The above information on filing a request for a contested case hearing before the Administrative Law Court is provided as a courtesy; parties before the ALC are responsible for complying with all applicable requirements of the Court.

OCG # 21301

I:\Share\LEGAL\ALL\MATTERS\21301 RFR HR Carolinas Medical Center Fort Mill\rc denial.doc

myCaseLoad

Welcome: Susan Dickerson

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Admin
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Cash Receipt

Number:	CR1111-0297	**Dated:**	11-17-2011
Till:	ALC Till	**Total Paid**	$500.00
Posted:	Yes		

Void Information

Void Method:		**Voided:**	No
Void Posted:	No		
Void Explanation:			

Generate

Cash Receipt Generate

Invoices (1)

Date	Number	Item Type	Customer	Paid
11-17-2011	NV1111-0291	Case Filing Fee - $500	Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center	500.00

Payments (1)

Payment Method	Reference	Paid
Check	Nelson Mullins Riley & Scarborough, 2 checks #681430 & 681488	500.00

Cash Receipt

Number:	CR1111-0298	**Dated:**	11-17-2011
Till:	ALC Till	**Total Paid**	$500.00
Posted:	Yes		

Void Information

Void Method:		**Voided:**	No
Void Posted:	No		
Void Explanation:			

Generate

Cash Receipt Generate

Invoices (1)

Date	Number	Item Type	Customer	Paid
11-17-2011	NV1111-0292	Case Filing Fee - $500	Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center	500.00

Payments (1)

Payment Method	Reference	Paid
Check	Nelson Mullins Riley & Scarborough, Check #681494	500.00

In order to project the total medical/surgical and ICU discharges from the service area in 2009, 2010, and 2011, the first three years of operation, the 2004 use rate for York County was used for each ZIP Code, unless the ZIP Code's actual use rate was higher than the use rate for York County; then the actual use rate was applied. The use rates were held constant and applied to the projected population in each ZIP Code in each respective year. As shown in Figure 15, there are projected to be a total of 12,123, 12,432, and 12,748 inpatient medical/surgical and ICU discharges for residents of Fort Mill Medical Center's primary service area in the years 2009, 2010, and 2011.

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

ZIP Code/ Area	Cases 2009	2010	2011
29708	1,102	1,135	1,168
29715	1,996	2,038	2,081
29730	4,875	4,978	5,084
29732	4,150	4,281	4,415
PSA	**12,123**	**12,432**	**12,748**
SSA	5,169	5,235	5,302
York County	**17,292**	**17,667**	**18,050**

Source: Claritas; SC ORS; Solucient; Mitretek methodology.
Note: Several ZIP Codes included PO boxes. ZIP Codes were combined with associated area.
Excludes: Open Heart Surgery, Angioplasty, Obstetrics, and Psychiatry.

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

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

	2004	2009			2010			2011		
Area	PMC	FMC	PMC	Combined	FMC	PMC	Combined	FMC	PMC	Combined
PSA	71.8%	22.1%	57.0%	79.0%	26.3%	53.4%	79.7%	29.3%	50.4%	79.7%
SSA	54.0%	14.3%	42.3%	56.7%	19.1%	39.3%	58.5%	19.1%	39.8%	58.9%
York County	66.4%	19.8%	51.5%	71.2%	24.2%	49.4%	73.6%	26.3%	47.3%	73.6%

Source: Claritas; SC ORS; Solucient; Mitretek methodology.
Note: Several ZIP Codes included PO boxes. ZIP Codes were combined with associated area.
Excludes: Open Heart Surgery, Angioplasty, Obstetrics, and Psychiatry.

Fort Mill Medical Center's proposed market share of the service area not only includes the redirection of patients from PMC to the new facility, but it also considers the recapture of patients from the area who currently travel to North Carolina for care. It is reasonable to assume that the market share levels proposed by Fort Mill Medical Center are achievable for the following reasons: 000030

ZIP Code primary service area. In total, there will be a projected 2,837, 3,315, and 3,806 discharges at the Fort Mill Medical Center in each of the first three years of operation. Assuming a four-day overall length of stay, these total projected discharges will result in 11,349, 13,259, and 15,226 patient days in 2009, 2010, and 2011. The following table summarizes these projections and illustrates the projected ADC and occupancy for the Fort Mill Medical Center during the first three years of operation.

Figure 16
Fort Mill Medical Center
Total Projected Discharges and Utilization Statistics

	Year 1 2009	Year 2 2010	Year 3 2011
29708	423	520	621
29710	1,044	1,213	1,385
29715	1,112	1,281	1,455
Service Area Total	2,579	3,013	3,460
All Other (10%)	258	301	346
Total Discharges	**2,837**	**3,315**	**3,806**
LOS	4.0	4.0	4.0
Total Patient Days	11,349	13,259	15,226
ADC	31.1	36.3	41.7
Beds	64	64	64
Occupancy	**48.6%**	**56.8%**	**65.2%**

Source: South Carolina State Budget and Control Board, Office of Research and Statistics.

As illustrated by Figure 16, the projected discharges in the proposed primary service area, coupled with the discharges expected to come from outside the primary service area are sufficient to generate utilization that results in the Fort Mill Medical Center to be approximately 65 percent occupied by 2011, the third year of operation.

Utilization Projections: Obstetrical Beds

The total female 15-44 population in the proposed primary service area is projected to grow 4.0 percent over the next five years, over double the projected growth rate of the state, as shown in Figure 17. The female population ages 15–44 in York County is projected to grow 7.6 percent between 2004 and 2009.

Figure 17
Fort Mill Medical Center
Females Aged 15–44 Population Projections
Primary Service Area

ZIP Code	2004	2009	Percent Change
29708	2,430	2,620	7.8%
29710	4,763	4,827	1.3%
29715	4,587	4,801	4.7%
Total	**11,780**	**12,248**	**4.0%**
York County	**41,142**	**44,250**	**7.6%**
South Carolina	903,250	918,250	1.7%

Source: Claritas, Inc., August 2004.

000029

1999 South Carolina Health Plan

South Carolina State Health
Planning Committee

South Carolina Department of
Health and Environmental Control

Petitioner's
Trial Exhibit
004

PET-EX004

1999 South Carolina Health Plan

South Carolina State Health Planning Committee

South Carolina Department of Health and Environmental Control

Effective June 30, 1999 for all but Obstetrics and Neonatal Services Section

Obstetrics and Neonatal Services Section became effective October 14, 1999

South Carolina State Health Planning Committee

Member	Representing	Term expires
Gerald A. Wilson, M.D. Chairman	Provider	6/30/98
Vacant	Finance/Business	6/30/96
Coleman F. Buckhouse, M.D.	Provider	6/30/00
Thomas G. Faulds	Finance/Insurance	6/30/00
Edward D. Tinsley, III	Consumer	6/30/02
Phillip S. Porter	Ex Officio	
Gilbert D. Johnson	Finance/Business	6/30/98
Bradley W. Moorhouse	Provider	6/30/02
John A. Miller, Jr.	Provider	6/30/00
Howard L. Cox	Finance-Insurance	6/30/98
Vacant	Consumer	6/30/98
Brian K. Smith	DHEC Board	6/30/01
Vacant	Consumer	6/30/96
Luther B. Wannamaker, Jr.	Consumer	6/30/98

All correspondance should be addressed to: State Health Planning Committee, Health Facilities and Services Development Branch, 2600 Bull Street, Columbia, South Carolina 29201 (803) 737-7200

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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 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 State 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 health planning commitee will review the State 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, Division on Aging and the Health and Human Services Finance Commission, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the Hospital Association, Home Health Association and the 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 which 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.

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, habilitation centers, 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 which 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;

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

(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 Health Facilities and Services Development Branch, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 737-7200; fax number is (803) 737-7579.

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.

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-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 which 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 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
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      - 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
  - Rural Health Care

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 need for hospitals, nursing homes, End Stage Renal Disease (ESRD) services and home health services is projected by county. The need for acute psychiatric services, alcohol and drug abuse services and comprehensive rehabilitation services is based on various service areas and utilization methodologies specified herein. Residential treatment centers for children and adolescents and institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, lithotripsy, etc.) is 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

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organization and whose relationship has been established for reasons other than for transferring beds, 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.

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 3,761,800 for 1997 and projected population of 4,038,100 for 2003 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 1997 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 November 1, 1999.

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.

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(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 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.

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 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.

(f) 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;

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.

(g) 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.

(h) 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.

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BEDS/1000 POPULATION

Existing Beds/1997 Population:	2.7
Projected Beds/2003 Population:	1.8
Existing Beds/2003 Population:	2.5

(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).

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 1997 was 54.3%. 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

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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.

FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON AREA MEDICAL CTR	<18	38820	39580	4563	12.75				
	18-64	97080	101820	38112	109.51				
	+65	22200	23500	46790	135.70				
	TOTAL	158100	164900	89464	257.96	0.80	322	495	-173
ANDERSON CO.	TOTAL						322	495	-173
UPSTATE CAROLINA MED CTR	<18	12220	12740	850	2.43				
	18-64	29480	30860	5965	17.11				
	+65	6700	7000	8363	23.94				
CHEROKEE CO.	TOTAL	48400	50600	15178	43.47	0.70	62	125	-63
ALLEN BENNETT MEM	<18	86500	90140	244	0.70				
	18-64	218000	232060	4788	13.96				
	+65	44200	47900	7804	23.17				
	TOTAL	348700	370100	12836	37.83	0.70	54	58	-4
	<18	86500	90140	12542	35.81				
GREENVILLE MEM MED CTR	18-64	218000	232060	86124	251.17				
	+65	44200	47900	68565	203.57				
	TOTAL	348700	370100	167231	490.56	0.80	813	828	-15
HILLCREST	<18	86500	90140	141	0.40				
	18-64	218000	232060	2334	6.81				
	+65	44200	47900	3390	10.07				
	TOTAL	348700	370100	5865	17.27	0.70	25	56	-31
NORTH GREENVILLE	<18	86500	90140	0	0.00				
	18-64	218000	232060	0	0.00				
	+65	44200	47900	0	0.00				
	TOTAL	348700	370100	0	0.00	0.70	0	5	-5
SAINT FRANCIS HOSP. AND	<18	86500	90140	662	1.89				
	18-64	218000	232060	26849	78.30				
ST.FRANCIS WOMAN'S HOSP #1	+65	44200	47900	32688	97.05				
	TOTAL	348700	370100	60199	177.25	0.75	236	268	-32
GREENVILLE CO	TOTAL						928	1015	-87
OCONEE MEM	<18	14680	15720	887	2.60				
	18-64	40620	44280	12166	36.33				
	+65	8100	9500	15573	50.04				
OCONEE CO	TOTAL	63400	69500	28626	88.98	0.75	119	160	-41
CANNON MEM.	<18	23040	25660	66	0.20				
	18-64	70360	79840	1678	5.22				
	+65	11400	13100	3296	10.38				
	TOTAL	104800	118600	5039	15.79	0.70	23	55	-32

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
PALMETTO BAPTIST MED CTR	<18	23040	25660	715	2.18				
EASLEY	18-64	70360	79840	8541	26.55				
	+65	11400	13100	7758	24.42				
	TOTAL	104800	118600	17013	53.16	0.75	71	96	-25
PICKENS CO	TOTAL						94	151	-57
B.J. WORKMAN MEM.	<18	58020	61180	293	0.85				
	18-64	153980	165620	683	2.01				
	+65	32900	36100	2541	7.64				
	TOTAL	244900	262900	3517	10.50	0.70	15	43	-28
SPGT HOSP RESTORATIVE CARE	<18	58020	61180	0	0.00				
	18-64	153980	165620	1396	4.11				
	+65	32900	36100	4866	14.63				
	TOTAL	244900	262900	6262	18.74	0.75	25	97	-72
MARY BLACK MEM.	<18	58020	61180	2525	7.29				
	18-64	153980	165620	14955	44.07				
	+65	32900	36100	14890	44.76				
	TOTAL	244900	262900	32370	96.13	0.75	128	176	-48
SPARTANBURG REG. MED.CTR.	<18	58020	61180	4571	13.21				
	18-64	153980	165620	51590	152.03				
	+65	32900	36100	52679	158.36				
	TOTAL	244900	262900	108840	323.60	0.80	404	532	-128
SPARTANBURG CO	TOTAL						572	848	-276
HOPE HOSP.	<18	7200	7200	6	0.02				
	18-64	18400	18500	940	2.59				
	+65	4900	5000	0	0.00				
	TOTAL	30500	30700	946	2.61	0.70	4	14	-10
WALLACE THOMSON	<18	7570	7200	594	1.65				
	18-64	18400	18500	7384	20.34				
	+65	4900	5000	10031	28.04				
	TOTAL	30870	30700	18009	49.93	0.70	71	143	-72
UNION CO	TOTAL						75	157	-82
REGION I	TOTAL						2172	2951	-779
ABBEVILLE CO. MEM.	<18	6140	6200	147	0.41				
	18-64	14560	15400	1425	4.13				
	+65	3200	3300	2301	6.50				
ABBEVILLE CO.	TOTAL	23900	24900	3873	11.04	0.70	16	52	-36
CHESTER CO. HOSP.	<18	9600	9900	1739	4.91				

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
	18-64	16100	19100	5495	15.89				
	+65	5500	5600	9023	26.17				
CHESTER CO.	TOTAL	33200	34600	16257	45.97	0.70	66	82	-16
EDGEFIELD CO.HOSP.	<18	5300	5300	186	0.51				
	18-64	12100	12700	886	2.56				
	+65	2200	2400	2246	6.71				
EDGEFIELD CO.	TOTAL	19600	20400	3318	9.77	0.70	14	40	-26
FAIRFIELD MEM	<18	5460	5720	255	0.73				
	18-64	12940	14480	1347	4.13				
	+65	3500	3900	2517	7.68				
FAIRFIELD CO.	TOTAL	21900	24100	4119	12.55	0.70	18	33	-15
SELF MEM.HOSP.	<18	15380	15660	2606	7.27				
	18-64	39320	40340	24415	68.63				
	+65	8600	8600	26170	71.70				
GREENWOOD CO.	TOTAL	63300	64600	53191	147.59	0.80	184	334	-150
KERSHAW CO.MEM HOSP	<18	12300	13060	1709	4.97				
	18-64	29400	31540	7130	20.96				
	+65	6300	6900	10803	32.42				
KERSHAW CO.	TOTAL	48000	51500	19642	58.34	0.75	78	121	-43
SPRINGS MEM	<18	13780	13580	891	2.41				
	18-64	36620	36620	10436	28.59				
	+65	7400	7500	14126	39.22				
LANCASTER CO.	TOTAL	57800	57700	25453	70.22	0.75	94	135	-41
LAURENS CO HOSP	<18	15420	15820	774	2.18				
	18-64	36980	39180	7202	20.91				
	+65	9900	10300	11384	32.45				
LAURENS CO.	TOTAL	62300	65300	19360	55.53	0.70	79	76	3
LEXINGTON MED CTR	<18	30302	33251	2189	6.58				
	18-64	83558	92994	28513	86.94				
	+65	11420	13200	30094	95.30				
LEXINGTON CO.	TOTAL	125280	139445	60796	188.82	0.75	252	292	-40
NEWBERRY CO. MEM.	<18	8680	9060	559	1.60				
	18-64	20520	21240	3481	9.87				
	+65	5300	5600	5765	16.69				
NEWBERRY CO.	TOTAL	34500	35900	9805	28.16	0.70	40	90	-50
PALMETTO BAPTIST MED CTR COLA & INTERMEDICAL HOSP OF SC	<18	86906	90677	2796	7.99				
	18-64	246329	263808	35156	103.15				
	+65	35075	37740	31941	94.16				
	TOTAL	368310	392225	69893	205.30	0.80	257	398	-141
PROVIDENCE HOSPITAL AND PROVIDENCE HOSPITAL NE	<18	86906	90677	124	0.35				
	18-64	246329	263808	25242	74.06				

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ. ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
	+65	35075	37740	36654	108.05				
	TOTAL	368310	392225	62020	182.47	0.75	243	293	-50
PALMETTO RICHLAND MEM HOSPITAL	<18	86906	90677	19500	55.74				
	18-64	246329	263808	84141	246.88				
	+65	35075	37740	49901	147.10				
	TOTAL	368310	392225	153542	449.73	0.80	562	579	-17
RICHLAND CO.	TOTAL						1062	1270	-208
PIEDMONT MED. CTR.	<18	35580	39700	2463	7.53				
	18-64	98520	113000	24468	76.89				
	+65	16500	19100	27807	88.19				
	TOTAL	150600	171800	54738	172.61	0.75	230	248	-18
YORK CO.	TOTAL						230	248	-18
REGION II	TOTAL						2133	2773	-640
CHESTERFIELD GENERAL	<18	9000	8860	1067	2.88				
	18-64	24900	25340	3541	9.87				
	+65	6200	6800	3296	9.90				
CHESTERFIELD CO.	TOTAL	40100	41000	7904	19.78	0.70	28	59	-31
CLARENDON MEM. HOSP.	<18	8220	7820	750	1.95				
	18-64	18580	19180	5058	14.31				
	+65	4500	4400	6293	16.86				
CLARENDON CO.	TOTAL	31300	31400	12101	33.12	0.70	47	56	-9
BYERLY HOSP.	<18	16380	16220	1718	4.66				
	18-64	40720	41980	8283	23.40				
	+65	8600	9000	9085	26.05				
	TOTAL	65700	67200	19086	54.10	0.75	72	116	-44
WILSON MEDICAL CTR	<18	16380	16220	58	0.16				
	18-64	40720	41980	1913	5.40				
	+65	8600	9000	2836	8.13				
	TOTAL	65700	67200	4807	13.69	0.70	20	50	-30
DARLINGTON CO.	TOTAL						92	166	-74
SAINT EUGENE MEDICAL CENTER	<18	8540	8740	2082	5.84				
	18-64	17660	18960	7023	20.86				
	+65	3400	3400	7419	20.33				
DILLON CO.	TOTAL	29600	31100	16524	46.82	0.70	67	79	-12

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
CAROLINAS HOSP SYS & WOMEN'S CENTER OF THE CAROLINAS HOSP. SYS. #3	<18	33220	33300	2273	6.24				
	18-64	76980	79600	24945	70.67				
	+65	14300	15100	35933	103.95				
	TOTAL	124500	128000	63151	180.86	0.75	241	310	-69
CAROLINAS HOSP SYS LAKE CITY	<18	33220	33300	69	0.19				
	18-64	76980	79600	1050	2.97				
	+65	14300	15100	2016	5.83				
	TOTAL	124500	128000	3135	8.83	0.70	13	48	-35
MCLEOD REG MED CTR	<18	33220	33300	7775	21.35				
	18-64	76980	79600	51154	144.92				
	+65	14300	15100	43378	125.49				
	TOTAL	124500	128000	102307	291.76	0.75	389	336	53
FLORENCE CO.	TOTAL						643	694	-51
GEORGETOWN CO. MEM.	<18	14660	15060	2043	5.75				
	18-64	31740	34140	14530	42.82				
	+65	6100	6500	15860	46.30				
GEORGETOWN CO.	TOTAL	52500	55700	32433	94.87	0.75	126	142	-16
CONWAY HOSP. INC.	<18	38400	41720	2308	6.87				
	18-64	105000	120380	16337	48.17				
	+65	26100	31300	13977	45.92				
	TOTAL	169500	193400	31622	100.97	0.75	135	160	-25
GRAND STRAND REG MED CTR	<18	38400	41720	592	1.76				
	18-64	105000	120380	14552	45.71				
	+65	26100	31300	21884	71.90				
	TOTAL	169500	193400	37028	119.37	0.75	159	172	-13
LORIS COMM. HOSP.	<18	38400	41720	682	2.03				
	18-64	105000	120380	6271	19.70				
	+65	26100	31300	8195	26.93				
	TOTAL	169500	193400	15148	48.65	0.70	70	105	-35
HORRY CO.	TOTAL						364	437	-73
MARION CO MEDICAL CTR	<18	9920	10240	1967	5.56				
	18-64	19980	21260	14539	42.38				
	+65	4600	4700	15732	44.04				
	TOTAL	34500	36200	32238	91.99	0.70	131	124	7
MARION CO.	TOTAL						131	124	7
MARLBORO PARK	<18	7960	8120	431	1.20				
	18-64	18040	19380	4292	12.63				

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
MARLBORO CO.	+65	3500	3700	4858	14.07				
	TOTAL	29500	31200	9581	27.91	0.70	40	94	-54
TUOMEY REG MED CTR	<18	31220	32880	3414	9.85				
	18-64	64880	69920	23034	68.01				
	+65	10500	11400	24512	72.91				
SUMTER CO.	TOTAL	106600	114200	50960	150.77	0.75	201	229	-28
CAROLINAS HOSP SYSTEM KINGSTREE	<18	10600	10220	294	0.78				
	18-64	23000	23180	2185	6.06				
	+65	3900	3800	3067	8.19				
WILLIAMSBURG CO.	TOTAL	37500	37200	5556	15.02	0.70	21	78	-57
REGION III	TOTAL						1760	2158	-398
ALLENDALE CO HOSP	<18	3280	3280	285	0.81				
	18-64	6520	6720	1207	3.41				
	+65	1800	2000	860	2.62				
ALLENDALE CO.	TOTAL	11600	12000	2362	6.83	0.70	10	36	-26
BAMBERG CO. MEM.	<18	4680	4500	223	0.59				
	18-64	9820	10100	2212	6.23				
	+65	2300	2400	4328	12.37				
BAMBERG CO.	TOTAL	16800	17000	6763	19.19	0.70	27	59	-32
BARNWELL CO. HOSP	<18	6120	6220	306	0.85				
	18-64	13580	14180	1681	4.81				
	+65	2600	2600	3471	9.51				
BARNWELL CO.	TOTAL	22300	23000	5458	15.17	0.70	22	53	-31
BEAUFORT CO. MEM.	<18	26180	26340	1526	4.21				
	18-64	66220	70560	11575	33.79				
	+65	14400	15800	10377	31.19				
	TOTAL	106800	112700	23478	69.19	0.75	92	106	-14
HILTON HEAD MEDICAL CTR & CLINICS	<18	26180	26340	182	0.50				
	18-64	66220	70560	5170	15.09				
	+65	14400	15800	7638	22.96				
	TOTAL	106800	112700	12990	38.55	0.70	55	68	-13
BEAUFORT CO.	TOTAL						147	174	-27
TRIDENT MED CTR AND SUMMERVILLE MED CTR	<18	54148	58825	2596	7.73				
	18-64	128962	144555	34701	106.57				
	+65	16290	19145	31012	99.86				
	TOTAL	199400	222525	68309	214.15	0.75	286	325	-39

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FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
BERKELEY/DORCHESTER COS.	TOTAL						286	325	-39
ROPER HOSP NORTH	<18	81012	87015	83	0.24				
	18-64	195378	216105	2617	7.93				
	+65	33810	38355	4187	13.01				
	TOTAL	310200	341475	6887	21.19	0.75	28	60	-32
CHARLESTON MEMORIAL & SPECIALITY HOSPITAL OF SC	<18	81012	87015	44	0.13				
	18-64	195378	216105	12754	38.65				
	+65	33810	38355	1929	6.00				
	TOTAL	310200	341475	14727	44.77	0.75	60	157	-97
MEDICAL UNIVERSITY HOSP.	<18	135160	145840	10291	30.42				
	18-64	324340	360660	32469	98.92				
	+65	50100	57500	12272	38.59				
	TOTAL	509600	564000	55032	167.93	0.80	210	224	-14
ROPER HOSP.	<18	81012	87015	1976	5.81				
	18-64	195378	216105	35475	107.50				
	+65	33810	38355	52359	162.73				
	TOTAL	310200	341475	89810	276.05	0.80	345	414	-69
BON SECOURS ST. FRANCIS XAVIER #2	<18	81012	87015	606	1.78				
	18-64	195378	216105	12629	38.27				
	+65	33810	38355	12022	37.36				
	TOTAL	310200	341475	25257	77.42	0.80	97	198	-101
EAST COOPER REG MED CTR.	<18	81012	87015	134	0.39				
	18-64	195378	216105	7911	23.97				
	+65	33810	38355	6853	21.30				
	TOTAL	310200	341475	14898	45.67	0.75	61	100	-39
CHARLESTON CO.	TOTAL						801	1153	-352
COLLETON MED CTR	<18	9560	9880	829	2.35				
	18-64	22740	24120	10168	29.56				
	+65	4700	4900	14110	40.30				
COLLETON CO.	TOTAL	37000	38900	25107	72.20	0.70	103	116	-13
HAMPTON REG MED CTR	<18	5760	5720	61	0.17				
	18-64	10940	11480	528	1.52				
	+65	2900	3000	1530	4.34				
HAMPTON CO.	TOTAL	19600	20200	2119	6.02	0.70	9	68	-59
LOW COUNTRY GEN HOSP	<18	5440	5600	122	0.34				
	18-64	9860	10100	978	2.74				

RECORD 003264

PET-EX004.0034

FY 2003 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	1997 POP	2003 POP	97 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
	+65	1600	1700	1727	5.03				
JASPER CO.	TOTAL	16900	17400	2827	8.12	0.70	12	31	-19
RMC ORANGEBURG-CALHOUN	<18	28160	28720	2881	8.06				
	18-64	61440	64080	21811	61.75				
	+65	12300	12500	28668	80.38				
ORANGEBURG CO.	TOTAL	101900	105300	53360	150.18	0.75	200	261	-61
AIKEN REG.MED. CTR.	<18	35300	39420	1875	5.74				
	18-64	80500	92480	21105	66.43				
	+65	18000	20700	20626	64.99				
AIKEN CO.	TOTAL	133800	152600	43606	137.15	0.75	183	178	6
REGION IV	TOTAL						1800	2454	-654

#1 DATA & BED NEEDS FOR COMBINED HOSPITALS.
#2/ CON ISSUED FOR 198 BED REPLACEMENT HOSP.
#3 BRUCE & FLORENCE GEN ARE LICENSED AS ONE HOSPITAL CAROLINAS HOSP SYS.
DATA INCLUDES THE WOMAN'S CTR.

RECORD 003265

PET-EX004.0035

% OCCUPANCY RATE

	1995	1996	1997
REGION I	53.1	50.1	52.0
ANDERSON AREA MED CTR	49.5	47.5	47.0
UPSTATE CAROLINA MED C	35.5	34.6	33.3
ALLEN BENNETT MEM	49.8	57.1	60.6
GREENVILLE GENERAL	0.0	0.0	0.0
GREENVILLE MEM MED CTR	79.1	71.4	73.0
HILLCREST	33.0	31.0	28.7
NORTH GREENVILLE	0.0	0.0	0.0
ST FRANCIS COMM	63.9	67.4	65.7
ST FRANCIS WOMEN"S & FAMILY	34.2	36.1	43.3
OCONEE MEM	48.9	45.8	49.0
CANNON MEM	28.2	28.7	25.1
PALMETTO BAPTIST M C EASLEY	54.9	47.2	48.6
BJ WORKMAN MEM	28.0	20.9	20.7
MARY BLACK MEM	57.5	50.7	45.1
SPGT HOSP RESTORATIVE C	0.0	7.4	17.7
SPARTANBURG REG MED CTR	56.3	50.7	56.1
HOPE	17.4	16.7	16.2
WALLACE THOMSON	33.0	33.3	34.5

	1995	1996	1997
REGION III	56.7	52.8	56.7
CHESTERFIELD GEN	31.0	25.1	36.7
CLARENDON MEM	57.4	55.3	59.2
BYERLY	49.7	38.8	45.1
WILSON CLINIC	27.9	26.8	26.3
ST. EUGENE REG MED CTR	47.1	44.3	57.3
CAROLINAS HOSPITAL SYS	74.5	55.0	56.8
CAROLINAS HOSP LAKE CITY	25.6	21.6	17.9
MCLEOD REG MED CTR	90.1	89.9	94.7
WOMEN'S CTR/CAROLINAS	37.2	34.3	41.8
GEORGETOWN CO MEM	61.1	57.4	62.6
CONWAY HOSP	52.8	55.9	54.1
COLUMBIA GRAND STRAND REG	60.3	57.2	59.0
LORIS COMM	35.3	36.2	39.5
MARION CO MED CTR	50.1	38.9	71.2
(MULLINS)	63.4	62.2	
MARLBORO PARK	24.7	23.9	26.9
TUOMEY	52.6	57.2	55.4
CAROLINAS HOSP KINGSTREE	20.3	17.8	19.5

% OCCUPANCY RATE

	1995	1996	1997
REGION II	56.6	54.2	54.8
ABBEVILLE CO	21.5	23.4	20.4
CHESTER CO	56.0	54.0	54.3
EDGEFIELD CO	23.5	23.5	22.7
FAIRFIELD MEM	38.9	42.1	34.2
SELF MEM	46.0	45.6	40.4
KERSHAW CO MEM	47.0	44.9	44.5
SPRINGS MEM	41.4	46.9	48.8
LAURENS COUNTY HOSP	66.1	66.5	58.9
LEXINGTON MED CTR	57.1	54.7	57.0
NEWBERRY CO MEM	34.5	28.1	26.3
PALMETTO BAPTIST MED CTR COLA	51.7	50.8	48.1
PROVIDENCE HOSPITAL	70.1	67.6	71.1
PALMETTO RICHLAND MEM	69.6	66.3	72.7
PIEDMONT MED CTR	58.0	58.5	60.5

	1995	1996	1997
REGION IV	50.3	49.0	52.4
ALLENDALE CO	27.8	19.3	18.0
BAMBERG CO MEM	34.2	33.7	31.4
BARNWELL CO	15.9	19.1	28.2
BEAUFORT CO MEM	54.3	56.3	60.7
HILTON HEAD	55.9	45.5	52.3
ROPER HOSP NORTH	37.1	60.4	31.4
CHARLESTON MEM	36.2	29.1	25.7
EAST COOPER REG MED CTR	41.2	37.0	40.8
MEDICAL UNIVERSITY	71.9	64.9	67.3
TRIDENT MED CTR	64.8	62.4	62.2
SUMMERVILLE MED CTR	38.5	48.5	40.6
ROPER	62.4	60.4	59.4
BON SECOURS ST FRANCIS	27.9	23.6	37.0
COLLETON MED CTR	39.8	49.7	59.3
HAMPTON REG MED CTR	8.6	12.1	8.5
LOW COUNTRY	41.4	28.1	25.0
RMC ORANGEBURG/CALHOUN	55.8	52.9	53.9
AIKEN REG MED CTR	66.0	65.8	67.1

Occupancy rates are based on general acute care beds and exclude psychiatric beds.

RECORD 003266

PET-EX004.0036

(D) Obstetrical and Neonatal Services

Obstetrical Services

Recent 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 1995-1997, 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. South Carolina's neonatal mortality rate has improved from 1985 through 1997 with a 1995-1997 rate of 6.3 neonatal deaths per thousand live births.

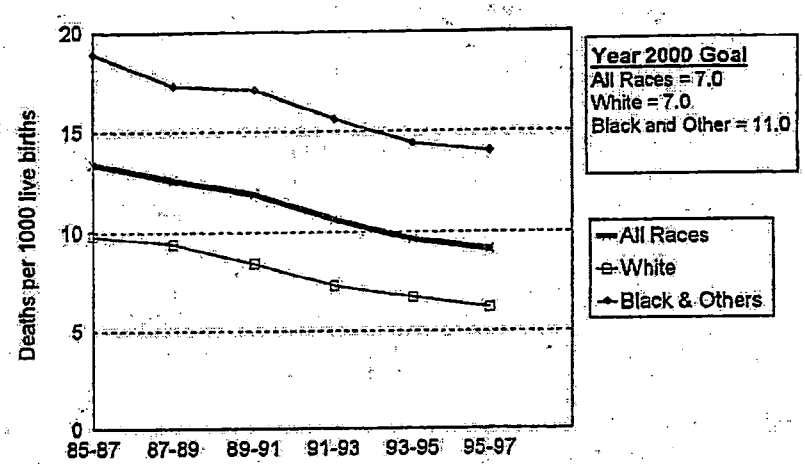
The Trends of Infant Mortality Rates and Neonatal Mortality Rates follow:

PET-EX004.0037

RECORD 003267

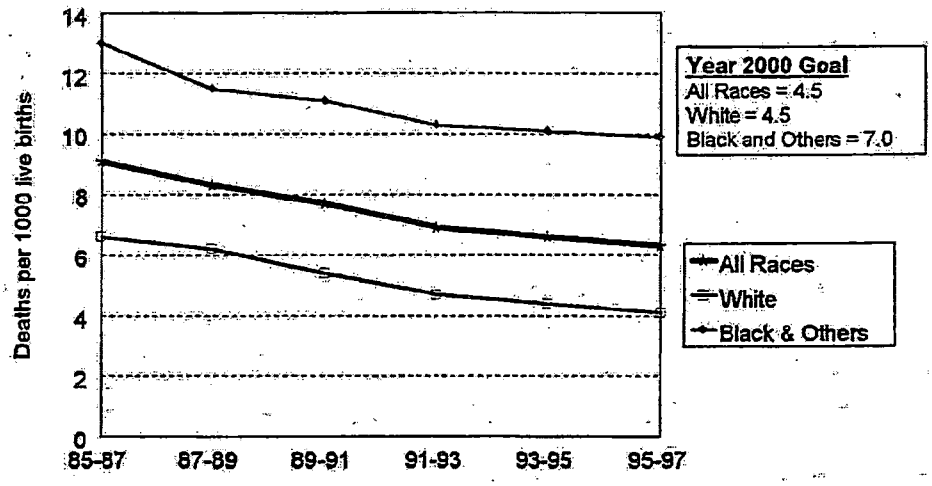
Three Year Infant Mortality Rates

State of South Carolina



Three Year Neonatal Mortality Rates

State of South Carolina



Source: Maternal and Child Health Epidemiology Branch
SCDHEC

INFANT MORTALITY NATIONAL RANKING BY RATES*
UNITED STATES, 1996
(RESIDENCE DATA)

RANK	STATE	RATE
1	DISTRICT OF COLUMBIA	14.9
2	MISSISSIPPI	11.0
3	ALABAMA	10.5
4	ARKANSAS	9.3
5.5	NORTH CAROLINA	9.2
5.5	GEORGIA	9.2
7	LOUISIANA	9.0
8.5	INDIANA	8.7
8.5	NEBRASKA	8.7
10	ILLINOIS	8.6
12	MARYLAND	8.5
12	TENNESSEE	8.5
12	OKLAHOMA	8.5
14	SOUTH CAROLINA	8.4
15	KANSAS	8.3
16	PENNSYLVANIA	7.8
17.5	OHIO	7.7
17.5	VIRGINIA	7.7
20.5	MICHIGAN	7.6
20.5	MISSOURI	7.6
20.5	DELAWARE	7.6
20.5	ARIZONA	7.6
23.5	FLORIDA	7.5
23.5	KENTUCKY	7.5
25.5	WEST VIRGINIA	7.4
25.5	IDAHO	7.4
27	WISCONSIN	7.3
28	VERMONT	7.1
29	ALASKA	7.2
31	NEW YORK	7.0
31	MONTANA	7.0
31	IOWA	7.0
33	NEW JERSEY	6.9
34	COLORADO	6.6
35.5	WYOMING	6.4
35.5	CONNECTICUT	6.4
37	TEXAS	6.3
38.5	NEW MEXICO	6.2
38.5	NEVADA	6.2
40.5	UTAH	6.0
40.5	WASHINGTON	6.0
42.5	CALIFORNIA	5.9
42.5	MINNESOTA	5.9
44	HAWAII	5.8
45	SOUTH DAKOTA	5.7
46	OREGON	5.6
47	NORTH DAKOTA	5.3
48	RHODE ISLAND	5.2
49	NEW HAMPSHIRE	5.0
50	MASSACHUSETTS	5.0
51	MAINE	4.4

*Rate per 1,000 Live Births.

Source: National Vital Statistics Report, 1996
Center for Disease Control and Prevention

NEONATAL DEATHS NATIONAL RANKING BY RATES
UNITED STATES, 1996
(RESIDENCE DATA)

RANK	STATE	RATE
1	DISTRICT OF COLUMBIA	10.0
2	MISSISSIPPI	7.2
3	ALABAMA	6.9
4	GEORGIA	6.2
5	NORTH CAROLINA	6.1
6.5	NEBRASKA	5.8
6.5	MARYLAND	5.8
8.5	ILLINOIS	5.7
8.5	SOUTH CAROLINA	5.7
11	INDIANA	5.6
11	ARKANSAS	5.6
11	LOUISIANA	5.6
13	KANSAS	5.5
14	PENNSYLVANIA	5.4
15.5	MICHIGAN	5.3
15.5	VIRGINIA	5.3
17	TENNESSEE	5.2
19	OHIO	5.1
19	DELAWARE	5.1
19	ARIZONA	5.1
21	OKLAHOMA	5.0
23	IOWA	4.9
23	WEST VIRGINIA	4.9
23	KENTUCKY	4.9
26	NEW YORK	4.8
26	NEW JERSEY	4.8
26	MISSOURI	4.8
28.5	WISCONSON	4.7
28.5	FLORIDA	4.7
30.5	VERMONT	4.6
30.5	CONNECTICUT	4.6
33	MONTANA	4.4
33	IDAHO	4.4
33	COLORADO	4.4
36	RHODE ISLAND	4.0
36	WYOMING	4.0
36	UTAH	4.0
38	NEW MEXICO	3.9
39.5	TEXAS	3.8
39.5	CALIFORNIA	3.8
41.5	NORTH DAKOTA	3.7
41.5	WASHINGTON	3.7
44	MASSACHUSETTS	3.6
44	MINNESOTA	3.6
44	HAWAII	3.6
46.5	NEW HAMPSHIRE	3.5
46.5	ALASKA	3.5
48.5	MAINE	3.4
48.5	NEVADA	3.4
50	OREGON	3.3
51	SOUTH DAKOTA	3.0

Rates per 1,000 Live Births
Source: National Vital Statistics Report, 1996
Center for Disease Control and Prevention

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 within a specific region or catchment area is identified by DHEC's Division of Licensing, as a Level I, II, or III facility, based on the degree of complexity of care it can provide to mothers and infants. 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 Department has developed criteria for classifying hospitals by levels of care. Level I, II, and III hospitals must meet the criteria and standards required in the hospital licensing regulations. Level II Enhanced Care hospital standards are being developed. All hospitals providing obstetrical and newborn services must meet the Level I standards contained in Regulation 61-16, "Standards for Licensing Hospitals and Institutional General Infirmaries". The following definitions apply:

A. Level I hospitals provide services for uncomplicated deliveries and normal newborn infants. They must have the capability to manage normal pregnant women and uncomplicated labor and delivery of full-term infants. Generally, the number of births at these hospitals is small. However, these hospitals must be able to manage an infant with acute or potentially life- threatening problems while preparing for immediate transfer to a Level II or Level III hospital. Management might include resuscitation and short term assisted ventilation with bag and mask or bag and endotracheal tube. This description does not constitute Certificate of Need review criteria.

B. Level II hospitals provide services for both the normal and high risk pregnant patient and for the management of selected neonatal illnesses. Illnesses that can be diagnosed and treated will be limited in part by the concentration and availability of the necessary consultants and in part by the concentration of skilled individuals delivering perinatal care. Most of these hospitals are located in communities where the majority of deliveries occur. This level of neonatal care includes the capability for resuscitation, short-term assisted ventilation with bag and mask or endotracheal tube, intravenous therapy with infusion pumps, arterial blood gas monitoring, continuous cardio-respiratory monitoring with appropriate equipment, performance of exchange transfusion, and oxygen administration. Level II facilities have the capability to manage normal pregnant women and uncomplicated labor and delivery of full term infants as well as the capability to manage certain high risk obstetric and complicated neonatal problems. Infants weigh at least 1,500 grams at birth, have completed 32 weeks gestation, and have no respiratory distress. Level II facilities manage no less than 500 deliveries annually. Consideration will be given to the number of transfers that each hospital made to higher level perinatal units. Evaluation will be made on an annual basis. This description does not constitute Certificate of Need review criteria.

C. While the Department strongly supports, promotes and encourages the delivery and care of newborns weighing less than 1,500 grams at Level III facilities, a newborn which weighs at least 1,250 grams at birth and has completed at least 30 weeks gestation may be cared for at a Level II Enhanced Care hospital when (a) such a newborn is born at that hospital and (b) the attending neonatologist, in his or her best medical judgement, believes that the newborn should remain there. To qualify as a

Level II Enhanced Care hospital, a hospital must meet the following criteria: (1) It is able to provide the same services as a Level II hospital; (2) It has a full-time certified neonatologist on staff; (3) It has had an average of at least 1,200 deliveries per year calculated over the previous three fiscal years; (4) Its support staff, equipment and operations meet the applicable provisions of the regulations. A Certificate of Need is required for a hospital to provide Level II Enhanced Care for perinatal services. Until licensing standards are approved, a Certificate of Need for a Level II Enhanced Care Hospital will not be issued.

D. Level III hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation. In addition to the Level II capabilities, Level III units have the staffing and technical capability to manage high risk obstetric and complex neonatal patients. Level III units manage at least 1,500 deliveries annually; or at least 125 admissions which weigh less than 1,500 grams, require ventilatory support, or require surgery. Consideration will be given to the number of transfers that a hospital makes to higher level perinatal units. The number of deliveries and transfers will be evaluated on an annual basis. A Certificate of Need is required for the establishment of a Level III unit. The Health Licensing Section is developing the licensing standards necessary to approve an Enhanced Care hospital, to include technological capabilities and on-site supervision by a licensed neonatologist.

E. In addition to the Level III capability for management of high risk obstetric and complex neonatal conditions, the Regional Perinatal Center (RPC) provides consultative, outreach, and support services to Level I, II, and III units in the region. The RPC participates in residency programs for obstetrics, pediatrics, or family practice, offers continuing education programs to all referring hospitals, and coordinates a regional maternal and neonatal transport system. The RPC manages at least 2,000 deliveries annually; or at least 250 admissions which weigh less than 1,500 grams, require ventilatory support, or require surgery. Consideration will be given to the number of transfers made to higher level perinatal units. Evaluation of the number of deliveries and transfers will be made on an annual basis. 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.

Desired occupancy rates are 65% for Level I and 75% for Levels II and III hospitals.

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

PET-EX004.0042

RECORD 003272

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.

Because obstetrical beds/services are located within approximately thirty minutes travel time for the majority of the residents of the State and the birth rate is declining, additional obstetrical services should only be approved in rural hospitals currently without this service. There may be a need for additional obstetrical beds in the hospitals currently providing this service. Counties experiencing a high utilization of OB beds, but having excess total beds must adjust their total bed complement in order to increase OB beds. Any 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. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service except as outlined above.

PET-EX004.0043

RECORD 003273

The following hospitals have requested a Perinatal Capability Review and been designated as a Level II or Level III 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 **
** Consortium

LEVEL III NICU CENTER

Palmetto Baptist Medical Center at Columbia

LEVEL II ENHANCED CARE HOSPITALS

None at present

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
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

PET-EX004.0044

RECORD 003274

FY97 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEM. MED. CTR.	4421	44	4686	12750	79.4%
PALMETTO BAPTIST MED. CTR. COLA.	3144	60	5339	12922	59.0%
PALMETTO RICHLAND MEM. HOSP.	3059	46	4397	11080	66.0%
SPARTANBURG REG. MED.CTR.	2278	44	1518	8006	49.9%
LEXINGTON MED. CTR.	2210	35			0.0%
MCLEOD REG. MED. CTR.	1981	24	2442	5199	59.3%
TRIDENT MED. CTR.	1956	19	2430	5524	79.7%
MEDICAL UNIVERSITY HOSP.	1908	34			0.0%
ANDERSON AREA MED CTR	1816	27	1791	4535	46.0%
ST. FRANCIS WOMEN'S AND	1753	24	1918	4755	54.3%
SELF MEM. HOSP.	1626	34	2624	6802	54.8%
ROPER HOSP.	1516	11	1623	3050	76.0%
PIEDMONT MED. CTR.	1405	38	2497	7161	51.6%
RMC ORANGEBURG-CALHOUN	1378	27	1622	3597	36.5%
MARY BLACK MEM.	1290	21	1342	3074	40.1%
TUOMEY REG MED CTR	1271	20	834	4659	63.8%
EAST COOPER REG MED CTR	1217	31	1610	3278	29.0%
WOMEN'S CTR /CAROLINAS	1187	20	1372	3047	41.7%
AIKEN REG.MED. CTR.	1091	18	1625	4560	69.4%
BEAUFORT CO. MEM.	1021	20	1155	2327	31.9%
CONWAY HOSP. INC.	961	27	949	2163	21.95%
BON SECOURS' ST. FRANCIS	818	12	733	1993	45.5%
GEORGETOWN CO. MEM.	701	14		2826	55.3%
BAPTIST MED CTR EASLEY	687	14	688	1859	36.4%
GRAND STRAND REG MED CTR	635	19	690	1762	25.4%
SPRINGS MEMORIAL HOSP	613	7	712	1493	58.4%
OCONEE MEM.	582				
BYERLY HOSP.	559	12	426	1255	28.7%
MARION CO. MEM.	541				
SUMMERVILLE MED CTR	434	4	687	1544	105.8%
LAURENS CO. HOSP.	404	8			
COLLETON REG MED CTR	388	5	508	1357	74.4%
LORIS COMM. HOSP.	384	8	431	936	32.1%
HILTON HEAD HOSP.	372	4	426	874	59.9%
ALLEN BENNETT MEM	335	4	335	597	40.9%
KERSHAW CO.	324	12	505	1253	28.6%
UPSTATE CAROLINA MED CTR	316	15	457	1039	19.0%
CLARENDON MEM.	301	8	301	662	22.7%
SAINT EUGENE MEDICAL CTR	297	11	398	931	23.2%
CHESTERFIELD GENERAL	266	6	335	896	40.9%
CHESTER CO.	249	9	326	844	25.7%
NEWBERRY CO. MEM.	213	9	240	547	16.7%
MARLBORO PARK	200				
ALLENDALE CO.	187				
WALLACE THOMSON	168				
CAROLINAS HOSP SYS KINGSTREE	136	4	194	396	27.1%
BAMBERG CO. MEM.	108				
ABBEVILLE CO. MEM.	97	6	113	239	10.9%
LOW COUNTY HOSP	77	5	89	240	13.2%
W.J. BARGE FAMILY HOSP	65				

Neonatal Services:

Neonatal services are highly specialized and only required by a very small percentage of infants. Thus, 4 neonatal bassinets for intensive and intermediate care per 1,000 live births will usually be adequate, taking into account the incidence of high-risk pregnancies, the percentage of live births requiring intensive care, and the average length of stay. The minimum size reflects a regionalized approach which is to foster the location of specialized units in medical centers which have available staff, equipment, and consultative services and facilities. Referral networks should be established to transfer infants requiring more sophisticated care than is available in less specialized facilities.

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

(b) The total number of neonatal (intensive and intermediate care) bassinets should not exceed 4 per 1,000 live births per year in a specific neonatal service area defined by referral patterns. An adjustment upward may be justified when the rate of high-risk pregnancies is unusually high. A Level II neonatal unit contains only intermediate care bassinets and a Level III neonatal unit contains both intensive and intermediate care bassinets.

(c) A single neonatal intensive care unit (Level III) should contain a minimum of 15 bassinets.

According to American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, the following ratio is 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 ratio was based on 80 low-birth weight (LBW) {2500 grams} births per 1,000 births. As indicated below, in 1996 South Carolina had 92.0 LBW births per 1,000 births with a white rate of 70.0 and a nonwhite rate of 130.0 per 1,000.

1996	TOTAL	WHITE	NONWHITE
All Births	51,105	32,309	18,788
<1,500 Grams	931	386	545
Rate/1,000	18.2	11.9	29.0
<2,500 Grams	4,704	2,262	2,442
Rate/1,000	92.0	70.0	130.0

By adjusting for the incidence of LBW births, South Carolina would need the following ratio of bassinets:

$$\frac{92.0}{80} = 1.15 \text{ bassinets}$$

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

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

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

Note: This should be the upper limit since the recommended level is 3-4 per 1,000 births when the prematurity rate is 80 per thousand births.

When the race variance and incidence of LBW births are factored in the intensive care ratios are:
White = $\frac{70.0}{80}$ = 0.88 Nonwhite = $\frac{130.0}{80}$ = 1.63

The intermediate care ratios are:
White = 0.88 x 4.60 = 4.05
Non-white = 1.63 x 4.60 = 7.50

Actual births have been:

1990	1991	1992	1993	1994	1995	1996
58,454	57,509	56,094	53,765	51,895	50,913	51,105

Projected births have been:

1995	1996	1997	1998	1999	2000	2001	2002
53,990	53,840	51,680	51,660	51,460	51,280	51,860	52,440

As noted above, both actual births and projected births are declining or remaining relatively constant. However, actual births are declining at a faster rate than projected births. To be conservative, the neonatal projection is based on projected births for 2003 (52,800) rather than actual births for 1996 (51,105), since both are decreasing and the projection of neonatal bassinets is a small number. By applying this methodology to the 2003 projected births by race and Perinatal Regions, the following beds are required statewide when using the greater of the race variance and incidence of LBW births:

	2003 Projected Births			Beds	
Region	White	Non-White	TOTAL	Inten-sive	Inter-mediate
Greenville	7,000	1,860	8,860	10	43
Spartanburg	3,400	1,420	4,820	6	25
Greenwood	1,540	1,140	2,680	4	15
Richland	9,900	7,940	17,840	22	100
Florence	3,920	3,380	7,300	9	42
Charleston	6,300	5,000	11,300	14	63
TOTAL	32,060	20,740	52,800	65	288

Note: S.C. presently has 1.6 neonatal intensive care bassinets and 5.5 neonatal intermediate care bassinets per 1,000 births. If births decrease as projected, the number of bassinets per thousand births will increase.

A neonatal unit should have an average annual occupancy rate of 75%. Facilities providing neonatal services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Anderson, Greenville, Oconee, Pickens		
Baptist Medical Ctr Easley	0	4
Greenville Memorial Med Ctr	12	29
Anderson Area Medical Ctr	0	7
St. Francis Women's & Fam Hosp	0	4
SUBTOTAL	12	44
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Med Ctr	10	14
Mary Black Memorial Hospital	0	7
SUBTOTAL	10	21
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	40
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	5
Tuomey Regional Med Ctr	0	8
SUBTOTAL	25	109
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Saint Eugene Community	0	2
Marion County Medical Ctr	0	2
McLeod Regional Medical Ctr	12	28
Conway Hospital	0	2
Grand Strand Regional	0	2
Women's Ctr. of Carolinas	0	7
SUBTOTAL	12	43

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Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	5
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	10
Roper Hospital	0	5
SUBTOTAL	16	57
TOTAL	82	285

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 additional neonatal bassinets are derived from the preceding methodology.

Perinatal Region	INTENSIVE Exist-ing	Need	To Be Added (Excess)	INTERMEDIATE Exist-ing	Need	To Be Added (Excess)
Greenville	12	10	(2)	44	43	(1)
Spartanburg	10	6	(4)	21	25	4
Greenwood	7	4	(3)	11	15	4
Richland	25	22	(3)	109	100	(9)
Florence	12	9	(3)	43	42	(1)
Charleston	16	14	(2)	57	63	6
TOTAL	82	65	(17)	285	288	3

Based on the above information, it appears that the number of intermediate care bassinets should be increased in some areas; however, there may be existing intermediate care bassinets which have not been included in these totals and there may be some continuing care bassinets included as intermediate care bassinets. The number of intermediate care bassinets should be increased in Level II 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 Level III facilities in some areas of the State. In order to improve the availability of existing Level III 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 facilities occurred, then some of the

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overcrowding problems of the existing Level III units would be alleviated. The current reimbursement system should be evaluated to ensure that there is not a disincentive for back transport.

In some cases, the number of bassinets shown in the attached tables are under construction and have not come on line to date. It should be noted that some 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. The one intensive and three/four intermediate care bassinet ratio is only suggested and applies more to the regional or statewide aggregate than individual hospitals or counties. 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 intermediate care bassinets does not constitute Certificate of Need review criteria.

PET-EX004.0050

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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-1997. 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 1997 JARS

HOSPITAL	ICU Bassinets	ICU P.D.'s	ADC	Intermediate Bassinets	Intermediate P.D.'s	ADC
Anderson				7	0	
Greenville Memorial	12	3257	8.9	29	7848	21.5
St. Francis Women's				4	1174	3.2
Baptist Med Ctr Easley				2	0	
SUBTOTAL	12	3257	8.9	42	9022	24.7
Spartanburg	10	1934	5.3	6	3135	8.6
Mary Black				7	1259	3.4
SUBTOTAL	10	1934	5.3	13	4394	12.0
Self Memorial	7	899	2.5	11	2192	6.0
SUBTOTAL	7	899	2.5	11	2192	6.0
Richland Memorial	21	6961	19.1	38	8549	23.4
Lexington				20	1861	5.1
Piedmont				8	875	2.4
Springs				4	0	0
Baptist Medical Center	4	1046	2.9	16	4182	11.5
Tuomey				8	0	
Orangeburg				5	339	0.9
Aiken Regional				5	724	2.0
SUBTOTAL	25	8007	21.9	104	16530	45.3
Women's of Carolinas				7	230	0.6
McLeod	12	2094	5.7	28	4887	13.4
St. Eugene				2	217	0.6
Marion				2	0	0
Columbia Grand Strand				2	39	0.1
Conway				2	377	1.0
SUBTOTAL	12	2094	5.7	43	5750	14.7
Georgetown				5	0	0
MUSC	16	3143	8.6	22	4322	11.8
Roper				5	489	1.3
East Cooper				6	148	0.4
Columbia Trident				10	290	0.8
Bon Secours-St. Francis				4	167	0.5
Beaufort Memorial				5	52	0.1
SUBTOTAL	16	3143	8.6	57	5468	14.8
GRAND TOTAL	82	19334	53.0	270	43356	117.6

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 neonatal centers; however; there may be a need for additional Level III neonatal bassinets in the existing hospitals 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 do not outweigh the adverse affects caused by the duplication of this existing service.

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 1997. The percentage of whites with adequate prenatal care has increased from 66.4% to 79.4% over this period. The percentage of non-whites with adequate prenatal care has increased from 42.4% to 59.7% over this same period.

The following tables indicate the adequacy of prenatal care by level of care at birth by hospital for 1997. For example, of the Level III hospitals, Medical University Hospital had 36.72% of births from mothers that received inadequate prenatal care and Baptist Medical Center-Columbia had 1.54%.

PERCENTAGE OF LIVE BIRTHS BY ADEQUACY OF PRENATAL CARE
(Kessener Index)

Statewide–White

Kessner	1983	1985	1987	1989	1990	1991	1992	1993	1994	1995	1996	1997
Adequate	66.4	68.7	65.9	68.1	69.9	70.5	70.6	73.9	76.2	77.6	78.5	79.4
Intermediate	26.5	24.6	25.7	24.2	23.3	22.4	22.8	20.4	18.6	17.8	16.9	15.7
Inadequate	7.1	6.6	8.4	7.7	6.8	7.1	6.6	5.6	5.2	4.6	4.6	4.9
Total	100	100	100	100	100	100	100	100	100	100	100	100

Statewide–Black and Others

Kessner	1983	1985	1987	1989	1990	1991	1992	1993	1994	1995	1996	1997
Adequate	42.4	44.1	40.6	40.6	43.5	44.1	43.2	48.9	53.7	57.1	58.6	59.7
Intermediate	39.9	37.5	38.0	38.3	37.4	37.2	37.9	34.8	31.9	30.1	29.2	26.6
Inadequate	17.8	18.4	21.3	21.2	19.2	18.7	18.9	16.3	14.4	12.8	12.2	13.8
Total	100	100	100	100	100	100	100	100	100	100	100	100

Source: S.C. Perinatal Regionalization Surveillance (Vol I) 1997

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PET-EX004:0053

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
EDGEFIELD CTY. HOSP	0.00	0.00	100.00	0.00	1	0	0	1	0
WJ BARGE MEM. HOSPITAL	0.00	9.09	87.88	3.03	33	0	3	29	1
20TH MEDICAL GROUP	0.28	6.16	89.64	3.92	357	1	22	320	14
US NAVAL-BEAUFORT	0.87	13.51	83.66	1.96	459	4	62	384	9
HILTON HEAD HOSPITAL	1.61	9.14	86.02	3.23	372	6	34	320	12
SUMMERVILLE MEDICAL CENTER	1.63	9.53	88.84	0.00	430	7	41	382	0
ABBEVILLE CTY. MEMORIAL	2.91	31.07	66.02	0.00	103	3	32	68	0
ALLEN BENNETT MEM. HOSP.	3.58	12.67	83.75	0.00	363	13	46	304	0
OCONEE MEM. HOSPITAL	4.14	15.86	79.14	0.86	580	24	92	459	5
KERSHAW CTY. MEMORIAL	4.22	14.46	80.12	1.20	332	14	48	266	4
UPSTATE CAROLINA MED.CTR.	4.29	17.48	75.15	3.07	326	14	57	245	10
BAMBERG CTY. MEM. HOSP.	5.15	16.49	75.26	3.09	97	5	16	73	3
BYERLY HOSPITAL	6.04	17.23	71.05	5.68	563	34	97	400	32
MARLBORO PARK HOSPITAL	6.15	21.03	69.23	3.59	195	12	41	135	7
LAURENS CTY. HOSPITAL	7.06	25.55	66.18	1.22	411	29	105	272	5
CHESTERFIELD GEN. HOSP	8.75	26.62	63.88	0.76	263	23	70	168	2
WALLACE THOMSON HOSP	9.14	33.14	56.00	1.71	175	16	58	98	3
CHESTER CTY. HOSPITAL	10.57	28.05	59.76	1.63	246	26	69	147	4
COLLETON REGIONAL HOSP	10.85	22.22	65.89	1.03	387	42	86	255	4
CLARENDON MEM. HOSPITAL	11.53	20.34	64.75	3.39	295	34	60	191	10
LOW COUNTRY GENERAL	13.16	42.11	38.16	6.58	76	10	32	29	5
LORIS COMM. HOSPITAL	13.18	21.19	64.34	1.29	387	51	82	249	5
NEWBERRY CTY. MEM.HOSP	14.54	33.48	49.34	2.64	227	33	76	112	6
CAR. HOSP SYS--KINGSTREE	17.58	23.08	53.85	5.49	182	32	42	98	10
ALLENDALE CTY. HOSPITAL	19.25	45.45	35.29	0.00	187	36	85	66	0
HAMPTON GENERAL HOSP	25.00	50.00	25.00	0.00	4	1	2	1	0
ROPER BERKELEY CENTER	66.67	0.00	33.33	0.00	3	2	0	1	0
FAIRFIELD MEM. HOSPITAL	100.00	0.00	0.00	0.00	1	1	0	0	0
CANNON MEM. HOSPITAL	100.00	0.00	0.00	0.00	1	1	0	0	0

Source: S.C. Perinatal Regionalization Surveillance (Vol II) 1997

RECORD 003284

PET-EX004.0054

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 COMM.HOSP	0.91	15.72	71.60	11.77	1215	11	191	870	143
ST FRANCIS WOMENS HOSP.	0.95	11.33	87.55	0.17	1783	17	202	1561	3
ST. FRANCIS XAVIER	1.97	8.01	88.90	1.11	811	16	65	721	9
MARY BLACK MEM. HOSPITAL	2.05	12.20	84.36	1.39	1221	25	149	1030	17
BAPTIST MED-EASLEY	2.83	16.39	78.69	2.09	671	19	110	528	14
TRIDENT REGIONAL MED.CTR.	3.23	15.98	80.53	0.26	1952	63	312	1572	5
ROPER HOSPITAL	3.72	19.70	74.93	1.65	1396	52	275	1046	23
ANDERSON AREA MED CTR	3.79	9.97	85.97	0.27	1846	70	184	1587	5
ELLIOTT WHITE SPRINGS	4.32	20.64	75.04	0.00	625	27	129	469	0
WOMEN CEN/CAR.HOSP. SYS	5.47	25.36	67.46	1.71	1171	64	297	790	20
CONWAY HOSPITAL	6.58	23.28	69.00	1.15	958	63	223	661	11
MARION MEM. HOSPITAL	8.01	22.07	69.73	0.20	512	41	113	357	1
REGIONAL MEDICAL CENTER	8.12	15.80	76.08	0.00	1367	111	216	1040	0
LEXINGTON MED. CTR.HOSP	8.32	20.39	71.29	0.00	2271	189	463	1619	0
PIEDMONT MED CTR	8.60	31.32	59.92	0.15	1325	114	415	794	2
HCA AIKEN REGIONAL MED.CTR.	10.67	23.50	52.65	13.18	1153	123	271	607	152
GRAND STRAND GENL. HOSP	11.37	18.07	66.82	3.74	642	73	116	429	24
TUOMEY REGIONAL MED CTR.	11.40	29.74	58.13	0.72	1254	143	373	729	9
BEAUFORT CTY. MEM. HOSP.	13.07	23.76	62.31	0.86	926	121	220	577	8
GEORGETOWN MEM. HOSPITAL	13.14	24.80	61.11	0.95	738	97	183	451	7
ST EUGENE COMM. HOSP	15.22	28.03	46.71	10.03	289	44	81	135	29

Source: S.C. Perinatal Regionalization Surveillance (Vol II) 1997

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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
BAPTIST MED-COLUMBIA	1.54	7.79	90.57	0.10	3118	48	243	2824	3
GREENVILLE HOSP. CENTER	5.32	20.20	69.20	5.28	4510	240	911	3121	238
SPARTANBURG REGIONAL MED.CTR	5.99	27.83	66.14	0.04	2271	136	632	1502	1
MCLEOD REGIONAL MED.CTR.	8.96	16.09	68.91	6.04	2020	181	325	1392	122
SELF MEMORIAL HOSPITAL	9.96	20.72	62.65	6.66	1636	163	339	1025	109
RICHLAND MEM. HOSPITAL	18.16	30.45	50.11	1.27	3061	556	932	1534	39
MEDICAL UNIV HOSP	36.72	20.00	42.63	0.66	1980	727	396	844	13

Source: S.C. Perinatal Regionalization Surveillance (Vol II) 1997

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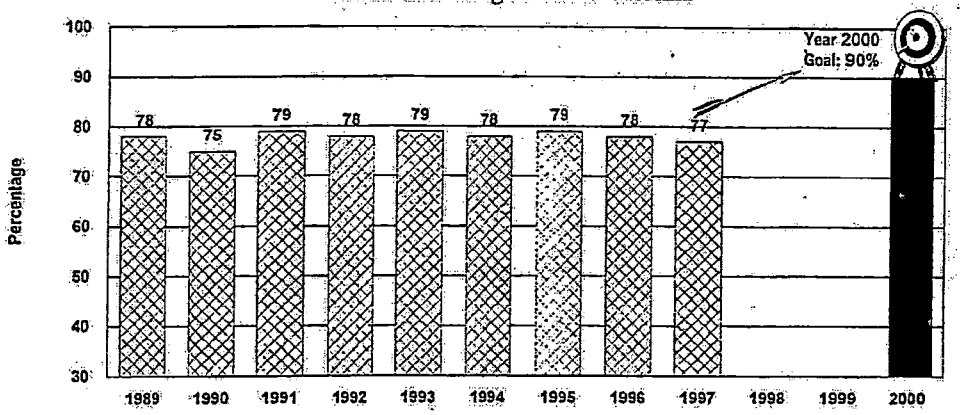
PET-EX004.0056

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 Level 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.

Percentages of VLBW Infants Delivered in Level III Hospitals
-- Births Occurring in South Carolina



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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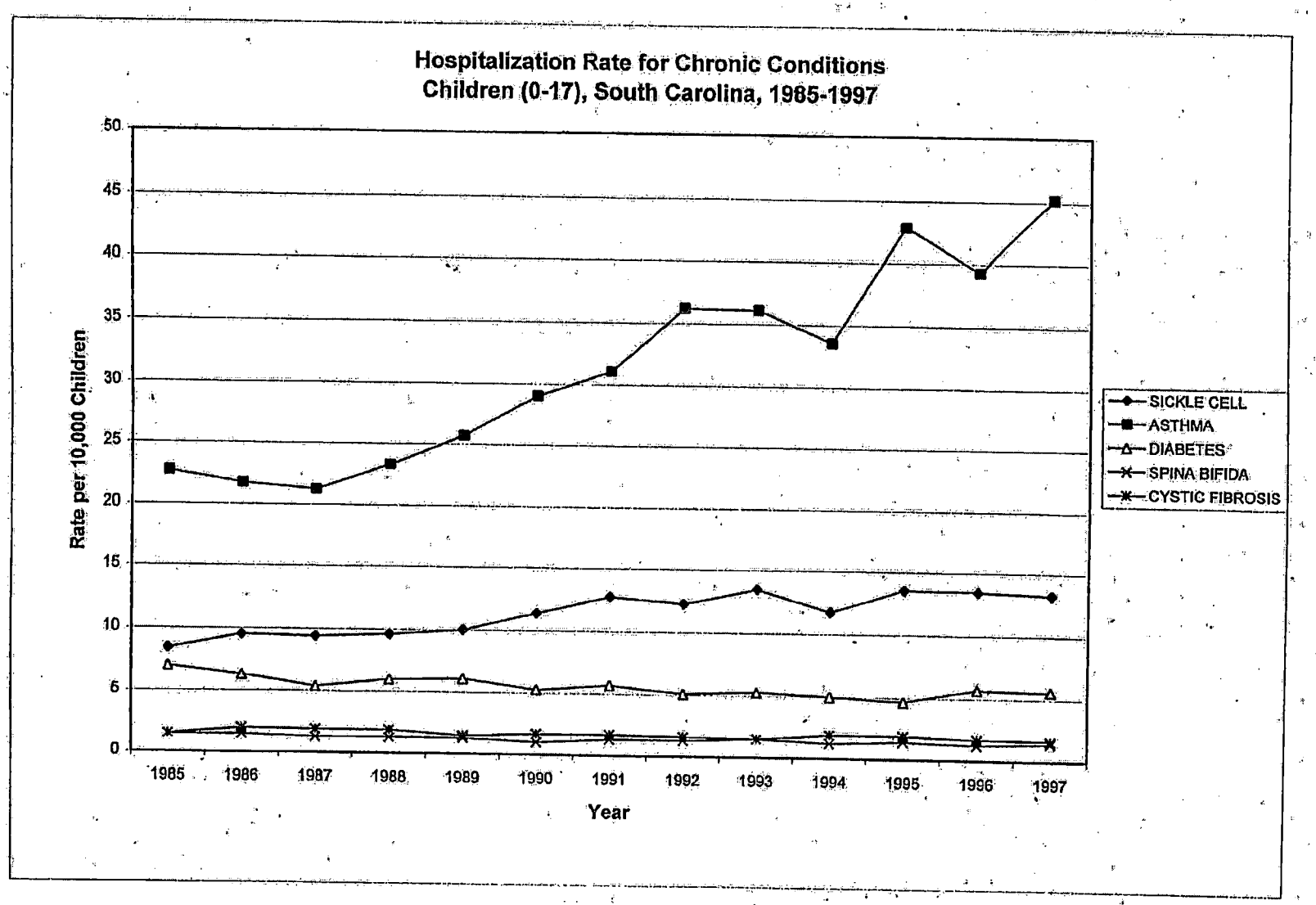


Source: Hospital Discharge Data System

RECORD 003289

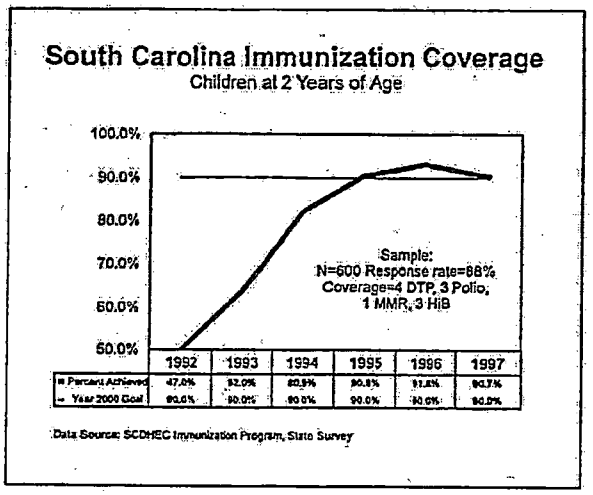
PET-EX004.0059

CHILDHOOD IMMUNIZATION RATE

Immunization is the most powerful and cost-effective method of preventing many formerly fatal or crippling childhood diseases such as measles and polio.

State Data -

In April, 1993, only 62% of South Carolina's children were fully immunized by age 2. The most serious vaccine-preventable diseases such as measles and polio can exist in a population of children until about 90 percent are immunized. Above 90 percent, children develop "group immunity." When a 90 percent immunization level is achieved, the disease can virtually be eliminated in the given population. South Carolina has set a goal of achieve "group immunity" for all vaccine-preventable diseases. A goal of 80 percent was set for April 1994, with 90 percent to be attained by 1995. With the efforts of a statewide campaign and many coalitions working together, these efforts were achieved and have been maintained.



National Data -

The National Immunization Survey (NIS) is a continuing survey that provides national estimates of vaccination coverage among children aged 19-35 months based on data for the most recent 12 months for each of the 50 states, the District of Columbia. CDC initiated this effort in April 1994 to monitor vaccination coverage levels as part of the Childhood Immunization Initiative (CII), a national strategeg y to ensure high vaccination coverage of children during the first 2 years of life. For this reporting period, July 1996-June 1997, the NIS included children born during August 1993-November 1995, with a median age of 27 months. The report indicates that vaccination levels among U.S. children aged 19-35 months remain the highest ever recorded.

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The following table is the estimated vaccination coverage and the 4:3:1:3 series* among children aged 19 - 35 months by coverage level and state. - United States National Immunization Survey, July 1996 - 1997 (Children in this period were born August 1993 - November 1995).

>=85%

Connecticut	88%
Maine	85%
Massachusetts	86%

75%-84%

Alabama	78%
Arkansas	75%
California	75%
Delaware	79%
Florida	77%
Georgia	80%
Hawaii	80%
Illinois	76%
Iowa	80%
Kansas	77%
Kentucky	77%
Louisiana	82%
Maryland	78%
Minnesota	83%
Mississippi	71%
Montana	88%
Nebraska	78%
New Hampshire	82%
New Mexico	75%
North Carolina	80%
North Dakota	80%
Ohio	75%
Pennsylvania	82%
Rhode Island	81%
South Carolina	82%
South Dakota	77%
Tennessee	78%
Vermont	84%
Virginia	75%
Washington	81%
West Virginia	80%
Wisconsin	79%

65%-76%

Alaska	72%
Arizona	69%
Colorado	73%
Idaho	67%
Indiana	71%
Michigan	73%
Missouri	74%
Nevada	70%
New Jersey	73%
New York	74%
Oklahoma	69%
Oregon	72%
Texas	72%
Utah	68%
Wyoming	74%

US Total	**76%**

*Four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of *Haemophilus influenzae* type b vaccine (Hib).

Data Source: National Immunization Survey, CDC

The national immunization survey ranks South Carolina fifth at 82%, with only five states having higher ratings. South Carolina uses a more current methodology than is employed by the national immunization survey, and continues to rise above the standards.

(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. They accounted for more than 40% of all deaths in the United States in 1995. The total death rate for all cardiovascular diseases in South Carolina was the second highest in the country, at 326.1 deaths per 100,000 people in 1995. Only Mississippi had a higher total death rate.

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. 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}.

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.

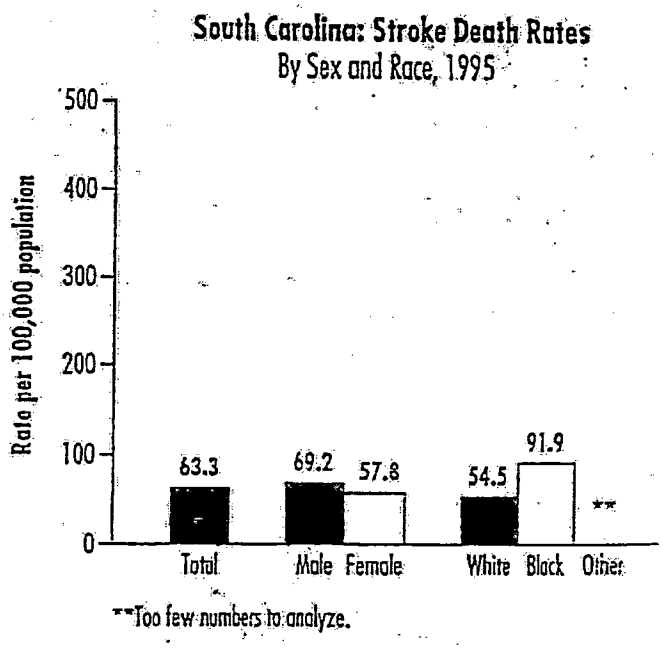
In 1995, South Carolina had the seventh highest mortality rate due to ischemic heart disease. Among southern states, only Tennessee had a higher death rate. The highest death rate per 100,000 population was found among white males; white females had the lowest rate.

South Carolina: Ischemic Heart Disease Death Rates
By Sex and Race, 1995

**Too few numbers to analyze.

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. Like in the case of 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. In 1995, South Carolina had by far the highest death rate for stroke in the country, at 63.3 deaths per 100,000 population. The second highest state, Tennessee, only recorded 56.0 deaths per 100,000 while New York was the lowest at 30.6. The highest rate in South Carolina was for black females at 91.9 deaths per 100,000. The lowest rate in South Carolina, for white females at 57.8 deaths per 100,000 population, was still higher than the state rates for all but four states. 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. In 1996, 24.5% of South Carolinians smoked, the 21st highest rate in the country. The national median was 23.5%.

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 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; in South Carolina in 1996, 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%.

In 1996, South Carolina had the highest percentage of overweight adults in the country, at a prevalence of 34.4% of the population. People who are seriously overweight are 3 times as likely to have coronary artery disease as people of normal weight. 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. In 1995, South Carolina had the 4th highest death rate in the country from diabetes at 24.7 deaths per 100,000.

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 with cardiac risk factors. 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 many 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. High blood pressure and cholesterol levels are declining due to earlier and increased screening, detection and management. Cigarette smoking rates have also decreased.

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.

The most common form of therapeutic catheterization is Percutaneous Transluminal Coronary Angioplasty (PTCA), 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. 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. Metallic wires 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. Stenting has been successful in 95-98% of patients, with emergency bypass surgery being required for fewer than 1%. There are also

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suggestions that the re-stenosis rate for coronary stenting may be lower than that after PTCA. However, there is a risk of blood clots, which form in 1-2% of patients, which can cause a heart attack. Therefore, 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 relatively 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 cases per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery cases 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 number of diagnostic cardiac catheterizations performed in South Carolina tripled in the time period from 1987-1997, increasing from 10,565 in 1987 to 34,946 in 1997. The average annual increase was 13.2% over this time period. The use of therapeutic catheterizations increased almost five-fold during this same time period, rising from 1,836 in 1987 to 8,908 in 1997. This represents an 17.7% average annual increase. Overall, total catheterizations increased from approximately 12,400 to 43,854 during this time period

A factor aiding the increasing number of catheterizations being performed is the number of laboratories in operation in the state. The number of cath labs in South Carolina has more than doubled from 1987-1997 and additional laboratories will be coming on-line. However, despite the increased number of laboratories in operation, they are being more efficiently utilized now than in the past. In 1987, the 18 existing cath labs averaged 791 cardiac equivalents per year; in 1997, the 43 labs in operation averaged 1,217 equivalents. There are at least 6 providers in each inventory region of the state, insuring geographic accessibility.

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 1997, there were 22 hospitals providing cardiac catheterization services in South Carolina. Of these, 17 were exceeding the minimum of 600 equivalents per lab and 13 were averaging more than 1,000 equivalents. Two of the facilities below the minimum, Mary Black Memorial and Georgetown Regional, recently converted from mobile to fixed cath labs and are still within the established time period following initiation of service. Self Memorial's utilization increased from 199 procedures in 1996 to 477 in 1997; likewise, Tuomey Regional's 1997 utilization of 453 was an increase over the 390 performed in 1996. Palmetto Baptist's 1997 utilization was 476 procedures, a decrease from the 491 catheterizations performed in 1996.

There are currently 15 open heart surgery programs approved in South Carolina, although 2 programs are not yet operational and 2 other programs have only recently initiated services.. 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. Of the 11 operational programs, 10 performed at least the minimum number. The only facility which did not was Piedmont Medical Center, which only initiated services in July 1997. It will be several years before Piedmont's compliance with this minimum compliance standard can be measured.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The State Health Plan Certificate of Need 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. 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 1997, 17 of the 20 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 approximately doubled in the time period of 1987-1997, from 2,787 in 1987 to 5,662 in 1997. The average annual growth was 7.6%.

From 1987-1995, there were 8 facilities providing open heart surgery in South Carolina. Grand Strand Regional initiated their program in 1995, Aiken Regional began in 1996, Piedmont Regional in 1997, and Carolinas Regional and St. Francis in 1999. Anderson Area and Self Memorial have received CON approval but have yet to begin performing open heart surgery. Because these 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 8 established programs in South Carolina.

In spite of the increased number of open heart surgeries performed, additional capacity remains in most programs in the state. The 8 established programs had a total of 19 open heart surgery suites in operation in 1997. With a stated capacity of 500 procedures per suite, the statewide capacity was 9,5000 cases. A total of 5,320 open heart surgeries were actually performed in these suites, giving an average utilization rate of 56.0%. This was an increase from the 1996 rate of 50.9%. The state average was 280.0 cases per suite, compared to the 1996 average of 254.5 cases 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.

Published studies indicate that hospitals that perform a minimum of 350 cases annually tend to have better outcomes than those that perform fewer cases. In 1997, 7 of the 8 established programs performed more than 350 total cases; Greenville Memorial and Providence Hospital both performed over 1,000 open heart surgeries. Trident Regional performed 206 open heart surgeries in 1997.

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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.

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.

"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.

"Directional Coronary Atherectomy (DCA)" is a therapeutic procedure that uses a cup-shaped cutting blade housed in the cylinder with a narrow window within a catheter. The opening is turned toward the plaque, and the balloon is inflated to force the plaque into the window and activating the cutting blade.

"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), acting to break up a blood clot that obstructs a blood vessel of the heart.

STANDARDS

(1) Because of the low utilization in this State of existing mobile cardiac catheterization laboratories, no additional mobile cardiac catheterization laboratories will be approved.

(2) Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PTCA and other therapeutic procedures, 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 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

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RECORD 003301

veins of the heart, or abnormalities in the heart structure, shall not be allowed to perform PTCA and other therapeutic procedures.

(3) The capacity of a 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.

(4) 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.

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

A. all existing labs in the service area have performed at a combined use rate of 80 percent 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.

(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 percent of capacity 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) 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; 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 services.

(8) Expansion of an existing comprehensive cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum of 600 diagnostic 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.

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RECORD 003302

(9) 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 percent 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.

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

(11) 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.

(12) 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.

(13) 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.

(14) 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 will be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

SCOPE OF SERVICES

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

A. 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.

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

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

PET-EX004.0074

RECORD 003304

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

D. 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 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 is recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

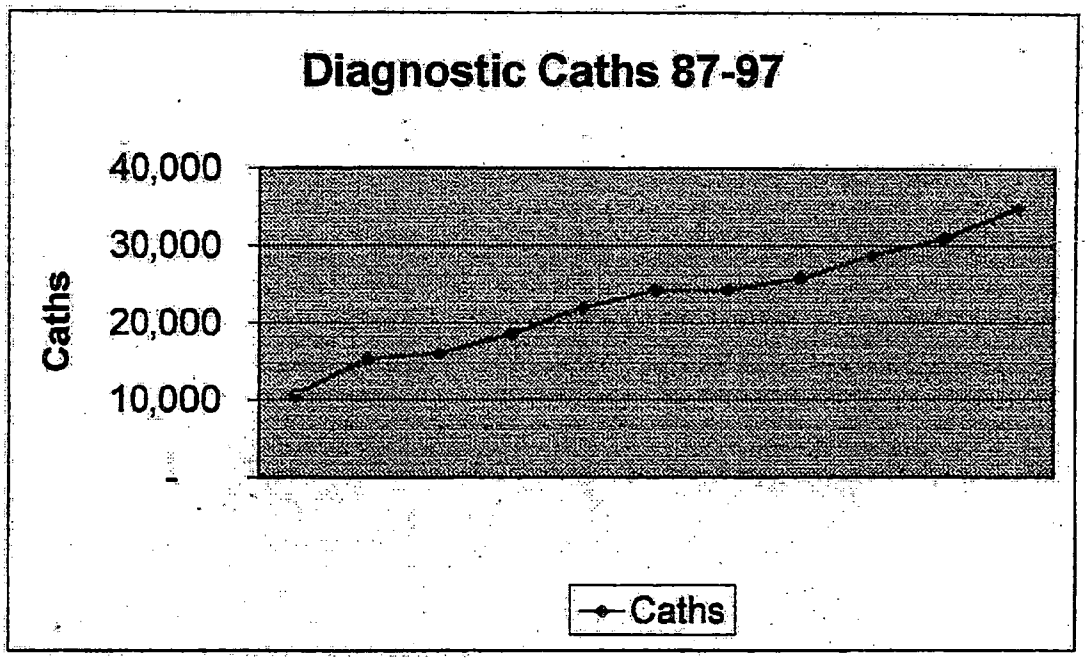
The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

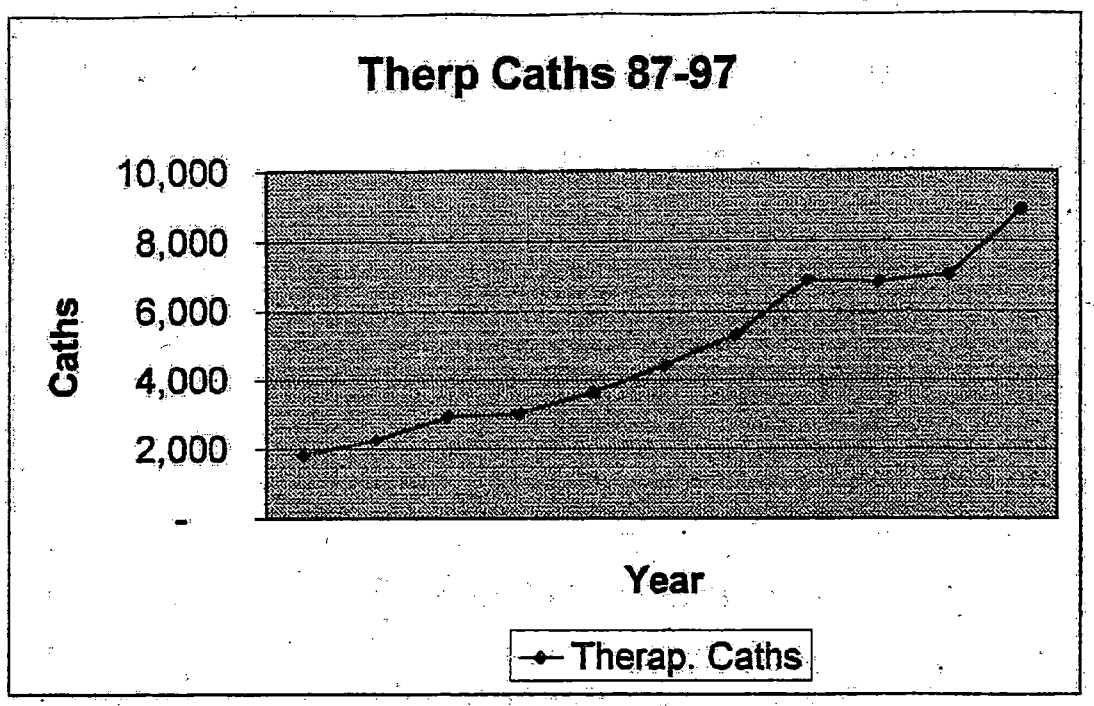
PET-EX004.0076

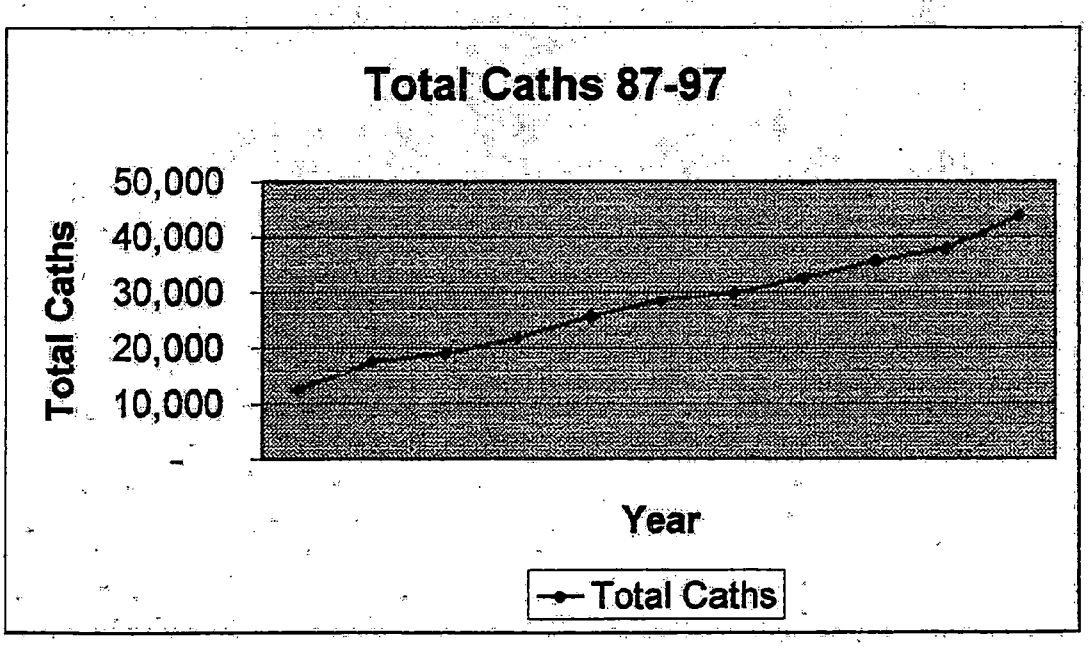
RECORD 003306

DIAGNOSTIC, THERAPEUTIC AND TOTAL CARDIAC CATHETERIZATIONS
SOUTH CAROLINA, 1987 - 1997

YEAR	DIAG.	THERAP.	TOTAL
1987	10,565	1,836	12,401
1988	15,253	2,263	17,516
1989	15,974	2,948	18,922
1990	18,561	3,016	21,577
1991	21,961	3,648	25,609
1992	24,217	4,404	28,621
1993	24,333	5,317	29,650
1994	25,729	6,864	32,593
1995	28,755	6,810	35,565
1996	30,942	7,038	37,980
1997	34,946	8,908	43,854




Therp Caths 87-97
10,000
8,000
6,000
4,000
2,000
-
Caths
Year
Therap. Caths


Total Caths 87-97
50,000
40,000
30,000
20,000
10,000
-
Total Caths
Year
Total Caths

CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	# CATH LABS	FY96 PEDS	FY96 ADULTS: DIAG	FY96 ADULTS: THERP	FY96 ADULTS: TOTAL	FY97 PEDS	FY97 ADULTS: DIAG	FY97 ADULTS: THERP	FY97 ADULTS: TOTAL	FY98 PEDS	FY98 ADULTS: DIAG	FY98 ADULTS: THERP	FY98 ADULTS: TOTAL	FY98 PEDS
I														
ANDERSON AREA MED CTR #16	3		2424		2424		2178		2178		2526		2526	
GREENVILLE MEM MED CTR #8	7		3826	1478	5304		4287	1619	5906		4192	1865	6057	
MARY BLACK MEM #6	1				0		108		108		92		92	
OCONEE MEM HOSP #5	1		46		46				0		888		888	
PALMETTO BAPTIST MED CTR-EASLEY #13	1													
SPARTANBURG REG MED CTR	3		2478	643	3121		2500	704	3204		2758	495	3253	
ST FRANCIS COMM #9	2		686		686		793		793		857		857	
UPSTATE CAROLINA MED CTR	MOBILE		7		7				0				0	
			9467	2121	11588		9866	2323	12189		11111	2360	13471	
II														
PALMETTO BAPTIST MED CTR-COLA	1		491		491		476		476		445		445	
SPRINGS MEM	MOBILE		111		111		178		178		252		252	
PROVIDENCE HOSPITAL	5		3270	1238	4508		3868	1210	5078		3541	1384	4925	
PIEDMONT MEDICAL CTR	2		1159	30	1189		2080	19	2079		2172	718	2890	
PALMETTO RICHLAND MEM HOSP #17	4		1897	482	2379		2080	755	2835		2264	951	3215	
WJB DORN (VA)	1		503	24	527				0				0	
SELF MEM HOSP #15	2		199		199		477		477		462		462	
CARDIOVASCULAR ASSOC #1	2				0				0				0	
			7630	1774	9404		9137	1984	11121		9136	3053	12189	
III														
CAROLINA PINES REG MED CTR #12	MOBILE				0									
CAROLINAS HOSP SYS #2	2		816		816		1251		1251		1167		1167	
CONWAY HOSP #14	1		144		144		193		193		428		428	
GEORGETOWN MEM HOSP #4	1		142		142		149		149		357		357	
GRAND STRAND REG MED CTR #7	2		829	158	987		832	338	1170		821	446	1267	
MCLEOD REG MED CTR #10	4		3149	987	4136		2972	1081	4053		3476	1224	4700	
MARION CO MED CTR	MOBILE				0				0		0		0	
(MULLINS HOSP)	(MOBILE)				0				0				0	
ST EUGENE MEDICAL CTR	MOBILE		36		36		44		44		51		51	
TUOMEY REG MED CTR	1		390		390		453		453		685		685	
			5506	1145	6651		5894	1419	7313		6985	1670	8655	

RECORD 003309

PET-EX004.0079

CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	# CATH LABS	FY96 PEDS	FY96 ADULTS: DIAG	FY96 ADULTS: THERP	FY96 ADULTS: TOTAL	FY97 PEDS	FY97 ADULTS: DIAG	FY97 ADULTS: THERP	FY97 ADULTS: TOTAL	FY98 PEDS	FY98 ADULTS: DIAG	FY98 ADULTS: THERP	FY98 ADULTS: TOTAL	FY98 PEDS
IV														
HILTON HEAD HOSP #3	1		734		734		887		887		720		720	
COLLETON REG HOSP	MOBILE				0				0				0	
EAST COOPER REG MED CTR	MOBILE				0				0				0	
MEDICAL UNIV HOSP	3	951	2116	558	2676	982	2102	883	2986	816	2535	1775	4310	862
ROPER HOSP #11	3		2672	680	3352		2656	671	3327		2978	815	3793	
TRIDENT MED CTR	2		1089	328	1417		1206	517	1723		1205	457	1683	
RH JOHNSON (VA)	1		177	167	344				0				0	
BON SECOURS ST. FRANCIS XAVIER	1		981		901		1212		1212		1962	33	1995	
RMC ORANGEBURG-CALHOUN	1		712		712		728		728		713		713	
AIKEN REG MED CTR	1		746	333	1079		1258	1111	2369		1539	1635	3174	
			9229	2066	11295		10049	3182	13231		11653	4715	16368	
TOTAL			31832	7106	38938		34946	8908	43854		38885	11798	50683	

#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
#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. APPROVED FOR 7TH CATH, 11/2/99.
#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.
#13 CON ISSUED FOR FIXED CATH, 6/16/99.
#14 CON TO REPLACE MOBILE W/ FIXED,6/21/99
#15 CON FOR 2ND CATH, 9/2/99.
#16 APP FOR 3RD CATH, 10/14/99.

RECORD 003310

PET-EX004.0080

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 which requires the temporary use of a heart-lung bypass machine to perform the functions of circulation during surgery. 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

PET-EX004.0081

RECORD 003311

35.81 Total repair of tetralogy of Fallot
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 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
(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 cases 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 cases annually).

(4) There should be a minimum of 200 adult open heart surgery cases 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 cases 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 cases 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.

B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery cases annually per open heart surgery unit, within three years after initiation. The standard for pediatric open heart surgery shall be 100 cases 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 cases or 130 pediatric cases 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 cases 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 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 procedures 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 or laboratories in which therapeutic catheterizations will be performed in or 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.

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 cases 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:

PET-EX004.0086

RECORD 003316

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

(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; and

(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.

(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.

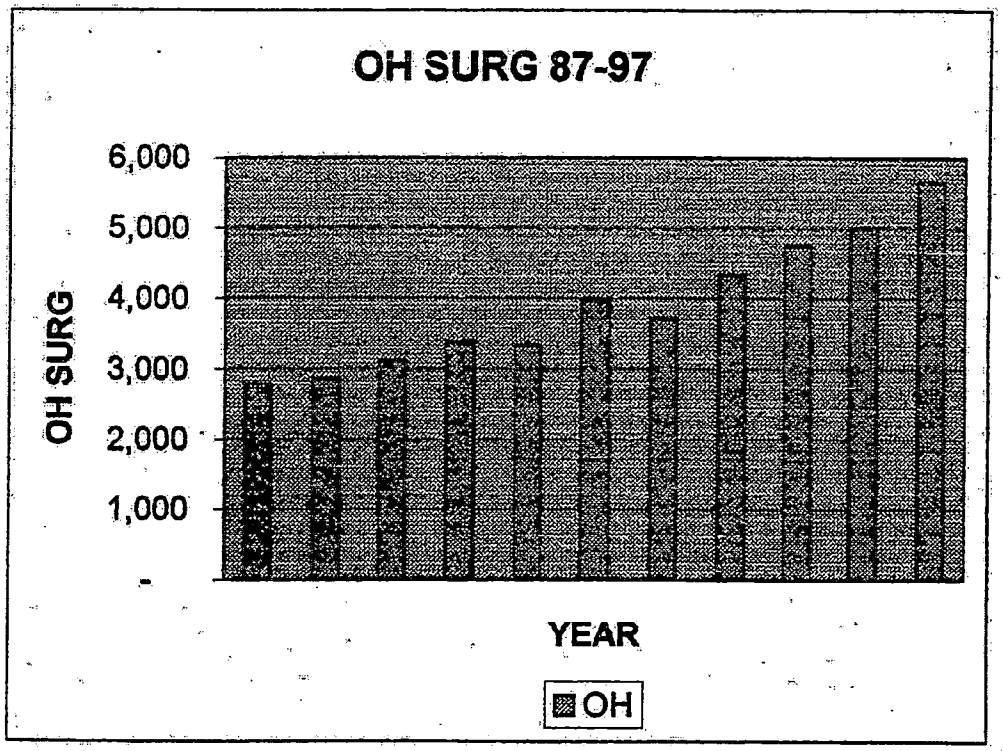
The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PET-EX004.0087

RECORD 003317

OPEN HEART SURGERIES IN SOUTH CAROLINA, 1987-1997

YEAR	OPEN HEART SURGERIES
1987	2,787
1988	2,864
1989	3,117
1990	3,385
1991	3,338
1992	3,963
1993	3,719
1994	4,335
1995	4,750
1996	4,988
1997	5,662



REGION/FACILITY	# OPEN HEART UNITS	FY96 ADULTS	FY96 PEDS	FY97 ADULTS	FY97 PEDS	FY98 ADULTS	FY98 PEDS
I							
ANDERSON AREA MED CTR #7	2						
GREENVILLE MEM MED CTR	5	1284		1404		1463	
ST FRANCIS HOSPITAL #4	2						
SPARTANBURG REG MED CTR	2	460		493		503	
II							
PIEDMONT MED CTR #2	2					188	
PROVIDENCE HOSPITAL	4	1090		1065		1136	
PALMETTO RICHLAND MEM HOSP	2	398		414		464	
SELF MEMORIAL HOSPITAL #6	2						
III							
CAROLINAS HOSPITAL SYSTEM #5	2						
MCLEOD REG MED CTR #6	3	560		608		765	
GRAND STRAND REG MED CTR #1	2	153		201		231	
IV							
AIKEN REG MED CTR #3	1	44		142		144	
MEDICAL UNIV HOSP	3	391	159	464	171	460	159
ROPER HOSP	1	452		665		491	
TRIDENT REG MED CTR	1	200		206		147	
VA(CHARLESTON)	1	142					
		5174		5662		5992	

#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

(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

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

PET-EX004.0091

RECORD 003321

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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5-YEAR CANCER SURVIVAL RATE BY LOCATION AND STAGE

CANCER	OVERALL RATE	LOCAL	REGIONAL	DISTANT
Female Breast	84%	97%	76%	21%
Cervix (Uterus)	69%	91%	49%	9%
Colon	62%	93%	67%	8%
Endometrium (Uterus)	84%	96%	66%	27%
Esophagus	11%	23%	10%	2%
Kidney	59%	88%	60%	9%
Larynx	67%	85%	55%	42%
Liver	6%	13%	7%	2%
Lung	14%	49%	18%	2%
Melanoma	88%	95%	61%	16%
Oral Cavity	53%	81%	42%	18%
Ovary	46%	93%	55%	25%
Pancreas	4%	15%	5%	2%
Prostate	89%	100%	94%	31%
Rectum	60%	88%	55%	5%
Stomach	21%	61%	23%	2%
Testes	95%	99%	97%	72%
Thyroid	95%	100%	94%	45%
Urinary Bladder	81%	94%	49%	6%

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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.

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;

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.

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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; 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 44 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 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 21 facilities operating a total of 40 linear accelerators in South Carolina. Of these, 5 were not in operation in 1998. This analysis will focus on the 35 accelerators in operation in 1998.

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 1998, the 35 existing accelerators averaged 5,772 treatments per unit (82% of overall capacity). The utilization for each provider per linear accelerator was as follows:

Provider	# Accelerators	Treatments/ Accelerator
Trident Regional	1	9,306
Greenville Radiation Care	1	9,243
Rock Hill Radiation	1	8,741
Lexington Med. Ctr.	1	7,399
Greenville Memorial Hosp.	3	6,762
RMC-Orangeburg/Calhoun	1	6,474
Roper Hospital	2	6,299
Beaufort-Hilton Head	1	6,218
Self Memorial	1	6,141
Palmetto Baptist	2	6,140
Myrtle Beach Radiation	2	6,050
Anderson Area Med. Ctr.	2	5,868
McLeod Regional	4	4,992
Palmetto Richland Memorial	4	4,666
Spartanburg Regional	3	4,664
Aiken Regional	1	4,635
MUSC	3	4,591
Tuomey Regional	2	4,234

2. GAMMA KNIFES

Palmetto Richland Memorial received a CON for a gamma knife on March 18, 1997. A total of 110 people had received treatment since it became operational in November, 1998.

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

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;

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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RECORD 003330

MEGAVOLTAGE VISITS

REGION	# UNITS	FY1995	FY1996	FY1997	FY1998
I					
ANDERSON AREA MED CTR #5					
COBALT 60	1	3251	3559	3493	764
LINEAR ACCELERATOR	2	10488	8971	9210	11735
EASTSIDE CANCER TREATMENT CTR #3					
LINEAR ACCELERATOR	1				
CANCER CENTERS OF THE CAROLINAS #4					
EASTSIDE					
LINEAR ACCELERATOR	1				
GREENVILLE MEM MED CTR:					
LINEAR ACCELERATORS	3	20723	21638	22646	20287
GREENVILLE RADIATION CARE					
LINEAR ACCELERATOR	1	6534	7276	5300	9243
SPARTANBURG REG MED CTR:					
LINEAR ACCELERATORS	3	14752	14501	15477	13992
II					
PALMETTO BAPTIST MED CTR COLA:					
LINEAR ACCELERATORS	2	6439	11003	12107	12280
LEXINGTON MED CTR: #7					
LINEAR ACCELERATOR	2	5161	5344	5608	7399
PALMETTO RICHLAND MEMORIAL HOSP:					
LINEAR ACCELERATORS	4	11626	15778	18026	18662
SELF MEMORIAL:					
LINEAR ACCELERATOR	1	4301	5285	5079	6141
ROCK HILL RADIATION THERAPY CT:					
LINEAR ACCELERATOR #1	2	8966	7877	8807	8741
III					
CAROLINAS HOSP SYS #2	1				
MCLEOD REGIONAL:					
LINEAR ACCELERATORS	4	18046	16686	20753	19968
MYRTLE BEACH RADIATION:					
THERAPY CENTER					
LINEAR ACCELERATORS	2	10771	11822	13082	12100
TUOMEY REG MED CTR					
LINEAR ACCELERATOR	2	7255	8292	8727	8467

MEGAVOLTAGE VISITS

REGION	# UNITS	FY1995	FY1996	FY1997	FY1998
IV					
MEDICAL UNIVERSITY: LINEAR ACCELERATORS	3	12765	14579	12932	13773
ROPER: LINEAR ACCELERATOR	2	11143	11917	11216	12597
TRIDENT MED CTR: #6 LINEAR ACCELERATOR	2	6698	7655	9246	9306
REG MED CTR ORANGEBURG/CALHOUN LINEAR ACCELERATOR	1	5082	5444	5078	6474
BEAUFORT/HILTON HEAD RADIATION ONCOLOGY CTR LINEAR ACCELERATOR	1	4137	4683	5083	6218
AKIEN REG MED CTR	1	4209	3381	3984	4635

#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 , 10/27/99.

LINEAR ACCELERATORS 1999 STATE HEALTH PLAN

SERVICE AREAS	1998 POPULATION	# OF LIN. ACC.	POP/ LIN. ACC.	TOTAL AREA TREATMENTS	TREATMENTS/ LIN. ACC.	PLANNING AREA CAPACITY
ANDERSON,OCONEE	223,000	2	111,500	11,735	5,868	14,000
GREENVILLE,PICKENS	460,100	6	76,683	29,530	4,922	42,000
CHEROKEE,SPARTANBURG UNION	327,600	3	109,200	13,992	4,664	21,000
CHESTER,LANCASTER,YORK	244,500	2	122,250	8,741	4,371	14,000
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	196,300	1	196,300	6,141	6,141	7,000
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	618,600	7	88,371	38,341	5,477	49,000
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	327,400	5	65,480	19,968	3,994	35,000
CLARENDON,LEE,SUMTER	160,400	2	80,200	8,467	4,234	14,000
GEORGETOWN,HORRY WILLIAMSBURG	261,800	2	130,900	12,100	6,050	14,000
BAMBERG,CALHOUN ORANGEBURG	120,300	1	120,300	6,474	6,474	7,000
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	187,500	1	187,500	6,218	6,218	7,000
BERKELEY,CHARLESTON DORCHESTER	532,500	7	76,071	35,676	5,097	49,000
AIKEN,BARNWELL	163,100	1	163,100	4,635	4,635	7,000
STATE TOTAL	3,823,100	40	95,578	202,018	5,050	280,000

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

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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RECORD 003335

(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 withing the external magnetic field. The result is a two-dimensional pictures 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 an "open" design have been developed to alleviate these concerns.

A table follows listing the facilities which have either received Certificate of Need approval or have been exempted from review for MRI units. Utilization data are from the 1997 Joint Annual Reports. This information is current as of November 1, 1999.

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.

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.

MRI SCANS

COUNTY	FACILITY	TYPE	FY97 CON SCANS	FY98 CON SCANS
ABBEVILLE	ABBEVILLE CO MEM HOSP	MOBILE		200
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	1517	638
AIKEN	AIKEN REG MED CTR	MOBILE	655	2164
AIKEN	CAROLINA ORTHOPAEDIC ASSOC	FIXED		
AIKEN	IMAGING CTR OF AIKEN	FIXED		
AIKEN	SOUTHERN NEUROLOGICAL INST	FIXED	2615	1723
ANDERSON	ANDERSON AREA MED CTR	3 FIXED	3474	5020
ANDERSON	ANDERSON RADIOLOGY	FIXED	146	1634
ANDERSON	HEALTH SOUTH DIAGNOSTIC CTR OF ANDERSON	FIXED	1868	
BEAUFORT	BEAUFORT MEM HOSP	FIXED	2749	2738
BEAUFORT	HILTON HEAD HOSP	MOBILE	157	160
BEAUFORT	HEALTH SOUTH DIAGNOSTIC CTR OF HILTON HEAD	FIXED	2152	2210
BEAUFORT	LOWCOUNTY MEDICAL GROUP	FIXED	39	758
BEAUFORT	LOWCOUNTY MEDICAL GROUP PORT ROYAL	FIXED		
BEAUFORT	NEUROLOGICAL INST OF HILTON HD	FIXED		
BEAUFORT	SOUTHERN MRI, LLC	2FIXED	0	
CLARENDON	CLARENDON MEM HOSP	MOBILE	156	642
CHARLESTON	ROPER HOSP	FIXED	3346	3636
CHARLESTON	ROPER DIAGNOSTIC CTR-FARMFIELD	FIXED	207	925
CHARLESTON	MEDICAL UNIVERSITY HOSP	2 FIXED	5593	6870
CHARLESTON	MEDICAL UNIVERSITY HOSP	(PED FIXED)		
CHARLESTON	UMA AMBULATORY CARE FAC	FIXED		
CHARLESTON	TRIDENT MED CTR	2 FIXED	5311	5439
CHARLESTON	EAST COOPER REG MED CTR	MOBILE	337	220
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	MOBILE	780	1199
CHARLESTON	DISC IMAGING	2 FIXED	5668	5938
CHARLESTON	HEALTH SOUTH DIAGNOSTIC CTR OF CHARLESTON	FIXED	986	483
CHARLESTON	CHARLESTON PHYSICIANS IMAGING CTR	FIXED		267
CHARLESTON	TRI-COUNTY RADIOLOGY ASSOC.	MOBILE	1481	3196
CHEROKEE	UPSTATE CAROLINA MED CTR	MOBILE	662	526
CHESTERFIELD	CHESTERFIELD GEN HOSP	MOBILE	290	503
COLLETON	COLLETON REG HOSP	FIXED	691	1118
DARLINGTON	CAROLINA PINES REG MED CTR	MOBILE	967	1527
DARLINGTON	WILSON MED CTR	MOBILE	132	198
DILLON	ST. EUGENE MED CTR	MOBILE	455	485
DORCHESTER	SUMMERVILLE MEDICAL CENTER	FIXED		
FLORENCE	CAROLINAS HSP SYS	FIXED	3325	3285
FLORENCE	MCLEOD REG MED CTR	2 FIXED	4686	5068
FLORENCE	FLORENCE MED IMAGING	FIXED	1188	1190
FLORENCE	CAROLINAS HSP SYS LAKE CITY	MOBILE	273	255
FLORENCE	INMED DIAGNOSTIC SERVICES	FIXED	229	122
FLORENCE	OPEN MRI & IMAGING OF FLORENCE	FIXED		
GEORGETOWN	GEORGETOWN MEM HOSP	FIXED	1414	1720
GREENVILLE	ST. FRANCIS HOSP	FIXED	2053	1952
GREENVILLE	ST. FRANCIS WOMAN'S HOSP	MOBILE	0	314
GREENVILLE	HILLCREST HOSP	MOBILE	0	13
GREENVILLE	GREENVILLE MEM HOSP	2 FIXED	8427	6946
GREENVILLE	HEALTH SOUTH DIAGNOSTIC CTR OF GREENVILLE	FIXED	4642	5116
GREENVILLE	G'VLLE PHYSICIANS IMAGING CTR	2 FIXED	1732	1897
GREENVILLE	GHS/PATEWOOD BLDG	2 MOBILE	1813	1801
GREENVILLE	SE NUEROSURGICAL & SPINE INSTITUTE	MOBILE		
GREENWOOD	LAKELANDS ORTHOPAEDICS CLINIC	MOBILE		
GREENWOOD	SELF MEM HOSP	FIXED	2619	3910
HAMPTON	HAMPTON REG MED CTR	MOBILE	0	218
HORRY	CONWAY HOSP	FIXED	1012	

MRI SCANS

COUNTY	FACILITY	TYPE	FY97 CON SCANS	FY98 CON SCANS
HORRY	GRAND STRAND REG MED CTR	FIXED	3195	3655
HORRY	GRAND STRAND REG MED CTR	MOBILE		
HORRY	MYRTLE BEACH MRI	FIXED	359	371
HORRY	LORIS COMM HOSP	MOBILE	807	985
HORRY	OPEN MRI OF MYTRLE BEACH	FIXED		
HORRY	PREFERRED IMAGING	FIXED	1467	1349
HORRY	COMMUNITY MED CTR-GRAND STRAND	FIXED		
KERSHAW	KERSHAW CO MEM HOSP	MOBILE	514	591
LANCASTER	SPRINGS MEMORIAL HOSP	FIXED	840	1022
LAURENS	LAURENS CO HOSP	MOBILE	571	737
LAURENS	LAURENS CO ORTHOPAEDICS ASSOC	FIXED		
LEXINGTON	LEXINGTON MED CTR	FIXED	2264	3716
LEXINGTON	LEXINGTON OPEN MRI	FIXED		2292
MARION	MARION CO MEDICAL CTR	MOBILE	466	623
MARLBORO	MARLBORO PARK	MOBILE	205	312
OCONEE	OCONEE MEM HOSP	FIXED	1878	2455
OCONEE	MOUNTAINVIEW RADIOLOGY,PA	FIXED		
ORANGEBURG	OPEN MRI & IMAGING ORANGEBURG	FIXED		
ORANGEBURG	RMC ORANGEBURG/CALHOUN	FIXED	2547	3346
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	FIXED		
PICKENS	BAPTIST MED CTR-EASLEY	MOBILE	433	697
PICKENS	CANNON MEM HOSP	MOBILE	0	29
RICHLAND	PALMETTO RICHLAND MEM HOSP	2 FIXED	3841	4363
RICHLAND	PALMETTO BAPTIST MED CTR-COLA	FIXED	3542	4323
RICHLAND	HEALTH SOUTH DIAGNOSTIC CTR	FIXED	830	1081
RICHLAND	PALMETTO IMAGING	2 FIXED	4429	4367
RICHLAND	PROVIDENCE HOSPITAL	FIXED	0	
RICHLAND	MIDLANDS ORTHOPAEDICS	FIXED	0	1300
RICHLAND	INMED DIAGNOSTIC SERVICES	FIXED	1228	154
SPARTANBURG	SPARTANBURG REG MED CTR	2 FIXED	6189	7639
SPARTANBURG	MARY BLACK MEM HOSP	MOBILE	1482	1903
SPARTANBURG	PIEDMONT IMAGING, INC #1	FIXED		1133
SUMTER	TUOMEY REG MED CTR	FIXED	2058	1946
UNION	WALLACE THOMSON HOSP	MOBILE	398	574
WILLIAMSBURG	CAROLINAS HSP SYS -KINGSTREE	MOBILE	38	114
YORK	PIEDMONT MED CTR	2 FIXED & MOBILE	4222	4950
YORK	MRI CHARLOTTE	FIXED	1163	1489

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

(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 is primarily used for research purposes, but has some 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.

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, with additional costs for a cyclotron to generate the radioisotopes needed for PET operation. Capital costs are approximately $500,000 and annual operating costs are approximately $1,500,000. The Institute for Clinical PET projects operating efficiency for a PET as being 6 scans per day.

There are currently no PET scanners in South Carolina.

Certificate of Need Standards for Positron Emission Tomography (PET)

STANDARDS

(1) A patient base large enough to support and adequate number of PET clinical studies must exist. One million persons should be considered a minimal referral base for PET services.

(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) Additional PET services shall only be approved if it is demonstrated that each existing PET service in the applicant's service area is performing 1,250 clinical procedures (5 clinical procedures/day x 250 working days) per PET unit per year.

(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.

(3) Computed Tomographic (CT) Scanners

The number of CT scanners and utilization of CT scanners for 1997 are as follows:

PET-EX004.0111

RECORD 003341

CT SCANS

REGION/COUNTY	FACILITY	TYPE	NUMBER	FY97 NUMBER OF PROCEDURES	FY98 NUMBER OF PROCEDURES
I					
ANDERSON	ANDERSON MED CTR	FIXED	3	15777	17452
ANDERSON	ANMED	FIXED	1		
CHEROKEE	UPSTATE CAROLINA	FIXED	1	2898	1754
GREENVILLE	GREENVILLE MEM HOSP	FIXED	3	15328	17515
GREENVILLE	ALLEN BENNETT MEM	FIXED	1	3197	2039
GREENVILLE	HILLCREST HOSP	FIXED	1	1596	2034
GREENVILLE	ST FRANCIS HOSP			5718	5801
GREENVILLE	ST FRANCIS WOMAN'S HOSP	FIXED	1	1370	2100
GREENVILLE	OUTPATIENT DIAG CTR	FIXED	1		
GREENVILLE	GREENVILLE PHYSICIAN IMAGING	FIXED	1		
SPARTANBURG	BJ WORKMAN HOSP	FIXED	1		520
SPARTANBURG	SPARTANBURG REG MED CTR	FIXED	2	12535	13969
SPARTANBURG	MARY BLACK MEM	FIXED	1	4441	4521
OCONEE	OCONEE MEM	FIXED	1	6275	6985
OCONEE	MOUNTAINVIEW RADIOLOGY, PA	FIXED	1		
PICKENS	BAPTIST MED CTR-EASLEY	FIXED	1	3275	3697
PICKENS	CANNON MEM	FIXED	1	806	726
UNION	WALLACE THOMSON	MOBILE	1	2489	3393
II					
ABBEVILLE	ABBEVILLE CO MEM	MOBILE	1	840	859
CHESTER	CHESTER CO	MOBILE	1	2209	2339
EDGEFIELD	EDGEFIELD CO HOSP	FIXED	1	339	357
FAIRFIELD	FAIRFIELD MEM	MOBILE	1	671	672
GREENWOOD	SELF MEM	FIXED	1	10807	11622
KERSHAW	KERSHAW CO MEM	FIXED	1	3166	3646
LANCASTER	SPRINGS MEMORIAL HOSP	MOBILE	1	3668	3600
LAURENS	LAURENS COUNTY HOSP	FIXED	1	2181	2194
LEXINGTON	LEXINGTON MED CTR	FIXED	3	13626	16365
LEXINGTON	LEXINGTON OPEN MRI	FIXED	1		
LEXINGTON	LEXINGTON MED CTR-IRMO	FIXED			
NEWBERRY	NEWBERRY CO MEM	FIXED	1	2123	1514
RICHLAND	IMAGETRUST COLA, INC	FIXED			
RICHLAND	PALMETTO BAPTIST MED CTR-COLA	FIXED	3	12443	15017
RICHLAND	PROVIDENCE HOSPITAL	FIXED	1	6062	8610
RICHLAND	PALMETTO RICHLAND MEM HOSP	FIXED	5	18870	18983
YORK	PIEDMONT MED CTR	FIXED	1	9281	10090
III					
CHESTERFIELD	CHESTERFIELD GENERAL	FIXED	1	1434	1831
CLARENDON	CLARENDON MEMHOSP	MOBILE	1	989	1147
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	1	3753	4258
DARLINGTON	WILSON CLINIC AND HOSP	FIXED	1	952	1011
DILLON	ST EUGENE MEDICAL CTR	FIXED	1	1535	1797
FLORENCE	CAROLINAS HOSP SYS	FIXED	1	8723	9508
FLORENCE	(FLORENCE GEN)	FIXED	1		
FLORENCE	CAROLINAS HOSP SYS LAKE CITY	MOBILE	1	922	1066
FLORENCE	MCLEOD REG MED CTR	FIXED	2	13718	16177
GEORGETOWN	GEORGETOWN CO MEM	FIXED	1	6139	7347
HORRY	CONWAY	FIXED	1	4960	5406
HORRY	GRAND STRAND REG MED CTR	FIXED	1	7949	10016
HORRY	LORIS COMM	FIXED	1	2916	3118
MARION	MARION CO MED CTR	FIXED	1	2931	2735
MARION	(MULLINS)	(MOBILE)	1		

CT SCANS

REGION/COUNTY	FACILITY	TYPE	NUMBER	FY97 NUMBER OF PROCEDURES	FY98 NUMBER OF PROCEDURES
MARLBORO	MARLBORO PARK	MOBILE	1	1411	1469
SUMTER	TUOMEY REG MED CTR	FIXED	1	6316	7229
WILLIAMSBURG	CAROLINAS HOSP KINGSTREE	MOBILE	1	614	970
IV					
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED	1		
AIKEN	AIKEN REG MED CTR	FIXED & MOBILE	1	5204	6259
AIKEN	IMAGING CTR OF AIKEN	FIXED	1		
ALLENDALE	ALLENDALE CO HOSP	MOBILE	1	430	493
BAMBERG	BAMBERG CO MEM HOSP	MOBILE	1	1263	1130
BARNWELL	BARNWELL CO HOSP	FIXED	1	987	1078
BEAUFORT	BEAUFORT MEM	FIXED	1	6255	4272
BEAUFORT	HILTON HEAD	FIXED	1	4054	3976
CHARLESTON	ROPER NORTH HOSPITAL	FIXED	1	1436	1660
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	FIXED	1	3444	4538
CHARLESTON	EAST COOPER REG MED CTR	FIXED	1	3089	2746
CHARLESTON	MEDICAL UNIVERSITY	FIXED	2	12312	15189
CHARLESTON	TRIDENT MED CTR	FIXED	2	9146	9951
CHARLESTON	ROPER HOSPITAL	FIXED	2	11541	13144
CHARLESTON	UMA AMBULATORY CARE FAC	FIXED	1		
COLLETON	COLLETON MED CTR	MOBILE	1	2055	2546
DORCHESTER	SUMMERVILLE MED CTR	FIXED	1	3232	3090
HAMPTON	HAMPTON REG MED CTR	FIXED	1	431	496
JASPER	LOW COUNTRY GEN HOSP	MOBILE	1		
ORANGEBURG	ADVANGE DIAGNOSTIC IMAGING	FIXED	1		
ORANGEBURG	RMC ORANGEBURG-CALHOUN	FIXED	1	6457	7217

(I) End Stage Renal Disease

Chronic renal failure is primarily treated by renal dialysis and/or kidney transplantation. There are two basis types of dialysis treatment - hemodialysis and peritoneal dialysis - with hemodialysis being used most often. Hemodialysis is generally required three times per week for patients who have complete kidney failure, and less frequently for patients with partial kidney failure. This maintenance dialysis is performed in either a hospital or outpatient dialysis facility. Also, self-dialysis can be performed by the patient either in the home or in an outpatient facility.

In addition, there are three primary forms of hemodialysis: conventional dialysis, high efficiency dialysis and high flux dialysis. High efficiency is a "speed up" of conventional dialysis. High flux has increased time for dialysis in an attempt to remove from the body certain substances that conventional and high efficiency dialysis do not remove. The essential difference between conventional and high efficiency, permitting the decrease in time, is the increase in blood flow and the use of acetate in the dialysate. High flux dialysis is a concept of simultaneous diffusion and convective transport in single-device open membranes with high diffuse and hydraulic permeability used in conjunction with volumetric control of ultrafiltration. Used in conjunction with high blood and high dialysate flow rates and bicarbonate, high flux dialysis offers greater efficiency and a wider range of solute transport than conventional dialysis; however, more patients can be treated in a shorter period of time in the high flux process. A high efficiency/high flux machine requires approximately three hours treatment time and a conventional machine requires approximately four hours treatment time.

It should be noted that most patients who do receive kidney transplants are usually on dialysis for an extended period of time prior to the transplantation. The Medical University Hospital of South Carolina performed 111 kidney transplants and Richland Memorial Hospital performed 17 kidney transplants in 1997.

Chronic maintenance dialysis services are available in every county except McCormick and Saluda Counties. A provider should give consideration to establishing this service in these two counties. Renal transplantation services are available at the Medical University Hospital in Charleston. The utilization/occupancy rate is based on the operation of two shifts per day, six days per week.

There are eighteen networks serving the United States devoted to helping health care professionals and patients improve the treatment and control of ESRD. South Carolina, North Carolina and Georgia are served by the Southeastern Kidney Council (Network Six). The following information came from the Southeastern Kidney Council and/or the Health Care Financing Administration (HCFA):

PET-EX004.0114

RECORD 003344

The number of new ESRD patients were provided by Network Six for the following South Carolina incidence rates. The incidence rates for the last three years (1995, 1996, & 1997) are:

YEAR	WHITE RATE/millions	NON-WHITE RATE/millions
1995	172.7	644.6
1996	166.3	747.7
1997	199.6	753.3

Based on the above information, the average incidence rates for the last three years (1995,1996,& 1997) are: White 180/million; Non-White 715/million.

Existing or proposed ESRD programs should be consistent with standards and procedures contained in Federal regulations governing conditions for coverage of supplies of end-stage renal disease services, 42 CFR part 405, sub-part U.

Dialysis Services do not require Certificate of Need Review.

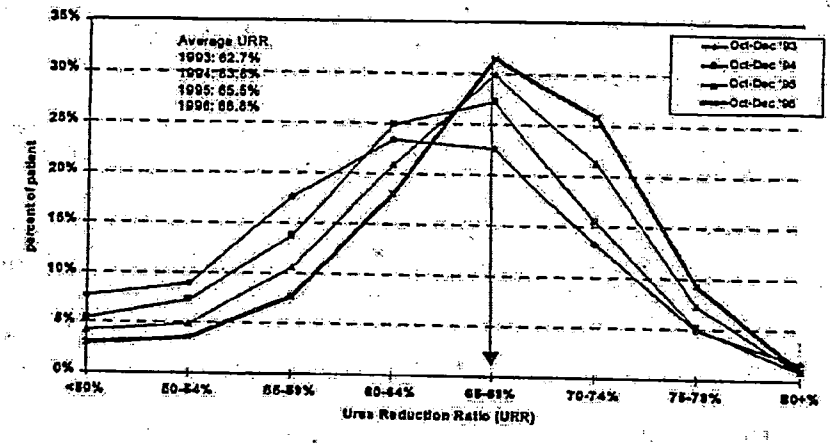
Quality Indicators: To improve the care of Medicare ESRD patients the Networks have reshaped the quality assurance and improvement program. Formerly, quality was monitored mainly through intensive review of individual case records that had been selected randomly. The ESRD Health Care Quality Improvement Program (HCQIP) is based upon the principle that the networks can do more to improve the quality and cost effectiveness of care by bringing typical care into line with best practices rather than by retrospective review to identify erred treatment.

Based on clinical information, the prevalence of several conditions of care called Core Indicators are used for assessing adult, incenter hemodialysis patients:

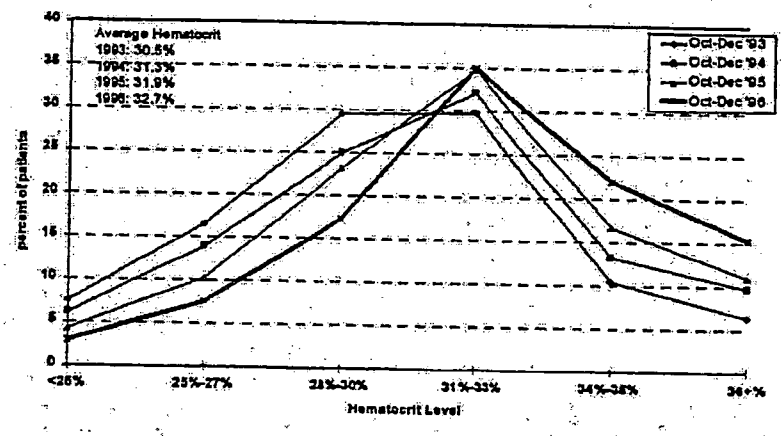
- Adequacy of Dialysis - pre and post BUN (Blood Urea Nitrogen) levels were chosen as indicators for assessing the adequacy of dialysis. Based on the RPA (Renal Physicians Assc.) guideline the mean urea reduction ratio (URR) of 65% or more was defined as adequate dialysis. Nationally, the average URR increased from 66% in late 1995 to 67% in late 1996. For 1995, in Network Six, 65% of the patients received adequate dialysis having URR's of greater than or equal to 65%.
- Anemia - Hematocrit level was chosen as an indicator for assessing the treatment of anemia. In Network Six the mean facility hematocrit was 31% and 64% of the patients had a hematocrit of >31%. However, 8% were severely anemic.
- Nutritional status - Serum albumin level was chosen as an indicator for assessing the nutritional status and mortality risk. Mean serum albumin values of less than 3.2 gm/dL by the BCP method and 3.5 gm/dL by the BCH method were defined as an indicator of inadequate nutritional status. Network Six has one of the highest rates (89%) of adequate nutrition.

The following charts indicate the 1993-1997 Distribution of URR

DISTRIBUTION OF URR VALUES



DISTRIBUTION OF HEMATOCRIT VALUES

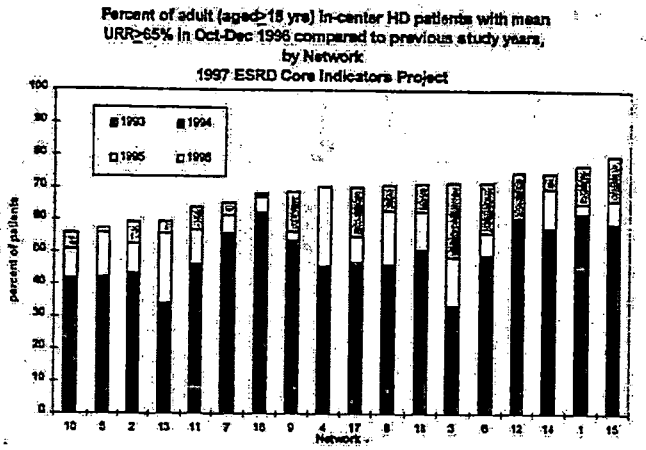


Data source:HCFA

ADEQUACY OF DIALYSIS

Findings:

- The average URR increased from 66% in late 1995 to 67% in late 1996.
- Measures of dialysis adequacy varied among ESRD Networks. In late 1996, the percent of patients who received hemodialysis with URR≥65% ranged from 56% to 80% (Figure 3).



SERUM ALBUMIN

Findings for the last quarter of 1996:

- Mean serum albumin values determined by the bromcresol green (BCG) laboratory method = 3.8 gm/dL.;
- Mean serum albumin values determined by the bromcresol purple (BCP) laboratory method = 3.6 gm/dL.; and
- Percent of patients in each Network area with mean serum albumin values ≥3.5 gm/dL by BCG or ≥3.2 gm/dL by BCP ranged from 76% to 86%.

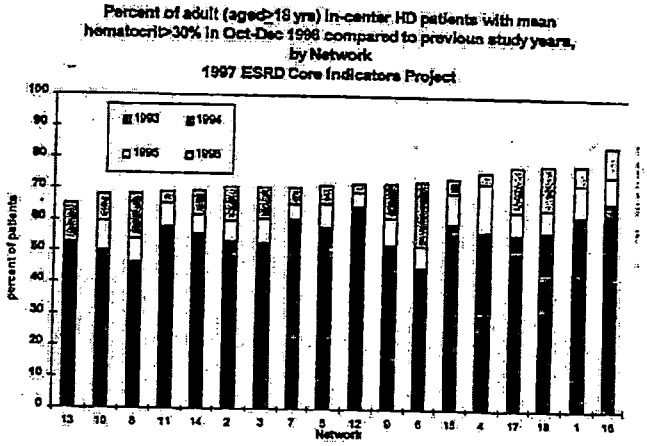
Optimal: Although no consensus guidelines have been established, the following initial targets are being used in the Core Indicators Project: ≥3.5 gm/dL (BCG method) or ≥3.2 gm/dL (BCP method).

Data Source: HCFA

HEMATOCRIT

Findings:

- The mean hematocrit (hct) increased from 31.9% in late 1995 to 32.7% in late 1996.
- The percentage of patients with hematocrits>30% varied among the Networks, ranging from 65% to 85% (Figure 6).
- New information collected in 1997:
  * Of patients receiving Epoetin, 93% received by the intravenous route.
  * The average ferritin value reported was 377 ng/ml.
  * The average transferrin saturation was 27%.
  * 75% of patients were receiving iron therapy at least one of the study months. Within this group,



52% received iron intravenously, and 48% orally.

FACILITIES	COUNTY	# OF STATIONS	FOOTNOTES	SHIFTS PER DAY DAYS PER WEEK	TREAT-MENTS	PERCENT OCCUPANCY
						6 days wk 6 days wk
I				1997 JOINT ANNUAL REPORT		
ANDERSON DIALYSIS CLINIC, INC.	ANDERSON	47	#19	3 shifts/ 3 days	14319	48.8%
DCI GAFFNEY	CHEROKEE	16	#49	2 shifts/ 6 days	7213	96.3%
GREENVILLE DIALYSIS CENTER, INC.	GREENVILLE	39	#11	2 shifts/ 6 days	1266	31.1%
GREER KIDNEY CENTER, INC.	GREENVILLE	27	#20	2 shifts/ 6 days	11761	69.8%
TWIN OAKS DIALYSIS CENTER	GREENVILLE	31	#36	3 mwf,2tts/ 6 days	13962	117.8%
UPSTATE DIALYSIS CENTER	GREENVILLE	52		2 shifts/ 6 days	26107	80.5%
OCONEE DIALYSIS CLINIC, INC.	OCONEE	14	#22	3 shifts/ 3 days	4977	57.0%
EASLEY DIALYSIS CENTER	PICKENS	28	#10	2 shifts/ 6 days	8014	71.3%
DCI EAST SPARTANBURG	SPARTANBURG	32	#15	2 shifts/ 6 days	12906	89.9%
DCI SPARTANBURG	SPARTANBURG	43	#52	2 shifts/ 6 days	12412	76.5%
DCI WEST SPARTANBURG	SPARTANBURG	25	#8	2 shifts/ 3 days	7285	46.7%
DCI UNION	UNION	15	#50	2 shifts/ 6 days	5956	95.4%
II						
GAMBRO HEALTHCARE – ABBEVILLE	ABBEVILLE	16	#33	3 shifts/ 3 days	2935	58.8%
TRI–COUNTY DIALYSIS CENTER	CHESTER	12		2 shifts/ 6 days	5128	68.5%
GAMBRO HEALTHCARE – EDGEFIELD	EDGEFIELD	14	#32	2 shifts/ 6 days	2687	86.1%
GAMBRO HEALTHCARE – WINNSBORO	FAIRFIELD	16	#9	3 shifts/ 3 days	2898	46.4%
GAMBRO HEALTHCARE – GREENWOOD	GREENWOOD	25	#26	3 mwf,2tts/ 6 days	7894	50.6%
CAMDEN DIALYSIS CENTER	KERSHAW	21	#53	2 shifts/ 6 days	9061	96.8%
GAMBRO HEALTHCARE – LANCASTER SC	LANCASTER	13	#18	3 shifts/ 6 days	8011	98.8%
LAURENS COUNTY DIALYSIS CENTER, INC.	LAURENS	27	#24	2 shifts/ 6 days	11949	71.2%
LEXINGTON DIALYSIS CENTER	LEXINGTON	15		3 shifts/ 6 days	9989	106.7%
WEST COLUMBIA DIALYSIS CENTER	LEXINGTON	15	#54	3 shifts/ 6 days	11276	129.1%
NEWBERRY DIALYSIS CENTER	NEWBERRY	12		2 shifts/ 6 days	6440	86.0%
BROAD RIVER DIALYSIS CENTER	RICHLAND	12	#2			
COLUMBIA DIALYSIS CENTER	RICHLAND	28		2 shifts/ 6 days	15963	91.4%
LOWER RICHLAND DIALYSIS CENTER	RICHLAND	20	#4	2 shifts/ 6 days	4802	52.3%
GAMBRO HEALTHCARE–COLUMBIA CENTRAL	RICHLAND	18	#27	2 shifts/ 6 days	8589	76.5%
BMA MEADOWLAKE DIALYSIS CENTER	RICHLAND	11	#51			
MIDTOWN DIALYSIS CENTER	RICHLAND	25	#41	3 shifts/ 6 days	11104	118.6%
SOUTH COLUMBIA DIALYSIS CENTER	RICHLAND	15		3 shifts/ 6 days	12271	131.1%
ROCK HILL DIALYSIS CENTER, INC.	YORK	37	#7	2 shifts/ 6 days	11547	50.0%

RECORD 003348

PET-EX004.0118

FACILITIES	COUNTY	# OF STATIONS	FOOTNOTES	SHIFTS PER DAY DAYS PER WEEK	TREAT-MENTS	PERCENT OCCUPANCY 6 days wk
III						
CHESTERFIELD COUNTY DIALYSIS CENTER	CHESTERFIELD	11		3 shifts/ 3 days	3799	55.3%
MANNING DIALYSIS CENTER	CLARENDON	20		2 shifts/ 6 days	9641	77.3%
DARLINGTON DIALYSIS CENTER	DARLINGTON	30	#23	2 shifts/ 6 days	13232	70.7%
DILLON DIALYSIS CENTER	DILLON	16		2-3 shifts/3 days	5448	54.6%
FLORENCE DIALYSIS CENTER	FLORENCE	55	#3	2 shifts/ 6 days	22130	66.9%
FMC DIALYSIS SERVICES-MURRELLS INLET	GEORGETOWN	12	#42			
FMC DIALYSIS SERVICES-GEORGETOWN	GEORGETOWN	28	#17	3 mwf,2tts/ 6 days	16683	95.5%
CONWAY DIALYSIS CENTER	HORRY	15		2 shifts/ 6 days	7572	80.9%
LORIS DIALYSIS CENTER	HORRY	9		2 shifts/ 6 days	3744	66.7%
MYRTLE BEACH DIALYSIS CENTER	HORRY	12		3 mwf,2tts/ 6 days	6562	87.6%
FMC DIALYSIS SERVICES-N. MYRTLE BEACH	HORRY	15	#1			
LEE COUNTY DIALYSIS CENTER	LEE	11	#13	2 shifts/3 days	1047	32.1%
MARION DIALYSIS CENTER	MARION	16		2 shifts/6 days	7918	79.3%
BENNETTSVILLE DIALYSIS CENTER	MARLBORO	20		2 shifts/ 6 days	5651	45.3%
SUMTER DIALYSIS CENTER	SUMTER	54	#16	2 shifts/ 6 days	20418	60.6%
KINGSTREE DIALYSIS CENTER, INC.	WILLIAMSBURG	33	#31	2 shifts/ 6 days	10423	50.6%
IV						
GAMBRO HEALTHCARE - AIKEN	AIKEN	14	#43	2 shifts/ 6 days	7270	83.2%
GAMBRO HEALTHCARE - NORTH AUGUSTA	AIKEN	13	#30	3 shifts/ 3 days	3839	47.3%
GAMBRO HEALTHCARE-ALLENDALE COUNTY	ALLENDALE	10	#26	3 shifts/ 3 days	2744	58.7%
GAMBRO HEALTHCARE - BAMBERG	BAMBERG	12	#44	3 mwf,2tts/ 6 days	6191	82.7%
GAMBRO HEALTHCARE - BARNWELL	BARNWELL	16	#12	2 shifts/ 6 days	6266	62.8%
GAMBRO HEALTHCARE - HILTON HEAD	BEAUFORT	10	#14	2 shifts/ 6 days	3997	64.1%
FMC DIALYSIS SVCS-LOW COUNTRY DIALYSIS	BEAUFORT	22	#55	2 shifts/ 6 days	10643	77.5%
GAMBRO HEALTHCARE - MONCKS CORNER	BERKELEY	22	#40	2 to 3 shifts/ 6 days	11671	85.0%
GAMBRO HEALTHCARE - ST. MATTHEWS	CALHOUN	12	#29	2 shifts/ 6 days	3999	87.5%
GAMBRO HEALTHCARE - CHARLESTON	CHARLESTON	28	#38	3 mwf,2tts/ 6 days	16887	96.7%
DCI AZALEA PLACE	CHARLESTON	20		2 shifts/ 6 days	9748	78.1%
DCI CHARLESTON	CHARLESTON	20		2 shifts/ 6 days	9615	77.0%
DCI EAST OF THE COOPER	CHARLESTON	13		2 shifts/ 6 days	5536	68.3%
DCI JAMES ISLAND	CHARLESTON	16	#45			
DCI MAGNOLIA COURT	CHARLESTON	16	#34	2 shifts/ 6 days	4893	93.1%
DCI WEST OF THE ASHLEY	CHARLESTON	23		2 shifts/ 6 days	11518	80.3%
MEDICAL UNIVERSITY OF SC ESRD	CHARLESTON	12	#6			
GAMBRO HEALTHCARE - CHARLESTON WEST	CHARLESTON	14	#25			
GAMBRO HEALTHCARE - TRIDENT	CHARLESTON	20	#39	2 shifts/ 6 days	9108	73.0%
GAMBRO HEALTHCARE - WALTERBORO	COLLETON	14	#48	3 mwf,2tts/ 6 days	7376	84.4%
GAMBRO HEALTHCARE - DORCHESTER	DORCHESTER	22	#21	3 shifts/ 3 days	4407	32.1%
HAMPTON REG MED CTR DIALYSIS CENTER	HAMPTON	13	#5	3 shifts/ 3 days	4465	55.0%
FMC DIALYSIS SERVCIES-THE MARSHLANDS	JASPER	17	#37			
GAMBRO HEALTHCARE-ORANGEBURG	ORANGEBURG	20	#46	2 shifts/ 6 days	10594	84.9%
GAMBRO HEALTHCARE-SO ORANGEBURG	ORANGEBURG	20	#35	2 shifts/ 3 days	3282	31.9%
GAMBRO HEALTHCARE-SANTEE	ORANGEBURG	14	#47	2 shifts/ 6 days	7318	83.8%

RECORD 003349

PET-EX004.0119

FACILITIES	COUNTY	# OF STATIONS	FOOTNOTES	SHIFTS PER DAY DAYS PER WEEK	TREAT-MENTS	PERCENT OCCUPANCY
						6 days wk

FOOTNOTES:

#1 CON issued 3/16/98 for 15 stations and 1 home training station; Licensed 2/22/99 for 15 stations.
#2 Licensed for 12 ESRD stations, 12/11/98. Located at SC Department of Corrections.
#3 CON issued for 4 additional stations, 12/19/94, for a total of 53 chronic and 2 home training stations. Licensed 9/12/98. Name changed 6/1/98, formerly BMA of Florence Dialysis Center; licensed for 55 stations.
#4 CON issued for 15 stations, 1/22/96. Licensed 2/7/97. Licensed for 17 stations, 9/16/98. Licensed increased from 17 to 20, 11/1/99.
#5 Facility has 13 chronic and 1 acute station. Licensed for 13 stations
#6 Not certified for outpatient; provides home training and outpatient.
#7 Facility has 36 chronic and 1 home training station; licensed for 37 stations.
#8 CON issued for 25 stations, 12/2/94. Licensed 3/9/96.
#9 CON issued for 10 stations, 4/25/95. Name changed 11/1/95, formerly Community Dialysis Center of Winnsboro; licensed 3/26/96. Name changed 7/1/97, formerly Vivra Renal Care–Winnsboro. License increased from 10 to 16, 2/1/99.
#10 CON issued for 10 additional stations, 6/3/96. Licensed 11/1/98 for 28 stations.
#11 CON issued for 14 hemodialysis stations 6/1/95. Licensed 7/15/97. Exempt from CON for 3 additional stations for 17 total, 5/27/98. Licensed stations increased from 14 to 39, 10/27/98.
#12 Name changed 7/1/97, formerly Vivra Renal Care – Barnwell. CON issued for 2 additional stations for a total of 16 stations, 8/22/97. Licensed stations increased from 14 to 16, 4/16/99.
#13 CON issued for 10 stations, 3/22/96; licensed 6/24/97 for 10 chronic and 1 home training station; licensed for 11 stations.
#14 CON issued for 4 additional stations, 3/13/96. Licensed 3/13/96. Name changed, formerly Vivra Renal Care of Hilton Head, 7/1/97.
#15 CON issued for 9 additional stations, 1/24/97. Licensed 3/9/98.
#16 CON issued for 25 additional stations, 1/16/95. Licensed 7/23/96.
#17 Facility has 28 chronic, 1 home and 1 periteneal station; licensed for 28 stations.
#18 Name changed 3/1/97, formerly Lancaster Kidney Center. Name changed formerly Vivra Renal Care–Lancaster, 7/1/97.
#19 CON issued for 4 additional stations, 7/8/96; licensed 12/20/96.
#20 CON issued for 7 additional stations, 10/31/95; licensed 10/8/96.
#21 Name changed 2/12/97, formerly Dorchester Kidney Center. Name changed 7/1/97, formerly Vivra Renal Care of Dorchester.
#22 CON issued for 4 additional stations, 6/20/96. Licensed 7/1/96.
#23 CON issued for 6 additional stations, 5/10/96. Licensed 12/1/96.
#24 CON issued for 9 additional stations, 4/10/95 for a total of 27 stations. Licensed for 22 chronic, 9/8/95; licensed for 27 stations 1/10/97.
#25 CON issued 8/12/97 for 13 stations and 1 home training station; licensed for 14 stations.
#26 Name changed 7/1/97, formerly Vivra Renal Care of Greenwood.License increased from 16 to 25, 2/2/99.
#27 Name changed 7/1/97, formerly Vivra Renal Care of Columbia.
#28 Name changed, formerly Vivra Renal Care of Allendale, 7/1/97. CON issued for 3 additional stations, 8/22/97; licensed 11/1/97 for a total of 10 chronic and 1 home training station; licensed for 10 stations.

RECORD 003350

PET-EX004.0120

FACILITIES	COUNTY	# OF STATIONS	FOOTNOTES	SHIFTS PER DAY DAYS PER WEEK	TREAT-MENTS	PERCENT OCCUPANCY
						6 days wk

#29 CON issued for 7 stations, 10/17/94. Licensed 7/24/96. Name changed 7/1/97, formerly Vivra Renal Care of St. Matthews. CON issued for 2 additional stations for a total of 9 stations, 8/22/97; licensed 11/3/97. Licensed for 12 stations, 3/10/99.
#30 Name changed formerly Vivra Renal Care of North Augusta, 7/1/97.
#31 CON issued for 16 additional stations, 2/10/95. Licensed 3/22/96.
#32 CON issued for 5 stations, 3/20/95; licensed 1/23/96. Name changed 7/1/97, formerly Vivra Renal Care of Edgefield; CON issued for 2 additional stations for a total of 7 stations, 8/22/97.Licensed 2/1/98. License increased form 7 to 14, 9/10/99.
#33 CON issued for 8 stations, 7/14/95. Licensed 7/12/96. Name changed 7/1/97, formerly Vivra Renal Care of Abbeville. License increased from 8 to 16, 2/26/99.
#34 CON issued for 8 stations, 7/17/95. Licensed 11/25/96. CON issued for 4 additional stations, 7/11/97; licensed 11/24/97. License increased from 12 to 16, 10/6/98.
#35 CON issued for 20 stations, 7/21/95. Licensed 3/6/97. Name changed 7/1/97, formerly Vivra Renal Care of South Orangeburg.
#36 CON issued to relocate and add 12 stations to the existing 19 station facility for a total of 31 stations and change the name from Piedmont Dialysis Center to Twin Oaks Dialysis Center, 1/21/97.
#37 CON issued for 8 stations, 3/27/97; formerly BMA Marshlands, licensed 3/16/99. License increased from 8 to 17 stations, 8/11/99
#38 Name changed 2/12/97, formerly Charleston Kidney Center. Name changed 7/1/97, formerly Vivra Renal Care of Charleston.
#39 Name changed 2/12/97, formerly Trident Kidney Center. Name changed 7/1/97, foremrly Vivra Renal Care of Trident.
#40 Name changed 2/12/97, formerly Moncks Corner Kidney Center. Name changed 7/1/97, formerly Vivra Renal Care of Moncks Corner.
#41 Name changed 4/28/97, formerly Northside Dialysis Center. Exempt from CON 5/27/98 for 5 additional stations; licensed 8/28/98. License increased from 20 to 25 on 2/16/99.
#42 CON issued 7/16/97 for 12 stations; licensed 6/10/99 and name changed from BMA Murrells Inlet Dialysis Clinic.
#43 Name changed 7/1/97, formerly Vivra Renal Care of Aiken.
#44 Name changed 7/1/97, formerly Vivra Renal Care of Bamberg. CON issued for 2 additional stations for a total of 12 stations, 8/22/97.
#45 CON issued 8/11/97 for 9 stations; licensed for 16 stations, 2/26/99.
#46 Name changed 7/1/97, formerly Vivra Renal Care of Orangeburg.
#47 Name changed 7/1/97, formerly Vivra Renal Care of Santee.
#48 Name changed 7/1/97, formerly Vivra Renal Care of Walterboro.
#49 CON issued 4/13/98 to add 4 stations for a total of 16 stations.
#50 CON issued 4/13/98 to add 5 stations for a total of 15 stations.
#51 CON issued 5/18/98 for 11 ESRD stations.
#52 License increased from 26 to 43 ESRD stations, 7/19/99.
#53 Licensed for 6 additional ESRD stations, 9/16/98.
#54 License increased from 14 to 15 stations, 9/1/98.
#55 Name changed 5/24/99, formerly Low Country Dialysis Facility.

RECORD 003351

PET-EX004:0121

(J) Lithotriptors

An extracorporeal lithotriptor is a medical device which pulverizes kidney stones by focusing hydraulic shock waves on the stone; surgical intervention is usually avoided. The patient is exposed to shock waves which are pinpointed to pulverize the stone(s). Lithotriptors are presently approved by the FDA for use in the disintegration of upper urinary stones {i.e. renal calyx stones, renal pelvis stones, and upper ureteral stones}.

Conventional treatment for kidney stones involves either surgery, with a typical 7 day hospital stay, or dissolution, which can involve 3 weeks in the hospital. Lithotripsy can be performed on either an inpatient or outpatient basis; inpatient stays average about 2 days.

The cost for a fixed immersion unit is between $1-2 million, although lower cost machines, including mobile, non-immersion, and laser units, are now available. Data from the American Hospital Association shows that the average procedure takes approximately 80 minutes, including patient preparation time. Assuming a rate of 5-6 patients per working day and a 5 day work week, a fixed machine has the capacity of performing at least 1,200 procedures annually.

During the time period of 1988-1997, the rate of lithotripsy procedures performed in South Carolina ranged from 6.52 to 9.41 per 10,000 population. From this, it can be estimated that between 3,120 and 3,930 lithotripsy procedures will be performed in 2003.

Based on the available data and existing capacity, there appears to be no additional need for lithotripsy services in South Carolina. The facilities listed on the following page either have been approved under the Certificate of Need program or have been exempted from review for lithotripsy services. Utilization data is for FY 1997. The information is current as of November 1, 1999.

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.

Because of the limited number of patients for whom lithotripsy is appropriate, and the number of facilities utilizing mobile lithotriptors, such services are available within approximately forty-five (45) minutes for the majority of the population 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.

PET-EX004.0122

RECORD 003352

LITHOTRIPTORS 1999 STATE HEALTH PLAN

COUNTY	FACILITY	TYPE	CON DATE/ PROCEDURES
AIKEN	AIKEN REGIONAL MED. CTR.	MOBILE	96
ANDERSON	ANDERSON AREA MED. CTR.	MOBILE	143
BEAUFORT	BEAUFORT MEMORIAL	MOBILE	13
BEAUFORT	HILTON HEAD HOSPITAL	MOBILE	18
CHARLESTON	EAST COOPER REGIONAL	MOBILE	32
CHARLESTON	ROPER HOSPITAL	MOBILE	254
CHARLESTON	ST. FRANCIS XAVIER	MOBILE	16
CHARLESTON	TRIDENT REGIONAL	MOBILE	181
CHESTERFIELD	CHESTERFIELD GENERAL	MOBILE	16
COLLETON	COLLETON REGIONAL	MOBILE	6
DARLINGTON	BYERLY HOSPITAL	MOBILE	21
DILLON	ST. EUGENE COMMUNITY	MOBILE	24
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE	121
FLORENCE	CAROLINAS - LAKE CITY	MOBILE	11/14/98
FLORENCE	MCLEOD REGIONAL MED. CTR.	MOBILE	214
GEORGETOWN	GEORGETOWN MEMORIAL	MOBILE	25
GREENVILLE	ST. FRANCIS HOSPITAL	MOBILE	542
GREENWOOD	SELF MEMORIAL	MOBILE	80
HORRY	CONWAY HOSPITAL	MOBILE	271
HORRY	COLUMBIA-GRAND STRAND	MOBILE	184
KERSHAW	KERSHAW MEMORIAL	MOBILE	47
LANCASTER	SPRINGS MEMORIAL	MOBILE	15
LAURENS	LAURENS REGIONAL	MOBILE	2
LEXINGTON	LEXINGTON MEDICAL CENTER	MOBILE	2/18/97
LEXINGTON	UROLOGY SURGERY CENTER	MOBILE	8/12/99
MARION	MARION MEMORIAL	MOBILE	9/22/97
OCONEE	OCONEE MEMORIAL HOSPITAL	MOBILE	33
ORANGEBURG	RMC-ORANGEBURG/CALHOUN	MOBILE	88
PICKENS	BAPTIST MED. CTR. - EASLEY	MOBILE	22
PICKENS	CANNON MEMORIAL HOSPITAL	MOBILE	9/3/99
RICHLAND	BAPTIST MED. CTR.-COLUMBIA	FIXED	542
SPARTANBURG	MARY BLACK MEMORIAL	MOBILE	210
SPARTANBURG	SPARTANBURG REGIONAL	FIXED	153
SUMTER	TOUMEY REGIONAL	MOBILE	5/29/98
UNION	WALLACE THOMSON	MOBILE	0
WILLIAMSBURG	CAROLINAS-KINGSTREE	MOBILE	11/18/98
YORK	PIEDMONT MED. CTR.	MOBILE	95
		TOTAL	3,464

(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 which 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 1997, a total of 261,583 outpatient surgeries were performed in either a freestanding surgical center or a hospital in South Carolina, amounting to 65.5% 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 to existing ambulatory surgical facilities, the following criteria must be satisfied:

1. 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.

PET-EX004.0124

RECORD 003354

2. There must be support from the physicians in the area to be served. The applicant must define the proposed service area and/or provide patient origin information on the current facility.

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

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

5. 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 endoscopy procedures, another Certificate of Need would be required before the center could provide other surgical specialties.

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

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.

PET-EX004.0125

RECORD 003355

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. However, it is the determination of the Department that the benefits of improved accessibility will not outweigh the adverse affects caused by the duplication of existing services or equipment.

(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.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 1997):

Facility	County	# of OR Suites	# of Procedures	
Region I:				
AnMed Health Campus Outpatient Surgery Center	Anderson	5	----	*1*
Bearwood Ambulatory Surgery Center	Anderson	1	314	
Medicus Surgery Center	Anderson	3	3,802	*2*
Cross Creek Surgery Center	Greenville	4	5,768	
Eastside Ambulatory Care Center	Greenville	6	----	*3*
Greenville Endoscopy Center	Greenville	3	2,889	
HealthSouth Surgery Center of Greenville	Greenville	4	3,284	
Jervey Eye Center	Greenville	2	----	*4*
Same Day Surgery East	Greenville	2	877	
Spartanburg Urology Surgicenter (urological surgery only)	Spartanburg	2	1,555	
Region II:				
Greenwood Endoscopy Center	Greenwood	2	3,369	
Outpatient Surgery Center of Lexington Medical Center - Irmo	Lexington	4	2,411	*5*
South Carolina Endoscopy Center {endoscopic procedures only}	Lexington	3	----	*6*
Urology Surgery Center	Lexington	2	----	*7*
Columbia Ambulatory Plastic Surgery Center	Richland	2	461	*8*

Facility	# of OR County	# of Suites	Procedures	
Columbia Eye Surgery Center (eye surgery only)	Richland	2	2,831	
Columbia Gastrointestinal Endoscopy Center	Richland	2	2,969	
Palmetto Surgery Center	Richland	4	----	*9*
Providence Hospital Surgery Center	Richland	4	3,605	
South Carolina Medical Endoscopy Center {endoscopic procedures only}	Richland	2	----	*10*
Carolina Surgical Center	York	4	3,965	
Region III:				
Darlington Endoscopy Center {endoscopic procedures only}	Darlington	2	----	*11*
Bay Microsurgical Unit	Georgetown	1	1,645	
McLeod Ambulatory Surgery Center	Florence	2	1,339	*12*
Palmetto Same Day Surgery Center	Georgetown	3	----	*13*
Carolina Regional Surgery Center	Horry	2	1,718	
North Myrtle Beach Day Hospital	Horry	3	----	*14*
North Strand Regional Medical Center	Horry	2	----	*15*
South Strand Medical Center	Horry	3	----	*16*
Doctor's Outpatient Surgical Clinic	Marlboro	2	----	*17*
Region IV:				
Carolina Ambulatory Surgery Center	Aiken	1	450	
Dermatology Surgery Center	Beaufort	2	----	*18*

Facility	County	# of OR Suites	# of Procedures	
Hilton Head Med. Ctr. & Clinic's Ambulatory Surgery Center	Beaufort	2	----	*19*
Surgery Center of Beaufort	Beaufort	5	----	*20*
Roper Berkeley Ambulatory Surgery Center	Berkeley	3	----	*21*
Charleston Plastic Surgery Center	Charleston	2	417	*22*
HealthSouth Surgery Center of Charleston	Charleston	4	3,168	
Roper West Ashley Surgery Center	Charleston	4	2,938	
Trident Ambulatory Surgery Center	Charleston	4	4,101	
Trident Eye Surgery Center Center (eye surgery only)	Charleston	2	749	*23*
Colleton Ambulatory Care	Colleton	2	----	*24*
Edisto Surgery Center	Orangeburg	4	----	*25*

---- Facility not licensed during reporting period.

1 Licensed 12/15/97.

2 Formerly Microsurgery Center.

3 CON issued 1/26/98; licensed 5/20/99.

4 CON issued 10/21/97.

5 CON issued 10/18/99 for a 4th operating room.

6 CON issued 12/22/97; licensed 12/17/98; restricted to endoscopic procedures only.

7 CON issued 10/27/98; licensed 9/17/99.

PET-EX004.0129

RECORD 003359

8 Formerly Columbia Ambulatory Plastic Surgery Center. CON issued 12/20/96 allowing expansion from plastic and reconstructive surgery only to unrestricted ambulatory surgery services with two operating rooms; 2nd OR licensed 5/13/97.

9 CON issued 8/27/98.

10 CON issued 9/1//98; licensed 8/9/99.

11 CON issued 10/29/99.

12 Formerly Pee Dee Ambulatory Surgery Center.

13 CON issued 8/15/97.

14 CON issued 7/28/98.

15 CON issued 7/28/98.

16 CON issued 7/21/97; licensed 10/28/99.

17 CON issued 2/2/98; licensed 2/9/99.

18 CON issued 10/19/99.

19 CON approved 12/17/98; under appeal.

20 CON issued 11/19/98, for 3 OR's and 2 Endoscopy suites.

21 CON approved 9/7/99; under appeal.

22 2nd OR licensed 6/19/99.

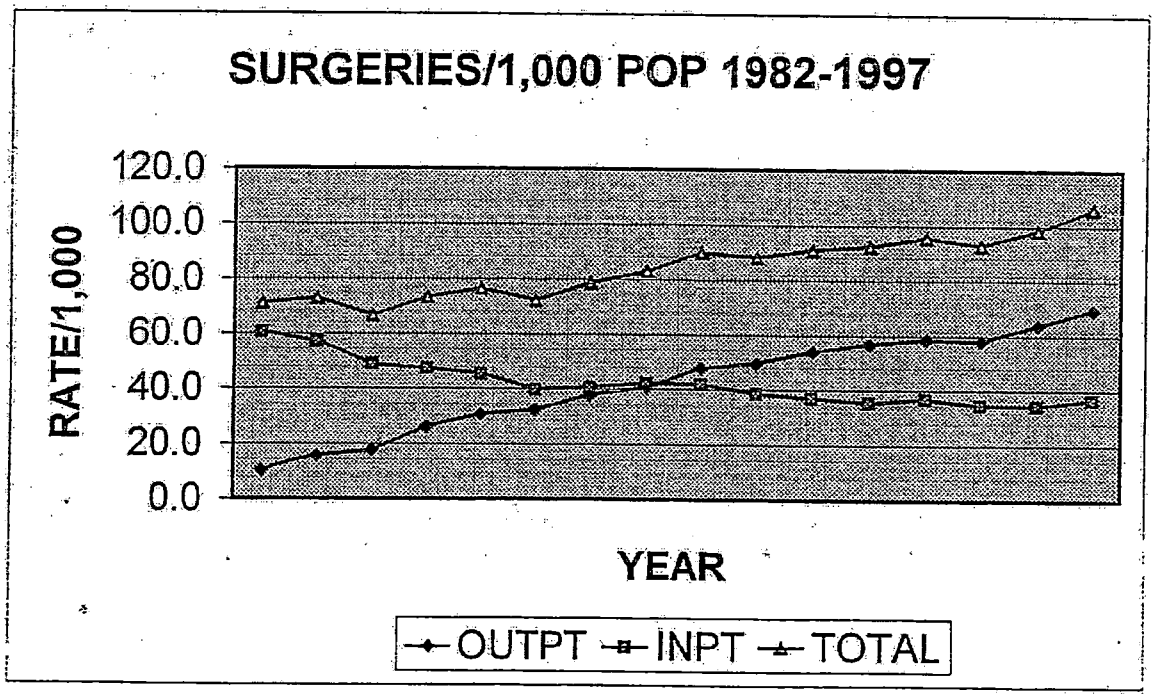
23 Formerly Ambulatory Eye & Laser Surgery Center.

24 Licensed 6/11/98.

25 CON denied 7/2/98; Board approved 11/12/98; appealed.

S.C. SURGERIES PER 1,000 POPULATION
OUTPATIENT, INPATIENT AND TOTAL
1982-1997

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%



TRAUMA REFERRAL SYSTEM

The Division of Emergency Medical Services, DHEC, has begun the development and implementation of a trauma referral system throughout the state. This system will allow 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.

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RECORD 003362

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 which 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 November 1, 1999.

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, recrational 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 which 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.

PET-EX004.0133

RECORD 003363

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.

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RECORD 003364

(3) Long-Term Care Needs

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

C.M. Tucker, Jr./Dowdy Gardner	572 beds
Dowdy Gardner/Farmer Building	162 beds
Richard Campbell Veteran's Center	220 beds
TOTAL	954 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 deinstitutionalization 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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RECORD 003365

PSYCHIATRIC BED UTILIZATION, 1997

COUNTY	FACILITY	1997 AVERAGE LICENSED BEDS	1997 OCC. RATE	
AIKEN	AURORA PAVILION	29	48.8%	
ANDERSON	ANDERSON MEMORIAL	38	43.6%	
BEAUFORT	BEAUFORT MEMORIAL	20	24.8%	
CHARLESTON	CHARLESTON MEMORIAL	15	27.5%	
CHARLESTON	MEDICAL UNIVERSITY	82	51.5%	
CHARLESTON	CHARTER - CHARLESTON	60	25.6%	
CHARLESTON	TRIDENT REGIONAL	20	53.7%	
FLORENCE	MCLEOD REGIONAL	35	39.1%	
GREENVILLE	CHARTER - GREENVILLE	45	81.8%	###
GREENVILLE	GREENVILLE MEMORIAL	72	53.5%	
GREENWOOD	SELF MEMORIAL	36	43.2%	
HORRY	COASTAL CAROLINA	45	39.7%	
LEXINGTON	CHARTER RIVERS	39	63.4%	###
MARLBORO	MARLBORO PARK HOSP.	8	12.4%	
ORANGEBURG	RMC-ORGBURG/CALHOUN	15	67.8%	
RICHLAND	BAPTIST - COLUMBIA	104	31.4%	
RICHLAND	RICHLAND MEMORIAL	60	81.6%	
SPARTANBURG	SPARTANBURG REGIONAL	56	44.4%	
SUMTER	TOUMEY REGIONAL	19	59.8%	
YORK	PIEDMONT MEDICAL CTR.	20	49.8%	
	TOTAL	**818**	**46.5%**	

TOTAL REFLECTS UTILIZATION OF DUAL-DIAGNOSIS SWING BEDS

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	1997 POP	2003 POP	97 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	<65	191200	201400	5355	15.45				
	+65	30300	33000	689	2.06				
	TOTAL	221500	234400	6044	17.51	0.80	22	38	-16
GREENVILLE,PICKENS	<65	397900	427700	19267	56.74				
	+65	55600	61000	8229	24.73				
	TOTAL	453500	488700	27496	81.47	0.80	116	125	-9
CHEROKEE,SPARTANBURG UNION	<65	279300	296100	6499	18.88				
	+65	44500	48100	2585	7.66				
	TOTAL	323800	344200	9084	26.53	0.80	33	71	-38
CHESTER,LANCASTER,YORK	<65	212200	231900	2513	7.52				
	+65	29400	32200	1124	3.37				
	TOTAL	241600	264100	3637	10.90	0.80	14	20	-6
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	165800	173600	4224	12.12				
	+65	27800	28800	1449	4.11				
	TOTAL	193600	202400	5673	16.23	0.80	20	36	-16
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	545500	586000	30311	89.21				
	+65	62500	68400	8515	25.53				
	TOTAL	608000	654400	38826	114.74	0.80	156	203	-47
DARLINGTON,FLORENCE MARION	<65	197200	202600	3952	11.12				
	+65	27500	28800	1044	3.00				
	TOTAL	224700	231400	4996	14.12	0.80	18	35	-17
CHESTERFIELD,DILLON MARLBORO	<65	86100	89400	75%	5.98				
	+65	13100	13900	STATE	2.1				
	TOTAL	99200	103300	USE RATE	8.08	0.80	10	8	2
CLARENDON,LEE,SUMTER	<65	140700	147600	3084	8.86				
	+65	17400	18200	1062	3.04				
	TOTAL	158100	165800	4146	11.91	0.80	15	19	-4

RECORD 003367

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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	1997 POP	2003 POP	97 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
GEORGETOWN,HORRY	<65	223400	244700	4600					
WILLIAMSBURG	+65	36100	41600	1922					
	TOTAL	259500	286300	6522	19.71	0.80	25	45	-20
BAMBERG,CALHOUN	<65	104100	107400	2376					
ORANGEBURG	+65	14600	14900	996					
	TOTAL	118700	122300	3372	9.52	0.80	12	15	-3
ALLENDALE,BEAUFORT	<65	166500	173800	2099	11.62				
COLLETON,HAMPTON,	+65	25400	27400	773	4.14				
JASPER	TOTAL	191900	201200	2872	15.76	0.80	23	20	3
BERKELEY,CHARLESTON	<65	459500	506500	20008	60.42				
DORCHESTER	+65	50100	57500	4009	12.61				
	TOTAL	509600	564000	24017	73.03	0.80	106	177	-71
AIKEN,BARNWELL	<65	135500	152300	3140	9.67				
	+65	20600	23300	1609	4.99				
	TOTAL	156100	175600	4749	14.64	0.80	18	29	-11
STATE TOTAL							588	841	-253
STATE MIMIMUM USE RATE	<65	3138400	3367200	102189	0.0325609	0.02			
	+65	429500	469700	31624	0.0736298	0.06			
	TOTAL	3567900	3836900	133813	0.0375047	0.03			

RECORD 003368

PET-EX004.0138

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 1997 Occ. Rate	
Charter Academy {Charleston}	32	64.3%	
Charter Rivers {West Columbia}	14	80.7%	
Charter Sands {Conway}	18	94.2%	1
Directions {DMH, Columbia}	31 (37)	66.2%	2
Marshall Pickens Hospital {Greenville}	22	83.2%	
New Hope-Charleston {Summerville}	52	92.8%	
New Hope-Midlands {West Columbia}	54	86.4%	
Southbridge {Columbia}	40	-------	3
Springbrook Behavioral Ctr. {Travelers Rest}	44	0.0%	4
York Place {York}	40	73.8%	
TOTAL	371		

1 Formerly Coastal Carolina Hospital.
2 License increased from 31 to 55 RTF beds 3/14/97, then decreased to 37 beds 4/21/99.
3 Licensed 2/11/98.
4 Formerly Chestnut Hill.

PET-EX004.0139

RECORD 003369

The following out-of-state facilities are located within 50 miles of the South Carolina border and are licensed by their respective states:

Charter of Augusta, GA	18 beds
Cedar Springs, Pineville, NC	20 beds
Charter of Savannah, GA	18 beds

CERTIFICATE OF NEED STANDARDS FOR RESIDENTIAL TREATMENT FACILITIES

Services available at a minimum should include the following:

a. 24-hour, awake supervision in a secure facility;

b. Individual treatment plans to assess the problems and determine specific patient goals;

c. Psychiatric consultation and professional psychological services for treatment supervision and consultation;

d. Nursing services, as required;

e. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

f. Recreational facilities with an organized youth development program;

g. A special education program with a minimum program defined by the South Carolina Department of Education; and

h. 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:

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

Facilities:	Marshall Pickens	22 beds
	Springbrook Behavioral	44 beds
	Total	66 beds

2002 Population Age 6-21:	226,560	
41.4 Beds/100,000 Population:	x .000414	
	94	beds
	- 66	beds
Need Shown:	28	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

2002 Population Age 6-21:	240,820	
41.4 Beds/100,000 Population:	x .000414	
	100	beds
	- 108	beds
Need Shown:	(8)	beds

Inventory Region III Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg.

Facilities:	Charter Sands	18 beds
	Total	18 beds

2002 Population Age 6-21:	175,480	
41.4 Beds/100,000 Population:	x .000414	
	73	beds
	- 18	beds
Need Shown:	55	beds

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

Facilities:	Charter Academy	32 beds
	New Hope Charleston	52 beds
	Total	84 beds

2002 Population Age 6-21:	213,120	
41.4 Beds/100,000 Population:	x .000414	
	89	beds
	- 84	beds
Need Shown:	5	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 Southbridge and Directions programs primarily serve court-ordered patients from the Department of Juvenile Justice (DJJ). As statewide facilities serving restricted populations, they are 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.

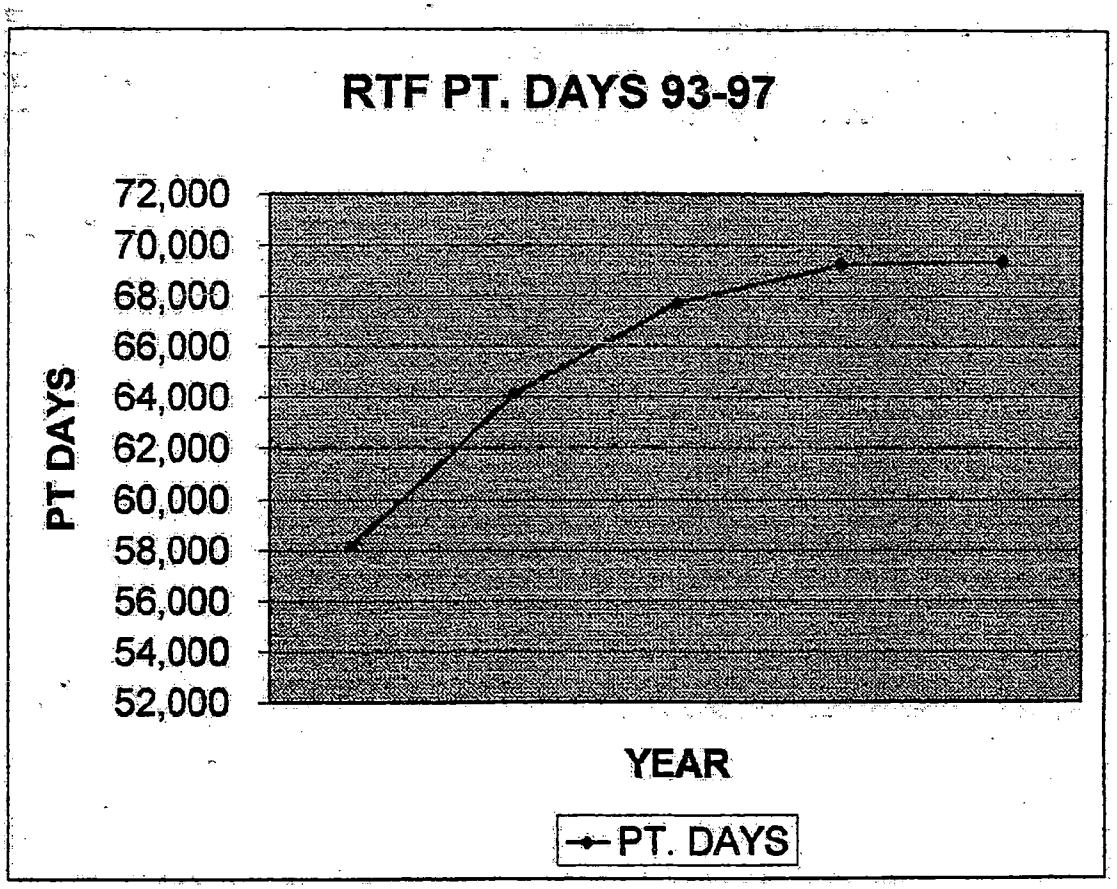
PET-EX004.0142

RECORD 003372

RTF UTILIZATION 1993-1997

DOES NOT INCLUDE DMH PROGRAMS

YEAR	PATIENT DAYS
1993	58,147
1994	64,147
1995	67,734
1996	69,235
1997	69,381



4. Alcohol and Drug Abuse Facilities

There are seven distinct providers of substance abuse treatment in South Carolina. These are: outpatient treatment services; social detoxification centers; freestanding medical detoxification facilities; supportive recovery environments; residential treatment programs; inpatient treatment services; and narcotic treatment programs. These are defined as follows:

(1) Outpatient Counseling Services

Traditional outpatient treatment includes 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 alcohol and other drug using behavior. These services address major livestyle, 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. Specialized outpatient counseling services include: intensive outpatient programs; dual diagnosis day treatment programs, and intensive in-home services. There are currently 83 licensed outpatient facilities for chemically dependent or addicted persons in South Carolina.

CERTIFICATE OF NEED REQUIREMENTS

Certificate of Need is not required for outpatient counseling services.

(2) Social Detoxification Centers (ASAM III.2-D)

A service providing supervised withdrawal from alcohol or other drugs in which neither the patient's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal. Admission to a social setting detoxification facility is authorized by a licensed health care professional. Written transfer agreements are in place for emergency medical services, if needed. Personnel are available who are specially trained to monitor the patient's physical condition and to obtain, not provide, medical services, except that lifesaving procedures such as CPR are provided. The primary objective of this service is to provide twenty-four hour a day observation of the patient until such time as he can be referred to the appropriate modality for ongoing treatment and rehabilitative care.

Social detoxification includes:

(a) Screening and intake provided by personnel specially trained to monitor the patient's physical condition. All admissions are authorized by a licensed health care professional within 24 hours of admission.

(b) Development of an individual treatment plan for supervised withdrawal.

PET-EX004.0144

RECORD 003374

(c) Continuing observation of each patient's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action.

(d) Dietary service, room and board, and other care and supervision necessary for the maintenance of the patient.

(e) Counseling designed to motivate patients to continue in the treatment process.

(f) Referral to the appropriate treatment modality.

INVENTORY

Facility	Beds
Horry County Commission	10
Suncrest Center (Marlboro County)	13
Spring Branch (Marion County)	9
Newberry County Commission	5
Spartanburg County Commission	15
Freedom House (Sumter County)	10
TOTAL	62

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a social detoxification center.

(3) Freestanding Medical Detoxification Facilities (ASAM III. 7-D)

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from chemically induced intoxification, with the capacity to provide screening for medical complications of alcohol and/or drug abuse and a structured program of counseling and referral for further rehabilitative care. Such facilities may offer social detoxification services. These facilities are not connected to or located on the same physical site as inpatient treatment facilities.

Medical detoxification services should provide at a minimum the following treatment and support services:

(a) Intake medical examination and screening on all admissions under the supervision of a licensed physician to determine need for further medical services and referral capacity for serious medical complications. All facilities should have definite transfer agreements in writing for emergency medical services as needed.

(b) Development of an individual treatment plan for supervised withdrawal including any medication to assist in the withdrawal process.

(c) Continuing observation of each patient's condition to recognize and evaluate significant signs and symptoms and take appropriate action.

(d) Dietary service, room and board, and other care and supervision necessary for the health and safety of the patient.

(e) Counseling designed to motivate patients to continue in the treatment process and referral to the appropriate treatment modality.

INVENTORY

Facility	Beds	1997 Occupancy
Carolinas Hospital System (Florence County)	4	20.4%
Charleston County Commission	15	75.3%
Greenville County Commission	27	36.2%
Lexington/Richland A.D.A.C.	25 (16)	55.4% *1*
Keystone Detoxification Center (York County)	12	51.8%
TOTAL	83 (74)	50.5%

1 Delicensed 9 beds 1/98.

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for freestanding medical detoxification beds. The 1997 utilization rates are used to project the need for services in 2003. 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.

PET-EX004.0146

RECORD 003376

DETOXIFICATION BED NEED

SERVICE AREA	1997 POP	2003 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	177,000	188,700	0	3.35	0.80	4	0	4
GREENVILLE,PICKENS	362,500	393,900	3,565	10.61	0.80	13	27	-14
CHEROKEE,SPARTANBURG UNION	258,900	277,000	0	4.91	0.80	6	0	6
CHESTER,LANCASTER,YORK	192,300	211,900	2,254	6.80	0.80	9	12	-3
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	153,900	160,700	0	2.85	0.80	4	0	4
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	486,700	528,200	5,059	9.37	0.80	12	16	-4
DARLINGTON,FLORENCE MARION	175,200	181,900	298	3.23	0.80	4	4	0
CHESTERFIELD,DILLON MARLBORO	77,900	81,900	0	1.45	0.80	2	0	2
CLARENDON,LEE,SUMTER	120,500	127,800	0	2.27	0.80	3	0	3
GEORGETOWN,HORRY WILLIAMSBURG	206,700	230,700	0	4.09	0.80	5	0	5
BAMBERG,CALHOUN ORANGEBURG	91,200	95,200	0	1.69	0.80	2	0	2
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	150,800	160,100	0	2.84	0.80	4	0	4
BERKELEY,CHARLESTON DORCHESTER	395,800	443,300	4,123	12.65	0.80	16	15	1
AIKEN,BARNWELL	121,700	138,000	0	2.45	0.80	3	0	3
STATE TOTAL	2,971,100	3,219,300	15,299	68.57		87	74	13
MINIMUM USE RATE	0.0064744							

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 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:

a. Compliance with the Need Outlined in this Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Ability of the Applicant to Complete the Project;
f. Cost Containment; and
g. 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 additional beds in almost every service area. 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 be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(4) Supportive Recovery Environment (ASAM III.1)

A short-term therapeutic group residence for persons who have a substance related disorder, designed as a halfway house or as a transitional living center for persons who are in need of a stable and supportive environment to aid in their recovery.

Supportive Recovery Environments provide the following services:

(a) Assessment and development of a treatment plan with the client.

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(b) Individual, group, and/or family counseling directed toward specific client goals indicated in the client's treatment plan. Counseling activities should be conducted at least once a week. Any and all treatment activities may occur in a separate program and/or separate location.

(c) Room and board including shared responsibility by residents for daily operation of the facility (i.e. cooking, cleaning, maintenance of house rules, etc.); self-government to the highest degree feasible is encouraged.

(d) Vocational counseling for any client when indicated. Eventual job placement, when appropriate, preferably in the immediate community, should occur as soon as possible.

(e) Leisure time activities including recreational activities.

(f) Discharge plans including any referrals made for follow-up treatment, and a summary of treatment outcome, and proposed frequency of aftercare contact.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a Supportive Recovery Environment.

(5) Residential Treatment Programs (ASAM III. 5 and III. 7)

An organized service with designated addictions personnel or addictions credentialed clinicians, that provides a planned regimen of 24 hour professionally directed evaluation, care, and treatment for addicted patients in a residential setting. Such a program functions under a defined set of policies and procedures.

This level of care utilizes a multidisciplinary staff for patients whose biomedical and emotional/behavioral problems are severe enough to require residential services. Twenty-four hour observation, monitoring, and treatment are available as appropriate. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment service system are not provided. The treatment is specific to psychoactive substance abuse/dependence.

Residential treatment programs have the following characteristics:

Support Systems:

(a) Availability of specialized professional consultation, supervision and direct affiliation with other levels of care.

(b) Physician availability and nursing care and observation are available as warranted based on clinical judgement.

(c) Ability to arrange for appropriate laboratory and toxicology tests.

Staff:

(a) A physician needs to be available 24 hours a day by telephone.

(b) A physician needs to assess the patient in person within 72 hours following admission and thereafter as medically necessary.

(c) A multidisciplinary team of appropriately trained clinicians is able to assess and treat adult alcohol and/or other drug dependent patients and to obtain and interpret information regarding the needs of these patients. Such clinicians must be knowledgeable about the biological and psychological dimensions of alcohol and/or other drug dependence.

(d) Licensed staff is available to administer medications in accordance with physician's prescription and/or orders. The intensity of nursing care is appropriate to the services provided by the unit.

(e) Licensed, certified or registered addictions clinicians provide a planned regimen of 24 hour professionally directed, evaluation, care and treatment services for addicted persons and their families.

Therapies:

(a) A multidisciplinary treatment team provides daily clinical services to assess and address the individual needs of each patient. Such clinical services may include appropriate medical services, individual and group services.

(b) A range of cognitive, behavioral and other therapies are administered to the patient on an individual and/or group basis.

(c) Health education services are provided.

(d) Planned clinical program activities are designed to enhance the patient's understanding of addiction.

(e) Multidisciplinary individualized assessments and treatment are provided.

(f) Family and significant other services are provided.

Assessments/Treatment Plan Review:

(a) Physical examination by a physician within 72 hours following admission or a physical examination which was conducted within 7 days prior to admission and evaluated by the facility physician within 24 hours following admission.

(b) Biopsychosocial assessment, individualized treatment and ongoing updates of treatment plans are based on the clinical progress of the patient as reviewed by the multidisciplinary treatment team.

(c) An individualized treatment plan includes problems and treatment goals.

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.

(6) 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.

INVENTORY

Facility	Beds	1997 Occupancy	
Aiken Regional Medical Center	18	15.0%	
AnMed-Wellspring (Anderson County)	27	27.1%	
Carolinas Hospital System (Florence County)	42	20.4%	
Charter - Charleston	10	31.9%	
Charter - Greenville	10	50.3%	*1*
Charter Rivers (Lexington County)	27	17.5%	
Charter Sands (Horry County)	15	24.6%	*2*
Eliott White Springs Memorial (Lancaster County)	45	41.1%	
Fairfield Memorial Hospital	17	2.4%	
Holmesview Center (Greenville County)	40	64.9%	*3*
Marshall Pickens (Greenville County)	18	18.8%	*4*
McCord Adolescent (Orangeburg County)	15	31.2%	*3*
Medical University (Charleston County)	23	41.1%	
Morris Village (Richland County)	173	82.3%	*3*
Palmetto Center (Florence County)	48	71.5%	*3*
Richland Springs (Richland County)	10	76.1%	
Roper North (Charleston County)	44	39.0%	
Self Memorial (Greenwood County)	24	23.4%	
TOTAL	330 (312)	31.2%	

1 Partial Year of Data.
2 Formerly Coastal Carolina Hospital
3 Statewide Facility, Not Included in Bed Need Calculations.
4 Approval granted 10/22/99 to permanently close the 18 beds at Marshall Pickens.

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for inpatient treatment beds. The 1997 utilization rates are used to project the need for services in 2003. An occupancy factor of 80% was used in the calculations. The greater of the service area's actual utilization or 75% of the

INPATIENT BED NEED

SERVICE AREA	1997 POP	2003 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	177,000	188,700	2,673	7.81	0.80	10	27	-17
GREENVILLE,PICKENS	362,500	393,900	5,090	15.15	0.80	19	10	9
CHEROKEE,SPARTANBURG UNION	258,900	277,000	0	9.05	0.80	11	0	11
CHESTER,LANCASTER,YORK	192,300	211,900	6,754	20.39	0.80	25	45	-20
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	153,900	160,700	2,048	5.86	0.80	7	24	-17
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	486,700	528,200	4,645	17.25	0.80	22	54	-32
DARLINGTON,FLORENCE MARION	175,200	181,900	3,135	8.92	0.80	11	42	-31
CHESTERFIELD,DILLON MARLBORO	77,900	81,900	0	2.67	0.80	3	0	3
CLARENDON,LEE,SUMTER	120,500	127,800	0	4.17	0.80	5	0	5
GEORGETOWN,HORRY WILLIAMSBURG	206,700	230,700	1,347	7.53	0.80	9	15	-6
BAMBERG,CALHOUN ORANGEBURG	91,200	95,200	0	3.11	0.80	4	0	4
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	150,800	160,100	0	5.23	0.80	7	0	7
BERKELEY,CHARLESTON DORCHESTER	395,800	443,300	10,882	33.39	0.80	42	77	-35
AIKEN,BARNWELL	121,700	138,000	983	4.51	0.80	6	18	-12
STATE TOTAL	2,971,100	3,219,300	37,557	145.04		181	312	-131
MINIMUM USE RATE	0.0119203							

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, 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:

h. Compliance with the Need Outlined in this Plan;
i. Distribution (Accessibility);
j. Projected Revenues;
k. Projected Expenses;
l. Ability of the Applicant to Complete the Project;
m. Cost Containment; and
n. Staff Resources.

There are currently 14 inpatient treatment facilities in the state. There is a projected need for additional beds in only a few 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 be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(7) 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:

Support Systems:

(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.

Staff:

(a) An interdisciplinary team of appropriately trained and credentialed addiction professionals, including a medical director, counselors, and the medical staff delineated below;

(b) 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

(c) A physician, who is available during medication dispensing and clinic operating hours, either in person or by telephone.

Therapies:

(a) Interdisciplinary individualized assessment and treatment;

(b) Assessing, prescribing, administering, reassessing and regulating dose levels appropriate to the individual; supervising detoxification from opiates, methadone or LAAM; overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders;

(c) Monitored urine testing;

(d) Counseling services;

(e) Case management; and

(f) Psychoeducation, including HIV/AIDS and other health education services.

INVENTORY

Facility	Location
Center for Behavioral Health South Carolina, Inc.	North Charleston
Columbia Metro Treatment Center, Inc.	West Columbia
DAODAS of Charleston	Charleston
Greenville Metro Treatment Center, Inc.	Greenville
Piedmont Treatment Center, Inc.	Greenville
York County Treatment Center, Inc.	Fort Mill

The following table indicates the number of clients as of September 1, 1998, 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 1997.

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METHADONE CLIENTS SERVED BY COUNTY AND
EMERGENCY ROOM VISITS FOR OPOID AND COCAINE DEPENDENCE
BY COUNTY OF RESIDENCE OF CLIENTS

COUNTY	Methadone Centers	Emergency Room Visits
Abbeville		4
Aiken		19
Allendale		
Anderson	30	61
Bamberg		4
Barnwell		6
Beaufort	6	3
Berkeley	29	8
Calhoun	2	
Charleston	228	38
Cherokee	5	11
Chester		1
Chesterfield		3
Clarendon		2
Colleton	1	1
Darlington		5
Dillon		
Dorchester	41	6
Edgefield		3
Fairfield	2	10
Florence	14	19
Georgetown	11	4
Greenville	179	19
Greenwood	6	14
Hampton		
Horry	6	16
Jasper	2	
Kershaw	4	10
Lancaster	13	9
Laurens	15	2
Lee		34
Lexington	44	
McCormick		1
Marion		1
Marlboro	3	29
Newberry	3	1
Oconee	2	6
Orangeburg	4	2
Pickens	18	9
Richland	115	76
Saluda	2	1
Spartanburg	135	28
Sumter		6
Union	4	3
Williamsburg		4
York	31	22
NC	181	
GA	18	
Other states	36	10
TOTAL	1190	511

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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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 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

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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, Regional Medical Center of Orangeburg and Calhoun Counties, and Tourney Hospital. It is also recognized that Crenshaw Creek, a nursing home in Lancaster County, treats Traumatic Brain Injury (TBI) patients; however, like the units mentioned above, it is not considered to be providing comprehensive rehabilitation services as defined in this section of the Plan.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	1997 Occupancy	
I	Roger C. Peace	Greenville	50 (53)	70.4%	*1*
I	St. Francis	Greenville	19	77.1%	
I	Mary Black	Spartanburg	18	81.3%	
II	HealthSouth	Richland	89 (77)	80.7%	*2*
II	Piedmont Med. Ctr.	York	0 (20)	---	*2*
III	HealthSouth	Florence	88	73.7%	
III	Carolinas Hospital	Florence	24	53.3%	
IV	HealthSouth	Charleston	39	76.0%	*3*
IV	M.U.S.C.	Charleston	25	82.5%	
IV	Roper Hospital	Charleston	39	62.4%	

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 10/26/98 to add 3 additional beds; licensed 11/23/98.

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 of over 48,000.

In addition to the above referenced beds, there are rehabilitation facilities in Charlotte (152 beds), Asheville (100 beds), Augusta (80 beds), Wilmington (120 beds) and Savannah (15 beds).

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CERTIFICATE OF NEED STANDARDS FOR REHABILITATION

DEFINITIONS

(1) A 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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 75% was used to calculate projected bed needs. The greater of the service area's actual utilization or 75% of the statewide use rate was used to project bed needs. This information is current as of November 1, 1999.

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; {continued next page}

e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

Rehabilitation facilities are now located throughout the state and are 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

1999 HEALTH PLAN

SERVICE AREA	1997 POP	2003 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	221,500	234,400	0	13.40	0.75	18	0	18
GREENVILLE,PICKENS	453,500	488,700	18,534	54.72	0.75	73	72	1
CHEROKEE,SPARTANBURG UNION	323,800	344,200	5,343	15.56	0.75	21	18	3
CHESTER,LANCASTER,YORK	241,660	264,100	0	15.09	0.75	20	20	0
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	195,600	202,400	0	11.57	0.75	15	0	15
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	560,000	602,900	26,213	77.32	0.75	103	77	26
CHESTERFIELD,DARLINGTON, DILLON,FLORENCE,MARION, MARLBORO,WILLIAMSBURG	361,400	371,900	28,327	79.86	0.75	106	112	-6
CLARENDON,KERSHAW,LEE SUMTER	206,100	217,300	0	12.42	0.75	17	0	17
GEORGETOWN,HORRY	222,000	249,100	0	14.24	0.75	19	0	19
AIKEN,ALLENDALE,BAMBERG, BARNWELL,CALHOUN, ORANGEBURG	286,400	309,900	0	17.71	0.75	24	0	24
BEAUFORT, COLLETON HAMPTON,JASPER	180,300	189,200	0	10.81	0.75	14	0	14
BERKELEY,CHARLESTON DORCHESTER	509,600	564,000	26,212	79.48	0.75	106	103	3
STATE TOTAL	3,761,860	4,038,100	104,629	402.18		536	402	134
MINIMUM USE RATE	0.0208598							

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:

(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 based on 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 2001. There are currently 343 additional nursing home beds approved and either under construction or development.

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A two-year projection, through 2001, of the nursing home bed need for the general (noninstitutional) population is used for the following reasons:

(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:

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(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.

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 December 1, 1999.

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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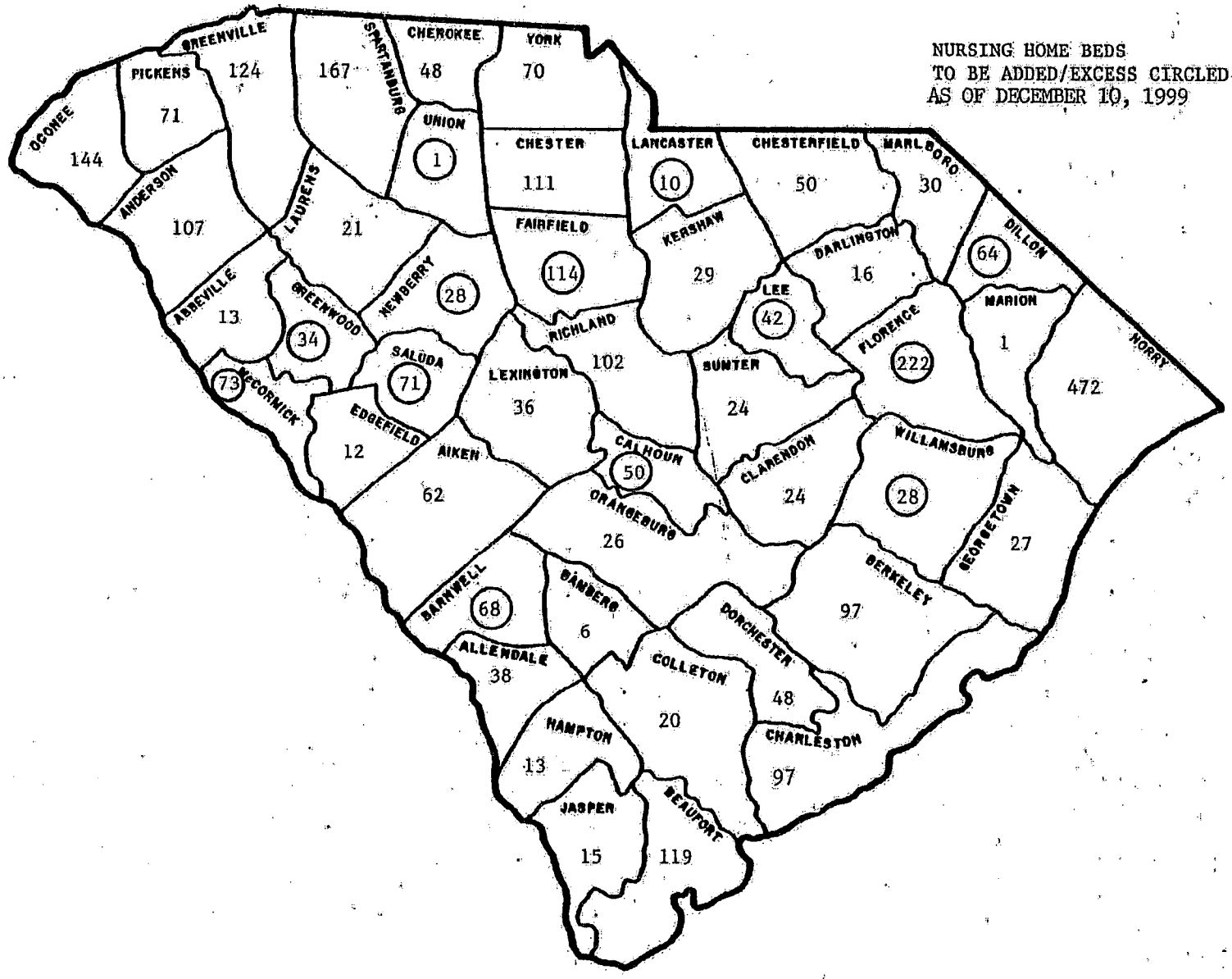
LONG TERM CARE BED NEED		2001 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	TO BE ADDED/OR EXCESS
	ANDERSON	23.100	901	794	107
	CHEROKEE	6.800	265	217	48
	GREENVILLE	46.800	1825	1701	124
	OCONEE	9.100	355	211	144
	PICKENS	12.700	495	424	71
	SPARTANBURG	35.000	1365	1198	167
	UNION	5.000	195	196	-1
REGION I	TOTAL	138.500	5401	4741	661
	ABBEVILLE	3.300	129	116	13
	CHESTER	5.400	211	100	111
	EDGEFIELD	2.400	100	88	12
	FAIRFIELD	3.800	148	262	-114
	GREENWOOD	8.600	335	369	-34
	KERSHAW	6.800	265	236	29
	LANCASTER	7.700	300	310	-10
	LAURENS	9.900	386	365	21
	LEXINGTON	20.000	780	744	36
	MCCORMICK	1.200	47	120	-73
	NEWBERRY	5.400	248	276	-28
	RICHLAND	30.500	1190	1088	102
	SALUDA	2.700	105	176	-71
	YORK	18.400	718	648	70
REGION II	TOTAL	126.100	4962	4898	394
	CHESTERFIELD	6.700	261	211	50
	CLARENDON	4.500	176	152	24
	DARLINGTON	8.600	366	350	16
	DILLON	3.700	144	208	-64
	FLORENCE	14.700	573	795	-222
	GEORGETOWN	6.900	269	242	27
	HORRY	29.900	1166	694	472
	LEE	2.000	78	120	-42
	MARION	4.700	191	190	1
	MARLBORO	3.800	148	118	30
	SUMTER	11.600	452	428	24
	WILLIAMSBURG	3.800	148	176	-28
REGION III	TOTAL	100.900	3972	3684	644
	AIKEN	20.000	780	718	62
	ALLENDALE	2.100	82	44	38
	BAMBERG	2.400	94	88	6
	BARNWELL	2.600	101	169	-68
	BEAUFORT	15.400	601	482	119
	BERKELEY	10.600	413	316	97
	CALHOUN	1.800	70	120	-50
	CHARLESTON	36.900	1439	1342	97
	COLLETON	5.000	195	175	20
	DORCHESTER	8.500	332	284	48
	HAMPTON	3.000	117	104	13
	JASPER	1.700	103	88	15
	ORANGEBURG	11.000	442	416	26
REGION IV	TOTAL	121.000	4769	4346	541
GRAND TOTAL		486.500	19104	17669	2240



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COUNTY	1999 POP	NURSING BEDS	BEDS/M	RANK
CHESTER	5.500	100	18.18	1
ALLENDALE	1.900	44	23.16	2
OCONEE	9.000	211	23.44	3
HORRY	28.000	694	24.79	4
CHESTERFIELD	6.700	211	31.49	5
BERKELEY	10.000	316	31.60	6
MARLBORO	3.700	118	31.89	7
CHEROKEE	6.700	217	32.39	8
HAMPTON	3.100	104	33.55	9
CLARENDON	4.500	152	33.78	10
DORCHESTER	8.400	284	33.81	11
BEAUFORT	14.100	482	34.18	12
PICKENS	12.300	424	34.47	13
ANDERSON	22.900	794	34.67	14
ABBEVILLE	3.300	116	35.15	15
SPARTANBURG	34.000	1198	35.24	16
COLLETON	4.900	175	35.71	17
LAURENS	10.100	365	36.14	18
RICHLAND	30.100	1088	36.15	19
KERSHAW	6.500	236	36.31	20
BAMBERG	2.400	88	36.67	21
YORK	17.600	648	36.82	22
AIKEN	19.500	718	36.82	23
GREENVILLE	45.700	1701	37.22	24
CHARLESTON	35.900	1342	37.38	25
LEXINGTON	19.500	744	38.15	26
SUMTER	11.100	428	38.56	27
ORANGEBURG	10.700	416	38.88	28
GEORGETOWN	6.200	242	39.03	29
MARION	4.800	190	39.58	30
EDGEFIELD	2.200	88	40.00	31
UNION	4.900	196	40.00	32
DARLINGTON	8.700	350	40.23	33
LANCASTER	7.300	310	42.47	34
GREENWOOD	8.600	369	42.91	35
WILLIAMSBURG	3.900	176	45.13	36
NEWBERRY	5.600	276	49.29	37
JASPER	1.700	88	51.76	38
LEE	2.300	120	52.17	39
FLORENCE	14.600	795	54.45	40
DILLON	3.300	208	63.03	41
BARNWELL	2.600	169	65.00	42
SALUDA	2.700	176	65.19	43
CALHOUN	1.700	120	70.59	44
FAIRFIELD	3.700	262	70.81	45
MCCORMICK	1.300	120	92.31	46
	474.2	17669	37.26	

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

NOTES: 36,500 patient days = 100 beds

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RECORD 003401

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. The following table indicates the types of residential programs needed to service this population through 1998. The numbers under current capacity are as of June 30, 1997.

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.

All of the 4,482 community beds indicated as needed do not need to be constructed. Some supervised living and community training home beds do not require construction. However, some beds need to be constructed to replace the loss of beds from the regional centers and to meet waiting list needs. 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.

Facility/Program	Current Capacity	Needed Capacity	Additional Need
ICF/MR's	1,182	1,635	453
CRCF Community Residences	74	74	0
Supervised Living Program	681	957	276
Community Training Homes	1,195	1,816	621
TOTAL (Community beds)	3,132	4,482	1,350
Regional Centers	1,426	1,426	0
GRAND TOTAL	4,558	5,908	1,350

B. Retirement Community: Nursing Home Units Restricted Beds)

A specialized nursing home bed need 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 retirement community nursing homes (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.

C. Swing Beds:

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.

Omnibus Budget Reconciliation Act of 1987 amendments permit payment under Medicaid or Medicare for extended care services to any hospital that:

-- Has a Medicare provider agreement;

-- Has fewer than 100 beds, excluding newborn and ICU/CCU beds;

-- 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 Medicare Skilled Nursing Facility (SNF) and Medicaid Nursing Care Facility (NCF) Conditions of Participation on patient's rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning (see below).

1. Patient's Rights: A swing-bed hospital is expected to meet 9 of 14 requirements appearing in "Subpart K.: Conditions of Participation; Skilled Nursing Facilities."

2. Rehabilitation Service: The regulations require the facility to meet SNF/NCF standards for specialized rehabilitation services, including physical therapy, occupational therapy, speech pathology, and audiology. Services made available to patients must be under the direction of qualified personnel. If a hospital does not offer these services directly, it must negotiate consulting arrangements in

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order to admit patients who need rehabilitation care. Conversely, a hospital is not required to offer these services unless it admits patients who are assessed by a physician as being in need of such care.

3. Dental Services: A swing-bed hospital must make arrangements to provide dental services. The hospital should keep accurate records of dentists available in its community and assist patients in obtaining dental services. In addition, the hospital must locate an advisory dentist to assist in staff development for nursing and other appropriate personnel and recommend oral hygiene policies and practices for the care of patients.

4. Social Services: A swing-bed hospital must make satisfactory arrangements for identifying the social and emotional needs of patients. In-house social services are not mandatory, but if referral arrangements are substituted, they must be documented. When services are provided in-house, social services must be delivered by a qualified social worker or a responsible individual who is receiving frequent and regular consultation from a qualified social worker.

5. Patient Activities: A qualified activities coordinator must be appointed to develop and deliver meaningful programs or activities designed to promote the physical, social, and mental well-being of patients. An occupational therapist or an occupational therapy assistant, as well as an individual with two years experience in patient activities, may qualify as a coordinator. A hospital can also arrange for regular consultation from an outside source if a qualified individual is unavailable for employment.

6. Discharge Planning: A swing-bed hospital must provide an organized discharge planning program with pertinent, up-to-date records managed by a discharge planning coordinator. The program must be evaluated periodically by the hospital's utilization review committee.

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 each SNF/NCF in its geographic region. The geographic region means an area that includes the SNF/NCFs with which a hospital has traditionally arranged transfers and all other SNF/NCFs within the same proximity to the hospital. For hospitals without existing transfer practices, the geographic region includes all SNF/NCFs within 50 miles of the hospital unless the hospital can demonstrate that the SNF/NCFs are inaccessible.

2. The hospital must transfer the swing-bed patient within 5 weekdays (excluding weekends and holidays) to a SNF/NCF in the

geographic area if there is an available SNF/NCF bed, unless the patient's physician certifies that the transfer is not medically appropriate.

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. **	24	56	1449	4.0
Allendale Co. **	19	60	4605	12.6
Bamberg Co. Mem. **	24	92	6589	18.1
Barnwell Co. **	24	33	1525	4.2
Beaufort Co. Mem.	--			
B.J. Workman **	21	34	7815	21.4
Cannon Memorial	--			
Carolinas-Kingstree **	39 (a)	21	171	0.7
Carolinas-Lake City **	23	80	3372	9.2
Chester County	--			
Chesterfield Gen.	--			
Clarendon Memorial	--			
Edgefield Co. **	19	42	5248	14.4
Fairfield Memorial **	24	18	800	2.2
Hampton Regional **	10	69	1797	4.9
Hilton Head	--			
Laurens County	--			
Loris Comm.	--			
Low Country	--			
Marion Co. Med. Ctr.	--			
Newberry Co. Mem.	--			
Saint Eugene Med. Ctr.	--			
Wallace Thompson **	49	91	3782	10.4
Williamsburg Co. Mem.	--			
Wilson Medical Ctr **	24	149	6484	17.8
TOTALS	276	745	43637	119.6

** Participates in the swing bed program.

(a) Approved for swing bed program on 4/14/97.

The number of swing beds listed above is the maximum that the hospital could utilize. Many hospitals are operating less than the maximum. In 1997, there were 12 hospitals participating in the swing bed program with 745 admissions and 43,637 patient days for an average length of stay of 58.6 days. The average number of patients per day in swing beds was 120.

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

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disorders; records and reports to the physician the patients reaction to treatment and 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-administerd, 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

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provides services planned to restore the patient to optimum social and health adjustment, assists patients and families with personal and environmental 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 1997 for the home health agencies in South Carolina were:

Total Visits	4,055,843
Nursing visits	40.6%
Home health aide visits	40.1%
Physical therapy visits	11.8%
Medical social worker visits	2.5%
Speech therapy visits	1.5%
Occupational therapy visits	2.2%
Other	1.3%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

The demand for home health services in recent years has been:

Year	People Served
1980	17,170
1981	18,021
1982	19,751
1983	24,013
1984	28,511
1985	30,360
1986	31,012
1987	30,004
1988	31,230
1989	32,727
1990	36,827
1991	41,912
1992	49,035
1993	55,551
1994	65,754
1995	77,214
1996	86,070
1997	88,711

Some of the reasons for the increased demand 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.

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Of the current patients receiving home health services, approximately 34% are less than age 65 and 66% 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 support for an additional home health agency. These need and support letters must be on letterhead and define which practice and speciality 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. These letters must also be personally signed by the physician or discharge planner. 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 90% 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 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.

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.

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 (Acceptability);
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 December 1, 1999. The number of patients served is for fiscal year 1997 for private agencies; for DHEC districts, July 1, 1996 to June 30, 1997.

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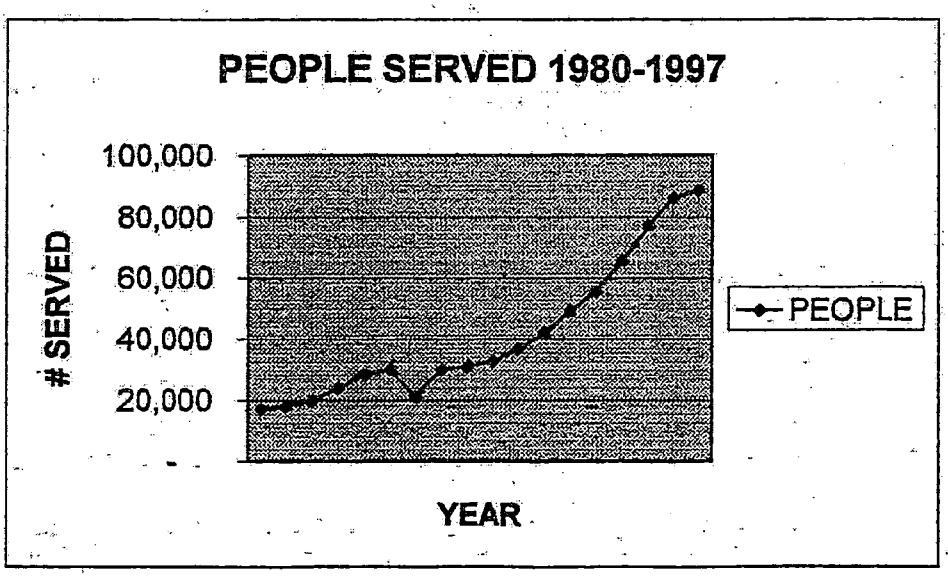
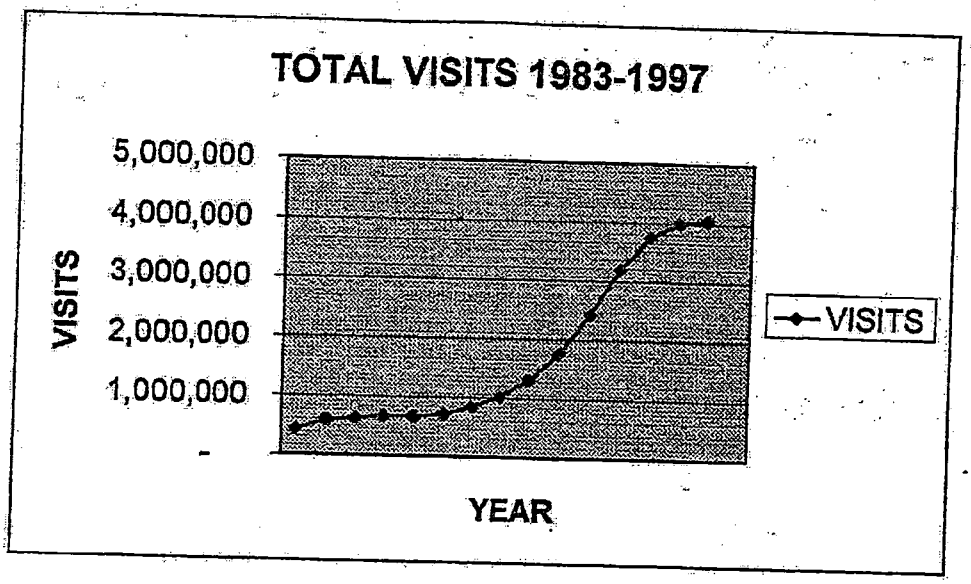
HOME HEALTH AGENCIES

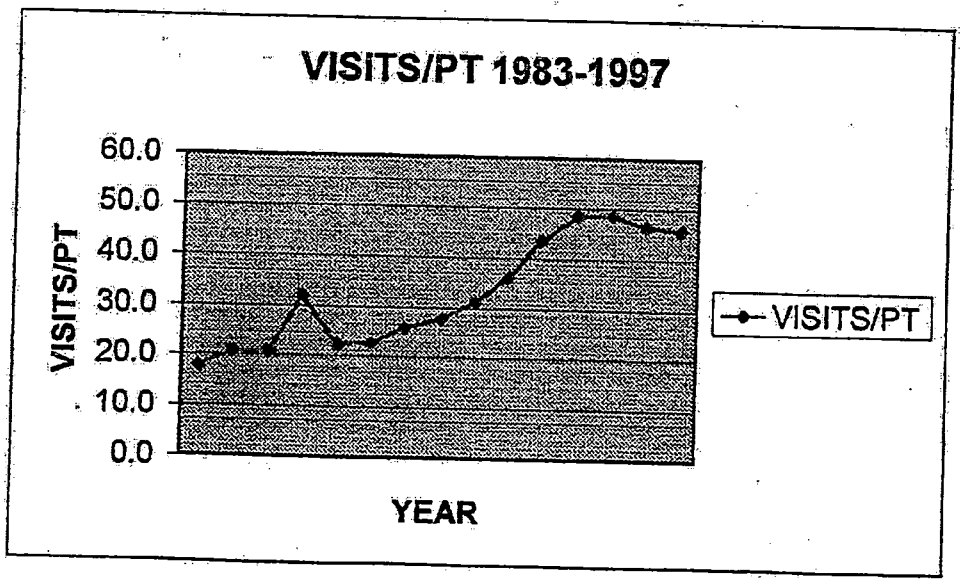
COUNTY OF RESIDENCE	1997 TOTAL PATIENTS	1997 POP. (000s)	PERSONS SERVED/ 1000 POP	BELOW STATE AVG.	NEW AGENCY /P 1/1/97	# OF EXIST. HHAs	NEW HHA CAN BE APPROVED
Abbeville	626	23.90	26.19	—	—	4	—
Aiken	2,591	133.80	19.36	YES	—	5	YES
Allendale	323	11.60	27.84	—	—	3	—
Anderson	3,550	158.10	22.45	—	—	6	—
Bamberg	531	16.80	31.61	—	—	2	—
Barnwell	518	22.30	23.23	—	—	3	—
Beaufort	2,435	106.80	22.80	—	—	6	—
Berkeley	2,037	134.40	15.16	YES	—	9	—
Calhoun	288	14.30	20.14	YES	YES	5	—
Charleston	7,925	284.80	27.83	—	—	11	—
Cherokee	1,275	48.40	26.34	—	—	5	—
Chester	716	33.20	21.57	—	—	3	—
Chesterfield	1,049	40.10	26.16	—	—	3	—
Clarendon	853	31.30	27.25	—	—	2	—
Colleton	1,278	37.00	34.54	—	—	6	—
Darlington	1,502	65.70	19.45	YES	—	4	—
Dillon	1,009	29.60	34.09	—	—	4	—
Dorchester	1,504	90.40	16.64	YES	—	9	—
Edgefield	459	19.60	23.42	—	—	4	—
Fairfield	574	21.90	26.21	—	—	3	—
Florence	3,607	124.50	28.97	—	—	4	—
Georgetown	1,219	52.50	23.22	—	—	6	—
Greenville	9,114	348.70	26.14	—	YES	7	—
Greenwood	1,252	63.30	19.78	YES	—	5	—
Hampton	505	19.60	25.77	—	—	4	—
Horry	3,948	169.50	23.29	—	YES	6	—
Jasper	416	16.90	24.62	—	—	5	—
Kershaw	1,268	48.00	26.42	—	—	3	—
Lancaster	1,710	57.80	29.58	—	—	2	—
Laurens	1,268	62.30	20.35	—	—	6	—
Lee	466	20.20	23.07	—	—	4	—
Lexington	3,762	200.20	18.79	YES	—	7	—
McCormick	207	9.40	22.02	—	—	3	—
Marion	1,144	34.50	33.16	—	—	3	—
Marlboro	863	29.50	29.25	—	—	4	—
Newberry	799	34.50	23.16	—	—	3	—
Oconee	1,719	63.40	27.11	—	—	4	—
Orangeburg	2,177	87.60	24.85	—	YES	5	—
Pickens	2,115	104.80	20.18	YES	—	6	—
Richland	5,819	303.40	19.18	YES	YES	8	—
Saluda	424	17.10	24.80	—	—	4	—
Spartanburg	6,256	244.90	25.55	—	—	5	—
Sumter	1,919	106.60	18.00	YES	—	4	YES
Union	841	30.50	27.57	—	—	2	—
Williamsburg	1,068	37.50	28.48	—	—	4	—
York	3,007	150.60	19.97	YES	—	4	YES
TOTALS	87,936	3,761.80	23.38			215	

HOME HEALTH UTILIZATION, 1980-1997

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




TOTAL VISITS 1983-1997
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-
VISITS
YEAR
VISITS


VISITS/PT 1983-1997
60.0
50.0
40.0
30.0
20.0
10.0
0.0
VISITS/PT
YEAR
VISITS/PT

HOME HEALTH AGENCIES INVENTORY-1997 DATA

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
(Abbeville Home Care) 17/	Abbeville & McCormick	(--)	(---)	---
Alliance Home Care 28/	Horry	--	---	--
ANMED Home Health Agency	Anderson	1466	55806	38.1
Appalachia I Home Health Care Services	Anderson & Oconee	1360	60099	44.2
Appalachia II Home Health Services	Greenville & Pickens	2112	100548	47.6
Appalachia III Home Health Services	Spartanburg, Union & Cherokee	3059	123047	40.2
Beaufort-Jasper Comprehensive Health Services-HHA	Beaufort & Jasper	178	6202	34.8
Bethea Home Health 30/	Darlington	2 (may serve retirement community only)	45	22.5
Care One Home Health Services 14/	Beaufort, Hampton, & Jasper	586	49524	84.5
CarePro Home Health 25/	Richland	64	2422	37.8
CareSouth Homecare Professionals, A Winyah Company-Georgetown 4/	Georgetown & Williamsburg	92	4622	50.2
CareSouth Homecare Professionals, A Winyah Company-Columbia 18/	Lexington, Richland, Orangeburg, Calhoun, Newberry, Lee & Sumter	895	50539	56.5
CareSouth of University Hosp. (North Augusta) 19/	Aiken & Edgefield	539	41684	77.3
Carolina Home Health Care 38/	Richland & Lexington	2244	56690	25.3

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Carolina Home Health Care-Greenville 8/	Anderson, Oconee, Greenville, Pickens, Cherokee, Spartanburg Laurens & Union	752 (may only serve patients in Union County whose initial diagnosis requires IV therapy services and/or home uterine activity monitoring)	25918	34.5
Catawba Home Health Svc.	Chester, York & Lancaster	2610	122434	46.9
Chesterfield General Home Health 21/	Chesterfield	195	9725	49.9
Chesterfield Visiting Nurses Services	Darlington, Marlboro & Chesterfield	439	36138	82.3
Choice Health Care Services	Colleton	403	38993	96.8
Clarendon Memorial Home Health 24/	Clarendon	210	12919	61.5
Clemson Area Retirement Center HHA 39/	Pickens	-- (may serve retirement community only)	---	---
Coastal Rivers Home Health of Low Country General Hospital 36/	Jasper	101	9236	91.4
(Community Home Care) 5/	York	58 (may serve terminally ill patients only)	1616	27.8
Cypress Club Home Health Agency 32/	Beaufort	13 (may serve retirement community only)	844	64.9
Edgefield County Hospital Home Health Services	Edgefield	164	12779	77.9
Edisto Health District Home Health Services	Bamberg, Calhoun & Orangeburg	1906	76508	40.1
Fairfield Home Health Services 10/	Fairfield	194	7096	36.6
Florence Visiting Nurses Services	Florence, Lee, Dillon & Marion	477	38413	80.5

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Foothills Home Care 6/	Oconee	1 (may serve terminally ill patients only)	57	57.0
Franke Home Health 42/	Charleston	-- (may serve retirement center residents only)	---	
Franklin C. Fetter Home Health Agency	Charleston	472	52871	112.0
Greenville Hospital System HHA	Greenville & Pickens	2317	67836	29.3
HealthCalls Professional Home Health Services 22/	Berkeley, Charleston & Dorchester	276	15894	57.6
Health Related Home Care, Inc. 17/	Abbeville, Laurens, Greenwood, Saluda & McCormick	672	24953	37.1
Hitchcock Rehabilitation Center, Inc.-HHA	Aiken	846	33533	39.6
HomeCare of HospiceCare of the Piedmont 11/	Abbeville, Greenwood, Laurens, McCormick, & Saluda	26 (may serve terminally ill patients only)	633	24.3
Home Care of Lancaster	Lancaster	751	43040	57.3
(Home Care of the Pee Dee) 33/	Florence, Marion & Darlington	9 (may serve terminally ill patients only)	386	42.9
Home Care of the Regional Medical Center 12/	Calhoun & Orangeburg	9	390	43.3
(Home Health Services Inc./Charleston) 22/	Charleston, Berkeley & Dorchester	239	20731	86.7
Home Health of S.C., Inc. - Lowcountry 20/	Berkeley & Dorchester	144	5286	36.7
Home Health of S.C., Inc. - Midlands 20/ 35/	Lexington & Richland	66	2816	42.7
Home Health of South Carolina, Inc.	York	780	62804	80.5

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Home Health Services of Carolinas 16/ Hospital System	Darlington, Dillon, Florence, (Sumter, Lee,) Marlboro & Williamsburg	1662	62262	37.5 (may serve terminally ill patients only in Williamsburg County)
(Home Health of Williamsburg) 7/	Williamsburg	1 (may serve terminally ill patients only)	122	122.0
Hospice Care of the Low Country Home Health	Beaufort & Jasper	71 (may serve terminally ill patients only)	1374	19.4
Hospice of Charleston HHA	Charleston, Berkeley & Dorchester	157	4177	26.6
Incare Home Health, Inc.	Horry & Georgetown	1218	58795	48.3
(Interim HealthCare 35/ of Columbia, Inc.)	Richland & Lexington	938	30229	32.2
Interim HealthCare of the Eastern Carolinas	Horry	294	7134	24.3
Interim HealthCare of Greater Charleston	Charleston, Berkeley, Dorchester, Jasper, Colleton, Beaufort, & Hampton	1920	103327	53.8
Interim HealthCare of Greenville	Anderson, Pickens, Spartanburg, Oconee, Greenville & Cherokee	6710	277249	41.3
Interim HealthCare, Rock Hill	York	595	36621	61.5
Island Health Care, Inc.	Beaufort	522	33980	65.1
Kershaw County Medical Center Home Health	Kershaw	673	36168	53.7
Liberty Home Care- 41/ Bennettsville	Marlboro	201	35043	174.3
Liberty Home Care- 15/ Myrtle Beach	Horry	297	17292	58.2
Low Country Home Health Services	Beaufort, Jasper, Colleton & Hampton	1292	43675	33.8

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Lower Savannah Home Health Services	Aiken, Allendale & Barnwell	1286	54314	42.2
Lowman Home Health 31/	Richland	0 (may serve retirement community only)	0	0
Matria Healthcare-Midlands 3/	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	231	329 (may serve obstetrical patients only)	1.4
Matria Healthcare-Piedmont 3/	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg & York	174	348 (may serve obstetrical patients only)	2.0
McLeod Home Health 2/	Florence, Dillon Darlington, Marion, & Lee	2221	100580	45.3
(Medshares Home Care of Coastal Carolina) 34/	Berkeley, Charleston Dorchester	1371	98831	72.1
Medshares Home Care of Southeastern South Carolina, Inc. 13/	Allendale, Berkeley Charleston, Colleton, Dorchester, Georgtetown	956	99521	104.1
Mercy Home Care	Horry	96 (may serve terminally ill patients only)	1625	16.9
NHC HomeCare - Aiken 23/	Aiken	63	2805	44.5
(NHC HomeCare-Greenville) 29/	Greenville	--	---	--
NHC HomeCare-Greenwood	Greenwood	99	6334	64.0
NHC HomeCare-Laurens 26/	Laurens and Greenville	238	11379	47.8
Neighbors Care Home Health Agency	Chester	340	21631	63.6

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Olsten Health Services	Fairfield, Kershaw, Richland, Newberry, Lexington, Calhoun, & Orangeburg	783	17309	22.1
Oconee Memorial Hospital HHA 43/	Anderson, Oconee & Pickens	--	---	
Palmetto Health HomeCare 37/	Richland, Lexington Bamberg	2485 (may serve terminally ill patients only in Bamberg County)	119861	48.2
Palmetto Home Health Services	Fairfield, Richland Lexington & Newberry	2233	77369	34.6
Pee Dee District Home Health Services	Dillon, Florence, Marion, Darlington, Marlboro, Chesterfield	3846	139843	36.4
PHC Home Health	Charleston	539	44589	82.7
Plan Home Health Care of Greenville 43/	Abbeville, Laurens, Greenville, (Oconee), Greenwood, (Anderson), & (Pickens)	1319	49219	37.3
Quality Home Health, Inc.	Beaufort	685	59079	86.2
Roper Home Health Care	Charleston, Berkeley & Dorchester	2337	84521	36.2
Sea Island Home Health 27/	Charleston & Colleton	206	28782	139.7
Self Memorial Hospital VNA	Abbeville, Laurens, Greenwood, Saluda & McCormick	862	15911	18.5
Spartanburg Regional Med. Center Home Care Services	Spartanburg	2719	62907	23.1
St. Francis Hospital Home Care	Anderson, Pickens, Greenville, & Spartanburg	3063	117975	38.5
St. Francis Xavier Home Health Care, Inc.	Charleston, Berkeley & Dorchester	2249	98193	43.6

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
St. Joseph Home Health Care Services	Aiken, Edgefield & Barnwell	792	22837	28.8
(TLC Home Health Care Agency) 40/	Marion & Dillon	335	41003	122.2
Total Care, Inc.	York, Cherokee, Chester, & Union	568	36364	64.0
Total Care, Inc.- Coastal 24/	Georgetown, Horry, Williamsburg	765	43316	56.6
Tri-County Home Health Care & Services	Saluda, Richland, Lexington, & Sumter	2373	106334	44.8
Trident Home Health Services	Charleston, Berkeley, & Dorchester	1358	63518	46.8
Tuomey Home Health 1/	Lee, Clarendon & Sumter	391 (may serve terminally ill patients only in Lee and Clarendon Counties)	15091	38.6
Upper Savannah Home Health Services	Abbeville, Laurens, Edgefield, Saluda, Greenwood & McCormick	1720	65055	37.8
(Upstate Carolina Home Health Care) 9/	Cherokee	177	11472	64.8
Village Home Health 44/	Greenville	-- (may only serve residents of rolling Green Village)	---	--
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Orangeburg, Hampton, & Colleton	775	49849	64.3
Waccamaw Home Health Services	Georgetown, Horry & Williamsburg	2889	125405	43.4
Wateree District Home Health Services	Clarendon, Lee, Kershaw & Sumter	2307	116599	50.5
Winyah Home Health Care	Georgetown & Williamsburg	647	26593	41.1

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NOTES:

1/ CON issued 2/2/95, for home health services to terminally ill only for Sumter and Lee counties. CON issued 3/14/94, for home health services to terminally ill only for Clarendon County, 3/14/95. Licensed 4/21/95. CON issued for full service home health agency in Sumter County, 1/11/96; licensed 1/17/96. Name changed 5/1/96, formerly Tuomey Regional Hospice Home Health.

2/ Name changed 6/1/96, formerly Home Health Inc..

3/ Licensed 6/4/92, for services to obstetrical patients only. Names changed 3/8/96, Tokos Clinical Services-Low Country changed to Matria Healthcare-Low Country; Tokos Clinical Services-Southside changed to Matria Healthcare-Southside; Tokos Clinical Services-Piedmont change to Matria Healthcare-Piedmont; Tokos Clinical Services-Midlands changed to Matria Healthcare-Midlands. Matria Healthcare-Southside combined with Matria Healthcare-Piedmont, 8/22/96. Matria Healthcare-Low Country combined with Matria Healthcare-Midlands, 8/22/96. Lancaster County deleted from license of Matria Healthcare-Piedmont, 2/10/97.

4/ Ownership and name changed, 9/15/95, formerly Healthmaster Home Health Care, Inc.-Georgetown Division. Name changed 10/28/98, formerly CareSouth-Georgetown.

5/ Name changed 6/27/96, formerly York County Hospice Home Health. Facility closed 10/19/98.

6/ CON approved 4/22/96 to serve terminally ill only in Oconee County. Licensed 2/19/97; name changed formerly Hospice of the Foothills.

7/ CON issued to serve the terminally ill only in Williamsburg County, 12/19/95. Licensed 5/30/96, formerly Hospice of Williamsburg. Agency purchased by Home Health Services of Carolinas Hospital System, 8/98.

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 Professsional 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/ CON issued 1/17/96 to serve Fairfield County. Licensed 6/6/96.

11/ CON issued 4/18/96 to serve terminally ill only in Abbeville, Greenwood, Laurens, McCormick, and Saluda. Licensed 9/24/96; name changed, formerly HospiceCare of the Piedmont.

12/ CON issued 5/17/95 to serve the terminally ill only in Calhoun and Orangeburg Counties. Formerly called Hospice of the Regional Medical Center; licensed 1/10/96. CON approved 11/21/96 to serve Calhoun and Orangeburg Counties;appealed. CON issued 1/9/97. Licensed 2/1/98 with no restrictions about terminally ill patients.

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/ Atlantic Home Health Agency and Nursing Registry, Inc. merged into CareOne Home Health Services, 12/28/95. Utilization data are separated.

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/ CON issued 9/27/95 to serve Abbeville County; licensed 12/28/95; CON issued 1/11/96, to serve McCormick County; licensed 1/17/96. Abbeville Home Care and Health Related Home Care merged, 1/27/97; now Health Related Home Care.

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/ Name and ownership changed, 9/15/95, formerly Healthmaster Home Health Care, Inc. Name changed, 10/31/96, formerly CareSouth-North Augusta.

20/ CON issued for Lexington County 10/18/96. CON issued for Berkeley and Dorchester Counties 10/23/96. Licensed for Berkeley and Dorchester Counties, 1/23/97. Licensed for Lexington County, 2/13/97. Partial year of data.

21/ CON issued to serve Chesterfield County, 1/4/96. Licensed 6/11/96.

22/ CON issued to East Cooper Regional Medical Center to purchase Home Health Services, Inc., and change name, 6/19/97. Licensed 6/30/97. Home Health Services, Inc. for 1/97-6/97 and East Cooper data for 7/97-12/97. Name changed 3/19/98, formerly East Cooper Regional Medical Center Home Health Services.

23/ CON issued 8/9/95 to serve Aiken County. Licensed 1/11/96.

24/ Clarendon County moved from Total Care, Inc.-Coastal and put as sub-unit of Total Care, Inc. of Charlotte, 11/21/96. Data for Clarendon reported under Total Care Inc.-Coastal. CON issued 1/24/97, to Clarendon Memorial Hospital to purchase the Clarendon County office of Total Care, Inc. Clarendon Total Care licensed 2/1/97 for Clarendon County. Partial year of data. Name changed 5/19/99, formerly Clarendon Total Care.

25/ 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. Partial year of data. Purchased by Advantage Health Systems, Inc., October, 1998, and licensed 10/29/98.

26/ CON issued 10/4/95 to serve Laurens County, licensed 4/16/96. NHC HomeCare-Greenville closed 2/1/99 and Greenville County added to NHC HomeCare-Laurens.

27/ License issued 6/26/97 to serve all of Charleston and Colleton Counties instead of just the Sea Islands.

28/ CON approved 7/23/97. Appeal by Nursepro withdrawn, CON issued 1/9/98. Licensed as Alliance Home Care, 11/17/98; formerly called Loris-Conway Home Health Care.

29/ CON approved 7/28/97. Appeal withdrawn, CON issued 10/20/97. Licensed 7/24/98. Agency closed 2/1/99 when Greenville County transferred to NHC HomeCare-Laurens.

30/ Licensed to serve residents of Bethea Baptist Retirement Community campus only, 7/25/97.

31/ Licensed to serve residents of The Lowman Home campus only, 7/22/97. No utilization for 1997.

32/ Licensed to serve residents of The Cypress campus only, 7/29/97. Partial year of data.

33/ License expired 2/28/98 and facility closed.

34/ 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.

35/ Interim HealthCare of Columbia purchased by Home Health of South Carolina, Inc.-Midlands and agencies merged, July 20, 1998. 1997 data seperated by agency.

36/ Name changed 6/1/98, formerly Medi Home Health of Low Country General Hospital.

37/ Name changed 8/28/98, formerly Home Care Resources.

38/ Carolina Home Health Care, Inc. purchased by Capital CareResources of South Carolina, Inc., November 16, 1998.

39/ Licensed to serve The Clemson Area Retirement Center only, 11/6/98.

40/ Facility closed when license expired, 7/28/98.

41/ Ownership and name changed 12/31/98, formerly Comprehensive Home Health Care-Bennettsville.

42/ Exempt from CON to serve residents of The Franke Home campus only, 7/14/99.

43/ 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.

44/ Licensed to serve Rolling Green Village only, 10/21/99.

PET-EX004.0195

RECORD 003425

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Abbeville	Health Related Home Care, Inc.	302	11402	37.75
Abbeville	HomeCare of HospiceCare of Piedmont (term)	3	61	20.33
Abbeville	Plan Home Health Care/Greenville	25	1098	43.92
Abbeville	Self Memorial Hospital VNA	86	1427	16.59
Abbeville	Upper Savannah Home Health	213	8618	40.46
Aiken	CareSouth of University Hosp–North Augusta	413	30437	73.70
Aiken	Hitchcock Rehabilitation Center HHA	846	33533	39.64
Aiken	Lower Savannah Home Health Services	592	23479	39.66
Aiken	Matria Healthcare–Midlands	6	6	1.00
Aiken	NHC Home Care – Aiken	63	2805	44.52
Aiken	St. Joseph Home Health Care	677	19735	29.15
Allendale	(Columbia Homecare Doctors)	5	313	62.60
Allendale	Lower Savannah Home Health Services	293	13765	46.98
Allendale	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		
Allendale	VNA of Greater Bamberg, Inc.	25	1608	64.32
Anderson	AnMed Home Health Agency	1466	55806	38.07
Anderson	Appalachia I Home Health	760	36643	48.21
Anderson	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Anderson	(Coram Home Care of South Carolina)	70	3049	43.56
Anderson	Interim Healthcare of Greenville	947	35847	37.85
Anderson	Matria Healthcare–Piedmont	10	20	2.00
Anderson	Oconee Memorial Hospital HHA	Licensed 7/28/99		
Anderson	(Plan Home Health Care/Greenville)	149	8281	55.58
Anderson	St. Francis Hospital Home Care	228	9160	40.18
Bamberg	Edisto Health District Home Health	349	12013	34.42
Bamberg	Palmetto Health HomeCare (terminal)	7	238	34.00
Bamberg	VNA of Greater Bamberg, Inc.	182	11707	64.32
Barnwell	Lower Savannah Home Health Services	401	17070	42.57
Barnwell	St. Joseph Home Health Care	74	1864	25.19
Barnwell	VNA of Greater Bamberg, Inc.	43	2766	64.33
Beaufort	Beaufort–Jasper Comprehensive HHA	143	4737	33.13
Beaufort	CareOne Home Health Services	445	33492	75.26
Beaufort	Hospice Care of Low Country (term)	57	1103	19.35
Beaufort	Interim Healthcare of Greater Charleston	184	11268	61.24
Beaufort	Island Health Care, Inc.	522	33980	65.10
Beaufort	Low Country Home Health Services	456	12839	28.16
Beaufort	Matria Healthcare–Midlands	6	6	1.00
Beaufort	(Nursing Registry, Inc.)	Merged with CareOne		
Beaufort	Quality Home Health, Inc.	685	59079	86.25
Beaufort	The Cypress Club Home Health Agency (restr)	13	844	64.92
Berkeley	(Columbia Homecare, Coastal Carolina)	463	29560	63.84
Berkeley	(Columbia Homecare Doctors)	259	17191	66.37
Berkeley	HealthCalls Professional Home Health Services	28	2067	73.82
Berkeley	Home Health of S. C., Inc.–Lowcountry	77	2669	34.66
Berkeley	Home Health Services, Inc.	20	965	48.25
Berkeley	Hospice of Charleston HHA	31	823	26.55
Berkeley	Interim Healthcare of Greater Charleston	213	11082	52.03

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Berkeley	Matria Healthcare–Midlands	12	12	1.00
Berkeley	(Medshares Home Care of Coastal SC)	Formerly Columbia Coastal		
Berkeley	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		
Berkeley	Roper Home Health Care	286	11803	41.27
Berkeley	St. Francis Xavier Home Health	343	11634	33.92
Berkeley	Trident Home Health Services	317	12865	40.58
Calhoun	CareSouth–Homecare Professionals–Cola	45	3634	80.76
Calhoun	Edisto Health District Home Health	203	8204	40.41
Calhoun	Home Care of Regional Medical Center	2	254	127.00
Calhoun	Olsten Health Services	9	902	100.22
Calhoun	VNA of Greater Bamberg, Inc.	29	1865	64.31
Charleston	(Columbia Homecare, Coastal Carolina)	570	39121	68.63
Charleston	(Columbia Homecare Doctors)	388	44467	114.61
Charleston	Franke Home Health (retirement only)	Exempt 7/14/99		
Charleston	Franklin C. Fetter Home Health	472	52871	112.01
Charleston	HealthCalls Professional Home Health Services	226	12308	54.46
Charleston	Home Health Services, Inc.	198	16836	85.03
Charleston	Hospice of Charleston HHA	97	2581	26.61
Charleston	Interim Healthcare of Greater Charleston	1025	53676	52.37
Charleston	Matria Healthcare–Midlands	61	91	1.49
Charleston	(Medshares Home Care of Coastal SC)	Formerly Columbia Coastal		
Charleston	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		
Charleston	PHC Home Health	539	44589	82.73
Charleston	Roper Home Health Care	1951	67840	34.77
Charleston	Sea Island Home Health	197	28383	144.08
Charleston	St. Francis Xavier Home Health	1719	77031	44.81
Charleston	Trident Home Health Services	543	24915	45.88
Cherokee	Appalachia III Home Health	498	23803	47.80
Cherokee	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Cherokee	(Coram Home Care of South Carolina)	26	1027	39.50
Cherokee	Interim Healthcare of Greenville	526	25410	48.31
Cherokee	Matria Healthcare–Piedmont	0	0	0.00
Cherokee	Total Care, Inc	48	5088	106.00
Cherokee	(Upstate Carolina Home Health Care)	177	11472	64.81
Chester	Catawba Home Health	357	12927	36.21
Chester	Neighbors Care Home Health Agency	340	21631	63.62
Chester	Total Care, Inc	19	1490	78.42
Chesterfield	Chesterfield General Hospital HHA	195	9725	49.87
Chesterfield	Chesterfield VNS	231	20466	88.60
Chesterfield	Pee Dee District Home Health Services	623	13337	21.41
Chesterfield	Matria Healthcare–Piedmont	0	0	0.00
Clarendon	Clarendon Memorial Home Health	210	12919	61.52
Clarendon	Tuomey Regional Home Health (term)	4	79	19.75
Clarendon	Wateree Home Health Services	643	27901	43.39
Colleton	Choice Healthcare Services	403	38993	96.76
Colleton	(Columbia Homecare Doctors)	210	29925	142.50
Colleton	Interim Healthcare of Greater Charleston	218	13434	61.62

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Colleton	Low Country Home Health Services	323	13640	42.23
Colleton	Matria Healthcare–Midlands	0	0	0.00
Colleton	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		
Colleton	Sea Island Home Health	9	399	44.33
Colleton	VNA of Greater Bamberg, Inc.	115	7397	64.32
Darlington	Bethea Home Health (retirement area)	2	45	22.50
Darlington	Chesterfield VNS	145	11549	79.65
Darlington	(Home Care of the Pee Dee (term))	4	95	23.75
Darlington	Home Health Services of Carolinas Hospital	251	8021	31.96
Darlington	McLeod Home Health	622	29167	46.89
Darlington	Pee Dee District Home Health Services	484	10957	22.64
Dillon	Florence VNS	49	3195	65.20
Dillon	Home Health Services of Carolinas Hospital	28	700	25.00
Dillon	McLeod Home Health	178	7041	39.56
Dillon	Pee Dee District Home Health Services	608	32395	53.28
Dillon	(TLC Home Health Care, Inc.)	146	17918	122.73
Dorchester	(Columbia Homecare, Coastal Carolina)	338	30150	89.20
Dorchester	(Columbia Homecare Doctors)	61	6433	105.46
Dorchester	HealthCalls Professional Home Health Services	22	1519	69.05
Dorchester	Home Health of S. C., Inc.–Lowcountry	67	2617	39.06
Dorchester	Home Health Services, Inc.	21	2917	138.90
Dorchester	Hospice of Charleston HHA	29	773	26.66
Dorchester	Interim Healthcare of Greater Charleston	181	7986	44.12
Dorchester	Matria Healthcare–Midlands	0	0	0.00
Dorchester	(Medshares Home Care of Coastal SC)	Formerly Columbia Coastal		
Dorchester	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		
Dorchester	Roper Home Health Care	100	4878	48.78
Dorchester	St. Francis Xavier Home Health	187	9528	50.95
Dorchester	Trident Home Health Services	498	25738	51.68
Edgefield	CareSouth of University Hosp–North Augusta	126	11247	89.26
Edgefield	Edgefield County Hospital HHA	164	12779	77.92
Edgefield	St. Joseph Home Health Care	41	1238	30.20
Edgefield	Upper Savannah Home Health	128	5147	40.21
Fairfield	Fairfield Home Health Services	194	7096	36.58
Fairfield	Matria Healthcare–Midlands	0	0	0.00
Fairfield	Olsten Health Services	32	609	19.03
Fairfield	Palmetto Home Health Services	348	8708	25.02
Florence	Florence VNS	296	25872	87.41
Florence	(Home Care of the Pee Dee (term))	2	164	82.00
Florence	Home Health Services of Carolinas Hospital	1193	38124	31.96
Florence	McLeod Home Health	1066	46267	43.40
Florence	Pee Dee District Home Health Services	1052	36317	34.52
Georgetown	CareSouth Home Care Professionals–Gtown	62	3541	57.11
Georgetown	(Columbia Homecare Doctors)	33	1192	36.12
Georgetown	Incare Home Health	194	11255	58.02
Georgetown	Matria Healthcare–Midlands	0	0	0.00
Georgetown	Medshares Home Care of Southeastern SC	Formerly Columbia Doctors		

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Georgetown	Total Care, Inc – Coastal	153	8925	58.33
Georgetown	Waccamaw Home Care Services	351	11482	32.71
Georgetown	Winyah Home Health Care	426	17509	41.10
Greenville	Appalachia II Home Health	1054	36679	34.80
Greenville	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Greenville	(Coram Home Care of South Carolina)	249	8756	35.16
Greenville	Greenville Hospital System HHA	2205	64894	29.43
Greenville	Interim Healthcare of Greenville	2229	86480	38.80
Greenville	Matria Healthcare–Piedmont	120	240	2.00
Greenville	(NHC HomeCare Greenville)	Lic 7/24/98,Closed 2/1/99		
Greenville	NHC HomeCare–Laurens	Licensed 2/1/99		
Greenville	Plan Home Health Care/Greenville	815	18233	22.37
Greenville	St. Francis Hospital Home Care	2562	99006	38.64
Greenville	Village Home Health, Inc.(retirement ctr. only)	Licensed 10/21/99		
Greenwood	Health Related Home Care, Inc.	233	8947	38.40
Greenwood	HomeCare of HospiceCare of Piedmont (term)	18	491	27.28
Greenwood	NHC Homecare–Greenwood	99	6334	63.98
Greenwood	Plan Home Health Care/Greenville	41	1379	33.63
Greenwood	Self Memorial Hospital VNA	548	11933	21.78
Greenwood	Upper Savannah Home Health	331	13983	42.24
Hampton	CareOne Home Health Services	41	373	9.10
Hampton	Interim Healthcare of Greater Charleston	51	3157	61.90
Hampton	Low Country Home Health Services	378	11366	30.07
Hampton	(Nursing Registry, Inc.)	Merged with CareOne		
Hampton	VNA of Greater Bamberg, Inc.	35	2251	64.31
Horry	Alliance Home Care	Licensed 11/17/98		
Horry	Liberty Home Care–Myrtle Beach	297	17292	58.22
Horry	Incare Home Health	1024	47540	46.43
Horry	Interim Healthcare of the Eastern Carolinas	294	7134	24.27
Horry	Mercy Home Care (terminal)	96	1625	16.93
Horry	Total Care, Inc – Coastal	453	22518	49.71
Horry	Waccamaw Home Care Services	1880	87741	46.67
Jasper	Beaufort–Jasper Comprehensive HHA	35	1465	41.86
Jasper	CareOne Home Health Services	100	12299	122.99
Jasper	Coastal Rivers Home Health of Low Country	101	9236	91.45
Jasper	Hospice Care of Low Country (term)	14	271	19.36
Jasper	Interim Healthcare of Greater Charleston	45	2724	60.53
Jasper	Low Country Home Health Services	135	5830	43.19
Jasper	(Nursing Registry, Inc.)	Merged with CareOne		
Kershaw	Kershaw Co. Medical Center Home Health	673	36168	53.74
Kershaw	Matria Healthcare–Midlands	0	0	0.00
Kershaw	Olsten Health Services	37	452	12.22
Kershaw	Wateree Home Health Services	558	32821	58.82
Lancaster	Catawba Home Health	959	50131	52.27
Lancaster	Home Care of Lancaster	751	43040	57.31
Lancaster	Matria Healthcare–Midlands	1	2	2.00
Laurens	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		

HOME HEALTH AGENCIES INVENTORY 1997 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Laurens	(Coram Home Care of South Carolina)	60	1974	32.90
Laurens	Health Related Home Care, Inc.	65	2187	33.65
Laurens	HomeCare of HospiceCare of Piedmont (term)	3	70	23.33
Laurens	National Home Care of Laurens	238	11379	47.81
Laurens	Plan Home Health Care/Greenville	126	6770	53.73
Laurens	Self Memorial Hospital VNA	123	1631	13.26
Laurens	Upper Savannah Home Health	656	23286	35.50
Lee	CareSouth Homecare Professionals–Cola	Licesned 9/8/99		
Lee	Florence VNS	52	3105	59.71
Lee	(Home Health Services of Carolinas Hospital)	25	3162	126.48
Lee	McLeod Home Health	44	2012	45.73
Lee	Tuomey Regional Home Health (term)	1	30	30.00
Lee	Wateree Home Health Services	345	18691	54.18
Lexington	CareSouth–Homecare Professionals–Cola	164	10623	64.77
Lexington	Carolina Home Health Care, Inc.	898	24008	26.73
Lexington	Palmetto Health HomeCare	564	23998	42.55
Lexington	Home Health of South Carolina, Inc.–Midlands	66	2816	42.67
Lexington	(Interim HealthCare of Columbia)	503	16210	32.23
Lexington	Matria Healthcare–Midlands	7	7	1.00
Lexington	Olsten Health Services	95	1682	17.71
Lexington	Palmetto Home Health Services	579	25991	44.89
Lexington	Tri–County Home Health Care	893	44300	49.61
Marion	Florence VNS	80	6241	78.01
Marion	(Home Care of the Pee Dee (term))	3	127	42.33
Marion	McLeod Home Health	311	16093	51.75
Marion	Pee Dee District Home Health Services	564	27942	49.54
Marion	(TLC Home Health Care, Inc.)	189	23085	122.14
Marlboro	Chesterfield VNS	63	4123	65.44
Marlboro	Liberty Home Care–Bennettsville	201	35043	174.34
Marlboro	Home Health Services of Carolinas Hospital	84	2100	25.00
Marlboro	Pee Dee District Home Health Services	515	18895	36.69
McCormick	Health Related Home Care	19	928	48.84
McCormick	HomeCare of HospiceCare of Piedmont (term)	2	11	5.50
McCormick	Self Memorial Hospital VNA	51	731	14.33
McCormick	Upper Savannah Home Health	137	4875	35.58
Newberry	CareSouth–Homecare Professionals–Cola	212	10159	47.92
Newberry	Olsten Kimberly Quality Care	18	229	12.72
Newberry	Palmetto Home Health Services	569	17813	31.31
Newberry	Matria Healthcare–Midlands	0	0	0.00
Oconee	Appalachia I Home Health	600	23456	39.09
Oconee	Carolina Home Health Care–Greenville	Formerly Coram Home Care of SC		
Oconee	(Coram Home Care of South Carolina)	133	5433	40.85
Oconee	Foothills Home Care (term)	1	57	57.00
Oconee	Interim Healthcare of Greenville	937	35392	37.77
Oconee	Matria Healthcare–Piedmont	6	12	2.00
Oconee	Oconee Memorial Hospital HHA	Licensed 7/28/99		
Oconee	(Plan Home Health Care/Greenville)	49	4909	100.18