

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas
Casey L. Manning, Circuit Court Judge

C.A. No.: 2016-CP-40-00818
Court of Appeals Docket No. 2016-000631

Amedisys SC, L.L.C Appellant,

v.

South Carolina Department of Health and Environmental Control.....Defendant,

and

National Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc.,
Tri-County Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers
of Bluffton, Tidewater Home Health, PA, and Hedgemark Brentwood Medical Services
Inc. d/b/a PHC Home Health Intervenor-Defendants;

Of whom, South Carolina Department of Health and Environmental Control, National
Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc., Tri-County
Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers of Bluffton,
Tidewater Home Health, PA, Hedgemark Brentwood Medical Services Inc. d/b/a PHC
Home Health are Respondents.

RECORD ON APPEAL

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STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND
Amedisys SC, LLC and South Carolina
Home Care & Hospice Association,

Plaintiffs,

v.

South Carolina Department of Health and
Environmental Control,

Defendant

and

National Healthcare Corporation, In-Care
Home Health, Inc., Tri-County Home Health
Care & Services, Inc., M&C Group, LLC
d/b/a Home Helpers of Bluffton, Tidewater
Home Health, P.A., Hedgemark Brentwood
Medical Services, Inc. d/b/a PHC Home
Health and PruittHealth Corporation,

Intervenor-Defendants.

IN THE COURT OF COMMON PLEAS

Civil Action No.: 2016-CP-40-00818

**ORDER DENYING PLAINTIFF'S
MOTION FOR PRELIMINARY
INJUNCTION**

RICHLAND COUNTY
FILED
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JEANETTE W. HOBBS
C.C.P. & U.S.

PROCEDURAL BACKGROUND

Plaintiffs Amedisys SC, LLC ("Amedisys") and South Carolina Home Care & Hospice Association (the "Home Care Association") instituted this action on or about February 8, 2016, pursuant to the Uniform Declaratory Judgments Act. The Plaintiffs in this action seek a declaratory judgment finding that Chapter XII of the South Carolina Health Plan does not comply with the statutory requirements of S.C. Code Ann. §§ 44-7-110 *et. seq.* (the "State Certification of Need and Health Facility Licensure Act (the "CON Act")). In addition, Plaintiffs filed a Notice of Motion and Motion for Temporary Restraining Order and Preliminary Injunction, wherein it sought an injunction prohibiting DHEC from accepting additional CON

applications relating to home health services and an injunction prohibiting DHEC from issuing decisions on any of the pending CON applications relating to home health services.

On February 12, 2016, National Healthcare Corporation ("NHC") filed a Motion to Intervene in the subject action. On February 16, 2016, In-Care Home Health, Inc. ("In-Care"), Tri-County Home Health Care & Services, Inc. ("Tri-County"), M&C Group, LLC d/b/a Home Helpers of Bluffton ("Home Helpers"), Tidewater Home Health, PA ("Tidewater") and Hedgemark Brentwood Medical Services, Inc. d/b/a PHC Home Health ("PHC") filed a joint Motion to Intervene in the action. Likewise, on February 16, 2016 PruittHealth Corporation ("PruittHealth") filed a Motion to Intervene.

Thereafter, on February 16, 2016, the Home Care Association filed a Notice of Dismissal, effectively dismissing itself from the pending action and leaving Amedisys as the sole Plaintiff in the action.

MOTION TO INTERVENE

This matter is before the Court pursuant to Plaintiff's Motion for Preliminary Injunction.¹ Prior to hearing the Motion for Temporary Injunction, the Court considered the pending motions to intervene filed by NHC, In-Care, Tri-County, Home Helpers, Tidewater, PHC and PruittHealth (hereinafter referred to collectively as the "Intervenors"). A hearing on these matters was conducted on February 22, 2016. After careful consideration of Amedisys' Complaint and Motion for Preliminary Injunction, the Intervenors' Motions to Intervene and arguments of counsel, I find that the motions to intervene should be granted.

¹ Amedisys' motion was styled as a Motion for Temporary Restraining Order and Preliminary Injunction. At the outset of the hearing, counsel for Amedisys represented that he believed there was no need to consider the motion as one for a temporary restraining order and believed it appropriate for the Court to consider the motion as seeking a preliminary injunction only.

It is undisputed that the Intervenor has filed multiple certificate of need applications which are currently being reviewed and/or pending a decision from DHEC. The Declaratory Judgment Act provides that “[w]hen declaratory relief is sought **all person shall be made parties who have or claim any interest which would be affected by the declaration.** See S.C. Code Ann. § 15-53-80 (emphasis added); see also, James F. Flanagan, *South Carolina Civil Procedure* 196 (2d ed. 1996) (listing Declaratory Judgment Act as possible example of a statute granting an unconditional right to intervene under Rule 24(a)(1)). As all of the Intervenor currently have pending CON applications, the outcome of this action undoubtedly affects their rights. Based on the foregoing, I find the Intervenor shall be made parties to the action pursuant to Rule 24(a)(1), SCRCF, which provides a party may intervene as a matter of right when a statute confers an unconditional right to intervene.

Furthermore, I find that the Intervenor has a right to intervene in the subject action pursuant to Rule 24(a)(2), in that they have satisfied the elements of intervention under Rule 24(a)(2), which requires a party to: (1) establish timely application; (2) assert an interest relating to the property or transaction which is the subject of the action; (3) demonstrate that it is in a position such that without intervention, disposition of the action may impair or impede its ability to protect that interest; and (4) demonstrate that its interest is inadequately represented by other parties. See *In re S.C. Dep’t of Health and Envtl. Control v. Columbia Organic Chem. Co.*, 310 S.C. 495, 498, 427 S.E.2d 661, 663 (1993); *Berkeley Elec. Coop., Inc. v. Mt. Pleasant*, 302 S.C. 186, 189, 394 S.E.2d 712, 715 (1990).

As to the first factor, I find that the Intervenor’s motions were timely filed. As to the second factor, the Intervenor has a strong financial and business interest in the subject of this action. They have invested significant resources in the numerous applications prepared and filed to

obtain CONs in an effort to meet the need of the patients residing in the Counties for which the applications were filed. The Court also finds that the third element was satisfied as the Intervenor's pending CON applications, which DHEC has either marked complete or are currently under review, will be put on hold for an indeterminate period if the relief sought is granted. Finally, this Court finds that the Intervenor's interest will not be protected by DHEC, as they have separate and distinct interests in protecting their own investments in its CON applications and to further their own legitimate business interests.

For the foregoing reasons, the Intervenor's motions to Intervene are hereby GRANTED.

MOTION FOR PRELIMINARY INJUNCTION

A hearing was held on Amedysis' motion for preliminary injunction pursuant to Rule 65, SCRPC, seeking to enjoin Defendant DHEC during the pendency of this action from accepting, reviewing or issuing staff decisions regarding applications for certificates of need ("CONs") to provide home health services pursuant to the 2014-15 State Health Plan ("SHP"), which was adopted by the DHEC Board on August 13, 2015. The Court has carefully reviewed the Plaintiff's Complaint, the Motion and Memorandum in Support of Motion for Preliminary Injunction, DHEC's Memorandum in Opposition to Plaintiff's Motion for Preliminary Injunction, what additional evidence that was submitted plus arguments of counsel. For the reasons that follow, I find that Amedyis' Motion for Temporary Injunction should be denied.

I. FACTS

This action arises out of the South Carolina Department of Health and Environmental Control's ("DHEC" or "Department") operation of its Certificate of Need Program pursuant to S.C. Code Ann. §§ 44-7-110 *et. seq.* (the "State Certification of Need and Health Facility Licensure Act (the "CON Act)"). The purpose of the CON Act is to promote cost containment, to

prevent the unnecessary duplication of health care facilities and services, to guide the establishment of health facilities and services which will best serve public needs, and to ensure that high quality services are provided in health facilities in South Carolina. See S.C. Code Ann. § 44-7-120. The CON Act requires certain health care providers, prior to undertaking certain health care activities, first obtain a certificate of need. In addition, the Licensure of Home Health Agencies Act, S.C. Code Ann. § 44-69-10, *et. seq.* ("Home Health Act"), requires the issuance of a CON prior to licensure for home health agencies.. The CON Act further requires the Department to establish procedures and criteria for the submission of an application and appropriate review prior to the issuance of a certificate of need. *Id.*

The CON Act requires the issuance of a State Health Plan ("SHP") to be utilized by the Department in its administration of the CON Program. Pursuant to Section 44-7-180(B), the Plan must include at a minimum the following:

- (1) An inventory of existing health care facilities, beds, specified health services, and equipment;
- (2) Projections of need for additional health care facilities, beds, health services, and equipment;
- (3) Standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services and proper planning of health care facilities; and
- (4) A general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding 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.

The CON Act sets forth a detailed process for the periodic review and issuance of the SHP. The State Health Planning Committee (the "SHP Committee"), whose members are primarily appointed by the Governor, reviews and revises the SHP as it sees fit at least every two years.

S.C. Code Ann. § 44-7-180. The review process includes mandatory regional public meetings throughout the State. The SHP Committee must accept and consider written comments from interested parties. After undergoing a significantly deliberative process, the SHP Committee makes a recommendation for the new SHP. The proposed SHP is then submitted to the DHEC Board for additional review, including additional meetings and deliberation, and approval. The current SHP passed through the full statutory process described above, received unanimous approval from the DHEC Board, and became effective August 13, 2015.

The current SHP's home health section sets forth the following selected relevant standards applicable to CON applications for home health services:

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....
3. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:
 - a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.
 - c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.
 - d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards...
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should it fail to reach this threshold number two years.

after initiation of services in a county, it will voluntarily relinquish its license for that county.

9. Nothing in this Section is intended to restrict the ability of the Department to approve more than one new Home Health Agency in a County at any given time.

2014-15 SHP, pp. XII-7 through XII-8. In addition, the SHP includes an inventory of existing home health agencies in the State and 2013 utilization data for home health agencies, the most recent data available to the Department at the time of the SHP's adoption, showing the total number of persons served and total visits per home health agency. 2014-15 SHP, p. XIII-51. The SHP also lists the project review criteria deemed most relevant for consideration of home health CON applications. 2014-15 SHP, p. XII-8.

The Intervenor are all home health agencies operating in South Carolina. In addition, shortly after the issuance of the current SHP, the Intervenor filed multiple CON applications. Each of these applications has been deemed complete by the Department or are currently under review. The application process required the Intervenor to incur considerable time and expense. Despite the prolonged and detailed review process which culminated in the approval of the current SHP over six months ago, Amedysis filed a complaint challenging the SHP seeking a declaratory judgment finding that Chapter XII of the SHP does not comply with the statutory requirements of the CON Act. In addition, Plaintiffs seek an injunction prohibiting DHEC from accepting additional CON applications relating to home health services and an injunction prohibiting DHEC from issuing decisions on any of the pending CON applications relating to home health services. Although Amedysis is currently operating in only 20 of the counties in which CON applications have been filed, it seeks an injunction prohibiting the Department from taking any action on CON applications in all 46 counties.

II. LEGAL STANDARD

“An injunction is a drastic remedy issued by the court in its discretion to prevent irreparable harm suffered by the plaintiff.” *Scratch Golf Co. v. Dunes Wes Residential Gold Properties, Inc.*, 361 S.C. 117, 121, 603 S.E.2d 905, 907 (2004). The party seeking an injunction has the burden of demonstrating the facts and circumstances warranting an injunction. *Calcutt v. Calcutt*, 282 S.C. 565, 320 S.E.2d 55 (Ct. App. 1984). For a preliminary injunction to be granted, “the plaintiff must establish that (1) it would suffer irreparable harm if the injunction is not granted; (2) it will likely succeed on the merits of the litigation; and (3) there is an inadequate remedy at law. *Scratch Golf Co.*, 361 S.C. at 121, 603 S.E.2d at 907.

III. DISCUSSION

A. Irreparable Harm

The purpose of an injunction is to preserve the status quo to avoid possible irreparable injury to a party pending litigation. *Peak v. Spartanburg*, 367 S.C. 450, 455, 626 S.E.2d 34, 37 (2005). Amedysis has not demonstrated that it will be irreparably harmed in the absence of an injunction. Generally, one may not enjoin a state agency from the performance of duties imposed by valid statute. *Frady v. Student Loan Servicing Center*, 313 S.C. 561, 564, 442 S.E.2d 580, 582 (1994). An injunction seeking to enjoin a government agency from performing tasks it has expressly been given authority to perform will only be granted upon a clear showing of injury. See *Tallevast v. Kaminski*, 146 S.C. 225, 143 S.E. 796, 800 (1928). Amedysis has not presented any evidence demonstrating how it will be harmed in the absence of an injunction. It relies solely on conclusory statements. Amedysis is presumably concerned with the possible adverse financial impacts it may suffer if other businesses are granted licenses to operate in the counties where it currently operates. However, Amedysis has not submitted affidavits or any other evidence indicating that the granting of additional licenses would negatively impact its business.

Furthermore, economic loss only constitutes irreparable harm if the economic loss threatens the very existence of Plaintiff's business. *Peek v. Spartanburg Regional Healthcare System*, 367 S.C. 450, 455 n. 2, 626 S.E.2d 34, 37 n. 2 (2005). All parties acknowledge that the revisions to the home health section of the SHP were made in order to allow for providers to address what was determined to be unmet need for home health services in the state. Amedysis has not presented any evidence showing that additional providers in the counties in which it operates or in which it has filed a certificate of need application would prevent its continued operations. Moreover, it cannot show how it could in any way be harmed by the issuance of certificates of need in counties in which it is not currently operating or seeking a certificate of need.

Furthermore, if a decision is made to grant a CON, affected persons may request a final review conference before the Board pursuant to S.C. Code Ann. § 44-1-60, and may thereafter request a contested case hearing with the Administrative Law Court ("ALC"). S.C. Code Ann. § 44-7-210(D) and (E). In the event a contested case hearing is filed with the ALC, the decision approving the CON is automatically stayed. S.C. Code Ann. § 1-23-600(H)(2). Amedysis has the opportunity to file a request for contested case hearing at the ALC to challenge a decision by the Department approving a new home health agency in a county where Amedysis is an affected person with standing. Such a filing would trigger the ALC's automatic stay provision. Because the status quo would remain pending resolution of a contested case hearing, Amedysis would suffer no irreparable harm prior to its opportunity for a full merits hearing on the application before the ALC.

Therefore, Plaintiff has not demonstrated that the granting of an injunction is necessary to prevent irreparable harm.²

² The Court also notes that the facts and circumstances which form the basis of the Complaint and Motion for Temporary Injunction were known to Amedysis upon the enactment of the SHP in August of 2015. Nevertheless,

B. Likelihood of Success on the Merits

Plaintiff has also failed to demonstrate that it is likely to succeed on the merits. When a court is asked to grant a preliminary injunction, it can consider the merits of the case to the extent necessary to determine whether an injunction is appropriate. *See AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 51, 674 S.E.2d 505, 509 (2009). The gravamen of Amedysis' complaint and the basis for its motion for a preliminary injunction is that the SHP as enacted by DHEC failed to comply with the statutory requirements of § 44-7-180(B) because it does not contain a projection of need for home health services.

Prior to the adoption of the current plan, the need for home health services was projected using a formulaic approach. After following the statutorily mandated revision procedure and receiving public comments regarding the degree of unmet need, the current SHP was adopted, which required an applicant to demonstrate it will serve 50 or more patients in non-rural counties and 25 or more patients in rural counties projected to be in need of services. The SHP contains additional objective criteria reflecting projection of need for home health services. The home health standards were recommended by the SHP Committee and, after thorough review, adopted by the DHEC Board, which is charged with administering the CON program under the CON Act. There is no requirement set forth in S.C. Code Ann. § 44-7-180(B) that a projection of need in the SHP must exist in a formulaic approach, as is suggested by Amedysis.

Courts will defer to an agency's interpretation of a statute unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Trident Medical Center v. South Carolina Dep't. of Health & Envtl. Control*, 412 S.C. 341, 354, 772 S.E.2d 177, 184 (2015); *see also Dorman v. S.C. Dep't. of Health & Envtl. Control*, 350 S.C. 159, 167, 565 S.E.2d 119, 123 (Ct.

Amedysis failed to take any action until initiating this lawsuit six months later. It now seeks "emergency interim relief" and an injunction from this Court based on allegations of irreparable harm which may not have existed if it had pursued its claims earlier.

App. 2002) (“The construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reason.”). Courts “give deference to agencies both because they have been entrusted with administering their statutes and regulations and because they have unique skill and expertise in administering those statutes and regulations. *Id.* After careful review, DHEC determined that the method of projecting need in the current State Health Plan is preferable to the formulaic approach that was previously used. Courts may not substitute their judgment for that of the agency.

In *MRI at Belfair v. South Carolina Department of Health & Environmental Control*, 379 S.C. 1, 664 S.E.2d 471 (2008), the Supreme Court of South Carolina addressed a similar challenge to the State Health Plan. In *MRI at Belfair*, the Plaintiff argued that the State Health Plan standards for MRI services did not comply with § 44-7-180(B). *Id.* at 5, 664 S.E.2d at 473. The SHP contained the following standards for MRI services:

- 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 the Department utilization data on the operation of the MRI service.

The plaintiff argued that the SHP did not comply with § 44-7-180(B) because the standards for MRI services did not contain projections of need or standards of distribution. *Id.* The Supreme Court disagreed finding that “[a]lthough the [State Health] Plan does not give specific projections of need or standards of distribution in terms that track the exact statutory language, the [State Health] Plan does not violate § 44-7-180.” *Id.* The court found that the reference to “each hospital” in the first standard satisfied the CON Act’s directive for a projection of need.

Id. The court found that the second standard was sufficient to provide guidance for the distribution and utilization of existing MRI resources. *Id.*

As in *MRI at Belfair*, Amedysis challenges the current SHP on the basis that it fails to provide specific standards for projecting need. The SHP provides that a CON will only be granted if the applicant shows that it will serve at least 25 or 50 patients (depending on the county where the applicant seeks to operate). The SHP also provides objective criteria upon which DHEC can evaluate the sufficiency of the need projected by the applicant. The need standards for home health services are far more specific than the standards upheld by the Supreme Court in *MRI at Belfair*. Accordingly, Amedysis has not shown that it is likely to succeed on the merits of the case.

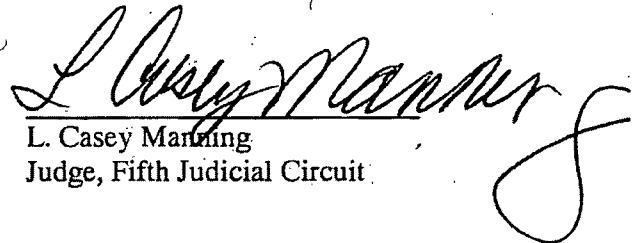
C. Adequate Remedy at Law

An injunction is inappropriate when the party seeking an injunction has an adequate remedy at law. *Strategic Resources Co. v. BCS Life Ins. Co.*, 367 S.C. 540, 545, 627 S.E.2d 687, 689 (2006). Injunctive relief is not available to one who has not exhausted all administrative remedies. *Garris v. Governing Board of South Carolina Reinsurance Facility*, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995). Here, Amedysis has an adequate remedy at law, which is to request a contested case hearing at the ALC challenging any decision granting a CON application for a home health agency in a county in which Amedysis is an affected person with standing. *See Strategic Resources Co.*, 367 S.C. at 545, 627 S.E.2d at 689. (stating the right to appeal provides an adequate remedy at law). The doctrine of exhaustion of administrative remedies promotes an orderly review process and allows courts with a greater understanding of particular issues to resolve those disputes. *See Garris*, 319 S.C. at 390, 461 S.E.2d at 821.

Previous challenges to the State Health Plan have been brought pursuant to the appeals process set forth in the CON Act. *See MRI at Belfair*, 379 S.C. 1, 664 S.E.2d 471 (2008). The facts and circumstances in this case do not warrant a deviation from the established appeals procedure. The right to request a contested case review of DHEC's decisions to the Administrative Law Court provides Amadysis with an adequate remedy at law. Therefore, the granting of an injunction is improper.

In summary, the Court denies the Motion for Preliminary Injunction because Amedysis has failed to meet its burden of proof. In reaching this decision, the Court expresses no final opinion or determination regarding the merits of Plaintiff's claims. The Court simply finds that Amedysis has not established the threshold requirements for obtaining a preliminary injunction.

IT IS, THEREFORE, ORDERED that the motion for temporary injunction be denied.


L. Casey Manning
Judge, Fifth Judicial Circuit

February 23 2016

Columbia, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

) COURT OF COMMON PLEAS
) C.A. No.: 2015-CP-40-____

AMEDISYS SC, L.L.C., AND SOUTH)
CAROLINA HOME CARE & HOSPICE)
ASSOCIATION,)

PLAINTIFFS,)

v.)

SOUTH CAROLINA DEPARTMENT OF HEALTH)
AND ENVIRONMENTAL CONTROL,)

DEFENDANT.)
_____)

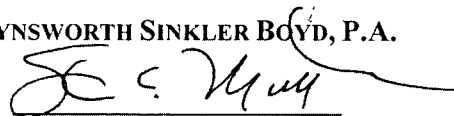
SUMMONS
NON-JURY

RICHLAND COUNTY
FILED
2016 FEB - 8 PM 3:55
JEANNE L. VANDERKAM
C.C.P. & C.V.

YOU ARE HEREBY SUMMONED and required to answer the Complaint herein, a copy of which is herewith served upon you, or otherwise appear and defend, and to serve a copy of your Answer to the said Complaint upon the subscriber at his offices, 1201 Main Street, 22nd Floor (29201-3226), Post Office Box 11889, Columbia, South Carolina 29211-1889, within thirty (30) days after the service hereof, exclusive of the day of such service; and if you fail to answer the Complaint within the time period aforesaid, or otherwise appear and defend, the Plaintiff in this action will apply to the Court for the relief demanded therein, and judgment by default will be rendered against you for the relief demanded in the Complaint.

HAYNSWORTH SINKLER BOYD, P.A.

By:



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) COURT OF COMMON PLEAS
) C.A. No.: 2015-CP-40-_____

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)
) **COMPLAINT**

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WILLIAMS, D.L.
FILED
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JAN 11 2016
CLERK & ASS.

- ## JURISDICTION AND VENUE

- 1

PARTIES

4. The plaintiff Amedisys SC, L.L.C. (“**Amedisys**”), is a South Carolina limited liability company in good standing.

5. Amedisys is duly authorized to and does provide home health care services in twenty-five South Carolina counties including Richland County.

6. The plaintiff South Carolina Home Care & Hospice Association (“**SCHCHA**”) is a South Carolina non-profit corporation in good standing.

7. SCHCHA represents over 250 home health, hospice, and home care agencies in South Carolina and provides education, technical assistance and advocacy on behalf of its members and their patients.

8. The defendant South Carolina Department of Health and Environmental Control (“**DHEC**”) is an agency of the State of South Carolina, created and governed by enactments of the South Carolina General Assembly, including S.C. Code §§ 44-1-20 *et seq.*, and in particular as it relates to this action by Title 44, Chapter 7, Article 3, that being S.C. Code §§ 44-7-110 *et seq.* (the “State Certification of Need and Health Facility Licensure Act (the “**CON Act**”)”).

9. DHEC is headquartered in, and its governing body (the South Carolina Board of Health and Environmental Control (the “**Board**”)) regularly meets and acts in, Richland County, South Carolina.

REGULATORY CONTEXT

10. In order “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,” the South Carolina General Assembly requires that certain health care providers, prior to undertaking certain health care activities, must first obtain a certificate of need. CON Act, S.C. Code §§ 44-7-120(1).

11. The South Carolina General Assembly has designated DHEC as “the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under this article.” CON Act, S.C. Code § 44-7-140.

12. For the same reasons set forth in Paragraph 10 above, the South Carolina General Assembly requires that not less often than every two years, a health planning committee recommend to the Board and the Board approve and adopt a State Health Plan (the “Plan”). The health planning committee (the “**Planning Committee**”) is established and comprised of appointed members pursuant to CON Act, S.C. Code Ann. § 44-7-180(A).

13. The General Assembly further requires that the Board adopt “procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need.” CON Act, S.C. Code §§ 44-7-120(2) and (3) and 44-7-180(C); and S.C. Reg. 61-106(3).

14. “The Plan at a minimum must include:

- (1) an inventory of existing health care facilities, beds, specified health services, and equipment;
- (2) projections of need for additional health care facilities, beds, health services, and equipment;
- (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors

relating to proper placement of services, and proper planning of health care facilities; and

(4) a general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding 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.

The South Carolina Health Plan must address and include projections and standards for specified health services and equipment which have a potential to substantially impact health care cost and accessibility. Nothing in this provision shall be construed as requiring the department to approve any project which is inconsistent with the South Carolina Health Plan.”

CON Act, S.C. Code § 44-7-180(B); S.C. Reg. 61-106(1) and (2); emphasis added.

15. The South Carolina General Assembly has forbidden DHEC to “issue a Certificate of Need unless an application complies with the South Carolina Health Plan” and certain other requirements. CON Act, S.C. Code § 44-7-210(B).

16. In addition, if multiple certificate of need applicants file applications to provide similar health care facilities or services in the same service area, DHEC is prohibited from approving more than one application if doing so would “exceed the need” for such facilities and services. CON Act, S.C. Code § 44-7-130(5); § 44-7-210(B).

17. Among the health care services requiring a certificate of need are those described as “home health services” by Title 44, Chapter 69, that being S.C. Code § 44-69-10 *et seq.* (the “Licensure of Home Health Agencies Act” (the “**HHA Act**”)). See, in particular, HHA Act, S.C. Code § 44-69-75(A): “A home health agency shall obtain a certificate of need before licensure. Procedures for applying for a certificate must be in accordance with the ‘State Certification of Need and Health Facility Licensure Act.’ . . .”

18. The HHA Act defines "home health services" to include certain statutorily-listed health care items and services furnished on a visiting basis in a patient's residence (or as an outpatient at a facility where certain equipment cannot be readily brought to the patient's home). HHA Act, S.C. Code § 44-69-20(5).

19. Entities providing home health services are defined as "home health agencies." HHA Act, S.C. Code § 44-69-20(4).

20. Any applicant for a certificate of need to provide home health services in any county must:

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

S.C. Reg. 61-202(11).

FACTS

21. The Board adopted a Plan for 2012-2013 (the "**Prior Plan**") on November 9, 2012. The Prior Plan replaced the Plan for 2010-2011 (the "**2010 Plan**") that it had previously adopted on November 12, 2010.

22. The Board adopted a Plan for 2014-2015 (the "**Current Plan**") on August 13, 2015. The Current Plan replaced the Prior Plan.

23. With respect to home health services, the Prior Plan, like earlier plans, had established a detailed methodology for determining need based on population, projected population growth, and utilization rates broken down by age-demographic.

24. **Exhibit A** to this Complaint consists of pages XII-12 through XII-22 of the Prior Plan, that being the portion of the Prior Plan related to home health services. The need calculation methodology of the Prior Plan is described in Paragraph 4 of "Certificate of Need Standards," at page XII-13, as follows:

"4. The need methodology creates statewide use rates for four population groups (0-17, 18-64, 65-74, 75+) based on 2011 utilization data; 75% of these rates are applied against the projected 2013 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2011 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2013. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county."

25. Beginning with the 2010 Plan, DHEC established a mechanism for keeping population and services-inventory information, both critical components of need determination, up-to-date throughout the life of a Plan, and followed through on that mechanism. **Exhibit B** to this Complaint includes information updates to the 2010 Plan from March 2011, June 2011 and September 2011 and an information update to the Prior Plan from May 2013.

26. In April 2015, the Director of DHEC's CON Program submitted to the Planning Committee a draft Plan that reflected updated population and utilization projections and determinations of need for certain health care facilities and services, including home health services. In the draft Plan, DHEC staff drew on its prior experience and subject

matter expertise to propose revisions to the Prior Plan. With respect to the home health section, DHEC staff proposed to modify the need standards by using population projections for South Carolina residents age 65 and older, who comprise the largest group of home health patients in the state, instead of the general population.

27. Upon receipt of the draft Plan, the Planning Committee rejected DHEC staff's proposed revisions to the home health section. On August 3, 2015, the Planning Committee then adopted a draft Plan that eliminated any projection of need of home health services based on population projections, and thus eliminated any objective basis on which DHEC could deny a CON application on the grounds that there is no need in the county in which the CON applicant seeks to establish home health services.

28. On August 13, 2015, just ten days later, the Planning Committee presented its draft Plan to the DHEC Board for consideration; and the Board adopted the entire draft Plan that same day.

29. The Current Plan has abandoned the established criteria related to population, growth, inventory of current services, and demographic need.

30. **Exhibit C** to this Complaint consists of pages XII-6 through XII-9 of the Current Plan, that being the portion of the Current Plan related to home health services. The need component of the Current Plan is described in Paragraphs 3 and 4 of "Certificate of Need Standards," at page XII-7, as follows:

3. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:

a. Letters of support that identify need for additional home health services from physicians and other referral sources.

b. Evidence of underutilization of home health services.

c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.

d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.

4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.

31. Following the adoption of the Current Plan, at least 87 CON applications have been submitted to establish new home health services in 40 counties. Of those 87 applications, National Healthcare Corporation and its affiliates and subsidiaries (collectively, "NHC"), whose employee served as Vice-Chair of the Planning Committee, has filed 30 applications to provide services in 30 counties.

32. Of the 40 counties with submitted applications, 20 are counties in which Amedisys currently holds a license to provide and provides home health services and 40 are counties in which one or more other members of SCHCHA hold a license to provide and provide home health services.

33. Of the 87 CON applications filed to date, 48 applications are to provide new home health services in counties in which Amedisys currently holds a license to provide and provides home health services and 87 applications are to provide new home health services in counties in which one or more other members of SCHCHA currently hold a license to provide and provide home health services.

34. Once an application is submitted and after DHEC deems it complete and notifies affected persons through publication in the *South Carolina State Register*, DHEC must either grant or deny the requested certificate of need within a maximum of 150 days. CON Act, S.C. Code § 44-7-210(A).

35. On information and belief, DHEC has deemed 42 out of the 87 submitted applications to be complete and has published a notice to affected persons in the January 22, 2016 issue of the *South Carolina State Register*.

36. With respect to the 42 applications deemed complete and published in the January 22, 2016 *South Carolina State Register*, DHEC may begin issuing staff decisions on these applications after thirty (30) calendar days, *i.e.*, beginning on February 22, 2016. CON Act, S.C. Code § 44-7-210(A).

FIRST CAUSE OF ACTION

37. The allegations contained in Paragraphs 1 through 34 above are incorporated in and made a part of this First Cause of Action.

38. Multiple certificate of need applications with respect to home health services have been filed, thus beginning the process whereby DHEC must consider and issue or deny certificates of need to the applicants.

39. DHEC must apply the standards of the State Health Plan in its consideration of the applications.

40. The Current Plan is deficient in that it does not meet the statutory minimum standards for home health services determinations of need but instead adopts a 25-patient

(rural)/50-patient (non-rural) county target, with no guidelines for how that 25-patient or 50-patient "need" is to be calculated, demonstrated, or tested.

41. The Current Plan is deficient in that it undermines the statutory definition of "competing applicant" by vitiating any ability to determine whether multiple applicants for home health services in a service area are "competing applicants," which requires a determination of whether approval of more than one application would "exceed the need" for home health facilities in the service area. CON Act, S.C. Code Ann. §44-7-130(5).

42. DHEC is thus without the tools that the CON Act and the HHA Act require it to utilize in its consideration of any new and pending applications.

43. If DHEC grants an application and issues a certificate of need for home health services in a county in which Amedisys (or other SCHCHA member) is already licensed to provide and is providing such services and in which a statutorily-compliant methodology would show that there is no unmet need for such services, the investment by Amedisys (or such other SCHCHA member) would be impaired and the legislative purposes of the CON Act would be thwarted, all to the endangerment of the care of home health patients in that county.

44. The same danger exists in other counties where other entities are currently licensed to provide and are currently providing home health services.

45. It is, therefore, a violation of both the CON Act and the HHA act, and directly contrary to the stated purposes of the CON Act, for DHEC to proceed with the consideration of applications for certificates of need for home health services unless and

until the Board adopts a State Health Plan with respect to such services that meets the minimum standards required by the South Carolina General Assembly.

SECOND CAUSE OF ACTION

46. The allegations contained in Paragraphs 1 through 43 above are incorporated in and made a part of this Second Cause of Action.

47. The Current Plan is deficient in that it deprives Amedisys and other SCHCHA members that previously received a CON, from any meaningful opportunity to challenge CON applications filed to establish new home health agencies in counties where Amedisys and such other existing providers currently operate, because the Current Plan fails to establish the statutory minimum need standards that must be applied to challenge an applicant's claim that there exists need for additional home health services in those counties.

48. It is, therefore, a violation of both the CON Act and the HHA act, and directly contrary to the stated purposes of the CON Act, for DHEC to proceed with the consideration of applications for certificates of need for home health services unless and until the Board adopts a State Health Plan with respect to such services that meets the minimum standards required by the South Carolina General Assembly.

PRAYER FOR RELIEF

For the foregoing reasons, the plaintiffs Amedisys and SCHCHA respectfully request that this Court issue its Order:

1. Declaring that a valid State Health Plan, as it relates to home health services, must be adopted and in place before DHEC may consider an application for or issue a certificate of need for any home health services;

2. Declaring that Chapter XII of the Current Plan, as it relates to home health services, does not comply with the mandate of the South Carolina General Assembly as to the required contents of such a plan;
3. Declaring that Chapter XII of the Current Plan, as it relates to home health services, does not comply with the duly-adopted regulations promulgated by DHEC and now in force as to the required contents of such a plan;
4. Enjoining DHEC from accepting for filing any new application, and from continuing to review any application already filed, for a certificate of need to establish any home health service until a valid State Health Plan relating to home health services has been adopted by the Board; or, in the alternative, until a valid State Health Plan relating to home health services has been adopted by the Board, ordering DHEC to accept for filing and review any such application filed after August 13, 2015 only under the Prior Plan as updated with population and services-inventory information for that Prior Plan promulgated after the date of this Order;
5. Enjoining DHEC and the Board from issuing any certificate of need or staff decision on any certificate of need application for any home health service until a valid State Health Plan relating to home health services has been adopted by the Board; or, in the alternative, until a valid State Health Plan relating to home health services has been adopted by the Board, ordering DHEC to issue any such certificate of need or any staff decision on any such certificate of need application filed after August 13, 2015 only under the Prior Plan as updated with population and services-inventory information for that Prior Plan promulgated after the date of this Order; and
6. For such further and other relief as shall seem proper to this Court.

February 8, 2016

Respectfully submitted,

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EXHIBIT A

H. Home Health

I. 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 mix of home health visits by type of service during FY 2011 for the home health agencies in South Carolina was:

Total Visits	2,022,665
Nursing Visits	44.4%
Physical Therapy Visits	34.5%
Occupational Therapy Visits	9.3%
Home Health Aide Visits	7.8%
Speech Therapy Visits	1.8%
Medical Social Worker Visits	1.7%
Other	0.5%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 19.6 in 2011.

Of the patients currently receiving home health services, about 2% are age 17 and under, approximately 32% are age 18-64, 24% are age 65-74, and about 42% are 75 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need 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. It is recommended that an application for a new home health agency should contain letters of support from physicians in the proposed service area.
4. The need methodology creates statewide use rates for four population groups (0-17, 18-64, 65-74, 75+) based on 2011 utilization data; 75% of these rates are applied against the projected 2013 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2011 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2013. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county.
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
6. An exception to the need methodology may be made for a home health agency restricted to the provision of services such as breast prosthetics and wigs, massage therapy, home health aide and nutritional services for female oncology patients. Any such approved agency will not be counted in the county inventories for need projection purposes.
7. Before an application for a new home health agency can be accepted for filing, all existing agencies in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have submitted

HOME HEALTH METHODOLOGY

Rate	0.00084		0.00830		0.04632		0.12204										New Agency Approved Since 12/31/10	New Agency Can be Approved
County	Projected 2013 Population Age 0-17	Estimated 2013 Pts Age 0- 17	Projected 2013 Population Age 18-64	Estimated 2013 Pts Age 18- 64	Projected Pop 2013 Age 65-74	Estimated Pts Age 65- 74	Projected Pop 2013 Age 75+	2013 Estimated Pts Age 75+	Total Estimated 2013 Patients	2011 Actual Patients	Population Growth Factor	Total Projected 2013 Patients	2013 Unmet (Need)/ Surplus	Need at 100 Patients				
Abbeville	5,800	5	15,600	129	2,700	125	1,700	207	467	780	1.009	787	320	-----	-----	-----		
Aiken	37,000	31	102,100	847	16,600	769	10,600	1,294	2,941	2,589	1.025	2,654	(287)	YES	-----	YES		
Allendale	2,300	2	6,600	55	900	42	600	73	172	104	1.000	103	(69)	-----	-----	-----		
Anderson	45,300	38	116,500	967	18,300	848	12,100	1,477	3,329	3,655	1.018	3,721	392	-----	-----	-----		
Bamberg	3,500	3	9,500	79	1,700	79	1,100	134	295	384	1.000	384	89	-----	-----	-----		
Barnwell	5,800	5	13,900	115	2,200	102	1,400	171	393	490	1.017	498	105	-----	-----	-----		
Beaufort	33,600	28	98,400	817	24,000	1,112	14,900	1,818	3,775	3,615	1.035	3,742	(33)	-----	-----	-----		
Berkeley	46,000	39	117,100	972	14,000	648	7,200	879	2,538	2,771	1.024	2,838	300	-----	-----	-----		
Calhoun	3,200	3	9,600	80	1,800	83	1,000	122	288	392	1.013	397	109	-----	-----	-----		
Charleston	73,800	62	231,800	1,924	29,500	1,366	20,000	2,441	5,793	9,152	1.009	9,235	3,442	-----	-----	-----		
Cherokee	13,900	12	35,300	293	5,000	232	3,000	366	902	1,249	1.023	1,278	375	-----	-----	-----		
Chester	8,000	7	20,500	170	3,200	148	1,900	232	557	985	1.029	1,014	457	-----	-----	-----		
Chesterfield	11,600	10	29,100	241	4,400	204	2,500	305	760	838	1.013	849	89	-----	-----	-----		
Clarendon	7,800	7	21,200	176	4,300	199	2,400	293	675	689	1.014	699	24	-----	-----	-----		
Colleton	9,600	8	23,600	196	4,200	195	2,500	305	704	1,235	1.020	1,260	556	-----	-----	-----		
Darlington	16,400	14	42,400	352	6,700	310	4,100	500	1,176	-1,229	1.010	1,241	65	-----	-----	-----		
Dillon	8,400	7	19,200	159	2,700	125	1,800	220	511	734	1.003	736	225	-----	-----	-----		
Dorchester	37,300	31	88,400	734	10,500	486	6,000	732	1,984	2,768	1.027	2,844	860	-----	-----	-----		
Edgefield	5,800	5	18,300	152	2,700	125	1,400	171	453	356	1.012	360	(92)	-----	-----	-----		
Fairfield	5,400	5	15,000	124	2,500	116	1,500	183	428	558	1.017	567	140	-----	-----	-----		
Florence	33,900	29	85,800	712	12,500	574	7,600	928	2,247	2,875	1.021	2,935	688	-----	-----	-----		
Georgetown	12,800	11	35,700	296	8,800	408	4,900	598	1,313	2,091	1.037	2,168	856	-----	-----	-----		
Greenville	110,500	93	293,600	2,436	37,500	1,737	24,800	3,027	7,293	8,592	1.022	8,781	1,488	-----	-----	-----		
Greenwood	16,700	14	43,300	359	6,300	292	5,000	610	1,275	1,967	1.021	2,008	733	-----	-----	-----		
Hampton	5,100	4	13,300	110	2,000	93	1,200	146	354	617	1.014	626	272	-----	-----	-----		
Horry	54,600	46	177,300	1,471	33,100	1,533	19,500	2,380	5,430	6,808	1.037	7,060	1,630	-----	-----	-----		
Jasper	6,000	5	16,500	137	2,000	93	1,200	146	381	587	1.024	601	220	-----	-----	-----		
Kershaw	15,400	13	38,900	323	6,000	278	3,600	439	1,053	1,389	1.021	1,418	365	-----	-----	-----		
Lancaster	17,800	15	47,700	396	8,100	375	4,600	561	1,347	1,721	1.016	1,749	401	-----	-----	-----		
Laurens	15,400	13	42,400	352	6,400	296	4,500	549	1,210	1,985	1.030	2,045	834	-----	-----	-----		
Lee	4,300	4	12,400	103	1,700	79	1,100	134	320	391	1.010	395	75	-----	-----	-----		
Lexington	65,000	55	173,300	1,438	22,400	1,038	13,900	1,696	4,227	5,333	1.030	5,493	1,266	-----	-----	-----		
Marion	8,000	7	20,200	168	3,400	157	1,800	220	552	618	1.009	624	72	-----	-----	-----		
Marlboro	6,300	5	18,300	152	2,600	120	1,300	159	436	639	0.986	630	194	-----	-----	-----		
McCormick	1,400	1	6,200	51	2,000	93	1,000	122	267	291	1.019	297	29	-----	-----	-----		
Newberry	8,600	7	23,200	193	3,900	181	2,600	317	698	1,061	1.016	1,078	380	-----	-----	-----		
Oconee	15,800	13	45,500	378	9,400	435	6,200	757	1,583	2,177	1.024	2,229	646	-----	-----	-----		
Orangeburg	21,500	18	57,500	477	9,100	422	6,000	732	1,649	3,694	1.011	3,128	1,479	-----	-----	-----		
Pickens	24,800	21	81,600	677	10,300	477	7,200	879	2,054	2,616	1.026	2,684	630	-----	-----	-----		
Richland	88,600	75	262,900	2,182	25,800	1,195	16,100	1,965	5,416	6,009	1.015	6,099	683	-----	-----	-----		
Saluda	4,500	4	12,300	102	2,000	93	1,400	171	369	337	1.005	339	(31)	-----	-----	-----		
Spartanburg	69,900	59	180,900	1,501	25,300	1,172	16,300	1,989	4,721	6,538	1.019	6,664	1,943	-----	-----	-----		
Sumter	27,900	23	66,700	554	9,000	417	6,200	757	1,751	2,828	1.015	2,870	1,120	-----	-----	-----		
Union	6,600	6	17,300	144	2,900	134	2,100	256	540	832	0.997	830	290	-----	-----	-----		
Williamsburg	7,900	7	20,800	173	3,400	157	2,100	256	593	963	0.994	957	364	-----	-----	-----		
York	58,200	49	149,600	1,241	17,900	829	10,700	1,306	3,425	4,064	1.030	4,186	761	-----	-----	-----		
TOTAL	1,088,000	915	2,977,300	24,707	431,700	19,997	270,600	33,024	78,643	100,996	1.021	103,099	24,456	-----	-----	-----		

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.

8. 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(s) where it operates them.
9. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

- a. Compliance with the Need Outlined in this Section of the Plan;
- b. Acceptability;
- c. Distribution (Accessibility);
- d. Medically Underserved Groups;
- e. Record of the Applicant; and
- f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond

those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.
2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.
3. The applicant must document the full range of services (RN, PT, ST, MSW, IV, etc.) that they intend to provide to pediatric patients.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. 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;
2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
3. 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 non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

Home Health Agency Utilization 2011

<u>Agency</u>	<u>Counties Served</u>	<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	296	1,592
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	415	2,303
Amedisys Home Health of Beaufort 1	Beaufort & Jasper	1,438	30,300
Amedisys Home Health of Bluffton 2	Beaufort, Hampton & Jasper	1,266	22,963
Amedisys Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,568	31,187
Amedisys Home Health of Charleston	Berkeley, Charleston & Dorchester	3,710	72,420
Amedisys Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,385	84,502
Amedisys Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,796	37,951
Amedisys Home Health of Conway	Horry	1,480	27,064
Amedisys Home Health Georgetown	Georgetown & Williamsburg	1,864	32,413
Amedisys HH Georgetown East	Georgetown & Williamsburg	327	5,067
Amedisys Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	6,481	135,463
Amedisys Home Health Myrtle Beach	Horry	1,346	27,112
AnMed Health Home Health	Anderson	1,345	28,134
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	199	4,156
Bethea Home Health (may serve retirement community only)	Darlington	20	21,148
CarePro Home Health	Richland & Sumter	409	8,072
Caring Neighbors Home Health	Fairfield	237	6,543
Carolinas Home Health	Darlington, Dillon, Florence & Marlboro	1,459	26,378
Chesterfield Visiting Nurses Services	Chesterfield, Darlington & Marlboro	407	9,397
Clarendon Memorial Home Health	Clarendon	411	7,105

Covenant Place Home Health (may serve retirement community only)	Sumter	-	-
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	70	3,233
DHEC Region 1 Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	605	15,867
DHEC Region 2 Home Health	Cherokee, Greenville, Pickens, Spartanburg & Union	672	10,677
DHEC Region 3 Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	1,000	15,118
DHEC Region 4 Home Health	Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro & Sumter	2,539	41,259
DHEC Region 5 Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	658	10,830
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	506	4,848
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	607	13,063
DHEC Region 8 Home Health 3	Beaufort, Colleton, Hampton & Jasper	611	6,542
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	249	6,734
Franklin C. Fetter Home Health Agency	Charleston	26	1,172
Gentiva Health Services 4	Lexington & Richland	1,524	35,306
Gentiva Health Services - Charleston 5	Berkeley, Charleston & Dorchester	753	14,636
Gentiva Health Services - Coastal 6	Georgetown, Horry & Williamsburg	1,630	37,332
Gentiva Health Services-Greenville 7 (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	3,469	95,088
Gentiva Health Services - Upstate 8	Cherokee, Chester, Union & York	3,529	79,161
Greenville Hospital System HHA	Greenville & Pickens	1,914	31,986
Health Related Home Care 9	Abbeville, Edgefield, Greenwood, Laurens, McCormick & Saluda	1,582	48,034
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick & Saluda	14	238
Home Care of Lancaster	Lancaster	1,458	49,759
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	1,307	22,616
HomeChoice Partners 10 (restricted to pediatric patients only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York	8	17

Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,645	49,296
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	22	420
Incare Home Health	Georgetown & Horry	1,694	25,329
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	9,869	144,378
Interim HealthCare of Rock Hill	York	1,603	20,318
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	2,329	44,865
Island Health Care	Beaufort	1,355	26,157
Kershawhealth Home Health	Kershaw	807	19,084
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington	-	-
Liberty Home Care - Aiken	Aiken	384	6,847
Liberty Home Care - Bennettsville	Marlboro	320	6,529
Liberty Home Care - Myrtle Beach	Horry	1,015	13,539
Live Long Wellcare of Brightwater (may serve retirement community only)	Horry	1	20
Live Long Wellcare Litchfield (may serve retirement community only)	Georgetown	6	77
Live Long Wellcare Summit Hills (may serve retirement community only)	Spartanburg	18	2,402
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	2,749	47,836
Methodist Manor Home Health 11 (may serve retirement community only)	Florence	-	-
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg	-	-
NHC HomeCare - Aiken	Aiken	539	12,943
NHC HomeCare - Greenwood	Greenwood	334	13,337
NHC HomeCare - Laurens	Greenville & Laurens	1,085	35,116
NHC HomeCare - LowCountry	Berkeley & Dorchester	238	3,660
NHC HomeCare - Midlands	Lexington & Richland	557	12,702
NHC HomeCare - Piedmont	York	557	10,121

Neighbors Care Home Health Agency	Chester	511	12,144
Oconee Memorial Home Health	Anderson, Oconee & Pickens	669	20,098
Palmetto Health HomeCare 12	Lexington & Richland	1,583	34,428
Pediatric Home Health 13 (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester	1,250	2,226
Presbyterian Communities of SC 14 (may serve retirement communities only)	Berkeley, Dorchester, Florence, Laurens, Lexington & Pickens	-	-
PHC Home Health	Charleston	511	13,434
Rolling Green Village 15 (may serve retirement community only)	Greenville	-	-
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	3,192	58,875
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	41	3,028
Sea Island Home Health	Charleston & Colleton	110	5,035
Spartanburg Reg Med Ctr Home Health	Spartanburg	2,406	35,132
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	2,275	27,773
Still Hopes Solutions for Living at Home (may serve retirement community only)	Lexington	-	-
Tri-County Home Health Care 16	Aiken, Allendale, Lexington, Richland, Saluda, & Sumter	4,137	65,365
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	942	23,446
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	1,002	18,832
United Home Care of Lowcountry 17	Beaufort	-	-
University Home Health North Augusta	Aiken & Edgefield	1,052	16,613
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	750	21,025
Wesley Commons Home Health Care (may serve retirement community only)	Greenwood	62	5,357
Westminster Campus Home Health (may serve retirement community only)	York	19	72
TOTALS		103,229	2,022,665

Home Health Agency Footnotes

- 1 Formerly Amedisys Home Health of Hilton Head.
- 2 Name changed, formerly Care One Home Care Services.
- 3 Licensed amended 2/17/11 to re-add Beaufort and Jasper Counties.
- 4 Formerly Carolina Home Health Care.
- 5 Formerly Carolina Home Health Care-Charleston; prior to that was Hospice of Charleston Home Health Agency.
- 6 Formerly Total Care – Coastal.
- 7 Formerly Carolina Home Health Care.
- 8 Formerly Total Care Home Health.
- 9 CON approved 4/25/12 to serve Edgefield County; appealed.
- 10 CONs issued 9/22/11 to establish a HHA restricted to pediatric patients only, SC-11-31 through SC-11-35, SC-11-37 through SC-11-40. Licensed 11/14/11.
- 11 Licensed 2/12/10.
- 12 De-licensed Bamberg County (served terminally ill patients only) 3/1/11.
- 13 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10. License amended 11/30/10 to raise the age limit from 14 years and under to 18 years and under.
- 14 Agency licensed to serve the 6 Presbyterian communities 12/31/11.
- 15 Exemption issued 7/5/12.
- 16 CON approved for Aiken County; appealed. CON issued 12/1/10, SC-10-35. Agency licensed for Aiken County 12/16/10. CON approved for Allendale County; appealed.
- 17 CON approved for Beaufort County; appealed.

EXHIBIT B-1

INPATIENT BED NEED

AS OF 3/24/11

SERVICE AREA	2009 POP	2016 POP	EXIST BEDS	2009 PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON, OCONEE	205,010	222,050	0	0	0.00	0.70	0	0	8	8	8
GREENVILLE, PICKENS	438,400	479,830	13	4,896	14.68	0.70	21	8	18	5	8
CHEROKEE, SPARTANBURG, UNION	292,190	313,420	0	0	10.37	0.70	15	15	12	12	15
CHESTER, LANCASTER, YORK	231,600	255,290	18	0	0.00	0.70	0	-18	10	-8	-8
ABBEVILLE, EDGEFIELD, GREENWOOD, LAURENS, MCCORMICK, SALUDA	188,780	204,050	24	0	6.75	0.70	10	-14	8	-16	-14
FAIRFIELD, KERSHAW, LEXINGTON, NEWBERRY, RICHLAND	575,950	625,610	37	6,874	20.46	0.70	29	-8	24	-13	-8
DARLINGTON, FLORENCE, MARION	190,340	199,010	12	1,931	5.53	0.70	8	-4	8	-4	-4
CHESTERFIELD, DILLON, MARLBORO	80,270	81,390	0	0	2.69	0.70	4	4	3	3	4
CLARENDON, LEE, SUMTER	134,410	141,490	0	0	4.68	0.70	7	7	5	5	7
GEORGETOWN, Horry, WILLIAMSBURG	278,560	315,600	14	2,526	10.44	0.70	15	1	12	-2	1
BAMBERG, CALHOUN, ORANGEBURG	103,440	107,510	0	0	3.56	0.70	5	5	4	4	5
ALLENDALE, BEAUFORT, HAMPTON, JASPER	167,240	190,820	0	0	6.31	0.70	9	9	7	7	9
BERKELEY, CHARLESTON, COLLETON DORCHESTER	522,110	557,410	33	7,604	22.24	0.70	32	-1	21	-12	-1
AIKEN, BARNWELL	151,610	166,670	18	4,121	12.41	0.70	18	0	6	-12	0
STATE TOTAL	3,559,910	3,860,150	169	27,952	120.12		173	4	147	-22	22
	0.012074		0.0438								

AS OF 3/24/11

REHABILITATION BED NEED

SERVICE AREA	2009 POP	2016 POP	EXIST BEDS	2009 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	253,230	271,040	45	13,010	38.15	0.70	55	10	30	-15	10
GREENVILLE,PICKENS	541,950	586,360	72	17,623	52.24	0.70	75	3	65	-7	3
CHEROKEE,SPARTANBURG UNION	364,780	387,190	18	4,260	12.39	0.70	18	0	43	25	26
CHESTER,LANCASTER YORK	288,250	313,010	46	12,636	37.59	0.70	54	8	35	-11	8
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	232,640	248,040	34	10,149	29.65	0.70	42	8	28	-6	8
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	654,730	704,230	96	21,721	64.01	0.70	91	-5	78	-18	-5
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	377,770	387,080	130	32,384	90.91	0.70	130	0	43	-87	0
CLARENDON,KERSHAW LEE,SUMTER	228,780	242,010	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN,HORRY	295,540	332,720	43	12,839	39.60	0.70	57	14	37	-6	14
AIKEN,ALLENDAL, BAMBERG BARNWELL,CALHOUN ORANGEBURG	327,460	347,330	24	6,174	17.94	0.70	26	2	39	15	15
BEAUFORT,HAMPTON,JASPER	188,940	211,530	14	3,739	11.47	0.70	16	2	24	10	10
BERKELEY,CHARLESTON COLLETON,DORCHESTER	647,160	688,990	98	24,316	70.93	0.70	101	3	77	-21	3
STATE TOTAL	4,401,230	4,719,530	620	158,851	464.9		665	45	526	-94	118
			0.1114								

EXHIBIT B-2

2009 ASF Utilization

As of 6/17/11

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region I:</u>										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,993	643	5,636	1,664		
Bearwood Ambulatory Surgery Center	Anderson	1		1	1068		1,068	1,068		
Physician Surgery Center at AnMed Health	Anderson	3		3	2119		2,119	1,060		
Upstate Endoscopy Center	Anderson		2	2		5,756	5,756			
Center for Special Surgery, The	Greenville	2		2	1,886		1,886	943		
Cross Creek Surgery Center	Greenville	4		4	2,055		2,055	514		
Endoscopy Center of the Upstate	Greenville		3	3		5,000	5,000		1,667	
Greenville Endoscopy Center	Greenville		3	3		6,010	6,010		2,003	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,001	6,001		2,000	
GHS Outpatient Surgery Center -- Patewood	Greenville	6	2	8	5,869	2,363	8,232	978	1,182	1
Greenville Surgery Center	Greenville	4		4	2,896		2,896	724		
Jervey Eye Center	Greenville	3		3	3,493		3,493	1,164		
Upstate Surgery Center	Greenville	2		2	3,169		3,169	1,585		
Blue Ridge Surgery Center	Oconee	2		2	2,161		2,161	1,081		
Synergy Spine Center	Oconee	2		2	687		687	344		2
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,670	3,425	11,095	1,096	1,713	3
Spartanburg Surgery Center	Spartanburg	4		4	3,937		3,937	984		4
Surgery Center at Pelham	Spartanburg	4	2	6	3,359	1,611	4,970	840	806	
Westside Eye Center	Spartanburg	2		2						
<u>Region II:</u>										
Greenwood Endoscopy Center	Greenwood		4	4		8,314			2,079	

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,564	19	4,583	813		
Surgery Center at Edgewater	Lancaster	3	2	5	2,161	4	2,165	720	2	5
Surgery & Laser Center at Professional Park	Laurens	2		2	2,908		2,908	1,454		
Columbia Surgery Center	Lexington	2		2						
Midlands Endoscopy Center	Lexington		2	2		1,902			951	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	3,267		3,267	1,634		6
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,646		1,646	412		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,197	1,559	3,756	549	1,559	
South Carolina Endoscopy Center	Lexington		4	4		10,746	10,746		2,687	
Urology Surgery Center	Lexington	2		2	1,911		1,911	956		
Berkeley Endoscopy Center	Richland		2	2		2,422	2,422		1,211	
Columbia Eye Surgery Center	Richland	4		4	4,787		4,787	1,197		
Columbia GI Endoscopy Center	Richland		4	4		6,228	6,228		1,557	
Lake Murray Endoscopy Center	Richland		2	2		1,700	1,700		850	
Midlands Orthopaedics Surgery Center	Richland	3		3	5,393		5,393	1,798		
Palmetto Gastroenterology	Richland		2	2						7
Palmetto Surgery Center	Richland	4		4	5,417		5,417	1,354		
Parkridge Surgery Center	Richland	4		4	2,576		2,576	644		
South Carolina Endoscopy Center - North East	Richland		5	5		4,218	4,218		844	
South Carolina Med Endoscopy Ctr.	Richland		2	2		3,170	3,170		1,585	8
Carolina Surgical Center	York	4		4	5,874		5,874	1,469		
Center for Orthopaedic Surgery	York	3		3	3,732		3,732			
York County Endoscopy Center	York		3	3	1,500					9

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region III:</u>										
Darlington Endoscopy Center	Darlington		2	2		678	678		339	
Florence Surgery & Laser Center	Florence	2		2	2,992		2,992	1,496		
McLeod Ambulatory Surgery Center	Florence	2		2	1,483		1,483	742		
Physicians Surgical Center of Florence	Florence	4	2	6	3,024	2,785	5,809	756	1,393	
Atlantic Surgery Center	Georgetown	1		1	1,200		1,200	1,200		
Bay Microsurgical Unit	Georgetown	1		1	3,519		3,519	3,519		
Waccamaw Endoscopy Center	Georgetown		1			1,986	1,986		1,986	
Carolina Bone and Joint Surgery Center	Horry	3		3	3,139		3,139	1,046		10
Grande Dunes Surgery Center	Horry	3	2	5	2,318	637	2,955	773	319	
Ocean Ambulatory Surgery Center	Horry	2		2	1,784		1,784			
Parkway Surgery Center	Horry	2		2	2,415		2,415	1,208		
Rivertown Surgery Center	Horry	2		3	2,870	1,848	4,718	1,435		
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	1,999	1,174	3,173	666		
Strand GI Endoscopy Center	Horry		2	2		5,033	5,033		2,517	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	1,564		1,564	782		
<u>Region IV:</u>										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,424	1,300	3,724	606	1,300	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,986		2,986			
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,037	622	1,659	519	622	
Laser and Skin Surgery Center	Beaufort	2		2	2,623		2,623	1,312		
Outpatient Surgery Ctr, Hilton Head	Beaufort	3	2	5	3,826	2,268	5,894	1,813	1,134	11
Surgery Center of Beaufort	Beaufort	3		3	3,734	1,368	5,102	1,245		

<u>Name of Facility:</u>	<u>County</u>	<u># of QRs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per QR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	232	658	890	77		
Charleston Endoscopy Center	Charleston		4	4		9,316	9,316		2,329	
Charleston Surgery Center	Charleston	4	1	5	4,477	536	5,013	1,119	536	
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2						12
Elms Endoscopy Center	Charleston		3	3		7,173	7,173		2,391	
Palmetto Endoscopy Center	Charleston		2	2		8,519	8,519		4,260	
Physicians' Eye Surgery Center	Charleston	2		2	2,685		2,685	1,343		
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4	1085		1,085	271		13
Roper West Ashley Surgery Center	Charleston	3		3	2,382		2,382	794		13
Southeastern Spine Institute	Charleston	2		2	8,389		8,389	4,195		14
Surgery Center of Charleston	Charleston	4		4	2,554	1,350	3,904	639	1,350	15
Trident Eye Surgery Center	Charleston	2		2	2,945		2,945	1,473		
Trident Surgery Center	Charleston	6		6	3,829		3,829	638		16
(West Ashley Endoscopy Center)	Charleston		(1)	(1)						17
Colleton Ambulatory Surgery Center	Colleton	2	1	3	842	616	1,458	421	616	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,663		2,663	1,332		
TOTALS		173	76	249	170,115	118,958	289,073	1,105	1,459	

Ambulatory Surgical Facility (ASF) Footnotes

As of 6/17/11

- No data available for facility during reporting period.
- 1 CON issued to add 2 Endoscopy Suites for a total of 4, 12/10/09, SC-09-54. CON voided 7/28/10.
- 2 Formerly Upstate Pain Management.
- 3 CON issued 10/22/07 to add 2 additional ORs and 1 Endoscopy Suite for a total of 9 ORs and 3 Endoscopy Suites, SC-07-55. CON voided 12/18/08.
- 4 CON issued 10/22/07 to add 2 additional ORs for a total of 4 ORs, SC-07-54. Licensed for 4 ORs 1/15/10. Formerly Spartanburg Urology Surgicenter.
- 5 CON issued 6/15/07 to add an additional OR for a total of 3 ORs and 2 Endoscopy Suites, SC-07-24; formerly Carolina Surgery Center. Licensed for the 3 ORs on 2/27/08; the 2 Endoscopy Suites were licensed 8/5/09.
- 6 CON issued 5/13/11 to add 2 ORs for a total of 4, SC-11-11.
- 7 CON issued 12/9/10 to construct an ASF with 2 Endoscopy Suites restricted to gastroenterology procedures only, SC-10-38.
- 8 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.
- 9 CON approved 2/26/07 for an ASF with 3 Endoscopy Suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08. Licensed 2 of the Endoscopy Suites 6/26/09; licensed 3rd Endoscopy Suite 6/1/10.
- 10 CON issued 7/15/10 to add a 3rd OR, SC-10-22. 3rd OR licensed 12/7/10.
- 11 CON issued 8/24/09 to add 1 OR for a total of 3 ORs and 2 Endoscopy Suites, SC-09-41. New OR licensed 3/22/10.
- 12 CON issued 6/3/11 to establish an ASF with 2 Endoscopy Suites, SC-11-20.
- 13 CON issued 1/3/09 to transfer 2 ORs from Roper West Ashley Surgery Center to Roper St. Francis James Island Surgery Center, for a total of 3 ORs at Roper West Ashley Surgery Center and 4 ORs at Roper St. Francis James Island Surgery Center. License decreased from 5 ORs to 3 at Roper West Ashley effective 6/1/09. Roper St. Francis James Island licensed 9/30/09.
- 14 CON issued 6/12/08 after appeal, SC-08-17. Licensed 11/17/08.
- 15 CON issued 5/13/11 to add 2 ORs and convert the existing endoscopy suite to an OR, for a total of 4 ORs, SC-11-16.
- 16 CON issued 12/9/10 to convert 2 procedures rooms to ORs for a total of 6 ORs, SC-10-36.
- 17 CON approved 12/29/09; appealed. CON issued 5/3/10, SC-10-14. CON voided 6/16/11.

INPATIENT HOSPICES, 2009 DATA

AS OF 6/17/11

NAME OF FACILITY	COUNTY	LICENSED BEDS	ADMIS SIONS	PATIENT DAYS	% OCCU RATE
REGION I					
CALLIE & JOHN RAINEY HOSPICE HOUSE	ANDERSON	32	659	8,456	72.4%
MCCALL HOSPICE HOUSE OF GREENVILLE	GREENVILLE	30	438	8,330	78.2%
OCONEE MEMORIAL HOSPICE FOOTHILLS	OCONEE	15	247	3,270	59.7%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	SPARTANBURG	12	97	1,245	28.4%
SPARTANBURG REG HEALTHCARE HOSPICE	SPARTANBURG	15	613	4,847	88.5%
TOTAL		104	2,054	25,157	68.9%
REGION II					
HOSPICE HOUSE OF HOSPICECARE PIEDMONT	GREENWOOD	15	440	2,842	51.9%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	LAURENS	12	114	1,314	30.0%
ASCENSION HOUSE	RICHLAND	14	312	2,573	50.4%
AGAPE HOSPICE HOUSE OF THE MIDLANDS ¹	RICHLAND	12			
HOSPICE AND COMMUNITY CARE HOUSE	YORK	18	250	3,020	51.7%
TOTAL		69	1,116	9,749	45.9%
REGION III					
MCLEOD HOSPICE HOUSE ²	FLORENCE	24	469	3,708	84.7%
TIDELANDS COMMUNITY HOSPICE HOUSE	GEORGETOWN	12	208	1,763	40.3%
AGAPE HOSPICE HOUSE OF HORRY COUNTY ³	HORRY	0	0	0	
TOTAL		36	675	5,471	62.5%
REGION IV					
HOSPICE CTR HOSPICE OF CHARLESTON	CHARLESTON	20	517	4,935	67.6%
TOTAL		20	517	4,935	67.6%
STATEWIDE TOTAL					
		229	4,362	46,312	61.9%

¹ CON ISSUED 5/13/11 TO ESTABLISH A 12 BED INPATIENT HOSPICE, SC-11-14.

² CON ISSUED 3/11/10 TO ADD 12 BEDS FOR A TOTAL OF 24, SC-10-10.

³ CON ISSUED 7/15/10 TO CONVERT THE INPATIENT HOSPICE BEDS TO NURSING HOME BEDS, SC-10-21.

INTERMEDIATE BASSINET NEEDAS OF 6/17/11

<u>Hospital</u>	<u>Intermed Bassinets</u>	<u>2009 Pt Days</u>	<u>Intermed ADC</u>	<u>Occupancy Factor</u>	<u>Projected Need</u>	<u>To Be Added</u>
AnMed Health Women's	13	999	3	0.65	4	-9
Greenville Memorial	68	13,795	38	0.65	58	-10
St. Francis-Eastside	10	2,216	6	0.65	9	-1
Palmetto Baptist-Easley	4	0	0	0.65	0	-4
Spartanburg Regional	22	3,575	10	0.65	15	-7
Mary Black Memorial	10	713	2	0.65	3	-7
Self Regional	11	2,349	6	0.65	10	-1
Alken Regional Med Ctr	8	314	1	0.65	1	-7
Springs Memorial Hosp	4	805	2	0.65	3	-1
Lexington Medical Ctr	20	2,850	8	0.65	12	-8
Reg Med Ctr Orangeburg	10	0	0	0.65	0	-10
Palmetto Health Baptist	22	4,152	11	0.65	17	-5
Palmetto Health Richland	38	12,668	35	0.65	53	15
Tuomey	22	545	1	0.65	2	-20
Piedmont Medical Ctr	12	1,440	4	0.65	6	-6
Carolina Pines Regional	4	111	0	0.65	0	-4
McLeod Regional Med Ctr	28	4,853	13	0.65	20	-8
Women's Ctr Carolinas	11	1,015	3	0.65	4	-7
Conway Hospital	6	611	2	0.65	3	-3
Grand Strand Regional	2	209	1	0.65	1	-1
Marion Co Medical Ctr	2	0	0	0.65	0	-2
Beaufort Memorial Hosp	5	0	0	0.65	0	-5
Bon Secours-St. Francis	11	1,238	3	0.65	5	-6
East Cooper Med Ctr	10	366	1	0.65	2	-8
MUSC Medical Center	50	11,305	31	0.65	48	-2
Roper Hospital	5	110	0	0.65	0	-5
Trident Medical Center	10	2,139	6	0.65	9	-1
Summerville Med. Ctr.	3	1,112	3	0.65	5	2
Georgetown Memorial	5	137	0	0.65	1	-4
Waccamaw Community	2	483	1	0.65	2	0
Totals	428	70,110	192		295	-133

LONG TERM CARE BED NEED
AS OF 6/17/11

	2013 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
ANDERSON	27.76	1,083	811	272	272
CHEROKEE	7.65	298	243	55	55
GREENVILLE	54.18	2,113	1,873	240	240
OCONEE	16.13	629	252	377	377
PICKENS	16.33	637	437	200	200
SPARTANBURG	38.67	1,508	1,279	229	229
UNION	5.25	205	201	4	4
REGION I TOTAL	165.97	6,473	5,096	1,377	1,377
ABBEVILLE	4.40	172	116	56	56
CHESTER	5.09	199	100	99	99
EDGEFIELD	3.73	145	120	25	25
FAIRFIELD	3.76	147	262	-115	
GREENWOOD	10.31	402	354	48	48
KERSHAW	8.68	339	244	95	95
LANCASTER	8.64	337	288	49	49
LAURENS	11.80	460	420	40	40
LEXINGTON	33.23	1,296	924	372	372
MCCORMICK	3.66	143	120	23	23
NEWBERRY	6.30	246	276	-30	
RICHLAND	39.09	1,525	1,352	173	173
SALUDA	3.52	137	176	-39	
YORK	23.36	911	693	218	218
REGION II TOTAL	165.57	6,459	5,445	1,014	1,198
CHESTERFIELD	6.16	240	224	16	16
CLARENDON	7.12	278	152	126	126
DARLINGTON	9.91	386	366	20	20
DILLON	3.84	150	195	-45	
FLORENCE	18.85	735	775	-40	
GEORGETOWN	14.18	553	249	304	304
HORRY	49.07	1,914	1,014	900	900
LEE	3.19	124	120	4	4
MARION	4.92	192	180	12	12
MARLBORO	3.52	137	110	27	27
SUMTER	15.97	623	456	167	167
WILLIAMSBURG	5.88	229	184	45	45
REGION III TOTAL	142.61	5,561	4,025	1,536	1,621
AIKEN	25.45	993	778	215	215
ALLENDALE	1.94	76	44	32	32
BAMBERG	2.51	98	88	10	10
BARNWELL	3.87	151	173	-22	
BEAUFORT	36.56	1,426	611	815	815
BERKELEY	23.57	919	355	564	564
CALHOUN	2.78	108	120	-12	
CHARLESTON	48.94	1,909	1,279	630	630
COLLETON	6.30	246	132	114	114
DORCHESTER	17.21	671	351	320	320
HAMPTON	3.35	131	104	27	27
JASPER	3.24	126	88	38	38
ORANGEBURG	15.46	603	393	210	210
REGION IV TOTAL	191.18	7,457	4,516	2,941	2,975
STATEWIDE TOTALS	665.33	25,950	19,082	6,868	7,171

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

AS OF 6/17/11

REGION/COUNTY	FACILITY	SCANNERS	FY07 SCANS	FY08 SCANS	FY09 SCANS	CON/DATE
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	423	500	502	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	1,958	2,330	2,413	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	713	881	908	
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	1,234	1,509	1,749	
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	415	545	748	
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	340	444	428	
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	904	954	946	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	—	—	549	CON 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	1,706	2,213	2,256	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	604	1,005	1,117	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	234	248	230	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	590	672	657	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	227	237	211	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
GEORGETOWN	WACCAMAW COMMUNITY HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	—	7	184	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
HORRY	ASSOCIATED MEDICAL SPECIALISTS	FIXED	—	—	—	CON ISSUED 5/13/11
HORRY	COASTAL CANCER CENTER	FIXED	—	850	1,306	
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE 2 DAYS	951	776	838	
HORRY	CONWAY HOSPITAL	MOBILE 2 DAYS	123	199	128	
SUMTER	TUOMEY	MOBILE 1/2 DAY	180	191	227	
IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE 1 DAY	428	341	347	
BEAUFORT	BEAUFORT IMAGING CENTER	MOBILE 2 DAYS	224	226	298	
CHARLESTON	MUSC MEDICAL CENTER	FIXED	1,168	1,559	1,088	
CHARLESTON	ROPER HOSPITAL	FIXED	1,017	1,300	1,423	
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE 1 DAY	431	457	408	
CHARLESTON	TRIDENT HOSPITAL	FIXED	—	—	—	CON 2/28/11
JASPER	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	—	—	293	EXEMPTION 7/24/07
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE 2 DAYS	50	98	75	CONVERTED TO PET/CT 6/17/09
		TOTALS	14,205	17,359	19,961	

PSYCHIATRIC BED NEED												
SERVICE AREA	AGE CAT	2009 POP	2016 POP	EXISTING BEDS	2009 POS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	BED NEED
ANDERSON, OCONEE	<65	213,630	223,140		4,228	12.09						
	+65	39,400	47,900		1,735	5.78						
	TOTAL	253,230	271,040	38	5,963	17.87	0.70	26	-12	43	5	5
GREENVILLE, PICKENS	<65	478,300	509,470		35,659	104.06						
	+65	63,650	76,890		8,098	26.80						
	TOTAL	541,950	586,360	182	43,757	130.86	0.70	187	5	93	-89	5
CHEROKEE, SPARTANBURG UNION	<65	317,950	331,160		3,712	10.59						
	+65	46,830	56,010		5,289	17.33						
	TOTAL	364,780	387,190	71	9,001	27.92	0.70	40	-31	61	-10	-10
CHESTER, LANCASTER YORK	<65	255,300	271,990		3,089	9.02						
	+65	32,950	41,020		335	1.14						
	TOTAL	288,250	313,010	20	3,424	10.16	0.70	15	-5	50	30	30
ABBEVILLE, EDGEFIELD GREENWOOD, LAURENS MCCORMICK, SALUDA	<65	199,270	206,880		4,025	11.45						
	+65	33,370	41,160		462	1.56						
	TOTAL	232,640	248,040	36	4,487	13.01	0.70	19	-17	39	3	3
FAIRFIELD, Kershaw LEXINGTON, NEWBERRY RICHLAND	<65	633,440	665,770		36,782	105.92						
	+65	79,470	101,640		8,607	30.16						
	TOTAL	712,910	767,410	235	45,389	136.08	0.70	194	-41	122	-113	-41
DARLINGTON, FLORENCE MARION	<65	208,940	210,080		4,453	12.27						
	+65	30,020	37,510		2,612	8.94						
	TOTAL	238,960	247,590	35	7,065	21.21	0.70	30	-6	39	4	4
CHESTERFIELD, DILLON MARLBORO	<65	88,590	88,050		0	0.00						
	+65	12,360	14,770		0	0.00						
	TOTAL	101,950	102,820	8	0	0.00	0.70	0	-8	16	8	8
CLARENDON, LEE, SUMTER	<65	147,320	149,650		0	0.00						
	+65	23,280	29,180		0	0.00						
	TOTAL	170,600	178,830	0	0	0.00	0.70	0	0	28	28	28
GEORGETOWN, HORRY WILLIAMSBURG	<65	273,790	280,730		5,313	23.10						
	+65	58,610	78,860		6,326	11.44						
	TOTAL	332,400	369,390	59	11,639	34.54	0.70	49	-10	59	0	0
BAMBERG, CALHOUN ORANGEBURG	<65	109,840	109,610		1,741	4.78						
	+65	18,500	22,930		963	3.27						
	TOTAL	128,340	132,540	15	2,704	8.03	0.70	11	-4	21	6	5
ALLENDALE, BEAUFORT HAMPTON, JASPER	<65	163,750	171,620		2,204	6.33						
	+65	37,140	52,030		288	1.11						
	TOTAL	200,890	223,650	36	2,492	7.43	0.70	11	-25	35	-1	-1
BERKELEY, CHARLESTON COLLETON, DORCHESTER	<65	565,810	579,760		31,775	89.20						
	+65	81,350	109,230		3,256	12.01						
	TOTAL	647,160	688,990	156	35,041	101.22	0.70	145	-11	109	-47	-11
AIKEN, BARNWELL	<65	161,210	170,170		8,879	25.68						
	+65	25,960	32,500		1,619	5.55						
	TOTAL	187,170	202,670	41	10,498	31.14	0.70	44	3	32	-9	3
	TOTAL			932				771	-161	749	-183	30
STATE TOTAL	<65	3,818,340	3,978,100	0.000159	141,851	0.038643385	0.03					
	+65	582,890	741,430		39,599	0.070762428	0.05					
	TOTAL	4,401,230	4,719,530		181,450	0.0429	0.03					

EXHIBIT B-3

2009 ASF Utilization

As of 9/23/11

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region I:</u>										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,893	843	5,636	1,664		
Bearwood Ambulatory Surgery Center	Anderson	1		1	1,068		1,068	1,068		
Physician Surgery Center at AnMed Health	Anderson	3		3	2,119		2,119	1,060		
Upstate Endoscopy Center	Anderson		2	2		5,756	5,756			
Center for Special Surgery, The	Greenville	2		2	1,886		1,886	943		
Cross Creek Surgery Center	Greenville	4		4	2,055		2,055	514		
Endoscopy Center of the Upstate	Greenville		3	3		5,000	5,000		1,667	
Greenville Endoscopy Center	Greenville		3	3		6,010	6,010		2,003	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,001	6,001		2,000	
GHS Outpatient Surgery Center – Patewood	Greenville	6	2	8	5,869	2,363	8,232	978	1,182	1
Greenville Surgery Center	Greenville	4		4	2,896		2,896	724		
Jervey Eye Center	Greenville	3		3	3,483		3,483	1,164		
Upstate Surgery Center	Greenville	2		2	3,169		3,169	1,585		
Blue Ridge Surgery Center	Oconee	2		2	2,161		2,161	1,081		
Synergy Spine Center	Oconee	2		2	687		687	344		2
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,670	3,425	11,095	1,096	1,713	3
Spartanburg Surgery Center	Spartanburg	4		4	3,937		3,937	984		4
Surgery Center at Pelham	Spartanburg	4	2	6	3,359	1,611	4,970	840	806	
Westside Eye Center	Spartanburg	2		2						
<u>Region II:</u>										
Greenwood Endoscopy Center	Greenwood		4	4		8,314			2,079	

<u>Name of Facility:</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,564	19	4,583	913		
Surgery Center at Edgewater	Lancaster	3	2	5	2,161	4	2,165	720	2	5
Surgery & Laser Center at Professional Park	Laurens	2		2	2,908		2,908	1,454		
Columbia Surgery Center	Lexington	2		2						
Midlands Endoscopy Center	Lexington		2	2		1,902			951	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	3,267		3,267	1,634		6
Outpt Surgery Center Lexington Med Ctr - Immo	Lexington	4		4	1,846		1,846	412		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,197	1,559	3,756	549	1,559	
South Carolina Endoscopy Center	Lexington		4	4		10,748	10,748		2,687	
Urology Surgery Center	Lexington	2		2	1,911		1,911	956		
Berkeley Endoscopy Center	Richland		2	2		2,422	2,422		1,211	
Columbia Eye Surgery Center	Richland	4		4	4,787		4,787	1,197		
Columbia GI Endoscopy Center	Richland		4	4		6,228	6,228		1,557	
Lake Murray Endoscopy Center	Richland		2	2		1,700	1,700		850	
Midlands Orthopaedics Surgery Center	Richland	3		3	5,393		5,393	1,798		
Palmetto Endoscopy Suite	Richland		2	2						7
Palmetto Surgery Center	Richland	4		4	5,417		5,417	1,354		
Parkridge Surgery Center	Richland	4		4	2,576		2,576	644		
South Carolina Endoscopy Center - North East	Richland		5	5		4,218	4,218		844	
South Carolina Med Endoscopy Ctr.	Richland		2	2		3,170	3,170		1,585	8
Carolina Surgical Center	York	4		4	5,874		5,874	1,469		
Center for Orthopaedic Surgery	York	3		3	3,732		3,732			
York County Endoscopy Center	York		3	3	1,500					9

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region III:</u>										
Darlington Endoscopy Center	Darlington		2	2		678	678		339	
Florence Surgery & Laser Center	Florence	2		2	2,982		2,982	1,496		
McLeod Ambulatory Surgery Center	Florence	2		2	1,483		1,483	742		
Physicians Surgical Center of Florence	Florence	4	2	6	3,024	2,785	5,809	756	1,393	
Atlantic Surgery Center	Georgetown	1		1	1,200		1,200	1,200		
Bay Microsurgical Unit	Georgetown	1		1	3,519		3,519	3,519		
Waccamaw Endoscopy Center	Georgetown		1			1,986	1,986		1,986	
Carolina Bone and Joint Surgery Center	Horry	3		3	3,139		3,139	1,046		10
Grande Dunes Surgery Center	Horry	3	2	5	2,318	637	2,955	773	319	
Ocean Ambulatory Surgery Center	Horry	2		2	1,784		1,784			
Parkway Surgery Center	Horry	2		2	2,415		2,415	1,208		
Rivertown Surgery Center	Horry	2		2	2,870	1,848	4,718	1,435		
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	1,998	1,174	3,173	666		
Strand GI Endoscopy Center	Horry		2	2		5,033	5,033		2,517	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	1,584		1,584	782		
<u>Region IV:</u>										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,424	1,300	3,724	606	1,300	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,986		2,986			
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,037	622	1,659	519	622	
Laser and Skin Surgery Center	Beaufort	2		2	2,623		2,623	1,312		
Outpatient Surgery Ctr. Hilton Head	Beaufort	3	2	5	3,626	2,266	5,894	1,813	1,134	11
Surgery Center of Beaufort	Beaufort	3		3	3,734	1,368	5,102	1,245		

<u>Name of Facility</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	232	658	890	77		
Charleston Endoscopy Center	Charleston		4	4		9,316	9,316		2,329	
Charleston Surgery Center	Charleston	4	1	5	4,477	536	5,013	1,119	536	
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2						12
Elms Endoscopy Center	Charleston		3	3		7,173	7,173		2,391	
Palmetto Endoscopy Center	Charleston		2	2		8,519	8,519		4,260	
Physicians' Eye Surgery Center	Charleston	4		4	2,685		2,685	1,343		13
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4	1085		1,085	271		14
Roper West Ashley Surgery Center	Charleston	3		3	2,382		2,382	794		14
Southeastern Spine Institute	Charleston	2		2	8,389		8,389	4,195		15
Surgery Center of Charleston	Charleston	4		4	2,554	1,350	3,904	639	1,350	16
Trident Eye Surgery Center	Charleston	2		2	2,945		2,945	1,473		
Trident Surgery Center	Charleston	6		6	3,829		3,829	638		17
(West Ashley Endoscopy Center)	Charleston		(1)	(1)						18
Colleton Ambulatory Surgery Center	Colleton	2	1	3	842	616	1,458	421	616	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,663		2,663	1,332		
TOTALS		175	76	250	170,115	118,958	289,073	1,105	1,459	

Ambulatory Surgical Facility (ASF) Footnotes

As of 9/23/11

- No data available for facility during reporting period.
- 1 CON issued to add 2 Endoscopy Suites for a total of 4, 12/10/09, SC-09-54. CON voided 7/28/10.
- 2 Formerly Upstate Pain Management.
- 3 CON issued 10/22/07 to add 2 additional ORs and 1 Endoscopy Suite for a total of 9 ORs and 3 Endoscopy Suites, SC-07-55. CON voided 12/18/08.
- 4 CON issued 10/22/07 to add 2 additional ORs for a total of 4 ORs, SC-07-54. Licensed for 4 ORs 1/15/10. Formerly Spartanburg Urology Surgicenter.
- 5 CON issued 6/15/07 to add an additional OR for a total of 3 ORs and 2 Endoscopy Suites, SC-07-24; formerly Carolina Surgery Center. Licensed for the 3 ORs on 2/27/08; the 2 Endoscopy Suites were licensed 8/5/09.
- 6 CON issued 5/13/11 to add 2 ORs for a total of 4, SC-11-11.
- 7 CON issued 12/9/10 to construct an ASF with 2 Endoscopy Suites restricted to gastroenterology procedures only, SC-10-38. Licensed 8/26/11.
- 8 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.
- 9 CON approved 2/26/07 for an ASF with 3 Endoscopy Suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08. Licensed 2 of the Endoscopy Suites 6/26/09; licensed 3rd Endoscopy Suite 6/1/10.
- 10 CON issued 7/15/10 to add a 3rd OR, SC-10-22. 3rd OR licensed 12/7/10.
- 11 CON issued 8/24/09 to add 1 OR for a total of 3 ORs and 2 Endoscopy Suites, SC-09-41. New OR licensed 3/22/10.
- 12 CON issued 6/3/11 to establish an ASF with 2 Endoscopy Suites, SC-11-20.
- 13 CON issued 7/29/11 to add 2 OR's for a total of 4, SC-11-26.
- 14 CON issued 1/3/09 to transfer 2 ORs from Roper West Ashley Surgery Center to Roper St. Francis James Island Surgery Center, for a total of 3 ORs at Roper West Ashley Surgery Center and 4 ORs at Roper St. Francis James Island Surgery Center. License decreased from 5 ORs to 3 at Roper West Ashley effective 6/1/09. Roper St. Francis James Island licensed 9/30/09.
- 15 CON issued 6/12/08 after appeal, SC-08-17. Licensed 11/17/08.
- 16 CON issued 5/13/11 to add 2 ORs and convert the existing endoscopy suite to an OR, for a total of 4 ORs, SC-11-16.
- 17 CON issued 12/9/10 to convert 2 procedures rooms to ORs for a total of 6 ORs, SC-10-36.
- 18 CON approved 12/29/09; appealed. CON issued 5/3/10, SC-10-14. CON voided on 6/16/11.

INPATIENT HOSPICES, 2009 DATAAS OF 9/23/11

NAME OF FACILITY	COUNTY	LICENSED BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
REGION I						
CALLIE & JOHN RAINEY HOSPICE HOUSE	ANDERSON	32	659	8,456	32	72.4%
MCCALL HOSPICE HOUSE OF GREENVILLE	GREENVILLE	30	438	8,339	30	76.2%
OCONEE MEMORIAL HOSPICE FOOTHILLS	OCONEE	15	247	3,270	15	59.7%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	SPARTANBURG	12	97	1,245	12	28.4%
SPARTANBURG REG HEALTHCARE HOSPICE	SPARTANBURG	15	613	4,847	15	88.5%
TOTAL		104	2,054	26,157	104	68.9%
REGION II						
HOSPICE HOUSE OF HOSPICECARE PIEDMONT	GREENWOOD	15	440	2,842	15	51.9%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	LAURENS	12	114	1,314	12	30.0%
AGAPE HOSPICE HOUSE OF THE MIDLANDS ¹	RICHLAND	12				
(ASCENSION HOUSE) ²	RICHLAND	(14)	312	2,573	14	50.4%
HOSPICE AND COMMUNITY CARE HOUSE	YORK	16	250	3,020	16	51.7%
TOTAL		55	1,116	9,749	57.0	46.9%
REGION III						
MCLEOD HOSPICE HOUSE ³	FLORENCE	24	469	3,708	12	84.7%
TIDELANDS COMMUNITY HOSPICE HOUSE	GEORGETOWN	12	206	1,763	12	40.3%
(AGAPE HOSPICE HOUSE OF Horry CO) ⁴	Horry	(24)	0	0	---	
TOTAL		36	675	5,471	24	62.5%
REGION IV						
HOSPICE CTR HOSPICE OF CHARLESTON	CHARLESTON	20	517	4,935	20	67.6%
TOTAL		20	517	4,935	20	67.6%
STATEWIDE TOTAL						
		215	4,362	46,312	205	61.9%

¹ CON ISSUED 5/13/11 TO ESTABLISH A 12 BED INPATIENT HOSPICE, SC-11-14.² FACILITY CLOSED 1/31/11.³ CON ISSUED 3/11/10 TO ADD 12 BEDS FOR A TOTAL OF 24, SC-10-10.⁴ CON ISSUED 7/15/10 TO CONVERT THE INPATIENT HOSPICE BEDS TO NURSING HOME BEDS, SC-10-21.

Home Health Agency Inventory - 2009 Data**As of 9/23/11**

<u>Agency</u>		<u>Counties Served</u>	<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	1	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	360	570
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	2	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	439	641
Amedysis Home Health of Camden		Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,103	21,738
Amedysis Home Health of Charleston		Berkeley, Charleston & Dorchester	3,470	77,798
Amedysis Home Health of North Charleston		Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,435	89,302
Amedysis Home Health of Clinton		Abbeville, Greenville, Greenwood & Laurens	1,940	45,487
Amedysis Home Health of Conway		Horry	1,395	34,733
Amedysis Home Health Georgetown		Georgetown & Williamsburg	1,868	32,890
Amedysis HH Georgetown East		Georgetown & Williamsburg	198	3,068
Amedisys Home Health Hilton Head		Beaufort & Jasper	1,113	27,707
Amedysis Home Health of Lexington		Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	5,721	128,285
Amedysis Home Health Myrtle Beach		Horry	1,179	20,392
AnMed Health Home Health		Anderson	1,134	27,461
Beaufort-Jasper Home Health Agency		Beaufort & Jasper	186	5,725
Bethea Home Health (may serve retirement community only)		Darlington	34	27,734
Care One Home Health		Beaufort, Hampton & Jasper	976	24,056
CarePro Home Health		Richland & Sumter	598	13,362
Caring Neighbors Home Health		Fairfield	253	5,709
Carolinas Home Health	3	Darlington, Dillon, Florence & Marlboro	1,351	28,119
Chesterfield Visiting Nurses Services		Chesterfield, Darlington & Marlboro	444	9,255

Clarendon Memorial Home Health	Clarendon	383	5,079
Clemson Area Retirement Ctr Home Health (may serve retirement community only)	Pickens	18	4,384
Covenant Place Home Health 4 (may serve retirement community only)	Sumter		
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	65	3,437
DHEC Region 1 Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	862	20,602
DHEC Region 2 Home Health West	Greenville & Pickens	603	6,615
DHEC Region 2 Home Health East	Cherokee, Spartanburg & Union	415	8,737
DHEC Region 3 Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	932	14,211
DHEC Region 4 Home Health East	Chesterfield, Darlington, Dillon, Florence, Marion & Marlboro	1,876	33,153
DHEC Region 4 Home Health West	Clarendon, Kershaw, Lee & Sumter	616	13,749
DHEC Region 5 Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	732	13,153
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	499	6,525
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	647	15,520
DHEC Region 8 Home Health 5	Beaufort, Colleton, Hampton & Jasper	407	5,952
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	306	7,535
Franklin C. Fetter Home Health Agency	Charleston	129	3,984
Gentiva Health Services 6	Lexington & Richland	1,624	35,202
Gentiva Health Services - Charleston 7	Berkeley, Charleston & Dorchester	300	6,724
Gentiva Health Services - Coastal 8	Georgetown, Horry & Williamsburg	1,334	29,507
Gentiva Health Services - Greenville 9 (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	2,845	75,968
Gentiva Health Services - Upstate 10	Cherokee, Chester, Union & York	3,030	66,237
Greenville Hospital System HHA	Greenville & Pickens	1,869	31,161
Health Related Home Care	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,479	47,534

HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick & Saluda	24	466
Home Care of Lancaster	Lancaster	1,331	40,641
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	947	20,895
HomeChoice Partners 11 (restricted to pediatric patients only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York		
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,807	43,857
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	27	413
Incare Home Health	Georgetown & Horry	1,820	24,895
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	8,732	151,848
Interim HealthCare of Rock Hill	York	1,649	23,911
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	1,849	32,097
Island Health Care	Beaufort	1,440	31,359
Kershawhealth Home Health	Kershaw	836	15,945
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington		
Liberty Home Care - Aiken	Aiken	365	7,070
Liberty Home Care - Bennettsville	Marlboro	288	4,286
Liberty Home Care - Myrtle Beach	Horry	946	14,539
Live Long Wellcare of Brightwater 12 (may serve retirement community only)	Horry		
Live Long Wellcare Litchfield 13 (may serve retirement community only)	Georgetown		
Live Long Wellcare Summit Hills 14 (may serve retirement community only)	Spartanburg		
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	3,047	44,815
Methodist Manor Home Health 15 (may serve retirement community only)	Florence		
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg		
NHC HomeCare - Aiken	Aiken	561	19,773

NHC HomeCare - Greenwood	Greenwood	272	12,454
NHC HomeCare - Laurens	Greenville & Laurens	995	37,967
NHC HomeCare - LowCountry 16	Berkeley & Dorchester	520	11,807
NHC HomeCare - Midlands 17	Lexington & Richland	1,180	21,463
NHC HomeCare - Piedmont 18	York	834	17,831
Neighbors Care Home Health Agency	Chester	379	9,333
Oconee Memorial Home Health	Anderson, Oconee & Pickens	699	21,495
Palmetto Health HomeCare 19	Lexington & Richland	1,423	32,039
Pediatric Home Health 20 (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester		
PHC Home Health	Charleston	651	18,384
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	2,917	57,709
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	34	1,976
Sea Island Home Health	Charleston & Colleton	76	3,123
Spartanburg Reg Med Ctr Home Health	Spartanburg	1,833	39,019
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	2,781	42,315
Still Hopes Solutions for Living at Home (may serve retirement community only)	Lexington	0	0
Tri-County Home Health Care 21	Aiken, Lexington, Richland, Saluda & Sumter	3,819	66,563
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	914	16,428
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	980	15,349
University Home Health North Augusta	Aiken & Edgefield	1,129	18,913
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	640	19,440
Wesley Commons Home Health Care (may serve retirement community only)	Greenwood	32	4,479
Westminster Campus Home Health (may serve retirement community only)	York	19	563
		97,112	2,024,461

Home Health Agency Footnotes

As of 9/23/11

- 1 Name changed, formerly Matria Healthcare-Midlands.
- 2 Name changed, formerly Matria Healthcare-Piedmont.
- 3 Name changed, formerly Home Health Services of Carolina Hospital System.
- 4 Licensed 5/4/10 to serve the residents of the retirement community.
- 5 Licensed amended 2/17/11 to re-add Beaufort and Jasper Counties.
- 6 Formerly Carolina Home Health Care.
- 7 Formerly Carolina Home Health Care-Charleston; prior to that was Hospice of Charleston Home Health Agency.
- 8 Formerly Total Care – Coastal.
- 9 Formerly Carolina Home Health Care.
- 10 Formerly Total Care Home Health.
- 11 CONs issued 9/22/11 to establish a HHA restricted to pediatric patients only, SC-11-31 through SC-11-35, SC-11-37 through SC-11-40.
- 12 Licensed 9/16/09. Previously Brightwater Home Health Agency.
- 13 Formerly Lakes of Litchfield.
- 14 Licensed 5/14/09. Formerly Summitt Hills Home Health Agency.
- 15 Licensed 2/12/10.
- 16 Formerly Home Health of South Carolina – Low Country.
- 17 Formerly Home Health of South Carolina – Midlands.
- 18 Formerly Home Health of South Carolina.
- 19 De-licensed Bamberg County (terminally ill only) 3/1/11.
- 20 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10. License amended 11/30/10 to raise the age limit from 14 years and under to 18 years and under.
- 21 CON approved for Aiken County; appealed. CON issued 12/1/10, SC-10-35.

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANNED HEALTH MEDICAL CENTER	<18	42,730	43,810	715	2				
	18-64	110,580	116,170	40,514	117				
	+65	25,330	30,090	34,666	113				
	TOTAL	178,640	190,070	75,895	231	0.75	309	423	-114
ANNED WOMEN'S & CHILDRENS HOSPITAL	<18	42,730	43,810	75	0				
	18-64	110,580	116,170	4,376	13				
	+65	25,330	30,090	3,564	12				
	TOTAL	178,640	190,070	8,015	24	0.65	38	72	-34
ANDERSON COUNTY TOTAL							347	495	-148
UPSTATE CAROLINA MEDICAL CENTER	<18	14,660	15,330	714	2				
	18-64	35,590	37,960	8,081	24				
	+65	6,980	8,270	8,621	28				
	TOTAL	57,230	61,560	17,417	54	0.65	83	125	-42
CHEROKEE COUNTY TOTAL							83	125	-42
GREENVILLE MEMORIAL MEDICAL CENTER	<18	99,330	102,030	19,155	54				
	18-64	268,100	288,490	108,811	321				
	+65	49,040	59,040	42,583	140				
	TOTAL	416,470	449,560	170,549	515	0.75	687	746	-59
GREER MEMORIAL HOSPITAL	<18	99,330	102,030	264	1				
	18-64	268,100	288,490	8,734	26				
	+65	49,040	59,040	4,853	16				
	TOTAL	416,470	449,560	13,851	42	0.65	65	82	-17
HILLCREST MEMORIAL HOSPITAL	<18	99,330	102,030	8	0				
	18-64	268,100	288,490	3,113	9				
	+65	49,040	59,040	3,432	11				
	TOTAL	416,470	449,560	6,553	21	0.65	32	43	-11
PATEWOOD MEMORIAL HOSPITAL	<18	99,330	102,030	86	0				
	18-64	268,100	288,490	1,629	5				
	+65	49,040	59,040	1,210	4				
	TOTAL	416,470	449,560	2,925	9	0.65	14	72	-58
SAINT FRANCIS - DOWNTOWN & SAINT FRANCIS MILLENNIUM 1	<18	99,330	102,030	365	1				
	18-64	268,100	288,490	26,046	77				
	+65	49,040	59,040	32,503	107				
	TOTAL	416,470	449,560	58,914	185	0.70	264	226	38
SAINT FRANCIS - EASTSIDE	<18	99,330	102,030	184	1				
	18-64	268,100	288,490	13,148	39				
	+65	49,040	59,040	4,707	16				
	TOTAL	416,470	449,560	18,039	55	0.65	84	93	-9
GREENVILLE COUNTY TOTAL							1,146	1,262	-116

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
=====									
OCONEE MEMORIAL HOSPITAL	<18	15,850	16,190	573	2				
	18-64	44,670	46,970	16,234	47				
	+65	14,070	17,810	11,205	39				
	TOTAL	74,590	80,970	28,012	87	0.65	134	169	-35
OCONEE COUNTY TOTAL							134	169	-35
=====									
CANNON MEMORIAL HOSPITAL	<18	29,100	30,670	15	0				
	18-64	81,770	88,280	1,528	5				
	+65	14,610	17,850	2,092	7				
	TOTAL	125,480	136,800	3,635	12	0.65	18	55	-37
PALMETTO BAPTIST MED CTR EASLEY	<18	29,100	30,670	277	1				
	18-64	81,770	88,280	8,392	25				
	+65	14,610	17,850	9,947	33				
	TOTAL	125,480	136,800	18,616	59	0.65	91	109	-18
PICKENS COUNTY TOTAL							109	164	-55
=====									
MARY BLACK MEMORIAL	<18	67,250	68,450	1,214	3				
	18-64	175,870	185,770	18,897	55				
	+65	34,870	42,220	6,823	23				
	TOTAL	277,990	296,440	26,934	81	0.70	115	176	-61
SPARTANBURG REG MED CTR & VILLAGE HEALTH CENTRE	<18	67,250	68,450	3,414	10				
	18-64	175,870	185,770	71,007	205				
	+65	34,870	42,220	65,502	217				
	TOTAL	277,990	296,440	139,923	432	0.75	576	532	44
SPARTANBURG COUNTY TOTAL							691	708	-17
=====									
WALLACE THOMSON HOSPITAL	<18	7,040	6,890	284	1				
	18-64	17,540	16,780	4,222	11				
	+65	4,980	5,520	4,960	15				
	TOTAL	29,560	29,190	9,466	27	0.65	41	143	-102
UNION COUNTY TOTAL							41	143	-102
=====									
REGION II									
=====									
ABBEVILLE AREA MEDICAL CENTER	<18	6,760	6,850	70	0				
	18-64	16,590	17,020	923	3				
	+65	4,120	4,740	1,564	5				
	TOTAL	27,470	28,610	2,557	8	0.65	12	25	-13
ABBEVILLE COUNTY TOTAL							12	25	-13
=====									
CHESTER REGIONAL MEDICAL CENTER	<18	8,940	9,050	413	1				
	18-64	21,680	21,970	3,127	9				
	+65	4,690	5,530	3,443	11				
	TOTAL	35,310	36,550	6,983	21	0.65	32	82	-50
CHESTER COUNTY TOTAL							32	82	-50

FACILITY/COUNTY	AGE CAT	2016 HOSPITAL BED NEED					BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
		2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU			
EDGEFIELD COUNTY HOSPITAL	<18	5,840	5,680	21	0				
	18-64	18,050	19,570	388	1				
	+65	3,130	4,290	1,339	5				
	TOTAL	27,020	29,740	1,748	6	0.65	10	25	-15
EDGEFIELD COUNTY TOTAL							10	25	-15
FAIRFIELD MEMORIAL HOSPITAL	<18	6,180	6,170	44	0				
	18-64	15,440	15,510	1,400	4				
	+65	3,250	4,220	1,472	5				
	TOTAL	24,870	25,900	2,916	9	0.65	14	25	-11
FAIRFIELD COUNTY TOTAL							14	25	-11
SELF REGIONAL HEALTHCARE	<18	17,830	18,260	1,586	4				
	18-64	43,290	44,970	25,638	73				
	+65	9,530	10,890	25,875	82				
	TOTAL	70,650	74,220	53,099	159	0.75	212	354	-142
GREENWOOD COUNTY TOTAL							212	354	-142
KERSHAW HEALTH	<18	14,120	14,690	1,069	3				
	18-64	36,290	38,920	11,304	33				
	+65	7,770	9,570	14,351	48				
	TOTAL	58,180	63,180	26,724	85	0.65	130	121	9
KERSHAW COUNTY TOTAL							130	121	9
SPRINGS MEMORIAL HOSPITAL	<18	15,490	15,470	1,088	3				
	18-64	40,240	41,430	13,804	39				
	+65	7,860	9,470	17,267	57				
	TOTAL	63,590	66,370	32,159	99	0.70	141	199	-58
LANCASTER COUNTY TOTAL							141	199	-58
LAURENS COUNTY HOSPITAL	<18	17,710	17,750	234	1				
	18-64	48,110	51,780	5,549	16				
	+65	10,530	12,950	6,194	21				
	TOTAL	76,350	82,480	11,977	38	0.65	58	76	-18
LAURENS COUNTY TOTAL							58	76	-18
LEXINGTON MEDICAL CENTER	<18	42,173	43,661	1,067	3				
	18-64	114,487	124,908	49,370	148				
	+65	19,789	25,701	39,550	141				
	TOTAL	176,449	194,270	89,987	291	0.75	388	414	-26
LEXINGTON COUNTY TOTAL							388	414	-26

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
NEWBERRY COUNTY MEMORIAL	<18	8,980	9,120	304	1				
	18-64	23,610	24,040	3,637	10				
	+65	5,700	6,920	6,074	20				
	TOTAL	38,290	40,080	10,015	31	0.65	48	90	-42
NEWBERRY COUNTY TOTAL							48	90	-42
PALMETTO HEALTH BAPTIST & PALMETTO HEALTH PARKRIDGE	<18	100,167	103,129	936	3				
	18-64	271,993	285,622	52,218	150				
	+65	42,961	55,229	17,550	62				
	TOTAL	415,121	443,980	70,704	215	0.75	286	363	-77
PALMETTO HEALTH RICHLAND	<18	100,167	103,129	24,804	70				
	18-64	271,993	285,622	98,010	282				
	+65	42,961	55,229	42,248	149				
	TOTAL	415,121	443,980	165,062	501	0.75	668	579	89
PROVIDENCE HOSPITAL	<18	100,167	103,129	55	0				
	18-64	271,993	285,622	21,915	63				
	+65	42,961	55,229	30,184	106				
	TOTAL	415,121	443,980	52,154	170	0.70	242	258	-16
PROVIDENCE HOSPITAL NORTHEAST	<18	100,167	103,129	88	0				
	18-64	271,993	285,622	6,401	18				
	+65	42,961	55,229	3,806	13				
	TOTAL	415,121	443,980	10,295	32	0.65	49	84	-35
RICHLAND COUNTY TOTAL							1,245	1,284	-39
PIEDMONT MEDICAL CENTER	<18	45,710	46,810	1,363	4				
	18-64	123,240	137,260	29,411	90				
	+65	20,400	26,020	25,064	88				
	TOTAL	189,350	210,090	55,838	181	0.70	259	268	-9
CAROLINAS MED CTR - FORT MILL	<18	45,710	46,810						
	18-64	123,240	137,260						
	+65	20,400	26,020						
	TOTAL	189,350	210,090			0.65		64	
YORK COUNTY TOTAL				55,838	181		259	332	-9
REGION III									
CHESTERFIELD GENERAL HOSPITAL	<18	11,120	11,130	559	2				
	18-64	27,410	27,860	4,899	14				
	+65	5,520	6,790	4,841	16				
	TOTAL	44,050	45,780	10,299	30	0.65	46	59	-13
CHESTERFIELD COUNTY TOTAL							46	59	-13
CLARENDON MEMORIAL HOSPITAL	<18	7,800	7,750	378	1				
	18-64	20,540	20,410	7,356	20				
	+65	6,000	8,110	5,764	21				
	TOTAL	34,340	36,270	13,498	42	0.65	65	56	9
CLARENDON COUNTY							65	56	9

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
=====									
CAROLINA PINES REGIONAL	<18	17,630	17,140	1,915	5				
	18-64	42,550	42,800	17,266	48				
	+65	8,840	10,980	10,876	37				
	TOTAL	69,020	70,920	30,057	90	0.65	138	116	22
MCLEOD MEDICAL CENTER - DARLINGTON	<18	17,630	17,140		0				
	18-64	42,550	42,800	687	2				
	+65	8,840	10,980	1,517	5				
	TOTAL	69,020	70,920	2,204	7	0.65	11	49	-38
DARLINGTON COUNTY TOTAL							149	165	-16
MCLEOD MEDICAL CENTER - DILLON	<18	8,150	7,810	621	2				
	18-64	18,610	18,340	5,844	16				
	+65	3,540	4,160	4,155	13				
	TOTAL	30,300	30,310	10,620	31	0.65	47	79	-32
DILLON COUNTY TOTAL							47	79	-32
CAROLINAS HOSPITAL SYSTEM	<18	32,670	32,950	1,646	5				
	18-64	84,320	85,860	34,070	95				
	+65	16,670	20,960	24,820	85				
	TOTAL	133,660	139,770	60,536	185	0.70	264	310	-46
WOMENS CTR CAROLINAS HOSP SYSTEM	<18	32,670	32,950	161	0				
	18-64	84,320	85,860	3,322	9				
	+65	16,670	20,960	0	0				
	TOTAL	133,660	139,770	3,483	10	0.65	15	20	-5
LAKE CITY COMMUNITY HOSPITAL	<18	32,670	32,950	117	0				
	18-64	84,320	85,860	2,244	6				
	+65	16,670	20,960	1,963	7				
	TOTAL	133,660	139,770	4,323	12	0.65	19	48	-29
MCLEOD REGIONAL MEDICAL CENTER	<18	32,670	32,950	7,424	21				
	18-64	84,320	85,860	58,392	163				
	+65	16,670	20,960	47,365	163				
	TOTAL	133,660	139,770	113,181	347	0.75	462	453	9
FLORENCE COUNTY TOTAL							760	831	-71
GEORGETOWN MEMORIAL HOSPITAL	<18	12,790	12,180	786	2				
	18-64	36,480	37,310	8,725	24				
	+65	11,870	16,420	17,978	68				
	TOTAL	61,140	65,910	27,489	95	0.65	146	131	15
WACCAMAW COMMUNITY HOSPITAL	<18	12,790	12,180	389	1				
	18-64	36,480	37,310	8,187	23				
	+65	11,870	16,420	19,396	74				
	TOTAL	61,140	65,910	27,972	97	0.65	150	124	26
GEORGETOWN COUNTY TOTAL							296	255	41
CONWAY HOSPITAL	<18	43,410	44,190	1,165	3				
	18-64	149,460	166,970	19,194	59				
	+65	41,530	55,650	15,411	57				
	TOTAL	234,400	266,810	35,770	119	0.70	170	210	-40

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
GRAND STRAND REGIONAL MEDICAL CTR	<18	43,410	44,190	954	3				
	18-64	149,460	166,970	24,122	74				
	+65	41,530	55,650	32,517	119				
	TOTAL	234,400	266,810	57,593	196	0.70	280	269	11
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER	<18	43,410	44,190	616	2				
	18-64	149,460	166,970	7,795	24				
	+65	41,530	55,650	8,054	30				
	TOTAL	234,400	266,810	16,465	55	0.65	85	155	-70
HORRY COUNTY TOTAL							535	634	-89
MARION REGIONAL HOSPITAL	<18	9,260	8,920	722	2				
	18-64	22,510	22,410	10,894	30				
	+65	4,510	5,570	6,037	20				
	TOTAL	36,280	36,900	17,653	52	0.65	80	124	-44
MARION COUNTY TOTAL							80	124	-44
MARLBORO PARK HOSPITAL	<18	7,150	6,880	236	1				
	18-64	17,150	16,030	2,330	6				
	+65	3,300	3,820	1,657	5				
	TOTAL	27,600	26,730	4,223	12	0.65	18	94	-76
MARLBORO COUNTY TOTAL							18	94	-76
TUOMEY	<18	30,990	31,900	3,803	11				
	18-64	69,940	71,540	37,497	105				
	+65	14,380	17,510	25,420	85				
	TOTAL	115,310	120,950	66,720	201	0.70	287	283	4
SUMTER COUNTY TOTAL							287	283	4
WILLIAMSBURG REGIONAL HOSPITAL	<18	9,560	8,950	11	0				
	18-64	22,090	21,130	661	2				
	+65	5,210	6,590	821	3				
	TOTAL	36,860	36,670	1,493	5	0.65	7	25	-18
WILLIAMSBURG COUNTY TOTAL							7	25	-18
REGION IV									
AIKEN REGIONAL MEDICAL CENTER	<18	37,760	38,170	447	1				
	18-64	101,650	109,680	19,351	57				
	+65	22,550	28,170	20,479	70				
	TOTAL	161,960	176,020	40,277	129	0.70	184	183	1
AIKEN COUNTY TOTAL							184	183	1
ALLENDALE COUNTY HOSPITAL	<18	3,030	3,030	21	0				
	18-64	7,200	6,910	380	1				
	+65	1,720	2,180	836	3				
	TOTAL	11,950	12,120	1,237	4	0.65	6	25	-19
ALLENDALE COUNTY TOTAL							6	25	-19

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
BAMBERG COUNTY MEMORIAL HOSPITAL	<18	3,890	3,600	24	0				
	18-64	9,640	8,890	623	2				
	+65	2,280	2,760	2,407	8				
	TOTAL	15,810	15,250	3,054	10	0.65	15	59	-44
BAMBERG COUNTY TOTAL							15	59	-44
BARNWELL COUNTY HOSPITAL	<18	6,150	5,980	101	0				
	18-64	15,650	16,340	1,083	3				
	+65	3,410	4,330	1,208	4				
	TOTAL	25,210	26,650	2,392	8	0.65	12	53	-41
BARNWELL COUNTY TOTAL							12	53	-41
BEAUFORT MEMORIAL HOSPITAL	<18	27,880	26,630	1,413	4				
	18-64	86,160	93,740	19,574	58				
	+65	29,700	42,450	19,425	76				
	TOTAL	143,740	162,820	40,412	138	0.65	213	169	44
HILTON HEAD HOSPITAL	<18	27,880	26,630	213	1				
	18-64	86,160	93,740	7,036	21				
	+65	29,700	42,450	11,815	46				
	TOTAL	143,740	162,820	19,064	68	0.65	104	93	11
BEAUFORT COUNTY TOTAL							317	262	55
TRIDENT MED CENTER & BERKELEY MEDICAL CENTER	<18	143,280	147,880	1,428	4				
	18-64	386,830	395,280	36,691	103				
	+65	75,760	102,240	32,998	122				
	TOTAL	605,870	645,400	71,117	229	0.70	327	346	-19
SUMMERVILLE MEDICAL CENTER	<18	143,280	147,880	417	1				
	18-64	386,830	395,280	10,725	30				
	+65	75,760	102,240	9,645	36				
	TOTAL	605,870	645,400	20,787	67	0.65	103	124	-21
MUSC MEDICAL CENTER	<18	143,280	147,880	26,116	74				
	18-64	386,830	395,280	85,832	240				
	+65	75,760	102,240	34,413	127				
	TOTAL	605,870	645,400	146,361	441	0.75	589	604	-15
ROPER, ROPER ST FRANCIS MT PLEASANT & ROPER ST FRANCIS - BERKELEY	<18	143,280	147,880	81	0				
	18-64	386,830	395,280	33,325	93				
	+65	75,760	102,240	46,987	174				
	TOTAL	605,870	645,400	80,393	267	0.75	356	401	-45
BON SECOURS ST FRANCIS XAVIER	<18	143,280	147,880	317	1				
	18-64	386,830	395,280	20,814	58				
	+65	75,760	102,240	14,245	53				
	TOTAL	605,870	645,400	35,376	112	0.70	160	204	-44
EAST COOPER REGIONAL MEDICAL CTR	<18	143,280	147,880	102	0				
	18-64	386,830	395,280	11,028	31				
	+65	75,760	102,240	5,836	22				
	TOTAL	605,870	645,400	16,966	53	0.65	81	140	-59
BERKELEY/CHARLESTON/DORCHESTER TOTAL							1,616	1,819	-203

2016 HOSPITAL BED NEED									
FACILITY/COUNTY	AGE CAT	2009 POP	2016 POP	2009 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
COLLETON MEDICAL CENTER	<18	10,690	10,970	503	1				
	18-64	25,010	25,630	11,009	31				
	+65	5,590	6,990	11,329	39				
	TOTAL	41,290	43,590	22,841	71	0.65	110	131	-21
COLLETON COUNTY TOTAL							110	131	-21
HAMPTON REGIONAL MEDICAL CTR	<18	5,520	5,500	37	0				
	18-64	14,050	14,470	1,576	4				
	+65	2,950	3,790	2,109	7				
	TOTAL	22,520	23,760	3,722	12	0.65	18	32	-14
HAMPTON COUNTY TOTAL							18	32	-14
COASTAL CAROLINA MED CTR	<18	5,090	4,890	27	0				
	18-64	14,820	16,450	1,603	5				
	+65	2,770	3,610	2,169	8				
	TOTAL	22,680	24,950	3,799	13	0.65	20	41	-21
JASPER COUNTY TOTAL							20	41	-21
REG MED CTR ORANGEBURG-CALHOUN	<18	23,760	23,840	2,079	6				
	18-64	58,790	59,200	24,788	68				
	+65	13,800	17,000	25,016	84				
	TOTAL	96,350	100,040	51,883	159	0.70	227	247	-20
ORANGEBURG/CALHOUN COUNTY TOTAL							227	247	-20

- 1 ST. FRANCIS MILLINIUM HOSPITAL CON APPROVED 6/12/09. CON VOIDED 8/1/11.
- 2 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 9/9/05.
- 3 BED NEEDS COMBINED; NEW HOSPITAL CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED, CON ISSUED 6/8/10.
- 4 CON APPROVED 9/9/11; APPEALED.
- 5 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED; CON 9/4/07
- 6 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL; APPEALED.
- 7 CON APPROVED 9/21/11 TO ADD 30 BEDS FOR A TOTAL OF 124.
- 8 BED NEEDS COMBINED; MT PLEASANT WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 5/31/06. BERKELEY WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.
- 9 CON ISSUED 1/11/11 TO CONVERT 10 REHAB BEDS TO ACUTE CARE BEDS.

LTACH FACILITIES**AS OF 9/23/11**

<u>FACILITY</u>		<u>COUNTY</u>	<u>BEDS</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
NORTH GREENVILLE LONG TERM ACUTE		GREENVILLE	45	48.6	58.0	62.3
REGENCY HOSPITAL OF GREENVILLE		GREENVILLE	32	78.6	74.2	71.6
SPARTANBURG HOSP RESTORATIVE CARE		SPARTANBURG	97	36.1	33.2	34.6
INTERMEDICAL HOSPITAL OF SC		RICHLAND	35	75.5	66.0	67.9
REGENCY HOSPITAL OF SOUTH CAROLINA		FLORENCE	40	86.4	73.7	77.0
PACE HEALTHCARE COMMONS	1	BEAUFORT	32	---	---	---
KINDRED HOSPITAL CHARLESTON	2	CHARLESTON	59	50.8	50.4	46.0
		TOTAL	340			

1 CON ISSUED 9/22/11, SC-11-36

2 CON ISSUED FOR REPLACEMENT HOSPITAL 6/3/11, SC-11-18

LONG TERM CARE BED NEED

AS OF 9/23/11

	2013 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
ANDERSON	27.76	1,083	811	272	272
CHEROKEE	7.65	298	243	55	55
GREENVILLE	54.18	2,113	1,937	176	176
OCONEE	16.13	629	252	377	377
PICKENS	16.33	637	437	200	200
SPARTANBURG	38.67	1,508	1,279	229	229
UNION	5.25	205	201	4	4
REGION I TOTAL	165.97	6,473	5,160	1,313	1,313
ABBEVILLE	4.40	172	116	56	56
CHESTER	5.09	199	100	99	99
EDGEFIELD	3.73	145	120	25	25
FAIRFIELD	3.76	147	262	-115	
GREENWOOD	10.31	402	354	48	48
KERSHAW	8.68	339	244	95	95
LANCASTER	8.64	337	288	49	49
LAURENS	11.80	460	420	40	40
LEXINGTON	33.23	1,296	924	372	372
MCCORMICK	3.66	143	120	23	23
NEWBERRY	6.30	246	276	-30	
RICHLAND	39.09	1,525	1,352	173	173
SALUDA	3.52	137	176	-39	
YORK	23.36	911	693	218	218
REGION II TOTAL	165.57	6,459	5,445	1,014	1,198
CHESTERFIELD	6.16	240	224	16	16
CLARENDON	7.12	278	152	126	126
DARLINGTON	9.91	386	366	20	20
DILLON	3.84	150	195	-45	
FLORENCE	18.85	735	775	-40	
GEORGETOWN	14.18	553	249	304	304
HORRY	49.07	1,914	1,014	900	900
LEE	3.19	124	120	4	4
MARION	4.92	192	180	12	12
MARLBORO	3.52	137	110	27	27
SUMTER	15.97	623	456	167	167
WILLIAMSBURG	5.88	229	184	45	45
REGION III TOTAL	142.61	5,561	4,025	1,536	1,621
AIKEN	25.45	993	778	215	215
ALLENDALE	1.94	76	44	32	32
BAMBERG	2.51	98	88	10	10
BARNWELL	3.87	151	173	-22	
BEAUFORT	36.56	1,426	611	815	815
BERKELEY	23.57	919	355	564	564
CALHOUN	2.78	108	120	-12	
CHARLESTON	48.94	1,909	1,279	630	630
COLLETON	6.30	246	132	114	114
DORCHESTER	17.21	671	351	320	320
HAMPTON	3.35	131	104	27	27
JASPER	3.24	126	88	38	38
ORANGEBURG	15.46	603	393	210	210
REGION IV TOTAL	191.18	7,457	4,516	2,941	2,975
STATEWIDE TOTALS	665.33	25,950	19,146	6,804	7,107

AS OF 9/23/11

REHABILITATION BED NEED

SERVICE AREA	2009 POP	2016 POP	EXIST BEDS	2009 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON, OCONEE	253,230	271,040	55	13,010	38.15	0.70	55	0	31	-24	0
GREENVILLE, PICKENS	541,950	586,360	72	17,623	52.24	0.70	75	3	66	-6	3
CHEROKEE, SPARTANBURG UNION	364,780	387,190	18	4,260	12.39	0.70	18	0	44	26	26
CHESTER, LANCASTER YORK	288,250	313,010	50	12,636	37.59	0.70	54	4	35	-15	4
ABBEVILLE, EDGEFIELD GREENWOOD, LAURENS MCCORMICK, SALUDA	232,640	248,040	42	10,149	29.65	0.70	42	0	28	-14	0
FAIRFIELD, LEXINGTON NEWBERRY, RICHLAND	654,730	704,230	96	21,721	64.01	0.70	91	-5	80	-16	-5
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO, WILLIAMSBURG	377,770	387,080	130	32,384	90.91	0.70	130	0	44	-86	0
CLARENDON, KERSHAW LEE, SUMTER	228,780	242,010	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN, HORRY	295,540	332,720	43	12,839	39.60	0.70	57	14	38	-5	14
AIKEN, ALLENDALE, BAMBERG BARNWELL, CALHOUN ORANGEBURG	327,460	347,330	24	6,174	17.94	0.70	26	2	39	15	15
BEAUFORT, HAMPTON, JASPER	188,940	211,530	14	3,739	11.47	0.70	16	2	24	10	10
BERKELEY, CHARLESTON COLLETON, DORCHESTER	647,160	688,990	101	24,316	70.93	0.70	101	0	78	-23	0
STATE TOTAL	4,401,230	4,719,530	645	158,851	464.9		665	20	534	-111	94

0.1132

EXHIBIT B-4

LONG TERM CARE BED NEED

AS OF 5/9/13

	2015 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
=====					
ANDERSON	31.90	1,244	1,021	223	223
CHEROKEE	8.30	324	243	81	81
GREENVILLE	65.70	2,562	1,937	625	625
OCONEE	16.70	651	252	399	399
PICKENS	18.50	722	453	269	269
SPARTANBURG	43.90	1,712	1,323	389	389
UNION	5.20	203	201	2	2
=====					
REGION I TOTAL	190.20	7,418	5,430	1,988	1,988
=====					
ABBEVILLE	4.60	179	116	63	63
CHESTER	5.30	207	100	107	107
EDGEFIELD	4.50	176	120	56	56
FAIRFIELD	4.40	172	262	-90	
GREENWOOD	11.70	456	354	102	102
KERSHAW	10.20	398	244	154	154
LANCASTER	13.40	523	288	235	235
LAURENS	11.60	452	420	32	32
LEXINGTON	39.00	1,521	1,016	505	505
MCCORMICK	3.30	129	120	9	9
NEWBERRY	6.90	269	264	5	5
RICHLAND	45.10	1,759	1,392	367	367
SALUDA	3.60	140	176	-36	
YORK	30.60	1,193	753	440	440
=====					
REGION II TOTAL	194.20	7,574	5,625	1,949	2,075
=====					
CHESTERFIELD	7.30	285	224	61	61
CLARENDON	7.30	285	152	133	133
DARLINGTON	11.40	445	366	79	79
DILLON	4.70	183	195	-12	
FLORENCE	21.40	835	775	60	60
GEORGETOWN	14.90	581	249	332	332
HORRY	56.80	2,215	973	1,242	1,242
LEE	2.90	113	120	-7	
MARION	5.40	211	180	31	31
MARLBORO	4.10	160	110	50	50
SUMTER	16.00	624	456	168	168
WILLIAMSBURG	6.60	257	184	73	73
=====					
REGION III TOTAL	158.80	6,194	3,984	2,210	2,229
=====					
AIKEN	28.80	1,123	858	265	265
ALLENDALE	1.60	62	44	18	18
BAMBERG	2.90	113	88	25	25
BARNWELL	3.80	148	173	-25	
BEAUFORT	42.60	1,661	611	1,050	1,050
BERKELEY	23.60	920	355	565	565
CALHOUN	3.00	117	120	-3	
CHARLESTON	53.00	2,067	1,359	708	708
COLLETON	7.10	277	132	145	145
DORCHESTER	18.20	710	351	359	359
HAMPTON	3.40	133	104	29	29
JASPER	3.40	133	88	45	45
ORANGEBURG	16.00	624	383	241	241
=====					
REGION IV TOTAL	207.40	8,088	4,666	3,422	3,450
=====					
STATEWIDE TOTALS	750.60	29,274	19,705	9,569	9,742

EXHIBIT C

CERTIFICATE OF NEED STANDARDS

1. *A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.*
2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.
3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.
4. 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. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);
3. Community Need Documentation;
4. Acceptability;
5. Financial feasibility; and
6. Staff Resources.

HOME HEALTH

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.

CERTIFICATE OF NEED 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. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:
 - a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.
 - c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.
 - d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.
4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
6. Specialty home health providers are exempt from the need calculation applicable to full-service home health agencies, but are otherwise subject to Certificate of Need.
7. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, consent order, abandonment of patients in other business operations, or loss of license. However, any consent orders or loss of licenses related to licenses that were obtained from the Department between July

1, 2013 and May 22, 2014 without a Certificate of Need shall not be grounds for denial of a Certificate of Need application pursuant to this Section. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should it fail to reach this threshold number two years after initiation of services in a county, it will voluntarily relinquish its license for that county.
9. Nothing in this Section is intended to restrict the ability of the Department to approve more than one new Home Health Agency in a county at any given time.

The Home Health Agency Utilization Chart is located in Chapter XIII of this Plan.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Acceptability;
3. Distribution (Accessibility);
4. Medically Underserved Groups;
5. Record of the Applicant; and
6. Financial Feasibility.

The benefits of improved accessibility outweigh the adverse effects caused by the duplication of any existing service.

Pediatric Home Health Agencies

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a Certificate of Need for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

CERTIFICATE OF NEED STANDARDS

1. A separate Certificate of Need application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.
2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.
3. The applicant must document the full range of services that they intend to provide to pediatric patients.

Continuing Care Retirement Community Home Health Agencies

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and *does not require Certificate of Need review 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 the applicable home health agency licensing standards; and
- 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 non-facility-based Medicare and/or Medicaid standards.

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

) COURT OF COMMON PLEAS
) C.A. No.: ~~2015~~-CP-40-00818

2016

AMEDISYS SC, L.L.C., AND SOUTH
CAROLINA HOME CARE & HOSPICE
ASSOCIATION,

PLAINTIFFS,

v.

SOUTH CAROLINA DEPARTMENT OF HEALTH
AND ENVIRONMENTAL CONTROL,

DEFENDANT.

) NOTICE OF MOTION AND MOTION
) FOR
) TEMPORARY RESTRAINING ORDER
) AND
) PRELIMINARY INJUNCTION
) INCLUDING
) MEMORANDUM OF LAW

TO DEFENDANT SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL
CONTROL AND ITS LEGAL COUNSEL

Plaintiffs Amedisys, Inc. (“Amedisys”) and South Carolina Home Care and Hospice Association (“SCHCA”) respectfully move, pursuant to Rule 65(b), SCRPC, for a temporary restraining order and a preliminary injunction. The requested order would restrain defendant South Carolina Department of Health and Environmental Control (“DHEC”) during the pendency of this action from accepting, reviewing, or issuing staff decisions regarding applications for certificates of need (“CONs”) to provide home health services pursuant to the State Health Plan for 2014-2015 (the “Current Plan”), adopted by the governing body of SCDHEC (the “Board”) on August 13, 2015.

The requested emergency interim relief is necessary to preserve the *status quo* for the pendency of this action because the Current Plan fails to adopt any objective criteria to determine need for new health services in South Carolina’s 46 counties. The portion of the Current Plan that relates to home health services therefore fails to meet the requirements and purposes of the “State Certification of Need and Health Facility

Licensure Act (the “**CON Act**” – S.C. Code §§ 44-7-110 *et seq.*) and the “Licensure of Home Health Agencies Act” (the “**HHA Act**” – S.C. Code § 44-69-10 *et seq.*).

As a result of that failure to adopt legislatively-required criteria, DHEC has recently received an unprecedented number of applications for new home health CONs under the Current Plan (87 in the past 5 months, compared to fewer than 25 in the 5 years from 2009 through 2014) and, unless enjoined, may begin issuing staff decisions on those applications as early as February 22, 2016.¹ Once approved and issued, such CONs would cause a permanent and costly disruption in the provision of home health services in South Carolina without the oversight and review required by the South Carolina General Assembly and contrary to the stated purposes of the CON Act and the HHA Act. Moreover, the implementation of the defective Current Plan would short-circuit a basic policy determination now actively under consideration by the General Assembly. This Court should postpone all such action until it is able to consider and rule on the merits of that portion of the Current Plan that relates to home health services.

This action and this motion do not affect the certificate of need program for any health care services or facilities other than home health care.

Plaintiffs request that the Court hear this motion at 4:00 p.m., February 9, 2016, or as soon thereafter as possible, at the Richland County Courthouse, 1701 Main Street, Columbia, South Carolina, or at such other place as the Court may direct.

¹ Of the 87 applications, 76 are for CONs to authorize services for which the applicants received licenses without a CON during the period from July 1, 2013 until April 14, 2014, when the CON program was suspended due to the veto of its funding in South Carolina’s FY 2013-14 budget. The remaining 11 applications are for previously unlicensed new services.

The facts as set forth in the Complaint in this matter, incorporated into this Motion by reference, as verified by affidavits that may be submitted herewith, satisfy the standards for granting the requested interim equitable protection for the reasons stated below.

This Motion is based on the following.

BACKGROUND FACTS

Nature of the Action

This action seeks (a) an injunction against a specific action by an agency of the State of South Carolina until that agency has performed the statutory pre-requisite for any such action, and (b) a declaration that the agency has not yet performed the statutory pre-requisite.

The Parties

Amedisys is a South Carolina limited liability company that provides home health care services in twenty-five South Carolina counties. SCHCHA is a South Carolina non-profit corporation that represents over 250 home health, hospice, and home care agencies in South Carolina and provides education, technical assistance and advocacy on behalf of its members and their patients.

DHEC is an agency of the State of South Carolina, created and governed by the General Assembly in S.C. Code §§ 44-1-20 *et seq.*, and in particular as it relates to this action in the CON Act and the HHA Act. DHEC's governing body is the South Carolina Board of Health and Environmental Control (the "**Board**").

The Regulatory Context

In order “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,” the General Assembly requires that certain health care providers, prior to undertaking certain health care activities, must first obtain a certificate of need. CON Act, S.C. Code §§ 44-7-120(1). The General Assembly has designated DHEC as “the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under this article.” CON Act, S.C. Code § 44-7-140.

The General Assembly requires that not less often than every two years, a health planning committee recommend to the Board and the Board approve and adopt a State Health Plan (the “**Plan**”). The health planning committee (the “**Planning Committee**”) is established and comprised of appointed members pursuant to CON Act, S.C. Code Ann. § 44-7-180(A). The General Assembly also requires that the Board adopt “procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need.” CON Act, S.C. Code §§ 44-7-120(2) and (3) and 44-7-180(C); and S.C. Reg. 61-106(3).

“The Plan at a minimum must include:

- (1) an inventory of existing health care facilities, beds, specified health services, and equipment;
- (2) projections of need for additional health care facilities, beds, health services, and equipment;
- (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided,

utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and

(4) a general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding 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.

The South Carolina Health Plan must address and include projections and standards for specified health services and equipment which have a potential to substantially impact health care cost and accessibility. Nothing in this provision shall be construed as requiring the department to approve any project which is inconsistent with the South Carolina Health Plan.”

CON Act, S.C. Code § 44-7-180(B); S.C. Reg. 61-106(1) and (2); emphasis added.

The South Carolina General Assembly has forbidden DHEC to “issue a Certificate of Need unless an application complies with the South Carolina Health Plan” and certain other requirements. CON Act, S.C. Code § 44-7-210(B). In addition, if multiple certificate of need applicants file applications to provide similar health care facilities or services in the same service area, DHEC is prohibited from approving more than one application if doing so would “exceed the need” for such facilities and services. CON Act, S.C. Code § 44-7-130(5); § 44-7-210(B).

Among the health care services requiring a certificate of need are those described as “home health services” by the HHA Act. See, in particular, S.C. Code § 44-69-75(A): “A home health agency shall obtain a certificate of need before licensure. Procedures for applying for a certificate must be in accordance with the [CON Act]. . . .” The HHA Act defines “home health services” to include certain statutorily-listed health care items and services furnished on a visiting basis in a patient’s residence (or as an outpatient at a facility where certain equipment cannot be readily brought to the patient’s home). S.C.

Code § 44-69-20(5). Entities providing home health services are defined as “home health agencies.” HHA Act, S.C. Code § 44-69-20(4).

Any applicant for a certificate of need to provide home health services in any county must:

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

S.C. Reg. 61-202(b)(11).

The Board adopted a Plan for 2012-2013 (the “**Prior Plan**”) on November 9, 2012. The Prior Plan replaced the Plan for 2010-2011 (the “**2010 Plan**”) that it had previously adopted on November 12, 2010. The Board adopted a Plan for 2014-2015 (the “**Current Plan**”) on August 13, 2015. The Current Plan replaced the Prior Plan.

With respect to home health services, the Prior Plan, like earlier plans, had established a detailed methodology for determining need based on population, projected population growth, and utilization rates broken down by age-demographic. The need calculation methodology of the Prior Plan related to home health services is described in Paragraph 4 of “Certificate of Need Standards,” at page XII-13, as follows:

“4. The need methodology creates statewide use rates for four population groups (0-17, 18-64, 65-74, 75+) based on 2011 utilization data; 75% of these rates are applied against the projected 2013 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2011 and multiplies them by the population growth factor to project the number of patients to be served

by the existing home health agencies in the county for 2013. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county.”

Beginning with the 2010 Plan, DHEC established a mechanism for keeping population and services-inventory information, both critical components of need determination, up-to-date throughout the life of a Plan, and followed through on that mechanism, with updates to the 2010 Plan in March 2011, June 2011 and September 2011 and an update to the Prior Plan in May 2013.

As a result of a sustained veto of funding for the certificate of need program (for all services, including home health services) in South Carolina’s state budget for FY 2014, the CON program was not operated from July 1, 2013, until April 14, 2014, when the South Carolina Supreme Court rendered its decision that the failure to fund did not terminate the program. *Amisub of South Carolina, Inc. v. S.C. Dept. of Health and Environmental Control*, 403 S.C. 576, 743 S.E.2d 786 (2014). During the hiatus, a number of entities that sought to provide new home health services obtained from DHEC the required license, but without the usually required preliminary step of obtaining a CON (the “Hiatus Licensees”). Some of those Hiatus Licensees began providing the licensed services; others did not.

Upon expiration of the Hiatus Licenses and applications by the Hiatus Licensees to renew after the re-instatement of the CON program, DHEC refused renewal on the basis that the Hiatus Licensees did not have the CON, which is a statutory pre-requisite for a license. In mid-2014 to early-2015, some of the Hiatus Licensees appealed to the

Administrative Law Court from DHEC's refusal, those appeals having now been continued several times.

As an alternative route to maintain their licenses without complying with the HHA Act's requirement for a CON, some of the Hiatus Licensees, as well as other types of providers who proceeded with projects during the program hiatus, attempted to include a "grandfather" provision in legislation (H. 3250) currently pending with the General Assembly. The bill was introduced in 2015 and has been taken up again in the 2016 session. The "grandfather" clause remains in the bill at this time. That clause essentially grants the DHEC Board, not staff, the broad discretion to grant a CON to any entity that initiated a CON project during the hiatus "if the project merits a Certificate of Need."

Because H. 3250 had not yet passed, some of the Hiatus Licensees sought to short-circuit both the General Assembly and the Administrative Law Court, by proposing the belated adoption of an emasculated Plan for 2014-2015. A consortium of Hiatus Licensees proposed a drastic reduction in the thresholds of requisite need for home health services. DHEC staff, through the director of DHEC's CON program, strongly supported a counter proposal that showed a significantly liberalized need in approximately 29 counties (as opposed to only one county in the Prior Plan), and recommended that proposal to the Planning Committee in April 2015. Drawing on its experience and subject matter expertise, the draft developed by DHEC's staff reflected updated population and utilization projections and determinations of need for home health services. DHEC staff also proposed to modify the need standards by using population projections for South Carolina residents over age 64, the largest group of home health patients in the state, instead of the general population.

The Planning Committee, however – whose vice-chair is an employee of National Healthcare Corporation (“NHC”), a forceful opponent of the staff recommendation, and an equally forceful proponent of the looser, non-compliant standards – completely rejected the DHEC staff recommendation with regard to home health services. (NHC and its affiliates and subsidiaries is one of the Hiatus Licensees and has filed 30 of the pending 87 CON applications to provide services in 30 counties.) On August 3, 2015, the Planning Committee adopted the proposal that became the Current Plan, which eliminated any projection of need of home health services based on population projections, and thus eliminated any objective basis on which DHEC could consider whether a home health services CON application served any need in the relevant county.

On August 13, 2015, just ten days later, the Planning Committee presented its draft Plan to the DHEC Board for consideration; and the Board adopted the entire draft Plan that same day.

The Current Plan has abandoned the established criteria related to population, growth, inventory of current services, and demographic need. The need component of the Current Plan related to home health services is described in Paragraphs 3 and 4 of “Certificate of Need Standards,” at page XII-7, as follows:

3. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:
 - a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.

c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.

d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.

4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.

Following the adoption of the Current Plan, at least 87 CON applications have been submitted to establish new home health services in 40 counties. Of those 87 CON applications filed to date, 48 applications are to provide new home health services in counties in which Amedisys currently holds a license to provide and provides home health services and 87 applications are to provide new home health services in counties in which one or more other members of SCHCHA currently hold a license to provide and provide home health services. Of the 40 counties with submitted applications, 20 are counties in which Amedisys currently holds a license to provide and provides home health services and 40 are counties in which one or more other members of SCHCHA hold a license to provide and provide home health services.

Once an application is submitted and after DHEC deems it complete and notifies affected persons through publication in the *South Carolina State Register*, DHEC must either grant or deny the requested certificate of need within a maximum of 150 days. CON Act, S.C. Code § 44-7-210(A). DHEC has deemed 42 out of the 87 submitted applications to be complete and has published a notice to affected persons in the January 22, 2016 issue of the *South Carolina State Register*. With respect to the 42 applications deemed complete and published in the January 22, 2016 *South Carolina State Register*,

DHEC may begin issuing staff decisions on these applications after thirty (30) calendar days, *i.e.*, beginning on February 22, 2016. CON Act, S.C. Code § 44-7-210(A).

IMPACT ANALYSIS

DHEC cannot objectively determine need under the Current Plan.

The Current Plan is deficient in that it does not meet the statutory minimum standards for home health services determinations of need. Instead, it adopts a 25-patient (rural)/50-patient (non-rural) county target, with no guidelines for how that 25-patient or 50-patient “need” is to be calculated, demonstrated, or tested.

The requirement that the Plan project need for additional services serves several purposes. First, it helps to direct service expansion to areas – and thus patients – most in need of the services, by alerting existing and prospective home health providers as to where DHEC believes a need exists. Second, it provides DHEC thresholds and baselines from which to measure whether a CON applicant has met the basic need requirement. Third, it provides DHEC with an objective measurement by which to determine whether CON applicants are “competing” within the meaning of the CON Act and the Department’s implementing regulations set forth at 24A S.C. Code Ann. Regs. 61-15 (the “*CON Regulations*”).

The home health need “standards” of the Current Plan are inconsistent with and undermine DHEC’s statutory obligation to administer the CON Program as required by the HHA Act and the CON Act.² The Current Plan, as recommended by the Planning

² Home health, as a separately licensed health service required to submit joint annual reports and comply with licensing regulations, is distinguishable from the MRI equipment at issue in *MRI at Belfair, LLC v. S.C. Dept. of Health and Environmental Control*, 379 S.C.1, 664 S.E.2d 471 (2008). In that case, the Court rejected the argument that the Health Plan standards violated the CON Act because it failed to adequately

Committee and adopted by the DHEC Board, arbitrarily rejected the use of population projections to determine whether additional home health services are needed, thus eliminating any meaningful threshold for the Department to apply to determine need.³ Without such a benchmark, DHEC will be forced to rely on need analyses prepared by one or more applicants that are skewed towards those particular applicants, not the needs of the service area as a whole. Even worse, DHEC likely will be forced to choose between need analyses prepared by multiple applicants, creating an additional issue for subsequent litigation. The bottom line is that under the Current Plan “standards,” DHEC has no independent, rational basis on which to make determinations as to whether: (1) a CON application complies with the need outlined in the statutorily-mandated standards, (2) the proposed project will result in an unnecessary duplication of services, and (3) multiple CON applicants seeking to establish home health services in the same county are “competing applicants” within the meaning of the CON Act and CON Regulations.

DHEC cannot objectively identify competing applicants under the Current Plan.

The Current Plan is additionally deficient in that it undermines the statutory definition of “competing applicant” by vitiating any ability to determine whether approval of more than one application would “exceed the need” in that area – that is,

establish need for additional MRI equipment. However, those standards included an objective minimum number of MRI’s that the Department believed was necessary to meet public need, *i.e.*, at least one MRI in every hospital. By contrast, the Committee’s proposal provides no objective quantification of what additional home health services are needed and what applicants must show to meet that need.

³ The use of population projections is a typical methodology with respect to home health. Most states in this region – including Georgia, North Carolina, Tennessee, Kentucky, Arkansas and Mississippi – have determined that projecting need for home health services requires use of objective population projections.

whether multiple applicants for home health services in a service area are “competing applicants.” CON Act, S.C. Code Ann. §44-7-130(5).

With respect to competing applicants, the CON Act and CON Regulations define this term as:

two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service. An application shall be considered competing if it is received by the Department no later than fifteen (15) calendar days after a Notice of Affected Persons is published in the State Register for one or more applications for similar services and/or facilities in the same service area. All applications received by the Department within fifteen (15) calendar days of publication of the Notice of Affected Persons in the State Register for the first application(s) will be considered to be competing. Any applications received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s).

S.C. Code Ann. §44-7-130(5); R. 61-15 §103(6) (emphasis added).

Without establishing, at the outset, any meaningful objective measurement of need, DHEC has no ability to rationally determine whether multiple CON applications, if granted, would exceed the need for home health services in a particular county.⁴ Put another way, the Current Plan renders the term “competing applicants” meaningless. Thus, there effectively will be no justifiable limit on the number of applicants who, if they satisfy the other criteria, will be entitled to a CON.⁵ DHEC consequently cannot discharge its statutory duty of preventing the unnecessary duplication of services, let

⁴ *Tri-County Home Health* at *29 (COL #176) (“the State Health Plan Standards are threshold requirements”).

⁵ *Cf.* R. 61-15 §307(1) (prohibiting the Department from issuing a CON unless the application is in compliance with the Health Plan, project review criteria and other Department regulations, and requiring the Department to identify any regulation used as a basis for denying an application that complies with the Health Plan).

alone its duties of promoting cost containment, guiding the establishment of services to best meet public need, and ensuring a high quality of health services in the State.⁶

Other parties with a statutory right to participate cannot do so meaningfully under the Current Plan.

The Current Plan is yet further deficient in that it deprives Amedisys and other SCHCHA members of any meaningful opportunity to challenge CON applications for additional home health services in counties where Amedisys and such other existing providers currently operate, because the Current Plan fails to establish the statutory minimum need standards that must be applied to challenge an applicant's claim that an unmet need exists. Those other parties that have a statutory right to participate in the DHEC review process are unable to make meaningful input when the decisional criteria themselves are devoid of meaning.

The Current Plan will necessitate protracted litigation that will harm those in need of services.

Importantly, as an additional consequence, the lack of objective criteria will only exacerbate already lengthy delays in enabling new home health services caused by protracted CON litigation.

Impact Summary

Thus, under the Current Plan, DHEC is without the tools that the CON Act and the HHA Act require it to utilize in its consideration of any new and pending applications

⁶ *Tri-County Home Health* at *25 (COL #155) (“[T]o determine whether an application is contrary to the purposes of the CON Act, the Court must consider: 1) whether the proposal results in duplicative health care . . . services, and 2) whether the duplication is unnecessary or should be allowed to promote cost containment and establish high quality health facilities and services.”).

and other involved parties are without the tools necessary to give their statutory rights substance.

If DHEC issues a CON in a county in which Amedisys (or other SCHCHA member) is already providing such services and in which a statutorily-compliant methodology would show that there is no unmet need, the investment by Amedisys (or such other SCHCHA member) would be impaired, those harmed investors would have no standard by which to defend their rights, and the legislative purposes of the CON Act would be thwarted, all to the endangerment of the care of home health patients in that county.

It is, therefore, a violation of both the CON Act and the HHA Act, and directly contrary to the stated purposes of the CON Act, for DHEC to proceed with the consideration of applications for certificates of need for home health services unless and until the Board adopts a State Health Plan with respect to such services that meets the minimum standards required by the South Carolina General Assembly.

LEGAL STANDARD AND APPLICATION TO FACTS

“Actions seeking relief by injunction are equitable in nature.” *City of Myrtle Beach v. Juel P. Corp.*, 344 S.C. 43, 522 S.E.2d 153 (Ct. App. 1999), *rev'd on other grounds*, 543 S.E.2d 538 (2001). Whether a temporary injunction should be granted rests in the sound discretion of the judge to whom the application is addressed. *Seabrook v. Carolina Power & Light Co.*, 159 S.C. 1, 156 S.E.1 (1930); *Brandt v. Gooding*, 630 S.E.2d 259 (S.C. 2006). Temporary and preliminary injunctive relief in this matter is warranted under Rule 65, SCRPC.

To obtain a temporary restraining order and a preliminary injunction, the moving

party must demonstrate that (1) it would suffer irreparable harm if the injunction is not granted; (2) it will likely succeed on the merits of the litigation; and (3) there is no adequate remedy at law. *Compton v. S.C. Dep't of Corr.*, 392 S.C. 361, 366, 709 S.E.2d 639, 642 (2011). There is no additional requirement that the trial judge must “balance the equities” before issuing an injunction. *Poynter Investments, Inc. v. Century Builders of Piedmont, Inc.*, 387 S.C. 583, 694 S.E.2d 15, 17 (2010).

In this case, (1) the plaintiffs, the General Assembly’s regulatory system, and those current and prospective consumers of home health services will suffer irreparable harm if an injunction is not granted; (2) the plaintiffs will likely succeed on the merits of the litigation, and (3) there is no adequate remedy at law. A temporary restraining order and preliminary injunction are needed to preserve this Court’s ability to render complete relief and to protect the legal rights of the plaintiffs, the integrity of the regulatory system established by the General Assembly, and the quality and availability of health care services for the South Carolina patients who are the intended beneficiaries of that system.

Irreparable Harm. “Irreparable injury means that the injunction is reasonably necessary to protect the rights of the plaintiff pending the litigation.” James F. Flanagan, *South Carolina Civil Procedure* 508 (2nd ed., 1996); *Multi-Channel TV Cable Co. v. Charlottesville Quality Cable Operating Co.*, 22 F.3d 546, 551 (4th Cir. 1994) (“Generally, ‘irreparable injury is suffered when monetary damages are difficult to ascertain or are inadequate.’” (citation omitted)). The element of irreparable harm is satisfied when it is difficult to calculate the amount of damages, such that an equitable remedy is necessary to make the aggrieved party whole. *Bethel Methodist Episcopal Church v. City of Greenville*, 211 S.C. 442, 45 S.E.2d 841 (1947) (“Irreparable injury, as

used in the law of injunction, does not necessarily mean that the injury is beyond the possibility of compensation in damages.”).

Although there is not a South Carolina case directly on point, the approach of our judiciary in two contexts is compelling.

First, one of the longest standing rules regarding injunctive relief in South Carolina is that an injunction is the appropriate remedy to abate an alleged waste of property or assets while ownership of the same property or assets is being litigated. *Kinsler v. Clarke*, 1837 WL 1551 (S.C.Ct.App. 1837); *Grosshuesch v. Cramer*, 367 S.C. 1, 623 S.E.2d 833 (2005); *County Council of Charleston v. Felkel*, 244 S.C. 480, 137 S.E.2d 577, 578 (1964). Here, the “asset” would be the right to serve in a particular county. Amedisys or some other member of SCHCHA has that valuable right in which it has invested substantially. Unless this Court issues its injunction, the Current Plan, contrary to the statutory directives of the General Assembly, would allow that right to be usurped and those investments to be impaired.

Second, an imminent violation of a reasonable restriction on competition is a proper basis for a finding of irreparable harm to support a preliminary injunction. See *Standard Lighting Distributors, Inc. v. Sweatman*, 2006 WL 4911571 (S.C.Com.Pl., October 9, 2006) (Trial Order, 2006-CP-32-2056). Here, the restriction (no standards of need, no CON; no CON, no license; no license, no market entry) is by definition legally reasonable, as it was established by the General Assembly.⁷

⁷ The present case does not present the situation of *John Doe v. State of South Carolina*, 2003 WL 25459546 (S.C.Com.Pl., May 12, 2003) (Trial Order, 2003-CP-10-1489), in which the Court stated that it was “mindful that ‘one may not generally enjoin a state agency from the performance of duties imposed by valid statutes.’ *Frady v. Student Loan Servicing Center*, 313 S.C. 561, 443 S.E.2d 580, 582 (Ct. App. 1994) (quoting 43A C.J.S. *Injunctions* § 116, at 192 (1978)).” That case involved the straightforward

Likelihood of Success on the Merits. Petitioner is “not required to prove an absolute legal right when seeking a preliminary injunction, but [she] must present a reasonable question as to the existence of such a right.” *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505, 509 (Ct. App. 2009); see also *Williams v. Jones & Amerman*, 92 S.C. 342, 75 S.E. 705 (1912) (“This does not mean an absolute legal right or certainty of success but rather that he has a fair question to raise as to the existence of such a right.”). Courts have broadly construed this element and a litigant is required to do little more than state a cause of action or make a prima facie showing. *County of Richland v. Simpkins*, 348 S.C. 664, 560 S.E.2d 902 (Ct. App. 2002); *Childs v. Columbia*, 87 S.C. 566, 70 S.E. 296 (1911).

“The determination of whether to grant an injunction should not be based on the merits of the underlying case except insofar as the merits may assist the trial court in determining whether a prima facie showing has been made.” *Peek v. Spartanburg Reg’l Healthcare Sys.*, 367 S.C. 450, 456, 626 S.E.2d 34, 37 (Ct. App. 2005). “Once a prima facie showing has been made entitling the plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits.” *Helsel v. City of N. Myrtle Beach*, 307 S.C. 29, 413 S.E.2d 824, 826 (1992).

The plaintiffs will likely succeed on the merits of this litigation. The relevant facts are all matters of public record. The dictates of the South Carolina General Assembly are set out in the South Carolina Code of Laws. The deficiencies of the Current Plan are patent. Allowing DHEC to proceed to consider and act upon applications for home health CONs under the Current Plan would inevitably disrupt the careful regulatory regime application of a valid law. The present issue, on the other hand, involves an agency application that is manifestly contrary to a valid law.

established by the General Assembly, in the face of ongoing General Assembly consideration of whether and how it wants to maintain or modify that system.

Adequacy of Remedy at Law. “[W]hether there is an adequate remedy at law for a wrong, [is a] question [] that [is] not decided by narrow and artificial rules.” *Kirk v. Clark*, 191 S.C. 205, 4 S.E.2d 13, 15 (1939). “The adequacy of a legal remedy is a pragmatic determination based upon the certainty of fixing damages, the practicality of obtaining relief, and the efficiency of the legal remedy in the particular circumstances.” Flanagan, *South Carolina Civil Procedure* at 508. “[I]f the available legal remedy in a given case reduces itself to a matter of words, rather than to a matter of efficacy, because of its impracticability, or because the threatened acts may continue during the progress of an action at law, or because successive actions at law would be necessary to protect the plaintiff’s rights, equity will hold that the existence of a legal remedy is not an obstacle to the exertion of the equitable power.” *Columbia Broadcasting Sys., Inc. v. Custom Recording Co.*, 258 S.C. 465, 189 S.E.2d 305, 312 (1972).

The plaintiffs have no adequate remedy at law for the harm or damage that would be done by the effectuation of the home health provisions of the Current Plan. Once new services are introduced without warrant, removing them done would be almost impossibly complicated, as would calculating the damages incurred by the plaintiffs. Again, the approach of South Carolina’s courts to issues of asset wasting and non-compete covenants is instructive. Trying to unscramble the egg of standardless CONs would require a costly and lengthy invocation of the legal and equitable powers of this Court. Avoiding that kind of tedious and uncertain un-wind is the very reason for preliminary relief to maintain the status quo until the merits can be resolved, especially in

a case such as this one where the issue is a legal issue susceptible of quick resolution.

Requirement of Bond. According to Rule 65(c), SCRCF, a preliminary injunction shall not issue "except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained." DHEC has no property or interest at stake in this issue other than the interest in making sure that the programs established by the General Assembly are faithfully implemented. Consequently, it would suffer no damages by the minimal delay necessary to resolve the legal issues in this case. For this reason, Petitioner submits that no bond or a bond in a minimal amount of \$100 is appropriate.

PRAYER FOR RELIEF

For the foregoing reasons, the plaintiffs Amedisys and SCHCHA respectfully request:

1. That this Court issue its Temporary Restraining Order enjoining DHEC until such time as a hearing may be held for a Preliminary Injunction from accepting, considering, or acting upon any application for a certificate of need for home health services under the Current Plan;
2. That, after a hearing, this Court issue its Preliminary Injunction enjoining DHEC during the further pendency of this action from accepting, considering, or acting upon any application for a certificate of need for home health services under the Current Plan;
3. That this Court, in its Temporary Restraining Order or Preliminary Injunction, permit DHEC, in DHEC's discretion, to accept, consider, and/or act upon any application relating to home health services filed after August 13, 2015 only under the Prior Plan as

updated with population and services-inventory information for that Prior Plan promulgated after the date of said Order; and

4. For such further and other interim or emergency relief as shall seem proper to this Court.

February 9, 2016

Respectfully submitted,

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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Amedisys SC, LLC and South Carolina
Home Care & Hospice Association,

Plaintiffs,

v.

South Carolina Department of Health and
Environmental Control,

Defendant.

IN THE COURT OF COMMON PLEAS

Civil Action No.: 2016-CP-40-00818

**NOTICE OF MOTION AND MOTION TO
INTERVENE**

RICHLAND COUNTY
FILED
2016 FEB 16 AM 9:31
JEANETTE W. MORRIS
C.C.P. & G.S.

TO: THE ABOVE-NAMED PLAINTIFFS AND DEFENDANT

YOU WILL PLEASE TAKE NOTICE that In-Care Home Health, Inc. ("In-Care"), Tri-County Home Health Care & Services, Inc. ("Tri-County"), M&C Group, LLC d/b/a Home Helpers of Bluffton ("Home Helpers"), Tidewater Home Health, PA ("Tidewater") and Hedgemark Brentwood Medical Services, Inc. d/b/a PHC Home Health ("PHC") (collectively referred to hereinafter as "Movants"), by and through their undersigned counsel, will move before the Presiding Judge for Richland County on the 10th day following service hereof or as soon thereafter as Counsel can be heard, for an Order granting Movants leave to intervene in the above-captioned case pursuant to Rule 24 of the South Carolina Rules of Civil Procedure.

BACKGROUND

This action arises out of the South Carolina Department of Health and Environmental Control's ("DHEC" or "Department") operation of its Certificate of Need Program pursuant to S.C. Code Ann. §§ 44-7-110 *et. seq.* (the "State Certification of Need and Health Facility Licensure Act (the "CON Act)"). The purpose of the CON Act is to promote cost containment, to prevent the unnecessary duplication of health care facilities and services, to guide the establishment

of health facilities and services which will best serve public needs, and to ensure that high quality services are provided in health facilities in South Carolina. *See* S.C. Code Ann. § 44-7-120. The CON Act requires that certain health care providers, prior to undertaking certain health care activities, first obtain a certificate of need. The CON Act further requires the Department to establish procedures and criteria for the submission of an application and appropriate review prior to the issuance of a certificate of need. *Id.*

The CON Act requires the issuance of a State Health Plan ("SHP") to be utilized by the Department in its administration of the CON Program. The CON Act sets forth a detailed process for the periodic review and issuance of the SHP. The State Health Planning Committee (the "SHP Committee"), whose members are primarily appointed by the Governor, reviews and revises the SHP as it sees fit at least every two years. S.C. Code Ann. § 44-7-180. The review process includes mandatory regional public meetings throughout the State. The SHP Committee must accept and consider written comments from interested parties. After undergoing a significantly deliberative process, the SHP Committee makes a recommendation for the new State Health Plan. The proposed SHP is then submitted to the DHEC Board for additional review, including additional meetings and deliberation, and approval. The current State Health Plan passed through the full statutory process described above, received unanimous approval from the DHEC Board, and became effective August 13, 2015.

The Movants are all home health agencies operating in South Carolina. In addition, shortly after the issuance of the current SHP, the Movants filed multiple CON applications. In-Care filed one CON application pursuant to the new SHP. Tri-County filed ten CON applications pursuant to the new SHP. Home Helpers filed two CON applications pursuant to the new SHP. Tidewater filed two CON applications pursuant to the new SHP. PHC also filed one CON

application pursuant to the new SHP. Each of these applications has been deemed complete by the Department. Furthermore, last week, In-Care filed eight additional CON applications and Tri-County filed fifteen additional CON applications. The application process required the Movants to incur considerable time and expense. Each application seeks to serve counties where there was an unmet need for home health services as proscribed by the SHP and the CON Act.

Upon information and belief, those applications that were declared complete are being prepared for a decision by the Department. Despite the prolonged and detailed review process which culminated in the approval of the current SHP over six months ago, Plaintiff's have filed a complaint challenging the SHP. The Plaintiffs in this action seek a declaratory judgment finding that Chapter XII of the SHP does not comply with the statutory requirements of the CON Act. In addition, Plaintiffs seek an injunction prohibiting DHEC from accepting additional CON applications relating to home health services and an injunction prohibiting DHEC from issuing decisions on any of the pending CON applications relating to home health services.

ARGUMENT

I. The Movants are entitled to Intervention as a Matter of Right Pursuant to Rule 24(a)(1) of the South Carolina Rules of Civil Procedure.

Rule 24(a)(1) provides that a party may intervene as of right when a statute confers an unconditional right to intervene. The Plaintiffs have brought this action pursuant to the Uniform Declaratory Judgments Act (the "Declaratory Judgment Act") in which they seek, among other relief, an Order: (1) declaring that a valid SHP, as it relates to home health services, must be adopted before DHEC can consider or issue a certificate of need for home health; (2) declaring that the current SHP does not comply with the CON Act or the applicable regulations promulgated by DHEC; and (3) enjoining DHEC from accepting, considering or issuing any home health certificates of need until a valid SHP is effected. As set forth above, the Movants

have filed multiple certificate of need applications which are currently being reviewed and/or pending a decision from DHEC.

The Declaratory Judgment Act provides that “[w]hen declaratory relief is sought all person shall be made parties who have or claim any interest which would be affected by the declaration. See S.C. Code Ann. § 15-53-80 (emphasis added); see also, James F. Flanagan, *South Carolina Civil Procedure* 196 (2d ed. 1996) (listing Declaratory Judgment Act as possible example of a statute granting an unconditional right to intervene under Rule 24(a)(1)). As all of the Movants currently have pending CON applications, the outcome of this action undoubtedly affects their rights. Based on the foregoing, Movants should be made parties to the action pursuant to Rule 24(a)(1), SCRPC.

II. The Movants are entitled to Intervention as a Matter of Right Pursuant to Rule 24(a)(2) of the South Carolina Rules of Civil Procedure.

In addition to their right to intervene pursuant to Rule 24(a)(1), the Movants also assert they are entitled to intervention under Rule 24(a)(2). Rule 24(a)(2), SCRPC, sets forth an additional basis for intervention in an action as a matter of right and provides in part as follows:

Upon timely application, anyone shall be permitted to intervene in an action . . . (2) when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

S.C. R. Civ. P. 24(a). Thus, a party seeking to intervene as of right under Rule 24(a)(2) must: (1) establish timely application; (2) assert an interest relating to the property or transaction which is the subject of the action; (3) demonstrate that it is in a position such that without intervention, disposition of the action may impair or impede its ability to protect that interest; and (4) demonstrate that its interest is inadequately represented by other parties. See *In re S.C. Dep't of Health and*

Envtl. Control v. Columbia Organic Chem. Co., 310 S.C. 495, 498, 427 S.E.2d 661, 663 (1993); *Berkeley Elec. Coop., Inc. v. Mt. Pleasant*, 302 S.C. 186, 189, 394 S.E.2d 712, 715 (1990). The rule relating to intervention is to be applied liberally, particularly where “judicial economy will be promoted by the declaration of rights of all parties who may be affected.” *Berkeley*, 302 S.C. at 189, 394 S.E.2d at 714.

A. The Movants’ Motion to Intervene is timely.

The timeliness of a motion to intervene is not an issue when the motion is filed days after the filing of the original complaint. *See Berkeley*, 302 S.C. at 189, 394 S.E.2d at 714. The Movants are filing this Motion to Intervene in this action with all deliberate haste and within days of the filing of this action. Thus, this Motion to intervene satisfies the timeliness requirement of Rule 24(a).

B. The Movants have a substantial interest in the transaction that is the subject of the action.

A party has a substantial interest in the subject of the action for purposes of Rule 24(a)(2) intervention if that party has a financial interest in the subject matter of an action, or the party faces the prospect of suffering economic harm as a result of the subject matter of the action. *See Berkeley*, 302 S.C. 190-91, 394 S.E.2d at 715 (holding in part that SCE&G’s financial interest in serving customers and receiving revenues was sufficient to satisfy Rule 24(a)’s interest requirement). The Movants have a strong financial and business interest in the subject of this action. They have invested significant resources in the numerous applications prepared and filed in an effort to obtain CONs in an effort to meet the need of the patients residing in the Counties for which the applications were filed. If the declaratory relief sought in this action was granted or if a temporary restraining order or preliminary injunction were granted in this matter, it would negatively affect the Movants’ ability to provide services, which would, in turn, harm the

members of the public who depend on the availability of home health care. In fact, during the review process for the current SHP, the SHP Committee and the DHEC Board concluded that South Carolina is severely underserved in the home health arena and that the public is actively being harmed by the lack of sufficient home health services. This reasoning led the SHP Committee to recommend and the DHEC Board to approve the current home health section in State Health Plan.

Furthermore, as set forth above, the Declaratory Judgment Act states that when declaratory judgment is the relief sought, "all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding." S.C. Code Ann. § 15-53-80. The express language of the Declaratory Judgment Act supports the Movants' position that it has a substantial interest in the transaction that is the subject of this action.

C. Without intervention, the disposition of this case may impair or impede the Movants' ability to protect their interest.

The Movants' pending CON applications, which DHEC has either marked complete or are currently under review, will be put on hold for an indeterminate period if the relief sought is granted. In turn, patients in need of home health services will go without needed services. *See Berkeley*, 302 S.C. at 190, 394 S.E.2d at 715 ("[A] party need not prove that it would be bound in a *res judicata* sense by the judgment, only that it would have difficulty adequately protecting its interest if not allowed to intervene."). Without intervention in this particular case, the Movants' have no adequate forum to protect their interests and the interests of ensuring that they meet the needs of those patients in the Counties for which the pending Certificate of Need applications have been applied.

D. The Movants' interests are not adequately represented by the existing parties.

DHEC will not adequately represent the Movants' interests in this matter. South Carolina courts look to three factors to assess whether a party seeking to intervene would be adequately represented by existing parties: "(1) whether the existing parties will undoubtedly make all of the intervenor's arguments; (2) whether the existing parties are capable and willing to make such arguments; and (3) whether the intervenor offers different knowledge, experience, or perspective on the proceedings that would otherwise be absent." *Berkeley*, 302 S.C. at 191, 394 S.E.2d at 715. The burden of proof on the party seeking intervention is very low. *See id.* ("This burden is minimal and the applicant need only show that the representation of his interest 'may be' inadequate.").

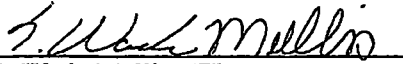
DHEC does not adequately represent the Movants because DHEC is a governmental entity. *See id.* ("It has been held that a governmental entity representation of a private party's interest does not constitute adequate representation."). Although DHEC's and the Movants' interests are aligned in ensuring that the public need for home health services is met, DHEC's purpose in this action is to uphold the law and to further the purposes of the CON Statute. The Movants' reason for intervening is to protect its own investment in its CON applications and to further its legitimate business interests.

Finally, as a matter of significance, DHEC has consented to the Movants' intervention in this action.

CONCLUSION

For the reason set forth above, the Movants respectfully request that the Court grant their Motion to Intervene.

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February 15, 2016

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Amedisys SC, L.L.C., and South
Carolina Home Care & Hospice
Association,

Petitioners,

vs.

South Carolina Department of Health
and Environmental Control,

Respondent.

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

Civil Action No.: 2016-CP-40-00818

**DEFENDANT DHEC'S MEMORANDUM
IN OPPOSITION TO MOTION FOR
TEMPORARY RESTRAINING ORDER AND
PRELIMINARY INJUNCTION**

Defendant South Carolina Department of Health and Environmental Control (Department) submits this memorandum of law in opposition to Plaintiff Amedisys SC, L.L.C. (Amedisys)'s¹ motion for temporary restraining order (TRO) and preliminary injunction.

BACKGROUND

The Department is the sole state agency charged with administering the *State Certification of Need and Health Facility Licensure Act*, S.C. Code Ann. §§ 44-7-110, *et seq.* (CON Act). S.C. Code Ann. § 44-7-140. The purposes of the CON Act are 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. S.C. Code Ann. § 44-7-120. To achieve these purposes, the CON Act requires the following: (1) the issuance of a Certificate of Need (CON) before undertaking a project prescribed by the Act; (2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a CON; (3) preparation and publication of a State Health Plan (Plan); and (4) the licensure of facilities rendering medical, nursing, and other health care. *Id.*

The issuance of a CON is required prior to undertaking certain medical-related projects, including a capital expenditure by a health care facility for the addition or substantial expansion of health services for which there are specific standards or criteria in the Plan. S.C. Code Ann. § 44-7-160. Additionally the *Licensure of Home Health Agencies Act*, S.C. Code Ann. §§ 44-69-10, *et seq.* (Home Health Act), requires the issuance of a CON prior to licensure for home health agencies. S.C. Code Ann. § 44-69-75(A).

The Department is charged with preparing a Plan for use in the administration of the CON program with the advice of the health planning committee (Committee). S.C. Code Ann.

¹ South Carolina Home Care & Hospice Association (the Association) is also a named Plaintiff in this lawsuit. However, the Association has since filed a notice of dismissal as to itself pursuant to Rule 41(a)(1), SCRCP.

§ 44-7-180(B). Pursuant to Section 44-7-180(B), the Plan must include at a minimum the following:

- (1) an inventory of existing health care facilities, beds, specified health services, and equipment;
- (2) projections of need for additional health care facilities, beds, health services, and equipment;
- (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and
- (4) a general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding 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.

Following a process that includes public notice and opportunity for public comments, as well as regional public hearings, the Committee approves the draft Plan to be submitted to the Board of Health and Environmental Control (Board) for final revision and adoption at least once every two years. S.C. Code Ann. § 44-7-180(C).

The most recent Plan was adopted by the Board on August 13, 2015. The Plan's home health section sets forth the following standards applicable to CON applications for home health services:

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. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:
 - a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.
 - c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.

- d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.
4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
6. Specialty home health providers are exempt from the need calculation applicable to full-service home health agencies, but are otherwise subject to Certificate of Need.
7. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, consent order, abandonment of patients in other business operations, or loss of license. However, any consent orders or loss of licenses related to licenses that were obtained from the Department between July 1, 2013 and May 22, 2014 without a Certificate of Need shall not be grounds for denial of a Certificate of Need application pursuant to this Section. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.
8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should it fail to reach this threshold number two years after initiation of services in a county, it will voluntarily relinquish its license for that county.
9. Nothing in this Section is intended to restrict the ability of the Department to approve more than one new Home Health Agency in a county at any given time.

August 13, 2015 South Carolina Health Plan, pp. XII-7 through XII-8. Additionally, the Plan includes an inventory of existing home health agencies in the State and 2013 utilization data for home health agencies, the most recent data available to the Department at the time of the Plan's adoption, showing the total number of persons served and total visits per home health agency. *Id.* at pp. XIII-46 through XIII-51. The Plan also lists the project review criteria deemed most relevant for consideration of home health CON applications. *Id.* at p. XII-8.

Plaintiff brought suit seeking a declaration that the Department has not performed its statutory obligation to adopt a Plan with the minimum requirements necessary for home health services. Plaintiff also filed a motion for a TRO and preliminary injunction to enjoin the Department from accepting, reviewing, and issuing decisions on CON applications for home health services under the Plan. For the following reasons, Plaintiff's motion for a TRO and preliminary injunction should be denied.

ARGUMENT

I. A TRO is unnecessary to preserve status quo or avoid possible irreparable injury, and therefore should be denied.

The sole purpose of a temporary injunction is to preserve the status quo, and thus avoid possible irreparable injury to plaintiff, pending the litigation. *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 601, 553 S.E.2d 110, 121 (2002); *Powell v. Immanuel Baptist Church*, 261 S.C. 219, 221, 199 S.E.2d 60, 61 (1973). See also *Cty. Council of Charleston v. Felkel*, 244 S.C. 480, 483-84, 137 S.E.2d 577, 578 (1964) ("The sole object of a temporary injunction is to preserve the subject of controversy in the condition which it is at the time of the Order until opportunity is offered for full and deliberate investigation and to preserve the existing status during litigation....") (internal citations omitted).

A TRO is not necessary to preserve the status quo. The CON Act and Regulation provide timeframes for the Department to follow in accepting, reviewing, and issuing decisions on CON applications. The key steps and timeframes include the following:

- After receipt of application, accompanied by proof the applicant timely published newspaper notice of its intent to file an application and payment of the filing fee, Department shall publish in the State Register a notice that the application was accepted for filing. S.C. Code Ann. § 44-7-200(D).
- The Department then has 30 days to request any additional information from the applicant as may be necessary to complete the application. *Id.* The applicant has 30 days to submit any requested additional information, or the application will be deemed withdrawn. *Id.*
- After Department deems the application to be complete, it must notify affected persons that the application is complete and the review cycle has begun. S.C. Code Ann. § 44-7-210(A). This notice must be published in the State Register. 3 S.C. Code Ann. Regs. 61-15 § 305(1).
- Staff shall issue its decision no earlier than 30 and no later than 120 calendar days after affected persons are notified that the application is deemed complete or, if a public hearing is requested, no later than 150 days after the deemed complete notice. S.C. Code Ann. § 44-7-210(A).

If a decision is made to grant a CON application, affected persons may request a final review conference before the Board pursuant to S.C. Code Ann. § 44-1-60, and may thereafter request a contested case hearing with the Administrative Law Court (ALC). S.C. Code Ann. § 44-7-210(D) and (E). In the event a contested case hearing is filed with the ALC, the decision approving the CON application is automatically stayed. S.C. Code Ann. § 1-23-600(H)(2).

The Department published notice in the January 22, 2016, State Register that 48 CON applications for home health services have been deemed complete. Pursuant to the above statutory deadlines, the Department may not issue a decision earlier than February 22, 2016, nor later than May 23, 2016, on those CON applications. Even if a decision is issued in that time period granting a home health application, the decision would be stayed upon a timely filing of a contested case hearing at the ALC challenging the decision by an affected person with standing. The status quo of home health services in any counties in which Amedysis currently operates would remain the same in the event the Department granted a CON application and Amedysis filed a contested case hearing with the ALC, until the ALC issues a final order and decision on the application. It is therefore unnecessary to grant Amedysis' motion for a TRO to preserve status quo.

For the same reasons, it is unnecessary to grant a TRO to avoid possible irreparable harm to Amedysis. As noted above, Amedysis has the opportunity to file a request for a contested case hearing at the ALC to challenge a decision by the Department approving a new home health agency in a county where Amedysis is an affected person with standing. Such a filing would trigger the ALC's automatic stay provision. Because the status quo would remain the same pending resolution of a contested case hearing, Amedysis would suffer no irreparable harm prior to its opportunity for a full merits hearing on the application before the ALC. Therefore no TRO is necessary.

II. Plaintiff has not met the burden of establishing the requisite elements for a preliminary injunction order.

"An injunction is a drastic remedy issued by the court in its discretion to prevent irreparable harm suffered by the plaintiff." *Scratch Golf Co. v. Dunes W. Residential Golf Props., Inc.*, 361 S.C. 117, 121, 603 S.E.2d 905, 907 (2004). To establish a cause of action for injunction, the plaintiff must show "(1) it would suffer irreparable harm if the injunction is not granted; (2) it will likely succeed on the merits of the litigation; and (3) there is an inadequate remedy at law." *Id.*

As discussed above, no irreparable harm would result to Amedysis in the absence of a preliminary injunction. Amedysis has an adequate remedy at law available to it, which is to request a contested case hearing at the ALC challenging any decision granting a CON application for a home health agency in a county in which Amedysis is an affected person with standing. This is the process by which MRI at Belfair sought to challenge the sufficiency of the MRI section of a previous edition of the Plan in the case of *MRI at Belfair v. SCDHEC and Coastal Carolina Medical Center*, 379 S.C.1, 664 S.E.2d 471 (2008). MRI at Belfair challenged a decision granting a CON to a hospital for a new MRI by filing a contested case with the ALC. As part of its challenge to the Department's decision, MRI at Belfair argued that the Plan did not contain sufficient projections of need and standards for distribution for MRI services, and therefore did not comply with the requirements of S.C. Code Ann. § 44-7-180. The ALC considered its arguments, as did the Supreme Court upon appeal. The Supreme Court ultimately issued an opinion upholding the Department's decision and finding that the MRI portion of the Plan sufficiently complied with Section 44-7-180. *Id.* at 7, 664 S.E.2d at 474. Because Amedysis has an adequate remedy at law available to it, a preliminary injunction should be denied.

As noted by the Supreme Court in the *MRI at Belfair* case, the language of the Plan does not have to track the exact statutory language in 44-7-180 in order to be sufficient. Projections of need do not have to be based upon a calculation that includes population and utilization data. Amedysis is therefore unlikely to succeed on the merits, and the motion for preliminary injunction should be denied.

III. It is inappropriate to enjoin a state agency from the performance of duties imposed by statute.

One may not generally enjoin a state agency from the performance of duties imposed by a valid state statute. *Frady v. Student Loan Servicing Ctr.*, 313 S.C. 561, 564, 443 S.E.2d 580, 582 (Ct.App.1994); *Compton v. S. Carolina Dep't of Corr.*, 392 S.C. 361, 369, 709 S.E.2d 639, 643-44 (2011).

Granting the relief requested would prevent the Department from complying with the statutory duties and timeframes set forth in the CON Act. Amedysis seeks to enjoin the Department from accepting, reviewing, and issuing decisions on CON applications for home health. Given the Department's statutory mandate to perform these duties, and given that the relief requested is not necessary to preserve the status quo or to prevent the possibility of irreparable harm, the motion for preliminary injunction should be denied.

CONCLUSION

For the foregoing reasons, the Department respectfully requests the Court deny Plaintiff's motion for temporary restraining order and preliminary injunction.

Respectfully submitted,



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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Amedisys SC, L.L.C., and South Carolina
Home Care & Hospice Association,

Plaintiffs,

vs.

South Carolina Department of Health and
Environmental Control,

Defendant

and

National Healthcare Corporation, In-Care
Home Health, Inc., Tri-County Home
Health Care & Services, Inc., M&C
Group, LLC d/b/a Home Helpers of
Bluffton, Tidewater Home Health, P.A.,
Hedgemark Brentwood Medical Services,
Inc. d/b/a PHC Home Health and
PruittHealth Corporation,

Intervenor-Defendants.

**IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT**

Civil Action No.: 2016-CP-40-00818

**DEFENDANT SOUTH CAROLINA
DEPARTMENT OF HEALTH AND
ENVIRONMENTAL CONTROL'S
ANSWER TO COMPLAINT**

Defendant South Carolina Department of Health and Environmental Control ("Department" or "Defendant"), by and through its undersigned counsel, answers Plaintiffs Amedisys SC, LLC ("Amedisys") and South Carolina Home Care & Hospice Association ("SCHCHA") (collectively "Plaintiffs") complaint as follows:

1. Defendant denies each and every allegation of Plaintiffs' complaint that is not hereinafter expressly admitted.

NATURE OF THE ACTION

2. Paragraph 1 of the complaint contains Plaintiffs' characterization of the nature of the action, to which no answer is required.

JURISDICTION AND VENUE

3. Defendant admits the allegations contained in paragraphs 2 and 3 of the complaint.

PARTIES

4. Defendant admits, upon information and belief, the allegations contained in paragraphs 4, 5, and 6 of the complaint. Further answering the allegations of paragraph 6 of the complaint, Defendant would show that SCHCHA filed a notice of dismissal of this suit as to itself on February 16, 2016.

5. Defendant is without sufficient information to form a reasonable belief as to the truth of the allegations contained in paragraph 7 of the complaint and therefore denies the same. Further answering the complaint, Defendant would show that SCHCHA filed a notice of dismissal of this suit as to itself on February 16, 2016.

6. Defendant admits the allegations contained in paragraphs 8 and 9 of the complaint.

REGULATORY CONTEXT

7. Defendant admits the allegations contained in paragraphs 10 and 11 of the complaint.

8. As to the allegations contained in paragraph 12 of the complaint, Defendant admits that S.C. Code Ann. § 44-7-180(B) requires the Department to prepare a South Carolina Health Plan with the advice of the health planning committee, and admits that S.C. Code Ann. § 44-7-180(C) requires “[u]pon approval by the health planning committee, the South Carolina Health Plan must be submitted at least once every two years to the board for final revision and adoption.” Defendant further admits that the health planning committee is established pursuant to S.C. Code Ann. § 44-7-180(A) and is comprised of twelve members appointed by the Governor and one member appointed by the chairman of the board; additionally, the South Carolina Consumer Advocate or the Consumer Advocate’s designee is an ex officio non-voting member. To the extent the allegations set forth in paragraph 12 of the complaint are inconsistent therewith, the Department denies the allegations, and craves reference to S.C. Code Ann. § 44-7-180.

9. As to the allegations contained in paragraph 13 of the complaint, Defendant admits that S.C. Code Ann. § 44-7-120(2) requires the Department to adopt "procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need." To the extent the allegations set forth in paragraph 13 of the complaint are inconsistent with the law cited in paragraph 13 of the complaint, the Department denies the allegations.

10. Defendant admits the allegations contained in paragraphs 14 of the complaint but would show that the citation to the regulation should be 3 S.C. Code Ann. Regs. 61-15 § 106(1) and (2).

11. In response to the allegations contained in paragraph 15 of the complaint, the Department craves reference to S.C. Code Ann. § 44-7-210(B), which states "The department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." To the extent the allegations contained in paragraph 15 of the complaint are inconsistent therewith, the Department denies the allegations.

12. To the extent that the allegations contained in paragraph 16 of the complaint are inconsistent with S.C. Code Ann. § 44-7-130(5) and § 44-7-210(B), Defendant denies the allegations. Further answering the allegations contained in paragraph 16, Defendant craves reference to S.C. Code Ann. § 44-7-130(5), § 44-7-210(B), and 3 S.C. Code Ann. Regs. 61-15 § 103(6). Defendant would show that the definition of "competing applicants" is "two or more persons or health care facilities as defined in this article who apply for Certificates of Need to provide similar services or facilities in the same service area within a time frame as established by departmental regulations and whose applications, if approved, would exceed the need for services or facilities." S.C. Code Ann. § 44-7-130(5). Defendant would further show that departmental regulations set forth the following time frame which must be met in order for applicants to meet the definition of "competing applicants":

An application shall be considered competing if it is received by the Department no later than fifteen (15) calendar days after a Notice of Affected Persons is published in the State Register for one or more applications for similar services and/or facilities in the same service area. All applications received by the Department within fifteen (15) calendar

days of publication of the Notice of Affected Persons in the State Register for the first application(s) will be considered to be competing. Any applications received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s).

3 S.C. Code Ann. Regs. 61-15 § 103(6). If two or more applicants meet the definition of “competing applicants,” including the time frame set forth above, “the Department shall award a Certificate of Need, if appropriate, on the basis of which, if any, most fully complies with the requirements, goals, and purposes of this article and the State Health Plan, Project Review Criteria, and the regulations adopted by the department.” S.C. Code Ann. § 44-7-210(B).

13. Defendant admits the allegations contained in paragraphs 17, 18, and 19 of the complaint.

14. In answer to the allegations contained in paragraph 20 of the complaint, Defendant admits that any applicant for a Certificate of Need (“CON”) must provide a response to the question in the CON application form set forth at 3 S.C. Code Ann. Regs. 61-15 § 202(2)(b)(11), which reads:

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

To the extent paragraph 20 of the complaint contains any allegations inconsistent therewith, the Department denies the allegations.

15. Defendant admits the allegations contained in paragraph 21 of the complaint.

16. In answer to the allegations contained in paragraph 22 of the complaint, Defendant admits the Board adopted the current South Carolina Health Plan (“Current Plan”) on August 13, 2015, but denies that the Board labeled it as being “for 2014-2015.” Defendant admits the remaining allegations in paragraph 22 of the complaint.

17. Defendant admits the allegations contained in paragraphs 23 and 24 of the complaint.

18. Defendant admits in part and denies in part the allegations contained in paragraph 25 of the complaint. Defendant admits that the Department has from time to time in the past posted on its website updated versions of some of the charts contained in previous issues of the South Carolina Health Plan to indicate CON approvals granted after the South Carolina Health Plan's publication date for the public's convenience, some copies of which are attached as Exhibit B to the Complaint. Defendant denies Plaintiffs' characterization of these updates as "a mechanism for keeping population and services-inventory information, both critical components of need determination, up-to-date throughout the life of a Plan."

19. Defendant admits the allegations contained in paragraph 26 of the complaint.

20. Defendant admits in part and denies in part the allegations contained in paragraph 27 of the complaint. Defendant admits the Planning Committee rejected Department staff's initial proposed revisions to the home health section. Defendant denies the remaining allegations of paragraph 27 of the complaint.

21. Defendant admits the allegations of paragraph 28 of the complaint.

22. Defendant denies the allegations of paragraph 29 of the complaint. Further answering the allegations of paragraph 29 of the complaint, Defendant would show that the Current Plan contains criteria for home health services, some of which are different from and some of which are similar to criteria contained in previous Plans.

23. Defendant admits the allegations contained in paragraph 30 of the complaint.

24. In response to the allegations contained in paragraph 31 of the complaint, Defendant denies the allegations regarding the number of CON applications and the number of counties for which CON applications have been filed. Further responding, Defendant would show that 148 CON applications have been submitted to date to establish new home health services in 45 different counties. Defendant admits the remaining allegations contained in paragraph 31 of the complaint.

25. In response to the allegations contained in paragraph 32 of the complaint, Defendant denies the allegation regarding the number of counties with submitted applications. Further responding, Defendant would show that CON applications have been submitted for home health services in 46 counties and that, upon information and belief, Amedisys currently holds a license to provide home health services in 25 of those counties. Defendant is without information sufficient to form a belief as to the remaining allegations of paragraph 32 and therefore denies the same.

26. In response to the allegations contained in paragraph 33 of the complaint, Defendant denies the allegation regarding the number of CON applications filed to date. Further responding, Defendant would show that 148 CON applications have been submitted to date to provide home health services, 81 of which are to provide new home health services in counties in which Amedisys currently holds a license to provide home health services. Defendant is without information sufficient to form a belief as to the truth of the remaining allegations of paragraph 33 and therefore denies the same.

27. Defendant admits the allegations contained in paragraph 34 of the complaint but, further responding, would show that the maximum of 150 days is applicable only where a public hearing has been requested on a CON application. *See* S.C. Code Ann. § 44-7-210(A). If no public hearing has been requested on a CON application, the maximum number of days to either grant or deny the CON application is 120 days from the date the application is deemed complete and notice is published in the *South Carolina State Register*. *Id.*

28. In response to the allegations contained in paragraph 35 of the complaint, Defendant denies the allegations regarding the number of submitted applications and the number of applications deemed complete. Further responding, Defendant would show that 148 applications have been submitted to date for home health services. Defendant would further show it published notice to affected persons in the January 22, 2016, issue of the *South Carolina State Register* that 48 of the CON applications for home health services had been deemed complete. Defendant further answers that it

published notice to affected persons in the February 26, 2016, issue of the *South Carolina State Register* that an additional 29 CON applications for home health services have been deemed complete.

29. In response to the allegations contained in paragraph 36 of the complaint, Defendant denies the allegation regarding the number of applications deemed complete and published in the January 22, 2016, issue of the *South Carolina State Register*. Further answering, Defendant would show that the number of submitted applications deemed complete in the January 22, 2016, issue of the *South Carolina State Register* was 48. Defendant admits the remaining allegations contained in paragraph 36 of the complaint.

FIRST CAUSE OF ACTION

30. Paragraph 37 of the complaint is merely an incorporation by reference that requires no answer of the Defendant. To the extent that an answer may be required, Defendant incorporates by reference each and every response set forth in the preceding paragraphs as if fully set forth in this paragraph in their entirety.

31. Defendant admits the allegations contained in paragraphs 38 and 39 of the complaint.

32. Defendant admits in part and denies in part the allegations contained in paragraph 40. Defendant denies that the Current Plan is deficient and denies that the Current Plan does not meet the statutory minimum standards for home health services determinations of need. Defendant admits that the Current Plan adopts a 25-patient (rural)/50-patient (non-rural) county target as a minimum threshold to demonstrate need, but denies that there are no guidelines for how the 25-patient or 50-patient need is to be calculated, demonstrated, or tested. Further responding to the allegations contained in paragraph 40 of the complaint, the Current Plan contains additional standards related to need, including in particular how to demonstrate need. Further answering, Defendant would show that the Current Plan meets the statutory standards set forth in S.C. Code Ann. § 44-7-180.

33. Defendant denies the allegations contained in paragraphs 41, 42, 43, 44, and 45 of the complaint.

SECOND CAUSE OF ACTION

34. Paragraph 46 of the complaint is merely an incorporation by reference that requires no answer of the Defendant. To the extent that an answer may be required, Defendant incorporates by reference each and every response set forth in the preceding paragraphs as if fully set forth in this paragraph in their entirety.

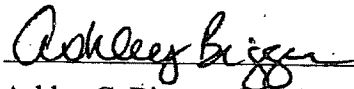
35. Defendant denies the allegations contained in paragraphs 47 and 48 of the complaint.

PRAYER FOR RELIEF

36. Defendant denies that Plaintiffs are entitled to any relief prayed for in the complaint.

WHEREFORE, Defendant South Carolina Department of Health and Environmental Control prays that judgment be entered in favor of the Defendant and against the Plaintiffs.

Respectfully submitted,



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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Casey L. Manning, Circuit Court Judge

RECEIVED

MAR 21 2016

SC Court of Appeals

C.A. No.: 2016-CP-40-00818

Amedisys SC, L.L.C. Plaintiff/ Appellant,

.....V.

South Carolina Department of Health and Environmental Control, ...Defendant,

and

National Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc.,
Tri-County Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers
of Bluffton, Tidewater Home Health, PA, and Hedgemark Brentwood Medical Services
Inc. d/b/a PHC Home Health, ...Intervenors.

Of whom, South Carolina Department of Health and Environmental Control, National
Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc., Tri-County
Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers of Bluffton,
Tidewater Home Health, PA, and Hedgemark Brentwood Medical Services Inc. d/b/a
PHC Home Health are Respondents.

NOTICE OF APPEAL

Amedisys SC, L.L.C. ("Amedisys") appeals the Order filed in this matter on
February 23, 2016, denying its motion for a preliminary injunction. Amedisys received
written notice of the entry of the Order denying its motion on February 23, 2016. A copy

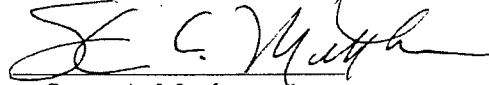
of the Order is attached to this Notice as Exhibit A. Amedisys does not appeal the grant of motions to intervene in this matter, also contained in the Order.

March 21, 2016

Respectfully submitted,

HAYNSWORTH SINKLER BOYD, P.A.

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*Counsel for Respondents National
Healthcare Corporation and Pruitthealth
Corporation*

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2
3
4 DHEC OPEN FORUM MEETING
5
6
7
8
9

10 DATE: September 18, 2015

11 TIME: 10:03 AM

12 LOCATION: DHEC
13 301 Gervais Street, Room 2407
Columbia, SC 29201

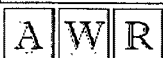
14 REPORTED BY: SAMANTHA R. QUEDENFELD,
15 Court Reporter
16
17

18 A. WILLIAM ROBERTS, JR., & ASSOCIATES

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1 APPEARANCES:

2 Shelly Kelly

3 MaryJo Roue

4 Ashley Biggers

5 Maggie Murdock

6 Venja Szatkowski

7 Lynn Bailey

8 James Chin

9 Andrea Brisbin

10 Jennifer Hyman

11 Joel Grice

12 Keith Guest

13 Paula Thars

14 Sam Tolbert

15 David Levitt

16 Will Thomas

17 Kimberly Coleman

18

19

20

21

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25

1 MS. KELLY: So I'm Shelly Kelly. I'm
2 director of health regulations. I know some of you,
3 I would like to get to know more of you a little bit
4 better. I'm going to let all of us introduce -- all
5 the department staff go ahead and introduce
6 themselves, and I'll start with MaryJo.

7 MS. ROUE: All right. My name is
8 MaryJo Roue, and I'm the bureau chief for
9 certification.

10 MS. BIGGERS: My name is Ashley
11 Biggers, and I am chief counsel for health
12 regulation.

13 MS. MURDOCK: I'm Maggie Murdock, I'm
14 the senior consultant for the certificate of need.

15 MS. SZATKOWSKI: I'm Venja Szatkowski,
16 I'm an administrative coordinator for certificate of
17 need.

18 And Jennifer Hyman has run downstairs to
19 get a few more people, and she's also an administrative
20 coordinator.

21 MS. KELLY: Okay. So when these new
22 people come in, we may just see if they can stand
23 against the wall. We may be able to -- if anybody's
24 uncomfortable, we can try to get some more chairs.
25 But hopefully -- I don't know where else we can put

1 them unless we put them over there. So --

2 MS. BAILEY: Right there with the
3 valet parking.

4 MS. KELLY: So -- air-conditioned? I
5 do not know. So -- is it right there? Okay.
6 You're in charge of A/C.

7 Okay. The agency did not provide the
8 court reporter so, you know, we're going to try to make
9 it as accommodating as possible, but we intended this
10 meeting to be an informal discussion.

11 We hold these regulation informational
12 meetings regularly within our area, health regulations.
13 We always have -- get feedback from the public when we
14 do any kind of regulation changes. We don't record, we
15 don't put them out on video streaming, so it's not
16 unusual for us to do -- we had one -- we had one
17 earlier in the week for midwives, and we have one for
18 birthing centers coming up.

19 So it's -- while, you know, you certainly
20 can, you know, I don't have a problem with you being
21 here, I just want to make sure everybody feels
22 comfortable. We want everybody to feel comfortable and
23 be able to speak their mind.

24 MR. CHIN: I have a question. James
25 Chin. Who asked for the court reporter?

1 MS. KELLY: It was Andrea.

2 MS. BRISBIN: Yeah.

3 MR. CHIN: Okay.

4 MS. BRISBIN: Okay.

5 MS. KELLY: So, I mean, if anybody
6 wants a copy or something -- so I'm going to get
7 started.

8 MS. HYMAN: Can I just make one more?
9 The receptionist asks that when we are done and
10 everyone leaves to please sign out on the way out so
11 that they know that everybody was here.

12 MS. KELLY: So you don't have to be
13 escorted down like you normally would.

14 Okay. So we're going to start.

15 MR. GRICE: This is Joel.

16 MS. KELLY: I'd ask everybody to
17 silence your phone, please.

18 MR. GRICE: Excuse me. This is a
19 person that is supposed to be coming in.

20 MS. KELLY: Oh, okay. All right. So
21 we're going to start with -- we're going to give you
22 a little bit of information, hopefully receive some
23 information from you as well. We're going to --
24 everybody will have a chance to speak.

25 Maggie, anything you'd like to --

1 MS. MURDOCK: No, that's okay.

2 MS. KELLY: Anything you'd like to --

3 MS. MURDOCK: That's okay, no. Thank
4 you all for being here, and I just wanted to assure
5 you we -- we are having this forum at the request of
6 the regulated community, many of whom wanted to
7 share some thoughts with us about home health and
8 the home health applications.

9 As you all know, we had a very robust
10 discussion about -- during the (inaudible) process
11 about home health need methodology. We appreciate all
12 the public input and the quality of that debate. I
13 just wanted to assure you all that the purpose of this
14 forum is not to rehash that discussion.

15 We have a state health plan already, so
16 this is really just a chance -- and again, it was at
17 the request of you all to have this forum as a chance
18 for us to hear from you, which we always like to do,
19 either at events like this or even, you know, any time
20 you have input or have suggestions or have anything
21 that you want us to know, we welcome it always.

22 Today is just a chance for us to get
23 together. One of the advantages of this is not only do
24 we get to hear from you, but you all get to hear from
25 each other as well. So we look forward to your

7
1 comments, and that's all I've got.

2 MS. KELLY: Oh, we're going to start
3 off with -- MaryJo Roue is going to give you a
4 little bit of information about the certification
5 process. I know that's of great interest to people,
6 so I'm going to turn the floor over MaryJo.

7 MS. ROUE: Morning, everyone. I just
8 wanted to talk a little bit about Medicare
9 certification and the implications of new HHA CONs.
10 We understand that some of the CONs that are going
11 to be issued will, of course, be service area
12 expansions. While they are just service area
13 expansions, we are adding counties.

14 This still is workload for certification.
15 There is a process that we go through. Our admin staff
16 have to process your 855s for those additional counties
17 along with your license, and it causes, of course,
18 additional workload for CMS regional office as well
19 because they have a part in processing your service
20 area expansions, and they authorize and make the final
21 approval of those.

22 So even though there might not be -- you
23 might not be starting a new facility, service area
24 expansions, you need to understand, will also involve
25 certification, a process, and paperwork that will have

1 to happen. And we anticipate having quite a few of
2 those.

3 I guess the other concern would be for
4 any of the new CONs that are going to result in a brand
5 new facility. For those, we would like to remind you
6 of CMS' priority for initial surveys. As you know,
7 they are the last priority in the CMS workload. We are
8 responsible to complete all other CMS workload prior to
9 performing initial surveys.

10 Right now, you know, if there were to be
11 an influx of HHA initial applications, I can tell you
12 that although CMS gives us over 90 days, it is unlikely
13 that we, if we were your survey entity, would be able
14 to fulfill those for many new official -- new initial
15 HHAs.

16 My suggestion is that although there is a
17 cost related to accreditation, that you recommend or
18 look into accreditation for initial HHAs as a survey
19 option. Although it is still -- although having an
20 accredit entity -- entity -- accrediting organization
21 perform the initial survey, there is still a processing
22 piece that we do to get your CMS certification number,
23 but it's a paperwork process that can be done
24 administratively.

25 So I just wanted to let everyone know

9.
1 what the potential increase in HHA CONs could mean for
2 certification. Right now, in the certification staff,
3 we have five nurses and four generalists. As you know,
4 CMS requires nurses to be on HHA surveys, at least one
5 nurse. And so out of those five nurses, three are new
6 and have not attended HHA training yet, as CMS only
7 offers training periodically. So that leaves us with
8 two staff at this point to be performing HHA surveys
9 until we get these staff trained.

10 We operate off a federal budget and not
11 state money, so we can only fund the amount of staff
12 persons that we are funded for. So, you know, our new
13 year starts October 1st. There is no plan at this time
14 to increase the number of FTEs in that area, although
15 we will be evaluating it and hoping we have the funding
16 to maybe look at that as an option. But I just wanted
17 to stress to you the importance of researching your
18 accreditation options if you are having an initial
19 facility.

20 Does anybody have any questions about
21 that?

22 Yes, Lynn.

23 MS. BAILEY: If you have an agency
24 that is certified, you know, out of state, will they
25 have to have -- will they be -- can they be an

10
1 expansion or they will be a new and they will have
2 to come under a South Carolina --

3 MS. ROUE: They will have to be a new
4 one.

5 MS. BAILEY: Okay.

6 MS. ROUE: There is no reciprocal
7 agreements to operate over state lines, so any HHA
8 coming in would have to be licensed and certified
9 within South Carolina.

10 MS. BAILEY: Okay.

11 MS. ROUE: Any other questions?

12 MR. GUEST: MaryJo, I've got one.
13 Let's say, for example, during that period of CON,
14 that you went through and you got, you know, you got
15 certified and you got Medicare surveys, you know,
16 all your surveys and everything and they're, you
17 know, operating like normal, but we have to go
18 through the process still; what -- how does that
19 fall in the hierarchy of what kind of class is that?

20 Because we have all of the surveys and
21 licensing and all that's already done. We have a
22 Medicare provider number, all of that. But we don't
23 have -- we have to get -- it would be the first time
24 we've ever gotten an actual CON. Do you know what I'm
25 talking about?

1 MS. ROUE: Well, you're probably -- if¹¹
2 you -- if you don't have a CON but you're a
3 certified home health agency, is that one that has
4 come in in-between the --

5 MR. GUEST: Yes.

6 MS. ROUE: -- time when -- okay.
7 Okay. I believe at this point, when you get your
8 CON, I mean the fact that you have it, because you
9 would be basically still certified. I don't think
10 there would be any change -- there's not going to be
11 any change in your certification.

12 MR. GUEST: Okay. All right. I just
13 wanted to make sure. Thank you.

14 MS. ROUE: But if you were to add
15 counties --

16 MR. GUEST: We haven't.

17 MS. ROUE: -- to your CON when you do
18 get it, then that would be not just what you have,
19 but in addition of your county -- your service area.

20 MR. GUEST: I actually thought about
21 that and decided that it's too complicated. We will
22 just stick with our two counties and just wait.

23 MS. ROUE: Okay.

24 MR. GUEST: It's too complicated.

25 MS. KELLY: Are there any other

1 questions for MaryJo?

2 All right, MaryJo, you're welcome to stay
3 or you're welcome to leave.

4 MS. ROUE: I can go if you don't mind.
5 Now someone can have a seat.

6 MS. KELLY: Someone can have a seat.

7 MS. ROUE: Well, this is going to be
8 cute getting though here, but I'll do my best.
9 Thank you so much.

10 MS. KELLY: Okay. If anyone wants to
11 take -- there's this one seat available, if you
12 would like to come in. Okay.

13 I think we're ready to hear from those of
14 you who have any comments or thoughts to share with the
15 group. Anybody in particular that would like to start?

16 MS. BAILEY: I'll start. Lynn Bailey,
17 I forgot to identify myself. Could you please
18 outline the CON staff process from the receipt of
19 the application through the review process to the
20 decision process so that everyone here understands
21 how a CON for home health will be processed by the
22 state.

23 MS. MURDOCK: Sure. We began with the
24 actual receipt of the application. We need a hard
25 copy plus one extra copy; is that right? I really

1 should get Venja to answer these questions because
2 she's the expert, but kick me if I'm wrong.

3 MS. SZATKOWSKI: I'll just keep
4 nodding.

5 MS. MURDOCK: And as long -- there are
6 a few requirements for us to be able to accept the
7 application. There needs to be a payment of a fee,
8 the application has to be in the -- in the form
9 required by regulation, there's actually a -- the
10 application itself is actually in regulation -- and
11 then we need proof that the proper notice to the
12 public -- the newspaper notice has run in the -- in
13 the required time period for the required number of
14 days. And those are the three things that we need
15 in order to actually accept the application.

16 Once we have all those and the
17 application is accepted, then we will -- there will be
18 a notice in the subsequent state register stating that
19 we had -- that the application has been accepted. Our
20 state register process is -- there's a little bit of
21 lag time. There's a two-week delay between the time
22 that we submit information to the, you know, entity in
23 charge of publishing the state register and the time
24 the register itself is actually published.

25 But then after the -- the application is

14
1 accepted, we will -- the department will review, and if
2 we -- the department needs any more information from
3 the applicant in order to deem the application
4 complete, we will request that information within 30
5 days of acceptance. And if we do request additional
6 information, the applicant has 30 days to respond.

7 Once that process is over, then we
8 will -- and the application is deemed complete, we will
9 run that notice in the state register. And, again,
10 there's the lag time with when we can submit
11 information and when the information is actually
12 published in the register. So just be aware of that.
13 I think it's a two -- it's a two-week lag.

14 And then once the -- once the state
15 register notice runs that the application has been
16 deemed complete, then the department must wait at least
17 30 days in order to render a decision. And then the
18 department renders a decision sometime in-between that
19 30 days and 120 days after the notice of completeness
20 is in the state register.

21 The only thing that changes that timeline
22 is if there is a proper request for a public hearing.
23 And if there is a request for a public hearing, then
24 that could extend the timeline for rendering the
25 decision out to 150 days instead of 120 days.

1 So that is generally how it works with
2 the timeline and, let's see, do you have any questions
3 about that? And of course, there are other things, you
4 know, you can -- yes.

5 MS. BAILEY: You've recently published
6 on the department's website a 13- to 14-page
7 spreadsheet that lists -- would that continue to be
8 updated as applications are received and accepted
9 and then under review, all of that would continue so
10 that we all know where all the players are in the
11 process?

12 MS. MURDOCK: Yes. Excuse me. Yes.
13 Right now, we are updating that monthly. That is
14 not -- we are publishing the update, the chart as a
15 courtesy to the regulated community. That is not
16 official notice of acceptance or deemed
17 completeness. But yes, we update it. But for now,
18 we only update it once a month. So I mean if --

19 MS. BAILEY: When?

20 MS. KELLY: It's going to be -- we're
21 going to -- the end of the month, so we get the
22 state register, you know, everything that was
23 published in that state register should -- the goal
24 is will show in that update. Now, with the
25 disclaimer that it's a -- it's a chart, not the

1 for-sure copy.

2 But we're going to -- the intent is to
3 make sure it's accurate. So we'll aim for perfection
4 on that. But everything published by that -- by that
5 state register should appear in that part -- or will --
6 I'll say will appear. So it'll be a little -- probably
7 the week after -- the very last week of -- of every
8 month. And the state register runs the fourth Friday
9 of each month.

10 MS. BAILEY: Right. And it has the
11 deadline for your submission into that is?

12 MS. MURDOCK: The second Friday of
13 every month.

14 MS. BAILEY: The second Friday in the
15 month.

16 So how long does it take you, typically,
17 from the time somebody mails you or drops off an
18 application with all the attachments and the check and
19 public notice to make a -- to clock that in as being
20 received and the notification of acceptance going to
21 the state register to the public?

22 MS. KELLY: I'm going to, I guess,
23 interject here that I don't know if we have a set
24 time. We're -- we are in the process, just for
25 everybody's information, of adding staff to the

1 program. You know, there's been a lot of staffing
2 changes in the last year. The program started from
3 nothing and then had to handle a huge backlog, and
4 it's -- and I have to say that the staff did a great
5 job getting everything done when they did. I mean,
6 if you look at that chart, it shows how many
7 applications have been handled this year. So I have
8 to commend them.

9 But we're committed to speeding up
10 things, making sure -- I mean, everybody at this table
11 recognizes that we can do better. So I can't give you
12 a -- I don't want to base what we're going to do next
13 week on what may have been done in the past because,
14 frankly, there was this huge backlog that we had to
15 address, so --

16 MS. BAILEY: Right.

17 MS. KELLY: I mean, we are -- I mean,
18 every attempt is to -- well, we're going to meet the
19 difference. I'll just say that right now. I'm firm
20 on that. So I don't know if we can really give you
21 a, you know, how soon within the required deadlines,
22 but I assure you --

23 MS. BAILEY: Well, we all here want to
24 do whatever the staff would like it, in the format
25 that they would like it so that it facilitates the

1 work of going -- and if you've got guidelines that
2 you would like us to follow in how we present an
3 application to you so that, you know, you only have
4 to look at the first six pages and get everything
5 checked off and that speeds your process, you
6 know --

7 MS. MURDOCK: That initial review,
8 getting from receipt of the application itself to
9 acceptance is a pretty cursory review. As long as
10 we see the proof of publication, the check, and, you
11 know, can look at the application to make sure it's
12 in generally the right -- you know, we're using the
13 form that answers the questions that the department
14 asks, that process is pretty quick.

15 And I don't think -- we're very aware,
16 well aware of when the state register information is
17 due. And so if we have applications that have come in
18 and we haven't stamped them as accepted, we usually
19 make every effort -- and I think every time, if we have
20 everything we need to deem it accepted, we will get --
21 get that information to the state register at the very
22 next deadline.

23 You know, I have not -- and again, you
24 know, I can't -- as soon as I say this, you know how
25 that works -- but I don't know of a time that we've

19

1 gotten an application in and haven't turned it around
2 and let the state register know that we have accepted
3 the application unless it was missing something that --
4 that was required for acceptance.

5 Now, that process is a lot simpler than
6 the, you know, the deemed complete element of it and,
7 you know, that's a little bit more of an in-depth
8 review, and it's to the benefit of the applicant that
9 we get as much information as we can and just
10 generally, you know -- we have a state health plan, we
11 have regulations with project review criteria and, you
12 know, as long as each applicant keeps an eye on what
13 the required state plan and applicable law and
14 regulations tell us we need to look at, that's -- we're
15 looking at what the law and the health plan requires us
16 to look at. I know that's frustratingly general,
17 but --

18 MS. BAILEY: Well, no, it gives me a
19 pretty good idea. I just think there are going to
20 be some people that are going to be DYI who have
21 never done one of these before that, you know -- and
22 are going to be --

23 MS. KELLY: Well, we have talked about
24 possibly doing an application informational session,
25 and that's something it sounds like if that's a

1 interest, you know, we would like to hear it, if
2 that would be something people would be interested
3 in. We would have it in a more of a classroom
4 setting, not all crammed in, and we would have
5 people let us know in advance who's coming so we can
6 do that. So if that's an interest, we certainly --
7 we've been talking about doing that, realizing
8 there'll probably be a lot of applicants that may
9 have never entered into the CON program before.

10 MS. BRISBIN: I just -- actually,
11 following up on that, so it's fair to say at this
12 time, although you're doing the courtesy of the
13 updates, if an application is filed between the
14 deadline for submitting to the state register and
15 the end of the month, then it's not necessarily
16 going to be reflected on the end of the month
17 summary, although you'll make every effort to do
18 that?

19 MS. KELLY: Oh, you mean as far as --

20 MS. BRISBIN: If an application is
21 filed.

22 MS. SZATKOWSKI: Well, we have a
23 column that says accepted for filing, and that's the
24 state registered application.

25 MS. KELLY: What you're saying --

1 MS. SZATKOWSKI: We can put it on
2 there and just not have it filled in on the date of
3 the state register.

4 MS. KELLY: I see what you're saying.

5 MS. BRISBIN: Yeah.

6 MS. KELLY: So you want to know if we
7 receive the application, it just hasn't -- well,
8 we'll talk to Ashley and see if -- we don't want to
9 publish information that's inaccurate. So we'll
10 talk -- I see what you're saying though, whether
11 we --

12 MS. BRISBIN: Yeah, because there's
13 going to be that time period, and so if it's -- and
14 the concept is: Will people -- can't necessarily
15 rely on the end of the month summary as the
16 complete --

17 MS. BAILEY: If it's going to reflect
18 what's in the state register, if somebody files
19 after the second Friday of the month --

20 MS. BRISBIN: Right.

21 MS. BAILEY: -- it will be six weeks
22 before it is published in the following month state
23 register. And if you're looking at what's going on,
24 the number of applicants in a particular county,
25 there could be four or five applications that are

1 sitting out there that you don't know about that you
2 don't have any way of --

3 MS. KELLY: Okay.

4 MS. BAILEY: -- responding.

5 MS. KELLY: I see that's --

6 MS. BRISBIN: Yeah. So that's --

7 MS. BAILEY: So I think if you have a
8 column that just says received.

9 MS. KELLY: Well, no, I understand.
10 If it were accepted and not published yet --

11 MS. BRISBIN: Yeah.

12 MS. KELLY: Well, we'll definitely --

13 MS. BRISBIN: Yeah, that's --

14 MS. KELLY: -- and maybe we can
15 publish it every two weeks or so. But we'll look
16 into whether we can do that.

17 MS. BRISBIN: And that's more to
18 minimize the inquiry, you know --

19 MS. KELLY: Yeah. Sure.

20 MS. BRISBIN: -- so there's not this
21 constant --

22 MS. BAILEY: So we're not always
23 calling in --

24 MS. KELLY: No, I --

25 MS. BAILEY: -- and leaving --

1 MS. KELLY: No, and this is good
2 information.

3 MS. BAILEY: -- voicemails.

4 MS. KELLY: That's why we're having
5 this meeting. Because we -- you know, this is --
6 instead of -- this is your chance to tell us how to
7 do our job better, so we do appreciate it. So we'll
8 make note of that.

9 And who's next? Anybody? Okay, I know
10 other people have questions or have -- yes.

11 MS. THARS: Paula Thars, here on
12 healthcare. I just have a question specifically
13 about the application, and for anyone that's scared,
14 I've done five of them, they're not hard, they're
15 tedious.

16 But now that the criteria has changed for
17 methodology, we have no more numbers to work off of.
18 So the application -- there's going to be a lot of
19 things that are not applicable. So I guess we really
20 do need something to do with the application where we
21 can go through -- because a lot of the stuff ties into
22 the methodology answering the questions, and if we're
23 not using that criteria anymore, there's a lot of
24 things that you're thinking, okay, I mean, do I really
25 need to do all the census data and all the other stuff

1 because it's not applicable anymore because we're doing
2 it based on more arbitrary letters of need, you know,
3 people not receiving service.

4 So I guess if there could be a way to do
5 an updated application, specifically to home health
6 that's not facility-based -- there's already, when you
7 do it for home health, a lot of nonapplicable transfer
8 agreements that they always made us apply for, but
9 really never, you know, made any sense for us. Would
10 there be a way to do that?

11 MS. MURDOCK: Well, the application
12 itself and the application process, all of that is
13 prescribed by regulation. So changing the format
14 itself, the actual application, is more complicated
15 than just --

16 MS. THARS: Or just letting us know
17 for home health what really would tie back to the
18 methodology numbers that are no longer there, if
19 that makes sense.

20 MS. KELLY: Well, that's part of why
21 we wanted to have this meeting, because that was the
22 questions we were receiving about ideas like how --
23 you still have to show need, so you --

24 MS. THARS: But how, arbitrarily, it's
25 different. Yeah, we don't have a number to use

1 where, okay, there's a hundred people not receiving
2 home health services anymore.

3 MS. KELLY: And that's -- that's part
4 of the challenge, that's part of why we're welcoming
5 this comment on this, to discuss ideas. And let me
6 just say a disclaimer, I guess. We're not -- we
7 haven't started reviewing any of the new, I don't
8 think, health plan -- I mean, the new home health
9 applications yet, so we don't have -- you know,
10 we're -- we're not -- we don't know how it's been
11 proposed yet. Now, we may -- we have a few.

12 MS. MURDOCK: Yeah, we started review,
13 but, you know, we're expecting a lot more. And so
14 we have -- we're not at the point now where we see
15 trends in how applicants are documenting the need.

16 And so -- and it's a very good question.
17 That's kind of the question of the day, is how do you
18 do that. And so this is -- this is new to all of us,
19 and I know we have some -- some folks here who have
20 some ideas about how to have documentation. I'm
21 hoping, at some point, that they can share them.

22 MS. THARS: I can go there, too.

23 MS. MURDOCK: But I didn't mean to cut
24 you off.

25 MS. THARS: No, but when we're talking

1 about regulation stuff, I think the other thing is
2 when we talk about sending it out, it's being opened
3 up and everyone's worried about everyone running out
4 and 500 agencies in one county, I just want to make
5 sure that everybody in the department understands
6 that home health is not necessarily Medicare
7 certification. You know, home health encompasses
8 what we do, pediatric, and in a lot of other single
9 services, even.

10 Here's the problem with single services:
11 It doesn't fit in the criteria of home health, yet I
12 need a license to be able to contract with the
13 different HMOs and Medicaid who want single service
14 like wound care or, you know, something else.

15 So that need, I think, needs to be looked
16 holistically when we're looking at certified agencies
17 that want to concentrate on the Medicare population and
18 agencies that want to pick up, you know, the private
19 insurances, Medicaid HMOs, the Medicaid. And we get
20 calls all the time for, you know, why we went into it,
21 for a lot of those payer groups. Workers' comp, for
22 example -- we got a call from MUSC Friday. They could
23 not find a home -- a certified home health agency that
24 would take a private pay because there were no codes in
25 their system for someone to pay privately.

1 And so, I mean, you know, the need, I
2 think, can be shown and I'd just like everyone to
3 remember because sometimes we get really caught up in
4 that Medicare dollar, the Medicare certification, but
5 home health is really holistic. It's care being
6 provided in the home, and there's lots of different
7 payers and lots of different people that require that.

8 MR. TOLBERT: So in terms of needs,
9 since there's no methodology in the plan, I assume
10 each one of us can develop the need to justify 25 or
11 50 patients in the second year of operation. Any
12 new methodology that makes sense to us, hopefully
13 it'll make sense to you.

14 MS. KELLY: That's probably the truth.

15 MS. BIGGERS: Yeah, that's right. And
16 I will just -- you know, just kind of reference in
17 following up to your question, the regulation in
18 Chapter 2, it spells out the -- what the application
19 questions are, and the B-11 question is the one that
20 primarily addresses need. And so even though, you
21 know, usually when people are filling out
22 applications, that's where they might reference the
23 state health plan standards in the answer to their
24 B-11, well, you know, still look at everything that
25 B-11 is asking for.

1 And so, essentially, between the plan and
2 that question, it will be up to the applicant to
3 demonstrate what they think that unmet need and
4 project, what they think the utilization will be and,
5 as Sam said, you know, kind of justify using their own
6 methodology, which we would then review.

7 MS. BAILEY: So I could list 25 people
8 and give you their phone numbers?

9 MS. BIGGERS: Well, I'm not going to
10 tell you which methodology to use, but --

11 MS. BAILEY: Okay.

12 MS. BIGGERS: -- we will review
13 whatever methodology the applicant provides.

14 MR. TOLBERT: I'd go with that one if
15 I were you, Lynn.

16 MS. BAILEY: Yeah.

17 MS. BRISBIN: So the question --

18 MS. BAILEY: All right.. Endorsed by
19 Sam Tolbert.

20 MS. BRISBIN: -- so the question for
21 Maggie will be -- or the department will be: When
22 Lynn and Sam submit their clearly different
23 approaches, what is the department going to utilize?

24 MS. MURDOCK: That is a very good
25 question. And, you know, I can't -- we don't -- we

1 can't -- at this point, we haven't established a set
2 policy outside of the methodology that we have
3 adopted in the state health plan. It's going to --
4 you know, we're going to have to look hard at all of
5 those standards. You know, it'll be -- the burden
6 will be on the applicant to show us -- to
7 demonstrate to the department that there is need
8 and, you know, all of the -- all of the things in
9 B-11. Not all of those questions are about numbers.

10 You know, just -- and there are many ways
11 that you can -- you can support the contention that
12 there's a need for whatever service it is that you want
13 to provide in that community, in that community.

14 If there is something that, you know, is
15 just, hypothetically, if there is a single service
16 service, you know, that would be -- you know, we would
17 need to know why -- you know, is there a need, show us
18 there is a need, and then looking at all the other --
19 you know, the purpose of CON, we have four main
20 purposes, cost containment, one of which is to prevent
21 unnecessary duplication of services. So tell us why
22 you're not duplicating other services.

23 Instead of just looking at a number,
24 which we don't have anymore, there's got to be -- we
25 need other information. And the burden has -- is on

1 the applicant to show us why that that's a necessary
2 service and not a necessary duplication and all the
3 other things that, you know, that we need to see.

4 MS. BRISBIN: Has the department
5 quantified what would be evidence of
6 under-utilization or is that going to be --

7 MS. MURDOCK: We have not quantified
8 that. Again, we have -- you know, we -- we -- as a
9 result of the robust debate about home health
10 methodology, these sort of quantifications, we -- we
11 don't have those. We have what's in the plan. And
12 so that's what -- that's how we will be looking at
13 all of these. And it will be difficult, frankly,
14 but -- but it's going to be -- you know, we have not
15 come up with a numerical quantification of how to
16 show any -- outside of what's already in the --

17 MS. BRISBIN: And then the other
18 question I have, just from some of my clients:
19 Where you get multiple letters of support from
20 physicians who say I will -- I will refer 30
21 patients to you -- I will refer 30 patients to you
22 who I believe aren't being met, and that's going to
23 be the demonstration of need for that rural county,
24 but another applicant files another application for
25 that same county but then the -- gets a letter from

1 that same physician for 30 patients, how is the
2 department going to make that determination as to
3 whether there really exists a need for those
4 patients?

5 MS. BIGGERS: I think it's not going
6 to depend just on, you know, from your example, this
7 one letter of support from a physician in two
8 different applications. It's going to depend on the
9 totality of all of the evidence that's submitted by
10 each of the applicants. And sometimes that might be
11 a one-on-one review of just this application,
12 sometimes it might be comparison review to see, you
13 know, if there are multiple applicants in the same
14 area, you know, reviewing them across the way.

15 So I don't think that -- and certainly,
16 you know, we're going to apply the state health plan
17 and the regulation, which have not put, you know,
18 quantifying numbers, so we are not going to provide
19 quantifying numbers on our own that are not in the plan
20 or in the regulation. So it'll depend upon what come
21 in -- what comes in in the applications and the review
22 of the totality of what is presented.

23 And David, did you have a comment?

24 MR. LEVITT: Yeah, I was going to
25 say -- I know most people in the room are sort of

1 thinking home health, but this is not unlike many
2 other services that don't have a quantified need.
3 So I think, you know, we're getting hung up on there
4 used to be a quantified need, now there's not.
5 Well, many services don't have a quantified need.

6 Ashley's exactly right, the burden is on
7 the applicant to demonstrate how they comply with the
8 standards in the plan, there are nine of them, they're
9 pretty clear, and even give some examples on how to
10 demonstrate the need. It also says it's not limited to
11 those examples. So I don't see it that different from
12 some of the other services that don't have a calculated
13 need.

14 MS. BIGGERS: For example, inventory
15 surgery facilities.

16 MR. LEVITT: Right.

17 MS. BRISBIN: Now, will home health
18 still be required to submit jars(phonetic)?

19 MS. BIGGERS: Yeah.

20 MS. BRISBIN: Okay.

21 MS. BAILEY: When are the --

22 MR. TOLBERT: May I ask a question
23 about jars?

24 Well, Lynn's got her hand up. She can
25 ask the question for me.

1 MS. BAILEY: Do we have a date for the
2 receipt and publication of the 2014 joint annual
3 report from home health agencies? The plan was
4 based on 2013.

5 MR. LEVITT: I know they haven't been
6 requested yet.

7 MS. KELLY: I don't know.

8 MS. MURDOCK: I don't know the answer
9 to that, but I'll find out.

10 MR. TOLBERT: DHEC hasn't
11 authorized -- finish it, David.

12 MR. LEVITT: Yeah, they haven't --
13 they haven't sent those out to the agencies yet, so
14 it'll be quite some time. If everyone responds
15 quickly, which no one does, then it'll be sometime
16 after that, but --

17 MS. BAILEY: So the most current
18 publicly available utilization data for home health
19 is what was in the recently approved state health
20 plan?

21 MR. TOLBERT: That's it.

22 MS. THARS: And just to follow up on
23 that, jars, because you have to show need per
24 county, so I had put a couple of requests to see --
25 and this is a good time to ask: It used to be --

1 Misty used to be on CON and used to be the jars
2 person, so when you would put a request on can I get
3 Charleston County jars, you know, that pulled out
4 for all the home health agencies, you know, because
5 it's just in the state plan, it's just all grouped
6 together by agency, which might include, you know,
7 several counties, who would be the person we could
8 direct those specific questions to now that the
9 department's all new?

10 MS. BAILEY: Byron.

11 MS. THARS: Who?

12 MS. BAILEY: Byron over at the office
13 of fiscal and --

14 MS. THARS: Oh, okay, over there.

15 MS. BAILEY: Yup. Yup.

16 MS. THARS: CON used to handle that.

17 MS. BAILEY: Yeah. Tell them you want
18 the Lynn Bailey report.

19 MS. THARS: Okay.

20 MR. TOLBERT: May I ask a question
21 about the application, particularly in Part C? That
22 relates to the facility description and the space
23 program, a whole lot of information that really it's
24 intended for a facility that's going to be housing
25 patients, but these are offices.

1 And a few home health application -- or
2 several at the time -- it was a pain in the rear to try
3 and identify a physical office, get a sketch of that
4 office, some of us may not want to rent an office,
5 putting well in advance and getting it CON approved, so
6 I just don't think those really apply to home health
7 and patients treated in the home. The office is just a
8 administrative space.

9 And it would be a whole lot easier on us
10 just to say those parts really just don't apply to home
11 health, because it's not a facility that treats
12 patients in the building.

13 MS. MURDOCK: Well, I can't say, you
14 know, home health does or does not need to answer X,
15 Y, Z question. But one -- many times, applicants
16 will decide which parts of the application are not
17 applicable to their application, and then they will,
18 you know, answer were they not applicable or
19 indicate, you know, that this is not applicable to
20 our application.

21 One way that -- and I'll just speak for
22 myself, when I'm reviewing an application, I think if
23 an applicant answers that that way and I disagreed and
24 thought that we really did need that, that would be
25 a -- an opportunity for the department to request that

1 information, you know, as part of the -- in order to --
2 you know, so that we could make the application
3 complete, so --

4 MR. TOLBERT: Understood.

5 MS. MURDOCK: -- I mean, I would -- I
6 think it's safe to say that, you know, the applicant
7 deciding not to answer a question like that, based
8 on that type of logic, you know, if we disagree, we
9 can let the applicant know we disagree.

10 MR. TOLBERT: With all of us here, it
11 would be nice to think about that.

12 MS. KELLY: Well, that's a good point.
13 I think we'll take notes.

14 MR. TOLBERT: And I understand --

15 MS. KELLY: And some of these
16 questions, we'll take notes. And if we can give
17 clear answers within a couple of weeks after this
18 meeting...

19 MR. TOLBERT: Am I the only one that
20 thinks it would be a lot easier not to have to deal
21 with the --

22 MS. BAILEY: No.

23 MR. LEVITT: And I think -- along with
24 that same point, some of the questions asked, if
25 you're going to -- if you don't own the building,

1 identify the owners of the building, the percentages
2 of that ownership, and all that, and that's very
3 difficult coming from a rental space to get that
4 information.

5 MR. TOLBERT: Well, you're supposed to
6 get the financial liability --

7 MR. LEVITT: Exactly.

8 MR. TOLBERT: -- and get the owner of
9 the building --

10 MR. LEVITT: That's right.

11 MR. GRICE: I'm Joel Grice, managing
12 director of health from Grice & Whiteside, LLC.
13 Several years ago -- and this was the only
14 problem -- when I submitted the applications for
15 home health, it was absurd. We were required, in
16 additional information, to give the floor plans of
17 the office including the restroom, because the
18 original one didn't have a restroom, we had to do
19 that.

20 And the problem is a home health agency
21 is not a healthcare facility. It does not follow the
22 definition of a healthcare facility. And that's why I
23 agree with both Sam and David. We need to be
24 reasonable on this and not require ridiculous
25 information.

1 MS. KELLY: Okay. Well, we'll try to
2 get some clarification.

3 MR. CHIN: And for the record, the
4 same question is asked for licenses. And they
5 clarified that we didn't have to provide the owner
6 information when we submitted the application a
7 couple years ago.

8 MS. KELLY: Okay. So we'll try to get
9 out -- some of these issues just -- we'll identify,
10 and if we can get back to you with a clear answer
11 and help the application process go more smoothly,
12 that's the intent of this thing. So we'll
13 definitely look into that.

14 MS. BAILEY: I think y'all have,
15 within your authority -- I'm sure Ashley will
16 disagree with me -- to just issue guidelines and
17 preferences to facilitate the administrative process
18 and, you know, which are -- which are the critical
19 questions. None of these are long-term care
20 facilities. So any question that lands in relation
21 to long-term care is going to get nonapplicable.

22 And, you know, what licensing needs to
23 look at, because licensing needs to know where your
24 physical office is, where your financial and medical
25 records are. And, you know, those kind of pieces of

1 information, I think, are critical to provide to the
2 department. Anything that licensing is going to need,
3 CON ought to need.

4 But, you know, do you have electrical
5 service, are you appropriately zoned, you know, do you
6 have utility for water and sewer and natural gas, you
7 know, that's important if you're an ambulatory surgery
8 center, you got a physical plant that you operate in.
9 But, you know, pretty much most of everything in
10 attachment -- or Part C, except for the indigent care
11 plan --

12 MR. TOLBERT: Correct.

13 MS. BAILEY: -- is, in terms of a
14 service, bullshit.

15 So I think if you all tell everybody
16 that, you know, the license -- the regulations require
17 that these questions be asked, but it's okay for home
18 health, from the staff's perspective on this, and
19 everybody knows this up front to answer N/A, we'll all
20 be happy. I know Sam will.

21 MR. TOLBERT: Well, we -- it would be
22 very helpful to have some direction so we all know
23 what to do because --

24 MS. BAILEY: Common administrative
25 guidelines.

1 MR. TOLBERT: -- without it, we have
2 to go to the nth degree to ensure it's 100 percent
3 complete in case somebody challenges us. But with
4 your guidelines, we are more comfortable doing -- a
5 little easier on everybody.

6 MS. BAILEY: And Ashley will know
7 because she's been through enough appeals, so --

8 MR. LEVITT: I think guidelines would
9 be helpful but, I mean, you're going to have 40, 50
10 applications within a week that wouldn't have had
11 the benefit of those guidelines. So I think it
12 might be helpful in the future, but we already have
13 a bunch doing whatever they need to do.

14 MS. BAILEY: Yeah, but then they'd
15 have 150 that don't, you know, kill a lot of trees
16 for -- with useless information.

17 MS. BRISBIN: Quick question: Getting
18 back to the patient projections for the 25 and 50
19 patient need threshold, it -- the department still
20 is going to have to review whether it's financially
21 feasible; is that right? Just because -- meaning
22 just because an applicant projects that there is
23 some need for 25 patients in a rural county or 50
24 patients in a nonrural county, that doesn't
25 necessarily trigger for you that this is a

1 financially feasible project; is that accurate?

2 MS. KELLY: Yeah, that's absolutely
3 correct, yeah.

4 MS. BRISBIN: Yeah.

5 MR. THOMAS: I have a question about
6 the 25, 50 and -- if you don't make your thresholds
7 within two years as an applicant and you're supposed
8 to, I guess, surrender your license, correct?

9 Is that going to also apply to
10 non-applicants that -- you know, existing providers in
11 counties that don't make their numbers? As you say,
12 annual projection right now, I know which one --

13 MS. BIGGERS: Yeah. I have to go
14 back -- and I think we would -- whatever standards
15 were in the plan at the time an application -- under
16 which the application was approved, those are the
17 standards we would apply. So if the last plan had a
18 similar standard, it would apply to all those that
19 were approved under that.

20 MS. KELLY: Okay. Anybody else? Any
21 questions from the --

22 MS. BAILEY: Do you want to do a quick
23 survey to see how many of us are going to file how
24 many applications so that you know whether you're
25 going to get 150 or 250?

1 MS. KELLY: Sure.

2 MR. TOLBERT: Or does that concern --

3 MS. BAILEY: Or is anything over 35
4 going to overload the system and just, you know --

5 MS. KELLY: I mean, I -- if people
6 want to -- I don't know, there's so many people
7 here, it would be hard to be able to quantify that.
8 I'm sure we'll know that soon enough.

9 (Simultaneous Cross-talk.)

10 MS. BAILEY: -- survey.

11 MR. TOLBERT: Well, some of us are
12 predicting in excess of 200. Is that a good number?

13 MS. COLEMAN: And so many not here to
14 have a number -- put a number out there.

15 MS. BAILEY: I'm thinking 200 is a
16 good number.

17 MS. MURDOCK: We're expecting many.

18 MR. TOLBERT: Over the next three
19 weeks?

20 MS. KELLY: All right. Well, we got
21 the entire health regulation staff, training --

22 MS. BAILEY: My problem is I got two
23 AFCs coming in getting mixed in with all this. I've
24 got some other projects that are going to come in in
25 addition to the myriad of home health applications

1 and, you know --

2 MS. KELLY: I -- we're working on -- I
3 really feel confident that we -- we're going to get
4 this done, and we're going to meet the timelines.
5 We're going to -- we have -- like I said, we're
6 adding staff to the office, we have other people
7 within the agency that have -- if we get a lot more
8 applications than we expect, I mean, we might have
9 to add more staff. And we'll consider that as we go
10 on. But the agency is committed to doing what we
11 need to do.

12 MS. BRISBIN: Okay. I actually have
13 one more question: The concept of, you know, you
14 have to project your timeline for coming on board
15 and being able to care for Medicare certified if
16 you're going to care for Medicare certified, for
17 the -- for the folks who went and expanded during
18 the hiatus and have their licenses on appeal so
19 their licenses are continuing, and they are
20 supposedly continuing their Medicare certification,
21 that's going to be measured up against folks who are
22 starting out from the beginning, and is the
23 department going to weight those timelines the same?

24 MS. MURDOCK: Are you asking from a
25 CON standpoint or from the -- because I can't

1 answer --

2 MS. BRISBIN: Well, and -- just from
3 the CO -- I mean, that's your -- that's your call.
4 But there's going to be a marked advantage for those
5 who have -- who expanded during the hiatus and are
6 Medicare certified. And when they go back to get
7 themselves a CON, they will say, well, we're already
8 Medicare certified, so day one of our license, we're
9 going to be able to serve these patients in a more
10 quicker time frame whereas there are going to be
11 other applicants who are seeking to go into that
12 county who may have to go through the Medicare
13 certification process which may take longer in the
14 initial Medicare certification. So has -- has that
15 been discussed about how you're going to measure
16 that?

17 MS. MURDOCK: We have not discussed
18 whether -- I mean, from a CON standpoint, we will
19 review the applications as they come in. And the
20 current certification status or lack thereof doesn't
21 in and of itself affect our CON review timelines.

22 MS. BRISBIN: Yeah. Oh, and I don't
23 mean the timelines, but I mean the evaluation of how
24 quickly an applicant can meet the need. That's --
25 that's actually --

1 MS. KELLY: And at this point, we
2 can't -- I can't address how we're going to look at
3 those applications. Every application is going to
4 stand on its own merits. And this meeting was -- is
5 really intended and -- to raise issues like that.
6 So it may -- it lets us take the information back
7 and it allows us to think about how we're -- you
8 know, how these applications are going to be
9 received, how many, how we're going to handle them.
10 So it's good to know what you're thinking. It'll
11 make us better process the applications.

12 MS. BAILEY: Can I venture out of the
13 home health and ask: Does -- the state health plan
14 now is a month old.

15 MS. KELLY: Uh-huh.

16 MS. BAILEY: Do we have a process in
17 place to begin the next state health plan?

18 MS. KELLY: We have -- well, we're --
19 we are going to breathe a minute. But, I mean, it
20 is part of the functions within the agency. Are we
21 starting it today? No, we're not starting it today.

22 MS. BAILEY: Okay.

23 MS. KELLY: But it will be --

24 MS. BAILEY: Well, data is -- data is
25 critical.

1 MS. KELLY: Uh-huh.

2 MS. BAILEY: And for -- you know, for
3 those of us that represent clients that are not
4 hospitals, hospital -- and through the association
5 has a -- has a very sophisticated data sharing
6 information that the rest of the facilities and
7 services out there don't. So we are heavily
8 dependent on what is publicly available. And
9 historically, the joint annual reports have been
10 critical to that. And there used to be a lot of
11 data available through what is now OFRA that is no
12 longer readily available. You have to call up and
13 ask for it. A lot of times, it used to be free, now
14 there's always a charge.

15 So, you know, just sort of advocating
16 that you can't do good planning without good data, and
17 good data is -- you know, data is terribly important.
18 And please do not overlook that.

19 MR. TOLBERT: Shelly, let me ask a
20 question: Some of us that do just CON consulting
21 might want to stay and have -- continue that little
22 dialogue, but I'm not sure everybody else is -- who
23 may not be interested in that, just to talk general
24 about the state health plan and some of the things
25 like Lynn has mentioned, if you're willing to stay a

1 few minutes after we adjourn.

2 MS. KELLY: Yeah, that would be fine.
3 I'm fine if anybody -- and anybody is welcome to
4 stay.

5 Do you -- does anybody else have
6 questions? Or does anybody have their application with
7 them they want to drop off?

8 MS. THARS: I just want to say,
9 Charleston County, ten people put in tomorrow, and
10 we're all projecting 50 patients. How do you make
11 the decision when to stop saying, okay, they're all
12 projecting the same 50 need and when to stop? Do we
13 all go head-to-head or do you -- are you just -- I
14 mean, is that arbitrary right now, we don't know
15 what's going to happen?

16 MS. KELLY: No, I mean, well, that's
17 what we're -- we need to see the applications and --
18 maybe defer to Ashley here.

19 MS. THARS: Is it a possibility they
20 can all -- you know, we can all go head-to-head and
21 do a public hearing and the best application wins or
22 like Beaufort and the rest of them?

23 MS. BIGGERS: Well, it -- I think
24 we'll have to wait until we see the applications --

25 MS. THARS: Okay.

1 MS. BIGGERS: -- to know. I mean,
2 either is a possibility. We'll have to wait and
3 see.

4 MS. MURDOCK: And always -- you know,
5 we're -- we -- if you have any questions or
6 comments, don't hesitate to contact us and, you
7 know, we -- we like, you know, we don't want to make
8 it hard for you, and we would always like to help as
9 much as we can.

10 So don't -- if there's something that
11 you -- that you want to know or want to say after
12 today, then we've got the coninfo email, I promise we
13 look at those all the time, and believe it or not, we
14 respond to those as well. And it is a very good
15 vehicle for letting -- because everyone on the CON
16 staff has access to the coninfo email. So if there's a
17 question -- you know, depending on the nature of the
18 question, all of us will have a chance to look at it,
19 and it's a really good way to get information to us or
20 to -- or to ask questions.

21 So, you know, that's a resource, and then
22 certainly call and we'll do the best we can to answer
23 your questions. You know, don't let our upcoming
24 avalanche of CON applications scare you away from
25 asking us for help or information, because we're here

1 to -- you know, we're here for service. That's what we
2 do. So that's why we're here.

3 MS. BRISBIN: As to Sam's suggestion
4 that the consultants kind of stay and talk a little
5 bit more, it was my understanding that that was the
6 primary -- well, not the primary, but one of the
7 reasons why we were going to have an open forum, is
8 to actually have that discussion in an open forum,
9 so --

10 MR. TOLBERT: And I wasn't talking
11 about home health.

12 MS. BRISBIN: Yeah. Okay.

13 MR. TOLBERT: I got some -- we have
14 some questions about some other services.

15 MS. BRISBIN: Sure.

16 MR. TOLBERT: You're welcome to stay
17 if you want.

18 MS. KELLY: Yeah, anybody's welcome.
19 I mean, that's -- so if anybody --

20 MR. TOLBERT: So I'm not going to talk
21 about home health once -- once this adjourns.

22 But I do have a point. I think the state
23 health plan in the standards allows the department to
24 approve as many new licenses for counties as they are
25 comfortable those applicants can do what they say they

1 were going to do in the application.

2 MS. THARS: Unless we're all showing
3 the same need. You know, we're all saying I can get
4 50 patients out of this hospital, then who gets them
5 for -- you know, are we all going to --

6 MR. TOLBERT: Well, we have to make
7 our best case.

8 MS. THARS: Well, that's a -- yeah.

9 MR. TOLBERT: Yeah. But that's --
10 that's how it works. As David points out, there are
11 many other services, and we'll just see what
12 happens.

13 And to the extent that we're counting --
14 all counting the same patients, that they may judge it
15 to be a problem. If it looks like they're looking at
16 different populations, absolutely not a problem.

17 MS. BRISBIN: And that remains to be
18 seen.

19 MR. TOLBERT: Yeah, and that remains
20 to be seen.

21 MS. KELLY: All right. Anybody else?
22 Well, we thank you all for coming.

23 MS. BAILEY: Thank you.

24 MS. KELLY: And I'm sorry for the
25 accommodations. Thank you to those that -- who were

1 outside for --

2 MS. BAILEY: Thank you for meeting
3 with us. Let's give them a round of applause.

4 MS. KELLY: And if anybody wants to
5 stick around and ask questions and talk to us,
6 that's fine, too. We're going to be around.

7 (The meeting was concluded at 11:02
8 AM.)

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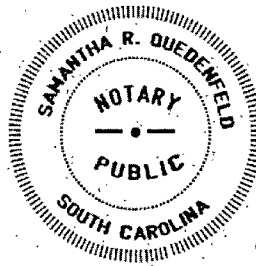
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1 CERTIFICATE OF REPORTER

2
3 I, Samantha R. Quedenfeld, Notary
4 Public for the State of South Carolina at Large, do
5 hereby certify that the foregoing transcript is a
6 true, accurate, and complete record.

7 I further certify that I am neither
8 related to nor counsel for any party to the cause
9 pending or interested in the events thereof.

10 Witness my hand, I have hereunto
11 affixed my official seal this 27th of September,
12 2015 at Charleston, Charleston County, South
13 Carolina.



Samantha R. Quedenfeld

18
19 Samantha R. Quedenfeld
20 My Commission expires
21 January 13, 2025
22
23
24
25

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1 STATE OF SOUTH CAROLINA) IN COMMON PLEAS
2 COUNTY OF RICHLAND) COURT
3)
4 AMEDISYS SC, L.L.C.,)
5) TRANSCRIPT
6 -V-) OF
7) RECORD
8 S.C. DHEC,) 2016-CP-40-00818
9 DEFENDANT.)

10

11

FEBRUARY 22, 2016

12

RICHLAND, SOUTH CAROLINA

13

14 B-E-F-O-R-E:

15

HONORABLE CASEY L. MANNING, JUDGE;

16

17

A-P-P-E-A-R-A-N-C-E-S:

18

FOR THE PLAINTIFF:

19

STEVE MATTHES, ESQ.

20

ASHLIE BRIGGERS, ESQ.

21

22

FOR THE DEFENDANT:

23

STUART ANDREWS, ESQ.

24

WADE MULLINS, ESQ.

25

I-N-D-E-X

PG.

MOTION:

3

CERTIFICATE OF REPORTER:

54

E-X-H-I-B-I-T-S

PLAINTIFF'S

EXB.

NO.

1. SECOND AMENDED ORDER.

2. MRI AT BELFAIR VS. SC DHEC CASE.

3. TRANSCRIPT OF MEETING, SEPTEMBER 18, 2015.

1 (The following proceedings were held on
2 February 22, 2016.)

3 THE COURT: Is everybody ready?

4 MR. MULLINS: Yes, sir.

5 MR. MATTHEWS: Yes, sir, Your Honor.

6 THE COURT: Who all wants to intervene?

7 MR. MULLINS: Your Honor, Wade Mullins. We filed
8 a motion to intervene on behalf of five home health
9 providers. Mr. Andrews is here on behalf of, I believe,
10 two. They filed two separate -- or filed a separate motion
11 to intervene. We filed one motion to intervene on behalf of
12 the five.

13 THE COURT: All right.

14 MR. ANDREWS: And we have two, Your Honor.

15 THE COURT: All right. It's all about the same
16 thing, isn't it?

17 Y'all don't have any objection or do you?

18 MR. MATTHEWS: Well, only to the extent that it
19 may delay the proceeding. This is a question of law. It's
20 a question of whether or not the State health plan meets the
21 requirements of the code. The Supreme Court has ruled on a
22 similar issue that this is a question of law, no fact,
23 discovery is needed. So we think that DHEC --

24 THE COURT: All right. They're all in the same
25 boat.

1 MR. MATTHEWS: They're all in the same boat. We
2 think that DHEC is fully equipped to present the argument on
3 the other side and to defend it. So we object on the basis
4 that it may slow it down, but we acknowledge they do have an
5 interest.

6 MR. ANDREWS: Your Honor, there are actually two
7 particular issues that I would like to draw the Court's
8 attention that distinction our position from DHEC's. One is
9 that there are 20 counties in which my clients, National
10 Healthcare Corporation, and Prudent Healthcare, have filed
11 CON applications in which Amedisys has no interest, no
12 operations at all. And the scope of their relief, we
13 believe, is far too broad and would adversely affect our
14 clients.

15 The second issue relates to the setting of the
16 bond. Our clients would be damaged if the Court were to
17 issue a preliminary injunction. And by the issuance of that
18 injunction relief --

19 THE COURT: So you represent the parties that
20 they've already approved?

21 MR. ANDREWS: No, sir. Those are applications
22 that are pending.

23 THE COURT: Pending. All right. 20 pending?

24 MR. ANDREWS: No, actually, there are 20 counties.
25 There are over 40 pending.

1 THE COURT: Okay.

2 MR. MULLINS: And Your Honor, we're in a similar
3 situation. Again, I represent five entities. They have 39
4 applications that are pending, many of which are eligible
5 for a decision this week. So I agree with Mr. Andrews's
6 argument, we believe that we do have distinct arguments and
7 interest that we need to protect. If I'm understanding Mr.
8 Matthews, I don't -- you know, if the Court is inclined to
9 go ahead and grant the motion --

10 THE COURT: I don't think he necessarily
11 disagrees, he's just not going to consent to it.

12 MR. MATTHEWS: Not going to consent and would urge
13 the Court to consider it on an expedited basis because there
14 are interest at stake here.

15 THE COURT: Yeah, okay.

16 So you're in, how is that?

17 MR. MULLINS: Your Honor, if you granted our
18 motion to intervene, then we're in.

19 THE COURT: That's what I said, you're in.

20 MR. MULLINS: The pending motion was filed by
21 Amedisys, so I believe it's their motion.

22 MR. MATTHEWS: Your Honor, we're here actually on
23 a motion that was scheduled with regard to a temporary
24 restraining order and a preliminary injunction. We filed
25 that motion, we, Amedisys, the Plaintiff, filed that motion.

1 Shortly after filing the complaint in this action and we're
2 seeking injunctive relief against the implementation of one
3 portion of the state health plan insofar as it relates to
4 home health agencies.

5 At the time we filed that -- we get to the court
6 the afternoon that we filed it. As it turned out, that
7 didn't happen. We've accomplished service on opposing
8 counsel, you've got the opposition, you've got our
9 memorandum in support of the motion and DHEC's memorandum
10 and our position to the motion, so the matter is actually
11 briefed and no longer the posture of the TRO part of our
12 motion where we defend the posture of preliminary injunction
13 part of our motion. And I'd like to address that if I
14 might.

15 THE COURT: Go ahead.

16 MR. MATTHEWS: Your Honor, just by way of
17 background on how this -- on how this case came about, let
18 me set the table if I could. In South Carolina, the general
19 assembly has determined that in order to control health
20 cost, to ensure that adequate services are available
21 throughout the state where they're needed and that
22 investment isn't improperly or unnecessarily duplicated to
23 the detriment of everybody involved, a certificate of need
24 is required before certain healthcare facilities are billed
25 or required or before certain healthcare services are

1 provided. This is the certificate of need act that is set
2 forth by the general assembly with a statement of those
3 purposes that I just outlined. It's a mandatory provision.
4 No one can begin providing those services or -- without
5 first getting a certificate of need. DHEC is the
6 administrative agency charged with overseeing that program
7 with certificate of needs applications and with either
8 granting or denying those needs.

9 One of the types of services that requires a
10 certificate of need is home health services. If let's say a
11 nurse goes to an elderly person's home or recuperating
12 patient's home to provide certain services, those are the
13 sorts of things covered here. There's a separate act that
14 governs that, which is the home health act, and that also
15 requires a certificate of need and it refers back to the CON
16 act of set up procedures as to how that's done.

17 A certificate of need application, once it's in
18 the hands of DHEC has to be measured and have something
19 called the state health plan. The general assembly requires
20 that every two years a state health plan be adopted which
21 sets out inventory of services and facilities already
22 available on a county-by-county basis, projections of future
23 need so that someone who wants to get in the business can
24 say okay, there's a need in Cherokee County, I can go there
25 and try to fill that. There's not a need in Edgefield, I

1 don't need to spend my time worrying about that. It also
2 gives DHEC the capability once they get the application in
3 to look at it and say is there a need that's being serviced
4 by this into the service area. It also gives existing
5 servers the ability to look at the application and say yeah,
6 they've identified a need pursuant to methodology of the
7 state health plan or no, they haven't, we can oppose it on
8 that basis. So everybody's guided by what's in the state
9 health plan on that. It's mandatory. The state health plan
10 is legally enforceable. The Court of Appeals --

11 THE COURT: Your position is they didn't follow
12 the health plan for 2016?

13 MR. MATTHEWS: Our position is that the current
14 health plan doesn't meet the statutory requirements for what
15 has to be in the state health plan for health services.
16 There was a health plan that was done in 2012 and '13 and
17 that was fine. You can see that as an attachment to the
18 complaint, the relevant parts of it on home health services.
19 Then there was a gap.

20 You may remember that the general assembly upheld
21 the governor's veto of funding for the certificate of need
22 program. And there was a big question as to what did that
23 do to the program? Does it mean you don't need a
24 certificate of need anymore? Does it mean you need it and
25 just can't get it? No one quite knew what that meant until

1 the State Supreme Court in 2014 ruled in the Amisub of South
2 Carolina v. DHEC case that the lack of funding did not kill
3 the program, you still needed to have the certificate of
4 need and the general assembly came back with the next budget
5 and also funded. So it's now funded. Per the Supreme
6 Court, it's always been operational. It is a mandatory
7 requirement, the general assembly said so, the Supreme Court
8 said so. The Court of Appeals said it's a legally
9 enforceable document, the state health plan is, but it has
10 to meet the requirements set out in the statute for what a
11 health plan is supposed to do.

12 Once that gap was cleared up, a new state health
13 plan was adopted in August of this past year. It's the
14 2014-2015 state health plan, although it wasn't adopted
15 until August of 2015. The process for adoption is this.
16 There is a group called the state health planning committee.
17 It's an appointed body, they're not elected. They go
18 through a series of hearings. They review drafts and
19 proposals. They come up with a proposed state health plan.
20 They provide it to DHEC and the DHEC board then adopts it or
21 revises it, modifies it. The DHEC board is the body that
22 actually issues the plan. They did that in August of 2015.
23 And it's our position that they did not set out a
24 methodology for the determining need for home health
25 services.

1 If you would look in the attachment to the
2 complaint, just by way of comparison, attachment A has the
3 previous health plan. And on Page 12-13, that's Roman
4 Numeral 12-13, it sets out the need methodology in Paragraph
5 4. The need methodology creates statewide use rates for
6 four population groups, 017, 18, 64, 65, 74, 75 plus. Based
7 on the 2011 utilization addendum, 75 percent of these rates
8 are applied against the projected 2013 population for each
9 county, it's done on a county-by-county basis, to get a
10 total number of estimated patients in need. It then takes
11 the actual number of patients served in 2011, multiplies then
12 by the population growth factor to predict the number of
13 patients to predict the number of patients to be served by
14 the existing home health agencies in the county for 2013.
15 The projected number of patients served by existing agencies
16 is subtracted from the total estimated number of patients in
17 need. If there's a difference of 100 or more patients
18 projected to be in need, then another agency could be
19 approved for that county.

20 The next page is a long spreadsheet that
21 calculates for each county. It goes exactly through that
22 and shows where a county has a need for home health
23 services. So anybody under that plan, either DHEC or a new
24 applicant or an existing server who wanted to oppose an
25 application, they all know exactly what the rules are.

1 In the 2015 -- 2014-2015 plan, which is Exhibit C,
2 page 12-7, that's Roman numeral 12-7. It's set out in
3 Paragraph 3. That simply says the new home health agents
4 that may be approved if an applicant can demonstrate it will
5 serve 50 or more patients projected to be in need in a
6 nonrural county or 25 or more patients projected to be in
7 need in rural counties through evidence that may include,
8 but would not be limited to the following: Letters of
9 support, evidence of limited utilization and of limited
10 scope. But there's nothing that says what the methodology
11 is for projected need, what need might or might not exist in
12 any particular county.

13 So that leaves a question of what does an
14 applicant have to show? How can DHEC rule on an application
15 without it being automatically arbitrary and capricious? If
16 there's no standards, any decision is arbitrary and
17 capricious. Those are the two things the administration
18 decision does not want to be. And any particular for an
19 existing service, such as our client Amedisys. Whether or
20 not to spend money opposing application when the standards
21 are completely unknown.

22 THE COURT: If the standards are unknown, how do
23 they issue a certificate of need?

24 MR. MATTHEWS: Well, they haven't yet.

25 THE COURT: It's pending?

1 MR. MATTHEWS: It is. They're pending. The first
2 day they could issue --

3 THE COURT: But today they go into effect or some
4 could go into effect?

5 MR. MATTHEWS: Possibly. DHEC has to act within a
6 window of time. Today's the earliest day they can act on
7 those applications they have deemed complete. And they've
8 deemed complete -- 48 applications so far are deemed
9 complete. So sometime between today, February 22nd, and I
10 believe May the 22nd, DHEC can act on those at any point in
11 that window.

12 THE COURT: Okay.

13 MR. MATTHEWS: It's within their discretion.

14 To give an idea of how open this is and to
15 indicate DHEC's concern about this, DHEC convened in
16 September of 2015 an open forum meeting. And they had a
17 court reporter come in and transcribe it. It was a meeting
18 with DHEC staff and various participants in the home health
19 care agency. And I'll be happy to provide copies to the
20 Court and also to opposing counsel. Your Honor, if you
21 would look at Pages 24 through 25, at the bottom of 24,
22 there's an indication --

23 THE COURT: What line, sir?

24 MR. MATTHEWS: I'm sorry, at Line 20.

25 THE COURT: All right.

1 MR. MATTHEWS: Ms. Kelly, Ms. Shelly Kelly, who is
2 the deputy director of health services I believe at DHEC. I
3 think that was her title. Ms. Kelly indicates that the
4 reason why they're having the meeting is because they're
5 receiving questions about exactly how they were going to
6 implement the state health plan. She says well, that's part
7 of why we want to have this meeting because that was the
8 questions we were receiving about ideas like how you still
9 have to show need. And then another participant, Ms. Thars,
10 indicated how arbitrarily it's different. We don't have a
11 number to use. Okay, there's a hundred peoples not
12 receiving home health services any more. Ms. Kelly of DHEC,
13 who is superintendent over this program, says, And that's
14 part of the challenge. That's part of why we're welcoming
15 this comment on this to discuss ideas.

16 When you come a little bit further down at Line
17 12, you have Ms. Murdock, also from DHEC staff. Come down
18 to Line 16, she says, I'm so -- and it's a very good
19 question. That's kind of the question of the day is how you
20 do that and so this is -- this is new to all of us. And I
21 know we have some folks here, who -- that is participants in
22 the plan, who have some ideas about how to have
23 documentation. I'm hoping at some point that they can share
24 them.

25 So DHEC after the adoption of the state health

1 plan is trying to figure out from the participants in the
2 industry what their own health plan means. I mean, it's, I
3 think, clear from that that it doesn't have a real meaning.

4 And then if you come over to Page 27 at Line 8,
5 Mr. Talbert, who's not a DHEC person. Mr. Talbert says, So
6 in terms of need, since there's no methodology in the plan,
7 I assume each one of us --

8 THE COURT: Slow down. You said Page 27?

9 MR. MATTHEWS: I'm sorry. Yes, Your Honor.

10 THE COURT: What line?

11 MR. MATTHEWS: Line 8.

12 THE COURT: All right. Go ahead.

13 MR. MATTHEWS: Mr. Talbert, So in terms of needs,
14 since there's no methodology in the plan, I assume each one
15 of us can develop the need to justify 25 or 50 patients in
16 the second year of operation. Any new methodology that
17 makes sense to us, hopefully, it'll make sense to you. Ms.
18 Kelly of DHEC says, That's probably true. So whatever the
19 applicants want to put in, DHEC is indicating that's
20 probably going to be fine.

21 And then finally, from this document on Page 28
22 beginning at Line 20. And this is the question they posed.
23 So the question for Maggie Murdock, who's also with DHEC,
24 will be -- or the department will be when Lynn and Sam,
25 healthcare providers, submit their clearly different

1 approaches, what is the department going to utilize?

2 And Ms. Murdock of DHEC responded, That's a very
3 good question. And you know, I can't -- at this point, we
4 haven't established a set policy outside of the methodology
5 that we can adopt from the state health plan.

6 So in looking at the plan itself, which is really
7 all that's required, to measure the plan against the
8 statute, in looking at the plan itself, there's no
9 methodology set out for determining need, which has to be
10 done under the statute. That's a prerequisite. That's
11 mandatory that that has to be done. It hasn't been done.
12 And our position is that because it hasn't been done, DHEC
13 can't utilize that part of the state health plan. The rest
14 of it's fine. Hospitals, x-ray machines, MRI machines, you
15 know, all the other sources of things that require CONs,
16 we've got no issue with those. We're not in that business.
17 We're not challenging that. We're only focused on that
18 section 12 of the state health plan, which is the home
19 health services agency, where we don't believe that they
20 have adopted a plan that meets the requirements of state
21 law.

22 Now, in the memorandum of opposition to the
23 request for preliminary injunction, DHEC raised three
24 issues. And I would like to address those. A couple of
25 them were addressed already in our own motion memorandum.

1 One is the idea that generally injunctive relief
2 against a government agency is frowned on. And generally,
3 that's true. But the case that they cited, which is also
4 the same one that we cited on this point, is that injunction
5 against a state agency from following a state law is
6 generally frowned upon. The question here is whether or not
7 they have implemented a state law or have they not? And
8 it's fairly clear that they have not.

9 The next issue they raised is the likelihood of
10 the success on the merits. And they point to a case MRI v.
11 Bellfair. And I believe I've got a copy of that that I can
12 share with Your Honor.

13 MRI v. Bellfair was a case in 2008 decided by the
14 South Carolina Supreme Court in which there was a challenge
15 to the state health plan at that point as to whether or not
16 it met the statutory requirements to adequately show what
17 the needs were. The question there had to do with an
18 emergency MRI unit at a hospital. The hospital said, look
19 we're seven days a week, 24 hours a day. We need to have an
20 MRI unit available to us all the time. There was one mobile
21 MRI unit owned by a doctor in the area and he was opened
22 from seven -- from 7:00 a.m. to 6:00 p.m. Monday through
23 Friday. If somebody comes into the emergency room on a
24 Saturday, that's not good enough.

25 And what the state health plan said was that there

1 has to be, at least, one MRI unit available to a hospital at
2 all times. That's a fairly clear standard. It's a binary
3 switch, either you've got one available at all times or you
4 don't. The statute was absolutely clear on that point.
5 The -- that's not the situation that we're looking at in
6 this case, whereas I mentioned, DHEC was still after the
7 adoption of the state health plan trying figure out what did
8 that mean, how could they possibly implement and interpret
9 it.

10 So the Bellfair case is not at all on point with
11 this case. The merits are entirely different. The Bellfair
12 case is instructive primarily for a footnote, in which I
13 think it was Justice Pleicones, I can't recall who wrote
14 that, wrote that the question of whether or not health plan
15 matches the requirements of the statute is a legal question.
16 It's not a court, it's not a jury issue, it's not a fact
17 issue. There's no factual development that needs to be done
18 here, which is one reason why we didn't think it was
19 necessary to have interveners. The law is the law. That's
20 the primary teaching of Bellfair that's relevant to this
21 case. The actual result where they said yeah, that's
22 sufficiently objective there. You have one or you don't
23 have one, that's an objective test, unlike what we've got
24 here.

25 The third issue that DHEC raised also pointed to

1 the Bellfair case. And it was a situation that I think
2 actually helps make our case in this particular
3 circumstance. DHEC said that we have an adequate remedy of
4 the law, that the appropriate procedure would be to wait
5 until DHEC acts. If they grant a certificate of need to
6 someone in the county where we're located, then we go in and
7 request a contested case hearing. And that would
8 automatically stay the issuance of the CON, so the applicant
9 would be enjoined at that point until the whole thing is
10 resolved. And you run through the administrative law court
11 and then up through the appellate levels. And the whole
12 thing is stayed while you're there.

13 Well, we're asking for a stay now. What they've
14 told is we're entitled to a stay if we use another avenue,
15 which is the ALC. So all of the issue about whether or not
16 it's going to harm the interveners or delay their ability to
17 get in the service area is irrelevant. If we do what DHEC
18 is asking us to do, they're stayed anyway. So the stay is
19 really irrelevant from that standpoint. The question is do
20 we have to go that route or is the declaratory judgment act
21 appropriate avenue of relief? And we argue that it is the
22 appropriate level of relief for two reasons --

23 THE COURT: Well, what harm have you suffered so
24 far?

25 MR. MATTHEWS: The harm that we've suffered so far

1 is that we are now -- and we will today, today is our
2 deadline for filing an opposition to certificates of need
3 applications.

4 THE COURT: So, in effect, you're asking me to
5 make the decision of whether contingency that's yet to
6 occur?

7 MR. MATTHEWS: No, Your Honor, not a contingency
8 at all. What has already occurred is the state health plan
9 has been adopted by DHEC. And we're asking for a
10 declaration that it does not -- health service, home health
11 service, it does not meet the requirements of the statute.

12 Now, if we were to go in and follow DHEC's route,
13 which has opposed every one of these applications, there's
14 48 of them, there are other service providers like Amedisys,
15 who are existing service providers who might want to oppose,
16 what you're going to find is you'll have 48 different, more
17 as things progress, the interveners and their filings if
18 indicated, just among those interveners, they've got 93
19 pending CON applications at this point. Now, they may have
20 more tomorrow, but they've 93 right now.

21 So for every one of those, you're going to have a
22 contested case hearing in the administrative law court which
23 would do exactly what they are concerned about, which is
24 staying the outcome. So it makes no difference in terms of
25 staying the outcome. What it does is it ties up the courts.

1 It's going to tie up ALC judges for an indeterminate period
2 of time --

3 THE COURT: I'm not worried about what other
4 judges --

5 (Laughter.)

6 THE COURT: Okay. You know, but go ahead. I
7 don't feel sorry for the ALJs or the magistrates or anybody
8 else on any level. Let's get that straight. Go ahead.

9 MR. MATTHEWS: But in terms of the utilization of
10 resources, state resources, each one of those cases will
11 proceed on its own track. It will have its own discovery.
12 But they all have one common underlying issue, legal issue
13 that can resolve, for the most part, what's involved in that
14 case, and that is if the state health plan that they've
15 applied under and that DHEC is trying to figure out some way
16 to help them out, is that state health plan valid or not?
17 If it's not, then all those resources are --

18 THE COURT: What if it is valid?

19 MR. MATTHEWS: If it is valid, then DHEC is going
20 to have try to come up with some method to implement it and
21 try to make that method uniform across every one of these
22 applications even though all the applicants -- as we noted
23 in the transcript that I read from, every applicant will
24 come in with its own different methodology for describing
25 need. So each one of those will have to wind its way up

1 through the court to be decided is this an adequate
2 methodology here or is this an adequate there, or is this an
3 adequate methodology here? Unlike what the general assembly
4 is required is that there be a methodology approved in
5 advanced by DHEC, not after the fact when each application
6 comes in.

7 So the harm that we suffer is having to try to
8 analyze at the front end what application -- what standard
9 is going to be applied? Do we have any basis for contesting
10 it or do we not? We don't know what the rules are. DHEC
11 doesn't know what the rules are. We can't have an
12 administrative agency applying a major program of state
13 government where they don't know what the rules are. That's
14 the primary issue.

15 I think that one indication of how vastly
16 different this is is that over the past five years, there
17 were 25 different applications filed, CON applications filed
18 for home health services throughout the state. 25 over five
19 years. Since August of last year, five months, there have
20 been over a hundred that have been filed. That's a pretty
21 strong indication that something -- there's been some shift
22 in terms of how this program is put together. There are
23 people -- providers trying to get in when it looks like the
24 door is opened. And I will be absolutely frank, no one
25 knows quite what to do. Everybody is trying to get a place

1 in line. Today's the last day we can file an opposition, so
2 we're going to file oppositions just in case it turns out to
3 be necessary because this is our last day.

4 We've already filed ourselves application for CONs
5 in counties where we thought we wanted to go in and serve
6 just in case this program is the right way, but doing things
7 just in case is a horrible way to allocate resources,
8 especially resources of health care where misallocation is
9 one of the primary concerns of the government at all levels.

10 So we've got -- kind of going back to where we
11 are, we've got a plan that on its face doesn't match up with
12 the statute, which is what Bellfair says is necessary to
13 match it up to the statute. If it doesn't match, it's gone.
14 DHEC's own personnel in trying to explain it or to get an
15 explanation of it from outsiders acknowledge that they
16 really don't know how works, how it's going to work. They
17 want somebody else to tell them how their own plan is going
18 to work. That's not the way an administrative agency works.

19 In terms of the adequacy of remedy, it's a wholly
20 inadequate remedy. They have to go in 93 different times to
21 pursue this and answer the same legal question. Now, you
22 may say all right, why didn't we go to the ALC first? Why
23 didn't we challenge the state health plan in front of the
24 ALC back in August when it first came out? And the answer
25 to that is that's not considered a contested case. Someone

1 tried that about three years ago with regard to another part
2 of the state health plan. They went to the ALC and said
3 look, we're asking for a contested case hearing to say the
4 state health care plan doesn't match up with the statute.
5 And the administrative law court ruled on that and said, no,
6 this is not a contested case, sorry. You're out of luck.
7 That was Trident -- I think I've got a copy of that here
8 somewhere. I'll have to find that for Your Honor. Here.
9 It was in 2013. So we didn't have that option.

10 There are two options available to us at law. One
11 is wait and protest all 92, go through that whole process.
12 It ties us up, it ties DHEC up, it ties the applicants up,
13 it ties the courts up, although they're answering the same
14 question 93 different times. Hopefully, we'll get the same
15 answer 93 different times.

16 The other route is to seek a declaratory judgment
17 in circuit court, which is where we are, what we're doing in
18 order to answer that one question of law and short circuit
19 everything else. So what we're asking the court for at this
20 point until this can be fully briefed on any issues that the
21 Court would want to know is just to make sure that in
22 between the time between now and May 22nd, where DHEC's got
23 discretion whether they act or not, make sure they don't act
24 until the Court has time to review this and decide on it.

25 I think that the matter could be fully briefed

1 within that three-month time period fairly easily. I think
2 all parties could probably submit briefs within about three
3 weeks, responsive briefs within two weeks after that and
4 then argue before the Court if the court needed further
5 argument. So I think it can all be done well within the
6 time frame that DHEC's got discretion over any way.

7 But that's the relief we're asking for today, Your
8 Honor, is preliminary injunction, that DHEC not act to grant
9 any certificates of need until the court has a chance to
10 review a full briefing on the issue of whether or not the --

11 THE COURT: All right. Thank you, sir.

12 Yes, ma'am.

13 MS. BIGGERS: Thank you, Your Honor. Ashlee
14 Biggers on behalf of DHEC. The state plan that was adopted
15 back in August does contain standards for distribution and
16 protections of need for home health services for all the
17 counties we're talking about right now. There's a rigorous
18 process that we go through in order to implement the state
19 health plan.

20 The statute says we have to include the state
21 health planning, those members appointed by the governor,
22 our staff at DHEC come up with an original draft and then
23 they present that both to committee and to the public. The
24 committee meets and has discussions and they revise as they
25 see fit. And those are, you know, people who have an

1 interest and expertise in the area of health planning and
2 health care and finance and also representing people who are
3 in insurance and people who are using health services
4 essentially.

5 And with that entire process, there was vigorous
6 discussion regarding the home health standards. We have in
7 the past had a standard which was -- which did include a
8 formulated calculation. And it used utilization and
9 population data and it came up with the mathematical formula
10 of, you know, here's how we're going to project whether they
11 might be a need for one new home health agency in a county.
12 In recent years, when state health plans were adopted, it
13 actually showed -- there was a plan where it showed only one
14 county needed one new home health agency. There was a plan
15 that showed three counties in the state need a new home
16 health agency.

17 And when -- when we did have this period that
18 Mr. Matthews alluded to of, you know, we weren't operating
19 due to lack of funding, we saw a lot of home health agencies
20 go forward with licensing. And what we saw is that there
21 were patients out there in need of services. And when we
22 then went back and looked at our past formula for how we're
23 determining whether there's a need for even one new home
24 health agency only in any given county, we realized it
25 really wasn't matching up with what the facts showed about

1 the need out there when you look at the actual numbers that
2 are reported of people who got licenses and found patients
3 and weren't affecting the ability of already existing
4 providers to serve there own patients.

5 So that is really why there was such an intense
6 discussion in the state health planning committee process.
7 There was a full day meeting where this was the only topic.
8 The committee didn't even look at other topics. They just
9 devoted it to home health. And then they came back and had
10 another meeting where they readdressed it. They considered
11 all comments that were raised, including those raised by
12 Amedisys that were -- that said, you know, we think you need
13 to stick with the formulated approach, that was also
14 considered.

15 And essentially, the committee decided, you know,
16 we need some standards to show well, if you're going to
17 establish new home health agency, you need to show that
18 you're going to serve a minimum of a certain number of
19 patients. And if you're going to serve those, we want to
20 make sure that you're not just taking them away from
21 existing providers and for those reasons, we include
22 additional criteria --

23 THE COURT: Is the number 50?

24 MS. BIGGERS: Yeah, right, it's 50, 25 in rural
25 counties.

1 And then there's additional criteria that goes
2 with that, including you've got to show us, you know,
3 letters of reference, letters from physicians saying they're
4 going to refer services to you, evidence of underutilization
5 of home health services, evidence about are there -- is
6 there a limitation on the scope of services. Because
7 there's a variety of different types of services home health
8 agency can provide, so does the county not have a full
9 range? Or is there evidence that people are being delayed
10 and denied in receiving these services?

11 So those are factors that then they wanted us to
12 take into consideration and determine whether an applicant
13 has, you know, met that they're going to show that they're
14 going to serve 50. And that takes into consideration -- you
15 know, that's -- we don't want that being taken away from
16 someone else, an existing provider.

17 So that was what the committee ultimately
18 determined would be the better method of determining
19 projected need. It's not formulated, but it is objective.
20 And the statute does not require that there has to be a
21 formula for projections of need. It just says there needs
22 to be projections of need.

23 And the MRI BellFair case that Mr. Matthews
24 discussed, it had even less standards when it came to MRI
25 and the Supreme Court ultimately upheld it. I know

1 Mr. Matthews had mentioned it being a hospital should have
2 an MRI available to it at all times. At all times is
3 actually not part of the criteria at the time for the MRI.
4 It was each hospital should have, at least, one MRI unit
5 available for diagnosis in emergency patients, inpatients
6 and outpatients. So it didn't say at all times. And so
7 then it also had a standard in order to promote cost
8 effectiveness, the use of shared mobile MRI units should be
9 considered. And then the third and last standard that went
10 to MRI at all in that plan was the applicant agrees in
11 writing to provide the department utilization data on
12 operation of MRI services.

13 And based on that, the Supreme Court said that
14 meets the requirement that you include projections of need
15 and standards of distribution in a statute. And it said
16 that although the plan does not give specific projections
17 and meet our standards of distribution in terms of the exact
18 statutory language, the plan didn't violate the statute.

19 And you know, there were issues. That was not
20 clear cut. That language didn't say every hospital is
21 entitled to have one inside its own building. It said it
22 should just have, at least, one available to it. It talked
23 about shared -- you know, encouraging shared mobile units.
24 Well, a person challenging the position of that had a unit
25 they thought would be available during relevant times. You

1 know, there were factual issues. It was not a black and
2 white formula and yet, the Supreme Court upheld it.

3 So I think our standards for the home health
4 section of the current plan have been vigorously reviewed by
5 staff, by the state health planning committee and they were
6 ultimately approved by our ward. In that respect, we've met
7 the statutory requirement for having a developed plan.

8 When it comes to injunctive relief, it is
9 generally noted that the state should not be enjoined from
10 complying with its statutory mandates pursuant to a valid
11 statute. Our statute requires that if people submit
12 applications to us, we have then time lines set for it by
13 which we have to deal with that. We have to do state
14 register notice of we've accepted it for filing. We have a
15 limited time frame in which we can review it to ask
16 additional questions to deem it complete. We have a
17 statutory requirement to then -- to send notice to effective
18 persons we've deemed it complete. Then after that, we have
19 statutory deadline for when we can first approve it and when
20 we can last -- or first make a decision and last make a
21 decision, that 30 to 120 days. So those are statutory
22 provisions. They're valid statutory provisions that the
23 department is required to comply with and it's inappropriate
24 to issue an injunction enjoining us from complying with
25 those.

1 I understand that the argument on the other side
2 is we think your state health plan is insufficient. Well,
3 the state health plan itself is not a statute. So we're
4 looking at being enjoined if this were granted from
5 complying with actual statutory provisions of accepting,
6 reviewing and issuing decision within time frames. And we
7 think that there is an adequate remedy of law. The MRI
8 Bellfair case before the Supreme Court came up through the
9 normal process of challenging a CON decision where you go to
10 the administrative law court and have a contested case
11 hearing. And that's one of your arguments that you make
12 there.

13 So we think that there is an adequate remedy at
14 law to stay -- Mr. Matthews referenced the automatic stay.
15 Well, the automatic stay at the administrative law court
16 just to stay the implementation of the department's
17 decision. But that's not relevant to the argument being
18 made here today by the Plaintiff because what they're
19 seeking to have us be enjoined from doing is actually
20 issuing a decision in the first place, from having us accept
21 review and issue decisions of CON applications that comply
22 with our statutory mandate to do those duties.

23 So the automatic stay at the administrative law
24 court, it simply stays, as it does for all licensing in
25 similar decision, just the affect of it -- of that decision

1 going into effect. But it would be harmful to the
2 department, in particular if we were enjoined from accepting
3 and reviewing these applications. We do have this statutory
4 time limit of, you know, what's our latest date by which we
5 can issue a decision. And there's a lot of review that has
6 to go into making decisions on applications. And again, we
7 have to comply with notice requirements.

8 If we were enjoined from even being able to review
9 these applications during this process, that would burden
10 staff because were we then eventually successful in this
11 lawsuit, and then we were -- then we would be stuck with now
12 we have, perhaps, a very short amount of time to meet our
13 statutory deadline for handing decisions out and we haven't
14 been able to do work on these applications because of a
15 preliminary injunction order.

16 So for all of those reasons, we don't think a
17 preliminary injunction is appropriate. The standards in the
18 plan are not arbitrary. They're not capricious. There are
19 other areas in our plan in addition to home health that
20 have -- that don't have this formula, such as the ambulatory
21 surgery facilities. And as in the MRI Bellfair case, when
22 we had MRI standards, those where, you know, we have to look
23 at applications and their individual facts and then apply
24 the standards and the plan and come up with decisions. It's
25 not a black and white process, but there are objective

1 standards here that satisfy the statute.

2 And then lastly, I just would like to mention in
3 the prayer for relief in the motion in the Plaintiff's
4 request, if you were to issue a TRO or preliminary
5 injunction that you could include a provision that gives the
6 department the discretion to apply the last plan that had
7 that formula and just update it based on inventory and
8 utilization, that would not be an adequate remedy from our
9 perspective because there is a statute that says that all
10 CON applications have to be decided based on the plan that
11 was in effect at the time the application was submitted. It
12 says it does give us discretion to consider any future plans
13 that take effect during the DHEC review process or if it
14 goes to the administrative law court, the administrative law
15 court could take it into consideration, but it certainly
16 does not allow us to go back and base decisions on prior
17 plans.

18 THE COURT: All right.

19 MS. BIGGERS: Thank you very much.

20 THE COURT: Mr. Mullins, anything y'all would like
21 to add?

22 MR. MULLINS: Your Honor, I think you've heard a
23 lot about it. We'll try to see if we can try to split some
24 of the issues, but we certainly have some points we want to
25 raise.

1 Judge, I do want -- and I think you probably know
2 this. I mean, what the Plaintiff in this case is asking you
3 to do is a very unusual step. Any type of injunction is an
4 unusual step and the Court ought to think very carefully
5 before it agrees to issue an injunction.

6 THE COURT: I thought very carefully before I
7 first got married.

8 (Laughter.)

9 THE COURT: Don't let me stop you. Go ahead.

10 MR. MULLINS: Ms. Biggers walked you through
11 somewhat of what brought us here in terms of this laborious
12 process that gave rise to this. This is the whole state
13 health plan as a whole and it's a pretty big document. What
14 they're asking you to enjoin is essentially the operation of
15 the home health section of the plan. But it's a very
16 specific and deliberate process in which this committee
17 receives a draft plan from the department, they schedule
18 meetings that the public is welcome to attend. They have
19 public hearings. In this case, they had four public
20 hearings all over the state. They solicit, they actively
21 solicit comments from the stakeholders, from the regulated
22 entities in terms of the proposed plan. And that's exactly
23 what happened in this case.

24 And Your Honor, I've been doing CON work for a
25 long time and I've been through the state health planning

1 process, revision process and I can tell you in almost every
2 instance that I've been involved in, there's dispute.
3 You've got different entities with different interests and
4 they're fighting over how the plan ought to be changed and,
5 you know, whether it ought to be loosened or whether it
6 ought to -- you know, everyone has an interest, a special
7 interest and there's normally fighting over that. I have
8 never seen a situation where an industry came together and
9 all were advocating for a revision to the home health plan,
10 with the exception of Amedisys, who I might add was quiet
11 throughout the entirety of this process until literally the
12 last few days before the state health planning committee
13 made a decision.

14 There were 120 different comments made for home
15 health supporting the loosening of the standards. And the
16 reason is because of what Ms. Biggers said and that is --
17 and I heard Mr. Matthews say that there were 25 applications
18 over the last five years. That sounds like a lot. That
19 could be correct. I think maybe Beaufort had 10 at one
20 time, maybe more than that, but I know over the last five,
21 maybe, 10 years there's only been four counties where under
22 this old formulated approach that there was determination
23 that there was need.

24 And what this process unfolded was or discovered
25 was that the home health industry believed and it had been

1 established through the -- when the CON program was
2 suspended and all of these agencies went out and got
3 licensed was that there's a huge need for home health.
4 People are being treated outside of the hospitals now, which
5 has essentially, completely been a metamorphosis in home
6 health treatment. So that became clear to DHEC during this
7 process, became clear to the state health planning committee
8 and they looked at a way to address that.

9 And the way they addressed it was passing a new
10 set of standards that -- Mr. Matthews is saying that the end
11 result was it doesn't set out a methodology for determining
12 need. Well, I beg to differ. I think the standards, and I
13 think it's an exhibit in their motion, is very specific and
14 it is very objective. It's not the old formula and they
15 don't like that because they're trying to preserve their
16 status quo. They don't like the idea of more agencies
17 entering into the market to service what everybody agrees is
18 a need. But I will tell you, and if you look, if you look
19 at the standards that we -- our position is that it does
20 satisfy the requirements of the statute.

21 And MRI Bellfair, it may be authored -- but I
22 would tell you it, to me, is very clear. On Page -- the
23 first section of the analysis, they talk about the state
24 health plan and the fact that this party, who had appealed a
25 CON -- and again, our position is that they do have an

1 adequate remedy of law. They do. They can appeal these
2 decisions. They may all be denied, we don't know right now.
3 We don't know. But if there are applications that are
4 appealed and they believe they have an interest, they can
5 appeal those decisions and they can go before the
6 administrative law clerk, just like MRI Bellfair did in this
7 case. But it's very clear.

8 If you look at the headnote 3, which discusses the
9 challenge that the standards were not specific enough under
10 MRI, Judge Pleicones and the Supreme Court found that it did
11 meet the need of the statute. And our contention is there
12 were three very nebulous, very general standards for MRI in
13 the MRI Bellfair case. We've got very specific standards.
14 The requirement is that there needs to be a showing that you
15 can serve 50 patients if you're in a nonrural county or 25
16 patients in a rural county. There's evidence of how you
17 show support through letters of support from physicians,
18 through evidence of underutilization of existing providers.
19 It's very specific. They're going to have to comply -- an
20 applicant is going to have to comply with the objective
21 criteria in the standard which is 25 or 50 and if they can't
22 do that, they're not going to get a CON.

23 Ms. Biggers alludes to other sections of the plan.
24 And maybe we should make this as an exhibit, but this -- the
25 entire plan. I will tell you that Mr. Matthews in the

1 Amedisys argument is that somehow this new standard is a
2 complete diversion from, you know, the way that DHEC
3 operates and the state health plan. Home health has had
4 this formulated approach. There are some others, hospitals
5 have that, but there's a whole slew of services in the state
6 health plan that don't have a formulated approach. Surgery
7 centers that Ms. Biggers alluded to doesn't even have the 25
8 or 50. It does not have any objective criteria. Maybe they
9 want to challenge that now, I don't know, but those have
10 gone unchallenged for years. And the idea that there has to
11 be some type of formula that has to use the population, we
12 just don't think is correct. So we don't think there's a
13 likelihood of success on the merits.

14 In their motion, they say they requested emergency
15 interim relief and they say it's necessary to preserve the
16 status quo for the pendency of this action because the
17 current plan fails to adopt any objective criteria to
18 determine need. Your Honor, I heard Mr. Matthews says that
19 they didn't think that they could go before the
20 administrative law court. And quite frankly, I have not
21 seen this order and I'm not sure. I think there are
22 mechanisms that you might be able to go before, but what
23 could have happened -- and let me -- you know, what I think
24 is undisputed is that on August 13th, the facts that they're
25 complaining of right now in terms of inadequacy of the plan

1 existed on that day. They could have filed this action back
2 in August, but they waited until now, until last week right
3 before DHEC is about to make decisions on these applications
4 to file this action and claim and scream that we've got an
5 emergency here and we need you to act. And they filed this
6 back in August.

7 Let me tell you what happened. There was no
8 opposition. There was a process it went through. There was
9 a decision by the health planning committee. What they do
10 is they take the plan, they hand it off to the DHEC board
11 and then they recommend, they say if we think you should
12 approve this plan. It went before the DHEC board. They had
13 more discussion about it and it was unanimously approved on
14 August 13th. The next day, it becomes effective.

15 My clients relying on that go out and spend a lot
16 of time, a lot of resources in preparing applications where
17 they believe that there's a need and where they want to
18 serve. And they file those applications and they
19 participate in the process. They provided more information
20 for DHEC. DHEC has asked them for more information.
21 They've gone through the process and now most -- many of the
22 applications that have been filed, my client stands to
23 receive the decision. And Amedisys has come in at the last
24 minute and, essentially, their goal is to stop the program.
25 Well, we think this emergent issue that they've brought

1 before you is self created. So we think that ought to be
2 taken into consideration in whether you're going to issue an
3 injunction in this case.

4 And they do, they do have an ability to protect
5 their interest. And saying that they've chosen to come here
6 instead of pursuing the contested case provision, Your
7 Honor, I don't -- I think in determining whether to issue an
8 injunction, you have to consider is there an adequate remedy
9 at law. There is. There is. And we know that MRI
10 Bellfair, that's what that entity chose to pursue. They
11 pursued it in a contested case hearing. And we think
12 that's -- if they believe that this is an issue that that's
13 the appropriate forum to raise that issue.

14 And again, as you alluded to earlier, we don't
15 have decisions yet. They could be denied. The CONS that
16 are granted could be in counties that they don't really have
17 an interest in, so a lot of this is preliminary. The
18 appropriate and more efficient and more reasonable way to
19 pursue this is for them to pursue an appeal in counties
20 where they believe their rights have been violated through
21 the contested case.

22 THE COURT: All right. Thank you, sir.

23 MR. ANDREWS: Your Honor, Stuart Andrews with
24 National Healthcare and Pruitt Healthcare. Ms. Biggers and
25 Mr. Mullins have done a good job of explaining the

1 misreading of the statute that the Plaintiffs present to
2 you. The statute in no way can be reasonably interpreted to
3 require methodology. In fact, the plan for decades has
4 provided more services than not without a formulated
5 approach.

6 Fundamentally, Your Honor, this is about the
7 challenge of the Plaintiffs and to the department's
8 interpretation of the CON act. There is a well-established
9 body of law where the courts defer to the department's
10 interpretation where the language is not plain on its face
11 as to what it means and how it should be interpreted. Here,
12 we have decades of interpretation that have been
13 unchallenged that a nonformulated approach to determining
14 need is left in the hands of the professional healthcare
15 planners, the DHEC employees and tasked with the
16 responsibility of determining whether or not application for
17 particular healthcare services demonstrates need or not.
18 And that's what the department has done here in ways that
19 have already been demonstrated to you by being very precise
20 about the quantifiable goals of 50 patients, except in rural
21 area, and there are only a few of those the way it's
22 defined.

23 And otherwise -- and evenly further providing
24 evidence that should be considered by the department's
25 healthcare plan is determining whether or not those

1 projections of utilization are reasonable. And I won't
2 belabor that point, I think it's been well made, but there
3 simply is a misinterpretation for which there is no
4 authority whatsoever that the Plaintiffs are asking you to
5 adopt. In contrast to the judgment that the department has
6 exercised and that the board has exercised in determining
7 how that need should be determined and it's well set out.

8 There are a couple of other issues, Your Honor,
9 that have not been addressed yet that I would like for you
10 to consider. Mr. Mullins began to address it concerning
11 what fundamentally is a latches issue. Had these -- had
12 this challenge been asserted six months ago when the plan
13 was developed and no facts have changed since then, except
14 applications that were easily predicted, then there could
15 have been an opportunity to consider these issues without
16 any pressure concerning the time.

17 In the absence of that, there have been scores of
18 applicants that have each spent tens of thousands of dollars
19 on healthcare planners and I'm sorry to say lawyers as well
20 to present these applications to the department that have
21 been -- and those are expenses and costs that have been
22 undertaken in the absence of any challenge in this very
23 unusual method that Mr. Mullins pointed out. Because there
24 is a standard process by which they can contest each
25 application and then take that to the administrative law

1 court.

2 And that leads me, Your Honor, to the final point
3 I'd like to make just to compliment what the others have
4 argued, which I alluded to earlier concerning the motion to
5 intervene. The scope sought by the belief of the Plaintiffs
6 is far too broad. It's overly broad. It's not something
7 for which they, in fact, have standing to assert. Amedisys
8 provides services, according to its pleadings, in 25
9 counties in the state. Our clients have applied for
10 certificates of need in 44 counties. So there are 19
11 counties in which Amedisys does not have a presence, does
12 not have any business interest, has no basis whatsoever for
13 asking you to enjoin the consideration of the CON
14 applications and the approval of those applications in
15 counties where they do no business at all. And our clients
16 would be held up by the relief that's being proposed.

17 The others that can be considered on a
18 case-by-case basis, Amedisys has not provided any evidence
19 that, in fact, they would be adversely affected in each of
20 the remaining 25 counties where they do provide services.
21 They would -- if they could demonstrate that to the
22 department, the department would take it into consideration.
23 If they are going to be materially adversely affected, that
24 could be a basis for the department's staff to determine
25 that the application should not be approved. And

1 consequently, their relief that they're seeking, there is an
2 alternative adequate remedy of law and they can't satisfy
3 the elements necessary.

4 THE COURT: All right. Thank you, sir.

5 MR. ANDREWS: Yes, sir.

6 MR. MATTHEWS: Just a few points if I could. I'd
7 like to try to take a few rocks out of my wagon that have
8 been loaded in. One has to do with the issue of whether or
9 not Amedisys had participated in the process. Amedysis did,
10 in fact, participate in the process. Amedisys, in fact,
11 made a proposal the DHEC staff agreed to. This was not a
12 proposal that worked its way through with DHEC staff going
13 up to the state planning committee and saying that makes
14 sense.

15 What happened was DHEC -- and I don't mean to
16 defend prior state health plans where only one or three or
17 four counties were deemed to be in need. Quite honestly, I
18 don't know if four counties were in need in 2010 or not.
19 But in looking at this and taking into account the things
20 that counsel for DHEC and the interveners had mentioned,
21 there was a recommendation that more counties have a need at
22 this point for home health services. And DHEC staff came
23 forward with a plan that they presented to the state health
24 planning committee where they found 37 counties, I think it
25 was, where there was a need. Amedisys, participating in the

1 process long before the last few days, came forward with a
2 proposal, also still addressing need and the Amedisys
3 proposal identified that there were some 29 counties where
4 there was a need. Some of these were counties where
5 Amedisys was already serving. This is not a question of
6 trying to preserve the status quo, as was mentioned, trying
7 to keep people out of our back yard. We were acknowledging
8 that there were counties where there was more need and that
9 needed to be done. DHEC agreed with that. DHEC staff
10 agreed with that 29 proposal Amedisys before. And that went
11 forward to the state health planning committee.

12 The state health planning committee, on the other
13 hand, then said no standards. We're just going to look at
14 the 25/50. I'll come back to that in a minute. While
15 that's not really a standard, I know they indicate they
16 think it's objective and I want to address that in a little
17 bit. But in terms of whether or not anybody was trying to
18 protect their back yard, it should be noted that the
19 vice-chairman of the state health planning committee was an
20 employee of one of the interveners opening up a much broader
21 area.

22 Now, let me come back then to the question of do
23 we have standing across the board. Mr. Andrews mentioned
24 that there were 19 counties where there was an overlap where
25 there might be standing. Well, the fact of the matter is

1 this is a statewide health plan that applies to all the
2 counties, so in any other county where Amedisys wanted to
3 come in, we would have to confront the same state health
4 plan. And Amedisys has, in fact, filed more applications.
5 We're not just doing this as someone who oppose
6 applications, we're doing this as someone who wants to make
7 application. We need to know what standard applies when we
8 do that. We've already applied for eight more counties. So
9 we're looking at it both ways, so 19 counties, plus eight.

10 But beyond that, when you seek an injunction
11 against a governmental action, you don't ask therefore to be
12 enjoined in the county where you are. If I'm a book
13 publisher and there is something -- a statute or ordinance
14 that prohibits my publication and I say no, you can't do
15 that, that violates my first amendment. I don't say that
16 you should quit enforcing that act in Richland County, but
17 go ahead in Kershaw and Fairfield. I say, no, you shouldn't
18 be allowed to enforce that. I've got standing to challenge
19 it anywhere it applies, especially since I'm going to be
20 doing business or try to do business anywhere it applies.

21 Next, with regard to delay. It was mentioned that
22 the state health plan came into effect in August. It did
23 come into effect in August. Amedisys didn't know at that
24 point they were going to apply. No application has been
25 submitted by anybody else. Fairly early on in September,

1 NHC, at least, one of the applicants, came in with their
2 applications. The application has various sections set out
3 on a DHEC form. Part B, section 11 addresses need, tell us
4 how you're going to be filling that need in particular
5 counties who are in question, but it's a need question.

6 And then all of those applications, there are like
7 12 or 15 of them, NHC, the intervener, left those blank.
8 They came back and filled it in later, but how were we
9 supposed to know whether they were doing something rational
10 or not rational without even being able to see what was
11 there? We also didn't know what DHEC was going to require.
12 DHEC, when they receive an application, that doesn't start
13 the clock immediately for the decision, that 90 days we were
14 talking about. That doesn't start until DHEC goes through
15 the application, goes back to the applicant and says we need
16 more information, you need to give us more about this point,
17 this point and this point. Finally, when DHEC deems it
18 complete, that's what starts the clock ticking. That's when
19 you know what it is that DHEC is going to be looking at and
20 whether or not it makes sense or doesn't make sense, whether
21 or not they're uniform standards or nonuniform standards.
22 And DHEC didn't make that decision on any of these
23 applications that they were deemed complete until I think it
24 was January the 23rd or something like -- or January the
25 22nd. We filed this action about two weeks later that which

1 the idea that we should have filed it earlier simply bare
2 up, I don't believe.

3 With regard to the Bellfair case and whether or
4 not there should be deferral to the agency interpretation,
5 the fact of the matter is Bellfair addressed this question,
6 was the plan adequate or was it not on a particular narrow
7 point. And the Supreme Court in Bellfair didn't say oh,
8 well, the agency has said this, therefore, we would affirm.
9 There was no chevron jurisprudence involved there. What the
10 court did in Bellfair was the court looked, as a court
11 should, at the plan and at the statute and said does it
12 match up? If not, we're going to punt the decision to
13 administrative agency. We're going to do our job as a court
14 and we're going to decide on our own as a matter of law does
15 it or does it not match up. So the issue of deference here,
16 deferral to the administrative agency simply does not apply
17 in a Bellfair type CON case.

18 Now, as to whether or not the Bellfair matter is
19 close to this and also with regard to the issue of whether
20 or not there are other parts of the state health plan that
21 don't have a formulated approach to determining need. In
22 Bellfair, Ms. Biggers was correct, the plan itself didn't
23 say you have to have available at all times. But if you say
24 that a hospital has to have an MRI unit available, 10
25 minutes a week isn't going to be enough. One day a week

1 isn't going to be enough. The fact of the matter is when a
2 hospital is opened 24 hours a day, seven days a week and
3 they have to have an MRI unit available to them, that means
4 they have to have it when the patient needs it. I don't
5 think there's any great leap of statutory interpretation or
6 plan of interpretation to acknowledge that that's a fact
7 whether it said 24/7 or not. The hospital needs it when it
8 needs it and when the patient has got something going on.
9 With regard to whether or not other types of services or
10 other types of facilities had this sort of formulated
11 approach or one more open-ended.

12 One thing you've got to remember is that there are
13 certain limitations on what can be done with a license that
14 are physical limitations that don't apply in home health
15 services. If I've got an ambulatory surgery center, this is
16 one of the examples that Ms. Biggers mentioned, there is a
17 limit on how many people it can serve. There's a limit
18 based on the square footage of it, how many beds they can
19 put in it and on how long a procedure takes. There is some
20 maximum number, a physically maximum number of how many you
21 can do. But when you've got a license to provide home
22 health services in Cherokee County or Marlboro County or
23 Charleston County, that's a license to do business. It
24 doesn't say you can serve 10 customers or you can serve 50
25 customers. It says you can serve. And those services are

1 scalable because as many homes as there are in that county,
2 you can go out and hire nurses or hire people, assuming you
3 can get them, and go out and serve those areas. So there's
4 a fundamental difference between what a home health service
5 is and how you to have determine need for them as opposed to
6 what would be done for an ambulatory surgery center or --
7 residence imaging unit or an x-ray machine or those other
8 things that have physical time based limitations.

9 Finally, with regard to what the standards are
10 that are in the health plan, the 25 for a rural county or
11 the 50 for an urban county. Ms. Biggers mentioned that
12 well, there are other criteria that are involved. There's
13 actually not other criteria. There's other evidence. She
14 mentioned letters from physicians, evidence of
15 underutilization. But that doesn't tell you what the scope
16 of that need is and how many new providers need to be
17 brought in in order to meet that.

18 Let's suppose that you've got say Richland County
19 and for someone to come in, they've got to show a need for
20 50. So they come in and they bring in letters from
21 physicians that say we think there's an unmet need here.
22 There's an unmet need in Richland County. We see patients
23 and we try to refer them to home health and we sometimes
24 have trouble doing that. Another entity comes in and they
25 say we want to serve in Richland County and they bring the

1 letters from physicians. And those letters say I'm a
2 physician in Richland County. I see patients, I try to
3 refer them to home health services and there's an unmet need
4 and sometimes it's difficult to find who can schedule them.

5 Even if those could be quantified as a need for 50
6 and a need for 50, there's no way to tell they're not
7 talking about the same 50. You could come in, you could
8 grant two applications, when, in fact, there's only need for
9 one. But the standards that are set forth such as they are
10 in the state health plan don't give you any way to determine
11 whether or not that 50 is being counted once or twice or
12 three times.

13 A large part of the state health plan is to allow
14 DHEC to determine what is a competing applicant. If they're
15 competing applicants to serve the same need, that they don't
16 both get the license. If one wants to serve 50 and another
17 wants to serve 50, there's only 50 of them that need, only
18 one of them will be licensed. So DHEC has to be able to
19 tell are they double counting the same need? Are these two
20 different pods of 50 out there or are they not? There's
21 nothing in the standards that will allow that.

22 It even gets worse, let's suppose that you've got
23 the same 50 and DHEC mistakenly gives a license to two
24 competing applicants or three competing applicants, or four
25 compete applicants, okay, and then those applicants come in

1 and they try to serve. Well, one of them picks up 15 and
2 one of them picks up 10 and another one picks up another 15,
3 another one picks up five and another one picks up five. So
4 then you've got five different entities all coming in trying
5 to serve. What happens? By the state health plan, two
6 years later, they all have to exit that county and there's
7 no service left because the state health plan provides that
8 unless you meet your 50 goal within two years, you have to
9 surrender your license. So not only do you have a problem
10 of misallocation of resources on the front end, you have the
11 problem of losing service, vitally needed service, at the
12 back end.

13 So no matter which way you look at it, if you look
14 at it coming, if you look at it going, the problem is DHEC
15 doesn't have the tools on the state health plan as they
16 acknowledged in the transcript of their own meeting, they
17 don't have the tools to make these decisions. Anything they
18 do is going to be arbitrary and capricious. There is no
19 standard that they can come in and say this is what we
20 looked at and it was met. That's the problem.

21 Yes, we could go in with 93 applications
22 oppositions in the administrative law court and do it that
23 way, but that's not the only way that state law gives us to
24 challenge this. We have standing to challenge it as a
25 declaratory judgment matter in the circuit court to

1 determine the one issue that is common across all 93 of
2 those. Not only opposing applications that applied by other
3 entities in business, our own applications. We want to know
4 should we spend our time and money pursuing these
5 applications or is it just a lost cause.

6 Mr. Andrews mentioned the large amount of time
7 spend on -- the time and money on consultants of lawyers.
8 We'd like to be able to avoid that if it's going to be
9 pointless. We'd like to be able to avoid it in 93 different
10 applications and have one court tell us as a matter of law
11 that either yes, this is adequate, you're just going to have
12 to do the best you can with it or no, it doesn't match the
13 state statute. DHEC needs to go back and look at it again.
14 That's all we're asking.

15 We think we have a right to a decision under the
16 declaratory judgment act. We clearly have standing to bring
17 it here. I think it's fairly clear based on the transcript
18 and based on some of the things that the interveners have
19 said, that there aren't any enforceable standards there, but
20 there has to be enforceable standards. The Court of Appeals
21 in another one of the Trident cases said the state health
22 plan is a legally enforceable document. So if it's going to
23 be legally enforceable against us, against Stuart's clients,
24 against Wade's clients and against DHEC, we all need to know
25 what it means. And right now, it doesn't mean anything and

1 DHEC needs to be told we've got to go back and put some
2 meaning in it.

3 I had a phone call where I asked all the various
4 applicants and people in the business what do you think.
5 They need as a government agency to do that, to do their job
6 and to make a definition for the benefit of everybody so
7 that we know going forward what it is that the law requires.

8 THE COURT: All right. Thank you, sir.

9 Anything further?

10 MS. BIGGERS: No, sir.

11 THE COURT: I thank you all for your lively
12 presentation. You can have proposed orders on my desk by
13 10:00 in the morning.

14 MR. MULLINS: Thank you, Your Honor.

15 THE COURT: You can e-mail it to me. Thank you,
16 all. It's good to see y'all. It's been a long time since
17 I've seen some of you.

18 (Laughter.)

19

20

END OF PROCEEDINGS ✓

21

22

23

24

25

1 COUNTY OF RICHLAND)

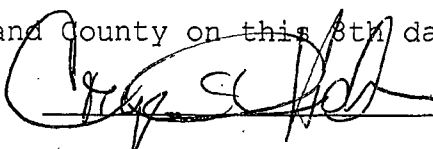
2 CERTIFICATE OF REPORTER

3 I, Crystal Holmes, hereby certify that I reported
4 the preceding case entitled Amedisys SC, LLC Vs. SC DHEC
5 Case No. 2016-CP-40-00818, at the Richland County
6 Courthouse, February 22, 2016.

7 I FURTHER CERTIFY that the foregoing pages 1
8 through 54 constitute a true, accurate and full transcript
9 of said hearing.

10 I FURTHER CERTIFY that I am not employed by any of
11 the parties hereto and I have no financial interest in the
12 outcome of said case.

13 IN WITNESS WHEREOF, I have heretofore set my hand
14 and seal at Richland County on this 8th day of March, 2016.

15 
16 Crystal Holmes, Official Court Reporter
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2010 – 2011 SOUTH CAROLINA HEALTH PLAN

**South Carolina State Health Planning Committee
South Carolina Department of Health and
Environmental Control**

Effective November 12, 2010

SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

<u>Member</u>	<u>Representing</u>
Gerald A. Wilson, M.D. Chairman	Provider
Douglas W. Bowling	Provider
Langdon A. Hartsock, M.D.	Provider
Thomas Little Robinson, M.D.	Provider
James E. Armbruster	Finance/ Insurance
Martin (Marty) Cope	Finance/Business
Nicki S. Davis	Finance/Business
Vacant	Finance/ Insurance
W. H. "Ham" Hudson	Consumer
Roger Leaks, Jr.	Consumer
Charles D. Lindley	Consumer
Edward D. Tinsley, III	Consumer
Elliott F. Elam, Jr.	Consumer Affairs Representative (Ex-Officio)
Coleman F. Buckhouse, M.D.	DHEC Board Representative

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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 aware 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.

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:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the 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.

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:
 - (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;
 - (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;
 - (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and
 - (d) 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. Relative Importance of Project Review Criteria:

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 effects caused by the duplication of any existing facility, service or equipment.

I. 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.

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of the current Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySCHospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-09 South Carolina Health Plan, the Planning Committee was requested to undertake a study to determine how best to incorporate nursing and technical staffing information into future Plans. We agreed to undertake such a study; however, we do not have the manpower or technical expertise to conduct this research single-handedly. Staff is currently participating on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which has a four-year Duke Endowment grant to develop a supply/demand forecast model for nursing (as part of a larger effort that includes also includes allied technical staff).

Staff amended the 2009 Joint Annual Report (JAR) formats to obtain the baseline numbers for the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc). The research will also involve getting health care facilities to project their future needs for additional staff, through both currently budgeted vacancies and planned new projects. We will also have to determine what, if any, staffing guidelines or requirements exist for the various health professions. Only when we have this information available can we attempt to create standards tying staffing requirements to sections in the Plan. Therefore, at this point, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

More information on the OHWRN study can be found at:

<http://sc.edu/nursing/workforce/workforce.html>

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 need for hospital beds is based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, 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. Due to factors that 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:

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are 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 want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as 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, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; 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 impact 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:

<u>Region</u>	<u>Counties</u>
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:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,401,230 for 2009 and projected population of 4,719,530 for 2016. 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 2009 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, 2010.

H. Home Health

1. 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 2009 for the home health agencies in South Carolina were:

Total Visits	2,017,737
Nursing Visits	43.82%
Home Health Aide Visits	8.22%
Physical Therapy Visits	34.78%
Medical Social Worker Visits	1.81%
Speech Therapy Visits	1.55%
Occupational Therapy Visits	9.00%
Other	0.84%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 20.9 in 2009. In 2007, CMS revised its policy on "case mix," which was expected to make a nearly 12%

reduction in the national 60-day standardized payment rate by 2011 and decrease home health expenditures by \$7 billion over that time.

Of the patients currently receiving home health services, less than 2% are age 14 and under, approximately 33% are age 15-64 and the rest are age 65 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need 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. It is recommended that an application for a new home health agency should contain letters of support from physicians in the proposed service area.
4. The need methodology creates statewide use rates for four population groups (0-14, 15-64, 65-74, 75+) based on 2009 utilization data; 75% of these rates are applied against the projected 2011 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2009 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2011. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of greater than 100 patients projected to be in need, then another agency could be approved for that county.
5. Before an application for a new home health agency can be accepted for filing, all existing agencies in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have 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.
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(s) where it operates them.

7. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

- a. Compliance with the Need Outlined in this Section of the Plan;
- b. Acceptability;
- c. Distribution (Accessibility);
- d. Medically Underserved Groups;
- e. Record of the Applicant; and
- f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving

children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.
2. The applicant must document that no other agency offers this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. 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;
2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
3. 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 non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

HOME HEALTH METHODOLOGY

County	Projected Pop 2011 Age 0-14	2011 Estimated Pts Age 0- 14	Projected Pop 2011 Age 15-64	2011 Estimated Pts Age 15- 64	Projected Pop 2011 Age 65-74	2011 Estimated Pts Age 65- 74	Projected Pop 2011 Age 75+	2011 Estimated Pts Age 75+	Total Estimated 2011 Patients	2009 Actual Patients	Population Growth Factor	Total Projected 2011 Patients	2011 Unmet (Need/ Surplus	Need at 100 Patients	New Agency Approved Since 12/31/08	New Agency Can be Approved
Abbeville	5,530	6	18,020	143	2,380	194	1,870	153	495	831	1.012	841	346	----	----	----
Aiken	30,520	31	111,530	883	13,680	1,117	10,210	834	2,864	2,512	1.025	2,575	(289)	YES	YES	----
Allendale	2,530	3	7,660	61	1,040	85	780	64	212	112	1.005	112	(100)	YES	----	YES
Anderson	35,330	35	120,130	951	15,740	1,285	10,730	876	3,148	3,357	1.018	3,419	271	----	----	----
Bamberg	2,990	3	10,280	81	1,440	118	940	77	279	261	0.990	258	(20)	----	----	----
Barnwell	4,940	5	17,070	135	2,060	168	1,550	127	435	464	1.016	472	37	----	----	----
Beaufort	22,270	22	94,010	744	19,790	1,616	13,130	1,072	3,455	3,231	1.038	3,354	(101)	YES	----	YES
Berkeley	34,880	35	113,830	901	13,190	1,077	7,810	638	2,651	2,514	1.027	2,582	(69)	----	----	----
Calhoun	2,790	3	11,130	88	1,640	134	970	79	304	271	1.022	277	(27)	----	----	----
Charleston	60,100	60	224,480	1,777	27,140	2,216	18,510	1,512	5,565	8,970	1.013	9,087	3,522	----	----	----
Cherokee	12,230	12	38,970	308	4,380	358	2,910	238	916	1,251	1.022	1,279	363	----	----	----
Chester	7,360	7	23,420	185	2,920	238	1,980	162	593	831	1.010	839	246	----	----	----
Chesterfield	9,120	9	29,630	235	3,630	296	2,180	178	718	880	1.012	891	172	----	----	----
Clarendon	6,240	6	22,120	175	4,170	341	2,360	193	715	625	1.016	635	(80)	----	----	----
Colleton	8,890	9	27,120	215	3,710	303	2,210	180	707	1,113	1.016	1,131	424	----	----	----
Darlington	14,290	14	45,970	364	5,810	474	3,470	283	1,136	1,304	1.008	1,314	178	----	----	----
Dillon	6,580	7	20,080	159	2,240	183	1,370	112	460	724	0.999	723	263	----	----	----
Dorchester	22,470	22	79,330	628	9,210	752	6,170	504	1,906	2,424	1.031	2,499	593	----	----	----
Edgefield	4,640	5	19,760	156	2,090	171	1,290	105	437	312	1.028	321	(116)	YES	----	YES
Fairfield	5,070	5	16,650	132	2,080	170	1,360	111	418	531	1.012	537	120	----	----	----
Florence	26,650	27	91,150	721	10,430	852	7,150	584	2,184	2,887	1.013	2,925	741	----	----	----
Georgetown	10,430	10	39,110	310	8,050	657	4,890	399	1,377	1,952	1.022	1,995	618	----	----	----
Greenville	81,890	82	292,670	2,316	30,410	2,483	20,940	1,710	6,592	8,721	1.023	8,922	2,330	----	----	----
Greenwood	14,590	15	47,240	374	5,710	466	4,150	339	1,194	2,125	1.015	2,157	963	----	----	----
Hampton	4,470	4	15,240	121	1,890	154	1,270	104	383	459	1.016	466	83	----	----	----
Horry	35,690	36	162,930	1,290	27,950	2,282	17,110	1,397	5,005	6,475	1.040	6,734	1,729	----	----	----
Jasper	4,080	4	16,270	129	1,750	143	1,230	100	376	392	1.029	403	27	----	----	----
Kershaw	11,610	12	39,870	316	4,850	396	3,310	270	994	1,383	1.025	1,418	424	----	----	----
Lancaster	12,620	13	43,490	344	5,190	424	3,000	245	1,026	1,584	1.011	1,602	576	----	----	----
Laurens	14,100	14	52,860	418	6,590	538	4,530	370	1,341	1,773	1.023	1,814	473	----	----	----
Lee	4,200	4	13,880	110	1,640	134	1,400	114	362	297	1.008	299	(63)	----	----	----
Lexington	48,560	49	177,250	1,403	17,940	1,465	12,750	1,041	3,958	5,140	1.032	5,304	1,347	----	----	----
Marion	7,470	7	24,260	192	2,950	241	1,760	144	584	783	1.009	790	206	----	----	----
Marlboro	5,810	6	18,150	144	2,140	175	1,240	101	425	568	0.991	563	137	----	----	----
McCormick	1,180	1	7,000	55	2,120	173	1,130	92	322	312	1.022	319	(3)	----	----	----
Newberry	7,390	7	25,440	201	3,470	283	2,510	205	697	875	1.014	887	190	----	----	----
Oconee	13,060	13	48,210	382	9,240	755	5,830	476	1,625	2,019	1.024	2,066	441	----	----	----
Orangeburg	19,120	19	63,770	505	8,540	697	5,990	489	1,710	2,739	1.011	2,769	1,059	----	----	----
Pickens	22,500	23	90,860	719	9,080	741	6,310	515	1,998	2,430	1.026	2,493	495	----	----	----
Richland	65,270	65	246,910	1,954	21,690	1,771	14,570	1,190	4,981	6,283	1.016	6,384	1,404	----	----	----
Saluda	3,740	4	13,140	104	1,880	154	1,480	121	382	350	1.014	355	(27)	----	----	----
Spartanburg	54,740	55	191,940	1,519	22,050	1,801	14,490	1,183	4,558	5,615	1.019	5,722	1,164	----	----	----
Sumter	25,970	26	75,840	600	8,570	700	6,500	531	1,857	2,649	1.014	2,686	829	----	----	----
Union	5,760	6	18,570	147	2,760	225	2,360	193	571	766	0.996	763	192	----	----	----
Williamsburg	7,630	8	23,660	187	3,350	274	2,140	175	643	914	0.998	912	269	----	----	----
York	36,750	37	136,820	1,083	13,120	1,071	8,590	701	2,892	3,997	1.031	4,122	1,230	----	----	----
SUM TOTAL	844,050	844	3,027,720	23,964	371,700	30,353	248,430	20,287	75,448	96,006	1.021	98,016	22,568			

HOME HEALTH UTILIZATION, 1980-2009

<u>YEAR</u>	<u>PATIENTS SERVED</u>
1980	17,120
1981	18,021
1982	19,751
1983	24,013
1984	28,511
1985	30,360
1986	21,012
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
1998	86,123
1999	83,969
2000	78,542
2001	77,869
2002	84,192
2003	81,708
2004	82,971
2005	81,754
2006	82,897
2007	89,851
2008	91,724
2009	97,112

Home Health Agency Utilization 2009

<u>Agency</u>		<u>Counties Served</u>	<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	1	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	360	570
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	2	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	439	641
Amedysis Home Health of Camden		Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,103	21,738
Amedysis Home Health of Charleston		Berkeley, Charleston & Dorchester	3,470	77,798
Amedysis Home Health of North Charleston		Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,435	89,302
Amedysis Home Health of Clinton		Abbeville, Greenville, Greenwood & Laurens	1,940	45,487
Amedysis Home Health of Conway		Horry	1,395	34,733
Amedysis Home Health Georgetown		Georgetown & Williamsburg	1,868	32,890
Amedysis HH Georgetown East		Georgetown & Williamsburg	198	3,068
Amedisys Home Health Hilton Head		Beaufort & Jasper	1,113	27,707
Amedisys Home Health of Lexington		Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	5,721	128,285
Amedisys Home Health Myrtle Beach		Horry	1,179	20,392
AnMed Health Home Health		Anderson	1,134	27,461
Beaufort-Jasper Home Health Agency		Beaufort & Jasper	186	5,725
Bethea Home Health (may serve retirement community only)		Darlington	34	27,734
Care One Home Health		Beaufort, Hampton & Jasper	976	24,056
CarePro Home Health		Richland & Sumter	598	13,362
Caring Neighbors Home Health		Fairfield	253	5,709
Carolina Home Health Care		Lexington & Richland	1,624	35,202

Carolina Home Health Care Charleston	3	Berkeley, Charleston & Dorchester		
Carolina Home Health Care Greenville (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)		Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	2,845	75,968
Carolinas Home Health	4	Darlington, Dillon, Florence & Marlboro	1,351	28,119
Chesterfield Visiting Nurses Services		Chesterfield, Darlington & Marlboro	444	9,255
Clarendon Memorial Home Health		Clarendon	383	5,079
Clemson Area Retirement Ctr HH (may serve retirement community only)		Pickens	18	4,384
Covenant Place Home Health	5	Sumter		
(may serve retirement community only)				
Cypress Club Home Health Agency (may serve retirement community only)		Beaufort	65	3,437
DHEC Region 1 Home Health		Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	862	20,602
DHEC Region 2 Home Health West		Greenville & Pickens	603	6,615
DHEC Region 2 Home Health East		Cherokee, Spartanburg & Union	415	8,737
DHEC Region 3 Home Health		Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	932	14,211
DHEC Region 4 Home Health East		Chesterfield, Darlington, Dillon, Florence, Marion & Marlboro	1,876	33,153
DHEC Region 4 Home Health West		Clarendon, Kershaw, Lee & Sumter	616	13,749
DHEC Region 5 Home Health		Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	732	13,153
DHEC Region 6 Home Health		Georgetown, Horry & Williamsburg	499	6,525
DHEC Region 7 Home Health		Berkeley, Charleston & Dorchester	647	15,520
DHEC Region 8 Home Health		Colleton & Hampton	407	5,952
Florence Visiting Nurses Services		Dillon, Florence, Lee & Marion	306	7,535
Franklin C. Fetter Home Health Agency		Charleston	129	3,984
Greenville Hospital System HHA		Greenville & Pickens	1,869	31,161
Health Related Home Care		Abbeville, Greenwood, Laurens, McCormick & Saluda	1,479	47,534
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)		Abbeville, Greenwood, Laurens, McCormick & Saluda	24	466

Home Care of Lancaster	Lancaster	1,331	40,641
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	947	20,895
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,807	43,857
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	27	413
Incare Home Health	Georgetown & Horry	1,820	24,895
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	8,732	151,848
Interim HealthCare of Rock Hill	York	1,649	23,911
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	1,849	32,097
Island Health Care	Beaufort	1,440	31,359
Kershawhealth Home Health	Kershaw	836	15,945
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington		
Liberty Home Care - Aiken	Aiken	365	7,070
Liberty Home Care - Bennettsville	Marlboro	288	4,286
Liberty Home Care - Myrtle Beach	Horry	946	14,539
Live Long Wellcare of Brightwater 6 (may serve retirement community only)	Horry		
Live Long Wellcare Litchfield 7 (may serve retirement community only)	Georgetown		
Live Long Wellcare Summit Hills 8 (may serve retirement community only)	Spartanburg		
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	3,047	44,815
Methodist Manor Home Health 9 (may serve retirement community only)	Florence		
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg		
NHC HomeCare - Aiken	Aiken	561	19,773
NHC HomeCare - Greenwood	Greenwood	272	12,454
NHC HomeCare - Laurens	Greenville & Laurens	995	37,967
NHC HomeCare - LowCountry 10	Berkeley & Dorchester	520	11,807
NHC HomeCare - Midlands 11	Lexington & Richland	1,180	21,463

NHC HomeCare - Piedmont	12	York	834	17,831
Neighbors Care Home Health Agency		Chester	379	9,333
Oconee Memorial Home Health		Anderson, Oconee & Pickens	699	21,495
Palmetto Health HomeCare (terminally ill Bamberg Co. patients only)		Bamberg, Lexington & Richland	1,423	32,039
Pediatric Home Health (restricted to pediatric patients only)	13	Berkeley, Charleston & Dorchester		
PHC Home Health		Charleston	651	18,384
Roper-St. Francis Home Health Care		Berkeley, Charleston & Dorchester	2,917	57,709
Seabrook Wellness & Home Health Care (may serve retirement community only)		Beaufort	34	1,976
Sea Island Home Health		Charleston & Colleton	76	3,123
Spartanburg Reg Med Ctr Home Health		Spartanburg	1,833	39,019
St. Francis Hospital Home Care		Anderson, Greenville, Pickens & Spartanburg	2,781	42,315
Still Hopes Solutions for Living at Home (may serve retirement community only)		Lexington		
Total Care Home Health		Cherokee, Chester, Union & York	3,030	66,237
Total Care - Coastal		Georgetown, Horry & Williamsburg	1,334	29,507
Tri-County Home Health Care	14	Aiken, Lexington, Richland, Saluda & Sumter	3,819	66,563
Trinity Home Service Home Health		Aiken, Barnwell & Edgefield	914	16,428
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)		Clarendon, Lee & Sumter	980	15,349
University Home Health North Augusta		Aiken & Edgefield	1,129	18,913
VNA of Greater Bamberg		Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	640	19,440
Wesley Commons Home Health Care (may serve retirement community only)		Greenwood	32	4,479
Westminster Campus Home Health (may serve retirement community only)		York	19	563
			97,112	2,017,737

Home Health Agency Footnotes

- 1 Name changed, formerly Matria Healthcare-Midlands.
- 2 Name changed, formerly Matria Healthcare-Piedmont.
- 3 Formerly Hospice of Charleston Home Health Agency.
- 4 Name changed, formerly Home Health Services of Carolina Hospital System.
- 5 Licensed 5/4/10 to serve the residents of the retirement community.
- 6 Licensed 9/16/09. Previously Brightwater Home Health Agency.
- 7 Formerly Lakes of Litchfield.
- 8 Licensed 5/14/09. Formerly Summitt Hills Home Health Agency.
- 9 Licensed 2/12/10.
- 10 Formerly Home Health of South Carolina – Low Country
- 11 Formerly Home Health of South Carolina – Midlands
- 12 Formerly Home Health of South Carolina
- 13 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10.
- 14 CON approved for Aiken County; appealed.

D H E C



PROMOTE PROTECT PROSPER

2012 – 2013

**SOUTH CAROLINA
HEALTH PLAN**

EFFECTIVE 11/9/12

SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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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, with one of the providers being a nursing home administrator. 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 aware 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.

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:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the 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.

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:
 - (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;
 - (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;
 - (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and
 - (d) 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. Relative Importance of Project Review Criteria:

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 effects caused by the duplication of any existing facility, service or equipment.

I. 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.

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of this Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySCHospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-2009 South Carolina Health Plan, the State Health Planning Committee agreed to undertake a study to determine how to incorporate nursing and technical staffing information into future Plans. Staff research indicates that California is the only state that mandates minimum nurse to patient ratios by law. Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington require hospitals to establish committees to address staffing planning and policy. Several of these states require that at least 50% of the membership must be direct care RNs. There are also 5 states (Illinois, New Jersey, New York, Rhode Island, and Vermont) that require some form of public notification or posting of staffing levels. These are all approaches that can be discussed for South Carolina.

Staff participated on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which was attempting to develop a supply/demand forecast model for nurses and allied technical staff. However, that research project was not completed.

Staff amended the Joint Annual Report (JAR) formats to obtain the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc) and the number of hours they work annually. From this information, staff can develop comparative staffing data for different types of facilities. However, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

CHAPTER II

INVENTORY 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 need for hospital beds is based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, 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. Due to factors that 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:

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are 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 want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as 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, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; 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 impact 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:

<u>Region</u>	<u>Counties</u>
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:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,673,000 for 2011 and projected population of 5,007,100 for 2018. 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. Please note that these are preliminary projections because not all of the 2010 Census data have been released. These numbers will be adjusted and finalized as the data become available.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2011 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 8, 2012.

G. Definitions:

This is a synopsis of the relevant definitions appearing in each Chapter of the Plan. They are more fully defined in the individual chapters:

Chapter III

"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.

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

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

"Critical Access Hospitals (CAHs)" are eligible for increased reimbursement without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities. In order to qualify as a CAH, a hospital must be located in a rural county and be located more than 35 miles from any other hospital or CAH (15 miles for areas with only

roads). It must be part of a rural health network with at least one full-service hospital. They have a maximum of 25 licensed beds and the annual average length of stay must be less than 4 days. Emergency services must be available 24 hours a day.

“Community Perinatal Center (Level I)”: These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital has 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 2,000 grams.

“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 1,500 grams.

“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 not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. These hospitals manage a three year average of at least 1,200 deliveries annually. A CON is required to provide Level IIE services.

“Subspecialty Perinatal Center (Level III)”: In addition to Level IIE requirements, these hospitals provide 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. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

“Regional Perinatal Center (RPC)”: In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC provides consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

“Pediatric Long Term Care Hospitals (PLATCHs)” are designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis. Care may be rehabilitative or palliative. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services, such as Neonatal Abstinence Syndrome (NAS), birth defects, spinal cord or trauma injury, seizure disorders,

chronic lung disease, and extensive wound care. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

Chapter IV

“Inpatient psychiatric services” are provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

“Local Inpatient Crisis Stabilization Beds”: the S.C. Department of Mental Health (SCDMH) has had substantial decreases in inpatient capacity, resulting in insufficient beds being available to meet the demand from referrals. This has led to persons in a behavioral crisis waiting in hospital emergency rooms for an appropriate inpatient psychiatric bed to become available. SCDMH has attempted to alleviate this problem by means of its “Crisis Stabilization Program.” The program provides short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs. For patients needing stabilization in a hospital, SCDMH contracts with local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

Chapter V

A “Comprehensive Rehabilitation Facility” is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. It provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients.

Chapter VI

“Freestanding Medical Detoxification Facilities” are a short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed. A CON is required for medical detoxification.

“Inpatient Treatment Facilities” are 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. A CON is required for an Inpatient Treatment Facility.

"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, suboxone and buprenorphine to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state.

Chapter VII

A "Residential Treatment Facility for Children and Adolescents" is operated for the assessment, diagnosis, treatment, and care of children and adolescents in need of mental health treatment. This 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 judgment, 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)

Chapter VIII

A "Cardiac Catheterization" is an invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiology, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies are considered to be one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed. They are located only in hospitals approved to provide open heart surgery, although diagnostic laboratories are allowed to perform emergent and/or elective therapeutic catheterizations in compliance with Standard 7 or 8 in the Plan.

"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; Angiocardiology, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Procedure 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

"Therapeutic catheterization" refers to a cardiac catheterization during which 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 Procedure Codes refer to therapeutic catheterizations:

- 00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
- 35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique
- 35.96 Percutaneous Valvuloplasty
- 36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
- 36.09 Other Removal of Coronary Artery Obstruction
- 37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

“Percutaneous Coronary Intervention (PCI)” is a therapeutic catheterization procedure used to revascularize occluded or partially occluded coronary arteries. A catheter with a balloon or a stent is inserted into the blood vessel and guided to the site of the constriction in the vessel. During a Percutaneous Transluminal Coronary Angioplasty (PTCA), a balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. When a stent is used, 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. These procedures may be performed on an emergent or elective basis.

“Emergent or Primary PCI” means that a patient needs immediate PCI because, in the treating physician’s best clinical judgment, delay would result in undue harm or risk to the patient.

An “Elective PCI” is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.

“Open Heart Surgery” refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine.

Chapter IX

“Adaptive Radiation Therapy (ART)”: Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

“Conformal Radiation Therapy (CRT)”: Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area.

“Conventional External Beam Radiotherapy (2DXRT)” is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. A single beam of radiation is delivered to the patient from several directions. It is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

“Fractionation”: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. The typical fractionation schedule for adults is once per day, five days a week. “Hyperfractionation” refers to radiation given in smaller doses twice a day. In “Hypofractionation,” individual doses are given less than daily, such as in two-five sessions.

“Image-Guided Radiation Therapy (IGRT)” combines with IMRT or CRT to visualize the patient’s anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

“IMRT (Intensity Modulated Radiation Therapy)” creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

“Stereotactic body radiation therapy (SBRT)” is a precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.

“Stereotactic Radiosurgery (SRS)” is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. A special frame is attached to the patient’s skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient’s head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy.

“Stereotactic Radiation Therapy (SRT)” is an approach similar to Stereotactic Radiosurgery that delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30-90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

Chapter X

“Positron Emission Tomography (PET)” uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. PET 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 small amounts of isotopes are needed. PETs are now being combined with a Computerized Tomography (CT) scanner to create PET/CT scanners. In the Plan standards, the terms PET and PET/CT are used interchangeably; the Department does not differentiate between these modalities. The addition of a CT component to an existing PET service

is not considered to be a new service that would trigger CON review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

“Positron Emission Mammography (PEM)” is a form of PET that uses high-resolution detection technology for imaging the breast. As with PET, a radiotracer is administered and the camera is used to provide a higher resolution image. However, the administered dose of FDG is only about half the amount of whole-body PET. PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and checking for recurrence of breast cancer. Three-dimensional reconstruction of the PEM images is also possible.

Chapter XI

An “Ambulatory Surgical Facility (ASF)” is a distinct, freestanding entity organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, 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 an office or clinic for the private practice of licensed health care professionals.

An “Endoscope” is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An “Endoscopy ASF” is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

Chapter XII

“Nursing Facilities” provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. 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.

An “Institutional Nursing Facility” means a nursing facility established within the jurisdiction of a larger non-medical institution that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. This category has been established to provide necessary services for retirement communities established by church, fraternal, or other organizations. Such beds must only serve the residents of the housing complex and be developed as a part of an entire housing construction 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 qualifications. To be considered under this special bed category, the following criteria must be met:

- (1) The nursing facility must be 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.

The Social Security Act [Section 1883(a)(1)], permits certain small, rural hospitals to enter into a "Swing Bed" agreement, under which the hospital can use its beds to provide either acute or skilled nursing care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. A Certificate of Need is not required to participate in the Swing Bed Program.

"Hospice" is 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. Home-based and outpatient hospice programs do not require CON review.

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. CON review is required for a hospice facility.

"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.

"Pediatric Home Health Agencies": Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the home health criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such agencies are not counted in the county inventories for need projection purposes.

“Continuing Care Retirement Community Home Health Agencies”: A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

- (1) 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;
- (2) The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
- (3) Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

H. Home Health

1. 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 mix of home health visits by type of service during FY 2011 for the home health agencies in South Carolina was:

Total Visits	2,022,665
Nursing Visits	44.4%
Physical Therapy Visits	34.5%
Occupational Therapy Visits	9.3%
Home Health Aide Visits	7.8%
Speech Therapy Visits	1.8%
Medical Social Worker Visits	1.7%
Other	0.5%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 19.6 in 2011.

Of the patients currently receiving home health services, about 2% are age 17 and under, approximately 32% are age 18-64, 24% are age 65-74, and about 42% are 75 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need 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. It is recommended that an application for a new home health agency should contain letters of support from physicians in the proposed service area.
4. The need methodology creates statewide use rates for four population groups (0-17, 18-64, 65-74, 75+) based on 2011 utilization data; 75% of these rates are applied against the projected 2013 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2011 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2013. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county.
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
6. An exception to the need methodology may be made for a home health agency restricted to the provision of services such as breast prosthetics and wigs, massage therapy, home health aide and nutritional services for female oncology patients. Any such approved agency will not be counted in the county inventories for need projection purposes.
7. Before an application for a new home health agency can be accepted for filing, all existing agencies in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have submitted

HOME HEALTH METHODOLOGY

Rate	0.00084		0.00830		0.04632		0.12204									
County	Projected 2013 Population Age 0-17	Estimated 2013 Pts Age 0-17	Projected 2013 Population Age 18-64	Estimated 2013 Pts Age 18-64	Projected 2013 Pop Age 65-74	Estimated 2013 Pts Age 65-74	Projected 2013 Pop Age 75+	Estimated 2013 Pts Age 75+	Total Estimated 2013 Patients	2011 Actual Patients	Population Growth Factor	Total Projected 2013 Patients	2013 Unmet (Need)/Surplus	Need at 100 Patients	New Agency Approved Since 12/31/10	New Agency Can be Approved
Abbeville	5,800	5	15,600	129	2,700	125	1,700	207	467	780	1.009	787	320	----	----	----
Aiken	37,000	31	102,100	847	16,600	769	10,600	1,294	2,941	2,589	1.025	2,654	(287)	YES	----	YES
Allendale	2,300	2	6,600	55	900	42	600	73	172	104	1.000	103	(69)	----	----	----
Anderson	45,300	38	116,500	967	18,300	848	12,100	1,477	3,329	3,655	1.018	3,721	392	----	----	----
Bamberg	3,500	3	9,500	79	1,700	79	1,100	134	295	384	1.000	384	89	----	----	----
Barnwell	5,800	5	13,900	115	2,200	102	1,400	171	393	490	1.017	498	105	----	----	----
Beaufort	33,600	28	98,400	817	24,000	1,112	14,900	1,818	3,775	3,615	1.035	3,742	(33)	----	----	----
Berkeley	46,000	39	117,100	972	14,000	648	7,200	879	2,538	2,771	1.024	2,838	300	----	----	----
Calhoun	3,200	3	9,600	80	1,800	83	1,000	122	288	392	1.013	397	109	----	----	----
Charleston	73,800	62	231,800	1,924	29,500	1,366	20,000	2,441	5,793	9,152	1.009	9,235	3,442	----	----	----
Cherokee	13,900	12	35,300	293	5,000	232	3,000	366	902	1,249	1.023	1,278	375	----	----	----
Chester	8,000	7	20,500	170	3,200	148	1,900	232	557	985	1.029	1,014	457	----	----	----
Chesterfield	11,600	10	29,100	241	4,400	204	2,500	305	760	838	1.013	849	89	----	----	----
Clarendon	7,800	7	21,200	176	4,300	199	2,400	293	675	689	1.014	699	24	----	----	----
Colleton	9,600	8	23,600	196	4,200	195	2,500	305	704	1,235	1.020	1,260	556	----	----	----
Darlington	16,400	14	42,400	352	6,700	310	4,100	500	1,176	1,229	1.010	1,241	65	----	----	----
Dillon	8,400	7	19,200	159	2,700	125	1,800	220	511	734	1.003	736	225	----	----	----
Dorchester	37,300	31	88,400	734	10,500	486	6,000	732	1,984	2,768	1.027	2,844	860	----	----	----
Edgefield	5,800	5	18,300	152	2,700	125	1,400	171	453	356	1.012	360	(92)	----	----	----
Fairfield	5,400	5	15,000	124	2,500	116	1,500	183	428	558	1.017	567	140	----	----	----
Florence	33,900	29	85,800	712	12,500	579	7,600	928	2,247	2,875	1.021	2,935	688	----	----	----
Georgetown	12,800	11	35,700	296	8,800	408	4,900	598	1,313	2,091	1.037	2,168	856	----	----	----
Greenville	110,500	93	293,600	2,436	37,500	1,737	24,800	3,027	7,293	8,592	1.022	8,781	1,488	----	----	----
Greenwood	16,700	14	43,300	359	6,300	292	5,000	610	1,275	1,967	1.021	2,008	733	----	----	----
Hampton	5,100	4	13,300	110	2,000	93	1,200	146	354	617	1.014	626	272	----	----	----
Horry	54,600	46	177,300	1,471	33,100	1,533	19,500	2,380	5,430	6,808	1.037	7,060	1,630	----	----	----
Jasper	6,000	5	16,500	137	2,000	93	1,200	146	381	587	1.024	601	220	----	----	----
Kershaw	15,400	13	38,900	323	6,000	278	3,600	439	1,053	1,389	1.021	1,418	365	----	----	----
Lancaster	17,800	15	47,700	396	8,100	375	4,600	561	1,347	1,721	1.016	1,749	401	----	----	----
Laurens	15,400	13	42,400	352	6,400	296	4,500	549	1,210	1,985	1.030	2,045	834	----	----	----
Lee	4,300	4	12,400	103	1,700	79	1,100	134	320	391	1.010	395	75	----	----	----
Lexington	65,000	55	173,300	1,438	22,400	1,038	13,900	1,696	4,227	5,333	1.030	5,493	1,266	----	----	----
Marion	8,000	7	20,200	168	3,400	157	1,800	220	552	618	1.009	624	72	----	----	----
Marlboro	6,300	5	18,300	152	2,600	120	1,300	159	436	639	0.986	630	194	----	----	----
McCormick	1,400	1	6,200	51	2,000	93	1,000	122	267	291	1.019	297	29	----	----	----
Newberry	8,600	7	23,200	193	3,900	181	2,600	317	698	1,061	1.016	1,078	380	----	----	----
Oconee	15,800	13	45,500	378	9,400	435	6,200	757	1,583	2,177	1.024	2,229	646	----	----	----
Orangeburg	21,500	18	57,500	477	9,100	422	6,000	732	1,649	3,094	1.011	3,128	1,479	----	----	----
Pickens	24,800	21	81,600	677	10,300	477	7,200	879	2,054	2,616	1.026	2,684	630	----	----	----
Richland	88,600	75	262,900	2,182	25,800	1,195	16,100	1,965	5,416	6,009	1.015	6,099	683	----	----	----
Saluda	4,500	4	12,300	102	2,000	93	1,400	171	369	337	1.005	339	(31)	----	----	----
Spartanburg	69,900	59	180,900	1,501	25,300	1,172	16,300	1,989	4,721	6,538	1.019	6,664	1,943	----	----	----
Sumter	27,900	23	66,700	554	9,000	417	6,200	757	1,751	2,828	1.015	2,870	1,120	----	----	----
Union	6,600	6	17,300	144	2,900	134	2,100	256	540	832	0.997	830	290	----	----	----
Williamsburg	7,900	7	20,800	173	3,400	157	2,100	256	593	963	0.994	957	364	----	----	----
York	58,200	49	149,600	1,241	17,900	829	10,700	1,306	3,425	4,064	1.030	4,186	761	----	----	----
TOTAL	1,088,000	915	2,977,300	24,707	431,700	19,997	270,600	33,024	78,643	100,996	1.021	103,099	24,456			

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.

8. 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(s) where it operates them.
9. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

- a. Compliance with the Need Outlined in this Section of the Plan;
- b. Acceptability;
- c. Distribution (Accessibility);
- d. Medically Underserved Groups;
- e. Record of the Applicant; and
- f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond

those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.
2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.
3. The applicant must document the full range of services (RN, PT, ST, MSW, IV, etc.) that they intend to provide to pediatric patients.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. 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;
2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
3. 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 non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

Home Health Agency Utilization 2011

<u>Agency</u>	<u>Counties Served</u>	<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	296	1,592
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	415	2,303
Amedisys Home Health of Beaufort 1	Beaufort & Jasper	1,438	30,300
Amedisys Home Health of Bluffton 2	Beaufort, Hampton & Jasper	1,266	22,963
Amedisys Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,568	31,187
Amedisys Home Health of Charleston	Berkeley, Charleston & Dorchester	3,710	72,420
Amedisys Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,385	84,502
Amedisys Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,796	37,951
Amedisys Home Health of Conway	Horry	1,480	27,064
Amedisys Home Health Georgetown	Georgetown & Williamsburg	1,864	32,413
Amedisys HH Georgetown East	Georgetown & Williamsburg	327	5,067
Amedisys Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	6,481	135,463
Amedisys Home Health Myrtle Beach	Horry	1,346	27,112
AnMed Health Home Health	Anderson	1,345	28,134
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	199	4,156
Bethea Home Health (may serve retirement community only)	Darlington	20	21,148
CarePro Home Health	Richland & Sumter	409	8,072
Caring Neighbors Home Health	Fairfield	237	6,543
Carolinas Home Health	Darlington, Dillon, Florence & Marlboro	1,459	26,378
Chesterfield Visiting Nurses Services	Chesterfield, Darlington & Marlboro	407	9,397
Clarendon Memorial Home Health	Clarendon	411	7,105

Covenant Place Home Health (may serve retirement community only)	Sumter	-	-
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	70	3,233
DHEC Region 1 Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	605	15,867
DHEC Region 2 Home Health	Cherokee, Greenville, Pickens, Spartanburg & Union	672	10,677
DHEC Region 3 Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	1,000	15,118
DHEC Region 4 Home Health	Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro & Sumter	2,539	41,259
DHEC Region 5 Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	658	10,830
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	506	4,848
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	607	13,063
DHEC Region 8 Home Health 3	Beaufort, Colleton, Hampton & Jasper	611	6,542
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	249	6,734
Franklin C. Fetter Home Health Agency	Charleston	26	1,172
Gentiva Health Services 4	Lexington & Richland	1,524	35,306
Gentiva Health Services - Charleston 5	Berkeley, Charleston & Dorchester	753	14,636
Gentiva Health Services - Coastal 6	Georgetown, Horry & Williamsburg	1,630	37,332
Gentiva Health Services-Greenville 7 (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	3,469	95,088
Gentiva Health Services - Upstate 8	Cherokee, Chester, Union & York	3,529	79,161
Greenville Hospital System HHA	Greenville & Pickens	1,914	31,986
Health Related Home Care 9	Abbeville, Edgefield, Greenwood, Laurens, McCormick & Saluda	1,582	48,034
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick & Saluda	14	238
Home Care of Lancaster	Lancaster	1,458	49,759
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	1,307	22,616
HomeChoice Partners 10 (restricted to pediatric patients only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York	8	17

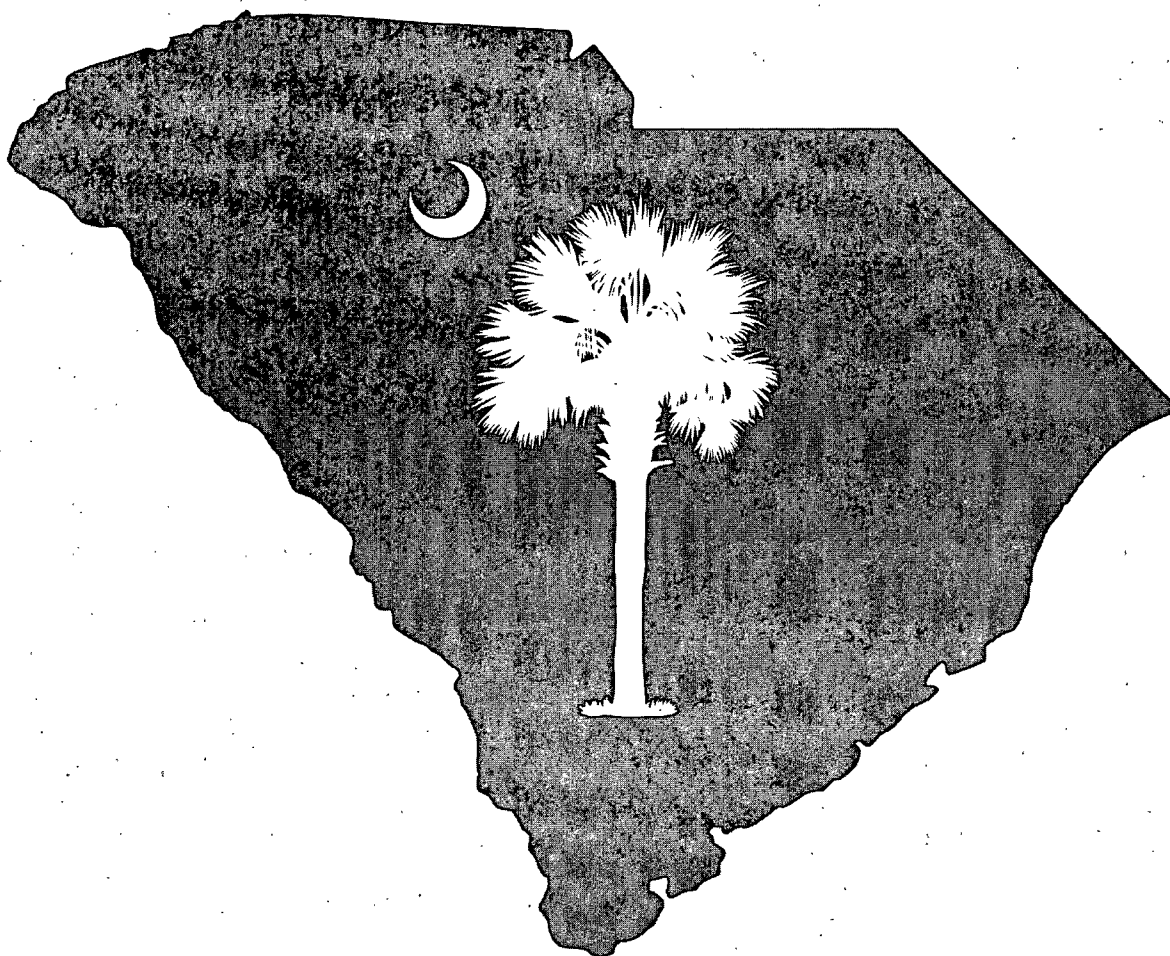
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,645	49,296
Hospice Care of Low Country Home Health (may serve terminally ill patients only)	Beaufort & Jasper	22	420
Incare Home Health	Georgetown & Horry	1,694	25,329
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	9,869	144,378
Interim HealthCare of Rock Hill	York	1,603	20,318
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	2,329	44,865
Island Health Care	Beaufort	1,355	26,157
Kershawhealth Home Health	Kershaw	807	19,084
Laurel Crest Home Health Agency (may serve retirement community only)	Lexington	-	-
Liberty Home Care - Aiken	Aiken	384	6,847
Liberty Home Care - Bennettsville	Marlboro	320	6,529
Liberty Home Care - Myrtle Beach	Horry	1,015	13,539
Live Long Wellcare of Brightwater (may serve retirement community only)	Horry	1	20
Live Long Wellcare Litchfield (may serve retirement community only)	Georgetown	6	77
Live Long Wellcare Summit Hills (may serve retirement community only)	Spartanburg	18	2,402
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	2,749	47,836
Methodist Manor Home Health 11 (may serve retirement community only)	Florence	-	-
Methodist Oaks Campus Home Health (may serve retirement community only)	Orangeburg	-	-
NHC HomeCare - Aiken	Aiken	539	12,943
NHC HomeCare - Greenwood	Greenwood	334	13,337
NHC HomeCare - Laurens	Greenville & Laurens	1,085	35,116
NHC HomeCare - LowCountry	Berkeley & Dorchester	238	3,660
NHC HomeCare - Midlands	Lexington & Richland	557	12,702
NHC HomeCare - Piedmont	York	557	10,121

Neighbors Care Home Health Agency	Chester	511	12,144
Oconee Memorial Home Health	Anderson, Oconee & Pickens	669	20,098
Palmetto Health HomeCare 12	Lexington & Richland	1,583	34,428
Pediatric Home Health 13 (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester	1,250	2,226
Presbyterian Communities of SC 14 (may serve retirement communities only)	Berkeley, Dorchester, Florence, Laurens, Lexington & Pickens	-	-
PHC Home Health	Charleston	511	13,434
Rolling Green Village 15 (may serve retirement community only)	Greenville	-	-
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	3,192	58,875
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	41	3,028
Sea Island Home Health	Charleston & Colleton	110	5,035
Spartanburg Reg Med Ctr Home Health	Spartanburg	2,406	35,132
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	2,275	27,773
Still Hopes Solutions for Living at Home (may serve retirement community only)	Lexington	-	-
Tri-County Home Health Care 16	Aiken, Allendale, Lexington, Richland, Saluda & Sumter	4,137	65,385
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	942	23,446
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	1,002	18,832
United Home Care of Lowcountry 17	Beaufort	-	-
University Home Health North Augusta	Aiken & Edgefield	1,052	16,613
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	750	21,025
Wesley Commons Home Health Care (may serve retirement community only)	Greenwood	62	5,357
Westminster Campus Home Health (may serve retirement community only)	York	19	72
TOTALS		103,229	2,022,665

Home Health Agency Footnotes

- 1 Formerly Amedisys Home Health of Hilton Head.
- 2 Name changed, formerly Care One Home Care Services.
- 3 Licensed amended 2/17/11 to re-add Beaufort and Jasper Counties.
- 4 Formerly Carolina Home Health Care.
- 5 Formerly Carolina Home Health Care-Charleston; prior to that was Hospice of Charleston Home Health Agency.
- 6 Formerly Total Care – Coastal.
- 7 Formerly Carolina Home Health Care.
- 8 Formerly Total Care Home Health.
- 9 CON approved 4/25/12 to serve Edgefield County; appealed.
- 10 CONs issued 9/22/11 to establish a HHA restricted to pediatric patients only, SC-11-31 through SC-11-35, SC-11-37 through SC-11-40. Licensed 11/14/11.
- 11 Licensed 2/12/10.
- 12 De-licensed Bamberg County (served terminally ill patients only) 3/1/11.
- 13 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10. License amended 11/30/10 to raise the age limit from 14 years and under to 18 years and under.
- 14 Agency licensed to serve the 6 Presbyterian communities 12/31/11.
- 15 Exemption issued 7/5/12.
- 16 CON approved for Aiken County; appealed. CON issued 12/1/10, SC-10-35. Agency licensed for Aiken County 12/16/10. CON approved for Allendale County; appealed.
- 17 CON approved for Beaufort County; appealed.

South Carolina Health Plan



Enacted 13 August 2015

SOUTH CAROLINA HEALTH PLANNING COMMITTEE

<u>MEMBER</u>	<u>REPRESENTING</u>	<u>EXPIRATION</u>
Michael N. Bohan, M.D.	Provider	6/30/2018
Bradley W. Moorhouse	Provider	6/30/2016
Gayle L. Resetar	Provider	6/30/2015
Rajeev Vasudeva	Provider	6/30/2018
Mary E. Phillips	Business (At-Large)	6/30/2016
Phyllis B. Buie	Finance/Business	6/30/2015
Ann M. McCraw	Finance/Business	6/30/2018
TBA	Finance/Business	
W.H. "Ham" Hudson	Consumer	6/30/2015
Roger Leaks, Jr.	Consumer	6/30/2015
Kurt E. Moore	Consumer	6/30/2018
Steve E. Nail	Consumer	6/30/2018
Matthew Aronson	Consumer Affairs (Ex-Officio)	
John O. Hutto, M.D.	Board of Health and Environmental Control	

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CHAPTER I

INTRODUCTION

SOUTH CAROLINA HEALTH PLAN

The South Carolina Code of Laws requires the Department of Health and Environmental Control ("Department") to prepare a South Carolina Health Plan ("Plan"), with the advice of the Health Planning Committee, for use in the administration of the Certificate of Need Program. *See § 44-7-180(B).*

CERTIFICATE OF NEED

The purpose of the Certificate of Need Program, as set forth in the *State Certification of Need and Health Facility Licensure Act* ("Certificate of Need Act"), 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. To achieve these purposes, the Certificate of Need Act requires a person or health care facility to obtain a Certificate of Need from the Department before undertaking certain health care related projects. *See § 44-7-120.*

HEALTH PLANNING COMMITTEE

The Health Planning Committee advises the Department in the drafting of the South Carolina Health Plan. It is comprised of fourteen members, twelve of whom are appointed by the Governor, which must include at least one member from each congressional district. One member is appointed by the chairman of the Department's Board, and by virtue of his office, the final member is either the South Carolina Consumer Advocate or his designee. Health care consumers, health care financiers (including business and insurance), and health care providers (which must include at least one nursing home administrator) are equally represented. The Health Planning Committee reviews the South Carolina Health Plan and submits it to the Board of Health and Environmental Control for final revision and adoption. *See § 44-7-180(A),(C).*

STATUTORY REQUIREMENTS

In accordance with § 44-7-180(B), this Plan contains (1) an *inventory* of existing health care facilities, beds, services and equipment; (2) *projections of need* for additional facilities, beds, services and equipment; (3) *standards for distribution* of facilities, beds, services and equipment ("Certificate of Need Standards"); and (4) the *project review criteria* taken into consideration of Certificate of Need applications for facilities, beds, services and equipment.

(1) INVENTORY

Chapter II of this Plan identifies the inventory regions and service areas used in the administration of the Certificate of Need Program. Beds and equipment are inventoried

where applicable.

(2) PROJECTIONS OF NEED

Chapters III – XII of this Plan discuss the need for additional facilities, beds, services and equipment in the State. While the methodologies used to determine these needs vary depending on the type of facility, service, or equipment, a determination of both current and projected need is calculated for most areas addressed by the Plan. Charts summarizing these needs are located in Chapter XIII of this Plan.

(3) CERTIFICATE OF NEED STANDARDS

In consultation with the Health Planning Committee, the Department formulated these standards to guide medical providers throughout the State. Inclusion of these standards in the application process is designed to give applicants notice of its requirements and to elicit from them a commitment to incorporate these standards into both their applications and finished projects.

(4) PROJECT REVIEW CRITERIA

A general statement has been added to most sections of the Plan setting forth 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 they are in Regulation 61-15. Where appropriate, the Plan contains a finding as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment.

DISCLAIMERS

- (1) The hyperlinks provided throughout this Plan were checked for accuracy immediately prior to publication. Due to factors outside our control, we cannot guarantee the links will not expire or otherwise become unavailable after publication. Should you be unable to access the hyperlinked information, please feel free to request the information from the Certificate of Need Program via e-mail to coninfo@dhec.sc.gov.
- (2) The population data set forth in this Plan was received from the South Carolina Revenue and Fiscal Affairs Office in February of 2015. The material includes population projections that are subject to the following conditions:

These projections offer only one scenario of future population change using the most current data available. The overall accuracy of the projections depends on the extent to which future events unfold in a manner that reflects previous trends observed within each group. The model cannot account for unprecedented events that may significantly

alter an area's demographic composition in the future. The possible events include large factory openings or closings, changes in technology, public health crises, environmental events, or other conditions that could have an effect on migration, birth rates, or death rates. This means that population projections are likely to be more accurate in the immediate future than in distant years into the future. The projections will be updated regularly as new data becomes available and future events unfold. Annual county population estimates released by the Census Bureau will be monitored along with births and deaths data released each year, and adjustments will be made to the projected population results as appropriate.

CHAPTER II

INVENTORY REGIONS AND SERVICE AREAS

INVENTORY REGIONS

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

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

NEED FOR HEALTH CARE FACILITIES AND HEALTH SERVICES

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

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

SERVICE AREAS

In addition to inventory regions, this Plan designates service areas for certain Health Care Facilities and Health Services. A service area is comprised of one or more counties, and may cross multiple administrative, geographic, trade and/or political boundaries. Due to factors that

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. 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, applicable statutes and regulations.

EXCEPTIONS TO SERVICE AREA STANDARDS

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are 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 want to transfer or exchange specific technologies or licensed beds in order to better meet an identified need. Affiliated hospitals are 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, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such transfers or exchanges could only occur between facilities within the same licensing category. *A Certificate of Need is required to transfer or exchange health 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 impact 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 service as justification for a subsequent request to establish 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.

ESTIMATED STATE CIVILIAN POPULATION

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,774,839 for 2013 and projected population of 5,116,870 for 2020. All population data (county, planning area, and statewide) were provided by the South Carolina Revenue and Fiscal Affairs Office, Health and Demographics Section, in February of 2015.

INVENTORY DATES

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was September 12, 2014. Inventory and utilization data set forth in this Plan is derived from the 2013 Joint Annual Reports (JARs). The period of time in which the individual data was collected is set forth by the reporting entity in its individual JAR submission.

CHAPTER IV

PSYCHIATRIC SERVICES

COMMUNITY PSYCHIATRIC BEDS

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. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

Special units for children, adolescents and geriatric patients have been developed throughout the State. If any additional beds are approved, they must come from the calculated psychiatric bed need in this Plan. 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.

According to the Department of Mental Health (DMH), there continues to be a great need for additional psychiatric beds and resources in communities throughout the state. Medicaid does not pay for psychiatric care provided by freestanding psychiatric hospitals (known as Institutions for Mental Disease or IMDs); however, the Emergency Medical Treatment & Labor Act (EMTALA) requires hospitals to provide psychiatric care for patients regardless of ability to pay. As a result, general hospitals have found their emergency departments over-burdened with patients requiring psychiatric care. DMH has had substantial decreases over the past 15 years in the number of its available adult inpatient psychiatric beds, and for many years has lacked the capacity to timely admit adult patients referred for emergency admission. Additionally, many general hospitals have reduced or eliminated their adult psychiatric hospital beds.

CMS's ongoing project called the Medicaid Emergency Psychiatric Demonstration could lead to Medicaid reimbursement for freestanding psychiatric hospitals. Twelve participating states, including North Carolina, will create Medicaid programs for psychiatric patients age 21-64 seeking emergency treatment at IMDs. The theory is that the IMDs can provide care at lower cost than warehousing the patients in hospital EDs. If the pilot project is successful, Congress may revise the Medicaid funding for psychiatric care nationally. Project results may be released as early as July of 2015.

The Psychiatric Programs Chart is located in Chapter XIII of this Plan.

CERTIFICATE OF NEED STANDARDS

1. Need projections are based on psychiatric service areas.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or 75% of the statewide average beds per 1,000 population to project need. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.
3. Should the service area show a need for additional beds, a general acute care hospital may be approved for the maximum of the actual projected bed need or up to 20 additional beds ("20 Bed Rule") to establish an economical unit ("Unit"). An applicant seeking more beds than are projected may not use such beds for the establishment of a specialty psychiatric unit. Any beds sought in excess of the projected bed need in the service area must be used for the provision of adult psychiatric services in order to address the growing number of psychiatric patients being held in hospital emergency departments. Finally, although more than one general acute care hospital per service area may apply for beds under this provision, the Department may approve no more than nineteen (19) beds, in any combination, beyond the need shown in this Plan for each service area.

An existing general acute care hospital or freestanding psychiatric facility that already has licensed psychiatric beds may apply for additional beds beyond the need demonstrated in the Plan. However, prior to applying for additional beds beyond the need demonstrated in the Plan, the facility must demonstrate that it has maintained a minimum 70% occupancy rate as demonstrated by its most recent Joint Annual Report ("JAR"). The Department shall not approve an application for more beds than are shown as needed in the Plan unless the applicant meets this 70% occupancy rate criteria.

4. 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.

The Psychiatric Bed Need Chart is located in Chapter XIII of this Plan.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Acceptability;
5. Financial Feasibility;
6. Ability of the Applicant to Complete the Project;
7. Cost Containment; and
8. Staff Resources.

Psychiatric beds are planned for and located within sixty minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into

service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to form a regional treatment facility.

7. 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.
8. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state.
9. Current utilization and population growth are factored into the methodology for determining the need for additional beds.
10. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this 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:

1. Compliance with the Need Outlined in this Section of the 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.

The Inpatient Treatment Bed Need Chart is located in Chapter XIII of this Plan.

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, suboxone and buprenorphine 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. Narcotic treatment programs are described in Regulation 61-93.

Charges for medication usually range between \$11 and \$17 per day. A Registered Pharmacist must dispense the medication. A minimum caseload of around 150 clients is required to ensure breaking even on the costs of providing this service.

The Narcotic Treatment Programs Chart is located in Chapter XIII of this Plan.

CERTIFICATE OF NEED STANDARDS

1. *A Certificate of Need is required for a narcotic treatment program.*
2. An applicant must project a minimum caseload of 150 clients.
3. According to the licensing standards, a narcotic treatment program shall not operate within 500 feet of: the property line of a church, the property line of a public or private 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.
4. Because clients must usually attend a center 6 days per week to receive their dose of medication, these centers should be located throughout the state. To improve accessibility, narcotic treatment programs should be developed in counties where none exist. An additional treatment program can only be approved in a county with an existing program if the applicant is able to document that the existing program has a sufficient waiting list for admission that would justify the need for an additional program.

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 this Plan;
2. Distribution (Accessibility);
3. Record of the Applicant;
4. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility will not outweigh the adverse effects of the duplication of this existing service.

PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and monitoring for recurrence of breast cancer. It detects lesions as small as 1.6 mm, which is not possible with whole-body PET. Three-dimensional reconstruction of the PEM images is also possible. PEM drastically reduces the number of false positives resulting in unnecessary biopsies incurred by patients using conventional mammography.

The actual scan takes 4-10 minutes and the entire process takes approximately 40 minutes to perform. The process requires a nuclear medical technologist certified to inject radiopharmaceuticals for handling of FDG, and either a mammography or nuclear medicine technologist to perform patient positioning and biopsy.

PEM was cleared for marketing by the U.S. Food and Drug Administration (FDA) in August of 2003.

CERTIFICATE OF NEED STANDARDS

1. PEM scanners are considered to be in operation five days per week, but because of their limited focus no capacity standard is established.
2. Hospitals that provide comprehensive cancer treatment services (including radiation therapy) are appropriate locations for fixed or mobile PEM services for the detection of breast cancer. Other hospitals must document that they treat a sufficient number of breast cancer patients that would justify the need for PEM services.
3. 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.
4. The applicant agrees in writing to provide to the Department utilization data on the operation of the PEM service.
5. The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Acceptability;
5. Financial Feasibility;
6. Ability of the Applicant to Complete the Project; and
7. Cost Containment.

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

CHAPTER XI

OUTPATIENT FACILITIES

Outpatient facilities provide community service for the diagnosis and treatment of ambulatory patients that is operated in connection with a hospital or as a freestanding facility under the professional supervision of a licensed physician. These facilities serve patients who do not require hospitalization and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

AMBULATORY SURGICAL FACILITY

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

For purposes of this Plan, an endoscope is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An Endoscopy ASF is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

A substantial increase has occurred in both the number and percentage of ambulatory surgeries performed and in the number of approved ASFs. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost.

CERTIFICATE OF NEED STANDARDS

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.
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 or endoscopic procedures 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. It is recommended that an application for a new ASF should contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility.
6. The applicant must document the potential impact that the proposed new ASF or expansion of an existing ASF 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 ASFs. However, for an ASF approved to perform only endoscopic procedures, *another Certificate of Need would be required* before the center could provide other surgical specialties.
8. Before an application for a new general Ambulatory Surgery Facility can be accepted for filing in a county having a current population of less than 100,000 people, all general ASFs in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for an ASF filing in a county having a current population of greater than 100,000 people.
9. Endoscopy suites are considered separately from other operating rooms and therefore are not considered competing applicants for Certificate of Need review purposes. Before an application for a new endoscopy-only ASF can be accepted for filing in a county having a current population of less than 100,000 people, all ASFs with endoscopy suites in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs with endoscopy suites

must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a new endoscopy-only ASF filing in a county having a current population of greater than 100,000 people.

10. The approval of a new general or endoscopy-only ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites. The merger of two existing ASFs in a county to construct a consolidated ASF does not constitute a "new ASF" for the purpose of interpreting Standards 8 and 9.
11. The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage that is comparable to all other existing ambulatory surgery facilities, if any, in the service area.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements and must commit to seek accreditation from CMS or any accrediting body with deemed status. Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most South Carolina residents. Most ASFs operate five days a week, with elective surgery being scheduled several days in advance.

The Ambulatory Surgical Facility Utilization Chart is located in Chapter XIII of this Plan.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of the Plan;
2. Adverse Effects on Other Facilities
3. Community Need Documentation;
4. Distribution (Accessibility);
5. Financial Feasibility;
6. Cost Containment;
7. Projected Revenues;
8. Projected Expenses;
9. Ability of the Applicant to Complete the Project; and
10. Staff Resources.

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

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 Joint Commission

1. Need for the Proposed Project;
2. Economic Consideration; and
3. Health System Resources.

Because Institutional Nursing Facility Beds are used solely by the residents of the retirement community, there is no justification for approving this type of nursing facility unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or facilities.

SWING-BEDS

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina; however, the hospital must obtain Medicare certification.

The Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt]) permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. The hospital must be located in a rural area and have fewer than 100 beds.

Medicare Part A covers the services furnished in a swing bed hospital under the SNF PPS. The PPS classifies residents into one of 44 categories for payment purposes. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a stay of at least three consecutive days, although it does not have to be from the same hospital as the swing bed. Typical medical criteria include daily physical, occupational and/or speech therapy, IV or nutritional therapy, complex wound treatment, pain management, and end-of-life care.

The Swing-Bed Participants Chart is located in Chapter XIII of this Plan.

HOSPICE FACILITIES AND HOSPICE PROGRAMS

Hospice is 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.

The Inpatient Hospice Facilities Chart is located in Chapter XIII of this Plan.

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 STANDARDS

1. *A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.*
2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.
3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.
4. 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. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);
3. Community Need Documentation;
4. Acceptability;
5. Financial feasibility; and
6. Staff Resources.

HOME HEALTH

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.

CERTIFICATE OF NEED 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. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:
 - a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.
 - c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.
 - d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.
4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.
5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.
6. Specialty home health providers are exempt from the need calculation applicable to full-service home health agencies, but are otherwise subject to Certificate of Need.
7. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, consent order, abandonment of patients in other business operations, or loss of license. However, any consent orders or loss of licenses related to licenses that were obtained from the Department between July

1, 2013 and May 22, 2014 without a Certificate of Need shall not be grounds for denial of a Certificate of Need application pursuant to this Section. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should it fail to reach this threshold number two years after initiation of services in a county, it will voluntarily relinquish its license for that county.
9. Nothing in this Section is intended to restrict the ability of the Department to approve more than one new Home Health Agency in a county at any given time.

The Home Health Agency Utilization Chart is located in Chapter XIII of this Plan.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Acceptability;
3. Distribution (Accessibility);
4. Medically Underserved Groups;
5. Record of the Applicant; and
6. Financial Feasibility.

The benefits of improved accessibility outweigh the adverse effects caused by the duplication of any existing service.

Pediatric Home Health Agencies

Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the above criteria may be made for a Certificate of Need for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

CERTIFICATE OF NEED STANDARDS

1. A separate Certificate of Need application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.
2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.
3. The applicant must document the full range of services that they intend to provide to pediatric patients.

Continuing Care Retirement Community Home Health Agencies

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and *does not require Certificate of Need review 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 the applicable home health agency licensing standards; and
- 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 non-facility-based Medicare and/or Medicaid standards.

CHAPTER XIII

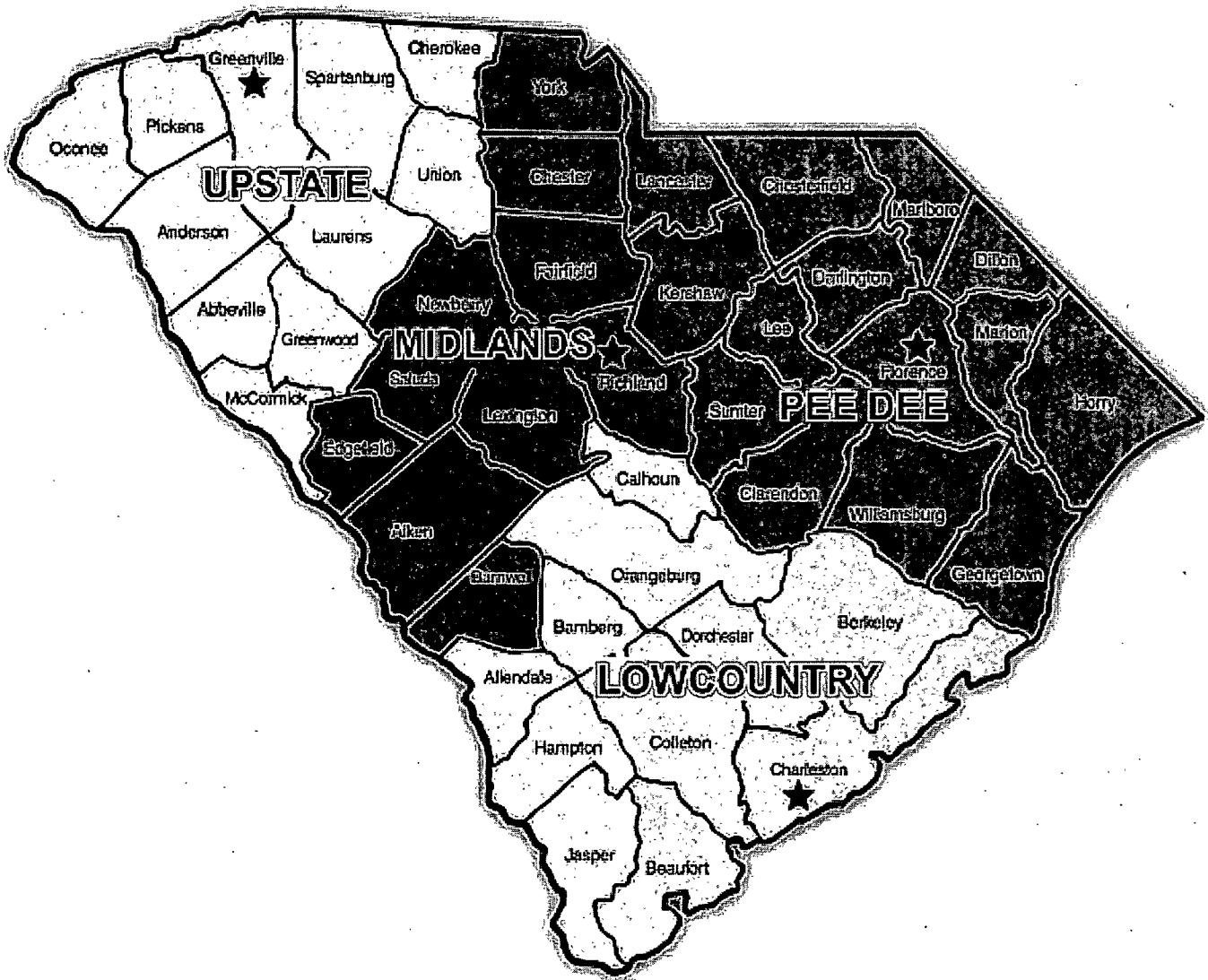
INVENTORIES & DETERMINATIONS OF NEED

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DHEC REGIONS MAP

(Chapter II)



**HOME HEALTH AGENCY UTILIZATION
(Chapter XII)**

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	<u>2013</u>	
		<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens - Midlands (May Serve Obstetrical Patients Only)	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, Richland	NR	NR
Alere Womens & Childrens - Piedmont (May Serve Obstetrical Patients Only)	Abbeville, Allendale, Anderson, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenville, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Saluda, Spartanburg, Sumter, Union, Williamsburg, York	NR	NR
Amedysis Home Health of Beaufort	Beaufort, Jasper	1,672	26,266
Amedysis Home Health of Bluffton	Beaufort, Hampton, Jasper	1,431	21,952
Amedysis Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg, Richland	1,819	29,145
Amedysis Home Health of Charleston	Berkeley, Charleston, Dorchester	4,081	68,497
Amedysis Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, Hampton	4,742	78,283
Amedysis Home Health of Clinton	Abbeville, Greenville, Greenwood, Laurens	1,562	26,941
Amedysis Home Health of Conway	Horry	1,268	26,026
Amedysis Home Health of Georgetown	Georgetown, Williamsburg	1,701	27,536
Amedysis Home Health of Georgetown East	Georgetown, Williamsburg	NR	NR
Amedysis Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter	6,548	113,777
Amedysis Home Health of Myrtle Beach	Horry	1,701	25,360
AnMed Health Home Health Agency	Anderson	1,489	28,132
Beaufort-Jasper Home Health Agency	Beaufort, Jasper	177	3,061
Bethea Home Health (May Serve Retirement Community Only)	Darlington	28	11,588

**HOME HEALTH AGENCY UTILIZATION
(Chapter XII)**

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	<u>2013</u>	
		<u>Persons Served</u>	<u>Total Visits</u>
CarePro Home Health 1	Richland, Sumter	--	--
CareSouth HHA Holdings of South Carolina 5	Aiken	--	--
Caring Neighbors Home Health	Fairfield	NR	NR
Carolinas Home Health	Darlington, Dillon, Florence, Marlboro	1,631	35,741
Chesterfield Visiting Nurses Services	Chesterfield, Darlington, Marlboro	393	6,718
Clarendon Memorial Home Health	Clarendon	548	19,549
Covenant Place Home Health (May Serve Retirement Community Only)	Sumter	17	936
Cypress Club Home Health Agency (May Serve Retirement Community Only)	Beaufort	60	2,768
DHEC Region I Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee, Saluda	923	18,775
DHEC Region II Home Health	Cherokee, Greenville, Pickens, Spartanburg, Union	207	2,857
DHEC Region III Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland, York	1,004	14,263
DHEC Region IV Home Health	Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro, Sumter	2,919	42,073
DHEC Region V Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg	210	2,290
DHEC Region VI Home Health	Georgetown, Horry, Williamsburg	178	1,421
DHEC Region VII Home Health	Berkeley, Charleston, Dorchester	929	13,189
DHEC Region VIII Home Health	Beaufort, Colleton, Hampton, Jasper	161	1,727
Florence Visiting Nurses Services	Dillon, Florence, Lee, Marion	NR	NR
Franklin C. Fetter Home Health Agency	Charleston	NR	NR

**HOME HEALTH AGENCY UTILIZATION
(Chapter XII)**

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	<u>2013</u>	
		<u>Persons Served</u>	<u>Total Visits</u>
Gentiva Health Services - Charleston	Berkeley, Charleston, Dorchester	1,551	35,427
Gentiva Health Services - Columbia	Lexington, Richland	2,060	52,591
Gentiva Health Services - Greenville (May Only Serve Patients in Union County with Initial Diag Requiring IV Therapy and/or Home Uterine Activity Monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union	<i>NR</i>	<i>NR</i>
Gentiva Health Services - Gaffney / Rock Hill	Cherokee, Chester, Union, York	4,361	109,434
Gentiva Health Services - Myrtle Beach	Georgetown, Horry, Williamsburg	2,317	49,146
Greenville Hospital System Home Health Agency	Greenville, Pickens	<i>NR</i>	<i>NR</i>
Health Related Home Care	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	1,762	54,499
HomeCare of HospiceCare of the Piedmont 2 (May Only Serve Terminally Ill Patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick, Saluda	--	--
Home Care of Lancaster	Lancaster	1,530	30,080
HomeCare of the Regional Medical Center	Calhoun, Orangeburg	1,193	17,881
HomeChoice Partners (May Serve Pediatric Patients Only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York	<i>NR</i>	<i>NR</i>
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick, Saluda	1,691	50,862
Hospice Care of the Lowcountry Home Health (May Serve Terminally Ill Patients Only)	Beaufort, Jasper	<i>NR</i>	<i>NR</i>
Incare Home Health	Georgetown, Horry	<i>NR</i>	<i>NR</i>
Interim HealthCare of Greenville	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg	<i>NR</i>	<i>NR</i>
Interim HealthCare of Rock Hill	York	1,798	25,474
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester, Georgetown	<i>NR</i>	<i>NR</i>

**HOME HEALTH AGENCY UTILIZATION
(Chapter XII)**

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	2013	
		<u>Persons Served</u>	<u>Total Visits</u>
Island Health Care	Beaufort	1,209	27,079
Kershawhealth Home Health	Kershaw	848	19,458
Laurel Crest Home Health Agency (May Serve Retirement Community Only)	Lexington	0	0
Liberty Home Care - Aiken	Aiken	235	2,642
Liberty Home Care - Bennettsville	Marlboro	236	3,132
Liberty Home Care - Myrtle Beach	Horry	909	9,208
Live Long Wellcare of Brightwater (May Serve Retirement Community Only)	Horry	36	3,451
Live Long Wellcare of Litchfield (May Serve Retirement Community Only)	Georgetown	47	6,926
Live Long Wellcare of Summit Hills (May Serve Retirement Community Only)	Spartanburg	49	844
McLeod Home Health	Darlington, Dillon, Florence, Lee, Marion	3,054	48,328
Methodist Manor Home Health (May Serve Retirement Community Only)	Florence	81	26,631
Methodist Oaks Campus Home Health (May Serve Retirement Community Only)	Orangeburg	<i>NR</i>	<i>NR</i>
NHC HomeCare - Aiken	Aiken	475	10,791
NHC HomeCare - Greenwood	Greenwood	442	14,590
NHC HomeCare - Laurens	Greenville, Laurens	1,257	37,980
NHC HomeCare - LowCountry	Berkeley, Dorchester	334	6,663
NHC HomeCare - Midlands	Lexington, Richland	<i>NR</i>	<i>NR</i>
NHC HomeCare - Piedmont	York	393	8,312
Neighbors Care Home Health Agency	Chester	625	14,488

HOME HEALTH AGENCY UTILIZATION
(Chapter XII)

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	2013	
		<u>Persons Served</u>	<u>Total Visits</u>
Oconee Home Health	Anderson, Oconee, Pickens	431	7,793
Palmetto Health HomeCare	Lexington, Richland	1,920	39,990
Pediatric Home Health (Restricted to Pediatric Patients Only)	Berkeley, Charleston, Dorchester	NR	NR
Presbyterian Communities of SC (May Serve Retirement Communities Only)	Berkeley, Dorchester, Florence, Laurens, Lexington, Pickens	6	177
PruittHealth Home Health 4	Aiken	--	--
PHC Home Health	Charleston	650	14,419
Roper - St. Francis Home Health Care	Berkeley, Charleston, Dorchester	3,768	61,040
Seabrook Wellness & Home Health Care (May Serve Retirement Community Only)	Beaufort	31	3,211
Sea Island Home Health	Charleston, Colleton	112	3,555
Spartanburg Regional Home Health	Spartanburg	2,315	42,986
St. Francis Hospital Home Care	Anderson, Greenville, Pickens, Spartanburg	3,768	61,040
Still Hopes Solutions for Living at Home (May Serve Retirement Community Only)	Lexington	0	0
Tri-County Home Health Care	Aiken, Allendale, Lexington, Richland, Saluda, Sumter	4,914	85,187
Trinity Home Service Home Health	Aiken, Barnwell, Edgefield	1,046	23,317
Tuomey Home Health (May Only Serve Terminally Ill Patients In Lee & Clarendon Counties)	Clarendon, Lee, Sumter	896	18,662
United Home Care of Lowcountry 3	Beaufort	0	0
University Home Health - North Augusta	Aiken, Edgefield	1,167	20,246
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton, Orangeburg	829	16,586

**HOME HEALTH AGENCY UTILIZATION
(Chapter XII)**

<u>HOME HEALTH AGENCY</u>	<u>COUNTIES SERVED</u>	<u>2013</u>	
		<u>Persons Served</u>	<u>Total Visits</u>
Wesley Commons Home Health Care (May Serve Retirement Community Only)	Greenwood	63	7,310
Westminster Campus Home Health (May Serve Retirement Community Only)	York	10	107
	TOTALS	87,818	1,720,414

NR = Not Reported

1 Facility no longer provides Home Health Care.

2 Discontinued Home Health Care 4/1/12.

3 CON appealed.

4 CON SC-15-05, issued 2/10/15, for the establishment of a new Home Health agency.

5 CON SC-15-04, issued 2/10/15, for the establishment of a new Home Health agency.

drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. *A Certificate of Need is required for a medical detoxification program.*

General Hospital	A facility with an organized medical staff to maintain and operate organized facilities and services to accommodate two or more nonrelated persons for the diagnosis, treatment and care of such persons over a period exceeding 24 hours and provides medical and surgical care of acute illness, injury or infirmity and may provide obstetrical care, and in which all diagnoses, treatment or care are administered by or performed under the direction of persons currently licensed to practice medicine and surgery in the State of South Carolina.	<u>S.C. Code of Regulations 61-16, Section 101(1)(A)</u>
Health Care Facility	Acute care, hospitals, psychiatric hospitals, alcohol and substance abuse hospitals, nursing homes, ambulatory surgical facilities, hospice facilities, radiation therapy facilities, rehabilitation facilities, residential treatment facilities for children and adolescents, intermediate care facilities for person with intellectual disability, narcotic treatment programs, and any other facility for which Certificate of Need review is required by federal law.	<u>S.C. Code Ann. Section 44-7-130(10)</u>
Health Service	Clinically related, diagnostic, treatment, or rehabilitative services and includes alcohol, drug abuse, and mental health services for which specific standards or criteria are prescribed in the South Carolina Health Plan.	<u>S.C. Code Ann. Section 44-7-130(11)</u>
Home Health Agency	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.	South Carolina Health Plan
Home Health Service	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,	South Carolina Health Plan

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.

Hospice	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. <i>Home-based and outpatient hospice programs do not require Certificate of Need review.</i>	South Carolina Health Plan
Hospice Facility	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. <i>A Certificate of Need is required for a hospice facility.</i>	South Carolina Health Plan
Hospice Program	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. <i>A Certificate of Need is not required for a hospice program.</i>	South Carolina Health Plan
Hospital	A facility organized and administered to provide overnight medical, surgical, or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy. Hospital may include residential treatment facilities	<u>S.C. Code</u> <u>Ann. Section</u> <u>44-7-130(12)</u>

) COURT OF COMMON PLEAS
) C.A. No.: 2016-CP-40-00818

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) **ORDER GRANTING PRELIMINARY**
) **INJUNCTION AND REQUIRING**
) **EXPEDITED BRIEFING AND**
) **ARGUMENT**

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THE PENDING MOTION

Plaintiff Amedisys, Inc. (“**Amedisys**”) has moved for a preliminary injunction to restrain Defendant South Carolina Department of Health and Environmental Control (“**DHEC**”) during the pendency of this action from accepting, reviewing, or issuing staff decisions regarding applications for certificates of need (“**CONs**”) to provide home

¹ This Court granted the motions of the Intervenor-Defendants to intervene on February 22, 2016.

health services pursuant to the State Health Plan for 2014-2015 (the “**Current Plan**”).²

This Court heard the motion on February 22, 2016.³

² Amedisys filed its motion on February 9, 2016, pursuant to Rule 65(b), SCRCP, initially seeking a temporary restraining order until a hearing, and a preliminary injunction from hearing until determination on the merits. The Defendant has agreed not to take any action sought to be enjoined until this Court acts on the motion, so that the Court need not address the request for a temporary restraining order. Both Amedisys and the Defendant submitted memoranda respectively in support of and in opposition to the request for a preliminary injunction, and all parties including the intervenors appeared at the hearing and spoke to that issue.

The record on this motion consists of the arguments and representations made by counsel at the hearing, and the following documents:

1. Complaint, filed February 8, 2016, and the following exhibits:
 - A. Home Health section of State Health Plan for 2012-2013;
 - B. Updates to population and need projections for prior State Health Plans
 - C. Home Health section of State Health Plan for 2012-2013;
2. Notice of Motion and Motion for Temporary Restraining Order and Preliminary Injunction Including Memorandum of Law, filed February 9, 2016;
3. Defendant DHEC’s Memorandum in Opposition to Motion for Temporary Restraining Order and Preliminary Injunction, filed February 19, 2016.
4. National Healthcare Corporation’s Amended Motion to Intervene, filed February 16, 2016;
5. PruittHealth Corporation’s Motion to Intervene, filed February 16, 2016; and
6. Transcript of DHEC Open Forum meeting of September 18, 2016, provided by counsel for Amedisys at the hearing without objection.

³ In attendance at the hearing were counsel for Amedisys, Steve A. Matthews and Andrea H. Brisbin; counsel for DHEC, Ashley C. Biggers; counsel for Intervenors-Defendants National Healthcare Corporation and PruittHealth Corporation, Stuart M. Andrews, Jr. and Meredith A. Weinberg; and counsel for Intervenors-Defendants In-Care Home Health, Inc., Tri-County Home Health Care & Services, Inc, M&C Group, LLC d/b/a/ Home Helpers of Bluffton, Tidewater Home Health, PA, and Hedgemark Brentwood Medical Services Inc. d/b/a PHC Home Health, E. Wade Mullins III and Robert C. Osborne.

GRAVAMEN OF THE UNDERLYING ACTION

Amedisys alleges that the home health services portion of the Current Plan contains insufficient objective criteria to determine need for new home health services in South Carolina's 46 counties and thus fails to meet the requirements and purposes of the "State Certification of Need and Health Facility Licensure Act (the **"CON Act"** – S.C. Code §§ 44-7-110 *et seq.*) and the "Licensure of Home Health Agencies Act" (the **"HHA Act"** – S.C. Code § 44-69-10 *et seq.*). On that basis, Amedisys alleges that the home health services portion of the Current Plan is invalid and cannot be used by DHEC in considering or deciding upon applications for home health CONs.⁴

LEGAL STANDARD FOR THE REQUESTED RELIEF

To obtain a preliminary injunction, the moving party must demonstrate that (1) it would suffer irreparable harm if the injunction is not granted; (2) it will likely succeed on the merits of the litigation; and (3) there is no adequate remedy at law. *Compton v. S.C. Dep't of Corr.*, 392 S.C. 361, 366, 709 S.E.2d 639, 642 (2011).

With regard to the likelihood of success on the merits, this Court is mindful that the merits here present solely a legal question. In a case presenting a similar question, the South Carolina Supreme Court ruled: "The issue whether the [State Health] Plan standards satisfy the statutory requirements is a legal conclusion based on statutory interpretation principles. Thus, no factual findings are necessary to determine compliance with § 44-7-180(B)." *MRI at Belfair, LLC v. S.C. Dept. of Health and Environmental Control*, 379 S.C.1, 664 S.E.2d 471, fn. 4 at 474 (2008). Consequently, other than

⁴ Neither this lawsuit as a whole, nor the pending motion, nor this Order affects the Certificate of Need Program for any health care services or facilities other than home health care.

statutory, regulatory, and administrative background, this Order will discuss only those facts necessary to understand the context.

BACKGROUND

The Parties

Each of Amedisys and the Intervenor-Defendants is an entity that provides home health care services in various South Carolina counties and/or that has multiple pending applications for CONs to provide home health services in additional counties.

DHEC is an agency of the State of South Carolina, created and governed by the General Assembly in S.C. Code §§ 44-1-20 *et seq.*, and in particular as it relates to this action in the CON Act and the HHA Act.

The Regulatory Regime

In order “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,” the General Assembly requires that certain health care providers, prior to undertaking certain health care activities, first obtain a certificate of need. CON Act, S.C. Code §§ 44-7-120(1). The General Assembly has designated DHEC as “the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under this article.” CON Act, S.C. Code § 44-7-140.

At least every two years, the State’s health planning committee (the “**Planning Committee**”) must recommend to the South Carolina Board of Health and Environmental Control (the “**Board**,” which is the governing body of DHEC) a State

Health Plan (the “**Plan**”); and the Board must make final revision of and adopt such a Plan. The Planning Committee is established by the CON Act and comprised of appointed members. The CON Act requires public review, comment, and regional public hearings before adoption of a Plan: CON Act, S.C. Code § 44-7-180(A) and (C).

“The Plan at a minimum must include:

- (1) an inventory of existing health care facilities, beds, specified health services, and equipment;
- (2) projections of need for additional health care facilities, beds, health services, and equipment;
- (3) standards for distribution of health care facilities, beds, specified health services, and equipment including scope of services to be provided, utilization, and occupancy rates, travel time, regionalization, other factors relating to proper placement of services, and proper planning of health care facilities; and
- (4) a general statement as to the project review criteria considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding 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.

The South Carolina Health Plan must address and include projections and standards for specified health services and equipment which have a potential to substantially impact health care cost and accessibility. Nothing in this provision shall be construed as requiring the department to approve any project which is inconsistent with the South Carolina Health Plan.”

CON Act, S.C. Code § 44-7-180(B); 24A S.C. Code Regs. 61-15, Section 106(1) and (2); emphasis added.

“[I]t is clear the legislature intended for the State Health Plan to be an enforceable document.” *Trident Med. Ctr. v. S.C. Dep’t of Health and Environmental Control*, 412 S.C. 341, 350, 772 S.E.2d 177, 182 (Ct. App. 2015), *cert. denied* (Dec. 18, 2015).

The Board must also adopt “procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need.” CON Act, S.C. Code §§ 44-7-120(2) and (3) and 44-7-180(C); and S.C. Reg. 61-106(3). The South Carolina General Assembly has forbidden DHEC to “issue a Certificate of Need unless an application complies with the South Carolina Health Plan” and certain other requirements. CON Act, S.C. Code § 44-7-210(B). In addition, if multiple certificate of need applicants file applications to provide similar health care facilities or services in the same service area, DHEC is prohibited from approving more than one application if doing so would “exceed the need” for such facilities and services. CON Act, S.C. Code § 44-7-130(5); § 44-7-210(B).

Among the health care services requiring a certificate of need are those described as “home health services” by the HHA Act. See, in particular, S.C. Code § 44-69-75(A): “A home health agency shall obtain a certificate of need before licensure. Procedures for applying for a certificate must be in accordance with the [CON Act]. . . .” The HHA Act defines “home health services” to include certain statutorily-listed health care items and services furnished on a visiting basis in a patient’s residence (or as an outpatient at a facility where certain equipment cannot be readily brought to the patient’s home). S.C. Code § 44-69-20(5). Entities providing home health services are defined as “home health agencies.” HHA Act, S.C. Code § 44-69-20(4).

Any applicant for a certificate of need to provide home health services in any county must:

“Demonstrate that the proposed project is needed or projected as necessary to meet an identified need of the public. This shall address at a minimum: identification of the target population; the degree of unmet need; projected

utilization of the proposed facility or service; utilization of existing facilities and services; past utilization of existing similar services within the facility; and justification that the proposed project will not unnecessarily duplicate existing entities. The applicant must show all assumptions, data sources, and methodologies used. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.”

S.C. Reg. 61-202(b)(11).

In or about July 2014,⁵ DHEC staff began the process of developing a new biennial Plan, including the statutorily required public hearings. DHEC staff developed a proposal that projected a need for additional home health services in 37 counties (compared to 1 county in the 2012-2013 Plan [see Complaint, Ex. A., p. XII-14] and 3 counties in the 2010-2011 Plan). Through the public input process, Amedisys proposed a need projection methodology that projected a need in 29 counties, some of which Amedisys already was licensed to serve. DHEC staff adopted that proposal and recommended it to the Planning Committee.

On August 3, 2015, however, the Planning Committee completely rejected that proposal and the earlier DHEC staff plan and the need projection methodology that had been used for the past several biennial plans as they related to home health services. [Compare Complaint, Ex. A (2012-2013 Plan) at ¶ 4 and page XII-14, with Complaint,

⁵ As a result of a sustained veto of funding for the CON program (for all services, including home health services) in South Carolina’s state budget for FY 2014, the CON program did not operate from July 1, 2013, until April 14, 2014. On that date, the South Carolina Supreme Court ruled that the failure to fund did not terminate the program and thus clarified that the CON program is still in full force and effect. *Amisub of South Carolina, Inc. v. S.C. Dep’t of Health and Environmental Control*, 403 S.C. 576, 743 S.E.2d 786 (2014). DHEC resumed operation of the CON program in or about July 2014.

Ex. C (Current Plan) at ¶¶ 3 and 4.]⁶ Ten days later, on August 13, 2015, the Planning Committee, without further public review, comment, or hearing, presented its draft Plan to the DHEC Board for consideration; and the Board adopted the entire draft Plan that same day.

The need component of the Current Plan related to home health services is set forth in Complaint, Ex. C (Current Plan) at ¶¶ 3 and 4 (page XII-7), as follows:

3. A new home health agency may be approved if an applicant can demonstrate it will serve 50 or more patients projected to be in need in non-rural counties, or 25 or more patients projected to be in need in rural counties, through evidence that may include, but would not be limited to, the following:

⁶ Those earlier plans and proposals had calculated need based on established criteria related to population, growth, inventory of current services, and demographic need. For example, the Plan for 2012-2013 (the “**Prior Plan**”) had, like earlier plans, established a detailed methodology for determining need based on population, projected population growth, and utilization rates broken down by age-demographic. The need calculation methodology of the Prior Plan related to home health services is described in Paragraph 4 of “Certificate of Need Standards,” at page XII-13 [Complaint, Ex. A], as follows:

- “4. The need methodology creates statewide use rates for four population groups (0-17, 18-64, 65-74, 75+) based on 2011 utilization data; 75% of these rates are applied against the projected 2013 populations for each county to get a total number of estimated patients in need. It then takes the actual number of patients served in 2011 and multiplies them by the population growth factor to project the number of patients to be served by the existing home health agencies in the county for 2013. The projected number of patients served by the existing agencies is subtracted from the total estimated number of patients in need. If there is a difference of 100 or more patients projected to be in need, then another agency could be approved for that county.”

This explanation of methodology was accompanied by a spreadsheet applying that methodology to calculate home-health services need in each of the 46 counties. Moreover, beginning with the Plan for 2010-2011, DHEC established a mechanism for keeping the population and services-inventory information up-to-date throughout the life of a Plan, and had followed through on that mechanism. See Complaint, Ex. B.

- a. Letters of support that identify need for additional home health services from physicians and other referral sources.
 - b. Evidence of underutilization of home health services.
 - c. Evidence of limited scope home health agency service including skilled nursing, physical therapy, occupational therapy, speech therapy, home health aides, and medical social workers.
 - d. Evidence of the denial or delay in the provision of home health services, including but not limited to long waiting lists or delays which exceed industry standards.
4. For the purposes of this Section, a rural county shall mean a county with a population of less than 50,000, according to the most recent projections of the South Carolina Revenue and Fiscal Affairs office as of the time the current Plan was adopted.

Amedisys contends that these paragraphs do not set or provide a method for determining a uniformly applicable and objective projection of need in any county, and thus provide no usable criteria for granting or denying an applicant a CON on a principled, reviewable basis. Moreover, Amedisys contends, even if the qualitative evidence described in subparagraphs 3(a) through 3(d) could lead to a quantifiable figure showing, say, a 50-patient need in a non-rural county, there would be no way to distinguish the 50 patient need shown by one applicant from the 50 patient need shown by another applicant. There would, thus, be no way to determine whether two applicants were competing applicants such that only one would be eligible for a CON under the CON Act. S.C. Code § 44-7-130(5); 24A S.C. Code Reg. 61-15, Section 103(6). As a result, neither potential applicants nor potential opponents of applications would be able to determine in advance whether there was any legal basis to justify their expenditure of resources in applying for or opposing a CON; and DHEC would find itself in the position of

having its decisions be, by definition, arbitrary and capricious and therefore subject to judicial invalidation. S.C. Code § 1-23-380(5)(f).

Current Administrative Posture

Following the adoption of the Current Plan and as of the date of the pending motion, at least 87 CON applications had been submitted to establish new home health services in 40 counties.⁷ As of the hearing on this motion, there had been 93 applications filed just by the 7 intervenors. [See information contained in the Intervenors-Defendants' motions to intervene.] In addition, Amedisys itself has filed 8 applications to preserve its interests in case DHEC is not enjoined.

Of the 87 CON applications pending at the date of the motion, 48 applications are to provide new home health services in counties in which Amedisys currently holds a license to provide and provides home health services. Of the 40 counties with submitted applications, 20 are counties in which Amedisys currently holds a license to provide and provides home health services.

Once an application is submitted, DHEC may request additional information. After DHEC deems an application complete, it must notify affected persons of that fact through publication in the *South Carolina State Register*. DHEC must then either grant or deny the requested certificate of need within 30 to 120 days of the publication of the last competing application (or up to 150 days if someone requests a public hearing). CON

⁷ That number of new applications appears to be unprecedented. The 87 in the 5 months following the adoption of the plan compares to fewer than 25 in the 5 years from 2009 through 2014. Amedisys points to that fact as evidence of the lack of objective criteria and, hence, the lack of any principled basis on which DHEC could reject an application due to inadequate need.

Act, S.C. Code § 44-7-210(A). DHEC has deemed 48 out of the 87 submitted applications to be complete and has published a notice to affected persons in the January 22, 2016 issue of the *South Carolina State Register*. Thus, with respect to those 48 applications, DHEC is now in the period in which it may issue staff decisions and must decide by May 23, 2016 (or June 20, 2016 on those applications for which public hearings have been requested).

CONCLUSIONS OF LAW

Standing

Intervenors-Defendants, at the hearing, questioned Amedisys's standing to seek statewide relief in this matter in light of the fact that the Intervenors-Defendants sought CONs in only a limited number of counties in which Amedisys is currently serving. I conclude that Amedisys does have standing to seek statewide relief in this matter. Not only are its interests implicated in its currently-served counties where the Intervenors-Defendants have applied for CONs; they are also implicated in its currently-served counties where other third parties have applied for CONs and in its currently-served counties where Intervenors-Defendants or third parties may yet apply for CONs and in those counties where Amedisys is not currently serving but has applied for or may apply for CONs. Moreover, where, as here, there is a statewide regime of uniform applicability and the statewide standards for implementation are challenged as contrary to law, the challenger need not have business interests in every county to make a statewide challenge.

Timely Request for Relief

Intervenors-Defendants, at the hearing, questioned the timing of Amedisys's request for relief, arguing that the request should have been made promptly after the adoption of the Current Plan on August 13, 2015. At that time, however, it was not known how DHEC would seek to implement the home health services provisions of the Current Plan and there was no imminent decision. For example, on September 18, 2015, DHEC convened an open forum meeting of participants in the home health services industry in South Carolina, but for the purpose of seeking rather than providing guidance on how the Current Plan could be implemented. The Intervenors-Defendants and others began submitting applications for CONs to DHEC under the Current Plan in early September, 2015; however, many of those applications simply did not answer the form question requesting a need analysis but rather supplemented their applications in November 2015. Even so, until DHEC deemed an application complete, observers could not know what information DHEC would require, much less know how it would be evaluated. DHEC did not notify affected persons that any applications were deemed complete until January 22, 2016. At that point, under the statutory timetable, a decision became imminent. Amedisys filed its complaint in this action 16 days later. The timing of Amedisys's seeking judicial relief in this matter was reasonable and, indeed, might will have been considered premature had it been sought earlier.

Injunctive Relief Requisites

Irreparable Harm. "Irreparable injury means that the injunction is reasonably necessary to protect the rights of the plaintiff pending the litigation." James F. Flanagan, *South Carolina Civil Procedure* 508 (2nd ed., 1996); *Multi-Channel TV Cable Co. v.*

Charlottesville Quality Cable Operating Co., 22 F.3d 546, 551 (4th Cir. 1994) (“Generally, ‘irreparable injury is suffered when monetary damages are difficult to ascertain or are inadequate.’” (citation omitted)). The element of irreparable harm is satisfied when it is difficult to calculate the amount of damages, such that an equitable remedy is necessary to make the aggrieved party whole. *Bethel Methodist Episcopal Church v. City of Greenville*, 211 S.C. 442, 45 S.E.2d 841 (1947) (“Irreparable injury, as used in the law of injunction, does not necessarily mean that the injury is beyond the possibility of compensation in damages.”).

Although there is not a South Carolina case directly on point for the present case, the approach of South Carolina’s courts in two contexts is compelling.

First, one of the longest standing rules regarding injunctive relief in South Carolina is that an injunction is the appropriate remedy to abate an alleged waste of property or assets while ownership of the same property or assets is being litigated. *Kinsler v. Clarke*, 1837 WL 1551 (S.C.Ct.App. 1837); *Grosshuesch v. Cramer*, 367 S.C. 1, 623 S.E.2d 833 (2005); *County Council of Charleston v. Felkel*, 244 S.C. 480, 137 S.E.2d 577, 578 (1964). Here, the “asset” would be the right to serve in a particular county. Amedisys has that valuable right in which it has invested substantially. Unless this Court issues its injunction, the Current Plan would allow that right to be usurped and those investments to be impaired.

Second, an imminent violation of a reasonable restriction on competition is a proper basis for a finding of irreparable harm to support a preliminary injunction. See *Standard Lighting Distributors, Inc. v. Sweatman*, 2006 WL 4911571 (S.C.Com.Pl., October 9, 2006) (Trial Order, 2006-CP-32-2056). Here, the restriction (no standards of

need, no CON; no CON, no license; no license, no market entry) is by definition legally reasonable, as it was established by the General Assembly.⁸

I therefore conclude that the requested emergency interim relief is necessary to preserve the *status quo* for the pendency of this action because the Current Plan.

Adequacy of Remedy at Law. “[W]hether there is an adequate remedy at law for a wrong, [is a] question [] that [is] not decided by narrow and artificial rules.” *Kirk v. Clark*, 191 S.C. 205, 4 S.E.2d 13, 15 (1939). “The adequacy of a legal remedy is a pragmatic determination based upon the certainty of fixing damages, the practicality of obtaining relief, and the efficiency of the legal remedy in the particular circumstances.” Flanagan, *South Carolina Civil Procedure* at 508. “[I]f the available legal remedy in a given case reduces itself to a matter of words, rather than to a matter of efficacy, because of its impracticability, or because the threatened acts may continue during the progress of an action at law, or because successive actions at law would be necessary to protect the plaintiff’s rights, equity will hold that the existence of a legal remedy is not an obstacle to the exertion of the equitable power.” *Kirk v. Clark, supra*, 4 S.E.2d at 16; *Columbia Broadcasting Sys., Inc. v. Custom Recording Co.*, 258 S.C. 465, 189 S.E.2d 305, 312 (1972).

If new services are introduced in the absence of the requested injunction, removing them would be almost impossibly complicated, as would calculating the

⁸ The present case does not present the situation of *John Doe v. State of South Carolina*, 2003 WL 25459546 (S.C.Com.Pl., May 12, 2003) (Trial Order, 2003-CP-10-1489), in which the Court stated that it was “mindful that ‘one may not generally enjoin a state agency from the performance of duties imposed by valid statutes.’ *Frady v. Student Loan Servicing Center*, 313 S.C. 561, 443 S.E.2d 580, 582 (Ct. App. 1994) (quoting 43A C.J.S. *Injunctions* § 116, at 192 (1978)).” That case involved the straightforward application of a valid law. The present issue, on the other hand, involves an agency application that is manifestly contrary to a valid law.

damages incurred by the plaintiff. Again, the approach of South Carolina's courts to issues of asset wasting and non-compete covenants is instructive. Trying to unscramble the egg of standardless CONs would require a costly and lengthy invocation of the legal and equitable powers of this Court. Avoiding that kind of tedious and uncertain un-wind is the very reason for preliminary relief to maintain the status quo until the merits can be resolved, especially in a case such as this one where the issue is a legal issue susceptible of quick resolution.

Defendant DHEC contends that the process utilized by the plaintiff in *MRI at Belfair, LLC v. S.C. Dept. of Health and Environmental Control*, 379 S.C. 1, 664 S.E.2d 471 (2008) affords Amedisys an adequate remedy at law. In that case, the plaintiff challenged the validity of a portion of the state health plan for noncompliance with the statutory requirements. The plaintiff made that challenge in the course of contesting the issuance of a CON to a hospital for an MRI unit, and proceeded through the administrative law court. Here, however, rather than a single challenge, Amedisys would have to bring scores of challenges, just to seek resolution of the identical legal issue in each one. Not only would that needlessly and wastefully exhaust judicial resources, it would run directly counter to the rule stated above that where "successive actions at law would be necessary to protect the plaintiff's rights, equity will hold that the existence of a legal remedy is not an obstacle to the exertion of the equitable power." *Kirk v. Clark*, *supra*, 4 S.E.2d at 16.⁹

⁹ Amedisys could not have brought this single action in the Administrative Law Court (rather than a series of case-by-case challenges to CONs), because such a challenge to the Current Plan would not be a "contested case" over which the Administrative Law Court could exercise jurisdiction. See *Trident Medical Center, LLC v. S.C. Dep't of Health and Environmental Control*, 12-AJL-07-0524-CC (June 19, 2013).

I therefore conclude that Amedisys has no adequate remedy at law sufficient to deprive it of preliminary injunctive relief.

Likelihood of Success on the Merits. Petitioner is “not required to prove an absolute legal right when seeking a preliminary injunction, but [she] must present a reasonable question as to the existence of such a right.” *AJG Holdings, LLC v. Dunn*, 382 S.C. 43, 674 S.E.2d 505, 509 (Ct. App. 2009); see also *Williams v. Jones & Amerman*, 92 S.C. 342, 75 S.E. 705 (1912) (“This does not mean an absolute legal right or certainty of success but rather that he has a fair question to raise as to the existence of such a right.”). Courts have broadly construed this element and a litigant is required to do little more than state a cause of action or make a prima facie showing. *County of Richland v. Simpkins*, 348 S.C. 664, 560 S.E.2d 902 (Ct. App. 2002); *Childs v. Columbia*, 87 S.C. 566, 70 S.E. 296 (1911).

“The determination of whether to grant an injunction should not be based on the merits of the underlying case except insofar as the merits may assist the trial court in determining whether a prima facie showing has been made.” *Peek v. Spartanburg Reg’l Healthcare Sys.*, 367 S.C. 450, 456, 626 S.E.2d 34, 37 (Ct. App. 2005). “Once a prima facie showing has been made entitling the plaintiff to injunctive relief, a temporary injunction will be granted without regard to the ultimate termination of the case on the merits.” *Helsel v. City of N. Myrtle Beach*, 307 S.C. 29, 413 S.E.2d 824, 826 (1992).

Upon review and for the following reasons, I conclude that the likelihood of the plaintiff’s succeeding on the merits of this litigation weighs in favor of granting the preliminary injunction.

1. DHEC cannot objectively determine need under the Current Plan.

The Current Plan is deficient in that it does not meet the statutory minimum standards for home health services determinations of need. Instead, it adopts a 25-patient (rural)/50-patient (non-rural) county target, with no guidelines for how that 25-patient or 50-patient “need” is to be calculated, demonstrated, or tested.

As noted earlier, on September 18, 2015, DHEC convened an open forum meeting of participants in the home health services industry in South Carolina for the express purpose of seeking guidance from those participants on how DHEC might implement the Current Plan. See, for example, Transcript of September 18, 2015 (“Tr.”) p. 24, l. 20 - p. 25, l. 21 (“ . . . [T]his is new to all of us, and I know we have some – some folks here who have some ideas about how to have documentation. I’m hoping, at some point, that they can share them.” Maggie Murdock, DHEC CON staff). Thus, more than a month after the final adoption of the Current Plan, DHEC acknowledged that there were no standards in place. In response to a question, “[W]hat is the department going to utilize?” when two different applicants submit their “clearly different approaches,” the response from DHEC staff (Ms. Murdock) was “That is a very good question. And, you know, I can’t – we don’t – we can’t – at this point, we haven’t established a set policy outside of the methodology that we have adopted in the state health plan.” Tr., p. 28, l. 20 - p. 29, l. 3. Perhaps most directly, one applicant consultant asked: “So in terms of needs, since there’s no methodology in the plan, I assume each one of us can develop the need to justify 25 or 50 patients in the second year of operation. Any new methodology that makes sense to us, hopefully will make sense to you.” The response from DHEC (Shelly Kelly, DHEC Director of Health Regulation): “That’s probably the truth.” Tr., p. 27, ll. 8-14.

The requirement that the Plan project need for additional services serves several purposes. First, it helps to direct service expansion to areas – and thus patients – most in need of the services, by alerting existing and prospective home health providers as to where DHEC believes a need exists. Second, it provides DHEC thresholds and baselines from which to measure whether a CON applicant has met the basic need requirement. Third, it provides DHEC with an objective measurement by which to determine whether CON applicants are “competing” within the meaning of the CON Act and the Department’s implementing regulations set forth at 24A S.C. Code Regs. 61-15 (the “*CON Regulations*”).

The Current Plan, as recommended by the Planning Committee and adopted by the DHEC Board, rejected the use of population projections to determine whether additional home health services are needed, thus eliminating the prior Plans’ longstanding criteria for the Department’s determination of need, without supplying any new criteria. Lacking such a benchmark, as noted in the September 18, 2015 open forum meeting, DHEC will be forced to rely on need analyses prepared by one or more applicants that are skewed towards those particular applicants, not the needs of the service area as a whole. Even worse, DHEC likely will be forced to choose between need analyses prepared by multiple applicants, creating an additional issue for subsequent litigation. The Current Plan supplies DHEC no independent, rational basis on which to make determinations as to whether: (1) a CON application complies with the need outlined in the statutorily-mandated standards, (2) the proposed project will result in an unnecessary duplication of services, and (3) multiple CON applicants seeking to establish home health services in

the same county are “competing applicants” within the meaning of the CON Act and CON Regulations.

2. **DHEC cannot objectively identify competing applicants under the Current Plan.**

The Current Plan contains no objective criteria for determining whether approval of more than one application would “exceed the need” in that area – that is, whether multiple applicants for home health services in a service area are “competing applicants.” CON Act, S.C. Code §44-7-130(5).

The CON Act and CON Regulations define “competing applicants” as:

two or more persons and/or health care facilities as defined in this regulation who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service. An application shall be considered competing if it is received by the Department no later than fifteen (15) calendar days after a Notice of Affected Persons is published in the State Register for one or more applications for similar services and/or facilities in the same service area. All applications received by the Department within fifteen (15) calendar days of publication of the Notice of Affected Persons in the State Register for the first application(s) will be considered to be competing. Any applications received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s).

S.C. Code §44-7-130(5); 24A S.C. Code Regs. 61-15 §103(6) (emphasis added).

Where need is subjectively established, it will not be possible to distinguish two separate needs from a single, double-counted need. Thus, as Amedisys argues, even assuming that an applicant, presenting subjective evidence, could show some quantifiable need in a county, it would not be possible to determine whether that “need” was identical to, overlapped with, or was completely separate from, the “need” similarly shown by another applicant in that same county. There would, thus, be no way to determine whether two applicants were competing applicants such that only one would be eligible

for a CON under the CON Act. This problem was also raised in the September 18, 2015 open forum meeting, but without any resolution. Tr., p. 30, l. 17 – p. 31, l. 22.

Without establishing, at the outset, any meaningful objective measurement of need, DHEC cannot non-arbitrarily and accountably determine whether multiple CON applications, if granted, would exceed the need for home health services in a particular county.¹⁰ Thus, there effectively will be no justifiable limit on the number of applicants who, if they satisfy the other criteria, will be entitled to a CON.¹¹ DHEC consequently cannot discharge its statutory duty of preventing the unnecessary duplication of services, let alone its duties of promoting cost containment, guiding the establishment of services to best meet public need, and ensuring a high quality of health services in the State.¹²

3. Other parties with a statutory right to participate cannot do so meaningfully under the Current Plan.

DHEC is not the only entity deprived of vital guidance. The Current Plan's failure to establish the statutory minimum need standards that must be applied to challenge an applicant's claim that an unmet need exists deprives Amedisys (and all other interested parties) of any meaningful opportunity to challenge CON applications for additional

¹⁰ *Tri-County Home Health Care & Servs., Inc. v. S.C. Dep't of Health and Environmental Control*, 12-ALJ-07-0005-CC, 2013 WL 5783540, at *29 (Oct. 23, 2013) ("the State Health Plan Standards are threshold requirements").

¹¹ Cf. 24A S.C. Code Regs. 61-15, §307(1) (prohibiting the Department from issuing a CON unless the application is in compliance with the Health Plan, project review criteria and other Department regulations, and requiring the Department to identify any regulation used as a basis for denying an application that complies with the Health Plan).

¹² *Tri-County Home Health, supra*, at *25. ("[T]o determine whether an application is contrary to the purposes of the CON Act, the Court must consider: 1) whether the proposal results in duplicative health care . . . services, and 2) whether the duplication is unnecessary or should be allowed to promote cost containment and establish high quality health facilities and services.").

home health services in counties where Amedisys and such other existing providers currently operate. Those other parties that have a statutory right to participate in the DHEC review process are unable to make meaningful input when the decisional criteria themselves are devoid of meaning.

4. The Belfair case, relied upon by DHEC, is not on point.

In *MRI at Belfair, LLC v. S.C. Dept. of Health and Environmental Control*, 379 S.C.1, 664 S.E.2d 471 (2008), concerning a hospital's application for a CON for MRI equipment, the Court rejected the argument that the Health Plan standards violated the CON Act because it failed to adequately establish need for additional MRI equipment. However, those standards included an objective minimum number of MRI's that the Department believed was necessary to meet public need, *i.e.*, at least one MRI available to every hospital. That constituted a clear, objective standard: was one available or was one not? It was a simple matter of ordinary judicial construction of a text and statutory interpretation to determine what was meant by that provision of the plan. By contrast, the Committee's proposal adopted now as the Current Plan provides no objective quantification of what additional home health services are needed and what applicants must show to meet that need.

5. Conclusion with regard to likelihood of success on the merits

Thus, under the Current Plan, DHEC is without the tools that the CON Act and the HHA Act require it to utilize in its consideration of any new and pending applications; and other involved parties are without the tools necessary to give their statutory rights substance.

If DHEC issues a CON in a county in which Amedisys is already providing such services and in which a statutorily-compliant methodology would show that there is no unmet need, the investment by Amedisys would be impaired, those harmed investors would have no standard by which to defend their rights, and the legislative purposes of the CON Act would be thwarted, all to the endangerment of the care of home health patients in that county.

In this case, (1) the plaintiff, the General Assembly's regulatory system, and those current and prospective consumers of home health services will suffer irreparable harm if an injunction is not granted; (2) the plaintiff will likely succeed on the merits of the litigation, and (3) there is no adequate remedy at law. A preliminary injunction is warranted to preserve this Court's ability to render complete relief and to protect the legal rights of the plaintiff, the integrity of the regulatory system established by the General Assembly, and the quality and availability of health care services for the South Carolina patients who are the intended beneficiaries of that system.

Requirement of Bond. According to Rule 65(c), SCRPC, a preliminary injunction shall not issue "except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained." DHEC has no property or interest at stake in this issue other than the interest in making sure that the programs established by the General Assembly are faithfully implemented. It is under no legal obligation to act on any CON application before either May 23, 2016, or June 20, 2016 (depending on whether oppositions are noticed and public hearings requested), both of which dates are after the expected conclusion of this action. The

Intervenors-Defendants have no legal right to a decision before such date; and, as DHEC pointed out in its memorandum on this motion, the actual issuance of a CON to an Intervenor-Defendant can be delayed well past either of those dates, even if DHEC is favorable, by a request for a contested case. Consequently, neither DHEC nor the Intervenors-Defendants would suffer any damages by the minimal delay necessary to resolve the legal issues in this case.

ORDER

For the foregoing reasons, I hereby order that:

1. Pending a final determination by the Court of this action, DHEC is hereby enjoined from issuing a staff decision with respect to any application for a home health services CON under the Current Plan;
2. All parties to this action submit to this Court and to all other parties their motions for summary judgment on the question of the validity of the home health services portion of the Current Plan, memoranda in support, and any supporting affidavits or documents, not later than Monday, March 21, 2016; that all parties to this action submit to this Court and to all other parties their responses to such motions not later than Monday, April 11, 2016; and that all parties submit to this Court not later than Monday, March 21, 2016, a joint statement of not fewer than five dates from April 18, 2016, through Friday, May 6, 2016, on which all parties will be available for a hearing on all such motions;
3. Amedisys shall, not later than 7 days hence, post a bond in the amount of \$100 as surety for any damage that any other party might suffer as a result of this Order.

AND IT IS SO ORDERED.

February __, 2016

L. Casey Manning
Judge of the Fifth Judicial Circuit

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas
Casey L. Manning, Circuit Court Judge

C.A. No.: 2016-CP-40-00818
Court of Appeals Docket No. 2016-000631

RECEIVED

JUL 11 2016

SC Court of Appeals

Amedisys SC, L.L.C Appellant,

v.

South Carolina Department of Health and Environmental Control Defendant,

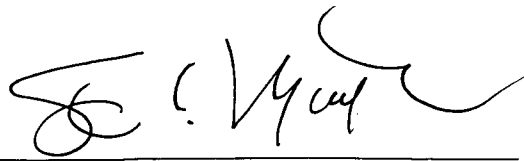
and

National Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc.,
Tri-County Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers
of Bluffton, Tidewater Home Health, PA, and Hedgemark Brentwood Medical Services
Inc. d/b/a PHC Home Health Intervenor-Defendants;

Of whom, South Carolina Department of Health and Environmental Control, National
Healthcare Corporation, Pruitthealth Corporation, In-Care Home Health, Inc., Tri-County
Home Health Care & Services, Inc., M&C Group, LLC d/b/a/ Home Helpers of Bluffton,
Tidewater Home Health, PA, Hedgemark Brentwood Medical Services Inc. d/b/a PHC
Home Health are Respondents.

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that the Record on Appeal contains all material
proposed to be included by any of the parties and not any other material.



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July 8, 2016

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