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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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

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SC Court of Appeals

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

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

v.

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

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

RECORD ON APPEAL – VOLUME IX OF XVII

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HOME HEALTH AGENCIES

2003 PLAN

COUNTY OF RESIDENCE	2001 TOTAL PATIENTS	2001 POP. (000s)	PATIENTS SERVED/ 1000 POP	BELOW STATE AVG.	NEW AGENCY /P 1/1/01	# OF EXIST. HHAs	NEW HHA CAN BE APPROVED
Abbeville	668	26.28	25.42	—	—	4	—
Aiken	2,124	144.84	14.66	—	—	5	—
Allendale	138	11.35	12.16	YES	—	3	—
Anderson	3,077	167.04	18.42	—	—	6	—
Bamberg	392	16.58	23.64	—	—	2	—
Barnwell	489	23.67	20.66	—	—	3	—
Beaufort	2,313	123.32	18.76	—	—	6	—
Berkeley	1,777	145.45	12.22	YES	—	7	—
Calhoun	307	15.25	20.13	—	—	5	—
Charleston	6,718	312.00	21.53	—	—	9	—
Cherokee	1,139	52.99	21.49	—	—	4	—
Chester	873	34.22	25.51	—	—	3	—
Chesterfield	940	42.84	21.94	—	—	3	—
Clarendon	733	32.71	22.41	—	—	2	—
Colleton	1,033	38.58	26.78	—	—	6	—
Darlington	1,593	67.46	23.61	—	—	4	—
Dillon	670	30.62	21.88	—	—	4	—
Dorchester	1,752	98.43	17.80	—	—	7	—
Edgefield	452	24.75	18.26	—	—	4	—
Fairfield	497	23.59	21.07	—	—	3	—
Florence	3,465	126.63	27.36	—	—	4	—
Georgetown	1,094	56.31	19.43	—	—	6	—
Greenville	6,963	383.18	18.17	—	—	7	—
Greenwood	1,644	66.69	24.65	—	—	5	—
Hampton	416	21.42	19.42	—	—	4	—
Horry	4,381	200.48	21.85	—	—	6	—
Jasper	349	20.81	16.77	—	—	5	—
Kershaw	1,056	53.23	19.84	—	—	3	—
Lancaster	996	61.44	16.21	—	—	2	—
Laurens	1,083	70.23	15.42	—	—	6	—
Lee	423	20.20	20.94	—	—	4	—
Lexington	3,621	219.41	16.50	—	—	7	—
McCormick	223	10.09	22.10	—	—	3	—
Marion	828	35.54	23.30	—	—	3	—
Marlboro	800	28.72	27.86	—	—	4	—
Newberry	594	36.37	16.33	—	—	3	—
Oconee	1,607	67.16	23.93	—	—	4	—
Orangeburg	1,972	92.10	21.41	—	—	5	—
Pickens	2,104	112.42	18.72	—	—	6	—
Richland	5,336	322.88	16.53	—	—	8	—
Saluda	329	19.18	17.15	—		4	—
Spartanburg	4,422	256.56	17.24	—	—	5	—
Sumter	1,905	106.12	17.95	—	YES	5	— 1
Union	456	29.85	15.28	—	—	2	—
Williamsburg	987	37.19	26.54	—	—	4	—
York	2,642	167.16	15.81	—	—	4	—
TOTALS	77,381	4,053.34	19.09			209	

1 CON under appeal.

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HOME HEALTH AGENCIES INVENTORY-2001 DATA

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Alliance Home Care	Horry	1020	15498	15.2
Amedisys Home Health 13/ Inc. of S.C.	Berkeley, Charleston & Dorchester	691	15166	21.9
ANMED Home Health Agency	Anderson	1348	31554	23.4
Appalachia I Home Health Care Services	Anderson & Oconee	1101	9166	8.3
Appalachia II Home Health Services	Greenville & Pickens	2341	29080	12.4
Appalachia III Home Health Services	Spartanburg, Union & Cherokee	2203	48098	21.8
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	148	2597	17.5
Benzie T. Rice Home Health 14/	Richland (may serve retirement community only)	0	0	---
Bethea Home Health 5/	Darlington (may serve retirement community only)	0	0	---
Care One Home Health Services	Beaufort, Hampton, & Jasper	674	13330	19.8
CarePro Home Health 7/	Richland & Sumter	346	9582	27.7
CareSouth Homecare Professionals, A Winyah Company-Georgetown	Georgetown & Williamsburg	30	493	16.4
CareSouth Homecare 17/ Professionals, A Winyah Company-Columbia	Lexington, Richland, Orangeburg, Calhoun, Newberry, Lee, Sumter & Edgefield	2676	40980	15.3
Caring Neighbors Home Health 19/	Fairfield	203	4425	21.8
Carolina Home Health 16/ Care	Richland & Lexington	913	13768	15.1

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Carolina Home Health 8/ Care-Greenville	Anderson, Oconee, Greenville, Pickens, Cherokee, Spartanburg Laurens & Union	266	5378	20.2 (may only serve patients in Union County whose initial diagnosis requires IV therapy services and/or home uterine activity monitoring)
Catawba Home Health Services	Chester, York & Lancaster	1145	15806	13.8
(Chesterfield General Home Health) 20/	Chesterfield	122	2061	16.9
Chesterfield Visiting Nurses Services	Darlington, Marlboro & Chesterfield	337	12786	37.9
Choice Health Care Services	Colleton	10	172	17.2
Clarendon Memorial Home Health	Clarendon	193	3237	16.8
Clemson Area Retirement Center HHA	Pickens	25	4543	181.7 (may serve retirement community only)
(Coastal Rivers Home 4/ Health of Low Country General Hospital)	Jasper	--	---	----
Cypress Club Home Health Agency	Beaufort	48	1331	27.7 (may serve retirement community only)
Edisto Health District Home Health Services	Bamberg, Calhoun & Orangeburg	1261	34284	27.2
Florence Visiting Nurses Services	Florence, Lee, Dillon & Marion	391	16655	42.6
Franke Home Health	Charleston	13	172	13.2 (may serve retirement center residents only)
Franklin C. Fetter Home Health Agency	Charleston	19	557	29.3
Greenville Hospital System HHA	Greenville & Pickens	1569	47641	30.4

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Health Related Home Care, Inc.	Abbeville, Laurens, Greenwood, Saluda & McCormick	1134	17707	15.6
Hitchcock Healthcare, Inc	Aiken	773	15116	19.6
HomeCare of HospiceCare of the Piedmont	Abbeville, Greenwood, Laurens, McCormick, & Saluda	15	603 (may serve terminally ill patients only)	40.2
Home Care of Lancaster	Lancaster	495	7263	14.6
Home Care of the Regional Medical Center	Calhoun & Orangeburg	254	4563	18.0
Home Health of S.C., Inc. - Lowcountry	Berkeley & Dorchester	690	9589	13.9
Home Health of S.C., Inc. - Midlands	Lexington & Richland	903	14970	16.6
Home Health of South Carolina, Inc.	York	959	20043	20.9
Home Health Services of Carolinas Hospital System	Darlington, Dillon, Florence, (Sumter, Lee,) Marlboro & Williamsburg	2492	44759 (may serve terminally ill patients only in Williamsburg County)	18.0
Home Health Services of Self Regional 12/ Healthcare	Abbeville, Laurens, Greenwood, Saluda Mccormick	1065	15689	14.7
Hospice Care of the Low Country Home Health	Beaufort & Jasper	38	697 (may serve terminally ill patients only)	18.3
Hospice of Charleston HHA	Charleston, Berkeley & Dorchester	183	2958	16.2
Incare Home Health, Inc.	Horry & Georgetown	1300	10211	7.9
Interim of Coastal Carolina 1/	Berkeley, Charleston, Colleton, Dorchester, & Hampton	--	---	--
Interim Healthcare of the Grand Strand, LLC A Winyah Company	Horry	250	2741	11.0

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RECORD 003920

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Interim HealthCare of Greenville	Anderson, Pickens, Spartanburg, Oconee, Greenville & Cherokee	6586	123220	18.7
Interim HealthCare of the Low Country 3/	Beaufort and Jasper	140	1482	10.6
Interim HealthCare, Rock Hill	York	757	8705	11.5
Island Health Care, Inc.	Beaufort	1062	16994	16.0
Kershaw County Medical Center Home Health	Kershaw	693	14911	21.5
Liberty Home Care-Bennettsville	Marlboro	205	4896	23.9
Liberty Home Care-Myrtle Beach	Horry	265	4012	15.1
Low Country Home Health Services	Beaufort, Jasper, Colleton & Hampton	902	13321	14.8
Lower Savannah Home Health Services	Aiken, Allendale & Barnwell	882	16039	18.2
Lowman Home Health 22/	Richland (may serve retirement community only)	29	472	16.3
Matria Healthcare-Midlands	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	169	169 (may serve obstetrical patients only)	1.0
Matria Healthcare-Piedmont 21/	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg & York	120	120 (may serve obstetrical patients only)	1.0
	Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Orangeburg, Saluda, Sumter, Union & Williamsburg			

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RECORD 003921

Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
McLeod Home Health	Florence, Dillon Darlington, Marion, & Lee	2182	38752	17.8
Medshares Home Care of Southeastern South Carolina, Inc.	Allendale, Berkeley Charleston, Colleton, Dorchester, Georgetown	708	16529	23.3
(Mercy Home Care) 18/	Horry (may serve terminally ill patients only)	--	---	----
NHC HomeCare - Aiken	Aiken	194	5878	30.3
NHC HomeCare-Greenwood	Greenwood	93	4205	45.2
NHC HomeCare-Laurens	Laurens and Greenville	319	9676	30.3
Neighbors Care Home Health Agency	Chester	422	8827	20.9
Oconee Memorial Hospital HHA	Anderson, Oconee & Pickens	409	5172	12.6
Palmetto Health HomeCare	Richland, Lexington Bamberg (may serve terminally ill patients only in Bamberg County)	2665	61161	22.9
Palmetto Home Health Services	Fairfield, Richland Lexington & Newberry	1458	19346	13.3
Pee Dee District Home Health Services	Dillon, Florence, Marion, Darlington, Marlboro, Chesterfield	2671	53837	20.2
PHC Home Health	Charleston	450	7717	17.1
(Plan Home Health Care of Greenville) 6/	Abbeville, Laurens, Greenville, Greenwood	--	---	---
(Quality Home Health, Inc.) 15/	Beaufort	--	---	---
Roper-St. Francis Home Health Care	Charleston, Berkeley, & Dorchester	3519	79912	22.7
Sea Island Home Health	Charleston & Colleton	135	4537	33.6

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Spartanburg Regional Med. Center Home Health Services	Spartanburg	1851	33263	18.0
St. Francis Hospital HomeCare	Anderson, Pickens, Greenville, & Spartanburg	1994	29768	14.9
St. Joseph Home Health Care Services	Aiken, Edgefield & Barnwell	465	5864	12.6
The Seabrook Wellness and Home Health 10/ Care	Beaufort (may only serve residents of The Seabrook of Hilton Head)	--	---	--
Total Care, Inc.	York, Cherokee, Chester, & Union	838	19527	23.3
Total Care, Inc.- Coastal	Georgetown, Horry, Williamsburg	860	24991	29.1
Tri-County Home Health Care & Services	Saluda, Richland, Lexington, & Sumter	2550	48180	18.9
Trident Home Health Services	Charleston, Berkeley, & Dorchester	2038	16473	8.1
Tuomey Home Health	Lee, Clarendon & Sumter	598 (may serve terminally ill patients only in Lee and Clarendon Counties)	14829	24.8
University Home Health -North Augusta 9/	Aiken & Edgefield	646	12840	19.9
Upper Savannah Home Health Services	Abbeville, Laurens, Edgefield, Saluda, Greenwood & McCormick	1216	24961	20.5
(Village Home Health) 2/	Greenville (may only serve residents of Rolling Green Village)	--	---	---
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Orangeburg, Hampton, & Colleton	628	19198	30.6
Waccamaw Home Health Services	Georgetown, Horry & Williamsburg	2271	31870	14.0

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Facility	Counties Served	Number of Persons Served	Visits	Visits per Patient
Wateree District Home Health Services	Clarendon, Lee, Kershaw & Sumter	1594	31004	19.5
Winyah Home Health Care Piedmont,LLC 11/	Fairfield, Kershaw, Richland, Newberry, Lexington, Calhoun, & Orangeburg	29	233	8.0
Winyah Home Health Care 3/ 1/	Georgetown, Williamsburg, (Berkeley, Dorchester, Colleton, Charleston and Hampton)	2669	36571	13.7
Winyah Home Health Care-Upstate 6/	Abbeville, Greenwood, Greenville and Laurens	0	0	0.0

NOTES:

1/ CON issued to establish separate agency to serve Berkeley, Charleston, Colleton, Dorchester and Hampton counties called Interim of Coastal Carolina, 6/16/02. Interim of Coastal Carolina licensed 8/19/02 for the additional counties and Winyah Home Health licensed counties decreased 8/19/02.

2/ Licensed to serve Rolling Green Village only, 10/21/99. Closed 2/9/01.

3/ Winyah Home Health Care purchased Interim HealthCare of Greater Charleston and incorporated license into Winyah Home Health Care license, 12/1/2000 to serve Georgetown, Williamsburg, Berkeley, Beaufort, Jasper, Hampton, Charleston, Colleton and Dorchester Counties. Beaufort and Jasper County moved to Interim HealthCare of the Low Country, CON issued 9/17/01; licensed 11/1/01. Data for Georgetown and Williamsburg Counties for 1/1/01-12/31/01 and data for Beaufort, Berkeley, Jasper, Hampton, Charleston, Colleton and Dorchester Counties for 1/1/01-10/31/01. Data for Interim Health Care of Lowcountry (Beaufort & Jasper Counties) is 11/1/01-12/31/01.

4/ Name changed 6/1/98, formerly Medi Home Health of Low Country General Hospital. Closed 6/12/2001.

5/ Licensed to serve residents of Bethea Baptist Retirement Community campus only, 7/25/97. No patients seen during 2001.

6/ Winyah Home Health Care-Upstate purchased Plan Home Health Care, licensed 8/1/01. No patients served in 2001.

7/ Name changed 3/12/98, formerly Health Force Home Health Care. CON approved 2/7/02 for Sumter County; appealed.

8/ CON issued 9/22/94, to Caremark, Inc., to serve Anderson, Cherokee, Pickens, Oconee, Greenville, Spartanburg, and Union counties for patients whose initial diagnosis requires intravenous therapy services and/or home uterine activity monitoring. Licensed 1/19/95. Name changed 4/1/95, from Caremark, Inc. to Coram Alternate Site Services, Inc. Professional Home Nursing, Inc. merged with Coram, 1/17/96, and name changed to Coram Home Health Care of South Carolina, Inc. The service to Union County is now

restricted to serving patients whose initial diagnosis requires intravenous therapy services and/or home uterine activity monitoring. Other counties are full service. Change in ownership and name, formerly Coram Home Care of South Carolina, Inc., 1/15/99.

9/ Name changed 11/1/00, formerly Caresouth of University Hospital-North Augusta.

10/ Licensed 11/7/01 to serve residents of The Seabrook of Hilton Head only. No patients seen until January 2002.

11/ Name changed 4/24/00, formerly Olsten Health Services. Name changed 3/15/01 when Winyah Home Health Care - Piedmont purchased Gentiva Health Services. Partial year of data, 3/15/01-12/31/01. Data for Fairfield and Kershaw Counties as no patients served in other counties.

12/ Name changed 2/21/02, formerly Self Memorial Visiting Nurses Association.

13/ Formerly HealthCalls Professional Home Health Services, name and ownership changed 9/13/01.

14/ Exempt to establish continuing care retirement center home health agency, 3/28/02.

15/ Agency closed 1/31/01.

16/ Carolina Home Health Care, Inc. purchased by Capital CareResources of South Carolina, Inc., November 16, 1998.

17/ Name changed 10/28/98, formerly CareSouth-Lexington. Agency purchased Lee and Sumter Counties from Home Health of Carolinas Hospital System, licensed 9/8/99. Purchase of assets of Edgefield County Hospital Home Health for Edgefield County by CareSouth Homecare Professionals, A Winyah Company-Columbia, 4/4/00. Edgefield County added to license, 5/1/00.

18/ Agency closed, 4/19/01.

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

20/ Agency closed 9/30/02 and license transferred to HomeCare of Lancaster.

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

22/ Agency closed, 4/16/03.

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PET-EX006.0148

RECORD 003925

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Abbeville	Health Related Home Care, Inc.	462	7214	15.6
Abbeville	HomeCare of HospiceCare of Piedmont (te	1	10	10.0
Abbeville	Home Health Services of Self Regional Hea	90	1573	17.5
Abbeville	Matria Healthcare-Piedmont	CON issued 2/14/03		
Abbeville	Upper Savannah Home Health	116	4092	35.3
Abbeville	Winyah Home Health Care-Upstate	0	0	0.0
Aiken	Hitchcock Healthcare, Inc.	773	15116	19.6
Aiken	Lower Savannah Home Health Services	336	5754	17.1
Aiken	Matria Healthcare-Midlands	7	7	1.0
Aiken	NHC Home Care - Aiken	194	5878	30.3
Aiken	St. Joseph Home Health Care	384	5207	13.6
Aiken	University Home Health-North Augusta	437	7313	16.7
Allendale	Lower Savannah Home Health Services	128	2176	17.0
Allendale	Matria Healthcare-Piedmont	CON issued 2/14/03		
Allendale	Medshares Home Care of Southeastern SC	0	0	0.0
Allendale	VNA of Greater Bamberg, Inc.	10	305	30.5
Anderson	AnMed Home Health Agency	1348	31554	23.4
Anderson	Appalachia I Home Health	696	988	1.4
Anderson	Carolina Home Health Care-Greenville	18	488	27.1
Anderson	Interim Healthcare of Greenville	885	15362	17.4
Anderson	Matria Healthcare-Piedmont	4	4	1.0
Anderson	Oconee Memorial Hospital HHA	8	46	5.8
Anderson	St. Francis Hospital Home Care	122	2088	17.1
Bamberg	Edisto Health District Home Health	294	7953	27.1
Bamberg	Matria Healthcare-Piedmont	CON issued 2/14/03		
Bamberg	Palmetto Health HomeCare (terminal)	2	46	23.0
Bamberg	VNA of Greater Bamberg, Inc.	98	2996	30.6
Barnwell	Lower Savannah Home Health Services	418	8109	19.4
Barnwell	Matria Healthcare-Piedmont	CON issued 2/14/03		
Barnwell	St. Joseph Home Health Care	46	197	4.3
Barnwell	VNA of Greater Bamberg, Inc.	25	764	30.6
Beaufort	Beaufort-Jasper Home Health Agency	109	1700	15.6
Beaufort	CareOne Home Health Services	478	8885	18.6
Beaufort	Hospice Care of Low Country (term)	31	697	22.5
Beaufort	Interim HealthCare of the Low Country	121	1224	10.1

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RECORD 003926

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Beaufort	Island Health Care, Inc.	1062	16994	16.0
Beaufort	Low Country Home Health Services	249	3621	14.5
Beaufort	Matria Healthcare-Midlands	1	1	1.0
Beaufort	The Cypress Club Home Health Agency (re	48	1331	27.7
Beaufort	The Seabrook Wellness and Home Health C	0	0	0.0
Beaufort	Winyah Home Health Care	294	6072	20.7
Berkeley	Amedisys Home Health Inc. of SC	131	2882	22.0
Berkeley	Home Health of S. C., Inc.-Lowcountry	361	5326	14.8
Berkeley	Hospice of Charleston HHA	38	733	19.3
Berkeley	Interim of Coastal Carolina	Formerly Winyah, licensed 8/19/02		
Berkeley	Matria Healthcare-Midlands	9	9	1.0
Berkeley	Medshares Home Care of Southeastern SC	149	4052	27.2
Berkeley	Roper-St. Francis Home Health Care	359	11188	31.2
Berkeley	Trident Home Health Services	408	3295	8.1
Berkeley	(Winyah Home Health Care)	331	6737	20.4
Calhoun	CareSouth-Homecare Professionals-Cola	65	894	13.8
Calhoun	Edisto Health District Home Health	183	3281	17.9
Calhoun	Home Care of Regional Medical Center	26	485	18.7
Calhoun	Matria Healthcare-Piedmont	CON issued 2/14/03		
Calhoun	VNA of Greater Bamberg, Inc.	33	1009	30.6
Calhoun	Winyah Home Health Care-Piedmont	0	0	0.0
Charleston	Amedisys Home Health Inc. of SC	491	10766	21.9
Charleston	Franke Home Health (retirement only)	13	172	13.2
Charleston	Franklin C. Fetter Home Health	19	557	29.3
Charleston	Hospice of Charleston HHA	119	1853	15.6
Charleston	Interim of Coastal Carolina	Formerly Winyah, licensed 8/19/02		
Charleston	Matria Healthcare-Midlands	18	18	1.0
Charleston	Medshares Home Care of Southeastern SC	232	5173	22.3
Charleston	PHC Home Health	450	7717	17.1
Charleston	Roper-St. Francis Home Health Care	2877	63130	21.9
Charleston	Sea Island Home Health	130	4456	34.3
Charleston	Trident Home Health Services	1019	8236	8.1
Charleston	(Winyah Home Health Care)	1381	16197	11.7
Cherokee	Appalachia III Home Health	521	13262	25.5
Cherokee	Carolina Home Health Care-Greenville	1	1	1.0

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RECORD 003927

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Cherokee	Interim Healthcare of Greenville	515	11401	22.1
Cherokee	Matria Healthcare-Piedmont	1	1	1.0
Cherokee	Total Care, Inc	102	3481	34.1
Chester	Catawba Home Health	185	2311	12.5
Chester	Matria Healthcare-Piedmont	CON issued 2/14/03		
Chester	Neighbors Care Home Health Agency	422	8827	20.9
Chester	Total Care, Inc	266	7021	26.4
Chesterfield	(Chesterfield General Hospital HHA)	122	2061	16.9
Chesterfield	Chesterfield VNS	218	7289	33.4
Chesterfield	Matria Healthcare-Piedmont	7	7	1.0
Chesterfield	Pee Dee District Home Health Services	600	9871	16.5
Clarendon	Clarendon Memorial Home Health	193	3237	16.8
Clarendon	Matria Healthcare-Piedmont	CON issued 2/14/03		
Clarendon	Tuomey Regional Home Health (term)	4	26	6.5
Clarendon	Wateree Home Health Services	540	10221	18.9
Colleton	Choice Healthcare Services	10	172	17.2
Colleton	Interim of Coastal Carolina	Formerly Winyah, licensed 8/19/02		
Colleton	Low Country Home Health Services	345	5718	16.6
Colleton	Matria Healthcare-Midlands	0	0	0.0
Colleton	Medshares Home Care of Southeastern SC	208	4912	23.6
Colleton	Sea Island Home Health	5	81	16.2
Colleton	VNA of Greater Bamberg, Inc.	36	1101	30.6
Colleton	(Winyah Home Health Care)	429	7246	16.9
Darlington	Bethea Home Health (retirement area)	0	0	0.0
Darlington	Chesterfield VNS	80	3523	44.0
Darlington	Home Health Services of Carolinas Hospita	448	8057	18.0
Darlington	Matria Healthcare-Piedmont	CON issued 2/14/03		
Darlington	McLeod Home Health	737	13067	17.7
Darlington	Pee Dee District Home Health Services	328	5818	17.7
Dillon	Florence VNS	50	2121	42.4
Dillon	Home Health Services of Carolinas Hospita	60	1151	19.2
Dillon	Matria Healthcare-Piedmont	CON issued 2/14/03		
Dillon	McLeod Home Health	176	3442	19.6
Dillon	Pee Dee District Home Health Services	384	9671	25.2
Dorchester	Amedisys Home Health Inc. of SC	69	1518	22.0

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HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Dorchester	Home Health of S. C., Inc.-Lowcountry	329	4263	13.0
Dorchester	Hospice of Charleston HHA	26	372	14.3
Dorchester	Interim of Coastal Carolina	Formerly Winyah, licensed 8/19/02		
Dorchester	Matria Healthcare-Midlands	8	8	1.0
Dorchester	Medshares Home Care of Southeastern SC	119	2392	20.1
Dorchester	Roper-St. Francis Home Health Care	283	5594	19.8
Dorchester	Trident Home Health Services	611	4942	8.1
Dorchester	(Winyah Home Health Care)	315	3265	10.4
Edgefield	CareSouth Homecare Professionals, Colum	79	1561	19.8
Edgefield	Matria Healthcare-Piedmont	CON issued 2/14/03		
Edgefield	St. Joseph Home Health Care	35	460	13.1
Edgefield	University Home Health-North Augusta	209	5527	26.4
Edgefield	Upper Savannah Home Health	129	3106	24.1
Fairfield	Caring Neighbors Home Health	203	4425	21.8
Fairfield	Matria Healthcare-Midlands	4	4	1.0
Fairfield	Palmetto Home Health Services	286	4285	15.0
Fairfield	Winyah Home Health Care-Piedmont	8	43	5.4
Florence	Florence VNS	194	8072	41.6
Florence	Home Health Services of Carolinas Hospita	1820	32674	18.0
Florence	Matria Healthcare-Piedmont	CON issued 2/14/03		
Florence	McLeod Home Health	974	16932	17.4
Florence	Pee Dee District Home Health Services	477	7465	15.6
Georgetown	CareSouth Home Care Professionals-Gtown	25	409	16.4
Georgetown	Incare Home Health	270	2125	7.9
Georgetown	Matria Healthcare-Midlands	3	3	1.0
Georgetown	Medshares Home Care of Southeastern SC	0	0	0.0
Georgetown	Total Care, Inc - Coastal	146	5506	37.7
Georgetown	Waccamaw Home Care Services	403	5316	13.2
Georgetown	Winyah Home Health Care	250	2365	9.5
Greenville	Appalachia II Home Health	1315	13816	10.5
Greenville	Carolina Home Health Care-Greenville	136	2785	20.5
Greenville	Greenville Hospital System HHA	1479	45952	31.1
Greenville	Interim Healthcare of Greenville	2466	45651	18.5
Greenville	Matria Healthcare-Piedmont	51	51	1.0
Greenville	NHC HomeCare-Laurens	13	256	19.7

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RECORD 003929

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Greenville	St. Francis Hospital Home Care	1554	22502	14.5
Greenville	Winyah Home Health Care-Upstate	0	0	0.0
Greenwood	Health Related Home Care, Inc.	462	7214	15.6
Greenwood	HomeCare of HospiceCare of Piedmont (te	10	501	50.1
Greenwood	Home Health Services of Self Regional Hea	715	10352	14.5
Greenwood	Matria Healthcare-Piedmont	CON issued 2/14/03		
Greenwood	NHC Homecare-Greenwood	93	4205	45.2
Greenwood	Upper Savannah Home Health	374	5632	15.1
Greenwood	Winyah Home Health Care-Upstate	0	0	0.0
Hampton	CareOne Home Health Services	69	1475	21.4
Hampton	Interim of Coastal Carolina	Formerly Winyah, licensed 8/19/02		
Hampton	Low Country Home Health Services	207	2874	13.9
Hampton	Matria Healthcare-Piedmont	CON issued 2/14/03		
Hampton	VNA of Greater Bamberg, Inc.	15	459	30.6
Hampton	(Winyah Home Health Care)	125	1662	13.3
Horry	Alliance Home Care	1020	15498	15.2
Horry	Incare Home Health	1030	8086	7.9
Horry	Interim Healthcare of the Grand Strand	250	2741	11.0
Horry	Liberty Home Care-Myrtle Beach	265	4012	15.1
Horry	Matria Healthcare-Piedmont	CON issued 2/14/03		
Horry	Total Care, Inc - Coastal	580	13237	22.8
Horry	Waccamaw Home Care Services	1236	19122	15.5
Jasper	Beaufort-Jasper Home Health Agency	39	897	23.0
Jasper	CareOne Home Health Services	127	2970	23.4
Jasper	Hospice Care of Low Country (term)	7	134	19.1
Jasper	Interim HealthCare of the Low Country	19	258	13.6
Jasper	Low Country Home Health Services	101	1108	11.0
Jasper	Matria Healthcare-Piedmont	CON issued 2/14/03		
Jasper	Winyah Home Health Care	63	923	14.7
Kershaw	Kershaw Co. Medical Center Home Health	693	14911	21.5
Kershaw	Matria Healthcare-Midlands	12	12	1.0
Kershaw	Wateree Home Health Services	342	5276	15.4
Kershaw	Winyah Home Health Care-Piedmont	21	190	9.0
Lancaster	Catawba Home Health	501	7822	15.6
Lancaster	Home Care of Lancaster	495	7263	14.7

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Lancaster	Matria Healthcare-Midlands	1	1	1.0
Laurens	Carolina Home Health Care-Greenville	18	299	16.6
Laurens	Health Related Home Care, Inc.	280	4374	15.6
Laurens	HomeCare of HospiceCare of Piedmont (te	2	61	30.5
Laurens	Matria Healthcare-Piedmont	CON issued 2/14/03		
Laurens	National Home Care of Laurens	306	9420	30.8
Laurens	Home Health Services of Self Regional Hea	166	2258	13.6
Laurens	Upper Savannah Home Health	313	4887	15.6
Laurens	Winyah Home Health Care-Upstate	0	0	0.0
Lee	CareSouth Homecare Professionals-Cola	52	900	17.3
Lee	Florence VNS	30	1310	43.7
Lee	Matria Healthcare-Piedmont	CON issued 2/14/03		
Lee	McLeod Home Health	74	870	11.8
Lee	Tuomey Regional Home Health (term)	5	65	13.0
Lee	Wateree Home Health Services	267	6051	22.7
Lexington	CareSouth-Homecare Professionals-Cola	755	10429	13.8
Lexington	Carolina Home Health Care, Inc.	402	6560	16.3
Lexington	Home Health of South Carolina, Inc.-Midla	490	8289	16.9
Lexington	Matria Healthcare-Midlands	30	30	1.0
Lexington	Palmetto Health HomeCare	638	13950	21.9
Lexington	Palmetto Home Health Services	279	3446	12.4
Lexington	Tri-County Home Health Care	1057	23548	22.3
Lexington	Winyah Home Health Care-Piedmont	0	0	0.0
Marion	Florence VNS	117	5152	44.0
Marion	Matria Healthcare-Piedmont	CON issued 2/14/03		
Marion	McLeod Home Health	221	4441	20.1
Marion	Pee Dee District Home Health Services	490	14509	29.6
Marlboro	Chesterfield VNS	39	1974	50.6
Marlboro	Home Health Services of Carolinas Hospita	164	2877	17.5
Marlboro	Liberty Home Care-Bennettsville	205	4896	23.9
Marlboro	Matria Healthcare-Piedmont	CON issued 2/14/03		
Marlboro	Pee Dee District Home Health Services	392	6503	16.6
McCormick	Health Related Home Care	68	1061	15.6
McCormick	HomeCare of HospiceCare of Piedmont (te	2	31	15.5
McCormick	Home Health Services of Self Regional Hea	57	1063	18.6

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RECORD 003931

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
McCormick	Matria Healthcare-Piedmont	CON issued 2/14/03		
McCormick	Upper Savannah Home Health	98	2530	25.8
Newberry	CareSouth-Homecare Professionals-Cola	193	2923	15.1
Newberry	Matria Healthcare-Midlands	15	15	1.0
Newberry	Palmetto Home Health Services	401	5603	14.0
Newberry	Winyah Home Health Care-Piedmont	0	0	0.0
Oconee	Appalachia I Home Health	405	8178	20.2
Oconee	Carolina Home Health Care-Greenville	11	88	8.0
Oconee	Interim Healthcare of Greenville	842	17037	20.2
Oconee	Matria Healthcare-Piedmont	3	3	1.0
Oconee	Oconee Memorial Hospital HHA	349	4476	12.8
Orangeburg	CareSouth-Homecare Professionals-Cola	549	10002	18.2
Orangeburg	Edisto Health District Home Health	784	23050	29.4
Orangeburg	Home Care of Regional Medical Center	228	4078	17.9
Orangeburg	Matria Healthcare-Piedmont	CON issued 2/14/03		
Orangeburg	VNA of Greater Bamberg, Inc.	411	12564	30.6
Orangeburg	Winyah Home Health Care-Piedmont	0	0	0.0
Pickens	Appalachia II Home Health	1026	15264	14.9
Pickens	Carolina Home Health Care-Greenville	36	965	26.8
Pickens	Clemson Area Retirement Center HHA (res	25	4543	181.7
Pickens	Greenville Hospital System HHA	90	1689	18.8
Pickens	Interim Healthcare of Greenville	726	13382	18.4
Pickens	Matria Healthcare-Piedmont	3	3	1.0
Pickens	Oconee Memorial Hospital HHA	52	650	12.5
Pickens	St. Francis Hospital Home Care	174	2775	15.9
Richland	Benzie T. Rice Home Health	0	0	0.0
Richland	CarePro Home Health	346	9582	27.7
Richland	CareSouth-Homecare Professionals-Cola	699	9470	13.5
Richland	Carolina Home Health Care, Inc.	511	7208	14.1
Richland	Home Health of South Carolina, Inc.-Midla	413	6681	16.2
Richland	Lowman Home Health (restricted)	29	472	16.3
Richland	Matria Healthcare-Midlands	65	65	1.0
Richland	Palmetto Health HomeCare	2025	47165	23.3
Richland	Palmetto Home Health Services	492	6012	12.2
Richland	Tri-County Home Health Care	850	14020	16.5

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RECORD 003932

HOME HEALTH AGENCIES INVENTORY 2001 DATA

COUNTY	AGENCY	PERSONS SERVED	VISITS	VISITS PER PT.
Richland	Winyah Home Health Care-Piedmont	0	0	0.0
Saluda	Health Related Home Care, Inc.	50	781	15.6
Saluda	HomeCare of HospiceCare of Piedmont (te	0	0	0.0
Saluda	Home Health Services of Self Regional Hea	37	443	12.0
Saluda	Matria Healthcare-Piedmont	CON issued 2/14/03		
Saluda	Tri-County Home Health Care	56	788	14.1
Saluda	Upper Savannah Home Health	186	4714	25.3
Spartanburg	Appalachia III Home Health	1229	24823	20.2
Spartanburg	Carolina Home Health Care-Greenville	46	752	16.3
Spartanburg	Interim Healthcare of Greenville	1152	20387	17.7
Spartanburg	Matria Healthcare-Piedmont	41	41	1.0
Spartanburg	Spartanburg Reg Med Ctr Home Care	1851	33263	18.0
Spartanburg	St. Francis Hospital Home Care	144	2403	16.7
Sumter	CarePro Home Health	CON approved 2/7/02; appealed		
Sumter	CareSouth Homecare Professionals-Cola	284	4801	16.9
Sumter	Matria Healthcare-Piedmont	CON issued 2/14/03		
Sumter	Tri-County Home Health Care	587	9824	16.7
Sumter	Tuomey Regional Home Health	589	14738	25.0
Sumter	Wateree Home Health Services	445	9356	21.0
Union	Appalachia III Home Health	453	10013	22.1
Union	Carolina Home Health Care-Greenville	0	0	0.0
Union	Matria Healthcare-Piedmont	CON issued 2/14/03		
Union	Total Care, Inc	3	15	5.0
Williamsburg	CareSouth Home Care Professionals-Gtown	6	84	14.0
Williamsburg	Home Health Services of Carolinas Hosp (t	0	0	0.0
Williamsburg	Matria Healthcare-Piedmont	CON issued 2/14/03		
Williamsburg	Total Care, Inc-Coastal	134	6248	46.6
Williamsburg	Waccamaw Home Care Services	632	7432	11.8
Williamsburg	Winyah Home Health Care	215	1293	6.0
York	Catawba Home Health	459	5673	12.4
York	Home Health of South Carolina, Inc.	959	20043	20.9
York	Interim Healthcare/Rock Hill	757	8705	11.5
York	Matria Healthcare-Piedmont	10	10	1.0
York	Total Care, Inc	467	9010	19.3
TOTAL		77853	1426895	18.3

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PET-EX006.0156

RECORD 003933

F. Other Services For The Elderly

1. Day Care Facilities for Adults

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

As of June 1, 2003, there were 102 licensed Day Care Facilities for Adults with 3,417 participants. Additional information may be found at www.scdhec.net under health regulations.

2. Community Residential Care Facilities

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

As of June 1, 2003, there were 517 licensed Community Residential Care Facilities with 16,759 beds. Additional information may be found at www.scdhec.net under health regulations.

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PET-EX006.0157

RECORD 003934

7. Critical Access Hospitals

South Carolina is a small state, with only 16 of its 46 counties classified as urban. A greater percentage of rural residents are employed in agriculture, forestry and fishing, which tend to be low-paying professions without health insurance. Due to the lack of employment opportunities in rural areas, the younger population immigrates to the urban areas in search of employment. As a result, rural counties tend to have a higher percentage of elderly residents, who use approximately 3 times as many health services per illness than the younger population.

Rural hospitals tend to be smaller than urban hospitals. Of the 28 rural hospitals in South Carolina, 6 have fewer than 50 licensed beds, 11 have between 50-99 beds, 8 are between 100-149 beds, and only 3 have more than 150 beds. Diagnostic and therapeutic technology is generally less available than at urban hospitals. For example, only 20 rural hospitals have MRI services available, and half of these rely on mobile services that are present 1-2 days per week. Only 8 offer cardiac catheterizations, 3 have Linear Accelerators, and none perform open-heart surgery.

Rural counties generally have fewer physicians and other health care professionals. Recruitment of staff is often difficult because of the limited availability of resources and lower reimbursements. Rural hospitals typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities, because of smaller wage allowances.

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

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

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

1) It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989.

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

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

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

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

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

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

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

As of January 1, 2002, 539 hospitals nationwide had been approved for CAH status and another 141 hospitals had applications pending. Allendale County Hospital is the only CAH in South Carolina. The facility permanently de-licensed 11 beds in April, 2002, to bring the total licensed capacity down to 25 beds.

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

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

Hospital	# Acute Beds	# Swing Beds	1999 ADC	2000 ADC	2001 ADC
Abbeville Memorial	52	24	14.1	12.8	12.5
Barnwell County	53	22	12.1	17.6	15.7
Fairfield County	33	6	11.9	12.1	11.2
Hampton Regional	68	10	8.7	11.8	12.5

The designation of a hospital as a "Critical Access Hospital" does not require Certificate of Need review, because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce the number of licensed beds in order to meet the criteria for a CAH. Should a hospital later desire to revert back to a general acute hospital, a Certificate of Need is required, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds.

PMC.2013.SHP.0424

PET-EX006.0160

RECORD 003937

8. Long-Term Care Hospitals

Section 42 Code of Federal Regulations 412.23(e) defines the requirements for a Long Term Care (LTC) Hospital. Long-term care hospitals provide diagnostic and medical treatment or rehabilitation to patients with chronic diseases or complex medical conditions with an average stay of 25 days or longer. Due to their extended illnesses, these patients would have exhausted their DRG benefits and would be considered outlier cases. Although these patients are no longer in need of general acute care, they still require extensive lengths of stay in a setting, which can provide highly skilled nursing, therapy, and medical treatment. The LTC hospital provides a level of care designed to minimize secondary medical conditions prior to discharge to nursing facilities, outpatient rehabilitation, or home health services. Long-term care hospitals are exempt from the Prospective Payment System (PPS) and are reimbursed based on allowable costs. They must have a Medicare provider agreement to participate as a hospital and must maintain a minimum 25-day average length of stay.

Examples of the type of conditions that fall into this category are strokes, cardiac care, HIV, ventilator dependency, general debilitation, wound care, respiratory infections, and post-surgical care. These patients are medically complex, often requiring life support and/or extended ICU care. Required intensive support services may include invasive monitoring, cardiac telemetry, transfusion therapy, dialysis, central line placement, nutritional support, hemodynamic monitoring, and ancillary support services. Targeted physician specialties include: Internal Medicine, Physical Medicine, Orthopedic Surgery, Pulmonology, Radiology, Nephrology, Oncology, and Gastroenterology.

A LTC hospital may either be a freestanding facility, or may occupy space in a building also being used by another hospital or in one or more buildings located on the same campus as buildings being used by another hospital {"the host facility"}. By locating within an existing hospital, they avoid the construction costs of a new facility while optimizing use of underutilized space in the host facility. Hospitals must meet additional Federal criteria in order to qualify as a LTC Hospital located in a building used by another hospital {"hospital-within-a-hospital"}:

1) The new hospital must have a governing board, which is distinct and separate from the governing body of the host hospital. In addition, the new board cannot be under the control of the host hospital or any entity that controls the host hospital.

2) The LTC hospital must have a separate CEO and administrative structure with no contract or affiliation with the host facility.

3) The hospital must have a separate Chief of Staff who reports directly to the governing board and is responsible for all medical staff activities. The Chief of Staff cannot be under contract with the host hospital or an affiliated organization.

4) There must be a separate and distinct medical staff directly to the governing board.

In addition, the LTC Hospital must demonstrate that it is organizationally and functionally separate from the host facility. This can be met in any of three ways:

PMC.2013.SHP.0425

PET-EX006.0161

RECORD 003938

1) The Basic Hospital Services Rule – The LTC hospital performs basic hospital functions such as Quality Assurance, Medical Staff, Nursing Services, Medical Records, Pharmacy, Radiology, Lab, Utilization Review, and Infection Control through its own employees or via contracts with entities other than the host hospital or a third entity controlling both facilities. The LTC hospital can only contract with the host hospital for food and dietary services, maintenance, housekeeping, and other services necessary to maintain a clean and safe physical environment.

2) The 15 % Rule – The cost of the services provided by the host hospital or controlling entity do not exceed 15% of the LTC hospital's total inpatient operating costs {as defined in the federal regulations}.

3) The 75% Rule – At least 75% of the inpatient population of the LTC hospital were referred there from a source other than another hospital occupying space in the same building or on the same campus.

There are currently five LTC hospitals in South Carolina:

1) Spartanburg Hospital for Restorative Care, a freestanding facility affiliated with Spartanburg Regional Medical Center, has 97 beds with a 2001 occupancy rate of 62.4%.

2) Greenville Hospital System received a CON on 4/15/03 to convert North Greenville Hospital into North Greenville Long Term Acute Care Hospital, with 45 licensed beds.

3) InterMedical Hospital of South Carolina, located within Palmetto Baptist Medical Center in Columbia, is licensed for 35 beds with a 2001 occupancy rate of 72.1%.

4) Regency Hospital of Florence, formerly Nextcare Specialty Hospital, a 28-bed facility affiliated with Carolinas Hospital System in Florence, was licensed on 7/17/01.

5) Kindred Hospital-Charleston, formerly Specialty Hospital of South Carolina, a 59-bed facility within Charleston Memorial Hospital, had a 2001 occupancy rate of 39.1%

STANDARDS

1) An application for a Long Term Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

2) Long Term Care Hospital beds will not be considered as a separate category for licensing or planning purposes. All LTC beds remain part of the inventory of general acute care hospital beds.

PMC.2013.SHP.0426

PET-EX006.0162

RECORD 003939

3) Approval will only be given for Long Term Acute Care hospital beds if an existing hospital converts existing general acute care beds to LTC beds or if there is a specific need for additional general acute care beds indicated in the Plan.

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

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

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes which occurred since the previous plan are explained by a footnote. The number of beds existing and needed are summarized by region. The inventory of beds and facilities was current as of July 1, 2003.

PMC.2013.SHP.0428

PET-EX006.0164

RECORD 003941

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE

FISCAL YEAR: 2003

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

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

RECORD 003942

PMC.2013.SHP.0429

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	INPATIENT INVENTORY OCT.1,1999-SEPT.30,2000 LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:									
	ALLENDALE CORRECTIONAL INF		ALLENDALE	FAIRFAX	ST	10	10			
	TURBEVILLE CORRECTIONAL INF		CLARENDON	TURBEVILLE	ST	8	8			
EXP	CHARLESTON CO DETENTION CTR		CHARLESTON	CHARLESTON	CO		14			
	LIEBER OP CLINIC & INF		DORCHESTER	RIDGEVILLE	ST	10	10			
YZ	PEE DEE REG CTR INF		FLORENCE	FLORENCE	ST	6	6			
	PERRY CORRECTIONAL INF		GREENVILLE	PELZER	ST	(20)	(20)			
X	SHRINERS HOSPITAL CHILDREN	29	GREENVILLE	GREENVILLE	NPA	50	50		1011	5260
	RIDGELAND CORRECTIONAL INF		JASPER	RIDGELAND	ST	8	8			
XYZ	(WHITTEN CTR INFIRMARY)	35	LAURENS	CLINTON	ST	(26)	(26)			
	LEE CORRECTIONAL INS INF		LEE	BISHOPVILLE	ST	20	20			
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		297	4847
	EVANS CORRECTIONAL INF		MARLBORO	BENNETTSVILLE	ST	10	10			
	MCCORMICK OP CLINIC & INF		MCCORMICK	MCCORMICK	ST	10	10			
	COLUMBIA CARE CENTER	27	RICHLAND	COLUMBIA	PROP	140	140			
XYZ	JF BYRNES CTR FOR GERIATRIC MED, ED & RESEARCH		RICHLAND	COLUMBIA	ST	(66)	(208)			
	KIRKLAND CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	24	24			
	WOMEN'S CORRECTIONAL INF		RICHLAND	COLUMBIA	ST	10	10			
	WILLOW LANE INF		RICHLAND	COLUMBIA	ST	8	8			
	CHILDREN'S HABILIATION CTR		SPARTANBURG	SPARTANBURG	ST	22	22		190	199
	TOTAL					346	350		1498	10306
	MENTAL HOSPITALS:									
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30	ANDERSON	ANDERSON	ST	206	206		2969	54162

RECORD 003943
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PET-EX006.0166

REGION:STATEWIDE

INPATIENT INVENTORY OCT.1,1999-SEPT.30,2000

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
XYZ	CRAFTS-FARROW STATE HOSPITAL	2 RICHLAND	COLUMBIA		ST	(117)	(129)	63 c		
XYZ	COLUMBIA CARE CENTER	27 RICHLAND	COLUMBIA		PROP	178	178			
	GILLIAM MENTAL HLTH CTR	RICHLAND	COLUMBIA		ST	87	87			
XYZ	SC STATE HOSPITAL	3 RICHLAND	COLUMBIA		ST	316	501	264 abc	241	104265
XYZ	G WERBER BRYAN PSYCHIATRIC HOSPITAL	RICHLAND	COLUMBIA		ST	288	305		3152	79656
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITUTE	4 RICHLAND	COLUMBIA		ST	89	89		976	65847
	TOTAL					1164	1386	327	7338	303930
	RESIDENTAL TREATMENT FAC FOR CHILDREN & ADOLESCENTS:									
XYZ	DIRECTIONS WS HALL	5 RICHLAND	COLUMBIA		ST	37	37		43	10024
XY	SOUTHBRIDGE RESIDENTAL TREATMENT FACILITY	26 RICHLAND	COLUMBIA		ST	(40)	(40)			
	TOTAL					37	37		43	10024
	DRUG AND ALCOHOL IPATIENT TREATMENT:									
XYZ	PATRICK B HARRIS PSYCHIATRIC HOSPITAL	30 ANDERSON	ANDERSON		ST	(44)	(44)		921	12396
	PALMETTO CTR	FLORENCE	FLORENCE		ST	48	48		521	11650
	HOMESVIEW ALCOHOLIC CTR	GREENVILLE	GREENVILLE		ST	36	36		489	11691
XYZ	WM J MCCORD ADOLESCENT TREAT	ORANGEBURG	ORANGEBURG		ST	15	15		153	5012
XYZ	EARL E. MORRIS ADA TREATMENT CT	32 RICHLAND	COLUMBIA		ST	174	174		2230	45900
	TOTAL					273	273	0	4314	86649
	LONG TERM FACILITIES:									
Y	RM CAMPBELL VA NURS HM	6 ANDERSON	ANDERSON		ST	220	220		72	75601

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RECORD 003944
PMC.2013.SHP.0431
PET-EX006.0167

					INPATIENT INVENTORY		OCT.1,1999-SEPT.30,2000		
				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
YN	PRESTON HEALTH CENTER	7 BEAUFORT	HILTON HEAD	PROP	8	8			
Y	FRASER HEALTH CTR	BEAUFORT	HILTON HEAD	PROP	14	14			
Y	BISHOP GADSDEN EPISCOPAL HLTH CARE CTR	8 CHARLESTON	CHARLESTON	NPA	9	9			
N	THE FRANKE HEALTH CARE CTR	CHARLESTON	MT PLEASANT	NPA	20	20			
N	BETHEA BAPTIST HM	9 DARLINGTON	DARLINGTON	NPA	52	52			
N	PRESBYTERIAN HM OF SC SUMMERVILLE	DORCHESTER	SUMMERVILLE	NPA	90	90		118	18010
N	PRESBYTERIAN HM OF SC FLORENCE	10 FLORENCE	FLORENCE	NPA	44	44		24	13440
N	METHODIST MANOR OF THE PEE DEE	11 FLORENCE	FLORENCE	NPA	32	32		13	9371
CON	THE LAKES AT LITCHFIELD SKILLED NURSING CENTER	34 GEORGETOWN	PAWLEYS ISLAND	PROP		7			
N	ROLLING GREEN VILLAGE HEALTH CARE FACILITY	33 GREENVILLE	GREENVILLE	NPA	34	34		77	14271
N	PRESBYTERIAN HM OF SC CLINTON	LAURENS	CLINTON	NPA	66	66		80	13889
N	MARTHA FRANK BAPTIST HM	LAURENS	LAURENS	NPA	44	44			
N	SC EPISCOPAL HM STILL HOPES	14 LEXINGTON	W COLUMBIA	NPA	42	42			
N	LAUREL CREST NURS HM	12 LEXINGTON	W COLUMBIA	NPA	12	12		10	3468
N	PRESBYTERIAN HM OF SC COLUMBIA	13 LEXINGTON	W COLUMBIA	NPA	44	44		50	15145
N	CLEMSON AREA RET CTR	15 PICKENS	CLEMSON	NPA	22	22			
N	FOOTHILLS PRESBYTERIAN HOME HE CARE CENTER	28 PICKENS	EASLEY	NPA	18	18		23	4897
YZN	CM TUCKER JR /DOWDY GARDNER NURS CTR FEWELL & STONE PAVILIONS	23 RICHLAND	COLUMBIA	ST	252	252	229.d	34	82798
YZN	CM TUCKER JR RODDY PAVILION	23 RICHLAND	COLUMBIA	ST	308	308		60	90362
YZN	(DOWDY GARDNER FARMER BLDG)	18 RICHLAND	COLUMBIA	ST	(132)	(132)		33	44623

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N	LOWMAN HOME-WC BOLICK	16	RICHLAND	WHITEROCK	CON-NPA	LICENSED 47	SURVEY 47	NONCON	ADMIS	PATIENT
N	WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	150	150		283	35284
N	SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	11	11			
N	CARTER NURSING CTR	17	SUMTER	SUMTER	NPA	44	44		20	9810
	TOTAL					1583	1580		897	430949
	LICENSED FACILITIES FOR HABILITATION:									
Z	WARE SHOALS HAB CTR I		ABBEVILLE	WARE SHOALS	ST	8	8		0	2920
Z	WARE SHOALS HAB CTR II		ABBEVILLE	WARE SHOALS	ST	8	8		0	2920
	ABBEVILLE CO		TOTAL			16	16		0	5840
Z	DUPONT I&II HABILITATION CTR		AIKEN	AIKEN	ST	16	16		0	5781
Z	LAURENS STREET ICF/MR		AIKEN	AIKEN	ST	8	8		0	2912
Z	LINDER STREET ICF/MR		AIKEN	AIKEN	ST	8	8		0	2920
Z	RUDNICK COMM RES		AIKEN	NORTH	ST	8	8		0	2873
Z	SANDERS COMM RES		AIKEN	NORTH	ST	8	8		0	2905
	AIKEN CO		TOTAL			48	48		0	17391
Z	ANDERSON HAB CTR		ANDERSON	ANDERSON	ST	8	8		0	2918
Z	BELTON HAB CTR		ANDERSON	BELTON	NPA	8	8		0	2878
Z	HONEA PATH HAB CTR		ANDERSON	BELTON	NPA	8	8		0	2866
	ANDERSON CO		TOTAL			24	24		0	8662
Z	HAMPTON ST COMM RES		BAMBERG	DENMARK	ST	8	8		0	2920
Z	ZEIGLER ST COMM RES		BAMBERG	BAMBERG	ST	8	8		0	2853
	BAMBERG CO		TOTAL			16	16		0	5773
Z	ACADEMY ST COMM RES		BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	BLACK'S DRIVE COMM RES		BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	HARLEY RD COMM RES		BARNWELL	BARNWELL	NPA	8	8		0	2882
Z	LEMON PARK COMM RES		BARNWELL	BARNWELL	NPA	8	8		0	2920
	BARNWELL CO		TOTAL			32	32		0	11566
Z	PORT ROYAL COMM RES		BEAUFORT	PORT ROYAL	ST	16	16		0	5811
	BEAUFORT CO		TOTAL			16	16			5811

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PMC.2013.SHP.0433
PET-EX006.0169

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	CONIFER I&II COMM RES	BERKELEY	MONCKS CORNER	ST		16	16		0	5775
Z	DEHAY COMM RES	BERKELEY	MONCKS CORNER	ST		8	8		0	2877
	BERKELEY CO	TOTAL				24	24		0	8652
Z	FLORENCE GRESSETTE RES	CALHOUN	ST MATTHEWS	NPA		8	8		0	2897
Z	WYLIE-BRUNSON RES	CALHOUN	ST MATTHEWS	NPA		8	8		0	2897
	CALHOUN CO	TOTAL			0	16	16		0	5794
Z	CAMP ROAD COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2748
Z	DILLS BLUFF COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2772
Z	FARMINGTON COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2725
Z	SECESSIONVILLE COMM RES	CHARLESTON	CHARLESTON	ST		8	8		0	2916
	CHARLESTON CO	TOTAL				32	32		0	11161
Z	JC FORT COMM RES #1	CHEROKEE	GAFFNEY	NPA		8	8		0	2830
Z	JC FORT COMM RES #2	CHEROKEE	GAFFNEY	NPA		8	8		0	2904
	CHEROKEE CO	TOTAL				16	16		0	5734
Z	CHARLES INGRAM, SR COMM RES	CHESTERFIELD	CHERAW	ST		8	8		0	2908
Z	CHESTERFIELD COMM RES	CHESTERFIELD	CHESTERFIELD	ST		8	8		0	2915
Z	PAGELAND COMM RES	CHESTERFIELD	PAGELAND	ST		8	8		0	2857
	CHESTERFIELD CO	TOTAL				24	24		0	8680
Z	VANGUARD COMM RES 1& 2	CLARENDON	MANNING	NPA		16	16		0	5838
	CLARENDON CO	TOTAL				16	16		0	5838
Z	JOSIE DRIVE COMM RES	COLLETON	WALTERBORO	ST		8	8		0	2914
Z	FOREST CIRCLE COMM RES	COLLETON	WALTERBORO	ST		8	8		0	2908
	COLLETON CO	TOTAL				16	16		0	5822
Z	JM REAGAN COMM RES	DARLINGTON	HARTSVILLE	NPA		8	8		0	2893
Z	THAD E SALEEBY DEVL CTR	DARLINGTON	HARTSVILLE	ST		96	128		0	35885
Z	WW BOWEN COMM RES	DARLINGTON	HARTSVILLE	NPA		8	8		0	2893
	DARLINGTON CO	TOTAL				112	144		0	41671
Z	DILLON COMM RES	DILLON	DILLON	ST		8	8		0	2890
	DILLON CO	TOTAL				8	8		0	2890
Z	COASTAL CTR -HIGHLAND & HILLSIDE	DORCHESTER	LADSON	ST		192	192		0	68855
Z	COASTAL CTR HIGHLANDS 510	DORCHESTER	LADSON	ST		18	18		0	8288
YZ	COASTAL CTR LIVE OAK VLG	DORCHESTER	SUMMERVILLE	ST		50	50		0	17599

RECORD 003947
PMC.2013.SHP.0434
PET-EX006.0170

REGION:STATEWIDE — INPATIENT INVENTORY — OCT.1,1999-SEPT.30,2000

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	PARSONS GRP HM 1&2	DORCHESTER	SUMMERVILLE	NPA	16	16		0	5825
	DORCHESTER CO	TOTAL			276	276		0	100567
Z	EDGEFIELD COMM RES	EDGEFIELD	EDGEFIELD	ST	8	8		0	2920
	EDGEFIELD CO	TOTAL			8	8		0	2920
Z	RC BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
Z	SL BLAIR GRP HM	FAIRFIELD	BLAIR	NPA	8	8		0	2920
	FAIRFIELD CO	TOTAL			16	16		0	5840
Z	ACLINE PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	CAROLINA PLACE	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	COIT ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2919
Z	CEDARS, THE	FLORENCE	PAMPLICO	ST	8	8		0	2920
Z	FLORENCE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2557
Z	GRAHAM ST COMM RES	FLORENCE	FLORENCE	ST	8	8		0	2920
Z	MAGNOLIA PLACE	FLORENCE	OLANTA	ST	8	8		0	2920
Z	MULBERRY PARK 301-307	FLORENCE	FLORENCE	ST	85	112		0	34243
Z	THE OAKS	FLORENCE	TIMMONSVILLE	ST	8	8		0	2597
Z	PALMETTO PLACE COMM RES	FLORENCE	FLORENCE	ST	8	8		0	1424
Z	PECAN LN 201-205	FLORENCE	FLORENCE	ST	120	132		0	34555
	FLORENCE CO	TOTAL			277	316		0	92895
Z	JESSAMINE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2715
Z	MARYVILLE COMM RES	GEORGETOWN	GEORGETOWN	NPA	8	8		0	2909
	GEORGETOWN CO				16	16		0	5624
Z	CIVITAN COMM RES	GREENVILLE	GREENVILLE	NPA	8	8		0	2919
Z	FOUNTAIN INN COMM RES	GREENVILLE	FOUNTAIN INN	NPA	12	12		0	4258
Z	HUGHES STREET RES	GREENVILLE	FOUNTAIN INN	NPA	8	8		0	2889
Z	MARIAN PARKINS COMM RES I & II	GREENVILLE	GREENVILLE	ST	16	16		0	5831
Z	RIDGE RD RES	20 GREENVILLE	GREENVILLE	NPA	12	12		0	4380
Z	TRAVELERS REST RES	GREENVILLE	TRAVELERS REST	NPA	8	8		0	2779
	GREENVILLE CO	TOTAL			64	64		0	23056
Z	HENRY & FREIDA BONDS C RES	GREENWOOD	GREENWOOD	NPA	8	8		0	2920
Z	MARION P CARNELL HAB CTR	GREENWOOD	WARE SHOALS	ST	8	8		0	2920
Z	DR PB PRITCHARD,JR RES	GREENWOOD	GREENWOOD	ST	12	12		0	4337
Z	JF BURTON COMM RES	GREENWOOD	GREENWOOD	ST	8	8		0	2819
	GREENWOOD CO	TOTAL			36	36		0	12996
Z	HORRY CO COMM RES	HORRY	CONWAY	ST	8	8		0	2893
Z	THE L EARGLE COMM RES	HORRY	CONWAY	ST	8	8		0	2877
	HORRY CO	TOTAL			16	16		0	5770

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PMC.2013.SHP.0435
PET-EX006.0171

INPATIENT INVENTORY OCT.1,1999-SEPT.30,2000

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
Z	CAMDEN I GRP HM	KERSHAW	CAMDEN		NPA	8	8		0	2912
Z	CAMDEN II GRP HM	KERSHAW	CAMDEN		NPA	8	8		0	2913
	KERSHAW CO	TOTAL				16	16		0	5825
Z	NJ MCCONNELL HM	LANCASTER	LANCASTER		ST	8	8		0	2873
Z	TOM MANGUM HM	LANCASTER	LANCASTER		ST	8	8		0	2886
	LANCASTER CO	TOTAL				16	16		0	5759
Z	CLINTON MANOR COMM RES	LAURENS	CLINTON		CO	8	8		0	2863
Z	DAVIDSON ST COMM RES	LAURENS	CLINTON		CO	8	8		0	2920
Z	MILL ST COMM RES	LAURENS	CLINTON		CO	8	8		0	2920
Z	S HARPER ST COMM RES	LAURENS	CLINTON		ST	8	8		0	2879
Z	SULLIVAN ST COMM RES	LAURENS	LAURENS		CO	8	8		0	2876
Z	OAKGROVE COMM RES	LAURENS	CLINTON		ST	8	8		0	2818
YZ	WHITTEN CTR CTL SQ 201-205,207,209	LAURENS	CLINTON		ST	143	143		0	
Z	WHITTEN CTR CAMPUS UNITS 101-110	LAURENS	CLINTON		ST	152	152		0	
Z	WHITTEN CTR WEBB 401-404	21 LAURENS	CLINTON		ST	156	174		0	
Z	WHITTEN CTR SUBER 301-303	22 LAURENS	CLINTON		ST	66	136		0	
	WHITTEN CTR TOTAL:								0	202945
	LAURENS CO	TOTAL				567	653		0	220221
Z	MCLEOD GRP HM 1 & II	LEE	BISHOPVILLE		NPA	16	16		0	5676
	LEE CO	TOTAL				16	16		0	5676
Z	B SMITH RD GRP HM	LEXINGTON	LEXINGTON		NPA	8	8		0	2920
Z	BATESBURG GROUP HM	LEXINGTON	BATESBURG		NPA	8	8		0	2920
Z	CLUSTER OF LEXINGTON A	LEXINGTON	LEXINGTON		NPA	8	8		0	17517
Z	CLUSTER OF LEXINGTON B	LEXINGTON	LEXINGTON		NPA	8	8			
Z	CLUSTER OF LEXINGTON C	LEXINGTON	LEXINGTON		NPA	8	8			
Z	CLUSTER OF LEXINGTON D	LEXINGTON	LEXINGTON		NPA	8	8			
Z	CLUSTER OF LEXINGTON E	LEXINGTON	LEXINGTON		NPA	8	8			
Z	CLUSTER OF LEXINGTON F	LEXINGTON	LEXINGTON		NPA	8	8			
Z	EAST HARTLEY HAB CTR	LEXINGTON	BATESBURG		NPA	4	4		0	1083
Z	HENDRIX ST GRP HM	LEXINGTON	LEXINGTON		NPA	8	8		0	2920
Z	KITTY WAKE HAB CTR	LEXINGTON	LEXINGTON		NPA	4	4		0	1083
Z	LEANING PINES TRAIL ICF/MR	LEXINGTON	LEXINGTON		NPA	4	4		0	1083
Z	NAZARETH ROAD COMM RES	LEXINGTON	LEXINGTON		NPA	8	8		0	2920
Z	PEACHTREE HAB CTR	LEXINGTON	BATESBURG		NPA	4	4		0	1082
Z	WIRE RD I&II	LEXINGTON	GILBERT		NPA	16	16		0	5840
	LEXINGTON CO	TOTAL				112	112		0	39368
Z	JENNINGS MCABEE COMM	MCCORMICK	MCCORMICK		ST	8	8		0	2920
	MCCORMICK CO	TOTAL				8	8		0	2920

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REGION:STATEWIDE

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Z	ES HUNTER COMM RES		NEWBERRY	NEWBERRY	CON-NPA	LICENSED 12	SURVEY 12	NONCON	ADMIS 0	PATIENT 4172
Z	HA MCCULLOUGH COMM RES		NEWBERRY	NEWBERRY	NPA	12	12		0	4162
	NEWBERRY CO		TOTAL			24	24		0	8334
Z	OCONEE COMM RES#1		OCONEE	SENECA	ST	16	16		0	5810
Z	OCONEE COMM RES #2		OCONEE	SENECA	ST	8	8		0	2920
	OCONEE CO		TOTAL			24	24		0	8730
Z	NANCE COMM RES		ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	KINGS COMM RES		ORANGEBURG	ORANGEBURG	ST	8	8		0	2920
Z	SIFLY ST COMM RES		ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
Z	WANNAMAKER ST COMM RES		ORANGEBURG	ORANGEBURG	NPA	8	8		0	2920
	ORANGEBURG CO		TOTAL			32	32		0	11680
Z	EASLEY COMM RES I&II		PICKENS	EASLEY	ST	16	16		0	5715
	PICKENS CO		TOTAL			16	16		0	5715
Z	ARCHIE DRIVE GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	BAY SPRINGS HAB CTR		RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	CARTER ST GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2920
YZN	CRAFTS-FARROW ST HOSP ICF/MR BLDG 16		RICHLAND	COLUMBIA	ST	80	80		0	36496
Z	FIRST MIDLANDS ICF-MR	25	RICHLAND	COLUMBIA	ST	344	344		0	43955
Z	HORRELL HILL COMM RES		RICHLAND	EASTEROVER	NPA	8	8		0	2920
Z	IDA LANE I&II COMM RES		RICHLAND	COLUMBIA	NPA	16	16		0	5839
Z	KENSINGTON GRP HM 1		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	KENSINGTON GRP HM 2		RICHLAND	COLUMBIA	NPA	8	8		0	2920
Z	NORTH PINES COMM RES		RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	PINE LAKE ICF-MR		RICHLAND	COLUMBIA	NPA	44	44		0	16060
Z	RABBIT RUN		RICHLAND	HOPKINS	NPA	8	8		0	2920
Z	SUNVIEW CIRCLE HAB CTR		RICHLAND	COLUMBIA	NPA	4	4		0	1460
Z	WOODLAWN AV GRP HM		RICHLAND	COLUMBIA	NPA	8	8		0	2917
	RICHLAND CO		TOTAL			556	556		0	128627
Z	BENCHMARK-SPGT		SPARTANBURG	SPARTANBURG	NPA	12	12		0	4351
Z	BENCHMARK HM-COWPENS		SPARTANBURG	COWPENS	NPA	12	12		0	4378
Z	LANDRUM COMM RES I&II		SPARTANBURG	LANDRUM	ST	16	16		0	5597
Z	JD FERGUSON COMM RES I&II		SPARTANBURG	SPARTANBURG	ST	8	16		0	5613
	SPARTANBURG CO		TOTAL			48	56		0	19939
Z	ATKINSON W&E GRP HM		SUMTER	SUMTER	NPA	18	18		0	6486
Z	THOMAS DR COMM RES		SUMTER	SUMTER	ST	8	8		0	2885
	SUMTER CO		TOTAL			26	26		0	9371
Z	WEST MAIN ST COMM RES		UNION	UNION	ST	8	8		0	2798

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REGION I STATEWIDE — PATIENT ... OCT.1,1999-SEPT.30,2000

					CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	UNION CO	TOTAL				8	8		0	2798
Z	BIRD ST HAB CTR I&II	YORK	ROCK HILL		ST	16	16		0	5693
	YORK CO	TOTAL				16	16		0	5693
	TOTAL					2505	2671		0	917447

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FOOTNOTES

REGION: STATEWIDE

FY2002 PLAN

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

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

1. Beds, admissions, and patient days allocated based on patient origin.
2. Licensed beds reduced from 629 to 519, 2/1/94. Licensed beds increased from 519 to 549 with closure of 30 licensed D&A beds, 3/1/95. Licensed beds reduced from 549 to 300, 3/1/96. Facility closed 6/30/96.
3. Licensed beds reduced from 450 to 350 3/1/95. Licensed beds increased from 350 to 400, 3/1/96. Licensed beds increased by 15 from 400 to 415, 11/18/97. Licensed beds at JF Byrnes closed & State licensed for 446 beds(424 psy & 22 instit general inf), 7/8/99. Licensed beds reduced from 446 to 346, 11/22/00. Licensed beds reduced from 346 to 316 ,12/5/01.
4. Licensed beds decreased from 239 to 215,3/14/97. Licensed beds at Hall increased from 215 to 232, 2/9/99 before the the exemption was issued. E-99-25 to increase licensed beds from 215 to 232 & to reduce licensed beds from 55 to 37 at Directions, 4/21/99. Beds at Hall to increase from 232 to 235, 7/28/99 e-99-43. Licensed beds at Hall to increase by 16 from 235 to 251, 8/12/99 e-99-48. Licensed beds increased from 232 to 235 12/8/99. Licensed beds increased from 235 to 272, 11/22/00. Licensed beds increased from 272 to 285, 8/14/01. Beds from 285 to 89 3/1/02.
5. Exemption to add a 13 bed RTF for Children and Adolescents with a 13 bed reduction in psy beds, 6/10/93. Licensed for 13 RTF beds, 3/11/94. Licensed beds increased from 13 to 31 by E-95-130 on 12/15/95.Exp to increase beds from 31 to 55, 11/8/96. See #4. Licensed beds increased from 31 to 55, 3/14/97. Licensed beds decreased from 55 to 37 4/21/99.
6. Licensed beds increased from 88 to 132, 10/12/92. Licensed beds increased from 132 to 176, 7/7/93. Licensed beds increased from 176 to 220, 1/3/94.
7. CON issued for 44 dual beds (36 community and 8 restricted), 8/28/89. Facility licensed for 36 comm and 8 restricted beds with name change from Cypress of Hilton Head, 4/7/92.
8. Con issued for 9 non-comm resulting in 53 comm & 9 non-comm beds , 12/19/00 sc-00-65.
9. CON issued to convert 6 non-comm beds to comm for a total of 62 non-comm & 26 comm, 10/11/94. Licensed for 62 non-comm and 26 comm, 1/1/95.
10. CON issued for 19 additional non-community LTC beds for a total of 44 beds, 12/16/92. Licensed for 44 beds,

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4/20/94. Con issued to convert 10 non-comm beds to comm. Beds for a total of 52 non-comm & 36 comm ,3/13/00. Facility licensed for 36 comm & 52 Inst. Beds , 6/29/00.

11. CON issued for 22 bed restricted nurs hm, 8/4/92. Facility licensed for 22 beds, 9/23/92. Con issued for 10 add non-comm beds for a total of 32, sc99-07 2/16/99. Facility licensed for 32 beds , 12/30/99.
12. CON issued for 12 beds restricted nurs. hm., 2/10/93. Licensed 9/16/94.
13. CON issued for 22 additional restricted beds for a total of 44, 1/8/93. Licensed beds increased from 22 to 44, 1/14/94.
14. Approved to convert 8 non-comm beds to comm for a total of 36 non-comm & 8 comm, 10/18/94. Licensed for 36 non-comm and 8 comm, 12/1/94. CON for 22 addditional non-comm beds for a total of 58 non-comm & 8 comm, 12/19/95.Licensed for 58 non-comm beds & 8 comm beds, 3/17/97. Facility licensed for 46 institutional & 20 comm nurs hm beds,1/1/99. Facility non-comm beds reduced from 46 to 42 ,e-99-41,7/15/99. Facility licensed for 42 non-comm & 20 comm, 7/16/99.
15. CON issued for 8 non-com beds & the conversion of 14 comm to non-comm for a total of 52 beds (30 comm & 22 non-comm), 8/9/94. Licensed for 30 comm and 22 non-comm, 2/20/95.
16. CON issued for 47 restricted beds and 85 replacement beds, 4/27/90. Licensed for 47 beds, 3/31/93.
17. CON issued for 22 restricted beds, 5/19/93. Licensed for 22 nurs hm beds, 5/11/94. CON issued for 22 additional restricted beds for a total of 44 nurs hm beds, 6/7/96. Licensed for 44 nurs beds, 6/1/97.
18. Beds reduced from 176 to 132, 2/1/95. Exp to transfer 32 beds from D&G Rock Hill 10/7/96. Facility licensed for 162 beds, 11/6/96. Reduced the survey beds at DG Farmer by 44 from 198 to 146 & licensed for 132, e-99-56, 10/1/99. Facility closed 2/17/00.
19. CON issued 3/14/94. Licensed 5/17/95.
20. Licensed beds changed from 16 to 12, 10/1/96.
21. Beds reduced from 174 to 168 and from 168 to 156.
22. Facility licensed for 68 beds.
23. Beds increased from 440 to 572, 7/18/95. Licensed as two facilities one for 264 & the other for 308, 7/1/97. Facility beds reduced by 12 from 264 to 252, 5/18/98.
24. No footnote 24.
25. Licensed beds increased from 332 to 344, 6/1/96. Transfer of 20 beds from 2nd Midlands to 1st Midlands with a bed increase from 344 to 364 and closure of 2nd Midlands 10/31/00 e-00-67. 2nd midlands closed 5/16/01 , but did not transfer the 20 beds.
26. Exemption for a 40 bed rtf, 2/9/98. Facility licensed for 40 rtf beds, 2/11/98. Facility closed.
27. Facility licensed as a 326 Institutional General Inf., 9/2/98. Facility licensed for 140 general & 178 psy (318 tal) which is a permanent reduction of 8 general beds, 11/13/01.
28. Con issued for 18 bed non community nurs home, 1/25/99 SC-99-03,. Facility licensed for 18 beds, 10/20/00.
29. Exp #e99-09 to reduce beds from 60 to 50,3/11/98. Facility licensed for 50 beds, 3/1/99.
30. Licensed beds changed for psy from 162 to 206 and D&A from 44 to , 12/4/01.

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31. Facility closed 12/1/99.
32. E-01-27 to permanent reduction of 9 d&a beds from 183 to 174, 5/21/01. Facility licensed reduced from 183 to 174 6/1/01.
33. App to convert 10 institutional beds to 10 community beds for 34 int & 10 comm. 10/29/01.
34. App to construct a 24 bed nurs hm with 17 comm beds and 7 instit beds,10/30/01.
35. Facility closed 11/30/01.
36. E-02-69 11/18/02 to maintain 14 bed infirmary.

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REGION NARRATIVE

REGION: I

FISCAL YEAR: 2003

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

2. General Hospitals: W.J. Barge Hospital is a restricted use facility.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in five facilities in this region and long term psychiatric beds available at Springbrook Behavioral Healthcare System in Greenville County. There is a small need for additional psychiatric beds in this region.

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

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

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REGION: I

INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCONFORMING	ADMISSIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	ANDERSON AREA MEDICAL CTR	28	ANDERSON	ANDERSON	NPA	495	423		18617	94448	495	52.3%
CON	WOMEN & CHILDREN'S HOSP	37	ANDERSON	ANDERSON	NPA		72					
	ANDERSON CO.		TOTAL			495	495		18617	94448	495	52.3%
XYZ	UPSTATE CAROLINA MED CTR		CHEROKEE	GAFFNEY	PROP	125	125		4040	15847	125	34.3%
	CHEROKEE CO.		TOTAL			125	125		4040	15847	125	34.3%
XYZ	ALLEN BENNETT MEM	1	GREENVILLE	GREER	NPA	58	58		3543	15054	58	71.1%
APP	GRENVILLE HOSP SYS - PATEWOOD	1		GREENVILLE	NPA		72					
XYZ	GREENVILLE MEM.MEDICAL CTR.	1	GREENVILLE	GREENVILLE	NPA	646	710		35821	187002	628	81.6%
XYZ	HILLCREST	1	GREENVILLE	SIMPSONVILLE	NPA	43	43		2096	8926	56	43.7%
XYZ	NORTH GREENVILLE LTC ACUTE CARE HOSP (W.J. BARGE)	2	GREENVILLE	TRAVELERS REST	NPA	(5)	45		0	0	5	0.0%
		3	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(90)	(3) c	(1338)	(3390)		
XYZ	SAINT FRANCIS HOSP.	21	GREENVILLE	GREENVILLE	NPA	206	226		9673	56185	206	74.7%
XYZ	SAINT FRANCIS WOMAN'S AND FAMILY HOSPITAL	21	GREENVILLE	GREENVILLE	NPA	62	93		4328	13533	62	59.8%
	GREENVILLE CO.		TOTAL			1015	1202		55461	280700	1015	75.8%
XYZ	OCONEE MEM		OCONEE	SENECA	NPA	160	160		7944	31890	160	54.8%
	OCONEE CO.					160	160		7944	31890	160	54.8%
XYZ	PALMETTO BAPTIST MED CTR-EASLEY	17	PICKENS	EASLEY	NPA	96	96		4581	17886	96	51.1%
XYZ	CANNON MEM.		PICKENS	PICKENS	NPA	55	55		1391	6260	55	31.2%
	PICKENS CO.		TOTAL			151	151		5972	24146	151	43.8%
XYZ	B.J. WORKMAN MEM.		SPARTANBURG	WOODRUFF	CO	43	43		943	2748	43	17.5%
XYZ	MARY BLACK MEM.	22	SPARTANBURG	SPARTANBURG	PROP	178	178		6596	26120	178	40.7%
XYZ	SPGT HOSP RESTORATIVE CARE	4	SPARTANBURG	SPARTANBURG	CO	97	97		724	22082	97	62.4%
XYZ	SPARTANBURG REG. MED.CTR.	30	SPARTANBURG	SPARTANBURG	CO	532	532		24059	111939	532	57.6%
	SPARTANBURG CO.		TOTAL			848	848		32322	162889	848	52.6%
	HOPE HOSP.		UNION	LOCKHART	CO	16	14	7 cd	118	808	16	13.8%
XYZ	WALLACE THOMSON		UNION	UNION	DIST	143	143	6 c	3856	16744	143	32.1%
	UNION CO.		TOTAL			159	157	13	3974	17552	159	30.2%
	TOTAL					2953	3138	13	126330	627374	2953	58.2%
	MENTAL FACILITIES:											
XYZ	ANDERSON AREA MEDICAL CTR		ANDERSON	ANDERSON	NPA	38	38		563	3777	38	27.2%
	ANDERSON CO.		TOTAL			38	38		563	3777	38	27.2%
YZ	THE CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	53	53		1803	13617	53	70.4%
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM (LTC PSYCHIATRIC)	6	GREENVILLE	TRAVELERS REST	PROP	5	5		376	3236		
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6	GREENVILLE	TRAVELERS REST	PROP	15	15					
XYZ	GREENVILLE MEM.MEDICAL CTR.	2	GREENVILLE	GREENVILLE	NPA	72	46		2010	16897	72	64.3%
	GREENVILLE CO.		TOTAL			145	119		4189	33750	125	74.0%
XYZ	MARY BLACK MEM.	22	SPARTANBURG	SPARTANBURG	PROP	15	15		293	2701	15	49.3%
XYZ	SPARTANBURG REG. MED. CTR.		SPARTANBURG	SPARTANBURG	CO	56	56		755	7327	56	35.8%
	SPARTANBURG CO.		TOTAL			71	71		1048	10028	71	38.7%

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REGION I — INPATIENT INVENTORY — OCT. 1, 2000-SEPT. 30, 2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	TOTAL					254	228		5800	47556	234	55.7%
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:											
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM	6	GREENVILLE	TRAVELERS REST	PROP	68	68		71	16478	53.5	84.4%
YZ	MARSHALL I. PICKENS CHILDREN'S PROGRAM	7	GREENVILLE	GREENVILLE	NPA	22	22		31	7999	22	99.8%
	GREENVILLE CO.		TOTAL			90	90		102	24477	75.5	88.8%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
YZ	ANMED-WELLSPRING		ANDERSON	WILLIAMSON	NPA	27	27		191	795	27	8.1%
YZ	THE CAROLINA CENTER FOR BEHAVIORAL HEALTH	5	GREENVILLE	GREENVILLE	PROP	13	13		423	2460	13	51.6%
	GREENVILLE MEM.MEDICAL CTR.	2	GREENVILLE	GREENVILLE	NPA	(18)	(18)					
	GREENVILLE CO.		TOTAL			40	40		614	3255	40	22.3%
	REHABILITATION FACILITIES:											
XYZ	ANMED HEALTHSOUTH REHAB HOSP	36	ANDERSON	ANDERSON	PROP	28	28					
	ANDERSON CO						28					
XYZ	GREENVILLE GEN.	29	GREENVILLE	GREENVILLE	NPA	(14)	(11)				14	0.0%
XYZ	GREENVILLE MEM.MEDICAL CTR.	8	GREENVILLE	GREENVILLE	NPA	53	53		1028	15838	53	81.9%
XYZ	SAINT FRANCIS HOSP.		GREENVILLE	GREENVILLE	NPA	19	19		585	6159	19	88.8%
	GREENVILLE CO.		TOTAL			72	72		1613	21997	86	70.1%
XYZ	MARY BLACK MEM HOSP		SPARTANBURG	SPARTANBURG	PROP	18	18		517	4598	18	70.0%
	SPARTANBURG CO					18	18		517	4598	18	70.0%
	INPATIENT HOSPICE FACILITIES:											
YZ	CALLIE & JOHN RAINEY HOSPICE HOUSE	16	ANDERSON	ANDERSON	NPA	32	32		258	4650		
	ANDERSON CO		TOTAL			32	32		258	4650		
	LONG TERM CARE FACILITIES:											
YZ	ANMED HEALTHSOUTH REHAB HOSP	36	ANDERSON	ANDERSON	PROP	12	12					
YZ	(ANDERSON MED CTR SUBACTUE)	28	ANDERSON	ANDERSON	NPA	(12)	(12)		565	8795	27	89.2%
YZ	ANDERSON PLACE		ANDERSON	ANDERSON	PROP	44	44		47	8784	44	54.7%
YZ	BROOKSIDE NURSING CTR		ANDERSON	ANDERSON	PROP	88	88	19 e	97	27336	88	85.1%
YZ	ELLENBURG NURS CTR	9	ANDERSON	ANDERSON	PROP	181	181		194	62856	181	95.1%
YZ	NHC HEALTHCARE ANDERSON (NHC HEALTHCARE EDGEBROOK)	25	ANDERSON	ANDERSON	PROP	290	290 (112)		332	103223	290	97.5%
YZ	RIVERSIDE NURSING CTR		ANDERSON	ANDERSON	PROP	88	88		122	31472	88	98.0%
ZI	WILLOW CREEK NURS CTR	10	ANDERSON	IVA	PROP	60	60	(16) cd	72	21160	60	96.6%
	ANDERSON CO		TOTAL			763	763	19	1429	283825	778	92.8%
YZ	BROOKVIEW HLTHCARE CTR		CHEROKEE	GAFFNEY	PROP	132	132		142	48098	132	95.7%
YZ	CHEROKEE CO. LTC	11	CHEROKEE	GAFFNEY	CO	85	85		43	30925	85	99.7%
	CHEROKEE CO		TOTAL			217	217		185	77023	217	97.2%

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REGION I

INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
Z	ALLEN BENNETT NURS HM	1	GREENVILLE	GREER	NPA	10	10		193	2843	10	77.9%
YZ	BRIARWOOD NURSING CTR		GREENVILLE	SIMPSONVILLE	PROP	42	39		30	12803	42	83.5%
NHM	BRIGHTON GARDENS	27	GREENVILLE	GREENVILLE	PROP	45	45					
CON	(BROOKSTONE TERRACE NURS HM)	12	GREENVILLE	GREENVILLE	PROP		(44)					
Z	FOUNTAIN INN NURS HM		GREENVILLE	FOUNTAIN INN	PROP	44	44	28 od	33	15619	44	97.3%
YZ	LAUREL BAYE HEALTHCARE OF GREENVILLE	33	GREENVILLE	GREENVILLE	CO	112	132		194	41371	116.1	97.6%
YZ	GREENVILLE NURSING CTR		GREENVILLE	GREENVILLE	PROP	79	79	18 d	97	23842	79	82.0%
NHM	GREENVILLE MEM CTR SUBACUTE UNIT	1	GREENVILLE	GREENVILLE	NPA	21	(3)		475	7225	46	41.2%
YZ	NORTH GREENVILLE	1	GREENVILLE	TRAVELERS REST	NPA	27	(27)					
YZ	MAGNOLIA MANOR-GREENVILLE	23	GREENVILLE	GREENVILLE	PROP	99	99	25 d	89	33273	99	92.1%
YZ	MAGNOLIA PLACE-GREENVILLE	23	GREENVILLE	GREENVILLE	PROP	120	120		143	41452	120	94.6%
Y	NHC CENTER GREENVILLE		GREENVILLE	GREER	PROP	176	176		197	61213	176	95.3%
YZ	NHC CENTER OF MAULDIN	13	GREENVILLE	MAULDIN	PROP	120	120		180	41453	120	94.7%
YZ	OAKMONT EAST NURS CTR		GREENVILLE	GREENVILLE	PROP	132	132		238	47184	132	97.9%
Z	OAKMONT WEST NURS CTR		GREENVILLE	GREENVILLE	PROP	125	125		130	44447	125	97.4%
Z	PIEDMONT NURSING AND REHAB		GREENVILLE	GREER	PROP	132	132		117	45858	132	95.2%
YZ	ROGER HUNTINGTON NURS CTR		GREENVILLE	GREENVILLE	NPA	88	88	12 d	99	31019	88	96.6%
NHM	ROLLING GREEN VILLAGE HEALTH CARE FAC	35	GREENVILLE	GREENVILLE	NPA	10	10				44	
YZ	ST FRANCIS TRANSITIONAL CARE TRANSITONAL CARE UNIT		GREENVILLE	GREENVILLE	NPA	32	32		641	10016	32	85.8%
YZ	SUMMIT PLACE		GREENVILLE	SIMPSONVILLE	PROP	132	132		136	46814	132	98.7%
Z	STROUD NURS HOME		GREENVILLE	MARIETTA	NPA	44	44	1 d	10	15915	44	99.1%
YZ	WESTSIDE NURS CTR		GREENVILLE	GREENVILLE	PROP	132	132		126	46956	132	97.5%
	GREENVILLE CO		TOTAL			1722	1691	82	3125	568893	1715.1	90.9%
YZ	LILA DOYLE NURS CARE	32	OCONEE	SENECA	CO	120	120		271	28615	79	92.3%
YZ	MARINER HLTH CARE OF SENECA		OCONEE	SENECA	PROP	132	132		225	42326	132	87.8%
	OCONEE CO		TOTAL			252	252		496	88941	211	89.5%
Z	BLUE RIDGE NURS CTR		PICKENS	EASLEY	PROP	66	66	33 d	72	23248	66	96.5%
Y	CLEMSON AREA RET CTR	14	PICKENS	CLEMSON	PROP	30	30		54	11319	52	59.6%
NHM	COUNTRYSIDE CARE CTR	34	PICKENS	EASLEY	PROP	44	44		73	15055	44	93.7%
YZ	EASLEY NURS CTR		PICKENS	EASLEY	PROP	103	100	50 d	243	38084	103	95.9%
Z	HARVEY'S NURSING HOME	24	PICKENS	SIX MILE	PROP	44	41	27 od	21	15492	44	96.5%
YZ	LAUREL HILL		PICKENS	PICKENS	PROP	80	80		62	28847	80	98.8%
Z	ROSEMOND NURSING CTR	20	PICKENS	PICKENS	PROP	44	44	22 d	20	15748	44	98.1%
Y	PALMETTO MEDICAL CTR-EASLEY TRANSITIONAL CARE FACILITY	17	PICKENS	EASLEY	NPA	13	13		185	1676	13	35.3%
	PICKENS CO		TOTAL			424	418	132	730	147449	446	90.6%
Z	CAMP CARE		SPARTANBURG	INMAN	PROP	88	88		53	31742	88	98.8%
YZ	(SPGT HOSP RESTORATIVE CARE SNF)	4	SPARTANBURG	SPARTANBURG	CO	(11)	(11)					
Z	GOLDEN AGE-INMAN		SPARTANBURG	INMAN	PROP	44	44		28	15662	44	97.5%
YZ	INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	35		32	14065	40	96.3%
YZ	MAGNOLIA MANOR/INMAN		SPARTANBURG	INMAN	PROP	176	176		179	60723	176	94.5%
YZ	MAGNOLIA MANOR-SPGT		SPARTANBURG	SPARTANBURG	PROP	95	69	62 od	147	32739	95	94.4%
YZ	MAGNOLIA PLACE-SPGT		SPARTANBURG	SPARTANBURG	PROP	88	88		62	31587	88	98.3%
NHN	MARY BLACK MEM HOSP-SNF	22	SPARTANBURG	SPARTANBURG	PROP	(20)	(20)		89	902	20	12.4%
YZ	MOUNTAINVIEW NURS HM		SPARTANBURG	SPARTANBURG	CO	132	132		35	47951	132	99.5%
NHN	ROSECREST NURSING CENTER	31	SPARTANBURG	INMAN	NPA	75	75		70	1506	20.4	20.2%
YZ	SKYLYN PLACE HEALTH CTR	15	SPARTANBURG	SPARTANBURG	PROP	33	33		75	11674	44	72.7%
YZ	VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88		72	31414	88	97.8%
YZ	WHITE OAK MANOR-SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192		207	67216	192	95.9%
Y	WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88		116	31051	88	96.7%
YZ	WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88		43	31593	88	98.4%
	SPARTANBURG CO		TOTAL			1227	1216	62	1226	409824	1203.4	93.3%
YZD	ELLEN SAGAR	16	UNION	UNION	CO	113	113		135	38927	108	98.7%
YZD	OAKMONT OF UNION		UNION	UNION	PROP	88	88		82	31209	88	97.2%
	UNION CO		TOTAL			201	201		217	70136	196	98.0%

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FOOTNOTES

__REGION:I
1.

FY2002 PLAN

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

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

1. CON issued to convert 17 general beds to 13 LTC beds at Allen Bennett Mem., to convert 34 general beds to 32 LTC beds and add 16 LTC beds in the Rehab Unit, resulting in 53 general beds & 13 LTC beds at Allen Bennett and 628 general beds, 72 psych., 50 rehab., 18 substance abuse an 48 LTC beds at Greenville Mem., 9/23/94. Greenville Mem licensed for 48 Nur Hm and Gen Mem licensed reduced from 662 to 628, 10/31/95. CON for Allen Bennett modified to conversion of 12 hosp beds to 10 nurs hm beds, 9/21/95. Allen Bennett licensed for 10 nurs hm & 56 general beds, 1/2/96. Con issued to transfer 13 beds from Hill Crest to GM resulting in 43 at Hill Crest & 641 at GM, 7/3/2000 SC-00-35. Con issued to transfer 5 general acute beds from NG to GM resulting in 646 general acute beds at GM and 0 acute beds at NG with the closure of the acute facility & the transfer of 28 nurs hm beds to NG with 20 at GM & 28 at GM, SC-01-09 2/20/01. Con issued for adding 55 new acute beds & converting 9 psy beds for a total of 710 general & 63 psy beds, SC-01-57 10/10/01. NG licensed for 27 nurs beds and GM licensed nurs hm beds reduced from 48 to 21 licensed and 20 survey beds 3/14/02. The nurs beds at NG reduced from 28 survey beds to 27 and the 1 bed added back to GMEM for 21 existing. Con issued for 45 bed LTC Acute Hosp by converting 27 nurs beds & 18 nurs beds from GMEM leaving 3 nurs hm beds at GMEM 4/15/03 SC-03-17. GMEM licensed generals increased from 628 to 646 Hillcrest licensed beds decreased by 13 from 56 to 43 & NG licensed beds decreased by 5 from 5 to 0 these licensure changes fulfill cons sc-0035 & sc-01 09 6/04/03. App for a 72 bed general acute hospital & 24 non-licensed observation beds by transferring the 52 beds to be added from Allen Bennett with the reduction of 17 psy beds from Mem and the trasfer of the 3 nurs hm beds from Mem. Thus resulting in a new 72 bed licensed acute hosp & Mem with 710 gen, 53 rehab 44 psy beds and 0 licensed nursing beds (18 were transferred to NG for the acute long term hosp) , 6/30/03.
2. Facility is licensed for 53 beds (5 acute, 48 inpatient treatment beds). CON issued to delicense 30 inpatient treatment beds from NGH, 18 psy beds from GMEM and transfer 18 inpat beds from NGH to GMEM resulting in 5 acute beds at NGH and 72 psy, 18 inpat treat beds to GMEM with 16 RT beds for children at MIP, 4/25/94. Facility licensed for only 5 general beds, 6/9/94. 18 inpat treatment beds closed by e-99-59, 10/22/99. 18 bed inpat treatment closed 1/1/00. Con issued to transfer 5 general acute care beds from NG to GM for 646 beds at GM and 0 beds at NG, SC-01-

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09 2/20/01. Con for adding 55 new acute beds & converting 9 psy beds for a total of 710 general & 63 psy beds, 10/10/01 SC-01-57. See footnote #1.

3. Facility use restricted to students.
4. Name changed from Doctors Mem., 10/1/95. Con issued to transfer the 11 nurs hm beds plus additional 15 new non-medicaid beds for a 26 nurs hm beds at Spart Reg Med Ctr, 8/28/98. Con voided, 1/24/00. 11 bed nurs hm at Spgt Restorative de-licensed and nurs hm closed 8/31/02.
5. CON issued to convert 14 inpat treatment beds to 14 crisis beds resulting in 21 inpat treat beds, 25 psy beds and 14 crisis beds (psy), 3/28/94. Facility licensed for 21 treatment beds, 3/29/94. Licensed for 45 psy(31 psy & 14 crisis beds) and 21 d&a beds, 5/10/95. Con issued to convert 8 of the 21 D&A beds to psy for a total of 53 psy (39 psy & 14 crisis beds) & 13 D&A beds, 07/14/99. Facility licensed for 13 D&A & 53 psy beds , 8/18/00.
6. Facility is licensed for 44 long term care psychiatric beds and 44 RTC beds. Con issued to reduce 24 long term psy beds from 44 to 20 and add 24 RFT beds from 44 ro 68 RFT and 20 Long Term Psy beds, 6/12/01 Facility licensed for 68 RFT and 20 LTC Psy, 8/10/01. Con issue to convert 15 ltc psy beds to 15 acute psy beds & 5 ltc psy beds , 2/19/03 SC-03-12. Facility licensed for 5 ltc psy & 15 psy. , 3/10/03.
7. CON issued for 16 RTF beds, 1/10/92. Facility licensed for 16 RTF beds, 4/1/93. CON issue for 6 additional beds for a total of 22 rtf beds, 10/16/95. Facility licensed for 22 rtf beds, 10/22/95.
8. Exemption for relocation of the inpatient component of the Pain Therapy Center at Greenville General to Greenville mem., 5/12/94. The licensed 14 rehab beds at Greenville Gen. are restricted to Pain Therapy only by CON SC F-749 issued 11/7/84. Con issued to transfer 3 rehab beds from general to Memorial resulting in 11 rehab at general & 53 rehab beds at memorial,4/13/98. GMH licensed for 53 rehab beds, 2/2/99.
9. CON issued to convert 5 private beds to semi for total of 181 beds, 3/19/93. Licensed for 181 beds 4/20/93.
10. CON issued for a 34 bed addition for a total of 60 beds, 4/12/93. Name changed from Golden Acres Nurs Fac.
11. CON issued for 32 dual Medicaid beds 6/15/90. Facility licensed for 76 beds, 1/25/93. CON issued for 9 additional non-Medicaid beds for a total of 85 beds, 9/12/94. Facility licensed for 85 beds, 8/16/94.
12. CON issued for 44 non-Medicaid LTC beds 5/13/94. Void 5/10/95.
13. CON issued for 81 non-medicaid LTC beds, 3/8/95. CON issued to increase LTC beds by 39 for a total of 120 non-medicaid beds & name change from Greenville HealthCare Ctr, 2/9/96. Facility licensed for 120 beds 10/20/97.
14. CON issued for 8 non-community beds, with conversion of 14 community beds to non-comm with a total of 52 beds (30 community and 22 non-comm), 8/9/94. Facility licensed for 52 beds (30 comm & 22 non-comm), 2/20/95.
15. Facility licensed for 44 bed (33 comm. and 11 non-comm beds), 8/1/90. Additon of 4 private rooms without any change of licensed beds (11 non-comm & 33 comm) of 44, exmpt # E-96-02, 1/10/96.
16. CON issued for 11 additional beds for a total of 106, 9/28/95.Facility licensed beds increased by 4 from 95 to 99 beds 10/1/96. Licensed beds increased by 7 from 99 to 106, 2/12/97. CON for 2 addtional beds for a total of 108, 8/1/97. Licensed beds increased from 106 to 108,8/26/97. Con issued to increase beds by 5 to 113, SC-02-47 , 8/12/02. Licensed beds increased by 5 from 108 to 113, 9/12/02.
17. CON issued for conversion of 13 hosp beds to 13 nurs hm beds, 9/25/95. Facility licensed hosp beds reduced from 109

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to 96 with 13 nurs hm beds licensed, 3/20/96.

18. CON issued for 16 nurs hm beds, 9/22/95. facility licensed for 16 nurs hm beds, 7/15/98. Con issued for 16 additional non-medicaid beds for a total of 32. SC-01-12 2/20/01. Facility licensed as a 32 bed Inpatient Hospice Facility 8/16/02.
19. App to added an ER , mobile MRI & add 12 general beds to SF Women's Hosp for a total of 62 general beds at SF Woman's Hosp & 206 general beds at SF Hosp, 12/14/95. See footnote #21.
20. Formerly Jonathan's Nursing Ctr.
21. CON issued to expanded SFW w/ addition of a er, expansion of surgery, ect & the transfer of 12 general beds from SFH to SFW for 62 general beds & SFH w/ 206 general, 19 rehab & 32 nurs hm bds; provision of mobile MRI services at both hospitals, 2/21/96. SFH licensed beds decreased by 12 from 218 to 206 & SFWF increased by 12 from 50 to 62, 9/30/97. Appto add 20 general beds to SF 206 for 226 & 31 to SFW&F 62 general beds for 93 6/30/03.
22. CON issued to convert 10 general beds to 20 nursing home beds for a total of 198 general beds , 18 rehab & 20 nurs hm beds, 8/26/96. Facility licensed general beds reduced from 208 to 198 & licensed for 20 nurs hm beds, 1/31/97.CON issued to convert 22 general beds to 15 psy with 176 general 18 rehab & 20 nurs hm beds,1/27/97. Facility licensed for the 15 psy beds & a reduction of general beds from 198 to 176,6/18/97. Exemption issued to close the 20 bed nurs hm , NA-00-23 4/03/00. Nurs hm closed 4/25/00.
23. CON to transfer 41 beds from the licensed 129 resulting in 88 at Magnolia Manor & construction of a new acility Magnolia Place for 88 beds (41+47 non-medicaid beds), 12/2/96. Con issued for additional 32 beds non-medicaid beds at Magnolia Place for a total of 120 nurs hm beds,10/27/97. Magnolia Place licensed for 60 beds & the 41 transferred beds will be phased in from 6/1 to 6/10, 5/26/98. Magnolia Manor reduced 129 licensed beds to 88, 7/28/98.Magnolia Place licensed beds increased by from 60 to 120 beds, 07/28/98. Magnolia Manor Greenville Con issued for 11 additional non-medicaid beds for a total of 99 nurs hm beds, 1/31/00 SC-00-04. Magnolia Manor licensed for 99 beds, 9/25/00.
24. CON issued to increase licensed nurs hm beds from 40 to 44 & survey beds from 37 to 41, 2/24/97. Facility licensed for 44 beds, 11/5/98.
25. Con issued for construction of a 112 non-medicaid nurs hm, 9/29/97.
26. App for conversion of 30 general beds to 30 nurs hm beds for a total of 492 general acute, 38 psy & 30 nurs hm beds, 10/20/97. CON voided 3/26/99.
27. Con to construct a 45 non-medicaid beds, 12/29/97. Facility licensed for 45 beds, 2/3/00.
28. Con issued to convert 27 general beds to 27 nurs hm beds resulting in 495 general, 38 psy & 27 nurs hm beds, 05/01/98. Facility licensed for 12 nurs hm beds and the hospital licensed beds reduced by 12 from 522 to 510, 9/29/98. Licensed nurs hm beds increased by 15 to 27 & hospital beds reduced from 510 to 495, 12/18/98. E-02-15 issued 3/20/02 to permanently reduce the 27 nurs beds by 15 to 12 nurs beds and reduction will be done upon licensure change. Licensed Nursing Home beds reduced by 15 from 27 to 12 , 7/11/02. E-02-67 issued for permanent reduction of the 12 nurs hm beds will remove after the beds are de-licensed 11/05/02. 12 nurs beds delicensed 12/24/02.

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29. Exempt to close & demolition Greenville Gen with a permanent reduction of 75 general , 11 rehab & trasfer of 3 rehab beds to Greenville Mem for a total of 53 rehab beds, 3/30/98. Building demolished , 1/14/99.
30. Exemption to temporary transfer of 18 ltc acute beds from Spgt Restorative for a total of 36 ltc acute beds at Spgt Gen and must revert back to Sgpt Res Care by 5/31/2002 na-00-42.
31. Con issued for a 43 non medicaid nursing home, 7/31/00 SC-00-39. Facility licensed for 43 non-medicaid nurs beds 4/11/01. Con issued for 32 additional nurs hm (non-medicaid) for a total 75 nurs hm beds, 1/16/02 SC-02-80. Licensed beds increased by 32 from 43 to 75 , 2/13/03.
32. Con issued for add 41 nurs hm beds (25 medicaid & 16 non-medicaid) for a total of 120 , 08/04/00 Sc-00-40. Facility licensed increased from 79 to 120 , 4/15/03.
33. Con issued for 20 add beds for a total of 132 name changed from Grady Hippe , 8/25/00 Sc-00-43. Licensed beds increased from 112 to 132 7/19/01.
34. E-01-20 issued for permanent reduction of nurs hm beds by 28 from 44 to 16 will apply upon licensure change. E-01-20 is voided, 10/4/01.
35. Con to convert 10 institutional beds to 10 community beds for 34 int & 10 comm. 11/13/01 SC 01-67.
36. Con issued for construction fo a 40 bed rehab hosp for 28 rehab & 12 nurs beds, SC-02-10 1/25/02. Facility licensed for 28 rehab & 12 nurs hm beds ,12/20/02.
37. Con SC-03-02 issued for a 72 bed Women & Children's hosp resulting in 423 general beds , 38 psy & 12 nurs hm beds at Anderson Area Med Ctr , 1/13/03.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

ATEGORY	NAME OF FACILITY	COUNTY	CITY	2001 ER VISITS
EGION I:	EMERGENCY FACILITIES			
II	ANDERSON AREA MED CTR	ANDERSON	ANDERSON	77732
III	UPSTATE CAROLINA M CTR	CHEROKEE	GAFFNEY	22539
III	NORTH GREENVILLE HOSP	GREENVILLE	TRAVELERS REST	17920
I	GREENVILLE MEM HOSP	GREENVILLE	GREENVILLE	85937
II	ST FRANCIS COMM HOSP	GREENVILLE	GREENVILLE	26644
II	ST FRANCIS WOMENS & FAMILY HOSP	GREENVILLE	GREENVILLE	19558
(*)	WJ BARGE	GREENVILLE	GREENVILLE	7431
II	ALLEN BENNETT MEM HOSP	GREENVILLE	GREER	25514
II	HILLCREST HOSP	GREENVILLE	SIMPSONVILLE	22528
III	OCONEE MEM HOSP	OCONEE	SENECA	34805
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	27539
III	CANNON MEM HOSP	PICKENS	PICKENS	14880
III	MARY BLACK MEM HOSP	SPARTANBURG	SPARTANBURG	25354
I	SPARTANBURG REG MED CTR	SPARTANBURG	SPARTANBURG	71804
III	BJ WORKMAN MEMHOSP	SPARTANBURG	WOODRUFF	7777
III	WALLACE THOMSON HOSP	UNION	UNION	15429
TOTALS				503391

(*) Met insufficient criteria to be classified.

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

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REGION NARRATIVE

REGION: II

FISCAL YEAR: 2003

1. Unusual Characteristics: This region has a military base at Fort Jackson with a military hospital to provide health care services for the active duty and dependents residing in this region. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation and communications. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

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

III#24

3. Nursing Homes: There is a need for additional nursing home beds in this region.

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

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

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCONFORMING	2000-SE ADMISSIONS	2001 PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
YZ	ABBEVILLE CO. MEM.	18	ABBEVILLE	ABBEVILLE	CO	52	52		1346	4558	52	24.0%
	ABBEVILLE CO.		TOTAL			52	52		1346	4558	52	24.0%
XYZ	CHESTER COUNTY HOSPITAL	44	CHESTER	CHESTER	DIST	82	82		3367	13292	82	44.4%
	CHESTER CO.		TOTAL			82	82		3367	13292	82	44.4%
XYZ	EDGEFIELD CO. HOSP.		EDGEFIELD	EDGEFIELD	CO	40	40		1087	3574	40	24.5%
	EDGEFIELD CO.		TOTAL			40	40		1087	3574	40	24.5%
XYZ	FAIRFIELD MEM.		FAIRFIELD	WINNSBORO	NPA	33	33		1052	4083	33	33.9%
	FAIRFIELD CO.		TOTAL			33	33		1052	4083	33	33.9%
XYZ	SELF MEM.	27	GREENWOOD	GREENWOOD	NPA	334	334		12289	60315	334	49.5%
	GREENWOOD CO.		TOTAL			334	334		12289	60315	361	45.8%
XYZ	KERSHAW CO. MED.CTR.		KERSHAW	CAMDEN	CO	121	121		5544	24865	121	56.3%
	KERSHAW CO.		TOTAL			121	121		5544	24865	121	56.3%
XYZ	SPRINGS MEM HOSPITAL	21	LANCASTER	LANCASTER	NPA	135	145		7010	37976	135	77.1%
	LANCASTER CO.		TOTAL			135	145		7010	37976	135	77.1%
XYZ	LAURENS CO. HOSP.	36	LAURENS	LAURENS	DIST	76	76		4101	17749	76	64.0%
	LAURENS CO.		TOTAL			76	76		4101	17749	90	54.0%
XYZ	LEXINGTON MED CTR		LEXINGTON	WEST COLUMBIA	CO	292	292		17546	76355	292	71.6%
	LEXINGTON CO.		TOTAL			292	292		17546	76355	292	71.6%
XYZ	NEWBERRY CO. MEM.	31	NEWBERRY	NEWBERRY	CO	102	90		2713	10906	102	29.3%
	NEWBERRY CO.		TOTAL			102	90		2713	10906	102	29.3%
XYZ	PALMETTO HEALTH BAPTIST	1	RICHLAND	COLUMBIA	NPA	363	351		15799	74105	363	55.9%
XYZ	PROVIDENCE HOSPITAL	23	RICHLAND	COLUMBIA	PROP	247	247		12164	63961	228	76.9%
XYZ	PROVIDENCE HOSPITAL NE	26	RICHLAND	COLUMBIA	PROP	48	48		2737	12439	48	74.1%
Y	INTERMEDICAL HOSP OF SC	1	RICHLAND	COLUMBIA	NPA	35	47		258	9237	35	72.3%
XYZ	PALMETTO HEALTH RICHLAND	15	RICHLAND	COLUMBIA	CO	579	579		28877	145909	579	69.0%
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(400)		(3498)	(34949)		
X	MONCRIEF ARMY H	2	RICHLAND	COLUMBIA	FED		(63)		(1037)	(4856)		
	RICHLAND CO		TOTAL			1270	1270		59835	305851	1170	71.6%
XYZ	PIEDMONT MED. CTR.	43	YORK	ROCK HILL	PROP	268	268		17279	59019	248	65.2%
	YORK CO		TOTAL			268	268		17279	59019	248	65.2%
	TOTAL					2805	2803		133169	618344	2726	62.1%
	MENTAL FACILITIES:											
YZ	THREE RIVERS BEHAVIORAL CARE	3	LEXINGTON	WEST COLUMBIA	PROP	39	39		1144	9919	39	69.7%
	LEXINGTON CO.		TOTAL			39	39		1144	9919	39	69.7%

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REGION:II

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	INPATIENT INVENTORY LICENSED BEDS	SURVEY BEDS	NONCON FORMING	OCT.1,2000-SEPT.30,2001 ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
XYZ	SELF MEM.		GREENWOOD	GREENWOOD	NPA	36	36		647	5386	36	41.0%
	GREENWOOD CO.		TOTAL			36	36		647	5386	36	41.0%
XYZ	PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	104	104		2010	18748	104	49.4%
XYZ	PALMETTO HEALTH RICHLAND	4	RICHLAND	COLUMBIA	CO	60	60		1119	12855	60	58.7%
X	MONCRIEF ARMY H	2	RICHLAND	COLUMBIA	FED		(20)		(377)	(3020)		
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(60)		(495)	(3576)		
	RICHLAND CO		TOTAL			164	164		3129	31603	164	52.8%
XYZ	PIEDMONT MED. CTR.	19	YORK	ROCK HILL	PROP	20	20		508	3602	20	49.3%
	YORK CO		TOTAL			20	20		508	3602	20	49.3%
	TOTAL					259	259		5428	50510	259	53.4%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:											
	THREE RIVERS BEHAVIORAL CARE	6	LEXINGTON	WEST COLUMBIA	PROP	18	18		19	2025	14	30.6%
	NEW HOPE MIDLANDS	6	LEXINGTON	WEST COLUMBIA	PROP	59	59		48	12977	64	65.8%
	LEXINGTON CO		TOTAL			77	77		97	15002	86	60.4%
	YORK PLACE		YORK	YORK	PROP	40	40		28	11903	40	81.5%
	YORK CO		TOTAL			40	40		28	11903	40	81.5%
	TOTAL					117	117		95	26905	108	68.3%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	THREE RIVERS BEHAVIORAL CARE	6	LEXINGTON	WEST COLUMBIA	PROP	27	27		350	1977	27	20.1%
	SPRINGS MEM HOSPITAL	21	LANCASTER	LANCASTER	NPA	45	35		882	4189	45	25.5%
	FAIRFIELD MEM.		FAIRFIELD	WINNSBORO	NPA	17	17		0	0	17	0.0%
	PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10		471	3555	10	97.4%
	SELF MEM. HOSP.		GREENWOOD	GREENWOOD	NPA	24	24		0	0	24	0.0%
	TOTAL					123	113		1503	9721	123	21.7%
	REHABILITATION FACILITIES:											
YZ	HEALTHSOUTH REHABILITATION HOSPITAL OF COLA.	29	RICHLAND	COLUMBIA	PROP	96	111		1395	28467	89	87.6%
	RICHLAND CO		TOTAL			96	111		1395	28467	89	87.6%
	HEALTHSOUTH REHABILITATION HOSPITAL	42	YORK	ROCK HILL	PROP	32	32		346	6322	20	86.6%
	YORK CO		TOTAL			32	32		346	6322	20	86.6%
	LONG TERM CARE FACILITIES:											
YZ	ABBEVILLE NURS HM		ABBEVILLE	ABBEVILLE	PROP	94	94		42	32971	94	96.1%
Z	CARLISLE NURSING CTR	30	ABBEVILLE	DUE WEST	NPA	22	22		11	6992	22	87.1%
	ABBEVILLE CO		TOTAL			116	116		53	39963	116	94.4%
YZ	CHESTER CO NURS CTR		CHESTER	CHESTER	CO	100	100		86	35831	100	98.2%

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INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCONFORMING	ADMISSIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	CHESTER CO		TOTAL			100	100		86	35831	100	98.2%
Z	EDGEFIELD HLTH CARE CTR	41	EDGEFIELD	EDGEFIELD	PROP	120	120		56	31015	88	96.6%
	EDGEFIELD CO		TOTAL			120	120		56	31015	88	96.6%
Z	FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	104	36 C	80	37950	112	92.8%
Z	RIDGEWAY HEALTH & REHABILITATION CTR		FAIRFIELD	RIDGEWAY	PROP	150	150		152	51127	150	93.4%
	FAIRFIELD CO		TOTAL			262	254	36	212	89077	262	93.1%
YZ	HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102		79	33766	102	90.7%
YZ	MAGNOLIA MANOR-GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88		52	31749	88	98.8%
YZ	NHC HEALTHCARE- GREENWOOD	8	GREENWOOD	GREENWOOD	PROP	152	152		158	52111	152	93.9%
YZ	TRANSITIONAL CARE OF SELF REG HEALTHC	27	GREENWOOD	GREENWOOD	NPA	27	27		398	4705	27	47.7%
	GREENWOOD CO		TOTAL			369	369		687	122351	369	90.8%
YX	A SAM KARESH LTC		KERSHAW	CAMDEN	CO	88	88		30	31986	88	99.6%
Y	SPRINGDALE HEALTHCARE CTR	7	KERSHAW	CAMDEN	PROP	148	148		266	47450	148	87.8%
	KERSHAW CO		TOTAL			236	236		296	79436	236	92.2%
YX	CENTRAL CAROLINAS REHAB COMPLEX	29	LANCASTER	LANCASTER	PROP	(22)	(22)		216	3685	22	45.5%
YZ	LANCASTER CONVL CTR	24	LANCASTER	LANCASTER	NPA	142	142		123	50044	142	96.6%
YZ	TRANSITIONAL CARE UNIT-SPRINGS MEM	21	LANCASTER	LANCASTER	NPA	14	14		382	4646	14	90.9%
YZ	WHITE OAK MANOR-LANCASTER		LANCASTER	LANCASTER	NPA	132	132		48	47961	132	99.5%
	LANCASTER CO		TOTAL			288	288		769	106306	310	94.0%
NHM	LAURENS CO HOSP/SNF	36	LAURENS	LAURENS	DIST	14	14		255	3384	14	66.2%
YZ	NHC HEALTHCARE LAURENS		LAURENS	LAURENS	PROP	178	178		267	61274	178	95.4%
NHM	MARTHA FRANK BAP RET CTR	9	LAURENS	LAURENS	NPA	44	44		167	25869	88	83.7%
YZ	NHC HEALTHCARE CLINTON		LAURENS	CLINTON	PROP	131	131		125	46456	131	97.2%
	LAURENS CO		TOTAL			365	365		814	137983	395	95.7%
NHM	AGAPE NURSING AND REHABILIATION	40	LEXINGTON	W.COLUMBIA	PROP	44	44					
YZ	BRIAN CTR-ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120		135	38760	120	88.5%
YZ	LEXINGTON MED CTR EXTENDED CARE	10	LEXINGTON	LEXINGTON	NPA	388	388		528	123830	352	96.4%
YZ	HEARTLAND OF LEXINGTON RHAB & NURSIN(	11	LEXINGTON	W.COLUMBIA	PROP	132	132		198	42089	132	87.4%
NHM	NHC HEALTHCARE LEXINGTON	12	LEXINGTON	W.COLUMBIA	PROP	120	120		208	41128	120	93.9%
NHM	SC EPISCOPAL HM @ STILL HOPES	13	LEXINGTON	W.COLUMBIA	NPA	20	20		39	21558	62	95.3%
	LEXINGTON CO		TOTAL			824	824	0	1109	267365	786	93.2%
YZD	MCCORMICK NURS CTR	25	MCCORMICK	MCCORMICK	CO	120	120		58	42508	120	97.1%
	MCCORMICK CO		TOTAL			120	120		58	42508	120	97.1%
YZ	J F HAWKINS NURS HM	20	NEWBERRY	NEWBERRY	CO	118	118		94	41215	118	95.7%
Y	NEWBERRY CO MEM HOSP-TRANSITIONAL C/	31	NEWBERRY	NEWBERRY	CO	12	12		49	661	7.3	21.6%
YZ	WHITE OAK MANOR-NEWBERRY	28	NEWBERRY	NEWBERRY	PROP	146	146		156	50239	146	94.3%
	NEWBERRY CO					276	276		299	92035	271.3	92.9%
Y	BENZIE T. RICE NURSING FACILITY	34	RICHLAND	COLUMBIA	NPA	32	32		72	6486	20	88.6%
y	(BERNADIN HOSPICE HOUSE)	39	RICHLAND	COLUMBIA	NPA	(12)			153	2389	12	54.8%
YZ	CENTRAL CAROLINA HLTH & REHAB	37	RICHLAND	COLUMBIA	PROP	257	250	146 cd	445	87434	257	93.2%
YZ	LIFE CARE CTR OF COLA	17	RICHLAND	COLUMBIA	PROP	140	179		264	48379	140	94.7%
YZ	LOWMAN HOME NURSING CTR		RICHLAND	WHITEROCK	NPA	129	129		153	61572	176	95.8%
YZ	MAGNOLIA MANOR-COLA		RICHLAND	COLUMBIA	PROP	88	88		110	30960	88	96.4%
YZ	HEARTLAND OF COLUMBIA RHAB & NURSING	14	RICHLAND	COLUMBIA	PROP	132	132		284	40759	132	84.6%
Y	NHC HEALTHCARE PARKLAND	16	RICHLAND	COLUMBIA	PROP	120	120		117	42451	120	96.9%
Y	PROVIDENCE HOSP-TCU	23	RICHLAND	COLUMBIA	NPA	(19)	(19)					

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REGION:II.

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	INPATIENT INVENTORY LICENSED BEDS	SURVEY BEDS	NONCON FORMING	OCT.1,2000-SEPT.30,2001 ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
Y	PROVIDENCE HOSP NE-TCU	26	RICHLAND	COLUMBIA	PROP	16	16		442	5357	16	61.5%
Y	PALMETTO BAPTIST MED CTR	1	RICHLAND	COLUMBIA	NPA	22	22		478	5347	22	66.6%
YZ	RIDGEVIEW MANOR	32	RICHLAND	HOPKINS	PROP	38	38		49	9994	30	91.3%
YZ	WHITE OAK MANOR-COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120		73	42878	120	97.9%
FED	W J B DORN VA		RICHLAND	COLUMBIA	FED		(150)		(76)	(30892)		
	RICHLAND CO		TOTAL			1096	1126	146	2640	384016	1135	92.7%
YZ	SALUDA NURS CTR		SALUDA	SALUDA	CO	176	176		141	62963	176	98.0%
	SALUDA CO		TOTAL			176	176		141	62963	176	98.0%
NHM	CAROLINA VILLAGE HLTH CARE CTR	33	YORK	ROCK HILL	PROP	40	40		48	4086	40	27.9%
NHM	EBENEZER SENIOR SERVICES	38	YORK	ROCK HILL	PROP	99	99		110	13998	44	87.2%
YZ	MAGNOLIA MANOR -ROCK HILL		YORK	ROCK HILL	PROP	106	106		82	37906	106	98.0%
YZ	ROCK HILL HEALTHCARE	45	YORK	ROCK HILL	PROP	132	132		282	46876	132	96.9%
YZ	HEALTHSOUTH REHABILITATION HOSP (SNF)	42	YORK	ROCK HILL	PROP	8	8		384	6690	20	91.6%
NHM	WESTMINSTER HEALTH & REHABILITATION	35	YORK	ROCK HILL	PROP	66	66		154	13555	44	84.4%
YZ	WHITE OAK MANOR-ROCK HILL		YORK	ROCK HILL	PROP	141	141		86	51180	141	99.4%
YZ	WHITE OAK MANOR-YORK	22	YORK	YORK	NPA	109	109		40	37177	99	102.9%
	YORK CO		TOTAL			701	701		1166	211230	628	92.4%
	TOTAL					5049	5073	182	8328	1659572	4870.3	93.4%

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FOOTNOTES

__REGION II

FY2002 PLAN

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

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

1. CON issued to transfer 35 general beds BMCC to est a 35 beds long term acute care hosp InterMedical Hosp of SC resulting in 363 general acute care, 104 psy 22 nursing hm & 35 long-term acute beds, 9/2/97. InterMedical licensed for 35 long term care acute beds & Palmetto Baptist MCC licensed gen beds reduced from 398 to 363, 10/21/98. Con issued for conversion of 12 gen beds from Baptist Med Ctr to 12 long-term acute from 35 to 47, 11/13/01 SC-01-74.
2. Bed use restricted. Beds reported by facility.
3. CON issued to convert 5 D&A beds to 5 Psy. beds for 41 D&A beds and 39 Psy. beds, 5/10/93. Facility licensed on same date as CON, 5/10/94.
4. CON issued for 23 crisis stab beds for a total of 60 psy(37 & 23 crisis) beds,12/22/94. Licensed per con, 2/1/95. CON issued to construct/renovate & create a 20 bed non licensed observation unit adjacent to the ER, 12/11/98.
5. Con issued to add 4 RTF beds for a total of 18 RTF beds, SC-02-26. Facility licensed for 18 beds 12/3/02.
6. Facility licensed for 30 RTF beds 1/13/93. CON issued to add 14 RFT beds with a total of 44 RFT beds, 11/2/93. CON issued to add 10 RTF beds with a total of 54 RTF beds, 4/26/94. Facility licensed, for 54 beds, 4/8/95. Con issued for 5 add beds for 59 , 11/13/01 SC-01 65. Facility licensed from 54 to 59 , 1/22/03.
7. CON for 23 additional non-Medicaid LTC beds for a total of 148 beds, 5/19/93. Licensed for 148 LTC beds, 9/20/94.
8. Formerly Greenwood Health Care.
9. CON issued to construct a 44 community non-Medicaid bed addition, 8/31/94. Licensed for 2 comm beds & 44 non-comm beds, 7/3/95. Licensed comm beds increased from 2 to 44, 2/5/96.
10. CON issued for 185 replacement facility, 10/10/94. CON for 35 additional non-Medicaid beds for a total of 220, 11/38/94. Licensed beds increased from 185 to 220, 8/29/96. Licensed combined for Rikard (132 beds) & Kiesler/Holstedt (220 beds) for 352, 10/1/97 and Facility licensed as Lexington Med Ctr Extended Care. Con issued for 36 non-medicaid beds for a total of 388,SC-00-12 2/29/00. Facility licensed beds increased by 36 from 352 to 388 , 4/15/02.
11. CON issued for 12 non-medicaid nurs beds for total of 132 beds, 1/20/95. Facility licensed for addtional 12 beds

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for 132 nurs hm beds, 3/1/97.

12. CON issued for 83 beds, 7/06/90. Facility licensed 3/9/94. CON issued for 5 additional beds for a total of 88, 5/16/94. Facility licensed for 88 beds, 10/19/94. Con issued for 23 addtional beds for a total of 111, 9/9/96. CON issued for 9 additional beds for a total of 120,3/21/97. Facility licensed beds increased by 32 from 88 to 120, 8/25/98.
13. Approved to convert 8 non-community beds to community beds for 36 non-community and 8 community beds, 10/18/94. Licensed per con, 12/1/94. con issued to convert 12 institutional beds to 12 comm for a total 46 institutional beds & 20 comm beds, 12/22/97. Facility licensed for 46 institutional & 20 comm nurs hm beds, 1/1/99. Facility licensed non-comm beds reduced by 4 to 42 non-comm & 20 comm, e-90-41, 7/15/99. Facility licensed for 42 non-comm & 20 comm,7/16/99.
14. CON issued for 14 additional non-Medicaid beds for a total of 132, 10/24/94. Facility licensed beds increased by 14 from 118 to 132 nurs hm beds, 1/14/97.
15. CON issued for purchase of a Gamma Knife,. 3/18/97. NA-99-97 for renovation of the 11th floor for the addition of 26 general beds with no change it the licensed bed capacity, 11/18/99.
16. CON issued to NHC Ctr. of Columbia for a 132 bed non-Medicaid nursing home, 6/6/94. CON reduced from 132 to 120, 5/5/95. Facility licensed for 120 nurs hm beds & name changed, 5/2/97.
17. CON issued 132 dual beds (80 Medicaid), 12/20/91. Facility licensed for 132 beds, 6/27/94. CON issued for 8 additional non-medicaid beds for a total of 140 (80 medicaid) nurs hm beds, 4/24/97. Facility licensed beds increased by 8 from 132 to 140, 6/23/98. Con issued for 39 additional non-medicaid nurs beds for a total of 179 , 5/20/03 SC-03-32.
18. Close ob service of 8 beds 9/8/95.
19. CON issued for relocation of the 20 psy beds to a new building & converting the semi-private rooms on the old psy floor to private with no change in licensed beds, 2/5/96.
20. CON issued to add 20 non-medicaid beds for a total of 98 nurs hm beds, 6/7/96. Facility licensed for 98 nur hm beds, 1/3/97. CON issued for 20 non-medicaid beds for a total of 118, 7/7/97. Facility licensed increased from 98 to 118 , 9/6/00.
21. CON issued for conversion of 14 general beds to 14 nurs hm beds for a total of 135 general beds , 45 D&A beds & 14 nurs hm beds, 9/16/96. Facility licensed for 14 nurs hm beds & 135 general beds ,4/25/97. Con issued to increased general beds by 10 & reduce D&A beds by 10 for 145 general & 35 D&A, SC-03-18 4/15/03.
22. CON issued for 33 additional non-medicaid nurs hm beds for a total of 99 nurs hm beds, 9/30/96. Facility licensed beds increased by 33 for 99 nurs hm beds, 9/23/97. Con issued for 10 add non-medicaid beds ,SC-00-10 2/23/00. License beds increased by 10 from 99 to 109 , 6/8/00.
23. Con for for renovation & construction to include the addition of 19 nurs hm beds resulting in 239 general & 19 nurs hm beds, 10/07/96. Licensed for 19 nurs hm beds, 12/4/96. Exempt #E99-12 to permanent close 19bed nurs hm, 3/15/99. The licensed 19 nurs hm beds at Providence closed, 4/5/99. Licensed general beds increased from 228 to 247 11/1/02.See fn #26.

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24. App for 10 additional non-medicaid beds & 22 replacement beds to increase from 110 to 120 nurs hm beds, 10/2/96. Facility licensed beds increased from 110 to 120,11/12/97. CON issued to add 22 non-medicaid beds for a total of 142 nurs hm beds, 1/26/99. Facility licensed for 142 nurs beds,6/15/99.
25. CON issued for 32 additional medicaid beds for a total of 120 beds, 11/25/96. Facility licensed for 120 beds, 2/13/98.
26. CON issued for construction of a new 46 general hosp & 18 non-medicaid nurs beds by the transfer of 46 general beds from Providence resulting in 193 general beds ,19 nurs beds at Cola Providence & 46 general ,18 nurs hm beds at Cola Providence NE, 2/14/97. Providence NE licensed for 34 gen beds & 18 nurs beds, 3/23/99. Providence Hosp licensed beds reduced by 34 from 239 to 205, 5/28/99. Con issued for 54 additional general beds for a total of 247 general beds, SC-99-41 11/2/99. Providence NE licensed beds increased from 34 to 46, 12/15/99. Licensed general beds at Providence increased by 23 from 205 to 228, 12/15/99.
Licensed general beds at Providence from 228 to 247 11/01/02.
27. App for conversion of 38 general beds to nurs hm beds for a capacity of 323 licensed general(326 survey), 36 psy, 24 sub abuse beds & 38 nurs hm beds, 2/20/97. Appealed. Court order compromise for 27 nurs hm beds & 334 licensed beds (made survey & licensed beds the same by reducing survey by 4 beds), con issued 7/29/97. Facility licensed beds reduced from 361 to 334 general beds & 27 nurs hm beds licensed, 1/1//99. Con issued for 10 additional critical beds w/o change of licensed bed capacity , 2/2/01 sc-01-07.
28. Con to add 20 non-medicaid beds for total of 146 nurs hm beds, 6/13/97. Facility licensed increased from 126 to 146, 5/1/98.
29. Con issued for a 20 beds rehab hosp & 20 nurs hm beds (non-medicaid) with a reduction of 12 rehab beds from Hlth South Cola from 89 to 77 rehab beds, 5/27/97. Licensed for 20 rehab beds & 20 nurs hm beds, 4/28/00. Facility closed in Lancaster for 22 nurs beds , 4/30/00. Health South Cola beds reduced from 89 to 77 4/28/00. Hlth South Con issued for Cola to added 19 rehab beds for a total of 96, 9/25/00 SC-00-47. Health South Cola licensed beds increased by 12 from 77 to 89 10/10/00. Con issued to increased beds for Cola from 89 to 96, 9/25/00 sc-00-47. Facility licensed beds increased from 89 to96 2/1/02. Con issued for additional 15 rehabs for a total of 111, 10/15/02 SC-02-63.
30. CON issued for a 22 bed non-medicaid nurs hm, 9/10/97. Facility licensed for 22 nurs hm beds, 6/11/99.
31. App to convert 12 acute care beds to 12 non-medicaid nurs hm beds resulting in 90 acute care & 12 nurs hm beds, 9/2/97. Licensed for 12 nurs hm beds and 90 hospital beds, 2/19/99.
32. Con issued to constructed a new facility to replace 26 licensed beds at Stanton Pines & 21 survey with 11cd beds plus 4 additional non-medicaid beds for a total of 30 nurs hm beds, 12/01/97. Name changed to Ridgeview Manor. Facility licensed beds increased by 4 from 26 to 30 , 4/17/00. CON issued for 8 add non-medicaid beds for toal of 38 12/23/02. Facility licensed for 38 beds, 4/99/03.
33 Con issued for a 40 bed non-medicaid nurs hm, 9//98. Licensed for 40 beds, 1/24/01.
34 Con issued for 20 non-medicaid nurs hm beds, 1/4/99. Facility licensed for 20 nurs hm beds, 3/29/99. Merger of Bernadine Hospice House'S 12 beds with the existin 20 at Rice Nursing Ctr for total of 32, 3/12/02 sc-02-18.

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Facility licensed for 32 nurs beds , 5/28/02.

35. CON issued for an add 22 non-medcaid nurs beds for a total of 66 nurs beds, 1/5/99. Licensed beds increased from 44 to 66, 8/6/01.
36. CON issued to convert 14 acute beds to 14 nurs hm beds resulting in 76 acute beds & 14 nurs hm beds, sc-99-08 2/25/99.Facility licensed for 76 hospital beds & 14 nurs beds, 3/31/00.
37. Name changed from Brian Ctr-Forest Hill.
38. Con issued for 55 add non-medicaid beds for a total of 99, SC-00-08 2/1/2000. Facility licensed for 55 add non-medicaid beds for 99 nurs hm beds , 1/30/02.
39 Con issued for 12 non-medicaid nurs beds , 3/9/98. Facility licensed 4/18/00. Merged with Rice Nursing home see footnote #34.
40. Con issued for 44 non-medicaid nurs beds , SC-01-55 10/9/01. Facility licensed for 44 beds 12/19/02.
41 Con issued for 32 add non-medicaid beds for a total of 120 sc-01-75, 11/16/01. Facility licensed beds increased from 88 to 120 6/27/03.
42. See also #29. Con issued to convert 12 nurs beds to 12 rehab for 8 nurs hm & 32 rehab beds, 2/28/02 sc-02-17. Facility licensed for 8 nurs hm & 32 rehab beds, 4/1/02.
43. Con issued for 20 additional general beds for a total of 268 general & 20 psy beds, 6/12/02 SC-02-37. Facility licensed for increased by 8 beds from 248 to 256 , 11/27/02. Licensed beds increased by 12 from 256 to 268 12/19/02.
44. Facility to discontinue provision of OB services 11/30/03.
45. Formerly Beverly Healthcare-Rock Hill.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2001 ER VISITS
REGION II:	EMERGENCY FACILITIES			
III	ABBEVILLE CO MEM HOSP	ABBEVILLE	ABBEVILLE	10774
II	CHESTER CO HOSP	CHESTER	CHESTER	16068
III	EDGEFIELD CO HOSP	EDGEFIELD	EDGEFIELD	7224
III	FAIRFIELD CO HOSP	FAIRFIELD	FAIRFIELD	13687
II	SELF MEM HOSP	GREENWOOD	GREENWOOD	48586
III	KERSHAW CO MEM HOSP	KERSHAW	CAMDEN	23964
II	SPTINGS MEMORIAL HOSP	LANCASTER	LANCASTER	28599
II	LAURENS COUNTY HOSP	LAURENS	LAURENS	24504
II	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	79020
III	NEWBERRY CO MEM HOSP	NEWBERRY	NEWBERRY	14016
II	PALMETTO BAPTIST MED CTR-COLA	RICHLAND	COLUMBIA	35996
II	PROVIDENCE HOSPITAL	RICHLAND	COLUMBIA	18434
II	PROVIDENCE HOSPITAL NE	RICHLAND	COLUMBIA	23460
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA	71972
II	PIEDMONT MED CTR	YORK	ROCK HILL	50803
TOTALS				467107
REGION II:	TRAUMA CENTERS			
III	SELF MEM REGIONAL HEALTH CARE	GREENWOOD		
III	LEXINGTON MED CTR	LEXINGTON	W. COLUMBIA	
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA	
III	PALMETTO HEALTH BAPTIST	RICHLAND	COLUMBIA	
III	PIEDMONT MEDICAL CTR	YORK	ROCK HILL	

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RECORD 003973

REGION NARRATIVE

REGION: III

FISCAL YEAR: 2003

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." Shaw Air Force Base near Sumter has a military hospital to provide health care services for the active duty and dependents residing in this region. The inland waterway is a barrier to transportation.

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

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There is a need for additional psychiatric beds in the this area.

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

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

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INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	PN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	CHESTERFIELD GENERAL	27	CHESTERFIELD	CHERAW	PROP	59	59		1655	5407	59	25.1%
	CHESTERFIELD CO.		TOTAL			59	59		1655	5407	59	25.1%
XY	CLARENDON MEM.		CLARENDON	MANNING	CO	56	56		2584	13703	56	67.0%
	CLARENDON CO.		TOTAL			56	56		2584	13703	56	67.0%
XYZ	CAROLINA PINES REG MED CTR	24	DARLINGTON	HARTSVILLE	NPA	116	116		6811	27566	116	65.1%
XYZ	WILSON MEDICAL CTR	36	DARLINGTON	DARLINGTON	NPA	49	49		737	3664	50	20.1%
	DARLINGTON CO.		TOTAL			165	165		7548	31230	166	51.5%
XYZ	SAINT EUGENE MEDICAL CENTER	23	DILLON	DILLON	NPA	79	79		3710	12617	79	43.8%
	DILLON CO.		TOTAL			79	79		3710	12617	79	43.8%
XYZ	CAROLINAS HOSP SYS	1	FLORENCE	FLORENCE	PROP	262	262		10833	57710	262	60.3%
XYZ	CAROLINAS HOSP SYS LAKE CITY		FLORENCE	LOWER FLORENCE	DIST	48	48		852	3771	48	21.5%
XYZ	MCLEOD REG MED CTR	2	FLORENCE	FLORENCE	NPA	336	336		24196	113478	336	92.6%
YZ	REGENCY HOSPITAL OF SC, LLC	1	FLORENCE	FLORENCE	PROP	28	28		16	261	5.6	12.8%
YZ	WOMEN'S CENTER CAROLINA HOSP SYS		FLORENCE	FLORENCE	PROP	20	20		1321	3887	20	53.2%
	FLORENCE CO.		TOTAL			694	694		37218	179107	671.6	73.1%
XYZ	GEORGETOWN MEMORIAL HOSPITAL	35	GEORGETOWN	GEORGETOWN	NPA	142	145		8826	41957	142	81.0%
XYZ	WACCAMAW COMMUNITY HOSP	35	GEORGETOWN	MURRELLS INLET	NPA	40	40					
	GEORGETOWN CO.		TOTAL			182	185		8826	41957	142	81.0%
XYZ	CONWAY HOSP, INC.		HORRY	CONWAY	NPA	160	160		9682	36971	160	63.3%
XYZ	GRAND STRAND REG MED CTR	19	HORRY	MYRTLE BEACH	PROP	219	219		11929	49350	172	78.6%
XYZ	LORIS COMM. HOSP.	3	HORRY	LORIS	DIST	105	105		4933	21449	105	56.0%
	HORRY CO.		TOTAL			484	484		28544	107770	437	67.6%
XYZ	MARION CO MEDICAL CTR	13	MARION	MARION	DIST	124	124		7118	40994	124	90.6%
	MARION CO.		TOTAL			124	124		7118	40994	124	90.6%
	MARLBORO PARK	27	MARLBORO	BENNETTSVILLE	PROP	94	94		2073	6576	94	19.2%
	MARLBORO CO.		TOTAL			94	94		2073	6576	94	19.2%
X	SHAW AFB	5	SUMTER	SUMTER	FED		(21)		(327)	(1273)		
XYZ	TUOMEY	20	SUMTER	SUMTER	NPA	248	248		10628	56628	229	67.7%
	SUMTER CO.		TOTAL			248	248		10628	56628	229	67.7%
XYZ	WILLIAMSBURG REGIONAL HOSP		WILLIAMSBURG	KINGSTREE	CO	78	78		651	2647	78	9.3%
	WILLIAMSBURG CO.		TOTAL			78	78		651	2647	78	9.3%
	TOTAL					2263	2266		108555	498634	2135.6	64.0%
	MENTAL FACILITIES:											
XYZ	MCLEOD REG.		FLORENCE	FLORENCE	NPA	35	35		1073	6465	35	50.6%
	FLORENCE CO.		TOTAL			35	35		1073	6465	35	50.6%

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REGION:III

INPATIENT INVENTORY OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING		ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
XYZ	LIGHTHOUSE CARE CENTER OF CONWAY	42	HORRY	CONWAY	PROP	8	8						
	HORRY CO.		TOTAL			8	8						
XYZ	MARLBORO PARK	27	MARLBORO	BENNETSVILLE	PROP	8	8			143	1492	8	51.1%
	MARLBORO CO.		TOTAL			8	8			143	1492	8	51.1%
XYZ	TUOMEY	20	SUMTER	SUMTER	NPA	(19)	(19)			449	2476	19	35.7%
	SUMTER CO.		TOTAL			0	0			449	2476	19	35.7%
	TOTAL					43	43			1685	10433	82	46.1%
	RESIDENTIAL TREATMENT FAC FOR CHILDREN & ADOLESCENT:												
YZ	PALMETTO PEE DEE RTC	6	FLORENCE	FLORENCE	PROP	59	59			29	5922	16	90.1%
	FLORENCE CO.		TOTAL			59	59			29	5922	16	90.1%
CON	LIGHTHOUSE CARE CENTER OF CONWAY	42	HORRY	CONWAY	PROP	16	16						
	HORRY CO.		TOTAL			16	16						
	DRUG AND ALCOHOL INPATIENT TREATMENT:												
	CAROLINAS HOSP SYS -CEDAR TOWERS	7	FLORENCE	FLORENCE	PROP	4	4						
	CAROLINAS HOSP SYS -CEDAR TOWERS (CHARTER SANDS BEHAVIORAL HLTH SYS)	7	FLORENCE	FLORENCE	PROP	18	18			490	2339	20	32.0%
		6	HORRY	CONWAY	PROP								
	TOTAL					22	22			490	2339	20	32.0%
	REHABILITATION FACILITIES:												
YZ	HEALTH-SOUTH REHABILITATION HOSPITAL OF FLORENCE		FLORENCE	FLORENCE		88	88			1499	28605	88	89.1%
	CAROLINAS HOSP SYS -CEDAR TOWERS	43	FLORENCE	FLORENCE	NPA	42	42			625	7063	24	80.6%
	FLORENCE CO.		TOTAL			130	130			2124	35668	112	87.3%
YZ	WACCAMAW NECK HOSP	35	GEORGETOWN	MURRELLS INLET	NPA	29	29						
	GEORGETOWN		TOTAL			29	29						
	LONG TERM FACILITIES:												
YZ	CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	100	99			25	36213	100	99.2%
Z	(CHESTERFIELD GEN HOSP SNF)	41	CHESTERFIELD	CHERAW	PROP	(7)	(7)			95	1063	7	41.6%
YZ	CHESTERFIELD CONVL CTR	15	CHESTERFIELD	CHERAW	PROP	104	104			27	37462	104	98.7%
	CHESTERFIELD CO		TOTAL			204	203			147	74738	211	97.0%
YX	LAKE MARION NURSING FAC		CLARENDON	SUMMERTON	PROP	88	88			37	31108	88	96.8%
YX	WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	26	cd	40	22301	64	95.5%
	CLARENDON CO		TOTAL			152	131	26		77	53409	152	96.3%
YZ	BETHEA BAPTIST HOME	8	DARLINGTON	DARLINGTON	NPA	36	36			88	14607	88	45.5%
YZ	MEDFORD PLACE	9	DARLINGTON	DARLINGTON	PROP	88	88			104	30062	88	93.7%
YZ	MORRELL MEM CONV CTR	28	DARLINGTON	HARTSVILLE	PROP	154	154			147	54880	154	97.6%

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ACC	NAME OF FACILITY	FN	COUNTY	CITY	CONTROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMISSIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	OAKHAVEN CONV CTR	21	DARLINGTON	DARLINGTON	PROP	88	88		65	31696	88	98.7%
	DARLINGTON CO		TOTAL			366	366		362	131265	418	86.0%
YZ	BEVERLY HEALTHCARE THE PINES		DILLON	DILLON	PROP	84	84		134	29999	84	97.8%
YZ	SUNNY ACRES , INC		DILLON	FORK	PROP	111	105		34	40225	111	99.3%
YZ	(ST EUGENE MED CTR-SNF)	23	DILLON	DILLON	NPA			58 cd	128	937	13	19.7%
	DILLON CO		TOTAL			195	190	58	296	71161	208	93.7%
YZ	CAROLINAS HOSP SYS TRANSITIONAL CARE UNIT	1&4	FLORENCE	FLORENCE	PROP	26	26		284	3568	44	22.2%
YZ	COMMANDER HLTH CARE		FLORENCE	FLORENCE	PROP	163	152		99	58642	163	98.6%
YZ	FAITH HEALTHCARE CTR		FLORENCE	FLORENCE	PROP	104	93		108	36327	104	95.7%
Z	CLARKE NURSING CENTER	38	FLORENCE	FLORENCE	PROP	88	88	44 d	71	28965	88	90.2%
YZ	HERITAGE HM OF FLORENCE	34	FLORENCE	FLORENCE	PROP	132	132		76	47223	132	98.0%
YZ	HONORAGE HM OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88		80	31332	88	97.6%
YZ	LAKE CITY/SCRANTON HLTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88		82	29366	88	91.4%
YZ	SOUTHLAND HLTH CARE CTR		FLORENCE	FLORENCE	PROP	88	88	(42) cd	49	31714	88	98.7%
	FLORENCE CO		TOTAL			777	755	44	829	267137	795	92.1%
	(GEORGETOWN MEM HOSP SNF)	35	(GEORGETOWN)	(GEORGETOWN)	NPA							
CON	THE LAKES AT LITCHFIELD SKILLED NURSING CENTER	36	GEORGETOWN	PAWLEYS ISLAND	PROP	24	(10) 24					
	(THE LAKES AT LITCHFIELD SKILLED NURSING CENTER)	36	(GEORGETOWN)	(PAWLEYS ISLAND	(PROP	(7)	(7)					
YZ	PRINCE GEORGE HLTHCARE CENTER	10	GEORGETOWN	GEORGETOWN	PROP	148	148		198	51584	148	95.6%
YZ	WINYAH EXTENDED CARE CTR		GEORGETOWN	GEORGETOWN	PROP	84	84		113	26829	84	87.5%
	GEORGETOWN CO		TOTAL			256	256		309	78413	232	92.6%
NH	(COMPASS TRANSITIONAL CARE)	6	HORRY	CONWAY	PROP	(20)	(20)					
Y	COVENANT TOWERS		HORRY	MYRTLE BEACH	PROP	30	30					
YZ	CONWAY NURS CTR		HORRY	CONWAY	PROP	190	190		46	7952	30	72.6%
Y	GRAND STRAND HLTH CARE	31	HORRY	CONWAY	PROP	88	88		125	64088	190	92.4%
NH	(GRAND STRAND REG /ECU)	19	HORRY	MYRTLE BEACH	PROP	(18)	(18)		61	31761	88	98.9%
YZ	KINGSTON NURS CTR		HORRY	CONWAY	PROP	88	88		619	6134	18	78.1%
YZ	LORIS EXTENDED CARE CTR	37	HORRY	LORIS	DIST	88	88		428	30166	88	93.9%
YZ	MYRTLE BEACH MANOR	12	HORRY	MYRTLE BEACH	PROP	104	104		75	31482	88	98.0%
Y	NHC HEALTHCARE GARDEN CITY		HORRY	MYRTLE BEACH	PROP	88	88		370	31462	104	82.9%
	HORRY CO		TOTAL			676	676		296	30836	88	96.0%
YZ	MCCOY MEM. NURS. CTR.	25	LEE	BISHOPVILLE	PROP	120	120		2020	232660	694	91.9%
	LEE CO.		TOTAL			120	120		122	42931	120	98.0%
YZ	MULLONS NURSING CTR	30	MARION	MARION	NPA	92	92		25	33552	92	99.9%
YZ	MARION NURSING CTR	14	MARION	MARION	PROP	88	88	1 c	43	31699	88	98.7%
	MARION CO		TOTAL			180	180	1	68	65251	180	99.3%
YZ	DUNDEE NURS HM		MARLBORO	BENNETTSVILLE	PROP	111	111	(24) (a)	52	38893	111	96.0%
Y	MARLBORO PARK HOSP SNF	40	MARLBORO	BENNETTSVILLE	PROP	(7)	(7)		61	974	7	38.1%
	MARLBORO CO		TOTAL			111	111		113	39867	118	92.6%
YZ	HOPEWELL HLTH CARE CTR		SUMTER	SUMTER	PROP	96	96	(48) cd	78	29427	96	84.0%
YZ	MARINER HLTH CARE SUMTER-EAST	33	SUMTER	SUMTER	PROP	176	176		144	61332	176	95.5%
YZ	NHC HEALTHCARE SUMTER	26	SUMTER	SUMTER	PROP	138	138		99	46993	138	93.3%
Y	TUOMEY HOSP-SNF	17	SUMTER	SUMTER	NPA	18	18		495	4939	18	75.2%
	SUMTER CO		TOTAL			428	428	0	816	142691	428	91.3%
YZ	KINGSTREE NURS FAC	32	WILLIAMSBURG	KINGSTREE	PROP	88	88	(45) d	32	31230	88	97.2%
YZ	RE MCNAIR NURS CTR		WILLIAMSBURG	CADES	PROP	88	88		44	31391	88	97.7%

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REGION:III | INPATIENT INVENTORY | OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	WILLIAMSBURG CO		TOTAL			176	176	0	76	62821	176	97.5%
	TOTAL					3641	3592	129	6255	1262364	3732	92.7%

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FOOTNOTES

__REGION III

FY2002 PLAN

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

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

1. CON issued to replace & relocate the existing 290 acute care bed on the site with the 20 bed women=s Ctr and with the 24 rehab, 44 nurs hm & the 46 d&a (42 inpat & 4 med detox) beds at their current site, 2/27/96. Con issued for conversion of 28 general beds to 28 nurs hm plus the existing 44 nurs beds for 72 nurs hm beds, 262 general beds, 46 d&a, 24 rehab, 12/09/97. Facility licensed for 290 general beds & the 28 additional nurs hm beds are being completed, 11/13/98. CON for additional 28 nurs hm beds expired and 28 acute beds added back to the 262 for 290 general beds, 12/9/98. Con issued to transfer 28 general beds to establish a 28 bed ltc acute hosp, SC-00-03 1/20/2000. NextCare licensed for 28 ltc acute beds and Carolinas Hosp licensed for 262, 7/17/01
2. CON issued for 40 additional general beds for a total of 336,10/21/97. CON issued for construction of a three story additional known as McLeod Day Hosp with two story day hosp, 89 holding & recovery beds, a GI lab with 5 procedure rooms, and a Child Life Activity Ctr, 12/5/97. Licensed beds increased from 296 to 336, 12/1/97. NA-00-21 issued for a ten beds non-licensed observation unit on the 1st floor , 3/31/00.
3. Exemption for use of 12 general beds for DMH patients w/o any licensure change, 1/9/95.
4. Exemption for permanent reduction of 35 general beds, 4/27/94. Facility closed 7/21/94. CON issued for ambulatory surgery ctr., 5/8/95.
5. Bed use restricted.
6. CON issued to convert 20 inpatient sub abuse beds to nurs hm beds resulting in licensed beds as 15 inpatient sub abuse beds, 45 psy (17 adolescent, 18 adult, 10 state contract beds), 18 RTF beds and 20 nurs hm beds. Facilty licensed per CON, 7/5/94. Nurs hm closed, 6/30/98. Exemption issued for Charter Conway to purchase the facility, 9/21/98. 18 RFT beds closed in Horry & move to Florence , 3/14/00. Approved for 41 additional beds for a total of 59 beds, 4/19/01. Facility licensed beds increase from by 41 beds from 18 to 59, 4/29/02.
7. Facility is licensed for 42 inpatient treatment beds (12 adolescent and 30 adult) and for 4 public detox beds for a total of 46 D&A beds. Exemption E-00-06 to reduce the inpat beds from 42 to 18 & licensed the same day, 1/27/99.
8. Facility licensed for 20 comm beds and 68 non-comm beds. CON issued for 6 additional comm. beds for a total of 26

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comm. beds and 62 non-comm beds, 10/11/94. licensed per CON, 1/1/95. Con issued to convert 10 non-comm beds to 10 comm for a total of 52 non-comm & 36 comm, 3/13/00. Facility for 52 & 36 , 6/29/00.

9. CON issued for 5 non-medicaid beds for a total of 88, 2/21/95. Facility licensed beds increased from 83 to 88, 9/29/95.
10. CON for 16 additional non-medicaid beds for a total of 148 LTC beds, 5/20/93. Facility licensed beds increased from 132 to 148, 10/13/94.
11. CON issued for 22 non-medicaid beds, 4/17/95. CON voided, 10/18/95.
12. CON issued 6 additional non-medicaid beds for a total of 85, 7/11/94. Licensed for 85 beds, 9/1/94. CON issued for 19 additional beds for a total of 104, 10/17/95.
13. CON issued for a 124 replacement hospital, 7/6/95. Facility licensed for 124 general beds, 6/17/97.
14. App name changed from Marion Co Convl Ctr & change of lease 9/25/95.
15. CON for 16 additional non-medicaid beds for a total of 104, 11/14/95. Facility licensed for 104 nurs hm beds, 11/27/96.
16. CON issued for 35 replacement beds with increase of survey from 86 to 96 & the reduction of non-conforming from 48 to 0, 12/19/95.
17. CON issued for conversion of 18 general beds to nurs hm beds with 229 general , 19 psy & 18 nurs hm beds, 12/18/95. Licensed for 18 nurs hm beds, 229 general, & 19 psy beds 2/7/96.
18. CON for conversion of 14 general beds to 14 nurs hm beds with 78 general & 14 nurs hm beds, 12/29/95.
19. CON to construct an 18 hospital base nurs hm beds unit, 1/30/96. Also, to temporarily licensed 10 general beds as 10 nurs hm beds (for appox. 10 months), the 10 beds were licensed as nurs hm beds & the general beds are temporarily reduced from 172 to 162, 3/1/96. Licensed nurs beds increased by 10 for 18 and licensed general beds licensed back to 172 from the temp 162, 9/16/97. Con issued for 47 additional beds with 18 coming the closing of the 18 bed nurs hm for a total of 219 general beds, 10/30/2000 sc-00-52. General beds increased by 18 from 172 to 190 with the delicensing of the 18 bed nurs hm 1/16/01.Licensed general beds increased by 20 from 190 to 210 , 4/4/01. licensed general beds increased from 210 to 218 10/30/01 and licensed beds increased from 218 to 219 4/30/02.
20. CON issued to convert 18 hosp beds to 18 nurs hm beds for 229 general beds, 19,psy beds & 18 nure hm beds, 12/18/95. Licensed for 18 nurs hm, 229 general & 19 psy beds, 2/7/96. Con issued to convert 19 psy beds to general for 248 general & 18 nurs hm beds, 6/12/02 SC-02-35. Facility licensed for 248 general and the closure of the 19 psy beds, 9/10/02.
21. Con issued for 8 non-medicaid beds for a total of 96 LTC beds, 3/19/96. Facility licensed beds increased by 4 from 88 to 92, 4/26/96. CON voided for additional 4 beds, 9/30/96. Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds incrased from 144 to 148, 12/10/97.
22. Con issued for 3 non-medicaid beds for a total of 123 LTC beds, 3/25/96.
23. Con issued for converting 14 general beds to nurs hm beds for 78 general beds & 14 nurs hm beds, 12/29/95.

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Con changed to reflect 79 general & 13 nurs hm beds, 7/24/96. Facility licensed for 79 general & 13 nurs hm beds, 8/14/96. Facility closed 13 bed nurs hm 2/25/02.

24. CON issued for 116 general beds replacement hospital, 8/15/96. Name changed from Byerly Hospital, 5/1/99.
25. CON for the adddition of 32 medicaid beds for a total of 120 nurs hm beds, 11/25/96. Facility licensed for 120 beds, 9/26/97.
26. CON issued to add 3 nurs hm beds to increase from 120 to 123,3/28/96. Licensed for 123 nurs hm beds, 1/16/97. Con issued for 15 non-medicaid nurs beds for a total of 138,10/20/98. Facility licensed for 15 additional beds for a total of 138, 3/9/00.
27. CON issued for transfer of 7 psy beds from Chesterfield plus 1 additional psy bed for 8 psy beds at Marlboro Park & 94 general with the transfer of 7 general beds from Marlboro to Chesterfield going from 52 general to 59, resulting in 94 general, 8 psy beds at Marlboro Park & 59general beds at Chesterfield, 2/6/97. Marlboro licensed for 94 gen & 8 psy beds with Chesterfield licensed for 59 gen beds, 4/26/97.
28. CON issued for 8 non-medicaid beds for a total of 140 nurs hm beds, 2/10/97. Facility licensed beds increased by 8 from 132 to 140,3/31/97. Con issued for 4 add nurs hm beds for a total of 144, 9/1597. Facility licensed beds increased by 4 to 144, 9/25/97.Con issued to transfer 4 non-medicaid beds to Morrell for a total of 148 at Morrell & 88 at Oakhaven, 11/10/97. Facility licensed beds reduced from 92 to 88, 12/10/97. Con issued to Morrell for 6 add nurs beds for a total of 154 , 4/13/00. Facility licensed beds increased by 6 from 148 to 154 , 6/1/00.
29. APP for 32 additional non medicaid beds for a total of 120, 9/12/97.
30. Exmp renovated vacated Mullins Hosp to replace English park & Jenkins Nursing Hm without a change of licensed beds, 9/22/97. Facility licensed for 92 nurs hm beds, 9/15/98. Existing beds reduced from 102 to 92 since over one year since the initial license of 92 beds, 11/20/00.
31. CON issued for 32 additional non-medicaid nurs hm beds for a total of 120, 9/30/97. Con voided for 32 additional nurs hm beds reduce back to 88 beds, 3/31/99.
32. Con SC 97-66 issued for 88 replacement facility 70 existing licensed beds (65 surveyed with 45 d) plus 18 new non-medicaid beds, 11/24/97. New facility licensed or 88 beds , 6/8/00.
33. Exmp to merge Mariner Hlth Ctr Sumter-East & West, 9/3/98. Facilities licensed as one with 176 nurs beds, 9/3/98.
34. Con # SC-97-32 issued for replacement of 44 nurs hm beds, 7/14/97. Pursuant to the 1998 medicaid proviso the 44 replacement beds will still licensed & medicaid certified for a total of 132, 9/98. Facility licensed beds increased by 44 from 88 to 132, 12/8/98.
35. Con issued to transfer 40 acute beds from Georgetown Mem to construct a new 40 hosp and add a 10 bed nurs hm to Georgetown mem resulting in 102 acute & 10 nurs hm at Georgetown Mem, SC-00-07 2/7/00. App to add 19 beds comprehensive rehab unit , 5/26/00 SC-00-27. Con issued for 43 general beds & delete the 10 bed nursing hm for a total of 145 general beds, sc-02-07, 1/9/02. Con issued for 10 additional rehab beds for a total of 29 rehab beds, 2/11/02 SC-02-15. Waccamaw Comm Hosp licensed for 40 general beds & 29 rehab beds with a concurrent increase in the licensed beds at Georgetown to remain at 142 with the partial meeting of sc-02-07 with 3 beds to be licensed, 10/21/02.

RECORD 003981
PMC.2013.SHP.0468
PET-EX006.0204

36. Exemption to reduce beds by 1 from 50 to 49, 4/20/00. Facility licensed for 49 general beds, 5/15/00.
37. Con issued for 44 additional nurs beds (25 medicaid) for a total of 132 nurs beds, 9/15/00.SC-00-45 Con voided for additional 44 nurs hm beds,8/02/01.
38. Formerly Florence Convl ctr.
39. Con issed to construct a 24 bed nurs hm with 17 comm beds and 7 instit beds sc-01-72 11/13/01. Facility licensed for 17 comm beds & 7 instit beds for a total of 24 nurs hm beds 12/03/02.
40. Facility closed 04/8/02.
41. Facility closed 05/8/02.
42. Con issued for 16 RTF and 8 Psychiatric beds sc-02-71 1/25/02. Facility licensed for 16 Res beds 4/29/03. Facility licensed for 8 psy beds 6/3/03.
43. Con issued to convert 18 nurs beds to rehab for 26 nurs hm beds & 42 rehab beds , SC-03-20 4/15/03. Licensed nursing hm beds reduced by 18 from 44 to 26 and rehab beds increased by 18 from 24 to 42 , 6/27/03.

RECORD 003982
PMC.2013.SHP.0469
PET-EX006.0205

INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2001 ER VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GEN HOSP	CHESTERFIELD	CHERAW	11818
III	CLARENDON MEM HOSP	CLARENDON	MANNING	20907
III	WILSON MEDICAL CTR	DARLINGTON	DARLINGTON	CLOSED
III	CAROLINA PINES REG MED CTR	DARLINGTON	HARTSVILLE	23676
III	ST EUGENE REG MED CTR	DILLON	DILLON	18758
III	CAROLINAS HOSPITAL SYS	FLORENCE	FLORENCE	30547
II	MCLEOD REG MED CTR	FLORENCE	FLORENCE	56330
III	CAROLINAS HOSPITAL SYS LAKE CITY	FLORENCE	LAKE CITY	19975
II	GEORGETOWN MEM HOSP	GEORGETOWN	GEORGETOWN	30812
II	CONWAY HOSP INC	HORRY	CONWAY	28097
III	LORIS COMM HOSP	HORRY	LORIS	30325
II	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH	59166
III	MARION CO MED CTR	MARION	MARION	22225
III	MARLBORO PARK HOSP	MARLBORO	BENNETTSVILLE	14438
II	TUOMEY	SUMTER	SUMTER	45060
III	WILLIAMSBURG	WILLIAMSBURG	KINGSTREE	7286
TOTALS				419430

REGION III:	TRAUMA CENTERS		
III	CAROLINA PINES REG MED CTR	DARLINGTON	HARTSVILLE
III	CAROLINAS HOSP SYSTEM	FLORENCE	FLORENCE
II	MCLEOD REG MED CTR	FLORENCE	FLORENCE
III	CONWAY HOSP INC	HORRY	CONWAY
III	LORIS COMM HOSP	HORRY	LORIS
III	GRAND STRAND REG MED CTR	HORRY	MYRTLE BEACH
III	MARION CO MED CTR	MARION	MARION

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PET-EX006.0206

RECORD 003983

REGION NARRATIVE

REGION: IV

FISCAL YEAR: 2003

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

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. By mutual agreement, Berkeley and Dorchester County hospitals were closed upon the opening of Trident Regional Medical Center.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

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

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. There is a small need for additional inpatient treatment beds in this region. The William J. McCord Adolescent Treatment Center in Orangeburg County serves adolescents exclusively from throughout the state.

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

RECORD 003984

PMC.2013.SHP.0471

PET-EX006.0207

REGION:IV — INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
	HOSPITALS:											
YZ	ALLENDALE CO.HOSP.	1	ALLENDALE	FAIRFAX	CO	25	25		653	1942	36	14.8%
	ALLENDALE CO.		TOTAL			25	25		653	1942	36	14.8%
XYZ	BAMBERG CO. MEM.		BAMBERG	BAMBERG	CO	59	59		1756	5804	59	27.0%
	BAMBERG CO.		TOTAL			59	59		1756	5804	59	27.0%
YZ	BARNWELL CO. HOSP.		BARNWELL	BARNWELL	CO	53	53		1277	5721	53	29.6%
	BARNWELL CO.		TOTAL			53	53		1277	5721	53	29.6%
X	NAVAL HOSP	2	BEAUFORT	BEAUFORT	FED		(64)		(1438)	(4325)		
XYZ	BEAUFORT CO. MEM.	44	BEAUFORT	BEAUFORT	CO	130	130		8926	37530	115.1	89.3%
XYZ	HILTON HEAD REGIONAL MEDICAL CENTER	27	BEAUFORT	HILTON HEAD	NPA	93	93		4999	20413	71	78.8%
	BEAUFORT CO.		TOTAL			223	223		13925	57943	186.1	85.3%
XYZ	BON-SECOURS ST. FRANCIS	6	CHARLESTON	CHARLESTON	NPA	141	201		8306	37149	141	72.2%
XYZ	CHARLESTON MEM. HOSP.	43	CHARLESTON	CHARLESTON	CO	98	98		314	4272	98	11.9%
YZ	EAST COOPER REG MED CTR	4	CHARLESTON	MT PLEASANT	PROP	100	100		4681	17511	100	48.0%
YZ	KINDRED HOSPITAL-CHARLESTON	43	CHARLESTON	CHARLESTON	PROP	59	59		286	8429	59	39.1%
XYZ	MEDICAL UNIVERSITY HOSP.	5	CHARLESTON	CHARLESTON	ST	466	466		23099	123298	466	72.5%
XYZ	ROPER HOSP.		CHARLESTON	CHARLESTON	NPA	414	414		17059	95745	414	63.4%
YZ	ROPER HOSPITAL NORTH	6	CHARLESTON	N CHARLESTON	NPA	60	(60)		269	1527	60	7.0%
XYZ	TRIDENT MED CTR.	7	CHARLESTON	CHARLESTON	PROP	251	271		15543	71113	251	77.6%
X	RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(197)		(3475)	(22192)		
			TOTAL			1589	1609	0	69957	359042	1589	61.9%
XYZ	COLLETON MED CTR	29	COLLETON	WALTERBORO	PROP	116	131		4849	29513	116	69.7%
	COLLETON CO.		TOTAL			116	116		4849	29513	116	69.7%
XYZ	SUMMERVILLE MED CTR	8	DORCHESTER	SUMMERVILLE	PROP	80	80		4115	16585	74	61.4%
	DORCHESTER CO.		TOTAL			80	80		4115	16585	74.8	60.7%
YZ	HAMPTON REG MED CTR		HAMPTON	VARNVILLE	CO	68	68		978	4576	68	18.4%
	HAMPTON CO.		TOTAL			68	68		978	4576	68	18.4%
APP	JASPER HOSPITAL	42	JASPER	HARDEEVILLE	PROP		31					
YZ	(LOW COUNTRY GENERAL HOSP)	42	JASPER	RIDGELAND	PROP	31	(31)				31	0.0%
	JASPER CO.		TOTAL			31	31		0	0	31	0.0%
XYZ	REGIONAL MEDICAL CENTER OF ORANGEBURG-CALHOUN	9 41	ORANGEBURG	ORANGEBURG	CO	271	247		10294	58079	271	58.7%
	ORANGEBURG CO.		TOTAL			271	247		10294	58079	271	58.7%
XYZ	AIKEN REG.MED. CTR.	53	AIKEN	AIKEN	PROP	178	183		10366	46037	178	70.9%
	AIKEN CO.		TOTAL			178	183		10366	46037	178	70.9%
	TOTAL					2693	2694	0	117770	585242	2661.9	60.2%
	MENTAL FACILITIES:											
XYZ	BEAUFORT MEM HOSP	10	BEAUFORT	BEAUFORT	CO	20	20		707	3958	20	54.2%
	BEAUFORT CO.		TOTAL			20	20		707	3958	20	54.2%

RECORD 003985
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REGION:IV

INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
XYZ	CHARLESTON MEM. HOSP.	33	CHARLESTON	CHARLESTON	CO	15	15				15	0.0%
XYZ	MEDICAL UNIVERSITY HOSP.	12	CHARLESTON	CHARLESTON	ST	82	82		2634	19961	82	66.7%
XY	PALMETTO LOWCOUNTY BEHAVIORAL HLTH	11	CHARLESTON	CHARLESTON	PROP	60	60		2094	14995	60	68.5%
XYZ	TRIDENT MEDICAL CENTER	7	CHARLESTON	CHARLESTON	PROP	20	(20)		473	2647	20	36.3%
X	RALPH H JOHNSON		CHARLESTON	CHARLESTON	FED		(36)		(599)	(4244)		
	VETERANS MEDICAL CTR											
	CHARLESTON CO.		TOTAL			177	157		5201	37593	177	58.2%
	RMC ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15		384	1899	15	34.7%
	ORANGEBURG CO.		TOTAL			15	15		384	1899	15	34.7%
XYZ	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	29	29		956	6119	29	57.8%
	AIKEN CO.		TOTAL			29	29		956	6119	29	57.8%
	TOTAL					241	221		6541	45611	241	51.9%
	RESIDENTIAL TRATMENT FAC FOR CHILDREN & ADOLESCENT:											
	PALMETTO LOWCOUNTY BEHAVIORAL HLTH RTC		CHARLESTON	CHARLESTON	PROP	32	32		47	10395	32	89.0%
	NEW HOPE SUMMERVILLE	13	SUMMERVILLE	DORCHESTER	PROP	52	60		26	17940	52	94.5%
	CHARLESTON CO.		TOTAL			84	92		73	28335	84	92.4%
	REHABILITATION FACILITIES:											
CON	BEAUFORT MEM HOSP	44	BEAUFORT	BEAUFORT	CO	14	14					
	BEAUFORT CO.		TOTAL				14					
XYZ	MEDICAL UNIVERSITY HOSP.	14	CHARLESTON	CHARLESTON	ST	25	25		28	898	25	9.8%
XYZ	ROPER HOSP.	3	CHARLESTON	CHARLESTON	NPA	39	39		1041	11547	39	81.1%
XYZ	HEALTHSOUTH CHARLESTON	15	CHARLESTON	CHARLESTON	PROP	42	42		768	13470	42	87.9%
	CHARLESTON CO.		TOTAL			106	106		1837	25913	106	67.0%
APP	JASPER HOSPITAL	42	JASPER	RIDGELAND	PROP		10					
	JASPER CO.		TOTAL				10					
CON	RMC ORANGEBURG-CALHOUN	41	ORANGEBURG	ORANGEBURG	CO		24					
	ORANGEBURG CO.		TOTAL			0	24					
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	AIKEN REG.MED. CTR.		AIKEN	AIKEN	PROP	18	18		191	795	18	12.1%
49	(ROPER HOSPITAL NORTH)		CHARLESTON	N CHARLESTON	NPA	(44)	(44)					
	PALMETTO LOWCOUNTY BEHAVIORAL HLTH	11	CHARLESTON	N CHARLESTON	PROP	10	10		291	1513	10	41.5%
	MUSC MEDICAL CTR	16	CHARLESTON	CHARLESTON	ST	23	23		687	4631	23	55.2%
	TOTAL					51	51		1169	6939	51	37.3%
	LONG TERM FACILITIES:											

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REGION:IV — INPATIENT INVENTORY — OCT.1,2000-SEPT.30,2001

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	JOHN E HARTER N HM		ALLENDALE	FAIRFAX	CO	44	44		18	15489	44	96.4%
	ALLENDALE CO		TOTAL			44	44		18	15489	44	96.4%
YZ	BAMBERG CO MEM NURS CTR	31	BAMBERG	BAMBERG	CO	88	88		45	31694	88	98.7%
	BAMBERG CO		TOTAL			88	88		45	31694	88	98.7%
YZ	BARNWELL CO NURS HM	47	BARNWELL	BARNWELL	CO	40	40		5	14513	40	99.4%
Z	LAUREL BAYE HEALTHCARE CTR OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	85 a	29	28835	85	92.9%
YZ	LAUREL BAYE HEALTHCARE OF WILLISTON	46	BARNWELL	WILLISTON	PROP	44	44		51	16279	44	101.4%
	BARNWELL CO		TOTAL			169	169	85	85	59627	169	96.7%
Y	BEAUFORT CO MEM HOSP TRANSITIONAL CARE UNIT	10	BEAUFORT	BEAUFORT	CO	18	18		629	7288	41.6	48.0%
YZ	BAYVIEW NURS CTR	45	BEAUFORT	BEAUFORT	PROP	170	170		426	61965	183.7	92.4%
NHM	BROAD CREEK	17	BEAUFORT	HILTON HEAD	PROP	44	44		163	10826	44	67.4%
Y	LIFE CARE CENTER OF HILTON HEAD	40	BEAUFORT	HILTON HEAD	PROP	88	88		134	27610	88	86.0%
Y	FRASER HEALTH CTR	50	BEAUFORT	HILTON HEAD	PROP	30	19		108	12668	44	78.9%
SW	(FRASER HEALTH CTR)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				(14)	
Y	HILTON HEAD HOSP NURS HM	27	BEAUFORT	HILTON HEAD	NPA	(15)	(15)		273	2490	15	45.5%
Y	PRESTON HEALTH CARE CTR	32	BEAUFORT	HILTON HEAD	PROP	89	89		107	15773	77	56.1%
SW	(PRESTON HEALTH CARE CTR)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				(8)	
	BEAUFORT CO		TOTAL			419	408		1840	138620	493.3	77.0%
YZ	HEARTLAND HLTH CARE CTR-CHARLESTON	51	BERKELEY	HANAHAN	PROP	96	105		119	32234	96	92.0%
YZ	LAKE MOULTRIE NURSING HOME	18	BERKELEY	ST STEPHENS	PROP	88	88		43	30831	88	95.4%
YZ	MAGNOLIA MANOR-MOCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132		113	43260	132	89.8%
	BERKELEY CO		TOTAL			316	325		275	106125	316	92.0%
YZ	CALHOUN CONV CTR	34	CALHOUN	ST. MATTHEWS	PROP	120	120		65	43007	120	98.2%
	CALHOUN CO		TOTAL			120	120		65	43007	120	98.2%
YZ	(ASHLEY CROSSING REHAB & NURS CTR)	48	CHARLESTON	CHARLESTON	NPA	(132)	(132)		497	38408	132	79.7%
Y	BISHOP GADSDEN EPISCOPAL HM	19	CHARLESTON	CHARLESTON	NPA	61	61		36	18910	53	97.8%
	(BISHOP GADSDEN EPISCOPAL HM)		CHARLESTON	CHARLESTON	NPA		(9)					
YZ	CHARLESTON NURS CTR		CHARLESTON	MT. PLEASANT	PROP	132	132		127	37202	132	77.2%
NHM	FRANKE NURSING HOME	30	CHARLESTON	CHARLESTON	NPA	44	44		90	12382	44	77.1%
	(FRANKE NURSING HOME)	30	CHARLESTON	CHARLESTON	NPA	(20)	(20)					
YZ	GRACE HALL- REHABILITATION	38	CHARLESTON	MT. PLEASANT	PROP	42	42		81	13821	42	88.9%
YZ	HERMINA TRAEYE NURSING CTR	20	CHARLESTON	CHARLESTON	NPA	132	132		86	39361	132	81.7%
YZ	INTEGRATED HLTH SERVICES CHARLESTON /DRIFTWOOD		CHARLESTON	CHARLESTON	PROP	160	160		385	53296	160	91.3%
NHM	LIFE CARE CTR/CHARLESTON	21	CHARLESTON	N CHARLESTON	PROP	148	148		476	51228	148	94.8%
YZ	HEARTHLAND OF WEST ASHLEY	37	CHARLESTON	CHARLESTON	NPA	82	82		245	23858	83.8	78.0%
	REHABILITATION AND NURSING CTR											
CON	(NHC CHARLESTON)	39	CHARLESTON	CHARLESTON	PROP		(120)					
YZ	SANDPIPER CONV CTR		CHARLESTON	MT. PLEASANT	PROP	176	176		281	59462	176	92.6%
Y	TRIDENT SKILLL NURS CTR	6	CHARLESTON	CHARLESTON	PROP	25	25		483	6642	25	72.8%
CON	TRINITY MISSION OF CHARLESTON	52	CHARLESTON	CHARLESTON	PROP		132					
YZ	WHITE OAK MANOR-CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176		181	58980	176	91.8%
	CHARLESTON CO		TOTAL			1178	1310		2948	413368	1303.8	86.9%
YZ	(COLLETON REG HOSP NURS HM)	29	COLLETON	WALTERBORO	PROP	15	(15)		169	2730	15	49.9%
YZ	OAKWOOD HLTH CARE CTR	22	COLLETON	WALTERBORO	PROP	132	132		144	44989	132	93.4%
	COLLETON CO		TOTAL			147	132		313	47719	147	88.9%
YZ	HALLMARK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		93	28260	88	88.0%
YZ	OAKBROOK HLTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		105	29984	88	93.3%
	ST GEORGE HLTH CARE CTR		DORCHESTER	ST. GEORGE	PROP	88	88		161	30123	88	93.8%

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REGION:IV

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	INPATIENT INVENTORY LICENSED BEDS	SURVEY BEDS	NONCON FORMING	OCT.1,2000-SEPT.30,2001 ADMIS SIONS	PATIENT DAYS	AVERAGE LIC BEDS	% OCCU
YZ	SUMMERVILLE MED CTR-SNF	8	DORCHESTER	SUMMERVILLE	PROP	14	14		283	3059	20	41.9%
	DORCHESTER CO		TOTAL			278	278		842	91428	284	88.2%
Z	HARPER NURSING CTR	35	HAMPTON	ESTILL	CO	104	104		85	31920	104	84.1%
	HAMPTON CO		TOTAL			104	104		85	31920	104	84.1%
YZ	RIDGELAND NURSING CTR		JASPER.	RIDGELAND	PROP	88	88		20	31734	88	98.8%
	JASPER CO		TOTAL			88	88		20	31734	88	98.8%
YZ	EDISTO CONV CTR		ORANGEBURG	ORANGEBURG	PROP	113	113		76	38829	113	94.1%
YZ	JOLLEY ACRES HLTHCARE CTR	23	ORANGEBURG	ORANGEBURG	PROP	60	60		70	20690	60	94.5%
YZ	ORANGEBURG NURS HM		ORANGEBURG	ORANGEBURG	PROP	88	88		87	31406	88	97.6%
YZ	THE METHODIST OAKS	24	ORANGEBURG	ORANGEBURG	NPA	132	132		105	44387	155	78.5%
	(REG MED CTR ORANGEBURG/CALHOUN SNF)	41	ORANGEBURG	ORANGEBURG	NPA		(10)					
	ORANGEBURG CO		TOTAL			393	393		318	135911	416	89.1%
YZ	ANNE MARIA REHAB & NURS CTR	25	AIKEN	N. AUGUSTA	PROP	132	132		130	47366	132	98.3%
YZ	AZALEA WOODS	28	AIKEN	AIKEN	PROP	66	66		94	30513	66	97.2%
YZ	CARRIAGE HILLS PLANTATION REHAB CTR	38	AIKEN	AIKEN	PROP	60	60		204	20478	60	93.5%
YZ	MATTIE CHAFEE HALL HLTH C		AIKEN	AIKEN	PROP	176	176		199	62500	176	97.3%
YZ	NHC HEALTHCARE N. AUGUSTA	26	AIKEN	N. AUGUSTA	PROP	132	132		166	45697	132	94.6%
YZ	PEPPER HILL NURS CTR		AIKEN	AIKEN	PROP	132	132		189	45432	132	94.3%
	AIKEN CO		TOTAL			718	718	0	951	251886	718	96.1%
	TOTAL					4062	4177	85	7605	1397926	4291.1	89.3%

III-48

RECORD 003988

PMC.2013.SHP.0475

PET-EX006.0211

FOOTNOTES

_REGION: IV

FY2002 PLAN

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

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

1. CON issued for renovation and construction with a 4 bed reduction from 40 general beds to 36 general beds, 2/8/92. Facility licensed for 36 general beds, 5/1/94. Permanent license reduction of 11 general beds from 36 to 25 to be a specialized critical access hospital, 4/11/02, E-02-23. Facility licensed for 25 beds, 5/1/02.
2. Bed use restricted. Beds as reported by facility.
3. CON to construct a new 100 bed hospital Baker-North by replacing 60 beds from Baker Hosp and the relocation of 40 beds from Roper Hospital. The bed capacities would be 44 D&A beds at Baker, 100 general beds at Baker-North and 381 general plus 28 rehab beds at Roper 09/07/93. CON issued for 11 additional rehab beds and a reduction of 7 general beds resulting in 374 general and 29 rehab beds, 7/13/94. CON rescinded for replacement of Baker, 3/9/95. Roper licensed for 414 general & 39 rehab beds,5/11/95. CON issue for transferring 26 acute beds from Roper North to establish Charleston LTC Hosp as a 26 beds long term acute hosp; resulting in Roper North 34 bed acute, 44 bed substance abuse & Charleston LTC as 26 long term acute beds, 4/15/96. Con rescinded fo 26 long term acute beds, 8/29/97.
4. CON issued for renovation and expansion of the outpatient capacity of OR area from 5 OR rooms and 2 endoscopy rooms to 8 OR rooms and 2 endos rooms, 5/13/93.
5. Total general beds, admissions, and patient days are allocated by patient origin to the Trident area and SW.
6. CON issued to construct a new 198 general bed hospital, west of the Ashley, to replace the existing licensed 362 general bed hospital, 12/7/92. Facility licensed for 141 general beds,12/16/96. Con issued to transfer 60 hosp beds from Roper North to Bon Secours St Francis for a total of 201 general beds & 44 D&A at Roper N, 8/10/2001 sc-01-37.
7. CON issued for expansion of ancillary areas and addition of 34 general beds, 7/1/87. Facility licensed for 280 general and 20 psy beds, 2/5/88. CON issued to relocate 39 general beds for construction of Summerville Medical Center licensed for 80 general beds, 8/13/93. CON issued for Trident Reg.Med Ctr to provide ambulatory surgery within the hospital, 12/28/95. CON to convert 10 general beds to nurs hm for a total of 251 general ,25 nurs hm & 20 psy, 10/15/96. See Footnote #8. Facility licensed for 251 general , 20 psy & 25 nurs hm beds, 2/21/97. Con issued to convert 20 psy to 20 general acute for 271 general , sc-01-58, 10/10/01. Licensed Psy beds no longer in

RECORD 003989
PMC.2013.SHP.0476
PET-EX006.0212

use 12/6/01.

8. CON issued to construct a 56 bed specialty hospital to include 20 psychiatric beds which would be transferred from TRMC and 36 rehab beds, 12/10/92. Authorization for temporary licensure of 20 general beds as 20 rehab beds as Trident Neurosciences Ctr. in Summerville Med. Ctr., 11/19/93. Licensed general beds still licensed at Trident Reg but to be licensed at Summerville, total 241 general, 20 psy and 15 nursing hm., 6/6/94. Trident skilled nur ctr. licensed for 15 LTC beds, 7/6/94. Neuroscience 36 rehab; Summerville Med. Ctr. 80 general beds, 9/7/94. Trident Neuro licensed for 36 rehab beds (which removes the 20 temp rehab beds from Summerville), 9/24/94. Con issued for 14 nurs hm beds and 80 general beds, 10/17/94. Cola Summerville SNF licensed for 14 beds 11/1/94. Con Trident for 10 addtional nurs hm beds for a total of 25 nurs hm, 251 general & 20 psy, 10/15/96. Con for Summerville to convert 6 general beds to nurs hm for 74 general & 20, 10/08/96. Fcaility licensed for 74 general & 20 nurs hm beds, 2/20/97. Con issued to convert 6 of the 20 nurs hm beds to 6 general for a total of 80 general & 14 nurs hm beds, 05/06/02 SC-02-23. Hospital licensed beds increased from 74 to 80 and nursing home beds reduced from 20 to 14, 6/26/02.
9. Provision of temporary detox for the Tri-county Commission of D&A, 8/31/94.
10. CON issued for 72 non-Medicaid nurs hm beds, 8/15/90. Licensed for 20 psych. beds, 7/18/94. Facility licensed for 44 LTC beds, 10/3/94. LTC beds reduced from 44 to 18, 8/28/01. See footnote #44.
11. CON issued for closure of Fenwick with the transfer of 8 psy & 10 d&a beds resulting in 78 psy & 10 d&a beds, 4/21/95. Charter licensed for 60 psy &10 d&a beds with partial fulfillment of the above con, 5/24/95. Since the facility did not fullfill rest of the con by 5/24/96 by licensing the additional 18 psy beds; these beds will be removed from the survey beds resuling in a 60 bed capicity at the facility, 7/2/97.
12. CON issued for 15 crisis stab beds to the existing 67 psy beds, 8/12/94. Facility licensed for 82 psy beds (67 & 15 crisis beds), 6/15/95.
13. CON issued for 52 RTC beds, 6/1/92. Licensed for 52 RTC beds, 1/26/93. Con issued for 8 add beds for a total of 60 sc-01-68 , 11/13/01. Con sc-01-68 expired & is void, 5/13/02. Con issued for 8 additional beds for 60 SC-02-66 10/8/02.+
14. CON issued for 11 additional rehab beds with total of 25 beds, 11/19/91. Facility licensed for 25 rehab beds, 12/1/94. Temporarily closure of the Rehab unit 9/1/00.
15. Licensed for 36 rehab bes, 9/7/94. Formerly Trident Neuroscience. Con issued for 3 additional rehab beds for a total of 39, 10/26/98. Facility licensed for 39 rehab beds, 11/23/98. Con issued for 3 add rehab beds for a total of 42, 4/10/2000 SC-00-19. Facility licensed beds increased by 3 form 39 to 42 rehab beds, 6/8/00.
16. CON issued for 23 D&A beds for research with funding from a federal grant and the beds will not be counted against the area, 10/2/92. Facility licensed for 23 D&A beds, 3/23/95.
17. CON issued for 44 non-Medicaid Nursing Home beds, 2/5/92. Facility licensed for 44 beds with name change from Sea Pines, 2/10/97.
18. CON issued for 88 dual beds (74 Medicaid), 10/29/91. Faility licensed for 22 beds, 4/13/95. Formerly, St. Stephens. Licensed beds increased from 22 to 44, 6/26/95. Licensed beds increased from 44 to 66, 9/18/95. Licensed beds

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increased from 66 to 76, 12/11/95. Licensed beds from 76 to 88, 1/29/96.

19. CON issued to convert 20 restricted beds to comm. for a total of 44 nursing hm beds, 6/7/94. Facility licensed for 44 comm beds, 10/18/94. CON issued for 10 addtional non-medicaid for a total of 54 beds,3/12/97. Facility licensed for 45 beds, 5/6/97. Licensed beds increased by 8 from 45 to 53,9/22/98. Licensed beds to stay at 53 with with the reduction of the 8 additional beds to 7, 7/7/99. Con issued for 9 non-comm beds for a total of 53 comm & 9 non-comm beds, 02/19/00 sc-00-65. Con issued for 8 non-medicaid beds from 53 to 61 comm & 9 non-comm beds, SC-01-44, 9/14/01. Facility licensed for 70 nurs beds (61 comm & 9 int nurs hm) 3/5/03.
20. CON issued for an additional 44 dual beds (40 Medicaid) with an increased from 88 to 132 beds, 12/11/89. Facility licensed for 132 beds, 6/2/95.
21. CON issued for 88 non-Medicaid beds, 8/6/91. Facility licensed, 11/22/93. Name changed from Elmwood Plantation. P CON issued for 60 non-medicaid for a total of 148, 5/19/97. Facility licensed for 60 additional beds for a total of 148, 1/27/99.
22. CON issued for 28 additional non-Medicaid beds for a total of 160 LTC beds, 4/13/93. Con voided 10/15/93.
23. CON for 17 additional non-Medicaid beds for a total of 60 LTC beds, 5/19/93. Licensed for 60 LTC beds, 9/30/94.
24. CON issued for replacement of 132 existing beds and the addition of 44 non-Medicaid beds for a total of 176 beds, 7/11/94. Facility licensed beds increased from 132 to 176, 5/10/96. Exemption issued for conversion of 21 nurs hm beds to 20 rcf beds for a total of 155 nurs hm & 64 crf beds, 9/22/98. Facility licensed for 155 nurs hm beds,9/24/98. E-01-48 Permanent reduction of 23 nurs hm beds from 155 to 132 , 10/2/01.The beds will be removed upon licensing of the reduction Licensed beds reduced by 23 from 155 to 132, 12/01/01.
25. CON issued for 3 additional beds for a total of 132, 10/19/94. Licensed beds increased from 129 to 132, 6/6/95.
26. CON issued for 82 dual beds, 1/23/90. CON issued for 6 additional beds total of 88, 9/10/90. Facility licensed for 44, 12/6/91. Licensed beds increased from 44 to 88, 3/23/92. CON issued for 44 additional beds for a total of 132 LTC beds, 12/16/92. Facility licensed for 132 LTC beds, 8/16/94.
27. CON issued to convert 4 acute beds plus 11 new nurs hm beds for a total of 15 nurs hm beds & 64 general acute beds, 8/29/95. Licensed for 15 nurs hm beds & 64 hosp beds, 12/19/95. Con for 4 additional general beds for a total of 68 gen beds,6/27/97. Closed 15 bed nurs hm, 1/7/2000. Con issue for additional 25 general beds for a total of 93 general beds, 1/15/00 sc-00-57. Facility licensed beds increased form 64 to 68, 11/1/00. Licensed increased from by 17 from 68 to 85, 2/21/01. Licensed beds increased by 8 beds from 85 to 93 , 10/23/01.
28. Name changed from Beverly Health & Rehab Ctr 9/1/00.
29. Nursing home is not operational but still licensed , 9/1/02. Con issued to convert 15 nurs hm beds to hospital for 131, 1/29/03 SC-03-04.
30. Con issued for 44 nurs hm ,without medicaid, with 24 community beds & 20 restricted beds, 9/16/98. Facility licensed 7/19/2000.
31. CON for 44 additional non-medicaid beds for a total of 88 beds, 11/17/95. Licensed beds increased from 44 to 88, 10/15/98.
32. CON issued for 33 additional non-medicaid beds for a total of 69 comm & 8 non-comm, 12/19/95.Facility licensed for

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69 comm & 8 noncomm beds, 5/1/97. Facility will temporarily close nursing unit, 11/18/97.

33. Temporary use of psy beds as detox without change of licensure, 8/21/96.
34. CON for 32 additional medicaid beds for a total of 120, 11/19/96. Facility licensed for 120 beds, 2/1/98.
35. CON for 16 additional medicaid beds for a total of 104 nurs beds, 11/25/96. Facility licensed beds increased by 16 from 88 to 104, 2/19/99.
36. CON issued for replacement facility with 31 non-medicaid additional beds for a total of 57 nurs hm beds, 8/7/96. Name changed and licensed for 57 nurs beds, 7/8/98. CON 99-35 issued for 3 non-medicaid beds for a total of 60, 10/11/99. Facility licensed for 3 additional beds for a total of 60, 3/7/00.
37. Exmpt to reduce 4 beds & relocate 19 nurs beds to add 23 res beds for total licensure of 128 nurs hm beds & 40 res beds, 2/20/97. Licensed nurs hm beds reduced from 132 to 128, 5/9/97. Exemption to close 46 nurs hm beds for a total of 82 nurs hm beds, 10/15/98. Facility licensed for 82 beds, 10/15/98.
38. CON issued for 42 non-medicaid nurs hm, 12/1/97. Facility licensed for 42 nurs beds, 6/11/99.
39. APP for a 120 non-medicaid nurs hm, 6/24/97.Appealed. CON issued for the 120 non-medcaid nurs hm beds, 8/17/98.
40. Fomerly Health Care Of Hilton Head, 6/1/97.
41. Con issued to convert 10 general beds to nurs hm for 261 general, 15 psy & 10 nurs hm beds, 12/8/97. Con voided to convert 10 hosp beds to nurs hm, 11/24/98. CON voided 12/9/99. App for conversion of 24 general beds to 24 rehab with the reduction of 32 licensed general beds for 239 general 24 rehab & 15 psy, 4/4/2000 SC-00-18. Con issued for major renovation to retain 8 beds lost in the rehab con, 11/27/00 sc-00-60
42. Con issued to relocate & replace the existing 31 bed hospital, 2/23/98. Discontinued OB services, 4/8/98. CON voided 2/23/00. E-01-10 change of ownership change name of the facility to Jasper County Hosp. , 3/6/01. Con issued to replace existing 31 general hospital beds plus add 10 rehab beds, 5/28/02 SC-02-29.
43. Con issued to transfer 59 beds from Charleston Mem to establish Speciality Hosp of SC a 59 long term acute care hospital, 8/4/98. Specialty Hosp of SC licensed for 37 of the 59 Ltc acute beds & Charleston Mem licensed gen acute beds reduced from 157 to 120,12/2/98. Specialty Hosp of SC licensed beds increased by 12 rom 37 to 59 & Charleston Mem reduced from 120 general to 98 general & 15 psy, 7/4/99.
44. NA-99-54 build out the hospital=s 5th for the addition of 12 non-licensed observation beds, 7/7/99. Con issued for 24 additional general beds for a total of 130 general beds, 11/17/00. Con issued to convert 14 of the 44 nurs hm beds to 14 rehab beds and to delicense 12 nurs beds resulting in 18 nurs beds & 14 rehab beds , 12/12/00 SC-00-62. Licensed general beds increased by 4 from 106 to 110, 4/3/01. Licensed gen beds increased by 11 from 110 to 121 , 4/19/01. licensed beds increased from 121 to 130 , 7/6/2001. Facility licensed nursing home beds reduced from 44 to 18, 8/28/2001. Facility licensed for 14 rehab beds, 9/5/01.
45. Exemption issued to permanently reduce licensed beds by 10 from 192 to 182, e-00-77 , 12/1/00. Licensed beds reduced from 192 to 182 , 12/01/00. Exemption to close 12 beds from 182 to 170 will change on licensure reduction, e-02-01 1/8/02. Facility licensed beds reduced from 182 to 170 2/7/02.
46. Formerly Silver Springs HealthCare Ctr.
47. Con issued to replace the existing 40 bed facility, 7/13/2001 sc-01-30.

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48. Facility closed 132 nurs hm 2/8/02.
49. Facility closed for 44 A&D beds, 4/5/02.
50. Permanent reduction in nursing home beds from 44 to 33 resulting in 14 inst nurs hm beds and a reduction of 11 comm beds from 30 to 19 E-02-56 9/4/02.
51. Con issued for 9 non-medicaid beds for a total of 105, SC-02-73 12/20/02.
52. Con issued for 132 non-medicaid beds SC-03-25 5/13/03.
53. Con issued for 5 additional general acute beds for 183, SC-03_37 6/13/03.

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INVENTORY OF EMERGENCY FACILITIES

FY 2001 PLAN

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2001 ER VISITS
REGION IV:	EMERGENCY FACILITIES			
II	AIKEN REG MED CTR	AIKEN	AIKEN	51021
IV	ALLENDALE CO HOSP	ALLENDALE	FAIRFAX	8399
III	BAMBERG CO MEM HOSP	BAMBERG	BAMBERG	9684
III	BARNWELL CO HOSP	BARNWELL	BARNWELL	12574
III	BEAUFORT CO MEM HOSP	BEAUFORT	BEAUFORT	30815
II	HILTON HEAD REG MED CTR	BEAUFORT	HILTON HEAD	20307
II	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON	32093
II	CHARLESTON MEM HOSP	CHARLESTON	CHARLESTON	18503
II	EAST COOPER REG MED CTR	CHARLESTON	MT PLEASANT	17756
II	TRIDENT MED CTR	CHARLESTON	CHARLESTON	46405
II	ROPER HOSP	CHARLESTON	CHARLESTON	73156
II	ROPER HOSP NORTH	CHARLESTON	CHARLESTON	5700
(*)	MUSC MEDICAL CTR	CHARLESTON	CHARLESTON	32004
III	COLLETON MED CTR	COLLETON	WALTERBORO	22525
II	SUMMERVILLE MED CTR	DORCHESTER	SUMMERVILLE	28685
III	HAMPTON REG MED CTR	HAMPTON	VARNVILLE	8695
III	LOW COUNTRY GEN HOSP	JASPER	RIDGELAND	7743
II	RMC ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG	41781
TOTALS				467846

(*) Met insufficient criteria to be classified.

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

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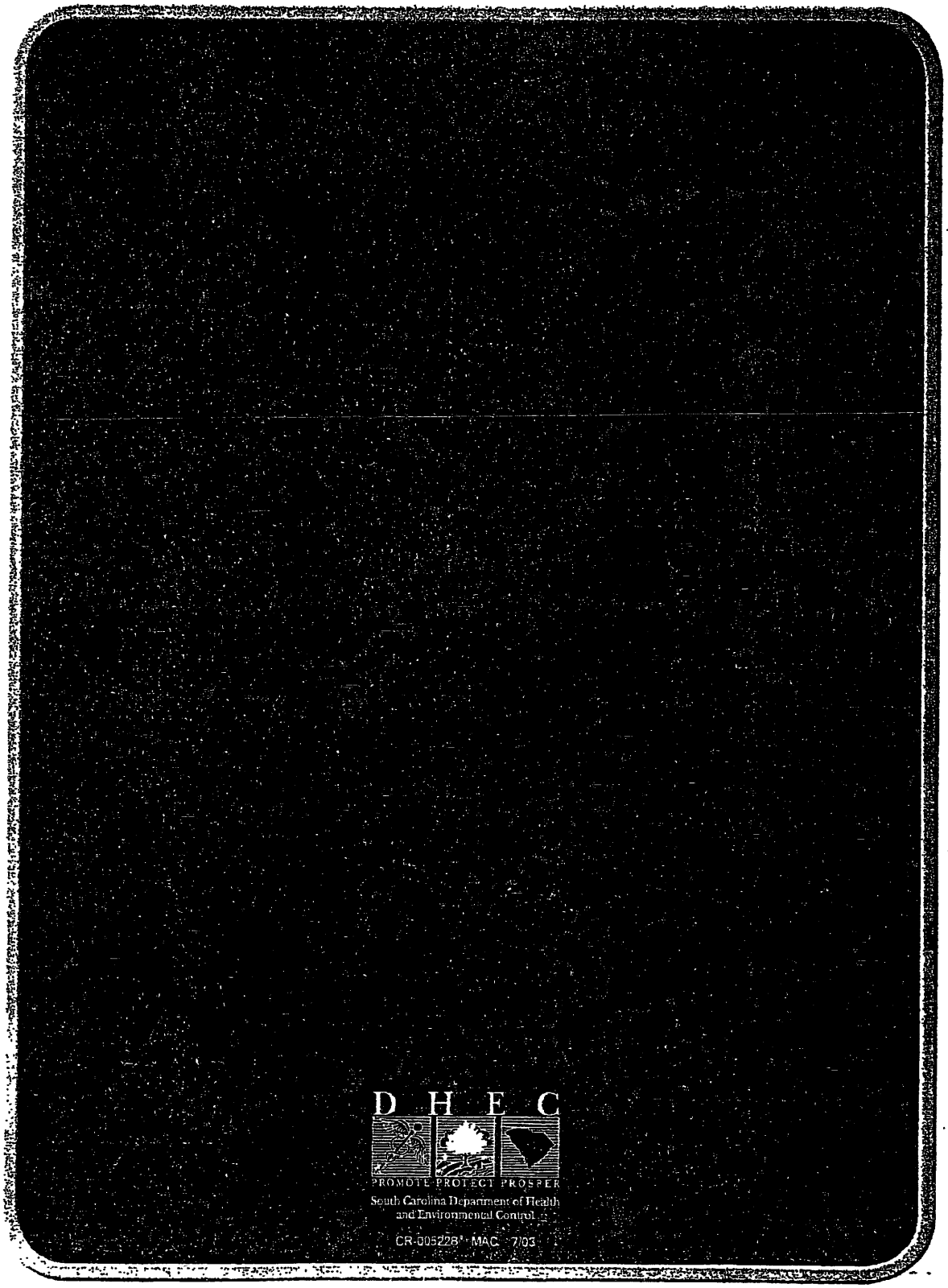

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Robert L. Walsh, P.E.

Campco Engineering, Inc.

Professional Experience:
Mr. Walsh has approximately 26 years experience on a wide variety of civil engineering projects. His exposure to federal, state, local, and private projects has provided experience for him to approach engineering issues from a variety of viewpoints and to effectively analyze design conditions.

His major emphasis has involved roadway design using computer applications. He is trained in the utilization of Geopak in the design of roadway geometrics and drainage systems. In addition to his work as Design Manager on a number of roadway projects, he has been the Project Manager on several SCDOT roadway improvement projects.

Mr. Walsh developed regional transportation planning models of the cities of Anderson, SC, Greenville, SC, and Rock Hill, SC, and for the U.S. 220 Corridor in southwest Virginia. These models were used to provide transportation forecasts for traffic analysis and highway planning.

YEARS OF EXPERIENCE: 26

EDUCATION:
BS Civil Engineering, 1986
West Virginia Institute of Technology

REGISTRATION:
Professional Engineer
South Carolina
North Carolina

RELATED PROJECT ASSIGNMENTS

SC Route 5 Improvements – Rock Hill, SC
Project Manager
SC Route 5 Business - York, SC
Project Manager
I-85 Improvements - Spartanburg, SC
Design Support
SC Route 274 Improvements – York County, SC
Design Support
Herlong Ave./India Hook Rd. – Rock Hill, SC
Design Support
York County Intersections (Group 1)
Design Manager

Petitioner's Trial Exhibit 007

WALSH.2013.0001

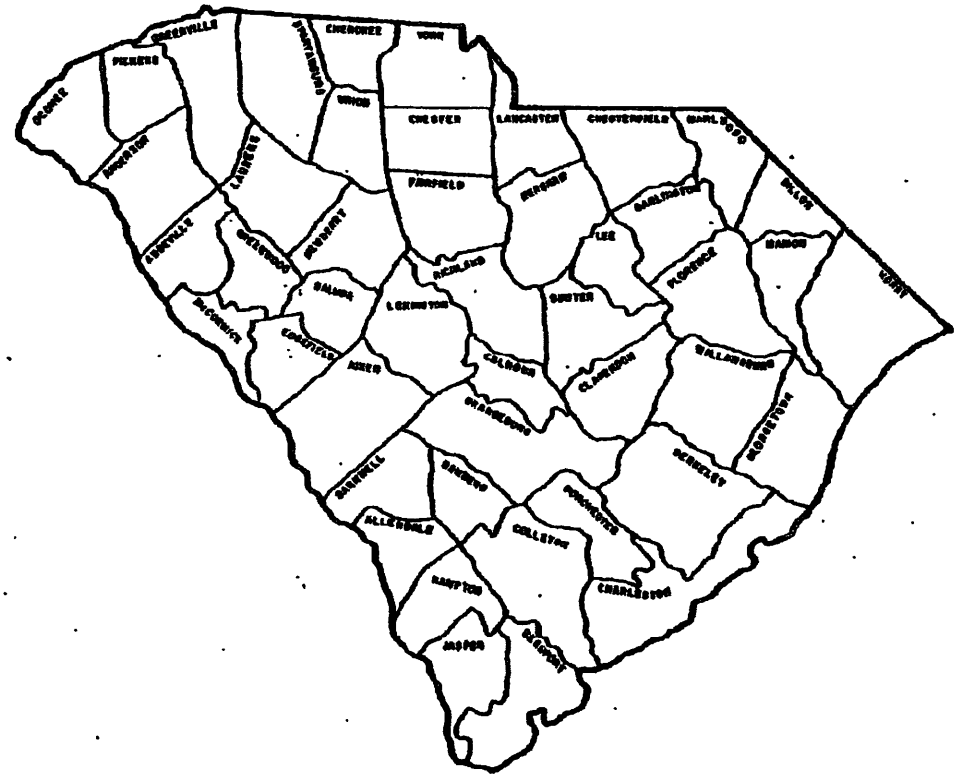
PET-EX007

2004 – 2005

South Carolina Health Plan

Petitioner's
Trial Exhibit
008

2004-2005
South Carolina Health Plan



South Carolina State Health Planning Committee

South Carolina Department of Health and Environmental Control

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

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South Carolina State Health Planning Committee

Member	Representing	Term expires
Gerald A. Wilson, M.D. Chairman	Provider	6/30/06
Langdon A. Hartsock, M.D.	Provider	6/30/04
Susan A. Lake	Provider	6/30/06
Frederick D. Hobby	Provider	6/30/04
Nicki S. Davis	Finance/Business	6/30/04
James E. Armbruster	Finance/Insurance	6/30/04
Angela H. McCrae	Finance/Business	6/30/06
Samuel A. Williams	Finance/Insurance	6/30/06
Edward D. Tinsley, III	Consumer	6/30/06
Oscar J. Harm, III, Ph.D.	Consumer	6/30/06
Vacant	Consumer	6/30/04
Billy R. Oswald	Consumer	6/30/04
Elliott Elam, Jr.	Ex Officio DHEC Board	(Consumer Affairs)

All correspondence should be addressed to: State Health Planning Committee, Division of Planning and Certification of Need, S.C. DHEC, 2600 Bull Street, Columbia, South Carolina 29201.

TEL: 803-545-4200 FAX: 803-545-4579

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CHAPTER I

INTRODUCTION

Legal Basis

Purpose

Health Planning Committee

Relationship with Other Agencies

Standards of Construction and Equipment

Standards for Maintenance and Operation

State Certification of Need and Health Facility Licensure Act

Indigent Care Policy

Relative Importance of Project Review Criteria

Existing Resources and Capacity

Interpretation of the Plan

Safety of Patient Care

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CHAPTER I

INTRODUCTION

A. Legal Basis:

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

B. Purpose:

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

C. Health Planning Committee:

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

D. Relationship With Other Agencies:

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

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

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E. Standards of Construction and Equipment:

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

F. Standards for Maintenance and Operation:

1. Pursuant to the "State Certification of Need and Health Facility Licensure Act," the South Carolina Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina. The Division of Health Licensing within DHEC is responsible for licensing Hospitals, Nursing Homes, Intermediate Care Facilities for the Mentally Retarded, Ambulatory Surgical Facilities, Home Health Agencies, Hospice Programs and Facilities, Community Residential Care Facilities, Renal Dialysis Facilities, Psychiatric Hospitals, Psychoactive Substance Abuse Treatment Facilities, Residential Treatment Programs, Detoxification Facilities, Residential Treatment Centers for Children and Adolescents, Abortion Clinics, Day Care Facilities for Adults, Chiropractic Inpatient Facilities, Hearing Aid Specialists, Licensed Midwives, Birthing Centers, and Body Piercing Facilities.

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

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

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

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

2. This law requires the:

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

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

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

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

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

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

H. Indigent Care Policy:

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

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

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

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

1. Indigent Care - That medical care (measured in dollars) provided to an individual who has been determined to be unable to pay for this care prior to admission in non-

emergency situations, and as soon as possible but before the discharge in emergency situations and for which only one billing has occurred and no other efforts have been undertaken to collect such debt. Indigent care does not include debt; contractual adjustments; or care that is reimbursed by a governmental program (Medicare, Medicaid, County indigent care program), church, or philanthropic organizations.

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

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

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

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

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

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

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

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

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

5. A discussion of why the above figures are adequate or inadequate for the needs of the community; the need of indigent care within the proposed service area; and any solutions, remedial plans or proposals by the facility or agency to better address the indigent care problems in the service area. Include any initiatives or undertakings the

facility or agency has begun to address the indigent care problems in the proposed service area.

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

I. Relative Importance of Project Review Criteria:

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

J. Existing Resources and Capacity:

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

K. Interpretation of the Plan:

The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole.

L. Safety of Patient Care:

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

The Department of Health and Environmental Control shares this concern. Therefore, it is the policy of the Department that all Certificate of Need applications must address the policies and procedures taken to assure patient safety by the applicant.

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CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

- Inventory Regions and Service Areas
- Exceptions to Service Area Standards
- Identification of Inventory Regions
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- Categories of Facilities and Services
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    - General Hospitals
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    - Diagnostic Imaging
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      - Ambulatory Surgical Facility
      - Emergency Hospital Services
      - Trauma Referral System
  - Community Psychiatric Beds
  - Residential Treatment Facilities for Children and Adolescents
  - Alcohol and Drug Abuse Facilities
  - Rehabilitation Facilities
  - Long-Term Care Facilities and Services
    - Nursing Homes
    - Medicaid Nursing Home Permits
    - Mental Retardation Facilities
    - Retirement Community: Nursing Home Units
    - Hospice Facilities and Hospice Programs
    - Swing Beds
    - Home Health Agencies
    - Other Services for the Elderly
  - Critical Access Hospitals
  - Long-Term Care Hospitals

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CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

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

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

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

B. Exceptions to Service Area Standards:

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

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

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equipment or services. There may be certain instances where such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

(1) A transfer or exchange of services may be approved only if there is no overall increase in the number or amount of such services;

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

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

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

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

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

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

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

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

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

D. Estimated State Civilian Population:

This Plan has been developed using the estimated civilian population of 4,136,020 for 2003 and projected population of 4,446,400 for 2010 where these projections were required for calculations. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2003 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was January14, 2005.

G. Categories of Facilities and Services:

1. General Medical Facilities and Services

(A) General Hospitals

(1) Definitions:

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

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

(2) Bed Capacity is as follows:

(a) For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds even though temporarily not used for such purposes. The number of beds counted in

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any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Adequate square footage is defined as:

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

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

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

(c) For Areas Included:

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

(d) For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.

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

(3) Inventory:

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

(b) Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming according to standards of plant evaluation, such as:

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

(4) Narrative: General Hospital Beds

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

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 75%.

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

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

The methodology for calculating bed needs is as follows:

(a) Calculations of bed need are made for individual facilities.

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

2. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75) to determine the number of beds needed to meet the area's need.

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

(d) Should there be a need shown for additional beds for a hospital, then an increase may be approved. In order to provide for a cost-effective addition, up to the greater of 50 beds or the actual projected number of additional beds may be approved, provided the hospital can document and demonstrate the need for additional beds.

(e) In some areas of South Carolina, there is a considerable influx of tourists who are not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population, and seasonal utilization fluctuations due to this population, then the Department may approve some additional beds at the existing hospital based on further analysis.

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

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

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

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

(h) Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:

TRANSFERS

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

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

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

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

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

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

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

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

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

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

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

The following pages depict the calculation of hospital bed need as described earlier.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

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

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANDERSON CO.									
ANDERSON AREA MEDICAL CTR & WOMEN AND CHILDREN'S HOSPITAL #1	<18	41,470	42,810	3,000	8.51				
	18-64	105,050	111,550	42,097	122.47				
	+65	23,050	26,920	45,734	140.30				
	TOTAL	169,560	180,280	90,923	271.27	0.75	362	495	-133
CHEROKEE CO.									
UPSTATE CAROLINA MEDICAL CTR	<18	13,980	14,770	1,151	3.33				
	18-64	33,380	35,980	7,241	21.37				
	+65	6,620	7,120	7,577	22.67				
	TOTAL	53,890	57,850	15,985	47.37	0.65	73	125	-52
GREENVILLE CO!									
ALLEN BENNETT MEMORIAL	<18	95,940	99,860	141	0.40				
	18-64	249,390	271,400	6,726	20.05				
	+65	45,090	49,950	8,851	26.95				
	TOTAL	390,420	421,210	15,719	47.41	0.65			
GREENVILLE MEMORIAL MED CTR	<18	95,940	99,860	15,512	44.52				
	18-64	249,390	271,400	103,885	309.74				
	+65	45,090	49,950	73,240	222.28				
	TOTAL	390,420	421,210	192,738	576.54	0.75			
ALLEN BENNETT MEM & GREENVILLE MEM MED CTR AND GREENVILL HOSP SYS-PATEWOOD #2	TOTAL						842	840	2
HILLCREST	<18	95,940	99,860	54	0.16				
	18-64	249,390	271,400	4,442	13.24				
	+65	45,090	49,950	6,259	19.00				
	TOTAL	390,420	421,210	10,755	32.39	0.65	50	43	7
NORTH GREENVILLE LTAC #3	<18	95,940	99,860	-	0.00				
	18-64	249,390	271,400	70	0.21				
	+65	45,090	49,950	163	0.49				
	TOTAL	390,420	421,210	233	0.70	0.65	1	45	-44
SAINT FRANCIS HOSPITAL	<64	345,330	371,260	24,841	73.17				
	+65	45,090	49,950	25,241	76.61				
	TOTAL	390,420	421,210	50,082	149.77	0.70			
ST FRANCIS WOMAN'S & FAMILY HOSP	<64	345,330	371,260	6,819	20.08				
	+65	45,090	49,950	6,916	20.99				
	TOTAL	390,420	421,210	13,721	41.07	0.65			

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY		AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
SAINT FRANCIS HOSPITAL & ST FRANCIS WOMAN'S & FAMILY HOSP	#4	TOTAL						278	319	-41
REGENCY HOSPITAL GREENVILLE	#5	<18	85,940	99,880	-	0.00				
		18-64	249,390	271,400	-	0.00				
		+65	45,090	49,950	-	0.00				
		TOTAL	390,420	421,210	-	0.00		0	32	-32
OCONEE CO										
OCONEE MEMORIAL		<18	15,380	16,810	855	2.42				
		18-64	42,240	45,020	13,966	40.79				
		+65	11,410	14,230	18,011	62.84				
		TOTAL	69,030	76,460	32,867	106.05	0.65	163	160	3
PICKENS CO										
CANNON MEMORIAL		<18	27,690	29,360	75	0.22				
		18-64	74,910	82,680	1,544	4.68				
		+65	13,160	14,910	4,164	12.84				
		TOTAL	115,750	127,150	5,784	17.84	0.65	27	55	-28
PALMETTO BAPTIST MED CTR EASLEY		<18	27,690	29,360	745	2.16				
		18-64	74,910	82,680	8,920	27.04				
		+65	13,160	14,910	8,956	27.83				
		TOTAL	115,750	127,150	18,623	57.03	0.65	88	109	-21
SPARTANBURG CO										
B.J. WORKMAN MEMORIAL		<18	65,080	67,440	77	0.22				
		18-64	164,700	177,870	957	2.86				
		+65	32,130	35,490	1,601	4.86				
		TOTAL	261,910	280,800	2,642	7.92	0.65	12	43	-31
SPART HOSP RESTORATIVE CARE		<18	65,080	67,440	-	0.00				
		18-64	164,700	177,870	5,513	16.29				
		+65	32,130	35,490	17,082	51.89				
		TOTAL	261,910	280,800	22,595	67.99	0.65	105	97	8
MARY BLACK MEMORIAL		<18	65,080	67,440	1,472	4.18				
		18-64	164,700	177,870	11,454	33.85				
		+65	32,130	35,490	11,601	38.11				
		TOTAL	261,910	280,800	24,527	73.14	0.70	104	176	-72
SPARTANBURG REGIONAL MED CTR		<18	65,080	67,440	4,883	13.86				
		18-64	164,700	177,870	63,861	188.74				
		+65	32,130	35,490	56,222	170.14				
		TOTAL	261,910	280,800	125,217	372.75	0.75	497	532	-35
UNION CO										

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
WALLACE THOMSON	<18	7,090	6,990	736	1.99				
	18-64	17,880	17,440	6,272	16.75				
	+65	4,770	5,000	10,560	30.33				
	TOTAL	29,760	29,430	17,570	49.07	0.65	75	143	-68
REGION II									
ABBEVILLE CO.									
ABBEVILLE CO. MEMORIAL	<18	6,700	6,750	186	0.51				
	18-64	15,940	16,710	1,651	4.74				
	+65	3,840	4,190	2,209	6.60				
	TOTAL	26,480	27,650	4,046	11.86	0.65	18	25	-7
CHESTER CO.									
CHESTER CO. HOSPITAL	<18	9,080	8,910	620	1.67				
	18-64	21,060	21,770	4,133	11.70				
	+65	4,290	4,820	4,640	14.28				
	TOTAL	34,430	35,500	9,393	27.65	0.65	43	82	-39
EDGEFIELD CO.									
EDGEFIELD CO. HOSPITAL #6	<18	5,660	5,840	140	0.38				
	18-64	16,510	18,360	937	2.55				
	+65	2,730	3,200	2,069	6.64				
	TOTAL	25,120	27,400	3,042	9.57	0.65	15	25	-10
FAIRFIELD CO.									
FAIRFIELD MEMORIAL #7	<18	6,170	6,150	68	0.19				
	18-64	14,700	15,440	1,459	4.20				
	+65	3,050	3,300	2,224	6.59				
	TOTAL	23,920	24,900	3,751	10.98	0.65	17	25	-8
GREENWOOD CO									
SELF MEMORIAL HOSPITAL	<18	17,400	17,920	2,129	6.01				
	18-64	41,190	43,630	27,662	80.33				
	+65	9,070	9,620	32,629	94.82				
	TOTAL	67,660	71,170	62,628	181.16	0.70	259	334	-75
KERSHAW CO									
KERSHAW CO. MEMORIAL HOSPITAL 9	<18	13,760	14,180	1,489	4.20				
	18-64	33,560	35,810	9,775	28.38				
	+65	6,920	7,920	12,647	39.56				
	TOTAL	54,230	58,910	22,911	70.24	0.65	108	121	-13
LANCASTER CO									

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FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
SPRINGS MEMORIAL	<18	15,630	15,450	2,114	5.76				
	18-64	38,810	40,540	20,293	58.08				
	+65	7,350	7,970	15,027	47.81				
	TOTAL	61,690	63,960	35,434	111.65	0.65	171	168	3
LAURENS CO									
LAURENS CO. HOSPITAL	<18	17,690	17,720	405	1.11				
	18-64	44,430	48,760	6,333	19.04				
	+65	9,420	10,770	9,443	29.58				
	TOTAL	71,540	77,240	16,197	49.73	0.65	77	76	1
LEXINGTON CO									
LEXINGTON MEDICAL CENTER	<18	35,450	36,961	2,103	6.01				
	18-64	90,687	101,337	42,652	139.58				
	+65	14,653	17,919	39,371	131.91				
	TOTAL	140,790	156,217	84,126	288.49	0.70	384	346	38
NEWBERRY CO									
NEWBERRY CO. MEMORIAL	<18	5,660	5,980	295	0.83				
	18-64	22,640	23,760	4,385	12.61				
	+65	5,330	5,760	7,232	21.49				
	TOTAL	33,650	35,520	11,915	34.92	0.65	54	90	-36
RICHLAND CO									
PALMETTO HEALTH BAPTIST	<18	103,241	105,950	1,919	5.40				
	18-64	268,753	289,794	38,967	115.12				
	+65	40,798	46,361	32,916	102.48				
	TOTAL	412,792	442,105	73,802	222.99	0.75	297	363	-66
PROVIDENCE HOSPITAL	<18	103,241	105,950	70	0.20				
	18-64	268,753	289,794	29,667	87.64				
	+65	40,798	46,361	39,905	124.24				
	TOTAL	412,792	442,105	69,642	212.08	0.70	303	258	45
PROVIDENCE HOSPITAL NORTHEAST	<18	103,241	105,950	74	0.21				
	18-64	268,753	289,794	6,725	19.87				
	+65	40,798	46,361	5,576	17.36				
	TOTAL	412,792	442,105	12,363	37.43	0.65	58	46	12
PALMETTO HEALTH RICHLAND	<18	103,241	105,950	21,430	60.26				
	18-64	268,753	289,794	78,907	233.11				
	+65	40,798	46,361	41,582	129.48				
	TOTAL	412,792	442,105	141,919	422.82	0.75	564	579	-15
INTERMEDICAL HOSPITAL OF SC	<18	103,241	105,950	-	0.00				
	>18	309,551	336,155	9,036	26.89				
	TOTAL	412,792	442,105	9,036	26.89	0.65	41	35	6

RECORD 004021
PMC.2013.SHP.0507
PET-EX008.0024

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2009 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
YORK CO									
PIEDMONT MEDICAL CENTER	<18	44,300	45,910	2,937	8.34				
	18-64	110,120	125,480	38,883	116.08				
	+65	17,670	20,910	33,632	109.04				
	TOTAL	172,090	192,300	73,432	232.46	0.70	332	268	64
REGION III									
CHESTERFIELD CO									
CHESTERFIELD GENERAL	<18	11,270	11,080	785	2.11				
	18-64	26,620	27,570	4,519	12.52				
	+65	5,050	5,620	2,096	6.99				
	TOTAL	42,940	44,270	7,400	19.21	0.65	30	59	-29
CLARENDON CO									
CLARENDON MEMORIAL HOSPITAL	<18	8,180	7,770	578	1.50				
	18-64	19,940	20,670	6,624	18.81				
	+65	4,900	5,210	5,367	18.64				
	TOTAL	33,020	34,650	12,569	38.95	0.65	60	56	4
DARLINGTON CO									
CAROLINA PINES REGIONAL HOSPITAL	<18	17,780	17,560	2,444	6.61				
	18-64	41,750	42,680	15,657	44.42				
	+65	8,200	9,000	13,036	38.20				
	TOTAL	67,730	69,250	31,337	89.23	0.65	138	166	-27
WILSON MEDICAL CENTER	<18	17,780	17,560	3	0.01				
	18-64	41,750	42,680	1,111	3.11				
	+65	8,200	9,000	1,974	5.84				
	TOTAL	67,730	69,250	3,085	9.06	0.65	14	49	-35
DILLON CO									
SAINT EUGENE MEDICAL CENTER	<18	8,590	8,090	1,416	3.71				
	18-64	18,360	18,670	6,628	18.47				
	+65	3,490	3,530	5,758	15.96				
	TOTAL	30,440	30,290	13,809	38.13	0.65	59	79	-20
FLORENCE CO									
CAROLINAS HOSP SYS & WOMEN'S CENTER OF THE CAROLINAS HOSP. SYS.	<18	32,740	32,610	1,877	5.12				
	18-64	80,440	84,930	39,123	110.28				
	+65	16,190	16,930	39,816	121.59				
	TOTAL	128,370	134,470	75,244	236.99	0.70	339	282	57
CAROLINAS HOSPITAL SYSTEM LAKE CITY	<18	32,740	32,610	103	0.28				
	18-64	80,440	84,930	1,547	4.47				
	+65	16,190	16,930	2,151	6.57				
	TOTAL	128,370	134,470	3,801	10.91	0.65	17	48	-31

RECORD 004022
PMC.2013.SHP.0508
PET-EX008.0025

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
MCLEOD REGIONAL MEDICAL CTR	<18	32,740	32,610	8,001	21.83				
	18-64	80,440	84,930	60,116	173.89				
	+65	15,190	16,930	43,116	131.65				
	TOTAL	128,370	134,470	111,121	327.38	0.70	468	453	15
REGENCY HOSPITAL OF SC	<18	32,740	32,610		0.00				
	18-64	80,440	84,930		0.00				
	+65	15,190	16,930		0.00				
	TOTAL	128,370	134,470	9,251	26.35	0.65	41	28	13
GEORGETOWN CO									
GEORGETOWN CO. MEMORIAL	<18	13,510	12,660	2,259	5.83				
	18-64	34,530	36,770	16,743	45.93				
	+65	9,280	12,320	17,481	63.56				
	TOTAL	57,320	61,750	35,458	115.34	0.65		131	
WACCAMAW COMMUNITY HOSPITAL	<18	13,510	12,660	122	0.31				
	18-64	34,530	36,770	3,672	11.30				
	+65	9,280	12,320	7,131	25.94				
	TOTAL	57,320	61,750	11,125	37.58	0.65		82	
GEORGETOWN CO. MEMORIAL & WACCAMAW COMMUNITY HOSP #9	TOTAL				152.88	0.65	236	213	23
HORRY CO									
CONWAY HOSPITAL	<18	42,520	43,600	2,313	6.50				
	18-64	132,550	152,460	16,242	46.03				
	+65	33,090	43,000	16,601	56.75				
	TOTAL	208,160	239,060	34,022	113.28	0.65	175	160	15
GRAND STRAND REGIONAL MED CTR	<18	42,520	43,600	1,095	3.08				
	18-64	132,550	152,460	21,295	67.11				
	+65	33,090	43,000	27,416	97.61				
	TOTAL	208,160	239,060	49,757	167.79	0.70	240	219	21
LORIS COMMUNITY HOSPITAL	<18	42,520	43,600	731	2.05				
	18-64	132,550	152,460	8,582	27.04				
	+65	33,090	43,000	9,929	35.35				
	TOTAL	208,160	239,060	19,242	64.45	0.65	99	105	-6
MARION CO									
MARION CO MEDICAL CENTER	<18	9,690	9,280	1,321	3.47				
	18-64	21,840	22,560	16,716	47.09				
	+65	4,190	4,610	16,716	50.39				
	TOTAL	35,720	36,370	34,763	100.95	0.65	155	124	31
MARLBORO CO									

RECORD 004023
PMC.2013.SHP.0509
PET-EX008.0026

FY 2010 HOSPITAL NEED

FACILITY/COUNTY		AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
MARLBORO PARK		<18	7,400	7,070	716	1.87				
		18-64	17,650	17,030	4,641	12.27				
		+65	3,320	3,340	650	1.79				
		TOTAL	28,370	27,440	6,020	15.93	0.65	25	94	-69
SUMTER CO										
TUOMEY		<18	30,250	31,020	2,095	5.69				
		18-64	66,240	70,420	30,012	87.41				
		+65	12,630	14,680	29,458	93.81				
		TOTAL	109,120	116,120	61,627	187.11	0.70	268	248	20
WILLIAMSBURG CO										
WILLIAMSBURG REG HOSPITAL	#10	<18	10,230	9,410	199	0.50				
		18-64	21,930	22,150	2,330	6.45				
		+65	4,890	5,300	2,707	8.04				
		TOTAL	37,050	36,860	5,236	14.99	0.65	23	25	-2
REGION IV										
AIKEN CO.										
AIKEN REGIONAL MEDICAL CTR.		<18	37,620	37,750	897	2.47				
		18-64	92,370	103,080	22,518	68.65				
		+65	19,460	23,110	21,442	69.76				
		TOTAL	149,350	163,940	44,856	141.09	0.65	217	183	34
ALLENDALE CO.										
ALLENDALE CO. HOSPITAL		<18	3,030	3,030	110	0.30				
		18-64	7,050	7,170	827	2.30				
		+65	1,500	1,750	960	3.07				
		TOTAL	11,580	11,950	1,897	5.67	0.65	9	25	-16
BAMBERG CO.										
BAMBERG CO. MEMORIAL		<18	4,210	3,850	68	0.25				
		18-64	9,910	9,560	2,881	7.83				
		+65	2,200	2,340	2,712	7.50				
		TOTAL	16,320	15,750	5,771	15.97	0.65	25	59	-34
BARNWELL CO.										
BARNWELL CO. HOSPITAL		<18	6,390	6,090	411	1.07				
		18-64	14,540	15,820	2,166	6.46				
		+65	3,060	3,490	2,758	8.52				
		TOTAL	23,990	25,400	5,335	16.15	0.65	25	53	-28
BEAUFORT CO.										
BEAUFORT CO. MEMORIAL		<18	25,750	27,740	1,852	4.90				
		18-64	77,320	87,650	20,329	63.14				

RECORD 004024
PMC.2013.SHP.0510
PET-EX008.0027

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
	+65	22,010	31,030	17,954	69.35				
	TOTAL	128,080	146,420	40,255	137.38	0.65	212	195	17
HILTON HEAD REGIONAL MEDICAL CTR	<18	28,750	27,740	352	0.93				
	18-64	77,320	87,650	8,491	26.37				
	+65	22,010	31,030	14,613	56.44				
	TOTAL	128,080	146,420	23,456	83.74	0.65	129	93	36
BERKELEY/CHARLESTON/DORCHESTER COS									
TRIDENT MEDICAL CENTER	<18	143,710	143,140	2,449	6.68				
	18-64	383,720	390,100	35,988	114.60				
	+65	62,130	78,300	32,897	113.27				
	TOTAL	589,560	611,540	74,225	234.48	0.75	313	271	42
SUMMERVILLE MEDICAL CENTER	0-64	507,430	533,240	11,491	33.08				
	+65	62,130	78,300	9,201	31.77				
	TOTAL	569,560	611,540	20,817	64.85	0.65	100	80	20
KINDRED HOSPITAL CHARLESTON	<18	143,710	143,140		0.00				
	18-64	383,720	390,100	3,533	10.35				
	+65	62,130	78,300	8,442	29.15				
	TOTAL	589,560	611,540	11,975	39.53	0.65	61	59	2
CHARLESTON MEMORIAL #11	<18	143,710	143,140	7	0.02				
	18-64	383,720	390,100	4,342	12.75				
	+65	62,130	78,300	499	1.72				
	TOTAL	589,560	611,540	4,850	14.50	0.65			
MEDICAL UNIVERSITY HOSPITAL #11	<18	143,710	143,140	23,201	63.31				
	18-64	383,720	390,100	75,653	226.24				
	+65	62,130	78,300	28,328	97.81				
	TOTAL	589,560	611,540	128,182	386.36	0.75	538	604	-66
ROPER HOSPITAL	<18	143,710	143,140	1,122	3.06				
	18-64	383,720	390,100	38,144	112.08				
	+65	62,130	78,300	54,224	187.22				
	TOTAL	589,560	611,540	93,488	302.37	0.75	403	414	-11
BON SECOURS ST FRANCIS XAVIER	<18	143,710	143,140	656	1.79				
	18-64	383,720	390,100	20,331	59.74				
	+65	62,130	78,300	17,631	60.88				
	TOTAL	589,560	611,540	38,679	122.41	0.70	175	141	34
EAST COOPER REG MED CTR.	<18	143,710	143,140	166	0.45				
	18-64	383,720	390,100	12,022	35.33				
	+65	62,130	78,300	8,611	29.73				
	TOTAL	589,560	611,540	20,800	65.51	0.65	101	100	1
COLLETON CO.									

RECORD 004025
PMC.2013.SHP.0511
PET-EX008.0028

FY 2010 HOSPITAL NEED

FACILITY/COUNTY	AGE CAT	2003 POP	2010 POP	2003 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
COLLETON MEDICAL CENTER	<18	10,520	10,690	626	1.74				
	18-64	23,780	25,180	11,429	33.20				
	+65	4,980	5,730	15,157	47.68				
	TOTAL	39,270	41,610	27,211	82.62	0.65	128	131	-3
HAMPTON CO.									
HAMPTON REGIONAL MEDICAL CTR	<18	5,740	5,480	65	0.17				
	18-64	13,340	14,170	1,616	4.71				
	+65	2,590	3,030	1,940	6.22				
	TOTAL	21,670	22,690	3,927	11.10	0.65	17	68	-51
JASPER CO.									
COASTAL CAROLINA MEDICAL CENTER	<18	5,350	5,050	-	0.00				
	18-64	13,410	15,120	-	0.00				
	+65	2,330	2,830	-	0.00				
	TOTAL	21,090	23,000	-	0.00	0.65	0	31	-31
ORANGEBURG CO.									
REG MED CTR ORANGEBURG-CALHOUN	<18	24,070	23,740	2,066	5.66				
	18-64	59,610	65,080	22,618	64.48				
	+65	12,530	14,050	24,486	75.22				
ORANGEBURG CO.	TOTAL	93,210	96,880	49,169	145.46	0.70	208	247	-39

#1 CON ISSUED TO TRANSFER 72 BEDS FOR NEW HOSPITAL.
#2 BED NEEDS ARE COMBINED FOR THESE HOSPITALS; SINCE, ADDITIONAL BEDS WERE APPROVED FOR TRANSFER AMONG THESE HOSPITALS. 6/30/03
#3 CON ISSUED TO CONVERT N GREENVILLE TO A 46 BED LTC HOSPITAL 4/1 5/03.
#4 BED NEEDS ARE COMBINED FOR THESE HOSPITALS, SINCE ADDITIONAL BEDS WERE APPROVED FOR TRANSFER AMONG THESE HOSPITALS. 6/30/03
#5 CON ISSUED FOR 32 BED LTACH 5/22/04 SC-04-26
#6 THE HOSPITAL DELICENSED FROM 40 TO 25 BEDS ON 5/31/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#7 THE HOSPITAL DELICENSED FROM 66 TO 25 BEDS ON 5/23/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#8 DATA AND BED NEEDS ARE COMBINED.
#9 NEEDS ARE COMBINED SINCE CON SC-03-66 TRANSFER 14 BEDS FROM GM TO WACCAMAW. 11/10/03. AND WACCAMAW ADDED 28 BEDS 4/12/04 SC-04-20.
#10 THE HOSPITAL DELICENSED FROM 75 TO 25 BEDS ON 9/20/04 TO BECOME A CRITICAL ACCESS HOSPITAL
#11 CON ISSUED TO COMBINE THESE TWO FACILITIES SC-03-60 10/14/03.

RECORD 004026
PMC.2013.SHP.0512
PET-EX008.0029

SOUTH CAROLINA GENERAL ACUTE BEDS

% OCCUPANCY RATE

	2001	2002	2003
REGION I	**58.3**	**58.7**	**59.4**
ANDERSON AREA MED CTR	52.3	52.6	50.3
UPSTATE CAROLINA MED CTR	34.3	31.7	35.0
ALLEN BENNETT MEMORIAL	71.1	71.3	74.3
GREENVILLE MEM MED CTR	61.6	61.5	63.5
NORTH GREENVILLE LTAC	-	-	13.0
HILLCREST HOSPITAL	43.7	52.7	55.7
ST FRANCIS HOSPITAL	74.7	73.7	66.5
ST FRANCIS WOMENS & FAMILY	59.8	58.4	60.6
OCONEE MEMORIAL	54.8	52.2	56.3
CANNON MEMORIAL	31.2	27.8	28.6
PALMETTO BAPTIST M C EASLEY	51.1	52.8	53.1
BJ WORKMAN MEMORIAL	17.5	18.0	16.8
MARY BLACK MEMORIAL	40.7	40.7	38.2
SPART HOSP RESTORATIVE CARE	62.4	40.7	63.8
SPARTANBURG REG MED CTR	62.4	65.6	64.6
HOPE HOSPITAL	13.8	11.5	0.0
WALLACE THOMSON	32.1	32.2	33.7
REGION II	**61.2**	**63.0**	**64.8**
ABBEVILLE COUNTY	24.0	25.0	21.3
CHESTER REGIONAL MED CTR	44.4	37.3	31.4
EDGEFIELD COUNTY	24.5	19.9	20.8
FAIRFIELD MEMORIAL	33.9	36.4	31.1
SELF REGIONAL MED CTR	49.5	46.5	51.4
KERSHAW COUNTY MEMORIAL	56.3	63.3	51.9
SPRINGS MEMORIAL	77.1	67.6	78.0
LAURENS COUNTY HOSPITAL	64.0	61.4	58.4
LEXINGTON MEDICAL CTR	71.6	76.2	78.9
NEWBERRY CO MEMORIAL	29.3	34.0	36.3
INTERMEDICAL HOSPITAL OF SC	72.3	78.5	70.7
PALMETTO HEALTH BAPTIST	55.9	62.7	55.7
PROVIDENCE HOSPITAL	76.9	79.0	83.7
PROVIDENCE HOSPITAL NE	74.1	82.6	73.6
PALMETTO HEALTH RICHLAND	69.0	68.5	67.2
PIEDMONT MEDICAL CTR	65.2	71.6	76.1

	2001	2002	2003
REGION III	**64.0**	**63.3**	**63.6**
CHESTERFIELD GENERAL	25.1	31.1	34.4
CLARENDON MEMORIAL	67.0	59.5	61.5
CAROLINA PINES REG MED CTR	65.1	69.4	74.0
WILSON CLINIC	20.6	19.7	17.2
ST. EUGENE REGIONAL MED CTR	43.8	48.2	47.9
CAROLINAS HOSPITAL SYSTEM	60.3	68.3	75.6
CAROLINAS HOSP LAKE CITY	21.5	19.9	21.7
MCLEOD REGIONAL MED CTR	92.5	92.0	90.6
WOMEN'S CTR/CAROLINAS	53.2	37.1	40.9
REGENCY HOSPITAL OF SC	12.8	78.6	90.5
GEORGETOWN MEMORIAL	81.0	81.1	68.4
WACCAMAW COMMUNITY	-	-	78.6
CONWAY HOSPITAL	63.3	57.3	58.3
GRAND STRAND REGIONAL	78.8	64.3	62.2
LORIS COMMUNITY	56.0	49.9	50.2
MARION COUNTY MED CTR	90.6	69.4	76.8
MARLBORO PARK	19.2	21.7	17.5
TUOMEY	67.7	70.7	68.1
WILLIAMSBURG REGIONAL	9.3	19.6	18.4
REGION IV	**60.8**	**62.9**	**62.2**
AIKEN REGIONAL MED CTR	70.9	71.1	69.0
ALLENDALE COUNTY	14.8	21.0	20.8
BAMBERG CO MEMORIAL	27.0	25.2	26.8
BARNWELL COUNTY	28.6	27.9	27.6
BEAUFORT MEMORIAL	89.3	94.7	84.8
HILTON HEAD	78.8	80.6	69.1
CHARLESTON MEMORIAL	11.9	12.3	13.7
EAST COOPER REG MED CTR	48.0	48.6	57.0
MEDICAL UNIVERSITY	72.5	72.2	75.4
TRIDENT MEDICAL CTR	77.6	82.4	76.9
KINDRED-HOSP CHARLESTON	39.1	50.9	55.6
SUMMERVILLE MED CTR	61.4	69.3	74.5
ROPER	63.4	63.9	61.9
BON SECOURS ST FRANCIS X	72.2	75.7	75.0
COLLETON MEDICAL CTR	69.7	81.6	84.3
HAMPTON REGIONAL MED CTR	18.4	13.2	14.8
LOW COUNTRY	0.0	0.0	0.0
RMC ORANGEBURG/CALHOUN	58.7	58.9	54.5

RECORD 004027
PMC.2013.SHP.0513
PET-EX008.0030

(B) Obstetrical and Neonatal Services

Obstetrical Services

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

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy, and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries constitute a small percentage of the total annual deliveries, but these patients require a high degree of specialized care.

Infant mortality is the death rate for babies from birth until their first birthday. South Carolina's infant mortality rate has declined faster than it has for the nation as a whole. For 2002, South Carolina's infant mortality rate was 9.3 per thousand infant births with a Healthy People 2010 objective for the nation of no more than 4.5 per thousand infant deaths per thousand live births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2002, South Carolina's neonatal mortality rate for all races was 6.4 neonatal deaths per 1,000 live births with a Healthy People 2010 objective for the nation of 2.9 neonatal deaths per 1,000 live births.

The following is a description of the five levels of perinatal services as outlined in Regulation Number 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the state to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services shall be designated by DHEC's Division of Licensing as a Level I, II, IIE (Enhanced), or III Perinatal Hospital or RPC (Regional Perinatal Center) and the hospital shall request such designation by letter to the Department. The determination shall be made by the Department based upon a hospital's ability to meet regulatory requirements to be determined by a special inspection by the Department following the initial request for designation and as an integral part of subsequent license renewal procedures. Each Level I, II, IIE and III hospital shall maintain and document a relationship with its designated RPC for consultation, transport and continuing education. All patients shall be transferred to the appropriate RPC when medically appropriate, if beds are available. This agreement/relationship shall include the ability to share data, as appropriate, related to these functions. This should ensure that patients are treated in the hospital best suited to handle their expected problems. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The following definitions apply:

A. **Community Perinatal Center (Level I):** These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital shall have the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2000 grams. When it is anticipated or determined that these criteria will not or have not been met, consultation and a plan of care shall be initiated and mutually agreed upon with the RPC. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for

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immediate transfer to a higher level hospital. Management shall include emergency resuscitation and/or stabilization for both maternal and neonatal patients in preparation for transfer/transport for more specialized services. Hospitals at this level shall not provide care or services which are designated only for higher level hospitals. This description does not constitute Certificate of Need review criteria.

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

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

D. **Subspecialty Perinatal Center (Level III):** In addition to Level IIE requirements, provides all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on

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site within 30 minutes, 24 hours a day. A board certified maternal-fetal medicine specialist (perinatologist) shall be available for supervision and consultation, 24 hours a day. In addition to the Level II and IIE capabilities, Level III hospitals shall have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. Hospitals with Level III designation shall manage no less than an average of 1500 deliveries annually, calculated over the previous three years, or at least an average of 125 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. Hospitals at this level shall not provide additional care or services designated only for RPCs. The establishment of a Level III service requires Certificate of Need review.

E. **Regional Perinatal Center (RPC):** In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to Level I, II, IIE, and III hospitals in the region. The RPC shall manage no less than an average of 2000 deliveries annually, calculated over the previous three years, or at least an average of 250 neonate admissions who weigh less than 1500 grams each, require ventilatory support, or require surgery. Personnel qualified to manage obstetric or neonatal emergencies shall be in-house. A board-certified maternal-fetal medicine specialist (perinatologist) shall be in the hospital or on site within 30 minutes for supervision and consultation, 24 hours a day. The RPC shall participate in residency programs for obstetrics, pediatrics, and/or family practice. Continuing education and outreach education programs shall be available to all referring hospitals, and physician-to-physician consultation shall be available 24 hours a day. The RPC shall provide a perinatal transport system that operates 24 hours a day, seven days a week, and return transports neonates to lower level perinatal hospitals when the neonates' condition and care requirements are within the capability of those hospitals. No more than one Regional Perinatal Center will be approved in each perinatal region. Regional Perinatal Centers must meet the criteria and standards required in the hospital licensing regulations. The establishment of a Regional Perinatal Center requires Certificate of Need review.

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

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

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

Relative Importance of Project Review Criteria

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

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

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

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

REGIONAL PERINATAL CENTERS

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

SUBSPECIALITY PERINATAL CENTER (LEVEL III HOSPITAL)

Palmetto Baptist Medical Center at Columbia
Self Memorial Hospital

ENHANCED PERINATAL CENTER (LEVEL II ENHANCED CARE HOSPITALS)

Piedmont Medical Center

SPECIALITY PERINATAL CENTERS (LEVEL II HOSPITALS)

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

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FY03 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEM. MED. CTR.	5208	65	6028	16382	69.0%
PALMETTO HEALTH BAPTIST	3705	61	5895	15224	68.4%
LEXINGTON MED. CTR.	2576	35	2769	6501	50.9%
SPARTANBURG REG. MED.CTR.	2506	43	3122	8738	55.7%
PIEDMONT MED. CTR.	2088	19	2239	5695	82.1%
MCLEOD REG. MED. CTR.	2058	20	2686	5777	79.1%
TRIDENT MED. CTR.	2035	25	2495	5947	65.2%
PALMETTO HEALTH RICHLAND	1967	59	5181	9980	46.3%
BEAUFORT MEMORIAL	1814	20	1968	4664	63.9%
MEDICAL UNIVERSITY HOSP.	1803	34			0.0%
ST. FRANCIS WOMEN'S & FAMILY HOSP	1780	24	1962	5113	58.4%
ANDERSON AREA MED CTR	1755	22	1447	3934	49.0%
EAST COOPER REG MED CTR	1539	27	1676	4839	49.1%
SELF MEM. HOSP.	1456	37	2569	6882	51.0%
BON SECOURS' ST. FRANCIS XAVIER	1429	12			0.0%
RMC ORANGEBURG-CALHOUN	1329	27	1885	4758	48.3%
TUOMEY	1153	20	813	4821	66.0%
CONWAY HOSP. INC.	1132	16	1481	3668	62.8%
MARY BLACK MEM.	1114	21	1377	3495	45.6%
WOMEN'S CTR /CAROLINAS	1072	20	1141	2984	40.8%
GRAND STRAND REG MED CTR	931	19	1311	3126	45.1%
ROPER HOSP.	875	11			0.0%
AIKEN REG.MED. CTR.	852	18	1584	4452	67.8%
SUMMERVILLE MED CTR	791	12	794	1684	38.4%
SPRINGS MEMORIAL HOSP	693	7	928	2145	84.0%
CAROLINA PINES REG MED CTR	625	11	712	2820	70.2%
CLARENDON MEM.	563	8	599	1282	43.9%
MARION CO. MEM.	563				
PALMETTO BAPTIST MED CTR EASLEY	547	14	920	2163	42.3%
GEORGETOWN CO. MEM.	527	14	840	2786	54.5%
PROVIDENCE HOSP NE	520	6	602	1347	61.5%
HILTON HEAD REG MED CTR	510	7	587	1385	54.2%
OCONEE MEM.	506	16	1092	3423	58.6%
COLLETON REG MED CTR	419	6	449	1066	48.7%
ALLEN BENNETT MEM	393	5	411	966	52.9%
LAURENS CO. HOSP.	391	8	391	778	26.6%
KERSHAW CO. MED CTR	383	10	597	1497	41.0%
LORIS COMM. HOSP.	382	8	560	1322	45.3%
UPSTATE CAROLINA MED CTR	352	15	546	1278	23.3%
NEWBERRY CO. MEM.	294	12	425	801	18.3%
WACCAMAW COMM HOSPITAL	271	5	379	1248	68.4%
SAINT EUGENE MEDICAL CTR	256	10	421	1078	29.5%
MARLBORO PARK	189				
WALLACE THOMSON	135	4	217	590	40.4%
ABBEVILLE CO. MEM.	131	8	170	499	17.1%
CHESTERFIELD GENERAL	120	7	153	559	21.9%
BAMBERG CO. MEM.	99				
ALLENDALE CO.	97				
WILLIAMSBURG REG HOSP	68	6	86	178	8.1%
CHESTER CO.	18	5	0	68	3.7%

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Neonatal Services:

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

(a) Neonatal services should be planned on a regional basis with linkages with obstetrical services.
(b) Only Level III and RPCs neonatal units contain both intensive and intermediate care bassinets.

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

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

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

The above ratios were based on 80 low-birth weight (LBW) {2500 grams} births per 1,000 births. As indicated below, in 2003 South Carolina had 100.7 LBW births per 1,000 births, with a white rate of 76.1 and a nonwhite rate of 146.3 per 1,000. Because South Carolina has a significant higher number of LBW infants per 1,000 births, an alternative method was selected for determining the need for intensive care bassinets in RPCs.

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

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

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

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

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

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

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

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

The intermediate care ratios are:

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

The actual births in South Carolina have been:

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

The projected births have been:

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

The following projected need for neonatal intensive care bassinets is based on the actual number of 2003 births by race and the need projected at 65% occupancy rate using the incidence of low-birth weight babies by Perinatal Center. The planning factor of 65% occupancy will allow for a potential increase in births and the small number of bassinets. There is no need for additional Level III hospitals or RPCs, and any facility not meeting the licensing criteria should not be categorized as such.

Perinatal Region With Facility	Bassinets Needed at 65% Occupancy	Existing Bassinets
Greenville & Self Memorial	27	19
Spartanburg Regional	13	10
Palmetto Richland & Baptist	39	31
McLeod Regional	24	12
MUSC Medical Center	25	16
TOTAL	128	88

Note: S.C. presently has 1.6 neonatal intensive care bassinets and 5.9 neonatal intermediate care bassinets per 1,000 births.

A neonatal unit should have an average annual occupancy rate of 65%. Facilities providing neonatal services must meet licensing requirements and either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certification standards.

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Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Anderson, Greenville, Oconee, Pickens, Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda		
Palmetto Baptist Med Ctr Easley	0	2
Greenville Memorial Med Ctr	12	34
Anderson Area Medical Ctr	0	7
St. Francis Women's & Fam Hosp	0	10
Self Memorial Hospital	7	11
SUBTOTAL	19	64
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Med Ctr	10	15
Mary Black Memorial Hospital	0	8
SUBTOTAL	10	23
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Lee Kershaw, Lancaster, Orangeburg, York, Lexington, Newberry, Richland, Sumter		
Palmetto Richland Memorial	27	40
Palmetto Baptist Columbia	4	16
Lexington Medical Ctr.	0	20
Piedmont Medical Ctr. *	0	8
Springs Memorial Hospital	0	4
Aiken Regional Med. Ctr.	0	8
Reg Med Ctr Orangeburg-Calhoun	0	3
Tuomey	0	8
SUBTOTAL	31	107
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Reg. Med. Ctr.	0	4
Marion County Medical Ctr	0	2
McLeod Regional Medical Ctr	12	28
Conway Hospital	0	6
Grand Strand Regional	0	3
Women's Ctr. of Carolinas	0	11
SUBTOTAL	12	54

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

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Perinatal Region	EXISTING BASSINETS Intensive	Intermediate
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	3
Georgetown County Memorial	0	5
MUSC Medical Center	16	46
East Cooper Reg Med Ctr	0	6
Bon Secours-St. Francis Xavier	0	4
Summerville Medical Center	0	3
Trident Medical Center	0	5
Roper Hospital	0	5
SUBTOTAL	16	78
TOTAL	88	326

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

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

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

Perinatal Region	INTERMEDIATE BASSINETS Existing	Need	To Be Added
Greenville	64	72	8
Spartanburg	23	30	7
Richland	107	123	16
Florence	54	52	(2)
Charleston	78	84	6
TOTAL	326	361	35

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

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It should be noted that some RPC and Level III facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies. The Medical University may require additional bassinets since babies with congenital heart disease are referred there. The Medical University will document the need for any additional bassinets. The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

Relative Importance of Project Review Criteria

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

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

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

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The following chart indicates the utilization of neonatal special care units by facility. Some facilities are not using any of the intermediate care bassinets. This information is from the Joint Annual Reports of Hospitals-2003. This utilization information supports the projected need.

NEONATAL UTILIZATION FROM 2003 JARS

HOSPITAL	ICU Bassinets	ICU P.D.'s	ICU ADC	Intermediate Bassinets	Intermediate P.D.'s	Intermed ADC	Total Bassinets	Total P.D.'s	Total ADC	Total Occupancy
Anderson Area Med Ctr				7	794	2.2	7	794	2.2	31.1%
Greenville Memorial	12	5748	15.7	34	7876	21.6	46	13624	37.3	81.1%
St. Francis Women's				10	1215	3.3	10	1215	3.3	33.3%
Palmetto Baptist-Easley				2	0	0	2	0	0	0.0%
REGION SUBTOTAL	12	5748	15.7	53	9885	27.1	65	15633	42.8	65.9%
Spartanburg Regional	10	2864	7.8	15	5309	14.5	25	8173	22.4	89.6%
Mary Black Memorial				8	967	2.6	8	967	2.6	33.1%
REGION SUBTOTAL	10	2864	7.8	23	6276	17.2	33	9140	25.0	75.9%
Self Memorial	7	446	1.2	11	2015	5.5	18	2461	6.7	37.5%
REGION SUBTOTAL	7	446	1.2	11	2015	5.5	18	2461	6.7	37.5%
Palmetto Richland Mem	21	7661	21.0	40	9005	24.7	61	16666	45.7	74.9%
Lexington Medical Center				20	2209	6.1	20	2209	6.1	30.3%
Piedmont Medical Center				8	1070	2.9	8	1070	2.9	36.6%
Springs Memorial Hosp				4	0	0	4	0	0	0.0%
Palmetto Baptist Med Ctr	4 *	*		16 *	*		20	7013	19.2	96.1%
Tuomey Regional				8	0	0.0	8	0	0.0	0.0%
Reg Med Ctr Orangeburg				3	438	1.2	3	438	1.2	40.0%
Aiken Regional Med Ctr				8	541	1.5	8	541	1.5	16.5%
REGION SUBTOTAL	25	7661	21.0	107	13263	36.3	132	20924	57.3	43.4%
Women's Ctr of Carolinas				11	853	2.3	11	853	2.3	21.2%
McLeod Regional	12	5322	14.6	28	4935	13.5	40	10257	28.1	70.3%
Carolina Pines				4	0	0.0	4	0	0.0	0.0%
Marion Co Medical Ctr				2	0	0	2	0	0	0.0%
Grand Strand Regional				3	24	0.1	3	24	0.1	2.2%
Conway Hospital				6	621	1.7	6	621	1.7	28.4%
REGION SUBTOTAL	12	5322	14.6	54	6433	15.9	66	11755	32.2	48.6%
Georgetown Co Memorial				5	273	0.7	5	273	0.7	15.0%
MUSC Medical Center	16	5655	15.5	46	11654	31.9	62	17309	47.4	76.5%
Roper Hospital				5	259	0.7	5	259	0.7	14.2%
East Cooper Reg Med Ctr				6	0	0.0	6	0	0.0	0.0%
Trident Reg Med Center				5	745	2.0	5	745	2.0	40.8%
Bon Secours-St. Francis				4	222	0.6	4	222	0.6	15.2%
Summerville Med. Ctr.				3	0	0.0	3	0	0.0	0.0%
Beaufort Memorial Hosp				3	70	0.2	3	70	0.2	6.4%
SUBTOTAL	16	5655	15.5	77	13223	36.0	93	18878	51.7	55.6%
GRAND TOTAL	82	27696	75.9	325	51095	138.1	407	78791	215.9	53.0%

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

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(C) Pediatric Inpatient Services:

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

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

Relative Importance of Project Review Criteria

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

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

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

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(D) Cardiovascular, Cerebrovascular and Associated Heart Disease

OVERVIEW

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. The heart requires oxygen and nutrients supplied through the coronary arteries in order to function. If the blood supply becomes inadequate, it can result in infarction, or death of the heart muscle {myocardium}.

The usual cause of a heart attack is arteriosclerosis, the accumulation of fat-filled cells {plaque} on the inner walls of blood vessels. Plaque narrows the blood flow through the coronary arteries and reduces blood flow to the heart muscle. Should a plaque crack or rupture, a blood clot {thrombus} forms on top of the plaque in order to repair the damage. However, if the blood clot is big enough to block all blood flow through the artery, the myocardium will not receive the oxygen needed and the muscle cells die. If blood flow is not quickly restored to the dying heart muscle, the victim will die. The amount of heart muscle that is damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive. Approximately 1/3 of all heart attacks are fatal; survivors may develop congestive heart failure or other problems.

Ambulances and Emergency Rooms are better equipped to treat these victims. Doctors are now able to limit heart damage through medications such as aspirin, nitroglycerin, beta-adrenergic blocking agents (beta blockers), and heparin (blood thinner). Drugs such as t-PA and streptokinase, which can dissolve blood clots and stop heart attacks, are often successful if administered within 6 hours of the onset of heart attack symptoms, although they do have a risk of bleeding complications. In addition, restoring blood flow to the dying heart muscle (reperfusion) by breaking up the blood clot through angioplasty or by grafting blood vessels from other body parts to construct a detour around the blockage have greatly improved survival rates.

Electron Beam Computer Tomography (EBCT) is a promising technology for predicting the likelihood of a heart attack. It is a non-invasive scanner that produces cross-sectional pictures depicting the presence amount of calcium in the coronary arteries. Calcium is an indicator of atherosclerosis; plaque rupture is the major mechanism for sudden coronary death. EBCT may be used for examining emergency room patients reporting chest pain. If the scan shows no calcification, patients are at low risk of having a heart attack. It may also be used for early detection of coronary artery disease of asymptomatic persons. The scanners cost approximately $1.8 million. The test costs $425-475, but most insurance companies do not yet cover it.

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

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

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

Percutaneous Transluminal Coronary Angioplasty (PTCA) is the most common PCI. Percutaneous Transluminal Coronary Angioplasty (PTCA) is the most common therapeutic procedure. A balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. Although the success rate for single-lesion dilation is 90-95%, the mortality rate is about 1% and severe complications requiring open heart surgery occur in 1-4%. In addition, nearly 20% of patients initially successfully treated experience re-narrowing within 3-6 months, requiring open heart surgery.

Another common therapeutic intervention is the coronary stent, often used in conjunction with a PTCA. When using a stent, an expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Stenting is successful in 95-98% of patients, with emergency bypass surgery required for less than 1%. The re-stenosis rate for coronary stenting may be lower, although it occurs in approximately 16% of patients. In addition, there is a risk of blood clots, which form in 1-2% of patients, which can cause a heart attack. After coronary stenting, patients must use a combination of blood-thinning medicines.

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

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

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requires the temporary use of a heart-lung bypass machine to perform the normal functions of the heart and lungs during surgery. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases. The saphenous vein from the leg or the internal mammary artery from the chest is extracted from the patient and grafted to bypass a constricted section of 1 or more of the coronary arteries. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. Mortality rates have declined significantly since its introduction, but CABG still carries significant risks. CABG surgery requires sawing through the breastbone and prying open the ribcage, resulting in a 1-week hospital stay and up to 2 months recuperation.

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

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

STATUS OF SOUTH CAROLINA PROVIDERS

1. CARDIAC CATHETERIZATIONS

The Certificate of Need standards for cardiac catheterization require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 32 hospitals approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Of these, 24 programs exceeded the minimum of 600 equivalents per lab. Bon Secours St. Francis Xavier, Oconee Memorial Hospital, and Mary Black Memorial Hospital fell below the minimum. Carolina Pines Regional received a CON to replace their mobile lab with a fixed lab. Beaufort Memorial Hospital received a CON to establish a diagnostic lab on 6/6/02. Colleton Medical Center received a

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

There are currently 16 open heart surgery programs approved for the general public in South Carolina, as well as the Veterans Administration (VA) Hospital in Charleston. These are the only facilities approved to perform therapeutic catheterizations. They should be performing a minimum of 300 therapeutic caths annually within 3 years of initiation of service. All of the programs that had been operational for 3 full years performed the minimum number of therapeutic caths in 2003.

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

There is a lack of available data to measure the quality of care provided by the facilities offering cardiac catheterization services in South Carolina. Comparing the utilization of these facilities with national and state standards can make an approximation of quality. In general, the providers of cardiac catheterization are in compliance with these standards. In 2003, 24 of the 27 facilities that have been offering cardiac caths for more than 3 years provided more than the minimum standard of 600 diagnostic equivalents per lab. Every established facility providing therapeutic catheterizations exceeded the minimum requirement of 300 procedures annually by the third year of operation.

2. OPEN HEART SURGERY

The number of open heart surgeries performed in South Carolina decreased from 6,279 in 2002 to 5,952 in 2003. There are 16 approved open heart surgery programs in South Carolina. Self Memorial and Anderson Area began in 2001, and Hilton Head Hospital began operation in 2002. Because these facilities had not completed 3 full years of operation, it is not possible to evaluate their performance compared to the Certificate of Need and literature standards.

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

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

Studies indicate that hospitals that perform a minimum of 350 cases annually tend to have better outcomes than those that perform fewer cases. In 2003, 8 of the 13 established programs performed more than 350 total surgeries; Trident Regional performed 304, Piedmont Regional performed 232, St. Francis performed 182, Aiken performed 128, and Carolinas Hospital System performed 87.

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MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2003, 238 pediatric open heart surgeries were performed there.

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

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Certificate of Need Standards for Cardiac Catheterization

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

35.96 Percutaneous Valvuloplasty
36.01 Atherectomy, Coronary, PTCA, Single Vessel, Without Mention of Thrombolytic Agent
36.02 Atherectomy, Coronary, PTCA, Single Vessel, With Thrombolytic Agent
36.05 Atherectomy, Coronary, PTCA, Multiple Vessel, With or Without Thrombolytic Agent
36.06 Insertion of Coronary Artery Stent(s)
36.07 Insertion of Drug Eluting Coronary Artery Stent(s)

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

STANDARDS

(1) The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Diagnostic catheterizations (ICD-9-CM Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Codes 35.96, 36.01, 36.02, 36.05, 36.06, and 36.07) and pediatric catheterizations shall be weighted as 2.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

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

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

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(4) An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

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

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

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

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

(6) Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 500 procedures per year on the additional equipment within three years of its implementation.

(7) Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PCI and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is considered to be a contraindication for PCI, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart, or abnormalities in the heart structure, shall not be allowed to perform PCI and other therapeutic procedures, unless they comply with all sections of standard 8.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Patient Selection Guidelines

a. Avoid intervention in hemodynamically stable patients with:

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

b. Transfer for emergent aortocoronary bypass surgery patients with:

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

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

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

B. an applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

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

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

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

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

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

(13) Documentation of need for the proposed service:

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

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

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

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

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

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

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

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

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

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

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

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

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SCOPE OF SERVICES

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

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

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

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

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

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

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

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

a. Compliance with the Need Outlined in this Section of the Plan;

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

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

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

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

The benefits of improved accessibility will not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 PEDS TOTAL	FY02 ADULTS: DIAG	FY02 ADULTS: THERP	FY02 PEDS TOTAL	FY03 ADULTS: DIAG	FY03 ADULTS: THERP	FY03 PEDS TOTAL
I										
ANDERSON AREA MEDICAL CTR #1	3	2060	137	2237	2075	610	3888	1838	711	2549
GREENVILLE MEMORIAL MED CTR #2	7	4580	2225	6805	5374	1999	7373	5918	2137	8055
MARY BLACK MEMORIAL	1	305		305	228		228	128		128
OCONEE MEMORIAL HOSPITAL	1	786		786	764		764	572		572
PALMETTO BAPTIST MED CTR-EASLEY	1	418		418	656		656	672		672
SPARTANBURG REG MED CTR #3	4	3030	678	3708	2713	568	3281	2069	965	3384
ST FRANCIS COMMUNITY HOSPITAL	2	1167	438	1605	1186	327	1493	1435	483	1918
TOTAL AREA I		12376	3478	15854	13974	3504	16478	13252	3996	17248
II										
KERSHAW COUNTY MEDICAL CTR #4	1									
LEXINGTON MEDICAL CENTER #5	1				670		670	1114		1114
PALMETTO HEALTH BAPTIST	1	858		858	660		660	712		712
PALMETTO HEALTH RICHLAND MEMORIAL	4	1783	674	2457	1723	665	2388	1723	686	2409
PIEDMONT MEDICAL CENTER #6	3	2581	639	3220	3053	928	3981	2578	1007	3585
PROVIDENCE HOSPITAL #7	9	3849	2195	6041	3748	2308	6052	3799	2878	6673
SELF MEMORIAL HOSPITAL	2	600		600	1056	35	1091	1283	184	1467
SOUTH CAROLINA HEART CENTER #8	2			0			0			0
SPRINGS MEMORIAL HOSPITAL #9	1	568		568	758		758	691		691
TOTAL AREA II		10033	3508	13979	11668	3934	15942	12139	4760	16899
III										
CAROLINA PINES REGIONAL MED CTR #10	1	177		177	431		431	477		477
CAROLINAS HOSPITAL SYSTEM	2	1305		1305	955	156	1112	994	131	1125
CONWAY HOSPITAL	1	584		584	857		857	788		788
GEORGETOWN MEMORIAL HOSPITAL #11	1	910	19	929	904	29	933	672	33	705
GRAND STRAND REGIONAL MED CTR	2	1113	932	2045	1132	1078	2210	1029	1034	2063
LORIS COMMUNITY HOSPITAL #12	1									
MCLEOD REGIONAL MEDICAL CTR	4	3304	753	4057	3247	867	4114	3130	841	3971
TUCKEY HOSPITAL	1	727		727	764		764	686		686
TOTAL AREA III		7820	1704	9524	7981	2130	10111	7726	2069	8795

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CARDIAC CATHETERIZATION PROCEDURES:

REGION/FACILITY	ADULT # CATH LABS	FY01 ADULTS: DIAG	FY01 ADULTS: THERP	FY01 ADULTS: TOTAL	FY01 PEDS	FY02 ADULTS: DIAG	FY02 ADULTS: THERP	FY02 ADULTS: TOTAL	FY02 PEDS	FY03 ADULTS: DIAG	FY03 ADULTS: THERP	FY03 ADULTS: TOTAL	FY03 PEDS
IV													
AIKEN REGIONAL MEDICAL CTR	1	660	508	1168		1238	375	1608		1147	323	1470	
BEAUFORT MEMORIAL HOSPITAL #13	1									82		82	
BON SECOURS ST. FRANCIS XAVIER	1	180		180		189		189		185		185	
COLLETON MEDICAL CENTER #14	MOBILE												
HILTON HEAD REGIONAL MED CTR #15	2	1044	128	1172		1015	123	1138		784	361	1145	
MEDICAL UNIVERSITY HOSPITAL #16	6	1551	583	2134	970	1317	610	2127	992	1962	610	2572	1349
RMC ORANGEBURG-CALHOUN	1	813		813		968		968		774		774	
ROPER HOSPITAL	3	2626	644	3269		2600	659	3259		2824	792	3616	
TRIDENT MEDICAL CENTER	2	1691	569	2260		1868	601	2496		1210	544	1754	
TOTAL AREA IV		8774	2430	9646		9385	2368	9956		9968	2630	9881	
TOTAL		39003	11120	48002		42203	11938	51567		42085	13447	52904	

#1 CON FOR 3RD CATH W/ THERAPEUTIC, 11/2/99.
#2 CON TO REPLACE AN EXISTING CATH LAB AND MAINTAINING 7 CATHS WITH 5 AT GMH AND 2 AT MEMORIAL MEDICAL OFFICE, 7/3/00.
#3 CON FOR 4TH CATH LAB, 11/13/01.
#4 CON ISSUED 6/11/19/04.
#5 CON ISSUED FOR FIXED CATH, 1/30/01 SC-01-06.
#6 CON FOR 3RD CATH AND REPLACEMENT OF THE 2 EXISTING CATHS 11/4/03 SC-03-64.
#7 CON FOR 6TH CATH, 03/18/02 SC-02-19.
#8 DOCTORS OFFICE, NOT A LICENSED ASF.
#9 CON TO REPLACE MOBILE W/ FIXED CATH, 07/12/01.
#10 CON FOR FIXED TO REPLACE MOBILE 6/20/01; BEGAN FIXED 4/12/02.
#11 FACILITY IS NOT APPROVED TO DO ANGIOPLASTY.
#12 CON ISSUED 6/2/04.
#13 CON FOR DIAGNOSTIC CATH LAB, 6/6/02.
#14 CON FOR MOBILE 1 DAY/WK, 4/15/03 SC-03-18.
#15 CON FOR 2ND CATH SC-01-06 1/13/01 AND CON ISSUED FOR THERAPEUTIC CATH PROGRAM 7/15/02 SC-02-41.
#16 CON ISSUED FOR 2 ADDITIONAL ADULT CATH LABS FOR A TOTAL OF 5 ADULT & 1 PED, SC-01-13 3/12/01.

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Certificate of Need Standards for Open Heart Surgery

DEFINITIONS

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

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

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

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

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

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

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

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

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(5) treatment of cardiac traumas.

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

STANDARDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(8) The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

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

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

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

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

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

SCOPE OF SERVICES

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

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

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

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

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

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

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

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

The Department makes the following findings:

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

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

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

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

(5) Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. As components of the Certificate of Need program, the Department is charged with guiding the establishment of health facilities and services which will best serve public needs and ensure that high quality services are provided in health facilities in this State.

Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflect an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

Therefore, the Department staff is directed to evaluate low-volume open heart surgery providers to monitor their progress and recommend to the State Health Planning Committee any changes deemed necessary by staff.

(6) The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

The benefits of improved accessibility will not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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REGION/FACILITY	FY00			FY01		FY02		FY03	
	# OPEN HEART UNITS	ADULTS	PEDS	ADULTS	PEDS	ADULTS	PEDS	ADULTS	PEDS
I									
ANDERSON AREA MED CTR	2			94		312		243	
GREENVILLE MEM MED CTR #1	4	1379		1147		936		844	
ST FRANCIS HOSPITAL	2	221		224		164		182	
SPARTANBURG REG MED CTR	2	599		628		587		546	
II									
PIEDMONT MEDICAL CTR	2	248		257		232		232	
PROVIDENCE HOSPITAL	4	1057		970		949		969	
PALMETTO HEALTH RICHLAND	2	486		443		499		425	
SELF MEMORIAL HOSPITAL	2					140		132	
III									
CAROLINAS HOSPITAL SYSTEM	2	88		122		139		87	
MCLEOD REGIONAL MED CTR	3	608		495		495		359	
GRAND STRAND REG MED CTR	2	278		358		401		432	
IV									
AIKEN REGIONAL MED CTR	1	113		125		128		142	
HILTON HEAD REG MED CTR #2	1							91	
MEDICAL UNIVERSITY HOSP	3	465	186	634	249	447	223	497	238
ROPER HOSPITAL	2	650		557		533		467	
TRIDENT REGIONAL MED CTR	1	283		310		317		304	
VA HOSP (CHARLESTON)	1								
				6372		6279		6952	

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

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RECORD 004063

(E) Cancer

OVERVIEW

Cancer is a group of many related diseases. All forms of cancer involve out-of-control growth and spread of abnormal cells. Normal cells of most tissues only divide to replace dying cells or to repair injuries. However, cancer cells continue to grow and divide, and can spread to other parts of the body. These cells accumulate and form tumors that invade and destroy normal tissue. Cells can break away from tumors through the blood stream or lymph system and form tumors in other parts of the body, a process known as Ametastasis. Cancer is classified by the part of the body in which it began, and by its appearance under a microscope. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment.

Cancer is the second leading cause of death, both nationally and South Carolina, accounting for approximately 22% of all deaths. It is estimated that there were 17,375 new cases of cancer diagnosed in South Carolina in 2002 and 7,730 cancer deaths. The most common types of cancer deaths are lung, colon/rectum, breast, and prostate.

Screening and self-examinations can result in the detection of cancers at earlier stages. The earlier the cancer is identified and treated, the greater the likelihood of successful treatment. The survival rate is much higher for cancers treated in situ (non-invasive earliest stage) than those that have metastasized to other locations. The overall relative 5-year survival rate, adjusted for normal life expectancy, is approximately 58%.

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

It is the primary treatment for many kinds of cancer in almost any part of the body. Internal radiation therapy uses a radioactive pellet that is sealed in an implant, which is placed directly into or near the tumor. Another form uses unsealed doses that are taken orally or by injection. External radiation requires a machine that directs high-energy rays at the cancer and some normal surrounding tissue.

There are 2 pieces of radiation therapy equipment reviewed under the Certificate of Need Program in South Carolina. They are:

1. LINEAR ACCELERATORS

The linear accelerator uses microwave technology to accelerate electrons and then allows these electrons to collide with a heavy metal target. As a result of these collisions, high energy x-rays are scattered from the target. The accelerator must sit in a room with lead and concrete walls to keep the rays from escaping. A portion of these x-rays is collected to form a beam that matches the size and

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RECORD 004064

shape of the patient's tumor. The patient lies on a movable couch. Radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry and moving the couch.

Linear accelerator treatments are usually performed on an outpatient basis. The total prescribed tumor-lethal dosage is divided into smaller doses called fractions, which are administered 5 days a week for 2-8 weeks, with weekend rest breaks to allow normal cells to recover. These sessions generally last about 15 minutes.

Minimal equipment requirements for a linear accelerator include:

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

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

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

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

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

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

g. field-shaping capability; and

h. access to CT scanning capability.

A realistic load for a megavoltage unit is 5,600 treatments per year. This measurement is based upon an average of 22 patients treated per day, 5 days per week, 51 weeks per year, allowing time for scheduled maintenance, portal filming, field checks, etc. The average treatment time for linear accelerator treatment can be longer because of highly specialized radiation therapy techniques such as total body irradiation, Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiosurgery, or for treating children. A facility providing such specialized treatment may not be able to average treating as many patients per day because of the longer treatment time per patient. Therefore, a lower measurement of functional capacity may be appropriate for such a facility.

2. GAMMA KNIFE

Stereotactic radiosurgery is an evolving technique of using radiant energy to treat brain tumors. The radiation damages the genetic code of the tumor, preventing it from replicating and causing it to slowly shrink. Patients routinely use only a local anesthesia with a mild sedative while undergoing

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the procedure. The gamma knife consists of a large 20 ton shield surrounding a circular or hemispheric array of 201 cobalt-60 beam channels, resembling a giant hair dryer.

The entire procedure takes about 3-4 hours, depending on complexity. First, a rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system then develops a treatment plan to position the patient for treatment and the paths and doses of radiation. When the plan is ready, the patient is positioned for treatment with the head affixed to the couch, and the treatment is delivered.

The gamma knife has a high success rate for certain types of tumors and avoids the complication risks of traditional neurosurgery. However, not many tumors qualify for gamma knife radiosurgery; most are too large to be safely treated this way and require conventional surgery. The targets must be small and far enough away from vital structures to avoid damaging healthy tissue.

A gamma knife costs approximately $3.5 million with installation costs of another $0.5 million, plus a further $0.5 million every 4-5 years to replenish the cobalt-60. As a result of the high costs and limited uses of the machine, average charges exceed $20,000, excluding physician's fees. However, this must be balanced against the overall charges for conventional neurosurgery. Experts estimate that a minimum caseload of 150 cases per year is needed for the unit to be financially viable. A less expensive alternative is to modify a standard linear accelerator (at a cost of about $300,000 above the initial cost of the machine) to allow it to perform radiosurgery; similar results are reported for these two technologies.

STATUS OF SOUTH CAROLINA PROVIDERS

1. LINEAR ACCELERATORS

There are currently 24 facilities either operating or approved for a total of 45 linear accelerators in South Carolina. This analysis will focus on the 42 accelerators that were in operation during 2003. The capacity of a linear accelerator is stated as 7,000 treatments per year, and a realistic load is 5,600 treatments per year (80% of capacity). For 2003, the 42 existing accelerators averaged 5,713 treatments per unit (81.6% of overall capacity). The utilization for each provider per linear accelerator was:

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

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

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

2. GAMMA KNIFES

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

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

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MEGAVOLTAGE VISITS

REGION	# UNITS	FY2001	FY2002	FY2003
I				
ANDERSON CO:				
ANDERSON AREA MEDICAL CTR				
LINEAR ACCELERATOR #1	2	12880	12937	13728
GREENVILLE CO:				
CANCER CENTERS OF THE CAROLINAS EASTSIDE				
LINEAR ACCELERATOR	1	9863	8343	9687
GREENVILLE MEMORIAL MEDICAL CTR				
LINEAR ACCELERATORS	3	19058	13074	16312
CANCER CENTERS OF THE CAROLINAS				
LINEAR ACCELERATOR	1	9007	8245	6092
CHEROKEE CO:				
GIBBS REGIONAL CANCER CENTER	1			
SATELLITE #2				
OCONEE CO:				
CANCER CENTERS OF THE CAROLINAS	1			
OCONEE COUNTY				4790
SPARTANBURG CO:				
SPARTANBURG REGIONAL MED CTR				
LINEAR ACCELERATORS	3	16648	18552	17611
II				
LEXINGTON CO:				
LEXINGTON MEDICAL CENTER				
LINEAR ACCELERATOR	2	9278	11810	15026
RICHLAND CO:				
PALMETTO HEALTH BAPTIST #3				
LINEAR ACCELERATORS	(2)	14742	14888	17190
PALMETTO HEALTH RICHLAND				
LINEAR ACCELERATORS	4	16842	17937	14419
GAMMA KNIFE	1	128	102	170
NEWCO #3				
LINEAR ACCELERATORS	2			
GREENWOOD CO:				
SELF MEMORIAL #4				
LINEAR ACCELERATOR	2	5911	6344	6998

PMC.2013.SHP.0554

PET-EX008.0071

RECORD 004068

MEGAVOLTAGE VISITS

REGION	# UNITS	FY2001	FY2002	FY2003
YORK CO:				
ROCK HILL RADIATION THERAPY CENTER LINEAR ACCELERATOR	2	11882	11125	11568
III				
FLORENCE CO:				
CAROLINAS HOSPITAL SYSTEM	1	8519	7197	7883
MCLEOD REGIONAL LINEAR ACCELERATORS	4	18398	17601	17124
HORRY CO:				
CAROLINA REGIONAL RADIATION CENTER LINEAR ACCELERATORS	2	15037	15408	17626
SUMTER:				
TUOMEY LINEAR ACCELERATOR	2	8435	8402	8884
GEORGETOWN CO:				
GEORGETOWN MEMORIAL HOSP #5	1			
IV				
CHARLESTON CO:				
MEDICAL UNIVERSITY #6 LINEAR ACCELERATORS	3	12484	14949	13328
ROPER HOSPITAL LINEAR ACCELERATOR	2	15325	12545	12237
TRIDENT MEDICAL CENTER LINEAR ACCELERATOR	2	12083	13001	12160
ORANGEBURG CO:				
REG MED CTR ORANGEBURG/CALHOUN LINEAR ACCELERATOR	1	5522	7185	6849
BEAUFORT CO:				
BEAUFORT/HILTON HEAD RADIATION ONCOLOGY CENTER LINEAR ACCELERATOR	1	7049	6518	5410
BEAUFORT MEMORIAL HOSPITAL #7	1			

PMC.2013.SHP.0555

PET-EX008.0072

RECORD 004069

MEGAVOLTAGE VISITS

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

#1 REPLACE ONE LA , 5/22/02: CON SC-03-07 TO MOVE THE 2 LAS FROM HOSP TO OP TREAMENT CTR ON CAMPUS & REPLACE 1 LA, 2/12/03.
#2 APPROVED FOR 1LA 3/31/03. APPEALED
#3 APPROVED TO TRANSFER & REPLACE 2 LAS FROM BAPTIST & TO TRANSFER OWNERSHIP OF 4 LAS FROM PAL RICHLAND 11/12/03 SC-03-68.
#4 CON FOR 2nd LA , 2/11/02 SC-02-14
#5 CON ISSUED 3/15/01
#6 CON TO MOVE & REPLACE EXISTING LA TO MT PLEASANT 7/08/03 SC-03-38
#7 CON SC-03-24 4/29/03

PMC.2013.SHP.0556

PET-EX008.0073

RECORD 004070

LINEAR ACCELERATORS

2004 Plan

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

PMC.2013.SHP.0557

PET-EX008.0074

RECORD 004071

Certificate of Need Standards for Linear Accelerators

STANDARDS

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

(2) There are 13 service areas established for megavoltage therapy units as shown on the preceding chart.

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

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

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

Each individual or average

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

BASS — Adverse impact not at issue

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

(6) The applicant must affirm the following:

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

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

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

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

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

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

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

The benefits of improved accessibility will not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PMC.2013.SHP.0559

PET-EX008.0076

RECORD 004073

Certificate of Need Standards for Gamma Knifes

STANDARDS

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

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

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

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

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

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

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

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

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

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

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

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

PMC.2013.SHP.0560

PET-EX008.0077

RECORD 004074

(8) The applicant must affirm the following:

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

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

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

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

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

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

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

The benefits of improved accessibility will not outweigh the adverse affects of duplication in evaluating Certificate of Need applications for this service.

PMC.2013.SHP.0561

PET-EX008.0078

RECORD 004075

(F) Diagnostic Imaging

1. Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging (MRI) uses radio waves, high magnetic fields and a powerful computer to create diagnostic images useful for detecting disease states. MRI produces spatial resolution and tissue contrast without the use of ionizing radiation, such as X-rays, or iodinated compound injections.

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

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

Capital costs for a fixed MRI unit; depending upon the type of magnet, range from approximately $500,000 to $2,500,000. Special radiofrequency shielding may be required to prevent the magnet from interfering with other electrical equipment and/or to prevent radio frequency interference from outside sources. MRI is contraindicated for patients with metal surgical implants and pacemakers, or who are on life support equipment. A new generation of MRIs with an open design has been developed to alleviate the concerns of patients who physically do not fit into an MRI unit and those who experience a claustrophobic reaction to the confined space of a regular MRI.

Certificate of Need Standards for Magnetic Resonance Imaging (MRI)

STANDARDS

(1) Each hospital should have at least one MRI unit available for diagnosis of emergency patients, inpatients and outpatients.

(2) In order to promote cost-effectiveness, the use of shared mobile MRI units should be considered.

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

PMC.2013.SHP.0562

PET-EX008.0079

RECORD 004076

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

a. Community Need Documentation;
b. Distribution (Accessibility);
c. Acceptability; and
d. Cost Containment.

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

PMC.2013.SHP.0563

PET-EX008.0080

RECORD 004077

MRI SCANS

COUNTY	FACILITY	TYPE	FY02 CON SCANS	FY03 CON SCANS
ABBEVILLE	ABBEVILLE CO MEM HOSP	MOBILE	507	563
AIKEN	AIKEN MEDICAL IMAGING, L.P.	FIXED		closed 1/02
AIKEN	AIKEN NEUROSCIENCES, PC	FIXED	1516	1575
AIKEN	AIKEN REG MED CTR	FIXED	2240	2415
AIKEN	CAROLINA MUSCULOSKELETAL ASSOC	2 FIXED	1159	2082
AIKEN	IMAGING CTR OF AIKEN #2	FIXED	2138	0
ALLENDALE	ALLENDALE CO HOSPITAL	MOBILE		0
ANDERSON	ANDERSON AREA MED CTR	3 FIXED	6182	7951
ANDERSON	ANDERSON DIAGNOSTIC IMAGING	FIXED & MOBILE	3281	3083
ANDERSON	BLUE RIDGE ORTHOPEDIC ASSOC	FIXED		
BAMBERG	BAMBERG CO MEM HOSPITAL	MOBILE		0
BARNWELL	BARNWELL CO HOSPITAL	MOBILE		0
BEAUFORT	BEAUFORT MEM HOSP	FIXED & MOBILE	3599	2787
BEAUFORT	BEAUFORT IMAGING CENTER	FIXED	1130	1570
BEAUFORT	BEAUFORT ORTHOPEDIC &SPORTS MED	MOBILE	159	112
BEAUFORT	HEALTHSOUTH DIAG CTR HILTON HEAD	FIXED	2413	1240
BEAUFORT	HILTON HEAD REGIONAL MEDICAL CTR	FIXED	363	522
BEAUFORT	LOWCOUNTY MEDICAL GROUP PORT ROYAL	FIXED & TEMP MOBILE	1438	1684
BEAUFORT	MRI AT BELFAIR	FIXED	1256	2367
BEAUFORT	NEUROLOGICAL INSTITUTE HILTON HEAD	FIXED	357	350
BEAUFORT	SOUTHERN MRI -HILTON HEAD	FIXED	1698	1486
BEAUFORT	SOUTHERN MRI, LLC	2FIXED	2662	1177
CHARLESTON	BON SECOURS ST FRANCIS XAVIER	FIXED	1950	2655
CHARLESTON	CHARLESTON PHYSICIANS IMAGING CTR	FIXED	2410	1963
CHARLESTON	DISC RADIOLOGISTS	MOBILE		2635
CHARLESTON	EAST COOPER DIAGNOSTIC IMAGING	MOBILE	1639	507
CHARLESTON	FARMFIELD DIAGNOSTIC IMAGING	FIXED	2839	
CHARLESTON	MEDICAL RESOURCES, INC -EAST COAST	MOBILE		0
CHARLESTON	MEDICAL RESOURCES, INC -FAMILY CHIRO	MOBILE		0
CHARLESTON	MEDICAL UNIVERSITY HOSP	3 FIXED	7714	8826
CHARLESTON	ORTHOPAEDIC SPECIALISTS CHARLESTON	MOBILE		0
CHARLESTON	ROPER DIAGNOSTIC CTR-FARMFIELD #3	FIXED	2038	
CHARLESTON	ROPER HOSPITAL	FIXED	5814	6055
CHARLESTON	SOUTHEASTERN SPINE INSTITUTE	FIXED		0
CHARLESTON	TRICOM DIAGNOSTIC IMAGING	FIXED	2061	8813
CHARLESTON	TRIDENT MEDICAL ARTS MRI	2 FIXED		
CHARLESTON	TRIDENT MEDICAL CTR	FIXED	10193	10481
CHARLESTON	UMA AMBULATORY CARE FACILITY	FIXED		
CHARLESTON	UNIVERSITY MEDICAL ASSOCIATES	FIXED		
CHARLESTON	WEST ASHLEY DIAGNOSTIC IMAGING #1	FIXED	735 see note	
CHEROKEE	UPSTATE CAROLINA MED CTR	FIXED	1295	1322
CHESTER	CHESTER CO HOSP	MOBILE	344	359
CHESTERFIELD	CHESTERFIELD GEN HOSP	MOBILE	282	147
CLARENDON	CLARENDON MEM HOSP	MOBILE	988	897
CLARENDON	MANNING DIAGNOSTICS	MOBILE		0
COLLETON	COLLETON REG HOSP	FIXED	1955	2180
DARLINGTON	CAROLINA PINES REG MED CTR	FIXED	2036	2143
DARLINGTON	WILSON MED CTR	MOBILE	59	0
DILLON	ACCIDENT AND INJURY CLINIC	MOBILE		0
DILLON	ST. EUGENE MED CTR	FIXED	781	1123
DORCHESTER	SUMMERVILLE MEDICAL CENTER	2 FIXED	1845	1360
FLORENCE	ACCIDENT AND INJURY CLINIC	MOBILE		0
FLORENCE	CAROLINAS HSP SYS	FIXED	2709	3258
FLORENCE	CAROLINAS HSP SYS LAKE CITY	MOBILE	312	396
FLORENCE	COMPREHENSIVE NEUROLOGICAL IMAGING	MOBILE	106	284
FLORENCE	INMED DIAGNOSTIC SERVICES	FIXED	3025	2137
FLORENCE	MCLEOD REG MED CTR	3 FIXED	6812	7194
FLORENCE	OPEN MRI & IMAGING OF FLORENCE	FIXED	4395	4109
GEORGETOWN	GEORGETOWN MEM HOSP	FIXED	3330	2318
GEORGETOWN	WACCAMAW COMM HOSP	FIXED		640
GREENVILLE	ALLEN BENNETT HOSP	MOBILE	853	1122

PMC.2013.SHP.0564

PET-EX008.0081

RECORD 004078

MRI SCANS

COUNTY	FACILITY	TYPE	FY02 CON SCANS	FY03 CON SCANS
GREENVILLE	CAROLINA ORTHAPEDIC CTR	FIXED	31	437
GREENVILLE	DIAGNOSTIC CENTERS OF CAROLINAS	MOBILE		0
GREENVILLE	GHS/EASTSIDE ACS	MOBILE		
GREENVILLE	GREENVILLE MEM HOSP	3 FIXED &	6082	7343
GREENVILLE	GREENVILLE PHYSICIANS IMAGING CTR	2 FIXED	2252	1750
GREENVILLE	GREENVILLE RADIOLOGY, PA	FIXED	2722	3666
GREENVILLE	HEALTHSOUTH DIAG CTR GREENVILLE	FIXED	5532	5045
GREENVILLE	HILLCREST HOSP	MOBILE	937	917
GREENVILLE	NEUROLOGY ASSOC OF GREENVILLE	MOBILE	625	559
GREENVILLE	OAKWOOD ORTHOPEDIC CLINIC	MOBILE	425	507
GREENVILLE	OPEN MRI OF SIMPSONVILLE	FIXED	2017	2478
GREENVILLE	OPEN MRI SIMPSONVILLE, LLC	MOBILE		2478
GREENVILLE	PIEDMONT ORTHOPAEDICS	FIXED	1413	1338
GREENVILLE	SE NUEROSURGICAL & SPINE INSTITUTE #4	MOBILE	905 see note	
GREENVILLE	ST. FRANCIS HOSPITAL	2 FIXED	2135	2150
GREENVILLE	ST. FRANCIS WOMAN'S & FAMILY HOSP	FIXED	1073	1044
GREENVILLE	THE FAMILY PRACTICE	MOBILE		0
GREENWOOD	LAKELANDS ORTHOPAEDIC CLINIC	MOBILE	691	654
GREENWOOD	PIEDMONT NEUROLOGY ASSOCIATES	MOBILE		
GREENWOOD	SELF MEM HOSP	2 FIXED	4950	5193
HAMPTON	HAMPTON REG MED CTR	MOBILE	0	0
HORRY	COASTAL ORTHOPAEDIC ASSOC	FIXED	599	201
HORRY	CONWAY HOSP	FIXED	3190	3627
HORRY	GRAND STRAND REG MED CTR	FIXED	4136	3704
HORRY	INMED DIAGNOSTIC SERVICES	FIXED		738
HORRY	LORIS COMM HOSP	FIXED	2090	2517
HORRY	MYRTLE BEACH MRI	FIXED	closed 7/03	
HORRY	LONG BAY DIAGNOSTIC IMAGING	FIXED	3084	3768
HORRY	LONG BAY DIAGNOSTIC IMAGING	MOBILE		
HORRY	SEACOAST MED CTR #5	FIXED	1231 see note	
HORRY	SOUTH STRAND AMB CARE CTR	FIXED	1649 closed 5/04	
HORRY	STRAND REG SPECIALTY ASSOC, LLC	FIXED	2763	2340
KERSHAW	KERSHAW CO MEM HOSP	FIXED	1299	1491
LANCASTER	LANCASTER IMAGING CTR	FIXED		
LANCASTER	SPRINGS MEMORIAL HOSP	FIXED	1988	1895
LAURENS	LAURENS CO HOSP	MOBILE	426	354
LAURENS	LAURENS CO ORTHOPEDIC ASSOC	FIXED	1650	1540
LEXINGTON	CAROLINA NEURO SPECIALISTS	MOBILE		0
LEXINGTON	LEXINGTON MED CTR	2 FIXED	4926	6796
LEXINGTON	LEXINGTON MED CTR-IRMO #6	FIXED	see note	
LEXINGTON	LEXINGTON MED CTR-LEXINGTON #5	FIXED	see note	
LEXINGTON	LEXINGTON OPEN MRI	FIXED	4327	4319
MARION	MARION CO MEDICAL CTR	MOBILE	1467	1575
MARLBORO	MARLBORO PARK	MOBILE	256	268
NEWBERRY	NEWBERRY CO MEM HOSP	MOBILE		504
OCONEE	BLUE RIDGE ORTHOPEDIC ASSOC	FIXED	122	678
OCONEE	MOUNTAINVIEW RADIOLOGY,PA	FIXED	2382	2097
OCONEE	OCONEE MEM HOSP	FIXED	2567	2815
ORANGEBURG	ADVANCED DIAGNOSTIC IMAGING	FIXED	1403	1254
ORANGEBURG	RMC ORANGEBURG/CALHOUN	FIXED	3370	3989
ORANGEBURG	SANTHILL DIAGNOSTICS	MOBILE		0
PICKENS	CANNON MEM HOSP.	MOBILE	0	0
PICKENS	PALMETTO BAPTIST MED CTR-EASLEY	FIXED	2496	2712
RICHLAND	CAROLINA MED IMAGING	FIXED	1415	1267
RICHLAND	COLUMBIA NUEROSURGICAL ASSOC	FIXED		1297
RICHLAND	HEALTH SOUTH DIAGNOSTIC CTR	FIXED	854	111
RICHLAND	IMAGECARE	FIXED	275	1944
RICHLAND	INMED DIAGNOSTIC SERVICES	2 FIXED	4365	4919
RICHLAND	MIDLANDS ORTHOPAEDICS	FIXED	3085	428
RICHLAND	MRI OF THE CAROLINAS	2 FIXED		
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	3623	3657
RICHLAND	PALMETTO HEALTH RICHLAND	2 FIXED	5352	5768
(RICHLAND)	(PALMETTO HEALTH ALLIANCE DIAG CTR)	(FIXED)		
RICHLAND	PALMETTO IMAGING	FIXED	5175	4405

PMC.2013.SHP.0565

PET-EX008.0082

RECORD 004079

MRI SCANS

COUNTY	FACILITY	TYPE	FY02 CON SCANS	FY03 CON SCANS
RICHLAND	PROVIDENCE HOSPITAL	FIXED	1600	1840
SPARTANBURG	CAROLINA HEALTH IMAGING	FIXED		285
SPARTANBURG	MARY BLACK MEM HOSP	2 FIXED	3694	4469
SPARTANBURG	ORTHOPEDIC ASSOCIATES,PA	MOBILE	193	1570
SPARTANBURG	ORTHOPEDIC SPECIALTIES OF SPART	FIXED	1150	1035
SPARTANBURG	PIEDMONT IMAGING CENTER	FIXED		0
SPARTANBURG	PIEDMONT IMAGING, INC #1	FIXED	4985	3655
SPARTANBURG	SPARTANBURG REG MED CTR	3 FIXED	10243	10364
SUMTER	TUOMEY	FIXED	4582	5208
SUMTER	TUOMEY OUTPATIENT IMAGING CTR #7	FIXED		
UNION	WALLACE THOMSON HOSP	FIXED	1228	1206
WILLIAMSBURG	WILLIAMSBURG REGIONAL HOSP	MOBILE	138	165
YORK	CAROLINA ORTHOPEDIC SURG ASSOC	FIXED	492	2294
YORK	METROLINA NEURODIAGNOSTICS CENTER	FIXED	1164	816
YORK	CAROLINAS DIAGNOSTIC IMAGING	FIXED	2354	2591
YORK	PIEDMONT MED CTR	FIXED & MOBILE	6274	6097

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

PMC.2013.SHP.0566

PET-EX008.0083

RECORD 004080

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

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

PET was developed in the 1970's and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent PET development has centered on oncology, and neurological applications such as epilepsy, Alzheimer's and Parkinson's Diseases. The Center for Medicare and Medicaid Services (CMS) has recently expanded the coverage of PET for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurological; and heart disease uses. The process takes around 45 minutes to an hour to perform.

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

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

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

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

PMC.2013.SHP.0567

PET-EX008.0084

RECORD 004081

POSITRON EMISSION TOMOGRAPHY (PET) SCANNER

COUNTY	FACILITY	SCANNERS	FY01 SCANS	FY02 SCANS	FY03 SCANS	CON/DATE
ANDERSON	ANDERSON AREA MEDICAL CTR	MOBILE FOR 2 DAYS		13	171	CON 5/30/02
GREENVILLE	THE CAROLINAS CLINICAL PET INST	FIXED	255	1,058	1,464	CON 1/26/2001
SPARTANBURG	SPARTANBURG REG MED CTR	MOBILE FOR 3 DAYS		229	535	CON 5/30/02
LEXINGTON	LEXINGTON MEDICAL CENTER	MOBILE FOR 3 DAYS		25	407	CON 7/19/02
RICHLAND	PALMETTO BAPTIST MED CTR	FIXED	507	1,386	1,325	CON 3/30/2000
YORK	PIEDMONT MEDICAL CENTER	MOBILE FOR 2 DAYS			123	CON 7/19/02
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE FOR 1/2 DAY				CON 3/5/04
FLORENCE	MCLEOD REGIONAL MEDICAL CTR	FIXED			48	CON 5/09/02
HORRY	GRAND STRAND REG MED CTR	MOBILE FOR 2 DAYS	4	357	571	CON 5/8/01
HORRY	CONWAY HOSPITAL	MOBILE FOR 2 DAYS				CON 7/11/03
SUMTER	TUOMEY	MOBILE FOR 1/2 DAY				CON 3/5/04
AIKEN	AIKEN REGIONAL	MOBILE FOR 1 DAY				CON 8/18/04
BEAUFORT	BEAUFORT IMAGING	MOBILE FOR 2 DAYS				APPROVAL APPEALED
CHARLESTON	ROPER HOSPITAL	FIXED	515	1,048	1,373	CON 7/12/2000
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE FOR 1 DAY	125	236	263	NA 3/21/2001
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE FOR 2 DAYS				CON 8/26/03
TOTAL			1,426	4,352	6,277	

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Certificate of Need Standards for Positron Emission Tomography (PET)

STANDARDS

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

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

(3) Applicants proposing new fixed PET services must project at a minimum 750 PET clinical procedures per year (3 clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (5 clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

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

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

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;

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

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

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(G) Outpatient Facilities

Outpatient facility means a facility located in or apart from a hospital, providing community service for the diagnosis and treatment of ambulatory patients: (1) which is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery (or dentistry in the case of dental diagnosis or treatment); or (3) which offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope from a full range of services at the larger hospitals to the basic medical specialties of the smaller hospitals. All are expected to offer a minimum of diagnostic laboratory, radiology, and clinical referral services.

(1) Ambulatory Surgical Facility (ASF)

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

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

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

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

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

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

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

4. The applicant must document the need for the expansion of or the addition of an ASF, based on the most current utilization data available. This need documentation must include the projected number of surgeries to be performed by medical specialty. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

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

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

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

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

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

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

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

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements, and must commit to seek accreditation from a nationally recognized organization such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF). Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most of the residents of South Carolina. Most ASF's operate five days a week, with elective surgery being scheduled several days in advance.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

There has been a substantial increase in the past decade in both the number and percentage of ambulatory surgeries performed and the number of ASF's approved and licensed. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, there is serious concern that ASF's are being proposed as a method of increasing reimbursement for procedures currently being performed in physician's offices, through the "facility fee" built into the reimbursement mechanisms, to the detriment of hospitals' ability to provide the range of services needed. The benefits of improved accessibility are to be balanced with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 2003):

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2003 ASF Utilization — Updated 12/14/04

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Outpatient Surgery Ctr.	Anderson	5	4	9	4,173	6,133	10,306	835	1,592	1
Bearwood Ambulatory Surgery Center	Anderson	1		1	159		159	159		
Medicus Surgery Center	Anderson	3		3	4,739		4,739	1,580		
Upstate Endoscopy Center	Anderson		2	2	—					2
Center for Special Surgery, The	Greenville	2		2	614		614	307		3
Cross Creek Surgery Center	Greenville	4		4	4,941		4,941	1,235		
Endoscopy Center of the Upstate	Greenville		3	3	—					4
Greenville Endoscopy Center	Greenville		3	3		6,148	6,148		2,049	
GHS Outpt. Surg. Ctr. – Patewood	Greenville	6	2	8	4,339	2,691	7,030	1,085	1,346	5
HealthSouth Surg Center - Greenville	Greenville	4		4	4,108		4,108	1,027		
Jervey Eye Center	Greenville	3		3	3,982		3,982	1,991		6
Patewood Surgery Center	Greenville	2		2	1,633		1,633	817		7
Physicians Surgery Ctr - St. Francis	Greenville	4			—					8
Blue Ridge Surgery Center	Oconee	2		2	1,133		1,133	567		9
Upstate Pain Mgt. & Surgery Center	Oconee	2		2	751		751	376		10
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,384	515	7,899	1,055	258	11
Spartanburg Urology Surgicenter	Spartanburg	2		2	2,334		2,334	1,167		

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

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Parkridge Surgery Center	Richland	4		4	12		12	3		20
Providence Hospital Surgery Center	Richland	4		4	1,874			469		
South Carolina Med Endoscopy Ctr.	Richland		4	4		3,500	3,500		1,750	21
South Carolina Endoscopy Ctr-NorthEast	Richland		5	5		1,605	1,605		521	22
Carolina Surgical Center	York	4		4	4,988			1,247		
Region III:										
Darlington Endoscopy Center	Darlington		2	2		836	836		418	
Florence Surgery & Laser Center	Florence	2		2	1,490		1,490	745		23
McLeod Ambulatory Surgery Center	Florence	2		2	1,320		1,320	660		
Physicians Surgical Center of Florence	Florence	4	2	6	—					24
Atlantic Surgery Center	Georgetown	2		2	—					25
Bay Microsurgical Unit	Georgetown	1		1	2,958		2,958	2,958		
Waccamaw Same Day Surgery Ctr.	Georgetown	(2)	(1)	(3)	89		59	30		26
Carolina Bone and Joint Surgery Ctr.	Horry	2		2	31		31	16		27
Community Medical Ctr - South Strand	Horry	(2)	(1)	(3)	2,355	954	3,309	1,178	954	28
Grande Dunes Surgery Center	Horry	2		2	4,578		4,578	2,289		29
Ocean Ambulatory Surgery Center	Horry	2		2	1,989		1,989	995		30
Parkway Surgery Center	Horry	2		2	1,687		1,687	844		31

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

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Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
HealthSouth Surgery Ctr Charleston	Charleston	4	1	5	4,638		4,638	1,160	0	
Palmetto Endoscopy Center	Charleston		2	2	—					43
Roper West Ashley Surgery Center	Charleston	4		4	5,642		5,642	1,411		
Surgery Center of Charleston	Charleston	1	1	2	1,198	461	1,659	1,198	461	44
Trident Eye Surgery Center	Charleston	2		2	2,237		2,237	1,119		45
Trident Surgery Center	Charleston	4		4	6,014		6,014	1,504		
Colleton Ambulatory Surgery Center	Colleton	2	1	3	1,094	937	2,031	547	937	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	—					46
Summerville Surgery Center	Dorchester	2		2	—					47
TOTALS		154	65	215	113,920	52,608	166,526	917	1,163	

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2004 Plan ASF Footnotes

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

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RECORD 004093

(2) Emergency Hospital Services

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

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

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

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

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

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

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

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

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

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

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

(3) Trauma Referral System

The Division of Emergency Medical Services, DHEC, has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This trauma center has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patient arrives. Anesthesiology capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The major difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

Level III: These hospitals are committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

PMC.2013.SHP.0581

PET-EX008.0098

RECORD 004095

2. Community Psychiatric Beds

OVERVIEW

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

An occupancy factor of 65% was used to calculate short-term projected bed needs. A minimum use rate of 75% of the overall state use rate was used to project bed needs in areas not now having short-term psychiatric units and related utilization data. Need projections were developed based on psychiatric service areas, which were derived after analysis of patient origin data from the Hospital Discharge Data System. The following pages depict the calculations described above.

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

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

STATE MENTAL HEALTH FACILITIES

(A) Psychiatric Hospital Beds

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and

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expansion of the component programs should be allowed as long as the overall psychiatric hospital compliment is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, they are exempt from Certificate of Need review.

(B) Local Inpatient Crisis Stabilization Beds

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

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

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

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

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

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

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

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RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

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

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PSYCHIATRIC BED UTILIZATION

2004 PLAN

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

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

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

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

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

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

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

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

8 TOTAL REFLECTS UTILIZATION OF DUAL-DIAGNOSIS SWING BEDS.

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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2003 POP	2010 POP	2003 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	<65	204140	215390	3692	10.67				
	+65	34470	40350	833	2.67				
	TOTAL	238610	255740	4525	13.34	0.65	21	38	-17
GREENVILLE,PICKENS	<65	447930	483500	26901	79.55				
	+65	58240	64860	4122	12.58				
	TOTAL	506170	548360	31023	92.13	0.65	142	125	17
CHEROKEE,SPARTANBURG UNION	<65	302130	320270	5826	16.92				
	+65	43420	47610	5418	16.28				
	TOTAL	345550	367880	11244	33.20	0.65	51	71	-20
CHESTER,LANCASTER,YORK	<65	238900	258060	2058	6.09	1.04 / .65 = 11			
	+65	29510	33700	302	0.94				
	TOTAL	268410	291760	2360	7.04	0.65	11	20	-9
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	190590	200730	3822	10.45				
	+65	29900	34090	2316	7.23				
	TOTAL	220490	234820	6138	17.69	0.65	27	36	-9
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	597830	639470	42845	125.56				
	+65	70760	81280	8574	26.99				
	TOTAL	668580	720750	51419	152.55	0.65	235	203	32
DARLINGTON,FLORENCE MARION	<65	204240	209550	4830	13.58				
	+65	27580	30540	332	1.01				
	TOTAL	231820	240090	5162	14.58	0.65	22	23	-1
CHESTERFIELD,DILLON MARLBORO	<65	89890	89510	330	0.90				
	+65	11860	12490	1165	3.33				
	TOTAL	101750	102000	1465	4.23	0.65	7	8	-1
CLARENDON,LEE,SUMTER	<65	142440	147940	75%	12.32				
	+65	20120	23870	STATE USE	3.37				
	TOTAL	162560	171810	RATE	15.69	0.65	24	0	24

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PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2003 POP	2010 POP	2003 PAT. DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	ADDITION (EXCESS)
GEORGETOWN,HORRY	<65	255270	277060	75%	23.07				
WILLIAMSBURG	+65	47260	60620	STATE USE	8.55				
	TOTAL	302530	337670	RATE	31.62	0.65	49	28	21
BAMBERG,CALHOUN	<65	108120	110090	1612	4.50				
ORANGEBURG	+65	16840	18880	672	2.06				
	TOTAL	124960	128970	2284	6.56	0.65	10	15	-5
ALLENDALE,BEAUFORT	<65	188270	201300	2826	8.28				
COLLETON,HAMPTON,	+65	33420	44370	200	0.73				
JASPER	TOTAL	221690	245670	3026	9.01	0.65	14	14	0
BERKELEY,CHARLESTON	<65	507430	533240	30482	87.76				
DORCHESTER	+65	62130	78300	5120	17.68				
	TOTAL	569560	611540	35602	105.44	0.65	162	152	10
AIKEN,BARNWELL	<65	150820	162740	6006	17.76				
	+65	22520	26600	1186	3.84				
	TOTAL	173340	189340	7192	21.52	0.65	33	29	4
STATE TOTAL							808	762	46
STATE MIMIMUM USE RATE	<65	3230290	3423850	131030.75	0.0405632	0.03			
	+65	440640	513070	30230	0.0686048	0.05			
	TOTAL	3670930	3936920	161260.75	0.0439291	0.03			

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3. Residential Treatment Facilities for Children and Adolescents

OVERVIEW

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

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

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

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

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RECORD 004102

Certificate of Need Standards for Residential Treatment Facilities

Services available at a minimum should include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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RECORD 004104

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

Facilities:	New Hope Charleston	60 beds
	Pal. Low Cnty Behav. Hlth.	32 beds
	Total	92 beds

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

The projected need for additional RTF beds is based upon the number of clients of the Department of Mental Health (DMH), Department of Social Services (DSS), and the Continuum of Care for Emotionally Disturbed Children who are currently being served, waiting for service, and/or who could be appropriately placed in these facilities. Additionally, it allows for sufficient beds to be available to meet the needs of private pay and other non-governmental clients. Applicants must document sources for patient referral. The Directions program primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

Residential treatment facility beds for children and adolescents are distributed statewide and are located within seventy-five (75) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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RECORD 004105

4. Alcohol and Drug Abuse Facilities

There are six distinct providers of substance abuse treatment in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

(1) Outpatient Facilities

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment and referral, individual and group counseling, family counseling, case management and crisis management services. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 63 licensed outpatient facilities for chemically dependent or addicted persons in South Carolina, with a total of 85 locations.

CERTIFICATE OF NEED REQUIREMENTS

Certificate of Need is not required for outpatient facilities described above.

(2) Social Detoxification Facilities

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides education and referral. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized medical provider. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a social detoxification center.

(3) Freestanding Medical Detoxification Facilities N/A

A short-term residential facility, separated from an inpatient treatment facility, providing for

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medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse and referral. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized medical provider. The services provided by these facilities are described in Section 3101 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

INVENTORY

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

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for freestanding medical detoxification beds. The 2003 utilization rates are used to project the need for services in 2010. An occupancy factor of 70% was used in the calculations. The greater of the service areas' actual utilization or 100% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Freestanding detoxification centers should be available within 60 minutes one-way automobile travel time for 90% of the service area's population. Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed: however, the bed need projections refer to two distinct treatment modes which cannot be commingled.

Since 1987, courts in South Carolina have had the authority to order individuals involuntarily into addiction treatment. Because of this law, the number of detoxification beds shown as needed in this Plan may need to be increased. If an applicant can document an increased need and if either the

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DETOXIFICATION BED NEED — 2004 PLAN

SERVICE AREA	2003 POP	2010 POP	PAT. DAYS	PROJ ADC	% OCCUP.	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	191,190	207,420	0	4.00	0.70	6	0	6
GREENVILLE,PICKENS	405,400	444,340	4,841	14.54	0.70	21	27	-6
CHEROKEE,SPARTANBURG UNION	273,970	295,300	0	5.70	0.70	8	0	8
CHESTER,LANCASTER,YORK	211,570	235,160	3,152	9.60	0.70	14	10	4
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	176,150	191,030	0	3.68	0.70	5	0	5
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	532,870	583,620	5,101	11.26	0.70	16	16	0
DARLINGTON,FLORENCE MARION	182,180	191,720	425	3.70	0.70	5	4	1
CHESTERFIELD,DILLON MARLBORO	79,130	80,530	0	1.55	0.70	2	0	2
CLARENDON,LEE,SUMTER	126,680	135,590	0	2.62	0.70	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	247,910	283,950	0	5.48	0.70	8	0	8
BAMBERG,CALHOUN ORANGEBURG	99,370	104,130	0	2.01	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	177,920	203,370	0	3.92	0.70	6	0	6
BERKELEY,CHARLESTON DORCHESTER	452,960	495,230	3,237	9.55	0.70	14	16	-2
AIKEN,BARNWELL	137,130	153,940	0	2.97	0.70	4	0	4
STATE TOTAL	3,294,430	3,605,330	16,756	80.68		116	73	43

South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) or the South Carolina Department of Mental Health (DMH) submits a letter of support for additional detoxification beds beyond those shown as needed in the Plan, then additional detoxification beds could be approved.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 5 freestanding medical detoxification facilities in the state operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Services are accessible within sixty (60) minutes travel time for the majority of state residents. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(4) Residential Treatment Program Facilities

A 24-hour facility offering an organized service in a residential setting which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is not required for a Residential Treatment Program. However, an exemption request is required prior to the establishment of such a program.

Fred's impression is that these beds can be used for psych. but only if primary diagnosis is alcohol/drug abuse

Inpatient Treatment Facilities

This is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries; contact the Division of Health Licensing at (803) 545-4370 for further information.

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

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

2 Statewide Facility, Not Included in Bed Need Calculations.

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

CERTIFICATE OF NEED REQUIREMENTS

A utilization-based methodology is used to project the demand for inpatient treatment beds. The 2003 utilization rates are used to project the need for services in 2010. A 70% occupancy factor was used in the calculations. The greater of the service areas' actual utilization or 75% of the statewide minimum use rate was used to project bed needs. The calculations described above are depicted on the following pages.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Inpatient treatment centers should be available within 60 minutes one-way automobile travel time for 90% of the service areas' population. Morris Village, Holmesview, McCord Adolescent and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations.

Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to their clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

Additional inpatient treatment beds could be considered for the service area only if the following criteria are met:

(a) The service area shows a need for additional beds;

(b) The applicant demonstrates an un-served demand for the proposed service area; and

(c) The utilization of treatment facilities in the contiguous service areas should be considered prior to approval of additional beds. This should include occupancy rates, patient origin, scope of services offered, and patient mix.

It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

There are currently 11 inpatient treatment facilities in the state, not including state-operated facilties. There is a projected need for additional beds in some service areas. Services are accessible within

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RECORD 004111

INPATIENT BED NEED

2004 PLAN

SERVICE AREA	2003 POP	2010 POP	PAT DAYS	PROJ ADC	% OCCUP	BED NEED	EXIST BEDS	ADDITION (EXCESS)
ANDERSON,OCONEE	191,190	207,420	1,207	3.59	0.70	5	27	-22
GREENVILLE,PICKENS	405,400	444,340	889	2.67	0.70	4	13	-9
CHEROKEE,SPARTANBURG UNION	273,970	295,300	0	6.01	0.70	9	0	9
CHESTER,LANCASTER,YORK	211,570	235,160	1,977	6.02	0.70	9	12	-3
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	176,150	191,030	0	3.89	0.70	6	24	-18
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	532,870	583,620	6,336	19.02	0.70	27	37	-10
DARLINGTON,FLORENCE MARION	182,180	191,720	2,198	6.34	0.70	9	18	-9
CHESTERFIELD,DILLON MARLBORO	79,130	80,530	0	1.64	0.70	2	0	2
CLARENDON,LEE,SUMTER	126,680	135,590	0	2.76	0.70	4	0	4
GEORGETOWN,HORRY WILLIAMSBURG	247,910	283,950	0	5.78	0.70	8	0	8
BAMBERG,CALHOUN ORANGEBURG	99,370	104,130	0	2.12	0.70	3	0	3
ALLENDALE,BEAUFORT COLLETON,HAMPTON,JASPER	177,920	203,370	0	4.14	0.70	6	0	6
BERKELEY,CHARLESTON DORCHESTER	452,960	495,230	7,204	21.58	0.70	31	33	-2
AIKEN,BARNWELL	137,130	153,940	1,128	3.47	0.70	5	18	-13
STATE TOTAL	3,294,430	3,605,330	20,941	89.02		128	182	-54
MINIMUM USE RATE	0.0074319							

(6) NARCOTIC TREATMENT PROGRAMS

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and LAAM (levo-alpha-acetylmethadol) to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client's needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider.

Narcotic treatment programs are described in Section 3200 of Regulation Number 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

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

A Certificate of Need is required for a methadone treatment facility. The licensure standards include standards for the location of these facilities within the community. A narcotic treatment program shall not operate within 500 feet of: a church, a public or private of elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district or the property line of a lot devoted to residential use.

Because clients must usually attend a Methadone Treatment Center 6 days per week to receive their dose of methadone, these centers should be located throughout the state. Until these clinics are developed throughout the state, additional Methadone Treatment Centers are not needed in counties where an existing clinic exists, but should be developed in counties where none exists to improve accessibility.

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RECORD 004113

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

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

a. Compliance with this Plan;
b. Distribution (Accessibility);
c. Record of the Applicant;
d. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility may outweigh the adverse effects of the duplication of this existing service.

METHADONE CLIENTS AT CENTERS AND USE OF EMERGENCY ROOMS

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

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

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RECORD 004115

5. Rehabilitation Facilities

OVERVIEW

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision of (1) medical evaluation and services and (2) psychological, social, and/or vocational evaluation and services. The current concept of a rehabilitation facility is one in which the disabled person is assisted through an integrated program conducted by a team of specialized personnel representing several professional disciplines, under the direction of a person licensed to practice medicine or surgery in the State.

According to the American Medical Association (AMA), rehabilitation services are most effective when delivered in comprehensive medical rehabilitation units or centers located in either short-stay hospitals or freestanding facilities, where inpatients with severe disabilities receive medical, nursing, restorative and personal adjustment services in an integrated rehabilitation program. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with such physical impairments as stroke, spinal cord injury, head injury, multiple sclerosis and other neuromuscular diseases, arthritis, chronic pain, amputations, hip and pelvis fractures, and childhood birth defects and injuries are typical clients.

Patients requiring this level of care should be able based on interdisciplinary evaluation, to participate fully in the therapies, practice sessions, and other activities provided and to benefit from such therapies. Along with the capacity to endure the intensity of service offered, the individual must be emotionally ready to participate in and accept the treatment plan developed for his/her rehabilitation.

Rehabilitation facilities should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. It may be beneficial to utilize the services of, or affect a cooperative plan with, present medical and vocational centers when establishing a rehabilitation facility. Where separate freestanding facilities are established, the employees representing the professional fields mentioned above should be provided on a full-time basis.

Physical rehabilitation services which involve a single service such as physical therapy, occupational therapy, speech therapy, or recreation therapy, and outpatient rehabilitation services without the involvement of a formal interdisciplinary program, are provided by most general hospitals, nursing homes, home health agencies, and outpatient rehabilitation centers.

In addition, several hospitals have received approval to consolidate their therapy services into a single unit to improve the coordination of rehabilitative care for acute patients in their facilities. While these facilities provide a more coordinated and possible higher degree of care than in hospitals with indecent single services, these hospitals are not considered to be providing comprehensive

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RECORD 004116

physical rehabilitation services as defined in this section of the Plan. The consolidation of rehabilitative therapies is intended to improve the quality of care for patients currently being treated in the facility; it is not intended to allow hospitals to market themselves or advertise as offering comprehensive rehabilitation. Hospitals which have received permission to consolidate their rehabilitation services into a distinct unit include Colleton Regional and Tourney Hospital.

The following rehabilitation programs are currently available:

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

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

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

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

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

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

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

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

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

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

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RECORD 004117

STATEWIDE PROGRAMS

S.C. Vocational Rehabilitation Center, in West Columbia, has 30 beds. This facility is operated by the S.C. Vocational Rehabilitation Department to serve the vocational training needs of the disabled, and should be expanded to 44 beds to better enable VRD to served their statewide client caseload.

CERTIFICATE OF NEED STANDARDS FOR REHABILITATION

DEFINITIONS

"Disabled person" is an individual who has a physical or mental condition which, to a material degree, limits, or if not corrected, will probably result in limiting, the individual's performance or activities to the extent of constituting a substantial physical, mental, or vocational handicap.

"Medical service" means a service under the direct personal supervision of a medical director, varied and extensive availability of specialized medical consultants, and other evaluation and therapy services suitable to the needs of the disabled persons to be served.

"Psychological service" means evaluation and services by a qualified psychologist in amounts and variety appropriate to the needs of the disabled persons to be served.

"Social service" means evaluation and services by a qualified social worker in amounts and variety appropriate to the needs of the patients to be served.

"Vocational service" means a variety of vocational services appropriate to the program and persons to be served, such as pre-vocational exploration, work evaluation, and vocational training.

STANDARDS

The need for rehabilitation beds is calculated based on 12 service areas as defined on the following page. An occupancy factor of 70% was used to calculate projected bed needs. For service areas without existing licensed beds, the statewide average use rate was used to project bed needs.

Due to the low utilization of existing hospital beds, consideration should be given to the conversion of existing beds to rehabilitation beds rather than to the construction of new facilities and/or beds.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);

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

Rehabilitation facilities are now located throughout the state and are available within approximately ninety (90) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighted with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

REHABILITATION BED NEED

2004 PLAN

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

6. Long Term Care Facilities and Services

A. Nursing Homes:

Nursing homes provide inpatient care for convalescent or chronic disease patients who require nursing care and related medical services, in which such nursing care and medical services are prescribed by, or are performed under the general direction, of persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.gov the licensing list of nursing homes also denotes the facilities that have Alzheimer's units. For more specific detail about nursing homes, refer to the Department's Standards for Licensing Nursing Homes.

For existing licensed nursing homes, bed capacity is considered to be the number of licensed beds or the number of beds approved under the Certificate of Need program regardless of oversize room construction. The number of beds counted in any patient room is the maximum number for which adequate square footage is available. These minimums are: 100 square feet in single rooms; and 80 square feet per bed in multi-bed rooms. Only the net usable space in the room is considered. Space in the toilet rooms, washrooms, closets, vestibules, and corridors is not counted.

The following items should be noted regarding the inventory of long-term care facilities:

(1) Restricted usage facilities (federal and institutional) are counted as statewide facilities and not counted in the region located.

(2) Patient days and admissions are as reported by the nursing home.

(3) Existing beds are counted based upon the greater of licensed or survey capacity. Survey beds refer to the capacity; the survey beds do not exceed the licensed beds unless a Certificate of Need has been issued for an increase in the number of beds. The footnotes in the inventory explain any changes.

(4) The beds included in the inventory have been classified for planning purposes as conforming or nonconforming. This classification is based on U.S. Public Health Service standards of plant evaluation and an actual on-site survey of each facility and updated as changed by construction and/or modernization.

(5) The standards used in this survey are basically the same for general hospitals and nursing homes. Such standards include:

(a) Fire-resistivity of each building;
(b) Fire and other safety factors of each building;
(c) Bed capacity and evaluation of nursing units, including:

(1) Availability of nurses' call system;
(2) Adequacy of bed space;
(3) Patient rooms; grade level or above;
(4) Availability of outside windows in patient rooms;
(5) Availability of direct access to a corridor for each patient room;
(6) A minimum corridor width of eight (8) feet;
(7) Availability of a nurses' station within 120 feet of each patient room unless the alternative standard of 150 feet has been approved;
(8) Adequate toilet, bedpan, bath or handwashing facilities in each patient unit; and
(9) Maximum capacity of four (4) beds per patient room.

(d) Design and structural factors affecting the function of service departments, including:

(1) Dietary department;
(2) Dining, recreation and day room space;
(3) Rehabilitation services (for facilities in excess of 100 beds only)
(4) Laundry and linen department.

The nursing home bed need methodology developed and used in the Plan is derived from a factor of 39.33 beds per thousand population age 65 and over by county. This factor was selected after detailed analysis of the method outlined in the Public Health Service health grants manual 23-2 as amended; the South Carolina Projected Use Rate method, previously approved by the Department of Health, Education, and Welfare (HEW); and several other methodologies. These beds are generally used by the non-institutional population age 65+. In an effort to give more equitable distribution of beds throughout the State, these needs are developed by county.

This methodology factored in the utilization from the South Carolina Community Long Term Care Project (CLTC) regarding client utilization of nursing homes. This project provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing home placement under the Medicaid program.

Therefore, the ratio of 39 beds/1000 population age 65 and over was selected as the appropriate number of nursing home beds for 2007.

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

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(1) There is a shortage of Title XIX (Medicaid) funding in the state. Approximately 70% of all patients in nursing homes are financed by Medicaid.

(2) The state has limited resources to invest in meeting the long-term care needs of its population. The Long Term Care Committee of the Human Services Coordinating Council recommends that services toward home and community care should be stressed as an alternative to institutionalization.

(3) The CLTC program is operational with both Medicaid and Medicare waivers for a client assessment program to help people with disabilities find the right type of long-term care by expanding community-based services. These services include:

a. Medical Day Care
b. Personal Care
c. Respite Care
d. Home Delivered Meals
e. Transportation
f. Medical Social Services
g. Expanded Therapies
h. Mental Health Counseling

(4) Nursing homes can be developed and constructed in two years. A shorter planning horizon may lessen the potential for an over built situation in nursing home beds as alternatives are developed and funded.

There are no longer separate Federal and State standards for skilled nursing and intermediate care beds; therefore, the beds have been combined under nursing home beds.

The long-term care analyses and factor development was accomplished with the assistance of representatives of various agencies and organizations associated with long-term care.

Since the vast majority of patients utilizing nursing homes are 65 years of age or older, only this segment of the population is used in the projection of need for the general public. However, all patient days, including the under 65 population, were used to develop the bed need factor used in these methodologies.

The number of beds needed to be constructed is obtained by subtracting the number of existing beds (greater of license or survey capacity) from the bed need. In order to provide a more equitable distribution of nursing home beds throughout the State, the following policies will apply:

(1) Additional beds may be approved in counties with a positive bed need up to the need indicated.

(2) When a county has more beds than the projected need (i.e. excess beds), additional beds will not be approved.

(3) An exception to numbers (1) and (2) above can be made for an individual nursing home to add some additional nursing home beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing home may add up to 16 additional beds to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing home must document how these additional beds will make a more economical unit(s). In no case will more than 16 additional beds be approved for a specific facility unless there is a need in the particular county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand age 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating certificate of need applications for these beds or facilities:

a. Need;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing homes are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing home is located in every county, there is no justification for approving additional nursing homes or beds which are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since approximately 70% of all nursing home patients are paid for by the Medicaid Program. This Plan projects the need for nursing home beds by county. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

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

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

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PET-EX008.0130

RECORD 004127

Medicaid Nursing Home Permits

Beginning July 1, 1988, nursing homes which wish to continue to serve Medicaid patients must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing home may provide, and the nursing home must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

MEDICAID PATIENT DAYS AND MEDICAID BEDS REQUESTED AND AUTHORIZED

YEAR	# DAYS REQUESTED	BEDS	# DAYS AUTHORIZED	BEDS	# DAYS DIFFERENCE
1988-1989	3,032,839	8309	2,971,811	8142	61,028
1989-1990	3,644,248	9984	3,644,248	9984	0
1990-1991	3,709,814	10163	3,659,965	10028	49,849
1991-1992	3,856,833	10567	3,659,965	10028	196,868
1992-1993	3,976,576	10895	3,806,382	10429	170,194
1993-1994	4,012,359	10993	3,856,382	10566	155,977
1994-1995	4,023,690	11024	3,892,882	10665	130,808
1995-1996	3,969,681	10876	3,892,882	10665	76,799
1996-1997	4,072,519	11158	4,002,382	10965	70,137
1997-1998	4,119,753	11287	4,097,282	11225	22,471
1998-1999	4,265,182	11685	4,265,182	11685	0
1999-2000	4,367,134	11965	4,341,832	11895	25,302
2000-2001	4,420,522	12111	4,378,332	11995	42,190
2001-2002	4,473,170	12255	4,275,998	11715	197,172
2002-2003	4,340,158	11891	4,205,553	11522	134,605
2003-2004	4,304,160	11792	4,205,553	11522	98,607
2004-2005	4,294,977	11767	4,205,553	11522	89,424

NOTES: 36,500 patient days = 100 beds

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PET-EX008.0131

RECORD 004128

Mental Retardation Facilities

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed. Based on the known numbers of individuals in service systems as well as improved public awareness and acceptance of issues associated with mental retardation, it is believed that there are no significant numbers of citizens with mental retardation or related disabilities currently unrecognized.

The South Carolina Department of Disabilities and Special Needs is reducing the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds are being developed for those persons from the regional centers and those on the residential services waiting list. Community beds will be distributed over the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs will enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in.

Any certificate of need for mental retardation beds should not be approved unless it is supported by the South Carolina Department of Disabilities and Special Needs.

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PET-EX008.0132

RECORD 004129

C. Hospice Facilities and Hospice Programs

Hospice means a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including but not limited to home, outpatient and inpatient services provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

A Hospice Facility means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

CERTIFICATE OF NEED REQUIREMENTS

A Certificate of Need is required for an Inpatient Hospice Facility. A Certificate of Need is not required for the establishment of a Hospice Program; an inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program. An inpatient Hospice Facility must document the need for the facility and justify the number of inpatient beds that are being requested. The proposed facility must consider the impact on other existing inpatient hospice facilities.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service.

1. State Health Plan standards;
2. Distribution (Accessibility);
3. Community Need Documentation;
4. Acceptability;
5. Financial feasibility, and
6. Staff Resources

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

D. Swing Beds:

To participate in the Swing Bed Program, a Certificate of Need is not required in South Carolina. However, the hospital must be certified. The swing beds concept refers to beds in a hospital that alternate between hospital and long-term care and are occupied by long-term care patients for periods of a few days to several weeks. This concept does not refer to hospital beds being designated as nursing home beds and does not necessarily involve moving beds or patients into separate areas of the hospital.

Swing beds can be the link between inpatient acute care and home and community-based services, in a continuum of care for those patients requiring long-term care. Although the goal is to return patients to the community, this is not always possible. Should a return to the community not be possible, the swing bed hospital assists the patient and family with nursing home placement. The swing bed program improves the coordination of long-term care services within the community.

Section 1883 of the Omnibus Budget Reconciliation Act of 1987 amendments permit payment under Medicaid or Medicare for extended care services to any hospital that meet the following requirements:

-- Has a Medicare provider agreement;
-- Has fewer than 100 certified beds, excluding newborn, ICU/CCU beds, beds in certified distinct part SNFs and NFs, and beds in PPS-excluded distinct part psychiatric and rehabilitation units;
-- Is located in a rural (non-urbanized) region;
-- Has been granted a Certificate of Need for the provision of extended care services, if required by the State;
-- Does not have in effect a 24-hour nursing waiver;
-- Has not had a swing-bed approval that was terminated within the last two years; and
-- Meets the Skilled Nursing Facility (SNF) Conditions of Participation on resident rights, specialized rehabilitation services, dental services, social services, resident activities, discharge planning, admission, transfer and discharge rights and resident behavior and facility practices. The Code of Federal Regulations (CFR) section 42 Subpart A, section 482.66 details other specific requirements.

In addition, hospitals that have 50-99 beds and meet the above criteria must also meet the following criteria for approval:

1. The hospital must identify and enter into a transfer agreement with all of the Medicare SNFs in the geographic region. The SNF will notify the hospital when a post-hospital SNF care bed becomes available and the date it becomes available;

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RECORD 004131

E. Home Health Agencies

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan, and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

The average mix of home health visits by type of service during FY 2003 for the home health agencies in South Carolina were:

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

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

Some of the reasons for the increased demand through 1997 for home health services include: the Prospective Payment System, which encourages hospitals to reduce the average length of stay for most Medicare patients; changes in employee benefit plans which include economic incentives for home care; a greater awareness of community-based services such as home health, home-delivered meals, and adult day care; managed care and increased physician acceptance. The utilization of home health services has decreased since 1997 primarily due to the Balanced Budget Act

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RECORD 004132

MAXIMUM AGENCIES PER THOUSAND POPULATION

<30k pop. = 2 HHA's
30-50k pop. = 3 HHA's
50-75k pop. = 4 HHA's
75-125k pop. = 5 HHA's
125-175k pop. = 6 HHA's
175-225k pop. = 7 HHA's
225-275k pop. = 8 HHA's
275-325k pop. = 9 HHA's
>325k pop. = 10 HHA's

5. The applicant should have a track record of providing indigent care or a documented proposed plan for serving these patients. The applicant must provide for the past three years, the number of indigent people served, the number of indigent visits provided, the dollar amount of these services and the percentage of gross revenue devoted to indigent care. This does not include bad debt or contractual adjustments. The application must also include a pro-forma budget that contains both the dollar amount and percentage of gross revenue proposed for indigent care for the first three years of operation.

6. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state where it operates. If licensed in another state, the name, address, and telephone number of the licensing agency and a contact person at the State Agency must be provided.

7. The applicant must document that they can serve at least 50 patients annually in each county for which they are licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to less than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county.

8. Because of the limited number of patients that would require Home Uterine Activity Monitoring and administration of tocolytic therapy that requires obstetrical staff expertise and 24 hour fetal monitoring, an exception to the above criteria may be made for a Certificate of Need for only this restricted service. Only one Certificate of Need application will be required for a home health agency that proposes to provide this specialized service for the 25 counties that currently do not have this service. The applicant must document that no other provider offers this service in the counties and that the agency will only provide services to obstetrical patients. The license for the agency will be restricted to serving obstetrical patients only.

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RECORD 004133

adverse affects caused by the duplication of any existing service.

The home health agency inventory follows. The persons served and visits are based on Home Health Agency Reports. The "cut-off" date for inclusion in the inventory was January 14, 2005.

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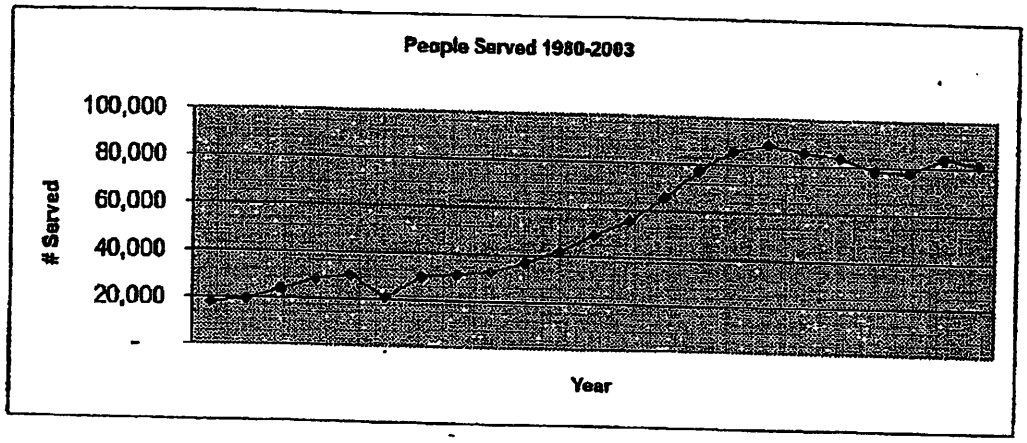
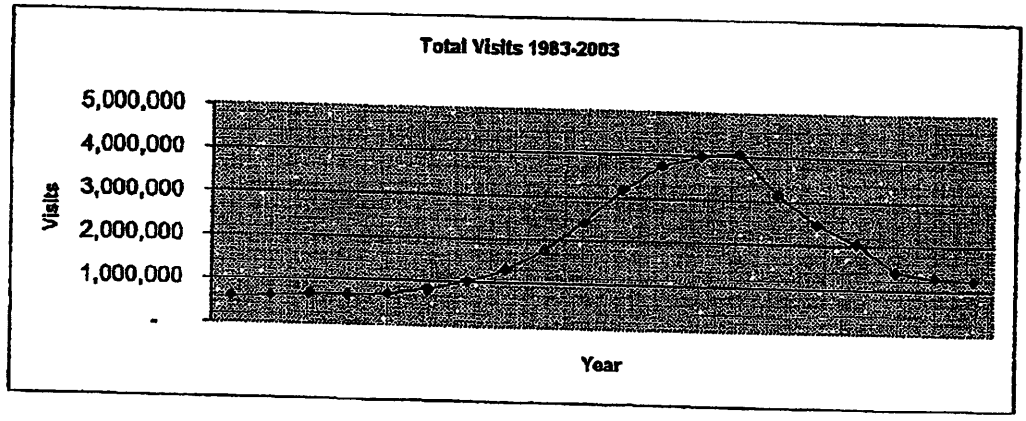
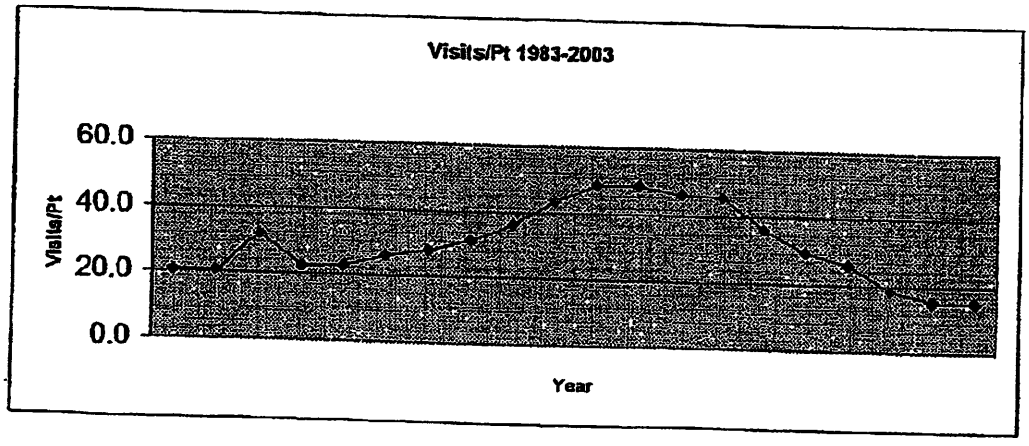
RECORD 004134







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RECORD 004135

HOME HEALTH AGENCIES INVENTORY-2003 DATA

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

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

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

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RECORD 004138

merged with Coram, 1/17/96, and name changed to Coram Home Health Care of South Carolina, Inc. The service to Union County is now restricted to serving patients whose initial diagnosis requires intravenous therapy services and/or home uterine activity monitoring. Other counties are full service. Change in ownership and name, formerly Coram Home Care of South Carolina, Inc., 1/15/99.

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

4/ Agency closed, 8/5/03.

5/ Agency closed, 4/16/03.

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

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

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

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

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

11/ Facility closed 10/1/04.

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

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

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

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

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RECORD 004139

HOME HEALTH AGENCIES INVENTORY 2003 DATA

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

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HOME HEALTH AGENCIES INVENTORY 2003 DATA

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

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HOME HEALTH AGENCIES INVENTORY 2003 DATA

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

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F. Other Services For The Elderly

1. Day Care Facilities for Adults

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

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

2. Community Residential Care Facilities

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

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

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for areas with only secondary roads) or be certified by the State as being a necessary provider of health care services to residents of the area;

4) The maximum number of licensed beds is 25, which can be operated as any combination of acute or Swing-Beds;

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

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

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

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

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

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

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

3) It maintains a 24-hour emergency room;

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

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

As of May 2004, 893 hospitals nationwide had been approved for CAH status. The impact of the Critical Access Hospital Program in South Carolina would be a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH would not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25 bed requirement.

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

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8. Long-Term Care Hospitals

Long Term Care (LTC) hospitals provide diagnostic and medical treatment or rehabilitation to patients with chronic diseases or complex medical conditions with an average stay of 25 days or longer. Although these patients are no longer in need of general acute care, they still require extensive lengths of stay in a setting, which can provide highly skilled nursing, therapy, and medical treatment. The LTC hospital provides a level of care designed to minimize secondary medical conditions prior to discharge to nursing facilities, outpatient rehabilitation, or home health services. Long-term care hospitals are exempt from the Prospective Payment System (PPS) and are reimbursed based on allowable costs. They must have a Medicare provider agreement to participate as a hospital and must maintain a minimum 25-day average length of stay. As of May 2004, there were 318 long-term care hospitals nationwide.

Examples of the type of conditions that fall into this category are strokes, cardiac care, HIV, ventilator dependency, general debilitation, wound care, respiratory infections, and post-surgical care. These patients are medically complex, often requiring life support and/or extended ICU care. Required intensive support services may include invasive monitoring, cardiac telemetry, transfusion therapy, dialysis, central line placement, nutritional support, and hemodynamic monitoring.

A LTC hospital may either be a freestanding facility, or may occupy space in a building also being used by another hospital or in one or more buildings located on the same campus as buildings being used by another hospital {"the host facility"}. By locating within an existing hospital, they avoid the construction costs of a new facility while optimizing use of underutilized space in the host facility. Hospitals must meet additional Federal criteria in order to qualify as a LTC Hospital located in a building used by another hospital {"hospital-within-a-hospital"}:

1) The new hospital must have a governing board, which is distinct and separate from the governing body of the host hospital. In addition, the new board cannot be under the control of the host hospital or any entity that controls the host hospital.

2) The LTC hospital must have a separate CEO and administrative structure with no contract or affiliation with the host facility.

3) The hospital must have a separate Chief of Staff who reports directly to the governing board and is responsible for all medical staff activities. The Chief of Staff cannot be under contract with the host hospital or an affiliated organization.

4) There must be a separate and distinct medical staff directly to the governing board.

In addition, the LTC Hospital must demonstrate that it is organizationally and functionally separate from the host facility. This can be met in any of three ways:

1) The Basic Hospital Services Rule – The LTC hospital performs basic hospital functions such as Quality Assurance, Medical Staff, Nursing Services, Medical Records, Pharmacy, Radiology, Lab, Utilization Review, and Infection Control through its own employees or

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PET-EX008.0148

RECORD 004145

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

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

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes which occurred since the previous plan are explained by a footnote. The number of beds existing and needed are summarized by region. The inventory of beds and facilities was current as of January 14, 2005.

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RECORD 004146

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

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

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

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

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

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

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

				CON-	LICENSED	SURVEY	NONCON	ADMIS	PATIENT
	FLORENCE CO TOTAL				253	253			
N	JESSAMINE COMMUNITY RESIDENCE	GEORGETOWN	GEORGETOWN	ST	6	6			
N	MARYVILLE COMMUNITY RESIDENCE	GEORGETOWN	GEORGETOWN	ST	6	6			
	GEORGETOWN CO				16	16			
N	CIVITAN COMMUNITY RESIDENCE	GREENVILLE	GREENVILLE	ST	6	6			
N	FOUNTAIN INN COMMUNITY RESIDENCE	GREENVILLE	FOUNTAIN INN	NPA	12	12			
N	HUGHES STREET COMMUNITY RES	GREENVILLE	FOUNTAIN INN	NPA	6	6			
N	MARIAN PARKINS COMMUNITY RES I	GREENVILLE	GREENVILLE	ST	6	6			
N	MARIAN PARKINS COMMUNITY RES II	GREENVILLE	GREENVILLE	ST	6	6			
N	RIDGE ROAD RESIDENCE	GREENVILLE	GREENVILLE	ST	12	12			
N	TRAVELERS REST COMMUNITY RES	GREENVILLE	TRAVELERS REST	NPA	6	6			
	GREENVILLE CO TOTAL				54	54			
N	HENRY & FREIDA BONDS HAB CTR	GREENWOOD	GREENWOOD	ST	6	6			
N	MARION P CARNELL HAB CTR	GREENWOOD	WARE SHOALS	ST	6	6			
N	J. FELTON BURTON COMMUNITY RES	GREENWOOD	GREENWOOD	ST	6	6			
	GREENWOOD CO TOTAL				24	24			
N	HORRY CO LADIES COMMUNITY RES	HORRY	CONWAY	ST	6	6			
N	THE LOIS EARGLE HOME	HORRY	CONWAY	ST	6	6			
	HORRY CO TOTAL				16	16			
N	CAMDEN I GROUP HOME	KERSHAW	CAMDEN	NPA	6	6			
N	CAMDEN II GROUP HOME	KERSHAW	CAMDEN	NPA	6	6			
	KERSHAW CO TOTAL				16	16			
N	NANCY J MCCONNELL COMMUNITY RES	LANCASTER	LANCASTER	ST	6	6			
N	TOM MANGUM COMMUNITY RESIDENCE	LANCASTER	LANCASTER	ST	6	6			
	LANCASTER CO TOTAL				16	16			
N	CLINTON MANOR COMMUNITY RES	LAURENS	CLINTON	NPA	6	6			
N	DAVIDSON STREET COMMUNITY RES	LAURENS	CLINTON	CO	6	6			
N	MILL STREET COMMUNITY RESIDENCE	LAURENS	CLINTON	CO	6	6			
N	SOUTH HARPER ST HABILITATION CTR	LAURENS	CLINTON	ST	6	6			
N	SULLIVAN STREET COMMUNITY RES	LAURENS	LAURENS	NPA	6	6			
N	OAK GROVE COMMUNITY RESIDENCE	LAURENS	LAURENS	ST	6	6			
N	WHITTEN CTR CTL SQ 201,204,205,207,209	LAURENS	CLINTON	ST	143	143			
N	WHITTEN CENTER CAMPUS AREA 101-110	LAURENS	CLINTON	ST	152	152			
N	WHITTEN CENTER WEBB UNIT 403	LAURENS	CLINTON	ST	60	60			
N	WHITTEN CENTER SUBER UNITS 301-303	LAURENS	CLINTON	ST	66	66			
	LAURENS CO TOTAL				471	471			
N	MCLEOD I GROUP HOME	LEE	BISHOPVILLE	NPA	6	6			
N	MCLEOD II GROUP HOME	LEE	BISHOPVILLE	NPA	6	6			

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PET-EX008.0152

REGION: STATEWIDE

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

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

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PET-EX008.0153

REGION NARRATIVE

REGION: I

FISCAL YEAR: 2004

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

2. General Hospitals: W.J. Barge Hospital is a restricted use facility.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: These needs are determined by psychiatric service areas. See Chapter II for discussion and calculation of needs. There are acute psychiatric beds in six facilities in this region and long term psychiatric beds available at Springbrook Behavioral Healthcare System in Greenville County. There is a need for additional psychiatric beds in this region.

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

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

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PMC.2013.SHP.0637
PET-EX008.0154

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCONFORMING		ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	HOSPITALS:												
XYZ	ANDERSON AREA MEDICAL CENTER		ANDERSON	ANDERSON	NPA	495	423			17,876	90,923	495	50.3%
CON	WOMEN & CHILDREN'S HOSPITAL	13	ANDERSON	ANDERSON	NPA		72						
	ANDERSON COUNTY		TOTAL			495	495			17,876	90,923	495	50.3%
XYZ	UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125			4,453	15,985	125	35.0%
	CHEROKEE COUNTY		TOTAL			125	125			4,453	15,985	125	35.0%
XYZ	ALLEN BENNETT MEMORIAL	1	GREENVILLE	GREER	NPA	58	58			3,424	15,719	58	74.3%
APP	GRENVILLE HOSPITAL SYSTEM - PATEWOOD	1	GREENVILLE	GREENVILLE	NPA		72						
XYZ	GREENVILLE MEMORIAL MEDICAL CENTER	1	GREENVILLE	GREENVILLE	NPA	710	710			35,036	192,736	632.3	83.5%
XYZ	HILLCREST	1	GREENVILLE	SIMPSONVILLE	NPA	43	43			2,211	10,755	52.9	55.7%
XYZ	NORTH GREENVILLE LTC ACUTE CARE HOSP (W.J. BARGE)	1	GREENVILLE	TRAVELERS REST	NPA	45	45			13	233	4.9	13.0%
		2	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(90)	(3)	c	(1231)	(2955)		
XYZ	REGENCY HOSPITAL OF GREENVILLE	15	GREENVILLE	GREENVILLE	NPA	32	32						
XYZ	SAINT FRANCIS HOSPITAL	7	GREENVILLE	GREENVILLE	NPA	206	226			8,792	50,082	206	66.6%
XYZ	SAINT FRANCIS WOMANS & FAMILY HOSPITAL	7	GREENVILLE	GREENVILLE	NPA	62	83			4,614	13,721	62	60.6%
	GREENVILLE COUNTY		TOTAL			1,156	1,279			53,893	283,246	1,016.1	78.4%
XYZ	OCONEE MEMORIAL HOSPITAL		OCONEE	SENECA	NPA	160	160			7,776	32,867	160	56.3%
	OCONEE COUNTY					160	160			7,776	32,867	160	56.3%
XYZ	PALMETTO BAPTIST MED CTR - EASLEY	6	PICKENS	EASLEY	NPA	109	109			5,087	18,623	86	63.1%
XYZ	CANNON MEMORIAL		PICKENS	PICKENS	NPA	55	55			1,356	5,784	55	28.8%
	PICKENS COUNTY		TOTAL			164	164			6,443	24,407	151	44.3%
XYZ	B.J. WORKMAN MEMORIAL		SPARTANBURG	WOODRUFF	CO	43	43			991	2,642	43	16.8%
XYZ	MARY BLACK MEMORIAL		SPARTANBURG	SPARTANBURG	PROP	176	176			6,236	24,627	176	38.2%
XYZ	SPARTANBURG HOSP RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97			983	22,595	97	63.8%
XYZ	SPARTANBURG REGIONAL MEDICAL CTR.		SPARTANBURG	SPARTANBURG	CO	532	532			21,272	125,217	532	64.5%
	SPARTANBURG COUNTY		TOTAL			848	848			29,382	174,881	848	56.5%
	HOPE HOSPITAL	16	UNION	LOCKHART	CO	(0)	(0)	7	cd	-	-	16	0.0%
XYZ	WALLACE THOMSON		UNION	UNION	DIST	143	143	6	c	3,929	17,570	143	33.7%
	UNION COUNTY		TOTAL			143	143	13		3,929	17,570	159	30.3%
	TOTAL					3,091	3,214	13		123,652	639,979	2,954.1	59.4%
	MENTAL FACILITIES:												
XYZ	ANDERSON AREA MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38			699	4,525	38	32.6%
	ANDERSON COUNTY		TOTAL			38	38			699	4,525	38	32.6%
YZ	CAROLINA CENTER FOR BEHAVIORAL HEALTH	4	GREENVILLE	GREENVILLE	PROP	63	64			1,713	15,228	63	78.7%
YZ	SPRINGBROOK BEHAVIORAL HEALTHCARE SYSTEM (LTC PSYCHIATRIC)	5	GREENVILLE	TRAVELERS REST	PROP	5	5			199	2,201		
YZ	SPRINGBROOK BEHAV. HEALTHCARE SYSTEM	5	GREENVILLE	TRAVELERS REST	PROP	15	15						
XYZ	GREENVILLE MEMORIAL MEDICAL CTR.	1	GREENVILLE	GREENVILLE	NPA	53	46			1,551	13,594	53	59.1%
	GREENVILLE COUNTY		TOTAL			136	130			3,463	31,023	116	73.9%
XYZ	MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15			321	3,968	15	72.5%
XYZ	SPARTANBURG REGIONAL MEDICAL CTR.		SPARTANBURG	SPARTANBURG	CO	56	56			786	7,276	56	35.8%

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RECORD 004152

PMC.2013.SHP.0638

PET-EX008.0155

REGION: I

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING		ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	ANDERSON COUNTY		TOTAL			761	761	19		1,344	268,313	763	96.3%
YZ	BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132			128	46,789	132	97.1%
YZ	CHEROKEE COUNTY LTC	19	CHEROKEE	GAFFNEY	CO	85	97			36	30,958	85	99.8%
	CHEROKEE COUNTY		TOTAL			217	229			164	77,747	217	98.2%
Z	ALLEN BENNETT NURSING HOME	1	GREENVILLE	GREER	NPA	10	10			239	3,365	10	92.2%
YZ	BRIARWOOD NURSING CENTER		GREENVILLE	SIMPSONVILLE	PROP	42	39			30	12,803	42	83.5%
NHM	BRIGHTON GARDENS		GREENVILLE	GREENVILLE	PROP	45	45			110	14,453	45	88.2%
Z	FOUNTAIN INN NURSING HOME		GREENVILLE	FOUNTAIN INN	PROP	44	44	26	cd	19	15,347	44	95.8%
YZ	LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	CO	132	132			304	44,262	132	91.9%
YZ	GREENVILLE NURSING CENTER		GREENVILLE	GREENVILLE	PROP	79	79	18	d	88	22,995	79	79.7%
NHM	GREENVILLE MEM CTR SUBACUTE UNIT	1	GREENVILLE	GREENVILLE	NPA	18	(3)			-	-	3	0.0%
YZ	NORTH GREENVILLE	1	GREENVILLE	TRAVELERS REST	NPA	(27)	(27)			210	4,035	14.9	74.2%
YZ	MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	89	89	25	d	76	35,176	98	97.3%
YZ	MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120			139	42,650	120	97.4%
Y	NHC CENTER GREENVILLE		GREENVILLE	GREER	PROP	176	176			318	60,701	176	94.5%
YZ	NHC CENTER OF MAULDIN		GREENVILLE	MAULDIN	PROP	120	120			185	42,198	120	96.3%
YZ	OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132			207	46,649	132	96.8%
Z	OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125			154	44,021	125	96.5%
Z	PIEDMONT NURSING AND REHABILITATION		GREENVILLE	GREER	PROP	132	132			110	46,661	132	97.2%
YZ	ROGER HUNTINGTON NURSING CTR	14	GREENVILLE	GREENVILLE	NPA	88	176	(12)	s	66	31,014	88	96.6%
NHM	ROLLING GREEN VILLAGE HEALTH CARE FAC	11	GREENVILLE	GREENVILLE	NPA	10	10			17	3,180	10	87.1%
SW	(ROLLING GREEN VILLAGE HEALTH CARE FAC)		GREENVILLE	GREENVILLE	NPA	(34)	(34)					(34)	
YZ	ST FRANCIS TRANSITIONAL CARE UNIT	15	GREENVILLE	GREENVILLE	NPA	32	(32)			409	9,251	32	79.2%
YZ	SUMMIT PLACE		GREENVILLE	SIMPSONVILLE	PROP	132	132			137	46,610	132	96.7%
Z	STROUD NURSING HOME		GREENVILLE	MARIETTA	NPA	44	44	1	s	13	15,673	44	97.6%
YZ	WESTSIDE NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132			143	48,553	132	95.8%
	GREENVILLE COUNTY		TOTAL			1,712	1,747	70		2,868	587,917	1,711.9	94.1%
YZ	LILA DOYLE NURSING CARE	10	OCONEE	SENECA	CO	120	120			251	27,612	79	95.8%
YZ	MARINER HEALTH CARE OF SENECA		OCONEE	SENECA	PROP	132	132			258	44,531	132	92.4%
	OCONEE COUNTY		TOTAL			252	252			509	72,143	211	93.7%
Z	BLUE RIDGE NURSING CENTER		PICKENS	EASLEY	PROP	66	66	33	d	62	23,609	66	98.0%
Y	CLEMSON AREA RETIREMENT CENTER HEALTH		PICKENS	CLEMSON	PROP	30	30			36	8,019	30	73.2%
SW	(CLEMSON AREA RETIREMENT CENTER HEALTH)		PICKENS	CLEMSON	PROP	(22)	(22)					(22)	
NHM	COUNTRYSIDE CARE CENTER		PICKENS	EASLEY	PROP	44	44			44	9,932	44	61.8%
YZ	EASLEY NURSING CENTER		PICKENS	EASLEY	PROP	100	100	50	d	214	35,022	103	95.8%
Z	HARVEY'S NURSING HOME		PICKENS	SIX MILE	PROP	44	41	27	cd	23	15,721	44	97.9%
YZ	LAUREL HILL		PICKENS	PICKENS	PROP	80	80			47	26,706	80	98.3%
Z	ROSEMOND NURSING CTR		PICKENS	PICKENS	PROP	44	44	22	d	28	15,527	44	96.7%
Y	PALMETTO MED CTR-EASLEY TRANS CARE UNI	6	PICKENS	EASLEY	NPA	(13)	(13)			-	-	0	
	PICKENS COUNTY		TOTAL			411	405	132		445	137,535	411	91.7%
Z	CAMP CARE		SPARTANBURG	INMAN	PROP	88	88			47	31,388	88	97.7%
YZ	(SPARTANBURG HOSP RESTORATIVE CARE SNI	3	SPARTANBURG	SPARTANBURG	CO	(11)	(11)						
Z	GOLDEN AGE-INMAN		SPARTANBURG	INMAN	PROP	44	44			31	15,007	44	93.4%
YZ	INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	35			22	14,622	40	98.5%
YZ	MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176			175	62,741	176	97.7%
YZ	MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	89	89	62	ad	168	32,519	95	93.8%
YZ	MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88			88	31,705	88	98.7%
YZ	MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132			42	47,624	132	98.8%
NHN	ROSECREST NURSING CENTER	9	SPARTANBURG	INMAN	NPA	75	75			216	16,874	53.2	68.8%
YZ	SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33			65	9,128	33	75.8%
SW	(SKYLYN HEALTH CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)					(11)	
YZ	VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88			72	31,483	88	98.0%
YZ	WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192			210	68,284	192	97.4%
Y	WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88			106	31,423	88	97.8%
YZ	WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88			35	31,842	88	99.1%

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PMC.2013.SHP.0639

PET-EX008.0156

FOOTNOTES

2004 PLAN

REGION I

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

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

1. CON issued to transfer 13 beds from Hillcrest to GM resulting in 43 at Hillcrest & 641 at GM, 7/3/2000 SC-00-35. CON issued to transfer 5 general acute beds from NG to GM resulting in 646 general acute beds at GM and 0 acute beds at NG with the closure of the acute facility & the transfer of 28 nursing home beds to NG with 20 at GM & 28 at GM, SC-01-09 2/20/01. CON issued to add 55 new acute beds & convert 9 psych beds at GM for a total of 710 general & 63 psych beds, SC-01-57 10/10/01. NG licensed for 27 nursing beds and GM licensed nursing home beds reduced from 48 to 21 licensed and 20 survey beds 3/14/02. The nursing beds at NG reduced from 28 survey beds to 27 and the 1 bed added back to GM for 21 existing. CON issued for 45 bed LTC Acute Hosp at NG by converting the 27 nursing beds & moving 18 nursing beds from GM, leaving 3 nursing home beds at GM 4/15/03 SC-03-17. GM nursing home beds reduced from 21 to 3, 8/27/03. GM licensed general beds increased from 628 to 646, Hillcrest licensed beds decreased by 13 from 56 to 43 & NG licensed beds decreased from 5 to 0 to fulfill CONs SC-00-35 & SC-01-09 6/04/03. CON issued 8/25/03 for a 72 bed general acute hospital by transferring the 52 beds to be added from Allen Bennett with the reduction of 17 psych beds from Memorial and the transfer of the 3 nursing beds from GM, SC-03-46. This results in a new 72 bed licensed acute hospital, & GM with 710 general, 53 rehab, 46 psych beds and 0 licensed nursing beds. GM licensed general beds increased from 646 to 710 & licensed psych beds reduced from 72 to 63, 1/1/04. CON issued 4/21/04 to temporarily transfer 18 approved nursing home beds from Roger Huntington to GM, SC-04-21; licensed 10/26/04.
2. Facility use restricted to students.
3. Nursing home unit at Spartanburg Restorative de-licensed and closed 8/31/02.
4. CON issued to add 11 psych beds for a total of 64 psych and 13 substance abuse beds10/11/04 SC-04-46.
5. CON issued to reduce 24 long term psych beds from 44 to 20 and add 24 RFT beds from 44 to 68 RFT and 20 Long Term Psych beds, 6/12/01. Facility licensed for 68 RFT and 20 LTC Psych, 8/10/01. CON issued to convert 15 ltc psych beds to 15 acute psych beds & 5 ltc psych beds, 2/19/03, SC-03-12. Facility licensed for 5 ltc psych & 15 psych, 3/10/03.
6. CON issued to convert 13 nursing home beds to general for 109 general beds, 3/9/04 SC-04-13. Licensed for 109 general beds & Transitional Care Unit de-licensed 9/7/04.
7. CON issued to add 20 general beds to SF's 206 general beds for a total of 226, & 31 to SFW&F's 62 general beds for a total of 93, 8/25/03 SC-03-47.
8. E-02-15 issued 3/20/02 to permanently reduce the 27 nursing beds by 15 to 12 nursing beds. Licensed beds reduced to 12, 7/11/02. E-02-67 issued for permanent reduction of the 12 nursing home beds; de-licensed 12/24/02.
9. CON issued for 32 additional nursing home beds (non-Medicaid) for a total 75, 1/16/02 SC-02-80. Licensed beds increased 2/13/03.
10. CON issued for an additional 41 nursing home beds (25 Medicaid & 16 non-Medicaid) for a total of 120, 08/04/00, SC-00-40; licensed 4/15/03.

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INVENTORY OF EMERGENCY FACILITIES 2004 PLAN

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

(*) Met insufficient criteria to be classified.

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

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PET-EX008.0158

RECORD 004155

AREA SUMMARY

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

PMC.2013.SHP.0642

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RECORD 004156

REGION: II

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	GREENWOOD COUNTY		TOTAL			36	36		636	5,938	36	45.2%
YZ	THREE RIVERS BEHAVIORAL CARE		LEXINGTON	WEST COLUMBIA	PROP	39	39		1,490	13,675	39	96.1%
	LEXINGTON COUNTY		TOTAL			39	39		1,490	13,675	39	96.1%
XYZ	PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	104	104		2,537	22,975	104	60.5%
XYZ	PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60		1,837	14,789	60	67.4%
X	MONCRIEF ARMY HOSPITAL	2	RICHLAND	COLUMBIA	FED		(20)		(377)	(3020)		
X	W J B DORN VA	2	RICHLAND	COLUMBIA	FED		(60)		(515)	(4245)		
	RICHLAND COUNTY		TOTAL			164	164		4,374	37,744	164	63.1%
XYZ	PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20		362	2,360	20	32.3%
	YORK COUNTY		TOTAL			20	20		362	2,360	20	32.3%
	TOTAL					259	259		6,862	69,717	259	63.2%
	RESIDENTIAL TRATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
	THREE RIVERS BEHAVIORAL CARE	3	LEXINGTON	WEST COLUMBIA	PROP	20	20		20	6,321	18	96.2%
	NEW HOPE MIDLANDS	4	LEXINGTON	WEST COLUMBIA	PROP	59	59		45	17,829	59	83.3%
	YORK PLACE		YORK	YORK	PROP	40	40		36	9,115	40	62.4%
	TOTAL					119	119		101	33,365	117	78.1%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	THREE RIVERS BEHAVIORAL CARE		LEXINGTON	WEST COLUMBIA	PROP	27	27		427	2,840	27	28.8%
	SPRINGS MEMORIAL HOSPITAL	8	LANCASTER	LANCASTER	NPA	12	12		437	1,977	45	12.0%
	FAIRFIELD MEMORIAL HOSPITAL	21	FAIRFIELD	WINNSBORO	NPA	(17)	(17)		-	-	17	0.0%
	PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10		368	3,498	10	95.8%
	SELF MEMORIAL HOSPITAL		GREENWOOD	GREENWOOD	NPA	24	24		-	-	24	0.0%
	TOTAL					73	73		1,252	8,315	123	18.5%
	REHABILITATION FACILITIES:											
YZ	HEALTHSOUTH REHAB. HOSP. COLUMBIA	11	RICHLAND	COLUMBIA	PROP	96	96		1,602	26,824	96	76.6%
	RICHLAND COUNTY		TOTAL			96	96		1,602	26,824	96	76.6%
	HEALTHSOUTH REHAB. HOSP. ROCK HILL	16	YORK	ROCK HILL	PROP	34	34		663	10,588	32	90.7%
	YORK COUNTY		TOTAL			34	34		663	10,588	32	90.7%
	TOTAL					130	130		2,265	37,412	128	80.1%
	INPATIENT HOSPICE FACILITIES:											
CON	HOSPICE HOUSE HOSPICECARE PIEDMONT	24	GREENWOOD	GREENWOOD	NPA	-	15					
CON	PORTSBRIDGE INPATIENT HOSPICE	26	RICHLAND	COLUMBIA	PROP		12					
APP	HOSPICE AND COMMUNITY CARE	23	YORK	ROCK HILL	NPA	-	16					

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RECORD 004157
PMC.2013.SHP.0643
PET-EX008.0160

REGION: II

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING		ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
YZ	WHITE OAK MANOR - NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146			142	52,618	146	98.7%
	NEWBERRY COUNTY					276	276			418	97,737	276	97.0%
Y	RICE NURSING FACILITY	13	RICHLAND	COLUMBIA	NPA	32	32			76	10,814	32	93.4%
y	(BERNADIN HOSPICE HOUSE)	19	RICHLAND	COLUMBIA	NPA	(12)							
YZ	CAROLINA HEALTH & REHAB	29	RICHLAND	COLUMBIA	PROP	257	250	146	cd	317	87,191	257	92.9%
YZ	LIFE CARE CENTER OF COLUMBIA	7	RICHLAND	COLUMBIA	PROP	179	179			310	56,317	152.7	101.0%
YZ	LOWMAN HOME NURSING CENTER		RICHLAND	WHITEROCK	NPA	129	129			108	43,319	129	99.2%
SW	(LOWMAN HOME NURSING CENTER)		RICHLAND	WHITEROCK	NPA	(47)	(47)					(47)	
YZ	MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88			221	30,841	88	95.4%
YZ	HEARTLAND COLUMBIA REHAB & NURSING CTR		RICHLAND	COLUMBIA	PROP	132	132			328	41,356	132	85.8%
Y	NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	120	120			141	42,287	120	96.5%
Y	PROVIDENCE HOSPITAL NE - TRANS CARE UNIT		RICHLAND	COLUMBIA	PROP	18	18			398	5,298	18	80.6%
Y	PALMETTO BAPTIST MEDICAL CENTER		RICHLAND	COLUMBIA	NPA	22	22			662	6,324	22	78.8%
YZ	RIDGEVIEW MANOR	12	RICHLAND	HOPKINS	PROP	38	38			40	10,767	30	88.5%
YZ	WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120			73	42,625	120	97.8%
YZ	WILDEWOOD DOWNS NURSING CENTER	27	RICHLAND	COLUMBIA	PROP		32						
FED	W J B DORN VA		RICHLAND	COLUMBIA	FED		(160)			(248)	(33307)		
	RICHLAND COUNTY		TOTAL			1,135	1,160	146		2,674	379,259	1100.7	94.4%
YZ	SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176			151	62,088	176	96.7%
	SALUDA COUNTY		TOTAL			176	176			151	62,088	176	96.7%
NHM	CAROLINA VILLAGE HEALTH CARE CENTER		YORK	ROCK HILL	PROP	40	40			79	10,626	40	74.2%
NHM	EBENEZER SENIOR SERVICES	14	YORK	ROCK HILL	PROP	99	99			220	22,709	80.8	77.0%
YZ	MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106			103	37,395	106	96.7%
YZ	ROCK HILL HEALTHCARE		YORK	ROCK HILL	PROP	132	132			198	46,720	132	97.0%
YZ	HEALTHSOUTH REHABILITATION HOSP (SNF)	18	YORK	ROCK HILL	PROP	6	6			287	4,288	14	84.1%
NHM	WESTMINSTER HEALTH & REHABILITATION		YORK	ROCK HILL	PROP	66	66			195	20,211	66	83.8%
YZ	WHITE OAK MANOR - ROCK HILL		YORK	ROCK HILL	PROP	141	141			106	51,007	141	99.1%
YZ	WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109			81	39,327	109	98.8%
	YORK COUNTY		TOTAL			699	699			1,249	232,484	656.8	92.5%
	TOTAL					8,123	8,128	182		8,651	1,724,354	4883.9	96.7%

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

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

REGION NARRATIVE

REGION: III

FISCAL YEAR: 2004

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." Shaw Air Force Base near Sumter has a military hospital to provide health care services for the active duty and dependents residing in this region. The inland waterway is a barrier to transportation.

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

3. Nursing Homes: There is a need for additional nursing home beds in this region.

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

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

6. Rehabilitation Facilities: There is a need for additional rehabilitation beds in this region.

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REGION: III

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	HOSPITALS:											
XYZ	CHESTERFIELD GENERAL		CHESTERFIELD	CHERAW	PROP	59	59		2,263	7,408	59	34.4%
	CHESTERFIELD COUNTY TOTAL					59	59		2,263	7,408	59	34.4%
XY	CLARENDON MEMORIAL		CLARENDON	MANNING	CO	56	56		2,643	12,569	56	61.5%
	CLARENDON COUNTY TOTAL					56	56		2,643	12,569	56	61.5%
XYZ	CAROLINA PINES REGIONAL MEDICAL CTR	16	DARLINGTON	HARTSVILLE	NPA	116	166		7,913	31,337	116	74.0%
XYZ	WILSON MEDICAL CENTER		DARLINGTON	DARLINGTON	NPA	49	49		748	3,085	49	17.2%
	DARLINGTON COUNTY TOTAL					165	215		8,661	34,422	165	57.2%
XYZ	SAINT EUGENE MEDICAL CENTER	7	DILLON	DILLON	NPA	79	79		4,053	13,809	79	47.9%
	DILLON COUNTY TOTAL					79	79		4,053	13,809	79	47.9%
XYZ	CAROLINAS HOSPITAL SYSTEM	1	FLORENCE	FLORENCE	PROP	262	282		13,674	72,260	262	75.6%
XYZ	CAROLINAS HOSPITAL SYSTEM LAKE CITY		FLORENCE	LOWER FLORENCE	DIST	48	48		923	3,801	48	21.7%
XYZ	MCLEOD REGIONAL MEDICAL CENTER	2	FLORENCE	FLORENCE	NPA	336	453		23,453	111,121	336	90.6%
YZ	REGENCY HOSPITAL OF SC	1	FLORENCE	FLORENCE	PROP	28	28		342	9,251	28	90.5%
YZ	WOMEN'S CENTER CAROLINA HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20		1,141	2,984	20	40.9%
	FLORENCE COUNTY TOTAL					694	811		39,533	199,417	694	78.7%
XYZ	GEORGETOWN MEMORIAL HOSPITAL	8	GEORGETOWN	GEORGETOWN	NPA	131	131		7,452	35,458	142	68.4%
XYZ	WACCAMAW COMMUNITY HOSPITAL	8	GEORGETOWN	MURRELLS INLET	NPA	82	82		2,992	11,125	38.6	78.6%
	GEORGETOWN COUNTY TOTAL					213	213		10,444	46,583	180.6	70.6%
XYZ	CONWAY HOSPITAL		HORRY	CONWAY	NPA	160	160		9,047	34,022	160	58.3%
XYZ	GRAND STRAND REGIONAL MEDICAL CENTER	5	HORRY	MYRTLE BEACH	PROP	219	219		11,032	49,797	219	62.2%
XYZ	LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105		4,405	19,242	105	50.2%
	HORRY COUNTY TOTAL					484	484		24,484	103,021	484	58.3%
XYZ	MARION COUNTY MEDICAL CENTER		MARION	MARION	DIST	124	124		7,695	34,753	124	76.8%
	MARION COUNTY TOTAL					124	124		7,695	34,753	124	76.8%
	MARLBORO PARK		MARLBORO	BENNETTSVILLE	PROP	94	94		1,825	6,020	94	17.5%
	MARLBORO COUNTY TOTAL					94	94		1,825	6,020	94	17.5%
X	SHAW AFB	3	SUMTER	SUMTER	FED				(429)	(351)		
XYZ	TUOMEY	6	SUMTER	SUMTER	NPA	248	(11) 248		7,257	61,627	248	68.1%
	SUMTER COUNTY TOTAL					248	248		7,257	61,627	248	68.1%
XYZ	WILLIAMSBURG REGIONAL HOSPITAL	17	WILLIAMSBURG	KINGSTREE	CO	25	25		1,351	5,236	78	18.4%
	WILLIAMSBURG COUNTY TOTAL					25	25		1,351	5,236	78	18.4%
	TOTAL					2,241	2,408		110,229	524,985	2261.6	63.6%
	MENTAL FACILITIES:											
CON	WILSON MEDICAL CENTER	2	DARLINGTON	DARLINGTON			23					

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING		ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	LONG TERM FACILITIES:												
YZ	CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	100	99			36	35,680	100	97.5%
Z	(CHESTERFIELD GENERAL HOSPITAL SNF)	11	CHESTERFIELD	CHERAW	PROP	(7)	(7)						
YZ	CHESTERFIELD CONVALESCENT CTR		CHESTERFIELD	CHERAW	PROP	104	104			42	37,308	104	98.3%
	CHESTERFIELD COUNTY		TOTAL			204	203			78	72,988	204	98.0%
YX	LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88			44	31,162	88	97.0%
YX	WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	26	cd	39	22,503	64	96.3%
	CLARENDON COUNTY		TOTAL			152	131	26		83	53,665	152	96.7%
YZ	BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	36	36			39	6,543	36	49.8%
SW	(BETHEA BAPTIST HOME)		DARLINGTON	DARLINGTON	NPA	(52)	(52)					(52)	
YZ	MEDFORD PLACE		DARLINGTON	DARLINGTON	PROP	88	88			62	31,841	88	98.2%
YZ	MORRELL MEMORIAL CONVALESCENT CTR		DARLINGTON	HARTSVILLE	PROP	154	154			99	55,280	154	98.4%
YZ	OAKHAVEN CONVALESCENT CTR		DARLINGTON	DARLINGTON	PROP	88	88			61	31,378	88	97.7%
	DARLINGTON COUNTY		TOTAL			366	366			281	124,753	366	93.4%
YZ	THE PINES	18	DILLON	DILLON	PROP	84	84			49	29,622	84	97.3%
YZ	SUNNY ACRES		DILLON	FORK	PROP	111	106	58	cd	43	39,720	111	98.0%
YZ	(ST EUGENE MEDICAL CENTER - SNF)	7	DILLON	DILLON	NPA	(13)	(13)						
	DILLON COUNTY		TOTAL			195	190	58		92	69,342	195	97.7%
YZ	CAROLINAS HOSP SYSTEM TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	26	26			383	4,699	44	29.3%
YZ	COMMANDER HEALTH CARE		FLORENCE	FLORENCE	PROP	163	152			83	56,769	163	98.6%
YZ	FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	93			128	36,040	104	94.9%
Z	COOKE ASSOCCIATES OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88	44	d	34	28,940	88	90.1%
YZ	HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132			30	47,671	132	99.4%
YZ	HONORAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88			85	31,389	88	97.7%
YZ	LAKE CITY/SCRANTON HEALTH CARE CENTER		FLORENCE	SCRANTON	PROP	88	88			40	30,382	88	94.6%
YZ	SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	(42)	cd	41	31,705	88	98.7%
	FLORENCE COUNTY		TOTAL			777	755	44		844	269,795	795	93.0%
	(GEORGETOWN MEMORIAL HOSPITAL SNF)	8	(GEORGETOWN)	(GEORGETOWN)	NPA		(10)						
CON	LAKES AT LITCHFIELD SKILLED NURSING CTR	9	GEORGETOWN	PAWLEYS ISLAND	PROP	17	17			43	1,676	17	27.0%
	(LAKES AT LITCHFIELD SKILLED NURSING CTR)	9	(GEORGETOWN)	(PAWLEYS ISLAND	(PROP	(7)	(7)						
YZ	PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148			524	52,030	148	96.3%
YZ	WINYAH EXTENDED CARE CENTER		GEORGETOWN	GEORGETOWN	PROP	84	84			88	25,381	84	82.8%
	GEORGETOWN COUNTY		TOTAL			249	249			665	79,089	232	93.4%
Y	COVENANT TOWERS		HORRY	MYRTLE BEACH	PROP	30	30			43	7,561	30	69.0%
YZ	CONWAY NURSING CENTER		HORRY	CONWAY	PROP	190	190			148	63,419	190	91.4%
Y	GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88			145	31,226	88	97.2%
NH	(GRAND STRAND REGIONAL EXTEND CARE UNI	6	HORRY	MYRTLE BEACH	PROP	(18)	(18)			613	5,116	18	77.9%
YZ	KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88			399	29,889	88	92.4%
YZ	LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88			149	29,940	88	93.2%
YZ	MYRTLE BEACH MANOR		HORRY	MYRTLE BEACH	PROP	104	104			342	29,533	104	77.8%
Y	NHC HEALTHCARE GARDEN CITY		HORRY	MYRTLE BEACH	PROP	88	88			294	30,317	88	94.4%
	HORRY COUNTY		TOTAL			676	676			2,130	226,780	694	89.5%
YZ	MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120			105	41,621	120	95.0%
	LEE COUNTY		TOTAL			120	120			105	41,621	120	95.0%
YZ	MARION NURSING CENTER		MARION	MARION	PROP	88	88	1	c	62	31,269	88	97.4%
YZ	MULLINS NURSING CENTER		MARION	MARION	NPA	92	92			29	33,366	92	99.4%

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FOOTNOTES

2004 PLAN

REGION III

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

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

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

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RECORD 004163

INVENTORY OF EMERGENCY FACILITIES 2004 PLAN

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

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

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RECORD 004164

AREA SUMMARY

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

PMC.2013.SHP.0651

PET-EX008.0168

RECORD 004165

REGION: IV

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
	AIKEN COUNTY TOTAL					29	29		1,144	7,192	29	67.9%
XYZ	BEAUFORT MEMORIAL HOSPITAL	15	BEAUFORT	BEAUFORT	CO	20	14		608	3,026	20	41.5%
	BEAUFORT COUNTY TOTAL					20	14		608	3,026	20	41.5%
XYZ	CHARLESTON MEMORIAL HOSPITAL	13	CHARLESTON	CHARLESTON	CO	15	(15)				15	0.0%
XYZ	MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82		2,576	20,023	82	66.8%
XY	PALMETTO LOWCOUNTY BEHAVIORAL HEALTH	7	CHARLESTON	CHARLESTON	PROP	60	70		1,912	14,679	60	67.0%
XYZ	TRIDENT MEDICAL CENTER	5	CHARLESTON	CHARLESTON	PROP	(20)	(20)					
X	RALPH H JOHNSON VETERANS MEDICAL CTR		CHARLESTON	CHARLESTON	FED		(36)		(599)	(4244)		
	CHARLESTON COUNTY TOTAL					157	152		4,488	35,602	157	62.1%
	REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15		360	2,284	15	41.7%
	ORANGEBURG COUNTY TOTAL					15	15		360	2,284	15	41.7%
	TOTAL					221	210		5,992	45,078	221	55.8%
	RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
	PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32		2	593	32	5.0%
	NEW HOPE SUMMERVILLE	6	SUMMERVILLE	DORCHESTER	PROP	60	60		23	17,491	52	92.2%
	TOTAL					92	92		25	18,074	84	58.9%
	DRUG AND ALCOHOL INPATIENT TREATMENT:											
	AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18		218	1,128	18	17.2%
	(ROPER HOSPITAL NORTH)	19	CHARLESTON	N CHARLESTON	NPA	(44)	(44)					
	PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10		304	1,787	10	49.0%
	MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23		999	5,417	23	64.5%
	TOTAL					51	51		1,521	8,332	51	44.8%
	REHABILITATION FACILITIES:											
XYZ	BEAUFORT MEMORIAL HOSPITAL	16	BEAUFORT	BEAUFORT	CO	14	(14)		330	4,417	14	86.4%
	BEAUFORT COUNTY TOTAL					14	-		330	4,417	14	86.4%
XYZ	MEDICAL UNIVERSITY HOSPITAL	9	CHARLESTON	CHARLESTON	ST	25	(25)					
XYZ	ROPER HOSPITAL		CHARLESTON	CHARLESTON	NPA	39	39		1,099	11,150	39	78.3%
XYZ	HEALTHSOUTH CHARLESTON	10	CHARLESTON	CHARLESTON	PROP	46	46		858	14,494	42	84.5%
	CHARLESTON COUNTY TOTAL					110	85		1,957	25,644	81	68.7%
APP	COASTAL CAROLINA MEDICAL CENTER	14	JASPER	RIDGELAND	PROP		10					
	JASPER COUNTY TOTAL						10					
CON	REGIONAL MED CTR ORANGEBURG-CALHOUN	26	ORANGEBURG	ORANGEBURG	CO	24	24		442	7,360	24	84.0%
	ORANGEBURG COUNTY TOTAL					24	24		442	7,360	24	84.0%

RECORD 004166
PMC.2013.SHP.0652
PET-EX008.0169

REGION IV

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CONTROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU
YZ	HERMINA TRAEYE NURSING CENTER		CHARLESTON	CHARLESTON	NPA	132	132		70	44,132	132	91.6%
YZ	DRIFTWOOD REHAB. & NURSING CENTER		CHARLESTON	CHARLESTON	PROP	160	160		369	54,512	160	93.3%
NHM	LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148		518	52,386	148	97.0%
YZ	HEARTHLAND WEST ASHLEY REHAB & NURS CT	25	CHARLESTON	CHARLESTON	NPA	82	89		241	28,150	82	94.1%
YZ	SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176		246	60,104	176	93.5%
Y	TRIDENT SKILLED NURSING CENTER	6	CHARLESTON	CHARLESTON	PROP	25	25		473	5,181	25	56.8%
CON	TRINITY MISSION HEALTH & REHAB CHARLESTC	22	CHARLESTON	CHARLESTON	PROP	132	132					
YZ	WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176		118	60,588	176	94.3%
	CHARLESTON COUNTY		TOTAL			1,264	1,261		2,436	385,320	1150	91.8%
YZ	(COLLETON REGIONAL HOSP NURSING HOME)	12	COLLETON	WALTERBORO	PROP	(16)	(16)		119	2,255	16	41.2%
YZ	OAKWOOD HEALTH CARE CTR		COLLETON	WALTERBORO	PROP	132	132		197	44,814	132	92.5%
	COLLETON COUNTY		TOTAL			132	132		316	46,869	147	87.4%
YZ	HALLMARK HEALTHCARE CTR		DORCHESTER	SUMMERVILLE	PROP	88	88		186	32,120	88	100.0%
YZ	OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88		101	30,343	88	94.5%
	ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88		80	30,624	88	95.0%
YZ	SUMMERVILLE MED - SKILLED NURSING CARE C	8	DORCHESTER	SUMMERVILLE	PROP	14	14		307	3,642	20	49.8%
	DORCHESTER COUNTY		TOTAL			276	276		654	98,629	284	93.2%
Z	HARPER NURSING CENTER		HAMPTON	ESTILL	CO	104	104		133	29,073	104	76.6%
	HAMPTON COUNTY		TOTAL			104	104		133	29,073	104	76.6%
YZ	RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88		45	29,696	88	92.5%
	JASPER COUNTY		TOTAL			88	88		45	29,696	88	92.5%
YZ	LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113		146	33,335	113	80.8%
YZ	JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60		98	18,503	60	84.9%
YZ	ORANGEBURG NURSING HOME		ORANGEBURG	ORANGEBURG	PROP	88	88		64	30,569	88	95.1%
YZ	THE METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132		232	36,954	132	76.7%
	ORANGEBURG COUNTY		TOTAL			393	393		558	119,451	393	83.3%
	TOTAL					4,113	4,130	85	7,124	1,319,814	4032.8	89.7%

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PMC.2013.SHP.0653

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

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Duke University

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SULLIVAN.2013.0063

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Development of strategic plans for multihospital systems and individual health care organizations throughout the United States:

Assistance in the preparation of Certificate of Need applications for the construction of new hospitals and nursing homes, ambulatory surgery centers, major renovations of existing facilities, conversion of beds to new services, introduction of specialty services and technology, and development of home care services.

Preparation of financial feasibility studies for projects involving hospitals, long-term care facilities, ambulatory surgery centers, assisted living facilities, and other health care facilities and services.

Facilitation of planning processes for the creation of integrated health delivery systems.

Valuation of health care organizations and physician practices.

Market research for investor-owned health care companies in the areas of need and demand assessment, competition, and reimbursement characteristics of various geographic regions in connection with the development of specialty hospitals and long-term care services.

Expert testimony in connection with Certificate of Need litigation in several states in variety of areas relating to health care planning and financial issues.

Expert testimony in litigation challenging rules promulgated by various state agencies.

Expert testimony in civil litigation on a range of issues relating to health care planning, health care finance, and valuation of health care organizations.

Member of the South Carolina CON Review Panel, 2012, charged with evaluating the effectiveness of the CON program and suggesting changes.

Direction of product costing engagements for hospitals involving the determination of procedural level costs for use in product costing information systems.

Testimony before various state agencies and policy boards on issues related to health planning standards, need determination, financial access, and health financing.

PUBLICATIONS:

"Evaluating and Selecting Among Joint Venture Opportunities," *Topics in Health Care Financing*, Vol. 12, No.2, Winter 1985.

"New Strategies in a Changing Regulatory Environment," *Amherst Quarterly*, Winter 1985.

"Maximizing Hospital Outpatient Revenues," *Journal of Ambulatory Care Management*, Vol. 10, No.1, February 1983.

PRESENTATIONS:

"Economic Impact of Ambulatory Surgery Centers," Tennessee Bar Association, October 2003.

Considerations in Certificate of Need Regulation, Kentucky Health Strategy Forum, August 1999.

"Marketing Outpatient Services," Georgia Society for Health Care Planning and Marketing, October 1992.

"Evaluating and Negotiating Managed Care Contracts," West Virginia Hospital Association, February 1991.

"Certificate of Need Strategies," West Virginia Healthcare Financial Management Association, May 1990.

"Determining the Need for Retirement Housing," Florida Health Care Association, August 1989.
"Marketing Nursing Home Cost Effectiveness," American Health Care Association Annual Meeting, October 1989.

"Joint Ventures," Georgia Hospital Association, September 1986.

"Joint Ventures with Physicians," North Carolina-South Carolina Health Care Financial Management Associations Annual Meeting, August 1986.

"Medicare Reimbursement Trends," South Carolina Health Care Financial Management Association, January 1986.

"Alternative Revenue Sources," North Carolina Hospital Association, November 1985.

"Product Costing," Aspen Systems Seminar Series, 1984-85.

"Procedural Rate-Setting" Dixie Institute of Health Care Financial Management Association, 1983.

D H E C

PROMOTE PROTECT PROSPER

2012 – 2013

SOUTH CAROLINA HEALTH PLAN

EFFECTIVE 11/9/12

Petitioner's Trial Exhibit 012

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SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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Sophia Edwards-Bennett, M.D.	Provider
Bradley W. Moorhouse	Provider
Gayle L. Resetar	Provider
John H. Samies, M.D.	Provider
Phyllis B. Buie	Finance/Business
Martin (Marty) Cope	Finance/Business
William R. Shrader	Finance/ Insurance
W. H. "Ham" Hudson	Consumer
Roger Leaks, Jr.	Consumer
Charles D. Lindley (Vice Chairman)	Consumer
James S. Zoller, Ph.D.	Consumer
Elliott F. Elam, Jr.	Consumer Affairs Representative (Ex-Officio)
John O. Hutto, Sr., 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, 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.

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E. Standards of Construction and Equipment:

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

F. Standards for Maintenance and Operation:

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

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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:

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

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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 intoxification, 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 angiocardiography, 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; Angiocardiography, 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.

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"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.

CHAPTER III

ACUTE CARE HOSPITALS

A. General Hospitals:

1. Definitions:

"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.

2. Availability:

There are three counties in South Carolina that do not have an existing or approved hospital: Lee, McCormick, and Saluda. Calhoun County is served by the Regional Medical Center of Orangeburg and Calhoun Counties. General hospital beds are available within approximately thirty (30) minutes travel time for the majority of the residents of the State, and current utilization and population growth are factored into the methodology for determining the need for general hospital beds.

3. Bed Capacity:

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

Adequate square footage is defined as:

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

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

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

C. For Areas Included:

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

D. For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.
8. Corridors.
9. Solaria, waiting rooms and other areas that not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) [an area that is finished except for movable equipment shall not be considered unfinished space].
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are separate categories of bed utilizing the same criteria outlined for general acute beds.

4. Inventory:

A. All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding

inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

B. Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation, such as:
   1. Fire-resistivity of each building.
   2. Fire and other safety factors of each building.
   3. Design and structural factors affecting the function of nursing units.
   4. Design and structural factors affecting the function of service departments.

5. Narrative: General Hospital Beds:

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

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 75%.

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

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

Certificate of Need Standards

1. Calculations of bed need are made for individual hospitals, because of the differing occupancy factors used for individual facilities, and then summed by county or service area to get the overall county/service area bed need.

2. The methodology for calculating bed need is as follows:

A. Determine the current facility use rate by dividing the current utilization by the current population in each of the three age cohorts.

B. Multiply the current facility use rate by age cohort by the projected population for seven years in the future by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

C. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75) to determine the number of beds needed to meet the hospital's need.

D. The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing beds from the bed need.

E. The totals for each hospital in a county or service area are summed to determine whether there is an overall projected surplus or need for additional beds.

3. If a county or service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county/service area indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.

4. If there is a need for additional hospital beds in the county or service area, then any entity may apply to add these beds within the county, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the county/service area. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above, must document the need for additional beds based on historical and projected utilization, floor plan layouts, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

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

6. No additional hospitals will be approved unless they are a general hospital and will provide:

A. A 24-hour emergency services department, and meet the requirements to be a Level III emergency service as defined in Regulation 61-16 Sec. 613 Emergency Services.

B. Inpatient medical services to both surgical and non-surgical patients, and

C. Medical and surgical services on a daily basis within at least 6 of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS), as follows:

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

Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that unreimbursed services for indigent and charity patients are provided at a percentage which meets or exceeds other hospitals in the county or service area.

7. Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

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

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

8. In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.

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

10. Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:

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

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

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

D. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impact

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must be detailed, along with the perceived benefits of such an agreement;

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

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

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

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

11. Factors to be considered regarding modernization of facilities should include:

A. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
B. The ability to update medical technology within the existing plant.
C. Existence of The Joint Commission (TJC) or other accreditation body deficiencies or "grandfathered" licensure deficiencies.
D. Cost efficiency of the existing physical plant versus plant revision, etc.
E. Private rooms are now considered the industry standard.

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

The following pages depict the calculation of hospital bed need as described earlier.

Quality

CMS began implementing provisions of the Hospital Readmissions Reduction Program (part of the Patient Protection and Affordable Care Act) effective October 1, 2011. They will initially focus on readmission rates for heart attacks, heart failure, and pneumonia. Hospitals with excessive readmissions will face penalties of as much as 1% of their total Medicare billings for FY 2013, which will increase to 2% in FY 2014 and 3% in FY 2015.

A number of quality indicators have been identified for hospitals by organizations such as CMS (Hospital Compare), the Agency for Healthcare Research and Quality (AHRQ), and the Commonwealth Fund (Why Not the Best?). Data for these measures are accessible on-line, and it is possible to compare how hospitals rate on these various measures. They can also be compared against similar facilities (i.e. teaching hospitals) and against state and/or national averages.

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Unfortunately, because each organization categorizes its data differently, these indicators can only be discussed in generalities. They can be roughly divided into four categories. The first measurements are what CMS calls Hospital Process of Care measures. These capture how often hospitals perform the recommended processes for different diagnoses. For example, do the hospitals give heart attack patients aspirin when they arrive at the hospital and smoking cessation advice/counseling before they're discharged? Are surgical patients receiving the right antibiotics prior to surgery to prevent infections or the right treatment to prevent blood clots? Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

The second type of indicator is what AHRQ calls Patient Safety Indicators (PSIs). These are indicators on potential preventable in-hospital adverse events and complications following surgery, childbirth, and other procedures. They include anesthesia complications, decubitus ulcers, leaving foreign bodies in after surgery, post-operative infections, transfusion reactions, and birth trauma. Source: http://www.qualityindicators.ahrq.gov/downloads/psi/2006-Feb-PatientSafetyIndicators.pdf

A sub-set of patient safety indicators is DHEC's Hospital Acquired Infections (HAI) report. It lists the actual and expected rates of Surgical Site Infections (SSIs) for various types of surgeries (coronary bypass, gallbladder removal, hysterectomy, knee replacement, etc.) and Central Line Associated Blood Stream Infection (CLABSI) rates for hospitals. Source: http://www.scdhec.gov/health/disease/hai/reports.htm

Next are Inpatient Quality Indicators (IQIs). These include volume (where there has been a link determined between the number of procedures performed and an outcome such as mortality), in-house mortality (examines outcomes following procedures and for common medical conditions), and utilization (where questions have been raised about over-use or under-use of a procedure). Examples include in-house mortality from hip replacements, GI hemorrhages, strokes, and pneumonia, and the volume of open heart surgeries and cesarean sections performed. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

The final indicator is Patient Satisfaction. A patient's perceptions of the care received during a hospital stay impacts how the patient views the outcome of the stay. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was developed by CMS and AHRQ to collect patient feedback. It asks whether nurses were readily available when called, procedures were adequately explained before they were performed, the room was kept clean, it was quiet at night, etc. As part of these surveys, patients rate their overall satisfaction with the facility (0-10) and whether they would recommend the hospital to others. Perceptions of poor patient care can hurt a hospital, even if the outcomes were satisfactory. Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

Hospitals should have high compliance rates for the procedures that have been identified as improving the quality of care or reducing the risks of complications. Infection rates should be below or comparable to the expected numbers.

Relative Importance of Project Review Criteria

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

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

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

PET-EX012.0028

RECORD 004200

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANMED HEALTH MEDICAL CENTER	<18	45,000	46,000	621	2				
	18-64	114,800	119,700	35,222	101				
	+65	29,000	35,300	40,895	136				
	TOTAL	188,800	201,000	76,738	239	0.75	319	423	-104
ANMED WOMEN'S & CHILDRENS HOSPITAL	<18	45,000	46,000	121	0				
	18-64	114,800	119,700	6,845	20				
	+65	29,000	35,300	341	1				
	TOTAL	188,800	201,000	7,307	21	0.65	33	72	-39
ANDERSON COUNTY TOTAL							352	495	-143
UPSTATE CAROLINA MEDICAL CENTER	<18	13,700	14,300	535	2				
	18-64	34,600	36,700	6,052	18				
	+65	7,600	9,200	6,080	20				
	TOTAL	55,900	60,200	12,667	39	0.65	60	125	-65
CHEROKEE COUNTY TOTAL							60	125	-65
GREENVILLE MEMORIAL MEDICAL CENTER	<18	109,700	112,400	18,237	54				
	18-64	287,400	307,200	103,593	303				
	+65	59,100	72,600	50,695	171				
	TOTAL	456,200	492,200	172,525	525	0.75	700	746	-46
GREER MEMORIAL HOSPITAL	<18	109,700	112,400	220	1				
	18-64	287,400	307,200	7,277	21				
	+65	59,100	72,600	4,619	16				
	TOTAL	456,200	492,200	12,116	37	0.65	58	82	-24
HILLCREST MEMORIAL HOSPITAL	<18	109,700	112,400	7	0				
	18-64	287,400	307,200	3,687	11				
	+65	59,100	72,600	2,974	10				
	TOTAL	456,200	492,200	6,668	21	0.65	32	43	-11
PATEWOOD MEMORIAL HOSPITAL	<18	109,700	112,400	62	0				
	18-64	287,400	307,200	1,167	3				
	+65	59,100	72,600	1,173	4				
	TOTAL	456,200	492,200	2,402	8	0.65	12	72	-60
SAINT FRANCIS - DOWNTOWN & (SAINT FRANCIS MILLENNIUM) 1	<18	109,700	112,400	315	1				
	18-64	287,400	307,200	22,500	66				
	+65	59,100	72,600	32,025	108				
	TOTAL	456,200	492,200	54,840	175	0.70	249	226	23
SAINT FRANCIS - EASTSIDE	<18	109,700	112,400	189	1				
	18-64	287,400	307,200	13,507	40				
	+65	59,100	72,600	2,805	9				
	TOTAL	456,200	492,200	16,501	50	0.65	76	93	-17
GREENVILLE COUNTY TOTAL							1,127	1,262	-135

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
OCONEE MEMORIAL HOSPITAL	<18	15,700	16,100	588	2				
	18-64	44,800	46,900	16,942	49				
	+65	14,600	18,500	11,694	41				
	TOTAL	75,100	81,500	29,234	91	0.65	140	169	-29
OCONEE COUNTY TOTAL							140	169	-29
BAPTIST MEDICAL CENTER EASLEY	<18	24,500	25,700	263	1				
	18-64	78,800	85,800	7,945	23				
	+65	16,500	20,300	12,099	41				
	TOTAL	120,800	131,800	20,307	65	0.65	100	109	-9
CANNON MEMORIAL HOSPITAL	<18	24,500	25,700	15	0				
	18-64	79,800	85,600	1,599	5				
	+65	16,500	20,300	2,385	8				
	TOTAL	120,800	131,600	3,999	13	0.65	20	55	-35
PICKENS COUNTY TOTAL							120	164	-44
MARY BLACK MEMORIAL	<18	69,600	71,000	799	2				
	18-64	178,000	188,500	12,442	36				
	+65	39,300	46,400	13,438	45				
	TOTAL	286,900	305,900	26,679	83	0.65	128	174	-46
SPARTANBURG REG MED CTR	<18	69,600	71,000	3,261	9				
	18-64	178,000	188,500	67,929	195				
	+65	39,300	46,400	60,347	204				
	TOTAL	286,900	305,900	131,537	408	0.75	544	532	12
VILLAGE HEALTH CENTRE	<18	69,600	71,000	128	0				
	18-64	178,000	188,500	2,668	8				
	+65	39,300	46,400	2,461	8				
	TOTAL	286,900	305,900	5,257	16	0.68	25	48	-23
SPARTANBURG COUNTY TOTAL							672	706	-34
WALLACE THOMSON HOSPITAL	<18	6,600	6,400	298	1				
	18-64	17,500	18,700	4,440	12				
	+65	4,900	5,500	5,217	16				
	TOTAL	29,000	28,600	9,955	28	0.65	44	143	-99
UNION COUNTY TOTAL							44	143	-99
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	5,800	5,900	84	0				
	18-64	15,500	15,700	848	2				
	+65	4,300	5,200	1,728	6				
	TOTAL	25,600	26,800	2,640	8	0.65	13	25	-12
ABBEVILLE COUNTY TOTAL							13	25	-12

RECORD 004202

PET-EX012.0030

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	6,000	6,100	288	1				
	18-64	20,400	20,400	2,178	6				
	+65	4,900	6,000	2,394	8				
	TOTAL	33,300	34,500	4,858	15	0.65	23	82	-59
CHESTER COUNTY TOTAL							23	82	-59
EDGEFIELD COUNTY HOSPITAL	<18	5,600	5,600	21	0				
	18-64	17,900	19,100	391	1				
	+65	3,700	5,200	944	4				
	TOTAL	27,400	30,100	1,356	5	0.65	7	25	-18
EDGEFIELD COUNTY TOTAL							7	25	-18
FAIRFIELD MEMORIAL HOSPITAL	<18	5,400	5,500	81	0				
	18-64	15,000	14,800	976	3				
	+65	3,700	5,000	1,027	4				
	TOTAL	24,100	25,300	2,034	7	0.65	10	25	-15
FAIRFIELD COUNTY TOTAL							10	25	-15
SELF REGIONAL HEALTHCARE	<18	16,500	17,000	1,681	5				
	18-64	42,800	44,300	27,197	77				
	+65	10,800	12,500	25,580	81				
	TOTAL	70,100	73,800	54,458	183	0.75	217	354	-137
GREENWOOD COUNTY TOTAL							217	354	-137
KERSHAW HEALTH	<18	15,300	15,900	999	3				
	18-64	38,200	40,400	10,566	31				
	+65	9,100	11,500	13,413	46				
	TOTAL	62,600	67,800	24,978	80	0.65	123	121	2
KERSHAW COUNTY TOTAL							123	121	2
SPRINGS MEMORIAL HOSPITAL	<18	17,800	17,800	1,103	3				
	18-64	47,200	48,200	13,993	39				
	+65	12,000	14,900	16,860	57				
	TOTAL	77,000	81,000	31,956	100	0.70	142	199	-57
LANCASTER COUNTY TOTAL							142	199	-57
LAURENS COUNTY HOSPITAL	<18	15,400	15,600	220	1				
	18-64	41,500	44,300	5,260	15				
	+65	10,300	12,800	6,665	23				
	TOTAL	67,200	72,700	12,165	39	0.65	60	76	-16
LAURENS COUNTY TOTAL							60	76	-16
LEXINGTON MEDICAL CENTER	<18	45,982	47,801	1,045	3				
	18-64	124,039	133,494	47,800	141				
	+65	23,185	30,120	38,993	139				
	TOTAL	193,186	211,415	87,838	283	0.75	377	414	-37
LEXINGTON COUNTY TOTAL							377	414	-37

RECORD 004203

PET-EX012.0031

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
NEWBERRY COUNTY MEMORIAL	<18	6,600	6,700	269	1				
	18-64	23,000	23,200	3,223	9				
	+65	6,100	7,600	4,502	15				
	TOTAL	37,700	39,500	7,994	25	0.65	38	90	-52
NEWBERRY COUNTY TOTAL							38	90	-52
PALMETTO HEALTH BAPTIST & 2 PALMETTO HEALTH PARKRIDGE	<18	106,309	109,900	931	3				
	18-64	305,061	317,506	52,607	151				
	+65	49,435	64,581	17,784	64				
	TOTAL	460,805	491,987	71,522	217	0.75	289	363	-74
PALMETTO HEALTH RICHLAND	<18	106,309	109,900	24,439	69				
	18-64	305,061	317,506	96,548	275				
	+65	49,435	64,581	48,058	172				
	TOTAL	460,805	491,987	169,045	517	0.75	689	579	110
PROVIDENCE HOSPITAL	<18	106,309	109,900	244	1				
	18-64	305,061	317,506	17,698	50				
	+65	49,435	64,581	28,666	103				
	TOTAL	460,805	491,987	46,608	154	0.70	220	258	-38
PROVIDENCE HOSPITAL NORTHEAST	<18	106,309	109,900	91	0				
	18-64	305,061	317,506	6,559	19				
	+65	49,435	64,581	4,119	15				
	TOTAL	460,805	491,987	10,769	34	0.65	52	84	-32
RICHLAND COUNTY TOTAL							1,250	1,284	-34
PIEDMONT MEDICAL CENTER	<18	57,900	59,600	1,408	4				
	18-64	145,100	159,800	30,380	92				
	+65	26,600	34,500	28,952	103				
	TOTAL	229,600	253,900	60,750	199	0.70	284	268	16
CAROLINAS MED CTR - FORT MILL 3	<18	57,900	59,600						
	18-64	145,100	159,800						
	+65	26,600	34,500						
	TOTAL	229,600	253,900			0.65		84	
YORK COUNTY TOTAL				60,750	199		284	332	16
REGION III									
CHESTERFIELD GENERAL HOSPITAL	<18	11,600	11,600	418	1				
	18-64	28,900	29,100	3,760	10				
	+65	6,500	8,200	4,015	14				
	TOTAL	47,000	48,900	8,193	24	0.65	37	59	-22
CHESTERFIELD COUNTY TOTAL							37	59	-22
CLARENDON MEMORIAL HOSPITAL	<18	7,800	7,800	374	1				
	18-64	21,200	20,700	7,257	19				
	+65	6,200	8,400	3,734	14				
	TOTAL	35,200	36,900	11,365	34	0.65	53	56	-3
CLARENDON COUNTY							53	56	-3

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CAROLINA PINES REGIONAL	<18	16,600	16,200	1,094	3				
	18-64	42,300	42,000	9,848	27				
	+65	10,000	12,900	7,337	26				
	TOTAL	68,900	71,100	18,279	56	0.65	86	116	-30
MCLEOD MEDICAL CENTER - DARLINGTON	<18	16,600	16,200	0	0				
	18-64	42,300	42,000	599	2				
	+65	10,000	12,900	1,519	5				
	TOTAL	68,900	71,100	2,118	7	0.65	11	49	-38
DARLINGTON COUNTY TOTAL							97	165	-68
MCLEOD MEDICAL CENTER - DILLON	<18	8,500	8,200	586	2				
	18-64	19,200	18,800	5,514	15				
	+65	4,200	5,300	3,705	13				
	TOTAL	32,000	32,300	9,805	29	0.65	45	79	-34
DILLON COUNTY TOTAL							45	79	-34
CAROLINAS HOSPITAL SYSTEM	<18	33,800	34,200	1,819	5				
	18-64	85,400	86,000	37,722	104				
	+65	18,700	24,100	29,829	105				
	TOTAL	137,900	144,300	69,370	214	0.70	306	310	-4
WOMENS CTR CAROLINAS HOSP SYSTEM	<18	33,800	34,200	102	0				
	18-64	85,400	86,000	2,105	6				
	+65	18,700	24,100	0	0				
	TOTAL	137,900	144,300	2,207	6	0.65	9	20	-11
LAKE CITY COMMUNITY HOSPITAL	<18	33,800	34,200	101	0				
	18-64	85,400	86,000	1,847	5				
	+65	18,700	24,100	1,201	4				
	TOTAL	137,900	144,300	3,149	9	0.65	14	48	-34
MCLEOD REGIONAL MEDICAL CENTER	<18	33,800	34,200	7,404	21				
	18-64	85,400	86,000	58,238	161				
	+65	18,700	24,100	47,180	167				
	TOTAL	137,900	144,300	112,822	348	0.75	464	453	11
FLORENCE COUNTY TOTAL							793	831	-38
GEORGETOWN MEMORIAL HOSPITAL	<18	13,000	12,300	762	2				
	18-64	35,400	35,400	7,695	21				
	+65	12,500	17,800	14,859	58				
	TOTAL	60,900	65,500	23,316	81	0.65	125	131	-6
WACCAMAW COMMUNITY HOSPITAL	<18	13,000	12,300	417	1				
	18-64	35,400	35,400	6,777	24				
	+65	12,500	17,800	18,186	75				
	TOTAL	60,900	65,500	28,380	100	0.65	154	124	30
GEORGETOWN COUNTY TOTAL							279	255	24

RECORD 004205

PET-EX012.0033

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CONWAY HOSPITAL	<18	54,300	55,200	1,054	3				
	18-64	171,700	189,400	17,358	52				
	+65	48,300	65,100	15,065	56				
	TOTAL	274,300	309,700	33,477	111	0.70	159	210	-51
GRAND STRAND REGIONAL MEDICAL CTR	<18	54,300	55,200	1,125	3				
	18-64	171,700	189,400	28,489	86				
	+65	48,300	65,100	34,674	128				
	TOTAL	274,300	309,700	64,289	217	0.70	310	269	41
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER 4	<18	54,300	55,200	518	1				
	18-64	171,700	189,400	6,564	20				
	+65	48,300	65,100	7,687	28				
	TOTAL	274,300	309,700	14,769	50	0.65	76	155	-79
HORRY COUNTY TOTAL							545	634	-89
MARION REGIONAL HOSPITAL	<18	6,000	7,700	499	1				
	18-64	20,200	19,600	7,527	20				
	+65	4,900	6,800	4,171	16				
	TOTAL	33,100	34,100	12,197	37	0.65	57	124	-67
MARION COUNTY TOTAL							57	124	-67
MARLBORO PARK HOSPITAL	<18	6,300	6,000	218	1				
	18-64	18,700	17,200	2,144	5				
	+65	3,900	4,700	1,447	5				
	TOTAL	28,900	27,900	3,809	11	0.65	17	94	-77
MARLBORO COUNTY TOTAL							17	94	-77
TUOMEY	<18	27,600	28,400	2,487	7				
	18-64	68,300	67,200	24,512	68				
	+65	14,300	18,000	38,853	134				
	TOTAL	108,200	113,600	65,852	209	0.70	299	283	16
SUMTER COUNTY TOTAL							299	283	16
WILLIAMSBURG REGIONAL HOSPITAL	<18	8,100	7,600	18	0				
	18-64	21,100	19,800	1,030	3				
	+65	5,200	6,800	1,212	4				
	TOTAL	34,400	34,200	2,260	7	0.65	11	25	-14
WILLIAMSBURG COUNTY TOTAL							11	25	-14
REGION IV									
AIKEN REGIONAL MEDICAL CENTER	<18	35,900	37,600	470	1				
	18-64	99,800	106,300	20,310	59				
	+65	25,500	32,600	22,067	77				
	TOTAL	162,200	176,500	42,847	138	0.70	197	183	14
AIKEN COUNTY TOTAL							197	183	14

RECORD 004206

PET-EX012.0034

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
ALLENDALE COUNTY HOSPITAL	<18	2,300	2,300	12	0				
	18-64	6,700	6,400	220	1				
	+65	1,400	1,900	583	2				
	TOTAL	10,400	10,600	815	3	0.65	4	25	-21
ALLENDALE COUNTY TOTAL							4	25	-21
(BAMBERG COUNTY MEMORIAL) 5	<18	3,500	3,300	34	0				
	18-64	8,700	8,800	869	2				
	+65	2,600	3,300	1,245	4				
	TOTAL	15,800	15,400	2,148	7	0.65	10	59	-49
BAMBERG COUNTY TOTAL							10	59	-49
BARNWELL COUNTY HOSPITAL	<18	5,800	5,700	111	0				
	18-64	13,800	14,100	1,192	3				
	+65	3,300	4,400	1,329	5				
	TOTAL	22,900	24,200	2,632	8	0.65	13	53	-40
BARNWELL COUNTY TOTAL							13	53	-40
BEAUFORT MEMORIAL HOSPITAL	<18	34,100	32,500	1,230	3				
	18-64	98,000	102,800	17,037	50				
	+65	35,100	50,200	16,855	74				
	TOTAL	165,200	185,500	37,122	127	0.65	196	169	27
HILTON HEAD HOSPITAL	<18	34,100	32,500	189	0				
	18-64	98,000	102,800	6,250	18				
	+65	35,100	50,200	11,535	45				
	TOTAL	165,200	185,500	17,974	64	0.65	99	93	6
BEAUFORT COUNTY TOTAL							295	262	33
TRIDENT MED CENTER & BERKELEY 6 MEDICAL CENTER	<18	155,500	161,600	1,297	4				
	18-64	434,900	439,600	33,325	82				
	+65	79,900	108,700	33,020	123				
	TOTAL	670,300	709,900	67,642	219	0.70	313	346	-33
SUMMERVILLE MEDICAL CENTER	<18	155,500	161,600	454	1				
	18-64	434,900	439,600	11,672	32				
	+65	79,900	108,700	8,936	33				
	TOTAL	670,300	709,900	21,062	67	0.65	103	124	-21
MUSC MEDICAL CENTER	<18	155,500	161,600	28,715	82				
	18-64	434,900	439,600	94,369	261				
	+65	79,900	108,700	39,876	149				
	TOTAL	670,300	709,900	162,960	492	0.75	656	604	52
ROPER, ROPER ST FRANCIS MT PLEASANT & ROPER ST FRANCIS - BERKELEY 7	<18	155,500	161,600	81	0				
	18-64	434,900	439,600	32,474	90				
	+65	79,900	108,700	39,667	148				
	TOTAL	670,300	709,900	72,222	238	0.75	317	401	-84
BON SECOURS ST FRANCIS XAVIER	<18	155,500	161,600	256	1				
	18-64	434,900	439,600	19,483	54				
	+65	79,900	108,700	12,980	48				
	TOTAL	670,300	709,900	32,719	103	0.70	148	204	-56

RECORD 004207

PET-EX012.0035

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
EAST COOPER REGIONAL MEDICAL CTR	<18	155,500	161,600	5,749	16				
	18-64	434,900	439,600	3,014	8				
	+65	79,900	108,700	5,732	21				
	TOTAL	670,300	709,900	14,495	46	0.65	71	140	-69
BERKELEY/CHARLESTON/DORCHESTER TOTAL							1,608	1,819	-211
COLLETON MEDICAL CENTER	<18	9,500	9,900	541	2				
	18-64	23,400	23,700	11,857	33				
	+65	6,200	8,000	9,017	32				
	TOTAL	39,100	41,600	21,415	66	0.65	103	131	-28
COLLETON COUNTY TOTAL							103	131	-28
HAMPTON REGIONAL MEDICAL CTR	<18	5,100	5,100	40	0				
	18-64	13,200	13,400	1,888	5				
	+65	3,000	3,900	1,953	7				
	TOTAL	21,300	22,400	3,889	12	0.65	18	32	-14
HAMPTON COUNTY TOTAL							18	32	-14
COASTAL CAROLINA MED CTR	<18	6,100	5,900	695	2				
	18-64	16,100	17,700	959	3				
	+65	2,900	3,800	3,396	12				
	TOTAL	25,100	27,400	5,050	17	0.65	26	41	-15
JASPER COUNTY TOTAL							26	41	-15
REG MED CTR ORANGEBURG-CALHOUN	<18	21,500	21,600	1,903	5				
	18-64	57,400	57,200	22,688	62				
	+65	14,200	17,900	23,331	81				
	TOTAL	93,100	96,700	47,922	148	0.70	212	247	-35
ORANGEBURG/CALHOUN COUNTY TOTAL							212	247	-35

1 ST. FRANCIS MILLINIUM HOSPITAL CON APPROVED 6/12/09. CON VOIDED 8/1/11.
2 BED NEEDS COMBINED; NEW HOSPITAL CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED. CON ISSUED 6/8/10.
3 CON APPROVED 9/9/11; APPEALED.
4 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL.
5 HOSPITAL CLOSED 4/30/12. BAMBERG & BARNWELL BED NEEDS BROKEN BACK INTO INDIVIDUAL COUNTIES.
6 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL; APPEALED.
7 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.

RECORD 004208
PET-EX012.0036

HOSPITAL OCCUPANCY RATES

	2009	2010	2011
REGION I	**53.5**	**52.1**	**52.6**
ANMED HEALTH MEDICAL CENTER	49.2	48.8	49.7
ANMED HEALTH WOMEN'S & CHILDREN'S	30.5	28.9	27.8
UPSTATE CAROLINA MEDICAL CENTER	38.2	31.5	27.8
GREENVILLE MEMORIAL MEDICAL CTR	62.6	61.4	63.4
GREER MEMORIAL	55.1	40.0	40.5
HILLCREST MEMORIAL HOSPITAL	41.8	43.7	42.5
PATEWOOD MEMORIAL	11.1	10.3	9.1
SAINT FRANCIS - DOWNTOWN	71.4	65.5	66.5
SAINT FRANCIS - EASTSIDE	53.1	50.6	48.6
OCONEE MEMORIAL HOSPITAL	48.0	48.4	47.4
CANNON MEMORIAL HOSPITAL	18.1	19.6	19.9
BAPTIST MEDICAL CENTER EASLEY	46.8	47.5	51.0
MARY BLACK MEMORIAL HOSPITAL	41.9	42.3	41.5
SPARTANBURG REGIONAL MEDICAL CTR	71.8	74.2	74.5
VILLAGE HEALTHCARE CENTRE	18.0	30.6	30.0
WALLACE THOMSON HOSPITAL	18.1	17.8	19.1
REGION II	**57.4**	**55.7**	**55.0**
ABBEVILLE AREA MEDICAL CENTER	26.0	31.7	28.9
CHESTER REGIONAL MEDICAL CENTER	23.3	19.1	16.2
EDGEFIELD COUNTY HOSPITAL	19.2	13.3	14.9
FAIRFIELD MEMORIAL HOSPITAL	32.0	33.1	22.3
SELF REGIONAL HEALTHCARE	42.8	39.8	42.8
KERSHAW HEALTH	60.5	54.1	56.6
SPRINGS MEMORIAL HOSPITAL	52.4	39.6	44.0
LAURENS COUNTY HOSPITAL	43.2	42.9	43.9
LEXINGTON MEDICAL CENTER	66.2	63.8	58.1
NEWBERRY COUNTY MEM HOSPITAL	30.5	24.7	24.3
PALMETTO HEALTH BAPTIST	53.4	52.2	53.3
PALMETTO HEALTH RICHLAND	76.1	80.8	80.0
PROVIDENCE HOSPITAL	55.4	55.4	49.5
PROVIDENCE HOSPITAL NORTHEAST	61.3	51.6	52.7
PIEDMONT MEDICAL CENTER	57.1	58.0	62.1

	2009	2010	2011
REGION III	**57.0**	**54.3**	**54.1**
CHESTERFIELD GENERAL HOSPITAL	47.8	42.5	38.0
CLARENDON MEMORIAL HOSPITAL	66.0	60.9	55.6
CAROLINA PINES REGIONAL MED CTR	71.0	53.2	43.2
MCLEOD MED CTR - DARLINGTON	12.3	17.9	11.8
MCLEOD MED CTR - DILLON	36.8	41.5	34.0
CAROLINAS HOSPITAL SYSTEM	53.5	60.4	61.3
LAKE CITY COMMUNITY HOSPITAL	24.7	18.5	18.0
MCLEOD REGIONAL MEDICAL CENTER	68.5	70.5	68.2
WOMEN'S CENTER CAROLINAS HOSP	47.7	39.1	30.2
GEORGETOWN MEMORIAL HOSPITAL	57.3	54.0	48.6
WACCAMAW COMMUNITY HOSPITAL	87.4	57.8	62.5
CONWAY HOSPITAL	61.3	58.8	57.3
GRAND STRAND REGIONAL MED CTR	72.0	76.7	80.4
LORIS COMMUNITY HOSPITAL	43.0	39.4	35.0
SEACOAST	—	—	29.1
MARION REGIONAL HOSPITAL	39.0	29.8	26.9
MARLBORO PARK HOSPITAL	12.3	14.4	15.4
TUOMEY	64.6	63.3	63.8
WILLIAMSBURG REGIONAL HOSPITAL	16.4	38.0	24.8
REGION IV	**56.7**	**55.7**	**54.9**
AIKEN REGIONAL MEDICAL CENTER	60.3	61.8	64.1
ALLENDALE COUNTY HOSPITAL	13.6	10.3	8.9
BAMBERG COUNTY MEMORIAL HOSP	14.2	20.5	10.0
BARNWELL COUNTY HOSPITAL	12.4	14.5	13.6
BEAUFORT MEMORIAL HOSPITAL	65.5	60.4	60.2
HILTON HEAD REGIONAL MEDICAL CTR	56.2	53.8	53.0
SUMMERVILLE MEDICAL CENTER	60.6	65.4	61.4
BON SECOURS ST FRANCIS XAVIER	47.5	43.8	43.9
EAST COOPER MEDICAL CENTER	46.5	33.8	30.5
MUSC MEDICAL CENTER	68.7	72.5	73.9
ROPER HOSPITAL	54.9	51.5	59.3
ROPER MOUNT PLEASANT HOSPITAL	—	12.3	12.2
TRIDENT MEDICAL CENTER	65.8	64.9	62.6
COLLETON MEDICAL CENTER	47.8	43.7	44.8
HAMPTON REGIONAL MEDICAL CENTER	31.9	32.5	31.6
COASTAL CAROLINA MEDICAL CENTER	33.6	37.5	36.0
REG MED CTR ORANGEBURG/CALHOUN	57.5	56.1	53.2

RECORD 004209
PET-EX012.0037

B. Long-Term Acute Care Hospitals:

Long Term Acute Care Hospitals (LTACHs) are hospitals with an average Medicare inpatient length of stay of greater than 25 days, including all covered and non-covered days of stay of Medicare patients. The 25 day Medicaid ALOS requirement has been waived for some pilot programs. They provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care. Medicare pays for about 73% of all LTACH discharges; the standard federal reimbursement for 2011 was $37,405 per patient.

As of November 2010 there were 434 LTACHs nationwide, and they may be either a freestanding facility, or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional Federal criteria in order to qualify as a LTACH Hospital under the "hospital-within-a-hospital" model:

1) The new hospital must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.

2) The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.

3) The hospital must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4) The hospital must have a separate medical staff from the medical staff of the host hospital, which report directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

The existing LTACHs in South Carolina and their occupancy rates are:

FACILITY	COUNTY	BEDS	2009	2010	2011
NORTH GREENVILLE LONG TERM ACUTE	GREENVILLE	45	62.3	54.4	52.2
REGENCY HOSPITAL OF GREENVILLE *1*	GREENVILLE	32	71.6	---	77.7
SPARTANBURG HOSP RESTORATIVE CARE	SPARTANBURG	97	34.6	37.0	34.2
INTERMEDICAL HOSPITAL OF SC	RICHLAND	35	67.9	61.5	60.0

REGENCY HOSPITAL OF SOUTH CAROLINA		FLORENCE	40	77.0	85.4	81.0
PACE HEALTHCARE COMMONS	*2*	BEAUFORT	32	---	---	---
KINDRED HOSPITAL CHARLESTON	*3*	CHARLESTON	59	46.0	47.9	45.6
		TOTAL	340			

1 FACILITY FAILED TO PROVIDE UTILIZATION DATA FOR 2010.
2 CON ISSUED 9/22/11, SC-11-36.
3 CON ISSUED FOR REPLACEMENT HOSPITAL 6/3/11, SC-11-18.

Certificate of Need Standards

1. An application for a Long Term Acute Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

2. Although Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Long Term Acute Care Hospital beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.

4. A hospital that has leased general beds to a Long Term Acute Care Hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required:

   A. a hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;

   B. a hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.

5. A hospital which desires to be designated as an LTACH and has been awarded a CON for that purpose, must be certified as an LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose

shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Quality

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Central Line Associated Blood Stream Infections (CLABSI) ratio for LTACHs. Each LTACH is compared to the national standard population of hospitals entering HAI data into the National Healthcare Safety Network (NHSN) database. The Standardized Infection Ratio (SIR) is a summary measure used to compare the CLABSI experience among a group of reported locations to that of a standard population. It is the observed number of infections divided by the expected (predicted) number of infections. For HAI reports, the standard population comes from NHSN data reported from all hospitals using the system in the United States. The "expected" number of infections is based on historical data for those procedures at the national level. All South Carolina LTACHs should be lower than, or not different from, their statistically expected ratios. The 2009-2010 report is accessible online at: http://www.scdhec.gov/health/disease/hai/docs/10/Table%206%20-%20CLABSI%20SIR%20Long%20Term%20Acute%20Care.pdf. The Department may use the HAI report in evaluating a CON application for additional LTACH beds at an existing facility.

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

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

C. Critical Access Hospitals:

Rural counties tend to have higher unemployment and a preponderance of low-paying jobs that do not provide health insurance; a greater percentage of their population is elderly. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

CMS has several programs, such as the Medicare Rural Hospital Flexibility Program and the Frontier Community Health Integration Demonstration Program, that designate these hospitals for additional benefits. These include Medicare Dependent (fewer than 100 beds with more than 60% Medicare patients), Rural Referral Center (more than 275 beds), Sole Community Providers (geographically isolated, and Critical Access Hospitals (CAHs). Hospitals can qualify for more than one of these designations and they have varying financial benefits.

Critical Access Hospitals are eligible for reimbursement at 101% of costs without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities; converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost. However, due to a quirk in the Health Reform Law, CAHs are subject to review by the Independent Payment Advisory Board (IPAB) starting in 2014, whereas other hospitals aren't subject to IPAB review until 2019. Therefore, they are at a greater risk of funding cuts earlier than other hospitals.

The following criteria must be met in order for a facility to qualify as a CAH:

(1) It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989. A facility may be allowed to relocate or rebuild provided it meets the CMS criteria.

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

(3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or must have been certified by the State prior to January 1, 2006 as being a necessary provider of health care services to residents of the area;

(4) The maximum number of licensed beds is 25, which can be operated as any combination of acute or swing-beds;

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

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RECORD 004213

(6) Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes. CMS requires that any hospital, including a CAH, that does not have a physician on site 24 hours per day, 7 days per week, provide a notice to all patients upon admission that addresses how emergency services are provided when a physician is not on site.

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

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

In South Carolina, a hospital located in an urban Metropolitan Statistical Area (MSA) county can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

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

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

(3) It maintains a 24-hour emergency room;

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

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

A total of 1,327 hospitals nationwide had been approved for CAH status as of June 30, 2012. The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The following facilities in South Carolina are designated as CAHs, although there are other hospitals that could potentially be eligible:

Abbeville Memorial Hospital
Allendale County Hospital
Edgefield County Hospital
Fairfield Memorial Hospital
Williamsburg Regional Hospital

The designation of a hospital as a Critical Access Hospital does not require Certificate of Need review, because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce the number of licensed beds in

order to meet the criteria for a CAH. Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds.

D. Obstetrical and Neonatal Services:

1. Obstetrical Services:

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

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2007, 77.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center, whereas the Healthy People 2010 national objective was 90%.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2010 was 7.4 infant deaths per 1,000 live births versus the national rate of 6.4 infant deaths per 1,000 births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2010, South Carolina's neonatal mortality rate for all races was 4.6 neonatal deaths per 1,000 live births, while the Healthy People 2010 national objective was 2.9 neonatal deaths per 1,000 live births.

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the state to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by DHEC's Division of Health Licensing as a Level I, II, IIE (Enhanced), III Perinatal Hospital, or a RPC (Regional Perinatal Center). Each Level I, II, IIE and III hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services are outlined in Section 607.2 of Regulation Number 61-16: http://www.scdhec.net/administration/regs/docs/61-16.pdf

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. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. CON review is not required for a Level I program.

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. A board-eligible pediatrician must be in the hospital or on site within 30 minutes, 24 hours a day and the hospital must have at least a written consultative agreement with a board eligible neonatologist. These hospitals manage a three year average of at least 500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. CON review is not required for a Level II program.

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. A board-eligible neonatologist must be in the hospital or on site within 30 minutes, 24 hours a day. These hospitals manage a three year average of at least 1,200 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (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. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified perinatologist shall be available for supervision and consultation, 24 hours a day. Level III hospitals have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. 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 shall provide 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. A board-certified maternal-fetal medicine specialist (perinatologist) must be in the hospital or on site within 30 minutes, 24 hours a day. RPCs participate in residency programs for obstetrics, pediatrics, and/or family practice. 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.

PET-EX012.0045

RECORD 004217

2011 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEMORIAL MEDICAL CENTER	4,851	48	4,374	17,370	99.1%
PALMETTO HEALTH BAPTIST	3,494	91	5,442	12,734	38.3%
LEXINGTON MEDICAL CENTER	2,946	33	3,183	6,535	54.3%
SPARTANBURG REGIONAL MEDICAL CTR.	2,763	51	3,495	8,914	47.9%
SAINT FRANCIS - EASTSIDE	2,293	28	2,351	5,359	52.4%
MUSC MEDICAL CENTER	2,218	36	2,428	7,364	58.0%
PALMETTO HEALTH RICHLAND	2,202	42	3,688	10,240	66.8%
MCLEOD REGIONAL MEDICAL CTR.	2,068	21	2,289	6,196	80.8%
ANMED HEALTH WOMEN'S & CHILDREN'S	1,985	28	1,704	4,420	43.2%
PIEDMONT MEDICAL CENTER	1,922	17	2,031	5,244	84.5%
TRIDENT MEDICAL CENTER	1,879	25	2,072	4,670	51.2%
BON SECOURS ST. FRANCIS XAVIER	1,845	15	1,960	4,300	78.5%
BEAUFORT MEMORIAL HOSPITAL	1,582	23	1,666	3,952	47.2%
SELF REGIONAL HEALTHCARE	1,543	37	2,158	5,468	40.6%
EAST COOPER MEDICAL CENTER	1,428	38	1,724	4,339	31.3%
TUOMEY	1,284	24	602	5,088	58.1%
CONWAY HOSPITAL	1,246	16	1,521	3,174	54.3%
REG MED CTR ORANGEBURG-CALHOUN	1,210	32	1,690	4,020	34.4%
SUMMERVILLE MEDICAL CENTER	1,164	12	1,022	1,991	45.5%
AIKEN REGIONAL MEDICAL CENTER	1,122	18	1,540	4,023	61.2%
GRAND STRAND REGIONAL MED CTR	1,005	19	1,316	2,721	39.2%
MARY BLACK MEMORIAL HOSPITAL	964	21	1,024	2,507	32.7%
WOMEN'S CENTER / CAROLINAS HOSP. SYS	855	20	798	2,207	30.2%
SPRINGS MEMORIAL HOSPITAL	701	14	211	2,018	39.5%
ROPER HOSPITAL	677	16	810	1,854	31.7%
HILTON HEAD HOSPITAL	667	8	735	1,599	54.8%
CLARENDON MEMORIAL	615	10	641	1,391	38.1%
PROVIDENCE HOSPITAL NORTHEAST *1*	602	8	568	1,332	45.6%
GREER MEMORIAL	600	10	614	1,505	41.1%
WACCAMAW COMMUNITY HOSPITAL	584	19	1,708	4,940	71.2%
ODONEE MEDICAL CENTER	574	15	793	1,721	31.4%
CAROLINA PINES REGIONAL MED CTR	563	13	482	1,671	35.2%
BAPTIST MED CTR EASLEY	515	14	666	1,714	33.5%
LORIS COMMUNITY HOSPITAL	427	8	587	1,199	41.1%
KERSHAW HEALTH	407	10	542	1,194	32.7%
UPSTATE CAROLINA MEDICAL CENTER	383	15	500	1,071	19.6%
GEORGETOWN MEMORIAL HOSPITAL	372	14	821	2,042	40.0%
COLLETON MEDICAL CENTER	339	6	346	813	37.1%
NEWBERRY COUNTY MEMORIAL HOSPITAL	334	3	385	744	74.4%
LAURENS COUNTY HOSPITAL	306				
MCLEOD MEDICAL CENTER - DILLON	285	21	318	815	10.8%
CHESTERFIELD GENERAL HOSPITAL	160	9	208	511	15.6%
MARLBORO PARK HOSPITAL	116	8	225	508	17.4%
WALLACE THOMSON HOSPITAL	65	7	105	246	9.6%
TOTAL BIRTHS	53,161				

1 DISCONTINUED PERINATAL SERVICES 1/1/12

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

Quality

Cesarean sections are identified as a potentially over-used procedure, although an optimal rate has not been determined. While the appropriateness of a c-section depends on the patient's characteristics, it is largely impacted by the individual physician's practice patterns. Hospital rankings need to be risk-adjusted, but, overall, a lower c-section rate is viewed as representing higher quality. Conversely, a higher rate of Vaginal Birth After Cesarean (VBAC) equates to higher quality. To the extent practical, hospitals should attempt to lower their c-section rates.

Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

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

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

Regional Perinatal Centers

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
MUSC Medical Center
Palmetto Health Richland
Spartanburg Regional Medical Center

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Subspecialty Perinatal Center (Level III Hospital)

Palmetto Health Baptist
Self Regional Healthcare

Enhanced Perinatal Center (Level II Enhanced Care Hospitals)

Piedmont Medical Center

Specialty Perinatal Centers (Level II Hospitals)

Aiken Regional Medical Center
AnMed Health Women's and Children's Hospital
Baptist Easley Hospital
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital
East Cooper Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital
St. Francis - Eastside
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Waccamaw Community Hospital
The Women's Center of Carolinas Hospital System

2. Neonatal Services:

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

The inventory of Intensive and Intermediate Bassinets by Perinatal Region is as follows:

Perinatal Region	Existing Bassinets Intensive	Intermediate
Anderson, Abbeville, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda		
Greenville Memorial Medical Center	12	42
AnMed Health Women's & Children's Hospital	0	7
St. Francis Women's & Family Hospital	0	10
Self Regional Healthcare	7	11
SUBTOTAL	19	70
Cherokee, Chester, Spartanburg, Union		
Spartanburg Regional Medical Center	13	22
Mary Black Memorial Hospital	0	8
SUBTOTAL	13	30
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York		
Palmetto Health Richland	31	38
Palmetto Health Baptist	8	22
Lexington Medical Center	0	20
Piedmont Medical Center	0	12
Springs Memorial Hospital	0	4
Aiken Regional Medical Center	0	8
Regional Med Center Orangeburg-Calhoun	0	10
Tuomey	0	8
SUBTOTAL	39	122
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Regional Medical Center	0	4
McLeod Regional Medical Ctr. of Pee Dee	12	28
Conway Hospital	0	6
Grand Strand Regional Medical Center	0	2
Women's Center of Carolinas Hospital System	0	11
SUBTOTAL	12	51
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	5
Georgetown Memorial Hospital	0	5
Waccamaw Community Hospital	0	2
MUSC Medical Center	32	35
East Cooper Medical Center	0	10
Bon Secours-St. Francis Xavier Hospital	0	11
Summerville Medical Center	0	3
Trident Medical Center	0	10
Roper Hospital	0	5
SUBTOTAL	32	83
STATEWIDE TOTAL	115	356

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RECORD 004221

The 2011 utilization of neonatal special care units by facility follows:

HOSPITAL	ICU Bassinets	ICU Pt Days	Intermed Bassinets	Intermed Pt Days	Total Bassinets	Total Pt Days	Total Occupancy
AnMed Health Women's			7	929	7	929	36.4%
Greenville Memorial	12	4,365	42	15,834	56	20,199	98.8%
St. Francis-Eastside			10	1,154	10	1,154	31.6%
Self Regional	7	503	11	1,984	18	2,487	37.9%
REGION SUBTOTAL	19	4,868	70	19,901	91	24,769	74.6%
Mary Black Memorial			8	470	8	470	16.1%
Spartanburg Regional	13	5,440	22	2,360	35	7,800	61.1%
REGION SUBTOTAL	13	5,440	30	2,830	43	8,270	52.7%
Aiken Regional Med Ctr			8	289	8	289	9.9%
Springs Memorial Hosp			4	829	4	829	56.8%
Lexington Medical Ctr			20	2,474	20	2,474	33.9%
Reg Med Ctr Orangeburg			10	2,995	10	2,995	82.1%
Palmetto Health Baptist	8	1,334	22	3,670	30	5,004	45.7%
Palmetto Health Richland	31	8,776	38	10,845	65	19,621	82.7%
Tuomey			8	399	8	399	13.7%
Piedmont Medical Ctr			12	1,367	12	1,367	31.2%
REGION SUBTOTAL	39	10,110	122	22,868	157	32,978	57.5%
Carolina Pines Regional			4	69	4	69	4.7%
McLeod Regional	12	4,432	28	5,147	40	5,147	35.3%
Women's Ctr Carolinas			11	811	11	811	20.2%
Conway Hospital			6	457	6	457	20.9%
Grand Strand Regional			2	445	2	445	61.0%
REGION SUBTOTAL	12	4,432	51	6,929	63	6,929	30.1%
Beaufort Memorial Hosp			5	49	5	49	2.7%
Bon Secours-St. Francis			11	992	11	992	24.7%
East Cooper Medical Ctr			10	756	10	756	20.7%
MUSC Medical Center	32	7,655	35	12,232	67	19,015	77.8%
Roper Hospital			5	393	5	393	21.5%
Trident Medical Center			10	2,279	10	2,279	62.4%
Georgetown Memorial			5	198	5	198	10.8%
Waccamaw Community			2	222	2	222	30.4%
REGION SUBTOTAL	32	7,655	83	17,121	115	23,904	56.9%
GRAND TOTAL	115	32,505	356	69,649	469	95,850	56.6%

STANDARDS

1. The projected need for neonatal intensive care bassinets is calculated on a regional basis:

   A. For each region take the average number of births from 2009-2011 and the average population of women age 15-44 for 2009-2011 to generate an average birth rate.

   B. Multiply the average birth rate against the projected 2014 population of women age 15-44 to project the number of births in 2014.

   C. Calculate the average number of patient days per region by combining and then dividing the patient days for 2010 and 2011.

   D. Divide the projected 2014 births by the actual 2011 births to compute a growth rate in the number of births.

   E. The average number of patient days for 2010-2011 is multiplied against the growth rate to project the number of patient days for 2014.

   F. The projected number of patient days for 2014 is divided by a 65% occupancy factor to generate the projected number of NICU bassinets in a region.

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

The addition of neonatal intermediate care bassinets does not require Certificate of Need review. The need for intermediate neonatal bassinets is calculated based on the utilization of the individual providers using a 65% occupancy factor. Note that some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero, which decreases the need calculations.

Note: S.C. presently has 2.0 neonatal intensive care bassinets and 7.1 neonatal intermediate care bassinets per 1,000 births.

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

REGIONS	2011 BIRTHS	2010 BIRTHS	2009 BIRTHS	3 YR AVE	2011 15-44 POP	2010 15-44 POP	2009 15-44 POP	3 YR AVE POP	AVE BR	2014 15-44 POP	2014 PROJ BR	2011 PT DAYS	2010 PT DAYS	AVE PT DAYS	PROJ BR / AVE BR	2014 PROJ PDS	65% OCCUP	2014 BEDS	EXISTING	BED NEED
Abbeville	277	251	272	267	4,600	4,582	4,735	4,642		4,600										
Anderson	2,232	2,236	2322	2,264	35,700	35,558	35,127	35,464		36,100										
Edgefield	99	166	250	172	4,300	4,331	4,373	4,335		4,400										
Greenville	6,023	6,088	6445	6,185	93,500	93,112	91,731	92,781		95,000										
Greenwood	888	928	991	922	14,800	14,750	14,432	14,661		15,100										
Laurens	602	657	668	638	12,700	12,670	13,576	12,982		12,800										
McCormick	35	75	78	63	1,200	1,222	1,178	1,200		1,100										
Oconee	817	817	829	821	12,600	12,553	12,124	12,426		12,700										
Pickens	1,241	1,175	1172	1,196	26,100	25,852	24,775	25,576		27,000										
Saluda	244	249	259	251	3,600	3,595	3,267	3,487		3,600										
TOTAL	12,564	12,822	13,446	12,977	209,100	208,206	205,448	207,584	0.06252	212,600	13,279	4,958	5,578	5,273	1.022202	5,395	237	23	19	-4
Cherokee	681	698	707	695	11,200	11,106	10,980	11,095		11,300										
Chester	361	388	422	390	6,300	6,287	6,157	6,248		6,300										
Spartanburg	3,522	3,660	3,841	3,714	57,800	57,051	57,243	57,198		58,100										
Union	264	321	352	325	5,200	5,273	5,000	5,158		5,100										
TOTAL	4,852	5,067	5,435	5,125	80,500	79,717	79,380	79,699	0.06430	80,800	5,196	3,440	3,939	3,689	1.013514	3,738	237	27	13	14
Aiken	899	2,000	1,956	1,918	30,500	30,360	29,653	30,171		31,000										
Allendale	111	128	109	116	1,800	1,775	1,665	1,747		1,800										
Bamberg	183	179	167	176	3,100	3,166	3,019	3,095		2,900										
Barnwell	250	288	287	275	4,300	4,276	4,224	4,267		4,200										
Calhoun	192	180	191	188	2,600	2,597	2,643	2,613		2,500										
Clarendon	385	387	395	389	5,900	5,896	5,461	5,749		5,700										
Fairfield	258	237	258	248	4,400	4,372	4,341	4,371		4,300										
Kershaw	705	753	779	745	11,300	11,262	11,012	11,191		11,400										
Lancaster	604	674	905	794	14,200	14,161	14,782	14,381		14,100										
Lee	174	192	238	201	3,200	3,226	3,418	3,282		3,300										
Lexington	3,241	3,400	3,510	3,384	53,000	52,569	51,350	52,303		54,400										
Newberry	443	455	521	473	6,900	6,893	7,073	6,953		6,800										
Orangeburg	1,186	1,239	1,335	1,254	18,900	18,958	18,409	18,756		18,700										
Richland	4,904	4,671	4,986	4,920	90,600	90,846	89,252	89,733		91,800										
Sumter	1,507	1,534	1,598	1,546	21,800	21,823	21,385	21,673		21,700										
York	1,870	2,866	3,011	2,548	48,200	47,781	47,410	47,797		49,300										
TOTAL	16,514	19,815	20,217	18,915	320,700	319,505	314,104	318,103	0.05915	323,200	19,117	10,110	10,528	10,319	1.015023	10,464	237	44	39	5
Chesterfield	425	527	545	499	8,900	8,682	8,216	8,670		8,800										
Darlington	787	808	817	804	13,200	13,185	12,871	13,089		13,000										
Dillon	419	460	460	446	9,300	9,296	9,027	9,204		9,100										
Florence	1,828	1,786	1,888	1,837	28,400	28,417	27,178	27,998		28,400										
Horry	3,083	3,070	3,143	3,098	50,600	50,534	47,989	49,708		51,100										
Marion	435	491	479	468	6,400	6,432	6,460	6,431		6,300										
Marlboro	216	301	325	281	4,800	4,994	4,927	4,920		4,700										
Williamsburg	357	372	404	378	5,100	5,177	5,058	5,112		5,000										
TOTAL	7,549	7,757	8,069	7,792	124,500	124,867	119,728	123,132	0.06326	124,800	7,895	4,432	4,812	4,622	1.009466	4,666	237	19	12	7
Beaufort	1,899	2,155	2,211	2,088	27,900	28,081	27,027	27,669		27,400										
Berkeley	2,544	2,613	2,555	2,537	37,400	37,289	37,291	37,327		37,700										
Charleston	4,743	4,645	5,031	4,873	76,400	76,591	78,892	77,294		76,900										
Colleton	456	471	519	482	7,000	7,069	7,181	7,073		7,000										
Dorchester	1,755	1,851	1,850	1,819	28,000	28,888	27,443	28,043		29,100										
Georgetown	602	606	655	621	9,800	9,857	10,215	9,857		9,500										
Hampton	209	263	293	255	3,800	3,764	3,717	3,787		3,800										
Jasper	308	333	375	338	4,600	4,671	4,031	4,434		4,600										
TOTAL	12,516	13,037	13,520	13,026	194,800	196,018	195,777	195,598	0.06660	195,000	12,987	7,855	8,887	7,246	0.997111	7,225	237	30	53	-2
STATEWIDE				57,734				924,983	0.06243		55,444			33,569				143	115	28

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INTERMEDIATE BASSINET NEED

Hospital	Intermed Bassinets	2011 Pt Days	Intermed ADC	Occupancy Factor	Projected Need	To Be Added
AnMed Health Women's	7	929	3	0.65	4	-3
Greenville Memorial	42	15,834	43	0.65	67	25
St. Francis-Eastside	10	1,154	3	0.65	5	-5
Spartanburg Regional	22	2,360	6	0.65	10	-12
Mary Black Memorial	8	470	1	0.65	2	-6
Self Regional	11	1,984	5	0.65	8	-3
Aiken Regional Med Ctr	8	289	1	0.65	1	-7
Springs Memorial Hosp	4	829	2	0.65	3	-1
Lexington Medical Ctr	20	2,474	7	0.65	10	-10
Reg Med Ctr Orangeburg	10	2,995	8	0.65	13	3
Palmetto Health Baptist	22	3,670	10	0.65	15	-7
Palmetto Health Richland	38	10,845	30	0.65	46	8
Tuomey	8	399	1	0.65	2	-6
Piedmont Medical Ctr	12	1,367	4	0.65	6	-6
Carolina Pines Regional	4	69	0	0.65	0	-4
McLeod Regional Med Ctr	28	5,147	14	0.65	22	-6
Women's Ctr Carolinas	11	811	2	0.65	3	-8
Conway Hospital	6	457	1	0.65	2	-4
Grand Strand Regional	2	445	1	0.65	2	0
Beaufort Memorial Hosp	5	49	0	0.65	0	-5
Bon Secours-St. Francis	11	992	3	0.65	4	-7
East Cooper Med Ctr	10	756	2	0.65	3	-7
MUSC Medical Center	35	12,232	33	0.65	51	16
Roper Hospital	5	393	1	0.65	2	-3
Trident Medical Center	10	2,279	6	0.65	10	0
Georgetown Memorial	5	198	1	0.65	1	-4
Waccamaw Community	2	222	1	0.65	1	-1
Totals	356	69,649	190		293	-63

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

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

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RECORD 004226

E. Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants. It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care. Pediatric beds are licensed as general hospital beds and no separate need is calculated for them.

Quality

The Agency for Health Research and Quality (AHRQ) lists 13 provider-level quality indicators for pediatric services. Not all indicators are applicable for all hospitals. These include: accidental puncture and laceration; decubitus ulcer; foreign body left in during a procedure; iatrogenic pneumothorax in neonates and non-neonates; in-hospital mortality for pediatric heart surgery; volume of pediatric heart surgery; post-operative hemorrhage or hematoma; post-operative respiratory failure; post-operative sepsis; post-operative wound dehiscence (opening of a wound along the suture line); infection due to medical care; and transfusion reaction. South Carolina hospitals should be lower than or comparable to the national averages for these indicators.

Link: http://www.qualityindicators.ahrq.gov/downloads/pdi/2006-Feb-PediatricQualityIndicators.pdf

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

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

F. Pediatric Long Term Acute Care Hospitals:

Pediatric Long Term Care Hospitals (PLATCHs) are specialized health care facilities designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis (similar to adult LTACHs). Care may be rehabilitative or palliative. These facilities are designed to be as non-institutional as possible while meeting the psychological, physical, and emotional needs of chronically ill children and their families. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services.

Patients often have three or more chronic conditions. These may include 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.

The DHEC Division of Children with Special Health Care Needs has a caseload of approximately 12,000 children and it is envisioned that many of these clients would be candidates for Pediatric LTACH services. These patients are currently either staying for extended periods in one of the state's Children's Hospitals (Greenville Hospital System, Palmetto Health, McLeod, and MUSC) or are receiving daily therapy in their own homes. Neither option is optimal for these patients.

Pediatric LTACH facilities are currently located primarily in the Northeast and California. They are potentially a less costly alternative to maintaining these children in an acute care facility. Some states have nursing homes that specialize in extended care for pediatric patients, but there are currently no such facilities in South Carolina.

Certificate of Need Standards

1. An application for a Pediatric Long Term Acute Care Hospital must be in compliance with the relevant standards in DHEC Regulation No. 61-16, Licensing Standards for Hospitals and Institutional General Infirmaries.

2. Although Pediatric Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of PLTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Pediatric Long Term Acute Care Hospital beds. An applicant must document the need for PLTACH beds.

4. An applicant for PLTACH beds must submit an affiliation agreement with a SC Children's Hospital. This affiliation agreement will at a minimum include a transfer agreement and coverage for specialized medical services.

5. Should a hospital lease general beds to another entity to create a Pediatric Long Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required.

6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Once licensed, a Pediatric LTACH must remain licensed as such. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital and the licensed beds operated by the facility will be removed from the bed inventory.

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

There are currently no Pediatric Long Term Acute Care Hospital beds in South Carolina. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

PET-EX012.0057

RECORD 004229

CHAPTER IV

PSYCHIATRIC SERVICES

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

A major issue that general hospitals face is having their emergency departments over-burdened with patients requiring psychiatric care. Under EMTALA hospitals have to provide care for these patients whether or not they have insurance. Medicaid does not pay for psychiatric care provided by freestanding psychiatric hospitals, known as Institutions for Mental Disease (IMDs), because at the time the program was created mental health funding was considered to be the responsibility of the state. However, this may eventually change. On March 13, 2012, CMS announced a three-year project called the Medicaid Emergency Psychiatric Demonstration that could lead to Medicaid reimbursement for these hospitals. Eleven 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 for cheaper than warehousing them in hospital EDs. If the pilot project is successful, Congress may revise the Medicaid funding for psychiatric care nationally.

The existing psychiatric programs in the state are:

Region	Facility	County	Beds	2011 Occupancy
I	AnMed Health Medical Ctr.	Anderson	38	40.1%
I	Carolina Ctr. Behavioral Health	Greenville	104	77.0% *1*
I	Greenville Memorial Med. Ctr.	Greenville	46	83.2%
I	Springbrook Behavioral Health	Greenville	37	64.5% *2*
I	Mary Black Memorial	Spartanburg	15	64.3%
I	Spartanburg Regional Med. Ctr.	Spartanburg	56	25.9%
II	Self Memorial Regional	Greenwood	36	6.0%
II	Rebound Behavioral Health	Lancaster	18	— *3*
II	Springs Memorial Hospital	Lancaster	12	— *4*

II	Three Rivers Behavioral Health	Lexington	81	75.4%	
II	Palmetto Health Baptist	Richland	94	55.0%	
II	Palmetto Health Richland	Richland	60	21.9%	
II	Piedmont Medical Center	York	20	77.0%	
III	McLeod – Darlington	Darlington	23	64.9%	
III	Carolinas Hospital System	Florence	12	7.5%	
III	Lighthouse of Conway	Horry	59	84.9%	*5*
III	Marlboro Park Hospital	Marlboro	8	50.7%	
IV	Aiken Regional Med. Ctr.	Aiken	44	88.6%	*6*
IV	Beacon Harbor	Beaufort	22	---	*7*
IV	Beaufort Memorial	Beaufort	14	55.6%	
IV	Medical University SC	Charleston	82	73.9%	
IV	Palmetto Lowcountry Behavioral	Charleston	70	69.6%	
IV	Colleton Medical Center	Colleton	4	---	*8*
IV	RMC – Orangeburg & Calhoun	Orangeburg	15	49.4%	
SW	William J. McCord Adolescent	Orangeburg	(15)	93.4%	*9*
		Total	970	60.0%	

1 CON issued 8/10/09 to add 23 beds for a total of 99; 8 additional beds licensed for a total of 84 2/16/10. Licensed for 99 beds 9/23/10. CON issued 4/26/12 to add 5 beds for a total of 104.

2 CON issued 8/10/09 to add 17 beds for a total of 37. Licensed 8 additional beds for a total of 28 9/20/11.

3 CON issued 9/20/12 to construct an 18 bed facility, SC-12-28.

4 CON issued 9/20/12 to add 12 psych beds, SC-12-29.

5 CON issued 1/25/10 to add 15 beds for a total of 59; licensed for 59 beds 10/25/12.

6 CON issued 8/12/10 for the addition of 12 psych beds for a total of 41. Licensed for 41 psych beds 2/2/12. CON issued 8/22/12 to add 3 beds for a total of 44, SC-12-22.

7 CON issued 8/13/10 to construct a 22 bed psychiatric hospital.

8 CON issued 5/13/11 for the addition of 4 psychiatric beds; beds licensed 9/30/11.

9 CON issued 7/16/10 to re-classify William J. McCord Adolescent Treatment Facility as a specialized hospital with 15 psychiatric beds restricted for the primary purpose of providing alcohol and drug services to adolescents (see Section B.3.).

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. Should the service area show a need for additional beds, a general acute hospital may be approved for the maximum of the actual projected bed need or up to 20 additional beds to establish an economical unit. Other hospitals are limited to applying for the maximum of the projected bed need. However, an applicant seeking more beds than are projected may not use

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2011 POP	2018 POP	EXISTING BEDS	2011 PDS	PROJ ADC	% OCC	BED NEED (US6)	+/-	BED NEED (SW)	+/-	BED NEED
ANDERSON,OCONEE	<65	220,300	228,700		3,955	11.25						
	+65	43,600	53,800		1,601	5.41						
	TOTAL	263,900	282,500	38	5,556	16.65	0.70	24	-14	44	6	6
GREENVILLE,PICKENS	<65	501,400	530,900		37,778	109.59						
	+65	75,600	92,900		9,238	31.10						
	TOTAL	577,000	623,800	167	47,016	140.69	0.70	201	-14	97	-80	14
CHEROKEE,SPARTANBURG UNION	<65	320,000	351,600		3,165	8.99						
	+65	51,800	62,100		5,661	18.89						
	TOTAL	371,800	394,700	71	8,826	27.88	0.70	40	-31	81	-10	-10
CHESTER,LANCASTER YORK	<65	296,400	314,000		5,159	14.67						
	+65	43,500	55,400		461	1.61						
	TOTAL	339,900	369,400	50	5,620	16.58	0.70	24	-26	58	8	8
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	185,700	191,800		648	1.83						
	+65	35,100	43,500		136	0.46						
	TOTAL	220,800	235,300	36	784	2.30	0.70	3	-33	37	1	1
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	686,900	747,200		37,268	109.61						
	+65	91,500	116,800		8,687	30.90						
	TOTAL	778,400	835,000	235	45,955	137.51	0.70	196	-39	130	-105	-39
DARLINGTON,FLORENCE MARION	<65	206,300	205,700		5,273	14.40						
	+65	33,600	43,800		506	1.81						
	TOTAL	239,900	249,500	35	5,779	16.21	0.70	23	-12	39	4	4
CHESTERFIELD,DILLON MARLBORO	<65	93,300	90,900		918	2.46						
	+65	14,600	16,200		583	1.92						
	TOTAL	107,900	109,100	6	1,491	4.37	0.70	6	-2	17	9	9
CLARENDON,LEE,SUMTER	<65	139,600	140,500		0	0.00						
	+65	23,100	29,900		0	0.00						
	TOTAL	162,700	170,400	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN,HORRY WILLIAMSBURG	<65	303,800	319,700		7,726	22.26						
	+65	65,000	89,700		5,902	21.98						
	TOTAL	368,800	409,400	99	13,628	44.27	0.70	63	-4	64	5	5
BAMBERG,CALHOUN ORANGEBURG	<65	104,600	103,700		1,621	4.93						
	+65	19,400	24,700		852	3.08						
	TOTAL	124,300	128,400	15	2,703	8.01	0.70	11	-4	20	5	5
ALLENDALE,BEAUFORT HAMPTON,JASPER	<65	179,600	186,100		2,549	7.24						
	+65	42,400	59,800		292	1.13						
	TOTAL	222,000	245,900	36	2,841	8.36	0.70	12	-24	38	2	2
BERKELEY,CHARLESTON COLLETON,DORCHESTER	<65	623,300	634,800		36,028	100.53						
	+65	86,100	116,700		3,970	14.37						
	TOTAL	709,400	751,500	156	39,998	114.90	0.70	164	8	117	-39	8
AIKEN,BARNWELL	<65	158,300	163,700		8,235	23.62						
	+65	26,800	37,000		1,148	4.04						
	TOTAL	185,100	200,700	44	9,381	27.67	0.70	40	-4	31	-13	-4
	TOTAL			970				807	-163	779	-191	38
STATE TOTAL	<65	4,017,800	4,157,600	0.000156	150,521	0.038814079	0.03					
	+65	655,100	849,300		39,947	0.061625	0.05					
	TOTAL	4,672,700	5,007,100		189,468	0.0420	0.03					

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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. If a hospital already has licensed psychiatric beds they must have been used at a minimum of 70% occupancy rate for the most current year prior to applying for additional beds beyond those shown as needed in the Plan. The Department shall not approved an application for more beds than are shown as needed in the Plan unless the applicant meets the above criteria.

3. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.

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.

Quality

The Hospital-Based Inpatient Psychiatric Services (HBIPS) project grew from a partnership among the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors, the American Psychiatric Association and the Joint Commission. The HBIPS core measures focus on critical issues that affect the course of a patient's hospitalization, such as admissions screening and having a coordinated plan for continuity of treatment. Other measures address the use of anti-psychotic medications and the reduction in the use of restraints and seclusion. Collection and reporting of these measures are expected to become mandatory starting in 2013, and pilot testing of pay-for-performance measures by 2016. All South Carolina hospitals that offer inpatient psychiatric services should support the HBIPS project and be in compliance with its core measures.

Relative Importance of Project Review Criteria

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

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

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

B. State Mental Health Facilities:

1. Psychiatric Hospital Beds:

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital complement is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, any changes in facility bed capacity are exempt from Certificate of Need review.

2. Local Inpatient Crisis Stabilization Beds:

Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, insufficient adult inpatient beds are available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.

SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities, for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding, the SCDMH contracts with one or more 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.

Due to the low utilization, the Plan only projects a need for a small number of additional psychiatric beds in some service areas. To assist in alleviating the problems described above, the following policies will apply.

1. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services in existing acute care or existing psychiatric beds, then a Certificate of Need is not required.

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2. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services and desire to add psychiatric beds, a Certificate of Need is required. These additional beds could be approved if the Plan indicates a need for additional beds or some small number (ten beds or less) of additional beds could be approved for crisis stabilization patients only. These beds would not be restricted to any specific age group except that the patients would have to be over age 18.

3. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from the SCDMH to verify this additional need, such as the number of patients currently awaiting treatment, the estimated average length of stay, the pay source for the patients, the number of patients emergently admitted to SCDMH hospitals over the past year from the area, the number of crisis patients that are expected to require this service annually, and other information to justify these additional psychiatric beds. In addition, the SCDMH will supply verification that it made contact with all hospitals in the county and contiguous counties to notify them of the potential for adding some psychiatric beds to the area. The hospital seeking the Certificate of Need will provide the necessary care for these individuals referred by the SCDMH and may be reimbursed by for the care of the patients if there are sufficient funds, but the hospital must identify the minimum number of indigent (no source of funding) patient days it will provide to patients referred by SCDMH. Should the contract with SCDMH terminate for any reason or should the hospital fail to provide care to the patients referred from the SCDMH, the license for these beds will be voided.

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

3. William J. McCord Adolescent Treatment Facility:

The William J. McCord Adolescent Facility is a facility that has provided substance abuse treatment for adolescents statewide for a number of years. It was previously licensed as a specialized hospital with 15 substance abuse beds. Because of changes in reimbursement, McCord received a CON on 7/16/10 to convert to a specialized hospital with 15 psychiatric beds restricted primarily for the provision of alcohol and drug abuse treatments for adolescents. Although now licensed as a psychiatric hospital, the facility has not changed its scope of services. The bed classification change was made in order to continue receiving reimbursement. These beds are not counted in the psychiatric bed need calculations.

C. Critical Access Hospital Pilot Project:

On May 23, 2011 the General Assembly approved a pilot project to assess the provision of psychiatric crisis stabilization services for patients age 65 and over in Critical Access Hospitals

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(CAHs). The project will be conducted at two different CAHs and be coordinated between DHEC and the South Carolina Department of Mental Health (DMH). To the extent practicable, the CAHs must be located in different regions of the state and have different racial and socioeconomic demographics. Selection criteria include population trends, access to services for elderly patients in rural communities, the resources required to provide these services, the impact of increased accessibility, and the economics of the health care delivery system.

The participating facilities may license 10 beds to establish a Distinct Part Psychiatric unit for Prospective Payment System Exclusion, as defined by the Federal Centers for Medicare and Medicaid Services (CMS) for the purpose of conducting this project. If a participating hospital de-licensed beds prior to the commencement of the project in order to qualify as a CAH, the facility may re-license up to 10 of the original bed complement in order to participate.

The CAH must request a written exemption from the Department but a CON is not required for participation in the project. The Distinct Part Psychiatric unit must meet all applicable state and federal laws and regulations, including all licensing and certification requirements, and all the requirements pertaining to the Emergency Medical Treatment and Active Labor Act (EMTALA).

A CAH wishing to participate in the project must apply for selection to the Department by July 1, 2012. The 10 beds designated to participate must be licensed by July 1, 2013. The project must conclude no later than July 1, 2016. If the beds established by this pilot project are de-certified or the pilot project is closed, the CAH must not operate the beds for any other use. The pilot project beds must not be interchanged or combined with beds of other units and must be physically located on the same site as the hospital.

Upon completion of the project, DHEC and DMH will submit a report to the SHPC in order to advise the DHEC Board whether new standards and criteria should be established in the Plan regarding the accessibility of psychiatric services for patients age 65 and over in a psychiatric crisis situation. Williamsburg Regional Hospital received an Exemption on 8/25/11 to participate in the pilot project.

CHAPTER V

REHABILITATION FACILITIES

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service 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. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed that froze this threshold at 60% and allowed co-morbid conditions to be counted.

Most general hospitals and other health care facilities offer physical rehabilitation services such as physical therapy, occupational therapy, speech therapy, or occupational therapy without the involvement of a formal interdisciplinary program. In addition, some hospitals have consolidated their rehabilitation services into a single unit to improve the coordination of care for acute patients in their facilities. These consolidations are intended to improve the quality of care for patients currently being treated in the facility and are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2011 Occupancy	
I	AnMed Health Rehab	Anderson	55	92.3%	*1*
I	Roger C. Peace	Greenville	53	59.3%	
I	St. Francis	Greenville	19	84.4%	
I	Mary Black	Spartanburg	18	57.2%	
I	Spartanburg Rehab	Spartanburg	28	---	*2*
II	Greenwood Rehab Hosp	Greenwood	42	86.8%	*3*
II	HealthSouth Columbia	Richland	96	57.8%	
II	HealthSouth Rock Hill	York	50	80.4%	*4*
III	HealthSouth Florence	Florence	88	49.5%	
III	Carolinas Hospital	Florence	42	75.3%	
III	Waccamaw Community	Georgetown	43	87.9%	
IV	Beaufort Memorial	Beaufort	14	59.2%	
IV	PACE Healthcare	Beaufort	10	---	*5*
IV	HealthSouth Charleston	Charleston	49	74.3%	*6*
IV	Roper Hospital	Charleston	52	80.2%	
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	72.5%	

IV	Coastal Carolina Med Ctr.	Jasper	(0)	0.0% *7*
		Total	683	70.0%

1 CON issued 9/22/11 to add 10 rehab beds for a total of 55, SC-11-42. Licensed for 55 beds 1/10/12.
2 CON approved for a 28 bed rehab facility; appealed. CON issued 6/20/12, SC-12-17.
3 CON issued 7/29/11 to add 8 rehab beds for a total of 42 rehab beds, SC-11-27.
4 CON issued 9/22/11 to add 4 rehab beds for a total of 50, SC-11-41. Licensed for 50 rehab beds 2/9/12.
5 CON issued 1/30/12 to establish a 10 bed rehabilitation hospital, SC-12-04.
6 CON issued 9/22/11 to add 3 rehab beds for a total of 49, SC-11-43. Licensed for 49 beds 3/7/12.
7 CON issued 1/31/11 to convert the 10 rehabilitation beds to general acute beds, SC-11-04. Rehabilitation beds were de-licensed 4/5/11.

Certificate of Need Standards

1. The need for beds is calculated based on rehabilitation service areas.

2. The methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 population to project need.

3. For service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections.

Quality

CMS has identified two quality measures that inpatient rehabilitation facilities must begin reporting. The data collection starts October 1, 2012 and must be used for all Medicare patients admitted on or after that date. Facilities that fail to comply face a two percent reduction in their reimbursement starting in FY 2014. The quality measures are the number of catheter-associated urinary-tract infections and the percentage of patients with new or worsened pressure ulcers. CMS is considering additional measures to be incorporated later.

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);

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REHABILITATION BED NEED

SERVICE AREA	2011 POP	2018 POP	EXIST BEDS	2011 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	263,900	282,500	55	15,156	44.45	0.70	63	8	31	-24	8
GREENVILLE,PICKENS	577,000	623,800	72	17,330	51.33	0.70	73	1	68	-4	1
CHEROKEE,SPARTANBURG UNION	371,800	394,700	46	3,760	10.94	0.70	16	-30	43	-3	-3
CHESTER,LANCASTER YORK	339,900	369,400	50	13,506	40.21	0.70	57	7	40	-10	7
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	220,800	235,300	42	10,767	31.44	0.70	45	3	26	-16	3
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	715,800	768,200	96	20,242	59.52	0.70	85	-11	84	-12	-11
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	382,200	392,800	130	27,442	77.27	0.70	110	-20	43	-87	-20
CLARENDON,KERSHAW LEE,SUMTER	225,300	238,200	0	0	0.00	0.70	0	0	26	26	26
GEORGETOWN,HORRY	335,200	375,200	43	13,796	42.31	0.70	60	17	41	-2	17
AIKEN,ALLENDALE,BAMBERG BARNWELL,,CALHOUN ORANGEBURG	319,800	339,700	24	6,353	18.49	0.70	26	2	37	13	13
BEAUFORT,HAMPTON,JASPER	211,600	235,300	24	3,024	9.21	0.70	13	-11	26	2	2
BERKELEY,CHARLESTON COLLETON,DORCHESTER	709,400	751,500	101	27,689	80.36	0.70	115	14	82	-19	14
STATE TOTAL	4,672,700	5,006,600	683	159,065	465.5		663	-20	549	-134	57
			0.1096								

RECORD 004239

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

Rehabilitation facilities are now located throughout the state and are available within approximately sixty (60) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Statewide Programs

The S.C. Vocational Rehabilitation Center operates a 30-bed facility in West Columbia to serve the vocational training needs of the disabled.

PET-EX012.0068

RECORD 004240

CHAPTER VI

Alcohol and Drug Abuse Facilities

There are six types of licensed substance abuse treatment facilities in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

A. Outpatient Facilities:

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 74 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 101 locations.

Certificate of Need Standards

A Certificate of Need is not required for outpatient facilities as described above.

B. Social Detoxification Facilities:

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93.

Certificate of Need Standards

A Certificate of Need is not required for a social detoxification facility.

C. Freestanding Medical Detoxification Facilities:

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93. The services provided by these facilities are described in Section 3101 of the Regulation. 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.

Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities.

Facility	County	Beds
Charleston Center Subacute Detoxification Program	Charleston	16
The Phoenix Center Behavioral Health Services	Greenville	16
Lexington/Richland Alcohol & Drug Abuse/Detox Unit	Richland	16
Keystone Inpatient Services	York	10
Statewide Total		58

Certificate of Need Standards

1. Medical detoxification services are allocated by service area.

2. Facilities can be licensed for a maximum of 16 beds in order to meet federal requirements.

3. Because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit may be approved in any service area without an existing detoxification unit, provided the applicant can document the need.

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.

Currently four freestanding medical detoxification facilities are located in the state, operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Additional facilities are needed for the services to be accessible within sixty (60) minutes travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

D. Residential Treatment Program Facilities:

RTPFs are 24-hour facilities offering an organized service in a residential setting, which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff for clients whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Certificate of Need Standards

A Certificate of Need is not required for a Residential Treatment Program.

E. Inpatient Treatment Facilities:

This is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

Region	Facility	County	Beds	2011 Occupancy	
I	Carolina Center Behavioral Health	Greenville	21	135.6%	*1*
I	Holmesview Center (Statewide)	Greenville	44	-----	*2*
II	Self Regional Healthcare	Greenwood	24	0.0%	
II	Springs Memorial	Lancaster	18	0.0%	*3*
II	Three Rivers Behavioral Health	Lexington	17	63.2%	
II	Morris Village (Statewide)	Richland	163	68.4%	*2*
II	Palmetto Health Baptist	Richland	10	0.0%	
II	Palmetto Richland Springs	Richland	10	69.7%	
II	William S. Hall (Statewide)	Richland	19	80.0%	*2*
III	Carolinas Hospital System	Florence	12	52.0%	
III	Palmetto Center (Statewide)	Florence	48	-----	*2*
III	Lighthouse Care Center Conway	Horry	13	126.7%	*4*
IV	Aiken Regional Medical Center	Aiken	18	99.7%	
IV	Medical University	Charleston	23	43.6%	
IV	Palmetto Lowcountry Behavioral	Charleston	10	128.7%	
IV	[William J. McCord (Statewide)]	Orangeburg	(0)	93.4%	*5*
	Total (Does Not Include Statewide Beds)		176	52.3%	

1 CON issued 4/26/12 to add 8 beds for a total of 21.

2 Not Included in Bed Need Calculations.

3 CON approved 8/22/08 to convert the 18 substance abuse beds to general beds. However, it was appealed and the applicant withdrew the proposal.

4 CON issued 1/25/10 for 6 additional beds for a total of 14, SC-10-07. CON amended 2/10/12 to 13 beds. Licensed for 13 beds 10/25/12.

5 CON issued 7/16/10 to re-classify William J. McCord Adolescent Treatment Facility as a specialized hospital with 15 psychiatric beds restricted for the primary purpose of providing alcohol and drug services to adolescents. These beds are no longer classified as inpatient substance abuse treatment beds.

Morris Village, Holmesview, Palmetto Center and William S. Hall are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities and need calculations.

Certificate of Need Standards

1. Need projections are calculated by service area.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.

4. Because a minimum of 10 beds is needed for an inpatient program, a 10-bed unit may be approved in an area that does not have any existing beds provided the applicant can document the need.

5. Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to its clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

6. The establishment of a regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area without existing services with another service area providing this other service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the 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 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.

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);

INPATIENT TREATMENT BED NEED

SERVICE AREA	2011 POP	2018 POP	EXIST BEDS	2011 PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	263,900	282,500	0	0	0.00	0.70	0	0	11	11	11
GREENVILLE,PICKENS	577,000	623,800	21	6,435	19.06	0.70	27	6	24	3	6
CHEROKEE,SPARTANBURG,UNION	371,800	394,700	0	0	11.81	0.70	17	17	15	15	17
CHESTER,LANCASTER,YORK	339,900	369,400	18	0	0.00	0.70	0	-18	14	-4	-4
ABBEVILLE,EDGEFIELD,GREENWOOD, LAURENS,MCCORMICK,SALUDA	220,800	235,300	24	0	7.04	0.70	10	-14	9	-15	-14
FAIRFIELD,KERSHAW,LEXINGTON, NEWBERRY,RICHLAND	778,400	836,000	37	6,464	19.02	0.70	27	-10	32	-5	-5
DARLINGTON,FLORENCE,MARION	239,900	249,500	12	2,279	6.49	0.70	9	-3	9	-3	-3
CHESTERFIELD,DILLON,MARLBORO	107,900	109,100	0	0	3.26	0.70	5	5	4	4	5
CLARENDON,LEE,SUMTER	162,700	170,400	0	0	5.10	0.70	7	7	6	6	7
GEORGETOWN,HORRY,WILLIAMSBURG	369,600	409,400	13	3,701	12.25	0.70	18	5	16	3	5
BAMBERG,CALHOUN,ORANGEBURG	124,300	128,400	0	0	3.84	0.70	5	5	5	5	5
ALLENDALE,BEAUFORT,HAMPTON, JASPER	222,000	245,900	0	0	7.36	0.70	11	11	9	9	11
BERKELEY,CHARLESTON,COLLETON DORCHESTER	709,400	751,500	33	8,356	24.25	0.70	35	2	29	-4	2
AIKEN,BARNWELL	185,100	200,700	18	6,553	19.47	0.70	28	10	8	-10	10
STATE TOTAL	4,672,700	5,006,600	176	33,788	138.95		199	23	190	14	53
	0.010922		0.0352								

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3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently, 11 inpatient treatment facilities are located in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

F. Narcotic Treatment Programs:

Note: Narcotic treatment programs were added back under CON review by the General Assembly in 2011 after being removed during the 2010 CON law revisions.

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. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider. Narcotic treatment programs are described in Section 3200 of Regulation Number 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

An average charge for medication would be approximately $12 per day or $70 per week. In South Carolina a Registered Pharmacist must dispense the medication. Therefore, because of the staffing and associated costs with providing this care, it requires providers to have a minimum caseload of around 150 clients to break even on the costs of providing this service.

There are currently 16 licensed programs in the state:

Region	Facility	County
I	Southwest Carolina Treatment Center	Anderson
I	Crossroads Treatment Center of Greenville	Greenville
I	Greenville Metro Treatment Center	Greenville
I	Crossroads Treatment Center	Oconee
I	Recovery Concepts of the Carolina Upstate	Pickens

I	Spartanburg Treatment Associates	Spartanburg
II	Columbia Metro Treatment Center	Lexington
II	Crossroads Treatment Center of Columbia	Richland
II	York County Treatment Center	York
III	Starting Point of Darlington	Darlington
III	Starting Point of Florence	Florence
III	Center of Hope Myrtle Beach	Horry
IV	Aiken Treatment Specialists	Aiken
IV	Center for Behavioral Health South Carolina	Charleston
IV	Recovery Concepts	Jasper

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: a church, 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. The minimum 500 feet should be measured from any point of the property line.

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. Narcotic treatment programs should be developed in counties where none exists to improve accessibility. An additional treatment program can only be approved in counties where an existing program exists 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:

a. Compliance with this Plan;
b. Distribution (Accessibility);
c. Record of the Applicant;
d. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility will not outweigh the adverse effects of the duplication of this existing service.

CHAPTER VII

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS

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). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are currently licensed or approved as Residential Treatment Facilities:

Region	Facility	County	Beds	FY 2011 Occ. Rate	
I	Excalibur Youth Services	Greenville	60	54.5%	
I	Generations	Greenville	30	---	*1*
I	Marshall Pickens	Greenville	22	95.5%	
I	Springbrook Behavioral	Greenville	68	81.0%	
I	Avalonia Group Homes	Pickens	55	65.1%	
II	Three Rivers Behavioral	Lexington	20	95.0%	
II	Three Rivers – Midlands	Lexington	59	94.0%	
II	Carolina Children's Home	Richland	30	33.3%	*2*
II	Directions (DMH)	Richland	37	28.6%	*3*
II	New Hope Carolinas	York	150	92.6%	
II	York Place Episcopal	York	40	57.0%	
III	Palmetto Pee Dee	Florence	59	80.9%	
III	Lighthouse of Conway	Horry	30 (18)	71.3%	*4*
III	Willowglen Academy	Williamsburg	40 (54)	72.2%	*5*
IV	Palmetto Low Country	Charleston	32	78.8%	
IV	Riverside at Windwood	Charleston	12	92.5%	*6*
IV	Palmetto Pines Behavioral	Dorchester	60	79.5%	
IV	Pinelands RTC	Dorchester	14 (28)	52.3%	*7*
	Total (Does Not Include Directions)		781 (797)	77.3%	

1 Exempted to convert from a Group Home to an RTF. Licensed 8/25/11.
2 Licensed for 20 RTF beds 6/16/09; licensed 10 additional beds for a total of 30, 1/20/11.

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3 Statewide facility not included in need calculations.
4 Exemption issued 9/20/12 to permanently reduce from 30 to 18 beds, E-12-20.
5 Licensed for 40 beds 3/20/09; intend to license 54 total beds.
6 Licensed 3/18/10.
7 Licensed for 14 beds 7/21/10; intend to license 28 total beds.

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;

2. Individual treatment plans to assess the problems and determine specific patient goals;

3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;

4. Nursing services, as required;

5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. Recreational facilities with an organized youth development program;

7. A special education program with a minimum program defined by the South Carolina Department of Education; and

8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

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

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

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RECORD 004250

Certificate of Need Standards

1. Except in the case of high management group homes that received exemption from CON through Health and Human Services Budget Proviso 8.35, the establishment or expansion of an RTF requires a CON.

2. The applicant must document the need for the expansion of or the addition of an RTF based on the most current utilization data available. The existing resources must be considered and documentation presented as to why these resources are not adequate to meet the needs of the community.

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 potential impact that the proposed new RTF or expansion will have upon the existing service providers and referral patterns.

5. The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.

6. The applicant agrees to provide utilization data on the operation of the facility to the Department.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 5 years of age would be candidates for this type of care, the bed need will be based on the population age 5-21. The projected bed needs by service area are as follows:

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

Facilities:	Avalonia Group Homes	55 beds
	Excalibur Youth Services	60
	Generations – Bridges	10
	Generations – Horizons	20
	Marshall Pickens	22
	Springbrook Behavioral	68
	Total	235 beds

2018 Population Age 5-21:	289,500
41.4 Beds/100,000 Population:	x .000414

		120 beds
		- 235 beds
	Need Shown:	(115) beds

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

Facilities:	Carolina Children's Home	30 beds
	New Hope Carolinas	150
	Three Rivers Behavioral	20
	Three Rivers – Midlands	59
	York Place	40
	Total	299 beds

2018 Population Age 5-21:		320,500
41.4 Beds/100,000 Population:		x .000414
		133 beds
		- 299 beds
	Need Shown:	(166) beds

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

Facilities:	Lighthouse of Conway	18 beds
	Palmetto Pee Dee	59
	Willowglen Academy	54
	Total	131 beds

2018 Population Age 5-21:		192,300
41.4 Beds/100,000 Population:		x .000414
		80 beds
		- 131 beds
	Need Shown:	(51) beds

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

Facilities:		
	Palmetto Low Country	32 beds
	Palmetto Pines Behavioral	60
	Pinelands RTC	28
	Riverside at Windwood	12
	Total	132 beds

2018 Population Age 5-21:	274,800
41.4 Beds/100,000 Population:	x .000414
	114 beds
	- 132 beds
Need Shown:	(18) beds

The Directions program primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

Relative Importance of Project Review Criteria

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

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

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER VIII

CARDIOVASCULAR CARE

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. Approximately one-third of all heart attacks are fatal. The amount of heart muscle damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. During a cardiac catheterization, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of contrast material allow blockages or areas of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed. Diagnostic catheterizations take approximately one and one-half hours to perform, while therapeutic catheterizations average three hours.

Percutaneous Coronary Interventions (PCIs) are therapeutic catheterization procedures used to revascularize occluded or partially occluded coronary arteries. These interventions include, but are not limited to: bare and drug-eluting stent implantation; Percutaneous Transluminal Coronary Angioplasty (PTCA); cutting balloon atherectomy; rotational atherectomy; directional atherectomy; excimer laser angioplasty; and extractional thrombectomy.

These procedures may be performed on an emergent or elective basis. "Emergent or Primary" 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.

In 2011, the American College of Cardiology (ACC) and American Heart Association (AHA) revised their Guidelines for PCI. The previous version of the Guidelines allowed the provision of Emergent/Primary PCIs in hospitals without an on-site open heart surgery program if certain criteria could be met, but, due to the risk of arterial damage and the resulting need for immediate open heart surgery, elective PCI was contraindicated for institutions without on-site surgical backup. The new Guidelines state that:

> Elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection...Primary or elective PCI should not be performed in hospitals without on-site cardiac surgery capabilities without a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital or without appropriate hemodynamic support capability for transfer.

Hospitals without an open heart surgery program shall be allowed to provide Emergent/Primary and/or Elective PCIs only if they comply with all sections of Standard 7 or 8 of the Standards for Cardiac Catheterization.

Open heart surgery or cardiac 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. Another option is "beating heart surgery," like Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. The mortality rate continues to decline, but CABG still carries significant risks.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect unnecessary duplication of services in an area, which may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 500 diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0). Emergent PCI providers should perform a minimum of 36 PCIs annually; all other therapeutic cath providers should perform a minimum of 300 therapeutic caths annually. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in the utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to appear in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year, at least 75 of which should be open heart surgery.

A. Status of South Carolina Providers:

1. Cardiac Catheterizations:

The Certificate of Need standards for cardiac catheterization require a minimum of 500 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 32 facilities approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Please note that in the spreadsheet of cardiac cath lab utilization, the columns showing the 2009 through 2011 total caths are now reported in cardiac equivalents rather than summing the number of diagnostic and therapeutic caths performed. Therefore, the 2009 totals are not comparable to those

reported in the previous Plan, but this modification gives a more accurate accounting of the total cath lab utilization for each facility.

Of the 31 facilities that have been offering cardiac caths for more than three years, 21 exceeded the minimum of 500 equivalents per lab in 2011. Baptist Easley Hospital, Bon Secours St. Francis Xavier, Carolina Pines, Hilton Head Hospital, Loris Community Hospital, Mary Black Memorial, Palmetto Health Baptist, Regional Medical Center–Orangeburg/Calhoun, Springs Memorial and Tuomey Hospital fell below the minimum. Village Hospital was approved for a diagnostic cath lab in November 2010. There are two mobile cath labs approved in the state, at Colleton Medical Center and Chester Regional Medical Center. The number of diagnostic catheterizations performed statewide decreased from 34,536 in 2010 to 33,801 in 2011.

Seventeen hospitals with open heart surgery programs provide therapeutic caths. They should be performing a minimum of 300 therapeutic caths annually within three years of initiation of service. Of the programs that had been operational for three full years, all but Carolinas Hospital System and Hilton Head Regional Medical Center performed the minimum number in 2011. In addition, Baptist Easley Hospital and Georgetown Memorial Hospital have received CONs to perform Emergent PCIs without open heart surgery back-up. Lexington Medical Center received a CON to perform Emergent PCIs without open heart surgery back-up in 2009, but then established comprehensive cath services through the transfer of an open heart surgery suite from Providence Hospital in 2010. The number of therapeutic catheterizations performed statewide increased from 15,684 in 2010 to 15,691 in 2011.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The standard recommends a minimum of 600 cardiac equivalents per year; MUSC performed 1,177 equivalents in 2011.

2. Open Heart Surgery:

Currently 17 open heart surgery programs have been approved for the general public in South Carolina, in addition to the Veterans Administration (VA) Hospital in Charleston. Lexington Medical Center received a CON on 6/18/10 to establish open heart surgery services through the relocation of one open heart surgery suite from Providence Hospital. They expect to start performing surgeries in 2012. The number of open heart surgeries performed decreased from 4,870 in 2010 to 4,568 in 2011. A total of 34 open heart surgery suites were in operation in 2011. With a capacity of 500 surgeries per suite, the statewide capacity was 17,000 surgeries. The state average utilization rate of 26.9% equated to 133.4 surgeries per suite. Unused capacity remains in all programs in the state.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within three years of initiation of service. Only Spartanburg Regional, Providence Hospital, Roper Hospital, and Trident Medical Center averaged at least 200 open heart surgeries per suite in 2011. Grand Strand Regional (193.5) came close to meeting this standard. Studies indicate that hospitals that perform a minimum of 350 total cases annually tend to have better outcomes than those that perform fewer cases. In 2011, only seven of the 16 existing programs performed more than 350 total surgeries.

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MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2011, 199 pediatric open heart surgeries were performed there.

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

B. Cardiac Catheterization:

1. Definitions:

"Cardiac Catheterization Procedure" 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 angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed, in a facility with on-site open heart surgery backup.

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

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

"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. For adult labs, diagnostic catheterizations are weighted as 1.0 equivalents and therapeutic caths are weighted as 2.0 equivalents. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, and biopsies performed after heart transplants as 1.0 equivalents.

"Percutaneous Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation. These procedures may be performed on an emergent or elective basis. "Emergent or Primary" 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.

"Therapeutic catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, 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
36.06 Insertion of Coronary Artery Stent(s)
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

2. Scope of Services:

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

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

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

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

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

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

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

services should meet full accreditation standards for The Joint Commission (TJC) or similar accrediting body.

Certificate of Need Standards

1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Adult diagnostic catheterizations (ICD-9-CM Procedure Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Procedure Codes 00.66, 35.52, 35.96, 36.06, 36.07, 36.09, and 37.34) shall be weighted as 2.0 equivalents. For pediatric and adult congenital cath labs, diagnostic caths shall be weighted as 2.0 equivalents, therapeutic caths shall be weighted as 3.0 equivalents, electrophysiology (EP) studies shall be weighted as 2.0 equivalents, and biopsies performed after heart transplants shall be weighted as 1.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

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

Diagnostic and Mobile Catheterization Services

3. New diagnostic cardiac catheterization services, including mobile services, shall be approved only if all existing labs in the service area have performed at a minimum of 500 diagnostic cardiac catheterization procedures per laboratory during the most recent year;

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 500 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 500 diagnostic cardiac catheterization procedures per laboratory.

5. Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 500 procedures per year on the additional equipment within three years of its implementation.

6. An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 100 diagnostic equivalents annually for each day of the week that the mobile lab is located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 500 diagnostic cardiac catheterization procedures per laboratory (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of

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200 equivalents at the applicant's facility by the end of the third year of operation). In addition:

A. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 500 diagnostic equivalents per year;

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

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

Emergent and Elective PCI Without On-Site Cardiac Backup

7. In 2005, the ACCF/AHA/SCAI Writing Committee determined that Emergency PCI (Primary PCI) is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished. Hospitals with diagnostic laboratories may be approved to perform emergency PCI without an on-site open heart surgery program only if all of the following criteria based on the 2005 ACC/AHA Guideline Update for PCI are met:

A. Therapeutic catheterizations must be limited to Percutaneous Coronary Interventions (PCIs) performed only in emergent circumstances (Primary PCIs). Elective PCI may not be performed at institutions that do not provide on-site cardiac surgery except as provided for in Standard 8 below.

B. The applicant has performed a minimum of 250 diagnostic cardiac cath procedures in the most recent year and can reasonably demonstrate that it will perform a minimum of 500 diagnostic catheterizations annually within three years of the initiation of services.

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

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

E. An application shall be approved only if it is consistent with the criteria from Smith et al., ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) and the 2007 Focused Update of the guidelines. A complete copy of the guidelines can be found at: www.acc.org/clinical/guidelines/ percutaneous/update/index.pdf

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

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

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

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

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

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

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

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

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

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

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2. Patient Selection Guidelines

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

b. Transfer emergent aortocoronary bypass surgery patients after PCI of occluded vessels if high-grade residual left main or multi-vessel coronary disease and clinical or hemodynamic instability are present, preferably with intra-aortic balloon pump support.

8. In 2011, the ACCF/AHA/SCAI Writing Committee determined that elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection. Hospitals with diagnostic laboratories that have been approved to perform primary PCI without on-site open heart surgical backup under the 2005 ACC/AHA Guideline Update for PCI must obtain a Certificate of Need in order to upgrade to designation as providing elective PCI without on-site cardiac surgery backup. The following standards must be met:

A. The applicant has performed a minimum of 250 diagnostic cardiac cath procedures in the most recent year and can reasonably demonstrate that it will perform a minimum of 500 diagnostic catheterizations annually within three years of the initiation of services.

B. All existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations in the most recent year.

C. An applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the cardiac catheterizations performed at existing comprehensive catheterization programs in the service area below the minimum thresholds of 300 therapeutic procedures and 500 diagnostic procedures at each facility.

D. The physicians must be experienced interventionalists who perform a minimum of 75 elective PCI cases per year and preferably at least 11 PCI procedures for STEMI each year. Ideally, operators with an annual procedure volume of fewer than 75

procedures per year should only work at institutions with an activity level of more than 600 procedures per year. Operators who perform fewer than 75 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures.

E. For cath labs in facilities without on-site surgical backup, there must be formalized written protocols in place for immediate (within one hour by appropriate transportation) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed and tested on a regular basis.

1. Applicants must provide documentation of an agreement with an ambulance or transport service capable of advanced life support and intra aortic balloon pump and that guarantees a thirty (30) minute or less response time from contact.

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

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

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

I. Applicants must offer primary percutaneous coronary intervention (PCI) services and procedures twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty five (365) days a year.

J. Applicants must provide documentation to show that guidelines for determining patients appropriate for PCI procedures in a setting without on-site open heart backup consistent with standards of the American College of Cardiology have been developed and will be maintained.

K. Applicants must agree to participate in the South Carolina STEMI Alert/Mission Lifeline Program.

L. Every therapeutic cath program should operate a quality-improvement program that routinely:

1. reviews quality and outcomes of the entire program;
2. reviews results of individual operators;
3. includes risk adjustment;

4. provides peer review of difficult or complicated cases; and
5. performs random case reviews.

M. Every PCI program should participate in a regional or national PCI registry for the purpose of benchmarking its outcomes against current national norms.

N. An applicant for provision of elective PCI without on-site surgical backup agrees, as a condition for issuance of its Certificate of Need for such service, to discontinue therapeutic cardiac catheterization services and surrender the Certificate of Need for that service if they have failed to achieve 200 therapeutic cardiac catheterizations per year by the expiration of the first three years of operation of such services.

Comprehensive Catheterization Services

9. Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PCI and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations in the most recent year; and

B. An applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the therapeutic cardiac catheterizations performed at existing comprehensive catheterization programs in the service area below 300 procedures at each facility.

10. To prevent the unnecessary duplication of comprehensive cardiac catheterization services, expansion of an existing comprehensive cardiac catheterization service shall be approved only if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. The 600 equivalents may consist of a combination of diagnostic and therapeutic procedures.

Pediatric Catheterization Services

11. New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

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

B. An applicant must project that the proposed service will perform a minimum of 500 diagnostic equivalent procedures annually within three years of initiation of services.

12. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 500 equivalents per year on the additional equipment within three years of its implementation.

13. Documentation of need for the proposed service:

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

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

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

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

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

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

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

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

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

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

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

16. Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. Applicants must provide documentation that one (1) or more interventional cardiologist(s) will be required to respond to a call in a timely manner consistent with the hospital Medical Staff bylaws and clinical indications. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

17. Applicants must agree to report annual the data on number of PCI procedures, type, and outcomes to the National Cardiovascular Data Registry Cat/PCI registry.

    A. Applicants must agree to provide accurate and timely data, including outcomes analysis and formal periodic external and internal case review by appropriate entities.

    B. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

No ideal rate has been established for PTCA [PCI] and the rates vary widely by area and population group. The IQI considers PCI to be a potentially over-used procedure and a more average rate equates to better quality care. However, high PCI utilization has not been shown to necessarily be associated with higher rates of inappropriate utilization. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

There are several national benchmarks for the treatment of heart attacks, such as administration of aspirin and time from door-to-treatment. Whynotthebest.org was established by The Commonwealth Fund to track the performance of hospitals in various measures of health care quality. According to

their website, every hospital that performs therapeutic cardiac caths in the state scored at least 96% on their composite ratings for heart attack care in 2010. Source: http://whynotthebest.org

Relative Importance of Project Review Criteria

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

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

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

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

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

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

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY		# CATH LABS	2009 ADULT DIAG	2009 ADULT THERP	2009 TOTAL EQUIV	2009 PED DIAG	2009 PED THERP	2009 OTHER	2009 TOTAL	2010 ADULT DIAG	2010 ADULT THERP	2010 TOTAL EQUIV	2010 PED DIAG	2010 PED THERP	2010 OTHER	2010 TOTAL	2011 ADULT DIAG	2011 ADULT THERP	2011 TOTAL EQUIV	2011 PED DIAG	2011 PED THERP	2011 OTHER	2011 TOTAL
I																							
ANMED HEALTH MEDICAL CENTER	1	4	1,807	1,301	4,509					1,911	1,220	4,371					2,086	1,152	4,390				
GREENVILLE MEMORIAL HOSPITAL		7	2,858	2,208	7,462					5,626	2,061	9,750					3,047	2,617	9,281				
SAINT FRANCIS - DOWNTOWN	2	4	2,077	1,401	4,829					2,275	1,418	5,111					1,961	1,174	4,309				
OCONEE MEMORIAL HOSPITAL		1	776		776					657		657					675		675				
BAPTIST MED CTR-EASLEY	3	1	400		400					368		368					232		232				
MARY BLACK MEMORIAL		1	159		159					106		106					105		105				
SPARTANBURG REGIONAL MEDICAL CTR		4	2,299	864	4,227					2,500	928	4,356					2,067	950	3,767				
VILLAGE HOSPITAL	4	1																	0				
TOTAL REGION I		22	10,467	5,968	22,403					10,455	5,627	21,729					10,233	5,783	21,819				
II																							
CHESTER REGIONAL MEDICAL CENTER		MOBILE	95		95					110		110					27		27				
SELF REGIONAL HEALTHCARE		2	1,137	395	1,929					1,035	406	1,847					1,038	407	1,852				
KERSHAW HEALTH		1	507		507					461		461					540		540				
SPRINGS MEMORIAL HOSPITAL		1	567		567					489		489					415		413				
LEXINGTON MEDICAL CENTER	5	2	1,242	16	1,274					1,293	54	1,401					1,419	157	1,733				
PALMETTO HEALTH BAPTIST		1	293		293					320		320					277		277				
PALMETTO HEALTH RICHLAND		4	5,338	1,248	6,828					3,169	1,134	5,437					2,676	1,155	4,985				
PROVIDENCE HOSPITAL		6	3,474	2,700	6,674					3,332	2,742	6,816					3,313	2,543	6,299				
PIEDMONT MEDICAL CENTER		3	1,422	769	2,940					1,328	762	2,852					1,460	715	2,910				
SOUTH CAROLINA HEART CENTER	6	2	1,750		1,750					NO 2010 DATA REPORTED							NO 2011 DATA REPORTED						
TOTAL REGION II		23	13,825	5,116	24,057					11,538	5,099	21,733					11,082	4,977	21,036				
III																							
CAROLINA PINES REGIONAL MEDICAL CTR		1	62		62					NO 2010 DATA REPORTED							30		30				
CAROLINAS HOSPITAL SYSTEM		2	2,406	547	3,500					1,228	240	1,708					996	257	1,510				
MCLEOD REGIONAL MEDICAL CENTER		5	1,504	585	2,594					1,540	919	2,876					1,433	573	2,578				
GEORGETOWN MEMORIAL HOSPITAL		1	611	63	737					695	77	850					747	79	893				
CONWAY HOSPITAL		1	585		585					521		521					584		584				
GRAND STRAND REGIONAL MED CTR	7	3	1,057	697	2,891					1,238	529	2,696					1,158	818	2,794				
LORIS COMMUNITY HOSPITAL		1	247		247					326		326					231		231				
TUOMEY		1	281		281					204		204					185		185				
TOTAL REGION III		15	6,753	1,872	10,497					5,855	1,765	9,485					5,364	1,721	8,806				
IV																							
AIKEN REGIONAL MEDICAL CENTER		1	519	243	1,005					448	278	1,006					945	378	1,701				
BEAUFORT MEMORIAL HOSPITAL		1	482		482					494		494					681		681				
HILTON HEAD HOSPITAL		2	478	240	958					454	231	916					408	210	828				
COLLETON MEDICAL CENTER		MOBILE	0		0					0		0					0		0				
BON SECOURS ST. FRANCIS XAVIER		1	0		0					2		2					7		7				
MUSC MEDICAL CENTER	8	7	1,517	1,154	3,885	252	241	130	1,357	1,694	1,227	4,148	266	252	133	1,421	1,734	1,262	4,258	250	219		1,177
ROPER HOSPITAL		3	1,843	910	3,753					1,904	882	3,885					1,776	929	3,634				
TRIDENT MEDICAL CENTER		2	1,429	370	2,169					1,321	494	2,249					1,326	421	2,168				
REG MED CTR ORANGEBURG-CALHOUN		1	400		400					271		271					247		247				
RALPH HENRY VA MED CTR CHARLESTON		(1)																					
TOTAL REGION IV		19	6,768	2,947	12,652	252	241	130	1,357	6,588	3,183	12,954	266	252	133	1,421	7,122	3,200	13,522	250	219		1,177
STATEWIDE TOTALS		79	37,813	15,903	69,619	252	241	130	1,357	34,536	15,694	65,901	266	252	133	1,421	33,801	15,681	65,183	250	219		1,177

1 CON ISSUED 5/14/09 FOR A 4TH CATH LAB, SC-09-24.
2 CON ISSUED 7/8/09 FOR A 4TH CATH LAB, SC-09-34; OPERATIONAL 12/2009.
3 CON ISSUED 6/2/06 TO ALLOW EMERGENT PCI.
4 CON ISSUED 11/22/10 FOR A DIAGNOSTIC LAB, SC-10-34.
5 CON ISSUED 5/12/09 TO ADD 2ND LAB & ALLOW EMERGENT PCI, SC-09-23. CON ISSUED 8/19/10 TO ESTABLISH COMPREHENSIVE CATH SERVICES THROUGH TRANSFER OF AN OPEN HEART SUITE FROM PROVIDENCE HOSPITAL, SC-10-19.
6 DOCTORS OFFICE; PURCHASED BY PROVIDENCE HOSPITAL.
7 CON ISSUED 9/14/07 FOR A 3RD CATH LAB, SC-07-10.

C. Open Heart Surgery

1. Definitions

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

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60-35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

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

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

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

1. repair/replacement of heart valves
2. repair of congenital defects
3. cardiac revascularization
4. repair/reconstruction of intrathoracic vessels
5. treatment of cardiac traumas.

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

2. Scope of Services

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

a. services for hematology and coagulation disorders;
b. electrocardiography, including exercise stress testing;
c. diagnostic radiology;
d. clinical pathology services which include blood chemistry and blood gas analysis;

e. nuclear medicine services which include nuclear cardiology;
f. echocardiography;
g. pulmonary function testing;
h. microbiology studies;
i. Coronary Care Units (CCU's);
j. medical telemetry/progressive care; and
k. perfusion.

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

a. Cardiology;
b. Anesthesiology;
c. Pathology;
d. Thoracic Surgery; and
e. Radiology.

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

Adult open heart surgery services should be available within 60 minutes one-way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks. All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements and should meet the full accreditation standards for The Joint Commission (TJC), if the facility is TJC accredited.

Certificate of Need Standards

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

2. Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery.

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

4. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery

there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

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

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

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

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

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

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

      2. The applicant shall provide an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services, including:

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

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

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

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

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

8. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

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

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

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

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

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

11. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

Volume is a proxy measure for quality. Higher volumes have been associated with better outcomes although some low-volume hospitals have very good outcomes. There is a potential for variation in CABG rates between area populations.

There are several national benchmarks for the treatment of heart attacks, such as administration of aspirin and time from door-to-treatment. Whynotthebest.org was established by The Commonwealth Fund to track the performance of hospitals in various measures of health care quality. According to their website, every hospital that performs open heart surgery in the state scored at least 96% on their composite ratings for heart attack care in 2010. Source: http://whynotthebest.org

Relative Importance of Project Review Criteria

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

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

The Department makes the following findings:

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

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

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

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

5. Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This number is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflects an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

6. The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

REGION/FACILITY	# OPEN HEART UNITS	FY09 ADULTS	FY09 PEDS	FY10 ADULTS	FY10 PEDS	FY11 ADULTS	FY11 PEDS
I							
ANMED HEALTH MEDICAL CENTER	2	216		194		170	
GREENVILLE MEMORIAL MEDICAL CENTER	4	596		503		451	
ST FRANCIS - DOWNTOWN	2	392		381		353	
SPARTANBURG REGIONAL MEDICAL CENTER	2	400		450		463	
TOTAL REGION I	10	1,604		1,528		1,437	
II							
SELF REGIONAL HEALTHCARE	2	106		95		99	
LEXINGTON MEDICAL CENTER 1	1			—		—	
PALMETTO HEALTH RICHLAND	2	438		384		355	
PROVIDENCE HOSPITAL 1	3	692		669		637	
PIEDMONT MEDICAL CENTER	2	155		127		138	
TOTAL REGION II	10	1,391		1,275		1,230	
III							
CAROLINAS HOSPITAL SYSTEM	2	177		214		146	
MCLEOD REGIONAL MEDICAL CENTER	3	327		333		221	
GRAND STRAND REGIONAL MEDICAL CENTER	2	361		389		387	
TOTAL REGION III	7	865		936		754	
IV							
AIKEN REGIONAL MEDICAL CENTER	1	62		47		39	
HILTON HEAD HOSPITAL	1	67		64		76	
MUSC MEDICAL CENTER	3	378	209	361	210	314	199
ROPER HOSPITAL	2	462		470		485	
TRIDENT REGIONAL MEDICAL CENTER	1	224		189		233	
VA HOSPITAL (CHARLESTON)	1						
TOTAL REGION IV	9	1,193	209	1,131	210	1,147	199
STATEWIDE TOTALS	36	5,053	209	4,870	210	4,568	199

1 LEXINGTON SERVICE ESTABLISHED THROUGH THE TRANSFER OF AN OPEN HEART SUITE FROM PROVIDENCE 6/18/10, SC-10-19.

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PET-EX012.0104

CHAPTER IX

MEGAVOLTAGE RADIOTHERAPY & RADIOSURGERY

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and in South Carolina, accounting for approximately 22% of all deaths. According to the South Carolina Central Cancer Registry (SCCCR), there were 23,240 new cases of cancer diagnosed in South Carolina in 2010 and 9,180 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall five-year survival rate is approximately 62%. The national death rates decreased 1.8% annually for men and 1.6% for women between 2004 and 2008.

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and delivery radiation to that precise location. The amount of radiation used is measured in "gray" (Gy) and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for two to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77402-77404, 77406-77409, 77411-77414, 77416, 77418, 77432, and 0073T.

A. Definitions

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

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. Synonyms include Conformal External Beam Radiation Therapy

(CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

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. It consists of a single beam of radiation delivered to the patient from several directions. It is reliable, but is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

Because of the increased complexity of treatment planning and delivery techniques, Electronic Portal Imaging Devices (EPIDs) have been developed. The most common EPIDs are video-based systems; on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of IMRT fields and to reduce errors in patient positioning.

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation) refers to radiation given in smaller doses twice a day. In Hypofractionation, individual doses are given less often than daily, such as in two-five sessions.

Image-Guided Radiation Therapy (IGRT) combines with IMRT or 3DCRT to visualize (by means of EPIDs, kV scans or mV scans) 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. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

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 to 90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

B. Types of Radiation Equipment

1. Particle Beam (Proton)

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of more than $100 million will limit their expansion.

2. Linear Accelerator (X-Ray)

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

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

2. access to an electron beam source or a low energy X-ray unit;

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

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

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

6. field-shaping capability; and

7. access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment. A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per week, 50 weeks per year. Linacs with IMRT and IGRT systems (such as Tomotherapy and Novalis TX) take longer to set up and perform treatments than those relying on previously generated images. Therefore, a lower capacity of 5,000 treatments per year is established for such equipment (20 patients treated per day, 5 days per week, 50 weeks per year). IMRT/IGRT machines that perform stereotactic procedures have a lower capacity of 4,500 treatments per year (18 patients treated per day, 5 days per week, 50 weeks per year). MUSC has three linacs designated with a capacity of 5,000 treatments and two with a capacity of 4,500. The Tomotherapy unit at Spartanburg Regional has been designated with a capacity of 4,500 treatments and the Tomotherapy unit at Carolina Regional Radiation Center has been designated as having a capacity of 5,000 treatments per year. Greenville Memorial has a Novalis Brainlab used for stereotactic procedures with a 4,500 treatment capacity. McLeod Regional and AnMed Health each replaced an existing linac with one having stereotactic capabilities and a capacity of 4,500 treatments. Lexington Medical Center has a linac with stereotactic capabilities and a capacity of 5,000 treatments. Trident Medical Center has an ElektaSynergy linac with a capacity of 4,500 treatments and an approved CON for an additional linac with a capacity of 5,000 treatments. The capacities for these machines and the need calculations for their service areas have been adjusted accordingly.

There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized linacs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 1,500 treatments per year per unit, based on 6 treatments per day, 5 days per week, for 50 days per year. The Cyberknife at Roper Hospital is the only equipment so designated. It is an older generation unit with a previously designated capacity of 1,000 treatments per year. The capacity and need calculations for this facility and service area have also been adjusted.

3. Cobalt-60 (Photon)

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs

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between $3.4 and $5 million, plus an additional $0.25 to $0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

C. Status of South Carolina Providers

1. Linear Accelerators

There are currently 31 facilities either operating or approved for a total of 60 linear accelerators in South Carolina. In 2011, the 53 operational linear accelerators performed 273,291 treatments, or an average of 5,156 treatments per unit.

2. Gamma Knife

Palmetto Health Richland performed 199 Gamma Knife treatments in 2011 while MUSC's Gamma Knife performed 163 treatments that year.

D. Certificate of Need Standards for Radiotherapy

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.

2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

3. IMRT/IGRT linear accelerators performing stereotactic procedures have a capacity of 4,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

4. Linear Accelerators designed strictly to provide Stereotactic Radiotherapy have a capacity of 1,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

5. There are 13 service areas established for Radiotherapy units as shown on the following chart.

6. New Radiotherapy services shall only be approved if the following conditions are met:

   A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the year immediately preceding the filing of the applicant's CON application; and

   B. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or 4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.

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

9. The applicant must affirm the following:

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

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

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

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

The institution shall operate its own tumor registry or actively participate in a central tumor registry.

Quality

Incorrect doses of radiation can be dangerous. Two patients in New York died from lethal overdoses. In response, the Medical Imaging & Technology Alliance and the Advanced Medical Technology Alliance recently announced the Radiation Therapy Readiness Check Initiative, which is intended to incorporate safety-check mechanisms into radiation therapy equipment. The manufacturers have agreed to make equipment modifications to improve patient safety, by preventing equipment from operating unless the users verify that safeguards are in place.

The initiative requires medical physicists to record the performance of quality-assurance reviews of treatment plans. Technicians are required to perform beam modification checks, verify correct placement of machine accessories, and confirm correct patient placement. Individual manufacturers will be responsible for incorporating the safety-check software into new equipment and creating software add-ons that can be incorporated into existing equipment. However, some older machines may not be capable of adding the safeguards.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

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

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

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RADIOTHERAPY

SERVICE AREAS	2011 POPULATION	# OF LIN ACC	POP PER LIN ACC	TOTAL AREA TREATMENTS	TREATMENTS PER LIN ACC	PLANNING AREA CAPACITY	UNMET NEED?	PERCENT CAPACITY
ANDERSON,OCONEE	263,900	3	87,967	17,816	5,939	18,500	NEED	96.3%
GREENVILLE,PICKENS	577,000	8	72,125	31,314	3,914	53,500	—	58.5%
CHEROKEE,SPARTANBURG UNION	371,800	5	74,360	17,954	3,591	32,500	—	55.2%
CHESTER,LANCASTER,YORK	339,900	3	113,300	15,054	5,018	21,000	—	71.7%
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	220,800	2	110,400	7,782	3,891	14,000	—	55.6%
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	778,400	9	86,489	46,831	5,203	61,000	—	76.8%
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	347,800	5	69,560	22,215	4,443	32,500	—	68.4%
CLARENDON,LEE,SUMTER	162,700	2	81,350	9,499	4,750	14,000	—	67.9%
GEORGETOWN,HORRY WILLIAMSBURG	369,600	5	73,920	31,902	6,380	33,000	NEED	96.7%
BAMBERG,CALHOUN ORANGEBURG	124,300	2	62,150	6,579	3,290	14,000	—	47.0%
ALLENDALE,BEAUFORT, HAMPTON,JASPER	222,000	2	111,000	10,242	5,121	14,000	—	73.2%
BERKELEY,CHARLESTON COLLETON,DORCHESTER	709,400	12	59,117	47,639	3,970	62,500	—	76.2%
AIKEN,BARNWELL	185,100	2	92,550	8,464	4,232	14,000	—	60.5%
STATE TOTAL	4,672,700	60	77,878	273,291	4,555	384,500	—	71.1%

MEGAVOLTAGE VISITS

REGION & FACILITY	COUNTY	# UNITS	FY 2009	FY 2010	FY 2011
REGION I					
ANMED HEALTH MEDICAL CENTER *1*	ANDERSON	2	12,449	11,923	11,643
GIBBS REGIONAL CANCER CTR SATELLITE *2*	CHEROKEE	1	—	—	—
GMH-CANCER CENTERS OF THE CAROLINAS	GREENVILLE	1	4,834	5,325	4,848
GMH-CANCER CENTERS CAROLINAS - EASTSIDE		1	9,487	7,678	6,875
GREENVILLE MEMORIAL MEDICAL CENTER		3	15,433	16,846	14,838
GREER MEDICAL CAMPUS CANCER CTR *3*		1	—	4,340	4,753
ST FRANCIS MILLINIUM CANCER CENTER *4*		1	—	—	—
GMH-CANCER CTRS CAROLINAS - OCONEE CO.	OCONEE	1	6,279	5,402	6,173
BAPTIST MEDICAL CENTER EASLEY *5*	PICKENS	1	—	—	—
CANCER CTRS CAROLINAS - MARY BLACK *6*	SPARTANBURG	1	—	—	656
SPARTANBURG REGIONAL MED CTR		2	18,512	19,525	17,298
VILLAGE AT PELHAM CANCER CENTER *7*		1	—	—	—
REGION II					
SELF REGIONAL HEALTHCARE	GREENWOOD	2	6,747	7,688	7,782
LANCASTER RADIATION THERAPY CTR *8*	LANCASTER	1	—	—	4,104
LEXINGTON MEDICAL CENTER	LEXINGTON	2	10,433	10,431	11,953
NEWBERRY ONCOLOGY ASSOCIATES *9*	NEWBERRY	1	—	2,565	2,307
PALMETTO HEALTH RICHLAND	RICHLAND				
LINEAR ACCELERATORS		2	14,107	11,783	10,754
GAMMA KNIFE		1	210	218	199
SOUTH CAROLINA ONCOLOGY ASSOCIATES		4	22,671	21,463	21,817
ROCK HILL RADIATION THERAPY CENTER	YORK	2	13,416	13,368	10,950
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	5,015	3,659	3,693
MCLEOD REGIONAL MEDICAL CENTER *10*		4	17,176	19,352	18,522
FRANCIS B FORD CANCER CENTER *11*	GEORGETOWN	1	5,305	5,515	6,193
CAROLINA REGIONAL CANCER CENTER	HORRY	2	15,613	20,946	25,709
CAROLINA REG CA CTR - CONWAY *12*		1			
CAROLINA REG CA CTR - MURRELS INLET *13*		1			
TUOMEY	SUMTER	2	10,812	9,846	9,499
REGION IV					
RADIATION ONCOLOGY CTR OF AIKEN *14*	AIKEN	2	7,886	8,880	8,464
SJC ONCOLOGY SERVICES - SC	BEAUFORT	1	6,182	5,481	6,036
BEAUFORT MEMORIAL HOSPITAL		1	4,633	4,437	4,206
MUSC MEDICAL CENTER *15*	CHARLESTON				
LINEAR ACCELERATORS		5	18,184	18,707	20,290
GAMMA KNIFE		1		47	163

ROPER WEST ASHLEY CANCER CTR	*16*		4	14,440	14,250	15,938
TRIDENT MEDICAL CENTER	*17*		3	11,664	13,307	11,411
REG MED CTR ORANGEBURG/CALHOUN	*18*	ORANGEBURG	2	6,545	6,318	6,579
TOTAL			60	257,623	269,016	273,291

1 CON ISSUED 1/30/12 TO REPLACE ONE OF OF THE EXISTING LINACS WITH A UNIT WITH STEREOTACTIC RADIOTHERAPY CAPABILITIES, SC-12-03.
2 LINAC APPROVED 3/31/03; APPEALED. CON ISSUED BY SUPREME COURT RULING 3/31/10. UTILIZATION FOR 2011 INCLUDED WITH SPARTANBURG REGIONAL MEDICAL CENTER.
3 CON ISSUED 10/12/07, SC-07-53.
4 CON ISSUED 6/12/12, SC-12-18.
5 CON ISSUED 6/12/12, SC-12-19.
6 CON ISSUED BY SUPREME COURT RULING 3/31/10.
7 CON TO MOVE A LINAC FROM SRMC TO VILLAGE AT PELHAM APPEALED 2/12/08. APPEAL WITHDRAWN, CON ISSUED 7/25/11, SC-11-25.
8 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
9 CON APPROVED 3/20/08.
10 CON ISSUED 8/22/11 TO REPLACE AN EXISTING LINACS WITH ONE WITH STEREOTACTIC RADIOTHERAPY CAPABILITIES, SC-11-30.
11 CON APPROVED 9/26/11 TO RELOCATE THE FACILTY FROM GEORGETOWN TO MURRELL'S INLET; APPEALED.
12 CON APPROVED 12/28/11 TO INSTALL A LINAC; APPEALED.
13 CON APPROVED 9/26/11 TO RELOCATE ONE LINAC FROM THE EXISTING LOCATION IN MYRTLE BEACH TO MURRELL'S INLET; APPEALED.
14 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL MED CTR & ADD 2ND LINAC 6/11/09, SC-09-29.
15 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC ISSUED 7/8/09.
16 CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
17 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07; CON ISSUED 10/10/12 FOR A 3RD LINAC. WITH A CAPACITY OF 5,000 TREATMENTS, SC-12-33.
18 CON ISSUED FOR 2ND LINAC 9/28/10, SC-10-31.

Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.

2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.

3. New Radiosurgery services shall only be approved if the following conditions are met:

   A. All existing dedicated Stereotactic Radiosurgery units in the service area have performed at a combined use rate of 80 percent of capacity for the most recent year; and

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

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

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

   A. Epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;

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

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

6. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

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

8. The applicant must affirm the following:

   A. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;

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

   C. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;

   D. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and

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

9. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

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

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

CHAPTER X

POSITRON EMISSION TECHNOLOGY

A. POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. The tracer nucleotide most frequent used is FDG (Fluorodeoxyglucose). 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. The isotopes only have about a two-hour half-life and are quickly expelled from the body.

PET was developed in the 1970s and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent research has centered on the diagnosis and staging of cancer and neurological applications such as epilepsy, Alzheimer's and Parkinson's diseases. PET is covered for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurology; and heart disease uses.

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. The process requires a nuclear medical technologist certified for both PET and CT or dually certified in radiography.

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2,000,000-$2,7000,000 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000. Charges vary from around $2,500 - $4,000 depending on the type and location of the scan.

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

The operational or approved PET scanners in the state are listed on the following pages.

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

REGION/COUNTY	FACILITY	SCANNERS	FY09 SCANS	FY10 SCANS	FY11 SCANS	CON/DATE
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	502	565	510	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	2,413	2,259	2,272	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	808	891	1,000	
GREENVILLE	ST. FRANCIS - EASTSIDE	MOBILE 2 DAYS	--	--	--	CON 10/19/11
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	1,749	1,849	1,806	
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	746	850	716	
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	428	474	656	
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	946	922	891	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	549	934	375	CON 2/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	2,259	2,297	2,032	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	1,117	1,284	1,076	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	230	258	239	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	667	738	714	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	211	191	160	CON 10/10/08 TO SHARE 1 DAY / 2 WEEKS
GEORGETOWN	WACCAMAW COMMUNITY HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	164	224	320	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	1,309	1,404	1,811	
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE 2 DAYS	636	533	544	
HORRY	CONWAY HOSPITAL	MOBILE 2 DAYS	128	95	113	
SUMTER	TUOMEY	MOBILE 1/2 DAY	227	251	200	
IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE 1 DAY	347	302	329	
BEAUFORT	BEAUFORT IMAGING CENTER	MOBILE 2 DAYS	266	313	277	
CHARLESTON	MUSC MEDICAL CENTER	FIXED	1,966	1,894	1,723	
CHARLESTON	ROPER WEST ASHLEY CANCER CENTER	FIXED	1,423	1,346	1,344	RELOCATED 8/21/09
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE 1 DAY	408	527	420	
CHARLESTON	TRIDENT HOSPITAL	FIXED	--	--	309	CON 2/28/11
JASPER	CANDLER	FIXED	293	202	156	OWNERSHIP CHANGED 10/7/11, FORMERLY SC CA SPECIALISTS
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE 2 DAYS	75	116	88	CONVERTED TO PET/CT 6/12/09
		TOTALS	19,661	20,397	19,567	

Certificate of Need Standards

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

(2) Full-time PET scanner service is defined as having PET scanner services available five days per week. Fixed PET scanners are considered to be in operation five days per week. Capacity is considered to be 1,500 procedures annually. For PET/CT equipment, only procedures that utilize the PET component should be counted; procedures using the CT component as a stand-alone scanner are not included. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

(3) Applicants proposing new fixed PET services must project at a minimum 750 PET clinical procedures per year (three clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (five clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

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

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

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

(7) 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.

(8) CMS requires that a provider seeking Medicare reimbursement must be accredited after January 1, 2012.

B. POSITRON EMISSION MAMMOGRAPHY (PEM)

Positron Emission Mammography (PEM) is a form of PET that uses high-resolution detection technology for imaging the breast. It creates images that are more easily compared to mammography since they are acquired in the same position. 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, which reduces the radiation dose to the patient.

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. The exams can be read either by a breast imaging radiologist or a nuclear medicine physician.

PEM was cleared for marketing by the U.S. Food and Drug Administration (FDA) in August 2003, and there are now more than 50 scanners installed worldwide. The equipment costs between $500,000 and $725,000.

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.

(6) CMS requires that a provider seeking Medicare reimbursement must be accredited after January 1, 2012.

Relative Importance of Project Review Criteria

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

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

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

CHAPTER XI

OUTPATIENT FACILITIES

Outpatient facility means a facility providing community service for the diagnosis and treatment of ambulatory patients: (1) that is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of a licensed physician; or (3) that offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

A. 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, self-contained 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, i.e. an 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. However, hospitals have expressed concern that ASFs that are not hospital joint ventures are impacting their ability to fund their services. From 2003-2008, an average of 331 ASFs opened nationally each year while 59 closed or merged with other facilities per year. CMS is considering replacing volume-based reimbursement with a value-based purchasing system. This could potentially reward higher-quality providers and would have the greatest impact on gastrointestinal, eye, nervous system, and musculoskeletal surgeries (90% of total 2009 ASF procedures).

In 2010, a total of 340,346 outpatient surgeries and 214,755 endoscopies were performed in either a freestanding surgical center or a hospital in South Carolina, accounting for 68.7% of all surgeries and 87.7% of all endoscopies.

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, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

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 CON 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 a 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 CON 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 Standard 8.

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.

PET-EX012.0124

RECORD 004296

Quality

The ASC Quality Collaboration (ASCQC) is a voluntary cooperative effort between a number of organizations and companies working to ensure that quality data are measured and reported in a meaningful way. Participants in the National Quality Forum (NQF) include CMS, TJC, AAAJC, American College of Surgeons (ACOS), American Osteopathic Association (AOA), Association of periOPerative Registered Nurses (AORN), and Hospital Corporation of American (HCA).

The NQF has identified 6 standardized measurements that are feasible and useable as quality indicators. These are:

1. Patient burn;
2. Prophylactic IV antibiotic timing;
3. Patient falls within facility;
4. Wrong site, side, patient, procedure, or implant;
5. Hospital transfer/admission; and
6. Appropriate surgical site hair removal.

These quality indicators are proposed as goals for performance improvement measurement and improvement. CMS is developing a quality measure reporting system for ASFs, but the guidelines have not been released yet. Facilities will eventually face a two percent financial penalty for failing to report data, but, for now, any data collection efforts are voluntary.

If and when a data reporting system is created under CMS, the results for ASFs should be used in evaluating CON applications.

Relative Importance of Project Review Criteria

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

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

The number of surgeries performed on an outpatient basis and the number of ASFs approved and licensed have increased over time. However, there is concern that ASFs are

being proposed as a method of increasing reimbursement for procedures currently being performed in physicians' offices through the "facility fee" built into the reimbursement mechanisms, to the detriment of a hospital's ability to provide the range of services needed. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

PET-EX012.0126

RECORD 004298

2011 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,459	875	5,334	1,778		
Bearwood Ambulatory Surgery Center	Anderson	1		1	521		521	521		
Physician Surgery Center at AnMed Health	Anderson	3		3	2,193		2,193	731		
Upstate Endoscopy Center	Anderson		2	2		4,327	4,327		2,164	
Bon Secours St Francis Surgery Center	Greenville	2		2	1,862		1,862	931		1
Cross Creek Surgery Center	Greenville	4		4	3,915		3,915	979		
Endoscopy Center of the Upstate	Greenville		3	3		3,397	3,397		1,132	
Greenville Endoscopy Center	Greenville		3	3		6,067	6,067		2,029	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,524	6,524		2,175	
GHS Outpatient Surgery Center – Patewood	Greenville	6	2	8	5,890	2,504	8,394	982	1,252	
Greenville Surgery Center	Greenville	4		4	3,723		3,723	931		
Jervey Eye Center	Greenville	3		3	3,562		3,562	1,187		
Upstate Surgery Center	Greenville	2		2	2,817		2,817	1,409		
Blue Ridge Surgery Center	Oconee	2		2	2,052		2,052	1,026		
Synergy Spine Center	Oconee	2		2	408		408	204		2
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	6,653	3,136	9,789	950	1,568	
Spartanburg Surgery Center	Spartanburg	4		4	4,053		4,053	1,013		3
Surgery Center at Pelham	Spartanburg	4	2	6	2,730	1,210	3,940	683	605	
Westside Eye Center	Spartanburg	2		2	1,338		1,338	669		
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		8,180	8,180		2,045	

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Name of Facility	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,385	89	4,474	895		
Surgery Center at Edgewater	Lancaster	3	2	5	2,608	20	2,628	869	10	
Surgery & Laser Center at Professional Park	Laurens	2		2	2,610		2,610	1,305		
(Columbia Surgery Center)	Lexington	(0)		(0)						4
Midlands Endoscopy Center	Lexington		2	2		2,331	2,331		1,166	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	4,366		4,366	1,092		5
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,542		1,542	386		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	1,371	1,445	2,816	343	1,445	
South Carolina Endoscopy Center	Lexington		4	4		10,092	10,092		2,523	
Urology Surgery Center	Lexington	2		2	2,438		2,438	1,219		
Berkeley Endoscopy Center	Richland		2	2		2,133	2,133		1,067	
Columbia Eye Surgery Center	Richland	4		4	5,971		5,971	1,493		
Columbia GI Endoscopy Center	Richland		4	4		6,251	6,251		1,563	
Lake Murray Endoscopy Center	Richland		2	2		1,768	1,768		884	
Midlands Orthopaedics Surgery Center	Richland	3		3	3,038		3,038	1,013		
Palmetto Endoscopy Suite	Richland		2	2		6,291	6,291		3,146	6
Palmetto Surgery Center	Richland	4		4	4,556		4,556	1,139		
Parkridge Surgery Center	Richland	4		4	3,366		3,366	842		
South Carolina Endoscopy Center - North East	Richland		5	5		4,405	4,405		881	
South Carolina Med Endoscopy Ctr.	Richland		2	2		2,799	2,799		1,400	7
Carolina Surgical Center	York	4		4	5,321		5,321	1,330		
Center for Orthopaedic Surgery	York	3		3	3,336		3,336	1,112		
York County Endoscopy Center	York		3	3		4,685	4,685		1,562	8

RECORD 004300

PET-EX012.0128

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region III:										
Darlington Endoscopy Center	Darlington		2	2		520	520		260	
Florence Surgery & Laser Center	Florence	2		2	3,304		3,304	1,652		
McLeod Ambulatory Surgery Center	Florence	2		2	1,896		1,896	948		
Physicians Surgical Center of Florence	Florence	4	2	6	3,711	2,337	6,048	928	1,169	
Bay Microsurgical Unit	Georgetown	1		1	3,753		3,753	3,753		
Murrell's Inlet Ambulatory Surgery Center	Georgetown	2		2						9
(Waccamaw Endoscopy Center)	Georgetown		(0)	(0)						10
Waccamaw Surgery Center	Georgetown	1		1	2,138		2,138	2,138		11
Carolina Bone and Joint Surgery Center	Horry	3		3	2,811		2,811	937		12
Grande Dunes Surgery Center	Horry	3	2	5	3,228	571	3,797	1,075	286	
Ocean Ambulatory Surgery Center	Horry	2		2	0		0			13
Parkway Surgery Center	Horry	2		2	3,803		3,803	1,902		
Rivertown Surgery Center	Horry	3		3	1,355	1,101	2,456	819		
(Seacoast Med Ctr Ambulatory Surgery)	Horry	(0)		(0)	1,049	860	1,909	636		14
Strand GI Endoscopy Center	Horry		2	2		5,157	5,157		2,579	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	6,777		6,777	3,389		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,112	1,659	3,771	528	1,659	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,676		2,676	2,676		
Bluffon-Okatie Outpatient Center	Beaufort	2	1	3	1,173	624	1,797	587	624	
Laser and Skin Surgery Center	Beaufort	2		2	1,773		1,773	887		
Outpatient Surgery Ctr. Hilton Head	Beaufort	3	2	5	3,466	2,336	5,802	1,155	1,168	15

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PET-EX012.0129

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Center of Beaufort	Beaufort	3		3	3,254	1,703	4,957	1,652		
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	436	761	1,197	399		
Charleston Endoscopy Center	Charleston		4	4		9,861	9,861		2,465	
Charleston Surgery Center	Charleston	4	1	5	6,483	2,309	8,792	1,621	2,309	
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2						*16*
Elms Endoscopy Center	Charleston		3	3		5,945	5,945		1,982	
Lowcountry Ambulatory Center	Charleston	2		2						*17*
Palmetto Endoscopy Center	Charleston		2	2		6,291	6,291		3,146	
Physicians' Eye Surgery Center	Charleston	4		4	5,272		5,272	2,636		*18*
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4	3,605		3,605	901		
Roper St. Francis Eye Center	Charleston	3		3	495		495	165		*19*
Southeastern Spine Institute	Charleston	2		2	9,616		9,616	4,808		
Surgery Center of Charleston	Charleston	4		4	4,293		4,293	1,073		*20*
Trident Eye Surgery Center	Charleston	2		2	3,051		3,051	1,526		
Trident Surgery Center	Charleston	6		6	5,004	842	5,846	974		*21*
(West Ashley Endoscopy Center)	Charleston		(0)	(0)						*22*
Colleton Ambulatory Surgery Center	Colleton	2	1	3	763	169	932	382	169	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	3,973		3,973	1,987		
TOTALS		175	75	250	182,352	121,595	303,947	1,235	1,496	

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Ambulatory Surgical Facility (ASF) Footnotes

— No data available for facility during reporting period.

1 Formerly The Center for Special Surgery.

2 Formerly Upstate Pain Management.

3 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.

4 Facility was de-licensed effective 2/28/11.

5 CON issued 5/13/11 to add 2 ORs for a total of 4, SC-11-11.

6 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.

7 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.

8 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.

9 CON issued 1/6/12 to establish an ASF with 2 ORs, SC-11-56.

10 Facility purchased by Georgetown Memorial Hospital with the intent of converting to a provider-based outpatient surgical department of the hospital. Closed effective 3/10/12.

11 Formerly Atlantic Surgery Center.

12 CON issued 7/15/10 to add a 3rd OR, SC-10-22. 3rd OR licensed 12/7/10.

13 Facility temporarily closed 8/12/11. Facility must re-open by 12/31/12 or be de-licensed. Failed to provide 2011 utilization data.

14 Facility was de-licensed effective 11/23/11.

15 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.

16 CON issued 6/3/11 to establish an ASF with 2 Endoscopy Suites, SC-11-20. Licensed 10/26/12.

17 CON issued 11/28/11 for an ASF with 2 ORs, SC-11-48.

18 CON issued 7/29/11 to add 2 OR's for a total of 4, SC-11-26.

19 Formerly Roper West Ashley.

20 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.

21 CON issued 12/9/10 to convert 2 procedures rooms to ORs for a total of 6 ORs, SC-10-36. Licensed for 6 ORs on 11/15/11.

22 CON approved 12/29/09; appealed. CON issued 5/3/10, SC-10-14. CON voided 6/16/11.

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B. 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 TJC standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one-way travel time.

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

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

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

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

According to DHEC Health Licensing, the following facilities are considered to be freestanding emergency services (along with the hospital they are an extension of):

Moncks Corner Medical Center (Trident Medical Center) – Moncks Corner, Dorchester County
Seacoast Medical Center (Loris Community Hospital) – Little River, Horry County
South Strand Ambulatory Care Center (Grand Strand Regional) – Myrtle Beach, Horry County
Roper St. Francis Berkeley (Roper St. Francis) – Moncks Corner, Berkeley County
Roper St. Francis Northwoods (Roper St. Francis) – North Charleston, Charleston County

Certficate of Need Standards for Freestanding Emergency Services

(1) A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

(2) All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

(3) Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

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

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

(6) The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Resource Availability; and
d. Financial Feasibility.

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

C. Trauma Referral System:

Trauma centers are designed and equipped to handle complex injuries. In 1990, there were 1,125 trauma centers nationwide. By 2005, about 30 percent of them had closed (339). A recent study has determined that a quarter of all Americans had to travel further to a trauma center in 2007 than they did in 2001. The median travel time increased by 10 minutes, which is significant when the first hour after injury is vital for severe injury victims (the so-called "golden hour").

The DHEC Division of Emergency Medical Services has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become so designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This hospital has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patient arrives. Anesthesiology capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The primary difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call in Level II trauma centers but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

Level III: This hospital is committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer of the patient to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

PET-EX012.0134

RECORD 004306

CHAPTER XII

LONG TERM CARE FACILITIES AND SERVICES

A. Nursing Facilities:

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. Under www.scdhec.gov the licensing list of nursing facilities also denotes the facilities that have Alzheimer's units. For more specific detail about nursing facilities, refer to Regulation 61-17, Standards for Licensing Nursing Homes.

A ratio of 39 beds/1,000 population age 65 and over is used to project the need for 2015. Since the vast majority of patients utilizing nursing facilities are 65 years of age or older, only this segment of the population is used in the need calculations. A two-year projection is used because nursing facilities can be constructed and become operational in two years.

Certificate of Need Standards

1. Bed need is calculated on a county basis. Additional beds may be approved in counties with a positive bed need up to the need indicated.

2. When a county shows excess beds, additional beds will not be approved, except to allow an individual nursing facility to add some additional beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in a three bed ward. A nursing facility may add up to 16 additional beds per nursing unit to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing facility must document how these additional beds will make a more economical unit(s).

3. Some Institutional Nursing Facilities (see Chapter XII E.) are dually licensed, with some beds restricted to residents of the retirement community and the remaining beds are available to the general public. The beds restricted to residents of the retirement community are not eligible to be certified for Medicare or Medicaid. Should such a facility have restricted beds that are inadvertently certified, the facility will be allowed to apply for a Certificate of Need to convert these beds to general nursing home beds, regardless of the projected bed need for that county.

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand aged 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Quality

CMS has established the 5-Star Quality Rating System for nursing facilities. It gives consumers the opportunity to see how different nursing facilities have rated on measurements of quality. The system gives each Medicare/Medicaid-participating nursing facility between 1-5 stars with 5 having the highest overall quality and 1 the lowest. This overall score is based on 3 components, each of which is also individually rated. These are:

a. Health inspections – from the past 3 years plus any complaint investigations.
b. Staffing ratios – the number of nursing hours of staff per patient per day, adjusted by the level of need of the patients.
c. Quality measures – 9 physical and clinical measures of patient care derived from MDS 3.0.

The system is accessible online and allows the user to compare multiple facilities at the same time. The URL is: http://www.medicare.gov/NHCompare

The Department may use the 5-Star data in evaluating a CON application for additional nursing facility beds at an existing facility.

Relative Importance of Project Review Criteria

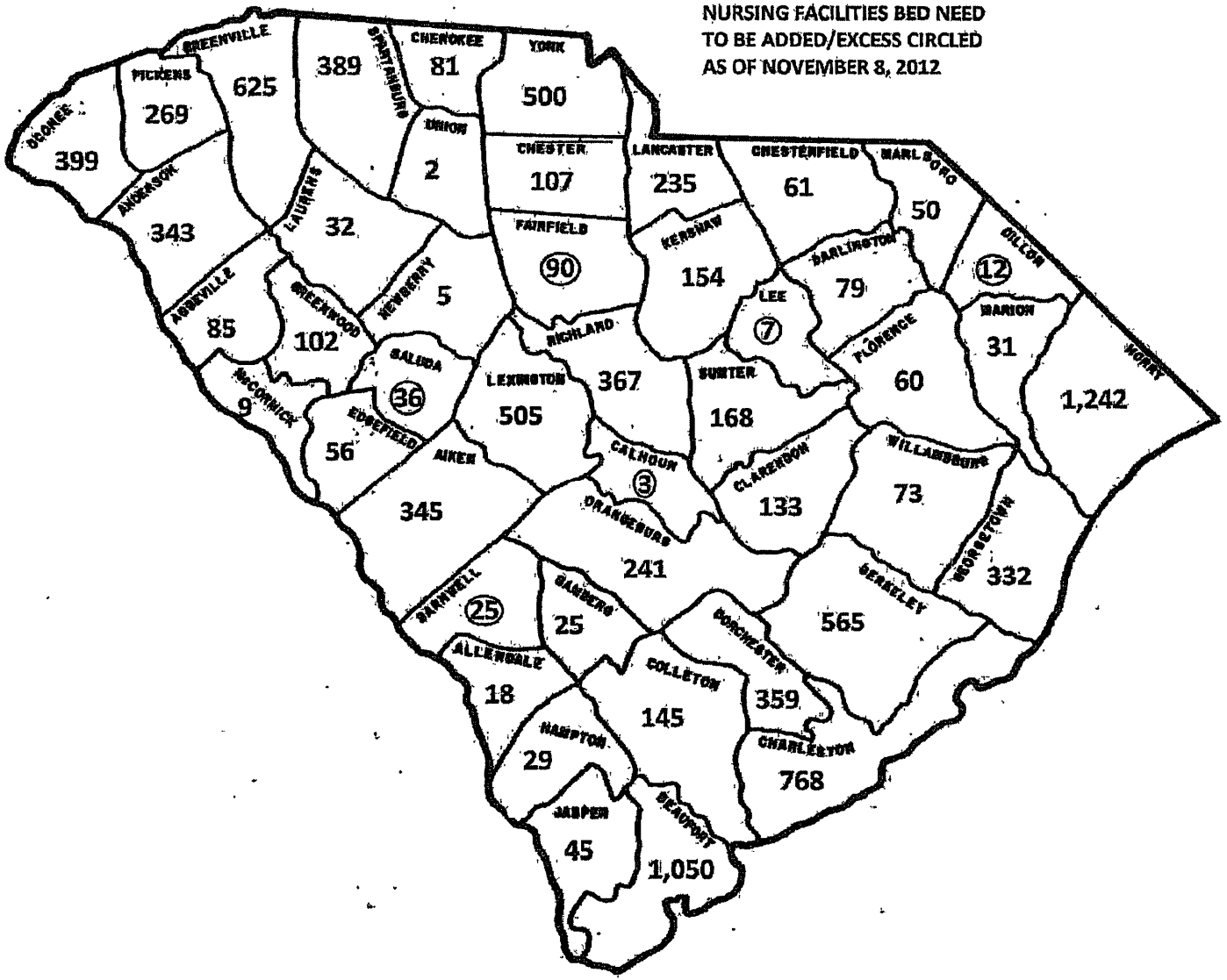
The following project review criteria are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing facilities are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

PET-EX012.0136

RECORD 004308



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PET-EX012.0137

LONG TERM CARE BED NEED

		2015 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
	ANDERSON	31.90	1,244	901	343	343
	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	5,310	2,108	2,108
	ABBEVILLE	4.60	179	94	85	85
	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	11.80	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	693	500	500
REGION II	TOTAL	194.20	7,574	5,543	2,031	2,157
	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	778	345	345
	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	1,299	768	768
	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	4,526	3,562	3,590
STATEWIDE TOTALS		750.60	29,274	19,363	9,911	10,084

COUNTY	2015 POP (000s 65+)	NURSING FACILITY BEDS	BEDS PER 1,000 POP	RANK
BEAUFORT	42.60	611	14.34	1
BERKELEY	23.60	355	15.04	2
OCONEE	16.70	252	15.09	3
GEORGETOWN	14.90	249	16.71	4
HORRY	56.80	973	17.13	5
COLLETON	7.10	132	18.59	6
CHESTER	5.30	100	18.87	7
DORCHESTER	18.20	351	19.29	8
ABBEVILLE	4.60	94	20.43	9
CLARENDON	7.30	152	20.82	10
LANCASTER	13.40	288	21.49	11
YORK	30.60	693	22.65	12
KERSHAW	10.20	244	23.92	13
ORANGEBURG	16.00	383	23.94	14
PICKENS	18.50	453	24.49	15
CHARLESTON	53.00	1,299	24.51	16
JASPER	3.40	88	25.88	17
LEXINGTON	39.00	1,016	26.05	18
EDGEFIELD	4.50	120	26.67	19
MARLBORO	4.10	110	26.83	20
AIKEN	28.80	778	27.01	21
ALLENDALE	1.60	44	27.50	22
WILLIAMSBURG	6.60	184	27.88	23
ANDERSON	31.90	901	28.24	24
SUMTER	16.00	456	28.50	25
CHEROKEE	8.30	243	29.28	26
GREENVILLE	65.70	1,937	29.48	27
SPARTANBURG	43.90	1,323	30.14	28
GREENWOOD	11.70	354	30.26	29
BAMBERG	2.90	88	30.34	30
HAMPTON	3.40	104	30.59	31
CHESTERFIELD	7.30	224	30.68	32
RICHLAND	45.10	1,392	30.86	33
DARLINGTON	11.40	366	32.11	34
MARION	5.40	180	33.33	35
LAURENS	11.60	420	36.21	36
FLORENCE	21.40	775	36.21	37
MCCORMICK	3.30	120	36.36	38
NEWBERRY	6.90	264	38.26	39
UNION	5.20	201	38.65	40
CALHOUN	3.00	120	40.00	41
LEE	2.90	120	41.38	42
DILLON	4.70	195	41.49	43
BARNWELL	3.80	173	45.53	44
SALUDA	3.60	176	48.89	45
FAIRFIELD	4.40	262	59.55	46
	750.60	19,363	25.80	

B. Medicaid Nursing Home Permits:

Beginning July 1, 1988, nursing facilities that wish to continue to serve Medicaid residents must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing facility may provide, and the nursing facility must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849
1991-1992	3,856,833	10,567	3,659,965	10,028	196,868
1992-1993	3,976,576	10,895	3,806,382	10,429	170,194
1993-1994	4,012,359	10,993	3,856,382	10,566	155,977
1994-1995	4,023,690	11,024	3,892,882	10,665	130,808
1995-1996	3,969,681	10,876	3,892,882	10,665	76,799
1996-1997	4,072,519	11,158	4,002,382	10,965	70,137
1997-1998	4,119,753	11,287	4,097,282	11,225	22,471
1998-1999	4,265,182	11,685	4,265,182	11,685	0
1999-2000	4,367,134	11,965	4,341,832	11,895	25,302
2000-2001	4,420,522	12,111	4,378,332	11,995	42,190
2001-2002	4,473,170	12,255	4,275,998	11,715	197,172
2002-2003	4,340,158	11,891	4,205,553	11,522	134,605
2003-2004	4,304,160	11,792	4,205,553	11,522	98,607
2004-2005	4,294,977	11,767	4,205,553	11,522	89,424
2005-2006	4,291,812	11,758	4,205,553	11,522	86,259
2006-2007	4,283,209	11,735	4,205,553	11,522	77,656
2007-2008	4,263,785	11,682	4,205,553	11,522	58,232
2008-2009	4,231,047	11,592	4,205,553	11,522	25,494
2009-2010	4,215,522	11,549	4,205,553	11,522	9,969
2010-2011	4,217,584	11,555	4,205,553	11,522	12,031
2011-2012	4,250,190	11,644	3,771,878	10,333	478,312
2012-2013	4,268,032	11,693	3,815,921	10,455	452,111

C. Community Long Term Care (CLTC) Program:

The South Carolina Community Long Term Care Project (CLTC) provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing facility placement under the Medicaid program. It also provides the following community-based services for participants who prefer to receive care in the community rather than institutional care:

a. Personal Care;
b. Environmental Modifications;
c. Home-Delivered Meals;
d. Adult Day Health Care (ADHE);
e. Respite Care;
f. Personal Emergency Response System (PERS);
g. Durable Medical Equipment;
h. Nursing Services; and
i. Case Management.

DHHS operates three home and community-based Medicaid waiver programs through the CLTC program. The Community Choices program served around 13,000 patients in FY 09-10; DHHS projected the daily cost of this program as $32 versus $127 for nursing home care. The other waivers served about 900 persons with HIV disease and approximately 1,300 adults who are dependent upon mechanical ventilation. The PACE program is jointly funded by Medicare and provides primary and long-term care services to participants age 55 and older who meet the State's nursing facility level of care. The Palmetto SeniorCare (PSC) Program operates four PACE Centers in Richland and Lexington Counties and serves approximately 365 participants annually. The only other PACE site in South Carolina is operated by The Oaks CCRC in Orangeburg. DHHS is also participating in a federal initiative called Money Follows the Person (MFP), which allows people who have been in a nursing facility for at least six months to transition back to the community.

D. Mental Retardation Facilities:

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed.

The South Carolina Department of Disabilities and Special Needs (DDSN) has reduced the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds have been developed for those persons from the regional centers and those on the residential services waiting list. These beds represent the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in. DDSN also operates three home and community-based Medicaid waiver programs for the following target groups: Mental Retardation and Related Disabilities, Head and Spinal Cord Injuries, and Pervasive Developmental Disorders.

PET-EX012.0141

RECORD 004313

E. Institutional Nursing Facility (Retirement Community Nursing Facility):

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. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

(1) The nursing facility must be a part of and located on the campus of the retirement community.

(2) It must restrict admissions to campus residents.

(3) The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home," and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, a generally accepted ratio of nursing facility beds to retirement beds is 1:4. However, this ratio may high for a newly established retirement center as new residents are typically not in need of nursing facility care as soon as the facility is licensed. The nursing facility could operate at low utilization for the first several years.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing 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.

PET-EX012.0142

RECORD 004314

F. Swing Beds:

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified to participate in Medicare.

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. The Code of Federal Regulations (CFR) section 42 details the other specific program requirements

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 following hospitals in South Carolina participated in the swing bed program during 2011:

Hospital	Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Medical Ctr.	25	9	36	0.1
Allendale County Hospital	15	87	2,386	6.6
Bamberg County Memorial	24	13	135	0.4
Chesterfield General	49	33	307	0.8
Coastal Carolina *1*	10			
Edgefield Co. Hospital	25	93	1,108	3.0
Fairfield Memorial	25	67	912	2.5
Hampton Regional Hospital *2*	10			
Marlboro Park Hospital *1*	6			
McLeod-Darlington	24	165	2,262	14.4
Newberry County Memorial	20	8	39	0.1
Wallace Thompson *1*	12			
Williamsburg Regional	10	259	4,085	11.2
TOTALS	255	734	11,270	30.8

1 Participates in the program but did not use the beds in 2011.

2 Unit established 9/28/11.

G. 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.

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.

The existing and approved inpatient hospices in South Carolina are listed on the following page.

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:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Community Need Documentation;
d. Acceptability;
e. Financial feasibility; and
f. Staff Resources.

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One hundred licensed Hospice Programs exist with at least one licensed hospice serving every county in the state. According to the S.C. Budget & Control Board, 38.9% of deaths in 2010 were served by hospices. Additional information may be found at http://www.scdhec.net/health/hrreg.htm. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

NAME OF FACILITY	COUNTY	LICENSED BEDS	ADMISSIONS	PATIENT DAYS	% OCCU RATE
REGION I					
CALLIE & JOHN RAINEY HOSPICE HOUSE	ANDERSON	32	671	8,658	74.1%
MCCALL HOSPICE HOUSE OF GREENVILLE	GREENVILLE	30	693	9,417	86.0%
OCONEE MEMORIAL HOSPICE FOOTHILLS	OCONEE	15	263	3,221	58.8%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	SPARTANBURG	12	234	2,668	60.9%
SPARTANBURG REG HEALTHCARE HOSPICE	SPARTANBURG	15	589	5,106	93.3%
TOTAL		104	2,450	29,070	76.6%
REGION II					
HOSPICE HOUSE OF HOSPICECARE PIEDMONT	GREENWOOD	16	322	2,117	36.7%
HOSPICE OF LAURENS INPT HOSPICE HOUSE	LAURENS	12	133	1,340	30.6%
(ASCENSION HOUSE) *1*	RICHLAND	(14)			
AGAPE HOSPICE HOUSE OF THE MIDLANDS *2*	RICHLAND	12			
HOSPICE AND COMMUNITY CARE HOUSE	YORK	16	247	2,060	86.3%
TOTAL		55	702	5,517	35.2%
REGION III					
MCLEOD HOSPICE HOUSE *3*	FLORENCE	24	579	3,768	86.0%
TIDELANDS COMMUNITY HOSPICE HOUSE	GEORGETOWN	12	249	2,304	52.6%
AGAPE HOSPICE HOUSE OF HORRY COUNTY *4*	HORRY	(24)			
MERCY CARE HOSPICE HOUSE CONWAY *5*	HORRY	14			
TOTAL		50	828	6,072	69.3%
REGION IV					
HOSPICE CTR HOSPICE OF CHARLESTON	CHARLESTON	20	701	4,978	68.2%
TOTAL		20	701	4,978	68.2%
STATEWIDE TOTAL		229	4,681	45,637	85.5%

1 FACILITY CLOSED 1/1/11.

2 CON ISSUED 5/13/11 TO ESTABLISH A 12 BED INPATIENT HOSPICE, SC-11-14; LICENSED 8/8/11.

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.

5 CON ISSUED 3/23/12 TO ESTABLISH A 14 BED INPATIENT HOSPICE; SC-12-09.

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

PET-EX012.0147

RECORD 004319

HOME HEALTH METHODOLOGY

Rate		0.00084		0.00830		0.04632		0.12204								
County	Projected 2013 Population Age 0-17	2013 Estimated Pts Age 0-17	Projected 2013 Population Age 18-64	2013 Estimated Pts Age 18-64	Projected Pop 2013 Age 65-74	2013 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	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	7,280	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	38,200	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			

RECORD 004320

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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

Agency	Counties Served	Persons Served	Total Visits
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
Amedysis Home Health of Bluffton 2	Beaufort, Hampton & Jasper	1,266	22,963
Amedysis Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	1,568	31,187
Amedysis Home Health of Charleston	Berkeley, Charleston & Dorchester	3,710	72,420
Amedysis Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,385	84,502
Amedysis Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,796	37,951
Amedysis Home Health of Conway	Horry	1,480	27,064
Amedysis Home Health Georgetown	Georgetown & Williamsburg	1,864	32,413
Amedysis HH Georgetown East	Georgetown & Williamsburg	327	5,067
Amedysis Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	6,481	135,463
Amedysis 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	47,636
Methodist Manor Home Health (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	759	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**	**2,022,865**

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.

STATE SUMMARY

PROGRAM OF EACH REGION

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

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes that have occurred since the previous Plan are explained by a footnote. The numbers of existing and approved beds are summarized by region. The inventory of beds and facilities was current as of November 8, 2012.

PET-EX012.0157

RECORD 004329

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR: 2011

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds. The William J. McCord Adolescent Treatment Facility received a CON on 7/16/10 to convert to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.

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

RECORD 004330

PET-EX012.0158

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2011**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS
HOSPITALS:								
THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38		
LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10		
SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50	458	940
W.J. BARGE MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	79	90		
LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20		
SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		
GEO CARE OF SOUTH CAROLINA		RICHLAND	COLUMBIA	PROP	196	196		
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	11	11		
KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24		
WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8		
CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22		
TOTAL					450	461	458	940
MENTAL HOSPITALS:								
PATRICK B HARRIS PSYCHIATRIC		ANDERSON	ANDERSON	ST	200	200	878	41,266
G WERBER BRYAN PSYCHIATRIC HOSP		RICHLAND	COLUMBIA	ST	492	492	758	67,339
GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87		
(SC STATE HOSPITAL)	1	RICHLAND	COLUMBIA	ST	(0)	(0)		
WM J MCCORD ADOLESCENT TREAT	2	ORANGEBURG	ORANGEBURG	ST	15	15	118	5,111
WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89	389	5,613
TOTAL					883	883	2,143	119,329
RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:								
DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37	24	3,860
TOTAL					37	37	24	3,860
DRUG & ALCOHOL INPT TREATMENT:								
PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48		
HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36		
(WM J MCCORD ADOLESCENT TREAT)	2	ORANGEBURG	ORANGEBURG	ST	(0)	(0)		
WILLIAM S HALL		RICHLAND	COLUMBIA	ST	19	19	49	5,554
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	163	163	1,512	40,710
TOTAL					266	266	1,561	46,264
LONG TERM FACILITIES:								
RICHARD M CAMPBELL VA NURS HOME		ANDERSON	ANDERSON	ST	220	220	132	85,778
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14	46	3,995
PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8	16	1,798
BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	13	2,768
THE FRANKE HEALTH CARE CTR	3	CHARLESTON	MT PLEASANT	NPA	(0)	(0)	98	6,928
VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	93	79,193

RECORD 004331

PET-EX012.0159

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2011**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	52	52	40	16,199
METHODIST MANOR HEALTHCARE CTR		FLORENCE	FLORENCE	NPA	32	32	9	11,406
PRESBYTERIAN HOME FLORENCE	4	FLORENCE	FLORENCE	NPA	26	26	21	7,297
LAKES AT LITCHFIELD SKILLED NSG CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	7	7	40	2,138
(ROLLING GREEN VILLAGE HC FACILITY)	5	GREENVILLE	GREENVILLE	NPA	(0)	(0)	69	12,018
(LINVILLE COURTS CASCADES VERDAE)	6	GREENVILLE	GREENVILLE	PROP	(0)	(0)	66	3,989
(ARBORETUM WOODLANDS)	7	GREENVILLE	GREENVILLE	PROP	(13)	(13)		
MARTHA FRANK BAPTIST HOME		LAURENS	LAURENS	NPA	7	7	4	2,517
PRESBYTERIAN HOME OF SC CLINTON		LAURENS	CLINTON	NPA	48	48	70	14,627
(SC EPISCOPAL HOME STILL HOPES)	8	LEXINGTON	W COLUMBIA	NPA	(0)	(0)	45	11,819
LAUREL CREST RETIREMENT CENTER		LEXINGTON	W COLUMBIA	NPA	12	12	4	4,012
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	22	22	27	6,198
PRESBYTERIAN HOME OF SC - FOOTHILLS		PICKENS	EASLEY	NPA	18	18	22	5,610
CM TUCKER JR NURS CTR-FEWELL/STONE		RICHLAND	COLUMBIA	ST	252	252	23	24,358
CM TUCKER JR NURS CTR-RODDEY		RICHLAND	COLUMBIA	ST	308	308	4	72,654
WILDEWOOD DOWNS NSG & REHAB		RICHLAND	COLUMBIA	PROP	8	8	34	1,906
WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	62	150		
EMERITUS AT SKYLYN HEALTH CARE CTR		SPARTANBURG	SPARTANBURG	PROP	11	11	18	3,523
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	6	6	36	1,808
(COVENANT PLACE NURS CTR)	9	SUMTER	SUMTER	NPA	16	16	21	7,084
TOTAL					1,358	1,446	951	389,623

RECORD 004332

PET-EX012.0160

FOOTNOTES 2012-2013 PLAN

STATEWIDE

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

1. Facility closed effective 2/29/12.
2. CON issued 7/16/10 to convert the McCord Adolescent Treatment Facility to a specialized hospital restricted primarily to the provision of alcohol and drug abuse treatment for adolescents.
3. CON issued 12/20/11 to convert 20 institutional nursing home beds to community beds, for a total of 44 community beds, SC-11-54.
4. Exemption issued 4/16/10 for the permanent de-licensure of 18 beds, for a total of 26 licensed nursing home beds. Licensed for 26 beds 6/24/10.
5. CON issued 7/28/11 to convert 34 existing institutional nursing home beds to community beds and add 30 new community beds for a total of 74 community nursing home beds not participating in the Medicaid program, SC-11-28. The 34 institutional beds were converted on 10/31/11.
6. CON issued 7/1/11 to convert the 22 institutional beds to nursing home beds not participating in the Medicaid program, for a total of 44 community nursing home beds, SC-11-23. Licensed for 44 community nursing home beds 7/18/11.
7. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds effective 6/10/10.
8. CON issued 12/28/11 to convert 42 institutional nursing home beds to community beds, for a total of 62 community and 0 institutional beds, SC-11-53.
9. CON issued 1/31/11 to convert 28 institutional nursing home beds to community beds that do not participate in the Medicaid program, for a total of 16 institutional and 28 community beds, SC-11-03. Licensed for 28 community and 16 institutional beds 6/21/11.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: I FISCAL YEAR: 2011

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

2. General Hospitals: W.J. Barge Hospital is a privately owned Educational Institutional Infirmary.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

RECORD 004334

PET-EX012.0162

REGION: I

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CONTROL	LICENSED BEDS	SURVEY BEDS	ADMISSIONS	PATIENT DAYS	AVE. LIC BEDS	% OCCU RATE
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	14,781	76,738	423	49.7%
ANMED HEALTH WOMENS & CHILDRENS HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,221	7,307	72	27.8%
ANDERSON COUNTY		TOTAL			495	495	18,012	84,045	495	46.5%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125	3,338	12,667	125	27.8%
CHEROKEE COUNTY		TOTAL			125	125	3,338	12,667	125	27.8%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	746	746	32,426	172,525	746	63.4%
GREER MEMORIAL HOSPITAL		GREENVILLE	GREER	NPA	82	82	3,603	12,116	82	40.5%
HILLCREST MEMORIAL HOSPITAL		GREENVILLE	SIMPSONVILLE	NPA	43	43	2,002	6,668	43	42.5%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,057	2,402	72	9.1%
SAINT FRANCIS - DOWNTOWN	1	GREENVILLE	GREENVILLE	NPA	226	226	12,021	54,840	226	66.5%
(SAINT FRANCIS MILLENNIUM)	1	GREENVILLE	GREENVILLE	NPA		(0)				
SAINT FRANCIS - EASTSIDE		GREENVILLE	GREENVILLE	NPA	93	93	5,814	18,501	93	48.6%
GREENVILLE COUNTY		TOTAL			1,262	1,262	56,933	265,052	1,262	57.5%
OCONEE MEDICAL CENTER		OCONEE	SENECA	NPA	169	169	7,290	29,234	169	47.4%
OCONEE COUNTY					169	169	7,290	29,234	169	47.4%
BAPTIST EASLEY HOSPITAL		PICKENS	EASLEY	NPA	109	109	4,771	20,307	109	51.0%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	55	55	948	3,999	55	19.9%
PICKENS COUNTY		TOTAL			164	164	5,719	24,306	164	40.6%
MARY BLACK MEMORIAL HOSPITAL	2	SPARTANBURG	SPARTANBURG	PROP	176	174	6,398	26,679	176	41.6%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	484	484	25,829	131,537	484	74.5%
VILLAGE HOSPITAL		SPARTANBURG	GREER	CO	48	48	1,441	5,257	48	30.0%
SPARTANBURG COUNTY		TOTAL			708	706	33,669	163,473	708	63.3%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	2,633	9,955	143	19.1%
UNION COUNTY		TOTAL			143	143	2,633	9,955	143	19.1%
TOTAL					3,066	3,064	127,594	588,732	3,066.0	52.6%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS REST	NPA	45	45	281	8,668	45	52.2%
REGENCY HOSPITAL OF GREENVILLE		GREENVILLE	GREENVILLE	NPA	32	32	334	9,071	32	77.7%
SPARTANBURG HOSPITAL FOR RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97	383	12,119	97	34.2%
TOTAL					129	129	998	29,758	174	46.9%
MENTAL FACILITIES:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38	1,043	5,556	38	40.1%
ANDERSON COUNTY		TOTAL			38	38	1,043	5,556	38	40.1%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	3	GREENVILLE	GREENVILLE	PROP	99	104	2,385	27,817	99	77.0%
SPRINGBROOK BEHAVIORAL HEALTHCARE	4	GREENVILLE	TRAVELERS REST	PROP	28	37	472	5,229	22.2	64.5%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	46	46	1,370	13,970	46	83.2%
GREENVILLE COUNTY		TOTAL			173	187	4,237	47,016	167.2	77.0%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15	281	3,523	15	64.3%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56	588	5,303	56	25.9%
SPARTANBURG COUNTY		TOTAL			71	71	869	8,826	71	34.1%
TOTAL					282	296	6,149	61,398	276.2	60.5%

XIII-7

RECORD 004335

PET-EX012.0163

REGION: I

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
EXCALIBUR YOUTH SERVICES		GREENVILLE	SIMPSONVILLE	PROP	60	60	88	11,925	60	54.5%
GENERATIONS RESIDENTIAL PROGRAM	5	GREENVILLE	GREENVILLE	PROP	30	30				
MARSHALL I. PICKENS CHILDREN'S PROGRAM		GREENVILLE	GREENVILLE	NPA	22	22	24	7,669	22	95.5%
SPRINGBROOK BEHAVIORAL HEALTHCARE		GREENVILLE	TRAVELERS REST	PROP	68	68	83	20,098	68	81.0%
AVALONIA GROUP HOME		PICKENS	PICKENS	PROP	55	55	74	13,088	55	65.1%
TOTAL					235	235	269	52,760	205	70.5%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINA CENTER FOR BEHAVIORAL HEALTH	3	GREENVILLE	GREENVILLE	PROP	13	21	760	6,435	13	135.6%
TOTAL					13	21	760	6,435	13	135.6%
REHABILITATION FACILITIES:										
ANMED HEALTH REHABILITATION HOSPITAL	6	ANDERSON	ANDERSON	PROP	55	55	1,114	15,158	45	92.3%
ANDERSON COUNTY		TOTAL			55	55	1,114	15,158	45	92.3%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53	707	11,476	53	59.3%
SAINT FRANCIS HOSPITAL - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	19	19	466	5,854	19	84.4%
GREENVILLE COUNTY		TOTAL			72	72	1,173	17,330	72	66.6%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18	273	3,760	18	57.2%
SPARTANBURG REHABILITATION INSTITUTE	7	SPARTANBURG	SPARTANBURG	PROP		28				
SPARTANBURG COUNTY		TOTAL			18	46	273	3,760	18	57.2%
TOTAL					145	173	2,560	36,246	136	73.5%
INPATIENT HOSPICE FACILITIES:										
CALLIE & JOHN RAINEY / HOSPICE OF THE UPSTATE		ANDERSON	ANDERSON	NPA	32	32	671	8,658	32	74.1%
MCCALL HOSPICE HOUSE OF GREENVILLE		GREENVILLE	SIMPSONVILLE	NPA	30	30	693	9,417	30	86.0%
OCONEE MEMORIAL HOSPICE FOOTHILLS		OCONEE	SENECA	NPA	15	15	283	3,221	15	58.8%
HOSPICE HOUSE OF CAROLINA FOOTHILLS		SPARTANBURG	LANDRUM	NPA	12	12	234	2,668	12	60.9%
SPARTANBURG REG HEALTHCARE HOSPICE		SPARTANBURG	SPARTANBURG	NPA	15	15	569	5,106	15	93.3%
TOTAL					104	104	2,450	28,070	104	75.6%
LONG TERM CARE FACILITIES:										
CHIQUOLA MANOR	8	ANDERSON	HONEA PATH	NPA		150				
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181	234	63,003	181	95.4%
EMERITUS AT ANDERSON PLACE HEALTH CARE CENTER		ANDERSON	ANDERSON	PROP	44	44	136	14,345	44	89.3%
EXALTED HEALTH & REHAB IVA		ANDERSON	IVA	PROP	60	60	130	20,924	60	95.5%
FELLOWSHIP HEALTH & REHAB ANDERSON		ANDERSON	ANDERSON	PROP	88	88	157	30,642	88	95.4%
(GARDENS AT TOWN CREEK)	9	ANDERSON	PENDLETON	PROP	(0)	(0)				
HOSANNA HEALTH & REHAB PIEDMONT		ANDERSON	ANDERSON	PROP	88	88	272	31,157	88	97.0%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290	529	103,283	290	97.5%
ANDERSON COUNTY		TOTAL			751	901	1,458	263,354	751	96.1%
BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132	294	45,510	132	94.2%
CHEROKEE COUNTY LONG TERM CARE FACILITY		CHEROKEE	GAFFNEY	CO	111	111	234	35,857	111	88.3%
CHEROKEE COUNTY		TOTAL			243	243	528	81,367	243	91.5%
ALPHA HEALTH & REHAB GREER	10	GREENVILLE	GREER	PROP	132	132	462	44,838	132	92.6%
ARBORETUM OF WOODLANDS AT FURMAN	11	GREENVILLE	GREENVILLE	PROP	30	30	168	9,977	30	91.1%
(ARBORETUM OF WOODLANDS AT FURMAN)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
COTTAGES AT BRUSHY CREEK		GREENVILLE	GREENVILLE	NPA	144	144	422	50,474	144	96.0%
DAYSPRING HEALTH & REHAB SIMPSONVILLE	12	GREENVILLE	SIMPSONVILLE	PROP	42	120	26	13,654	42	89.1%
DIAMOND HEALTH & REHAB SIMPSONVILLE		GREENVILLE	SIMPSONVILLE	PROP	132	132	206	46,915	132	97.4%
EMERITUS AT GREENVILLE		GREENVILLE	GREENVILLE	PROP	45	45	250	12,988	45	79.1%
FOUNTAIN INN NURSING HOME		GREENVILLE	FOUNTAIN INN	PROP	60	60	114	20,280	60	92.6%
GLORIFIED HEALTH & REHAB GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	234	46,091	132	95.7%
GREENVILLE MEMORIAL MED CTR SUBACUTE		GREENVILLE	GREENVILLE	NPA	15	15	310	5,053	15	92.3%
HOPE HEALTH & REHAB MARIETTA		GREENVILLE	MARIETTA	NPA	44	44	29	15,280	44	95.0%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	330	43,884	132	91.1%

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REGION: I

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LINVILLE COURTS AT CASCADES VERDAE	12	GREENVILLE	GREENVILLE	PROP	44	44	177	10,637	32	91.1%
(LINVILLE COURTS AT CASCADES VERDE)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	66	34,295	99	94.9%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	174	41,911	120	95.7%
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176	554	61,701	176	96.0%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	560	61,595	180	93.8%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	255	44,129	132	91.6%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125	358	42,062	125	92.2%
OMEGA HEALTH & REHAB GREENVILLE	10	GREENVILLE	GREENVILLE	PROP	79	0	90	26,600	79	92.2%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY	13	GREENVILLE	GREENVILLE	NPA	50	74	20	3,535	17	57.0%
(ROLLING GREEN VILLAGE HEALTH CARE FACILITY)		GREENVILLE	GREENVILLE	NPA	(0)	(0)				
GREENVILLE COUNTY		TOTAL			1,913	1,937	4,796	535,676	1,568	93.0%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120	480	41,900	120	94.3%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132	182	44,076	132	91.5%
OCONEE COUNTY		TOTAL			252	252	842	85,976	252	92.6%
CAPSTONE HEALTH & REHAB EASLEY	14	PICKENS	EASLEY	PROP	66	60	96	23,298	66	96.7%
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	30	30	30	8,453	30	77.2%
(CLEMSON AREA RETIREMENT CENTER)		PICKENS	CLEMSON	PROP	(22)	(22)				
EMERITUS COUNTRYSIDE HEALTHCARE CENTER	15	PICKENS	EASLEY	PROP	44	60	43	12,800	44	79.5%
HERITAGE HEALTHCARE OF PICKENS		PICKENS	SIX MILE	PROP	44	44	82	14,614	44	91.0%
MAJESTY HEALTH & REHAB EASLEY		PICKENS	EASLEY	PROP	103	103	280	35,877	103	95.4%
MANNA HEALTH & REHAB PICKENS	14	PICKENS	PICKENS	PROP	80	130	180	28,323	80	97.0%
PRESBYTERIAN HOME - FOOTHILLS	16	PICKENS	EASLEY	PROP	26	26	14	3,353	10.8	85.1%
(PRESBYTERIAN HOME - FOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
REDEEMER HEALTH & REHAB PICKENS	14	PICKENS	PICKENS	PROP	44	(0)	63	15,397	44	95.9%
PICKENS COUNTY		TOTAL			437	453	748	141,915	421.8	92.2%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	84	31,433	88	97.9%
EMERITUS AT SKYLYN HEALTH CARE CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33	56	10,570	33	87.8%
(EMERITUS AT SKYLYN HEALTH CARE CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)				
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44	43	14,586	44	90.9%
INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	40	48	13,007	40	89.1%
MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176	263	61,812	176	96.2%
MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	95	95	133	31,840	95	91.8%
MAGNOLIA PLACE - SPARTANBURG	17	SPARTANBURG	SPARTANBURG	PROP	88	120	188	30,738	88	95.7%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132	131	47,441	132	98.5%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75	235	21,535	75	78.7%
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	488	5,686	25	62.8%
SPARTANBURG REHABILITATION INSTITUTE	7	SPARTANBURG	SPARTANBURG	PROP		12				
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	27	27	166	9,135	27	92.5%
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88	24	31,100	88	96.8%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88	166	31,141	88	97.0%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192	151	84,389	192	91.6%
WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88	49	31,503	88	98.1%
SPARTANBURG COUNTY		TOTAL			1,279	1,323	2,205	434,899	1,279	93.2%
ELLEN SAGAR NURSING HOME		UNION	UNION	CO	113	113	94	40,799	113	98.9%
OAKMONT OF UNION		UNION	UNION	PROP	88	88	341	41,317	88	128.6%
UNION COUNTY		TOTAL			201	201	435	82,116	201	111.9%
TOTAL					5,076	5,310	10,811	1,724,703	5,015.8	94.2%

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FOOTNOTES 2012-2013 PLAN

REGION I

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

1. CON issued 6/12/09 to construct a new 52 bed hospital (St. Francis millennium) through the transfer of the 50 bed need generated by St. Francis Downtown and the transfer of 2 beds from St. Francis Downtown, for a total of 224 beds at St. Francis Downtown, SC-09-28. CON voided 8/1/11, St. Francis Downtown remains licensed for 226 beds.
2. Notified the Department on 4/16/12 that they intended to de-license 2 general acute beds for a total of 174 general acute, 15 psychiatric, and 18 rehabilitation beds.
3. CON issued 4/26/12 to add 5 psych beds for a total of 104 and 8 substance abuse beds for a total of 21, SC-12-10.
4. CON issued 8/10/09 to add 17 psych beds for a total of 37 psych and 68 RTF beds, SC-09-38. Licensed 8 additional beds for a total of 28, 9/20/11.
5. Exemption to convert from a High Maintenance Group Home to an RTF. Licensed for 30 RTF beds on 8/25/11.
6. CON issued 9/22/11 to add 10 rehab beds for a total of 55, SC-11-42. Licensed for 55 beds 1/1/12.
7. CON issued 6/20/12 for a facility with 28 rehab and 12 nursing home beds, SC-12-17.
8. CON approved 11/8/12 to construct a 150 bed nursing home that does not participate in the Medicaid program.
9. CON issued 9/9/10 to construct a 60 bed nursing home that does not participate in the Medicaid program, SC-10-29. CON voided 7/30/12.
10. CON issued 11/28/11 to construct a 120 bed nursing facility to consolidate the existing 42 beds at Dayspring Health & Rehab, and 78 of the 79 existing beds at Omega Health & Rehab of Greenville, SC-11-51. The remaining bed from Omega Health & Rehab was added to Alpha Health & Rehab of Greer, for a total of 133 beds.
11. CON issued 6/10/10 to convert the 13 institutional beds to community beds, SC-10-17. Licensed for 30 community beds, 6/10/10.
12. CON issued 7/1/11 to convert 22 institutional beds to nursing home beds not participating in the Medicaid program, for a total of 44 community nursing home beds, SC-11-23. Licensed for 44 community nursing home beds 7/18/11
13. CON issued 7/28/11 to convert 34 existing institutional nursing home beds to community beds and add 30 new community beds for a total of 74 community nursing home beds not participating in the Medicaid program, SC-11-28. The 34 institutional beds were converted on 10/31/11 for a total of 44 community beds. Licensed for 6 additional beds for a total of 50 beds 5/31/12.
14. CON issued 10/19/11 to construct a 50 bed addition at Manna Health & Rehab of Pickens by consolidating 44 beds from Redeemer Health & Rehab of Pickens and 6 beds from Capstone Health & Rehab of Easley, SC-11-47. The final result will be 130 beds at Manna, 60 beds at Capstone, and Redeemer will close.

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15. CON issued 10/10/12 to add 16 beds for a total of 60 nursing home beds, SC-12-30.
16. CON issued 1/14/10 to construct 26 nursing home beds for a total of 44, with 18 restricted to residents of the retirement community, SC-10-04. The facility was licensed for 18 institutional nursing home beds and 26 community nursing home beds 8/2/11.
17. CON issued 8/22/12 to add 32 beds for a total of 120 nursing home beds, SC-12-26.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2010 ER VISITS	2011 ER VISITS
REGION I:	EMERGENCY FACILITIES		
II	ANMED HEALTH MEDICAL CENTER	59,549	61,953
III	UPSTATE CAROLINA MEDICAL CENTER	33,497	35,783
II	GREENVILLE MEMORIAL HOSPITAL	87,006	91,297
I	GREER MEMORIAL HOSPITAL	31,478	30,890
II	HILLCREST HOSPITAL	29,134	30,452
III	NORTH GREENVILLE LTACH	17,265	16,342
II	SAINT FRANCIS - DOWNTOWN	42,327	43,049
II	SAINT FRANCIS - EASTSIDE	29,644	29,799
III	OCONEE MEMORIAL HOSPITAL	36,603	38,163
III	BAPTIST MED CTR-EASLEY	42,979	42,773
III	CANNON MEMORIAL HOSPITAL	17,867	18,589
III	MARY BLACK MEMORIAL HOSPITAL	28,650	33,465
I	SPARTANBURG REGIONAL MED CTR	102,699	104,295
III	VILLAGE HOSPITAL	15,434	17,693
III	WALLACE THOMSON HOSPITAL	18,210	18,278
		592,342	612,821

REGION I:	TRAUMA CENTERS	
II	ANMED HEALTH MEDICAL CENTER	
I	GREENVILLE MEMORIAL HOSPITAL	
I	SPARTANBURG REGIONAL MED CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: II

FISCAL YEAR: 2011

1. Unusual Characteristics: This region has a military base at Fort Jackson with a military hospital to provide health care services for the active duty and dependents residing in this region. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 87.9% of the Richland County population plus 45.1% of the population of Lexington County. For Lexington County, 54.9% of the Lexington County population plus 12.1% of the Richland County population is used. A separate bed need is indicated for each county.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

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REGION: II — INPATIENT INVENTORY — FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ABBEVILLE AREA MEDICAL CENTER		ABBEVILLE	ABBEVILLE	CO	25	25	724	2,640	25	28.9%
ABBEVILLE COUNTY		TOTAL			25	25	724	2,640	25	28.9%
CHESTER REGIONAL MEDICAL CENTER		CHESTER	CHESTER	DIST	82	82	1,620	4,858	82	16.2%
CHESTER COUNTY		TOTAL			82	82	1,620	4,858	82	16.2%
EDGEFIELD COUNTY HOSPITAL		EDGEFIELD	EDGEFIELD	CO	25	25	357	1,358	25	14.9%
EDGEFIELD COUNTY		TOTAL			25	25	357	1,358	25	14.9%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25	401	2,034	25	22.3%
FAIRFIELD COUNTY		TOTAL			25	25	401	2,084	25	22.3%
GELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	354	354	13,106	54,456	354	42.1%
GREENWOOD COUNTY		TOTAL			354	354	13,106	54,456	354	42.1%
KERSHAW HEALTH		KERSHAW	CAMDEN	CO	121	121	5,691	24,978	121	56.6%
KERSHAW COUNTY		TOTAL			121	121	5,691	24,978	121	56.6%
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	199	199	7,288	31,956	199	44.0%
LANCASTER COUNTY		TOTAL			199	199	7,288	31,956	199	44.0%
LAURENS COUNTY HOSPITAL		LAURENS	LAURENS	DIST	76	76	2,809	12,165	76	43.9%
LAURENS COUNTY		TOTAL			76	76	2,809	12,165	76	43.9%
LEXINGTON MEDICAL CENTER	2	LEXINGTON	WEST COLUMBIA	CO	414	414	18,096	87,838	414	58.1%
LEXINGTON COUNTY		TOTAL			414	414	18,096	87,838	414	58.1%
NEWBERRY COUNTY MEMORIAL HOSPITAL		NEWBERRY	NEWBERRY	CO	90	90	2,161	7,994	90	24.3%
NEWBERRY COUNTY		TOTAL			90	90	2,161	7,994	90	24.3%
PALMETTO HEALTH BAPTIST	3	RICHLAND	COLUMBIA	NPA	393	287	15,191	71,522	393	54.0%
PALMETTO HEALTH PARKRIDGE	3	RICHLAND	COLUMBIA	NPA		76				
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	NPA	579	579	29,533	169,045	579	80.0%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROF	258	258	8,508	46,608	258	49.5%
PROVIDENCE HOSPITAL NORTHEAST	4	RICHLAND	COLUMBIA	PROP	56	84	3,447	10,769	46	64.1%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(63)				
(W J B DORN VA HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(400)				
RICHLAND COUNTY		TOTAL			1,256	1,284	56,777	297,944	1,246	65.5%
CAROLINAS MEDICAL CENTER - FORT MILL	6	YORK	FORT MILL	NPA		50				
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	268	268	13,850	60,750	268	62.1%
YORK COUNTY		TOTAL			268	318	13,850	60,750	268	62.1%
TOTAL					2,935	3,013	122,880	588,971	2,925	55.2%
LONG TERM ACUTE HOSPITALS:										
INTERMEDICAL HOSPITAL OF SOUTH CAROLINA		RICHLAND	COLUMBIA	NPA	35	35	278	7,666	35	60.0%
TOTAL					35	35	278	7,666	35	60.0%
MENTAL FACILITIES:										
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	36	36	108	784	36	6.0%
GREENWOOD COUNTY		TOTAL			36	36	108	784	36	6.0%
REBOUND BEHAVIORAL HEALTH	7	LANCASTER	LANCASTER	PROP	0	18				
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	0	12				
LANCASTER COUNTY					0	30				
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	81	81	1,916	22,282	81	75.4%
LEXINGTON COUNTY		TOTAL			81	81	1,916	22,282	81	75.4%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	94	94	1,929	18,681	94	55.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60	505	4,792	60	21.9%
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED		(20)				

RECORD 004342

PET-EX012.0170

REGION: II

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W.J.B DORN VA)	5	RICHLAND	COLUMBIA	FED		(60)				
RICHLAND COUNTY		TOTAL			154	154	2,434	23,873	154	42.1%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20	842	5,620	20	77.0%
YORK COUNTY		TOTAL			20	20	842	5,620	20	77.0%
TOTAL					291	321	5,302	52,389	291	49.2%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
THREE RIVERS RESIDENTIAL TREATMENT - MIDLANDS		LEXINGTON	WEST COLUMBIA	PROP	59	59	65	20,240	59	94.0%
THREE RIVERS BEHAVIORAL HEALTH RTC		LEXINGTON	WEST COLUMBIA	PROP	20	20	20	6,935	20	95.0%
CAROLINA CHILDREN'S HOME	8	RICHLAND	COLUMBIA	NPA	30	30	21	3,583	29.5	33.3%
NEW HOPE CAROLINAS		YORK	ROCK HILL	PROP	150	150	317	50,690	150	92.6%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	43	8,325	40	57.0%
TOTAL					299	299	469	89,773	298.5	82.4%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	18	18	0	0	18	0.0%
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	17	17	542	3,921	17	63.2%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	CO	10	10	0	0	10	0.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10	239	2,543	10	69.7%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24	0	0	24	0.0%
TOTAL					79	79	781	6,464	79	22.4%
REHABILITATION FACILITIES:										
GREENWOOD REGIONAL REHAB HOSPITAL	9	GREENWOOD	GREENWOOD	NPA	34	42	787	10,787	34	86.8%
GREENWOOD COUNTY		TOTAL			34	42	787	10,787	34	86.8%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96	1,546	20,242	96	57.8%
RICHLAND COUNTY		TOTAL			96	96	1,546	20,242	96	57.8%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	10	YORK	ROCK HILL	PROP	50	50	1,005	13,506	46	80.4%
YORK COUNTY		TOTAL			50	50	1,005	13,506	46	80.4%
TOTAL					180	188	3,338	44,515	176	69.3%
INPATIENT HOSPICE FACILITIES:										
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15	322	2,117	15	38.7%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE		LAURENS	CLINTON	PROP	12	12	133	1,940	12	30.6%
AGAPE HOSPICE HOUSE OF THE MIDLANDS	11	RICHLAND	COLUMBIA	PROP	12	12				
(ASCENSION HOUSE)	12	RICHLAND	IRMO	PROP	(0)	(0)				
HOSPICE AND COMMUNITY CARE		YORK	ROCK HILL	NPA	16	16	247	2,060	16	35.3%
TOTAL					55	55	702	6,517	43	33.2%
LONG TERM CARE FACILITIES:										
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94	32	32,789	91	95.6%
(CARLISLE NURSING CENTER)	13	ABBEVILLE	DUE WEST	NPA	22	(0)	10	3,740	22	46.6%
ABBEVILLE COUNTY		TOTAL			116	94	42	36,529	116	86.3%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100	191	29,986	100	82.2%
CHESTER COUNTY		TOTAL			100	100	191	29,986	100	82.2%
TRINITY MISSION - EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120	72	40,856	120	93.3%
EDGEFIELD COUNTY		TOTAL			120	120	72	40,856	120	93.3%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	112	68	38,286	112	96.1%
UNIHEALTH POST ACUTE - TANGLEWOOD		FAIRFIELD	RIDGEWAY	PROP	150	150	140	48,641	150	88.8%
FAIRFIELD COUNTY		TOTAL			262	262	208	87,927	262	91.9%

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REGION: II

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	12	12	218	2,276	12	52.0%
HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102	212	30,679	102	82.4%
MAGNOLIA MANOR - GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88	72	31,594	88	98.4%
NHC HEALTHCARE - GREENWOOD		GREENWOOD	GREENWOOD	PROP	152	152	177	51,478	152	92.8%
GREENWOOD COUNTY		TOTAL			354	354	679	116,025	354	89.8%
KERSHAW KARESH LONG TERM CARE CENTER		KERSHAW	CAMDEN	CO	96	96	277	33,524	96	95.7%
SPRINGDALE HEALTHCARE CENTER		KERSHAW	CAMDEN	PROP	148	148	400	51,327	148	93.0%
KERSHAW COUNTY		TOTAL			244	244	677	84,851	244	95.3%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142	87	49,552	142	95.6%
TRANSITIONAL CARE UNIT - SPRINGS MEMORIAL		LANCASTER	LANCASTER	NPA	14	14	338	3,421	14	66.9%
WHITE OAK MANOR - LANCASTER		LANCASTER	LANCASTER	NPA	132	132	87	46,421	132	96.3%
LANCASTER COUNTY		TOTAL			288	288	512	99,404	288	94.6%
LAURENS COUNTY HEALTHCARE SYSTEM SNF		LAURENS	LAURENS	DIST	14	14	164	2,785	14	54.5%
MARTHA FRANK BAPTIST RETIREMENT CENTER		LAURENS	LAURENS	NPA	81	81	50	29,131	81	98.5%
(MARTHA FRANK BAPTIST RETIREMENT CENTER)		LAURENS	LAURENS	NPA	(7)	(7)				
NHC HEALTHCARE - CLINTON		LAURENS	CLINTON	PROP	131	131	105	46,215	131	96.7%
NHC HEALTHCARE - LAURENS		LAURENS	LAURENS	PROP	176	176	336	61,082	176	95.1%
PRESBYTERIAN HOME OF SC CLINTON		LAURENS	CLINTON	NPA	18	18	27	5,487	18	83.5%
(PRESBYTERIAN HOME OF SC CLINTON)		LAURENS	CLINTON	NPA	(48)	(48)				
LAURENS COUNTY		TOTAL			420	420	682	144,700	420	94.4%
AGAPE NURSING AND REHABILIATION CENTER		LEXINGTON	W.COLUMBIA	PROP	100	100	655	34,881	100	95.6%
BRIAN CENTER NURSING CARE - ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120	108	39,592	120	90.4%
HEARTLAND LEXINGTON REHAB & NURSING CTR		LEXINGTON	W.COLUMBIA	PROP	132	132	359	39,723	132	82.4%
LEXINGTON MEDICAL CENTER EXTENDED CARE		LEXINGTON	LEXINGTON	NPA	388	888	570	134,253	388	94.8%
NHC HEALTHCARE - LEXINGTON	14	LEXINGTON	W.COLUMBIA	PROP	120	170	298	41,997	120	95.9%
PRESBYTERIAN HOME OF SC COLUMBIA		LEXINGTON	W COLUMBIA	NPA	44	44	79	15,244	44	94.9%
SC EPISCOPAL HOME AT STILL HOPES	15	LEXINGTON	W.COLUMBIA	NPA	62	62	21	5,628	20	77.1%
(SC EPISCOPAL HOME AT STILL HOPES)		LEXINGTON	W.COLUMBIA	NPA	(0)	(0)				
LEXINGTON COUNTY		TOTAL			966	1,016	2,090	311,318	924	92.3%
PETRA HEALTH & REHAB MCCORMICK		MCCORMICK	MCCORMICK	CO	120	120	118	41,341	120	94.4%
MCCORMICK COUNTY		TOTAL			120	120	118	41,341	120	94.4%
J F HAWKINS NURSING HOME		NEWBERRY	NEWBERRY	CO	118	118	244	37,482	118	87.0%
(NEWBERRY CO MEM HOSP - TRANS CARE UNIT)	16	NEWBERRY	NEWBERRY	CO	(0)	(0)	123	1,123	6	51.3%
WHITE OAK OF NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146	95	34,913	146	65.0%
NEWBERRY COUNTY					264	264	462	73,198	270	74.3%
COUNTRYWOOD NURSING CENTER		RICHLAND	HOPKINS	PROP	38	38	41	12,934	38	92.5%
HEARTLAND COLUMBIA REHAB & NURSING CTR		RICHLAND	COLUMBIA	PROP	132	132	364	40,900	132	84.9%
HERITAGE AT LOWMAN REHAB & HEALTHCARE		RICHLAND	WHITE ROCK	NPA	176	176	227	58,252	176	90.7%
LIFE CARE CENTER OF COLUMBIA		RICHLAND	COLUMBIA	PROP	179	179	354	49,192	179	75.3%
MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88	116	28,470	88	88.8%
NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	180	180	999	61,104	180	93.0%
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22	601	5,525	22	68.8%
RICE ESTATE REHAB & HEALTHCARE	17	RICHLAND	COLUMBIA	NPA	36	80	29	11,248	82	98.3%
UNI-HEALTH POST ACUTE CARE BLYTHEWOOD	18	RICHLAND	BLYTHEWOOD	PROP	120	120	503	27,839	120	69.6%
UNI-HEALTH POST ACUTE CARE COLUMBIA	18	RICHLAND	COLUMBIA	PROP	185	185	159	58,882	174.2	92.6%
WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120	85	42,444	120	96.9%
WILDEWOOD DOWNS NURSING CENTER		RICHLAND	COLUMBIA	PROP	72	72	303	17,158	72	65.3%
(WILDEWOOD DOWNS NURSING CENTER)		RICHLAND	COLUMBIA	PROP	(8)	(8)				
(W J B DORN VA)	5	RICHLAND	COLUMBIA	FED	-	(94)				
RICHLAND COUNTY		TOTAL			1,348	1,392	3,181	413,847	1,333.2	85.0%
SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176	102	60,154	176	93.6%
SALUDA COUNTY		TOTAL			176	176	102	60,154	176	93.6%

RECORD 004344

PET-EX012.0172

REGION: II

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
AGAPE REHABILITATION ROCK HILL		YORK	ROCK HILL	PROP	99	99	406	30,874	99	85.4%
MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106	168	38,654	106	99.9%
UNI-HEALTH POST ACUTE CARE ROCK HILL		YORK	ROCK HILL	PROP	132	132	564	45,008	132	93.4%
WESTMINSTER HEALTH & REHABILITATION CTR		YORK	ROCK HILL	PROP	88	88	260	20,767	88	86.3%
WHITE OAK OF ROCK HILL		YORK	ROCK HILL	PROP	141	141	124	49,148	141	95.5%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109	102	39,155	109	98.4%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40	104	5,151	40	35.2%
YORK COUNTY		TOTAL			693	693	1,718	228,777	693	90.4%
TOTAL					5,471	6,543	10,734	1,768,913	5,429.2	89.4%

RECORD 004345

PET-EX012.0173

REGION II

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

1. CON approved 8/22/08 to convert 18 substance abuse beds to general beds, for a total of 217 general beds. The CON was appealed; the application was withdrawn 3/22/11 and the facility remains licensed for 199 acute and 18 substance abuse beds. CON issued 9/20/12 to add 12 psych beds, SC-12-29.
2. CON approved 10/20/09 to add 30 beds for a total of 414; appealed. CON issued 1/21/10, SC-10-6. Licensed for 414 beds 8/25/10.
3. CON approved to construct a new 76 bed hospital by transferring 76 beds from Palmetto Health Baptist, resulting in 287 general beds, 104 psych and 22 nursing home beds remaining at Palmetto Health Baptist; appealed. CON issued 6/8/10, SC-10-16.
4. CON approved 8/27/07 to add 38 general beds for a total of 84 beds; SC-09-10 issued 3/3/09 after the appeal was withdrawn.
5. Bed use restricted. Beds reported by facility.
6. CON approved 9/9/11 to build a 50 bed hospital; appealed.
7. CON issued 9/20/12 to construct an 18 bed psych facility, SC-12-28.
8. Licensed 10 additional beds for a total of 30 RTF beds, 1/20/11.
9. CON issued 7/29/11 to add 8 rehab beds for a total of 42 rehab beds and 12 nursing home beds, SC-11-27.
10. CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32; licensed for 46 beds 7/9/10. CON issued 9/22/11 to add 4 rehab beds for a total of 50, SC-11-41. Licensed for 50 rehab beds 2/9/12.
11. Former facility (Heartland Hospice House of the Midlands) de-licensed. CON issued 5/13/11 to establish a 12 bed inpatient hospice, SC-11-14. Licensed 8/8/11.
12. Facility closed 1/1/11.
13. Facility went to zero census on 3/15/12 and suspended operations.
14. CON issued 12/28/11 to add 50 nursing home beds for a total of 170 beds, SC-11-52.
15. CON issued 12/28/11 to convert 42 institutional nursing home beds to community beds, for a total of 62 community and 0 institutional beds, SC-11-53.
16. Transitional Care Unit closed 6/30/11.
17. CON issued 7/1/11 to add 4 nursing home beds for a total of 36, SC-11-21. Licensed for 36 beds 10/7/11. CON issued 8/6/12 to add 44 beds for a total of 80 beds, SC-12-21.
18. CON issued 1/29/07 for the construction of a 123 bed nursing home with a Medicaid Nursing Home Permit of 21,900 Medicaid patient days by transferring 89 beds from Carolina Health and Rehab and adding 34 new beds. Carolina Health and Rehab retained 168 nursing home beds and a Medicaid Nursing Home Permit for 47,100 Medicaid patient days; SC-07-04. CON amended 5/14/08 to reduce the number of beds at the Oaks of Blythewood from 123 to 120, with the number of beds retained at UniHealth Post-Acute Columbia increased from 168 to 171. UniHealth Post-Acute Care – Blythewood (formerly Oaks of Blythewood) licensed for 120 beds 8/20/10; UniHealth Post-Acute Columbia licensed beds decreased to 171 the same day. CON issued 1/31/11 to license 18 additional beds at UniHealth Post-Acute Columbia, for a total of 189 beds, SC-11-01. Licensed 14 additional beds for a total of 185 beds on 10/11/11. The CON for the remaining 4 beds was voided and facility continues to be licensed for 185 beds.

PET-EX012.0174

RECORD 004346

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2010 ER VISITS	2011 ER VISITS
REGION II:	EMERGENCY FACILITIES		
III	ABBEVILLE CO MEMORIAL HOSPITAL	10,783	11,424
II	CHESTER MEDICAL CENTER	16,875	16,587
III	EDGEFIELD COUNTY HOSPITAL	5,793	6,380
III	FAIRFIELD MEMORIAL HOSPITAL	11,404	10,882
II	SELF REGIONAL HEALTH CARE	44,181	45,712
III	KERSHAW HEALTH	26,121	25,532
II	SPRINGS MEMORIAL HOSPITAL	31,278	33,701
II	LAURENS COUNTY HOSPITAL	29,272	29,886
II	LEXINGTON MEDICAL CENTER	94,842	96,605
III	NEWBERRY CO MEMORIAL HOSPITAL	22,478	20,411
II	PALMETTO HEALTH BAPTIST	39,903	41,987
I	PALMETTO HEALTH RICHLAND	83,525	84,480
II	PROVIDENCE HOSPITAL	20,390	19,142
II	PROVIDENCE HOSPITAL NORTHEAST	33,554	31,522
II	PIEDMONT MEDICAL CENTER	49,162	51,933
		519,561	526,184

REGION II:	TRAUMA CENTERS	
III	SELF MEM REGIONAL HEALTH CARE	
III	LEXINGTON MEDICAL CENTER	
I	PALMETTO HEALTH RICHLAND	
III	PIEDMONT MEDICAL CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: III FISCAL YEAR: 2011

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." The inland waterway is a barrier to transportation.

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

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

RECORD 004348

PET-EX012.0176

REGION: III

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
CHESTERFIELD GENERAL HOSPITAL		CHESTERFIELD	CHERAW	PROP	59	59	2,315	8,193	59	38.0%
CHESTERFIELD COUNTY		TOTAL			59	59	2,315	8,193	59	38.0%
CLARENDON MEMORIAL HOSPITAL	1	CLARENDON	MANNING	CO	81	81	2,670	11,366	56	55.6%
CLARENDON COUNTY		TOTAL			81	81	2,670	11,366	56	55.6%
CAROLINA PINES REGIONAL MEDICAL CENTER		DARLINGTON	HARTSVILLE	NPA	116	116	5,275	18,278	116	43.2%
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	49	49	384	2,116	49	11.8%
DARLINGTON COUNTY		TOTAL			165	165	5,659	20,397	165	33.9%
MCLEOD MEDICAL CENTER - DILLON		DILLON	DILLON	NPA	79	79	2,792	9,805	79	34.0%
DILLON COUNTY		TOTAL			79	79	2,792	9,805	79	34.0%
CAROLINAS HOSPITAL SYSTEM		FLORENCE	FLORENCE	PROP	310	310	12,883	69,370	310	61.3%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLORENC	DIST	48	48	950	3,149	48	18.0%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	22,478	112,822	453	68.2%
WOMEN'S CENTER CAROLINAS HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20	798	2,207	20	30.2%
FLORENCE COUNTY		TOTAL			831	831	36,804	187,548	831	61.8%
GEORGETOWN MEMORIAL HOSPITAL	2	GEORGETOWN	GEORGETOWN	NPA	131	131	5,678	23,316	131	48.6%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	124	124	7,367	28,380	124	62.5%
GEORGETOWN COUNTY		TOTAL			255	255	13,045	51,696	255	55.4%
CONWAY HOSPITAL		HORRY	CONWAY	NPA	210	210	8,003	33,477	160	57.3%
GRAND STRAND REGIONAL MEDICAL CENTER	3	HORRY	MYRTLE BEACH	PROP	269	269	15,107	64,289	219	80.4%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105	3,290	13,432	105	35.0%
SEACOAST MEDICAL CENTER	4	HORRY	LITTLE RIVER	DIST	60	60	340	1,337	12.6	29.1%
HORRY COUNTY		TOTAL			694	694	26,740	112,535	497	62.1%
MARION REGIONAL HOSPITAL		MARION	MARION	DIST	124	124	3,425	12,197	124	26.9%
MARION COUNTY		TOTAL			124	124	3,425	12,197	124	26.9%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	94	94	1,361	5,280	94	15.4%
MARLBORO COUNTY		TOTAL			94	94	1,361	5,280	94	15.4%
TUOMEY		SUMTER	SUMTER	NPA	283	283	8,018	65,652	283	63.8%
SUMTER COUNTY		TOTAL			283	283	8,018	65,652	283	63.8%
WILLIAMSBURG REGIONAL HOSPITAL		WILLIAMSBURG	KINGSTREE	CO	25	25	703	2,260	25	24.8%
WILLIAMSBURG COUNTY		TOTAL			25	25	703	2,260	25	24.8%
TOTAL					2,630	2,630	103,232	497,138	2,466	64.1%
LONG TERM ACUTE HOSPITALS:										
REGENCY HOSPITAL OF FLORENCE		FLORENCE	FLORENCE	PROP	40	40	441	11,819	40	81.0%
TOTAL					40	40	441	11,819	40	81.0%
MENTAL FACILITIES:										
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	23	23	669	5,450	23	64.9%
DARLINGTON COUNTY		TOTAL			23	23	669	5,450	23	64.9%
CAROLINAS HOSP SYS - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	48	329	12	7.5%
FLORENCE COUNTY		TOTAL			12	12	48	329	12	7.5%
LIGHTHOUSE CARE CENTER OF CONWAY	5	HORRY	CONWAY	PROP	59	59	1,448	13,628	44	84.9%
HORRY COUNTY		TOTAL			59	59	1,448	13,628	44	84.9%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8	169	1,481	8	50.7%
MARLBORO COUNTY		TOTAL			8	8	169	1,481	8	50.7%
TOTAL					102	102	2,332	20,888	87	65.8%

RECORD 004349

PET-EX012.0177

REGION: III

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	%.OCCU-RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO PEE DEE RES TREATMENT CTR		FLORENCE	FLORENCE	PROP	59	59	48	17,415	59	80.9%
LIGHTHOUSE CARE CENTER OF CONWAY	5	HORRY	CONWAY	PROP	30	18	46	7,811	30	71.3%
WILLOWGLEN ACADEMY SOUTH CAROLINA	5	WILLIAMSBURG	KINGSTREE	PROP	40	54	47	10,542	40	72.2%
TOTAL					129	131	141	35,768	129	75.8%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	302	2,279	12	52.0%
LIGHTHOUSE CARE CENTER OF CONWAY	5	HORRY	CONWAY	PROP	13	13	636	3,701	8	126.7%
TOTAL					25	25	938	5,980	20	81.9%
REHABILITATION FACILITIES:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	NPA	42	42	795	11,537	42	75.3%
HEALTHSOUTH REHAB HOSPITAL FLORENCE		FLORENCE	FLORENCE	PROP	88	88	1,122	15,905	88	49.5%
FLORENCE COUNTY		TOTAL			130	130	1,917	27,442	130	57.8%
WACCAMAW COMMUNITY HOSPITAL		GEORGETOWN	MURRELLS INLET	NPA	43	43	1,001	13,795	43	87.9%
GEORGETOWN COUNTY		TOTAL			43	43	1,001	13,795	43	87.9%
TOTAL					173	173	2,918	41,238	173	65.3%
INPATIENT HOSPICE FACILITIES:										
MCLEOD HOSPICE HOUSE	7	FLORENCE	FLORENCE	NPA	12	24	579	3,768	12	86.0%
TIDELANDS COMMUNITY HOSPICE HOUSE		GEORGETOWN	GEORGETOWN	NPA	12	12	249	2,904	12	62.6%
(AGAPE HOSPICE HOUSE OF HORRY COUNTY)	8	HORRY	CONWAY	PROP	(24)	(24)				
MERCY CARE HOSPICE HOUSE CONWAY	9	HORRY	CONWAY	NPA		14				
TOTAL					24	50	828	6,672	24	69.3%
LONG TERM FACILITIES:										
CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	120	120	55	43,019	120	98.2%
CHESTERFIELD CONVALESCENT CENTER		CHESTERFIELD	CHERAW	PROP	104	104	54	36,309	104	95.7%
CHESTERFIELD COUNTY		TOTAL			224	224	109	79,328	224	97.0%
LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88	68	29,247	88	91.1%
WINDSOR MANOR		CLARENDON	MANNING	PROP	64	64	31	21,355	64	91.4%
CLARENDON COUNTY		TOTAL			152	152	100	50,602	152	91.2%
BETHEA BAPTIST HEALTH CARE CENTER		DARLINGTON	DARLINGTON	NPA	36	36	28	11,215	36	85.4%
(BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	(52)	(52)				
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	53	29,931	88	93.2%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154	271	51,837	154	82.4%
OAKHAVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	57	29,569	88	92.1%
DARLINGTON COUNTY		TOTAL			366	366	409	122,552	366	91.8%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84	124	28,833	84	94.0%
SUNNY ACRES		DILLON	FORK	PROP	111	111	64	23,040	111	56.9%
DILLON COUNTY		TOTAL			195	195	188	51,873	195	72.9%
CAROLINAS HOSP SYS TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	24	24	446	6,203	24	70.8%
COMMANDER NURSING CENTER		FLORENCE	FLORENCE	PROP	163	163	69	58,801	163	98.8%
FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	104	237	35,095	104	92.5%
FLORENCE REHAB & NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	64	23,360	88	72.7%

RECORD 004350

PET-EX012.0178

REGION: III

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	73	48,796	132	97.1%
HONORAGE NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	55	31,185	88	97.1%
LAKE CITY - SCRANTON HEALTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88	320	30,258	88	94.2%
SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	34	31,464	88	98.0%
FLORENCE COUNTY		TOTAL			776	776	1,298	263,182	776	93.0%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	58	26,587	84	86.7%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	17	17	97	5,191	17	83.4%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLAND	(PROP)	(7)	(7)				
PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148	180	6,570	148	12.2%
GEORGETOWN COUNTY		TOTAL			249	249	335	38,348	249	42.2%
AGAPE REHABILITATION CTR CONWAY	10	HORRY	CONWAY	PROP	95	95	567	17,473	89.6	53.9%
BRIGHTWATER SKILLED NURSING CENTER	11	HORRY	MYRTLE BEACH	PROP	67	67	171	4,275	67	17.4%
CONWAY MANOR		HORRY	CONWAY	PROP	180	180	165	60,906	180	92.2%
COVENANT TOWERS HEALTH CARE		HORRY	MYRTLE BEACH	PROP	30	30	107	8,192	30	74.8%
GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88	92	31,093	88	95.8%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88	358	29,915	88	93.1%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88	238	29,095	88	90.6%
MYRTLE BEACH MANOR	12	HORRY	MYRTLE BEACH	PROP	100	59	403	26,603	100	72.9%
NHC HEALTHCARE - GARDEN CITY		HORRY	MYRTLE BEACH	PROP	148	148	525	48,632	148	90.0%
SEASIDE LIVING CENTER	13	HORRY	MYRTLE BEACH	PROP	0	60				
SHEPHERD'S LANDING NURSING & REHAB CTR	14	HORRY	LITTLE RIVER	PROP	0	60				
HORRY COUNTY		TOTAL			894	973	2,726	259,165	887.6	80.0%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	129	42,692	120	97.5%
LEE COUNTY		TOTAL			120	120	129	42,692	120	97.5%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	80	28,939	88	90.1%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92	60	32,605	92	97.1%
MARION COUNTY		TOTAL			180	180	140	61,544	180	93.7%
DUNDEE MANOR		MARLBORO	BENNETTSVILLE	PROP	110	110	83	37,878	110	94.3%
MARLBORO COUNTY		TOTAL			110	110	83	37,878	110	94.3%
COVENANT PLACE NURSING CENTER	15	SUMTER	SUMTER	PROP	28	28	11	3,621	14.9	66.6%
(COVENANT PLACE NURSING CENTER)		(SUMTER)	(SUMTER)	(PROP)	(0)	(0)				
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138	159	47,278	138	93.9%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176	116	61,738	176	96.1%
SUMTER VALLEY NURSING & REHAB CENTER		SUMTER	SUMTER	PROP	96	96	147	28,792	96	82.2%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	422	4,857	18	73.5%
SUMTER COUNTY		TOTAL			456	456	855	146,286	442.9	90.5%
DR. RONALD E. MCNAIR NURSING & REHAB		WILLIAMSBURG	CADES	PROP	88	88	69	27,135	88	84.5%
KINGSTREE NURSING FACILITY		WILLIAMSBURG	KINGSTREE	PROP	96	96	62	29,138	96	83.2%
WILLIAMSBURG COUNTY		TOTAL			184	184	131	56,273	184	83.6%
TOTAL					3,905	3,984	6,553	1,268,824	3,885.5	85.3%

RECORD 004351

PET-EX012.0179

FOOTNOTES 2012-13 PLAN

REGION III

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

1. CON issued 10/27/08 to add 25 beds for a total of 81 beds, SC-08-44. Licensed 5/29/12.
2. CON issued 3/2/09 to construct a replacement of the existing hospital, with a decrease in bed capacity from 131 to 129 beds, SC-09-09. CON voided 12/15/10.
3. CON issued 9/24/07 to add 50 general acute beds for a total of 269, SC-07-45. Licensed 40 additional beds for a total of 259, 5/1/11. Licensed for 269 beds 4/19/12.
4. CON approved 8/29/05 to establish a hospital with 50 general acute beds; appealed. CON issued per ALJ Order 9/28/07, SC-07-47. Facility licensed 7/6/11.
5. CON approved to add 15 psych beds, for a total of 59, and 6 inpatient substance abuse beds, for a total of 14; appealed. Appeal withdrawn, CON SC-10-07 issued 1/25/10. CON amended 2/10/12 to 13 substance abuse beds. Exemption issued 9/20/12 to permanently reduce from 30 to 18 RTF beds, E-12-20. Licensed for 59 psych beds and 13 substance abuse beds 10/25/12.
6. Converted 40 beds from a High Maintenance Group Home to Residential Treatment Facility beds on 3/20/09; intend to license 54 RTF beds. Facility relocated from Greeleyville to Kingstree 4/14/11.
7. CON issued 3/11/10 to add 12 beds for a total of 24, SC-10-10.
8. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21.
9. CON issued 3/23/12 to establish a 14 bed inpatient hospice, SC-12-09.
10. CON issued 7/15/10 to convert the 24 inpatient hospice beds to nursing home beds for a total of 96 nursing home beds, SC-10-21. Facility licensed for 95 beds 4/1/11. Because of the need for an isolation room, the remaining bed approved under SC-10-11 was voided.
11. CON issued 1/31/11 to add 35 beds, for a total of 67 beds, SC-11-06. Licensed for 67 beds 8/17/11.
12. De-licensed 4 nursing home beds for a total of 100 beds, 2/22/10. Exemption issued 7/27/12 to permanently reduce the bed capacity from 100 beds to 59 beds, E-12-14. The facility is also withdrawing from the Medicaid program.
13. CON issued 10/14/10 for a 60 bed nursing home that does not participate in the Medicaid program, SC-10-30.
14. CON issued 3/12/09 for a 60 bed nursing home that does not participate in the Medicaid program, SC-09-12.
15. CON issued 1/31/11 to convert 28 institutional nursing home beds to community beds that do not participate in the Medicaid program, for a total of 16 institutional and 28 community beds, SC-11-03. Licensed for 28 community beds 6/21/11.

PET-EX012.0180

RECORD 004352

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2010 ER VISITS	2011 ER VISITS
REGION III:	EMERGENCY FACILITIES		
II	CHESTERFIELD GENERAL HOSPITAL	12,582	12,067
III	CLARENDON MEMORIAL HOSPITAL	17,475	17,642
III	CAROLINA PINES REGIONAL MED CTR	32,070	30,521
III	MCLEOD - DILLON	24,967	25,794
III	CAROLINAS HOSPITAL SYSTEM	34,349	30,602
II	MCLEOD REGIONAL MED CENTER	53,719	52,955
III	LAKE CITY COMMUNITY HOSPITAL	15,221	15,487
II	GEORGETOWN MEMORIAL HOSPITAL	29,775	30,228
II	WACCAMAW COMMUNITY HOSPITAL	26,418	27,285
II	CONWAY HOSPITAL	46,276	45,860
III	LORIS COMMUNITY HOSPITAL	40,511	36,866
II	GRAND STRAND REGIONAL MED CTR	69,202	73,116
III	MARION COUNTY MEDICAL CENTER	21,786	20,766
III	MARLBORO PARK HOSPITAL	14,452	13,212
II	TUOMEY	54,579	57,087
III	WILLIAMSBURG REGIONAL	10,603	10,445
		503,985	499,933

REGION III:	TRAUMA CENTERS	
III	CAROLINA PINES REGIONAL MED CTR	
III	CAROLINAS HOSPITAL SYSTEM	
II	MCLEOD REGIONAL MED CENTER	
II	GRAND STRAND REGIONAL MED CTR	

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: IV

FISCAL YEAR: 2011

1. Unusual Characteristics: This region has a military presence in Charleston. A naval hospital provides health care services for the active duty and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with naval hospital to provide care to the active duty and dependents. The sea islands, rivers and sounds are barriers to transportation.

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

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter IV for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter VI for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter V for discussion and calculation of needs.

RECORD 004354

PET-EX012.0182

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	%OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	9,330	42,647	183	64.1%
AIKEN COUNTY		TOTAL			183	183	9,330	42,647	183	64.1%
ALLENDALE COUNTY HOSPITAL		ALLENDALE	FAIRFAX	CO	25	25	238	815	25	8.9%
ALLENDALE COUNTY		TOTAL			25	25	238	815	25	8.9%
BAMBERG COUNTY MEMORIAL	1	BAMBERG	BAMBERG	CO	59	(0)	575	2,148	59	10.0%
BAMBERG COUNTY		TOTAL			59	(0)	575	2,148	59	10.0%
BARNWELL COUNTY HOSPITAL		BARNWELL	BARNWELL	CO	53	53	672	2,632	53	13.6%
BARNWELL COUNTY		TOTAL			53	53	672	2,632	53	13.6%
BEAUFORT COUNTY MEMORIAL		BEAUFORT	BEAUFORT	CO	169	169	9,419	37,122	169	60.2%
HILTON HEAD HOSPITAL		BEAUFORT	HILTON HEAD	NPA	93	93	5,019	17,974	93	53.0%
NAVAL HOSPITAL	2	BEAUFORT	BEAUFORT	FED		(94)				
BEAUFORT COUNTY		TOTAL			262	262	14,438	55,096	262	57.5%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCKS CORNER	PROP		50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA		50				
BERKELEY COUNTY		TOTAL			0	100				
BON SECOURS ST. FRANCIS XAVIER		CHARLESTON	CHARLESTON	NPA	204	204	8,634	32,719	204	43.9%
EAST COOPER MEDICAL CENTER	5	CHARLESTON	MT PLEASANT	PROP	130	130	4,391	14,495	130	30.5%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	604	604	29,237	162,960	604	73.9%
ROPER HOSPITAL	4	CHARLESTON	CHARLESTON	NPA	316	266	14,278	68,440	316	59.3%
ROPER ST. FRANCIS MOUNT PLEASANT HOSPITAL	4	CHARLESTON	MT PLEASANT	NPA	85	85	188	3,782	85	12.2%
TRIDENT MEDICAL CENTER		CHARLESTON	CHARLESTON	PROP	296	296	15,191	67,842	296	62.6%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(144)				
CHARLESTON COUNTY		TOTAL			1,635	1,585	71,919	350,038	1,635	58.7%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	4,495	21,415	131	44.8%
COLLETON COUNTY		TOTAL			131	131	4,495	21,415	131	44.8%
SUMMERVILLE MEDICAL CENTER	7	DORCHESTER	SUMMERVILLE	PROP	94	124	5,837	21,062	94	61.4%
DORCHESTER COUNTY		TOTAL			94	124	5,837	21,062	94	61.4%
HAMPTON REGIONAL MEDICAL CENTER		HAMPTON	VARNVILLE	CO	32	32	972	3,689	32	31.6%
HAMPTON COUNTY		TOTAL			32	32	972	3,689	32	31.6%
COASTAL CAROLINA MEDICAL CENTER	8	JASPER	HARDEEVILLE	PROP	41	41	1,483	5,050	38.4	36.0%
JASPER COUNTY		TOTAL			41	41	1,483	5,050	38.4	36.0%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	8,923	47,922	247	53.2%
ORANGEBURG COUNTY		TOTAL			247	247	8,923	47,922	247	53.2%
TOTAL					2,762	2,783	120,082	552,714	2,759.4	54.9%
LONG TERM ACUTE HOSPITALS:										
PACE HEALTHCARE COMMONS	9	BEAUFORT	BLUFFTON	PROP		32				
KINDRED HOSPITAL - CHARLESTON	10	CHARLESTON	CHARLESTON	PROP	59	59	228	9,829	59	45.6%
TOTAL					59	91	228	9,829	59	45.6%
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER	11	AIKEN	AIKEN	PROP	41	41	991	9,381	29	88.6%
AIKEN COUNTY		TOTAL			41	41	991	9,381	29	88.6%
BEACON HARBOR GERIATRIC PSYCHIATRIC CARE	12	BEAUFORT	BLUFFTON	PROP		22				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	494	2,841	14	55.6%
BEAUFORT COUNTY		TOTAL			14	36	494	2,841	14	55.6%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,436	22,108	82	73.9%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	CHARLESTON	PROP	70	70	1,901	17,782	70	69.6%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(36)				
CHARLESTON COUNTY		TOTAL			152	152	4,337	39,898	152	71.9%
COLLETON MEDICAL CENTER	13	COLLETON	WALTERBORO	PROP	4	4				

RECORD 004355

PET-EX012.0183

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
COLLETON COUNTY		TOTAL			4	4				
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15	346	2,703	15	49.4%
ORANGEBURG COUNTY		TOTAL			15	15	346	2,703	15	49.4%
TOTAL					226	248	5,158	54,823	216	71.6%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32	71	9,207	32	78.8%
RIVERSIDE BEHAVIORAL AT WINDWOOD FARM	14	CHARLESTON	AWENDAW	PROP	12	12	23	4,050	12	92.5%
PALMETTO PINES BEHAVIORAL HEALTH		SUMMERVILLE	DORCHESTER	PROP	60	60	48	17,415	60	79.5%
PINELANDS RESIDENTIAL TREATMENT CENTER	15	SUMMERVILLE	DORCHESTER	PROP	14	28	11	2,671	14	52.3%
TOTAL					118	132	153	33,343	118	77.2%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18	824	6,553	18	99.7%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23	706	3,559	23	43.6%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10	643	4,597	10	126.7%
TOTAL					51	51	2,173	14,909	51	80.1%
REHABILITATION FACILITIES:										
PACE HEALTHCARE COMMONS	16	BEAUFORT	BLUFFTON	PROP		10				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	237	3,024	14	59.2%
BEAUFORT COUNTY		TOTAL			14	24	237	3,024	14	59.2%
ROPER HOSPITAL		CHARLESTON	CHARLESTON	NPA	52	52	1,152	15,221	52	80.2%
HEALTHSOUTH CHARLESTON	17	CHARLESTON	CHARLESTON	PROP	49	49	978	12,468	46	74.3%
CHARLESTON COUNTY		TOTAL			101	101	2,130	27,689	98	77.4%
(COASTAL CAROLINA MEDICAL CENTER)	8	JASPER	HARDEEVILLE	PROP	(0)	(0)	0	0	2.6	0.0%
JASPER COUNTY		TOTAL			0	0	0	0	2.6	0.0%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	24	24	643	6,353	24	72.5%
ORANGEBURG COUNTY		TOTAL			24	24	643	6,353	24	72.5%
TOTAL					139	149	2,910	37,066	136.6	73.3%
INPATIENT HOSPICE FACILITIES:										
THE HOSPICE OF CHARLESTON		CHARLESTON	CHARLESTON	NPA	20	20	701	4,978	20	68.2%
TOTAL					20	20	701	4,978	20	68.2%
LONG TERM FACILITIES:										
ANCHOR HEALTH & REHAB AIKEN	18	AIKEN	AIKEN	PROP	60	60	509	19,819	60	90.5%
AZALEAWOODS REHAB & NURSING CENTER		AIKEN	AIKEN	PROP	66	66	47	30,220	66	56.3%
NHC HEALTHCARE N. AUGUSTA		AIKEN	N. AUGUSTA	PROP	192	192	262	60,488	192	86.1%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	132	271	40,826	132	84.7%
UNIHEALTH POST-ACUTE - AIKEN		AIKEN	AIKEN	PROP	176	176	158	56,413	176	80.7%
UNIHEALTH POST-ACUTE - NORTH AUGUSTA		AIKEN	N. AUGUSTA	PROP	132	132	157	39,695	132	82.2%
AIKEN COUNTY		TOTAL			778	778	1,404	249,461	778	87.8%
JOHN E HARTER NURSING HOME		ALLENDALE	FAIRFAX	CO	44	44	26	12,820	44	79.8%
ALLENDALE COUNTY		TOTAL			44	44	26	12,820	44	79.8%
UNIHEALTH POST-ACUTE CARE BAMBERG		BAMBERG	BAMBERG	CO	88	88	186	29,562	88	91.8%
BAMBERG COUNTY		TOTAL			88	88	186	29,562	88	91.8%

RECORD 004356

PET-EX012.0184

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS-SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	74	26,801	85	84.8%
LAUREL BAYE HEALTHCARE OF WILLISTON		BARNWELL	WILLISTON	PROP	44	44	101	15,175	44	94.5%
UNIHEALTH POST-ACUTE BARNWELL		BARNWELL	BARNWELL	CO	44	44	92	15,132	44	94.2%
BARNWELL COUNTY		TOTAL			173	173	267	56,808	173	89.5%
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170	321	52,737	170	85.0%
BEACON HARBOR SUBACUTE CARE	19	BEAUFORT	BLUFTON	PROP	0	120				
BROAD CREEK CARE CENTER		BEAUFORT	HILTON HEAD	PROP	25	25	126	8,282	25	90.8%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88	230	19,701	88	61.3%
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19	62	5,422	19	78.2%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
NHC BLUFFTON		BEAUFORT	BLUFTON	PROP	120	120	560	31,969	120	73.0%
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	135	15,510	69	61.6%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				
BEAUFORT COUNTY		TOTAL			491	611	1,485	133,621	491	74.6%
HEARTLAND HEALTH CARE CTR - CHARLESTON	20	BERKELEY	HANAHAN	PROP	135	135	470	36,208	135	73.5%
LAKE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88	60	30,112	88	93.7%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132	176	40,103	132	83.2%
BERKELEY COUNTY		TOTAL			356	356	696	106,423	355	82.1%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	108	39,252	120	89.6%
CALHOUN COUNTY		TOTAL			120	120	108	39,252	120	89.6%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	58	12,613	41	84.1%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)				
FRANKE HEALTH CARE CENTER	21	CHARLESTON	CHARLESTON	NPA	44	44	119	8,314	24	94.6%
(FRANKE HEALTH CARE CENTER)		CHARLESTON	CHARLESTON	NPA	(0)	(0)				
HARVEST HEALTH & REHAB JOHNS ISLAND		CHARLESTON	CHARLESTON	NPA	132	132	148	46,358	132	96.0%
HEARTLAND WEST ASHLEY REHAB & NURSING CTR	22	CHARLESTON	CHARLESTON	NPA	121	125	531	30,923	99	85.6%
KINDRED HOSPITAL CHARLESTON SUBACUTE UNIT	18	CHARLESTON	MT. PLEASANT	PROP		35				
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148	730	51,722	148	95.7%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132	116	46,557	132	96.7%
NATIONAL HEALTH CARE CHARLESTON	23	CHARLESTON	CHARLESTON	PROP	88	88	658	28,274	88	88.0%
RIVERSIDE HEALTH & REHAB CENTER	24	CHARLESTON	CHARLESTON	PROP	160	160	163	55,172	160	94.2%
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176	297	60,855	176	94.7%
SAVANNAH GRACE AT PALMS OF MT PLEASANT	25	CHARLESTON	MT. PLEASANT	PROP	42	42	289	12,977	42	84.4%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176	244	60,300	176	93.9%
CHARLESTON COUNTY		TOTAL			1,260	1,299	3,350	414,085	1,218	93.1%
UNIHEALTH POST-ACUTE CARE OAKWOOD	26	COLLETON	WALTERBORO	PROP	132	132	312	45,083	132	93.6%
COLLETON COUNTY		TOTAL			132	132	312	45,083	132	93.6%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	190	30,596	88	95.0%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	175	30,071	88	93.4%
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	87	87	191		87	
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88	111	30,834	88	96.0%
DORCHESTER COUNTY		TOTAL			351	351	667	91,493	351	94.6%
UNI-HEALTH POST ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	75	33,461	104	88.1%
HAMPTON COUNTY		TOTAL			104	104	75	33,461	104	88.1%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	49	28,455	88	88.6%
JASPER COUNTY		TOTAL			88	88	49	28,455	88	88.6%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60	122	20,197	60	92.2%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113	168	35,216	113	92.7%
METHODIST OAKS	27	ORANGEBURG	ORANGEBURG	NPA	132	122	311	96,839	132	76.5%
UNIHEALTH POST-ACUTE CARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	88	88	124	30,406	88	94.7%
ORANGEBURG COUNTY		TOTAL			393	383	720	125,658	393	87.5%
TOTAL					4,377	4,526	9,283	1,365,982	4,336	86.3%

RECORD 004357

PET-EX012.0185

REGION IV

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

1. Facility filed notice that it intended to close effective 4/30/12.
2. Bed use restricted.
3. CON approved 6/26/09 to construct a new 50 bed hospital in Berkeley County using the bed need generated by Trident Medical Center. Appealed.
4. CON issued 5/31/06 to construct a new hospital in Mount Pleasant by transferring 85 acute beds from Roper Hospital, SC-06-27, leaving a total of 316 beds at Roper Hospital. CON approved 6/26/09 to construct a new 50 bed hospital (Roper St. Francis Hospital – Berkeley) by transferring 50 existing beds from Roper Hospital, leaving 266 beds at Roper Hospital. Project was appealed. Mount Pleasant Hospital licensed for 85 beds on 11/1/10 and Roper Hospital licensed for 316 beds the same day.
5. CON issued 5/31/06 to construct a replacement hospital with 40 additional beds for a total of 140 acute beds, SC-06-26. Facility reduced the number of additional beds at the replacement hospital from 40 to 30 on 2/27/09, for a total of 130 beds. Licensed for 129 beds 3/17/10. Licensed for 130 beds 6/18/10.
6. CON issued to replace and consolidate Charleston Memorial with Medical University by adding 138 beds (98 from Charleston Memorial, 15 from psych beds, 25 from conversion of rehab beds) for a total of 604 general beds 82 psych & 23 D&A beds, SC-03-60 10/14/03. On 1/30/08, 78 general and 15 psych beds were transferred from Charleston Memorial to MUSC and the 25 rehab beds at MUSC were converted to general acute beds. Charleston Memorial was licensed for 20 acute care beds; MUSC was licensed for 584 acute care beds, 82 psych beds, and 23 substance abuse beds. Charleston Memorial de-licensed 11/25/08. MUSC licensed for 604 acute care beds 9/9/10.
7. CON to add 30 general acute beds approved 9/21/11; appealed.
8. CON issued 1/31/11 to convert the 10 rehabilitation beds to general acute beds, for a total of 41 general acute beds, SC-11-04. Licensed for 41 general acute beds and 0 rehabilitation beds 4/5/11.
9. CON issued 9/22/11 to develop a 32 bed LTACH, SC-11-36.
10. CON issued 6/3/11 to develop a 59 bed replacement LTACH in the former East Cooper Regional Medical Center by renovating the facility and relocating the LTACH from its present site, SC-11-18. The project also includes a 35 bed skilled nursing unit.
11. CON issued 8/12/10 for the addition of 12 psych beds for a total of 41, SC-10-25. Licensed for 41 psych beds 2/2/12.
12. CON issued 8/13/10 to construct a 22 bed psychiatric hospital, SC-10-27.
13. CON issued 5/13/11 for the addition of 4 psychiatric beds, for a total of 131 general acute and 4 psychiatric beds, SC-11-10. Beds licensed 9/30/11.
14. Converted from a High Maintenance Group Home to an RTF 3/18/10.
15. Licensed as a 14 bed RTF 7/21/10; intend to license 28 RTF beds.
16. CON issued 1/30/12 to establish a 10 bed rehabilitation hospital, SC-12-04.

17. CON issued 9/22/11 to add 3 rehab beds for a total of 49, SC-11-43. Licensed for 49 beds 3/7/12.
18. Formerly Faith Health & Rehab of Aiken.
19. CON issued 5/7/10 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-10-15.
20. CON issued 10/15/08 for 30 additional nursing home beds for a total of 135, SC-08-40. Licensed for 135 beds 1/1/11.
21. CON issued 12/20/11 to convert 20 institutional nursing home beds to community beds, for a total of 44 community beds, SC-11-54.
22. CON issued 6/15/09 to add 26 nursing home beds for a total of 125 beds, SC-09-30. Licensed 22 additional beds for a total of 121 beds 6/12/12.
23. Facility voluntarily de-licensed 44 nursing home beds 12/7/10 for a total of 88 licensed beds.
24. Formerly Driftwood Rehabilitation and Nursing Center.
25. Formerly Grace Hall Rehabilitation.
26. Formerly Heritage Healthcare of Walterboro.
27. Exemption issued 8/1/12 to permanently de-license 10 beds for a total of 122 nursing home beds.

INVENTORY OF EMERGENCY FACILITIES

CATEGORY	NAME OF FACILITY	2010 ER VISITS	2011 ER VISITS
REGION IV:	EMERGENCY FACILITIES		
II	AIKEN REGIONAL MEDICAL CTR	55,610	55,597
IV	ALLENDALE COUNTY HOSPITAL	8,366	8,207
III	BAMBERG CO MEMORIAL HOSPITAL	10,714	10,169
III	BARNWELL COUNTY HOSPITAL	12,092	11,657
III	BEAUFORT CO MEMORIAL HOSPITAL	39,626	39,832
II	HILTON HEAD HOSPITAL	21,611	18,365
II	BON SECOURS ST FRANCIS XAVIER	43,914	44,089
II	EAST COOPER MEDICAL CENTER	18,268	14,755
I	MUSC MEDICAL CENTER	75,352	74,292
II	ROPER HOSPITAL	70,769	67,088
II	TRIDENT MEDICAL CENTER	60,871	62,750
III	COLLETON MEDICAL CENTER	23,150	24,856
II	SUMMERVILLE MEDICAL CENTER	42,050	43,607
III	HAMPTON REGIONAL MEDICAL CENTER	11,230	11,669
III	COASTAL CAROLINA MEDICAL CENTER	14,152	16,976
II	REG MED CTR ORANGEBURG-CALHOUN	54,172	58,326
		562,147	562,235

REGION IV:	TRAUMA CENTERS
I	MUSC MEDICAL CENTER
I	MUSC MEDICAL CENTER PEDIATRIC TRAUMA
II	EAST COOPER MEDICAL CENTER
II	ROPER HOSPITAL
II	BON SECOURS ST FRANCIS XAVIER
II	TRIDENT MEDICAL CENTER