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**SOUTH CAROLINA
HEALTH PLAN**

EFFECTIVE 11/9/12

SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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CHAPTER I

INTRODUCTION

A. Legal Basis:

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

B. Purpose:

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

C. Health Planning Committee:

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

D. Relationship With Other Agencies:

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

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

E. Standards of Construction and Equipment:

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

F. Standards for Maintenance and Operation:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina.

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

1. The purpose of the State Certification of Need and Health Facility Licensure Act, as amended, is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.
2. This law requires the:
 - (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;
 - (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;
 - (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and
 - (d) licensure of facilities rendering medical, nursing and other health care.
3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.
4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet through www.scdhec.net.

H. Relative Importance of Project Review Criteria:

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

I. Interpretation of the Plan:

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

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of this Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySCHospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-2009 South Carolina Health Plan, the State Health Planning Committee agreed to undertake a study to determine how to incorporate nursing and technical staffing information into future Plans. Staff research indicates that California is the only state that mandates minimum nurse to patient ratios by law. Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington require hospitals to establish committees to address staffing planning and policy. Several of these states require that at least 50% of the membership must be direct care RNs. There are also 5 states (Illinois, New Jersey, New York, Rhode Island, and Vermont) that require some form of public notification or posting of staffing levels. These are all approaches that can be discussed for South Carolina.

Staff participated on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which was attempting to develop a supply/demand forecast model for nurses and allied technical staff. However, that research project was not completed.

Staff amended the Joint Annual Report (JAR) formats to obtain the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc) and the number of hours they work annually. From this information, staff can develop comparative staffing data for different types of facilities. However, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

CHAPTER II

INVENTORY REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration.

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

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

B. Exceptions to Service Area Standards:

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

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such

transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

- (1) A transfer or exchange of services may be approved only if there is no overall increase in the number or amount of such services;
- (2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;
- (3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;
- (4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impact must be detailed, along with the perceived benefits of the proposal;
- (5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;
- (6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;
- (7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

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

D. Estimated State Civilian Population:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,673,000 for 2011 and projected population of 5,007,100 for 2018. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies. Please note that these are preliminary projections because not all of the 2010 Census data have been released. These numbers will be adjusted and finalized as the data become available.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2011 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was November 8, 2012.

G. Definitions:

This is a synopsis of the relevant definitions appearing in each Chapter of the Plan. They are more fully defined in the individual chapters:

Chapter III

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

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

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

"Critical Access Hospitals (CAHs)" are eligible for increased reimbursement without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities. In order to qualify as a CAH, a hospital must be located in a rural county and be located more than 35 miles from any other hospital or CAH (15 miles for areas with only

roads). It must be part of a rural health network with at least one full-service hospital. They have a maximum of 25 licensed beds and the annual average length of stay must be less than 4 days. Emergency services must be available 24 hours a day.

“Community Perinatal Center (Level I)”: These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital has the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2,000 grams.

“Specialty Perinatal Center (Level II)”: In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1,500 grams.

“Enhanced Perinatal Center (Level IIE)”: In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. These hospitals manage a three year average of at least 1,200 deliveries annually. A CON is required to provide Level IIE services.

“Subspecialty Perinatal Center (Level III)”: In addition to Level IIE requirements, these hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

“Regional Perinatal Center (RPC)”: In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC provides consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

“Pediatric Long Term Care Hospitals (PLATCHs)” are designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis. Care may be rehabilitative or palliative. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services, such as Neonatal Abstinence Syndrome (NAS), birth defects, spinal cord or trauma injury, seizure disorders,

chronic lung disease, and extensive wound care. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

Chapter IV

“Inpatient psychiatric services” are provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

“Local Inpatient Crisis Stabilization Beds”: the S.C. Department of Mental Health (SCDMH) has had substantial decreases in inpatient capacity, resulting in insufficient beds being available to meet the demand from referrals. This has led to persons in a behavioral crisis waiting in hospital emergency rooms for an appropriate inpatient psychiatric bed to become available. SCDMH has attempted to alleviate this problem by means of its “Crisis Stabilization Program.” The program provides short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs. For patients needing stabilization in a hospital, SCDMH contracts with local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

Chapter V

A “Comprehensive Rehabilitation Facility” is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. It provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients.

Chapter VI

“Freestanding Medical Detoxification Facilities” are a short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed. A CON is required for medical detoxification.

“Inpatient Treatment Facilities” are a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as

needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. A CON is required for an Inpatient Treatment Facility.

"Narcotic Treatment Programs" provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, suboxone and buprenorphine to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state.

Chapter VII

A "Residential Treatment Facility for Children and Adolescents" is operated for the assessment, diagnosis, treatment, and care of children and adolescents in need of mental health treatment. This means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment, including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others. These facilities provide medium to long-term care (6 months or longer

Chapter VIII

A "Cardiac Catheterization" is an invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiology, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies are considered to be one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed. They are located only in hospitals approved to provide open heart surgery, although diagnostic laboratories are allowed to perform emergent and/or elective therapeutic catheterizations in compliance with Standard 7 or 8 in the Plan.

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

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

"Therapeutic catheterization" refers to a cardiac catheterization during which any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants

and Cardiac Valvuloplasty. The following ICD-9-CM Procedure Codes refer to therapeutic catheterizations:

- 00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
- 35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique
- 35.96 Percutaneous Valvuloplasty
- 36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
- 36.09 Other Removal of Coronary Artery Obstruction
- 37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

“Percutaneous Coronary Intervention (PCI)” is a therapeutic catheterization procedure used to revascularize occluded or partially occluded coronary arteries. A catheter with a balloon or a stent is inserted into the blood vessel and guided to the site of the constriction in the vessel. During a Percutaneous Transluminal Coronary Angioplasty (PTCA), a balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. When a stent is used, an expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. These procedures may be performed on an emergent or elective basis.

“Emergent or Primary PCI” means that a patient needs immediate PCI because, in the treating physician’s best clinical judgment, delay would result in undue harm or risk to the patient.

An “Elective PCI” is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.

“Open Heart Surgery” refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine.

Chapter IX

“Adaptive Radiation Therapy (ART)”: Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

“Conformal Radiation Therapy (CRT)”: Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area.

“Conventional External Beam Radiotherapy (2DXRT)” is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. A single beam of radiation is delivered to the patient from several directions. It is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

“Fractionation”: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. The typical fractionation schedule for adults is once per day, five days a week. “Hyperfractionation” refers to radiation given in smaller doses twice a day. In “Hypofractionation,” individual doses are given less than daily, such as in two-five sessions.

“Image-Guided Radiation Therapy (IGRT)” combines with IMRT or CRT to visualize the patient’s anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

“IMRT (Intensity Modulated Radiation Therapy)” creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

“Stereotactic body radiation therapy (SBRT)” is a precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.

“Stereotactic Radiosurgery (SRS)” is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. A special frame is attached to the patient’s skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient’s head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy.

“Stereotactic Radiation Therapy (SRT)” is an approach similar to Stereotactic Radiosurgery that delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30-90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

Chapter X

“Positron Emission Tomography (PET)” uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. PET allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. PETs are now being combined with a Computerized Tomography (CT) scanner to create PET/CT scanners. In the Plan standards, the terms PET and PET/CT are used interchangeably; the Department does not differentiate between these modalities. The addition of a CT component to an existing PET service

is not considered to be a new service that would trigger CON review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

“Positron Emission Mammography (PEM)” is a form of PET that uses high-resolution detection technology for imaging the breast. As with PET, a radiotracer is administered and the camera is used to provide a higher resolution image. However, the administered dose of FDG is only about half the amount of whole-body PET. PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and checking for recurrence of breast cancer. Three-dimensional reconstruction of the PEM images is also possible.

Chapter XI

An “Ambulatory Surgical Facility (ASF)” is a distinct, freestanding entity organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff. This definition does not apply to an office or clinic for the private practice of licensed health care professionals.

An “Endoscope” is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An “Endoscopy ASF” is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

Chapter XII

“Nursing Facilities” provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. Such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included.

An “Institutional Nursing Facility” means a nursing facility established within the jurisdiction of a larger non-medical institution that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. This category has been established to provide necessary services for retirement communities established by church, fraternal, or other organizations. Such beds must only serve the residents of the housing complex and be developed as a part of an entire housing construction program. There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the qualifications. To be considered under this special bed category, the following criteria must be met:

- (1) The nursing facility must be part of and located on the campus of the retirement community.
- (2) It must restrict admissions to campus residents.
- (3) The facility may not participate in the Medicaid program.

The Social Security Act [Section 1883(a)(1)], permits certain small, rural hospitals to enter into a "Swing Bed" agreement, under which the hospital can use its beds to provide either acute or skilled nursing care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. A Certificate of Need is not required to participate in the Swing Bed Program.

"Hospice" is a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services provided directly or through written agreement. Home-based and outpatient hospice programs do not require CON review.

A "Hospice Facility" means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician. CON review is required for a hospice facility.

"Home Health Agency" means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

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

“Continuing Care Retirement Community Home Health Agencies”: A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

- (1) The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;
- (2) The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
- (3) Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

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
- MDC 20: 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

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.

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.

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	51				
	18-64	287,400	307,200	103,593	303				
	+65	59,100	72,600	50,895	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	4,819	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	3,887	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)	<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	14,800	18,500	11,694	41	0.65	140	169	-29
	TOTAL	75,100	81,500	29,234	91		140	169	-29
OCONEE COUNTY TOTAL									
							140	169	-29
BAPTIST MEDICAL CENTER EASLEY	<18	24,500	25,700	263	1				
	18-64	79,800	85,600	7,945	23				
	+65	16,500	20,300	12,099	41	0.65	100	109	-9
	TOTAL	120,800	131,600	20,307	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	0.65	20	55	-35
	TOTAL	120,800	131,600	3,999	13		20	55	-35
PICKENS COUNTY TOTAL									
							120	164	-44
MARY BLACK MEMORIAL	<18	69,600	71,000	799	2				
	18-64	178,000	186,500	12,442	36				
	+65	39,300	48,400	13,438	45	0.65	128	174	-46
	TOTAL	286,900	305,900	26,679	83		128	174	-46
SPARTANBURG REG MED CTR	<18	69,600	71,000	3,261	9				
	18-64	178,000	186,500	67,929	195				
	+65	39,300	48,400	60,347	204	0.75	544	532	12
	TOTAL	286,900	305,900	131,537	408		544	532	12
VILLAGE HEALTH CENTRE	<18	69,600	71,000	128	0				
	18-64	178,000	186,500	2,668	8				
	+65	39,300	48,400	2,461	8	0.65	25	48	-23
	TOTAL	286,900	305,900	5,257	16		25	48	-23
SPARTANBURG COUNTY TOTAL									
							672	706	-34
WALLACE THOMSON HOSPITAL	<18	6,600	6,400	298	1				
	18-64	17,500	16,700	4,440	12				
	+65	4,900	5,500	5,217	16	0.65	44	143	-99
	TOTAL	29,000	28,600	9,955	28		44	143	-99
UNION COUNTY TOTAL									
							44	143	-99
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	5,900	5,900	64	0				
	18-64	15,500	15,700	848	2				
	+65	4,300	5,200	1,728	6	0.65	13	25	-12
	TOTAL	25,600	26,800	2,640	8		13	25	-12
ABBEVILLE COUNTY TOTAL									
							13	25	-12

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	8,000	8,100	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	5,800	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	31	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	163	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	17,900	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	5,280	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	23,165	30,120	38,993	139				
	TOTAL	193,186	211,415	87,838	283	0.75	377	414	-37
LEXINGTON COUNTY TOTAL									
							377	414	-37

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	8,600	8,700	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 & PALMETTO HEALTH PARKRIDGE									
	<18	106,309	109,900	981	3				
	18-64	305,061	317,506	52,807	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	669	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	64	-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	30,390	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									
	<18	57,900	59,600						
	18-64	145,100	159,800						
	+65	26,600	34,500						
	TOTAL	229,600	253,900			0.65		64	
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	1,084	3				
	18-64	42,300	42,000	9,848	27				
	+65	10,000	12,900	7,337	26				
	TOTAL	66,900	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	66,900	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	19,300	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	16,700	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	14,889	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	8,777	24				
	+65	12,500	17,800	19,186	75				
	TOTAL	60,900	65,500	28,380	100	0.65	154	124	30
GEORGETOWN COUNTY TOTAL							279	255	24

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	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	1,126	3				
	18-64	171,700	189,400	28,489	86				
	+65	48,300	65,100	34,574	128				
TOTAL		274,300	308,700	64,289	217	0.70	310	269	41
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER	<18	54,300	55,200	518	1				
	18-64	171,700	189,400	6,554	20				
	+65	48,300	65,100	7,697	28				
TOTAL		274,300	309,700	14,769	50	0.65	76	155	-79
HORRY COUNTY TOTAL							545	634	-89
MARION REGIONAL HOSPITAL	<18	8,000	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	66,300	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	36,900	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

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	9,700	8,800	869	2				
	+65	2,600	3,300	1,245	4	0.65	10	59	-49
	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	96,000	102,800	17,037	50				
	+65	35,100	50,200	18,855	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	96,000	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 MEDICAL CENTER 6	<18	155,500	161,600	1,297	4				
	18-64	434,900	439,600	33,325	92				
	+65	79,900	108,700	33,020	123				
	TOTAL	670,300	709,900	67,642	219	0.70	313	346	-33
SUMMERSVILLE 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	296	1				
	18-64	434,900	439,600	18,463	54				
	+65	79,900	108,700	12,960	48				
	TOTAL	670,300	709,900	32,719	103	0.70	148	204	-56

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	1,686	5				
	+65	3,000	3,900	1,963	7				
	TOTAL	21,300	22,400	3,689	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	2,800	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 BEDS 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.

HOSPITAL OCCUPANCY RATES

	2009	2010	2011	2009	2010	2011
REGION I	53.5	52.1	52.6	57.0	54.3	54.1
ANMED HEALTH MEDICAL CENTER	49.2	48.8	49.7	47.8	42.5	38.0
ANMED HEALTH WOMEN'S & CHILDREN'S	30.5	28.9	27.8	66.0	60.9	55.6
UPSTATE CAROLINA MEDICAL CENTER	38.2	31.5	27.8	71.0	53.2	43.2
GREENVILLE MEMORIAL MEDICAL CTR	62.6	61.4	63.4	12.3	17.9	11.8
GREER MEMORIAL	55.1	40.0	40.5	36.8	41.5	34.0
HILLCREST MEMORIAL HOSPITAL	41.8	43.7	42.5	53.5	60.4	61.3
PATEWOOD MEMORIAL	11.1	10.3	9.1	24.7	18.5	18.0
SAINT FRANCIS - DOWNTOWN	71.4	65.5	66.5	68.5	70.5	68.2
SAINT FRANCIS - EASTSIDE	53.1	50.6	48.6	47.7	39.1	30.2
OCONEE MEMORIAL HOSPITAL	48.0	48.4	47.4	57.3	54.0	48.6
CANNON MEMORIAL HOSPITAL	18.1	19.6	19.9	87.4	57.8	62.5
BAPTIST MEDICAL CENTER EASLEY	46.8	47.5	51.0	61.3	58.8	57.3
MARY BLACK MEMORIAL HOSPITAL	41.9	42.3	41.5	72.0	76.7	80.4
SPARTANBURG REGIONAL MEDICAL CTR	71.8	74.2	74.5	43.0	39.4	35.0
VILLAGE HEALTHCARE CENTRE	18.0	30.6	30.0	---	---	29.1
WALLACE THOMSON HOSPITAL	18.1	17.8	19.1	39.0	29.8	26.9
				12.3	14.4	15.4
				64.6	63.3	63.8
				16.4	38.0	24.8
REGION II	57.4	55.7	55.0	56.7	55.7	54.9
ABBEVILLE AREA MEDICAL CENTER	28.0	31.7	28.9	60.3	61.8	64.1
CHESTER REGIONAL MEDICAL CENTER	23.3	19.1	16.2	13.6	10.3	8.9
EDGEFIELD COUNTY HOSPITAL	19.2	13.3	14.9	14.2	20.5	10.0
FAIRFIELD MEMORIAL HOSPITAL	32.0	33.1	22.3	12.4	14.5	13.6
SELF REGIONAL HEALTHCARE	42.8	39.8	42.8	65.5	60.4	60.2
KERSHAW HEALTH	60.5	54.1	56.6	56.2	53.8	53.0
SPRINGS MEMORIAL HOSPITAL	52.4	39.6	44.0	60.6	65.4	61.4
LAURENS COUNTY HOSPITAL	43.2	42.9	43.9	47.5	43.8	43.9
LEXINGTON MEDICAL CENTER	68.2	63.8	58.1	46.5	33.8	30.5
NEWBERRY COUNTY MEM HOSPITAL	30.5	24.7	24.3	68.7	72.5	73.9
PALMETTO HEALTH BAPTIST	53.4	52.2	53.3	54.9	51.5	59.3
PALMETTO HEALTH RICHLAND	78.1	80.8	80.0	---	12.3	12.2
PROVIDENCE HOSPITAL	55.4	55.4	49.5	65.8	64.9	62.6
PROVIDENCE HOSPITAL NORTHEAST	61.3	51.6	52.7	47.8	43.7	44.8
PIEDMONT MEDICAL CENTER	57.1	58.0	62.1	31.9	32.5	31.6
				33.6	37.5	36.0
				57.5	56.1	53.2
REGION III						
CHESTERFIELD GENERAL HOSPITAL						
CLARENDON MEMORIAL HOSPITAL						
CAROLINA PINES REGIONAL MED CTR						
MCLEOD MED CTR - DARLINGTON						
MCLEOD MED CTR - DILLON						
CAROLINAS HOSPITAL SYSTEM						
LAKE CITY COMMUNITY HOSPITAL						
MCLEOD REGIONAL MEDICAL CENTER						
WOMEN'S CENTER CAROLINAS HOSP						
GEORGETOWN MEMORIAL HOSPITAL						
WACCAMAW COMMUNITY HOSPITAL						
CONWAY HOSPITAL						
GRAND STRAND REGIONAL MED CTR						
LORIS COMMUNITY HOSPITAL						
SEACOAST						
MARION REGIONAL HOSPITAL						
MARLBORO PARK HOSPITAL						
TUOMEY						
WILLIAMSBURG REGIONAL HOSPITAL						
REGION IV						
AIKEN REGIONAL MEDICAL CENTER						
ALLENDALE COUNTY HOSPITAL						
BAMBERG COUNTY MEMORIAL HOSP						
BARNWELL COUNTY HOSPITAL						
BEAUFORT MEMORIAL HOSPITAL						
HILTON HEAD REGIONAL MEDICAL CTR						
SUMMERVILLE MEDICAL CENTER						
BON SECOURS ST FRANCIS XAVIER						
EAST COOPER MEDICAL CENTER						
MUSC MEDICAL CENTER						
ROPER HOSPITAL						
ROPER MOUNT PLEASANT HOSPITAL						
TRIDENT MEDICAL CENTER						
COLLETON MEDICAL CENTER						
HAMPTON REGIONAL MEDICAL CENTER						
COASTAL CAROLINA MEDICAL CENTER						
REG MED CTR ORANGEBURG/CALHOUN						

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:

<u>FACILITY</u>	<u>COUNTY</u>	<u>BEDS</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
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;

- (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 multispecialty 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.

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	56.0%
PALMETTO HEALTH RICHLAND	2,202	42	3,588	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	3,962	47.2%
SELF REGIONAL HEALTHCARE	1,543	37	2,158	5,468	40.5%
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%
OCONEE 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	10.6%
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

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

The 2011 utilization of neonatal special care units by facility follows:

<u>HOSPITAL</u>	<u>ICU Bassinets</u>	<u>ICU Pt Days</u>	<u>Intermed Bassinets</u>	<u>Intermed Pt Days</u>	<u>Total Bassinets</u>	<u>Total Pt Days</u>	<u>Total Occupancy</u>
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	96,850	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	2009 AVE POP	3 YR AVE BR	2014 PROJ BR	2011 PT DAYS	2010 PT DAYS	AVE /AVE BR	2014 PROJ BR	65% OCCUP	2014 BEDS	EXISTING	BED NEED
Abbeville	277	251	272	264	4,600	4,592	4,735	4,642	0.66252	212,400	4,668	5,678	5,273	1,023,202	237	23	19	4
Anderson	2,232	2,238	2,322	2,264	35,700	35,556	35,137	35,464		4,600								
Edgefield	96	166	172	172	4,300	4,331	4,373	4,335		4,400								
Greenville	6,023	6,088	6,445	6,185	69,500	93,112	91,731	92,761		96,000								
Greenwood	888	928	951	922	14,800	14,750	14,432	14,661		15,100								
Lauriens	808	837	868	838	12,700	12,670	13,576	12,982		12,900								
McComick	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	1,173	1,172	1,195	26,100	25,852	24,775	25,576		27,000								
Saluda	244	249	259	251	3,600	3,585	3,397	3,517		3,500								
TOTAL	12,664	12,822	13,446	12,977	208,100	208,203	205,448	207,564	0.06328	212,400	13,278	4,668	5,273	1,023,202	237	23	19	4
Cherokee	681	608	707	695	11,200	11,105	10,980	11,095		11,300								
Chester	361	386	422	390	6,300	6,287	6,157	6,246		6,300								
Shelburne	3,522	3,680	3,941	3,714	57,300	57,051	57,243	57,198		58,100								
Union	284	321	350	325	5,200	5,273	5,000	5,158		5,100								
TOTAL	4,858	5,087	5,430	5,126	80,000	79,717	79,380	79,699	0.06430	80,800	6,196	6,959	6,200	1,013,814	237	27	13	14
Alcon	899	2,000	1,956	1,918	30,500	30,390	29,653	30,161		31,000								
Allendale	111	126	109	115	1,800	1,775	1,665	1,747		1,800								
Barnes	163	179	187	176	3,100	3,166	3,019	3,065		2,900								
Barnwell	250	283	287	273	4,300	4,276	4,224	4,267		4,200								
Calhoun	162	150	161	158	2,600	2,597	2,643	2,613		2,500								
Clarendon	335	367	395	366	5,900	5,896	5,451	5,749		5,700								
Fairfield	258	237	250	248	4,400	4,372	4,341	4,371		4,300								
Fairfield	705	753	770	743	11,300	11,262	11,012	11,191		11,400								
Kershaw	604	674	605	794	14,200	14,181	14,792	14,391		14,100								
Lancaster	174	192	238	201	3,200	3,228	3,419	3,282		3,200								
Lee	3,241	3,400	3,510	3,384	53,000	52,559	51,350	52,303		54,400								
Lexington	443	455	521	473	8,900	8,885	7,073	6,953		8,700								
Newberry	1,188	1,239	1,335	1,254	18,900	18,968	18,405	18,758		18,700								
Orangeburg	4,904	4,871	4,986	4,920	90,600	90,348	88,952	89,733		91,200								
Richland	1,507	1,534	1,596	1,546	21,800	21,823	21,395	21,673		21,700								
Sumter	1,870	2,055	2,011	2,585	46,200	47,281	47,410	47,297		49,300								
York	1,614	1,615	2,027	1,616	320,700	319,505	314,104	316,103	0.06315	323,200	19,117	10,110	10,528	1,016,023	237	44	39	5
TOTAL	16,914	16,915	20,217	16,916	520,700	519,505	514,104	516,103	0.06315	523,200	19,117	10,110	10,528	1,016,023	237	44	39	5
Chesterfield	425	527	545	489	8,900	8,892	8,218	8,670		8,800								
Darlington	787	808	817	804	13,200	13,195	12,871	13,089		13,000								
Dillon	418	460	480	446	6,300	6,286	6,027	6,204		6,100								
Florence	1,828	1,788	1,896	1,837	26,400	26,417	27,178	27,998		28,400								
Horry	3,083	3,070	3,143	3,099	50,600	50,534	47,989	49,708		51,100								
Marion	435	431	478	448	6,400	6,432	6,460	6,431		6,300								
Marion	216	301	325	281	4,900	4,924	4,927	4,920		4,700								
Marlboro	357	372	404	378	5,100	5,177	6,059	6,112		5,900								
Williamsburg	7,549	7,757	8,069	7,782	124,800	124,967	119,729	123,132	0.06328	124,300	7,866	4,432	4,612	1,009,486	237	19	12	7
TOTAL	18,999	20,155	21,211	20,088	27,900	28,081	27,027	27,669	0.06328	27,400	12,987	7,655	7,246	1,009,486	237	30	32	2
Beaufort	1,899	2,155	2,211	2,088	27,900	28,081	27,027	27,669		27,400								
Berkley	2,544	2,513	2,555	2,537	37,400	37,289	37,291	37,327		37,700								
Charleston	4,743	4,845	5,031	4,873	76,400	76,591	76,892	77,294		75,900								
Colleton	458	471	519	483	7,000	7,059	7,181	7,073		7,000								
Durham	1,765	1,851	1,850	1,819	26,000	26,688	27,443	28,043		26,100								
Georgetown	602	606	696	631	9,800	9,857	10,215	9,657		9,800								
Hanilton	209	263	293	255	3,600	3,600	3,717	3,767		3,800								
Jasper	308	333	329	329	4,600	4,671	4,951	4,854		4,800								
TOTAL	12,518	13,037	13,520	13,026	194,900	196,016	185,777	195,665	0.06360	195,000	12,987	7,655	7,246	1,009,486	237	30	32	2
STATEWIDE				57,734				924,093	0.06248		59,444			33,560		143	115	28

INTERMEDIATE BASSINET NEED

<u>Hospital</u>	<u>Intermed Bassinets</u>	<u>2011 Pt Days</u>	<u>Intermed ADC</u>	<u>Occupancy Factor</u>	<u>Projected Need</u>	<u>To Be Added</u>
AnMed Health Women's Greenville Memorial	7	929	3	0.65	4	-3
St. Francis-Eastside	42	15,834	43	0.65	67	25
	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.

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 (PLTACHs) 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.

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:

<u>Region</u>	<u>Facility</u>	<u>County</u>	<u>Beds</u>	<u>2011 Occupancy</u>
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 (USE)	+/-	BED NEED (SM)	+/-	BED NEED
ANDERSON, OCOONEE	<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	16.66	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	187	47,016	140.69	0.70	201	14	97	-80	14
CHEROKEE, SPARTANBURG UNION	<65	320,000	331,600		3,165	8.99						
	+65	51,800	65,100		5,661	18.89						
TOTAL		371,800	394,700	71	8,826	27.88	0.70	40	-31	61	-10	-10
CHESTER, LANCASTER YORK	<65	298,400	314,000		5,159	14.97						
	+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	<65	185,700	191,800		648	1.83						
	+65	95,100	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	688,900	717,200		37,268	106.61						
	+65	91,500	118,800		8,687	30.90						
TOTAL		778,400	836,000	235	45,955	137.51	0.70	196	-39	130	-105	-39
DARLINGTON, FLORENCE MARION	<65	208,300	205,700		5,273	14.40						
	+65	33,600	43,800		508	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	2.45						
	+65	14,600	18,200		563	1.92						
TOTAL		107,900	109,100	8	1,481	4.37	0.70	6	-2	17	9	9
CLARENDON, LEE, SUMNER	<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	303,600	319,700		7,728	22.29						
	+65	96,000	89,700		5,902	21.98						
TOTAL		399,600	409,400	59	13,628	44.27	0.70	63	4	64	5	5
BAMBERG, CALHOUN ORANGEBURG	<65	104,900	103,700		1,821	4.93						
	+65	19,400	24,700		882	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	634,900		36,028	100.53						
	+65	86,100	116,700		3,870	14.37						
TOTAL		709,400	751,500	156	39,898	114.90	0.70	164	8	117	-39	8
AIKEN, BARNWELL	<65	166,300	163,700		8,233	23.62						
	+65	28,900	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	35
STATE TOTAL	<65	4,017,600	4,157,800	0.000156	150,521	0.038814079	0.03					
	+65	655,100	849,300		36,947	0.061625	0.05					
TOTAL		4,672,700	5,007,100		189,468	0.0420	0.03					

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.

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.

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

(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:

<u>Region</u>	<u>Facility</u>	<u>County</u>	<u>Beds</u>	<u>2011 Occupancy</u>
I	AnMed Health Rehab	Anderson	55	92.3% <i>1</i>
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	--- <i>2</i>
II	Greenwood Rehab Hosp	Greenwood	42	86.8% <i>3</i>
II	HealthSouth Columbia	Richland	96	57.8%
II	HealthSouth Rock Hill	York	50	80.4% <i>4</i>
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	--- <i>5</i>
IV	HealthSouth Charleston	Charleston	49	74.3% <i>6</i>
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);

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

- 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.

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 intoxication 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 intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. 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.

<u>Facility</u>	<u>County</u>	<u>Beds</u>
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	<u>10</u>
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.

<u>Region</u>	<u>Facility</u>	<u>County</u>	<u>Beds</u>	<u>2011 Occupancy</u>
I	Carolina Center Behavioral Health	Greenville	21	135.6% <i>1</i>
I	Holmesview Center (Statewide)	Greenville	44	----- <i>2</i>
II	Self Regional Healthcare	Greenwood	24	0.0%
II	Springs Memorial	Lancaster	18	0.0% <i>3</i>
II	Three Rivers Behavioral Health	Lexington	17	63.2%
II	Morris Village (Statewide)	Richland	163	68.4% <i>2</i>
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% <i>2</i>
III	Carolinas Hospital System	Florence	12	52.0%
III	Palmetto Center (Statewide)	Florence	48	----- <i>2</i>
III	Lighthouse Care Center Conway	Horry	13	126.7% <i>4</i>
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)	<u>93.4%</u> <i>5</i>
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 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								

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:

<u>Region</u>	<u>Facility</u>	<u>County</u>
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:

<u>Region</u>	<u>Facility</u>	<u>County</u>	<u>Beds</u>	<u>FY 2011 Occ. Rate</u>
I	Excalibur Youth Services	Greenville	60	54.5%
I	Generations	Greenville	30	--- <i>1</i>
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% <i>2</i>
II	Directions (DMH)	Richland	37	28.6% <i>3</i>
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% <i>4</i>
III	Willowglen Academy	Williamsburg	40 (54)	72.2% <i>5</i>
IV	Palmetto Low Country	Charleston	32	78.8%
IV	Riverside at Windwood	Charleston	12	92.5% <i>6</i>
IV	Palmetto Pines Behavioral	Dorchester	60	79.5%
IV	Pinelands RTC	Dorchester	14 (28)	52.3% <i>7</i>
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.

- 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.

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	<u>68</u>
	Total	235 beds

2018 Population Age 5-21:	289,500
41.4 Beds/100,000 Population:	x <u>.000414</u>

	120 beds
	- <u>235</u> 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	<u>40</u>
	Total	299 beds

2018 Population Age 5-21:	320,500
41.4 Beds/100,000 Population:	x <u>.000414</u>
	133 beds
	- <u>299</u> 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	<u>54</u>
	Total	131 beds

2018 Population Age 5-21:	192,300
41.4 Beds/100,000 Population:	x <u>.000414</u>
	80 beds
	- <u>131</u> 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	<u>12</u>
	Total	132 beds

2018 Population Age 5-21:	274,800
41.4 Beds/100,000 Population:	x <u>.000414</u>
	114 beds
	- <u>132</u> 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 catheters 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 catheters. They should be performing a minimum of 300 therapeutic catheters 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.

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 angiocardiology, 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; Angiocardiology, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Procedure Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization

37.22 Left Heart Cardiac Catheterization

37.23 Combined Right and Left Heart Cardiac Catheterization

"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 (angiocardiology, 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

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 (ACCF/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.

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 catheters 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				2010				2011				
		ADULT		PED		ADULT		PED		ADULT		PED		
		DIAG	THERP	DIAG	THERP	DIAG	THERP	DIAG	THERP	DIAG	THERP	DIAG	THERP	
I														
ANMED HEALTH MEDICAL CENTER	1	1,307	1,301	1,911	1,230	4,371	2,086	1,152	4,390	2,086	1,152	4,390		
GREENVILLE MEMORIAL HOSPITAL	7	2,858	2,302	2,628	2,061	6,750	3,047	2,617	8,281	3,047	2,617	8,281		
SANT FRANCIS - DOWNTOWN	2	2,077	1,401	4,879	1,418	5,111	1,961	1,174	4,309	1,961	1,174	4,309		
OCONEE MEMORIAL HOSPITAL	3	776	400	667	368	1,066	675	292	967	675	292	967		
BAPTIST MED CTR-EASLEY	1	400	400	368	368	1,066	292	105	1,066	292	105	1,066		
MARY BLACK MEMORIAL	1	150	150	106	106	435	105	105	435	105	105	435		
SPARTANBURG REGIONAL MEDICAL CTR	4	2,299	964	2,500	928	4,356	2,067	850	3,767	2,067	850	3,767		
VILLAGE HOSPITAL	1													
TOTAL REGION I	22	10,467	5,968	22,403		21,729	10,233	5,793	21,819	10,233	5,793	21,819		
II														
CHESTER REGIONAL MEDICAL CENTER	MOBILE	96	396	1,137	1,929	1,110	1,038	406	1,847	1,110	1,038	406	1,847	27
SELF REGIONAL HEALTHCARE	2	1,137	396	1,929	1,929	1,110	1,038	406	1,847	1,110	1,038	406	1,847	27
KERSHAW HEALTH	1	507	507	461	461	461	540	461	540	461	461	540	461	413
SPRINGMOUNT MEDICAL CENTER	2	1,242	16	1,274	1,274	1,233	54	1,401	1,419	1,233	54	1,401	1,419	157
LEXINGTON MEDICAL CENTER	5	283	283	283	283	320	320	320	320	277	277	277	277	277
PALMETTO HEALTH BAPTIST	1	3,338	1,245	5,828	5,828	3,169	1,134	5,437	2,675	1,155	4,985	2,675	1,155	4,985
PALMETTO HEALTH RICHLAND	4	3,474	2,700	8,874	8,874	3,332	2,742	8,616	3,213	2,543	8,299	3,213	2,543	8,299
PROVIDENCE HOSPITAL	6	1,422	759	2,940	2,940	1,328	762	2,562	1,480	715	2,810	1,480	715	2,810
PIEDMONT MEDICAL CENTER	2	1,750		1,750										
SOUTH CAROLINA HEART CENTER	6													
TOTAL REGION II	23	13,825	5,116	24,057		11,538	5,099	21,733	11,082	4,977	21,036	11,082	4,977	21,036
III														
CAROLINA PINES REGIONAL MEDICAL CTR	1	62	547	3,500	62	1,228	240	1,708	30	935	257	1,510	30	935
CAROLINAS HOSPITAL SYSTEM	2	2,406	595	2,694	2,694	1,640	619	2,278	1,433	573	73	893	1,433	573
MCLEOD REGIONAL MEDICAL CENTER	5	1,504	611	63	63	696	77	850	747	73	893	747	73	893
GEORGETOWN MEMORIAL HOSPITAL	1	595	595	595	595	521	521	521	584	584	584	584	584	584
CONWAY HOSPITAL	1	1,057	667	2,391	2,391	1,258	829	2,956	1,158	818	2,794	1,158	818	2,794
GRAND STRAND REGIONAL MED CTR	3	247	247	247	247	238	238	238	231	231	231	231	231	231
LORIS COMMUNITY HOSPITAL	1	281	281	281	281	204	204	204	185	185	185	185	185	185
TUOMEY	1													
TOTAL REGION III	15	6,753	1,872	10,497		5,955	1,765	9,485	5,364	1,721	8,806	5,364	1,721	8,806
IV														
AIKEN REGIONAL MEDICAL CENTER	1	519	243	1,005	1,005	448	279	1,005	945	378	1,701	945	378	1,701
BEAUFORT MEMORIAL HOSPITAL	1	482	482	482	482	484	484	484	681	681	681	681	681	681
HILTON HEAD HOSPITAL	2	478	240	958	958	454	231	916	406	210	826	406	210	826
COLLETON MEDICAL CENTER	MOBILE	0	0	0	0	0	0	0	0	0	0	0	0	0
BON SECOURS ST. FRANCIS XAVIER	1	0	0	0	0	0	0	0	0	0	0	0	0	0
MUSC MEDICAL CENTER	7	1,517	1,184	3,885	3,885	1,694	1,227	4,148	2,666	252	7	2,666	252	7
ROPER HOSPITAL	3	1,943	910	3,763	3,763	1,904	882	3,688	1,776	929	4,256	1,776	929	4,256
TRIDENT MEDICAL CENTER	2	1,429	370	2,169	2,169	1,321	464	2,249	1,326	421	2,168	1,326	421	2,168
REG MED CTR ORANGEBURG-CALHOJN	1	400	400	400	400	271	271	271	247	247	247	247	247	247
RALPH HENRY VA MED CTR CHARLESTON	(1)													
TOTAL REGION IV	19	6,768	2,947	12,662		6,588	3,183	12,954	7,122	3,200	13,522	7,122	3,200	13,522
STATEWIDE TOTALS														
	79	37,813	15,903	69,619		34,536	15,684	65,901	33,001	15,091	65,183	33,001	15,091	65,183

1 CON ISSUED 5/14/09 FOR A 4TH CATH LAB, SC-09-24
 2 CON ISSUED 7/6/09 FOR A 4TH CATH LAB, SC-09-34; OPERATIONAL 12/30/09.
 3 CON ISSUED 6/2/09 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 6/18/10 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 3/14/07 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

- 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

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.

<u>REGION/FACILITY</u>	<u># OPEN HEART UNITS</u>	<u>FY09 ADULTS</u>	<u>PEDS</u>	<u>ADULTS</u>	<u>FY10 PEDS</u>	<u>ADULTS</u>	<u>FY11 ADULTS</u>	<u>PEDS</u>
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							
PALMETTO HEALTH RICHLAND	2	438		384		356		
PROVIDENCE HOSPITAL	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	35	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.

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

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.

RADIOTHERAPY

<u>SERVICE AREAS</u>	<u>2011 POPULATION</u>	<u># OF LIN ACC</u>	<u>POP PER LIN ACC</u>	<u>TOTAL AREA TREATMENTS</u>	<u>TREATMENTS PER LIN ACC</u>	<u>PLANNING AREA CAPACITY</u>	<u>UNMET NEED?</u>	<u>PERCENT CAPACITY</u>
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

<u>REGION & FACILITY</u>	<u>COUNTY</u>	<u># UNITS</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
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	13,358	10,950
REGION III					
CAROLINAS HOSPITAL SYSTEM	FLORENCE	1	5,015	3,650	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	CHARLESTON				
LINEAR ACCELERATORS 15		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	2	6,545	6,318	6,579
		ORANGEBURG			
TOTAL		60	257,823	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 3/20/06.
- 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 FACILITY 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.

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-\$2,700,000 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

<u>REGION/COUNTY</u>	<u>FACILITY</u>	<u>SCANNERS</u>	<u>FY09 SCANS</u>	<u>FY10 SCANS</u>	<u>FY11 SCANS</u>	<u>CON/DATE</u>
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	502	565	510	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	2,413	2,269	2,272	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	908	891	1,000	
GREENVILLE	ST. FRANCIS - EASTSIDE	MOBILE 2 DAYS	---	---	---	CON 10/19/11
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	1,749	1,643	1,606	
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	746	656	718	
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	428	474	556	
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	946	922	881	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	549	934	375	CON 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	2,256	2,297	2,032	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	1,117	1,254	1,076	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	230	258	233	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	667	736	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	1,306	1,404	1,611	
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	1,994	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	406	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 6/17/09
		TOTALS	19,961	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.

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.

2011 ASF Utilization

<u>Name of Facility:</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region I:</u>										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,459	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		6,087	6,087		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	663	605	
Westside Eye Center	Spartanburg	2		2	1,338		1,338	669		
<u>Region II:</u>										
Greenwood Endoscopy Center	Greenwood		4	4		8,180	8,180		2,045	

<u>Name of Facility:</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Surgery Ctr. at Self Memorial Hospital	Greenwood	5	5	4,385	89	4,474	895	10		
Surgery Center at Edgewater	Lancaster	3	2	2,608	20	2,628	869			
Surgery & Laser Center at Professional Park (Columbia Surgery Center)	Laurens	2	2	2,610	2,610	1,305				4
Midlands Endoscopy Center	Lexington	(0)	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	1,371	1,445	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	4	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

<u>Name of Facility:</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
<u>Region III:</u>										
Darlington Endoscopy Center	Darlington		2	2		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	3,226	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		
<u>Region IV:</u>										
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		
Bluffton-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

<u>Name of Facility:</u>	<u>County</u>	<u># of ORs</u>	<u># of Endos</u>	<u>Total # of Suites</u>	<u>Total Operations</u>	<u>Total Endos</u>	<u>Combined Total</u>	<u>Operations per OR</u>	<u>Endos per Suite</u>	<u>Footnote</u>
Surgery 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	1,498	

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.

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

Certificate 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.

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.

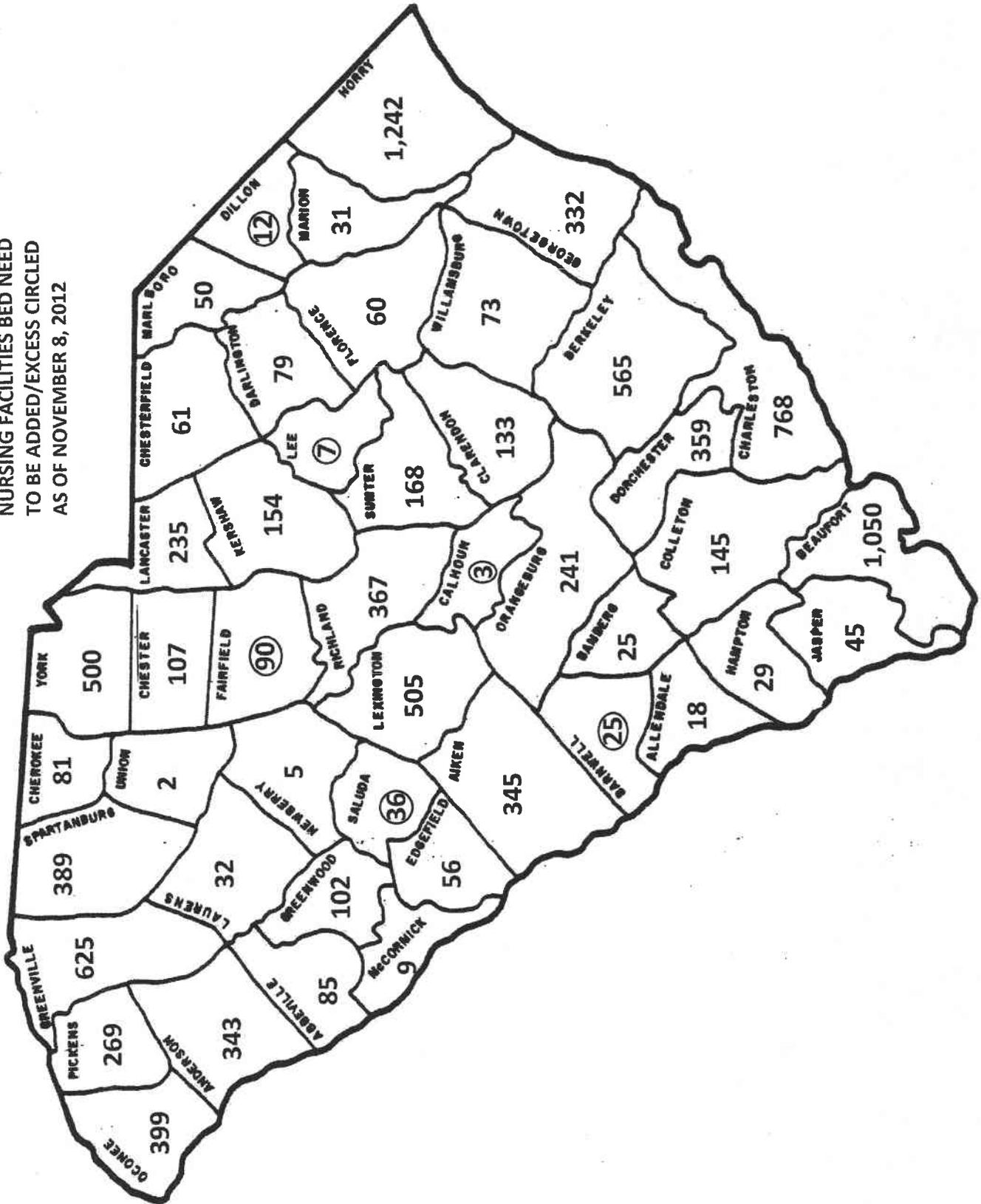
Relative Importance of Project Review Criteria

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.

NURSING FACILITIES BED NEED
 TO BE ADDED/EXCESS CIRCLED
 AS OF NOVEMBER 8, 2012



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	11.60	452	420	32	32
LEXINGTON	39.00	1,521	1,016	505	505
MCCORMICK	3.30	129	120	9	9
NEWBERRY	6.90	269	264	5	5
RICHLAND	45.10	1,759	1,392	367	367
SALUDA	3.60	140	176	-36	
YORK	30.60	1,193	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.

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.

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:

<u>Hospital</u>	<u>Swing Beds</u>	<u>Admissions</u>	<u>Patient Days</u>	<u>Average Census</u>
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 <i>1</i>	10			
Edgefield Co. Hospital	25	93	1,108	3.0
Fairfield Memorial	25	67	912	2.5
Hampton Regional Hospital <i>2</i>	10			
Marlboro Park Hospital <i>1</i>	6			
McLeod-Darlington	24	165	2,262	14.4
Newberry County Memorial	20	8	39	0.1
Wallace Thompson <i>1</i>	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.

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	ADMIS SIONS	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	15	322	2,117	38.7%
HOSPICE OF LAURENS INPT HOSPICE HOUSE (ASCENSION HOUSE) 1	LAURENS RICHLAND	12 (14)	133	1,340	30.6%
AGAPE HOSPICE HOUSE OF THE MIDLANDS 2	RICHLAND	12			
HOSPICE AND COMMUNITY CARE HOUSE	YORK	16	247	2,060	35.3%
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	65.5%

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

HOME HEALTH METHODOLOGY

Rate	0.00084		0.00830		0.04632		0.12204		Total Estimated Patients	2011 Actual Patients	Population Growth Factor	Total Projected Patients	2013 Unmet (Need)/ Surplus	Need at 100 Patients	New Agency Approved Since 12/31/10	New Agency Can be Approved
	Projected 2013 Population Age 0-17	Estimated Pts Age 0-17	Projected 2013 Population Age 18-64	Estimated Pts Age 18-64	Projected 2013 Population Age 65-74	Estimated Pts Age 65-74	Projected 2013 Population Age 75+	Estimated Pts Age 75+								
County	5,800	5	15,600	129	2,700	125	1,700	207	467	780	1.009	787	320			
Abbeville	37,000	31	102,100	847	16,600	769	10,600	1,294	2,941	2,589	1.025	2,654	(287)	YES		YES
Albion	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			
Bamburg	3,500	3	9,500	79	1,700	79	1,100	134	295	384	1.000	384	89			
Barnwell	5,800	5	13,900	115	2,200	102	1,400	171	393	490	1.017	498	105			
Beaufort	33,600	28	98,400	817	24,000	1,112	14,900	1,818	3,775	3,615	1.035	3,742	(33)			
Berkeley	46,000	39	117,100	972	14,000	648	7,200	879	2,538	2,771	1.024	2,838	300			
Calhoun	3,200	3	9,600	80	1,800	83	1,000	122	288	392	1.013	397	109			
Charleston	73,800	62	231,800	1,924	29,500	1,366	20,000	2,441	5,793	9,152	1.009	9,235	3,442			
Cherokee	13,900	12	35,300	293	5,000	232	3,000	366	902	1,249	1.023	1,278	375			
Chester	8,000	7	20,500	170	3,200	148	1,900	232	557	985	1.029	1,014	457			
Chesterfield	11,600	10	29,100	241	4,400	204	2,500	305	760	838	1.013	849	89			
Clarendon	7,800	7	21,200	176	4,300	199	2,400	293	675	689	1.014	699	24			
Colleton	9,600	8	23,600	196	4,200	195	2,500	305	704	1,235	1.020	1,260	556			
Darlington	16,400	14	42,400	352	6,700	310	4,100	500	1,176	1,229	1.010	1,241	65			
Dillon	8,400	7	19,200	159	2,700	125	1,800	220	511	734	1.003	736	225			
Dorchester	37,300	31	88,400	734	10,500	486	6,000	732	1,984	2,768	1.027	2,844	860			
Edgefield	5,800	5	18,300	152	2,700	125	1,400	171	453	356	1.012	360	(92)			
Fairfield	5,400	5	15,000	124	2,500	116	1,500	183	428	558	1.017	567	140			
Florence	33,900	29	85,800	712	12,500	579	7,600	928	2,247	2,875	1.021	2,935	688			
Georgetown	12,800	11	35,700	296	8,800	408	4,900	598	1,313	2,091	1.037	2,168	856			
Greenville	110,500	93	293,600	2,436	37,500	1,737	24,800	3,027	7,293	8,592	1.022	8,781	1,488			
Greenwood	16,700	14	43,300	359	6,300	292	5,000	610	1,275	1,967	1.021	2,008	733			
Hampton	5,100	4	13,300	110	2,000	93	1,200	146	354	617	1.014	626	272			
Horry	54,600	46	177,300	1,471	33,100	1,533	19,500	2,380	5,430	6,808	1.037	7,060	1,630			
Jasper	6,000	5	16,500	137	2,000	93	1,200	146	381	587	1.024	601	220			
Kershaw	15,400	13	38,900	323	6,000	278	3,600	439	1,053	1,389	1.021	1,418	365			
Lancaster	17,800	15	47,700	396	8,100	375	4,600	561	1,347	1,721	1.016	1,749	401			
Laurens	15,400	13	42,400	352	6,400	296	4,500	549	1,210	1,985	1.030	2,045	834			
Lee	4,300	4	12,400	103	1,700	79	1,100	134	320	391	1.010	395	75			
Lexington	65,000	55	173,300	1,438	22,400	1,038	13,900	1,696	4,227	5,333	1.030	5,493	1,266			
Marion	8,000	7	20,200	168	3,400	157	1,800	220	552	618	1.009	624	72			
Marlboro	6,300	5	18,300	152	2,600	120	1,300	159	436	639	0.986	630	194			
McCormick	1,400	1	6,200	51	2,000	93	1,000	122	267	291	1.019	297	29			
Newberry	8,600	7	23,200	193	3,900	181	2,600	317	698	1,061	1.016	1,078	380			
Oconee	15,800	13	45,500	378	9,400	435	6,200	757	1,583	2,177	1.024	2,229	646			
Orangeburg	21,500	18	57,500	477	9,100	422	6,000	732	1,649	3,094	1.011	3,128	1,479			
Pickens	24,800	21	81,600	677	10,300	477	7,200	879	2,054	2,616	1.026	2,684	630			
Richland	88,600	75	262,900	2,182	25,800	1,195	16,100	1,965	5,416	6,009	1.015	6,099	683			
Saluda	4,500	4	12,300	102	2,000	93	1,400	171	369	337	1.005	339	(31)			
Spartanburg	69,900	59	180,900	1,501	25,300	1,172	16,300	1,989	4,721	6,538	1.019	6,664	1,943			
Sumter	27,900	23	66,700	554	9,000	417	6,200	757	1,751	2,828	1.015	2,870	1,120			
Union	6,600	6	17,300	144	2,900	134	2,100	256	540	832	0.997	830	290			
Williamsburg	7,900	7	20,800	173	3,400	157	2,100	256	593	963	0.994	957	364			
York	58,200	49	149,600	1,241	17,900	829	10,700	1,306	3,425	4,064	1.030	4,186	761			
TOTAL	1,088,000	915	2,977,300	24,707	431,700	19,997	270,600	33,024	78,643	100,996	1.021	103,099	24,456			

data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization.

8. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.
9. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

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

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

Relative Importance of Project Review Criteria

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

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

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

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

2. Pediatric Home Health Agencies:

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

Certificate of Need Standards

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

3. Continuing Care Retirement Community Home Health Agencies:

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

1. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;
2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and
3. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

Home Health Agency Utilization 2011

<u>Agency</u>	<u>Counties Served</u>	<u>Persons Served</u>	<u>Total Visits</u>
Alere Womens & Childrens-Midlands (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	296	1,592
Alere Womens & Childrens-Piedmont (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	415	2,303
Amedysis 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
Betha 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, Barnberg, Barnwell, Calhoun & Orangeburg	658	10,830
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	506	4,848
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	607	13,063
DHEC Region 8 Home Health 3	Beaufort, Colleton, Hampton & Jasper	611	6,542
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	249	6,734
Franklin C. Fetter Home Health Agency	Charleston	26	1,172
Gentiva Health Services 4	Lexington & Richland	1,524	35,306
Gentiva Health Services - Charleston 5	Berkeley, Charleston & Dorchester	753	14,636
Gentiva Health Services - Coastal 6	Georgetown, Horry & Williamsburg	1,630	37,332
Gentiva Health Services-Greenville 7 (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	3,469	95,088
Gentiva Health Services - Upstate 8	Cherokee, Chester, Union & York	3,529	79,161
Greenville Hospital System HHA	Greenville & Pickens	1,914	31,986
Health Related Home Care 9	Abbeville, Edgefield, Greenwood, Laurens, McCormick & Saluda	1,582	48,034
HomeCare of HospiceCare Piedmont (may only serve terminally ill patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick & Saluda	14	238
Home Care of Lancaster	Lancaster	1,458	49,759
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	1,307	22,616
HomeChoice Partners 10 (restricted to pediatric patients only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York	8	17

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

Neighbors Care Home Health Agency	Chester	511	12,144
Oconee Memorial Home Health	Anderson, Oconee & Pickens	669	20,098
Palmetto Health HomeCare 12	Lexington & Richland	1,583	34,428
Pediatric Home Health 13 (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester	1,250	2,226
Presbyterian Communities of SC 14 (may serve retirement communities only)	Berkeley, Dorchester, Florence, Laurens, Lexington & Pickens	-	-
PHC Home Health	Charleston	511	13,434
Rolling Green Village 15 (may serve retirement community only)	Greenville	-	-
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	3,192	58,875
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	41	3,028
Sea Island Home Health	Charleston & Colleton	110	5,035
Spartanburg Reg Med Ctr Home Health	Spartanburg	2,406	35,132
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	2,275	27,773
Still Hopes Solutions for Living at Home (may serve retirement community only)	Lexington	-	-
Tri-County Home Health Care 16	Aiken, Allendale, Lexington, Richland, Saluda & Sumter	4,137	65,385
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	942	23,446
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	1,002	18,832
United Home Care of Lowcountry 17	Beaufort	-	-
University Home Health North Augusta	Aiken & Edgefield	1,052	16,613
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	750	21,025
Wesley Commons Home Health Care (may serve retirement community only)	Greenwood	62	5,357
Westminster Campus Home Health (may serve retirement community only)	York	19	72
TOTALS		103,229	2,022,665

Home Health Agency Footnotes

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

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.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE

FISCAL YEAR: 2011

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

REGION: STATEWIDE

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMS 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

RESIDENTIAL 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		CHARLESTON	CHARLESTON	NPA	8	8	16	1,798
BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	13	2,768
THE FRANKIE HEALTH CARE CTR	3	CHARLESTON	MT PLEASANT	NPA	(0)	(0)	98	6,928
VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	93	79,193

REGION: STATEWIDE

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	PATIENT DAYS
BETHA 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 - FOOHILLS		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	18	3,523
EMERITUS AT SKYLYN HEALTH CARE CTR		SPARTANBURG	SPARTANBURG	PROP	11	11	36	1,808
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	6	6	21	7,084
(COVENANT PLACE NURS CTR)	9	SUMTER	SUMTER	NPA	16	16		
TOTAL					1,358	1,446	951	389,623

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.

REGION: I

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	14,791	76,738	423	49.7%
ANNED HEALTH WOMEN'S & CHILDRENS HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,221	7,307	72	27.8%
ANDERSON COUNTY		TOTAL			495	495	18,012	84,045	495	46.3%
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	6,688	43	42.5%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,067	2,402	72	9.1%
SAINT FRANCIS - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	226	226	12,021	54,840	226	66.5%
SAINT FRANCIS - MILLENNIUM	1	GREENVILLE	GREENVILLE	NPA	93	(0)	5,814	16,501	93	48.6%
SAINT FRANCIS - EASTSIDE	1	GREENVILLE	GREENVILLE	NPA	93	93	5,814	16,501	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		TOTAL			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		SPARTANBURG	SPARTANBURG	PROP	176	174	6,399	26,679	176	41.5%
SPARTANBURG REGIONAL MEDICAL CENTER	2	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	706	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	3,064	127,594	585,732	3,063.0	52.6%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS REST NPA	NPA	45	45	281	8,566	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%
GREENVILLE COUNTY		TOTAL			129	129	998	29,756	129	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	2,395	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	296	6,149	61,368	276.2	60.9%

REGION: I INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
EXCALIBUR YOUTH SERVICES		GREENVILLE	SIMPSONVILLE	PROP	60	60	88	11,925	60	64.5%
GENERATIONS RESIDENTIAL PROGRAM		GREENVILLE	GREENVILLE	PROP	30	30				
MARSHALL I. PICKENS CHILDREN'S PROGRAM	5	GREENVILLE	GREENVILLE	NPA	22	22	24	7,669	22	95.5%
SPRINGBROOK BEHAVIORAL HEALTHCARE		GREENVILLE	TRAVELERS REST	PROP	68	68	63	20,088	68	81.0%
AVALONIA GROUP HOME		PICKENS	PICKENS	PROP	55	55	74	13,068	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	15,156	45	92.3%
ANDERSON COUNTY		TOTAL			55	55	1,114	15,156	45	92.3%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53	707	11,478	53	56.3%
SAINT FRANCIS HOSPITAL - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	19	19	486	5,854	19	84.4%
GREENVILLE COUNTY		TOTAL			72	72	1,173	17,330	72	65.9%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18	273	3,760	18	57.2%
SPARTANBURG REHABILITATION INSTITUTE	7	SPARTANBURG	SPARTANBURG	PROP	18	28	273	3,760	18	57.2%
SPARTANBURG COUNTY		TOTAL			18	46	273	3,760	18	57.2%
TOTAL					145	173	2,560	36,246	136	73.6%
INPATIENT HOSPICE FACILITIES:										
CALLIE & JOHN RAINY / 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	683	9,417	30	86.0%
OCONEE MEMORIAL HOSPICE Foothills		OCONEE	SENECA	NPA	15	15	263	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	589	5,106	15	93.3%
TOTAL					104	104	2,450	28,070	104	76.6%
LONG TERM CARE FACILITIES:										
CHIQUOLA MAISON	8	ANDERSON	HONEA PATH	NPA	150	150	234	63,003	181	95.4%
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181	234	14,345	44	89.3%
EMERITUS AT ANDERSON PLACE HEALTH CARE CENTER		ANDERSON	ANDERSON	PROP	44	44	136	20,924	60	95.5%
EXALTED HEALTH & REHAB IVA		ANDERSON	IVA	PROP	60	60	130	30,642	88	95.4%
FELLOWSHIP HEALTH & REHAB ANDERSON		ANDERSON	ANDERSON	PROP	88	88	157			
(GARDENS AT TOWN CREEK)		ANDERSON	PENDLETON	PROP	(0)	(0)				
HOSANIVA HEALTH & REHAB PIEDMONT	9	ANDERSON	ANDERSON	PROP	88	88	272	31,157	88	97.0%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290	529	103,283	290	97.6%
ANDERSON COUNTY		TOTAL			751	901	1,456	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	133	462	44,635	132	92.6%
ARBORETUM OF WOODLANDS AT FURMAN	11	GREENVILLE	GREENVILLE	PROP	30	30	158	9,977	30	91.1%
COTTAGES AT BRUSHY CREEK		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
DAYSpring HEALTH & REHAB SIMPSONVILLE		GREENVILLE	SIMPSONVILLE	PROP	144	144	422	50,474	144	96.0%
DIAMOND HEALTH & REHAB SIMPSONVILLE	10	GREENVILLE	SIMPSONVILLE	PROP	42	120	26	13,654	42	89.1%
EMERITUS AT GREENVILLE		GREENVILLE	SIMPSONVILLE	PROP	132	132	206	46,915	132	97.4%
FOUNTAIN INN NURSING HOME		GREENVILLE	GREENVILLE	PROP	45	45	260	12,988	45	79.1%
GLOVERIFIED HEALTH & REHAB GREENVILLE		GREENVILLE	FOUNTAIN INN	PROP	60	60	114	20,280	60	92.6%
GREENVILLE MEMORIAL MED CTR SUBACUTE		GREENVILLE	GREENVILLE	PROP	132	132	234	46,091	132	95.7%
HOPE HEALTH & REHAB MARIETTA		GREENVILLE	GREENVILLE	NPA	15	15	310	5,053	15	92.3%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	MARIETTA	NPA	44	44	29	15,260	44	95.0%
		GREENVILLE	GREENVILLE	PROP	132	132	330	43,884	132	91.1%

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 (LINVILLE COURTS AT CASCADES VERDE)	12	GREENVILLE	GREENVILLE	PROP	44	44	177	10,637	32	91.1%
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	(0)	(0)	66	34,295	99	94.9%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	174	41,911	120	95.7%
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREENVILLE	PROP	176	176	554	61,701	176	96.0%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	560	81,595	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	79	0	26,600	79	92.2%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY (ROLLING GREEN VILLAGE HEALTH CARE FACILITY)	13	GREENVILLE	GREENVILLE	NFA	50	74	20	3,535	17	57.0%
GREENVILLE COUNTY		TOTAL			1,913	1,957	4,795	635,676	1,868	93.0%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120	460	41,300	120	94.3%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132	182	44,076	132	91.5%
OCONEE COUNTY		TOTAL			252	252	642	85,376	252	92.8%
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	44	43	12,600	44	78.5%
HERITAGE HEALTHCARE OF PICKENS		PICKENS	SIX MILE	PROP	44	44	62	14,614	44	91.0%
MAJESTY HEALTH & REHAB EASLEY		PICKENS	EASLEY	PROP	103	103	260	35,877	103	95.4%
MANNA HEALTH & REHAB PICKENS	14	PICKENS	PICKENS	PROP	80	130	160	26,323	80	97.0%
PRESBYTERIAN HOME - FOOOTHILLS	16	PICKENS	EASLEY	PROP	26	26	14	3,353	10.8	85.1%
(PRESBYTERIAN HOME - FOOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
REDEEMER HEALTH & REHAB PICKENS	14	PICKENS	PICKENS	PROP	44	(0)	63	15,397	44	96.9%
PICKENS COUNTY		TOTAL			437	453	748	141,915	421.8	92.2%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	84	31,433	88	97.8%
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	14,598	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		SPARTANBURG	SPARTANBURG	PROP	88	120	188	30,739	88	95.7%
MOUNTAINVIEW NURSING HOME	17	SPARTANBURG	SPARTANBURG	CO	132	132	131	47,441	132	98.5%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NFA	75	75	235	21,535	75	78.7%
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	468	5,686	25	62.3%
SPARTANBURG REHABILITATION INSTITUTE	7	SPARTANBURG	SPARTANBURG	PROP	27	27	166	8,135	27	82.5%
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
(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	64,359	192	91.8%
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%

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.

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.

REGION: # INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	PATIENT DAYS	AVE LC 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	1,356	25	14.9%
EDGEFIELD COUNTY		TOTAL			25	25	357	1,356	25	14.9%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25	401	2,034	25	22.3%
FAIRFIELD COUNTY		TOTAL			25	25	401	2,034	25	22.3%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	354	354	13,106	54,458	354	42.1%
GREENWOOD COUNTY		TOTAL			354	354	13,106	54,458	354	42.1%
KERSHAW HEALTH		KERSHAW	CAMDEN	CO	121	121	5,891	24,978	121	56.6%
KERSHAW COUNTY		TOTAL			121	121	5,891	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	7,984	90	24.3%
NEWBERRY COUNTY		TOTAL			90	90	2,161	7,984	90	24.3%
PALMETTO HEALTH BAPTIST	3	RICHLAND	COLUMBIA	NPA	363	287	15,191	71,522	363	54.0%
PALMETTO HEALTH PARKRIDGE	3	RICHLAND	COLUMBIA	NPA	579	579	28,533	186,045	579	80.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	PROP	258	258	8,608	46,608	258	49.5%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROP	84	84	3,447	10,769	84	64.1%
PROVIDENCE HOSPITAL NORTHEAST	4	RICHLAND	COLUMBIA	FED	(63)	(63)				
(MONCRIEF ARMY HOSPITAL)	5	RICHLAND	COLUMBIA	FED	(400)	(400)				
(W.J.B DORN VA HOSPITAL)		RICHLAND COUNTY			1,255	1,284	56,777	297,944	1,246	65.5%
RICHLAND COUNTY		TOTAL			1,255	1,284	56,777	297,944	1,246	65.5%
CAROLINAS MEDICAL CENTER - FORT MILL	6	YORK	FORT MILL	NPA	268	268	13,850	60,750	268	62.1%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	268	318	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	688,971	2,925	56.2%
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		TOTAL			0	30				
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	81	81	1,918	22,282	81	75.4%
LEXINGTON COUNTY		TOTAL			81	81	1,918	22,282	81	75.4%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	NPA	94	94	1,929	18,881	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)	(20)				

REGION: II INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W.J.B DORN VA) RICHLAND COUNTY	5	RICHLAND	COLUMBIA	FED	154	(60) 154	2,434	23,673	154	42.1%
PIEDMONT MEDICAL CENTER YORK COUNTY		YORK	ROCK HILL	PROP	20	20	842	5,620	20	77.0%
TOTAL					291	321	5,302	52,359	291	49.2%

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:

THREE RIVERS RESIDENTIAL TREATMENT - MIDLANDS		LEXINGTON	WEST COLUMBIA	PROP	59	59	85	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	50,660	150	92.6%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	43	8,325	40	57.0%
TOTAL					289	289	486	89,773	288.5	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	68.2%
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	68.7%
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 GREENWOOD COUNTY	9	GREENWOOD	GREENWOOD	NPA	34	42	787	10,767	34	86.8%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA RICHLAND COUNTY		RICHLAND	COLUMBIA	PROP	96	96	1,546	20,242	96	57.8%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL YORK COUNTY	10	YORK	ROCK HILL	PROP	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 HOSPIECARE PIEDMONT HOSPICE OF LAURENS CO INPT HOSPICE HOUSE AGAPE HOSPICE HOUSE OF THE MIDLANDS (ASCENSION HOUSE) HOSPICE AND COMMUNITY CARE	11 12	GREENWOOD LAURENS RICHLAND RICHLAND YORK	GREENWOOD CLINTON COLUMBIA IRMO ROCK HILL	NPA PROP PROP PROP NPA	15 12 12 (0) 16	15 12 12 (0) 16	322 133	2,117 1,340	15 12	38.7% 30.6%
TOTAL					55	55	702	5,517	43	35.2%

LONG TERM CARE FACILITIES:

ABBEVILLE NURSING HOME (CARLISLE NURSING CENTER) ABBEVILLE COUNTY	13	ABBEVILLE	ABBEVILLE	PROP	94	94	32	32,789	94	95.6%
CHESTER NURSING CENTER CHESTER COUNTY		CHESTER	CHESTER	CO	100	100	191	29,986	100	82.2%
TRINITY MISSION EDGEFIELD COUNTY		EDGEFIELD	EDGEFIELD	PROP	120	120	72	40,856	120	83.3%
FAIRFIELD HEALTHCARE CENTER UNI-HEALTH POST ACUTE - TANGLEWOOD FAIRFIELD COUNTY		FAIRFIELD	RIDGEWAY	PROP	112	112	68	39,286	112	96.1%
TOTAL					262	262	208	87,927	262	91.9%

REGION: II INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISSIONS	PATIENT DAYS	AVERAGE 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	51,476	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	95.0%
KERSHAW COUNTY		TOTAL			244	244	677	84,851	244	95.3%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142	87	49,562	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 REHABILITATION 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	388	570	134,253	388	94.8%
NHC HEALTHCARE - LEXINGTON	14	LEXINGTON	W.COLUMBIA	PROP	120	170	298	41,987	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	2,080	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	37,462	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	85	34,613	146	95.0%
NEWBERRY COUNTY		TOTAL			264	264	462	73,198	270	74.3%
COUNTRYWOOD NURSING CENTER		RICHLAND	HOPKINS	PROP	38	38	41	12,834	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	88.6%
NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	180	180	399	61,104	180	93.0%
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22	601	5,526	22	88.8%
RICE ESTATE REHAB & HEALTHCARE	17	RICHLAND	COLUMBIA	NPA	36	80	29	11,246	32	96.3%
UNI-HEALTH POST ACUTE CARE BLYTHEWOOD	18	RICHLAND	BLYTHEWOOD	PROP	120	120	503	27,839	120	63.6%
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	(6)	(6)				
(W.J.B. DORN VA)	5	RICHLAND	COLUMBIA	FED	(94)	(94)				
RICHLAND COUNTY		TOTAL			1,348	1,362	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%

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	66	66	260	20,787	66	86.3%
WHITE OAK OF ROCK HILL		YORK	ROCK HILL	PROP	141	141	124	49,148	141	95.5%
WILLOW BROOK COURT		YORK	YORK	NPA	109	109	102	39,155	109	98.4%
YORK COUNTY		YORK	ROCK HILL	PROP	40	40	104	5,151	40	35.2%
TOTAL					693	693	1,718	228,777	693	90.4%
TOTAL					5,471	5,543	10,734	1,768,913	5,420.2	89.4%

FOOTNOTES

2012-13 PLAN

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.

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.

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	2,570	11,365	56	55.6%
CLARENDON COUNTY		TOTAL			81	81	2,570	11,365	56	55.6%
CAROLINA PINES REGIONAL MEDICAL CENTER		DARLINGTON	HARTSVILLE	NPA	116	116	5,275	18,279	116	43.2%
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	49	49	384	2,118	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	12,383	68,370	310	61.3%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLORENCE	DIST	48	48	950	3,149	48	18.0%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	22,473	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	36,604	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	28,390	124	62.5%
GEORGETOWN COUNTY		TOTAL			255	255	13,045	51,698	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	3,280	13,432	105	35.0%
SEACOAST MEDICAL CENTER	4	HORRY	LITTLE RIVER	DIST	50	50	340	1,337	12.6	29.1%
HORRY COUNTY		TOTAL			634	634	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	5,290	94	15.4%
MARLBORO COUNTY		TOTAL			94	94	1,361	5,290	94	15.4%
TUOMEY		SUMTER	SUMTER	NPA	283	283	8,018	65,852	283	63.8%
SUMTER COUNTY		TOTAL			283	283	8,018	65,852	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	2,630	103,232	487,138	2,468	54.1%
LONG TERM ACUTE HOSPITALS:										
REGENCY HOSPITAL OF FLORENCE		FLORENCE	FLORENCE	PROP	40	40	441	11,819	40	81.0%
TOTAL		40			40	40	441	11,819	40	81.0%
MENTAL FACILITIES:										
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	23	23	668	5,450	23	64.9%
DARLINGTON COUNTY		TOTAL			23	23	668	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	6	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	168	1,481	8	50.7%
MARLBORO COUNTY		TOTAL			8	8	168	1,481	8	50.7%
TOTAL		102			102	102	2,332	20,888	87	66.8%

REGION: III

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	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	6	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	13,796	43	87.9%
GEORGETOWN COUNTY		TOTAL			43	43	1,001	13,796	43	87.9%
TOTAL					173	173	2,918	41,238	173	66.3%

INPATIENT HOSPICE FACILITIES:

MCLEOD HOSPICE HOUSE		FLORENCE	FLORENCE	NPA	12	24	579	3,768	12	86.0%
TIDELANDS COMMUNITY HOSPICE HOUSE	7	GEORGETOWN	GEORGETOWN	NPA	12	12	249	2,304	12	52.6%
(AGAPE HOSPICE HOUSE OF HORRY COUNTY)	8	HORRY	CONWAY	PROP	(24)	(24)				
MERCY CARE HOSPICE HOUSE CONWAY	9	HORRY	CONWAY	NPA	14	14				
TOTAL					24	50	828	6,072	24	69.3%

LONG TERM FACILITIES:

CHERAW HEALTHCARE		CHESTERFIELD	CHERAW	PROP	120	120	55	43,019	120	88.2%
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	69	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 (BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	36	36	28	11,215	36	85.4%
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	(52)	(52)	53	29,891	88	93.2%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154	271	51,837	154	92.4%
OKHAIVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	57	29,559	88	92.1%
DARLINGTON COUNTY		TOTAL			366	366	409	122,652	366	91.8%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84	124	28,633	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%

REGION: III

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	73	46,796	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			775	775	1,298	283,162	775	93.0%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	58	26,567	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	36,348	249	42.2%
AGAPE REHABILITATION CTR CONWAY	10	HORRY	CONWAY	PROP	95	95	667	17,473	88.6	53.9%
BRIGHTWATER SKILLED NURSING CENTER	11	HORRY	MYRTLE BEACH	PROP	67	67	171	4,275	67	17.4%
CONWAY MANOR		HORRY	CONWAY	PROP	190	190	165	63,908	190	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	96.8%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88	358	29,915	88	93.1%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88	238	29,085	88	90.6%
MYRTLE BEACH MANOR	12	HORRY	MYRTLE BEACH	PROP	100	99	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	0	60			
SHEPHERD'S LANDING NURSING & REHAB CTR	14	HORRY	LITTLE RIVER	PROP	0	0	60			
HORRY COUNTY		TOTAL			884	973	2,726	259,186	887.6	80.0%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	129	42,662	120	97.6%
LEE COUNTY		TOTAL			120	120	129	42,662	120	97.5%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	60	28,939	88	90.1%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92	80	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	28,782	96	82.2%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	422	4,857	18	73.9%
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					3,906	3,984	6,503	1,209,824	3,085.5	85.3%

FOOTNOTES

2012-13 PLAN

REGION III

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 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.

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.

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS LIC BEDS	AVE	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	9,330	42,847	183	64.1%
AIKEN COUNTY		TOTAL			183	183	9,330	42,847	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	872	2,632	53	13.6%
BARNWELL COUNTY		TOTAL			53	53	872	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	(64)	(64)				
BEAUFORT COUNTY		TOTAL			262	262	14,438	55,096	262	57.6%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCK'S CORNER	PROP	50	50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA	0	100				
BERKELEY COUNTY		TOTAL			50	100				
BON-SECOURS ST. FRANCIS XAVIER		CHARLESTON	CHARLESTON	NPA	204	204	8,634	32,719	204	43.9%
EAST COOPER MEDICAL CENTER		CHARLESTON	MT PLEASANT	PROP	130	130	4,391	14,495	130	30.5%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	604	604	29,237	162,980	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	67,642	296	62.6%
RALPH H. JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED	(144)	(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%
SUMMERSVILLE MEDICAL CENTER		94	DORCHESTER	PROP	94	124	5,837	21,062	94	61.4%
DORCHESTER COUNTY	7	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		41	JASPER	PROP	41	41	1,483	5,060	38.4	36.0%
JASPER COUNTY	8	TOTAL			41	41	1,483	5,060	38.4	36.0%
REGIONAL MED CTR ORANGEBURG-CALHOUN		247	ORANGEBURG	CO	247	247	9,923	47,922	247	53.2%
ORANGEBURG COUNTY		TOTAL			247	247	9,923	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	32	228	9,829	59	45.6%
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		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		22	BLUFFTON	PROP	14	14	484	2,841	14	55.6%
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	484	2,841	14	55.6%
BEAUFORT COUNTY		TOTAL			14	14	484	2,841	14	55.6%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,436	22,106	82	73.9%
PALMETTO LOWCOUNTRY BEHAVIORAL HEALTH		CHARLESTON	CHARLESTON	PROP	70	70	1,901	17,792	70	69.6%
RALPH H. JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED	(36)	(36)				
CHARLESTON COUNTY		TOTAL			152	152	4,337	39,898	152	71.9%
COLLETON MEDICAL CENTER		4	WALTERBORO	PROP	4	4				

REGION: IV

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISS IONS	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	6,158	54,823	210	71.5%

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		CHARLESTON	AWENDAW	PROP	12	12	23	4,050	12	92.5%
PALMETTO PINES BEHAVIORAL HEALTH	14	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	3,659	23	43.6%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10	643	4,697	10	128.7%
TOTAL					51	51	2,173	14,909	51	80.1%

REHABILITATION FACILITIES:

PACE HEALTHCARE COMMONS	16	BEAUFORT	BLUFFTON	PROP	14	10	237	3,024	14	59.2%
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	237	3,024	14	59.2%
TOTAL					14	24	237	3,024	14	59.2%
ROPER HOSPITAL		CHARLESTON	CHARLESTON	NPA	52	52	1,152	15,221	52	90.2%
HEALTHSOUTH CHARLESTON	17	CHARLESTON	CHARLESTON	PROP	49	49	978	12,468	49	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	543	6,353	24	72.5%
ORANGEBURG COUNTY		TOTAL			24	24	543	6,353	24	72.5%
TOTAL					139	149	2,910	37,066	138.6	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	86	47	30,220	86	96.3%	
NHC HEALTHCARE N. AUGUSTA		AIKEN	N. AUGUSTA	PROP	192	192	262	60,488	192	86.1%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	271	40,826	132	84.7%	
UNIHEALTH POST-ACUTE - AIKEN		AIKEN	AIKEN	PROP	176	168	58,413	176	90.7%	
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	79.6%
ALLENDALE COUNTY		TOTAL			44	44	26	12,820	44	79.6%
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%

REGION: IV

INPATIENT INVENTORY

FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMISSIONS	PATIENT DAYS	AVERAGE LC BEDS	% OCCU RATE
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	74	26,301	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%
TOTAL					173	173	267	56,608	173	89.6%
BEAUFORT 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)		(14)	(14)				
NHC BLUFTON		BEAUFORT	BLUFTON	PROP	120	120	560	31,969	120	73.0%
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	136	15,510	69	61.6%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)		(8)	(8)				
TOTAL					491	611	1,435	133,621	491	74.6%
HEARTLAND HEALTH CARE CTR - CHARLESTON	20	BERKELEY	HANAHAN	PROP	135	135	470	36,208	135	73.5%
LAYE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88	50	30,112	88	93.7%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132	176	40,103	132	83.2%
TOTAL					355	355	696	106,423	355	82.1%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	106	39,252	120	89.6%
TOTAL					120	120	106	39,252	120	89.6%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	56	12,613	41	84.1%
(BISHOP GADSDEN EPISCOPAL HOME)		(CHARLESTON)	(CHARLESTON)		(9)	(9)				
FRANKE HEALTH CARE CENTER	21	CHARLESTON	CHARLESTON	NPA	44	44	119	8,314	24	94.6%
(FRANKE HEALTH CARE CENTER)		(CHARLESTON)	(CHARLESTON)		(0)	(0)				
HARVEST HEALTH & REHAB JOHNS ISLAND		CHARLESTON	CHARLESTON	NPA	132	132	148	46,366	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		CHARLESTON	MT PLEASANT	PROP	35	35	730	51,722	148	95.7%
LIFE CARE CENTER - CHARLESTON	10	CHARLESTON	N.CHARLESTON	PROP	148	132	115	46,567	132	96.7%
(LIFE CARE CENTER - CHARLESTON)		(CHARLESTON)	(MT PLEASANT)		(8)	(8)				
MOUNT PLEASANT MANOR		CHARLESTON	CHARLESTON	PROP	88	88	666	28,274	88	88.0%
NATIONAL HEALTH CARE CHARLESTON	23	CHARLESTON	CHARLESTON	PROP	160	160	163	55,172	160	94.2%
RIVERSIDE HEALTH & REHAB CENTER	24	CHARLESTON	CHARLESTON	PROP	176	176	297	60,865	176	94.7%
SANDPIPER REHAB & NURSING		CHARLESTON	MT PLEASANT	PROP	42	42	289	12,977	42	84.4%
SAVANNAH GRACE AT PALMS OF MT PLEASANT	25	CHARLESTON	MT PLEASANT	PROP	176	176	244	60,300	176	93.9%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	1,260	1,299	3,350	414,085	1,218	93.1%
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%
TOTAL					132	132	312	45,083	132	93.6%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERSVILLE	PROP	88	88	190	30,588	88	95.0%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERSVILLE	PROP	88	88	175	30,071	88	93.4%
PRESBYTERIAN HOME SUMMERSVILLE		DORCHESTER	SUMMERSVILLE	NPA	87	87	191	30,834	87	96.0%
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88	111	30,834	88	94.9%
TOTAL					351	351	667	91,483	351	94.9%
UNIHEALTH POST-ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	75	33,461	104	88.1%
TOTAL					104	104	75	33,461	104	88.1%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	49	28,455	88	88.6%
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	163	36,216	113	92.7%
METHODIST OAKS	27	ORANGEBURG	ORANGEBURG	NPA	132	122	311	36,839	132	76.5%
UNIHEALTH POST-ACUTE CARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	88	88	124	30,405	88	94.7%
TOTAL					383	383	720	125,658	383	87.6%
TOTAL					4,377	4,526	9,293	1,364,982	4,335	86.3%

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	21,811	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		
III	EAST COOPER MEDICAL CENTER		
III	ROPER HOSPITAL		
III	BON SECOURS ST FRANCIS XAVIER		
III	TRIDENT MEDICAL CENTER		
