2012 – 2013

SOUTH CAROLINA HEALTH PLAN

EFFECTIVE 11/9/12

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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.

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.

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

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

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

Chapter IV

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

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

Chapter V

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

Chapter VI

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

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

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.

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:

"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.

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

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. 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

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.

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	50,695	171				
	TOTAL	456,200	492,200	172,525	525	0.75	700	746	-46
GREER MEMORIAL HOSPITAL	<18	109,700	112,400	220	1				
	18-64	287,400	307,200	7,277	21				
	+65	59,100	72,600	4,619	16				
	TOTAL	456,200	492,200	12,116	37	0.65	58	82	-24
HILLCREST MEMORIAL HOSPITAL	<18	109,700	112,400	7	0				
	18-64	287,400	307,200	3,687	11				
	+65	59,100	72,600	2,974	10				
	TOTAL	456,200	492,200	6,668	21	0.65	32	43	-11
PATEWOOD MEMORIAL HOSPITAL	<18	109,700	112,400	62	0				
	18-64	287,400	307,200	1,167	3				
	+65	59,100	72,600	1,173	4				
	TOTAL	456,200	492,200	2,402	8	0.65	12	72	-60
SAINT FRANCIS - DOWNTOWN & (SAINT FRANCIS MILLENNIUM) 1	<18	109,700	112,400	315	1				
	18-64	287,400	307,200	22,500	66				
	+65	59,100	72,600	32,025	108				
	TOTAL	456,200	492,200	54,840	175	0.70	249	226	23
SAINT FRANCIS - EASTSIDE	<18	109,700	112,400	189	1				
	18-64	287,400	307,200	13,507	40				
	+65	59,100	72,600	2,805	9				
	TOTAL	456,200	492,200	16,501	50	0.65	76	93	-17
GREENVILLE COUNTY TOTAL							1,127	1,262	-135

2018 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2011 POP	2018 POP	2011 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	8,000	8,100	288	1				
	18-64	20,400	20,400	2,176	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	5,800	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	45,992	47,801	1,045	3				
	18-64	124,039	133,494	47,800	141				
	+65	23,165	30,120	38,993	139				
	TOTAL	193,196	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)
CAROLINA PINES REGIONAL	<18	16,600	16,200	1,094	3				
	18-64	42,300	42,000	9,848	27				
	+65	10,000	12,900	7,337	26				
	TOTAL	68,900	71,100	18,279	56	0.65	86	116	-30
MCLEOD MEDICAL CENTER - DARLINGTON	<18	16,600	16,200	0	0				
	18-64	42,300	42,000	599	2				
	+65	10,000	12,900	1,519	5				
	TOTAL	68,900	71,100	2,118	7	0.65	11	49	-38
DARLINGTON COUNTY TOTAL							97	165	-68
MCLEOD MEDICAL CENTER - DILLON	<18	8,500	8,200	586	2				
	18-64	19,300	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	18,700	24,100	0	0				
	TOTAL	137,900	144,300	2,207	6	0.65	9	20	-11
LAKE CITY COMMUNITY HOSPITAL	<18	33,800	34,200	101	0				
	18-64	85,400	86,000	1,847	5				
	+65	18,700	24,100	1,201	4				
	TOTAL	137,900	144,300	3,149	9	0.65	14	48	-34
MCLEOD REGIONAL MEDICAL CENTER	<18	33,800	34,200	7,404	21				
	18-64	85,400	86,000	58,238	161				
	+65	18,700	24,100	47,180	167				
	TOTAL	137,900	144,300	112,822	348	0.75	464	453	11
FLORENCE COUNTY TOTAL							793	831	-38
GEORGETOWN MEMORIAL HOSPITAL	<18	13,000	12,300	762	2				
	18-64	35,400	35,400	7,695	21				
	+65	12,500	17,800	14,859	58				
	TOTAL	60,900	65,500	23,316	81	0.65	125	131	-6
WACCAMAW COMMUNITY HOSPITAL	<18	13,000	12,300	417	1				
	18-64	35,400	35,400	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	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				
	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 COOUNTY 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
SUMMERVILLE MEDICAL CENTER	<18	155,500	161,600	454	1				
	18-64	434,900	439,600	11,672	32				
	+65	79,900	108,700	8,936	33				
	TOTAL	670,300	709,900	21,062	67	0.65	103	124	-21
MUSC MEDICAL CENTER	<18	155,500	161,600	28,715	82				
	18-64	434,900	439,600	94,369	261				
	+65	79,900	108,700	39,876	149				
	TOTAL	670,300	709,900	162,960	492	0.75	656	604	52
ROPER, ROPER ST FRANCIS MT PLEASANT & ROPER ST FRANCIS - BERKELEY 7	<18	155,500	161,600	81	0				
	18-64	434,900	439,600	32,474	90				
	+65	79,900	108,700	39,667	148				
	TOTAL	670,300	709,900	72,222	238	0.75	317	401	-84
BON SECOURS ST FRANCIS XAVIER	<18	155,500	161,600	296	1				
	18-64	434,900	439,600	19,463	54				
	+65	79,900	108,700	12,960	48				
	TOTAL	670,300	709,900	32,719	103	0.70	148	204	-56

HOSPITAL OCCUPANCY RATES

	2009	2010	2011
REGION I	**53.5**	**52.1**	**52.6**
ANMED HEALTH MEDICAL CENTER	49.2	48.8	49.7
ANMED HEALTH WOMEN'S & CHILDREN'S	30.5	28.9	27.8
UPSTATE CAROLINA MEDICAL CENTER	38.2	31.5	27.8
GREENVILLE MEMORIAL MEDICAL CTR	62.6	61.4	63.4
GREER MEMORIAL	55.1	40.0	40.5
HILLCREST MEMORIAL HOSPITAL	41.8	43.7	42.5
PATEWOOD MEMORIAL	11.1	10.3	9.1
SAINT FRANCIS - DOWNTOWN	71.4	65.5	66.5
SAINT FRANCIS - EASTSIDE	53.1	50.6	48.6
OCONEE MEMORIAL HOSPITAL	48.0	48.4	47.4
CANNON MEMORIAL HOSPITAL	18.1	19.6	19.9
BAPTIST MEDICAL CENTER EASLEY	46.8	47.5	51.0
MARY BLACK MEMORIAL HOSPITAL	41.9	42.3	41.5
SPARTANBURG REGIONAL MEDICAL CTR	71.8	74.2	74.5
VILLAGE HEALTHCARE CENTRE	18.0	30.6	30.0
WALLACE THOMSON HOSPITAL	18.1	17.8	19.1
REGION II	**57.4**	**55.7**	**55.0**
ABBEVILLE AREA MEDICAL CENTER	28.0	31.7	28.9
CHESTER REGIONAL MEDICAL CENTER	23.3	19.1	16.2
EDGEFIELD COUNTY HOSPITAL	19.2	13.3	14.9
FAIRFIELD MEMORIAL HOSPITAL	32.0	33.1	22.3
SELF REGIONAL HEALTHCARE	42.8	39.8	42.8
KERSHAW HEALTH	60.5	54.1	56.6
SPRINGS MEMORIAL HOSPITAL	52.4	39.6	44.0
LAURENS COUNTY HOSPITAL	43.2	42.9	43.9
LEXINGTON MEDICAL CENTER	68.2	63.8	58.1
NEWBERRY COUNTY MEM HOSPITAL	30.5	24.7	24.3
PALMETTO HEALTH BAPTIST	53.4	52.2	53.3
PALMETTO HEALTH RICHLAND	78.1	80.8	80.0
PROVIDENCE HOSPITAL	55.4	55.4	49.5
PROVIDENCE HOSPITAL NORTHEAST	61.3	51.6	52.7
PIEDMONT MEDICAL CENTER	57.1	58.0	62.1

	2009	2010	2011
REGION III	**57.0**	**54.3**	**54.1**
CHESTERFIELD GENERAL HOSPITAL	47.8	42.5	38.0
CLARENDON MEMORIAL HOSPITAL	66.0	60.9	55.6
CAROLINA PINES REGIONAL MED CTR	71.0	53.2	43.2
MCLEOD MED CTR - DARLINGTON	12.3	17.9	11.8
MCLEOD MED CTR - DILLON	36.8	41.5	34.0
CAROLINAS HOSPITAL SYSTEM	53.5	60.4	61.3
LAKE CITY COMMUNITY HOSPITAL	24.7	18.5	18.0
MCLEOD REGIONAL MEDICAL CENTER	68.5	70.5	68.2
WOMEN'S CENTER CAROLINAS HOSP	47.7	39.1	30.2
GEORGETOWN MEMORIAL HOSPITAL	57.3	54.0	48.6
WACCAMAW COMMUNITY HOSPITAL	87.4	57.8	62.5
CONWAY HOSPITAL	61.3	58.8	57.3
GRAND STRAND REGIONAL MED CTR	72.0	76.7	80.4
LORIS COMMUNITY HOSPITAL	43.0	39.4	35.0
SEACOAST	—	—	29.1
MARION REGIONAL HOSPITAL	39.0	29.8	26.9
MARLBORO PARK HOSPITAL	12.3	14.4	15.4
TUOMEY	64.6	63.3	63.8
WILLIAMSBURG REGIONAL HOSPITAL	16.4	38.0	24.8
REGION IV	**56.7**	**55.7**	**54.9**
AIKEN REGIONAL MEDICAL CENTER	60.3	61.8	64.1
ALLENDALE COUNTY HOSPITAL	13.6	10.3	8.9
BAMBERG COUNTY MEMORIAL HOSP	14.2	20.5	10.0
BARNWELL COUNTY HOSPITAL	12.4	14.5	13.6
BEAUFORT MEMORIAL HOSPITAL	65.5	60.4	60.2
HILTON HEAD REGIONAL MEDICAL CTR	56.2	53.8	53.0
SUMMERVILLE MEDICAL CENTER	60.6	65.4	61.4
BON SECOURS ST FRANCIS XAVIER	47.5	43.8	43.9
EAST COOPER MEDICAL CENTER	46.5	33.8	30.5
MUSC MEDICAL CENTER	68.7	72.5	73.9
ROPER HOSPITAL	54.9	51.5	59.3
ROPER MOUNT PLEASANT HOSPITAL	—	12.3	12.2
TRIDENT MEDICAL CENTER	65.8	64.9	62.6
COLLETON MEDICAL CENTER	47.8	43.7	44.8
HAMPTON REGIONAL MEDICAL CENTER	31.9	32.5	31.6
COASTAL CAROLINA MEDICAL CENTER	33.6	37.5	36.0
REG MED CTR ORANGEBURG/CALHOUN	57.5	56.1	53.2

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

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;

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.

Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1,500 grams. A board-eligible pediatrician must be in the hospital or on site within 30 minutes, 24 hours a day and the hospital must have at least a written consultative agreement with a board eligible neonatologist. These hospitals manage a three year average of at least 500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. CON review is not required for a Level II program.

Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. A board-eligible neonatologist must be in the hospital or on site within 30 minutes, 24 hours a day. These hospitals manage a three year average of at least 1,200 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services.

Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, these hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified perinatologist shall be available for supervision and consultation, 24 hours a day. Level III hospitals have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. A board-certified maternal-fetal medicine specialist (perinatologist) must be in the hospital or on site within 30 minutes, 24 hours a day. RPCs participate in residency programs for obstetrics, pediatrics, and/or family practice. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

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

Perinatal Region	Existing Bassinets Intensive	Existing Bassinets 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

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.

INTERMEDIATE BASSINET NEED

Hospital	Intermed Bassinets	2011 Pt Days	Intermed ADC	Occupancy Factor	Projected Need	To Be Added
AnMed Health Women's	7	929	3	0.65	4	-3
Greenville Memorial	42	15,834	43	0.65	67	25
St. Francis-Eastside	10	1,154	3	0.65	5	-5
Spartanburg Regional	22	2,360	6	0.65	10	-12
Mary Black Memorial	8	470	1	0.65	2	-6
Self Regional	11	1,984	5	0.65	8	-3
Aiken Regional Med Ctr	8	289	1	0.65	1	-7
Springs Memorial Hosp	4	829	2	0.65	3	-1
Lexington Medical Ctr	20	2,474	7	0.65	10	-10
Reg Med Ctr Orangeburg	10	2,995	8	0.65	13	3
Palmetto Health Baptist	22	3,670	10	0.65	15	-7
Palmetto Health Richland	38	10,845	30	0.65	46	8
Tuomey	8	399	1	0.65	2	-6
Piedmont Medical Ctr	12	1,367	4	0.65	6	-6
Carolina Pines Regional	4	69	0	0.65	0	-4
McLeod Regional Med Ctr	28	5,147	14	0.65	22	-6
Women's Ctr Carolinas	11	811	2	0.65	3	-8
Conway Hospital	6	457	1	0.65	2	-4
Grand Strand Regional	2	445	1	0.65	2	0
Beaufort Memorial Hosp	5	49	0	0.65	0	-5
Bon Secours-St. Francis	11	992	3	0.65	4	-7
East Cooper Med Ctr	10	756	2	0.65	3	-7
MUSC Medical Center	35	12,232	33	0.65	51	16
Roper Hospital	5	393	1	0.65	2	-3
Trident Medical Center	10	2,279	6	0.65	10	0
Georgetown Memorial	5	198	1	0.65	1	-4
Waccamaw Community	2	222	1	0.65	1	-1
Totals	356	69,649	190		293	-63

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.

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.

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

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.

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

CHAPTER V

REHABILITATION FACILITIES

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed that froze this threshold at 60% and allowed co-morbid conditions to be counted.

Most general hospitals and other health care facilities offer physical rehabilitation services such as physical therapy, occupational therapy, speech therapy, or occupational therapy without the involvement of a formal interdisciplinary program. In addition, some hospitals have consolidated their rehabilitation services into a single unit to improve the coordination of care for acute patients in their facilities. These consolidations are intended to improve the quality of care for patients currently being treated in the facility and are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan.

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2011 Occupancy	
I	AnMed Health Rehab	Anderson	55	92.3%	*1*
I	Roger C. Peace	Greenville	53	59.3%	
I	St. Francis	Greenville	19	84.4%	
I	Mary Black	Spartanburg	18	57.2%	
I	Spartanburg Rehab	Spartanburg	28	---	*2*
II	Greenwood Rehab Hosp	Greenwood	42	86.8%	*3*
II	HealthSouth Columbia	Richland	96	57.8%	
II	HealthSouth Rock Hill	York	50	80.4%	*4*
III	HealthSouth Florence	Florence	88	49.5%	
III	Carolinas Hospital	Florence	42	75.3%	
III	Waccamaw Community	Georgetown	43	87.9%	
IV	Beaufort Memorial	Beaufort	14	59.2%	
IV	PACE Healthcare	Beaufort	10	---	*5*
IV	HealthSouth Charleston	Charleston	49	74.3%	*6*
IV	Roper Hospital	Charleston	52	80.2%	
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	72.5%	

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								

CHAPTER VI

Alcohol and Drug Abuse Facilities

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

A. Outpatient Facilities:

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 74 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 101 locations.

Certificate of Need Standards

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

B. Social Detoxification Facilities:

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93.

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.

Certificate of Need Standards

1. Need projections are calculated by service area.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.

4. Because a minimum of 10 beds is needed for an inpatient program, a 10-bed unit may be approved in an area that does not have any existing beds provided the applicant can document the need.

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

6. The establishment of a regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area without existing services with another service area providing this other service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to used to form a regional treatment facility.

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

Relative Importance of Project Review Criteria

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

1. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);

3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently, 11 inpatient treatment facilities are located in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

F. Narcotic Treatment Programs:

Note: Narcotic treatment programs were added back under CON review by the General Assembly in 2011 after being removed during the 2010 CON law revisions.

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, suboxone and buprenorphine to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client's needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider. Narcotic treatment programs are described in Section 3200 of Regulation Number 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

An average charge for medication would be approximately $12 per day or $70 per week. In South Carolina a Registered Pharmacist must dispense the medication. Therefore, because of the staffing and associated costs with providing this care, it requires providers to have a minimum caseload of around 150 clients to break even on the costs of providing this service.

There are currently 16 licensed programs in the state:

Region	Facility	County
I	Southwest Carolina Treatment Center	Anderson
I	Crossroads Treatment Center of Greenville	Greenville
I	Greenville Metro Treatment Center	Greenville
I	Crossroads Treatment Center	Oconee
I	Recovery Concepts of the Carolina Upstate	Pickens

CHAPTER VII

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS

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

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

Region	Facility	County	Beds	FY 2011 Occ. Rate	
I	Excalibur Youth Services	Greenville	60	54.5%	
I	Generations	Greenville	30	---	*1*
I	Marshall Pickens	Greenville	22	95.5%	
I	Springbrook Behavioral	Greenville	68	81.0%	
I	Avalonia Group Homes	Pickens	55	65.1%	
II	Three Rivers Behavioral	Lexington	20	95.0%	
II	Three Rivers – Midlands	Lexington	59	94.0%	
II	Carolina Children's Home	Richland	30	33.3%	*2*
II	Directions (DMH)	Richland	37	28.6%	*3*
II	New Hope Carolinas	York	150	92.6%	
II	York Place Episcopal	York	40	57.0%	
III	Palmetto Pee Dee	Florence	59	80.9%	
III	Lighthouse of Conway	Horry	30 (18)	71.3%	*4*
III	Willowglen Academy	Williamsburg	40 (54)	72.2%	*5*
IV	Palmetto Low Country	Charleston	32	78.8%	
IV	Riverside at Windwood	Charleston	12	92.5%	*6*
IV	Palmetto Pines Behavioral	Dorchester	60	79.5%	
IV	Pinelands RTC	Dorchester	14 (28)	52.3%	*7*
	Total (Does Not Include Directions)		781 (797)	77.3%	

1 Exempted to convert from a Group Home to an RTF. Licensed 8/25/11.

2 Licensed for 20 RTF beds 6/16/09; licensed 10 additional beds for a total of 30, 1/20/11.

Certificate of Need Standards

1. Except in the case of high management group homes that received exemption from CON through Health and Human Services Budget Proviso 8.35, the establishment or expansion of an RTF requires a CON.

2. The applicant must document the need for the expansion of or the addition of an RTF based on the most current utilization data available. The existing resources must be considered and documentation presented as to why these resources are not adequate to meet the needs of the community.

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

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

5. The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.

6. The applicant agrees to provide utilization data on the operation of the facility to the Department.

The bed need methodology to be used in South Carolina is based upon a standard of 41.4 beds per 100,000 children. Since few, if any, children under 5 years of age would be candidates for this type of care, the bed need will be based on the population age 5-21. The projected bed needs by service area are as follows:

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

Facilities:		
	Avalonia Group Homes	55 beds
	Excalibur Youth Services	60
	Generations – Bridges	10
	Generations – Horizons	20
	Marshall Pickens	22
	Springbrook Behavioral	68
	Total	235 beds

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

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

Facilities:		
	Palmetto Low Country	32 beds
	Palmetto Pines Behavioral	60
	Pinelands RTC	28
	Riverside at Windwood	12
	Total	132 beds

2018 Population Age 5-21:	274,800
41.4 Beds/100,000 Population:	x .000414
	114 beds
	- 132 beds
Need Shown:	(18) beds

The Directions program primarily serves court-ordered patients from the Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it is not included in the regional inventories for bed need calculations.

Relative Importance of Project Review Criteria

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

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

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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

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.

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

2. Scope of Services:

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

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

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

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

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

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

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

200 equivalents at the applicant's facility by the end of the third year of operation). In addition:

A. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 500 diagnostic equivalents per year;

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

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

Emergent and Elective PCI Without On-Site Cardiac Backup

7. In 2005, the ACCF/AHA/SCAI Writing Committee determined that Emergency PCI (Primary PCI) is reasonable in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished. Hospitals with diagnostic laboratories may be approved to perform emergency PCI without an on-site open heart surgery program only if all of the following criteria based on the 2005 ACC/AHA Guideline Update for PCI are met:

A. Therapeutic catheterizations must be limited to Percutaneous Coronary Interventions (PCIs) performed only in emergent circumstances (Primary PCIs). Elective PCI may not be performed at institutions that do not provide on-site cardiac surgery except as provided for in Standard 8 below.

B. The applicant has performed a minimum of 250 diagnostic cardiac cath procedures in the most recent year and can reasonably demonstrate that it will perform a minimum of 500 diagnostic catheterizations annually within three years of the initiation of services.

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

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

E. An application shall be approved only if it is consistent with the criteria from Smith et al., ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) and the 2007 Focused Update of the guidelines. A complete copy of the guidelines can be found at: www.acc.org/clinical/guidelines/ percutaneous/update/index.pdf

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

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

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

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY	# CATH LABS	2009 ADULT DIAG	2009 ADULT THERP	2009 ADULT TOTAL EQUIV	2009 PED DIAG	2009 PED THERP	2009 PED OTHER	2009 PED TOTAL	2010 ADULT DIAG	2010 ADULT THERP	2010 ADULT TOTAL EQUIV	2010 PED DIAG	2010 PED THERP	2010 PED OTHER	2010 PED TOTAL	2011 ADULT DIAG	2011 ADULT THERP	2011 ADULT TOTAL EQUIV	2011 PED DIAG	2011 PED THERP	2011 PED OTHER	2011 PED TOTAL
I																						
ANMED HEALTH MEDICAL CENTER [1]	4	1,907	1,301	4,509					1,911	1,230	4,371					2,086	1,152	4,390				
GREENVILLE MEMORIAL HOSPITAL	7	2,858	2,302	7,462					2,628	2,061	6,750					3,047	2,617	8,281				
SAINT FRANCIS - DOWNTOWN [2]	4	2,077	1,401	4,879					2,275	1,418	5,111					1,961	1,174	4,309				
OCONEE MEMORIAL HOSPITAL	1	776		776					667		667					675		675				
BAPTIST MED CTR-EASLEY [3]	1	400		400					368		368					292		292				
MARY BLACK MEMORIAL	1	150		150					106		106					105		105				
SPARTANBURG REGIONAL MEDICAL CTR	4	2,289	964	4,227					2,500	928	4,356					2,067	850	3,767				
VILLAGE HOSPITAL [4]	1																	0				
TOTAL REGION I	22	10,467	5,968	22,403					10,455	5,637	21,729					10,233	5,793	21,819				
II																						
CHESTER REGIONAL MEDICAL CENTER	MOBILE	95		95					110		110					27		27				
SELF REGIONAL HEALTHCARE	2	1,137	396	1,929					1,035	406	1,847					1,038	407	1,852				
KERSHAWHEALTH	1	507		507					461		461					540		540				
SPRINGS MEMORIAL HOSPITAL	1	567		567					489		489					413		413				
LEXINGTON MEDICAL CENTER [5]	2	1,242	16	1,274					1,293	54	1,401					1,419	157	1,733				
PALMETTO HEALTH BAPTIST	1	293		293					320		320					277		277				
PALMETTO HEALTH RICHLAND	4	3,338	1,245	5,828					3,169	1,134	5,437					2,675	1,155	4,985				
PROVIDENCE HOSPITAL	6	3,474	2,700	8,874					3,332	2,742	8,816					3,213	2,543	8,299				
PIEDMONT MEDICAL CENTER	3	1,422	759	2,940					1,328	762	2,852					1,480	715	2,910				
SOUTH CAROLINA HEART CENTER [6]	2	1,750		1,750					NO 2010 DATA REPORTED							NO 2011 DATA REPORTED						
TOTAL REGION II	23	13,825	5,116	24,057					11,538	5,099	21,733					11,082	4,977	21,036				
III																						
CAROLINA PINES REGIONAL MEDICAL CTR	1	62		62					NO 2010 DATA REPORTED							30		30				
CAROLINAS HOSPITAL SYSTEM	2	2,406	547	3,500					1,228	240	1,708					996	257	1,510				
MCLEOD REGIONAL MEDICAL CENTER	5	1,504	595	2,694					1,640	619	2,878					1,433	573	2,579				
GEORGETOWN MEMORIAL HOSPITAL	1	611	63	737					696	77	850					747	73	893				
CONWAY HOSPITAL	1	585		585					621		621					584		584				
GRAND STRAND REGIONAL MED CTR [7]	3	1,057	667	2,391					1,238	829	2,896					1,158	818	2,794				
LORIS COMMUNITY HOSPITAL	1	247		247					328		328					231		231				
TUOMEY	1	281		281					204		204					185		185				
TOTAL REGION III	16	6,753	1,872	10,497					5,955	1,765	9,485					5,364	1,721	8,806				
IV																						
AIKEN REGIONAL MEDICAL CENTER	1	519	243	1,005					448	279	1,006					945	378	1,701				
BEAUFORT MEMORIAL HOSPITAL	1	482		482					494		494					681		681				
HILTON HEAD HOSPITAL	2	478	240	958					454	231	916					406	210	826				
COLLETON MEDICAL CENTER	MOBILE	0		0					0		0							0				
BON SECOURS ST. FRANCIS XAVIER	1	0		0					2		2					7		7				
MUSC MEDICAL CENTER [6]	7	1,517	1,184	3,885	252	241	130	1,357	1,694	1,227	4,148	266	252	133	1,421	1,734	1,262	4,258	260	219		1,177
ROPER HOSPITAL	3	1,943	910	3,763					1,904	982	3,868					1,776	929	3,634				
TRIDENT MEDICAL CENTER	2	1,429	370	2,169					1,321	464	2,249					1,326	421	2,168				
REG MED CTR ORANGEBURG-CALHOUN	1	400		400					271		271					247		247				
RALPH HENRY VA MED CTR CHARLESTON	(1)																					
TOTAL REGION IV	19	6,768	2,947	12,662	252	241	130	1,357	6,588	3,183	12,954	266	252	133	1,421	7,122	3,200	13,522	260	219		1,177
STATEWIDE TOTALS	79	37,813	15,903	69,619	252	241	130	1,357	34,536	15,684	66,901	266	252	133	1,421	33,801	15,691	65,183	260	219		1,177

1 CON ISSUED 5/14/09 FOR A 4TH CATH LAB, SC-09-24.
2 CON ISSUED 7/8/09 FOR A 4TH CATH LAB, SC-09-34; OPERATIONAL 12/30/09.
3 CON ISSUED 6/2/06 TO ALLOW EMERGENT PCI.
4 CON ISSUED 11/22/10 FOR A DIAGNOSTIC LAB, SC-10-34.
5 CON ISSUED 5/12/09 TO ADD 2ND LAB & ALLOW EMERGENT PCI, SC-09-23. CON ISSUED 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.

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

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.

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.

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

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;

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.

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.

MEGAVOLTAGE VISITS

REGION & FACILITY		COUNTY	# UNITS	FY 2009	FY 2010	FY 2011
REGION I						
ANMED HEALTH MEDICAL CENTER	1	ANDERSON	2	12,449	11,923	11,643
GIBBS REGIONAL CANCER CTR SATELLITE	2	CHEROKEE	1	---	---	---
GMH-CANCER CENTERS OF THE CAROLINAS		GREENVILLE	1	4,834	5,325	4,848
GMH-CANCER CENTERS CAROLINAS - EASTSIDE			1	9,487	7,678	6,875
GREENVILLE MEMORIAL MEDICAL CENTER			3	15,433	16,846	14,838
GREER MEDICAL CAMPUS CANCER CTR	3		1	---	4,340	4,753
ST FRANCIS MILLINIUM CANCER CENTER	4		1	---	---	---
GMH-CANCER CTRS CAROLINAS - OCONEE CO.		OCONEE	1	6,279	5,402	6,173
BAPTIST MEDICAL CENTER EASLEY	5	PICKENS	1	---	---	---
CANCER CTRS CAROLINAS - MARY BLACK	6	SPARTANBURG	1	---	---	656
SPARTANBURG REGIONAL MED CTR			2	18,512	19,525	17,298
VILLAGE AT PELHAM CANCER CENTER	7		1	---	---	---
REGION II						
SELF REGIONAL HEALTHCARE		GREENWOOD	2	6,747	7,688	7,782
LANCASTER RADIATION THERAPY CTR	8	LANCASTER	1	---	---	4,104
LEXINGTON MEDICAL CENTER		LEXINGTON	2	10,433	10,431	11,953
NEWBERRY ONCOLOGY ASSOCIATES	9	NEWBERRY	1	---	2,565	2,307
PALMETTO HEALTH RICHLAND		RICHLAND				
LINEAR ACCELERATORS			2	14,107	11,783	10,754
GAMMA KNIFE			1	210	218	199
SOUTH CAROLINA ONCOLOGY ASSOCIATES			4	22,671	21,463	21,817
ROCK HILL RADIATION THERAPY CENTER		YORK	2	13,416	13,358	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	15	CHARLESTON				
LINEAR ACCELERATORS			5	18,184	18,707	20,290
GAMMA KNIFE			1		47	163

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.

CHAPTER X

POSITRON EMISSION TECHNOLOGY

A. POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. The tracer nucleotide most frequent used is FDG (Fluorodeoxyglucose). PET allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. The isotopes only have about a two-hour half-life and are quickly expelled from the body.

PET was developed in the 1970s and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent research has centered on the diagnosis and staging of cancer and neurological applications such as epilepsy, Alzheimer's and Parkinson's diseases. PET is covered for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurology; and heart disease uses.

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. The process requires a nuclear medical technologist certified for both PET and CT or dually certified in radiography.

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2,000,000-$2,7000,000 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000. Charges vary from around $2,500 - $4,000 depending on the type and location of the scan.

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

The operational or approved PET scanners in the state are listed on the following pages.

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.

(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.

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.

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

2011 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,459	875	5,334	1,778		
Bearwood Ambulatory Surgery Center	Anderson	1		1	521		521	521		
Physician Surgery Center at AnMed Health	Anderson	3		3	2,193		2,193	731		
Upstate Endoscopy Center	Anderson		2	2		4,327	4,327		2,164	
Bon Secours St Francis Surgery Center	Greenville	2		2	1,862		1,862	931		1
Cross Creek Surgery Center	Greenville	4		4	3,915		3,915	979		
Endoscopy Center of the Upstate	Greenville		3	3		3,397	3,397		1,132	
Greenville Endoscopy Center	Greenville		3	3		6,087	6,087		2,029	
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,524	6,524		2,175	
GHS Outpatent Surgery Center – Patewood	Greenville	6	2	8	5,890	2,504	8,394	982	1,252	
Greenville Surgery Center	Greenville	4		4	3,723		3,723	931		
Jervey Eye Center	Greenville	3		3	3,562		3,562	1,187		
Upstate Surgery Center	Greenville	2		2	2,817		2,817	1,409		
Blue Ridge Surgery Center	Oconee	2		2	2,052		2,052	1,026		
Synergy Spine Center	Oconee	2		2	408		408	204		2
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	6,653	3,136	9,789	950	1,568	
Spartanburg Surgery Center	Spartanburg	4		4	4,053		4,053	1,013		3
Surgery Center at Pelham	Spartanburg	4	2	6	2,730	1,210	3,940	683	605	
Westside Eye Center	Spartanburg	2		2	1,338		1,338	669		
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		8,180	8,180		2,045	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region III:										
Darlington Endoscopy Center	Darlington		2	2		520	520		260	
Florence Surgery & Laser Center	Florence	2		2	3,304		3,304	1,652		
McLeod Ambulatory Surgery Center	Florence	2		2	1,896		1,896	948		
Physicians Surgical Center of Florence	Florence	4	2	6	3,711	2,337	6,048	928	1,169	
Bay Microsurgical Unit	Georgetown	1		1	3,753		3,753	3,753		
Murrell's Inlet Ambulatory Surgery Center	Georgetown	2		2						*9*
(Waccamaw Endoscopy Center)	Georgetown		(0)	(0)						*10*
Waccamaw Surgery Center	Georgetown	1		1	2,138		2,138	2,138		*11*
Carolina Bone and Joint Surgery Center	Horry	3		3	2,811		2,811	937		*12*
Grande Dunes Surgery Center	Horry	3	2	5	3,226	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		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	2,112	1,659	3,771	528	1,659	
Carolina Ambulatory Surgery Center	Aiken	1		1	2,676		2,676	2,676		
Blufton-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*

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.

(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").

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.

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

OCONEE 399
PICKENS 269
GREENVILLE 625
SPARTANBURG 389
CHEROKEE 81
YORK 500
UNION 2
CHESTER 107
LANCASTER 235
CHESTERFIELD 61
MARLBORO 50
ANDERSON 343
LAURENS 32
FAIRFIELD (90)
KERSHAW 154
DARLINGTON 79
DILLON (12)
ABBEVILLE 85
GREENWOOD 102
NEWBERRY 5
LEE (7)
MARION 31
McCORMICK 9
SALUDA (36)
RICHLAND 367
FLORENCE 60
HORRY 1,242
EDGEFIELD 56
LEXINGTON 505
SUMTER 168
CALHOUN (3)
CLARENDON 133
WILLIAMSBURG 73
AIKEN 345
ORANGEBURG 241
GEORGETOWN 332
BARNWELL (25)
BAMBERG 25
BERKELEY 565
DORCHESTER 359
ALLENDALE 18
COLLETON 145
HAMPTON 29
CHARLESTON 768
JASPER 45
BEAUFORT 1,050

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	

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.

F. Swing Beds:

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified to participate in Medicare.

The Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt] permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. The Code of Federal Regulations (CFR) section 42 details the other specific program requirements

Medicare Part A covers the services furnished in a swing bed hospital under the SNF PPS. The PPS classifies residents into one of 44 categories for payment purposes. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a stay of at least three consecutive days, although it does not have to be from the same hospital as the swing bed. Typical medical criteria include daily physical, occupational and/or speech therapy, IV or nutritional therapy, complex wound treatment, pain management, and end-of-life care.

The following hospitals in South Carolina participated in the swing bed program during 2011:

Hospital		Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Medical Ctr.		25	9	36	0.1
Allendale County Hospital		15	87	2,386	6.6
Bamberg County Memorial		24	13	135	0.4
Chesterfield General		49	33	307	0.8
Coastal Carolina	*1*	10			
Edgefield Co. Hospital		25	93	1,108	3.0
Fairfield Memorial		25	67	912	2.5
Hampton Regional Hospital	*2*	10			
Marlboro Park Hospital	*1*	6			
McLeod-Darlington		24	165	2,262	14.4
Newberry County Memorial		20	8	39	0.1
Wallace Thompson	*1*	12			
Williamsburg Regional		10	259	4,085	11.2
TOTALS		255	734	11,270	30.8

1 Participates in the program but did not use the beds in 2011.

2 Unit established 9/28/11.

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		LAURENS	12	133	1,340	30.6%
(ASCENSION HOUSE)	*1*	RICHLAND	(14)			
AGAPE HOSPICE HOUSE OF THE MIDLANDS	*2*	RICHLAND	12			
HOSPICE AND COMMUNITY CARE HOUSE		YORK	16	247	2,060	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.

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

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

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.

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

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**

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.

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
HOSPITALS:								
THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38		
LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10		
SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50	458	940
W.J. BARGE MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	79	90		
LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20		
SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		
GEO CARE OF SOUTH CAROLINA		RICHLAND	COLUMBIA	PROP	196	196		
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	11	11		
KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24		
WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8		
CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22		
TOTAL					450	461	458	940
MENTAL HOSPITALS:								
PATRICK B HARRIS PSYCHIATRIC		ANDERSON	ANDERSON	ST	200	200	878	41,266
G WERBER BRYAN PSYCHIATRIC HOSP		RICHLAND	COLUMBIA	ST	492	492	758	67,339
GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87		
(SC STATE HOSPITAL)	1	RICHLAND	COLUMBIA	ST	(0)	(0)		
WM J MCCORD ADOLESCENT TREAT	2	ORANGEBURG	ORANGEBURG	ST	15	15	118	5,111
WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89	389	5,613
TOTAL					883	883	2,143	119,329
RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:								
DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37	24	3,860
TOTAL					37	37	24	3,860
DRUG & ALCOHOL INPT TREATMENT:								
PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48		
HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36		
(WM J MCCORD ADOLESCENT TREAT)	2	ORANGEBURG	ORANGEBURG	ST	(0)	(0)		
WILLIAM S HALL		RICHLAND	COLUMBIA	ST	19	19	49	5,554
MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	163	163	1,512	40,710
TOTAL					266	266	1,561	46,264
LONG TERM FACILITIES:								
RICHARD M CAMPBELL VA NURS HOME		ANDERSON	ANDERSON	ST	220	220	132	85,778
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14	46	3,995
PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8	16	1,798
BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	13	2,768
THE FRANKE HEALTH CARE CTR	3	CHARLESTON	MT PLEASANT	NPA	(0)	(0)	98	6,928
VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	93	79,193

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.

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
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	14,791	76,738	423	49.7%
ANMED HEALTH WOMEN'S & CHILDREN'S HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,221	7,307	72	27.8%
ANDERSON COUNTY		TOTAL			495	495	18,012	84,045	495	46.5%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125	3,338	12,667	125	27.8%
CHEROKEE COUNTY		TOTAL			125	125	3,338	12,667	125	27.8%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	746	746	32,426	172,525	746	63.4%
GREER MEMORIAL HOSPITAL		GREENVILLE	GREER	NPA	82	82	3,603	12,116	82	40.5%
HILLCREST MEMORIAL HOSPITAL		GREENVILLE	SIMPSONVILLE	NPA	43	43	2,002	6,668	43	42.5%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,067	2,402	72	9.1%
SAINT FRANCIS - DOWNTOWN	1	GREENVILLE	GREENVILLE	NPA	226	226	12,021	54,840	226	66.5%
(SAINT FRANCIS MILLENNIUM)	1	GREENVILLE	GREENVILLE	NPA		(0)				
SAINT FRANCIS - EASTSIDE		GREENVILLE	GREENVILLE	NPA	93	93	5,814	16,501	93	48.6%
GREENVILLE COUNTY		TOTAL			1,262	1,262	58,933	265,052	1,262	57.5%
OCONEE MEDICAL CENTER		OCONEE	SENECA	NPA	169	169	7,290	29,234	169	47.4%
OCONEE COUNTY					169	169	7,290	29,234	169	47.4%
BAPTIST EASLEY HOSPITAL		PICKENS	EASLEY	NPA	109	109	4,771	20,307	109	51.0%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	55	55	948	3,999	55	19.9%
PICKENS COUNTY		TOTAL			164	164	5,719	24,306	164	40.6%
MARY BLACK MEMORIAL HOSPITAL	2	SPARTANBURG	SPARTANBURG	PROP	176	174	6,399	26,679	176	41.5%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	484	484	25,829	131,537	484	74.5%
VILLAGE HOSPITAL		SPARTANBURG	GREER	CO	48	48	1,441	5,257	48	30.0%
SPARTANBURG COUNTY		TOTAL			708	706	33,669	163,473	708	63.3%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	2,633	9,955	143	19.1%
UNION COUNTY		TOTAL			143	143	2,633	9,955	143	19.1%
TOTAL					3,066	3,064	127,594	588,732	3,066.0	52.6%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS REST	NPA	45	45	281	8,566	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%
TOTAL					129	129	998	29,756	174	46.9%
MENTAL FACILITIES:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38	1,043	5,556	38	40.1%
ANDERSON COUNTY		TOTAL			38	38	1,043	5,556	38	40.1%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	3	GREENVILLE	GREENVILLE	PROP	98	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	48	46	1,370	13,970	46	83.2%
GREENVILLE COUNTY		TOTAL			173	187	4,237	47,016	167.2	77.0%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15	281	3,523	15	64.3%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56	588	5,303	56	25.9%
SPARTANBURG COUNTY		TOTAL			71	71	869	8,826	71	34.1%
TOTAL					282	296	6,149	61,398	276.2	60.9%

REGION: I

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LINVILLE COURTS AT CASCADES VERDAE	12	GREENVILLE	GREENVILLE	PROP	44	44	177	10,637	32	91.1%
(LINVILLE COURTS AT CASCADES VERDE)		GREENVILLE	GREENVILLE	PROP	(0)	(0)				
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	66	34,295	99	94.9%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	174	41,911	120	95.7%
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176	554	61,701	176	96.0%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	560	61,595	180	93.8%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	255	44,129	132	91.6%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125	358	42,062	125	92.2%
OMEGA HEALTH & REHAB GREENVILLE	10	GREENVILLE	GREENVILLE	PROP	79	0	90	26,600	79	92.2%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY	13	GREENVILLE	GREENVILLE	NPA	50	74	20	3,535	17	57.0%
(ROLLING GREEN VILLAGE HEALTH CARE FACILITY)		GREENVILLE	GREENVILLE	NPA	(0)	(0)				
GREENVILLE COUNTY		TOTAL			1,913	1,937	4,795	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	60	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	180	28,323	80	97.0%
PRESBYTERIAN HOME - FOOTHILLS	16	PICKENS	EASLEY	PROP	26	26	14	3,353	10.8	85.1%
(PRESBYTERIAN HOME - FOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
REDEEMER HEALTH & REHAB PICKENS	14	PICKENS	PICKENS	PROP	44	(0)	63	15,397	44	95.9%
PICKENS COUNTY		TOTAL			437	453	748	141,915	421.8	92.2%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	84	31,433	88	97.9%
EMERITUS AT SKYLYN HEALTH CARE CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33	56	10,570	33	87.8%
(EMERITUS AT SKYLYN HEALTH CARE CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)				
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44	43	14,598	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	17	SPARTANBURG	SPARTANBURG	PROP	88	120	188	30,739	88	95.7%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132	131	47,441	132	98.5%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75	235	21,535	75	78.7%
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	468	5,686	25	62.3%
SPARTANBURG REHABILITATION INSTITUTE	7	SPARTANBURG	SPARTANBURG	PROP		12				
SUMMIT HILLS NURSING CENTER		SPARTANBURG	SPARTANBURG	PROP	27	27	166	8,135	27	82.5%
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88	24	31,100	88	96.8%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88	166	31,141	88	97.0%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192	151	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%

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.

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.

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W J B DORN VA)	5	RICHLAND	COLUMBIA	FED		(60)				
RICHLAND COUNTY		TOTAL			154	154	2,434	23,673	154	42.1%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20	842	5,620	20	77.0%
YORK COUNTY		TOTAL			20	20	842	5,620	20	77.0%
TOTAL					291	321	5,302	52,359	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	50,690	150	92.6%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	43	8,325	40	57.0%
TOTAL					299	299	486	89,773	298.5	82.4%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
SPRINGS MEMORIAL HOSPITAL	1	LANCASTER	LANCASTER	NPA	18	18	0	0	18	0.0%
THREE RIVERS BEHAVIORAL HEALTH		LEXINGTON	WEST COLUMBIA	PROP	17	17	542	3,921	17	63.2%
PALMETTO HEALTH BAPTIST		RICHLAND	COLUMBIA	CO	10	10	0	0	10	0.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10	239	2,543	10	69.7%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24	0	0	24	0.0%
TOTAL					79	79	781	6,464	79	22.4%
REHABILITATION FACILITIES:										
GREENWOOD REGIONAL REHAB HOSPITAL	9	GREENWOOD	GREENWOOD	NPA	34	42	787	10,767	34	86.8%
GREENWOOD COUNTY		TOTAL			34	42	787	10,767	34	86.8%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96	1,546	20,242	96	57.8%
RICHLAND COUNTY		TOTAL			96	96	1,546	20,242	96	57.8%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	10	YORK	ROCK HILL	PROP	50	50	1,005	13,506	46	80.4%
YORK COUNTY		TOTAL			50	50	1,005	13,506	46	80.4%
TOTAL					180	188	3,338	44,515	176	69.3%
INPATIENT HOSPICE FACILITIES:										
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15	322	2,117	15	38.7%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE		LAURENS	CLINTON	PROP	12	12	133	1,340	12	30.6%
AGAPE HOSPICE HOUSE OF THE MIDLANDS	11	RICHLAND	COLUMBIA	PROP	12	12				
(ASCENSION HOUSE)	12	RICHLAND	IRMO	PROP	(0)	(0)				
HOSPICE AND COMMUNITY CARE		YORK	ROCK HILL	NPA	16	16	247	2,060	16	35.3%
TOTAL					55	55	702	5,517	43	35.2%
LONG TERM CARE FACILITIES:										
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94	32	32,789	94	95.6%
(CARLISLE NURSING CENTER)	13	ABBEVILLE	DUE WEST	NPA	22	(0)	10	3,740	22	46.6%
ABBEVILLE COUNTY		TOTAL			116	94	42	36,529	116	86.3%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100	191	29,986	100	82.2%
CHESTER COUNTY		TOTAL			100	100	191	29,986	100	82.2%
TRINITY MISSION EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120	72	40,858	120	93.3%
EDGEFIELD COUNTY		TOTAL			120	120	72	40,858	120	93.3%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	112	68	39,286	112	96.1%
UNIHEALTH POST ACUTE - TANGLEWOOD		FAIRFIELD	RIDGEWAY	PROP	150	150	140	48,641	150	88.8%
FAIRFIELD COUNTY		TOTAL			262	262	208	87,927	262	91.9%

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	250	20,787	66	86.3%
WHITE OAK OF ROCK HILL		YORK	ROCK HILL	PROP	141	141	124	49,148	141	95.5%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109	102	39,155	109	98.4%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40	104	5,151	40	35.3%
YORK COUNTY		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%

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

CATEGORY	NAME OF FACILITY
REGION II:	TRAUMA CENTERS
III	SELF MEM REGIONAL HEALTH CARE
III	LEXINGTON MEDICAL CENTER
I	PALMETTO HEALTH RICHLAND
III	PIEDMONT MEDICAL CTR

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	69,370	310	61.3%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLORENC	DIST	48	48	950	3,149	48	18.0%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	22,473	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	28,380	124	62.5%
GEORGETOWN COUNTY		TOTAL			255	255	13,045	51,696	255	55.4%
CONWAY HOSPITAL		HORRY	CONWAY	NPA	210	210	8,003	33,477	160	57.3%
GRAND STRAND REGIONAL MEDICAL CENTER	3	HORRY	MYRTLE BEACH	PROP	269	269	15,107	64,289	219	80.4%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105	3,290	13,432	105	35.0%
SEACOAST MEDICAL CENTER	4	HORRY	LITTLE RIVER	DIST	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	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	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	5	HORRY	CONWAY	PROP	59	59	1,448	13,628	44	84.9%
HORRY COUNTY		TOTAL			59	59	1,448	13,628	44	84.9%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8	168	1,481	8	50.7%
MARLBORO COUNTY		TOTAL			8	8	168	1,481	8	50.7%
TOTAL					102	102	2,332	20,888	87	65.8%

REGION: III

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	73	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	263,162	775	93.0%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	58	26,587	84	86.7%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	17	17	97	5,191	17	83.4%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLANI	(PROP)	(7)	(7)				
PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148	180	6,570	148	12.2%
GEORGETOWN COUNTY		TOTAL			249	249	335	38,348	249	42.2%
AGAPE REHABILITATION CTR CONWAY	10	HORRY	CONWAY	PROP	95	95	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	29,095	88	90.6%
MYRTLE BEACH MANOR	12	HORRY	MYRTLE BEACH	PROP	100	59	403	26,603	100	72.9%
NHC HEALTHCARE - GARDEN CITY		HORRY	MYRTLE BEACH	PROP	148	148	525	48,632	148	90.0%
SEASIDE LIVING CENTER	13	HORRY	MYRTLE BEACH	PROP	0	60				
SHEPHERD'S LANDING NURSING & REHAB CTR	14	HORRY	LITTLE RIVER	PROP	0	60				
HORRY COUNTY		TOTAL			894	973	2,726	259,186	887.6	80.0%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	129	42,692	120	97.5%
LEE COUNTY		TOTAL			120	120	129	42,692	120	97.5%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	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	3,821	14.9	66.6%
(COVENANT PLACE NURSING CENTER)		(SUMTER)	(SUMTER)	(PROP)	(0)	(0)				
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138	159	47,278	138	93.9%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176	116	61,738	176	96.1%
SUMTER VALLEY NURSING & REHAB CENTER		SUMTER	SUMTER	PROP	96	96	147	28,792	96	82.2%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	422	4,857	18	73.9%
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					3,905	3,984	6,503	1,209,824	3,885.5	85.3%

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

CATEGORY	NAME OF FACILITY
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

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	9,330	42,847	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)				
BEAUFORT COUNTY		TOTAL			262	262	14,438	55,096	262	57.6%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCKS CORNER	PROP		50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA		50				
BERKELEY COUNTY		TOTAL			0	100				
BON-SECOURS ST. FRANCIS XAVIER		CHARLESTON	CHARLESTON	NPA	204	204	8,634	32,719	204	43.9%
EAST COOPER MEDICAL CENTER	5	CHARLESTON	MT PLEASANT	PROP	130	130	4,391	14,495	130	30.5%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	604	604	29,237	162,960	604	73.9%
ROPER HOSPITAL	4	CHARLESTON	CHARLESTON	NPA	316	266	14,278	68,440	316	59.3%
ROPER ST. FRANCIS MOUNT PLEASANT HOSPITAL	4	CHARLESTON	MT PLEASANT	NPA	85	85	188	3,782	85	12.2%
TRIDENT MEDICAL CENTER		CHARLESTON	CHARLESTON	PROP	296	296	15,191	67,642	296	62.6%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(144)				
CHARLESTON COUNTY		TOTAL			1,635	1,585	71,919	350,038	1,635	58.7%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	4,495	21,415	131	44.8%
COLLETON COUNTY		TOTAL			131	131	4,495	21,415	131	44.8%
SUMMERVILLE MEDICAL CENTER	7	DORCHESTER	SUMMERVILLE	PROP	94	124	5,837	21,062	94	61.4%
DORCHESTER COUNTY		TOTAL			94	124	5,837	21,062	94	61.4%
HAMPTON REGIONAL MEDICAL CENTER		HAMPTON	VARNVILLE	CO	32	32	972	3,689	32	31.6%
HAMPTON COUNTY		TOTAL			32	32	972	3,689	32	31.6%
COASTAL CAROLINA MEDICAL CENTER	8	JASPER	HARDEEVILLE	PROP	41	41	1,483	5,050	38.4	36.0%
JASPER COUNTY		TOTAL			41	41	1,483	5,050	38.4	36.0%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	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	652,714	2,759.4	64.8%
LONG TERM ACUTE HOSPITALS:										
PACE HEALTHCARE COMMONS	9	BEAUFORT	BLUFFTON	PROP		32				
KINDRED HOSPITAL - CHARLESTON	10	CHARLESTON	CHARLESTON	PROP	59	59	228	9,829	59	45.6%
TOTAL					59	91	228	9,829	59	45.6%
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER	11	AIKEN	AIKEN	PROP	41	41	991	9,381	29	88.6%
AIKEN COUNTY		TOTAL			41	41	991	9,381	29	88.6%
BEACON HARBOR GERIATRIC PSYCHIATRIC CARE	12	BEAUFORT	BLUFFTON	PROP		22				
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	484	2,841	14	55.6%
BEAUFORT COUNTY		TOTAL			14	36	484	2,841	14	55.6%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,436	22,106	82	73.9%
PALMETTO LOWCOUNTY 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)				
CHARLESTON COUNTY		TOTAL			152	152	4,337	39,898	152	71.9%
COLLETON MEDICAL CENTER	13	COLLETON	WALTERBORO	PROP	4	4				

REGION: IV

INPATIENT INVENTORY FISCAL YEAR 2011

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	74	26,301	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%
BARNWELL COUNTY		TOTAL			173	173	267	56,608	173	89.6%
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170	321	52,737	170	85.0%
BEACON HARBOR SUBACUTE CARE	19	BEAUFORT	BLUFTON	PROP	0	120				
BROAD CREEK CARE CENTER		BEAUFORT	HILTON HEAD	PROP	25	25	126	8,282	25	90.8%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88	230	19,701	88	61.3%
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19	62	5,422	19	78.2%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
NHC BLUFFTON		BEAUFORT	BLUFTON	PROP	120	120	560	31,969	120	73.0%
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	136	15,510	69	61.6%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				
BEAUFORT COUNTY		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%
LAKE 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%
BERKELEY COUNTY		TOTAL			355	355	696	106,423	355	82.1%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	106	39,252	120	89.6%
CALHOUN COUNTY		TOTAL			120	120	106	39,252	120	89.6%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	58	12,613	41	84.1%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)				
FRANKE HEALTH CARE CENTER	21	CHARLESTON	CHARLESTON	NPA	44	44	119	8,314	24	94.6%
(FRANKE HEALTH CARE CENTER)		CHARLESTON	CHARLESTON	NPA	(0)	(0)				
HARVEST HEALTH & REHAB JOHNS ISLAND		CHARLESTON	CHARLESTON	NPA	132	132	148	46,358	132	96.0%
HEARTLAND WEST ASHLEY REHAB & NURSING CTR	22	CHARLESTON	CHARLESTON	NPA	121	125	531	30,923	99	85.6%
KINDRED HOSPITAL CHARLESTON SUBACUTE UNIT	10	CHARLESTON	MT. PLEASANT	PROP		35				
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148	730	51,722	148	95.7%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132	115	46,567	132	96.7%
NATIONAL HEALTH CARE CHARLESTON	23	CHARLESTON	CHARLESTON	PROP	88	88	656	28,274	88	88.0%
RIVERSIDE HEALTH & REHAB CENTER	24	CHARLESTON	CHARLESTON	PROP	160	160	163	55,172	160	94.2%
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176	297	60,865	176	94.7%
SAVANNAH GRACE AT PALMS OF MT PLEASANT	25	CHARLESTON	MT. PLEASANT	PROP	42	42	289	12,977	42	84.4%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176	244	60,300	176	93.9%
CHARLESTON COUNTY		TOTAL			1,280	1,299	3,350	414,085	1,218	93.1%
UNIHEALTH POST-ACUTE CARE OAKWOOD	26	COLLETON	WALTERBORO	PROP	132	132	312	45,083	132	93.6%
COLLETON COUNTY		TOTAL			132	132	312	45,083	132	93.6%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	190	30,588	88	95.0%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	175	30,071	88	93.4%
PRESBYTERIAN HOME SUMMERVILLE		DORCHESTER	SUMMERVILLE	NPA	87	87	191		87	
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88	111	30,834	88	96.0%
DORCHESTER COUNTY		TOTAL			351	351	667	91,493	351	94.9%
UNI-HEALTH POST ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	75	33,461	104	88.1%
HAMPTON COUNTY		TOTAL			104	104	75	33,461	104	88.1%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	49	28,455	88	88.6%
JASPER COUNTY		TOTAL			88	88	49	28,455	88	88.6%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60	122	20,197	60	92.2%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113	163	38,216	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	30,406	88	94.7%
ORANGEBURG COUNTY		TOTAL			393	383	720	125,658	393	87.6%
TOTAL					4,377	4,526	9,293	1,368,982	4,335	86.3%

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.

Aaron Gantt
Andrew Roxburgh
Barbara Brague
Brandi Code
Charles Ditmer
Daisy Brown
Dianne Bunker
Edward Chmiel
Frederick Mullis
Gwendolyn Thompson
Heather Carstetter
Joan Sprouse
john travis, II
Karen Moore
Katina Rosenborough
Kelly Barrett
Leland Cave
Lois Dean
Mark Windham
Mary Jo Roue
Michael Winnington
Pam Bustle
Patrick Westcott
Rhonda Staley
Sharon Robinson
Shelton Elliott
Sherry Ford
Susan Fink
Timothy Brown