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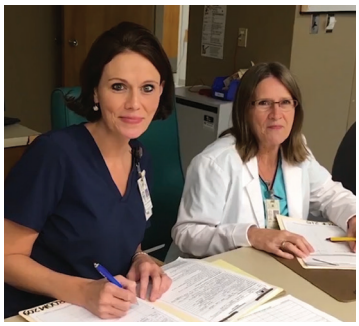
2018–2019 South Carolina Health Plan

Enacted July 12, 2018



CR-012044 6/17

SOUTH CAROLINA HEALTH PLANNING COMMITTEE

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CHAPTER 1

INTRODUCTION

SOUTH CAROLINA HEALTH PLAN

The South Carolina Code of Laws requires the Department of Health and Environmental Control ("Department") to prepare a South Carolina Health Plan ("Plan"), with the advice of the Health Planning Committee, for use in the administration of the Certificate of Need Program. *See* § 44-7-180(B).

CERTIFICATE OF NEED

The purpose of the Certificate of Need Program, as set forth in the *State Certification of Need and Health Facility Licensure Act* ("Certificate of Need Act"), is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State. To achieve these purposes, the Certificate of Need Act requires a person or health care facility to obtain a Certificate of Need from the Department before undertaking certain health care related projects. *See* §§ 44-7-120 and 44-7-160.

HEALTH PLANNING COMMITTEE

The Health Planning Committee advises the Department in the drafting of the South Carolina Health Plan. It is comprised of fourteen members, twelve of whom are appointed by the Governor, which must include at least one member from each congressional district. One member is appointed by the chairman of the Department's Board, and by virtue of his office, the final member is either the South Carolina Consumer Advocate or his designee. Health care consumers, health care financiers (including business and insurance), and health care providers (which must include at least one administrator of a for-profit nursing home) are equally represented. The Health Planning Committee reviews the South Carolina Health Plan and submits it to the Board of Health and Environmental Control for final revision and adoption. *See* § 44-7-180.

STATUTORY REQUIREMENTS

In accordance with § 44-7-180(B), this Plan contains (1) an *inventory* of existing health care facilities, beds, specified health services and equipment; (2) *projections of need* for additional healthcare facilities, beds, specified health services, and equipment; (3) *standards for distribution* of healthcare facilities, beds, specified health services, and equipment ("Certificate of Need Standards"); and (4) the *project review criteria* considered to be the most

important in evaluating Certificate of Need applications for each type of facility, service and equipment.

(1) INVENTORY

Chapter 2 of this Plan identifies the inventory regions and service areas used in the administration of the Certificate of Need Program. Healthcare facilities, specified health services, beds and equipment are inventoried where applicable.

(2) PROJECTIONS OF NEED

Chapters 3 through 11 of this Plan discuss the need for additional healthcare facilities, beds, specified health services and equipment in the State. While the methodologies used to determine these needs vary depending on the type of healthcare facility, bed, specified health service, or equipment, a determination of projected need is calculated for most areas addressed by the Plan.

(3) CERTIFICATE OF NEED STANDARDS

In consultation with the Health Planning Committee, the Department formulated these standards to guide health providers throughout the State. Inclusion of these standards in the application process is designed to give applicants notice of its requirements and to elicit from them a commitment to incorporate these standards into both their applications and finished projects.

(4) PROJECT REVIEW CRITERIA

A general statement has been added to most sections of the Plan setting forth the Project Review Criteria considered to be the most important in reviewing Certificate of Need applications for each type of healthcare facility, bed, specified health service, and equipment. These criteria are not listed in order of importance, but sequentially, as they are in Regulation 61-15. Where appropriate, the Plan contains a finding as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment.

DISCLAIMERS

(1) The hyperlinks provided throughout this Plan were checked for accuracy immediately prior to publication. Due to factors outside our control, we cannot guarantee the links will not expire or otherwise become unavailable after publication. Should you be unable to access the hyperlinked information, please feel free to request the information from the Certificate of Need Program via e-mail to coninfo@dhec.sc.gov.

(2) The population data set forth in this Plan was received from the South Carolina Revenue and Fiscal Affairs Office in February of 2018. The material includes population projections that are subject to the following conditions:

> These projections offer only one scenario of future population change using the most current data available. The overall accuracy of the projections depends on the extent to which future events unfold in a manner that reflects previous trends observed within each group. The model cannot account for unprecedented events that may significantly alter an area's demographic composition in the future. The possible events include large factory openings or closings, changes in technology, public health crises, environmental events, or other conditions that could have an effect on migration, birth rates, or death rates. This means that population projections are likely to be more accurate in the immediate future than in distant years into the future. The projections will be updated regularly as new data becomes available and future events unfold. Annual county population estimates released by the Census Bureau will be monitored along with birth and death data released each year, and adjustments will be made to the projected population results as appropriate.

CHAPTER 2

INVENTORY REGIONS AND SERVICE AREAS

INVENTORY REGIONS

This Plan has adopted the Department's regions for the purpose of inventorying Health Care Facilities and Health Services as designated and enumerated below:

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

NEED FOR HEALTH CARE FACILITIES AND HEALTH SERVICES

This Plan calculates the need for certain Health Care Facilities and Health Services throughout South Carolina based on certain formula and criteria set forth in detail in this Plan. For example:

- The need for hospital beds is based on the utilization of individual facilities.
- The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified in this Plan.
- The need for most health services (e.g., cardiac catheterization, open heart surgery) is based upon the service standard, which is a combination of utilization criteria and travel time requirements.
- The need for long-term care and skilled nursing service is projected by county.

SERVICE AREAS

In addition to inventory regions, this Plan designates service areas for certain Health Care Facilities and Health Services. These service areas may be comprised of one or more counties. Service areas may cross inventory regions. The need for a service is analyzed by assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan, applicable statutes and regulations.

TRANSFER BETWEEN AFFILIATED FACILITIES

Given the ever-changing nature of the health care delivery system, affiliated facilities may want to transfer or exchange specific technologies or licensed beds in order to better meet an identified need. Affiliated facilities are two or more health care facilities, whether inpatient or outpatient, owned, leased, 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. *A Certificate of Need is required to transfer or exchange beds, services, and/or equipment*. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

1. A transfer or exchange of beds, services, and/or equipment may be approved only if there is no overall increase in the number or amount of such beds and/or services.

2. A transfer or exchange initiated under this Chapter may only occur within the service area(s) established in this Plan.

3. The facility receiving the beds, services, and/or equipment must demonstrate the need for the additional capacity based on historical and/or projected utilization patterns.

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

5. The facility giving up beds, services, and/or equipment may not use the loss of such beds, services, and/or equipment as justification for a subsequent request to establish or re-establish such beds, services, and/or equipment.

6. A written contract or agreement between the governing bodies of the affiliated

facilities approving the transfer or exchange of beds, services, and/or equipment must be included in the Certificate of Need process.

7. Each facility giving up beds, services, and/or equipment must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

ESTIMATED STATE CIVILIAN POPULATION

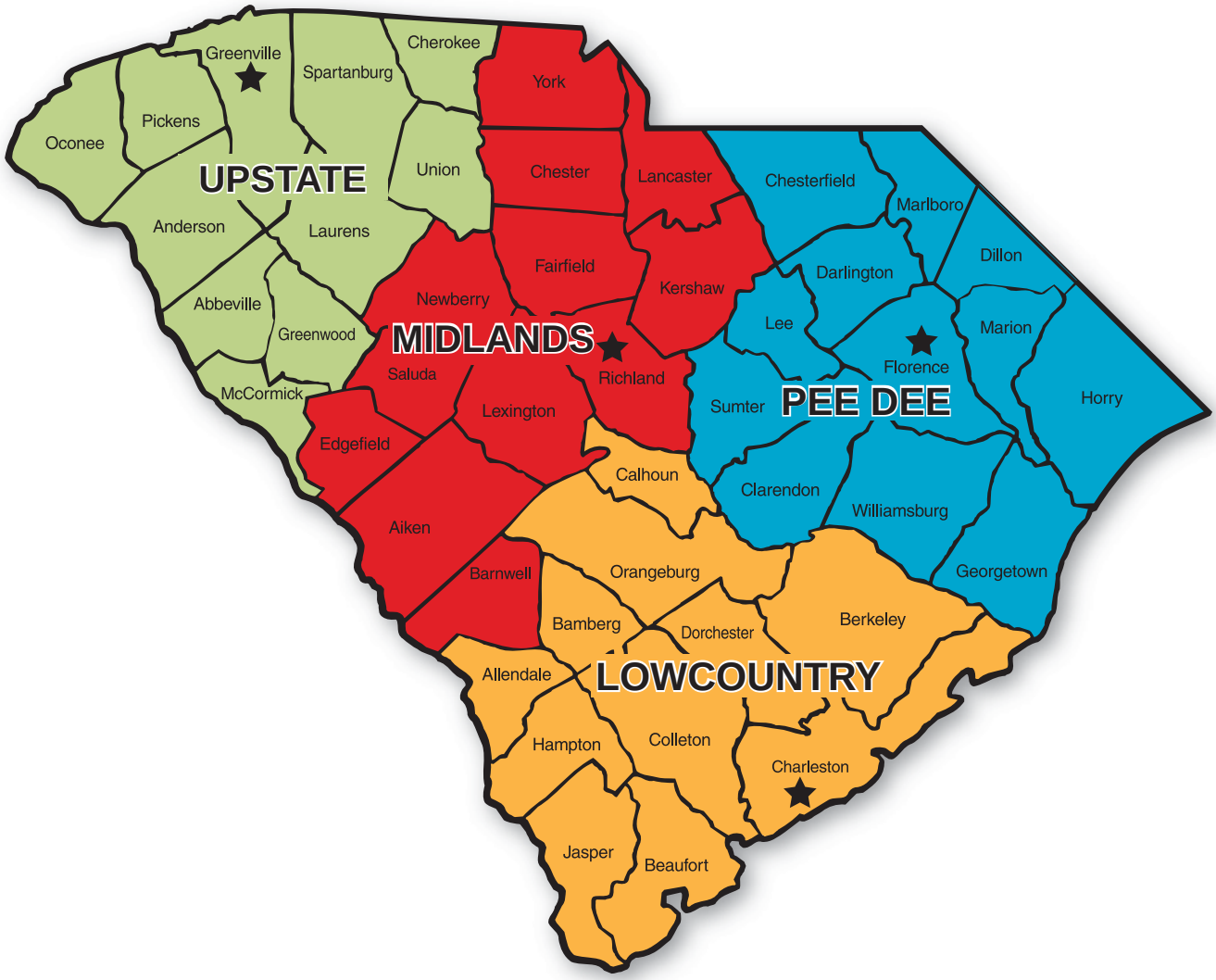
Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,961,119 for 2016 and projected population of 5,344,940 for 2023. All population data (county, planning area, and statewide) were provided by the South Carolina Revenue and Fiscal Affairs Office, Health and Demographics Section, in February 2018.

INVENTORY DATES

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was April 25, 2018. Inventory and utilization data set forth in this Plan is derived from the 2016 Joint Annual Reports (JARs). The period of time in which the individual data was collected is set forth by the reporting entity in its individual JAR submission.

DHEC REGIONS MAP

(Chapter 2)



CHAPTER 3

GENERAL HOSPITALS

GENERAL HOSPITALS

Relevant Definitions

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

Hospital may include residential treatment facilities for children and adolescents in need of mental health treatment which are physically a part of a licensed psychiatric hospital. This definition does not include facilities which are licensed by the Department of Social Services.

"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.

Bed Capacity

For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Inventory and Bed Need

All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital in its JAR. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the

number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation.

Variable Occupancy Rate

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0 - 174 bed hospitals → 65%
175 - 349 bed hospitals → 70%
350+ bed hospital → 75%

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, in recognition that different population groups have different hospital utilization rates.

Where the term "hospital bed need" is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

Availability

Bamberg, Barnwell, Lee, Marlboro, McCormick and Saluda counties no longer have local hospitals. Calhoun County is served by the Regional Medical Center of Orangeburg and Calhoun Counties. The need for general hospital beds is determined through the consideration of current utilization and projected population growth with the goal of having beds available within approximately 30 minutes' travel time for the majority of the residents of the State.

CERTIFICATE OF NEED PROJECTION AND STANDARDS

1. Calculations of hospital bed need are made for individual hospitals and totaled by county to determine the overall bed need for that service area, which is the county for CON purposes.

2. For individual hospitals, the methodology for calculating bed need is as follows:

    a. Determine the current facility use rate by dividing the current utilization by the current population in each of the three age cohorts.

    b. Multiply the current facility use rate by age cohort by the projected population for seven years in the future by age cohort (in thousands) and divide by 365 to

obtain a projected average daily census by age cohort.

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

d. The number of additional beds needed or excess beds for the hospital is obtained by subtracting the number of existing beds from the bed need.

e. The totals for each hospital in a county or service area are summed to determine whether there is an overall projected surplus or need for additional beds.

3. If a service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the 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 service area, then any entity may apply to add these beds within the service area, 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 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, 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 service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need. 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 service area.

6. No additional hospital will be approved unless it is a general hospital and will provide:

   a. A 24-hour emergency services department that meets the requirements to be a Level III emergency service as defined in the *Emergency Services* section of Regulation 61-16;

   b. Inpatient medical services to both surgical and non-surgical patients; and

   c. Medical and surgical services on a daily basis within at least six of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS). Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that unreimbursed services for indigent and charity patients are provided at a percentage that meets or exceeds other hospitals in the service area. The CMS Diagnostic Categories Chart is located at the end of this Chapter.

7. Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric, rehabilitation and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

   a. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert nursing home beds to general acute care hospital beds only within the hospital, provided the hospital can document an actual need for additional general acute care beds. Need will be based on actual utilization, using current information. *A Certificate of Need is required for this conversion.*

   b. Existing acute care hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert such beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds. *A Certificate of Need is required for this conversion.*

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 the deletion of services at a federal facility result in an immediate impact on the utilization of a hospital, then the Department may approve a request for additional beds at the affected hospital. The affected hospital must document the

increase in demand and explain why additional beds are needed to accommodate patients previously served at the federal facility.

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 provisions outlined in Chapter 2, Transfer between Affiliated Facilities.

11. Factors to be considered regarding modernization of facilities include:

    a. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.

    b. The ability to update medical technology within the existing plant.

    c. Existence of The Joint Commission (TJC) or other accreditation body deficiencies or "grandfathered" licensure deficiencies.

    d. Cost efficiency of the existing physical plant versus plant revision, etc.

    e. Private rooms are now considered the industry standard.

12. Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on healthcare delivery within the service area.

The Hospital Bed Need Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Acceptability;
5. Record of the Applicant;
6. Cost Containment; and
7. Adverse Effects on Other Facilities.

General hospital beds are typically located within approximately 30 minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

LONG-TERM ACUTE CARE HOSPITALS

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

A LTACH may be either a freestanding facility or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional federal criteria in order to qualify as a LTACH under the "hospital-within-a-hospital" model:

1. The new LTACH must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.

2. The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.

3. The LTACH must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4. The LTACH must have a separate medical staff which reports directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. An application for a LTACH must be in compliance with the relevant standards in Regulation 61-16 *(Minimum Standards for Licensing Hospitals and Institutional General Infirmaries).*

2. Although LTACH 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 LTACH 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 LTACH shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital (or its successor) that initially leased the general acute beds to the LTACH shall be entitled 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 seeks to be designated as a LTACH, and has been awarded a CON for that purpose, must be certified as a LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

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. 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 Certificate of Need issued to that hospital for that purpose shall be revoked.

The Long-Term Acute Care Hospitals Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of this Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Record of the Applicant.

Long-Term Acute Care Hospital beds are located within approximately 60 minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need

applications for these beds.

CRITICAL ACCESS HOSPITALS (CAH)

The South Carolina Department of Health and Human Services administers programs through the Medicaid program to assist struggling rural hospitals. One such program designates rural hospitals as Critical Access Hospitals (CAH) who are then eligible for more favorable Medicaid reimbursement methodology.

A CAH is 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. CAHs are subject to review by the Independent Payment Advisory Board (IPAB), whereas other hospitals are not currently subject to IPAB review.

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

The designation of a hospital as a Critical Access Hospital *does not require Certificate of Need review* because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce its number of licensed beds in order to meet the criteria for a CAH. *Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required*, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds without regard or affect to the current bed need shown in the service area.

The Critical Access Hospitals Chart is located at the end of this Chapter.

PERINATAL REGIONS

The Perinatal Regions referred to in the Obstetrical Services and Neonatal Services sections below are distinct from the Department's Regions defined in Chapter 2 of this Plan, and are identified by the name of its designated Regional Perinatal Center.

Perinatal Region	Counties
I - Greenville Memorial	Abbeville, Anderson, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda
II - Spartanburg Regional	Cherokee, Chester, Spartanburg, Union

III - Palmetto Health Richland	Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York
IV - McLeod Regional	Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg
V - MUSC Medical	Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown

PERINATAL SERVICE LEVELS

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the State to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by the Department's Division of Health Licensing as a Level I, II, III, or IV Perinatal Hospital, or a Regional Perinatal Center (RPC). Each Level I, II, III and IV hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. True regionalization for the optimization of perinatal care includes a stated goal of back-transporting infants when they no longer require the highest level of care. Convalescing infants benefit from a community-based program closer to home that promotes parent education and family bonding to facilitate a safe and timely discharge. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services described briefly below are outlined in the Section of Regulation 61-16 entitled *Designation of Inpatient Perinatal Care Services.*

Basic Perinatal Center with Well Newborn Nursery (Level I). Level I hospitals provide services for normal uncomplicated pregnancies. A full list of the requirements for a Level I Basic Perinatal Center with Well Newborn Nursery can be found at Regulation 61-16, Section 1306.A. *Certificate of Need review is not required to establish a Level I program.*

Specialty Perinatal Center with Special Care Nursery (Level II). In addition to the requirements of Regulation 61-16, Section 1306.A, Level II hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. A full list of the requirements for a Level II Specialty Perinatal Center can be found at Regulation 61-16, Section 1306.B. *Certificate of Need review is not required to establish a Level II program.*

Subspecialty Perinatal Center with Neonatal Intensive Care Unit (Level III). In addition to the requirements of Regulation 61-16, Sections 1306.A and 1306.B, Level III hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the most recent edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A full list of the requirements for a Level III Subspecialty Perinatal Center with Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.C. Neonatal transport may only be performed by Regional Perinatal Centers. *Certificate of Need Review is required to establish a Level III program.*

Regional Perinatal Center with Neonatal Intensive Care Unit (RPC). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, RPCs provide consultative, outreach, and support services to other hospitals in the region. A full list of the requirements for a Regional Perinatal Center can be found at Regulation 61-16, Section 1306.D. No more than one Regional Perinatal Center will be approved in each perinatal region. *Certificate of Need Review is required to establish a RPC.*

Complex Neonatal Intensive Care Unit (Level IV). In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, Level IV hospitals shall include additional capabilities and considerable experience in the care of the most complex and critically ill newborn infants and have pediatric medical and surgical specialty consultants available 24 hours a day. A full list of the requirements for a Complex Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.E. A Level IV hospital need not act as a Regional Perinatal Center (RPC). *Certificate of Need Review is required to establish a Level IV program.*

The Perinatal-Capable Facilities Chart is located at the end of this Chapter.

OBSTETRICAL SERVICES

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

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2015, 81.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center, whereas the Healthy People 2020 national objective was 83.7%.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2016 was 7.0 infant deaths per 1,000 live births versus the national rate of 5.87 infant deaths per 1,000 births in 2016.

Neonatal mortality is the death rate for infants up to 28 days old. For 2016, South Carolina's neonatal mortality rate for all races was 4.4 neonatal deaths per 1,000 live births, while the Healthy People 2020 national objective was 4.1 neonatal deaths per 1,000 live births.

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.

The OB Utilization and Births Chart is located at the end of this Chapter.

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:

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

NEONATAL SERVICES

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

CERTIFICATE OF NEED PROJECTIONS AND 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 2014-2016 and the average population of women age 15-44 for 2014-2016 to generate an average birth rate.

    b. Multiply the average birth rate against the projected 2020 population of women age 15-44 to project the number of births in 2020.

    c. Generate the projected number of intensive care bassinets needed in a region by applying a constant of 3.25 bassinets per 1,000 live births to the projected birth rate and subtracting the existing bassinets from this total.

    d. Any Level III, Level IV, or RPC neonatal unit may request additional intensive care bassinets beyond those indicated as needed by the methodology above. The Level III, Level IV, or RPC neonatal unit requesting the addition must document the need for additional intensive care bassinets based on historical and projected utilization, projected population growth, routine swing of intermediate care bassinets into the intensive care setting, or other factors demonstrating the need for the proposed bassinets.

2. Only Level III, Level IV, and RPCs neonatal units have intensive care bassinets.

The Intensive and Intermediate Bassinets Chart, Utilization of Neonatal Special Care Units Chart and NICU Bed Need Chart are located at the end of this Chapter.

The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II 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 facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC, Level III, and Level IV facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Compliance with the Need Outlined in this Section of this Plan;
2. Distribution (Accessibility);
3. Acceptability
4. Record of the Applicant; and
5. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the small percentage of infants requiring neonatal services, this service is available within approximately 30 minutes' travel time for the majority of the population. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CMS DIAGNOSTIC CATEGORIES
(Chapter 3)

MDC 1:	Diseases and disorders of the nervous system
MDC 2:	Diseases and disorders of the eye
MDC 3:	Diseases and disorders of the ear, nose, mouth and throat
MDC 4:	Diseases and disorders of the respiratory system
MDC 5:	Diseases and disorders of the circulatory system
MDC 6:	Diseases and disorders of the digestive system
MDC 7:	Diseases and disorders of the hepatobiliary system and pancreas
MDC 8:	Diseases and disorders of the musculoskeletal system and
MDC 9:	Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10:	Endocrine, nutritional and metabolic diseases and disorders
MDC 11:	Diseases and disorders of the kidney and urinary tract
MDC 12:	Diseases and disorders of the male reproductive system
MDC 13:	Diseases and disorders of the female reproductive system
MDC 14:	Pregnancy, childbirth and the puerperium
MDC 15:	Newborns/other neonates with conditions originating in the
MDC 16:	Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC 17:	Myeloproliferative diseases and disorders and poorly differentiated
MDC 18:	Infectious and parasitic diseases
MDC 19:	Mental diseases and disorders
MDC20:	Alcohol/drug use and alcohol/drug-induced organic mental
MDC 21:	Injury, poisoning and toxic effects of drugs
MDC 22:	Burns
MDC 23:	Factors influencing health status and other contact with health
MDC 24:	Multiple significant traumas
MDC 25:	Human immunodeficiency virus infections

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Region I										
Abbeville Area Medical Center	<18	5283	4890	22	0					
	18-64	14493	13090	368	1					
	+65	5096	5940	1287	4					
	TOTAL	**24872**	**23920**	**1677**	**5**	**65%**	**8**	**25**	**-17**	**18.38%**
Abbeville County Total							**8**	**25**	**-17**	
AnMed Health Medical Center	<18	45231	44960	4846	13					
	18-64	116668	118970	32481	91					
	+65	34670	41820	40725	135					
	TOTAL	**196,569**	**205,750**	**78,052**	**239**	**75%**	**319**	**423**	**-104**	**50.55%**
AnMed Health Women's and Children's Hospital	<18	45231	44960	569	2					
	18-64	116668	118970	5343	15					
	+65	34670	41820	1019	3					
	TOTAL	**196,569**	**205,750**	**6,931**	**20**	**65%**	**31**	**72**	**-41**	**26.37%**
Anderson County Total							**350**	**495**	**-145**	
Mary Black Health System - Gaffney (Gaffney Medical Center) ***1***	<18	13336	13040	0	0					
	18-64	34359	33520	0	0					
	+65	8951	10460	0	0					
	TOTAL	**56,646**	**57,020**	**9,528**	**26**	**65%**	**41**	**125**	**-84**	**20.88%**
Cherokee County Total							**41**	**125**	**-84**	
Greenville Memorial Medical Center	<18	116015	124100	27781	81					
	18-64	307912	336250	85667	256					
	+65	74839	98600	56204	203					
	TOTAL	**498,766**	**558,950**	**169,652**	**541**	**75%**	**721**	**746**	**-25**	**62.31%**
Greer Memorial Hospital (GHS)	<18	116015	124100	77	0					
	18-64	307912	336250	5531	17					
	+65	74839	98600	5030	18					
	TOTAL	**498,766**	**558,950**	**10,638**	**35**	**65%**	**54**	**82**	**-28**	**35.54%**
Hillcrest Memorial Hospital (GHS)	<18	116015	124100	2	0					
	18-64	307912	336250	3165	9					
	+65	74839	98600	2532	9					
	TOTAL	**498,766**	**558,950**	**5,699**	**19**	**65%**	**29**	**43**	**-14**	**36.31%**
Patewood Memorial Hospital (GHS)	<18	116015	124100	3	0					
	18-64	307912	336250	1106	3					
	+65	74839	98600	1224	4					
	TOTAL	**498,766**	**558,950**	**2,333**	**8**	**65%**	**12**	**72**	**-60**	**8.88%**
Saint Francis - Downtown & Saint Francis - Millennium	<18	116015	124100	41	0					
	18-64	307912	336250	23398	70					
	+65	74839	98600	34654	125					
	TOTAL	**498,766**	**558,950**	**58,093**	**195**	**70%**	**279**	**226**	**53**	**70.42%**
Saint Francis - Eastside	<18	116015	124100	47	0					
	18-64	307912	336250	11114	33					
	+65	74839	98600	7183	26					
	TOTAL	**498,766**	**558,950**	**18,344**	**59**	**65%**	**92**	**93**	**-1**	**54.04%**
Greenville County Total							**1,187**	**1,262**	**-75**	
Self Regional Healthcare	<18	16150	15750	745	2					
	18-64	41578	39350	22056	57					
	+65	12405	14270	24258	76					
	TOTAL	**70,133**	**69,370**	**47,059**	**136**	**70%**	**194**	**326**	**-132**	**39.55%**
Greenwood County Total							**194**	**326**	**-132**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Laurens County Memorial Hospital (GHS)	<18	14673	14200	108	0					
	18-64	40339	38370	5308	14					
	+65	11765	13600	4373	14					
	TOTAL	**66,777**	**66,170**	**9,789**	**28**	**65%**	**44**	**76**	**-32**	**35.29%**
Laurens County Total							**44**	**76**	**-32**	
Oconee Memorial Hospital (GHS)	<18	15356	14550	217	1					
	18-64	43929	42510	9832	26					
	+65	17070	20230	13245	43					
	TOTAL	**76,355**	**77,290**	**23,294**	**70**	**65%**	**108**	**169**	**-61**	**37.76%**
Oconee County Total							**108**	**169**	**-61**	
Baptist Easley Hospital	<18	23912	26410		3					
	18-64	79454	74670	6139	16					
	+65	19497	23300	7499	25					
	TOTAL	**122,863**	**124,380**	**13,638**	**44**	**65%**	**68**	**109**	**-41**	**34.28%**
AnMed Health Cannon	<18	23912	26410	10	0					
	18-64	79454	74670	1076	3					
	+65	19497	23300	1463	5					
	TOTAL	**122,863**	**124,380**	**2,549**	**7**	**65%**	**11**	**55**	**-44**	**12.70%**
Pickens County Total							**79**	**164**	**-85**	
Mary Black Health System - Spartanburg	<18	70352	71820	97	0					
	18-64	183614	187990	11100	31					
	+65	47497	57520	10573	35					
	TOTAL	**301,463**	**317,330**	**21,770**	**66**	**65%**	**103**	**174**	**-71**	**34.28%**
Spartanburg Medical Center	<18	70352	71820	1684	5					
	18-64	183614	187990	66335	186					
	+65	47497	57520	64313	213					
	TOTAL	**301,463**	**317,330**	**132,332**	**404**	**75%**	**539**	**484**	**55**	**74.91%**
Pelham Medical Center (Village Hospital)	<18	70352	71820	0	0					
	18-64	183614	187990	4709	13					
	+65	47497	57520	5811	19					
	TOTAL	**301,463**	**317,330**	**10,520**	**32**	**65%**	**50**	**48**	**2**	**60.05%**
Spartanburg County Total							**692**	**706**	**-14**	
Union Medical Center	<18	5951	5300	0	0					
	18-64	16383	14460	1793	4					
	+65	5339	6060	2179	7					
	TOTAL	**27,673**	**25,820**	**3,972**	**11**	**65%**	**18**	**143**	**-125**	**7.61%**
Union County Total							**18**	**143**	**-125**	
Region II										
Aiken Regional Medical Center ***3***	<18	36673	35430	397	1					
	18-64	99762	98870	19687	53					
	+65	31023	39110	20867	72					
	TOTAL	**167,458**	**173,410**	**40,951**	**127**	**70%**	**181**	**197**	**-16**	**56.95%**
Aiken County Total							**181**	**197**	**-16**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Chester Regional Medical Center	<18	7323	6820	64	0					
	18-64	19187	17210	1205	3					
	+65	5671	6630	1505	5					
	TOTAL	**32,181**	**30,660**	**2,774**	**8**	**65%**	**13**	**82**	**-69**	**9.27%**
Chester County Total							**13**	**82**	**-69**	
Edgefield County Hospital	<18	4949	4130	1	0					
	18-64	16876	15750	27	0					
	+65	4533	5540	574	2					
	TOTAL	**26,358**	**25,420**	**602**	**2**	**65%**	**4**	**25**	**-21**	**6.60%**
Edgefield County Total							**4**	**25**	**-21**	
Fairfield Memorial Hospital	<18	4453	3750	0	0					
	18-64	13744	11820	158	0					
	+65	4456	5180	619	2					
	TOTAL	**22,653**	**20,750**	**777**	**2**	**65%**	**4**	**25**	**-21**	**8.52%**
Fairfield County Total							**4**	**25**	**-21**	
Kershaw Health	<18	15,015	14,580	151	0					
	18-64	38,010	37,880	6,807	19					
	+65	11,072	13,690	10,118	34					
	TOTAL	**64,097**	**66,150**	**17,076**	**48**	**65%**	**75**	**121**	**-46**	**38.66%**
Kershaw County Total							**75**	**121**	**-46**	
Springs Memorial Hospital ***1***	<18	19603	19740	NR	0					
	18-64	51879	56580	NR	0					
	+65	18112	26050	NR	0					
	TOTAL	**89,594**	**102,370**	**20,255**	**63**	**70%**	**91**	**199**	**-108**	**27.89%**
Lancaster County Total							**91**	**199**	**-108**	
Lexington Medical Center ***4***	<18	66988	67090	152	0					
	18-64	176290	187110	64883	189					
	+65	42918	57520	62220	228					
	TOTAL	**286,196**	**311,720**	**127255**	**418**	**75%**	**557**	**485**	**72**	**71.89**
Lexington County Total							**557**	**485**	**72**	
Newberry County Memorial Hospital	<18	8395	8160	117	0					
	18-64	22474	21730	2807	7					
	+65	7210	8680	3835	13					
	TOTAL	**38,079**	**38,570**	**6,759**	**20**	**65%**	**32**	**90**	**-58**	**20.58%**
Newberry County Total							**32**	**90**	**-58**	
Palmetto Health Baptist Parkridge	<18	88327	97540	1506	5					
	18-64	271806	283080	8514	24					
	+65	49416	65220	9123	33					
	TOTAL	**409,549**	**445,840**	**19,143**	**62**	**65%**	**96**	**76**	**20**	**69.01%**
Palmetto Health Baptist	<18	88327	97540	7754	23					
	18-64	271806	283080	26085	74					
	+65	49416	65220	40954	148					
	TOTAL	**409,549**	**445,840**	**74,793**	**246**	**70%**	**352**	**287**	**65**	**71.40%**
Palmetto Health Richland	<18	88327	97540	38204	116					
	18-64	271806	283080	80891	231					
	+65	49416	65220	52849	191					
	TOTAL	**409,549**	**445,840**	**171,944**	**537**	**75%**	**717**	**579**	**138**	**81.36%**
Providence Health	<18	88327	97540	1	0					
(Providence Hospital)	18-64	271806	283080	15798	45					
	+65	49416	65220	24493	89					
	TOTAL	**409,549**	**445,840**	**40,292**	**134**	**70%**	**191**	**258**	**-67**	**42.79%**

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Providence Health Northeast	<18	88327	97540	4	0					
	18-64	271806	283080	1656	5					
	+65	49416	65220	2167	8					
	TOTAL	**409,549**	**445,840**	**3,827**	**13**	**65%**	**20**	**74**	**-54**	**14.17%**
Richland County Total							**1,376**	**1,274**	**102**	
Piedmont Medical Center ***5***	<18	63199	66580	1015	3					
	18-64	159935	177820	32291	98					
	+65	35392	49230	28131	107					
	TOTAL	**258,526**	**293,630**	**61,437**	**208**	**70%**	**298**	**268**	**30**	**62.81%**
Fort Mill Medical Center ***5***	<18	63199	66580							
	18-64	159935	177820							
	+65	35392	49230							
	TOTAL	**258,526**	**293,630**	**0**	**0**	**70%**		**64**	**-100**	**0**
York County Total							**298**	**332**	**-34**	
Region III										
McLeod Health Cheraw	<18	10485	9600	190	0					
	18-64	27785	25810	2741	7					
	+65	7743	9010	3137	10					
	TOTAL	**46,013**	**44,420**	**6,068**	**17**	**65%**	**27**	**59**	**-32**	**28.18%**
Chesterfield County Total							**27**	**59**	**-32**	
McLeod Health Clarendon	<18	6848	5910	41	0					
	18-64	19916	17320	3743	9					
	+65	7187	8260	3892	12					
	TOTAL	**33,951**	**31,490**	**7,676**	**21**	**65%**	**33**	**81**	**-48**	**25.96%**
Clarendon County Total							**33**	**81**	**-48**	
Carolina Pines Regional Medical Center	<18	15296	14060	474	1					
	18-64	39967	37320	7481	19					
	+65	11971	13810	6075	19					
	TOTAL	**67,234**	**65,190**	**14,030**	**40**	**65%**	**61**	**116**	**-55**	**33.14%**
McLeod Medical Center - Darlington	<18	15296	14060	0	0					
	18-64	39967	37320	0	0					
	+65	11971	13810	0	0					
	TOTAL	**67,234**	**65,190**	**0**	**0**	**65%**	**0**	**49**	**-49**	**0.00%**
Darlington County Total							**61**	**165**	**-104**	
McLeod Medical Center - Dillon	<18	7861	7520	444	1					
	18-64	18063	16520	4602	12					
	+65	4934	5770	3244	10					
	TOTAL	**30,858**	**29,810**	**8,290**	**23**	**65%**	**36**	**79**	**-43**	**28.75%**
Dillon County Total							**36**	**79**	**-43**	
Carolinas Hospital System	<18	33196	32680	212	1					
	18-64	83231	81580	29958	80					
	+65	22315	26410	29325	95					
	TOTAL	**138,742**	**140,670**	**59495**	**165**	**70%**	**237**	**310**	**-73**	**52.58%**
Women's Center - Carolinas Hospital System ***2***	<18	33196	32680	NR	0					
	18-64	83231	81580	NR	0					
	+65	22315	26410	NR	0					
	TOTAL	**138,742**	**140,670**	**0**	**0**	**65%**	**0**	**20**	**-20**	**0.00%**
Lake City Community Hospital ***1***	<18	33196	32680	NR	0					
	18-64	83231	81580	NR	0					
	+65	22315	26410	NR	0					
	TOTAL	**138,742**	**140,670**	**3,038**	**8**	**65%**	**13**	**48**	**-35**	**17.34%**
McLeod Regional Medical Center - Pee Dee ***6,7***	<18	33196	32680	4131	11					
	18-64	83231	81580	66878	180					
	+65	22315	26410	60685	197					
	TOTAL	**138,742**	**140,670**	**131,694**	**388**	**75%**	**517**	**517**	**0**	**69.79%**
Florence County Total							**767**	**895**	**-128**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Tidelands Georgetown Memorial Hospital	<18	11748	10780	170	0					
	18-64	33731	31800	7722	20					
	+65	15920	19840	8632	29					
	TOTAL	**61,399**	**62,420**	**16,524**	**50**	**65%**	**77**	**131**	**-54**	**34.56%**
Tidelands Waccamaw Community Hospital	<18	11748	10780	166	0					
	18-64	33731	31800	9054	23					
	+65	15920	19840	15809	54					
	TOTAL	**61,399**	**62,420**	**25,029**	**78**	**65%**	**120**	**124**	**-4**	**55.30%**
Georgetown County Total							**197**	**255**	**-58**	
Conway Hospital	<18	60209	64340	3781	11					
	18-64	190406	208900	16500	50					
	+65	71727	112200	14094	60					
	TOTAL	**322,342**	**385,440**	**34,375**	**121**	**70%**	**173**	**210**	**-37**	**44.85%**
Grand Strand Medical Center ***8***	<18	60209	64340	2130	6					
	18-64	190406	208900	34267	103					
	+65	71727	112200	49318	211					
	TOTAL	**322,342**	**385,440**	**85,715**	**321**	**70%**	**458**	**325**	**133**	**72.26%**
McLeod Loris ***9***	<18	60209	64340	177	1					
	18-64	190406	208900	4003	12					
	+65	71727	112200	4133	18					
	TOTAL	**322,342**	**385,440**	**8,313**	**30**	**65%**	**47**	**50**	**-3**	**45.55%**
McLeod Seacoast ***9***	<18	60209	64340	15	0					
	18-64	190406	208900	3573	11					
	+65	71727	112200	6305	27					
	TOTAL	**322,342**	**385,440**	**9,893**	**38**	**65%**	**59**	**105**	**-46**	**25.81%**
Horry County Total							**737**	**690**	**47**	
Carolinas Hospital System - Marion	<18	7463	6800	2893	7					
	18-64	18459	16300	2894	7					
	+65	5804	6390	2981	9					
	TOTAL	**31,726**	**29,490**	**8,768**	**23**	**65%**	**36**	**124**	**-88**	**19.37%**
Marion County Total							**36**	**124**	**-88**	
Palmetto Health Tuomey	<18	26203	25100	NR	0					
	18-64	64602	61570	25108	66					
	+65	16591	19870	24123	79					
	TOTAL	**107,396**	**106,540**	**49,231**	**145**	**70%**	**207**	**283**	**-76**	**47.66%**
Sumter County Total							**207**	**283**	**-76**	
Williamsburg Regional Hospital	<18	6,847	5,990	0	0					
	18-64	18,863	16,400	664	2					
	+65	6,245	7,220	906	3					
	TOTAL	**31,955**	**29,610**	**1,570**	**4**	**65%**	**7**	**25**	**-18**	**17.21%**
Williamsburg County Total							**7**	**25**	**-18**	
Region IV										
Allendale County Hospital	<18	1735	1330	5	0					
	18-64	5630	4840	240	1					
	+65	1680	1920	285	1					
	TOTAL	**9,045**	**8,090**	**530**	**1**	**65%**	**3**	**25**	**-22**	**5.81%**
Allendale County Total							**3**	**25**	**-22**	
Beaufort Memorial Hospital	<18	35497	36910	919	3					
	18-64	100764	107550	17922	52					
	+65	46888	63960	18495	69					
	TOTAL	**183,149**	**208,420**	**37,336**	**116**	**65%**	**180**	**169**	**11**	**60.53%**

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Hilton Head Hospital	<18	35497	36910	43	0					
	18-64	100764	107550	6580	19					
	+65	46888	63960	14761	55					
	TOTAL	**183,149**	**208,420**	**21,384**	**75**	**65%**	**115**	**93**	**22**	**63.00%**
Beaufort County Total							**295**	**262**	**33**	
Berkeley Medical Center ***10***	<18	51,009	54,610		0					
	18-64	132,471	149,070		0					
	+65	27,418	42,040		0					
	TOTAL	**210,898**	**245,720**	**0**	**0**	**65%**		**50**		**0.00%**
Roper St. Francis- Berkeley ***11***	<18	51,009	54,610	0	0					
	18-64	132,471	149,070	0	0					
	+65	27,418	42,040	0	0					
	TOTAL	**210,898**	**245,720**	**0**	**0**	**65%**		**50**		**0.00%**
Berkeley County Total							**0**	**100**	**0**	
Bon Secours - Saint Francis Xavier Hospital	<18	79126	86330	99	0					
	18-64	256665	282710	19630	59					
	+65	60693	84780	13524	52					
	TOTAL	**396,484**	**453,820**	**33,253**	**111**	**70%**	**159**	**204**	**-45**	**44.66%**
East Cooper Medical Center	<18	79126	86330	7	0					
	18-64	256665	282710	9115	28					
	+65	60693	84780	6206	24					
	TOTAL	**396,484**	**453,820**	**15,328**	**51**	**65%**	**79**	**130**	**-51**	**32.30%**
Mount Pleasant Hospital	<18	79126	86330	8	0					
	18-64	256665	282710	3122	9					
	+65	60693	84780	2656	10					
	TOTAL	**396,484**	**453,820**	**5,786**	**20**	**65%**	**31**	**85**	**-54**	**18.65%**
MUSC Medical Center ***12***	<18	79126	86330	25365	76					
	18-64	256665	282710	109000	329					
	+65	60693	84780	53501	205					
	TOTAL	**396,484**	**453,820**	**187,866**	**610**	**75%**	**813**	**656**	**157**	**78.46%**
Roper Hospital ***11***	<18	79126	86330	18	0					
	18-64	256665	282710	23994	72					
	+65	60693	84780	34331	131					
	TOTAL	**396,484**	**453,820**	**58,343**	**204**	**70%**	**292**	**316**	**-24**	**50.58%**
Trident Medical Center	<18	79126	86330	1645	5					
	18-64	256665	282710	37012	112					
	+65	60693	84780	35598	136					
	TOTAL	**396,484**	**453,820**	**74,255**	**233**	**70%**	**333**	**296**	**37**	**68.73%**
Charleston County Total							**1,707**	**1687**	**20**	
Summerville Medical Center	<18	38529	40860	2101	6					
	18-64	95648	112030	12107	39					
	+65	19596	27110	9720	37					
	TOTAL	**153,773**	**180,000**	**23,928**	**82**	**65%**	**126**	**124**	**2**	**52.87%**
Dorchester County Total							**126**	**124**	**2**	
Colleton Medical Center	<18	8,515	7,570	817						
	18-64	21854	19280	7365	18					
	+65	7554	8750	8118	26					
	TOTAL	**37,923**	**35,600**	**16,300**	**44**	**65%**	**68**	**116**	**-48**	**38.50%**
Colleton County Total							**68**	**116**	**-48**	
Hampton Regional Medical Center	<18	4338	3770	1	0					
	18-64	12133	10640	1022	2					
	+65	3451	3970	1899	6					
	TOTAL	**19,922**	**18,380**	**2,922**	**8**	**65%**	**13**	**32**	**-19**	**25.02%**
Hampton County Total							**13**	**32**	**-19**	
Coastal Carolina Medical Center	<18	5945	5630	39	0					
	18-64	17302	18550	4551	13					
	+65	5218	10870	5178	30					
	TOTAL	**28,465**	**35,050**	**9,768**	**43**	**65%**	**67**	**41**	**26**	**65.27%**
Jasper County Total							**67**	**41**	**26**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2016 Pop	2023 Pop	2016 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2016 % Occup Rate
Regional Medical Center of Orangeburg & Calhoun Counties	<18	19702	18740	429	1					
	18-64	52130	45730	15056	36					
	+65	16071	18450	26008	82					
	TOTAL	**87,903**	**82,920**	**41,493**	**107**	**70%**	**154**	**247**	**-93**	**46.02%**
Orangeburg County Total							**154**	**247**	**-93**	
Bamberg										
Barnwell										
Lee										
McCormick										
Marlboro										
Saluda										
Calhoun										
Counties Without General Hospitals										

* This chart does not count beds already counted in the charts for psychiatric beds, rehabiliation beds, and substance abuse beds. The patient days associated with these beds have been deducted from the reported total number of patient days.

1 Age cohorts not adequately reported.

2 Facility did not submit 2016 JAR.

3 SC-17-12 issued 3/2/2017 for the addition of 14 acute care beds.

4 SC-16-08 issued 3/2/2016 for addition of 71 acute care beds, some of which have been liscenced.

5 Pending resolution of an appeal, Piedmont proposes constructing a 100-bed hospital in Fort Mill using a combination of new and transferred hospital beds. Piedmont Medical Center's licensed bed count remains 268 and the Fort Mill Medical Center bed count remains 64 until such time as the Fort Mill Medical Center Project is complete. Upon final completion of the project, Fort Mill Medical Center will have 100 general beds and Piedmont Medical Center's licensed bed count will be reduced by the 36 beds transferred to Fort Mill.

6 SC-16-42 issued 8/11/2016 for addition of 8 acute care beds. Project completed 09/12/2017.

7 SC-18-14 issued 3/12/2018 for the addition of 56 general beds.

8 SC-16-17 issued 5/12/2016 for the addition of 24 acute care beds.

9 SC-15-29 issued 8/18/2015 for transfer of 55 acute care beds from McLeod Loris to McLeod Loris Seacoast for a total of 50 beds at McLeod Loris and 105 beds at McLeod Seacoast.

10 SC-16-19 issued 5/26/2016 for the construction of a new 50 bed acute care hospital.

11 SC-16-01 issued 1/6/2016 for construction of a new acute care hospital by transfer of 50 beds from Roper Hospital to the new hospital.

12 CON SC-15-26 issued 6/30/15 for the addition of 52 acute hospital beds, some of which have been liscenced.

LONG-TERM ACUTE CARE HOSPITALS
(Chapter 3)

		2014			2015			2016		
Facility By Region	**County**	**Beds**	**Pt Days**	**Occupancy Rate**	**Beds**	**Pt Days**	**Occupancy Rate**	**Beds**	**Pt Days**	**Occupancy Rate**
Region I										
GHS North Greenville Long Term Acute Care	Greenville	45	7,758	47.2%	45	7,841	47.7%	45	7,310	44.5%
Regency Hospital of Greenville	Greenville	32	9,960	85.3%	32	9,607	82.3%	32	7,766	66.5%
Spartanburg Hospital for Restorative Care	Spartanburg	97	10,892	30.8%	97	10,118	28.6%	97	10,034	28.3%
Region II										
Continuecare Hospital at Palmetto Health Baptist	Richland	35	NR	0.0%	35	NR	0.0%	35	8,394	65.7%
Region III										
Regency Hospital of Florence	Florence	40	12,527	85.8%	40	12,946	88.7%	40	12,177	83.4%
Region IV										
Vibra Hospital of Charleston	Charleston	59	15,883	73.8%	59	NR	0.0%	59	13,744	63.8%

CRITICAL ACCESS HOSPITALS*
(Chapter 3)

Facility by Region

Region I
Abbeville Memorial Hospital

Region II
Edgefield County Hospital
Fairfield Memorial Hospital

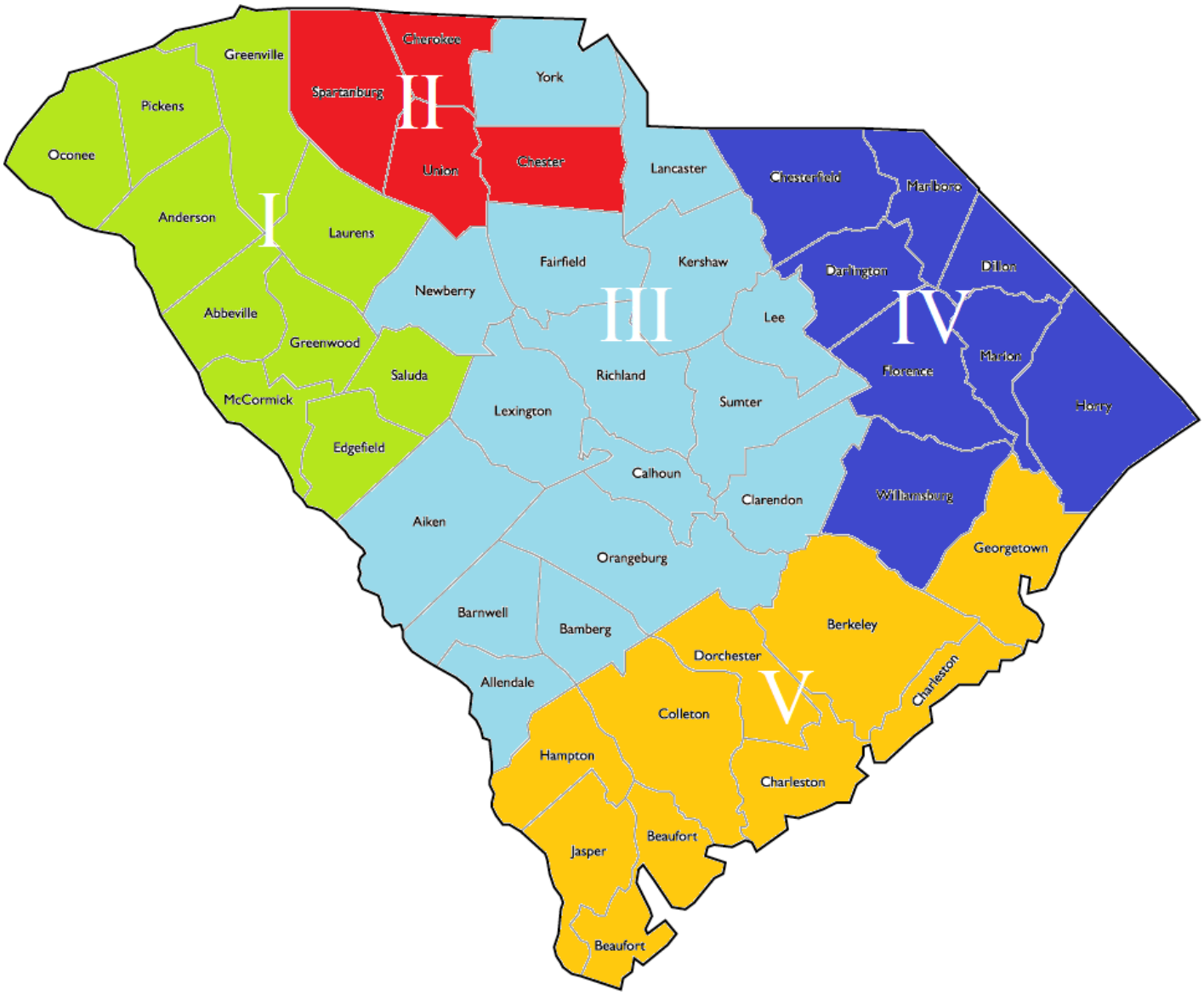
Region III
Williamsburg Regional Hospital

Region IV
Allendale County Hospital

* Other facilities may potentially be eligible for CAH status.

PERINATAL REGIONS MAP

(Chapter 3)



PERINATAL-CAPABLE FACILITIES
(Chapter 3)

Facility by Service Level	Perinatal Region
Regional Perinatal Centers (RPCs)	
GHS Greenville Memorial Hospital	I
Spartanburg Medical Center	II
Palmetto Health Richland	III
McLeod Regional Medical Center of the Pee Dee	IV
MUSC Medical Center	V
Subspecialty Perinatal Center (Level III Hospital)	
Self Regional Healthcare	I
Palmetto Health Baptist	III
Piedmont Medical Center	III
Specialty Perinatal Centers (Level II Hospitals)	
AnMed Health Women's and Children's Hospital	I
Baptist Easley Hospital	I
St. Francis - Eastside	I
Mary Black Health System - Spartanburg	II
Aiken Regional Medical Center	III
Lexington Medical Center	III
Regional Medical Center of Orangeburg & Calhoun Counties	III
Springs Memorial Hospital	III
Palmetto Health Tuomey	III
Carolinas Hospital System - Marion	IV
Carolina Pines Regional Medical Center	IV
Conway Hospital	IV
Grand Strand Medical Center	IV
The Women's Center of Carolinas Hospital System	IV
Beaufort Memorial Hospital	V
Bon Secours - St. Francis Xavier Hospital	V
East Cooper Medical Center	V
Tidelands Georgetown Memorial Hospital	V
Summerville Medical Center	V
Trident Medical Center	V
Tidelands Waccamaw Community Hospital	V

OB UTILIZATION AND BIRTHS
(Chapter 3)

Facility	2016 Births	OB Beds	Admissions	Patient Days	% Occup Rate
Aiken Regional Medical Center	1,058	18	1,214	2,839	43.2%
AnMed Health Women's & Children's Hospital	1,807	28	1,502	3,834	37.5%
Baptist Easley Hospital	437	14	516	1,340	26.2%
Beaufort Memorial Hospital	1,020	23	926	2,245	26.7%
Bon Secours Saint Francis Xavier Hospital	2,625	30	2,729	6,406	58.5%
Carolina Pines Regional Medical Center	578	13	734	1,706	36.0%
Carolinas Health System - Marion **1**	245	5	263	574	31.5%
Coastal Carolina Hospital	654	10	720	1,671	45.8%
Colleton Medical Center	298	6	311	716	32.7%
Conway Hospital	1,465	16	1,682	3,996	68.4%
East Cooper Medical Center	1,553	38	1,816	4,559	32.9%
Grand Strand Medical Center	937	19	1,186	2,523	36.4%
GHS Greenville Memorial Hospital	5,522	59	6,230	17,285	80.3%
GHS Greer Memorial Hospital	679	10	718	1,618	44.3%
GHS Laurens County Memorial Hospital	333	5	339	757	41.5%
GHS Oconee Memorial Hospital	488	15	552	1,127	20.6%
Hilton Head Hospital	463	8	513	1,008	34.5%
Kershaw Health	286	10	307	656	18.0%
Lexington Medical Center	3,388	29	3,757	9,229	87.2%
Mary Black Health System - Gaffney	262	15	614	763	13.9%
Mary Black Health System - Spartanburg	780	21	832	1,933	25.2%
McLeod Health Cheraw	196	10	211	425	11.6%
McLeod Health Clarendon	357	11	420	955	23.8%
McLeod Loris	440	8	474	945	32.4%
McLeod Medical Center Dillon	265	12	307	697	15.9%
McLeod Regional Medical Center of the Pee Dee	2,120	26	2,307	6,490	68.4%
Mount Pleasant Hospital	551	8	562	1,256	43.0%
MUSC Medical Center	2,640	36	2,788	8,921	67.9%
Newberry County Memorial Hospital	276	10	286	566	15.5%
Palmetto Health Baptist	3,179	83	7,018	11,550	38.1%
Palmetto Health Baptist Parkridge	649	34	733	2,385	19.2%
Palmetto Health Richland	2,412	42	4,056	11,325	73.9%
Palmetto Health Tuomey	1,260	24	265	3,643	41.6%
Piedmont Medical Center	1,637	19	1,737	4,528	65.3%
Regional Medical Center of Orangeburg & Calhoun Counties	910	32	NR	2,393	20.5%
St. Francis - Eastside	2,143	33	2,245	5,870	48.7%
Self Regional Healthcare	1,389	36	1,507	3,813	29.0%
Spartanburg Medical Center	3,033	39	2,015	8,224	57.8%
Springs Memorial Hospital	579	5	105	1,748	95.8%
Summerville Medical Center **2**	1,492	12	988	2,062	47.1%
Tidelands Georgetown Memorial Hospital	247	14	412	1,013	19.8%
Tidelands Waccamaw Community Hospital	561	19	1,277	3,706	53.4%
Trident Medical Center **2**	1,492	25	1,576	3,611	39.6%
Womens Center of Carolinas Hospital System	NR	NR	NR	NR	0.0%
		930	58,750	152,911	18
Total Births	**52,706**				

1 E-18-17 issued March 8, 2018 for the return of 2 intermediate bassinets to inventory and the closure of OB service.

2 CON SC-17-44 issued June 26, 2017 to consolidate Trident's and Summerville's obstretics and neonatal services into one unit at the Summerville campus, not yet completed.

INTENSIVE AND INTERMEDIATE BASSINETS
(Chapter 3)

Facility by Perinatal Region	Service Level	Existing Bassinets Intensive	Existing Bassinets Intermediate
Region I - Greenville Memorial			
GHS Greenville Memorial Hospital	RPC	12	68
Self Regional Healthcare	Level III	7	11
AnMed Health Women's & Children's Hospital	Level II	0	13
St. Francis - Eastside	Level II	0	14
Baptist Easley Hospital	Level I	0	4
Subtotal		**19**	**110**
Region II - Spartanburg Regional			
Spartanburg Medical Center	RPC	13	22
Mary Black Health System - Spartanburg	Level II	0	10
Subtotal		**13**	**32**
Region III - Palmetto Health Richland			
Palmetto Health Richland	RPC	31	38
Palmetto Health Baptist	Level III	8	22
Piedmont Medical Center	Level III	5	7
Aiken Regional Medical Centers	Level II	0	8
Lexington Medical Center	Level II	0	20
Regional Medical Center of Orangeburg & Calhoun Counties	Level II	0	10
Springs Memorial Hospital	Level II	0	4
Palmetto Health Tuomey	Level II	0	22
Subtotal		**44**	**131**
Region IV - McLeod Regional			
McLeod Regional Medical Center of the Pee Dee ***1***	RPC	25	23
Carolinas Hospital System - Marion **2**	Level II	0	0
Carolina Pines Regional Medical Center	Level II	0	4
Conway Hospital	Level II	0	6
Grand Strand Medical Center	Level II	0	2
Women's Center of Carolinas Hospital System	Level II	0	11
Subtotal		**25**	**46**
Region V - MUSC Medical			
MUSC Medical Center ***4***	RPC	46	36
Beaufort Memorial Hospital	Level II	0	5
Bon Secours St. Francis Xavier Hospital	Level II	0	11
East Cooper Medical Center	Level II	0	10
Tidelands Georgetown Memorial Hospital	Level II	0	5
Summerville Medical Center **3**	Level II	0	12
Trident Medical Center **3**	Level II	0	0
Tidelands Waccamaw Community Hospital	Level II	0	2
Subtotal		**46**	**81**
Totals		**147**	**400**

1 CON SC-18-14 issued March 27, 2018 for, among other things, the conversion of 5 intermediate bassinets to intensive care bassinets for a total of 23 intermediate bassinets and 25 intensive care bassinets, not yet implemented.

2 E-18-17 issued March 8, 2018 for the return of 2 intermediate bassinets to inventory and the closure of OB services.

3 CON SC-17-44 issued June 26, 2017 to consolidate Trident's and Summerville's obstretrics and neonatal services into one unit at the Summerville campus for a total of 12 intermediate bassinets at Summerville and 0 intermediate bassinets at Trident, not yet implemented.

4 Approved March 26, 2018 for the conversion of 14 Level II bassinets to Level III bassinets for a total of 46 Level III bassinets and 36 Level II bassinets, under appeal.

UTILIZATION OF NEONATAL SPECIAL CARE UNITS
(Chapter 3)

			2016					
Facility by Perinatal Region	**Service Level**	**Intensive Bassinets**	**Intensive Pt Days**	**Intermediate Bassinets**	**Intermediate Pt Days**	**Total Bassinets**	**Total Pt Days**	**Total Occupancy**
Region I - Greenville Memorial								
GHS Greenville Memorial Hospital	RPC	12	7,192	68	15,202	80	22,394	76.7%
Self Regional Healthcare	Level III	7	382	11	1,767	18	2,149	32.7%
AnMed Health Women's & Children's Hospital	Level II	0	0	13	1,358	13	1,358	28.6%
St. Francis - Eastside	Level II	0	0	14	1,456	14	1,456	28.5%
Baptist Easley Hospital	Level I	0	NR	4	NR	4	0	0.0%
SUBTOTAL		**19**	**7,574**	**110**	**19,783**	**129**	**27,357**	**58.1%**
Region II - Spartanburg Regional								
Spartanburg Medical Center	RPC	13	4,746	22	3,987	35	8,733	68.4%
Mary Black Health System - Spartanburg	Level II	0	0	10	177	10	177	4.8%
SUBTOTAL		**13**	**4,746**	**32**	**4,164**	**45**	**8,910**	**54.2%**
Region III - Palmetto Health Richland								
Palmetto Health Richland	RPC	31	11,901	38	9,581	69	21,482	85.3%
Palmetto Health Baptist	Level III	8	2,253	22	4,363	30	6,616	60.4%
Piedmont Medical Center	Level III	5	0	7	1,815	12	1,815	41.4%
Aiken Regional Medical Centers	Level II	0	0	8	202	8	202	6.9%
Lexington Medical Center	Level II	0	0	20	3,308	20	3,308	45.3%
Regional Medical Center of Orangeburg & Calhoun Counties	Level II	0	0	10	1,979	10	1,979	54.2%
Springs Memorial Hospital	Level II	0	0	4	100	4	100	6.8%
Palmetto Health Tuomey	Level II	0	0	22	166	22	166	2.1%
SUBTOTAL		**44**	**14,154**	**131**	**21,514**	**175**	**35,668**	**55.8%**
Region IV - McLeod Regional								
McLeod Regional Medical Center of the Pee Dee **1**	RPC	25	9,172	23	1,508	48	10,680	61.0%
Carolinas Hospital System - Marion **2**	Level II	0	33	0	0	0	33	0.0%
Carolina Pines Regional Medical Center	Level II	0	0	4	227	4	227	15.5%
Conway Hospital	Level II	0	0	6	932	6	932	42.6%
Grand Strand Medical Center	Level II	0	0	2	NR	2	0	0.0%
Women's Center of Carolinas Hospital System	Level II	0	0	11	NR	11	0	0.0%
SUBTOTAL		**25**	**9,205**	**46**	**2,667**	**71**	**11,872**	**45.8%**
Region V - MUSC Medical								
MUSC Medical Center ***4***	RPC	46	11,789	36	11,501	82	23,290	77.8%
Beaufort Memorial Hospital	Level II	0	0	5	102	5	102	5.6%
Bon Secours-St. Francis Xavier Hospital	Level II	0	0	11	1,859	11	1,859	46.3%
East Cooper Medical Center	Level II	0	0	10	981	10	981	26.9%
Tidelands Georgetown Memorial Hospital	Level II	0	0	5	97	5	97	5.3%
Summerville Medical Center **3**	Level II	0	0	12	1,188	12	1,188	27.1%
Trident Medical Center **3**	Level II	0	0	0	1,399	0	1,399	0.0%
Tidelands Waccamaw Community Hospital	Level II	0	0	2	418	2	418	57.3%
SUBTOTAL		**46**	**11,789**	**81**	**17,545**	**127**	**29,334**	**63.3%**
GRAND TOTAL		**147**	**47,468**	**400**	**65,673**	**547**	**113,141**	**56.7%**

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NICU BED NEED
(Chapter 3)

Counties by Perinatal Region	2016 Births	2015 Births	2014 Births	3 YR Average Births	2016 15-44 Female Population	2015 15-44 Female Population	2014 15-44 Female Population	3 YR 15-44 Female Population	Average Birth Rate	2020 15-44 Female Population	2020 Projected Births	Proj Birth Rate / Average Birth Rate	Existing NICU Beds	Bed Need
Region I														
Abbeville	208	246	248	234	4,305	4,337	4,403	4,348		4,110				
Anderson	2,320	2,254	2,273	2,282	36,461	36,321	36,070	36,284		37,130				
Edgefield	197	210	194	200	4,036	4,097	4,105	4,079		3,920				
Greenville	6,292	6,421	6,340	6,351	99,461	98,894	97,396	98,584		105,390				
Greenwood	794	820	865	826	14,086	14,143	14,100	14,110		13,500				
Laurens	779	761	736	759	12,278	12,256	12,339	12,291		12,070				
McCormick	52	56	87	65	986	1,026	1,090	1,034		880				
Oconee	748	792	801	780	12,274	12,243	12,253	12,257		12,010				
Pickens	1,225	1,254	1,295	1,258	25,743	25,723	25,574	25,680		25,330				
Saluda	237	251	279	256	3,308	3,350	3,421	3,360		3,160				
Total	**12,852**	**13,065**	**13,118**	**13,012**	**212,938**	**212,390**	**210,751**	**212,026**	**0.06137**	**217,500**	**13,348**	**1.025816**	**19**	**24**
Region II														
Cherokee	653	676	700	676	10,999	10,904	10,927	10,943		10,730				
Chester	354	376	388	373	5,692	5,738	5,810	5,747		5,340				
Spartanburg	3,689	3,560	3,574	3,608	58,872	58,361	57,663	58,299		60,100				
Union	326	314	325	322	4,818	4,874	4,935	4,876		4,490				
Total	**5,022**	**4,926**	**4,987**	**4,978**	**80,381**	**79,877**	**79,335**	**79,864**	**0.06233**	**80,660**	**5,028**	**1.009963**	**13**	**3**
Region III														
Aiken	1,964	1,997	1,901	1,954	30,617	30,307	30,281	30,402		30,670				
Allendale	74	77	103	85	1,339	1,431	1,510	1,427		1,150				
Bamberg	128	122	148	133	2,642	2,855	2,903	2,800		2,530				
Barnwell	248	247	265	253	3,908	3,914	3,984	3,935		3,670				
Calhoun	122	150	126	133	2,392	2,389	2,406	2,396		2,260				
Clarendon	313	332	353	333	5,455	5,500	5,591	5,515		5,310				
Fairfield	206	213	195	205	3,875	3,952	4,020	3,949		3,570				
Kershaw	793	751	741	762	11,473	11,404	11,317	11,398		11,670				
Lancaster	1,062	1,043	1,005	1,037	15,975	15,341	14,881	15,399		16,570				
Lee	190	158	175	174	2,853	2,868	2,917	2,879		2,590				
Lexington	3,261	3,205	3,207	3,224	55,352	54,889	54,192	54,811		57,340				
Newberry	453	455	461	456	6,689	6,757	6,776	6,741		6,630				
Orangeburg	970	1,004	953	976	16,784	17,315	17,547	17,215		15,790				
Richland	4,803	5,010	4,768	4,860	95,059	94,778	93,698	94,512		100,610				
Sumter	1,379	1,527	1,459	1,455	20,848	21,006	21,315	21,056		20,500				
York	3,011	2,933	2,909	2,951	52,166	50,917	50,056	51,046		54,670				
Total	**18,977**	**19,224**	**18,769**	**18,990**	**327,427**	**325,623**	**323,394**	**325,481**	**0.05834**	**335,530**	**19,576**	**1.030873**	**44**	**20**
Region IV														
Chesterfield	483	518	521	507	8,243	8,272	8,382	8,299		7,760				
Darlington	774	843	800	806	12,581	12,823	12,897	12,767		12,270				
Dillon	389	412	400	400	5,839	5,934	5,953	5,909		5,690				
Florence ***1***	1,656	1,697	1,763	1,705	27,973	28,196	28,370	28,180		28,070				
Horry	3,125	3,178	3,051	3,118	55,827	54,279	53,159	54,422		58,610				
Marion	369	382	404	385	5,836	5,899	5,943	5,893		5,520				
Marlboro	277	342	302	307	4,426	4,477	4,541	4,481		4,020				
Williamsburg	317	357	342	339	5,464	5,582	5,591	5,546		5,080				
Total	**7,390**	**7,729**	**7,583**	**7,567**	**126,189**	**125,462**	**124,836**	**125,496**	**0.06030**	**127,020**	**7,659**	**1.012147**	**25**	**0**
Region V														
Beaufort	1,956	2,057	2,046	2,020	29,357	29,214	28,850	29,140		30,670				
Berkeley	2,756	2,722	2,650	2,709	42,469	40,707	40,047	41,074		44,870				
Charleston ***2***	5,010	4,991	4,961	4,987	83,794	83,035	81,313	82,714		90,390				
Colleton	441	482	449	457	6,602	6,616	6,669	6,629		6,180				
Dorchester	1,799	1,817	1,907	1,841	31,183	31,296	30,419	30,966		34,460				
Georgetown	578	551	562	564	9,303	9,512	9,468	9,428		9,190				
Hampton	207	213	220	213	3,413	3,446	3,504	3,454		3,130				
Jasper	349	356	379	361	4,767	4,762	4,686	4,738		4,920				
Total	**13,096**	**13,189**	**13,174**	**13,153**	**210,888**	**208,588**	**204,956**	**208,144**	**0.06319**	**223,810**	**14,143**	**1.075265**	**46**	**0**
Statewide	**57,337**	**58,133**	**57,631**	**57,700**	**957,823**	**951,940**	**943,272**	**951,012**		**984,520**	**59,754**		**147**	**47**

1 CON SC-18-14 issued March 27, 2018 for, among other things, the conversion of 5 intermediate bassinets to intensive care bassinets for a total of 23 intermediate bassinets and 25 intensive care bassinets, not yet implemented.

2 Medical University of South Carolina approved on March 26, 2018 for the conversion of 14 intermediate bassinets to intensive care bassinets for a total of 46 intensive care bassinets, under appeal.

CHAPTER 4

PSYCHIATRIC SERVICES

COMMUNITY PSYCHIATRIC BEDS

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

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

The Psychiatric Programs Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. Need projections are based on psychiatric service areas. The service areas are consistent for psychiatric services, inpatient alcohol and drug abuse facilities, and inpatient residential treatment facilities for children and adolescents.

2. The methodology for calculating psychiatric bed need is as follows:

    a. For the service area, take the greater of the service area utilization rate or the statewide utilization rate for psychiatric beds by age cohort. The statewide utilization rate for each age cohort will be used for those service areas where no beds currently exist.

    b. Multiply the applicable utilization rate by the projected population for the year 2023 for each age cohort (where such data is available) and divide by 365 to obtain a projected average daily census by age cohort.

    c. Take the sum of average daily censuses by age cohort and divide by the target occupancy rate of 70% to determine the number of beds needed in the service area.

d. The number of additional beds needed or excess beds for the service area is obtained by subtracting the number of existing beds from the bed need.

3. Should the service area show a need for additional beds, a general acute care hospital which has no licensed or CON-approved psychiatric beds may be approved for the maximum of the actual projected bed need or up to 20 additional beds ("20 Bed Rule") to establish an economical unit ("Unit"). An applicant seeking more beds than are projected may not use such beds for the establishment of a specialty psychiatric unit. Any beds sought in excess of the projected bed need in the service area must be used for the provision of general adult psychiatric services in order to address the growing number of psychiatric patients being held in hospital emergency departments. Finally, although more than one general acute care hospital per service area may apply for beds under this provision, the Department may approve no more than 19 beds, in any combination, beyond the need shown in this Plan for each service area.

4. In the absence of a projected need for beds in a psychiatric service area, an existing facility can apply to add up to eight additional beds, given that it has achieved an occupancy rate of at least 70% as reported on the most recent Joint Annual Report ("JAR").

5. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

The Psychiatric Bed Need Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Acceptability;
4. Record of the Applicant;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Psychiatric beds are planned for and located within 60 minutes' travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of

improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these services.

STATE MENTAL HEALTH FACILITIES

Psychiatric Hospital Beds

DMH operates a variety of psychiatric facilities. DMH has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement and expansion of the component programs should be allowed as long as the overall psychiatric hospital complement is maintained or reduced. As long as DMH does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, any changes in facility bed capacity *would not require Certificate of Need review.*

Local Inpatient Crisis Stabilization Beds

DMH reports there are an insufficient number of adult inpatient psychiatric beds in a number of regions of the State. As a result of this situation, significant numbers of persons in a behavioral crisis are being held in hospital emergency rooms for inordinate periods of time until an appropriate inpatient psychiatric bed becomes available. These emergency room patients may not have a source of funding.

DMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities, for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding, DMH contracts with one or more local hospitals willing to admit indigent patients assessed by DMH 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.

To assist in alleviating this problem, the following policies will apply:

a. *A Certificate of Need is not required* to convert existing acute care beds or existing psychiatric beds to create Crisis Stabilization services pursuant to a contract with DMH.

b. *A Certificate of Need is required* to add psychiatric beds pursuant to a contract with DMH to provide Crisis Stabilization services. 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.

c. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from DMH 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 DMH 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, DMH 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 DMH and may be reimbursed 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 DMH. Should the contract with DMH terminate for any reason or should the hospital fail to provide care to the patients referred from DMH, the license for these beds will be voided.

If justified by DMH, the Department will consider converting inpatient psychiatric beds to other levels of care provided that alternative community-based resources are not available. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

PSYCHIATRIC PROGRAMS
(Chapter 4)

Facility by Region	County	Beds	2016 Pt. Days	Occup Rate
Region I				
AnMed Health Medical Center	Anderson	38	7,433	53.6%
Carolina Center Behavioral Health	Greenville	117	32,240	75.5%
GHS Marshall I. Pickens Hospital	Greenville	65	11,468	48.3%
Mary Black Health System - Spartanburg	Spartanburg	15	3,553	64.9%
Self Regional Healthcare	Greenwood	32	3,869	33.1%
Spartanburg Medical Center	Spartanburg	56	5,289	25.9%
Springbrook Behavioral Health ***1***	Greenville	56	10,829	53.0%
Region II				
Aiken Regional Medical Center	Aiken	44	13,047	81.2%
KershawHealth ***2***	Kershaw	20	0	0.0%
Palmetto Health Baptist	Richland	55	10,888	54.2%
Palmetto Health Richland	Richland	52	13,114	69.1%
Piedmont Medical Center	York	20	4,871	66.7%
Rebound Behavioral Health	Lancaster	24	8,261	94.3%
Springs Memorial Hospital ***7***	Lancaster	12	2,147	49.0%
Three Rivers Behavioral Health	Lexington	105	31,918	83.3%
Region III				
Carolinas Hospital System - Cedar Tower ***3***	Florence	20	0	0.0%
South Strand Medical Center (Grand Strand Medical Center) ***4***	Horry	20	0	0.0%
Lighthouse Behavioral Health Center ***5***	Horry	69	18,988	75.4%
McLeod Medical Center - Darlington	Darlington	23	6,380	76.0%
Region IV				
Hilton Head Hospital ***6***	Beaufort	16	0	0.0%
Beaufort Memorial Hospital	Beaufort	14	2,811	55.0%
Colleton Medical Center	Colleton	19	5,293	76.3%
MUSC Medical Center	Charleston	82	31,722	106.0%
Palmetto Lowcountry Behavioral	Charleston	92	21,896	65.2%
Trident Medical Center ***7***	Charleston	17	6,155	99.2%
Regional Medical Center - O'burg & Calhoun	Orangeburg	15	2,628	48.0%
Government Facilities				
G. Werber Bryan Psychaitric Hospital ***8***	Richland	530	52,015	26.9%

Gilliam Psychiatric Hospital ***8 & 9***	Richland	87	NR	
Patrick B. Harris Psychiatric Hospital ***8***	Anderson	200	39,964	54.7%
William J McCord Adolescent Treatment Facility ***8***	Orangeburg	15	0	0.0%
	Total	**1098**	**254,800**	**63.6%**

1 SC-17-08 issued 2/16/2017 for the addition of 18 psychiatric beds for a total of 56 psychiatric beds, not yet implemented.
2 SC-18-10 issued 3/12/18 for the development of a 20 bed inpatient psychiatric unit, not yet implemented.

3 SC-17-79 issued 12/7/17 for the establishment of a 20 bed psychiatric unit, not yet implemented.

4 CON SC-16-35 issued 8/1/2016 for the establishmet of a 20 bed psychiatric program, not yet complete.
5 SC-17-78 issued 12/5/17 for the addition of 9 psychiatric beds for a total of 69 psychiatric beds, not yet implemented.
6 SC-17-68 issued 10/10/17 for the development of a 16 bed inpatient psychiatric unit, not yet implemented.

7 Age cohorts not adequately reported.
8 State facility not operating all its licensed beds. Their utilization does not impact calculation of need.
9 Did not submit 2016 JAR.

PSYCHIATRIC BED NEED
(Chapter 4)

Service Area	Age Cat	2016 Pop	2023 Pop	Existing Beds	2016 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Bed Need
Anderson, Oconee	<18	60,587	59,510		-							
	18-64	160,597	161,480		6,940	19						
	+65	51,740	62,050		493	2						
	TOTAL	**272,924**	**283,040**	**38**	**7,433**	**21**	**0.70**	**30**	**-8**	**57**	**19**	**19**
Greenville, Pickens	<18	139,927	150,510		3,627	11						
	18-64	387,366	410,920		39,350	114						
	+65	94,336	121,900		11,560	41						
	TOTAL	**621,629**	**683,330**	**238**	**54,537**	**166**	**0.70**	**237**	**-1**	**137**	**-101**	**-1**
Cherokee, Spartanburg, Union	<18	89,639	90,160		-							
	18-64	234,356	235,970		4,116	11						
	+65	61,787	74,040		4,726	16						
	TOTAL	**385,782**	**400,170**	**71**	**8,842**	**27**	**0.70**	**38**	**-33**	**80**	**9**	**9**
Chester, Lancaster, York	<18	90,125	93,140									
	18-64	231,001	251,610									
	+65	59,175	81,910									
	TOTAL	**380,301**	**426,660**	**56**	**15,279**	47	**0.70**	**67**	**11**	**86**	**30**	**30**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	<18	46,750	44,150		-							
	18-64	130,429	122,080		2,666	7						
	+65	40,801	47,480		1,203	4						
	TOTAL	**217,980**	**213,710**	**32**	**3,869**	**11**	**0.70**	**15**	**-17**	**43**	**11**	**11**
Fairfield, Kershaw, Lexington, Newberry, Richland	<18	183,178	191,120		8,461	24						
	18-64	522,324	541,620		36,428	103						
	+65	115,072	150,290		11,031	39						
	TOTAL	**820,574**	**883,030**	**232**	**55,920**	**167**	**0.70**	**239**	**7**	**178**	**-54**	**7**
Darlington, Florence, Marion	<18	55,955	53,540		77	0						
	18-64	141,657	135,200		4,297	11						
	+65	40,090	46,610		2,006	6						
	TOTAL	**237,702**	**235,350**	**43**	**6,380**	**18**	**0.70**	**25**	**-18**	**47**	**4**	**4**
Chesterfield, Dillon, Marlboro	<18	23,806	22,020									
	18-64	62,911	57,740									
	+65	17,099	19,650									
	TOTAL	**103,816**	**99,410**	**-**	**-**	**0**	**0.70**	**0**	**0**	**20**	**20**	**20**
Clarendon, Lee, Sumter	<18	36,685	34,070									
	18-64	95,342	87,970									
	+65	26,955	31,920									
	TOTAL	**158,982**	**153,960**	**-**	**-**	**0**	**0.70**	**0**	**0**	**31**	**31**	**31**
Georgetown, Horry, Williamsburg	<18	78,804	81,110		2,778	8						
	18-64	243,000	257,100		13,015	38						
	+65	93,892	139,260		3,195	13						
	TOTAL	**415,696**	**477,470**	**89**	**18,988**	**59**	**0.70**	**84**	**-5**	**96**	**7**	**7**
Bamberg, Calhoun, Orangeburg	<18	25,548	24,050		-							
	18-64	69,480	60,610		2,185							
	+65	22,105	25,380		443							
	TOTAL	**117,133**	**110,040**	**15**	**2,628**	**7**	**0.70**	**10**	**-5**	**22**	**7**	**7**
Allendale, Beaufort, Hampton, Jasper	<18	47,515	47,640		-							
	18-64	135,829	141,580		2,594							
	+65	57,237	80,720		217							
	TOTAL	**240,581**	**269,940**	**30**	**2,811**	**9**	**0.70**	**12**	**-18**	**54**	**24**	**24**
Berkeley, Charleston, Colleton, Dorchester	<18	177,179	189,370									
	18-64	506,638	563,090									
	+65	115,261	162,680									
	TOTAL	**799,078**	**915,140**	**210**	**65,066**	**204**	**0.70**	**292**	**82**	**184**	**-26**	**82**
Aiken, Barnwell	<18	41,923	40,460		2,827	7						
	18-64	112,336	109,980		8,001	21						
	+65	34,682	43,250		2,219	8						
	TOTAL	**188,941**	**193,690**	**44**	**13,047**	**37**	**0.70**	**52**	**8**	**39**	**-5**	**8**
Statewide Totals	<18	1,097,621	1,120,850									
	18-64	3,033,266	3,136,950									
	+65	830,232	1,087,140									
	TOTAL	**4,961,119**	**5,344,940**	**1,098**	**254,800**	**752**	**0.000201**	**1101**		**1074**		**259**

CHAPTER 5

REHABILITATION FACILITIES

A Rehabilitation Facility is operated for the primary purpose of providing comprehensive physical rehabilitation services through an intensive, coordinated team approach for patients with severe physical ailments. These facilities 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. CMS identifies 13 specific conditions for which facilities must treat 60% of their patients ("the compliance threshold") in order to qualify for Medicare reimbursement. Certain comorbidities as specified in 42 CFR 412.29(b)(1) must be used to determine the compliance threshold.

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 Rehabilitation Programs Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. The need for beds is calculated based on rehabilitation service areas.

2. The methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 of the 65+ population cohort to project need.

3. For service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections.

The Rehabilitation Bed Need Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses; and
5. Cost Containment

Rehabilitation facilities are now located throughout the state and are available within approximately 60 minutes' travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Statewide Programs

The South Carolina Vocational Rehabilitation Center operates a 30-bed facility in West Columbia to serve the vocational training needs of the disabled.

REHABILITATION PROGRAMS
(Chapter 5)

Facility by Region	County	2016 Beds	Pt. Days	Occup Rate
Region I				
AnMed Health Rehab Hospital	Anderson	60	17,656	80.6%
Roger C. Peace (GHS Greenville Memorial)	Greenville	53	10,396	53.7%
St. Francis - Downtown	Greenville	19	4,294	61.9%
Greenwood Regional Rehab Hospital	Greenwood	42	10,717	69.9%
Mary Black Health System - Spartanburg	Spartanburg	18	3,685	56.1%
Spartanburg Rehabilitation Institute	Spartanburg	40	10,559	72.3%
Region II				
Aiken Regional Medical Centers ***1***	Aiken	14	0	0.0%
Midlands Regional Rehabilitation Hospital ***2***	Kershaw	40	0	0.0%
HealthSouth Rehab Hospital of Columbia	Richland	96	23,899	68.2%
Palmetto Health Children's Hospital ***3***	Richland	13	0	0.0%
HealthSouth Rehab Hospital of Rock Hill	York	50	15,767	86.4%
Region III				
Carolinas Hospital System - Cedar Tower ***10***	Florence	42	NR	0.0%
HealthSouth Rehab Hospital of Florence	Florence	88	16,635	51.8%
Tidelands Waccamaw Community Hospital ***4 & 5***	Georgetown	29	12,127	114.6%
Grand Strand Medical Center ***6***	Horry	24	0	0.0%
Myrtle Beach Rehabilitation Hospital ***5***	Horry	46	0	0.0%
Region IV				
Beaufort Memorial Hospital	Beaufort	14	2,602	50.9%
Encompass Health Rehabilitation Hospital of Hilton Head ***7***	Beaufort	38	0	0.0%
HealthSouth Rehab Hospital of Charleston	Charleston	49	14,351	80.2%
Roper Hospital ***8***	Charleston	66	14,845	61.6%
Trident Medical Center ***9***	Charleston	14	0	0.0%
Regional Medical Center of Orangeburg & Calhoun	Orangeburg	24	4,989	57.0%
	TOTAL	879	162,522	50.7%

1 CON SC-16-200 issued 12/28/16 for the establishment of a new 14 bed inpatient rehabiliation unit.

2 CON SC-16-183 issued 12/15/16 for the construction of a new 40 bed Comprehensive Rehabilitation Hospital, not yet implemented.

3 CON SC-16-43 issued 8/11/16 for the establishment of a new 13 bed rehabilitation unit, not yet implemented.

4 CON SC-16-37 issued 8/10/16 for the addition of 17 rehabilitation beds for a total of 60 rehabilitation beds, not yet completed.

5 CON SC-17-18 issued 4/6/17 for construction of a new 46 bed Comprehensive Rehabilitation Hospital, through the transfer of 31 rehabilitation beds from Tidelands Waccamaw and an additional 15 rehabilitation beds, not yet completed.

6 CON SC-17-17 issued 4/6/17 for the establishment of a 24 bed rehabilitation unit, not yet completed.

7 CON SC-16-44 issued 8/11/16 for the construction of a new 38 bed Comprehensive Rehabilitation Hospital, not yet completed. Facility changed name from HealthSouth Rehab Hospital of the Lowcountry.

8 CON SC-16-75 issued 9/23/16 for the addition of 14 rehabilitation beds for a total of 66 rehabilitation beds, not yet completed.

9 CON approved 9/26/16 for the establishment of a 14 bed rehabilitation unit; CON to be issued July 2018, per court order.

REHABILITATION BED NEED
(Chapter 5)

Service Area	>65 2016 Pop	>65 2023 Pop	2016 Pop	2023 Pop	Existing Beds	2016 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Need
Anderson, Oconee	51,740	62,050	272,924	283,040	**60**	17,656	50	0.70	71	11	66	6	**11**
Greenville, Pickens	94,336	121,900	621,629	683,330	**72**	14,690	44	0.70	63	-9	129	57	**57**
Cherokee, Spartanburg, Union	61,787	74,040	385,782	400,170	**58**	14,244	40	0.70	57	-1	78	20	**20**
Chester, Lancaster, York	59,175	81,910	380,301	426,660	**50**	15,767	48	0.70	69	19	87	37	**37**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	40,801	47,480	217,980	213,710	**42**	10,717	29	0.70	41	-1	50	8	**8**
Fairfield, Lexington, Newberry, Richland	104,000	136,600	756,477	816,880	**109**	23,899	71	0.70	101	-8	145	36	**36**
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	63,434	73,480	373,473	364,370	**130**	16,635	44	0.70	63	-67	78	-52	**-52**
Clarendon, Kershaw, Lee, Sumter	38,027	45,610	223,079	220,110	**40**	0	0	0.70	0	-40	34	-6	**-6**
Georgetown, Horry	87,647	132,040	383,741	447,860	**99**	12,127	39	0.70	56	-43	140	41	**41**
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Orangeburg	58,467	70,550	315,119	311,820	**38**	4,989	14	0.70	20	-18	75	37	**37**
Beaufort, Hampton, Jasper	55,557	78,800	231,536	261,850	**52**	2,602	8	0.70	11	-41	83	31	**31**
Berkeley, Charleston, Colleton, Dorchester	115,261	162,680	799,078	915,140	**129**	29,196	92	0.70	131	2	172	43	**43**
Statewide Totals	**830,232**	**1,087,140**	**4,961,119**	**5,344,940**	**879**	**162,522**	**480**	**1.05874**	**683**		**1,137**		**263**

CHAPTER 6

ALCOHOL AND DRUG ABUSE FACILITIES

There are six types of licensed substance abuse treatment facilities in South Carolina. These are (1) outpatient facilities, (2) social detoxification centers, (3) freestanding medical detoxification facilities, (4) residential treatment programs, (5) inpatient treatment services, and (6) opioid (narcotic) treatment programs.

OUTPATIENT FACILITIES

An outpatient facility provides treatment, care and services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 71 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 98 locations.

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

SOCIAL DETOXIFICATION FACILITIES

A social detoxification facility provides supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxication nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. It provides 24-hour-a-day observation of the client until discharge.

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

FREESTANDING MEDICAL DETOXIFICATION FACILITIES

A freestanding medical detoxification facility is a short-term residential facility, separate from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed. There are currently four freestanding medical detoxification facilities located in the State, operated by local County Alcohol and Drug Abuse Agencies.

The Freestanding Medical Detoxification Facilities Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. Medical detoxification services are allocated by Department region.

2. Facilities can be licensed for a maximum of 16 beds in order to meet federal requirements.

3. Because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit may be approved in any service area without an existing detoxification unit, provided the applicant can document the need.

4. Additional facilities are needed for the services to be accessible within 60 minutes' travel time for the majority of state residents.

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. Distribution (Accessibility);
2. Projected Revenues;
3. Projected Expenses;
4. Ability to Complete the Project;
5. Cost Containment; and
6. Staff Resources.

Additional facilities are needed for the services to be accessible within 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.

RESIDENTIAL TREATMENT PROGRAM FACILITIES

A residential treatment program facility is a 24-hour facility offering an organized service in a residential setting, which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff 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.

A Certificate of Need is not required for a Residential Treatment Program.

INPATIENT TREATMENT FACILITIES

An inpatient treatment facility is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. For reference purposes only, these facilities are also subject to compliance with Regulation 61-16.

The Inpatient Treatment Facilities Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. Need projections are calculated by service area. Because patients in need of alcohol and/or drug abuse treatment frequently require psychiatric treatment services as well, the inpatient treatment service areas mirror the psychiatric service areas (e.g., Anderson/Oconee, Greenville/Pickens, etc.) to facilitate planning in a manner that recognizes the comorbidity of this patient population.

2. The methodology for calculating inpatient treatment bed need is as follows:

    a. For the service area, take the greater of the service area utilization rate or the statewide utilization rate for inpatient treatment beds by age cohort. The statewide utilization rate for each age cohort will be used for those service areas where no beds currently exist.

    b. Multiply the applicable utilization rate by the projected population for the year 2023 for each age cohort (where such data is available) and divide by 365 to obtain a projected average daily census by age cohort.

    c. Take the sum of average daily censuses by age cohort and divide by the target occupancy rate of 75% to determine the number of beds needed in the service area.

    d. The number of additional beds needed or excess beds for the service area is obtained by subtracting the number of existing beds from the bed need.

3. Because a minimum of 20 beds is needed for an inpatient program, a 20-bed unit may be approved in a service area that does not have any existing beds provided the applicant can document the need.

4. In the absence of a projected need in the service area, an existing inpatient treatment facility can apply to add up to eight additional inpatient treatment beds if it has achieved an occupancy rate of at least 70% as reported on its most recent Joint Annual Report ("JAR").

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 to serve more than a single service area may be proposed in order to improve access to care for patients in service areas that are not currently well served. Such a proposed center would be allowed to combine the bed need for separate, contiguous service areas, provided that each service area to be combined shows a positive bed need. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to form a regional treatment facility.

7. It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, 75% of licensed substance abuse beds may be utilized alternatively for the treatment of 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. Distribution (Accessibility);
2. Projected Revenues;
3. Projected Expenses;
4. Ability to Complete the Project;
5. Cost Containment; and
6. Staff Resources.

Services are accessible within 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.

The Inpatient Treatment Bed Need Chart is located at the end of this Chapter.

OPIOID TREATMENT PROGRAMS

Opioid treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and non-pharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, 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. For reference purposes only, Opioid (narcotic) treatment programs are described in Regulation 61-93.

Charges for medication usually range between $11 and $17 per day. A Registered Pharmacist must dispense the medication.

The Opioid Treatment Programs Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. Because clients must usually attend a center 6 days per week to receive their dose of medication, these centers should be located throughout the state, with at least one center per county. To improve accessibility, opioid treatment programs should be developed in counties where none exist.

2. An additional treatment program can only be approved in a county with an existing program if the applicant is able to document sufficient need for the service.

3. For reference purposes only, Regulation 61-93 states that a narcotic (opioid) treatment program shall not operate within 500 feet of: the property line of a church, the property line of a public or private elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district, or the property line of a lot devoted to residential use.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Record of the Applicant;
4. Ability to Complete the Project.

Due to the increasing number of opioid deaths in South Carolina, additional facilities are needed for the services to be accessible within 30 minutes' travel time for the majority of state residents. The benefits of improved accessibility will outweigh the adverse effects of the duplication of this existing service.

FREESTANDING MEDICAL DETOXIFICATION FACILITIES*
(Chapter 6)

FACILITY BY REGION	COUNTY	BEDS
REGION I		
The Phoenix Center Behavioral Health Services	Greenville	16
REGION II		
Keystone Inpatient Services	York	10
Lexington/Richland Alcohol & Drug Abuse/Detox Unit	Richland	16
REGION IV		
Charleston Center Subacute Detoxification Program	Charleston	16
	TOTAL	**58**

* Holmesview Treatment Center, Patrick B. Harris Psychiatric Hospital, James F. Byrnes Center, Morris Village Alcohol & Drug Addiction Treatment Center, and Palmetto Treatment Center are classified as statewide facilities with restricted admissions procedures and are not included in this inventory.

INPATIENT TREATMENT FACILITIES (SUBSTANCE ABUSE FACILITIES)*
(Chapter 6)

Facility by Region	County	Beds	2016 Pt. Days	Occup Rate
Region I				
Carolina Center for Behavioral Health **1**	Greenville	29	8,299	78.4%
Springbrook Behavioral Health System	Greenville	6	0	0.0%
Region II				
Aiken Regional Medical Centers	Aiken	18	5,338	81.2%
Palmetto Health Baptist	Richland	10	0	0.0%
Palmetto Richland Springs (Palmetto Health Richland)	Richland	10	0	0.0%
Rebound Behavioral Health	Lancaster	18	2,041	31.1%
Three Rivers Behavioral Health	Lexington	17	1,647	26.5%
Region III				
Carolinas Hospital System Cedar Tower **2**	Florence	12	NR	0.0%
Lighthouse Behavioral Health Hospital	Horry	27	6,933	70.4%
Region IV				
MUSC Medical Center	Charleston	23	3,323	39.6%
Palmetto Lowcountry Behavioral Health	Charleston	16	746	12.8%
	TOTAL	**186**	**28,327**	**41.7%**

* Morris Village is a State facility licensed for one hundred and sixty-three (163) substance abuse treatment beds that are not counted in the CON methodology.

1 SC-17-09 issued 2/16/17 for the addition of 8 substance abuse beds for a total of 29 substance abuse beds, not yet completed.

2 Did not complete 2016 JAR.

INPATIENT TREATMENT BED NEED (SUBSTANCE ABUSE)
(Chapter 6)

SERVICE AREA	AGE CAT	2016 POP	2023 POP	EXISTING BEDS	2016 PT. DAYS	2016 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
Anderson, Oconee	0-17	60,587	59,510	0		0.00000	0.75	0		2		
	18-64	160,597	161,480			0.00000	0.75	0	0	4	8	8
	65+	51,740	62,050			0.00000	0.75	0		2		
Cherokee, Spartanburg,	0-17	89,639	90,160	0		0.00000	0.75	0		2		
Union	18-64	234,356	235,970			0.00000	0.75	0	0	5	9	9
	65+	61,787	74,040			0.00000	0.75	0		2		
Greenville, Pickens	0-17	139,927	150,510	35	0	0.00000	0.75	0		4		
	18-64	387,366	410,920		7,539	0.01946	0.75	30	-1	9	-19	-1
	65+	94,336	121,900		760	0.00806	0.75	4		3		
Abbeville, Edgefield,	0-17	46,750	44,150	0		0.00000	0.75	0		1		
Greenwood, Laurens,	18-64	130,429	122,080			0.00000	0.75	0	0	3	5	5
McCormick, Saluda	65+	40,801	47,480			0.00000	0.75	0		1		
Chester, Lancaster, York	0-17	90,125	93,140	18	42	0.00047	0.75	1		2		
	18-64	231,001	251,610		1,794	0.00777	0.75	8	-7	6	-8	-7
	65+	59,175	81,910		205	0.00346	0.75	2		2		
Fairfield, Kershaw,	0-17	183,178	191,120	37	5	0.00003	0.75	1		4		
Lexington, Newberry,	18-64	522,324	541,620		1,406	0.00269	0.75	6	-28	12	-17	-17
Richland	65+	115,072	150,290		236	0.00205	0.75	2		4		
Chesterfield, Dillon,	0-17	23,806	22,020	0		0.00000	0.75	0		1		
Marlboro	18-64	62,911	57,740			0.00000	0.75	0	0	2	4	4
	65+	17,099	19,650			0.00000	0.75	0		1		
Clarendon, Lee, Sumter	0-17	36,685	34,070	0		0.00000	0.75	0		1		
	18-64	95,342	87,970			0.00000	0.75	0	0	2	4	4
	65+	26,955	31,920			0.00000	0.75	0		1		
Darlington, Florence,	0-17	55,955	53,540	12		0.00000	0.75	0		2		
Marion	18-64	141,657	135,200			0.00000	0.75	0	-12	3	-6	-6

INPATIENT TREATMENT BED NEED (SUBSTANCE ABUSE)
(Chapter 6)

SERVICE AREA	AGE CAT	2016 POP	2023 POP	EXISTING BEDS	2016 PT. DAYS	2016 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
	65+	40,090	46,610			0.00000	0.75	0		1		
Georgetown, Horry,	0-17	78,804	81,110	27		0.00000	0.75	0		2		
Williamsburg	18-64	243,000	257,100		6,097	0.02509	0.75	24	2	6	-16	2
	65+	93,892	139,260		836	0.00890	0.75	5		3		
Aiken, Barnwell	0-17	41,923	40,460	18	771	0.01839	0.75	3		1		
	18-64	112,336	109,980		3,753	0.03341	0.75	14	3	3	-13	3
	65+	34,682	43,250		814	0.02347	0.75	4		1		
Allendale, Beaufort,	0-17	47,515	47,640	0		0.00000	0.75	0		1		
Hampton, Jasper	18-64	135,829	141,580			0.00000	0.75	0	0	3	6	6
	65+	57,237	80,720			0.00000	0.75	0		2		
Bamberg, Calhoun,	0-17	25,548	24,050	0		0.00000	0.75	0		1		
Orangeburg	18-64	69,480	60,610			0.00000	0.75	0	0	2	4	4
	65+	22,105	25,380			0.00000	0.75	0		1		
Berkeley, Charleston,	0-17	177,179	189,370	39	3	0.00002	0.75	1		4		
Colleton, Dorchester	18-64	506,638	563,090		3,889	0.00768	0.75	16	-21	12	-19	-19
	65+	115,261	162,680		177	0.00154	0.75	1		4		
Statewide Totals		**4,961,119**		**186**	**28,327**			**122**		**128**		**-5**

			State
0-64	**4,130,887**	**4,257,800**	**Usage**
65+	**830,232**	**1,087,140**	**Rate**
Total	**4,961,119**	**5,344,940**	**0.000016**

OPIOID TREATMENT PROGRAMS
(Chapter 6)

Region	Facility	County
I	Southwest Carolina Treatment Center	Anderson
I	Crossroads Treatment Center of Greenville	Greenville
I	Greenville Metro Treatment Center	Greenville
I	Greenwood Treatment Specialists	Greenwood
I	Clear Skye Treatment Center	Laurens
I	Crossroads Treatment Center of Seneca	Oconee
I	Recovery Concepts of the Carolina Upstate, LLC	Pickens
I	BHG- Spartanburg Treatment Center	Spartanburg
I	Palmetto Carolina Treatment Center	Spartanburg
II	BHG - Aiken Treatment Center	Aiken
II	Columbia Metro Treatment Center	Lexington
II	Lexington Treatment Specialists ***1***	Lexington
II	Crossroads Treatment Center of Columbia	Richland
II	York County Treatment Center	York
II	Rock Hill Treatment Specialists	York
III	Starting Point of Darlington	Darlington
III	Starting Point of Florence PC	Florence
III	Center of Hope of Myrtle Beach	Horry
IV	Center for Behavioral Health South Carolina	Charleston
IV	Charleston Center	Charleston
IV	Crossroads Treatment Centers of Charleston	Charleston
IV	Recovery Concepts	Jasper

1 CON SC-18-16 issued March 13, 2018.

CHAPTER 7

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND ADOLESCENTS

A Residential Treatment Facility for Children and Adolescents (RTF) is operated for the assessment, diagnosis, treatment, and care of two or more children and/or adolescents in need of mental health treatment. Children and/or adolescents up to age 21 who manifest a substantial disorder of cognitive or emotional process which lessens or impairs to a marked degree their capacity either to develop or to exercise age-appropriate or age-adequate behavior are treated by these facilities.

These facilities provide medium to long-term care (six months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the South Carolina Continuum of Care (COC) to provide these services.

Services available, at a minimum, should include the following:

1. 24-hour, awake supervision in a secure facility;

2. individual treatment plans to assess the problems and determine specific patient goals;

3. psychiatric consultation and professional psychological services for treatment supervision and consultation;

4. nursing services, as required;

5. regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. recreational facilities with an organized youth development program;

7. a special education program with a minimum program defined by the South Carolina Department of Education; and

8. discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

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

such hospitalization becomes necessary. A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Department of Social Services (DSS), DMH, and COC

The Residential Treatment Facilities for Children & Adolescents Chart is located at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. *The establishment or expansion of an RTF requires a Certificate of Need*.

2. Need projections are calculated by service area. The RTF service areas mirror the psychiatric service and inpatient drug and alcohol abuse service areas (i.e., Anderson/Oconee, Greenville/Pickens, etc.) to facilitate planning in a consistent manner.

3. 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.

4. An existing facility that can demonstrate a 70% or greater occupancy rate for the most recent year prior can apply to add up to five additional beds, regardless of whether there is a bed need in the service area.

5. 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.

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

7. 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.

8. 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 five 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 Need for Residential Treatment Facilities for Children & Adolescents Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Record of the Applicant;
4. Staff Resources; and
5. Medically Underserved Groups.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within 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.

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS
(Chapter 7)

Region	Facility	County	Beds	PT Days	2016 % Occupancy
I	Avalonia Group Homes	Pickens	55	16,712	83.2%
I	Excalibur Youth Services	Greenville	60	18,341	83.7%
I	Generations Residential Programs	Greenville	30	7,110	64.9%
I	GHS Marshall I Pickens Hospital Childrens Program	Greenville	22	6,448	80.3%
I	Springbrook Behavioral Health System RTF	Greenville	68	22,944	92.4%
II	New Hope Carolinas	York	150	49,707	90.8%
II	Three Rivers Residential Treatment - Midlands Campus	Lexington	64	21,482	92.0%
III	Lighthouse Behavioral Health	Horry	18	4,964	75.6%
III	Palmetto Pee Dee Residential Treatment Center ***1***	Florence	59	21,553	100.1%
III	Willowglen Academy South Carolina	Williamsburg	40	14,267	97.7%
IV	Palmetto Pines Behavioral Health	Dorchester	64	21,565	92.3%
IV	Riverside Behavioral Health Services at Windwood Farm	Charleston	12	4,302	98.2%
		Totals	**642**	**209,395**	**89.4%**

1 CON SC-16-153 for the addition of 5 residential treatment beds for a total of 64 residential treatment beds will not be implemented per applicant.

PROJECTED BED NEED FOR RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS
(Chapter 7)

Service Area	2016 Pop	2023 Pop	Existing Beds	Bed Need (Use)	Need
Anderson, Oconee	57,036	56,310	0	23	**23**
Cherokee, Spartanburg, Union	86,316	85,970	0	36	**36**
Greenville, Pickens	140,368	147,710	235	61	**-174**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	45,581	42,460	0	18	**18**
Chester, Lancaster, York	84,167	89,840	150	37	**-113**
Fairfield, Kershaw, Lexington, Newberry, Richland	190,923	194,770	64	81	**17**
Chesterfield, Dillon, Marlboro	22,198	20,460	0	8	**8**
Clarendon, Lee, Sumter	35,075	32,420	0	13	**13**
Darlington, Florence, Marion	52,867	50,690	59	21	**-38**
Georgetown, Horry, Williamsburg	75,261	78,780	58	33	**-25**
Aiken, Barnwell	39,239	38,580	0	16	**16**
Allendale, Beaufort, Hampton, Jasper	46,426	46,490	0	19	**19**
Bamberg, Calhoun, Orangeburg	26,128	23,480	0	10	**10**
Berkeley, Charleston, Colleton Dorchester	166,014	181,460	76	75	**-1**
Statewide Totals	**1,067,599**	**1,089,420**	**642**	**451**	**-191**

CHAPTER 8

CARDIOVASCULAR CARE

Current guidelines issued by the Society for Cardiovascular Angiography and Interventions (SCAI), the American College of Cardiology (ACC), and the American Heart Association (AHA) allow for Emergent/Primary PCI as well as Elective PCI in facilities without on-site open heart surgery backup. 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.

In 2013, SCAI, ACC, and AHA updated their joint statement on clinical competence regarding coronary artery intervention procedures. The joint statement defined certain requirements for PCI operator competence and PCI facility volume requirements. The statement also noted an overall decrease in PCI volumes.

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 350 procedures per year. Emergent PCI operators should perform a minimum of 36 PCIs annually; all other PCI operators should perform a minimum of 200 combined procedures annually. Individual providers should perform a minimum of 50 PCIs annually (averaged over two years), including no less than 11 emergent/primary PCIs annually. It is recommended these be performed in facilities meeting a 200 procedure-per-year threshold.

CARDIAC CATHETERIZATION

Relevant Definitions

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

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which PCIs as well as diagnostic and therapeutic catheterizations are performed, in a facility with on-site open heart surgery backup.

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

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

"Percutaneous Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation. These procedures may be performed on an emergent or elective basis. "Emergent or Primary" means that a patient needs immediate PCI because, in the treating physician's best clinical judgment, delay would result in undue harm or risk to the patient. An "Elective" PCI is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.

"Therapeutic Catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty.

Scope of Services

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

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

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

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

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

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

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 procedures per year, as measured on an equivalent basis. Each adult diagnostic cardiac catheterization shall carry a weight of 1.0 procedures, while each adult therapeutic catheterization performed in the fixed laboratory shall carry a weight of 2.0 procedures. For pediatric and adult congenital catheterization labs, diagnostic catheterizations shall carry the weight of 2.0 procedures, therapeutic catheterizations shall carry the weight of 3.0 procedures, electrophysiology (EP) studies shall carry the weight of 2.0 procedures, and biopsies performed after heart transplants shall carry the weight of 1.0 procedures. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

2. The service area for a diagnostic catheterization laboratory is defined as all facilities within 30 minutes' emergency medical transport time[1]; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes' emergency medical transport time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

Diagnostic and Mobile Catheterization Services

3. New diagnostic catheterization services, including mobile services, shall be approved only if all existing labs in the service area have performed a minimum of 350 diagnostic catheterization procedures per laboratory during the most recent year;

1 Emergency medical transport time shall be determined by the DHEC Bureau of EMS and Trauma, and for the purposes of this Plan shall mean transport by ground ambulance. Potential applicants may obtain this information for any laboratory or proposed laboratory by calling 803-545-4489.

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 350 procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 350 diagnostic cardiac catheterization procedures per laboratory.

5. Expansion of an existing diagnostic catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e., 960 procedures by equivalent measure) for each of the past two years and can project a minimum of 350 procedures per year on the additional equipment within three years of its implementation.

6. An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 75 diagnostic procedures annually for each day of the week that the mobile lab is located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 350 diagnostic catheterization procedures per laboratory In addition:

    a. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 350 procedures 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.

7. An applicant for provision of diagnostic catheterization service agrees, as a condition for issuance of its Certificate of Need for such service, to discontinue such services and surrender the Certificate of Need for that service if they have failed to achieve 350 diagnostic catheterizations per year by the expiration of the first three years of operation of such services.

<u>Emergent and Elective PCI without On-Site Cardiac Backup</u>

8. 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 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 catheterization procedures in the most recent Joint Annual Report and can reasonably demonstrate that it will continue to perform a minimum of 350 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 current guidelines mentioned below are and will continue to be met at all times.

e. An application shall be approved only if it is consistent with current guidelines established by SCAI/ACC/AHA as they appear at the time an application for a CON is filed under this Chapter. A complete copy of the current guidelines can be found at: www.acc.org/guidelines.

f. An applicant for provision of emergent/primary PCI without on-site surgical backup agrees, as a condition for issuance of its Certificate of Need for such service, to discontinue such services and surrender the Certificate of Need for that service if they have failed to achieve 350 diagnostic catheterizations per year by the expiration of the first three years of operation of such services.

9. In 2014, the SCAI/ACC/AHA affirmed that elective PCI may be safely performed 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 *must obtain a Certificate of Need* in order to upgrade to a 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 catheterization procedures in the most recent Joint Annual Report and can reasonably demonstrate that it will continue to perform a minimum of 350 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 200 therapeutic catheterizations (PCIs) in the most recent year.

c. An applicant must project that the proposed service will perform a minimum of 200 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 200 therapeutic procedures and 350 diagnostic procedures at each facility.

d. The physicians must be experienced interventionalists who perform a minimum of 50 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 50 procedures per year should only work at institutions with an activity level of more than 600 procedures per year. Operators who perform fewer than 50 procedures per year should develop a defined mentoring relationship with a highly experienced operator who has an annual procedural volume of at least 150 procedures.

e. For catheterization labs in facilities without on-site surgical backup, there must be formalized written protocols in place for immediate (emergency transport beginning with 30 minutes and arriving at surgical facility within 60 minutes) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed and tested on a regular basis.

   – Applicants must provide documentation of an agreement with an ambulance or transport service capable of advanced life support and intra-aortic balloon pump and that guarantees a 30 minute or less response time from contact.

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

g. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule, and must be available within 30 minutes of facility call-back.

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

i. Applicants must offer primary percutaneous coronary intervention (PCI) services and procedures twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty five (365) days a year.

j. Applicants must provide documentation to show that guidelines for determining patients appropriate for PCI procedures in a setting without on-site open heart backup consistent with standards of the American College of Cardiology have been developed and will be maintained.

k. Applicants must agree to participate in the South Carolina STEMI Mission Lifeline Program.

l. Every therapeutic catheterization program should operate a quality-improvement program that routinely:

1) reviews quality and outcomes of the entire program;
2) reviews results of individual operators;
3) includes risk adjustment;
4) provides peer review of difficult or complicated cases; and
5) performs random case reviews.

m. Every PCI program should participate in a regional or national PCI registry for the purpose of benchmarking its outcomes against current national norms.

n. An applicant for provision of elective PCI without on-site surgical backup agrees, as a condition for issuance of its Certificate of Need for such service, to discontinue therapeutic catheterization services and surrender the Certificate of Need for that service if they have failed to achieve 200 therapeutic catheterizations (PCIs) per year by the expiration of the first three years of operation of such services.

Comprehensive Catheterization Services

10. Comprehensive 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 200 therapeutic catheterizations (PCIs) in the most recent year; and

b. An applicant must project that the proposed service will perform a minimum of 200 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the therapeutic catheterizations performed at existing comprehensive catheterization programs in the service area below 200 procedures at each facility.

11. 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 procedures, as measured on an equivalent basis, 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.
12. An applicant for expansion of comprehensive cardiac catheterization agrees, as a condition for issuance of its Certificate of Need for such expansion, to discontinue the expanded services and surrender the Certificate of Need for that expanded service if they have failed to achieve 600 procedures, as measured on an equivalent basis, per year within three years of its implementation.

<u>Pediatric Catheterization Services</u>

13. New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

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

    b. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of services.

14. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 200 procedures per year, on the additional equipment within three years of its implementation.

15. Documentation of need for the proposed service:

    a. The applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric

catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

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

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

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

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

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

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

b. Regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

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

d. Development of linkages with the receiving institution's peer review mechanism.

17. 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.

18. 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.

19. 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.

The Cardiac Catheterization Procedures Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Record of the Applicant.
4. Ability to Complete the Project;
5. Staff Resources;
6. Adverse Effects on Other Facilities; and
7. Medically Underserved Groups.

The Department finds that:

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

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

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

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

OPEN HEART SURGERY

Relevant Definitions

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels.

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

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

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

1. repair/replacement of heart valves
2. repair of congenital defects
3. cardiac revascularization
4. repair/reconstruction of intrathoracic vessels
5. treatment of cardiac traumas

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

Scope of Services

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

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

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

1. cardiology
2. anesthesiology
3. pathology
4. thoracic surgery
5. radiology

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

Adult open heart surgery services should be available within 60 minutes' one-way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly two 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 to 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 PROJECTIONS AND STANDARDS

1. *The establishment of an open heart surgery program requires Certificate of Need review*.

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 per open heart surgery unit (*i.e.*, each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

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

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

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

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

        2) The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic procedures, as measured on an equivalent basis, in the previous year of operation.

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

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

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

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

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

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

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

7. *A one-time incremental expansion of one open heart surgery unit shall not be considered a substantial expansion of a health service, and therefore shall not be grounds for Certificate of Need review.* Expansion of an existing open heart surgery service beyond the one-time incremental increase of one open heart unit 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 percutaneous transluminal coronary angioplasty (PTCA) and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

11. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

12. An applicant for open heart surgery service agrees, as a condition for issuance of its Certificate of Need for such service, to discontinue services and surrender the Certificate of Need for that service if they have failed to achieve 200 open heart procedures per open heart unit per year by the expiration of the first three years of operation of such services. One time incremental expansions of one open heart unit are subject to the same threshold, and any such unit shall be closed if it does not achieve 200 open heart procedures within three years of the expansion.

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

The Open Heart Units Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Ability to Complete the Project;
4. Cost Containment;
5. Record of the Applicant;
6. Staff Resources; and
7. Adverse Effects on Other Facilities.

The Department makes the following findings:

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

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

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

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

(5) Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This number is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflects an efficient use of an expensive resource. It is in the public's interest that facilities

achieve their projected volumes.

(6) The Department recognizes the important correlation between volume and proficiency. The Department 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.

CARDIAC CATHETERIZATION PROCEDURES
(Chapter 8)

		2014							2015 [1]							2016						
Facility by Region	**# Cath Labs**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total Equiv**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total Equiv**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total Equiv**
Region I																						
Anmed Health Medical Center	6	1,981	1,235	4,451					1,777	952	3,681					2,317	976	4,269				
GHS Greenville Memorial Hospital	5	1,962	1,531	5,024					1,914	1,753	5,420					2,068	1,654	5,376				
Saint Francis - Downtown	4	2,004	1,246	4,496					2,053	1,229	4,511					2,091	1,033	4,157				
Self Regional Healthcare	2	847	349	1,545					903	457	1,817					947	631	2,209				
GHS Oconee Memorial Hospital	1	358	0	358					228		228					301		301				
Baptist Easley Hospital	1	167		167					112		112							0				
Mary Black Hospital Systems	2	49	0	49					82		82					44		44				
Spartanburg Medical Center	4	1,896	751	3,398			642		1,849	937	3,723			842		1,735	950	3,635			852	
Pelham Medical Center	1	0	0	0						0	0					1	0	1				
Total Region I	**26**	**9,264**	**5,112**	**19,488**					**8,918**	**5,328**	**19,574**					**9,504**	**5,244**	**19,992**				
Region II																						
Aiken Regional Medical Centers	1	691	257	1,205					701	283	1,267					961	332	1,625				
Kershaw Health	1	666		666					703		703					541		541				
Springs Memorial Hospital	1	397		397					203		203					353		353				
Lexington Medical Center	3	1,895	801	3,497					2,140	791	3,722					2,345	940	4,225				
Palmetto Health Baptist	1	444	0	444					485		485					522	2	526				
Palmetto Health Baptist Parkridge ***2***	1																					
Palmetto Health Richland	4	3,070	1,284	5,638					3,153	1,254	5,661					3,583	1,695	6,973				
Providence Health ***3***	7	2,440	1,396	5,232					2,352	1,553	5,458					2,552	1,463	5,478				
Piedmont Medical Center	3	1,166	667	2,500					1,211	574	2,359					1,245	682	2,609				
Total Region II	**21**	**10,769**	**4,405**	**19,579**					**10,948**	**4,455**	**19,858**					**12,102**	**5,114**	**22,330**				
Region III																						
Carolina Pines Regional Medical Center	1	116		116					205		205							0				
Carolinas Hospital System	3	660	233	1,126					747	225	1,197					625	226	1,077				
McLeod Regional Medical Center of the Pee Dee	5	1,419	542	2,503					1,533	671	2,875					1,873	376	2,625				
Tidelands Georgetown Memorial Hospital	2	717	56	829					670	94	858					748	119	986				
Conway Hospital	1	774	0	774					693	0	693					571	0	571				
Grand Strand Medical Center	4	2,090	911	3,912					2,422	1,057	4,536					2,615	1,234	5,083				
McLeod Loris ***4***	0	282	0	282					308		308					222		222				
McLeod Seacoast ***4***	1	0	0	0					0	0	0					0	0	0				
Palmetto Health Tuomey	1	160	0	160					84	0	84					61	0	61				
Total Region III	**18**	**6,218**	**1,742**	**9,702**					**6,662**	**2,047**	**10,756**					**6,715**	**1,955**	**10,625**				
Region IV																						
Beaufort Memorial Hospital	1	447	133	713					494	147	788					389	77	543				
Hilton Head Hospital	2	433	227	887					381	170	721					626	194	1,014				
East Cooper Medical Center ***5***	1	0	0	0					0	0	0					0	0	0				

MUSC Medical Center	6	1,697	1,156	4,009	285	284	112	1,534	1,559	1,163	3,885	245	286	99	1,447	1,738	1,165	4,068	220	276	73	1,341
Roper Berkeley Hospital ***6***	1	0	0	0					0	0	0					0	0	0				
Roper Hospital	3	1,578	896	3,370					1,568	883	3,334					1,625	879	3,383				
Trident Medical Center	2	1,007	445	1,897					1,081	525	2,131					1,512	523	2,558				
Regional Medical Center of Orangeburg & Calhoun	1	215		215					341		341					268		268				
Total Region IV	**17**	**5,377**	**2,857**	**11,091**				**1,414**	**5,424**	**2,888**	**11,200**				**1,534**	**6,158**	**2,838**	**11,834**				**1,341**
Statewide Totals	**82**	**31,628**	**14,116**	**59,860**				**1,414**	**31,952**	**14,718**	**61,388**				**1,534**	**34,479**	**15,151**	**64,781**				**1,341**

1 Some figures adjusted by Revenue & Fiscal Affairs following ICD9/10 conversion.
2 CON SC-18-01 issued January 5, 2018 for establishment of diagnostic cardiac catheterization services through addition of a single diagnostic catheterization lab.
3 South Carolina Heart Center catheterization lab now controlled by Providence Health and reported in their utilization.
4 CON SC-17-16 issued April 6, 2017 to transfer single cardiac catheterization lab from McLeod Loris Hospital to McLeod Seacost Hospital.
5 CON SC-16-47 issued August 15, 2016 for addition of a single diagnostic cardiac catheterization lab for a total of one diagnostic catheterization lab.
6 Approved July 25, 2016 for addition of a single diagnostic cardiac catheterization lab for a total of one diagnostic cardiac catheterization lab. Currently on appeal.

OPEN HEART UNITS
(Chapter 8)

Region/Facility	# Open Heart Units	FY 14 Adults	FY 14 Peds	FY 15 Adults	FY 15 Peds	FY 16 Adults	FY 16 Peds
Region I							
Anmed Health Medical Center	2	200		157		145	
GHS Greenville Memorial Hospital	3	400		454		443	
Saint Francis - Downtown	2	311		323		350	
Self Regional Healthcare	1	85		77		92	
Spartanburg Medical Center	3	467		443		434	
Total Region I	**11**	**1,463**		**1,454**		**1,464**	
Region II							
Aiken Regional Medical Centers	1	33		55		26	
Lexington Medical Center	2	294		312		342	
Palmetto Health Richland ***1***	3	344		349		356	
Piedmont Medical Center	2	102		164		148	
Providence Health	4	500		409		427	
Total Region II	**12**	**1,273**		**1,289**		**1,299**	
Region III							
Carolinas Hospital System	1	101		97		60	
Grand Strand Medical Center	2	418		427		432	
McLeod Regional Medical Center of the Pee Dee	3	279		403		372	
Total Region III	**6**	**798**		**927**		**864**	
Region IV							
Hilton Head Hospital	2	74		86		60	
MUSC Medical Center ***2***	5	360	191	423	237	358	295
Roper Hospital	2	424		474		502	
Trident Medical Center ***1***	2	238		241		240	
Total Region IV	**11**	**1,096**	**191**	**1,224**	**237**	**1,160**	**295**
Statewide Totals	**40**	**4,630**	**191**	**4,894**	**237**	**4,787**	**295**

1 Reflects an additional open-heart suite pursuant to *South Carolina Health Plan* allowance.
2 SC-17-63 issued 8/11/2017 for addition of one pediatric open-heart suite. Not yet implemented.

CHAPTER 9

RADIATION ONCOLOGY

Cancer is a group of related diseases that involve out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. The American Cancer Society (ACS) estimates that 1 in 2 men and 1 in 3 women will suffer from cancer during their lifetimes. The most common types of cancer include prostate cancer for men, breast and uterine cancer for women, whereas lung and colon cancer are a common occurrence in both genders. The Department tracks the occurrence of cancer in the State, including identification of "cancer cluster" locations, through the South Carolina Central Cancer Registry.

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. Beams of ionizing radiation are aimed to meet at a specific point and deliver 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 ten weeks, depending on the type of cancer and the treatment goal.

Relevant 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. This type of therapy is provided through a number of methods know by different names.

"Electronic Portal Imaging Devices (EPIDs)" have been developed because of the increased complexity of treatment planning and delivery techniques. The most common EPIDs are video-based systems wherein on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of Intensity Modulated Radiation Therapy fields and to reduce errors in patient positioning.

"Fractionation" is the practice of providing only a small fraction of the entire prescribed dose of radiation in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation**)** refers to radiation given in smaller doses twice a day. In Hypofractionation**,** individual doses are given less often than daily, such as in two-five sessions.

"Image-Guided Radiation Therapy (IGRT)" visualizes (by means of EPIDs, kV scans or mV scans) the patient's anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.

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

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

"Stereotactic Radiosurgery (SRS)" is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

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

TYPES OF RADIATION EQUIPMENT

Particle Beam (Proton)

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Most tumors could be cured with a sufficiently high dose of radiation; however, such a treatment

is ineffective due to collateral damage to healthy tissue. Particle therapy can lessen the damage to healthy tissue by tailoring the particle (either a proton particle or a heavier carbon particle) dose to the tumor. Unfortunately, this promising treatment option is not readily available.

Linear Accelerator (X-Ray or LINAC)

The LINAC produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. Radiation can be delivered to the tumor from any angle by a rotating robotic arm. A LINAC 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 one 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.
5. Equipment for accurate simulation of the treatment units in the department (in general, one simulator can service two to three megavoltage treatment units).
6. Field-shaping capability.
7. Access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment and are addressed in the Standards below.

There is also LINAC equipment designed strictly to provide Stereotactic Radiotherapy in one to five treatment sessions. These specialized LINACs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 1,500 treatments per year per unit.

Cobalt-60 (Photon)

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery**.** It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from

replicating and causing it to slowly shrink.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 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.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS FOR RADIOTHERAPY

1. The capacity of a conventional linear accelerator, either with or without EPID, is 7,000 treatments per year.

2. Linear accelerators providing IMRT or IGRT have a capacity of 5,000 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

3. IMRT/IGRT linear accelerators performing stereotactic procedures have a capacity of 4,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

4. Linear Accelerators designed strictly to provide Stereotactic Radiotherapy have a capacity of 1,500 treatments per year. A facility must document that it is providing or will provide these specialized treatments in sufficient volume to justify why it should be held to this planning capacity.

5. There are 13 service areas established for Radiotherapy units.

6. New Radiotherapy services shall only be approved if the following conditions are met:

    a. All existing units in the service area have performed at a combined use rate of 80 percent of capacity as evidenced in the most recent Joint Annual Reports preceding the filing of the applicant's Certificate of Need application; and

    b. An applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in Standards 2, 3 or

4 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in Certificate of Need application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

7. Expansion of an existing service, whether the expansion occurs at the existing site or at an alternate location in the service area, shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum use rate of 50 percent of capacity per year on the additional equipment within three years of its implementation. If the additional equipment is a specialized radiotherapy unit as described in either Standards 2, 3 or 4 above, then the existing provider may propose an annual capacity for that additional equipment, based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant.

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

9. The applicant must affirm the following:

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

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

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

    d. The applicant will have access to a custom block design and cutting system; and

    e. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

The Megavoltage Visits Chart and Radiotherapy Chart are located at the end of this Chapter.

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:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Cost Containment; and
5. Medically Underserved Groups.

Radiotherapy services are distributed statewide and are located within 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.

CERTIFICATE OF NEED PROJECTIONS AND 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. 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 as evidenced in the most recent Joint Annual Reports; 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.

3. 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 prior two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

4. 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.

5. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

6. The applicant must document that protocols will be established to assure that all clinical radiosurgery procedures performed are medically necessary and that alternative treatment modalities have been considered.

7. The applicant must affirm the following:

a. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;

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

c. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;

d. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and

e. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

8. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Record of the Applicant;
4. Cost Containment; and
5. Medically Underserved Groups.

The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes' travel time. 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
(Chapter 9)

Facility by Region	County	Units	FY 2014	FY 2015	FY 2016
REGION 1					
Anmed Health Medical Center	Anderson	2	10,916	12,568	13,159
Greenville Health System					
GHS Cancer Centers of the Carolinas - Andrews ***1***	Greenville	0	4,613	3,811	1,168
GHS Cancer Institute - Eastside	Greenville	1	3,567	6,849	7,831
GHS Cancer Institute - Faris	Greenville	3	11,884	10,194	11,923
GHS Cancer Institute - Greer	Greenville	1	4,177	2,627	2,835
GHS Cancer Institute- Seneca	Oconee	1	4,971	4,609	2,867
GHS Cancer Institute- Spartanburg	Spartanburg	1	3,168	2,312	2,819
St. Francis Millennium Cancer Center ***2***	Greenville	1	1,063	7,901	9,385
Spartanburg Regional Healthcare System					
Spartanburg Regional Medical Center ***3***	Spartanburg	2	24,594	19,739	21,162
Gibbs Cancer Center & Research Institute - Pelham	Spartanburg	1			
Cyberknife		1			
Gibbs Cancer Center & Research Institute - Gaffney	Cherokee	1			
Self Regional Healthcare	Greenwood	2	6,794	7,642	8,149
REGION II					
Aiken Regional Medical Center	Aiken	2	8,080	8,841	9,480
Lancaster Radiation Therapy Center	Lancaster	1	5,290	4,513	4,600
Lexington Medical Center	Lexington	3	15,444	17,533	18,013
Newberry Oncology Associates ***4***	Newberry	1	NR	NR	NR
Palmetto Health Richland ***5***	Richland	0	733	110	0
Gamma Knife		1	159	100	138
Radiation Oncology, LLC ***5***	Richland	5	27,417	35,487	39,831
Rock Hill Radiation Therapy Center	York	2	10,846	11,341	12,500
REGION III					
Carolinas Hospital System	Florence	1	2,806	NR	3,187
McLeod Regional Medical Center - Pee Dee	Florence	4	14,976	12,587	10,424
Tidelands Health					
Tideland's Georgetown Memorial Hospital ***6***	Georgetown	0	6,398	5,501	7,839
Tideland's Waccamaw Community Hospital ***6, 7***	Georgetown	2			
Carolina Regional Cancer Center					
Carolina Regional Cancer Center ***8***	Horry	2	23,547	22,840	23,716
Carolina Regional Cancer Center - Conway	Horry	1			
Carolina Regional Cancer Center - Murrels Inlet ***9***	Horry	0			
Grand Strand Regional Medical Center ***10***	Horry	1	0	0	0
Palmetto Health Tuomey	Sumter	2	9,065	7,841	9,154
REGION IV					
SJC Oncology Services - SC (Hilton Head)	Beaufort	1	4,644	7,191	7,098
Beaufort Memorial Hospital	Beaufort	1	4,851	7,382	6,049

Medical University Hospital Authority					
MUSC Medical Center	Charleston				
Linear Accelerators		5	18,871	19,823	19,221
Gamma Knife		1	213	258	292
MUSC Radiation Therapy Center-Berkeley County ***11***	Berkeley	1			
Roper St. Francis Healthcare					
Roper Hospital	Charleston	1	8,270	6,905	5,507
CyberKnife ***12***		1		473	408
Bon Secours St. Francis Xavier	Charleston	2	6,557	7,328	10,191
Roper St. Francis Hospital - Berkeley ***13***	Berkeley	1			
Trident Medical Center	Charleston	3	11,239	12,493	10,422
Regional Medical Center of Orangeburg & Calhoun Counties	Orangeburg	2	5,739	5,607	4,710
	Totals	**64**	**260,892**	**272,406**	**284,078**

1 2016 JAR Comment Section states Effective January 29, 2016, GHS discontinued radiation therapy services provided at the GHS Cancer Institute-Andrews facility.

2 Linear Accelerator utilization reported on St. Francis-Downtown JAR.

3 Spartanburg Regional Health System reported all linear accelerator and CyberKnife data on Spartanburg Regional Medical Center JAR. CyberKnife utilization has not been seperated.

4 Facility did not report required JAR data.

5 Correction to inventory -- 2016 JAR Comment Section states, linear accelerator machines and treatments edited on March 12, 2018 to reflect 0 as Radiation Oncology LLC reports these machines and volumes. Richland does not own any machines.

6 CON SC-15-42 issued November 6, 2015 for relocation of an existing LINAC to a new facility located on Tidelands Waccamaw campus.

7 CON SC-18-15 issued March 20, 2018 for the addition of one linear accelerator for a total of two.

8 Carolina Regional Cancer Center reports all locations on one JAR.

9 CON SC-16-09 issued March 7, 2016 for relocation and replacement of an existing linear accelerator at a new facility. Note: On December 7, 2017, the Department denied Certificate holder's request for 2nd extension, not appealed.

10 CON SC-16-10 issued March 7, 2016 for establishment of new radiation center attached to facility. Project licensed March 6, 2018.

11 CON application approved November 22, 2017 for one additional linear accelerator to be located in Berkeley county, under appeal.

12 Per Roper Hospital's 2014 JAR, CyberKnife utlization is included in linear accelerator utlization.

13 Approved November 22, 2017 for the establishment of radiation therapy services, under appeals.

RADIOTHERAPY*
(Chapter 9)

Service Areas	2016 Population	# OF LINAC	Pop Per LINAC	Total Area Treatments	Planning Area Capacity	Percent Capacity
Anderson, Oconee	272,924	3	90,975	16,026	14,500	110.5%
Greenville, Pickens	621,629	6	103,605	33,142	28,500	116.3%
Cherokee, Spartanburg, Union	385,782	6	64,297	23,981	28,000	85.6%
Chester, Lancaster, York	380,301	3	126,767	17,100	14,500	117.9%
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	217,980	2	108,990	8,149	9,500	85.8%
Fairfield, Kershaw, Lexington, Newberry, Richland	820,574	10	82,057	57,982	48,000	120.8%
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	341,518	5	68,304	13,611	28,500	47.8%
Clarendon, Lee, Sumter	158,982	2	79,491	9,154	10,000	91.5%
Georgetown, Horry, Williamsburg	415,696	6	69,283	31,555	29,000	108.8%
Bamberg, Calhoun, Orangeburg	117,133	2	58,567	4,710	9,500	49.6%
Allendale, Beaufort, Hampton, Jasper	240,581	2	120,291	13,147	9,000	146.1%
Berkeley, Charleston, Colleton, Dorchester	799,078	15	53,272	46,041	68,000	67.7%
Aiken, Barnwell	188,941	2	94,471	9,480	10,000	94.8%
State Total	**4,961,119**	**64**	**77,517**	**284,078**	**307,000**	**92.5%**

*** NOTE: DURING THE CURRENT PLANNING PERIOD, DEPARTMENT STAFF HAVE RESEARCHED HISTORICAL RECORDS AND, BASED ON THAT RESEARCH, HAVE ADJUSTED PLANNING AREA CAPACITY TO BETTER REFLECT EXISTING UNITS IN EACH SERVICE AREA.**

CHAPTER 10

OUTPATIENT FACILITIES

Outpatient facilities provide community service for the diagnosis and treatment of ambulatory patients that is operated in connection with a hospital or as a freestanding facility under the professional supervision of a licensed physician. These facilities serve patients who do not require hospitalization and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

AMBULATORY SURGICAL FACILITY

Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in a freestanding Ambulatory Surgical Facility (ASF). An ASF is a distinct, freestanding, entity that is organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, treatment, procedures, and/or services, and be discharged on the same day, as defined in Regulation 61-91, Section 101.RR. The owner or operator makes the facility available to other providers who comprise an organized professional staff (open medical staff). This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care professionals.

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

A substantial increase has occurred in both the number and percentage of ambulatory surgeries performed and in the number of approved ASFs. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties.

2. The applicant must identify the physicians who are affiliated or have an ownership

interest in the proposed facility by medical specialty. These physicians must identify where they currently perform their surgeries and whether they anticipate making any changes in staff privileges or coverage should the application be approved.

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

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

5. 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.

6. The applicant must document whether it will restrict surgeries by specialty. Applicants that wish to restrict surgeries by specialty understand that *another Certificate of Need would be required* before the ASF could provide other surgical specialties. Applicants seeking to perform only endoscopic procedures are considered restricted.

7. Before an application for a new general Ambulatory Surgery Facility can be accepted for filing in a county having a current population of less than 100,000 people, all general ASFs in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for an ASF filing in a county having a current population of greater than 100,000 people.

8. Endoscopy suites are considered separately from other operating rooms and therefore are not considered competing applicants for Certificate of Need review purposes. Before an application for a new endoscopy-only ASF can be accepted for filing in a county having a current population of less than 100,000 people, all ASFs with endoscopy suites in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs with endoscopy suites must have been licensed and

operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a new endoscopy-only ASF filing in a county having a current population of greater than 100,000 people.

9. The approval of a new general or endoscopy-only ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites. The merger of two existing ASFs in a county to construct a consolidated ASF does not constitute a "new ASF" for the purpose of interpreting Standards 8 and 9.

10. The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage that is comparable to all other existing ambulatory surgery facilities, if any, in the service area.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements and must commit to seek accreditation from CMS or any accrediting body with deemed status. Ambulatory surgical services are generally available within 30 minutes' one-way automobile travel time of most South Carolina residents. Most ASFs operate five days a week, with elective surgery being scheduled several days in advance.

The Ambulatory Surgical Facility Utilization Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Record of the Applicant;
6. Cost Containment;
7. Medically Underserved Groups;
8. Staff Resources; and
9. 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.

FREESTANDING EMERGENCY HOSPITAL SERVICES

The popularity of freestanding emergency hospital services is increasing as a means of providing ready access to such services at the community level.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. *A Certificate of Need is required to establish a freestanding emergency service.*

2. All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

3. Regulation 61-16 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.

The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.

The Freestanding Emergency Services Chart is located at the end of this Chapter.

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. Community Need Documentation;
2. Distribution (Accessibility);
3. Medically Underserved Groups;
4. Record of the Applicant; and,
5. Staff Resources.

Access to emergency medical services should be available within 15 minutes' travel time for the majority of residents of the State. The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for this service.

AMBULATORY SURGERY FACILITY UTILIZATION
(Chapter 10)

Facility by Region	County	2016 # of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite
Region I									
AnMed Health Medicus Surgery Center	Anderson	3		3	4,292	392	4,684	1,561	
Upstate Endoscopy Center	Anderson		2	2		6,266	6,266		3,133
GHS Cross Creek Surgery Center	Greenville	4		4	4,976		4,976	1,244	
Endoscopy Center of the Upstate*	Greenville		3	3					
Greenville Endoscopy Center	Greenville		3	3		6,779	6,779		2,260
Greenville Endoscopy Center - Patewood	Greenville		3	3		7,122	7,122		2,374
GHS Patewood Outpatient Surgery Center	Greenville	6	2	8	6,009	2,648	8,657	1,002	1,324
Piedmont Surgery Center	Greenville	4		4	3,748		3,748	937	
Jervey Eye Center	Greenville	3		3	4,315		4,315	1,438	
Upstate Surgery Center	Greenville	2		2	3,042		3,042	1,521	
Greenwood Endoscopy Center	Greenwood		4	4		8,128	8,128		2,032
Surgery Center of the Lakelands	Greenwood	5		5	4,153		4,153	831	
Surgery & Laser Center at Professional Park	Laurens	2		2	3,434		3,434	1,717	
Blue Ridge Surgery Center *	Oconee	2		2					
Synergy Spine Center	Oconee	2		2	996		996	498	
Ambulatory Surgery Center of Spartanburg	Spartanburg	7	2	9	10,482	3,105	13,587	1,497	1,553
Spartanburg Surgery Center	Spartanburg	4		4	4,805		4,805	1,201	
Surgery Center at Pelham	Spartanburg	4	2	6	2,502	1,262	3,764	626	631
GHS Surgery Center - Spartanburg ***1***	Spartanburg	2		2					
Carolina Specialty Eye Surgery ***2***	Spartanburg	2		2					
Region II									
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	3,689	923	4,612	922	923
Carolina Ambulatory Surgery Center	Aiken	1		1	3,180		3,180	3,180	
Center for Colon & Digestive Diseases *	Aiken		2	2					0
Surgery Center at Edgewater	Lancaster	3	1	4	1,767	19	1,786	589	19
Chapin Orthopedic Surgery Center ***3***	Lexington	2		2					
Midlands Endoscopy Center	Lexington		2	2	2,862	2,943	5,805		2,903
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	4,424		4,424	1,106	
Outpatient Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,936	693	3,629	734	693
Urology Surgery Center	Lexington	2		2	1,847		1,847	924	
Lake Murray Endoscopy Center	Lexington		2	2		2,268	2,268		1,134
South Carolina Endoscopy Center	Lexington		4	4		6,733	6,733		1,683
Outpatient Surgery Center Lexington Med Ctr - Irmo	Richland	4		4	2,083		2,083	521	
Berkeley Endoscopy Center	Richland		2	2		1,235	1,235		618
Columbia Eye Surgery Center	Richland	4		4	7,967		7,967	1,992	
Columbia GI Endoscopy Center	Richland		4	4		4,079	4,079		1,020
Midlands Orthopaedics Surgery Center	Richland	4		4	2,973		2,973	743	
Palmetto Endoscopy Suite *	Richland		2	2					
Palmetto Surgery Center	Richland	5		5	5,400		5,400	1,080	
South Carolina Endoscopy Center - Northeast	Richland		5	5		6,733	6,733		1,347
Carolina Colonoscopy Center	Richland		2	2		4,017	4,017		2,009
Columbia Nephrology Associates ***4***	Richland	2		2					
Carolina Interventional Pain Institute ***5***	Richland	2		2					
Carolina Surgical Center	York	4		4	5,716		5,716	1,429	
Center for Orthopaedic Surgery	York	3		3	2,539		2,539	846	
York County Endoscopy Center	York		3	3		5,965	5,965		1,988
Kershaw Health Ambulatory Surgery Center ***6***	Kershaw	3		3					
Region III									
Florence Surgery & Laser Center	Florence	2		2	4,067		4,067	2,034	
McLeod Ambulatory Surgery Center	Florence	2		2	1,650		1,650	825	
Physicians Surgical Center of Florence *	Florence	4	2	6					
Bay Microsurgical Unit	Georgetown	1		1	5,392		5,392	5,392	
Carolina Coast Surgery Center	Georgetown	2		2	3,110		3,110	1,555	
Tidelands Georgetown Endoscopy Center	Georgetown		1	1		982	982		982
Tidelands Waccamaw Surgery Center	Georgetown	1		1	1,000		1,000	1,000	
Carolina Bone and Joint Surgery Center	Horry	3		3	2,539		2,539	846	
Grande Dunes Surgery Center	Horry	3	1	4	4,273	1,619	5,892	1,424	1,619
Parkway Surgery Center	Horry	2		2	4,368		4,368	2,184	
Rivertown Surgery Center	Horry	3		3	3,970		3,970	1,323	
Strand GI Endoscopy Center	Horry		2	2		5,687	5,687		2,844
Wesmark Ambulatory Surgery Center	Sumter	2		2	3,065	3,346	6,411	3,206	

AMBULATORY SURGERY FACILITY UTILIZATION
(Chapter 10)

Facility by Region	County	2016 # of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite
Region IV									
Bluffton Okatie Surgery Center	Beaufort	2		2	1,724	753	2,477	1,239	
Laser and Skin Surgery Center	Beaufort	2		2	1,285		1,285	643	
Outpatient Surgery Center of Hilton Head	Beaufort	3	2	5	3,831	3,065	6,896	1,277	1,533
Roper Hospital Ambulatory Surgery Berkeley	Berkeley	3		3	124	439	563	188	
Center for Advanced Surgery ***7***	Charleston	2		2					
Charleston Endoscopy Center	Charleston		5	5	4	10,024	10,028		2,006
Charleston Surgery Center	Charleston	4	1	5	3,290	3,529	6,819	823	3,529
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2	181	412	593		297
Elms Endoscopy Center*	Charleston		3	3					
Lowcountry Ambulatory Center	Charleston	2		2	2,264		2,264	1,132	
MUSC Musculoskeletal Institute ***8***	Charleston	2	2	4					
Palmetto Endoscopy Center	Charleston		2	2		6,438	6,438		3,219
Physicians Eye Surgery Center	Charleston	4		4	11,900		11,900	2,975	
Roper Hosp Ambulatory Surg & Pain Mgt James Island	Charleston	4		4	3,169		3,169	792	
Roper St. Francis Eye Center	Charleston	3		3	1,428		1,428	476	
Southeastern Spine Institute	Charleston	2		2	14,981		14,981	7,491	
Surgery Center of Charleston	Charleston	4		4	5,967		5,967	1,492	
Trident Ambulatory Surgery Center	Charleston	6		6	4,632	543	5,175	863	
MUSC Pediatric Ambulatory Sugery Center ***9***	Charleston	4	1	5					
MUSC Health Mount Pleasant Surgery Center ***10***	Charleston	2	1	3					
Colleton Ambulatory Surgery Center	Colleton	2	1	3	764	0	764	382	0
Lowcountry Outpatient Surgery Center	Dorchester	3		3	7,481		7,481	2,494	
Summerville Endoscopy Center	Dorchester		2	2	11	3,368	3,379		1,690
	Totals	**182**	**80**	**262**	**196,607**	**108,147**	**304,754**	**1,080**	**1,352**

***** Facility did not report JAR data.
1 Facility was not operation until April 2017.
2 Approved 11/17/2017, in appeal.
3 CON SC-15-49 issued 12/23/15 for the construction of a general ASF with 2 ORs, implemented not yet closed out.
4 CON SC-17-49 issued 7/20/17 for the construction of a new ASF with 2 ORs.
5 CON SC-17-48 issued 7/20/17 for the construction of a new ASF with 2 ORs.
6 CON SC-17-80 issued 12/13/17 for the construction of a new ASF with 3 ORs.
7 CON SC-15-08 issued 4/13/15 for the construction of a new ASF with 2 ORs, implemented not yet closed out.
8 CON SC-17-31 issued 5/22/17 for the construction of a new ASF with 2 ORs.
9 CON SC-17-30 issued 5/22/17 for the construction of a new pediatric ASF with 4 ORs and 1 endoscopy suite.
10 CON SC-17-64 issued 9/14/17 for the construction of a new ASF with 2 ORs and 1 endoscopy suite.

FREESTANDING EMERGENCY HOSPITAL SERVICES
(Chapter 10)

Freestanding ED	Licensed Under	City	County
Moncks Corner Medical Center	Trident Medical Center	Moncks Corner	Berkeley
Roper Hospital Diagnostics and ER - Berkeley	Roper Hospital	Moncks Corner	Berkeley
Summerville Freestanding ED ***1***	Trident Medical Center	Summerville	Berkeley
MUSC Health Emergency Services ***2***	Medical University Hospital Authority	Summerville	Berkeley
Roper Hospital Diagnostics and ER - Northwoods ***3***	Roper Hospital	North Charleston	Charleston
Centre Pointe Emergency	Trident Medical Center	Charleston	Charleston
North Strand Medical Center	Grand Strand Medical Center	Myrtle Beach	Horry
South Strand Ambulatory Care Center	Grand Strand Medical Center	Myrtle Beach	Horry
Seacoast Medical Center	McLeod Loris	Little River	Horry
McLeod Health Carolina Forest Campus ***4***	McLeod Seacoast	Myrtle Beach	Horry
Carolina Forest Emergency ***5***	Grand Strand Medical Center	Myrtle Beach	Horry
Coastal Carolina Hospital ***6***	Coastal Carolina Hospital	Hardeeville	Jasper
Fort Mill Freestanding Emergency Department ***7***	Piedmont Medical Center	Fort Mill	York
West Palmetto Emergency Center ***8***	Carolinas Hospital System	Florence	Florence

1 Approved September 25, 2017, under appeal.
2 Approved September 25, 2017, under appeal.
3 CON SC-17-43 issued June 26, 2017 for relocation, not yet implemented.
4 Approved January 23, 2017, under appeal.
5 Approved January 23, 2017, under appeal.
6 CON SC-17-65 issued October 4, 2017.
7 Approved March 27, 2017.
8 CON SC-18-18 issued April 10, 2018.

CHAPTER 11

LONG-TERM CARE FACILITIES AND SERVICES

NURSING FACILITIES

Nursing facilities provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. This care is performed under the general direction of persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. 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 2018. 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 PROJECTIONS AND STANDARDS

1. Bed need is calculated on a county basis using the ratio of 39 beds/1,000 population age 65 and over.

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 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 Long-Term Care Inventory and Bed Need Chart are located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

1. Community Need Documentation;
2. Projected Revenues;
3. Projected Expenses;
4. Net Income;
5. Methods of Financing;
6. Staff Resources;
7. Record of the Applicant; and
8. Distribution (accessibility).

Because nursing facilities are located within approximately 30 minutes' travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

MEDICAID NURSING HOME PERMITS

The Medicaid Nursing Home Permit Act, formerly known as the Nursing Home Licensing Act of 1987, sets forth a regulatory scheme whereby Medicaid nursing home permits and Medicaid patient days are allocated in South Carolina. A long-term care facility (nursing home) must obtain a Medicaid Nursing Home Permit from the Department in order to serve Medicaid patients. A Medicaid patient is a person who is eligible for Medicaid (Title XIX) sponsored long-term care services. Each year, the South Carolina General Assembly establishes the maximum number of Medicaid patient days the Department is authorized to issue. A Medicaid patient day is a day of nursing home care for which the holder of a Medicaid nursing home Permit can receive Medicaid reimbursement. The South Carolina Department of Health and Human Services provides the Department with the total number of Medicaid patient days available so the Department may distribute those patient days amongst Permit holders.

The Medicaid Patient Days and Medicaid Beds Requested & Authorized Chart is located at the end of this Chapter.

COMMUNITY LONG-TERM CARE (CLTC) PROGRAM

South Carolina is seeking to increase access to long-term care facilities through a number of different programs. The Community Long-Term Care Project (CLTC) provides mandatory pre-admission screening and case management to Medicaid-eligible individuals who are in need of applying for nursing facility placement under the Medicaid program. It also provides several community-based services for Medicaid participants who prefer to receive care in the community rather than institutional care. In certain counties, those services include:

Adult Day Healthcare: CLTC offers Adult Day Health Care to individuals enrolled in the Community Choices Waiver. This is medically supervised care and services provided at a licensed day care center. Transportation to and from the home is provided within 15 miles of the center.

Attendant/Personal Assistance: CLTC offers attendant services to individuals enrolled in the Community Choices Waiver. Nurses assist by observing care and helping consumers develop skills in managing their attendant. Services may include assistance with general household activities; help with activities such as bathing, dressing, preparing meals, and housekeeping; and observing health signs.

Care Management (Case Management - Service Coordination): CLTC assigns a nurse to help determine the services for which the participant qualifies and what services will best meet the needs of an individual enrolled in the Community Choices Waiver. Nursing Facility Transition Services may also be offered to help a participant residing in a nursing facility return to the community.

Companion (Sitter): CLTC provides an approved companion to provide supervision of an individual and short-term relief for regular caregivers to individuals enrolled in the Community Choices Waiver.

Home Repair/Modification Assistance: CLTC helps provide pest control services, ramps, heater fans and air conditioners to individuals enrolled in the Community Choices Waiver. It can also help make minor adaptations to non-rental property for the safety and health of the Medicaid participant.

Medical Equipment/Personal Care Supplies: CLTC provides limited durable medical equipment and incontinence supplies (diapers, underpads, wipes, etc.) to individuals enrolled in the Community Choices Waiver.

Nutritional Supplement Assistance: CLTC's Community Choices Program provides two cases per month of Nutritional Supplements to its participants.

The Program for All-Inclusive Care for the Elderly (PACE) is a Medicaid State option that

provides comprehensive long-term care to primarily elderly residents of the State. PACE is available to Medicaid participants who are certified as "nursing home" eligible, but prefer care from community services. GHS Senior Care, Palmetto SeniorCare, and The Methodist Oaks currently operate PACE programs in the State.

SPECIAL NEEDS FACILITIES

The South Carolina Department of Disabilities and Special Needs (DDSN) provides 24-hour care to individuals with complex, severe disabilities through five in-state regional facilities located in Columbia, Florence, Clinton, Summerville and Hartsville. These facilities serve those individuals who cannot be adequately cared for by one of DDSN's community living options and focus on those with special needs, head and spinal cord injuries and pervasive development disorders. In 2014, the Centers for Medicare and Medicaid Services (CMS) issued its final rule on Home and Community Based Services (HCBS) that will, inter alia, ensure that individuals who receive services through Medicaid's HCBS programs have access to the benefits of community living. DDSN believes the HCBS initiative will affect its Day Programs and where its clients live. The South Carolina Department of Health and Human Services (DHHS) will be the lead agency in implementing HCBS which will be phased in over the next five years.

INSTITUTIONAL NURSING FACILITY (RETIREMENT COMMUNITY NURSING FACILITY)

An institutional nursing facility means a nursing facility (established within the jurisdiction of a larger non-medical institution) that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. These facilities provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

To be considered under this special bed category, the following criteria must be met:

1. The nursing facility must be a part of and located on the campus of the retirement community.

2. It must restrict admissions to campus residents.

3. The facility may not participate in the Medicaid program.

There is no projection of need for this bed category. The applicant must demonstrate that

the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home," and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, a generally accepted ratio of nursing facility beds to retirement beds is 1:4.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

1. Need for the Proposed Project;
2. Economic Consideration; and
3. Health System Resources.

Because Institutional Nursing Facility Beds are used solely by the residents of the retirement community, there is no justification for approving this type of nursing facility unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or facilities.

SWING-BEDS

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina; however, the hospital must obtain Medicare certification.

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

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

The Swing-Bed Participants Chart is located at the end of this Chapter.

HOSPICE FACILITIES AND HOSPICE PROGRAMS

Hospice is a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

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

The Inpatient Hospice Facilities Chart is located at the end of this Chapter.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. *A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.*

2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.

3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.

4. The proposed facility must consider the impact on other existing inpatient hospice facilities.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Acceptability;
4. Record of the Applicant; and
5. Staff Resources.

Hospice services should be available within 60 minutes' travel time for the majority of residents of the State. The benefits of improved accessibility will be weighed equally with the adverse effects of duplication in evaluating Certificate of Need applications for this facility type.

HOME HEALTH

Home Health Agencies

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

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

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

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

    a. Letters of support that identify need for additional home health services from

physicians and other referral sources.

b. Evidence of underutilization of home health services.

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

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

e. Evidence that one or more existing home health agencies has failed to meet the minimum patient service requirements set forth in Standard 8 of this section of the Plan within two years of the initiation of patient services after receiving a home health license.

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

5. All home health agency services (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, and Medical Social Worker) should be available within a county. If there is no hospital in a county and the existing licensed home health agencies between them do not provide all of the services identified above, this may be cited as potential justification for the approval of an additional agency that intends to offer these services.

6. Specialty home health providers are exempt from the need calculation applicable to full-service home health agencies, but are otherwise subject to Certificate of Need.

7. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, consent order, abandonment of patients in other business operations, or loss of license. However, any consent orders or loss of licenses related to licenses that were obtained from the Department between July 1, 2013 and May 22, 2014 without a Certificate of Need shall not be grounds for denial of a Certificate of Need application pursuant to this Section. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must

assure the Department that, should it fail to reach this threshold number two years after initiation of services in a county, it will voluntarily relinquish its license for that county.

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

The Home Health Agency Inventory Chart is located at the end of this Chapter.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

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

Pediatric Home Health Agencies

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

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. A separate Certificate of Need application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.

2. The applicant must document that there is an unmet need for this service in the county of application, and the agency will limit such services to the pediatric population 18 years or younger.

3. The applicant must document the full range of services that they intend to provide to pediatric patients.

Continuing Care Retirement Community Home Health Agencies

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and *does not require Certificate of Need review provided:*

a. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;

b. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and

c. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

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

LONG-TERM CARE INVENTORY
(Chapter 11)

Region I	# Beds
Abbeville	
Abbeville Nursing Home	94
Anderson	
Brookdale Anderson	44
Ellenburg Nursing Center	181
Iva Rehabilitation and Healthcare Center	60
Linley Park Rehabiliation and Healthcare	88
NHC HealthCare Anderson	290
Richard M. Campbell Veterans Nursing Home	220
Southern Oaks Rehabilitation and Healthcare Center	88
Cherokee	
Blue Ridge in Brookview House	132
Peachtree Centre	111
Greenville	
Arboretum at the Woodlands	30
Brookdale Greenville	45
Brushy Creek Rehabilitation and Healthcare Center	144
Carlyle Senior Care of Fountian Inn ***1***	60
GHS Greenville Memorial Hospital Subacute	15
Greenville Rehabilitation & Healthcare Center	132
Greer Rehabilitation and Healthcare Center	133
Heartland Health Care Center - Greenville East	132
Heartland Health Care Center - Greenville West	125
Linville Courts at the Cascades Verdae	44
Magnolia Manor - Greenville	99
NHC HealthCare Greenville	176
NHC HealthCare Mauldin	180
Patewood Rehabilitation and Healthcare Center	120
Poinsett Rehabilitation and Healthcare Center	132
River Falls Rehabilitation and Healthcare Center	44
Rolling Green Village Health Care Facility	74
Simpsonville Rehabilitation and Healthcare Center	132
Southpointe Healthcare and Rehabilitation ***2***	120
Greenwood	
Greenwood Transitional Rehabilitation Unit	12
Magnolia Manor - Greenwood	88
NHC HealthCare Greenwood	152
Wesley Commons Health and Rehabilitation Center ***3***	80

LONG-TERM CARE INVENTORY
(Chapter 11)

Laurens	
GHS Laurens County Memorial Subacute Unit	14
Martha Franks Baptist Retirement Community	88
NHC HealthCare Clinton	131
NHC HealthCare Laurens	176
Presbyterian Communities of SC - Clinton	66
McCormick	
McCormick Rehabilitation and Healthcare Center	120
Oconee	
GHS Lila Doyle	120
Seneca Health and Rehabilitation Center	132
Pickens	
Brookdale Easley	60
Capstone Rehabilitation and Healthcare Center	60
Clemson Area Retirement Center - Health Care Center	68
Fleetwood Rehabilitation and Healthcare Center	103
Manna Rehabilitation and Healthcare Center	130
Presbyterian Communities of South Carolina - Foothills	44
PruittHealth - Pickens	44
Spartanburg	
Golden Age - Inman	44
Inman Healthcare	40
Lake Emory Post Acute Care	88
Magnolia Manor - Inman	176
Magnolia Manor - Spartanburg	95
Mountainview Nursing Home	132
Physical Rehabilitation & Wellness Center of Spartanburg	120
Rosecrest Rehabilitation and Healthcare	75
Skyland Nursing and Rehabilitation Center	44
Spartanburg Hospital for Restorative Care SNF	25
Summit Hills Skill Nursing Facility	33
Valley Falls Terrace	88
White Oak at North Grove ***4***	132
White Oak Estates	88
White Oak Manor Spartanburg ***4***	60
Woodruff Manor	88
Union	
Ellen Sagar Nursing Center	113
Heartland Health Care Center - Union	88

LONG-TERM CARE INVENTORY
(Chapter 11)

Region II

Aiken	
Anchor Rehabilitation and Healthcare Center of Aiken	120
Carlyle Senior Care of Aiken ***5***	86
NHC HealthCare North Augusta	192
Pepper Hill Nursing & Rehab Center ***6***	125
PruittHealth - Aiken	176
PruittHealth - North Augusta	132
Barnwell	
Laurel Baye Healthcare of Blackville, LLC	85
Laurel Baye Healthcare of Williston, LLC	44
PruittHealth - Barnwell	44
Chester	
Chester Nursing Center ***7***	80
Edgefield	
Ridge Rehabilitation and Healthcare Center	120
Fairfield	
Blue Ridge in the Fields	112
PruittHealth - Ridgeway	150
Kershaw	
KershawHealth Karesh Long Term Care	96
Springdale Healthcare Center	148
Lancaster	
Lancaster Convalescent Center	142
Transitional Care Unit at Springs Memorial Hospital	14
White Oak Manor Lancaster	132
Lexington	
Brian Center of Nursing Care - St. Andrews	108
Heritage at Lowman Rehabilitation & Healthcare	176
Laurel Crest Retirement Community	12
Lexington Medical Center Extended Care	388
Millennium Post Acute Rehabilitation	132
NHC HealthCare Lexington	170
Opus Post Acute Rehabilitation	100
Presbyterian Communities of South Carolina - Columbia	44
South Carolina Episcopal Home at Still Hope ***8***	70
Retreat at Wellmore of Lexington	60
Newberry	
JF Hawkins Nursing Home	118
White Oak Manor Newberry	146

LONG-TERM CARE INVENTORY
(Chapter 11)

Richland

CM Tucker Jr. Nursing Center Fewell & Stone Pavilions	252
CM Tucker Jr. Nursing Center Roddey Pavilion	308
Countrywood Nursing Center	38
Heartland of Columbia Rehabilitation & Nursing Center	132
Life Care Center of Columbia	179
Midlands Health & Rehabilitation Center	88
NHC HealthCare Parklane	180
Palmetto Health Rehabilitation Center	22
PruittHealth - Blythewood	120
PruittHealth - Columbia	185
Rice Estate Rehabilitation and Healthcare	80
White Oak Manor Columbia	120
Wildewood Downs Nursing and Rehabilitation Center	80

Saluda

Saluda Nursing Center	176

York

Lodge at Wellmore	60
Magnolia Manor - Rock Hill	106
PruittHealth Rock Hill	132
Rock Hill Post Acute Care Center	99
Westminster Health and Rehabilitation Center	66
White Oak Manor York	109
White Oak of Rock Hill	141
Willow Brook Court at Park Pointe Village	40

Region III

Chesterfield

Cheraw Healthcare	120
Chesterfield Convalescent Center	104

Clarendon

Lake Marion Nursing Facility	88
Windsor Manor Nursing Home	64

Darlington

Bethea Baptist Health Care Center	88
Medford Nursing Center	88
Morrell Nursing Center	154
Oakhaven Nursing Center	88

LONG-TERM CARE INVENTORY
(Chapter 11)

Dillon	
PruittHealth Dillon	84
Carlyle Senior Care of Fork ***9***	111
Florence	
Commander Nursing Home	163
Faith Healthcare Center	104
Carlyle Senior Care of Florence ***10***	88
Heritage Home of Florence	132
Honorage Nursing Center	88
Lake City-Scranton Healthcare Center	88
Methodist Manor Healthcare Center	32
Presbyterian Communities of South Carolina - Florence	44
Southland Health Care Center	88
Georgetown	
Blue Ridge in Georgetown	84
Lakes at Litchfield Skilled Nursing Center	24
Prince George Healthcare Center	148
Horry	
Brightwater Skilled Nursing Center	67
Compass Post Acute Rehabilitation	95
Conway Manor	190
Covenant Towers Health Care	30
Grand Strand Rehab and Nursing Center	88
Kingston Nursing Center	88
Loris Rehab and Nursing Center	88
Myrtle Beach Manor	60
NHC HealthCare Garden City	148
Lee	
McCoy Memorial Nursing Center	120
Marion	
Mullins Nursing Center	92
Senior Care of Marion ***11***	95
Marlboro	
Dundee Manor	110
Sumter	
Blue Ridge of Sumter	96
Covenant Place Nursing Center	44
NHC HealthCare Sumter	138
Palmetto Health Tuomey Subacute Skilled Care Program	18
Sumter East Health and Rehabilitation Center	176
Williamsburg	
Carlyle Senior Care of Kingstree ***12***	96
Dr. Ronald E McNair Nursing and Rehabilitation Center	88

LONG-TERM CARE INVENTORY
(Chapter 11)

Region IV

Allendale	
John Edward Harter Nursing Center	44
Bamberg	
Pruitthealth - Bamberg	88
Beaufort	
Bayview Manor	170
Broad Creek Care Center Skilled Nursing	25
Fraser Health Care	33
Life Care Center of Hilton Head	88
NHC HealthCare Bluffton	120
Preston Health Center	77
Sprenger Healthcare of Port Royal ***13***	65
Sprenger Healthcare of Bluffton ***14***	65
Berkeley	
Heartland Health and Rehab Care Center - Hanahan	135
Lake Moultrie Nursing Home	88
PruittHealth - Moncks Corner	132
Retreat at Wellmore of Daniel Island	60
Calhoun	
Calhoun Convalescent Center	120
Charleston	
Bishop Gadsden Episcopal Health Care Center	50
Franke Health Care Center	44
Heartland of West Ashley Rehabilitation & Nursing Center	125
Johns Island Rehabilitation and Healthcare Center	132
Life Care Center of Charleston	148
Mount Pleasant Manor	132
NHC HealthCare Charleston	132
North Charleston Post Acute ***15***	70
Riverside Health and Rehab	160
Sandpiper Rehab & Nursing	176
Savannah Grace at the Palms of Mt. Pleasant	48
South Bay at Mount Pleasant ***16***	40
Vibra Hospital of Charleston - TCU	35
White Oak Manor Charleston, Inc.	176
Colleton	
Pruitthealth - Walterboro	132
Veterans Victory House	220

LONG-TERM CARE INVENTORY
(Chapter 11)

Dorchester	
Hallmark Healthcare Center	88
Oakbrook Health and Rehabilitation Center	88
Presbyterian Communities of South Carolina - Summerville	87
St. George Healthcare Center	88
Hampton	
Pruitthealth Estill	104
Jasper	
Ridgeland Nursing Center	88
Orangeburg	
Jolley Acres Healthcare Center	60
Methodist Oaks	122
PruittHealth - Orangeburg	88
Riverside Rehabilitation and Healthcare Center	113
Statewide Total	**20,752**

1 Formerly known as Fountain Inn Nursing Home.
2 Formerly known as Magnolia Place at Greenville.
3 Formerly known as Health Care Center of Wesley Commons.
4 CON SC-15-37 issued October 1, 2015 for construction for the replacement of an existing nursing home facility (White Oak Manor Spartanburg) to accommodate the relocation of one hundred and thirty-two (132) existing non-institutional beds, for a total of 132 nursing home beds at White Oak Manor North Grove and 60 nursing home beds at While Oak Manor Spartanburg. Project completed in July 2017.
5 Formerly known as Azaleawoods Rehab & Nursing Center.
6 E-18-24 issued April 13, 2018 for the decrease of licensed bed capacity from 132 to 125.
7 E-18-22 issued April 13, 2018 for the decrease of licensed bed capacity from 100 to 80.
8 CON SC-17-05 issued January 13 2017 for construction for the addition of 8 nursing home beds for a total of 70 nursing home beds, not yet complete.
9 Formerly known as Sunny Acres Nursing Home.
10 Formerly known as Florence Rehab & Nursing Center.
11 CON SC-17-60 issued August 11, 2017 for renovation to an existing structure for the establishment of a new 95 bed long term care facility.
12 Formerly known as Kingstree Nursing Facility.
13 CON SC-16-06 issued February 22, 2016 for construction for a new 65 bed nursing home.
14 CON SC-17-19 issued April 13, 2017 for construction for a new 65 bed nursing home.
15 Decision granting approval for the construction of a 70 bed skilled nursing facility, under appeal.
16 CON SC-16-154 issued December 9, 2016 for construction for a new 40 bed nursing home.

LONG-TERM CARE BED NEED
(Chapter 11)

Regions	2020 Pop 65+ (000)	Bed Need (Pop x 39)	Existing Beds	Total # Beds to be Added
Region I				
Abbeville	5.66	221	94	127
Anderson	38.72	1,510	971	539
Cherokee	9.89	386	243	143
Greenville	87.82	3,425	1,937	1,488
Greenwood	13.50	527	332	195
Laurens	12.84	501	475	26
McCormick	3.34	130	120	10
Oconee	18.91	737	252	485
Pickens	21.67	845	509	336
Spartanburg	53.24	2,076	1,328	748
Union	5.81	227	201	26
Region I Total	**271.40**	**10,585**	**6,462**	**4,123**
Region II				
Aiken	35.71	1,393	831	562
Barnwell	3.99	156	173	(17)
Chester	6.27	245	80	165
Edgefield	5.15	201	120	81
Fairfield	4.83	188	262	(74)
Kershaw	12.6	491	244	247
Lancaster	22.36	872	288	584
Lexington	51.07	1,992	1,260	732
Newberry	8.09	316	264	52
Richland	58.6	2,285	1,784	501
Saluda	4.42	172	176	(4)
York	42.85	1,671	753	918
Region II Total	**255.94**	**9,982**	**6,235**	**3,747**
Region III				
Chesterfield	8.52	332	224	108
Clarendon	7.88	307	152	155
Darlington	13.2	515	418	97
Dillon	5.47	213	195	18
Florence	24.81	968	827	141
Georgetown	18.39	717	256	461
Horry	92.69	3,615	854	2,761
Lee	3.58	140	120	20
Marion	6.21	242	187	55
Marlboro	4.71	184	110	74
Sumter	18.41	718	472	246
Williamsburg	6.94	271	184	87
Region III Total	**210.81**	**8,222**	**3,999**	**4,223**
Region IV				
Allendale	1.86	73	44	29
Bamberg	3.03	118	88	30
Beaufort	56.65	2,209	643	1,566
Berkeley	35.29	1,376	415	961
Calhoun	3.60	140	120	20
Charleston	73.85	2,880	1,468	1,412
Colleton	8.33	325	352	(27)
Dorchester	23.54	918	351	567
Hampton	3.76	147	104	43
Jasper	7.94	310	88	222
Orangeburg	17.69	690	383	307
Region IV Total	**235.54**	**9,186**	**4,056**	**5,130**
Statewide Totals	**973.69**	**37,974**	**20,752**	**17,222**

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849
1991-1992	3,856,833	10.567	3,659,965	10,028	196,868
1992-1993	3,976,576	10,895	3,806,382	10,429	170,194
1993-1994	4,012,359	10,993	3,856,382	10,566	155,977
1994-1995	4,023,690	11,024	3,892,882	10,665	130,808
1995-1996	3,969,681	10,876	3,892,882	10,665	76,799
1996-1997	4,072,519	11,158	4,002,382	10,965	70,137
1997-1998	4,119,753	11,287	4,097,282	11,225	22,471
1998-1999	4,265,182	11,685	4,265,182	11,685	0
1999-2000	4,367,134	11,965	4,341,832	11,895	25,302
2000-2001	4,420,522	12,111	4,378,332	11,995	42,190
2001-2002	4,473,170	12,255	4,275,998	11,715	197,172
2002-2003	4,340,158	11,891	4,205,553	11,522	134,605
2003-2004	4,304,160	11,792	4,205,553	11,522	98,607
2004-2005	4,294,977	11,767	4,205,553	11,522	89,424
2005-2006	4,291,812	11,758	4,205,553	11,522	86,259
2006-2007	4,283,209	11,735	4,205,553	11,522	77,656
2007-2008	4,263,785	11,682	4,205,553	11,522	58,232
2008-2009	4,231,047	11,592	4,205,553	11,522	25,494
2009-2010	4,215,522	11,549	4,205,553	11,522	9,969
2010-2011	4,217,584	11,555	4,205,553	11,522	12,031
2011-2012	4,250,190	11,644	3,771,878	10,333	478,312
2012-2013	4,268,032	11,693	3,815,921	10,455	452,111
2013-2014	4,132,731	11,323	3,815,921	10,455	316,810
2014-2015	4,094,917	11,219	3,815,921	10,455	278,996
2015-2016	4,112,740	11,268	3,815,921	10,455	296,819
2016-2017	4,006,470	10,977	3,815,921	10,455	190,549
2017-2018	4,020,582	11,015	3,815,921	10,455	204,661

SWING-BED PARTICIPANTS
(Chapter 11)

FACILITY	TOTAL BEDS	SWING BEDS	2016 ADMISSIONS	2016 PT DAYS	ADC
Abbeville Area Medical Center	25	25	148	1,375	3.77
Allendale County Hospital	25	25	51	2,113	5.79
Mcleod Health Cheraw	59	49	35	1,439	3.94
Edgefield County Hospital	25	25	128	1,784	4.89
Fairfield Memorial Hospital	25	25	59	779	2.13
Hampton Regional Medical Center ***1***	32	10	NR	NR	0.00
Carolinas Hospital System- Marion	124	10	5	44	0.12
McLeod Medical Center - Darlington	72	24	121	7,230	19.81
Newberry County Memorial Hospital	90	20	54	497	1.36
Union Medical Center	143	12	0	0	0.00
Williamsburg Regional Hospital	25	10	21	319	0.87

1 Facility did not report required JAR data.

INPATIENT HOSPICE FACILITIES
(Chapter 11)

Facility by Region	County	2016 Total Beds	Admissions	Patient Days	% Occupancy Rate
Region I					
Callie & John Rainey Hospice House	Anderson	32	671	6077	52.0%
McCall Hospice House of Greenville	Greenville	30	728	5824	53.2%
Hospice House of Hospicecare of the Piedmont	Greenwood	15	283	2302	42.0%
Hospice of Laurens County	Laurens	12	84	1899	43.4%
GHS Cottingham Hospice House	Oconee	15	299	3015	55.1%
Hospice House of the Carolina Foothills	Spartanburg	12	261	2,187	49.9%
Spartanburg Regional Hospice Home	Spartanburg	15	460	3469	63.4%
Total		**131**	**2,786**	**24,773**	**51.8%**
Region II					
Agape House of Lexington	Lexington	30	100	3,296	30.1%
Agape Hospice House of the Midlands	Richland	12	234	2,081	47.5%
Hospice & Community Care House	York	16	315	6064	103.8%
Total		**58**	**649**	**11,441**	**54.0%**
Region III					
McLeod Hospice House	Florence	24	769	5123	58.5%
Tidelands Community Hospice House ***1***	Georgetown	0	212	1718	39.2%
Embrace Hospice House of the Grand Strand ***2***	Horry	36	--	--	--
Total		**60**	**981**	**6,841**	**31.2%**
Region IV					
Agape House of Summerville ***3***	Berkeley	30	--	--	--
Hospice Center of Hospice of Charleston	Charleston	20	743	4199	57.5%
Total		**50**	**743**	**4,199**	**23.0%**
Statewide Total		**299**	**5,159**	**47,254**	**43.3%**

1 CON E-17-13, Permanent closure of facility March 18, 2017
2 CON SC-15-20, issued April 30, 2015 for the construction of a 36-bed inpatient hospice. Facility licensed August 1, 2017.
3 CON SC-16-07, issued February 16, 2016 for the construction of a 30-bed inpatient hospice, not yet complete.

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Advanced Home Care	Lancaster, York
Amedysis Home Health Care	Clarendon, Florence, Georgetown, Williamsburg
Amedisys Home Health of Beaufort	Beaufort, Jasper
Amedysis Home Health of Bluffton	Allendale, Beaufort, Hampton, Jasper
Amedysis Home Health of Camden	Calhoun, Darlington, Fairfield, Kershaw, Lexington, Marlboro, Newberry, Orangeburg, Richland
Amedysis Home Health of Charleston	Berkeley, Charleston, Dorchester
Amedysis Home Health of Charleston East	Berkeley, Charleston, Colleton, Dorchester, Hampton
Amedysis Home Health of Clinton	Abbeville, Anderson, Cherokee*,Greenville, Greenwood, Laurens, Oconee*, Pickens*, Spartanburg, Union
Amedysis Home Health of Conway ***1***	Dillon, Horry, Marion
Amedysis Home Health of Georgetown	Georgetown, Williamsburg
Amedysis Home Health of Lexington	Aiken, Bamberg, Barnwell, Calhoun, Edgefield, Lee, Lexington, McCormick, Newberry, Orangeburg, Richland, Saluda, Sumter
Amedysis Home Health of Myrtle Beach	Horry
AnMed Health Home Health Agency	Anderson, Pickens*
Bayada Home Health Care	Anderson*, Florence*, Greenville*, Lexington*, Richland*, Spartanburg*, Sumter*
Bayada Home Health Care - Rock Hill	Lancaster*, York*
Beaufort-Jasper Home Health Agency	Beaufort, Jasper
Bethea Home Health (May Serve Retirement Community Only)	Darlington
Bioscrip Infusion Services ***2*** (May Serve Pediatric Patients Only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, York
Brightstar Care	Lancaster, York

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Brighstar Care of Charleston	Charleston*
Brightstar Care-Bluffton ***3***	Beaufort, Jasper
Brightstar of Spartanburg ***4***	Greenville, Spartanburg
Carolinas Home Health	Darlington, Dillon, Florence, Marlboro
Chesterfield Visiting Nurses Services	Chesterfield, Darlington, Marlboro
Covenant Place CCRC Home Health Services (May Serve Retirement Community Only)	Sumter
Critical Nurse Staffing, Inc.	Aiken, Allendale, Barnwell, Beaufort, Charleston, Edgefield, Hampton, Jasper, Lexington, Orangeburg, Richland
Cypress Club Home Health Agency (May Serve Retirement Community Only)	Beaufort
Encompass Home Health of South Carolina	Aiken
Encompass Home Health of South Carolina - Bluffton ***5***	Beaufort, Jasper
Florence Visiting Nurses Service	Dillon, Florence, Lee, Marion
GHS Home Health Agency ***6***	Anderson, Greenville, Oconee, Pickens
Health Related Home Care	Abbeville, Anderson, Edgefield, Greenville, Greenwood, Laurens, McCormick, Newberry, Saluda
Healthy @ Home	Lancaster, York
HomeCare of HospiceCare of the Piedmont (In Saluda County, May Only Serve Terminally Ill Patients)	Abbeville, Greenwood, Laurens, McCormick, Saluda
Home Care of Lancaster	Lancaster
HomeCare of the Regional Medical Center	Bamberg, Calhoun, Orangeburg

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Home Health Services of Self Regional Healthcare	Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry, Saluda
Interim HealthCare	Beaufort, Berkeley, Charleston, Dorchester
Interim HealthCare of the Upstate ***7***	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg
Interim HealthCare of Rock Hill	York
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester, Georgetown
Island Health Care	Beaufort, Jasper
Kershawhealth Home Health	Kershaw
Kindred at Home ***8***	Lexington, Richland
Kindred at Home - Anderson ***9***	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union
Kindred at Home - Charleston ***10***	Berkeley, Charleston, Dorchester
Kindred at Home - Coastal ***11***	Georgetown, Horry, Williamsburg
Kindred at Home - Greenville ***12*** (May Only Serve Patients in Union County with Initial Diag Requiring IV Therapy and/or Home Uterine Activity Monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union
Kindred at Home - Low Country ***13***	Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg
Kindred at Home - Midlands ***14***	Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York
Kindred at Home - Pee Dee ***15***	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Kindred at Home - Upstate ***16***	Cherokee, Chester, Union, York
Laurel Crest Home Health Agency (May Serve Retirement Community Only)	Lexington
Liberty Home Care - Bennettsville	Chesterfield*, Marlboro
Liberty Home Care - Myrtle Beach	Georgetown*, Horry
McLeod Home Health	Chesterfield, Clarendon, Darlington, Dillon, Florence, Horry, Lee, Marion, Marlboro, Sumter
Medical Services of America - Coastal ***17***	Berkeley, Charleston, Chesterfield, Darlington, Dillon, Florence, Georgetown, Horry, Marion, Marlboro, Williamsburg
Medical Services of America Home Health ***18***	Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Calhoun, Cherokee, Chester, Clarendon, Colleton, Dorchester, Edgefield, Fairfield, Greenville, Greenwood, Hampton, Jasper, Kershaw Lancaster, Laurens, Lee, Lexington, Newberry, McCormick, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, York
Methodist Manor Home Health (May Serve Retirement Community Only)	Florence
MUSC Health at Home by Bayada - Conway	Georgetown*, Horry*
MUSC Health at Home by Bayada - Charleston	Berkeley*, Charleston, Dorchester*
MUSC Health at Home by BAYADA	Beaufort*, Colleton*, Orangeburg*
Neighbors Care Home Health Agency an Amedisys Company	Cherokee, Chester, Lancaster, York
NHC HomeCare - Aiken	Aiken, Allendale*, Barnwell, Edgefield, Orangeburg
NHC HomeCare - Beaufort	Beaufort, Colleton, Jasper, Hampton
NHC HomeCare - Darlington	Chesterfield*, Darlington*, Florence*, Lee*, Marlboro*

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
NHC HomeCare - Greenwood	Abbeville, McCormick, Greenwood, Newberry, Saluda
NHC HomeCare - Laurens	Anderson, Greenville, Laurens, Oconee*, Pickens*, Spartanburg
NHC HomeCare - LowCountry	Bamberg, Berkeley, Charleston, Clarendon, Dorchester, Williamsburg
NHC HomeCare - Midlands	Calhoun, Fairfield, Kershaw, Lexington, Richland, Sumter
NHC HomeCare - Murrells Inlet	Dillon, Georgetown, Horry, Marion
NHC HomeCare - Piedmont	Chester, Lancaster, Union, York
Oaks Home Health (Restricted to residents of the Methodist Oaks Continuing Care campus only) ***19***	Orangeburg
Optum Women's and Children's Health LLC (May Serve Obstetrical Patients Only) ***20***	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, Richland
Optum Women's and Children's Health - Piedmont (May Serve Obstetrical Patients Only) ***21***	Abbeville, Allendale, Anderson, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenville, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Saluda, Spartanburg, Sumter, Union, Williamsburg, York
Palliative Care of the Lowcountry (Restricted to Terminally Ill Residents)	Beaufort, Jasper
Palmetto Health HomeCare	Lexington, Richland
Palmetto Health Tuomey Home Health (May Only Serve Terminally Ill Patients In Lee & Clarendon Counties)	Clarendon, Lee, Sumter
Personal Home Care of North Carolina, LLC d/b/a PHC-SC	York*

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	Counties Served
PHC Home Health	Berkeley, Charleston, Dorchester
Presbyterian Communities of SC Home Health Agency (May Serve Retirement Communities Only)	Berkeley, Dorchester, Florence, Laurens, Lexington, Pickens, Richland
PruittHealth Home Health Columbia	Abbeville, Anderson, Calhoun, Cherokee, Chester,Edgefield, Fairfield, Greenville, Greenwood, Kershaw, Lancaster, Laurens, Lexington,McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, York
PruittHealth Home Health Florence	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Williamsburg
PruittHealth Home Health Low Country	Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg
Renaissance Home Health, LLC	Abbeville
Rolling Green Village Home Health (Serving Community Residents Only)	Greenville
Roper - St. Francis Home Health Care	Berkeley, Charleston, Dorchester
Seabrook Wellness & Home Health Care (May Serve Retirement Community Only)	Beaufort
Sea Island Healthcare	Beaufort*, Jasper*
Sea Island Home Health	Charleston, Colleton
South Carolina Homecare	Richland, Sumter
Spartanburg Medical Center Home Health	Cherokee, Greenville, Spartanburg, Union
St. Francis Hospital Home Care	Anderson, Greenville, Pickens, Spartanburg
Still Hopes Home Health (May Serve Retirement Community Only)	Lexington

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Tidewater Home Health, PA	Lexington, Richland
Trinity Home Health of Aiken	Aiken, Barnwell, Edgefield
University Home Health - North Augusta	Aiken, Edgefield
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton, Orangeburg
Well Care Home Health of the Lowcountry	Beaufort*, Berkeley*, Charleston*, Colleton*, Dorchester*, Horry*, Georgetown*, Marion*, Williamsburg*
Well Care Home Health of the Midlands	Aiken*, Calhoun*, Clarendon*, Fairfield*, Florence*, Kershaw*, Lexington*, Newberry*, Orangeburg*, Richland*, Saluda*, Sumter*
Well Care Home Health of the Upstate	Anderson*, Greenville*, Spartanburg*
Wesley Commons Home Health Care (May Serve Retirement Community Only)	Greenwood
Westminster Towers Home Health (May Serve Retirement Community Only)	York

* Received CON June 10, 2017-2018.
Liberty Home Care - Aiken closed in June 2016 and has been removed from inventory.
Caring Neighbors Home Health - Fairfield closed in December 2017 and has been removed from inventory.

1 Amedisys Home Health of Conway - Chesterfield County removed from license in August 2017.
2 Change in the facility name from HomeChoice Partners to BioScrip Infusion Services.
3 Change in the facility name from Brightstar Care Lowcountry to Brightstar Care-Bluffton.
4 Change in the facility name from Brightstar Care Upstate to Brightstar of Spartanburg.
5 Change in the facility name from Home Helpers of Bluffton to Encompass Home Health of South Carolina - Bluffton.
6 E-17-25 Closure of GHS Home Health Agency- Oconee listed on previous inventory due to merger of two organizations.
7 Change in the facility name from Interim HealthCare of Greenville Inc. Personal Care to Interim HealthCare of the Upstate.
8 Change in the facility name from Gentiva Health Services - Columbia to Kindred at Home.
9 Change in the facility name from Gentiva Health Services - Anderson to Kindred at Home - Anderson.
10 Change in the facility name from Gentiva Health Services - Charleston to Kindred at Home - Charleston.

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	Counties Served

11 Change in the facility name from Gentiva Health Services - Coastal to Kindred at Home - Coastal.
12 Change in the facility name from Gentiva Health Services - Greenville to Kindred at Home - Greenville.
13 Change in the facility name from Gentiva Health Services - Low Country to Kindred at Home - Low Country.
14 Change in the facility name from Gentiva Health Services - Midlands to Kindred at Home - Midlands.
15 Change in the facility name from Gentiva Health Services - Pee Dee to Kindred at Home - Pee Dee.
16 Change in the facility name from Gentiva Health Services - Upstate to Kindred at Home - Upstate.
17 Change in the facility name from Incare Home Health to Medical Services of America - Coastal.
18 Change in the facility name from Tri-County Home Health Care to Medical Services of America Home Health.
19 Previously listed as Methodist Oaks Campus Home Health.
20 Change in the facility name from Alere Womens & Childrens Health LLC - Midlands to Optum Women's and Children's Health LLC.
21 Change in the facility name from Alere Womens & Childrens Health LLC - Piedmont to Optum Women's and Children's Health - Piedmont.

GLOSSARY

TERM	DEFINITION	SOURCE
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.	South Carolina Health Plan
Affiliated Facilities	Two or more health care facilities, whether inpatient or outpatient, owned, leased, 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.	South Carolina Health Plan
Ambulatory Surgical Facility (ASF)	A distinct, freestanding, entity that is organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, treatment, procedures, and/or services, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff (open medical staff). This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care professionals.	South Carolina Health Plan
Basic Perinatal Center with Well Newborn Nursery (Level I)	Level I hospitals provide services for normal uncomplicated pregnancies. A full list of the requirements for a Level I Basic Perinatal Center with Well Newborn Nursery can be found at Regulation 61-16, Section 1306.A. *Certificate of Need review is not required to establish a Level I program.*	South Carolina Health Plan
Bed Capacity	Bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes.	South Carolina Health Plan
Cardiac Catheterization Procedure	An invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the	South Carolina Health Plan

	chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.	
Complex Neonatal Intensive Care Unit (Level IV)	In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, Level IV hospitals shall include additional capabilities and considerable experience in the care of the most complex and critically ill newborn infants and have pediatric medical and surgical specialty consultants available 24-hours a day. A full list of the requirements for a Complex Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.E. A Level IV hospital need not act as a Regional Perinatal Center (RPC). *Certificate of Need Review is required to establish a Level IV program.*	South Carolina Health Plan
Comprehensive Catheterization Laboratory	A dedicated room or suite of rooms in which PCI as well as diagnostic and therapeutic catheterizations are performed. They are located only in hospitals approved to provide open heart surgery, although diagnostic laboratories are allowed to perform emergent and/or elective therapeutic catheterizations in compliance with Standard 7 or 8 in the Plan.	South Carolina Health Plan
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.	South Carolina Health Plan
Continuing Care Retirement Community Home Health Agency	A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and *does not require Certificate of Need review provided:* a. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by	South Carolina Health Plan

	the continuing care retirement community pursuant to a continuing care contract; b. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and c. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.	
Critical Access Hospital (CAH)	Hospitals 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 secondary roads). It must be part of a rural health network with at least one full-service hospital. They can have a maximum of 25 licensed beds and the annual average length of stay must be less than 4 days. Emergency services must be available 24 hours a day.	South Carolina Health Plan
Diagnostic Catheterization	A cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography.	South Carolina Health Plan
Diagnostic Catheterization Laboratory	A dedicated room in which only diagnostic catheterizations are performed.	South Carolina Health Plan
Elective PCI	Scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.	South Carolina Health Plan

Electronic Portal Imaging Devices (EPIDs)	EPIDs have been developed because of the increased complexity of treatment planning and delivery techniques. The most common EPIDs are video-based systems wherein on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of Intensity Modulated Radiation Therapy fields and to reduce errors in patient positioning.	South Carolina Health Plan
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.	South Carolina Health Plan
Endoscope	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).	South Carolina Health Plan
Fractionation	The practice of providing only a small fraction of the entire prescribed dose of radiation in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation**)** refers to radiation given in smaller doses twice a day. In Hypofractionation**,** individual doses are given less often than daily, such as in two-five sessions.	South Carolina Health Plan
Freestanding Medical Detoxification Facilities	Short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. *A Certificate of Need is required for a medical detoxification program.*	South Carolina Health Plan

General Hospital	A facility with an organized medical staff to maintain and operate organized facilities and services to accommodate two or more nonrelated persons for the diagnosis, treatment and care of such persons over a period exceeding 24 hours and provides medical and surgical care of acute illness, injury or infirmity and may provide obstetrical care, and in which all diagnoses, treatment or care are administered by or performed under the direction of persons currently licensed to practice medicine and surgery in the State of South Carolina.	S.C. Code of Regulations 61-16, Section 101(1)(A)
Health Care Facility	Acute care, hospitals, psychiatric hospitals, alcohol and substance abuse hospitals, nursing homes, ambulatory surgical facilities, hospice facilities, radiation therapy facilities, rehabilitation facilities, residential treatment facilities for children and adolescents, intermediate care facilities for person with intellectual disability, narcotic treatment programs, and any other facility for which Certificate of Need review is required by federal law.	S.C. Code Ann. Section 44-7-130(10)
Health Service	Clinically related, diagnostic, treatment, or rehabilitative services and includes alcohol, drug abuse, and mental health services for which specific standards or criteria are prescribed in the South Carolina Health Plan.	S.C. Code Ann. Section 44-7-130(11)
Home Health Agency	A public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.	South Carolina Health Plan
Home Health Service	Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows: Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at	South Carolina Health Plan

	least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan and the use of medical appliances, to include durable medical equipment; and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.	
Hospice	A centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services provided directly or through written agreement. *Home-based and outpatient hospice programs do not require Certificate of Need review.*	South Carolina Health Plan
Hospice Facility	An institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician. *A Certificate of Need is required for a hospice facility.*	South Carolina Health Plan
Hospice Program	An entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility. *A Certificate of Need is not required for a hospice program.*	South Carolina Health Plan
Hospital	A facility organized and administered to provide overnight medical, surgical, or nursing care of illness, injury, or infirmity and may provide	S.C. Code Ann. Section 44-7-130(12)

	obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy. Hospital may include residential treatment facilities for children and adolescents in need of mental health treatment which are physically a part of a licensed psychiatric hospital. This definition does not include facilities which are licensed by the Department of Social Services.	
Hospital Bed	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.	South Carolina Health Plan
Image-Guided Radiation Therapy (IGRT)	Combines with IMRT or CRT to visualize the patient's anatomy during treatments. This allows for confirmation of beam location and adjustment of the beams if needed during treatments due to breathing. IGRT facilitates more accurate patient positioning and reduces healthy tissue damage.	South Carolina Health Plan
Inpatient Psychiatric Services	Those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.	South Carolina Health Plan
Inpatient Treatment Facility	Short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. *A Certificate of Need is required for an Inpatient Treatment Facility.*	South Carolina Health Plan

Institutional Nursing Facility	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. These facilities provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project. To be considered under this special bed category, the following criteria must be met: 1. The nursing facility must be a part of and located on the campus of the retirement community. 2. It must restrict admissions to campus residents. 3. The facility may not participate in the Medicaid program. There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications.	South Carolina Health Plan
Intensity Modulated Radiation Therapy (IMRT)	Creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.	South Carolina Health Plan
Long-Term Acute Care Hospital (LTACH)	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.	South Carolina Health Plan

Nursing Facility	Facilities which 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.	South Carolina Health Plan
Open Heart Surgery	An operation performed on the heart or intrathoracic great vessels.	South Carolina Health Plan
Open Heart Surgical Procedure	An operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.	South Carolina Health Plan
Open Heart Surgical Program	The combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including: 1. repair/replacement of heart valves; 2. repair of congenital defects; 3. cardiac revascularization; 4. repair/reconstruction of intrathoracic vessels; and 5. treatment of cardiac traumas. In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.	South Carolina Health Plan
Open Heart Surgery Unit	An operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical	South Carolina Health Plan

	procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.	
Opioid Treatment Program	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. *A Certificate of Need is required for an Opioid Treatment Program.*	South Carolina Health Plan
Outpatient Facility	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. *A Certificate of Need is not required for outpatient facilities.*	South Carolina Health Plan
Pediatric Home Health Agency	Due to the limited number of home health providers available to treat children 18 years or younger, an exception to the home health criteria may be made for a Certificate of Need for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 18 years or younger. The license for the agency will be restricted to serving children 18 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such agencies are not counted in the county inventories for need projection purposes.	South Carolina Health Plan
Percutaneous Coronary Intervention (PCI)	A therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation. These procedures may be performed on	South Carolina Health Plan

	an emergent or elective basis. "Emergent or Primary" means that a patient needs immediate PCI because, in the treating physician's best clinical judgment, delay would result in undue harm or risk to the patient. An "Elective" PCI is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure. 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. These procedures may be performed on an emergent or elective basis.	
Person	An individual, a trust or estate, a partnership, a corporation including an association, joint stock company, insurance company, and a health maintenance organization, a health care facility, a state, a political subdivision, or an instrumentality including a municipal corporation of a state, or any legal entity recognized by the State.	S.C. Code Ann. Section 44-7-130(15)
Regional Perinatal Center with Neonatal Intensive Care Unit (RPC)	In addition to the requirements of Regulation 61-16, Sections 1306.A through 1306.C, RPCs provide consultative, outreach, and support services to other hospitals in the region. A full list of the requirements for a Regional Perinatal Center can be found at Regulation 61-16, Section 1306.D. 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.*	South Carolina Health Plan
Residential Treatment Facility for Children and Adolescents	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	South Carolina Health Plan

	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.	
Residential Treatment Program Facility	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. *A Certificate of Need is not required for a Residential Treatment Program.*	South Carolina Health Plan
Social Detoxification Facility	Facilities which provide supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxication nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. *A Certificate of Need is not required for these facilities.*	South Carolina Health Plan
Specialty Perinatal Center with Special Care Nursery (Level II)	In addition to the requirements of Regulation 61-16, Section 1306.A, Level II hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. A full list of the requirements for a Level II Specialty Perinatal Center can be found at Regulation 61-16, Section 1306.B. *Certificate of Need review is not required to establish a Level II program.*	South Carolina Health Plan
Stereotactic Body Radiation Therapy (SBRT)	A precision radiation therapy delivery concept derived from cranial stereotactic radiosurgery. It is characterized by one to five fraction delivery of focal high-dose radiation while limiting dose to surrounding normal tissues. SBRT has become an established treatment technique for lung, liver, and spinal lesions.	South Carolina Health Plan

Stereotactic Radiation Therapy (SRT)	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.	South Carolina Health Plan
Stereotactic Radiosurgery (SRS)	A single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.	South Carolina Health Plan
Subspecialty Perinatal Center with Neonatal Intensive Care Unit (Level III)	In addition to the requirements of Regulation 61-16, Sections 1306.A and 1306.B, Level III hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the most recent edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A full list of the requirements for a Level III Subspecialty Perinatal Center with Neonatal Intensive Care Unit can be found at Regulation 61-16, Section 1306.C. *Certificate of Need Review is required to establish a Level III program.*	South Carolina Health Plan
Swing-Bed	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 skilled nursing care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. *A Certificate of Need is not required to participate in the Swing Bed Program.*	South Carolina Health Plan

Therapeutic Catheterization	A cardiac catheterization during which any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty.	South Carolina Health Plan