South Carolina Board of Health and Environmental Control

Agenda
June 8, 2017

Call to Order – 10:00 a.m., Board Room (#3420)
South Carolina Department of Health and Environmental Control
2600 Bull Street, Columbia, S.C.

1. Minutes of May 11, 2017 meeting

2. Administrative Orders and Consent Orders issued by Environmental Affairs

3. Administrative Orders, Consent Orders and Sanction Letters issued by Health Regulation

4. Public Hearing for Notice of Final Regulation amending Regulation 61-16, Minimum Standards for Licensing Hospitals and Institutional General Infirmaries

5. Request for approval of the Draft State Health Plan

Executive Session (if needed)

Adjournment

Note: The next scheduled meeting will be July 13.

SUMMARY SHEET
BOARD OF HEALTH AND ENVIRONMENTAL CONTROL
June 8, 2017

_____ ACTION/DECISION

__X__ INFORMATION

1. **TITLE:** Administrative and Consent Orders issued by Environmental Affairs.

2. **SUBJECT:** Administrative and Consent Orders issued by Environmental Quality Control (EQC) and Ocean and Coastal Resource Management (OCRM) during the period April 1, 2017 – April 30, 2017.

3. **FACTS:** For the period of April 1, 2017, through April 30, 2017, Environmental Affairs issued, forty-three (43) Consent Orders with total assessed civil penalties in the amount of $58,889.39. Also, five (5) Consent Agreements were issued during the reporting period.

Bureau and Program Area	Administrative Orders	Assessed Penalties	Consent Agreements	Consent Orders	Assessed Penalties
Land and Waste Management					
UST Program	0	0		0	0
Aboveground Tanks	0	0		0	0
Solid Waste	0	0		2	$500.00
Hazardous Waste	0	0		2	$23,400.00
Infectious Waste	0	0		4	$2,880.00
Mining	0	0		2	$1,200.00
SUBTOTAL	0	0		10	$27,980.00
Water					
Recreational Water	0	0		0	0
Drinking Water	0	0		4	$859.39
Water Pollution	0	0		1	$4,000.00
Dam Safety	0	0	5	0	0
SUBTOTAL	0	0	5	5	$4,859.39
Air Quality					
SUBTOTAL	0	0		0	0
Environmental Health Services					
SUBTOTAL	0	0		28	$26,050.00
OCRM					
SUBTOTAL	0	0		0	0
TOTAL	**0**	**0**	**5**	**43**	**$58,889.39**

Submitted by:

Myra C. Reece

Myra C. Reece
Director of Environmental Affairs

ENVIRONMENTAL AFFAIRS ENFORCEMENT REPORT
BOARD OF HEALTH AND ENVIRONMENTAL CONTROL
June 8, 2017

BUREAU OF LAND AND WASTE MANAGEMENT

Solid Waste Enforcement

1) Order Type and Number: Consent Order 16-22-SW
Order Date: April 26, 2017
Individual/Entity: **Gantt Family Trust, LLC**
Facility: Leaphart Road, TMS #004597-08-039
Location: Leaphart Road
West Columbia, SC
Mailing Address: 101 Beaver Tail Circle
Cayce, SC 29033
County: Lexington
*Previous Orders: None
Permit/ID Number: N/A
Violations Cited: South Carolina Solid Waste Policy and Management Act (2002), Solid Waste Management: Solid Waste Landfills and Structural Fill Regulation 61-107.19 (2012), and, Solid Waste Management: Compost and Mulch Production from Land-clearing Debris, Yard Trimmings, and Organic Residuals Regulation 61-107.4 (2014).

Summary: Gantt Family Trust, LLC (Individual/Entity) operated an unpermitted Class One landfill and wood-grinding facility located in West Columbia, South Carolina, without permits from the Department. The Individual/Entity has violated the Solid Waste Management: Solid Waste Landfills and Structural Fill Regulation, and, Solid Waste Management: Compost and Mulch Production from Land-clearing Debris, Yard Trimmings, and Organic Residuals Regulation 61-107.4 as follows: failed to obtain written Department approval to operate under the General Permit prior to operation of a Class One landfill; and, failed to obtain the appropriate permit or permits from the Department in accordance with Regulation 61-107.4 prior to the construction, operation, expansion, or modification of a facility.

Action: The Individual/Entity is required to: recycle/sell or remove and properly dispose of all chipped material and un-useable material (LCD, yard trimmings, solid waste) on the Site at a permitted solid waste management facility; and, submit disposal receipts to the Department.

2) Order Type and Number: Consent Order 17-06-SW
Order Date: April 13, 2017
Individual/Entity: **Greenworks Recycling, Inc.**
Facility: Southern Grading Site I

Location: 20 Piney Mountain Road
Greenville, SC 29609
Mailing Address: 7 Beverly Road
Greenville, SC 29609
County: Greenville
Previous Orders: None
Permit/ID Number: 232701-3001
Violations Cited: The South Carolina Solid Waste Policy and Management Act of 1991 §44-96-10; the Solid Waste Management: Compost and Mulch Production from Land-clearing Debris, Yard Trimmings and Organic Residuals, 8 S.C. Code Ann. Regs., R.61-107.4. Part III.E.5.c and 61-107.4. Part III.E.15; and Permit Number 232701-3001 (Permit).

Summary: Greenworks Recycling, Inc. (Individual/Entity), located in Greenville, South Carolina, owns and is responsible for the proper operation and maintenance of Southern Grading Site I (Facility), a Type One composting facility. The Department conducted inspections at the facility on November 9, 2016, December 9, 2016, January 12, 2017 and February 10, 2017. The Individual/Entity has violated the South Carolina Solid Waste Management: Solid Waste Landfills and Structural Fill Regulation and Permit as follows: failed to maintain all materials in such a way as to have sufficient space around piles of material to allow access of emergency fire-fighting equipment; and failed to maintain a minimum of 26' Fire Lanes on all sides of material stockpiles or windrows.

Action: The Individual/Entity is required to establish twenty-six (26) foot fire lanes around all stockpiles at the Facility and submit proof to the Department; and, pay a civil penalty in the amount of five hundred dollars **($500.00)**.

Hazardous Waste Enforcement

3) Order Type and Number: Consent Order 17-04-HW
Order Date: April 11, 2017
Respondent: **Oerlikon Balzers Coating USA, Inc.**
Facility: Oerlikon Balzers Coating USA, Inc.
Location: 463 Lakeshore Parkway
Rock Hill, SC 29730
Mailing Address: Same
County: York
Previous Orders: None
Permit/ID Number: SCD 987 582 053
Violations Cited: The South Carolina Hazardous Waste Management Act S.C. Code Ann. §44-56-130(2) *et seq.* (2002); The South Carolina Hazardous Waste Management Regulations, 6 and 7 S.C. Code Ann. Regs. 61-79.262.31(c)(1)(i)/R.61-79.265.173(a), R.61-79.262.34(a)(1)(ii)/R.61-79.265.192(a), R.61-79.262.34(a)(3), R.61-79.262.34(a)(2), R.61-79.262.34(a)(1)(ii)/R.61-79.265.195(e), R.61-79.261.4(b)(18)(i), R.61-

79.262.34(a)(1)(i)/R.61-79.265.174, R.61-79.262.34(a)(4)/R.61-79.265.52(e), R.61-79.262.34(a)(4)/R.61-79.265.52(d), R.61-79.262.34(a)(4)/R.61-79.265.52(c), and, R.61-79.262.34(a)(4)/R.61-79.265.53(b) (2012 and Supp. 2015).

Summary: Oerlikon Balzers Coating USA, Inc. (Individual/Entity) operates a facility in Rock Hill, South Carolina. On February 25, 2016, the Department conducted an inspection of the facility and determined that the Individual/Entity violated the Hazardous Waste Management Regulations as follows: failed to ensure that each container holding hazardous waste is closed during storage, except when necessary to add or remove waste; failed to have a professional engineer certify the design and installation of a tank system holding hazardous waste; failed to ensure that each container or tank is labeled or marked clearly with the EPA Hazardous Waste Number and the words "Hazardous Waste - federal laws prohibit improper disposal"; failed to ensure that the date upon which each period of accumulation begins is clearly marked and visible for inspection on each container; failed to inspect tank ancillary equipment not equipped with secondary containment at least once per operating day; failed to contain solvent-contaminated wipes in containers marked as "Excluded Solvent-Contaminated Wipes"; failed to inspect areas where containers are stored at least weekly; failed to have a contingency plan which lists all emergency equipment and where this equipment is located. This list must be kept up to date; failed to have a contingency plan which lists the names, addresses, phone numbers (home and office) of all persons qualified to act as emergency coordinators; failed to have a contingency plan which describes arrangements agreed to by local police departments, fire departments, hospitals, contractors, and State and local emergency response teams to coordinate emergency services; and, failed to submit a copy of the contingency plan to local police departments, fire departments, hospitals, contractors, and State and local emergency response teams that may be called upon to provide emergency services.

Action: The Individual/Entity has agreed to: ensure that a hazardous waste determination is made on all solid waste in accordance with the regulations; ensure that hazardous waste containers and areas where hazardous waste containers are stored are managed according to the regulations; ensure that hazardous waste tanks are managed in accordance with the regulations; ensure that solvent wipes are managed in accordance with the regulations; ensure that the contingency plan is managed in accordance with the regulations; and, pay a civil penalty in the amount of five thousand, four hundred dollars (**$5,400.00**).

4)	Order Type and Number:	Consent Order 17-05-HW
	Order Date:	April 13, 2017
	Respondent:	**Tidelands Georgetown Memorial Hospital**
	Facility:	Tidelands Georgetown Memorial Hospital
	Location:	606 Black River Road Georgetown, SC 29440-3368

Mailing Address:	PO Box 421718 Georgetown, SC 29440
County:	Georgetown
Previous Orders:	None
Permit/ID Number:	SCD 987 597 895
Violations Cited:	The South Carolina Hazardous Waste Management Act S.C. Code Ann. §44-56-130(2) *et seq.* (2002); The South Carolina Hazardous Waste Management Regulations, 6 and 7 S.C. Code Ann. Regs. 61-79.262.31(c)(1)(i)/R.61-79.265.173(a), R.61-79.262.11, R.61-79.262.34(c)(1), R.61-79.262.34(d)(4)/R.61-79.262.34(a)(2), R.61-79.262.32(b), R.61-79.273.13(d)(1), R.61-79.273.15(c), R.61-79.262.34(d)(2)/R.61-79.265.174, R.61-79.262.34(b), R.61-79.262.13(d), and, R.61-79.262.32(b) (2012 and Supp. 2015).

Summary: Tidelands Georgetown Memorial Hospital (Individual/Entity) operates a facility in Rock Hill, South Carolina. On February 25, 2016, the Department conducted an inspection of the facility determined that the Individual/Entity violated the Hazardous Waste Management Regulations as follows: failed to ensure that each container holding hazardous waste is closed during storage, except when necessary to add or remove waste; failed to accurately determine if a solid waste is a hazardous waste; accumulated hazardous waste greater than one quart of acutely hazardous waste; failed to ensure that the date upon which each period of accumulation begins is clearly marked and visible for inspection on each container; failed to mark containers for transport with the following: generators name and address, generator's EPA ID number and manifest number; failed to contain any lamp in containers or packages that are structurally sound, adequate to prevent breakage, and compatible with the contents of the lamps. Such containers and packages must remain closed and must lack evidence of leakage, spillage or damage that could cause leakage under reasonable foreseeable conditions; failed to demonstrate the length of time that the universal waste has been accumulated from the date that it becomes a waste or is received; failed to inspect areas where hazardous wastes are stored at least weekly; as a generator who accumulates greater than 1 kilogram of acute hazardous waste listed in 261.31 or 261.33(e) in a calendar month, who accumulates waste for more than 90 days is a storage facility and subject to the requirements of 264 and 265, and the permit requirements of 270 unless the facility has been granted an extension of the 90-day period; failed to file a revised or new Notification Form whenever the information previously provided becomes outdated or inaccurate; and, failed to file with the Department a new or revised Notification Form within thirty (30) days.

Action: The Individual/Entity has agreed to: ensure that hazardous waste containers and areas where hazardous waste and hazardous waste containers are managed and stored according to the regulations; ensure that hazardous waste determination is made on all solid waste in accordance with the regulations; ensure that universal waste is managed in accordance with the regulations; ensure that hazardous waste notifications are managed in accordance with the regulations; and, pay a civil penalty in the amount of eighteen thousand dollars (**$18,000.00**).

Infectious Waste Enforcement

5) Order Type and Number: Consent Order 17-04-IW
Order Date: April 10, 2017
Individual/Entity: **The Landrum Rescue Squad**
Facility: The Landrum Rescue Squad
Location: 100 West Coleman Street
Landrum, SC 29356
Mailing Address: PO Box 434
Landrum, SC 29356
County: Spartanburg
Previous Orders: None
Permit/ID Number: IWG000061
Violations Cited: The South Carolina Infectious Waste Management Act, S.C. Code Ann. § 44-93-30 (2002) (Act); and the South Carolina Infectious Waste Management Regulation 61-105 (Supp. 2012).

Summary: The Landrum Rescue Squad (Individual/Entity), located in Landrum, South Carolina, is an Emergency Medical Service (EMS) provider. On April 14, 2016 and December 21, 2016, the Department requested the Individual/Entity to submit a completed Infectious Waste Generator Registration Form to the Department. The Individual/Entity failed to respond and did not comply. The Individual/Entity has violated the Act and the South Carolina Infectious Waste Management Regulation 61-105 as follows: failed to register with the Department in writing on a Department approved form as an infectious waste generator, prior to generating Infectious Waste.

Action: The Individual/Entity is required to register with the Department in writing on the infectious Waste Generator Form; or, if exempt, submit in writing, preferably on letterhead, its company name, address, and contact person as well as the name, address, and contact person of the registered generator accepting responsibility for the proper disposal of the waste generated; and, pay a civil penalty in the amount of seven hundred twenty dollars **($720.00)**.

6) Order Type and Number: Consent Order 17-05-IW
Order Date: April 13, 2017
Individual/Entity: **Marion Rescue Squad, Inc.**
Facility: Marion Rescue Squad, Inc.
Location: 107 East Bond Street
Marion, SC 29571
Mailing Address: PO Box 817
Marion, SC 29571
County: Marion

Previous Orders: None
Permit/ID Number: IWG000032
Violations Cited: The South Carolina Infectious Waste Management Act, S.C. Code Ann. § 44-93-30 (2002) (Act); and the South Carolina Infectious Waste Management Regulation 61-105 (Supp. 2012).

Summary: Marion Rescue Squad, Inc. (Individual/Entity), located in Marion, South Carolina, is an Emergency Medical Service (EMS) provider. On April 13, 2016, May 26, 2016 and December 21, 2016, the Department requested the Individual/Entity to submit a completed Infectious Waste Generator Registration Form to the Department. The Individual/Entity failed to respond and did not comply. The Individual/Entity has violated the Act and the South Carolina Infectious Waste Management Regulation 61-105 as follows: failed to register with the Department in writing on a Department approved form as an infectious waste generator, prior to generating Infectious Waste.

Action: The Individual/Entity is required to register with the Department in writing on the infectious Waste Generator Form; or, if exempt, submit in writing, preferably on letterhead, its company name, address, and contact person as well as the name, address, and contact person of the registered generator accepting responsibility for the proper disposal of the waste generated; and, pay a civil penalty in the amount of seven hundred twenty dollars **($720.00)**.

7) Order Type and Number: Consent Order 17-06-IW
Order Date: April 19, 2017
Individual/Entity: **Marlboro Rescue Squad, Inc. d/b/a Palmetto Transport Systems**
Facility: Palmetto Transport Systems
Location: 3176 East Highway 76
Mullins, SC 29574
Mailing Address: PO Box 123
Bennettsville, SC 29512
County: Marion
Previous Orders: None
Permit/ID Number: IWG000042
Violations Cited: The South Carolina Infectious Waste Management Act, S.C. Code Ann. § 44-93-30 (2002) (Act); and the South Carolina Infectious Waste Management Regulation 61-105 (Supp. 2012).

Summary: Marlboro Rescue Squad, Inc. d/b/a Palmetto Transport Systems (Individual/Entity), located in Mullins, South Carolina, is an Emergency Medical Service (EMS) provider. On April 13, 2016, May 26, 2016 and December 21, 2016, the Department requested the Individual/Entity to submit a completed Infectious Waste Generator Registration Form to the Department. The Individual/Entity failed to respond and did not comply. The Individual/Entity has violated the Act and the South Carolina Infectious Waste Management Regulation 61-105 as follows: failed to

register with the Department in writing on a Department approved form as an infectious waste generator, prior to generating Infectious Waste.

Action: The Individual/Entity is required to register with the Department in writing on the infectious Waste Generator Form; or, if exempt, submit in writing, preferably on letterhead, its company name, address, and contact person as well as the name, address, and contact person of the registered generator accepting responsibility for the proper disposal of the waste generated; and, pay a civil penalty in the amount of seven hundred twenty dollars **($720.00)**.

8)

Order Type and Number:	Consent Order 17-07-IW
Order Date:	April 25, 2017
Individual/Entity:	**Med Atlantic**
Facility:	Med Atlantic
Location:	6759 Old Ebenezer Road Latta, SC 29565
Mailing Address:	Same
County:	Dillon
Previous Orders:	None
Permit/ID Number:	IWG000065
Violations Cited:	The South Carolina Infectious Waste Management Act, S.C. Code Ann. § 44-93-30 (2002) (Act); and the South Carolina Infectious Waste Management Regulation 61-105 (Supp. 2012).

Summary: Med Atlantic (Individual/Entity), located in Dillon, South Carolina, is an Emergency Medical Service (EMS) provider. On April 13, 2016, May 26, 2016 and December 21, 2016, the Department requested the Individual/Entity to submit a completed Infectious Waste Generator Registration Form to the Department. The Individual/Entity failed to respond and did not comply. The Individual/Entity has violated the Act and the South Carolina Infectious Waste Management Regulation 61-105 as follows: failed to register with the Department in writing on a Department approved form as an infectious waste generator, prior to generating Infectious Waste.

Action: The Individual/Entity is required to register with the Department in writing on the infectious Waste Generator Form; or, if exempt, submit in writing, preferably on letterhead, its company name, address, and contact person as well as the name, address, and contact person of the registered generator accepting responsibility for the proper disposal of the waste generated; and, pay a civil penalty in the amount of seven hundred twenty dollars **($720.00)**.

Mining Enforcement

9)

Order Type and Number:	Consent Order 17-03-MSWM
Order Date:	April 13, 2017
Individual/Entity:	**D&S Construction of Pineville, Inc. d.b.a. Swamp Fox Utility**

Facility:	Cedar Hill Mine
Location:	Secondary Highway SC-S-8-351 Moncks Corner, SC
Mailing Address:	2080 Mendel Rivers Road St. Stephen, SC 29479
County:	Berkeley
Previous Orders:	None
Permit/ID Number:	GP1-001694
Violations Cited:	South Carolina Mining Act (2008 and Supp. 2015), and, South Carolina Mining Regulation (2012).

Summary: D&S Construction of Pineville, Inc. d.b.a. Swamp Fox Utility (Individual/Entity) operates a mine located in Moncks Corner, South Carolina. On July 1, 2016, the Department sent an invoice to the Individual/Entity for an annual report and an annual operating fee for fiscal year 2017. The Individual/Entity has violated the South Carolina Mining Act and the South Carolina Mining Regulation as follows: failed to submit an annual report and an annual operating fee for fiscal year 2017.

Action: The Individual/Entity is required to: submit an annual report and an annual operating fee; and, pay a civil penalty in the amount of six hundred dollars **($600.00)** for the violations cited herein.

10)

Order Type and Number:	Consent Order 17-04-MSWM
Order Date:	April 25, 2017
Individual/Entity:	**Demtek LLC**
Facility:	Wall Property Soil Borrow Mine
Location:	US 221 Spartanburg, SC
Mailing Address:	PO Box 1332 Spartanburg, SC 29304
County:	Spartanburg
Previous Orders:	None
Permit/ID Number:	I-002019
Violations Cited:	South Carolina Mining Act (2008 and Supp. 2015), and, South Carolina Mining Regulation (2012).

Summary: Demtek LLC (Individual/Entity) operates a mine located in Spartanburg, South Carolina. On July 1, 2016, the Department sent an invoice to the Individual/Entity for an annual report and an annual operating fee for fiscal year 2017. The Individual/Entity has violated the South Carolina Mining Act and the South Carolina Mining Regulation as follows: failed to submit an annual report and an annual operating fee for fiscal year 2017.

Action: The Individual/Entity is required to: submit an annual report and an annual operating fee; and, pay a civil penalty in the amount of six hundred dollars **($600.00)** for the violations cited herein.

BUREAU OF WATER

Drinking Water Enforcement

11)	Order Type and Number:	Consent Order 17-004-DW
	Order Date:	April 4, 2017
	Individual/Entity:	**Mary Moore, Individually and d.b.a. Moore's Park**
	Facility:	Moore's Park
	Location:	3724 Old State Road Santee, SC 29142
	Mailing Address:	113 Oriental Avenue Santee, SC 29142
	County:	Orangeburg
	Previous Orders:	None
	Permit/ID Number:	3860019
	Violations Cited:	S.C. Code Ann. Regs. 61-30(G)(2)(a)

Summary: Mary Moore, Individually and d.b.a. Moore's Park (Individual/Entity) owns and is responsible for the proper operation and maintenance of a public water system. On October 20, 2016, the Department sent final notice to the Individual/Entity requiring payment of the annual Safe Drinking Water Act fee for fiscal year 2017. The Individual/Entity has violated the Environmental Protection Fees Regulation as follows: failed to pay to the Department the annual Safe Drinking Water Act fee for fiscal Year 2017.

Action: The Individual/Entity is required to: pay to the Department the owed annual Safe Drinking Water Act fee for fiscal year 2017, which totals two hundred forty dollars and sixty-three cents (**$240.63**).

12)	Order Type and Number:	Consent Order 17-005-DW
	Order Date:	April 7, 2017
	Individual/Entity:	**Kenneth Pifer, Individually and d.b.a. Showgirlz**
	Facility:	Showgirlz
	Location:	220 Parklane Drive Santee, SC 29142
	Mailing Address:	Same
	County:	Orangeburg
	Previous Orders:	None
	Permit/ID Number:	3870907
	Violations Cited:	S.C. Code Ann. Regs. 61-30(G)(2)(a)

Summary: Kenneth Pifer, Individually and d.b.a. Showgirlz (Individual/Entity) owns and is responsible for the proper operation and maintenance of a public water system. On October 20, 2016, the Department sent final notice to the Individual/Entity requiring payment of the annual Safe Drinking Water Act fee for fiscal year 2017. The Individual/Entity has violated the Environmental Protection Fees Regulation as follows: failed to pay to the Department the annual Safe Drinking Water Act fee for fiscal Year 2017.

Action: The Individual/Entity is required to: pay to the Department the owed annual Safe Drinking Water Act fee for fiscal year 2017, which totals three hundred seventy-eight dollars and thirteen cents (**$378.13**).

13)	Order Type and Number:	Consent Order 17-006-DW
	Order Date:	April 18, 2017
	Individual/Entity:	**Bobby Marlowe, Individually and d.b.a. Enterprise Mobile Home Park**
	Facility:	Enterprise Mobile Home Park
	Location:	6699 Enterprise Road Myrtle Beach, SC 29575
	Mailing Address:	Same
	County:	Horry
	Previous Orders:	None
	Permit/ID Number:	2660041
	Violations Cited:	S.C. Code Ann. Regs. 61-30(G)(2)(a)

Summary: Bobby Marlowe, Individually and d.b.a. Enterprise Mobile Home Park (Individual/Entity) owns and is responsible for the proper operation and maintenance of a public water system. On October 20, 2016, the Department sent final notice to the Individual/Entity requiring payment of the annual Safe Drinking Water Act fee for fiscal year 2017. The Individual/Entity has violated the Environmental Protection Fees Regulation as follows: failed to pay to the Department the annual Safe Drinking Water Act fee for fiscal Year 2017.

Action: The Individual/Entity is required to: pay to the Department the owed annual Safe Drinking Water Act fee for fiscal year 2017, which totals two hundred forty dollars and sixty-three cents (**$240.63**).

14)	Order Type and Number:	Consent Order 17-007-DW
	Order Date:	April 17, 2017
	Individual/Entity:	**Doran, LLC**
	Facility:	Oakview Mobile Home Park
	Location:	1574 Carolina Avenue Beaufort, SC 29906
	Mailing Address:	Same
	County:	Beaufort

Previous Orders:	None
Permit/ID Number:	0760059
Violations Cited:	S.C. Code Ann. Regs. 61-58.7

Summary: Doran, LLC (Individual/Entity) owns and is responsible for the proper operation and maintenance of a public water system (PWS). On January 30, 2017, the PWS was inspected and rated unsatisfactory for failure to properly operate and maintain. The Individual/Entity has violated the State Primary Drinking Water Regulations as follows: the pump for Well 2 was removed and the casing was left exposed, a viable cross connection control program was not established and maintained, there was trash and items not related to the wells and appurtenances in both well houses, there was overgrown vegetation around both well houses; and the pressure switch at Well 1 was uncovered and the wiring was exposed.

Action: The Individual/Entity is required to: submit a corrective action plan to include proposed steps to correct the deficiencies; and pay a **stipulated penalty** in the amount of four thousand dollars (**$4,000.00**), should any requirement of the Order not be met.

Water Pollution Enforcement

15)

Order Type and Number:	Consent Order 17-016-W
Order Date:	April 10, 2017
Individual/Entity:	**SI Group, Inc.**
Facility:	N/A
Location:	775 Cannon Bridge Road Orangeburg, SC
Mailing Address:	Same
County:	Orangeburg
Previous Orders:	None in last five years
Permit/ID Number:	SC0001180
Violations Cited:	Water Pollution Control Permits, Regs. 61-9.122.4 (d) (2016) and Pollution Control Act, S.C. Code Ann. § 48-1-110(a) and (d) (Supp. 2016)

Summary: SI Group, Inc. (Individual/Entity) owns and is responsible for the proper operation and maintenance of a wastewater treatment facility located in Orangeburg County, South Carolina. On February 1, 2017, a Notice of Violation was issued as a result of discharge monitoring reports submitted to the Department. The Individual/Entity has violated the Pollution Control Act and the Water Pollution Control Permits Regulation as follows: failed to comply with the effluent limits of its National Pollutant Discharge Elimination System Permit for biochemical oxygen demand.

Action: The Individual/Entity is required to: submit a corrective action plan to address the deficiencies; and, pay a civil penalty in the amount of four thousand

dollars **($4,000.00)**.

Dams Enforcement

16) Order Type and Number: Consent Agreement 17-017-W
Order Date: April 10, 2017
Individual/Entity: **Millvale Plantation Inc.**
Facility: Ellerbees Millpond Dam
Location: Lat: 34.06819, Long: -80.53170
Mailing Address: 3229 Sunset Blvd.
West Columbia, SC 29169
County: Sumter
Previous Orders: 2015 Emergency Order (10/15/2015)
Permit/ID Number: D 1460
Law Citations: SC Dams and Reservoirs Safety Act, S.C. Code Ann. § 49-11-110, *et seq*., (2008) and Dams and Reservoirs Safety Act Regulation 72.1, *et seq*. (2012)

Summary: Millvale Plantation Inc. (Individual/ Entity) owns and is responsible for the proper operation and maintenance of the Ellerbees Millpond Dam (Dam) in Sumter County, South Carolina. On October 15, 2015, the Department issued an Emergency Order to the Individual/Entity as a result of unsafe conditions at the Dam. On July 28, 2016, the Department issued a permit to the Individual/Entity for the repair of the Dam. The Agreement is entered into by the Department and the Individual/Entity with respect to remedial actions addressing deficiencies in the condition of the Dam.

Action: The Individual/Entity is required to: comply with all schedules and deadlines identified in its permit for repair of the Dam; and, submit to the Department quarterly summary reports detailing the repair status of the Dam until a Certificate of Completion and Operation is issued by the Department.

17) Order Type and Number: Consent Agreement 17-018-W
Order Date: April 17, 2017
Individual/Entity: **Kathy B. Allen**
Facility: Cullums Pond Dam
Location: Lat: 33.87071608, Long: -81.74175507
Mailing Address: 77 Meeting Street
Edgefield, SC 29824
County: Saluda
Previous Orders: 2015 Emergency Order (10/15/2015)
Permit/ID Number: D 1600
Law Citations: SC Dams and Reservoirs Safety Act, S.C. Code Ann. § 49-11-170 (2008) and Dams and Reservoirs Safety Act Regulation 72.1, et seq. (2012)

Summary: Kathy B. Allen (Individual/ Entity) owns and is responsible for the proper operation and maintenance of the Cullums Pond Dam (Dam) in Saluda County, South Carolina. On October 15, 2015, the Department issued an Emergency Order to the Individual/Entity as a result of unsafe conditions at the Dam. The Individual/Entity has failed to comply with the SC Dams and Reservoirs Safety Act and the Dams and Reservoirs Safety Act Regulation in that the dam or reservoir was not maintained in safe condition throughout the life of the structure.

Action: The Individual/Entity is required to: maintain a lowered water level in the reservoir until a Certificate and Operation is issued by the Department; submit a permit application prepared by a qualified Professional Engineer for the repair or removal of the Dam; submit documentation that all local, state, and federal permit applications have been submitted; complete all construction activities in accordance with approved plans for the repair or removal of the Dam; and, pay a **stipulated** expense recovery in the amount of two hundred fifty-one thousand, nine hundred ninety-four dollars and fifteen cents **($251, 994.15)** should the Individual/Entity fail to comply with any requirement pursuant to the Consent Agreement.

18)

Order Type and Number:	Consent Agreement 17-019-W
Order Date:	April 17, 2017
Individual/Entity:	**South Carolina Department of Parks, Recreation, & Tourism**
Facility:	Chester State Park Dam
Location:	Lat: 34.6779, Long: -81.247
Mailing Address:	1205 Pendleton Street Columbia, SC 29201
County:	Chester
Previous Orders:	2015 Emergency Order (10/19/2015)
Permit/ID Number:	D 0206
Law Citations:	SC Dams and Reservoirs Safety Act, S.C. Code Ann. § 49-11-110, *et seq*., (2008) and Dams and Reservoirs Safety Act Regulation 72.1, *et seq*. (2012)

Summary: South Carolina Department of Parks, Recreation, & Tourism (Individual/Entity) owns and is responsible for the proper operation and maintenance of the Chester State Park Dam (Dam) in Chester County, South Carolina. On October 19, 2015, the Department issued an Emergency Order to the Individual/Entity as a result of unsafe conditions at the Dam. On November 9, 2016, the Department issued a permit to the Individual/Entity for the repair of the Dam. The Agreement is entered into by the Department and the Individual/Entity with respect to remedial actions addressing deficiencies in the condition of the Dam.

Action: The Individual/Entity is required to: comply with all schedules and deadlines identified in its permit for repair of the Dam; and, submit to the

Department quarterly summary reports detailing the repair status of the Dam until a Certificate of Completion and Operation is issued by the Department.

19) Order Type and Number: Consent Agreement 17-020-W
Order Date: April 25, 2017
Individual/Entity: **Anderson County Public Works Stormwater Department**
Facility: Broadway Lake Dam
Location: Lat: 34.44760, Long: -82.58870
Mailing Address: 731 Michelin Blvd.
Anderson, SC 29626
County: Anderson
Previous Orders: 2015 Emergency Order (10/19/2015)
Permit/ID Number: D 1573
Law Citations: SC Dams and Reservoirs Safety Act, S.C. Code Ann. § 49-11-110, *et seq.*, (2008) and Dams and Reservoirs Safety Act Regulation 72.1, *et seq*. (2012)

Summary: Anderson County Public Works Stormwater Department (Individual/Entity) owns and is responsible for the proper operation and maintenance of the Broadway Lake Dam (Dam) in Anderson County, South Carolina. On October 19, 2015, the Department issued an Emergency Order to the Individual/Entity as a result of unsafe conditions at the Dam. On September 27, 2016, the Department issued a permit to the Individual/Entity for the repair of the Dam. The Agreement is entered into by the Department and the Individual/Entity with respect to remedial actions addressing deficiencies in the condition of the Dam.

Action: The Individual/Entity is required to: comply with all schedules and deadlines identified in its permit for repair of the Dam; and, submit to the Department quarterly summary reports detailing the repair status of the Dam until a Certificate of Completion and Operation is issued by the Department.

20) Order Type and Number: Consent Agreement 17-021-W
Order Date: April 25, 2017
Individual/Entity: **David Atkinson**
Facility: Chapman's Pond Dam
Location: Lat: 34.41969, Long: -79.94150
Mailing Address: 2922 New Hopewell Road
Hartsville, SC 29550
County: Darlington
Previous Orders: 2015 Emergency Order (10/15/2015)
Permit/ID Number: D 3533
Law Citations: SC Dams and Reservoirs Safety Act, S.C. Code Ann. § 49-11-110, *et seq.*, (2008) and Dams and Reservoirs Safety Act Regulation 72.1, *et seq*. (2012)

Summary: David Atkinson (Individual/ Entity) owns and is responsible for the proper operation and maintenance of the Chapman's Pond Dam (Dam) in Darlington County, South Carolina. On October 15, 2015, the Department issued an Emergency Order to the Individual/Entity as a result of unsafe conditions at the Dam. On December 29, 2016, the Department issued a permit to the Individual/Entity for the repair of the Dam. The Agreement is entered into by the Department and the Individual/Entity with respect to remedial actions addressing deficiencies in the condition of the Dam.

Action: The Individual/Entity is required to: comply with all schedules and deadlines identified in its permit for repair of the Dam; and, submit to the Department quarterly summary reports detailing the repair status of the Dam until a Certificate of Completion and Operation is issued by the Department.

BUREAU OF ENVIRONMENTAL HEALTH SERVICES

Food Safety Enforcement

21)	Order Type and Number:	Consent Order 2016-206-07-068
	Order Date:	April 4, 2017
	Individual/Entity:	**Mellow Mushroom Charleston**
	Facility:	Mellow Mushroom Charleston
	Location:	309 King Street Charleston, SC 29402
	Mailing Address:	Same
	County:	Charleston
	Previous Orders:	None
	Permit Number:	10-206-03701
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Mellow Mushroom Charleston (Individual/Entity), located in Charleston, South Carolina, is a restaurant. The Department conducted inspections on July 29, 2016, and August 9, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

22)	Order Type and Number:	Consent Order 2016-206-07-066
	Order Date:	April 4, 2017

Individual/Entity:	**Five Loaves Café**
Facility:	Five Loaves Café
Location:	43 Cannon Street Charleston, SC 29403
Mailing Address:	4 Carriage Lane, Suite 400F Charleston, SC 29407
County:	Charleston
Previous Orders:	None
Permit Number:	10-206-04363
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Five Loaves Cafe (Individual/Entity), located in Charleston, South Carolina, is a restaurant. The Department conducted inspections on August 24, 2015, and August 1, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

23)

Order Type and Number:	Consent Order 2016-206-07-067
Order Date:	April 4, 2017
Individual/Entity:	**The Rarebit**
Facility:	The Rarebit
Location:	474 King Street Charleston, SC 29403
Mailing Address:	60 Poplar Street Charleston, SC 29403
County:	Charleston
Previous Orders:	None
Permit Number:	10-206-08558
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: The Rarebit (Individual/Entity), located in Charleston, South Carolina, is a restaurant. The Department conducted inspections on August 4, 2016, and August 15, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

24) Order Type and Number: Consent Order 2016-206-07-063
Order Date: April 4, 2017
Individual/Entity: **Three Little Birds LLC**
Facility: Three Little Birds LLC
Location: 65 Windermere Boulevard
Charleston, SC 29402
Mailing Address: Same
County: Charleston
Previous Orders: None
Permit Number: 10-206-06209
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Three Little Birds LLC (Individual/Entity), located in Charleston, South Carolina, is a restaurant. The Department conducted inspections on July 27, 2016, and August 5, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of five hundred fifty dollars **($550.00)**.

25) Order Type and Number: Consent Order 2016-206-08-033
Order Date: April 4, 2017
Individual/Entity: **Panda Chinese Restaurant**
Facility: Panda Chinese Restaurant
Location: 860 Parris Island Gateway
Beaufort, SC 29906
Mailing Address: Same
County: Beaufort
Previous Orders: None
Permit Number: 07-206-02431
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Panda Chinese Restaurant (Individual/Entity), located in Beaufort, South Carolina, is a restaurant. The Department conducted inspections on July 13, 2016, July 25, 2016, and January 19, 2017. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

26) Order Type and Number: Consent Order 2016-206-06-141
Order Date: April 7, 2017
Individual/Entity: **On the ½ Shell**
Facility: On the ½ Shell
Location: 4500 Highway 17
Murrells Inlet, SC 29576
Mailing Address: Same
County: Georgetown
Previous Orders: None
Permit Number: 22-206-05954
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: On the ½ Shell (Individual/Entity), located in Georgetown, South Carolina, is a restaurant. The Department conducted inspections on July 25, 2016, August 3, 2016, and November 2, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

27) Order Type and Number: Consent Order 206-206-07-080
Order Date: April 7, 2017
Individual/Entity: **Krishna of Summerville**
Facility: Krishna of Summerville
Location: 10002 Dorchester Road
Summerville, SC 29485
Mailing Address: Same
County: Dorchester
Previous Orders: None
Permit Number: None
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Krishna of Summerville (Individual/Entity), located in Summerville, South Carolina, is a convenience store. The Department conducted inspections on July 27, 2016, and August 25, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to obtain a retail food establishment permit prior to providing food to the public.

Action: The Individual/Entity is required to: cease all food service operations until a Retail Food Service Permit is obtained through the Department;

and pay a civil penalty in the amount of one thousand six hundred dollars **($1,600.00)**.

28)

Order Type and Number:	Consent Order 2016-206-06-123
Order Date:	April 7, 2017
Individual/Entity:	**Murrells Inlet Elks Lodge 2797**
Facility:	Murrells Inlet Elks Lodge 2797
Location:	3816 Highway 17 Bypass Murrells Inlet, SC 29576
Mailing Address:	PO Box 1746 Murrells Inlet, SC 29576
County:	Horry
Previous Orders:	None
Permit Number:	22-206-05614
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Murrells Inlet Elks Lodge 2797 (Individual/Entity), located in Murrells Inlet, South Carolina, operates a restaurant. The Department conducted inspections on August 4, 2015, and June 27, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper sanitization concentration for the warewashing (dish) machine.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of one hundred dollars **($100.00)**.

29)

Order Type and Number:	Consent Order 2016-206-01-040
Order Date:	April 7, 2017
Individual/Entity:	**Dunkin Donuts**
Facility:	Dunkin Donuts
Location:	1827 East Greenville Street Anderson, SC 29621
Mailing Address:	68 Main Street, Suite 102 Tuckahoe, NY 10707
County:	Anderson
Previous Orders:	None
Permit Number:	04-206-03821
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Dunkin Donuts (Individual/Entity), located in Anderson, South Carolina, is a restaurant. The Department conducted inspections on June 13, 2016, June 22, 2016, and June 29, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to provide a minimum of 100°F water at all handsinks.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of four hundred dollars **($400.00)**.

30)

Order Type and Number:	Consent Order 2016-206-02-027
Order Date:	April 10, 2017
Individual/Entity:	**Carolina Ale House**
Facility:	Carolina Ale House
Location:	113 South Main Street Greenville, SC 29601
Mailing Address:	PO Box 7367 Columbia, SC 29202
County:	Greenville
Previous Orders:	None
Permit Number:	23-206-10160
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Carolina Ale House (Individual/Entity), located in Greenville, South Carolina, is a restaurant. The Department conducted inspections on January 5, 2016, June 29, 2016, and July 8, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of one thousand two hundred dollars **($1,200.00)**.

31)

Order Type and Number:	Consent Order 2016-206-06-075
Order Date:	April 10, 2017
Individual/Entity:	**Fiorentinos**
Facility:	Fiorentinos
Location:	4335 Big Barn Road Little River, SC 29566
Mailing Address:	Same
County:	Horry
Previous Orders:	None
Permit Number:	26-206-12736
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Fiorentinos (Individual/Entity), located in Little River, South Carolina, is a restaurant. The Department conducted inspections on September 1, 2015, and April 13, 2016. The Individual/Entity has violated the South Carolina Retail

Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

32)	Order Type and Number:	Consent Order 2016-206-01-041
	Order Date:	April 10, 2017
	Individual/Entity:	**Stop-A-Minit #10**
	Facility:	Stop-A-Minit #10
	Location:	1 Saluda Avenue Ware Shoals, SC 29692
	Mailing Address:	3052 East Calhoun Street Anderson, SC 29621
	County:	Greenwood
	Previous Orders:	2015-206-01-047 ($800)
	Permit Number:	24-206-01612
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Stop-A-Minit #10 (Individual/Entity), located in Ware Shoals, South Carolina, is a convenience store. The Department conducted an inspection on July 28, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of one thousand two hundred dollars **($1,200.00)**.

33)	Order Type and Number:	Consent Order 2017-206-01-001
	Order Date:	April 17, 2017
	Individual/Entity:	**Empire Chinese Restaurant**
	Facility:	Empire Chinese Restaurant
	Location:	1706-E East Greenville Street Anderson, SC 29621
	Mailing Address:	Same
	County:	Anderson
	Previous Orders:	None
	Permit Number:	04-206-03333
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Empire Chinese Restaurant (Individual/Entity), located in Anderson, South Carolina, is a restaurant. The Department conducted inspections on January 4, 2017, January 5, 2017, March 6, 2017, March 7, 2017, and March 15, 2017.

The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to ensure the person in charge shall demonstrate knowledge; failed to ensure employees washed their hands between tasks or working with foods, prior to donning gloves; failed to sanitize utensils and food contact surfaces of equipment before use and after cleaning; failed to keep food contact surfaces, nonfood contact surfaces, and utensils clean and free of accumulation of dust, dirt, food residue and other debris; failed to maintain the plumbing system in good repair; and failed to clean physical facilities as often as necessary to keep them clean.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of two thousand six hundred dollars **($2,600.00)**.

34)

Order Type and Number:	Consent Order 2016-206-06-128
Order Date:	April 17, 2017
Individual/Entity:	**Beach Burger**
Facility:	Beach Burger
Location:	608 North Ocean Boulevard Myrtle Beach, SC 29577
Mailing Address:	Same
County:	Horry
Previous Orders:	None
Permit Number:	26-206-11474
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Beach Burger (Individual/Entity), located in Myrtle Beach, South Carolina, is a restaurant. The Department conducted inspections on June 9, 2016, and November 21, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

35)

Order Type and Number:	Consent Order 2016-206-03-079
Order Date:	April 17, 2017
Individual/Entity:	**El Paso**
Facility:	El Paso
Location:	1937 Augusta Highway Lexington, SC 29072
Mailing Address:	Same

County: Lexington
Previous Orders: None
Permit Number: 32-206-06469
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: El Paso (Individual/Entity), located in Lexington, South Carolina, is a restaurant. The Department conducted inspections on July 12, 2016, July 20, 2016, and August 18, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

36) Order Type and Number: Consent Order 2016-206-07-060
Order Date: April 20, 2017
Individual/Entity: **Olive Garden #1150**
Facility: Olive Garden #1150
Location: 2156 Northwoods Boulevard
North Charleston, SC 29406
Mailing Address: PO Box 695016
Orlando, FL 32869
County: Charleston
Previous Orders: None
Permit Number: 10-206-00401
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Olive Garden #1150 (Individual/Entity), located in North Charleston, South Carolina, is a restaurant. The Department conducted inspections on July 30, 2015, and June 28, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

37) Order Type and Number: Consent Order 2016-206-03-086
Order Date: April 20, 2017
Individual/Entity: **City Tavern of Fort Mill**
Facility: City Tavern of Fort Mill
Location: 501 Crossroads Plaza

	Fort Mill, SC 29708
Mailing Address:	Same
County:	York
Previous Orders:	None
Permit Number:	46-206-03285
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: City Tavern of Fort Mill (Individual/Entity), located in Fort Mill, South Carolina, is a restaurant. The Department conducted inspections on July 29, 2015, August 6, 2015, and July 28, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

38)	Order Type and Number:	Consent Order 2016-206-03-060
	Order Date:	April 20, 2017
	Individual/Entity:	**One Stop**
	Facility:	One Stop
	Location:	912 Kendall Road Newberry, SC 29108
	Mailing Address:	PO Box 103 Newberry, SC 29108
	County:	Newberry
	Previous Orders:	None
	Permit Number:	36-206-01262
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: One Stop (Individual/Entity), located in Newberry, South Carolina, is a convenience store. The Department conducted inspections on July 29, 2016, and August 9, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to store foods in a manner to prevent cross contamination; and failed to properly cool cooked time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

39)	Order Type and Number:	Consent Order 2016-206-03-088
	Order Date:	April 20, 2017

Individual/Entity:	**San Jose**
Facility:	San Jose
Location:	110 Creech Road Blythewood, SC 29016
Mailing Address:	Same
County:	Richland
Previous Orders:	None
Permit Number:	40-206-06265
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: San Jose (Individual/Entity), located in Blythewood, South Carolina, is a restaurant. The Department conducted inspections on September 8, 2015, July 27, 2016, and March 17, 2017. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

40)

Order Type and Number:	Consent Order 2016-206-03-080
Order Date:	April 20, 2017
Individual/Entity:	**Jimmy's Mart**
Facility:	Jimmy's Mart
Location:	9900 Two Notch Road Columbia, SC 29223
Mailing Address:	Same
County:	Richland
Previous Orders:	None
Permit Number:	40-206-1417
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Jimmy's Mart (Individual/Entity), located in Columbia, South Carolina, is a convenience store. The Department conducted inspections on July 14, 2015, July 12, 2016, July 21, 2016, and July 29, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods; failed to properly cool cooked time/temperature control for safety foods; and failed to use effective methods to cool cooked time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of one thousand six hundred dollars **($1,600.00)**.

41) Order Type and Number: Consent Order 2016-211-05-001
Order Date: April 21, 2017
Individual/Entity: **Bowman IGA #52**
Facility: Bowman IGA #52
Location: 6511 Charleston Highway
Bowman, SC 29018
Mailing Address: Same
County: Orangeburg
Previous Orders: None
Permit Number: 38-211-02179
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Bowman IGA #52 (Individual/Entity), located in Bowman, South Carolina, is a grocery store. The Department conducted inspections on August 24, 2016, and December 9, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

42) Order Type and Number: Consent Order 2016-206-07-070
Order Date: April 21, 2017
Individual/Entity: **Kiawah Island Beach Club**
Facility: Kiawah Island Beach Club
Location: 225 Ocean Marsh Road
Kiawah Island, SC 29455
Mailing Address: Same
County: Charleston
Previous Orders: None
Permit Number: 10-206-05427
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: Kiawah Island Beach Club (Individual/Entity), located in Kiawah Island, South Carolina, is a restaurant. The Department conducted inspections on August 19, 2015, and August 2, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

43) Order Type and Number: Consent Order 2016-206-03-082
Order Date: April 21, 2017
Individual/Entity: **S & C Family Restaurant**
Facility: S & C Family Restaurant
Location: 1691 Great Falls Highway
Lancaster, SC 29720
Mailing Address: PO Box 1613
Lancaster, SC 29721
County: Lancaster
Previous Orders: None
Permit Number: 29-206-01287
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: S & C Family Restaurant (Individual/Entity), located in Lancaster, South Carolina, is a restaurant. The Department conducted inspections on January 21, 2015, January 21, 2016, and August 16, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

44) Order Type and Number: Consent Order 2016-206-03-084
Order Date: April 21, 2017
Individual/Entity: **La Poblanita Bar and Grill**
Facility: La Poblanita Bar and Grill
Location: 2301 Dave Lyle Boulevard, Suite 320
Rock Hill, SC 29730
Mailing Address: 11928 Planters Estates Drive
Charlotte, NC 28278
County: York
Previous Orders: None
Permit Number: 46-206-03131
Violations Cited: S.C. Code Ann. Regs. 61-25

Summary: La Poblanita Bar and Grill (Individual/Entity), located in Lancaster, South Carolina, is a restaurant. The Department conducted inspections on December 3, 2015, July 27, 2016, and September 19, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including

S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

45)	Order Type and Number:	Consent Order 2015-206-02-035
	Order Date:	April 25, 2017
	Individual/Entity:	**V-Stop**
	Facility:	V-Stop
	Location:	5916 Augusta Road Greenville, SC 29605
	Mailing Address:	Same
	County:	Greenville
	Previous Orders:	None
	Permit Number:	23-206-11008
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: V-Stop (Individual/Entity), located in Greenville, South Carolina, is a convenience store. The Department conducted inspections on July 20, 2015, July 30, 2015, August 7, 2015, and August 17, 2015. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to keep food contact surfaces, nonfood contact surfaces, and utensils clean and free of accumulation of dust, dirt, food residue and other debris: and failed to provide a test kit or other device that accurately measures the concentration in MG/L of sanitizing solutions.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of one thousand six hundred dollars **($1,600.00)**.

46)	Order Type and Number:	Consent Order 2015-206-07-101
	Order Date:	April 25, 2017
	Individual/Entity:	**Hollings Café**
	Facility:	Hollings Café
	Location:	86 Jonathan Lucas Boulevard Charleston, SC 29403
	Mailing Address:	Same
	County:	Charleston
	Previous Orders:	None
	Permit Number:	10-206-08425
	Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Hollings Café (Individual/Entity), located in Charleston, South Carolina, is a restaurant. The Department conducted inspections on August 5, 2014, and August 24, 2015. The Individual/Entity has violated the South Carolina Retail

Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

47)

Order Type and Number:	Consent Order 2016-206-02-037
Order Date:	April 25, 2017
Individual/Entity:	**Japan Express**
Facility:	Japan Express
Location:	201-C West Butler Road Mauldin, SC 29662
Mailing Address:	Same
County:	Greenville
Previous Orders:	None
Permit Number:	23-206-10541
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Japan Express (Individual/Entity), located in Mauldin, South Carolina, is a restaurant. The Department conducted inspections on June 30, 2016, July 11, 2016, and March 23, 2017. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

48)

Order Type and Number:	Consent Order 2016-206-06-124
Order Date:	April 26, 2017
Individual/Entity:	**Ruby Tuesday #4271**
Facility:	Ruby Tuesday #4271
Location:	101 North Strand Parkway Myrtle Beach, SC 29588
Mailing Address:	Same
County:	Horry
Previous Orders:	None
Permit Number:	26-206-08460
Violations Cited:	S.C. Code Ann. Regs. 61-25

Summary: Ruby Tuesday #4271 (Individual/Entity), located in Myrtle Beach, South Carolina, is a restaurant. The Department conducted inspections on

June 8, 2016, and June 28, 2016. The Individual/Entity has violated the South Carolina Retail Food Establishment Regulation as follows: failed to maintain proper holding temperatures of time/temperature control for safety foods.

Action: The Individual/Entity is required to: operate and maintain the facility in accordance with the requirements of all applicable regulations, including S.C. Regs. 61-25; and pay a civil penalty in the amount of eight hundred dollars **($800.00)**.

* Unless otherwise specified, "Previous Orders" as listed in this report include orders issued by Environmental Affairs Programs within the last five (5) years.

SUMMARY SHEET
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

June 8, 2017

( ) ACTION/DECISION

(X) INFORMATION

I. **TITLE:** Health Regulation Administrative and Consent Orders.

II. **SUBJECT:** Health Regulation Administrative Orders, Consent Orders, and Emergency Suspension Orders for the period of April 1, 2017, through April 30, 2017.

III. **FACTS:** For the period of April 1, 2017, through April 30, 2017, Health Regulation reports five (5) Consent Orders with a total of one hundred two thousand one hundred seventy-five dollars and seventy cents ($102,175.70) in assessed monetary penalties.

Health Regulation Bureau	Health Care Facility, Provider or Equipment	Administrative Orders	Consent Orders	Emergency Suspension Orders	Assessed Penalties
Certificate of Need	Hospital	0	1	0	$99,175.70
EMS & Trauma	Paramedic	0	2	0	$1,500
	EMT	0	2	0	$1,500
TOTAL		**0**	**5**	**0**	**$102,175.70**

Approved By:

Shelly Bezanson Kelly
Director of Health Regulation

HEALTH REGULATION ENFORCEMENT REPORT
SOUTH CAROLINA BOARD OF HEALTH AND ENVIRONMENTAL CONTROL

June 8, 2017

Certificate of Need Program

1. Bon Secours St. Francis Xavier Hospital, Inc. – Charleston, SC

Investigation: On January 9, 2017, Bon Secours St. Francis Xavier Hospital ("Bon Secours") filed a Certificate of Need ("CON") application for the purchase of a radiosurgery technology package, with a total cost of nine hundred ninety-one thousand seven hundred fifty-seven dollars ($991,757). The CON application stated that the technology package was already purchased and installed. Upon inquiry, Bon Secours stated that the equipment was purchased September 9, 2015, and delivered to Bon Secours February 11, 2016. During an enforcement conference thereafter, Bon Secours presented evidence that the equipment had yet to be commissioned or installed. Bon Secours further stated to the Department that the equipment presently resides in a treatment room at the facility and that the equipment has not been utilized to date. The Department has not issued a CON for this equipment purchase nor rendered a decision on the pending CON application.

Violations: Pursuant to S.C. Code Section 44-7-160(6), a health care facility is required to obtain a CON from the Department prior to the acquisition of medical equipment if the total project cost exceeds the regulatory threshold. S.C. Code of Regulations 61-15, Section 102(1)(f), requires a CON from the Department for the acquisition of medical equipment if the total project cost is in excess of six hundred thousand dollars ($600,000). Therefore, Bon Secours was not authorized by the Department to acquire the technology package prior to written approval from the Department

Enforcement Action: The Department finds that public interest would be served by the assessment of a monetary penalty in the amount of ninety-nine thousand one hundred seventy-five dollars and seventy cents ($99,175.70), representing ten percent (10%) of the total project cost. However, the Department further finds that public interest would be served by requiring payment of one percent (1%) ($9,917.57) of the monetary penalty at this time, with the remainder to be held in abeyance for a period of one (1) year. Therefore, pursuant to the Consent Order executed April 21, 2017, Bon Secours agreed to pay the assessed monetary penalty of nine thousand nine hundred seventeen dollars and fifty-seven cents ($9,917.57) within thirty (30) days of execution of the Consent Order. Bon Secours further agreed to not utilize the medical equipment absent written approval from the Department. Finally, Bon Secours agreed to return the equipment if the Department determines that a CON should not be granted for this equipment. The assessed monetary penalty has been paid by Bon Secours.

Prior Sanctions: None.

Bureau of EMS & Trauma

EMS Provider Type	Total # of Providers in South Carolina
EMT	5,647
EMT – Intermediate	196
Advanced EMT	366
Paramedic	3,645

Athletic Trainers	889
Ambulance Services Provider	257
First Responder Services Provider	2

2. Susan M. Baker (Paramedic)

Investigation: On October 27, 2016, the Department received notification regarding an October 22, 2016, incident involving alleged inappropriate actions by Ms. Baker. The Department initiated an investigation and made the following findings. On October 22, 2016, Ms. Baker attended a party at a friend's residence. During the party, another attendee appeared to be under the influence of some intoxicant and nearly passed out. The host of the party, a certified EMT, assisted the individual to the couch in the living room of the residence. The host then retrieved some intravenous ("IV") supplies from a box at her residence. At this time, Ms. Baker entered the room and attempted to start the IV on the individual, but was unsuccessful. Subsequently, the host was successful in starting the IV line and administered fluids to the individual. After the host started the IV, Ms. Baker left the room and returned to the party outside. Neither Ms. Baker nor the host performed an assessment on the individual prior to starting the IV, which would have assisted in determining whether the individual was merely intoxicated or was suffering from some form of head injury. Administration of IV fluid to a patient with a head injury can exacerbate the injury with the potential of being fatal.

Violations: As a result of its investigation, the Department found Ms. Baker committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(8) and Section 1100(B)(8) of Regulation 61-7, by discontinuing care and abandoning a patient without the patient's consent and without providing for the further administration of care by an equal or higher medical authority. Specifically, after initiating care, Ms. Baker discontinued care, abandoned the patient, and returned to the party without providing for the continuation of care by an equal or higher medical authority. Ms. Baker further committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(14) of Regulation 61-7, by creating a substantial possibility that serious physical harm could result from her inactions. Specifically, Ms. Baker failed to perform a complete initial assessment of the patient, unsuccessfully attempted to start an IV line, and observed an off-duty EMT successfully start the IV line and administer fluids to the individual.

Enforcement Action: The parties met and were able to resolve this matter pursuant to a Consent Order executed April 4, 2017. Pursuant to the terms of the Consent Order, Ms. Baker agreed to a one thousand five hundred dollar ($1,500) assessed monetary penalty, due within one hundred eighty (180) days after execution of the Consent Order. Ms. Baker further agreed to a one (1) year suspension of her Paramedic certificate. The suspension will be held in abeyance for a period of one (1) year, pending compliance with the EMS Act, Regulation 61-7, and the terms of the Consent Order. Finally, Ms. Baker agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six (6) months of execution of the Consent Order and provide proof of completion to the Department.

Prior Sanctions: None.

3. Kathleen M. Gumaer (EMT)

Investigation: On October 27, 2016, the Department received notification regarding an October 22, 2016, incident involving alleged inappropriate actions by Ms. Gumaer. The Department initiated an

investigation and made the following findings. On October 22, 2016, Ms. Gumaer hosted a party at her residence. During the party, another attendee appeared to be under the influence of some intoxicant and nearly passed out. Ms. Gumaer assisted the individual to the couch in the living room of her residence. Ms. Gumaer then retrieved some intravenous ("IV") supplies from a box at her residence. At this time, another attendee who is a certified paramedic entered the room and attempted to start the IV on the individual, but was unsuccessful. Subsequently, Ms. Gumaer was successful in starting the IV line and administered fluids to the individual. After she started the IV, Ms. Gumaer left the room and returned to the party outside. Neither Ms. Gumaer nor the paramedic performed an assessment on the individual prior to starting the IV, which would have assisted in determining whether the individual was merely intoxicated or was suffering from some form of head injury. Administration of IV fluid to a patient with a head injury can exacerbate the injury with the potential of being fatal.

Violations: As a result of its investigation, the Department found Ms. Gumaer committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(12) and Section 1100(B)(12) of Regulation 61-7, by performing skills above the level for which she was certified. Specifically, establishing an IV and administering IV fluids to a patient is an advanced skill that only certified advanced EMTs and paramedics may perform. Ms. Gumaer further committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(14) and Section 1100(B)(14) of Regulation 61-7, by creating a substantial possibility that serious physical harm could result from her inactions. Specifically, Ms. Gumaer failed to perform a complete initial assessment of the patient, and started IV fluids believing that the individual was only intoxicated and possibly dehydrated due to vomiting. Finally, Ms. Gumaer committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(17) and Section 1100(B)(15) of Regulation 61-7, by breaching a section of the EMS Act. Specifically, Ms. Gumaer violated S.C. Code Section 44-61-130 by possessing and administering IV fluid while not on duty with a licensed service and without an order of a physician possessing a license to practice medicine in South Carolina.

Enforcement Action: The parties met and were able to resolve this matter pursuant to a Consent Order executed April 17, 2017. Pursuant to the terms of the Consent Order, Ms. Gumaer agreed to a one thousand five hundred dollar ($1,500) assessed monetary penalty, due within one hundred eighty (180) days after execution of the Consent Order. Ms. Gumaer further agreed to a one (1) year suspension of her EMT certificate. The suspension will be held in abeyance for a period of one (1) year, pending compliance with the EMS Act, Regulation 61-7, and the terms of the Consent Order. Finally, Ms. Gumaer agreed to successfully complete a National Association of Emergency Medical Technicians Principles of Ethics and Personal Leadership course within six (6) months of execution of the Consent Order and provide proof of completion to the Department.

Prior Sanctions: None.

4. Courtney L. Clements (Paramedic)

Investigation: On April 28, 2016, the Department received a complaint regarding patient care provided by Aiken County Emergency Medical Services ("Aiken EMS") EMTs on April 27, 2016. The Department initiated an investigation into the matter and made the following findings. On April 27, 2016, while working for Aiken EMS, Ms. Clements responded to a patient complaining of severe pain. After loading the patient into the ambulance, Ms. Clements and her EMT partner began providing patient care. Ms. Clements allowed her EMT partner, who at the time was in advanced EMT school, to attempt to start an intravenous ("IV") line on the patient. Ms. Clements' EMT partner was unsuccessful in starting the IV which resulted in extreme pain for the patient and bruising and swelling on the patient's hand due to the EMT partner repeatedly attempting to find the vein.

Violations: As a result of its investigation, the Department found Ms. Clements committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(13) and Section 1100(B)(14) of Regulation 61-7, by

observing the administration of substandard care by another EMT without documenting the event and notifying a supervisor. Specifically, Ms. Clements allowed her EMT partner to attempt an IV on a patient, a skill that is outside the scope of practice for an EMT. The IV attempt was unsuccessful and painful for the patient. Ms. Clements failed to document the event and notify a supervisor.

Enforcement Action: Pursuant to the Consent Order executed April 3, 2017, Ms. Clements agreed to a one (1) year suspension of her Paramedic certificate. The suspension will be held in abeyance for one (1) year. Should Ms. Clements fail to comply with the EMS Act, Regulation 61-7, or the terms of the Consent Order, the Department may call in all or a portion of the agreed upon suspension.

Prior Sanctions: None.

5. Courtney L. White (EMT)

Investigation: On April 28, 2016, the Department received a complaint regarding patient care provided by Aiken County Emergency Medical Services ("Aiken EMS") EMTs on April 27, 2016. The Department initiated an investigation into the matter and made the following findings. On April 27, 2016, while working for Aiken EMS, Ms. White responded to a patient complaining of severe pain. After loading the patient into the ambulance, Ms. White and her paramedic partner began providing patient care. Ms. White, who at the time was in advanced EMT school, attempted to start an intravenous ("IV") line on the patient. Ms. White was unsuccessful in starting the IV which resulted in extreme pain for the patient and bruising and swelling on the patient's hand due to Ms. White repeatedly attempting to find the vein.

Violations: As a result of its investigation, the Department found Ms. White committed "misconduct," as defined by S.C. Code Section 44-61-80(F)(12) and Section 1100(B)(13) of Regulation 61-7, by performing a skill above the level for which she was certified. Specifically, Ms. White attempted an IV on a patient, which is an advanced level skill and can only be performed by either an AEMT or a paramedic in South Carolina.

Enforcement Action: Pursuant to the Consent Order executed April 10, 2017, Ms. White agreed to a one (1) year suspension of her EMT certificate. The suspension will be held in abeyance for one (1) year. Should Ms. White fail to comply with the EMS Act, Regulation 61-7, or the terms of the Consent Order, the Department may call in all or a portion of the agreed upon suspension.

Prior Sanctions: None.

Date: June 8, 2017

To: Board of the S.C. Department of Health and Environmental Control

From: Health Regulation

Re: Public hearing for Notice of Final Regulation amending R.61-16, Minimum Standards for Licensing Hospitals and Institutional General Infirmaries.

I. Introduction

The Bureau of Health Facilities Licensing proposes the attached Notice of Final Regulation amending R.61-16, *Minimum Standards for Licensing Hospitals and Institutional General Infirmaries* for submission to the General Assembly. Legal authority for this amendment resides in S.C. Code Sections 44-7-110 through 44-7-394, which requires the Department to establish and enforce basic standards for the licensure, maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this state, and S.C. Code Section 44-41-70(a), which incorporates hospital certification as a requirement for the performance of abortions. General Assembly review is required.

II. Facts

1. The amendments to R.61-16 incorporate provisions allowing dietitians to prescribe diets and other dietary services; incorporate new requirements of S.C. Code Sections 44-41-410 through 480 relating to the provision of abortion services; incorporate existing inspection and construction fees; and incorporate new requirements relating to safe havens.

2. A Notice of Drafting for the amendment was published on September 23, 2016, and the Department received two (2) public comments by the October 24, 2016, close of the comment period. The South Carolina Academy of Nutrition and Dietetics commented in support of the changes made to regulatory requirements regarding dietitians. Drs. Annibale and Cahill from MUSC Children's Hospital submitted comments in support of perinatal regulations promulgated in 2015.

3. A Notice of Proposed Regulation for the amendment was published on December 23, 2016, and the Department received public comments from three (3) people by the January 23, 2017, close of the comment period. Summaries of the comments and staff responses appear in Attachment B, Summary of Public Comments and Department Responses.

4. Pursuant to agency internal review policy, all appropriate Department personnel have reviewed the proposed amendments.

5. The Department held a regulation development meeting on January 17, 2017, for hospital licensees and other interested parties to discuss regulatory revisions with Department representatives. Notice of the meeting was provided to all hospital licensees and stakeholders as well as posted on the Department's website. The meeting was attended by five (5) individuals and gave Department staff an opportunity to discuss the regulation with stakeholders and licensees and receive guidance and clarification on certain items within the regulation. Department staff considered comments received during the public comment period as well as guidance provided at the regulation development meeting in finalizing the regulatory text for the Notice of Final Regulation.

6. After consideration of all timely received comments, Staff has made substantive changes to regulatory text of the Notice of Proposed Regulation approved by the Board in the December 8, 2016, Board meeting and published in the December 23, 2016, State Register. Description of the changes appear in Attachment B, Summary of Public Comments and Department Responses.

III. Request for Approval

Based on the public hearing and documents herein, the Bureau of Health Facilities Licensing requests the Board to grant a finding a need and reasonableness of the attached Notice of Final Regulation in order to proceed with submission to the General Assembly.

Gwen C. Thompson
Chief
Bureau of Health Facilities Licensing

Shelly Bezanson Kelly, J.D.
Director
Health Regulation

Attachments:

A. Notice of Final Regulation
B. Summary of Public Comments and Department Responses

ATTACHMENT A

Document No. 4740
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61
Statutory Authority: 1976 Code Sections 44-7-110 through 44-7-394 and 44-41-10(d)

61-16. Minimum Standards for Licensing Hospitals and Institutional General Infirmaries.

Synopsis:

The Department of Health and Environmental Control is amending Regulation 61-16. These amendments are necessary to incorporate recent changes in state law as well as changes to current practices and standards. The amendment incorporates provisions allowing dietitians to prescribe diets and other dietary services; incorporate requirements of S.C. Code Sections 44-41-410 through -480 relating to the provision of abortion services; incorporate existing inspection and construction fees; and incorporate new safe haven requirements.

A Notice of Drafting was published in the *State Register* on September 23, 2016.

Section-by-Section Discussion of Proposed Amendments:

TABLE OF CONTENTS

The table of contents was updated to reflect amended sections.

Section 61-16.101. Definitions
The definition of 101.G Dietitian has been redefined as an individual who is registered by the Commission on Dietetic Registration and currently licensed as a dietitian by the South Carolina Department of Labor, Licensing and Regulation.

Section 61-16.201. License Requirements
Section 201.E was amended to delete an unnecessary statutory reference and to require that a hospital shall comply with Chapter 41 of Title 44 of the S.C. Code of Laws. Former Section 201.G was relocated to new Section 201.H. Section 201.G (formerly 202) was amended to require that annual license fees include any outstanding inspection fees.

Section 61-16.202. Licensing Fees
Section 202 has been deleted and moved to Section 201.G.

Section 61-16.202. Exceptions to Licensing Standards (formerly 61-16.203)
Section 202 (formerly 203) was renumbered to adjust the codification.

Section 61-16.302. Inspections and Investigations
New Section 302.F was added to delineate inspection fees the Department is authorized to collect pursuant to S.C. Code Section 44-7-270.

Section 61-16.1303. Providing a Safe Haven for Abandoned Babies
Section 1303.A was amended to require that facilities accept infants not more than sixty (60) days old, pursuant to a statutory change.

Section 61-16.1505. Diets
Section 1505 introductory paragraph was amended to include dietitians. Section 1505.A was amended to require that diets be prescribed, dated and signed or authenticated by the physician or dietitian. New Section 1505.F was added to allow facility policy to permit a dietitian to order or prescribe patient diets, including therapeutic diets; order laboratory tests to monitor the effectiveness of diets; and/or make subsequent modifications to patient diets based on lab results, if permitted by the facility's policies.

Section 61-16.1903. Submission of Plans
New Section 1903.D was added to require the licensee to pay inspection fees during the construction phase of a project. A Construction Inspection Fees table was added to clearly delineate the required construction inspection fees.

Instructions: Amend Regulation 61-71 pursuant to each individual instruction provided with the text of the amendments below.

~~Indicates Matter Stricken~~
Indicates New Matter

Text:

61-16. Minimum Standards for Licensing Hospitals and Institutional General Infirmaries.

Revise Section 200 of Table of Contents to read:

TABLE OF CONTENTS

SECTION 200. LICENSE REQUIREMENTS AND FEES
201. License Requirements.
~~202. Licensing Fees.~~
~~203~~202. Exceptions to Licensing Standards.

Revise Section 61-16.101.G to read:

G. Dietitian: An individual who is registered by the Commission on Dietetic Registration and currently licensed as a dietitian by the South Carolina Department of Labor, Licensing and Regulation.

Revise Section 61-16.201 to read:

Section 201. License Requirements.

A. No person, private or public organization, political subdivision, or governmental agency shall establish, operate, maintain, or represent itself (advertise or market) as a hospital or institutional general infirmary in South Carolina without first obtaining a license from the Department. Admission of patients or the provision of care, treatment, and/or services to patients prior to the effective date of licensure is a violation of S.C. Code Ann. Section 44-7-260(A) (1976, as amended). (I)

B. A license shall be effective for a period of time specified by the Department.

C. A new facility, or one that has not been continuously licensed under these or prior standards, shall not admit patients until permission is granted by the Department.

D. Hospitals that provide services to patients requiring skilled nursing care must maintain a separate license for the areas where the services are provided.

E. Upon receipt of a written request from the hospital authorities to the Department requesting such certification, any general hospital having a current license to operate may be certified as a suitable facility for the performance of abortions. ~~(Section 44-41-10(d) of the S.C. Code of Laws of 1976.)~~A hospital shall comply with Chapter 41 of Title 44 of the S.C. Code of Laws. (I)

F. Applicants for a license shall file application under oath on a form and frequency specified by the Department. An application shall be signed/authenticated by the owner, if an individual or partnership; or in the case of a corporation, by two of its officers; or in the case of a governmental unit, by the head of the governmental department having jurisdiction over it. The application shall set forth the full name and address of the facility for which the license is sought and of the owner in case his address is different from that of the facility; the names of persons in control thereof and such additional information as the Department may require, including affirmative evidence of ability to comply with reasonable standards, rules and regulations as may be lawfully prescribed. No proposed hospital shall be named nor may an existing hospital have its name changed to the same or similar name as a hospital licensed in the State.

~~G. A facility shall request issue of an amended license, by application to the Department prior to any of the following circumstances:~~

~~1. Change of ownership by purchase or lease;~~

~~2. Change of facility's name;~~

~~3. Addition or replacement of beds (an inspection will be required prior to issuance of license);~~

~~4. Deletion of beds; or~~

~~5. Reallocation of types of beds as shown on license.~~

G. Licensing Fees. The initial and annual license fee shall be ten dollars ($10.00) per licensed bed. Annual license fees must also include any outstanding inspection fees. Such fees shall be made payable by check or credit card to the Department.

H. A facility shall request issue of an amended license, by application to the Department prior to any of the following circumstances:

1. Change of ownership by purchase or lease;

2. Change of facility's name;

3. Addition or replacement of beds (an inspection will be required prior to issuance of license);

4. Deletion of beds; or

5. Reallocation of types of beds as shown on license.

Delete Section 61-16.202 entirely:

~~**Section 202. Licensing Fees.**~~

~~Each applicant shall pay a license fee prior to issuance of a license. The annual license fee shall be $10.00 per licensed bed. Such fee shall be made payable by check or credit card to the Department and is not refundable.~~

Revise Section 61-16.203 to read:

Section ~~203~~202. Exceptions to Licensing Standards.

The Department reserves the right to make exceptions to these standards where it is determined that the health and welfare of the community requires the services of the facility. When an "exception" applies to an existing facility, it will continue to meet the standards in effect at the time it was licensed.

Add Section 61-16.302.F to read:

Section 302. Inspections and Investigations.

F. In accordance with S.C. Code Section 44-7-270, the Department may charge a fee for inspections. The fee for initial and biennial routine inspections shall be four hundred fifty dollars ($450.00) plus ten dollars ($10.00) per licensed bed. The fee for initial unit increase or service modification is two hundred fifty dollars ($250.00) plus ten dollars ($10.00) per licensed bed. The fee for follow-up inspections shall be two hundred fifty dollars ($250.00) plus ten dollars ($10.00) per licensed bed.

Revise Section 61-16.1303.A to read:

Section 1303. Providing a Safe Haven for Abandoned Babies.

Facilities and outpatient facilities shall:

A. Accept temporary physical custody of an infant ~~under thirty days of age~~not more than sixty (60) days old who is voluntarily left by a person who does not express an intent to return for the infant and the circumstances create a reasonable belief that a person does not intend to return for the infant.

Revise Section 61-16.1505 to read:

Section 1505. Diets.

Diets shall be prepared in conformance with ~~physicians'~~ orders of a physician or, if permitted by the facility's policies, a dietitian. A current diet manual shall be readily available to attending physicians, food and nutrition service personnel, ~~and~~ nursing personnel, and dietitians.

A. Diets shall be prescribed, dated and signed~~/~~ or authenticated by the physician or dietitian.

B. Facilities with patients in need of special or therapeutic diets shall provide for such diets.

C. Notations shall be made in the medical record of diet served, counseling or instructions given, as identified by patient and/or nutritional assessment and patient's tolerance of the diet.

D. Diets shall be planned, written, prepared and served with consultation from a dietitian.

E. Persons responsible for diets shall have sufficient knowledge of food values in order to make substitutions when necessary. All substitutions made on the master menu shall be documented.

F. Nothing in this regulation shall be read or interpreted to prohibit a facility's policies from allowing a dietitian to:

1. Order or prescribe patient diets, including therapeutic diets;

2. Order laboratory tests to monitor the effectiveness of dietary plans and orders; and/or

3. Make subsequent modifications to patient diets based on the results of laboratory tests.

Revise Section 61-16.1903 to read:

Section 1903. Submission of Plans.

A. When construction is contemplated either for new buildings, additions or major alterations or replacement to existing buildings, buildings being licensed for the first time, buildings changing license type, or facilities increasing occupant load/licensed capacity, plans and specifications shall be submitted to the Department for review. Final plans and specifications shall be prepared by an architect and/or engineer registered in South Carolina and shall bear their seals and signatures. Architectural plans shall also bear the seal of a South Carolina registered architectural corporation. These submissions shall be made in at least three stages: schematic, design development, and final. All plans shall be drawn to scale with the title, stage of submission and date shown thereon. Any construction changes from the approved documents shall be approved by the Department. Construction work shall not commence until a plan approval has been received from the Department. During construction the owner shall employ a registered architect and/or engineer for supervision and inspections. The Department shall conduct periodic inspections throughout each project.

B. When alterations are contemplated that are new construction, or projects with changes to the physical plant of a licensed facility which has an effect on: the function, use or accessibility of an area; structural integrity; active and passive fire safety systems (including kitchen equipment such as exhaust hoods or equipment required to be under the said hood); door, wall and ceiling system assemblies; exit corridors; Increase the occupant load/licensed capacity; and projects pertaining to any life safety systems, require preliminary drawings and specifications, accompanied by a narrative completely describing the proposed work, shall be submitted to the Department Cosmetic changes utilizing paint, wall covering, floor covering, etc., that are required to have a flame-spread rating or other safety criteria shall be documented with copies of the documentation and certifications, kept on file at the facility and made available to the Department.

C. All subsequent addenda, change orders, field orders, and documents altering the Department review must be submitted. Any substantial deviation from the accepted documents shall require written notification, review and re-approval from the Department.

D. The licensee shall pay the following inspection fees during the construction phase of the project. The plan inspection fee is based on the total estimated cost of the project whether new construction, an addition, or a renovation. The fees are detailed in the table below.

Construction Inspection Fees	
Plan Inspection	
Total Project Cost	**Fee**
< $10,001.00	$750
$10,001 - $100,000	$1,500

$100,001 - $500,000	$2,000
> $500,000	$2,500 plus $100 for each additional $100,000 in project cost
Site Inspection	
50% Inspection	$500
80% Inspection	$500
100% Inspection	$500

Fiscal Impact Statement:

Implementation of this regulation will not require additional resources. There is no anticipated additional cost by the Department or state government due to any inherent requirements of this regulation. There are no external costs anticipated.

Statement of Need and Reasonableness:

The following is based on an analysis of the factors listed in 1976 Code Section 1-23-115(C)(1)-(3) and (9)-(11):

DESCRIPTION OF REGULATION: R.61-16, Minimum Standards for Licensing Hospitals and Institutional General Infirmaries.

Purpose: The purpose of these amendments to R.61-16 is to update statutory requirements recently enacted by the General Assembly. These amendments include incorporation of provisions allowing dietitians to prescribe diets and other dietary services; new requirements of S.C. Code Sections 44-41-410 through -480 relating to the provision of abortion services; adding existing inspection and construction fees; and new requirements relating to safe havens.

Legal Authority: 1976 Code Sections 44-7-110 through 44-7-394 and 44-41-70(a).

Plan for Implementation: Copies of the regulation will be available electronically on the South Carolina Legislature website and the Department regulation development website (http://www.scdhec.gov/Agency/RegulationsAndUpdates/RegulationDevelopmentUpdate). Printed copies will be available for a fee from the Department's Freedom of Information Office.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

These amendments are necessary to incorporate recent statutory changes for abortion services and safe haven requirements. Additionally, the amendments incorporate provisions allowing dietitians to prescribe diets and other dietary services, and incorporate existing inspections and construction fees.

DETERMINATION OF COSTS AND BENEFITS:

Implementation of these amendments will not require additional resources. There is no anticipated additional cost to the Department or state government due to any inherent requirements of these amendments. There are no anticipated additional costs to the regulated community. Amendments to R.61-16 update statutory requirements enacted by the General Assembly, update requirements for dietitians, and incorporate existing inspection and construction fees.

UNCERTAINTIES OF ESTIMATES:

None.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

The amendments to R.61-16 seek to support the Department's goals relating to the protection of public health through the anticipated benefits highlighted above. There is no anticipated effect on the environment.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

There is no anticipated detrimental effect on the environment. If the revision is not implemented, the regulation will be maintained in its current form without realizing the benefits of the amendments herein.

Statement of Rationale:

The Department of Health and Environmental Control is amending Regulation 61-16. These amendments are necessary to incorporate recent changes in state law as well as changes to current practices and standards. The amendments incorporate provisions allowing dietitians to prescribe diets and other dietary services; incorporate requirements of S.C. Code Sections 44-41-410 through -480 relating to the provision of abortion services; incorporate existing inspection and construction fees; and incorporate new safe haven requirements.

ATTACHMENT B

SUMMARY OF PUBLIC COMMENTS AND DEPARTMENT RESPONSES

Document No. 4740
R.61-16, Minimum Standards for Licensing Hospitals and Institutional General Infirmaries

As of the January 23, 2017, close of the Notice of Proposed Regulation Comment period:

NAME	SECTION CITATION	PUBLIC COMMENT	DEPARTMENT RESPONSE
1. Rebecca Fuller, Registered Dietitian	101.G	I would like to ask that you consider the following in the wording of the regulation change: "An individual who is registered by the Commission on Dietetics Registration and currently licensed as a dietitian by the South Carolina Department of Labor, Licensing and Regulation." This would keep only credentialed practitioners able to prescribe diets in the event that licensure was ever dissolved.	Adopted.
2. Charlotte Caperton-Kilburn, Nutrition for Life Performance		Please consider the following in the wording of the regulation change: "An individual who is registered by the Commission on Dietetics Registration and currently licensed as a dietitian by the South Carolina Department of Labor, Licensing and Regulation."	
3. South Carolina Panel for Dietetics, SCLLR		The South Carolina Panel for Dietetics under the Department of Labor, Licensing and Regulation recommends that the definition of "dietitian" be as follows: "An individual who is registered by the Commission on Dietetics Registration and currently licensed as a dietitian by the South Carolina Department of Labor, Licensing and Regulation."	

BOARD OF HEALTH AND ENVIRONMENTAL CONTROL
SUMMARY SHEET
June 8, 2017

[x] ACTION/DECISION
[ ] INFORMATION

I. TITLE: Request for approval of the Draft South Carolina Health Plan.

II. SUBJECT: Presentation of the Draft South Carolina Health Plan for final Board approval.

III. FACT: The Draft South Carolina Health Plan ("Draft Plan" or "SHP") has been developed by the South Carolina State Health Planning Committee (Committee). It was released for public comment on March 8, 2017, and four regional public hearings were held in March 2017 to solicit comments. The Committee met on three occasions to review the Draft Plan, review public comments, make revisions to the Draft Plan, and submit a final version to the Board for approval.

IV. ANALYSIS: The Committee recommends the Board adopt the attached Draft South Carolina State Health Plan. Proposed changes to sections of the Plan are set forth below and organized by SHP chapter.

Chapter 1. Introduction.

No significant changes.

Chapter 2. Inventory Regions.

Inventory Regions reflect the existing four regions of DHEC's organization. The requirement that facilities contemplating a transfer of beds, services, and/or equipment be within the same licensing category has been removed. This provides flexibility within service areas to transfer those beds, services, and/or equipment to facilities where they will provide maximum benefit to the patient.

Chapter 3. General Hospitals.

No major changes to the hospital subsection. The pediatric long-term acute care hospital (LTACH) section has been reduced in scope and added to the general LTACH standards. NICU bed need methodology has been updated and simplified to better distribute these beds across the five perinatal regions, providing for 3.25 beds per 1,000 live births. Additionally, neonatal providers now have the ability to add bassinets if utilization rates within the facility warrant the expansion. This standardizes the ability of general hospitals to add beds and services based on actual utilization.

Chapter 4. Psychiatric Services.

The Draft Plan clarifies that the Department may approve a general hospital which has no licensed or approved psychiatric beds to establish 20 such beds under the "economical unit" provision. This limitation seeks to balance the need of general hospitals for more psychiatric beds in their emergency rooms with the prevention of unnecessary duplication of psychiatric services in the service area.

The methodology for determining bed need has been updated to provide sufficient beds to achieve a 70% utilization rate in five years' time based on current statewide or service area utilization. This has the practical effect of increasing access to such beds throughout the Draft Plan's psychiatric service areas.

The Draft Plan standardizes the methodologies for psychiatric and substance abuse services as treatment is often delivered for these comorbid conditions.

Chapter 5. Rehabilitation Facilities.

No significant changes.

Chapter 6. Alcohol and Drug Abuse Facilities.

The methodology for determining bed need has been updated to provide sufficient beds to achieve a 75% utilization rate in five years' time based on current statewide or service area utilization. This has the practical effect of increasing access to such beds throughout the Draft Plan's inpatient treatment (substance abuse) service areas.

The Draft Plan standardizes the methodologies for psychiatric and substance abuse services as treatment is often delivered for these comorbid conditions. Additionally, facilities with both approved substance abuse and psychiatric beds may use, alternatively, up to 75% of the substance abuse beds for the treatment of psychiatric patients.

The Narcotic Treatment Program section is now referred to as the Opioid Treatment Program section. The Draft Plan contemplates additional opioid treatment programs in all counties in South Carolina to assist in curbing the epidemic of overdose deaths.

Chapter 7 - Residential Treatment Facilities for Children and Adults

The service areas for residential treatment facilities (RTF) for children and adolescents have been revised to match those of substance abuse facilities and psychiatric facilities. This is done to recognize that many facilities may choose to, or need to, operate all three of these service lines. This has provided for an increased need in RTF beds in many service areas.

Chapter 8. Cardiovascular Care.

Language regarding equivalents and procedures has been clarified. The mention of guidelines from the national accrediting bodies for cardiovascular care has been updated.

The service area definition for cardiac catheterization has been changed from "drive time" to "emergency medical transport time" as defined by DHEC's Bureau of EMS and Trauma. This provides potential applicants, as well as the Department, with a more defined service area boundary (drive times varied based on time of day, thus artificially inflating or deflating the service area).

Enforcement provisions based on quality thresholds in catheterization services have been clarified.

A one-time, incremental increase of a single open heart surgical unit will not require CON review as it is not a substantial expansion of that health service. Required quality measures and enforcement provisions remain for any surgical unit opened under this provision.

Chapter 9 – Radiation Oncology.

No significant changes.

Chapter 10. Positron Emission Technology.

This Chapter has been deleted. PET service was the final imaging service in the South Carolina Health Plan. MRI and CT services had been removed many years ago.

Chapter 11 - Outpatient Facilities

This is now Chapter 10.

Ambulatory surgery facility (ASF) applicants may now self-restrict by surgical specialty. This may reduce project and opposition and future litigation. Any ASF wishing to expand surgical services in the future would be required to file an additional CON application to do so.

Freestanding emergency hospital services are now called for within approximately 15-minutes travel time of most state residents. The intent is to increase access to high quality, licensed emergency care throughout the state.

Chapter 12. Long Term Care Facilities and Services.

This is now Chapter 11. No significant changes.

Chapter 13. Inventories.

This Chapter has been deleted and all relevant tables, charts, and graphs have been located within their representative Chapters.

Glossary.

Definitions related to the PET scanning have been removed. All hyperlinks to definitions have been checked for accuracy and operational status.

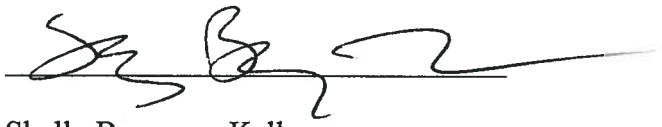
V. RECOMMENDATION:

The State Health Planning Committee recommends that the Board approve the Draft South Carolina Health Plan for use in the Certificate of Need Program, and that all applications received after the effective date of the Plan be reviewed under this Plan.

Submitted by:

Louis Eubank
Director, Certificate of Need Program

Approved by:



Shelly Bezanson Kelly,
Director, Health Regulation

FINAL DRAFT 2017 State Health Plan

dhec
Healthy People. Healthy Communities.

2017-2018 South Carolina Health Plan

Enacted [INSERT DATE HERE]

SOUTH CAROLINA HEALTH PLANNING COMMITTEE

MEMBER	REPRESENTING	EXPIRATION
Michael N. Bohan, M.D.	Provider	6/30/2018
Bradley W. Moorhouse	Provider	6/30/2016
Parkes B. Coggins	Provider	6/30/2019
Rajeev Vasudeva, MD	Provider	6/30/2018
Mary E. Phillips	Business (At-Large)	6/30/2016
Phyllis B. Buie	Finance/Business	6/30/2015
Ann M. McCraw	Finance/Business	6/30/2018
Sarah C. Harrell	Finance/Business	6/30/2018
W.H. "Ham" Hudson	Consumer	6/30/2015
Vacant	Consumer	
Kurt E. Moore	Consumer	6/30/2018
Steve E. Nail	Consumer	6/30/2018
L. Becky Dover. Esq	Consumer Affairs (Ex-Officio)	
Ann B. Kirol, DDS	Board of Health and Environmental Control	

South Carolina Health Planning Committee
Department of Health & Environmental Control
Certificate of Need Program
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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 3-11 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 April of 2017. 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

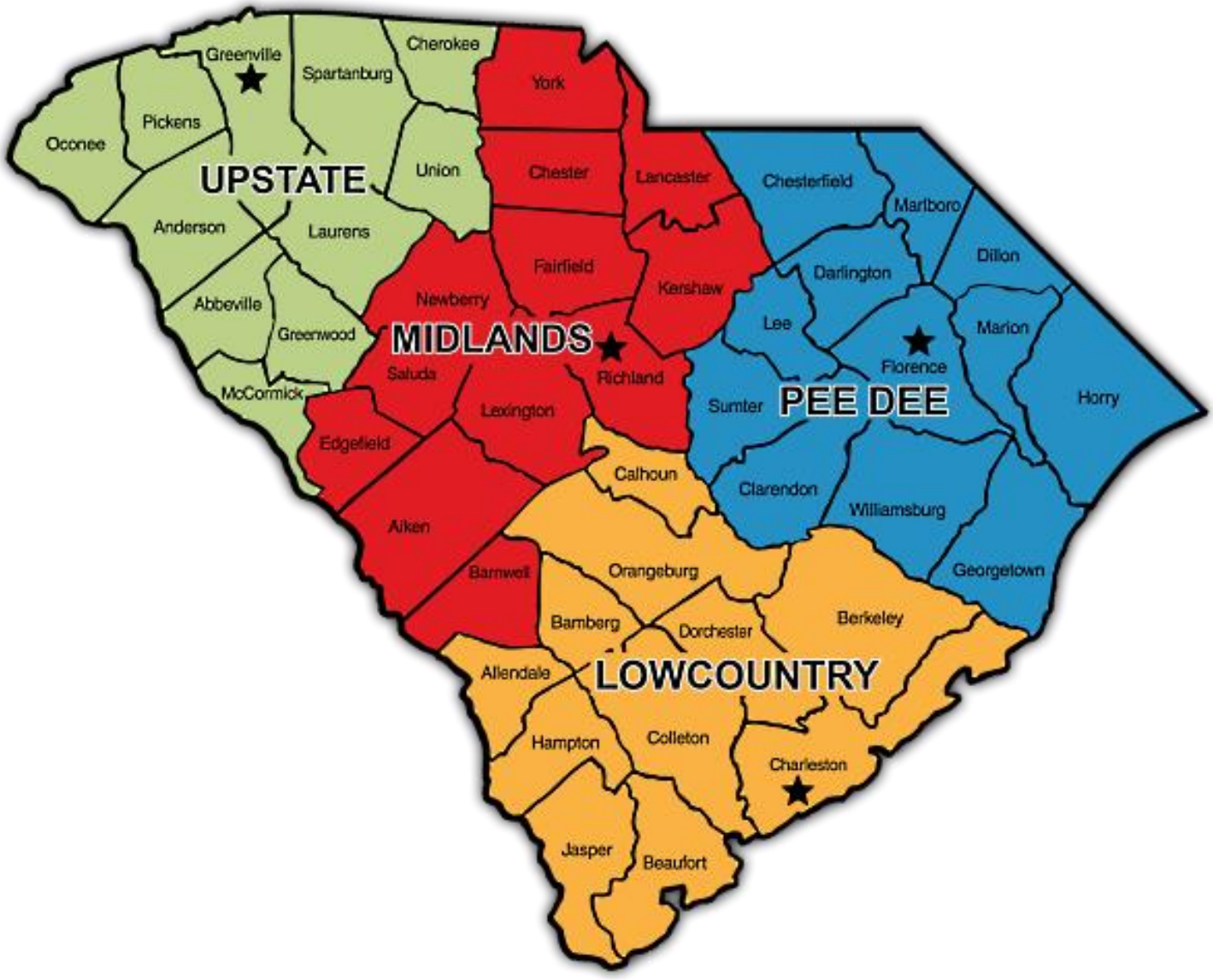
Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,896,146 for 2015 and projected population of 5,288,470 for 2022. All population data (county, planning area, and statewide) were provided by the South Carolina Revenue and Fiscal Affairs Office, Health and Demographics Section, in April 2017.

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 13, 2017. Inventory and utilization data set forth in this Plan is derived from the 2015 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 thirty (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 in Chapter XIII of this Plan.

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 II, 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 thirty (30) minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

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 sixty (60) minutes' travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating

Certificate of Need applications for these beds.

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 II 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 2015 was 7.0 infant deaths per 1,000 live births versus the national rate of 5.82 infant deaths per 1,000 births in 2014.

Neonatal mortality is the death rate for infants up to 28 days old. For 2015, South Carolina's neonatal mortality rate for all races was 4.6 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 2013-2015 and the average population of women age 15-44 for 2013-2015 to generate an average birth rate.

    b. Multiply the average birth rate against the projected 2019 population of women age 15-44 to project the number of births in 2019.

    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	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Region I										
Abbeville Area Medical Center	<18	5332	4930	15	0					
	18-64	14627	13270	451	1					
	+65	4973	5860	1621	5					
	TOTAL	**24932**	**24060**	**2087**	**6**	**65%**	**10**	**25**	**-15**	**22.87%**
Abbeville County Total							**10**	**25**	**-15**	
AnMed Health Medical Center	<18	45054	44870	4586	13					
	18-64	115809	118750	32824	92					
	+65	33829	40780	41805	138					
	TOTAL	**194,692**	**204,400**	**79,215**	**243**	**75%**	**324**	**423**	**-99**	**51.31%**
AnMed Health Women's and Children's Hospital	<18	45054	44870	787	2					
	18-64	115809	118750	5432	15					
	+65	33829	40780	1086	4					
	TOTAL	**194,692**	**204,400**	**7,305**	**21**	**65%**	**33**	**72**	**-39**	**27.80%**
Anderson County Total							**357**	**495**	**-138**	
Mary Black Health System - Gaffney (Gaffney Medical Center) ***1***	<18	13378	13070		0					
	18-64	34082	33600		0					
	+65	8734	10260		0					
	TOTAL	**56,194**	**56,930**	**9,107**	**25**	**65%**	**39**	**125**	**-86**	**19.96%**
Cherokee County Total							**39**	**125**	**-86**	
Greenville Memorial Medical Center	<18	115082	122900	43222	126					
	18-64	305057	332480	75796	226					
	+65	71724	95000	53186	193					
	TOTAL	**491,863**	**550,380**	**172,204**	**546**	**75%**	**728**	**746**	**-18**	**63.24%**
Greer Memorial Hospital (GHS)	<18	115082	122900	134	0					
	18-64	305057	332480	6264	19					
	+65	71724	95000	4592	17					
	TOTAL	**491,863**	**550,380**	**10,990**	**36**	**65%**	**56**	**82**	**-26**	**36.72%**
Hillcrest Memorial Hospital (GHS)	<18	115082	122900	6	0					
	18-64	305057	332480	3661	11					
	+65	71724	95000	2543	9					
	TOTAL	**491,863**	**550,380**	**6,210**	**20**	**65%**	**32**	**43**	**-11**	**39.57%**
Patewood Memorial Hospital (GHS)	<18	115082	122900	1	0					
	18-64	305057	332480	1090	3					
	+65	71724	95000	1265	5					
	TOTAL	**491,863**	**550,380**	**2,356**	**8**	**65%**	**13**	**72**	**-59**	**8.96%**
Saint Francis - Downtown & Saint Francis - Millennium	<18	115082	122900	47	0					
	18-64	305057	332480	21508	64					
	+65	71724	95000	32636	118					
	TOTAL	**491,863**	**550,380**	**54,191**	**183**	**70%**	**262**	**226**	**36**	**65.69%**
Saint Francis - Eastside	<18	115082	122900	87	0					
	18-64	305057	332480	10701	32					
	+65	71724	95000	6827	25					
	TOTAL	**491,863**	**550,380**	**17,615**	**57**	**65%**	**88**	**93**	**-5**	**51.89%**
Greenville County Total							**1,179**	**1,262**	**-83**	
Self Regional Healthcare	<18	16127	15820	707	2					
	18-64	41616	39630	26134	68					
	+65	12095	14010	27362	87					
	TOTAL	**69,838**	**69,460**	**54,203**	**157**	**70%**	**225**	**326**	**-101**	**45.55%**
Greenwood County Total							**225**	**326**	**-101**	
Laurens County Memorial Hospital (GHS) ***1***	<18	14781	14280	551	1					
	18-64	40410	38640	4703	12					
	+65	11432	13340	5500	18					
	TOTAL	**66,623**	**66,260**	**10,754**	**31**	**65%**	**49**	**76**	**-27**	**38.77%**

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Laurens County Total							**49**	**76**	**-27**	
Oconee Memorial Hospital (GHS)	<18	15209	14540	1132	3					
	18-64	43859	42760	9468	25					
	+65	16645	19800	14267	46					
	TOTAL	**75,713**	**77,100**	**24,867**	**75**	**65%**	**116**	**169**	**-53**	**40.31%**
Oconee County Total							**116**	**169**	**-53**	
Baptist Easley Hospital	<18	23855	26370		0					
(Palmetto Baptist Medical Center - Easley)	18-64	78931	75000	6819	18					
	+65	18905	22760	8403	28					
	TOTAL	**121,691**	**124,130**	**15,222**	**45**	**65%**	**70**	**109**	**-39**	**38.26%**
AnMed Health Cannon ***1***	<18	23855	26370		0					
(Cannon Memorial Hospital)	18-64	78931	75000		0					
	+65	18905	22760		0					
	TOTAL	**121,691**	**124,130**	**2,983**	**8**	**65%**	**13**	**55**	**-42**	**14.86%**
Pickens County Total							**83**	**164**	**-81**	
Mary Black Health System - Spartanburg	<18	69835	71550	262	1					
(Mary Black Memorial Hospital)	18-64	181834	187240	11468	32					
	+65	45633	56090	10472	35					
	TOTAL	**297,302**	**314,880**	**22,202**	**68**	**65%**	**106**	**174**	**-68**	**34.96%**
Spartanburg Medical Center	<18	69835	71550	2135	6					
	18-64	181834	187240	75692	214					
	+65	45633	56090	64463	217					
	TOTAL	**297,302**	**314,880**	**142,290**	**437**	**75%**	**583**	**484**	**99**	**80.54%**
Pelham Medical Center (Village Hospital)	<18	69835	71550	0	0					
	18-64	181834	187240	4263	12					
	+65	45633	56090	5116	17					
	TOTAL	**297,302**	**314,880**	**9,379**	**29**	**65%**	**46**	**48**	**-2**	**53.53%**
Spartanburg County Total							**735**	**706**	**29**	
Union Medical Center ***1***	<18	5990	5340		0					
	18-64	16480	14740		0					
	+65	5307	5960		0					
	TOTAL	**27,777**	**26,040**	**6,034**	**15**	**65%**	**24**	**143**	**-119**	**11.56%**
Union County Total							**24**	**143**	**-119**	
Region II										
Aiken Regional Medical Center ***3***	<18	36383	35570	426	1					
	18-64	99461	99060	18141	50					
	+65	29985	37980	21129	73					
	TOTAL	**165,829**	**172,610**	**39,696**	**124**	**70%**	**178**	**197**	**-19**	**55.21%**
Aiken County Total								**197**	**-19**	
Southern Palmetto Hospital ***4***	<18	5,554	5,370							
(Barnwell County Hospital)	18-64	13,140	11,830							
	+65	3,425	3,980							
	TOTAL	**22,119**	**21,180**			**65%**	**25**	**0**	**25**	**0.00%**
Barnwell County Total							**25**	**0**	**25**	
Chester Regional Medical Center	<18	7397	6880	77	0					
	18-64	19340	17480	1572	4					
	+65	5530	6510	1541	5					
	TOTAL	**32,267**	**30,870**	**3,190**	**9**	**65%**	**14**	**82**	**-68**	**10.66%**
Chester County Total							**14**	**82**	**-68**	
Edgefield County Hospital	<18	5036	4250	1	0					
	18-64	17084	15940	123	0					
	+65	4394	5410	392	1					

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
	TOTAL	**26,514**	**25,600**	**516**	**2**	**65%**	**3**	**25**	**-22**	**5.65%**
Edgefield County Total							**3**	**25**	**-22**	
Fairfield Memorial Hospital	<18	4634	3830	3	0					
	18-64	13900	12110	119	0					
	+65	4213	5090	222	1					
	TOTAL	**22,747**	**21,030**	**344**	**1**	**65%**	**2**	**25**	**-23**	**3.77%**
Fairfield County Total							**2**	**25**	**-23**	
Kershaw Health ***2***	<18	14,867	14,640		0					
(Kershaw County Medical Center)	18-64	37,676	37,800		0					
	+65	9,973	12,590		0					
	TOTAL	**62,516**	**65,030**	**19,001**	**54**	**65%**	**84**	**121**	**-37**	**43.02%**
Kershaw County Total							**84**	**121**	**-37**	
Springs Memorial Hospital ***1***	<18	18749	19580		0					
	18-64	50359	55790		0					
	+65	16734	24810		0					
	TOTAL	**85,842**	**100,180**	**24,205**	**77**	**70%**	**111**	**199**	**-88**	**33.32%**
Lancaster County Total							**111**	**199**	**-88**	
Lexington Medical Center ***5***	<18	66209	66910	223	1					
	18-64	174401	185810	64183	187					
	+65	41223	55370	60486	223					
	TOTAL	**281,833**	**308,090**	**124,892**	**411**	**75%**	**548**	**485**	**63**	**70.55%**
Lexington County Total							**548**	**485**	**63**	
Newberry County Memorial Hospital	<18	8378	8210	113	0					
	18-64	22648	21850	3004	8					
	+65	6986	8460	4244	14					
	TOTAL	**38,012**	**38,520**	**7,361**	**22**	**65%**	**35**	**90**	**-55**	**22.41%**
Newberry County Total							**35**	**90**	**-55**	
Palmetto Health Baptist Parkridge	<18	88453	96860	1255	4					
	18-64	271087	281250	7215	21					
	+65	47511	63010	7186	26					
	TOTAL	**407,051**	**441,120**	**15,656**	**50**	**65%**	**78**	**76**	**2**	**56.44%**
Palmetto Health Baptist	<18	88453	96860	13536	41					
	18-64	271087	281250	30251	86					
	+65	47511	63010	26425	96					
	TOTAL	**407,051**	**441,120**	**70,212**	**223**	**70%**	**319**	**287**	**32**	**67.02%**
Palmetto Health Richland	<18	88453	96860	37913	114					
	18-64	271087	281250	81421	231					
	+65	47511	63010	48509	176					
	TOTAL	**407,051**	**441,120**	**167,843**	**521**	**75%**	**696**	**579**	**117**	**79.42%**
Providence Health	<18	88453	96860	11	0					
(Providence Hospital)	18-64	271087	281250	15827	45					
	+65	47511	63010	24080	87					
	TOTAL	**407,051**	**441,120**	**39,918**	**133**	**70%**	**190**	**258**	**-68**	**42.39%**
Providence Health Northeast	<18	88453	96860	18	0					
	18-64	271087	281250	2193	6					
	+65	47511	63010	3116	11					
	TOTAL	**407,051**	**441,120**	**5,327**	**18**	**65%**	**28**	**74**	**-46**	**19.72%**
Richland County Total							**1,311**	**1,274**	**37**	
Piedmont Medical Center ***6***	<18	61836	65930	1060	3					
	18-64	155706	175120	29476	91					
	+65	33653	47100	26179	100					
	TOTAL	**251,195**	**288,150**	**56,715**	**194**	**70%**	**278**	**268**	**10**	**57.98%**
Fort Mill Medical Center ***6***								**100**		

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
York County Total							**278**	**368**	**-90**	
Region III										
McLeod Health Cheraw	<18	10586	9690	19	0					
(Chesterfield General Hospital)	18-64	27903	26100	842	2					
	+65	7528	8850	769	2					
	TOTAL	**46,017**	**44,640**	**1,630**	**5**	**65%**	**8**	**59**	**-51**	**7.57%**
Chesterfield County Total							**8**	**59**	**-51**	
McLeod Health Clarendon	<18	6891	6010	69	0					
(Clarendon Memorial Hospital)	18-64	19893	17660	4605	11					
	+65	6991	8140	5419	17					
	TOTAL	**33,775**	**31,810**	**10,093**	**29**	**65%**	**45**	**81**	**-36**	**34.14%**
Clarendon County Total							**45**	**81**	**-36**	
Carolina Pines Regional Medical Center	<18	15405	14200	1822	5					
	18-64	40608	37730	6867	17					
	+65	11535	13620	6839	22					
	TOTAL	**67,548**	**65,550**	**15,528**	**44**	**65%**	**69**	**116**	**-47**	**36.67%**
McLeod Medical Center - Darlington	<18	15405	14200	0	0					
	18-64	40608	37730	217	1					
	+65	11535	13620	328	1					
	TOTAL	**67,548**	**65,550**	**545**	**2**	**65%**	**3**	**49**	**-46**	**3.05%**
Darlington County Total							**72**	**165**	**-93**	
McLeod Medical Center - Dillon	<18	8060	7530	525	1					
	18-64	18348	16750	4634	12					
	+65	4826	5680	3265	11					
	TOTAL	**31,234**	**29,960**	**8,424**	**23**	**65%**	**37**	**79**	**-42**	**29.21%**
Dillon County Total							**37**	**79**	**-42**	
Carolinas Hospital System ***1***	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	**54320**	**151**	**70%**	**216**	**310**	**-94**	**48.01%**
Women's Center - Carolinas Hospital System ***1***	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	**2,491**	**7**	**65%**	**11**	**20**	**-9**	**34.12%**
Lake City Community Hospital ***1***	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	**4,007**	**11**	**65%**	**18**	**48**	**-30**	**22.87%**
McLeod Regional Medical Center - Pee Dee ***7***	<18	33464	32770	3938	11					
	18-64	83923	81910	67808	181					
	+65	21513	25870	59492	196					
	TOTAL	**138,900**	**140,550**	**131,238**	**388**	**75%**	**518**	**461**	**57**	**77.99%**
Florence County Total							**763**	**839**	**-76**	
Tidelands Georgetown Memorial Hospital	<18	12107	10870	189	0					
	18-64	33924	32090	7950	21					
	+65	15267	19350	8661	30					
	TOTAL	**61,298**	**62,310**	**16,800**	**51**	**65%**	**79**	**131**	**-52**	**35.14%**
Tidelands Waccamaw Community Hospital	<18	12107	10870	225	1					
	18-64	33924	32090	10013	26					
	+65	15267	19350	17628	61					
	TOTAL	**61,298**	**62,310**	**27,866**	**88**	**65%**	**135**	**124**	**11**	**61.57%**
Georgetown County Total							**214**	**255**	**-41**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Conway Hospital	<18	58904	63740	3612	11					
	18-64	184214	205840	15761	48					
	+65	66081	105690	13463	59					
	TOTAL	**309,199**	**375,270**	**32,836**	**118**	**70%**	**169**	**210**	**-41**	**42.84%**
Grand Strand Medical Center ***8***	<18	58904	63740	1174	3					
	18-64	184214	205840	38020	116					
	+65	66081	105690	43033	189					
	TOTAL	**309,199**	**375,270**	**82,227**	**308**	**70%**	**441**	**325**	**116**	**69.32%**
McLeod Loris (Loris Community Hospital) ***9***	<18	58904	63740	219	1					
	18-64	184214	205840	4230	13					
	+65	66081	105690	4762	21					
	TOTAL	**309,199**	**375,270**	**9,211**	**34**	**65%**	**54**	**50**	**4**	**50.47%**
McLeod Seacoast (Seacoast Medical Center) ***9***	<18	58904	63740	31	0					
	18-64	184214	205840	3138	10					
	+65	66081	105690	6088	27					
	TOTAL	**309,199**	**375,270**	**9,257**	**36**	**65%**	**56**	**105**	**-49**	**24.15%**
Horry County Total							**664**	**585**	**79**	
Carolinas Hospital System - Marion	<18	7473	6870	3229	8					
(Marion County Medical Center)	18-64	18657	16570	3230	8					
	+65	5617	6320	3328	10					
	TOTAL	**31,747**	**29,760**	**9,787**	**26**	**65%**	**41**	**124**	**-83**	**21.62%**
Marion County Total							**41**	**124**	**-83**	
Marlboro Park Hospital ***4***	<18	5,766	5,100							
	18-64	18,097	16,530							
	+65	4,140	4,730							
	TOTAL	**28,003**	**26,360**			**65%**	**25**	**0**	**25**	**0.00%**
Marlboro County Total							**25**	**0**	**25**	
Palmetto Health Tuomey	<18	26388	25270		0					
	18-64	64991	62120	26055	68					
	+65	16101	19360	25033	82					
	TOTAL	**107,480**	**106,750**	**51,088**	**151**	**70%**	**216**	**283**	**-67**	**49.46%**
Sumter County Total							**216**	**283**	**-67**	
Williamsburg Regional Hospital ***1***	<18	7,271	6,300		0					
	18-64	20,162	17,270	1,956	5					
	+65	5,634	6,690	2,995	10					
	TOTAL	**33,067**	**30,260**	**4,951**	**14**	**65%**	**23**	**25**	**-2**	**54.26%**
Williamsburg County Total							**23**	**25**	**-2**	
Region IV										
Allendale County Hospital ***1***	<18	1795	1360	0	0					
	18-64	6004	4970	314	1					
	+65	1634	1900	353	1					
	TOTAL	**9,433**	**8,230**	**667**	**2**	**65%**	**3**	**25**	**-22**	**7.31%**
Allendale County Total							**3**	**25**	**-22**	
Beaufort Memorial Hospital ***1***	<18	35395	36880		0					
	18-64	99620	106450		0					
	+65	44574	61540		0					
	TOTAL	**179,589**	**204,870**	**39,898**	**125**	**65%**	**192**	**169**	**23**	**64.68%**
Hilton Head Hospital	<18	35395	36880	117	0					
	18-64	99620	106450	7558	22					
	+65	44574	61540	14803	56					
	TOTAL	**179,589**	**204,870**	**22,478**	**78**	**65%**	**121**	**93**	**28**	**66.22%**
Beaufort County Total							**313**	**262**	**51**	

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Trident Medical Center & Berkeley	<18	166114	180030		0					
Medical Center ***1, 10***	18-64	476343	535390		0					
	+65	102069	146830		0					
	TOTAL	**744,526**	**862,250**	**71,955**	**228**	**70%**	**327**	**296**	**31**	**66.60%**
Summerville Medical Center ***11***	<18	166114	180030	2028	6					
	18-64	476343	535390	11593	36					
	+65	102069	146830	8513	34					
	TOTAL	**744,526**	**862,250**	**22,134**	**75**	**65%**	**116**	**124**	**-8**	**48.90%**
MUSC Medical Center ***12***	<18	166114	180030	28399	84					
	18-64	476343	535390	105594	325					
	+65	102069	146830	48814	192					
	TOTAL	**744,526**	**862,250**	**182,807**	**602**	**75%**	**803**	**656**	**147**	**76.35%**
Mount Pleasant Hospital	<18	166114	180030	8	0					
	18-64	476343	535390	2645	8					
	+65	102069	146830	2400	9					
	TOTAL	**744,526**	**862,250**	**5,053**	**18**	**65%**	**28**	**85**	**-57**	**16.29%**
Roper Hospital ***13***	<18	166114	180030	13	0					
	18-64	476343	535390	22148	68					
	+65	102069	146830	34258	135					
	TOTAL	**744,526**	**862,250**	**56,419**	**203**	**70%**	**291**	**316**	**-25**	**48.92%**
Bon Secours - Saint Francis Xavier Hospital	<18	166114	180030	92	0					
	18-64	476343	535390	19206	59					
	+65	102069	146830	12379	49					
	TOTAL	**744,526**	**862,250**	**31,677**	**108**	**70%**	**155**	**204**	**-49**	**42.54%**
East Cooper Medical Center	<18	166114	180030	19	0					
	18-64	476343	535390	8607	27					
	+65	102069	146830	5979	24					
	TOTAL	**744,526**	**862,250**	**14,605**	**50**	**65%**	**78**	**130**	**-52**	**30.78%**
Berkeley / Charleston / Dorchester County Total							**1,798**	**1,811**	**-13**	
Colleton Medical Center	<18	8550	7680	825	2					
	18-64	21940	19620	8934	22					
	+65	7241	8630	9478	31					
	TOTAL	**37,731**	**35,930**	**19,237**	**55**	**65%**	**85**	**116**	**-31**	**45.43%**
Colleton County Total							**85**	**116**	**-31**	
Hampton Regional Medical Center	<18	4447	3830	10	0					
	18-64	12266	10850	1033	3					
	+65	3336	3910	1512	5					
	TOTAL	**20,049**	**18,590**	**2,555**	**7**	**65%**	**12**	**32**	**-20**	**21.88%**
Hampton County Total							**12**	**32**	**-20**	
Coastal Carolina Medical Center	<18	5922	5660	20	0					
	18-64	17158	18410	3921	12					
	+65	4744	9900	4804	27					
	TOTAL	**27,824**	**33,970**	**8,745**	**39**	**65%**	**61**	**41**	**20**	**58.44%**
Jasper County Total							**61**	**41**	**20**	
Regional Medical Center of Orangeburg &	<18	23030	21720		0					
Calhoun Counties ***1***	18-64	62137	54260		0					
	+65	18822	21980		0					
	TOTAL	**103,989**	**97,960**	**44,741**	**115**	**70%**	**165**	**247**	**-82**	**49.63%**
Orangeburg / Calhoun County Total							**165**	**247**	**-82**	

* 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 2015 JAR.

GENERAL BED NEED*
(Chapter 3)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate

3 SC-16-17 issued 3/2/2017 for the addition of 14 acute care beds.

4 Facility is closed. Bed need is based minimally on CAH bed count limit.

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

6 Pending resolution of an appeal, Piedmont proposes constructing a 100-bed hospital in Fort Mill using a combination of new and transferred hospital beds.

7 SC-16-42 issued 8/11/2016 for addition of 8 acute care 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-14-07 issued 10/27/2014 for addition of 30 acute care beds.

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

13 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.

LONG-TERM ACUTE CARE HOSPITALS
(Chapter 3)

Facility By Region	County	2013 Beds	2013 Pt Days	2013 Occupancy Rate	2014 Beds	2014 Pt Days	2014 Occupancy Rate	2015 Beds	2015 Pt Days	2015 Occupancy Rate
Region I										
North Greenville Long-Term Acute	Greenville	45	7,626	46.4%	45	7,758	47.2%	45	7,841	47.7%
Regency Hospital of Greenville	Greenville	32	10,467	89.6%	32	9,960	85.3%	32	9,607	82.3%
Spartanburg Hospital Restorative for Care	Spartanburg	97	11,365	32.1%	97	10,892	30.8%	97	10,118	28.6%
Region II										
Continuecare Hospital at Palmetto Health Baptist ***1***	Richland	35	6,966	54.5%	35	NR	0.0%	35	NR	0.0%
Region III										
Regency Hospital of South Carolina	Florence	40	11,986	82.1%	40	12,527	85.8%	40	12,946	88.7%
Region IV										
Vibra Hospital of Charleston ***2***	Charleston	59	5,161	24.0%	59	15,883	73.8%	59	NR	0.0%

1 Intermedical Hospital of South Carolina change of ownership 08/2016. New owner has not submitted required JAR data.

2 Facility missing required JAR data.

CRITICAL ACCESS HOSPITALS*
(Chapter 3)

Facility by Region

Region I
Abbeville Memorial Hospital

Region II
Edgefield County Hospital
Fairfield Memorial Hospital

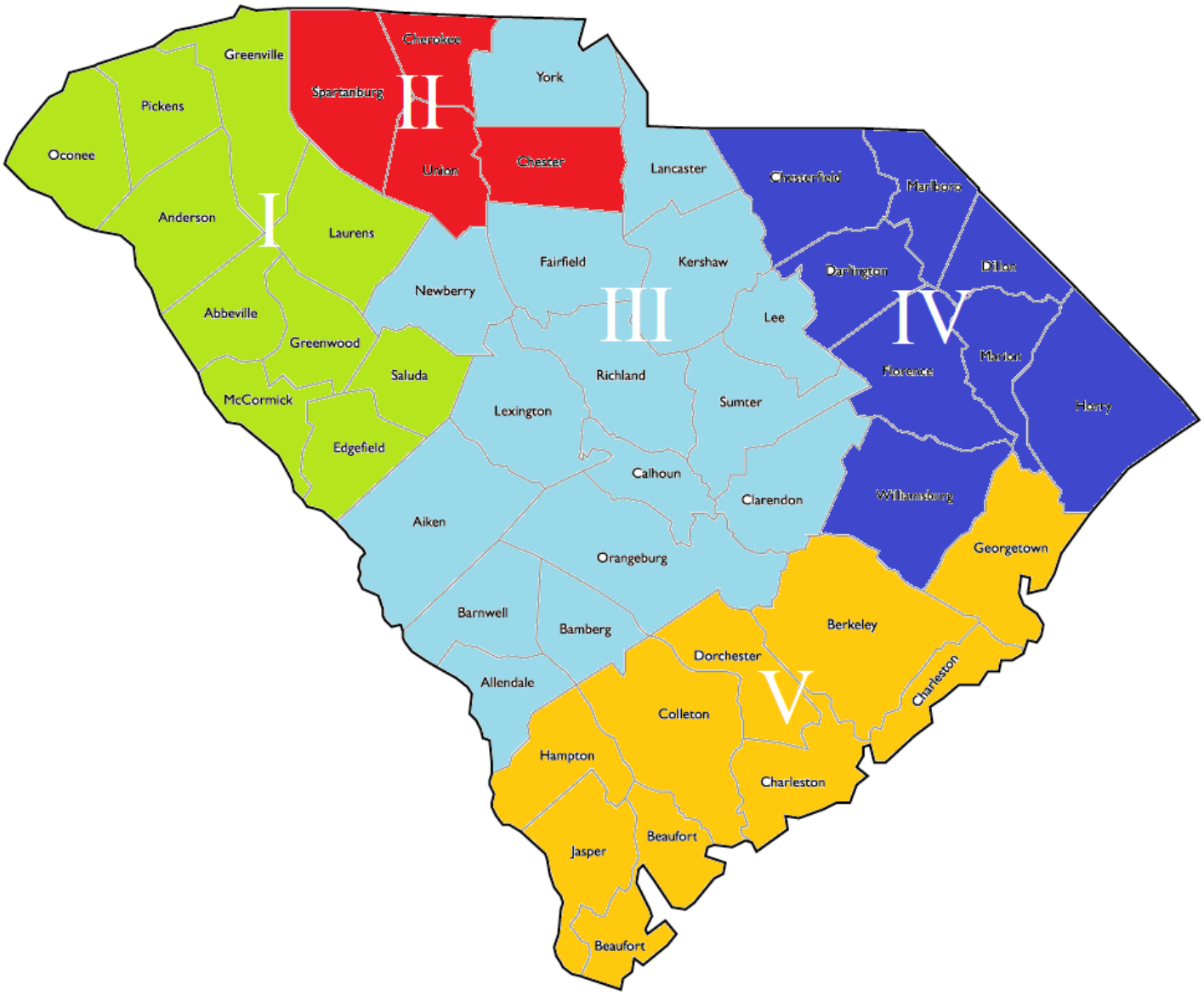
Region III
Williamsburg Regional Hospital ***1***

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	2015 Births	OB Beds	Admissions	Patient Days	% Occup Rate
Aiken Regional Medical Center	1132	18	1328	3179	48.4%
AnMed Health Women's & Children's Hospital	1825	28	1561	3831	37.5%
Beaufort Memorial Hospital	934	9	949	2055	62.6%
Bon Secours Saint Francis Xavier Hospital	2620	15	2799	6455	117.9%
Carolina Pines Regional Medical Center	553	13	731	1770	37.3%
McLeod Health Cheraw	65	10	72	134	3.7%
McLeod Health Clarendon	417	11	471	1026	25.6%
Coastal Carolina Hospital	711	10	780	1773	48.6%
Colleton Medical Center	316	6	322	740	33.8%
Conway Hospital	1406	16	1633	3699	63.3%
East Cooper Medical Center	1476	38	1772	4510	32.5%
Tidelands Georgetown Memorial Hospital	299	14	414	999	19.5%
Grand Strand Medical Center	956	19	1205	2739	39.5%
GHS Greenville Memorial Hospital	5657	59	4971	17642	81.9%
GHS Greer Memorial Hospital	673	10	679	1610	44.1%
Hilton Head Hospital	558	8	592	1207	41.3%
Kershaw Health	270	10	300	672	18.4%
GHS Laurens County Memorial Hospital	343	5	383	783	42.9%
Lexington Medical Center	3674	39	3894	9365	65.8%
McLeod Loris	452	8	478	946	32.4%
Carolinas Health System - Marion	261	5	298	630	34.5%
Mary Black Health System - Spartanburg	810	21	884	2110	27.5%
McLeod Medical Center Dillon	276	12	324	774	17.7%
McLeod Regional Medical Center of the Pee Dee	2205	22	2249	6759	84.2%
MUSC Medical Center	2738	36	2888	8326	63.4%
Newberry County Memorial Hospital	298	10	309	604	16.5%
GHS Oconee Memorial Hospital	515	15	541	1239	22.6%
Baptist Easley Hospital	435	14	510	1416	27.7%
Palmetto Health Baptist	3008	83	6663	11024	36.4%
Palmetto Health Baptist Parkridge	558	33	678	2067	17.2%
Palmetto Health Richland	2424	42	4022	10335	67.4%
Piedmont Medical Center	1638	19	1712	4619	66.6%
Regional Medical Center of Orangeburg & Calhoun Counties	987	32	1291	2716	23.3%
St. Francis - Eastside	2318	33	2380	6147	51.0%
Self Regional Healthcare	1418	36	1568	4074	31.0%
Spartanburg Medical Center	2754	39	3627	8519	59.8%
Springs Memorial Hospital	681	5	132	1866	102.2%
Summerville Medical Center	1176	12	1237	1980	45.2%
Trident Medical Center	1524	25	1562	3545	38.8%
Palmetto Health Tuomey	1370	24	338	4532	51.7%
Mary Black Health System - Gaffney	240	15	304	741	13.5%
Tidelands Waccamaw Community Hospital	577	19	1320	3864	55.7%
Union Medical Center (Formerly Wallace Thomson) **1**	91	-	95	246	0.0%
Women's Center of Carolinas Hospital System	694	20	1,046	1,602	21.9%
Total Births	**53,333**				

1 Facility ceased OB service line effective July 27, 2015

INTENSIVE AND INTERMEDIATE BASSINETS
(Chapter 3)

		Existing Bassinets	
Facility by Perinatal Region	**Service Level**	**Intensive**	**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
Baptist Easley Hospital	Level II	0	4
St. Francis - Eastside	Level II	0	10
Subtotal		**19**	**106**
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 Center	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	20	28
Carolinas Hospital System - Marion	Level II	0	2
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		**20**	**53**
Region V - MUSC Medical			
MUSC Medical Center	RPC	16	50
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	Level II	0	12
Trident Medical Center	Level II	0	0
Tidelands Waccamaw Community Hospital	Level II	0	2
Subtotal		**16**	**95**
Totals		**112**	**417**

1 CON SC-16-42 issued August 11, 2016 for the addition of 8 intensive care bassinets for a total of 20. Not yet implemented.

UTILIZATION OF NEONATAL SPECIAL CARE UNITS
(Chapter 3)

		2015						
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	6,098	68	15,681	80	21,779	74.6%
Self Regional Healthcare	Level III	7	538	11	1,738	18	2,276	34.6%
AnMed Health Women's & Children's Hospital	Level II	0	0	13	971	13	971	20.5%
Baptist Easley Hospital	Level II	0	0	4	0	4	0	0.0%
St. Francis - Eastside	Level II	0	0	10	1,541	10	1,541	42.2%
SUBTOTAL		**19**	**6,636**	**106**	**19,931**	**125**	**26,567**	**58.2%**
Region II - Spartanburg Regional								
Spartanburg Medical Center	RPC	13	5,042	22	3,548	35	8,590	67.2%
Mary Black Health System - Spartanburg	Level II	0	0	10	182	10	182	5.0%
SUBTOTAL		**13**	**5,042**	**32**	**3,730**	**45**	**8,772**	**53.4%**
Region III - Palmetto Health Richland								
Palmetto Health Richland	RPC	31	10,431	38	9,002	69	19,433	77.2%
Palmetto Health Baptist	Level III	8	1,575	22	4,339	30	5,914	54.0%
Piedmont Medical Center	Level III	5		7	1,901	12	1,901	43.4%
Aiken Regional Medical Center	Level II	0	0	8	220	8	220	7.5%
Lexington Medical Center	Level II	0	0	20	3,287	20	3,287	45.0%
Regional Medical Center of Orangeburg & Calhoun Counties	Level II	0	0	10	2,115	10	2,115	57.9%
Springs Memorial Hospital	Level II	0	0	4	38	4	38	2.6%
Palmetto Health Tuomey	Level II	0	0	22	118	22	118	1.5%
SUBTOTAL		**44**	**12,006**	**131**	**21,020**	**175**	**33,026**	**51.7%**
Region IV - McLeod Regional								
McLeod Regional Medical Center of the Pee	RPC	20	5,261	28	5,146	48	10,407	59.4%
Carolinas Hospital System - Marion	Level II	0	0	2	14	2	14	1.9%
Carolina Pines Regional Medical Center	Level II	0	0	4	407	4	407	27.9%
Conway Hospital	Level II	0	0	6	955	6	955	43.6%
Grand Strand Medical Center	Level II	0	0	2	968	2	968	132.6%
Women's Center of Carolinas Hospital System	Level II	0	0	11	889	11	889	22.1%
SUBTOTAL		**20**	**5,261**	**53**	**8,379**	**73**	**13,640**	**51.2%**
Region V - MUSC Medical								
MUSC Medical Center	RPC	16	8,026	50	12,143	66	20,169	83.7%
Beaufort Memorial Hospital	Level II	0	0	5	0	5	0	0.0%
Bon Secours St. Francis Xavier Hospital	Level II	0	0	11	2,180	11	2,180	54.3%
East Cooper Medical Center	Level II	0	0	10	943	10	943	25.8%
Tidelands Georgetown Memorial Hospital	Level II	0	0	5	132	5	132	7.2%
Summerville Medical Center **2**	Level II	0	0	12	1,190	12	1,190	27.2%
Trident Medical Center **2**	Level II	0	0	0	1,516	0	1,516	0.0%
Tidelands Waccamaw Community Hospital	Level II	0	0	2	452	2	452	61.9%
SUBTOTAL		**16**	**8,026**	**95**	**18,556**	**111**	**26,582**	**65.6%**
GRAND TOTAL		**112**	**36,971**	**417**	**71,616**	**529**	**108,587**	**56.2%**

1 CON SC-16-42 issued August 11, 2016 for the addition of 8 intensive care bassinets for a total of 20 intensive care bassinets, not yet implemented.
2 CON approved February 21, 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 bassients at Summerville and 0 intermediate bassinets at Trident, pending appeal.

NICU BED NEED
(Chapter 3)

Counties by Perinatal Region	2015 Births	2014 Births	2013 Births	3 YR Ave Births	2015 15-44 Pop	2014 15-44 Pop	2013 15-44 Pop	3 YR AVE 15-44 Pop	Avg Birth Rate	2019 15-44 Pop	2019 Proj Births	Proj Br / Avg Br	Existing NICU Beds	Bed Need
Region I														
Abbeville	246	248	259	251	4337	4403	4401	4,380		4160				
Anderson	2254	2273	2286	2,271	36321	36070	35748	36,046		36970				
Edgefield	210	194	254	219	4097	4105	4180	4,127		3960				
Greenville	6421	6340	6039	6,267	98894	97396	96235	97,508		104090				
Greenwood	820	865	901	862	14143	14100	14372	14,205		13630				
Laurens	761	736	727	741	12256	12339	12319	12,305		12100				
McCormick	56	87	40	61	1026	1090	1119	1,078		910				
Oconee	792	801	703	765	12243	12253	12356	12,284		12050				
Pickens	1254	1295	1160	1,236	25723	25574	25352	25,550		25410				
Saluda	251	279	211	247	3350	3421	3488	3,420		3200				
Total	**13,065**	**13,118**	**12,580**	**12,921**	**212,390**	**210,751**	**209,570**	**210,904**	**0.06126**	**216,480**	**13,263**	**1.026440**	**19**	**24**
Region II														
Cherokee	676	700	637	671	10904	10927	10941	10,924		10760				
Chester	376	388	373	379	5738	5810	5964	5,837		5420				
Spartanburg	3560	3574	3495	3,543	58361	57663	57271	57,765		59750				
Union	314	325	310	316	4874	4935	4950	4,920		4560				
Total	**4,926**	**4,987**	**4,815**	**4,909**	**79,877**	**79,335**	**79,126**	**79,446**	**0.06179**	**80,490**	**4,974**	**1.013141**	**13**	**3**
Region III														
Aiken	1997	1901	1749	1,882	30307	30281	30374	30,321		30590				
Allendale	77	103	91	90	1431	1510	1541	1,494		1200				
Bamberg	122	148	161	144	2855	2903	2976	2,911		2590				
Barnwell	247	265	315	276	3914	3984	4054	3,984		3720				
Calhoun	150	126	139	138	2389	2406	2480	2,425		2280				
Clarendon	332	353	350	345	5500	5591	5686	5,592		5340				
Fairfield	213	195	239	216	3952	4020	4073	4,015		3650				
Kershaw	751	741	662	718	11404	11317	11215	11,312		11610				
Lancaster	1043	1005	919	989	15341	14881	14405	14,876		16330				
Lee	158	175	194	176	2868	2917	2943	2,909		2650				
Lexington	3205	3207	3250	3,221	54889	54192	53711	54,264		56850				
Newberry	455	461	453	456	6757	6776	6681	6,738		6660				
Orangeburg	1004	953	1121	1,026	17315	17547	17834	17,565		16100				
Richland	5010	4768	4798	4,859	94778	93698	92933	93,803		99440				
Sumter	1527	1459	1526	1,504	21006	21315	21403	21,241		20600				
York	2933	2909	2889	2,910	50917	50056	49026	50,000		53920				
Total	**19,224**	**18,769**	**18,856**	**18,950**	**325,623**	**323,394**	**321,335**	**323,451**	**0.05859**	**333,530**	**19,540**	**1.031162**	**44**	**20**
Region IV														
Chesterfield	518	521	523	521	8272	8382	8466	8,373		7860				
Darlington	843	800	756	800	12823	12897	12936	12,885		12380				
Dillon	412	400	457	423	5934	5953	5982	5,956		5740				
Florence ***1***	1697	1763	1717	1,726	28196	28370	28256	28,274		28090				
Horry	3178	3051	3170	3,133	54279	53159	52311	53,250		57750				
Marion	382	404	397	394	5899	5943	5961	5,934		5590				
Marlboro	342	302	307	317	4477	4541	4554	4,524		4110				
Williamsburg	357	342	313	337	5582	5591	5649	5,607		5180				
Total	**7,729**	**7,583**	**7,640**	**7,651**	**125,462**	**124,836**	**124,115**	**124,804**	**0.06130**	**126,700**	**7,767**	**1.015189**	**20**	**5**
Region V														
Beaufort	2057	2046	2077	2,060	29214	28850	28503	28,856		30,380				
Berkeley	2722	2650	2608	2,660	40707	40047	39410	40,055		44,040				
Charleston	4991	4961	4764	4,905	83035	81313	79918	81,422		88,920				
Colleton	482	449	439	457	6616	6669	6739	6,675		6,270				
Dorchester	1817	1907	1809	1,844	31296	30419	29954	30,556		33,830				
Georgetown	551	562	612	575	9512	9468	9481	9,487		9,260				
Hampton	213	220	225	219	3446	3504	3530	3,493		3,190				
Jasper	356	379	312	349	4762	4686	4726	4,725		4,890				
Total	**13,189**	**13,174**	**12,846**	**13,070**	**208,588**	**204,956**	**202,261**	**205,268**	**0.06367**	**220,780**	**14,057**	**1.075568**	**16**	**30**
Statewide	**58,133**	**57,631**	**56,737**	**57,500**	**951,940**	**943,272**	**936,407**	**943,873**		**977,980**	**59,601**		**112**	**82**

1 CON SC-16-42 issued August 11, 2016 for the addition of 8 intensive bassinets to McLeod Regional Medical Center of the Pee Dee for a total of 20 intensive bassinets.

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 2022 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 nineteen (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 8 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 sixty 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	2015 Pt. Days	Occup Rate
Region I				
AnMed Health Medical Center	Anderson	38	6,368	45.9%
Carolina Center Behavioral Health ***1***	Greenville	117	29,144	68.2%
GHS Marshall I. Pickens Hospital ***2***	Greenville	65	11,913	50.2%
Mary Black Health System - Spartanburg	Spartanburg	15	2,413	44.1%
Self Regional Healthcare	Greenwood	32	3,980	34.1%
Spartanburg Medical Center	Spartanburg	56	6,816	33.3%
Springbrook Behavioral Health ***3***	Greenville	56	11,395	55.7%
Region II				
Aiken Regional Medical Center	Aiken	44	12,919	80.4%
Palmetto Health Baptist	Richland	55	10,688	53.2%
Palmetto Health Richland	Richland	52	12,902	68.0%
Piedmont Medical Center	York	20	4,201	57.5%
Rebound Behavioral Health	Lancaster	24	0	0.0%
Springs Memorial Hospital	Lancaster	12	239	5.5%
Three Rivers Behavioral Health ***4***	Lexington	105	30,618	79.9%
Region III				
Carolinas Hospital System - Cedar Tower	Florence	12	0	0.0%
South Strand Medical Center ***5***	Horry	20		
Marlboro Park Hospital ***6***				
Lighthouse Behavioral Health Center	Horry	60	17,974	82.1%
McLeod Medical Center - Darlington	Darlington	23	6,124	72.9%
Region IV				
Beaufort Memorial Hospital ***7***	Beaufort	14	2,610	51.1%
Colleton Medical Center	Colleton	19	5,085	73.3%
Medical University SC	Charleston	82	28,011	93.6%
Palmetto Lowcountry Behavioral	Charleston	92	18,186	54.2%
Trident Medical Center ***7***	Charleston	17	6,079	98.0%
Regional Medical Center - O'burg & Calhoun ***7***	Orangeburg	15	1,651	30.2%
Government Facilities				
G. Werber Bryan Psychaitric Hospital ***8***	Richland	530	51,200	26.5%
Gilliam Psychiatric Hospital ***9***	Richland	87	--	0.0%

Patrick B. Harris Psychiatric Hospital ***8***	Anderson	200	40,334	55.3%
William J McCord Adolescent Treatment	Orangeburg	15	N/R	N/R
William S. Hall Psychiatric Institute ***6***	Richland	68	5,663	22.8%
	Total	**1045**	**229,316**	**60.1%**

1 SC-15-35 issued 9/16/2015 for the addition of 8 psychiatric beds for a total of 117 psychiatric

2 SC-17-07 issued 2/16/2017 for the addition of 19 psychiatric beds for a total of 65 psychiatric beds.

3 SC-17-08 issued 2/16/2017 for the addition of 18 psychiatric beds for a total of 56 psychiatric beds

4 SC-16-12 issued 3/18/2016 for the addition of 24 psyciatric beds for a total of 105 psychiatric beds.

5 CON SC-16-35 issued 8/1/2016 for the establishmet of a 20 bed psychiatric program.

6 Facility has closed.

7 Age cohorts not adequately reported.

8 State facility not operating all its licensed beds. Their utilization does not impact calculation of n

9 Did not submit 2015 JAR.

PSYCHIATRIC BED NEED
(Chapter 4)

Service Area	Age Cat	2015 Pop	2022 Pop	Existing Beds	2015 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Bed Need
Anderson, Oconee	<18	60263	59410		0							
	18-64	159668	161510		5121	14						
	+65	50474	60580		1247	4						
	TOTAL	**270,405**	**281,500**	**38**	**6,368**	**18**	**0.70**	**26**	**-12**	**52**	**14**	**14**
Greenville, Pickens	<18	138937	149270		3673	11						
	18-64	383988	407480		36564	106						
	+65	90629	117760		12215	43						
	TOTAL	**613,554**	**674,510**	**238**	**52,452**	**161**	**0.70**	**229**	**-9**	**124**	**-114**	**-9**
Cherokee, Spartanburg, Union	<18	89203	89960		0							
	18-64	232396	235580		2923	8						
	+65	59674	72310		6306	21						
	TOTAL	**381,273**	**397,850**	**71**	**9,229**	**29**	**0.70**	**42**	**-29**	**73**	**2**	**2**
Chester, Lancaster, York	<18	87982	92390									
	18-64	225405	248390									
	+65	55917	78420									
	TOTAL	**369,304**	**419,200**	**56**	**4,440**	14	**0.70**	**20**	**-36**	**77**	**21**	**21**
Abbeville, Edgefield, Greenwood,	<18	46930	44490		0							
Laurens, McCormick, Saluda	18-64	131027	123220		2695	7						
	+65	39709	46630		1285	4						
	TOTAL	**217,666**	**214,340**	**32**	**3,980**	**11**	**0.70**	**16**	**-16**	**39**	**7**	**7**
Fairfield, Kershaw, Lexington,	<18	182593	190410		4391	13						
Newberry, Richland	18-64	519977	538960		38928	111						
	+65	110676	145250		10889	39						
	TOTAL	**813,246**	**874,620**	**212**	**54,208**	**162**	**0.70**	**232**	**20**	**160**	**-52**	**20**
Darlington, Florence, Marion	<18	56342	53840		77	0						
	18-64	143188	136210		5772	15						
	+65	38665	45810		275	1						
	TOTAL	**238,195**	**235,860**	**35**	**6,124**	**16**	**0.70**	**23**	**-12**	**43**	**8**	**8**
Chesterfield, Dillon, Marlboro	<18	24240	22180									
	18-64	63816	58540									
	+65	16689	19350		0							
	TOTAL	**104,745**	**100,070**	**0**	**0**	**0**	**0.70**	**0**	**0**	**18**	**18**	**18**
Clarendon, Lee, Sumter	<18	36997	34370									
	18-64	95982	89100		0							
	+65	26172	31240		0							
	TOTAL	**159,151**	**154,710**	**0**	**0**	**0**	**0.70**	**0**	**0**	**28**	**28**	**28**
Georgetown, Horry, Williamsburg	<18	78057	80700		1717	5						
	18-64	237594	254680		12117	36						
	+65	87381	132180		4140	17						
	TOTAL	**403,032**	**467,560**	**80**	**17,974**	**58**	**0.70**	**82**	**2**	**86**	**6**	**6**
Bamberg, Calhoun, Orangeburg	<18	25997	24480									
	18-64	71242	61780									
	+65	21630	25040									
	TOTAL	**118,869**	**111,300**	**15**	**1,651**	**4**	**0.70**	**6**	**-9**	**20**	**5**	**5**
Allendale, Beaufort, Hampton,	<18	47559	47730									
Jasper	18-64	135048	140680									
	+65	54288	77250									
	TOTAL	**236,895**	**265,660**	**14**	**2,610**	**8**	**0.70**	**11**	**-3**	**49**	**35**	**35**
Berkeley, Charleston, Colleton,	<18	174664	187710									
Dorchester	18-64	498283	555010									
	+65	109310	155460									
	TOTAL	**782,257**	**898,180**	**210**	**57,361**	**180**	**0.70**	**258**	**48**	**165**	**-45**	**48**
Aiken, Barnwell	<18	41824	40650		3220	9						
	18-64	112149	110380		7840	21						
	+65	33581	42080		1859	6						
	TOTAL	**187,554**	**193,110**	**44**	**12,919**	**36**	**0.70**	**52**	**8**	**35**	**-9**	**8**
Statewide Totals	<18	1,091,588	1117590									
	18-64	3,009,763	3,121,520									
	+65	794,795	1,049,360									
	TOTAL	**4,896,146**	**5,288,470**	**1045**	**229,316**	**679**	**0.000183**	**997**		**969**		**211**

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

Statewide Programs

The 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	Beds	2015 Pt. Days	Occup Rate
Region I				
AnMed Health Rehab Hospital	Anderson	60	18,294	83.5%
Roger C. Peace (GHS Greenville Memorial)	Greenville	53	11,572	59.8%
St. Francis - Downtown	Greenville	19	4,775	68.9%
Greenwood Regional Rehab Hospital	Greenwood	42	10,628	69.3%
Mary Black Health System - Spartanburg	Spartanburg	18	3,477	52.9%
Spartanburg Rehabilitation Institute	Spartanburg	40	10,038	68.8%
Region II				
Aiken Regional Medical Centers **1**	Aiken	14	0	0.0%
Midlands Regional Rehabilitation Hospital **2**	Kershaw	40	0	0.0%
HealthSouth Columbia	Richland	96	23,899	68.2%
Palmetto Health Children's Hospital **3**	Richland	13	0	0.0%
HealthSouth Rock Hill	York	50	15,005	82.2%
Region III				
Carolinas Hospital System - Cedar Tower	Florence	42	6,048	39.5%
HealthSouth Florence	Florence	88	15,449	48.1%
Tidelands Waccamaw Community Hospital **4 & 6**	Georgetown	29	11,984	113.2%
Grand Strand Medical Center **5**	Horry	24	0	0.0%
Myrtle Beach Rehabilitation Hospital **6**	Horry	46	0	0.0%
Region IV				
Beaufort Memorial Hospital	Beaufort	14	2,579	50.5%
HealthSouth Lowcountry **7**	Beaufort	38	0	0.0%
HealthSouth Charleston	Charleston	49	14,690	82.1%
Roper Hospital **8**	Charleston	66	16,179	67.2%
Trident Medical Center **9**	Charleston	14	0	0.0%
Regional Medical Center of Orangeburg & Calhoun	Orangeburg	24	4,680	53.4%
	TOTAL	879	169,297	52.8%

1 CON SC-16-200 issued 12/28/16 for the establishment of a new 14 bed rehabilitation program, not yet implemented.

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 implemented.

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

6 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 implemented.

7 CON SC-16-44 issued 8/11/16 for the construction of a new 38 bed Comprehensive Rehabilitation Hospital, not yet implemented.

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 implemented.

9 CON approved 9/26/16 for the establishment of a 14 bed rehabilitation unit, pending appeal.

REHABILITATION BED NEED
(Chapter 5)

Service Area	>65 2015 Pop	>65 2022 Pop	2015 Pop	2022 Pop	Existing Beds	2015 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Need
Anderson, Oconee	50,474	60,580	270,405	281,500	60	15,584	44	0.70	63	3	67	7	**7**
Greenville, Pickens	90,629	117,760	316,383	328,530	72	7,097	20	0.70	29	-43	130	58	**58**
Cherokee, Spartanburg, Union	59,674	72,310	381,273	397,850	58	12,270	35	0.70	50	-8	80	22	**22**
Chester, Lancaster, York	55,917	78,420	369,304	419,200	50	15,005	47	0.70	67	17	87	37	**37**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	39,709	46,630	217,666	214,340	42	10,628	29	0.70	41	-1	52	10	**10**
Fairfield, Lexington, Newberry, Richland[1]	99,933	131,930	749,643	808,760	109	23,899	71	0.70	101	-8	146	37	**37**
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	61,387	72,300	376,516	308,080	130	21,497	48	0.70	69	-61	80	-50	**-50**
Clarendon, Kershaw[2], Lee, Sumter	36,915	44,560	222,754	220,570	40	0	0	0.75	0	-40	49	9	**9**
Georgetown, Horry[3]	81,348	125,040	370,497	437,580	99	11,984	39	0.70	56	-43	138	39	**39**
Aiken[4], Allendale, Bamberg, Barnwell, Calhoun, Orangeburg	56,845	69,020	315,856	312,640	38	4,680	13	0.70	19	-19	76	38	**38**
Beaufort[5], Hampton, Jasper	52,654	75,350	227,462	257,430	52	2,579	8	0.70	11	-41	83	31	**31**
Berkeley, Charleston[6], Colleton, Dorchester	109,310	155,460	782,257	898,180	129	30,869	97	0.70	139	10	172	43	**43**
Statewide Totals	**794,795**	**1,049,360**	**4,600,016**	**4,884,660**	**879**	**156,092**	**565**	**1.10595**	**511**		**1,161**		**282**

[1] Service Area bed count includes SC-16-43 for 13 rehabilitation beds issued to Palmetto Health Children's Hospital on 8/11/16, not yet implemented.

[2] Service Area bed count includes SC-16-183 for 40 rehabilitation beds issued to Midlands Regional Rehabilitation Hospital on 12/15/16, not yet implemented.

[3] Service Area bed count reflects SC-16-37 for 17 rehabilitation beds issued to Tidelands Waccamaw Community Hospital on 8/10/16; SC-17-17 for 24 rehabilitation beds issued to Grand Strand Medical Center and 15 new rehabilitation beds issued to Myrtle Beach Rehabilitation Hospital on 4/6/17, all of which are not yet implemented.

[4] Service Area bed count includes SC-16-200 for 14 rehabilitation beds issued to Aiken Regional Medical Centers on 12/28/16, not yet implemented.

[5] Service Area bed count includes SC-16-44 for 38 rehabilitation beds issued to HealthSouth Lowcountry on 8/11/16.

[6] Service Area bed county includes CON approval for 14 rehabilitation beds issued Trident Medical Center on 9/26/16, pending appeal.

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 4 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 sixteen (16) beds in order to meet federal requirements.

3. Because a minimum of ten (10) beds is needed for a medical detoxification program, a ten (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 sixty (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 sixty (60) minutes' travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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 2022 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 8 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 sixty (60) minutes' travel time for the majority of residents of the state. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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 thirty (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)

		2015		
Facility by Region	**County**	**Beds**	**Pt. Days**	**Occup Rate**
Region I				
Carolina Center Behavioral Health System ***1***	Greenville	29	10,925	103.2%
Springbrook Behavioral Health ***2***	Greenville	6	0	0.0%
Region II				
Aiken Regional Medical Center	Aiken	18	4,151	63.2%
Palmetto Health Baptist	Richland	10	0	0.0%
Palmetto Richland Springs (Palmetto Health Richland)	Richland	10	0	0.0%
Rebound Behavioral Health ***3***	Lancaster	18	--	0.0%
Three Rivers Behavioral Health	Lexington	17	2,859	46.1%
Region III				
Carolinas Hospital System - Cedar Tower ***4***	Florence	12	2,033	46.4%
Lighthouse Behavioral Health Hospital ***5***	Horry	27	5,647	57.3%
Region IV				
MUSC Medical Center	Charleston	23	3,539	42.2%
Palmetto Lowcountry Behavioral	Charleston	16	4,733	81.0%
	TOTAL	**186**	**33,887**	**49.9%**

* 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 2/16/2017 for the addition of 8 substance abuse beds for a total of 29 substance abuse beds.

2 SC-15-34 issued 9/16/2015 for the addition of 6 substance abuse beds for a total of 6 substance abuse beds.

3 Did not complete 2015 JAR.

4 Did not adequately report age cohort data.

5 SC-16-16 issued 4/27/2016 for addition of 9 substance abuse beds for a total of 27 substance abuse beds.

INPATIENT TREATMENT BED NEED (SUBSTANCE ABUSE)

(Chapter 6)

SERVICE AREA	AGE CAT	2015 POP	2022 POP	EXISTING BEDS	2015 PT. DAYS	2015 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
Anderson, Oconee	0-17	60263	59410	0		0.00000	0.75	0		2		
	18-64	159668	161510			0.00000	0.75	0	0	5	9	9
	65+	50474	60580			0.00000	0.75	0		2		
Cherokee, Spartanburg, Union	0-17	89203	89960	0		0.00000	0.75	0		3		
	18-64	232396	235580			0.00000	0.75	0	0	6	11	11
	65+	59674	72310			0.00000	0.75	0		2		
Greenville, Pickens	0-17	138937	149270	35	20	0.00014	0.75	1		4		
	18-64	383988	407480		10267	0.02674	0.75	40	10	11	-17	10
	65+	90629	117760		638	0.00704	0.75	4		3		
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	0-17	46930	44490	0		0.00000	0.75	0		2		
	18-64	131027	123220			0.00000	0.75	0	0	4	8	8
	65+	39709	46630			0.00000	0.75	0		2		
Chester, Lancaster, York	0-17	87982	92390	18		0.00000	0.75	0		3		
	18-64	225405	248390			0.00000	0.75	0	-18	7	-6	-6
	65+	55917	78420			0.00000	0.75	0		2		
Fairfield, Kershaw, Lexington, Newberry, Richland	0-17	182593	190410	37	0	0.00000	0.75	0		5		
	18-64	519977	538960		2320	0.00446	0.75	9	-25	14	-14	-14
	65+	110676	145250		539	0.00487	0.75	3		4		
Chesterfield, Dillon, Marlboro	0-17	24240	22180	0		0.00000	0.75	0		1		
	18-64	63816	58540			0.00000	0.75	0	0	2	4	4
	65+	16689	19350			0.00000	0.75	0		1		
Clarendon, Lee, Sumter	0-17	36997	34370	0		0.00000	0.75	0		1		
	18-64	95982	89100			0.00000	0.75	0	0	3	5	5
	65+	26172	31240			0.00000	0.75	0		1		

INPATIENT TREATMENT BED NEED (SUBSTANCE ABUSE)

(Chapter 6)

SERVICE AREA	AGE CAT	2015 POP	2022 POP	EXISTING BEDS	2015 PT. DAYS	2015 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
Darlington, Florence,	0-17	56342	53840	12		0.00000	0.75	0		2		
Marion	18-64	143188	136210			0.00000	0.75	0	-3	4	-4	-3
	65+	38665	45810		2033	0.05258	0.75	9		2		
Georgetown, Horry,	0-17	78057	80700	27	0	0.00000	0.75	0		3		
Williamsburg	18-64	237594	254680		5207	0.02192	0.75	21	-3	7	-13	-3
	65+	87381	132180		440	0.00504	0.75	3		4		
Aiken, Barnwell	0-17	41824	40650	18	534	0.01277	0.75	2		2		
	18-64	112149	110380		3126	0.02787	0.75	12	-1	3	-11	-1
	65+	33581	42080		491	0.01462	0.75	3		2		
Allendale, Beaufort,	0-17	47559	47730	0		0.00000	0.75	0		2		
Hampton, Jasper	18-64	135048	140680			0.00000	0.75	0	0	4	8	8
	65+	54288	77250			0.00000	0.75	0		2		
Bamberg, Calhoun,	0-17	25997	24480	0		0.00000	0.75	0		1		
Orangeburg	18-64	71242	61780			0.00000	0.75	0	0	2	4	4
	65+	21630	25040			0.00000	0.75	0		1		
Berkeley, Charleston,	0-17	174664	187710	39	181	0.00104	0.75	1		5		
Colleton, Dorchester	18-64	498283	555010		7812	0.01568	0.75	32	-4	15	-15	-4
	65+	109310	155460		279	0.00255	0.75	2		4		
Statewide Totals		**4,896,146**		**186**	**33,887**			**142**		**155**		**28**

			State
0-64	**4,101,351**	**4,239,110**	**Usage**
65+	**794,795**	**1,049,360**	**Rate**
Total	**4,896,146**	**5,288,470**	**0.000019**

OPIOID TREATMENT PROGRAMS
(Chapter 6)

Region	Facility	County
I	Crossroads Treatment Center of Seneca	Oconee
I	Crossroads Treatment Center of Greenville	Greenville
I	Greenwood Treatment Specialists ***1***	Greenwood
I	Greenville Metro Treatment Center	Greenville
I	Palmetto Carolina Treatment Center	Spartanburg
I	Recovery Concepts of the Carolina Upstate	Pickens
I	Southwest Carolina Treatment Center	Anderson
I	BHG- Spartanburg Treatment Center	Spartanburg
I	Clear Skye Treatment Center of Laurens County ***3***	Laurens
II	BHG- Aiken Treatment Center	Aiken
II	Columbia Metro Treatment Center	Lexington
II	Crossroads Treatment Center of Columbia	Richland
II	York County Treatment Center	York
II	Rock Hill Treatment Specialists ***2***	York
III	Center of Hope Myrtle Beach	Horry
III	Starting Point of Darlington	Darlington
III	Starting Point of Florence	Florence
IV	Center for Behavioral Health South Carolina	Charleston
IV	Charleston Center	Charleston
IV	Crossroads Treatment Center of Charleston	Charleston
IV	Recovery Concepts	Jasper

1 CON SC-15-44 issued December 1, 2015.
2 CON SC-16-86 issued November 1, 2016.
3 CON SC-17-29 issued May 11, 2017.

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 5 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 5 years of age would be

candidates for this type of care, the bed need will be based on the population age 5-21.

The Projected Bed 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 sixty (60) minutes' travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS*
(Chapter 7)

Region	Facility	County	Beds	PT Days	2015 % Occupancy
I	Avalonia Group Homes	Pickens	55	17,136	85.4%
I	Excalibur Youth Services	Greenville	60	15,687	71.6%
I	Generations Residential Programs	Greenville	30	7,756	70.8%
I	GHS Marshall I Pickens Hospital Childrens Program	Greenville	22	5,849	72.8%
I	Springbrook Behavioral Health System RTF	Greenville	68	22,168	89.3%
II	The Hearth Center for Eating Disorders **1**	Richland	0	-	
II	New Hope Carolinas	York	150	48,739	89.0%
II	Three Rivers Behavioral RTF **2**	Lexington	0	-	
II	Three Rivers Residential Treatment - Midlands Campus	Lexington	64	21,408	91.6%
III	Lighthouse Care Center of Conway	Horry	18	4,939	75.2%
III	Palmetto Pee Dee Residential Treatment Center	Florence	64	21,498	92.0%
III	Willowglen Academy South Carolina	Williamsburg	40	13,825	94.7%
IV	Palmetto Pines Behavioral Health	Dorchester	64	19,688	84.3%
IV	Riverside Behavioral Health Services at Windwood Farm	Charleston	12	4,350	99.3%
		Totals	**647**	**203,043**	**86.0%**

* The Directions program primarily served court-ordered patients from the South Carolina Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it was not included in this inventory. The Directions Program ceased operation in December 2015.

1 The Hearth Center for Eating Disorders ceased operation in October of 2016.

2 Three Rivers Behavioral RTF ceased operation in October of 2016.

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

Service Area	2015 Pop	2022 Pop	Existing Beds	Bed Need (Use)	Need
Anderson, Oconee	56794	56340	0	23	**23**
Cherokee, Spartanburg, Union	85813	85830	0	36	**36**
Greenville, Pickens	140665	146580	235	61	**-174**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	46003	42750	0	18	**18**
Chester, Lancaster, York	83088	89080	150	37	**-113**
Fairfield, Kershaw, Lexington, Newberry, Richland	191157	194120	64	80	**16**
Chesterfield, Dillon, Marlboro	22670	20630	0	9	**9**
Clarendon, Lee, Sumter	35523	32730	0	14	**14**
Darlington, Florence, Marion	53494	50920	64	21	**-43**
Georgetown, Horry, Williamsburg	74031	78280	58	32	**-26**
Aiken, Barnwell	39451	38680	0	16	**16**
Allendale, Beaufort, Hampton, Jasper	46461	46490	0	19	**19**
Bamberg, Calhoun, Orangeburg	26850	23720	0	10	**10**
Berkeley, Charleston, Colleton Dorchester	164778	179620	76	74	**-2**
Statewide Totals	**875,150**	**882,430**	**647**	**365**	**-282**

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.

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 803-545-4501.

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;

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.

Emergent and Elective PCI without On-Site Cardiac Backup

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 thirty (30) minute or less response time from contact.

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

g. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated

interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule, 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.

Pediatric Catheterization Services

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

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

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

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

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 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks. All facilities providing open heart surgery must conform 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 sixty (60) minutes' travel time for the majority of residents of South Carolina;

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

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

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

(5) Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the

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

(6) The 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)

		2013							2014							2015 [1]						
Facility by Region	**# Cath Labs**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**
Region I																						
Anmed Health Medical Center	6	2,146	1,396	4,938					1,981	1,235	4,451					1,723	1,023	3,768				
GHS Greenville Memorial Hospital	5	2,328	1,715	5,758					1,962	1,531	5,024					1,914	1,753	5,420				
Saint Francis - Downtown	4	1,925	945	3,815					2,004	1,246	4,496					2,053	1,229	4,511				
Self Regional Healthcare	2	1,074	359	1,792					847	349	1,545					885	447	1,779				
GHS Oconee Memorial Hospital	1	509	0	509					358	0	358					228	0	228				
Baptist Easley Hospital	1	193	0	193					167	0	167					112	0	112				
Mary Black Hospital Systems	2	42	0	42					49	0	49					82	0	82				
Spartanburg Medical Center	4	1,794	761	3,316					1,896	751	3,398					1,849	937	3,723				
Pelham Medical Center	1	0	0	0					0	0	0					0	0	0				
Total Region I	**26**	**10,011**	**5,176**	**20,363**					**9,264**	**5,112**	**19,488**					**8,846**	**5,389**	**19,623**				
Region II																						
Aiken Regional Medical Centers	1	835	299	1,433					691	257	1,205					701	283	1,267				
Kershaw Health	1	610	0	610					666	0	666					***NR***	***NR***	***NR***				
Springs Memorial Hospital	1	398	0	398					397	0	397					271	0	271				
Lexington Medical Center	3	1,801	764	3,329					1,895	801	3,497					2,140	791	3,722				
Palmetto Health Baptist	1	355	0	355					444	0	444					485	0	485				
Palmetto Health Richland	4	3,120	1,247	5,614					3,070	1,284	5,638					3,153	1,254	5,661				
Providence Health ***2***	7	2,844	1,687	6,218					2,440	1,396	5,232					3,136	1,553	5,458				
Piedmont Medical Center	3	1,266	672	2,610					1,166	667	2,500					1,211	766	3,146				
Total Region II	**20**	**11,229**	**4,669**	**20,567**					**10,769**	**4,405**	**19,579**					**11,097**	**4,647**	**20,010**				
Region III																						
Carolina Pines Regional Medical Center	1	97	0	97					116	0	116					205	0	205				
Carolinas Hospital System	3	759	184	1,127					660	233	1,126					747	225	1,197				
McLeod Regional Medical Center of the Pee Dee	5	1,242	518	2,278					1,419	542	2,503					1,521	639	2,799				
Tidelands Georgetown Memorial Hospital	2	681	73	827					717	56	829					670	94	858				
Conway Hospital	1	683	0	683					774	0	774					693	0	693				
Grand Strand Medical Center	4	1,714	893	3,500					2,090	911	3,912					2,422	1,057	4,536				
McLeod Loris ***3***	0	264	0	264					282	0	282					294	0	294				
McLeod Seacoast ***3***	1	0	0	0					0	0	0					0	0	0				
Palmetto Health Tuomey	1	166	0	166					160	0	160					84	0	84				
Total Region III	**18**	**5,606**	**1,668**	**8,942**					**6,218**	**1,742**	**9,702**					**6,636**	**2,015**	**10,666**				
Region IV																						
Beaufort Memorial Hospital	1	300	34	368					447	133	713					494	147	788				
Hilton Head Hospital	2	318	169	656					433	227	887					299	172	643				
Bon Secours - St. Francis Xavier ***4***	1	3	0	3					4	0	4					3	0	3				
East Cooper Medical Center ***5***	1	0	0	0					0	0	0					0	0	0				
MUSC Medical Center	6	1,692	1,326	4,344	262	260	110	1,414	1,697	1,156	4,009	285	284	112	1,534	1,436	1,124	3,684	197	272	61	1,271
Roper Berkeley Hospital ***6***	1	0	0	0					0	0	0					0	0	0				
Roper Hospital	3	1,651	908	3,467					1,578	896	3,370					1,568	883	3,334				
Trident Medical Center	2	995	479	1,953					1,007	445	1,897					1,081	525	2,131				
Regional Medical Center of Orangeburg & Calhoun Counti	1	238	0	238					215	0	215					299	0	299				
Total Region IV	**18**	**5,197**	**2,916**	**11,029**				**1,414**	**5,381**	**2,857**	**11,095**				**1,534**	**5,180**	**2,851**	**10,882**				**1,271**
Statewide Totals	**82**	**32,043**	**14,429**	**60,901**				**1,414**	**31,632**	**14,116**	**59,864**				**1,534**	**31,759**	**14,902**	**61,181**				**1,271**

1 Some figures adjusted by Revenue & Fiscal Affairs following ICD9/10 conversion.
2 South Carolina Heart Center catheterization lab now controlled by Providence Health and reported in their utilization.
3 CON SC-17-16 issued April 6, 2017 to transfer single cardiac catheterization lab from McLeod Loris Hospital to McLeod Seacost Hospital.
4 Cardiac catheterization lab closed August 1, 2016.
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 13 Adults	FY 13 Peds	FY 14 Adults	FY 14 Peds	FY 15[1] Adults	FY 15[1] Peds
Region I							
Anmed Health Medical Center	2	217		200		210	
GHS Greenville Memorial Hospital	3	473		400		454	
Saint Francis - Downtown	2	336		311		323	
Self Regional Healthcare	1	113		85		77	
Spartanburg Medical Center	3	430		467		443	
Total Region I	**11**	**1,569**		**1,463**		**1,507**	
Region II							
Aiken Regional Medical Centers	1	30		33		55	
Lexington Medical Center	1	212		294		312	
Palmetto Health Richland	2	353		344		349	
Piedmont Medical Center	2	105		102		164	
Providence Health	4	559		500		546	
Total Region II	**10**	**1,259**		**1,273**		**1,426**	
Region III							
Carolinas Hospital System	1	97		101		97	
Grand Strand Medical Center	2	238		418		427	
McLeod Regional Medical Center of the Pee Dee	3	407		279		403	
Total Region III	**6**	**742**		**798**		**927**	
Region IV							
Hilton Head Hospital	2	76		74		86	
MUSC Medical Center	4	318	205	360	191	423	237
Roper Hospital	2	408		424		474	
Trident Medical Center	1	248		238		241	
Total Region IV	**9**	**1,050**	**205**	**1,096**	**191**	**1,224**	**237**
Statewide Totals	**36**	**4,620**	**205**	**4,630**	**191**	**5,084**	**237**

1 Some figures adjusted by Revenue & Fiscal Affairs following ICD9/10 conversion

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-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 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm.
2. Access to an electron beam source or a low energy X-ray unit.
3. Adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department.
4. Capability to provide appropriate dose distribution information for external beam treatment.
5. Equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units).
6. Field-shaping capability.
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 1-5 treatment sessions. These specialized LINACs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 1,500 treatments per year per unit.

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 sixty (60) minutes' travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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.

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

4. 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.

5. 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.

6. 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 ninety (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 2013	FY 2014	FY 2015
Region I					
Anmed Health Medical Center	Anderson	2	12,816	10,916	12,568
GHS Cancer Centers of the Carolinas - Andrews	Greenville	1	3,619	4,613	3,811
GHS Cancer Centers of the Carolinas - Eastside	Greenville	1	7,116	3,567	6,849
GHS Cancer Institute - Faris	Greenville	3	13,548	11,884	10,194
GHS Cancer Institute - Greer	Greenville	1	4,183	4,177	2,627
St. Francis Millennium Cancer Center ***1***	Greenville	1	--	--	--
GHS Cancer Institute- Seneca	Oconee	1	4,542	4,971	4,609
Baptist Medical Center Easley ***7***	Pickens	0	--	--	--
GHS Cancer Institute- Spartanburg	Spartanburg	1	3,058	3,168	2312
Spartanburg Regional Medical Center ***3***	Spartanburg				
Linear Accelerators		4	17790	24594	19739
Cyberknife		1	--	--	--
Self Regional Healthcare	Greenwood	2	7,374	6,794	7,642
Region II					
Aiken Regional Medical Center	Aiken	2	7,904	8,080	8,841
Lancaster Radiation Therapy Center	Lancaster	1	2,675	5,290	4,513
Lexington Medical Center	Lexington	3	13,858	15,444	17,533
Newberry Oncology Associates ***2***	Newberry	1	2,675	**NR**	**NR**
Palmetto Health Richland	Richland				
Linear Accelerators		4	799	733	110
Gamma Knife		1	158	159	100
South Carolina Oncology Associates ***2***	Richland	4	**NR**	**NR**	**NR**
Radiation Oncology, LLC ***2***	Richland	6	30,624	27,417	**NR**
Rock Hill Radiation Therapy Center	York	2	11,002	10,846	11,341
Region III					
Carolinas Hospital System ***2***	Florence	1	3,064	2,806	**NR**
Mcleod Regional Medical Center - Pee Dee	Florence	4	17,147	14,976	12,587
Georgetown Memorial Hospital ***4***	Georgetown	1	6,393	6,398	5,501
Carolina Regional Cancer Center	Horry	2	22,143	23,547	22,840
Carolina Regional Cancer Center - Conway	Horry	1	--	--	--
Carolina Regional Cancer Center - Murrels Inlet ***5***	Horry	1	--	--	--
Grand Strand Regional Medical Center ***6***	Horry	1	0	0	0
Tuomey	Sumter	2	9,204	9,065	7,841
Region IV					
SJC Oncology Services - SC	Beaufort	1	4,385	4,644	7,191
Bon Secours St. Francis Xavier ***2***	Charleston	1	**NR**	6,557	7,328
Beaufort Memorial Hospital	Beaufort	1	4,686	4,851	7,382
MUSC Medical Center	Charleston				
Linear Accelerators		5	19824	18871	19823
Gamma Knife		1	202	213	258
Roper Hospital	Charleston	3	14,209	8,270	6,905
Trident Medical Center	Charleston	3	11,724	11,239	12,493
Regional Medical Center of Orangeburg & Calhoun Counties	Orangeburg	2	6,761	5,739	5,607
	Totals		**263,483**	**259,829**	**228,545**

1 Facility not operational until April 2016.
2 Facility did not report required JAR data.
3 Gibbs Regional Cancer Center utilization included with Spartanburg Regional Medical Center.
4 CON SC-15-42 issued November 6, 2015 for relocation of an existing LINAC to a new facility.
5 CON SC-16-09 issued March 7, 2016 for relocation and replacement of an existing LINAC at a new center.
6 CON SC-16-10 issued March 7, 2016 for establishment of new radiation center attached to facility. Facility reported "0" utilization.
7 SC-12-19 not implemented and CON has expired. Facility will be removed from inventory.

RADIOTHERAPY
(Chapter 9)

Service Areas	2015 Population	# OF LINAC	Pop Per LINAC	Total Area Treatments	Planning Area Capacity	Percent Capacity
Anderson, Oconee	270405	3	90,135	17177	18,500	92.8%
Greenville, Pickens	613554	7	87,651	23481	53,500	43.9%
Cherokee, Spartanburg, Union	381273	6	63,546	22051	34,000	64.9%
Chester, Lancaster, York	369304	3	123,101	15854	21,000	75.5%
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	217666	2	108,833	7642	14,000	54.6%
Fairfield, Kershaw, Lexington, Newberry, Richland	813246	18	45,180	17743	124,000	14.3%
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	342940	5	68,588	12587	32,500	38.7%
Clarendon, Lee, Sumter	159151	2	79,576	7841	14,000	56.0%
Georgetown, Horry, Williamsburg	403032	6	67,172	28341	40,000	70.9%
Bamberg, Calhoun, Orangeburg	118869	2	59,435	5607	14,000	40.1%
Allendale, Beaufort, Hampton, Jasper	236895	2	118,448	14573	14,000	104.1%
Berkeley, Charleston, Colleton, Dorchester	782257	12	65,188	46807	56,500	82.8%
Aiken, Barnwell	187554	2	93,777	8841	14,000	63.2%
State Total	**4,896,146**	**70**	**69,945**	**228,545**	**450,000**	**50.8%**

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 fifteen (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	2015 # 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	3,942	464	4,406	1,469	
Upstate Endoscopy Center	Anderson		2	2		4,499	4,499		2,250
GHS Cross Creek Surgery Center	Greenville	4		4	4,690		4,690	1,173	
Endoscopy Center of the Upstate *	Greenville		3	3			0		0
Greenville Endoscopy Center	Greenville		3	3		6,063	6,063		2,021
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,373	6,373		2,124
GHS Patewood Outpatient Surgery Center	Greenville	6	2	8	6,525	2,352	8,877	1,088	1,176
Piedmont Surgery Center	Greenville	4		4	3,957		3,957	989	
Jervey Eye Center *	Greenville	3		3			0	0	
Upstate Surgery Center	Greenville	2		2	2,684		2,684	1,342	
Greenwood Endoscopy Center	Greenwood		4	4		8,835	8,835		2,209
Surgery Center of the Lakelands	Greenwood	5		5	4,199		4,199	840	
Surgery & Laser Center at Professional Park	Laurens	2		2	3,480		3,480	1,740	
Blue Ridge Surgery Center	Oconee	2		2	1,985		1,985	993	
Synergy Spine Center *	Oconee	2		2			0	0	
Ambulatory Surgery Center of Spartanburg	Spartanburg	7	2	9	7,053	3,413	10,466	1,008	1,707
Spartanburg Surgery Center	Spartanburg	4		4	4,644		4,644	1,161	
Surgery Center at Pelham	Spartanburg	4	2	6	2,234	1,144	3,378	559	572
GHS Surgery Center - Spartanburg *	Spartanburg	2		2			0	0	
Region II									
Ambulatory Surgical Center of Aiken *	Aiken	4	1	5			0	0	0
Carolina Ambulatory Surgery Center	Aiken	1		1	2,853		2,853	2,853	
Center for Colon & Digestive Diseases *	Aiken		2	2			0		0
Surgery Center at Edgewater	Lancaster	3	1	4	1,726	23	1,749	575	23
Chapin Orthopedic Surgery Center **1**	Lexington	2		2					
Midlands Endoscopy Center	Lexington		2	2	2643	2,571	5,214		2,607
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	4,550		4,550	1,138	
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,898		1,898	475	
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,829	731	3,560	707	731
South Carolina Endoscopy Center	Lexington		4	4		11,425	11,425		2,856
Urology Surgery Center *	Lexington	2		2			0	0	
Berkeley Endoscopy Center	Richland		2	2		1,353	1,353		677
Columbia Eye Surgery Center	Richland	4		4	6,349		6,349	1,587	
Columbia GI Endoscopy Center	Richland		4	4		4,297	4,297		1,074
Lake Murray Endoscopy Center	Richland		2	2		2,248	2,248		1,124
Midlands Orthopaedics Surgery Center	Richland	4		4	2,943		2,943	736	
Palmetto Endoscopy Suite	Richland		2	2		3,969	3,969		1,985
Palmetto Surgery Center	Richland	5		5	5,104		5,104	1,021	
South Carolina Endoscopy Center - Northeast	Richland		5	5		6,562	6,562		1,312
Carolina Colonoscopy Center *	Richland		2	2			0		0
Carolina Surgical Center	York	4		4	5,519		5,519	1,380	
Center for Orthopaedic Surgery	York	3		3	2,878		2,878	959	
York County Endoscopy Center	York		3	3		6,166	6,166		2,055
Region III									
Florence Surgery & Laser Center	Florence	2		2	4,067		4,067	2,034	
McLeod Ambulatory Surgery Center	Florence	2		2	1,815		1,815	908	
Physicians Surgical Center of Florence *	Florence	4	2	6			0	0	0
Bay Microsurgical Unit	Georgetown	1		1	5,069		5,069	5,069	
Carolina Coast Surgery Center	Georgetown	2		2	682		682	341	
Tidelands Georgetown Endoscopy Center	Georgetown		1	1		1,046	1,046		1,046
Tidelands Waccamaw Surgery Center	Georgetown	1		1	942		942	942	
Carolina Bone and Joint Surgery Center	Horry	3		3	2,859		2,859	953	
Grande Dunes Surgery Center *	Horry	3	1	4			0	0	0
Parkway Surgery Center	Horry	2		2	5,035		5,035	2,518	
Rivertown Surgery Center	Horry	3		3	512	441	953	318	
Strand GI Endoscopy Center	Horry		2	2		4,982	4,982		2,491
Wesmark Ambulatory Surgery Center	Sumter	2		2	6,169		6,169	3,085	
Region IV									
Bluffton Okatie Surgery Center	Beaufort	2			1,466	601	2,067	1,034	
Laser and Skin Surgery Center	Beaufort	2		2	1,548		1,548	774	
Outpatient Surgery Center of Hilton Head	Beaufort	3	2	5	3,796	3,200	6,996	1,265	1,600
Roper Hospital Ambulatory Surgery Berkeley	Berkeley	3		3	412	439	851	284	

AMBULATORY SURGERY FACILITY UTILIZATION
(Chapter 10)

		2015							
Facility by Region	**County**	**# of Ors**	**# of Endos**	**Total # of Suites**	**Total Operations**	**Total Endos**	**Combined Total**	**Operations per OR**	**Endos per Suite**
Center for Advanced Surgery *****	Charleston	2		2			0	0	
Charleston Endoscopy Center	Charleston		5	5		9,937	9,937		1,987
Charleston Surgery Center	Charleston	4	1	5	3,839	1,994	5,833	960	1,994
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2	179	340	519		260
Elms Endoscopy Center	Charleston		3	3		7,426	7,426		2,475
Lowcountry Ambulatory Center	Charleston	2		2	1,703		1,703	852	
MUSC Musculoskeletal Institute **2**	Charleston	2	2	4					
Palmetto Endoscopy Center	Charleston		2	2		4,844	4,844		2,422
Physicians Eye Surgery Center	Charleston	4		4	11,084		11,084	2,771	
Roper Hosp Ambulatory Surg & Pain Mgt James Island	Charleston	4		4	3,044		3,044	761	
Roper St. Francis Eye Center	Charleston	3		3	1,464		1,464	488	
Southeastern Spine Institute	Charleston	2		2	14,376		14,376	7,188	
Surgery Center of Charleston	Charleston	4		4	5,516		5,516	1,379	
Trident Ambulatory Surgery Center	Charleston	6		6	4,449	657	5,106	851	
MUSC Pediatric Ambulatory Sugery Center **3**	Charleston	4	1	5					
Colleton Ambulatory Surgery Center	Colleton	2	1	3	753		753	377	
Lowcountry Outpatient Surgery Center	Dorchester	3		3	7,065		7,065	2,355	
Summerville Endoscopy Center *****	Dorchester		2	2			0		0
	Totals	**171**	**79**	**248**	**172,529**	**108,395**	**280,924**	**1,009**	**1,372**

***** Facility did not report 2015 JAR.

1 CON SC-15-49 issued 12/23/15 for the construction of a general ASF with 2 ORs.

2 CON SC-17-31 issued 5/22/17 for the construction of a new ASF with 2 ORs.

3 CON-17-30 issued 5/22/17 for the construction of a new pediatric ASF with 4 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	Dorchester
Roper Hospital Diagnostics and ER - Berkeley	Roper St. Francis	Moncks Corner	Berkeley
Roper Hospital Diagnostics and ER - Northwoods ***1***	Roper St. Francis	North Charleston	Charelston
North Strand Medical Center	Grand Strand Medical Center	Myrtle Beach	Horry
Seacoast Medical Center	McLeod Loris	Little River	Horry
South Strand Ambulatory Care Center	Grand Strand Medical Center	Myrtle Beach	Horry
McLeod Health Carolina Forest Campus ***2***	McLeod Seacoast	Myrtle Beach	Horry
Carolina Forest Emergency ***3***	Grand Strand Medical Center	Myrtle Beach	Horry
Coastal Carolina Hospital ***4***	Coastal Carolina Hospital	Hardeeville	Jasper
Fort Mill Freestanding Emergency Department ***5***	Piedmont Medical Center	Fort Mill	York

1 Relocation approved November 15, 2016, in appeal
2 Approved January 23, 2017, in appeal
3 Approved January 23, 2017, in appeal
4 Approved January 23, 2017, in appeal
5 Approved April 11, 2015, in appeal

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 2017. 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 thirty (30) minutes' travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

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 2 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 (5) 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 (5) 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 sixty (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 paragraph 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 & Healthcare Center	60
Linley Park Rehab & Healthcare	88
NHC HealthCare of Anderson	290
Richard M. Campbell Veterans Nursing Home	220
Southern Oaks Rehab & Healthcare	88
Cherokee	
Blue Ridge in Brookview House	132
Peachtree Centre	111
Greenville	
Arboretum at the Woodlands	30
Brookdale Greenville	45
Brushy Creek Rehab & Healthcare	144
Fountain Inn Nursing Home	60
GHS Memorial Hospital Subacute Unit	15
Greenville Rehab & Healthcare	132
Greer Rehab & Healthcare	133
Heartland Health Care Center - East	132
Heartland Health Care Center - West	125
Linville Courts at the Cascades Verdae	44
Magnolia Manor - Greenville	99
Magnolia Place at Greenville	120
NHC HealthCare Greenville	176
NHC HealthCare Mauldin	180
Patewood Rehab & Healthcare	120
Poinsett Rehab & Healthcare	132
River Falls Rehab & Healthcare	44
Rolling Green Village Health Care	74
Simpsonville Rehab & Healthcare	132
Greenwood	
Greenwood Transitional Rehab Unit	12
Health Care Center of Wesley Commons ***1***	80
Magnolia Manor - Greenwood	88
NHC HealthCare Greenwood	152

LONG-TERM CARE INVENTORY
(Chapter 11)

Laurens	
GHS Laurens County Memorial Subacute	3
Martha Franks Baptist Retirement	88
NHC HealthCare Clinton	131
NHC HealthCare Laurens	176
Presbyterian Communities - Clinton	66
McCormick	
McCormick Rehab & Healthcare	120
Oconee	
GHS Lila Doyle	120
Seneca Health & Rehab	132
Pickens	
Brookdale Easley	60
Capstone Rehab & Healthcare	60
CARC Health Care Center ***2***	68
Fleetwood Rehab & Healthcare	103
Manna Rehab & Healthcare	130
Presbyterian Communities - 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 Rehab & Wellness	120
Rosecrest Rehab & Healthcare	75
Skyland Nursing and Rehabilitation Center	44
Spartanburg Hospital for Restorative Care	25
Summit Hills Skill Nursing	33
Valley Falls Terrace	88
White Oak Estates	88
White Oak Manor Spartanburg	192
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 Rehab & Healthcare ***3***	120
Azaleawoods Rehab & Nursing Center	86
NHC HealthCare N. Augusta	192
Pepper Hill Nursing & Rehab	132
PruittHealth Aiken	176
PruittHealth North Augusta	132
Barnwell	
Laurel Baye Healthcare of Blackville	85
Laurel Baye Healthcare of Williston	44
PruittHealth Barnwell	44
Chester	
Chester Nursing Center	100
Edgefield	
Ridge Rehab & Healthcare	120
Fairfield	
Blue Ridge in the Fields	112
PruittHealth Ridgeway	150
Kershaw	
KershawHealth Karesh Long Term Care	96
Springdale Healthcare	148
Lancaster	
Lancaster Convalescent Center	142
Transitional Care Unit at Springs Memorial	14
White Oak Manor Lancaster	132
Lexington	
Brian Center of Nursing Care - St. Andrews	108
Heritage at Lowman Rehab & Healthcare	176
Laurel Crest Retirement Center	12
Lexington Medical Center Extended Care	388
Millennium Post Acute Rehab	132
NHC HealthCare Lexington	170
Opus Post Acute Rehab	100
Presbyterian Communities - Columbia	44
SC Episcopal Home at Still Hope ***4***	70
Wellmore of Lexington ***5***	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 Rehab & Nursing	132
Life Care Center of Columbia	179
Midlands Health & Rehab	88
NHC HealthCare Parklane	180
Palmetto Health Rehab Center	22
PruittHealth Blythewood	120
PruittHealth Columbia	185
Rice Estate Rehab & Healthcare	80
White Oak Manor Columbia	120
Wildewood Downs Nursing & Rehab	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 & Rehab	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
Sunny Acres Nursing Home	111
Florence	
Commander Nursing Home	163
Dr. Ronald E McNair Nursing & Rehab	88
Faith Healthcare Center	104
Florence Rehab & Nursing Center	88
Heritage Home of Florence	132
Honorage Nursing Center	88
Lake City-Scranton Healthcare Center	88
Methodist Manor Healthcare Center	32
Presbyterian Communities - 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 Rehab	95
Conway Manor	190
Covenant Towers Health Care	30
Grand Strand Rehab & Nursing Center	88
Kingston Nursing Center	88
Loris Rehab & Nursing	88
Myrtle Beach Manor	60
NHC HealthCare Garden Center	148
Lee	
McCoy Memorial Nursing Center	120
Marion	
Mullins Nursing Center	92
Marlboro	
Dundee Manor	110
Sumter	
Blue Ridge of Sumter	96
Covenant Place Nursing Center	44
NHC HealthCare Sumter	138
Palmetto Health Tuomey Subacute	18
Sumter East Health & Rehab	176
Williamsburg	
Kingstree Nursing Facility	96

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Region IV

LONG-TERM CARE INVENTORY
(Chapter 11)

Allendale	
John Edward Harter Nursing Center	44
Bamberg	
Pruitthealth Bamberg	88
Beaufort	
Bayview Manor	170
Broad Creek Care Center	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 ***6***	65
Sprenger Healthcare of Bluffton ***7***	65
Berkeley	
Heartland Health & Rehab - Hanahan	135
Lake Moultrie Nursing Home	88
Pruitthealth Moncks Corner	132
Wellmore of Daniel Island ***8***	60
Calhoun	
Calhoun Convalescent Center	120
Charleston	
Bishop Gadsden Episcopal Health Care	50
Franke Health Care Center	44
Heartland of West Ashley Rehab & Nursing	125
John's Island Rehab & Healthcare	132
Life Care Center of Charleston	148
Mount Pleasant Manor	132
NHC HealthCare Charleston	132
Riverside Health & Rehab	160
Sandpiper Rehab & Nursing	176
Savannah Grace at the Palms of Mt. Pleasant ***9***	48
South Bay at Mount Pleasant ***10***	40
Vibra Hospital of Charleston - TCU	35
White Oak Manor Charleston	176
Colleton	
Pruitthealth Walterboro	132
Veterans Victory House	220

LONG-TERM CARE INVENTORY
(Chapter 11)

Dorchester	
Hallmark Healthcare Center	88
Oakbrook Health & Rehab	88
Presbyterian Communities - Summerville	87
St. George Healthcare Center	88
Hampton	
Pruitthealth Estill	104
Jasper	
Ridgeland Nursing Center	88
Orangeburg	
Jolley Acres Healthcare	60
Methodist Oaks	122
Pruitthealth Orangeburg	88
Riverside Rehab & Healthcare	113
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Statewide Total	**20,603**

1 CON SC-15-31 issued August 20, 2015 for construction of a replacement facility and reduction from 102 to 80 nursing home beds.

2 CON SC-15-17 issued April 29, 2015 for construction for the addition of 16 nursing home beds for a total of 68 nursing home beds.

3 CON SC-15-02 issued January 16, 2015 for construction for the addition of 60 nursing home beds for a total of 120 nursing home beds.

4 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.

5 CON SC-15-28 issued August 18, 2015 for the construction for a new 60 bed nursing home.

6 CON SC-16-06 issued February 22, 2016 for construction for a new 65 bed nursing home.

7 CON SC-17-19 issued April 13, 2017 for construction for a new 65 bed nursing home.

8 CON SC-15-43 issued November 20, 2015 for construction for a new 60 bed nursing home.

9 CON SC-16-15 issued April 8, 2016 for renovation for the addition of six nursing home beds for a total of 48 nursing home beds.

10 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	2019 Pop 65+ (000)	Bed Need (Pop x 39)	Existing Beds	Total # Beds to be Added
Region I				
Abbeville	5.52	215	94	121
Anderson	37.75	1,472	971	501
Cherokee	9.66	377	243	134
Greenville	84.61	3,300	1,937	1,363
Greenwood	13.23	516	332	184
Laurens	12.57	490	464	26
McCormick	3.28	128	120	8
Oconee	18.47	720	252	468
Pickens	21.11	823	509	314
Spartanburg	51.74	2,018	1,328	690
Union	5.70	222	201	21
Region I Total	**263.64**	**10,282**	**6,451**	**3,831**
Region II				
Aiken	34.56	1,348	838	510
Barnwell	3.9	152	173	(21)
Chester	6.12	239	100	139
Edgefield	5	195	120	75
Fairfield	4.73	184	262	(78)
Kershaw	12.23	477	244	233
Lancaster	21.24	828	288	540
Lexington	49.1	1,915	1,260	655
Newberry	7.88	307	264	43
Richland	56.37	2,198	1,784	414
Saluda	4.28	167	176	(9)
York	41.01	1,599	753	846
Region II Total	**246.42**	**9,610**	**6,262**	**3,348**
Region III				
Chesterfield	8.33	325	224	101
Clarendon	7.71	301	152	149
Darlington	12.85	501	418	83
Dillon	5.34	208	195	13
Florence	24.16	942	915	27
Georgetown	17.78	693	256	437
Horry	87.36	3,407	854	2,553
Lee	3.49	136	120	16
Marion	6.11	238	92	146
Marlboro	4.66	182	110	72
Sumter	17.96	700	472	228
Williamsburg	6.78	264	96	168
Region III Total	**202.53**	**7,899**	**3,904**	**3,995**
Region IV				
Allendale	1.82	71	44	27
Bamberg	2.99	117	88	29
Beaufort	54.24	2,115	643	1,472
Berkeley	33.41	1,303	415	888
Calhoun	3.51	137	120	17
Charleston	70.66	2,756	1,398	1,358
Colleton	8.11	316	352	(36)
Dorchester	22.51	878	351	527
Hampton	3.69	144	104	40
Jasper	7.31	285	88	197
Orangeburg	17.33	676	383	293
Region IV Total	**225.58**	**8,798**	**3,986**	**4,812**
Statewide Totals	**938.17**	**36,589**	**20,603**	**15,986**

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

SWING-BED PARTICIPANTS
(Chapter 11)

FACILITY	TOTAL BEDS	SWING BEDS	2015 ADMISSIONS	2015 PT DAYS	ADC
Abbeville Area Medical Center	25	25	65	719	1.97
Allendale County Hospital	25	25	76	2,051	5.62
Mcleod Health Cheraw ***1***	59	49	NR	NR	0.00
Edgefield County Hospital	25	25	130	209	0.57
Fairfield Memorial Hospital	25	25	66	495	1.36
Hampton Regional Medical Center	32	10	9	88	0.24
Carolinas Hospital System- Marion	124	10	13	98	0.27
McLeod Medical Center - Darlington	72	24	116	7,293	19.98
Newberry County Memorial Hospital	90	20	69	585	1.60
Union Medical Center	143	12	0	0	0.00
Williamsburg Regional Hospital	25	10	64	900	2.47

1 Facility did not report required JAR data.

INPATIENT HOSPICE FACILITIES
(Chapter 11)

Facility by Region	County	2015 Total Beds	2015 Admissions	2015 Patient Days	2015 % Occupancy Rate
Region I					
Callie & John Rainey Hospice House	Anderson	32	*633*	*6570*	56.3%
McCall Hospice House of Greenville	Greenville	30	777	6,035	55.1%
Hospice House of Hospicecare of the Piedmont	Greenwood	15	*478*	*2270*	41.5%
Hospice of Laurens County	Laurens	12	*102*	*933*	21.3%
GHS Cottingham Hospice House	Oconee	15	284	2,922	53.4%
Hospice House of the Carolina Foothills	Spartanburg	12	200	1,787	40.8%
Spartanburg Regional Hospice Home	Spartanburg	15	572	5,050	92.2%
Total		**131**	**3,046**	**25,567**	**53.5%**
Region II					
Agape House of Lexington ***1***	Lexington	30	--	--	--
Agape Hospice House of the Midlands	Richland	12	195	2,031	46.4%
Hospice & Community Care House	York	16	242	2,734	46.8%
Total		**28**	**437**	**4,765**	**46.6%**
Region III					
McLeod Hospice House	Florence	24	735	4,741	54.1%
Tidelands Community Hospice House	Georgetown	12	318	2,311	52.8%
Embrace Hospice House of the Grand Strand **2**	Horry	36	--	--	--
Total		**72**	**1,053**	**7,052**	**26.8%**
Region IV					
Agape House of Summerville **3**	Berkeley	30	--	--	--
Hospice Center of Hospice of Charleston	Charleston	20	780	3,440	47.1%
Total		**20**	**780**	**3,440**	**47.1%**
Statewide Total		**251**	**5,316**	**40,824**	**44.6%**

1 CON SC-15-13, issued March 30, 2015 for the construction of a 30-bed inpatient hospice.
2 CON SC-15-20, issued April 30, 2015 for the construction of a 36-bed inpatient hospice.
3 CON SC-16-07, issued February 16, 2016 for the construction of a 30-bed inpatient hospice.

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Advanced Home Care	Lancaster*, York*
Alere Womens & Childrens Health LLC - Midlands (May Serve Obstetrical Pattients Only)	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, Richland
Alere Womens & Childrens Health LLC - Piedmont (May Serve Obstetrical Pattients Only)	Abbeville, Allendale, Anderson, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenville, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Saluda, Spartanburg, Sumter, Union, Williamsburg, York
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*, Greenville, Greenwood, Laurens, Spartanburg*, Union*
Amedysis Home Health of Conway	Chesterfield*, 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

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Amedysis Home Health of Myrtle Beach	Horry
AnMed Health Home Health Agency	Anderson
Beaufort-Jasper Home Health Agency	Beaufort, Jasper
Bethea Home Health (May Serve Retirement Community Only)	Darlington
Brightstar Care	Lancaster*, York*
Brightstar Care Lowcountry	Beaufort*, Jasper*
Brightstar Care Upstate	Greenville*, Spartanburg*
Caring Neighbors Home Health	Fairfield
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
Florence Visiting Nurses Services	Dillon, Florence, Lee, Marion
Gentiva Health Services - Anderson	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union
Gentiva Health Services - Charleston	Berkeley, Charleston, Dorchester

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Gentiva Health Services - Coastal	Georgetown, Horry, Williamsburg
Gentiva Health Services - Columbia	Lexington, Richland
Gentiva Health Services - Greenville (May Only Serve Pattients in Union County with Initial Diag Requiring IV Therapy and/or Home Uterine Activity Monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union
Gentiva Health Services - Low Country	Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg
Gentiva Health Services - Midlands	Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York
Gentiva Health Services - Pee Dee	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg
Gentiva Health Services - Upstate	Cherokee, Chester, Union, York
GHS Home Health Agency	Greenville, Pickens
GHS Home Health Agency - Oconee	Anderson, 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 (May Only Serve Terminally Ill Patients in Saluda County)	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**
HomeChoice Partners (May Serve Pediatric Patients Only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York
Home Health Services of Self Regional Healthcare	Abbeville, Edgefield*, Greenwood, Laurens, McCormick, Newberry*, Saluda
Home Helpers of Bluffton	Beaufort*, Jasper*
Incare Home Health	Berkeley*, Charleston*, Chesterfield*, Darlington*, Dillon*, Florence*, Georgetown, Horry, Marion*, Marlboro*, Williamsburg*
Interim HealthCare	Beaufort, Berkeley*, Charleston*, Dorchester*
Interim HealthCare of Greenville Inc. Personal Care	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
Laurel Crest Home Health Agency (May Serve Retirement Community Only)	Lexington
Liberty Home Care - Aiken	Aiken
Liberty Home Care - Bennettsville	Marlboro
Liberty Home Care - Myrtle Beach	Horry
McLeod Home Health	Chesterfield*, Clarendon, Darlington, Dillon, Florence, Horry*, Lee, Marion, Marlboro* Sumter*
Methodist Manor Home Health (May Serve Retirement Community Only)	Florence

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Methodist Oaks Campus Home Health (May Serve Retirement Community Only)	Orangeburg
MUSC Health at Home by Bayada - Charleston	Charleston
Neighbors Care Home Health Agency an Amedisys Company	Cherokee*, Chester, Lancaster*, York*
NHC HomeCare - Aiken	Aiken, Barnwell*, Edgefield*, Orangeburg*
NHC HomeCare - Beaufort	Beaufort*, Colleton*, Jasper*, Hampton*
NHC HomeCare - Greenwood	Abbeville*, McCormick*, Greenwood, Newberry*, Saluda*
NHC HomeCare - Laurens	Anderson*, Greenville, Laurens, 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
Palliative Care of the Lowcountry (Restricted to Terminally Ill Residents)	Beaufort, Jasper
Palmetto Health HomeCare	Lexington, Richland
Presbyterian Communities of SC Home Health Agency (May Serve Retirement Communities Only)	Berkeley, Dorchester, Florence, Laurens, Lexington, Pickens

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
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*, Hapton*, Jasper*, Orangeburg*
PHC Home Health	Berkeley*, Charleston, Dorchester*
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 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
Tidewater Home Health, PA	Lexington*, Richland*

HOME HEALTH AGENCY INVENTORY
(Chapter 11)

Home Health Agency	**Counties Served**
Tri-County Home Health Care & Services	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*
Trinity Home Health of Aiken	Aiken, Barnwell, Edgefield
Palmetto Health Tuomey Home Health (May Only Serve Terminally Ill Patients In Lee & Clarendon Counties)	Clarendon, Lee, Sumter
University Home Health - North Augusta	Aiken, Edgefield
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton, Orangeburg
Wesley Commons Home Health Care (May Serve Retirement Community Only)	Greenwood
Westminster Towers Home Health (May Serve Retirement Community Only)	York

* Received CON in 2016-2017

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. 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

DRAFT 2017 State Health Plan

(Redline/Strikethrough Version)

2017-2018 Draft South Carolina Health Plan

Staff Change Log

Since the original draft of the 2017-2018 South Carolina Health Plan was published for public review on March 8, 2017, the following changes have been made by CON Program staff:

Chapter	Subsection	Original Draft Language	Change
Chapter III	Neonatal Services	a. 1.c. Generate the projected number of intensive care bassinets in a region by applying a constant of 4.0 bassinets per 1,000 live births to the projected birth rate.	a. Generate the projected number of intensive care bassinets in a region by applying a constant of **1.0** bassinets per 1,000 live births to the projected birth rate.
Chapter II	Estimated Population	4,774,839 for 2013	4,896,146 for 2015
Chapter II	Estimated Population	5,116,870 for 2020	5,288,470 for 2022
Chapter II	Inventory Dates	September 12, 2014	April 13, 2017
Chapter III	Obstetrical Services	...Healthy People 2020 national objective was 82.5%.	...Healthy People 2020 national objective was **83.7%.**

SOUTH CAROLINA HEALTH PLANNING COMMITTEE

MEMBER	**REPRESENTING**	**EXPIRATION**
Michael N. Bohan, M.D.	Provider	6/30/2018
Bradley W. Moorhouse	Provider	6/30/2016
Gayle L. Resetar	Provider	6/30/2015
Rajeev Vasudeva, MD	Provider	6/30/2018
Mary E. Phillips	Business (At-Large)	6/30/2016
Phyllis B. Buie	Finance/Business	6/30/2015
Ann M. McCraw	Finance/Business	6/30/2018
~~TBA~~ Vacant	Finance/Business	
W.H. “Ham” Hudson	Consumer	6/30/2015
~~Roger Leaks, Jr.~~ Vacant	Consumer	~~6/30/2015~~
Kurt E. Moore	Consumer	6/30/2018
Steve E. Nail	Consumer	6/30/2018
~~Matthew Aronson~~L. Becky Dover, Esq	Consumer Affairs (Ex-Officio)	
~~John O. Hutto~~Ann B. Kirol, ~~M.D.~~DDS	Board of Health and Environmental Control	

South Carolina Health Planning Committee
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CHAPTER I

INTRODUCTION

SOUTH CAROLINA HEALTH PLAN

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

CERTIFICATE OF NEED

The purpose of the Certificate of Need Program, as set forth in the *State Certification of Need and Health Facility Licensure Act* ("Certificate of Need Act"), is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State. To achieve these purposes, the Certificate of Need Act requires a person or health care facility to obtain a Certificate of Need from the Department before undertaking certain health care related projects. *See* §§ 44-7-120 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 non-profit nursing home ~~administrator~~) are equally represented. The Health Planning Committee reviews the South Carolina Health Plan and submits it to the Board of Health and Environmental Control for final revision and adoption. *See* § 44-7-180~~(A),(C)~~.

STATUTORY REQUIREMENTS

In accordance with § 44-7-180(B), this Plan contains (1) an *inventory* of existing health care facilities, beds, 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 ~~taken into consideration of~~ Certificate of Need applications for each

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type of facilit~~y~~~~ies~~, ~~beds,~~ service~~s~~ and equipment.

(1) INVENTORY

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

(2) PROJECTIONS OF NEED

Chapters III – XII 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 ~~both current and~~ projected need is calculated for most areas addressed by the Plan. ~~Charts summarizing these needs are located in Chapter XIII of this Plan.~~

(3) CERTIFICATE OF NEED STANDARDS

In consultation with the Health Planning Committee, the Department formulated these standards to guide ~~medical~~ 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.

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(2) The population data set forth in this Plan was received from the South Carolina Revenue and Fiscal Affairs Office in ~~February~~ April of 201~~5.~~7. 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~~s~~ and death~~s~~ data released each year, and adjustments will be made to the projected population results as appropriate.

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CHAPTER II

INVENTORY REGIONS AND SERVICE AREAS

INVENTORY REGIONS

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

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

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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~~ distance requirements.
- The need for long-term care and skilled nursing ~~home~~ service~~s~~ is projected by county.
- ~~Institutions serving a restricted population throughout the state are planned on a statewide basis.~~

SERVICE AREAS

In addition to inventory regions, this Plan designates service areas for certain Health Care Facilities and Health Services. ~~A~~ These service areas may be ~~is~~ comprised of one or more counties~~, and may cross multiple administrative, geographic, trade and/or political boundaries~~. ~~Due to factors that may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the State. Therefore, service~~ Service areas may ~~specifically~~ cross inventory regions. The need for a service is analyzed by ~~an~~ assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan, applicable statutes and regulations.

~~EXCEPTIONS TO SERVICE AREA STANDARDS~~ TRANSFER BETWEEN AFFILIATED FACILITIES

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

Given the ever-changing nature of the health care delivery system, affiliated ~~hospitals~~ facilities may ~~sometimes~~ want to transfer or exchange specific technologies or licensed beds in order to better meet an identified need. ~~Affiliated hospitals~~ Affiliated facilities are two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services~~; however, such transfers or exchanges could only occur between facilities within the same licensing category~~. *A Certificate of Need is required to transfer or exchange health services*. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

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

2. ~~Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department.~~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 and/or services must demonstrate the need for the additional capacity based on both historical and/or projected utilization patterns.

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

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

6. A written contract or agreement between the governing bodies of the ~~affected~~ affiliated facilities approving the transfer or exchange of beds and/or services must be included in the Certificate of Need process.

7. Each facility giving up ~~a~~ beds and/or services 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 4,896,146 for 2015 and projected population of 5,288,470 for 2022. All population data (county, planning area, and statewide) were provided by the South Carolina Revenue and Fiscal Affairs Office, Health and Demographics Section, in April 2017.

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 13, 2017. Inventory and utilization data set forth in this Plan is derived from the ~~2013~~ 2015 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.

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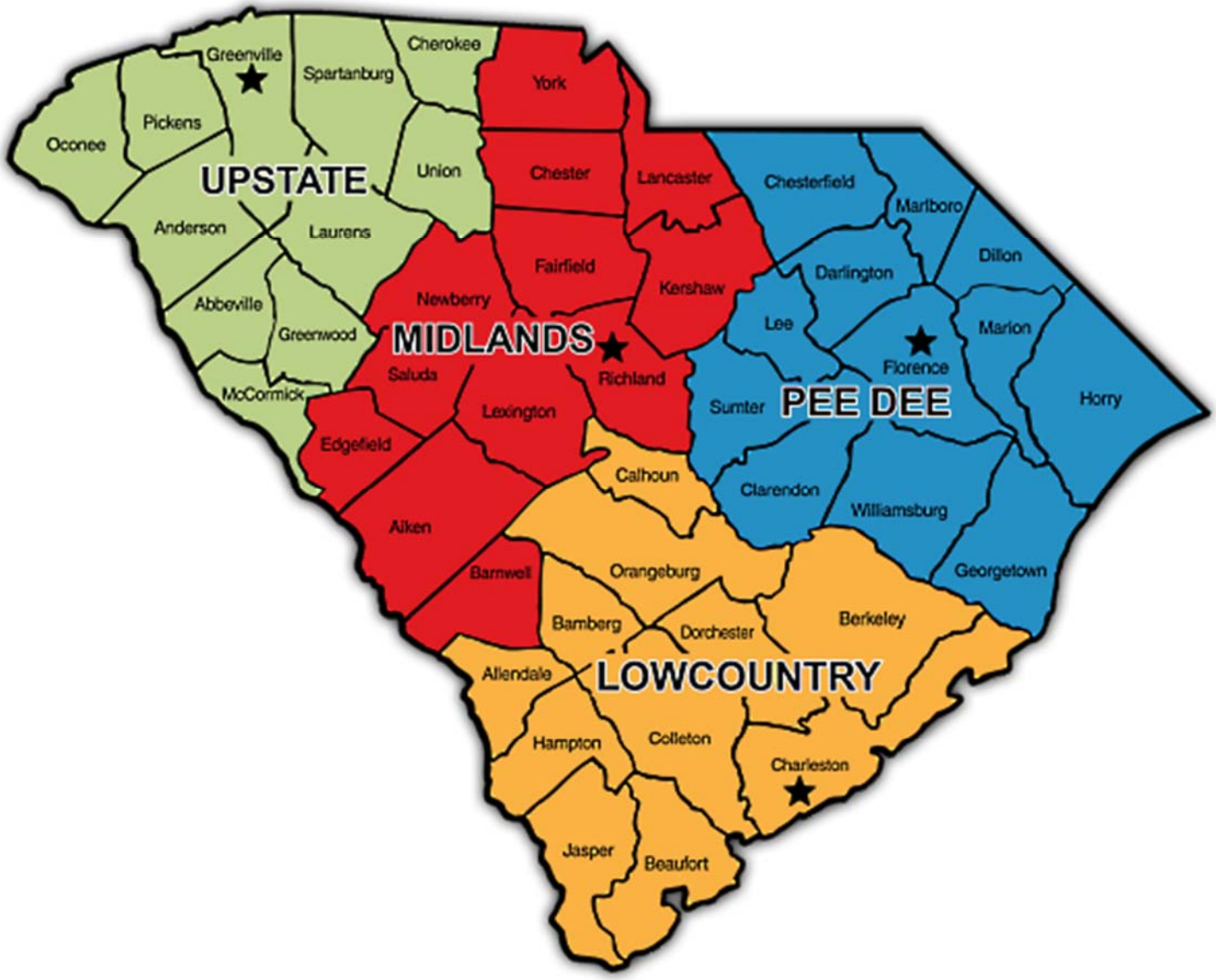
DHEC REGIONS MAP

(Chapter II)



CHAPTER III

ACUTE CARE HOSPITALS

GENERAL HOSPITALS

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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

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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. ~~For some hospitals, different age groups were used based on the data provided by the facility.~~

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

Availability

~~Many rural hospitals in South Carolina are struggling financially. Chesterfield General Hospital and Marlboro Park Hospital ceased operation in April of 2015. With the closings of these hospitals, residents of several South Carolina counties (~~Bamberg, Barnwell, Chesterfield, Lee, Marlboro, McCormick and Saluda~~)~~ counties no longer have ~~a~~ local hospitals ~~in their counties~~. 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 thirty (30) ~~minutes~~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~~, because of the differing occupancy factors used for individual facilities, then~~ and ~~summed~~ totaled by county ~~or service area~~ to ~~get~~ determine the overall ~~county/service area~~ bed need for that county service area.

2. For individual hospitals, ~~T~~the methodology for calculating ~~hospital~~ bed need is as

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follows:

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

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

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

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

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

3. If a ~~county or~~ service area indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the ~~county/~~service area indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.

4. If there is a need for additional hospital beds in the ~~county or~~ service area, then any entity may apply to add these beds within the service area~~county~~, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the ~~county/~~service area. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above~~,~~ must document the need for additional beds based on historical and projected utilization, ~~floor plan layouts,~~ projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

5. A facility may apply to create a new additional hospital at a different site within the same ~~county or~~ service area through the transfer of existing licensed beds, the projected bed need for the facility, or a combination of both existing beds and projected bed need~~s~~. The facility is not required to have a projected need for additional beds in order to create a new additional hospital. There is no required minimum number of beds in order to approve the CON application. The applicant must justify, through patient origin and other data, the need for a new hospital at the chosen site and the potential adverse impact a new hospital at the chosen site could have on the existing hospitals in the ~~county or~~ service area.

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

   a. A 24-hour emergency services department~~,~~ ~~and meet~~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 ~~which~~ that meets or exceeds other hospitals in the ~~county or~~ service area. The CMS Diagnostic Categories Chart is located in Chapter XIII of this Plan.

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

   a. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert ~~these~~ nursing home beds to general acute care hospital beds only within the hospital, provided the hospital can document an actual need for ~~these~~ 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 ~~general~~acute care hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert such ~~these specialty~~ beds to acute care hospital beds, regardless of the projected need

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for general acute care hospital beds~~.~~ ~~*provided A*~~*a Certificate of Need is* ~~*received*~~ *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. ~~Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital.~~ The ~~impacted~~ affected hospital must document ~~this~~ the increase in demand and explain why additional beds are needed to accommodate ~~the care of~~ patients previously served at ~~a~~ the f~~F~~ederal facility. ~~Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.~~

10. Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. *A proposal to transfer or exchange hospital beds requires a Certificate of Need* and must comply with the ~~following criteria~~provisions outlined in Chapter II, ~~Exceptions to Service Area Standards~~Transfer between Affiliated Facilities~~.~~:

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

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

~~c. Should the response to criterion b fail to demonstrate a history of residents of the county transferring the beds utilizing the receiving facility, the applicant must document why it is in the best interest of those residents to transfer the beds to a facility with no historical affinity for them;~~

~~d. The applicant must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impact must be detailed, along with the perceived benefits of such~~

~~an agreement;~~

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

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

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

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

11. Factors to be considered regarding modernization of facilities 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 ~~and status~~ within the service area.

The Hospital Bed Need Chart is located ~~in Chapter XIII of this Plan,~~at the end of this Chapter.

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RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

5. ~~Financial Feasibility~~Record of the Applicant;
6. Cost Containment; and
7. Adverse Effects on Other Facilities.

General hospital beds are typically located within approximately thirty (30) ~~minutes~~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~~s~~ may be either a freestanding facility~~,~~ or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional f~~F~~ederal criteria in order to qualify as a LTACH ~~Hospital~~ under the "hospital-within-a-hospital" model:

1. The new ~~hospital~~ 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 ~~hospital~~ 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 ~~hospital~~ LTACH must have a separate medical staff ~~from the medical staff of the host hospital,~~ 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 ~~Long-Term Acute Care Hospital~~LTACH must be in compliance with the relevant standards in Regulation 61-16 *(Minimum Standards for Licensing Hospitals and Institutional General Infirmaries).*

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2. Although LTACH~~Acute Care Hospital~~ beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for ~~Long-Term Acute Care Hospital~~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 ~~Long-Term Acute Care Hospital~~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 ~~(or its successor)~~ to the ~~Long-Term Acute Care Hospital~~LTACH shall be entitled to ~~obtain the rights to~~ the beds upon termination of the lease. *A Certificate of Need application is required*:

   a. A hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;

   b. A hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.

5. A hospital which seeks~~desires~~ to be designated as a~~n~~ LTACH, and has been awarded a CON for that purpose, must be certified as a~~n~~ 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.

~~5.~~ 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 ~~in Chapter XIII of this Plan~~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:

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

Long-Term Acute Care Hospital beds are located within approximately sixty (60) ~~minutes~~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.

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CRITICAL ACCESS HOSPITALS (CAH)

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~~Rural counties often encounter higher unemployment rates, a greater preponderance of low-paying jobs that do not provide health insurance, and a larger elderly population than found in more urban counties. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.~~

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. ~~Another program seeks to award funds up to $4 million to struggling rural hospitals (designated as "Advising Hospital") from a $40 million allocation in South Carolina Budget Proviso 33.33 for FY 2014/2015 known as the "Hospital Transformation Pool" although to date no such funds have been disbursed. Provisions in President Obama's FY 2016 Budget call for additional cuts to the funding of rural hospitals including either cuts in cost-based reimbursements to CAHs or the elimination of that designation.~~

~~The Department is in the process of considering changes to the requirements for hospitals operating in rural counties to allow for the development of a cost-effective facility with a free-standing emergency room, surgical facilities and a small number of acute care hospital beds.~~

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 following criteria must be met in order for a facility to qualify as a CAH:~~

1. It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989. A facility may be allowed to relocate or rebuild provided it meets the CMS criteria.

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

3. The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or must have been certified by the State prior to January 1, 2006 as being a necessary provider of health care services to residents of the area.

4. The maximum number of licensed beds is 25, which can be operated as any combination of acute or swing beds.

5. Required services include inpatient care, emergency care, laboratory and pharmacy.

6. Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes. CMS requires that any hospital, including a CAH, that does not have a physician on site 24 hours per day, 7 days per week, provide a notice to all patients upon admission that addresses how emergency services are provided when a physician is not on site.

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

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

In South Carolina, a hospital located in an urban Metropolitan Statistical Area (MSA) county can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

1. It is enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients.

2. It provides emergency health care services to indigent patients.

3. It maintains a 24-hour emergency room.

~~4. It staffs 50 or fewer acute care beds.~~

~~5. It is located in a county with 25% or more rural residents, as defined by the most recent Census.~~

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 ~~in Chapter XIII of this Plan~~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 II 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,

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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. 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. *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

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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 ~~in Chapter XIII of this Plan~~at the end of this Chapter.

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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 201~~3~~5, ~~80.4~~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 ~~82.5~~83.7%.

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Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 201~~3~~5 was ~~6.9~~7.0 infant deaths per 1,000 live births versus the national rate of 5.82~~6.0~~ infant deaths per 1,000 births in 201~~4~~2.

Neonatal mortality is the death rate for infants up to 28 days old. For 201~~3~~5, South Carolina's neonatal mortality rate for all races was 4.6 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 and Intermediate Bassinet Need Chart are located ~~in Chapter XIII of this Plan.~~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. ~~Financial Feasibility~~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 2013~~1~~-2015~~3~~ and the average population of women age 15-44 for 2013~~1~~-2015~~3~~ to generate an average birth rate.

    b. Multiply the average birth rate against the projected 2019~~7~~ population of

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women age 15-44 to project the number of births in 2019~~7~~.

c. ~~Calculate the average number of patient days per region by combining and then dividing the patient days for 2012 and 2013~~ Generate the projected number of intensive care bassinets in a region by applying a constant of 1.0 bassinets per 1,000 live births to the projected birth rate.

d. ~~Divide the projected 2017 births by the actual 2013 births to compute a growth rate in the number of births.~~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.

~~e. The average number of patient days for 2012-2013 is multiplied against the growth rate to project the number of patient days for 2017.~~

~~f. The projected number of patient days for 2017 is divided by a 65% occupancy factor to generate the projected number of NICU bassinets in a region.~~

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 ~~in Chapter XIII of this Plan~~at the end of this Chapter.

The addition of neonatal intermediate care bassinets does not require Certificate of Need review. ~~The need for intermediate neonatal bassinets is calculated based on the utilization of the individual providers using a 65% occupancy factor. Note that some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero, which decreases the need calculations.~~

~~South Carolina presently has 2.9 neonatal intensive care bassinets and 12 neonatal intermediate care bassinets per 1,000 births.~~

~~In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II 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~~

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~~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. ~~Financial Feasibility~~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 90 ~~minutes~~minutes' travel time for the majority of the population. ~~Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals.~~ The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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~~PEDIATRIC INPATIENT SERVICES~~

~~A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants. It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care. Pediatric beds are licensed as general hospital beds and no separate need is calculated for them.~~

~~CERTIFICATE OF NEED STANDARDS~~

1. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds.

2. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of this existing service.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following criteria are considered 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. Distribution (Accessibility);
3. Acceptability;
4. Financial Feasibility; and
5. Adverse Effects on Other Facilities.

PEDIATRIC LONG-TERM ACUTE CARE HOSPITALS

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Pediatric Long-Term Acute Care Hospitals (PLTACHs) are specialized health care facilities that provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis (similar to adult LTACHs). Care may be rehabilitative or palliative. These facilities are designed to be as non-institutional as possible while meeting the psychological, physical, and emotional needs of chronically ill children and their families. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services.

Patients often have three or more chronic conditions. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

Despite the need for Pediatric LTACH services, the State has no such facility at this time. Candidates are currently either staying for extended periods in one of the State's Children's Hospitals or are receiving daily therapy in their own homes. The establishment of a Pediatric LTACH would provide an important treatment option for these children.

Pediatric LTACH facilities are currently located primarily in the Northeast and California. They are potentially a less costly alternative to maintaining these children in an acute care facility. Some states have nursing homes that specialize in extended care for pediatric patients, but there are currently no such facilities in South Carolina.

CERTIFICATE OF NEED STANDARDS

1. An application for a Pediatric Long-Term Acute Care Hospital must be in compliance with the relevant standards in the Department's Regulation 61-16.

2. Although Pediatric Long-Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of PLTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Pediatric Long-Term Acute Care Hospital beds. An applicant must document the need for PLTACH beds.

4. An applicant for PLTACH beds must submit an affiliation agreement with one of the State's children's hospitals. This affiliation agreement will at a minimum include a transfer agreement and coverage for specialized medical services.

5. Should a hospital lease general beds to another entity to create a Pediatric Long-Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long-Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. *A Certificate of Need application is required.*

6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Once licensed, a Pediatric LTACH must remain licensed as such. Should the facility attempt to provide care that is inconsistent with this requirement or patient demand or other economic conditions require the facility to close, the Certificate of Need issued to that hospital for that purpose shall be revoked. The entity that has had its Certificate of Need revoked shall not have the authority to operate as a general acute care hospital and the licensed beds operated by the facility will be removed from the bed inventory.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

There are currently no Pediatric Long-Term Acute Care Hospital beds in South Carolina. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

CMS DIAGNOSTIC CATEGORIES
(Chapter III)

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 III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Region I										
Abbeville Area Medical Center	<18	5332	4930	15	0					
	18-64	14627	13270	451	1					
	+65	4973	5860	1621	5					
	TOTAL	24932	24060	2087	**6**	**65%**	**10**	**25**	**-15**	**22.87%**
Abbeville County Total							**10**	**25**	**-15**	
AnMed Health Medical Center	<18	45054	44870	4586	13					
	18-64	115809	118750	32824	92					
	+65	33829	40780	41805	138					
	TOTAL	**194,692**	**204,400**	**79,215**	**243**	**75%**	**324**	**423**	**-99**	**51.31%**
AnMed Health Women's and Children's Hospital	<18	45054	44870	787	2					
	18-64	115809	118750	5432	15					
	+65	33829	40780	1086	4					
	TOTAL	**194,692**	**204,400**	**7,305**	**21**	**65%**	**33**	**72**	**-39**	**27.80%**
Anderson County Total							**357**	**495**	**-138**	
Gaffney Medical Center/Novant Health ***1***	<18	13378	13070		0					
(Upstate Carolina Medical Center)	18-64	34082	33600		--					
	+65	8734	10260		--					
	TOTAL	**56,194**	**56,930**	**9,107**	**25**	**65%**	**39**	**125**	**-86**	**19.96%**
Cherokee County Total							**39**	**125**	**-86**	
Greenville Memorial Medical Center ***1***	<18	115082	122900		0					
	18-64	305057	332480		0					
	+65	71724	95000		0					
	TOTAL	**491,863**	**550,380**	**172,204**	**528**	**75%**	**704**	**746**	**-42**	**63.24%**
Greer Memorial Hospital (GHS)	<18	115082	122900	134	0					
	18-64	305057	332480	6264	19					
	+65	71724	95000	4592	17					
	TOTAL	**491,863**	**550,380**	**10,990**	**38**	**65%**	**59**	**82**	**-23**	**36.72%**
Hillcrest Memorial Hospital (GHS)	<18	115082	122900	6	0					
	18-64	305057	332480	3661	11					
	+65	71724	95000	2543	9					
	TOTAL	**491,863**	**550,380**	**6,210**	**20**	**65%**	**32**	**43**	**-11**	**39.57%**
Patewood Memorial Hospital (GHS)	<18	115082	122900	1	0					
	18-64	305057	332480	1090	3					
	+65	71724	95000	1265	5					
	TOTAL	**491,863**	**550,380**	**2,356**	**8**	**65%**	**13**	**72**	**-59**	**8.96%**
Saint Francis - Downtown & Saint Francis - Millenium	<18	115082	122900	47	0					
	18-64	305057	332480	21508	64					
	+65	71724	95000	32636	118					
	TOTAL	**491,863**	**550,380**	**54,191**	**183**	**70%**	**262**	**226**	**36**	**65.69%**
Saint Francis - Eastside	<18	115082	122900	87	0					
	18-64	305057	332480	10701	32					
	+65	71724	95000	6827	25					
	TOTAL	**491,863**	**550,380**	**17,615**	**57**	**65%**	**88**	**93**	**-5**	**51.89%**
Greenville County Total							**1,158**	**1,262**	**-104**	
Self Regional Healthcare	<18	16127	15820	707	2					
	18-64	41616	39630	23439	61					
	+65	12095	14010	26077	83					
	TOTAL	**69,838**	**69,460**	**50,223**	**146**	**70%**	**209**	**326**	**-117**	**42.21%**
Greenwood County Total							**209**	**326**	**-117**	

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Laurens County Memorial Hospital (GHS) ***1***	<18	14781	14280		0					
	18-64	40410	38640		0					
	+65	11432	13340		0					
	TOTAL	**66,623**	**66,260**	**10,754**	**29**	**65%**	**46**	**76**	**-30**	**38.77%**
Laurens County Total							**46**	**76**	**-30**	
Oconee Memorial Hospital (GHS)	<18	15209	14540	1132	3					
	18-64	43859	42760	9468	25					
	+65	16645	19800	14267	46					
	TOTAL	**75,713**	**77,100**	**24,867**	**75**	**65%**	**116**	**169**	**-53**	**40.31%**
Oconee County Total							**116**	**169**	**-53**	
Baptist Easley Hospital	<18	23855	26370		0					
(Palmetto Baptist Medical Center - Easley)	18-64	78931	75000	6819	18					
	+65	18905	22760	8403	28					
	TOTAL	**121,691**	**124,130**	**15,222**	**45**	**65%**	**70**	**109**	**-39**	**38.26%**
Cannon Memorial Hospital ***2***	<18	23855	26370		0					
(AnMed Health Cannon)	18-64	78931	75000		0					
	+65	18905	22760		0					
	TOTAL	**121,691**	**124,130**	**3,631**	**10**	**65%**	**16**	**55**	**-39**	**18.09%**
Pickens County Total							**86**	**164**	**-78**	
Mary Black Memorial Hospital	<18	69835	71550	262	1					
	18-64	181834	187240	11468	32					
	+65	45633	56090	10472	35					
	TOTAL	**297,302**	**314,880**	**22,202**	**68**	**65%**	**106**	**174**	**-68**	**34.96%**
Spartanburg Medical Center ***1***	<18	69835	71550	2135	6					
	18-64	181834	187240	75692	214					
	+65	45633	56090	64463	217					
	TOTAL	**297,302**	**314,880**	**142,290**	**437**	**75%**	**583**	**484**	**99**	**80.54%**
				10118						
Pelham Medical Center (Village Hospital) ***1***	<18	69835	71550		0					
	18-64	181834	187240		0					
	+65	45633	56090		0					
	TOTAL	**297,302**	**314,880**	9,379	**27**	**65%**	**42**	**48**	**-6**	**53.53%**
Spartanburg County Total							**731**	**706**	**25**	
Union Medical Center ***1***	<18	5990	5340		0					
	18-64	16480	14740		0					
	+65	5307	5960		0					
	TOTAL	**27,777**	**26,040**	**6,034**	**15**	**65%**	**24**	**143**	**-119**	**11.56%**
Union County Total							**24**	**143**	**-119**	
Region II										
Aiken Regional Medical Center ***3***	<18	36383	35570	426	1					
	18-64	99461	99060	18141	50					
	+65	29985	37980	21129	73					
	TOTAL	**165,829**	**172,610**	**39,696**	**124**	**70%**	**178**	**197**	**-19**	**55.21%**
Aiken County Total								**197**	**-19**	
Southern Palmetto Hospital ***4***	<18	5,554	5,370							
(Barnwell County Hospital)	18-64	13,140	11,830							
	+65	3,425	3,980							
	TOTAL	**22,119**	**21,180**	**9,125**	**16**	**65%**	**25**	**0**	**25**	**0.00%**
Barnwell County Total							**25**	**0**	**25**	

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Chester Regional Medical Center	<18	7397	6880	77	0					
	18-64	19340	17480	1572	4					
	+65	5530	6510	1541	5					
	TOTAL	**32,267**	**30,870**	**3,190**	**9**	**65%**	**14**	**82**	**-68**	**10.66%**
Chester County Total							**14**	**82**	**-68**	
Edgefield County Hospital	<18	5036	4250	1	0					
	18-64	17084	15940	123	0					
	+65	4394	5410	392	1					
	TOTAL	**26,514**	**25,600**	**516**	**4**	**65%**	**7**	**25**	**-18**	**5.65%**
Edgefield County Total							**7**	**25**	**-18**	
Fairfield Memorial Hospital	<18	4634	3830	3	0					
	18-64	13900	12110	119	0					
	+65	4213	5090	222	1					
	TOTAL	**22,747**	**21,030**	**344**	**1**	**65%**	**2**	**25**	**-23**	**3.77%**
Fairfield County Total							**2**	**25**	**-23**	
Kershaw County Medical Center ***2***	<18	14,867	14,640		0					
(Kershaw Health)	18-64	37,676	37,800		0					
	+65	9,973	12,590		0					
	TOTAL	**62,516**	**65,030**		**0**	**65%**	**0**	**121**	**-121**	**0.00%**
Kershaw County Total							**0**	**121**	**-121**	
Springs Memorial Hospital ***1***	<18	18749	19580							
	18-64	50359	55790							
	+65	16734	24810							
	TOTAL	**85,842**	**100,180**	22,925	**73**	**70%**	**105**	**199**	**-94**	**31.56%**
Lancaster County Total							**105**	**199**	**-94**	
Lexington Medical Center ***5***	<18	66209	66910	223	1					
	18-64	174401	185810	64183	187					
	+65	41223	55370	60486	223					
	TOTAL	**281,833**	**308,090**	**124,892**	**411**	**75%**	**548**	**485**	**63**	**70.55%**
Lexington County Total							**548**	**485**	**63**	
Newberry County Memorial Hospital	<18	8378	8210	113	0					
	18-64	22648	21850	3004	8					
	+65	6986	8460	4244	14					
	TOTAL	**38,012**	**38,520**	**7,361**	**22**	**65%**	**35**	**90**	**-55**	**22.41%**
Newberry County Total							**35**	**90**	**-55**	
Palmetto Health Baptist Parkridge	<18	88453	96860	1255	4					
	18-64	271087	281250	7215	21					
	+65	47511	63010	7186	26					
	TOTAL	**407,051**	**441,120**	**15,656**	**46**	**65%**	**72**	**76**	**-76**	**56.44%**
Palmetto Health Baptist	<18	88453	96860	13536	41					
	18-64	271087	281250	30251	86					
	+65	47511	63010	26425	96					
	TOTAL	**407,051**	**441,120**	**69,291**	**206**	**70%**	**294**	**287**	**7**	**66.15%**
Palmetto Health Richland	<18	88453	96860	37913	114					
	18-64	271087	281250	81421	231					
	+65	47511	63010	48509	176					
	TOTAL	**407,051**	**441,120**	**167,843**	**521**	**75%**	**696**	**579**	**117**	**79.42%**
Providence Hospital	<18	88453	96860	11	0					
	18-64	271087	281250	15827	45					
	+65	47511	63010	24080	87					
	TOTAL	**407,051**	**441,120**	**39,918**	**133**	**70%**	**190**	**258**	**-68**	**42.39%**

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Providence Hospital Northeast	<18	88453	96860	18	0					
	18-64	271087	281250	2193	6					
	+65	47511	63010	3116	11					
	TOTAL	**407,051**	**441,120**	**7,614**	**18**	**65%**	**28**	**74**	**-46**	**28.19%**
Richland County Total							**1,280**	**1,274**	**-66**	
Piedmont Medical Center ***6***	<18	61836	65930	1060	3					
	18-64	155706	175120	29476	91					
	+65	33653	47100	26179	100					
	TOTAL	**251,195**	**288,150**	**56,715**	**194**	**70%**	**278**	**268**	**10**	**57.98%**
Fort Mill Medical Center ***6***								**100**		
York County Total							**278**	**368**	**-90**	
Region III										
McLeod Health Cheraw	<18	10586	9690	19	0					
(Chesterfield General Hospital)	18-64	27903	26100	842	2					
	+65	7528	8850	769	2					
	TOTAL	**46,017**	**44,640**	**1,630**	**5**	**65%**	**8**	**59**	**-51**	**7.57%**
Chesterfield County Total							**8**	**59**	**-51**	
McLeod Health Clarendon	<18	6891	6010	69	0					
(Clarendon Memorial Hospital)	18-64	19893	17660	4605	11					
	+65	6991	8140	5419	17					
	TOTAL	**33,775**	**31,810**	**10,093**	**29**	**65%**	**45**	**81**	**-36**	**34.14%**
Clarendon County Total							**45**	**81**	**-36**	
Carolina Pines Regional	<18	15405	14200	1822	5					
	18-64	40608	37730	6867	17					
	+65	11535	13620	6839	22					
	TOTAL	**67,548**	**65,550**	**15,528**	**44**	**65%**	**69**	**116**	**-47**	**36.67%**
McLeod Medical Center - Darlington	<18	15405	14200	0	0					
	18-64	40608	37730	217	1					
	+65	11535	13620	328	1					
	TOTAL	**67,548**	**65,550**	**545**	**3**	**65%**	**5**	**49**	**-44**	**3.05%**
Darlington County Total							**74**	**165**	**-91**	
McLeod Medical Center - Dillon	<18	8060	7530	525	1					
	18-64	18348	16750	4634	12					
	+65	4826	5680	3265	11					
	TOTAL	**31,234**	**29,960**	**8,424**	**23**	**65%**	**37**	**79**	**-42**	**29.21%**
Dillon County Total							**37**	**79**	**-42**	
Carolinas Hospital System	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	54320	151	**70%**	**216**	**310**	**-94**	**48.01%**
Women's Center - Carolinas Hospital System	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	2,491	7	**65%**	**11**	**20**	**-9**	**34.12%**
Lake City Community Hospital	<18	33464	32770		0					
	18-64	83923	81910		0					
	+65	21513	25870		0					
	TOTAL	**138,900**	**140,550**	4,007	11	**65%**	**18**	**48**	**-30**	**22.87%**
McLeod Regional Medical Center ***7***	<18	33464	32770	3938	11					
	18-64	83923	81910	67808	181					
	+65	21513	25870	59492	196					
	TOTAL	**138,900**	**140,550**	**131,238**	**388**	**75%**	**518**	**461**	**57**	**77.99%**
Florence County Total							**763**	**839**	**-76**	

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Tidelands Georgetown Memorial Hospital	<18	12107	10870	189	0					
	18-64	33924	32090	7950	21					
	+65	15267	19350	8661	30					
	TOTAL	**61,298**	**62,310**	**16,800**	**51**	**65%**	**79**	**131**	**-52**	**35.14%**
Tidelands Waccamaw Community Hospital	<18	12107	10870	225	1					
	18-64	33924	32090	10013	26					
	+65	15267	19350	17628	61					
	TOTAL	**61,298**	**62,310**	**27,866**	**88**	**65%**	**135**	**124**	**11**	**61.57%**
Georgetown County Total							**214**	**255**	**-41**	
Conway Hospital	<18	58904	63740	3612	11					
	18-64	184214	205840	15761	48					
	+65	66081	105690	13463	59					
	TOTAL	**309,199**	**375,270**	**32,836**	**118**	**70%**	**169**	**210**	**-41**	**42.84%**
Grand Strand Medical Center ***8***	<18	58904	63740	1174	3					
	18-64	184214	205840	38020	116					
	+65	66081	105690	43033	189					
	TOTAL	**309,199**	**375,270**	**82,227**	**308**	**70%**	**441**	**325**	**116**	**69.32%**
McLeod Loris (Loris Community Hospital) ***9***	<18	58904	63740	219	1					
	18-64	184214	205840	4230	13					
	+65	66081	105690	4762	21					
	TOTAL	**309,199**	**375,270**	**9,211**	**34**	**65%**	**54**	**50**	**4**	**50.47%**
McLeod Seacoast (Seacoast Medical Center) ***9***	<18	58904	63740	31	0					
	18-64	184214	205840	3138	10					
	+65	66081	105690	6088	27					
	TOTAL	**309,199**	**375,270**	**9,257**	**36**	**65%**	**56**	**105**	**-49**	**24.15%**
Horry County Total							**664**	**585**	**79**	
Carolinas Hospital System - Marion	<18	7473	6870	3229	8					
(Marion County Medical Center)	18-64	18657	16570	3230	8					
	+65	5617	6320	3328	10					
	TOTAL	**31,747**	**29,760**	**9,787**	**26**	**65%**	**41**	**124**	**-83**	**21.62%**
Marion County Total							**41**	**124**	**-83**	
Marlboro Park Hospital ***4***	<18	5,766	5,100	0	0					
	18-64	18,097	16,530		0					
	+65	4,140	4,730		0					
	TOTAL	**28,003**	**26,360**	**9,125**	**16**	**65%**	**25**	**0**	**25**	**0.00%**
Marlboro County Total							**25**	**0**	**25**	
Palmetto Health Tuomey	<18	26388	25270		0					
	18-64	64991	62120	26055	68					
	+65	16101	19360	25033	82					
	TOTAL	**107,480**	**106,750**	**51,088**	**151**	**70%**	**216**	**283**	**-67**	**49.46%**
Sumter County Total							**216**	**283**	**-67**	
Williamsburg Regional Hospital ***2***	<18	7,271	6,300		0					
	18-64	20,162	17,270		0					
	+65	5,634	6,690		0					
	TOTAL	**33,067**	**30,260**	**0**	**0**	**65%**	**0**	**25**	**-25**	**0.00%**
Williamsburg County Total							**0**	**25**	**-25**	
Region IV										
Allendale County Hospital ***2***	<18			0	0					
	18-64			0	0					
	+65			0	0					
	TOTAL	**0**	**0**	**0**	**0**	**65%**	**0**	**25**	**-25**	**0.00%**
Allendale County Total							**0**	**25**	**-25**	
Beaufort Memorial Hospital	<18	35395	36880		0					
	18-64	99620	106450		0					
	+65	44574	61540		0					
	TOTAL	**179,589**	**204,870**	39,898	125	**65%**	**192**	**169**	**23**	**64.68%**

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Hilton Head Hospital	<18	35395	36880	117	0					
	18-64	99620	106450	7558	22					
	+65	44574	61540	14803	56					
	TOTAL	**179,589**	**204,870**	**22,478**	**78**	**65%**	**121**	**93**	**28**	**66.22%**
Beaufort County Total							**313**	**262**	**51**	
Trident Medical Center & Berkeley	<18	166114	180030		0					
Medical Center ***10***	18-64	476343	535390		0					
	+65	102069	146830		0					
	TOTAL	**744,526**	**862,250**	**71,955**	228	**70%**	**327**	**296**	**31**	**66.60%**
Summerville Medical Center ***11***	<18	166114	180030	2028	6					
	18-64	476343	535390	11593	36					
	+65	102069	146830	8513	34					
	TOTAL	**744,526**	**862,250**	**22,134**	**75**	**65%**	**116**	**94**	**22**	**64.51%**
MUSC Medical Center ***12***	<18	166114	180030	28399	84					
	18-64	476343	535390	105594	325					
	+65	102069	146830	48814	192					
	TOTAL	**744,526**	**862,250**	**182,807**	**602**	**75%**	**803**	**656**	**147**	**76.35%**
Mount Pleasant Hospital	<18	166114	180030	8	0					
	18-64	476343	535390	2645	8					
	+65	102069	146830	2400	9					
	TOTAL	**744,526**	**862,250**	**5,053**	**18**	**65%**	**28**	**85**	**-57**	**16.29%**
Roper Hospital ***13***	<18	166114	180030	13	0					
	18-64	476343	535390	22148	68					
	+65	102069	146830	34258	135					
	TOTAL	**744,526**	**862,250**	**56,419**	**203**	**70%**	**291**	**316**	**-25**	**48.92%**
Bon Secours - Saint Francis Xavier	<18	166114	180030	92	0					
	18-64	476343	535390	19206	59					
	+65	102069	146830	12379	49					
	TOTAL	**744,526**	**862,250**	**31,677**	**108**	**70%**	**155**	**204**	**-49**	**42.54%**
East Cooper Regional Medical Center	<18	166114	180030	19	0					
	18-64	476343	535390	8607	27					
	+65	102069	146830	5979	24					
	TOTAL	**744,526**	**862,250**	**14,605**	**50**	**65%**	**78**	**130**	**-52**	**30.78%**
Berkeley / Charleston / Dorchester County Total							**1,798**	**1,781**	**17**	
Colleton Medical Center	<18	8550	7680	825	2					
	18-64	21940	19620	8326	20					
	+65	7241	8630	8640	28					
	TOTAL	**37,731**	**35,930**	**17,791**	**51**	**65%**	**78**	**102**	**-24**	**47.79%**
Colleton County Total							**78**	**102**	**-24**	
Hampton Regional Medical Center	<18	4447	3830	10	0					
	18-64	12266	10850	1033	3					
	+65	3336	3910	1512	5					
	TOTAL	**20,049**	**18,590**	**2,555**	6	**65%**	**10**	**32**	**-22**	**21.88%**
Hampton County Total							**10**	**32**	**-22**	
Coastal Carolina Medical Center	<18	5922	5660	20	0					
	18-64	17158	18410	3921	12					
	+65	4744	9900	4804	27					
	TOTAL	**27,824**	**33,970**	**8,745**	**39**	**65%**	**61**	**41**	**20**	**58.44%**
Jasper County Total							**61**	**41**	**20**	

GENERAL BED NEED*
(Chapter III)

Facility by Region and County	Age Cat	2015 Pop	2022 Pop	2015 Pt Days	Proj ADC	Variable Rate Factor	Bed Need	Existing Beds	To Be Added / Excess	2015 % Occup Rate
Regional Medical Center of Orangeburg /	<18	23030	21720		0					
Calhoun Counties ***1***	18-64	62137	54260		0					
	+65	18822	21980		0					
	TOTAL	**103,989**	**97,960**	**44,741**	**115**	**70%**	**165**	**247**	**-82**	**49.63%**
Orangeburg / Calhoun County Total							**165**	**247**	**-82**	

* 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 2015 JAR.

3 SC-16-17 issued 3/2/2017 for the addition of 14 acute care beds.

4 Facility is closed. Bed need is based minimally on CAH bed count requirement.

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

6 Pending resolution of an appeal, Piedmont proposes constructing a 100-bed hospital in Fort Mill using a combination of new and transferred hospital beds.

7 SC-16-42 issued 8/11/2016 for addition of 8 acute care 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-14-07 issued 10/27/2014 for addition of 30 acute care beds.

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

13 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.

LONG-TERM ACUTE CARE HOSPITALS
(Chapter III)

		2013			2014			2015		
Facility By Region	**County**	**Beds**	**Pt Days**	**Occupancy Rate**	**Beds**	**Pt Days**	**Occupancy Rate**	**Beds**	**Pt Days**	**Occupancy Rate**
Region I										
North Greenville Long-Term Acute	Greenville	45	7,626	46.4%	45	7,758	47.2%	45	7,841	47.7%
Regency Hospital of Greenville	Greenville	32	10,467	89.6%	32	9,960	85.3%	32	9,607	82.3%
Spartanburg Hospital Restorative for Care	Spartanburg	97	11,365	32.1%	97	10,892	30.8%	97	10,118	28.6%
Region II										
Intermedical Hospital of SC ***1***	Richland	35	6,966	54.5%	35		0.0%	35		0.0%
Region III										
Regency Hospital of South Carolina	Florence	40	11,986	82.1%	40	12,527	85.8%	40	12,946	88.7%
Region IV										
Vibra Hospital of Charleston ***1***	Charleston	59	5,161	24.0%	59	15,883	73.8%	59		0.0%

1 Facility missing required JAR data.

CRITICAL ACCESS HOSPITALS*
(Chapter III)

Facility by Region

Region I
Abbeville Memorial Hospital

Region II
Edgefield County Hospital
Fairfield Memorial Hospital

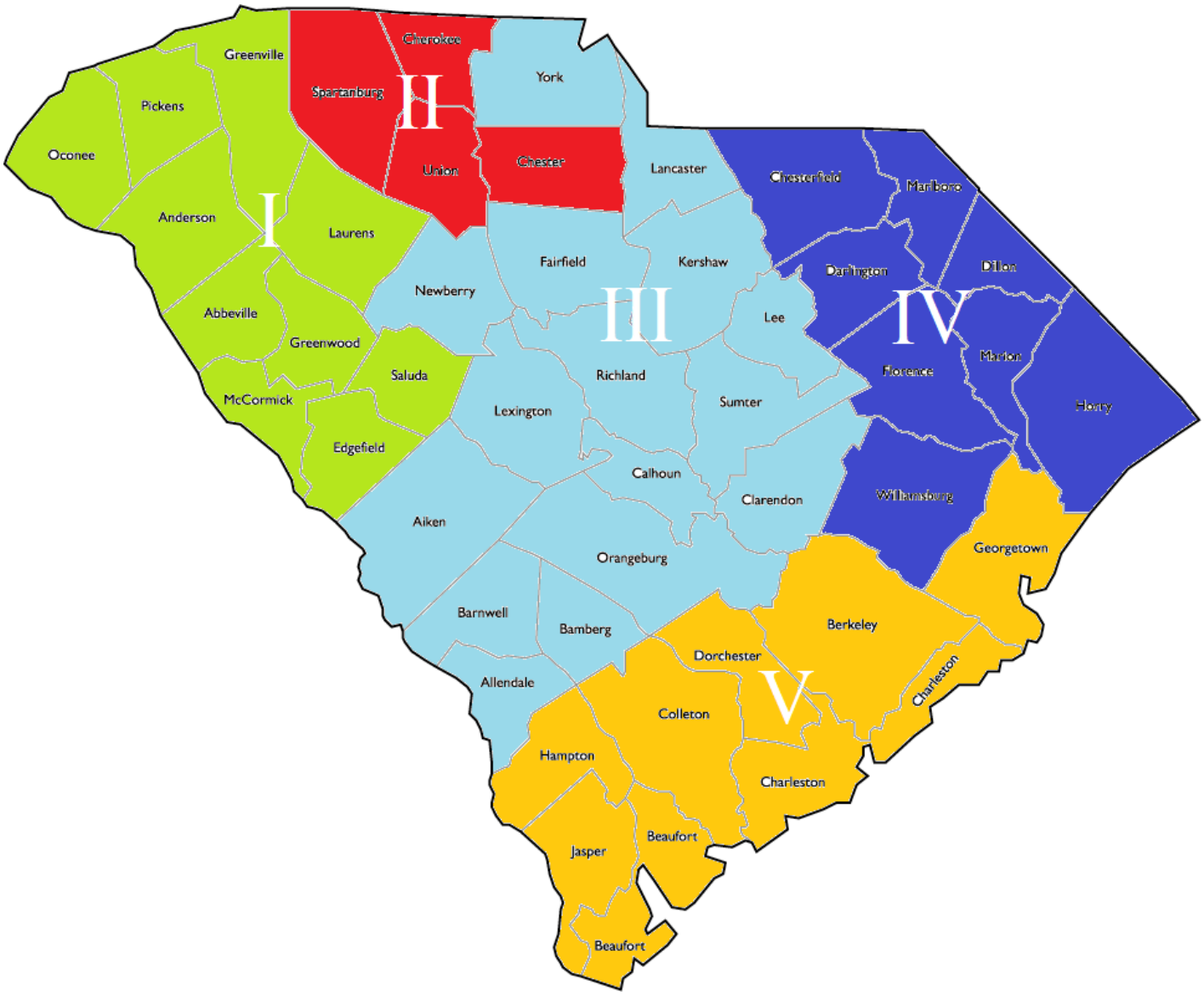
Region III
Williamsburg Regional Hospital ***1***

Region IV
Allendale County Hospital

* Other facilities may potentially be eligible for CAH status.

PERINATAL REGIONS MAP

(Chapter III)



PERINATAL-CAPABLE FACILITIES
(Chapter III)

Facility by Service Level	**Perinatal Region**
Regional Perinatal Centers (RPCs)	
Greenville Memorial Medical Center	I
Spartanburg Regional 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 Memorial Hospital	II
Aiken Regional Medical Center	III
Lexington Medical Center	III
Regional Medical Center of Orangeburg & Calhoun Counties	III
Springs Memorial Hospital	III
Tuomey	III
Carolinas Hospital System - Marion	IV
Carolina Pines Regional Medical Center	IV
Conway Hospital	IV
Grand Strand Regional 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
Georgetown Memorial Hospital	V
Summerville Medical Center	V
Trident Medical Center	V
Waccamaw Community Hospital	V

OB UTILIZATION AND BIRTHS
(Chapter III)

	2015				
Facility	**Births**	**OB Beds**	**Admissions**	**Patient Days**	**% Occup Rate**
Aiken Regional Medical Center	1132	18	1328	3179	48.4%
AnMed Health Women's & Children's	1825	28	1561	3831	37.5%
Beaufort Memorial Hospital	934	9	949	2055	62.6%
Bon Secours Saint Francis Xavier	2620	15	2799	6455	117.9%
Carolina Pines Regional Medical Center	553	13	731	1770	37.3%
Chesterfield General Hospital	65	10	72	134	3.7%
Clarendon Memorial	417	11	471	1026	25.6%
Coastal Carolina Hospital	711	10	780	1773	48.6%
Colleton Medical Center	316	6	322	740	33.8%
Conway Hospital	1406	16	1633	3699	63.3%
East Cooper Medical Center	1476	38	1772	4510	32.5%
Georgetown Memorial Hospital	299	14	414	999	19.5%
Grand Strand Regional Medical Center	956	19	1205	2739	39.5%
Greenville Memorial Medical Center	5657	59	4971	17642	81.9%
Greer Memorial Hospital	673	10	679	1610	44.1%
Hilton Head Hospital	558	8	592	1207	41.3%
Kershaw County Medical Center***1***	-	10	-	-	0.0%
Laurens County Hospital	343	5	383	783	42.9%
Lexington Medical Center	3674	39	3894	9365	65.8%
Loris Community Hospital	452	8	478	946	32.4%
Marion County Medical Center***1***	261	-	-	-	0.00%
Mary Black Memorial Hospital	810	21	884	2110	27.5%
McLeod Medical Center - Dillon	276	12	324	774	17.7%
McLeod Regional Medical Center - Pee Dee	2205	22	2249	6759	84.2%
MUSC Medical Center	2738	36	2888	8326	63.4%
Newberry County Memorial Hospital	298	10	309	604	16.5%
Oconee Memorial Hospital	515	15	541	1239	22.6%
Palmetto Baptist Medical Center - Easley	435	14	510	1416	27.7%
Palmetto Health Baptist	3008	83	6663	11024	36.4%
Palmetto Health Baptist Parkridge	558	33	678	2067	17.2%
Palmetto Health Richland	2424	42	4022	10335	67.4%
Piedmont Medical Center	1638	19	1712	4619	66.6%
Regional Medical Center of Orangeburg & Calhoun Counties	987	32	1291	2716	23.3%
Saint Francis - Eastside	2318	33	2380	6147	51.0%
Self Regional Healthcare	1418	36	1568	4074	31.0%
Spartanburg Regional Medical Center	2754	39	3627	8519	59.8%
Springs Memorial Hospital	681	5	132	1866	102.2%
Summerville Medical Center	1176	12	958	1980	45.2%
Trident Medical Center	1524	25	1562	3545	38.8%
Tuomey	1370	24	338	4532	51.7%
Upstate Carolina Medical Center***1***	240	15	-	505	9.2%
Waccamaw Community Hospital	577	19	1320	3864	55.7%
Union Medical Center (Formerly Wallace Thomson)***2***	91	-	95	246	0.0%
Women's Center of Carolinas Hospital System	694	20	1,046	1,602	21.9%
Total Births	**53,063**				

1 Facility did not accurately or completely report JAR data.

2 Facility ceased OB service line effective July 27, 2015

INTENSIVE AND INTERMEDIATE BASSINETS
(Chapter III)

Facility by Perinatal Region	Service Level	Existing Bassinets Intensive	Existing Bassinets Intermediate
Region I - Greenville Memorial			
Greenville Memorial Medical Center	RPC	12	68
Self Regional Healthcare	Level III	7	11
AnMed Health Women's & Children's Hospital	Level II	0	13
Palmetto Baptist Medical Center Easley	Level II	0	4
St. Francis - Eastside	Level II	0	10
Subtotal		**19**	**106**
Region II - Spartanburg Regional			
Spartanburg Regional Medical Center	RPC	13	22
Mary Black Memorial Hospital	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 Center	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
Tuomey Health	Level II	0	22
Subtotal		**44**	**131**
Region IV - McLeod Regional			
McLeod Regional Medical Center - Pee Dee *1*	RPC	20	28
Carolinas Hospital System - Marion	Level II	0	2
Carolina Pines Regional Medical Center	Level II	0	4
Conway Hospital	Level II	0	6
Grand Strand Regional Medical Center	Level II	0	2
Women's Center of Carolinas Hospital System	Level II	0	11
Subtotal		**20**	**53**
Region V - MUSC Medical			
MUSC Medical Center	RPC	16	50
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
Georgetown Memorial Hospital	Level II	0	5
Summerville Medical Center ***2***	Level II	0	12
Trident Medical Center ***2***	Level II	0	0
Waccamaw Community Hospital	Level II	0	2
Subtotal		**16**	**95**
Totals		**112**	**417**

1 CON SC-16-42 issued August 11, 2016 for the addition of 8 intensive care bassinets for a total of 20. Not yet implemented.

2 Approved February 21, 2017, consolidation of OB services to Summerville Medical Center. Currently appealed.

UTILIZATION OF NEONATAL SPECIAL CARE UNITS
(Chapter III)

				2015				
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								
Greenville Memorial Medical Center	RPC	12	6,098	68	15,681	80	21,779	74.6%
Self Regional Healthcare	Level III	7	538	11	1,738	18	2,276	34.6%
AnMed Health Women's & Children's	Level II	0	0	13	971	13	971	20.5%
Palmetto Baptist Medical Center Easley	Level II	0	0	4	0	4	0	0.0%
St. Francis - Eastside	Level II	0	0	10	1,541	10	1,541	42.2%
SUBTOTAL		**19**	**6,636**	**106**	**19,931**	**125**	**26,567**	**58.2%**
Region II - Spartanburg Regional								
Spartanburg Regional Medical Center	RPC	13	5,042	22	3,548	35	8,590	67.2%
Mary Black Memorial Hospital	Level II	0	0	10	182	10	182	5.0%
SUBTOTAL		**13**	**5,042**	**32**	**3,730**	**45**	**8,772**	**53.4%**
Region III - Palmetto Health Richland								
Palmetto Health Richland	RPC	31	19,433	38	0	69	19,433	77.2%
Palmetto Health Baptist	Level III	8	1,575	22	4,339	30	5,914	54.0%
Piedmont Medical Center	Level III	5		7	1,901	12	1,901	43.4%
Aiken Regional Medical Center	Level II	0	0	8	220	8	220	7.5%
Lexington Medical Center	Level II	0	0	20	3,287	20	3,287	45.0%
Regional Medical Center of Orangeburg & Calhoun Counties	Level II	0	0	10	2,115	10	2,115	57.9%
Springs Memorial Hospital	Level II	0	0	4	38	4	38	2.6%
Tuomey Health	Level II	0	0	22	118	22	118	1.5%
SUBTOTAL		**44**	**21,008**	**131**	**12,018**	**175**	**33,026**	**51.7%**
Region IV - McLeod Regional								
McLeod Regional Medical Center - Pee Dee	RPC	12	5,261	28	5,146	40	10,407	71.3%
Carolinas Hospital System - Marion ***1***	Level II	0	0	2	14	2	14	1.9%
Carolina Pines Regional Medical Center	Level II	0	0	4	407	4	407	27.9%
Conway Hospital	Level II	0	0	6	955	6	955	43.6%
Grand Strand Regional Medical Center	Level II	0	0	2	968	2	968	132.6%
Women's Center of Carolinas Hospital System ***1***	Level II	0	0	11	889	11	889	22.1%
SUBTOTAL		**12**	**5,261**	**53**	**8,379**	**65**	**13,640**	**57.5%**
Region V - MUSC Medical								
MUSC Medical Center	RPC	16	8,026	50	12,143	66	20,169	83.7%
Beaufort Memorial Hospital	Level II	0	0	5	0	5	0	0.0%
Bon Secours - St. Francis Xavier	Level II	0	0	11	2,180	11	2,180	54.3%
East Cooper Medical Center	Level II	0	0	10	943	10	943	25.8%
Georgetown Memorial Hospital	Level II	0	0	5	132	5	132	7.2%
Summerville Medical Center	Level II	0	0	4	1,190	4	1,190	81.5%
Trident Medical Center	Level II	0	0	10	1,516	10	1,516	41.5%
Waccamaw Community Hospital	Level II	0	0	2	452	2	452	61.9%
SUBTOTAL		**16**	**8,026**	**97**	**18,556**	**113**	**26,582**	**64.4%**
GRAND TOTAL		**104**	**45,973**	**419**	**62,614**	**523**	**108,587**	**56.9%**

1 2015 JAR reports intensive bassinet patient days, but facility is only licensed for intermediate bassinets.

NICU BED NEED
(Chapter III)

Counties by Perinatal Region	2015 Births	2014 Births	2013 Births	3 YR Ave Births	2015 15-44 Pop	2014 15-44 Pop	2013 15-44 Pop	3 YR AVE 15-44 Pop	Avg Birth Rate	2019 15-44 Pop	2017 Proj Births	Proj Br / Avg Br	Existing NICU Beds	Bed Need
Region I														
Abbeville	246	248	259	251	8649	8700	8728	8693		8280				
Anderson	2254	2273	2286	2,271	71198	70732	70057	70663		72530				
Edgefield	210	194	254	219	10134	10205	10195	10178		9890				
Greenville	6421	6340	6039	6,267	195885	192975	190655	193172		206520				
Greenwood	820	865	901	862	26404	26458	26901	26588		25480				
Laurens	761	736	727	741	24382	24465	24406	24418		23910				
McCormick	56	87	40	61	2767	2944	3015	2909		2490				
Oconee	792	801	703	765	25201	25183	25328	25238		24830				
Pickens	1254	1295	1160	1,236	53414	53270	52643	53109		52740				
Saluda	251	279	211	247	7007	7165	7304	7159		6620				
Total	**13,065**	**13,118**	**12,580**	**12,921**	**425,041**	**422,097**	**419,232**	**422,123**	**0.03061**	**433,290**	**13,263**	**1.026454**	**19**	**13**
Region II														
Cherokee	637	676	710	674	21,398	21,425	21,604	21,476		21,070				
Chester	373	442	410	408	11,558	11,662	11,986	11,735		10,760				
Spartanburg	3,495	3,582	3,541	3,539	113,085	112,652	112,533	112,757		113,890				
Union	310	301	295	302	9,748	9,873	10,091	9,904		9,050				
Total	**4,815**	**5,001**	**4,956**	**4,924**	**155,789**	**155,612**	**156,214**	**155,872**	**0.03159**	**154,770**	**4,889**	**0.992932**	**13**	**5**
Region III														
Aiken	1,749	1,915	1,861	1,842	60,124	60,109	59,876	60,036		61,240				
Allendale	91	95	118	101	3,880	3,944	4,067	3,964		3,430				
Bamberg	161	152	164	159	5,865	5,993	6,058	5,972		5,560				
Barnwell	315	320	304	313	7,870	7,964	8,063	7,966		7,410				
Calhoun	139	147	162	149	4,971	4,955	5,114	5,013		4,680				
Clarendon	350	362	336	349	12,261	12,235	12,398	12,298		11,740				
Fairfield	239	213	258	237	7,759	7,816	8,045	7,873		7,090				
Kershaw	662	732	708	701	22,151	22,145	22,231	22,176		22,350				
Lancaster	919	911	866	899	29,489	29,263	28,983	29,245		30,200				
Lee	194	185	174	184	7,052	7,135	7,291	7,159		6,570				
Lexington	3,250	3,232	3,255	3,246	106,911	106,261	105,632	106,268		110,930				
Newberry	453	410	443	435	13,685	13,743	13,779	13,736		13,370				
Orangeburg	1,121	1,085	1,193	1,133	34,170	34,634	35,048	34,617		32,390				
Richland	4,798	4,779	4,920	4,832	188,203	185,616	183,693	185,837		197,990				
Sumter	1,526	1,540	1,512	1,526	43,128	43,186	43,058	43,124		43,420				
York	2,889	2,983	2,821	2,898	94,606	93,329	92,447	93,461		98,390				
Total	**18,856**	**19,061**	**19,095**	**19,004**	**642,125**	**638,328**	**635,783**	**638,745**	**0.02975**	**656,760**	**19,540**	**1.028203**	**44**	**20**
Region IV														
Chesterfield	523	518	510	517	17,077	17,220	17,526	17,274		16,320				
Darlington	756	823	790	790	24,762	24,864	25,096	24,907		23,810				
Dillon	457	437	422	439	11,525	11,721	11,926	11,724		11,250				
Florence ***1***	1,717	1,832	1,831	1,793	53,484	53,511	53,728	53,574		53,450				
Horry	3,170	2,938	3,105	3,071	104,633	103,501	102,925	103,686		108,050				
Marion	397	372	435	401	11,386	11,565	11,768	11,573		10,610				
Marlboro	307	298	321	309	11,303	11,377	11,582	11,421		10,790				
Williamsburg	313	344	358	338	11,897	12,188	12,568	12,218		11,020				
Total	**7,640**	**7,562**	**7,772**	**7,658**	**246,067**	**245,947**	**247,119**	**246,378**	**0.03108**	**245,300**	**7,625**	**0.995626**	**20**	**8**
Region V														
Beaufort	2,077	2,027	2,034	2,046	60,594	59,827	58,701	59,707		62,180				
Berkeley	2,608	2,600	2,548	2,585	81,970	80,740	78,573	80,428		88,120				
Charleston	4,764	4,685	4,753	4,734	159,581	156,983	154,453	157,006		166,400				
Colleton	439	454	460	451	12,948	13,228	13,442	13,206		12,180				
Dorchester	1,809	1,833	1,758	1,800	59,408	58,396	57,631	58,478		63,640				
Georgetown	612	588	604	601	18,611	18,605	18,798	18,671		17,700				
Hampton	225	230	212	222	7,916	8,076	8,154	8,049		7,480				
Jasper	312	308	341	320	10,754	10,597	10,607	10,653		11,360				
Total	**12,846**	**12,725**	**12,710**	**12,760**	**411,782**	**406,452**	**400,359**	**406,198**	**0.03141**	**429,060**	**13,479**	**1.056284**	**16**	**13**
Statewide	**57,222**	**57,467**	**57,113**	**57,267**	**1,880,804**	**1,868,436**	**1,858,707**	**1,869,316**		**1,919,180**	**58,795**		**112**	**59**

1 CON SC-16-42 issued August 11, 2016 for the addition of 8 intensive bassinets to McLeod Regional Medical Center of the Pee Dee for a total of 20 intensive bassinets.

CHAPTER IV

PSYCHIATRIC SERVICES

COMMUNITY PSYCHIATRIC BEDS

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

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

~~According to the Department of Mental Health (DMH), there continues to be a great need for additional psychiatric beds and resources in communities throughout the state. Medicaid does not pay for psychiatric care provided by freestanding psychiatric hospitals (known as Institutions for Mental Disease or IMDs); however, the Emergency Medical Treatment & Labor Act (EMTALA) requires hospitals to provide psychiatric care for patients regardless of ability to pay. As a result, general hospitals have found their emergency departments over-burdened with patients requiring psychiatric care. DMH has had substantial decreases over the past 15 years in the number of its available adult inpatient psychiatric beds, and for many years has lacked the capacity to timely admit adult patients referred for emergency admission. Additionally, many general hospitals have reduced or eliminated their adult psychiatric hospital beds.~~

~~CMS's ongoing project called the Medicaid Emergency Psychiatric Demonstration could lead to Medicaid reimbursement for freestanding psychiatric hospitals. Twelve participating states, including North Carolina, will create Medicaid programs for psychiatric patients age 21-64 seeking emergency treatment at IMDs. The theory is that the IMDs can provide care at lower cost than warehousing the patients in hospital EDs. If the pilot project is successful, Congress may revise the Medicaid funding for psychiatric care nationally. Project results may be released as early as July of 2015.~~

The Psychiatric Programs Chart is located ~~in Chapter XIII of this Plan~~at the end of this Chapter.

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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 bed need methodology takes the greater of the actual utilization of the facilities in the service area or 875% of the statewide average beds per 1,000 population to project need. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.

3. 2. Should the service area show a need for additional beds, a general acute care hospital may be approved for the maximum of the actual projected bed need or up to 20 additional beds ("20 Bed Rule") to establish an economical unit ("Unit"). An applicant seeking more beds than are projected may not use such beds for the establishment of a specialty psychiatric unit. Any beds sought in excess of the projected bed need in the service area must be used for the provision of 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 nineteen (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 8 additional beds, given that it has achieved an occupancy rate of at least 70% as reported on the most recent Joint Annual Report ("JAR").

~~An existing general acute care hospital or freestanding psychiatric facility that already has licensed psychiatric beds may apply for additional beds beyond the need demonstrated in the Plan. However, prior to applying for additional beds beyond the need demonstrated in the Plan, the facility must demonstrate that it has maintained a minimum 70% occupancy rate as demonstrated by its most recent Joint Annual Report ("JAR"). The Department shall not approve an application for more beds than are shown as needed in the Plan unless the applicant meets this 70% occupancy rate criteria.~~

~~3.~~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.

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The Psychiatric Bed Need Chart is located ~~in Chapter XIII of this Plan~~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.~~1. Community Need Documentation;
~~3.~~2. Distribution (Accessibility);
~~4.~~3. Acceptability;
~~5.~~4. ~~Financial Feasibility~~Record of the Applicant;
~~6.~~5. Ability of the Applicant to Complete the Project;
~~7.~~6. Cost Containment; and
~~8.~~7. Staff Resources.

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Psychiatric beds are planned for and located within sixty ~~minutes~~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.

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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.

~~William J. McCord Adolescent Treatment Facility~~ (MOVE TO FOOTNOTE)

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~~The William J. McCord Adolescent Facility provides substance abuse treatment for adolescents statewide. It received a Certificate of Need on 7/16/10 to convert to a specialized hospital with 15 psychiatric beds restricted primarily for the provision of alcohol and drug abuse treatments for adolescents. The bed classification change was made in order to continue receiving reimbursement. These beds are not counted in the psychiatric bed need calculations.~~

~~DEPARTMENT OF MENTAL HEALTH INITIATIVES~~

~~The South Carolina General Assembly approved a pilot project in 2011 to assess the provision of psychiatric crisis stabilization services for patients age 65 and over in Critical Access Hospitals (CAHs). Participating facilities could establish a ten-bed Distinct Part Psychiatric unit for Prospective Payment System Exclusion, as defined by the Federal Centers for Medicare and Medicaid Services (CMS) for the purpose of conducting this project. If a participating hospital de-licensed beds prior to the commencement of the project in order to qualify as a CAH, the facility may re-license up to 10 of the original bed complement in order to participate, pursuant to a written exemption from the Department. A Certificate of Need was *not* required for participation in the project.~~

~~DMH requested and received assistance from The Duke Endowment to develop a telepsychiatry network for all South Carolina hospitals operating emergency departments. Modern, high-speed interactive video conference equipment will be purchased by DMH through public procurement, including a three-year warranty for such equipment and placed in local participating hospitals containing emergency departments and directly linked to DMH where psychiatrists will be available for psychiatric consultation. Springs Memorial Hospital of Lancaster is participating in the program as part of its establishment of a Geriatric Psychiatric Unit pursuant to SC-12-29.~~

PSYCHIATRIC PROGRAMS
(Chapter IV)

Facility by Region	County	Beds	2015 Pt. Days	Occup Rate
Region I				
AnMed Health Medical Center	Anderson	38	6,368	45.9%
Carolina Center Behavioral Health ***1***	Greenville	117	29,144	68.2%
GHS Marshall I. Pickens Hospital ***2***	Greenville	65	11,913	50.2%
Mary Black Memorial	Spartanburg	15	2,413	44.1%
Self Regional Healthcare	Greenwood	32	3,980	34.1%
Spartanburg Medical Center	Spartanburg	56	6,816	33.3%
Springbrook Behavioral Health ***3***	Greenville	56	11,395	55.7%
Region II				
Aiken Regional Medical Center	Aiken	44	12,919	80.4%
Palmetto Health Baptist	Richland	55	10,688	53.2%
Palmetto Health Richland	Richland	52	12,902	68.0%
Piedmont Medical Center	York	20	4,201	57.5%
Rebound Behavioral Health	Lancaster	24	0	0.0%
Springs Memorial Hospital	Lancaster	12	239	5.5%
Three Rivers Behavioral Health ***4***	Lexington	105	30,618	79.9%
Region III				
Carolinas Hospital System - Cedar Tower	Florence	12	0	0.0%
South Strand Medical Center ***5***	Horry	20		
Marlboro Park Hospital ***6***				
Lighthouse Behavioral Health Center	Horry	60	17,974	82.1%
McLeod - Darlington	Darlington	23	6,124	72.9%
Region IV				
Beaufort Memorial	Beaufort	14	2,610	51.1%
Colleton Medical Center	Colleton	19	5,085	73.3%
Medical University SC	Charleston	82	28,011	93.6%
Palmetto Lowcountry Behavioral	Charleston	92	18,186	54.2%
Trident Medical Center	Charleston	17	6,079	98.0%
Regional Medical Center - O'burg & Calhoun	Orangeburg	15	1,651	30.2%
Government Facilities				
G. Werber Bryan Psychaitric Hospital ***8***	Richland	530	51,200	26.5%
Gilliam Psychiatric Hospital ***9***	Richland	87	--	0.0%
Patrick B. Harris Psychiatric Hospital ***8***	Anderson	200	40,334	55.3%
William J McCord Adolescent Treatment Facility	Orangeburg	15	N/R	N/R
William S. Hall Psychiatric Institute ***6***	Richland	68	5,663	22.8%
	Total	**1045**	**229,316**	**60.1%**

1 SC-15-35 issued 9/16/2015 for the addition of 8 psychiatric beds for a total of 117 psychiatric beds.

2 SC-17-07 issued 2/16/2017 for the addition of 19 psychiatric beds for a total of 65 psychiatric beds.

3 SC-17-08 issued 2/16/2017 for the addition of 18 psychiatric beds for a total of 56 psychiatric beds

4 SC-16-12 issued 3/18/2016 for the addition of 24 psyciatric beds for a total of 105 psychiatric beds.

5 CON SC-16-35 issued 8/1/2016 for the establishmet of a 20 bed psychiatric program.

6 Facility has closed.

8 State facility not operating all its licensed beds. Their utilization does not impact calculation of need.

9 Did not submit 2015 JAR.

PSYCHIATRIC BED NEED
(Chapter IV)

Service Area	Age Cat	2015 Pop	2022 Pop	Existing Beds	2015 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Bed Need
Anderson, Oconee	<18	60263	59410		0							
	18-64	159668	161510		5121	14.19						
	+65	50474	60580		1247	4.10						
	TOTAL	**270,405**	**281,500**	**38**	**6,368**	**18**	**0.70**	**26**	**-12**	**51**	**13**	**13**
Greenville, Pickens	<18	138937	149270			0.00						
	18-64	383988	407480			0.00						
	+65	90629	117760			0.00						
	TOTAL	**613,554**	**674,510**	**238**	**52,452**	**0**	**0.70**	**0**	**-238**	**122**	**-116**	**-116**
Cherokee, Spartanburg, Union	<18	89203	89960		0							
	18-64	232396	235580		2923	8.12						
	+65	59674	72310		6306	20.94						
	TOTAL	**381,273**	**397,850**	**71**	**9,229**	**29**	**0.70**	**42**	**-29**	**72**	**1**	**1**
Chester, Lancaster, York	<18	87982	92390									
	18-64	225405	248390			0.00						
	+65	55917	78420			0.00						
	TOTAL	**369,304**	**419,200**	**56**	**4,440**	**0**	**0.70**	**0**	**-56**	**76**	**20**	**20**
Abbeville, Edgefield, Greenwood,	<18	46930	44490		0							
Laurens, McCormick, Saluda	18-64	131027	123220		2695	6.94						
	+65	39709	46630		1285	4.13						
	TOTAL	**217,666**	**214,340**	**32**	**3,980**	**11**	**0.70**	**16**	**-16**	**39**	**7**	**7**
Fairfield, Kershaw, Lexington,	<18	182593	190410		4394							
Newberry, Richland	18-64	519977	538960		39047	110.88						
	+65	110676	145250		11111	39.95						
	TOTAL	**813,246**	**874,620**	**212**	**54,208**	**151**	**0.70**	**215**	**3**	**159**	**-53**	**3**
Darlington, Florence, Marion	<18	56342	53840		77							
	18-64	143188	136210		5772	15.04						
	+65	38665	45810		275	0.89						
	TOTAL	**238,195**	**235,860**	**35**	**6,124**	**16**	**0.70**	**23**	**-12**	**43**	**8**	**8**
Chesterfield, Dillon, Marlboro	<18	24240	22180									
	18-64	63816	58540			0.00						
	+65	16689	19350		0	0.00						
	TOTAL	**104,745**	**100,070**	**0**	**0**	**0**	**0.70**	**0**	**0**	**18**	**18**	**18**
Clarendon, Lee, Sumter	<18	36997	34370									
	18-64	95982	89100		0	0.00						
	+65	26172	31240		0	0.00						
	TOTAL	**159,151**	**154,710**	**0**	**0**	**0**	**0.70**	**0**	**0**	**28**	**28**	**28**
Georgetown, Horry, Williamsburg	<18	78057	80700		1717							
	18-64	237594	254680		12117	35.58						
	+65	87381	132180		4140	17.16						
	TOTAL	**403,032**	**467,560**	**80**	**17,974**	**53**	**0.70**	**75**	**-5**	**85**	**5**	**5**
Bamberg, Calhoun, Orangeburg	<18	25997	24480									
	18-64	71242	61780			0.00						
	+65	21630	25040			0.00						
	TOTAL	**118,869**	**111,300**	**15**	**1,651**	**0**	**0.70**	**0**	**-15**	**20**	**5**	**5**
Allendale, Beaufort, Hampton,	<18	47559	47730									
Jasper	18-64	135048	140680			0.00						
	+65	54288	77250			0.00						
	TOTAL	**236,895**	**265,660**	**14**	**2,610**	**0**	**0.70**	**0**	**-14**	**48**	**34**	**34**
Berkeley, Charleston, Colleton,	<18	174664	187710									
Dorchester	18-64	498283	555010		44,503	135.81						
	+65	109310	155460		6,675	26.01						
	TOTAL	**782,257**	**898,180**	**210**	**57,361**	**162**	**0.70**	**231**	**21**	**163**	**-47**	**21**
Aiken, Barnwell	<18	41824	40650		3220							
	18-64	112149	110380		7840	21.14						
	+65	33581	42080		1859	6.38						
	TOTAL	**187,554**	**193,110**	**44**	**12,919**	**28**	**0.70**	**39**	**-5**	**35**	**-9**	**-5**
Statewide Totals	<18	1,091,588	1117590		9,408							
	18-64	3,009,763	3,121,520		120,018	348						
	+65	794,795	1,049,360		32,898	120						
	TOTAL	**4,896,146**	**5,288,470**	**1045**	**229,316**	**467**	0.000181	**667**	**-378**	**959**	**-86**	**43**

CHAPTER V

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 ~~in Chapter XIII of this Plan~~at the end of this Chapter.

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CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

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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 ~~in Chapter XIII of this Plan~~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.~~1. Community Need Documentation;
~~3.~~2. Distribution (Accessibility);
~~4.~~3. Projected Revenues;
~~5.~~4. Projected Expenses; and
~~6.~~5. Cost Containment~~; and~~
~~7. Resource Availability.~~

Rehabilitation facilities are now located throughout the state and are available within approximately sixty (60) ~~minutes~~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.

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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 V)

Facility by Region	County	Beds	2015 Pt. Days	2015 Occup Rate
Region I				
AnMed Health Rehab Hospital	Anderson	60	18,294	83.5%
Roger C. Peace (GHS Greenville Memorial)	Greenville	53	11,572	59.8%
St. Francis - Downtown	Greenville	19	4,775	68.9%
Greenwood Regional Rehab Hospital	Greenwood	42	10,628	69.3%
Mary Black Health System - Spartanburg	Spartanburg	18	3,477	52.9%
Spartanburg Rehabilitation Institute	Spartanburg	40	10,038	68.8%
Region II				
Aiken Regional Medical Centers **1**	Aiken	14	0	0.0%
Midlands Regional Rehabilitation Hospital **2**	Kershaw	40	0	0.0%
HealthSouth Columbia	Richland	96	23,899	68.2%
Palmetto Health Children's Hospital **3**	Richland	13	0	0.0%
HealthSouth Rock Hill	York	50	15,005	82.2%
Region III				
Carolinas Hospital System - Cedar Tower	Florence	42	6,048	39.5%
HealthSouth Florence	Florence	88	15,449	48.1%
Tidelands Waccamaw Community Hospital **4 & 6**	Georgetown	29	11,984	113.2%
Grand Strand Medical Center **5**	Horry	24	0	0.0%
Myrtle Beach Rehabilitation Hospital **6**	Horry	46	0	0.0%
Region IV				
Beaufort Memorial Hospital	Beaufort	14	2,579	50.5%
HealthSouth Lowcountry **7**	Beaufort	38	0	0.0%
HealthSouth Charleston	Charleston	49	14,690	82.1%
Roper Hospital **8**	Charleston	66	16,179	67.2%
Trident Medical Center **9**	Charleston	14	0	0.0%
Regional Medical Center of Orangeburg & Calhoun	Orangeburg	24	4,680	53.4%
	TOTAL	879	169,297	52.8%

1 CON SC-16-200 issued 12/28/16 for the establishment of a new 14 bed rehabilitation program, not yet implemented.
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 implemented.
5 CON approved 2/27/17 for the establishment of a 24 bed rehabilitation unit, pending appeal.
6 CON approved 2/27/17 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, pending appeal.
7 CON SC-16-44 issued 8/11/16 for the construction of a new 38 bed Comprehensive Rehabilitation Hospital, not yet implemented.
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 implemented.
9 CON approved 9/26/16 for the establishment of a 14 bed rehabilitation unit, pending appeal.

REHABILITATION BED NEED
(Chapter V)

Service Area	2015 Pop	2022 Pop	Existing Beds	2015 PT Days	Proj ADC	Occup Factor	Bed Need (Use)	+ / -	Bed Need (SW)	+ / -	Need
Anderson, Oconee	50,474	60,580	60	18,294	60	0.70	86	26	67	7	**26**
Greenville, Pickens	90,629	117,760	72	16,347	58	0.70	83	11	130	58	**58**
Cherokee, Spartanburg, Union	59,674	72,310	58	13,515	45	0.70	64	6	80	22	**22**
Chester, Lancaster, York	55,917	78,420	50	15,005	58	0.70	83	33	87	37	**37**
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	39,709	46,630	42	10,628	34	0.70	49	7	52	10	**10**
Fairfield, Lexington, Newberry, Richland[1]	99,933	131,930	109	23,899	86	0.70	123	14	146	37	**37**
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	61,387	72,300	130	21,497	69	0.70	99	-31	80	-50	**-31**
Clarendon, Kershaw[2], Lee, Sumter	36,915	44,560	40	0	0	0.70	0	-40	49	9	**9**
Georgetown, Horry[3]	81,348	125,040	99	11,984	50	0.70	71	-28	138	39	**39**
Aiken[4], Allendale, Bamberg, Barnwell, Calhoun, Orangeburg	56,845	69,020	38	4,680	16	0.70	23	-15	76	38	**38**
Beaufort[5], Hampton, Jasper	52,654	75,350	52	2,579	10	0.70	14	-38	83	31	**31**
Berkeley, Charleston[6], Colleton, Dorchester	109,310	155,460	129	30,869	120	0.70	171	42	172	43	**43**
Statewide Totals	**794,795**	**1,049,360**	**879**	**169,297**	**612**	**1.10595**	**866**	**-13**	**1,161**	**282**	**320**

[1] Service Area bed count includes SC-16-183 for 40 rehabilitation beds issued to Midlands Regional Rehabilitation Hospital on 12/15/16, not yet implemented.

[2] Service Area bed count includes SC-16-43 for 13 rehabilitation beds issued to Palmetto Health Children's Hospital on 8/11/16, not yet implemented.

[3] Service Area bed count reflects SC-16-37 for 17 rehabilitation beds issued to Tidelands Waccamaw Community Hospital on 8/10/16; SC-17-17 for 24 rehabilitation beds issued to Grand Strand Medical Center and 15 new rehabilitation beds issued to Myrtle Beach Rehabilitation Hospital on 4/6/17, all of which are not yet implemented.

[4] Service Area bed count includes SC-16-200 for 14 rehabilitation beds issued to Aiken Regional Medical Centers on 12/28/16, not yet implemented.

[5] Service Area bed count includes SC-16-44 for 38 rehabilitation beds issued to HealthSouth Lowcountry on 8/11/16.

[6] Service Area bed county includes CON approval for 14 rehabilitation beds issued Trident Medical Center on 9/26/16, pending appeal.

CHAPTER VI

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) narcotic treatment programs.

OUTPATIENT FACILITIES

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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.

~~CERTIFICATE OF NEED STANDARDS~~

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

SOCIAL DETOXIFICATION FACILITIES

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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.

~~CERTIFICATE OF NEED STANDARDS~~

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

FREESTANDING MEDICAL DETOXIFICATION FACILITIES

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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 ~~intoxification~~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 4 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 ~~in Chapter XIII of this Plan~~at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

1. Medical detoxification services are allocated by Department region.~~service area~~.

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

3. Because a minimum of ten (10) beds is needed for a medical detoxification program, a ten (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 sixty (60) ~~minutes~~minutes' travel time for the majority of state residents.

~~5. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.~~

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

Additional facilities are needed for the services to be accessible within sixty (60) minutes' travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

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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.

~~CERTIFICATE OF NEED PROJECTIONS AND STANDARDS~~

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. ~~Inpatient treatment facilities must comply with either Regulation 61-93 or Regulation 61-16.~~ For reference purposes only, these facilities are also subject to compliance with Regulation 61-16.

The Inpatient Treatment Facilities Chart is located ~~in Chapter XIII of this Plan~~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 bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing inpatient treatment facilities~~psychiatric units~~ and

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related utilization data, the state use rate was used in the projections.

4. 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.

5. In the absence of ~~numerical~~ a projected need in the service area, an existing inpatient treatment facility can apply to add up to 8 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").

~~4.~~

~~5.~~6. 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.~~7. The establishment of a regional treatment center ~~that~~ to serve~~s~~ more than a single service area may be proposed in order to improve access to care for patients in service areas that ~~do not currently have such services available~~are not currently well served. Such a proposed center would be allowed to combine the bed need for ~~a~~ separate, contiguous service area~~s, provided that each service area to be combined shows a positive bed need without existing services with another service area providing this other service area shows a need for additional beds~~. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to form a regional treatment facility.

~~7.~~8. It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology ~~to their illnesses~~. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

~~8. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state.~~

9. Current utilization and population growth are factored into the methodology for determining the need for additional beds.

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~~10. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.~~

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

Services are accessible within sixty (60) ~~minutes~~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.

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The Inpatient Treatment Bed Need Chart is located ~~in Chapter XIII of this Plan~~at the end of this Chapter.

NARCOTIC TREATMENT PROGRAMS

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Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug ~~of that group~~. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and 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, ~~N~~narcotic treatment programs are described in Regulation 61-93.

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Charges for medication usually range between $11 and $17 per day. A Registered Pharmacist must dispense the medication. ~~A minimum caseload of around 150 clients is required to ensure breaking even on the costs of providing this service.~~

The Narcotic Treatment Programs Chart is located ~~in Chapter XIII of this Plan~~at the end of this Chapter.

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

~~*1. A Certificate of Need is required for a narcotic treatment program.*~~

1. ~~An applicant must project a minimum caseload of 150 clients.~~ 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, narcotic 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.

~~2.~~

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

~~4. Because clients must usually attend a center 6 days per week to receive their dose of medication, these centers should be located throughout the state. To improve accessibility, narcotic treatment programs should be developed in counties where none exist. An additional treatment program can only be approved in a county with an existing program if the applicant is able to document that the existing program has a sufficient waiting list for admission that would justify the need for an additional program.~~

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

1. ~~Compliance with this Plan~~Community Need Documentation;
2. Distribution (Accessibility);
3. Record of the Applicant;
4. Ability ~~of the Applicant~~ 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 thirty (30) minutes' travel time for the majority of state residents. The benefits of improved accessibility will ~~not~~ outweigh the adverse effects of the duplication of this existing service.

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FREESTANDING MEDICAL DETOXIFICATION FACILITIES*
(Chapter VI)

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 VI)

Facility by Region	County	Beds	2015 Pt. Days	Occup Rate
Region I				
Carolina Center Behavioral Health ***1***	Greenville	29	10,925	103.2%
Springbrook Behavioral Health ***2***	Greenville	6	0	0.0%
Region II				
Aiken Regional Medical Center	Aiken	18	4,151	63.2%
Palmetto Health Baptist	Richland	10	0	0.0%
Palmetto Richland Springs (Palmetto Health Richland)	Richland	10	0	0.0%
Rebound Behavioral Health ***3***	Lancaster	18	--	0.0%
Three Rivers Behavioral Health	Lexington	17	2,859	46.1%
Region III				
Carolinas Hospital System - Cedar Tower	Florence	12	2,033	46.4%
Lighthouse Care Center Conway ***4***	Horry	27	5,647	57.3%
Region IV				
MUSC Medical Center	Charleston	23	3,539	42.2%
Palmetto Lowcountry Behavioral	Charleston	16	4,733	81.0%
	TOTAL	**186**	**33,887**	**49.9%**

* 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 2/16/2017 for the addition of 8 substance abuse beds for a total of 29 substance abuse beds.

2 SC-15-34 issued 9/16/2015 for the addition of 6 substance abuse beds for a total of 6 substance abuse beds.

3 Did not complete 2015 JAR.

4 SC-16-16 issued 4/27/2016 for addition of 9 substance abuse beds for a total of 27 substance abuse beds.

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

REGIONS	AGE CAT	2015 POP	2022 POP	EXISTING BEDS	2015 PATIENTS	2015 PT. DAYS	2013 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
Anderson, Oconee	0-17	60263	59410	0				0.75					
	18-64	159668	161510				0.00000	0.75	0	0	4	5	5
	65+	50474	60580				0.00000	0.75	0		1		
Cherokee, Spartanburg, Union	0-17	89203	89960	0				0.75					
	18-64	232396	235580				0.00000	0.75	0	0	6	8	8
	65+	59674	72310				0.00000	0.75	0		2		
Greenville, Pickens	0-17	138937	149270	35		20		0.75					
	18-64	383988	407480			10267	0.01963	0.75	40	9	9	-24	9
	65+	90629	117760			638	0.00704	0.75	4		2		
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	0-17	46930	44490	0				0.75					
	18-64	131027	123220				0.00000	0.75	0	0	3	4	4
	65+	39709	46630				0.00000	0.75	0		1		
Chester, Lancaster, York	0-17	87982	92390	18				0.75					
	18-64	225405	248390				0.00000	0.75	0	-18	6	-10	-10
	65+	55917	78420				0.00000	0.75	0		2		
Fairfield, Kershaw, Lexington, Newberry, Richland	0-17	182593	190410	37		0		0.75					
	18-64	519977	538960			2320	0.00330	0.75	9	-15	12	-22	-15
	65+	110676	145250			539	0.00487	0.75	13		3		
Chesterfield, Dillon, Marlboro	0-17	24240	22180	0				0.75					
	18-64	63816	58540				0.00000	0.75	0	0	2	3	3
	65+	16689	19350				0.00000	0.75	0		1		
Clarendon, Lee, Sumter	0-17	36997	34370	0				0.75					
	18-64	95982	89100				0.00000	0.75	0	0	2	3	3
	65+	26172	31240				0.00000	0.75	0		1		
Darlington, Florence, Marion	0-17	56342	53840	12				0.75					
	18-64	143188	136210				0.00000	0.75	0	23	4	-7	23
	65+	38665	45810			2033	0.05258	0.75	35		1		
Georgetown, Horry, Williamsburg	0-17	78057	80700	27		0		0.75					
	18-64	237594	254680			5207	0.01650	0.75	21	-1	6	-18	-1
	65+	87381	132180			440	0.00504	0.75	5		3		
Aiken, Barnwell	0-17	41824	40650	18		534		0.75					
	18-64	112149	110380			3126	0.02030	0.75	12	3	3	-14	3

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

REGIONS	AGE CAT	2015 POP	2022 POP	EXISTING BEDS	2015 PATIENTS	2015 PT. DAYS	2013 USAGE RATE	CON RATE	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
	65+	33581	42080			491	0.01462	0.75	9		1		
Allendale, Beaufort,	0-17	47559	47730	0				0.75					
Hampton, Jasper	18-64	135048	140680				0.00000	0.75	0	0	3	5	5
	65+	54288	77250				0.00000	0.75	0		2		
Bamberg, Calhoun,	0-17	25997	24480	0		3927		0.75					
Orangeburg	18-64	71242	61780				0.00000	0.75	0	0	2	3	3
	65+	21630	25040				0.00000	0.75	0		1		
Berkeley, Charleston,	0-17	174664	187710	39		181		0.75					
Colleton, Dorchester	18-64	498283	555010			7812	0.01161	0.75	32	0	12	-24	0
	65+	109310	155460			279	0.00255	0.75	7		3		
Statewide Totals				**186**					**187**	**1**	**98**	**-88**	**40**

			State
0-64	**4,101,351**	**4,239,110**	**Usage**
65+	**794,795**	**1,049,360**	**Rate**
Total	**4,896,146**	**5,288,470**	**0.000016**

NARCOTIC TREATMENT PROGRAMS
(Chapter VI)

Region	Facility	County
I	Crossroads Treatment Center of Seneca	Oconee
I	Crossroads Treatment Center of Greenville	Greenville
I	Gaffney Treatment Specialist	Cherokee
I	Greenville Metro Treatment Center	Greenville
I	Palmetto Carolina Treatement Center	Spartanburg
I	Recovery Concepts of the Carolina Upstate	Pickens
I	Southwest Carolina Treatment Center	Anderson
I	Spartanburg Treatment Center	Spartanburg
II	Aiken Treatment Specialists	Aiken
II	Alternative Life Improvement Center	Richland
II	Columbia Metro Treatment Center	Lexington
II	Crossroads Treatment Center of Columbia	Richland
II	York County Treatment Center	York
II	Rock Hill Treatment Specialists ***1***	York
III	Center of Hope Myrtle Beach	Horry
III	Starting Point of Darlington	Darlington
III	Starting Point of Florence	Florence
IV	Center for Behavioral Health South Carolina	Charleston
IV	Charleston Center	Charleston
IV	Crossroads Treatment Center of Charleston	Charleston
IV	Recovery Concepts	Jasper

1 CON SC-16-86 issued November 1, 2016.

CHAPTER VII

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. ~~The behaviors treated include, but are not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment, including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.~~

These facilities provide medium to long-term care (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.

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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~~. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and those with other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the above agencies.~~

The Residential Treatment Facilities for Children & Adolescents Chart is located ~~in Chapter XIII of this Plan.~~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*~~, unless the Department of Health and Human Services (DHHS) designates the facility as an existing high management group home (HMGH) or similar program.~~

~~1.~~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.

~~2.~~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.

~~3.~~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 5 additional beds, regardless of whether there is a bed need in the region.

~~4.~~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.

~~5.~~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.

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~~6.~~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.

~~7.~~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 5 years of age would be candidates for this type of care, the bed need will be based on the population age 5-21.

The Projected Bed Need for Residential Treatment Facilities for Children & Adolescents Chart is located ~~in Chapter XIII of this Plan~~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 the Plan;~~
1. Community Need Documentation;
2. Distribution (Accessibility);
~~3. Projected Revenues;~~
~~4. Projected Expenses~~Medically Underserved Groups~~;~~
3. Record of the Applicant;
4. Staff Resources; and~~,~~
~~5. and~~
~~6.~~ Medically Underserved Groups.~~Ability of the Applicant to Complete the Project;~~
~~7.~~5. ~~Cost Containment; and~~
~~8.~~1. ~~Staff Resources.~~

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) ~~minutes~~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.

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RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS*
(Chapter VII)

Region	Facility	County	Beds	PT Days	2015 % Occupancy
I	Avalonia Group Homes	Pickens	55	17,136	85.4%
I	Excalibur Youth Services	Greenville	60	15,687	71.6%
I	Generations Residential Programs	Greenville	30	7,756	70.8%
I	GHS Marshall I Pickens Hospital Childrens Program	Greenville	22	5,849	72.8%
I	Springbrook Behavioral Health System RTF	Greenville	68	22,168	89.3%
II	The Hearth Center for Eating Disorders ***1***	Richland	0	-	
II	New Hope Carolinas	York	150	48,739	89.0%
II	Three Rivers Behavioral RTF ***2***	Lexington	0	-	
II	Three Rivers Residential Treatment - Midlands Campus	Lexington	64	21,408	91.6%
III	Lighthouse Care Center of Conway	Horry	18	4,939	75.2%
III	Palmetto Pee Dee Residential Treatment Center	Florence	64	21,498	92.0%
III	Willowglen Academy South Carolina ***3***	Williamsburg	40	-	0.0%
IV	Palmetto Pines Behavioral Health	Dorchester	64	19,688	84.3%
IV	Riverside Behavioral Health Services at Windwood Farm	Charleston	12	4,350	99.3%
		Totals	**647**	**189,218**	**80.1%**

* The Directions program primarily served court-ordered patients from the South Carolina Department of Juvenile Justice (DJJ). As a statewide facility serving a restricted population, it was not included in this inventory. The Directions Program ceased operation in December 2015.

1 The Hearth Center for Eating Disorders ceased operation in October of 2016.

2 Three Rivers Behavioral RTF ceased operation in October of 2016.

3 Facility did not report required JAR data.

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

Region I

Facilities:	Avalonia Group Homes		55 beds
	Excalibur Youth Services		60 beds
	Generations - Pathways		30 beds
	GHS Marshall Pickens Hospital		22 beds
	Springbrook Behavioral Health System		68 beds
	Total		235 beds
2022 Population Age 5-21:			323,280
41.4 Beds / 100,000 Population:		x	.000414
			134 beds
			-235 beds
	Need Shown:		(101) beds

Region II

Facilities:	New Hope Carolinas		150 beds
	Three Rivers Residential Treatment Midlands		64 beds
	Total		214 beds
2022 Population Age 5-21:			330,100
41.4 Beds / 100,000 Population:		x	.000414
			137 beds
			-214 beds
	Need Shown:		(77) beds

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

Region III

Facilities:	Lighthouse Care Center of Conway	18 beds
	Palmetto Pee Dee Residential Treatment Center	64 beds
	Willowglen Academy	40 beds
	Total	122 beds
2022 Population Age 5-21:		182,560
41.4 Beds / 100,000 Population:	x	.000414
		76 beds
		-122 beds
	Need Shown:	(46) beds

Region IV

Facilities:	Palmetto Pines Behavioral Health	64 beds
	Riverside Behavioral Health Services at Windwood	12 beds
	Total	76 beds
2022 Population Age 5-21:		249,830
41.4 Beds / 100,000 Population:	x	.000414
		103 beds
		-76 beds
	Need Shown:	27 beds

CHAPTER VIII

CARDIOVASCULAR CARE[1]

~~Diseases of the heart were responsible for as many deaths in South Carolina as cancer during 2013. Annually, heart disease and stroke are the leading cause of death in the State. Approximately one-third of all heart attacks are fatal. The amount of heart muscle damaged during a heart attack is an important determinant of whether patients live or die – and what their quality of life will be if they survive.~~

~~Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. During a cardiac catheterization, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of contrast material allow blockages or areas of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed.~~

~~Percutaneous Coronary Interventions (PCIs) are therapeutic catheterization procedures used to revascularize occluded or partially occluded coronary arteries. These interventions include, but are not limited to: bare and drug-eluting stent implantation; Percutaneous Transluminal Coronary Angioplasty (PTCA); cutting balloon atherectomy; rotational atherectomy; directional atherectomy; excimer laser angioplasty; and extractional thrombectomy.~~

~~These procedures may be performed on an emergent or elective basis. "Emergent or Primary" means that a patient needs immediate PCI because, in the treating physician's best clinical judgment, delay would result in undue harm or risk to the patient. An "Elective" PCI is scheduled in advance and performed on a patient with cardiac function that has been stable in the days prior to the procedure.~~

~~In 2011, the American College of Cardiology (ACC) and the American Heart Association (AHA) revised their Guidelines for PCI. The previous version of the Guidelines allowed the provision of Emergent/Primary PCIs in hospitals without an on-site open heart surgery program if certain criteria could be met, but, due to the risk of arterial damage and the resulting need for immediate open heart surgery, elective PCI was contraindicated for institutions without on-site surgical backup. The new Guidelines state that:~~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

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~~1 Due to the October 1, 2015, transition from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures, all ICD-9 codes referenced in the South Carolina Health Plan shall be deemed to refer to the corresponding ICD-10 codes, as determined by CMS, once this transition takes place.~~

on-site open heart surgery backup.

~~Elective PCI might be considered in hospitals without on-site cardiac surgery, provided that appropriate planning for program development has been accomplished and rigorous clinical and angiographic criteria are used for proper patient selection . . . . Primary or elective PCI should not be performed in hospitals without on-site cardiac surgery capabilities without a proven plan for rapid transport to a cardiac surgery operating room in a nearby hospital or without appropriate hemodynamic support capability for transfer.~~

Hospitals without an open heart surgery program shall be allowed to provide Emergent/Primary and/or Elective PCIs only if they comply with all sections of Standard 7 or 8 of the Standards for Cardiac Catheterization.

In 2013, ~~the Society of Cardiovascular Angiography and Interventions (SCAI)~~SCAI, ~~AHA~~ACC, and ~~ACC~~ 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. ~~This statement does not contain a material change in the Plan's existing Certificate of Need requirements.~~

~~Open heart surgery or cardiac surgery refers to an operation performed on the heart or intrathoracic great vessels. The operations include Coronary Artery Bypass Graft (CABG), where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery, and Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used.~~

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect unnecessary duplication of services in an area, which may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of ~~500~~ 350 ~~diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0)~~ procedures per year. Emergent PCI ~~providers~~ operators should perform a minimum of 36 PCIs annually; all other ~~therapeutic catheterization providers~~PCI ~~–~~ operators should perform a minimum of ~~300~~ 200 combined ~~therapeutic catheterizations~~ 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. ~~For pediatric catheterization and adult congenital catheterization labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as~~

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~~3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in the utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to occur in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year, at least 75 of which should be open heart surgery.~~

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. The following ~~ICD-9-CM~~ICD-10-PCS Procedure Codes refer to diagnostic catheterizations:

~~37.21~~4A023N6 Cardiac Sampling and Pressure, Right Heart, Percutaneous Approach~~Right Heart Cardiac Catheterization~~

~~37.22~~4A023N7 Cardiac Sampling and Pressure, Left Heart, Percutaneous Approach~~Left Heart Cardiac Catheterization~~

~~37.23~~4A023N8 Cardiac Sampling and Pressure, Bilateral, Percutaneous Approach ~~Combined Right and Left Heart Cardiac Catheterization~~

Additional clinical interpretation of Procedure Codes may be necessary to ensure appropriate conversions from ICD-9-CM to the new ICD-10-PCS.

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

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

"Therapeutic Catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty. The following ~~ICD-9-CM~~ICD-10-PCS Procedure Codes refer to therapeutic catheterizations:

~~00.66~~ 02703ZZ and related Dilation of Coronary Artery, One Artery, Percutaneous Approach~~Percutaneous Transluminal Coronary Angioplasty (PTCA)~~
~~17.55~~ 02C03ZZ Extirpation of Matter from Coronary Artery, One Artery, Percutaneous Approach~~Transluminal Coronary Atherectomy~~
~~35.52~~ 02U53JZ Supplement Atrial Septum with Synthetic Substitute, Percutaneous Approach~~Repair of Atrial Septal Defect with Prosthesis, Closed Technique~~
~~35.55~~ 02RM4JZ Replacement of Ventricular Septum with Synthetic Substitute, Percutaneous Endoscopic Approach~~Repair of Ventricular Septal Defect with Prosthesis, Closed Technique~~
~~35.96~~ 027F3ZZ and related Dilation of Aortic Valve, Percutaneous Approach~~Percutaneous Valvuloplasty~~
~~36.06~~02703DZ Insertion of Non-Drug Eluting Coronary Artery Stent(s)
~~36.07~~027034Z Insertion of Drug Eluting Coronary Artery Stent(s)
~~36.09~~ 02C03ZZ and related Extirpation of Matter from Coronary Artery, One Artery, Percutaneous Approach~~Other Removal of Coronary Artery Obstruction~~
~~37.34~~ 02563ZZ and related Destruction of Right Atrium, Percutaneous Approach~~Excision or Destruction of Other Lesion or Tissue of Heart, Endovascular Approach~~

Additional clinical interpretation of Procedure Codes may be necessary to ensure appropriate conversions from ICD-9-CM to the new ICD-10-PCS.

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

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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 ~~diagnostic equivalents~~procedures per year, as measured on an equivalent basis. ~~Adult diagnostic catheterizations shall be weighted as 1.0 equivalents, while therapeutic catheterizations shall be weighted as 2.0 equivalents.~~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 ~~be weighted as 2.0 equivalents~~carry the weight of 2.0 procedures, therapeutic catheterizations shall ~~be weighted as 3.0 equivalents~~carry the weight of 3.0 procedures, electrophysiology (EP) studies shall ~~be weighted as~~carry the weight of 2.0 ~~equivalents~~procedures, and biopsies performed after heart transplants shall ~~be weighted as 1.0 equivalents~~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.

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2. The service area for a diagnostic catheterization laboratory is defined as all facilities within ~~45~~ 30 ~~minutes~~minutes'' ~~one way automobile travel~~emergency medical transport time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes' ~~one way automobile travel~~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 ~~500~~ 350 diagnostic catheterization procedures per laboratory during the most recent year;

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of ~~500~~ 350 ~~diagnostic equivalent~~ procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below ~~500~~ 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 ~~equivalents per laboratory~~procedures by equivalent measure) for each of the past two years and can project a minimum of ~~500~~ 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 ~~100~~ 75 diagnostic ~~equivalents~~ 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 ~~500~~ 350 diagnostic catheterization procedures per laboratory ~~(i.e., an applicant wishing to have a mobile catheterization lab 2 days per week must project a minimum of 200 equivalents at the applicant's facility by the end of the third year of operation).~~ In addition:

   a. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of ~~500~~ 350 ~~diagnostic equivalents~~ procedures per year;

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

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

Emergent and Elective PCI without On-Site Cardiac Backup

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

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

b. The applicant has performed a minimum of ~~250~~350 diagnostic catheterization procedures in the most recent year and can reasonably demonstrate that it will continue to perform a minimum of ~~500~~ 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 criteria listed~~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 ~~the~~ current ~~criteria from Smith et al., ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) and the 2007 Focused Update of the guidelines~~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/~~clinical/guidelines/percutaneous/update/index.pdf.~~guidelines.

~~c.~~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

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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.

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~~1) Criteria for the Performance of Emergency (Primary) PCI:~~

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

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

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

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

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

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

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

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

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

~~2) Patient Selection Guidelines~~

~~a) Avoid intervention in hemodynamically stable patients with:~~

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

~~b) Transfer emergent aortocoronary bypass surgery patients after PCI of occluded vessels if high-grade residual left main or multi-vessel coronary disease and clinical or hemodynamic instability are present, preferably with intra-aortic balloon pump support.~~

8. In ~~2011~~2014, the ~~ACCF/AHA/SCAI Writing Committee~~SCAI/ACC/AHA ~~determined~~ affirmed that elective PCI ~~might be considered~~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 ~~under the 2005 ACC/AHA Guideline Update for PCI~~ *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~~ 350 diagnostic catheterization procedures in the most recent year and can reasonably demonstrate that it will continue to perform a minimum of ~~500~~ 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 ~~300~~ 200 therapeutic catheterizations (PCIs) in the most recent year.

   c. An applicant must project that the proposed service will perform a minimum of ~~300~~ 200 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the cardiac catheterizations

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performed at existing comprehensive catheterization programs in the service area below the minimum thresholds of ~~300~~ 200 therapeutic procedures and ~~500~~ 350 diagnostic procedures at each facility.

d. The physicians must be experienced ~~interventionalists~~interventionists who perform a minimum of ~~75~~ 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 ~~75~~ 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 ~~75~~ 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 (~~within one hour by appropriate transportation~~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 thirty (30) minute or less response time from contact.

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

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

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

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

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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.

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Comprehensive Catheterization Services

9. 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 ~~300~~ 200 therapeutic catheterizations (PCIs) in the most recent year; and

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b. An applicant must project that the proposed service will perform a minimum of ~~300~~ 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 ~~300~~ 200 procedures at each facility.

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10. To prevent the unnecessary duplication of comprehensive cardiac catheterization services, expansion of an existing comprehensive cardiac catheterization service shall be approved only if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 ~~equivalents~~ 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.

Pediatric Catheterization Services

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

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

    b. An applicant must project that the proposed service will perform a minimum of 500 ~~diagnostic equivalent~~ procedures, as measured on an equivalent basis, annually within three years of initiation of services.

12. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 500 ~~equivalents~~ procedures, per year, as measured on an equivalent basis, on the additional equipment within three years of its implementation.

13. Documentation of need for the proposed service:

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

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

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

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

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

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

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

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

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

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

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

16. Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. Applicants must provide documentation that one (1) or more interventional cardiologist(s) will be required to

respond to a call in a timely manner consistent with the hospital Medical Staff bylaws and clinical indications. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

17. Applicants must agree to report annual the data on number of PCI procedures, type, and outcomes to the National Cardiovascular Data Registry Cat/PCI registry.

    a. Applicants must agree to provide accurate and timely data, including outcomes analysis and formal periodic external and internal case review by appropriate entities.

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

The Cardiac Catheterization Procedures Chart is located ~~in Chapter XIII of this Plan~~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 the Plan;~~
~~2.~~1. Community Need Documentation;
2. Distribution (Accessibility);
~~Record of the Applicant.~~
3.
~~4. Projected Revenues;~~
~~5. Projected Expenses;~~
~~6.~~4. Ability ~~of the Applicant~~ to Complete the Project;
~~7. Financial Feasibility;Medically Underserved Groups;~~
~~8.~~5. Staff Resources;
~~9.~~6. Adverse Effects on Other Facilities; and
7. ~~Record of the Applicant.~~Medically Underserved Groups.
~~10.~~

The Department finds that:

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

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(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. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60- 35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

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

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CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

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

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2. Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery.

3. The capacity of an open heart surgery program is 500 open heart procedures per year ~~for the initial open heart surgery unit and each additional dedicated~~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~~minutes" one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

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

      2) The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic ~~equivalents~~ 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

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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. *An incremental expansion of one open heart surgery unit shall not be grounds for Certificate of Need review.* Expansion of an existing open heart surgery service beyond the 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.

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

9. Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial

and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

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

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

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

    c. A predetermined protocol adopted by the cardiac catheterization service governing the provision of 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. 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.

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

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document the other service providers, if any, from which these additional patients will be drawn.

~~11.~~

The Open Heart Units Chart is located ~~in Chapter XIII of this Plan~~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 the Plan;~~
~~2.~~1. Community Need Documentation;
~~3.~~2. Distribution (Accessibility);
~~4. Projected Revenues;~~
~~5. Projected Expenses;~~
3. Ability ~~of the Applicant~~ to Complete the Project;
4. Cost Containment;
~~6.~~
~~7.~~5. ~~Financial Feasibility~~Record of the Applicant;
6. Staff Resources; and
~~8.~~1. ~~Cost Containment;~~
~~9. Staff Resources; and~~
~~10.~~7. Adverse Effects on Other Facilities.

The Department makes the following findings:

(1) Open heart surgery services are available within sixty (60) ~~minutes~~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)

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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.

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CARDIAC CATHETERIZATION PROCEDURES
(Chapter VIII)

		2013							2014							2015 *1*						
Facility by Region	**# Cath Labs**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**	**Diag**	**Adult Therp**	**Total Equiv**	**Diag**	**Ped Therp**	**Other**	**Total**
Region I																						
Anmed Health Medical Center	6	2,146	1,396	4,938					1,981	1,235	4,451					1,723	1,023	3,768				
Greenville Memorial Hospital	5	2,328	1,715	5,758					1,962	1,531	5,024					1,914	1,753	5,420				
Saint Francis - Downtown	4	1,925	945	3,815					2,004	1,246	4,496					2,053	1,229	4,511				
Self Regional Healthcare	2	1,074	359	1,792					847	349	1,545					885	447	1,779				
Oconee Memorial Hospital	1	509	0	509					358	0	358					228	0	228				
Baptist Medical Center - Easley	1	193	0	193					167	0	167					112	0	112				
Mary Black Memorial	2	42	0	42					49	0	49					82	0	82				
Spartanburg Regional Medical Center	4	1,794	761	3,316					1,896	751	3,398					1,849	937	3,723				
Village Hospital/Pelham ***1***	1	***NR***	***NR***	***NR***					***NR***	***NR***	***NR***					***NR***	***NR***	***NR***				
Total Region I	**26**	**10,011**	**5,176**	**20,363**					**9,264**	**5,112**	**19,488**					**8,846**	**5,389**	**19,623**				
Region II																						
Aiken Regional Medical Center	1	835	299	1,433					691	257	1,205					701	283	1,267				
Kershaw Health ***3***	1	610	0	610					666	0	666					***NR***	***NR***	***NR***				
Springs Memorial Hospital	1	398	0	398					397	0	397					271	0	271				
Lexington Medical Center	3	1,801	764	3,329					1,895	801	3,497					2,140	791	3,722				
Palmetto Health Baptist	1	355	0	355					444	0	444					485	0	485				
Palmetto Health Richland	4	3,120	1,247	5,614					3,070	1,284	5,638					3,153	1,254	5,661				
Providence Hospital ***4***	7	2,844	1,687	6,218					2,440	1,396	5,232					3,136	1,553	5,458				
Piedmont Medical Center	3	1,266	672	2,610					1,166	667	2,500					1,211	766	3,146				
Total Region II	**20**	**10,394**	**4,370**	**19,134**					**10,078**	**4,148**	**18,374**					**10,396**	**4,364**	**18,743**				
Region III																						
Carolina Pines Hospital	1	97	0	97					116	0	116					205	0	205				
Carolinas Hospital System	3	759	184	1,127					660	233	1,126					747	225	1,197				
McLeod Regional Medical Center	5	1,242	518	2,278					1,419	542	2,503					1,521	639	2,799				
Georgetown Memorial Hospital	2	681	73	827					717	56	829					670	94	858				
Conway Hospital	1	683	0	683					774	0	774					693	0	693				
Grand Strand Regional Medical Center	4	1,714	893	3,500					2,090	911	3,912					2,422	1,057	4,536				
Loris Community Hospital ***3***	1	264	0	264					282	0	282					294	0	294				
Tuomey	1	166	0	166					160	0	160					84	0	84				
Total Region III	**18**	**5,606**	**1,668**	**8,942**					**6,218**	**1,742**	**9,702**					**6,636**	**2,015**	**10,666**				
Region IV																						
Beaufort Memorial Hospital	1	300	34	368					447	133	713					494	147	788				
Hilton Head Hospital	2	318	169	656					433	227	887					299	172	643				
Bon Secours St. Francis Xavier ***5***	1	3	0	3					4	0	4					3	0	3				
East Cooper Medical Center ***6***	1	0	0	0					0	0	0					0	0	0				
MUSC Medical Center	6	1,692	1,326	4,344	262	260	110	1,414	1,697	1,156	4,009	285	284	112	1,534	1,436	1,124	3,684	197	272	61	1,271
Roper Berkeley Hospital ***7***	1	0	0	0					0	0	0					0	0	0				
Roper Hospital	3	1,651	908	3,467					1,578	896	3,370					1,568	883	3,334				
Trident Medical Center	2	995	479	1,953					1,007	445	1,897					1,081	525	2,131				
Regional Medical Center of Orangeburg/Calhoun	1	238	0	238					215	0	215					299	0	299				
Total Region IV	**18**	**5,197**	**2,916**	**11,029**				**1,414**	**5,381**	**2,857**	**11,095**				**1,534**	**5,180**	**2,851**	**10,882**				**1,271**
Statewide Totals	**82**	**31,208**	**14,130**	**59,468**				**1,414**	**30,941**	**13,859**	**58,659**				**1,534**	**31,058**	**14,619**	**59,914**				**1,271**

1 Some figures adjusted by Revenue & Fiscal Affairs following ICD9/10 conversion
2 No data reported for 2013, 2014, 2015
3 CON SC-17-16 issued April 6, 2017 to transfer single cardiac catheterization lab from McLeod Loris Hospital to McLeod Seacost Hospital.
4 South Carolina Heart Center catheterization lab now controlled by Providence Health and reported in their utilization.
5 Cardiac catheterization lab closed August 1, 2016
6 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.
7 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 VIII)

Region/Facility	# Open Heart Units	FY 13 Adults	FY 13 Peds	FY 14 Adults	FY 14 Peds	FY 15 *1* Adults	FY 15 *1* Peds
Region I							
Anmed Health Medical Center	2	217		200		210	
Greenville Memorial Medical Center	3	473		400		454	
Saint Francis - Downtown	2	336		311		323	
Self Regional Healthcare	1	113		85		77	
Spartanburg Regional Medical Center	3	430		467		443	
Total Region I	**11**	**1,569**		**1,463**		**1,507**	
Region II							
Aiken Regional Medical Center	1	30		33		55	
Lexington Medical Center	1	212		294		312	
Palmetto Health Richland	2	353		344		349	
Piedmont Mediclal Center	2	105		102		164	
Providence Hospital	4	559		500		546	
Total Region II	**10**	**1,259**		**1,273**		**1,426**	
Region III							
Carolinas Hospital System	1	97		101		97	
Grand Strand Regional Medical Center	2	238		279		403	
McLeod Regional Medical Center	3	407		418		427	
Total Region III	**6**	**742**		**798**		**927**	
Region IV							
Hilton Head Hospital	2	76		74		86	
MUSC Medical Center	3	318	205	360	191	423	237
Roper Hospital	2	408		424		474	
Trident Medical Center	1	248		238		241	
Total Region IV	**8**	**1,050**	**205**	**1,096**	**191**	**1,224**	**237**
Statewide Totals	**35**	**4,620**	**205**	**4,630**	**191**	**5,084**	**237**

1 Some figures adjusted by Revenue & Fiscal Affairs following ICD9/10 conversion

CHAPTER IX

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. ~~The five-year survival rate in South Carolina for all persons diagnosed with cancer was 68% from 2003 to 2009. This was an increase from the 49% survival rate calculated for 1975-1977.~~

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. ~~It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).~~

Beams of ionizing radiation are aimed to meet at a specific point and 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,

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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.

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"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.

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"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.

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"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.

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"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.

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"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.

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"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

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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~~minutes' for two-five sessions. It can be used to treat both brain and extracranial tumors.

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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 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm.
2. Access to an electron beam source or a low energy X-ray unit.
3. Adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department.
4. Capability to provide appropriate dose distribution information for external beam treatment.
5. Equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units).
6. Field-shaping capability.
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. ~~A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per week, 50 weeks per year. LINACs with IMRT and IGRT systems (such as Tomotherapy and Novalis TX) take longer to set up and perform treatments than those relying on previously generated images. Therefore, a lower capacity of 5,000 treatments per year is established for such equipment (20 patients treated per day, 5 days per week, 50 weeks per year). IMRT/IGRT machines that perform stereotactic procedures have a lower capacity of 4,500 treatments per year (18 patients treated per day, 5 days per week, 50 weeks per year).~~

There is also LINAC equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized LINACs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 1,500 treatments per year per unit~~, based on 6 treatments per day, 5 days per week, for 50 days per year. The Cyberknife is the only equipment so designated. It is an older generation unit with a previously designated capacity of 1,000 treatments per year. The capacity and need calculations for this facility and service area have also been adjusted.~~

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

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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 for the year immediately 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 ~~in Chapter XIII of this Plan~~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);
~~3.~~4. Cost Containment; and
~~4. Projected Revenues;~~
~~5. Projected Expenses;~~ Medically Underserved Groups.~~; and~~
~~6. Financial Feasibility; and~~
~~7.~~5. ~~Cost Containment.~~

Radiotherapy services are distributed statewide and are located within sixty (60) minutes' travel time for the majority of residents of the State. The benefits of improved accessibility

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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. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.~~

~~3.~~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 for the most recent year; and

   b. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of service, without reducing the utilization of existing units below the 80 percent threshold.

~~4.~~ Expansion of an existing radiosurgery service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the prior two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

~~3.~~

~~5.~~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

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circumstances.

~~6.~~5. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

~~7.~~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.

~~8.~~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.

~~9.~~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. Compliance with the Need Outlined in this Section of the Plan;~~
~~2.~~1. Community Need Documentation;
~~3.~~2. Distribution (Accessibility);
~~4. Projected Revenues;~~
~~5. Projected Expenses;~~Medically Underserved Groups;
3. ~~Financial Feasibility~~Record of the Applicant;
~~6. and~~

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4. Cost Containment; and
5. Medically Underserved Groups.
~~7.~~

The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within ninety (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.

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MEGAVOLTAGE VISITS
(Chapter IX)

Facility by Region	County	# Units	FY 2013	FY 2014	FY 2015
Region I					
Anmed Health Medical Center	Anderson	2	15,834	10,916	12,568
GHS Cancer Centers of the Carolinas - Andrews	Greenville	1	3,619	4,613	3,811
GHS Cancer Centers of the Carolinas - Eastside	Greenville	1	7,116	3,567	6,849
GHS Cancer Institute - Faris	Greenville	3	13,548	11,884	10,194
GHS Cancer Institute - Greer	Greenville	1	4,183	4,177	2,627
St. Francis Millenium Cancer Center ***1***	Greenville	1	--	--	--
GHS Cancer Institute- Seneca ***2***	Oconee	1	0	4,971	4,609
Baptist Medical Center Easley ***2***	Pickens	1	0	0	0
GHS Cancer Institute- Spartanburg	Spartanburg	1	3,058	3,168	2312
Spartanburg Regional Medical Center ***3***	Spartanburg				
Linear Accelerators		4	17790	24594	19739
Cyberknife		1			
Self Regional Healthcare	Greenwood	2	7,374	6,794	7,642
Region II					
Aiken Regional Medical Center	Aiken	2	7,904	8,080	8,841
Lancaster Radiation Therapy Center	Lancaster	1	2,675	5,290	4,513
Lexington Medical Center	Lexington	3	13,858	15,444	17,533
Newberry Oncology Associates ***2***	Newberry	1	2,675	0	0
Palmetto Health Richland ***2***	Richland				
Linear Accelerators		4	799	733	0
Gamma Knife		1	158	159	100
South Carolina Oncology Associates ***2***	Richland	4	0	0	0
Radiation Oncology, LLC ***2***	Richland	6	30,624	27,417	0
Rock Hill Radiation Therapy Center	York	2	11,002	10,846	11,341
Region III					
Carolinas Hospital System ***2***	Florence	1	3,064	2,806	0
Mcleod Regional Medical Center - Pee Dee	Florence	4	17,147	14,976	12,587
Georgetown Memorial Hospital ***4***	Georgetown	1	6,393	6,398	5,501
Carolina Regional Cancer Center	Horry	2	22,143	23,547	22,840
Carolina Regional Cancer Center - Conway ***2***	Horry	1	0	0	0
Carolina Regional Cancer Center - Murrels Inlet ***2,6***	Horry	1	0	0	0
Grand Strand Regional Medical Center ***7***	Horry	1	0	0	0
Tuomey	Sumter	2	9,204	9,065	7,841
Region IV					
SJC Oncology Services - SC	Beaufort	1	4,385	4,644	7,191
Bon Secours St. Francis Xavier ***2***	Charleston	1	0	6,557	7,328
Beaufort Memorial Hospital ***2***	Beaufort	1	4,686	4,851	0
MUSC Medical Center	Charleston				
Linear Accelerators		5	19824	18871	19823
Gamma Knife		1	202	213	258
Roper Hospital	Charleston	3	14,209	8,270	6,905
Trident Medical Center	Charleston	3	11,724	11,239	12,493
Regional Medical Center of Orangeburg & Calhoun Counties	Orangeburg	1	6,761	5,739	5,607
	Totals		**261,959**	**259,829**	**221,053**

1 Facility completed April 2016.
2 Facility did not report required JAR data.
3 Gibbs Regional Cancer Center utilization included with Spartanburg Regional Medical Center.
4 CON SC-15-42 issued November 6, 2015 for relocation of an existing LINAC to a new facility.
5 CON SC-16-09 issued March 7, 2016 for relocation and replacement of an existing LINAC at a new center.
6 CON SC-16-10 issued March 7, 2016 for establishment of new radiation center attached to facility.

RADIOTHERAPY
(Chapter IX)

Service Areas	2013 Population	# OF LINAC	Pop Per LINAC	Total Area Treatments	Treatments Per LINAC	Planning Area Capacity	Percent Capacity
Anderson, Oconee	270405	3	90,135	17177	5726	18,500	92.8%
Greenville, Pickens	613554	8	76,694	23481	4696	53,500	43.9%
Cherokee, Spartanburg, Union	381273	6	63,546	22051	3675	34,000	64.9%
Chester, Lancaster, York	369304	3	123,101	15854	5285	21,000	75.5%
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	217666	2	108,833	7642	3821	14,000	54.6%
Fairfield, Kershaw, Lexington, Newberry, Richland	813246	19	42,802	17533	2505	131,000	13.4%
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro	342940	5	68,588	12587	2517	32,500	38.7%
Clarendon, Lee, Sumter	159151	2	79,576	7841	3921	14,000	56.0%
Georgetown, Horry, Williamsburg	403032	6	67,172	28341	7085	40,000	70.9%
Bamberg, Calhoun, Orangeburg	118869	2	59,435	5607	5607	14,000	40.1%
Allendale, Beaufort, Hampton, Jasper	236895	2	118,448	7191	3596	14,000	51.4%
Berkeley, Charleston, Colleton, Dorchester	782257	12	65,188	46549	4232	56,500	82.4%
Aiken, Barnwell	187554	2	93,777	8841	4421	14,000	63.2%
State Total	**4,896,146**	**72**	**68,002**	**220,695**	**3,065**	**457,000**	**48.3%**

CHAPTER X

POSITRON EMISSION TECHNOLOGY

POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

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

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

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and fused with the PET images for interpretation. Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time.

It is anticipated that PET and PET/CT will become a standard diagnostic modality in the fields of cardiology, oncology and neurology. This technology is often available in health care facilities providing specialized therapeutic services such as open heart surgery and radiation oncology. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger Certificate of Need review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

CERTIFICATE OF NEED STANDARDS*

* In the standards below, PET and PET/CT are used interchangeably.

1. Hospitals that provide specialized therapeutic services (open heart surgery and/or radiation therapy) should have either fixed or mobile PET services for the diagnosis of both inpatients and outpatients. Other hospitals must document that they provide a sufficient range of comprehensive medical services that would justify the need for

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PET services. Applicants for a freestanding PET service not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

2. Full-time PET scanner service is defined as having PET scanner services available five days per week. Fixed PET scanners are considered to be in operation five days per week. Capacity is considered to be 1,500 procedures annually. For PET/CT equipment, only procedures that utilize the PET component should be counted; procedures using the CT component as a stand-alone scanner are not included. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

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

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

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

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

7. The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

8. CMS requires that a provider seeking Medicare reimbursement must be accredited after January 1, 2012.

The Positron Emission Tomography (PET) and PET-CT Utilization Chart is located in Chapter XIII of this Plan.

~~POSITRON EMISSION MAMMOGRAPHY (PEM)~~

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~~Positron Emission Mammography (PEM) is a form of PET that uses high-resolution detection technology for imaging the breast. It creates images that are more easily compared to mammography since they are acquired in the same position. As with PET, a radiotracer is administered and the camera is used to provide a higher resolution image. However, the administered dose of tracer is only about half the amount of whole-body PET, which reduces the radiation dose to the patient.~~

~~PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and monitoring for recurrence of breast cancer. It detects lesions as small as 1.6 mm, which is not possible with whole-body PET. Three-dimensional reconstruction of the PEM images is also possible. PEM drastically reduces the number of false positives resulting in unnecessary biopsies incurred by patients using conventional mammography.~~

~~The actual scan takes 4-10 minutes and the entire process takes approximately 40 minutes to perform. The process requires a nuclear medical technologist certified to inject radiopharmaceuticals for handling of FDG, and either a mammography or nuclear medicine technologist to perform patient positioning and biopsy.~~

~~PEM was cleared for marketing by the U.S. Food and Drug Administration (FDA) in August of 2003.~~

~~CERTIFICATE OF NEED STANDARDS~~

1. ~~PEM scanners are considered to be in operation five days per week, but because of their limited focus no capacity standard is established.~~

2. ~~Hospitals that provide comprehensive cancer treatment services (including radiation therapy) are appropriate locations for fixed or mobile PEM services for the detection of breast cancer. Other hospitals must document that they treat a sufficient number of breast cancer patients that would justify the need for PEM services.~~

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

4. ~~The applicant agrees in writing to provide to the Department utilization data on the operation of the PEM service.~~

5. ~~The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.~~

~~RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA~~

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

~~1. Compliance with the Need Outlined in this Section of the Plan;~~
~~2. Community Need Documentation;~~
~~3. Distribution (Accessibility);~~
~~4. Acceptability;~~
~~5. Financial Feasibility;~~
~~6. Ability of the Applicant to Complete the Project; and~~
~~7. Cost Containment.~~

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

CHAPTER XI

OUTPATIENT FACILITIES

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

AMBULATORY SURGICAL FACILITY

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

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

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

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

CERTIFICATE OF NEED PROJECTIONS AND STANDARDS

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1. The county in which the proposed facility is to be located is considered to be the

service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties.

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

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

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

~~5. It is recommended that an application for a new ASF should contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility.~~

~~6.~~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 and referral patterns.

~~7.~~6. ~~All new Certificate of Need approvals by the Department will not restrict the specialties of ASFs. However, for an ASF approved to perform only endoscopic procedures, *another Certificate of Need would be required* before the center could provide other surgical specialties.~~The applicant must document whether it will restrict surgeries by specialty. Applicants who 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.

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~~8.~~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.

~~9.~~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.

~~10.~~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.

~~11.~~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~~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.

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The Ambulatory Surgical Facility Utilization Chart is located in Chapter XIII of this Plan.

RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

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

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

~~2.~~1. ~~Adverse Effects on Other Facilities~~
~~3.~~2. Community Need Documentation;
3. Distribution (Accessibility);
4. Projected Revenues;
~~4.~~5. Projected Expenses;
~~5.~~6. ~~Financial Feasibility~~Record of the Applicant;
~~6.~~7. Cost Containment;
~~7.~~1. ~~Projected Revenues;~~
~~8. Projected Expenses;~~
8. ~~Ability of the Applicant to Complete the Project~~Medically Underserved Groups;
~~9. and~~
9. Staff Resources; and
~~.~~Adverse Effects on Other Facilities.
10.

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

FREESTANDING EMERGENCY HOSPITAL SERVICES

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

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

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

~~Level III: Offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster.~~

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~~Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.~~

~~Level IV: Offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.~~The popularity of freestanding emergency hospital services is increasing as a means of providing ready access to such services at the community level.

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CERTIFICATE OF NEED PROJECTIONS AND STANDARDS ~~FOR FREESTANDING EMERGENCY SERVICES~~

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1. *A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).*

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

3. Regulation 61-16 will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

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

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

~~6.~~ The applicant must demonstrate need for this service by documenting ~~where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.~~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.

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The Freestanding Emergency Services Chart is located at the end of this Chapter. ~~in Chapter XIII of this Plan~~.

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RELATIVE IMPORTANCE OF PROJECT REVIEW CRITERIA

The following project review criteria are considered to be the most important in evaluating

Certificate of Need applications for this service:

~~1. Compliance with the Need Outlined in this Section of the Plan;~~
~~2.~~1. Community Need Documentation;
2. Distribution (Accessibility);
~~3.1. Medically Underserved Groups;~~
3. Resource Availability; ~~and~~
~~4.~~
4. ~~Financial Feasibility~~Record of the Applicant; and~~.~~
5. Medically Underserved Groups.~~;~~
~~5.~~

Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will ~~be equally weighed with~~outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

~~TRAUMA REFERRAL SYSTEM~~

~~The morbidity and mortality of a patient is negatively affected if trauma services are not provided in the first hour after an injury. This concept is often referred to as the "golden hour" to emphasize the need to provide timely care to trauma patients. The Department's Division of Emergency Medical Services (EMS) recognizes the National Fire Protection Association's benchmark for the organization and deployment for emergency medical operations to the public. The NFPA 1710 requires a turnout time of one (1) minute with a four (4) minute or less arrival of the first responder at an emergency medical incident on ninety percent (90%) of all calls.~~

~~EMS has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become so designated. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency Departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.~~

~~Level I: A Level I facility is a regional trauma center that provides the highest level of trauma services available. It must possess an adequate depth of resources and personnel to meet this central role. The facility must have a surgically directed Intensive Care Unit (ICU) and in-house physician coverage at all times. The facility must possess an adequately staffed operating room that is immediately available to treat trauma victims. The operating room staff may not have duties requiring their presence outside of the operating room, and in-house anesthesia services must be available 24 hours a day. A mechanism must exist for staffing a second operating room if the first room is occupied. The facility must have a full spectrum of specialists available including cardiology, infectious disease, pulmonary~~

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~~medicine, and nephrology along with adequate support staff.~~

~~Level II: A Level II facility is a hospital that provides initial trauma services to all trauma victims. It must possess a surgical director or co-director for the ICU and have physician coverage in the emergency department whenever there is an emergency in the ICU. The facility must possess an adequately staffed operating room that is readily available to treat trauma victims. A mechanism must exist for staffing a second operating room if the first room is occupied. The facility must have surgical, internal medicine and pulmonary specialists available at all times with the ability to order specialty consultations for internal medicine, cardiology, infectious disease, pulmonary medicine, and gastroenterology as needed.~~

~~Level III: A Level III facility provides prompt assessment, resuscitation, emergency operations and stabilization to trauma victims. It is led by a trauma surgeon who remains in charge of multiple-injured adult trauma patients in the ICU. When a patient is critically ill, there must be a mechanism to promptly provide ICU physician coverage 24 hours per day. The facility must have an ongoing performance improvement and patient safety (PIPS) program to review admissions and arrange transfers to ensure the appropriateness of medical care. The facility must possess an adequately staffed operating room that is readily available to treat trauma victims. Orthopedic surgery and internal medicine specialists must be available.~~

AMBULATORY SURGERY FACILITY UTILIZATION
(Chapter XI)

		2015							
Facility by Region	**County**	**# 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	3,942	464	4,406	1,469	
Upstate Endoscopy Center	Anderson		2	2		4,499	4,499		2,250
GHS Cross Creek Surgery Center	Greenville	4		4	4,690		4,690	1,173	
Endoscopy Center of the Upstate *****	Greenville		3	3			0		0
Greenville Endoscopy Center	Greenville		3	3		6,063	6,063		2,021
Greenville Endoscopy Center - Patewood	Greenville		3	3		6,373	6,373		2,124
GHS Patewood Outpatient Surgery Center	Greenville	6	2	8	6,525	2,352	8,877	1,088	1,176
Piedmont Surgery Center	Greenville	4		4	3,957		3,957	989	
Jervey Eye Center *	Greenville	3		3			0	0	
Upstate Surgery Center	Greenville	2		2	2,684		2,684	1,342	
Greenwood Endoscopy Center	Greenwood		4	4		8,835	8,835		2,209
Surgery Center of the Lakelands	Greenwood	5		5	4,199		4,199	840	
Surgery & Laser Center at Professional Park	Laurens	2		2	3,480		3,480	1,740	
Blue Ridge Surgery Center	Oconee	2		2	1,985		1,985	993	
Synergy Spine Center *****	Oconee	2		2			0	0	
Ambulatory Surgery Center of Spartanburg	Spartanburg	7	2	9	7,053	3,413	10,466	1,008	1,707
Spartanburg Surgery Center	Spartanburg	4		4	4,644		4,644	1,161	
Surgery Center at Pelham	Spartanburg	4	2	6	2,234	1,144	3,378	559	572
GHS Surgery Center - Spartanburg *****	Spartanburg	2		2			0	0	
Region II									
Ambulatory Surgical Center of Aiken *****	Aiken	4	1	5			0	0	0
Carolina Ambulatory Surgery Center	Aiken	1		1	2,853		2,853	2,853	
Center for Colon & Digestive Diseases *****	Aiken		2	2			0		0
Surgery Center at Edgewater	Lancaster	3	1	4	1,726	23	1,749	575	23
Chapin Orthopedic Surgery Center **1**	Lexington	2		2					
Midlands Endoscopy Center	Lexington		2	2	2643	2,571	5,214		2,607
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	4		4	4,550		4,550	1,138	
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,898		1,898	475	
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,829	731	3,560	707	731
South Carolina Endoscopy Center	Lexington		4	4		11,425	11,425		2,856
Urology Surgery Center *	Lexington	2		2			0	0	
Berkeley Endoscopy Center	Richland		2	2		1,353	1,353		677
Columbia Eye Surgery Center	Richland	4		4	6,349		6,349	1,587	
Columbia GI Endoscopy Center	Richland		4	4		4,297	4,297		1,074
Lake Murray Endoscopy Center	Richland		2	2		2,248	2,248		1,124
Midlands Orthopaedics Surgery Center	Richland	4		4	2,943		2,943	736	
Palmetto Endoscopy Suite	Richland		2	2		3,969	3,969		1,985
Palmetto Surgery Center	Richland	5		5	5,104		5,104	1,021	
South Carolina Endoscopy Center - Northeast	Richland		5	5		6,562	6,562		1,312
Carolina Colonoscopy Center *	Richland		2	2			0		0
Carolina Surgical Center	York	4		4	5,519		5,519	1,380	
Center for Orthopaedic Surgery	York	3		3	2,878		2,878	959	
York County Endoscopy Center	York		3	3		6,166	6,166		2,055
Region III									
Florence Surgery & Laser Center	Florence	2		2	4,067		4,067	2,034	
McLeod Ambulatory Surgery Center	Florence	2		2	1,815		1,815	908	
Physicians Surgical Center of Florence *	Florence	4	2	6			0	0	0
Bay Microsurgical Unit	Georgetown	1		1	5,069		5,069	5,069	
Carolina Coast Surgery Center	Georgetown	2		2	682		682	341	
Tidelands Georgetown Endoscopy Center	Georgetown		1	1		1,046	1,046		1,046
Tidelands Waccamaw Surgery Center	Georgetown	1		1	942		942	942	
Carolina Bone and Joint Surgery Center	Horry	3		3	2,859		2,859	953	
Grande Dunes Surgery Center *	Horry	3	1	4			0	0	0
Parkway Surgery Center	Horry	2		2	5,035		5,035	2,518	
Rivertown Surgery Center	Horry	3		3	512	441	953	318	
Strand GI Endoscopy Center	Horry		2	2		4,982	4,982		2,491
Wesmark Ambulatory Surgery Center	Sumter	2		2	6,169		6,169	3,085	
Region IV									
Bluffton Okatie Surgery Center	Beaufort	2			1,466	601	2,067	1,034	
Laser and Skin Surgery Center	Beaufort	2		2	1,548		1,548	774	
Outpatient Surgery Center of Hilton Head	Beaufort	3	2	5	3,796	3,200	6,996	1,265	1,600
Roper Hospital Ambulatory Surgery Berkeley	Berkeley	3		3	412	439	851	284	

AMBULATORY SURGERY FACILITY UTILIZATION
(Chapter XI)

		2015							
Facility by Region	**County**	**# of Ors**	**# of Endos**	**Total # of Suites**	**Total Operations**	**Total Endos**	**Combined Total**	**Operations per OR**	**Endos per Suite**
Center for Advanced Surgery *	Charleston	2		2			0	0	
Charleston Endoscopy Center	Charleston		5	5		9,937	9,937		1,987
Charleston Surgery Center	Charleston	4	1	5	3,839	1,994	5,833	960	1,994
Colorectal EndoSurgery Institute of the Carolinas	Charleston		2	2	179	340	519		260
Elms Endoscopy Center	Charleston		3	3		7,426	7,426		2,475
Lowcountry Ambulatory Center	Charleston	2		2	1,703		1,703	852	
MUSC Musculoskeletal Institute **2**	Charleston	2	2	4					
Palmetto Endoscopy Center	Charleston		2	2		4,844	4,844		2,422
Physicians Eye Surgery Center	Charleston	4		4	11,084		11,084	2,771	
Roper Hosp Ambulatory Surg & Pain Mgt James Island	Charleston	4		4	3,044		3,044	761	
Roper St. Francis Eye Center	Charleston	3		3	1,464		1,464	488	
Southeastern Spine Institute	Charleston	2		2	14,376		14,376	7,188	
Surgery Center of Charleston	Charleston	4		4	5,516		5,516	1,379	
Trident Ambulatory Surgery Center	Charleston	6		6	4,449	657	5,106	851	
Colleton Ambulatory Surgery Center	Colleton	2	1	3	753		753	377	
Lowcountry Outpatient Surgery Center	Dorchester	3		3	7,065		7,065	2,355	
Summerville Endoscopy Center *	Dorchester		2	2			0		0
	Totals	**167**	**78**	**243**	**172,529**	**108,395**	**280,924**	**1,033**	**1,390**

***** Facility did not report 2015 JAR.

1 CON SC-15-49 issued 12/23/15 for the construction of a general ASF with 2 ORs.

2 CON granted on 6/27/16 for the construction of a new ASF with 2 ORs and 2 endoscopy suites, pending appeal.

FREESTANDING EMERGENCY SERVICES*
(Chapter XI)

Freestanding ER	**Associated With**	**City**	**County**
Moncks Corner Medical Center	Trident Medical Center	Moncks Corner	Dorchester
Roper Hospital Diagnostics and ER - Berkeley	Roper St. Francis	Moncks Corner	Berkeley
Roper Hospital Diagnostics and ER - Northwoods ***1***	Roper St. Francis	North Charleston	Charelston
North Strand Medical Center	Grand Strand Regional Medical Center	Myrtle Beach	Horry
Seacoast Medical Center	Loris Community Hospital	Little River	Horry
South Strand Ambulatory Care Center	Grand Strand Regional	Myrtle Beach	Horry
McLeod Health Carolina Forest Campus ***2***	McLeod Loris Seacoast Hospital	Myrtle Beach	Horry
Carolina Forest Emergency ***3***	Grand Strand Regional Medical Center	Myrtle Beach	Horry
Coastal Carolina Hospital ***4***	Coastal Carolina Medical Center	Hardeeville	Jasper
Fort Mill Freestanding Emergency Department ***5***	Piedmont Medical Center	Fort Mill	York

1 Approved November 15, 2016, in appeal
2 Approved January 23, 2017, in appeal
3 Approved January 23, 2017, in appeal
4 Approved January 23, 2017, in appeal
5 Approved April 11, 2015, in appeal

CHAPTER XII

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 ~~2015~~2017. 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. ~~Additional beds may be approved in counties with a positive bed need up to the need indicated~~ using the ratio of 39 beds/1,000 population age 65 and over.

~~2.~~1. 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.~~2. 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 Bed Need Chart is located ~~in Chapter XIII of this Plan~~at the end of this

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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. ~~Compliance with the Need Outlined in this Section of the Plan~~Community Need Documentation;
2. Projected Revenues;
3. Projected Expenses;
4. Net Income;
5. Methods of Financing;
6. ~~Financial Feasibility~~Staff Resources;
7. Record of the Applicant; and
8. Distribution (accessibility).

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Because nursing facilities are located within approximately thirty (30) ~~minutes~~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.

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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 ~~in Chapter XIII of this Plan.~~at the end of this Chapter.

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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 2 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. 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 (5) 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 (5) 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

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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.

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The Swing-Bed Participants Chart is located ~~in Chapter XIII of this Plan~~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 ~~in Chapter XIII of this Plan~~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:

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1. ~~Compliance with the Need Outlined in this Section of the Plan~~Community Need Documentation;
2. Distribution (Accessibility);
3. ~~Community Need Documentation;~~
4. ~~4.~~3. Acceptability;
5. ~~5.~~4. ~~Financial feasibility~~Record of the Applicant; and
5. Staff Resources.

Hospice services should be available within sixty (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.

6. ~~6.~~

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.

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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 paragraph 8 of this section of the Plan within two years of the initiation of patient services after receiving a home health license.

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

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

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

7. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, consent order, abandonment of

patients in other business operations, or loss of license. However, any consent orders or loss of licenses related to licenses that were obtained from the Department between July 1, 2013 and May 22, 2014 without a Certificate of Need shall not be grounds for denial of a Certificate of Need application pursuant to this Section. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

8. The applicant must document that it can serve at least 25 patients annually in each rural county for which it is licensed and 50 patients annually in each non-rural county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should it fail to reach this threshold number two years after initiation of services in a county, it will voluntarily relinquish its license for that county.

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

The Home Health Agency Utilization Chart is located ~~in Chapter XIII of this Plan~~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;
~~1.~~2. Distribution (Accessibility);
~~2.~~3. Acceptability;
~~3. Distribution (Accessibility);~~
~~4. Medically Underserved Groups;~~
~~5.~~4. Record of the Applicant; and
5. ~~Financial Feasibility.~~Medically Underserved Groups.
~~6.~~

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

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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

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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 XII)

Region I	# Beds
Abbeville	
Abbeville Nursing Home	94
Anderson	
Brookdale Anderson	44
Ellenburg Nursing Center	181
IVA Rehabilitation & Healthcare Center	60
Linley Park Rehab & Healthcare	88
NHC HealthCare of Anderson	290
Richard M. Campbelle VA Nursing Home	220
Southern Oaks Rehab & Healthcare	88
Cherokee	
Blue Ridge in Brookview House	132
Cherokee County LTC Facility	111
Greenville	
Arboretum at the Woodlands	30
Brookdale Greenville	45
Brushy Creek Rehab & Healthcare	144
Fountain Inn Nursing Home	60
GHS Memorial Hospital Subacute Unit	15
Greenville Rehab & Healthcare	132
Greer Rehab & Healthcare	133
Heartland Health Care Center - East	132
Heartland Health Care Center - West	125
Linville Courts at the Cascades Verdae	44
Magnolia Manor	99
Magnolia Place at Greenville	120
NHC HealthCare Greenville	176
NHC HealthCare Mauldin	180
Patewood Rehab & Healthcare	120
Poinsett Rehab & Healthcare	132
River Falls Rehab & Healthcare	44
Rolling Green Village Health Care	74
Simpsonville Rehab & Healthcare	132
Greenwood	
Greenwood Transitional Rehab Unit	12
Health Care Center of Wesley Commons ***1***	80
Magnolia Manor - Greenwood	88
NHC HealthCare Greenwood	152
Laurens	
GHS Laurens County Memorial Subacute	3
Martha Franks Baptist Retirement	88
NHC HealthCare Clinton	131
NHC HealthCare Laurens	176

LONG-TERM CARE INVENTORY
(Chapter XII)

Presbyterian Communities - Clinton	66
McCormick	
McCormick Rehab & Healthcare	120
Oconee	
GHS Lila Doyle	120
Seneca Health & Rehab	132
Pickens	
Brookdale Easley	60
Capstone Rehab & Healthcare	60
CARC Health Care Center ***2***	68
Fleetwood Rehab & Healthcare	103
Manna Rehab & Healthcare	130
Presbyterian Communities - Foothills	44
PruittHealth Pickens	44
Spartanburg	
Brookdale Skylyn	44
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 Rehab & Wellness	120
Rosecrest Rehab & Healthcare	75
Spartanburg Hospital for Restorative Care	25
Summit Hills Skill Nursing	33
Valley Falls Terrace	88
White Oak Estates	88
White Oak Manor Spartanburg	192
Woodruff Manor	88
Union	
Ellen Sagar Nursing Center	113
Heartland Health Care Center- Union	88

Region II

Aiken	
Anchor Rehab & Healthcare ***3***	120
Azaleawoods Rehab & Nursing	86
NHC HealthCare N. Augusta	192
Pepper Hill Nursing & Rehab	132
PruittHealth Aiken	176
PruittHealth N. Augusta	132
Barnwell	
Laurel Baye Healthcare of Blackville	85

LONG-TERM CARE INVENTORY
(Chapter XII)

Laurel Baye Healthcare of Williston	44
PruittHealth Barnwell	44
Chester	
Chester Nursing Center	100
Edgefield	
Ridge Rehab & Healthcare	120
Fairfield	
Blue Ridge in the Fields	112
PruittHealth Ridgeway	150
Kershaw	
KershawHealth Karesh Long Term Care	96
Springdale Healthcare	148
Lancaster	
Lancaster Convalescent Center	142
Transitional Care Unit at Springs Memorial	14
White Oak Manor Lancaster	132
Lexington	
Brian Center of Nursing Care	108
Heritage at Lowman Rehab & Healthcare	176
Laurel Crest Retirement Center	12
Lexington Medical Center Extended Care	388
Millennium Post Acute Rehab	132
NHC HealthCare Lexington	170
Opus Post Acute Rehab	100
Presbyterian Communities - Columbia	44
SC Episcopal Home at Still Hope ***4***	70
Wellmore of Lexington ***5***	60
Newberry	
JF Hawkins Nursing Home	118
White Oak Manor Newberry	146
Richland	
CM Tucker Jr. Nursing Center Fewell & Stone Pavilions	252
CM Tucker Jr. Nursing Center Rodney Pavilion	308
Countrywood Nursing Center	38
Heartland of Columbia Rehab & Nursing	132
Life Care Center of Columbia	179
Midlands Health & Rehab	88
NHC HealthCare Parklane	180
Palmetto Health Rehab Center	22
PruittHealth Blythewood	120
PruittHealth Columbia	185
Rice Estate Rehab & Healthcare	80
White Oak Manor Columbia	120
Wildewood Downs Nursing & Rehab	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 & Rehab	66
White Oak Manor York	109
White Oak of Rock Hill	141
Willow Brook Court at Park Point 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	88
Dillon	
PruittHealth Dillon	84
Sunny Acres Nursing Home	111
Florence	
Commander Nursing Home	163
Dr. Ronald E McNair Nursing & Rehab	88
Faith Healthcare Center	104
Florence Rehab & Nursing Center	88
Heritage Home of Florence	132
Honorage Nursing Center	88
Lake City-Scranton Healthcare Center	88
Methodist Manor Healthcare Center	32
Presbyterian Communities - 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

LONG-TERM CARE INVENTORY
(Chapter XII)

Compass Post Acute Rehab	95
Conway Manor	190
Covenant Towers Health Care	30
Grand Strand Rehab & Nursing Center	88
Kingston Nursing Center	88
Loris Rehab & Nursing	88
Myrtle Beach Manor	60
NHC HealthCare Garden Center	148
Lee	
McCoy Memorial Nursing Center	120
Marion	
Mullins Nursing Center	92
Marlboro	
Dundee Manor	110
Sumter	
Blue Ridge of Sumter	96
Covenant Place Nursing Center	44
NHC HealthCare Sumter	138
Palmetto Health Tuomey Subacute	18
Sumter East Health & Rehab	176
Williamsburg	
Kingstree Nursing Facility	96

Region IV

Allendale	
John Edward Harter Nursing Center	44
Bamberg	
Pruitthealth Bamberg	88
Beaufort	
Bayview Manor	170
Broad Creek Care Center	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 ***6***	65
Sprenger Healthcare of Bluffton ***7***	65
Berkeley	
Heartland Health & Rehab	135
Lake Moultrie Nursing Home	88
Pruitthealth Moncks Corner	132
Wellmore of Daniel Island ***8***	60
Calhoun	

LONG-TERM CARE INVENTORY
(Chapter XII)

Calhoun Convalescent Center	120
Charleston	
Bishop Gadsden Episcopal Health Care	50
Franke Health Care Center	44
Heartland of West Ashley Rehab & Nursing	125
John's Island Rehab & Healthcare	132
Life Care Center of Charleston	148
Mount Pleasant Manor	132
NHC HealthCare Charleston	132
Riverside Health & Rehab	160
Sandpiper Rehab & Nursing	176
Savannah Grace at the Palms of Mt. Pleasant ***9***	48
South Bay at Mount Pleasant ***10***	40
Vibra Hospital of Charleston - TCU	35
White Oak Manor Charleston	176
Colleton	
Pruitthealth Walterboro	132
Veteran's Victory House	220
Dorchester	
Hallmark Healthcare Center	88
Oakbrook Health & Rehab	88
Presbyterian Communities - Summerville	87
St. George Healthcare Center	88
Hampton	
Pruitthealth Estill	104
Jasper	
Ridgeland Nursing Center	88
Orangeburg	
Jolley Acres Healthcare	60
Methodist Oaks	122
Pruitthealth Orangeburg	88
Riverside Rehab & Healthcare	113
==========	==========
Statewide Total	**20,603**

1 CON SC-15-31 issued August 20, 2015 for construction of a replacement facility and reduction from 102 to 80 nursing home beds.

2 CON SC-15-17 issued April 29, 2015 for construction for the addition of 16 nursing home beds for a total of 68 nursing home beds.

3 CON SC-15-02 issued January 16, 2015 for construction for the addition of 60 nursing home beds for a total of 120 nursing home beds.

4 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.

5 CON SC-15-28 issued August 18, 2015 for the construction for a new 60 bed nursing home.

LONG-TERM CARE INVENTORY
(Chapter XII)

6 CON SC-16-06 issued February 22, 2016 for construction for a new 65 bed nursing home.

7 CON SC-17-19 issued April 13, 2017 for construction for a new 65 bed nursing home.

8 CON SC-15-43 issued November 20, 2015 for construction for a new 60 bed nursing home.

9 CON SC-16-15 issued April 8, 2016 for renovation for the addition of six nursing home beds for a total of 48 nursing home beds.

10 CON SC-16-154 issued December 9, 2016 for construction for a new 40 bed nursing home.

LONG-TERM CARE BED NEED
(Chapter XII)

Regions	2019 Pop 65+ (000)	Bed Need (Pop x 39)	Existing Beds	Total # Beds to be Added
Region I				
Abbeville	5.52	215	94	121
Anderson	37.75	1,472	971	501
Cherokee	9.66	377	243	134
Greenville	84.61	3,300	1,937	1,363
Greenwood	13.23	516	332	184
Laurens	12.57	490	464	26
McCormick	3.28	128	120	8
Oconee	18.47	720	252	468
Pickens	21.11	823	509	314
Spartanburg	51.74	2,018	1,328	690
Union	5.70	222	201	21
Region I Total	**263.64**	**10,281**	**6,451**	**3,830**
Region II				
Aiken	34.56	1,348	838	510
Barnwell	3.9	152	173	(21)
Chester	6.12	239	100	139
Edgefield	5	195	120	75
Fairfield	4.73	184	262	(78)
Kershaw	12.23	477	244	233
Lancaster	21.24	828	288	540
Lexington	49.1	1,915	1,260	655
Newberry	7.88	307	264	43
Richland	56.37	2,198	1,784	414
Saluda	4.28	167	176	(9)
York	41.01	1,599	753	846
Region II Total	**246.42**	**9,609**	**6,262**	**3,347**
Region III				
Chesterfield	8.33	325	224	101
Clarendon	7.71	301	152	149
Darlington	12.85	501	418	83
Dillon	5.34	208	195	13
Florence	24.16	942	915	27
Georgetown	17.78	693	256	437
Horry	87.36	3,407	854	2,553
Lee	3.49	136	120	16
Marion	6.11	238	92	146
Marlboro	4.66	182	110	72
Sumter	17.96	700	472	228
Williamsburg	6.78	264	96	168
Region III Total	**202.53**	**7,897**	**3,904**	**3,993**
Region IV				
Allendale	1.82	71	44	27
Bamberg	2.99	117	88	29
Beaufort	54.24	2,115	643	1,472
Berkeley	33.41	1,303	415	888
Calhoun	3.51	137	120	17
Charleston	70.66	2,756	1,398	1,358
Colleton	8.11	316	352	(36)
Dorchester	22.51	878	351	527
Hampton	3.69	144	104	40
Jasper	7.31	285	88	197
Orangeburg	17.33	676	383	293
Region IV Total	**225.58**	**8,798**	**3,986**	**4,812**
Statewide Totals	**938.17**	**36,585**	**20,603**	**15,982**

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

SWING-BED PARTICIPANTS
(Chapter XII)

FACILITY	TOTAL BEDS	SWING BEDS	2015 ADMISSIONS	2015 PT DAYS	ADC
Abbeville Area Medical Center	25	25	65	719	1.97
Allendale County Hospital ***1***	25	25	0	0	0.00
Mcleod Health Cheraw ***1***	59	49	0	0	0.00
Edgefield County Hospital	25	25	130	209	0.57
Fairfield Memorial Hospital	25	25	66	495	1.36
Hampton Regional Medical Center	32	10	9	88	0.24
Carolinas Hospital System- Marion	124	10	13	98	0.27
McLeod Medical Center - Darlington	72	24	116	7,293	19.98
Newberry County Memorial Hospital	90	20	69	585	1.60
Union Medical Center ***1***	143	12	0	0	0.00
Williamsburg Regional Hospital ***1***	25	10	0	0	0.00

1 Facility did not report required JAR data.

INPATIENT HOSPICE FACILITIES
(Chapter XII)

Facility by Region	County	2015 Total Beds	2015 Admissions	2015 Patient Days	2015 % Occupancy Rate
Region I					
Callie & John Rainey Hospice House	Anderson	32	*633*	*6570*	56.3%
McCall Hospice House of Greenville	Greenville	30	777	6,035	55.1%
Hospice House of Hospicecare of the Piedmont	Greenwood	15	*478*	*2270*	41.5%
Hospice of Laurens County	Laurens	12	*102*	*933*	21.3%
GHS Cottingham Hospice House	Oconee	15	284	2,922	53.4%
Hospice House of the Carolina Foothills	Spartanburg	12	200	1,787	40.8%
Spartanburg Regional Hospice Home	Spartanburg	15	572	5,050	92.2%
Total		**131**	**3,046**	**25,567**	**53.5%**
Region II					
Agape House of Lexington ***1***	Lexington	30	--	--	--
Agape Hospice House of the Midlands	Richland	12	195	2,031	46.4%
Hospice & Community Care House	York	16	242	2,734	46.8%
Total		**28**	**437**	**4,765**	**46.6%**
Region III					
McLeod Hospice House	Florence	24	735	4,741	54.1%
Tidelands Community Hospice House	Georgetown	12	318	2,311	52.8%
Embrace Hospice House of the Grand Strand **2**	Horry	36	--	--	--
Total		**72**	**1,053**	**7,052**	**26.8%**
Region IV					
Agape House of Summerville **3**	Berkeley	30	--	--	--
Hospice Center of Hospice of Charleston	Charleston	20	780	3,440	47.1%
Total		**20**	**780**	**3,440**	**47.1%**
Statewide Total		**251**	**5,316**	**40,824**	**44.6%**

1 CON SC-15-13, issued March 30, 2015 for the construction of a 30-bed inpatient hospice.
2 CON SC-15-20, issued April 30, 2015 for the construction of a 36-bed inpatient hospice.
3 CON SC-16-07, issued February 16, 2016 for the construction of a 30-bed inpatient hospice.

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Advanced Home Care	Lancaster*, York*
Alere Womens & Childrens Health LLC - Midlands (May Serve Obstetrical Pattients Only)	Aiken, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, Richland
Alere Womens & Childrens Health LLC - Piedmont (May Serve Obstetrical Pattients Only)	Abbeville, Allendale, Anderson, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenville, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Saluda, Spartanburg, Sumter, Union, Williamsburg, York
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, Fairfield, Kershaw, Lexington, 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*, Greenville, Greenwood, Laurens, Spartanburg*
Amedysis Home Health of Conway	Horry
Amedysis Home Health of Georgetown	Georgetown, Williamsburg
Amedysis Home Health of Lexington	Aiken*, Barnwell*, Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland, Saluda*, Sumter
Amedysis Home Health of Myrtle Beach	Horry
AnMed Health Home Health Agency	Anderson

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Beaufort-Jasper Home Health Agency	Beaufort, Jasper
Bethea Home Health (May Serve Retirement Community Only)	Darlington
Brightstar Care	Lancaster*, York*
Brightstar Care Lowcountry	Beaufort*, Jasper*
Brightstar Care Upstate	Greenville*, Spartanburg*
Caring Neighbors Home Health	Fairfield
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
Florence Visiting Nurses Services	Dillon, Florence, Lee, Marion
Gentiva Health Services - Anderson	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Spartanburg, Union
Gentiva Health Services - Charleston	Berkeley, Charleston, Dorchester
Gentiva Health Services - Coastal	Georgetown, Horry, Williamsburg
Gentiva Health Services - Columbia	Lexington, Richland

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Gentiva Health Services - Greenville (May Only Serve Pattients in Union County with Initial Diag Requiring IV Therapy and/or Home Uterine Activity Monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union
Gentiva Health Services - Low Country	Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg
Gentiva Health Services - Midlands	Aiken, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, Newberry, Richland, Saluda, York
Gentiva Health Services - Pee Dee	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, Williamsburg
Gentiva Health Services - Upstate	Cherokee, Chester, Union, York
GHS Home Health Agency	Greenville, Pickens
GHS Home Health Agency - Oconee	Anderson, 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 (May Only Serve Terminally Ill Patients in Saluda County)	Abbeville, Greenwood, Laurens, McCormick, Saluda
Home Care of Lancaster	Lancaster
HomeCare of the Regional Medical Center	Bamberg*, Calhoun, Orangeburg
HomeChoice Partners (May Serve Pediatric Patients Only)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg, Union, & York
Home Health Services of Self Regional Healthcare	Abbeville, Edgefield*, Greenwood, Laurens, McCormick, Newberry*, Saluda

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Home Helpers of Bluffton	Beaufort*, Jasper*
Incare Home Health	Berkeley*, Charleston*, Chesterfield*, Darlington*, Dillon*, Florence*, Georgetown, Horry, Marion*, Marlboro*, Williamsburg*
Interim HealthCare	Beaufort, Berkeley*, Charleston*, Dorchester*
Interim HealthCare of Greenville Inc. Personal Care	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
Laurel Crest Home Health Agency (May Serve Retirement Community Only)	Lexington
Liberty Home Care - Aiken	Aiken
Liberty Home Care - Bennettsville	Marlboro
Liberty Home Care - Myrtle Beach	Horry
McLeod Home Health	Chesterfield*, Clarendon, Darlington, Dillon, Florence, Horry*, Lee, Marion, Marlboro* Sumter*
Methodist Manor Home Health (May Serve Retirement Community Only)	Florence
Methodist Oaks Campus Home Health (May Serve Retirement Community Only)	Orangeburg
MUSC Health at Home by Bayada - Charleston	Charleston

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Neighbors Care Home Health Agency an Amedisys Company	Chester, Lancaster*, York*
NHC HomeCare - Aiken	Aiken, Barnwell*, Edgefield*, Orangeburg*
NHC HomeCare - Beaufort	Beaufort*, Colleton*, Jasper*, Hampton*
NHC HomeCare - Greenwood	Abbeville*, McCormick*, Greenwood, Newberry*, Saluda*
NHC HomeCare - Laurens	Anderson*, Greenville, Laurens, 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
Palliative Care of the Lowcountry (Restricted to Terminally Ill Residents)	Beaufort, Jasper
Palmetto Health HomeCare	Lexington, Richland
Presbyterian Communities of SC Home Health Agency (May Serve Retirement Communities Only)	Berkeley, Dorchester, Florence, Laurens, Lexington, Pickens
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*

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
PruittHealth Home Health Low Country	Aiken, Allendale*, Bamberg*, Barnwell*, Beaufort, Berkeley*, Charleston*, Colleton*, Dorchester*, Hapton*, Jasper*, Orangeburg*
PHC Home Health	Berkeley*, Charleston, Dorchester*
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 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
Tidewater Home Health, PA	Lexington*, Richland*
Tri-County Home Health Care & Services	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*
Trinity Home Health of Aiken	Aiken, Barnwell, Edgefield

HOME HEALTH AGENCY INVENTORY
(Chapter XII)

Home Health Agency	**Counties Served**
Palmetto Health Tuomey Home Health (May Only Serve Terminally Ill Patients In Lee & Clarendon Counties)	Clarendon, Lee, Sumter
University Home Health - North Augusta	Aiken, Edgefield
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton, Orangeburg
Wesley Commons Home Health Care (May Serve Retirement Community Only)	Greenwood
Westminster Towers Home Health (May Serve Retirement Community Only)	York

* Received CON in 2016

~~CHAPTER XIII~~

~~INVENTORIES & DETERMINATIONS OF NEED~~

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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 Hospitals	Two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services.	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	An invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then	South Carolina

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Procedure	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.	Health Plan
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
Comprehensive Rehabilitation Facility	A facility operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. It provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty.	South Carolina Health Plan

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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 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.	South Carolina Health Plan
Crisis Stabilization Bed (Local Inpatient Crisis Stabilization Bed)	The South Carolina Department of Mental Health (DMH) has had substantial decreases in inpatient capacity, resulting in insufficient adult inpatient beds being available to meet the demand from referral sources for its beds. This has led to persons in a behavioral crisis waiting in hospital emergency rooms for an appropriate inpatient psychiatric bed to become available. DMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program."	South Carolina Health Plan
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	South Carolina Health Plan

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	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.	
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. The following ICD-9-CM Procedure Codes refer to diagnostic catheterizations: 37.21 Right Heart Cardiac Catheterization 37.22 Left Heart Cardiac Catheterization 37.23 Combined Right and Left Heart Cardiac Catheterization	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	South Carolina

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	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).	Health Plan
Endoscopy ASF	One organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.	South Carolina Health Plan
Exempt, Exemption	The following are exempt from Certificate of Need review: (1) The acquisition by a person of medical equipment to be used solely for research, the offering of an institutional health service by a person solely for research, or the obligation of a capital expenditure by a person to be made solely for research if it does not: (a) affect the charges imposed by the person for the provision of medical or other patient care services other than the services that are included in the research; (b) change the bed capacity of a health care facility; or (c) substantially change the medical or other patient care services provided by the person. A written description of the proposed research project must be submitted to the department in order for the department to determine if these conditions are met. A Certificate of Need is required in order to continue use of the equipment or service after the equipment or service is no longer being used solely for research. (2) The offices of a licensed private practitioner whether for individual or group practice except as	S.C. Code Ann. Section 44-7-170

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	provided for in Section 44-7-160(1) and (6). (3) The replacement of like equipment for which a Certificate of Need has been issued which does not constitute a material change in service or a new service.	
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,	S.C. Code Ann. Section 44-7-130(10)

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	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.	
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 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	South Carolina Health Plan

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	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 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.	S.C. Code Ann. Section 44-7-130(12)
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	South Carolina Health Plan

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	exclusively for emergency purposes are not included in this definition.	
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	South Carolina Health Plan

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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.

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
Narcotic 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 a Narcotic Treatment Program.*	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	South Carolina Health Plan

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	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.	
Open Heart Surgery	An operation performed on the heart or intrathoracic great vessels. The thoracic cavity is typically opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine.	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 procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.	South Carolina Health Plan
Outpatient Facility	Provide treatment/care/services to individuals	South

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	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.*	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
Pediatric Long-Term Care Hospital (PLATCH)	Specialized Healthcare Facilities that provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis. Care may be rehabilitative or palliative. Children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services. Many patients are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.	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 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 procedure used to revascularize occluded or partially occluded coronary arteries. A catheter with a balloon or a stent is inserted into the	South Carolina Health Plan

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	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)
Positron Emission Mammography (PEM)	A form of PET that uses high-resolution detection technology for imaging the breast. It creates images that are more easily compared to mammography since they are acquired in the same position. As with PET, a radiotracer is administered and the camera is used to provide a higher resolution image. However, the administered dose of FDG is only about half the amount of whole-body PET. PEM imaging is used for pre-surgical planning and staging, monitoring response to therapy, and monitoring for recurrence of breast cancer. Three-dimensional reconstruction of the PEM images is also possible.	South Carolina Health Plan
Positron Emission Tomography (PET)	Uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. PET allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. PETs are now being combined with a Computerized Tomography (CT) scanner to create PET/CT scanners. In the Certificate of Need standards cited below, the terms PET and PET/CT are used interchangeably; the Department does not differentiate between these modalities. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger Certificate of Need review and is interpreted by the	South Carolina Health Plan

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	Department to be the replacement of like equipment with similar capabilities.	
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 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.	South Carolina Health Plan
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

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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	South Carolina Health Plan

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	radiation therapy. It is also known as Stereotaxic Radiosurgery.	
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. The following ICD-9-CM Procedure Codes refer to therapeutic catheterizations: 00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) 17.55 Transluminal Coronary Atherectomy 35.52 Repair of Atrial Septal Defect with Prosthesis, Closed Technique 35.55 Repair of Ventricular Septal Defect with Prosthesis, Closed Technique 35.96 Percutaneous Valvuloplasty 36.06 Insertion of Non-Drug Eluting Coronary Artery	South Carolina Health Plan

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Stent(s)
36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
36.09 Other Removal of Coronary Artery Obstruction
37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Endovascular Approach

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