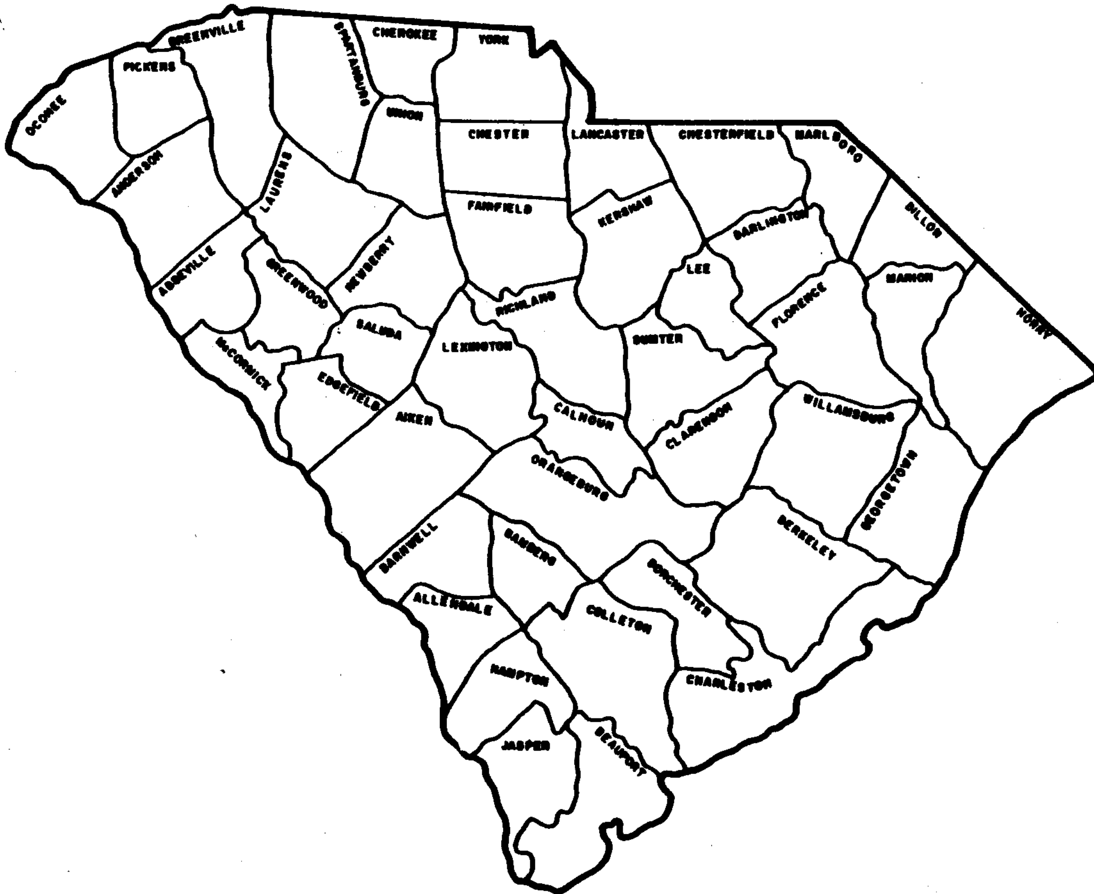
2008-2009

South Carolina Health Plan



South Carolina State Health Planning Committee
South Carolina Department of Health and Environmental Control

Effective September 12, 2008

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CHAPTER I

INTRODUCTION

Legal Basis

Purpose

Health Planning Committee

Relationship with Other Agencies

Standards of Construction and Equipment

Standards for Maintenance and Operation

State Certification of Need and Health Facility Licensure Act

Relative Importance of Project Review Criteria

Interpretation of the Plan

Safety of Patient Care

CHAPTER I

INTRODUCTION

A. Legal Basis:

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

B. Purpose:

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

C. Health Planning Committee:

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

D. Relationship With Other Agencies:

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

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

E. Standards of Construction and Equipment:

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

F. Standards for Maintenance and Operation:

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

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

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

2. This law requires the:

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

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

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

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

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

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

H. Relative Importance of Project Review Criteria:

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

I. Interpretation of the Plan:

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

J. Safety of Patient Care:

There is both local and national concern regarding issues of patient safety in the delivery of health care services. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon the quality of health care services, particularly in relation to patient safety. These issues include but are not limited to reduction of medical errors, elimination of wrong-patient/wrong-procedure surgical errors, reduction of medication errors and reducing the risk of health care-acquired infections. The Department of Health and Environmental Control shares this serious concern. Therefore, an applicant for a CON may be requested to provide specific detailed information related to patient safety and quality concerning specific services or programs. Through the use of benchmark data from mySChospitals.com, hospitalcompare.hhs.gov, leapfroggroup.org, or other sources, the applicant will document how its quality of care on the available measures compares to state, regional, or national averages.

CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

- Inventory Regions and Service Areas
- Exceptions to Service Area Standards
- Identification of Inventory Regions
- Estimated State Civilization Population
- Patient Statistics
- Facility Information and Plan Cut-Off Date
- Categories of Facilities & Services
    - General Medical Facilities and Services
        - General Hospitals
        - General Hospitals – Bed Supply
        - General Hospitals – Occupancy
        - Long-Term Care Hospitals
        - Critical Access Hospitals
        - Obstetrical & Neonatal Services
            - Obstetrical Services
            - Neonatal Services
        - Pediatric Inpatient Services
        - Cardiovascular Care
            - Cardiac Catheterization
            - Open Heart Surgery
        - Megavoltage Radiotherapy & Radiosurgery
            - Radiotherapy Equipment
            - Radiosurgery Equipment
        - Positron Emission Tomography (PET) & PET/CT
        - Outpatient Facilities
            - Ambulatory Surgical Facility
            - Emergency Hospital Services
            - Trauma Referral System
        - Community Psychiatric Beds
            - Crisis Stabilization Beds
        - Residential Treatment Facilities for Children & Adolescents
        - Alcohol & Drug Abuse Facilities
            - Medical Detoxification
            - Inpatient Treatment
            - Narcotic Treatment Programs
        - Rehabilitation Facilities
        - Long-Term Care Facilities & Services
            - Nursing Facilities
            - Medicaid Nursing Home Permits
            - Mental Retardation Facilities
            - Retirement Community Nursing Homes (Restricted Beds)
            - Hospice Programs
        - Home Health Agencies

CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

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

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

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

B. Exceptions to Service Area Standards:

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

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

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

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

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

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

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

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

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

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

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

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

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

D. Estimated State Civilian Population:

This Plan has been developed using the estimated civilian population of 4,263,980 for 2006 and projected population of 4,583,130 for 2013 where these projections were required for calculations. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2006 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was September 1, 2008.

G. Categories of Facilities and Services:

1. General Medical Facilities and Services

(A) General Hospitals

(1) Definitions:

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

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

(2) Bed Capacity is as follows:

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

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

Adequate square footage is defined as:

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

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

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

(c) For Areas Included:

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

(d) For Areas Excluded:

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

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

(3) Inventory:

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

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

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

(4) Narrative: General Hospital Beds

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

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

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

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

The methodology for calculating bed need is as follows:

(a) Calculations of bed need are made for individual hospitals, because of the differing occupancy factors used for individual facilities, and then summed by county to get the overall county bed need.

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

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

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

(d) If a county indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county 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.

(e) If there is a need for additional hospital beds in the county, then any entity may apply to add these beds within the county, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the county. 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.

(f) No additional hospitals will be approved unless they are a general hospital and will provide:

1. A 24-hour emergency services department, and meet the requirements to be a Level III emergency service as defined in Regulation 61-16 Sec. 613 Emergency Services.

2. Inpatient medical services to both surgical and non-surgical patients, and

3. Medical and surgical services on a daily basis within at least 6 of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS), as follows:

MDC 1: Diseases and disorders of the nervous system
MDC 2: Diseases and disorders of the eye
MDC 3: Diseases and disorders of the ear, nose, mouth and throat
MDC 4: Diseases and disorders of the respiratory system
MDC 5: Diseases and disorders of the circulatory system
MDC 6: Diseases and disorders of the digestive system
MDC 7: Diseases and disorders of the hepatobiliary system and pancreas
MDC 8: Diseases and disorders of the muscoskeletal system and connective tissue
MDC 9: Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10: Endocrine, nutritional and metabolic diseases and disorders
MDC 11: Diseases and disorders of the kidney and urinary tract
MDC 12: Diseases and disorders of the male reproductive system
MDC 13: Diseases and disorders of the female reproductive system
MDC 14: Pregnancy, childbirth and the puerperium
MDC 15: Newborns/other neonates with conditions originating in the prenatal period
MDC 16: Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC 17: Myeloproliferative diseases and disorders and poorly differentiated neoplasms
MDC 18: Infectious and parasitic diseases
MDC 19: Mental diseases and disorders
MDC 20: Alcohol/drug use and alcohol/drug-induced organic mental disorders
MDC 21: Injury, poisoning and toxic effects of drugs
MDC 22: Burns

MDC 23: Factors influencing health status and other contact with health services
MDC 24: Multiple significant traumas
MDC 25: Human immunodeficiency virus infections

Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients are provided at a percentage which meets or exceeds other hospitals in the service area.

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

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

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

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

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

(j) 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:

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

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

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

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

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

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

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

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

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

1. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
2. The ability to update medical technology within the existing plant.
3. Existence of The Joint Commission (TJC) deficiencies or "grandfathered" licensure deficiencies.
4. Cost efficiency of the existing physical plant versus plant revision, etc.
5. Private rooms are now considered the industry standard.

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

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

Relative Importance of Project Review Criteria

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

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

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

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANMED HEALTH MEDICAL CENTER	<18	42,240	43,370	2,734	8				
	18-64	107,660	114,030	41,368	120				
	+65	23,810	27,760	37,111	119				
	TOTAL	173,710	185,160	81,213	246	0.75	329	423	-94
ANMED WOMEN'S & CHILDRENS HOSPITAL	<18	42,240	43,370	318	1				
	18-64	107,660	114,030	4,811	14				
	+65	23,810	27,760	4,101	13				
	TOTAL	173,710	185,160	9,230	28	0.65	44	72	-28
ANDERSON COUNTY TOTAL							**373**	**495**	**-122**
UPSTATE CAROLINA MEDICAL CENTER	<18	14,350	15,050	1,014	3				
	18-64	34,390	37,060	9,024	27				
	+65	6,650	7,650	7,431	23				
	TOTAL	55,390	59,760	17,469	53	0.65	82	125	-43
CHEROKEE COUNTY TOTAL							**82**	**125**	**-43**
ALLEN BENNETT / GREER MEMORIAL HOSP	<18	97,810	100,960	103	0				
	18-64	258,150	280,240	6,796	20				
	+65	46,370	54,180	7,595	24				
	TOTAL	402,330	435,380	14,494	45	0.65			
GREENVILLE MEMORIAL MEDICAL CENTER	<18	97,810	100,960	14,875	42				
	18-64	258,150	280,240	104,127	310				
	+65	46,370	54,180	73,643	236				
	TOTAL	402,330	435,380	192,645	588	0.75			
ALLEN BENNETT/GREER MEMORIAL & **#1** GREENVILLE MEMORIAL MEDICAL CTR & GREENVILLE HOSP SYSTEM - PATEWOOD	TOTAL						852	900	-48
HILLCREST MEMORIAL HOSPITAL	<18	97,810	100,960	18	0				
	18-64	258,150	280,240	4,255	13				
	+65	46,370	54,180	5,366	17				
	TOTAL	402,330	435,380	9,639	30	0.65	46	43	3
SAINT FRANCIS - DOWNTOWN	<64	355,960	381,200	25,057	74				
	+65	46,370	54,180	33,404	107				
	TOTAL	402,330	435,380	58,461	180	0.70	258	226	32
SAINT FRANCIS - EASTSIDE	<64	355,960	381,200	10,943	32				
	+65	46,370	54,180	2,727	9				
	TOTAL	402,330	435,380	13,650	41	0.65	63	93	-30
GREENVILLE COUNTY TOTAL							**1,219**	**1,262**	**-43**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
OCONEE MEMORIAL HOSPITAL	<18	15,690	16,020	789	2				
	18-64	43,570	46,040	18,448	53				
	+65	12,590	16,130	12,825	45				
	TOTAL	71,850	78,190	32,062	101	0.65	155	169	-14
OCONEE COUNTY TOTAL							**155**	**169**	**-14**
CANNON MEMORIAL HOSPITAL	<18	28,450	30,010	26	0				
	18-64	78,420	85,630	1,948	6				
	+65	13,780	16,330	3,158	10				
	TOTAL	120,650	131,970	5,132	16	0.65	25	55	-30
PALMETTO BAPTIST MED CTR EASLEY	<18	28,450	30,010	395	1				
	18-64	78,420	85,630	7,059	21				
	+65	13,780	16,330	10,647	35				
	TOTAL	120,650	131,970	18,101	57	0.65	87	109	-22
PICKENS COUNTY TOTAL							**112**	**164**	**-52**
MARY BLACK MEMORIAL	<18	66,570	67,890	1,356	4				
	18-64	170,480	181,970	21,628	63				
	+65	32,990	38,670	8,490	27				
	TOTAL	270,040	288,530	31,474	94	0.70	135	176	-41
SPARTANBURG REG MED CTR & **#2**	<18	66,570	67,890	4,108	11				
VILLAGE HEALTH CENTRE	18-64	170,480	181,970	67,262	197				
	+65	32,990	38,670	56,993	183				
	TOTAL	270,040	288,530	128,363	391	0.75	522	532	-10
SPARTANBURG COUNTY TOTAL							**657**	**708**	**-51**
WALLACE THOMSON HOSPITAL	<18	7,080	6,950	372	1				
	18-64	17,770	17,140	5,771	15				
	+65	4,870	5,280	7,630	23				
	TOTAL	29,720	29,370	13,773	39	0.65	60	143	-83
UNION COUNTY TOTAL							**60**	**143**	**-83**
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	6,730	6,810	136	0				
	18-64	16,230	16,890	1,466	4				
	+65	3,920	4,400	1,906	6				
	TOTAL	26,880	28,100	3,508	10	0.65	16	25	-9
ABBEVILLE COUNTY TOTAL							**16**	**25**	**-9**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	9,030	9,000	619	2				
	18-64	21,380	21,910	3,045	9				
	+65	4,350	5,090	3,599	12				
	TOTAL	34,760	36,000	7,263	22	0.65	34	82	-48
CHESTER COUNTY TOTAL							**34**	**82**	**-48**
EDGEFIELD COUNTY HOSPITAL	<18	5,840	5,850	107	0				
	18-64	17,180	19,000	700	2				
	+65	2,850	3,730	1,461	5				
	TOTAL	25,870	28,580	2,268	8	0.65	12	25	-13
EDGEFIELD COUNTY TOTAL							**12**	**25**	**-13**
FAIRFIELD MEMORIAL HOSPITAL	<18	6,220	6,170	69	0				
	18-64	15,110	15,600	1,328	4				
	+65	3,090	3,760	2,062	7				
	TOTAL	24,420	25,530	3,459	11	0.65	17	25	-8
FAIRFIELD COUNTY TOTAL							**17**	**25**	**-8**
SELF REGIONAL HEALTHCARE	<18	17,670	18,080	2,018	6				
	18-64	42,260	44,350	25,259	73				
	+65	9,170	10,310	30,995	95				
	TOTAL	69,100	72,740	58,272	174	0.75	232	354	-122
GREENWOOD COUNTY TOTAL							**232**	**354**	**-122**
KERSHAW COUNTY MEDICAL CENTER	<18	13,980	14,430	1,088	3				
	18-64	34,840	37,940	10,960	33				
	+65	7,200	8,680	13,861	46				
	TOTAL	56,020	61,050	25,909	82	0.65	125	121	4
KERSHAW COUNTY TOTAL							**125**	**121**	**4**
SPRINGS MEMORIAL HOSPITAL	<18	15,530	15,460	1,377	4				
	18-64	39,360	41,030	20,485	59				
	+65	7,420	8,640	13,399	43				
	TOTAL	62,310	65,130	35,261	105	0.70	150	217	-67
LANCASTER COUNTY TOTAL							**150**	**217**	**-67**
LAURENS COUNTY HOSPITAL	<18	17,740	17,700	374	1				
	18-64	46,120	50,300	5,661	17				
	+65	9,790	11,800	6,703	22				
	TOTAL	73,650	79,800	12,738	40	0.65	62	76	-14
LAURENS COUNTY TOTAL							**62**	**76**	**-14**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
LEXINGTON MEDICAL CENTER		<18	40,395	41,754	1,755	5				
		18-64	106,186	117,355	49,868	151				
		+65	17,553	22,368	43,975	154				
		TOTAL	164,134	181,477	95,598	309	0.75	413	384	29
LEXINGTON COUNTY TOTAL								**413**	**384**	**29**
NEWBERRY COUNTY MEMORIAL		<18	8,930	9,060	638	2				
		18-64	23,150	23,930	4,636	13				
		+65	5,410	6,300	5,962	19				
		TOTAL	37,490	39,290	11,236	34	0.65	52	90	-38
NEWBERRY COUNTY TOTAL								**52**	**90**	**-38**
PALMETTO HEALTH BAPTIST	**#3**	<18	100,415	102,906	2,098	6				
& PALMETTO HEALTH PARKRIDGE		18-64	266,254	283,965	61,487	180				
		+65	40,717	49,952	16,323	55				
		TOTAL	407,386	436,823	79,908	240	0.75	321	363	-42
PALMETTO HEALTH RICHLAND		<18	100,415	102,906	21,571	61				
		18-64	266,254	283,965	89,169	261				
		+65	40,717	49,952	41,167	138				
		TOTAL	407,386	436,823	151,907	459	0.75	613	579	34
PROVIDENCE HOSPITAL		<18	100,415	102,906	68	0				
		18-64	266,254	283,965	27,058	79				
		+65	40,717	49,952	36,668	123				
		TOTAL	407,386	436,823	63,794	202	0.70	289	258	31
PROVIDENCE HOSPITAL NORTHEAST	**#4**	<18	100,415	102,906	57	0				
		18-64	266,254	283,965	7,485	22				
		+65	40,717	49,952	4,808	16				
		TOTAL	407,386	436,823	12,350	38	0.65	59	84	-25
RICHLAND COUNTY TOTAL								**1,282**	**1,284**	**-2**
PIEDMONT MEDICAL CENTER &	**#5**	<18	45,170	46,290	2,753	8				
FORT MILL MEDICAL CENTER		18-64	116,330	131,570	38,343	119				
		+65	18,910	23,360	29,666	100				
		TOTAL	180,410	201,220	70,762	227	0.70	324	332	-8
YORK COUNTY TOTAL								**324**	**332**	**-8**
REGION III										
CHESTERFIELD GENERAL HOSPITAL		<18	11,220	11,100	560	2				
		18-64	26,940	27,770	4,265	12				
		+65	5,180	6,160	4,222	14				
		TOTAL	43,340	45,030	9,047	26	0.65	40	59	-19
CHESTERFIELD COUNTY TOTAL								**40**	**59**	**-19**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CLARENDON MEMORIAL HOSPITAL	<18	7,990	7,750	492	1				
	18-64	20,230	20,560	7,374	21				
	+65	5,360	7,120	6,194	23				
	TOTAL	33,580	35,430	14,046	44	0.65	68	56	12
CLARENDON COUNTY							**68**	**56**	**12**
CAROLINA PINES REGIONAL **#6**	<18	17,790	17,330	2,352	6				
	18-64	42,060	42,840	18,834	53				
	+65	8,370	9,910	13,972	45				
	TOTAL	68,220	70,080	35,158	104	0.65	160	116	44
MCLEOD MEDICAL CENTER - DARLINGTON	<18	17,790	17,330	0	0				
	18-64	42,060	42,840	2,048	6				
	+65	8,370	9,910	2,250	7				
	TOTAL	68,220	70,080	4,298	13	0.65	20	49	-29
DARLINGTON COUNTY TOTAL							**180**	**165**	**15**
MCLEOD MEDICAL CENTER - DILLON	<18	8,380	7,940	1,035	3				
	18-64	18,420	18,560	6,923	19				
	+65	3,430	3,840	3,481	11				
	TOTAL	30,230	30,340	11,439	32	0.65	50	79	-29
DILLON COUNTY TOTAL							**50**	**79**	**-29**
CAROLINAS HOSPITAL SYSTEM	<18	32,800	32,760	2,100	6				
	18-64	82,480	85,540	43,551	124				
	+65	15,740	18,850	34,438	113				
	TOTAL	131,020	137,150	80,089	242	0.70	346	310	36
WOMENS CTR CAROLINAS HOSP SYSTEM	0-64	115,280	118,300	3,077	9				
	+65	15,740	18,850	0	0				
	TOTAL	131,020	137,150	3,077	9	0.65	13	20	-7
LAKE CITY COMMUNITY HOSPITAL	<18	32,800	32,760	80	0				
	18-64	82,480	85,540	2,263	6				
	+65	15,740	18,850	1,887	6				
	TOTAL	131,020	137,150	4,230	12	0.65	19	48	-29
MCLEOD REGIONAL MEDICAL CENTER	<18	32,800	32,760	7,888	22				
	18-64	82,480	85,540	61,301	174				
	+65	15,740	18,850	45,124	148				
	TOTAL	131,020	137,150	114,313	344	0.75	458	453	5
FLORENCE COUNTY TOTAL							**836**	**831**	**5**
GEORGETOWN MEMORIAL HOSPITAL	<18	13,160	12,450	1,559	4				
	18-64	35,460	37,240	11,538	33				
	+65	10,350	14,180	19,755	74				
	TOTAL	58,970	63,870	32,852	111	0.65	171	131	40

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
WACCAMAW COMMUNITY HOSPITAL		<18	13,160	12,450	481	1				
		18-64	35,460	37,240	9,190	26				
		+65	10,350	14,180	12,209	46				
		TOTAL	58,970	63,870	21,880	74	0.65	113	124	-11
GEORGETOWN COUNTY TOTAL								**284**	**255**	**29**
CONWAY HOSPITAL		<18	42,940	43,880	1,803	5				
		18-64	140,590	159,960	20,732	65				
		+65	36,950	49,070	15,137	55				
		TOTAL	220,480	252,910	37,596	125	0.70	179	210	-31
GRAND STRAND REGIONAL MEDICAL CTR		<18	42,940	43,880	926	3				
		18-64	140,590	159,960	24,793	77				
		+65	36,950	49,070	31,513	115				
		TOTAL	220,480	252,910	57,232	195	0.70	278	269	9
LORIS COMMUNITY HOSPITAL &	**#7**	<18	42,940	43,880	558	2				
SEACOAST MEDICAL CENTER		18-64	140,590	159,960	7,194	22				
		+65	36,950	49,070	8,887	32				
		TOTAL	220,480	252,910	16,639	56	0.65	87	155	-68
HORRY COUNTY TOTAL								**544**	**634**	**-90**
MARION COUNTY MEDICAL CENTER		<18	9,490	9,080	1,038	3				
		18-64	22,340	22,650	14,234	40				
		+65	4,230	4,920	8,115	26				
		TOTAL	36,060	36,650	23,484	68	0.65	105	124	-19
MARION COUNTY TOTAL								**105**	**124**	**-19**
MARLBORO PARK HOSPITAL		<18	7,300	6,990	311	1				
		18-64	17,480	16,570	2,591	7				
		+65	3,180	3,520	1,622	5				
		TOTAL	27,960	27,080	4,524	12	0.65	19	94	-75
MARLBORO COUNTY TOTAL								**19**	**94**	**-75**
TUOMEY		<18	30,830	31,500	2,083	6				
		18-64	68,550	71,090	32,728	93				
		+65	13,470	15,970	32,392	105				
		TOTAL	112,850	118,560	67,204	204	0.70	292	283	9
SUMTER COUNTY TOTAL								**292**	**283**	**9**
WILLIAMSBURG REGIONAL HOSPITAL		<18	9,900	9,180	81	0				
		18-64	22,040	21,680	1,254	3				
		+65	4,980	5,880	1,647	5				
		TOTAL	36,920	36,740	2,982	9	0.65	14	25	-11
WILLIAMSBURG COUNTY TOTAL								**14**	**25**	**-11**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION IV									
AIKEN REGIONAL MEDICAL CENTER	<18	37,800	37,880	512	1				
	18-64	97,280	106,660	21,758	65				
	+65	20,820	25,450	20,168	68				
	TOTAL	155,900	169,990	42,438	134	0.70	192	183	9
AIKEN COUNTY TOTAL							**192**	**183**	**9**
ALLENDALE COUNTY HOSPITAL	<18	3,060	3,020	58	0				
	18-64	7,180	3,740	764	1				
	+65	1,580	9,260	675	11				
	TOTAL	11,820	2,510	1,497	12	0.65	19	25	-6
ALLENDALE COUNTY TOTAL							**19**	**25**	**-6**
BAMBERG COUNTY MEMORIAL HOSPITAL	<18	4,090	3,740	122	0				
	18-64	9,850	9,260	2,870	7				
	+65	2,150	2,510	2,817	9				
	TOTAL	16,090	15,510	5,809	17	0.65	26	59	-33
BAMBERG COUNTY TOTAL							**26**	**59**	**-33**
BARNWELL COUNTY HOSPITAL	<18	6,270	6,050	203	1				
	18-64	15,090	16,090	1,225	4				
	+65	3,200	3,870	1,947	6				
	TOTAL	24,560	26,010	3,375	11	0.65	16	53	-37
BARNWELL COUNTY TOTAL							**16**	**53**	**-37**
BEAUFORT MEMORIAL HOSPITAL	<18	28,400	27,140	1,599	4				
	18-64	81,570	90,940	21,220	65				
	+65	25,510	36,560	17,144	67				
	TOTAL	135,480	154,640	39,963	136	0.65	210	169	41
HILTON HEAD HOSPITAL	<18	28,400	27,140	293	1				
	18-64	81,570	90,940	5,950	18				
	+65	25,510	36,560	11,275	44				
	TOTAL	135,480	154,640	17,518	63	0.65	97	93	4
BEAUFORT COUNTY TOTAL							**307**	**262**	**45**
TRIDENT MEDICAL CENTER	<18	143,670	145,480	1,837	5				
	18-64	377,080	393,320	41,899	120				
	+65	68,150	89,720	33,741	122				
	TOTAL	588,900	628,520	77,477	247	0.70	352	296	56
SUMMERVILLE MEDICAL CENTER	0-64	520,750	538,800	13,621	39				
	+65	68,150	89,720	10,509	38				
	TOTAL	588,900	628,520	24,130	77	0.65	118	94	24

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHARLESTON MEMORIAL HOSPITAL	#8	<18	143,670	145,480	75	0				
		18-64	377,080	393,320	4,076	12				
		+65	68,150	89,720	198	1				
		TOTAL	588,900	628,520	4,349	13	0.65			
MUSC MEDICAL CENTER	#8	<18	143,670	145,480	24,639	68				
		18-64	377,080	393,320	78,025	223				
		+65	68,150	89,720	26,962	97				
		TOTAL	588,900	628,520	129,626	389	0.75	539	604	-65
ROPER HOSPITAL & ROPER ST FRANCIS MOUNT PLEASANT	#9	<18	143,670	145,480	3,503	10				
		18-64	377,080	393,320	37,395	107				
		+65	68,150	89,720	49,831	180				
		TOTAL	588,900	628,520	87,576	296	0.75	395	401	-6
BON SECOURS ST FRANCIS XAVIER		<18	143,670	145,480	617	2				
		18-64	377,080	393,320	23,114	66				
		+65	68,150	89,720	17,432	63				
		TOTAL	588,900	628,520	41,163	131	0.70	187	204	-17
EAST COOPER REGIONAL MEDICAL CTR		<18	143,670	145,480	1,164	3				
		18-64	377,080	393,320	10,439	30				
		+65	68,150	89,720	8,848	32				
		TOTAL	588,900	628,520	19,404	65	0.65	100	140	-40
BERKELEY/CHARLESTON/DORCHESTER TOTAL								**1,691**	**1,739**	**-48**
COLLETON MEDICAL CENTER		<18	10,640	10,850	629	2				
		18-64	24,430	25,470	13,148	38				
		+65	5,150	6,300	13,558	45				
		TOTAL	40,220	42,620	27,335	85	0.65	131	131	0
COLLETON COUNTY TOTAL								**131**	**131**	**0**
HAMPTON REGIONAL MEDICAL CTR		<18	5,650	5,500	70	0				
		18-64	13,680	14,360	1,830	5				
		+65	2,710	3,350	1,932	7				
		TOTAL	22,040	23,210	3,832	12	0.65	18	32	-14
HAMPTON COUNTY TOTAL								**18**	**32**	**-14**
COASTAL CAROLINA MEDICAL CENTER		<18	5,190	4,970	88	0				
		18-64	14,010	15,770	2,032	6				
		+65	2,490	3,240	2,753	10				
		TOTAL	21,690	23,980	4,873	16	0.65	25	31	-6
JASPER COUNTY TOTAL								**25**	**31**	**-6**
REG MED CTR ORANGEBURG-CALHOUN		<18	23,900	23,780	1,619	4				
		18-64	57,830	59,220	27,289	77				
		+65	13,050	15,460	26,137	85				
		TOTAL	94,780	98,460	55,045	166	0.70	237	247	-10
ORANGEBURG/CALHOUN COUNTY TOTAL								**237**	**247**	**-10**

FY 2013 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2006 POP	2013 POP	2006 PAT DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)

#1 BED NEEDS COMBINED; GHS-PATEWOOD WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 8/25/03.
#2 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 9/9/05.
#3 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.
#4 CON TO ADD 38 BEDS APPEALED.
#5 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.
#6 CON FOR 50 BED EXPANSION VOIDED 2/5/07.
#7 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED; CON 9/4/07.
#8 CON ISSUED TO COMBINE THESE TWO FACILITIES 10/14/03.
#9 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 5/31/06.

HOSPITAL OCCUPANCY RATES

	2004	2005	2006
REGION I	**58.5**	**60.1**	**59.4**
ANMED HEALTH MEDICAL CENTER	47.6	52.3	52.6
ANMED HEALTH WOMEN'S & CHILDREN'S	-----	28.6	35.1
UPSTATE CAROLINA MEDICAL CENTER	38.0	37.9	38.3
ALLEN BENNETT MEMORIAL HOSPITAL	76.7	73.9	68.5
GREENVILLE MEMORIAL MEDICAL CTR	77.8	78.6	74.3
HILLCREST MEMORIAL HOSPITAL	63.2	59.8	61.4
SAINT FRANCIS - DOWNTOWN	72.4	64.3	76.3
SAINT FRANCIS - EASTSIDE	66.9	62.4	54.9
OCONEE MEMORIAL HOSPITAL	57.9	57.2	54.9
CANNON MEMORIAL HOSPITAL	30.2	28.7	25.6
PALMETTO BAPTIST MED CTR EASLEY	53.7	50.7	45.5
BJ WORKMAN MEMORIAL	11.9	-----	-----
MARY BLACK MEMORIAL HOSPITAL	40.2	47.9	49.0
SPARTANBURG REGIONAL MEDICAL CTR	64.5	67.8	66.1
WALLACE THOMSON HOSPITAL	34.0	31.2	26.4

	2004	2005	2006
REGION II	**63.1**	**63.7**	**61.6**
ABBEVILLE AREA MEDICAL CENTER	20.6	32.5	38.4
CHESTER REGIONAL MEDICAL CENTER	31.3	26.4	24.3
EDGEFIELD COUNTY HOSPITAL	20.2	27.0	24.9
FAIRFIELD MEMORIAL HOSPITAL	23.2	35.3	33.9
SELF REGIONAL HEALTHCARE	50.9	51.3	45.6
KERSHAW COUNTY MEDICAL CENTER	55.2	57.5	58.7
SPRINGS MEMORIAL HOSPITAL	65.6	61.3	54.6
LAURENS COUNTY HOSPITAL	61.7	50.7	45.9
LEXINGTON MEDICAL CENTER	87.2	83.8	77.3
NEWBERRY COUNTY MEMORIAL HOSPITAL	37.0	34.1	34.2
PALMETTO HEALTH BAPTIST	57.2	60.0	60.3
PALMETTO HEALTH RICHLAND	70.6	71.0	71.9
PROVIDENCE HOSPITAL	74.7	73.6	67.7
PROVIDENCE HOSPITAL NORTHEAST	62.8	74.5	73.6
PIEDMONT MEDICAL CENTER	74.1	73.6	72.3

	2004	2005	2006
REGION III	**64.3**	**66.8**	**64.2**
CHESTERFIELD GENERAL HOSPITAL	40.1	36.8	42.0
CLARENDON MEMORIAL HOSPITAL	53.7	64.0	68.7
CAROLINA PINES REGIONAL MED CTR	85.2	83.4	83.0
MCLEOD-DARLINGTON (WILSON MED)	20.5	27.1	24.0
MCLEOD MED CTR - DILLON (ST EUGENE)	55.0	41.0	39.7
CAROLINAS HOSPITAL SYSTEM	74.9	79.5	75.4
LAKE CITY COMMUNITY HOSPITAL	30.5	22.7	24.1
MCLEOD REGIONAL MEDICAL CENTER	89.6	91.4	90.0
WOMEN'S CENTER CAROLINAS HOSP	51.8	55.1	42.2
GEORGETOWN MEMORIAL HOSPITAL	68.9	78.8	68.7
WACCAMAW COMMUNITY HOSPITAL	81.2	63.6	73.1
CONWAY HOSPITAL	59.5	65.0	64.4
GRAND STRAND REGIONAL MED CTR	61.8	67.1	71.6
LORIS COMMUNITY HOSPITAL	44.4	42.4	43.4
MARION COUNTY MEDICAL CENTER	67.3	62.2	51.9
MARLBORO PARK HOSPITAL	20.5	16.8	13.2
TUOMEY	70.0	70.6	74.2
WILLIAMSBURG REGIONAL HOSPITAL	17.5	44.3	32.7

	2004	2005	2006
REGION IV	**60.4**	**61.0**	**61.0**
AIKEN REGIONAL MEDICAL CENTER	64.1	66.3	63.5
ALLENDALE COUNTY HOSPITAL	19.6	21.8	16.4
BAMBERG COUNTY MEMORIAL HOSPITAL	28.1	24.5	27.0
BARNWELL COUNTY HOSPITAL	26.5	20.5	17.4
BEAUFORT MEMORIAL HOSPITAL	85.0	73.8	76.2
HILTON HEAD HOSPITAL	61.0	54.4	51.6
SUMMERVILLE MEDICAL CENTER	74.9	72.9	70.3
BON SECOURS ST FRANCIS XAVIER	78.0	81.5	79.1
CHARLESTON MEMORIAL HOSPITAL	16.9	16.3	12.2
EAST COOPER REGIONAL MED CTR	53.6	57.7	53.2
MUSC MEDICAL CENTER	74.0	76.7	76.2
ROPER HOSPITAL	58.9	59.6	58.0
TRIDENT MEDICAL CENTER	75.1	75.8	78.3
COLLETON MEDICAL CENTER	54.2	55.4	57.2
HAMPTON REGIONAL MEDICAL CENTER	15.2	14.2	15.4
COASTAL CAROLINA MEDICAL CENTER	28.9	37.4	43.1
REG MED CTR ORANGEBURG/CALHOUN	53.7	56.0	61.1

NOTE: LTCH HOSPITALS REMOVED FROM 2006 DATA, SO 2006 REGIONAL AVERAGE OCCUPANCY RATES NOT COMPARABLE TO PREVIOUS YEARS

(B) Long-Term Acute Care Hospitals

Long Term Acute Care Hospitals (LTACHs) provide treatment to patients with complex medical conditions like strokes, cardiac care, ventilator dependency, wound care and post-surgical care. These patients require up to 3 hours per day of rehabilitative treatment and have an average length of stay of 25 days or longer. Medicare pays for about 73% of all LTACH discharges; the proposed standard federal reimbursement for 2009 is $39,076 per patient.

There are more than 350 LTACHs nationwide, which may either be a freestanding facility, or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional Federal criteria in order to qualify as a LTACH Hospital under the "hospital-within-a-hospital" model:

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

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

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

4) The hospital must have a separate medical staff from the medical staff of the host hospital, which report directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

LTACHs have their own Prospective Payment System (PPS). In 2006, CMS established a "25 percent payment threshold policy" for hospitals-within-hospitals. If the LTACH's Medicare discharges exceed 25 percent from the host hospital, the LTACH would be paid the lesser of the otherwise payable amount under the LTACH PPS or the equivalent amount that Medicare would have paid under the Acute Care Hospital Inpatient PPS.

On May 1, 2007, CMS revised the reimbursement policy and extended the 25% rule to all LTACHs; if any LTACH gets more than 25% of their admissions from a single hospital they will receive less reimbursement. The rule will be implemented over a three-year period that began on July 1, 2007 (75% the 1st year, 50% the 2nd year and down to 25% the 3rd year). Due to this and other changes in funding methodologies, CMS projects an overall decrease in payments to Medicare certified LTACHs of 3.8% in the first year alone. However, legislation was signed in December 2007 that would provide regulatory relief for 3 years and impose a limited moratorium on the development of new facilities.

The existing LTACH's in South Carolina and their occupancy rates are:

FACILITY	COUNTY	BEDS	2004	2005	2006
NORTH GREENVILLE LONG TERM ACUTE	GREENVILLE	45	37.5	54.5	53.9
REGENCY HOSPITAL OF GREENVILLE	GREENVILLE	32	-----	52.2	88.4
SPARTANBURG HOSP RESTORATIVE CARE	SPARTANBURG	97	59.8	41.9	36.0
INTERMEDICAL HOSPITAL OF SC	RICHLAND	35	61.9	63.5	66.5
REGENCY HOSPITAL SOUTH CAROLINA *1*	FLORENCE	40	84.1	89.3	90.8
SAVANNAH RIVER SPECIALTY HOSPITAL *2*	AIKEN	(34)			
KINDRED HOSPITAL CHARLESTON	CHARLESTON	59	47.8	42.1	49.4
	TOTAL	308			

1 CON issued 8/30/06 to add 12 beds for a total of 40; licensed 8/8/07.
2 CON issued 3/27/07; voided 4/15/08.

Certificate of Need Standards for Long Term Hospitals

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

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

(3) The utilization of LTACHs are not included in the bed need for general acute care hospital beds. No bed need will be calculated for Long Term Acute Care Hospital beds. An applicant must document the need for LTACH beds considering the utilization of existing LTACH beds.

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

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

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

(5) A hospital which desires to be designated as an LTACH and has been awarded a CON for that purpose, must be certified as an LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Relative Importance of Project Review Criteria

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

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility;

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

(C) Critical Access Hospitals

Rural counties tend to have higher unemployment or low-paying professions without health insurance and a greater percentage of their population are elderly. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

The Medicare Rural Hospital Flexibility Program allows the designation of Critical Access Hospitals (CAHs). These hospitals are eligible for cost-based reimbursement without having to meet all of the criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities; converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost.

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 1 full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

(3) The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or 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;

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

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

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

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

(2) It provides emergency health care services to indigent patients;

(3) It maintains a 24-hour emergency room;

(4) It staffs 50 or fewer acute care beds; and

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

A total of 1,292 hospitals nationwide had been approved for CAH status as of December 2007. The impact of the Critical Access Hospital Program in South Carolina would be a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH would not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The following facilities in South Carolina are designated as CAHs:

Abbeville Memorial Hospital
Allendale County Hospital
Edgefield County Hospital
Fairfield Memorial Hospital
Williamsburg Regional Hospital

Based on their 2006 Average Daily Census (ADC), the following hospitals in South Carolina could potentially participate in the CAH program: Cannon Memorial (14.1), McLeod-Darlington (11.8), Lake City Community (11.6), Marlboro Park (12.4), Bamberg County Memorial (15.9), Barnwell Hospital (9.3), Hampton Regional (10.5), and Coastal Carolina Medical Center (13.4).

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

(D) Obstetrical and Neonatal Services

(1) Obstetrical Services

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

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

Infant mortality is the death rate for babies from birth until their first birthday. South Carolina's infant mortality rate has declined faster than it has for the nation as a whole. For 2004, South Carolina's infant mortality rate was 9.3 per thousand infant births with a Healthy People 2010 objective for the nation of no more than 4.5 per thousand infant deaths per thousand live births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2004, South Carolina's neonatal mortality rate for all races was 6.4 neonatal deaths per 1,000 live births with a Healthy People 2010 objective for the nation of 2.9 neonatal deaths per 1,000 live births.

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

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

The following definitions apply:

Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital shall have the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2000 grams. When it is anticipated or determined that these criteria will not or have not been met, consultation and a plan of care shall be initiated and mutually agreed upon with the RPC. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. Management shall include emergency resuscitation and/or stabilization for both maternal and neonatal patients in preparation for transfer/transport for more specialized services. Hospitals at this level shall not provide care or services that are designated only for higher level hospitals. This description does not constitute Certificate of Need review criteria.

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

Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may be located only in areas of the state that are no closer than 60 miles from a South Carolina Regional Perinatal Center. This level of neonatal care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1250 grams, as determined by estimations based upon best professional judgement, ultrasound, and/or other available medical technology and instruments. A board-eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. Neonates shall not be in need of ventilatory support for more than 24 cumulative hours. When it is anticipated or determined that any of the preceding criteria relating to gestation, weight, and length of ventilatory support will not be or have not been met, the neonate may remain at the Level IIE facility, pursuant to a plan of care developed in consultation with and agreement to by the RPC. Such plan of care shall be documented in the patient's medical record. Neonates shall not require high-frequency ventilation support. These hospitals shall manage no less than an average of 1200 deliveries annually, calculated over the previous three years. This calculation shall include the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Level IIE hospital shall not

admit outborn neonates into its nursery without prior concurrence with the RPC. Hospitals at this level shall not provide care or services which are designated only for higher level hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services. Level IIE hospitals must have an adequate number of neonatal bassinets to provide care for these neonates and the number of bassinets will be justified by the hospital in the Certificate of Need application. Because these hospitals already have neonatal bassinets, the number of bassinets will not be counted against the needs projected in the following sections of this Plan. Once utilization information is obtained, the projections may be revised.

Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, provides all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified maternal-fetal medicine specialist (perinatologist) shall be available for supervision and consultation, 24 hours a day. In addition to the Level II and IIE capabilities, Level III hospitals shall have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. Hospitals with Level III designation shall manage no less than an average of 1500 deliveries annually, calculated over the previous three years, or at least an average of 125 neonate admissions that weigh less than 1500 grams each, require ventilatory support, or require surgery. This calculation shall include the number of maternal transfers made prior to delivery to higher-level perinatal hospitals. Hospitals at this level shall not provide additional care or services designated only for RPCs. The establishment of a Level III service requires Certificate of Need review.

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

2006 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEMORIAL MEDICAL CTR.	5,388	53	6,055	17,559	90.8%
PALMETTO HEALTH BAPTIST	3,829	82	7,747	15,301	51.1%
LEXINGTON MEDICAL CENTER	2,892	29	3,038	6,692	63.2%
SPARTANBURG REGIONAL MED.CTR.	2,795	43	3,605	9,065	57.8%
PALMETTO HEALTH RICHLAND	2,424	57	5,476	12,590	60.5%
SAINT FRANCIS - EASTSIDE	2,354	35	2,538	6,762	52.9%
PIEDMONT MEDICAL CENTER	2,321	19	2,326	5,850	84.4%
MUSC MEDICAL CENTER	2,315				
TRIDENT MEDICAL CENTER	2,253	25	2,693	6,331	69.4%
BEAUFORT MEMORIAL HOSPITAL	2,075	23	1,949	5,455	65.0%
ANMED HEALTH WOMEN'S & CHILDREN'S	2,056	28	1,822	5,064	49.5%
MCLEOD REGIONAL MEDICAL CTR.	2,052	18	2,526	5,925	90.2%
BON SECOURS' ST. FRANCIS XAVIER	1,705	16	2,020	3,385	58.0%
SELF REGIONAL HEALTHCARE	1,610	37	2,697	6,844	50.7%
CONWAY HOSPITAL	1,566	16	1,641	4,179	71.6%
TUOMEY	1,529	20	684	4,559	62.5%
EAST COOPER REGIONAL MED CTR	1,508	27	2,017	4,868	49.4%
REG MED CTR ORANGEBURG-CALHOUN	1,434	27	1,696	4,340	44.0%
MARY BLACK MEMORIAL HOSPITAL	1,237	21	1,437	3,605	47.0%
AIKEN REGIONAL MEDICAL CENTER	1,217	18	1,661	4,527	68.9%
SUMMERVILLE MEDICAL CENTER	1,195	12	1,122	2,373	54.2%
WOMEN'S CENTER / CAROLINAS HOSP.	1,117	20	1,340	3,077	42.2%
GRAND STRAND REGIONAL MED CTR	1,042	19	1,405	3,167	45.7%
SPRINGS MEMORIAL HOSPITAL	775	14	1,123	3,013	59.0%
CAROLINA PINES REGIONAL MED CTR	694	13	753	3,105	65.4%
ROPER HOSPITAL	670	16	1,099	2,364	40.5%
CLARENDON MEMORIAL	617	10	636	1,401	38.4%
COLLETON MEDICAL CENTER	602	6	600	1,408	64.3%
HILTON HEAD HOSPITAL	550	8	646	1,478	50.6%
PROVIDENCE HOSPITAL NORTHEAST	528	6	540	1,278	58.4%
OCONEE MEMORIAL	524	16	723	2,376	40.7%
WACCAMAW COMMUNITY HOSPITAL	522	9	735	2,205	67.1%
MARION COUNTY MEDICAL CENTER	519				
PALMETTO BAPTIST MED CTR EASLEY	507	14	765	1,801	35.2%
GEORGETOWN MEMORIAL HOSPITAL	473	14	649	2,271	44.4%
LAURENS COUNTY HOSPITAL	442				
KERSHAW COUNTY MEDICAL CENTER	428	10	611	1,521	41.7%
ALLEN BENNETT MEMORIAL HOSPITAL	427	5	418	999	54.6%
UPSTATE CAROLINA MEDICAL CENTER	386	15	566	1,308	23.9%
NEWBERRY COUNTY MEMORIAL HOSP.	381	2	484	959	131.4%
LORIS COMMUNITY HOSPITAL	316	8	543	1,194	40.9%
MCLEOD MEDICAL CENTER-DILLON	302	14	347	1,272	24.9%
CHESTERFIELD GENERAL HOSPITAL	161	7	244	607	23.8%
MARLBORO PARK HOSPITAL	131	8	161	375	12.8%
BAMBERG COUNTY MEMORIAL HOSPITAL	98				
ABBEVILLE COUNTY MEMORIAL HOSPITAL	79	3	107	244	22.3%
WALLACE THOMSON HOSPITAL	50	4	79	217	14.9%
COASTAL CAROLINA MEDICAL CENTER	1				
TOTAL BIRTHS	58,097				

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

Relative Importance of Project Review Criteria

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

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

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

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

Regional Perinatal Centers

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
MUSC Medical Center
Palmetto Health Richland
Spartanburg Regional Medical Center

Subspecialty Perinatal Center (Level III Hospital)

Palmetto Health Baptist
Self Regional Healthcare

Enhanced Perinatal Center (Level II Enhanced Care Hospitals)

Piedmont Medical Center

Specialty Perinatal Centers (Level II Hospitals)

Aiken Regional Medical Center
AnMed Health Women's and Children's Hospital
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital
East Cooper Regional Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital
Palmetto Baptist Medical Center - Easley
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital
St. Francis Women's and Family Hospital
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Waccamaw Community Hospital
The Women's Center of Carolinas Hospital System

(2) Neonatal Services

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

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

The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists suggest the following ratios for calculating the number of neonatal bassinets:

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

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

The above ratios were based on 80 low-birth weight (LBW) {2500 grams} births per 1,000 births. As indicated below, in 2005 South Carolina had 102.4 LBW births per 1,000 births, with a white rate of 77.0 and a nonwhite rate of 147.5 per 1,000. Because South Carolina has a significant higher number of LBW infants per 1,000 births, an alternative method was selected for determining the need for intensive care bassinets in RPCs.

2005	TOTAL	WHITE	NONWHITE
All Births	57,538	36,874	20,573
<2,500 Grams	5,895	2,839	3,034
Rate/1,000	102.4	77.0	147.5

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

$$\frac{102.4}{80} = 1.28 \text{ bassinets}$$

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

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

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

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

$$\text{White} = \frac{77.0}{80} = 0.96 \qquad \text{Non-White} = \frac{147.5}{80} = 1.84$$

The intermediate care ratios are:

White = 0.96 x 5.12 = 4.92 Non-White = 1.84 x 5.12 = 9.42

The actual births in South Carolina have been:

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
50,913	51,105	52,205	53,833	54,706	55,964	55,748	54,453	55,461	56,543	57,538

The projected births have been:

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
53,120	53,210	53,330	53,440	53,490	53,500	53,560	53,600	53,670	54,080	54,450

The following projected need for neonatal intensive care bassinets is based on the actual number of 2005 births by race using the incidence of low-birth weight babies by Perinatal Center with the

need projected at a 65% occupancy factor. The planning factor of 65% occupancy will allow for a potential increase in births and the small number of bassinets. In some areas, the utilization of intensive care bassinets is high and there is a need for additional intensive care bassinets.

Perinatal Region With Facilities	Bassinets Needed at 65% Occupancy	Existing Bassinets
Greenville Memorial & Self Regional	23	19
Spartanburg Regional Med Center	10	13
Palmetto Health Richland & Baptist	42	35
McLeod Regional Medical Center	17	12
MUSC Medical Center	25	16
TOTAL	111	95

Note: S.C. presently has 1.6 neonatal intensive care bassinets and 5.7 neonatal intermediate care bassinets per 1,000 births.

A neonatal unit should have an average annual occupancy rate of 65%. Facilities providing neonatal services must meet licensing requirements and either The Joint Commission (TJC) or certification standards.

Perinatal Region	Existing Bassinets Intensive	Existing Bassinets Intermediate
Anderson, Greenville, Oconee, Pickens, Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda		
Palmetto Baptist Medical Center - Easley	0	2
Greenville Memorial Medical Center *1*	12	44
AnMed Health Women's & Children's Hospital	0	7
St. Francis Women's & Family Hospital	0	10
Self Regional Healthcare	7	11
SUBTOTAL	19	74
Spartanburg, Cherokee, Union, Chester		
Spartanburg Regional Medical Center *2*	13	22
Mary Black Memorial Hospital	0	8
SUBTOTAL	13	30
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Lee, Kershaw, Lancaster, Orangeburg, York, Lexington, Newberry, Richland, Sumter		
Palmetto Health Richland	27	38
Palmetto Health Baptist *3*	8	21
Lexington Medical Center	0	20
Piedmont Medical Center (Level II-E)	0	12
Springs Memorial Hospital	0	4
Aiken Regional Medical Center	0	8
Regional Med Center Orangeburg-Calhoun	0	5
Tuomey	0	8
SUBTOTAL	35	116

Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg			
Carolina Pines Regional Medical Center		0	4
Marion County Medical Center		0	2
McLeod Regional Medical Ctr. of Pee Dee		12	28
Conway Hospital		0	6
Grand Strand Regional Medical Center		0	2
Women's Center of Carolinas Hospital System		0	11
SUBTOTAL		12	53
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown			
Beaufort Memorial Hospital		0	3
Georgetown Memorial Hospital		0	5
Waccamaw Community Hospital	*4*	0	2
MUSC Medical Center		16	46
East Cooper Regional Medical Center		0	6
Bon Secours-St. Francis Xavier Hospital	*5*	0	7
Summerville Medical Center		0	3
Trident Medical Center		0	5
Roper Hospital		0	5
SUBTOTAL		16	82
STATEWIDE TOTAL		95	355

1 Licensed for 7 additional intermediate care bassinets 5/30/08.

2 CON approved for 3 additional intensive and 7 additional intermediate bassinets 6/12/06; licensed 11/21/06.

3 Licensed for 9 additional intermediate care bassinets 7/16/08. CON issued 9/11/08 to convert 4 intermediate bassinets to intensive.

4 Licensed for 2 intermediate care bassinets 4/21/08.

5 Licensed for 3 additional intermediate care bassinets 9/21/07.

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

The projected need for intermediate neonatal bassinets was derived from the preceding methodology:

	Intermediate Bassinets		
Perinatal Region	Existing	Need	To Be Added
Greenville	74	76	2
Spartanburg	30	30	0
Richland	116	132	16
Florence	53	65	12
Charleston	82	84	2

TOTAL	355	387	32

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

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

Relative Importance of Project Review Criteria

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

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

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the majority of the population. In addition, most of the hospitals offering this service provide specialized transportation vehicles. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service. The need for bassinets in Level IIE hospitals has not been determined, but will be justified by the individual hospital seeking this level of service.

The following chart indicates the utilization of neonatal special care units by facility. Some facilities are not using any of the intermediate care bassinets. This information is from the Joint Annual Report - Hospitals 2006. This information supports the projected need.

NEONATAL UTILIZATION FROM 2006 JARS

HOSPITAL	ICU Bassinets	ICU Pt Days	ICU ADC	Intermed Bassinets	Intermed Pt Days	Intermed ADC	Total Bassinets	Total Pt Days	Total ADC	Total Occupancy
AnMed Health Women's				7	1,325	3.6	7	1,325	3.6	51.9%
Greenville Memorial *1*	12	4,362	12.0	44	11,168	30.6	56	15,530	42.5	86.8%
St. Francis-Women's & Fam				10	1,799	4.9	10	1,799	4.9	49.3%
Palmetto Baptist-Easley				2	0	0.0	2	0	0.0	0.0%
REGION SUBTOTAL	12	4,362	12.0	63	14,292	39.2	75	18,654	51.1	68.1%
Spartanburg Regional *2*	13	2,802	7.7	22	5,137	14.1	35	7,939	21.8	62.1%
Mary Black Memorial				8	833	2.3	8	833	2.3	28.5%
REGION SUBTOTAL	13	2,802	7.7	30	5,970	16.4	43	8,772	24.0	55.9%
Self Regional	7	671	1.8	11	2,613	7.2	18	3,284	9.0	50.0%
REGION SUBTOTAL	7	671	1.8	11	2,613	7.2	18	3,284	9.0	50.0%
Palmetto Health Richland	27	8,061	22.1	38	10,822	29.6	65	18,883	51.7	79.6%
Lexington Medical Ctr				20	2,701	7.4	20	2,701	7.4	37.0%
Piedmont Medical Ctr				12	1,882	5.2	12	1,882	5.2	43.0%
Springs Memorial Hosp				4	889	2.4	4	889	2.4	60.9%
Palmetto Health Baptist *3*	8	*	*	21	*	*	29	6,081	16.7	83.3%
Tuomey				8	598	1.6	8	598	1.6	20.5%
Reg Med Ctr Orangeburg				5	0	0.0	5	0	0.0	0.0%
Aiken Regional Med Ctr				8	483	1.3	8	483	1.3	16.5%
REGION SUBTOTAL	35	8,061	22.1	116	17,375	47.6	151	25,436	69.7	46.2%
Women's Ctr Carolinas				11	618	1.7	11	618	1.7	15.4%
McLeod Regional	12	4,626	12.7	28	4,526	12.4	40	9,152	25.1	62.7%
Carolina Pines Regional				4	80	0.2	4	80	0.2	5.5%
Marion Co Medical Ctr				2	0	0.0	2	0	0.0	0.0%
Grand Strand Regional				2	140	0.4	2	140	0.4	19.2%
Conway Hospital				6	858	2.4	6	858	2.4	39.2%
REGION SUBTOTAL	12	4,626	12.7	53	6,222	14.7	65	10,848	29.7	45.7%
Georgetown Memorial				5	251	0.7	5	251	0.7	13.8%
Waccamaw Community *4*				2						
MUSC Medical Center	16	7,514	20.6	46	9,541	26.1	62	17,055	46.7	75.4%
Roper Hospital				5	310	0.8	5	310	0.8	17.0%
East Cooper Regional				6	77	0.2	6	77	0.2	3.5%
Trident Medical Center				5	1,531	4.2	5	1,531	4.2	83.9%
Bon Secours-St. Francis *5*				7	600	1.6	7	600	1.6	23.5%
Summerville Med. Ctr.				3	0	0.0	3	0	0.0	0.0%
Beaufort Memorial Hospital				3	135	0.4	3	135	0.4	12.3%
REGION SUBTOTAL	16	7,514	20.6	82	12,445	33.7	98	19,959	54.7	55.8%
GRAND TOTAL	95	28,036	76.8	355	58,917	158.7	450	86,953	238.2	52.9%

1 Licensed for 7 additional intermediate care bassinets for a total of 44 5/30/08.
2 CON issued 6/28/06 for 3 additional intensive and 7 intermediate care bassinets; licensed 11/21/06.
3 Hospital did not separate data; lic. 9 additional intermediate 7/16/08, converted 4 intermediate to intensive 8/26/08.
4 Licensed for 2 intermediate bassinets 4/21/08.
5 Licensed for 3 additional intermediate care bassinets for a total of 7, 9/21/07.

(E) Pediatric Inpatient Services

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

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

Relative Importance of Project Review Criteria

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

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

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

(F) Cardiovascular Care

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. Approximately 1/3 of all heart attacks are fatal. The amount of heart muscle that is damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive.

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 radioactive dye allow blockages or area of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed. Diagnostic catheterizations take approximately 1-1/2 hours to perform while therapeutic catheterizations average 3 hours.

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

During a Percutaneous Transluminal Coronary Angioplasty (PTCA), a balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. When using a stent, an expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Newer drug-eluting stents are coated with an anti-rejection drug. It is anticipated that the increased use of stents may reduce the number of open heart surgeries performed.

Open heart surgery or intracardiac surgery refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine. Another option is "beating heart surgery" like Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. The mortality rate continues to decline, but CABG still carries significant risks.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect

unnecessary duplication of services in an area. This may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0). Emergent PCI providers should perform a minimum of 36 PCIs annually; all other therapeutic cath providers should perform a minimum of 300 therapeutic caths annually. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in their utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to appear in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year; at least 75 of which should be open heart surgery.

Status of South Carolina Providers

1. Cardiac Catheterizations

The Certificate of Need standards for cardiac catheterization require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 31 facilities approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Of the 29 facilities that have been offering cardiac caths for more than 3 years, 20 exceeded the minimum of 600 equivalents per lab in 2006. Beaufort Memorial, Bon Secours St. Francis Xavier, Carolina Pines, Hilton Head Regional, Mary Black Memorial, Palmetto Health Baptist, Palmetto Baptist-Easley, Springs Memorial, and Tuomey Hospital fell below the minimum. The program at Loris Community Hospital had not been operational for 3 full years. Kershaw County Medical Center received a CON on 6/11/04 to establish a fixed cardiac cath lab. A joint venture between Palmetto Health and Columbia Heart to establish a diagnostic lab on the campus of Palmetto Richland was approved on 1/4/07, but the CON was voided on 12/28/07. There are 2 mobile cath labs approved in the state, at Colleton Medical Center and Chester Regional Medical Center. The number of diagnostic catheterizations performed statewide increased from 38,806 in 2005 to 39,997 in 2006.

There are 16 hospitals with open heart surgery programs providing therapeutic caths. They should be performing a minimum of 300 therapeutic caths annually within 3 years of initiation of service. Of the programs that had been operational for 3 full years, all but Carolinas Hospital System and Hilton Head Regional Medical Center performed the minimum number in 2006. In addition, Georgetown Memorial Hospital and Palmetto Baptist Easley have received CONs to perform Emergent PCIs without open heart surgery back-up. The number of therapeutic catheterizations performed statewide increased from 14,268 in 2005 to 14,551 in 2006.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The standard recommends a minimum of 600 cardiac equivalents per year; MUSC performed 1,130 equivalents in 2006.

2. Open Heart Surgery

There are currently 16 open heart surgery programs approved for the general public in South Carolina, as well as the Veterans Administration (VA) Hospital in Charleston. The number of open heart surgeries performed decreased from 5,893 in 2005 to 5,438 in 2006. There were a total of 35 open heart surgery suites in operation in 2006. With a capacity of 500 surgeries per suite, the statewide capacity was 17,500 surgeries. The state average utilization rate of 31.1% equated to 155.4 surgeries per suite. Unused capacity remains in all programs in the state.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within 3 years of initiation of service. Aiken Regional, Hilton Head Regional, Piedmont Medical Center, and Self Memorial performed less than the minimum in 2006. However, this minimum volume should not be interpreted as an optimal level of operation. Studies indicate that hospitals that perform a minimum of 350 total cases annually tend to have better outcomes than those that perform fewer cases. In 2006, only 7 of the 16 programs performed more than 350 total surgeries.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2006, 308 pediatric open heart surgeries were performed there.

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

Certificate of Need Standards for Cardiac Catheterization

Definitions

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

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

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

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

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

"Diagnostic Equivalents" are the measurements of capacity and utilization for cardiac catheterization laboratories. For adult labs, diagnostic catheterizations are weighted as 1.0 equivalents and therapeutic caths are weighted as 2.0 equivalents. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, and biopsies performed after heart transplants as 1.0 equivalents.

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

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

00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique
35.96 Percutaneous Valvuloplasty
36.06 Insertion of Coronary Artery Stent(s)

36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
36.09 Other Removal of Coronary Artery Obstruction
37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

Standards

(1) The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Adult diagnostic catheterizations (ICD-9-CM Procedure Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Procedure Codes 00.66, 35.52, 35.96, 36.06, 36.07, 36.09, and 37.34) shall be weighted as 2.0 equivalents. For pediatric and adult congenital cath labs diagnostic caths shall be weighted as 2.0 equivalents, therapeutic caths shall be weighted as 3.0 equivalents, electrophysiology (EP) studies shall be weighted as 2.0 equivalents, and biopsies performed after heart transplants shall be weighted as 1.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

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

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

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

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

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

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

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

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

(7) Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PCI and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The ACC/AHA/SCAI Writing Committee continues to support the recommendation that elective PCI should not be performed in facilities without on-site cardiac surgery, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart, or abnormalities in the heart structure, shall be allowed to perform emergency PCI provided they comply with all sections of standard 8.

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

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

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

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

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

E. An application shall be approved only if it is consistent with the criteria from *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).* The complete guidelines can be found at: www.acc.org/clinical/guidelines/percutaneous/update/index.pdf

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

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

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

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

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

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

f. There must be formalized written protocols in place for immediate (within 1 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 3- to 6-month-period of implementation during which time development of a formalized primary PCI program is instituted that includes establishing standards, training staff, detailed logistic development, and creation of a quality assessment and error management system.

2. Patient Selection Guidelines

a. Avoid intervention in hemodynamically stable patients with:

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

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

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

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

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

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

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

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

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

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

(13) Documentation of need for the proposed service:

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

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

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

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

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

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

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

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

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

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

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

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

Scope of Services

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

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

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

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

a. Nuclear Cardiology
b. Echocardiography
c. Pulmonary Function Testing
d. Exercise Testing
e. Electrocardiography
f. Cardiac Chest X-ray and Cardiac Fluoroscopy
g. Clinical Pathology and Blood Chemistry Analysis
h. Phonocardiography

i. Coronary Care Units (CCUs)
j. Medical Telemetry/Progressive Care

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

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

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

Relative Importance of Project Review Criteria

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

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

The Department finds that:

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

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

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

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

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY		# CATH LABS	FY04 ADULT DIAG	FY04 ADULT THERP	FY04 ADULT TOTAL	FY04 PED	FY05 ADULT DIAG	FY05 ADULT THERP	FY05 ADULT TOTAL	FY05 PED	FY06 ADULT DIAG	FY06 ADULT THERP	FY06 ADULT TOTAL	FY06 PED
I														
ANMED HEALTH MEDICAL CENTER		3	1,960	989	2,949		2,135	1,150	3,285		1,976	1,134	3,110	
GREENVILLE MEMORIAL HOSPITAL		7	5,553	2,485	8,038		3,841	2,358	6,199		2,864	2,121	4,985	
SAINT FRANCIS - DOWNTOWN	1	3	1,194	404	1,598		1,347	538	1,885		1,307	625	1,932	
OCONEE MEMORIAL HOSPITAL		1	808		808		1,121		1,121		993		993	
PALMETTO BAPTIST MED CTR-EASLEY	2	1	618		618		636		636		567		567	
MARY BLACK MEMORIAL		1	106		106		148		148		213		213	
SPARTANBURG REGIONAL MEDICAL CTR		4	2,380	639	3,019		2,061	898	2,959		3,254	1,130	4,384	
TOTAL AREA I		20	12,619	4,517	17,136		11,289	4,944	16,233		11,174	5,010	16,184	
II														
CHESTER REGIONAL MEDICAL CENTER	3	MOBILE									73		73	
SELF REGIONAL HEALTHCARE		2	1,068	230	1,298		1,238	354	1,592		1,224	333	1,557	
KERSHAW COUNTY MEDICAL CTR	4	1			0				0				0	
SPRINGS MEMORIAL HOSPITAL		1	675		675		637		637		382		382	
LEXINGTON MEDICAL CENTER		1	1,398		1,398		1,472	22	1,494		1,355	19	1,374	
PALMETTO HEALTH BAPTIST		1	482		482		490		490		365		365	
PALMETTO HEALTH RICHLAND		4	2,813	834	3,647		2,846	865	3,711		2,898	1,039	3,937	
(PALMETTO HEART)	5	(1)												
PROVIDENCE HOSPITAL		6	3,901	2,749	6,650		3,716	2,876	6,592		3,924	3,039	6,963	
PIEDMONT MEDICAL CENTER		3	1,866	943	2,809		1,829	894	2,723		1,673	828	2,501	
SOUTH CAROLINA HEART CENTER	6	2			0				0		2,318		2,318	
TOTAL AREA II		22	12,203	4,756	16,959		12,228	5,011	17,239		14,212	5,258	19,470	
III														
CAROLINA PINES REGIONAL MEDICAL CTR		1	502		502		473		473		322		322	
CAROLINAS HOSPITAL SYSTEM		2	892	160	1,052		1,028	222	1,250		1,188	268	1,456	
MCLEOD REGIONAL MEDICAL CENTER		4	3,152	830	3,982		2,480	624	3,104		1,868	723	2,591	
GEORGETOWN MEMORIAL HOSPITAL	7	1	837	54	891		859	46	905		915	44	959	
CONWAY HOSPITAL		1	834		834		652		652		763		763	
GRAND STRAND REGIONAL MEDICAL CTR		2	769	623	1,392		851	607	1,458		845	595	1,440	
LORIS COMMUNITY HOSPITAL	8	1	0		0		43		43		318		318	
TUOMEY		1	505		505		361		361		331		331	
TOTAL AREA III		13	7,491	1,667	9,158		6,747	1,499	8,246		6,550	1,630	8,180	

IV		# CATH LABS	FY04 ADULT DIAG	FY04 ADULT THERP	FY04 ADULT TOTAL	FY04 PED	FY05 ADULT DIAG	FY05 ADULT THERP	FY05 ADULT TOTAL	FY05 PED	FY06 ADULT DIAG	FY06 ADULT THERP	FY06 ADULT TOTAL	FY06 PED
AIKEN REGIONAL MEDICAL CENTER		1	1,070	381	1,451		1,162	400	1,562		908	447	1,355	
BEAUFORT MEMORIAL HOSPITAL		1	485		485		436		436		397		397	
HILTON HEAD HOSPITAL		2	580	243	823		494	244	738		501	233	734	
COLLETON MEDICAL CENTER	9	MOBILE			0				0				0	
BON SECOURS ST. FRANCIS XAVIER		1	111		111		98		98		21		21	
MUSC MEDICAL CENTER	10	5	1,379	827	2,206	207	1,742	885	2,627	286	1,802	734	2,536	1,130
ROPER HOSPITAL		3	2,841	779	3,620		2,778	766	3,544		2,055	736	2,791	
TRIDENT MEDICAL CENTER		2	1,132	462	1,594		1,308	519	1,827		1,686	503	2,189	
REG MED CTR ORANGEBURG-CALHOUN		1	763		763		524		524		691		691	
TOTAL AREA IV		17	8,361	2,692	11,053	207	8,542	2,814	11,356	286	8,061	2,653	10,714	1,130
STATEWIDE TOTALS		72	40,674	13,632	54,306	207	38,806	14,268	53,074	286	39,997	14,551	54,548	1,130

1 CON ISSUED 11/17/05 FOR 3RD CATH LAB.
2 CON ISSUED 6/2/06 TO ALLOW EMERGENT PCI.
3 CON FOR MOBILE 2 DAYS/WEEK 2/17/06.
4 CON ISSUED 6/19/04.
5 CON ISSUED AS A JOINT VENTURE BETWEEN COLUMBIA HEART AND PALMETTO RICHLAND 1/29/07; CON VOIDED 12/28/07.
6 DOCTORS OFFICE, NOT A LICENSED ASF.
7 CON ISSUED 5/11/05 TO ALLOW EMERGENT PCI.
8 CON ISSUED 6/2/04.
9 CON FOR MOBILE 1 DAY/WEEK, 4/15/03.
10 PEDIATRIC METHODOLOGY CHANGED FOR 2006 UTILIZATION.

Certificate of Need Standards for Open Heart Surgery

Definitions

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

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60- 35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

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

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

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

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

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

Standards

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

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

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

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

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

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

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

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

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

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

1. using a standard of every seven (7) diagnostic cardiac catheterizations performed generating one (1) open heart surgery, the applicant must demonstrate that the facility performs sufficient diagnostic cardiac catheterizations to generate the minimum volume of open heart surgeries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scope of Services

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

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

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

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

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

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

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

Relative Importance of Project Review Criteria

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

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

The Department makes the following findings:

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

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

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

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

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

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

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

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

OPEN HEART SURGERIES

REGION/FACILITY	# OPEN HEART UNITS	FY04 ADULT	FY04 PEDS	FY05 ADULTS	FY05 PEDS	FY06 ADULTS	FY06 PEDS
I							
ANMED HEALTH MEDICAL CENTER	2	265		306		265	
GREENVILLE MEMORIAL MED CTR	4	850		823		710	
ST FRANCIS - DOWNTOWN	2	147		245		226	
SPARTANBURG REGIONAL MED CTR	2	476		370		383	
TOTAL REGION I	10	1,738		1,744		1,584	
II							
SELF REGIONAL HEALTHCARE	2	104		130		132	
PALMETTO HEALTH RICHLAND	2	435		410		450	
PROVIDENCE HOSPITAL	4	1,047		939		826	
PIEDMONT MEDICAL CENTER	2	144		252		166	
TOTAL REGION II	10	1,730		1,731		1,574	
III							
CAROLINAS HOSPITAL SYSTEM	2	121		224		247	
MCLEOD REGIONAL MEDICAL CENTER	3	493		387		309	
GRAND STRAND REGIONAL MED CTR	2	495		450		404	
TOTAL REGION III	7	1,109		1,061		960	
IV							
AIKEN REGIONAL MEDICAL CTR	1	107		77		91	
HILTON HEAD HOSPITAL	1	59		46		12	
MUSC MEDICAL CENTER	3	380	225	508	296	530	308
ROPER HOSPITAL	2	471		471		451	
TRIDENT REGIONAL MED CTR	1	235		260		236	
VA HOSPITAL (CHARLESTON)	1						
TOTAL REGION IV	9	1,252	225	1,362	296	1,320	308
STATEWIDE TOTALS	35	5,829	225	5,898	296	5,438	308

(G) Megavoltage Radiotherapy & Radiosurgery

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and South Carolina, accounting for approximately 22% of all deaths. It is estimated that there were 21,860 new cases of cancer diagnosed in South Carolina in 2005 and 9,080 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall 5-year survival rate is approximately 62%.

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 pallative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and delivery radiation to that precise location. The amount of radiation used is measured in "gray" (Gy), and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for 2 to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77401-77404, 77406-77409, 77411-77414, 77416, 77418, 77432 and 77470.

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

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

Conformal Radiation Therapy (CRT): Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area. Synonyms include Conformal External Beam Radiation Therapy (CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

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

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

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. **Hyperfractionation** (Superfractionation) is when the radiation is given in smaller doses twice a day. In **Hypofractionation**, individual doses are given less often than daily, such as 2-5 sessions.

Image-Guided Radiation Therapy (IGRT) combines IMRT with On-Board Imaging (OBI) scans. It visualizes the patient's anatomy during treatments and allows for real-time adjustment of the beams. Since tumors move between treatments and due to breathing during treatments, IGRT ensures correct patient positioning and reducing healthy tissue damage.

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

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 patient's head is placed in a special frame, which is attached to the patient' skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient's head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

Stereotactic Radiation Therapy (SRT) is a similar approach as Stereotactic Radiosurgery to delivering 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 2-5 sessions. It can be used to treat both brain and extracranial tumors.

There are 3 types of radiation equipment available:

1. Particle Beam (Proton)

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of greater than $100 million will limit their expansion.

2. Linear Accelerator (X-Ray)

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

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

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

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

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

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

f. field-shaping capability; and

g. access to CT scanning capability.

The capacity standards for a linear accelerator vary by the capability of the equipment. A conventional linear accelerator, either with or without EPID, has a capacity of 7,000 treatments per year, based upon an average of 28 patients treated per day, 5 days per

week, 50 weeks per year. 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. In addition, the average treatment time for highly specialized techniques such as total body irradiation or for treating children is longer. Therefore, these systems cannot treat as many patients per day and a lower capacity of 4,000 treatments per year (16 patients treated per day, 5 days per week, 50 weeks per year) is established for such equipment. At this time, 2 of the linear accelerators at MUSC, and the Tomotherapy units at Spartanburg Regional and Carolina Regional Radiation Center are determined to meet this definition and their capacities and the need calculations for their service areas have been adjusted accordingly.

There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in 1-5 treatment sessions. These specialized linacs have an even lower capacity because of the treatment time associated with this type of care. The capacity for such equipment is established as 1,000 treatments per year per unit, based on 4 treatments per day, 5 days per week, for 50 days per year. The Cyberknife approved at Roper Hospital (CON 8/10/06) is the only equipment so designated, and the capacity and need calculations for this facility and service area have also been adjusted.

3. Cobalt-60 (Photon)

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs between $3.4 and $5 million, plus an additional $0.25 to $0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

Status of South Carolina Providers

1. Linear Accelerators

There are currently 26 facilities either operating or approved for a total of 50 linear accelerators in South Carolina. In 2006, the 45 operational linear accelerators averaged 5,248 treatments per unit. The utilization for each provider per linear accelerator was:

Provider	# Accelerators	Treatments/ Accelerator
Cancer Ctr. Carolinas Eastside	1	9,700
SC Oncology Associates	2	8,710
Carolina Regional Radiation	2	7,016
Lexington Medical Ctr.	2	6,478
Roper Hospital	2	6,184
Aiken Regional	1	6,134
AnMed Health Med. Ctr.	2	6,100
Spartanburg Regional *1*	3	5,984
Rock Hill Radiation	2	5,900
Cancer Ctr. Carolinas Oconee	1	5,799
RMC-Orangeburg/Calhoun	1	5,722
Greenville Memorial Hospital	3	5,569
Cancer Center Carolinas	1	5,455
Georgetown Memorial	1	5,416
Beaufort-Hilton Head	1	5,412
Trident Regional	2	5,397
Tuomey Regional	2	5,021
Carolinas Hospital System	1	4,953
McLeod Regional	4	4,141
MUSC *2*	4	3,779
Self Memorial	2	3,347
Palmetto Health Richland	4	2,724
Beaufort Memorial Hospital	1	2,053

1 Spartanburg Regional has a Tomotherapy linac with a 4,000 treatment capacity
2 2 of the MUSC linacs have a 4,000 treatment capacity

2. Gamma Knife

Palmetto Health Richland is currently the only hospital to operate a Gamma Knife in South Carolina. A total of 240 patients received Gamma Knife treatment in 2006.

The Certificate of Need standards for Radiotherapy and Stereotactic Radiosurgery follow.

Certificate of Need Standards for Radiotherapy

Standards

(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 or performing highly specialized techniques such as total body irradiation or for treating children have a capacity of 4,000 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) Linear Accelerators designed strictly to provide Stereotactic Radiotherapy has a capacity of 1,000 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.

(4) There are 13 service areas established for Radiotherapy units as shown on the following chart.

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

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

B. an applicant must project that the proposed service will perform a minimum number of treatments equal to 50 percent of capacity annually within three years of initiation of services, without reducing the utilization of the existing machines in the service area below the 80 percent threshold. If the new equipment is a specialized radiotherapy unit as described in either Standard 2 or 3 above, then the applicant may propose an annual capacity based on the specialized use of the equipment by that applicant. If the applicant can justify this proposed annual capacity, then this capacity will be used in CON application calculations, as well as future capacity calculations, for that applicant. The applicant must document where the potential patients for this new service will come from and where they are currently being served, to include the expected shift in patient volume from existing providers.

(6) 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 Standard 2 or 3 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.

(7) 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, with expected annual referral volumes.

(8) 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.

Relative Importance of Project Review Criteria

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

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

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

MEGAVOLTAGE VISITS

REGION & FACILITY		# UNITS	FY2004	FY2005	FY2006
I					
ANDERSON COUNTY					
ANMED HEALTH MEDICAL CENTER		2	10,931	12,346	12,199
CHEROKEE COUNTY					
GIBBS REGIONAL CANCER CTR SATELLITE	*1*	(1)	---	---	---
GREENVILLE COUNTY					
CANCER CENTERS OF THE CAROLINAS		1	5,637	4,593	5,455
CANCER CENTERS CAROLINAS - EASTSIDE		1	9,815	9,423	9,700
GREENVILLE MEMORIAL MEDICAL CENTER		3	14,687	14,728	16,707
GREER MEDICAL CAMPUS CANCER CTR	*2*	1	---	---	---
OCONEE COUNTY					
CANCER CENTERS CAROLINAS - OCONEE CO.		1	5,014	5,571	5,799
SPARTANBURG COUNTY					
SPARTANBURG REGIONAL MED CTR		3	16,860	16,309	17,953
VILLAGE AT PELHAM CANCER CENTER	*1*	1			
II					
GREENWOOD COUNTY					
SELF REGIONAL HEALTHCARE		2	7,537	6,506	6,694
LEXINGTON COUNTY					
LEXINGTON MEDICAL CENTER		2	13,398	12,302	12,956
NEWBERRY COUNTY					
NEWBERRY ONCOLOGY ASSOCIATES	*3*	1	---	---	---
RICHLAND COUNTY					
PALMETTO HEALTH BAPTIST	*4*	(2)	3,281	---	---
PALMETTO HEALTH RICHLAND	*4*				
LINEAR ACCELERATORS		2	20,500	10,817	10,895
GAMMA KNIFE		1	225	214	240
SOUTH CAROLINA ONCOLOGY ASSOCIATES	*4*	4	11,513	18,065	17,420
YORK COUNTY					
ROCK HILL RADIATION THERAPY CENTER		2	11,471	11,529	11,800

MEGAVOLTAGE VISITS

REGION & FACILITY		# UNITS	FY2004	FY2005	FY2006
III					
FLORENCE COUNTY					
CAROLINAS HOSPITAL SYSTEM		1	10,208	4,667	4,953
MCLEOD REGIONAL MEDICAL CENTER		4	17,760	17,519	16,562
GEORGETOWN COUNTY					
GEORGETOWN MEMORIAL HOSPITAL		1	1,889	4,217	5,416
HORRY COUNTY					
CAROLINA REGIONAL RADIATION CENTER	*5*	3	15,442	15,770	14,032
SUMTER COUNTY					
TUOMEY		2	8,635	10,067	10,041
IV					
AIKEN COUNTY					
AIKEN REGIONAL MEDICAL CENTER		1	5,426	5,902	6,134
BEAUFORT COUNTY					
BEAUFORT/HILTON HEAD RAD ONCOLOGY CTR		1	6,147	5,774	5,412
BEAUFORT MEMORIAL HOSPITAL	*6*	1	---	---	2,053
CHARLESTON COUNTY					
MUSC MEDICAL CENTER	*7*	4	13,616	13,896	15,116
ROPER HOSPITAL	*8*	3	11,806	11,759	12,368
TRIDENT MEDICAL CENTER		2	11,110	12,017	10,794
ORANGEBURG COUNTY					
REGIONAL MED CTR ORANGEBURG/CALHOUN		1	5,832	5,944	5,722
TOTAL		**50**	**238,515**	**229,721**	**236,181**

1 GIBBES LINAC APPROVED 3/31/03; APPEALED. CON TO MOVE PROPOSED GIBBES LINAC TO VILLAGE AT PELHAM APPEALED 2/12/08.
2 CON ISSUED 10/12/07, SC-07-53.
3 CON APPROVED 3/20/06.
4 TRANSFER & REPLACE 2 LAS FROM PAL BAPTIST & TRANSFER OWNERSHIP OF 4 LAS FROM PAL RICHLAND 11/12/03 SC-03-68. CON TO REPLACE & TRANSFER 2 LAS FROM PAL RICHLAND TO SC ONCOLOGY ASSOC SITE FOR A TOTAL OF 4, 5/1/06.
5 CON APPROVED FOR A TOMOTHERAPY UNIT AS A 3RD LINAC; APPEALED. CON ISSUED 7/18/07.
6 CON SC-03-24 4/29/03
7 CON TO MOVE & REPLACE EXISTING LA TO MT PLEASANT 7/8/03 SC-03-38. CON ISSUED 7/18/05 TO REPLACE A LA & RETAIN THE OLD UNIT FOR PEDIATRIC & TIME-INTENSIVE PROC SC-05-45
8 CON ISSUED FOR A CYBERKNIFE LINEAR ACCELERATOR 8/10/06.

RADIOTHERAPY

SERVICE AREAS	2006 POPULATION	# OF LIN ACC	POP PER LIN ACC	TOTAL AREA TREATMENTS	TREATMENTS PER LIN ACC	PLANNING AREA CAPACITY
ANDERSON,OCONEE	245,560	3	81,853	17,998	5,999	21,000
GREENVILLE,PICKENS	522,980	6	87,163	31,862	5,310	42,000
CHEROKEE,SPARTANBURG UNION	355,150	4	88,788	17,953	4,488	25,000
CHESTER,LANCASTER,YORK	277,480	2	138,740	11,800	5,900	14,000
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	225,800	2	112,900	6,694	3,347	14,000
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	689,450	9	76,606	41,271	4,586	63,000
CHESTERFIELD, DARLINGTON DILLON, FLORENCE, MARION MARLBORO	336,830	5	67,366	21,515	4,303	35,000
CLARENDON,LEE,SUMTER	167,110	2	83,555	10,041	5,021	14,000
GEORGETOWN,HORRY WILLIAMSBURG	316,370	4	79,093	19,448	4,862	25,000
BAMBERG,CALHOUN ORANGEBURG	126,640	1	126,640	5,722	5,722	7,000
ALLENDALE,BEAUFORT, HAMPTON,JASPER	191,030	2	95,515	7,465	3,733	14,000
BERKELEY,CHARLESTON COLLETON,DORCHESTER	629,120	9	69,902	38,278	4,253	57,000
AIKEN,BARNWELL	180,460	1	180,460	6,134	6,134	7,000
STATE TOTAL	4,263,980	50	85,280	236,181	4,724	338,000

Certificate of Need Standards for Stereotactic Radiosurgery

Standards

(1) The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of 2 procedures per day times 3 days per week times 50 weeks per year.

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

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

A. all existing 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 services, without reducing the utilization of existing units below the 80 percent threshold.

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

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

A. epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;

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

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

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

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

(8) The applicant must affirm the following:

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

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

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

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

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

(9) Because of the unique nature and limited need for this type of equipment, the applicant should document how they intend to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

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

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

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

(H) Positron Emission Tomography (PET) and PET/CT

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

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

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

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2.0-2.7 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000.

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

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

Certficate of Need Standards

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

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

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

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

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

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

(7) The Department encourages all applicants and providers to share their outcomes 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:

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

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

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

REGION/COUNTY	FACILITY	SCANNERS	FY04 SCANS	FY05 SCANS	FY06 SCANS	CON/DATE
REGION I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE FOR 2 DAYS	214	255	372	REPLACE PET W/ PET-CT 5/1/06
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	1,956	2,154	2,203	REPLACE PET W/ PET-CT 6/27/06
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE FOR 4 DAYS	---	---	49	CON 5/1/06
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	532	681	880	REPLACE MOBILE W/ FIXED 8/22/06
REGION II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE FOR 3 DAYS	---	---	---	CONVERT TO 3 DAYS/WK & CONV TO PET/CT 11/27/06
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE FOR 3 DAYS	512	533	488	REPLACE PET W/ PET-CT 3/22/06 2 DAYS LMC-LEX 1DAY LMC-IRMO
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	1,391	1,265	1,099	REPLACE PET W/ PET-CT 7/1/05
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	---	---	---	CON FOR PET 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	---	---	1,324	CON 11/16/05
YORK	PIEDMONT MEDICAL CENTER	MOBILE FOR 2 DAYS	282	317	531	REPLACE PET W/ PET-CT 3/21/06
REGION III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE FOR 1 DAY	---	181	232	REPLACE PET W/ PET-CT 11/13/06

REGION/COUNTY	FACILITY	SCANNERS	FY04 SCANS	FY05 SCANS	FY06 SCANS	CON/DATE
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	523	470	576	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE FOR 1 DAY	---	---	146	CON 9/14/05
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE FOR 2 DAYS	669	736	838	
HORRY	CONWAY HOSPITAL	MOBILE FOR 2 DAYS	103	120	80	REPLACE PET W/ PET-CT 8/22/06
SUMTER	TUOMEY	MOBILE FOR 1/2 DAY	18	118	131	CON 3/5/04
REGION IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE FOR 1 DAY	---	202	328	CON 8/18/04
BEAUFORT	BEAUFORT IMAGING	MOBILE FOR 2 DAYS	---	---	128	REPLACE PET W/ PET-CT 9/11/08
BEAUFORT	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	---	---	299	CONVERTED TO FIXED 7/25/07
CHARLESTON	MUSC MEDICAL CENTER	FIXED	---	---	329	CON 2/10/06
CHARLESTON	ROPER HOSPITAL	FIXED	1,367	1,380	823	REPLACE PET W/ PET-CT 9/14/06
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE FOR 1 DAY	262	288	350	
CHARLESTON	NORTH CHARLESTON DIAGNOSTIC	FIXED	---	---	---	CON 3/20/06
JASPER	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	---	---	---	EXEMPTION 7/24/07
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE FOR 2 DAYS	123	111	62	
		TOTALS	7,952	8,811	11,268	

(I) Outpatient Facilities

Outpatient facility means a facility providing community service for the diagnosis and treatment of ambulatory patients: (1) which is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of a licensed physician; or (3) which offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

(1) Ambulatory Surgical Facility

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

There has been a substantial increase in both the number and percentage of ambulatory surgeries performed and the number of approved ASF's. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, hospitals have expressed concern that ASF's that are not hospital joint ventures are impacting their ability to fund their services. CMS has recently revised the payment system for ASF's, setting a new compensation rate of 65% of the hospital outpatient rate under Medicare, to be phased in by 2011. This is anticipated to particularly impact endoscopy centers, which are currently paid 89% of the hospital rate, while other specialties may receive increased reimbursement. At the same time, CMS added more than 700 procedures to the list that ASF's can be reimbursed for.

In 2006, a total of 314,960 outpatient surgeries and 198,898 endoscopies were performed in either a freestanding surgical center or a hospital in South Carolina, amounting to 68.2% of all surgeries and 83.6% of all endoscopies.

Certificate of Need Standards

Prior to the approval of additional ambulatory surgical facilities or the addition of operating rooms and/or endoscopy suites to existing ambulatory surgical facilities, the following criteria must be addressed:

(1) The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service

area that encompasses additional counties, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

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

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

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

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

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

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

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

(9) Before an application for a new Ambulatory Surgery Facility can be accepted for filing, all existing ASF's in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization. For purposes of this standard, endoscopy suites are considered separately from other operating rooms. Endoscopy-only ASF's do not impact other ASF's. Before additional licensed endoscopy suites can be added in a county, all ASF's with licensed endoscopy suites must have had these suites licensed and operational for one year to allow for a determination of the utilization of the endoscopy providers.

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

(11) The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage which 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 a nationally recognized organization, such as The Joint Commission (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC), or the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF). Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most South Carolina residents. Most ASF's operate five days a week, with elective surgery being scheduled several days in advance.

Relative Importance of Project Review Criteria

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

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

j. Staff Resources.

The number of surgeries performed on an outpatient basis and the number of ASF's approved and licensed have increased over time. However, there is concern that ASF's are being proposed as a method of increasing reimbursement for procedures currently being performed in physician's offices, through the "facility fee" built into the reimbursement mechanisms, to the detriment of hospital's ability to provide the range of services needed. The benefits of improved accessibility will be weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 2006):

2006 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	4,299	39	4,338	1,433		1
Bearwood Ambulatory Surgery Center	Anderson	1		1	216		216	216		
Physician Surgery Center at AnMed Health	Anderson	3		3	0					2
Upstate Endoscopy Center	Anderson		2	2		3,367	3,367		1,684	
Center for Special Surgery, The	Greenville	2		2	2,926		2,926	1,463		3
Cross Creek Surgery Center	Greenville	4		4	3,748		3,748	937		
Endoscopy Center of the Upstate	Greenville		3	3		5,151	5,151		1,717	
Greenville Endoscopy Center	Greenville		3	3		6,836	6,836		2,279	
Greenville Endoscopy Center - Patewood	Greenville		3	3						4
GHS Outpatent Surgery Center – Patewood	Greenville	6	2	8	5,111	2,511	7,622	852	1,256	
HealthSouth Surg Center - Greenville	Greenville	4		4	2,306		2,306	577		
Jervey Eye Center	Greenville	3		3	3,454		3,454	1,151		
Upstate Surgery Center	Greenville	2		2	3,820		3,820	1,910		5
Blue Ridge Surgery Center	Oconee	2		2	2,766		2,766	1,383		
Upstate Pain Management & Surgery Center	Oconee	2		2	933		933	467		
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	9	3	12	6,830	3,417	10,247	759	1,139	6
Spartanburg Urology Surgicenter	Spartanburg	4		4	3,092		3,092	773		7
Surgery Center at Pelham	Spartanburg	4	2	6	3,134	2,171	5,305	784	1,086	
Westside Eye Center	Spartanburg	2		2	967		967	484		
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		7,602	7,602		1,901	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Ctr. of Self Memorial Hospital	Greenwood	5		5	4,458		4,458	892		
Surgery Center at Edgewater	Lancaster	3	2	5			0			*8*
Surgery & Laser Center at Professional Park	Laurens	2		2	4		4			*9*
Columbia Ambulatory Surgery Center	Lexington	2		2	646		646	323		
Midlands Endoscopy Center	Lexington		2	2		1,484			742	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	2		2			0			*10*
Outpt Surg Ctr Lexington Med Ctr - Irmo	Lexington	4		4	1,501		1,501	375		
Outpt Surg Ctr Lex Med Ctr - Lexington	Lexington	4	1	5	1,731	1,558	3,289	509	1,558	*11*
South Carolina Endoscopy Center	Lexington		4	4		11,784	11,784		2,946	
Urology Surgery Center	Lexington	2		2	2,200		2,200	1,100		
Berkeley Endoscopy Center	Richland		2	2			0			*12*
Columbia Eye Surgery Center (Eye Surgery Only)	Richland	4		4	4,313		4,313	1,078		
Columbia GI Endoscopy Center	Richland		4	4		5,756	5,756		1,439	
Lake Murray Endoscopy Center	Richland		2	2		1,578	1,578		789	
Midlands Orthopaedics Surgery Center	Richland	3		3	2,040		2,040	680		*13*
Palmetto Surgery Center	Richland	4		4	5,760		5,760	1,440		
Parkridge Surgery Center	Richland	4		4	3,149		3,149	787		
Providence Hospital Surgery Center	Richland	4		4	1,228		1,228	307		
South Carolina Endoscopy Ctr-NorthEast	Richland		5	5		3,716	3,716		743	
South Carolina Med Endoscopy Center	Richland		2	2		3,201	3,201		1,601	*14*
Carolina Surgical Center	York	4		4	4,775		4,775	1,194		
Center for Orthopaedic Surgery	York	3		3			0			*15*
York County Endoscopy Center	York		3	3						*16*

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region III:										
Darlington Endoscopy Center	Darlington		2	2		826	826		413	
Florence Surgery & Laser Center	Florence	2		2	2,149		2,149	1,075		
McLeod Ambulatory Surgery Center	Florence	2		2	1,381		1,381	691		
Physicians Surgical Center of Florence	Florence	4	2	6	2,770	2,079	4,849	693	1,040	
Atlantic Surgery Center	Georgetown	2		2	1,251		1,251	626		
Bay Microsurgical Unit	Georgetown	1		1	3,595		3,595	3,595		
Waccamaw Endoscopy Center	Georgetown		1	1						***17***
Carolina Bone and Joint Surgery Ctr.	Horry	2		2	1,892		1,892	946		
Grande Dunes Surgery Center	Horry	3	2	5	3,519	677	4,196	1,173	339	***18***
Ocean Ambulatory Surgery Center	Horry	2		2	1,541		1,541	771		***19***
Parkway Surgery Center	Horry	2		2	2,322		2,322	1,161		
Rivertown Surgery Center	Horry	2		2	2,228		2,228	1,114		
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	2,479	1,051	3,530	826		
Strand GI Endoscopy Center	Horry		2	2		3,704	3,704		1,852	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	2,632	45	2,677	1,316		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	1,600	879	2,479	400	879	***20***
Carolina Ambulatory Surgery Center	Aiken	1		1	141		141			
Blufton-Okatie Outpatient Center	Beaufort	2	1	3	798	704	1,502	399	704	
Laser and Skin Surgery Center	Beaufort	2		2	1,603		1,603	802		
Outpatient Surgery Ctr. Hilton Head	Beaufort	2	2	4	2,457	2,209	4,666	1,229	1,105	
Surgery Center of Beaufort	Beaufort	3	2	5	3,557	1,127	4,684	1,186	564	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Roper Berkeley Ambulatory Surgery	Berkeley	3		3	379	594	973	126		
Charleston Endoscopy Center	Charleston		4	4		7,274	7,274		1,819	
Charleston Surgery Center	Charleston	4	1	5	2,863	0	2,863	716	0	*21*
Elms Endoscopy Center	Charleston		3	3		4,279	4,279		1,426	*22*
Palmetto Endoscopy Center	Charleston		2	2		5,011	5,011		2,506	
Physicians' Eye Surgery Center	Charleston	2		2	1,626		---	813		*23*
Roper St. Francis James Island Surgery Center	Charleston	2		2	12		12	6		*24*
Roper West Ashley Surgery Center	Charleston	5		5	4,545		4,545	909		*25*
Southeastern Spine Institute	Charleston	2		2						*26*
Surgery Center of Charleston	Charleston	1	1	2	1,840	720	2,560	1,840	720	
Trident Eye Surgery Center	Charleston	2		2	2,423		2,423	1,212		
Trident Surgery Center	Charleston	4		4	4,025		4,025	1,006		
Colleton Ambulatory Surgery Center	Colleton	2	1	3	883	758	1,641	442	758	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,248		2,248	1,124		
(Summerville Surgery Center)	Dorchester	(2)		(2)						*27*
Edisto Surgery Center	Orangeburg	4	2	6			0	0		*28*
TOTALS		175	78	253	134,166	92,108	226,274	907	1,250	

Ambulatory Surgical Facility (ASF) Footnotes

--- No data available for facility during reporting period.

1 CON issued 2/14/06 for AnMed Health to purchase and rename Medicus Surgery Center as AnMed Health Medicus Surgery Center, SC-06-07.

2 CON issued 1/29/07 for an ASF with 3 OR's, SC-07-03.

3 CON approved 10/17/06 to construct a 3rd OR in the existing ASF; appealed. Applicant withdrew the CON application and the case was dismissed by the ALJ 7/11/07.

4 CON issued 8/22/06 for an ASF with 3 Endoscopy rooms. Licensed 8/30/07.

5 Formerly Patewood Surgery Center.

6 CON issued 10/22/07 to add 2 additional OR's and 1 endoscopy suite for a total of 9 OR's and 3 endoscopy suites, SC-07-55.

7 CON issued 10/22/07 to add 2 additional OR's for a total of 4 OR's, SC-07-54.

8 CON approved 1/23/04, appealed. CON issued 6/10/05 after dismissal of appeal, SC-05-40. CON issued 6/15/07 to add an additional OR for a total of 3 ORs and 2 Endoscopy suites, SC-07-24. Licensed 2/27/08; formerly Carolina Surgery Center.

9 CON issued 7/29/05, SC-05-51; licensed 11/22/06.

10 CON issued 4/26/05, SC-05-27; licensed 12/10/07.

11 Addition of 1 OR 4/26/05, SC-05-29; licensed 5/10/06.

12 CON issued 7/18/06, SC-06-40. Licensed 1/8/07.

13 CON issued 3/1/05, SC-05-15; licensed 7/6/06.

14 CON denied to expand from 2 to 4 Endoscopy suites 9/19/03; under appeal.

15 CON issued 1/12/06, SC-06-02. Licensed 5/3/07.

16 CON approved 2/26/07 for an ASF with 3 Endoscopy suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08.

17 CON issued 7/7/06, SC-06-35. Licensed 8/15/07.

18 CON issued 4/19/05 for a 3rd OR, SC-05-24. The 3rd OR was licensed 5/11/06. CON issued 4/13/07 to convert 2 treatment rooms into 2 licensed Endoscopy suites, for a total of 3 ORs and 2 Endoscopy suites, SC-07-14. The Endoscopy suites were licensed 7/2/07.

19 Temporarily closed due to fire, 7/21/04; re-licensed 11/05.

20 CON issued 11/10/03; licensed 11/9/05.

21 Formerly HealthSouth Surgery Center of Charleston.

22 CON issued 9/20/05, SC-05-66; licensed 5/10/06.

23 CON issued 1/16/04. Licensed 12/9/05 but did not perform 1st surgery until 1/10/06. Formerly Health First.

24 Formerly Charleston Plastic Surgery Center. CON issued 10/12/06 to relocate the ASF and rename it Roper St. Francis James Island Surgery Center, SC-06-64. Charleston Plastic Surgery Center was de-licensed on 12/27/06.

25 CON issued 4/12/05 to convert a procedure room to a 5th operating room, SC-05-21. Licensed for 5 ORs 10/4/05.

26 CON issued 6/12/08 after appeal, SC-08-17.

27 CON issued 6/28/04; CON voided 8/28/06.

28 CON approved 5/31/05; appealed. CON issued 9/21/06.

(2) Emergency Hospital Services

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

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

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

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

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

According to DHEC Health Licensing, the following facilities are considered to be freestanding emergency services (along with the hospital they are an extension of):

Moncks Corner Medical Center (Trident Medical Center) – Moncks Corner, Dorchester County
Seacoast Medical Center (Loris Community Hospital) – Little River, Horry County
South Strand Ambulatory Care Center (Grand Strand Regional) – Myrtle Beach, Horry County
Roper St. Francis Northwoods (Roper St. Francis) – North Charleston, Charleston County

Certficate of Need Standards for Freestanding Emergency Services

(1) A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

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

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

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

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

(6) The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

Relative Importance of Project Review Criteria

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

a. Compliance with the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Resource Availability; and
d. Financial Feasibility.

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

(3) Trauma Referral System

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

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

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

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

2. 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. Such services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

Need projections are based on psychiatric service areas. The bed need methodology takes the greater of the actual utilization or 75% of the statewide beds per 1,000 population to project need. For the service areas without existing psychiatric units and related utilization data, 75% of the overall state use rate was used in the projections. The following pages depict the calculations described above.

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

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

State Mental Health Facilities

(A) Psychiatric Hospital Beds

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital compliment is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, they are exempt from Certificate of Need review.

(B) Local Inpatient Crisis Stabilization Beds

Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, there are not enough adult inpatient beds available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms

inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.

SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding the SCDMH contracts with one or more local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

The average occupancy rate in the 808 licensed non-State owned acute psychiatric beds in 2006 was 61.7%. These beds had an average daily census of 477 patients. There were 19,984 admissions and 174,081 patient days in these licensed psychiatric beds, for an average length of stay (ALOS) of 8.7 days. Note that a 10 bed psychiatric unit with an ALOS of 8.7 days and an occupancy rate of 70% would allow for the treatment of approximately 295 patients annually.

Because of the low utilization, the Plan only projects a need for a small number of additional psychiatric beds in a few areas. To assist in alleviating the problems described above, the following policies will apply.

1. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services in existing acute care or existing psychiatric beds, then a Certificate of Need is not required.

2. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services and desire to add psychiatric beds, a Certificate of Need would be required. These additional beds could be approved if the Plan indicates a need for additional beds or some small number (ten beds or less) of additional beds could be approved for crisis stabilization patients only. These beds would not be restricted to any specific age group except that the patients would have to be over age 18.

3. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from the SCDMH to verify this additional need such as the number of patients currently awaiting treatment, the estimated average length of stay, the pay source for the patients, the number of patients emergently admitted to SCDMH hospitals over the past year from the area, the number of crisis patients that are expected to require this service annually, and other information to justify these additional psychiatric beds. In addition, the SCDMH will supply verification that it made contact with all hospitals in the county and contiguous counties to notify them of the potential for adding some psychiatric beds to the area. The hospital seeking the Certificate of Need will provide the necessary care for these individuals referred by the SCDMH and may be reimbursed by for the care of the patients if there are sufficient funds, but the hospital must identify the minimum number of

indigent (no source of funding) patient days it will provide to patients referred by SCDMH. Should the contract with SCDMH terminate for any reason or should the hospital fail to provide care to the patients referred from the SCDMH, the license for these beds will be voided.

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

Relative Importance of Project Review Criteria

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

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

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

PSYCHIATRIC BED UTILIZATION

COUNTY	FACILITY	BEDS		2006 OCC. RATE	
AIKEN	AIKEN REGIONAL MEDICAL CENTER	29		91.8%	
ANDERSON	ANMED HEALTH MEDICAL CENTER	38		46.4%	
BEAUFORT	BEAUFORT MEMORIAL	14		61.6%	
CHARLESTON	MEDICAL UNIVERSITY SC	82		70.8%	
CHARLESTON	PALMETTO LOWCOUNTRY BEHAV	70		73.3%	*1*
DARLINGTON	MCLEOD DARLINGTON	23		59.8%	
FLORENCE	CAROLINAS HOSPITAL SYSTEM	~~14~~	12	---------	*2*
GREENVILLE	CAROLINA CTR BEHAV. HEALTH	76		87.7%	*3*
GREENVILLE	GREENVILLE MEMORIAL	~~63~~	46	68.1%	*4*
GREENVILLE	SPRINGBROOK BEHAVIORAL HEALTH	20		66.1%	*5*
GREENWOOD	SELF MEM REGIONAL HEALTHCARE	36		31.2%	
HORRY	LIGHTHOUSE - CONWAY	44		30.1%	*6*
LEXINGTON	THREE RIVERS BEHAV HEALTH	~~71~~	81	98.8%	*7*
MARLBORO	MARLBORO PARK HOSPITAL	8		42.4%	
ORANGEBURG	RMC-ORANGEBURG/CALHOUN	15		54.2%	
RICHLAND	PALMETTO BAPTIST - COLUMBIA	~~104~~	94	65.7%	*7*
RICHLAND	PALMETTO RICHLAND MEMORIAL	60		42.6%	
SPARTANBURG	MARY BLACK MEMORIAL	15		77.7%	
SPARTANBURG	SPARTANBURG REGIONAL	56		40.1%	
YORK	PIEDMONT MEDICAL CENTER	20		38.3%	
	TOTAL	858	839	61.7%	

1 CON ISSUED 10/18/04 TO ADD 10 PSYCH BEDS FOR A TOTAL OF 70; LICENSED 3/25/08.
2 CON APPROVED 2/24/06 TO ADD 24 CRISIS STABILIZATION PSYCH BEDS; APPEALED. BY ALJ ORDER, A 14 BED UNIT WAS APPROVED; 12 OF THE 14 BEDS WERE LICENSED 4/25/07. THE 2 REMAINING APPROVED BEDS WERE RELEASED BY CAROLINAS HOSPITAL SYSTEM 7/9/08.
3 CON ISSUED 10/11/04 TO ADD 11 PSYCH BEDS FOR A TOTAL OF 64. CON ISSUED 3/22/05 TO ADD 5 BEDS FOR A TOTAL OF 69. CON APPROVED 7/12/05 TO ADD 7 BEDS FOR A TOTAL OF 76. LICENSED BEDS INCREASED FROM 53 TO 69 BEDS, 7/27/05. LICENSED FOR 76 BEDS 3/15/07.
4 CON ISSUED 8/25/03 TO CONVERT 17 PSYCH BEDS TO GENERAL ACUTE FOR A TOTAL OF 46. LICENSED FOR 46 PSYCH BEDS ON 6/12/07.
5 CON APPROVED 7/12/05 TO CONVERT 5 LONG-TERM PSYCHIATRIC TO ACUTE PSYCH, FOR A TOTAL OF 20 PSYCHIATRIC BEDS. LICENSED BEDS INCREASED FROM 15 TO 20, 8/8/05.
6 CON ISSUED 7/7/06 TO ADD 16 PSYCH BEDS FOR A TOTAL OF 44; LICENSED FOR 44 BEDS ON 5/24/07.
7 CON ISSUED 7/18/06 TO ADD 32 PSYCH BEDS FOR A TOTAL OF 71 AT THREE RIVERS. CON VOIDED ON 4/17/07. AFTER APPEAL, A NEW CON WAS ISSUED 12/14/07. CON ISSUED 2/13/08 TO TRANSFER 10 PSYCH BEDS FROM PALMETTO BAPTIST TO THREE RIVERS IN EXCHANGE FOR 10 SUBSTANCE ABUSE BEDS.

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2006 POP	2013 POP	EXIST BEDS	2006 PDS	PROJ ADC	% OCC	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
ANDERSON,OCONEE	<65	209,160	219,460		4,621	13.28						
	+65	36,400	43,890		1,809	5.98						
	TOTAL	245,560	263,350	38	6,430	19.26	0.70	28	-10	44	6	6
GREENVILLE,PICKENS	<65	462,830	496,840		35,682	104.94						
	+65	60,150	70,510		6,901	22.16						
	TOTAL	522,980	567,350	142	42,583	127.11	0.70	182	40	95	-47	40
CHEROKEE,SPARTANBURG	<65	310,640	326,060		7,348	21.13						
UNION	+65	44,510	51,600		5,099	16.19						
	TOTAL	355,150	377,660	71	12,447	37.33	0.70	53	-18	63	-8	-8
CHESTER,LANCASTER	<65	246,800	265,260		2,325	6.85						
YORK	+65	30,680	37,090		472	1.56						
	TOTAL	277,480	302,350	20	2,797	8.41	0.70	12	-8	50	30	30
ABBEVILLE,EDGEFIELD	<65	194,710	203,930		3,575	10.26						
GREENWOOD,LAURENS	+65	31,090	37,420		538	1.77						
MCCORMICK,SALUDA	TOTAL	225,800	241,350	36	4,113	12.03	0.70	17	-19	40	4	4
FAIRFIELD,KERSHAW	<65	615,480	653,110		39,167	113.87						
LEXINGTON,NEWBERRY	+65	73,970	91,060		9,174	30.94						
RICHLAND	TOTAL	689,450	744,170	235	48,341	144.81	0.70	207	-28	124	-111	-28
DARLINGTON,FLORENCE	<65	206,960	210,200		4,566	12.71						
MARION	+65	28,340	33,680		452	1.47						
	TOTAL	235,300	243,880	35	5,018	14.18	0.70	20	-15	41	6	6
CHESTERFIELD,DILLON	<65	89,740	88,930		280	0.76						
MARLBORO	+65	11,790	13,520		958	3.01						
	TOTAL	101,530	102,450	8	1,238	3.77	0.70	5	-3	17	9	9

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2006 POP	2013 POP	EXIST BEDS	2006 PDS	PROJ ADC	% OCC	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	BED NEED
CLARENDON,LEE,SUMTER	<65	145,580	148,970		75%	13.18						
	+65	21,530	26,280		USE	2.33						
	TOTAL	167,110	175,250	0	RATE	15.51	0.70	22	22	29	29	29
GEORGETOWN,HORRY	<65	264,090	284,390		2,896	25.17						
WILLIAMSBURG	+65	52,280	69,130		178	10.19						
	TOTAL	316,370	353,520	44	3,074	35.36	0.70	51	7	59	15	15
BAMBERG,CALHOUN	<65	109,230	110,030		1,858	5.13						
ORANGEBURG	+65	17,410	20,750		1,109	3.62						
	TOTAL	126,640	130,780	15	2,967	8.75	0.70	12	-3	22	7	7
ALLENDALE,BEAUFORT	<65	158,740	168,790		2,536	7.39						
HAMPTON,JASPER	+65	32,290	45,090		611	2.34						
	TOTAL	191,030	213,880	14	3,147	9.73	0.70	14	0	36	22	22
BERKELEY,CHARLESTON	<65	555,820	575,120		32,118	91.05						
COLLETON,DORCHESTER	+65	73,300	96,020		5,112	18.35						
	TOTAL	629,120	671,140	152	37,230	109.40	0.70	156	4	112	-40	4
AIKEN,BARNWELL	<65	156,440	166,680		8,654	25.26						
	+65	24,020	29,320		1,060	3.54						
	TOTAL	180,460	196,000	29	9,714	28.91	0.70	41	12	33	4	12
	TOTAL			839				820	-19	765	-74	149
STATE TOTAL	<65	3,316,550	3,484,410	0.1669	142,731	0.043	0.03					
	+65	463,950	569,950		33,294	0.0718	0.05					
	TOTAL	3,780,500	4,054,360		176,025	0.0466	0.03					

3. Residential Treatment Facilities for Children and Adolescents

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

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

Facility	Beds	FY 2006 Occ. Rate
Directions (Department of Mental Health, Columbia)	37	39.5 %
Lighthouse Care Center of Conway (Conway)	16	54.0%
Marshall Pickens Hospital Children's Program (Greenville)	22	97.8%
Palmetto Low Country Behavioral Health (Charleston)	32	84.5%
Palmetto Pee Dee Residential Treatment Center (Florence)	59	99.1%
Palmetto Pines Behavioral Health (Summerville)	60	76.0%
Springbrook Behavioral Healthcare System (Travelers Rest)	68	86.1%
Three Rivers Behavioral Health RTC (West Columbia)	20	93.9%
Three Rivers Residential Treatment – Midlands (West Columbia)	59	62.6%
York Place Episcopal Church Home (York)	40	74.2%
Total (Does Not Include Statewide Beds)	376	81.2%

Services available at a minimum should include the following:

1. 24-hour, awake supervision in a secure facility;
2. Individual treatment plans to assess the problems and determine specific patient goals;
3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;
4. Nursing services, as required;
5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. Recreational facilities with an organized youth development program;

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

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

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

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

Certificate of Need Standards

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

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

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

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

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

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

Relative Importance of Project Review Criteria

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

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

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

4. Alcohol and Drug Abuse Facilities

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

(1) Outpatient Facilities

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 66 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 92 locations.

Certificate of Need Standards

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

(2) Social Detoxification Facilities

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation No. 61-93. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Certificate of Need Standards

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

(3) Freestanding Medical Detoxification Facilities

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation No. 61-93. The services provided by these facilities are described in Section 3101 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Facility	Beds	2006 Occupancy
Carolinas Hospital System Cedar Towers (Florence County) *1*	4 (0)	26.6%
Charleston Center Subactute Detoxification Program	16	44.7%
The Phoenix Center Behavioral Health Services (Greenville County)	16	89.2%
Lexington/Richland Alcohol & Drug Abuse/Detox Unit (Richland Co.)	16	83.6%
Keystone Inpatient Services (York County)	10	84.2%
Statewide Totals	62 (58)	71.5%

1 CON issued 8/30/06 to convert the detox beds to general acute beds; licensed as general acute beds on 8/8/07.

Certificate of Need Standards

Need projections are calculated by service area; the greater of the actual utilization or the statewide beds per 1,000 population was used to project need. In order to more accurately reflect total utilization, the data include social detoxification patients for those facilities that serve both medical and social detox patients within the same single facility. For service areas without existing detoxification units and related utilization data, the state use rate was used in the utilization projections. Facilities can only be licensed for a maximum of 16 beds, but because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit could be approved in an area that does not have any existing beds provided the applicant can document the need. Since 1987, courts in South Carolina have had the authority to order individuals involuntarily into addiction treatment. This law may justify an increase in the number of detoxification beds beyond those shown as needed in this Plan. The calculations described above are depicted on the following page.

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

DETOXIFICATION BED NEED

SERVICE AREA	2006 POP	2013 POP	EXIST BEDS	PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	197,570	214,780	0	0	4.27	0.70	6	6	3	3	6
GREENVILLE,PICKENS	420,690	462,160	16	5,214	15.69	0.70	22	6	7	-9	6
CHEROKEE,SPARTANBURG UNION	282,650	304,580	0	0	6.06	0.70	9	9	5	5	9
CHESTER,LANCASTER,YORK	220,610	245,290	10	3,075	9.37	0.70	13	3	4	-6	3
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	181,650	197,590	0	0	3.93	0.70	6	6	3	3	6
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	552,890	604,800	16	4,883	14.63	0.70	21	5	9	-7	5
DARLINGTON,FLORENCE MARION	185,960	195,350	0	389	1.12	0.70	2	2	3	3	3
CHESTERFIELD,DILLON MARLBORO	79,350	80,940	0	0	1.61	0.70	2	2	1	1	2
CLARENDON,LEE,SUMTER	130,960	138,340	0	0	2.75	0.70	4	4	2	2	4
GEORGETOWN,HORRY WILLIAMSBURG	262,190	299,700	0	0	5.96	0.70	9	9	5	5	9
BAMBERG,CALHOUN ORANGEBURG	101,370	105,760	0	0	2.10	0.70	3	3	2	2	3
ALLENDALE,BEAUFORT, HAMPTON,JASPER	156,690	180,740	0	0	3.60	0.70	5	5	3	3	5
BERKELEY,CHARLESTON, COLLETON,DORCHESTER	504,370	542,390	16	2,612	7.70	0.70	11	-5	8	-8	-5
AIKEN,BARNWELL	144,470	160,380	0	0	3.19	0.70	5	5	2	2	5
STATE TOTAL	3,421,420	3,732,800	58	16,173	81.98		118	60	58	0	61
STATE TOTAL	0.0072637		0.0155								

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

Relative Importance of Project Review Criteria

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

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

There are currently 4 freestanding medical detoxification facilities in the state operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. 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 affects of duplication in evaluating Certificate of Need applications for this service.

(4) Residential Treatment Program Facilities

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

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

Certificate of Need Standards

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

(5) Inpatient Treatment Facilities

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

Facility	Beds	2006 Occupancy	
Aiken Regional Medical Center (Aiken County)	18	28.8%	
AnMed Health Wellspring (Anderson County)	27	19.7%	
Carolina Center Behavioral Health (Greenville County)	13	82.8%	
Carolinas Hospital System (Florence County)	~~18~~ (12)	26.6%	*1*
Holmesview Center (Greenville County)	44	71.9%	*2*
Lighthouse Care Ctr Conway (Horry County)	8	-----	*3*
Medical University (Charleston County)	23	52.4%	
Morris Village (Richland County)	163	67.1%	*2*
Palmetto Center (Florence County)	48	71.9%	*2*
Palmetto Lowcountry Behav. Health (Charleston County)	10	61.3%	
Palmetto Baptist (Richland County)	~~0~~ (10)		*4*
Palmetto Richland Springs (Richland County)	10	94.0%	
Self Regional Healthcare (Greenwood County)	24	0.0%	
Springs Memorial (Lancaster County)	~~18~~ (0)	27.3%	*5*
Three Rivers Behavioral Health (Lexington County)	~~27~~ (17)	30.2%	*4*
William J. McCord Adolescent (Orangeburg County)	15	97.3%	*2*
Total (Does Not Include Statewide Beds)	196 (172)	34.6%	

1 CON issued 8/30/06 to convert 6 beds to general acute beds; licensed as general acute beds on 8/8/07.

2 Statewide Facility, Not Included in Bed Need Calculations.

3 CON issued 7/25/06 for 8 impatient beds; licensed 5/24/07.

4 CONs issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psych beds from Palmetto Baptist. Beds licensed at Baptist and de-licensed at Three Rivers 7/21/08.

5 CON approved 8/22/08 to convert the 18 substance abuse beds to general beds.

Certificate of Need Standards

Need projections are calculated by service area; the greater of the actual utilization or the statewide beds per 1,000 population was used to project need. For service areas without existing units and

related utilization data, the state use rate was used in the utilization projections. Because a minimum of 10 beds is needed for an inpatient program, a 10 bed unit could be approved in an area that does not have any existing beds provided the applicant can document the need. The calculations described above are provided on the following page.

For planning purposes, substance abuse services are allocated and developed according to the same service areas used for psychiatric services. Inpatient treatment centers should be available within 60 minutes one-way automobile travel time for 90% of the service areas' population. Morris Village, Holmesview, McCord Adolescent and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventories of facilities or the service area allocations. Because of the high use rate at the McCord Facility and the lack of other adolescent services, it may be necessary for an additional adolescent state facility to be constructed to increase geographic accessibility to services. Any such proposal must have DAODAS support.

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

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

(a) The service area shows a need for additional beds;
(b) The applicant demonstrates an un-served demand for the proposed service area; and
(c) The utilization of treatment facilities in the contiguous service areas should be considered prior to approval of additional beds. This should include occupancy rates, patient origin, scope of services offered, and patient mix.

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

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.

INPATIENT BED NEED

SERVICE AREA	2006 POP	2013 POP	EXIST BEDS	PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	197,570	214,780	27	1,946	5.80	0.70	8	-19	10	-17	-17
GREENVILLE,PICKENS	420,690	462,160	13	3,928	11.82	0.70	17	4	21	8	8
CHEROKEE,SPARTANBURG UNION	282,650	304,580	0	0	9.27	0.70	13	13	14	14	14
CHESTER,LANCASTER,YORK	220,610	245,290	0	1,796	5.47	0.70	8	8	11	11	11
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	181,650	197,590	24	0	6.01	0.70	9	-15	9	-15	-15
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	552,890	604,800	37	6,411	19.21	0.70	27	-10	28	-9	-9
DARLINGTON,FLORENCE MARION	185,960	195,350	12	2,137	6.15	0.70	9	-3	9	-3	-3
CHESTERFIELD,DILLON MARLBORO	79,350	80,940	0	0	2.46	0.70	4	4	4	4	4
CLARENDON,LEE,SUMTER	130,960	138,340	0	0	4.21	0.70	6	6	6	6	6
GEORGETOWN,HORRY WILLIAMSBURG	262,190	299,700	8	0	9.12	0.70	13	5	14	6	6
BAMBERG,CALHOUN ORANGEBURG	101,370	105,760	0	0	3.22	0.70	5	5	5	5	5
ALLENDALE,BEAUFORT, HAMPTON,JASPER	156,690	180,740	0	0	5.50	0.70	8	8	8	8	8
BERKELEY,CHARLESTON, COLLETON,DORCHESTER	504,370	542,390	33	6,632	19.54	0.70	28	-5	25	-8	-5
AIKEN,BARNWELL	144,470	160,380	18	1,889	5.75	0.70	8	-10	7	-11	-10
STATE TOTAL	3,421,420	3,732,800	172	24,739	113.53		163	-9	172	0	4
STATE TOTAL	0.011111		0.0461								

Relative Importance of Project Review Criteria

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

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

There are currently 12 inpatient treatment facilities in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

(6) Narcotic Treatment Programs

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

Facility	County	2005 Clients During Year	2006 Clients During Year
Aiken Treatment Associates	Aiken	CON voided 9/25/06	
Center for Behavioral Health South Carolina	Charleston	273	350
Center of Hope of Myrtle Beach	Horry	379	624
Charleston Center	Charleston	339	329
Choices, Inc.	Beaufort	CON voided 8/31/07	
Columbia Metro Treatment Center	Lexington	440	504
Greenville Metro Treatment Center	Greenville	414	460

Laurens Treatment Associates	Laurens	CON voided 9/25/06	
Piedmont Metro Treatment Center	Greenville	372	364
Recovery Concepts (Licensed 9/15/05)	Jasper	70	120
Southwest Carolina Treatment Center	Anderson	266	406
Spartanburg Treatment Associates	Spartanburg	486	514
Starting Point	Richland	344	Closed 3/9/07
Starting Point of Florence (Licensed 7/26/05)	Florence	221	510
York County Treatment Center	York	333	313
	TOTALS	4,007	4,494

Certificate of Need Standards

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

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

As of December 31, 2006, there were 3,118 clients currently being served by Methadone Treatment Centers, and a total of 4,494 clients were served during 2006.

Relative Importance of Project Review Criteria

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

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

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

5. Rehabilitation Facilities

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed in December 2007 that would freeze this threshold at 60% and allow co-morbid conditions to be counted.

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

The following rehabilitation programs are currently available:

Region	Facility	County	Beds	2006 Occupancy	
I	AnMed Health Rehab	Anderson	37	92.5%	*1*
I	Roger C. Peace	Greenville	53	64.2%	
I	St. Francis	Greenville	19	84.9%	
I	Mary Black	Spartanburg	18	82.2%	
II	Greenwood Rehab Hosp	Greenwood	34	---	*2*
II	HealthSouth Columbia	Richland	96	66.4%	
II	HealthSouth Rock Hill	York	40	86.3%	*3*
III	HealthSouth Florence	Florence	88	63.6%	
III	Carolinas Hospital	Florence	42	74.2%	
III	Waccamaw Community	Georgetown	43	88.1%	*4*
III.	Georgetown Memorial	Georgetown	0	---	*4*
IV	Beaufort Memorial	Beaufort	14	79.9%	*5*
IV	HealthSouth Charleston	Charleston	46	75.5%	
IV	Medical University	Charleston	0	---	*6*
IV	Roper Hospital	Charleston	52	82.9%	*7*
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	64.5%	
IV	Coastal Carolina Med Ctr.	Jasper	10	42.6%	
		Total	616	73.2%	

1. CON issued 8/1/06 for 7 additional rehab beds, for a total of 37 beds. Licensed 10/5/06.
2. CON issued 7/3/06 to build a 34 bed rehab hospital; licensed 10/16/07.
3. CON issued 5/16/07 to convert 6 nursing home beds to rehab for a total of 40; licensed 10/16/07.
4. CON issued 8/19/04 to create a 10 bed unit at Georgetown; CON voided 8/21/06. CON issued 10/24/05 to add 9 rehab beds at Waccamaw for a total of 33; CON voided 4/25/06. CON issued 6/15/07 to add 14 rehab beds at Waccamaw for a total of 43, SC-07-22.
5. CON issued 6/8/04 to convert the 14 rehab beds to general acute as part of an overall bed expansion project. In 7/06, Beaufort amended their final project and retained the beds as licensed for rehab.
6. CON issued 10/14/03 to convert their 25 rehabilitation beds to general acute beds. The beds were re-licensed as general acute beds on 1/30/08.
7. CON approved for 13 additional beds for a total of 52, 10/16/07, appealed.

Statewide Programs

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

Standards

The need for beds is calculated based on rehabilitation service areas. The methodology takes the greater of the actual utilization or the statewide average beds per 1,000 population to project need. For the service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections. The following pages depict the calculations described above.

Relative Importance of Project Review Criteria

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

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

Rehabilitation facilities are now located throughout the state and are available within approximately 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 affects of duplication in evaluating Certificate of Need applications for this service.

REHABILITATION BED NEED

SERVICE AREA	2006 POP	2013 POP	EXIST BEDS	2006 PDS	PROJ ADC	% OCC	BED NEED (USE)	+ / -	BED NEED (SW)	+ / -	NEED
ANDERSON,OCONEE	245,560	263,350	37	10,699	31.44	0.70	45	8	32	-5	8
GREENVILLE,PICKENS	522,980	567,350	72	18,313	54.43	0.70	78	6	69	-3	6
CHEROKEE,SPARTANBURG UNION	355,150	377,660	18	5,399	26.15	0.70	37	19	46	28	28
CHESTER,LANCASTER YORK	277,480	302,350	40	10,704	31.95	0.70	46	6	37	-3	6
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	225,800	241,350	34	0	16.71	0.70	24	-10	29	-5	-5
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	633,430	683,120	96	23,263	68.73	0.70	98	2	83	-13	2
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	373,750	383,070	130	31,786	89.26	0.70	128	-2	46	-84	-2
CLARENDON,KERSHAW LEE,SUMTER	223,130	236,300	0	0	16.37	0.70	23	23	29	29	29
GEORGETOWN,HORRY	279,450	316,780	43	9,326	28.96	0.70	41	-2	38	-5	-2
AIKEN,ALLENDALE,BAMBERG BARNWELL,CALHOUN ORANGEBURG	318,920	338,830	24	5,651	16.45	0.70	23	-1	41	17	17
BEAUFORT,HAMPTON,JASPER	179,210	201,830	24	4,082	12.60	0.70	18	-6	24	0	0
BERKELEY,CHARLESTON COLLETON,DORCHESTER	629,120	671,140	98	24,482	71.55	0.70	102	4	81	-17	4
STATE TOTAL	4,263,980	4,583,130	616	143,705	464.6		663	47	555	-61	91

6. Long Term Care Facilities and Services

A. Nursing Facilities

Nursing facilities provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services, in which such nursing care and medical services are prescribed by, or are performed under the general direction, of persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.gov the licensing list of nursing facilities also denotes the facilities that have Alzheimer's units. For more specific detail about nursing facilities, refer to the Department's Regulation 61-17, Standards for Licensing Nursing Homes.

For existing licensed nursing facilities, bed capacity is considered to be the number of licensed beds or the number of beds approved under the Certificate of Need program regardless of oversize room construction. The number of beds counted in any patient room is the maximum number for which adequate square footage is available. These minimums are: 100 square feet in single rooms; and 80 square feet per bed in multi-bed rooms. Only the net usable space in the room is considered. Space in the toilet rooms, washrooms, closets, vestibules, and corridors is not counted.

The following items should be noted regarding the inventory of long-term care facilities:

1. Restricted usage facilities (federal and institutional) are counted as statewide facilities and not counted in the region located.

2. Resident days and admissions are as reported by the nursing facility.

3. Existing beds are counted based upon the greater of licensed or survey capacity. Survey beds refer to the capacity; the survey beds do not exceed the licensed beds unless a Certificate of Need has been issued for an increase in the number of beds. The footnotes in the inventory explain any changes.

4. The beds included in the inventory have been classified for planning purposes as conforming or nonconforming. This classification is based on U.S. Public Health Service standards of plant evaluation and an actual on-site survey of each facility and updated as changed by construction and/or modernization.

5. The standards used in this survey are basically the same for general hospitals and nursing facilities. Such standards include:

   (a) Fire-resistivity of each building;
   (b) Fire and other safety factors of each building;
   (c) Bed capacity and evaluation of nursing units, including:

      (1) Availability of nurses' call system;
      (2) Adequacy of bed space;

(3) Patient rooms; grade level or above;
(4) Availability of outside windows in patient rooms;
(5) Availability of direct access to a corridor for each patient room;
(6) A minimum corridor width of eight (8) feet;
(7) Availability of a nurses' station within 120 feet of each patient room unless the alternative standard of 150 feet has been approved;
(8) Adequate toilet, bedpan, bath or handwashing facilities in each patient unit; and
(9) Maximum capacity of four (4) beds per patient room.

(d) Design and structural factors affecting the function of service departments, including:

(1) Dietary department;
(2) Dining, recreation and day room space;
(3) Rehabilitation services (for facilities in excess of 100 beds only)
(4) Laundry and linen department.

DHHS operates 3 home and community-based Medicaid waiver programs through its Community Long Term Care (CLTC) network. These programs provide alternatives to institutional care for participants who are eligible to receive an institutional level of long term care but prefer to receive their care in the home and/or in a community setting. Community Choices is funded for 12,000 slots for FY 07-08; the other waivers serve 1,000 persons with HIV disease and approximately 30 adults who are dependent upon mechanical ventilation. The PACE program is jointly funded by Medicare and provides primary and long-term care services to participants' age 55 and older that meet the State's nursing facility level of care. The Palmetto SeniorCare (PSC) Program operates 5 PACE Centers in Richland and Lexington Counties and served 440 participants during FY 2007. A second PACE site began operation in March 2008 operated by The Oaks CCRC in Orangeburg. DHHS is also participating in a federal initiative called Money Follows the Person, which allows people who have been in a nursing facility for at least 6 months to transition back to the community.

The nursing facility bed need methodology developed and used in the Plan is derived from a factor of 39.33 beds per thousand population age 65 and over by county. This factor was selected after detailed analysis of the method outlined in the Public Health Service health grants manual 23-2 as amended; the South Carolina Projected Use Rate method, previously approved by the Department of Health, Education, and Welfare (HEW); and several other methodologies. These beds are generally used by the non-institutional population age 65 and older. In an effort to give a more equitable distribution of beds throughout the State, these needs are developed by county.

This methodology factored in the utilization from the South Carolina Community Long Term Care Project (CLTC) regarding client utilization of nursing facilities. This project provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing facility placement under the Medicaid program.

Therefore, the ratio of 39 beds/1,000 population age 65 and over was selected as the appropriate

number of nursing facility beds for 2010. A two-year projection, through 2010, of the nursing facility bed need for the general (non-institutional) population is used for the following reasons:

1. There is a shortage of Title XIX (Medicaid) funding in the state. Approximately 65% of all patients in nursing facilities are financed by Medicaid.

2. The CLTC program provides the following community-based services for participants who prefer to receive care in the community rather than institutional care:

   a. Personal Care;
   b. Environmental Modifications;
   c. Home Delivered Meals;
   d. Adult Day Health Care (ADHE);
   e. Respite Care;
   f. Personal Emergency Response System (PERS);
   g. Durable Medical Equipment;
   h. Nursing Services; and
   i. Case Management

3. Nursing facilities can be developed and constructed in two years.

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 projection of need for the general public. However, all patient days, including the under 65 population, were used to develop the bed need factor used in these methodologies.

The number of beds needed is obtained by subtracting the number of existing beds (greater of license or survey capacity) from the bed need. In order to provide a more equitable distribution of nursing facility beds throughout the State, the following policies will apply:

1. Additional beds may be approved in counties with a positive bed need up to the need indicated.

2. When a county has more beds than the projected need (i.e. excess beds), additional beds will not be approved.

3. An exception to the above standards can be made for an individual nursing facility to add some additional nursing facility beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing 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).

The following pages depict the calculation of long-term care bed need and the current ratio of beds per thousand aged 65 and over by county. The following map depicts the number of additional beds needed or the number of excess beds (circled) by county.

Relative Importance of Project Review Criteria

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

a. Need;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing 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, there is no justification for approving additional nursing facilities or beds which 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 affects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

Medicaid Nursing Home Permits

Beginning July 1, 1988, nursing facilities that wish to continue to serve Medicaid residents must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing facility may provide, and the nursing facility must provide within 10 percent of this number of days of care. As mandated by the Nursing Home Licensing Act of 1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849

LONG TERM CARE BED NEED

		2010 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
	ANDERSON	25.820	1,007	751	256	256
	CHEROKEE	7.120	278	229	49	49
	GREENVILLE	49.950	1,948	1,816	132	132
	OCONEE	14.530	567	252	315	315
	PICKENS	14.910	581	411	170	170
	SPARTANBURG	35.490	1,384	1,279	105	105
	UNION	5.000	195	201	-6	
REGION I	TOTAL	152.820	5,960	4,939	1,021	1,027
	ABBEVILLE	4.190	163	116	47	47
	CHESTER	4.820	188	100	88	88
	EDGEFIELD	3.200	125	120	5	5
	FAIRFIELD	3.300	129	262	-133	
	GREENWOOD	9.620	375	354	21	21
	KERSHAW	7.920	309	288	21	21
	LANCASTER	7.970	311	288	23	23
	LAURENS	10.770	420	402	18	18
	LEXINGTON	29.410	1,147	924	223	223
	MCCORMICK	3.040	119	120	-1	
	NEWBERRY	5.780	225	276	-51	
	RICHLAND	34.870	1,360	1,283	77	77
	SALUDA	3.270	128	176	-48	
	YORK	20.910	815	693	122	122
REGION II	TOTAL	149.070	5,814	5,402	412	645
	CHESTERFIELD	5.620	219	221	-2	
	CLARENDON	6.210	242	152	90	90
	DARLINGTON	9.000	351	366	-15	
	DILLON	3.530	138	195	-57	
	FLORENCE	16.930	660	775	-115	
	GEORGETOWN	12.320	480	249	231	231
	HORRY	43.000	1,677	840	837	837
	LEE	2.980	116	120	-4	
	MARION	4.610	180	180	0	
	MARLBORO	3.340	130	110	20	20
	SUMTER	14.680	573	428	145	145
	WILLIAMSBURG	5.300	207	184	23	23
REGION III	TOTAL	127.520	4,973	3,820	1,153	1,346
	AIKEN	23.110	901	778	123	123
	ALLENDALE	1.750	68	44	24	24
	BAMBERG	2.340	91	88	3	3
	BARNWELL	3.490	136	173	-37	
	BEAUFORT	31.030	1,210	491	719	719
	BERKELEY	19.760	771	325	446	446
	CALHOUN	2.490	97	120	-23	
	CHARLESTON	44.040	1,718	1,262	456	456
	COLLETON	5.730	223	132	91	91
	DORCHESTER	14.500	566	351	215	215
	HAMPTON	3.030	118	104	14	14
	JASPER	2.830	110	88	22	22
	ORANGEBURG	14.050	548	393	155	155
REGION IV	TOTAL	168.150	6,557	4,349	2,208	2,268
GRAND TOTAL		597.560	23,304	18,510	4,794	5,286

NURSING FACILITY BED NEED
TO BE ADDED / EXCESS CIRCLED
AS OF SEPTEMBER 1, 2008

OCONEE 315
PICKENS 170
GREENVILLE 132
SPARTANBURG 105
CHEROKEE 49
YORK 122
UNION (6)
CHESTER 88
LANCASTER 23
CHESTERFIELD (2)
MARLBORO 20
DILLON (57)
MARION 0
HORRY 837
ANDERSON 256
LAURENS 18
FAIRFIELD (133)
KERSHAW 21
DARLINGTON (15)
LEE (4)
FLORENCE (115)
ABBEVILLE 47
GREENWOOD 21
NEWBERRY (51)
SALUDA (48)
RICHLAND 77
SUMTER 145
McCORMICK (1)
EDGEFIELD 5
LEXINGTON 223
AIKEN 123
CALHOUN (23)
CLARENDON 90
WILLIAMSBURG 23
GEORGETOWN 231
ORANGEBURG 155
BERKELEY 446
BARNWELL (37)
BAMBERG 3
DORCHESTER 215
ALLENDALE 24
COLLETON 91
CHARLESTON 456
HAMPTON 14
JASPER 22
BEAUFORT 719

COUNTY	2010 POP	NURSING BEDS	BEDS/K POP	RANK
BEAUFORT	31.060	491	15.81	1
BERKELEY	19.760	325	16.45	2
OCONEE	14.530	252	17.34	3
HORRY	43.000	840	19.53	4
GEORGETOWN	12.320	249	20.21	5
CHESTER	4.820	100	20.75	6
COLLETON	5.730	132	23.04	7
DORCHESTER	14.500	351	24.21	8
CLARENDON	6.210	152	24.48	9
ALLENDALE	1.750	44	25.14	10
PICKENS	14.910	411	27.57	11
ABBEVILLE	4.190	116	27.68	12
ORANGEBURG	14.050	393	27.97	13
CHARLESTON	44.040	1,262	28.66	14
ANDERSON	25.820	751	29.09	15
SUMTER	14.680	428	29.16	16
JASPER	2.830	88	31.10	17
LEXINGTON	29.410	924	31.42	18
CHEROKEE	7.120	229	32.16	19
MARLBORO	3.340	110	32.93	20
YORK	20.910	693	33.14	21
AIKEN	23.110	778	33.67	22
HAMPTON	3.030	104	34.32	23
WILLIAMSBURG	5.300	184	34.72	24
SPARTANBURG	35.490	1,279	36.04	25
LANCASTER	7.970	288	36.14	26
GREENVILLE	49.950	1,816	36.36	27
KERSHAW	7.920	288	36.36	28
RICHLAND	34.870	1,283	36.79	29
GREENWOOD	9.620	354	36.80	30
LAURENS	10.770	402	37.33	31
EDGEFIELD	3.200	120	37.50	32
BAMBERG	2.340	88	37.61	33
MARION	4.610	180	39.05	34
CHESTERFIELD	5.620	221	39.32	35
MCCORMICK	3.040	120	39.47	36
UNION	5.000	201	40.20	37
LEE	2.980	120	40.27	38
DARLINGTON	9.000	366	40.67	39
FLORENCE	16.930	775	45.78	40
NEWBERRY	5.780	276	47.75	41
CALHOUN	2.490	120	48.19	42
BARNWELL	3.490	173	49.57	43
SALUDA	3.270	176	53.82	44
DILLON	3.530	195	55.24	45
FAIRFIELD	3.300	262	79.39	46
	597.590	18,510	30.97	

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

Mental Retardation Facilities

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed. Based on the known numbers of individuals in service systems as well as improved public awareness and acceptance of issues associated with mental retardation, it is believed that there are no significant numbers of citizens with mental retardation or related disabilities currently unrecognized.

The South Carolina Department of Disabilities and Special Needs (DDSN) is reducing the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds are being developed for those persons from the regional centers and those on the residential services waiting list. Community beds will be distributed over the continuum of programs, which includes community residences, supervised living programs, and community

training homes. These programs will enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in. DDSN also operates three home and community-based Medicaid waiver programs for the following target groups: Mental Retardation and Related Disabilities, Head and Spinal Cord Injuries, and Pervasive Developmental Disorders.

Any Certificate of Need application for mental retardation beds should not be approved unless the South Carolina Department of Disabilities and Special Needs supports it.

B. Institutional Nursing Facility (Retirement Community Nursing Facility)

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

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

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

(2) It must restrict admissions to campus residents.

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

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home" and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, the generally accepted ratio of nursing facility beds to retirement beds is 1:4. This ratio appears to be high for newly established retirement centers as the new residents are not in need of nursing facility care until several years later.

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

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

C. Hospice Facilities and Hospice Programs

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

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

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

Certificate of Need Standards

A Certificate of Need is required for an Inpatient Hospice Facility. A Certificate of Need is not required for the establishment of a Hospice Program; an inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program. An inpatient Hospice Facility must document the need for the facility and justify the number of inpatient beds that are being requested. The proposed facility must consider the impact on other existing inpatient hospice facilities. The existing and approved inpatient hospices in South Carolina are listed on the following page.

Relative Importance of Project Review Criteria

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

1. Compliance with the Need Outlined in this Plan;
2. Distribution (Accessibility);
3. Community Need Documentation;
4. Acceptability;
5. Financial feasibility, and
6. Staff Resources

There are 92 licensed Hospice Programs with at least one licensed hospice serving every county in the state. Additional information may be found at www.scdhec.gov under Health Regulation. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

Inpatient Hospices

Name of Facility	County	2006 Patients	2006 Pt. Days
Region I:			
Callie & John Rainey Hospice House	Anderson	603	9,184
Spartanburg Regional Hospice Home	Spartanburg	12	55
Region II:			
Hospice House HospiceCare Piedmont	Greenwood	299	3,667
Heartland Hospice House of the Midlands	Richland	47	429
Region III:			
McLeod Hospice House	Florence	417	2,871
Region IV:			
Hospice Center Hospice of Charleston	Charleston	127	1,583
	Totals	**1,505**	**17,789**

D. Swing Beds

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified. The swing beds concept refers to beds in a hospital that alternate between hospital and long-term care and are occupied by long-term care patients for periods of a few days to several weeks. This concept does not refer to hospital beds being designated as nursing home beds and does not necessarily involve moving beds or patients into separate areas of the hospital.

Swing beds can be the link between inpatient acute care and home and community-based services, in a continuum of care for those patients requiring long-term care. Although the goal is to return patients to the community, this is not always possible. Should a return to the community not be possible, the swing bed hospital assists the patient and family with nursing home placement. The swing bed program improves the coordination of long-term care services within the community.

Under the Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt], any hospital that has an agreement with the Centers for Medicare & Medicaid Services (CMS) in which its inpatient hospital facilities may be used for furnishing the types of service that, if furnished in a skilled nursing facility (SNF), would constitute extended care services (subject to Section 1883(b) is known a swing bed hospital.

The hospital must be located in a rural area and have fewer than 100 beds. Also (except as otherwise provided under CMS regulations) under subsection (c), an agreement with a hospital must:

1. Be of the same duration and subject to termination on the same conditions as are agreements with SNFs under the Social Security Act (Section 1866).
2. Impose the same duties, responsibilities, conditions, and limitations as those imposed under such agreements entered into under Section 1866 of the Social Security Act.
3. Be in substantial compliance with the SNF requirements of resident rights, admission, transfer, and discharge rights; resident behavior and facility practices; patient activities; social services; discharge planning; specialized rehabilitation services and dental services.
4. Not have a 24-hour nursing waiver in effect.
5. Not have had a swing-bed approval terminated within two years previous to the current application for swing beds.
6. Meet all of the Conditions of Participation applicable to a Medicare certified hospital.

The Code of Federal Regulations (CFR) section 42 details other specific requirements.

The following hospitals in South Carolina either meet the swing bed eligibility requirements or participate in the swing bed program. The 2006 utilization is reported by the facility:

Hospital		Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Med. Ctr.	**	12	48	382	1.0
Allendale County Hosp.	**	12	54	1,359	3.7
Bamberg County Mem. *1/*	**	24	0	0	---
Barnwell County *1/*	**	24	0	0	---
Cannon Memorial Hosp.		--			
Chester Regional Med.		--			
Chesterfield General	**	29	113	857	2.4
Clarendon Memorial		--			
Coastal Carolina *2/*	**	10			
Edgefield Co. Hosp. *1/*	**	12	0	0	---
Fairfield Memorial	**	15	52	365	1.0
Hampton Regional		--			
Hilton Head Regional		--			
Lake City Community	**	23	35	1,582	4.3
Laurens County Hosp.		--			
Loris Community		--			
Marlboro Park Hosp.	**	49	23	126	0.3
McLeod-Darlington	**	24	70	5,004	13.7
McLeod-Dillon		--			
Newberry Co. Mem.		--			
Wallace Thompson		--			
Williamsburg Regional		--			
TOTALS		234	437	10,813	27.9

** Participates in the swing bed program.

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

2/ Began participating in the program on 11/15/06.

E. Home Health Agencies

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

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

The average mix of home health visits by type of service during FY 2006 for the home health agencies in South Carolina were:

Total Visits	1,530,519
Nursing Visits	44.4%
Home Health Aide Visits	10.7%
Physical Therapy Visits	34.6%
Medical Social Worker Visits	1.5%
Speech Therapy Visits	1.6%
Occupational Therapy Visits	7.1%
Other	0.1%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 18.5 in 2006. In 2007, CMS revised its policy on "case mix" which will make a nearly 12% reduction in the national 60-day standardized payment rate by 2011 and decrease home health expenditures by $7 billion over that time.

Of the current patients receiving home health services, approximately 37% are less than age 65 and 63% are age 65 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need Standards

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

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

3. There should be documentation from physicians and discharge planners in the proposed service area substantiating the need and support for an additional home health agency. These need and support letters must be on letterhead and define which practice and specialty or facility the physician/discharge planner represents as well as the county from which their patient base will be drawn. They must clearly state the number of additional patients that will be referred to a new home health agency and why another home health agency is needed. The physician or discharge planner must also personally sign these letters. If there are problems with the existing agencies serving the area, the physicians and discharge planners should state the reasons.

4. The attached table indicates the counties where one additional home health agency could be approved or an existing home health agency expanded. This table is based on the number of persons served per thousand population and the maximum number of agencies needed per county based on the projected population (see below). Counties that are below 75% of the state average of patients served per thousand population and have less than the maximum number of agencies based on the projected population could accommodate one additional agency in order to assist the residents of the county in receiving services. Only these counties will be approved for an additional service. No additional agency will be approved in these counties until the approved agencies have been licensed and a year of utilization data are available and have been incorporated into the methodology.

Maximum Agencies Per Thousand Population

<30k pop.	=	2 HHA's
30-50k pop.	=	3 HHA's
50-75k pop.	=	4 HHA's
75-125k pop.	=	5 HHA's
125-175k pop.	=	6 HHA's
175-225k pop.	=	7 HHA's

225-275k pop. =	8 HHA's
275-325k pop. =	9 HHA's
>325k pop. =	10 HHA's

5. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state where it operates.

6. The applicant must document that they can serve at least 50 patients annually in each county for which they are licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to less than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

7. Because of the limited number of home health providers available to treat children 14 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 14 years or younger. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties. The applicant must document that no other agency offers this service in the county of application, and the agency will limit such services to the pediatric population 14 years or younger. The license for the agency will be restricted to serving children 14 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.

Continuing Care Retirement Community Home Health Agencies

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

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

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

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

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

Relative Importance of Project Review Criteria

The following project review criteria as outlined in Chapter 8 of Regulation No. 61-15 are considered to be the most important in reviewing CON applications for this service:

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

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of any existing service.

The home health agency inventory follows. The persons served and visits are based on data from the Joint Annual Reports (JARs) for Home Health Agencies.

HOME HEALTH AGENCIES

County of Residence	2006 Total Patients	2006 Pop. (000s)	Patients Served/ 1000 Pop.	Below State Average	New Agency /P 1/1/06	Max. # of Agencies	# of Existing HHAs	New HHA Can Be Approved
Abbeville	812	26.88	30.21	---	---	2	4	---
Aiken	1,840	155.90	11.80	YES	---	6	5	YES
Allendale	29	11.82	2.45	YES	---	2	3	---
Anderson	3,081	173.71	17.74	---	---	6	6	---
Bamberg	372	16.09	23.12	---	---	2	2	---
Barnwell	259	24.56	10.55	YES	---	2	3	---
Beaufort	2,614	135.48	19.29	---	---	6	4	---
Berkeley	2,152	158.79	13.55	YES	---	6	7	---
Calhoun	250	15.77	15.85	---	---	2	5	---
Charleston	8,055	321.76	25.03	---	---	9	9	---
Cherokee	1,263	55.39	22.80	---	---	4	4	---
Chester	714	34.76	20.54	---	---	3	3	---
Chesterfield	887	43.34	20.47	---	---	3	2	---
Clarendon	692	33.58	20.61	---	---	3	2	---
Colleton	957	40.22	23.79	---	---	3	5	---
Darlington	1,217	68.22	17.84	---	---	4	4	---
Dillon	692	30.23	22.89	---	---	3	4	---
Dorchester	2,061	108.35	19.02	---	---	5	7	---
Edgefield	280	25.87	10.82	YES	---	2	4	---
Fairfield	406	24.42	16.63	---	---	2	3	---
Florence	2,165	131.02	16.52	---	---	6	4	---
Georgetown	1,506	58.97	25.54	---	---	4	6	---
Greenville	7,092	402.33	17.63	---	---	10	7	---
Greenwood	1,737	69.10	25.14	---	---	4	5	---
Hampton	412	22.04	18.69	---	---	2	4	---
Horry	5,559	220.48	25.21	---	---	7	6	---
Jasper	353	21.69	16.27	---	---	2	3	---
Kershaw	1,007	56.02	17.98	---	---	4	3	---
Lancaster	1,049	62.31	16.84	---	---	4	2	---
Laurens	1,500	73.65	20.37	---	---	4	6	---
Lee	356	20.68	17.21	---	---	2	4	---
Lexington	4,080	236.95	17.22	---	---	8	7	---
McCormick	265	10.77	24.61	---	---	2	3	---
Marion	808	36.06	22.41	---	---	3	3	---
Marlboro	547	27.96	19.56	---	---	2	4	---
Newberry	735	37.49	19.61	---	---	3	3	---
Oconee	1,731	71.85	24.09	---	---	4	4	---
Orangeburg	2,219	94.78	23.41	---	---	5	5	---
Pickens	2,036	120.65	16.88	---	---	5	6	---
Richland	5,187	334.57	15.50	---	---	10	8	---
Saluda	382	19.53	19.56	---	---	2	4	---
Spartanburg	4,831	270.04	17.89	---	---	8	5	---
Sumter	2,140	112.85	18.96	---	---	5	5	---
Union	1,035	29.72	34.83	---	---	2	2	---
Williamsburg	932	36.92	25.24	---	---	3	4	---
York	3,634	180.41	20.14	---	---	7	4	---
Totals	81,931	4,263.98	19.21				203	
	75% State Average		14.41					

HOME HEALTH UTILIZATION, 1980-2006

YEAR	PATIENTS SERVED	TOTAL VISITS	VISITS/ PATIENT
1980	17,120	------	------
1981	18,021	------	------
1982	19,751	------	------
1983	24,013	427,759	17.8
1984	28,511	590,657	20.7
1985	30,360	631,498	20.8
1986	21,012	672,361	32.0
1987	30,004	673,346	22.4
1988	31,230	710,756	22.8
1989	32,727	843,514	25.8
1990	36,827	1,024,177	27.8
1991	41,912	1,307,371	31.2
1992	49,035	1,767,825	36.1
1993	55,551	2,417,241	43.5
1994	65,754	3,192,689	48.6
1995	77,214	3,755,027	48.6
1996	86,070	3,995,110	46.4
1997	88,711	4,055,843	45.7
1998	86,123	3,131,997	36.4
1999	83,969	2,472,078	29.4
2000	78,542	2,041,754	26.0
2001	77,869	1,427,436	18.3
2002	84,192	1,290,991	15.3
2003	81,708	1,235,335	15.1
2004	82,971	1,291,738	15.6
2005	81,754	1,454,745	17.8
2006	82,897	1,537,455	18.5

Home Health Agency Utilization 2006

Facility	Counties Served	Persons Served	Total Visits	Visits/ Person
Amedysis Home Health of Camden *1*	Fairfield, Kershaw, Richland, Newberry, Lexington, Calhoun & Orangeburg	219	4,174	19.1
Amedysis Home Health of Clinton *2*	Abbeville, Greenwood, Greenville & Laurens	434	6,709	15.5
Amedysis Home Health of Conway *3*	Horry	778	13,171	16.9
Amedysis Home Health of Charleston	Berkeley, Charleston & Dorchester	3,336	59,133	17.7
Amedysis Home Health Georgetown *4*	Georgetown & Williamsburg	1,390	22,784	16.4
Amedysis HH Georgetown East *5*	Georgetown & Williamsburg	32	338	10.6
Amedisys Home Health Hilton Head *6*	Beaufort and Jasper	754	10,712	14.2
Amedysis Home Health of Lexington *7*	Lexington, Richland, Lee, Orangeburg, Calhoun, Newberry, Sumter & Edgefield	4,595	71,439	15.5
Amedysis Home Health Myrtle Beach *8*	Horry	921	13,178	14.3
Amedysis Home Health of North Charleston *9*	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,751	47,687	10.0
AnMed Health Home Health *10*	Anderson	1,210	23,413	19.3
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	139	842	6.1
Bethea Home Health (may serve retirement community only)	Darlington	26	15,430	593.5
Care One Home Health *11*	Beaufort, Hampton & Jasper	526	11,821	22.5
CarePro Home Health	Richland & Sumter	536	15,215	28.4
Caring Neighbors Home Health	Fairfield	220	4,240	19.3
Carolina Home Health Care	Richland & Lexington	1,390	22,932	16.5
Carolina Home Health Care Greenville (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Oconee, Greenville, Pickens, Cherokee, Spartanburg, Laurens & Union	2,356	58,109	24.7
Chesterfield Visiting Nurses Services	Darlington, Marlboro & Chesterfield	406	13,662	33.7
Clarendon Memorial Home Health	Clarendon	293	6,201	21.2
Clemson Area Retirement Ctr HH (may serve retirement community only)	Pickens	25	3,443	137.7
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	60	2,179	36.3
DHEC Region 1 Home Health *12*	Anderson, Oconee, Abbeville, Laurens, Edgefield, Greenwood, Saluda & McCormick	1,057	23,678	22.4
DHEC Region 2 Home Health West *13*	Greenville & Pickens	582	9,905	17.0

Home Health Agency Utilization 2006

Facility		Counties Served	Persons Served	Total Visits	Visits/ Person
DHEC Region 2 Home Health East	***14***	Spartanburg, Union & Cherokee	839	16,472	19.6
DHEC Region 3 Home Health	***15***	Lancaster, Lexington, Newberry, Richland, Chester, Fairfield & York	867	11,017	12.7
DHEC Region 4 Home Health East	***16***	Dillon, Florence, Marion, Darlington, Marlboro & Chesterfield	2,254	35,638	15.8
DHEC Region 4 Home Health West	***17***	Clarendon, Lee, Kershaw & Sumter	978	19,847	20.3
DHEC Region 5 Home Health	***18***	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	1,141	19,647	17.2
DHEC Region 6 Home Health	***19***	Georgetown, Horry & Williamsburg	1,017	18,193	17.9
DHEC Region 7 Home Health	***20***	Charleston, Berkeley & Dorchester	539	13,645	25.3
DHEC Region 8 Home Health	***21***	Beaufort, Colleton, Jasper & Hampton	412	6,101	14.8
Florence Visiting Nurses Services		Florence, Lee, Dillon & Marion	325	11,349	34.9
Franklin C. Fetter Home Health Agency		Charleston	66	3,946	59.8
Greenville Hospital System HHA		Greenville & Pickens	2,031	31,841	15.7
Health Related Home Care, Inc.		Abbeville, Laurens, Greenwood, Saluda, & McCormick	1,367	35,216	25.8
HomeCare of HospiceCare Piedmont (may only serve terminally ill Saluda County patients)		Abbeville, Laurens, Greenwood, Saluda, & McCormick	38	826	21.7
Home Care of Lancaster		Lancaster	848	16,235	19.1
Home Care of the Regional Medical Ctr		Calhoun & Orangeburg	624	17,478	28.0
Home Health of S.C. - Lowcountry		Berkeley & Dorchester	364	5,436	14.9
Home Health of S.C. - Midlands		Lexington & Richland	994	15,604	15.7
Home Health of S.C., Inc.		York	818	17,972	22.0
Home Health Services of Carolinas Hospital System		Darlington, Dillon, Florence & Marlboro	1,292	32,314	25.0
Home Health Services of Self Regional Healthcare		Abbeville, Laurens, Greenwood, Saluda, & McCormick	1,595	29,456	18.5
Hospice Care of Low Country HH (may serve terminally ill patients only)		Beaufort & Jasper	33	1306	39.6
Hospice of Charleston HHA		Charleston, Berkeley & Dorchester	71	1,729	24.4
Incare Home Health		Horry & Georgetown	1,688	25,234	14.9
Interim HealthCare of Greenville		Anderson, Oconee, Greenville, Pickens, Cherokee & Spartanburg	7,878	153,788	19.5

Home Health Agency Utilization 2006

Facility	Counties Served	Persons Served	Total Visits	Visits/ Person
Interim HealthCare of Rock Hill	York	1,573	25,513	16.2
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Dorchester, Colleton & Georgetown	955	14,953	15.7
Island Health Care	Beaufort	1,645	19,520	11.9
Kershaw County Medical Ctr Home Health	Kershaw	744	17,100	23.0
Lakes at Litchfield ***22*** (may serve retirement community only)	Georgetown			
Liberty Home Care - Aiken ***23***	Aiken	394	4,806	12.2
Liberty Home Care - Bennettsville	Marlboro	262	4,374	16.7
Liberty Home Care - Myrtle Beach	Horry	533	6,934	13.0
Matria Healthcare - Midlands (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	347	376	1.1
Matria Healthcare - Piedmont (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	365	602	1.6
McLeod Home Health	Florence, Darlington, Dillon, Marion & Lee	2,231	39,155	17.6
NHC HomeCare - Aiken	Aiken	449	15,256	34.0
NHC HomeCare - Greenwood	Greenwood	263	10,197	38.8
NHC HomeCare - Laurens	Laurens & Greenville	782	19,499	24.9
Neighbors Care Home Health Agency	Chester	366	7,288	19.9
Oconee Memorial Home Health ***24***	Anderson, Oconee & Pickens	598	13,195	22.1
Palmetto Health HomeCare (terminally ill Bamberg Co. Patinents only)	Richland, Lexington & Bamberg	1,713	38,233	22.3
PHC Home Health	Charleston	590	13,722	23.3
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	2,382	51,411	21.6
Sandpiper Home Health Services ***25*** (may serve retirement community only)	Charleston	6	6	1.0
Sea Island Home Health	Charleston & Colleton	64	3,846	60.1
Spartanburg Reg Med Ctr Home Health	Spartanburg	1,619	33,378	20.6

Home Health Agency Utilization 2006

Facility	Counties Served	Persons Served	Total Visits	Visits/ Person
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	1,751	18,219	10.4
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	28	3,750	133.9
Still Hopes Solutions for Living at Home ***26*** (may serve retirement community only)	Lexington			
Total Care of North Carolina - Rock Hill	York, Cherokee, Chester & Union	2,836	58,289	20.6
Total Care - Coastal	Georgetown, Horry & Williamsburg	1,638	24,570	15.0
Tri-County Home Health Care & Services	Saluda, Richland, Sumter & Lexington	2,457	47,937	19.5
Trinity Home Service Home Health ***27***	Aiken, Edgefield & Barnwell	484	5,549	11.5
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Lee, Clarendon & Sumter	835	12,559	15.0
University Home Health North Augusta	Aiken & Edgefield	824	12,587	15.3
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Orangeburg, Hampton & Colleton	551	22,469	40.8
Westminster Campus Home Health ***28*** (may serve retirement community only)	York			

Home Health Agency Footnotes

1 Name changed 8/14/06, formerly Winyah Home Health Agency-Piedmont; prior years data.

2 Name and ownership changed 2/1/05, formerly Winyah Home Health Care-Upper State.

3 Name changed, formerly Alliance Home Care.

4 Name changed 8/10/06, formerly Winyah Home Health Care, An Amedysis Company.

5 Name and ownership changed 2/1/05, formerly Winyah Home Health Care-Georgetown. Name and ownership changed 8/10/06, formerly Winyah Home Health Care-Georgetown, An Amedysis Company.

6 Name and ownership changed 2/1/05, formerly Winyah Home Health Care of Beaufort County. Name changed 1/10/06, formerly Winyah Home Health Care of Beaufort County, An Amedisys Company. Name changed 8/9/06, formerly Amedisys of Hilton Head.

7 Name and ownership changed 2/1/05, formerly Winyah Home Health Care-Midlands. Name changed 8/10/06. Name changed to Amedisys Home Health of Lexington 2/1/08.

8 Name and ownership changed 2/1/05, formerly Winyah Home Health Care of the Grand Strand. Name changed 8/10/06.

9 Name and ownership changed 2/1/05, formerly Winyah Home Health Care-Coastal Carolina. Name changed 8/10/06, formerly Winyah Home Health Care of the Low Country, An Amedysis Company.

10 Named changed 10/5/05, formerly AnMed Home Health Agency.

11 Name changed, formerly Memorial Care One Home Health Services.

12 Named changed 9/8/05 to DHEC Region 1 North Home Health Services, formerly Appalachia I Home Health Services. The former Upper Savannah Home Health Services (DHEC Region 1 South) was merged with this service on 3/16/07 and the new 8 county agency was renamed DHEC Region 1 Home Health Services.

13 Named changed 9/8/05, formerly Appalachia II Home Health Services.

14 Named changed 9/8/05, formerly Appalachia III Home Health Services.

15 Named changed 9/8/05 and combined formerly Palmetto Home Health Services and Region III Home Health Services, previously Catawba Home Health Services.

16 Named changed 9/8/05, formerly Pee Dee Health District.

17 Named changed 9/8/05, formerly Wateree Health District.

18 Name changed when Lower Savannah Home Health Services and Edisto Health District Home Health Services merged, 9/20/04. Name changed, 9/8/05, formerly Edisto/Savannah Home Health Services.

19 Named changed 9/8/05, formerly Waccamaw Home Health Services.

20 Named changed 9/8/05, formerly Trident Home Health Services.

21 Named changed, formerly Low Country Home Health Services.

22 Licensed 5/7/08.

23 Name changed, formerly Hitchcock Healthcare.

24 Name changed, formerly Oconee Memorial Hospital Home Health Agency.

25 Licensed 2/8/06.
26 Licensed 12/17/07.
27 Name changed, formerly St. Joseph Home Services.
28 Licensed 1/23/08.

CHAPTER III

STATE SUMMARY

PROGRAM OF EACH REGION

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

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes that have occurred since the previous Plan are explained by a footnote. The numbers of existing and approved beds are summarized by region. The inventory of beds and facilities was current as of September 1, 2008.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR: 2006

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds. The William J. McCord Adolescent Treatment Center has an occupancy rate of greater than 90% and should be allowed to increase the number of beds for adolescents. The facility will justify the need for additional beds and obtain the support of the Department of Alcohol and Other Drug Abuse Services.

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

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:									
	THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38			
	LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10			
X	SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50		1,018	3,227
	W.J. BARGE MEMORIAL HOSPITAL	1	GREENVILLE	GREENVILLE	NPA	79	90	(3) c	1,210	2,259
	LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20			
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30		489	302
	COLUMBIA CARE CENTER	2	RICHLAND	COLUMBIA	PROP	196	198		327	29,256
XYZ	MORRIS VILLAGE	3	RICHLAND	COLUMBIA	ST	11	11			
	KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24			
	WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8			
	CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22			
	TOTAL					**450**	**463**		**3,044**	**35,044**
	MENTAL HOSPITALS:									
XYZ	PATRICK B HARRIS PSYCHIATRIC	4	ANDERSON	ANDERSON	ST	200	200		1,515	48,735
XYZ	COLUMBIA CARE CENTER	5	RICHLAND	COLUMBIA	PROP	178	(0)		354	68,262
XYZ	G WERBER BRYAN PSYCHIATRIC HOSP	5	RICHLAND	COLUMBIA	ST	288	466		1,161	86,079
	GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87			
XYZ	SC STATE HOSPITAL	6	RICHLAND	COLUMBIA	ST	144	501	264 abc		
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89			
	TOTAL					**986**	**1,343**	**264**	**3,030**	**203,076**
	RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:									
XYZ	DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37		20	5,334
	TOTAL					**37**	**37**		**20**	**5,334**
	DRUG & ALCOHOL INPT TREATMENT:									
	PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48			
	HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36			
XYZ	WM J MCCORD ADOLESCENT TREAT		ORANGEBURG	ORANGEBURG	ST	15	15		114	5,328
XYZ	MORRIS VILLAGE	3	RICHLAND	COLUMBIA	ST	163	163		1,669	39,917
	TOTAL					**262**	**262**	**0**	**1,783**	**45,245**
	LONG TERM FACILITIES:									
Y	RICHARD M CAMPBELL VA NURS HOME	7	ANDERSON	ANDERSON	ST	220	220		86	74,820
YN	PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8		13	1,620
Y	FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14		43	3,874
Y	BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9		13	2,914
N	THE FRANKE HEALTH CARE CTR		CHARLESTON	MT PLEASANT	NPA	20	20		27	7,112
	VETERANS VICTORY HOUSE	8	COLLETON	WALTERBORO	ST	220	220			
N	BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	52	52		57	9,805

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
N	PRESBYTERIAN HOME SUMMERVILLE	9	DORCHESTER	SUMMERVILLE	NPA	0	0		1,193	16,398
N	PRESBYTERIAN HOME FLORENCE		FLORENCE	FLORENCE	NPA	44	44		22	10,441
N	METHODIST MANOR OF THE PEE DEE		FLORENCE	FLORENCE	NPA	32	32		31	9,080
N	LAKES AT LITCHFIELD SKILLED NSG CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	7	7		63	1,963
N	ROLLING GREEN VILLAGE HC FACILITY		GREENVILLE	GREENVILLE	NPA	34	34		49	11,739
	SKILLED NURS CTR CASCADES VERDE	10	GREENVILLE	GREENVILLE	PROP		44			
N	WOODLANDS AT FURMAN	11	GREENVILLE	GREENVILLE	PROP		13			
N	PRESBYTERIAN HOME OF SC CLINTON		LAURENS	CLINTON	NPA	66	66		85	19,794
N	MARTHA FRANK BAPTIST RET COMM		LAURENS	LAURENS	NPA	7	7		14	2,441
N	SC EPISCOPAL HOME STILL HOPES		LEXINGTON	W COLUMBIA	NPA	42	42		27	12,826
N	LAUREL CREST RETIREMENT CENTER		LEXINGTON	W COLUMBIA	NPA	12	12		7	2,889
N	PRESBYTERIAN HOME OF SC COLUMBI/	12	LEXINGTON	W COLUMBIA	NPA	0	0		64	15,024
N	CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	22	22		8	6,419
N	PRESBYTERIAN HOME OF SC-FOOTHILLS		PICKENS	EASLEY	NPA	18	18		15	6,186
YZN	CM TUCKER JR NURS CTR-FEWELL/STON		RICHLAND	COLUMBIA	ST	252	252	126 d	63	101,122
YZN	CM TUCKER JR NURS CTR-RODDEY		RICHLAND	COLUMBIA	ST	308	308	154 d	57	71,094
N	LOWMAN HOME - WC BOLICK		RICHLAND	WHITEROCK	NPA	47	47		29	16,452
	WILDEWOOD DOWNS NSG & REHAB	13	RICHLAND	COLUMBIA	PROP		8			
N	WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	62	150		32	21,100
N	SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	11	11		17	3,644
N	SUMMIT HILLS NURSING CENTER	14	SPARTANBURG	SPARTANBURG	PROP	6	6			
N	COVENANT PLACE NURS CTR		SUMTER	SUMTER	NPA	44	44		25	15,052
	TOTAL					**1,557**	**1,697**		**2,040**	**443,809**

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED:

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
Z	DR DON LESTER PEOPLES COMM RES		ABBEVILLE	WARE SHOALS	ST	8	8			
Z	WARE SHOALS HAB CTR I		ABBEVILLE	WARE SHOALS	ST	8	8			
	ABBEVILLE COUNTY		TOTAL			16	16			
Z	DUPONT I HABILITATION CTR		AIKEN	AIKEN	ST	8	8			
Z	DUPONT II HABILITATION CTR		AIKEN	AIKEN	ST	8	8			
Z	LAURENS STREET ICF/MR		AIKEN	AIKEN	ST	8	8			
Z	LINDEN STREET ICR/MR		AIKEN	AIKEN	ST	8	8			
Z	RUDNICK HABILITATION CTR		AIKEN	AIKEN	ST	8	8			
Z	SANDERS HABILITATION CTR		AIKEN	AIKEN	ST	8	8			
	AIKEN COUNTY		TOTAL			48	48			
Z	ACADEMY STREET COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8			
Z	BLACK'S DRIVE COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8			
Z	HARLEY ROAD COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8			
Z	LEMON PARK COMMUNITY RES		BARNWELL	BARNWELL	ST	8	8			
	BARNWELL COUNTY		TOTAL			32	32			
Z	CONIFER I COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8			
Z	CONIFER II COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8			
	BERKELEY COUNTY		TOTAL			16	16			
Z	FLORENCE GRESSETTE RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8			
Z	WYLIE-BRUNSON RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8			
	CALHOUN COUNTY		TOTAL			16	16			

REGION: STATEWIDE

INPATIENT INVENTORY

FISCAL YEAR 2006

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
Z	DILLS BLUFF COMMUNITY RESIDENCE		CHARLESTON	CHARLESTON	ST	8	8			
	CHARLESTON COUNTY		TOTAL			8	8			
Z	J. CLAUDE FORT COMMUNITY RES #1		CHEROKEE	GAFFNEY	ST	8	8			
Z	J. CLAUDE FORT COMMUNITY RES #2		CHEROKEE	GAFFNEY	ST	8	8			
	CHEROKEE COUNTY		TOTAL			16	16			
Z	CHARLES M. INGRAM, SR COMM RES		CHESTERFIELD	CHERAW	ST	8	8			
Z	CHESTERFIELD COMMUNITY RES		CHESTERFIELD	CHESTERFIELD	ST	8	8			
	CHESTERFIELD COUNTY		TOTAL			16	16			
Z	JOSIE DRIVE COMMUNITY RESIDENCE		COLLETON	WALTERBORO	ST	8	8			
Z	FOREST CIRCLE COMMUNITY RES		COLLETON	WALTERBORO	ST	8	8			
	COLLETON COUNTY		TOTAL			16	16			
Z	JOHN A REAGAN COMMUNITY RES		DARLINGTON	HARTSVILLE	ST	8	8			
Z	THAD E SALEEBY DEVELOPMENT CTR		DARLINGTON	HARTSVILLE	ST	96	96			
Z	WILLIAM W BOWEN RESIDENCE		DARLINGTON	HARTSVILLE	ST	8	8			
	DARLINGTON COUNTY		TOTAL			112	112			
Z	COASTAL CTR -HIGHLANDS & HILLSIDE		DORCHESTER	SUMMERVILLE	ST	192	192			
Z	COASTAL CENTER- HIGHLANDS 510		DORCHESTER	SUMMERVILLE	ST	18	18			
Z	PARSONS I GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8			
Z	PARSONS II GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8			
	DORCHESTER COUNTY		TOTAL			226	226			
Z	EDGEFIELD COMMUNITY RESIDENCE		EDGEFIELD	EDGEFIELD	ST	8	8			
	EDGEFIELD COUNTY		TOTAL			8	8			
Z	THE CEDARS		FLORENCE	PAMPLICO	ST	8	8			
Z	FLORENCE COMMUNITY RESIDENCE		FLORENCE	FLORENCE	ST	8	8			
Z	JOHNSONVILLE HAMPTON PLACE COM		FLORENCE	JOHNSONVILLE	ST	8	8			
Z	MAGNOLIA PLACE		FLORENCE	OLANTA	ST	8	8			
Z	MULBERRY PARK, UNITS 301-306		FLORENCE	FLORENCE	ST	85	85			
Z	THE OAKS		FLORENCE	TIMMONSVILLE	ST	8	8			
Z	PECAN LANE, BUILDINGS 201-205		FLORENCE	FLORENCE	ST	120	120			
	FLORENCE COUNTY		TOTAL			245	245			
Z	JESSAMINE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8			
Z	MARYVILLE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8			
	GEORGETOWN COUNTY					16	16			
Z	CIVITAN COMMUNITY RESIDENCE		GREENVILLE	GREENVILLE	ST	8	8			
Z	FOUNTAIN INN COMMUNITY RESIDENCE		GREENVILLE	FOUNTAIN INN	ST	12	12			
Z	HUGHES STREET COMMUNITY RES		GREENVILLE	FOUNTAIN INN	ST	8	8			
Z	MARIAN PARKINS COMMUNITY RES I		GREENVILLE	GREENVILLE	ST	8	8			
Z	MARIAN PARKINS COMMUNITY RES II		GREENVILLE	GREENVILLE	ST	8	8			
Z	RIDGE ROAD RESIDENCE		GREENVILLE	GREENVILLE	ST	12	12			
Z	TRAVELERS REST COMMUNITY RES		GREENVILLE	TRAVELERS REST	ST	8	8			
	GREENVILLE COUNTY		TOTAL			64	64			

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
Z	HENRY & FREIDA BONDS HAB CTR		GREENWOOD	GREENWOOD	ST	8	8			
Z	MARION P CARNELL HAB CTR		GREENWOOD	WARE SHOALS	ST	8	8			
Z	J. FELTON BURTON COMMUNITY RES		GREENWOOD	GREENWOOD	ST	8	8			
	GREENWOOD COUNTY		TOTAL			24	24			
Z	HORRY CO LADIES COMMUNITY RES		HORRY	CONWAY	ST	8	8			
Z	THE LOIS EARGLE HOME		HORRY	CONWAY	ST	8	8			
	HORRY COUNTY		TOTAL			16	16			
Z	CAMDEN I GROUP HOME		KERSHAW	CAMDEN	ST	8	8			
Z	CAMDEN II GROUP HOME		KERSHAW	CAMDEN	ST	8	8			
	KERSHAW COUNTY		TOTAL			16	16			
Z	NANCY J MCCONNELL COMMUNITY RES		LANCASTER	LANCASTER	ST	8	8			
Z	TOM MANGUM COMMUNITY RESIDENCE		LANCASTER	LANCASTER	ST	8	8			
	LANCASTER COUNTY		TOTAL			16	16			
Z	CLINTON MANOR COMMUNITY RES		LAURENS	CLINTON	ST	8	8			
Z	DAVIDSON STREET COMMUNITY RES		LAURENS	CLINTON	ST	8	8			
Z	MILL STREET COMMUNITY RESIDENCE		LAURENS	CLINTON	ST	8	8			
Z	SOUTH HARPER ST HABILITATION CTR		LAURENS	CLINTON	ST	8	8			
Z	SULLIVAN STREET COMMUNITY RES		LAURENS	LAURENS	ST	8	8			
Z	OAK GROVE COMMUNITY RESIDENCE		LAURENS	LAURENS	ST	8	8			
YZ	WHITTEN CTR CTL SQ 201,204,205,207,209		LAURENS	CLINTON	ST	143	143			
Z	WHITTEN CENTER CAMPUS AREA 101-110		LAURENS	CLINTON	ST	152	152			
Z	WHITTEN CENTER SUBER UNITS 301-303		LAURENS	CLINTON	ST	68	68			
	LAURENS COUNTY		TOTAL			411	411			
Z	MCLEOD I GROUP HOME		LEE	BISHOPVILLE	ST	8	8			
Z	MCLEOD II GROUP HOME		LEE	BISHOPVILLE	ST	8	8			
	LEE COUNTY		TOTAL			16	16			
Z	BRUTON SMITH ROAD GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8			
Z	BATESBURG GROUP HOME		LEXINGTON	BATESBURG	ST	8	8			
Z	HENDRIX STREET GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8			
Z	NAZARETH ROAD COMMUNITY RES		LEXINGTON	LEXINGTON	ST	8	8			
Z	WIRE ROAD COMMUNITY RESIDENCE I		LEXINGTON	GILBERT	ST	8	8			
Z	WIRE ROAD COMMUNITY RESIDENCE II		LEXINGTON	GILBERT	ST	8	8			
	LEXINGTON COUNTY		TOTAL			48	48			
Z	JENNINGS MCABEE HABILITATION CTR		MCCORMICK	MCCORMICK	ST	8	8			
	MCCORMICK COUNTY		TOTAL			8	8			
Z	H.A. MCCULLOUGH COMMUNITY RES		NEWBERRY	NEWBERRY	ST	12	12			
	NEWBERRY COUNTY		TOTAL			12	12			
Z	OCONEE COMMUNITY RESIDENCE I		OCONEE	SENECA	ST	8	8			
	OCONEE COUNTY		TOTAL			8	8			
Z	NANCE COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8			
Z	KINGS COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8			
Z	SIFLY COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8			
Z	WANNAMAKER ST COMMUNITY RES		ORANGEBURG	ORANGEBURG	ST	8	8			
	ORANGEBURG COUNTY		TOTAL			32	32			

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS
Z	ARCHIE DRIVE GROUP HOME		RICHLAND	COLUMBIA	ST	8	8			
Z	CARTER STREET GROUP HOME		RICHLAND	COLUMBIA	ST	8	8			
Z	FIRST MIDLANDS ICF-MR		RICHLAND	COLUMBIA	ST	344	344			
Z	HORRELL HILL COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8			
Z	IDA I COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8			
Z	IDA II COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8			
Z	KENSINGTON I GROUP HOME		RICHLAND	COLUMBIA	ST	8	8			
Z	KENSINGTON II GROUP HOME		RICHLAND	COLUMBIA	ST	8	8			
Z	NORTH PINES COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8			
Z	RABBIT RUN COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8			
Z	WOODLAWN GROUP HOME		RICHLAND	COLUMBIA	ST	8	8			
	RICHLAND COUNTY		TOTAL			424	424			
Z	BENCHMARK HOMES-SPARTANBURG		SPARTANBURG	SPARTANBURG	ST	12	12			
Z	BENCHMARK HOMES-COWPENS		SPARTANBURG	COWPENS	ST	12	12			
Z	LANDRUM COMMUNITY RESIDENCE I		SPARTANBURG	LANDRUM	ST	8	8			
Z	LANDRUM COMMUNITY RESIDENCE II		SPARTANBURG	LANDRUM	ST	8	8			
	SPARTANBURG COUNTY		TOTAL			40	40			
Z	ATKINSON EAST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9			
Z	ATKINSON WEST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9			
Z	THOMAS DRIVE COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	8	8			
	SUMTER COUNTY		TOTAL			26	26			
Z	WEST MAIN STREET COMMUNITY RES		UNION	UNION	ST	8	8			
	UNION COUNTY		TOTAL			8	8			
	TOTAL					**1,960**	**1,960**			

STATEWIDE

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	TJC Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. Facility licensed as an Institutional General Infirmary as of 6/29/07. The facility received an exemption (E-07-140) on 12/19/07 to de-license as an IGF and subsequently become a 79 bed Privately-Owned Educational General Infirmary.
2. De-licensed 2 general beds for a total of 138 general and 178 psych 11/1/05. Licensed 60 additional general beds for a total of 198 general and 178 psych 3/14/07. De-licensed 2 general beds for a total of 196 on 3/25/08 (E-07-65).
3. 11 general infirmary beds transferred from Byrnes and de-licensed 11 substance abuse beds. Licensed for 11 general infirmary beds and 163 substance abuse beds 7/29/05. Name changed from Earl E. Morris, Jr. Alcohol and Drug Addiction Treatment Center on 3/14/07.
4. Decrease of 6 licensed psych beds, from 206 to 200, effective 8/18/05.
5. E-08-78 granted 8/8/08 to return the 178 psychiatric beds on loan to Just Care to G. Werber Bryan for a total of 466 psychiatric beds at GWB.
6. Licensed for 140 psychiatric beds on 2/26/07. License increased from 140 to 144 beds 1/2/08.
7. Number of licensed beds increased from 219 to 220 on 12/6/07.
8. Facility licensed for 168 beds on 10/23/06; licensed an additional 52-bed Alzheimer unit on 5/4/07 for a total of 220 licensed beds.
9. Exemption 4/3/06 to de-license 3 beds for a total of 87 nursing home beds, E-06-17. Licensed for 87 beds 4/5/06. CON issued 2/14/08 to convert the 87 institutional nursing home beds to 87 general nursing home beds that do not participate in the Medicaid program, SC-08-08. License classification changed 2/14/08.
10. CON approved 8/28/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds.
11. CON approved 6/13/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds that do not participate in the Medicaid program.
12. CON issued 2/14/08 to convert the 44 institutional nursing home beds to 44 general nursing home beds that do not participate in the Medicaid program, SC-08-09. License classification changed 2/14/08.
13. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35.
14. CON issued 3/14/07 for a Continuing Care Retirement Community with 6 institutional nursing home beds and 27 nursing home beds that do not participate in the Medicaid program. Licensed 3/18/08.

REGION NARRATIVE

REGION: I FISCAL YEAR: 2006

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

2. General Hospitals: W.J. Barge Hospital is a privately owned Educational Institutional Infirmary.

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

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. Because of the high use rate at the William J. McCord Facility in Orangeburg and the lack of other adolescent services, it may be necessary for an additional adolescent state facility to be constructed in this Region to increase geographic accessibility to services. Any such proposal must have DAODAS support. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:											
ANMED HEALTH MEDICAL CENTER	1	ANDERSON	ANDERSON	NPA	423	423		14,344	81,213	423	52.6%
ANMED HEALTH WOMEN'S & CHILDREN'S HOSPITAL	1	ANDERSON	ANDERSON	NPA	72	72		3,582	9,230	72	35.1%
ANDERSON COUNTY		TOTAL			495	495		17,926	90,443	495	50.1%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125		4,432	17,469	125	38.3%
CHEROKEE COUNTY		TOTAL			125	125		4,432	17,469	125	38.3%
ALLEN BENNETT MEMORIAL/GREER MEMORIAL	2	GREENVILLE	GREER	NPA	68	82		3,235	14,494	58	68.5%
GRENVILLE HOSPITAL SYSTEM - PATEWOOD	2	GREENVILLE	GREENVILLE	NPA	72	72					
GREENVILLE MEMORIAL MEDICAL CENTER	2	GREENVILLE	GREENVILLE	NPA	746	746		34,608	192,645	710	74.3%
HILLCREST MEMORIAL HOSPITAL	2	GREENVILLE	SIMPSONVILLE	NPA	43	43		1,852	9,639	43	61.4%
(W.J. BARGE MEMORIAL HOSPITAL)	3	(GREENVILLE)	(GREENVILLE)	NPA	(79)	(90)	(3) c	(1,210)	(2,259)	(79)	(7.8%)
SAINT FRANCIS - DOWNTOWN	4	GREENVILLE	GREENVILLE	NPA	226	226		10,433	58,461	209.9	76.3%
SAINT FRANCIS - EASTSIDE	4	GREENVILLE	GREENVILLE	NPA	93	93		4,805	13,650	68.2	54.9%
GREENVILLE COUNTY		TOTAL			1,248	1,262		54,933	288,889	1,089.1	72.7%
OCONEE MEMORIAL HOSPITAL	5	OCONEE	SENECA	NPA	160	169		6,820	32,062	160	54.9%
OCONEE COUNTY					160	169		6,820	32,062	160	54.9%
PALMETTO BAPTIST MEDICAL CENTER - EASLEY		PICKENS	EASLEY	NPA	109	109		4,663	18,101	109	45.5%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	55	55		1,141	5,132	55	25.6%
PICKENS COUNTY		TOTAL			164	164		5,804	23,233	164	38.8%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	176	176		6,953	31,474	176	49.0%
SPARTANBURG REGIONAL MEDICAL CENTER	6	SPARTANBURG	SPARTANBURG	CO	532	484		26,352	128,363	532	66.1%
VILLAGE HEALTH CENTRE	6	SPARTANBURG	GREER	CO		48					
SPARTANBURG COUNTY		TOTAL			708	708		33,305	159,837	708	61.9%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	6 c	2,807	13,773	143	26.4%
UNION COUNTY		TOTAL			143	143	6	2,807	13,773	143	26.4%
TOTAL					**3,043**	**3,066**	**6**	**126,027**	**625,706**	**2,884**	**59.4%**
LONG TERM ACUTE HOSPITALS:											
NORTH GREENVILLE HOSP LONG TERM ACUTE	2	GREENVILLE	TRAVELERS REST	NPA	45	45		253	8,851	45	53.9%
REGENCY HOSPITAL OF GREENVILLE		GREENVILLE	GREENVILLE	NPA	32	32		420	10,320	32	88.4%
SPARTANBURG HOSPITAL FOR RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97		353	12,756	97	36.0%
TOTAL					**129**	**129**		**1,026**	**31,927**	**174**	**50.3%**
MENTAL FACILITIES:											
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38		849	6,430	38	46.4%
ANDERSON COUNTY		TOTAL			38	38		849	6,430	38	46.4%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	7	GREENVILLE	GREENVILLE	PROP	76	76		2,124	22,098	69	87.7%
SPRINGBROOK BEHAVIORAL HEALTHCARE	8	GREENVILLE	TRAVELERS REST	PROP	20	20		412	4,823	20	66.1%
GREENVILLE MEMORIAL MEDICAL CENTER	2	GREENVILLE	GREENVILLE	NPA	46	46		1,489	15,662	63	68.1%
GREENVILLE COUNTY		TOTAL			142	142		4,025	42,583	152	76.8%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15		318	4,254	15	77.7%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56		961	8,193	56	40.1%
SPARTANBURG COUNTY		TOTAL			71	71		1,279	12,447	71	48.0%
TOTAL					**251**	**251**		**6,153**	**61,460**	**261.0**	**64.5%**

REGION: I

INPATIENT INVENTORY

FISCAL YEAR 2006

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
SPRINGBROOK BEHAVIORAL HEALTHCARE	8	GREENVILLE	TRAVELERS REST	PROP	68	68		58	21,368	68	86.1%
MARSHALL I. PICKENS CHILDREN'S PROGRAM		GREENVILLE	GREENVILLE	NPA	22	22		23	7,857	22	97.8%
TOTAL					**90**	**90**		**81**	**29,225**	**90**	**89.0%**
DRUG AND ALCOHOL INPATIENT TREATMENT:											
ANMED HEALTH WELLSPRING		ANDERSON	WILLIAMSON	NPA	27	27		673	1,946	27	19.7%
CAROLINA CENTER FOR BEHAVIORAL HEALTH		GREENVILLE	GREENVILLE	PROP	13	13		561	3,928	13	82.8%
TOTAL					**40**	**40**		**1,234**	**5,874**	**40**	**40.2%**
REHABILITATION FACILITIES:											
ANMED HEALTH REHABILITATION HOSPITAL	9	ANDERSON	ANDERSON	PROP	37	37		660	10,699	31.7	92.5%
ANDERSON COUNTY		TOTAL			37	37		660	10,699	31.7	92.5%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53		940	12,422	53	64.2%
SAINT FRANCIS HOSPITAL		GREENVILLE	GREENVILLE	NPA	19	19		521	5,891	19	84.9%
GREENVILLE COUNTY		TOTAL			72	72		1,461	18,313	72	69.7%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18		400	5,399	18	82.2%
SPARTANBURG COUNTY		TOTAL			18	18		400	5,399	18	82.2%
TOTAL					**127**	**127**		**2,521**	**34,411**	**122**	**77.5%**
INPATIENT HOSPICE FACILITIES:											
CALLIE & JOHN RAINEY HOSPICE HOUSE		ANDERSON	ANDERSON	NPA	32	32		603	9,184	32	78.6%
MCCALL HOSPICE HOUSE OF GREENVILLE	10	GREENVILLE	GREENVILLE	NPA	30	30					
OCONEE MEMORIAL HOSPICE FOOTHILLS	11	OCONEE	SENECA	NPA	10	15					
HOSPICE HOUSE OF CAROLINA FOOTHILLS	12	SPARTANBURG	LANDRUM	NPA		12					
SPARTANBURG REG HEALTHCARE HOSPICE	13	SPARTANBURG	SPARTANBURG	NPA	15	15		12	55	1.1	14.1%
TOTAL					**87**	**104**		**615**	**9,239**	**33**	**76.5%**
LONG TERM CARE FACILITIES:											
(ANMED HEALTH REHAB HOSPITAL - SUBACUTE)	9	ANDERSON	ANDERSON	PROP	0	0		192	2,036	7	82.0%
ANDERSON PLACE		ANDERSON	ANDERSON	PROP	44	44		44	9,416	44	58.6%
BROOKSIDE LIVING CENTER		ANDERSON	ANDERSON	PROP	88	88	19 c	257	30,176	88	93.9%
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181		233	63,365	181	95.9%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290		441	103,957	290	98.2%
RIVERSIDE LIVING CENTER		ANDERSON	ANDERSON	PROP	88	88		216	31,338	88	97.6%
WILLOW CREEK LIVING CENTER		ANDERSON	IVA	PROP	60	60		125	20,805	60	95.0%
ANDERSON COUNTY		TOTAL			751	751	19	1,508	261,093	758	94.4%
BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132		119	47,062	132	97.7%
CHEROKEE COUNTY LONG TERM CARE FACILITY		CHEROKEE	GAFFNEY	CO	97	97		149	33,271	97	94.0%
CHEROKEE COUNTY		TOTAL			229	229		268	80,333	229	96.1%
ALLEN BENNETT MEMORIAL HOSPITAL SNF	2	GREENVILLE	GREER	NPA	0	0		216	3,313	10	90.8%
BRIARWOOD LIVING CENTER		GREENVILLE	SIMPSONVILLE	PROP	42	42		43	12,624	42	82.3%
BRIGHTON GARDENS		GREENVILLE	GREENVILLE	PROP	45	45		175	14,591	45	88.8%
COTTAGES AT BRUSHY CREEK	14	GREENVILLE	GREENVILLE	NPA	144	144					
FALLS CREEK LIVING CENTER		GREENVILLE	MARIETTA	NPA	44	44	1 c	16	15,572	44	97.0%
FOUNTAIN INN NURSING HOME	15	GREENVILLE	FOUNTAIN INN	PROP	44	60		17	15,788	44	98.3%
GREENVILLE LIVING CENTER		GREENVILLE	GREENVILLE	PROP	79	79	18 d	38	28,051	79	97.3%
GREENVILLE MEMORIAL MED CTR SUBACUTE	2	GREENVILLE	GREENVILLE	NPA	15	15		371	5,859	18	89.2%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132		569	46,111	132	95.7%
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	25 d	76	35,278	99	97.6%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120		234	42,821	120	97.8%

REGION: I

INPATIENT INVENTORY

FISCAL YEAR 2006

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176		300	62,401	176	97.1%
NHC HEALTHCARE MAULDIN	16	GREENVILLE	MAULDIN	PROP	180	180		300	44,521	151	80.8%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132		305	45,224	132	93.9%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125		305	42,058	125	92.2%
PIEDMONT LIVING CENTER		GREENVILLE	GREER	PROP	132	132		105	47,337	132	98.3%
(ROGER HUNTINGTON NURSING CENTER)	14	GREENVILLE	GREENVILLE	NPA	0	0		89	31,236	88	97.2%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY		GREENVILLE	GREENVILLE	NPA	10	10		15	3,453	10	94.6%
(ROLLING GREEN VILLAGE HEALTH CARE FAC)		GREENVILLE	GREENVILLE	NPA	(34)	(34)					
(SKILLED NURSING CTR CASCADES VERDE)	17	GREENVILLE	GREENVILLE	PROP		(44)					
SUMMIT PLACE LIVING CENTER		GREENVILLE	SIMPSONVILLE	PROP	132	132		123	47,243	132	98.1%
WESTSIDE LIVING CENTER		GREENVILLE	GREENVILLE	PROP	132	132		144	47,570	132	98.7%
WOODLANDS AT FURMAN	18	GREENVILLE	GREENVILLE	PROP		17					
(WOODLANDS AT FURMAN)		GREENVILLE	GREENVILLE	PROP		(13)					
GREENVILLE COUNTY		TOTAL			1,783	1,816	44	3,441	591,051	1,711	94.6%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120		477	41,176	120	94.0%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132		222	46,720	132	97.0%
OCONEE COUNTY		TOTAL			252	252		699	87,896	252	95.6%
BLUE RIDGE LIVING CENTER		PICKENS	EASLEY	PROP	66	66	33 d	66	23,389	66	97.1%
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	30	30		11	8,752	30	79.9%
(CLEMSON AREA RETIREMENT CENTER)		PICKENS	CLEMSON	PROP	(22)	(22)					
COUNTRYSIDE HEALTHCARE CENTER		PICKENS	EASLEY	PROP	44	44		34	9,695	44	60.4%
EASLEY LIVING CENTER		PICKENS	EASLEY	PROP	103	103	50 d	104	36,847	103	98.0%
HARVEY'S NURSING HOME		PICKENS	SIX MILE	PROP	44	44	27 cd	15	15,242	44	94.9%
LAUREL HILL LIVING CENTER		PICKENS	PICKENS	PROP	80	80		106	28,418	80	97.3%
ROSEMOND LIVING CENTER		PICKENS	PICKENS	PROP	44	44	22 d	28	15,564	44	96.9%
PICKENS COUNTY		TOTAL			411	411	132	364	137,907	411	91.9%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88		49	31,676	88	98.6%
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44		46	15,567	44	96.9%
INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	40		20	14,443	40	98.9%
MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176		135	63,248	176	98.5%
MAGNOLIA MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	95	95	62 ad	133	33,759	95	97.4%
MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88		158	31,658	88	98.6%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132		47	47,853	132	99.3%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75		333	25,584	75	93.5%
SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	33	33		53	10,931	33	90.8%
(SKYLYN HEALTH CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)					
SPARTANBURG HOSP RESTORATIVE CARE SNF	19	SPARTANBURG	SPARTANBURG	CO	25	25		237	2,721	14	52.5%
SUMMIT HILLS NURSING CENTER	20	SPARTANBURG	SPARTANBURG	PROP	27	27					
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)					
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88		48	31,404	88	97.8%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192		129	68,475	192	97.7%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88		110	31,525	88	98.1%
WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88		38	31,932	88	99.4%
SPARTANBURG COUNTY		TOTAL			1,279	1,279	62	1,536	440,776	1,241	97.3%
ELLEN SAGAR NURSING HOME		UNION	UNION	CO	113	113		132	40,953	113	99.3%
OAKMONT OF UNION		UNION	UNION	PROP	88	88		245	29,924	88	93.2%
UNION COUNTY		TOTAL			201	201		377	70,877	201	96.6%
TOTAL					4,906	4,939	257	8,193	1,669,933	4,802.9	95.3%

FOOTNOTES 2008 PLAN

REGION I

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	TJC Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. SC-03-02 issued for a 72 bed Women & Children's Hospital resulting in 423 general beds, 38 psych & 12 nursing beds at Anderson Area Medical Center, 1/13/03. AnMed Health Women's & Children's Hospital licensed 6/2/2005; AnMed Health Med. Ctr. license decreased to 423 general beds.
2. CON issued 8/25/03 for a new 72 bed general acute hospital (Patewood Memorial) by transferring the 52 beds to be added from ABM with the reduction of 17 psych beds from GMH and the transfer of the 3 nursing beds from GMH, SC-03-46. This results in a new 72 bed licensed acute hospital, & GMH with 710 general, 53 rehab, 46 psych beds and 0 licensed nursing beds. GM nursing home beds reduced from 21 to 3, 8/27/03. GMH licensed general beds increased from 646 to 710 & licensed psych beds reduced from 72 to 63, 1/1/04. CON issued 4/21/04 to temporarily transfer 18 approved nursing home beds from Roger Huntington to GMH, SC-04-21; licensed 10/26/04. CON issued 7/18/05 to construct a replacement hospital for ABM to include the existing 58 beds and the conversion of the 10 nursing home beds to acute care for a total of 68 general beds, SC-05-49. The replacement facility will be named Greer Memorial Hospital. The CON was amended 1/5/06 to withdraw the conversion of the 10 nursing home beds. CON issued 8/14/06 to add 14 beds to Greer Memorial for a total of 72, SC-06-48. CON issued 8/14/06 to add 36 general beds at GMH, for a total of 746, SC-06-49. Effective 11/7/06, 28 of the beds approved by SC-06-49 were licensed at GMH for a total of 738 general beds licensed. GMH Subacute Unit decreased the number of licensed nursing home beds from 18 to 15 on 2/9/07. The remaining 8 beds approved by SC-06-49 were licensed at GMH on 6/7/07 for a total of 746 general beds. Patewood Memorial was licensed for 72 general beds on 6/12/07; the 17 psych beds transferred from GMH as part of SC-03-46 were de-licensed from GMH on the same day. GMH now has 746 general beds, 46 psych, and 53 rehab beds. CON issued 6/22/07 to convert the 10 nursing home beds at ABM to general acute for a total of 68 acute beds; these beds will be relocated to Greer Memorial when it opens, for a total of 82 acute beds, SC-07-28. CON issued 10/12/07 to permanently transfer 15 nursing home beds from Roger Huntington to GMH Subacute, for a total of 161 beds at RH and 15 beds at GMH, SC-07-48. The last patient left the ABM Subacute Unit on 9/28/06, but the 10 nursing home beds were not de-licensed and converted to general acute beds until 11/20/07, for a total of 68 currently licensed acute beds. Greer Memorial was licensed and Allen Bennett closed 8/5/08.
3. Facility use restricted to students; licensed as an Institutional General Infirmary 6/29/07.
4. CON issued to add 20 general beds to St. Francis for a total of 226, & 31 beds to St. Francis Womens & Family for a total of 93, 8/25/03 SC-03-47. Number of licensed beds at St. Francis increased from 206 to 208 on 1/25/06 and then to 218 beds on 5/24/06. Number of licensed beds at SFW&F increased from 62 to 86 on 6/7/06 and then to 93 beds on 7/27/06. St. Francis Hospital name changed to St. Francis – Downtown and St. Francis Womens &

Family Hospital name changed to St. Francis – Eastside on 2/6/07. St. Francis – Downtown licensed for 226 beds on 6/21/07.

5. CON issued for a 9 bed addition 9/14/06, SC-06-55.
6. CON issued 9/9/05 to construct Village Health Centre, a new 48-bed hospital, by transferring 48 acute care beds from Spartanburg Regional Medical Center, SC-05-63.
7. CON issued to add 11 psych beds for a total of 64 psych and 13 substance abuse beds10/11/04 SC-04-46. CON issued 3/22/05 to add 5 psych beds for a total of 69, SC-05-20. Licensed for 69 psych beds on 7/27/05. CON issued 8/2/05 for 7 additional psych beds for a total of 76 psych beds, SC-05-54. Licensed for 76 psych beds on 3/15/07.
8. CON issued 7/29/05 to convert 5 long-term psychiatric beds to acute psychiatric beds, for a total of 20 psychiatric beds, SC-05-52; licensed 8/8/05.
9. CON issued 8/1/06 to convert the existing 10-bed nursing home unit to 7 rehab beds, for a total of 37 rehab beds, SC-06-45. The 10-bed nursing home unit was de-licensed 9/7/06. Facility licensed for 37 rehab beds 10/5/06.
10. CON issued 4/12/05 for a 30-bed inpatient hospice, SC-05-22. Licensed 7/18/07.
11. CON issued 6/28/06 to construct a 10-bed inpatient hospice, SC-06-31. CON approved 8/28/07 to add 5 additional beds for a total of 15 inpatient hospice beds. Licensed for 10 beds on 9/21/07.
12. CON issued 7/28/06 for a 12-bed inpatient hospice facility, SC-06-44.
13. CON issued 3/22/05 for a 15-bed inpatient hospice facility, SC-05-18. Licensed 12/20/07.
14. CON issued for relocation and expansion of Roger Huntington & adding 88 non-Medicaid beds for a total of 176, 11/12/03 SC-03-71. CON issued for the temporary transfer of 18 nursing beds from SC-03-71 from Roger Huntington to GM, 4/12/04, SC-04-21. Licensed for 18 beds at Memorial, 10/26/04. CON issued 10/12/07 to permanently transfer 15 nursing home beds from Roger Huntington to GMH Subacute, for a total of 161 beds at RH and 15 beds at GMH, SC-07-48. Roger Huntington de-licensed on 10/12/07 and Cottages at Brushy Creek was licensed for 144 beds. Greenville Hospital System voided the remaining 17 beds approved for Brushy Creek on 5/30/08.
15. CON issued 7/29/05 to construct a replacement facility and add 16 beds that do not participate in the Medicaid Program, for a total of 60 nursing home beds, SC-05-53. CON voided and then replaced with CON SC-08-04, 1/24/08.
16. CON issued 2/15/05 for a 60-bed addition for a total of 180 nursing home beds, SC-05-14; licensed 6/27/06.
17. CON issued 9/14/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds, SC-07-41.
18. CON issued 7/3/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds which do not participate in Medicaid, SC-06-34.
19. CON issued 11/16/05 to add 25 hospital-based nursing home beds that do not participate in the Medicaid program, SC-05-80; licensed 2/14/06.
20. CON issued 3/14/07 for a Continuing Care Retirement Community with 6 institutional nursing home beds and 27 nursing home beds that do not participate in the Medicaid program, SC-07-09. Facility licensed 3/18/08.

INVENTORY OF EMERGENCY FACILITIES 2006 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2006 ER VISITS
REGION I:	EMERGENCY FACILITIES			
II	ANMED HEALTH MEDICAL CENTER	ANDERSON	ANDERSON	67,664
III	UPSTATE CAROLINA MEDICAL CENTER	CHEROKEE	GAFFNEY	27,342
II	ALLEN BENNETT MEMORIAL HOSPITAL	GREENVILLE	GREER	27,454
I	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE	79,210
II	HILLCREST HOSPITAL	GREENVILLE	SIMPSONVILLE	22,799
III	NORTH GREENVILLE LTACH	GREENVILLE	TRAVELERS REST	16,856
II	SAINT FRANCIS - DOWNTOWN	GREENVILLE	GREENVILLE	30,900
II	SAINT FRANCIS - EASTSIDE	GREENVILLE	GREENVILLE	26,160
(*)	WJ BARGE	GREENVILLE	GREENVILLE	5,450
III	OCONEE MEMORIAL HOSPITAL	OCONEE	SENECA	36,669
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	33,750
III	CANNON MEMORIAL HOSPITAL	PICKENS	PICKENS	15,159
III	MARY BLACK MEMORIAL HOSPITAL	SPARTANBURG	SPARTANBURG	26,987
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG	93,471
III	WALLACE THOMSON HOSPITAL	UNION	UNION	16,653
			TOTAL	526,524

(*) Met insufficient criteria to be classified.

CATEGORY	NAME OF FACILITY	COUNTY	CITY
REGION I:	TRAUMA CENTERS		
II	ANMED HEALTH MEDICAL CENTER	ANDERSON	ANDERSON
I	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE
III	ALLEN BENNETT MEMORIAL HOSPITAL	GREENVILLE	GREER
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG

REGION NARRATIVE

REGION: II FISCAL YEAR: 2006

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

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 91.7% of the Richland County population plus 42.5% of the population of Lexington County. For Lexington County, 57.5% of the Lexington County population plus 8.3% of the Richland County population is used. The bed needs are developed separately with a separate need indicated for each county.

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

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: II

INPATIENT INVENTORY

FISCAL YEAR 2006

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:											
ABBEVILLE AREA MEDICAL CENTER		ABBEVILLE	ABBEVILLE	CO	25	25		1,081	3,508	25	38.4%
ABBEVILLE COUNTY		TOTAL			25	25		1,081	3,508	25	38.4%
CHESTER REGIONAL MEDICAL CENTER		CHESTER	CHESTER	DIST	82	82		1,996	7,263	82	24.3%
CHESTER COUNTY		TOTAL			82	82		1,996	7,263	82	24.3%
EDGEFIELD COUNTY HOSPITAL		EDGEFIELD	EDGEFIELD	CO	25	25		703	2,268	25	24.9%
EDGEFIELD COUNTY		TOTAL			25	25		703	2,268	25	24.9%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25		802	3,094	25	33.9%
FAIRFIELD COUNTY		TOTAL			25	25		802	3,094	25	33.9%
SELF REGIONAL HEALTHCARE	1	GREENWOOD	GREENWOOD	NPA	354	354		13,143	55,541	334	45.6%
GREENWOOD COUNTY		TOTAL			354	354		13,143	55,541	334	45.6%
KERSHAW COUNTY MEDICAL CENTER		KERSHAW	CAMDEN	CO	121	121		5,568	25,909	121	58.7%
KERSHAW COUNTY		TOTAL			121	121		5,568	25,909	121	58.7%
SPRINGS MEMORIAL HOSPITAL	2	LANCASTER	LANCASTER	NPA	168	217		6,913	33,465	168	54.6%
LANCASTER COUNTY		TOTAL			168	217		6,913	33,465	168	54.6%
LAURENS COUNTY HOSPITAL		LAURENS	LAURENS	DIST	76	76		2,889	12,738	76	45.9%
LAURENS COUNTY		TOTAL			76	76		2,889	12,738	76	45.9%
LEXINGTON MEDICAL CENTER	3	LEXINGTON	WEST COLUMBIA	CO	384	384		19,554	95,598	338.8	77.3%
LEXINGTON COUNTY		TOTAL			384	384		19,554	95,598	338.8	77.3%
NEWBERRY COUNTY MEMORIAL HOSPITAL		NEWBERRY	NEWBERRY	CO	90	90		2,934	11,236	90	34.2%
NEWBERRY COUNTY		TOTAL			90	90		2,934	11,236	90	34.2%
PALMETTO HEALTH BAPTIST	4	RICHLAND	COLUMBIA	NPA	363	287		18,628	79,908	363	60.3%
PALMETTO HEALTH PARKRIDGE	4	RICHLAND	COLUMBIA	NPA		76					
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	NPA	579	579		30,916	151,907	579	71.9%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROP	258	258		12,478	63,794	258	67.7%
PROVIDENCE HOSPITAL NORTHEAST	5	RICHLAND	COLUMBIA	PROP	46	84		3,514	12,350	46	73.6%
(MONCRIEF ARMY HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(63)		(1,037)	(4,856)		
(W J B DORN VA HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(400)		(4,197)	(23,607)		
RICHLAND COUNTY		TOTAL			1,246	1,284		65,536	307,959	1,246	67.7%
FORT MILL MEDICAL CENTER	7	YORK	FORT MILL	PROP		100					
PIEDMONT MEDICAL CENTER	7	YORK	ROCK HILL	PROP	268	232		15,742	70,762	268	72.3%
YORK COUNTY		TOTAL			268	332		15,742	70,762	268	72.3%
TOTAL					**2,864**	**3,015**		**136,861**	**629,341**	**2,799**	**61.6%**
LONG TERM ACUTE HOSPITALS:											
INTERMEDICAL HOSPITAL OF SOUTH CAROLINA		RICHLAND	COLUMBIA	NPA	35	35		240	8,491	35	66.5%
TOTAL					35	35	0	**240**	**8,491**	**35**	**66.5%**
MENTAL FACILITIES:											
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	36	36		613	4,113	36	31.3%
GREENWOOD COUNTY		TOTAL			36	36		613	4,113	36	31.3%
THREE RIVERS BEHAVIORAL HEALTH	8	LEXINGTON	WEST COLUMBIA	PROP	49	81		1,370	14,064	39	98.8%
LEXINGTON COUNTY		TOTAL			49	81		1,370	14,064	39	98.8%
PALMETTO HEALTH BAPTIST	9	RICHLAND	COLUMBIA	NPA	94	94		2,164	24,947	104	65.7%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60		1,566	9,330	60	42.6%
(MONCRIEF ARMY HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(20)		(377)	(3,020)		

REGION: II — **INPATIENT INVENTORY** — **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W J B DORN VA)	6	RICHLAND	COLUMBIA	FED		(60)		(515)	(4,245)		
RICHLAND COUNTY		TOTAL			154	154		3,730	34,277	164	57.3%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20		542	2,797	20	38.3%
YORK COUNTY		TOTAL			20	20		542	2,797	20	38.3%
TOTAL					**259**	**291**		**6,255**	**55,251**	**259**	**58.4%**
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
THREE RIVERS RES. TREAT. - MIDLANDS	10	LEXINGTON	WEST COLUMBIA	PROP	59	59		74	13,491	59	62.6%
THREE RIVERS BEHAVIORAL HEALTH RTC		LEXINGTON	WEST COLUMBIA	PROP	20	20		19	6,857	20	93.9%
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40		40	10,827	40	74.2%
TOTAL					**119**	**119**		**133**	**31,175**	**119**	**71.8%**
DRUG AND ALCOHOL INPATIENT TREATMENT:											
SPRINGS MEMORIAL HOSPITAL	2	LANCASTER	LANCASTER	NPA	18	0		352	1,796	18	27.3%
THREE RIVERS BEHAVIORAL HEALTH	8	LEXINGTON	WEST COLUMBIA	PROP	17	17		420	2,980	27	30.2%
PALMETTO HEALTH BAPTIST	9	RICHLAND	COLUMBIA	CO	10	10					
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10		280	3,431	10	94.0%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24		0	0	24	0.0%
TOTAL					**79**	**61**		**1,052**	**8,207**	**79**	**28.5%**
REHABILITATION FACILITIES:											
GREENWOOD REGIONAL REHAB HOSPITAL	11	GREENWOOD	GREENWOOD	NPA	34	34					
GREENWOOD COUNTY		TOTAL			34	34					
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96		1,442	23,263	96	66.4%
RICHLAND COUNTY		TOTAL			96	96		1,442	23,263	96	66.4%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	12	YORK	ROCK HILL	PROP	40	40		740	10,704	34	86.3%
YORK COUNTY		TOTAL			40	40		740	10,704	34	86.3%
TOTAL					**170**	**170**		**2,182**	**33,967**	**130**	**71.6%**
INPATIENT HOSPICE FACILITIES:											
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15		299	3,667	15	67.0%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	13	LAURENS	CLINTON	PROP		12					
HEARTLAND HOSPICE HOUSE MIDLANDS	14	RICHLAND	COLUMBIA	PROP	12	12		47	429	1.8	64.9%
ASCENSION HOUSE	15	RICHLAND	IRMO	PROP	14	14					
HOSPICE AND COMMUNITY CARE	16	YORK	ROCK HILL	NPA	16	16					
TOTAL					**57**	**69**		**346**	**4,096**	**16.8**	**66.8%**
LONG TERM CARE FACILITIES:											
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94		54	32,771	94	95.5%
CARLISLE NURSING CENTER		ABBEVILLE	DUE WEST	NPA	22	22		15	5,568	22	69.3%
ABBEVILLE COUNTY		TOTAL			116	116		69	38,339	116	90.6%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100		97	34,293	100	94.0%
CHESTER COUNTY		TOTAL			100	100		97	34,293	100	94.0%
TRINITY MISSION EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120		78	41,648	120	95.1%
EDGEFIELD COUNTY		TOTAL			120	120		78	41,648	120	95.1%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	104	36 c	65	40,100	112	98.1%
HERITAGE HEALTHCARE OF RIDGEWAY	17	FAIRFIELD	RIDGEWAY	PROP	150	150		157	52,903	150	96.6%
FAIRFIELD COUNTY		TOTAL			262	254	36	222	93,003	262	97.3%

INPATIENT INVENTORY

FISCAL YEAR 2006

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
GREENWOOD REGIONAL REHAB HOSPITAL	11	GREENWOOD	GREENWOOD	NPA	12	12					
HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102		92	34,434	102	92.5%
MAGNOLIA MANOR - GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88		60	29,190	88	90.9%
NHC HEALTHCARE - GREENWOOD		GREENWOOD	GREENWOOD	PROP	152	152		167	52,126	152	94.0%
TRANSITIONAL CARE SELF REGIONAL	1	GREENWOOD	GREENWOOD	NPA	0	0		543	6,182	27	62.7%
GREENWOOD COUNTY		TOTAL			354	354		862	121,932	369	90.5%
A SAM KARESH LONG TERM CARE CENTER	18	KERSHAW	CAMDEN	CO	88	96		24	31,970	88	99.5%
SPRINGDALE HEALTHCARE CENTER	19	KERSHAW	CAMDEN	PROP	148	192		460	51,830	148	95.9%
KERSHAW COUNTY		TOTAL			236	288		484	83,800	236	97.3%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142		80	50,995	142	98.4%
TRANSITIONAL CARE UNIT - SPRINGS MEMORIAL		LANCASTER	LANCASTER	NPA	14	14		357	4,494	14	87.9%
WHITE OAK MANOR - LANCASTER		LANCASTER	LANCASTER	NPA	132	132		60	45,529	132	94.5%
LANCASTER COUNTY		TOTAL			288	288		497	101,018	288	96.1%
LAURENS COUNTY HEALTHCARE SYSTEM SNF		LAURENS	LAURENS	DIST	14	14		193	3,284	14	64.3%
MARTHA FRANK BAPTIST RETIREMENT COMMUNITY		LAURENS	LAURENS	NPA	81	81		166	28,074	81	87.4%
(MARTHA FRANK BAPTIST RETIREMENT COMM)		LAURENS	LAURENS	NPA	(7)	(7)					
NHC HEALTHCARE - CLINTON		LAURENS	CLINTON	PROP	131	131		124	46,769	131	97.8%
NHC HEALTHCARE - LAURENS		LAURENS	LAURENS	PROP	176	176		197	60,911	176	94.8%
LAURENS COUNTY		TOTAL			402	402		680	139,038	402	93.1%
AGAPE NURSING AND REHABILIATION CENTER	20	LEXINGTON	W.COLUMBIA	PROP	100	100		323	14,405	44	89.7%
BRIAN CENTER NURSING CARE - ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120		130	41,770	120	95.4%
HEARTLAND LEXINGTON REHAB & NURSING CTR		LEXINGTON	W.COLUMBIA	PROP	132	132		336	39,385	132	81.7%
LEXINGTON MEDICAL CENTER EXTENDED CARE		LEXINGTON	LEXINGTON	NPA	388	388		514	136,818	388	96.6%
NHC HEALTHCARE - LEXINGTON		LEXINGTON	W.COLUMBIA	PROP	120	120		260	42,192	120	96.3%
PRESBYTERIAN HOME OF SC COLUMBIA	21	LEXINGTON	W COLUMBIA	NPA	44	44		64	15,024		
SC EPISCOPAL HOME AT STILL HOPES		LEXINGTON	W.COLUMBIA	NPA	20	20		13	6,107	20	83.7%
(SC EPISCOPAL HOME AT STILL HOPES)		LEXINGTON	W.COLUMBIA	NPA	(42)	(42)					
LEXINGTON COUNTY		TOTAL			924	924		1,640	295,701	824	98.3%
SAVANNAH HEIGHTS LIVING CENTER	22	MCCORMICK	MCCORMICK	CO	120	120		81	42,658	120	97.4%
MCCORMICK COUNTY		TOTAL			120	120		81	42,658	120	97.4%
J F HAWKINS NURSING HOME		NEWBERRY	NEWBERRY	CO	118	118		88	41,610	118	96.6%
NEWBERRY CO MEM HOSP - TRANS CARE UNIT		NEWBERRY	NEWBERRY	CO	12	12		171	1,424	12	32.5%
WHITE OAK MANOR - NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146		60	52,128	146	97.8%
NEWBERRY COUNTY					276	276		319	95,162	276	94.5%
COUNTRYWOOD NURSING CENTER	23	RICHLAND	HOPKINS	PROP	38	38		46	13,505	38	97.4%
HEARTLAND COLUMBIA REHAB & NURSING CTR		RICHLAND	COLUMBIA	PROP	132	132		355	43,186	132	89.6%
LIFE CARE CENTER OF COLUMBIA		RICHLAND	COLUMBIA	PROP	179	179		510	61,197	179	93.7%
LOWMAN REHABILITATION & HEALTH CARE CTR		RICHLAND	WHITE ROCK	NPA	129	129		100	45,156	129	95.9%
(LOWMAN REHAB & HEALTH CARE CTR)		RICHLAND	WHITE ROCK	NPA	(47)	(47)					
MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88		39	31,347	88	97.6%
NHC HEALTHCARE - PARKLANE	24	RICHLAND	COLUMBIA	PROP	180	180		189	42,639	120	97.3%
OAKS OF BLYTHEWOOD	25	RICHLAND	BLYTHEWOOD	PROP		123					
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22		596	6,554	22	81.6%
PROVIDENCE HOSP NE - TRANS CARE UNIT	5	RICHLAND	COLUMBIA	PROP	0	0		93	858	7	34.6%
RICE NURSING HOME		RICHLAND	COLUMBIA	NPA	32	32		30	11,012	32	94.3%
UNIHEALTH POST-ACUTE COLUMBIA	25	RICHLAND	COLUMBIA	PROP	257	168	146 cd	261	66,599	257	71.0%
WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120		56	43,144	120	98.5%
WILDEWOOD DOWNS NURSING CENTER	26	RICHLAND	COLUMBIA	PROP	32	72		71	6,516	32	55.8%
(W J B DORN VA)		RICHLAND	COLUMBIA	FED		(94)		(124)	(24,846)		
RICHLAND COUNTY		TOTAL			1,209	1,283	146	2,346	371,713	1,156	88.1%
SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176		142	62,066	176	96.6%
SALUDA COUNTY		TOTAL			176	176		142	62,066	176	96.6%

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
AGAPE REHABILITATION ROCK HILL		YORK	ROCK HILL	PROP	99	99		303	31,574	99	87.4%
(HEALTHSOUTH REHAB HOSP ROCK HILL SNF)	12	YORK	ROCK HILL	PROP	(0)	(0)		123	1,320	6	60.3%
MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106		101	32,178	106	83.2%
UNI-HEALTH POST-ACUTE CARE - ROCK HILL	27	YORK	ROCK HILL	PROP	132	132		249	41,178	132	85.5%
WESTMINSTER HEALTH & REHABILITATION CTR		YORK	ROCK HILL	PROP	66	66		206	22,206	66	92.2%
WHITE OAK MANOR - ROCK HILL		YORK	ROCK HILL	PROP	141	141		87	50,965	141	99.0%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109		58	39,051	109	98.2%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40		83	8,861	40	60.7%
YORK COUNTY		TOTAL			693	693		1,210	227,333	699	89.1%
TOTAL					**5,276**	**5,394**	**182**	**8,727**	**1,747,704**	**5,144**	**93.1%**

REGION II

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	TJC Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 5/19/08 to convert the remaining 20 nursing beds at Self Memorial Transitional Care Unit (**see Footnote 11**) to general acute beds, for a total of 354 general, 24 substance abuse, and 36 psych, SC-08-16. Licensed for 354 general beds and the 20 bed TCU de-licensed on 6/12/08.
2. CON issued 5/24/06 to add 10 general beds for a total of 178 general and 18 substance abuse beds, SC-06-23. CON voided 5/29/07. CON issued 10/12/07 to add 31 general beds for a total of 199 acute and 18 substance abuse beds, SC-07-49. CON approved 8/22/08 to convert the 18 substance abuse beds to general beds, for a total of 217 general beds; appealed.
3. CON issued to add 54 additional general beds for a total of 346, 12/29/03 SC-03-77; licensed beds increased from 292 to 319 on 10/11/04. Remaining 27 beds licensed 1/6/06 for a total of 346 general beds. CON issued 9/14/07 for 38 additional acute beds for a total of 384 beds, SC-07-35. License increased to 354 beds 1/29/08. Licensed for 384 beds 6/13/08.
4. CON approved to construct a new 76 bed hospital (Palmetto Health Parkridge) by transferring 76 beds from Palmetto Health Baptist, resulting in 287 general beds, 104 psych and 22 nursing home beds remaining at Palmetto Health Baptist; appealed.
5. CON approved 9/26/05 to convert 11 nursing home beds at Providence NE to general acute beds and to de-license the other 7 nursing home beds, for a total of 57 acute beds. Project was appealed and subsequently withdrawn 11/06. Exemption issued 3/23/06 to de-license the 18 nursing home beds at Providence Northeast, E-06-13; beds were de-licensed on 5/24/06. CON approved 8/27/07 to add 38 general beds for a total of 84 beds; appealed.
6. Bed use restricted. Beds reported by facility.
7. CON approved 5/30/06 to construct a new 100-bed hospital in Fort Mill, including the 64 beds shown as needed in the Plan plus the transfer of 36 beds from Piedmont Medical Center. Approval has been appealed.
8. CON issued 7/18/06 for the addition of 32 psych beds for a total of 71 psych beds, SC-06-42. CON voided on 4/17/07, but the applicant appealed the Department's decision. After appeal, a new CON was issued 12/14/07, SC-07-65. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 17 substance abuse and 81 psych beds at Three Rivers, SC-08-05. Licensed for 49 psych beds and 17 substance abuse beds on 7/21/08.
9. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 10 substance abuse and 94 psych beds at Palmetto Baptist, SC-08-06. Licensed for 10 substance abuse and 94 psych beds 7/21/08.
10. Name changed from The Pines Residential Treatment Facility – Midlands Campus 5/16/07.
11. CON issued 7/3/06 to construct a rehab hospital with 34 rehab and 12 nursing home beds, with 7 of these nursing home beds transferred from Self Memorial Transitional Care Unit, SC-06-36. Greenwood Rehab Hospital was licensed 10/16/07 and the Self Memorial TCU license was decreased from 27 to 20 beds (**see Footnote 1**)

12. CON issued 5/16/07 to convert 6 nursing care beds to rehabilitation beds, for a total of 40 rehab beds and 0 nursing care beds, SC-07-18. Licensed for 40 rehab beds and nursing care beds de-licensed 8/1/07.
13. CON issued 9/15/06 for a 12-bed inpatient hospice, SC-06-61.
14. CON issued 1/19/05 for a 12-bed inpatient hospice. Licensed 6/1/06. Formerly Portsbridge Hospice House.
15. CON issued 4/10/06 for a 14-bed inpatient hospice, SC-06-16. Licensed 6/8/07.
16. CON issued 6/6/05 for construction of a 16-bed hospice, SC-05-39. Licensed 12/31/07.
17. Formerly Ridgeway Health & Rehabilitation Center.
18 CON issued 11/15/07 to add 8 nursing home beds that do not participate in the Medicaid program, for a total of 96 beds, SC-07-58.
19. CON issued 1/18/08 to add 44 beds for a total of 192, SC-08-02.
20. CON issued 10/7/05 to add 56 nursing home beds that do not participate in the Medicaid Program, for a total of 100 beds. Licensed for 100 beds on 7/13/07.
21. CON issued 2/14/08 to convert 44 institutional nursing home beds to 44 general nursing home beds that do not participate in the Medicaid program, SC-08-08. Licensed as general nursing home beds 2/14/08.
22. CON issued 11/16/06 to acquire the former McCormick Nursing Center and change the name to Savannah Heights Living Center, SC-06-70.
23. Formerly Ridgeview Manor.
24. CON issued 7/18/05 to add 60 beds that do not participate in the Medicaid program for a total of 180 beds, SC-05-50. Licensed for 180 beds on 1/12/07.
25. CON issued 1/29/07 for the construction of a 123 bed nursing home with a Medicaid Nursing Home Permit of 21,900 Medicaid patient days by transferring 89 beds from Carolina Health and Rehab and adding 34 new beds. Carolina Health and Rehab will retain 168 nursing home beds and a Medicaid Nursing Home Permit for 47,100 Medicaid patient days; SC-07-04. Name of Carolina Health and Rehab changed to UniHealth Post-Acute Columbia 6/20/08.
26. CON issued 10/18/04 for a 32-bed nursing home that does not participate in the Medicaid program, SC-04-50; licensed 12/22/05. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35.
27. Formerly Rock Hill Healthcare.

INVENTORY OF EMERGENCY FACILITIES 2006 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2006 ER VISITS
REGION II:	EMERGENCY FACILITIES			
III	ABBEVILLE CO MEMORIAL HOSPITAL	ABBEVILLE	ABBEVILLE	9,204
II	CHESTER MEDICAL CENTER	CHESTER	CHESTER	14,139
III	EDGEFIELD COUNTY HOSPITAL	EDGEFIELD	EDGEFIELD	6,499
III	FAIRFIELD MEMORIAL HOSPITAL	FAIRFIELD	FAIRFIELD	10,237
II	SELF REGIONAL HEALTH CARE	GREENWOOD	GREENWOOD	53,120
III	KERSHAW CO MEMORIAL HOSPITAL	KERSHAW	CAMDEN	22,258
II	SPRINGS MEMORIAL HOSPITAL	LANCASTER	LANCASTER	28,219
II	LAURENS COUNTY HOSPITAL	LAURENS	LAURENS	27,369
II	LEXINGTON MEDICAL CENTER	LEXINGTON	W. COLUMBIA	71,230
III	NEWBERRY CO MEMORIAL HOSPITAL	NEWBERRY	NEWBERRY	15,865
II	PALMETTO HEALTH BAPTIST	RICHLAND	COLUMBIA	32,934
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA	67,997
II	PROVIDENCE HOSPITAL	RICHLAND	COLUMBIA	17,877
II	PROVIDENCE HOSPITAL NORTHEAST	RICHLAND	COLUMBIA	29,890
II	PIEDMONT MEDICAL CENTER	YORK	ROCK HILL	43,514
			TOTAL	450,352

CATEGORY	NAME OF FACILITY	COUNTY	CITY
REGION II:	TRAUMA CENTERS		
III	SELF REGIONAL HEALTH CARE	GREENWOOD	GREENWOOD
III	LEXINGTON MEDICAL CENTER	LEXINGTON	W. COLUMBIA
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA
III	PIEDMONT MEDICAL CENTER	YORK	ROCK HILL

REGION NARRATIVE

REGION: III FISCAL YEAR: 2006

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." The inland waterway is a barrier to transportation.

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

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

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:											
CHESTERFIELD GENERAL HOSPITAL		CHESTERFIELD	CHERAW	PROP	59	59		2,791	9,047	59	42.0%
CHESTERFIELD COUNTY		TOTAL			59	59		2,791	9,047	59	42.0%
CLARENDON MEMORIAL HOSPITAL		CLARENDON	MANNING	CO	56	56		2,847	14,046	56	68.7%
CLARENDON COUNTY		TOTAL			56	56		2,847	14,046	56	68.7%
CAROLINA PINES REGIONAL MEDICAL CENTER	1	DARLINGTON	HARTSVILLE	NPA	116	116		8,444	35,158	116	83.0%
MCLEOD MEDICAL CENTER - DARLINGTON	2	DARLINGTON	DARLINGTON	NPA	49	49		783	4,298	49	24.0%
DARLINGTON COUNTY		TOTAL			165	165		9,227	39,456	165	65.5%
MCLEOD MEDICAL CENTER - DILLON	3	DILLON	DILLON	NPA	79	79		3,277	11,439	79	39.7%
DILLON COUNTY		TOTAL			79	79		3,277	11,439	79	39.7%
CAROLINAS HOSPITAL SYSTEM	4	FLORENCE	FLORENCE	PROP	310	310		14,836	80,089	291	75.4%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLORENCE	DIST	48	48		1,232	4,230	48	24.1%
MCLEOD REGIONAL MEDICAL CENTER	5	FLORENCE	FLORENCE	NPA	453	453		22,503	114,313	348	90.0%
WOMEN'S CENTER CAROLINAS HOSP SYS		FLORENCE	FLORENCE	PROP	20	20		1,340	3,077	20	42.2%
FLORENCE COUNTY		TOTAL			831	831		39,911	201,709	707	78.2%
GEORGETOWN MEMORIAL HOSPITAL	6	GEORGETOWN	GEORGETOWN	NPA	131	131		7,016	32,852	131	68.7%
WACCAMAW COMMUNITY HOSPITAL	6	GEORGETOWN	MURRELLS INLET	NPA	124	124		5,567	21,880	82	73.1%
GEORGETOWN COUNTY		TOTAL			255	255		12,583	54,732	213	70.4%
CONWAY HOSPITAL	7	HORRY	CONWAY	NPA	160	210		9,992	37,596	160	64.4%
GRAND STRAND REGIONAL MEDICAL CENTER	8	HORRY	MYRTLE BEACH	PROP	219	269		12,655	57,232	219	71.6%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105		4,146	16,639	105	43.4%
SEACOAST MEDICAL CENTER	9	HORRY	LITTLE RIVER	DIST		50					
HORRY COUNTY		TOTAL			484	634		26,793	111,467	484	63.1%
MARION COUNTY MEDICAL CENTER		MARION	MARION	DIST	124	124		5,732	23,484	124	51.9%
MARION COUNTY		TOTAL			124	124		5,732	23,484	124	51.9%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	94	94		1,549	4,524	94	13.2%
MARLBORO COUNTY		TOTAL			94	94		1,549	4,524	94	13.2%
TUOMEY	10	SUMTER	SUMTER	NPA	283	283		8,597	67,204	248	74.2%
SUMTER COUNTY		TOTAL			283	283		8,597	67,204	248	74.2%
WILLIAMSBURG REGIONAL HOSPITAL		WILLIAMSBURG	KINGSTREE	CO	25	25		818	2,982	25	32.7%
WILLIAMSBURG COUNTY		TOTAL			25	25		818	2,982	25	32.7%
TOTAL					**2,455**	**2,605**		**114,125**	**540,090**	**2,254**	**65.6%**
LONG TERM ACUTE HOSPITALS:											
REGENCY HOSPITAL OF SOUTH CAROLINA	4	FLORENCE	FLORENCE	PROP	40	40		331	9,275	28	90.8%
TOTAL					**40**	**40**	**0 0**	**331**	**9,275**	**28**	**90.8%**
MENTAL FACILITIES:											
MCLEOD MEDICAL CENTER - DARLINGTON	5	DARLINGTON	DARLINGTON	NPA	23	23		748	5,018	23	59.8%
DARLINGTON COUNTY		TOTAL			23	23		748	5,018	23	59.8%
CAROLINAS HOSP SYS - CEDAR TOWERS	11	FLORENCE	FLORENCE	PROP	12	12					
FLORENCE COUNTY		TOTAL			12	12		0	0	0	
LIGHTHOUSE CARE CENTER OF CONWAY	12	HORRY	CONWAY	PROP	44	44		437	3,074	28	30.1%
HORRY COUNTY		TOTAL			44	44		437	3,074	28	30.1%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8		147	1,238	8	42.4%
MARLBORO COUNTY		TOTAL			8	8		147	1,238	8	42.4%
TOTAL					**87**	**87**		**1,332**	**9,330**	**59**	**43.3%**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
PALMETTO PEE DEE RESID TREATMENT CTR		FLORENCE	FLORENCE	PROP	59	59		55	21,335	59	99.1%
LIGHTHOUSE CARE CENTER OF CONWAY		HORRY	CONWAY	PROP	16	16		9	3,152	16	54.0%
TOTAL					75	75		64	24,487	75	89.5%
DRUG AND ALCOHOL INPATIENT TREATMENT:											
CAROLINAS HOSP SYS - CEDAR TOWERS	4	FLORENCE	FLORENCE	PROP	12	12		407	2,137	22	26.6%
LIGHTHOUSE CARE CENTER OF CONWAY	12	HORRY	CONWAY	PROP	8	8					
TOTAL					20	20		407	2,137	22	26.6%
REHABILITATION FACILITIES:											
CAROLINAS HOSP SYS - CEDAR TOWERS		FLORENCE	FLORENCE	NPA	42	42		810	11,368	42	74.2%
HEALTHSOUTH REHAB HOSPITAL FLORENCE		FLORENCE	FLORENCE	PROP	88	88		1,297	20,418	88	63.6%
FLORENCE COUNTY		TOTAL			130	130		2,107	31,786	130	67.0%
WACCAMAW COMMUNITY HOSPITAL	6	GEORGETOWN	MURRELLS INLET	NPA	43	43		817	9,326	29	88.1%
GEORGETOWN COUNTY		TOTAL			43	43		817	9,326	29	88.1%
TOTAL					173	173		2,924	41,112	159	70.8%
INPATIENT HOSPICE FACILITIES:											
MCLEOD HOSPICE HOUSE	13	FLORENCE	FLORENCE	NPA	12	12		417	2,871	12	65.5%
TIDELANDS COMMUNITY HOSPICE HOUSE	14	GEORGETOWN	GEORGETOWN	NPA	12	12					
AGAPE HOSPICE HOUSE OF HORRY COUNTY	15	HORRY	CONWAY	PROP		24					
(HOSPICE OF MARLBORO COUNTY)	16	MARLBORO	BENNETTSVILLE	NPA	(10)	(10)					
TOTAL					24	48		417	2,871	12	65.5%
LONG TERM FACILITIES:											
CHERAW HEALTHCARE	17	CHESTERFIELD	CHERAW	PROP	117	117		38	35,522	100	97.3%
CHESTERFIELD CONVALESCENT CENTER		CHESTERFIELD	CHERAW	PROP	104	104		32	37,563	104	99.0%
CHESTERFIELD COUNTY		TOTAL			221	221		70	73,085	204	98.2%
LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88		52	27,007	88	84.1%
WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	26 cd	22	22,596	64	96.7%
CLARENDON COUNTY		TOTAL			152	131	26	74	49,603	152	89.4%
BETHEA BAPTIST HEALTH CARE CENTER		DARLINGTON	DARLINGTON	NPA	36	36		39	6,786	36	51.6%
(BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	(52)	(52)					
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88		33	31,393	88	97.7%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154		176	53,758	154	95.6%
OAKHAVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88		31	31,648	88	98.5%
DARLINGTON COUNTY		TOTAL			366	366		279	123,585	366	92.5%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84		72	29,639	84	96.7%
SUNNY ACRES		DILLON	FORK	PROP	111	106	58 cd	41	38,902	111	96.0%
DILLON COUNTY		TOTAL			195	190	58	113	68,541	195	96.3%
CAROLINAS HOSP SYS TRANS CARE UNIT	4	FLORENCE	FLORENCE	PROP	24	24		346	4,632	26	48.8%
COMMANDER NURSING CENTER		FLORENCE	FLORENCE	PROP	163	152		88	58,751	163	98.7%
COOKE ASSOCIATES OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88	44 d	67	28,799	88	89.7%
FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	93		92	35,545	104	93.6%

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132		88	47,582	132	98.8%
HONORAGE NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88		70	31,284	88	97.4%
LAKE CITY - SCRANTON HEALTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88		283	28,634	88	89.1%
SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	(42) cd	51	31,406	88	97.8%
FLORENCE COUNTY		TOTAL			775	753	44	1,085	266,633	777	94.0%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84		28	30,096	84	98.2%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	17	17		152	4,768	17	76.8%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLAND)	(PROP	(7)	(7)					
PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148		133	53,599	148	99.2%
GEORGETOWN COUNTY		TOTAL			249	249		313	88,463	249	97.3%
AGAPE REHABILITATION CTR CONWAY	18	HORRY	CONWAY	PROP	0	72					
BRIGHTWATER SKILLED NURSING CENTER	19	HORRY	MYRTLE BEACH	PROP	0	32					
CONWAY MANOR		HORRY	CONWAY	PROP	190	190		256	66,275	190	95.6%
COVENANT TOWERS HEALTH CARE		HORRY	MYRTLE BEACH	PROP	30	30		165	8,365	30	76.4%
GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88		130	31,718	88	98.7%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88		362	29,957	88	93.3%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88		180	29,540	88	92.0%
MYRTLE BEACH MANOR		HORRY	MYRTLE BEACH	PROP	104	104		441	30,792	104	81.1%
NHC HEALTHCARE - GARDEN CITY	20	HORRY	MYRTLE BEACH	PROP	148	148		306	31,088	88	96.8%
HORRY COUNTY		TOTAL			736	840		1,840	227,735	676	92.3%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120		102	43,075	120	98.3%
LEE COUNTY		TOTAL			120	120		102	43,075	120	98.3%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	1 c	53	30,797	88	95.9%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92		24	33,444	92	99.6%
MARION COUNTY		TOTAL			180	180	1	77	64,241	180	97.8%
DUNDEE MANOR		MARLBORO	BENNETTSVILLE	PROP	110	110	(24) (a)	78	38,455	110	95.8%
MARLBORO COUNTY		TOTAL			110	110		78	38,455	110	95.8%
HOPEWELL HEALTH CARE CENTER		SUMTER	SUMTER	PROP	96	96	(48) cd	59	32,898	96	93.9%
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138		91	47,951	138	95.2%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176		177	61,240	176	95.3%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18		445	4,579	18	69.7%
SUMTER COUNTY		TOTAL			428	428	0	772	146,668	428	93.9%
DR. RONALD E. MCNAIR NURSING & REHAB		WILLIAMSBURG	CADES	PROP	88	88		87	29,740	88	92.6%
KINGSTREE NURSING FACILITY	21	WILLIAMSBURG	KINGSTREE	PROP	96	96		55	29,264	96	83.5%
WILLIAMSBURG COUNTY		TOTAL			184	184	0	142	59,004	184	87.9%
TOTAL					3,716	3,772	129	4,945	1,249,088	3,641	94.0%

FOOTNOTES — 2008 PLAN

REGION III

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	TJC Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 7/30/04 to add 50 general beds for a total of 166 general beds, SC-04-41. CON voided 2/5/07.
2. Formerly Wilson Medical Center.
3. Name changed from St. Eugene Medical Center.
4. CON issued for construction of a 4-floor addition with 98 observation beds with no change of licensed capacity, 2/20/04 SC-04-10. CON issued 5/11/05 to add 48 additional beds for a total of 310, SC-05-35. Licensed beds increased from 262 to 274 on 6/28/05. Licensed beds increased to 310 on 7/13/06. CON issued 9/15/06 to convert 4 detox beds, 6 inpatient substance abuse beds and 2 nursing home beds to general acute hospital beds and then lease these 12 beds to Regency Hospital as LTACH beds. The resulting capacity will be 12 inpatient substance abuse beds, 42 rehab beds and 24 nursing home beds at CHS-Cedar Tower and 40 LTACH beds at Regency. SC-06-59. CON issued 1/11/07 pursuant to an ALJ Consent Order of Dismissal to create a 14 bed geriatric crisis stabilization center at Carolinas Hospital System Cedar Tower by converting 12 general acute beds from Carolinas Hospital System to psychiatric beds and adding 2 psych beds, SC-07-01. This CON was voided and replaced by SC-07-05 on 2/14/07, which authorized the renovation of space for the addition of 14 geriatric crisis stabilization (psychiatric) beds. The final result will be 310 general beds at Carolinas Hospital System and 12 inpatient substance abuse beds, 42 rehab beds, 24 nursing home beds and 14 psychiatric beds at CHS Cedar Tower. On April 25 2007, 12 of the 14 approved psych beds were licensed. Regency was licensed for 40 beds on 8/8/07 and CHS-Cedar Tower was licensed for 12 inpatient substance abuse beds, 42 rehab beds, 12 psych beds and 24 nursing home beds.
5. CON issued for 105 new general beds to increase from 336 to 441 general beds 9/22/03 SC-03-53. CON issued to convert 12 psych beds to general for 453 general & transfer 23 psych beds to Wilson Med Center [now McLeod Med. Ctr. Darlington] 1/20/04 SC-04-04. McLeod Regional licensed for 348 general beds 6/14/04. McLeod Med. Ctr. Darlington licensed for 23 psych beds 8/18/05 and the 23 psych beds at McLeod Regional were de-licensed at the same time. McLeod Regional licensed for 453 general beds on 1/3/07.
6. CON issued to establish a 10 bed rehab unit at Georgetown by adding 5 new beds and transferring 5 rehab beds from Waccamaw, for a total licensed capacity of 82 acute beds and 24 rehab beds at WCH and 131 acute beds and 10 rehab beds at GMH, 8/19/04 SC-04-44. CON voided 8/21/06. CON issued 10/24/05 to add 9 rehab beds at Waccamaw and to transfer 4 general acute beds from WCH to GMH, resulting in a total of 78 general and 33 rehab beds at Waccamaw and 135 general and 10 rehab beds at Georgetown, SC-05-76. CON voided on 4/25/06. CON issued 6/15/07 for Waccamaw to add 42 general beds

and 14 rehab beds, for a total of 124 general and 43 rehab beds, SC-07-22. Waccamaw licensed for 124 general and 43 rehab beds, 8/15/08.

7. CON issued 2/1/06 to add 50 general beds for a total of 210 general beds, SC-06-04.
8. CON approved 9/4/07 to add 50 general acute beds for a total of 269.
9. CON approved 8/29/05 to establish a hospital with 50 general acute beds; appealed. CON issued per ALJ Order 9/28/07, SC-07-47.
10. CON approved 4/26/05 to add 35 additional beds for a total of 283; appealed. Per ALJ Order of Dismissal, CON was issued 8/3/05, SC-05-55. On 6/28/07, 11 additional beds were licensed for a total of 259. The remaining 24 additional beds were licensed 8/23/07 for a total of 283.
11. CON approved 2/24/06 for 24 crisis-stabilization psychiatric beds. Appealed. CON issued 1/11/07 pursuant to an ALJ Consent Order of Dismissal to create a 14 bed geriatric crisis stabilization center at Carolinas Hospital System Cedar Tower by converting 12 general acute beds from Carolinas Hospital System to psychiatric beds and adding 2 psych beds, SC-07-01. This CON was voided and replaced by SC-07-05 on 2/14/07, which authorized the renovation of space for the addition of 14 geriatric crisis stabilization (psychiatric) beds. The final result will be 310 general beds at Carolinas Hospital System and 12 inpatient substance abuse beds, 42 rehab beds, 24 nursing home beds and 14 psychiatric beds at CHS-Cedar Tower. On 4/25/07, 12 of the 14 approved psych beds were licensed. CHS-Cedar Tower licensed for 12 inpatient substance abuse beds, 42 rehab beds, 24 nursing home beds and 12 psychiatric beds on 8/8/07. Carolinas voided the remaining 2 approved crisis-stabilization beds on 7/9/08.
12. CON issued 7/25/06 to add 16 psych beds and 8 substance abuse beds for a total of 44 psych, 8 substance abuse, and 16 RTF beds, SC-06-43. The additional 16 psych beds and 8 substance abuse beds were licensed on 5/24/07.
13. CON issued for 12-bed inpatient hospice, 1/27/04 SC-04-08. Licensed 9/19/05.
14. CON issued 3/21/05 for a 12-bed inpatient hospice facility. Licensed 2/26/07.
15. CON issued 3/5/07 for a 24-bed inpatient hospice, SC-07-08.
16. CON issued for 10 bed inpatient hospice 1/20/04 SC-04-06. CON voided 6/24/06.
17. CON approved 6/26/07 to construct a replacement facility and add 17 beds that do not participate in the Medicaid program for a 117 bed nursing home. New facility licensed for 117 beds 5/1/08.
18. CON issued 3/5/07 for a 72-bed nursing home that does not participate in the Medicaid program/ SC-07-07.
19. CON issued 5/9/08 for a 32-bed nursing home that does not participate in the Medicaid program, SC-08-15.
20. CON issued 4/19/05 for 60 additional nursing home beds not participating in the Medicaid program, for a total of 148 beds, SC-05-23. Licensed for 148 beds 12/21/06.
21. CON issued 6/28/06 to add 8 non-Medicaid nursing home beds for a total of 96 beds, SC-06-32; licensed for 96 beds 8/3/06.

INVENTORY OF EMERGENCY FACILITIES — 2006 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2006 ER VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GENERAL HOSPITAL	CHESTERFIELD	CHERAW	13,472
III	CLARENDON MEMORIAL HOSPITAL	CLARENDON	MANNING	18,664
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE	31,127
III	MCLEOD - DILLON (ST EUGENE)	DILLON	DILLON	23,471
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE	37,629
II	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE	57,813
III	LAKE CITY COMMUNITY HOSPITAL	FLORENCE	LAKE CITY	18,918
II	GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	GEORGETOWN	27,949
II	WACCAMAW COMMUNITY HOSPITAL	GEORGETOWN	MURRELLS INLET	21,928
II	CONWAY HOSPITAL	HORRY	CONWAY	40,604
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS	38,238
II	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH	66,991
III	MARION COUNTY MEDICAL CENTER	MARION	MARION	22,481
III	MARLBORO PARK HOSPITAL	MARLBORO	BENNETTSVILLE	14,174
II	TUOMEY	SUMTER	SUMTER	52,074
III	WILLIAMSBURG REGIONAL	WILLIAMSBURG	KINGSTREE	12,262
			TOTAL	497,795

CATEGORY	NAME OF FACILITY	COUNTY	CITY
REGION III:	TRAUMA CENTERS		
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE
III	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE
III	CONWAY HOSPITAL	HORRY	CONWAY
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS
III	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH

REGION NARRATIVE

REGION: IV FISCAL YEAR: 2006

1. Unusual Characteristics: This region has a military presence in Charleston. A naval hospital provides health care services for the active duty and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with naval hospital to provide care to the active duty and dependents. The sea islands, rivers and sounds are barriers to transportation.

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

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

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. The William J. McCord Adolescent Treatment Center in Orangeburg County serves adolescents exclusively from throughout the state.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: IV — **INPATIENT INVENTORY** — **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY NONCON BEDS FORMING	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	8,752	42,438	183	63.5%
AIKEN COUNTY		TOTAL			183	183	8,752	42,438	183	63.5%
ALLENDALE COUNTY HOSPITAL		ALLENDALE	FAIRFAX	CO	25	25	322	1,497	25	16.4%
ALLENDALE COUNTY HOSPITAL		TOTAL			25	25	322	1,497	25	16.4%
BAMBERG COUNTY MEMORIAL	1	BAMBERG	BAMBERG	CO	59	59	1,510	5,809	59	27.0%
BAMBERG COUNTY		TOTAL			59	59	1,510	5,809	59	27.0%
BARNWELL COUNTY HOSPITAL		BARNWELL	BARNWELL	CO	53	53	1,093	3,375	53	17.4%
BARNWELL COUNTY		TOTAL			53	53	1,093	3,375	53	17.4%
BEAUFORT COUNTY MEMORIAL	2	BEAUFORT	BEAUFORT	CO	169	169	10,045	44,765	169	72.6%
HILTON HEAD HOSPITAL		BEAUFORT	HILTON HEAD	NPA	93	93	4,301	17,518	93	51.6%
NAVAL HOSPITAL	3	BEAUFORT	BEAUFORT	FED		(64)	(1438)	(4,325)		
BEAUFORT COUNTY		TOTAL			262	262	14,346	62,283	262	65.1%
BON-SECOURS ST. FRANCIS XAVIER	4	CHARLESTON	CHARLESTON	NPA	204	204	9,516	41,163	142.6	79.1%
CHARLESTON MEMORIAL HOSPITAL	5	CHARLESTON	CHARLESTON	CO	20	(98)	133	4,349	98	12.2%
EAST COOPER REGIONAL MEDICAL CENTER	6	CHARLESTON	MT PLEASANT	PROP	100	140	5,208	19,404	100	53.2%
MEDICAL UNIVERSITY HOSPITAL	5	CHARLESTON	CHARLESTON	ST	584	604	25,300	129,606	466	76.2%
ROPER HOSPITAL	4	CHARLESTON	CHARLESTON	NPA	401	316	10,526	87,576	414	58.0%
ROPER ST. FRANCIS MOUNT PLEASANT HOSP	4	CHARLESTON	MT PLEASANT	NPA		85				
TRIDENT MEDICAL CENTER	7	CHARLESTON	CHARLESTON	PROP	296	296	16,164	77,477	271	78.3%
RALPH H JOHNSON VETERANS MEDICAL CTR	3	CHARLESTON	CHARLESTON	FED		(144)	(3,434)	(22,392)		
CHARLESTON COUNTY		TOTAL			1,605	1,645	66,847	359,575	1,492	66.0%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	5,250	27,335	131	57.2%
COLLETON COUNTY		TOTAL			131	131	5,250	27,335	131	57.2%
SUMMERVILLE MEDICAL CENTER	8	DORCHESTER	SUMMERVILLE	PROP	94	94	5,834	24,130	94	70.3%
DORCHESTER COUNTY		TOTAL			94	94	5,834	24,130	94	70.3%
HAMPTON REGIONAL MEDICAL CENTER	9	HAMPTON	VARNVILLE	CO	32	32	1,097	3,832	68	15.4%
HAMPTON COUNTY		TOTAL			32	32	1,097	3,832	68	15.4%
COASTAL CAROLINA HOSPITAL		JASPER	HARDEEVILLE	PROP	31	31	1,257	4,873	31	43.1%
JASPER COUNTY		TOTAL			31	31	1,257	4,873	31	43.1%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	10,866	55,045	247	61.1%
ORANGEBURG COUNTY		TOTAL			247	247	10,866	55,045	247	61.1%
TOTAL					**2,722**	**2,762**	**117,174**	**590,192**	**2,644.6**	**61.1%**
LONG TERM ACUTE HOSPITALS:										
(SAVANNAH RIVER SPECIALTY HOSPITAL)	10	AIKEN	AIKEN	PROP		(34)				
KINDRED HOSPITAL - CHARLESTON		CHARLESTON	CHARLESTON	PROP	59	59	327	10,630	59	49.4%
TOTAL					**59**	**59**	**327**	**10,630**	**59**	**49.4%**
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	29	29	1,282	9,714	29	91.8%
AIKEN COUNTY		TOTAL			29	29	1,282	9,714	29	91.8%
BEAUFORT MEMORIAL HOSPITAL	2	BEAUFORT	BEAUFORT	CO	14	14	484	3,147	14	61.6%
BEAUFORT COUNTY		TOTAL			14	14	484	3,147	14	61.6%
CHARLESTON MEMORIAL HOSPITAL	5	CHARLESTON	CHARLESTON	CO	0	(15)	0	0	15	0.0%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,636	21,184	82	70.8%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH	11	CHARLESTON	CHARLESTON	PROP	70	70	2,254	16,046	60	73.3%
RALPH H JOHNSON VETERANS MEDICAL CTR		CHARLESTON	CHARLESTON	FED		(36)	(569)	(4,420)		
CHARLESTON COUNTY		TOTAL			152	152	4,890	37,230	157	65.0%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15	336	2,967	15	54.2%
ORANGEBURG COUNTY		TOTAL			15	15	336	2,967	15	54.2%

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
TOTAL					210	210		6,992	53,058	215	67.6%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:											
PALMETTO PINES BEHAVIORAL HEALTH	12	SUMMERVILLE	DORCHESTER	PROP	60	60		33	16,636	60	76.0%
PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32		62	9,872	32	84.5%
TOTAL					92	92		95	26,508	92	78.9%
DRUG AND ALCOHOL INPATIENT TREATMENT:											
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18		372	1,889	18	28.8%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10		371	2,236	10	61.3%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23		793	4,396	23	52.4%
TOTAL					51	51		1,536	8,521	51	45.8%
REHABILITATION FACILITIES:											
BEAUFORT MEMORIAL HOSPITAL	2	BEAUFORT	BEAUFORT	CO	14	14		336	4,082	14	79.9%
BEAUFORT COUNTY		TOTAL			14	14		336	4,082	14	79.9%
ROPER HOSPITAL	13	CHARLESTON	CHARLESTON	NPA	39	52		964	11,803	39	82.9%
MEDICAL UNIVERSITY HOSPITAL	5	CHARLESTON	CHARLESTON	ST	(0)	(0)					
HEALTHSOUTH CHARLESTON		CHARLESTON	CHARLESTON	PROP	46	46		879	12,679	46	75.5%
CHARLESTON COUNTY		TOTAL			85	98		1,843	24,482	85	78.9%
COASTAL CAROLINA HOSPITAL		JASPER	HARDEEVILLE	PROP	10	10		129	1,556	10	42.6%
JASPER COUNTY		TOTAL			10	10		129	1,556	10	42.6%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	24	24		479	5,651	24	64.5%
ORANGEBURG COUNTY		TOTAL			24	24		479	5,651	24	64.5%
TOTAL					133	146		2,787	35,771	133	73.7%
INPATIENT HOSPICE FACILITIES:											
(LOWCOUNTRY HOSPICE HOUSE)	14	BEAUFORT	HILTON HEAD	NPA	(15)	(15)					
THE HOSPICE OF CHARLESTON	15	CHARLESTON	CHARLESTON	NPA	20	20		127	1,583	12.9	33.6%
TOTAL					20	20		127	1,583	12.9	33.6%
LONG TERM FACILITIES:											
AZALEA WOODS		AIKEN	AIKEN	PROP	86	86		24	25,845	86	82.3%
CARRIAGE HILLS LIVING CENTER		AIKEN	AIKEN	PROP	60	60		368	20,368	60	93.0%
HERITAGE HEALTHCARE AT MATTIE HALL		AIKEN	AIKEN	PROP	176	176		189	58,244	176	90.7%
NHC HEALTHCARE NORTH AUGUSTA	16	AIKEN	N. AUGUSTA	PROP	192	192		166	46,988	132	97.5%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	132		213	44,590	132	92.5%
SAVANNAH RIVER SPECIALTY HOSPITAL	10	AIKEN	AIKEN	PROP	(0)	(0)					
UNIHEALTH POST-ACUTE - NORTH AUGUSTA	17	AIKEN	N. AUGUSTA	PROP	132	132		138	45,478	125	99.7%
AIKEN COUNTY		TOTAL			778	778		1,098	241,513	711	93.1%
JOHN E HARTER NURSING HOME		ALLENDALE	FAIRFAX	CO	44	44		35	14,315	44	89.1%
ALLENDALE COUNTY		TOTAL			44	44		35	14,315	44	89.1%
BAMBERG COUNTY MEMORIAL NURSING CTR		BAMBERG	BAMBERG	CO	88	88		66	31,435	88	97.9%
BAMBERG COUNTY		TOTAL			88	88		66	31,435	88	97.9%
BARNWELL COUNTY NURSING HOME	18	BARNWELL	BARNWELL	CO	44	44		27	15,226	44	94.8%
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	85 a	38	29,578	85	95.3%
LAUREL BAYE HEALTHCARE OF WILLISTON		BARNWELL	WILLISTON	PROP	44	44		66	15,298	44	95.3%
BARNWELL COUNTY		TOTAL			173	173	85	131	60,102	173	95.2%
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170		167	58,049	170	93.6%
BROAD CREEK	19	BEAUFORT	HILTON HEAD	PROP	25	25		85	5,454	25	59.8%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88		212	30,704	88	95.6%

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2006**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	NONCON FORMING	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19		58	5,258	19	75.8%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)					
NHC BLUFFTON	20	BEAUFORT	BLUFTON	PROP		120					
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69		114	13,957	69	55.4%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)					
BEAUFORT COUNTY		TOTAL			371	491		636	113,422	371	83.8%
HEARTLAND HEALTH CARE CTR - CHARLESTON		BERKELEY	HANAHAN	PROP	105	105		317	31,588	105	82.4%
LAKE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88		47	30,643	88	95.4%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132		63	45,165	132	93.7%
BERKELEY COUNTY		TOTAL			325	325		427	107,396	325	90.5%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120		91	42,563	120	97.2%
CALHOUN COUNTY		TOTAL			120	120		91	42,563	120	97.2%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41		62	13,277	41	88.7%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)					
DRIFTWOOD REHAB. & NURSING CENTER		CHARLESTON	CHARLESTON	PROP	160	160		308	55,667	160	95.3%
FRANKE HEALTH CARE CENTER		CHARLESTON	CHARLESTON	NPA	24	24		33	8,349	24	95.3%
(FRANKE NURSING HOME)		CHARLESTON	CHARLESTON	NPA	(20)	(20)					
GRACE HALL - REHABILITATION		CHARLESTON	MT. PLEASANT	PROP	42	42		63	12,120	42	79.1%
HEARTHLAND WEST ASHLEY REHAB & NURS		CHARLESTON	CHARLESTON	NPA	99	99		138	32,462	99	89.8%
ISLAND OAKS LIVING CENTER	21	CHARLESTON	CHARLESTON	NPA	132	132		176	46,490	132	96.5%
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148		499	52,146	148	96.5%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132		144	43,505	132	90.3%
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176		327	61,220	176	95.3%
(TRIDENT SKILLED NURSING CENTER)	7	CHARLESTON	CHARLESTON	PROP	(0)	(0)		550	5,508	25	60.4%
TRINITY MISSION HEALTH & REHAB CHARLESTON		CHARLESTON	CHARLESTON	PROP	132	132					
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176		85	62,307	176	97.0%
CHARLESTON COUNTY		TOTAL			1,262	1,262		2,385	393,051	1,155	93.2%
HERITAGE HEALTHCARE OF WALTERBORO		COLLETON	WALTERBORO	PROP	132	132		146	45,032	132	93.5%
COLLETON COUNTY		TOTAL			132	132		146	45,032	132	93.5%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88		90	26,912	88	83.8%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88		85	31,130	88	96.9%
PRESBYTERIAN HOME SUMMERVILLE	22	DORCHESTER	SUMMERVILLE	NPA	87	87		1,193	16,398		
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88		89	30,524	88	95.0%
SUMMERVILLE MED - SKILLED NURSING CARE	8	DORCHESTER	SUMMERVILLE	PROP	0	0					
DORCHESTER COUNTY		TOTAL			351	351		1,457	104,964	264	108.9%
UNIHEALTH POST-ACUTE CARE LOW COUNTRY	23	HAMPTON	ESTILL	CO	104	104		88	33,322	104	87.8%
HAMPTON COUNTY		TOTAL			104	104		88	33,322	104	87.8%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88		64	30,997	88	96.5%
JASPER COUNTY		TOTAL			88	88		64	30,997	88	96.5%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113		336	38,996	113	94.5%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60		135	20,840	60	95.2%
ORANGEBURG NURSING HOME		ORANGEBURG	ORANGEBURG	PROP	88	88		71	31,224	88	97.2%
THE METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132		229	40,244	132	83.5%
ORANGEBURG COUNTY		TOTAL			393	393		771	131,304	393	91.5%
TOTAL					**4,229**	**4,349**	**85**	**6,297**	**1,107,903**	**3,257**	**93.2%**

REGION IV

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	TJC Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON approved 10/24/06 to construct a replacement hospital; appealed. CON issued after ALJ Order to Dismiss 9/14/07, SC-07-36.
2. Approved for 65 additional general beds by converting 6 psych, 18 nursing home, 14 rehab & conversion of 27 private to semi-private for 195 general & 14 psych beds 6/8/04 SC-04-29. Transitional Care Unit (18 beds closed), 5 new general beds licensed for a total of 153 general beds, 20 psychiatric beds & 14 rehabilitation beds, 7/28/04. On 3/4/05 2 additional general beds were licensed. The 6 psych beds were converted to general beds and 8 additional general beds were licensed on 4/7/05 for a total of 169 general beds, 14 psych and 14 rehab beds. The remainder of the CON was voided on 8/8/06 and the hospital remains as currently licensed.
3. Bed use restricted.
4. CON issued 6/24/05 to construct 50 additional beds at St. Francis Xavier and transfer 13 beds from Roper Hospital, for a total of 204 general acute beds at St. Francis Xavier and 401 general beds at Roper Hospital, SC-05-43. On 1/31/06, 3 additional general beds were licensed at St. Francis Xavier for a total of 144 general beds. CON issued 5/31/06 to construct a new hospital in Mount Pleasant by transferring 85 acute beds from Roper Hospital, SC-06-27. The approval requires that the applicant not commence construction on the project until 2 years (24 months) from the date of issuance of the CON. The number of licensed beds at St. Francis Xavier increased from 144 to 168 2/20/08. Of these 24 additional beds, 13 were transferred from Roper and 11 were new beds. Roper license decreased from 414 to 401 general acute beds 2/20/08. St. Francis Xavier licensed for 204 general acute beds 5/8/08.
5. CON issued to replace and consolidate Charleston Memorial with Medical University by adding 138 beds (98 from Charleston Memorial, 15 from psych beds, 25 from conversion of rehab beds) for a total of 604 general beds 82 psych & 23 D&A beds, SC-03-60 10/14/03. On 1/30/08, 78 general and 15 psych beds were transferred from Charleston Memorial to MUSC and the 25 rehab beds at MUSC were converted to general acute beds. Charleston Memorial is now licensed for 20 acute care beds. MUSC is licensed for 584 acute care beds, 82 psych beds, and 23 substance abuse beds.
6. CON issued 5/31/06 to construct a replacement hospital with 40 additional beds for a total of 140 acute beds, SC-06-26.
7. CON issued 11/27/07 to convert the 25 nursing home beds in the Skilled Nursing Center to general acute beds for a total capacity of 296 general acute beds, SC-07-61. Licensed for 296 acute beds and the Trident Medical Skilled Nursing Center closed on 5/1/08.
8. CON issued 6/24/05 to convert the 14 nursing home beds at Summerville Medical Center to general acute beds, for a total of 94 general acute beds, SC-05-42. The nursing home was closed and the hospital was licensed for 94 general acute beds as of 8/11/05.
9. CON issued 10/20/05 to construct a replacement hospital with a reduced bed capacity from 68 to 32 beds, SC-05-74. New facility licensed 7/15/08.

10. CON issued 4/12/07 to construct an LTCH with 34 LTCH and 6 nursing home beds that does not participate in the Medicaid program, SC-07-13. CON voided 4/15/08.
11. CON issued 10/20/04 to add 10 additional psych beds for a total of 70. SC-04-52. Licensed for 70 psych beds 3/25/08.
12. Name changed from New Hope Charleston to The Pines Residential Treatment Facility – Charleston Campus. Name changed to Palmetto Pines Behavioral Health 2/26/07.
13. CON approved 10/16/07 to add 13 rehabilitation beds for a total of 52; appealed. Case dismissed by ALJ Order 8/29/08.
14. CON issued 2/24/06 to establish a 15-bed inpatient hospice, SC-06-09. CON voided 8/9/07.
15. CON issued for 20 bed inpatient Hospice SC-03-51 9/12/03. Licensed 5/9/06.
16. CON issued 9/14/06 for 60 additional non-Medicaid beds for a total of 192 nursing home beds, SC-06-56. Licensed for 192 beds 6/26/08.
17. Formerly Anne Maria Rehabilitation and Nursing Center.
18. CON issued 8/16/05 to add 4 nursing home beds that do not participate in the Medicaid Program for a total of 44 beds, SC-05-58. Licensed for 44 beds on 9/14/05.
19. Decreased license from 44 to 25 beds effective 2/1/05.
20. CON issued 3/28/07 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-07-11.
21. Name changed from Charleston Nursing Center, and 6 additional beds approved for a total of 132, 5/6/05 SC-05-30. On 8/11/05, 4 of the 6 approved additional beds were licensed, for a total of 130. An additional bed, for a total of 131, was licensed on 9/6/05. The final additional bed was licensed on 9/15/05.
22. CON issued 2/14/08 to convert the 87 institutional nursing home beds to 87 general nursing home beds that do not participate in the Medicaid program, SC-08-09. License classification changed 2/14/08.
23. Formerly Heritage Healthcare of the Low Country.

INVENTORY OF EMERGENCY FACILITIES 2006 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2006 ER VISITS
REGION IV:	EMERGENCY FACILITIES			
II	AIKEN REGIONAL MEDICAL CTR	AIKEN	AIKEN	46,192
IV	ALLENDALE COUNTY HOSPITAL	ALLENDALE	FAIRFAX	9,006
III	BAMBERG CO MEMORIAL HOSPITAL	BAMBERG	BAMBERG	11,146
III	BARNWELL COUNTY HOSPITAL	BARNWELL	BARNWELL	12,482
III	BEAUFORT CO MEMORIAL HOSPITAL	BEAUFORT	BEAUFORT	34,767
II	HILTON HEAD HOSPITAL	BEAUFORT	HILTON HEAD	20,261
II	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON	37,720
II	CHARLESTON MEMORIAL HOSPITAL	CHARLESTON	CHARLESTON	12,377
II	EAST COOPER REGIONAL MED CTR	CHARLESTON	MT PLEASANT	18,163
(*)	MUSC MEDICAL CENTER	CHARLESTON	CHARLESTON	50,427
II	ROPER HOSPITAL	CHARLESTON	CHARLESTON	68,556
II	TRIDENT MEDICAL CENTER	CHARLESTON	CHARLESTON	57,745
III	COLLETON MEDICAL CENTER	COLLETON	WALTERBORO	19,945
II	SUMMERVILLE MEDICAL CENTER	DORCHESTER	SUMMERVILLE	35,252
III	HAMPTON REGIONAL MEDICAL CENTER	HAMPTON	VARNVILLE	9,167
III	COASTAL CAROLINA MEDICAL CENTER	JASPER	RIDGELAND	14,980
II	REG MED CTR ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG	50,222
			TOTAL	508,408

(*) Met insufficient criteria to be classified.

CATEGORY	NAME OF FACILITY	COUNTY	CITY
REGION IV:	TRAUMA CENTERS		
III	BEAUFORT CO MEMORIAL HOSPITAL	BEAUFORT	BEAUFORT
I	MUSC MEDICAL CENTER	CHARLESTON	CHARLESTON
III	ROPER HOSPITAL	CHARLESTON	CHARLESTON
III	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON
III	TRIDENT MEDICAL CENTER	CHARLESTON	CHARLESTON
III	REG MED CTR ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG