All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
The threshold of $600K for medical equipment (total project cost) is too low and has not been updated in over 20 years. $600,000 new equipment threshold is too low The threshold of $600K for medical equipment (total project cost) is too low	Increase the threshold and index to medical inflation Raise threshold from $600,000 to $750,000 Raise threshold from $600,00 to $1 million Eliminate $ threshold and instead focus on the category of equipment being purchased or leased and for which standards are included in the State Health Plan	*Requires statutory change to eliminate threshold* *Requires regulatory change to change threshold*	According to a DHEC attorney this threshold is most litigated area of CON *No info. given on whether this is a current situation or past history. Staff does not believe this is the case anymore.*	1, 3
Capital projects have too low a threshold requirement Capital threshold of $2 million is too low.	Raise to $5,000,000 for urban and $2,500,000 for rural Raise capital threshold to $3 million Raise capital threshold to $4 million Raise capital threshold to $5 million and relate only to capital associated with patient care activities or increase in square		Alternative: index thresholds for healthcare inflation index	1, 3

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	footage. Require capital threshold only for expenditures associated with direct patient care areas or increase in square footage. Expand list in 44-7-140 (B)(1) for things which do not require CON review. Get clearer statement from DHEC that new regulation only requires notification, not written exemption. Healthcare facility expenditures in excess of $2M – either raise $ or delete CON review Eliminate capital threshold for areas which otherwise do not require a certificate of need. Require capital threshold only for expenditures associated with patient care activities or increase in square footage.			

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
"Total project cost" definition needs to be reworked. Definition of Total Project Cost has not been applied uniformly in the past to all applicants.	A process needs to be created to ensure the definition is interpreted and applied consistently to all categories Provide resources to DHEC to hire an accountant for CON review.	A process needs to be created to ensure the definition is interpreted and applied consistently to all categories Provide resources to DHEC to hire an accountant for CON review. Regarding projects related to hospital-based services in leased spaces, the land/building value calculation to be included in the total project cost should be accepted in the form of the most recent tax statement or a limited appraisal. The currently required full appraisal process is too costly and time-consuming.	*Need to clarify what is meant by "carefully re-define so that it can be applied uniformly."* *Limited "desktop" appraisals are acceptable.*	1, 3
Health Plan standards/ criteria should be revised/ enhanced for the following: • Psychiatric beds	Take into account rural vs.	Change to Health Plan needed/Potential change to Licensing standards *Psych beds are based upon Dept of Mental Health's*		1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	urban; possible bed distinction (geriatric, adult, child)	*catchment areas/service by local Mental Health centers.*		
• Rehabilitation beds	Use discharge data to determine need vs. historical utilization	*Unsure what this means.*		
• Neonatal Services	Re-write Level III standards in accordance with current perinatal guidelines and have criteria and requirements for Level III only (RPC would become III-C)	*This requires a change to Licensing regulations.*		
• Emergency PCI	Exemption for hospitals that perform a minimum TBD number of diagnostic caths	*This is not consistent with ACC/AHA guidelines.*		
• Establishment of diagnostic cath service	Make hospital-based diagnostic cardiac cath service exempt from CON review	*The # of diagnostic caths are down. Of 32 facilities with fixed labs, and 2 facilities with mobile labs, only 19 provided the minimum number of caths required for quality purposes. This seems to go against the purpose of CON.*		
• LTACHs	Either eliminate or establish meaningful need-based criteria	*These beds used to be included with the acute care need, but doing so can adversely affect acute care need. No good methodology has been found for need projection. Up to applicant to demonstrate need.*		
• ASFs	Keep; however, incorporate two			

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	additional points: 1) Minimum two rooms for all ASFs 2) Either no CON or abbreviated process to expand	*A minimum of 2 rooms is already required, except for endoscopy.* *Now have separate requirements in the plan for expansion. F&LS and Licensing concerns with expansion.*		
• Freestanding Emergency Services	Either eliminate or establish meaningful criteria	*Have a standard that they must be in the same county as the affiliated hospital.*		
Create more transparency and awareness of healthcare projects. Requirement to place public notice in newspaper prior to submitting application seems antiquated	Publish required notifications about projects on the DHEC website in addition to local newspapers Posting on website could also be required of an applicant when requesting written exemption/NAD from the department. The required public notification for filing of CON applications should occur on the DHEC website, rather than local newspapers. In addition, DHEC should post on the website approval of exemptions and NADs as public notification. This would clarify the notification date to start the window for providers to appeal an exemption or NAD. Provide mechanism to post notice on DHEC website; interested parties can monitor website for such postings or sign up for automated email notification; consider eliminating notice requirement altogether and simply post notice online of applications upon receipt		*Are working on putting more information on web site. Can put weekly update on website of who's applied and who has been approved for exemptions and NADs.*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
Affected Person Definition Need change to affected person definition	*Statutory Change required* Create improved definition of "affected parties" to limit who could possibly appeal. Consider narrowing the definition of affected persons to eliminate frivolous opposition to CON projects Current Definition: "'Affected person' means the applicant, a person residing within the geographic area served or to be served by the applicant, persons located in the health service area in which the project is to be located and who provide similar services to the proposed project, persons who before receipt by the department of the proposal being reviewed have formally indicated an intention to provide similar services in the future, persons who pay for health services in the health service area in which the project is to be located and who have notified the department of their interest in Certificate of Need applications, the State Consumer Advocate, and the State Ombudsman. Persons from another state who would otherwise be considered "affected persons" are not included unless that state provides for similar involvement of persons from South Carolina in its certificate of need process." S.C. Code Ann. § 44-7-130(1)(Supp. 2011). Proposed Change: "Affected person" means: a. the applicant, b. a health care facility located in the geographic area served or proposed to be served by the applicant which health care facility provides the same or similar services as those proposed by the applicant; c. a person located in the geographic area served or proposed to be served by the applicant which person provides similar health services as those proposed by the			1, 3

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	applicant; or d. a person, who before receipt by the department of the application being reviewed, has formally indicated to the Department an intention to provide similar services in the future [if batching is adopted: "a person who has timely applied within the batching window to provide similar services"]; and e. a person operating a health care facility or providing a health service in a state other than South Carolina who does not operate a health care facility providing similar services or providing a health service similar to that being sought by the applicant is not deemed to be an affected person. *Note: This change eliminates an individual in the area, such as a consumer of healthcare services, and entities that pay for healthcare (insurance companies).*			
CON review timeline is too long Review process is too lengthy	Create two categories for review--Expedited Review and a Regular Review Create a new category of expedited or "nonsubstantive reviews" that have a shorter application and a shorter timeline for staff review. Reduce DHEC staff review from 120 days to 90 days to streamline the process for regular review. Create new category of "non-substantive review" that is	Need to create a list of projects that fall under expedited review. Need to create criteria for projects to be considered for expedited review if not listed specifically	People will appreciate the shorter applications for small projects and will not mind the longer applications for bigger projects *Will require additional FTEs*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	shorter Create new category of "expedited review" that is shorter Need an expedited review process for specific services that would involve a simpler template for project submission and a shorter review period. Applicable services to this revised standard would be projects that would require CON review solely due to project cost (i.e. OR expansion) but would not qualify for full CON review as the technology is not reviewable per the State Health Plan.			
Project review meeting serves no purpose.	Eliminate project review meeting and create a new process. Provide process for questioning of applicant and for written responses/ submission of briefs	Eliminate project review meeting and create a new process. Provide process for questioning of applicant and for written responses.	Some concern that this meeting would only be replaced by a public hearing.	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
Need greater distinction & clarity for projects which are exempted but still require a written exemption. Streamline the exemption and non-applicability process	Eliminate requirement for written exemption if it is clearly exempted in the law. Create new and more relevant definitions for projects that are exempted in 44-7-170 (B) (1)	Statutory change required Eliminate requirement for written exemption if it is clearly exempted in the law. Set specific cost threshold for projects that would require some form of correspondence with DHEC CON. The present, unwritten rule is that DHEC CON should be notified in writing of projects that exceed $500K in cost.	Cumbersome and can be litigated. *Clarification has been provided in revised regulations.*	1
Replacement equipment should be exempt Confusion/frustration about "replacement of like equipment." This should not require a CON review, but it can be very challenging to prove it is like equipment	Require reporting rather than approval If equipment was approved under CON and is now being replaced, eliminate requirement for filing an exemption request and needing to prove it is "like equipment." If equipment was not approved	Statutory change required The replacement of existing equipment that has previously undergone full CON review should not require any level of CON review. If equipment was not		1, 3

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	under CON and it will cost less than $1 million, eliminate requirement for filing an exemption request. If cost will be greater than $1 million, maintain requirement of filing an exemption request.	approved under CON and it will cost less than $1 million, eliminate requirement for filing an exemption request. If cost will be greater than $1 million, maintain requirement of filing an exemption request.		
Relocation of equipment within service area if upfit costs are less than $1,000,000	Require reporting rather than approval		*Need more info. May be able to do this now as an NAD.*	1, 4
No regulatory deadline for submitting Final Completion Report	Add deadline based on time table	Regulation revision. Section 607.3	*Provide on-line template*	1
No reporting required between implementation and final completion report submission		Regulation revision. Section 607.3	*Issue could possibly be alleviated largely by revision above to Section 607.3 – do not want to create requirements that would be burdensome on staff or regulated community*	1
Need clarification re: what constitutes a substantial change	Provide listing of examples and implement by policy	Regulation revision. Add clarification to Section 605	*It would be difficult to create a detailed, all-inclusive list; provide on-line template for reporting*	1
Need clarification re: what constitutes a cost overrun	Provide guidance and implement by policy	Regulation revision. Add clarification to Section 606	*Provide guidance and on-line template for reporting; check other states for what*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
			overage they allow (10%, 15%, etc.)	
Ensure submission of quality info required by revised Section 202.2(B)(27) is not burdensome	Provide guidance, such as use of applicable National Patient Safety Goals	None- provide guidance	*Revised regs will be useful for this*	1
Shift to electronic filing		Regulation change required		1
No specific regulatory implementation reporting deadlines or final completion report requirements for exemption determinations; need to have to way to document projects are underway and complete	Establish reporting deadlines for exemption determinations in regs – currently mentioned in a guidance document; or "beef up" guidance document	Regulation revision. Further revisions to Section 104	*Revised regs, Section 104, reorganized and revised section to ensure compliance with Act 278; See what other states are doing*	1
No specific regulatory implementation reporting deadlines or final completion report requirements for written non-applicability determinations; need to have a way to document projects are underway and complete	Establish reporting deadlines for non-applicability determinations in regs – currently mentioned in a guidance document; or "beef up" guidance document	Further revisions to Section 105	*Revised regs, Section 105, address NAs for the first time in the regs as per Act 278; See what other states are doing*	1
Increase data transparency	Data already collected by SCORS should be publicly available	Produce a limited public data use file similar to the inpatient and outpatient discharge data files available in other CON states. Remove the limitation on hospital identification in custom	*This is an Office of Research and Statistics issue, not DHEC.*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
		data requests.		
State health plan does not always reflect current needs.	Re-do overall plan every two years. Re-do projections of need and add new data once a year.	None	*The plan is redone every two years.* *Projections of need are redone as data is available and posted on DHEC's website.*	1
Bed need methodology should be at county level, not by facility	If need is demonstrated in Health Plan, existing hospitals should be allowed up to 20 beds without CON if they have occupancy level of 75% over last 3 years.	None-an occupancy rate of 75% will result in a projected need. Regardless of number of beds projected as needed, a hospital can add up to 50 beds to allow for an economical unit.	*Concern and options are contradictory*	1
Hospitals should be able to convert existing beds on their main campus to specialty units of psych and rehab beds as needed.	Create an expedited review process and shorter application for bed conversion to provide new psych and rehab beds. Bed conversion would be permitted in main hospital building only. Create new project review criteria to provide for conversion regardless of whether bed need is shown in State Health Plan.			1
Ambulatory Surgery Centers either should have no CON to expand or			*Would need to define abbreviated process.*	1,3,4

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
abbreviated process				
Simplify process for transferring beds to another campus.	Distinguish between transfer to existing facility vs. transfers to create a new facility	Draft changes to next Health Plan explicitly states ability to move beds to new campus.	*Some provision for bed transfer already exists in State Health Plan.*	1
Additional language needed in acute care hospital section	Incorporate the following: 1) New facility to meet service area population need 2) Transfer of existing licensed beds to create a new hospital 3) Complete hospital relocations	Change in Health Plan. See above.		1
There should be no time limit for implementation for NA or exempted projects.	Eliminate timelines for NA and exempted projects.	Eliminate timelines for NA and exempted projects. Due to our internal cash flow and shifting project prioritization, we have at times not been able to implement a project within the six month period. You must void the exemption and reapply.	*Changed to one year in revised regulations – need an end date for implementation.*	1, 3
Acute care hospital bed additions should become less onerous	Add if bed need shown and occupancy rate of licensed beds > "TBD"% (one rate for under 100 beds, one for over 100 beds) for two most recent years, then can add up to 10% of their licensed beds via notification letter / documentation only	Change Health Plan Note: there are three rates now in the plan. Need to consider reconfiguration of current space versus new construction when determining if notification	*Note: there are three rates now in the plan. Need to consider reconfiguration of current space versus new construction when determining if notification alone is sufficient.*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
		alone is sufficient.		
Expansion of existing services should be data driven, not subjective	Once a facility meets the "need threshold" for expansion of a service as demonstrated through the Joint Annual Report, there would be no requirement for a CON or exemption, the facility would merely put the department on notice that the expansion will occur	Change Health Plan Note: If JAR data shows need for expansion, then need is reflected in the plan projections. Simple notice to DHEC removes an affected party's ability to argue adverse impact.		1, 4
No repercussions for providers who do not submit Joint Annual Reports which delays Health Plan updates and consumes too much staff time in follow up attempts	Add daily penalty and/or licensure suspension for not submitting Joint Annual Reports by deadline	Would require change to Licensing regulations.	*Note: DHEC has revised process for collecting data. Have had better response.*	1
Appeals cause delays in provision of needed facilities and services.	Eliminate stays. A CON issued by the state takes effect immediately regardless of appeals. (may be addressed in current bill before General Assembly that deals with environmental permitting.) Create new limits on what can be appealed, i.e. exemption determinations should not be appealable.	Statutory change required to allow issuance of CON after decision rather than after appeals		1, 3
If DHEC determines a project is	Remove exempted projects from	Statutory change required		1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
exempt from CON review, eliminate any appeal of that determination.	judicial review.			
Appeal of non-applicability decisions can delay a project. "If CON does not apply, then it does not apply."	Limit appeal of NA determinations only to DHEC Board review. Do not allow judicial review.	Statutory change required		1
Streamlining appeals accomplished in 2010 may need to be strengthened. Did the changes result in any changes to costs to DHEC, and can there be further changes to lower DHEC's costs?			*Difficult to say at this time…ALC scheduling is more timely; compressed cost; stresses staff resources*	1
Discovery in a contested case is often cost prohibitive	Limit discovery to three depositions or consider other alternatives that would reduce the costs of contested cases (look at NC and GA) Reduce depositions in cases from 10 to 3 representative groups.	Statutory change required	Some states have no discovery	1, 3
Appeals process is too lengthy and too costly	Reduce timeline for ALC decisions in contested cases from 18 months to 6 months after hearing Shorten timeline for ALC decision from the current 18 months to 12 months or less.	Statutory change required	NC has 75 days	1, 3

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
Both healthcare facilities and the legislature want a defined, finite timeframe for final resolution of appeals	Process change whereby any CON project will be fully adjudicated within 36 months with the exception of new hospitals (60 months). This may require imposing time timeframes/limits on the various systems/review or eliminating systems/review in the judicial review process	Statutory change required	*Have not seen the full effect of the 2010 statutory change yet*	1
DHEC Board rarely takes up contested CON cases	Remove DHEC Board from hearing contested decisions Remove DHEC Board from appeal process. Decision of agency could go directly to ALC.	Statutory change required The DHEC staff decision becomes the final decision of the agency. Parties could then appeal decisions directly to the ALC if necessary.		1
Lack of continuity in application review process. While the CON application itself seems to be a fairly straightforward data request, additional complexity unpredictably arises based on an individual reviewer's areas of interest. For example, one reviewer may add many questions regarding details of demographic information, while	Better standardize definitions and data requests; provide guidance to reviewers to ensure that applications for similar facilities and services are reviewed in a standard manner.		*One difficulty is in variations in completeness of submissions of CON applications. We could use more forms for standardization.*	1

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
another may focus on the number and types of alternatives considered.				
Relative Importance of Project Review Criteria may be weighted differently per specific project even among projects/services of the same type. Clearer delineation of Project Review Criteria and weighting	Establish consistent weighting of project review criteria per facility or service type. Ensure applicant addressed Criteria in the Plan as a minimum & other identified criteria	Revise Section 304. Relative Importance Criteria, Section 801. Applicability and Weighting, and Section 802. Criteria for Project Review as needed	*Revisit items in the regs – ensure all categories in 44-7-190 are included; look at other states; identify redundancy and eliminate; develop a process so applicant knows expectations "up front"*	2
Project Review Criterion "Adverse Effects on Other Facilities" may be weighted more heavily than "Cost Containment" in reviewing ASF applications	Establish consistent weighting of project review criteria for Ambulatory Surgical Facilities to include weighting "Cost Containment" more heavily than "Adverse Impact to Other Facilities".		*Consistent weighting difficult when dealing with competing applications.*	2
Inadequate funding for state health planning DHEC staff lacks accounting and clinical background experience.	Add fees to various document and approval requests. Have fees allotted to the CON section rather than the general fund Provide more resources to DHEC to hire staff with clinical and accounting experience.		Statutory change required	3
Representation from a broader range of health care providers associated with services/service		Statutory change required. Section 44-7-180 – further	Membership/required composition of the committee will be a limiting	3

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
types identified in the Plan		delineate health care providers to ensure representation from the most utilized services/service types identified in the Plan	factor. Only 4 Provider positions with 1 already allocated as nursing home representative. Governor is the final party to decide committee membership.	
Some facilities/services should no longer require CON review such as: • Freestanding Medical Detox Facilities • Substance abuse beds • Diagnostic cardiac cath expansion • Residential Treatment Facilities for Children • Both community and restricted nursing home beds • Inpatient Hospice Facilities • Home Health Agencies • Outpatient Narcotic Treatment Programs Eliminate some things that require CON.	Statutory change required -- Will require strong consensus, or it will not get through the Legislature. Note: in many instances may require development of stronger licensure requirements • *None of these have been added in years.* • *Possible proliferation of dual diagnosis patients* • *Removes affected party's ability to argue adverse impact* • *Already have excess of beds needed* • *No Medicaid bed days has led to renewed interest in private pay NHs. May interfere with orderly development of NH beds.* • *Potential for overbuilding. Just have to demonstrate need now. Need based on outpatient utilization.* • *Potential proliferation of services. Has led to significant fraud in other states.* • *These were removed in 2010 and added back in 2011 for public safety reasons.* Compare to Fla or other states.			4

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	Allow a third party, such as State Health Plans, to have the ability to revise what is and is not required for the CON. – *This removes authority from the Legislature. Becomes difficult if one plan requires CON and another doesn't.*			
The addition of <10,000 sf with a project cost of <$5M doesn't require CON review	*If this is done, should be a % of sq ft. Right now, it's 10%.*			
Add that renovation/remodeling of a healthcare facility does not require a CON, regardless of cost	*No change needed-CON is not required.*			
Private physicians' offices of today are not like they were when statute was first enacted. Some docs have in-office surgery suites that are not licensed. Urgent care centers are simply physician offices that are renamed	Physicians' offices should be included in definition of healthcare facility and therefore subject to CON. More clearly define physician office where in-office surgical procedures are performed. Determine procedures using CMS list for ASC.	Physicians' offices need more supervision to ensure that they are operating within the scope approved through CON, ie performing procedures only, versus surgeries that would require approval as an ASC.	Be certain that any facility that wants to operate as an ASC is licensed and subject to CON review. Always challenging to get agreement among members about what is a diagnostic service center.	4
CON should not apply to any services (or equipment needed to provide such services) rendered as part of a physician's group practice: for example, MRI offered within a physician practice to that practice's	Try to address through more stringent zoning requirements. Create a new definition of diagnostic service center and	Use the construction guidelines from IBC and NFPA to set definition and approved scope. Statutory change required	*Need to evaluate clinical versus non-clinical space in a MOB.*	

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
patients only as opposed to a freestanding imaging facility No definition of diagnostic service center, so therefore not covered by CON Medical office buildings should not require any written review/approval	add diagnostic service center to healthcare facility list. Exempt from CON any service, and corresponding equipment, offered by a "group practice"(as defined by STARK) when group practice and services meet the criteria for STARK's In-office Ancillary Services Exception			
Home health should not be covered by CON.	Eliminate CON review for home health. No capital cost for establishment of new agency. Replace CON Review with tighter licensure requirements.	*Statutory Change.* Eliminate CON review for home health. No capital cost for establishment of new agency. Replace CON Review with tighter licensure requirements.	*Tighter licensing requirements will not work—licensure is not limiting. If licensure requirements are met, a license is issued.*	4
CON needs to include Hospice (Home Care) programs. Currently only hospice facilities are within CON review.	Institute temporary moratorium; develop hospice methodology and review criteria.	*Statutory change required.*	*See attachments*	4
Indigent Care Policy projections (C-1-d) should have follow-up reporting/auditing for compliance and repercussions if proposed amounts not met	Staff to develop a template for reporting and select a number of providers to audit each year. Fines for those who have in excess of a defined percentage	Statutory change required *–No authority to follow-up after CON is fulfilled*	*Would require more staff time.*	Outside of goals

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	variance from projections presented in original CON application (fine = delta + punitive) and for those who do not respond to audit.			
CON process should be designed with understanding of capital markets.	The Certificate of Need process should, especially with respect to long-term care facilities and acute care hospitals, be designed with an in-depth understanding of the capital markets. Access to capital through tax-exempt bond issues is the primary source of funding capital projects for governmental and 501(c)(3) healthcare organizations in South Carolina. Bond issues for rural hospitals are generally in the range of $5,000,000-$25,000,000. Bond issues for hospitals in the metropolitan area range from $25,000,000 to in excess of $100,000,000. If a borrower has a higher bond rating, the costs of borrowing for capital projects is lower. The key ratio for healthcare institutions in determining the bond rating is "Days Cash on Hand". The practical result of maintaining an investment grade rating is to have Days Cash on Hand of at least 90 days. In order to achieve this level of Cash on Hand healthcare institutions routinely borrow for equipment and building projects rather than spend cash. This is a reality of the requirements of the rating agencies and the capital markets environment. The usual financing structure is to aggregate equipment and building projects over a one to two year period and then issue tax-exempt bonds for such purposes. This reduces the costs of issuance. The bond issue will consist of a component for reimbursement to the hospital for amounts already expended and a project fund for costs to be incurred. Future projects, which may obtain a certificate of need later, cannot be included since all certificates of need must be in place prior to closing the bond issue. Federal tax law provides for a three year period in which to expend all bond proceeds. Reimbursement of expenditures paid before the bonds are issued are limited to expenditures			Outside of goals

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
	for projects for which the hospital adopted a reimbursement resolution within 60 days of the expenditure and the project cannot be placed in service more than 18 months at the time of the reimbursement through the bond issue. Because of the relatively high amount of the principal amount of each bond issue, a change in market conditions by only a very small amount can result in a much higher borrowing cost. It is inefficient but often necessary often to wait on a CON for a small project ($1,500,000-$5,000,000) before closing the bond issue. Much of the work undertaken in a bond issue deals with market timing to obtain the best interest rate. This function is performed by the financial adviser and underwriter. Too often the market timing is dictated by a CON process for small amounts of equipment. To raise the CON limit to $2,500,000 in rural areas and $5,000,000 in non-rural areas would serve two purposes: 1. Makes it more efficient for hospitals to be reimbursed for capital costs, thereby increasing Days Cash on Hand since there would not be a delay due to the CON process. 2. Allows for more efficient access to the bond market since a large bond issue would not be subject to timing delay. It is my understanding that DHEC will no longer be requiring an exemption letter for the refunding (refinancing) of bonds. Refunding bonds are especially time sensitive since most hospitals want to see a specified level of savings which requires the ability to enter the bond market relatively quickly to achieve such savings requirements.			
Delete requirement in Hospital Revenue Bond Act that permits a challenge directly to circuit court	Amend Hospital Revenue Bond Act	Statutory change required	State Budget & Control Board is requiring the publication of notice of right	Outside of goals

All Goals				
Concern	**Options**	**Changes Required**	**Notes**	**Board Goal number**
			to challenge CON approval directly in circuit court	
No enforcement of volume projections or projected percentage of indigent/charity care to be provided as stated in CON applications.	A tracking mechanism should be created by DHEC to ensure that facilities are fulfilling their obligation to treat a percentage of indigent/charity patients and their volume projection in order to keep their license. Create new enforcement procedures for DHEC licensure section.	Create new enforcement procedures for DHEC licensure section.	Difficult to create consistent definition of indigent/charity patients that works for all facilities.	Outside of goals