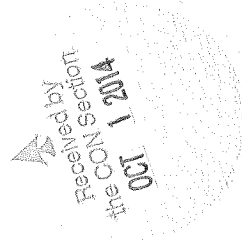




October 1, 2014



Ms. Martha Frisone, Chief  
Certificate of Need Section  
Division of Health Service Regulation  
809 Ruggles Drive  
Raleigh, NC 27603

Re: Public Written Comments  
CON Project ID # N-10319-14  
CON Project ID # N-10321-14  
CON Project ID # N-10323-14

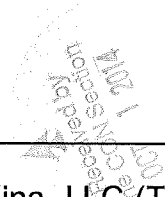
Dear Ms. Frisone:

The attached Public Written Comments are forward for consideration by the CON Project Analyst conducting the respective reviews. If you have any questions regarding these comments please feel free to contact me.

Respectfully,

A handwritten signature in black ink, appearing to read "Jim Swann".

Jim Swann  
Director of Operations, Certificate of Need



The application submitted by Total Renal Care of North Carolina, LLC (TRC) presents the CON Section with an incomplete picture, inaccurate information, and an application which is not conforming to the CON Review Criteria and Rules for End Stage Renal Disease Treatment facilities. The application should be not be approved, or conditionally approved. The following information identifies multiple failures within the application.

1. From the outset, this application fails to conform to CON Review Criterion 18a. NC General Statute 131E-183, Review Criteria includes the following language at 18a.

*(18a) The applicant **shall** demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a **positive impact** upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.*  
[emphasis added by BMA]

The Applicant has not provided any discussion with regard to the expected effects of the proposed services on competition in the proposed service area. In fact, the applicant has totally ignored the probable effects of competition in this area. Furthermore, enhanced competition in this area is more likely to have a detrimental impact upon the existing providers in the area, and will not have a positive impact upon the cost effectiveness, quality, and access to the services proposed.

Question V.7 of the ESRD CON Application asks the applicant to address the following:

*Explain the expected effects of the proposed project on competition in the proposed service area, including how any enhanced competition will have a positive impact on the cost effectiveness, quality and access to the proposed services. For projects where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the proposed services, explain why the proposed project is a service on which competition will not have a favorable impact.*

This question appears to be essentially the same language as is included in CON Review Criterion 18a. In response to this question, the applicant has included the following statements:

Page 41-42: *“DaVita Healthcare Partners Inc. and Total Renal Care of North Carolina, LLC do not expect that this proposal will have any adverse effect on competition within **Robeson or Scotland Counties...**”*  
[emphasis added]

*“In this application, TRC is not proposing that its initial census dialysis patients choosing to utilize this facility will be an entirely new dialysis patient population. Rather, TRC is suggesting that many patients residing in and around Maxton will be willing to transfer their treatment to the facility.”*

The applicant has proposed to relocate its 10 station facility from St. Pauls, in northern Robeson County, to Maxton, in western Robeson County. This is a distance of greater than 22 miles.

The applicant does not propose that the patients currently served by the St. Pauls facility will relocate. Rather the applicant has suggested that essentially 100% of its proposed patient population to be served would be transferring their care to the new facility. In fact, many of the patient letters of support provided by the applicant were obtained through the medical practice of Dr. Nestor. The patients indicate in their letters that they are a patient of Dr. Nestor. It is imminently obvious that a significant number of the proposed patient population to be served at the new facility, are patients currently dialyzing at a BMA facility in the area.

The Map at Exhibit 1 depicts Robeson and Scotland Counties, and the dialysis facilities within the counties. The map also depicts the projected location of the Maxton facility and a 10 mile ring around the facility. There are three existing dialysis facilities within 10 miles of the proposed facility. These facilities are:

FMC Pembroke  
BMA Laurinburg  
FMC Scotland County

In evaluating this application, BMA suggests the CON Project Analyst must consider the impact to other dialysis facilities in the area. The proposed facility is planned to be located in Maxton, Robeson County, and within one quarter mile of the Robeson-Scotland County line. Indeed, the applicant has proposed to serve 16 in-center patients and one home dialysis patients from Scotland at the end of the second year. This represents 42.5% of the proposed patient population at the facility. Consequently, the Analyst should consider the impact to local dialysis facilities in Scotland County as well as the facilities in Robeson County.

Both Robeson County and Scotland County are economically distressed counties. The North Carolina Department of Commerce has identified both counties as Tier 1 counties, meaning they rank within the 40 most distressed counties in our State. (See Exhibit 2).

The July 2013 SDR reported a Need Determination for 11 dialysis stations in Scotland County. BMA filed two applications in response to this need determination; DaVita filed one application. In the BMA application seeking to add two dialysis stations to FMC Scotland County, BMA noted that Scotland County was included in the 40 most economically distressed counties in our state. That fact hasn't changed.

In the FMC Scotland County application, BMA included the following:

*"FMC Scotland County financial performance has been marginal due to the very low commercial mix at the facility. As is noted above, the most recent historical review indicates that 0.5% of revenue has been from commercial insurance. BMA will be working with the admissions team to re-direct one or two new dialysis patients, who reside on the north side of Laurinburg or Scotland County, with commercial insurance, to the FMC Scotland County facility. In a small facility population such as in FMC Scotland County, one or two patients with commercial insurance can dramatically alter the financial performance of the facility.*

*BMA will not mandate patient admission to one facility or another. However, given the close proximity of the two facilities, it is reasonable to conclude that some patients with commercial insurance would choose FMC Scotland County."*

BMA also filed a CON application for FMC Pembroke in September 2013. TRC obviously had copies of the BMA Laurinburg and FMC Scotland County applications, as they filed public written comments regarding both. TRC similarly could have obtained a copy of the FMC Pembroke CON application which was also filed in September 2013. TRC should have known from the BMA applications that both counties, Robeson County and Scotland County, are economically distressed counties. The BMA payor mix information was included in each of the applications. Interestingly, TRC did use the exact same BMA payor mix in its application for Sampson Home Dialysis. Obviously the applicant has access to public records.

The FMC Scotland County facility continues to struggle financially. The current financial picture indicates the facility financial picture has not yet improved. The BMA Laurinburg facility and FMC Pembroke facility are also experiencing low percentages of commercially insured patients.

The next table demonstrates the commercial payor mix (January 1 through August 31, 2014) for the three dialysis facilities within 10 miles of the proposed facility in Maxton. In short, these three facilities have very low percentages of commercially insured patients and continue to struggle financially.

As of August 31, 2014	Dialysis TX	Commercial TX	% Commercial
Pembroke	4841	104	2.148%
Laurinburg	7526	398	5.288%
Scotland County	3697	0	0.000%
Total	16064	502	3.125%

Thus, as of August 31, 2014, the three facilities had provided 16,064 in-center dialysis treatments. Of these, only 502, or 3.125% of the treatments were commercially insured.

In a recent dialysis CON contested case (the FMC Tar River case, 13-DHR-18127 and 13-DHR-18223), Ms. Lauren Coyle, a DaVita Regional Operations Director, testified that dialysis facilities necessarily relied upon the commercially insured patients to ensure a facility remained financially viable. Note the following copied from the court transcript (excerpts included as Exhibit 3).

*"So the type of work I'm doing is trying to analyze where we have or do not have a strong commercial mix among our patient base. So Medicare, just as you may read from the press and you can also read in our--you know, in the annual reports, Your Honor, Medicare doesn't pay a high enough rate for any of the dialysis providers to make any money off of-- we lose money on every single Medicare treatment we do. And this is really tough because--again, you can read just in the press and in DaVita's 10-K, 90 percent of our patients are Medicare patients.*

*So we rely on a really tiny patient base--as an industry, we rely on a really tiny patient base to make all of our money for us. We don't stay in business without these private pay or commercially insured patients. So you can easily see that one patient will--could send a clinic either into profitability or losing one patient could send a clinic out of profitability."*

Transcript of Ms. Coyle, page 40

BMA would agree that the loss of a single commercially insured patient can have significant impact on the profitability of a facility. In this case, the applicant proposes to enlist the assistance of the Medical Director to refer existing patients away from the current provider, and transfer to a facility which is not needed in the area.

Given the bleak financial outlook for the existing facilities in the area, BMA suggests that it is not reasonable to add yet another dialysis facility to the area and further dilute the payor mix. The application by TRC should be found non-conforming to CON Review Criterion 18a.

2. The application should be found non-conforming to CON Review Criterion 5. Because the applicant has not provided reasonable and credible projections of a patient population to be served, the resultant projections of revenues must be determined to be unreliable. If they are unreliable, then the application can not be found conforming to CON Review Criterion 5.

TRC has indicated that it utilized the same payor mix projections from its 2013 CON application for a new facility in Scotland County. See the following from page 43/44 of the CON application:

*"See below the proposed payor mix for Maxon Dialysis. DaVita submitted a CON application in 2013 to develop a facility in Laurinburg in Scotland County. An analysis was conducted at that time to determine the payor mix for that facility. Since the proposed site was less than nine miles from the proposed site of the Maxton facility, the same payor mix was used."*

BMA notes that the applicant has not provided any evidence of an "analysis" which was conducted. There is nothing to support the projected payor mix for the proposal.

As is noted within these comments, and from the very patient letters of support for the project, the applicant is proposing that a significant number of dialysis patients from existing BMA facilities. To the extent that the applicant is proposing to serve patients currently served by BMA, it would be appropriate to consider BMA historical experience with payor mix in the area. The applicant was well aware of the BMA applications to expand BMA Laurinburg and FMC Scotland County. The BMA application for FMC Pembroke, also filed in September 2013, was public record as well. Thus, the applicant had the opportunity to review BMA payor mix projections for the three nearest dialysis facilities, all within 10 miles of Maxton.

BMA evaluated its payor mix situation for FMC Pembroke, FMC Scotland County and BMA Laurinburg, as of August 3, 2014 (September 2014 numbers are not yet available). The following table reflects the commercial payor mix of these facilities, again, all within 10 miles of the proposed TRC facility.

Facility	Commercial Payor Mix
FMC Pembroke	2.15%
FMC Scotland County	0.00%
BMA Laurinburg	5.24%
<b>Average</b>	<b>2.46%</b>

The average commercial payor mix for BMA facilities in the area is only 2.46%. Compare this with the projected commercial payor mix of the applicant: 7.3%. In other words, the applicant has proposed a commercial payor mix which is nearly 300% of the experience of the local facilities.

The current mix notwithstanding, BMA notes that the applicant could have relied upon BMA information from the CON applications filed in September 2014. Again, this information was available to the applicant by reviewing BMA applications filed. BMA proposed the following commercial mix for the three facilities in its September 2013 CON applications:

Facility	Proposed in 2013 CON Applications
FMC Pembroke	5.0%
FMC Scotland County	4.5%
BMA Laurinburg	6.0%
<b>Average</b>	<b>5.17%</b>

In those applications, BMA projected an average of only 5.17% commercial mix. BMA also notes that it projected to achieve the 4.5% at FMC Scotland County by redirecting one or two new patients with commercial insurance from BMA Laurinburg to the FMC Scotland County facility. The historical performance of FMC Scotland County up to that point had been only 0.5% commercial insurance. Despite the available information, the applicant chose to utilize a commercial mix more than 2% higher, and equivalent to 141% of the demonstrated experience in the area.

Thus, it should be patently obvious that the applicant has overstated projected revenues for the facility by its failure to utilize realistic projections of commercial revenues. Harken back to the testimony of Ms. Coyle:

*“So we rely on a really tiny patient base--as an industry, we rely on a really tiny patient base to make all of our money for us. **We don't stay in business without these private pay or commercially insured patients.** So you can easily see that one patient will--could send a clinic either into profitability or losing one patient could send a clinic out of profitability.”*

A more appropriate payor mix projection would have demonstrated that the proposed facility would not meet the long term financial viability prong of CON Review Criterion 5.

The next table is a comparison of the Applicant's projected payor mix and the payor mix for BMA facilities in the area. All of these are from the September 2031 CON applications (the applicant has replicated their September 2013 payor mix projections in the current application).

September 2013 CON Applications	FMC Pembroke	BMA Laurinburg	FMC Scotland County	BMA Average	DaVita Maxton
Private Pay	0.0%	0.0%	0.0%	0.0%	0.00%
Commercial Insurance	5.0%	6.0%	4.5%	5.2%	7.30%
Medicare	87.9%	78.6%	89.6%	85.4%	85.40%*
Medicaid	2.5%	9.3%	1.8%	4.5%	4.20%
Medicare/Medicaid	0.0%	0.0%	0.0%	0.0%	0.00%
Medicare/Commercial	0.0%	0.0%	0.0%	0.0%	0.00%
State Kidney Program	0.0%	0.0%	0.0%	0.0%	0.00%
VA	4.6%	5.7%	4.1%	4.8%	3.10%
Other: Self/Indigent	0.0%	0.5%	0.0%	0.2%	0.00%
Total	100%	100%	100%	100%	100%

Note: BMA summed the TRC Medicare (21.9%), Medicare/Medicaid (30.2%), and Medicare/Commercial (33.3%) for ease of comparison.

As the table suggests, there is no distinguishable difference between the BMA average Medicare percentage and the TRC Medicare percentage. Medicare reimbursement is the same regardless of provider.

There is however a most distinguishable difference is in the commercial payor percentages. This is significant because of the much higher reimbursement from commercial payor sources as opposed to government payors (i.e., Medicare, Medicaid, and VA). In the TRC application the applicant indicates the commercial reimbursement identified in the chart on page 59 of the application "is the actual average amount of reimbursement received after any deductions for contractual allowances". The applicant reports commercial reimbursement at a rate of \$1,275, or greater than 533% of Medicare reimbursement. To the extent that the applicant has overstated, or overestimated the commercial payor mix for the proposed facility, then the applicant has overstated the reasonable commercial reimbursements which may be expected by the facility.

Within the following table, BMA offers a more realistic projection of revenues based upon the same number of treatments as proposed by TRC within the application.



BMA notes that the Medicare percentage in the TRC applications is coincidentally the same percentage as the BMA average. However, BMA does not break out its Medicare reimbursement in the same fashion as TRC. Thus, to offer an apples-to-apples comparison, BMA has utilized weighted analysis of the TRC Medicare reimbursements to provide an accurate assessment of probable revenues.

Step 1: Determine TRC percentages from the application

Medicare	21.9%
Medicare/Medicaid	30.2%
<u>Medicare/Commercial</u>	<u>33.3%</u>
Total Medicare	85.4%

Step 2: Determine equivalent percentages of Medicare reimbursements

Divide each of the above percentages by the whole (85.4%)

Medicare	$21.9\% / 85.4\% = 25.64\%$
Medicare/Medicaid	$30.2\% / 85.4\% = 29.88\%$
Medicare/Commercial	$33.3\% / 85.4\% = 38.99\%$

BMA notes that TRC did not project Self Pay and Indigent treatments. BMA has experienced a very small percentage (0.17%) within this payor classification. In the reformed financial projects which follow, BMA has not included this percentage, but rather has distributed this among the various payor categories. The following represents a more correct payor mix projection for the TRC Maxton proposal.

Payor Source	Percentage
Private Pay	0.00%
Commercial Insurance	5.17%
Medicare	21.67%
Medicaid	4.53%
Medicare/Medicaid	29.88%
Medicare/Commercial	32.95%
State Kidney Program	0.00%
VA	4.80%
Other: Self/Indigent	0.00%
Total	99.00%

BMA notes that the above sums to only 99%. BMA assumes the small 1% difference was a function of the weighted analysis and the Self Pay percentage.

BMA has divided this remaining 1% among the Medicare payor categories included in the TRC application to arrive at the following payor mix:

Payor Source	Percentage
Private Pay	0.00%
Commercial Insurance	5.17%
Medicare	22.00%
Medicaid	4.53%
Medicare/Medicaid	30.22%
Medicare/Commercial	33.28%
State Kidney Program	0.00%
VA	4.80%
Other: Self/Indigent	0.00%
Total	100%

The next table represents the probable revenues for Operating Year 2, based upon the more correct payor mix as discussed.

Payor Source	Patients X 3 days / week X 52 weeks per year	Total Treatments less 5% Missed Treatment	Patient Payment % by source of revenue	\$ Paid by Source	Projected Revenue
Private Pay	6084	5780	0.00%	\$ -	\$ -
Commercial Insurance	6084	5780	5.17%	\$ 1,275.00	\$ 380,757.50
Medicare	6084	5780	22.00%	\$ 239.02	\$ 303,972.88
Medicaid	6084	5780	4.53%	\$ 143.00	\$ 37,469.81
Medicare/Medicaid	6084	5780	30.22%	\$ 239.02	\$ 417,431.90
Medicare/Commercial	6084	5780	33.28%	\$ 239.02	\$ 459,808.16
State Kidney Program	6084	5780	0.00%	\$ -	\$ -
VA	6084	5780	4.80%	\$ 193.00	\$ 53,545.92
Other: Self/Indigent	6084	5780	0.00%	\$ -	\$ -
Total			100%		\$ 1,652,986.17

BMA offers a side by side comparison of revenues for the proposed facility.

	TRC Application, Maxton Dialysis	BMA Analysis, with Reformed Payor Mix
Private Pay		
Medicare	\$ 302,599	\$ 303,973
Medicaid	\$ 34,749	\$ 37,470
Medicar/Medicaid	\$ 417,329	\$ 417,432
Commercial	\$ 538,050	\$ 380,758
VA	\$ 34,547	\$ 53,546
State Kidney Program		
Other - Specify		
Medicare/Commercial	\$ 459,874	\$ 459,808
Medicare Adjustment 20% of Medicare Line Item	\$ (60,520)	\$ (60,795)
Total Net Revenue	\$ 1,726,628	\$ 1,592,192

Thus, if TRC had used a more correct payor mix assumption, based upon information which was available to the applicant, the projected net revenues of the facility would have been \$134,795 less than that suggested by TRC within the application.

Ultimately, if TRC had used a more correct payor mix, it is likely that TRC would have realized the project would be unprofitable. A profitability analysis would require a minor adjustment to the projected expenses. The projected income taxes should be subtracted from the proposed expenses, and thereby reducing expenses.

	TRC Application, Maxton Dialysis	BMA Analysis, with Reformed Payor Mix
Total Net Revenue	\$ 1,726,628	\$ 1,592,192
TRC Expenses	\$ (1,648,198)	\$ (1,648,198)
Add tax back		\$ 50,620
Profitability	\$ 78,430	\$ (5,386)

The applicant has not demonstrated the long term financial viability of the proposal. Therefore the application should be determined to be non-conforming to CON Review Criterion 5.

3. The applicant has not demonstrated a reasonable need to relocate the existing facility in St. Pauls.
  - The applicant has not documented any physical plant deficiency with its St. Pauls Dialysis facility.

- The applicant has not demonstrated any problems with geographic accessibility of the patient population of its St. Pauls facility. The applicant has not demonstrated that any of its existing patient population resides closer to Maxton than to St. Pauls.
- The applicant has not discussed the existing facilities in the area. BMA operates the FMC Pembroke facility approximately nine miles from Maxton. FMC Pembroke is currently certified for 15 dialysis stations and has CON approval for an additional four stations. BMA also operates two dialysis facilities in Laurinburg, approximately six miles from Maxton. BMA Laurinburg facility is certified for 30 dialysis stations. FMC Scotland County facility is certified for 12 stations (BMA has requested certification of two CON approved stations, effective Monday, October 6, 2014).

The three dialysis facilities within 10 miles of Maxton have a current total of 57 certified dialysis stations and CON approval for six additional stations. Capacity at 80% utilization on 57 stations is 182 dialysis patients. As of mid-September, the census at the BMA facilities in the area was only 164 in-center patients. Thus, there is capacity for 18 additional patients before achieving 80% capacity. The following table provides a brief summary of the three facilities and their utilization.

	Certified Stations	Pending Stations	Total CON Approved Stations	Facility Census September 30, 2014
FMC Pembroke	15	4	19	52
BMA Laurinburg	30	0	30	73
FMC Scotland County	12	2	14	39
TOTAL	57	6	63	164
Capacity at 80%	182.4		201.6	
Actual Patients per station:				2.88

The applicant has offered a proposal which will very clearly duplicate existing and approved health services. There are three existing facilities within 10 miles of the proposed location, operating with an aggregate utilization of only 2.88 patients per stations. The applicant has not demonstrated the proposed facility is needed and would not create a duplication of existing resources. The applicant proposes to relocate the stations to an area with underutilized dialysis capacity. The application is not conforming to CON Review Criterion 6 and should be denied.

4. The applicant fails to conform to CON Review Criterion 3. The applicant has included patient letters of support within Exhibit 17 of the application; however, some of these letters are duplicates (some letters have the same patient signature). For example, one letter with a Fax date/time stamp of 08/31/2030 (not a typographical error), includes a sequence number on the top right side of the page, 0005/0005

(presumably page 5 of 5). Another letter with the same patient signature is included with a date time stamp of 08/22/2030 (again, not a typographical error), and includes a sequence number of 0001/0007 (presumably page 1 of 7). This second letter also includes a Fax date/time stamp of 08/07/2014 with a sequence number 39/42 (presumably page 39 of 42). The point is that this letter, and others, appear to be duplicates. Consequently, the patient letters of support are dubious and should not be relied upon as evidence of support for the project. Thus the application is based on unreasonable and questionable letters of support, and should be found non-conforming to CON Review Criterion 3.

5. The applicant has failed to provide sufficient evidence of a patient population which supports the projections of patients to be served by the facility. In this case, the applicant has relied upon the patient letters of support in Exhibit 17 to support the projections of a patient population to be served.

The CON Agency has previously indicated that patient letters of support should provide sufficient information so that the Analyst may determine the credibility of the patient letters. In the CON decision for Project ID # F-7912-07, the CON Analyst determined that it was *“not possible to tell, from the information given in the application and exhibits, which part of...”* the county the patients may reside. (See Exhibit 4, Required State Agency Findings, page 4).

In this case, many of the patient letters of support are questionable as to their representations of Maxton being more convenient. BMA has evaluated the travel distance for the patient letters of support when those patients are dialyzing with TRC already. If travel distance is indeed the overarching concern, then patients would presumably want to dialyze at the dialysis facility closest to their residence location.

The applicant has included 20 patient letters of support from patients dialyzing at a TRC facility. BMA considered those letters and the residence location. Obviously BMA, just like the CON Analyst does not have access to the patient residence address. Thus, in evaluating these letters, BMA has utilized the center of the locale identified. For example one of the letters is from a patient residing in Lumberton. It is a road trip of 26 miles from Lumberton to Maxton. Yet, there is a dialysis facility in Lumberton, and another facility in Pembroke; both are closer to Lumberton than a 26 mile road trip to Maxton.

The following table identifies the patient residence location, mileage to Maxton, and mileage to the closest—more convenient—dialysis facility.

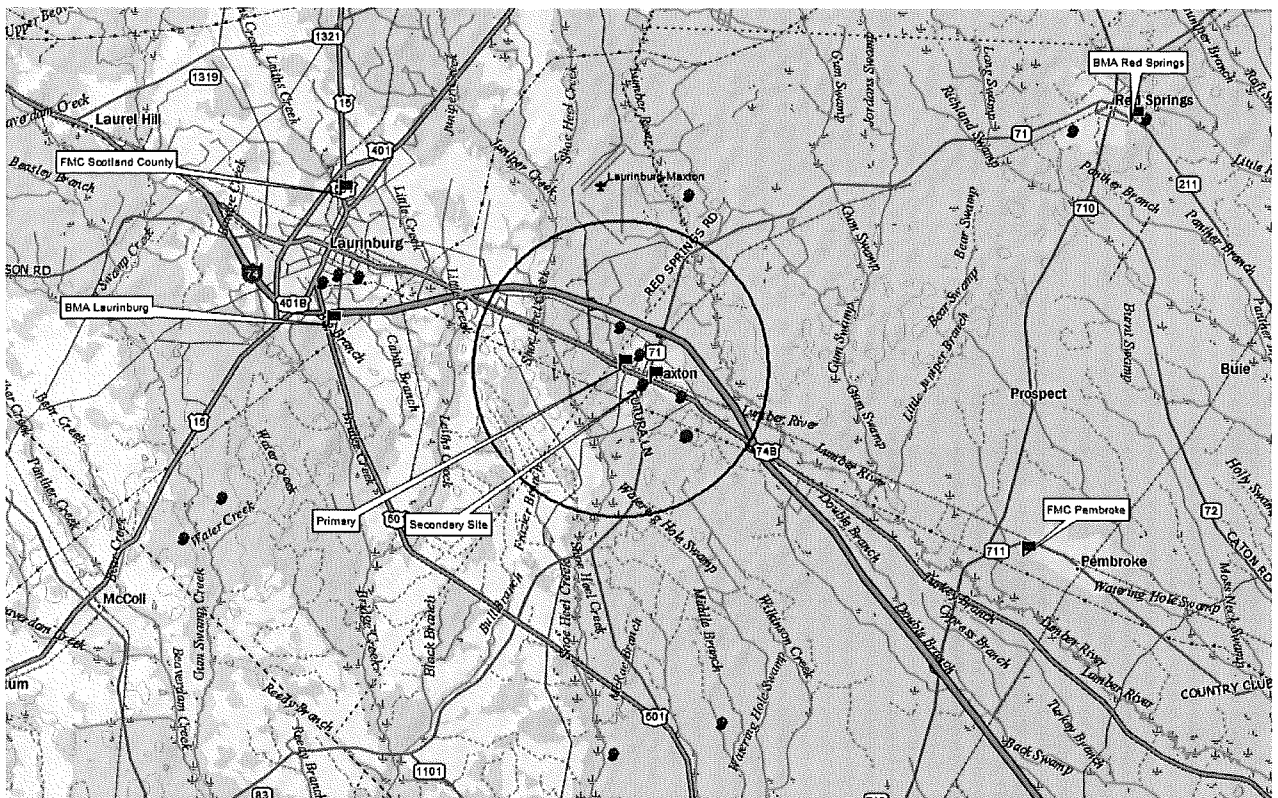
Patient Residence location	Maxton	Closest Dialysis Facility	Mileage	Number of Letters
Maxton	0	BMA Laurinburg	6	3
Laurel Hill	14	TRC, Hamlet	10	7
Pembroke	9	FMC Pembroke	0	1
Wagram	12	FMC Scotland County	9	6
Red Springs	13	BMA Red Springs	0	1
Laurinburg	6	BMA Laurinburg	0	1
Lumberton	26	BMA Lumberton	0	1
Total Number of letters				20

As the table indicates, if convenience is the key to patient support, then only three of the 20 patients would be better served by a dialysis facility in Maxton. Again, the application is not based on reasonable methodology, is not conforming to CON Review Criterion 3 and should be denied.

- As noted earlier in these comments, BMA is serving many of these patients and therefore is knowledgeable of their residence address. BMA has mapped the residence location of those patients it could determine were currently dialyzing with BMA. The map is telling.

BMA was able to identify 14 patients and mapped these patients. The above map depicts the primary and secondary location of the proposed facility and the residence of 12 of the patients; two of the patients were plotted at the center of the patient zip code (the mapping program did not recognize the address).

- Six of the patients had a Maxton address, and are indicated on the map; one patient had a Maxton PO box and is not indicated on the map.
- Five of the patients had a Laurinburg address and are on the map.
- Two of the patients had a Red Springs address and are on the map.



Again, the applicant has failed to demonstrate the needs of the patient population for the services propose at the proposed location. The applicant fails to conform to CON Review Criterion 3 and 6.

7. The applicant fails to conform to CON Review Criterion 3a. The applicant has made no provision for the care of the patients currently dialyzing at their St. Pauls facility. The applicant cannot simply say they would refer the patients elsewhere and then walk away. The applicant has said at one point that if the patients did not want to transfer their care to another DaVita facility (Red Springs or Elizabethtown) then they would work with the patients to transfer their care to the FMC St. Pauls facility. However, the applicant has not indicated how the patients would be admitted. The nephrology physicians attending the patients of the DaVita St. Pauls facility do not have rounding privileges at the FMC St. Pauls facility. Nor have they applied. Are the patients going to change their nephrology physician? What efforts have been made to ensure the patients have continuous care? The applicant fails to address Criterion 3a in a satisfactory manner.

8. The applicant has also indicated that it would write off the 20% required co-pay for Medicare patients (application, Page 59, Note 3). This is not an acceptable practice and the applicant may be in violation of Medicare claims processing procedures.

CMS guidelines for write-offs require the provider to make reasonable efforts to collect the amounts due. A bill must be forwarded to the responsible party. A "token, collection effort" is not sufficient. In other words the provider has a responsibility to make collection efforts. The very idea of proposing to simply write the 20% co-payment off without first seeking to collect seems contradictory to the Medicare laws. See excerpts from CMS regarding bad debt at Exhibit 7.

Given the absolute failure by the applicant on this matter, BMA suggests the financial projects of the applicant are not credible and the application should be found non-conforming to CON Review Criterion 5.

9. Given the many failures within the application, the application is clearly not the best alternative and fails to conform to CON Review Criterion 4.

#### SUMMARY:

The TRC application to relocate the St. Pauls dialysis facility and develop at a new location in Maxton should be denied.

- The applicant has not provided any reasonable justification for relocation of the stations except to say that their facility is financially stressed.
- The applicant proposes to relocate the stations to an area with underutilized dialysis capacity.
- The applicant proposes to relocate the stations to an area with severe financial stress on the existing facilities and further dilute the payor mix.
- The applicant has provided duplicated letters of support from patients proposing to transfer their care to the facility.
- The applicants financial projections are based upon an inflated payor mix. Consequently the revenue projections are not reasonable and supported.

BMA suggests the application fails on multiple levels and should not be approved. The application fails to conform to CON Review Criteria 3, 4, 5, 6 and 18a.

For these reasons, the application should be denied.



Public Witten Comments  
CON Project ID # N-10321-14  
Total Renal Care of North Carolina, LLC. d/b/a Maxton Dialysis  
Prepared and Submitted by Jim Swann  
FMC Director of Operations, Certificate of Need

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Exhibits:

- 1) Map of the area
- 2) NC Department of Commerce information
- 3) Ms. Lauren Coyle, transcript excerpts
- 4) Required State Agency Findings, F-7912-07
- 5) Excerpts from Medicare Provider Reimbursement Manual







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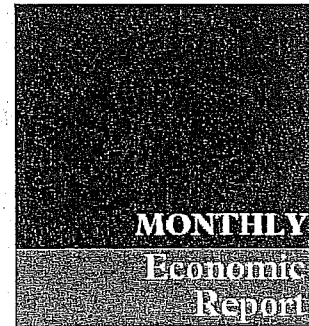
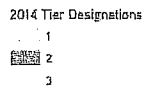
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2014 North Carolina County Tier Designations

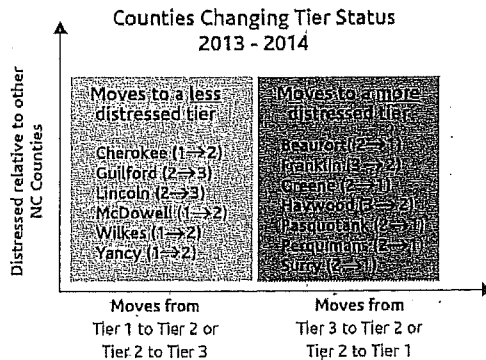


2014 County Tier Designations

The N.C. Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a Tier designation. The 40 most distressed counties are designated as Tier 1, the next 40 as Tier 2 and the 20 least distressed as Tier 3.

This Tier system is incorporated into various state programs, including the Article 3J Tax Credits, to encourage economic activity in the less prosperous areas of the state. Please see the 2014 County Tier Designations for a detailed view of designations.

Note: Article 3J Tax Credits should not be confused with Article 3A William S. Lee (WSL) Tax Credits. Article 3J is not a revision of the Lee Act; it replaces it. In general, William S. Lee Credits are repealed for business activities that occur on or after January 1, 2007 and Article 3J Credits take effect for taxable years beginning on or after January 1, 2007. Please see the 2014 County Tier Designations for a detailed view of designations.



- [2014 County Tier Designations \(current page\)](#)
- [2013 County Tier Designations](#)
- [2012 County Tier Designations](#)
- [2011 County Tier Designations](#)
- [2010 County Tier Designations](#)
- [2009 County Tier Designations](#)
- [2008 County Tier Designations](#)
- [2007 County Tier Designations](#)

Click the county name to view the current county profile. To sort, click the *county* or *tier designation* in the head of the table.

County	Tier Designation
<a href="#">Alamance</a>	2
<a href="#">Alexander</a>	2
<a href="#">Alleghany</a>	1
<a href="#">Anson</a>	1
<a href="#">Ashe</a>	2
<a href="#">Avery</a>	2
<a href="#">Beaufort</a>	1
<a href="#">Bertie</a>	1
<a href="#">Bladen</a>	1
<a href="#">Brunswick</a>	3
<a href="#">Buncombe</a>	3
<a href="#">Burke</a>	1
<a href="#">Cabarrus</a>	3
<a href="#">Caldwell</a>	1
<a href="#">Camden</a>	1
<a href="#">Carteret</a>	3
<a href="#">Caswell</a>	1
<a href="#">Catawba</a>	2
<a href="#">Chatham</a>	3
<a href="#">Cherokee</a>	2
<a href="#">Chowan</a>	1
<a href="#">Clay</a>	1
<a href="#">Cleveland</a>	2
<a href="#">Columbus</a>	1
<a href="#">Craven</a>	2
<a href="#">Cumberland</a>	2
<a href="#">Currituck</a>	2
<a href="#">Dare</a>	2
<a href="#">Davidson</a>	2
<a href="#">Davie</a>	2
<a href="#">Duplin</a>	2
<a href="#">Durham</a>	3
<a href="#">Edgecombe</a>	1
<a href="#">Forsyth</a>	3
<a href="#">Franklin</a>	2
<a href="#">Gaston</a>	2
<a href="#">Gates</a>	1
<a href="#">Graham</a>	1
<a href="#">Granville</a>	2
<a href="#">Greene</a>	1
<a href="#">Guilford</a>	3

Halifax	1
Harnett	2
Haywood	2
Henderson	3
Hertford	1
Hoke	1
Hyde	1
Iredell	3
Jackson	1
Johnston	3
Jones	1
Lee	2
Lenoir	1
Lincoln	3
Macon	2
Madison	2
Martin	1
McDowell	2
Mecklenburg	3
Mitchell	1
Montgomery	1
Moore	3
Nash	2
New Hanover	3
Northampton	1
Onslow	2
Orange	3
Pamlico	2
Pasquotank	1
Pender	3
Perquimans	1
Person	2
Pitt	2
Polk	2
Randolph	2
Richmond	1
Robeson	1
Rockingham	1
Rowan	2
Rutherford	1
Sampson	2
Scotland	1
Stanly	2
Stokes	2
Surry	1
Swain	1
Transylvania	2
Tyrrell	1
Union	3
Vance	1
Wake	3

Warren	1
Washington	1
Watauga	3
Wayne	2
Wilkes	2
Wilson	1
Yadkin	2
Yancey	2

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# Scotland County (NC)

## April 2014



County Profile Contact (919) 707-1500

Commerce Economic Development Contact (919) 733-4151

### Demographics

#### Population & Growth

	Population	Annual Growth
2018 Proj Total Population	35,543	( 0.3%)
2013 Proj Total Population	36,006	
2010 Census Total Population	36,157	0.0%
2000 Census Total Population	35,998	
July 2012 Certified Population Estimate (NC only)	36,387	

#### Urban/Rural Representation

	Population	Urban/Rural Percent
2010 Census Total Population: Urban	18,660	51.6%
2010 Census Total Population: Rural	17,497	48.4%

#### Estimated Population by Age

	Population	Pop by Age
2018 Proj Median Age	39	
2013 Proj Median Age	39	
2000 Census Median Age	35	
2013 Proj Total Pop 0-19	9,607	26.7%
2013 Proj Total Pop 20-29	4,619	12.8%
2013 Proj Total Pop 30-39	4,219	11.7%
2013 Proj Total Pop 40-49	4,653	12.9%
2013 Proj Total Pop 50-59	5,122	14.2%
2013 Proj Total Pop 60+	7,786	21.6%

### Commuters, Workers Age 16 and over, 2011 Est

#### Percent of Workers, By Travel Time

Avg Travel Time, Minutes	20.0
Workers Not Working at Home	11,605
Travel Time to Work: < 10 minutes	16.1%
Travel Time to Work: 10-14 minutes	22.2%
Travel Time to Work: 15-19 minutes	23.2%
Travel Time to Work: 20-24 minutes	12.1%
Travel Time to Work: 25-29 minutes	3.6%
Travel Time to Work: 30-34 minutes	9.3%
Travel Time to Work: 35-44 minutes	4.8%
Travel Time to Work: 45-59 minutes	4.2%
Travel Time to Work: 60+ minutes	4.5%

#### Workers, By Transportation

Worker Transp, Base	11,605
Work at Home	2.9%
Drove Car/Truck/Van Alone	84.6%
Carpooled Car/Truck/Van	9.8%
Public Transportation	0.2%
Walked	1.2%
Other Transportation	1.3%

#### Place of Work

Worked in State/County of Residence	8,239
Worked in State/Outside County of Residence	2,884
Worked Outside State of Residence	482

#### Commuters

#### Residents

	71.0%
	24.9%
	4.2%

### Education

	Population	Pop Age 25+
2012-13 Kindergarten-12th Enrollment	6,055	
2013 Average SAT score (2400 scale)	1,289	
2013 Percent of Graduates taking SAT	60.6%	
2011-12 Higher Education Completions	81	
2011-12 Higher Education Total Enrollment	480	
Est Education Attainment - At Least High School Graduate	18,296	77.3%
Est Education Attainment - At Least Bachelor's Degree	3,315	14.0%

## Housing

		Growth or % of Total
2018 Proj Total Housing	15,159	( 0.2%)
2013 Proj Total Housing	15,193	
2010 Census Total Housing	13,614	
2010 Census Occupied Housing	12,035	88.4%
2010 Census Vacant Housing	1,579	11.6%
2011 Est Median Value of Owner Occupied Housing	\$75,600	
2011 Est Median Value of Renter Occupied Housing	\$621	
2011 Est Owner Occupied Housing	8,655	66.2%
2011 Est Renter Occupied Housing	4,420	33.8%
2011 Est Owner Occupied Housing Vacancy	1.7%	
2011 Est Renter Occupied Housing Vacancy	8.9%	
2010 Census Total Households	15,193	

## Income

		Percent Growth or Total
2011 Est Median Family Income	\$37,700	( 3.3%)
2000 Census Median Family Income	\$38,971	
2018 Proj Median Household Income	\$36,244	22.2%
2013 Proj Median Household Income	\$29,663	( 4.4%)
2000 Census Median Household Income	\$31,024	
2011 Est Median Worker Earnings	\$23,089	
2018 Proj Per Capita Income	\$18,675	2.5%
2013 Proj Per Capita Income	\$16,545	5.4%
2000 Census Per Capita Income	\$15,693	
Est Total Pop with Income Below Poverty Level, Last 12 months	10,296	0.3%

## Employment / Unemployment

	Currently	Annual
Jan2014, 2012 Employment	10,895	10,960
Jan2014, 2012 Unemployment	1,637	2,235
Jan2014, 2012 Unemployment Rate	13.1%	16.9%
2013Q4 YTD, 2013 Announced Job Creation	87	87
2013Q4 YTD, 2013 Total Announced Investments (\$mil)	\$26.9	\$26.9

### Employment / Wages by Industry

	2013 3rd Qtr Employment	2012 Annual Employment	2013 3rd Qtr Avg Weekly Wage	2012 Avg Weekly Wage
Total All Industries	11,315	11,572	\$632	\$621
Total Government	2,158	2,398	\$702	\$664
Total Private Industry	9,158	9,174	\$615	\$610
Agriculture Forestry Fishing & Hunting	0	0	.	.
Mining	0	0	.	.
Utilities	0	0	.	.
Construction	314	314	\$706	\$670
Manufacturing	1,862	1,796	\$874	\$898
Wholesale Trade	0	0	.	.
Retail Trade	1,617	1,630	\$411	\$398
Transportation and Warehousing	344	326	\$796	\$704
Information	89	104	\$869	\$884
Finance and Insurance	217	223	\$740	\$779
Real Estate and Rental and Leasing	52	49	\$585	\$539
Professional and Technical Services	106	131	\$722	\$720
Mgt of Companies, Enterprises	46	62	\$965	\$918
Administrative and Waste Services	789	709	\$454	\$423
Educational Services	0	1,322	.	\$637
Health Care and Social Assistance	0	2,111	.	\$743
Arts, Entertainment and Recreation	64	75	\$331	\$296
Accommodation and Food Services	1,107	1,057	\$236	\$239
Other Services Ex. Public Admin	152	165	\$352	\$355
Public Administration	546	559	\$645	\$632
Unclassified	0	0	\$0	.

## Commercial/Retail/Industrial

### Local Businesses

Apr2014 Available Industrial Buildings	5
2013Q3 Establishments: Total Private Industry	621
2013Q3 Establishments: Manufacturing	41
2011 Est Self Employed	781

### Local Retail Business

2013 Total Retail Sales (With Food/Drink) (\$mil)	\$288.3
2013 Total Retail Businesses (With Food/Drink)	232
2013 Avg Sales/Business Total (with Food/Drink)	\$1,242,496

## Quality of Life

### Taxes

FY2013-14 Property Tax Rate per \$100 Value	\$1.0300
FY2012-13 Annual Taxable Retail Sales (\$mil)	\$233.6
2014 Tier designation	1

### Childcare

2014Q1 Licensed Child Care Facilities	43
2014Q1 Licensed Child Care Enrollment	990

### Weather

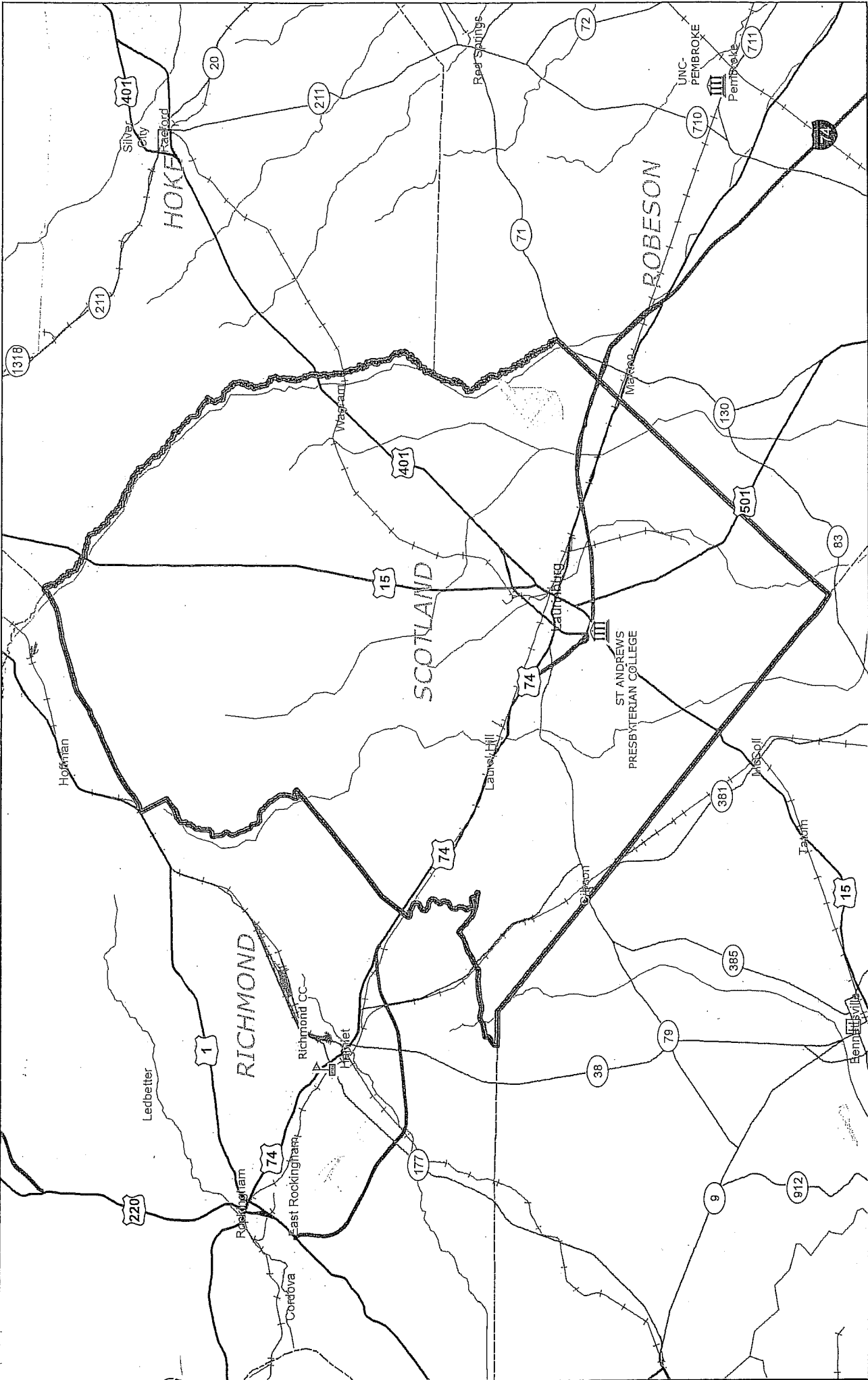
Annual Rainfall, inches	51
Annual Snowfall, inches	4
Average Annual Temperature, F	63
Average Annual High Temperature, F	71
Average Annual Low Temperature, F	48

### Healthcare Providers

2011 Number of Physicians	65
2011 Physicians per 10,000 population	18.0
2011 RNs per 10,000 population	92.7
2011 Dentists per 10,000 population	2.2
2011 Pharmacists per 10,000 population	8.0

Sources:  
 ESRI for demographics, housing, income, and retail data. Applied Geographic Solutions for weather and crime data. [www.appliedgeographic.com](http://www.appliedgeographic.com). NC Dept. of Education for SAT data by county system. <http://www.ncpublicschools.org>. US Dept. of Education, National Center for Education Statistics for higher education data. <http://nces.ed.gov/ipeds/>. NC Commerce, Labor and Economic Analysis Division, for announced new jobs and investment, NC tiers, occupational data, and industrial buildings. <http://www.nccommerce.com/en>. NC Dept. of Health & Human Services for childcare data. <http://www.ncdhhs.gov/>. UNC Sheps Center for healthcare provider statistics. <http://www.shepscenter.unc.edu/>. US Bureau of Labor Statistics for employment and unemployment, wages and establishments by industry. <http://www.bls.gov>. US Census, 2010 and 2000 Census, 2007-11 American Community Survey for demographics, commuters, place of work, educational attainment, housing, and income. <http://factfinder2.census.gov>.

Notes:  
 Data are the latest available at the date the profile was prepared. SAT scores use the new scoring system including a writing test for a perfect score of 2400 and represent county systems. ESRI 2013/2018 data are projections and noted as proj. Some data may be available only for North Carolina. 2010 Census data is noted as such. American Community Survey (ACS) data are estimates and noted as est and is from the 2007-11, 5 year survey and data is as of 2011 with dollars inflated to 2011. For further details or questions, please check the Data Sources Guide at [https://edis.commerce.state.nc.us/docs/bibliography/Data\\_Sources\\_Guide.pdf](https://edis.commerce.state.nc.us/docs/bibliography/Data_Sources_Guide.pdf) or click on it under the map on the homepage.



**Legend**

- Airports by Enplanements >14
- Airports by Enplanements 3-14
- Airports by Enplanements <3 (Million)
- Pub/Private Univ./Comm Col.
- Hospital
- Interstate
- US Highway
- State Highway
- USA Railroads
- National Forests
- County Boundary

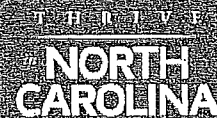


**Scotland County, North Carolina**



# Robeson County (NC)

## April 2014



County Profile Contact (919) 707-1500

Commerce Economic Development Contact (919) 733-4151

### Demographics

#### Population & Growth

2018 Proj Total Population	139,641	0.5%
2013 Proj Total Population	135,966	
2010 Census Total Population	134,168	0.9%
2000 Census Total Population	123,339	
July 2012 Certified Population Estimate (NC only)	134,822	

#### Population

2018 Proj Total Population	139,641
2013 Proj Total Population	135,966
2010 Census Total Population	134,168
2000 Census Total Population	123,339
July 2012 Certified Population Estimate (NC only)	134,822

#### Annual Growth

2018 Proj Total Population	0.5%
2010 Census Total Population	0.9%

#### Urban/Rural Representation

2010 Census Total Population: Urban	50,161	37.4%
2010 Census Total Population: Rural	84,007	62.6%

#### Urban/Rural Percent

2010 Census Total Population: Urban	37.4%
2010 Census Total Population: Rural	62.6%

#### Estimated Population by Age

2018 Proj Median Age	36	
2013 Proj Median Age	35	
2000 Census Median Age	32	
2013 Proj Total Pop 0-19	39,674	29.2%
2013 Proj Total Pop 20-29	19,564	14.4%
2013 Proj Total Pop 30-39	17,278	12.7%
2013 Proj Total Pop 40-49	17,390	12.8%
2013 Proj Total Pop 50-59	17,595	12.9%
2013 Proj Total Pop 60+	24,465	18.0%

2018 Proj Median Age	36
2013 Proj Median Age	35
2000 Census Median Age	32

#### Pop by Age

2013 Proj Total Pop 0-19	29.2%
2013 Proj Total Pop 20-29	14.4%
2013 Proj Total Pop 30-39	12.7%
2013 Proj Total Pop 40-49	12.8%
2013 Proj Total Pop 50-59	12.9%
2013 Proj Total Pop 60+	18.0%

### Commuters, Workers Age 16 and over, 2011 Est

#### Percent of Workers, By Travel Time

Avg Travel Time, Minutes	47,176
Workers Not Working at Home	12.8%
Travel Time to Work: < 10 minutes	15.7%
Travel Time to Work: 10-14 minutes	16.9%
Travel Time to Work: 15-19 minutes	18.5%
Travel Time to Work: 20-24 minutes	4.7%
Travel Time to Work: 25-29 minutes	16.3%
Travel Time to Work: 30-34 minutes	3.9%
Travel Time to Work: 35-44 minutes	4.5%
Travel Time to Work: 45-59 minutes	6.8%
Travel Time to Work: 60+ minutes	

#### Workers, By Transportation

Worker Transp, Base	47,176
Work at Home	2.1%
Drove Car/Truck/Van Alone	80.1%
Carpooled Car/Truck/Van	14.9%
Public Transportation	0.1%
Walked	1.7%
Other Transportation	1.1%

#### Place of Work

Worked in State/County of Residence	34,727	73.6%
Worked in State/Outside County of Residence	11,021	23.4%
Worked Outside State of Residence	1,428	3.0%

#### Commuters

Worked in State/County of Residence	34,727
Worked in State/Outside County of Residence	11,021
Worked Outside State of Residence	1,428

#### Residents

Worked in State/County of Residence	73.6%
Worked in State/Outside County of Residence	23.4%
Worked Outside State of Residence	3.0%

### Education

2012-13 Kindergarten-12th Enrollment	23,561	
2013 Average SAT score (2400 scale)	1,233	
2013 Percent of Graduates taking SAT	35.7%	
2011-12 Higher Education Completions	1,425	
2011-12 Higher Education Total Enrollment	11,194	
Est Education Attainment - At Least High School Graduate	57,186	69.3%
Est Education Attainment - At Least Bachelor's Degree	10,287	12.5%

2012-13 Kindergarten-12th Enrollment	23,561
2013 Average SAT score (2400 scale)	1,233
2013 Percent of Graduates taking SAT	35.7%
2011-12 Higher Education Completions	1,425
2011-12 Higher Education Total Enrollment	11,194
Est Education Attainment - At Least High School Graduate	57,186
Est Education Attainment - At Least Bachelor's Degree	10,287

#### Pop Age 25+

Est Education Attainment - At Least High School Graduate	69.3%
Est Education Attainment - At Least Bachelor's Degree	12.5%

## Housing

		Growth or % of Total
2018 Proj Total Housing	55,658	3.3%
2013 Proj Total Housing	53,878	
2010 Census Total Housing	47,997	
2010 Census Occupied Housing	43,243	90.1%
2010 Census Vacant Housing	4,754	9.9%
2011 Est Median Value of Owner Occupied Housing	\$68,900	
2011 Est Median Value of Renter Occupied Housing	\$572	
2011 Est Owner Occupied Housing	29,934	67.2%
2011 Est Renter Occupied Housing	14,594	32.8%
2011 Est Owner Occupied Housing Vacancy	1.4%	
2011 Est Renter Occupied Housing Vacancy	6.7%	
2010 Census Total Households	52,751	

## Income

		Percent Growth or Total
2011 Est Median Family Income	\$35,814	10.3%
2000 Census Median Family Income	\$32,484	
2018 Proj Median Household Income	\$31,508	15.0%
2013 Proj Median Household Income	\$27,387	( 2.6%)
2000 Census Median Household Income	\$28,125	
2011 Est Median Worker Earnings	\$21,496	
2018 Proj Per Capita Income	\$16,534	2.5%
2013 Proj Per Capita Income	\$14,616	10.5%
2000 Census Per Capita Income	\$13,224	
Est Total Pop with Income Below Poverty Level, Last 12 months	39,625	0.3%

## Employment / Unemployment

	Currently	Annual
Jan2014, 2012 Employment	48,625	48,718
Jan2014, 2012 Unemployment	5,474	7,268
Jan2014, 2012 Unemployment Rate	10.1%	13.0%
2013Q4 YTD, 2013 Announced Job Creation	476	476
2013Q4 YTD, 2013 Total Announced Investments (\$mil)	\$43.2	\$43.2

Employment / Wages by Industry	2013 3rd Qtr Employment	2012 Annual Employment	2013 3rd Qtr Avg Weekly Wage	2012 Avg Weekly Wage
Total All Industries	37,474	38,053	\$598	\$582
Total Government	7,539	8,268	\$717	\$682
Total Private Industry	29,935	29,785	\$568	\$554
Agriculture Forestry Fishing & Hunting	256	231	\$546	\$510
Mining	0	0	\$0	\$0
Utilities	138	0	\$1,455	.
Construction	1,207	1,316	\$597	\$577
Manufacturing	6,138	5,980	\$662	\$645
Wholesale Trade	1,139	1,132	\$999	\$919
Retail Trade	4,721	4,819	\$429	\$422
Transportation and Warehousing	785	151	\$855	\$919
Information	185	190	\$749	\$642
Finance and Insurance	1,027	1,046	\$649	\$755
Real Estate and Rental and Leasing	156	182	\$538	\$478
Professional and Technical Services	0	539	.	\$541
Mgt of Companies, Enterprises	0	651	.	\$437
Administrative and Waste Services	4,378	1,381	\$364	\$349
Educational Services	78	101	\$387	\$355
Health Care and Social Assistance	7,941	7,849	\$660	\$650
Arts, Entertainment and Recreation	167	225	\$284	\$294
Accommodation and Food Services	3,243	3,142	\$231	\$230
Other Services Ex. Public Admin	365	385	\$436	\$430
Public Administration	2,773	2,761	\$712	\$691
Unclassified	0	0	\$0	.

## Commercial/Retail/Industrial

### Local Businesses

Apr2014 Available Industrial Buildings	28
2013Q3 Establishments: Total Private Industry	1,911
2013Q3 Establishments: Manufacturing	63
2011 Est Self Employed	3,499

### Local Retail Business

2013 Total Retail Sales (With Food/Drink) (\$mil)	\$1,088.1
2013 Total Retail Businesses (With Food/Drink)	745
2013 Avg Sales/Business Total (with Food/Drink)	\$1,460,560

## Quality of Life

### Taxes

FY2013-14 Property Tax Rate per \$100 Value	\$0.7700
FY2012-13 Annual Taxable Retail Sales (\$mil)	\$842.2
2014 Tier designation	1

### Childcare

2014Q1 Licensed Child Care Facilities	123
2014Q1 Licensed Child Care Enrollment	4,249

### Weather

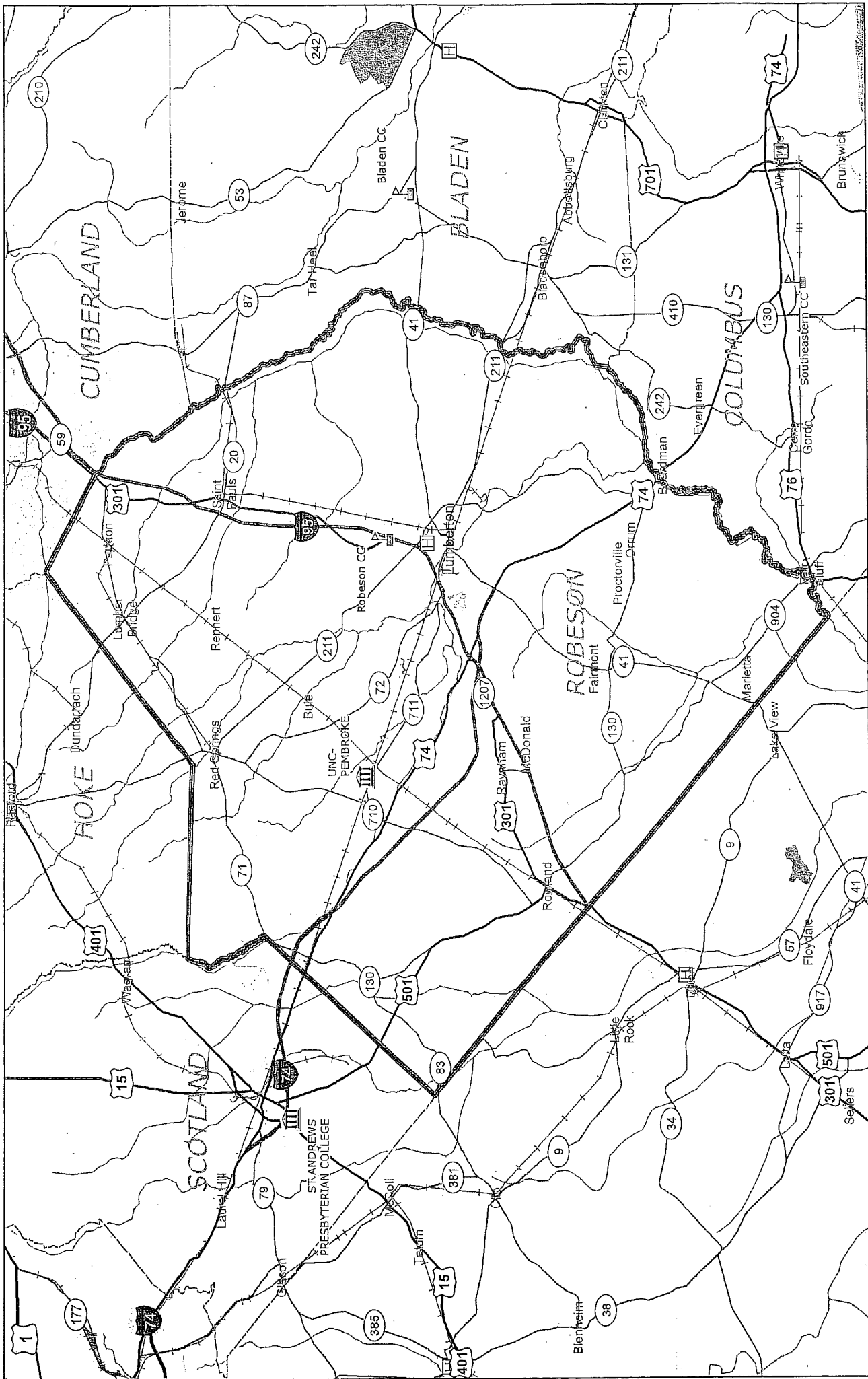
Annual Rainfall, inches	49
Annual Snowfall, inches	3
Average Annual Temperature, F	58
Average Annual High Temperature, F	71
Average Annual Low Temperature, F	50

### Healthcare Providers

2011 Number of Physicians	162
2011 Physicians per 10,000 population	12.0
2011 RNs per 10,000 population	69.0
2011 Dentists per 10,000 population	2.0
2011 Pharmacists per 10,000 population	6.2

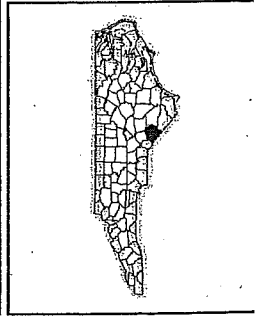
**Sources:**  
 ESRI for demographics, housing, income, and retail data. Applied Geographic Solutions for weather and crime data. [www.appliedgeographic.com](http://www.appliedgeographic.com). NC Dept. of Education for SAT data by county system. <http://www.ncpublicschools.org>. US Dept. of Education, National Center for Education Statistics for higher education data. <http://nces.ed.gov/ipeds/>. NC Commerce, Labor and Economic Analysis Division, for announced new jobs and investment, NC tiers, occupational data, and industrial buildings. <http://www.nccommerce.com/en>. NC Dept. of Health & Human Services for childcare data. <http://www.ncdhhs.gov/>. UNC Sheps Center for healthcare provider statistics. <http://www.shepscenter.unc.edu/>. US Bureau of Labor Statistics for employment and unemployment, wages and establishments by industry. <http://www.bls.gov>. US Census, 2010 and 2000 Census, 2007-11 American Community Survey for demographics, commuters, place of work, educational attainment, housing, and income. <http://factfinder2.census.gov>.

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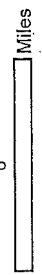
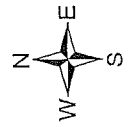


**Legend**

- Airports by Enplanements >14
- Airports by Enplanements 3 - 14
- USA Railroads
- National Forests
- County Boundary
- Hospital
- Interstate
- US Highway
- State Highway
- USA Railroads
- National Forests
- County Boundary



**Robeson County, North Carolina**



**NORTH CAROLINA**  
DEPARTMENT OF COMMERCE





STATE OF NORTH CAROLINA  
COUNTY OF FRANKLIN

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
13-DHR-18127 and 13-DHR-18223

TOTAL RENAL CARE OF NORTH )  
CAROLINA, LLC, )  
 )  
Petitioner, )  
 )  
v. )  
 )  
NORTH CAROLINA DEPARTMENT OF )  
HEALTH AND HUMAN SERVICES, )  
DIVISION OF HEALTH SERVICE )  
REGULATION, CERTIFICATE OF )  
NEED SECTION, )  
 )  
Respondent, )  
 )  
and )  
 )  
BIO-MEDICAL APPLICATIONS OF )  
NORTH CAROLINA, INC., )  
 )  
Respondent-Intervenor. )

TRANSCRIPT OF HEARING

BEFORE HONORABLE CRAIG CROOM  
ADMINISTRATIVE LAW JUDGE

MONDAY, MARCH 24, 2014

Courtroom B  
Office of Administrative Hearings  
1711 New Hope Road  
Raleigh, North Carolina  
8:00 a.m.

Volume 1 of 8

Pages 1 through 280

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1 Mr. Shenton: No. We are going ahead and  
2 calling Ms. Coyle now, Your Honor.

3 The Court: Okay. All right. Place your  
4 left hand on the bible and raise your right.

5 (Whereupon,

6 **LAUREN COYLE**

7 was called as a witness, duly sworn and testified as  
8 follows:)

9 The Court: All right, ma'am. You may take  
10 a seat. When a seat, if you could, just state your name and  
11 spell your name.

12 The Witness: Lauren Coyle, L-a-u-r-e-n  
13 C-o-y-l-e.

14 The Court: All right. Thank you, ma'am.  
15 You may proceed, sir--ma'am.

16 **D I R E C T E X A M I N A T I O N** 8:52 a.m.

17 By Ms. Scott:

18 Q Ms. Coyle, are you employed with DaVita?

19 A Yes.

20 Q And does DaVita have any relationship to Total  
21 Renal Care, the company that we've been talking about in the  
22 opening statements?

23 A Yes. DaVita owns Total Renal Care.

24 Q Okay. And how long have you worked with DaVita?

25 A Since September 7th of 2010, so just--so three and

1 a half years.

2 Q What is your current position with the company?

3 A I'm a regional operations director for the region  
4 known as Region 4, which is--basically stretches from Raleigh  
5 to Greensboro along I-40 up to the Virginia state line.

6 Q So that includes Franklin, Wake, and Durham  
7 counties?

8 A It does.

9 Q How long have you held that position?

10 A Since May 15th of 2012, so about a year and a  
11 half, almost two years.

12 Q So since--okay, so since May 2012?

13 A Uh-huh.

14 Q What did you do before you became regional  
15 operations director?

16 A I was the regional operations director for a  
17 smaller region of home hemodialysis and peritoneal dialysis  
18 facilities that went--that included Pinehurst, Durham,  
19 Roxboro, and Vance counties.

20 Q And what services--what types of services did  
21 those clinics provide?

22 A Home hemodialysis and peritoneal dialysis.

23 Q Did each of those clinics provide both of those  
24 types of services?

25 A The Pinehurst facility offered home hemodialysis

1 and peritoneal dialysis. My Durham facility offered both  
2 home hemodialysis and peritoneal dialysis. And then Roxboro  
3 and Vance both offered peritoneal dialysis only.

4 Q And what were your responsibilities in that prior  
5 position with regard to running those home dialysis clinics?

6 A I had complete responsibility for the clinical  
7 outcomes and financial outcomes of those facilities, hiring  
8 and firing for all the teammates and, you know, taking care  
9 of those patients.

10 Q So for the judge's benefit could you just explain  
11 what a typical workday or workweek in your position with  
12 those home dialysis clinics would have involved?

13 A Sure. So each day of the week I would kind of  
14 have planned out which clinics I was going to go to. And I  
15 would drive to the clinic, you know, first thing in the  
16 morning, get there.

17 And depending on what was going on, I would meet  
18 with patients or teammates to see--and teammates usually  
19 meaning nurses who care for the patients--to understand  
20 better how things were going. I might observe a clinic day  
21 in which patients--home patients usually come into the clinic  
22 twice a month to see their nurse and to see their doctor.  
23 Even though they're doing their dialysis at home, they need  
24 to be checked up on.

25 So I might be there to help the clinic day just go

1 more smoothly and ask the patients how things are going with  
2 them as well as work with the doctors to make sure things are  
3 going well with them. So I'd meet with the patients, talk  
4 with them, meet with the nurses, talk with them, and then  
5 might do, you know, some additional e-mail or conference  
6 calls, depending on what was going on later in the day.

7 Q You mentioned working with the doctors. What  
8 would your work with the physicians involve?

9 A So I mean making sure we're providing the right  
10 services for the patients, making sure we're getting the  
11 patients everything they need, that we are training the  
12 patients that the doctors are referring into home dialysis in  
13 a timely manner, making sure that if I needed to ask a nurse  
14 for instance from Pinehurst to come help out in Durham so  
15 that we could train an extra patient that the doctors wanted  
16 trained, we could do that.

17 And when I say training, I mean we have to train  
18 them to do their dialysis at home because it's not  
19 particularly simple, so--I mean simple enough that they could  
20 learn it in a couple of weeks, but you can't just auto-  
21 matically go home and do it with an instruction booklet. So  
22 it usually--for peritoneal dialysis it takes two weeks of  
23 training. For home hemodialysis it can take anywhere up--  
24 from a minimum of three and up to six weeks of training with  
25 a registered nurse.



1 Q In your position managing those home clinics did  
2 you have business management responsibilities?

3 A Yes.

4 Q And what did those entail?

5 A Just complete financial responsibility for the  
6 revenue, the costs--and the costs associated with those  
7 programs. So I would make sure I understood exactly, you  
8 know, who our patients were, what kind of insurance they had,  
9 how we were billing for them, making sure that we had  
10 everything that we needed to be able to bill for them, and  
11 have all of that in place.

12 Q And what did you do before this position managing  
13 the home clinics?

14 A So before that, I was on a brief maternity leave,  
15 but before that, I was in our Redwoods--we call it a Redwoods  
16 training program. So we have a program that brings in people  
17 who don't have dialysis experience from business schools and  
18 brings them into the company and spends a year teaching them  
19 dialysis, so everything from the very basics and science of  
20 dialysis that we teach our nurses and technicians where we go  
21 off to a class and learn exactly how dialysis works and we  
22 have to take a test at the end, which is rather difficult,  
23 and then we--to just all the different business aspects of  
24 dialysis from people services to payor contracting to just  
25 finance and to labor management, various cost management, as

1 well as marketing, how we would--how we would work with  
2 doctors to get them excited about referring patients to our  
3 programs.

4 Q And how did you learn about that large variety of  
5 matters pertaining to dialysis?

6 A So it's a pretty heavily structured program in  
7 which we have a huge checklist with hundreds of items of  
8 things that we have to learn, and you must complete the  
9 checklist. And so some of that includes just like what we  
10 call Star learning, our computer learning management program.  
11 So there's some basics like the adequacy of dialysis that  
12 you just need to read and learn and do a computer program and  
13 a WebEx on and then take a test to show you've learned that.

14 They also flew us all around the country to all of  
15 the different business hubs that we have including our head-  
16 quarters in Denver, our previous headquarters in El Segundo,  
17 and various other business offices like in Nashville and  
18 Tacoma, Washington to meet with various heads of the  
19 different businesses and learn more about things there.

20 So in Nashville we met with Tad Stahel, who's the  
21 vice president of home modalities. Out in Tacoma, the team  
22 met with the folks who do all of our billing, our revenue  
23 operations folks. You know, in Denver we met with our people  
24 services people. And we would go in and we would have two to  
25 three days' worth of meetings with those folks and then fly

1 back home.

2           Additionally, we did shadowing in order to get  
3 that huge checklist of items learned. We would do shadowing  
4 with various teammates of all different levels in the  
5 clinics. And so I spent a week working with a patient care  
6 technician to learn exactly how she worked, so I got to work  
7 at 4:30 in the morning and would, you know, watch her stream  
8 machines and would carry boxes and do the things that I was  
9 allowed to do, but which usually meant carrying things back  
10 and forth from the storage room and saying hi to our  
11 patients.

12           And then, you know, I would work with our nurses  
13 to shadow them, work with our dietitians to shadow them, our  
14 social workers, all the way up to the folks who are now my  
15 peers, the regional operations directors in North Carolina,  
16 and our vice president, Clarkston Hines.

17           Q     Did this intensive training program, the Redwoods  
18 program, did it involve any education regarding--you've  
19 mentioned revenue---

20           A     (interposing) Uh-huh.

21           Q     ---operations. Did it involve any information or  
22 orientation to insurance and reimbursement type matters?

23           A     Absolutely, so our--we have an entire insurance---

24           Ms. Hedrick:           (interposing) Your Honor, I  
25 just want to raise an objection for the record. The

1 testimony so far has focused almost entirely on what DaVita  
2 does and what its experience is with dialysis. And I don't  
3 see that this has any relevance to the issues in this case,  
4 which are related to BMA's projections, and BMA didn't  
5 purport to rely on DaVita's experience. I don't think this  
6 testimony is relevant.

7 The Court: Yes, ma'am.

8 Ms. Scott: Your Honor, Ms. Coyle is just  
9 testifying about basic components of the dialysis business  
10 and industry. Your Honor asked late last week to be educated  
11 and have some basic information in this area. And that is  
12 all we are trying to do is to give you some foundational  
13 information about the basics of dialysis to facilitate your  
14 understanding of the discussion and testimony that's going to  
15 come regarding the issues in this case, which do relate to  
16 dialysis.

17 The Court: That was good, but let me do it  
18 this way. I'm just going to treat it now as background and  
19 give it the appropriate weight, so at this point your  
20 objection is overruled.

21 Ms. Hedrick: Thank you, Your Honor.

22 The Court: You may proceed.

23 By Ms. Scott:

24 Q Ms. Coyle, I had asked you if the intensive  
25 Redwoods training program involved any education or

1 orientation to insurance and reimbursement matters, and you  
2 were---

3 A (interposing) Yes. So we---

4 Q ---getting ready to respond.

5 A ---have an insurance management team and I spent  
6 time with them. Jean Baker is one of our insurance  
7 counselors, who's great with working with patients, so I  
8 spent a lot of time with her as well as learning more about  
9 just the overall financials of the dialysis industry, which  
10 you can read in the annual reports of each of the dialysis  
11 companies. I would do a lot of reading there and  
12 understanding of what's going on with how reimbursement works  
13 and how we get paid. There's a lot in the news about it  
14 right now because of everything going on in Washington.

15 Q And just to touch on one final background point,  
16 can I ask you to turn to the TRC exhibit notebook, the one  
17 that has Exhibit 276? And I think it might be just to your  
18 right there.

19 The Court: I didn't see all this behind me  
20 back here. Where is my book? Give me that number again.

21 Ms. Scott: TRC Exhibit 276, Your Honor.  
22 There are three volumes of the TRC exhibits with the range on  
23 the spine of each.

24 The Court: 276 to 326, okay. Yes, ma'am.

25 Ms. Scott: We're looking at Exhibit 276,

1 Your Honor.

2 Ms. Hedrick: Your Honor, I'm sorry; I'm  
3 going to raise an objection for the record again. It looks  
4 like Ms. Scott is directing Ms. Coyle to a copy of her  
5 résumé, and it's my understanding at this point that Ms.  
6 Coyle is not intended to be offered as an expert. I don't  
7 know what relevance her résumé has to do with any of the  
8 issues in this case.

9 The Court: Yes, ma'am. I'll hear you.

10 Ms. Scott: She is not going to be offering  
11 any expert opinion testimony. This is just one final  
12 background point we're talking about to let Your Honor know  
13 who Ms. Coyle is and what her background is. This is easily  
14 the most efficient way for Your Honor to hear about her  
15 educational background, which is the point of turning to her  
16 résumé.

17 The Court: Again I'll overrule that  
18 objection. I'll give it the appropriate weight.

19 Ms. Hedrick: Thank you, Your Honor.

20 The Court: And she is not testifying as an  
21 expert, though?

22 Ms. Scott: No, Your Honor.

23 The Court: Okay.

24 Ms. Scott: That's correct.

25 The Court: All right. Yes, ma'am. Go

1 ahead.

2 By Ms. Scott:

3 Q Ms. Coyle, have you found TRC Exhibit 276?

4 A Yes.

5 Q Do you recognize what that is?

6 A It's a very old copy of my résumé, yes.

7 Q When you say very old---

8 A (interposing) I made it around April 2011, May  
9 2011, so it's a few years old.

10 Q And referring to your résumé there, could you just  
11 tell us generally about your educational background?

12 A Yeah. So I went to Harvard College, graduated in  
13 2000. I worked at Bain & Company as a consultant right after  
14 college and then moved into for-profit education for Kaplan,  
15 where I worked for six years. And then I went to Harvard  
16 business school, graduated with high honors there and came to  
17 work for DaVita following that, so---

18 Q (interposing) Did you go straight to DaVita from  
19 Harvard business school?

20 A I did, yes.

21 Q Okay. And what did your studies in the business  
22 school--did they have any health care component to them?

23 A Absolutely; so the Harvard business school is  
24 based on a case study method, so a little bit like law school  
25 in that you're going to see lots of different cases in your

1 classes every day that could be from lots of different  
2 places.

3           And so all of my classes had a health care  
4 component and had multiple health care cases as part of  
5 those. Even consumer marketing had health care cases in it.  
6 And then in addition I specifically took a health care  
7 related class on the innovation--innovations in health care  
8 during my second year.

9           Q     Okay. Turning back to your current role with  
10 DaVita, which you've held since May of 2012 as regional  
11 operations director, can you describe generally what your  
12 responsibilities are in that position?

13           A     So I have complete--I have complete responsibility  
14 for all of my patients' health outcomes and all of my  
15 clinics' financial outcomes for my clinics.

16           Q     And how many clinics do you oversee?

17           A     I oversee 11 total clinics, which includes one  
18 home hemodialysis program, eight peritoneal dialysis  
19 programs, and 11 in-center dialysis programs. It's about  
20 1,000 patients in this area.

21           Q     Okay. And again, for the judge's benefit could  
22 you describe just what a typical workday or workweek---

23           A     (interposing) Sure.

24           Q     ---looks like for you?

25           A     So my calendar is a little ridiculous, but it's



1 planned about, you know, a quarter at a time. And I make  
2 sure I get to each of my clinics. And what I do is each week  
3 I plan a trip to several clinics and then I plan a couple of  
4 days in which I can be available to patients or teammates  
5 over the phone, as needed.

6           So for instance, today if we had not had this, I'd  
7 be going to my clinic in Burlington, meeting with the  
8 teammates, rounding on all of the patients, seeing the  
9 physicians there, and speaking with them about their  
10 experience and what's going on in their clinics right now.

11           And then, you know, at the end of the day after  
12 all the patients have gone home, I usually try to catch up on  
13 e-mail and work around the financial responsibilities for the  
14 clinics. So I might be looking into--part of what I do right  
15 now as well is work on--so I would say--I would back up and  
16 say each of the directors in our division has a different  
17 specific role. And one of those roles for me is working on  
18 private pay and working on our--understanding what our payor  
19 mix is.

20           Q     And without referring to the---

21           A     (interposing) Yeah.

22           Q     ---specific data---

23           A     (interposing) Okay.

24           Q     ---or talking about the specific data, what does  
25 that particular special role involve? What is the work, the

1 type of work that you're doing?

2           A     So the type of work I'm doing is trying to analyze  
3 where we have or do not have a strong commercial mix among  
4 our patient base. So Medicare, just as you may read from the  
5 press and you can also read in our--you know, in the annual  
6 reports, Your Honor, Medicare doesn't pay a high enough rate  
7 for any of the dialysis providers to make any money off of--  
8 we lose money on every single Medicare treatment we do. And  
9 this is really tough because--again, you can read just in the  
10 press and in DaVita's 10-K, 90 percent of our patients are  
11 Medicare patients.

12                     So we rely on a really tiny patient base--as an  
13 industry, we rely on a really tiny patient base to make all  
14 of our money for us. We don't stay in business without these  
15 private pay or commercially insured patients. So you can  
16 easily see that one patient will--could send a clinic either  
17 into profitability or losing one patient could send a clinic  
18 out of profitability.

19           Q     Thank you. How often do you visit the facilities  
20 that you manage during the regular course of your work?

21           A     I'm in a clinic almost every day. I mean there's  
22 days like today where I'm not in a clinic, although if we end  
23 early, I'll get to Burlington this afternoon. But I'm in a  
24 clinic almost every day. DaVita has some national meetings  
25 and things like that, so I might not be in a clinic on a day



## ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

### FINDINGS

C = Conforming

CA = Conditional

NC = Nonconforming

NA = Not Applicable

DECISION DATE: December 28, 2007

FINDINGS DATE: January 7, 2008

PROJECT ANALYST: Tanya S. Rupp

ASSISTANT CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: F-7912-07 / Bio-Medical Applications of North Carolina, Inc. d/b/a FMC Huntersville / Develop a new 12-station dialysis facility in Huntersville by relocating 12 existing certified dialysis stations from three BMA facilities in Mecklenburg County: BMA Beatties Ford, BMA North Charlotte, and BMA Charlotte / Mecklenburg County

### REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

- (1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

C

Bio-Medical Applications of North Carolina, Inc. d/b/a FMC Huntersville, proposes to establish a new dialysis facility located at 9801 W. Kinsey Avenue in Huntersville, by relocating three dialysis stations from the BMA Beatties Ford facility, four stations from the BMA North Charlotte facility, and five dialysis stations from the BMA Charlotte facility. The applicant does not propose to add dialysis stations to an existing facility or to establish new dialysis stations. Therefore, neither of the two need methodologies in the *2007 State Medical Facilities Plan* (SMFP) is applicable to the review. However, SMFP Policy ESRD-2 is applicable to this review. Policy ESRD-2, found on page 26 states:

*“Relocations of existing dialysis stations are allowed only within the host county and to contiguous counties currently served by the facility. Certificate of Need applicant proposing to relocate dialysis stations shall:*

- (A) *demonstrate that the proposal shall not result in a deficit in the number of dialysis stations in the county that would be losing stations as a result of the proposed project, as reflected in the most recent Dialysis Report, and*
- (B) *demonstrate that the proposal shall not result in a surplus of dialysis stations in the county that would gain stations as a result of the proposed project, as reflected in the most recent Dialysis Report.*

The applicant proposes to relocate 12 existing, certified dialysis stations within Mecklenburg County. Consequently, there is no change in the inventory in Mecklenburg County and the application is conforming to Policy ESRD-2. Therefore, the application is conforming to this criterion.

- (2) Repealed effective July 1, 1987.
- (3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

The applicant, Bio-Medical Applications of North Carolina, Inc., operates several dialysis facilities located throughout central and southern Mecklenburg County. In this application, BMA proposes to develop a new 12-station dialysis facility in Huntersville by relocating existing dialysis stations from three existing facilities in the Charlotte area. The facilities involved, pending CON projects, current number of stations, and current transfer proposals in Mecklenburg County are as follows:

FACILITY	CURRENT # STATIONS	CON PROJECT #	PROPOSAL	END STATION RESULT
BMA Beatties Ford	32	F-7912-07	Relocate three stations	29 stations
BMA North Charlotte	28	F-7912-07	Relocate four stations	24 stations
BMA North Charlotte	28	F-7787-07	Delete one station	23 stations
BMA Charlotte	46	F-7912-07	Relocate five stations	41 stations
FMC Huntersville	-0-	F-7912-07	Est. new facility with 12 relocated stations	12 stations

The applicant does not propose to establish new dialysis stations.

Population to be Served

In Section III.7, pages 24 – 26 of the application, the applicant states that 100% of the patients to be served at the proposed Huntersville facility will come from Mecklenburg County. On pages 24 and 25 of the application the applicant states:

*“BMA has provided 48 letters of support for this project. Each of these patients has indicated that commute to the proposed facility in Huntersville would be more convenient than to their current dialysis facility. Each of these patients has indicated their desire to maintain continuity of their care by continuing to dialyze in a BMA facility, maintaining their existing physician-patient relationship. BMA offers a conservative estimate of the number of patients expected to transfer to this facility. BMA is projecting that 38 patients will transfer to the new facility. Each of these transferring patients is a Mecklenburg County residents [sic]. BMA suggests that this is a conservative approach to projecting future growth; BMA could have suggested that 100% of the patients who have signed letters of support for this project would transfer. BMA also notes that this facility will provide In-Center dialysis only. Home patients will be referred to the BMA Charlotte facility.”*

The applicant projects that the facility will be certified on January 1, 2009. As shown above, BMA projects 100% of the population to be served in the proposed facility will be residents of Mecklenburg County. On page 25, the applicant provides a table, reproduced below, that shows the projected patient origin:

COUNTY	PROJECTED BEGINNING CENSUS	OPERATING YEAR 1	OPERATING YEAR 2	COUNTY PATIENTS AS A PERCENT OF TOTAL	
	#PTS DIALYZING IN-CENTER	#PTS DIALYZING IN-CENTER	#PTS DIALYZING IN-CENTER	YEAR 1	YEAR 2
Mecklenburg	38	39.9	41.9	100.0%	100.0%
TOTAL	38	39.9	41.9	100.0%	100.0%

The applicant adequately identified the population it proposes to serve.

Need for the Proposed Service

The applicant states on page 18 of the application:

*“Geographic accessibility is the primary basis for this application. Geographic accessibility may not necessarily be a function of distance traveled. BMA is suggesting that geographic accessibility is also a function of time necessarily involved in the commute to and from dialysis, and the ease of that commute. Time and ease of commute are directly related to the volume and complexity of vehicular traffic along a route.”*

...BMA proposes to establish a new In-Center Hemodialysis facility in Huntersville. Huntersville is on the northern side of Mecklenburg County. Currently, there is not a dialysis facility providing In-Center Hemodialysis in this area of the county. The area map referenced in Exhibit 27 has each of the 15 operational and planned In-Center dialysis facilities in Mecklenburg County plotted by street address, and marked on the map. After it becomes operational and certified, the DaVita DVA North Charlotte facility, nearly nine miles south of Huntersville, will be the closest dialysis facility offering CON approved In-Center Hemodialysis; the DVA North Charlotte facility is still under development and not yet certified. The next closest facility is the RAI Latrobe facility, nearly 10 miles away.”

Also on page 18, the applicant states it has identified “many patients receiving treatment at various BMA facilities within Mecklenburg County who might be better served by a dialysis facility in Huntersville.” In Exhibit 22 the applicant provides 47 signed letters of support for the proposed project. The Exhibit contains 48 letters; however, one letter is unsigned and therefore cannot be considered as evidence. Each letter includes a statement that the patient will consider transferring to the proposed location in Huntersville. The project analyst prepared a table that shows patient residence ZIP codes and the number of BMA dialysis patients currently residing in those ZIP codes, as shown in the patient letters in Exhibit 22:

PATIENT ZIP CODE	28269	28262	28216	28078	28070	28213	UNSIGNED LETTER	NO ZIP CODE GIVEN
Numbers of Patients	12	3	8	5	1	2	1	16
<b>Total</b>								<b>48</b>

The proposed facility will be located in Huntersville in ZIP code 28078. This ZIP code area is less than ten miles from all ZIP codes listed in the table above, except for 28213, from which only two patients indicated an intent to transfer. ZIP code 28213 is a Charlotte ZIP code, approximately 11.5 miles from the proposed facility in Huntersville.<sup>1</sup> Thus, the patient residence ZIP codes are close to the proposed facility in Huntersville.

However, 16 of the 47 signed letters signed by patients have no ZIP code listed. Instead, the first paragraph indicates simply that the patient “lives in Mecklenburg County.” Mecklenburg County is composed of many ZIP codes, and the Charlotte regional area is extremely populous. It is not possible to tell, from the information given in the application and exhibits, which part of Mecklenburg County these 16 patients are from. For example, ZIP code 28031 is in Northern Mecklenburg County, and is nearly 28 miles from ZIP code 28134, in Southern Mecklenburg County. Likewise, from Eastern Mecklenburg County, ZIP code 28130 to Western

<sup>1</sup> See <http://www.zipfind.net> for distance between ZIP codes given in the application.

Mecklenburg County, ZIP code 28227, is approximately 18 miles. Both of these commute times would be burdensome to dialysis patients who could seek dialysis treatments in a facility closer to the Northern, Southern, Eastern, or Western areas of Mecklenburg County. Therefore it is not possible, based on the 16 letters lacking a ZIP code as supplied in Exhibit 22, to draw a reasonable conclusion with regard to the distance of a potential commute and the relative ease of that commute for the prospective patient seeking dialysis treatments three times weekly.

Further, NCAC 14C .2203(a) states,

*“An applicant proposing to establish a new End Stage Renal Disease facility shall document the need for at least 10 stations based on utilization of 3.2 patients per station per week as of the end of the first operating year of the facility, with the exception that the performance standard shall be waived for a need in the State Medical Facilities Plan that is based on an adjusted need determination.”*

In this application, the applicant seeks to establish a 12-station dialysis facility, by relocating existing stations and transferring 38 patients. However, the applicant has only provided corroborating evidence that 31 patients would transfer to the proposed facility in Huntersville as a result of its proposed location and proximity to the patients' residence (47 signed letters – 16 with no ZIP code = 31 letters). Since only 31 of the 48 patient letters indicate a ZIP code residence that is within close proximity to the proposed facility, only 31 of the 48 letters can be relied upon as credible evidence of a need for additional dialysis stations in the Huntersville area of Mecklenburg County. 31 initial patients amounts to only 2.7 patients per station at the end of the first operating year, when grown by five percent (see following discussion).

On page 19 of the application, the applicant projects that 38 of the 47 patients who signed support letters will initially transfer to the proposed facility when it is certified (anticipated January 1, 2009). BMA projects the initial 38 patient population to grow at a rate consistent with the 5.0% Mecklenburg County Five Year Average Annual Change Rate (AACR) as reported in the July, 2007 Semi Annual Dialysis Report (July, 2007 SDR). Since the projected number of patients to transfer initially is 38, then the projected census for the proposed facility for the period ending December 31, 2009 (the end of the first project year) is 40 patients ( $38 \times 1.05 = 39.9$ ). The applicant rounded that number down rather than up, to project an 81.25% utilization rate, or 3.25 patients per station at the end of Project Year one ( $39 \text{ patients} / 12 \text{ stations} = 3.25$ ). However, since only 31 patients can reasonably be projected to initially transfer to the facility based on the letters in Exhibit 22, then the utilization projections are not consistent with 10A NCAC 14C .2203(a). An initial transfer of 31 patients increased by five percent results in 32.6 patients at the end of the first project year ( $31 \times 1.05 = 32.55$ ). Further, 32.6 patients divided by 12 stations results in a utilization of only 2.7 patients per station, or a 68% utilization rate at the end of the first project year ( $32.6 / 12 = 2.72$ ;  $2.72 / 4 = 0.679$ ). These projections are not



consistent with 10A NCAC 14C .2203(a), which requires a proposed ESRD facility to reasonably project a facility utilization of 3.2 patients per station by the end of the first project year.

On page 23 the applicant states

*“BMA has performed a thorough ZIP Code analysis of dialysis patients residing within 10 miles of Huntersville. ...The Southeastern Kidney Council has reported that there are 261 In-Center dialysis patients residing in the ZIP Codes within 10 miles of Huntersville. BMA is currently serving 132 of these patients at one of the BMA dialysis facilities indicated. BMA does not suggest that each of the patients in these ZIP Codes is actually closer to Huntersville; rather, due to the geographic makeup of these ZIP Codes, BMA suggests that some of these patients would be closer to Huntersville and the BMA facility proposed for Huntersville [emphasis in original].*

Thus, the applicant states it currently serves 50.6% of the dialysis population residing in the ZIP codes that are within a ten-mile radius of the proposed FMC Huntersville facility ( $132 / 261 = 0.5057$ ). However, according to the information supplied in the letters in Exhibit 22, there are only five patients in Huntersville, which is only 3.8% of the 132 patients currently served ( $5 / 132 = 0.0378$ ). Thus, the applicant did not adequately demonstrate that Huntersville is the most effective location for the proposed facility, given that less than four percent of BMA's 132 patients reside in that ZIP code.

In summary, the applicant adequately identified the population to be served but failed to adequately demonstrate the need to establish a 12-station dialysis facility in Huntersville. Consequently, the application is not conforming to this criterion.

- (3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

### C

The applicant states that the proposed facility, BMA Huntersville, will be located on W. Kinsey Avenue in Huntersville. The applicant provided 47 signed letters from current patients stating they would consider transferring to the proposed facility, because they reside within 10 miles of the proposed facility. Exhibit 22 of the application contains patient letters of support for the proposed project, which state

*"I am a dialysis patient receiving my dialysis treatments at FMC [several different BMA facilities in Mecklenburg County]. My residence ZIP code is [2269, 28262, 28216, 28078, 28070, 28213] and I live in Mecklenburg County.*

*I understand that Bio-Medical Applications of North Carolina is submitting an application for a Certificate of Need to develop a new 12 station dialysis facility in Huntersville, Mecklenburg County. It is my understanding that BMA will accomplish this by way of transferring dialysis stations from the BMA Charlotte, BMA Beatties Ford, and BMA North Charlotte dialysis facilities. I want to strongly encourage the CON agency to approve the application to transfer the 12 stations to Huntersville. I enthusiastically support the efforts of Bio-Medical Applications of North Carolina.*

*If the application to relocate 12 stations to Huntersville is approved, I would consider transferring to the new facility. I understand that the new facility would be operated in the same manner as my current dialysis center. There are two very important reasons to approve this application:*

- a. A new facility in Huntersville will be closer to my home, and will be much more convenient for me and my transportation. Patients on dialysis have many hardships, especially arranging transportation three days per week. The location of this proposed facility will mean that my family or other transportation will not have to deal with the heavy traffic in Charlotte three days per week for each of my dialysis treatments....*
- b. Continuity of care is very important to me. I understand that the new facility would be operated in the same manner as my current facility. I DO prefer to dialyze in a singly use dialysis facility, and I don't want to leave my current facility without knowing that my doctor will also be going with me."*

47 patients signed the letters; however, only 31 of the letters provided a residence zip code. Consequently, the evidence documents that only 31 of the patients live closer to the proposed facility and thus would reasonably be expected to transfer. Therefore, upon completion of the proposed project (January 1, 2009), BMA would have the following patients in the affected facilities:

FACILITY	# PATIENTS	# STATIONS	PTS. PER STATION	UTILIZATION
BMA Beatties Ford	86	29	2.96	74.13%
BMA North Charlotte	79	23	3.43	85.86%
BMA Charlotte	122	41	2.98	74.39%
FMC Huntersville	32.5	10	3.25	81.38%

None of the three facilities from which stations will be relocated will be overcrowded as a result of this project. The needs of the population presently served will continue to be adequately met following the relocation of dialysis stations from the above three dialysis facilities to the proposed facility in Huntersville. However, see Criterion (3) for discussion of need. Therefore, the application is conforming to this criterion.

- (4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Section III.9, pages 26 - 27 of the application, the applicant describes the alternatives considered. The applicant proposes to relocate existing stations to establish a 12-station facility in Huntersville. However, the applicant did not adequately demonstrate the need for the proposed project. See discussion in Criterion (3). Further, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (6), (18a), (20), and 10A NCAC 14C .2200. Therefore, the application is not conforming to this criterion.

- (5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

C

In Section VIII.1, page 46, the applicant projects that the total capital cost will be \$916,106, including \$617,784 in construction costs, \$51,500 for water treatment equipment, \$148,360 for additional equipment, and \$98,462 in Architect and Engineering fees and contingencies. In Section VIII.2, page 47, the applicant states FMC Huntersville will finance the total capital costs with accumulated reserves. In Section IX.1, page 50, the applicant states there will be \$22,017 in start-up expenses and \$320,001 in initial operating expenses, for total working capital required of \$342,018. Exhibit 24 contains a July 16, 2007 letter from the Assistant Treasurer of Fresenius Medical Care North America, which states:

*"This is to inform you that Fresenius Medical Care Holding, Inc. is the parent company of National Medical Care, Inc. and Bio-Medical Applications of North Carolina, Inc.*

*BMA proposes to transfer three dialysis stations from BMA Beatties Ford, transfer four dialysis stations from BMA North Charlotte, and transfer five dialysis stations from BMA Charlotte, to establish a new 12-station*

*dialysis facility, FMC Huntersville. The project calls the following capital expenditures on behalf of BMA.*

<i>Capital Expenditure</i>	<i>\$ 916,106</i>
<i>Start-up Expenses</i>	<i>\$ 22,017</i>
<i>Working Capital (first 2 months operations)</i>	<i>\$ 320,001</i>
<i>Total Working Capital Required</i>	<i>\$1,258,124.</i>

*As Assistant Treasurer, I am authorized and do hereby authorize the relocation of these 12 stations, and development of the new facility Fresenius Medical Care of Huntersville for capital costs, start-up expenses, and working capital as identified above. Further, I am authorized and do hereby authorize and commit cash reserves for the capital cost of \$916,106, and for the start up and working capital totaling \$342,018, as may be needed for this project."*

Exhibit 10 contains the financial statements for Fresenius Medical Care Holdings, Inc. As of December 31, 2006, Fresenius Medical Care Holdings, Inc. had \$3,411,916,000 in Total Current Assets, and \$159,010,000 in cash and cash equivalents. Therefore, the applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

The rates in Section X.1, page 53 are consistent with the standard Medicare/Medicaid rates established by the Center for Medicare and Medicaid Services. In the revenue and expense statements in Sections X.2, X.3, and X.4, pages 53 - 54, the applicant projects that revenues will exceed operating costs in each of the first two years of operation. The assumptions used by the applicant in preparation of the pro forma financial statements are reasonable, including the number of treatments to be provided, which are based on industry standards, according to the applicant on page 54. See Section X, page 54 for the applicant's assumptions.

In summary, the applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project. Further, the applicant adequately demonstrated that the financial feasibility of the proposal is based on reasonable projections of revenues and operating costs. Therefore, the application is conforming to this criterion.

- (6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

The applicant proposes to relocate existing stations to establish a 12-station facility in Huntersville. However, the applicant did not adequately demonstrate the need for the

proposed project. See discussion in Criterion (3). Therefore, the application is not conforming to this criterion.

- (7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

In Section V.4, page 33, the applicant states George M. Hart, M.D. has agreed to serve as Medical Director for the proposed facility. In Exhibit 21 the applicant provides a June 25, 2007 letter from Dr. Hart, in which he agrees to serve as Medical Director. In Section VII the applicant provides a table that shows the FTE positions to be added at the facility. The information provided in that table is summarized below:

POSITION	PROPOSED FTE'S
RN	2.00
Technician	4.00
Nurse Assistant	1.00
Clinical Manager	1.00
Medical Director	<i>Contract position</i>
Admin (FMC Area Mgr)	0.25
Dietician	0.50
Social Worker	0.50
Chief Technician	0.10
Equipment Technician	0.35
In-Service	0.25
Clerical	1.00
Total	10.95

In Section VII.4, page 44, the applicant describes the experience it has in recruiting and hiring staff necessary to operate dialysis facilities. The additional information provided in Application Sections V and VII is reasonable and credible and supports a finding of conformity to this criterion.

- (8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system. See also 10A NCAC 14C .2205 in these findings.

C

In Application Section V.1, the applicant lists the providers of the necessary ancillary and support services. The information regarding coordination of services provided in Application Section V and referenced exhibits is reasonable and

credible and supports a finding of conformity to this criterion. See also 10A NCAC 14C .2204 in these findings.

- (9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

- (10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

- (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

NA

- (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

- (i) would be available under a contract of at least 5 years duration;
- (ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
- (iii) would cost no more than if the services were provided by the HMO; and
- (iv) would be available in a manner which is administratively feasible to the HMO.

NA

- (11) Repealed effective July 1, 1987.

- (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

C

In Section XI.6(h), page 63 of the application, the applicant states it will construct 7,964 square feet of new space for the proposed dialysis facility in Huntersville. In Section XI.6(d) of the application, the applicant state that applicable energy saving features and water treatment equipment will be incorporated into the construction plans. The applicant adequately demonstrated that the cost, design and means of construction represent the most reasonable alternative, and that the construction cost will not unduly increase costs and charges for health services. See Criterion (5) for discussion of costs and charges. The application is conforming to this criterion.

- (13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:
- (a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

In Section VI.1, pages 38 - 39, the applicant states it used a composite of the historical mix of patients from the three facilities proposed to contribute stations to the Huntersville facility to project Medicare and Medicaid recipients. Thus, the applicant states 86.77% of the patients who received treatments at the BMA Mecklenburg facilities had some or all of their services paid by Medicare, and 3.77% of the patients had some or all of their services paid by Medicaid. Therefore, the applicant provides adequate access to medically underserved groups, and the application is conforming to this criterion.

- (b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

The Licensure and Certification Section of DHSR reports no civil rights equal access complaints have been made against BMA facilities in North Carolina.

- (c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In Section VI.1, page 38 of the application, the applicant states "*It is BMA policy to provide all services to all patients regardless of income, racial/ethnic origin, gender, physical or mental conditions, age, ability to pay or any other factor that would classify a patient as underserved.*" In Section VI.1(d) of the application, the applicant states "*The admission policy included at Exhibit 8 indicates that patients are required to have some type of insurance prior to admission for treatment. ... However, in the interest of providing services where needed, the Regional Vice President does have the authority to override the policy. The Social Worker and Business office staff will assist the patient by identifying available sources of funding and completing the required information necessary to obtain assistance.*" In Section VI.1(c) of the application, the applicant projects no change in the payor mix resulting from this proposal. Thus, the applicant projects that 86.77% of patients will have some or all of their services paid for by Medicare, and 3.77% of patients will have some or all of their services paid for by Medicaid. The applicant demonstrated that medically underserved populations will have adequate access to the proposed services. Therefore, the application is conforming to this criterion

- (d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

The information provided in Application Section VI.5(a) is reasonable and credible and supports a finding of conformity with this criterion.

- (14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C



In Section V.3, the applicant states it has proposed agreements to Central Piedmont Community College and Gaston College. In Exhibit 19, the applicant provides copies of these letters. The application is conforming to this criterion.

- (15) Repealed effective July 1, 1987.
- (16) Repealed effective July 1, 1987.
- (17) Repealed effective July 1, 1987.
- (18) Repealed effective July 1, 1987.

- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicant did not adequately demonstrate that the proposal would have a positive impact on the quality of the proposed services. See Criterion (20). Therefore, the application is not conforming to this criterion.

- (19) Repealed effective July 1, 1987.
- (20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

NC

The applicant currently provides dialysis services at other facilities in Mecklenburg County. According to the Licensure and Certification Section, Division of Health Services Regulation, a re-certification was conducted at BMA North Charlotte on June 30, 2007. According to the survey, several incidents occurred at the BMA North Charlotte facility for which Medicare certification deficiencies constituting substandard quality of care were imposed on the facility. The applicant has not demonstrated that it has provided quality of care in the past, and therefore, the application is not conforming to this criterion.

- (21) Repealed effective July 1, 1987.
- (b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any

facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

The application does not conform to all applicable Criteria and Standards for End Stage Renal Disease Services as required by 10A NCAC 14C Section .2200. The specific criteria are listed below.

## **.2202 INFORMATION REQUIRED OF APPLICANT**

*(a) An applicant that proposes to increase stations in an existing certified facility or relocated stations must provide the following information:*

- .2202(a)(1) Utilization rates;*  
-C- See Section III.7, pages 24 -26.
- .2202(a)(2) Mortality rates;*  
-C- The applicant reported mortality rates in Section IV, pages 28 - 29.
- .2202(a)(3) The number of patients that are home trained and the number of patients on home dialysis;*  
-C- The applicant reported home trained patients and patients on home dialysis in Section IV.3.
- .2202(a)(4) The number of transplants performed or referred;*  
-C- The applicant reported transplants referred and performed in Section IV.4, pages 28 - 29.
- .2202(a)(5) The number of patients currently on the transplant waiting list;*  
-C- The applicant reported a total of 36 patients on the transplant waiting lists in Mecklenburg County facilities. See Section IV.5, page 29.
- .2202(a)(6) Hospital admission rates, by admission diagnosis, i.e., dialysis related versus non-dialysis related;*  
-C- The applicant reported hospital admissions in Section IV.6.
- .2202(a)(7) The number of patients with infectious disease, e.g., hepatitis, and the number converted to infectious status during the last calendar year.*  
-C- The applicant provided this information in Section IV.7, page 29.

(b) An applicant that proposes to develop a new facility, increase the number of stations in an existing facility, establish a new dialysis station, or the relocation of existing dialysis stations shall provide the following information requested on the End Stage Renal Disease (ESRD) Treatment application form:

.2202(b)(1) For new facilities, a letter of intent to sign a written agreement with an acute care hospital that specifies the relationship with the dialysis facility and describes the services that the hospital will provide to patients of the dialysis facility. The agreement must comply with 42 C.F.R., Section 405.2100.

-C- Exhibit 16 contains a copy of an agreement between Bio-Medical Applications of North Carolina, Inc. and The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center, as specified by this rule.

.2202(b)(2) For new facilities, a letter of intent to sign a written agreement with a transplantation center describing the relationship with the dialysis facility and the specific services that the transplantation center will provide to patients of the dialysis facility. The agreements must include the following:

(A) timeframe for initial assessment and evaluation of patients for transplantation,

(B) composition of the assessment/evaluation team at the transplant center,

(C) method for periodic re-evaluation,

(D) criteria by which a patient will be evaluated and periodically re-evaluated for transplantation, and

(E) signatures of the duly authorized persons representing the facilities and the agency providing the services.

-C- Exhibits 17 contains a copy of a July, 2007 written agreement between Carolinas Medical Center Transplant Center and FMC-Huntersville.

.2202(b)(3) Documentation of standing service from a power company and back-up capabilities.

-C- See Section XI.6(f), page 62, and Exhibits 12 and 30.

.2202(b)(4) For new facilities, the location of the site on which the services are to be operated. If such site is neither owned by nor under option to the applicant, the applicant must provide a written commitment to pursue acquiring the site if and when the approval is granted, must specify a secondary site on which the services could be operated should acquisition efforts relative to the primary site ultimately fail, and must demonstrate that the primary and secondary sites are available for acquisition.

-C- In Exhibits 30 and 31, the applicant provides site location

information as required by this rule.

.2202(b)(5) *Documentation that the services will be provided in conformity with applicable laws and regulations pertaining to staffing, fire safety equipment, physical environment, and other relevant health and safety requirements.*

-C- See Sections II and VII, pages 9 – 17 and 43 – 45.

.2202(b)(6) *The projected patient origin for the services. All assumptions, including the specific methodology by which patient origin is projected, must be stated.*

-C- See Section III.7 and Criterion (3).

.2202(b)(7) *For new facilities, documentation that at least 80 percent of the anticipated patient population resides within 30 miles of the proposed facility.*

-C- In Section III.8, page 26 of the application, FMC Huntersville states that 100 percent of the anticipated patients reside within 30 miles of the proposed facility.

.2202(b)(8) *A commitment that the applicant shall admit and provide dialysis services to patients who have no insurance or other source of payment, but for whom payment for dialysis services will be made by another healthcare provider in an amount equal to the Medicare reimbursement rate for such services.*

-C- In Section VI.1(d), page 39 of the application, the applicant states that it will admit and provide services as required in this rule.

## **.2203 PERFORMANCE STANDARDS**

.2203(a) *An applicant proposing to establish a new End Stage Renal Disease facility shall document the need for at least 10 stations based on utilization of 3.2 patients per station per week as of the end of the first operating year of the facility, with the exception that the performance standard shall be waived for a need in the State Medical Facilities Plan that is based on an adjusted need determination.*

-NC- In Section III.7 of the application, FMC Huntersville projects to serve 39 in-center patients by the end of the first operating year, for a utilization of 3.25 patients per station, based on letters in Exhibit 22 signed by patients indicating a willingness to transfer to the proposed facility. However, the evidence provided in the application supports a transfer of only 31 patients to the proposed facility, because 16 of the 47 signed letters lack a patient residence ZIP code. (47 signed letters – 16 with no ZIP code = 31 letters). Since only 31 of the 47 patient letters indicate a ZIP code residence that is within close proximity to the proposed facility, only 31 of the 47 letters can

be relied upon as credible evidence of a need for additional dialysis stations in the Huntersville area of Mecklenburg County. An initial transfer of 31 patients increased by five percent results in 32.6 patients at the end of the first project year ( $31 \times 1.05 = 32.55$ ). 32.6 patients divided by 12 stations results in a utilization of only 2.7 patients per station at the end of the first project year ( $32.6 / 12 = 2.72$ ). These projections are not consistent with 10A NCAC 14C .2203(a), which requires a proposed ESRD facility to reasonably project a facility utilization of 3.2 patients per station by the end of the first project year.

.2203(b) *An applicant proposing to increase the number of dialysis stations in an existing End Stage Renal Disease facility shall document the need for the additional stations based on utilization of 3.2 patients per station per week as of the end of the first operating year of the additional stations.*

-NA- The applicant does not propose to increase the number of dialysis stations in any of its existing facilities.

.2203(c) *An applicant shall provide all assumptions, including the specific methodology by which patient utilization is projected.*

-C- In Section III, pages 18 - 27, the applicant provided the assumptions and methodology used to project utilization of the proposed facility. See Criterion (3) for discussion of reasonableness of projections.

#### **.2204 SCOPE OF SERVICES**

*To be approved, the applicant must demonstrate that the following services will be available:*

.2204(1) *Diagnostic and evaluation services;*

-C- See Section V.1.

.2204(2) *Maintenance dialysis;*

-C- See Section V.1.

.2204(3) *Accessible self-care training;*

-C- See Section V.1, page 31.

.2204(4) *Accessible follow-up program for support of patients dialyzing at home;*

-C- See Section V.1.

.2204(5) *X-ray services;*

-C- See Section V.1.

.2204(6) *Laboratory services;*

-C- See Section V.1.

.2204(7) *Blood bank services;*

-C- See Section V.1.

- .2204(8) *Emergency care;*  
-C- See Section V.1.
- .2204(9) *Acute dialysis in an acute care setting;*  
-C- See Section V.1.
- .2204(10) *Vascular surgery for dialysis treatment patients;*  
-C- See Section V.1.
- .2204(11) *Transplantation services;*  
-C- See Section V.1.
- .2204(12) *Vocational rehabilitation counseling and services;*  
-C- See Section V.1.
- .2204(13) *Transportation*  
-C- See Section V.1.

**.2205 STAFFING AND STAFF TRAINING**

- .2205(a) *To be approved, the state agency must determine that the proponent can meet all staffing requirements as stated in 42 C.F.R., Section 405.2100.*  
-C- See Sections VII.1 of the application, page 43.
- .2205(b) *To be approved, the state agency must determine that the proponent will provide an ongoing program of training for nurses and technicians in dialysis techniques at the facility.*  
-C- See Section VII.5, page 44 of the application.





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**Title** The Provider Reimbursement Manual - Part 1

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### 300. PRINCIPLE

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

### 302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

302.3 Charity Allowances.--Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

302.4 Courtesy Allowances.--Courtesy Allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

302.5 Deductible and Coinsurance Amounts.--Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, out-patient services, and medical and other health services furnished by a provider of services.

### 304. BAD DEBTS UNDER MEDICARE

Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program. Payment for

deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, the inability of the provider to collect deductibles and coinsurance amounts from beneficiaries of the Program could result in part of the costs of covered services being borne by others who are not beneficiaries of the Program. Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and coinsurance amounts, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all beneficiaries. In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program.

### 305. EFFECT OF THE WAIVER OF LIABILITY PROVISION ON BAD DEBTS

A. Beneficiary Liability.--The waiver of liability provision of the law protects a beneficiary from liability for payments to a provider for noncovered services when (1) the services are found to be not reasonable and necessary or to involve custodial care (i.e., excluded from coverage under section 1862(a)(1) or (9) of the Social Security Act), and (2) the beneficiary did not know or could not reasonably be expected to have known that the services were not covered. Where the beneficiary had knowledge that the services were not covered, liability will remain with the beneficiary.

B. Provider Not Accountable.--The program will reimburse the provider for the services if the provider did not know and could not reasonably be expected to have known that the services were not covered and the beneficiary had no knowledge as described in paragraph A. If the provider has such knowledge, it will assume accountability for the noncovered services. Where neither the provider nor the beneficiary is found accountable, the provider's charges for the services and the patient days are recorded as Medicare charges and Medicare patient days. The provider is entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts. If these amounts are not collected, they can be reimbursed under the Medicare bad debt provision (see 304) since the effect of the waiver of liability provision is to reimburse the provider as it would have been reimbursed had the services been covered.

C. Provider Accountable.--Where the provider is found accountable, any bad debts the provider experiences from such a program decision (i.e., those charges the provider cannot collect from the beneficiary) cannot be reimbursed under the Medicare bad debt provision as defined in §302. Provider costs attributable to these noncovered services furnished a beneficiary where the beneficiary's liability to the provider has been waived must be included in a provider's total costs for cost report purposes. The provider's charges for the services and the patient days must be shown as non-Medicare charges and non-Medicare patient days. The provider is nevertheless entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts had the services been covered. If these

amounts are not collected, however, they cannot be reimbursed under the Medicare bad debt provision since they apply to services held to be not covered. (See §306 below.)

### 306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

If a beneficiary does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable under the program.

Services which are not covered are defined generally in the following Health Insurance Manuals:

<i>CMS-Pub. 10</i>	Hospital Manual - §260
<i>CMS-Pub. 11</i>	Home Health Agency Manual - §§230 and 232
<i>CMS-Pub. 12</i>	Skilled Nursing Facility Manual - §240

### 308. CRITERIA FOR ALLOWABLE BAD DEBT

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

### 310. REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

A. Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters,

telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required.--The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

310.1 Collection Fees.--Where a provider utilizes the services of a collection agency and the reasonable collection effort described in §310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects \$40 from the beneficiary, and its fee is 50 percent, the agency keeps \$20 as its fee for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and records the collection fee (\$20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

310.2 Presumption of Noncollectibility.--If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

### 312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)

#### 314. ACCOUNTING PERIOD FOR BAD DEBTS

Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts. This proposed list is illustrative and not obligatory.

#### 316. RECOVERY OF BAD DEBTS

Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.

Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

### 320. METHODS OF DETERMINING BAD DEBT EXPENSE

320.1 Direct Charge-Off.--Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services. Those bad debts which are applicable to beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. (See §§300, 302.2, 314, and 316.)

320.2 Reserve Method.--Bad debt expenses computed by use of the reserve method are not allowable bad debts under the program. However, the specific uncollectible deductibles and coinsurance amounts applicable to beneficiaries and charged against the reserve are includable in the calculation of reimbursable bad debts. (See §308.)

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any particular debts, but is based on the aggregate of receivables or services.

### 322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

Prior to 1968, title XIX State plans under the Federal medical assistance programs were required to pay the Part A deductible and coinsurance amounts for inpatient hospital services furnished through December 31, 1967. Any such deductible or coinsurance amounts not paid by the State were not allowable as a bad debt.

Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.

Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not

allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of \$42.50 per day for SNF services and the provider's cost is \$60.00 a day. The coinsurance is \$32.50 a day so that Medicare pays \$27.50 (\$60.00 less \$32.50). In this case, the State limits its payment towards the coinsurance to \$15.00 (\$42.50 less \$27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met.

If the State is not participating under title XIX, but State or local law requires the welfare agency to pay the deductible and coinsurance amounts, any such amounts are not includable in allowable bad debts. If neither the title XIX plan nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312 or, if applicable, §310 are met.

#### 324. PROVIDER-BASED PHYSICIANS--PROFESSIONAL COMPONENT NOT A BAD DEBT

The professional component of a provider-based physician's remuneration is not recognized as an allowable bad debt in the event the provider is unable to collect the charges for the professional services of such physicians. Bad debts are recognized only if they relate to a provider's "allowable"

costs. "Allowable" costs pertain only to covered services for which the provider can bill on its own behalf under Part A and Part B. They do not pertain to costs of services the provider might bill on behalf of the provider-based physician. Technically, the professional component is a physician charge, not a provider cost. Thus, considering physician reimbursement as a provider cost in determining allowable bad debts would not be in conformance with the law.

### 326. APPLYING COLLECTIONS FROM BENEFICIARIES

When a beneficiary or a third party on behalf of the beneficiary makes a partial payment of an amount due the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and coinsurance, Part B deductibles and coinsurance and noncovered services. The basis for proration of partial payments is the proportionate amount of amounts owed in each of the categories.

### 328. CHARITY, COURTESY, AND THIRD-PARTY PAYER ALLOWANCES--COST TREATMENT

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.

Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of \$40, the provider billed the third party payer \$30. The charge of \$40 would be used to apportion costs and the \$10 allowance would be recorded in a revenue reduction account.

### 331. CREDIT CARD COSTS

Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs. Credit card charges incurred by a provider of services represent costs incurred for prompt collection of accounts receivable. These charges have come to be recognized as a substitute for the costs that would otherwise be incurred for credit administration (e.g., credit investigation and collection costs).

### 332. ALLOWANCE TO EMPLOYEES

Allowances, or reduction in charges, granted to employees for medical services as fringe benefits related to their employment are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs. However, any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.



332.1 Method for Including Unrecovered Cost.--The unrecovered cost of services furnished to employees as fringe benefits may be included in allowable costs by treating the amount actually charged to the employees as a recovery of costs. Where the cost of the service exceeds the amount charged to the employee, the amount charged to the employee would be applied as a reduction in the costs of the particular department(s) rendering the services. If costs should be apportioned by the RCCAC Method, all charges related to employees' services would be subtracted from the total charges used to apportion such costs, so that unrecovered costs relating to employees' allowances would be apportioned between Medicare patients and other patients. Likewise, where an average cost per diem is used to apportion costs, the days applicable to the employees who received the allowances should be removed from the total days used to apportion costs.

Where the amount charged to an employee exceeds the costs of the services provided, there is no unrecovered cost and, therefore, no cost of fringe benefit. In this case, the amount charged to the employee is not offset against the department costs and the charges for the services given to the employee are not deleted from the total charges. The services furnished to employees are treated the same as services furnished to any other patients.

A. Example (Where Departmental Costs are Equivalent to 90% of Charges).-

	<u>Gross Charges</u>	<u>Costs</u>
Other than Employees		
Medicare-----	\$ 900	
Non-Medicare-----	1,800	
	<u>\$2,700</u>	
Employees	300	
Total-----	<u>\$3,000</u>	<u>\$2,700</u>
Computation of employee fringe benefit (30% discount):		
To be collected--70% of \$300		(\$210)
Cost applicable to service provided (90% x \$300)		<u>270</u>
Unrecovered Cost-----		<u>\$ 60</u>
Total charges-----	\$3,000	Total costs \$2,700
Less: Employee charges-----	<u>300</u>	Employee payment <u>210</u>
	(Amount charged)	
Adjusted charges-----	<u>\$2,700</u>	Adjusted cost <u>\$2,490</u>

Payment by Medicare-- $900/2700 \times \$2,490 = \$830$

The unrecovered cost of \$60 remains in the departmental costs and is apportioned among the users of the department other than employees.

B. Example (Where Departmental Costs are Equivalent to 50% of Charges).--

	<u>Gross Charges</u>	<u>Costs</u>
Other than Employees		
Medicare-----	\$ 900	
Non-Medicare-----	1,800	
	<u>\$2,700</u>	
Employees-----	300	
Total-----	<u>\$3,000</u>	<u>\$1 500</u>
Computation of employee fringe benefit (30% discount):		
To be collected--70% of \$300		(\$210)
Cost applicable to service provided (50% x \$300)		<u>150</u>
Excess of amount charged to employees over cost		<u>\$ 60</u>
Unrecovered Cost-----		None
Payment by Medicare (900/3,000 x \$1,500)--		\$ 450

334. EXAMPLES: COMPUTATION OF BAD DEBTS REIMBURSABLE UNDER THE PROGRAM

334.1 Computation under Part A.-- Under Part A, deductible and coinsurance amounts are subtracted from the program's share of allowable costs in determining the amount reimbursable. Therefore, any uncollectible deductible and coinsurance amounts under Part A represent unrecovered costs to the provider. Bad debts reimbursable under the program are included in Medicare reimbursement under part A as follows:

Cost of covered services for Medicare patients-----		\$160,000
Deductible and coinsurance billed to Medicare patients (from provider's records)-----	\$8,500	
Less: Allowable bad debts for deductible and coinsurance less amount recovered in excess of costs under Part B-----	<u>1,500</u>	<u>7,000</u>
Balance due provider for covered services-----		<u>\$153,000</u>

(See § 334.2, Example C, for offset to allowable bad debts.)

334.2 Computation Under Part B.-- Under Part B, the amount reimbursable by the program (exclusive of bad debts) is determined by applying 80% to the reasonable cost of covered services furnished to beneficiaries, after application of the deductible provisions. The remaining 20% of the reasonable cost should be recovered from the beneficiary through the coinsurance amount of 20% of the charges. Where the provider's charges exceed costs, coinsurance amounts contain an amount in excess of costs. Where charges are lower than costs, coinsurance amounts are less than the equivalent percentage of costs. Since the program reimburses the provider for the unrecovered costs resulting from beneficiaries' allowable bad debts, a calculation must be made to determine whether or not there are any such unrecovered provider costs and whether and to what extent the provider may be reimbursed for bad debts in order to offset any such unrecovered costs.

Where the provider recovers an amount in excess of the total Part B costs of the Medicare program reimbursement by the program, together with deductibles and coinsurance amounts collectible from beneficiaries, allowable bad debts under Part A are reduced by the amount of this excess.

The cost reports provide a special schedule for making this calculation.

The following examples illustrate the method to be used and the results that could be obtained under the different conditions.

A. Example: Provider Charges Higher Than Costs--Part B Services.--

1. Total gross charges, all patients -----	\$180,000
2. Total program charges-----	45,000
3. Percent of program charges-----	<u>25%</u>
4. Total cost of covered services -----	<u>\$150,000</u>
5. 25% of cost applicable to beneficiaries -----	\$ 37,500
6. Less: Deductibles billed to beneficiaries-----	2,000
7. Net Cost-----	<u>\$ 35,500</u>
8. 80% of net cost applicable to program -----	\$ 28,400
9. Less: Amount received or receivable from <i>contractor</i> or SSA -----	<u>25,560</u>
10. Balance due provider or program -----	\$ 2,840
11. Add: Reimbursable bad debts (line 20 below) -----	2,500
12. Balance due provider or program (line 20 plus 11) -----	<u>\$ 5,340</u>

Computation of Reimbursable Bad Debts

13. Total costs applicable to Part B -----	\$ 37,500
14. Less: 80% of net costs applicable to Part B -----	28,400
15. Balance of costs to be recovered from beneficiaries -----	<u>\$ 9,100</u>

16.	Deductible and coinsurance to beneficiaries (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	<u>4,000</u>
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15, do not complete lines 19 and 20)-----	\$ 6,600
19.	Unrecovered costs from program (\$9,100 minus \$6,600) (line 15 less line 18)-----	\$ 2,500
20.	Reimbursable bad debts (lesser of line 17 or line 19)-----	<u>\$ 2,500</u>

B. Example: Provider Charges Lower Than Costs--Part B Services.--

1.	Total gross charges, all patients -----	\$180,000
2.	Total program charges -----	45,000
3.	Percent of program charges -----	25%
4.	Total cost of covered services -----	<u>\$200,000</u>
5.	25% of cost applicable to beneficiaries-----	\$ 50,000
6.	Less: Deductibles billed to beneficiaries -----	<u>\$ 2,000</u>
7.	Net Cost-----	<u>\$ 48,000</u>
8.	80% of net cost applicable to program -----	\$ 38,400
9.	Less: Amount received or receivable from <i>contractor</i> of SSA-----	34,560
10.	Balance due provider or program -----	\$ 3,840
11.	Add: Reimbursable bad debts (line 20 below) -----	4,000
12.	Balance due provider or program (lines 10 plus 11)-----	<u>\$ 7,840</u>

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B-----	\$ 50,000
14.	Less: 80% of net costs applicable to Part B-----	<u>38,400</u>
15.	Balance of costs to be recovered from beneficiaries -----	\$ 11,600
16.	Deductible and coinsurance billed to program (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	<u>4,000</u>
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15 do not complete lines 19 and 20) -----	\$ 6,600
19.	Unrecovered costs from program (\$11,600 minus \$6,600) (line 15 less line 18)-----	\$ 5,000
20.	Reimbursable bad debts (lesser of line 17 or line 19)-----	<u>\$ 4,000</u>

C. Example: Provider Charges Higher than Costs--Part B Services Collections by Provider Exceed Costs.--

1.	Total gross charges all patients -----	\$180,000
2.	Total program charges -----	45,500
3.	Percent of program charges -----	<u>25%</u>
4.	Total cost of covered services -----	\$150,000
5.	25% of cost applicable to beneficiaries-----	\$ 37,500
6.	Less: Deductible billed to beneficiaries -----	2,000
7.	Net Cost-----	<u>\$ 35,500</u>
8.	80% of net cost applicable to program -----	\$ 28,400
9.	Less: Amount received or receivable from intermediary or SSA-----	<u>25,560</u>
10.	Balance due provider or program -----	\$ 2,840
11.	Add: Reimbursable bad debts (line 20 below) -----	-0---
12.	Balance due provider or program (lines 10 plus 11)-----	<u>\$ 2,840</u>

## Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B-----	\$ 37,500
14.	Less: 80% of net costs applicable to Part B-----	28,400
15.	Balance of costs to be recovered from beneficiaries -----	<u>\$ 9,100</u>
16.	Deductibles and coinsurance billed to beneficiaries (\$2,000 plus \$8,600) -----	\$ 10,600
17.	Less: Uncollectible deductible and coinsurance -----	1,000
18.	Net deductible and coinsurance billed to beneficiaries-----	<u>\$ 9,000</u>
19.	Unrecovered costs from program (line 15 less line 18)-----	\$ (500)
20.	Reimbursable bad debts (less of line 17 or line 19) -----	<u>-0---</u>

\* Amount collected in excess of costs is transferred to computation of reimbursable and bad debts under part A and reduces allowable bad debts under Part A. (See § 334.1.)