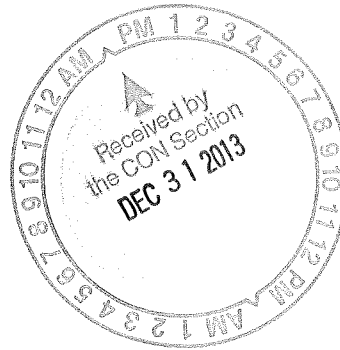




**FRESENIUS
MEDICAL CARE**



December 31, 2013

Jane Rhoe-Jones, Project Analyst
Certificate of Need Section
Division of Health Service Regulation
809 Ruggles Drive
Raleigh, N.C. 27603

Re: Public Written Comments / CON Project ID # M-10234-13 / Total Renal Care, Inc., d/b/a/ Sampson County Home Dialysis

Dear Ms. Rhoe-Jones:

On behalf of Bio-Medical Applications of North Carolina, Inc., and Bio-Medical Applications of Clinton, Inc. I am forwarding the following public written comments regarding the Total Renal Care (TRC) CON application to develop a free standing home program in Clinton, Sampson County, North Carolina.

1. The applicant has used an exaggerated growth rate of 9.5% to project a patient population to be served. Consequently projections of future patient populations are overstated.

The July 2013 SDR reports that Sampson County Five Year Average Annual Change Rate for dialysis patient population is only 3.6%. The home patient population is included in the 5 year average annual change rate. Further, the Sampson County home dialysis patient population comprises only 8.1% of the total ESRD patient population of the county. The applicant has failed to provide any substantive support for a growth rate of 9.5%.

It is not appropriate to suggest that a segment of a patient population which has been increasing in the 3.6% range is going to somehow miraculously triple that growth and increase at a rate of 9.5%.

According to the July 2013 SDR, the statewide home dialysis patient population comprises approximately 12.24% of the dialysis patient population [1840 / 15,032 = .1224, or 12.24%; this is actually a slight decline from the previous SDR]. The applicant has not provided any rationale or explanation as to why the ESRD patient population of Sampson County should be considered to be different from the entirety of North Carolina.

As an additional consideration, the Applicant has not addressed the differences between home peritoneal dialysis and home hemodialysis and changes in those respective patient populations.

The Southeastern Kidney Council for many years published zip code reports indicating ESRD patient populations by modality and zip code across North Carolina. BMA has reviewed zip code reports for the period ending December 31, 2007, December 31, 2009, and March 31, 2012 (the last published report available). The data in the following table is extracted from these reports and addresses the North Carolina ESRD patient population.

| Census Date | In-Center | Home HD | Home PD | IC PD | Other | Total |
|-------------|-----------|---------|---------|-------|-------|-------|
| 3/31/2012 | 12836 | 277 | 1420 | 2 | 0 | 14535 |
| 12/31/2009 | 12128 | 123 | 1186 | 1 | 6 | 13444 |
| 12/31/2007 | 11704 | 59 | 1115 | 0 | 6 | 12884 |

The data indicates the following changes over the 51 months from December 31, 2007 to March 31, 2012:

| | In-Center | Home HD | Home PD | Total |
|-------------------|-----------|----------|----------|----------|
| Raw Change | 1132 | 218 | 305 | 1651 |
| Percent of Change | 0.096719 | 3.694915 | 0.273543 | 0.128143 |
| Annualized Change | 0.022757 | 0.869392 | 0.064363 | 0.030151 |

Thus, it becomes obvious that while the statewide ESRD patient population experienced an annualized change rate of 3% over this period, the home hemodialysis patient population changed by 86.9% annually while the PD patient population changed by only 6.4% annually.

The information above supports the assertion that the applicant has utilized a growth factor far and above the statewide growth factor for peritoneal dialysis patients. The Applicant has ignored the differing growth factors in the PD and home hemodialysis populations and has used a growth factor of 9.5% for a PD only patient population. The applicant is proposing a growth factor 148% higher than that experienced by the PD population within our state.

In addition to the forgoing, BMA notes that dialysis facilities are now self-reporting data to the DHSR/Medical Facilities Planning Section. In the reports filed by BMA on November 1, 2013, BMA reported to serve a total of eight home dialysis patients from Sampson County at four dialysis facilities. The following table demonstrates where the eight patients were being served and the modality.

| Sampson Home Patients | Home Pts | PD | Home Hemo |
|-----------------------|----------|----|-----------|
| FMC Roseboro | 3 | 3 | 0 |
| BMA Fayetteville | 1 | 0 | 1 |
| BMA Dunn | 1 | 1 | 0 |
| RAI Warsaw | 3 | 1 | 2 |
| TOTALS | 8 | 5 | 3 |

Copies of the reports are included as attachments to these public comments. These reports would have been available to the applicant in advance of filing the application. Thus 37.5% of the Sampson County home patient population served by BMA is dialyzing via home hemodialysis.

More significant is that BMA was serving eight home dialysis patients. The July 2013 SDR reports a home patient population for Sampson County as of December 31, 2012 of only 13 patients. BMA was serving eight home patients as of November 1, 2013.

A more appropriate mathematical projection of a population to be served would be to project the entire ESRD patient population of Sampson County forward at the County Five Year Average Annual Change Rate of 3.6% and then to factor the percentage of home patients from that population using the 8.1% factor for identification of the home patient population. The applicant has not offered any compelling rationale for a change in the percentage of home patients from Sampson County. BMA offers the following alternative projections:

| | 12/31/2012 | 12/31/2013 | 12/31/2014 | 12/31/2015 | 12/31/2016 | 12/831/17 | 12/31/2018 |
|---------------------------------|------------|------------|------------|------------|------------|-----------|------------|
| Sampson ESRD Patient Population | 160 | 165.76 | 171.73 | 177.91 | 184.31 | 190.95 | 197.82 |
| Sampson % Home Patients | 0.081 | 0.081 | 0.081 | 0.081 | 0.081 | 0.081 | 0.081 |
| Net projected Home Patients | 13 | 13.47 | 13.95 | 14.46 | 14.98 | 15.51 | 16.07 |

Consider the above projected home patient population with the reality of the patient population served by BMA. The Sampson County home dialysis patient population is projected to be 13.47 patients by December 31, 2013. Yet, BMA was known to be serving eight of those patients as of November 1, 2013. Thus, by this projection, 5.47 Sampson County home patients were not being served by BMA. The applicant had knowledge of its patient population as of November 1, 2013. The applicant had the same burden of responsibility as BMA with regard

to self-reporting. The applicant could have reviewed the information filed with DHSR to determine exactly how many Sampson County home patients were being treated by TRC/DaVita, and the modality of those patients.

Despite the absence of any specifics which the applicant could have reported, one may assume that the six patient letters of support for this project represent the universe of home patients served by the applicant at its facilities providing home dialysis outside of Sampson County.

The above projections by BMA suggest that there would be 5.47 Sampson County home dialysis patients as of December 31, 2013 who were not served by BMA. Thus, it seems highly probable that the six patient letters of support do indeed represent the universe of Sampson County home dialysis patients served by TRC/DaVita.

Based upon the above calculations, BMA would be serving eight of 13.47 patients as of December 31, 2013. Since it is assumed that the applicant was serving six patients, for the sake of discussion, BMA was serving eight of 14 Sampson County home dialysis patients and the applicant was serving six of 14 Sampson County home dialysis patients as of December 31, 2013. Thus the corresponding percentages of available market share are as follows:

| | |
|--------|-----------------|
| BMA | 8 / 14 = 57.14% |
| DaVita | 6 / 14 = 42.86% |

The applicant has not provided any data or assumptions to support a change in market share. On the other hand, BMA has recently been approved by CON to add home hemodialysis and home peritoneal dialysis training and support at its BMA Clinton facility.

It is not probable that the six home patients served by the applicant will increase to the nine home patients projected by the applicant in Operating Year 1, or the 10 home patients projected by the applicant in Operating Year 2. Consider the following calculations based upon these six patients:

| Begin Date | Starting Census | Growth Rate | Ending Date | Projected Census |
|------------|-----------------|--------------------|-------------|------------------|
| 11/15/2013 | 6 | 0.012 ¹ | 12/31/2013 | 6.07 |
| 1/1/2014 | 6.1 | 0.095 | 12/31/2013 | 6.6 |
| 1/1/2015 | 6.6 | 0.095 | 12/31/2014 | 7.3 |
| 1/1/2016 | 7.3 | 0.095 | 12/31/2015 | 8.0 |
| 1/1/2017 | 8.0 | 0.095 | 12/31/2016 | 8.7 |
| 1/1/2018 | 8.7 | 0.095 | 12/31/2017 | 9.6 |
| 1/1/2019 | 9.6 | 0.095 | 12/31/2018 | 10.5 |

¹ .012 = Applicant's growth rate of 9.5% divided by 12 and multiplied by 1.5 months to year end 2013

Consider again the table on Page 3 which projects the Sampson County ESRD patient population forward through December 31, 2018. BMA has projected the home patient population to be only 16 patients by the end of 2018. Further, it is known that BMA is already serving eight of 14 Sampson County home patients, or 57.14% of the patient population. Assuming that this percentage remains the same, the applicant can possibly project to serve 42.86% of 18 patients, or only 7.7 patients by the end of 2018. Yet the applicant has projected to serve nine patients in 2015 and 10 patients in 2016. The applicant will fail to achieve its projections of a patient population to be served.

Based upon reasonable projections, using either the applicant's starting census of six patients and a 9.5% growth rate, or in the alternative, the BMA suggested growth of the entire Sampson County ESRD patient population followed by an identification of the home patient population, the applicant has failed to appropriately identify the patient population to be served. The applicant has therefore failed to conform to CON Review Criterion 3. The applicant must be denied on this basis.

Further, the CON Section has traditionally held that Criterion 3 is not a criterion that may be conditionally approved

2. To the extent that the applicant fails to adequately identify the patient population to be served, the resultant financial projections of revenues are therefore based upon unreliable projections of patient treatments. Consequently, the application is non-conforming to CON Review Criterion 5 and is not approvable.
3. BMA suggests the applicant has provided an application which is internally inconsistent and has provided unreliable financial information.
 - a. In the table of staffing provided in response to VII.1, the applicant has indicated that it would hire one RN for the PD HTRN. However, on the very next page, the applicant indicates in the descriptive information for Nurse Responsible for Nursing Service that it would "*hire a full-time registered nurse and a half-time registered nurse to training and follow-up the peritoneal dialysis patients.*" Thus, the information provided by the applicant with regard to staffing is internally inconsistent and unreliable.
 - b. If the applicant truly intends to hire 1.5 RNs, the applicant has not provided sufficient funding for such staffing in its table of Expenses at X.4. Further, the applicant fails to account for such an additional one half FTE in the table provided in response to X.5.
 - c. The applicant has indicated in the Table of Actual and Estimated Annual Operating Costs at X.4 that it would pay rent of \$43,500 annually. However, this is inconsistent with the information found in

Exhibit 26, Site information for the primary site. Exhibit 26 includes a letter executed by Robert E. Scott of Granny Scott, LLC and Mr. William L. Hyland representing the applicant. The letter indicates that the landlord would lease 2,940 square feet to the applicant. Following this letter is a description of the property at 321-339 N East Blvd – Phase III – Clinton Plaza; this page included a hand written denotation of “Site 1” at the top of the page. The information therein indicates that the applicant will be paying rent of \$15.00 per square foot, triple net. In addition to rent, the applicant would also be responsible for Taxes at \$2.80 per square foot and Common Area Maintenance (CAM) at \$2.00 per square foot. Thus, rent would total to \$19.80 per square foot on 2,940 square feet. This nets to an annual amount of \$58,212. Thus, the applicant has under reported its true projections of rents to be paid.

Clearly the applicant has provided unreliable financial information and should be found non-conforming to CON Review Criterion 5.

4. The applicant has not provided “a letter of intent to sign a written agreement or a signed written agreement with an acute care hospital” that is capable of providing acute dialysis treatment for the ESRD patients of the facility. The Rule at 10A NCAC 14C .2202(b)(1) states:

10A NCAC 14C .2202 INFORMATION REQUIRED OF APPLICANT

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

- (1) For new facilities, a letter of intent to sign a written agreement or a signed 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.*

For the benefit of the Project Analyst, BMA notes that 42 CFR, Section 405.2100 has been changed to 42 CFR Section 494.

BMA notes for the Project Analyst that 42 CFR 494.180 requires the dialysis facility to have “an identifiable governing body”. One requirement of the governing body is to ensure that the dialysis facility must have an agreement with a hospital that can provide inpatient care. Relevant portions of the Code are below:

“§ 494.180 Condition: Governance.

The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and responsibility for the governance and operation of the facility. The governing body adopts and enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients' personal and property rights, and to the general operation of the facility.

(g) Standard: Emergency coverage. (1) The governing body is responsible for ensuring that the dialysis facility provides patients and staff with written instructions for obtaining emergency medical care.

(2) The dialysis facility must have available at the nursing/monitoring station, a roster with the names of physicians to be called for emergencies, when they can be called, and how they can be reached.

(3) The dialysis facility must have an agreement with a hospital that can provide inpatient care, routine and emergency dialysis and other hospital services, and emergency medical care which is available 24 hours a day, 7 days a week. The agreement must:

(i) Ensure that hospital services are available promptly to the dialysis facility's patients when needed.

(ii) Include reasonable assurances that patients from the dialysis facility are accepted and treated in emergencies.”

(Emphasis added by BMA).

The applicant has provided a letter of intent from Sampson Regional Medical Center which does not conform to the Rule at 10A NCAC 14C .2202. Sampson Regional Medical Center does not currently offer acute dialysis services. Further, the hospital has not offered acute dialysis services within the most recent 12 months. Nor has the hospital filed a Certificate of Need application seeking to add acute dialysis services to its service offerings.

Absent a recent history (within past 12 months) of providing acute dialysis services, the addition of acute dialysis services at Sampson Regional Medical Center would be classified as a New Institutional Health Service pursuant to GS 131E-176 (16)(d). Thus it would appear that the applicant has proposed to refer patients to a hospital that does not have the ability to provide acute dialysis care and treatment.

Within the application submitted by Total Renal Care, the only letter with a hospital provided by the applicant is a letter from Sampson Regional Medical Center (Application Exhibit 6). Therefore the applicant is not conforming to 10A NCAC 14C .2202(b)(1) and should be denied.

BMA notes that this same criticism was offered in the first iteration of the DaVita application seeking to develop a facility offering home peritoneal dialysis services in Clinton, Sampson County. The applicant has merely recycled its letter of February 2013. The Sampson Regional Hospital is not certified to provide acute dialysis services. The requirements of the CFR are very clear in that it specifically requires an agreement with a hospital that can provide inpatient care for the dialysis patient. Unfortunately, Sampson Regional Medical Center does not and therefore can not provide acute dialysis services. The applicant has not provided a Transfer agreement with a hospital that meets the requirements of the CFR. The applicant must be found non-conforming to this rule. A copy of the CFR is attached to these public written comments. Failure to find the applicant non-conforming on this issue is a departure from Agency past practice.

5. Further complicating the issue is the applicant's assertion that it would refer patients to the Cape Fear Valley Hospital (CFVH) in Fayetteville. The nephrology physicians supporting this proposal do not have admitting privileges at CFVH. Absent hospital privileges, who, or which nephrology physicians would be responsible for care of the patient admitted to CFVH? There is no indication within the application that the physicians supporting the proposal would seek admitting privileges at CFVH.

The applicant has suggested that patients could be referred to Wayne Memorial Hospital in Goldsboro. However, the applicant is remarkably silent with regard to a transfer agreement with Wayne Memorial Hospital, or even a letter of support from Wayne Memorial Hospital.

The applicant has proposed a project which does not provide for the full gamut of health care services normally needed by ESRD patients and as required by 42 CFR 494. The application is therefore not approvable.

6. The applicant intends to duplicate existing health services already available within Sampson County, or CON approved for development within Sampson County. FMC Roseboro offers both peritoneal and hemodialysis home training. BMA Clinton has been approved to develop peritoneal and hemodialysis home training. Thus, the applicant is proposing to duplicate existing health services.

The applicant has suggested on page 37, in response to III.7 that the referring physicians would "*have to refer the Sampson County patients desiring peritoneal dialysis training and follow-up to a facility outside the county, in Goldsboro.*" In fact, nothing could be further from the truth. The referring physicians already

have admitting privileges at the BMA facilities in Sampson County. Thus, the referring physicians could refer their home patients to the same BMA facilities.

The applicant is therefore non-conforming to CON Review Criterion 6.

7. The applicant has offered at floor plan at Exhibit 29 with a clear reference to home hemodialysis training stations. There are three rooms labeled PD-HHD. Within the industry, PD refers to Peritoneal Dialysis (the predominant home dialysis modality) and HHD refers to Home HemoDialysis.

In our state the Certificate of Need Section has determined that home hemodialysis training and support requires dialysis stations. Further, the CON Section has denied at least two CON applications (DaVita, Union County / BMA, Cabarrus County) wherein an applicant proposed to include home hemo-dialysis stations in a facility with less than 10 dialysis stations.

It is remarkable that the applicant was fully aware of this criticism as related to its early application and yet the applicant has not deemed it appropriate to correct the floor plan. Is it possible that the applicant expects to place hemodialysis stations in the facility?

The application is non-conforming to Review Criterion 12.

8. The applicant has provided an application which is not the best alternative and does not offer the most cost effective approach to health care services in Sampson County. The applicant is non-conforming to CON Review Criteria 3, 5, 6 and 12 and the rule at 10A NCAC 14C .2202 (b) (1). Therefore the applicant fails to conform to CON Review Criterion 4.

Summary:

Taken as a whole, BMA suggests that the application submitted by Total Renal Care Inc., seeking to develop a free-standing peritoneal dialysis facility in Clinton, Sampson County, North Carolina, is not approvable. The application fails to conform to CON Review Criteria 3, 4, 5, 6 and 12. The application fails to conform to the Rule at 10A NCAC 14C .2202 (b)(1).

For the forgoing reasons, the application for Sampson County Home Dialysis should be denied.

Upon further review, BMA may determine that other non-conformities exist.

If you have any questions or I can be of further assistance, please feel free to contact me at 919.896.7230 or via email, jim.swann@fmc-na.com.

Sincerely,



Jim Swann, Director of Operations
Certificate of Need

5 Atch:

- 1) 42 CFR 494-180
- 2) Copy of Data Collection Form, RAI Care Centers West College, Warsaw
- 3) Copy of Data Collection Form, FMC Roseboro
- 4) Copy of Data Collection Form, BMA Fayetteville
- 5) Copy of Data Collection Form, BMA Dunn

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CFR > Title 42 > Chapter IV > Subchapter G > Part 494 >
Subpart D > Section 494.180[PREV](#) | [next](#)

42 CFR 494.180 - CONDITION: GOVERNANCE.

CFR Updates Authorities (U.S. Code)

§ 494.180 Condition: Governance.

The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and responsibility for the governance and operation of the facility. The governing body adopts and enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients' personal and property rights, and to the general operation of the facility.

(a) Standard: Designating a chief executive officer or administrator. The governing body or designated person responsible must appoint an individual who serves as the dialysis facility's chief executive officer or administrator who exercises responsibility for the management of the facility and the provision of all dialysis services, including, but not limited to—

- (1) Staff appointments;
- (2) Fiscal operations;
- (3) The relationship with the ESRD networks; and
- (4) Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program as described in § 494.110.

(b) Standard: Adequate number of qualified and trained staff. The governing body or designated person responsible must ensure that—

- (1) An adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient/staff ratio is appropriate to the level of dialysis care given and meets the needs of patients; and the registered nurse, social worker and dietitian members of the interdisciplinary team are available to meet patient clinical needs;
- (2) A registered nurse, who is responsible for the nursing care provided, is present in the facility at all times that in-center dialysis patients are being treated;
- (3) All staff, including the medical director, have appropriate orientation to the facility and their work responsibilities; and
- (4) All employees have an opportunity for continuing education and related development activities.

(c) Standard: Medical staff appointments. The governing body—

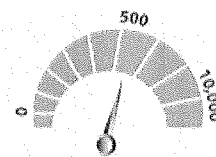
- (1) Is responsible for all medical staff appointments and credentialing in accordance with State law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists; and
- (2) Ensures that all medical staff who provide care in the facility are informed of all facility policies and procedures, including the facility's quality assessment and performance improvement program specified in § 494.110.
- (3) Communicates expectations to the medical staff regarding staff participation in improving the quality of medical care provided to facility patients.

(d) Standard: Furnishing services. The governing body is responsible for ensuring that the dialysis facility furnishes services directly on its main premises or on other premises that are contiguous with the main premises and are under the direction of the same

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professional staff and governing body as the main premises (except for services provided under § 494.100).

(e) Standard: Internal grievance process. The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services. The grievance process must include:

- (1) A clearly explained procedure for the submission of grievances.
- (2) Timeframes for reviewing the grievance.
- (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance.

(f) Standard: Involuntary discharge and transfer policies and procedures. The governing body must ensure that all staff follow the facility's patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless—

- (1) The patient or payer no longer reimburses the facility for the ordered services;
- (2) The facility ceases to operate;
- (3) The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs; or
- (4) The facility has reassessed the patient and determined that the patient's behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient's interdisciplinary team—
 - (i) Documents the reassessments, ongoing problem(s), and efforts made to resolve the problem(s), and enters this documentation into the patient's medical record;
 - (ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge;
 - (iii) Obtains a written physician's order that must be signed by both the medical director and the patient's attending physician concurring with the patient's discharge or transfer from the facility;
 - (iv) Contacts another facility, attempts to place the patient there, and documents that effort; and
 - (v) Notifies the State survey agency of the involuntary transfer or discharge.
- (5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.

(g) Standard: Emergency coverage.

- (1) The governing body is responsible for ensuring that the dialysis facility provides patients and staff with written instructions for obtaining emergency medical care.
- (2) The dialysis facility must have available at the nursing/monitoring station, a roster with the names of physicians to be called for emergencies, when they can be called, and how they can be reached.
- (3) The dialysis facility must have an agreement with a hospital that can provide inpatient care, routine and emergency dialysis and other hospital services, and emergency medical care which is available 24 hours a day, 7 days a week. The agreement must:
 - (i) Ensure that hospital services are available promptly to the dialysis facility's patients when needed.
 - (ii) Include reasonable assurances that patients from the dialysis facility are accepted and treated in emergencies.

(h) Standard: Furnishing data and information for ESRD program administration.

Effective February 1, 2009, the dialysis facility must furnish data and information to CMS and at intervals as specified by the Secretary. This information is used in a national ESRD information system and in compilations relevant to program administration, including claims processing and reimbursement, quality improvement, and performance assessment. The data and information must—

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- (1) Be submitted at the intervals specified by the Secretary;
- (2) Be submitted electronically in the format specified by the Secretary;
- (3) Include, but not be limited to—
 - (i) Cost reports;
 - (ii) ESRD administrative forms;
 - (iii) Patient survival information; and
 - (iv) Existing ESRD clinical performance measures, and any future clinical performance standards developed in accordance with a voluntary consensus standards process identified by the Secretary.

(i) **Standard: Relationship with the ESRD network.** The governing body receives and acts upon recommendations from the ESRD network. The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD network activities and pursue network goals.

(j) **Standard: Disclosure of ownership.** In accordance with § [420.200](#) through § [420.206](#) of this chapter, the governing body must report ownership interests of 5 percent or more to its State survey agency.

A

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Data Collection Form End-Stage Renal Disease Facilities June 2013

Instructions

This is a data form for dialysis providers who are certified to provide services for individuals with end-stage renal disease.

This information is needed to determine current utilization of in-center dialysis stations services and the percentage of patients receiving home dialysis in the state to project future need for new dialysis stations and facilities. **Documented need for such service is a requirement in order to expand the number of facilities or stations for any county in the state.**

There are five sections in this data collection form on four pages. **Please answer all of the questions in the designated location on each page.**

Section A collects information regarding the particular dialysis facility.

Sections B and C are related to the time period of this report and the number of certified stations in the facility.

Section D and E collects patient origin information on the facility's active patients on June 30, 2013.

Section F is for the electronic signature. Enter the name of the individual who is certifying the accuracy of the information in the Name box. **This Section must be completed and returned along with the Sections B, C, D and E of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.**

Please rename this Excel workbook to include the facility's Medicare provider number in the filename. For example: ESRD-343815

Email the completed Excel workbook to DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov by **November 1, 2013**. It is imperative that all forms are submitted by the deadline. **Any facility that does not submit this data collection form by November 1, 2013 will be shown as having zero patients on June 30, 2013 in the North Carolina Semiannual Dialysis Report January 2014.**

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov.

Section A: Contact Information

1. Facility Information

Facility Name **RAI CARE CENTERS WEST COLLEGE WARSAW (FMC)**
Medicare Provider Number **34-2630**

2. Facility Address

Street Address **213 WEST COLLEGE STREET**
City **WARSAW**
State **NC**
Zip Code **28398**
Phone Number **919.293.9984**

3. County where Facility Located

County **DUPLIN**

4. Chief Executive Officer or approved designee certifying the information in this data collection form

Chief Executive Officer **DAVID WELLS**
Street Address **1605 SOUTH MAIN STREET**
City **LILLINGTON**
State **NC**
Zip Code **27546**
Phone Number **910.814.2116**
Email **DAVID.WELLS@FMC-NA.COM**

5. Information Compiled or Prepared By

Name **JIM SWANN**
Title **DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED**
Phone Number **919.896.7230**
Email **JIM.SWANN@FMC-NA.COM**

Section B. Time Period

| | |
|-------------------------------|-----------|
| 1/1/2013-6/30/2013 | Yes |
| Other Time Period: Start date | |
| End date | 6/30/2013 |

Section C. Certification Information

| | |
|--|-----|
| 1. Is your facility certified for Medicare/Medicaid? | Yes |
| 2. How many certified dialysis stations were at this location on June 30, 2013? | 16 |
| 3. Was there a change to the certified station capacity between January 1, 2013 and June 30, 2013? | |
| 3.a. Were certified stations added? | No |
| 3.b. If yes, how many were added? | |
| 3.c. If yes, what was the effective date of this change? | |
| 3.d. Were certified stations removed? | No |
| 3.e. If yes, how many were removed? | |
| 3.f. If yes, what was the effective date of this change? | |

Section D: In-Center Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **in-center dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number In-Center Patients |
|----------|---------------------------|
| SAMPSON | 1 |
| DUPLIN | 22 |
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Section E: Home Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **home dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number Home Patients |
|----------|----------------------|
| SAMPSON | 3 |
| DUPLIN | 1 |
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Section F: Certification and Signature

This Section must be completed and returned along with the Sections B, C and D of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

| | |
|--------------------|---|
| Name | JIM SWANN |
| Title | DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED |
| Date Signed | |

| | |
|-------------------------|----------------------|
| Email Address | JIM.SWANN@FMC-NA.COM |
| Telephone Number | 919.896.7230 |

| Facility Patient Summary | |
|--|----|
| Total Number In-Center Patients | 23 |
| Total Number Home Patients | 4 |
| Total Number of Patients | 27 |



Data Collection Form
End-Stage Renal Disease Facilities
June 2013

Instructions

This is a data form for dialysis providers who are certified to provide services for individuals with end-stage renal disease.

This information is needed to determine current utilization of in-center dialysis stations services and the percentage of patients receiving home dialysis in the state to project future need for new dialysis stations and facilities. **Documented need for such service is a requirement in order to expand the number of facilities or stations for any county in the state.**

There are five sections in this data collection form on four pages. **Please answer all of the questions in the designated location on each page.**

Section A collects information regarding the particular dialysis facility.

Sections B and C are related to the time period of this report and the number of certified stations in the facility.

Section D and E collects patient origin information on the facility's active patients on June 30, 2013.

Section F is for the electronic signature. Enter the name of the individual who is certifying the accuracy of the information in the Name box. **This Section must be completed and returned along with the Sections B, C, D and E of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.**

Please rename this Excel workbook to include the facility's Medicare provider number in the filename. For example: ESRD-343815

Email the completed Excel workbook to DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov by **November 1, 2013**. It is imperative that all forms are submitted by the deadline. **Any facility that does not submit this data collection form by November 1, 2013 will be shown as having zero patients on June 30, 2013 in the North Carolina Semiannual Dialysis Report January 2014.**

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov.

Section A: Contact Information

1. Facility Information

Facility Name FMC ROSEBORO
Medicare Provider Number 34-2688

2. Facility Address

Street Address 100 EAST PLEASANT STREET
City ROSEBORO
State NC
Zip Code 28382
Phone Number 910.525.0405

3. County where Facility Located

County SAMPSON

4. Chief Executive Officer or approved designee certifying the information in this data collection form

Chief Executive Officer SAMUEL E. LONG
Street Address 111 EAST ELIZABETH STREET
City CLINTON
State NC
Zip Code 28328
Phone Number 910.592.0333
Email SAMUEL.LONG@FMC-NA.COM

5. Information Compiled or Prepared By

Name JIM SWANN
Title DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED
Phone Number 919.896.7230
Email JIM.SWANN@FMC-NA.COM

Section B. Time Period

| | |
|-------------------------------|-----------|
| 1/1/2013-6/30/2013 | Yes |
| Other Time Period: Start date | |
| End date | 6/30/2013 |

Section C. Certification Information

| | |
|--|-----|
| 1. Is your facility certified for Medicare/Medicaid? | Yes |
| 2. How many certified dialysis stations were at this location on June 30, 2013? | 10 |
| 3. Was there a change to the certified station capacity between January 1, 2013 and June 30, 2013? | |
| 3.a. Were certified stations added? | No |
| 3.b. If yes, how many were added? | |
| 3.c. If yes, what was the effective date of this change? | |
| 3.d. Were certified stations removed? | No |
| 3.e. If yes, how many were removed? | |
| 3.f. If yes, what was the effective date of this change? | |

Section D: In-Center Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **in-center dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number In-Center Patients |
|-----------------|--|
| Sampson | 32 |
| Cumberland | 1 |
| Bladen | 1 |
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Section E: Home Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **home dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number Home Patients |
|----------|----------------------|
| Sampson | 3 |
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Section F: Certification and Signature

This Section must be completed and returned along with the Sections B, C and D of the form to NC DHR by the established deadline in order for the data submission to be considered complete.

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

| | |
|--------------------|---|
| Name | JIM SWANN |
| Title | DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED |
| Date Signed | |

| | |
|-------------------------|----------------------|
| Email Address | JIM.SWANN@FMC-NA.COM |
| Telephone Number | 919.896.7230 |

| Facility Patient Summary | |
|--|----|
| Total Number In-Center Patients | 34 |
| Total Number Home Patients | 3 |
| Total Number of Patients | 37 |



Data Collection Form
End-Stage Renal Disease Facilities
June 2013

Instructions

This is a data form for dialysis providers who are certified to provide services for individuals with end-stage renal disease.

This information is needed to determine current utilization of in-center dialysis stations services and the percentage of patients receiving home dialysis in the state to project future need for new dialysis stations and facilities. **Documented need for such service is a requirement in order to expand the number of facilities or stations for any county in the state.**

There are five sections in this data collection form on four pages. **Please answer all of the questions in the designated location on each page.**

Section A collects information regarding the particular dialysis facility.

Sections B and C are related to the time period of this report and the number of certified stations in the facility.

Section D and E collects patient origin information on the facility's active patients on June 30, 2013.

Section F is for the electronic signature. Enter the name of the individual who is certifying the accuracy of the information in the Name box. **This Section must be completed and returned along with the Sections B, C, D and E of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.**

Please rename this Excel workbook to include the facility's Medicare provider number in the filename. For example: ESRD-343815

Email the completed Excel workbook to DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov by **November 1, 2013**. It is imperative that all forms are submitted by the deadline. **Any facility that does not submit this data collection form by November 1, 2013 will be shown as having zero patients on June 30, 2013 in the North Carolina Semiannual Dialysis Report January 2014.**

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov.

Section A: Contact Information

1. Facility Information

| | |
|--------------------------|----------------------------|
| Facility Name | FAYETTEVILLE KIDNEY CENTER |
| Medicare Provider Number | 34-2510 |

2. Facility Address

| | |
|----------------|------------------|
| Street Address | 1315 AVON STREET |
| City | FAYETTEVILLE |
| State | NC |
| Zip Code | 28304 |
| Phone Number | 910.323.5288 |

3. County where Facility Located

| | |
|--------|------------|
| County | CUMBERLAND |
|--------|------------|

4. Chief Executive Officer or approved designee certifying the information in this data collection form

| | |
|-------------------------|---------------------------|
| Chief Executive Officer | SAMUEL E LONG |
| Street Address | 111 EAST ELIZABETH STREET |
| City | CLINTON |
| State | NC |
| Zip Code | 28328 |
| Phone Number | 910.592.0333 |
| Email | SAMUEL.LONG@FMC-NA.COM |

5. Information Compiled or Prepared By

| | |
|--------------|---|
| Name | JIM SWANN |
| Title | DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED |
| Phone Number | 919.896.7230 |
| Email | JIM.SWANN@FMC-NA.COM |

Section B. Time Period

| | |
|-------------------------------|-----------|
| 1/1/2013-6/30/2013 | Yes |
| Other Time Period: Start date | |
| End date | 6/30/2013 |

Section C. Certification Information

| | |
|--|-----|
| 1. Is your facility certified for Medicare/Medicaid? | Yes |
| 2. How many certified dialysis stations were at this location on June 30, 2013? | 39 |
| 3. Was there a change to the certified station capacity between January 1, 2013 and June 30, 2013? | |
| 3.a. Were certified stations added? | No |
| 3.b. If yes, how many were added? | |
| 3.c. If yes, what was the effective date of this change? | |
| 3.d. Were certified stations removed? | No |
| 3.e. If yes, how many were removed? | |
| 3.f. If yes, what was the effective date of this change? | |

Section D: In-Center Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **in-center dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number In-Center Patients |
|-----------------|----------------------------------|
| Cumberland | 138 |
| Hoke | 2 |
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Section E: Home Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **home dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number Home Patients |
|-----------------|-----------------------------|
| Cumberland | 55 |
| Hoke | 5 |
| Harnett | 1 |
| Robeson | 1 |
| Sampson | 1 |
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Section F: Certification and Signature

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The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

| | |
|--------------------|---|
| Name | JIM SWANN |
| Title | DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED |
| Date Signed | |

| | |
|-------------------------|----------------------|
| Email Address | JIM.SWANN@FMC-NA.COM |
| Telephone Number | 919.896.7230 |

| Facility Patient Summary | |
|--|-----|
| Total Number In-Center Patients | 140 |
| Total Number Home Patients | 63 |
| Total Number of Patients | 203 |



Data Collection Form
End-Stage Renal Disease Facilities
June 2013

Instructions

This is a data form for dialysis providers who are certified to provide services for individuals with end-stage renal disease.

This information is needed to determine current utilization of in-center dialysis stations services and the percentage of patients receiving home dialysis in the state to project future need for new dialysis stations and facilities. **Documented need for such service is a requirement in order to expand the number of facilities or stations for any county in the state.**

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Section A collects information regarding the particular dialysis facility.

Sections B and C are related to the time period of this report and the number of certified stations in the facility.

Section D and E collects patient origin information on the facility's active patients on June 30, 2013.

Section F is for the electronic signature. Enter the name of the individual who is certifying the accuracy of the information in the Name box. **This Section must be completed and returned along with the Sections B, C, D and E of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.**

Please rename this Excel workbook to include the facility's Medicare provider number in the filename. For example: ESRD-343815

Email the completed Excel workbook to **DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov** by **November 1, 2013**. It is imperative that all forms are submitted by the deadline. **Any facility that does not submit this data collection form by November 1, 2013 will be shown as having zero patients on June 30, 2013 in the North Carolina Semiannual Dialysis Report January 2014.**

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email **DHSR.SMFP.ESRD-Inventory@dhhs.nc.gov**.

Section A: Contact Information

1. Facility Information

Facility Name **BMA DUNN**
Medicare Provider Number **34-2557**

2. Facility Address

Street Address **605 TILGHMAN DRIVE**
City **DUNN**
State **NC**
Zip Code **28334**
Phone Number **910.892.7811**

3. County where Facility Located

County **HARNETT**

4. Chief Executive Officer or approved designee certifying the information in this data collection form

Chief Executive Officer **DAVID WELLS**
Street Address **1605 SOUTH MAIN STREET**
City **LILLINGTON**
State **NC**
Zip Code **27546**
Phone Number **910.814.2116**
Email **DAVID.WELLS@FMC-NA.COM**

5. Information Compiled or Prepared By

Name **JIM SWANN**
Title **DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED**
Phone Number **919.896.7230**
Email **JIM.SWANN@FMC-NA.COM**

Section B. Time Period

| | |
|-------------------------------|-----------|
| 1/1/2013-6/30/2013 | Yes |
| Other Time Period: Start date | |
| End date | 6/30/2013 |

Section C. Certification Information

| | |
|--|-----------|
| 1. Is your facility certified for Medicare/Medicaid? | Yes |
| 2. How many certified dialysis stations were at this location on June 30, 2013? | 24 |
| 3. Was there a change to the certified station capacity between January 1, 2013 and June 30, 2013? | |
| 3.a. Were certified stations added? | Yes |
| 3.b. If yes, how many were added? | 1 |
| 3.c. If yes, what was the effective date of this change? | 3/25/2013 |
| 3.d. Were certified stations removed? | Yes |
| 3.e. If yes, how many were removed? | 2 |
| 3.f. If yes, what was the effective date of this change? | 3/22/2013 |

Section D: In-Center Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **in-center dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number In-Center Patients |
|----------|---------------------------|
| HARNETT | 77 |
| SAMPSON | 11 |
| JOHNSTON | 4 |
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Section E: Home Dialysis Population by County

1. By *county of residence*, report the total patients for whom dialysis services were provided on June 30, 2013 for **home dialysis patients**.

Note: County of Residence means the county where the patient lives.

| Counties | Number Home Patients |
|-----------------|-----------------------------|
| HARNETT | 8 |
| SAMPSON | 1 |
| JOHNSTON | 2 |
| CUMBERLAND | 2 |
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Section F: Certification and Signature

This Section must be completed and returned along with the Sections B, C and D of the form to NC DHSR by the established deadline in order for the data submission to be considered complete.

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

Name JIM SWANN
Title DIRECTOR OF OPERATIONS, CERTIFICATE OF NEED
Date Signed

Email Address JIM.SWANN@FMC-NA.COM
Telephone Number 919.896.7230

| Facility Patient Summary | |
|--|-----|
| Total Number In-Center Patients | 92 |
| Total Number Home Patients | 13 |
| Total Number of Patients | 105 |