Written Comments Filed by North Randolph Dialysis Center of Wake Forest University
Concerning BMA Asheboro CON Application, HSA II - G-10254-14

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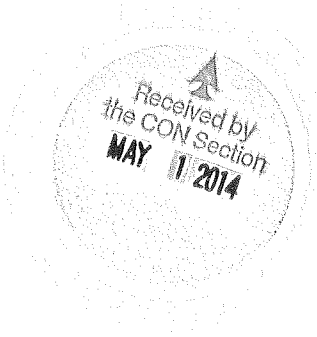


May 1, 2014

RE: Written Comments regarding Bio-Medical Applications of North Carolina, Inc., d/b/a BMA Asheboro CON Application, HSA II, Project I.D. #G-10254-14

Dear Ms. Frisone and Ms. Randolph:

I am writing to provide comments from North Randolph Dialysis Center of Wake Forest University (NRDC) in response to the competing CON application filed by Bio-Medical Applications of North Carolina, Inc., d/b/a BMA Asheboro (BMA) in Health Service Area II (HSA II). These comments are filed in accordance with NCGS 131E-185(a1)(1). After a review of the BMA application, NRDC is concerned that BMA's application does not conform with the applicable review criteria and does not reflect the most reasonable alternative to improve the access, cost-efficiency and quality of care for residents in Randolph County, HSA II.

INTRODUCTION

The BMA Application is non-conforming and cannot be approved. Quite simply, the BMA Asheboro facility is underutilized, and its historical experience shows that the facility has no need for additional stations. Rather, the station deficit generated in the SMFP for 10 additional stations in Randolph County would best be served by the development of a new facility in northern Randolph County, to serve the needs of current residents who are now traveling out of county for dialysis services. NRDC is the only fully conforming application and the only applicant which proposes to meet this need.

There are several specific issues that follow the CON review criteria in §131E-183 where the BMA project is not compliant and/or the NRDC project is superior. Each of the following will be discussed in turn:

1. BMA Asheboro failed to meet the 80% utilization criteria to file for an expansion of services as required in the Basic Principles stated in the 2014 State Medical Facilities Plan, Chapter 14. Therefore, the applicant is non-conforming with Criterion 1. **See pages 2 through 5 below.**

2. Facility Need Methodology calculations demonstrate a station surplus at BMA Asheboro of 12 stations. As of the next SDR in July, the surplus will increase to 18 stations. The applicant was ineligible to file for additional stations due to having no facility need. **See pages 4 and 5 below.**

3. The applicant failed to adequately identify the projected patient population which would be served by the project. After obtaining Medicare certification of 19 additional stations in July 2013 for a total of 46 ICH stations, the facility's ICH patient population decreased from 107 patients as of June 30, 2013, to 101 ICH patients as of December 31, 2013, a net loss of one (1) patient per month. The applicant failed to consider that its existing facility is underutilized due to geographical location and **not** due to a lack in the availability of services in Asheboro. **See pages 6 through 15 below.**

4. The two patients projected to transfer their care to BMA Asheboro from BMA South Greensboro live twice as close to BMA South Greensboro than they live to BMA Asheboro. Since their patient letters of support indicate proximity to service is a priority, it is unlikely either of those patients will genuinely transfer their care to BMA Asheboro. **See pages 7 through 12 below.**

5. The applicant does not project its proposed project to be complete until 12/31/2016. The applicant projects the 80% utilization level of the **existing** and proposed stations will not be reached until late 2017. **See pages 12 and 13 below.**

6. An increase in stations at BMA Asheboro as requested would effectively set a course for a greater county station deficit in the future and fail to expand services to Randolph County patients currently going outside of Randolph County for their dialysis care. **See pages 14 and 15 below.**

7. BMA fails to project sufficient operating costs, including staff salaries. The application's financial and operational projections fail to adequately account for annual staff salary increases during the years between filing the application and certification. Costs have been increased for the same percentage from current timeframe (12/31/2013) to OY1 (12/31/2017), a span of 48 months, as they are increased from OY1 (12/31/2017) to OY2 (12/31/2018), a span of 12 months. **See pages 16 through 17 below.**

8. While the applicant projects to increase its patient population by 54 ICH patients by its OY1 and a total of 69 ICH patients by its OY2, it fails to add additional staffing and fails to explain how current staffing levels will be able to care for the projected large number of new patients. **See pages 16 and 17 below.**

9. BMA Asheboro has failed to establish and/or provide evidence of a serious intent to establish arrangements with the local community college to accommodate the clinical needs of health professional training programs in the area. **See page 17 below.**

10. The BMA Application is a much less effective alternative than the NRDC application to meet the need for the 10 station county deficit in Randolph County. **See pages 18 through 22.**

Each of these issues is addressed below under the applicable policies, criteria and rules.

ANALYSIS

I. Compliance with Applicable Policies (Criterion 1)

Criterion 1 requires the Department to determine that each application is consistent with the applicable policies and need determinations in the SMFP. While there is no applicable need determination here, there are applicable policies. One of those is Basic Principle 6, which is found in Chapter 14 of the 2014 SMFP. That policy states as follows:

> *"6. No existing facility may expand unless its utilization is 80 percent or greater. Any facility at 80 percent utilization or greater may apply to expand."*

The 2014 SMFP indicates the methods used for projecting the need for new dialysis stations. Under Item 1. County Need *(for the January 2014 SDR – Using the trend line ending with 12/31/12 data)*, the following excerpt identifies when a "County Need" is published versus a "County Deficit."

> *"e. If a county's June 30, 2014, projected station deficit is 10 or greater and the January SDR shows that utilization of each dialysis facility in the county is 80% or greater, the June 30, 2014, county station need determination is the same as the June 30, 2014, projected station deficit. If a county's June 30, 2014, projected station deficit is less than 10 or* ***if the utilization of any dialysis facility in the county is less than 80%*** (emphasis added), *the county's June 30, 2014 station need determination is zero."*

The January 2014 SDR indicated a 10 station deficit projected for June 30, 2014, for Randolph County as demonstrated below:

AACR	6/30/13 Total Pts	6/30/14 Projected Pts.	6/30/13 Home Pts	6/30/13 % Home Pts	Projected 6/30/14 Home Pts.	Projected 6/30/2014 ICH Pts.	Projected 6/30/2014 ICH Utilization	Total Available Stations	Projected Station Surplus or Deficit
0.115	177	197.355	16	0.0903955	17.84	179.515	56.098438	46	10.098438
CALCULATIONS		**(177 × 1.115)**		**(16 ÷ 177)**	**(197.355 × 0.0903955) or (16 × 1.115)**	**(197.355 – 17.84)**	**(179.515 ÷ 3.2)**		**(56.098438 – 46)**

The last page of the January 2014 SDR states,

> *"For the January 2014 Semi-annual Dialysis Report, it is determined that there is no need for additional stations through the application of the County Need Methodology, and no reviews are scheduled."*

There is only one existing dialysis provider in Randolph County, which is BMA Asheboro. The only reason there is no published County Need for Randolph County, is because BMA Asheboro was not operating at 80% utilization.

BMA has been certified to operate 46 dialysis stations since July 18, 2013. See BMA Application, Exhibit 18. Those 46 stations have been and currently remain significantly underutilized.

On page 47 of its CON application, BMA provides the table below:

"Current Dialysis Patients as of December 31, 2013"

BMA Asheboro:

County of Residence	# of patients dialyzing at home	# of patients dialyzing in-center
Randolph	6	98
Davidson	0	1
Guilford	0	2
Totals	6	101

With 101 ICH patients and 46 certified stations as of 12/31/2013, the facility's utilization rate is/was 54.89%. To serve its current patient population at a rate of 80% utilization, BMA Asheboro would need no more than 32 ICH stations (101 / (46 × 4) = 32). The existing BMA Asheboro has a facility station surplus of 14 stations (46 – 32 = 14). Because BMA Asheboro was not and is not at 80% utilization, the facility is ineligible to apply to expand.

In fact, if BMA had chosen to apply for additional dialysis stations under the SMFP's facility need methodology, that methodology would show that the facility has a need for 12 ***less*** stations than it currently has based upon the SDR 1 (January 2013) and SDR 2 (June 2013) data, as shown below:

BMA Asheboro Facility Need	
NC Semiannual Dialysis Report Month	**January**
NC Semiannual Dialysis Report Year	**2014**
Beginning Data Period	Jan-13
Ending Data Period	Jun-13
Existing Stations at end of SDR reporting period	46
(i) The facility's number of in-center dialysis patients reported in the previous SDR (SDR1) is subtracted from the number of in-center dialysis patients reported in the current SDR (SDR2). The difference is multiplied by 2 to project the net incenter change for 1 year. Divide the projected net in-center change for the year by the number of in-center patients from SDR1 to determine the projected annual growth rate	
In-center patients as of (SDR2) Current SDR	107
In-center patients as of (SDR1) Previous SDR	104
Difference	3.00
(multiply Difference by 2)	× 2
Net in-center change for 1 year	6.00
Divide the projected net in-center change by the number of in-center patients as of (SDR1) [6 ÷ 104]	0.057692
(ii) Divide the result of Step i. by 12 [0.057692 ÷ 12]	0.004808
(iii) Multiply the result of Step ii by 6 for June 30 data [0.004808 × 6]	0.028846
(iv) Multiply the result of Step iii by the number of the facility's in-center patients reported in the SDR2 and add the product to the number of in-center patients reported [0.028846 x 107] + 107	110.0865
(v) Divide the result of Step iv by 3.2 and [95.33645 ÷3.2]	34.40204
Subtract the number of certified and pending stations as recorded in the SDR2 to determine the number of stations needed [34.40204 - 46]	-11.598 **-12**

Rounding is only allowed in the last step to determine the needed number of stations.

Because BMA has already provided the data that will be included in the July 2014 SDR, that data can be used now to determine the potential Facility need determination for BMA Asheboro under the facility need methodology for the July 2014 SDR as demonstrated below:

BMA Asheboro Facility Need	
NC Semiannual Dialysis Report Month	**July**
NC Semiannual Dialysis Report Year	**2014**
Beginning Data Period	Jun-13
Ending Data Period	Jan-14
Existing Stations at end of SDR reporting period	46
(i) The facility's number of in-center dialysis patients reported in the previous SDR (SDR1) is subtracted from the number of in-center dialysis patients reported in the current SDR (SDR2). The difference is multiplied by 2 to project the net incenter change for 1 year. Divide the projected net in-center change for the year by the number of in-center patients from SDR1 to determine the projected annual growth rate	
In-center patients as of (SDR2) Current SDR	101
In-center patients as of (SDR1) Previous SDR	107
Difference	(6.00)
(multiply Difference by 2)	× 2
Net in-center change for 1 year	(12.00)
Divide the projected net in-center change by the number of in-center patients as of (SDR1) [-12 ÷ 107]	(0.11215)
(ii) Divide the result of Step i. by 12 [-0.11215 ÷ 12]	(0.00935)
(iii) Multiply the result of Step ii by 6 for June 30 data [-0.00935 × 12]	(0.11215)
(iv) Multiply the result of Step iii by the number of the facility's in-center patients reported in the SDR2 and add the product to the number of in-center patients reported [-0.11215 × 101] + 101	89.6729
(v) Divide the result of Step iv by 3.2 and [89.6729 ÷ 3.2]	28.02278
Subtract the number of certified and pending stations as recorded in the SDR2 to determine the number of stations needed [28.02278 - 46]	-17.9772 **-18**

Rounding is only allowed in the last step to determine the needed number of stations.

Application of the Facility Need Methodology for the July 2014 SDR utilizing the June 30, 2013, BMA Asheboro SDR data and the December 31, 2013, BMA Asheboro facility census reported in its application currently under review indicates a further decline in the ***needed*** number of stations at BMA Asheboro. In fact, the facility is projected to have an 18 station surplus based upon patient growth trends at that location.

A ***negative*** station need calculation supports the conclusion that the BMA Asheboro facility was not at the 80% utilization rate required in order to apply to expand its services as stated in Principle 6, when the BMA Asheboro application was filed for the April 1, 2014, Review Cycle. Its underutilization is the sole reason a station deficit versus a published "County Need" was indicated in the January 2014 SDR.

For these reasons, BMA Asheboro's application is non-conforming with Criterion 1.

II. REASONABLENESS OF IDENTIFIED POPULATION AND NEED FOR ADDITIONAL STATIONS (CRITERION 3)

A. Projected Service Area

1. Percentage of Randolph County Patients Served

On page 38 of its application, the applicant states,

> *"BMA Asheboro was providing dialysis care and treatment for 104 Randolph County residents (see Table IV.1) as of December 31, 201(sic). BMA suggests that this 104 does represent the majority of the Randolph County ESRD patient population. Thus, BMA is (sic) represents that the majority of the ESRD patients from Randolph County reside in or very near Asheboro."*

While it is correct that BMA Asheboro serves the majority of Randolph County patients, it ***barely*** does so, as shown from the following data:

ALL RANDOLPH COUNTY PATIENTS
(ICH & HOME)

Date	Total Patients Randolph County[1]	Total Randolph County Patients at BMA Asheboro	BMA Asheboro Randolph County Patients as a Percentage of Total Randolph County Patients
12/31/2013	187.15	104	55.57%

RANDOLPH COUNTY ICH PATIENTS

Date	Total ICH Patients Randolph County[2]	Total Randolph County ICH Patients at BMA Asheboro	BMA Asheboro ICH Randolph County Patients as a Percentage of Total ICH Randolph County Patients
12/31/2013	170.1 (170)	98	57.64%

Further, based on 2009-2013 Semi-Annual Dialysis Report data, BMA Asheboro's percentage of Randolph County patients in terms of market share has been steadily decreasing as the overall county patient population has grown. Instead, as shown in the chart below, that steadily growing ESRD population has chosen other facilities, many of which are located in counties north of Randolph County.

[1] The June 30, 2013, Randolph County patient population from the January 2014 SDR was added to the projected June 30, 2014, Randolph County patient population from the January 2014 SDR, and the mean was taken to determine the approximate December 31, 2013, Randolph County patient population. (177 + 197.3) / 2 = 187.15

[2] The June 30, 2013, Randolph County ICH patient population from the January 2014 SDR was added to the projected June 30, 2014, Randolph County ICH patient population from the January 2014 SDR, and the mean was taken to determine the approximate December 31, 2013 (Jan 14), Randolph County ICH patient population. (161 + 179.2) / 2 = 170.1

Randolph County Resident Patients Reported in the SDR for the Years Below											
	Jan 09	Jul 09	Jan 10	Jul 10	Jan 11	Jul 11	Jan 12	Jul 12	Jan 13	Jul 13	Jan 14
Total Randolph Co. Patients	114	126	141	143	142	154	151	177	174	177	187
BMA Asheboro - Randolph Co. Patients	87	94	101	111	106	106	113	105	106	104	101
Others - Randolph Co. Patients	27	32	40	32	36	48	38	72	68	73	86
BMA Asheboro - Mkt Share	76%	75%	72%	78%	75%	69%	75%	59%	61%	59%	54%
Others - Mkt Share	24%	25%	28%	22%	25%	31%	25%	41%	39%	41%	46%

Excerpts from the SDR's for the time periods identified in the table above are contained in **Exhibit 1**, attached.

Further, facilities identified as "other" are comprised of four BMA/FMC and five WFUHS facilities located north and northwest of Randolph County in Forsyth, Davidson, Guilford and Alamance Counties as well as one BMA facility in Chatham County that served 9 ICH Randolph County patients as of June 30, 2013, and one BMA facility in Orange County that served 1 Home Randolph County patient as of June 30, 2013. It is assumed that BMA Asheboro's patient population is 100% Randolph County residents. However, readily available data make it impossible to know that for sure. Nine of the eleven "other" facilities serving Randolph County patients are closer to NRDC's proposed site in northwestern Randolph County than to BMA Asheboro. See map, **Exhibit 2** attached hereto.

According to the data in the Patient Origin Report created by the Medical Facilities Planning Branch and used in the January 2014 SDR (**Exhibit 5**), the nine facilities north of Randolph County (four BMA/FMC serving 16 Randolph County patients and five WFUHS serving 44 Randolph County patients) served 60 (or 34.48% of the total) Randolph County resident patients as of June 30, 2013[3].

It is likely that many Randolph County patients choosing out-of-county facilities are doing so in large part due to the fact that they reside closer to those facilities than to BMA Asheboro. Clearly, if BMA thought that more patients in **its** Guilford, Alamance, Chatham, and Orange County facilities (26 Randolph County patients total) could be served more conveniently in Asheboro, it would have sought letters from them for the application and/or those patients would have already transferred to the underutilized BMA Asheboro facility.

2. BMA's Proposed Randolph County Transfer Patients

On page 38 of its application, BMA states,

> *BMA notes that Policy ESRD-2 is comprised of two distinct prongs. First, the transferring facility must be currently serving dialysis patients from the gaining county. Indeed, BMA South Greensboro is serving at least two patients who reside in Randolph County. Their letters of support for this project are included in Exhibit 22.*

On page 41 of its application, BMA States,

> *BMA assumes that at least two patients currently dialyzing in the BMA South Greensboro facility, will transfer their care to the BMA Asheboro facility as this project is completed.*

[3] At the time WFUHS filed its NRDC CON, its Randolph County patient census had grown to 52 (39 ICH and 13 Home), and its application included letters received from 50 of those patients in time for the March 17, 2014, filing deadline.

In the patient letters of support at Exhibit 22 of the application, there are two patient letters from BMA South Greensboro patients indicating those patients are residents of Randolph County, the patient's names and the zip code where the patients reside. An excerpt from those letters is included below:

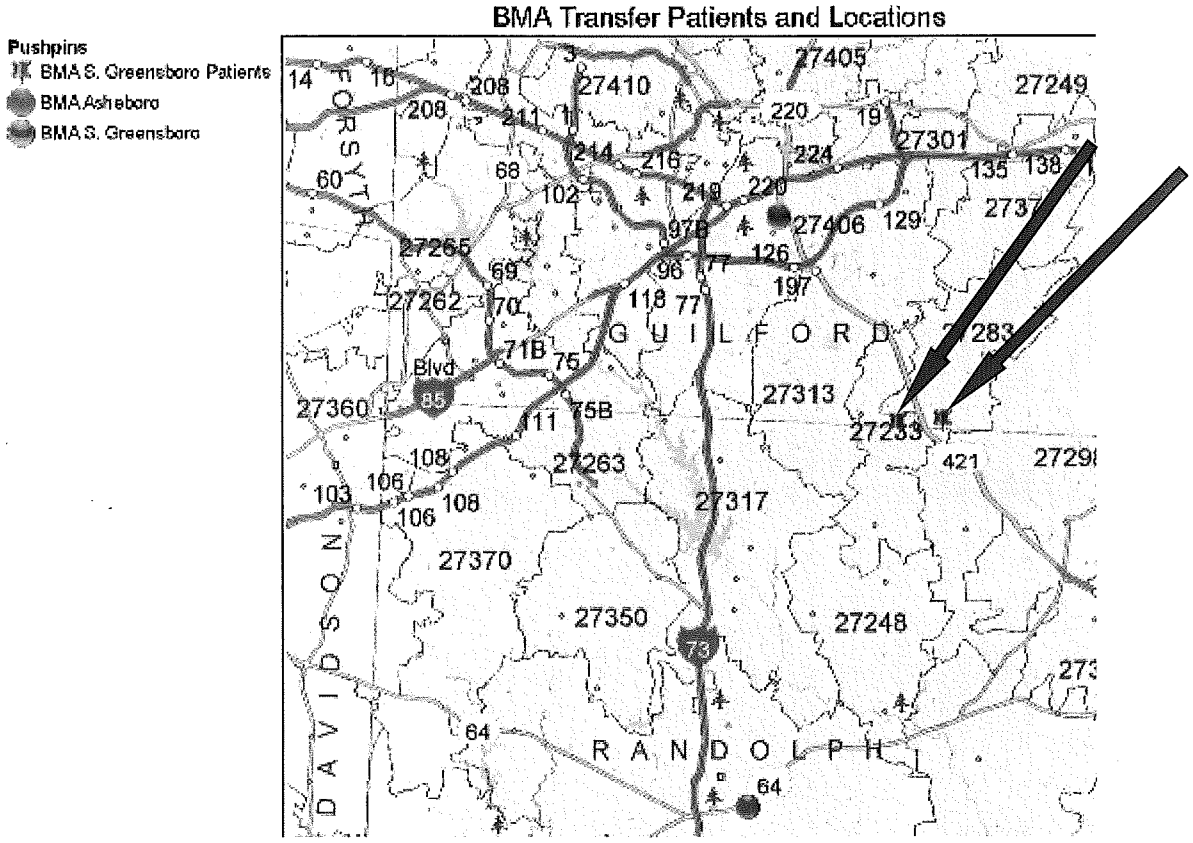
> *"Patients on dialysis have many hardships, especially arranging transportation three days per week. Transferring to BMA Asheboro will be much more convenient for me and is closer to my home. Dialyzing at the BMA Asheboro facility would mean less time involved in transportation and more time for me, and my needs.*
>
> *I am aware that this letter will be used as support for the Bio-Medical Applications of North Carolina application for Certificate of Need. By my signature below, I consent to my name being associated with this application."*

One letter is signed by ***"Jewell S. Cox"*** in zip code 27283 and the other is signed by ***"Charles P. McSwain, Jr."*** in zip code 27233.

The website http://www.whitepages.com allows the search of public address records by name and zip code. In order to determine the location of the two transfer patients, that website was used and physical addresses for each transfer patient matching the patients' names and zip codes identified in the Exhibit 22 patient support letters was found.

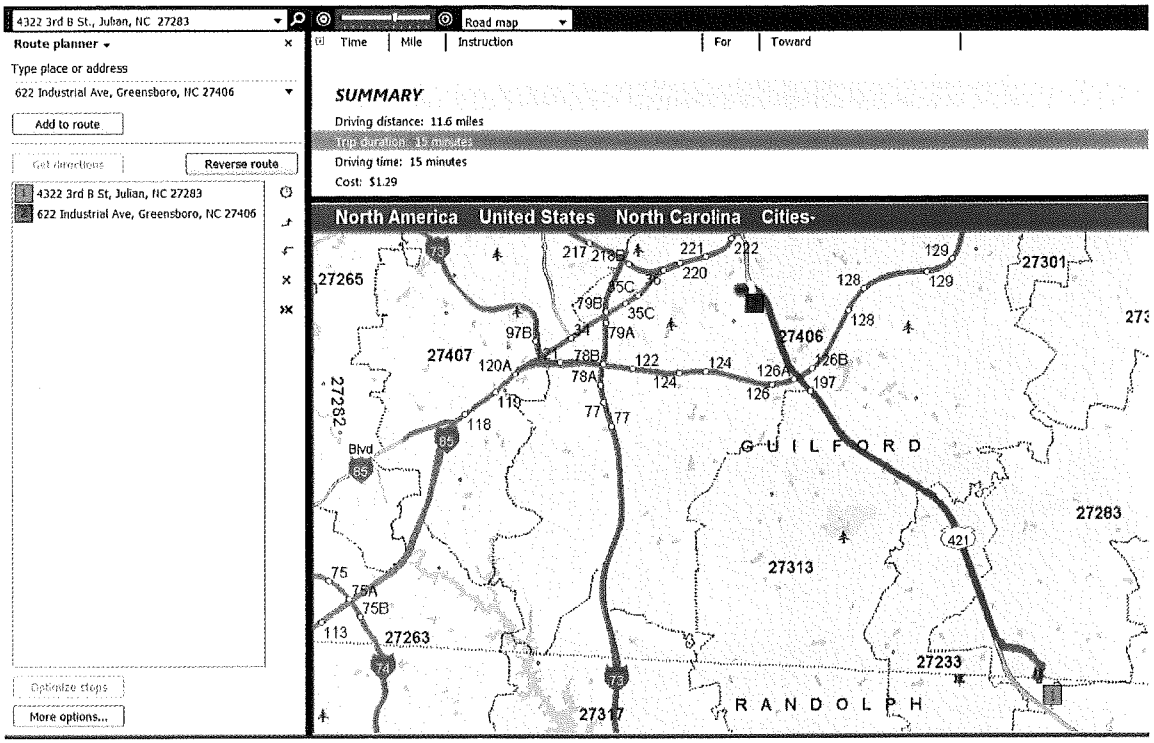
Using the Dialysis Facility Compare website, street address information was obtained for BMA South Greensboro and BMA Asheboro.

The map below depicts the BMA South Greensboro facility by address, the BMA Asheboro facility by address and pushpins the location of the proposed transfer patients by street address.

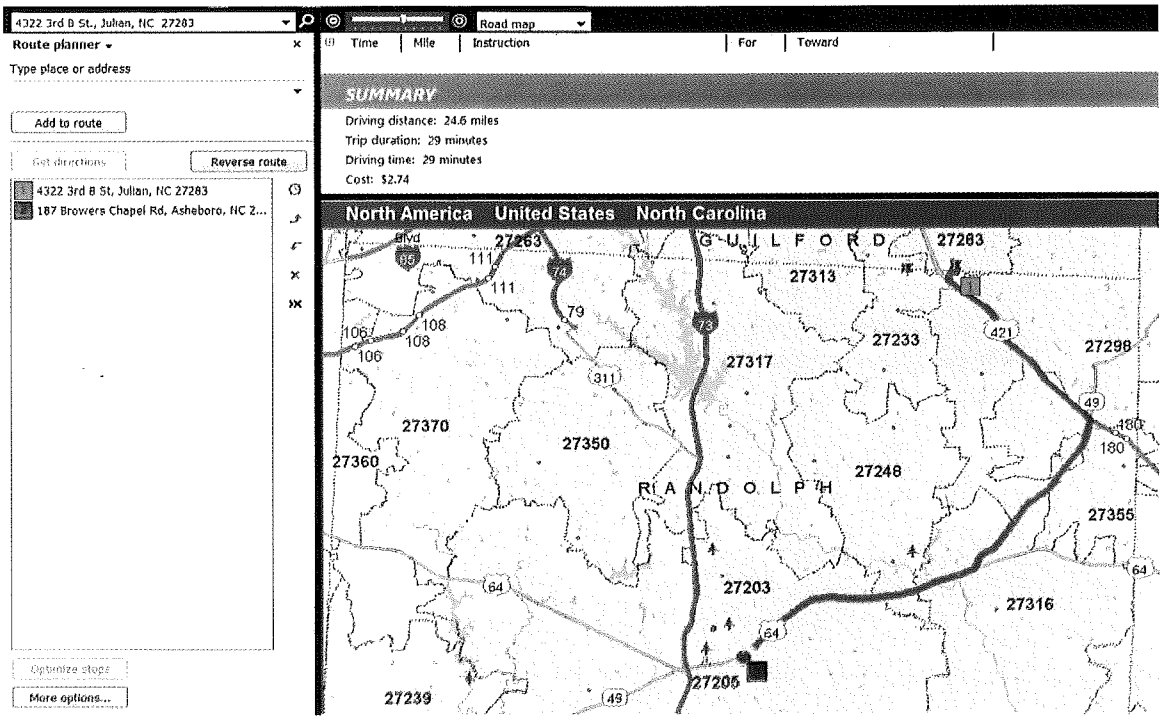


Both patients (Cox and McSwain) live on the northern border of Randolph County. The large red arrows point out the locations of their residence pushpins on the map.

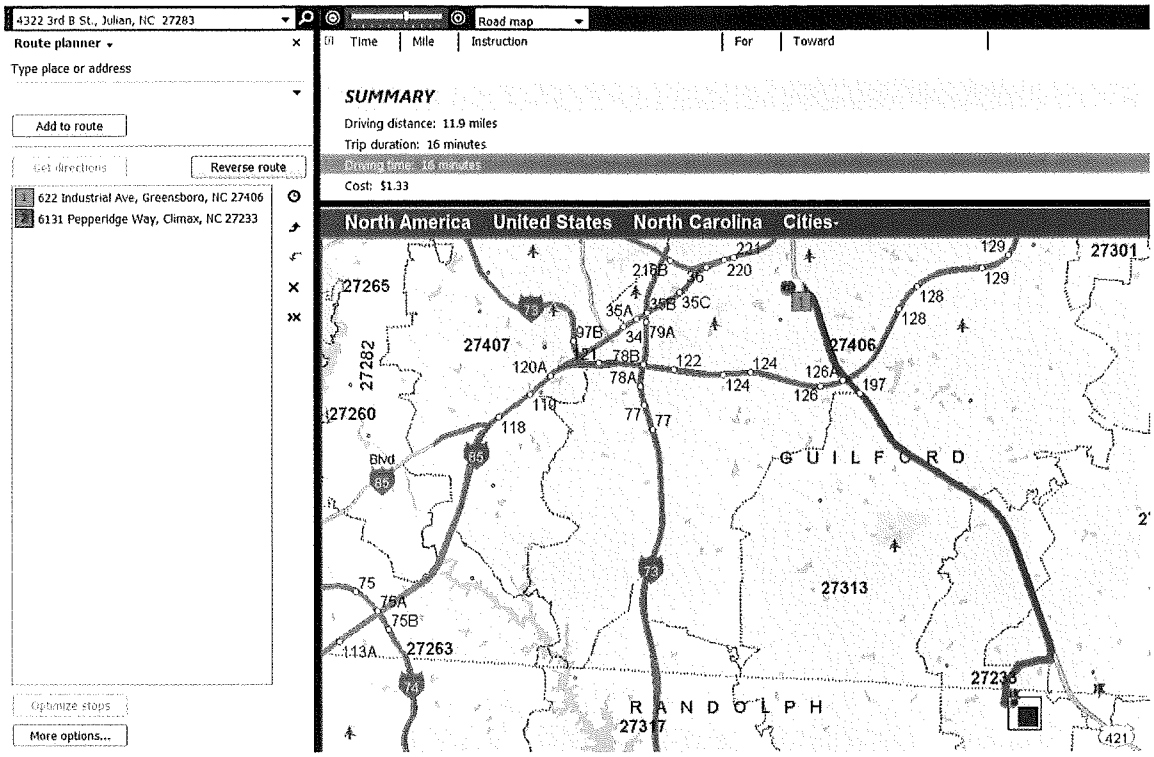
The following map depicts the travel distance and travel time from the residence of patient Cox to BMA South Greensboro:



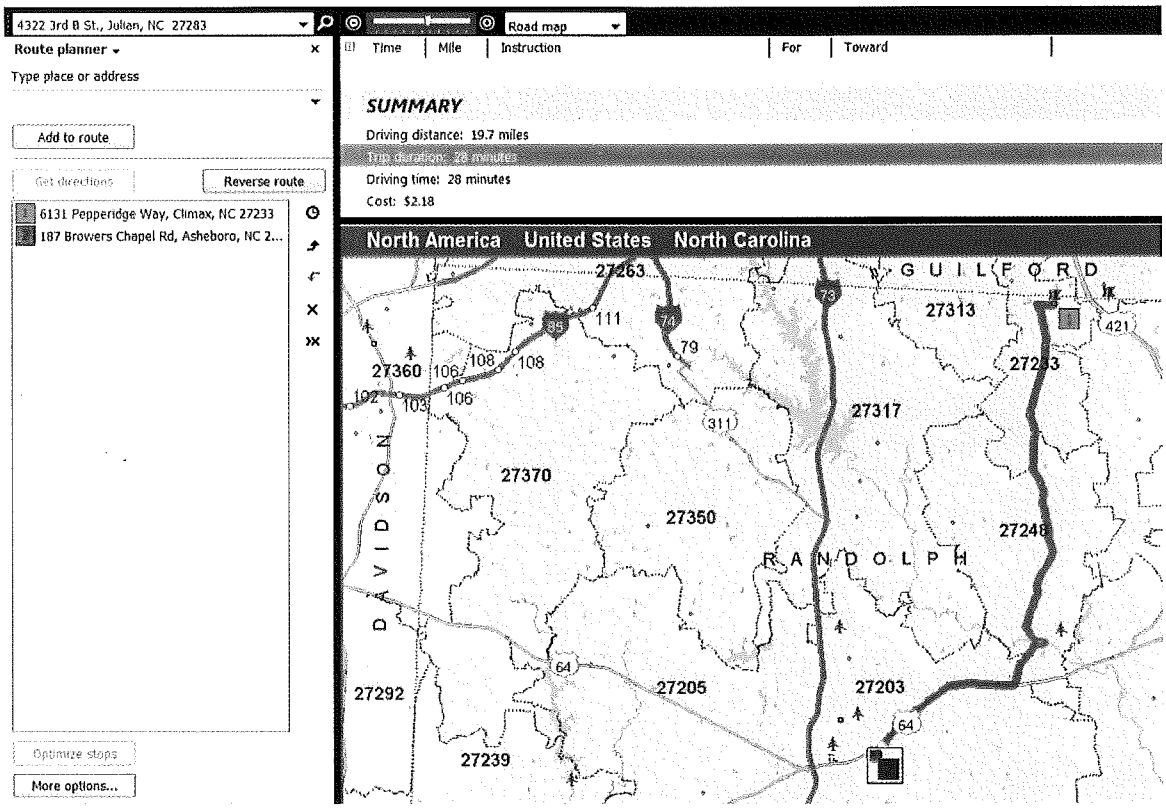
The following map depicts the travel distance and travel time from the residence of patient Cox to BMA Asheboro:



The following map depicts the travel distance and travel time from the residence of patient McSwain to BMA South Greensboro:



The following map depicts the travel distance and travel time from the residence of patient McSwain to BMA Asheboro:



Both patients indicate a desire for a greater convenience of service and that a decrease in travel time is of great importance to them. However, as shown in the chart below, travel ***distance*** for patient Cox would be more than doubled. Travel ***time*** for patient Cox would be nearly doubled. Travel ***distance*** for patient McSwain would increase by nearly 8 miles. Travel ***time*** for patient McSwain would nearly double.

Patient	Travel Distance (Miles)to BMA South Greensboro	Travel Distance (Miles) to BMA Asheboro	+/- (Miles)	Travel Time (Minutes) to BMA South Greensboro	Travel Time (Minutes) to BMA Asheboro	+/- (Minutes)
Cox	11.6	24.6	**+13**	15	29	**+14**
McSwain	11.9	19.7	**+7.8**	16	28	**+12**

The applicant indicates the potential transfer patients will not transfer their care to BMA Asheboro until 12/31/2016 – upon certification of the additionally requested two dialysis stations. However, BMA Asheboro is severely underutilized at a current rate of 54.89% for 46 stations. There is no reason either patient could not transfer their care prior to certification of the additional stations should they so desire. There is no reason ***any*** of the BMA/FMC Randolph County patients going out of county for their dialysis care (22 total) could not transfer their care to BMA Asheboro, now, less and except geographical convenience.

Neither patient Cox nor patient McSwain would reduce travel time nor travel distance by transferring their care to BMA Asheboro. If neither patient has chosen to transfer their care to the facility now, when the facility is severely underutilized, it is unlikely either patient would do so in 2 ½ years, when BMA projects that the two additional stations would be certified.

The CON Section found a previous CON application filed by BMA non-conforming for similar reasons. In 2011, BMA filed an application (Project I.D. No. C-8759-11) to establish a 10-station dialysis facility in Cleveland County by relocating two stations from BMA Burke County, an existing 25-station dialysis facility in Burke County; six stations from BMA Hickory, an existing 33-station dialysis facility in Catawba County; one station from BMA Lincolnton, an existing 25-station dialysis facility in Lincoln County; and one station from BMA Kings Mountain, an existing 14-station facility in Gaston County. The CON Section disapproved that application, finding that BMA failed to adequately identify the population to be served. Specifically, the CON Section found the following:

> *However, the applicant does not adequately demonstrate the reasonableness of patients who live in Cleveland County and currently choose to receive treatment in Hickory, Morganton, Lincolnton and Kings Mountain choosing to travel to Shelby, in Cleveland County when they currently have that option, but choose not to use it. In addition, the applicant does not adequately demonstrate that BMA's current Cleveland County patients, particularly those who reside near and receive dialysis at BMA Kings Mountain, actually live closer to the proposed facility than to the facility where they are currently receiving treatment.*

See **Exhibit 3**, Required State Agency Findings, 2011 Cleveland County ESRD Review, p. 24. For similar reasons, the CON Section found that BMA did not demonstrate a need for the proposed service. See **Exhibit 3**, p. 28.

3. Conclusion

BMA Asheboro is underutilized, reports a decrease in patient census since certification of 19 new ICH stations between July 2013 and December 2013, and fails to project reaching utilization of its existing 46

stations until 2017. The applicant erroneously assumes additional stations are needed to serve Randolph County patients at its location in Asheboro, even though the facility's share of Randolph County patients has steadily decreased. That decrease is largely due to the increase in Randolph County patient use of more convenient facilities north of the Randolph County line. The two Randolph County patients who wrote letters supporting the application are two such patients. They live closer to their existing facility than to BMA Asheboro, and would not be better served by changing their care. The applicant has failed to adequately identify the population to be served by the proposed project.

B. Projected Need

The BMA Application need methodology is based on the projected growth in Randolph County dialysis patients, according to the Randolph County five-year average annual change rate contained in the SDR (11.5%). However, given BMA Asheboro's actual experience, BMA has failed to demonstrate why the annual growth in overall Randolph County dialysis patients should result in a growth of Randolph County dialysis patients at BMA Asheboro.

Further, unlike its 2010 Randolph County application BMA has failed to take into account patient geography or patient choice of physicians. In that application, BMA included the following assumptions:

> *e. BMA assumes that patients are NOT* [emphasis in original] *likely to change nephrology physicians in order to received* (sic) *dialysis at an alternate facility in Randolph County.*
>
> .....
>
> *BMA is aware that Carolina Dialysis-Siler City is providing treatment for eight in-center dialysis patients from Randolph County; these patients reside in Asheboro or areas east of Asheboro. It is not likely that these patients will leave physicians or access to a major medical facility and its teaching institution.*
>
> *f. With regard to patient populations going out of county for dialysis, and specifically with regard to the discussion above, BMA does not believe that there is a centralized location within the County which could potentially entice these two disparate groups of patients (only 20 in-center patients) to forgo their existing physician-patient relationship and transfer their care to another facility centrally located in Randolph County.*

See **Exhibit 4**, Required State Agency Findings, 2010 Randolph County Competitive Dialysis Review, p. 14.

As set forth in Table B of the January 2014 SDR, the number of Randolph County dialysis patients has steadily grown over the last five years, from 114 total patients as of December 31, 2008, to 177 total patients as of June 30, 2013. Despite this fact, the number of dialysis patients being treated at BMA Asheboro has remained flat or decreased. According to the July 2010 SDR, BMA Asheboro had 111 ICH patients on December 31, 2009. According to the January 2014 SDR, BMA Asheboro's patient population had **dropped** to 107 ICH patients as of June 30, 2013. According to the BMA Application, that total dropped again, to 101 ICH patients as of December 31, 2013, despite the fact that the BMA Asheboro facility was certified to operate 19 more dialysis stations (for a total of 46 stations) on July 21, 2013.

To serve the existing 12/31/2013 ICH patients at BMA Asheboro at 80% utilization the facility needs 31.56 or 32 ICH stations:

101 ÷ 3.2 = 31.56 (32 Stations)

BMA Asheboro was certified on 7/21/2013 for 46 ICH stations. Thus, as of 12/31/2013, BMA Asheboro had 14 surplus stations:

46 – 32 = 14 Surplus Stations

In fact, the BMA application projects that the existing 46 stations will not be at 80% utilization until **December 2017, at the earliest**. On page 43 of its application, the applicant provides a table demonstrating projected facility growth beginning as of December 31, 2013, through its end of OY2, December 31, 2018. The table indicates the beginning census upon certification of the proposed project, December 31, 2016, to be 140.8 patients which includes three dialysis patients from counties other than Randolph. Rounding up to 141 patients, the utilization rate of the facility's ***existing*** 46 stations would only be 76.63%. It is not until December 31, 2017, over 2½ years from now, when BMA projects that it will have a total of 153.7 patients, which would increase utilization to greater than 80% of capacity. If BMA truly has a need for two more stations within the next three years, it can file a CON application for those two stations pursuant to the facility need methodology at that time.

An increase in the number of available dialysis stations does not equate an increase in patient utilization at BMA Asheboro. The facility currently has 14 more stations than needed to serve its patient base at rate of 80% utilization. July 2014 projected facility need methodology indicates that when the next SDR is published, the BMA Asheboro facility need will be only 28 stations, resulting in an 18 station surplus as discussed under Criterion 1, above. The applicant has failed to demonstrate a need its patients have for additional dialysis stations.

For these reasons, BMA is non-conforming to Criterion 3.

III. LEAST COSTLY, MOST-EFFECTIVE ALTERNATIVE (CRITERION 4)

A. Underutilization of Existing Resources – Not Cost Effective

BMA serves 55.57% of all Randolph County dialysis patients. BMA ignores the fact that its Asheboro facility is currently underutilized at 54.89% utilization for 46 stations. Underutilization is indicative of potential problems which may be related to geographic accessibility and provider preference. While the BMA Asheboro location is new, it may not be located geographically convenient to patients residing outside of Asheboro (in the Trinity / Archdale areas) within Randolph County. BMA ignores this possibility, assuming all Randolph County patients reside near Asheboro and/or that BMA Asheboro is convenient to all Randolph County resident patients. The evidence of underutilization suggests otherwise.

BMA is focused on the needs of patients utilizing BMA Asheboro. However, those patients' needs are more than adequately met. The facility currently has a 14-station surplus as discussed under Criterion 3, above. Maxing out an underutilized facility (48-station maximum capacity) is neither the least costly nor most effective method for meeting the needs of the Randolph County patient population, which has triggered a 10-station deficit for Randolph County. Had the existing facility been at 80% utilization or greater, a 10-station county need would have been published for Randolph County versus the 10-station deficit. BMA Asheboro at 80% utilization could have filed an application based on facility need methodology. Spending ***any*** monies to further the underutilization of the existing BMA Asheboro facility is not a cost-effective alternative to the station deficit in Randolph County.

B. Failure to Acknowledge the Location of Need in Randolph County

On page 45 of its application, BMA states,

> *"BMA could have elected to relocate a total of 10 stations to develop another dialysis facility to serve the needs of Randolph County. However, another new facility is a costly venture, especially considering that BMA has just invested significant capital dollars into the new BMA Asheboro facility. Furthermore, there was not another area of Randolph County with a patient population of sufficient size to support a second facility in Randolph County."*

On page 38 of its application, BMA states,

"The DHSR / Medical Facilities Planning Branch creates a Patient Origin Report based upon provider self-reported information. The Patient Origin Report then becomes the basis for the SDR. Under current guidelines, providers will report twice annually so that Medical Facilities Planning may create and publish the SDR (January and July each year.)

The Patient Origin Report leading to the January 2014 SDR indicates there were 177 dialysis patients residing in Randolph County as of June 30, 2013. Of these, 16 were home dialysis patients and 161 were In-Center dialysis patients. The Patient Origin Report indicates that the dialysis patients of Randolph County were receiving their dialysis care at one of 12 dialysis facilities."

The Patient Origin Report mentioned in the BMA Asheboro application and included in **Exhibit 5** includes a list of the providers serving Randolph County dialysis patients as well as the number of patients by modality served by those providers. The CMS website contains address information for all Medicare participating providers. By utilizing the Patient Origin Report and the address information for non-BMA/FMC providers, BMA Asheboro could have easily seen that the patients not served by BMA Asheboro and the other BMA/FMC providers in Guilford, Chatham and Alamance Counties were receiving their care at the WFUHS locations in Guilford and Davidson Counties northwest of Randolph County (36 ICH and 11 Home) as of June 30, 2013.

Clearly, there was / is another area of Randolph County ***"with a patient population of sufficient size to support a second facility in Randolph County."*** It is in the area of Randolph County nearest the WFUHS locations in Guilford and Davidson Counties near the towns of Archdale and Trinity. However, BMA chose to ignore the data it had at hand and focus on maxing out the underutilized BMA Asheboro location.

C. Ineffective Alternative

On page 43 of its application, BMA Asheboro's methodology projects that by the end of OY2 (December 31, 2018), it will have 169.1 in-center patients and 15.6 home patients. Based upon that timeframe using the five-year AACR for Randolph County, it is clear by the tables below that BMA does not intend to increase its Randolph County market share within a timeframe that would **effectively** reduce the Randolph County station deficit.

BMA Asheboro Projected Market Share of Randolph County Patients Over the Duration of Its Proposed Project

	6/30/2013	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Total Randolph Co. Patients (ICH & Home)	177.00	187.17	197.36	220.05	245.36	273.57	305.03
BMA Asheboro Randolph Co. Patients (ICH & Home)	107	104	116	129.3	146.1	163	181.7
BMA Asheboro Market Share Randolph Co. Patients (ICH & Home)	60%	56%	59%	59%	60%	60%	60%

The January 2014 SDR indicates a 10-station deficit for Randolph County is projected to occur by 6/30/2014. Over the course of BMA Asheboro's project timeline that projected deficit is likely to increase. BMA's patient projections for BMA Asheboro take the existing BMA Asheboro patient population and increase that number by the five-year average annual change rate for Randolph County published in the

January 2014 SDR (11.5%). All of BMA Asheboro's patient projections and assumptions are centered solely on the growth of its existing patient base, the utilization of its BMA Asheboro facility by its current patients, and the growth of those current patients. No services are projected for the patients for whom the published station deficit exists – those patients in Randolph County NOT currently served by BMA Asheboro.

Projected Randolph County Station Need

	6/30/2013	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Randolph County ICH Patients	**161**	**170.1**	**189.66**	**211.47**	**235.79**	**262.91**	**293.14**
Dialysis Stations Required for 80% Utilization	50.31	53.16	59.27	66.09	73.68	82.16	91.61
BMA Asheboro Available / Proposed Dialysis Stations	46	46	46	46	48	48	48
BMA Asheboro Utilization Rate	58.15%	54.89%	59.78%	66.30%	73.43%	80.20%	88.02%
Randolph County Station Deficit	**-4.31**	**-7.16**	**-13.27**	**-20.09**	**-25.68**	**-34.16**	**-43.61**

As BMA Asheboro strives to reach 80% utilization of its existing and proposed stations (which BMA projects will not occur until sometime in 2017) the station deficit for Randolph County continues to increase at an alarming rate. The largest annual deficit increases are projected to occur during OY1 and OY2 of BMA Asheboro's proposed project (12/31/2016 – 12/31/2018.)

BMA had full knowledge of the Randolph County patient need via the Patient Origin Report and SDR data, yet chose to ignore it. Approving BMA's application will ultimately ***increase*** the station deficit in Randolph County as BMA has indicated its newly expanded location can hold no more than 48 stations and it has no intentions of creating a new facility elsewhere.

For these reasons, BMA is non-conforming to Criterion 4.

IV. Availability of Funds and Financial Feasibility (Criterion 5)

Criterion 5 requires the applicant to demonstrate the availability of funds to finance the capital and operating needs of the project, and to demonstrate the financial feasibility of the project, based upon reasonable projections of costs and charges.

The BMA Application does not realistically account for inflation from the present to Operating Year 1. The financial and operational projections fail to account for the years between filing the application and certification as most staff costs have been increased for the same percentage from current timeframe (12/31/2013) to OY1 (12/31/2017), a span of 48 months, as they are increased from OY1 (12/31/2017) to OY2 (12/31/2018), a span of 12 months. The BMA application fails to demonstrate that there will sufficient staff after completion of the project. See BMA Application, pp. 60, 78 and discussion under Criterion 7, below. Therefore, the applicant has under-projected operating costs, which affect financial feasibility.

Further, for the reasons discussed under Criterion 3 above, BMA's application clearly does not demonstrate financial feasibility. A realistic analysis of BMA's utilization projections demonstrates that Randolph

County residents are choosing and will continue to choose to receive dialysis services elsewhere, meaning that the facility will remain underutilized. Because BMA's costs and charges are based, in part, on its utilization projections, the application fails to demonstrate financial feasibility.

For these reasons, BMA is non-conforming to Criterion 5.

V. UNNECESSARY DUPLICATION OF EXISTING AND APPROVED SERVICES (CRITERION 6)

As discussed above BMA already has more than sufficient capacity to handle the current and future needs of dialysis patients choosing its facility. BMA does not propose to service non-BMA Asheboro patients. It proposes that additional station utilization shall occur based upon growth of its "***existing***" patient base. However, with a 10-station deficit in the county, BMA cannot gain additional patients from its sister facilities serving Randolph County patients in Guilford, Chatham and Alamance Counties, which would increase BMA Asheboro's facility utilization rate. Two additional dialysis stations which would not be operational for three years would be an unnecessary duplication of its existing and approved services.

For these reasons, BMA is non-conforming to Criterion 6.

VI. INSUFFICIENT FACILITY STAFF (CRITERION 7)

On page 60, the applicant demonstrates the projected staffing and salary amounts for its facility for current, OY1 and OY2.

The salary amounts for OY1 and OY2 are understated. The application projects that current staff hourly rates will increase 3% annually. BMA Application, p. 78. However, those salaries in fact reflect one 3% increase from Current to December 2017 (the end OY1), followed by a 3% to OY2. It is unrealistic for BMA to assume that current staff will receive no wage increases from the present until the end of 2017.

On page 60 of its application, BMA indicates its BMA Asheboro facility currently employs 17.50 direct-care staff FTE's. Those staff include 5 RN's, 11 Techs, 1 DON, and 0.50 RN Home Training Nurse. BMA does not identify that it will hire additional staffing and has not budgeted for the hire of additional staffing in the table on page 60 nor in its Table X.5 on page 78 of its application.

On page 62 of its application BMA indicates in a tabled response to item 10., that it provides 10 direct-care staff for each shift offered in its facility, which will operate 10 hours per day, six days per week for a total of 600 FTE hours serving 104 patients per week, 26 patients per shift on average, which translates to 2.52 or 2.6 patients per one direct-care staff per shift. BMA does not indicate any anticipated changes to its shift schedule with the addition of two new dialysis stations and 50 additional patients.

On page 40 of its application BMA indicates it will serve 154.7 ICH patients by its End of OY1 and 169.1 by its End of OY2. If BMA Asheboro maintains its 10 direct-care staff per shift as indicated in its application, and continues operating two shifts per day, staffing ratios will be reduced to about 4:1 in OY1 and reduced to greater than 4:1 in OY2. The increase in patient to staffing ratios indicates a degradation in service with an increase in facility census.

Medicare Interpretive Guidelines V757 requires:

> *"(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.*

There must be sufficient numbers of qualified and trained staff on duty while patients are on dialysis in-center to meet the individualized needs of the patients. Consideration should be given to the acuity and care needs of the patients, staff experience and areas of expertise when evaluating the adequacy of staffing. Sufficient numbers of staff must be present in the treatment area to be able to see every patient during treatment (including lunch breaks, shift change, etc. [refer to V407]; to deliver routine care, patient assessment and monitoring per facility policy; and to promptly respond to and address patient needs (such as changes in physical or mental condition) and machine alarms. Staffing assignments and schedules should demonstrate a pattern of sufficient staff coverage to ensure safe patient care.

Facilities are expected to meet any applicable State regulations that identify specific patient-to-staff ratio requirements. Failure to comply with those State requirements may be cited at this tag."

The number of direct care FTE's is not increased from Current to OY1 to maintain reported patient to staff ratios. The number of direct care FTE's is not increased from OY1 to OY2, either. BMA has not made a provision to hire additional staffing to accommodate a projected increase in patients (additional 68 patients from current to OY2), nor does the application attempt to explain how or why existing staff will be sufficient to accommodate those additional patients.

For these reasons, BMA is non-conforming to Criterion 7.

VII. FAILURE TO ACCOMMODATE THE NEEDS OF HEALTH TRAINING PROGRAMS (CRITERION 14)

Criterion 14 requires that the applicant demonstrate that the proposed health services will accommodate the clinical needs of health professional training programs in the area. As an existing dialysis facility in Randolph County, BMA Asheboro should already have existing agreements and/or arrangements in place with area clinical health professional training programs. However, instead of demonstrating the existence of such agreements, BMA includes a letter to Randolph Community College, ostensibly dated "2/29/14", inviting the College "to include the BMA Asheboro dialysis facility in your list of facilities for clinical rotation of your nursing students." BMA Application, Ex. 19. Significantly, this letter states that BMA intends to file a CON application on ***September 15, 2010***, and that "the new facility/stations would become operational at (sic) June 30, 2012." A review of the letter attached as Exhibit 19 to BMA's 2010 CON application (**Exhibit 6** hereto), shows that **BMA simply appears to have photocopied that letter and typed the new date on it**. Since BMA Asheboro has not apparently actually made any arrangements or agreements with Randolph Community College, and could not even be bothered to draft a new letter to them, this raises a question as to whether BMA actually has any intent to enter into any such agreement.

VIII. COST EFFECTIVENESS OF THE SERVICES PROPOSED (CRITERION 18A)

Criterion 18a requires the applicant to adequately demonstrate that the proposal would have a positive impact upon the cost effectiveness of the services proposed. As discussed under Criteria 3 and 5 above, BMA's overstated utilization projections demonstrate that the proposal will not be cost effective or financially feasible.

For these reasons, BMA is non-conforming to Criterion 18a.

IX. COMPLIANCE WITH APPLICABLE RULES

The BMA application is non-conforming with the following rules:

10 NCAC 14C .2203 PERFORMANCE STANDARDS

.2203(b) *An applicant proposing to increase the number of dialysis stations in an existing End Stage Renal Disease facility or one that was not operational prior to the beginning of the review period but which had been issued a certificate of need 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.*

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

For the reasons discussed under Criteria 1 and 3 above, the BMA application does not document the need for two additional dialysis stations, and does not provide adequate assumptions to justify its proposal.

10 NCAC 14C .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.*

For the reasons discussed under Criterion 7 above, the BMA application does not adequately meet CMS required patient to staff ratios.

X. COMPARATIVE ANALYSIS

The CON Section does not necessarily need to conduct a comparative review of the two applications at issue here. Under 10A NCAC 14C .0202(f), applications are competitive only if they are for the same or similar services and the CON Section determines that the approval of one or more of the applications may result in the denial of another application reviewed in the same review period. The BMA Application is clearly inadequate for approval, and should be disapproved irrespective of the CON Section's findings regarding the NRDC application. Therefore, no comparison is necessary. See Required State Agency Findings, 2011 Cleveland County ESRD review, page 62, **Exhibit 3** hereto.

However if the CON Section does conclude that a comparative analysis is necessary, the NRDC application is clearly superior, based on factors that the CON Section has found to be relevant in past dialysis reviews when conducting a comparative analysis of competing proposals such as those considered here. The specific factors below were used in the 2011 Randolph County dialysis review, where BMA was awarded a CON to relocate 27 dialysis stations and add 10 new stations, for a total of 46 stations. See **Exhibit 4, pp. 45-49**.[4]

SMFP Principles

There are two Basic Principals of the 2014 SMFP which bear comparing in this Review, Basic Principal 6 and Basic Principal 12.

Basic Principal 6

Basic Principle 6 regarding the Expansion of Existing Facilities in Chapter 14, page 360 of the 2014 SMFP states:

> *"No existing facility may expand unless its utilization is 80 percent or greater. Any facility at 80 percent utilization or greater may apply to expand."*

As discussed under Criterion 1, BMA is non-conforming with this Basic Principal, and therefore is a less effective alternative than NRDC.

[4] The comparative reviews in the Agency Findings in the 2012 Macon County ESRD Review and the 2013 Scotland County ESRD Review used the same factors to compare the competing applications.

Basic Principal 12

Basic Principle 12 regarding the Availability of Dialysis Care in Chapter 14, page 361, of the 2014 SMFP states:

> *"The North Carolina State Health Coordinating Council encourages applicants for dialysis stations to provide or arrange for:*
>
> *a. Home training and backup for patients suitable for home dialysis in the ESRD dialysis facility or in a facility that is a reasonable distance from the patient's residence;*
>
> *b. ESRD dialysis service availability at times that do not interfere with ESRD patients' work schedules;*
>
> *c. Services in rural, remote areas."*

a) Home Training

Both NRDC and BMA state that they will provide home training services and follow-up at the proposed facility. Therefore, both applications are comparable with regard to this service. WFUHS currently serves 13 Randolph County home dialysis patients. BMA Asheboro serves 6 Randolph county home dialysis patients.

b) Hours of Availability

In Section VII.10, BMA states that dialysis services will be available 7:00 a.m. – 5:00 p.m. Monday through Saturday, which is 60 hours per week. In Section VII.10, page 77, NRDC states that dialysis services will be available 6:30 a.m. – 10:00 p.m. Monday through Saturday; which is 93 hours per week. Therefore, NRDC is the more effective alternative with regard to hours of availability.

c) Services in rural, remote areas

Neither proposed facility site is in a remote rural area. Therefore, both are equally effective.

Facility Location

As discussed under Criterion 3, the number of Randolph County dialysis patients receiving ICH services in a facility outside of Randolph County has grown from 27 in 2009 to 86 in December 2013. Conversely, BMA Asheboro has lost patient population during that time frame, despite the fact that it was certified for 19 additional stations in July of 2013 increasing it from 27 ICH stations to 46 ICH stations. NRDC's facility in northern Randolph County is a significantly more effective alternative than adding more stations to the severely underutilized BMA Asheboro.

Service to Randolph County Patients

There is a deficit of 10 stations in Randolph County. NRDC proposes to develop a new facility with 10 stations, all of which are projected to serve Randolph County patients. BMA's proposal is to add only two stations to serve Randolph County patients, which would bring its ***facility surplus*** from 14 surplus stations to 16 surplus stations.

Further, the NRDC application projects to open a brand new facility and begin operations on November 30, 2015, over a **year** before BMA Asheboro expects to add two new stations to an existing facility, despite the fact that BMA projects **no** construction costs.

Therefore, NRDC's proposal will provide dialysis service more quickly to more Randolph County patients without duplicating services in an underutilized area of Randolph County, and is the more effective alternative.

Access to Alternative Providers

As the only provider of dialysis services in Randolph County, BMA clearly is not an effective alternative. NRDC will bring a new provider to the county, and therefore would be a more effective alternative.

Access by Underserved Groups

The following table compares access to Medicare and/or Medicaid recipients, as reported by NRDC and BMA in Section VI.1(c) of their respective applications.

Payor Category	% of Total Patients			
	NRDC		BMA	
	In-center	Home	In-center	Home
Medicare	11%	11%	65.24%	57.13%
Medicaid	4%	4%	6.16%	0
Medicare/Medicaid	27%	27%	0	0
Medicare/Commercial	36%	36%	14.83%	25.70%
Medicare Advantage	7%	7%	0	0
Total % Medicare/ Medicaid	**85%**	**85%**	**86.23%**	**82.83%**
Commercial	4%	4%	7.94%	17.17%
VA	11%	11%	8.10%	0
Self/Indigent	0	0	.73%	0
Total	100%	100%	100%	100%

The applicants project comparable access by underserved groups. However, NRDC offers access to a greater variety of Medicare-primary payors as well as a larger percentage of service to VA than BMA Asheboro.

Access to Support Services

The following table summarizes the information provided in Section V of the applications regarding the proposed providers of support services, including diagnostic evaluation, laboratory, blood bank, acute care, emergency care, and X-ray:

SUPPORT SERVICES	NRDC*	BMA
Diagnostic/Evaluation	On-site	Randolph County Hospital, Moses Cone Hospital
X-ray	North Carolina Baptist Hospital, High Point Regional Health System	Randolph County Hospital
Laboratory	Meridian	SPECTRA
Blood Bank	North Carolina Baptist Hospital, High Point Regional Health System	Moses Cone Hospital
Emergency Care	North Carolina Baptist Hospital, High Point Regional Health System	Randolph County Hospital

Vascular Surgery	North Carolina Baptist Hospital, High Point Regional Health System	Randolph County Hospital
Acute Care Services	North Carolina Baptist Hospital, High Point Regional Health System	Moses Cone Hospital

* *Although NRDC does not yet have an affiliation agreement with High Point Regional Health System, High Point Kidney Center, from which patients are expected to transfer, does have such an agreement. The NRDC application includes a letter of support from High Point Regional Health System, and projects that such an agreement will be reached upon approval of the application.*

The following table represents the distance calculations between addresses, as reported in response to Section XI.5 of the application form.

Distance between Proposed Dialysis Facilities and Projected Affiliated Hospitals in Above Table				
Start	**Destination**	**Distance/Est Travel Time**	**Destination**	**Distance/Est Travel Time**
NRDC Proposed Site	NC Baptist Hospital Medical Center Blvd Winston Salem, NC	23.38 miles / 33 minutes	High Point Regional Health System 601 N. Elm St. High Point, NC	7.39 miles / 13 minutes
BMA Proposed Site 186 Brower's Chapel Rd. Asheboro, NC	Randolph County Hosp. 364 White Oak St. Asheboro, NC	2.97 miles / 6 minutes	Moses Cone Hospital 1200 North Elm St. Greensboro, NC	31.38 miles / 37 minutes

The distance between the proposed facility sites and their projected affiliated hospitals is similar.

Operating Costs and Revenues

Because BMA overstates utilization, its cost and revenue information is not reliable. Therefore, it is not possible to compare operating costs or revenues of the two proposals.

However, it is notable that BMA's "Allowable" charge for Commercial Insurance at $1,425.00 per treatment is significantly higher than NRDC's allowable charge per treatment for Commercial Insurance projected for OY1 of $1208.19 per treatment.

Staffing

Direct Care Staff Salaries

Because BMA has under-projected operating costs, including staff salaries, it is not possible to compare direct care staff salaries. However, if a comparison were possible, NRDC would be the more effective alternative.

The following table compares projected annual salaries plus benefits for the registered nurse and dialysis technician positions during the first year of operation, as reported in Sections VII.1 of the applications.

	NRDC – OY1 2016[5]	BMA – OY1 2017	Difference
RN	$58,160 + 25% = **$72,700**	$58,787 + 21% = **$71,132**	$ 1,568 **(NRDC)**
Home Training Nurse	$58,160 + 25% = **$72,700**	$61,058 + 21% = **$73,880**	$ 1,180 **(BMA)**
Patient Care Technician	$27,978 + 25% = **$34,973**	$27,894 + 21% = **$33,752**	$ 1,221 **(NRDC)**

** NRDC payroll taxes and benefits = 25% of salaries (App., p. 63)*
*** BMA payroll taxes and benefits = 21% of salaries (App. p. 76)*

As shown in the above table, NRDC shows comparative, if not superior employee pay, including payroll taxes and benefits. Since payroll taxes are fixed by the government, NRDC's combined salary and benefits presents a more effective alternative with regard to direct care salaries.

Availability of Staff

As discussed under Criterion 7 above, BMA does not project additional staffing or how the current staffing level of direct care staff will serve the projected number of patients in OY1 and OY2. Conversely, NRDC does project sufficient staff for its project and an increase in staffing as patient demand is projected to increase. Therefore, NRDC is the more effective alternative.

Summary

Thus, under all of the above factors, either (1) NRDC is the more effective alternative; (2) the applicants are equally effective; or (3) no comparison can be made, due to incomplete or erroneous information in the BMA application.

CONCLUSION

In conclusion, the BMA application contains a number of crucial errors, which make its application non-approvable if not void. In contrast, NRDC has provided reliable data in its application that is based on sound and substantiated assumptions.

For these reasons, NRDC recommends approval of its project and disapproval of BMA's project.

Thank you for the opportunity to provide these comments and your careful consideration of these important issues. Please do not hesitate to contact me at (229) 387-3527.

Respectfully Submitted,

William F. McDonald
Director of Development
Health Systems Management, Inc.

[5] NRDC's OY1 is planned to occur a full year prior to BMA's OY1. A comparative analysis of NRDC's salaries for the same time period (2017) with BMA's shows NRDC's salaries superior in all categories.

EXHIBIT LIST

1. January 2009-January 2014 Semi-Annual Dialysis Report data for Randolph County
2. Map of Randolph County and surrounding counties with locations of existing dialysis facilities
3. Required State Agency Findings, 2011 Cleveland County ESRD Review
4. Required State Agency Findings, 2010 Randolph County Competitive Dialysis Review
5. Patient Origin Report with data as of June 30, 2013 (Randolph County)
6. Exhibit 19 to BMA Randolph 2010 CON application

2009

STATE HEALTH COORDINATING COUNCIL

North Carolina Semiannual Dialysis Report January 2009

EXHIBIT 1

North Carolina Department of Health and Human Services

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates

(Inventory Compiled 12.29.08. Utilization Rates Calculated for 6.30.08)

COUNTY	PROVIDER NUMBER	FACILITY	CITY	Number of Dialysis Stations as of 12.29.08					Certified Stations 6.30.08	Number In-Center Patients 6.30.08	Utilization Rates	
				Certified	CON Issued/Not Certified	Decision Rendered	Decision Pending	TOTAL			Utilization by Percent	Patients per Station
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	141	73%	2.94
Pitt	34-2632	FMC Care of Ayden	Ayden	10	0	0	0	10	10	30	75%	3.00
Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	124	82%	3.26
Polk	n/a	Polk County Dialysis Center	Columbus	0	0	0	10	10	0	0		
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	0	0	0	27	27	87	81%	3.22
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	0	0	0	32	32	110	86%	3.44
Robeson	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	32	-3	0	0	29	38	112	74%	2.95
Robeson	34-2623	FMC Dialysis Services of Robeson County	Fairmont	19	0	0	4	23	19	61	80%	3.21
Robeson	34-2607	BMA of Red Springs	Red Springs	18	-4	0	0	14	20	50	63%	2.50
Robeson	34-2662 - New site consisting of existing stations.	BMA of St. Pauls - utilization included with BMA Lumberton and BMA Red Springs.	St. Pauls	10	0	0	0	10				
Robeson	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	16	40%	1.60
Robeson	Proposed new site consisting of existing stations.	FMC of Pembroke - utilization included with BMA Lumberton, BMA Red Springs, and BMA Laurinburg.	Pembroke	0	10	0	0	10				
Rockingham	34-2536	Dialysis Care of Rockingham County	Eden	20	3	0	0	23	20	53	66%	2.65
Rockingham	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	25	63%	2.50
Rockingham	34-2640	Reidsville Dialysis	Reidsville	18	0	0	0	18	18	58	81%	3.22
Rockingham	34-2641	Rockingham Kidney Center (BMA)	Reidsville	15	0	0	0	15	15	41	68%	2.73
Rowan	34-2546	Dialysis Care of Rowan County	Salisbury	28	0	0	0	28	28	97	87%	3.46
Rowan	34-2592	Dialysis Care of Kannapolis/Rowan	Kannapolis	25	0	0	0	25	25	63	63%	2.52
Rutherford	34-2566	Dialysis Care of Rutherford County	Forest City	30	0	0	0	30	30	84	70%	2.80
Sampson	34-2559	BMA of Clinton	Clinton	39	0	0	-10	29	39	125	80%	3.21
Sampson	Proposed new site consisting of existing stations.	FMC of Roseboro - utilization included with BMA of Clinton.	Roseboro	0	0	0	10	10				
Scotland	34-2540	BMA of Laurinburg	Laurinburg	29	-3	0	0	26	34	125	92%	3.68

Table B: ESRD Dialysis Station Need Determinations by Planning Area

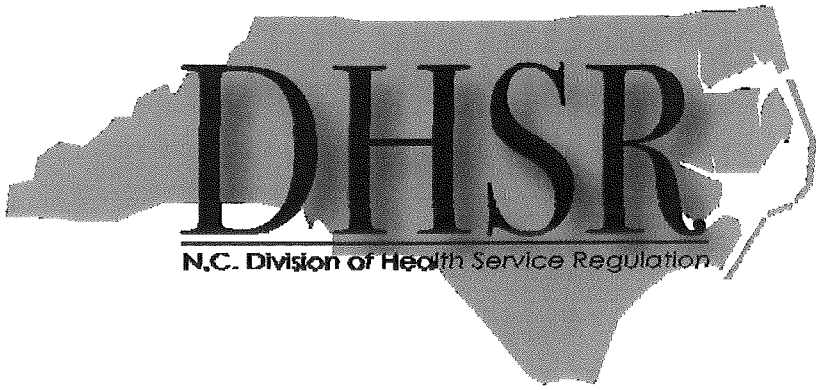
(Note: Except for the Cherokee-Clay-Graham Multi-County Planning Area and the Mitchell-Avery-Yancey Multi-County Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.)

County/ Multi-County Planning Area	12.31.03 Total Patients	12.31.04 Total Patients	12.31.05 Total Patients	12.31.06 Total Patients	12.31.07 Total Patients	Average Annual Change Rate for Past Five Years	6.30.08 Total Patients	Projected 6.30.09 Total Patients	6.30.08 Home Patients	6.30.08 % Home Patients	Projected 6.30.09 Home Patients	Projected 6.30.09 In-Center Patients	Projected 6.30.09 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Guilford	714	731	761	769	792	0.026	797	818.0	49	6.1%	50.3	767.7	240	270	Surplus of 30	**0**
Halifax	135	148	171	175	182	0.079	188	202.8	28	14.9%	30.2	172.6	54	46	**8**	**0**
Harnett	111	127	120	122	139	0.061	148	157.1	13	8.8%	13.8	143.3	45	35	**10**	**0**
Pursuant to Step (1) (E) of the County Need Methodology, the Harnett County Need Determination is 0 because a facility in Harnett County was below 80% utilization.																
Haywood	51	47	50	48	49	-0.008	54	53.5	4	7.4%	4.0	49.6	15	17	Surplus of 2	**0**
Henderson	65	73	75	74	71	0.024	69	70.7	10	14.5%	10.2	60.4	19	26	Surplus of 7	**0**
Hertford	74	71	76	84	78	0.016	69	70.1	7	10.1%	7.1	63.0	20	27	Surplus of 7	**0**
Hoke	70	69	68	67	64	-0.022	69	67.5	10	14.5%	9.8	57.7	18	26	Surplus of 8	**0**
Hyde	10	9	6	7	6	-0.102	8	7.2	0	0.0%	0.0	7.2	2	0	**2**	**0**
Iredell	148	167	174	185	192	0.068	197	210.4	28	14.2%	29.9	180.5	56	70	Surplus of 14	**0**
Jackson	12	11	18	20	25	0.229	27	33.2	1	3.7%	1.2	31.9	10	18	Surplus of 8	**0**
Johnston	157	165	161	181	193	0.054	192	202.4	24	12.5%	25.3	177.1	55	56	Surplus of 1	**0**
Jones	21	24	25	23	24	0.037	28	29.0	1	3.6%	1.0	28.0	9	10	Surplus of 1	**0**
Lee	91	90	91	106	100	0.027	93	95.5	12	12.9%	12.3	83.2	26	39	Surplus of 13	**0**
Lenoir	179	180	182	184	175	-0.005	171	170.1	10	5.8%	9.9	160.1	50	63	Surplus of 13	**0**
Lincoln	44	48	55	62	66	0.107	78	86.4	11	14.1%	12.2	74.2	23	25	Surplus of 2	**0**
Macon	13	11	16	20	21	0.150	27	31.1	5	18.5%	5.8	25.3	8	0	**8**	**0**
Madison	12	13	13	12	9	-0.061	9	8.5	1	11.1%	0.9	7.5	2	0	**2**	**0**
Martin	78	73	67	58	64	-0.044	66	63.1	6	9.1%	5.7	57.3	18	23	Surplus of 5	**0**
McDowell	26	31	37	40	38	0.104	41	45.3	4	9.8%	4.4	40.9	13	13	0	**0**
Mecklenburg	870	878	959	986	1071	0.054	1081	1139.3	96	8.9%	101.2	1038.1	324	330	Surplus of 6	**0**
Mitchell	6	7	8	12	8	0.119	7	7.8	1	14.3%	1.1	6.7	2	9	Surplus of 7	
Avery	12	8	11	11	10	-0.012	9	8.9	1	11.1%	1.0	7.9	2	0	**2**	
Yancey	13	15	13	15	18	0.094	18	19.7	3	16.7%	3	16	5	0	**5**	
Mitchell-Avery-Yancey Planning Area Total															0	**0**
Montgomery	37	45	35	44	53	0.114	53	59.0	1	1.9%	1.1	57.9	18	19	Surplus of 1	**0**
Moore	112	116	141	138	150	0.079	144	155.4	10	6.9%	10.8	144.6	45	47	Surplus of 2	**0**
Nash	128	145	162	167	176	0.084	176	190.7	22	12.5%	23.8	166.9	52	52	0	**0**
New Hanover	170	167	186	175	180	0.016	189	192.1	15	7.9%	15.2	176.9	55	49	**6**	**0**
Northampton	57	67	63	71	71	0.061	72	76.4	7	9.7%	7.4	68.9	22	16	**6**	**0**
Onslow	106	106	119	121	125	0.043	118	123.1	12	10.2%	12.5	110.6	35	38	Surplus of 3	**0**
Orange	111	106	112	114	142	0.069	135	144.3	10	7.4%	10.7	133.6	42	36	**6**	**0**
Pamlico	17	16	16	17	20	0.045	18	18.8	1	5.6%	1.0	17.8	6	0	**6**	**0**
Pasquotank	54	63	62	65	76	0.092	77	84.1	11	14.3%	12.0	72.1	23	22	**1**	**0**
Pender	57	56	66	83	71	0.069	75	80.1	7	9.3%	7.5	72.7	23	20	**3**	**0**
Perquimans	17	22	20	19	18	0.025	19	19.5	2	10.5%	2.1	17.4	5	0	**5**	**0**
Person	79	82	86	84	86	0.022	87	88.9	2	2.3%	2.0	86.9	27	24	**3**	**0**
Pitt	259	263	262	285	292	0.031	296	305.2	25	8.4%	25.8	279.4	87	96	Surplus of 9	**0**
Polk	16	2	11	15	16	1.014	14	28.2	0	0.0%	0.0	28.2	9	10	Surplus of 1	**0**
Randolph	106	97	100	104	105	-0.001	109	108.9	9	8.3%	9.0	99.9	31	27	**4**	**0**

2009

STATE HEALTH COORDINATING COUNCIL

North Carolina Semiannual Dialysis Report July 2009



North Carolina Department of Health and Human Services

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 6.29.09. Utilization Rates Calculated for 12.31.08)

County	Provider Number	Facility	City	Number of Dialysis Stations as of 6.29.09					Certified Stations 12.31.08	Number In-Center Patients 12.31.08	Utilization Rates	
				Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total			Utilization by Percent	Patients per Station
Montgomery	34-2583	Dialysis Care of Montgomery County	Biscoe	19	0	0	0	19	14	59	105%	4.21
Moore	34-2555	Dialysis Care of Pinehurst (Moore County)	Pinehurst	33	-11	0	0	22	33	107	81%	3.24
Moore	34-2638	Southern Pines Dialysis Center	Southern Pines	12	1	0	0	13	12	41	85%	3.42
Moore	Proposed new site consisting of existing stations.	Carthage Dialysis Center - utilization included with Dialysis care of Moore County and Southern Pines Dialysis Center.	Carthage	0	12	0	0	12	0	0		
Nash	34-2517	Rocky Mount Kidney Center (BMA)	Rocky Mount	42	0	0	0	42	42	149	89%	3.55
Nash	34-2644	FMC Dialysis Services of Spring Hope	Spring Hope	10	0	0	0	10	10	21	53%	2.10
New Hanover	34-2511	Southeastern Dialysis Center	Wilmington	49	0	0	-21	28	49	183	93%	3.73
New Hanover	Proposed new site consisting of existing stations.	Cape Fear Dialysis Center - utilization included with Southeastern Dialysis Center - Wilmington	Wilmington	0	0	0	28	28	0	0		
Northampton	34-2586	Rich Square Dialysis Unit (BMA Northampton)	Rich Square	16	0	0	0	16	14	43	77%	3.07
Onslow	34-2532	Southeastern Dialysis Ctr. Jacksonville	Jacksonville	35	3	0	0	38	35	122	87%	3.49
Orange	34-2622	Carolina Dialysis Carrboro (UNC)	Carrboro	36	0	0	0	36	36	118	82%	3.28
Pamlico												
Pasquotank	34-2515	Elizabeth City Dialysis	Elizabeth City	22	0	2	0	24	21	78	93%	3.71
Pender	34-2558	Southeastern Dialysis Center Inc.	Burgaw	20	0	0	0	20	20	66	83%	3.30
Perquimans												
Person	34-2562	Roxboro Dialysis	Roxboro	24	0	0	0	24	24	86	90%	3.58
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	144	75%	3.00
Pitt	34-2632	FMC Care of Ayden	Ayden	10	0	0	0	10	10	35	88%	3.50
Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	124	82%	3.26
Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0		
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	0	0	0	27	27	94	87%	3.48
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	0	0	0	32	32	111	87%	3.47

Table B Revised 7.7.09 - "12.31.08 % Home Patients" was corrected, which changed the 12.31.09 Patient Projections and some Projected Station Surpluses and Deficits.
Need Determination did not change.

Revised July 2009 SDR Table B: ESRD Dialysis Station Need Determinations by Planning Area

(supersedes Table B posted on July 1, 2009)

County/ Multi-County Planning Area	12.31.04 Total Patients	12.31.05 Total Patients	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	Average Annual Change Rate for Past Five Years	Projected 12.31.09 Total Patients	12.31.08 Home Patients	12.31.08 % Home Patients	Projected 12.31.09 Home Patients	Projected 12.31.09 In-Center Patients	Projected 12.31.09 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Guilford	731	761	769	792	787	0.019	801.8	52	6.6%	53.0	748.8	234	270	Surplus of 36	0
Halifax	148	171	175	182	192	0.068	205.1	24	12.5%	25.6	179.5	56	54	**2**	0
Harnett	127	120	122	139	153	0.050	160.7	12	7.8%	12.6	148.1	46	38	**8**	0
Haywood	47	50	48	49	52	0.026	53.4	4	7.7%	4.1	49.3	15	18	Surplus of 3	0
Henderson	73	75	74	71	79	0.022	80.7	15	19.0%	15.3	65.4	20	26	Surplus of 6	0
Hertford	71	76	84	78	77	0.023	78.8	7	9.1%	7.2	71.6	22	27	Surplus of 5	0
Hoke	69	68	67	64	67	-0.007	66.5	7	10.4%	7.0	59.6	19	30	Surplus of 11	0
Hyde	9	6	7	6	6	-0.077	5.5	0	0.0%	0.0	5.5	2	0	**2**	0
Iredell	167	174	185	192	201	0.047	210.5	30	14.9%	31.4	179.1	56	72	Surplus of 16	0
Jackson	11	18	20	25	24	0.239	29.7	1	4.2%	1.2	28.5	9	18	Surplus of 9	0
Johnston	165	161	181	193	191	0.039	198.4	19	9.9%	19.7	178.7	56	56	0	0
Jones	24	25	23	24	28	0.043	29.2	1	3.6%	1.0	28.2	9	10	Surplus of 1	0
Lee	90	91	106	100	102	0.035	105.6	12	11.8%	12.4	93.1	29	39	Surplus of 10	0
Lenoir	180	182	184	175	174	-0.008	172.6	12	6.9%	11.9	160.7	50	63	Surplus of 13	0
Lincoln	48	55	62	66	78	0.130	88.1	11	14.1%	12.4	75.7	24	25	Surplus of 1	0
Macon	11	16	20	21	24	0.224	29.4	5	20.8%	6.1	23.3	7	0	**7**	0
Madison	13	13	12	9	8	-0.110	7.1	1	12.5%	0.9	6.2	2	0	**2**	0
Martin	73	67	58	64	62	-0.036	59.8	7	11.3%	6.7	53.0	17	23	Surplus of 6	0
McDowell	31	37	40	38	44	0.096	48.2	4	9.1%	4.4	43.8	14	13	**1**	0
Mecklenburg	878	959	986	1071	1097	0.058	1160.3	84	7.7%	88.8	1071.5	335	335	0	0
Mitchell	7	8	12	8	8	0.077	8.6	2	25.0%	2.2	6.5	2	9	Surplus of 7	
Avery	8	11	11	10	9	0.046	9.4	1	11.1%	1.0	8.4	3	0	**3**	
Yancey	15	13	15	18	17	0.041	17.7	4	23.5%	4	14	4	0	**4**	
Mitchell-Avery-Yancey Planning Area Total														0	0
Montgomery	45	35	44	53	54	0.065	57.5	1	1.9%	1.1	56.4	18	19	Surplus of 1	0
Moore	116	141	138	150	156	0.080	168.5	11	7.1%	11.9	156.6	49	47	**2**	0
Nash	145	162	167	176	186	0.065	198.0	26	14.0%	27.7	170.4	53	52	**1**	0
New Hanover	167	186	175	180	191	0.036	197.9	19	9.9%	19.7	178.2	56	56	0	0
Northampton	67	63	71	71	76	0.034	78.6	6	7.9%	6.2	72.4	23	16	**7**	0
Onslow	106	119	121	125	131	0.055	138.2	16	12.2%	16.9	121.3	38	38	0	0
Orange	106	112	114	142	128	0.055	135.1	12	9.4%	12.7	122.4	38	36	**2**	0
Pamlico	16	16	17	20	18	0.035	18.6	1	5.6%	1.0	17.6	5	0	**5**	0
Pasquotank	63	62	65	76	74	0.044	77.2	10	13.5%	10.4	66.8	21	24	Surplus of 3	0
Pender	56	66	83	71	77	0.094	84.2	11	14.3%	12.0	72.2	23	20	**3**	0
Perquimans	22	20	19	18	17	-0.062	15.9	2	11.8%	1.9	14.1	4	0	**4**	0
Person	82	86	84	86	86	0.012	87.1	3	3.5%	3.0	84.0	26	24	**2**	0
Pitt	263	262	285	292	303	0.037	314.1	26	8.6%	27.0	287.1	90	96	Surplus of 6	0
Polk	2	11	15	16	12	1.170	26.0	0	0.0%	0.0	26.0	8	10	Surplus of 2	0
Randolph	97	100	104	105	114	0.042	118.7	8	7.0%	8.3	110.4	35	27	**8**	0
Richmond	90	104	100	105	109	0.051	114.6	7	6.4%	7.4	107.2	34	32	**2**	0

Note: Except for the Cherokee-clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

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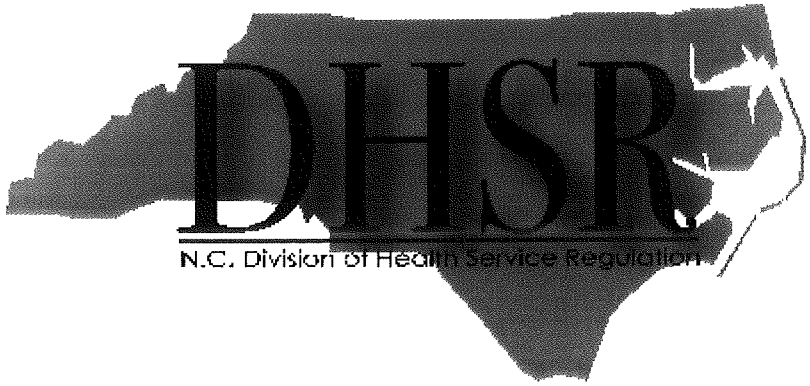

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 12.30.09. Utilization Rates Calculated for 6.30.09.)

	County	Provider Number	Facility	City	Number of Dialysis Stations as of 12.30.09					Certified Stations 6.30.09	Number In-Center Patients 6.30.09	Utilization Rates	
					Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total			Utilization by Percent	Patients per Station
	Montgomery	34-2583	Dialysis Care of Montgomery County	Biscoe	19	0	0	0	19	19	54	71%	2.84
	Moore	34-2555	Dialysis Care of Pinehurst (Moore County)	Pinehurst	33	-11	0	3	25	33	110	83%	3.33
	Moore	34-2638	Southern Pines Dialysis Center	Southern Pines	12	1	0	0	13	12	41	85%	3.42
	Moore	Proposed new site consisting of existing stations.	Carthage Dialysis Center - utilization included with Dialysis care of Moore County and Southern Pines Dialysis Center.	Carthage	0	12	0	0	12	0	0		
	Nash	34-2517	Rocky Mount Kidney Center (BMA)	Rocky Mount	42	0	0	0	42	42	147	88%	3.50
	Nash	34-2644	FMC Dialysis Services of Spring Hope	Spring Hope	10	0	0	0	10	10	25	63%	2.50
	New Hanover	34-2511	Southeastern Dialysis Center	Wilmington	49	-28	0	8	29	49	184	94%	3.76
	New Hanover	Proposed new site consisting of existing stations.	Cape Fear Dialysis Center - utilization included with Southeastern Dialysis Center - Wilmington	Wilmington	0	28	0	0	28	0	0		
	Northampton	34-2586	Rich Square Dialysis Unit (BMA Northampton)	Rich Square	16	0	0	0	16	16	45	70%	2.81
	Onslow	34-2532	Southeastern Dialysis Ctr. Jacksonville	Jacksonville	35	3	0	0	38	35	124	89%	3.54
	Orange	34-2622	Carolina Dialysis Carrboro (UNC)	Carrboro	36	0	0	0	36	36	124	86%	3.44
	Pamlico												
	Pasquotank	34-2515	Elizabeth City Dialysis	Elizabeth City	22	2	0	0	24	22	89	101%	4.05
	Pender	34-2558	Southeastern Dialysis Center Inc.	Burgaw	20	0	0	0	20	20	70	88%	3.50
	Perquimans												
	Person	34-2562	Roxboro Dialysis	Roxboro	24	0	0	0	24	24	88	92%	3.67
	Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	142	74%	2.96
	Pitt	34-2632	FMC Care of Ayden	Ayden	10	0	5	0	15	10	36	90%	3.60
	Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	122	80%	3.21
	Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0		
	Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	0	7	0	34	27	101	94%	3.74
	Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	0	-12	3	23	32	121	95%	3.78
	Richmond	Proposed new site consisting of existing stations.	Sandhills Dialysis Center - utilization included with Dialysis Care of Richmond County	Rockingham	0	0	12	0	12	0	0		

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.04 Total Patients	12.31.05 Total Patients	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	Average Annual Change Rate for Past Five Years	6.30.09 Total Patients	Projected 6.30.10 Total Patients	6.30.09 Home Patients	6.30.09 % Home Patients	Projected 6.30.10 Home Patients	Projected 6.30.10 In-Center Patients	Projected 6.30.10 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Guilford	731	761	769	792	787	0.019	803	818.1	56	7.0%	57.1	761.0	238	270	Surplus of 32	0
Halifax	148	171	175	182	192	0.068	205	219.0	21	10.2%	22.4	196.6	61	58	**3**	0
Harnett	127	120	122	139	153	0.050	170	178.6	15	8.8%	15.8	162.8	51	44	**7**	0
Haywood	47	50	48	49	52	0.026	62	63.6	5	8.1%	5.1	58.5	18	18	0	0
Henderson	73	75	74	71	79	0.022	70	71.5	14	20.0%	14.3	57.2	18	26	Surplus of 8	0
Hertford	71	76	84	78	77	0.023	82	83.9	7	8.5%	7.2	76.7	24	27	Surplus of 3	0
Hoke	69	68	67	64	67	-0.007	73	72.5	8	11.0%	7.9	64.6	20	30	Surplus of 10	0
Hyde	9	6	7	6	6	-0.077	6	5.5	1	16.7%	0.9	4.6	1	0	**1**	0
Iredell	167	174	185	192	201	0.047	190	199.0	29	15.3%	30.4	168.6	53	74	Surplus of 21	0
Jackson	11	18	20	25	24	0.239	27	33.5	3	11.1%	3.7	29.7	9	18	Surplus of 9	0
Johnston	165	161	181	193	191	0.039	196	203.6	23	11.7%	23.9	179.7	56	59	Surplus of 3	0
Jones	24	25	23	24	28	0.043	31	32.3	1	3.2%	1.0	31.3	10	10	0	0
Lee	90	91	106	100	102	0.035	105	108.7	12	11.4%	12.4	96.2	30	39	Surplus of 9	0
Lenoir	180	182	184	175	174	-0.008	176	174.6	12	6.8%	11.9	162.7	51	63	Surplus of 12	0
Lincoln	48	55	62	66	78	0.130	71	80.2	13	18.3%	14.7	65.5	20	25	Surplus of 5	0
Macon	11	16	20	21	24	0.224	26	31.8	4	15.4%	4.9	26.9	8	0	**8**	0
Madison	13	13	12	9	8	-0.110	14	12.5	1	7.1%	0.9	11.6	4	0	**4**	0
Martin	73	67	58	64	62	-0.036	71	68.4	9	12.7%	8.7	59.8	19	23	Surplus of 4	0
McDowell	31	37	40	38	44	0.096	43	47.1	3	7.0%	3.3	43.8	14	13	**1**	0
Mecklenburg	878	959	986	1071	1097	0.058	1133	1198.4	104	9.2%	110.0	1088.4	340	343	Surplus of 3	0
Mitchell	7	8	12	8	8	0.077	8	8.6	2	25.0%	2.2	6.5	2	9	Surplus of 7	
Avery	8	11	11	10	9	0.046	12	12.6	2	16.7%	2.1	10.5	3	0	**3**	
Yancey	15	13	15	18	17	0.041	15	15.6	3	20.0%	3	12	4	0	**4**	
Mitchell-Avery-Yancey Planning Area Total															0	0
Montgomery	45	35	44	53	54	0.065	48	51.1	1	2.1%	1.1	50.0	16	19	Surplus of 3	0
Moore	116	141	138	150	156	0.080	160	172.8	15	9.4%	16.2	156.6	49	50	Surplus of 1	0
Nash	145	162	167	176	186	0.065	197	209.7	28	14.2%	29.8	179.9	56	52	**4**	0
New Hanover	167	186	175	180	191	0.036	192	198.9	20	10.4%	20.7	178.2	56	56	0	0
Northampton	67	63	71	71	76	0.034	77	79.7	5	6.5%	5.2	74.5	23	16	**7**	0
Onslow	106	119	121	125	131	0.055	136	143.5	18	13.2%	19.0	124.5	39	38	**1**	0
Orange	106	112	114	142	128	0.055	131	138.3	11	8.4%	11.6	126.6	40	36	**4**	0
Pamlico	16	16	17	20	18	0.035	20	20.7	1	5.0%	1.0	19.7	6	0	**6**	0
Pasquotank	63	62	65	76	74	0.044	84	87.7	9	10.7%	9.4	78.3	24	24	0	0
Pender	56	66	83	71	77	0.094	81	88.6	11	13.6%	12.0	76.6	24	20	**4**	0
Perquimans	22	20	19	18	17	-0.062	21	19.7	1	4.8%	0.9	18.8	6	0	**6**	0
Person	82	86	84	86	86	0.012	84	85.0	2	2.4%	2.0	83.0	26	24	**2**	0
Pitt	263	262	285	292	303	0.037	308	319.3	27	8.8%	28.0	291.3	91	101	Surplus of 10	0
Polk	2	11	15	16	12	1.170	15	32.6	0	0.0%	0.0	32.6	10	10	0	0
Randolph	97	100	104	105	114	0.042	130	135.4	7	5.4%	7.3	128.1	40	34	**6**	0
Richmond	90	104	100	105	109	0.051	114	119.8	3	2.6%	3.2	116.7	36	35	**1**	0

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

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North Carolina Semiannual Dialysis Report July 2010

North Carolina Department of Health and Human Services

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 6.28.10. Utilization Rates Calculated for 12.31.09.)

County	Provider Number	Facility	City	Number of Dialysis Stations as of 6.28.10					Certified Stations 12.31.09	Number In-Center Patients 12.31.09	Utilization Rates	
				Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total			Utilization by Percent	Patients per Station
Person	34-2562	Roxboro Dialysis	Roxboro	24	0	0	0	24	24	95	99%	3.96
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	145	76%	3.02
Pitt	34-2632	FMC Care of Ayden	Ayden	15	0	0	0	15	10	39	98%	3.90
Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	117	77%	3.08
Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0		
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	7	0	2	36	27	111	103%	4.11
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	0	-12	7	27	32	122	95%	3.81
Richmond	Proposed new site consisting of existing stations.	Sandhills Dialysis Center - utilization included with Dialysis Care of Richmond County	Rockingham	0	0	12	0	12	0	0		
Robeson	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	32	-3	0	0	29	32	114	89%	3.56
Robeson	34-2623	FMC Dialysis Services of Robeson County	Fairmont	23	0	0	0	23	19	57	75%	3.00
Robeson	34-2607	BMA of Red Springs	Red Springs	18	-4	0	0	14	18	43	60%	2.39
Robeson	34-2662	BMA of St. Pauls	St. Pauls	10	0	0	0	10	10	27	68%	2.70
Robeson	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	21	53%	2.10
Robeson	Proposed new site consisting of existing stations.	FMC of Pembroke - utilization included with BMA Lumberton, BMA Red Springs, and BMA Laurinburg.	Pembroke	0	10	0	0	10	0	0		
Rockingham	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	62	67%	2.70
Rockingham	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	29	73%	2.90
Rockingham	34-2640	Reidsville Dialysis	Reidsville	19	0	0	0	19	18	53	74%	2.94
Rockingham	34-2641	Rockingham Kidney Center (BMA)	Reidsville	15	0	0	0	15	15	40	67%	2.67
Rowan	34-2546	Dialysis Care of Rowan County	Salisbury	29	0	0	0	29	29	96	83%	3.31
Rowan	34-2592	Dialysis Care of Kannapolis/Rowan	Kannapolis	25	0	0	0	25	25	77	77%	3.08
Rutherford	34-2566	Dialysis Care of Rutherford County	Forest City	30	0	0	0	30	30	83	69%	2.77
Sampson	34-2559	BMA of Clinton	Clinton	39	-9	0	0	30	39	123	79%	3.15

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.05 Total Patients	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	Average Annual Change Rate for Past Five Years	Projected 12.31.10 Total Patients	12.31.09 Home Patients	12.31.09 % Home Patients	Projected 12.31.10 Home Patients	Projected 12.31.10 In-Center Patients	Projected 12.31.10 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Harnett	120	122	139	153	164	0.082	177.5	17	10.4%	18.4	159.1	50	41	**9**	**0**
Haywood	50	48	49	52	53	0.015	53.8	4	7.5%	4.1	49.8	16	18	Surplus of 2	**0**
Henderson	75	74	71	79	70	-0.014	69.0	14	20.0%	13.8	55.2	17	26	Surplus of 9	**0**
Hertford	76	84	78	77	87	0.038	90.3	9	10.3%	9.3	80.9	25	27	Surplus of 2	**0**
Hoke	68	67	64	67	73	0.019	74.4	4	5.5%	4.1	70.3	22	30	Surplus of 8	**0**
Hyde	6	7	6	6	7	0.048	7.3	2	28.6%	2.1	5.2	2	0	**2**	**0**
Iredell	174	185	192	201	192	0.026	197.0	41	21.4%	42.1	154.9	48	74	Surplus of 26	**0**
Jackson	18	20	25	24	23	0.070	24.6	2	8.7%	2.1	22.5	7	18	Surplus of 11	**0**
Johnston	161	181	193	191	202	0.059	214.0	19	9.4%	20.1	193.9	61	59	**2**	**0**
Jones	25	23	24	28	32	0.068	34.2	2	6.3%	2.1	32.0	10	10	0	**0**
Lee	91	106	100	102	107	0.044	111.7	15	14.0%	15.7	96.1	30	39	Surplus of 9	**0**
Lenoir	182	184	175	174	174	-0.011	172.1	14	8.0%	13.8	158.3	49	63	Surplus of 14	**0**
Lincoln	55	62	66	78	77	0.090	83.9	17	22.1%	18.5	65.4	20	25	Surplus of 5	**0**
Macon	16	20	21	24	23	0.100	25.3	4	17.4%	4.4	20.9	7	0	**7**	**0**
Madison	13	12	9	8	13	0.047	13.6	2	15.4%	2.1	11.5	4	0	**4**	**0**
Martin	67	58	64	62	74	0.033	76.4	6	8.1%	6.2	70.2	22	23	Surplus of 1	**0**
McDowell	37	40	38	44	43	0.042	44.8	2	4.7%	2.1	42.7	13	13	0	**0**
Mecklenburg	959	986	1071	1097	1122	0.040	1167.3	95	8.5%	98.8	1068.4	334	352	Surplus of 18	**0**
Mitchell	8	12	8	8	7	0.010	7.1	3	42.9%	3.0	4.0	1	9	Surplus of 8	
Avery	11	11	10	9	10	-0.020	9.8	2	20.0%	2.0	7.8	2	0	**2**	
Yancey	13	15	18	17	12	0.001	12.0	3	25.0%	3	9	3	0	**3**	
Mitchell-Avery-Yancey Planning Area Total														Surplus of 3	**0**
Montgomery	35	44	53	54	44	0.074	47.2	2	4.5%	2.1	45.1	14	19	Surplus of 5	**0**
Moore	141	138	150	156	155	0.025	158.8	18	11.6%	18.4	140.4	44	50	Surplus of 6	**0**
Nash	162	167	176	186	204	0.060	216.2	33	16.2%	35.0	181.2	57	52	**5**	**0**
New Hanover	186	175	180	191	198	0.017	201.3	18	9.1%	18.3	183.0	57	57	0	**0**
Northampton	63	71	71	76	79	0.059	83.7	6	7.6%	6.4	77.3	24	16	**8**	**0**
Onslow	119	121	125	131	133	0.028	136.8	14	10.5%	14.4	122.4	38	38	0	**0**
Orange	112	114	142	128	138	0.061	146.4	12	8.7%	12.7	133.7	42	41	**1**	**0**
Pamlico	16	17	20	18	21	0.076	22.6	1	4.8%	1.1	21.5	7	0	**7**	**0**
Pasquotank	62	65	76	74	86	0.088	93.6	10	11.6%	10.9	82.7	26	30	Surplus of 4	**0**
Pender	66	83	71	77	82	0.066	87.4	11	13.4%	11.7	75.7	24	20	**4**	**0**
Perquimans	20	19	18	17	22	0.034	22.7	1	4.5%	1.0	21.7	7	0	**7**	**0**
Person	86	84	86	86	90	0.012	91.1	2	2.2%	2.0	89.0	28	24	**4**	**0**
Pitt	262	285	292	303	310	0.043	323.4	26	8.4%	27.1	296.3	93	101	Surplus of 8	**0**
Polk	11	15	16	12	14	0.087	15.2	1	7.1%	1.1	14.1	4	10	Surplus of 6	**0**
Randolph	100	104	105	114	141	0.093	154.1	6	4.3%	6.6	147.6	46	36	**10**	**10**
Richmond	104	100	105	109	122	0.042	127.2	4	3.3%	4.2	123.0	38	39	Surplus of 1	**0**
Robeson	305	312	327	314	327	0.018	332.9	21	6.4%	21.4	311.6	97	96	**1**	**0**
Rockingham	154	166	159	161	175	0.034	180.9	7	4.0%	7.2	173.7	54	67	Surplus of 13	**0**
Rowan	134	128	143	149	150	0.030	154.5	32	21.3%	33.0	121.6	38	54	Surplus of 16	**0**
Rutherford	93	94	88	80	87	-0.014	85.8	5	5.7%	4.9	80.8	25	30	Surplus of 5	**0**

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

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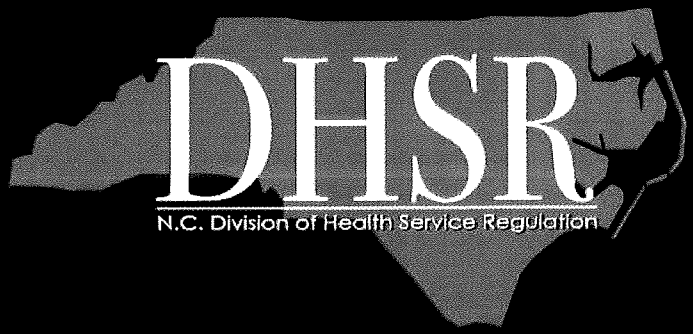

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 12.30.10. Utilization Rates Calculated for 6.30.10.)

				Number of Dialysis Stations as of 12.30.10							Utilization Rates	
County	Provider Number	Facility	City	Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total	Certified Stations 6.30.10	Number In-Center Patients 6.30.10	Utilization by Percent	Patients per Station
Orange	34-2622	Carolina Dialysis Carrboro (UNC)	Carrboro	36	5	0	0	41	36	132	92%	3.67
Pamlico												
Pasquotank	34-2515	Elizabeth City Dialysis	Elizabeth City	24	6	0	0	30	24	94	98%	3.92
Pender	34-2558	Southeastern Dialysis Center Inc.	Burgaw	20	0	0	2	22	20	65	81%	3.25
Perquimans												
Person	34-2562	Roxboro Dialysis	Roxboro	24	0	0	6	30	24	98	102%	4.08
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	123	64%	2.56
Pitt	34-2632	FMC Care of Ayden	Ayden	15	0	0	0	15	15	47	78%	3.13
Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	118	78%	3.11
Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0		
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	9	0	0	36	27	106	98%	3.93
Randolph	n/a	July 2010 Randolph County Need Determination - Two CON applications submitted	TBD	0	0	0	10	10	0	0		
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	-12	0	7	27	32	120	94%	3.75
Richmond	Proposed new site consisting of existing stations.	Sandhills Dialysis Center - utilization included with Dialysis Care of Richmond County	Rockingham	0	12	0	0	12	0	0		
Robeson	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	32	-6	4	0	30	32	113	88%	3.53
Robeson	34-2623	FMC Dialysis Services of Robeson County	Fairmont	23	0	0	0	23	23	57	62%	2.48
Robeson	34-2607	BMA of Red Springs	Red Springs	18	-4	0	0	14	18	44	61%	2.44
Robeson	34-2662	BMA of St. Pauls	St. Pauls	10	0	0	0	10	10	31	78%	3.10
Robeson	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	23	58%	2.30
Robeson	Proposed new site consisting of existing stations.	FMC of Pembroke - utilization included with BMA Lumberton, BMA Red Springs, and BMA Laurinburg.	Pembroke	0	13	0	0	13	0	0		
Rockingham	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	68	74%	2.96
Rockingham	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	26	65%	2.60
Rockingham	34-2640	Reidsville Dialysis	Reidsville	19	0	0	0	19	19	55	72%	2.89

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.05 Total Patients	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	Average Annual Change Rate for Past Five Years	6.30.10 Total Patients	Projected 6.30.11 Total Patients	6.30.10 Home Patients	6.30.10 % Home Patients	Projected 6.30.11 Home Patients	Projected 6.30.11 In-Center Patients	Projected 6.30.11 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Harnett	120	122	139	153	164	0.082	180	194.8	21	11.7%	22.7	172.1	54	49	**5**	**0**
Haywood	50	48	49	52	53	0.015	50	50.8	6	12.0%	6.1	44.7	14	18	Surplus of 4	**0**
Henderson	75	74	71	79	70	-0.014	78	76.9	14	17.9%	13.8	63.1	20	20	0	**0**
Hertford	76	84	78	77	87	0.038	93	96.5	11	11.8%	11.4	85.1	27	27	0	**0**
Hoke	68	67	64	67	73	0.019	83	84.6	5	6.0%	5.1	79.5	25	30	Surplus of 5	**0**
Hyde	6	7	6	6	7	0.048	7	7.3	2	28.6%	2.1	5.2	2	0	**2**	**0**
Iredell	174	185	192	201	192	0.026	196	201.1	34	17.3%	34.9	166.2	52	74	Surplus of 22	**0**
Jackson	18	20	25	24	23	0.070	28	30.0	4	14.3%	4.3	25.7	8	18	Surplus of 10	**0**
Johnston	161	181	193	191	202	0.059	205	217.2	18	8.8%	19.1	198.1	62	59	**3**	**0**
Jones	25	23	24	28	32	0.068	30	32.0	3	10.0%	3.2	28.8	9	10	Surplus 1	**0**
Lee	91	106	100	102	107	0.044	112	117.0	14	12.5%	14.6	102.3	32	39	Surplus of 7	**0**
Lenoir	182	184	175	174	174	-0.011	170	168.1	11	6.5%	10.9	157.3	49	63	Surplus of 14	**0**
Lincoln	55	62	66	78	77	0.090	76	82.9	15	19.7%	16.4	66.5	21	25	Surplus of 4	**0**
Macon	16	20	21	24	23	0.100	29	31.9	7	24.1%	7.7	24.2	8	0	**8**	**0**
Madison	13	12	9	8	13	0.047	10	10.5	1	10.0%	1.0	9.4	3	0	**3**	**0**
Martin	67	58	64	62	74	0.033	77	79.5	10	13.0%	10.3	69.2	22	23	Surplus of 1	**0**
McDowell	37	40	38	44	43	0.042	41	42.7	1	2.4%	1.0	41.7	13	13	0	**0**
Mecklenburg	959	986	1071	1097	1122	0.040	1163	1209.9	119	10.2%	123.8	1086.1	339	359	Surplus of 20	**0**
Mitchell	8	12	8	8	7	0.010	7	7.1	0	0.0%	0.0	7.1	2	9	Surplus of 7	
Avery	11	11	10	9	10	-0.020	9	8.8	2	22.2%	2.0	6.9	2	0	**2**	
Yancey	13	15	18	17	12	0.001	11	11.0	1	9.1%	1.0	10.0	3	0	**3**	
Mitchell-Avery-Yancey Planning Area Total															Surplus of 2	**0**
Montgomery	35	44	53	54	44	0.074	50	53.7	3	6.0%	3.2	50.5	16	19	Surplus of 3	**0**
Moore	141	138	150	156	155	0.025	161	165.0	19	11.8%	19.5	145.5	45	50	Surplus of 5	**0**
Nash	162	167	176	186	204	0.060	202	214.0	30	14.9%	31.8	182.2	57	52	**5**	**0**
New Hanover	186	175	180	191	198	0.017	204	207.4	24	11.8%	24.4	183.0	57	60	Surplus of 3	**0**
Northampton	63	71	71	76	79	0.059	82	86.9	9	11.0%	9.5	77.3	24	16	**8**	**0**
Onslow	119	121	125	131	133	0.028	129	132.6	23	17.8%	23.7	109.0	34	38	Surplus 4	**0**
Orange	112	114	142	128	138	0.061	140	148.5	12	8.6%	12.7	135.8	42	41	**1**	**0**
Pamlico	16	17	20	18	21	0.076	22	23.7	1	4.5%	1.1	22.6	7	0	**7**	**0**
Pasquotank	62	65	76	74	86	0.088	83	90.3	8	9.6%	8.7	81.6	26	30	Surplus of 4	**0**
Pender	66	83	71	77	82	0.066	84	89.5	13	15.5%	13.9	75.7	24	22	**2**	**0**
Perquimans	20	19	18	17	22	0.034	22	22.7	1	4.5%	1.0	21.7	7	0	**7**	**0**
Person	86	84	86	86	90	0.012	94	95.1	2	2.1%	2.0	93.1	29	30	Surplus of 1	**0**
Pitt	262	285	292	303	310	0.043	300	313.0	28	9.3%	29.2	283.8	89	101	Surplus of 12	**0**
Polk	11	15	16	12	14	0.087	13	14.1	1	7.7%	1.1	13.0	4	10	Surplus of 6	**0**
Randolph	100	104	105	114	141	0.093	141	154.1	12	8.5%	13.1	141.0	44	46	Surplus of 2	**0**
Richmond	104	100	105	109	122	0.042	120	125.1	3	2.5%	3.1	121.9	38	39	Surplus of 1	**0**
Robeson	305	312	327	314	327	0.018	329	335.0	21	6.4%	21.4	313.6	98	100	Surplus of 2	**0**
Rockingham	154	166	159	161	175	0.034	180	186.1	6	3.3%	6.2	179.9	56	67	Surplus of 11	**0**
Rowan	134	128	143	149	150	0.030	150	154.5	36	24.0%	37.1	117.5	37	54	Surplus of 17	**0**
Rutherford	93	94	88	80	87	-0.014	90	88.7	8	8.9%	7.9	80.8	25	30	Surplus of 5	**0**

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

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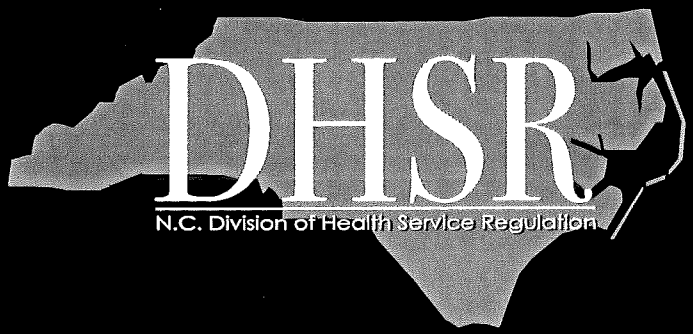


North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 6.29.11. Utilization Rates Calculated for 12.31.10.)

County	Provider Number	Facility	City	Number of Dialysis Stations as of 6.29.11					Certified Stations 12.31.10	Number In-Center Patients 12.31.10	Utilization Rates	
				Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total			Utilization by Percent	Patients per Station
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	9	10	0	46	27	106	98%	3.93
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	-5	0	0	27	32	116	91%	3.63
Richmond	Proposed new site consisting of existing stations.	Sandhills Dialysis Center - utilization included with Dialysis Care of Richmond County	Rockingham	0	12	0	0	12	0	0	0%	0.00
Robeson	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	30	0	0	0	30	32	102	80%	3.19
Robeson	34-2623	FMC Dialysis Services of Robeson County	Fairmont	23	0	0	0	23	23	61	66%	2.65
Robeson	34-2607	BMA of Red Springs	Red Springs	18	-4	0	0	14	18	52	72%	2.89
Robeson	34-2662	BMA of St. Pauls	St. Pauls	10	0	0	0	10	10	35	88%	3.50
Robeson	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	26	65%	2.60
Robeson	34-2682	FMC of Pembroke - utilization included with BMA Lumberton, BMA Red Springs, and BMA Laurinburg.	Pembroke	13	0	0	0	13	0	0	0%	0.00
Rockingham	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	72	78%	3.13
Rockingham	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	30	75%	3.00
Rockingham	34-2640	Reidsville Dialysis	Reidsville	19	0	0	0	19	19	60	79%	3.16
Rockingham	34-2641	Rockingham Kidney Center (BMA)	Reidsville	15	0	0	0	15	15	45	75%	3.00
Rowan	34-2546	Dialysis Care of Rowan County	Salisbury	29	0	0	0	29	29	91	78%	3.14
Rowan	34-2592	Dialysis Care of Kannapolis/Rowan	Kannapolis	25	0	0	0	25	25	79	79%	3.16
Rutherford	34-2566	Dialysis Care of Rutherford County	Forest City	30	0	0	0	30	30	88	73%	2.93
Sampson	34-2559	BMA of Clinton	Clinton	39	-9	0	3	33	39	129	83%	3.31
Sampson	Proposed new site consisting of existing stations.	FMC of Roseboro - utilization included with BMA of Clinton.	Roseboro	0	10	0	0	10	0	0	0%	0.00
Scotland	34-2540	BMA of Laurinburg	Laurinburg	29	-3	0	0	26	29	82	71%	2.83
Scotland	34-2664	FMC of Scotland County	Laurinburg	12	0	0	0	12	12	45	94%	3.75
Stanly	34-2565	BMA of Albemarle	Albemarle	22	0	0	0	22	22	70	80%	3.18
Stokes	34-2633	King Dialysis Center	King	17	0	0	0	17	17	49	72%	2.88

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	Average Annual Change Rate for Past Five Years	Projected 12.31.11 Total Patients	12.31.10 Home Patients	12.31.10 % Home Patients	Projected 12.31.11 Home Patients	Projected 12.31.11 In-Center Patients	Projected 12.31.11 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Harnett	122	139	153	164	199	0.131	225.1	23	11.6%	26.0	199.1	62	51	**11**	**11**
Haywood	48	49	52	53	52	0.021	53.1	9	17.3%	9.2	43.9	14	18	Surplus of 4	**0**
Henderson	74	71	79	70	74	0.004	74.3	16	21.6%	16.1	58.2	18	20	Surplus of 2	**0**
Hertford	84	78	77	87	84	0.003	84.2	9	10.7%	9.0	75.2	24	27	Surplus of 3	**0**
Hoke	67	64	67	73	92	0.088	100.1	3	3.3%	3.3	96.8	30	30	**0**	**0**
Hyde	7	6	6	7	6	-0.030	5.8	1	16.7%	1.0	4.9	2	0	**2**	**0**
Iredell	185	192	201	192	200	0.020	204.1	41	20.5%	41.8	162.2	51	74	Surplus of 23	**0**
Jackson	20	25	24	23	28	0.096	30.7	4	14.3%	4.4	26.3	8	18	Surplus of 10	**0**
Johnston	181	193	191	202	213	0.042	221.9	21	9.9%	21.9	200.1	63	59	**4**	**0**
Jones	23	24	28	32	31	0.080	33.5	4	12.9%	4.3	29.2	9	10	Surplus of 1	**0**
Lee	106	100	102	107	112	0.015	113.7	9	8.0%	9.1	104.5	33	39	Surplus of 6	**0**
Lenoir	184	175	174	174	183	-0.001	182.9	9	4.9%	9.0	173.9	54	63	Surplus of 9	**0**
Lincoln	62	66	78	77	87	0.091	94.9	16	18.4%	17.5	77.5	24	25	Surplus of 1	**0**
Macon	20	21	24	23	23	0.038	23.9	7	30.4%	7.3	16.6	5	0	**5**	**0**
Madison	12	9	8	13	11	0.028	11.3	0	0.0%	0.0	11.3	4	0	**4**	**0**
Martin	58	64	62	74	81	0.090	88.3	8	9.9%	8.7	79.6	25	23	**2**	**0**
McDowell	40	38	44	43	42	0.015	42.7	5	11.9%	5.1	37.6	12	13	Surplus of 1	**0**
Mecklenburg	986	1071	1097	1122	1201	0.051	1262.2	129	10.7%	135.6	1126.6	352	367	Surplus of 15	**0**
Mitchell	12	8	8	7	9	-0.043	8.6	0	0.0%	0.0	8.6	3	9	Surplus of 6	**0**
Avery	11	10	9	10	10	-0.020	9.8	3	30.0%	2.9	6.9	2	0	**2**	**0**
Yancey	15	18	17	12	15	0.025	15.4	1	6.7%	1.0	14.4	4	0	**4**	**0**
Mitchell-Avery-Yancey Planning Area Total														0	**0**
Montgomery	44	53	54	44	54	0.066	57.6	3	5.6%	3.2	54.4	17	19	Surplus of 2	**0**
Moore	138	150	156	155	152	0.025	155.8	20	13.2%	20.5	135.3	42	52	Surplus of 10	**0**
Nash	167	176	186	204	198	0.045	206.8	28	14.1%	29.2	177.6	55	52	**3**	**0**
New Hanover	175	180	191	198	201	0.035	208.1	25	12.4%	25.9	182.2	57	57	**0**	**0**
Northampton	71	71	76	79	88	0.056	92.9	9	10.2%	9.5	83.4	26	16	**10**	**10**
Onslow	121	125	131	133	127	0.013	128.6	25	19.7%	25.3	103.3	32	38	Surplus of 6	**0**
Orange	114	142	128	138	137	0.054	144.5	13	9.5%	13.7	130.8	41	41	**0**	**0**
Pamlico	17	20	18	21	21	0.061	22.3	1	4.8%	1.1	21.2	7	0	**7**	**0**
Pasquotank	65	76	74	86	89	0.085	96.6	11	12.4%	11.9	84.6	26	30	Surplus of 4	**0**
Pender	83	71	77	82	83	0.004	83.4	12	14.5%	12.1	71.3	22	22	**0**	**0**
Perquimans	19	18	17	22	23	0.058	24.3	1	4.3%	1.1	23.3	7	0	**7**	**0**
Person	84	86	86	90	91	0.020	92.9	5	5.5%	5.1	87.8	27	30	Surplus of 3	**0**
Pitt	285	292	303	310	309	0.021	315.3	33	10.7%	33.7	281.7	88	101	Surplus of 13	**0**
Polk	15	16	12	14	11	-0.058	10.4	1	9.1%	0.9	9.4	3	10	Surplus of 7	**0**
Randolph	104	105	114	141	142	0.085	154.0	14	9.9%	15.2	138.9	43	46	Surplus of 3	**0**
Richmond	100	105	109	122	119	0.046	124.4	6	5.0%	6.3	118.2	37	39	Surplus of 2	**0**
Robeson	312	327	314	327	335	0.019	341.2	23	6.9%	23.4	317.8	99	100	Surplus of 1	**0**
Rockingham	166	159	161	175	197	0.046	206.0	11	5.6%	11.5	194.5	61	67	Surplus of 6	**0**
Rowan	128	143	149	150	145	0.033	149.8	34	23.4%	35.1	114.7	36	54	Surplus of 18	**0**
Rutherford	94	88	80	87	98	0.015	99.5	9	9.2%	9.1	90.3	28	30	Surplus of 2	**0**

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

STATE HEALTH COORDINATING COUNCIL

2012

North Carolina Semiannual Dialysis Report January 2012

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 12.23.11. Utilization Rates Calculated for 6.30.11.)

County	Provider Number	Facility	City	Number of Dialysis Stations as of 12.23.11					Certified Stations 6.30.2011	Number In-Center Patients 6.30.11	Utilization Rates	
				Certified	CON Issued/ Not Certified	Decision Rendered	Decision Pending	Total			Utilization by Percent 6.30.11	Patients per Station
Moore	34-2638	Southern Pines Dialysis Center	Southern Pines	13	2	0	0	15	13	47	90.38%	3.6154
Moore	34-2679	Carthage Dialysis Center	Carthage	12	0	0	0	12	12	23	47.92%	1.9167
Nash	34-2517	Rocky Mount Kidney Center (BMA)	Rocky Mount	42	0	0	0	42	42	155	92.26%	3.6905
Nash	34-2644	FMC Dialysis Services of Spring Hope	Spring Hope	10	0	0	0	10	10	32	80.00%	3.2000
New Hanover	34-2511	Southeastern Dialysis Center	Wilmington	49	-20	0	0	29	49	200	102.04%	4.0816
New Hanover	Proposed new site consisting of existing stations.	Cape Fear Dialysis Center - utilization included with Southeastern Dialysis Center - Wilmington	Wilmington	0	28	0	0	28	0	0	0.00%	0.0000
Northampton	n/a	Two applications were received in response to the July 2011 County Need Determination.		0	0	0	10	10	0	0	0.00%	0.0000
Northampton	34-2586	Rich Square Dialysis Unit (BMA Northampton)	Rich Square	16	0	0	0	16	16	55	85.94%	3.4375
Onslow	34-2532	Southeastern Dialysis Ctr. Jacksonville	Jacksonville	38	0	0	0	38	35	125	89.29%	3.5714
Orange	34-2622	Carolina Dialysis Carrboro (UNC)	Carrboro	36	5	0	0	41	36	121	84.03%	3.3611
Pamlico												
Pasquotank	34-2515	Elizabeth City Dialysis	Elizabeth City	30	0	0	0	30	24	101	105.21%	4.2083
Pender	34-2558	Southeastern Dialysis Center Inc.	Burgaw	20	2	0	0	22	20	69	86.25%	3.4500
Perquimans												
Person	34-2562	Roxboro Dialysis	Roxboro	24	6	0	0	30	24	89	92.71%	3.7083
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	130	67.71%	2.7083
Pitt	34-2632	FMC Care of Ayden	Ayden	15	0	0	0	15	15	57	95.00%	3.8000
Pitt	34-2596	FMC Dialysis of East Carolina University	Greenville	38	0	0	0	38	38	117	76.97%	3.0789
Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0	0.00%	0.0000
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	19	0	0	46	27	113	104.63%	4.1852
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	-5	0	0	27	32	122	95.31%	3.8125

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.06 Total Patients	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	Average Annual Change Rate for Past Five Years	6.30.11 Total Patients	Projected 6.30.12 Total Patients	6.30.11 Home Patients	6.30.11 % Home Patients	Projected 6.30.12 Home Patients	Projected 6.30.12 In-Center Patients	Projected 6.30.12 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Jackson	20	25	24	23	28	0.096	30	32.9	5	16.7%	5.5	27.4	9	18	Surplus of 9	0
Johnston	181	193	191	202	213	0.042	213	221.9	17	8.0%	17.7	204.2	64	62	**2**	0
Jones	23	24	28	32	31	0.080	33	35.7	5	15.2%	5.4	30.3	9	10	Surplus of 1	0
Lee	106	100	102	107	112	0.015	106	107.6	7	6.6%	7.1	100.5	31	39	Surplus of 8	0
Lenoir	184	175	174	174	183	-0.001	176	175.9	10	5.7%	10.0	165.9	52	63	Surplus of 11	0
Lincoln	62	66	78	77	87	0.091	80	87.3	17	21.3%	18.5	68.7	21	24	Surplus of 3	0
Macon	20	21	24	23	23	0.038	29	30.1	6	20.7%	6.2	23.9	7	0	**7**	0
Madison	12	9	8	13	11	0.028	10	10.3		0.0%	0.0	10.3	3	0	**3**	0
Martin	58	64	62	74	81	0.090	79	86.1	7	8.9%	7.6	78.5	25	23	**2**	0
McDowell	40	38	44	43	42	0.015	41	41.6	7	17.1%	7.1	34.5	11	13	Surplus of 2	0
Mecklenburg	986	1071	1097	1122	1201	0.051	1259	1323.1	135	10.7%	141.9	1181.2	369	371	Surplus of 2	0
Mitchell	12	8	8	7	9	-0.043	12	11.5	1	8.3%	1.0	10.5	3	9	Surplus of 6	0
Avery	11	10	9	10	10	-0.020	9	8.8	3	33.3%	2.9	5.9	2	0	**2**	0
Yancey	15	18	17	12	15	0.025	16	16.4	1	6.3%	1.0	15.4	5	0	**5**	0
Mitchell-Avery-Yancey Planning Area Total															**1**	0
Montgomery	44	53	54	44	54	0.066	58	61.8	4	6.9%	4.3	57.6	18	19	Surplus of 1	0
Moore	138	150	156	155	152	0.025	155	158.9	19	12.3%	19.5	139.4	44	52	Surplus of 8	0
Nash	167	176	186	204	198	0.045	198	206.8	19	9.6%	19.8	187.0	58	52	**6**	0
New Hanover	175	180	191	198	201	0.035	199	206.0	27	13.6%	28.0	178.1	56	57	Surplus of 1	0
Northampton	71	71	76	79	88	0.056	93	98.2	7	7.5%	7.4	90.8	28	26	**2**	0
Onslow	121	125	131	133	127	0.013	142	143.8	27	19.0%	27.3	116.5	36	38	Surplus of 2	0
Orange	114	142	128	138	137	0.054	133	140.2	17	12.8%	17.9	122.3	38	41	Surplus of 3	0
Pamlico	17	20	18	21	21	0.061	21	22.3	1	4.8%	1.1	21.2	7	0	**7**	0
Pasquotank	65	76	74	86	89	0.085	88	95.5	10	11.4%	10.8	84.6	26	30	Surplus of 4	0
Pender	83	71	77	82	83	0.004	87	87.4	11	12.6%	11.0	76.3	24	22	**2**	0
Perquimans	19	18	17	22	23	0.058	22	23.3	2	9.1%	2.1	21.2	7	0	**7**	0
Person	84	86	86	90	91	0.020	88	89.8	6	6.8%	6.1	83.7	26	30	Surplus of 4	0
Pitt	285	292	303	310	309	0.021	312	318.4	34	10.9%	34.7	283.7	89	101	Surplus of 12	0
Polk	15	16	12	14	11	-0.058	13	12.2	1	7.7%	0.9	11.3	4	10	Surplus of 6	0
Randolph	104	105	114	141	142	0.085	157	170.3	16	10.2%	17.4	153.0	48	46	**2**	0
Richmond	100	105	109	122	119	0.046	128	133.8	7	5.5%	7.3	126.5	40	39	**1**	0
Robeson	312	327	314	327	335	0.019	349	355.5	26	7.4%	26.5	329.0	103	103	**0**	0
Rockingham	166	159	161	175	197	0.046	187	195.6	12	6.4%	12.5	183.0	57	67	Surplus of 10	0
Rowan	128	143	149	150	145	0.033	149	153.9	39	26.2%	40.3	113.6	36	54	Surplus of 18	0
Rutherford	94	88	80	87	98	0.015	106	107.6	11	10.4%	11.2	96.4	30	30	**0**	0
Sampson	134	147	140	142	161	0.049	163	171.0	14	8.6%	14.7	156.4	49	43	**6**	0
Scotland	108	110	99	109	108	0.003	114	114.3	9	7.9%	9.0	105.3	33	38	Surplus of 5	0
Stanly	61	64	74	67	70	0.039	66	68.6	6	9.1%	6.2	62.3	19	22	Surplus of 3	0
Stokes	45	45	51	54	56	0.057	54	57.1	9	16.7%	9.5	47.6	15	17	Surplus of 2	0
Surry	82	96	100	99	107	0.071	111	118.9	10	9.0%	10.7	108.2	34	46	Surplus of 12	0
Swain	50	48	48	48	44	-0.031	48	46.5	4	8.3%	3.9	42.6	13	20	Surplus of 7	0
Transylvania	24	23	16	15	20	-0.019	27	26.5	5	18.5%	4.9	21.6	7	8	Surplus of 1	0
Tyrrell	12	11	7	9	6	-0.124	5	4.4	1	20.0%	0.9	3.5	1	0	**1**	0
Union	142	135	148	156	183	0.069	185	197.7	21	11.4%	22.4	175.2	55	61	Surplus of 6	0
Vance	130	139	152	158	163	0.058	161	170.4	9	5.6%	9.5	160.9	50	49	**1**	0
Wake	792	864	929	952	995	0.059	995	1053.7	106	10.7%	112.3	941.5	294	301	Surplus of 7	0
Warren	48	57	60	63	60	0.061	57	60.5	2	3.5%	2.1	58.3	18	25	Surplus of 7	0
Washington	32	29	33	38	37	0.042	32	33.4		0.0%	0.0	33.4	10	14	Surplus of 4	0
Watauga	30	30	32	27	31	0.015	29	29.4	9	31.0%	9.1	20.3	6	14	Surplus of 8	0

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

STATE HEALTH COORDINATING COUNCIL

2012

North Carolina Semiannual Dialysis Report July 2012

DHSR
N.C. Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 6.25.2012. Utilization Rates Calculated for 12.31.2011.)

County	Provider Number	Facility	City	Number of Dialysis Stations as of 6.25.12					Certified Stations 12.31.2011	Number In-Center Patients 12.31.11	Utilization Rates	
				Certified	CON Issued/ Not Certified	Decision Rendered (Conditional Approvals)	Decision Pending	Total			Utilization by Percent 12.31.11	Patients per Station
Person	34-2562	Roxboro Dialysis	Roxboro	24	6	0	0	30	24	101	105.21%	4.2083
Pitt	34-2502	Greenville Dialysis Center (BMA)	Greenville	48	0	0	0	48	48	130	67.71%	2.7083
Pitt	34-2632	FMC Care of Ayden	Ayden	15	0	0	0	15	15	57	95.00%	3.8000
Pitt	34-2596	FMC East Carolina University	Greenville	38	0	0	0	38	38	120	78.95%	3.1579
Polk	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0	0.00%	0.0000
Randolph	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	19	0	0	46	27	105	97.22%	3.8889
Richmond	34-2539	Dialysis Care of Richmond County	Hamlet	32	-5	0	0	27	32	115	89.84%	3.5938
Richmond	Proposed new site consisting of existing stations.	Sandhills Dialysis Center (Utilization included with Dialysis Care of Richmond County)	Rockingham	0	12	0	0	12	0	0	0.00%	0.0000
Robeson	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	29	0	0	0	29	29	89	76.72%	3.0690
Robeson	34-2623	FMC Dialysis Services Robeson County	Fairmont	23	0	0	0	23	23	63	68.48%	2.7391
Robeson	34-2607	BMA Red Springs	Red Springs	14	0	0	0	14	14	34	60.71%	2.4286
Robeson	34-2662	BMA St. Pauls	St. Pauls	10	0	4	0	14	10	36	90.00%	3.6000
Robeson	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	23	57.50%	2.3000
Robeson	34-2682	FMC of Pembroke	Pembroke	13	0	0	0	13	13	39	75.00%	3.0000
Rockingham	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	63	68.48%	2.7391
Rockingham	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	28	70.00%	2.8000
Rockingham	34-2640	Reidsville Dialysis	Reidsville	19	0	0	0	19	19	55	72.37%	2.8947
Rockingham	34-2641	Rockingham Kidney Center (BMA)	Reidsville	15	0	0	0	15	15	49	81.67%	3.2667
Rowan	34-2546	Dialysis Care Rowan County	Salisbury	29	0	0	0	29	29	95	81.90%	3.2759
Rowan	34-2592	Dialysis Care Kannapolis/Rowan	Kannapolis	25	0	0	0	25	25	61	61.00%	2.4400
Rutherford	34-2566	Dialysis Care Rutherford County	Forest City	30	0	0	0	30	30	86	71.67%	2.8667
Sampson	34-2559	BMA Clinton	Clinton	33	0	0	0	33	39	131	83.97%	3.3590
Sampson	34-2688	FMC Roseboro (Utilization included with BMA of Clinton)	Roseboro	10	0	0	0	10	0	0	0.00%	0.0000

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	12.31.11 Total Patients	Average Annual Change Rate for Past Five Years	Projected 12.31.12 Total Patients	12.31.11 Home Patients	12.31.11 Percent Home Patients	Projected 12.31.12 Home Patients	Projected 12.31.12 In-Center Patients	Projected 12.31.12 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Jackson	25	24	23	28	34	0.088	37.0	8	23.5%	8.7	28.3	9	18	Surplus of 9	**0**
Johnston	193	191	202	213	230	0.045	240.4	20	8.7%	20.9	219.5	69	62	**7**	**0**
Jones	24	28	32	31	33	0.086	35.8	3	9.1%	3.3	32.6	10	10	**0**	**0**
Lee	100	102	107	112	108	0.020	110.2	8	7.4%	8.2	102.0	32	39	Surplus of 7	**0**
Lenoir	175	174	174	183	170	-0.006	168.9	11	6.5%	10.9	158.0	49	63	Surplus of 14	**0**
Lincoln	66	78	77	87	81	0.057	85.7	18	22.2%	19.0	66.6	21	24	Surplus of 3	**0**
Macon	21	24	23	23	33	0.134	37.4	8	24.2%	9.1	28.3	9	7	**2**	**0**
Madison	9	8	13	11	13	0.135	14.8	1	7.7%	1.1	13.6	4	0	**4**	**0**
Martin	64	62	74	81	85	0.077	91.5	8	9.4%	8.6	82.9	26	23	**3**	**0**
McDowell	38	44	43	42	49	0.070	52.4	5	10.2%	5.3	47.1	15	13	**2**	**0**
Mecklenburg	1071	1097	1122	1201	1327	0.056	1400.8	139	10.5%	146.7	1254.0	392	377	**15**	**0**
Mitchell	8	8	7	9	11	0.096	12.1	1	9.1%	1.1	11.0	3	9	Surplus of 6	
Avery	10	9	10	10	9	-0.022	8.8	4	44.4%	3.9	4.9	2	0	**2**	
Yancey	18	17	12	15	16	-0.008	15.9	0	0.0%	0.0	15.9	5	0	**5**	
Mitchell-Avery-Yancey Planning Area Total														**1**	**0**
Montgomery	53	54	44	54	60	0.043	62.6	2	3.3%	2.1	60.5	19	19	**0**	**0**
Moore	150	156	155	152	157	0.012	158.8	22	14.0%	22.3	136.6	43	52	Surplus of 9	**0**
Nash	176	186	204	198	193	0.025	197.8	22	11.4%	22.5	175.2	55	55	**0**	**0**
New Hanover	180	191	198	201	217	0.048	227.4	34	15.7%	35.6	191.8	60	57	**3**	**0**
Northampton	71	76	79	88	76	0.022	77.7	8	10.5%	8.2	69.5	22	19	**3**	**0**
Onslow	125	131	133	127	156	0.062	165.6	27	17.3%	28.7	136.9	43	42	**1**	**0**
Orange	142	128	138	137	126	-0.027	122.6	11	8.7%	10.7	111.9	35	41	Surplus of 6	**0**
Pamlico	20	18	21	21	21	0.017	21.4	4	19.0%	4.1	17.3	5	0	**5**	**0**
Pasquotank	76	74	86	89	90	0.045	94.1	10	11.1%	10.5	83.6	26	30	Surplus of 4	**0**
Pender	71	77	82	83	96	0.080	103.6	11	11.5%	11.9	91.8	29	22	**7**	**0**
Perquimans	18	17	22	23	22	0.060	23.3	2	9.1%	2.1	21.2	7	0	**7**	**0**
Person	86	86	90	91	102	0.045	106.6	7	6.9%	7.3	99.2	31	30	**1**	**0**
Pitt	292	303	310	309	317	0.021	323.6	33	10.4%	33.7	289.9	91	101	Surplus of 10	**0**
Polk	16	12	14	11	14	-0.006	13.9	3	21.4%	3.0	10.9	3	10	Surplus of 7	**0**
Randolph	105	114	141	142	151	0.098	165.8	16	10.6%	17.6	148.3	46	46	**0**	**0**
Richmond	105	109	122	119	121	0.037	125.5	9	7.4%	9.3	116.2	36	39	Surplus of 3	**0**
Robeson	327	314	327	335	337	0.008	339.7	22	6.5%	22.2	317.5	99	103	Surplus of 4	**0**
Rockingham	159	161	175	197	181	0.036	187.5	12	6.6%	12.4	175.1	55	67	Surplus of 12	**0**
Rowan	143	149	150	145	140	-0.005	139.3	29	20.7%	28.9	110.5	35	54	Surplus of 19	**0**
Rutherford	88	80	87	98	113	0.069	120.8	22	19.5%	23.5	97.3	30	30	**0**	**0**
Sampson	147	140	142	161	164	0.030	168.9	14	8.5%	14.4	154.5	48	43	**5**	**0**
Scotland	110	99	109	108	121	0.028	124.4	9	7.4%	9.3	115.1	36	38	Surplus of 2	**0**
Stanly	64	74	67	70	65	0.009	65.6	5	7.7%	5.0	60.5	19	22	Surplus of 3	**0**
Stokes	45	51	54	56	49	0.026	50.3	8	16.3%	8.2	42.1	13	17	Surplus of 4	**0**
Surry	96	100	99	107	106	0.026	108.7	11	10.4%	11.3	97.4	30	46	Surplus of 16	**0**
Swain	48	48	48	44	56	0.047	58.7	4	7.1%	4.2	54.5	17	20	Surplus of 3	**0**
Transylvania	23	16	15	20	33	0.154	38.1	7	21.2%	8.1	30.0	9	8	**1**	**0**
Tyrrell	11	7	9	6	5	-0.144	4.3	3	60.0%	2.6	1.7	1	0	**1**	**0**
Union	135	148	156	183	182	0.079	196.5	27	14.8%	29.1	167.3	52	61	Surplus of 9	**0**
Vance	139	152	158	163	165	0.044	172.3	11	6.7%	11.5	160.8	50	49	**1**	**0**
Wake	864	929	952	995	1016	0.042	1058.2	133	13.1%	138.5	919.7	287	299	Surplus of 12	**0**
Warren	57	60	63	60	60	0.014	60.8	2	3.3%	2.0	58.8	18	21	Surplus of 3	**0**
Washington	29	33	38	37	36	0.059	38.1	1	2.8%	1.1	37.1	12	14	Surplus of 2	**0**
Watauga	30	32	27	31	30	0.007	30.2	12	40.0%	12.1	18.1	6	14	Surplus of 8	**0**

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

STATE HEALTH COORDINATING COUNCIL

2013

North Carolina Semiannual Dialysis Report January 2013

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 12.21.2012. Utilization Rates Calculated for 6.30.2012.)

County	Facility Identification Number	Provider Number	Facility	City	Number of Dialysis Stations as of 12.21.12					Certified Stations 6.30.2012	Number In-Center Patients 6.30.12	Utilization Rates	
					Certified	CON Issued/ Not Certified	Decision Rendered (Conditional Approvals)	Decision Pending	Total			Utilization by Percent 6.30.12	Patients per Station
Pitt	960406	34-2596	FMC of East Carolina University	Greenville	38	0	0	0	38	38	120	78.95%	3.1579
Polk	070220	n/a	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0	0.00%	0.0000
Randolph	955777	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	19	0	0	46	27	106	98.15%	3.9259
Richmond	955843	34-2539	Dialysis Care of Richmond County	Hamlet	27	0	0	0	27	32	114	89.06%	3.5625
Richmond	090624	34-2690	Sandhills Dialysis Center (Utilization included with Dialysis Care of Richmond County)	Rockingham	12	0	0	0	12	0	0	0.00%	0.0000
Robeson	955445	34-2528	Lumberton Dialysis Unit (BMA)	Lumberton	29	0	0	0	29	29	86	74.14%	2.9655
Robeson	991061	34-2623	FMC of Dialysis Services Robeson County	Fairmont	23	0	0	0	23	23	64	69.57%	2.7826
Robeson	980754	34-2607	BMA of Red Springs	Red Springs	14	0	0	-2	12	14	33	58.93%	2.3571
Robeson	060514	34-2662	FMC of St. Pauls	St. Pauls	13	0	0	2	15	10	40	100.00%	4.0000
Robeson	070039	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	24	60.00%	2.4000
Robeson	971335	34-2682	FMC of Pembroke	Pembroke	13	0	0	0	13	13	40	76.92%	3.0769
Rockingham	955844	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	63	68.48%	2.7391
Rockingham	001557	34-2624	Madison Dialysis Center	Madison	10	0	0	0	10	10	28	70.83%	2.8333
Rockingham	030453	34-2640	Reidsville Dialysis	Reidsville	19	0	0	0	19	19	57	75.00%	3.0000
Rockingham	001548	34-2641	Rockingham Kidney Center (BMA)	Reidsville	15	0	2	0	17	15	52	86.67%	3.4667
Rowan	944673	34-2546	Dialysis Care Rowan County	Salisbury	29	0	0	0	29	29	93	80.17%	3.2069
Rowan	980409	34-2592	Dialysis Care Kannapolis	Kannapolis	25	0	0	0	25	25	60	60.00%	2.4000
Rutherford	955824	34-2566	Dialysis Care Rutherford County	Forest City	30	0	0	0	30	30	86	71.67%	2.8667
Sampson	955787	34-2559	BMA of Clinton	Clinton	33	0	0	3	36	39	103	66.03%	2.6410
Sampson	080822	34-2688	FMC of Roseboro (Utilization included with BMA of Clinton)	Roseboro	10	0	0	0	10	0	26	0.00%	0.0000
Scotland	924648	34-2540	BMA of Laurinburg	Laurinburg	26	0	0	0	26	26	85	81.41%	3.2564
Scotland	060982	34-2664	FMC of Scotland County	Laurinburg	12	0	0	0	12	12	43	89.58%	3.5833
Stanly	955784	34-2565	BMA of Albemarle	Albemarle	22	0	0	0	22	22	69	78.41%	3.1364
Stokes	020980	34-2633	King Dialysis Center	King	17	0	0	0	17	17	39	57.35%	2.2941

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.07 Total Patients	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	12.31.11 Total Patients	Average Annual Change Rate for Past Five Years	6.30.12 Projected Patients	Projected 6.30.13 Total Patients	6.30.12 Projected Home Patients	6.30.12 Percent Home Patients	Projected 6.30.13 Home Patients	Projected 6.30.13 In-Center Patients	Projected 6.30.13 In-Center Station Utilization	Total Available Stations	Projected Station Deficit (bolded) or Surplus	County Station Need Determination
Jackson	25	24	23	28	34	0.088	36	37.0	10	29.4%	10.9	26.1	8	16	Surplus of 8	**0**
Johnston	193	191	202	213	230	0.045	238	240.4	20	8.7%	20.9	219.5	69	67	**2**	**0**
Jones	24	28	32	31	33	0.086	33	35.8	4	12.1%	4.3	31.5	10	10	**0**	**0**
Lee	100	102	107	112	108	0.020	109	110.2	8	7.4%	8.2	102.0	32	46	Surplus of 14	**0**
Lenoir	175	174	174	183	170	-0.006	169	168.9	11	6.5%	10.9	158.0	49	63	Surplus of 14	**0**
Lincoln	66	78	77	87	81	0.057	83	85.7	19	23.5%	20.1	65.6	20	25	Surplus of 5	**0**
Macon	21	24	23	23	33	0.134	35	37.4	10	30.3%	11.3	26.1	8	9	Surplus of 1	**0**
Madison	9	8	13	11	13	0.135	13	14.8	1	6.4%	0.9	13.8	4	0	**4**	**0**
Martin	64	62	74	81	85	0.077	88	91.5	8	9.4%	8.6	82.9	26	23	**3**	**0**
McDowell	38	44	43	42	49	0.070	50	52.4	8	16.3%	8.6	43.9	14	13	**1**	**0**
Mecklenburg	1071	1097	1122	1201	1327	0.056	1370	1400.8	148	11.2%	156.2	1244.5	389	383	**6**	**0**
Mitchell	8	8	7	9	11	0.096	12	12.1	1	10.6%	1.3	10.8	3	9	Surplus of 6	
Avery	10	9	10	10	9	-0.022	9	8.8	5	55.6%	4.9	3.9	1	0	**1**	
Yancey	18	17	12	15	16	-0.008	16	15.9	0	0.0%	0.0	15.9	5	0	**5**	
Mitchell-Avery-Yancey Planning Area Total															**0**	**0**
Montgomery	53	54	44	54	60	0.043	63	62.6	3	5.0%	3.1	59.5	19	19	**0**	**0**
Moore	150	156	155	152	157	0.012	157	158.8	24	15.3%	24.3	134.6	42	52	Surplus of 10	**0**
Nash	176	186	204	198	193	0.025	192	197.8	21	10.9%	21.5	176.3	55	55	**0**	**0**
New Hanover	180	191	198	201	217	0.048	223	227.4	38	17.5%	39.8	187.6	59	57	**2**	**0**
Northampton	71	76	79	88	76	0.022	76	77.7	9	11.8%	9.2	68.5	21	19	**2**	**0**
Onslow	125	131	133	127	156	0.062	161	165.6	30	19.2%	31.8	133.8	42	42	**0**	**0**
Orange	142	128	138	137	126	-0.027	125	122.6	11	8.7%	10.7	111.9	35	41	Surplus of 6	**0**
Pamlico	20	18	21	21	21	0.017	21	21.4	6	28.6%	6.1	15.3	5	0	**5**	**0**
Pasquotank	76	74	86	89	90	0.045	91	94.1	10	10.7%	10.1	84.0	26	30	Surplus of 4	**0**
Pender	71	77	82	83	96	0.080	99	103.6	11	11.5%	11.9	91.8	29	22	**7**	**0**
Perquimans	18	17	22	23	22	0.060	22	23.3	2	9.1%	2.1	21.2	7	0	**7**	**0**
Person	86	86	90	91	102	0.045	106	106.6	10	9.8%	10.4	96.1	30	35	Surplus of 5	**0**
Pitt	292	303	310	309	317	0.021	319	323.6	34	10.7%	34.7	288.9	90	101	Surplus of 11	**0**
Polk	16	12	14	11	14	-0.006	14	13.9	4	28.6%	4.0	9.9	3	10	Surplus of 7	**0**
Randolph	105	114	141	142	151	0.098	156	165.8	20	13.2%	22.0	143.9	45	46	Surplus of 1	**0**
Richmond	105	109	122	119	121	0.037	123	125.5	12	9.9%	12.4	113.1	35	39	Surplus of 4	**0**
Robeson	327	314	327	335	337	0.008	342	339.7	22	6.5%	22.2	317.5	99	102	Surplus of 3	**0**
Rockingham	159	161	175	197	181	0.036	185	187.5	14	7.7%	14.5	173.0	54	69	Surplus of 15	**0**
Rowan	143	149	150	145	140	-0.005	137	139.3	29	20.7%	28.9	110.5	35	54	Surplus of 19	**0**
Rutherford	88	80	87	98	113	0.069	119	120.8	29	25.7%	31.0	89.8	28	30	Surplus of 2	**0**
Sampson	147	140	142	161	164	0.030	170	168.9	18	11.0%	18.5	150.3	47	46	**1**	**0**
Scotland	110	99	109	108	121	0.028	126	124.4	9	7.4%	9.3	115.1	36	38	Surplus of 2	**0**
Stanly	64	74	67	70	65	0.009	64	65.6	5	7.7%	5.0	60.5	19	22	Surplus of 3	**0**
Stokes	45	51	54	56	49	0.026	48	50.3	9	18.4%	9.2	41.0	13	17	Surplus of 4	**0**
Surry	96	100	99	107	106	0.026	109	108.7	14	13.2%	14.4	94.4	29	46	Surplus of 17	**0**
Swain	48	48	48	44	56	0.047	59	58.7	6	10.7%	6.3	52.4	16	20	Surplus of 4	**0**
Transylvania	23	16	15	20	33	0.154	38	38.1	11	33.3%	12.7	25.4	8	9	Surplus of 1	**0**
Tyrrell	11	7	9	6	5	-0.144	5	4.3	4	80.0%	3.4	0.9	0	0	**0**	**0**
Union	135	148	156	183	182	0.079	190	196.5	30	16.5%	32.4	164.1	51	61	Surplus of 10	**0**
Vance	139	152	158	163	165	0.044	167	172.3	11	6.7%	11.5	160.8	50	48	**2**	**0**
Wake	864	929	952	995	1016	0.042	1034	1058.2	139	13.7%	144.8	913.5	285	304	Surplus of 19	**0**
Warren	57	60	63	60	60	0.014	60	60.8	2	3.9%	2.4	58.5	18	21	Surplus of 3	**0**
Washington	29	33	38	37	36	0.059	36	38.1	1	2.8%	1.1	37.1	12	14	Surplus of 2	**0**
Watauga	30	32	27	31	30	0.007	31	30.2	14	46.7%	14.1	16.1	5	14	Surplus of 9	**0**

Note: Except for the Cherokee-Clay-Graham Multi-county Planning Area and the Mitchell-Avery-Yancey Multi-county Planning Area, each of the 94 remaining counties is a separate dialysis station planning area.

STATE HEALTH COORDINATING COUNCIL

2013

North Carolina Semiannual Dialysis Report July 2013

DHSR
N.C. Division of Health Service Regulation

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 6/21/2013. Utilization Rates Calculated for 12/31/2012.)

County	Facility Identification Number	Provider Number	Facility	City	Number of Dialysis Stations as of 6/21/2013					Certified Stations 12/31/2012	Number In-Center Patients 12/31/2012	Utilization Rates	
					Certified	CON Issued/ Not Certified	Decision Rendered (Conditional Approval)	Decision Pending	Total			Utilization by Percent 12/31/2012	Patients Per Station
Northampton	970120	34-2586	FMC East Northampton County	Rich Square	16	3	0	0	19	16	50	78.13%	3.1250
Onslow	130178	Proposed new site consisting of existing stations	New River Dialysis (DaVita)		0	0	0	18	18				
Onslow	956056	34-2532	Southeastern Dialysis Center (DaVita)	Jacksonville	42	0	0	-18	24	42	138	82.14%	3.2857
Orange	956088	34-2622	Carolina Dialysis Carrboro (UNC)	Carrboro	41	0	0	0	41	41	112	68.29%	2.7317
Pamlico													
Pasquotank	955812	34-2515	Elizabeth City Dialysis (DaVita)	Elizabeth City	30	0	0	0	30	30	113	94.17%	3.7667
Pender	130180	Proposed new site consisting of existing stations	Hampstead Dialysis (DaVita)		0	0	0	10	10				
Pender	945252	34-2558	Southeastern Dialysis Center (DaVita)	Burgaw	22	0	0	-10	12	22	69	78.41%	3.1364
Perquimans													
Person	120225	34-2562	Roxboro Dialysis (DaVita)	Roxboro	24	11	0	0	35	24	106	110.42%	4.4167
Pitt	011155	34-2632	FMC Care of Ayden	Ayden	15	0	0	0	15	15	51	85.00%	3.4000
Pitt	960406	34-2596	FMC Dialysis Services East Carolina University	Greenville	38	0	0	0	38	38	147	96.71%	3.8684
Pitt	944657	34-2502	Greenville Dialysis Center (FMC)	Greenville	48	0	0	0	48	48	130	67.71%	2.7083
Polk	070220	Proposed new site consisting of new stations	Polk County Dialysis Center	Columbus	0	10	0	0	10				
Randolph	955777	34-2524	Bio-Medical Applications of Asheboro	Asheboro	27	19	0	0	46	27	104	96.30%	3.8519
Richmond	955843	34-2539	Dialysis Care of Richmond County	Hamlet	27	0	0	0	27	27	85	78.70%	3.1481
Richmond	090624	34-2690	Sandhills Dialysis Center	Rockingham	12	0	0	0	12	12	27	56.25%	2.2500
Robeson	980754	34-2607	BMA of Red Springs	Red Springs	14	-2	0	0	12	14	39	69.64%	2.7857
Robeson	991061	34-2623	FMC of Dialysis Services Robeson County	Fairmont	23	0	0	0	23	23	65	70.65%	2.8261
Robeson	971335	34-2682	FMC of Pembroke	Pembroke	13	0	0	0	13	13	48	92.31%	3.6923

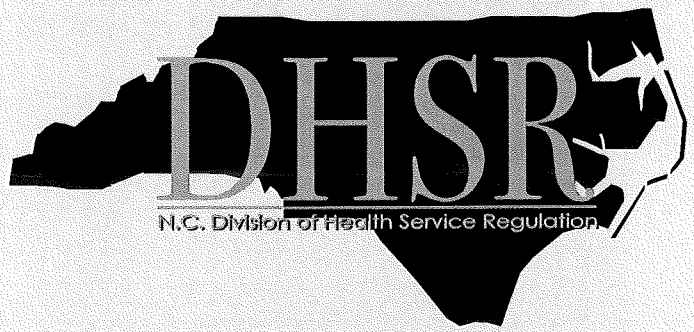
Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	12.31.11 Total Patients	12.31.12 Total Patients	Average Annual Change Rate for Past Five Years	Projected 12.31.13 Total Patients	12.31.12 Home Patients	12.31.12 Percent Home Patients	Projected 12.31.13 Home Patients	Projected 12.31.13 In-Center Patients	Projected 12.31.13 In-Center Station Utilization	Total Available Stations	Projected Station Deficit or Surplus	County Station Need Determination
Avery	9	10	10	9	13	0.114	14.5	5	38.5%	5.6	8.9	3	0	**3**	
Mitchell	8	7	9	11	7	0.005	7.0	0	0.0%	0.0	7.0	2	9	Surplus of 7	
Yancey	17	12	15	16	18	0.037	18.7	1	5.6%	1.0	17.6	6	0	**6**	
Mitchell-Avery-Yancey Planning Area Total														**1**	0
Montgomery	54	44	54	60	70	0.080	75.6	4	5.7%	4.3	71.3	22	19	**3**	0
Moore	156	155	152	157	153	-0.005	152.3	22	14.4%	21.9	130.4	41	52	Surplus of 11	0
Nash	186	204	198	193	259	0.096	283.9	43	16.6%	47.1	236.7	74	55	**19**	19
New Hanover	191	198	201	217	228	0.046	238.4	41	18.0%	42.9	195.5	61	61	0	0
Northampton	76	79	88	76	81	0.021	82.7	8	9.9%	8.2	74.5	23	19	**4**	0
Onslow	131	133	127	156	166	0.066	176.9	32	19.3%	34.1	142.8	45	42	**3**	0
Orange	128	138	137	126	120	-0.014	118.3	11	9.2%	10.8	107.4	34	41	Surplus of 7	0
Pamlico	18	21	21	21	16	-0.018	15.7	3	18.8%	2.9	12.8	4	0	**4**	0
Pasquotank	74	86	89	90	97	0.072	103.9	14	14.4%	15.0	88.9	28	30	Surplus of 2	0
Pender	77	82	83	96	98	0.064	104.2	15	15.3%	16.0	88.3	28	22	**6**	0
Perquimans	17	22	23	22	27	0.131	30.5	3	11.1%	3.4	27.1	8	0	**8**	0
Person	86	90	91	102	108	0.059	114.4	10	9.3%	10.6	103.8	32	35	Surplus of 3	0
Pitt	303	310	309	317	326	0.019	332.0	48	14.7%	48.9	283.2	88	101	Surplus of 13	0
Polk	12	14	11	14	9	-0.033	8.7	3	33.3%	2.9	5.8	2	10	Surplus of 8	0
Randolph	114	141	142	151	174	0.115	194.0	17	9.8%	19.0	175.0	55	46	**9**	0
Richmond	109	122	119	121	121	0.028	124.4	11	9.1%	11.3	113.1	35	39	Surplus of 4	0
Robeson	314	327	335	337	330	0.013	334.2	20	6.1%	20.3	314.0	98	102	Surplus of 4	0
Rockingham	161	175	197	181	139	-0.025	135.5	10	7.2%	9.7	125.8	39	69	Surplus of 30	0
Rowan	149	150	145	140	177	0.051	186.0	46	26.0%	48.3	137.7	43	48	Surplus of 5	0
Rutherford	80	87	98	113	117	0.101	128.8	26	22.2%	28.6	100.2	31	30	**1**	0
Sampson	140	142	161	164	160	0.036	165.7	13	8.1%	13.5	152.2	48	46	**2**	0
Scotland	99	109	108	121	148	0.109	164.1	8	5.4%	8.9	155.2	49	38	**11**	11
Stanly	74	67	70	65	69	-0.015	68.0	5	7.2%	4.9	63.0	20	22	Surplus of 2	0
Stokes	51	54	56	49	45	-0.028	43.8	7	15.6%	6.8	36.9	12	17	Surplus of 5	0
Surry	100	99	107	106	98	-0.004	97.7	11	11.2%	11.0	86.7	27	46	Surplus of 19	0
Swain	48	48	44	56	65	0.088	70.7	11	16.9%	12.0	58.7	18	20	Surplus of 2	0

STATE HEALTH COORDINATING COUNCIL

2014

North Carolina Semiannual Dialysis Report January 2014



North Carolina Department of Health and Human Services
Division of Health Service Regulation

Table A: Inventory of Dialysis Stations and Calculation of Utilization Rates (Inventory Compiled 12/16/2013. Utilization Rates Calculated for 6/30/2013.)

County	Facility Identification Number	Provider Number	Facility	City	Number of Dialysis Stations as of 12/16/2013					Certified Stations 6/30/2013	Number In-Center Patients 6/30/2013	Utilization Rates	
					Certified	CON Issued/ Not Certified	Decision Rendered (Conditional Approval)	Decision Pending	Total			Utilization by Percent 6/30/2013	Patients Per Station
Polk	070220	Proposed new site consisting of new stations	Polk County Dialysis Center	Columbus	0	10	0	0	10	0	0	0.00%	0.0000
Randolph	955777	34-2524	BMA of Asheboro	Asheboro	46	0	0	0	46	27	107	99.07%	3.9630
Richmond	955843	34-2539	Dialysis Care of Richmond County	Hamlet	27	0	0	0	27	27	92	85.19%	3.4074
Richmond	090624	34-2690	Sandhills Dialysis	Rockingham	12	0	0	0	12	12	30	62.50%	2.5000
Robeson	980754	34-2607	BMA of Red Springs	Red Springs	12	0	0	0	12	14	40	71.43%	2.8571
Robeson	991061	34-2623	FMC Dialysis Services of Robeson County	Fairmont	23	0	0	0	23	23	66	71.74%	2.8696
Robeson	971335	34-2682	FMC Pembroke	Pembroke	13	0	0	6	19	13	49	94.23%	3.7692
Robeson	060514	34-2662	FMC St. Pauls	St. Pauls	15	0	0	0	15	13	44	84.62%	3.3846
Robeson	955445	34-2528	Lumberton Dialysis Unit	Lumberton	30	0	0	3	33	30	104	86.67%	3.4667
Robeson	070039	34-2651	St. Pauls Dialysis Center	St. Pauls	10	0	0	0	10	10	16	40.00%	1.6000
Rockingham	955844	34-2536	Dialysis Care of Rockingham County	Eden	23	0	0	0	23	23	71	77.17%	3.0870
Rockingham	001557	34-2624	Madison Dialysis Center	Madison	10	-8	0	0	2	10	10	25.00%	1.0000
Rockingham	030453	34-2640	Reidsville Dialysis	Reidsville	19	8	0	0	27	19	69	90.79%	3.6316
Rockingham	001548	34-2641	Rockingham Kidney Center	Reidsville	17	0	0	0	17	17	51	75.00%	3.0000
Rowan	980409	34-2592	Dialysis Care of Kannapolis	Kannapolis	25	-6	0	0	19	25	61	61.00%	2.4400
Rowan	944673	34-2546	Dialysis Care of Rowan County	Salisbury	29	0	0	0	29	29	85	73.28%	2.9310
Rutherford	955824	34-2566	Dialysis Care of Rutherford County	Forest City	30	0	0	0	30	30	84	70.00%	2.8000
Sampson	955787	34-2559	BMA of Clinton	Clinton	36	0	0	0	36	36	97	67.36%	2.6944
Sampson	080822	34-2688	FMC of Roseboro	Roseboro	10	0	0	0	10	10	34	85.00%	3.4000
Scotland	924648	34-2540	BMA of Laurinburg	Laurinburg	26	0	0	4	30	26	87	83.65%	3.3462
Scotland	060982	34-2664	FMC Scotland County	Laurinburg	12	0	0	2	14	12	37	77.08%	3.0833
Scotland	130458	Proposed new site consisting of new stations	Scotland County Dialysis		0	0	0	10	10	0	0	0.00%	0.0000
Stanly	955784	34-2565	BMA Albemarle	Albemarle	22	0	0	2	24	22	80	90.91%	3.6364
Stokes	020980	34-2633	King Dialysis Center	King	17	0	0	0	17	17	43	63.24%	2.5294
Surry	001558	34-2614	Elkin Dialysis Center	Elkin	19	0	0	0	19	19	43	56.58%	2.2632

Table B: ESRD Dialysis Station Need Determinations by Planning Area

County/ Multi-County Planning Area	12.31.08 Total Patients	12.31.09 Total Patients	12.31.10 Total Patients	12.31.11 Total Patients	12.31.12 Total Patients	Average Annual Change Rate for Past Five Years	6.30.13 Total Patients	Projected 6.30.14 Total Patients	6.30.13 Home Patients	6.30.13 Percent Home Patients	Projected 6.30.14 Home Patients	Projected 6.30.14 In-Center Patients	Projected 6.30.14 In-Center Station Utilization	Total Available Stations	Projected Station Deficit or Surplus	County Station Need Determination
McDowell	44	43	42	49	47	0.020	57	58.1	11	23.4%	13.6	44.5	14	14	0	0
Mecklenburg	1097	1122	1201	1327	1416	0.066	1464	1,561.1	165	11.7%	181.9	1,379.2	431	424	**7**	0
Avery	9	10	10	9	13	0.114	10	11.1	3	23.1%	2.6	8.6	3	0	**3**	
Mitchell	8	7	9	11	7	0.005	7	7.0	0	0.0%	0.0	7.0	2	9	Surplus of 7	
Yancey	17	12	15	16	18	0.037	16	16.6	1	5.6%	0.9	15.7	5	0	**5**	
Mitchell-Avery-Yancey Planning Area Total															**1**	0
Montgomery	54	44	54	60	70	0.080	64	69.1	3	4.3%	3.0	66.2	21	20	**1**	0
Moore	156	155	152	157	153	-0.005	169	168.2	26	17.0%	28.6	139.6	44	52	Surplus of 8	0
Nash	186	204	198	193	201	0.021	208	212.3	21	10.4%	22.2	190.2	59	78	Surplus of 19	0
New Hanover	191	198	201	217	228	0.046	240	250.9	53	23.2%	58.3	192.6	60	61	Surplus of 1	0
Northampton	76	79	88	76	81	0.021	82	83.7	13	16.0%	13.4	70.3	22	19	**3**	0
Onslow	131	133	127	156	166	0.066	168	179.0	31	18.7%	33.4	145.6	45	42	**3**	0
Orange	128	138	137	126	120	-0.014	128	126.2	16	13.3%	16.8	109.4	34	41	Surplus of 7	0
Pamlico	18	21	21	21	16	-0.018	17	16.7	4	25.0%	4.2	12.5	4	0	**4**	0
Pasquotank	74	86	89	90	97	0.072	98	105.0	13	13.4%	14.1	90.9	28	39	Surplus of 11	0
Pender	77	82	83	96	98	0.064	87	92.5	10	10.2%	9.4	83.1	26	22	**4**	0
Perquimans	17	22	23	22	27	0.131	31	35.1	3	11.1%	3.9	31.2	10	0	**10**	0
Person	86	90	91	102	108	0.059	105	111.2	12	11.1%	12.4	98.9	31	35	Surplus of 4	0
Pitt	303	310	309	317	355	0.041	347	361.4	44	12.4%	44.8	316.6	99	101	Surplus of 2	0
Polk	12	14	11	14	9	-0.033	9	8.7	4	44.4%	3.9	4.8	2	10	Surplus of 8	0
Randolph	114	141	142	151	174	0.115	177	197.3	16	9.2%	18.1	179.2	56	46	**10**	0
Richmond	109	122	119	121	122	0.030	127	130.8	12	9.8%	12.9	117.9	37	39	Surplus of 2	0
Robeson	314	327	335	337	348	0.026	353	362.2	27	7.8%	28.1	334.1	104	112	Surplus of 8	0
Rockingham	161	175	197	181	186	0.040	197	204.8	9	4.8%	9.9	194.9	61	69	Surplus of 8	0
Rowan	149	150	145	140	177	0.051	173	181.8	52	29.4%	53.4	128.4	40	48	Surplus of 8	0
Rutherford	80	87	98	113	117	0.101	118	129.9	28	23.9%	31.1	98.8	31	30	**1**	0
Sampson	140	142	161	164	160	0.036	171	177.1	20	12.5%	22.1	154.9	48	46	**2**	0
Scotland	99	109	108	121	121	0.053	116	122.2	10	8.3%	10.1	112.1	35	54	Surplus of 19	0
Stanly	74	67	70	65	69	-0.015	68	67.0	4	5.8%	3.9	63.1	20	24	Surplus of 4	0

Providers Serving Randolph County Dialysis Patients

Pushpins
- NRDC Potential Sites

Providers
- BMA / FMC
- WFU

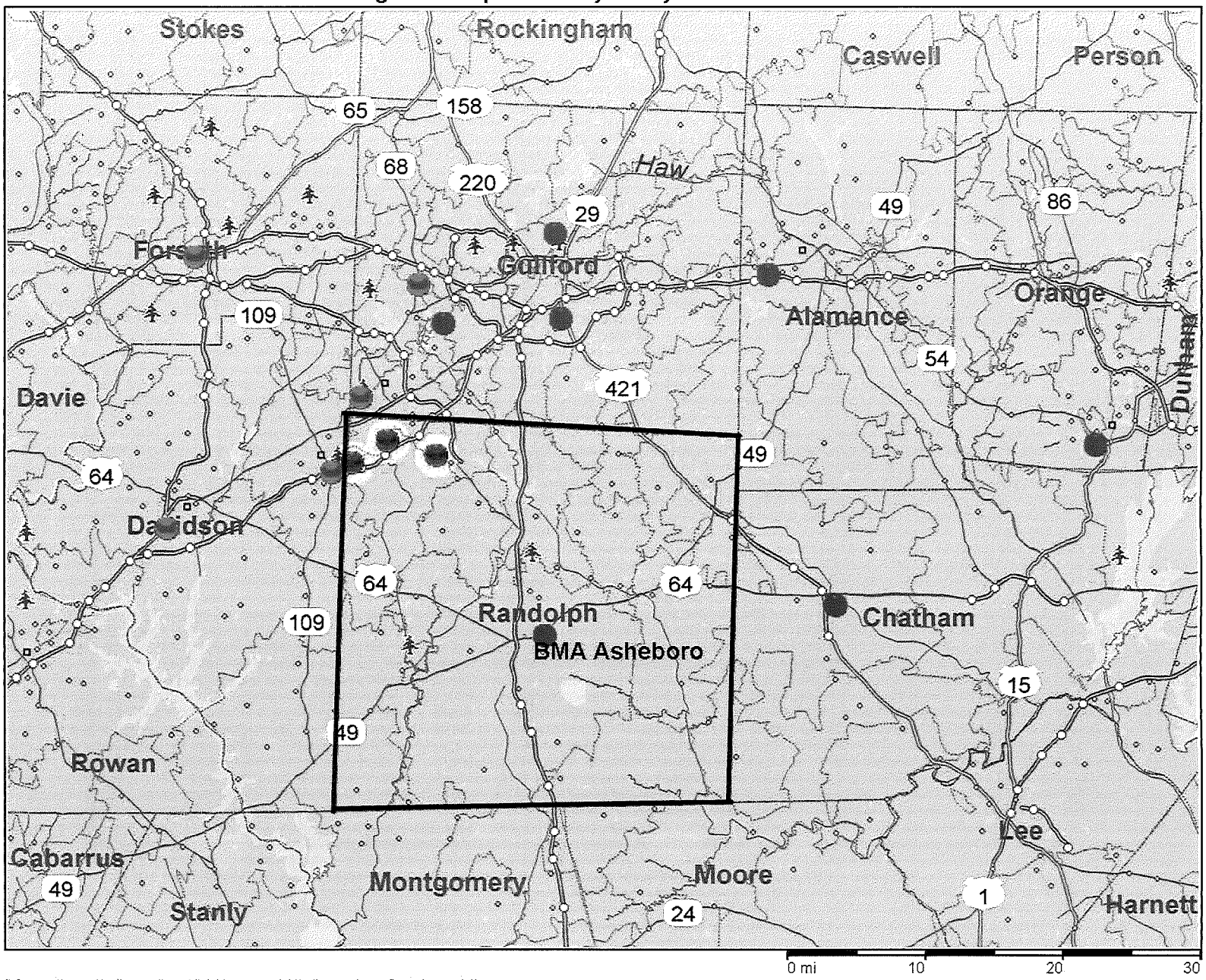


EXHIBIT 2

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: January 20, 2012
PROJECT ANALYST: Lisa Pittman
SECTION CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: C-8732-11/ Dialysis Clinic, Inc. d/b/a DCI Shelby/ Add 4 stations to current dialysis facility / Cleveland County

C-8733-11/ Dialysis Clinic, Inc. d/b/a DCI Boiling Springs/ Add 4 stations to current dialysis facility / Cleveland County

C-8756-11/ Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a FMC Cleveland County/ Relocate 10 existing stations into Cleveland County to develop a new 10-station dialysis facility / Cleveland 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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

The 2011 State Medical Facilities Plan (SMFP) and the July 2011 Semiannual Dialysis Report (SDR) provide a county need methodology for determining the need for additional dialysis stations. According to the county need methodology, found on page 350 of the 2011 SMFP, *"If a county's December 31, 2011 projected station deficit is 10 or greater and the July SDR shows that utilization of each dialysis facility in the county is 80*

EXHIBIT 3

percent or greater, the December 31, 2011 county station need determination is the same as the December 31, 2011 projected station deficit. If a county's December 31, 2011 projected station deficit is less than 10 or if the utilization of any dialysis facility in the county is less than 80 percent, the county's December 31, 2011 station need determination is zero." Although the July 2011 SDR shows a deficit of 11 stations, the county need methodology results in a need determination of zero additional dialysis stations in Cleveland County.

Following is a description of the three proposals submitted in this review:

C-8732-11 Dialysis Clinic, Inc. d/b/a DCI Shelby proposes to add 4 stations to the current DCI Shelby dialysis facility in Cleveland County in response to the facility need methodology. In Section VIII.1, page 83, the applicant states the project will require the addition of dialysis machines, chairs, and patient TVs. DCI Shelby currently has 25 certified dialysis stations, including one station for isolation patients; therefore, after completion of this project, DCI Shelby will have a facility total of 29 dialysis stations, including one isolation station. DCI Shelby is eligible to apply for additional stations in its existing facility based on the facility need methodology.

The utilization rate reported for DCI Shelby in the June 2011 SDR is 3.64 patients per station. This utilization rate was calculated based on 91 in-center dialysis patients and 25 certified dialysis stations as of December 31, 2010 (91 patients / 25 stations = 3.64 patients per station). Therefore, application of the facility need methodology indicates additional stations are needed for this facility, as illustrated in the following table.

DCI Shelby Utilization and Needs

Required SDR Utilization		80%
Center Utilization Rate as of 12/31/10		91.0%
Certified Stations		25
Pending Stations		0
Total Existing and Pending Stations		**25**
In-Center Patients as of 12/31/10 (SDR2)		91
In-Center Patients as of 06/30/10 (SDR1)		90
Difference (SDR2 - SDR1)		1
Step	Description	
(i)	Multiply the difference by 2 for the projected net in-center change	2
	Divide the projected net in-center change for 1 year by the number of in-center patients as of 6/30/10	0.0222
(ii)	Divide the result of Step (i) by 12	0.0019
(iii)	Multiply the result of Step (ii) by the number of months from the most recent month reported in the July 2011 SDR (12/31/10) until the end of calendar year 2010 (12 months)	0.0222
(iv)	Multiply the result of Step (iii) by the number of in-center patients reported in SDR2 and add the product to the number of in-center patients reported in SDR2	93.0222
(v)	Divide the result of Step (iv) by 3.2 patients per station	29.0694
	and subtract the number of certified and pending stations as recorded in SDR2 [25] to determine the number of stations needed	4

Step C of the facility need methodology states *"The facility may apply to expand to meet the need established in (2)(B)(v)* [Step (v) in the table above], *up to a maximum of ten stations."* Based on the facility need methodology for dialysis stations, the number of stations needed at DCI Shelby is four and the applicant proposes to add no more than four new stations. Therefore, the DCI Shelby application is consistent with the facility need determination for dialysis stations.

C-8733-11 Dialysis Clinic, Inc. d/b/a DCI Boiling Springs proposes to add 4 stations to the current DCI Boiling Springs dialysis facility in Cleveland County in response to the facility need methodology. In Section VIII.1, page 83, the applicant states the project will require the addition of dialysis machines, chairs, patient TVs and plumbing. DCI Boiling Springs currently has 10 certified dialysis stations, including one station for isolation patients; therefore, after completion of this project, DCI Boiling Springs will have a facility total of 14 dialysis stations, including one isolation station. DCI Boiling Springs is eligible to apply for additional stations in its existing facility based on the facility need methodology.

The utilization rate reported for DCI Boiling Springs in the July 2011 SDR is 3.20 patients per station. This utilization rate was calculated based on 32 in-center dialysis patients and 10 certified dialysis stations as of December 31, 2010 (32 patients / 10 stations = 3.20 patients per station). Therefore, application of the facility need methodology indicates additional stations are needed for this facility, as illustrated in the following table.

DCI Boiling Springs Utilization and Needs

Required SDR Utilization		80%
Center Utilization Rate as of 12/31/10		80.0%
Certified Stations		10
Pending Stations		0
Total Existing and Pending Stations		**10**
In-Center Patients as of 12/31/10 (SDR2)		32
In-Center Patients as of 6/30/10 (SDR1)		26
Difference (SDR2 - SDR1)		6
Step	Description	
(i)	Multiply the difference by 2 for the projected net in-center change	12
	Divide the projected net in-center change for 1 year by the number of in-center patients as of 6/30/10	0.4615
(ii)	Divide the result of Step (i) by 12	0.0385
(iii)	Multiply the result of Step (ii) by the number of months from the most recent month reported in the July 2011 SDR (12/31/10) until the end of calendar year 2011 (12 months)	0.4615
(iv)	Multiply the result of Step (iii) by the number of in-center patients reported in SDR2 and add the product to the number of in-center patients reported in SDR2	46.7692
(v)	Divide the result of Step (iv) by 3.2 patients per station	14.6154
	and subtract the number of certified and pending stations as recorded in SDR2 [10] to determine the number of stations needed	5

Step C of the facility need methodology states *"The facility may apply to expand to meet the need established in (2)(B)(v)* [Step (v) in the table above], *up to a maximum of ten stations."* Based on the facility need methodology for dialysis stations, the number of stations needed at DCI Boiling Springs is five and the applicant proposes to add no more than five new stations. Therefore, the DCI Boiling Springs application is consistent with the facility need determination for dialysis stations.

C-8759-11 Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a FMC Cleveland County proposes to establish a 10-station dialysis facility by relocating two stations from BMA Burke County, an existing 25-station dialysis facility in Burke County; six stations from BMA Hickory, an existing 33-station dialysis facility in Catawba County; one station from BMA Lincolnton, an existing 25-station dialysis facility in Lincoln County; and one station from BMA Kings Mountain, an existing 14-station facility in Gaston County. Therefore, neither of the need methodologies in the 2011 SMFP is applicable to the review of this application. However, 2011 SMFP Policy ESRD-2: Relocation of Dialysis Stations is applicable in this review to FMC Cleveland. Policy ESRD-2: Relocation of Dialysis Stations, found on page 33 of the SMFP, 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 applicants proposing to relocate dialysis stations to contiguous counties shall:*
>
> 1. *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 North Carolina Semiannual Dialysis Report, and*
>
> 2. *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 North Carolina Semiannual Dialysis Report."*

The following table reflects the projected station deficit/surplus for the four counties from which BMA proposes to relocate stations.

	Current Projected Station Surplus (Deficit)	Proposed # Stations to be Relocated Out of County	Projected Station Surplus (Deficit) After Proposed Relocation
Burke County	2	2	0
Catawba County	6	6	0
Gaston County	2	1	1
Lincoln County	1	1	0

Source: July 2011 SDR for 12/30/10.

Cleveland County, the county into which the applicant proposes to move stations, has a projected station deficit of 11, as of the July 2011 SDR. Therefore, because the proposed relocation will not leave counties loosing stations with a deficit and will not create a surplus in the county where the relocated stations move, BMA is eligible to apply to relocate 10 existing stations into Cleveland County and develop a new 10 station dialysis facility based on Policy ESRD-2: Relocation of Dialysis Stations.

Additionally, Policy GEN-3: Basic Principles in the 2011 SMFP is applicable in this review to DCI Shelby and DCI Boiling Springs because their proposals are based on the facility need determination of the SMFP. BMA's application is not based on a need

determination in the SMFP therefore Policy GEN-3 is not applicable to its review. Policy GEN-3 Basic Principles states:

> *"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."*

The applicants respond to Policy GEN-3 as follows:

DCI Shelby

Promote Equitable Access
In Section VI.1(a), page 73, **DCI Shelby** states:

> *"As discussed throughout this application, DCI is a not-for-profit corporation that was created solely to meet the needs of dialysis patients. This commitment to patient need has remained strong not only at the corporate level but also at the clinic level. Because of this commitment, DCI willingly serves* ***any and all population groups*** *without regard to income, race or ethnic minority, sex, ability, age, or any perceived underserved status. ... Locally, during FY 2010, DCI Shelby incurred more than $635,000 in bad debt and charity care. The amount is approximately 10 percent of the Shelby clinic's gross revenue. DCI's commitment to its patients is exemplified in its admission policy and its equal treatment policy. Please see Exhibit 6 for copies of these policies."* [Emphasis in original.]

In Section VI.1(b), page 73, DCI Shelby reports that 86.5% of the patients who received treatment at DCI Shelby had some or all of their services paid for by Medicare or Medicaid. The applicant demonstrates that it currently provides adequate access to medically underserved populations.

In Section VI.2, page 76, the applicant states

> *"As an existing Medicare approved facility, DCI Shelby is in full compliance with all Americans with Disabilities Act requirements as well as Section 11.X of the North Carolina building code."*

In Section VI.7, page 78, the applicant states

> *"The equal treatment policy of DCI states, 'No patient will be denied services or be otherwise treated in a discriminatory manner because of any disease, illness or disability.' DCI treats all patients deemed appropriate for dialysis care by the nephrologists who refer to the dialysis center. DCI's acceptance of patients includes behavioral issues as well. ... DCI is willing to accept* ***any*** *patient that is in need of dialysis care."* [Emphasis in original.]

The applicant adequately demonstrates how the proposal will promote equitable access to the proposed services.

Promote Safety and Quality

In Section II.3, pages 42-43, the applicant states:

> *"DCI has exceptionally high quality standards which are not only obvious in the clinics themselves but are recognized nationally by quality organizations. For example, the most recent annual report from the United States Renal Data System (URDS) found that DCI clinics consistently rank at the top in many of the important ESRD categories related to outpatient care. Specifically, the data indicate that:*
>
> - *DCI has lower mortality rates than other providers;*
> - *DCI has lower hospitalization rates than other providers;*
> - *DCI is most consistent at meeting target hemoglobin levels/* [sic]
> - *DCI is best at maintaining hemoglobin levels for three months or more;*
> - *DCI patients are staying at hemoglobin levels longer than patients with other providers;*
> - *DCI has a higher percentage of patients in their target hemoglobin range of 10-12 grams/deciliter;*
> - *DCI has fewer patient*[s] *likely to exceed hemoglobin levels of 12, 13, 14; and*
> - *DCI is the national provider with the lowest monthly cost to CMS at $1,366 per patient per month compared to a national average of $1,425 per patient per month.*
>
> ...
>
> *Locally, DCI utilizes a team approach to the quality improvement process. ... Realistic goals, which promote safe, therapeutically effective and individualized care for each patient, are defined in the patient care plan."*

The applicant adequately demonstrates how the proposal will promote safety and quality.

Maximize Healthcare Value

In Section III.9, pages 54-55, DCI Shelby discusses how this was its most effective alternative:

"As described throughout this application, DCI's primary focus and commitment is to its patients. Meeting their needs is DCI's first priority. ... This project is the result of a careful evaluation of patient needs at DCI Shelby.

The 'July 2011 Semiannual Dialysis Report' indicates a facility need of four stations for DCI Shelby. In order to determine the appropriateness of adding four stations, DCI considered other alternatives."

The applicant states that it considered maintaining the status quo, operating a third shift and the current proposal adding stations in the existing facility.

The applicant adequately demonstrates the proposal will maximize healthcare value. Additionally, the applicant demonstrates projected volumes for the proposed services incorporate the basic principles in meeting the needs of patients to be served. See Criteria (3) and (13c) for additional discussion.

The application is consistent with Policy GEN-3 and is conforming to this criterion.

DCI Boiling Springs

Promote Equitable Access
In Section VI.1(a), page 73, **DCI Boiling Springs** states:

"As discussed throughout this application, DCI is a not-for-profit corporation that was created solely to meet the needs of dialysis patients. This commitment to patient need has remained strong not only at the corporate level but also at the clinic level. Because of this commitment, DCI willingly serves ***any and all population groups*** *without regard to income, race or ethnic minority, sex, ability, age, or any perceived underserved status. ... Locally, DCI Boiling Springs has incurred more than $49,486 in bad debt and charity care during FY 2010. DCI's commitment to its patients is exemplified in its admission policy and its equal treatment policy. Please see Exhibit 5 for copies of these policies."* [Emphasis in original.]

In Section VI.1(b), page 73, DCI Boiling Springs reports that 85.3% of the patients who received treatment at DCI Boiling Springs had some or all of their services paid for by Medicare or Medicaid. The applicant demonstrates that it currently provides adequate access to medically underserved populations.

In Section VI.2, page 76, the applicant states:

"As an existing Medicare approved facility, DCI Boiling Springs is in full compliance with all Americans with Disabilities Act requirements as well as Section 11.X of the

North Carolina building code. Because the Boiling Springs clinic was constructed specifically for dialysis use, the building is fully accessible, with no barriers to any patient, even those with physical disabilities or with visual impairments."

In Section VI.7, page 78, the applicant states

"The equal treatment policy of DCI states, 'No patient will be denied services or be otherwise treated in a discriminatory manner because of any disease, illness or disability.' DCI treats all patients deemed appropriate for dialysis care by the nephrologists who refer to the dialysis center. DCI's acceptance of patients includes behavioral issues as well. ... Clearly, DCI is willing to accept ***any*** *patient that is in need of dialysis care."* [Emphasis in original.]

The applicant adequately demonstrates how the proposal will promote equitable access to the proposed services.

Promote Safety and Quality

In Section II.3, pages 40-41, the applicant states:

"DCI has exceptionally high quality standards which are not only obvious in the clinics themselves but are recognized nationally by quality organizations. For example, the most recent annual report from the United States Renal Data System (URDS) found that DCI clinics consistently rank at the top in many of the important ESRD categories related to outpatient care. Specifically, the data indicate that:

- *DCI has lower mortality rates than other providers;*
- *DCI has lower hospitalization rates than other providers;*
- *DCI is most consistent at meeting target hemoglobin levels/* [sic]
- *DCI is best at maintaining hemoglobin levels for three months or more;*
- *DCI patients are staying at hemoglobin levels longer than patients with other providers;*
- *DCI has a higher percentage of patients in their target hemoglobin range of 10-12 grams/deciliter;*
- *DCI has fewer patient*[s] *likely to exceed hemoglobin levels of 12, 13, 14; and*
- *DCI is the national provider with the lowest monthly cost to CMS at $1,366 per patient per month compared to a national average of $1,425 per patient per month.*

...

Locally, DCI uses a team approach to the quality improvement process. ... Realistic goals, which promote safe, therapeutically effective and individualized care for each patient, are defined in the patient care plan."

The applicant adequately demonstrates how the proposal will promote safety and quality.

Maximize Healthcare Value

In Section III.9, pages 54-55, DCI Boiling Springs discusses how this was its most effective alternative:

> *"As described throughout this application, DCI's primary focus and commitment is to its patients. Meeting their needs is DCI's first priority. ... This project is the result of a careful evaluation of patient needs at DCI Boiling Springs.*
>
> *The July 2011 Semiannual Dialysis Report indicates a facility need of five stations for DCI Boiling Springs. In order to determine the appropriateness of adding four or five stations, DCI considered these alternatives."*

The applicant states that it considered maintaining the status quo, operating a third shift, adding five additional stations and the current proposal of adding four stations in the existing facility.

The applicant adequately demonstrates the proposal will maximize healthcare value. Additionally, the applicant demonstrates projected volumes for the proposed services incorporate the basic principles in meeting the needs of patients to be served. See Criteria (3) and (13c) for additional discussion.

The application is consistent with Policy GEN-3 and is conforming to this criterion.

In this review, 2011 SMFP Policy GEN-4: Energy Efficiency and Sustainability for Health Service Facilities is not applicable to any of the three applicants.

Policy Gen-4 states in part *"Any person proposing a capital expenditure greater than $2 million to develop, replace, renovate or add to a health service facility pursuant to G.S. 131E-178 shall include in its certificate of need application a written statement describing the project's plan to assure improved energy efficiency and water conservation."*

The capital costs of the **DCI Shelby** and **DCI Boiling Springs** proposed projects are $66,000 and $70,000, respectively; therefore Policy Gen-4 is not applicable to either project. **FMC Cleveland**'s proposed project involves a new health service facility; however the capital cost of the proposed project is less than $2 million ($857,751); therefore, Policy Gen-4 is not applicable to the FMC Cleveland project.

Three applications were received by the Certificate of Need Section, proposing to develop a total of 18 new dialysis stations. However, pursuant to facility need determination, Policy ESRD-2 and an 11-station county station deficit, 11 is the limit on the number of new dialysis stations that may be approved in this review for Cleveland County. A competitive review of these applications began on October 1, 2011.

(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.

C
DCI Shelby

CA
DCI Boiling Springs

NC
FMC Cleveland

DCI Shelby, located at 1610 North Lafayette Street in Shelby, proposes to add four additional stations for a total of 29 stations following completion of the project. The June 2011 SDR indicates a total of 25 certified station at DCI Shelby, as of December 31, 2010.

Population to be Served

The following table illustrates the current patient origin at DCI Shelby, as reported in Section IV.1, page 59.

DCI Shelby - Patient Origin as of 6/30/11

County of Residence	# Patients Dialyzing In-Center	# Patients Dialyzing at Home
Cleveland	85	13
Gaston	12	2
Lincoln	1	2
Cherokee, SC	0	2
Total	**98**	**19**

In Section III.7, page 54, the applicant provides the projected patient origin for the first two years of operation following completion of the proposed project, as illustrated in the following table:

DCI Shelby - Projected Patient Origin

County	Year One FFY12		Year Two FFY13		County Patients as a Percent of Total	
	In-Center Patients	Home Dialysis Patients	In-Center Patients	Home Dialysis Patients	Year 1	Year 2
Cleveland	80	16	82	16	83.7%	83.7%
Gaston	12	2	12	2	12.0%	12.0%
Lincoln	3	1	3	1	2.6%	2.6%
Cherokee, SC	1	0	1	0	1.7%	1.7%
TOTAL	**96**	**19**	**98**	**19**	100.0%	100.0%

The applicant adequately identified the population proposed to be served.

Need for the Proposed Stations

The applicant proposes to add four stations to the DCI Shelby facility. The DCI Shelby facility is currently certified for 25 stations. In Section III.2, pages 47-51, the applicant describes the need methodology and assumptions it used to project the number of patients to be served in each of the first two operating years following project completion. The July 2011 SDR states that the Five Year Average Annual Change Rate for Cleveland County is 4.1%. However, based on the ESRD Facility Need Methodology, DCI Shelby used its current in-center patient growth rate of 2.2% to project utilization through Year 2. The growth rate was only applied to in-center patients. DCI Shelby's current low growth rate reflects the patients who transferred to the DCI Shelby South facility which opened in June 2010.

In Section III.2, pages 48-51, the applicant provides its methodology, including the projected utilization for the first two project years:

> *"As demonstrated in the table above, DCI currently needs 4.0 additional stations in order to meet the facility need....total patients were projected using the State* [sic] *need methodology as defined in the 'July 2011 Semiannual Dialysis Report.' As shown in the table above, DCI is expected to care for 93 in-center patients by the end of 2011, which is a conservative methodology as DCI Shelby is currently providing care to 98 in-center patients at DCI Shelby. ... Based on this same methodology (Step 2), the growth rate of 2.2 percent has been projected forward through 2014, as shown in the table below.*

Year	*Total In-Center Patients*	*Annual Growth Rate^*
2010	*90*	*2.2%*
2011	*93*	*2.2%*
2012	*95*	*2.2%*
2013	*97*	*2.2%*
2014	*99*	*2.2%*

^Based on Step 2 of the methodology table.

> *... Since the project is expected to begin July 1, 2012, DCI converted the calendar year projections above to project years. Patient volume for PY 1 is calculated as the sum of one-half of the patient volume for 2012 and one-half of the patient volume for 2013; volume for PY 2 is the sum of one-half of the volume for 2013 and one-half of the patient volume for 2014, as shown in the following table.*

Year	*Total In-Center Patients*
PY 1	*96*
PY 2	*98*

DCI Shelby is the clinic that cares for all the in-home patients served by DCI, even those that originate at one of the other DCI clinics. As shown in the table below, during the past twelve months, the number of DCI patients home trained and on peritoneal dialysis has not changed. Typically peritoneal dialysis patients are far less in number than in-center patients and the total number home trained and on peritoneal dialysis does not fluctuate a great deal. For this reason, DCI is projecting a flat in-home growth rate through project year two.

Year	*Total In-Home Patients*	*% Change from Prior Year*
2010	*19*	*0%*
2011	*19*	*0%*
PY 1	*19*	*0%*
PY 2	*19*	*0%*

The following table summarizes the estimated volume at the DCI Shelby location through the second project year.

Year	*Total In-Center Patients*	*Total In-Home Patients*	*Total*
2010	*91*	*19*	*110*
2011	*93*	*19*	*112*
PY 1	*96*	*19*	*115*
PY 2	*98*	*19*	*117*

In order to determine the need for additional stations based on utilization of 3.2 patients per station per week as of the end of the second project year, DCI used the SDR methodology (Step #6) and the total in-center patients as projected above.

Year	*Total In-Center Patients*	*Patients per Station*	*# Existing Stations*	*Total Stations Needed*	*Additional Stations Needed*
2010	*91*	*3.2*	*25*	*28*	*3*
2011	*93*	*3.2*	*25*	*29*	*4*
PY 1	*96*	*3.2*	*29*	*30*	*1*
PY 2	*98*	*3.2*	*29*	*31*	*2*

As shown in the table above, DCI currently needs four additional stations and, even with the proposed increase of four stations is expected to need an additional station by the end of the first project year."

The following table illustrates the applicant's projected number of patients based on the above stated assumptions and utilizing a 2.2% average annual increase for DCI Shelby.

Existing DCI Shelby In-Center Patients as of 12/31/10	91
Jan. 2011 - Dec. 2011	91 x 1.022 = 93.0020
Jan. 2012 - Dec. 2012	93.0020 x 1.022 = 95.0480 80 Cleveland County in-center patients + 11 Gaston County in-center patients + 2 Lincoln County in-center patients + 2 Cherokee, SC in-center patients for a total of 95 projected patients.
Jan. 2013 – Dec. 2013	95.0480 x 1.022 = 97.1390 81 Cleveland County in-center patients + 12 Gaston County in-center patients + 2 Lincoln County in-center patients + 2 Cherokee, SC in-center patients for a total of 97 projected patients.
Jan. 2014 – Dec 2014	97.1390 x 1.022 = 99.2760 83 Cleveland County in-center patients + 12 Gaston County in-center patients + 2 Lincoln County in-center patients + 2 Cherokee, SC in-center patients for a total of 99 projected patients.

[To convert calendar years to project years:
Project Year 1 = ½ x CY12 + ½ x CY13 = 95/2 + 97/2 = 47.5 + 48.5 = 96
Project Year 2 = ½ x CY13 + ½ x CY14 = 97/2 + 99/2 = 48.5 + 49.5 = 98]

The following shows the number of in-center patients per station per week and the utilization rate for each of the first two operating years following completion of the project.

Year 1 (July 1, 2012- June 30, 2012)
Patients/Station/Week: 96 in-center patients dialyzing on 29 stations = 3.31
Utilization Rate: 96 patients / (4 shift-cycles per week x 29 stations) = 96 / 116 = .8276 or 83% utilization.

Year 2 (July 1, 2013- June 30, 2013)
Patients/Station/Week: 98 in-center patients dialyzing on 29 stations = 3.38
Utilization Rate: 98 patients/ (4 shift-cycles per week x 29 stations) = 98 / 116 = .8448 or 84% utilization.

Projected utilization at the end of Year 1 equals at least 3.2 in-center patients per station per week as required by 10A NCAC 14C .2203(b). The number of in-center patients projected to be served is based on reasonable and supported assumptions regarding future growth.

In summary, the applicant adequately identified the population to be served and demonstrated the need this population has for four additional dialysis stations. Therefore, the application is conforming to this criterion.

DCI Boiling Springs, located at 108 Creekside Drive in Shelby, proposes to add four additional stations for a total of 14 stations following completion of the project. The July 2011 SDR indicates a total of 10 certified station at DCI Boiling Springs, as of December 31, 2010.

Population to be Served

The following table illustrates the current patient origin at DCI Boiling Springs, as reported in Section IV.1, page 58.

DCI Boiling Springs - Patient Origin as of 6/30/11

County of Residence	# Patients Dialyzing In-Center	# Patients Dialyzing at Home
Cleveland	25	NA
Rutherford	9	NA
Cherokee, SC	1	NA
Total*	**35**	**NA**

*Source: Application.

In Section III.7, page 53, the applicant provides the projected patient origin for the first two years of operation following completion of the proposed project, as illustrated in the following table:

DCI Boiling Springs - Projected Patient Origin

County	Year One FFY12		Year Two FFY13		County Patients as a Percent of Total	
	In-center Patients	Home Dialysis Patients	In-center Patients	Home Dialysis Patients	Year 1	Year 2
Cleveland	34	0	40	0	71%	71%
Rutherford	13	0	14	0	26%	26%
Cherokee, SC	1	0	2	0	3%	3%
TOTAL	**48**	**0**	**56**	**0**	100%	100%

The applicant adequately identified the population proposed to be served.

Need for the Proposed Stations

The applicant proposes to add four stations to the DCI Boiling Springs facility. The DCI Boiling Springs facility is currently certified for 10 stations.

In Section III.2, pages 45-51, the applicant describes the need methodology and assumptions it used to project the number of patients to be served in each of the first two operating years following project completion.

> *"As demonstrated in the table above, DCI Boiling Springs currently needs 4.6 or 5 additional stations in order to meet the facility need. Because of the space that is*

currently available in the dialysis room that can be converted to additional stations without extensive upfit, DCI is applying for four additional stations rather than five.

...

total patients were projected using the State [sic] *need methodology as defined in the 'July 2011 Semiannual Dialysis Report.' As shown in the table above, DCI is expected to care for 47 in-center patients by the end of 2011, which is seven patients more than the clinic's capacity and, if the projections become a reality, would require the operation of a third shift. (See Section III.9 for a discussion of the difficulties associated with operating a third shift.) Based on this same SDR methodology (Step 2), the growth rate of 46.2 percent has been projected forward through 2014, as shown in the table below.*

Year	*Total In-Center Patients*	*Annual Growth Rate^*
2010	*32*	*46.2%*
2011	*47*	*46.2%*
2012	*69*	*46.2%*
2013	*100*	*46.2%*
2014	*147*	*46.2%*

^Based on Step 2 of the methodology table.

While this methodology is consistent with the methodology typically used to project dialysis need, DCI Boiling Springs believes it is unreasonable to use to project need for additional stations in this project. This position is based on the fact that the Boiling Springs clinic has limited capacity and, by the end of the current year would be well above capacity, which would require the operation of a third shift in order to meet patient needs. As explained in Section III.9, operating a third shift is used only as a short-term means of providing dialysis to a limited number of patients until additional stations can be approved and become operational. Thus, using a third shift as part of general dialysis operations is not optimal and certainly would not be used on a routine basis by DCI clinics, primarily due to the negative attitude of patients toward third shift dialysis treatments. Furthermore, while DCI does anticipate steady growth in the coming years, the clinic does not believe it will continue to grow consistently at a rate of 46.2 percent.

Consequently, DCI believes a more conservative growth rate must be used to project need for this project. Please note, if the SDR growth rate does continue at 46.2 percent, at its earliest opportunity, DCI Boiling Springs will submit a certificate of need application to increase the number of stations at the Boiling Springs clinic so that the dialysis needs of patients referred to the clinic can be met without the need to operate a third shift on an ongoing basis.

DCI believes that its growth rate will be limited by the capacity available during the AM and PM shifts at the clinic rather than a consistent growth rate percentage that would require routine operation of a third shift. With the addition of four stations,

capacity will increase from 40 patients to 56 patients as shown in the Existing and Proposed capacity tables below."

Capacity with 10 Dialysis Stations (Existing)		
	Monday/Wednesday/Friday	**Tuesday/Thursday/Saturday**
AM	10	10
PM	10	10
Night	10	10
AM/PM Capacity	20	20
Capacity with 3rd Shift	30	30
Total Capacity with 2 Shifts = 40 patients		
Total Capacity with 3 Shifts = 60 patients		

Capacity with 14 Dialysis Stations (Proposed)		
	Monday/Wednesday/Friday	**Tuesday/Thursday/Saturday**
AM	14	14
PM	14	14
Night	14	14
AM/PM Capacity	28	28
Capacity with 3rd Shift	42	42
Total Capacity with 2 Shifts = 56 patients		
Total Capacity with 3 Shifts = 84 patients		

Continuing on page 49, the applicant states:

"Based on the two-shift capacity of the Boiling Springs clinic, DCI projects that its patient volume will be limited to a total of 40 patients in 2011 through the first six months of 2012, with a capacity of no more than 56 patients thereafter (the clinic's AM/PM capacity with four additional stations). To calculate projected patients for the project years, which begins July 12, 2012, DCI assumed a capacity of 20 patients for the first half of 2012 (one-half of the total annual capacity with 10 stations) and a capacity of 28 patients for the second half of 2012 (one-half of the total annual capacity with 14 stations). Patient volume for 2013 and 2014 is projected to be the full annual capacity of 14 stations, or 56 patients. These projections are shown in the table below.

Year	*Total In-Center Patients*
2010	*32*
2011	*40*
2012	*48*
2013	*56*
2014	*56*

The first two project years are July 2012 through June 2013 and July 2013 through June 2014. Since DCI Boiling Springs will have all 14 proposed stations operational for this time period, it assumes that the patient volume for the first two project years will reach the capacity of 56 patients.

...

In order to determine the need for additional stations based on utilization of 3.2 patients per station per week as of the end of the second project year, DCI used the SDR methodology (Step #6) and the total in-center patients as projected above using the SDR methodology.

Year	Total In-Center Patients	Patients per Station	# Existing Stations	Total Stations Needed	Additional Stations Needed
2010	32	3.2	10	10	0
2011	47	3.2	10	15	5
2012	69	3.2	12*	22	10
2013	100	3.2	14	31	17
2014	147	3.2	14	46	32

**The 12 existing stations are based on the average of 10 stations for the first six months and 14 stations for the last six months of the calendar year.*

As shown in the table above, using the SDR methodology, DCI Boiling Springs currently needs five additional stations and is expected to need an additional 32 by the end of the second project year. However, because DCI used a more conservative methodology to project need for the Boiling Springs clinic, it is also reasonable to calculate the utilization of 3.2 patients per stations on the DCI modified need methodology, as shown in the table below.

Year	Total In-Center Patients	Patients per Station	# Existing Stations	Total Stations Needed	Additional Stations Needed
2010	32	3.2	10	10	0
2011	40	3.2	10	13	3
2012*	48	3.2	12	15	3
PY 1	56	3.2	14	18	4
PY 2	56	3.2	14	18	4

Using the more conservative methodology, even after the proposed increase of four stations, DCI Boiling Springs will need an additional four stations by the end of the first year."

The following table illustrates the applicant's projected number of patients based on the above stated assumptions which utilize decreasing growth rates that are much lower than the actual increase per year of 46.2% based on the ESRD Facility Need Method.

Existing DCI Boiling Springs In-Center Patients as of 12/31/10	32
Jan 2011-Dec 2011	32 x 1.25 = 40.0000
Jan 2012- Dec 2012	40.0000 x 1.20 = 48.0000 34 Cleveland County patients + 13 Rutherford County patients + 1 Cherokee, SC patient for a total of 48 projected patients.
Jan 2013 – Dec 2013	48.0000 x 1.167 = 56.0000 40 Cleveland County patients + 14 Rutherford County patients + 2 Cherokee, SC patients for a total of 56 projected patients.
Jan. 2014 – Dec. 2014	56.0000 x 1.0 = 56.0000 40 Cleveland County patients + 14 Rutherford County patients + 2 Cherokee, SC patients for a total of 56 projected patients

[To convert calendar years to project years:
Project Year 1 = ½ x CY12 + ½ x CY13 = 48/2 + 56/2 = 24 + 28 = 52
Project Year 2 = ½ x CY13 + ½ x CY14 = 56/2 + 56/2 = 28 + 28 = 56]

The following shows the average number of in-center patients per station per week and the utilization rate for each of the first two operating years following completion of the project.

Year 1 (July 1, 2012- June 30, 2013)
Patients/Station/Week: 56 in-center patients dialyzing on 14 stations = 4.0
Utilization Rate: 56 patients/ (4 shift-cycles x 14 stations) = 1.0 or 100% utilization

Year 2 (July 1, 2013- June 30, 2014)
Patients/Station/Week: 56 in-center patients dialyzing on 14 stations = 4.0
Utilization Rate: 56 patients/ (4 shift-cycles x 14 stations) = 1.0 or 100% utilization

Analysis of Methodology
Currently there are four dialysis facilities in Cleveland County. The number of stations and patients for the past four years for each facility is shown in the tables below.

Number of Stations

	12/31/07	12/31/08	6/30/09	12/31/09	6/30/10	12/31/10
DCI Boiling Springs	-	10	10	10	10	10
DCI Kings Mt.	12	12	12	12	12	14
DCI Shelby	36	35	35	35	35	25
DCI Shelby South	-	-	-	-	1	10

Source: SDR Reports

Number of Patients

	12/31/07	12/31/08	6/30/09	12/31/09	6/30/10	12/31/10
DCI Boiling Springs	-	22	21	20	26	32
DCI Kings Mt.	44	50	48	46	44	42
DCI Shelby	130	127	116	121	90	91
DCI Shelby South	-	-	-	-	0	35

Source: SDR Reports

Utilization (Patients per Station)

	12/31/10
DCI Boiling Springs	32/10 = 3.2
DCI Kings Mt.	42/14 = 3.0
DCI Shelby	91/25 = 3.6
DCI Shelby South	35/10 = 3.5

Although DCI Boiling Springs had an actual facility increase of 46.2% per year based on the ESRD Facility Need Method as of the June 30, 2011 SDR, its growth has been based on patient referrals from DCI, not from growth in the overall number of patients dialyzing in Cleveland and Rutherford Counties. Cleveland County's Five Year Average Annual Change Rate is 4.1%, while Rutherford County's is 1.5%. Therefore it is unrealistic that DCI Boiling Springs' growth rate would be four – five times the county average [25% vs. 4.1%].

If DCI Boiling Springs' current utilization is projected forward based on the current, published Five Year Average Annual Change Rate of 4.1% for Cleveland County, its growth through FY 2014 would be as follows:

Existing DCI Boiling Springs In-Center Patients as of 6/30/11	35
July 2011-June 2012	35 x 1.041 = 36.4350
July 2012 – June 2013 (PY1)	36.4350 x 1.041 = 37.9288
July 2013 – June 2014 (PY2)	37.9288 x 1.041 = 39.4839

To determine the actual number of stations needed based on the projections resulting from using the Five Year Average Annual Change Rate (FYAACR) of 4.1%; divide the number of projected in-center patients by 3.2, the regulatory standard for the end of PY1, as shown in the following table.

Number of Stations Needed

Year	Total In-Center Patients	Patients per Station	# Existing Stations	Total Stations Needed	Additional Stations Needed
CY10	32	3.2	10	10.00	0
FY11	35	3.2	10	10.94	1
FY12	36	3.2	10	11.25	1
FY13 (PY1)	37	3.2	10	11.56	1
FY14 (PY2)	39	3.2	10	12.19	2

Therefore, projected utilization at the end of Year 1 equals at least 3.2 in-center patients per station per week as required by 10A NCAC 14C .2203(b). The number of in-center patients projected to be served is based on reasonable and supported assumptions regarding future growth.

In summary, the applicant adequately identified the population to be served, however it did not demonstrate the need this population has for four additional stations. It did demonstrate the need for one additional dialysis station. Therefore, the application is conforming to this criterion, subject to the limitation on additional stations to one. See Criterion (4), Condition 2.

BMA d/b/a FMC Cleveland County, proposes to establish a 10-station dialysis facility by relocating two stations from BMA Burke County, an existing 25-station dialysis facility in Burke County; six stations from BMA Hickory, an existing 33-station dialysis facility in Catawba County; one station from BMA Lincolnton, an existing 25-station dialysis facility in Lincoln County; and one station from BMA Kings Mountain, an existing 14-station facility in Gaston County. The proposed facility will be located on Kennedy Street in Shelby, in Cleveland County. The applicant does not propose to add dialysis stations to existing facilities or increase the total number of dialysis stations in the contiguous five-county area. However the applicant is proposing to add 10 dialysis stations in Cleveland County.

Further, in Section III.3, pages 43-54, the applicant states that 26 in-center patients for the proposed 10-station facility will originate from the four facilities identified above: 1 patient from BMA Burke County, 1 patient from BMA Hickory, 1 patient from BMA Lincolnton, and 23 patients from BMA Kings Mountain. Exhibit 22 contains 19 letters from in-center patients and 7 letters from home hemodialysis patients who have indicated an interest in transferring because the proposed facility would be closer to their home. The table below illustrates the number of patients transferred and dialysis stations relocated from the four existing facilities to the proposed facility.

Existing BMA Dialysis Facilities 12/31/10				Proposed Facility
	Beginning	Relocate / Transfer	Remaining	Totals
BMA Burke County				
Stations	25	2	23	2
Patients	73	1	72	1
BMA Hickory				
Stations	33	6	27	6
Patients	112	1	111	1
BMA Lincolnton				
Stations	25	1	24	1
Patients	73	1	72	1
BMA Kings Mountain				
Stations	14	1	13	1
Patients	45	23	22	23
			Total Stations	**10**
			Total In-Center Patients	**26**

Population to be Served

From Section III.3, pages 45-54, the applicant provides the current (June 30, 2011) patient origin for the four BMA facilities contributing stations to the proposed project, as shown in the following tables.

BMA Burke County Census: 6/30/11	# In-Center Patients	# Home Patients
Burke	70	7
Cleveland	1	0
Lincoln	1	0
Caldwell	2	1
McDowell	2	1
Total	**76**	**9**

BMA Hickory Census: 6/30/11	# In-Center Patients	# Home Patients
Catawba	95	18
Caldwell	6	6
Burke	6	4
Alexander	4	2
Lincoln	2	4
Iredell	1	0
Cleveland	1	0
Total	**115**	**34**

BMA Lincolnton Census: 6/30/11	# In-Center Patients	# Home Patients
Lincoln	54	NA, BMA Lincolnton does not offer home dialysis
Cleveland	1	
Catawba	2	
Gaston	9	
Total	**66**	

BMA Kings Mt. Census: 6/30/11	# In-Center Patients	# Home Patients
Gaston	18	NA, BMA Kings Mt. does not offer home dialysis
Cleveland	23	
Total	**41**	

As shown in the tables above, the applicant states that the four dialysis centers proposing to relocate stations to the new facility are currently serving 26 in-center patients from Cleveland County and no home patients from Cleveland County.
In Section III.7, page 57, BMA states:

> *"As of December 31, 2011, there were 238 dialysis patients residing within Cleveland County. Of these, 22 were home dialysis patients (Source: July 2011 SDR, Table B). Of the 22 home dialysis patients, six were home hemo-dialysis patients (Source: SEKC Zip Code reports). Of the six home hemo-dialysis patients, BMA assumes that all were being followed by the BMA Gastonia facility; BMA Gastonia is providing treatment for six Cleveland County home hemo-dialysis patients (Source: BMA records)."*

The following table reflects the number of home hemodialysis patients and home peritoneal dialysis patients dialyzing in the counties served by the four facilities from which BMA is proposing to transfer patients, plus Gaston County.

Home Patients Dialyzing by County

County	# Home Hemodialysis Patients	# Home Peritoneal Dialysis Patients
Alexander	0	7
Burke	0	13
Caldwell	0	12
Catawba	3	26
Cleveland	6	16
Gaston	20	14
Iredell	1	42
Lincoln	5	12
McDowell	2	4

Source: Southeastern Kidney Council's (SKC) June 30, 2011 ESRD Prevalence Report.

In Section III.7, pages 55-60, the applicant provides the following assumptions and methodology used to project utilization. Beginning on page 56, the applicant states:

> *"This project has significant patient support and nephrology physician support. BMA conservatively projects that 37 patients will transfer their care to the new FMC Cleveland County upon completion of this project. Of these 37 patients, BMA projects that 31 will be in-center patients and seven will* [be] *home hemo-dialysis patients.*

The next table identifies the expected county of origin for the patients expected to be dialyzing at FMC Cleveland County during Operating Years 1 and 2 of this project."

County	Operating YR 1 CY14			Operating YR 2 CY15			County Patients as % of Total	
	In-Center	Home Hemo	Home PD	In-Center	Home Hemo	Home PD	Year 1	Year 2
Cleveland	32.2	7.4	1.0	34	7.8	2.0	100 %	100 %
Total	**32.2**	**7.4**	**1.0**	**34**	**7.8**	**2.0**	**100%**	**100%**

As illustrated in the chart above, from page 56, the applicant projects to have an in-center total of 32 patients (32 patients / 10 stations = 3.2 patients per station) by the end of Year 1 and 34 patients (34 patients / 10 stations = 3.4 patients per station) by the end of Year 2 for the 10 proposed stations. However, the applicant does not adequately demonstrate the reasonableness of patients who live in Cleveland County and currently choose to receive treatment in Hickory, Morganton, Lincolnton and Kings Mountain choosing to travel to Shelby, in Cleveland County when they currently have that option, but choose not to use it. In addition, the applicant does not adequately demonstrate that BMA's current Cleveland County patients, particularly those who reside near and receive dialysis at BMA Kings Mountain, actually live closer to the proposed facility than to the facility where they are currently receiving treatment. Further, the applicant provides letters from only 19 in-center patients who have indicated an interest in transferring because the proposed facility would be closer to their home. Therefore, the applicant does not adequately identify the population proposed to be served.

Need for the Proposed Relocation of Stations and Development of a New Facility

The applicant proposes to establish a 10-station dialysis facility by relocating two stations from BMA Burke County, an existing 25-station dialysis facility in Burke County; six stations from BMA Hickory, an existing 33-station dialysis facility in Catawba County; one station from BMA Lincolnton, an existing 25-station dialysis facility in Lincoln County; and one station from BMA Kings Mountain, an existing 14-station facility in Gaston County.

In Section III.7, pages 56-58, the applicant provides the following assumptions:

"***Assumptions:***

1. *BMA assumes that the patient population of FMC Cleveland will be comprised of patients from Cleveland County. BMA is serving a significant number of Cleveland County dialysis patients at its facilities in Burke, Catawba, Lincoln and Gaston Counties.*

2. *BMA assumes that the patient population of Cleveland County will grow at a rate exceeding the current published Five Year Average Annual Change Rate of 4.1%.*

   a. *The Cleveland County Five Year Average Annual Change Rate published within the July 2011 SDR is a function of the growth of the ESRD patient population over the most recent five years.*

   b. *The change rate is not compatible with the significant increase in the ESRD patient population of Cleveland County since December 31, 2009.*

   c. *BMA has evaluated the change in the ESRD patient population of Cleveland County on a quarterly basis since December 31, 2009.*

...

12/31/2009	3/31/2010	6/30/2010	9/30/2010	12/31/2010	3/31/2011	6/30/2011
210	210	221	231	238	239	247

Source: SEKC Zip Code Reports for periods indicated

   d. *The above table demonstrates that the ESRD patient population of Cleveland county* [sic] *has increased from 210 total patients as of December 31, 2009 to 247 patients as of June 30, 2011. This is a raw change of 37 patients or 17.62% in a period of 18 months. This calculates to and* [sic] *average annual change of 11.75%.*

Step 1: *247-210 = 37*
Step 2: *37/210 = .17619048, rounded to 17.62%*
Step 3: *17.62% / 6 quarters = 2.937%*
Step 4: *Multiply 2.937 X 4 quarters to obtain annual change: 11.75%*

   e. *... As the table above demonstrates, the population has increased by 9 patients in the first six months of this year. If that rate were annualized it is equivalent to 18 new patients in 2011, or a rate of 7.56% for this year.*

   f. *The published change rate of 4.1% is not consistent with the realities of Cleveland County for 2010 and 2011.*

   g. *Based upon the foregoing information, BMA suggests that a more appropriate growth rate to be used for Cleveland County patient projections is* ***5.5202%.*** *This is* ***one half*** *of the calculated recent*

annual growth rate for Cleveland County (see d. above). [Emphasis in original.]

3. *BMA also assumes that as the home peritoneal dialysis patient population increases, some home PD patients will begin their care with the new BMA facility. BMA is conservatively projecting few PD patients. ... Rather, BMA assumes that only one new home PD patient will utilize FMC Cleveland County in the first year of operations, and that only two PD patients will utilize the facility in the second year of operations. ...*

4. *BMA assumes that the four DCI dialysis facilities currently operating in Cleveland County will continue to see an increase in their patient populations at a rate as described above, 5.5202%. BMA is not proposing that patients served by those facilities would transfer to the new FMC Cleveland County dialysis facility. Rather, BMA is proposing that any increases in the ESRD patient population of Cleveland County will be a function of existing provider patient populations increasing at a similar rate.*

5. *As of December 31, 2011* [2010] *there were 238 dialysis patients residing within Cleveland County. Of these, 22 were home dialysis patients (Source: July 2011 SDR, Table B). Of the 22 home dialysis patients, six were home hemo-dialysis patients (Source: SEKC Zip Code Reports). Of the six home hemo-dialysis patients, BMA assumes that all were being followed by the BMA Gastonia facility; BMA Gastonia is providing treatment for six Cleveland County home hemo-dialysis patients (Source: BMA records).*

6. *BMA is also providing treatment for 26 in-center dialysis patients at its dialysis facilities in Burke County, Catawba County, Lincoln County and Cleveland County."*

As shown above, the applicant projects a 5.5202% annual growth rate for Cleveland County based on *"**one half** of the calculated recent annual growth rate for Cleveland County (see d. above)"*; not on the Semiannual Dialysis Report (SDR) currently published Five Year Annual Change Rate of 4.1%. [Emphasis in original.] Project analyst calculated one-half of the "calculated rate" referenced in *d* above (11.75%) which equals 5.875%, not 5.5202% [11.75% x .5 = 5.875]. In addition, the "calculated rate" is basically the annual growth rate for the last year (6/30/10 – 6/30/11) [(247 – 221)/221 = 26 / 221 = .117647 or 11.76%], since there was no growth over the first 3 months of the 18-month period the applicant used in its "calculated rate". The methodology used in determining County Need in the SDR includes a Five Year Annual Change Rate in order to smooth out the ups and downs of any one year, including changes in the number of facilities, stations or patients throughout a county and thus provides a more stable, predictive growth rate than using a shorter time period. The 11 station deficit is based on the County Need

Methodology, so the 10 stations proposed to be relocated under ESRD-2: Relocation of Dialysis Stations are the result of the Five Year Annual Change Rate of 4.1% applied to Cleveland County's dialysis population, and not recent growth. The applicant is proposing to develop a new facility and thus does not have a facility growth rate to use in projections. In addition, it did not provide a growth rate for the Cleveland County patients it currently serves in the transferring facilities. Therefore, the most reasonable growth rate to use is the Five Year Annual Change Rate published in the SDR, which is 4.1%: not 11.76% or 5.5202%.

Continuing in Section III.7, page 59, the applicant states *"BMA begins projections of future patient population to be served with the patients it is currently treating."*

The following table illustrates the applicant's projected number of patients based on the assumptions quoted above and a growth rate of 5.5202%.

	In-Center Patients	Home Hemodialysis Patients
Proposed facility begins with Cleveland County patients currently served by BMA as of 12/31/10	26	6
1/1/10 – 12/31/11	26.0000 x 1.055202 = 27.4353	6.0000 x 1.055202 = 6.3312
1/1/12 – 12/31/12	27.4353 x 1.055202 = 28.9497	6.3312 x 1.055202 = 6.6807
1/1/13 – 12/31/13	28.9497 x 1.055202 = 30.5478	6.6807 x 1.055202 = 7.0495
1/1/14 – 12/31/14 **(PY1)**	30.5478 x 1.055202 = **32.2341**	7.0495 x 1.055202 = 7.4386
1/1/15 – 12/31/15 **(PY2)**	32.2341 x 1.055202 = **34.0135**	7.4386 x 1.055202 = 7.8493

If the applicant used the Five Year Annual Change Rate of 4.1%, as shown in the table below, the applicant would not meet the performance standard of at least 3.2 patients per week, per station by the end of the first operating year. See 10A NCAC 14C .2203.

	In-Center Patients	Home Hemodialysis Patients
Proposed facility begins with Cleveland County patients currently served by BMA as of 12/31/10	26	6
1/1/10 – 12/31/11	26.0000 x 1.041 = 27.0660	6.0000 x 1.041 = 6.2460
1/1/12 – 12/31/12	27.0660 x 1.041 = 28.1757	6.2460 x 1.041 = 6.5021
1/1/13 – 12/31/13	28.1757 x 1.041 = 29.3309	6.5021 x 1.041 = 6.7687
1/1/14 – 12/31/14 **(PY1)**	29.3309 x 1.041 = **30.5335**	6.7687 x 1.041 = 7.0462
1/1/15 – 12/31/15 **(PY2)**	30.5335 x 1.041 = **31.7853**	7.0462 x 1.041 = 7.3351

In Section III.3, page 43, the applicant states *"This proposal is designed to make more effective use of existing certified dialysis stations."* Further, in Section III.9, page 61, the applicant states:

"a) BMA considered not applying to develop this facility. However, as noted within the application BMA is serving a significant number of Cleveland County dialysis patients. BMA expects this patient population to continue to increase based upon the patient relationship with BMA facilities and the presence of Metrolina Nephrology Associates.

b) BMA could have chosen another part of the county for development of the facility. However, as described within this application, development in Shelby is the most logical of choices."

Cleveland County already has four dialysis facilities; two of which are in Shelby. Further, in Exhibit 22, Patient Letters of Support, the applicant includes 26 letters from BMA patients who live in Cleveland County: 19 letters from in-center patients and 7 from home hemodialysis patients. Of the in-center letters, 79% (15 / 19 = .79) have a Kings Mountain ZIP Code, 3 have ZIP Codes from the northern part of the county, and 1 has a Shelby ZIP Code. If only 19 patients transfer, the new facility would serve 22 patients per week, or 2.2 patients per station, by the end of the first operating year

In summary, the applicant does not adequately identify the population to be served by the proposed relocation of stations, transfer of patients and development of a new dialysis facility; and does not adequately demonstrate the need this population has for the proposed project, in the proposed location. Therefore, the application is non-conforming with 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.

NA
DCI Shelby
DCI Boiling Springs

NC
BMA

In Section III.6, page 54, the **FMC Cleveland** states:

"Not applicable. This is an application to transfer existing certified stations from the four BMA facilities to develop FMC Cleveland County in Cleveland County. To the extent that this could be considered a reduction in service at BMA Burke County, BMA Lincolnton, BMA Hickory or BMA Kings Mountain, BMA notes that the projected

utilization at these facilities is not negatively impacted and no patients will be denied treatment as a result of this transfer (See discussion at III.3 (c). BMA Burke County, BMA Hickory, BMA Lincolnton, BMA Kings Mountain will continue to have capacity to accept dialysis patients. BMA will apply for additional stations at these facilities using the Facility Need Methodology as each demonstrates need for additional stations. BMA has specifically discussed the future potential need for additional stations at BMA Hickory."

This Criterion is applicable to the proposed reduction in service at BMA Burke County, BMA Lincolnton, BMA Hickory and BMA Kings Mountain.

According to the applicant, 56% (23/41 = .561) of the patients dialyzing at BMA Kings Mountain are from Cleveland County, which is reasonable since the BMA Kings Mountain facility is less than 750 feet from the Cleveland County line, and the majority of Kings Mountain is in Cleveland County. In addition, BMA Kings Mountain is 15.4 miles from to DCI Shelby South, 17.3 miles from DCI Shelby and 15 miles from the proposed location.

Distance Between Facilities

	DCI Shelby	DCI Shelby South	Proposed Location Kennedy St., Shelby	DCI Boiling Springs
BMA Kings Mountain	17.3 miles, 25 minutes	15.4 miles, 21 minutes	15 miles, 22 minutes	23.8 miles, 35 minutes
Kennedy Street, Shelby	2.2 miles, 5 minutes	2.9 miles, 8 minutes		12.5 miles, 21 minutes

The following table shows the current utilization of the four BMA facilities as well as the expected utilization after the proposed station relocations.

Existing BMA Dialysis Facilities 12/31/10				Proposed Utilization Subtracting Relocations*
	Beginning	Current Utilization	Remaining	
BMA Burke County				
Stations	25	2.92	23	3.13
Patients	73	73%	72	78%
BMA Hickory				
Stations	33	3.39	27	4.11
Patients	112	85%	111	103%
BMA Lincolnton				
Stations	25	2.92	24	3.00
Patients	73	73%	72	75%
BMA Kings Mountain				
Stations	14	3.21	13	1.69
Patients	45	80%	22	42%

* Assuming total # of patients stays constant.

Assuming that the number of patients the applicant contends will transfer from each existing facility actually transfer, this proposal would leave BMA Hickory operating at 103% of capacity and would unable to serve all of its remaining patients without either

offering a third shift or developing additional stations. Further, updated data shows that by June 30, 2011, the number of in-center patients dialyzing at BMA Hickory had increased to 115, which would increase utilization of the facility to 106% of capacity, exacerbating the issue.

The applicant's projected patient transfer from BMA Kings Mountain would leave that facility seriously underutilized at 42% of capacity. Further, updated data shows that by June 30, 2011, the number of in-center patients at BMA Kings Mountain had decreased to 41, further lowering its utilization after project completion to only 35% of capacity.

In summary, the applicant does not adequately demonstrate that the needs of the population presently served will be met by the proposed relocation or that the effect of the 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 will not be negative. Therefore, the application is non-conforming with 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.

CA
DCI Shelby
DCI Boiling Springs

NC
FMC Cleveland

DCI Shelby - In Section III.9, pages 54-58, **DCI Shelby** discusses the alternatives it considered to meet the need for the proposed services. The application is conforming to the facility need methodology for additional stations. See Criterion (1) for discussion. Furthermore, the applicant adequately demonstrates the need for four additional stations based on the number of in-center patients it proposes to serve. See Criterion (3) for discussion. The application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (7), (8), (13), (14), (18a), (20) and 10A NCAC 14C .2200 for discussion. The applicant adequately demonstrates that the proposal to add four dialysis stations is its least costly or most effective alternative. Consequently, the application is conforming to this criterion and approved subject to the following conditions:

1. **Dialysis Clinic, Inc. d/b/a DCI Shelby shall materially comply with all representations made in its certificate of need application.**

2. **Dialysis Clinic, Inc. d/b/a DCI Shelby shall be certified for no more than 29 dialysis stations, which shall include any home hemodialysis and isolation stations, upon completion of this project.**

3. **Dialysis Clinic, Inc. d/b/a DCI Shelby shall install plumbing and electrical wiring through the walls for no more than four additional dialysis stations for a total of 29 stations, which shall include any home hemodialysis and isolation stations, upon completion of this project.**

4. **Dialysis Clinic, Inc. d/b/a DCI Shelby shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

DCI Boiling Springs - In Section III.9, pages 54-57, **DCI Boiling Springs** discusses the alternatives it considered to meet the need for the proposed services. The application is conforming to the facility need methodology for additional stations. See Criterion (1) for discussion. Furthermore, as conditioned, the applicant adequately demonstrates the need for one additional station based on the number of in-center patients it proposes to serve. See Criterion (3) for discussion. The application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (7), (8), (13), (14), (18a), (20) and 10A NCAC 14C .2200 for discussion. As conditioned, the applicant adequately demonstrates that the proposal to add one dialysis stations is a least costly or most effective alternative. Consequently, the application is conforming to this criterion and approved subject to the following conditions:

1. **Dialysis Clinic, Inc. d/b/a DCI Boiling Springs shall materially comply with all representations made in its certificate of need application.**

2. **Dialysis Clinic, Inc. d/b/a DCI Boiling Springs shall be certified for no more than 11 dialysis stations, which shall include any home hemodialysis and isolation stations, upon completion of this project.**

3. **Dialysis Clinic, Inc. d/b/a DCI Boiling Springs shall install plumbing and electrical wiring through the walls for no more than one additional dialysis station for a total of 11 stations, which shall include any home hemodialysis and isolation stations, upon completion of this project.**

4. **Dialysis Clinic, Inc. d/b/a DCI Boiling Springs shall acknowledge acceptance of and agree to comply with all conditions stated herein to the Certificate of Need Section in writing prior to issuance of the certificate of need.**

FMC Cleveland - In Section III.9, page 61, BMA discusses the alternatives it considered to meet the need for the proposed services, including not applying to develop the facility and choosing another part of Cleveland County to locate the proposed facility. The application is consistent with Policy ESRD-2: Relocation of Dialysis Stations. See Criterion (1) for discussion. However, the applicant does not adequately demonstrate that this proposal is the least costly or most effective alternative. The applicant does not adequately demonstrate the need to relocate 10 stations and develop a new dialysis facility in Cleveland County, based on the current number of in-center patients it reasonably proposes to serve and on the current treatment location of the in-center patients it proposes to transfer to serve. The applicant fails to adequately demonstrate that Shelby is the best location for developing a new facility to serve Cleveland County patients currently served by BMA in other counties. In Section III.3, pages 53-54, the applicant uses total Cleveland County ESRD patient origin by ZIP code, to justify Shelby as the appropriate location. However, the ZIP code data provided in support letters from 19 in-center patients and 7 home-hemodialysis patients indicates the majority of BMA's Cleveland County patients live in the Kings Mountain ZIP Code 28086. See Criterion (3) for discussion. In addition, on the map provided by BMA, the locations of BMA's Cleveland County patients do not indicate a need for a facility in Cleveland County, in Shelby. Furthermore, the application is an unnecessary duplication of services. See discussion in Criterion (6). The application is non-conforming to the following applicable statutory and regulatory criteria: (3), (5), (6), (12) (18a), (20) and 10A NCAC 14C .2200. See each Criterion for discussion. The applicant does not adequately demonstrate that the proposal to relocate ten dialysis stations and develop a new facility in Cleveland County is its least costly or most effective alternative. Consequently, the application is non- conforming to this criterion and is disapproved.

(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
DCI Shelby
DCI Boiling Springs

NC
FMC Cleveland

DCI Shelby - In Section VIII.1, page 83, **DCI Shelby** states the capital cost of the proposed project is projected to be $66,000. In Section IX, page 90, the applicant states that there will be no start-up costs or initial operating expenses.

In Section VIII.2, page 86, DCI Shelby states it will fund the capital costs of the project from the accumulated reserves of DCI Shelby. Exhibit 20 contains a letter, dated August 31, 2011, from the Secretary and Treasurer which states in part:

"As the Secretary and Treasurer for Dialysis Clinic, Inc., I am responsible for the financial operations of the corporation. As such, I am very familiar with the financial position of DCI Shelby. DCI Shelby reserve funds totaling $66,000 will be used for the purchase of new dialysis machines, chairs and televisions for the four additional stations to be restored at the DCI Shelby clinic. No new services are proposed; therefore there are no start-up or initial operating costs for the project.

For verification of reserve funds available for this project, please see the June 2011 [sic] *balance sheet for DCI Shelby indicating an available cash amount of $6,772,800, which is more than sufficient to fund this project."*

In Exhibit 21, the applicant provides FFY09 and FFY10 financial statements for DCI Shelby which document that DCI Shelby had $6,183,859 in cash and cash equivalents as of September 30, 2010. The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In pages 105-110, the applicant projects revenues will exceed expenses in the first two years of operation after completion of the project.

In Section X, pages 92-93, and in the financials in pages 105-110, the applicant projects revenues and operating costs. The following table illustrates the allowable charge per patient treatment in 2010, as reported by the applicant on page 92.

Source of Payment	Charge per Treatment
Private Pay	NA
Medicare	$152.00
Medicaid	$145.00
Blue Cross/Blue Shield	$980.00
Commercial Insurance	$547.00
VA	$319.00

The rates shown above are consistent with the standard Medicare/Medicaid rates established by the Centers for Medicare and Medicaid Services. The applicant states in the notes to the financials, page 108 *"Hemodialysis treatments per year are based on the assumption of 3 treatments per week, 52 weeks per year, less 7% missed treatments, based on DCI's historical experience."*

The applicant projects 96 in-center patients and 13,926 treatments in Year One. At 100% attendance, 96 patients would have 14,976 treatments in Year One [96 x 3 = 288; 288 x 52 = 14,976]. After deducting 7% of the treatments as missed treatments, the applicant projects 13,926 treatments for Year One [14,976 x 7% = 1,048.3; 14,976 – 1,048 = 13,928]. The applicant projects 98 in-center patients and 14,216 treatments in Year Two. At 100% attendance, 98 patients would have 15,288 treatments in Year One [98 x 3 = 294; 294 x 52 = 15,288]. After deducting 7% of the treatments as missed treatments, the

applicant projects 14,216 treatments for Year One [15,288 x 7% = 1,070.2; 15,288 – 1,070 = 14,218]. Therefore, the applicant has under-projected its revenue.

The applicant adequately demonstrates that the financial feasibility of the proposal is based on reasonable projections of revenues and operating costs. Therefore, the application is conforming with this criterion.

DCI Boiling Springs - In Section VIII.1, page 83, **DCI Boiling Springs** states the capital cost is projected to be $70,000. In Section IX, page 90, the applicant states that there will be no start-up costs or initial operating expenses.

In Section VIII.2, page 86, DCI Boiling Springs states it will fund the capital costs of the project from the accumulated reserves of DCI Shelby. Exhibit 18 contains a letter, dated August 31, 2011, from the Secretary and Treasurer which states in part:

> *"As the Secretary and Treasurer for Dialysis Clinic, Inc., I am responsible for the financial operations of the corporation. As such, I am very familiar with the financial position of DCI Shelby, the funding source for the DCI Boiling Springs project. DCI Shelby reserve funds totaling $70,000 will be used to purchase new dialysis machines, chairs, televisions and plumbing connectors for the four additional stations to be developed at the DCI Boiling Springs clinic. No new services are proposed; therefore there are no start-up or initial operating costs for the project.*
>
> *For verification of reserve funds available for this project, please see the June 2011* [sic] *balance sheet for DCI Shelby indicating an available cash amount of $6,772,800, which is more than sufficient to fund this project."*

In Exhibit 19, the applicant provides FFY09 and FFY10 financial statements for DCI Shelby which document that DCI Shelby had $6,183,859 in cash and cash equivalents as of September 30, 2010. The applicant adequately demonstrated the availability of sufficient funds for the capital needs of the project.

In pages 105-109, the applicant projects revenues will exceed expenses in the first two years of operation after completion of the project.

In Section X, pages 92-93, and in the financials in pages 105-109, the applicant projects revenues and operating costs. The following table illustrates the allowable charge per patient treatment in 2010, as reported by the applicant on page 92.

Source of Payment	Charge per Treatment
Private Pay	NA
Medicare	$153.00
Medicaid	$145.00
Commercial Insurance	$333.00

The rates shown above are consistent with the standard Medicare/Medicaid rates established by the Centers for Medicare and Medicaid Services. The applicant states in the notes to the financials, page 107 *"Hemodialysis treatments per year are based on the assumption of 3 treatments per week, 52 weeks per year, less 7.0% missed treatments, based on DCI's historical experience of missed treatments."*

The applicant projects 56 in-center patients and 8,125 treatments in Year One and in Year Two. At 100% attendance, 56 patients would have 8,736 treatments in Year One and in Year Two [56 x 3 = 168; 168 x 52 = 8,736]. After deducting 7% of the treatments as missed treatments, the applicant projects 8,124 treatments for Year One and for Year Two [8,736 x 7% = 611.52; 8,736 – 612 = 8,124]. Therefore, the applicant has under-projected its revenue.

The applicant adequately demonstrates that the financial feasibility of the proposal is based on reasonable projections of revenues and operating costs. Therefore, the application is conforming with this criterion. However, see Criterion (3) for a discussion of the number of stations needed.

FMC Cleveland - In Section VIII.1, page 80, BMA states the capital cost is projected to be $857,751. In Section IX, pages 85-86, the applicant states that total start-up costs and initial operating expenses will be $1,091,217. However, the projected start-up costs and initial operating expenses are based on unreasonable projections of patient volume; therefore the start-up costs and initial operating costs are also unreasonable.

In Section VIII.2, page 82, BMA states it will fund the capital costs of the project from corporate accumulated reserves. Exhibit 24 contains a letter, dated September 15, 2011, from the Vice President of Fresenius Medical Care Holdings, Inc. which states in part:

> *"This is to inform you that Fresenius Medical Care Holdings, Inc. is the parent company of National Medical Care, Inc. and Bio-Medical Applications of North Carolina, Inc.*
>
> *BMA proposes to develop a new 10 station dialysis facility in Shelby, Cleveland County by transferring existing certified dialysis stations from contiguous counties into Cleveland County. The project calls* [for] *the following capital expenditures on behalf of BMA.*
>
> *Capital Expenditure* *$857,751*
>
> *As Vice President, I am authorized and do hereby authorize the development of this 10 station dialysis facility, Fresenius Medical Care of Cleveland County, for capital costs of $857,751. Further, I am authorized and do hereby authorize and commit all necessary cash and cash reserves for the start-up and working capital which may be needed for this project."*

In Exhibit 10, the applicant provides CY09 and CY10 financial statements for Fresenius Medical Care Holdings, Inc. and Subsidiaries which document that Fresenius Medical Care Holdings, Inc. and Subsidiaries had $163,292,000 in cash and cash equivalents as of December 31, 2010. In addition, as of December 31, 2010, the applicant had Total Current Assets of $2,753,682,000, Total Assets of $12,017,618,000, and Total Net Assets of $6,561,629,000 [total assets – total liabilities]. The applicant adequately demonstrates the availability of sufficient funds for the capital needs of the project.

In Section X, pages 89 and 94, the applicant projects revenues will exceed expenses in the first two years of operation after completion of the project, as shown in the table below.

Projected Revenues and Operating Costs for Years One and Two

	Year 1	Year 2
Projected Net Revenue	$1,636,735	$1,761,822
Projected Total Operating Costs	$1,484,155	$1,585,969
Projected Surplus/deficit*	$152,580	$175,853

* Calculated by Project Analyst.

The following table illustrates the allowable charge per patient treatment, as reported by the applicant in Section X.1, page 88.

BMA's Allowable Charge per Treatment

Source of Payment	In-Center	Home PD	Home Hemo
Private Pay	$1,375.00	$550.20	$1,375.00
Medicare	$234.00	$234.00	$234.00
Medicaid	$137.29	$55.41	$137.29
Commercial Insurance	$1,375.00	$550.20	$1,375.00
VA	$146.79	$63.39	$147.85

The rates shown above are consistent with the standard Medicare/Medicaid rates established by the Centers for Medicare and Medicaid Services.

The applicant projects 31 in-center patients and 4,522 treatments in Year One. At 100% attendance, 31 patients would have 4,836 treatments in Year One [31 x 3 = 93; 93 x 52 = 4,836]. After deducting 6.5% of the treatments as missed treatments, the applicant projects 4,522 treatments for Year One [4,836 x 6.5% = 314; 4,836 – 314 = 4,522]. The applicant projects 33 in-center patients and 4,813 treatments in Year Two. At 100% attendance, 33 patients would have 5,148 treatments in Year Two [33 x 3 = 99; 99 x 52 = 5,148]. After deducting 6.5% of the treatments as missed treatments, the applicant projects 4,813 treatments for Year Two [5,148 x 6.5% = 335; 5,148 – 335 = 4,813]. Therefore, the applicant has under-projected its revenue. However the projected revenue is based on unreasonable projections of patient volume, therefore the projected revenue is also unreasonable.

The applicant does not adequately demonstrate that the financial feasibility of the proposal is based on reasonable projections of revenues and operating costs. Therefore, the application is non-conforming with 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.

C
DCI Shelby

CA
DCI Boiling Springs

NC
FMC Cleveland

DCI Shelby proposes to add four dialysis stations to the existing DCI Shelby facility for a total of 29 dialysis stations upon completion of this project. The applicant adequately demonstrates the need to add four stations based on the number of in-center patients it currently serves and the number it proposes to serve. See Section III.7, pages 53-54, Section III.9, pages 54-58, and Section V.7, pages 71-72. See Criteria (1) and (3) for additional discussion. The applicant adequately demonstrates that the proposal will not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is conforming with this criterion.

DCI Boiling Springs proposes to add four dialysis stations to the existing DCI Boiling Springs facility for a total of 14 dialysis stations upon completion of this project. The applicant adequately demonstrates the need to add one, not four stations based on the number of in-center patients it currently serves and the number it proposes to serve. See Section III.7, page 53, Section III.9, pages 54-57, and Section V.7, pages 70-72. See Criteria (1) and (3) for additional discussion. The applicant adequately demonstrates that the proposal as conditioned will not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is conforming with this criterion, subject to the condition to add one station in Condition 2, Criterion (4).

FMC Cleveland proposes to relocate ten dialysis stations and transfer 26 in-center patients to develop a dialysis facility in Shelby, Cleveland County. The following table shows the current utilization of the transferring facilities as well as the expected utilization after the proposed transfers.

Existing BMA Dialysis Facilities 12/31/10				Proposed Utilization Subtracting Transfers*
	Beginning	Current Utilization	Remaining	
BMA Burke County				
Stations	25	2.92	23	3.13
Patients	73	73%	72	78%
BMA Hickory				
Stations	33	3.39	27	4.11
Patients	112	85%	111	103%
BMA Lincolnton				
Stations	25	2.92	24	3.00
Patients	73	73%	72	75%
BMA Kings Mountain				
Stations	14	3.21	13	1.69
Patients	45	80%	22	42%

* Assuming total # of patients stays constant.

The proposed relocation of only 1 station and 22 patients from BMA Kings Mountain would leave that facility severely underutilized, operating at only 42% of capacity. Further, updated data shows that by June 30, 2011, the number of in-center patients at BMA Kings Mountain had decreased to 41, further lowering its projected utilization to 35% of capacity.

According to the applicant, 56% (23/41 = .561) of the patients dialyzing at BMA Kings Mountain are from Cleveland County. The BMA Kings Mountain facility is less than 750 feet from the Cleveland County line, and the majority of Kings Mountain is in Cleveland County. Cleveland County has 4 ESRD facilities; 2 of which are in Shelby. In addition, BMA Kings Mountain is 15.4 miles from DCI Shelby South, 17.3 miles from DCI Shelby and 15 miles from the proposed location.

Distance Between Facilities

	DCI Shelby	DCI Shelby South	Proposed Location Kennedy St., Shelby	DCI Boiling Springs
BMA Kings Mountain	17.3 miles, 25 minutes	15.4 miles, 21 minutes	15 miles, 22 minutes	23.8 miles, 35 miles
Kennedy Street, Shelby	2.2 miles, 5 minutes	2.9 miles, 8 minutes		12.5 miles, 21 minutes

The applicant does not adequately demonstrate the need to relocate ten stations and develop a new facility in Shelby based on the location and number of in-center patients it currently serves from Cleveland County, the number of patients it proposes to serve, and the location where it proposes to serve the transferred patients. See Section III.3, pages 43-54, Section III.7, pages 55-60, Section III.9, page 61, and Section V.7, pages 70-71. See Criteria (3) and (3a) for additional discussion. The applicant's proposal will result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is non-conforming with 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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

In Exhibit 19, page 266, **DCI Shelby** provides its current and proposed staffing table. The applicant states that three additional full-time equivalent (FTE) positions will be required as a result of this project. Exhibit 17 contains a letter from Aamir Iqbal, MD stating that he is the current Medical Director of DCI Shelby and supports the proposed expansion of the facility. The information regarding staffing provided in Exhibit 19 is reasonable and credible and supports a finding of conformity with this criterion.

In Exhibit 6, page 158, **DCI Boiling Springs** provides its current and proposed staffing table. The applicant states that three additional full-time equivalent (FTE) positions will be required as a result of this project. Exhibit 16 contains a letter from Syed Ahmed, MD stating that he is the current Medical Director of DCI Boiling Springs and supports the proposed expansion of the facility. The information regarding staffing provided in Exhibit 6 is reasonable and credible and supports a finding of conformity with this criterion, subject to the limitation on additional stations to one. See Criterion (4) Condition 2.

In Section VII.1, page 76, **FMC Cleveland** provides its proposed staffing table. The applicant states that 7.93 full-time equivalent (FTE) positions will be required to staff the proposed 10 station facility. Exhibit 21 contains a letter from M. Gene Radford, Jr., MD stating that he has agreed to serve as the Medical Director of the proposed FMC Cleveland facility. The information regarding staffing provided in Section VII is reasonable and credible and supports a finding of conformity with 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.

C
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section V.1, page 62, **DCI Shelby** lists the providers of the necessary ancillary and support services, and in Sections V.2, pages 64-66, V.4, pages 67-68, and

V.5, pages 68-69, illustrates how the project will be coordinated with the existing health care system. The information provided in Section V is reasonable and credible and supports a finding of conformity with this criterion.

DCI Boiling Springs - In Section V.1, pages 61-62, **DCI Boiling Springs** lists the providers of the necessary ancillary and support services, and in Sections V.2, pages 63-65, V.4, pages 67-68, and V.5, pages 68-69, illustrates how the project will be coordinated with the existing health care system. The information provided in Section V is reasonable and credible and supports a finding of conformity with this criterion.

FMC Cleveland - In Section V.1, pages 66-67, BMA lists the providers of the necessary ancillary and support services, and in Sections V.2, pages 67-68, V.4, pages 68-69, and V.5, pages 69-70, illustrates how the project will be coordinated with the existing health care system. Although neither BMA nor Metrolina Nephrology Associates currently have a relationship or privileges at Cleveland Regional Medical Center, each state they will establish a relationship/privileges with the hospital if the proposal is approved. The information provided in Section V is reasonable and credible and supports a finding of conformity with this criterion.

(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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

(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.

NA
DCI Shelby
DCI Boiling Springs

C
FMC Cleveland

FMC Cleveland – In Section XI, pages 96-99, the applicant discusses the primary and secondary sites for the proposed dialysis facility. The applicant plans to upfit leased space. The primary site has not been developed yet. The applicant states that the primary site will provide easy access from a major highway, Business-74 (north-south), through Shelby and the secondary site is easily accessible from local area thoroughfares. The applicant also proposes that both sites are close to many current BMA dialysis patients and close to the local hospital. Both sites are currently zoned for a dialysis center. On page 101, the applicant states the facility will be 4,666 square feet with energy saving features as described on pages 99-100. Therefore, the applicant adequately demonstrates that for the project as proposed, the cost, design and means of construction represent the most reasonable alternative and that the construction project would not unduly increase the costs of or charges for providing health services if the project were approvable. 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
DCI Selby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section VI.1(b), page 73, **DCI Shelby** reports that 86.5% of the patients who received treatment at DCI Shelby had some or all of their services paid for by Medicare or Medicaid. The applicant demonstrates that it currently provides adequate access to medically underserved populations. Therefore, the application is conforming to this criterion.

DCI Boiling Springs - In Section VI.1(b), page 73, **DCI Boiling Springs** reports that 85.3% of the patients who received treatment at DCI Boiling Springs had some or all of their services paid for by Medicare or Medicaid. The applicant demonstrates that it currently provides adequate access to medically underserved populations. Therefore, the application is conforming to this criterion.

FMC Cleveland - In Section VI.1(c), pages 72-73, **FMC Cleveland** states that 82.6% of the patients who are projected to receive treatment at the proposed facility will have some or all of their services paid for by Medicare or Medicaid. The applicant further states:

> *"Projections of future reimbursement are a function of historical performance of the facilities contributing stations to this project. The facilities contributing stations to the project are operating in contiguous counties. BMA believes that the economic complexion of these counties is similar to Cleveland County and that it is therefore appropriate to use a blended payor mix from these facilities to develop the projected payor mix."*

The applicant demonstrates that it projects to provide adequate access to medically underserved populations. Therefore, 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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section VI.1(f), page 75, **DCI Shelby** states:

"None of the DCI clinics have any obligation under any federal regulations to provide uncompensated care, community service or access by minorities and handicapped persons. However, during fiscal year 2010, DCI provided more than $635,000 in bad debt and charity care or approximately 10 percent of its gross revenue."

In Section VI.6(a), page 77, the applicant states:

"There have been no civil rights equal access complaints filed against DCI Shelby, DCI Kings Mountain, DCI Boiling Springs, DCI South or Dialysis Clinic, Inc., the parent company, during the past five years."

The application is conforming to this criterion.

DCI Boiling Springs - In Section VI.1(f), page 75, **DCI Boiling Springs** states:

"None of the DCI clinics have any obligation under any federal regulations to provide uncompensated care, community service or access by minorities and handicapped persons. However, during fiscal year 2010, DCI Boiling Springs provided more than $49,486 in bad debt and charity care."

In Section VI.6(a), page 77, the applicant states:

"There have been no civil rights equal access complaints filed against DCI Shelby, DCI Kings Mountain, DCI Boiling Springs, DCI South or Dialysis Clinic, Inc., the parent company, during the past five years."

The application is conforming to this criterion.

FMC Cleveland – In Section VI.1(f), page 74, BMA states:

> *"BMA of North Carolina facilities do not have any obligation to provide uncompensated care or community service under any federal regulations. The facility will be responsible to provide care to both minorities and handicapped people. The applicant will treat all people the same regardless of race or handicap status. In accepting payments from Medicare, Title XVIII of the Social Security Act, and Medicaid, Title XIX, all BMA North Carolina Facilities are obligated to meet federal requirements of the Civil Rights Act, Title VI and the Americans with Disabilities Act."*

The application is conforming to this criterion.

(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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section VI.1(a), page 73, **DCI Shelby** states:

> *"Because of this commitment, DCI willingly serves **any and all population groups** without regard to income, race or ethnic minority, sex, ability, age, or any perceived underserved status. ... DCI's commitment to its patients is exemplified in its admission policy and its equal treatment policy. Please see Exhibit 6 for copies of these policies."* [Emphasis in original.]

In Section VI.1(c), page 74, DCI Shelby projects that that 86.5% of in-center patients will have some or all of their services paid for by Medicare or Medicaid, as illustrated in the following table.

DCI Shelby – Projected Utilization by Payor Source

Payor	Percent Utilization by Payor	
	% In-Center Patients	% Home Patients
Medicare	81.3%	33.3%
Medicaid	5.2%	4.8%
Commercial Insurance	5.2%	23.8%
VA	5.2%	14.3%
Blue Cross/Blue Shield	3.1%	23.8%
TOTAL	100.0%	100.0%

The applicant demonstrated that medically underserved populations will have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

DCI Boiling Springs - In Section VI.1(a), page 73, **DCI Boiling Springs** states:

> *"Because of this commitment, DCI willingly serves **any and all population groups** without regard to income, race or ethnic minority, sex, ability, age, or any perceived underserved status. ... DCI's commitment to its patients is exemplified in its admission policy and its equal treatment policy. Please see Exhibit 5 for copies of these policies."* [Emphasis in original.]

In Section VI.1(c), page 74, DCI Boiling Springs projects that that 85.3% of in-center patients will have some or all of their services paid for by Medicare or Medicaid, as illustrated in the following table.

DCI Boiling Springs – Projected Utilization by Payor Source

Payor	% In-Center Patients
Medicare	82.4%
Medicaid	2.9%
Commercial Insurance	14.7%
TOTAL	**100.0%**

The applicant demonstrated that medically underserved populations will have adequate access to the proposed services. Therefore, the application is conforming to this criterion.

FMC Cleveland – In Section VI.1(a), page 72, BMA states:

> *"BMA has a long history of providing dialysis services to the underserved populations of North Carolina. ...Each of our facilities has a patient population which includes low-income persons, racial and ethnic minorities, women, handicapped persons, elderly, or other traditionally underserved persons. The patient population of the FMC Cleveland County facility is expected to be similar to the facilities contributing stations to the project, and will likely be comprised of the following:*

Facility	*Medicaid/ Low Income*	*Elderly (65+)*	*Medicare*	*Women*	*Racial Minorities*
FMC Cleveland County	*3.60%*	*40.14%*	*75.86%*	*41.64%*	*37.58%*

Note: The Medicare percentage here represents the percentage of patients receiving some type of Medicare benefit. This is not to say that 75.86% of the facility treatment reimbursement is from Medicare.

In Section VI.1(c), page 73, BMA projects that that 82.6% of in-center patients will have some or all of their services paid for by Medicare or Medicaid, as illustrated in the following table.

FMC Cleveland County – Projected Utilization by Payor Source

Payor	Percent Utilization by Payor	
	% In-Center Patients	% Home Patients
Medicare	80.0%	64.0%
Medicaid	2.6%	0.0%
Commercial Insurance	11.0%	33.0%
VA	6.4%	3.0%
Self/Indigent	0.1%	0.0%
TOTAL	100.0%	100.0%

The applicant further states:

> *"Projections of future reimbursement are a function of historical performance of the facilities contributing stations to this project. The facilities contributing stations to the project are operating in contiguous counties. BMA believes that the economic complexion of these counties is similar to Cleveland County and that it is therefore appropriate to use a blended payor mix from these facilities to develop the projected payor mix for this facility."*

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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section VI.5, page 76, **DCI Shelby** describes the range of means by which patients will have access to the proposed services:

"Any patient with a medical need for dialysis treatments may be admitted to DCI clinics by any nephrologist who has admitting privileges with the clinic. To facilitate patient access, DCI has an open-door policy regarding physician admitting privileges and any licensed nephrologist may apply to admit his or her patients to any of the DCI clinics, including the Shelby clinic."

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

DCI Boiling Springs - In Section VI.5, page 76, **DCI Boiling Springs** describes the range of means by which patients will have access to the proposed services:

"Any patient with a medical need for dialysis treatments may be admitted to DCI clinics by any nephrologist who has admitting privileges with the clinic. To facilitate patient access, DCI has an open-door policy regarding physician admitting privileges and any licensed nephrologist may apply to admit his or her patients to any of the DCI clinics, including the Boiling Springs clinic."

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

FMC Cleveland - In Section VI.5, page 74, **BMA** describes the range of means by which patients will have access to the proposed services:

"Those Nephrologists who apply for and receive medical staff privileges will admit patients with End Stage Renal Disease to the facility. FMC Cleveland County will have an open policy, which means that any Nephrologist may apply to admit patients at the facility. The attending physicians receive referrals from other physicians or Nephrologists or hospital emergency rooms."

The information provided in Section VI.5 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
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - In Section V.3(a), page 66, **DCI Shelby** states:

"DCI Shelby has well established relationships with clinical programs in the area. For example, the Cleveland County Emergency Medical Services utilizes the DCI Shelby facility as a training site for advanced life support, critical care and paramedic training for students. DCI provides didactic education as well as clinical instruction on-site for these students. Additionally, DCI Shelby offers the dialysis facility as a clinical training internship site for Gardner-Webb University's senior nursing students who are under the direction of a registered nurse. Cleveland Community College allied health students as well as Crest High School's health occupation students have clinical access to DCI Shelby and will continue with these rotations following completion of this project. See Exhibit 16 for documentation of some of these well-established clinical relationships.

Winston Salem State University and Western Carolina University also use DCI as a clinical experience for BSN students in the management area as well as dietitians and social workers. This clinical training is provided on an as-needed basis.

All of these clinical training programs are supportive of the proposed project and some have submitted letters to document that support. See Exhibit 23."

In Section V.3(c), page 67, DCI Shelby states:

"At the present time, the only clinical programs that have indicated a need for clinical rotations for their students are the programs already established with DCI Shelby. Certainly, other programs that have a need for clinical training sites for their students would be welcome. ...

In addition to offering its facilities for clinical rotations, DCI has endowed two scholarships ($25,000 each) for nursing students to allow qualified students to enter the nursing program at Gardner Webb University"

The information provided in Section V.3 is reasonable and credible and supports a finding of conformity with this criterion.

DCI Boiling Springs - In Section V.3(a), pages 65-66, **DCI Boiling Springs** states:

"As existing dialysis facilities that operate under the same management, DCI Shelby, DCI Boiling Springs, DCI Kings Mountain and DCI South have well established relationships with clinical programs in the Cleveland County area. Although DCI Boiling Springs has only been in operation for four years, the DCI clinic has taken advantage of its relationship with the other DCI clinics to establish its own clinical training relationships with area programs. For example, the Cleveland County Emergency Medical Services utilizes the DCI Boiling Springs facility as a training site for advanced life support, critical care and paramedic training for students. DCI

provides didactic education as well as clinical instruction on-site for these students. Additionally, DCI Boiling Springs offers the dialysis facility as a clinical training internship site for Gardner-Webb University's senior nursing students who are under the direction of a registered nurse. Cleveland Community College allied health students as well as Crest High School's health occupation students have clinical access to DCI Boiling Springs and will continue with this rotation following completion of this project. See Exhibit 15 for documentation of these well-established clinical relationships.

Winston Salem State University and Western Carolina University also use DCI as a clinical experience for BSN students in the management area as well as dietitians and social workers. This clinical training is provided on an as-needed basis.

All of these clinical training programs are supportive of the proposed project and some have submitted letters to document that support. See Exhibit 21."

In Section V.3(c), page 66, DCI Boiling Springs states:

"At the present time, the only clinical programs that have indicated a need for clinical rotations for their students are the programs already established with DCI Boiling Springs. Certainly, other programs that have a need for clinical training sites for their students would be welcome. ...

In addition to offering its facilities for clinical rotations, DCI has endowed two scholarships ($25,000 each) for nursing students to allow qualified students to enter the nursing program at Gardner Webb University"

The information provided in Section V.3 is reasonable and credible and supports a finding of conformity with this criterion.

FMC Cleveland- In Section V.3(a), page 68, BMA states:

"Exhibit 19 contains an executed affiliation agreement between FMC Cleveland County and Gaston College. Students are provided tours through the facilities and discussions regarding the different aspects of dialysis and facility operations.

All health related education and training programs are welcomed [sic] *to visit the facility, receive instruction and observe the operation of the unit while patients are receiving treatment. This experience enhances the clinical experience of the students enrolled in these programs enabling them to learn about the disease, prognosis and treatment for the patient with end stage renal disease."*

In Section V.3(b), page 68, BMA states:

"BMA facilities regularly receive requests for information from individual students or program directors. The Center Manager or In-Service Coordinator of the facility provide discussion of ESRD and dialysis for students, after which time the students may observe, tour the facility and talk with patients. It is expected that FMC Cleveland County will similarly support health professional programs in Cleveland, Wake and Johnston Counties. [sic]"

In Section V.3(c), page 68, BMA states:

"Terri Carlton, RN, FMC Director of Operations for this facility has executed a formal relationship with Gaston College."

Although Gaston College is not very close to the proposed site in Shelby, FMC Cleveland has shown general conformity with this criterion and said in the Public Hearing that they would be contacting Gardner-Webb University regarding health education and training. The information provided in Section V.3 is reasonable and credible and supports a finding of conformity with 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.

C
DCI Shelby

CA
DCI Boiling Springs

NC
FMC Cleveland

Dialysis Clinic, Inc. d/b/a DCI Shelby See Sections II, III, V, VI, and VII. The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the addition of four dialysis stations at DCI Shelby would have a positive impact on cost-effectiveness, quality and access to the proposed services because:

- The addition of four dialysis stations at DCI Shelby is needed and the proposal is a cost-effective alternative to meet the need for four dialysis stations [see Criteria (1), (3), (4) (5), and (12) for additional discussion];
- The applicant has and will continue to provide quality services [see Criteria (7), (8) and (20) for additional discussion];
- The applicant has and will continue to provide adequate access to medically underserved populations [see Criterion (13) for additional discussion].

Therefore, the application is conforming to this criterion.

Dialysis Clinic, Inc. d/b/a DCI Boiling Springs Dialysis See Sections II, III, V, VI, and VII. The information provided by the applicant in those sections is reasonable and credible and adequately demonstrates that the addition of one dialysis station, not four, at DCI Boiling Springs would have a positive impact on cost-effectiveness, quality and access to the proposed services because:

- The addition of one dialysis station at DCI Boiling Springs is needed and the proposal is a cost-effective alternative to meet the need for one dialysis station [see Criteria (1), (3), (4) (5), (6), and (12) for additional discussion];
- The applicant has and will continue to provide quality services [see Criteria (7), (8) and (20) for additional discussion];
- The applicant has and will continue to provide adequate access to medically underserved populations [see Criterion (13) for additional discussion].

Therefore, the application is conforming to this criterion, subject to the condition to add one station in Condition 2, Criterion (4).

Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a FMC Cleveland County In Sections II, III, V, VI, and VII, the applicant discussed its proposal and the impact it would have upon the quality and access to the proposed services; however the information provided by the applicant in those sections is not reasonable and credible and fails to adequately demonstrate that the proposal would have a positive impact upon the cost effectiveness of the project for the following reason: The relocation of ten dialysis stations from four existing facilities in counties contiguous to Cleveland County to develop a new facility in Cleveland County is not needed and the proposal is not a cost-effective alternative to meet the need of the current patients [see Criteria (1), (3), (4) (5) and (6) for additional discussion].

Therefore, the application is non-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.

C
DCI Shelby
DCI Boiling Springs
FMC Cleveland

DCI Shelby - The applicant currently provides dialysis services at **DCI Shelby**. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, the facility operated in compliance with the Medicare Conditions of Participation and there were no incidents resulting in a determination of immediate jeopardy within the eighteen months immediately preceding the date of this decision. Therefore, the application is conforming to this criterion.

DCI Boiling Springs - The applicant currently provides dialysis services at **DCI Boiling Springs**. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, the facility operated in compliance with the Medicare Conditions of Participation and there were no incidents resulting in a determination of immediate jeopardy within the eighteen months immediately preceding the date of this decision. Therefore, the application is conforming to this criterion.

FMC Cleveland - The applicant is proposing to relocate 10 stations from four other locations and develop a new facility. The four locations from which the applicant proposes to transfer stations include: BMA Burke County, BMA Hickory, BMA Lincolnton, and BMA Kings Mountain. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, the transferring facilities operated in compliance with the Medicare Conditions of Participation and there were no incidents resulting in a determination of immediate jeopardy within the eighteen months immediately preceding the date of this decision. Therefore, the application is 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.

C
DCI Shelby

CA
DCI Boiling Springs

NC
FMC Cleveland

The Criteria and Standards for End Stage Renal Disease Services, as promulgated in 10A NCAC 14C Section .2200, are applicable to this review.

The proposal submitted by **DCI Shelby** is conforming to all applicable Criteria and Standards for End Stage Renal Disease Services as required by 10A NCAC 14C .2200.

The proposal submitted by **DCI Boiling Springs** is conditionally conforming to all applicable Criteria and Standards for End Stage Renal Disease Services as required by 10A NCAC 14C .2200.

The proposal submitted by **FMC Cleveland** is not conforming to all applicable Criteria and Standards for End Stage Renal Disease Services as required by 10A NCAC 14C .2200.

The specific findings are discussed below.

.2202 INFORMATION REQUIRED OF APPLICANTS

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

.2202(a)(1) Utilization Rates;

-C-	**DCI Shelby**	See Section III.7, page 53, Section IV.1-2, page 59, and the July 2011 SDR, Table A.
-C-	**DCI Boiling Springs**	See Section III.7, page 53, Section IV.1-2, page 58, and the July 2011 SDR, Table A.
-NC-	**FMC Cleveland**	For projected utilization rates see Section III.7, page 56. For utilization rates for the facilities proposing to transfer stations see Section IV.1-2, pages 62-63, and the July 2010 SDR, Table A. However the proposed utilization rates are not credible. See Criterion 3 for discussion.

If the applicant used the Five Year Annual Change

Rate of 4.1%, as shown in the table below, the applicant would not meet the performance standard of at least 3.2 patients per week, per station by the end of the first operating year. See 10A NCAC 14C .2203.

	In-Center Patients
Proposed facility begins with Cleveland County patients currently served by BMA as of 12/31/10	26
1/1/10 – 12/31/11	26.0000 x 1.041 = 27.0660
1/1/12 – 12/31/12	27.0660 x 1.041 = 28.1757
1/1/13 – 12/31/13	28.1757 x 1.041 = 29.3309
1/1/14 – 12/31/14 **(PY1)**	29.3309 x 1.041 = **30.5335**
1/1/15 – 12/31/15 **(PY2)**	30.5335 x 1.041 = **31.7853**

.2202(a)(2) *Mortality rates;*

-C- **DCI Shelby** See Section IV.2, page 59.
-C- **DCI Boiling Springs** See Section IV.2, page 58.
-C- **FMC Cleveland** For the facilities proposed to transfer stations see Section IV.2, page 63

.2202(a)(3) *The number of patients that are home trained and the number of patients on home dialysis;*

-C- **DCI Shelby** See Section IV.1 & 3, pages 59-60.
-C- **DCI Boiling Springs** See Section IV.1 & 3, pages 58-59.
-C- **FMC Cleveland** For the facilities proposed to transfer stations see Section IV.1 & 3, pages 62-63.

.2202(a)(4) *The number of transplants performed or referred;*

-C- **DCI Shelby** See Section IV.4, page 60.
-C- **DCI Boiling Springs** See Section IV.4, page 59.
-C- **FMC Cleveland** For the facilities proposed to transfer stations see Section IV.4, page 64.

.2202(a)(5) *The number of patients currently on the transplant waiting list;*

-C- **DCI Shelby** See Section IV.5, page 60.
-C- **DCI Boiling Springs** See Section IV.5, page 59.
-C- **FMC Cleveland** For the facilities proposed to transfer stations see Section IV.5, page 64.

.2202(a)(6) *Hospital admission rates, by admission diagnosis, i.e., dialysis related versus non-dialysis related;*

-C- **DCI Shelby** See Section IV.6, pages 60.
-C- **DCI Boiling Springs** See Section IV.6, pages 59.
-C- **FMC Cleveland** For the facilities proposed to transfer stations see Section IV.6, page 64.

.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-	**DCI Shelby**	See Section IV.7, page 61.
-C-	**DCI Boiling Springs**	See Section IV.7, page 60.
-C-	**FMC Cleveland**	For the facilities proposed to transfer stations see Section IV.7, pages 64-65.

(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:

.2202(b)(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.

-NA-	**DCI Shelby**	DCI Shelby is an existing facility.
-NA-	**DCI Boiling Springs**	DCI Boiling Springs is an existing facility.
-C-	**FMC Cleveland**	See Exhibit 16 for an agreement with Gaston Hospital.

.2202(b)(2) For new facilities, a letter of intent to sign a written agreement or 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.

-NA-	**DCI Shelby**	DCI Shelby is an existing facility.
-NA-	**DCI Boiling Springs**	DCI Boiling Springs is an existing facility.
-C-	**FMC Cleveland**	See Exhibit 17.

.2202(b)(3) For new or replacement facilities, documentation that power and water will be available at the proposed site.

-NA-	**DCI Shelby**	DCI Shelby is an existing facility.
-NA-	**DCI Boiling Springs**	DCI Boiling Springs is an existing facility.
-C-	**FMC Cleveland**	See Exhibits 30 and 31.

.2202(b)(4) *Copies of written policies and procedures for back up for electrical service in the event of a power outage.*

-C- **DCI Shelby** See Section XI.6(f), page 99, and Exhibit 22.

-C- **DCI Boiling Springs** See Section XI.6(f), page 99, and Exhibit 20.

-C- **FMC Cleveland** See Section XI.6(f), page 100, and Exhibit 12.

.2202(b)(5) *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.*

-NA- **DCI Shelby** DCI Shelby is an existing facility.

-NA- **DCI Boiling Springs** DCI Boiling Springs is an existing facility.

-C- **FMC Cleveland** See Section XI.1-2, pages 96-98, and Exhibits 29-31.

.2202(b)(6) *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- **DCI Shelby** See Section VII, pages 79-81, Section XI.5, page 97, and Section XI.6(g), pages 99-100.

-C- **DCI Boiling Springs** See Section VII, pages 79-82, Section XI.5, page 97, and Section XI.6(g), page 99.

-C- **FMC Cleveland** See Section VII, pages 77-78, Section XI.5, page 99, and Section XI.6(g), pages 100-101.

.2202(b)(7) *The projected patient origin for the services. All assumptions, including the methodology by which patient origin is projected, must be stated.*

-C- **DCI Shelby** See Section III.7, pages 53-54. See Criterion (3) for discussion.

-C- **DCI Boiling Springs** See Section III.7, page 53. See Criterion (3) for discussion.

-NC- **FMC Cleveland** The applicant does not adequately demonstrate the reasonableness of projected patient origin. See Section III.7, pages 55-60. See Criterion (3) for discussion.

Furthermore, the applicant does not adequately demonstrate the reasonableness of patients who live in Cleveland County and currently choose to receive treatment in Hickory, Morganton, Lincolnton and

Kings Mountain choosing to travel to Shelby, in Cleveland County when they currently have that option, but choose not to use it. In addition, the applicant does not adequately demonstrate that BMA's current Cleveland County patients actually live closer to the proposed facility than to the facility where they are currently receiving treatment. Therefore, the applicant does not adequately identify the population proposed to be served.

.2202(b)(8) *For new facilities, documentation that at least 80 percent of the anticipated patient population resides within 30 miles of the proposed facility.*

-NA-	**DCI Shelby**	DCI Shelby is an existing facility.
-NA-	**DCI Boiling Springs**	DCI Boiling Springs is an existing facility.
-C-	**FMC Cleveland**	See Section II.1, pages 20-21 and Section III.9, page 60.

.2202(b)(9) *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-	**DCI Shelby**	See Section II.1, page 20.
-C-	**DCI Boiling Springs**	See Section II.1, pages 20-21.
-C-	**FMC Cleveland**	See Section II.1, page 21.

.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.*

-NA-	**DCI Shelby**	DCI Shelby is an existing facility.
-NA-	**DCI Boiling Springs**	DCI Boiling Springs is an existing facility.
-NC-	**FMC Cleveland**	BMA does not adequately demonstrate the need to develop a 10-station facility in Cleveland County based on utilization of 3.2 patients per station per week. See Criterion 3 for discussion. If the applicant used the Five Year Annual Change Rate of 4.1%, as shown in the table below, the applicant would not meet the performance standard of at least 3.2 patients per week, per station by the end of the first operating

year. See 10A NCAC 14C .2203.

	In-Center Patients
Proposed facility begins with Cleveland County patients currently served by BMA as of 12/31/10	26
1/1/10 – 12/31/11	26.0000 x 1.041 = 27.0660
1/1/12 – 12/31/12	27.0660 x 1.041 = 28.1757
1/1/13 – 12/31/13	28.1757 x 1.041 = 29.3309
1/1/14 – 12/31/14 **(PY1)**	29.3309 x 1.041 = **30.5335**
1/1/15 – 12/31/15 **(PY2)**	30.5335 x 1.041 = **31.7853**

.2203(b) *An applicant proposing to increase the number of dialysis stations in an existing End Stage Renal Disease facility or one that was not operational prior to the beginning of the review period but which had been issued a certificate of need 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.*

-C- **DCI Shelby** In Section III.7, pages 53-54, the applicant projects to serve 96 in-center patients or 3.3 patients per station [96 / 29 = 3.3] by the end of Year 1 for the proposed 29-station facility. See Criterion (3) for discussion.

-CA- **DCI Boiling Springs** In Section III.2, page 50, the applicant projects to serve 56 in-center patients by the end of Year 1 for the proposed 14-station facility. However, the number of stations was conditioned and lowered to 1. See Criterion 4, Condition 2.
Using Cleveland County's Five Year Average Annual Change Rate of 4.1% to project growth, the facility would project to serve 37 in-center patients or 3.36 patients per station [37 / 11 = 3.36] by the end of Year 1 for the conditioned 11-station project. See Criterion (3) for discussion.

-NA- **FMC Cleveland** BMA is not proposing to add stations to an existing or previously CON-approved facility. BMA is proposing to develop a new facility.

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

-C- **DCI Shelby** In Section III.2, pages 47-51, the applicant provides the assumptions and methodology used to project patient utilization. See Criterion (3) for discussion.

-CA- **DCI Boiling Springs** In Section III.2, pages 45-51, the applicant provides the assumptions and methodology used

to project patient utilization. The methodology includes using a growth rate that is lower than the Facility Change Method, but unsubstantiated and still too high. As conditioned, using the Five Year Average Annual Change Rate of 4.1% to project utilization, the facility needs 1 additional station. See Criterion (3) for discussion.

-NC- **FMC Cleveland**

In Section III.3, pages 43-54, and Section III.7, pages 55-60, the applicant provides the assumptions and methodology used to project patient utilization. See Criterion 3 for discussion of reasonableness of projections.

The applicant projects a 5.5202% annual growth rate for Cleveland County based on *"**one half** of the calculated recent annual growth rate for Cleveland County (see d. above)"*; not on the Semiannual Dialysis Report (SDR) currently published Five Year Annual Change Rate of 4.1%. [Emphasis in original.] Project analyst calculated one-half of the "calculated rate" referenced in *d* above (11.75%) which equals 5.875%, not 5.5202% [11.75% x .5 = 5.875]. In addition, the "calculated rate" is basically the annual growth rate for the last year (6/30/10 – 6/30/11) [(247 – 221)/221 = 26 / 221 = .117647 or 11.76%]; since there was no growth over the first 3 months of the 18-month period the applicant used in its "calculated rate". The methodology used in determining County Need in the SDR includes a Five Year Annual Change Rate in order to smooth out the ups and downs of any one year, including changes in the number of facilities, stations or patients throughout a county and thus provides a more stable, predictive growth rate. The methodology used in determining Facility Need in the SDR includes a one year growth rate based on the most recent 6 months' growth because a facility's own experience is being used to predict its future growth and need. The applicant is proposing to develop a new facility and thus does not have a facility growth rate to use in projections and it did not provide a growth rate for the Cleveland

County patients it currently serves in the transferring facilities. Therefore, the most reasonable growth rate to use is the Five Year Annual Change Rate published in the SDR, which is 4.1%: not 11.76% or 5.5202%.

.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- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(2) Maintenance dialysis;

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(3) Accessible self-care training;

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66

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

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(5) X-ray services;

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(6) Laboratory services;

-C- **DCI Shelby** See Section V.1, page 63.
-C- **DCI Boiling Springs** See Section V.1, pages 61-62.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(7) Blood bank services;

-C- **DCI Shelby** See Section V.1, page 63.
-C- **DCI Boiling Springs** See Section V.1, page 62.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(8) *Emergency care;*

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(9) *Acute dialysis in an acute care setting;*

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 61.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(10) *Vascular surgery for dialysis treatment patients;*

-C- **DCI Shelby** See Section V.1, page 63.
-C- **DCI Boiling Springs** See Section V.1, page 62.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(11) *Transplantation services;*

-C- **DCI Shelby** See Section V.1, page 62.
-C- **DCI Boiling Springs** See Section V.1, page 62.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(12) *Vocational rehabilitation counseling and services;*

-C- **DCI Shelby** See Section V.1, page 63.
-C- **DCI Boiling Springs** See Section V.1, page 62.
-C- **FMC Cleveland** See Section V.1, page 66.

.2204(13) *Transportation*

-C- **DCI Shelby** See Section V.1, page 63.
-C- **DCI Boiling Springs** See Section V.1, page 62.
-C- **FMC Cleveland** See Section V.1, page 66.

.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- **DCI Shelby** See Section VII, pages 79-82.
-C- **DCI Boiling Springs** See Section VII, pages 79-82.
-C- **FMC Cleveland** See Section VII, pages 76-79.

.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- **DCI Shelby** See Section VII.5, page 80, and Exhibit 7.
-C- **DCI Boiling Springs** See Section VII.5, page 80, and Exhibit 7.
-C- **FMC Cleveland** See Section VII.5, page 77, and Exhibit 15.

DISCUSSION OF COMPARATIVE ANALYSIS

DCI, Inc. d/b/a **DCI Shelby**, DCI, Inc. d/b/a **DCI Boiling Springs** and BMA d/b/a **FMC Cleveland** each filed an application for review beginning October 1, 2011. DCI Shelby proposes to add four stations to its existing ESRD facility in Shelby and DCI Boiling Springs proposes to add four stations to its existing ESRD facility in Boiling Springs; each pursuant to the ESRD Facility Need Methodology. FMC Cleveland proposes to relocate ten stations from four existing facilities outside of Cleveland County to develop a 10-station ESRD facility in Shelby, Cleveland County, pursuant to Policy ESRD 2: Relocation of Dialysis Stations. Thus, the proposals are for the same or similar services. Further, the proposed FMC Cleveland site is within two and one-half miles and five minutes of the current DCI Shelby site, and 11 miles and 21 minutes from the current DCI Boiling Springs site. Although FMC Cleveland states that it is only going to serve its own patients and is not going to take patients from the existing providers, geographically FMC Cleveland proposes to serve essentially the same patient population as the DCI facilities. The following table illustrates the proposed service areas for each proposal.

PATIENT ORIGIN	DCI SHELBY	DCI BOILING SPRINGS	FMC CLEVELAND
Facility ZIP Code	28150	28152	28150 (Proposed)
Cleveland County	83.7%	70.8%	100.0%
Gaston County	12.0%		
Lincoln County	2.6%	3% [2.1%]	
Rutherford County		26% [27.1%]	
Cherokee, SC County	1.7%		

Pursuant to 10A NCAC 14C .0202(f), *"Applications are competitive if they, in whole or in part, are for the same or similar services and the agency determines that the approval of one or more of the applications may result in the denial of another application reviewed in the same review period."* The analyst determined that the approval of the DCI Shelby application (Project I.D. #C-8732-11) and/or the DCI Boiling Springs application (Project I.D. #C-8733-11) filed in this review period did not result in the disapproval of the FMC Cleveland application (Project I.D. #C-8756-11) also filed in this review period. Rather, the FMC Cleveland application was disapproved for other reasons.

In summary, the Agency determined that the three applications submitted for review beginning October 1, 2011 are not competitive, and therefore, a comparative analysis was not prepared.

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE:	February 25, 2011
FINDINGS DATE:	March 4, 2011
PROJECT ANALYST:	Jane Rhoe-Jones
TEAM LEADER:	Angie Matthes

PROJECT I.D. NUMBER: G-8583-10/ Total Renal Care of North Carolina, LLC (TRC) d/b/a Randolph County Dialysis/ Develop a new 10-station dialysis facility / Randolph County

G-8594-10/ Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro/ Relocate existing 27-station dialysis facility and add 10 dialysis stations, for a total of 46 stations upon project completion and completion of Project I.D. #G-8420-09 (add 7 stations) and Project I.D. #G-8489-10 (relocate 2 stations) / Randolph 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.

NC – TRC
C – BMA

The 2010 State Medical Facilities Plan (SMFP) and the July 2010 Semiannual Dialysis Report (SDR) provide a county need methodology for determining the need for additional dialysis stations. According to the county need methodology, found on page 333 of the 2010 SMFP, *"If a county's December 31, 2010 projected station deficit is 10 or greater and the July SDR shows that utilization of each dialysis facility in the county is 80 percent or greater, the December 31, 2010 county station need determination is the same as the December 31, 2010 projected station deficit. If a county's December 31, 2010*

EXHIBIT 4

projected station deficit is less than 10 or if the utilization of any dialysis facility in the county is less than 80 percent, the county's December 31, 2010 station need determination is zero." The county need methodology results in a need determination of 10 additional dialysis stations in Randolph County. Two competing applications were received by the Certificate of Need Section, proposing a total of 20 new dialysis stations. However, pursuant to the need determination, 10 stations is the limit on the number of new dialysis stations that may be approved in this review for Randolph County. See the comparative analysis for the decision. A brief description of the two proposals follows.

Total Renal Care of North Carolina, LLC (TRC) d/b/a Randolph County Dialysis proposes to develop a new 10-station dialysis facility in Asheboro in response to the July 2010 SDR. TRC will lease and up-fit the space in a shell building. TRC proposes to up-fit the facility to offer in-center hemodialysis, training for home hemodialysis and peritoneal dialysis. The proposal submitted by TRC is conforming to the need determination in the 2010 SMFP.

Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro proposes to develop a new 46 station dialysis facility in Asheboro; including relocating the existing 27 station facility, develop CON Project ID G-8420-09 (add 7 stations) and Project ID G-8489-10 (relocate 2 stations) and add 10 stations (in response to the July 2010 SDR) with this application. BMA proposes to up-fit the facility to offer in-center hemodialysis, training for home hemodialysis and peritoneal dialysis. BMA also proposes to offer nocturnal dialysis. The proposal submitted by BMA is conforming to the need determination in the 2010 SMFP.

Additionally, Policy GEN-3 on page 39 of the 2010 SMFP is applicable to this review. Policy GEN-3 states:

> *"A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project shall promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."*

The applicants respond to Policy GEN-3 as follows:

Promote Safety and Quality

TRC – In Section I., pages 6-7, Section II., pages 25-26, and in Section III., 33-34, TRC discusses how it will ensure quality care. The applicant states on pages 25-26:

> *"DaVita, Inc. is committed to providing quality care to the ESRD population through a comprehensive Quality Management Program. DaVita's Quality Management Program is facilitated by a dedicated clinical team of Registered Nurses who make up our Clinical Support Services and Biomedical Quality Management Coordinators working under the direction of our Director of Clinical Support Services and Area Biomedical Administrator. These efforts receive the full support and guidance of the clinical executive leadership team of DaVita. Combined, this group brings hundreds of years of ESRD experience to the program. The program exemplifies DaVita's total commitment to enhancing the quality of patient care through its willingness to devote the necessary resources to achieve our clinical goals. ...*
>
> *DaVita's Quality Management team works closely with each facility's Quality Improvement team to:*
> - *Improve patient outcomes*
> - *Provide patient and teammate training*
> - *Develop Quality Improvement Programs*
> - *Facilitate the Quality Improvement Process*
> - *Continuously improve care delivered*
> - *Assure facilities meet high quality standards"*

The applicant adequately demonstrates how its proposal will promote safety and quality.

Maximize Healthcare Value

TRC - In Section III.9, page 34 and Section V.7, page 41, the applicant discusses how the proposal would promote cost effectiveness. On page 34, the applicant states:

> *"Randolph County Dialysis will promote cost-effective approaches in the facility in the following ways:*
> - *... The corporation has a centralized purchasing department that negotiates national contracts with*

numerous vendors in order to secure the best product available at the best price.

- *... purchase all of the products utilized in the facility, from office supplies to drugs to clinical supplies, under a national contract in order to secure the best products at the best price.*
- *... utilize the reuse process that contains costs and the amount of dialyzer waste generated by the facility. ...*
- *... install an electronic patient charting system that reduces the need for paper in the facility. Much of the other documentation in the facility will also be done on computer which reduces the need for paper.*
- *... conduct preventative maintenance on the dialysis machines on a monthly, quarterly and semi-annual schedule that reduces the need for repair maintenance and parts. This will extend the life of the dialysis machines.*
- *... have an inventory control plan that ensures enough supplies are available without having in inordinate amount of supplies on hand. Supply orders will be done in a timely manner to ensure that the facility does not run out of supplies, thus avoiding emergency ordering, which is costly."*

The applicant adequately demonstrates how the proposal will maximize healthcare value.

Promote Equitable Access

TRC – In Section V., page 41 and Section VI.1, pages 42-45, the applicant states the following:

"Randolph County Dialysis, by policy, will make dialysis services available to all residents in its service area without qualifications. We will serve patients without regard to race, sex, age, or handicap. We will serve patients regardless of ethnic or socioeconomic situation.

Randolph County Dialysis will make every reasonable effort to accommodate all of its patients; especially those with special needs such as the handicapped, patients attending school or patients who work. The facility will provide dialysis six days per week with two patient shifts per day to accommodate patient need.

Randolph County Dialysis will not require payment upon admission to its services; therefore, services are available to all patients including low income persons, racial and ethnic minorities, women, handicapped persons, elderly and other under-served persons."

The applicant does not adequately demonstrate that its proposal would promote access by the medically underserved, as the applicant states on page 42 that the projected payor mix for the proposed facility is the same as "*average percentages of patients who are currently dialyzing at the Dialysis Care of Montgomery County facility. Montgomery County is contiguous to Randolph County and located to the south of Randolph County.*" Census data on poverty and income are not comparable for the two counties; thus it is not reasonable to assume that the payor mix for Randolph County will replicate that of Montgomery County merely due to the counties being contiguous. See Criterion (13c) for additional discussion.

In summary TRC adequately demonstrates how its proposal will promote safety and quality and how it will maximize healthcare value for the resources expended. However, TRC does not demonstrate that its projected payor mix is based upon reasonable and supported assumptions. See additional discussion in Criterion (13c). Therefore, it does not adequately demonstrate that its proposal will promote equitable access by the medically underserved and is not consistent with Policy GEN-3. Consequently, the application is not conforming to this criterion.

Promote Safety and Quality

BMA - In Section II.1, pages 32-33, the applicant describes how the proposal will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for the resources expended, as follows:

> *"BMA is a high quality health care provider. The Table at II.3D provides a comparison of quality indicators for the BMA Asheboro facility. In addition, BMA parent company, Fresenius Medical Care, encourages all BMA facilities to attain the FMC UltraCare certification. This is not a one time test, but rather is an ongoing process aimed at encouraging all staff, vendors, physicians, and even patients to be a part of the quality care program. Facilities are evaluated annually for UltraCare certification."*

In Section II.3, pages 41-43, the applicant describes the methods it uses to ensure and maintain quality care which include the following:

- Facility programs
    1) Quality Improvement Program;
    2) Staff Orientation and Training; and
    3) In-service Education
- Corporate programs
    1) Technical Audits;
    2) Continuous Quality Improvement
    3) External Surveys- DFS [sic] Certification Surveys

4) Core Indicators of Quality; and
5) Single Use Dialyzers

The applicant adequately demonstrates how its proposal will promote safety and quality.

Maximize Healthcare Value

BMA - In Section II, page 35, the applicant the applicant discusses how the proposal would promote cost effectiveness. The applicant states:

> *"As an additional consideration, BMA notes that the overwhelming majority of dialysis treatments are reimbursed through Medicare, Medicaid, or other government payor sources. ... The point here is that government payors are working from a fixed payment schedule, often at significantly lower reimbursement rates than the posted charges. As a consequence BMA must work diligently to control costs of delivery for dialysis. BMA does."*

The applicant adequately demonstrates how the proposal will maximize healthcare value.

Promote Equitable Access

BMA - In Section II, pages 34-36, the applicant describes how the proposal would enhance access by medically underserved groups, as follows:

> *"BMA has removed the economic barriers with regard to access to treatment. The overwhelming majority of dialysis treatments are covered by Medicare/Medicaid; ... BMA is projecting that 82.76% of the In-Center dialysis treatments will be covered by Medicare or Medicaid; an additional 2.57% are expected to be covered by VA. Thus, 85.33% of the In-Center revenue is derived from government payors.*
>
> ...
>
> *...BMA is also keenly sensitive to the second element of 'equitable access' - time and distance barriers. BMA continually strives to develop facilities and dialysis stations in close proximity to the patient residence. ...*
>
> *...BMA has projected that the facility will be comprised of the following demographics:*

Facility	*Medicaid/Low Income*	*Elderly (65+)*	*Medicare*	*Women*	*Racial Minorities*
BMA Asheboro	*10.4%*	*50.0%*	*63.2%*	*39.6%*	*35.8%*

In Section VI.2, pages 72, the applicant states,

> *"The design of the facility is such that handicapped persons will have easy access to the facility; the facility will comply with ADA requirements."*

The applicant adequately demonstrates that the proposal would promote access by the medically underserved. See Criteria (13c) for additional discussion.

In summary, BMA adequately demonstrates how its proposal will promote safety and quality and how it will maximize healthcare value for the resources expended. BMA demonstrates that its projected payor mix is based upon reasonable and supported assumptions. See additional discussion in Criterion (13c). Therefore, it adequately demonstrates that its proposal will promote equitable access by the medically underserved. Consequently, the application is consistent with Policy GEN-3 and 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.

C – Both Applications

TRC - proposes to develop a new 10-station dialysis facility in Asheboro. The applicant proposes a site near Highway 64 (the primary east-west routing through the county) and Highway 49. TRC proposes to provide in-center hemodialysis, home hemodialysis and peritoneal dialysis training.

Population to be Served

In Section III.7, page 33, TRC discusses the patient population proposed to be served. The applicant states:

> *"TRC is not suggesting that the patient* [sic] *for the facility will come from a single zip code nor is TRC suggesting that any proportional numbers of patients will change providers. TRC has identified a patient population of 32 patients who could be served by Randolph County Dialysis, which meets the requirement of 10A NCAC 14 C.2203(a)."*

The following table illustrates projected patient origin during the first and the second operating years for the proposed dialysis center, as reported by the applicant in Section III.7, page 29.

COUNTY	OPERATING YEAR 1 2012/13		OPERATING YEAR 2 2013/14		COUNTY PATIENTS AS A PERCENT OF TOTAL	
	IN-CENTER PATIENTS	HOME DIALYSIS PATIENTS	IN-CENTER PATIENTS	HOME DIALYSIS PATIENTS	YEAR 1	YEAR 2
Randolph	32	1	35	1	100.00%	100.00%
Total	32	1	35	1	100.00%	100.00%

The applicant adequately identified the population it proposes to serve.

Demonstration of Need

In Section III, pages 27-32, TRC describes the need methodology and assumptions it used to project utilization. The applicant states:

> *"There is one dialysis facility in Randolph County. We propose to establish a ten-station ESRD facility based on the need determination identified in the SDR. We are proposing to locate the facility in Asheboro in Randolph County. Asheboro, located just south of the center of the county, is the county seat of Randolph County. The proposed facility will be located near the intersection of Highway 49, a major highway artery in Asheboro and Randolph County. The highway will provide easy access to our proposed facility."*

In Section III.3(b), page 29, the applicant also states:

> *"The July 2010 SDR, Table B indicates that there were 141 dialysis patients in Randolph County as of December 31, 2009. Total Renal Care uses the following assumptions in projecting a future census for the Randolph County ESRD dialysis patient population.*
>
> - *TRC assumes that ESRD patients residing in Randolph County will want to dialyze at a facility in Randolph County.*
> - *The patient population in Randolph County will be projected forward using the current Five Year Average Annual Change Rate as published in the July 2010 SDR.*
> - *The percentage of patients dialyzing on home therapies will remain constant. The July 2010 SDR indicates that as of December 31, 2009, 4.3% of the dialysis patients in Randolph County were home dialysis patients.*
> - *The July 2010 SDR indicates that the Bio-Medical Applications of Asheboro dialysis facility in Asheboro had an in-center dialysis patient population of 111 patients as of December 31, 2009 (July 2010 SDR, Table A, Page 14).*

In Section III.3(b), pages 29-32, the applicant projects utilization as follows:

TRC begins with the ESRD patient population of 141 total dialysis patients in Randolph County as of December 31, 2009.

TRC projects this census forward for one year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census as of December 31, 2010.

- *141 X 0.093 = 13.113 + 141 = 154.113*

TRC again projects that census forward for one year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census as of December 31, 2011.

- *154.1 X 0.093 = 14.3313 + 154.1 = 168.4313*

TRC then projects this census forward for one half year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census for June 30, 2012. This is the day before the projected certification date for the project.

- *168.4 X 0.0465 = 7.8306 + 168.4 = 176.2306*

On June 30, 2012, TRC is projecting that there will be 176.2 total dialysis patients residing in Randolph County. TRC notes that this calculation methodology is consistent with that in the SDR Table B. ...

Given that the calculations will project 176.2 patients for June 30, 2012, TRC will now reduce this number by the percentage of patients using home therapies. The July 2010 SDR indicates that 4.3% of the patients residing in Randolph County were home dialysis patients.

- *176.2 X 0.043 = 7.5766*
- *176.2 – 7.5766 = 168.6234*

TRC assumes that of the 168.6 ESRD dialysis patients projected to be residing in Randolph County on June 30, 2012, will be in-center patients.

TRC recognizes that BMA Asheboro was serving 111 Randolph County in-center patients at its Asheboro facility on December 31, 2009. It is reasonable to conclude that this census will grow in proportion with the Randolph County Five Year Average Annual Change Rate. TRC offers the following projections for this patient population.

TRC begins with the reported patient population of the BMA Asheboro facility as of December 31, 2009. As noted above, 111 of these patients are apparently residents of Randolph County.

- *111 in-center patients*

TRC projects this census forward for one year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected BMA in-center census for December 31, 2010.

- *111 X 0.093 = 10.323 + 111 = 121.323*

TRC projects this census forward for one year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected BMA in-center census for December 31, 2011.

- *121.3 X 0.093 = 11.2809 + 121.3 = 132.5809*

TRC projects this census forward for one half year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census for June 30, 2012.

- *132.6 X 0.0465 = 6.1659 + 132.6 = 138.7659*

TRC notes that the projected aggregate patient population for the BMA facility in Asheboro could reasonably be expected to total 138.8 in-center patients. Therefore, TRC concludes that the difference in the projected BMA population is equal to 29.8 in-center patients.

- *168.6 Randolph County in-center patients as of 6/30/12 – 138.8 in-center BMA patients as of 6/30/12 = 29.8 in-center patients.*

TRC has arrived at a projected patient population which is not being served by any facility within Randolph County. Therefore, these in-center patients could be reasonably served by a TRC facility. This is a projected patient population for June 30, 2010, the day before the proposed TRC facility is scheduled for certification.

TRC projects that [sic] *the patient population forward to calculate the expected patient populations for the end of Operating Years 1 and 2.*

TRC begins with the projected patient population of 29.8 patients as noted above. This is the projected census as of July 1, 2012.

- *29.8*

TRC projects this census forward one year, using Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census for June 30, 2013, the last day of Operating Year 1.

- *29.8 X 0.093 = 2.7714 + 29.8 = 32.5714*

TRC projects this census forward one year, using the Five Year Average Annual Change Rate as published in the July 2010 SDR. This is the projected patient census for June 30, 2014, the last day of Operating Year 2.

- *32.5 X .093 – 3.0225 + 32.5 = 35.5225*

TRC is not projecting that 100% of the new patients in Randolph County would become TRC patients. TRC has

- *Projected growth for the entire patient population in Randolph County*
- *Reduced that population by the appropriate percentage of home patients*
- *Projected growth of the BMA population and subtracted that from the projected population as a whole*
- *Total Renal Care of North Carolina, LLC is projecting to serve 32 in-center patients by the end of operating year one for a utilization rate of 80% or 3.2 patients per station*
- *Total Renal Care of North Carolina, LLC is projecting to serve 35 in-center patients by the end of operating year two for a utilization rate of 87.5% or 3.5 patients per station"*

The applicant further states on pages 32 and 33:

"We intend to provide training and follow-up for home-trained patients, both of peritoneal and home hemodialysis patients. The July 2010 SDR indicates that there were six home-trained patients living in Randolph County as of December 31, 2009. Using the Five Year Average Annual Change Rate, that figure will not change substantially.

Total Renal Care of North Carolina will use a conservative projection of serving one home-trained patient during the first two operating years.

TRC notes that it is not inconceivable for the proponent of a project to suggest that patients not currently served by a provider may in fact change providers when offered a choice of providers."

The applicant projects to serve 32 in-center patients and one home dialysis patient in Year One following project completion, which is 3.2 patients per station [32 / 10 = 3.2] or 80% utilization, which conforms to the requirement in 10A NCAC 14C .2203(a). The applicant projects to serve 35 in-center and one home dialysis patient in the second operating year following project completion; which is 3.5 patients per station [35 / 10 = 3.5] or 87% utilization.

In summary, the applicant adequately identified the population proposed to be served and demonstrated the need for the proposed 10-station dialysis facility. Therefore, the application is conforming to this criterion.

BMA - proposes to develop a 46 station dialysis facility by doing the following: relocating the existing 27 station facility located in Asheboro; adding 10 new stations pursuant to the county need methodology in the 2010 SMP; adding seven stations [for a total of 34] which was approved in Project ID # G-8420-09; and relocating two stations from BMA Southwest Greensboro [for a total of 36 stations] which was approved in Project ID # G-8489-10.

The applicant chose a primary site immediately south of US 64 (the primary east-west routing through the county), and near Interstate 74 (the primary north-south routing through the county). The primary site is located within two miles of the current facility. BMA proposes to provide in-center hemodialysis, training for home hemodialysis and peritoneal dialysis, and will also offer nocturnal dialysis.

Population to be Served

BMA projects patient population by beginning with their patient origin as of December 31, 2009. The following table shows the four counties currently served by the existing facility.

COUNTY	12/31/2009	
	In-Center	Home
Randolph	106	0
Davidson	3	0
Guilford	1	0
Chatham	1	0
TOTAL	111	0

In Sections II.1, pages 12-14, 22-23 and III.7, pages 50-57, BMA discusses the patient population proposed to be served. The following table illustrates projected patient origin during the first and the second operating years for the proposed dialysis center, as reported by the applicant in Section III.7, page 57.

COUNTY	OPERATING YEAR 1 2012/13			OPERATING YEAR 2 2013/14			COUNTY PATIENTS as a PERCENT OF TOTAL	
	IN-CENTER	HH	PD	IN-CENTER	HH	PD	YEAR 1	YEAR 2
Randolph	145	2	4	152	4	9	96.8%	97.1%
Davidson	3			3			1.9%	1.8%
Guilford	1			1			0.6%	0.6%
Chatham	1			1			0.6%	0.6%
Sub Totals	150	2	4	157	4	9	100%	100%
TOTAL	156			170				

On page 22 the applicant states:

> *"Based upon BMA Asheboro facility census, SEKC zip code reports for July 1, 2010, and the July 2010 SDR, it is obvious that some dialysis patients are going out of county for in-center dialysis and currently all home dialysis patients are going out of county for their care. Three of these patients are going to BMA Greensboro, and have indicated their support for this project."*

Additionally, the applicant provides 75 signatures on a patient petition in Exhibit 22. The petition indicates that they are current BMA patients, that they are aware the letter will be used as support for the BMA CON application, and that they consent for their names to be associated with the application. The applicant states the endorsement from the three BMA Greensboro patients is included.

The applicant adequately identified the population proposed to be served by BMA Asheboro.

Demonstration of Need

a. *"BMA assumes that the patient population of Randolph County will continue to increase at a rate commensurate with the Randolph County Five Year Average Annual Change Rate as published in the July 2010 Semiannual* [sic] *Dialysis Report. That rate is 9.3%*

b. ...

c. *BMA assumes that the patients of BMA Asheboro are not likely to change nephrology physicians due to the physician-patient relationship. ... The CKA physicians are the only nephrology group with admitting privileges at the BMA Asheboro facility. If patients were inclined to change physicians, another nephrologist, or nephrology practice would already be in existence in Asheboro ... To the extent that this is not the case, then BMA*

must assume that other nephrology practices have not established themselves in response to market forces.

d. ...

e. ...BMA assumes that patients are NOT [emphasis in original] *likely to change nephrology physicians in order to received dialysis at an alternate facility in Randolph County.*

BMA is affiliated with the Carolina Dialysis---Siler City dialysis facility. That facility is affiliated with the Renal Research Institute and the University of North Carolina at Chapel Hill. BMA is aware that Carolina Dialysis---Siler City is providing treatment for eight in-center dialysis patients from Randolph County; these patients reside in Asheboro or areas east of Asheboro. It is not likely that these patients will leave physicians or access to a major medical facility and its teaching institution.

Likewise, zip code 27370 is on the west side of Randolph County (see Map 2, Exhibit 27). This zip code is proximate to High Point, Guilford County, North Carolina. According to the SEKC zip code report there are 17 dialysis patients residing in this zip code; 13 are in-center patients and four are home dialysis patients. BMA Asheboro is serving one of the in-center patients; thus are 12 in-center patients and four home patients who are served by another provider. Due to the proximity to High Point, it seems logical to conclude that these patients are receiving dialysis treatment at one of the two Wake Forest University dialysis facilities in High Point. BMA postulates that these patients are not likely to leave their current provider for the same reasons as the patients are not likely to leave Carolina Dialysis---Siler City. The Wake Forest University facilities are linked with a premier teaching institution and the team of nephrologists associated with Wake Forest University Baptist Hospital.

f. With regard to patient populations going out of county for dialysis, and specifically with regard to the discussion above, BMA does not believe that there is a centralized location within the County which could potentially entice these two disparate groups of patients (only 20 in-center patients) to forgo their existing physician-patient relationship and transfer their care to another facility centrally located in Randolph County.

g. BMA assumes that the Randolph County patients who were projected to transfer to BMA Asheboro from BMA Southwest Greensboro in CON Project ID# G-8489-10 will continue with their transfer plans, subsequent to development of that project, commensurate with this project, at the new location. Thus, their transfer will essentially be delayed by approximately six months as BMA projects this project to be completed as of June 30, 2012 (G-8489-10 was projected to be completed as of 12/31/11).

h. BMA does propose to establish a home dialysis training program at BMA Asheboro subsequent to relocation and expansion of the facility. BMA necessarily assumes that the home patient population of BMA Asheboro will start with three Randolph County patients currently receiving their home care through BMA Greensboro; BMA does expect the home patient population will increase. BMA also assumes that the initial growth of the home patient population will exceed recent Randolph County experience. This will be a result of the additional services becoming available within the County.

In Section II., pages 14-29 and Section III., pages 50-57, BMA describes the need methodology and assumptions it used to project utilization. The applicant states:

"BMA projections of future patient population of the BMA Asheboro facility begin with facility census on December 31, 2009. According to the July 2010 SDR, BMA Asheboro census on December 31, 2009 was 111 patients, with a utilization rate of 103%. The census was comprised of the following:

	12/31/2009	
COUNTY	In-Center	Home
Randolph	106	0
Davidson	3	0
Guilford	1	0
Chatham	1	0
TOTAL	111	0

Note: BMA recognizes that in CON Project ID# G8489-10 that BMA reported fewer patients for the December 31, 2009 census. BMA regrets the inconsistency; but to the extent that there is an inconsistency, Project G-8489-10 actually understates the census at BMA Asheboro for December 31, 2009. ... the SEKC reported in January 2010 that the census of Randolph County was on 137 patients; when SEKC provided its information to DHSR/Medical Facilities Planning Section in May 2010, SEKC reported 141 patients in Randolph County. Given that the Medical Facilities Planning Section has relied upon the SEKC [d]*ata as the basis for the SDR, BMA has likewise relied upon the July 2010 SDR as the official census at BMA Asheboro for December 31, 2009. BMA has re-evaluated its assessment for December 31, 2009 and now concurs with SEKC and the SDR.*

BMA will begin projections of the future census with the census reported for December 31, 2009. Growth projections are a function of the Randolph County Five Year Average Annual Change Rate; utilization of the published Five Year Average Annual Change Rate is a widely held practice, ...

...

In addition to utilizing the published Five Year Average Annual Change Rate, BMA is not demonstrating growth for patient populations which originate outside of Randolph County.

In this case, BMA notes that there were five patients residing in Davidson, Guilford or Chatham counties. BMA assumes that these patients are dialyzing at BMA Asheboro by patient choice and that these patients will continue to dialyze at BMA Asheboro in the future. As BMA demonstrates growth of the Randolph County patient population, these five patients will be added to the census at appropriate points in time to demonstrate the facility census for certain dates and the projected utilization for those dates." ...

BMA begins with the BMA Asheboro census reported in the July 2010 SDR, December 31, 2009, less the five patients from other counties.	*111-5 =106*
BMA projects this population forward for 12 months to December 31, 2010 at the Randolph County Five Year Average Annual Change Rate[.]	*(106 X .093) +106 = 115.9*
BMA again projects this population forward for 12 months to December 31, 2011.	*(115.9 X .093) + 115.9 = 126.6*
BMA projects this population forward for 6 months to June 30, 2012 at one half of the Randolph County Five Year Average Annual Change Rate. This is the projected certification date of the project[.]	*[126.6 X (.093/12) X 6)] + 126.6 = 132.5*
BMA adds the 3 Randolph County in-center patients projected to transfer with CON Project ID# G-8489-10, and 5 patients from other counties. This is the projected beginning census of this project.	*132.5 + 3 + 5 = 140.5 (135.5 Randolph County patients)*
There are three Randolph County Peritoneal Dialysis patients at BMA Greensboro who desire to transfer their care to the BMA Asheboro facility upon completion of this project. This transfer is scheduled for June 30, 2012[.]	*140.5 + 3 = 143.5 (138.5 Randolph County patients)*
Project the Randolph County patient population forward for one year to June 30, 2013. This is the end of Operating Year 1.	*(138.5 X .093) + 138.5 = 151.4 Includes home patients*
Add the five patients from other counties; this is the projected ending census for Operating Year 1.	*151.4 + 5 = 156.4 Includes home patients*
Project the Randolph County patient population forward for one year to June 30, 2014. This is the end of Operating Year 2.	*(151.4 X .093) + 151.4 = 165.5 Includes home patients*
Add the five patients from other counties; this is the projected ending census for Operating Year 2.	*165.5 + 5 = 170.5 Includes home patients*

In calculating patient projections, the applicant rounds down to the nearest whole number. Thus, the applicant projects 150 in-center patients dialyzing on 44 dialysis stations in Operating Year One and 157 in-center patients dialyzing on 44 dialysis stations (applicant proposes to dedicate two stations to home dialysis) Operating Year Two; which results in the following utilization:

Operating Year One
Station Utilization: 150 patients dialyzing on 44 stations = 3.4 patients/station.
Facility Utilization: 150 / (4 X 44) = 0.85 or 85% utilization

Or if calculated using all 46 stations, utilization is also consistent with 10A NCAC 14C .2203(b).

Station Utilization: 150 patients dialyzing on 46 stations = 3.2 patients/station.
Facility Utilization: 150 / (4 X 46) = 0.81 or 81% utilization

Operating Year Two
Station Utilization: 157 patients dialyzing on 44 stations = 3.5 patients/station.
Facility Utilization: 157 / (4 X 44) = 0.89 or 89% utilization

Or if calculated using all 46 stations, utilization is also consistent with 10A NCAC 14C .2203(b).

Station Utilization: 157 patients dialyzing on 46 stations = 3.4 patients/station.
Facility Utilization: 157 / (4 X 46) = 0.85 or 85% utilization

The applicant projects to serve 150 in-center patients using 44 stations (two dedicated to home training) in Operating Year One which is 3.4 patients per station [150 / 44 = 3.4] or 3.2 patients per station if calculated using all 46 stations [150 / 46 = 3.2], which is consistent with 10A NCAC 14C .2203(b).

The applicant proposes to offer home training at the new BMA Asheboro location and discusses the proposed home therapy program in Section II., pages 26-29 and Section III., pages 54-57. The applicant states:

> *"BMA will offer home hemo-dialysis and home peritoneal dialysis training and home support. At present, BMA Asheboro does not offer home therapies; this is a function of space constraints at the facility. The relocated facility will have more space, and is planned to have space dedicated to the home training program. BMA proposes to offer two of the 46 dialysis stations as training stations for home hemo-dialysis, and will also have two home training rooms for peritoneal dialysis.*
>
> *The July 2010 SDR reports that there were six home dialysis patients in Randolph County as of December 31, 2009. This represented 4.3 % of the ESRD patient population of the County. This percentage is low when compared to North Carolina as a whole. The SDR reports that the State had 13,751 dialysis patients as of December 31, 2009; of these, 1,344 or 9.77% were home patients.*
>
> *It is probable that the home patient population of Randolph County is lower than the State average in part due to the absence of a home training program at BMA Asheboro. …*

BMA is currently providing home care for three of the Randolph County home patients at the BMA Greensboro facility under the care of a nephrologist from Carolina Kidney Associates; these patients have expressed support for the project. BMA is NOT going to suggest that other current home patients will transfer their care to the new BMA Asheboro facility. However, BMA does project the three patients currently receiving home care at BMA Greensboro will transfer their care to the relocated and expanded BMA Asheboro. In addition, BMA is going to project that as the facility is relocated and a home therapy program is initiated at BMA Asheboro, some of the projected patient population at BMA Asheboro will transition to home dialysis.

In making such projections, BMA necessarily assumes that the home patient population of BMA Asheboro will start with three transferring patients; BMA also projects the home patient population is going will [sic] *increase. BMA projects this program to eventually reach, or exceed the State averages. However, in making projections for the home patient population, BMA must offer conservative and reasonable projections. Given the relatively small home patient population in Randolph County as reported in the SDR, the addition of even one patient gives the appearance of a 16% growth (1 /6 = 16.7%). Despite the possible assertion that such growth is unreasonable, BMA projects that the home patient population of BMA Asheboro will be a function of patients projected to receive dialysis at BMA Asheboro making the choice to transition to home dialysis. From the above projections, BMA projects in-center and home patients as follows:*

Completion of Project June 30, 2012 143.5 round down to 143

At this point due to the absence of a home training program at BMA Asheboro, the home census is projected to begin at zero. However, three patients are planned to transfer from BMA Greensboro home training (not to be confused with three patients transferring from BMA Southwest Greensboro, CON Project ID # G-8489-10). Thus the beginning home census is three patients. These three peritoneal patients added to the calculated census above result in a total census of 143. The following table identifies the patient population by modality.

BMA Asheboro, June 30, 2012		
In-center	*140*	*140*
Home hemo-dialysis	*0*	*0*
Home peritoneal dialysis	*3 transfers from BMA Greensboro*	*3*
	Total	*143*

End Operating Year 1 June 30, 2013 146.4, round down to 156

BMA projects that one of the 153 patients will choose to use home peritoneal dialysis and two patients will choose home hemo-dialysis.

BMA Asheboro, June 30, 2013		
In-center		*150*
Home hemo-dialysis	*2 change modality*	*2*
Home peritoneal dialysis	*1 change modality + 3*	*4*
	Total	*156*

End Operating Year 2 June 30, 2014 170.5, round down to 170

BMA projects that five additional patients will change modality to home peritoneal dialysis and two additional patients will utilize home hemo-dialysis; thus, the home program will be nine PD patients and four HH patients at this point.

BMA Asheboro, June 30, 2014		
In-center		*157*
Home hemo-dialysis	*2 + 2 change modality*	*4*
Home peritoneal dialysis	*4 + 5 change modality*	*9*
	Total	*170*

BMA clearly recognizes that the above projections, three new home patients in the first operating year, and seven new home patients in the second year may seem aggressive growth projections. Couple these projections with the home patient population reported in the July SDR, and it appears that BMA is projecting the home patient population to more than double in two years. However, BMA is cognizant of the fact that the State average for home patients is 9.77%. At the end of Operating Year two of this project, assuming no growth in the six patients as reported in the SDR, plus the nine new patients BMA projects in Operating Year 2, the home patient population of the County could be 16 patients. If Randolph County home patient population were equal to the State average, 9.77%, then the home patient population for Randolph County could be projected to be 15 patients at the end of 2010 (Table B of the July 2010 SDR projects the Randolph County ESRD patient population to be 154.1 patients as of December 31, 2010; 151.4 X .0977 = 15.1). Thus, BMA does not believe its projections of a home patient population of 16 patients by June 30, 2014 to be excessive; rather, this is conservative considering that the new facility will offer an otherwise unavailable service in the County."

...

"It has been FMC (parent to BMA) experience that the home hemo-dialysis patient population is growing nationwide and significantly within North Carolina. After careful consideration of the above, BMA plans to utilize two dialysis stations as dedicated home hemo-dialysis training station[s]*. This will assure BMA Asheboro is properly prepared for future growth of the home hemo-dialysis patient population.*

The following table identifies the expected county of origin for the patients expected to be dialyzing at BMA Asheboro during Operating Years 1 and 2 of this project."

County	Operating Year 1			Operating Year 2			County patients as a Percent of Total	
	In-Center	HH	PD	In-Center	HH	PD	Year 1	Year 2
Randolph	145	2	4	152	4	9	96.8%	97.1%
Davidson	3	0	0	3	0	9	1.9%	1.8%
Guilford	1	0	0	1	0	0	0.6%	0.6%
Chatham	1	0	0	1	0	0	0.6%	0.6%
Subtotals	150	2	4	157	4	9	100%	100%
TOTAL	156			170				

The applicant's projected patient utilization in the first two operating years is reasonable, based on 75 signatures on a petition of support from patients who have expressed an interest in transferring to the proposed facility in Asheboro, historical origin, and the historical rate of growth for Randolph County in-center hemodialysis patients. The petition indicates that they are current BMA patients, that they are aware the letter will be used as support for the BMA CON application, and that they consent for their names to be associated with the application. The applicant states the endorsement from the three BMA Greensboro patients is included. Thus, the application conforms to the required minimum of 3.2 patients per station per week as required by 10A NCAC 14C .2203(b).

BMA Asheboro currently is not able to offer home training and their patients who want home dialysis have to leave the county. With this proposal, current home dialysis patients who are residents of Randolph County can remain in Randolph County for home training follow-up.

The applicant projects to serve 150 in-center patients using 44 stations (two dedicated to home training) in Operating Year One which is 3.4 patients per station [150 / 44 = 3.4] or 3.2 patients per station if calculated using all 46 stations [150 / 46 = 3.2], which is consistent with 10A NCAC 14C .2203(b).

In summary, the applicant adequately identified the population to be served and adequately demonstrated the need that this population has for the proposed service. Therefore, the application is 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.

NA – TRC
C – BMA

TRC - NA

BMA - proposes to relocate its existing Asheboro facility and expand by 10 stations. The replacement facility will also be in Asheboro. In Section XI., page 92, the applicant states, *"The site is located less than two miles from the current facility."* In Section III.6, page 49, the applicant states, *"The patient population of BMA Asheboro will not be adversely affected by this relocation project. ... There is no effect to any patient currently served, or patients to be served by relocation of the facility.*

... failure to relocate the facility will inhibit BMA's ability to develop home therapies to serve the ESRD patient population of Randolph County. ..."

In Section II., pages 26-27 and Section III., pages 54-55, the applicant states,

> *"BMA will offer home hemo-dialysis and home peritoneal dialysis training and home support. At present, BMA Asheboro does not offer home therapies; this is a function of space constraints at the facility. The relocated facility will have more space, and is planned to have space dedicated to the home training program. BMA proposes to offer two of the 46 dialysis stations as training stations for home hemo-dialysis, and will also have two home training rooms for peritoneal dialysis."*

BMA Asheboro currently is not able to offer home training and their patients who want home dialysis have to leave the county. With this proposal, current home dialysis patients who are residents of Randolph County can remain in Randolph County for home training follow-up.

In summary, the patients proposed to transfer to BMA Asheboro have demonstrated their willingness to do so by signing a petition of support for the proposed project. The petition indicates that they are current BMA patients, that they are aware the letter will be used as support for the CON application filed by BMA, and that they consent for their names to be associated with the application. The applicant states the endorsement from the three BMA Greensboro patients is included. The *Zip Code of Residence* report from the Southeastern Kidney Council shows eleven total Randolph County home patients as of October 6, 2010.

The applicant has further demonstrated that the needs of the population presently served at BMA Asheboro will continue to be adequately met following the relocation of the existing facility. 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 – TRC
C – BMA

TRC – In Section III.9, pages 33-34, the applicant discusses the alternatives it considered which included doing nothing or giving dialysis patients in Randolph County another

alternative for dialysis care. The applicant proposes to develop a new dialysis facility to serve Randolph County patients.

However, the application is not conforming to all other applicable statutory and regulatory review criteria. See Criteria (1) and (13c). Therefore, the applicant did not adequately demonstrate that the proposal is its most effective alternative. Consequently, the application is not conforming to this criterion and is disapproved.

BMA – In Section III.9, pages 58-59, the applicant discusses the alternatives it considered which included maintaining the current location and developing a new 10 station dialysis facility with home therapies at another location. The applicant states this is too costly. The option of fewer stations was dismissed by the applicant as the applicants states the Asheboro facility will exceed the 3.2 patients per station utilization requirement within the first year of operation. The third option the applicant considered was not to develop home therapies at the new facility. The applicant chose not to pursue this option because the applicant has a history of offering home dialysis services in the communities in which their patients live. Currently, no home dialysis training services are available in Randolph County, thus, any patient currently on home dialysis or any in-center patient for whom home dialysis is an option, must travel out of Randolph County to receive theses services. The applicant states, *"... Relocation is cost effective and will allow BMA to develop home therapies at BMA Asheboro to better serve the patients of Randolph County."*

Furthermore, the application is conforming to all other applicable statutory and regulatory review criteria. See Criteria (1), (3), (5), (6), (7), (8), (12), (13), (14), (18a), (20), and the Criteria and Standards for End Stage Renal Disease Services promulgated in 10A NCAC 14C .2200. Therefore the applicant adequately demonstrates that the proposal is its most effective alternative, subject to the conditions at the conclusions of these findings.

(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 – Both Applications

TRC – In Section VIII., pages 50-51, the applicant projects a total capital cost of $1,416,767, as shown in the following table. The project analyst notes that the applicant projects the cost of each dialysis machine as $3,800 on page 50, however, page 51 shows a total cost for 12 dialysis machines as $165,000, which would be for 12 dialysis machines at a cost of $13,800 each. Thus, the $3,800 appears to be a typographical error only.

Capital Costs	
Cost of Materials	$492,000
Cost of Labor	$328,000
Equipment/Furniture	$477,667
Architect/Engineering Fees	$69,000
Miscellaneous Equipment	$50,100
Total	$1,416,767

In Section IX, pages 54-55, the applicant projects start-up costs. In Section IX.2(b), page 54, the applicant states initial operating expenses as $947,261 and then as $719,007, as shown below.

2. Estimated Initial Operating Expenses
   Total Estimated Initial Operating Expenses: *"$947,261"*

   "RESPONSE: Randolph County Dialysis projects that the ten stations will be at breakeven within six months of opening. The only cash requirements will be the amounts needed to initially up-fit the facility. The first six months of operation is calculated to be 50% of the annual operating expense budget or $719,007 added to the pre-opening start up expense of $134,797."

3. Total Working Capital:

   "RESPONSE: Estimated start-up expenses of $134,797 and estimated initial operating expenses of $719,007 a total of $853,804."

The $947,261 appears to be a typographical error as the applicant projects the total working capital to be $853,804 in multiple responses.

On page 55, the applicant indicates $853,804 in cash reserves to be used to fund the total working capital. Exhibit 21 contains a letter from the Chief Accounting Officer of DaVita, Inc. which states in part:

> *"I am the Chief Accounting Officer of DaVita, Inc., the parent and 100% owner of Total Renal Care, Inc. I also serve as the Chief Accounting Officer of Total Renal Care, Inc which owns 85% of the ownership interests in Total Renal Care of North Carolina, LLC ("TRC"). ... The project calls for a capital expenditure of $1,416,767, and a working capital requirement of $719,007. DaVita and Total Renal Care of North Carolina, LLC have committed cash reserves in the amount of $2,272,004 for this project. We will ensure that these funds are made available for the development and operation of this project."*

Exhibit 22 contains the audited financial statements for DaVita, Inc. for fiscal years ending December 31, 2007 – December 31, 2009. As of December 31, 2009, DaVita, Inc. had $539,459,000 in cash and cash equivalents, total assets of $7,558,236,000, and

$2,525,884,000 in total net assets [total assets – total liabilities ($5,032,352,000)]. The applicant adequately demonstrates the availability of sufficient funds for the capital and working capital needs of the project.

In Section X, pages 56-59, the applicant projects revenues and operating costs, as illustrated in the following table:

	Year 1	Year 2
Projected Operating Expenses	$1,446,054	$1,571,904
Projected # of Dialysis Treatments*	4,594	5,113
Average Cost per Treatment	$314.77	$307.43
Net Patient Revenue	$1,458,512	$1,623,222
Net Revenue per Treatment	$317.48	$317.47
Net Profit/Loss	$12,458	$51,318

*Based on applicant's assumption of total treatments less 5% for missed treatments.

As shown in the above table, revenues are projected to exceed operating expenses in Year One and Year Two. The rates in Section X.1 are consistent with standard Medicare/Medicaid rates established by the Centers for Medicare and Medicaid Services.

The assumptions used in preparation of the pro formas, including the number of projected treatments are reasonable. See Criterion (3) for discussion of projected utilization. The applicant adequately demonstrated that the financial feasibility of the project is based on reasonable projections of revenue and costs. Therefore the application is conforming to this criterion.

BMA - In Section VIII., pages 78-80, the applicant projects a total capital cost of $1,416,767, as shown in the following table:

Capital Costs	
Construction Contract	$1,860,785
Equipment/Furniture	$467,533
Architect/Engineering Fees	$130,166
Contingency	$157,645
Total	$2,616,129

In Section IX, pages 82, the applicant projects that there will be no start-up costs or initial operating expenses. In Section IX, page 79, the applicant states that capital costs associated with the project will be funded through accumulated reserves. Exhibit 24 contains a letter from the Vice President, Fresenius Medical Care Holdings, Inc. which states in part:

> *"This is to inform you that Fresenius Medical Care Holdings, Inc. is the parent company of National Medical Care, Inc. and Bio-Medical Applications of North Carolina, Inc. … The project calls for the following capital expenditure on behalf of*

BMA. ... $2,616,129. ... Further, I am authorized and do hereby authorize and commit cash reserves for the capital cost of $2,616,129 for the project."

Exhibit 10 contains the audited financial statements for Fresenius Medical Care Holdings, Inc for fiscal years ending December 31, 2008 – December 31, 2009. As of December 31, 2009, Fresenius Medical Care Holdings, Inc. had $153,303,000 in cash and cash equivalents, total assets of $11,840,412,000, and $5,996,739,000 in total net assets [total assets – total liabilities ($5,843,673,000)]. The applicant adequately demonstrates the availability of sufficient funds the capital and working capital needs of the project.

In Section X, pages 83-89, the applicant projects revenues and operating costs, as illustrated in the following table:

	Year 1	Year 2
Projected Operating Expenses	$7,175,183	$7,655,155
Projected # of Dialysis Treatments*	22,017	23,613
Average Cost per Treatment	$325.89	$324.19
Net Patient Revenue	$9,072,989	$9,738,064
Net Revenue per Treatment	$412.09	$412.40
Net Profit/Loss	$1,897,806	$2,082,909

*Based on applicant's assumption of total treatments less 6.5% for missed treatments.

As shown in the above table, revenues are projected to exceed operating expenses in Year One and Year Two. The rates in Section X.1 are consistent with standard Medicare/Medicaid rates established by the Centers for Medicare and Medicaid Services. The assumptions used in preparation of the pro formas, including the number of projected treatments are reasonable. See Criterion (3) for the discussion of projected utilization.

The assumptions used in preparation of the pro formas, including the number of projected treatments are reasonable. See Criterion (3) for discussion of projected utilization. The applicant adequately demonstrated that the financial feasibility of the project is based on reasonable projections of revenue and 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.

C- Both Applications

TRC - proposes to develop a new 10-station dialysis facility in Randolph County pursuant to a county need determined in the 2010 SMFP. See Criterion (1) for discussion. The applicant adequately demonstrated the need for the proposal. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrated that the proposal would not result in unnecessary duplication of existing or approved health service capabilities or facilities, and the application is conforming to this criterion.

BMA - proposes to develop a 46 station dialysis facility by doing the following: relocating the existing 27 station facility located in Asheboro; adding 10 new stations pursuant to the county need methodology in the 2010 SMFP; adding seven stations [for a total of 34] which was approved in Project ID # G-8420-09; and relocating two stations from BMA Southwest Greensboro [for a total of 36 stations] which was approved in Project ID # G-8489-10. The applicant adequately demonstrated the need for the proposal. See Criterion (3) for discussion. Therefore, the applicant adequately demonstrated that the proposal would not result in unnecessary duplication of existing or approved health service capabilities or facilities, and the application is 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- Both Applications

TRC – In Section V.4(c), page 39, the applicant states that Jennifer Klenzak, MD has agreed to serve as Medical Director for the facility. Exhibit 16 contains a letter from Dr. Klenzak stating her intent to serve in that role. Additionally, Exhibit 15 contains letters of support from two nephrologists who have agreed to provide medical coverage at the facility. In Section VII, page 46, the applicant projects the following staffing following project completion. As shown in the table below, TRC proposes a total of 9.1 FTE positions, 6.7 of which will be direct care positions.

Position	Full-Time Equivalents (FTEs)
RN (dc)	1.0
RN Home Training (dc)	0.2
Patient Care Technician (dc)	4.5
Bio-Med Tech	0.3
Medical Director	Contracted Position
Administrator (dc)	1.0
Dietician	0.3
Social Worker	0.3
Unit Secretary	1.0
Reuse	0.5
Total	9.1

dc = direct care

The following table shows hours of operation as proposed by the applicant in Section VII, page 49.

Weekly Hours of Operation					
	Morning	Afternoon	Evening	Nocturnal	Total
Monday	4	4	0	0	8
Tuesday	4	4	0	0	8
Wednesday	4	4	0	0	8
Thursday	4	4	0	0	8
Friday	4	4	0	0	8
Saturday	4	4	0	0	8
Sunday	0	0	0	0	0
Total	24	24	0	0	48
Total Hrs. Operation per Year (wkly hrs. x 52)					2,496

This table shows the number of direct care FTE staff the applicant proposes as well as an analysis of how many FTEs will be required based on the number of hours the facility will operate.

	FTEs	Hrs/Yr/FTE	Projected FTE Hrs (annual)	Total Hrs of Operation (annual)	FTE Hrs/Hrs of Operation
RNs	2.2	2,080	4,576	2,496	1.8
Techs	4.5	2,080	9,360	2,496	3.8
Total	6.7	2,080	13,936	2,496	5.6

In Section VII, page 46 the applicant projects 6.7 direct care FTE positions. Assuming one FTE works 2,080 hours annually, the project analyst calculated the projected direct care FTE hours [for example: 2.2 RNs x 2,080 hrs = 4,576 FTE hrs available and 2,496 FTE hrs are needed]. Therefore the applicant has projected sufficient direct care FTE hours to operate the dialysis facility. Based on the proposed operating hours, the applicant has 2,496 hours of operation to cover. The applicant proposed more FTE hours than necessary, thus the applicant has sufficient staffing.

In addition, the applicant projects to serve 32 patients on ten stations in two shifts in the first Operating Year and 35 patients on ten stations in the second Operating Year. The facility can serve 10 in-center patients on ten stations per shift. The morning and afternoon dialysis shifts run Monday – Saturday four hours each, based on the projected operating schedule in Section VII, page 49.

Time/Shift	M/W/F Patients	T/TH/SA Patients
Morning (10 stations)	10	10
Afternoon (10 stations)	10	10
Evening (10 stations)	na	na
Nocturnal (10 stations)	na	na

The table above illustrates that the proposed TRC Randolph County dialysis facility would have capacity to dialyze up to 40 in-center patients in Operating Year One on ten dialysis stations, assuming one patient per station per patient shift, which is sufficient to accommodate the 32 in-center patients it projects to serve [example: 4 shifts x 10 dialysis stations = 40 patient capacity]. In the Second Project Year, the applicant projects to serve 35 in-center patients on ten stations. Likewise, the applicant has sufficient capacity to accommodate the 35 in-center patients it projects to serve.

The applicant states that it does not anticipate having any difficulty staffing the proposed facility. The applicant adequately documented the availability of resources, including health manpower and management personnel for the level of dialysis services proposed. Therefore, the application is conforming to this criterion.

BMA - In Section V.4(c), page 65, the applicant states that Martin Webb, MD has agreed to serve as Medical Director for the facility. Exhibit 21 contains a letter from Dr. Webb stating his intent to serve in that role. Additionally, Exhibit 21 contains letters of support from seven nephrologists who have agreed to provide medical coverage at the facility. In Section VII, page 75, the applicant projects the following staffing following project completion. As shown in the table below, BMA proposes a total of 32.6 FTE positions, 26.5 of which will be direct care positions.

Position	Full-Time Equivalents (FTEs)
RN (dc)	7.0
Technician (dc)	17.0
Nurse Assistant (dc)	1.5
Clinical Manager	1.0
Medical Director	Contracted Position
Administrator	0.2
Dietician	1.0
Social Worker	1.0
Home Training Nurse (dc)	1.0
Chief Tech	0.5
Equipment Tech	1.0
In-Service	0.4
Clerical	1.0
Total	32.6

dc = direct care

The following table shows hours of operation as proposed by the applicant in Section VII, page 77.

Weekly Hours of Operation					
	Morning	Afternoon	Evening	Nocturnal	Total
Monday	5	5	5	0	15
Tuesday	5	5	0	8	18
Wednesday	5	5	5	0	15
Thursday	5	5	0	8	18
Friday	5	5	5	0	15
Saturday	5	5	0	0	10
Sunday	0	0	0	8	8
Total	30	30	15	24	99
Total Hrs. Operation per Year (wkly hrs. x 52)					5,148

This table shows the number of direct care FTE staff the applicant proposes as well as an analysis of how many FTEs will be required based on the number of hours the facility will operate.

	FTEs	Hrs/Yr/FTE	Projected FTE Hrs (annual)	Total Hrs of Operation (annual)	FTE Hrs/Hrs of Operation
RNs	7.0	2,080	14,560	5,148	2.8
NA	1.5	2,080	3,120	5,148	.6
Techs	17.0	2,080	35,360	5,148	6.9
Total	25.5	2,080	53,040	5,148	10.3

In Section VII., page 75, the applicant projects 26.5 direct care FTE positions. Assuming one FTE works 2,080 hours annually, the project analyst calculated the projected FTE hours [for example: 7 RNs x 2,080 hrs = 14,560 FTE hrs available and 5,148 FTE hrs are needed]. Therefore the applicant has projected sufficient direct care FTE hours to operate the dialysis facility. Based on the proposed operating hours, the applicant has 5,148 hours of operation to cover. The applicant proposed more FTE hours than necessary, thus the applicant has proposed sufficient staffing.

In addition, the applicant projects to serve 150 patients on 44 stations in morning and afternoon (2 shifts) shifts Monday – Saturday; evening (1 shift) shift Monday, Wednesday and Friday; and a nocturnal (1 shift) shift Tuesday, Thursday and Sunday, in Operating Year One and 157 patients on 44 stations (same shifts) in Operating Year Two. The facility can serve 44 in-center patients on 44 stations per shift. The morning and afternoon dialysis shifts run Monday – Saturday for four hours each. The evening shift runs Monday, Wednesday and Friday for five hours each. The nocturnal shift runs Tuesday, Thursday and Sunday, for eight hours each, based on the projected operating schedule in Section VII, page 77.

Time/Shift	M/W/F Patients	T/TH/SA Patients
Morning (44 stations)*	44	44
Afternoon (44 stations)	44	44
Evening (44 stations)	44	na

*per the applicant 44 stations will be in regular use for in-center patients; two stations will be reserved for home training.

The table above illustrates that the proposed BMA Randolph County dialysis facility would have capacity to dialyze up to 220 in-center patients in Operating Year One on 44 dialysis stations, assuming one patient per station per patient shift, which is sufficient to accommodate the 150 in-center patients it projects to serve [example: 5 shifts x 44 dialysis stations = 220 patient capacity]. In the Second Project Year, the applicant projects to serve 157 in-center patients on 44 stations. Likewise, the applicant has sufficient capacity to accommodate the 157 in-center patients it projects to serve. The applicant also proposes a nocturnal shift for Tuesday, Thursday and Sunday.

The applicant states that it does not anticipate having any difficulty staffing the proposed facility. The applicant adequately documented the availability of resources, including health manpower and management personnel for the level of dialysis services proposed. Therefore, the application is conforming 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.

C- Both Applications

TRC – In Section V, page 37 and referenced exhibits, the applicant provides a list of the ancillary and support services provided by the facility and other area providers, including: Moore Regional Hospital - acute dialysis services, emergency services, diagnostic evaluation, X-ray, blood bank, and vascular surgery, Carolinas Medical Center - renal transplantation and pediatric nephrology services, and Dialysis Laboratories will provide laboratory services. The applicant adequately demonstrated that the necessary ancillary and support services will be available and that the proposed services will be coordinated with the existing health system. Therefore, the application is conforming to this criterion.

BMA - In Section V, page 62 and referenced exhibits, the applicant provides a list of the ancillary and support services provided by the facility and other area providers, including: Moses Cone Hospital - acute dialysis services, diagnostic evaluation and blood bank, Randolph County Hospital - emergency services, diagnostic evaluation, vascular surgery and X-ray, University of North Carolina Medical Center, Duke University Medical Center, North Carolina Baptist Hospital and Carolinas Medical Center - renal transplantation, and University of North Carolina Medical Center - pediatric nephrology services. SPECTRA will provide laboratory services. The applicant adequately demonstrated that the necessary

ancillary and support services will be available and that the proposed services will be coordinated with the existing health system. Therefore, the application is conforming to this criterion.

(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 – Both Applications

(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 (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 – Both Applications

(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 – Both Applications

TRC – In Section XI, pages 62-64, the applicant discusses the primary and secondary sites for the proposed dialysis facility. The applicant plans to upfit leased space. Both sites are located at Randolph Mall which is near Highway 64, one of the major thoroughfares in Asheboro. The applicant proposes that either site will provide easy access to patients in Randolph County. On page 62, the applicant states the facility proposed on the primary site

will be 90,169 square feet with energy saving features as described on page 65. Therefore, the applicant adequately demonstrates that the cost, design and means of construction represent the most reasonable alternative, and that the construction project will not unduly increase the costs of or charges for providing health services. See Criterion (5) for discussion of costs and charges. The application is conforming to this criterion.

BMA – In Section XI, pages 91-94, the applicant discusses the primary and secondary sites for the proposed dialysis facility. The applicant plans to upfit leased space. The applicant states that the primary and secondary sites will provide easy access from the major highways of US 64 (east-west), and I-74 (north-south) through Asheboro. The applicant also proposes that the sites are central to the current BMA dialysis patients and will reduce their commute time. Neither site is currently zoned for a dialysis center; however the applicant states that BMA has engaged a real estate firm that has expressed confidence that the City of Asheboro would allow the necessary rezoning for the proposed facility. On page 98, the applicant states the facility will be 17,280 square feet with energy saving features as described on page 96. Therefore, the applicant adequately demonstrates that the cost, design and means of construction represent the most reasonable alternative, and that the construction project will not unduly increase the costs of or charges for providing 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;

NA – TRC
C – BMA

BMA – In Section II., page 34-35 and Section VI., page 70 the applicant discusses equitable access. The applicant states, *"... BMA Asheboro provides services to historically underserved populations. 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 addition, on page 70 the applicant states that in FY 2009, Medicare represented 80% of the dialysis treatments given in BMA facilities in North Carolina, and Medicaid treatments represented 4.1%; while the BMA Asheboro facility 63.2%

of its patients received some type of Medicare benefit and 10.4% some type of Medicaid/Low Income benefit. The applicant demonstrated that BMA Asheboro currently provides adequate access to medically underserved populations. Therefore, 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 – Both Applications

TRC – In Section VI.6(a), page 45, the applicant denies any civil rights equal access complaints filed within the last five years against any of the facilities operated by Total Renal Care of North Carolina, LLC or by any DaVita-owned facility in North Carolina. Therefore, the application is conforming with this criterion.

BMA – In Section VI.6(a), page 73, the applicant denies any civil rights equal access complaints filed within the last five years against any BMA facilities in North Carolina. Therefore, the application is conforming with this criterion.

(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

NC – TRC
C – BMA

TRC – In Section VI.1, page 42, the applicant states the following:

"Randolph County Dialysis, by policy, will make dialysis services available to all residents in its service area without qualifications. We will serve patients without regard to race, sex, age, or handicap. We will serve patients regardless of ethnic or socioeconomic situation.

Randolph County Dialysis will make every reasonable effort to accommodate all of its patients; especially those with special needs such as the handicapped, patients attending school or patients who work. The facility will provide dialysis six days per week with two patient shifts per day to accommodate patient need.

Randolph County Dialysis will not require payment upon admission to its services; therefore, services are available to all patients including low income

persons, racial and ethnic minorities, women, handicapped persons, elderly and other under-served persons."

The following table illustrates the projected payor mix, as provided by the applicant in Section VI.1, page 42:

Payor Source	
Medicare/Medicaid	40.7%
Medicare/ Commercial	24.1%
Medicare	22.2%
Commercial Insurance	5.6%
Medicaid	3.7%
VA	3.7%
Total	100.0%

On page 42, the applicant states:

"These are average percentages of patients who are currently dialyzing at the Dialysis Care of Montgomery County facility. Montgomery County is contiguous to Randolph County and located to the south of Randolph County. ..."

The applicant is correct that Montgomery County is contiguous to Randolph County, however, the applicant fails to demonstrate that the economic status of residents in Montgomery County is comparable to Randolph County and that the payor mix is comparable, as well. US Census Bureau data show substantial differences in the economic status of the two counties. The poverty level in Montgomery County is 40% higher than in Randolph County. The families living below the poverty level is 37.7% higher in Montgomery County than in Randolph County. The per capita income is 21.2% higher in Randolph County than in Montgomery County. Further, the population in Randolph County is 138,134 and in Montgomery County the population is 26,723. Of that population, the black or African American population in Randolph County is 6%; while in Montgomery County it is 19.5%. It is widely held that race impacts the incidence of kidney disease. These indicators impact the eligibility for Medicaid (source: US Census Bureau, 2005-2009 Survey). The applicant fails to provide any documentation which supports its assertion that the payor mix in Randolph County will duplicate that of Montgomery County. Thus it is not reasonable to assume that these two counties, although contiguous, are comparable in economic status.

The applicant did not demonstrate that the projected payor mix is based upon reasonable and supported assumptions. Therefore, the applicant did not demonstrate

that the facility will provide adequate access to medically underserved populations. Consequently, the application is not conforming to this criterion.

BMA – In Section VI.1, page 70, the applicant states the following:

> *"BMA has a long history of providing dialysis to the underserved populations of North Carolina. ... Each of our facilities has a patient population which includes low-income persons, racial and ethnic minorities, women, handicapped persons, elderly, or other traditionally underserved persons.*
>
> *... 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."*

The following table illustrates the projected payor mix for the dialysis facility, as provided by the applicant in Section VI.1, page 71. The project analyst averaged the proposed in-center and home patient payments:

Payor Source	
Medicare	75.0%
Commercial Insurance	14.6%
Medicaid	7.7%
VA	2.6%
Self/Indigent	.03%
Total	100.0%

Table may not foot due to rounding.

On page 71, the applicant states:

> "*Projections of future reimbursement are a function of historical performance. As the above table demonstrates, BMA does not expect any significant changes in the in-center payor mix for this facility. The home payor mix is obviously a new proposal for BMA Asheboro. The payor mix here is an estimate based upon BMA experience in other home programs, of similar size, in similar situation*[s]. *BMA has also considered the BMA Greensboro home payor mix; it should be noted that Greensboro is a more urban setting than Randolph County."*

The applicant demonstrates that medically underserved populations would have adequate access to the proposed dialysis facility. 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 – Both Applicants

TRC – In Section VI.5, pages 43-44, the applicant states:

> *"Patients with End Stage Renal Disease will have access to dialysis services upon referral to a Nephrologist with privileges at Randolph County Dialysis. These referrals will come from primary care physicians or specialty physicians in the Randolph County area or transfer referrals from other Nephrologists outside of the immediate area. …"*

The information provided by the applicant is reasonable and credible and supports a finding of conformity with this criterion.

BMA - In Section VI.5, page 73, the applicant states:

> *"Those Nephrologists who apply for and receive medical staff privileges will admit patients with End Stage Renal Disease to the facility. BMA Asheboro Dialysis Facility will have an open policy, which means any Nephrologist may apply to admit patients at the facility. The attending physicians receive referrals from other physicians or Nephrologists or hospital emergency rooms."*

The information provided by the applicant 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 – Both Applications

TRC – In Section V.3, pages 38-39, the applicant describes how the proposed dialysis facility will help meet the clinical training needs of the area health professional training programs. Exhibit 14 contains a copy of a letter the applicant sent to the President of Randolph Community College inviting the college to use the proposed dialysis facility as a clinical training site. The information provided is reasonable and credible and supports a finding of conformity with this criterion.

BMA – In Section V.3, pages 64-65, the applicant describes how the proposed dialysis facility will help meet the clinical training needs of the area health professional training

programs. Exhibit 19 contains a copy of a letter the applicant sent to the chair of Health Sciences and Public Services at Randolph Community College inviting the college to use the proposed dialysis facility as a clinical training site. The information provided is reasonable and credible and supports a finding of conformity with 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 – TRC
C – BMA

TRC - adequately demonstrated that the proposal would have a positive impact upon the cost effectiveness (See Section III.9, page 34, Section V.7, page 41, and Section VI, pages 42-43 of the Application), and quality (See Section II, pages 6-7, 25-26, and 33-34 of the Application) of the services proposed, for the following reasons:

a) the applicant adequately demonstrated that the proposal is cost effective [See Criteria (1), (3) (5)] and (6);
b) the applicant adequately demonstrated that its proposal will promote quality services [See Criteria (1), (7), (8), and (20)].

However, the applicant did not adequately demonstrate that its proposal would have a positive impact on access (See Section V, pages 37-38, 41, Section VI, pages 42-45 of the Application) to the services proposed, for the following reasons:

a) the applicant did not adequately demonstrate that its proposal would promote access to the proposed dialysis services [See Criteria (1) and (13c)].

Therefore, the application is not conforming to this criterion.

BMA - adequately demonstrated that the proposal would have a positive impact upon the cost effectiveness (See Section II, pages 35-36, Section III, pages 58-59, Section V, page 67, and Section VI pages 70-72 of the Application), quality (See Section II, pages 33-34 and

41-44 of the Application), and access (See Section II, pages 34-36, Section V, pages 62-63 and 67-69, and Section VI, pages 70-74 of the Application) to the services proposed, for the following reasons:

a) the applicant adequately demonstrated that the proposal is cost effective [See Criteria (1), (3) (5)] and (6);
b) the applicant demonstrated that it will provide adequate access to the proposed dialysis services [See Criteria (1) and (13)];
c) the applicant adequately demonstrated that it will provide quality services [See Criteria (1), (7), (8), and (20)].

Therefore, the application is 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.

NA – TRC
C – BMA

TRC – The applicant has no facility in Randolph County but currently provides dialysis services at other facilities in North Carolina.

BMA – The applicant currently provides dialysis services at the existing Randolph County facility. According to the files in the Acute and Home Care Licensure and Certification Section, Division of Health Service Regulation, the BMA Asheboro facility operated in compliance with the Medicare Conditions of Participation within the 18 months immediately preceding the date of this decision. Therefore, the application is 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.

C – Both Applications

The Criteria and Standards for End Stage Renal Disease Services, as promulgated in 10A NCAC 14C Section .2200, are applicable to this review.

The proposal submitted by TRC is conforming to all applicable Criteria and Standards for End Stage Renal Disease Services promulgated in 10A NCAC 14C Section .2200.

The proposal submitted by BMA is conforming to all applicable Criteria and Standards for End Stage Renal Disease Services promulgated in 10A NCAC 14C Section .2200.

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The specific findings are discussed below.

10A NCAC 14C .2202 INFORMATION REQUIRED OF APPLICANT

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

.2202(a)(1) Utilization rates;

-NA- **TRC.**

-C- **BMA.** See Section IV.1, page 60, and Exhibit 2 (copy of the July 2010 SDR).

.2202(a)(2) Mortality rates;

-NA- **TRC.**

-C- **BMA.** See Section IV.2, page 60, the applicant reports a 2009 facility mortality rate of 5.9%.

.2202(a)(3) The number of patients that are home trained and the number of patients on home dialysis;

-NA- **TRC.**

-NA- **BMA.** See Section IV.3, page 60, the applicant states that BMA Asheboro does not currently offer a home dialysis training program.

.2202(a)(4) The number of transplants performed or referred;

-NA- **TRC.**

-C- **BMA.** See Section IV.4, page 60, the applicant reports that in 2009 there were 0 transplants performed and 13 patients referred for transplant.

.2202(a)(5) The number of patients currently on the transplant waiting list;

-NA- **TRC.**

-C- **BMA.** See Section IV.5, page 60, the applicant reports 10 BMA Asheboro patients on the transplant waiting list.

.2202(a)(6) Hospital admission rates, by admission diagnosis, i.e., dialysis related versus non-dialysis related;

-NA- **TRC.**

-C- **BMA.** See Section IV.6, page 60, the applicant reported 144 hospital admissions; 18 admissions were dialysis related and 126 admissions were non-dialysis related in 2009.

.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.*

-NA- **TRC.**

-C- **BMA.** See Section IV.7, page 61, the applicant reported no conversions and no patients with infectious disease.

(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:

.2202(b)(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*

-C- **TRC.** See Exhibit 6, copy of a letter from Moore Regional Hospital which states the intent to enter into a patient transfer agreement upon issuance of a Certificate of Need.

-NA- **BMA.** Not a new facility and already has an existing provider agreement.

.2202(b)(2) *For new facilities, a letter of intent to sign a written agreement or 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- **TRC.** See Exhibit 7, a copy of the letter from Carolinas Medical Center for services related to renal transplantation.

-NA- **BMA.** Not a new facility and already has existing provider agreements.

.2202(b)(3) *For new or replacement facilities, documentation that power and water will be available at the proposed site.*

-C- **TRC.** See Section II.b(3), page 10 and Exhibit 8.

-C- **BMA.** See Section II.b(3), page 11 and Exhibits 30 and 31.

.2202(b)(4) *Copies of written policies and procedures for back up for electrical service in the event of a power outage.*

-C- **TRC.** See Section XI.6(f), page 66 and Exhibit 8.

-C- **BMA.** See Exhibit 12.

.2202(b)(5) *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- **TRC.** See Exhibit 24, information regarding the primary site – 345 Randolph Mall, Parcel C-2, Asheboro and the secondary site – 345 Randolph Mall, Parcel D-2, Asheboro.

-C- **BMA.** See Exhibit 30, information regarding the primary site – 187 Browers Chapel Road, Asheboro and Exhibit 31, the secondary site – 527 Central Avenue, Asheboro.

.2202(b)(6) *Documentation that the services will be provided in conformity with applicable laws and regulations pertaining to staffing, fire safety equipment, physical environment, water supply, and other relevant health and safety requirements.*

-C- **TRC.** See Sections II.(b)(5), page 11, VII, page 47, XI.6(g), pages 66-67. See also Exhibits 9, 26 and 27.

-C- **BMA.** See Sections II.1, page 12; VII.2, pages 75-76; and, XI.6(g), page 97. See also Exhibits 9, 11, 14, and 15.

.2202(b)(7) *The projected patient origin for the services. All assumptions, including the methodology by which patient origin is projected, must be stated.*

-C- **TRC.** See Sections II.(b)(6), page 11-22; III.7, pages 29-33, and Criterion (3).

-C- **BMA.** See Sections II.(b)(6), pages14-19; III.7, pages 50-59, and Criterion (3).

.2202(b)(8) *For new facilities, documentation that at least 80 percent of the anticipated patient population resides within 30 miles of the proposed facility.*

-C- **TRC.** See Sections II.(b)(8), page 14; III.8, page 33 and Exhibit 24.

-NA- **BMA.** Not a new facility and current patient population lives within 30 miles of the current facility. The new facility is located less than two miles from the current facility.

.2202(b)(9) *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 for such services.*

-C- **TRC.** See Section II, page 15.

-C- **BMA.** See Section II, page 20.

10 NCAC 14C .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.

-C- **TRC.** See Section III.7, page 32, TRC projects to have an in-center total of 32 patients (3.2 patients/station) [32/10 = 3.2] by the end of Year 1 and 35 in-center patients (3.5 patients/station) [35/10 = 3.5] by the end of Year 2 for the proposed 10-station facility. See Criterion (3) for additional discussion.

-NA- **BMA.** Not a new facility.

.2203(b) *An applicant proposing to increase the number of dialysis stations in an existing End Stage Renal Disease facility or one that was not operational prior to the beginning of the review period but which had been issued a certificate of need 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- **TRC.** The applicant does not propose to increase the number of dialysis stations in an existing facility.

-C- **BMA.** See Section III.7, page 54, BMA projects to have an in-center total of 150 patients (3.4 patients/station) [150/44 = 3.4] by the end of Year 1 and 157 in-center patients (3.5 patients/station) [157/44 = 3.5] by the end of Year 2 for the proposed 44-station facility (will dedicate 2 stations to home dialysis). See Criterion (3) for additional discussion.

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

-C- **TRC.** See Section III.7, pages 27-34, the applicant provides the assumptions and methodology used to project utilization of the proposed facility.

-C- **BMA.** See Section III.7, pages 50-59, the applicant provides the assumptions and methodology used to project utilization of the proposed facility.

10 NCAC 14C .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- **TRC.** See Sections II., page 22 and V.1(e), page 37, and Exhibit 6.
-C- **BMA.** See Sections II., page 30 and V.1(e), page 62, and Exhibit 16.

.2204(2) Maintenance dialysis;
-C- **TRC.** See Sections II., page 22 and V.1(c), page 37.
-C- **BMA.** See Sections II., page 30 and V.1(c), page 62.

.2204(3) Accessible self-care training;
-C- **TRC.** See Sections II., page 22 and V.1(d), page 37.
-C- **BMA.** See Sections II., page 30 and V.1(d), page 62.

.2204(4) Accessible follow-up program for support of patients dialyzing at home;
-C- **TRC.** See Section II., page 23.
-C- **BMA.** See Section II., page 30.

.2204(5) X-ray services;
-C- **TRC.** See Sections II., page 23 and V.1(g), page 37; and Exhibit 6.
-C- **BMA.** See Sections II., page 30 and V.1(g), page 62.

.2204(6) Laboratory services;
-C- **TRC.** See Sections II., page 23 and V.1(h), page 37; and Exhibit 10.
-C- **BMA.** See Sections II., page 30 and V.1(h), page 62; and Exhibit 18.

.2204(7) Blood bank services;
-C- **TRC.** See Sections II., page 23 and V.1(i), page 37; and Exhibit 6.
-C- **BMA.** See Sections II., page 30 and V.1(i), page 62.

.2204(8) Emergency care;
-C- **TRC.** See Sections II., page 23 and V.1(b), page 37; and Exhibit 6.
-C- **BMA.** See Sections II., page 30 and V.1(b), page 62.

.2204(9) Acute dialysis in an acute care setting;
-C- **TRC.** See Sections II., page 23 and V.1(a), page 37; and Exhibit 6.
-C- **BMA.** See Sections II., page 30 and V.1(a), page 62.

.2204(10) Vascular surgery for dialysis treatment patients
-C- **TRC.** See Sections II., page 23 and V.1(p), page 37; and Exhibit 6.
-C- **BMA.** See Sections II., pages 30-31 and V.1(p), page 62.

.2204(11) Transplantation services;
-C- **TRC.** See Sections II., pages 23-24 and V.1(f), page 37; and Exhibit 7.
-C- **BMA.** See Sections II., page 31 and V.1(f), page 62; and Exhibit 17.

.2204(12) Vocational rehabilitation counseling and services; and,
-C- **TRC.** See Sections II., page 24 and V.1(o), page 37.
-C- **BMA.** See Sections II., page 31 and V.1(o), page 62.

.2204(13) Transportation
-C- **TRC.** See Sections II., page 24 and V.1(q), page 37.
-C- **BMA.** See Sections II., page 31 and V.1(q), page 62.

10 NCAC 14C .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- **TRC.** See Sections II., page 24 and VII., pages 46-49. See Criterion (7) for discussion.

-C- **BMA.** See Sections II., page 31 and VII., pages 75-77. See Criterion (7) for discussion.

.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- **TRC.** See Sections II., page 24 and VII., pages 46-49; and Exhibits 20, 26 and 27

-C- **BMA.** See Sections II., page 31 and VII., pages 75-77; and Exhibits 14 and 15.

COMPARATIVE ANALYSIS OF THE COMPETING APPLICATIONS

Pursuant to N.C.G.S. 131E-183(a)(1) and the need determination in the July 2010 SDR, no more than 10 new dialysis stations may be approved in this review for Randolph County. Because both applications in this review collectively propose the development of more than 10 dialysis stations, both applications cannot be approved, since it would result in the approval of dialysis stations in excess of the need determination in the 2010 SMFP. After considering the information in each application and reviewing each application individually against all applicable review criteria, the project analyst also conducted a comparative analysis of the two proposals. For the reasons set forth below and in the remainder of the findings, the application submitted by Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro is approved and the application submitted by Total Renal Care of North Carolina, LLC (TRC) d/b/a Randolph County Dialysis is denied.

SMFP Principles

Basic Principle 12 regarding the Availability of Dialysis Care in Chapter 14, page 331, of the 2010 State Medical Facilities Plan states:

> *"The North Carolina State Health Coordinating Council encourages applicants for dialysis stations to provide or arrange for:*
> *a. Home training and backup for patients suitable for home dialysis in the ESRD dialysis facility or in a facility that is a reasonable distance from the patient's residence;*
> *b. ESRD dialysis service availability at times that do not interfere with ESRD patients' work schedules;*
> *c. Services in rural, remote areas."*

a) Home Training

In Section V.2(d), page 38, TRC states it will provide home training services and follow-up at the proposed facility. In Section V.2(d), pages 64, BMA states it will provide home training services and follow-up at the proposed facility. Both applications are equally effective alternatives with regard to the provision of home training services.

b) Hours of Availability

In Section VII.10, page 49 TRC states that dialysis services will be available 6:00 a.m. – 2:30 p.m. Monday through Saturday, which is 48 hours per week. In Section VII.10, page 77, BMA states that dialysis services will be available 7:00 a.m. – 5:00 p.m. Monday through Saturday; 5:00 p.m. – 10:00 p.m. Monday, Wednesday and Friday; and 9:00 p.m. – 5:00 a.m. Sunday, Tuesday and Thursday; which is 99 hours per week. BMA is the more effective alternative with regard to hours of availability.

c) Services in rural, remote areas

Asheboro in Randolph County is not a remote rural area.

Facility Location

Currently, BMA has a facility in Asheboro, Randolph County. Both applicants propose locations in Asheboro, which is centrally located within Randolph County and both locations are in close proximity to major highways. Therefore, both proposals are equally effective with regard to location for Randolph County residents.

Service to Randolph County Patients

BMA currently serves 111 in-center hemodialysis patients at the BMA facility in Asheboro. The nephrologists currently serving these patients will continue to do so at the proposed facility. On the other hand, TRC does not currently an in-center hemodialysis facility in Randolph County. With regard to service to Randolph County patients, the proposal submitted by BMA is the more effective alternative.

Access to Alternative Providers

Currently, BMA operates the only dialysis facility located in Randolph County. BMA operates six dialysis facilities in counties contiguous to Randolph County. TRC operates six dialysis facilities in counties contiguous to Randolph County and operates no dialysis facilities in Randolph County. With regard to providing dialysis patients access to an alternative provider in Randolph County, the TRC proposal is the more effective alternative.

Access by Underserved Groups

The following table compares access to Medicare and/or Medicaid recipients, as reported by TRC and BMA in Section VI.1(c) of their respective applications.

Payor Category	% of Total Patients	
	TRC	BMA*
Medicare	22.2%	72.5%
Medicaid	3.7%	7.4%
Medicare/Medicaid	40.7%	0.0%
Medicare/Commercial	24.1	0.0%
Total % Medicare/Medicaid	**90.7%**	**87.3%**
Commercial	5.6%	17.3%
VA	3.7%	2.8%
Self/Indigent	0.0%	.03%
Total	100.0%	100.0%

*Project analyst averaged projected in-center and home patient payor mix data.

As shown in the above table, TRC proposes the highest percentage of patients (90.7%) to have some or all of their services paid for by Medicare or Medicaid. However, TRC's projections were based on Montgomery County data (see Section VI., page 42), which are

not comparable to Randolph County economic characteristics as reported in U.S. Census data. See Criterion (13c) for discussion.

BMA proposes 87.3% (based on actual experience in Randolph County). Therefore, the proposal submitted by BMA is the more effective alternative with regard to access by underserved groups.

Access to Support Services

In Section V of the application, the applicants are required to identify the proposed providers of several support services including diagnostic evaluation, laboratory, blood bank, acute care, emergency care, and X-ray. The following table summarizes the proposed providers of these services for the applicants:

SUPPORT SERVICES	**TRC**	**BMA**
Diagnostic/Evaluation	Moore Regional Hospital	Randolph County Hospital, Moses Cone Hospital
X-ray	Moore Regional Hospital	Randolph County Hospital
Laboratory	DVA Laboratory Services	SPECTRA
Blood Bank	Moore Regional Hospital	Moses Cone Hospital
Emergency Care	Moore Regional Hospital	Randolph County Hospital
Vascular Surgery	Moore Regional Hospital	Randolph County Hospital
Acute Care Services	Moore Regional Hospital	Moses Cone Hospital

BMA proposes ancillary and support services to be provided by the only hospital in Randolph County, Randolph County Hospital and by Moses Cone Hospital in Guilford County. TRC proposes ancillary and support services to be provided by Moore Regional Hospital, which is in Moore County. Both Guilford and Moore Counties are contiguous to Randolph County. However, Moses Cone is a shorter distance from the proposed dialysis center facilities than Moore Regional Hospital.

The following table represents a mileage chart, prepared by the analyst with information derived from *MapQuest,* a website providing distance calculations between addresses.

Distance between Proposed Dialysis Facilities and Affiliated Hospitals in Above Table				
Start	Destination	Distance/Est Travel Time	Destination	Distance/Est Travel Time

TRC Proposed Site – Randolph Mall, 1437 E Dixie Drive Asheboro NC	Moore Regional Hospital – 155 Memorial Drive, Pinehurst, NC	50.12 miles/55 minutes	na	na
BMA Proposed Site – 186 Brower's Chapel Road, Asheboro, NC	Randolph County Hospital – 364 White Oak Street, Asheboro, NC	2.97 miles/6 minutes	Moses Cone Hospital – 1200 North Elm Street, Greensboro, NC	31.38 miles/37 minutes

Each of the applicants proposes to offer ancillary and support services via the above named hospitals. The only hospital that is less than fifteen miles from the proposed dialysis facilities is Randolph County Hospital in Asheboro, and is approximately three miles in distance. Moses Cone, the second hospital with which BMA proposes as a provider of ancillary and support services, is approximately 31 miles. TRC proposes Moore Regional Hospital as a provider of ancillary services and support services, which is the greatest distance at approximately 50 miles from the proposed TRC dialysis facility. With regard to accessibility to support services, the proposal submitted by BMA is the more effective alternative.

Operating Costs and Revenues

In Section X of the application, each applicant projects revenues and operating costs for the first two operating years of the proposed project. The following tables compare operating costs and revenues.

Operating Costs

TRC	Year 1	Year 2
Projected Expenses	$1,446,054	$1,571,904
# of Dialysis Treatments	4,594	5,113
Average Cost per Treatment	$314.77	$307.43

BMA	Year 1	Year 2
Projected Expenses	$7,175,183	$7,655,155
# of Dialysis Treatments	22,017	23,613
Average Cost per Treatment	$325.89	$324.19

As shown in the above table, TRC projects lower costs per treatment in each of the first two operating years; $11.12 less in Year One and $16.76 less in Year Two.

Revenues

TRC	Year 1	Year 2

Patient Revenue	$1,458,512	$1,623,222
# of Dialysis Treatments	4,594	5,113
Net Revenue per Treatment	$317.48	$317.47

BMA	Year 1	Year 2
Net Patient Revenue	$9,072,989	$9,738,064
# of Dialysis Treatments	22,017	23,613
Net Revenue per Treatment	$412.09	$412.40

As shown in the above table, TRC projects lower revenue per treatment in each of the first two operating years; $94.61 less in Year One and $94.93 less in Year Two. Therefore, the proposal submitted by TRC is the less costly alternative with regard to operating costs and revenues.

Direct Care Staff Salaries

The following table compares annual salaries for the registered nurse and dialysis technician positions during the first year of operation, as reported by the applicants in Section VII.1 of their respective applications. Higher salaries enhance recruitment and retention of employees.

	TRC	BMA
RN	$52,000	$53,389
Home Training Nurse	$52,000	$57,845
Patient Care Technician	$26,000	$25,816

As shown in the above table, BMA projects the higher salary for both registered nurses and home training nurses, but projects the lower salary for patient care technicians. TRC projects the higher salary for technicians, but projects the lower salary for registered nurses and home training nurses. The two proposals are equally effective with regard to direct care salaries.

SUMMARY

The following is a summary of the reasons the proposal submitted by Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro is determined to be the most effective alternative in this review.

- BMA is conforming to all Regulatory and Statutory review criteria.
- BMA offers more hours of availability.
- BMA currently provides in-center dialysis service to Randolph County patients.
- BMA demonstrates access by underserved groups. See Criterion (13c) for discussion.
- BMA demonstrates better accessibility to ancillary and support services.

The following is a summary of the reasons the proposal submitted by TRC is determined to be a less effective alternative than the proposal submitted by BMA.

- TRC does not adequately demonstrate that access to care for the proposed Randolph County Dialysis facility. See Criteria (1), (13c) and (18a) for discussion.
- TRC proposes providers of ancillary and support services farther away from the proposed facility.

Therefore, the proposal submitted by Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro is approved, subject to the following conditions:

1. **Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro shall materially comply with all representations made in their certificate of need application.**

2. **Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro shall construct plumbing and electrical wiring through the walls for no more than 46 stations, which shall include any home hemodialysis training and isolation stations.**

3. **Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro shall relocate 27 stations from the current BMA Asheboro dialysis facility, add 10 stations for a total of 46 stations upon completion of this project, Project I.D.# G-8420-09 (add 7 stations) and Project I.D.# G-8489-10 (relocate 2 stations); which shall include any home hemodialysis training and isolation stations.**

4. **Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro upon completion of this project, shall not offer dialysis services at the current BMA Asheboro dialysis facility located at 312 West Ward Street, Asheboro, NC 27203.**

5. **Bio-Medical Applications of North Carolina, Inc. (BMA) d/b/a BMA Asheboro shall acknowledge acceptance of and agree to comply with all conditions stated herein in writing prior to issuance of the certificate of need.**

Consequently, the proposal submitted by Total Renal Care of North Carolina, LLC (TRC) d/b/a Randolph County Dialysis to establish a new dialysis facility in Randolph County is disapproved.

Patient Origin Report

Provider Number	Facility Name	Facility County	Home Patients	In-Center	County Total
34-2534	New Bern Dialysis (FMC)	Craven	0	7	7
	Pamlico Totals		3	13	16
Facilities serving residents of Pasquotank County					
34-2515	Elizabeth City Dialysis (DaVita)	Pasquotank	14	78	92
34-2541	Edenton Dialysis	Chowan	0	4	4
34-2570	Ahoskie Dialysis	Hertford	0	1	1
	Pasquotank Totals		14	83	97
Facilities serving residents of Pender County					
34-2558	Southeastern Dialysis Center (DaVita)	Pender	0	69	69
34-2511	Southeastern Dialysis Center	New Hanover	13	1	14
34-2685	Cape Fear Dialysis	New Hanover	0	8	8
34-2532	Southeastern Dialysis Center (DaVita)	Onslow	1	4	5
34-2535	Southeastern Dialysis Center	Duplin	0	1	1
34-2596	FMC Dialysis Services East Carolina University	Pitt	1	0	1
	Pender Totals		15	83	98
Facilities serving residents of Perquimans County					
34-2515	Elizabeth City Dialysis (DaVita)	Pasquotank	3	13	16
34-2541	Edenton Dialysis	Chowan	0	11	11
	Perquimans Totals		3	24	27
Facilities serving residents of Person County					
34-2562	Roxboro Dialysis (DaVita)	Person	0	94	94
34-2562	Roxboro Dialysis (DaVita)	Person	8	0	8
34-2550	Durham Dialysis	Durham	0	2	2
34-2616	Durham West Dialysis	Durham	1	0	1
34-2520	FMC Services Neuse River	Granville	1	0	1
34-3504	Duke University Hospital ESRD Unit	Durham	0	1	1
34-2590	FMC Dialysis Services West Pettigrew	Durham	0	1	1
	Person Totals		10	98	108
Facilities serving residents of Pitt County					
34-2596	FMC Dialysis Services East Carolina University	Pitt	12	138	150
34-2502	Greenville Dialysis Center (FMC)	Pitt	34	115	149
34-2632	FMC Care of Ayden	Pitt	0	49	49
34-2561	FMC Pamlico	Beaufort	2	3	5
34-2637	Forest Hills Dialysis	Wilson	0	1	1
34-2518	BMA Kinston	Lenoir	0	1	1
	Pitt Totals		48	307	355
Facilities serving residents of Polk County					
34-2566	Dialysis Care of Rutherford County (DaVita)	Rutherford	0	4	4
34-2506	Asheville Kidney Center	Buncombe	3	0	3
34-2564	Hendersonville Dialysis Center	Henderson	0	2	2
	Polk Totals		3	6	9
Facilities serving residents of Randolph County					
34-2524	Bio-Medical Applications of Asheboro	Randolph	0	104	104
34-2514	High Point Kidney Center (WFU)	Guilford	8	18	26
34-2639	Thomasville Dialysis Center (WFU)	Davidson	0	14	14
34-2621	Carolina Dialysis Siler City	Chatham	0	9	9
34-2504	BMA of Greensboro	Guilford	5	1	6

EXHIBIT 5

Patient Origin Report

Provider Number	Facility Name	Facility County	Home Patients	In-Center	County Total
34-2600	BMA of Southwest Greensboro	Guilford	0	6	6
34-2537	BMA of South Greensboro	Guilford	0	3	3
34-2505	Piedmont Dialysis Center (WFU)	Forsyth	2	0	2
34-2622	Carolina Dialysis Carrboro (UNC)	Orange	1	0	1
34-2553	Lexington Dialysis Center (WFU)	Davidson	1	0	1
34-2533	BMA of Burlington	Alamance	0	1	1
34-2599	Triad Dialysis Center (WFU)	Guilford	0	1	1
		Randolph Totals	17	157	174
Facilities serving residents of Richmond County					
34-2539	Dialysis Care of Richmond County	Richmond	6	74	80
34-2690	Sandhills Dialysis Center	Richmond	0	27	27
34-2555	Dialysis Care of Moore County (DaVita)	Moore	5	5	10
34-2583	Dialysis Care of Montgomery County	Montgomery	0	3	3
34-2638	Southern Pines Dialysis Center (DaVita)	Moore	0	1	1
		Richmond Totals	11	110	121
Facilities serving residents of Robeson County					
34-2528	Lumberton Dialysis Unit (BMA)	Robeson	14	93	107
34-2623	FMC of Dialysis Services Robeson County	Robeson	0	62	62
34-2682	FMC of Pembroke	Robeson	0	48	48
34-2607	BMA of Red Springs	Robeson	0	38	38
34-2662	FMC St. Pauls	Robeson	0	37	37
34-2651	St. Pauls Dialysis Center (DaVita)	Robeson	0	19	19
34-2579	Dialysis Care Hoke County	Hoke	0	11	11
34-2555	Dialysis Care of Moore County (DaVita)	Moore	3	2	5
34-2539	Dialysis Care of Richmond County	Richmond	2	0	2
34-3504	Duke University Hospital ESRD Unit	Durham	1	0	1
		Robeson Totals	20	310	330
Facilities serving residents of Rockingham County					
34-2640	Reidsville Dialysis (DaVita)	Rockingham	0	57	57
34-2641	Rockingham Kidney Center (FMC)	Rockingham	0	43	43
34-2624	Madison Dialysis Center (DaVita)	Rockingham	0	21	21
34-2536	Dialysis Care of Rockingham County (DaVita)	Rockingham	6	0	6
34-2613	Northwest Greensboro Kidney Center	Guilford	0	4	4
34-2504	BMA of Greensboro	Guilford	2	0	2
34-2597	FMS Caswell (Renal Care Group)	Caswell	0	1	1
34-2599	Triad Dialysis Center (WFU)	Guilford	0	1	1
34-2505	Piedmont Dialysis Center (WFU)	Forsyth	1	0	1
34-2533	BMA of Burlington	Alamance	1	0	1
34-2567	Burlington Dialysis Center	Alamance	0	1	1
34-2569	Salem Kidney Center (WFU)	Forsyth	0	1	1
		Rockingham Totals	10	129	139
Facilities serving residents of Rowan County					
34-2546	Dialysis Care Rowan County (DaVita)	Rowan	23	91	114
34-2592	Dialysis Care Kannapolis (DaVita)	Rowan	16	31	47
34-2553	Lexington Dialysis Center (WFU)	Davidson	1	3	4
34-2527	Statesville Dialysis Center (WFU)	Iredell	2	1	3
34-2606	Lake Norman Dialysis Center (WFU)	Iredell	1	1	2

Fresenius Medical Care

09/13/10

Cieanna Hairston, MHA,MSN,RN
Division Chair for Health Sciences and Public Services
Randolph Community College
PO Box 1009
Asheboro NC 27204-1009

Dear Ms. Hairston:

Fresenius Medical Care is a national provider of dialysis services, operating 81 dialysis facilities across North Carolina. We are currently developing a Certificate of Need application to relocate the entire dialysis facility and add 10 dialysis stations. Our application will be submitted to the North Carolina Division of Facility Services, Certificate of Need Section, on September 15, 2010. We expect that the new facility/stations would become operational at June 30, 2012

Fresenius would like to invite you to include the BMA Asheboro dialysis facility in your list of facilities for clinical rotation of your nursing students. We feel that a dialysis facility rotation would accomplish a variety of educational purposes, to include:

a. exposure to a patient population with a chronic need for dialysis, to include the co-morbid health issues associated with End Stage Renal Disease
b. exposure to the daily operation of a dialysis facility, which would involve work with a cross section of health care professionals from direct patient care staff such as the Nephrologist Physician and the Patient Care Technicians, to the ancillary staff including Social Workers, Dietitians, and Medical Records, and others as appropriate.
c. Exposure to both the In-Center Hemodialysis facility as well as the Home Training programs for Home Peritoneal dialysis or Home Hemodialysis.

In addition to the above stated value, rotation through a dialysis facility also exposes the student to other nursing career tracks within the nursing profession.

I look forward the opportunity to discuss our facility and establishing a more formalized affiliation agreement regarding this invitation. Please contact me at your convenience.

Sincerely,

Dave Lincoln
FMC Director of Operations

EXHIBIT 6