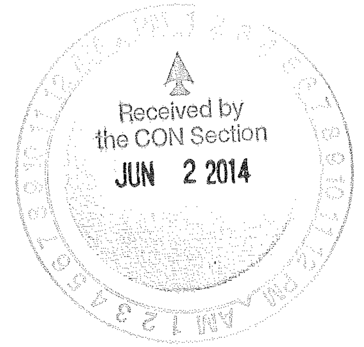
FRESENIUS MEDICAL CARE



June 2, 2014

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

Re: Public Written Comments
CON Project ID # N-10283-14

Dear Ms. Frisone:

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

Respectfully,

Jim Swann
Director of Operations, Certificate of Need

3717 National Drive, Suite 206
Raleigh, North Carolina 27612

Phone 919-896-7230
FAX 919-896-7233

Public Witten Comments
CON Project ID # N-10283-14
Total Renal Care of North Carolina, LLC. d/b/a Maxton Dialysis
Prepared and Submitted by Jim Swann
FMC Director of Operations, Certificate of Need

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

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

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

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

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

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

   This question appears to be essentially the same language as is included in CON Review Criterion 18a.

In response to this question, the applicant has included the following statements:

Page 34/35: "*DaVita Healthcare Partners Inc. and Total Renal Care of North Carolina, LLC do not expect that this proposal will have any adverse effect on competition within* ***Robeson or Scotland Counties.***" [emphasis added]

"*Given that both providers operate by the same federal standards for participation in the Medicare program, and that both are monitored by the same state agency for compliance, what then would be the effect of competition.*"

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

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

The applicant does not propose that the patients currently served by the St. Pauls facility will relocate. Rather the applicant has suggested that essentially 100% of its proposed patient population to be served would be transferring their care to the new facility.

Thus, it is imminently obvious that a significant number of the proposed patient population to be served at the new facility, are patients currently dialyzing at a BMA facility in the area.

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

FMC Pembroke
BMA Laurinburg
FMC Scotland County

In evaluating this application, BMA suggests the CON Project Analyst must consider the impact to other dialysis facilities in the area. The proposed facility is planned to

be located in Maxton, Robeson County, and within one quarter mile of the Robeson-Scotland County line. Indeed, the applicant has proposed to serve 14 in-center patients and three home dialysis patients from Scotland at the end of the second year. This represents 41% of the proposed patient population at the facility. Consequently, the Analyst should consider the impact to local dialysis facilities in Scotland County as well as the facilities in Robeson County.

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

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

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

> *"FMC Scotland County financial performance has been marginal due to the very low commercial mix at the facility. As is noted above, the most recent historical review indicates that 0.5% of revenue has been from commercial insurance. BMA will be working with the admissions team to re-direct one or two new dialysis patients, who reside on the north side of Laurinburg or Scotland County, with commercial insurance, to the FMC Scotland County facility. In a small facility population such as in FMC Scotland County, one or two patients with commercial insurance can dramatically alter the financial performance of the facility.*
>
> *BMA will not mandate patient admission to one facility or another. However, given the close proximity of the two facilities, it is reasonable to conclude that some patients with commercial insurance would choose FMC Scotland County."*

BMA also filed a CON application for FMC Pembroke in September 2013. TRC obviously had copies of the BMA Laurinburg and FMC Scotland County applications, as they filed public written comments regarding both. TRC similarly could have obtained a copy of the FMC Pembroke CON application which was also filed in September 2013. TRC should have known from the BMA applications that both counties, Robeson County and Scotland County, are economically distressed counties. The BMA payor mix information was included in each of the applications.

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

The next table demonstrates the commercial payor mix (January 1 through April 30, 2014) for the three dialysis facilities within 10 miles of the proposed facility in Maxton. In short, these three facilities have very low percentages of commercially insured patients and continue to struggle financially.

As of April 30, 2014	Dialysis TX	Commercial TX	% Commercial
BMA Laurinburg	3690	174	4.72%
FMC Scotland County	1805	0	0.0%
FMC Pembroke	2377	52	2.19%
Total	7872	226	2.87%

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

> *"So the type of work I'm doing is trying to analyze where we have or do not have a strong commercial mix among our patient base. So Medicare, just as you may read from the press and you can also read in our--you know, in the annual reports, Your Honor, Medicare doesn't pay a high enough rate for any of the dialysis providers to make any money off of-- we lose money on every single Medicare treatment we do. And this is really tough because--again, you can read just in the press and in DaVita's 10-K, 90 percent of our patients are Medicare patients.*
>
> *So we rely on a really tiny patient base--as an industry, we rely on a really tiny patient base to make all of our money for us. We don't stay in business without these private pay or commercially insured patients. So you can easily see that one patient will--could send a clinic either into profitability or losing one patient could send a clinic out of profitability."*
> Transcript of Ms. Coyle, page 40

Thus, by their own admission, the loss of a single commercially insured patient can have significant impact on the profitability of a facility. Yet, in this case, the applicant proposes to enlist the assistance of the Medical Director to refer existing patients

away from the current provider, and transfer to a facility which is not needed in the area.

Given the bleak financial outlook for the existing facilities in the area, BMA suggests that it is not reasonable to add yet another dialysis facility to the area and further dilute the payor mix.

2. The applicant fails to conform to CON Review Criterion 3. The applicant has provided letters of support from only 21 in-center dialysis patients. Even if the applicant were to begin increasing that population of 21 patients at the current five year average annual change rate for Robeson County as of January 1, 2014, the applicant can not hope to achieve a projected in-center patient population of 32 patients by the end of the first year for greater than 15 years. It is not sufficient to say that other patients will be added to the waiting list. It is incumbent upon the applicant to provide the CON Section with an application that is reasonable and credible. The applicant has simply failed to provide sufficient evidence of a patient population willing to transfer their care to the proposed new facility.

   The applicant suggests that there is no CON Review Criteria or Rule which requires patient letters of support. BMA would agree. However, CON Agency has historically relied upon Agency past practice. The Agency has utilized patient letters of support to demonstrate sufficient interest in a project. In this case the applicant has provided only 21 letters from current dialysis patients. In multiple other CON reviews the Agency has determined that the absence of sufficient numbers of patient letters, or patient letters with sufficient information (such as residence location) was enough of a reason to determine an application to be non-conforming to Criterion 3.

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

   In this case, many of the patient letters of support are questionable as to their representations of Maxton being more convenient. As noted earlier in these comments, BMA is serving many of these patients and therefore is knowledgeable of their residence address. By BMA records, of the patient letters provided, only one (1) of the patients had a Maxton address. Eight of the patients had a McColl, South Carolina address; two patients reside in Laurinburg; one patient resides in Pembroke, two other patients had addresses in South Carolina and one patient had an address in Watauga County, NC. Arguably this is only 15 of the patient letters

provided by TRC. However, this should be more than sufficient to cause the Analyst to question the veracity of the information provided: one, a single patient letter, of the 15 that BMA could verify, had an address in Maxton.

BMA can, and will provide the specific letters with address at the request of the Agency. However, BMA is not in the business of putting a patient in the position of having to defend any provider. Patients are often reluctant to oppose their physician. In as much as these letters were obtained through Dr. Nestor, BMA suggests that the patient may have felt compelled to sign the letter. After all, the physician who is prescribing life supporting dialysis care and treatment has asked the patient to sign the letter. Surely the patient could have declined. But, the Analyst should for the moment assume the position of the patient. Would the analyst (or, the patient) feel comfortable saying "no" to the physician who prescribes life saving treatment?

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

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

5. The application should be found non-conforming to CON Review Criterion 6. There are ample dialysis resources within a 10 mile radius of the proposed facility. The following table indicates that there are 51 certified dialysis stations at the three closes facilities; in addition there are another 12 CON approved stations in these facilities for a total of 63 stations. Yet these facilities have a combined census of 172 in-center dialysis patients. Using the approved but not yet developed stations, this would equate to 2.73 patients per station. If the utilization is calculated on just the existing certified stations, (51), the resultant utilization rate is 3.37 patients per

station. There is more than a sufficient number of dialysis stations within 10 miles of the proposed location. There is not a need for additional dialysis stations in the area.

As of June 1, 2014				
Facility	Dialysis Stations		In-Center Census	Home Census
	Certified	Pending		
BMA Laurinburg	26	4	82	6
FMC Scotland County	12	2	40	NA
FMC Pembroke	13	6	50	NA
Total	51	12	172	6
Total Stations / Patients	63		172	
Patients per station	2.73			

6. The applicant has indicated in Section X of the application, on page 49) that the Medicare Allowable Charge for dialysis is $240. The applicant also notes that Medicare reimbursement is only 80% of the allowable rate. The applicant has followed this by indicating its intent to write off the 20% billable to "Medicare only" patients. BMA suggests this is not appropriate and not consistent with Medicare guidelines.

   Beyond the above issue, BMA notes that Medicare has indeed proposed a 12% cut in drug payments for ESRD care (See Exhibit 5). This reduction for dialysis treatment was announced on November 22, 2013, and is scheduled to go into effect beginning in 2016.

   The applicant's parent company commented on November 25, 2013 about *"the bad news"* (See Exhibit 6).

   Thus it is clear that the applicant was aware of the projected decrease in reimbursement as related to dialysis treatment. Consequently the applicant should have projected lower Medicare allowable rates for 2016 and forward. As a result of using the current Medicare allowable and failing to use a lower rate for future years, the applicant has overstated revenues to be earned by the facility. The application is therefore not based upon credible information and should be found non-conforming to CON Review Criterion 5.

7. The applicant has also indicated that it would write off the 20% required co-pay for Medicare patients (application, Page 49, Note 3). This is not an acceptable practice and the applicant may be in violation of Medicare claims processing procedures.

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

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

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

SUMMARY:

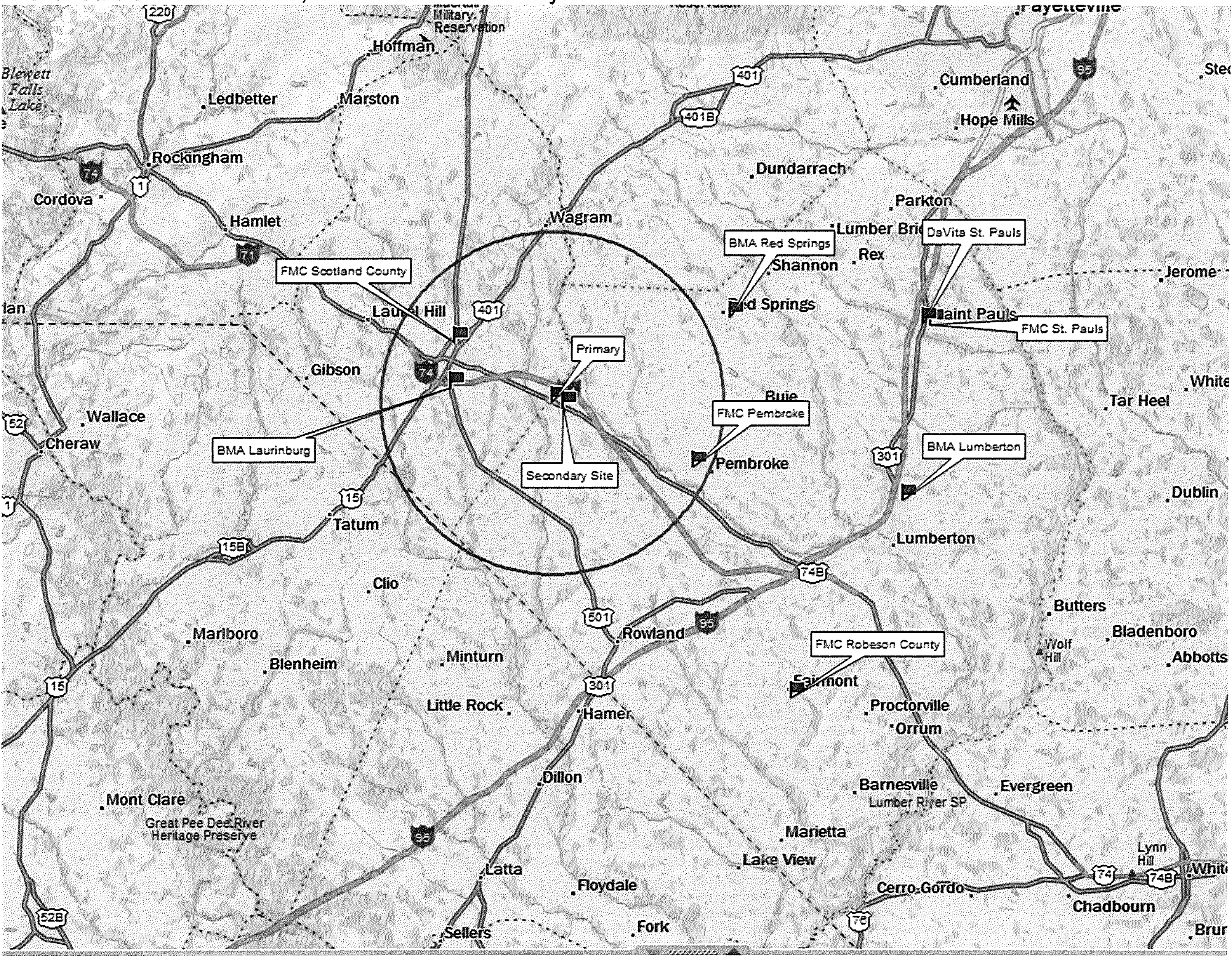
BMA suggests the application fails on multiple levels and should not be approved. BMA suggests the applicant fails to conform to CON Review Criteria 3, 4, 5, 6 and 18a.

For these reasons, the application should be denied.

Exhibits:

1) Map of the area
2) NC Department of Commerce information
3) Ms. Lauren Coyle, transcript excerpts
4) Required State Agency Findings, F-7912-07
5) News article, Medicare cuts to dialysis reimbursement
6) DaVita article, re: reduction to reimbursement
7) Excerpts from Medicare Provider Reimbursement Manual

Public Witten Comments, Exhibit 1
CON Project ID # N-10283-14
Total Renal Care of North Carolina, LLC. d/b/a Maxton Dialysis



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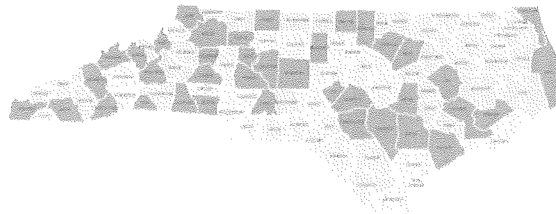
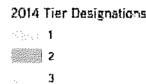
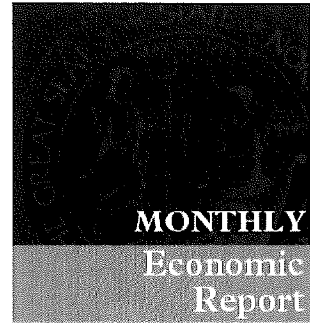
Quick Links

- AccessNC
- BLNC
- NC.gov
- North Carolina's Interactive Purchasing System
- Office of State Human Resources
- Our Partners and Allies
- SEUS/Canadian Provinces Conference in Raleigh May 4-6!
- Sign up for our weekly e-newsletter SYNC!
- ThriveNC.com

2014 North Carolina County Tier Designations





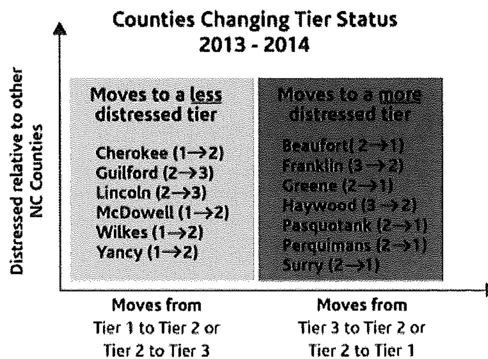


2014 County Tier Designations

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

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

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



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

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

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

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

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

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Scotland County (NC)
April 2014

THRIVE in NORTH CAROLINA

County Profile Contact (919) 707-1500 | Commerce Economic Development Contact (919) 733-4151

Demographics

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

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

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

Commuters, Workers Age 16 and over, 2011 Est

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

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

Place of Work	Commuters	Residents
Worked in State/County of Residence	8,239	71.0%
Worked in State/Outside County of Residence	2,884	24.9%
Worked Outside State of Residence	482	4.2%

Education

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

Housing

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

Income

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

Employment / Unemployment

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

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

Commercial/Retail/Industrial

Local Businesses

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

Local Retail Business

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

Quality of Life

Taxes

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

Childcare

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

Weather

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

Healthcare Providers

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

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

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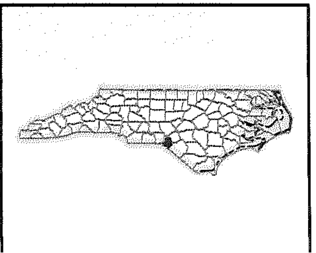


Legend

Airports by Enplanements

>14 3 -14 < 3 (Million)

Pub/Pri Univ./Comm Col.

Hospital

Interstate

US Highway

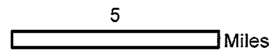
State Highway

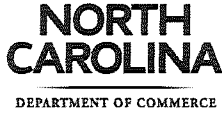
USA Railroads

National Forests

County Boundary

Scotland County, North Carolina





Prepared by North Carolina Department of Commerce.Labor & Economic Analysis Division. March 2014

Robeson County (NC)
April 2014

THRIVE in NORTH CAROLINA

County Profile Contact (919) 707-1500 | Commerce Economic Development Contact (919) 733-4151

Demographics

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

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

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

Commuters, Workers Age 16 and over, 2011 Est

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

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

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

Education

		Pop Age 25+
2012-13 Kindergarten-12th Enrollment	23,561	
2013 Average SAT score (2400 scale)	1,233	
2013 Percent of Graduates taking SAT	35.7%	
2011-12 Higher Education Completions	1,425	
2011-12 Higher Education Total Enrollment	11,194	
Est Education Attainment - At Least High School Graduate	57,186	69.3%
Est Education Attainment - At Least Bachelor`s Degree	10,287	12.5%

Housing

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

Income

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

Employment / Unemployment

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

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

Commercial/Retail/Industrial

Local Businesses

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

Local Retail Business

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

Quality of Life

Taxes

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

Childcare

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

Weather

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

Healthcare Providers

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

Sources:
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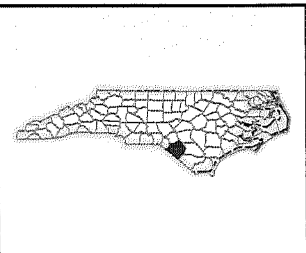

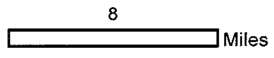

Robeson County, North Carolina

8 Miles

Legend

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

Prepared by North Carolina Department of Commerce.Labor & Economic Analysis Division. March 2014

STATE OF NORTH CAROLINA | IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF FRANKLIN | 13-DHR-18127 and 13-DHR-18223

TOTAL RENAL CARE OF NORTH CAROLINA, LLC,

Petitioner,

v.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, CERTIFICATE OF NEED SECTION,

Respondent,

and

BIO-MEDICAL APPLICATIONS OF NORTH CAROLINA, INC.,

Respondent-Intervenor.

TRANSCRIPT OF HEARING

BEFORE HONORABLE CRAIG CROOM

ADMINISTRATIVE LAW JUDGE

MONDAY, MARCH 24, 2014

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

Volume 1 of 8

Pages 1 through 280

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TABLE OF CONTENTS

PRELIMINARY MATTERS	7-10			
OPENING STATEMENTS				
By Mr. Shenton	11-14			
By Mr. Hewitt	15-24			
By Mr. Stroud	24-26			
WITNESSES	DIRECT	CROSS	REDIRECT	RECROSS
Petitioner				
LAUREN COYLE				
By Ms. Scott	27-69		87-92 93	
By Ms. Hedrick		71-87		92-93
KIM RANDOLPH				
By Mr. Shenton	95-140		159-161	
By Mr. Hewitt		141-154		
By Mr. Stroud		155-159		
CLARKSTON HINES				
By Mr. Shenton	163-172		203	
By Ms. Hedrick		172-202		
MIKE McKILLIP				
By Mr. Shenton	206-262			

1 Mr. Shenton: No. We are going ahead and
2 calling Ms. Coyle now, Your Honor.
3 The Court: Okay. All right. Place your
4 left hand on the bible and raise your right.
5 (Whereupon,
6 **LAUREN COYLE**
7 was called as a witness, duly sworn and testified as
8 follows:)
9 The Court: All right, ma'am. You may take
10 a seat. When a seat, if you could, just state your name and
11 spell your name.
12 The Witness: Lauren Coyle, L-a-u-r-e-n
13 C-o-y-l-e.
14 The Court: All right. Thank you, ma'am.
15 You may proceed, sir--ma'am.
16 **D I R E C T E X A M I N A T I O N** 8:52 a.m.
17 By Ms. Scott:
18 Q Ms. Coyle, are you employed with DaVita?
19 A Yes.
20 Q And does DaVita have any relationship to Total
21 Renal Care, the company that we've been talking about in the
22 opening statements?
23 A Yes. DaVita owns Total Renal Care.
24 Q Okay. And how long have you worked with DaVita?
25 A Since September 7th of 2010, so just--so three and

1 a half years.
2 Q What is your current position with the company?
3 A I'm a regional operations director for the region
4 known as Region 4, which is--basically stretches from Raleigh
5 to Greensboro along I-40 up to the Virginia state line.
6 Q So that includes Franklin, Wake, and Durham
7 counties?
8 A It does.
9 Q How long have you held that position?
10 A Since May 15th of 2012, so about a year and a
11 half, almost two years.
12 Q So since--okay, so since May 2012?
13 A Uh-huh.
14 Q What did you do before you became regional
15 operations director?
16 A I was the regional operations director for a
17 smaller region of home hemodialysis and peritoneal dialysis
18 facilities that went--that included Pinehurst, Durham,
19 Roxboro, and Vance counties.
20 Q And what services--what types of services did
21 those clinics provide?
22 A Home hemodialysis and peritoneal dialysis.
23 Q Did each of those clinics provide both of those
24 types of services?
25 A The Pinehurst facility offered home hemodialysis

1 and peritoneal dialysis. My Durham facility offered both
2 home hemodialysis and peritoneal dialysis. And then Roxboro
3 and Vance both offered peritoneal dialysis only.
4 Q And what were your responsibilities in that prior
5 position with regard to running those home dialysis clinics?
6 A I had complete responsibility for the clinical
7 outcomes and financial outcomes of those facilities, hiring
8 and firing for all the teammates and, you know, taking care
9 of those patients.
10 Q So for the judge's benefit could you just explain
11 what a typical workday or workweek in your position with
12 those home dialysis clinics would have involved?
13 A Sure. So each day of the week I would kind of
14 have planned out which clinics I was going to go to. And I
15 would drive to the clinic, you know, first thing in the
16 morning, get there.
17 And depending on what was going on, I would meet
18 with patients or teammates to see--and teammates usually
19 meaning nurses who care for the patients--to understand
20 better how things were going. I might observe a clinic day
21 in which patients--home patients usually come into the clinic
22 twice a month to see their nurse and to see their doctor.
23 Even though they're doing their dialysis at home, they need
24 to be checked up on.
25 So I might be there to help the clinic day just go

1 more smoothly and ask the patients how things are going with
2 them as well as work with the doctors to make sure things are
3 going well with them. So I'd meet with the patients, talk
4 with them, meet with the nurses, talk with them, and then
5 might do, you know, some additional e-mail or conference
6 calls, depending on what was going on later in the day.
7 Q You mentioned working with the doctors. What
8 would your work with the physicians involve?
9 A So I mean making sure we're providing the right
10 services for the patients, making sure we're getting the
11 patients everything they need, that we are training the
12 patients that the doctors are referring into home dialysis in
13 a timely manner, making sure that if I needed to ask a nurse
14 for instance from Pinehurst to come help out in Durham so
15 that we could train an extra patient that the doctors wanted
16 trained, we could do that.
17 And when I say training, I mean we have to train
18 them to do their dialysis at home because it's not
19 particularly simple, so--I mean simple enough that they could
20 learn it in a couple of weeks, but you can't just auto-
21 matically go home and do it with an instruction booklet. So
22 it usually--for peritoneal dialysis it takes two weeks of
23 training. For home hemodialysis it can take anywhere up--
24 from a minimum of three and up to six weeks of training with
25 a registered nurse.

1 Q In your position managing those home clinics did
2 you have business management responsibilities?
3 A Yes.
4 Q And what did those entail?
5 A Just complete financial responsibility for the
6 revenue, the costs--and the costs associated with those
7 programs. So I would make sure I understood exactly, you
8 know, who our patients were, what kind of insurance they had,
9 how we were billing for them, making sure that we had
10 everything that we needed to be able to bill for them, and
11 have all of that in place.
12 Q And what did you do before this position managing
13 the home clinics?
14 A So before that, I was on a brief maternity leave,
15 but before that, I was in our Redwoods--we call it a Redwoods
16 training program. So we have a program that brings in people
17 who don't have dialysis experience from business schools and
18 brings them into the company and spends a year teaching them
19 dialysis, so everything from the very basics and science of
20 dialysis that we teach our nurses and technicians where we go
21 off to a class and learn exactly how dialysis works and we
22 have to take a test at the end, which is rather difficult,
23 and then we--to just all the different business aspects of
24 dialysis from people services to payor contracting to just
25 finance and to labor management, various cost management, as

1 well as marketing, how we would--how we would work with
2 doctors to get them excited about referring patients to our
3 programs.
4 Q And how did you learn about that large variety of
5 matters pertaining to dialysis?
6 A So it's a pretty heavily structured program in
7 which we have a huge checklist with hundreds of items of
8 things that we have to learn, and you must complete the
9 checklist. And so some of that includes just like what we
10 call Star learning, our computer learning management program.
11 So there's some basics like the adequacy of dialysis that
12 you just need to read and learn and do a computer program and
13 a WebEx on and then take a test to show you've learned that.
14 They also flew us all around the country to all of
15 the different business hubs that we have including our head-
16 quarters in Denver, our previous headquarters in El Segundo,
17 and various other business offices like in Nashville and
18 Tacoma, Washington to meet with various heads of the
19 different businesses and learn more about things there.
20 So in Nashville we met with Tad Stahel, who's the
21 vice president of home modalities. Out in Tacoma, the team
22 met with the folks who do all of our billing, our revenue
23 operations folks. You know, in Denver we met with our people
24 services people. And we would go in and we would have two to
25 three days' worth of meetings with those folks and then fly

1 back home.
2 Additionally, we did shadowing in order to get
3 that huge checklist of items learned. We would do shadowing
4 with various teammates of all different levels in the
5 clinics. And so I spent a week working with a patient care
6 technician to learn exactly how she worked, so I got to work
7 at 4:30 in the morning and would, you know, watch her stream
8 machines and would carry boxes and do the things that I was
9 allowed to do, but which usually meant carrying things back
10 and forth from the storage room and saying hi to our
11 patients.
12 And then, you know, I would work with our nurses
13 to shadow them, work with our dietitians to shadow them, our
14 social workers, all the way up to the folks who are now my
15 peers, the regional operations directors in North Carolina,
16 and our vice president, Clarkston Hines.
17 Q Did this intensive training program, the Redwoods
18 program, did it involve any education regarding--you've
19 mentioned revenue---
20 A (interposing) Uh-huh.
21 Q ---operations. Did it involve any information or
22 orientation to insurance and reimbursement type matters?
23 A Absolutely, so our--we have an entire insurance---
24 Ms. Hedrick: (interposing) Your Honor, I
25 just want to raise an objection for the record. The

1 testimony so far has focused almost entirely on what DaVita
2 does and what its experience is with dialysis. And I don't
3 see that this has any relevance to the issues in this case,
4 which are related to BMA's projections, and BMA didn't
5 purport to rely on DaVita's experience. I don't think this
6 testimony is relevant.
7 The Court: Yes, ma'am.
8 Ms. Scott: Your Honor, Ms. Coyle is just
9 testifying about basic components of the dialysis business
10 and industry. Your Honor asked late last week to be educated
11 and have some basic information in this area. And that is
12 all we are trying to do is to give you some foundational
13 information about the basics of dialysis to facilitate your
14 understanding of the discussion and testimony that's going to
15 come regarding the issues in this case, which do relate to
16 dialysis.
17 The Court: That was good, but let me do it
18 this way. I'm just going to treat it now as background and
19 give it the appropriate weight, so at this point your
20 objection is overruled.
21 Ms. Hedrick: Thank you, Your Honor.
22 The Court: You may proceed.
23 By Ms. Scott:
24 Q Ms. Coyle, I had asked you if the intensive
25 Redwoods training program involved any education or

1 orientation to insurance and reimbursement matters, and you
2 were---
3 A (interposing) Yes. So we---
4 Q ---getting ready to respond.
5 A ---have an insurance management team and I spent
6 time with them. Jean Baker is one of our insurance
7 counselors, who's great with working with patients, so I
8 spent a lot of time with her as well as learning more about
9 just the overall financials of the dialysis industry, which
10 you can read in the annual reports of each of the dialysis
11 companies. I would do a lot of reading there and
12 understanding of what's going on with how reimbursement works
13 and how we get paid. There's a lot in the news about it
14 right now because of everything going on in Washington.
15 Q And just to touch on one final background point,
16 can I ask you to turn to the TRC exhibit notebook, the one
17 that has Exhibit 276? And I think it might be just to your
18 right there.
19 The Court: I didn't see all this behind me
20 back here. Where is my book? Give me that number again.
21 Ms. Scott: TRC Exhibit 276, Your Honor.
22 There are three volumes of the TRC exhibits with the range on
23 the spine of each.
24 The Court: 276 to 326, okay. Yes, ma'am.
25 Ms. Scott: We're looking at Exhibit 276,

1 Your Honor.
2 Ms. Hedrick: Your Honor, I'm sorry; I'm
3 going to raise an objection for the record again. It looks
4 like Ms. Scott is directing Ms. Coyle to a copy of her
5 résumé, and it's my understanding at this point that Ms.
6 Coyle is not intended to be offered as an expert. I don't
7 know what relevance her résumé has to do with any of the
8 issues in this case.
9 The Court: Yes, ma'am. I'll hear you.
10 Ms. Scott: She is not going to be offering
11 any expert opinion testimony. This is just one final
12 background point we're talking about to let Your Honor know
13 who Ms. Coyle is and what her background is. This is easily
14 the most efficient way for Your Honor to hear about her
15 educational background, which is the point of turning to her
16 résumé.
17 The Court: Again I'll overrule that
18 objection. I'll give it the appropriate weight.
19 Ms. Hedrick: Thank you, Your Honor.
20 The Court: And she is not testifying as an
21 expert, though?
22 Ms. Scott: No, Your Honor.
23 The Court: Okay.
24 Ms. Scott: That's correct.
25 The Court: All right. Yes, ma'am. Go

1 ahead.
2 By Ms. Scott:
3 Q Ms. Coyle, have you found TRC Exhibit 276?
4 A Yes.
5 Q Do you recognize what that is?
6 A It's a very old copy of my résumé, yes.
7 Q When you say very old---
8 A (interposing) I made it around April 2011, May
9 2011, so it's a few years old.
10 Q And referring to your résumé there, could you just
11 tell us generally about your educational background?
12 A Yeah. So I went to Harvard College, graduated in
13 2000. I worked at Bain & Company as a consultant right after
14 college and then moved into for-profit education for Kaplan,
15 where I worked for six years. And then I went to Harvard
16 business school, graduated with high honors there and came to
17 work for DaVita following that, so---
18 Q (interposing) Did you go straight to DaVita from
19 Harvard business school?
20 A I did, yes.
21 Q Okay. And what did your studies in the business
22 school--did they have any health care component to them?
23 A Absolutely; so the Harvard business school is
24 based on a case study method, so a little bit like law school
25 in that you're going to see lots of different cases in your

1 classes every day that could be from lots of different
2 places.
3 And so all of my classes had a health care
4 component and had multiple health care cases as part of
5 those. Even consumer marketing had health care cases in it.
6 And then in addition I specifically took a health care
7 related class on the innovation--innovations in health care
8 during my second year.
9 Q Okay. Turning back to your current role with
10 DaVita, which you've held since May of 2012 as regional
11 operations director, can you describe generally what your
12 responsibilities are in that position?
13 A So I have complete--I have complete responsibility
14 for all of my patients' health outcomes and all of my
15 clinics' financial outcomes for my clinics.
16 Q And how many clinics do you oversee?
17 A I oversee 11 total clinics, which includes one
18 home hemodialysis program, eight peritoneal dialysis
19 programs, and 11 in-center dialysis programs. It's about
20 1,000 patients in this area.
21 Q Okay. And again, for the judge's benefit could
22 you describe just what a typical workday or workweek---
23 A (interposing) Sure.
24 Q ---looks like for you?
25 A So my calendar is a little ridiculous, but it's

1 planned about, you know, a quarter at a time. And I make
2 sure I get to each of my clinics. And what I do is each week
3 I plan a trip to several clinics and then I plan a couple of
4 days in which I can be available to patients or teammates
5 over the phone, as needed.
6 So for instance, today if we had not had this, I'd
7 be going to my clinic in Burlington, meeting with the
8 teammates, rounding on all of the patients, seeing the
9 physicians there, and speaking with them about their
10 experience and what's going on in their clinics right now.
11 And then, you know, at the end of the day after
12 all the patients have gone home, I usually try to catch up on
13 e-mail and work around the financial responsibilities for the
14 clinics. So I might be looking into--part of what I do right
15 now as well is work on--so I would say--I would back up and
16 say each of the directors in our division has a different
17 specific role. And one of those roles for me is working on
18 private pay and working on our--understanding what our payor
19 mix is.
20 Q And without referring to the---
21 A (interposing) Yeah.
22 Q ---specific data---
23 A (interposing) Okay.
24 Q ---or talking about the specific data, what does
25 that particular special role involve? What is the work, the

1 type of work that you're doing?
2 A So the type of work I'm doing is trying to analyze
3 where we have or do not have a strong commercial mix among
4 our patient base. So Medicare, just as you may read from the
5 press and you can also read in our--you know, in the annual
6 reports, Your Honor, Medicare doesn't pay a high enough rate
7 for any of the dialysis providers to make any money off of--
8 we lose money on every single Medicare treatment we do. And
9 this is really tough because--again, you can read just in the
10 press and in DaVita's 10-K, 90 percent of our patients are
11 Medicare patients.
12 So we rely on a really tiny patient base--as an
13 industry, we rely on a really tiny patient base to make all
14 of our money for us. We don't stay in business without these
15 private pay or commercially insured patients. So you can
16 easily see that one patient will--could send a clinic either
17 into profitability or losing one patient could send a clinic
18 out of profitability.
19 Q Thank you. How often do you visit the facilities
20 that you manage during the regular course of your work?
21 A I'm in a clinic almost every day. I mean there's
22 days like today where I'm not in a clinic, although if we end
23 early, I'll get to Burlington this afternoon. But I'm in a
24 clinic almost every day. DaVita has some national meetings
25 and things like that, so I might not be in a clinic on a day

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

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

DECISION DATE: December 28, 2007

FINDINGS DATE: January 7, 2008

PROJECT ANALYST: Tanya S. Rupp
ASSISTANT CHIEF: Craig R. Smith

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

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

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

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

C

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

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

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

(B) demonstrate that the proposal shall not result in a surplus of dialysis stations in the county that would gain stations as a result of the proposed project, as reflected in the most recent Dialysis Report.

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

(2) Repealed effective July 1, 1987.

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

NC

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

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

The applicant does not propose to establish new dialysis stations.

Population to be Served

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

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

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

	Projected Beginning Census	Operating Year 1	Operating Year 2	County Patients as a Percent of Total	
County	# Pts Dialyzing In-Center	# Pts Dialyzing In-Center	# Pts Dialyzing In-Center	Year 1	Year 2
Mecklenburg	38	39.9	41.9	100.0%	100.0%
TOTAL	38	39.9	41.9	100.0%	100.0%

The applicant adequately identified the population it proposes to serve.

Need for the Proposed Service

The applicant states on page 18 of the application:

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

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

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

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

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

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

[1] See http://www.zipfind.net for distance between ZIP codes given in the application.

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

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

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

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

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

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

On page 23 the applicant states

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

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

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

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

C

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

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

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

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

a. A new facility in Huntersville will be closer to my home, and will be much more convenient for me and my transportation. Patients on dialysis have many hardships, especially arranging transportation three days per week. The location of this proposed facility will mean that my family or other transportation will not have to deal with the heavy traffic in Charlotte three days per week for each of my dialysis treatments….

b. Continuity of care is very important to me. I understand that the new facility would be operated in the same manner as my current facility. I DO prefer to dialyze in a singly use dialysis facility, and I don't want to leave my current facility without knowing that my doctor will also be going with me."

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

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

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

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

NC

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

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

C

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

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

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

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

Capital Expenditure	*$ 916,106*
Start-up Expenses	*$ 22,017*
Working Capital (first 2 months operations)	*$ 320,001*
Total Working Capital Required	*$1,258,124*

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

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

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

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

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

NC

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

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

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

C

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

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

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

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

C

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

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

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

NA

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

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

NA

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

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

NA

(11) Repealed effective July 1, 1987.

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

C

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

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

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

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

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

C

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

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

C

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

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

C

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

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

C

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

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

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

NC

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

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

NC

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

(21) Repealed effective July 1, 1987.

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

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

NC

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

.2202 INFORMATION REQUIRED OF APPLICANT

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

.2202(a)(1) *Utilization rates;*

-C- See Section III.7, pages 24 -26.

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

-C- The applicant reported mortality rates in Section IV, pages 28 – 29.

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

-C- The applicant reported home trained patients and patients on home dialysis in Section IV.3.

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

-C- The applicant reported transplants referred and performed in Section IV.4, pages 28 - 29.

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

-C- The applicant reported a total of 36 patients on the transplant waiting lists in Mecklenburg County facilities. See Section IV.5, page 29.

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

-C- The applicant reported hospital admissions in Section IV.6.

.2202(a)(7) *The number of patients with infectious disease, e.g., hepatitis, and the number converted to infectious status during the last calendar year.*

-C- The applicant provided this information in Section IV.7, page 29.

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

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

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

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

(A) *timeframe for initial assessment and evaluation of patients for transplantation,*
(B) *composition of the assessment/evaluation team at the transplant center,*
(C) *method for periodic re-evaluation,*
(D) *criteria by which a patient will be evaluated and periodically re-evaluated for transplantation, and*
(E) *signatures of the duly authorized persons representing the facilities and the agency providing the services.*

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

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

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

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

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

information as required by this rule.

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

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

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

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

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

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

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

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

.2203 PERFORMANCE STANDARDS

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

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

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

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

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

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

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

.2204 SCOPE OF SERVICES

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

.2204(1) *Diagnostic and evaluation services;*
-C- See Section V.1.

.2204(2) *Maintenance dialysis;*
-C- See Section V.1.

.2204(3) *Accessible self-care training;*
-C- See Section V.1, page 31.

.2204(4) *Accessible follow-up program for support of patients dialyzing at home;*
-C- See Section V.1.

.2204(5) *X-ray services;*
-C- See Section V.1.

.2204(6) *Laboratory services;*
-C- See Section V.1.

.2204(7) *Blood bank services;*
-C- See Section V.1.

.2204(8) *Emergency care;*

-C- See Section V.1.

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

-C- See Section V.1.

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

-C- See Section V.1.

.2204(11) *Transplantation services;*

-C- See Section V.1.

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

-C- See Section V.1.

.2204(13) *Transportation*

-C- See Section V.1.

.2205 STAFFING AND STAFF TRAINING

.2205(a) *To be approved, the state agency must determine that the proponent can meet all staffing requirements as stated in 42 C.F.R., Section 405.2100.*

-C- See Sections VII.1 of the application, page 43.

.2205(b) *To be approved, the state agency must determine that the proponent will provide an ongoing program of training for nurses and technicians in dialysis techniques at the facility.*

-C- See Section VII.5, page 44 of the application.

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CMS retains 12% cut in drug payments for ESRD care, approves new QIP measures

By Mark E. Neumann
November 25, 2013
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The Centers for Medicare and Medicaid Services issued its much-anticipated **final rule** Nov. 22 that updates 2014 payment rates for dialysis facilities paid under the end-stage renal disease Prospective Payment System (PPS). The agency also approved final changes to the ESRD Quality Incentive Program for performance year 2014, which will impact dialysis clinic payments in 2016.

Despite more than 1,000 comments protesting the proposed cut by the dialysis industry, patients, renal association groups, and even members of Congress, the agency decided to keep a 12% reduction in the drug utilization adjustment to the base rate, but implement it over a three- to four-year transition period.

(Where Medicare and the ESRD Program are headed)

CMS released a proposed rule in July that called for a 12% reduction in payments for injectable drugs based on a 30%+ drop in utilization—primarily in the prescribing of anemia drugs—from 2007 to 2012. The agency proposed to temper the cut with a 2.6% payment increase for 2014 based on the annual Medicare market basket review of costs of providing care to dialysis patients.

Congress required CMS to implement a payment reduction as part of the American Taxpayer Relief Act passed by Congress in 2012, but Congress left it up to the agency to determine the amount of the cut.

CMS said it would implement the first portion of the cut in 2014—a 3.3% reduction to the drug payment adjustment—but dialysis clinics won't see a change in the overall payment for patients for 2014 and 2015 because of other offsets, the agency said.

The cuts will still have an impact on the bottom line for dialysis clinics, said Kidney Care Council and Kidney Care Partners in prepared statements released on Friday in response to the final rule. "Today's Medicare ruling substantially reduces funding needed for patient care and interferes with the ability of our physicians, nurses, and clinical teams to do the very best for their patients," said KCC chairman Tom Weinberg. Ultimately, the payment cut of $29.93 per dialysis treatment "contradicts the unified voice of patients, clinicians, providers, facilities, and members of Congress to correct the total amount of the reduction" originally proposed in July, said Weinberg. "Phasing in a cut of this magnitude only delays the harm."

(Mineral and bone disease testing attestation in the ESRD QIP: A tale of two cities)

According to Kidney Care Partners, a coalition of patients, physicians, nurses, providers, and manufacturers, the rule deals a "significant blow to an already fragile system" by ultimately reducing Medicare payments to a level that will not cover the cost of care for individuals on dialysis. "Phasing in this cut does not solve the problem," said KCP chairman Ron Kuerbitz. "Instead, it only delays the inevitable harm that will come as a result of failing to cover the cost of care. Simply put, this model is unsustainable."

As a result of the rule, KCP said, providers and physicians will face difficult choices regarding staffing, facility hours, quality improvement interventions, and ultimately whether an entire facility can be kept open to service a community. In turn, Medicare beneficiaries could face reduced access to care.

"Our community worked with Congress to establish a sustainable bundled payment system," said Kuerbitz. "It is troubling that, as we celebrate the 40th anniversary of the Medicare dialysis benefit, this rule appears to be a step backwards. We appreciate those in Congress on both sides of the aisle who support their constituents living with kidney failure, and we will continue to work with them to ensure that these, and all Americans with kidney failure, have access to the highest quality care in the years to come."

Details of the final rule include:

The ESRD payment base rate: This remains the same from CY 2013 to CY 2014 at $239.02. CMS said the rate reflects the CY 2013 ESRD PPS base rate of $240.36 adjusted by the ESRD market basket (3.2%) minus the productivity (0.4%) increase, the wage index budget neutrality factor of 1.000454, and the home dialysis training add-on budget neutrality adjustment factor of 0.999912. That brings the base rate up to $247.18, but then CMS makes a 3.3% cut in the portion of the CY 2014 drug utilization adjustment that is being transitioned for 2014, or $8.16, to arrive at a final CY 2014 ESRD PPS base rate of $239.02 ($247.18 - $8.16 =$239.02).

The wage index: No changes

The outlier policy: Outlier services fixed dollar loss amounts are updated for 2014 for adult and pediatric patients, along with Medicare Allowable Payments (MAPs) for adult patients for CY 2014 using 2012 claims data. Based on the use of more current data, the fixed-dollar loss amount for pediatric beneficiaries would increase from $47.32 to $54.01 and the adjusted average outlier services MAP amount would decrease from $41.39 to $40.49 as compared to CY 2013 values. For adult beneficiaries, the fixed-dollar loss amount would decrease from $110.22 to $98.67 and the adjusted average outlier services MAP amount would decrease from $59.42 to $50.25. The 1% target for outlier payments was not achieved in CY 2012. "We believe using CY 2012 claims data to update the outlier MAP and fixed dollar loss amounts for CY 2014 will increase payments for ESRD beneficiaries requiring higher resource utilization in accordance with a 1% outlier policy," CMS said in the final rule.

The self-dialysis and home dialysis training add-on adjustment: Medicare is increasing this add-on adjustment by 50% for both peritoneal dialysis and home hemodialysis training treatments. In CY 2014, the nursing time accounted for in the training add-on adjustment will increase from one hour to 1.5 hours per training treatment, resulting in an increase of $16.72, for a total training add-on adjustment of $50.16 per training treatment.

The 50% increase in payment, however, is one of the offsets the agency is using to keep the 2014 base rate the same as 2013. "We note that the increase to the training add-on adjustment will be made in a budget neutral manner in that we have applied a training add-on budget-neutrality adjustment factor of 0.999912 to the base rate."

The final rule also ends the four-year transition period for dialysis clinics that chose not to move directly into the new bundled payment system when it took effect in January 2011. Dialysis facilities were paid a blended payment with a portion of payments based on the composite rate methodology and a portion based on the new

PPS rate. In 2014, the final year of the four-year transition period, all dialysis facilities will be paid 100% of the ESRD PPS rate for dialysis services.

(SDO perspective on the bundle cuts: Dialysis patients face fewer options)

QIP measures finalized
The final rule also includes new reporting and clinical measures as part of the ESRD Quality Incentive Program. For the ESRD QIP Payment Year (PY) 2016 program (which will rely on measures of dialysis facility performance during 2014), CMS is finalizing 11 measures addressing infections, anemia management, dialysis adequacy, vascular access, mineral metabolism management, and patient experience of care. Performance scores will be calculated by weighting clinical measures at 75% of the total performance score and weighting the reporting measures at 25%.

More details on Provider Call
On Jan. 15, CMS will hold a National Provider Call to help facilities and other stakeholders in the ESRD community understand the final rule. The discussion will be recorded and made available at www.cms.gov/live.

Dowload the final rule.

Find more articles about the ESRD bundle

Mr. Neumann has been executive editor of Nephrology News & Issues since 1989.
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DaVita HealthCare Partners Inc. Comments on the Final CMS ESRD Rates and Provides Initial 2014 Operating Income Guidance

November 25, 2013 05:00 AM Eastern Standard Time

DENVER--(BUSINESS WIRE)--DaVita HealthCare Partners Inc. (NYSE: DVA) today commented on the final Centers for Medicare and Medicaid Services (CMS) Medicare ESRD rule for 2014 and announced initial 2014 operating income guidance.

Final CMS Rule

LeAnne Zumwalt, Group Vice President said, "On the dialysis rule, the bad news is that CMS appears to have accepted the premise that the language in the American Taxpayer Relief Act of 2012 required it to make a partial rebasing of the bundle. This could unfairly result in cuts of nearly $30 per treatment over a three to four year period by looking only at pharmaceutical economics. This means that Medicare dialysis rates will be flat in 2014 and 2015 in an environment of increasing expenses.

"The good news is that Medicare rates will not be decreased next year, when most thought rates would be down. In addition, we get to work with Congress and CMS on trying to mitigate future cuts, and CMS has a number of appropriate reimbursement levers to pull to offset cuts a few years out if it chooses to do so, since Medicare reimbursement already fails to cover the full cost of caring for Medicare patients."

Guidance

Given the issuance of the final CMS rule, the company is now in a position to provide initial 2014 guidance and expects 2014 enterprise operating income to be in a range of $1.675 to $1.850 billion.

The company expects 2014 operating income for our dialysis services and related ancillary business to be in the range of $1.425 to $1.540 billion. The primary reasons for a likely year-on-year decline in operating income are Medicare patient expense increases, commercial rate and mix pressures, and health care exchange dynamics.

The company expects 2014 operating income for HealthCare Partners (HCP) to be in the range of $250 to $310 million. The primary reason for a substantial expected year-on-year decline in HCP operating income in 2014 is the previously announced Medicare Advantage rate cuts, which the company will have limited ability to offset.

These projections and the underlying assumptions involve significant risks and uncertainties, including those described below and actual results may vary significantly from these current projections.

Capital Markets Day

The company will discuss its outlook in more detail at its upcoming Capital Markets Day in New York City on Monday, December 9, 2013, at 9:30 a.m. Eastern Time.

This meeting is being broadcast live by conference call and webcast. You can access the webcast at the DaVita HealthCare Partners investor relations web page. You can join this call on:

Monday, December 9, 2013
Starting at 9:30 a.m. EST
Dial in number: 800-399-4406
Webcast: www.davita.com/investors

The event will be held at the New York Palace Hotel, 455 Madison Avenue, New York, NY 10022. If you plan to attend, please register with us by emailing your name and company affiliation to **Kelly.Perez@davita.com**.

If you are joining the presentation by conference call, please refer to the "DaVita HealthCare Partners Capital Markets Call" and provide the operator with your name and company affiliation. Investors who are unable to listen live will be able to access the presentation and an audio replay via our web site at **www.davita.com/investors**. There will be no telephone replay.

About DaVita HealthCare Partners

DaVita HealthCare Partners, a Fortune 500® company, is the parent company of DaVita and HealthCare Partners. DaVita is a leading provider of kidney care in the United States, delivering dialysis services to patients with chronic kidney failure and end stage renal disease. As of September 30, 2013, DaVita operated or provided administrative services at 2,042 outpatient dialysis centers in the United States serving approximately 166,000 patients, and at 66 centers in ten countries outside of the United States. HealthCare Partners manages and operates medical groups and affiliated physician networks in California, Nevada, Florida, Arizona and New Mexico in its pursuit to deliver excellent-quality health care in a dignified and compassionate manner. As of September 30, 2013, HealthCare Partners provided integrated care management for approximately 760,000 managed care patients. For more information, please visit DaVitaHealthCarePartners.com.

DaVita, HealthCare Partners and DaVita HealthCare Partners are trademarks or registered trademarks of DaVita HealthCare Partners Inc.

Forward Looking Statements

This release contains forward-looking statements within the meaning of the federal securities laws, including statements related to our guidance and expectations for our 2014 consolidated and dialysis services and related ancillary businesses operating income and HCP's 2014 operating income. Factors that could impact future results include the uncertainties associated with the risk factors set forth in our SEC filings, including our annual report on Form 10-K for the year ended December 31,

2012, our quarterly report on Form 10-Q for the quarter ended September 30, 2013 and subsequent quarterly reports to be filed on Form 10-Q, or our current reports on Form 8-K. The forward-looking statements should be considered in light of these risks and uncertainties.

These risks and uncertainties include, but are not limited to, and are qualified in their entirety by reference to the full text of those risk factors in our SEC filings relating to:

- *the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients,*
- *further reduction in government payment rates under the Medicare End Stage Renal Disease program or other government-based programs,*
- *the impact of health care reform legislation that was enacted in the United States in March 2010,*
- *the impact of the Center for Medicare and Medicaid Services (CMS) 2014 Medicare Advantage benchmark structure,*
- *the impact of the American Taxpayer Relief Act,*
- *the impact of the sequestration that went into effect on April 1, 2013,*
- *the impact of disruptions in federal government operations and funding,*
- *changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing,*
- *legal compliance risks, including our continued compliance with complex government regulations and current or potential investigations by various government entities and related government or private-party proceedings, including risks relating to the resolution of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations,*
- *our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector, that may erode our patient base and reimbursement rates,*

- *our ability to complete any acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including HCP, or to expand our operations and services to markets outside the United States,*
- *risks arising from the use of accounting estimates, judgments and interpretations in our financial statements,*
- *the risk that the cost of providing services under HCP's agreements may exceed our compensation,*
- *the risk that further reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact HCP's business, revenue and profitability,*
- *the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability,*
- *the risk that a disruption in HCP's healthcare provider networks could have an adverse effect on HCP's business operations and profitability,*
- *the risk that reductions in the quality ratings of health maintenance organization plan customers of HCP could have an adverse effect on HCP's business, or*
- *the risk that health plans that acquire health maintenance organizations may not be willing to contract with HCP or may be willing to contract only on less favorable terms.*

We base our forward-looking statements on information currently available to us at the time of this release, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

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Details for title: 15-1

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Title The Provider Reimbursement Manual - Part 1

Downloads

Chapter 1 -- Depreciation [ZIP, 141KB]
Chapter 2 -- Interest Expense [ZIP, 77KB]
Chapter 3 -- Bad Debts, Charity, and Courtesy Allowances [ZIP, 22KB]
Chapter 4 -- Cost of Educational Activities [ZIP, 17KB]
Chapter 5 -- Research Costs [ZIP, 11KB]
Chapter 6 -- Grants, Gifts and Income From Endowments [ZIP, 4KB]
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Chapter 11 - Allowance In Lieu Of Specific Recognition Of Other Costs - RESERVED [ZIP, 5KB]
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Chapter 14 -- Reasonable Cost of Therapy and Other Services [ZIP, 89KB]
Chapter 15 -- Change of Ownership [ZIP, 12KB]
Chapter 21 -- Costs Related to Patient Care [ZIP, 833KB]
Chapter 22 -- Determination of Cost of Services [ZIP, 94KB]
Chapter 23 -- Adequate Cost Data and Cost Finding [ZIP, 188KB]
Chapter 24 -- Payment to Providers [ZIP, 114KB]

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

302. DEFINITIONS

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

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

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

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

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

304. BAD DEBTS UNDER MEDICARE

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

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

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

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

A. Beneficiary Liability.--The waiver of liability provision of the law protects a beneficiary from liability for payments to a provider for noncovered services when (l) the services are found to be not reasonable and necessary or to involve custodial care (i.e., excluded from coverage under section l862(a)(l) or (9) of the Social Security Act), and (2) the beneficiary did not know or could not reasonably be expected to have known that the services were not covered. Where the beneficiary had knowledge that the services were not covered, liability will remain with the beneficiary.

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

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

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

306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

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

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

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

308. CRITERIA FOR ALLOWABLE BAD DEBT

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

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)

2. The provider must be able to establish that reasonable collection efforts were made.

3. The debt was actually uncollectible when claimed as worthless.

4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

310. REASONABLE COLLECTION EFFORT

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

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

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

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

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

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

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

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

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

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

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

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

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

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

314. ACCOUNTING PERIOD FOR BAD DEBTS

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

316. RECOVERY OF BAD DEBTS

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

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

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

320. METHODS OF DETERMINING BAD DEBT EXPENSE

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

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

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

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

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

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

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

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

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

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

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

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

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

326. APPLYING COLLECTIONS FROM BENEFICIARIES

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

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

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

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

331. CREDIT CARD COSTS

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

332. ALLOWANCE TO EMPLOYEES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.	Total gross charges, all patients	$180,000
2.	Total program charges	45,000
3.	Percent of program charges	25%
4.	Total cost of covered services	$150,000
5.	25% of cost applicable to beneficiaries	$ 37,500
6.	Less: Deductibles billed to beneficiaries	2,000
7.	Net Cost	$ 35,500
8.	80% of net cost applicable to program	$ 28,400
9.	Less: Amount received or receivable from *contractor* or SSA	25,560
10.	Balance due provider or program	$ 2,840
11.	Add: Reimbursable bad debts (line 20 below)	2,500
12.	Balance due provider or program (line 20 plus 11)	$ 5,340
	Computation of Reimbursable Bad Debts	
13.	Total costs applicable to Part B	$ 37,500
14.	Less: 80% of net costs applicable to Part B	28,400
15.	Balance of costs to be recovered from beneficiaries	$ 9,100

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

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

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

Computation of Reimbursable Bad Debts

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

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

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

Computation of Reimbursable Bad Debts

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

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