



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: I-02	BOARD MEETING: October 30, 2018	PROJECT NO: 17-043	PROJECT COST:
FACILITY NAME: Romeoville Dialysis		CITY: Romeoville	Original: \$4,115,927
TYPE OF PROJECT: Substantive			HSA: IX

PROJECT DESCRIPTION: The Applicants (DaVita Inc. and Tovell Dialysis, LLC d/b/a Romeoville Dialysis) propose to establish a twelve station (12) ESRD facility in 7,000 GSF of leased space located at 480-490 North Independence Boulevard, Romeoville, Illinois. The cost of the project is \$4,115,927 and the completion date is October 31, 2020.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants (DaVita Inc. and Tovell Dialysis, LLC) propose to establish a twelve station (12) ESRD facility in 7,000 GSF of leased space located at 480-490 North Independence Boulevard, Romeoville, Illinois. The cost of the project is \$4,115,927 and the completion date is October 31, 2020.
- This project was deemed complete (August 27, 2017) before the effective date of the new distance requirements (77 ILAC 1100.510(d)) became effective (March 7, 2018). Therefore, this Application is being reviewed with a Geographic Service Area (GSA) of 30 minutes, adjusted based on the location of the project.
- The Applicants were deferred from the January 2018 State Board Meeting and received an Intent to Deny at the April 17, 2018 State Board Meeting and were deferred from the June 5, 2018 State Board Meeting.
- On April 30, 2018, the Applicants modified the project by providing revised zip code and population information that increased the population of the 30-minute service area provided in the Original Application for Permit. The State Board Staff review of the revised 30-minute service area confirmed the Applicants contention that the original submittal was incorrect. The State Board Staff had relied upon the zip code and population information that was provided in the Original Application for Permit. The original submittal had used a 10-mile radius to determine the population instead of a 30-minute radius.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The Applicants are proposing to establish a health care facility as defined by the Illinois Health Facilities Planning Act. (20 ILCS 3960/3)
- One of the objectives of the Health Facilities Planning Act is *“to assess the financial burden to patients caused by unnecessary health care construction and modification. Evidence-based assessments, projections and decisions will be applied regarding **capacity, quality, value and equity** in the delivery of health care services in Illinois. Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process.”* [20 ILCS 3960/2]

PUBLIC HEARING/COMMENT:

- A public hearing was offered in regard to the proposed project, but none was requested. Letters of support and opposition were received by the State Board Staff and those comments are provided in Appendix I at the end of this report.

CONCLUSIONS:

- The Applicants addressed a total of twenty one (21) criteria and have failed to adequately address the following:

Criteria	Reasons for Non-Compliance
77 ILAC 1110.1430(c)(1), (2), (3) & (5) – Planning Area Need	There is a calculated excess of 7-stations in this planning area. There are 22 facilities within thirty (30) minutes with an average utilization of approximately 57%. 14 of the 18 (78%) facilities within 30 minutes are not at target occupancy there does appear to be an access issue in this planning area.
77 ILAC 1110.1430(d)(1), (2) and (3) - Unnecessary Duplication of Service, Mal-distribution of Service, Impact on Other Providers	There are 22 facilities within thirty (30) minutes with an average utilization of approximately 57%. Four of the 22 facilities are not operational, or are in ramp-up phase. The 18 remaining facilities have an average utilization of approximately 69%. Fourteen of these 18 facilities are not at target occupancy.

STATE BOARD STAFF REPORT
Project #17-043
Romeoville Dialysis

APPLICATION/CHRONOLOGY/SUMMARY	
Applicants	DaVita Inc. and Tovell Dialysis, LLC d/b/a Romeoville Dialysis
Facility Name	Romeoville Dialysis
Location	480-490 North Independence Boulevard, Romeoville, Illinois
Permit Holder	DaVita Inc. and Tovell Dialysis, LLC
Operating Entity	Tovell Dialysis, LLC
Owner of Site	TD Romeoville, LLC
Description	Establish a twelve (12) station ESRD facility
Total GSF	7,000 GSF
Application Received	August 23, 2017
Application Deemed Complete	August 25, 2017
Review Period Ends	December 23, 2017
Financial Commitment Date	October 30, 2020
Project Completion Date	October 31, 2020
Review Period Extended by the State Board Staff?	Yes
Can the Applicants request a deferral?	No
Received an Intent to Deny?	Yes (April 17, 2018)

I. Project Description

The Applicants (DaVita Inc. and Tovell Dialysis, LLC) are proposing to establish a twelve station (12) ESRD facility in 7,000 GSF of leased space located at 480-490 North Independence Boulevard, Romeoville, Illinois. The cost of the project is \$4,115,927 and the completion date is October 31, 2020.

II. Summary of Findings

- A. State Board Staff finds the proposed project is **not** in conformance with the provisions of 77 ILAC 1110 (Part 1110).
- B. State Board Staff finds the proposed project in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

The Applicants are DaVita Inc. and Tovell Dialysis, LLC d/b/a Romeoville Dialysis. DaVita Inc, a Fortune 500 company, is the parent company of Total Renal Care, Inc. and Tovell Dialysis, LLC. DaVita Inc. 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. DaVita serves patients with low incomes, racial and ethnic minorities, women, handicapped persons, elderly, and other underserved persons in its facilities in the State of Illinois.

Tovell Dialysis, LLC d/b/a as Romeoville Dialysis is a Delaware limited liability corporation jointly owned by:

- DaVita, Inc. (51% Indirect)
- Total Renal Care, Inc. (51% Direct),
- DuPage Medical Group, Ltd. (24.5% Direct),
- Nephron Ventures LLC (24.5% Direct).

Financial commitment will occur after permit issuance. This project is a substantive project subject to a Part 1110 and 1120 review.

Project Costs and Sources of Funds

The Applicants are funding the project with cash of \$2,212,097 and the FMV of leased space of \$1,903,830. The operating deficit and start-up costs are \$2,511,640. All project costs are classified as clinical.

TABLE ONE			
Project Costs and Sources of Funds			
USE OF FUNDS	Reviewable	Total	% of Total
Modernization Contracts	\$1,354,426	\$1,354,426	32.91%
Contingencies	\$100,000	\$100,000	2.43%
Architectural/Engineering Fees	\$130,500	\$130,500	3.17%
Consulting & Other Fees	\$78,500	\$78,500	1.91%
Movable or Other Equipment (not in construction contracts)	\$548,671	\$548,671	13.33%
Fair Market Value of Leased Space & Equipment	\$1,903,830	\$1,903,830	46.26%
TOTAL USES OF FUNDS	\$4,115,927	\$4,115,927	100.00%
SOURCE OF FUNDS	Reviewable	Total	% of Total
Cash and Securities	\$2,212,097	\$2,212,097	53.74%
Leases (fair market value)	\$1,903,830	\$1,903,830	46.26%
TOTAL SOURCES	\$4,115,927	\$4,115,927	100.00%

IV. Health Planning Area

The proposed facility will be located in the HSA IX ESRD Planning Area. The HSA IX ESRD Planning Area includes Kendall, Grundy, Will, and Kankakee counties. As of September 2018 there is a calculated excess of 7 ESRD stations in this planning area. The State Board is estimating a growth of 2.89% compounded annually in the population in this ESRD Planning Area from 2015 to 2020.¹

¹ Source: 2017 Inventory of Health Care Facilities and Services Need Determinations Other Health Services page A-19.

Planning Area Population – 2015	970,600
In Station ESRD patients -2015	1,086
Area Use Rate 2015 ⁽¹⁾	.977
Planning Area Population – 2020 (Est.)	1,111,300
Projected Patients – 2020 ⁽²⁾	1,086
Adjustment	1.33x
Patients Adjusted	1,444
Projected Treatments – 2020 ⁽³⁾	225,323
Existing Stations	308
Stations Needed-2018	301
Number of Stations Excess	7
<ol style="list-style-type: none"> 1. Usage rate determined by dividing the number of in-station ESRD patients in the planning area by the 2015 – planning area population per thousand. 2. Projected patients calculated by taking the 2020 projected population per thousand x the area use rate. Projected patients are increased by 1.33 for the total projected patients. 3. Projected treatments are the number of patients adjusted x 156 treatments per year per patient 	

V. Background of the Applicants

A) Criterion 1110.1430(b)(1)&(3) – Background of the Applicants

An applicant must demonstrate that it is fit, willing and able, and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. To demonstrate compliance with this criterion, the Applicants must provide

- A) A listing of all health care facilities currently owned and/or operated by the applicant in Illinois or elsewhere, including licensing, certification and accreditation identification numbers, as applicable;
- B) A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility;
- C) Authorization permitting HFSRB and IDPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide the authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.
- D) An attestation that the Applicants have not had *adverse action*³ taken against any facility owned or operated that they own.

³ ³ “Adverse action is defined as a disciplinary action taken by IDPH, CMMS, or any other State or federal agency against a person or entity that owns or operates or owns and operates a licensed or Medicare or Medicaid certified healthcare facility in the State of Illinois. These actions include, but are not limited to, all Type "A" and Type "AA" violations.” (77 IAC 1130.140)

1. The Applicants attested that there has been no adverse action taken against any of the facilities owned or operated by DaVita, Inc. and Tovell Dialysis, LLC during the three (3) years prior to filing the application. [Application for Permit page 69-70]
2. The Applicants have authorized the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to have access to any documents necessary to verify information submitted in connection to the applicants' certificate of need to establish a twelve-station ESRD facility. The authorization includes, but is not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. [Application for Permit pages 69-70]
3. The site is owned by TD Romeoville LLC and evidence of this can be found at pages 31-41 of the application for permit in the Letter of Intent to lease the property at 480-490 North Independence Boulevard, Romeoville, Illinois.
4. The Applicants provided evidence that they were in compliance with Executive Order #2006-05 that requires *all State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order. State Agencies engaged in planning programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order.*
5. The proposed location of the ESRD facility is in compliance with the Illinois State Agency Historic Resources Preservation Act which requires *all State Agencies in consultation with the Director of Historic Preservation, institute procedures to ensure that State projects consider the preservation and enhancement of both State owned and non-State owned historic resources* (20 ILCS 3420/1).

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION BACKGROUND OF THE APPLICANTS (77 ILAC 1110.1430(b)(1) & (3))

VI. Purpose of the Project, Safety Net Impact, Alternatives

A) Criterion 1110.230 – Purpose of the Project

To demonstrate compliance with this criterion the Applicants must document that the project will provide health services that improve the health care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other area, per the applicant's definition.

According to the applicants:

“The purpose of the project is to improve access to life sustaining dialysis services to the residents of Romeoville, Illinois, and the surrounding area. There are 19 dialysis facilities within 30 minutes of the proposed Romeoville Dialysis. Excluding recently approved dialysis facilities which are being developed to serve distinct groups of patients, average utilization of area dialysis facilities is 72.8%, or just below the State Board’s utilization standard of 80%. Furthermore, patient census among the existing facilities within the Romeoville Dialysis GSA has increased 6.9% since March 31, 2015. This growth is anticipated to

continue to increase for the foreseeable future due to the demographics of the community. Teresa Kravets, M.D., with Northeast Nephrology Consultants, Inc. (NENC), is currently treating 96 late stage CKD patients (Stage 4-5), who reside within 30 minutes of the proposed Romeoville Dialysis. Conservatively, based on attrition due to patient death, transplant, stable disease, or relocation away from the area, and in consideration of other treatment modalities (HHD and peritoneal dialysis), Dr. Kravets anticipates at least 58 of these 96 patients will initiate in-center hemodialysis within 12-24 months following project completion. DuPage Medical Group will also add 12 late-stage CKD patients in support of the application. Conservatively, based on attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities, it is anticipated that 7 of these 12 additional patients will initiate in-center dialysis within 12-24 months following project completion. Thus, a total of 65 patients (58 from NENC, 7 from DMG), will be expected to initiate in-center hemodialysis within 12-24 months following project completion. Based upon historical utilization trends, the existing facilities will not have sufficient capacity to accommodate Dr. Kravet's and DuPage Medical Group's combined projected ESRD patients."

A map of the market area was provided, which encompasses an approximate 30-minute radius around the proposed facility. The boundaries of this market area are identified below.

- 30 minutes north to Villa Park, IL (DuPage County)
- 30 minutes northeast to Lyons, IL (Cook County)
- 30 minutes east to Orland Park (Cook County)
- 30 minutes southeast to Mokena, IL (Will County)
- 30 minutes south to Rockdale, IL (Will County)
- 30 minutes southwest to Minooka, IL (Grundy/Kendall/Will Counties)
- 30 minutes west to Oswego, IL (Kendall County)
- 30 minutes northwest to Naperville, IL (DuPage/Will Counties)

B) Criterion 1110.230 (b) - Safety Impact Statement

To demonstrate compliance with this criterion the Applicants must document the safety net impact if any of the proposed project. *Safety net services are the services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. [20 ILCS 3960/5.4]*

DaVita stated the following:

DaVita Inc. and its affiliates are safety net providers of dialysis services to residents of the State of Illinois. DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and Kidney Smarting patients, and community outreach. DaVita led the industry in quality, with twice as many four and five-star centers than other major dialysis providers. DaVita also led the industry in Medicare's Quality Incentive Program, ranking number 1 in 3 out of 4 clinical measures and receiving the fewest penalties. DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Furthermore, DaVita is an industry leader in the rate of fistula use, and has the lowest 90-day catheter rates among large dialysis providers. During 2000-2014, DaVita improved its fistula adoption rate by 103%. Its commitment to improving clinical outcomes directly translated into 7% reduction in hospitalizations among DaVita patients. The proposed Romeoville Dialysis will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. The utilization of existing dialysis facilities within the Romeoville GSA that have been operational for at least 2 years is 72.8%. Further, patient census among the existing facilities within the Romeoville GSA has increased 6.9% since March 31, 2015. The growth is anticipated to increase for the foreseeable future due to demographics of the community and the U.S. Centers for Disease Control and Prevention that estimates that 15% of American adults suffer from CKD.

Further, a total of 65 patients (58 from NENC, 7 for DMG), will be expected to initiate in-center hemodialysis within 12-24 months following project completion. Accordingly, the proposed dialysis facility will not impact other general health care providers' ability to cross-subsidize safety net services.

TABLE THREE
DaVita, Inc.

	2014	2015	2016
Net Patient Revenue	\$266,319,949	\$311,351,089	\$353,226,322
Amt of Charity Care (charges)	\$2,477,363	\$2,791,566	\$2,400,299
Cost of Charity Care	\$2,477,363	\$2,791,566	\$2,400,299
% of Charity Care/Net Patient Revenue	0.93%	0.90%	0.68%
Number of Charity Care Patients	146	109	110
Number of Medicaid Patients	708	422	297
Medicaid	\$8,603,971	\$7,381,390	\$4,692,716
% of Medicaid to Net Patient Revenue	3.23%	2.36%	1.33%

C) Criterion 1110.230 (c) – Alternatives to the Proposed Project

To demonstrate compliance with this criterion the Applicants must document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

The Applicants considered three (3) alternatives

A) Reducing the Scope and Size of Current Project

The Applicants considered, but ultimately rejected, an 8-station in-center hemodialysis facility. This was rejected due to the expected utilization, as documented throughout this proposal. The Applicants fully expect the facility to reach the required number of patients for a 12-station facility within two years. In order to establish a facility within the HSA proposed, the facility must not have less than eight stations, pursuant to 77 Ill. Adm. Code § 1110.1430(h). The physician's patient data and referral network exhibits a large number of expected patients from within 30 minutes of the proposed location. As a result of the expected referral numbers, the number of patients would quickly overcome the required utilization levels for an 8-station facility. Although the reduced number of stations would have reduced the size and cost of the proposed project, the Applicants came to the decision that a 12-station facility would ultimately better serve the patient population, as it would allow for the expected growth of patients to benefit from the facility. The alternative plan of only establishing an 8-station facility was therefore rejected by the applicants.

B) Utilize Existing Facilities

There are 19 dialysis facilities within Romeoville GSA. Excluding recently approved dialysis facilities which are being developed to serve distinct groups of patients, average utilization of area dialysis facilities is 72.8%, or just below the State standard of 80%. Furthermore, patient census among the existing facilities within the Romeoville GSA has increased 6.9% since March 31, 2015. This growth is anticipated to continue to increase for the foreseeable future due to the demographics of the community and U.S. Centers for Disease Control and Prevention estimates that 15% of Americans adults suffer CKD. Dr. Teresa Kravets, M.D., with Northeast Nephrology Consultants, Inc., anticipates the referral of at least 58 of her 96 patients currently being treated for CKD. This, combined with 7 estimated referrals from DuPage Medical Group, results in an estimated 65 patients who will be expected to require dialysis treatment within 12-24 months after

project completion. Based on these referral data, existing facilities will not have sufficient capacity to accommodate Dr. Kravet's and DuPage Medical Group's combined projected ESRD patients. As a result, the Applicants rejected this option. There is no capital cost with this alternative.

C) Pursue a Joint Venture for the Establishment of a New Facility

DaVita, Inc., DuPage Medical Group, Ltd. and Northeast Nephrology Consultants, Inc., have entered into a joint venture agreement to combine resources and areas of expertise in order to offer the highest level of patient care. Given the historic growth of ESRD patients and the current utilization levels of area clinics, it is expected that area clinics will exceed the 80% utilization mark over the next few years. The Romeoville Dialysis facility is necessary to address this growth and allow existing facilities to operate at an optimum capacity. Further, without any current partnerships with existing in-center hemodialysis facilities, DaVita is seeking to collaborate with DMG and NENC on the proposed facility in order to increase access to care for individuals with ESRD, and address identified issues with care coordination and physician communication in the treatment of patients with kidney disease. The establishment of a 12-station dialysis facility will improve access to life-sustaining dialysis treatment for those individuals in the Romeoville community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being. As a result, the Applicants chose this option. The cost of this alternative is \$4,115,927.

D) Empirical Evidence

There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these measures has been directly linked to 15-20 percent fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into a 7 percent reduction in hospitalizations among DaVita patients, which resulted in more than \$1.5 billion in savings to the health care system and the taxpayer from 2010 -2012. Although not quantifiable by empirical data, the Applicants also anticipate the improvement of patient care and experiences through the development of the joint venture facility. Identified issues anticipated to be addressed include maintaining patients' continuum of care and resolving physician communication and care coordination deficiencies that are barriers to optimal care.

VII. Size of the Project, Projected Utilization, and Assurances

A) Criterion 1110.234(a) –Size of the Project

To demonstrate compliance with this criterion the Applicants must document that the size of the project is in conformance with State Board Standards published in Part 1110 Appendix B.

The Applicants are proposing a twelve (12) station ESRD facility in 7,000 GSF of clinical space or 583.3 GSF per station. This is within the State Board Standard of 650 GSF per station or a total of 7,800 GSF. The Applicants have successfully addressed this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SIZE OF THE PROJECT (77 ILAC 1110.234(a))

B) Criterion 1110.234(b) – Projected Utilization

To demonstrate compliance with this criterion the Applicants must document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Part 1110 Appendix B. The number of years projected shall not exceed the number of historical years documented.

The Applicants are projecting sixty-five (65) patients by the second year after project completion.

$$\begin{aligned} \text{Sixty-five (65) patients} \times 156 \text{ treatments per year} &= 10,140 \text{ treatments} \\ \text{Twelve (12) stations} \times 936 \text{ treatments available} &= 11,232 \text{ treatments} \\ 10,140 \text{ treatments} / 11,232 \text{ treatments} &= 90.2\% \text{ }^4 \end{aligned}$$

The Applicants have successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED UTILIZATION (77 ILAC 1110.234(b))

C) Criterion 1110.234 (e) - Assurances

To demonstrate compliance with this criterion the Applicants submit a signed and dated statement attesting to the applicant's understanding that, by the end of the second year of operation after the project completion, the applicant will meet or exceed the utilization standards specified in Appendix B.

The necessary attestation is provided at pages 121-122 of the application for permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.234(e))

IX. In-Center Hemodialysis Projects

A) Criterion 1110.1430(c) - Planning Area Need

To demonstrate compliance with this criterion the Applicants must document that the number of stations to be established or added is necessary to serve the planning area's population.

1) 77 Ill. Adm. Code 1100 (Formula Calculation)

To demonstrate compliance with this sub-criterion the Applicants must document that the number of stations to be established is in conformance with the projected station need.

There is a calculated excess of 7 ESRD stations in the HSA IX ESRD Planning Area per the September 2018 Revised Station Need Determination.

The Applicants provided additional information on February 8, 2018 stating that end-stage renal disease (ESRD) clinic utilization data demonstrates a growth

⁴ Assumes the proposed facility will operate six (6) days a week fifty-two (52) weeks a year three (3) shifts a day.

trend in ESRD incidence and prevalence in Romeoville and the area immediately surrounding it and provides more detailed demographic data for the area which helps illustrate why the Romeoville location in Will County was selected for a new clinic site.

The Applicants stated that HSA IX ESRD Planning Area (Kendall, Grundy, Will, and Kankakee County) population has grown by 12.2% from 2013-2018 and the over 65-population has grown by 33.6% for this same time period. The Will County Population (the location of the proposed Romeoville facility) has grown by 12.9% over the same period (2013-2018) and the over age 65 populations by 34.3%. The patient count for the facilities within the patient service area has increased by 9 percent or from 395 patients to 431 since the September 30, 2017 through December 31, 2017. Annualized, this figure represents a 36% increase in patients.

2) Service to Planning Area Residents

To demonstrate compliance with this sub-criterion the Applicants must document that the primary purpose is to serve the residents of the planning area.

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of Romeoville, Illinois and the surrounding communities. As evidenced in the physician referral letters, a combined total of one hundred-eight (108) late-stage pre-ESRD patients reside within 30 minutes of the proposed facility. The Applicants are projecting sixty-five (65) patients by the second year after project completion. The sixty-five patients will come from the zip codes identified below. It would appear that the proposed facility will provide dialysis services to the residents of the planning area.

3) Service Demand – Establishment of In-Center Hemodialysis Service

To demonstrate compliance with this sub-criterion the Applicants must document that there is sufficient demand to justify the twelve stations being proposed.

The Applicants have submitted two (2) referral letters, predicting that 108 patients from the service area will require dialysis services within 2 years of project completion (application for permit, pg. 82). Conservative estimates (based on attrition) has the number of referrals at sixty-five (65) patients requiring dialysis by the second year after project completion.

Zip Code	City	County	Patient #
60446	Romeoville	Will	8
60403	Crest Hill	Will	14
60490	Bolingbrook	Will	6
60544	Plainfield	Will	2
60435	Joliet	Will	15
60441	Lockport	Will	21
60439	Lemont	Cook	7
60586	Plainfield	Will	8
60431	Joliet	Will	4
60432	Joliet	Will	11
60491	Homer Glen	Will	2

60404	Shorewood	Will	10
Total			108

The Applicants provided the necessary information at page 82 of the application for permit. From the referral letter it appears that there is sufficient demand (patient population) to justify the proposed number of stations (12) being requested by this application for permit.

5) Service Accessibility

To demonstrate compliance with this sub-criterion the Applicants must document that the number of stations being established or added for the subject category of service is necessary to improve access for planning area residents. The applicant must document one of the following:

- i) The absence of the proposed service within the planning area;
 - ii) Access limitations due to payor status of patients, including, but not limited to, individuals with health care coverage through Medicare, Medicaid, managed care or charity care;
 - iii) Restrictive admission policies of existing providers;
 - iv) The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population;
 - iv) For purposes of this subsection (c)(5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.
1. There is a calculated excess of 7 dialysis stations in the HSA IX ESRD Planning Area.
 2. There has been no evidence of the access limitations due to payor status of patients.
 3. There has been no evidence of restrictive admission policies of existing providers.
 4. There are 22 facilities within thirty (30) minutes with an average utilization of approximately 57%. Four of the 22 facilities are not operational or are in “ramp-up” stage. For the 18 remaining facilities the average utilization is approximately 69%. Four of the 19 facilities (21%), are operating in excess of the State Board standard (80%). [See Table Below]

The State Board has estimated an excess of 7 ESRD stations in the planning area by CY 2020 based upon the estimated population and the historical usage rate in the planning area. Additionally there is not a service access issue in this planning area as there is existing facilities within 30-minute service area not at target occupancy. Based on the information above the Applicants are not in compliance with this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION PLANNING AREA NEEDS (77 ILAC 1110.1430(c)(1), (2), (3) and (5)).

TABLE FOUR
Facilities within 30 minutes of the proposed facility

Name	City	HSA	Stations	Adjusted Time ⁽¹⁾	Utilization ⁽²⁾	Star Rating ⁽³⁾	Meets Standard?
USRC Bolingbrook Dialysis	Bolingbrook	9	13	8.05	76.92%	2	No
FMC Bolingbrook Dialysis	Bolingbrook	9	24	11.5	83.33%	4	Yes
FMC Lemont (Completion 05/2016)	Lemont	7	12	11.5	37.50%	N/A	No
FMC Naperville	Naperville	9	24	18.4	75.00%	5	No
FMC Joliet	Joliet	9	18	19.5	65.74%	3	No
FMC Willowbrook	Willowbrook	7	20	19.5	62.50%	3	No
DaVita Renal Center New Lenox	New Lenox	9	19	20.7	98.25%	3	Yes
DaVita Renal Center West Joliet	Joliet	9	29	20.7	68.97%	4	No
FMC Plainfield	Plainfield	9	16	21.8	77.08%	5	No
FMC Plainfield North (Completion 11/2016)	Plainfield	9	10	20.7	60.00%	3	No
USRC Oak Brook	Downers Grove	7	13	23	83.33%	2	Yes
FMC Downers Grove	Downers Grove	7	16	25.3	63.54%	3	No
FMC Dialysis Center Orland Park	Orland Park	7	18	26.4	55.56%	4	No
Davita Sun Health Joliet	Joliet	9	17	26.4	62.75%	5	No
Fox Valley Dialysis Center	Aurora	8	29	28.7	83.33%	5	Yes
DaVita Palos Park Dialysis	Orland Park	7	12	28.7	65.28%	2	No
FMC Summit (Completion 11/2016)	Summit	7	12	28.75	51.39%	NA	No
FMC Mokena	Mokena	9	14	29.9	70.24%	3	No
					68.93%		
Davita Hickory Creek	Joliet	9	12	20	0.00%	NA	
Davita Rutgers Park	Woodridge	7	12	21	0.00%	NA	
Fresenius New Lenox	New Lenox	9	12	21	0.00%	NA	

FMC Woodridge (Completion 03/2019)	Woodridge	7	12	16.1	0.00%	NA
			364		56.40%	
<ol style="list-style-type: none"> 1. Adjusted time taken from MapQuest and adjusted at 1.15 times the MapQuest time. 2. Utilization from June 30, 2018. 3. Star rating taken from the Medicare ESRD website. 						

B) Criterion 1110.1430(d) - Unnecessary Duplication/Mal-distribution

To demonstrate compliance with this criterion the Applicants must document that the proposed project will not result in

1. An unnecessary duplication of service
2. A mal-distribution of service
3. An impact on other area providers

1. To determine if there is an unnecessary duplication of service the State Board identifies all facilities within thirty (30) minutes and ascertains if there is existing capacity to accommodate the demand identified in the application for permit. There are 22 facilities within thirty (30) minutes with an average utilization of approximately 57%. Four of the 22 facilities are not operational, or are in ramp-up phase. The 18 remaining facilities have an average utilization of approximately 69%. [See Table Above]
2. To determine a mal-distribution (i.e. surplus) of stations in the thirty (30) minute service area the State Board compares the ratio of the number of stations per population in the thirty (30) minute service area to the ratio of the number of stations in the State of Illinois to the population in the State of Illinois. To determine a surplus of stations the number of stations per resident in the thirty (30) minute service area must be 1.5 times the number of stations per resident in the State of Illinois.

	Population	Stations	Ratio
30 Minute Service Area	1,142,723	364	1 Station per every 3,131 residents
State of Illinois (2015 est.)	12,978,800	4,850	1 Station per every 2,676 residents

The population in the thirty (30) minute service area is 1,142,723 residents. The number of stations in the (30) minute service area is 364 stations. The ratio of stations to population is one (1) station per every 3,131 residents.

The number of stations in the State of Illinois is 4,850 stations (*as of September 2018*). The 2015 estimated population in the State of Illinois is 12,978,800 residents (*Illinois Department of Public Health Office of Health Informatics Illinois Center for Health Statistics -2014 Edition*). The ratio of stations to population in the State of Illinois is one (1) station per every 2,676 residents. To have a surplus of stations in this thirty (30) minute service area the number of stations per population would need to be one (1) station per every 1,784 residents. Based upon this methodology there is no surplus of stations in this service area.

3. The Applicants stated the following regarding the impact on other facilities. *The proposed dialysis facility will not have an adverse impact on existing facilities in the Romeoville GSA. Based on March 2017 data from the Renal Network, 672 ESRD patients live within 30 minutes of the proposed facility. Excluding recently approved dialysis facilities which are being developed to serve distinct groups of patients, average utilization of area dialysis facilities is 72.8%, or just below the State standard of 80%.*

The proposed facility is necessary to allow the existing facilities to operate at an optimum capacity, while at the same time accommodating the growing demand for dialysis services. As a result, the Romeoville Dialysis facility will not lower the utilization of area providers below the occupancy standards. Further, the three in-center hemodialysis facilities approved by the State Board within the last few years are either in development (FMC Woodridge), or operational less than two years (FMC Plainfield North, FMC Summit). Each facility will serve a distinct patient base within the greater southwest suburban area. As stated in the physician referral letters for these facilities, each physician projects to refer a sufficient number of patients to achieve 80% utilization by the second year after project completion.

There are 22 facilities within thirty (30) minutes with an average utilization of approximately 57%. Four of the 22 facilities are not operational, or are in ramp-up phase. The 18 remaining facilities have an average utilization of approximately 69%. Four of the 18 facilities that have been in operation for two years or more, or 78% of the facilities (14/18 = 78%) are not at target occupancy as of June 2018. The Applicants are not in compliance with this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION OF SERVICE, MALDISTRIBUTION OF SERVICE IMPACT ON OTHER FACILITIES (77 ILAC 1110.1430(d)(1), (2) and (3))

C) Criterion 1110.1430(f) - Staffing

To demonstrate compliance with this criterion the Applicants must document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and Joint Commission staffing requirements can be met.

The proposed facility will be staffed in accordance with all State and Medicare staffing requirements. The Medical Director will be Dr. Teresa Kravets, M.D. A copy of Dr. Kravets's curriculum vitae has been provided as required. Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

- Administrator (1.04 FTE)
- Registered Nurse (4.53 FTE)
- Patient Care Technician (4.54 FTE)
- Biomedical Technician (0.29 FTE)
- Social Worker (licensed MSW) (0.57 FTE)
- Registered Dietitian (0.58 FTE)
- Administrative Assistant (0.84 FTE)

As patient volume increases, nursing and patient care technician staffing will increase accordingly to maintain a ratio of at least one direct patient care provider for every 4 ESRD patients. At least one registered nurse will be on duty while the facility is in operation. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis,

laboratory draws, and miscellaneous testing devices used. In addition, it includes in depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program was provided. Romeoville Dialysis will maintain an open medical staff.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION STAFFING (77 ILAC 1110.1430(f))

D) Criterion 1110.1430(g) - Support Services

To demonstrate compliance with this criterion the Applicants must submit a certification from an authorized representative that attests to each of the following:

- 1) Participation in a dialysis data system;
- 2) Availability of support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric and social services; and
- 3) Provision of training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training provided at the proposed facility, or the existence of a signed, written agreement for provision of these services with another facility.

The Applicants provided the necessary attestation as required at pages 107-108 of the application for permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SUPPORT SERVICES (77 ILAC 1110.1430(g))

E) Criterion 1110.1430(h) - Minimum Number of Stations

To demonstrate compliance with this criterion the Applicants must document that the minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

- 1) Four dialysis stations for facilities outside an MSA;
- 2) Eight dialysis stations for a facility within an MSA.

The proposed twelve (12) station facility will be located in the Chicago-Arlington Heights-Naperville metropolitan statistical area ("MSA"). The Applicants have met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION MINIMUM NUMBER OF STATIONS (77 ILAC 1110.1430(h))

F) Criterion 1110.1430(i) - Continuity of Care

To demonstrate compliance with this criterion the Applicants document that a signed, written affiliation agreement or arrangement is in effect for the provision of inpatient care and other hospital services. Documentation shall consist of copies of all such agreements.

The Applicants provided the necessary signed affiliation agreement with Silver Cross Hospital, New Lenox, as required at pages 109-120 of the application for permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION CONTINUITY OF CARE (77 ILAC 1110.1430(i))

G) Criterion 1110.1430(k) - Assurances

To demonstrate compliance with this criterion the representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that:

- 1) By the second year of operation after the project completion, the applicant will achieve and maintain the utilization standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal; and
- 2) An applicant proposing to expand or relocate in-center hemodialysis stations will achieve and maintain compliance with the following adequacy of hemodialysis outcome measures for the latest 12-month period for which data are available:
≥ 85% of hemodialysis patient population achieves urea reduction ratio (URR) ≥ 65%
and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II 1.2.

The necessary attestation has been provided at pages 121-122 of the application for permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.1430(k))

VIII. Financial Viability

This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; and (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs. (20 ILCS 3960)

A) **Criterion 1120.120 – Availability of Funds**

To demonstrate compliance with this criterion the Applicants must document that the resources are available to fund the project.

The Applicants are funding this project with cash in the amount of \$2,212,097 and a lease with a FMV of \$1,903,830. The Applicants attested that the total estimated project costs and related costs will be funded in total with cash and cash equivalents. A summary of the financial statements of the Applicants is provided below. The Applicants have sufficient cash to fund this project.

	2017	2016	2015
Cash	\$508,234	\$674,776	\$1,499,116
Current Assets	\$8,744,358	\$3,994,748	\$4,503,280
Total Assets	\$18,948,193	\$18,755,776	\$18,514,875
Current Liabilities	\$3,041,177	\$2,710,964	\$2,399,138
LTD	\$9,158,018	\$8,944,676	\$9,001,308
Patient Service Revenue	\$9,608,272	\$9,269,052	\$9,480,279
Total Net Revenues	\$10,876,634	\$10,707,467	\$13,781,837
Total Operating Expenses	\$9,063,879	\$8,677,757	\$12,611,142
Operating Income	\$1,812,755	\$2,029,710	\$1,170,695
Net Income	\$830,555	\$1,033,082	\$427,440

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION AVAILABILITY OF FUNDS (77 ILAC 1120.120)

B) **Criterion 1120.130 - Financial Viability**

To demonstrate compliance with this criterion the Applicants must document that they have a Bond Rating of “A” or better, they meet the State Board’s financial ratio standards for the past three (3) fiscal years or the project will be funded from internal resources.

The Applicants are funding this project with cash in the amount of \$2,212,097 and a lease with a FMV of \$1,903,830. The Applicants have qualified for the financial waiver.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION FINANCIAL VIABILITY (77 ILAC 1120.130)

IX. Economic Feasibility

A) Criterion 1120.140(a) – Reasonableness of Financing Arrangements

B) Criterion 1120.140(b) – Terms of Debt Financing

To demonstrate compliance with these criteria the Applicants must document that leasing of the space is reasonable. The State Board considers the leasing of space as debt financing.

The Applicants are funding this project with cash in the amount of \$2,212,097 and a lease with a FMV of \$1,903,830. The lease is for fifteen (15) years at a base rent of \$29.50/gsf for the first five (5) years, with a ten percent (10%) increase every five (5) years. It appears the lease is reasonable when compared to previously approved projects.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERIA REASONABLENESS OF FINANCING ARRANGEMENTS AND TERMS OF DEBT FINANCING (77 ILAC 1120.140(a) & (b))

C) Criterion 1120.140(c) – Reasonableness of Project Costs

To demonstrate compliance with this criterion the Applicants must document that the project costs are reasonable by the meeting the State Board Standards in Part 1120 Appendix A.

As shown below, the Applicants have met all of the State Board Standards published in Part 1120, Appendix A.

New Construction and Contingencies Costs are \$1,454,426 or \$207.77 per GSF for 7,000 GSF of clinical space. This appears reasonable when compared to the State Board Standard of \$278.19 per GSF, with 2018 listed as mid-point of construction.

Contingencies – These costs total \$100,000 and are 7.3% of the new construction costs identified for this project. This is in compliance with the State standard of 10%.

Architectural/Engineering Fees are \$130,500 and are 8.9% of new construction and contingencies. This appears reasonable when compared to the State Board Standard of 6.64% to 9.98%.

Consulting and Other Fees are \$78,500. The State Board does not have a standard for these costs.

Movable or Other Equipment – These costs are \$548,671 or \$45,722 per station (12 stations). This appears reasonable when compared to the State Board Standard of \$53,682 per station.

Fair Market Value of Leased Space and Equipment – These costs are \$1,903,830. The State Board does not have a standard for these costs.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION REASONABLENESS OF PROJECT COSTS (77 ILAC 1120.140(c))

D) Criterion 1120.140(d) – Projected Operating Costs

To demonstrate compliance with this criterion the Applicants must document the projected direct annual operating costs for the first full fiscal year at target utilization, but no more than two years following project completion. Direct costs mean the fully allocated costs of salaries, benefits and supplies for the service.

The Applicants are projecting \$247.70 operating expense per treatment.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED OPERATING COSTS (77 ILAC 1120.140(d))

E) Criterion 1120.140(e) – Total Effect of the Project on Capital Costs

To demonstrate compliance with this criterion the Applicants must provide the total projected annual capital costs for the first full fiscal year at target utilization, but no more than two years following project completion. Capital costs are defined as depreciation, amortization and interest expense.

The Applicants are projecting capital costs of \$19.20 per treatment.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS (77 ILAC 1120.140(e))

Appendix I

Support and Opposition Comments

Northeast Nephrology Consultants stated in support

“I am writing to express support of the Certificate of Need request for the development of new In-Center Hemodialysis facility located at 480 - 490 North Independence Boulevard, Romeoville, Illinois 60446 to provide life-sustaining dialysis treatment, education, and support for patients with kidney disease. I am a physician that is board certified in Nephrology and currently practicing within the market area for this facility. As related within the application, there is an identified need for additional dialysis stations to serve an identified patient population. In-center hemodialysis care is a burdensome and time intensive process for patients. Through this facility, we can transform the lives of patients and their families by having more options in their dialysis care providers, locations, and treatment times. As you know, it is not a simple matter of having one time slot available for a patient, as patients often cannot receive dialysis at the times dictated by limited facility openings. The utilization rate of area facilities is over 72% and it is projected to continue increasing on an annual basis. This will lead to even more competition for dialysis stations by patients and complicate their already difficult lives. Ensuring patients have practical access to dialysis care is a mission we all have a responsibility to support within the community. In partnership with DaVita, DuPage Medical Group, and other minority investors, we can bring high- quality, integrated, and necessary care to the Romeoville and surrounding community. By leveraging the latest technology and care platforms, we will be offering patient-centered care on the forefront of dialysis care. With well-resourced partners, a local focus, and a care model seeking coordination across the metropolitan area, the proposed facility will be a positive step for patients suffering from renal disease and the providers that care for them. For these reasons, I ask that the Illinois Health Facilities & Services Review Board approve the dialysis facility application for the proposed Romeoville Dialysis facility.”

Troutman & Dams LLC stated in support

“We offer our enthusiastic support for the DaVita Dialysis Project. Our firm, Troutman & Dams, has been working closely with the Village of Romeoville in the development of the Village's "Uptown" area. We have similarly worked with DaVita in finding a location for its facility that will be accessible and convenient for its patients. In working with DaVita we have come to understand that most dialysis patients receive treatment three times each week. This means traveling to the facility over 150 times per year. Obviously, access to transportation becomes very important to DaVita and its patients. What is particularly attractive about this site is the abundant availability of multiple modes of convenient transportation. The proposed facility is located on Illinois Route 53. For patients who drive, this major highway is the primary north/south route serving this area. The route links Joliet with Downers Grove, and communities in between such as Lockport, Romeoville and Bolingbrook. The proposed site will have ample free parking for patients. For those patients using mass transit, there is a Pace bus stop located only 900 feet from the DaVita site and accessed with a new 8 foot wide sidewalk. Metra has also recently opened a new station within one mile that can similarly serve this area. The site is also easily accessible through the Village's very affordable "Ride Around Town" program for residents. For those patients who desire, the facility is also located directly on a wide bike path that would go right past the DaVita door.”

Appendix I Support and Opposition Comments

Presence Saint Joseph Medical Center stated in support

“Presence Saint Joseph Medical Center has proudly served Romeoville and the southern suburbs area for over 100 years. The Romeoville community has grown significantly in recent years. Unfortunately, the percentage of people with chronic kidney disease is also rising. The population growth combined with the increased incident in kidney disease is creating greater need for dialysis services in the area. We are seeing an increased number of patients with kidney disease in our hospital as almost 15% of American adults suffer chronic kidney disease (CKD). We are fortunate to collaborate with many excellent nephrologists on our staff in caring for our patients with kidney disease. We are pleased that Dr. Teresa Kravets, the medical director of the proposed DaVita Romeoville facility, and many of the other nephrologists involved are members of our medical staff. We would value continuing to work with them in this new facility. An optimal care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Early identification of CKD and deliberate treatment of end-stage renal disease (ESRD) by multidisciplinary teams leads to improved disease management and care, mitigating the risk of disease advancement and patient mortality. We believe we can work well with Dr. Kravets and DaVita in caring for their patients with kidney disease, and we support the Review Board's approval of DaVita Romeoville ESRD facility.”

Nephrology Associates of Northern Illinois, LTD stated in opposition

“Never in this history of the planning board have so many unnecessary dialysis stations been approved for a single operator in a defined geographic at one time. At the January Board meeting the Board will consider two applications by the Applicants for the first time, and will consider four other applications which already received an Intent to Deny. However, all of the applications have three things in common: (1) the lack of referral letters to justify the patient population for the facilities; (2) overlapping service areas; and (3) emphasis on market share instead of patient care. It is inexplicable that the Applicants would provide no new information to the Board regarding projects: #17-014 Rutgers Park Dialysis, #17-15 Stone Quarry, and #17-06 Salt Creek Dialysis. There are still substantial deficiencies that remain as evidenced by this letter and the staff report released for the November Board meeting and that justified the indent-to-deny that the applications received. Further, applications for project #17-029 Melrose Village Dialysis and 17-043 DaVita Romeoville Dialysis have identical deficiencies and introduce even more new problems that Board members cannot overlook. As simply as can be put - approving these projects would adversely alter the healthcare delivery system in this HSA in a way that is entirely inconsistent with the HFSRB at its rules. In an effort to help Board members visualize the issue with the applicant's proposal for 72 stations, we have created a map (Attachment A) which plots out each of the proposed facilities and creates a circle around a 10-mile service area per the Board's rule (77 Ill. Admin. 1110.1430.). This picture certainly is worth 1,000 words. You can clearly see how each of the proposed facility service areas completely overlaps with one another. There is only one way an applicant could explain this sort of unnecessary duplication of services. An applicant would have to be able to identify patients to fill these stations. But the Applicants cannot do that and have refused to comply with the Board's rules.

The applicant's referral letter included in these applications and referenced in the SBSR by the applicant's own admission do **not** meet HFSRB standards and serve as an indictment of the applicant's disregard for the HFSRB planning process. The HFSRB has in its possession six copies of the exact same letter (with the date changed on each), that word for word regurgitates the same flawed understanding the HFSRB planning process. It would alter

Appendix I Support and Opposition Comments

longstanding practice to require referrals sufficient to justify a project - and even more so the express prohibition of utilizing the same patients to justify multiple projects. It is not clear how these "referrals" were accepted by Board staff- but they certainly should not be accepted by this Board. There have been instances in the past when the HFSRB has approved applications for new dialysis facilities with negative findings in an application. In many of those instances the applicant provided context for why they received a negative finding. After several public commenters's noted this important issue for the Board at the September Meeting, the Applicants responded to the elephant in the room but in the process only obfuscated the truth. The applicant's only explanation was that they expected to fill the facilities with "DMG patients and they are not patients of other providers at this time." With this one statement the Applicants managed to not only admit their inability to identify patients for these facilities but they also neglected to mention that some of the "DMG patients" are already seen by other area nephrologists, and those same patients receive dialysis treatments at facilities with excess capacity. The applicant's "innovative" approach for these stations is to plant a flag and siphon patients from existing providers. If you approve it, we will build it, and they will come is not innovative and certainly is not responsible health planning. This will undoubtedly put great strain on other area providers who currently have excess capacity in HSA 7, and undermine the cost savings achieved through the area's End Stage Renal Disease (ESRD) Seamless Care Organization (ESCO). This planning process is designed to protect against the very ill-conceived market saturation that the Applicants propose. A more practicable approach would be for the Applicants to withdraw their applications and assess where there is a true need in the HSA and then submit only necessary applications to this Board. For these reasons, we pray the HFSRB continue to deny these applications and allow for more organized development of ESRD services within these communities."

Juan Morado, Jr. Benesch, Friedlander, Coplan & Aronoff, LLP stated in part

The applicant's project reflects the continuation of a poorly planned hostile take-over of dialysis care in Illinois. This duo of Applicants has filed eight applications proposing to establish ESRD services in a Health Service Area already served by an abundance of providers. This signifies an all-out assault which would undermine the Board's mission with regards to health planning in our state. The reason for this is that these applications do not reflect a desire to serve patients that are without access to care, but rather to manipulate the service of those patients from quality existing providers to serve the financial needs of the applicants. This is exactly what the Certificate of Need program was designed to prevent. This application will greatly undermine the cost savings achieved by the nation's first ESRD Seamless Care Organization ("ESCO"), and the quality of patient care by oversaturating a planning area where the average utilization rate is a meager 67%. This project was originally slated for consideration by the Board at your January 2018 meeting, but was deferred by the Applicants in an effort to delay what would have surely been an intent-to-deny by this Board. As you may recall during the January 2018 meeting, this Board was provided with a full and honest assessment of the applicant's quest to increase their market share. We would ask that the abundance of public comment, both in written form and in oral testimony before the Board, be incorporated by reference into this application file. This application would contribute to the unnecessary duplication of service and have a severe impact on other providers in violation of ILL. Admin. Code 1110.1430(d) (1) (3). You have heard the testimony from several of them. The greatest indication of this imbalance is evidenced by reviewing the utilization rate of other area facilities.

- There are nineteen (19) facilities in the planning area and only 30% or six (6) of those facilities are at the state's target utilization rate.
- Four (4) of the nineteen (19) area facilities are still ramping up, and have only been in service for a couple of months.

Appendix I

Support and Opposition Comments

When taking a comprehensive review of the planning area where this project is proposed, it is clear that there are simply not enough patients to fill the existing stations in the planning area. The only way this project will succeed is to syphon patients from existing providers to the benefit of the applicants. Nothing exhibits this better than the fact that these Applicants had patients testify to support related projects, and the only available patients were those already being provided with care by those existing providers who are opposing these projects. The applicant's also continue use the same stale "referral" letter for several projects that was submitted to support their other projects. This letter cites unidentified patients from the same zip code multiple times- in a clear violation of Board rules that prohibit the same referral to support multiple projects. This project proposes to serve patients in the same overlapping geographic area that the applicant's five (5) other projects propose to serve. The Applicants have already admitted before the Board that they do not know where their patients will come from and they are asking the Board to abandon rational health planning in favor of an "if you build it they will come" mentality. This was not enough for the Board members to approve the applicant's project in September, it wasn't enough in January, and it should certainly not be enough in February. As noted above, this application is part of a larger bundle of applications filed by the applicant, to have this Board approve the largest number of dialysis stations at one time to a single provider in Illinois CON history. There is something wrong with these proposals and the applicant knows it. The five (5) other applications were deferred again by the Applicants to the April 2018 agenda in a pointless attempt to delay their inevitable final denial by this Board. Nothing has changed since this application was last slated to be considered by the Board. The obvious is still true. There is **NO** need for these stations in HSA 9. It is not problematic for these Applicants to repeatedly come before this Board to propose ESRD facilities, because they do not have ESRD patients they are busy caring for. The providers opposing these projects do have to care for such patients. The fact that the dozens of people previously opposing these projects may not make every meeting to which these projects are strategically deferred should not undermine the opposition, its validity, and the prior denials of these projects. For these reasons, we pray that the Board continue to deny this application and allow for a more organized development of ESRD services within this community.

- There are nineteen (19) facilities in the planning area and only 30% or six (6) of those facilities are at the state's target utilization rate.
- Four (4) of the nineteen (19) area facilities are still ramping up, and have only been in service for a couple of months.

When taking a comprehensive review of the planning area where this project is proposed, it is clear that there are simply not enough patients to fill the existing stations in the planning area. The only way this project will succeed is to syphon patients from existing providers to the benefit of the applicants. Nothing exhibits this better than the fact that these Applicants had patients testify to support related projects, and the only available patients were those already being provided with care by those existing providers who are opposing these projects. The applicant's also continue use the same stale "referral" letter for several projects that was submitted to support their other projects. This letter cites unidentified patients from the same zip code multiple times- in a clear violation of Board rules that prohibit the same referral to support multiple projects. This project proposes to serve patients in the same overlapping geographic area that the applicant's five (5) other projects

Appendix I

Support and Opposition Comments

propose to serve. The Applicants have already admitted before the Board that they do not know where their patients will come from and they are asking the Board to abandon rational health planning in favor of an "if you build it they will come" mentality. This was not enough for the Board members to approve the applicant's project in September, it wasn't enough in January, and it should certainly not be enough in February. As noted above, this application is part of a larger bundle of applications filed by the applicant, to have this Board approve the largest number of dialysis stations at one time to a single provider in Illinois CON history. There is something wrong with these proposals and the applicant knows it. The five (5) other applications were deferred again by the Applicants to the April 2018 agenda in a pointless attempt to delay their inevitable final denial by this Board. Nothing has changed since this application was last slated to be considered by the Board. The obvious is still true. There is **NO** need for these stations in HSA 9. It is not problematic for these Applicants to repeatedly come before this Board to propose ESRD facilities, because they do not have ESRD patients they are busy caring for. The providers opposing these projects do have to care for such patients. The fact that the dozens of people previously opposing these projects may not make every meeting to which these projects are strategically deferred should not undermine the opposition, its validity, and the prior denials of these projects. For these reasons, we pray that the Board continue to deny this application and allow for a more organized development of ESRD services within this community.



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Transcript of Full Meeting

Date: April 17, 2018

Case: State of Illinois Health Facilities and Services Review Board

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1 CHAIRMAN SEWELL: Public participation.

2 MS. MITCHELL: Please come up when your
3 name is called. You will come to the table right
4 in front of the court reporter.

5 Please, if you have written testimony,
6 leave your written testimony for the benefit of
7 the court reporter, just so she can make sure she
8 gets the spelling of everything correctly. You do
9 not have to speak in the order in which you are
10 called.

11 First up, on Project 17-043, DaVita
12 Romeoville Dialysis, Romeoville, Grant Asay,
13 Lori Wright, Dr. Mohammed Ahmed, Bill Brennan, and
14 Annette Gean.

15 You may begin.

16 MR. ASAY: Good morning. I'm Grant Asay,
17 general manger for Fresenius.

18 I'm testifying in opposition to 17-043,
19 Romeoville Dialysis, submitted by DaVita and
20 DuPage Medical Group.

21 DuPage Medical Group contends that
22 patients dialyzing in Fresenius clinics have
23 electronic medical records or an EMR that's not
24 accessible to them because they use an EMR called

1 EPIC. However, the Fresenius nephrology EMR is
2 part of the EPIC platform and is fully compatible.
3 All DuPage Medical Group physicians will be able
4 to access nephrology records for their patients
5 treated in Fresenius clinics and import their data
6 through the EPIC interface.

7 The hospitals where they practice also use
8 EPIC, which integrates seamlessly with our EMR
9 powered by EPIC. This alleged barrier between
10 medical records -- our medical records and
11 theirs -- does not exist.

12 The applicants state that they have a new
13 way of delivering dialysis care through
14 coordination with DuPage Medical Group's
15 accountable care organization or ACO. Available
16 CMS data on that ACO has shown it increased health
17 care costs significantly.

18 Coordination of health care for ESRD
19 patients already exists in the Chicago area with
20 Fresenius' participation in the CMS-sponsored
21 ESRD Seamless Care Organization or ESCO. This
22 ESCO, which includes nearly 4,000 patients, has
23 proven to increase quality while lowering health
24 care costs with an \$11 million savings to Medicare

1 in Chicagoland during 2016.

2 The approval of Romeoville and the
3 applicants' other projects will be detrimental to
4 the ESRD services by inundating the market with
5 stations all at once, relocating patients
6 participating in the ESCO from current providers,
7 and causing mass underutilization, which is
8 contrary to the Planning Act.

9 DaVita claimed that they are the only
10 Illinois dialysis provider contracted with
11 IlliniCare managed Medicaid program, which is
12 incorrect. As of January 1 Fresenius was back in
13 network with IlliniCare, and we're treating
14 71 IlliniCare patients at our clinics today. We
15 can provide care to these Medicaid members without
16 an issue. The IlliniCare argument DaVita uses is
17 incorrect.

18 Thank you.

19 CHAIRMAN SEWELL: Thank you.

20 MS. WRIGHT: Good morning.

21 I'm Lori Wright, CON specialist for
22 Fresenius. I'm testifying in opposition to
23 17-043, Romeoville Dialysis.

24 While DaVita and DuPage Medical Group's

1 nine pending applications are considered on an
2 individual basis, it is important to note that the
3 Romeoville application is part of this
4 unprecedented bundle of applications to establish
5 9 clinics and 108 stations, all within an
6 approximate 14-mile radius.

7 They overlap service areas and, if
8 approved, would all begin operations at the same
9 time. It is unlikely they will all meet target
10 utilization within the first two years of
11 operation, creating maldistribution in the service
12 area for years to come.

13 DaVita Romeoville is only 8 miles from
14 their Hickory Creek Joliet project also being
15 heard here today. These two applications'
16 referral letters contain many overlapping
17 zip codes where identified pre-ESRD patients
18 reside. Additional information does little to
19 address the lack of need in Romeoville, as
20 indicated by the Board staff report.

21 The applicants argue that the newly
22 adopted 10-mile radius, representing a smaller
23 geographical service area, is more consistent with
24 providing access. We agree, but their Hickory

1 Creek project is within the same 10-mile service
2 area as Romeoville. It seems redundant and
3 irresponsible for DaVita to ask for approval today
4 of two applications within this small service area
5 to begin operations at the same time.

6 This is particularly a problem since our
7 Woodridge facility, approved but not yet open, is
8 only 6 miles away from the proposed Romeoville
9 site.

10 The applicants discount the Board's
11 five-year station inventory from September 2017
12 and recalculate it with more recent data that
13 shows an increased and a more urgent need in
14 Romeoville. The applicants cannot make up their
15 own need calculation to negate the Board's.

16 While there may be a need for 17 stations
17 in HSA 9, the station-to-population ratio within
18 the 30-minute travel radius from the proposed
19 clinic indicates there is, in fact, a surplus of
20 stations in Romeoville.

21 MR. ROATE: Two minutes.

22 MS. WRIGHT: Thank you.

23 CHAIRMAN SEWELL: Thank you.

24 MS. GEAN: Good morning.

1 My name is Annette Gean, G-e-a-n, and I'm
2 here this morning to express my support for
3 Dr. Kravets, the Board's new rule on shorter ESRD
4 travel times, and for the DaVita Romeoville,
5 Project No. 17-043.

6 I have been a kidney patient -- I am at
7 end stage renal failure right now -- four years
8 today. And for sometime I've required my dialysis
9 for the four years, and I do know and I hope you
10 understand that kidney dialysis can be very
11 discouraging.

12 For the last two years of my dialysis
13 treatment, I did not believe that I was
14 progressing under the care that I received from my
15 then-nephrologist. I was visiting a doctor's
16 office in downtown Chicago, and I discovered that
17 Dr. Kravetz had been appointed one of the top
18 100 doctors in the Chicago metropolitan area. And
19 when I read her name in the magazine, I got very
20 happy. I knew of her, but she was not my doctor
21 at the time.

22 When an emergency arose and I had to end
23 up at the hospital on two different occasions, my
24 nephrologist was not available, and it was then

1 that I decided, with my husband and family, that
2 I needed to do something and move forward because
3 of my treatments and my medical history.

4 I then decided with the family that
5 I needed to go with Dr. Kravetz and her practice.
6 I am very pleased with the care that she provides
7 all of us. When she comes into our dialysis
8 center, she just doesn't talk to us; she knows
9 about us and she remembers us. And when she
10 visits all the patients, it makes us all very
11 happy.

12 I'm an advocate for my dialysis center,
13 DaVita, because when she goes there -- I talk to a
14 lot of the patients -- she makes us all very
15 happy. Because if we miss a dialysis treatment, a
16 lot of us kidney patients won't make it after
17 two weeks if we continue not to go to dialysis.
18 So I hope you understand the importance of what it
19 is to be a kidney dialysis patient.

20 I would also like to express my
21 appreciation to the Review Board for the new rule
22 on the travel times. While a 30-minute time --
23 travel time -- may not be inappropriate for
24 hospitals or surgery centers, a shorter time is

1 essential for dialysis patients.

2 My dialysis schedule is Monday,
3 Wednesdays, and Fridays and sometimes Saturday if
4 I need a treatment.

5 MR. ROATE: Time.

6 MS. GEAN: Patients on the first shift
7 begin at 5:30. In addition to many Saturdays,
8 I also need to go for a shorter time.

9 MR. ROATE: Two minutes.

10 MS. GEAN: Thank you.

11 CHAIRMAN SEWELL: Thank you.

12 MS. GEAN: Thank you.

13 MR. BRENNAN: Good morning, members of the
14 Board.

15 My name is Bill Brennan. I'm here to
16 oppose the DMG DaVita Romeoville project, 17-043.

17 The application has serious deficiencies,
18 like several other DMG applications have been --
19 like several other DMG applications. The
20 applicant claims that these facilities will
21 increase care to and provide new options where
22 none currently exist for patients. Neither of
23 those arguments is true.

24 The applicant would have this Board

1 believe that HSA 9 is lacking when it comes to
2 ESRD facilities. That is false. I looked at the
3 Medicare Dialysis Facility Compare website and
4 found that there are significantly more facilities
5 providing ESRD care than what's listed in the
6 State Board staff report.

7 I found eight more dialysis facilities,
8 full facilities, containing 131 stations that were
9 not included in the Board report. Each of these
10 eight facilities is within the geographic service
11 area of the proposed Romeoville facility.

12 Looking at the facilities that are
13 reflected in your report, the utilization in HSA 9
14 is 66 percent. These four new facilities --
15 excuse me. There are four new facilities with
16 46 stations that are nowhere near target
17 utilization at this point in time.

18 As you know, the state of Illinois
19 continues to lose residents, yet the report would
20 show that Romeoville is just bursting at the
21 seams, which I -- which probably is not true.

22 Members of the Board, you have already --
23 you already have the information in your State
24 staff Board report to deny this project. The

1 applicant has given this Board no additional
2 information that would justify approval of this
3 application or change the staff -- or they did not
4 change the staff report, as well.

5 All of this -- excuse me. And all of this
6 delay by the applicant is an additional reason to
7 vote no.

8 MR. ROATE: Two minutes.

9 CHAIRMAN SEWELL: Thank you.

10 DR. AHMED: Good morning. My name is
11 Dr. Mohammed Ahmed, and I'm a nephrologist with
12 NANI, and I'm here to oppose the DMG DaVita
13 Romeoville Dialysis facility.

14 I started my practice 10 to 11 years ago
15 when Bolingbrook first opened its doors to the
16 patients, both in Bolingbrook and neighboring
17 suburbs, including Romeoville. And through
18 working, making sacrifices on life, family, and
19 social life, I was able to establish a practice of
20 hundreds of patients serving the local
21 communities, including Romeoville, many of whom
22 were referred by DMG primary care.

23 And the minute the -- when DMG decided to
24 hire their own seven nephrologists, many of my

1 patients who I had cultivated a relationship
2 through their good times and bad times, saved them
3 during their worst times in the hospital and
4 congratulated them for their good times in the
5 outpatient setting, many of these patients were
6 directed and obliged to switch care from myself to
7 their own nephrologists.

8 And unfortunately, despite the patients'
9 wishes to continue to -- continue care with my
10 practice, they were asked to change to the new
11 nephrology group.

12 And having done -- I happen to be the
13 medical director of the US Renal Care Bolingbrook
14 dialysis unit that you guys fortunately approved.
15 That need was demonstrated after seven years of
16 working hard to establish the volume of patients
17 that one needs to have another dialysis unit.

18 And I can tell you that after doing
19 multiple outpatient programs in -- to increase
20 chronic kidney disease awareness not only in
21 Bolingbrook but also in the neighboring suburbs,
22 including Romeoville, it took -- it took that
23 time -- that amount of time to, number one, have
24 the volume of patients and, because of the

1 attrition that occurs with dialysis patients --
2 many patients moving on to transplant, some
3 patients having improvement of their renal
4 disease -- we are designed to accommodate four
5 shifts, and we're barely even filling just two
6 shifts.

7 And the proposed unit is only
8 eight minutes away from the current unit that I'm
9 the medical director. By virtue of its location
10 alone, this facility is designed to do one thing,
11 and that is to take patients from existing
12 providers. And voting to approve this project
13 would be a tacit approval of DMG's attempt to
14 limit access to care for patients in this area and
15 to take patients from existing nephrologists and
16 also --

17 MR. ROATE: Two minutes.

18 DR. AHMED: Thank you.

19 CHAIRMAN SEWELL: Thank you.

20 MS. MITCHELL: Okay. The next five are
21 Lilly Hodewa, Tara Kamradt, Teresa Kravets,
22 Dr. Huma Rohail, Anna Walters -- again, these are
23 all speaking on Project 17-043, Romeoville
24 Dialysis.

1 Again, please -- if you have written
2 comments, please leave them at the table for the
3 court reporter.

4 Anyone can begin.

5 MS. KAMRADT: I'll begin.

6 Ladies and gentlemen, on four separate
7 occasions NANI and its physician have appeared
8 before this Board to oppose the six projects
9 currently proposed between DuPage Medical Group
10 and DaVita, and every one of these projects that
11 have come forward to a vote has failed and with
12 good reason.

13 I have been working with NANI for over
14 20 years. And rather than have NANI physicians
15 again take another day away from patient care,
16 I've been asked to summarize for the Board,
17 particularly for the benefit of the newest
18 members, the issues that justify denying each of
19 these projects.

20 DMG, with its private equity backers, has
21 decided to buy their way into the marketplace.
22 This is in lieu of establishing themselves like
23 everybody else.

24 DMG is proposing to add 72 new dialysis

1 stations to its service area. This is despite the
2 fact that DMG does not have the existing
3 nephrology patients to justify such an
4 unprecedented expansion. These proposals are
5 designed, instead, to divert existing patients to
6 DMG who are already being served by existing area
7 providers.

8 The best evidence of this is that the
9 applicants have brought in patients to testify
10 before this Board about not wanting to lose their
11 quality nephrology care. The irony is these were
12 NANI nephrology patients, not DMG patients.

13 This is not about access because these
14 patients already have access to quality care at
15 Medicare five-star facilities closer to where they
16 live. This is all about DMG's bottom line.

17 The "Let us build it and we can fill it"
18 approach is the exact opposite of what this Board
19 was established to do. Every staff report shows
20 that approving these projects will result in
21 unnecessary duplication.

22 Nothing has changed since these projects
23 were denied other than the Applicant switching
24 consultants.

1 MR. ROATE: Two minutes.

2 MS. KAMRADT: This does not change the
3 content of the application or the lack of quality
4 or need behind the project.

5 CHAIRMAN SEWELL: Please conclude your
6 remarks.

7 MS. KAMRADT: This project is unnecessary
8 and should be denied.

9 CHAIRMAN SEWELL: Thank you.

10 DR. ROHAIL: Good morning, members of the
11 Board. My name is Dr. Huma Rohail, and I'm a NANI
12 nephrologist.

13 The applicants will try to brush off our
14 opposition as us being against competition. If
15 that were true, then we would be opposing all
16 seven of DaVita's applications up today but we are
17 not. We are opposing the Romeoville project
18 because it is designed to undermine a health care
19 delivery system already served by dedicated
20 providers that has maintained an open competitive
21 balance that was driven by patient care and is
22 filled with patients already having access to
23 quality care.

24 DMG knows all of the buzzwords to say.

1 They talk about the limitations on EMR and being
2 innovative and stress the importance of
3 comprehensive communication for patient care. It
4 is easy to rely on lots of buzzwords and say
5 nothing. Consider that all of their supplemental
6 information did not change a single finding in the
7 staff report.

8 As far as innovative, members of the
9 Board, putting profits ahead of patients is not
10 innovative. In fact, it is what created the need
11 for boards like this.

12 Yes, communication and EMR are important,
13 but what DMG does not tell you is that limitation
14 on sharing information comes from them. We work
15 with every other provider in the area, including
16 DaVita, and the group that is creating the
17 information-sharing issue is DMG, and they should
18 not be rewarded for solving a problem they
19 created.

20 This project is about DMG producing a
21 return on investment for its private equity
22 backers. The problem with that is, if they are
23 successful, it will inevitably increase costs on
24 the Medicare program and flood the area with

1 unnecessary stations that can only be utilized by
2 plundering patients from other existing providers,
3 all of this to pad the DMG bottom line.

4 We don't come here to protect ourselves
5 from competition. We come here to protect our
6 patients. We would ask you to deny this project.

7 Thank you.

8 MR. ROATE: Two minutes.

9 CHAIRMAN SEWELL: Thank you.

10 MS. HODEWA: Good morning. My name is
11 Lilly Hodewa.

12 My background -- or education, rather --
13 is in community health and applied science. I'm
14 here today to voice my support for DaVita
15 Romeoville Dialysis.

16 Northern Will County and Romeoville
17 specifically has the highest population density in
18 the planning area. It is growing, in part,
19 because seniors like my mom are leaving the city
20 and coming to this area for a more comfortable
21 suburban lifestyle. Many of these people are baby
22 boomers who are retiring.

23 Romeoville has three large senior
24 communities. These are entire neighborhoods of

1 seniors. They need health care services, and
2 dialysis is an essential service for some of them.
3 To understand the growing demand for dialysis
4 services across the state, also recognize that
5 obesity can hurt your kidneys and obesity is a
6 public crisis nearly everywhere in this country.

7 Corporations like Pepsi and McDonald's
8 have made fast food a way of life. Fast food is
9 cheap, calorie dense, and nutrient poor. These
10 products are heavily marketed, easily accessible,
11 and addictive.

12 In Illinois 65 percent of adults are
13 overweight or obese, and the problem is getting
14 worse, not better. Obesity is a main risk factor
15 for diabetes and hypertension. Both are primary
16 contributors, along with aging, to kidney failure.

17 My mother has been able to maintain her
18 kidney function despite her history of obesity and
19 hypertension due to having gastric bypass and a
20 good -- and good physician care, but many are not
21 so lucky.

22 Fresenius is the dominant provider in this
23 area and across Chicagoland. It should not be
24 allowed to leverage your process to block

1 competition. Until we majorly invest in solving
2 the obesity epidemic, you are going to see these
3 providers continue to develop additional clinics
4 to provide the supply of these necessary services.

5 I urge you to approve Romeoville Dialysis.

6 CHAIRMAN SEWELL: All right.

7 DR. KRAVETS: My name is Dr. Kravets, and
8 I am a board-certified nephrologist with Northeast
9 Nephrology Consultants, a five-physician practice
10 in Will County.

11 I have been in practice for over 20 years,
12 and I practice in Romeoville. Together with my
13 partners, we have noticed that there is increased
14 incidence of chronic kidney disease and, also, end
15 stage renal disease in this area.

16 Our patients are compromised by
17 transportation. They need to get to dialysis
18 three times a week and during the working hours,
19 many times -- many depending on public
20 transportation, and public transportation in
21 Romeoville area will not transport them outside to
22 DuPage County, to Woodridge, or other -- every
23 other unit, and they are possibly within the
24 30 miles -- 30-minutes period.

1 I urge the Board to approve this unit. My
2 patients will benefit, and I will be medical
3 director at this projected DaVita facility.
4 DaVita has provided excellent care to my patients.

5 We -- my patients have to travel from
6 Romeoville to Joliet or New Lenox, which is not
7 easy for them. And if this unit is approved, it
8 would be much easier to get to dialysis
9 three times a week on the public transportation,
10 which is more -- much easier for them.

11 Thank you very much for your
12 consideration. By your own report, the Board has
13 determined that there is 17 additional stations
14 needed in this area.

15 Thank you very much.

16 CHAIRMAN SEWELL: Thank you.

17 MS. WALTERS: My name is Anna Walters.
18 I'm assistant executive director for Senior Star
19 at Weber Place, independent assisted living and
20 memory care, 346 apartments, on Weber Road in
21 Romeoville.

22 And we have residents -- we provide the
23 transportation to get dialysis, but we have
24 residents that have to go to Bolingbrook,

1 Naperville, Joliet three times a week. And when
2 the traffic -- the traffic has changed on Weber
3 Road recently, and it takes them more than
4 30 minutes. When they get back to our community
5 exhausted and utterly -- it affects their quality
6 of life every time -- every Monday, Wednesday, and
7 Friday.

8 And I don't know that -- how much the ride
9 of being over 30 minutes contributes to that, but
10 I do know that it would certainly be much easier
11 for them to have a facility in Romeoville, much
12 closer to our community.

13 So I do see the need, and I support the
14 facility in Romeoville.

15 CHAIRMAN SEWELL: Thank you.

16 MS. MITCHELL: All right. Final two. For
17 Project 17-061, Cary Bolton. For Project 17-066,
18 Scott Schiffner.

19 And you -- when you're speaking at the
20 beginning of your remarks, since you're speaking
21 on two different projects, if you could state
22 which project you're talking to.

23 Come on up.

24 Again, if you have written comments, if

1 CHAIRMAN SEWELL: So, now, applications
2 subsequent to initial review.

3 H-01, Project 17-043, DaVita Romeoville
4 Dialysis. I need a motion to approve
5 Project 17-043, DaVita Romeoville Dialysis, to
6 establish a 12-station ESRD facility in
7 Romeoville.

8 MEMBER MURPHY: Motion.

9 CHAIRMAN SEWELL: Is there a second?

10 MEMBER DEMUZIO: Second.

11 CHAIRMAN SEWELL: All right.

12 MS. MITCHELL: If I can make a comment
13 before we begin discussions.

14 CHAIRMAN SEWELL: Sure. Go ahead.

15 MS. MITCHELL: Is this better?

16 If I can make a quick comment, not
17 necessarily towards this Applicant but just all
18 applications on today's agenda.

19 There was some discussion about there
20 being shorter travel time due to a change of
21 rules. We worked on these rules for a long time,
22 and I'm happy to report that the new distances are
23 in effect, but they are not applicable to any of
24 the applications on today's agenda. They're only

1 applicable to applications that were deemed
2 complete after March 7th, and so all these
3 applications were put in prior to that date.

4 So if there's any discussion about new
5 distances pursuant to the new rules, I just ask
6 that you keep that in mind because those are not
7 applicable to today's discussion.

8 CHAIRMAN SEWELL: Thank you.

9 Would you swear in the Applicant.

10 THE COURT REPORTER: Would you raise your
11 right hands, please.

12 (Four witnesses sworn.)

13 THE COURT REPORTER: Thank you. And
14 please print your names and leave any written
15 remarks on the edge.

16 CHAIRMAN SEWELL: Mr. Constantino.

17 MR. CONSTANTINO: Thank you, sir.

18 The Applicants propose to establish a
19 12-station ESRD facility in Romeoville, Illinois.
20 The cost of the project is approximately
21 \$4.1 million, and the expected completion date is
22 November 30th, 2019.

23 There was no public hearing. There was
24 opposition to this project as well as support

1 letters received by the State Board staff.

2 This project was deferred from the
3 January 2018 State Board meeting. There is
4 one finding regarding surplus of stations in the
5 30-minute area.

6 Thank you, sir.

7 CHAIRMAN SEWELL: Yes.

8 Could you introduce yourselves and -- if
9 you have a presentation for the Board.

10 MR. BHATTACHARYYA: Yes.

11 My name is Gaurav Bhattacharyya -- it's a
12 long name so here it is -- and I'm the vice
13 president for DaVita here in the Chicagoland area.

14 With me today is Dr. Preeti Nagarkatte,
15 who is a partner of Dr. Kravetz's, who you heard
16 from earlier, as well as Kara Friedman, our legal
17 counsel.

18 I would just like to start by responding
19 to some of the comments from earlier today. A lot
20 of the commentary today was around DMG and
21 describing this project as -- in that context.
22 I'd just like to clarify that the physicians that
23 we're working with on this project are
24 Dr. Nagarkatte and Dr. Kravets from Northeast

1 Nephrology Consultants, who are a local physician
2 group. They've been in the community for
3 20 years, and the CKD data that we used for this
4 application was prominently from them.

5 The second point I'd like to make is
6 FMC and NANI are opposing this project and are
7 characterizing it as a flood of new projects
8 coming in. I think it's important to understand
9 where they're coming from and why they might be
10 opposing it.

11 It is because they currently have a
12 monopoly in this part of the Chicagoland area --
13 or very close to one -- and they've been
14 characterizing this as the corporate side of
15 medicine. Let's also, again, help to understand
16 where they're coming from. FMC is the largest
17 dialysis company in the world, and NANI is the
18 largest nephrology practice in Illinois and the
19 second largest in the country.

20 And so I just ask that you think about
21 what could be motivating their opposition to this
22 project. I don't think it is quality of care and
23 access of care to patients, which we do believe
24 this project brings.

1 What I would like to do today is really
2 just make two points as it relates to this project
3 specifically: One, there is a need for
4 this dialysis clinic in this community; and, two,
5 there's broad support for this project in this
6 community.

7 First, on the need, Romeoville is a
8 community of about 40,000 residents, and it
9 doesn't have a single dialysis facility in the
10 city. The demographic indicators of this
11 community are powerful, its high population
12 density and growth, and much of this population
13 growth is in two groups, aging and senior
14 citizens, as you heard earlier today, as well as
15 low income and minority groups. And as this Board
16 knows, both older individuals and those from lower
17 income communities are the ones who need dialysis
18 the most and are at risk of getting disease the
19 most.

20 Secondly, on the support, we have support
21 from important local leaders in the community.
22 Two of the closest area hospitals, Adventist
23 Bolingbrook and St. Joseph's Medical Center in
24 Joliet, and the mayor of Romeoville have all

1 endorsed this project. You heard from the patient
2 earlier today talking about the quality of care
3 that they receive from these medical directors as
4 well as the senior living community, as you heard
5 from two individuals here today.

6 And so it's something that the local
7 hospitals want, the local community leaders want,
8 the patients want. And the reason is because this
9 is ultimately what's best for patient access and
10 for patient care.

11 Thank you.

12 MS. FRIEDMAN: The single negative
13 finding, as Mr. Constantino reported, for this
14 proposed clinic relates to the fact that
15 historical utilization rates of certain clinics in
16 a 30-minute drive time has not yet reached the
17 target utilization.

18 That takes a snapshot back in time without
19 considering the current growth trends. What's
20 fundamentally important is that these clinics will
21 operate well in excess of the target when this
22 clinic becomes operational, and I'm talking about
23 all the clinics in the 30-minute drive time of
24 this proposed site.

1 This is based on the use rate trends
2 identified on page 6 of your Board staff report.
3 At the very bottom, in the health planning area
4 description, you'll see that the State Board did
5 acknowledge that, in the last four years, there
6 was a 5.75 percent compounded annual growth rate
7 in the planning area, so that's an annual increase
8 in utilization of services in this area.

9 Clinics in the immediate area of the
10 proposed site are experiencing rapid increases in
11 utilization. This is what you're seeing in the
12 30-minute area and in the larger planning area.
13 (Indicating.)

14 Within the narrower 30-minute area,
15 however, that growth rate is even higher for the
16 facilities in the 30-minute. It's 7.1 per year,
17 which outpaces population growth and demonstrates
18 some of the changing demographics in this
19 community.

20 As documented in DaVita's submission, the
21 use rate that the Board has most recently
22 collected, which is December 31st, 2017, indicates
23 the need for 67 dialysis stations in the planning
24 area for 2020 when this project is coming online.

1 So as you can see, while we believe this
2 stated 17-station need, as documented, is correct,
3 we also believe that it's understated, and that
4 helps understand why we would be seeking to add
5 stations in different areas of this planning area.
6 It's particularly disingenuous for Fresenius to
7 assert that use rates are diminishing when it's
8 relying on similar data to support its projects
9 pending at this meeting.

10 If you go with the overall growth rate in
11 the planning area, which is the more conservative
12 route, we project an additional 250 dialysis
13 patients receiving services in area facilities.
14 That's about a total of 1600 patients in the area.
15 If you look at the more recent use rates, this
16 figure increases over 300 patients.

17 With either methodology, this means
18 utilization in the area to be served by this
19 clinic will be well above your target utilization
20 when it opens. On the low end, that would be
21 84 percent across all of these facilities; relying
22 on the more area-specific data utilization would
23 be 88 percent.

24 While 250 or 300 patients might seem like

1 a small number, you have to remember -- and maybe
2 some of you are not as familiar with ESRD care --
3 a clinic only has about 60 patients enrolled at
4 any given time. And, remember, dialysis patients
5 are typically on dialysis for many years,
6 indefinitely, so this 250 patients signals
7 significant demand for services in the area. The
8 opponents' claim in their materials that the use
9 rate is declining is not supported by the State
10 Board data.

11 As Gaurav indicated, this facility is
12 primarily driven by the Northeast Nephrology
13 patients. These opponents prevented their
14 competitors from developing a clinic in
15 Will County six years ago. There were excess
16 stations at that time; however, this project
17 is now justified by a need for stations in the
18 planning area and specifically Northern
19 Will County.

20 Fresenius and DaVita will continue to
21 compete. You cannot allow any provider to use
22 this Board process to protect their market share.
23 It's contrary to the laws applicable to health
24 planning in this state.

1 Fresenius has the largest share of market
2 in Will County, larger than the two next providers
3 combined. As we stated in our most recent
4 submission in this project, they're throwing
5 whatever they can against the wall for this
6 project to see what opposition points might stick.
7 We don't believe that any of them are compelling,
8 and so many of them are misleading.

9 Just a couple more points, and we did get
10 a map out -- a map together -- which we submitted
11 in our materials so you can kind of see what this
12 planning area looks like.

13 So this purple area that you see is where
14 the dialysis patients or the CKD patients that
15 Dr. Kravetz's practice is taking care of reside.
16 This 10-mile line represents -- well, this
17 line represents 10 miles.

18 So as you can see, when we assisted in the
19 process to help the Board realign what the
20 planning area driving distances should be, we very
21 much lined this up with what we believe is
22 appropriate and what reflects common practices,
23 given the different demographics of a community.
24 The more dense a population area is, the smaller

1 that radius would be. So you know that in the
2 city of Chicago, for example, you've shrunk that
3 radius down to 5 miles.

4 One final point on the staff report
5 relates to some facilities that are still in
6 ramp-up. Certain clinics listed on page 15 of the
7 report are still in sort of a ramp-up period or
8 not -- and one is not yet operating.

9 These are all Fresenius clinics. The only
10 one in the planning area is 15 or 20 minutes away.
11 They are Fresenius Plainfield North, Summit, and
12 Lemont. They are serving a distinct patient base.
13 They're serving the patients of Dr. Lohmann,
14 Alohosha, and Choppy [phonetic], and nothing about
15 this project at all implicates those facilities.
16 The facility that's not open yet has identified
17 481 patients of Dr. Schlieben, and they projected
18 191 percent utilization of that clinic to justify
19 getting it approved last March.

20 So it seems that, you know, this need
21 number that we provided of 67 stations in the
22 planning area is basically supported by the data
23 that Fresenius has submitted for their most recent
24 application in this area. Again, these clinics

1 are committed to different patients who are not
2 duplicated by the referrals associated with this
3 project.

4 Using the data of the 30-minute
5 utilization rate, there's a need for 18 stations
6 in the Romeoville service area alone. We
7 specifically identified the patients that will be
8 treated at the clinic. Couple these factors with
9 the significant and growing utilization of area
10 clinics, and we believe the Board should be fully
11 satisfied that the slight deficiency in the Board
12 report is inconsequential.

13 At this point, Dr. Nagarkatte, if you
14 could tell them a little bit more about your
15 practice.

16 DR. NAGARKATTE: Good morning.

17 My name is Preeti Nagarkatte. I'm a
18 nephrologist with a practice mostly in Joliet and
19 Romeoville for the last 16 years. Our practice,
20 Northeast Nephrology Consultants, is dedicated to
21 patient-focused care. We take pride in the
22 exceptional care that we provide our patients, as
23 this commitment is essential to having them lead
24 healthy and long lives.

1 For years we have cared for patients in
2 the Romeoville area but only have recently had a
3 full practice here. This is, in part, due to the
4 fact that Romeoville has been growing as a city
5 over the last 10 to 15 years due to outward
6 migration from the city of Chicago.

7 Many of my patients are older, as well as
8 minorities, who have higher rates of kidney
9 disease than the general population, yet, until
10 this proposal, there was no in-center dialysis
11 clinic in Romeoville.

12 Due to the significant growth in
13 utilization that we have documented, there is not
14 capacity within the current system for our
15 patients whose kidney function is declining and
16 those who will require dialysis in the next two to
17 three years.

18 For those patients who are identified with
19 kidney disease in its early stages, I try all
20 interventions to extend kidney function. These
21 include dietary changes, medication, exercise to
22 manage high blood pressure, keep their blood sugar
23 levels under control. For some patients these
24 interventions work, but, unfortunately for others,

1 the renal insufficiency continues to worsen and
2 they will ultimately need dialysis for end stage
3 renal decease.

4 Despite our efforts and all the strategies
5 we employ to reduce the risk of ESRD, this area's
6 ESRD rates continue to rise, and this project is
7 merely addressing this demand in a community that
8 is not currently served.

9 We have issues facing existing patients as
10 well as needing capacity for future referrals in
11 the immediate Romeoville market. One such issue
12 is when a patient misses a dialysis treatment.
13 The ability to reschedule or make up that
14 appointment when facilities are already running
15 utilizations of 70 percent or higher is not
16 possible without having to take an early first
17 shift or a late third shift. These alternate
18 times are when transportation becomes most scarce.
19 As a result, many patients are faced with having
20 to take a less convenient time, which may lead to
21 compliance issues and can affect their health.

22 In my experience, transportation can be a
23 major hurdle to receiving dialysis care, and this
24 is true in most communities. Romeoville does not

1 have a true bus service. Most patients depend on
2 their loved ones or families to drop them off at
3 dialysis.

4 Romeoville does have a Ride Around Town
5 program sponsored by the parks and recreation
6 department; its hours of operations are generally
7 9:00 to 3:00. So this is in part why that second
8 shift between ten o'clock and two o'clock is most
9 coveted by dialysis patients, as they can get
10 rides to and from the unit without being a burden
11 on their caregivers or families.

12 In conclusion, I'd like to assure the
13 Board that we want what's best for our patients.
14 In addition to providing chronic kidney care in
15 our clinics, we take care of our patients both
16 when they have ESRD and are on dialysis as well as
17 encouraging them to get kidney transplant. As an
18 example, at DaVita Renal West Joliet, we've had
19 six transplants in the last six months, and this
20 is far more than the number of patients that get
21 transplants in other units over one to two years.

22 We, as a practice, encourage our patients
23 to be as healthy as can be and work together with
24 them to get the best possible treatment.

1 Thank you for your consideration for this
2 project.

3 CHAIRMAN SEWELL: Thank you.

4 MS. FRIEDMAN: We're happy to answer
5 questions at this time.

6 MEMBER MC GLASSON: Mr. Chairman, I have a
7 question.

8 CHAIRMAN SEWELL: Yes, Mr. McGlasson.

9 MEMBER MC GLASSON: Are DaVita and
10 Northeast -- oh, I'm sorry.

11 Are DaVita and Northeast Nephrology
12 for-profit entities?

13 DR. NAGARKATTE: We, in Northeast
14 Nephrology, are an independent practice and we are
15 not for -- I mean, we are a medical practice, not
16 for profit.

17 MS. FRIEDMAN: It's not possible for a
18 medical practice that has physician owners, which
19 is the State law, to be anything but a for-profit.

20 MEMBER MC GLASSON: Thank you.

21 And for staff, is Fresenius, to your
22 knowledge, a for-profit entity?

23 MR. CONSTANTINO: Yes.

24 CHAIRMAN SEWELL: Yes.

1 MEMBER GOYAL: Thank you, Mr. Chairman.

2 I have two questions. One is I'm looking
3 at your table on page 10, on top of the page,
4 Table 3, and it talks about the number of Medicaid
5 patients reduced between 2'14 and 2'16 from 708
6 to 297 and percentage, in terms of net patient
7 revenue, down from 3.23 percent to 1.33 percent.

8 Now, our rates have not reduced, and our
9 numbers of patients have not reduced -- and I need
10 to also qualify my name is Arvind Goyal and
11 I represent Medicaid on the Board.

12 Would you respond to that? And then
13 I have one other question for the practice.

14 MR. BHATTACHARYYA: Sure.

15 The overall message here is that we accept
16 all patients, including Medicaid, Medicare, any
17 payer type. At no point is a patient ever denied
18 admission into the facility because of their payer
19 type.

20 We -- at the same time, we don't know what
21 patients we're getting from the discharge planners
22 at the hospitals or patients who crash into
23 dialysis, so this is just a reflection of what our
24 admissions team is getting. We at no point skew

1 or have any filters based on payer type.

2 MEMBER GOYAL: So based on your response,
3 I have a follow-up question.

4 MR. BHATTACHARYYA: Sure.

5 MEMBER GOYAL: Do your intake people even
6 ask the patient what their payer is?

7 MR. BHATTACHARYYA: Yes. It is one of the
8 pieces of information they have to collect as part
9 of the admission process, but a decision to accept
10 that patient or not is never determined based on
11 their payer type.

12 MEMBER GOYAL: So if you were to not
13 accept a patient who is on Medicaid or who does
14 not have insurance, what is there to guarantee
15 that it does not factor into your admissions
16 process? Why do you even ask?

17 MR. BHATTACHARYYA: It's part of the
18 coordination of care. It's just part of the
19 entrance and documentation that we need as part of
20 the transfer from the hospital.

21 MS. FRIEDMAN: And if I could also note,
22 the social workers -- who have been, you know,
23 working with dialysis providers for a long time --
24 they really work with the patient to ensure that

1 any type of reimbursement program that would be
2 available for patients is one that they take
3 advantage of.

4 So it's very important that they know what
5 their payer source is when they come in so that
6 they can make arrangements for them to qualify for
7 some emergency programs or American Kidney Fund
8 program reimbursement.

9 MEMBER GOYAL: Thank you.

10 And I have a question for the doctor for
11 your practice, Northeast Nephrology.

12 DR. NAGARKATTE: Yes, sir.

13 MEMBER GOYAL: I got your first name,
14 Preeti. I didn't catch your last name.

15 DR. NAGARKATTE: Nagarkatte,
16 N-a-g-a-r-k-a-t-t-e.

17 MEMBER GOYAL: Thank you, Dr. Nagarkatte.

18 My question is, in your practice,
19 specifically Romeoville at this time --

20 DR. NAGARKATTE: Yes.

21 MEMBER GOYAL: -- are you signed up with
22 all five managed care plans that are operated in
23 that area?

24 DR. NAGARKATTE: I don't know but I do

1 know that we take all patients. I don't know
2 specifically the plans. But I do know as -- I do
3 take all patients.

4 Also, as people who get discharged from
5 the hospital, we follow up with them, even if they
6 don't have ability to pay. Is that your question?

7 We do take -- we do take all patients.
8 I do know that we're one of the few practices in
9 Will County that takes all payers, nonpayers,
10 Medicaid, Medicare, everybody, regardless.

11 MEMBER GOYAL: So your answer is very
12 noble; however, there is a way to exclude Medicaid
13 if you don't sign up with managed care.

14 DR. NAGARKATTE: We are signed up, sir, yes.

15 MEMBER GOYAL: All five of them?

16 MS. FRIEDMAN: She can answer --

17 DR. NAGARKATTE: Yes -- I'm sorry --

18 DR. KRAVETZ: I'm Dr. Kravetz --

19 CHAIRMAN SEWELL: Hold it. You need to be
20 sworn in.

21 THE COURT REPORTER: Would you raise your
22 right hand, please.

23 (One witness sworn.)

24 THE COURT REPORTER: Thank you.

1 DR. KRAVETZ: Yes. To answer your
2 question --

3 MS. AVERY: State your name for the
4 record.

5 DR. KRAVETZ: This is -- I am Dr. Kravets.
6 And I was -- together with our manager, I am
7 involved in the practice management.

8 So there was a recent change in the
9 Medicaid programs that are accepted in Illinois.
10 We're always on all of them. And if there is any
11 that we still -- you know, there was, I think,
12 Blue Cross -- IlliniCare is no more in Illinois,
13 so we had to change and apply to include all of
14 them.

15 So it's -- we always accept all the
16 Medicaid programs, and Medicaid -- also not an
17 issue for patients.

18 MEMBER GOYAL: Thank you very kindly.

19 CHAIRMAN SEWELL: Other questions from
20 Board members?

21 (No response.)

22 CHAIRMAN SEWELL: I wanted to ask
23 Mr. Constantino -- I wanted to ask about this
24 increase in use rates that apparently the

1 Applicant has cited in the HSA.

2 Is that something that the staff agrees
3 that they're seeing?

4 MR. CONSTANTINO: On page 6 we relied
5 upon -- what's quoted here is the population
6 estimate that the State demographer does for us,
7 Mohammed, who works for the Illinois Department of
8 Public Health.

9 And they are projecting approximately a
10 2.9 percent increase in the population in that
11 health service area; not Romeoville but that
12 health service area, which includes four counties,
13 as identified above, Kendall, Grundy, Will, and
14 Kankakee.

15 And then the dialysis patient -- the
16 actual dialysis patient increase is from the data
17 we collect quarterly through our survey process.
18 And from 2013 to 2017, we've seen a 5.75 percent
19 increase in the number of actual dialysis patients
20 in this planning area, in this ESR planning area,
21 which is that four-county area. Not Romeoville
22 specifically but the four-county area.

23 CHAIRMAN SEWELL: But the finding that we
24 have in the State agency report is based on the

1 current use; right?

2 MR. CONSTANTINO: That's correct.

3 CHAIRMAN SEWELL: It doesn't take that
4 into consideration?

5 MR. CONSTANTINO: That's -- what we've
6 done -- based upon your rules, it's a
7 maldistribution. And based upon that, when we
8 compared it to the state of Illinois, we
9 determined that there is a surplus of stations in
10 that 30-minute area, which is smaller than the
11 large service area or the HSA.

12 CHAIRMAN SEWELL: Okay. Thank you.

13 Are there other questions?

14 (No response.)

15 CHAIRMAN SEWELL: If not, then roll call.

16 MR. ROATE: Thank you, Chairman.

17 Motion made by Ms. Murphy; seconded by
18 Senator Demuzio.

19 Senator Demuzio.

20 MEMBER DEMUZIO: I am going to be voting
21 no, due to the staff report of surplus of stations
22 in the area, in the service area.

23 MR. ROATE: Thank you.

24 Ms. Hemme.

1 MEMBER HEMME: No, based on unnecessary
2 duplication, based on the staff report.

3 MR. ROATE: Thank you.

4 Mr. McGlasson.

5 MEMBER MC GLASSON: Yes, based on my
6 capitalistic beliefs.

7 MR. ROATE: Mr. McNeil.

8 MEMBER MC NEIL: I am in between.

9 I would vote no, but this probably needs
10 to come up later because the demographics
11 projected for the four-county area versus
12 Romeoville -- more data.

13 And I think it's trending that way, but
14 I can't vote yes because I think it's trending.
15 We need more data. It's a two-year wait period --
16 I think, from what you testified -- to bring up a
17 facility like this.

18 So no.

19 MR. ROATE: Thank you.

20 Ms. Murphy.

21 MEMBER MURPHY: I vote yes, based on the
22 testimony heard here today.

23 MR. ROATE: Thank you.

24 Chairman Sewell.

1 CHAIRMAN SEWELL: Okay. We're going to
2 proceed.

3 The next project is Proctor Community
4 Hospital Dialysis Center. It's Project 17-045,
5 H-02.

6 Can I have a motion to approve
7 Project 17-045, Proctor Hemodialysis Center, to
8 establish a 14-station ESRD facility in Peoria?

9 MEMBER MC NEIL: So moved.

10 MEMBER DEMUZIO: Second.

11 CHAIRMAN SEWELL: Moved and seconded. All
12 right.

13 Would you swear in the Applicants.

14 THE COURT REPORTER: Would you raise your
15 right hands, please.

16 (Two witnesses sworn.)

17 THE COURT REPORTER: Thank you.

18 CHAIRMAN SEWELL: All right.

19 State agency report.

20 MR. CONSTANTINO: Thank you, sir.

21 The Applicants propose to establish a
22 14-station ESRD facility in Peoria, Illinois. The
23 cost of the project is approximately \$4.3 million,
24 and the expected completion date is December 31st,

1 2019.

2 There was no public hearing on this
3 project, no opposition, and we did have findings
4 related to this project.

5 Thank you, Mr. Chairman.

6 CHAIRMAN SEWELL: All right.

7 Could you all introduce yourselves and
8 make whatever presentation to the Board you wish.

9 MS. SIMON: Thank you, Mr. Chairman.

10 I'm Debbie Simon. I'm the regional CEO of
11 Proctor Hospital, which is a subsidiary of
12 Methodist Health Service Corporation in Peoria.
13 To my left is Terry Waters, who is our vice
14 president of strategy and development.

15 And I would like to begin by thanking the
16 staff for their review of our application. As
17 Mr. Constantino indicated, we are proposing to
18 establish a 14-station hemodialysis center to be
19 located on our Proctor campus. Our goals for the
20 project are twofold: First, we want to improve
21 the outcomes through our integrated model of care,
22 a model that we have utilized with other chronic
23 diseases, such as COPD, diabetes, or heart
24 failure.

1 Patients, as you know, with end stage
2 renal disease are medically complex and are often
3 suffering from multiple comorbidities, resulting
4 in a need for a variety of medical specialists.
5 At present we employ 270 providers of both primary
6 care and a variety of specialists, such as
7 cardiologists and endocrinologists, that serve
8 this patient population. We can offer these
9 patients an effective disease management process
10 by coordinating the care of the primary care with
11 the specialists and the care coordinator and care
12 management theme.

13 Our second goal is to significantly lower
14 the cost of hemodialysis by introducing price
15 competition into this market. Currently there are
16 12 hemodialysis centers in our planning area, 11
17 of which are owned by Fresenius. The lack of
18 competition in the market, we believe, harms both
19 the consumers and the payers.

20 If you are a patient, you do not have the
21 ability to select a provider based on the service
22 or quality or price; you are essentially limited
23 to a Fresenius facility and must accept the
24 services they offer, the care they provide, and

1 the price they want to charge.

2 If you are a payer, your ability to
3 negotiate is severely compromised by the absence
4 of alternate providers. By the impact -- the
5 impact of a single-provider market is well
6 documented in our application.

7 We have submitted eight letters of
8 support, representing a cross-section of our
9 community. These include letters from payers,
10 including our largest employer, Caterpillar; a
11 small not-for-profit agency; an insurance company;
12 a third-party administrator; a state senator; and
13 the mayor of Peoria. The concern over the
14 status quo and the effect it is having on the
15 health care costs is universal.

16 I'd like to share two quotes from those
17 letters. The vice president of human resource for
18 Illinois Central College states, "Because of the
19 lack of competition, this provider has established
20 a pricing structure that strains both the patient
21 and the health plans. Self-funded nonprofits like
22 ours are hit especially hard by these pricing
23 structures. It causes budget strain long after
24 the treatment has been completed," end of quote.

1 The CFO of Consociate, a third-party
2 administrator, says, "Through health plan design
3 and negotiation efforts, we are able to assist our
4 employer health plans save some money at the
5 Fresenius facilities; however, there is little
6 leverage for negotiations due to their hold -- a
7 near monopoly -- on the market. The establishment
8 of a locally owned hemodialysis facility would
9 provide services at more reasonable charges, be an
10 organization that is rooted in the community, is
11 focused on the quality and affordability of health
12 care of its own citizens and employers."

13 The State agency's principal negative is
14 that there are a sufficient number of dialysis
15 stations to ensure access to treatment. That is a
16 fact and we don't dispute it. But we also believe
17 it's a fact that the mere availability of a
18 dialysis station does not assure access to quality
19 care at a reasonable price. Limiting access to a
20 single provider benefits no one but the provider.

21 Our view is that competition is essential
22 to lowering health care costs. Our commitment to
23 you is that we will introduce a charge structure
24 that is significantly below the prevailing rate

1 and that the overall cost of dialysis, we believe,
2 will be decreased by that.

3 We'll be happy to take questions, and we
4 thank you for your consideration of our proposal.

5 CHAIRMAN SEWELL: Go ahead.

6 MR. WATERS: No. I'm just here for
7 questions.

8 CHAIRMAN SEWELL: All right.

9 Does the Board have any questions?

10 MEMBER MC NEIL: I have a question.

11 CHAIRMAN SEWELL: Yes.

12 MEMBER MC NEIL: You said it would be less
13 expensive than the current offerings. You said
14 significantly. From an academic perspective,
15 "significant" is one thing.

16 What kind of percentage are you talking
17 about?

18 MS. SIMON: We're talking about 50 to
19 75 percent reduction in the current prevailing
20 charge structure as we know it today.

21 MEMBER MC NEIL: 50 to 75 percent
22 reduction? Okay.

23 CHAIRMAN SEWELL: Yeah, go ahead.

24 MR. ROATE: Thank you, Mr. Chairman.

1 CHAIRMAN SEWELL: No, no, no, no, no.
2 I'm sorry. I thought you had a comment. I'm not
3 sure Board members have exhausted their questions.

4 Okay. We -- so help me understand this.
5 We've got an excess of stations -- the State
6 agency report says 16 -- and we've got low
7 utilization. But your presentation centers around
8 there only being a single provider and the need
9 for competition --

10 MS. SIMON: Yes, sir.

11 CHAIRMAN SEWELL: -- and the fact that you
12 will have a charge structure that is lower than
13 the existing provider; is that correct?

14 MS. SIMON: Yes.

15 CHAIRMAN SEWELL: I see. All right.
16 I just wanted to understand that.

17 Other questions?

18 (No response.)

19 CHAIRMAN SEWELL: Now, roll call.

20 MR. ROATE: Thank you, Chairman.

21 Motion made by Mr. McNeil; seconded by
22 Senator Demuzio.

23 Senator Demuzio.

24 MEMBER DEMUZIO: There are several things

1 that I am concerned about.

2 In regard to the State report, there is a
3 comment in there indicating that there's no
4 growth, no growth is predicted in that area
5 from -- they're looking at from 2015 to 2020 --
6 and that there's also an excess of 15 stations.

7 Also, as was -- our Chairman indicated
8 here just a moment ago, the lack of competition.
9 And I find that term kind of disturbing to me,
10 that we're looking at health care, and I don't
11 think we should be looking at a competitive forum
12 going in there.

13 And so I'm going to be voting no.

14 Thank you.

15 MS. SIMON: Thank you.

16 MR. ROATE: Thank you.

17 Ms. Hemme.

18 MEMBER HEMME: I agree with what's been
19 stated. My concern is that the Peoria area has
20 lost a lot from Cat and all of their layoffs down
21 in that area. So as much as I like competition,
22 I think there's going to be too many beds
23 available if we approve this.

24 So I vote no.

1 MR. ROATE: Thank you.

2 Mr. McGlasson.

3 MEMBER MC GLASSON: I vote yes for the
4 opposite reason. I would hope that the
5 competition would have long-term benefits.

6 MR. ROATE: Thank you.

7 Mr. McNeil.

8 MEMBER MC NEIL: I vote yes because of the
9 "competition," quote/unquote. You already have a
10 hospital there, so you're offering an additional
11 service as a provider. And the marketplace -- I'm
12 very familiar with Peoria, and you have support
13 from the community for that.

14 So yes.

15 MR. ROATE: Thank you.

16 Ms. Murphy.

17 MEMBER MURPHY: I'm a big fan of free
18 markets. And I applaud -- I applaud your honesty
19 today about competition, which basically every one
20 of these applications ends up being about
21 competition. You're just brave enough to say it.

22 I vote yes.

23 MR. ROATE: Thank you.

24 Mr. Chairman.



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April 30, 2018

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HEALTH FACILITIES &
SERVICES REVIEW BOARD

Ms. Kathryn J. Olson, Chair
IL Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

**Re: DaVita Romeoville Dialysis (Proj. No. 17-043) ("Proposed Clinic")
Submission of Additional Information**

Dear Ms. Olson:

Polsinelli represents DaVita Inc. and Tovell Dialysis, LLC (collectively, the "Applicants") in the above-referenced proposal to establish a 12-station dialysis clinic in Romeoville, Illinois (the "Proposed Clinic"). In this capacity, we are writing to provide additional information subsequent to the Illinois Health Facilities and Services Review Board's (the "State Board") April 17, 2018 meeting where the Proposed Clinic received three favorable votes but did not pass. Pursuant to Section 1130.670 of the State Board's Procedural Rules, the Applicants respectfully submit supplemental information regarding the Proposed Clinic.

As further described in this submission, Romeoville is located in diverse and dynamic planning area. The need for additional dialysis services in Romeoville is compelling but a careful assessment of the planning area and the target area to be served is essential for a full understanding of the clear health planning rationale for the establishment of the Proposed Clinic. The key points of this submission are summarized as follows:

- As it is targeting Romeoville, a highly populated area, which is more population dense than any other part of the planning area, the addition of the Proposed Clinic will help to properly distribute needed stations in the planning area.
- The Proposed Clinic would not create a maldistribution of stations based on the capacity of existing providers and the population
- There is a need for 50 more dialysis stations than the current Need Determination of State Board identifies and, conservatively, a need for 18 stations in the 30 minute driving radius of the proposed clinic site

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- The growth rate of ESRD patients in the patient service area far outpaces growth of ESRD patients in the State of Illinois as a whole and also outpaces growth in the HSA and Will County
- The rapid increase in utilization of dialysis clinics in the patient service area indicates that the average utilization of those clinics will well exceed 80% in 2020 when this clinic will be coming online
- DaVita's competitor, which opposes this project, cannot factually dispute this evidence and, in fact, its own recent applications which document planning area trends support the establishment of additional dialysis services in this area.
- Recognizing the demand for additional services, the Proposed Clinic is well supported including by area hospitals, Bolingbrook Hospital and St. Joseph Medical Center in Joliet

As discussed below, DaVita's primary competitor, the German-based Fresenius Medical Center and its affiliated nephrologists have been extremely vocal and misleading in opposing the Proposed Clinic. As you will see from the data provided in this letter, however, the project is fully justified by patient demand and will address one of the most significant and growing needs for additional dialysis services in the State of Illinois.

1. Proposed Clinic is well placed to meet Planning Area Demand

a. Distribution of Services/Ratio of Stations to Population

In its previous findings, the State Board staff made a singular negative finding that determined a maldistribution of stations existed in the 30 minute travel contour (or geographic service area) of the Proposed Clinic. Based upon subsequent review of its application, the Applicants identified an error in the number of zip codes captured in the Proposed Clinic's geographic service area as designated by the State Board's rules. The application had 18 identified zip codes in the application. In reviewing this item, however, we identified that the geographic service area encompasses 43 zip codes. As shown in Exhibit 1, the total population for the Proposed Clinic's geographic service is over twice what was erroneously documented in the application. This unfortunate error resulted in an overstatement of the ratio of stations to population and inaccurately reflected a maldistribution of service in the Proposed Clinic's geographic service area.

The inaccurate population data negatively skewed the ratio of stations to population calculation. If the correct geographic service area population was identified in the application, it would have shown there was no maldistribution of stations within the Proposed Clinic's geographic service area. To the contrary, the current ratio of stations to population in the



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Proposed Clinic's geographic service area is 80% of the State ratio. See Table 1110.230(c)(2)(A).

Table 1110.230(c)(2)(A) Ratio of Stations to Population				
	Population	Dialysis Stations	Stations to Population	Standard Met?
Geographic Service Area	1,142,723	314	1:3,639	Yes
State	12,978,800	4,745	1:2,735	

b. High Population Density in Romeoville Patient Service Area

Relatedly, as shown on the attached population density map, the planned site for the Proposed Clinic has extremely high population density when compared to other parts of the HSA 9 planning area. As shown in the table below, a substantial majority of the population of HSA 9 resides in Will County. More specifically within Will County, the highest population density is in the Romeoville patient service area, i.e. the northeast corner adjacent to the Cook County border.

	2016 Population Estimate ¹	% HSA 9 Population	Pop. per Square Mile
HSA 9	968,661		424
Will County	685,378	70.8%	810
Romeoville PSA	345,689	35.7%	2152
Grundy County	111,493	11.5%	117
Kankakee Cty	50,338	5.2%	259
Kendall County	121,452	12.5%	377

As you can see, Romeoville is four times more dense from a population perspective than the planning area as a whole so it isn't any surprise that the need for additional services would be focused in Will County and Romeoville specifically.

¹ Source: U.S. Census Bureau, Census 2010, American Factfinder available at <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml> (last visited April 26, 2018)



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In the planned service area for the Proposed Clinic, recent economic development has created thousands of jobs in manufacturing and in the services and other light industries. As one supporter noted at the April 17th hearing, many residents of the City of Chicago are relocating out of the City to suburban communities, including Romeoville and Bolingbrook. This shift has been reported in the Chicago Sun-Times as part of a series on housing in the City of Chicago.² The changes in the demographics in the target patient service area for the Proposed Clinic are driving demand for dialysis services in Romeoville. As more individuals and families relocate to northeastern Will County and as Will County's population continues to age there will be a greater need for dialysis services. The Proposed Clinic will be well-positioned to meet this growing need.

2. High Compound Annual Growth Rate for Dialysis Services and 2020 Projected Utilization of Dialysis Clinics

As noted in the April 2018 State Board Reports, the growth in the number of dialysis patients in HSA 9 for the period 2013 to 2017 has been 5.75% compounded annually.³ This is over 1.75 times the State growth rate (3.23%).

Importantly, much of this growth is centered in the Proposed Clinic's geographic service area. From December 2013 to December 2017, the Proposed Clinic's geographic service area experienced 31.6% growth in ESRD patients (or 323 net patients). See Exhibit 2. This amounts to a compound annual growth rate of 7.10% in this area during that four year period. If the current trend continues, as we as health planners must assume it will in order to meet demand for care, the Applicants project there will be 1,654 in-center hemodialysis patients by CY 2020, and the 314 existing and approved stations will operate at 88% utilization. This projected utilization was a key finding in the April 17, 2018 State Board Report for Fresenius Kidney Care New Lenox. Based on the application of the four year CAGR to the New Lenox patient service area, that proposal received a fully positive State Board Report. This competitor is opposing the Proposed Clinic despite the fact that the Proposed Clinic is has a distinct patient base. Importantly, 30 additional stations are needed in the Proposed Clinic's geographic service area by 2020.⁴

² Mick Dumke et al. *The CHA's Great Upheaval – A Sun-Times/BGA Special Report*, Chicago Sun-Times, Apr. 25, 2016 available at <https://chicago.suntimes.com/news/the-chas-great-upheaval-a-sun-timesbga-special-report/amp/> (last visited Apr. 25, 2018).

³ Ill. Health Facilities and Services Review Board, *Fresenius Kidney Care New Lenox State Board Report pp2-3* (Apr. 17, 2018) available at <https://www2.illinois.gov/sites/hfsrb/Projects/ProjectDocuments/2017/17-065/17-065%20FKC%20New%20Lenox.pdf> (last visited Apr. 24, 2018).

⁴ Even taking a more conservative approach, there is a need for 18 stations in the 10 mile service area around the Proposed Clinic. This more conservative approach would utilize the State Board's 5.75%



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Assuming the more conservative HSA 9 annual growth rate (5.75%), the Applicants project there will be 1,592 in-center hemodialysis patients by CY 2020 and the 314 existing and approved stations will operate at 85% utilization. Under this scenario, 18 additional stations are needed in the Applicants' identified patient service area for average utilization to operate at optimal 80% utilization.

The patient service area for the Proposed Clinic, if drawn as a circle, is approximately 10 miles. This PSA is aligned with new State Board rules. Consistent with the methodology used in projects 17-063(FMC-New Lenox) and 17-065(DVA- Hickory Creek), we analyzed the 4 year compound annual growth rate for the existing clinics in the Proposed Clinic's PSA and found the growth was even more pronounced in the immediate area surrounding the Proposed Clinic than in either the larger 30 minute geographic service area or HSA 9. As shown in Exhibit 3, patient census at the clinics within 10 miles of the Proposed Clinic grew by 44% from 2013 to 2017, which is a compound annual growth rate of 9.5%. Applying the 9.5% growth rate to the 12/31/2017 patient census, the Applicants project there will be 1,044 dialysis patients in the 10 mile service area by 2020, which will result in average utilization of 96.6% for the existing and approved clinics. Importantly, for the existing and approved clinics to operate at their optimal capacity (80% per the State Board's rules) 30 additional stations are warranted for this area.

Importantly, what this data shows is not only is there a need for additional stations in HSA 9, despite the State Board calculation, but more specifically, there is an acute need for stations in northeastern Will County, where the Proposed Clinic will be located.

3. Dialysis Station Need in HSA 9 is Understated by 50 Stations

Our February 8, 2018 correspondence addressed the dialysis services utilization growth in the immediate area surrounding the Proposed Clinic site. It also analyzed the demographic trends of Will County and Romeoville more specifically. In further reviewing the historical data pertinent to need for the Proposed Clinic, we note the State updated its inventory of Health Care Facilities and Services and Need Determinations for ESRD in August of 2017. This is important because at that time, the State used a 5-year projection to 2020 with the base year of 2015. Based on the need formula, the need calculation used the year 2015 dialysis use rates combined with the population estimates for that same year and projected that use rate on the anticipated population in 2020. Since that static 2015 use data was generated (as explained below), we now have the benefit of more current data and now know that the resulting calculation identifying an excess of 7 stations materially understates the 2020 demand for services.

To evaluate demand for ESRD services or "need" for the Proposed Clinic, we next reviewed more current utilization data that the State collects and publishes, namely dialysis

growth factor for HSA 9. In that scenario, the Applicants project 940 patients will require dialysis in 2020, or average utilization of existing and approved clinics of 87.1%.



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utilization information dated as of 12/31/2017. This review revealed, as Exhibit 4 indicates, that there was an 11.35% increase in ESRD patients between 2015 and 2017 in HSA 9. Due to a lag in use rate data reporting, the increased dialysis services use rate based on the projected 2020 population results in a calculated need for 43 additional stations not an excess of seven stations as reported by the State Board. This increased station need is due to the dialysis patient census in HSA 9 increasing by 120 patients in that two year period (or a compound annual growth rate of 5.5%). Note that we used the same formula that the State Board uses to reach this conclusion with the only difference being that we used more current dialysis use rates (12/31/2017) rather than the older data from 12/31/2015.

The Proposed Clinic will address the need for dialysis stations in HSA 9. We now know, from analyzing more current data, dialysis station need in HSA 9 is understated by the State Board. It is important to note that the State's station need calculation factors in not only the capacity of existing facilities but also that all facilities existing and newly permitted projects which will be opening soon. This need for additional stations is addressed by the Proposed Clinic. More specifically, the Applicant has identified an area that has a high concentration of groups at high-risk of acquiring ESRD that are aging. Given the significant growth in both the HSA 9 planning area as well as in Will County and the more immediate Proposed Clinic's geographic service area, the Proposed Clinic is warranted as demonstrated by a methodical and objective assessment of current and future demand.

4. Safety Net Impact

We have updated the data relating to Medicaid and charity care for DaVita in Illinois to reflect the most current data available in the following table.

Safety Net Impact			
	2015	2016	2017
Charity (# of Patients)	109	110	98
Charity (Cost in Dollars)	\$ 2,791,566	\$ 2,400,299	\$ 2,818,603
Medicaid (# of Patients)	422	297	407
Medicaid (Cost in Dollars)	\$ 7,381,390	\$ 4,692,716	\$ 9,493,634
Net Patient Revenue	\$ 311,351,089	\$ 353,226,322	\$ 357,821,315

Note that for the DaVita metro Chicago applications approved by the State Board within the last five years, 70 percent of its newly approved stations are located in medically underserved areas. Medically underserved areas are areas designated by the Health Resources and Services Administration as having too few primary care providers, high infant mortality, high poverty or a high elderly population. DaVita's commitment to serving underserved communities is unparalleled in the State of Illinois.



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We have also included some additional information to support the State Board's positive consideration of the Proposed Clinic including a discussion of as exhibits. Thank you for your consideration on this project. If you have any questions and concerns, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Anne M. Cooper".

Anne M. Cooper

Attachments

Cc: Gaurav Bhattacharyya

Exhibit 1

Population by Zip Code Romeoville 30 Minute GSA		
Zip Code	City	Population
60137	Glen Ellyn	37,805
60403	Crest Hill	17,529
60404	Shorewood	17,395
60421	Elwood	3,968
60431	Joliet	22,577
60432	Joliet	21,403
60433	Joliet	17,160
60435	Joliet	48,899
60436	Joliet	18,315
60439	Lemont	22,919
60440	Bolingbrook	52,911
60441	Lockport	36,869
60446	Romeoville	39,807
60451	New Lenox	34,063
60455	Bridgeview	16,446
60457	Hickory Hills	14,049
60458	Justice	14,428
60464	Palos Park	9,620
60465	Palos Hills	17,495
60467	Orland Park	26,046
60480	Willow Springs	5,246
60490	Bolingbrook	20,463
60491	Homer Glen	22,743
60501	Summit Argo	11,626
60503	Aurora	16,717
60504	Aurora	37,919
60514	Clarendon Hills	9,708
60515	Downers Grove	27,503
60516	Downers Grove	29,084
60517	Woodridge	32,038
60521	Hinsdale	17,597
60523	Oak Brook	9,890
60525	La Grange	31,168
60527	Willowbrook	27,486
60532	Lisle	27,066
60534	Lyons	10,649
60540	Naperville	42,910
60544	Plainfield	25,959

Population by Zip Code Romeoville 30 Minute GSA		
Zip Code	City	Population
60558	Western Springs	12,960
60559	Westmont	24,852
60561	Darien	23,115
60563	Naperville	35,922
60564	Naperville	41,312
60565	Naperville	40,524
60585	Plainfield	22,311
60586	Plainfield	46,251
Total		1,142,723

Source: U.S. Census Bureau, Census 2010,
American Factfinder available at
<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml> (last visited April 24, 2018)

Facility	Ownership	Address	City	Time	Distance	HSA	Number of Stations 12/31/17	Number of Patients 12/31/2013	Utilization % 12/31/2013	Number Patients 12/31/17	Utilization % 12/31/17
USRC Bolingbrook	USRC	396 Remington Blvd.	Bolingbrook	8.05	4.1	9	13	37	47.44%	63	80.77%
Fresenius Medical Care Lemont ²	Fresenius	16177 West 127th Street	Lemont	11.5	4.9	7	12			25	34.72%
Bolingbrook Dialysis Center	Fresenius	538 Boughton Road	Bolingbrook	11.5	5.9	9	24	120	83.33%	123	85.42%
Fresenius Medical Care Naperville	Fresenius	2451 S Washington	Naperville	18.4	6.4	9	18	0	0.00%	101	93.52%
Fresenius Medical Care Plainfield North ¹	Fresenius	24020 Riverwalk Court	Plainfield	20.7	8.5	9	10			33	55.00%
Fresenius Medical Care Woodridge ³	Fresenius	7550 Janes Avenue	Woodridge	16.1	9.1	7	12			-	0.00%
Fresenius Medical Care Joliet	Fresenius	721 E. Jackson Street	Joliet	19.5	9.4	9	16	48	50.00%	72	75.00%
DaVita Sun Health	Davita	2121 Oneida	Joliet	26.4	10.8	9	17	53	51.96%	61	59.80%
Renal Center West Joliet	Davita	1051 Essington Road	Joliet	20.7	11.1	9	29	132	75.86%	130	74.71%
FMC Dialysis Services of Willowbrook	Fresenius	6300 South Kingery Highway	Willowbrook	19.5	12.6	7	20	76	63.33%	75	62.50%
Palos Park Dialysis	Davita	13155 S. LaGrange Road	Orland Park	28.7	12.6	7	12	27	37.50%	49	68.06%
Renal Center New Lenox	Davita	1890 Silver Cross Blvd.	New Lenox	20.7	12.9	9	19	83	72.81%	107	93.86%
Fresenius Medical Care of Plainfield	Fresenius	2320 Michas Drive	Plainfield	21.8	13.5	9	10	80	133.33%	80	133.33%
Downers Grove Dialysis Center	Fresenius	3825 Highland Ave., Suite 102	Downers Grove	25.3	15.1	7	16	73	76.04%	68	70.83%
USRC Oak Brook	USRC	1201 Butterfield Rd Suite B	Downers Grove	23	15.4	7	13	34	43.59%	66	84.62%
Fox Valley Dialysis Center	ARA	1300 Waterford Drive	Aurora	28.7	15.6	8	29	123	70.69%	143	82.18%
Fresenius Medical Care Orland Park	Fresenius	9160 West 159th Street	Orland Park	26.4	16.2	7	18	85	78.70%	65	60.19%
Fresenius Medical Care Summit ⁴	Fresenius	7319 Archer Avenue	Summit	28.8	20.1	7	12			30	41.67%
Fresenius Medical Care of Mokena	Fresenius	8910 W. 192nd Street	Mokena	29.9	20.7	9	14	52	61.90%	55	65.48%
Total							314	1,023	54.30%	1,346	71.44%

Total Growth 2013 - 2017 31.57%

¹ Medicare Certified November 18, 2016

² Medicare Certified November 17, 2016

³ Received permit March 14, 2017

⁴ Medicare Certified November 2, 2016

4 Year GSA CAGR 7.10%

2018 Projected Patients 1,442
 2019 Projected Patients 1,544
 2020 Projected Patients 1,654
 2020 Projected Utilization 87.8%

2020 Projected Station Need 344
 Existing Stations 314
 Stations Needed 30

4 Year HSA CAGR 5.75%

2018 Projected Patients 1,423
 2019 Projected Patients 1,505
 2020 Projected Patients 1,592
 2020 Projected Utilization 84.5%

2020 Projected Station Need 332
 Existing Stations 314
 Stations Needed 18

Facility	Ownership	Address	City	Distance	HSA	Number of Stations 12/31/17	Number of Patients 12/31/2013	Utilization % 12/31/2013	Number Patients 12/31/17	Utilization % 12/31/17
USRC Bolingbrook	USRC	396 Remington Blvd.	Bolingbrook	4.1	9	13	37	47.44%	63	80.77%
Fresenius Medical Care Lemont ²	Fresenius	16177 West 127th Street	Lemont	4.9	7	12			25	34.72%
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Fresenius Medical Care Plainfield North ¹	Fresenius	24020 Riverwalk Court	Plainfield	8.5	9	10			33	55.00%
Fresenius Medical Care Woodridge ³	Fresenius	7550 Janes Avenue	Woodridge	9.1	7	12			-	0.00%
Fresenius Medical Care Joliet	Fresenius	721 E. Jackson Street	Joliet	9.4	9	16	48	50.00%	72	75.00%
Fresenius Medical Care of Plainfield	Fresenius	2320 Michas Drive	Plainfield	13.5	9	10	80	133.33%	80	133.33%
Renal Center West Joliet	Davita	1051 Essington Road	Joliet	11.1	9	29	132	75.86%	130	74.71%
DaVita Sun Health	Davita	2121 Oneida	Joliet	10.8	9	17	53	51.96%	61	59.80%
Renal Center New Lenox	Davita	1890 Silver Cross Blvd.	New Lenox	12.9	9	19	83	72.81%	107	93.86%
Total						180	553	51.20%	795	73.61%
Total Clinics Operational >2 Years						146	553		737	84.13%

Total Growth 2013 - 2017 43.76%

4 Year GSA CAGR 9.50%

2018 Projected Patients 871
 2019 Projected Patients 953
 2020 Projected Patients 1,044
 2020 Projected Utilization 96.6%

2020 Projected Station Need 217
 Existing Stations 180
 Stations Needed 37

4 Year HSA CAGR 5.75%

2018 Projected Patients 841
 2019 Projected Patients 889
 2020 Projected Patients 940
 2020 Projected Utilization 87.1%

2020 Projected Station Need 196
 Existing Stations 180
 Stations Needed 16

¹ Medicare Certified November 18, 2016

² Medicare Certified November 17, 2016

³ Received permit March 14, 2017

⁴ Medicare Certified November 2, 2016

EXHIBIT 4

Updated Need Calculation Based on 2017 Use Rate					
	HSA 9	Grundy	Kankakee	Kendall	Will
Planning Area Population - 2015	1,033,750	53,015	115,128	129,201	736,406
In Station ESRD Patients - 2017	1,177	58	204	90	825
Area Use Rate 2017	1.14	1.09	1.77	0.70	1.12
Planning Area Population - 2020 (Est)	1,111,300	55,970	117,167	142,818	795,345
Projected Patients - 2020	1,265	61	208	99	891
Adjustment	1.33	1.33	1.33	1.33	1.33
Patients Adjusted	1,683	81	276	132	1,185
Projected Treatments - 2020	262,524	12,705	43,076	20,641	184,871
Existing Stations	308	19	54	27	208
Stations Needed - 2020	351	17	58	28	247
Number of Stations Needed	43	(2)	4	1	39
In Station ESRD Patients - 12/31/2015	1,057	29	179	82	767
% Increase in Patients 2015 to 2017	11.35%	100.00%	13.97%	9.76%	7.56%
Area Use Rate - 2015	0.977	0.55	1.55	0.63	1.04

Exhibit 5

DaVita – DMG Care Innovation

DaVita is Innovating the ESRD Model of Care to Achieve the Triple Aim

The shift toward value-based healthcare is providing a substantial opportunity to improve patient care experiences and clinical outcomes while reducing costs. While many providers and health plans are deploying chronic care management programs for the general patient population, few are doing what DaVita is doing addressing a unique set of chronically-ill patients. DaVita is pulling ahead of the curve to launch comprehensive models of care that address the unique needs of the highest-risk, most medically complex outlier groups, with a focus on patients with ESRD. DaVita aims to achieve three key goals, the triple aim: enhanced patient experience, improved population health and reduced costs.

Both DaVita and its partner DuPage Medical Group, Ltd. (DMG) bring values, assets and innovative roots to the Proposed Clinic that are critical to the success of a high-quality patient delivery model. People with compromised renal function face multiple challenges—such as multiple comorbidities, healthcare system navigation and emotional challenges—that require customized capabilities to manage across the care continuum. DaVita is partnering with DMG to advance its model of integrated kidney care which comprehensively addresses these concerns and can extend across multiple programs: the government’s End Stage Renal Disease Seamless Care Organizations (ESCOs), Medicare Advantage Chronic Special Needs Plans (C-SNPs) and population health management programs with providers and payers that address not only ESRD but also kidney disease patients whose condition has not advanced to ESRD and who may be able to maintain their kidney function for their lifetime with proper intervention.

DaVita has been at the forefront of innovation in the care of patients with end-stage renal disease throughout its history. This has resulted in outstanding quality, patient satisfaction, and provider accolades. Examples of the many ways that DaVita has delivered high-quality care with innovative models are included below:

1. **DaVita Rx.** DaVita offered the first ever renal-specific pharmacy, DaVita Rx, which focuses on the unique needs of dialysis patients. Since 2005, DaVita Rx has been helping improve outcomes by delivering medications to dialysis centers or patients’ homes, thereby helping patients stay on top of their drug regimens. As a result, DaVita Rx patients have medication adherence rates greater than 80% – almost double that of patients who fill their prescriptions elsewhere – and are correlated with 40% fewer hospitalizations.
2. **Medicare Compare Star Program Leader.** DaVita has exceptional Star Ratings for its clinics across the country and in the Chicago metropolitan area. The Star Ratings system, also known as the Dialysis Facility Compare Star Program, is a rating system developed by Medicare that assigns one to five stars to dialysis clinics by comparing the health statistics of the patients in DaVita’s clinics to patients in other dialysis clinics across the country. Each dialysis clinic is graded on nine separate health statistics. These include (i) mortality ratios, (ii) hospitalizations, (iii) blood transfusions; (iv) incidents of

hypercalcemia (too much calcium in the blood); (v) percentage of waste removed during hemodialysis, (vi) percentage of waste removed in adults during peritoneal dialysis, (vii) percentage of AV fistulas; and (viii) percentage of catheters in use over 90 days. The Star Ratings system is an objective and simple measure of DaVita's innovation. 48% of DaVita clinics in the Chicago area have four- or five-star ratings. Comparing this to competitor clinics, only 16% have four- or five-star ratings. Additionally, DaVita's average Star Rating in the Chicago area is 3.5, compared to an average of 2.5 for other dialysis providers.

On April 27, 2018, DaVita announced that it has led the industry for the fourth year by meeting or exceeding Medicare standards in the CMS Star Ratings System. DaVita's focus on helping improve patients' health and quality of life is demonstrated in this year's Five-Star ratings, where the company has more three, four and five star centers than it has ever had in the history of the program. The results mark DaVita's best quality performance in the program to date.

3. **Medicare Quality Incentive Program Leader.** DaVita was the clinic leader nationally of the Medicare Quality Incentive Program (QIP) based on 2016 data, a distinction that DaVita has won for four straight years. The QIP is part of Medicare's ESRD program aimed at improving the quality of care provided to Medicare patients. DaVita also had the highest average total performance score among all large dialysis organizations (those with at least 200 centers in the U.S.) and ranks first in four clinical measures in the ESRD QIP program. For example, DaVita's average QIP score is 76 compared to 69 for Fresenius and 66 for all other dialysis providers.
4. **Transplant Waitlist Support Program.** On April 24, 2018 DaVita and Methodist Specialty and Transplant Hospital in San Antonio, Texas, announced the launch of the co-developed Transplant Waitlist Support Program. The purpose of the program is to help keep waitlisted patients transplant-ready by deploying a technology-enabled solution to proactively and electronically exchange patient information between DaVita and the transplant center. With growing waitlists for transplant, transplant program coordinators struggle to maintain current patient data such as health status changes or correct contact information. Having outdated contact information can result in a patient missing a transplant opportunity when a matching donor becomes available. The Transplant Waitlist Support Program represents how transplantation and dialysis providers work together instead of operating in separate silos. The ultimate goal is to provide better care for patients suffering from chronic kidney disease (CKD). The Transplant Waitlist Support Program bridges gaps that have previously impacted the constancy of that care. The Transplant Waitlist Support Program will be available to other transplant centers in the near future, fulfilling a major goal for DaVita to help improve the transplant waitlist experience nationwide.
5. **Strong Promoter of Home Modalities.** DaVita works closely with patients to promote home dialysis modalities. All DaVita dialysis clinics also have a staff member designated as a "Home Champion," who meets with all new admissions to focus solely on home modalities and benefits. If patients express any interest or questions, DaVita

proactively schedules a follow up visit with a home nurse within 10 days and can typically help patients transition to home peritoneal dialysis within the first month.

6. **CKD Education with Kidney Smart.** DaVita offers the Kidney Smart program to help improve intervention and education for pre-ESRD patients, including education about home dialysis modalities. Kidney Smart includes the development of a care plan for patients with CKD with strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. These efforts help patients reduce, delay, and prevent adverse outcomes from otherwise untreated CKD, encouraging patients to take control of their health and make informed decisions about their care.
7. **New Dialysis Patient IMPACT Program.** DaVita operates the Incident Management of Patients, Actions Centered on Treatment or IMPACT program which seeks to reduce patient death rates during the first 90 days of dialysis, through the patient intake, education and management, and reporting efforts. IMPACT has helped address the critical issues of the incident dialysis patient and improved DaVita's overall gross mortality rate, which has decreased 28% in the last 13 years.
8. **CathAway Program: DaVita's Promotion of AV Fistulas for Vascular Access.** National guidelines promote increasing the prevalence of arteriovenous (AV) fistula use for dialysis access. AV fistulas are considered the preferred type of vascular access for hemodialysis patients, far superior to using a central venous catheter (CVC). DaVita works to reduce the number of patients with CVCs through the CathAway program. Compared to CVCs, AV fistulas have superior patency, lower complication rates, improved adequacy, lower costs, and decreased risk of patient death. CathAway is designed to comply with CMS's National Vascular Access Improvement Initiative (NVAII) through patient education outlining the benefits of AV fistula placement and support through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. Through DaVita's proactive efforts, patient catheter use rates decreased 46% in seven years.
9. **DaVita Hospital Services.** DaVita Hospital Services was the first inpatient kidney care service to receive Ambulatory Health Care Accreditation from The Joint Commission. This was the result of DaVita's efforts in identifying key areas for improvement, offering comprehensive training, and coordinating 156 hospital site visits for The Joint Commission Surveyors. This Accreditation allows DaVita to monitor and evaluate the safety of kidney care and apheresis therapies against ambulatory industry standards, and to have shared standards in place with hospital partners to further measure performance and improve alignment.
10. **Physician Engagement.** DaVita offers its affiliated nephrologists the opportunity to earn Maintenance of Certification credits for participating in dialysis unit quality improvement activities. This certification helps to engage DaVita medical staff members and highlights each participating nephrologists' knowledge and skill level to deliver high quality patient care.

11. **Digital Health.** DaVita is a partner of Rock Health, the first venture fund dedicated to digital health and a leader in fostering health care innovation. Rock Health identifies health technology companies supporting patients and consumers with many disease management and wellness initiatives including diabetes prevention and management, mental health and memory care, cardiovascular health, and wellness and general health. DaVita also directly delivers the top kidney care online resource in the world: DaVita.com

DAVITA'S INTEGRATED KIDNEY CARE MODEL

DaVita is leading the shift to integrated kidney care through promoting C-SNPs and ESCO demonstrations.¹ After being selected through the CMS bidding process, DaVita now operates demonstration program ESCOs in three markets, Phoenix, Miami and Philadelphia. These ESCOs are producing valuable experiences for DaVita to incorporate in its clinics throughout the country and providing a foundation for an even better integrated kidney care model for the future. DaVita passionately believes that integrated care should be the standard for all people with kidney disease. The shift to value-based reimbursement is helping to accelerate the opportunity for more patients to benefit from integrated care. The primary objective of VillageHealth, DaVita's renal population health management division, is for patients to live healthier and higher quality lives.

DaVita's integrated kidney care programs have demonstrated compelling results:

- 25 percent lower hospitalization rate than the industry average
- 51 percent lower readmission rate than the industry average
- Up to 21 percent addressable cost savings over four years

Patients with CKD are among the most vulnerable and medically complex populations suffering from a chronic illness. Integrating care for people with kidney disease involves coordinating care before and during the transition to dialysis or transplant and then inside and outside of the dialysis clinic to achieve better clinical outcomes and improve patient quality of life. When done right, integrated care can translate into significant cost savings for the greater health care system – including payors, providers and taxpayers – and ultimately patients themselves.

For more than two decades, DaVita has led the industry in providing proven, renal population health management. As the country's largest renal NCQA-accredited provider, DaVita currently impacts the lives of more than 20,000 patients each month through its health system partnerships, C-SNPs and ESCOs. DaVita's three ESCOs have achieved 100 percent quality reporting scores, experienced a 13 percent reduction in hospital readmissions and saved \$4,868 per patient per year. While DaVita is focused on a specific condition, ESRD, and more specifically on dialysis, DaVita is also committed to being a key player in population health management and value based care for kidney patients. This is in furtherance of DaVita's mission statement, which includes the missions of creating the greatest health care community the world has ever seen and being a role model for American health care.² As a niche provider, DaVita cannot do this alone.

¹ The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS partners with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The Model builds on Accountable Care Organization experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test Accountable Care Organizations for ESRD beneficiaries.

² For additional information, see <https://www.davita.com/about>.

This is where its partnership with DMG comes in. DaVita already works hand-in-hand with nephrologists to optimize care, but by partnering with DMG, DaVita has the opportunity to collaborate on population health management and further improve care delivery and coordination services to the benefit of patients.

Like DaVita, DMG continually strives to innovate. The practice's model is Quality, Efficiency and Access (QEA), and DMG seeks to offer a proactive model of health care – providing quality care, in the most advanced facilities, aided by the latest technology. Recent examples of innovation by DMG include the following:

1. **BreakThrough Care Center.** DMG operates the BreakThrough Care Center, a comprehensive, holistic outpatient clinic serving the most vulnerable Chicagoland seniors who struggle with chronic disease. The Center is designed to improve medical outcomes while lowering health care costs and improving patients' ability to manage their health outcomes. It has been a success since its opening in 2014. Patients' biometrics have improved, health care utilization has been optimized (with all patients seen within 24 hours of hospital discharge), and ER admission rates and acute admissions have decreased. Patients have a 30-day chronic readmission rate of only 7.2% and a high generic pharmacy utilization rate of 89%.³
2. **Illinois Health Partners.** Accountable Care Organizations (ACOs) are groups of doctors, hospitals and other health providers who come together voluntarily to provide high quality care to their Medicare patients. DMG is part of Illinois Health Partners, the fifth largest ACO in the country, of which nearly half of patients are DMG members. Illinois Health Partners ranks in the bottom quartile for cost per beneficiary and the top 15% for quality. It is also the top-performing ACO in Illinois and the lowest cost ACO in Chicago.
3. **Integrated Oncology Program.** DMG cancer patients benefit from its renowned Integrated Oncology Program, which is comprised of physicians who specialized in medical and radiation oncology and partner with myriad other specialists to provide a broad range of oncology services. Through this model, DMG physicians help patients navigate the entire treatment process from screening and diagnosis to treatment recovery and support. DMG also continues to invest in technology to aid in the most accurate diagnoses and treatment options available. This allows DMG patients to access the latest clinical trials, emerging treatments, and adapt to the ever-changing needs of its patients. As a result, DMG's Integrated Oncology Program remains the only accredited Freestanding Cancer Center in Illinois, a distinction bestowed by the Commission on Cancer of the American College of Surgeons.⁴

³ Additional information is provided in the attached summary of the BreakThrough Care Center.

⁴ For additional information, see https://www.dupagemedicalgroup.com/userfiles/file/AnnualReport_2017_Web.pdf.

DMG's success in these and other areas of innovation will be invaluable as DaVita and DMG work to jointly manage highly complex CKD and ESRD patient populations. As discussed further in the Application, DaVita and DMG expect the Proposed Clinic to serve as the genesis of a patient care delivery model that will rectify current shortcomings and remove impediments to optimal care of patients with kidney disease within DuPage County. The symbiosis of DMG and DaVita's resources and talents will immediately address identified weaknesses within current care delivery models and lead to future advances designed to meet the growing needs of those with ESRD in DuPage County.

Patients at risk of losing their renal function will benefit from DMG's multi-disciplinary team that works to jointly maintain kidney function and slow the progression of kidney disease. DMG patients benefit from increased communication between primary care physicians, nephrologists and other specialists who work together at DMG to treat the entire patient. This process is set in motion by patients' timely referral to nephrologists and coordinated efforts by their physician care team to address a patient's kidney disease and any underlying factors leading to its progression. This includes efforts to help improve adherence to treatment plans and lifestyle modifications to reduce diabetes rates and manage hypertension. Additionally, because DMG physicians have centralized scheduling and coverage determinations, patients have an entire network of specialists they can call upon without facing administrative road blocks or insurance obstacles. DMG is committed to preventing CKD and its related comorbidities in its patient base. DaVita wants to support these efforts and regularly lends tools and other assistance to support these goals.

For those CKD patients whose kidney disease progresses to ESRD, DMG nephrologists are adept in ensuring a smooth transition to dialysis, including the timely placement of AV fistulas prior to a patient beginning hemodialysis to avoid unnecessary procedures and complications. DMG patients would then continue to receive seamless and coordinated care as they begin their dialysis with DaVita at the Proposed Clinic. Patients' care teams will continue to have aligned incentives to reduce hospitalization, improve clinical outcomes and delivery critical interventions. Patients will benefit from having renal nurse care managers who coordinate their care among the dialysis center care team (renal nurses, dieticians, and social workers), nephrologists, specialists, behavioral health specialists and pharmacists. Additionally, renal nurse care managers will utilize robust technology platforms, including predictive models and analytics to deliver clinical protocols developed with each patient in mind.

DaVita's proprietary patient care tools, educational resources, quality initiatives, and in-center hemodialysis operational expertise, along with DMG's medical staff collaboration, integrated EHR systems, patient-oriented health portal, and robust administrative support tools, further provide the foundation for an innovative approach to this joint venture.

The DaVita-DMG partnership truly integrates primary care physicians, nephrologists, and other specialists into the care model to enhance collaboration by all providers to decrease disease progression, mortality rates, and hospitalization rates. As illustrated in the attached diagram titled "DaVita Comprehensive Care Model," this collaboration will improve every aspect of patient care.

DaVita Comprehensive Care Model

Management Capabilities

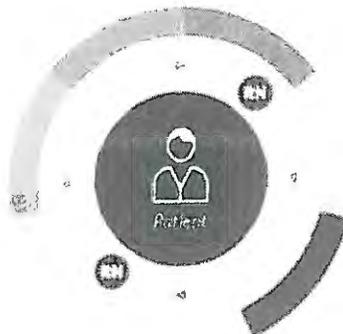
Multi-Insurance Plan Types

1

2

3

4



Approach to Care

A DMG-DaVita partnership integrates PCPs, Nephrologists, and other specialists into the care model to enhance collaboration by all providers to improve outcomes and reduce costs

EXHIBIT 6

THIS TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING THURSDAY, APRIL 26 AT 10:00 AM

Comments for the Record

U.S. House Committee on Ways and Means, Subcommittee on Health

Hearing on

Innovation in Healthcare

Thursday, April 26, 2018

By Mathew Philip, MD

Physician and Member of the Board of Directors

DuPage Medical Group

Mr. Chairman, Ranking Member Neal, members of the Committee, good morning and thank you for inviting me to appear here today to share with you our best practices and innovation in health care delivery. I am Dr. Mat Philip, an internal medicine physician with DuPage Medical Group, one of the largest, independent multi-specialty physician groups in the country located in Suburban Chicago. With more than 700 physicians, 200 advanced practice professionals and 4,900 employees, we see more than 800,000 unique patients annually. I joined DMG in 2009, after finishing my training at Northwestern University Feinberg School of Medicine and University of Illinois in Chicago. DMG is an organization that focuses on delivering the highest quality of care, service and value to the communities we serve. DMG accomplishes this through an integrated outpatient delivery model. I serve on the Board of Directors and my practice is dedicated to caring for fragile seniors.

It is critical that the Committee is seeking to understand this issue. As a physician-owned and directed group, we believe that the power to change health care delivery rests in large part with physicians and the relationship we have with our patients. DMG is constantly looking for ways to innovate and improve health care. As many of you know, an average of 10,000 people each day turn 65, each year, and that

number will increase. Several years ago, it became clear that the most vulnerable patients in our communities were seniors, and they were being underserved by the system. These patients are many times home-bound without any support system around them. Most have co-morbid diseases and lack access to doctors, medications, transportation and in many instances proper nutrition. The main access point to care for these seniors is dialing 911, which leads to a continuous cycle of emergency room visits and numerous hospitalizations. These patients can be hospitalized for the same diagnosis dozens of times per year. Our goal is to help keep these patients at home and out of the hospital. In fact, data from the Department of Health and Human Services noted that approximately 5% of patients account for 50% of healthcare costs among seniors. It was obvious to me and my colleagues that there was a better way to help these patients. Through a physician-driven exercise, we started an intensive team-oriented care model to meet the complicated needs of this fragile population. The model is set up with care teams led by a physician who is supported by advanced practice providers, pharmacists, social workers and health coaches. The results have been nothing less than transformational. Through our high-touch model we reduced admissions, re-admissions and complications for these fragile seniors by as much as 50%.

Last week in my clinic, I saw Mr. R, an 83-year-old with chronic pain. He was a former college football player and drives over an hour and a half to see me in my Intensive Outpatient Clinic (IOP) in Wheaton, because he realized his health was progressively getting worse and he needed help. He saw multiple physicians and specialists who placed him on stronger and stronger medications, such as Percocet (opiate), Hydrocodone (opiate), Lorazepam (anti-anxiety controlled substance), and Restoril (controlled substance that is a sleep aid). The combination of these pills more than doubled his risk of overdose, stroke and heart attack. My team and I developed a treatment plan for him and his wife, who is a nurse, to follow. He is now completely off all opiates and all controlled substances and feels better than he has

in years. He states he felt like he was walking under water before, and now his pain is better and he's able to spend more time with his grandchildren and attend a weekly men's breakfast which brings him a lot of joy.

This is an example of a systematic care delivery model that puts the patient at the center of our decision making. Being physician-owned and directed allows us to create a high-quality, high-value, high-safety environment for our patients to seek care. We utilize a uniform medical record across all of our locations and have built out an infrastructure that meets the needs of our community including immediate care centers, imaging services, ambulatory surgery centers and integrated oncology services - all in a safer environment and lower cost than the traditional system. We are able to reduce redundancy of services and decrease variation leading to increased quality and safety. We take fragmentation out of the system.

Another case that I also saw last week highlights the need of the IOP clinics and the value that DuPage Medical Group delivers, to our patients, and the health care system overall. Mr. T is a 71-year-old retired military serviceman who sought care at a neighboring private health system. He inevitably ended up in the local hospital emergency department, or was hospitalized, every two weeks. He was being cared for by multiple specialists and his primary care physician but would often call his doctor's office and be referred to the emergency department. His kidney function was progressing to the last stage before dialysis. Nobody seemed to be coordinating his care or taking an active role in the management of his chronic conditions. When he joined the IOP clinic eight months ago, we developed a treatment plan with him after understanding his ailments and his goals for improving his health. We realized he had been put on too many medications and was getting confused with his treatment plan. It seemed like every physician told him something different. By removing some of his medications, simplifying his treatments, and seeing him regularly, he hasn't been to the emergency room or the hospital in over six

months! He is also feeling better, and his kidney and heart function have shown significant improvements.

I think patient examples help tell the story of what we are able to achieve. We are improving the quality of life for our patients, keeping them out of the hospital when it is not necessary and improving the health care system. Real outcomes are demonstrated in metrics, and we are very pleased with our ACO results. DuPage Medical Group is part of IHP ACO, the 5th largest ACO in the country. This ACO ranks in the bottom quartile for cost per beneficiary and the top 15% for quality. Our members comprise nearly half of this ACO. We are proud of our results as the top-performing ACO in Illinois.

In closing, we will continue to innovate; it is part of our entrepreneurial nature. I would ask the Committee to examine these key areas to improve care for Medicare recipients:

1. Allow for additional services to be reimbursed in an Ambulatory Surgical Center (ASC) setting. Many services historically have exclusively been done on an inpatient basis and are now routinely done in an ASC setting at a much lower cost. Orthopedic procedures, such as total joint replacement and spine surgeries, are a few examples.
2. Pay for real value. The current ACO system does not recognize the best-performing organizations like DuPage Medical Group. We were the lowest cost ACO in Chicago and did not receive shared savings in the most recent year.
3. Include digital and telehealth services. We have the technology and experience in this area as we have been offering telehealth services for the last four years for patients who are willing to pay for these services. Covering these services would allow for greater access and efficiency for patients and providers. We could do a much better job of avoiding hospital admissions and re-admissions through the deployment of technology.

THIS TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING THURSDAY, APRIL 26 AT 10:00 AM

I want to thank the members of this Committee for the opportunity to share our doctor-directed, patient-focused model, and also thank my fellow panelists in leading the charge to use innovation to improve health care. DuPage Medical Group looks forward to being an active participant as the Committee and Congress work to improve health care delivery for our seniors, and all patients.

Exhibit 7

The opposition comments result from the market rivals' dissatisfaction that they will have to compete in a meaningful way in a market they have always dominated since dialysis and nephrology services became available to treat ESRD in the early 1970s. They must be viewed in that lens. All of the competitors' complaints against the Proposed Clinic fall under just a few themes.

False Narrative: Lack of Need/Demand for Services

Grouping the Proposed Clinic in Romeoville with a variety of other pending projects in other service areas, Fresenius Medical Care ("FMC") and its conspirators falsely assert that there is not demand for services in Romeoville. The material need for additional dialysis services in Romeoville has been thoroughly documented in this letter and previous submissions. Ironically, as described below, the need for the Proposed Clinic, is supported by FMC's own documentation provided in its submission for its newest clinic closest to the Romeoville area.

FMC, DaVita's primary competitor is a German conglomerate and is the world's largest manufacturer and distributor of dialysis products and provider of dialysis services. It is also the largest dialysis provider in the State of Illinois and specifically in HSA 7, 8 & 9 it controls more stations than all if its competitors combined (1,023 Stations of 55% of the market). FMC and its affiliated nephrologists who are contractually bound to work exclusively with FMC in this market and are the presumed equity partners of FMC dialysis clinics in the area have leveled multiple dishonest assaults against the Proposed Clinic.

Both FMC and Nephrology Associates of Northern Illinois and Indiana ("NANI") which dominate northern Will County and nearby planning areas (along with many others) have used aggressive tactics against the Proposed Clinic and against the entry of additional nephrologists into the market. But in doing, they have been deceitful and have shown a lack of respect for the process making their submissions on or near the last day of the public comment period and then swamping the public hearing testimony with a scattershot of intentionally misleading information denying that there is a need for additional dialysis services without providing supporting data.

As background, from 1997 to 2000, FMC developed its Chicagoland presence through the acquisition of NANI's affiliated dialysis clinic company called, Everest, for \$343 million. This was soon after its acquisition of the Associates in Nephrology affiliated dialysis company, Neomedica, about 20 years ago. At that time, DaVita did not operate in metropolitan Chicago. DaVita's ability to service patients in Chicago has been stifled by the exclusive relationships that these acquisitions have created with area nephrologists which have created barriers to entry based on those contractual arrangements with nephrologists. DaVita's barriers to entry include:

- 1) Limited available medical directors as required by CMS due to the large scale exclusive relationships between FMC and most of the nephrology practices in the area
- 2) Uncommon scale of the practices, particularly NANI which is the 2nd largest group in the nation (and growing as it has been purchasing many smaller nephrology practices and putting them under exclusive contracts and further reducing available medical directors required by CMS for clinical oversight of dialysis clinics for other dialysis providers.

3) While NANI and AIN physicians are welcome to treat their ESRD patients at DaVita facilities, these nephrologists have been unwilling to provide CKD data necessary to support the development of DaVita facilities which creates a further barrier to competition

FMC has previously leveraged this process to keep DaVita and Northeast Nephrology out of northern Will County. Several years ago, in 2011, Northeast Nephrology tried to develop a dialysis clinic in Crest Hill with DaVita, just south of Romeoville. At that time, there was a technical excess of 55 stations in the planning area. This was true despite the fact that area dialysis clinics had experienced significant growth in ESRD patients. FMC also had a project pending in Will County (10-066). In connection with that filing, it had submitted a data analysis showing that there was a need for 152 stations in HSA 9. In 2011, the FMC application was approved despite a technical excess of stations and strong opposition from Silver Cross Hospital which cited technical deficiencies with its application and from other area providers. The clinic proposed by DaVita and Northeast Nephrology was denied. Only by the acquisition of other clinics in this area does DaVita have any market presence in Will County.

Just like in 2011, at the last meeting where this project received an intent-to-deny despite strong demand and an identified need for stations, FMC was approved for a dialysis clinic approximately across a parking lot from another existing HSA 9 DaVita clinic in New Lenox. Based on identified planning area need, DaVita did not oppose that clinic. During the same meeting, with FMC and its physicians strenuously objecting, DaVita's Romeoville proposal was turned down despite evidence in the State Board staff report of demand for services. We believe the manipulation of the process by FMC is improperly creating confusion and makes it hard for Board members to hear the merits of the project. FMC tactics in Will County were effective in blocking out DaVita from this area in 2011 and have thus far been effective in blocking the Proposed Clinic in Will County. FMC uses the same or similar reasonable justifications as DaVita for explaining why a clinic is necessary despite technical deficiencies. This is illustrated by reviewing some of the data and arguments that used in project 10-066 which is included as an exhibit to this letter.

FACT: Using the same formula that FMC used to support approval of its Joliet clinic in 2011 which effectively blocked this joint venture, there is a need for 43 stations in the Planning Area and 18 are needed in Romeoville.

As referenced earlier, FMC despite its uproar against this project, has provided patient data supporting this proposal. Specifically, in its nearby FKC Woodridge clinic proposal approved last year, the referring NANI physician (Dr. David Schlieben) identified 481 pre-ESRD patients who live in the area of Woodridge, Bolingbrook and South Naperville who will ultimately require dialysis services. Of these pre-ESRD patients, he identified 138 patients he expects will require dialysis services at the planned FMC clinic in Woodridge to bring utilization of that clinic to 191% within two years of opening.[3] Further, FMC and NANI are well-aware that the State Board examines each application on the four corners of its application and does not batch projects. However, these aggressive competitors have taken advantage of the generally unrestricted public comment processes to loudly bellow objections to obscure the merits of the Proposed Clinic and the Applicant's thoughtful and purposeful planning of the Proposed Clinic in a growing area, both in population and ESRD patients. This ruse impacts the process and the community intended to be served which needs additional access to dialysis stations. It is particularly an abuse of process given the public record that FMC and NANI have created in advocating for additional capacity in nearby areas. Moreover, both opposing competitors are keenly aware that ESRD need and

the State's station need methodology is very specific than the other categories of service. New dialysis clinic justification is patient specific and updated utilization is available on a quarterly basis. The patients identified for the Proposed Clinic have not been used to justify another dialysis clinic and once they are placed on dialysis, most are expected to survive their kidney disease for many years and will effectively be the residents of the Proposed Clinic for their lifetime.

In legally defending its role in other matters, the State Board has pointed out that it is not the responsibility of the State Board to maintain market share of individual providers or to otherwise protect them. This is established by law. See *Cathedral Rock*, 308 Ill.App.3d at 540, 242 Ill.Dec. 158, 720 N.E.2d 1113, *Provena Health v. Illinois Health Facilities Planning Board*, Appellate Court of Illinois First District, First Division, No. 1-07-1952 (Decided March 31, 2008).

False Narrative: Corporate Takeover

The Proposed Clinic is an average sized, 12 station clinic that will serve approximately 65 patients. There are 870 existing patients on dialysis in the planning area.[4] The allegation that the Proposed Clinic amounts to a corporate takeover is completely contrary to the facts. Even if all the pending DaVita clinic proposals in metropolitan Chicago were approved, it would still lag far behind FMC in market share with FMC retaining a market share of more than all its competitors combined (52%) compared to DaVita's 17% in HSA's 7, 8 & 9. As to nephrology supply, Northeast Nephrology Consultants is a small, five physician nephrology practice and DMG, which may refer a few patients to this Proposed Clinic, employs 10 nephrologists. These nephrology groups are dwarfed by the size of the NANI and AIN groups which combined employ approximately 145 nephrologists. The next largest nephrology practice after these groups in Illinois is the University of Chicago faculty group which has 19 nephrologists, many of whom split their professional time between practicing medicine and teaching. As advertised on its website, NANI alone is the second largest nephrology group in the country.

The residents of Romeoville, a working town of 40,000 residents, have no immediate access to a dialysis clinic. In New Lenox, a community of approximately 34,000[5] outside of the Proposed Clinics patient service area, there are two clinics for a total of 31 stations. In the 10-mile geographic service area, FMC holds 74% of the total number of dialysis stations to DaVita's 19%. The impact of the Proposed Clinic on market share would be negligible and would alter the market share to 69% for FMC and 24% for DaVita. If the Proposed Clinic is approved, there will be change in number of stations in the 10 mile patient service area from 182 to 194 with FMC controlling 134 stations compared to DaVita's 47 stations. It is audacious and dishonest, particularly coming from the largest dialysis company in the world and one of the largest nephrology practices in the county to present the Proposed Clinic as a corporate takeover.

False Narrative 3: Lack of Innovation

This item has been used by the opposition to assert that it participates in an ESCO and therefore, the competitors and their physician partners provide seamless coordinated care for their ESRD patients. Moreover, by merely participating in the ESCO, the competitors' facilities are innovative and therefore providing cost savings. These competitors compare the ESCO to DMG's ACO, which is like comparing apples to oranges as DMG is an independent multi-specialty physician group of over 600 physicians yet only 10 are nephrologists. As an ESCO solely deals with dialysis, this is an erroneous analysis.

The competitors have doubled down on this red herring as they also criticize DaVita for not participating in the Chicago ESCO stating that if the Proposed Clinic is approved somehow innovation will be stifled and the ESCO will be undermined. The competitors acknowledge that DaVita does participate in ESCO's but just not this one. Moreover, participation in an ESCO does not preclude empirical quality measures to be implemented as DaVita's employed quality measures are second to none. Refer to the quality initiative data supplemented herein where it is documented that DaVita has been national clinical leader in CMS 5-Star for the past 4 years and had significantly fewer Medicare's quality incentive program (QIP) penalties. It is worth repeating that in the newly released 2017 star ratings DaVita continued the trend of highest percentage of four and five star clinics and is an industry leader with 93% of its clinics rated 3 star or better compared to 86 percent for the rest of the industry.

This is not just a national storyline. In Chicagoland, QIP penalties were at 13.3% DaVita clinics as compared to 19.3 for Chicagoland overall. The Five Star rating system has 48% of DaVita clinics as 4 or 5 star clinics compared to only 16% for the other dialysis providers. Conversely, 45% of the other dialysis providers are either 1 or 2 star facilities.



Fresenius Medical Care

January 13, 2011

RECEIVED

JAN 14 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Dale Galassie
Chairman
Illinois Health Facilities & Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Re: Additional Information
Project: #10-066, Fresenius Medical Care Joliet

Dear Mr. Galassie,

The enclosed pages contain additional information in response to the Intent to Deny given to the above mentioned project at the December 14, 2010 meeting and in response to information requested by the Board.

Thank you for your time and consideration of this information.

Sincerely,

Lori Wright
Senior CON Specialist

cc: Clare Ranalli

ADDITIONAL INFORMATION FOR #10-066, FRESenius MEDICAL CARE JOLIET

Criterion 77 Ill. Adm. Code 1100.1430(b) - Planning Area Need

1. Formula Calculation

According to the December 17, 2010 Board station inventory, there are 213 approved existing stations in HSA 9 with the calculated need being only 162. This leaves an excess of 51 stations. The Fresenius Medical Care Joliet project thus does not meet the Formula Need Calculation criteria. However, since the time this need was calculated, there has been significant population growth in HSA 9 as well as growth of ESRD, specifically in Will County and the Joliet area. A revised calculation utilizing updated statistics shows a significantly higher need for ESRD stations in HSA 9 by 2015. The revised calculation below exhibits a calculated need for 101 additional stations in HSA 9. Given this, the project meets the Formula Need criteria.

State Institutional Dialysis Patients 2010 ¹	14,440
State Population Projections 2010 ²	13,279,091
State Use Rate	1.087
Minimum Institutional Dialysis Use Rate	0.652

H S A 9 Institutional Dialysis Patients 2010 ³	809
H S A 9 Population Projection 2010 ⁴	927,536
H S A 9 Use Rate	0.872

H S A 9 2015 Population Projection ⁵	1,040,980
2015 Estimated Dialysis Patients	1132
5 Year Increase	1,506
Projected Treatments 2015	234,936
Stations Needed 2015	314
Approved Existing Stations	213
Additional Stations Needed	101

¹ The Renal Network 12-31-2010 Utilization Data

² Illinois Department of Commerce & Economic Opportunity (DECO) population projections summary by county.

³ The Renal Network 12-31-2010 Utilization Data

⁴ Illinois Department of Commerce & Economic Opportunity population projections summary by county.

⁵ Illinois Department of Commerce & Economic Opportunity population projections summary by county.

Although all facilities within 30 minutes travel time are not operating above 80% utilization a significant number of those that the patients identified for the Joliet facility could reasonably utilize are above 80% restricting these patients access to services.

Facility	Address	City	ZIP Code	Miles	Time	Adjusted	Stations	Util ¹
New Silver Cross Hosp	US-6 & N Clinton St	New Lenox	60451	4.31	7	8	14	101% ²
Fresenius Lockport	1062 Thomson Avenue	Lockport	60441	5.75	11	13	12	0% ³
Sun Health	2121 W Oneida St	Joliet	60435	5.79	13	15	17	55%
Silver Cross West	1051 Essington Rd	Joliet	60435	5.73	17	20	29	84%
Fresenius Mokena	8910 W 192nd St	Mokena	60448	13.82	22	25	12	57%
Fresenius Orland Park	9160 W 159th St	Orland Park	60462	14.33	22	25	18	76% ⁴
Fresenius Plainfield	2320 Michas Dr	Plainfield	60586	15.48	25	29	12	74% ⁵
Fresenius Bolingbrook	329 Remington Blvd	Bolingbrook	60440	13.12	28	30	20	96% ⁶

¹ Utilization for December 31, 2010 draft data from The Renal Network figured on currently operating stations

² Silver Cross Hospital #10-020, approved July 2010, will add 5 stations to the facility in 2012

³ Fresenius Lockport # 09-037, approved December 2009, will be operational in late 2011, early 2012

⁴ Historically over 80%, 2 stations added September 2010 to alleviate high utilization and improve access for patients in Orland Park market

⁵ Fresenius Plainfield open only one year and already just under 80% utilization

⁶ Fresenius Bolingbrook historically over 80% despite expansions, 4 additional stations will be operational mid 2011, facility will still be over 80%

⁷ 4 Additional stations not yet operational will bring the total to 24

⁸ Total operating stations 122. 5 stations at Silver Cross Hospital will not be operational until 2012, 12 stations at Lockport will not be operational until late 2011, early 2012 and 4 stations at Bolingbrook will be not be operational until mid 2011.

The facilities that the patients identified for Fresenius Medical Care Joliet could potentially be referred to are Silver Cross Hospital, Sun Health, Silver Cross West and Fresenius Lockport. It is unreasonable to expect these patients to go outside of Joliet 13 -15 miles away to a separate market for services. As will be explained in the following section, the Fresenius Joliet facility will serve a specific disadvantaged patient population that will be put at an even greater disadvantage if this facility is not established.

Silver Cross Hospital – Silver Cross Hospital has been operating above capacity with 14 stations for several years creating a waiting list for patients. Although the facility is adding 5 stations to be operational in 2012, Silver Cross identified 54 patients who would be referred to bring the facility above 80%. Given current and historic utilization and certified patient referrals, Silver Cross Hospital will not be able to accommodate the patients identified for the Fresenius Joliet facility.

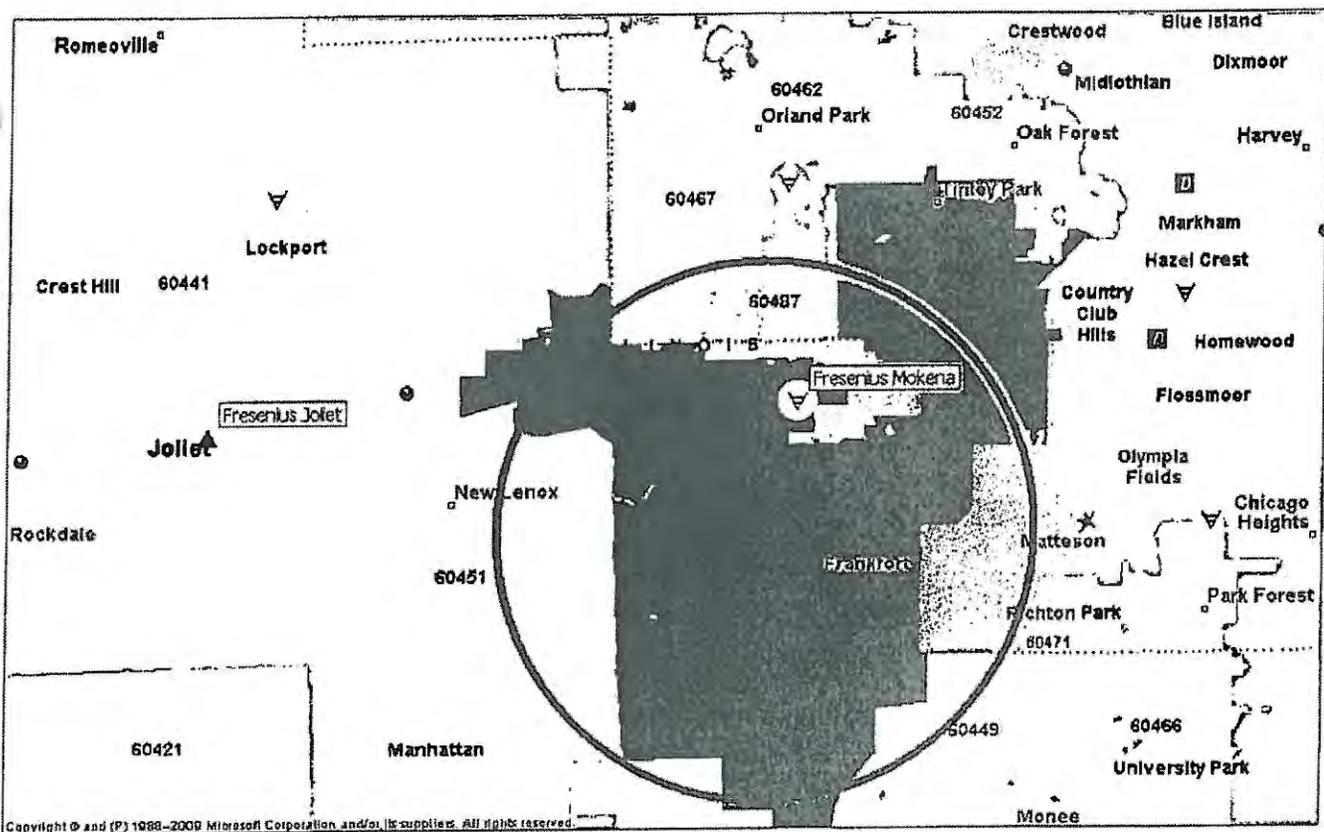
Silver Cross West – This facility is operating above 80% utilization and cannot accommodate the patients identified for the Joliet facility.

Sun Health – While underutilized, not all of the patients Dr. Alausa refers here are accepted and some are not able to be referred there due to their insurance provider.

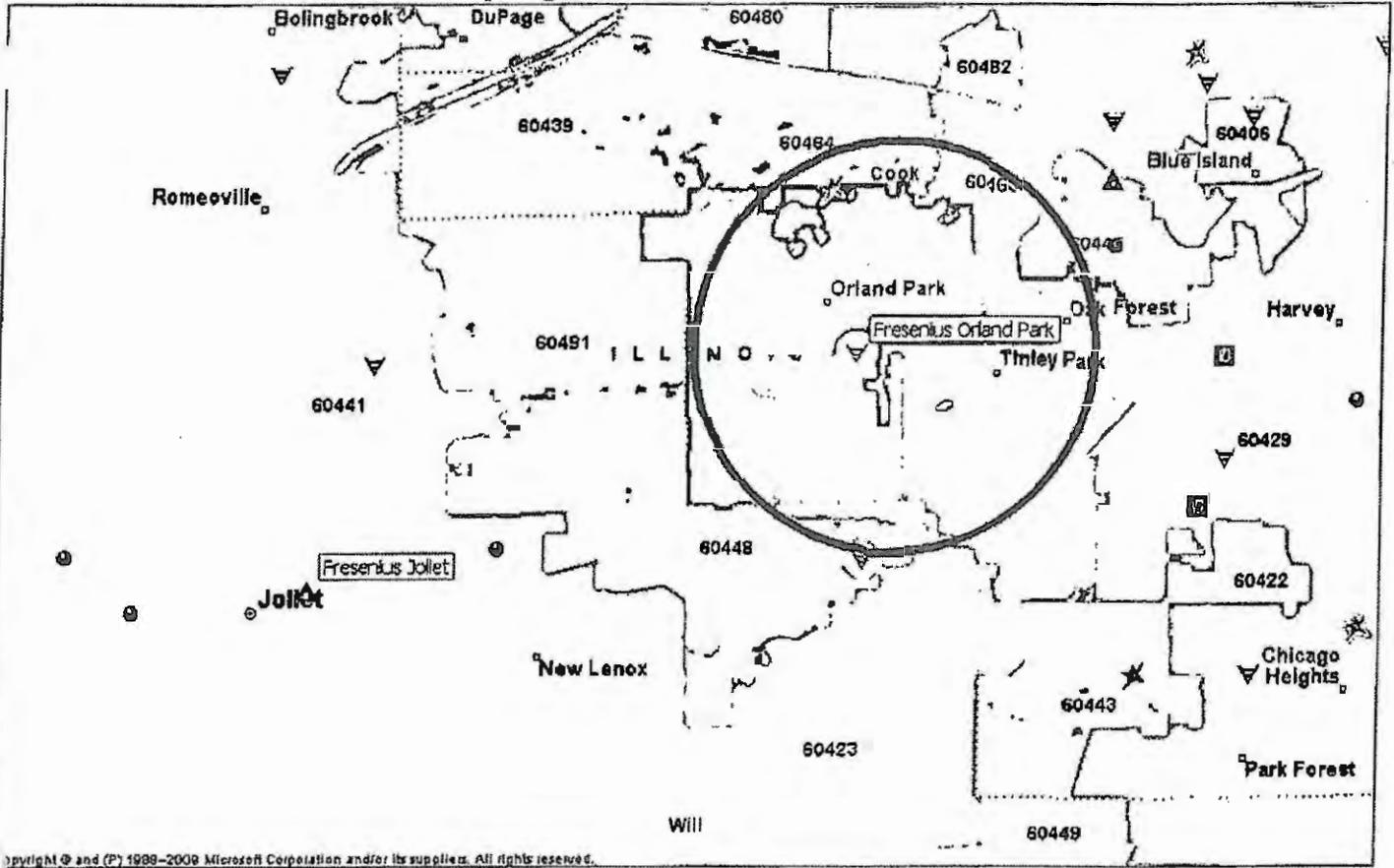
Fresenius Lockport – This facility will not be operational for another year and is supported by separate physicians/patients that do not practice/live in Joliet. Southwest Nephrology Associates based in Cook County (HSA 7) have identified 78 patients to bring that facility to 80% by the year 2013. Thus the facility cannot accommodate the patients identified for the Joliet facility. Aside from this, Dr. Alausa has also certified that he has pre-ESRD patients that he will refer to the Lockport facility that do live in the immediate Lockport area.

The only other facilities with any capacity within 30 minutes are Fresenius Mokena, almost 14 miles away and near the 30 minute travel time and Fresenius Plainfield over 15 miles away. (Given the extreme growth at Fresenius Plainfield, the facility is expected to be at 80% by the March 22nd meeting when the Joliet project is heard). While the Mokena facility did not reach target utilization within 2 years of operation, as most of the approved Fresenius facilities do, it is not a reasonable facility to send the patient population residing in East Joliet to. Dr. Alausa tries to place his patients in the facility nearest their home, due to the previously mentioned transportation problems experienced by dialysis patients. It would not be in the best interest of a patient from Joliet to be referred as far away as Mokena, unless it was the patient's preference, which is not likely. The maps below and on the following pages illustrate the distribution of patients dialyzing at current Fresenius facilities in the area and those identified for the not yet operating Lockport location and for Fresenius Joliet.

Patients dialyzing at Fresenius Medical Care Mokena

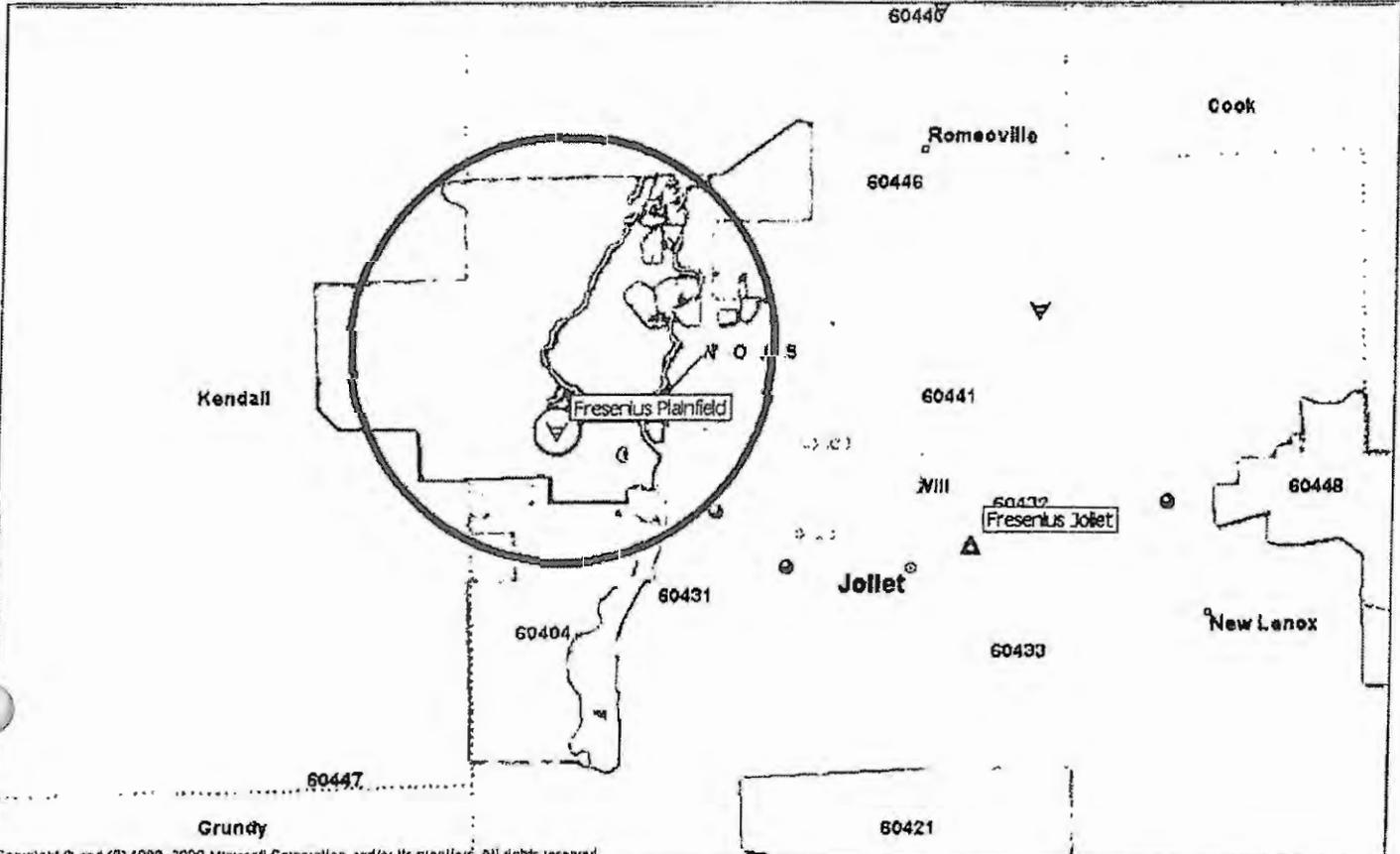


Patients dialyzing at Fresenius Medical Care Orland Park



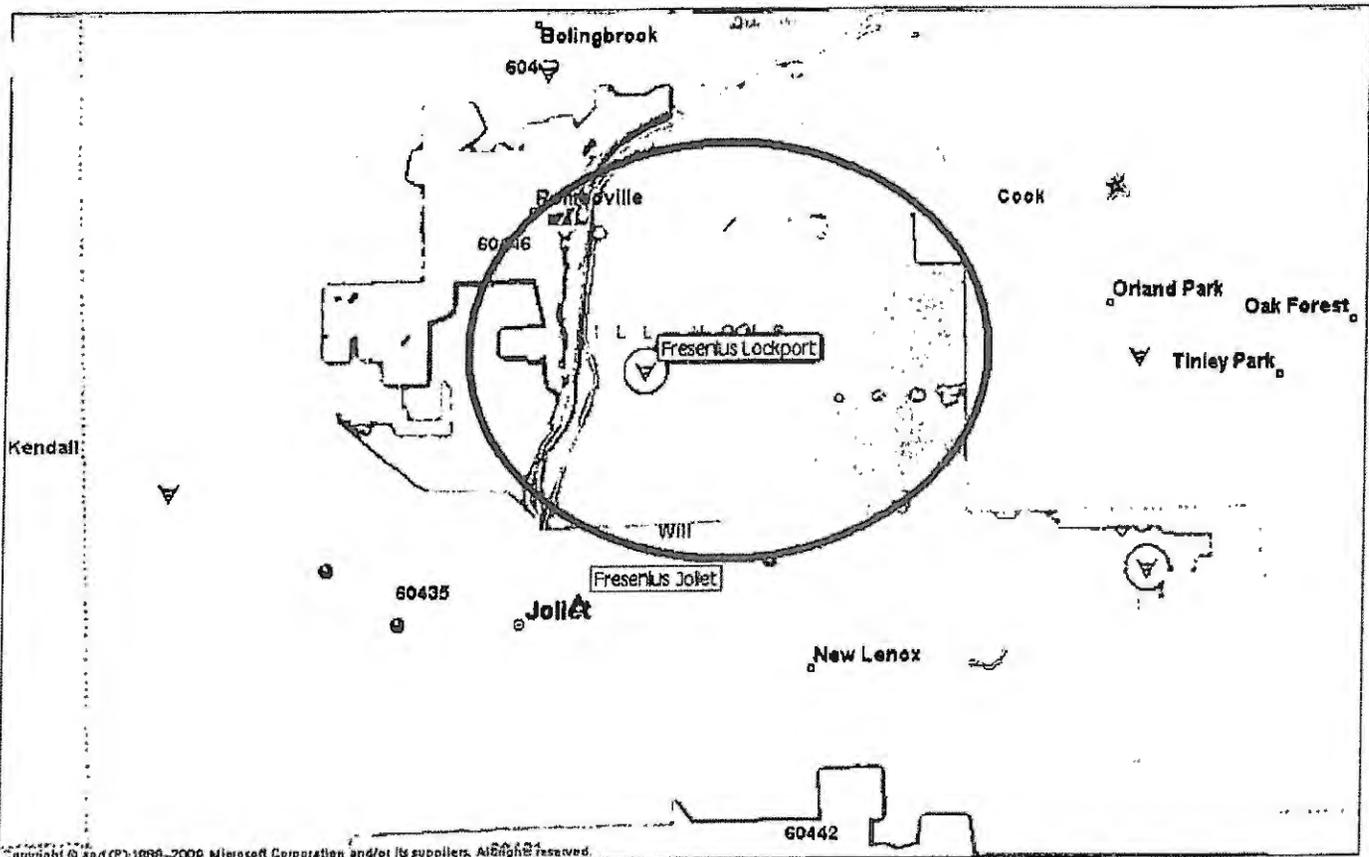
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Patients dialyzing at Fresenius Medical Care Plainfield

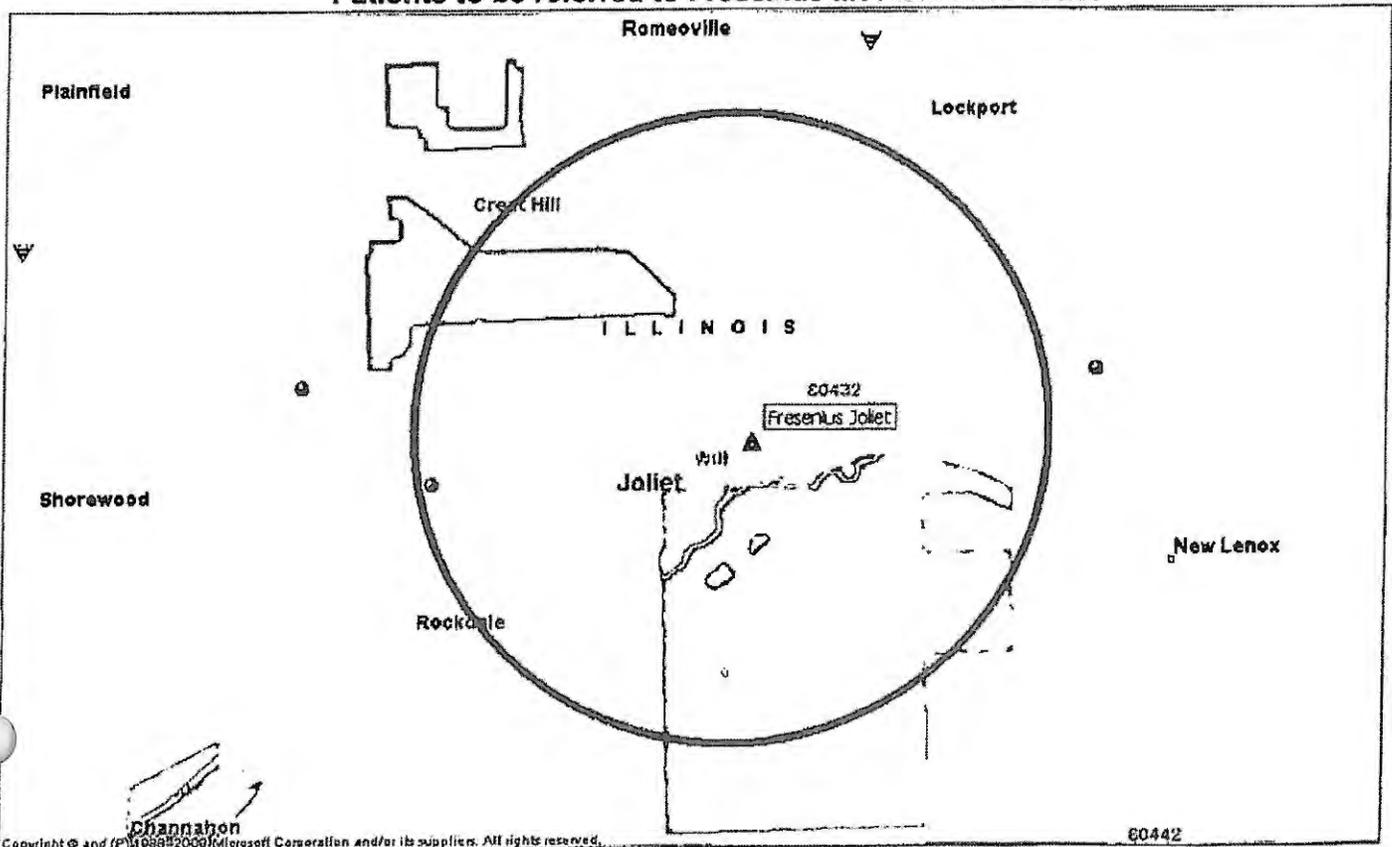


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Patients identified to be referred to Fresenius Medical Care Lockport

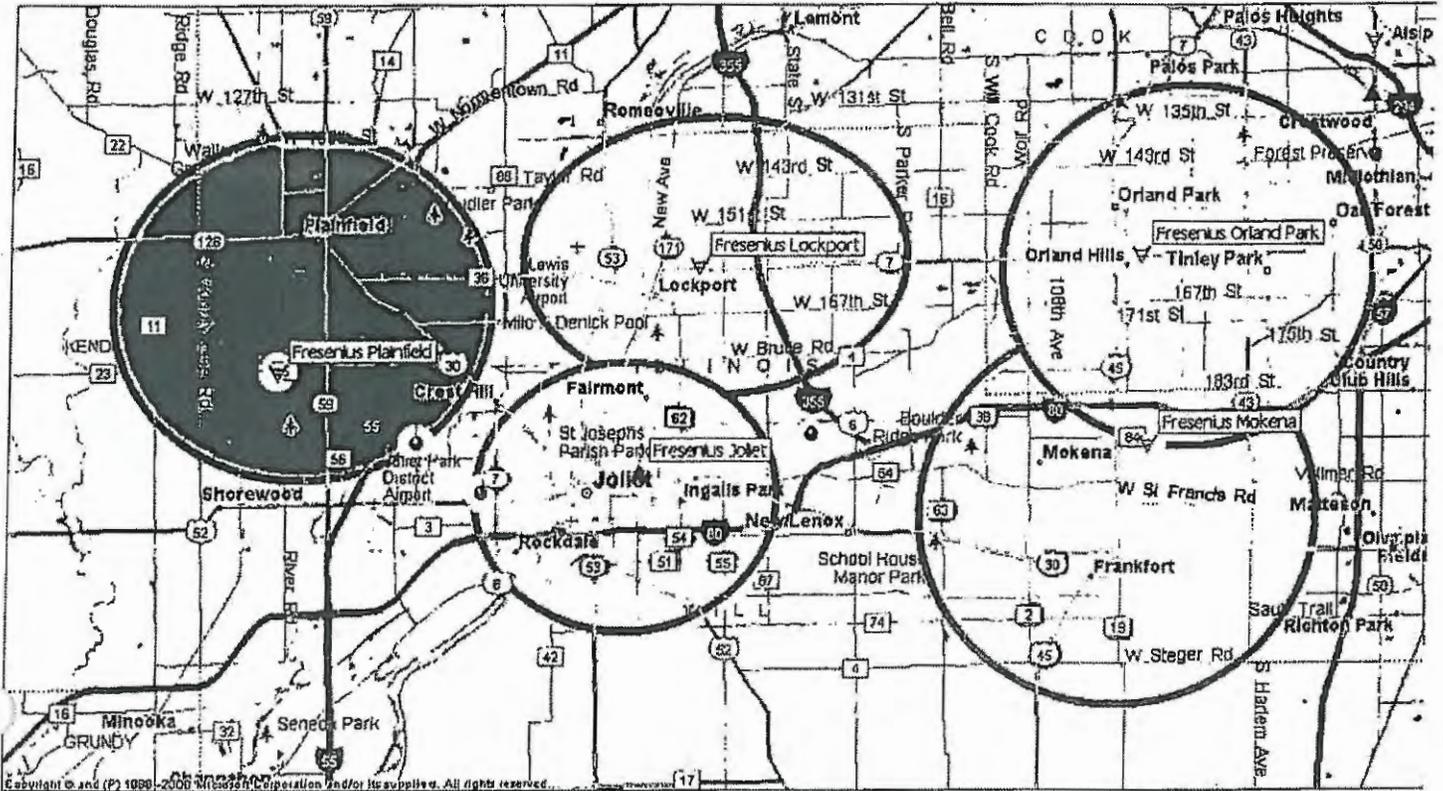


Patients to be referred to Fresenius Medical Care Joliet



Distribution of patients from Fresenius Mokena, Orland Park, Plainfield, Lockport and Joliet

Based on the previous maps, below is a radius around each facility where a majority of the patients dialyzing at that facility reside.



As is seen in the above map, the greatest majority of patients dialyze near their place of residence and do not wish to nor is it in their best interest to travel extreme distances for dialysis treatment.

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(a), Project Purpose, Background and Alternatives

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. This project is for the establishment of Romeoville Dialysis, a 12-station in-center hemodialysis facility to be located at 480 – 490 North Independence Boulevard, Romeoville, Illinois 60446.

TOVELL DIALYSIS, LLC (d/b/a ROMEOVILLE DIALYSIS)

With ultimate control of Tovell Dialysis through Total Renal Care Inc.'s 51% membership interest, DaVita Inc. is an applicant for the proposed facility. In addition, DuPage Medical Group, Ltd ("DMG") holds a significant minority interest in Tovell Dialysis, LLC. DaVita and DMG are leaders within the medical community and strive to continually improve clinical outcomes and deliver the highest level of care through innovative practices. DaVita and DMG envision that the Romeoville Dialysis station will address a need for ESRD services within the community.

DaVita consistently differentiates itself from other kidney care companies and surpasses national averages for clinical outcomes. DuPage Medical Group distinguishes itself through quality care, with clinical outcomes and cost savings for DMG's Medicare programs ranking in the top percentile for the nation. DaVita's proprietary patient care tools, educational resources, quality initiatives, and in-center hemodialysis operational expertise, along with DMG's medical staff collaboration, integrated EHR systems, patient-oriented health portal, and robust administrative support tools, will support ESRD patients along their continuum of care.

Today, chronic kidney disease ("CKD") and end stage renal disease ("ESRD") is common and associated with excess mortality. A diagnosis of CKD is ascribed to over 10 million people within the United States, with many more at risk. The rise in diabetes mellitus and hypertension are contributing to the rise in CKD and ESRD, with these risk factors highly prevalent throughout the United States.

An optimal care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Early identification of CKD and deliberate treatment of ESRD by multidisciplinary teams leads to improved disease management and care, mitigating the risk of disease advancement and patient mortality.

Accordingly, timely referral to and treatment by a multidisciplinary clinical team may improve patient outcomes and reduce cost. Indeed, research has found that late referral and suboptimal care result in higher mortality and hospitalization rates¹. Deficient knowledge about appropriate timing of patient referrals and poor communication between primary care physicians ("PCPs") and nephrologists have been cited as key contributing factors².

Critically, addressing the failure of communication and coordination among PCPs, nephrologists, and other specialists may alleviate a systemic barrier to mitigating the risk of patient progression from CKD to ESRD, and to effective care of patients with ESRD. Indeed a 2016 issue brief developed by the National Kidney Foundation and the Medicare Advantage Care Coordination ("MACC") Task Force found that because most patients with kidney disease have multiple complex health conditions, and see multiple providers and specialists, care coordination presents a particular challenge³.

¹ Navaneethan SD, Aloudat S, Singh S. A systematic review of patient and health system characteristics associated with late referral in chronic kidney disease. *BMC Nephrol.* 2008; 9:3.

² *Id.*

³ http://medicarechoices.org/wp-content/uploads/2016/04/MACC-Task-Force_CKD-and-Care-Coordination-Working-Together-to-Improve-Outcomes.pdf

Currently, DMG patients from the southwestern suburbs who require dialysis services may be removed from DMG's continuum of care. Remaining within DMG's continuum of care optimizes patient health and outcomes through provider collaboration and coordinated administrative tools. In addition to research emphasizing the value of care coordination among providers, research has generally displayed that the more information on a single EHR, the better the outcomes are for patient care. Patients receiving care on a single integrated EHR often experience reduced clinical errors and better outcomes as a result.⁴ With the development of the proposed facility, patient data generated at the dialysis facility will be migrated to the EHR systems accessible by all DMG providers.

This data integration ensures their PCP, nephrologist, and other specialists can access the patient dialysis records on demand. The applicants have the ability to design additional functionalities to address communication and coordination issues between physicians. This removes administrative burden and alleviates risks that a patient's PCP or specialist is missing information regarding their care, including dialysis treatments. By streamlining these processes, the applicants anticipate improved patient care and experiences.

The tailoring of familiar DaVita and DMG tools eases the burden on physicians and enhances the likelihood of success. In fact, studies have indicated that alleviating the perceived burden by physicians of implementation and participation to be vital to the success of new mechanisms designed to improve care⁵.

Patients will be empowered through DaVita and DMG's interest in the Romeoville Dialysis facility. DMG's "MyChart" enables a patient to access all their billing records and medical records stored within DMG's Epic-based EHR system. Similarly, DaVita maintains the "DaVita Health Portal," which tracks a patient's progress by sharing the patient's lab values, nutrition reports, health records, and for DaVita Rx members: prescriptions and medication lists. DMG and DaVita will integrate patient information from dialysis services and make it available to the patients through MyChart & DaVita Health Portal.

Through the development of the proposed facility, DMG and DaVita will improve the identification and treatment of CKD and ESRD patients. The increased communication and improvement in co-management between PCPs, nephrologists, and specialists will decrease disease progression, mortality rates, and hospitalization rates.

As detailed below, the applicants have the requisite qualifications, background, character and financial resources to provide dialysis services to the community. As discussed above, the applicants have a unique opportunity to develop an innovative continuum of care designed to improve the lives of area residents requiring dialysis treatment.

DAVITA, INC.

Pursuant to 20 ILCS 3960/2, the applicant DaVita Inc. has the requisite qualifications, background, character and financial resources to adequately provide a proper service for the community.

DaVita Inc. is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and empowering patients, and community outreach. As of September 30, 2016, DaVita provided services to approximately 199,000 patients. As detailed below, DaVita is committed to innovation, improving clinical outcomes, compassionate care, educating and empowering patients, and community outreach.

⁴ Nir Menachemi, Taleah H Collum, Risk Management Healthcare Policy, 2011; 4: 47-55. May 11, 2011).

⁵ Id.

DaVita is focused on providing quality care.

Based upon 2016 data from the Centers for Medicare and Medicaid Services, DaVita is the clinical leader in the Quality Incentive Program ("QIP") for the fourth straight year. DaVita had the highest average total performance score among large dialysis organizations, which are organizations that have at least 200 dialysis centers in the U.S. Further, DaVita ranked first in four clinical measures in the end stage renal disease ("ESRD") QIP program. QIP is part of Medicare's ESRD program aimed at improving the quality of care provided to Medicare patients. It was designed as the nation's first pay-for-performance quality incentive program.

In October of 2016, the Centers for Medicare and Medicaid Services ("CMS") released data on dialysis performance as part of its five star ratings program. For the third year in a row, DaVita outperformed the rest of the industry with the highest percentage of four- and five-star centers and lowest percentage of one- and two-star centers in the country. The Five-Star Quality Rating System was created as a way to help patients decide where they want to receive healthcare by providing more transparency about dialysis center performance. The rating system measures dialysis centers on seven different quality measures and compiles these scores into an overall rating. Stars are awarded for each center's performance.

On October 7, 2015, CMS announced DaVita won bids to operate ESRD seamless care organizations ("ESCO") in Phoenix, Miami and Philadelphia. ESCOs are shared savings programs, similar to accountable care organizations, where the dialysis providers share financial risks of treating Medicare beneficiaries with kidney failure. ESCOs encourage dialysis providers to take responsibility for the quality and cost of care for a specific population of patients, which includes managing comorbidities and patient medications.

In an effort to allow ESRD provider to assume full clinical and economic accountability, DaVita announced its support for the Dialysis PATIENT Demonstration Act (H.R. 5506/S. 3090). The Dialysis PATIENT Demonstration Act would allow ESRD providers to coordinate care both inside and outside the dialysis facility. The model empowers patients, emphasizes leadership, and facilitates innovation.

On June 17, 2016, CAPG awarded Healthcare Partners, DaVita's medical group division, multiple honors. CAPG awarded HealthCare Partners California and The Everest Clinic in Washington its Standards of Excellence™ Elite Award. Colorado Springs Health Partners received a Standards of Excellence™ Exemplary Award. Standards of Excellence™ awards are achieved by surpassing rigorous, peer-defined benchmarks in survey categories: Care Management Practices, Information Technology, Accountability and Transparency, Patient-Centered Care, Group Support of Advanced Primary Care, and Administrative and Financial Capability.

In August 2016, DaVita Hospital Services, the first inpatient kidney care service to receive Ambulatory Health Care Accreditation from The Joint Commission, was re-accredited for three years. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. For the past three years, DaVita identified key areas for improvement, created training presentations and documents, provided WebEx training sessions and coordinated 156 hospital site visits for The Joint Commission Surveyors and DaVita teammates. Accreditation allows DaVita to monitor and evaluate the safety of kidney care and apheresis therapies against ambulatory industry standards. The accreditation allows for increased focus on enhancing the quality and safety of patient care; improved clinical outcomes and performance metrics, risk management and survey preparedness. Having set standards in place can further allow DaVita to measure performance and become better aligned with its hospital partners.

On June 16, 2016, DaVita announced its partnership with Renal Physicians Association ("RPA") and the American Board of Internal Medicine ("ABIM") to allow DaVita-affiliated nephrologists to earn Maintenance of Certification ("MOC") credits for participating in dialysis unit quality improvement activities. MOC certification highlights nephrologists' knowledge and skill level for patients looking for high quality care.

Improving Patient Care

Kidney Disease Statistics

30 million or 15% of U.S. adults are estimated to have CKD.⁶ Current data reveals troubling trends, which help explain the growing need for dialysis services:

- Between 1999-2002 and 2011-2014, the overall prevalence estimate for CKD rose from 13.9 to 14.8 percent. The largest relative increase, from 38.2 to 42.6 percent, was seen in those with cardiovascular disease.⁷
- Many studies now show that diabetes, hypertension, cardiovascular disease, higher body mass index, and advancing age are associated with the increasing prevalence of CKD.⁸
- Over six times the number of new patients began treatment for ESRD in 2014 (120,688) versus 1980 (approximately 20,000).⁹
- Over eleven times more patients are now being treated for ESRD than in 1980 (678,383 versus approximately 60,000).¹⁰
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD; 44% of new ESRD cases have a primary diagnosis of diabetes; 28% have a primary diagnosis of hypertension.¹¹
- Lack of access to nephrology care for patients with CKD prior to reaching end stage kidney disease which requires renal replacement therapy continues to be a public health concern. Timely CKD care is imperative for patient morbidity and mortality. Beginning in 2005, CMS began to collect CKD data on patients beginning dialysis. Based on that data, it appears that little progress has been made to improve access to pre-ESRD kidney care. For example, in 2014, 24% of newly diagnosed ESRD patients had not been treated by a nephrologist prior to beginning dialysis therapy. And among these patients who had not previously been followed by a nephrologist, 63% of those on hemodialysis began therapy with a catheter rather than a fistula. Comparatively, only 34% of those patients who had received a year or more of nephrology care prior to reaching ESRD initiated dialysis with a catheter instead of a fistula.¹²

DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include the Kidney Smart, IMPACT, CathAway, FluidWise, WipeOut, MedsMatter, StepAhead, and transplant assistance programs.

⁶ Centers for Disease Control & Prevention, National Center for Chronic Disease Prevention and Health Promotion, National Chronic Kidney Disease Fact Sheet, 2017 (2017) available at https://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf (last visited Jul. 20, 2017).

⁷ US Renal Data System, USRDS 2016 Annual Data Report: Epidemiology of Kidney Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 39 (2016).

⁸ Id.

⁹ Id. at 215.

¹⁰ Id. at 216.

¹¹ Id. at 288.

¹² Id. at 292-294.

DaVita's Kidney Smart program helps to improve intervention and education for pre-ESRD patients. Approximately 69% of CKD Medicare patients have never been evaluated by a nephrologist.¹³ Timely CKD care is imperative for patient morbidity and mortality. Adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may improve patient outcomes and reduce ESRD:

- (i) Reduced GFR is an independent risk factor for morbidity and mortality. A reduction in the rate of decline in kidney function upon nephrologists' referrals has been associated with prolonged survival of CKD patients,
- (ii) Late referral to a nephrologist has been correlated with lower survival during the first 90 days of dialysis, and
- (iii) Timely referral of CKD patients to a multidisciplinary clinical team may improve outcomes and reduce cost.

A care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Through the Kidney Smart program, DaVita offers educational services to CKD patients that can help patients reduce, delay, and prevent adverse outcomes of untreated CKD. DaVita's Kidney Smart program encourages CKD patients to take control of their health and make informed decisions about their dialysis care.

DaVita's IMPACT program seeks to reduce patient mortality rates during the first 90-days of dialysis through patient intake, education and management, and reporting. Through IMPACT, DaVita's physician partners and clinical team have had proven positive results in addressing the critical issues of the incident dialysis patient. The program has helped improve DaVita's overall gross mortality rate, which has fallen 28% in the last 13 years.

DaVita's CathAway program seeks to reduce the number of patients with central venous catheters ("CVC"). Instead, patients receive arteriovenous fistula ("AV fistula") placement. AV fistulas have superior patency, lower complication rates, improved adequacy, lower cost to the healthcare system, and decreased risk of patient mortality compared to CVCs. In July 2003, the Centers for Medicare and Medicaid Services, the End Stage Renal Disease Networks and key providers jointly recommended adoption of a National Vascular Access Improvement Initiative ("NVAII") to increase the appropriate use of AV fistulas for hemodialysis. The CathAway program is designed to comply with NVAII through patient education outlining the benefits for AV fistula placement and support through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. DaVita has worked with its physician partners and clinical teammates to reduce catheter rates by 46 percent over the last seven years.

In 2013, DaVita was the first large dialysis provider to implement a comprehensive teammate vaccination order, requiring all teammates who work in or whose jobs require frequent visits to dialysis centers to either be vaccinated against influenza or wear surgical masks in patient-care areas. WipeOut, DaVita's infection surveillance, prevention and response program, aims to help patients live longer and avoid infection-related hospitalizations. DaVita led the industry with more than 90 percent of its dialysis patients immunized for influenza in 2016.

DaVita's FluidWise initiative aims to reduce fluid-related hospitalizations and mortality while enhancing the patient experience. DaVita develops fluid-related clinical care pathways to identify patients who are most at-risk for fluid-related hospitalizations, building care processes—such as achieving target weight, obtaining accurate vitals, standardizing dialysate sodium, and restricting fluid and sodium intake—to

¹³ Id at 4.

reduce fluid overload. To help ESRD patients prevent avoidable complications from diabetes mellitus, DaVita's StepAhead initiative provides an opt-in diabetes management program that includes an annual eye exam, annual glucometer check and monthly foot exams.

DaVita seeks to improve medication compliance rates, eliminate adverse interactions and reactions, and help keep patients healthy and out of the hospital. Through its MedsMatter initiative, DaVita provides medication management support, including targeted medication reviews and education, through a specialty renal pharmacy. DaVita Rx, the first and largest licensed, full-service U.S. renal pharmacy, focuses on the unique needs of dialysis patients. Since 2005, DaVita Rx has been helping improve outcomes by delivering medications to dialysis centers or to patients' homes, making it easier for patients to keep up with their drug regimens. DaVita Rx patients have medication adherence rates greater than 80%, almost double that of patients who fill their prescriptions elsewhere, and are correlated with 40% fewer hospitalizations.

For more than a decade, DaVita has been investing and growing its integrated kidney care capabilities. Through Patient Pathways, DaVita partners with hospitals to provide faster, more accurate ESRD patient placement to reduce the length of hospital inpatient stays and readmissions. Importantly, Patient Pathways is not an intake program. An unbiased onsite liaison, specializing in ESRD patient care, meets with both newly diagnosed and existing ESRD patients to assess their current ESRD care and provides information about insurance, treatment modalities, outpatient care, financial obligations before discharge, and grants available to ESRD patients. Patients choose a provider/center that best meets their needs for insurance, preferred nephrologists, transportation, modality and treatment schedule.

DaVita currently partners with over 350 hospitals nationwide through Patient Pathways. Patient Pathways has demonstrated benefits to hospitals, patients, physicians and dialysis centers. Since its creation in 2007, Patient Pathways has impacted over 130,000 patients. The Patient Pathways program reduced overall readmission rates by 18 percent, reduced average patient stay by a half-day, and reduced acute dialysis treatments per patient by 11 percent. Moreover, patients are better educated and arrive at the dialysis center more prepared and less stressed. They have a better understanding of their insurance coverage and are more engaged and satisfied with their choice of dialysis facility. As a result, patients have higher attendance rates, are more compliant with their dialysis care, and have fewer avoidable readmissions.

Since 1996, Village Health has innovated to become the country's largest renal National Committee for Quality Assurance accredited disease management program. VillageHealth's Integrated Care Management ("ICM") services partners with patients, providers and care team members to focus on the root causes of unnecessary hospitalizations such as unplanned dialysis starts, infection, fluid overload and medication management.

VillageHealth ICM services for payers and ACOs provide CKD and ESRD population health management delivered by a team of dedicated and highly skilled nurses who support patients both in the field and on the phone. Nurses use VillageHealth's industry-leading renal decision support and risk stratification software to manage a patient's coordinated needs. Improved clinical outcomes and reduced hospital readmission rates have contributed to improved quality of life for patients. As of 2014, VillageHealth ICM has delivered up to a 15 percent reduction in non-dialysis medical costs for ESRD patients, a 15 percent lower year-one mortality rate over a three-year period, and 27 percent fewer hospital readmissions compared to the Medicare benchmark. Applied to DaVita's managed ESRD population, this represents an annual savings of more than \$30 million.

DaVita has long been committed to helping its patients receive a thorough kidney transplant education within 30 days of their first dialysis treatment. Patients are educated about the step-by-step transplant process and requirements, health benefits of a transplant and the transplant center options available to them. The social worker or designee obtains transplant center guidelines and criteria for selection of appropriate candidates and assists transplant candidates with factors that may affect their eligibility, such as severe obesity, adherence to prescribed medicine or therapy, and social/emotional/financial factors related to post-transplant functioning.

In an effort to better serve all kidney patients, DaVita believes in requiring that all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers: dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients.

Awards

DaVita has been repeatedly recognized for its commitment to its employees (or teammates), particularly its more than 1,700 teammates who are reservists, members of the National Guard, military veterans, and military spouses. Victory Media, publisher of *GI Jobs*® and *Military Spouse* magazine, recently recognized DaVita as the best 2016 Military Friendly Employer in the health care industry and 34th among all industries. Companies competed for the elite Military Friendly® Employer title by completing a data-driven survey. Criteria included a benchmark score across key programs and policies, such as the strength of company military recruiting efforts, percentage of new hires with prior military service, retention programs for veterans, and company policies on National Guard and Reserve service. DaVita was also named as a *Civilianjobs.com* Most Valuable Employer (MVE) for Military winner for five consecutive years. The MVE was open to all U.S.-based companies, and winners were selected based on surveys in which employers outlined their recruiting, training and retention plans that best serve military service members and veterans.

In May 2016, DaVita was certified by WorldBlu as a "Freedom-Centered Workplace." For the ninth consecutive year, DaVita appeared on WorldBlu's list, formerly known as "most democratic" workplaces. WorldBlu surveys organizations' teammates to determine the level of democracy practiced. For the fifth consecutive year, DaVita was recognized as a Top Workplace by *The Denver Post*. DaVita was recognized among *Training* magazine's Top 125 for its whole-person learning approach to training and development programs for the twelfth year in a row. Finally, DaVita has been recognized as one of *Fortune*® magazine's Most Admired Companies in 2016 – for the ninth consecutive year and tenth year overall.

Service to the Community

DaVita is also committed to sustainability and reducing its carbon footprint. In fact, it is the only kidney care company recognized by the Environmental Protection Agency for its sustainability initiatives. In 2010, DaVita opened the first LEED-certified dialysis center in the U.S. *Newsweek* Green Rankings recognized DaVita as a 2016 Top Green Company in the United States, and it has appeared on the list every year since the inception of the program in 2009. Furthermore, DaVita annually saves approximately 8 million pounds of medical waste through dialyzer reuse and it also diverts more than 85 percent of its waste through composting and recycling programs. It has also undertaken a number of similar initiatives at its offices and has achieved LEED Gold certification for its corporate headquarters. In addition, DaVita was also recognized as an "EPA Green Power Partner" by the U.S. Environmental Protection Agency.

DaVita consistently raises awareness of community needs and makes cash contributions to organizations aimed at improving access to kidney care. DaVita provides significant funding to kidney disease awareness organizations such as the Kidney TRUST, the National Kidney Foundation, the American Kidney Fund, and several other organizations. Its own employees (or teammates), make up the "DaVita Village," assisting in these initiatives.

DaVita Way of Giving program donated \$2 million in 2016 to locally based charities across the United States. Since 2011, DaVita teammates have donated \$9.1 million to thousands of organizations through DaVita Way of Giving. Through Village Service Days, groups of three or more teammates can plan and execute a service project with a local nonprofit. DaVita teammates and their families and friends have volunteered more than 140,000 hours through 3,600 Village Service Days projects since 2006.

DaVita does not limit its community engagement to the U.S. alone. Bridge of Life is the primary program of DaVita Village Trust, an independent 501(c)(3) nonprofit organization, which supports approximately 30 international medical missions and over 50 domestic missions and CKD screening events each year. In 2016, more than 300 DaVita volunteers supported these missions, impacting nearly 19,000 men, women and children in 15 countries.

In 2016, DaVita celebrated the 10th anniversary of Tour DaVita, an annual, three-day, 250-mile bicycle ride, to raise awareness about kidney disease. The ride raised \$1.25 million to benefit Bridge of Life. Since 2007, DaVita cyclists and Tour supporters have raised more than \$8.6 million to fight kidney disease. Bridge of Life serves thousands of men, women and children around the world through kidney care, primary care, education and prevention and medically supported camps for kids.

DUPAGE MEDICAL GROUP

Although not an applicant, DuPage Medical Group is a minority owner and the applicants have included an overview of DuPage Medical Group's background in order to convey the importance of the proposed facility for DuPage Medical Group and their patients.

DuPage Medical Group was formed in 1999 when three healthcare groups serving the suburbs of Chicago since the 1960s joined together. The legal entity, DuPage Medical Group, Ltd., was incorporated as a medical corporation in the State of Illinois in July 1968 and is a for-profit, taxable corporation. DuPage Medical Group is now Illinois' leading multi-specialty independent physician group practice, and remains committed to superior care and innovation.

With more than 600 physicians, approximately 800 providers, and 50 specialties in more than 70 locations, DuPage Medical Group handles upwards of 1.1 million patient visits annually, treating about a third of DuPage County's population. Consistent with its physician growth, DuPage Medical Group has grown as an employer in the community. DuPage Medical Group employed 3908 people in 2016, an increase of nearly 30% from the 2996 people employed in 2015.

DuPage Medical Group is focused on providing quality care.

DuPage Medical Group is focused on providing the southwestern suburbs with access to the finest health care available and operating on the principal that physicians make the best decisions for patient care. DMG is led by experienced physicians who continually seek innovations through a model of QEA: Quality, Efficiency and Access.

Managing such a proactive model of medicine allows DMG to provide quality care, construct the most advanced facilities and implement the latest technology. Through secure access of an electronic health record and DMG's patient portal, MyChart, its physicians and patients stay closely connected on the care that forms the bigger picture of each patient's health. DMG promotes strong collaboration among its medical staff and solicits helpful feedback from patients. Strong administrative support creates stability for DMG physicians, empowering them to help drive the group forward.

DMG's commitment to quality and cost efficiency is further demonstrated by numerous value-based care initiatives, including DMG's Accountable Care Organization ("ACO") leadership, operation of the BreakThrough Care Center, and a CMS BPCI initiative.

DMG is a founding member of Illinois Health Partners, the 14th largest accountable care organization in the nation. DMG accounts for nearly 50% of the patients served by Illinois Health Partners, which is comprised of healthcare organizations such as Naperville, Ill.-based Edward Hospital and Arlington Heights, Ill.-based Northwest Community Hospital, along with 22 other organizations. According to 2015 data released by CMS, Illinois Health Partners ("IHP") maintained the lowest cost of care per beneficiary for any ACO in the Chicagoland area at \$8,847. IHP is also in the 76th percentile nationally in overall cost

efficiency and in the 88th percentile nationally in clinical quality. This makes IHP one of 38 of 393 (9%) of ACOs in the top quartile for both quality and cost efficiency

Since 2014, DMG has operated the BreakThrough Care Center, a comprehensive, holistic outpatient clinic serving the most vulnerable Chicagoland seniors struggling with chronic disease. Currently, the BreakThrough Care Center operates and accepts patients throughout DuPage County, with locations in the cities of Lisle, Naperville, and Wheaton. The BreakThrough Care Center is designed to improve medical outcomes while lowering healthcare costs and improving patients' ability to manage their health outcomes.

Improved care quality for BreakThrough Care Center patients is documented by improvements in patients'; biometrics for LDL-C levels, Total Cholesterol, A1C, Blood Pressure, and Body Mass Index. The BreakThrough Care Center optimizes the utilization of healthcare services, with all patients seen within 24 hours of hospital discharge, and patients experiencing lower ER admission rates, lower acute admissions, a 30-day chronic readmission rate of 7.2 percent, and high generic pharmacy utilization of 89 percent. Patients give the BreakThrough Care Center scores of over 91 percent on access to care and coordination of care metrics.

DMG has also demonstrated its commitment to promoting the development of orderly, value driven, healthcare facilities via the CMS Bundled Payments for Care Improvement ("BPCI") initiative. DMG reduced costs by over \$1.1 million under the BPCI program for major joint replacement of the lower extremity in Q3 and Q4 of 2015, lowering the cost of care and improving outcomes. DMG's participation and performance in these value-based care programs and organizations serves a critical role in cost containment and maximizing the quality of care in DuPage County and the surrounding communities served by DMG. DuPage Medical Group continues to expand the services and specialties it offers patients.

In September of 2016, DMG opened a new nephrology division when Kidney & Hypertension Associates joined the practice. DMG has always strived to provide its patients with access to timely, quality, and affordable health care. This mission is supported by the addition of the nephrology practice to DMG's wide array of medical specialties. Patients of DMG physicians with an identified need for nephrology services now have more immediate and reliable access through their existing provider's practice.

With physician scheduling and patient coverage determinations available throughout the DMG practices, DMG is able to eliminate common obstacles to patients obtaining necessary medical care. Managing patient's across specialties drives down costs by coordinating care and increasingly addressing the health of patients on a proactive basis.

In order to increase dialysis access points, DMG is partnering with DaVita in requesting authority to build the proposed facility in Romeoville to serve a growing ESRD population. By collaborating with an experienced dialysis provider, DMG is able to bring its patients excellent care while simultaneously bridging the gap between DMG and existing access points. This growth supports DMG's mission to deliver physician oriented healthcare at the highest level to its patients.

DMG promotes the orderly and economic development of health care facilities in Illinois.

DMG's trend of responsible, positive growth is tied to DMG's commitment to its physician and patient population. This focus is closely aligned with the Board's own mission for serving the patients of Illinois. In keeping with the purpose identified by the State: "The CON program promotes the development of a comprehensive health care delivery system that assures the availability of quality facilities, related services, and equipment to the public, while simultaneously addressing the issues of community need,

accessibility, and financing. In addition, it encourages health care providers to engage in cost containment, better management and improved planning."¹⁴

DMG practices the values and goals expressed by the CON program, and believes in the value of DMG's services and facilities to the Illinois healthcare system. As DMG has grown, quantitatively and qualitatively, it has continued to emphasize quality and accessibility for the community and its patients, tempered by responsible planning and growth. DMG has consistently presented accurate and conservative projections of patient population growth and referral patterns before the Board. *DMG's healthcare facilities operate above established state utilization levels, a clear sign of DMG's commitment to avoiding the development of unnecessary services within the community.*

In 2015, DuPage Medical Group received the Henry C. Childs Economic Development and Community Improvement Award from the Wheaton Chamber of Commerce. The Henry C. Childs Economic Development and Community Improvement Award was named after a local businessman responsible for designing safe community infrastructure, and it recognizes the development or redevelopment of a property that positively impacts economic development in the City of Wheaton.

DMG was recognized for the property redevelopment and construction of its 40,000-square-foot Wheaton Medical Office Building, which houses over 30 DMG physicians in Family Medicine, Internal Medicine, Pediatrics and Obstetrics/Gynecology, as well as the BreakThrough Care Center.

DMG promotes philanthropy and service within the communities it serves.

DuPage Medical Group is actively involved in philanthropy and community service as a way of giving back to the community in which it operates. As part of this effort, DMG established the DuPage Medical Group Charitable Fund in partnership with the DuPage Foundation. Providing a coordinated approach for combining the efforts of its physicians, care providers and staff into a single force.

The DuPage Medical Group Charitable Fund, which operates as a donor-advised fund under the umbrella of the DuPage Foundation's status as a 501(c)(3) public charity, seeks to make a significant impact within the communities DMG serves by combining impactful financial support with hands-on volunteerism.

The Fund seeks out community and health partners that serve those in need. In March, 2016 DMG reached \$1 million in grants to the community.¹⁵ In addition to providing some financial support to area organizations, the Charitable Fund provides in-kind donations, such as food, toys, coats and books. Volunteer service is also a key component of DMG's giving. Its financial contributions are extended by physicians and staff taking a hands-on role in helping these organizations. The Charitable Fund has also focused on magnifying its impact through volunteer service. Earlier this year DMG was honored with the Governor's Volunteer Service Award for Outstanding Business Volunteer Engagement for its work with People's Resource Center and DuPage Habitat for Humanity.¹⁶

Other Section 1110.230(a) Requirements.

Neither the Centers for Medicare and Medicaid Services nor the Illinois Department of Public Health ("IDPH") has taken any adverse action involving civil monetary penalties or restriction or termination of participation in the Medicare or Medicaid programs against any of the applicants, or against any Illinois health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

A list of health care facilities owned or operated by the Applicants in Illinois is attached at Attachment – 11A. Dialysis facilities are currently not subject to State Licensure in Illinois.

¹⁴ <https://www.illinois.gov/sites/hfsrb/CONProgram/Pages/default.aspx>

¹⁵ <http://www.dmgcharitablefund.com/news/story/4651>

¹⁶ <http://www.dailyherald.com/article/20161125/business/161129874/>

Certification that no adverse action has been taken against either of the Applicants or against any health care facilities owned or operated by the Applicants in Illinois within three years preceding the filing of this application is attached at Attachment - 11B.

An authorization permitting the Illinois Health Facilities and Services Review Board ("State Board") and IDPH access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment - 11B.

2018 Base: Population

Grundy Kankakee Kendall Will Counties IL (Count)

