



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: I-01	BOARD MEETING: October 22, 2019	PROJECT NO: 18-048	PROJECT COST:
FACILITY NAME: Sauganash Dialysis		CITY: Chicago	Original: \$4,678,689
TYPE OF PROJECT: Substantive			HSA: VI

PROJECT DESCRIPTION: The Applicants (DaVita Inc. and Total Renal Care, Inc.) propose a 12-station ESRD facility in 7,067 GSF of leased space in Chicago, Illinois. The cost of the project is \$4,678,689 and the expected completion date is April 30, 2021.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants (DaVita Inc. and Total Renal Care, Inc.) propose a 12-station ESRD facility in 7,067 GSF of leased space in Chicago, Illinois. The cost of the project is \$4,678,689 and the expected completion date is April 30, 2021.
- The Applicants received an Intent to Deny at the March 2019 State Board Meeting and has deferred this project until the October 2019 State Board Meeting.¹ Additional information addressing the Intent to Deny was received on April 17, 2019. The Applicants stated in part:
 - *“The Proposed Clinic will address a service restriction, the Medically Underserved Population, in the area to be served (the geographic service area). This fact was documented in the CON permit application with supporting documentation from the Health Resources and Services Administration of the U.S. Dept. of Health and Human Services (HRSA) and, as such, the application conforms with the requirements of Section 1110.230(5)(a)(iv) of the State Board rules.”*
 - *“The proposed clinic will address the need for 80 ESRD stations in the HSA VI ESRD Planning Area”.*
 - *“The growth of ESRD patients in the geographic service area far outpaces growth of ESRD patients in the State of Illinois and outpaces growth in HSA 6. None of this growth was anticipated in the State Board's last need calculation in 2017. The Complete Submittal received April 17, 2019 is attached at the end of this report as well as the transcripts from the March 2019 Meeting.”*

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The Applicants propose 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 regarding the proposed project, but none was requested. Letters of support were received from State Representative John D’Amico, Alderman Margaret Laurino, US Senator Richard Durbin, Rene Madrid, and Irma Lizcano. A letter of opposition was submitted by the Center for Renal Dialysis and that letter is included at the end of this report.

SUMMARY:

- There is a calculated need for 80-ESRD stations in the City of Chicago (HSA VI ESRD Planning Area) as of September 2019. The Applicants are requesting 12-ESRD stations.
- The GSA for proposed facility is a 5-mile radius that has a population estimate of 1,060,059 residents. Currently, there are a total of 14-ESRD facilities with 241 stations in this 5-mile GSA. Two of the 14-facilities are in ramp-up, the remaining 12-facilities are operating at 77% utilization.

¹77 ILAC 1130.640 states

An applicant may not defer:

2) HFSRB consideration of an application that has received an Intent to Deny beyond a meeting date that is more than 12 months from the date of HFSRB's decision of Intent to Deny.

Seven of the 12-facilities (59%) are not at target occupancy. As of June 30, 2019, there are a total of 1,071 patients receiving dialysis at these 14-facilities.

- The proposed facility will be in the HSA VI ESRD Planning Area which is the City of Chicago. Dr. Ho (proposed medical director) with the NorthShore Medical Group has identified 179 patients with chronic kidney disease that reside within the 5-mile radius of the proposed facility. Of these 179 patients, Dr. Ho is estimating 61 patients will require dialysis within 12-24 months of the project completion.
- The Applicants have addressed a total of 22 criteria and have met them all.

STATE BOARD STAFF REPORT
Project 18-048
Sauganash Dialysis

APPLICATION/CHRONOLOGY/SUMMARY	
Applicants	DaVita Inc. and Total Renal Care, Inc.
Facility Name	Sauganash Dialysis
Location	4054 W. Peterson Ave. Chicago, Illinois
Permit Holder	DaVita Inc. and Total Renal Care, Inc.
Operating Entity	Total Renal Care, Inc.
Owner of Site	Rule Transfer IL, Inc.
Total GSF	7,067 GSF
Application Received	December 10, 2018
Application Deemed Complete	December 12, 2018
Review Period Ends	April 11, 2019
Financial Commitment Date	April 30, 2021
Project Completion Date	April 30, 2021
Review Period Extended by the State Board Staff?	No
Can the Applicants request a deferral?	Yes
Expedited Review?	Yes
Intent to Deny	March 5, 2019

I. Project Description

The Applicants (DaVita Inc. and Total Renal Care, Inc.) propose a 12-station ESRD facility in 7,067 GSF of leased space in Chicago, Illinois. The cost of the project is \$4,678,689 and the expected completion date is April 30, 2021.

II. Summary of Findings

- A. State Board Staff finds the proposed project in conformance with the provisions of 77 ILAC 1110 (Part 1110).
- B. State Board Staff finds the proposed project appears to be in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

The Applicants are DaVita Inc. and Total Renal Care, Inc. DaVita Inc., a Fortune 500 company, is the parent company of Total Renal Care, Inc. 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, persons with disabilities, the elderly, and other underserved persons in its facilities in the State of Illinois. The operating entity will be Total Renal Care, Inc. and the owner of the site is Rule Transfer IL, Inc. This project is subject to a Part 1110 and Part 1120 review. Financial commitment will occur after permit approval.

IV. Health Planning Area

The proposed facility will be in the HSA VI Health Service Area. This planning area includes the City of Chicago. As of September 2019, the State Board is estimating a need for 80 ESRD stations by 2022. Growth in the number of ESRD patients in this Planning Area since 2008 has averaged 3.10%. The Illinois Department of Public Health is estimating very little to no growth in the population in this planning area by 2022.

Average Annual Growth HSA VI	
Number of Patients 2017	5,149 ⁽¹⁾
Number of Patients 2008	4,127
Difference	1,022
Average Annual Growth	3.10%

1. Patient numbers from 2008 and 2017 Inventory of Health Care Facilities and Services and Need Determination

TABLE ONE	
Need Methodology HSA VI ESRD Planning Area	
Planning Area Population – 2017	2,716,500
In Station ESRD patients - 2017	5,149
Area Use Rate 2017 ⁽¹⁾	1895.454
Planning Area Population – 2022 (Est.)	2,721,500
Projected Patients – 2022 ⁽²⁾	5,185.5
Adjustment	1.33
Patients Adjusted	6,891
Projected Treatments – 2022 ⁽³⁾	1,070,281
Calculated Station Needed ⁽⁴⁾	1,429
Existing Stations	1,349
Stations Needed-2022	80
<ol style="list-style-type: none"> Usage rate determined by dividing the number of in-station ESRD patients in the planning area by the 2017 – planning area population per thousand. Projected patients calculated by taking the 2022 projected population per thousand x the area use rate. Projected patients are increased by 1.33 for the total projected patients. Projected treatments are the number of patients adjusted x 156 treatments per year per patient $1,070,281 / 747 = 1,429$ $936 \times 80\% = 749$ [Number of treatments per station operating at 80%] 	

V. Project Uses and Sources of Funds

The Applicants are funding this project with cash in the amount of \$2,462,126 and the Fair Market Value of Leased Space of \$2,216,563. The estimated start-up costs and operating deficit is \$2,132,999.

Uses of Funds	Total	% of Total
New Construction Contracts	\$1,559,184	33.32%
Contingencies	\$155,918	3.33%
Architectural/Engineering Fees	\$127,606	2.73%
Consulting and Other Fees	\$38,000	0.81%
Movable or Other Equipment	\$581,818	12.43%
Fair Market Value of Leased Space or Equipment	\$2,216,563	47.38%
Total Uses of Funds	\$4,678,689	100.00%
Sources of Funds	Total	% of Total
Cash	\$2,462,126	52.62%
Fair Market Value of Leased Space	\$2,216,563	47.38%
Total Sources of Funds	\$4,678,689	100%

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

A) Criterion 1110.110(a) - Background of the Applicant

To address this criterion the applicants must provide a list of all facilities currently owned in the State of Illinois and an attestation documenting that no adverse actions² have been taken against any applicant’s facility by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities and Services Review Board or a certified listing of adverse action taken against any applicant’s facility; and authorization to the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of the application for permit.

1. A listing of DaVita Dialysis Facilities in Illinois has been provided at pages 59-62 of the Application for Permit. DaVita has 120 ESRD facilities in the State of Illinois. Average CMS Star Rating³ for the Illinois DaVita facilities that have the necessary data to compile a rating is 3.7. The national average is 3.71 for DaVita facilities.

² “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)

³ CMS Star Rating system is a rating system developed by Medicare that assigns 1 to 5 stars to dialysis facilities by comparing the health of the patients in their clinics to the patients in other dialysis facilities across the country. Each dialysis center is graded on nine separate health statistics. These include: mortality ratios (deaths), hospitalizations, blood transfusions, incidents of hypercalcemia (too much calcium in the blood), percentage of waste removed during hemodialysis in adults and children, percentage of waste removed in adults during peritoneal dialysis, percentage of AV fistulas, percentage of catheters in use over 90 days. Causes of death and reasons for hospitalization may not necessarily be related to the care

2. The Applicants provided the necessary attestation that no adverse action has been taken against any facility owned or operated by the Applicants and authorization allowing the State Board and IDPH access to all information to verify information in the Application for Permit. [Application for Permit pages 63-64]
3. Evidence of ownership (Copy of the Letter of Intent to Lease the Property) of the site has been provided as required at pages 29-39 of the Application for Permit. Organizational relationships can be found at pages 26 of the Application for Permit.
4. A Certificate of Good Standing has been provided as required for Total Renal Care, Inc., as a foreign entity with permission to transact business in the State of Illinois. An Illinois Certificate of Good Standing is evidence that an Illinois business franchise (i.e. Illinois Corporation, LLC or LP) is in existence, is authorized to transact business in the state of Illinois and complies with all state of Illinois business requirements and therefore is in "Good Standing" in the State of Illinois. [Application for Permit page 27-28]
5. 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.* [Application for Permit page 44-45]
6. The proposed location of the 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). [Application for Permit page 47]

B) Criterion 1110.110(b) - Purpose of the Project

To demonstrate compliance with this criterion the Applicants must document

- 1. That the project will provide health services that improve the health care or well-being of the market area population to be served.**
- 2. Define the planning area or market area, or other relevant area, per the applicant's definition.**
- 3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.**
- 4. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.**

at a dialysis facility. The statistics merely represent how many patients who attend that facility died or were hospitalized. Based on these nine statistics, each facility is given a summary rating of 1 to 5 stars. In addition, each facility is graded on a curve and ranked against one another nationwide. This results in clinics being rated in a bell-shaped curve where about 30% of facilities receive only one or two stars, 40% receive 3 stars. (Source: CMS ESRD Compare Website)

5. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

The Applicants stated the following in part:

“There is currently a need for 5 hemodialysis stations (current inventory need is for 80 ESRD stations approved at September 2019 State Board Meeting) in the City of Chicago, the only Health Service Area in the State with a need for dialysis stations. This project is intended to address that need and will improve access to life sustaining dialysis services to the residents residing on the north side of Chicago. The Sauganash geographic service area is one of the most ethnically diverse areas in Chicago. Since the 1970s, it has been a point of entry for immigrants from Latin America and Asia. The community is 28% Hispanic and 11% Asian. Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications. A limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians. Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, the Health Resources & Services Administration (“HRSA”) has designated this area a Medically Underserved Population.

Further, the incidence of ESRD in the Hispanic community is higher than in the general population. The ESRD incidence rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this burden of disease include diabetes and metabolic syndrome, both are common among Hispanic individuals. Other factors that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. Access to health care, the quality of care received, and barriers due to language and health literacy also play a role in the higher incident rates. Given these factors, readily accessible dialysis services are imperative for the health of the residents living in Sauganash and the surrounding communities. There are 14 existing or approved dialysis clinics within 5 miles of the proposed Sauganash Dialysis (the “Sauganash GSA”). Excluding Irving Park Dialysis, which recently came online and is being developed to serve a different patient group, and the one non-reporting clinic, average utilization of area dialysis clinics is 76.5% as of September 30, 2018. Further, over the past four years, patient census at the existing clinics has increased 3.3% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Accordingly, average utilization of the existing clinics is expected to reach 80% by the time the proposed Sauganash Dialysis becomes operational.” [Application for Permit 52-58]

C) Criterion 1110.110(c) – Safety Net Impact Statement

To demonstrate compliance with this criterion the Applicants must document

- **The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.**

- The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
- How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

The Applicants provided a safety net impact statement as required at pages 138-140.

TABLE THREE
DaVita, Inc. ⁽¹⁾
Net Revenue, Charity and Medicaid Information for the State of Illinois Facilities

	2014	2015	2016	2017	2018
Net Patient Revenue	\$266,319,949	\$311,351,089	\$353,226,322	\$357,821,315	\$394,665,498
Amt. of Charity Care (charges)	\$2,477,363	\$2,791,566	\$2,400,299	\$2,818,603	\$2,711,788
Cost of Charity Care	\$2,477,363	\$2,791,566	\$2,400,299	\$2,818,603	\$2,711,788
% of Charity Care/Net Patient Revenue	0.93%	0.90%	0.68%	.78%	.69%
Number of Charity Care Patients (self-pay)	146	109	110	98	128
Number of Medicaid Patients	708	422	297	407	298
Medicaid Revenue	\$8,603,971	\$7,361,390	\$4,692,716	\$9,493,634	\$7,951,548
% of Medicaid to Net Patient Revenue	3.23%	2.36%	1.33%	2.65%	2.01%

1. The Applicants do not define charity care per the Illinois Health Facilities Planning Act. "Charity Care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third party payer." [20 ILCS 3960/3] For profit entities do not have charity care. These costs are considered a bad debt expense.

D) Criterion 1110.110(d) – Alternatives to the Proposed Project

To demonstrate compliance with this criterion the Applicants must identify all the alternatives considered to the proposed project.

The Applicants considered two alternatives to the proposed project; **do nothing or utilize existing clinics.** Both alternatives were rejected based in part on the following;

“According to the Renal Network data 1,470 in-center ESRD patients live within 5 miles of the proposed clinic and this number is expected to grow. Importantly, 306 stations are needed to adequately serve this population; however, there are only 261 stations. Accordingly, there is a need for 45 stations in the Sauganash GSA. As noted above, additional stations recently came online; however, these stations are dedicated to a different patient base. The existing clinics will not have adequate capacity to treat NorthShore Medical Group's projected patients. As a result, DaVita rejected this option.” [See Application for Permit page 71-74 for complete discussion]

VII. Size of the Project, Projected Utilization and Assurances

A) Criterion 1110.120(a) - Size of the Project

To demonstrate compliance with this criterion the Applicants must document the size of the proposed facility is in compliance with the State Board Standards published in Part 77 ILAC 1110 Appendix B.

The Applicants are proposing 7,067 GSF for 12-stations. The State Board Standard is 650 GSF per station or 7,800 GSF. [7,800 GSF (State Standard) – 7,067 GSF (Proposed GSF) = (733 GSF). The Applicants have successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH SIZE OF THE PROJECT CRITERION (77 ILAC 1110.120(a))

B) Criterion 1110.120(b) – Projected Utilization

To demonstrate compliance with this criterion the Applicants must document that the proposed facility will be in compliance with the State Board Standards published in Part 77 ILAC 1110 Appendix B two (2) years after project completion.

The Applicants are estimating 61 patients will require dialysis within 12-24 months of project completion.

$$\begin{aligned} 61 \text{ patients} \times 156 \text{ treatment per year} &= 9,516 \\ 12 \text{ stations} \times 936 \text{ treatments per year per station} &= 11,232 \text{ treatments} \\ 9,516 \div 11,232 &= 84.7\% \end{aligned}$$

The Applicants have successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH PROJECTED UTILIZATION CRITERION (77 ILAC 1110.120(b))

C) Criterion 1110.120(e) – Assurance

To demonstrate compliance with this criterion the Applicants must document that the proposed facility will be in compliance with the State Board Standards published in Part 77 ILAC 1110 Appendix B two (2) years after project completion.

The Applicants have provided the necessary attestation as required at page 106 of the Application for Permit.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH ASSURANCE CRITERION (77 ILAC 1110.120(e))

VIII. In-Center Hemodialysis

A) Criterion 1110.230(b)(1)(A) & (B) - Planning Area Need

The applicant shall document that the number of stations to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100

A) The number of stations to be established for in-center hemodialysis is in conformance with the projected station deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

B) The number of stations proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the utilization standard specified in 77 Ill. Adm. Code 1100.

The Applicants are proposing a 12-station facility. There is a calculated need in this ESRD Planning Area for 80 stations. The Applicants have met this sub-criterion.

B) Criterion 1110.230 (b) (2) - Service to Planning Area Residents

A) Applicants proposing to establish or add stations shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

The proposed 12-station facility will be located at 4054 W. Peterson Ave, Chicago, IL. Dr. Ho (proposed medical director) with the NorthShore Medical Group has identified 179 patients with chronic kidney disease that reside within the 5-mile radius of the proposed facility. Of the 179 patients, Dr. Ho is estimating 61 patients will require dialysis within 12-24 months of the project completion [Application for Permit page 142].

TABLE FOUR
Number of Patients with CKD in the 5-mile GSA by zip code

Zip Code	City	Patients	Miles
60625	Chicago	10	4.4
60630	Chicago	23	2.6
60646	Chicago	33	0
60659	Chicago	43	3.3
60712	Lincolnwood	70	2.1
Total		179	

C) Criterion 1110.230 (b) (3) - Service Demand – Establishment of In-Center Hemodialysis Service

The number of stations proposed to establish a new in-center hemodialysis service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest 2-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new facility, the applicant shall submit projected referrals. The applicant shall document subsection (b) (3) (A) and either subsection (b) (3) (B) or (C).

Historical patient information and projected information was provided for patients of North Shore Medical Group as required. Dr Ho (the medical director of this proposed facility) stated in part *“I have identified 179 patients from our NorthShore practice who are suffering from chronic kidney disease ("CKD") and reside within 5 miles of the proposed Sauganash Dialysis. Conservatively, I predict at least 61 of the 179 CKD patients will progress to dialysis within 12 to 24 months or completion of Sauganash Dialysis. Our (North Shore Medical Group) large patient base demonstrates considerable demand for this clinic.”*

The Applicants are projecting 61 patients will require dialysis within 12-24 months of the opening of the proposed facility [See 77 ILAC 1110.120 (b) above].

D) Criterion 1110.230 (b) (5) - Service Accessibility

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 shall document the following:

A) Service Restrictions

The applicant shall document that at least one of the following factors exists in the planning area:

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;
- v) For purposes of this subsection (b)(5) only, all services within the established radii outlined in subsection (b)(5)(C) meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.
 - i) There is no absence of ESRD services in the HSA VI ESRD Planning Area-City of Chicago. There are 68-ESRD facilities within this planning area with 1,349 stations.
 - ii) No Access limitations have been identified by the Applicants.
 - iii) No restrictive admission policies of existing providers have been identified.
 - iv) The proposed facility will be located in an area that has been Federally designated as a Medically Underserved Area and Medically Underserved Population.⁴
 - v) There are 14 ESRD facilities within the 5-mile radius with an average utilization of approximately 71%. Seven of the 14-ESRD facilities are not at the target occupancy of 80%.

Summary

There is a calculated need for 80 ESRD stations in this planning area by 2022. The Applicants have identified 179 pre-ESRD patients that reside within the HSA VI Planning Area and are estimating that 61 of these patients will need dialysis within two years after project completion. Based upon information that has been provided and reviewed; the Applicants have met the requirements of this criterion.

⁴ Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) identify geographic areas and populations with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a geographic area such as:

- a whole county;
- a group of neighboring counties;
- a group of urban census tracts; or
- a group of county or civil divisions.

MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services. These groups may face economic, cultural, or linguistic barriers to health care. Examples include, but are not limited to, those who are:

- homeless;
- low-income;
- Medicaid-eligible;
- Native American; or
- migrant farmworkers.

MUA/P designations are based on the Index of Medical Underservice (IMU). IMU is calculated based on four criteria:

- the population to provider ratio;
- the percent of the population below the federal poverty level;
- the percent of the population over age 65; and
- the infant mortality rates.

IMU can range from 0 to 100, where zero represents the completely underserved. Areas or populations with IMUs of 62.0 or less qualify for designation as an MUA/P. Source: Health Resources and Services Administration.

**TABLE FIVE
Facilities in the 5-mile GSA**

Facilities	City	Ownership	Stations (1)	Miles (2)	Patients (3)	Utilization (3)	Star Rating (4)	Met Target Utilization of 80%?
Center for Renal Replacement	Lincolnwood		16	1.7	54	56.25%	5	No
Fresenius Medical Care North Kilpatrick	Chicago	Fresenius	28	1.71	134	79.76%	4	No
Nephron Dialysis Ctr. Swedish Covenant	Chicago	Swedish	16	1.96	94	97.92%	5	Yes
Dialysis Ctr. of America - (Rogers Park)	Chicago	Fresenius	20	2.36	90	75.00%	4	No
Big Oaks Dialysis	Niles	DaVita	12	2.43	43	59.72%	4	No
Fresenius Medical Care Northcenter	Chicago	Fresenius	16	3.55	63	65.63%	5	No
Fresenius Medical Care of Lakeview	Chicago	Fresenius	14	3.94	62	73.81%	3	No
DaVita Evanston	Evanston	DaVita	20	3.86	109	90.83%	5	Yes
Logan Square Dialysis	Chicago	DaVita	28	4.08	137	81.55%	5	Yes
Fresenius Medical Care Logan Square	Chicago	Fresenius	14	4.23	68	80.95%	3	Yes
Fresenius Medical Care West Belmont	Chicago	Fresenius	17	3.67	84	66.67%	4	No
RCG - Uptown	Chicago	Fresenius	14	4.46	79	94.05%	3	Yes
Total/Average Utilization			215		1,017	76.75%		
Irving Park Dialysis	Chicago	DaVita	12	2.12	30	41.67%	NA	No
Norwood Park	Chicago	DaVita	14	4.24	24	28.57%	NA	No
Total/Average Utilization (all 14 facilities)			241		1,071	70.88%		

1. Stations as of September 2019
2. Miles determined by MapQuest
3. Patients as of June 30, 2019

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PLANNING AREA NEED (77 ILAC 1110.230 (b) (1) (2) (3) (5))

C) Criterion 1110.230(c) - Unnecessary Duplication of Service/Maldistribution

- 1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information:
 - A) A list of all zip code areas that are located, in total or in part, within the established radii outlined in subsection (c)(4) of the project's site;
 - B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and
 - C) The names and locations of all existing or approved health care facilities located within the established radii outlined in subsection (c)(4) of the project site that provides the categories of station service that are proposed by the project.

- A. A list of zip codes was provided at page 83 of the Application for Permit. There are approximately 1,060,059 residents within this 5-mile radius. There are 14 ESRD facilities within this 5-mile radius with 241 stations.
- B. There is one station per every 4,399 residents in the identified 5-mile GSA. In the State of Illinois there is one station per every 2,581 residents. There is not a surplus of stations in this 5-mile GSA when compared to the State of Illinois ratio. To be at the State Ratio there would have to be a total of 411 stations in this 5-mile GSA (1,060,059 residents ÷ 2,581 resident per station = 411 stations)

TABLE SIX		
Station to Population Ratio Analysis		
	5-mile GSA	State of Illinois
Stations	241	4,962
Population	1,060,059	12,802,100
Ratio	1 station per 4,399 residents	1 station per 2,580 residents

C. The Applicants stated the following:

“The proposed dialysis clinic will not have an adverse impact on existing clinics in the Sauganash GSA NorthShore Medical Group is currently treating 179 CKD patients within 3 miles of the proposed Sauganash Dialysis. Conservatively, based upon 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. Ho anticipates that at least 61 of these 179 patients will initiate in-center hemodialysis within 12 to 24 months following project completion. No patients are expected to transfer from existing dialysis clinics. b. The proposed dialysis clinic will not lower the utilization of other area clinics that are currently operating below HFSRB standards. As noted above, there are 14 existing or approved dialysis clinics within the Sauganash GSA. Excluding Irving Park Dialysis, which recently came online and is being developed to serve a different patient group, and the one nonreporting clinic, average utilization of area dialysis clinics

is 76.5% as of September 30, 2018. Further, over the past four years, patient census at the existing clinics has increased 3.3% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Accordingly, average utilization of the existing clinics is expected to reach 80% by the time the proposed Sauganash Dialysis becomes operational. Further, NorthShore Medical Group is currently treating 179 CKD patients within 3 miles of the proposed Sauganash Dialysis. Conservatively, based upon 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. Ho anticipates that at least 61 of these 179 patients will initiate incenter hemodialysis within 12 to 24 months following project completion. No patients are expected to transfer from existing dialysis clinics.”

The State Board received a letter opposing this project from the Center for Renal Replacement that stated in part *“I’m writing this letter in opposition of the proposed DaVita project, DaVita Sauganash Dialysis, Chicago. It is our contention that there are several dialysis facilities in the surrounding community that are operating below full utilization.”* [See letter at the end of this report.]

Summary

Unnecessary duplication of service or maldistribution of service is not defined in statute or rule. The Board is being asked to determine if there is an unnecessary duplication of service or maldistribution of service within the defined 5-mile GSA. To determine this, we have looked at the number of existing stations and the number of patients currently dialyzing in this 5-mile GSA as of June 30, 2019. We then determine the number of stations needed two years after project completion (2023) in this 5-mile GSA by using the historical growth in the number of patients in this planning area (3.10% annually). IDPH has estimated little or no growth in the population in the City of Chicago by 2022.

The 12 existing facilities can accommodate 15 of the 61 patients identified as needing dialysis by 2023 before reaching the target occupancy of 80%. The remaining two facilities are in ramp-up so it is unclear if these two facilities could accommodate additional patients. If the average growth (3.10%) in the number of dialysis patients continues there will be a need for 253 stations by 2023 (two years after project completion) in this 5-mile GSA.

Number of Stations Needed at 3.10% Growth by 2023 at 80% target occupancy					
Year	2019	2020	2021	2022	2023
Patients	1,071	1,105	1,140	1,176	1,213
Number of Stations needed at 80% based upon the 3.10% growth	224	231	238	245	253

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION/MALDISTRIBUTION (77 ILAC 1110.230(c)(1)-(3))

D) Criterion 1110.230(e) - Staffing

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and The Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

The proposed clinic will be staffed in accordance with all State and Medicare staffing requirements. The Medical Director is Louisa Tammy Ho, M.D. A copy of Dr. Ho's curriculum vitae has been provided as required. 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 clinic is in operation. All staff will be training under the direction of the proposed clinic's Governing Body, utilizing DaVita's comprehensive training program. A summary of the training program has been provided. Sauganash Dialysis will maintain an open medical staff. [Application for Permit pages 88-104]

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION STAFFING (77 ILAC 1110.230(e))

E) Criterion 1110.230 (f) - Support Services

An applicant proposing to establish an in-center hemodialysis category of service 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 have attested to the following:

- DaVita utilizes an electronic dialysis data system;
- Sauganash Dialysis will have available all needed support services required by CMS which may consist of clinical laboratory services, blood bank, nutrition, rehabilitation, psychiatric services, and social services; and
- Patients, either directly or through other area DaVita facilities, will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis. [Application for Permit pages 116-117]

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SUPPORT SERVICES (77 ILAC 1110.230(f))

F) Criterion 1110.230(g) - Minimum Number of Stations

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 12-station ESRD facility will be located in the Chicago-Naperville-Elgin, IL-IN-WI MSA. The Applicants have successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION MINIMUM NUMBER OF STATIONS (77 ILAC 1110.230(g))

G) Criterion 1110.230(h) - Continuity of Care

An applicant proposing to establish an in-center hemodialysis category of service shall 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.

A signed transfer agreement with NorthShore University HealthSystem - Evanston Hospital has been provided as required. Evanston Hospital has agreed to provide Emergency, In-Patient and Backup Support Services to the dialysis patients. The Hospital is approximately 7.5 miles from the proposed facility.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION CONTINUITY OF CARE (77 ILAC 1110.230(h))

H) Criterion 1110.230(i) - Relocation of Facilities

This criterion may only be used to justify the relocation of a facility from one location in the planning area to another in the same planning area and may not be used to justify any additional stations. A request for relocation of a facility requires the discontinuation of the current category of service at the existing site and the establishment of a new category of service at the proposed location. The applicant shall document the following:

- 1) That the existing facility has met the utilization targets detailed in 77 Ill. Adm. Code 1100.630 for the latest 12-month period for which data is available; and
- 2) That the proposed facility will improve access for care to the existing patient population.

The Applicants are proposing the establishment of a new facility and not relocating an existing facility. This criterion is not applicable to this project.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION RELOCATION OF FACILITIES (77 ILAC 1110.230(i))

I) Criterion 1110.230 (j) - Assurances

The applicant 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 Applicants have provided the necessary attestation at pages 116-117 of the Application for Permit.

**STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE
WITH CRITERION ASSURANCES (77 ILAC 1110.230(j))**

IX. Financial Viability

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 \$2,462,126 and a lease with a FMV of \$2,216,563. A summary of the financial statements of the Applicants is provided below. The Applicants have sufficient cash to fund this project.

TABLE SEVEN
DaVita Audited Financial Statements
Ending December 31st
(in thousands (000))

	2018	2017	2016	2015
Cash	\$323,038	\$508,234	\$674,776	\$1,499,116
Current Assets	\$8,424,159	\$8,744,358	\$3,994,748	\$4,503,280
Total Assets	\$19,110,252	\$18,948,193	\$18,755,776	\$18,514,875
Current Liabilities	\$4,891,161	\$3,041,177	\$2,710,964	\$2,399,138
LTD	\$8,172,847	\$9,158,018	\$8,944,676	\$9,001,308
Patient Service Revenue	\$10,709,981	\$9,608,272	\$9,269,052	\$9,480,279
Total Net Revenues	\$11,404,851	\$10,876,634	\$10,707,467	\$13,781,837
Total Operating Expenses	\$9,879,027	\$9,063,879	\$8,677,757	\$12,611,142
Operating Income	\$1,525,824	\$1,812,755	\$2,029,710	\$1,170,695
Net Income	\$333,040	\$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 \$2,462,126 and a lease with a FMV of \$2,216,563. The Applicants have qualified for the financial waiver⁵.

⁵ The applicant is NOT required to submit financial viability ratios if:

1. all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or
HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.
- 2) the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA) or its equivalent; or
HFSRB NOTE: MBIA Inc. is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.
- 3) the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.

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

X. 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 \$2,462,126 and a lease with a FMV of \$2,216,563. The lease is for 15 years at \$31.50/GSF per year for the first 5 years with a 10% increase every 5 years. [Application for Permit pages 29-39]

**TABLE EIGHT
Terms of Lease Space**

Premises	Approximately 7,067 GSF, 4054 W. Peterson Ave. Chicago, Illinois 60646
Landlord:	Rule Transfer II. Inc.
Tenant:	Total Renal Care, Inc. or related entity
Term:	15 Years with three five year options
Base Rent:	\$31.50/psf with 10% increases every 5 years
Provisions:	Triple-net: Maintenance, real estate taxes/assessments, insurance premiums, utilities. Following the first full calendar year, the controllable CAMIT expenses shall not increase more than 3% annually thereafter.

The Applicants attested:

“I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code§ 1120.140(a) that the total estimated project costs and related costs will be funded in total with cash and cash equivalents. Further, the project involves the leasing of a facility. The expenses incurred with leasing the facility are less costly than constructing a new facility.” [Application for Permit page 131-132]

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.

Table below details the ESRD cost per GSF for new construction based upon 2015 historical information and inflated by 3% to the midpoint of the construction. Additionally, Table details the cost per station based upon 2008 historical information and inflated by 3% to the midpoint of construction.

TABLE NINE Calculation of ESRD Cost per GSF						
Year	2015	2016	2017	2018	2019	2020
ESRD Cost Per GSF	\$254.58	\$262.22	\$270.08	\$278.19	\$286.53	\$295.13

Calculation of Moveable Equipment Cost per ESRD Station						
Year	2015	2016	2017	2018	2019	2020
Cost per Station	\$49,127	\$50,601	\$52,119	\$53,683	\$55,293	\$56,952

New construction and Contingencies total \$1,715,102 or \$242.69 per GSF ($\$1,715,102 \div 7,067 \text{ per GSF} = \242.69). This appears reasonable when compared to the State Standard of \$295.13 per GSF or \$2,085,684.

Contingencies total \$155,918 and are 10% of new construction costs of \$1,559,184. This appears reasonable when compared to the State Board Standard of 10% [$\$155,918 \div \$1,559,184 = 10\%$].

Architectural and Engineering Fees total \$127,206 or 7.41% of new construction and contingencies [$\$127,206 \div \$1,715,102 = 7.41\%$]. This appears reasonable when compared to the State Board standard of 9.81 % or \$168,252.

Movable or Other Equipment totals \$581,818 or \$48,485 per station [$\$581,818 \div 12 \text{ stations} = \$48,485 \text{ per station}$]. This appears reasonable when compared to the State Board Standard of \$56,952 per station or \$683,424.

TABLE TEN Equipment Costs	
Communications	\$105,157
Water Treatment	\$140,500
Bio-Medical Equipment	\$15,940
Clinical Equipment	\$196,824
Clinical Furniture/Fixtures	\$22,335
Lounge Furniture/Fixtures	\$3,855
Storage Furniture/Fixtures	\$6,862
Business Office Fixtures	\$35,645
General Furniture/Fixtures	\$36,500
Signage	\$18,200
Total	\$581,818

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 that 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 \$151.72 operating expense per treatment. The Board does not have a standard for this criterion.

THE 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 \$22.09 per treatment. The Board does not have a standard for this criterion.

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

Center for Renal Replacement, LLC

JAMES K. YEUNG, M.D.

7301 North Lincoln Avenue Suite 205
Lincolnwood, IL 60712

TEL (847) 675 5555

FAX (847) 675 7019

Email crr@core.com

August 6, 2019

Michael Constantino

Supervisor, Project Review Section

Illinois Department of Public Health

Health Facilities and Services Review Board 525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Letter of Opposition –(18-048 - DaVita Sauganash Dialysis, Chicago)

Dear Mr. Constantino-

My name is Ted Simmons, CEO and Facility Administrator at Center for Renal Replacement, LLC, located at 7301 N. Lincoln Avenue, Lincolnwood, IL 60712. I'm writing this letter in opposition of the proposed DaVita project, DaVita Sauganash Dialysis, Chicago. It is our contention that there are several dialysis facilities in the surrounding community that are operating below full utilization. The table below shows the surrounding dialysis centers, the % utilization, and distance from the proposed project.

Facility	Medicare #	Distance from proposed project	June 2019 % Utilization
Center for Renal Replacement, LLC	142663	2.2 Miles	53%
Davita- Big Oaks	142712	3.9 Miles	59%
FMC- North Kilpatrick	142501	2.5 Miles	79%
FMC- Rodgers Park	142522	3.3 Miles	75%
Nephron Dialysis Center	142600	2.8 Miles	97%

As you can see, our facility has the space and resources available to accommodate the needs of the population outlined in the proposed facility. Our independently owned and operated center provides a dialysis experience different from the large corporate facilities. It has a family atmosphere, and the emphasis is placed on quality patient care and not just filling empty dialysis chairs. Credentialing for additional nephrologists is very simple, and our patient intake process is handled quickly and efficiently. Our diverse patient care team speaks English, Cantonese, Hindi, Russian, Spanish, and Tagalog. We operate with state-of-the-art equipment and are able to offer the latest cutting edge FDA approved medications for our dialysis patient's safety and well-being.

Center for Renal Replacement has been in operation since January, 2005, never reaching full utilization. We are committed to continuing to provide and improve access to high quality health care services in the local community. The opening of the proposed DaVita facility will have a negative impact on our and surrounding centers, and we request its CON application not be approved.

Thank you for your consideration, and please reach out to discuss this matter further.

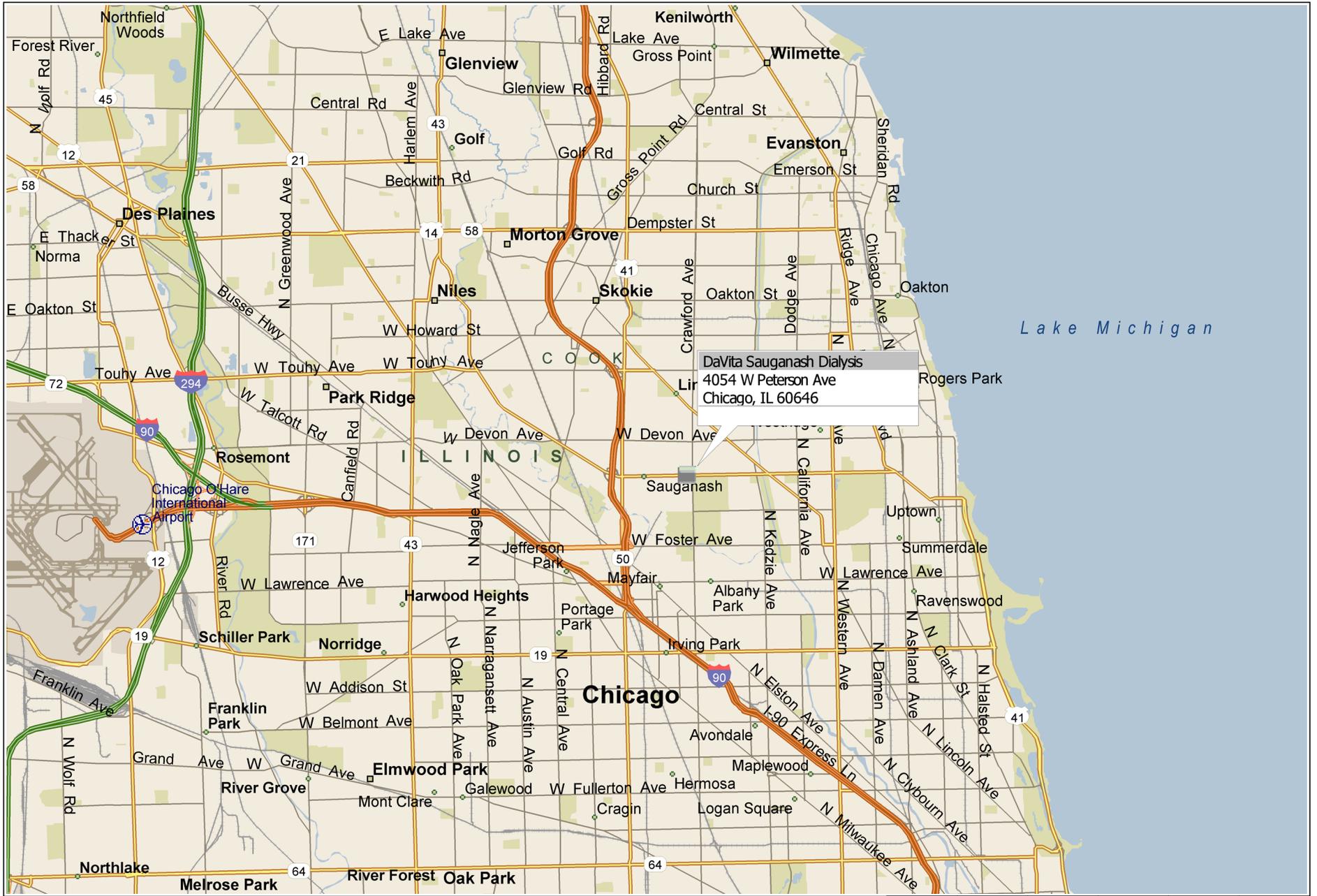
Sincerely,

A handwritten signature in black ink, appearing to read 'Ted Simmons', written in a cursive style.

Ted Simmons, CEO/Facility Administrator
Center for Renal Replacement, LLC
7301 N. Lincoln Avenue, Suite 205
Lincolnwood, IL 60712

847 675-5555
tsimmons@crrdialysis.com

18-048 DaVita Sauganash Dialysis - Chicago



Center for Renal Replacement, LLC

JAMES K. YEUNG, M.D.

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August 6, 2019

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Thank you for your consideration, and please reach out to discuss this matter further.

Sincerely,

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Ted Simmons, CEO/Facility Administrator
Center for Renal Replacement, LLC
7301 N. Lincoln Avenue, Suite 205
Lincolnwood, IL 60712

847 675-5555
tsimmons@crrdialysis.com

1 For all of these reasons, I ask that you
2 vote in favor of Project 18-044, the Illinois
3 Spine Institute.

4 Thank you so much for your time.

5 MS. MITCHELL: Thank you.

6 Next up for Project 18-048, Sauganash
7 Dialysis, Susan Griffin, Karen Seltzer, Ella Tate,
8 and Portia Randle.

9 Again, if you have written comments, if
10 you could please leave them at the table.

11 You may begin.

12 MS. GRIFFIN: Good morning. My name is
13 Susan Griffin, and I support the approval of
14 Sauganash Dialysis, Project 18-048.

15 I have Stage III kidney disease and Type 2
16 diabetes, which runs in both sides of my family.
17 I lost my mother to kidney failure, and other
18 family are on dialysis. They have transplants or
19 have suffered amputations from diabetes.

20 I started taking insulin eight years ago
21 and developed chronic kidney disease mainly from
22 uncontrolled diabetes and taking Advil to manage
23 the painful joint pain. Now I'm doing everything
24 I can to try to keep my kidney function at

1 Stage III.

2 While it is common to have both of these
3 ailments, having both has been a daily struggle
4 for me, and it's even harder if you need dialysis
5 and have to get to a clinic three times a week. A
6 big struggle is the cost of the drugs and supplies
7 for diabetes management. I take two kinds of
8 insulin. Basically, every time I eat I need it,
9 and I'm supposed to test my blood before or after
10 meals.

11 The insulin and the testing supplies are
12 very expensive. My insurance has a \$2700
13 deductible, so I pay out of pocket for these drugs
14 and supplies and doctors' visits every month for a
15 good part of the year. I make a living wage, but
16 this is hard to manage financially as a single
17 mother. People who are not well off cannot afford
18 these expenses and end up rationing their insulin
19 or testing far less than they should.

20 I have observed other family members
21 rationing their insulin and passing off medication
22 and supplies when a family member dies. I've
23 also seen them struggle with getting to the
24 dialysis clinic for their weekly care, which is

1 13 treatments a month.

2 Until we invest in a solution to these
3 problems, you're going to see demand for dialysis
4 grow. I urge you to approve the Sauganash
5 Dialysis to help serve patients who need dialysis
6 to live.

7 Thank you.

8 MS. RANDLE: I'm Portia Randle, supporting
9 Sauganash Dialysis, Project 18-048.

10 My uncle and grandmother are on dialysis.
11 I'm responsible for getting my grandmother to
12 dialysis every Monday, despite my busy -- a busy
13 job and the fact that I live on the far south side
14 of Chicago. I'm not close to my grandmother's
15 house nor her clinic.

16 We need better access to this care in
17 Chicago and a choice about what time of day she
18 gets treated as well as money. With stronger
19 disease indicators, including the older population
20 and obesity, new kidney failure patients are being
21 identified all the time.

22 Kidney failure is more common in Illinois
23 than any other state, yet access to such treatment
24 is in the bottom third of all states. In Illinois

1 obesity is at epidemic rates. 65 percent of
2 adults are overweight or obese. These stats are
3 expected to worsen as the population ages.

4 Food companies are partly to blame. They
5 heavily market cheap, addictive, high-calorie, and
6 nutrition-poor foods. This is how we put dinner
7 on the table, not to mention breakfast and lunch.

8 This problem is having major health
9 consequences. Specific to dialysis, being
10 overweight is a main risk factor for both disease
11 and hypertension or high blood pressure, which
12 both my uncle and my grandmother have.

13 Obesity is influenced by lifestyle,
14 genetic as well as dietary factors. There are
15 many social cues that encourage an unhealthy diet.
16 People love to eat and very few have the ability
17 to modify their behavior to avoid overeating and
18 to get the daily recommended exercise.

19 Outcomes are especially dire when diet and
20 lifestyle changes are recommended at earlier ages,
21 when people are very much set in their ways.

22 It does not help that the easiest way to
23 feed the family is to go through the drive-through
24 and to take advantage of cheap food alternatives.

1 Until we investigate a solution for this
2 problem, I believe that the demands will continue
3 to grow.

4 MR. ROATE: Two minutes.

5 MS. RANDLE: All right. I encourage you
6 to support the establishment of Sauganash
7 Dialysis.

8 MS. TATE: I am Minister Ella Tate. For
9 my mom and memory of my sister and on behalf of my
10 congregation and the rest of my family, I support
11 the Sauganash Dialysis Clinic.

12 Dialysis access is a personal matter to
13 me. My sister passed away from complications from
14 kidney failure, and my mom also has it. Today my
15 mom and my daughter's father are receiving
16 dialysis. It is a part of our daily lives.

17 My mother cannot afford to pay rides, and
18 we cannot get the State to process her Medicaid
19 application so we can have MediVan transport, so
20 my family works today together to help her to get
21 to her appointments. Coordinating this is hard.
22 I take Wednesdays off through unpaid family leave
23 to transport my mother. With three treatments a
24 week, others in my family also cover.

1 Transporting my mother for treatment takes
2 a toll on my family. Many aspects of our lives
3 are compromised, our livelihood, family time,
4 sleep, even our own health. I wake up at
5 4:15 a.m. every workday to meet my obligations.
6 On Wednesday I have to drive at least 45 minutes,
7 depending on the traffic, to pick up my mom and
8 then drive 20 minutes to get to her clinic that
9 has space for her.

10 I am not alone. These challenges face
11 everyone whose lives are impacted by kidney
12 failure. It is so important to have a good access
13 to dialysis close to home and the chair time that
14 works best for patients and for our family. For
15 me, I would -- really be great if I did have not
16 go so far. The area clinics are full and are
17 getting busier all the time, and this means more
18 traveling to get dialysis for patients. We must
19 have a better access.

20 I am here today because I faithfully serve
21 God's people through love, humility, and
22 empowerment of the Holy Spirit, and I ask that you
23 please approve the Sauganash Dialysis Clinic for
24 the betterment of my community.

1 Thank you.

2 MS. SELTZER: Good morning.

3 My name is Karen Seltzer, and I support
4 the establishment of the DaVita Clinic in Chicago,
5 Sauganash Dialysis.

6 Many of the patients who will receive care
7 from this clinic are from Albany Park where I grew
8 up. It's an incredibly diverse community that
9 lacks resources for health, education, wellness,
10 and healthy food.

11 There is no dialysis clinic here, and it
12 also lacks primary care services. It's designated
13 as a medically underserved community by the
14 Federal government.

15 I, myself, am working hard to make sure
16 that I never need dialysis, but I want to advocate
17 for those who do.

18 My father is a diabetic and certainly at
19 risk for kidney failure. I was diagnosed with
20 prediabetes, but I adopted a grain-free,
21 sugar-free lifestyle and lost 50 pounds. And my
22 A1C is now back under control, but I have to be
23 extremely careful about what I eat.

24 In past decades people didn't have access

1 to proper education about nutritional guidelines.
2 The food industry was in control of the
3 nutritional guidelines, and we were convinced that
4 a low-fat, high-carb, high-sugar, processed diet
5 was okay. In fact, the sugar industry worked hand
6 in hand with the NIH to validate this diet, so
7 because of that, diabetes is more prevalent today
8 than ever, obesity is at epidemic proportion, and
9 people have kidney disease because sugar's at the
10 root of this.

11 Kidney failure is disproportionately
12 affecting low-income families because affordable
13 meals are hard to manage. It's much easier to go
14 to McDonald's than it is to get a piece of grilled
15 fish and broccoli and it's much cheaper.

16 I know that we as a nation can swing out
17 of this health crisis, but we need a significant
18 investment in the wellness and nutrition --

19 MR. ROATE: Two minutes.

20 MS. SELTZER: -- and other primary care
21 initiatives which are currently lacking.

22 CHAIRMAN SEWELL: Please conclude your
23 remarks.

24 MS. SELTZER: Please approve the DaVita

1 Sauganash application to provide access to
2 community members who need the service.

3 Thank you.

4 MS. MITCHELL: Next up are speakers for
5 Project 18-042, Quincy Medical Group.

6 But before we begin with them, I want to
7 make sure that everybody who signed up to speak
8 for another project name has been called.

9 So is there anybody who signed up to speak
10 for another project whose name has not been
11 called?

12 (No response.)

13 MS. MITCHELL: Okay. Project 18-042,
14 Quincy Medical Group, please come up. Adam Booth,
15 John Simon, Jessica Frese, and Dr. Debra Phillips.

16 MR. BOOTH: My name is Adam Booth. I'm
17 here to oppose Project 18-042.

18 I've been a satisfied customer of QMG and
19 Blessing for the last 35 years. I haven't
20 experienced any issues at the current surgery
21 center in regards to their scheduling, costs, or
22 quality of care.

23 I have personally been involved in health
24 care construction projects for the last 20 years,

1 CHAIRMAN SEWELL: Okay. Now we have H-04,
2 Project No. 18-048, DaVita Sauganash Dialysis.

3 May I have a motion to approve this
4 project to establish a 12-station end-stage renal
5 disease facility in Chicago.

6 MEMBER DEMUZIO: Motion.

7 CHAIRMAN SEWELL: Is there a second?

8 MEMBER MURPHY: Second.

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

11 (Three witnesses sworn.)

12 THE COURT REPORTER: Thank you.

13 CHAIRMAN SEWELL: Could you identify
14 yourselves, please.

15 MS. FRIEDMAN: Good morning. I'm Kara
16 Friedman with Polsinelli, counsel for the
17 Applicant, DaVita and Sauganash Dialysis.

18 To my left is Gaurav Bhattacharyya; he's
19 the division vice president for DaVita; Dr. Tammy
20 Ho, who will be the medical director; she's with
21 NorthShore Medical Group; and my colleague
22 Anne Cooper.

23 CHAIRMAN SEWELL: State agency report.

24 MR. CONSTANTINO: Thank you, sir.

1 The Applicants propose a 12-station ESRD
2 facility in approximately 7100 gross square feet
3 of leased space in Chicago, Illinois.

4 The cost of the project is approximately
5 \$4.7 million, and the expected completion date is
6 April 30th, 2021. We had two findings related to
7 this project, planning area need and unnecessary
8 duplication of service.

9 Thank you, sir.

10 CHAIRMAN SEWELL: Thank you.

11 Do you have a presentation for the Board?

12 MS. FRIEDMAN: Yes.

13 MR. BHATTACHARYYA: Yes, we do. Good
14 afternoon.

15 My name is Gaurav Bhattacharyya. I'm
16 division vice president for DaVita here in
17 Chicago. With me is Dr. Tammy Ho, who is part of
18 the NorthShore University Health System medical
19 group and the planned medical director for our
20 facility, as well as our CON attorneys Kara
21 Friedman and Anne Cooper.

22 So DaVita's plan for dialysis services on
23 the northwest side of Chicago has received support
24 from the ward's aldermen, Senator Durbin, State

1 Representative D'Amico, and from other community
2 members.

3 I'd also like to thank Ms. Griffin,
4 Ms. Randle, Ms. Seltzer, and Minister Tate for
5 traveling here today to support this planned
6 clinic, as you heard from them this morning.
7 Their lives are all directly affected by kidney
8 disease and its comorbidities, and we appreciate
9 that this forum provides them a voice and a face.

10 I'd also like to thank the Board staff for
11 a generally positive report. Anne and Kara will
12 discuss those specifics in a little bit.

13 Importantly, this planned clinic will
14 serve a community which is federally designated as
15 both a medically underserved area and a medically
16 underserved population. These designations are
17 described at the bottom of page 11 of the staff
18 report. Relatedly, it will address your current
19 identified need for stations in the planning area.
20 As your staff report notes, this is a nonopposed
21 project.

22 I'd just like to spend a little bit of
23 time talking about the socioeconomic challenges in
24 this part of Chicago. As you know, Chicago has

1 general socioeconomic challenges and associated
2 health care disparities.

3 Despite having several nationally
4 recognized tertiary care centers like the
5 University of Chicago, Northwestern, Rush, in many
6 neighborhoods such as the one we're proposing to
7 build this clinic, there's scarce access to
8 primary care for disease screening and management
9 of chronic disease.

10 As you know, those living in poverty
11 receive the least amount of health care and are
12 less likely to have a family physician for
13 preventive care and have relatively more
14 difficulty navigating their health care system.

15 All these factors contribute to higher
16 incidence and prevalence of chronic disease,
17 including diabetes, hypertension, and kidney
18 disease.

19 I'd also like to describe the challenges
20 that we and other providers face in identifying
21 and securing appropriate real estate in the city
22 of Chicago.

23 I mention this because, while it could
24 have theoretically -- we theoretically could have

1 delayed consideration of this clinic until
2 Governor Pritzker filled the vacancies, presumably
3 next month or the month after, we're here today to
4 move forward so that we don't jeopardize the site
5 that we have secured. We would need unanimous
6 approval today to avoid that delay that could
7 jeopardize that real estate arrangement.

8 For well over a year, DaVita has worked to
9 identify or go under contract for a site for this
10 clinic. Not only is the real estate market tight,
11 but the site parameters for our dialysis
12 facilities eliminate many locations that would be
13 acceptable for other types of businesses.

14 Typically we prefer to rent a space in an
15 existing building, but in locating a site for this
16 clinic, we encountered the typical small city
17 parcels, third or fourth generation dilapidated
18 and/or multitenant mixed-use buildings that were
19 not appropriate for a site of health care.

20 So to accommodate the requirements for
21 this clinic, we were required to shift to a
22 ground-up construction format. Building ground-up
23 will ensure a high quality building with the
24 support space we need to accommodate patients,

1 supply deliveries, and some staff and patient
2 parking.

3 While we have lost sites in the past due
4 to aldermanic privilege, fortunately, in this
5 case, we are appropriately zoned and have the
6 blessing of Alderman Laurino, who provided a
7 letter of support for this project.

8 If we would not get approved today, we
9 would likely need to give up the site due to the
10 landlord wanting to use the space for another
11 purpose. And given the difficulty of securing a
12 site that fits the needs of a dialysis clinic in
13 this neighborhood, it is unlikely that DaVita or,
14 frankly, any other dialysis provider would be able
15 to put up a clinic in the near future to serve the
16 patients in this neighborhood where the care is
17 much needed.

18 With that, I'd like to introduce Dr. Ho,
19 who's taken time out of her clinic schedule to be
20 here today to discuss her patients and the
21 importance of this planned clinic to those
22 individuals.

23 DR. HO: Good afternoon.

24 My name is Dr. Tammy Ho.

1 MS. AVERY: Hold on a second.

2 DR. HO: Hello? Good.

3 My name is Dr. Tammy Ho. I'm a practicing
4 nephrologist from NorthShore University
5 HealthSystems. I've been practicing for about
6 20 years, and I care for patients -- sorry.

7 I care for patients who have a wide range
8 of adversity. There are socioeconomic ranges,
9 educational ranges, as well as cultural ranges,
10 and they come from as far south as Hyde Park, as
11 far north as Waukegan, and I also have a few
12 patients that travel from DeKalb to come see us in
13 NorthShore, as well.

14 This proposed clinic will provide
15 much-needed continuity of care as well as being a
16 really essential part of their management of their
17 chronic kidney disease.

18 The division of kidney disease at
19 NorthShore philosophically really believes in an
20 integrative and a collaborative kind of format to
21 caring for their patients who have kidney disease.

22 We know that kidney disease does not occur
23 in a vacuum. It occurs as a result of the
24 intersection of a multitude of very complex

1 diseases, so we believe that integrating our
2 management of our patients with that of cardiology
3 at NorthShore, which manages the heart disease;
4 endocrinology, which manages their diabetes;
5 neurology, which manages, you know, stroke risk,
6 post-surgical care, and lots of other
7 specialists -- we believe that that's very
8 important to managing the whole patient and
9 actually has better outcomes.

10 But, also, we really feel really strongly
11 that patient engagement and patient education is
12 like critical to the success of any kind of
13 management program that we have. We also really
14 believe that chronic kidney disease is a continuum
15 and that dialysis, whatever form it takes --
16 outpatient, you know, dialysis, outpatient home
17 dialysis -- is just one part of that continuum.

18 Now, ideally, I'd like to meet patients
19 early in the course of their kidney disease, but
20 the reality is that many patients have their first
21 contact point with a kidney specialist when
22 they're transitioning to dialysis, and this is
23 probably the most terrible time in which to meet a
24 patient like this. They're in shock because

1 they've never heard this diagnosis before; they
2 don't feel good; they don't think straight because
3 all the waste products from a nonfunctioning
4 kidney actually impair their ability to process
5 information.

6 So it becomes really important and really
7 difficult at that time to engage them, to educate
8 them, and to make sure that they understand the
9 choices and their role in their own care, and that
10 has to take place at the dialysis clinics. And so
11 our division's philosophy is also that the
12 initiation of dialysis is not the end of the care
13 of their kidney disease.

14 So if you look at this proposed clinic
15 specifically, the area surrounding the clinic
16 actually serves a -- has a very diverse
17 demographic makeup, predominantly minority. And
18 as Gaurav has already said, it is a population
19 that is medically underserved, and, by inference,
20 that means that access to care is limited, access
21 to care of medical problems in general and
22 dialysis management in specific.

23 As well, the need for a dialysis clinic,
24 I think, is there. Even though the population

1 growth in the city of Chicago's relatively flat,
2 there's an increasing incidence of diabetes and
3 hypertension, which is not different than across
4 the country, and those things, diabetes and
5 hypertension, are the number one cause of kidney
6 disease, and uncontrolled diabetes and
7 uncontrolled hypertension is the number one cause
8 of progressive kidney disease leading to dialysis.

9 So in terms of access, general access, if
10 you don't access care, you can't take care of
11 diseases. If you don't take care of diseases, the
12 diseases get worse more rapidly and lead to more
13 catastrophic outcomes, and it ends up being
14 terrible for everybody, terrible for the patient
15 because they are not able to be fully functional
16 members of their community. They can't go to
17 school; they can't take care of their family; they
18 can't go to work. It's also terrible for our
19 health systems because it's expensive. The cost
20 is high for more intensive care when the disease
21 complications are worse. It's more costly because
22 of hospitalizations.

23 Now, in terms of access specifically in
24 terms of dialysis clinics, it makes a real

1 difference where the dialysis clinic is
2 geographically. Dialysis patients don't feel
3 good. They take multiple medications. They have
4 multiple physicians. They go to the hemodialysis
5 three times a week, oftentimes for four hours each
6 session. So if they have to travel via public
7 transportation for a long distance or they have no
8 way to get to the dialysis unit consistently, it
9 makes it really hard for them to get the dialysis
10 and get the care that they need.

11 As Ms. Tate and Ms. Randle presented in
12 the patient commentary earlier today, it's a real
13 barrier to the delivery of the dialysis care, and
14 as a result, patients don't get care for their
15 hypertension, they don't get care for their
16 cardiac disease, their bone disease, their anemia,
17 and they just actually are far worse off in terms
18 of a medical standpoint.

19 And it's been thought that their mortality
20 doubles if they don't present to dialysis
21 consistently, and they're 40 percent more likely
22 to end up hospitalized.

23 Now, DaVita and NorthShore have been in a
24 working relationship for a number of years. We

1 have successfully entered into a number of
2 outpatient hemodialysis units and outpatient home
3 dialysis units, and we've been able to provide,
4 I think, good care for our patients, educating
5 them and treating them.

6 NorthShore also has expressed an interest
7 in expanding their urgent care and primary care
8 facilities in this surrounding region, as well, to
9 help support the dialysis patients.

10 So thank you for listening to me, and
11 I hope that you will look upon this request
12 positively. I think it will do a lot for the
13 continuity of the care of these patients in this
14 area and also to providing greater access to them
15 for the care that they need.

16 Thank you very much.

17 MS. FRIEDMAN: Thank you, Dr. Ho. Now,
18 I've been working with dialysis clinics for a long
19 time, but I'm not in the trenches, and you see
20 things every day that really help to educate me
21 about what we're working towards accomplishing.
22 So thank you.

23 Just a few comments on the staff report,
24 and I'll try to be brief.

1 Just to be clear -- so there's a need for
2 five stations according to your calculations that
3 were based on the 2015 data.

4 And as you probably know, you typically
5 see clinics being developed with the size of
6 12 stations or chairs. Pursuant to your rules,
7 the minimum size for a dialysis clinic in the city
8 of Chicago and any other metropolitan statistical
9 area is eight stations.

10 From the DaVita perspective, except in
11 circumstances of very rural areas, they're always
12 going to do at least 12 stations from a staffing
13 and operational perspective and, also, to ensure
14 that you have more dialysis clinics spread out
15 amongst multiple neighborhoods.

16 And if we get this clinic approved, there
17 will be 1357 stations in the city of Chicago.
18 That's a like .05 percent deviation from your
19 technical need determination that you have, and as
20 we'll show you in a moment, we do believe that
21 that need is understated when we use the more
22 current 2017 use data that the agency's produced.

23 Anne, did you want to get the visuals in?

24 Just to confirm for you, Ms. Mitchell,

1 this data has been submitted as part of our
2 application.

3 So this map represents Dr. Ho's CKD
4 patient referral data, and it's shaded to document
5 how many patients are coming from the zip codes
6 near the clinic. The darker the shade, the more
7 patients are coming from that zip code.

8 In metro Chicago as a whole, there's a
9 general expectation that patients will come from a
10 5-mile driving radius through -- here, though, in
11 the city where the population is more dense, we
12 have a more compressed patient service area, and
13 the circle that you see in this area only
14 represents a 3-mile radius. So we're happy to say
15 the patients that receive the services will be
16 receiving them very close to home. So the site is
17 we think a very good site for this patient base.

18 (Telephone interruption.)

19 MS. FRIEDMAN: What song was that?

20 MEMBER MC NEIL: That wasn't for the
21 chart.

22 (Laughter.)

23 MEMBER MC NEIL: I can't read it.

24 MS. FRIEDMAN: So, also for key importance

1 in terms of internal planning at DaVita as well as
2 documenting the need based on Board
3 considerations, we reviewed the data which
4 underlies the Board's current station need
5 calculation. And as we said before, that's based
6 on 2015 use data and the associated trends from
7 2013 to 2015.

8 We updated that data based on more current
9 data, and we found the Board calculation
10 underrepresents demand because it predicted that
11 there would be zero growth in dialysis patients in
12 the city of Chicago, and that prediction did not
13 bear out based on the growth that the city of
14 Chicago saw from 2015 to 2017.

15 We recently learned that there's only a
16 single demographer engaged by the State of
17 Illinois to fulfill all the forecasting
18 requirements of State agencies, so this limits the
19 State's resources to stay up-to-date with these
20 calculations, but, fortunately, the data needed
21 for the calculation is collected more frequently
22 by this agency, so we were able to calculate the
23 figure based on the 2017 data.

24 And I'm going to let Anne go over that

1 based on the document that she's showing you as a
2 visual here.

3 MS. COOPER: So the first column to the
4 right, which is the actual Board staff
5 calculation, it shows that the -- this is the
6 planning area -- or the planning area population
7 estimates of 2015, which is about 2.7 million.
8 The number of end-stage renal patients as of
9 December 31st, 2015, was about 4900.

10 And as you can see, the projected
11 population for -- or projected number of patients
12 for 2020 remained flat at 4886 based upon the
13 Board's calculation, their calculated need for
14 five stations for HSA 6, which is the Chicago --
15 city of Chicago.

16 This middle column is actually the revised
17 need calculation, just -- the only variable that
18 changed was the number of in-station patients or
19 in-station -- in-station ESRD patients as of
20 12/31/2017.

21 And as I mentioned and Kara mentioned, as
22 well, the Board staff calculation projected no
23 growth from 2015 to 2020. What we found was there
24 were actually 5,004 patients as of 12/31/2017, so

1 that increased the use rate from 1.91 to 1.95.
2 And because of that, all the other calculations
3 are the same calculations that are defined in the
4 Board's rules. We came up with a need for
5 39 stations in the planning area.

6 And, also, we looked at just the
7 incremental growth between 2015 and 2017, and
8 there were 118 new patients, which would justify,
9 based upon 80 percent utilization, a need for
10 25 stations.

11 The third column is the 2020 projected
12 number, and that's based upon looking at the
13 growth from 2015 and 2017 and projecting that all
14 the way forward to 2020. And, basically, what
15 we've projected was, assuming the growth stays the
16 same, there would be 5,188 patients in 2020.

17 And based upon that, we're calculating a
18 need for 89 stations. And once again, just that
19 incremental growth between 2015 and what we're
20 projecting as far as 2020, we're projecting
21 there's a need for another 63 stations, assuming
22 those stations would be operating at 80 percent
23 utilization.

24 MS. FRIEDMAN: Finally, the last comment

1 that I wanted to note about the Board staff report
2 is that in the executive summary, as you can see
3 on the second page, area clinics are averaging
4 79 percent utilization, which means they're
5 effectively operating at target currently. And
6 with the growth trend that we see, we know that
7 these clinics will be operating above target
8 next year and into the future when this clinic
9 comes online.

10 So thank you for your time. We're happy
11 to answer questions.

12 MS. MITCHELL: I just want to make a quick
13 comment that the Board is compelled to consider
14 the need figures in the rules that's set forth in
15 the State Board staff report.

16 CHAIRMAN SEWELL: Do Board members have
17 comments or questions?

18 Yes, sir.

19 MEMBER MC NEIL: Well, it's interesting
20 because it's a four-hour procedure. So one chair,
21 if you operate, really can do two to three
22 patients a day three times a week.

23 And the issue that comes up many times are
24 patients are assigned at 6:00 in the morning or

1 6:00 in the evening to 10:00 p.m. So in one
2 sense, utilization is an interesting figure
3 because you really would like a more convenient
4 schedule.

5 And the question I always have -- once
6 someone goes on dialysis, the average lifespan is
7 five years. The only solution is a kidney
8 transplant. That's 3.1 years, average. It
9 doesn't mean everybody dies at five years but --
10 50 percent. And we could look at standard
11 deviations and distributions, that kind of thing.

12 And I always ask the question, how quickly
13 do you start recommending -- and you mentioned it
14 with the hospitals -- getting them into the
15 line to get in shape to get a kidney transplant?

16 DR. HO: So there's a lot of factors that
17 go into that. One is as you're meeting the
18 patient for the first time, when you talk about
19 kidney disease, they're a little bit uncertain
20 about what they're hearing, so I've learned that
21 it's best to first develop a relationship with the
22 patient, begin their care process, and begin
23 outlining to them the options that are available
24 to them.

1 We do provide a very robust education --
2 patient education system that is offered
3 one-to-one or in a group setting where they can
4 listen to other people ask questions that they may
5 not have thought about. The transplant and also
6 the choice of not doing dialysis at all are both
7 addressed very clearly with the patient so -- and
8 multiple times. Sometimes you can't hear the
9 first time; you need to maybe approach it as you
10 approach the need for dialysis over time.

11 MEMBER MC NEIL: Okay.

12 CHAIRMAN SEWELL: Other questions or
13 comments?

14 (No response.)

15 CHAIRMAN SEWELL: Roll call.

16 MR. ROATE: Thank you, sir.

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

19 Senator Demuzio.

20 MEMBER DEMUZIO: I vote yes based upon the
21 very thorough testimony I've heard today.

22 MR. ROATE: Thank you.

23 Mr. McGlasson.

24 MEMBER MC GLASSON: I vote yes based on

1 the testimony.

2 MR. ROATE: Thank you.

3 Dr. McNeil.

4 MEMBER MC NEIL: I vote yes based on the
5 report supplemented by the testimony and comments
6 made.

7 MR. ROATE: Thank you.

8 Ms. Murphy.

9 MEMBER MURPHY: I'm going to vote yes
10 based on the report and today's very helpful
11 testimony.

12 MR. ROATE: Thank you.

13 Chairman Sewell.

14 CHAIRMAN SEWELL: I vote no based on the
15 State agency report.

16 MR. ROATE: That's 4 votes in the
17 affirmative, 1 vote in the negative.

18 MS. FRIEDMAN: Thank you.

19 MS. COOPER: Thank you.

20 CHAIRMAN SEWELL: Next --

21 MS. MITCHELL: Sorry. You've received an
22 intent to deny. You'll have another opportunity
23 to come before the Board and present additional
24 information.

