



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: I-01	BOARD MEETING: June 30, 2020	PROJECT NO: 19-015	PROJECT COST:
FACILITY NAME: Dialysis Care Center Chicago Heights		CITY: Chicago Heights	Original: \$2,558,925
TYPE OF PROJECT: Substantive			HSA: VII

PROJECT DESCRIPTION: The Applicants (Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights, LLC) propose to establish a 14-station ESRD facility in Chicago Heights, Illinois. The cost of the project is \$2,558,925 and the expected completion date is May 31, 2021.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants (Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights, LLC) propose to establish a 14-station ESRD facility in Chicago Heights, Illinois. The cost of the project is \$2,558,925 and the expected completion date is May 31, 2021.
- This project received an Intent to Deny at the September 2019 State Board Meeting. The Applicants modified this project by stating that they will be using eight of the 14 requested stations as transitional care stations.¹ The Board Staff did not consider this modification a Type A modification because it did not meet the requirements of 77 ILAC 1130.650. This modification did not change any of the findings from the Original State Board Report.
- **Transitional care units/stations** are described as an innovative model designed to gently transition patients into the dialysis modality best suited to their individual clinical and lifestyle needs. Patients for a transitional start unit can include those new to dialysis; those who have already failed at PD or HHD at home; failed transplant patients; and acute renal failure patients who do not know if they will need outpatient dialysis. The physician, nurse, dialysis administrator, or patient cannot avoid starting in this unit unless the patient has decided to do PD or HHD or is medically or mentally unstable. The reason for starting all the patients in the transitional start unit is so all patients receive appropriate education about modality options. Easing patients into dialysis and educating them on their modality choices can help them make informed decisions that meet their clinical and quality of life goals. Using existing center staff and infrastructure, transitional care provides the opportunity of expanding home hemodialysis (HHD), in-center dialysis (ICHD), and peritoneal dialysis (PD) programs. (Source: National Kidney Foundation).
- The transcript from the September 2019 State Board Meeting, the additional information provided by the Applicants and the opposition letter are attached to the end of this report.

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. **No letters of support** were received by the State Board Staff.
- Letters of opposition was received from DaVita Inc. that stated in part *“there is no need for the Proposed Facility in the DCC Chicago Heights geographic service area or in the planning area*

¹ Section 1130.650 - Modification of an Application

a) Modifications to an application are allowed during the review period, prior to final HFSRB decision. Modifications (as defined in Section 1130.140) shall be classified as Type A or Type B. Type A modifications shall be subject to the public hearing requirements of the Act. If requested, a hearing would occur within the time allocated for HFSRB staff review. Type A modifications consist of any of the following:

- 1) A change in the number of beds proposed in the project.
- 2) A change in the project site to a new location within the planning area. A change in site to a location outside the planning area originally identified in the application is not considered a modification. It voids the application.
- 3) A change in the cost of the project exceeding 10% of the original estimated project cost.
- 4) A change in the total gross square footage (GSF) of the project exceeding 10% of the original GSF.
- 5) An increase in the categories of service to be provided.
- 6) A change in the person who is the applicant, including the addition of one or more co-applicants to the application.
- 7) Any modification to a project, including modifications specified in subsections (a)(1) through (a)(6), that, by itself, would require a certificate of need (CON) permit or exemption.

as a whole. HSA 7 has an excess of 56 stations, the second largest excess in the State. Of the ten dialysis facilities within five miles of the proposed facility site, only one exceeds the Illinois Health Facilities and Services Review Board's ("State Board") target utilization of 80%."

SUMMARY:

- The State Board has estimated **an excess of 128-stations in the HSA VII ESRD Planning Area**² by 2022. The Applicants have identified 110 pre-ESRD patients that reside within the 5-mile GSA. Of these 110 pre-ESRD patients the Applicants believe 77 will require dialysis within 2 years after project completion. There are nine facilities within the 5-mile GSA. These nine facilities are operating at an average utilization of 63%. One of the eight facilities (DCC Olympia Fields, LLC) is at target occupancy. The ratio of stations to population in this 5-mile GSA currently denotes a surplus of stations in this 5-mile area.
- The Applicants have two facilities within this 5-mile GSA. DCC Olympia Fields is at approximately 98% utilization as of March 31, 2020. DCC Hazel Crest with 12-stations is operating at approximately 44% as of March, 31,2020.
- The Applicants believe the alternative of utilizing a DaVita or a Fresenius facility in the 5-mile GSA is not a viable option because these facilities are not physician owned where the physicians have the independence they need to improve quality indicators set by the Board's quality criteria.

Criterion	Reasons for Non-Compliance
77 ILAC 1110.230 (b) – Planning Area Need	The State Board has estimated <u>an excess of 128-stations</u> in the HSA VII ESRD Planning Area by 2022. There are nine facilities within the 5-mile GSA operating at an average of 63% occupancy. With the excess stations in the ESRD planning area and the number of facilities (8 of 9 facilities) not at target occupancy patients and accessibility can be accommodated with the existing facilities and will not be improved with the addition of these 14-stations at this time.
77 ILAC 1110.230 (c) – Unnecessary Duplication of Service/Maldistribution	There are nine facilities in the GSA operating at approximately 63% occupancy. One of the nine facilities is at target occupancy of 80% in this 5-mile GSA. The ratio of stations to population within the 5-mile GSA denotes a surplus of stations currently in this area. The additional 14-stations will result in unnecessary duplication of service and maldistribution of service at this time.

² This excess of stations is the result of an estimated decrease in the population in Suburban Cook and DuPage County (HSA VII) of approximately 10% or approximately 331,000 residents for the period 2017-2022. The usage rate increased by approximately 8% (*number of patients ÷ 2017 estimated population.*) over this same period.

STATE BOARD STAFF REPORT
Project 19-015
Dialysis Care Center Chicago Heights

APPLICATION/CHRONOLOGY/SUMMARY	
Applicants	Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights LLC
Facility Name	Dialysis Care Center Chicago Heights LLC
Location	222 Vollmer Road 1 st Floor, Chicago Heights, Illinois
Permit Holder	Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights LLC
Operating Entity	Dialysis Care Center Holdings, LLC
Owner of Site	Meridian Investments Partners, LLC
Total GSF	7,280 GSF
Application Received	March 22, 2019
Application Deemed Complete	March 27, 2019
Review Period Ends	July 15, 2019
Financial Commitment Date	August 6, 2021
Project Completion Date	May 31, 2021
Review Period Extended by the State Board Staff?	No
Can the Applicants request a deferral?	Yes
Expedited Review?	No

I. Project Description

The Applicants (Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights LLC) propose to establish a 14-station ESRD facility in Chicago Heights, Illinois. The cost of the project is \$2,558,925 and the expected completion date is May 31, 2021.

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 appears to be in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

The Applicants are Dialysis Care Center Holdings, LLC and Dialysis Care Center Chicago Heights LLC. These two entities are owned equally by Morufu Alausa M.D. (50%) and Sameer M. Shafi M.D (50%). Financial commitment will occur after permit approval. Dialysis Care Center Holdings, LLC has been approved for a total of seven ESRD facilities in Illinois and has one outstanding permit.

#18-019 – DCC Evergreen Park, construction ongoing

IV. Health Planning Area

The proposed facility will be in the HSA VII ESRD Planning Area. HSA VII ESRD Planning area includes DuPage and Suburban Cook County. As of May 2020, there is a **calculated excess of 128 ESRD stations** in this planning area.

TABLE ONE	
Need Methodology HSA VII ESRD Planning Area	
Planning Area Population – 2017	3,424,900
In Station ESRD patients -2017	5,433
Area Use Rate 2017 ⁽¹⁾	1,586.324
Planning Area Population – 2022 (Est.)	3,094,300
Projected Patients – 2022 ⁽²⁾	4,908.6
Adjustment	1.33
Patients Adjusted	6,528
Projected Treatments – 2022 ⁽³⁾	1,018,428
Calculated Station Needed ⁽⁴⁾	1,360
Existing Stations	1,488
Stations in Excess 2022	128
<ol style="list-style-type: none"> 1. Usage rate determined by dividing the number of in-station ESRD patients (2017) in the planning area by the 2017 – planning area population per thousand. 2. 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. 3. Projected treatments are the number of patients adjusted x 156 treatments per year per patient 4. $1,018,428/747 = 1,360$ 5. $936 \times 80\% = 747$ [Number of treatments per station operating at 80%] 	

V. Project Costs and Sources of Funds

The Applicants are funding this project with cash in the amount of \$1,678,685 and the fair market value of a lease (FMV) of \$880,242. The estimated start-up costs and operating deficit is \$930,873.

TABLE TWO			
Project Costs and Sources of Funds			
Uses of Funds	Reviewable	Total	% of Total
Modernization	\$1,094,986	\$1,094,986	42.79%
Contingencies	\$87,599	\$87,599	3.42%
Architectural/Engineering Fees	\$45,000	\$45,000	1.76%
Movable or Other Equipment	\$451,100	\$451,100	17.63%
Fair Market Value of Leased Space or Equipment	\$880,242	\$880,242	34.40%
Total Uses of Funds	\$2,558,927	\$2,558,927	100.00%
Sources of Funds	Reviewable	Total	% of Total
Cash and Securities	\$1,678,685	\$1,678,685	65.60%
Leases (fair market value)	\$880,242	\$880,242	34.40%

TABLE TWO Project Costs and Sources of Funds			
Uses of Funds	Reviewable	Total	% of Total
Total Sources of Funds	\$2,558,927	\$2,558,927	100.00%

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

A) Criterion 1110.110 (a)(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 they own or operate.

The Applicants have attested that there has been no adverse action taken against any of the facilities owned or operated by the Applicants and 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. [Application for Permit page 92-93] Certificates of Good Standing have been provided for both Applicants as required at pages 27 and 29 of the Application for Permit. The site is owned by Meridian Investment Partners, LLC. The Applicants provided evidence that the site is not in a Special Flood Hazard Area in compliance Executive Order #2006-05 that requires *all State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas⁴ 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.* The proposed location of the ESRD facility is in compliance with the Illinois State Agency Historic Resources

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)

⁴ **Special Flood Hazard Area (SFHA) Definition** A term used by the Federal Emergency Management Agency (FEMA) in the National Flood Insurance Program (NFIP) to refer to the land area covered by the floodwaters of the base or 100-year flood (an area of land that has an approximate 1 percent probability of a flood occurring on it in any given year). <https://www.fema.gov/special-flood-hazard-area>

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).

B) Criterion 1110.110 (b) – 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.

The Applicants addressed this criterion at pages 94-104 of the Application for Permit. The purpose of the project is for the facility to provide improved access for life-sustaining dialysis patients in the Chicago Heights and the Cook County market. The proposed geographical service area for this project is a 5-mile radius from the proposed location of the facility. There are approximately 262,000 residents within this 5-mile radius.

C) Criterion 1110.110(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]

“The establishment of Dialysis Care Center Chicago Heights will not have any impact on safety net services in the Chicago Heights area. Outpatient dialysis facilities services are not typically considered or viewed as “safety net” services. As a result, the presence of Dialysis Care Center Chicago Heights as a provider is not expected to alter the way any other healthcare providers function in the community. Dialysis Care Center Chicago Heights has no reason to believe that this project would have any adverse impact on any provider or health care system to cross-subsidize safety net services. Dialysis Care Center Chicago Heights will be committed to providing ESRD services to all patients with or without insurance or patients to no regards for source of payment. Dialysis Care Center Chicago Heights will not refuse any patients. Medicaid patients wishing to be served at Dialysis Care Center Chicago Heights will not be denied services. Because of the Medicare guidelines for qualification for ESRD, a few patients with ESRD are left uninsured for their care.”

“The policy of Dialysis Care Center Chicago Heights is to provide services to all patients regardless of race, color, national origin. Dialysis Care Center Chicago Heights will provide services to patients with or without insurance and as well as patients who may require assistance in determining source of payment. Dialysis Care Center will not refuse any patient. Medicaid patients wishing to be served will not be denied services. Through Medicare guidelines, patients who are prequalified for ESRD or for the few that are currently ESRD status and are left uninsured, Dialysis Care Center will be committed to providing continued care. Dialysis Care Center Chicago Heights will be committed to work with any patient to try and find any financial resources and any programs for which they may qualify for. Dialysis Care Center will be an "open dialysis unit" meaning through our policy, any nephrologist will be able to refer their patients and apply for privileges to round at the facility, if they desire. Dialysis Care Center will participate in

American Kidney Fund (AKF) to assist patients with insurance premiums which will be at no cost to the patient. Currently as Dialysis Care Center Chicago Heights will be a new entity there is no current Charity documentation that can be provided to the board, however the Charity policy is attached.” [Application for Permit pages 107-108]

DCC Holdings, LLC first dialysis facility was approved in 2016 and became fully operational in 2018.

Safety Net Information DCC Holdings, LLC (For Operating ESRD Facilities)	
CHARITY CARE (self-pay)	2018
Revenue	\$1,254,657
Self-Pay Charity Care #	19
Total Charity (cost in dollars)	\$44,055
MEDICAID	
Medicaid (number of patients)	31
Out-Patient Only	\$220,715

D) Criterion 1110.110(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 stated “*the only option other than what was proposed in the application, would entail a lesser scope and cost than the project proposed in this application would be to do nothing, which was considered. This option, however, does not address the need of current stations in Chicago Heights, IL. To do nothing would cause existing area facilities to reach or exceed capacity as patient access declines in this HSA defined zone.* No cost was provided for this alternative.

The Applicants believe the alternative of utilizing a DaVita or a Fresenius facility in the 5-mile GSA is not a viable option because these facilities are not physician owned where the physicians have the independence they need to improve quality indicators set by the Board’s quality criteria.

VII. Size of the Project, Project Utilization, Assurances

A) Criterion 1110.120 (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 the State Board Standards published in Part 1110 Appendix B.

The Applicants propose 14 stations in 7,280 GSF of space or 520 GSF per station [7,280 GSF ÷ 14 stations = 520 GSF]. The State Board Standard is 450-650 GSF per station or 9,100 GSF of space [14 x 650 GSF = 9,100 GSF]. The Applicants have successfully addressed this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SIZE OF THE PROJECT (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 14-stations will be at target occupancy of 80% within 2-years after project completion.

The Applicants stated that by the second year after project completion they are estimating that 77 patients will be utilizing the proposed 14-station facility.

If all 77 patients materialize the proposed new facility will be at target occupancy of 80% within 2-years after project completion. The Applicants have successfully addressed this criterion.

77 patients x 156 treatments per year = 12,012 treatments
14 stations x 936 treatments per year = 13,104 treatments
12,012 treatments ÷ 13,104 treatments = 91.7%

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

C) Criterion 1110.120 (e) – Assurances

To demonstrate compliance with this criterion the Applicants must attest that the proposed project will be at target occupancy within 2-years after project completion.

The Applicants have provided the necessary attestation at page 131 of the Application for Permit.

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

A) Criterion 1110.230 (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 requesting a facility with 14-stations. The State Board has calculated an excess of the 128 ESRD stations in the HSA VII ESRD Planning Area.

As mentioned the above Applicants modified the project requesting that 8 of the 14 stations be considered two 4-station transitional care units. This change does not result in any changes to the review of this Application for Permit. There remains an excess of 128 ESRD stations in the ESRD Planning Area and if this project is approved the excess will increase to 142 ESRD Stations.

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 geographical service area for this project is the 5-mile radius⁵ from zip code 60411. The table below was provided as additional information on March 26, 2019. The Applicants identified the 5-mile service area as including 16 zip codes. Only those zip codes and the population within the 5-mile radius are being considered as part of this project. The population within that the 5-mile radius is 262,432. All the pre-ESRD patients identified by the Applicants reside within this 5-mile radius.

60426	Markham	29,784
60428	Markham	12,344
60429	Hazel Crest	15,532
60478	Country Club Hills	17,173
60430	Homewood	19,835
60422	Homewood	9,821
60422	Flossmoor	9,403
60425	Glenwood	9,117
60461	Olympia Fields	4,836
60443	Matteson	21,145
60471	Richton	14,101
60466	Park Forest	22,115
60484	Park Forest	6,829

⁵ a line segment extending from the center of a circle or sphere to the circumference or bounding surface. the **radius** of a circle or sphere is the shortest connection between the center and the boundary. It is half of the diameter.

60411	Chicago Heights	58,136
60475	Steger	9,870
60476	Thornton	2,391
Total		262,432

**TABLE FOUR
Pre-ESRD Patients**

Zip Code	City	Stage 4	Stage 3
60411/60412	Chicago Heights	34	41
60466	Park Forest	5	8
60475	Steger	3	7
60422	Flossmoor	3	9
Total		45	65

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).

The State Board received one referral letter from Dr. Sampson. Dr. Sampson identified 110 pre ESRD patients that live within the 5-mile GSA. Of that 110 pre ESRD patients the Applicants believe 77 patients will utilize the proposed 14-station facility within two-years after project completion.

**TABLE FIVE
Historical Referrals ⁽¹⁾ by Dr. Sampson**

2016		2017		2018	
Facility	Number	Facility	Number	Facility	Number
DaVita Country Club Hills	3	DaVita Chicago Heights	19	DaVita Chicago Heights	12
DaVita Hazel Crest	6	DaVita Country Club Hills	14	DaVita Country Club Hills	8
DaVita Olympia Fields	6	DaVita Harvey	1	FKC South Deering	3
DaVita Chicago Heights	11	DaVita Hazel Crest	9	DaVita Hazel Crest	7
Total	26	DaVita Olympia Fields	5	DaVita Olympia Fields	79
		FMC Orland Park	1	DaVita Stony Island	5
		Total	49	Total	114

1. Referrals to nursing homes are not included.

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 service in the HSA VII ESRD Planning Area or the 5-mile GSA. There are nine facilities within the 5-mile GSA and there are 84 ESRD facilities within the HSA-VII ESRD Planning Area.
- ii.) There are no access limitations due to payor status within the 5-mile GSA.
- iii.) There are no restrictive admission policies at existing providers.
- iv.) There has been no indication of medical care problems within the 5-mile GSA.
- v.) There are nine facilities within the 5-mile GSA. Average utilization of the nine facilities is approximately 63%. One of nine facilities are at target utilization in this 5-mile GSA.

TABLE SIX

ESRD facilities within the 5-mile GSA.

Name	City	Star Rating (1)	Miles (2)	Patients (3)	Stations (4)	Utilization	Met Standard
DaVita Chicago Heights	Chicago Heights	3	1	56	16	58.33%	No
Fresenius Kidney Care Chicago Heights	Chicago Heights	NA	2.3	50	12	69.44%	No
Dialysis Care Center of Olympia Fields	Olympia Fields	NA	2.7	70	12	97.22%	Yes
Fresenius Kidney Care South Suburban	Olympia Fields	4	2.8	97	27	59.88%	No
DaVita Olympia Fields Dialysis Center	Matteson	3	4.7	80	24	55.56%	No
DaVita Harvey Dialysis	Harvey	2	5	46	18	42.59%	No
Fresenius Kidney Care Hazel Crest	Hazel Crest	5	5	68	16	70.83%	No
DaVita Hazel Crest	Hazel Crest	4	4.3	77	20	64.17%	No
Dialysis Care Center Hazel Crest	Hazel Crest	NA	5	31	12	43.06%	No
Patients/Stations/Average Utilization				575	157	62.34%	

1. Star Rating from <https://www.medicare.gov/dialysisfacilitycompare/>

2. Miles from MapQuest

3. Number of Patients as of March 2020

4. Number of patients as of May 2020.

Summary

The State Board has estimated an excess of 128-stations in the HSA VII ESRD Planning Area by 2022. There are nine facilities within the 5-mile GSA operating at approximately 63% occupancy. With the excess stations in the ESRD planning area and the number of facilities (8 of 8 facilities) not at target occupancy patients, service accessibility can be accommodated with the existing facilities and will not be improved at this time by the addition of 14 stations.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION PLANNING AREA NEED (77 ILAC 1110.230 (b))

B) Unnecessary Duplication/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.*
 - 2) *The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, stations and services characterized by such factors as, but not limited to:*
 - A) *A ratio of stations to population that exceeds one and one-half times the State average;*
 - B) *Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the utilization standard established pursuant to 77 Ill. Adm. Code 1100; or*
 - C) *Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards.*
 - 3) *The applicant shall document that, within 24 months after project completion, the proposed project:*
 - A) *Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and*
 - B) *Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.*
1. As seen in Table Six above there are nine facilities within the 5-mile GSA. Of the nine facilities only one is at the target occupancy of 80% or above. One facility is in ramp-up.
 2. There are 157 stations in the 5-mile GSA and a population of 262,432. The ratio of stations to population in this GSA is one station per every 1,672 residents. There are 4,964 ESRD stations in the State of Illinois (May 2020) and a population of 12,802,000 (2017 population projected)⁶ for a ratio of one station per 2,578 residents. To have a maldistribution (surplus) of stations in this 5-mile GSA, the ratio of stations to population in the 5-mile GSA must be 1.5 times the State of Illinois ratio. Based upon this analysis there is a surplus of stations in this 5-mile GSA.

⁶ Taken from Illinois Department of Public Health Office of Health Informatics Illinois Center for Health Statistics most recent projections available at the time of this report.

3. Based upon the 10-year average historical growth in the number of ESRD patients of 3.2% in the HSA VII the 157 existing stations will not be at target until 2028. This did not take into consideration the increase or decrease in the population in the State of Illinois.
4. The Applicant stated the following: *“the proposed dialysis facility will not have an adverse impact on existing facilities in the proposed geographic service area. All the identified patients will be referrals from identified physicians and are on pre-ESRD list. No patients will be transferred from other existing dialysis facilities. The proposed dialysis facility will not lower utilization of other area providers that are operating below the target utilization standard.”*

Summary

As noted above one of the eight operating ESRD facilities within the 5-mile GSA is at target occupancy of 80%. Additionally, based upon the ratio of the stations to population there is a surplus of stations in this 5-mile GSA now. The proposed 14-station ESRD facility will result in an unnecessary duplication/maldistribution of service at this time.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT NOT IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION/MALSDISTRIBUTION (77 ILAC 1110.230 (c))

C) 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.

1) Qualifications

- A) Medical Director** – Medical direction of the facility shall be vested in a physician who has completed a board-approved training program in nephrology and has at least 12-months experience providing care to patients receiving dialysis.
- B) Registered Nurse** – The nurse responsible for nursing services in the unit shall be a registered nurse (RN) who meets the practice requirements of the State of Illinois and has at least 12-months experience in providing nursing care to patients on maintenance dialysis.
- C) Dialysis Technician** – This individual shall meet all applicable State of Illinois requirements (see the End Stage Renal Disease Facility Act). In addition, the applicant shall document its requirements for training and continuing education.
- D) Dietitian** – This individual shall be a registered dietitian with the Commission on Dietetic Registration, meet the practice requirements of the State of Illinois (see the Dietitian Nutritionist Practice Act) and have a minimum of one year of professional work experience in clinical nutrition as a registered dietitian.
- E) Social Worker** – The individual responsible for social services shall have a Master of Social Work and meet the State of Illinois requirements (see the Clinical Social Work and Social Work Practice Act).

The Applicants provided the following narrative: Dialysis Care Center Chicago Heights will be staffed in accordance with all state and Medicare staffing guidelines and requirements. Dr. Suresh Samson will serve as the Medical Director for Dialysis Care Center Chicago Heights. Upon opening, the facility will hire a Clinic Manager who is a Registered Nurse (RN), this nurse will have at least a minimum of twelve months

experience in a hemodialysis center. Additionally, we will hire one Patient Care Technician (PCT). After we have more than one patient, we will hire another RN and another PCT. All personnel will undergo an orientation process, led by the Medical Director and experienced members of the nursing staff prior to participating in any patient care activities.

- Upon opening we will also employ:
- Part-Time Registered Dietician
- Part-Time Registered Master Level Social Worker (MSW)
- Part-Time Equipment Technician
- Part-Time Secretary

These positions will go full time as the clinic census increases. Additionally, the patient Care staff will increase to the following:

- One Clinic Manager - Registered Nurse
- Four Registered Nurses
- Ten Patient Care Technicians

The facility will be certified by Medicare. The Survey and Certification Program certifies ESRD facilities for inclusion in the Medicare Program by validating that the care and services of each facility meet specified safety and quality standards, called "Conditions for Coverage." The Survey and Certification Program provides initial certification of each dialysis facility and ongoing monitoring to ensure that these facilities continue to meet these basic requirements (*source: medicare.gov*). The Applicants have met the requirements of this criterion.

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

D) 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 provided the necessary attestation at page 129 of the Application for Permit. The Applicants have met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PLANNING AREA NEED (77 ILAC 1110.230 (f))

E) 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 Applicants are proposing 14-stations. The proposed facility will be located in the Chicago–Naperville-Elgin IL–IN–WI 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 1110.230 (g))

F) Criterion 1120.230 (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.

The Applicants have provided a signed affiliation agreement with Advocate South Suburban Hospital. The Applicants have met the requirements of this criterion.

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

G) Criterion 1110.230 (i) - 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 page 140 of the Application for Permit. The Applicants have met the requirements of this criterion.

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

XI. 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 the project with cash in the amount of \$1,678,685, and the FMV (Fair Market Value) of a lease in the amount of \$880,242. The Applicants provided their 2018 audited financial statements as required. Based upon the review of the audited financial statements the Applicants have enough resources to fund the cash portion of this project. The lease is an operating lease and the lease expense will be paid from revenues generated by the facility. The Applicants have met the requirements of this criterion.

TABLE SEVEN			
Pro-forma Financial Income Statement			
DCC Chicago Heights			
	Initial	Year 1	Year 2
# Patients	5	56	68
Treatments	726	8,131	9,874
Revenue	\$193,000	\$2,238,803	\$2,808,407
Revenue per Treatment	\$266	\$275	\$284
Expenses			
Personnel	\$556,000	\$823,604	\$991,136
Supplies	\$47,190	\$540,156	\$657,829
Facility Exp.	\$442,144	\$604,801	\$645,100
Initial Fees	\$5,025	\$0	\$0
Depreciation	\$54,657	\$54,657	\$54,657
Amortization	\$11,667	\$11,667	\$11,667
Overhead 3% of Rev	\$5,807	\$67,164	\$84,252
Write-Offs-1% of Revenue	\$1,936	\$22,388	\$28,084
Total Expenses	\$1,124,426	\$2,124,437	\$2,472,725
Income Before Tax	-\$931,426	\$114,366	\$335,682
Percent Profit	-482.60%	5.11%	11.95%

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 the project with cash in the amount of \$1,678,685, and the FMV (Fair Market Value) of a lease in the amount of \$880,242. The Applicants have qualified for the financial waiver. To qualify for the financial waiver an applicant must document one of the following:

- 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.

The Applicants have met the first requirement above that all capital expended will be funded through internal sources.

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

XII. 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 the project with cash in the amount of \$1,678,685, the FMV (Fair Market Value) of a lease in the amount of \$880,242. The operating lease (NNN)⁷ is for 10-years at a base rent of \$15.00/psf⁸ for years 1 through 5, with a 10% increase every 5-years with two 5-year options. [See Application for Permit pages 146-186]

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.

Only Clinical Costs are reviewed in this criterion. As shown below, the Applicants have met all the State Board Standards published in Part 1120, Appendix A. The Applicants are proposing 7,280 GSF of clinical space.

Modernization and Contingency Costs total \$1,182,585 or \$162.44 per GSF. This appears reasonable when compared to the State Board Standard of \$206.83 per GSF or \$1,505,722 (7,280 GSF x \$206.83 = \$1,505,722).

**TABLE EIGHT
Modernization and Contingency Costs ⁽³⁾**

Year	2015	2016	2017	2018	2019	2020 ⁽¹⁾	2021	2022
Cost per GSF	\$178.33 ⁽²⁾	\$183.68	\$189.19	\$194.87	\$200.71	\$206.73	\$212.94	\$219.32

1. Midpoint of the construction
2. 2015 is based year costs and inflated by 3% per year.
3. See Part 1120 Appendix A Modernization and Contingency Costs ESRD

Contingency Costs are \$87,599 or 8% of modernization costs. This appears reasonable when compared to the State Board Standard of 10-15% of modernization costs or \$177,388.

Architectural/Engineering Fees are \$45,000 or 3.81% of modernization and contingency costs. This appears reasonable when compared to the State Board Standard of 6.77% - 10.17% or \$120,269 (\$1,182,585 x 10.17% = \$120,269)

⁷ A triple net lease is a lease agreement that designates the lessee, which is the tenant, as being solely responsible for all the costs relating to the asset being leased, in addition to the rent fee applied under the lease. The structure of this type of lease requires the lessee to pay the net amount for three types of costs, including net real estate taxes on the leased asset, net building insurance and net common area maintenance. The lease is an operating lease and the lease expense is paid over the life of the lease and not depreciated.

⁸ Price per square foot

Movable or Other Equipment Costs not in Construction Contracts are \$451,100 or \$32,222 per station (\$451,100 ÷ 14 stations). This appears reasonable when compared to the State Board standard of \$55,293 or \$774,102 (\$55,293 x 14 stations = \$774,102).

TABLE NINE
Movable or Other Equipment Costs ⁽³⁾

Year	2008	2016	2017	2018	2019	2020	2021
Cost per Station	\$39,945 ⁽¹⁾	\$49,127	\$50,601	\$52,119	\$53,683	\$55,293	\$56,952

1. 2008 is base year inflated by 3% per year to midpoint of construction.
2. 2020 midpoint of construction
3. See Part 1120 Appendix A – Movable or Other Equipment not in Construction Contracts

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 \$207.10 operating expense per treatment. The Applicants have addressed this criterion.

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 \$12.40 per treatment. The Applicants have addressed this criterion.

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

Transcript of Open Session Meeting
Conducted on September 17, 2019

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1 CHAIRMAN SEWELL: Next on the agenda is
2 H-02, Project No. 19-015, Dialysis Care Center of
3 Chicago Heights in Chicago Heights.

4 May I have a motion to approve this
5 project to establish a 14-station end stage renal
6 disease facility in Chicago Heights.

7 (No response.)

8 CHAIRMAN SEWELL: Can I get a motion?

9 MEMBER SAVAGE: So moved.

10 CHAIRMAN SEWELL: Is there a second?

11 MEMBER MURRAY: Second.

12 CHAIRMAN SEWELL: All right.

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

15 (Five witnesses sworn.)

16 THE COURT REPORTER: Thank you. And
17 please print your names.

18 CHAIRMAN SEWELL: State agency report.

19 MR. CONSTANTINO: Thank you, Mr. Sewell.

20 DCC Chicago Heights is asking the
21 State Board to approve a 14-station ESRD facility
22 in Chicago Heights.

23 The estimated cost of the project is
24 approximately 2.6 million, and the expected

1 completion date is May 31st, 2021.

2 There was no request for a public hearing,
3 and no letters of support were received by the
4 State Board. There was one letter of opposition
5 received, and it has been included in your packet
6 of information.

7 The Applicant has not met all of the
8 criteria of the State Board.

9 Thank you, sir.

10 CHAIRMAN SEWELL: Thank you.

11 Is there a -- are there comments for the
12 Board?

13 DR. SALAKO: Good afternoon, Chairman
14 Sewell and members of the Board.

15 I am Dr. Babajide Salako. I am the CEO of
16 Dialysis Care Center. With me today are a couple
17 of my colleagues.

18 Immediately to my left is Dr. Mohammad
19 Shafi. He's the chief medical director of
20 Dialysis Care Center. Next to Dr. Shafi is
21 Mr. Asim Shazzad. He's the chief operating
22 officer of Dialysis Care Center.

23 To his left is Ms. Therese O'Donnell. She
24 is the area manager for that territory of our

1 business. And finally, at the end of the table,
2 is Dr. Tauseef Saragough. He is a medical
3 director at -- one of the physicians at Kidney
4 Care Centers in Olympia Fields.

5 So I'll let Dr. Saragough start.

6 DR. SARAGOUGH: Thank you, Dr. Salako.

7 Hello and good afternoon, distinguished
8 members.

9 My name is Tauseef Saragough, MD. I'm a
10 board-certified nephrologist and medical director
11 at DCC of Olympia Fields. I'd first like to thank
12 the Board for approving our unit, DCC of Olympia
13 Fields, in January of last year.

14 You guys heard one of our patients earlier
15 this morning, who was here for the testimony, and
16 he's somebody who I took care of at that unit that
17 you approved, and I'd like to thank you for that.

18 I, here, represent all of those patients or
19 similar patients as the one you heard this
20 morning, and, you know, these are patients who
21 are -- they're our CKD patients or are on dialysis
22 awaiting renal transplants.

23 Let me also share this opportunity to tell
24 you about another success story that we had at

1 Chicago Heights.

2 This is a story that was actually reported
3 by the Chicago Tribune. I'd like to hold it up
4 here for you guys. This is a 23-year-old patient
5 who was one of my patients who I had in Chicago
6 Heights who had this rare kidney condition called
7 atypical hemolytic uremic syndrome.

8 And she basically had renal failure, was
9 on dialysis, and we took care of her at our home
10 program for a good two months where she was doing
11 peritoneal dialysis with us before she had
12 recovery of renal function and is now doing -- is
13 now doing great. Our practice draws significant
14 numbers of patients like her from the Chicago
15 Heights area.

16 And DCC of Olympia Fields, which is less
17 than 5 miles from the proposed clinic, which I had
18 just mentioned in my opening remarks, is now at
19 capacity. And it obtained this utilization within
20 a record span of one year since its inception.
21 And due to the rapid growth of ESRD patients that
22 we have seen in our practice, attributable to
23 growing elderly African-American and Hispanic
24 population and ESRD patients in our practice, we

1 generally look to continue to increase these
2 patients.

3 So Dialysis Care clinics focuses on
4 individualized care and encourages our patients to
5 choose home therapies, and they have all modality
6 options at our practice. Besides this, you know,
7 our nephrologists work really closely with the
8 nurses of DCC clinics to reduce hospitalizations
9 and improve quality indicators of the dialysis
10 patients.

11 I request our esteemed Board members here
12 to approve our proposed clinic in Chicago Heights,
13 which will be completed in 2021. It will provide
14 continuity of care to our patients, and our team
15 will have an opportunity to give them the
16 excellent care that they need.

17 Thank you, Board.

18 MS. O'DONNELL: Good afternoon.

19 My name is Therese O'Donnell. I'm the
20 clinical area manager for the home dialysis
21 Olympia Fields office.

22 At Dialysis Care Centers we are
23 predominantly a home-based dialysis company. We
24 encourage all our new patients as well as our

1 existing patients to try and transition to home
2 dialysis due to flexibility, convenience, better
3 understanding of their disease process as well as
4 better control of their disease process. We also
5 work with and encourage our patients to become
6 transplanted.

7 Eventually, over time, though, our home
8 dialysis patients will fail either home PD or home
9 hemo and will need to transition to the in-center.
10 When that happens, we're able to keep our patients
11 in our network and continue to provide continuity
12 of care to them. When our patients stay in our
13 network, they will keep the same -- their same
14 doctors, social workers, dieticians, and nurses.

15 In the event that our patients have access
16 issues or end up with peritoneal dialysis and need
17 bridge dialysis, we're able to keep our patients
18 in their network and keep the continuity of care.
19 We are also able to transition them back into
20 their home therapy unit faster because our home
21 nurses can visit and follow up with the patient in
22 our own in-centers.

23 Since we are a home-based dialysis
24 company, we work early on when patients crash into

1 the in-center dialysis and educate them on home
2 therapy options as well as successfully transition
3 our patients to home dialysis.

4 Please vote favorably for our Chicago
5 Heights location so we can continue to provide our
6 patients with the continuity of care they need.

7 Thank you for your time.

8 DR. SHAFI: Good afternoon, Chairman and
9 esteemed members.

10 I am Dr. Mohammad Shafi. I'm a board-
11 certified nephrologist. I also serve as the chief
12 medical officer at Dialysis Care Center and would
13 like to bring the attention of the distinguished
14 members of the Board on two core principles we
15 follow in our organization rather vigorously. One
16 is care coordination of the patient and
17 encouraging home dialysis.

18 Let me explain to you why care
19 coordination has become so much important this day
20 and age. Care coordination is a value-based
21 system focused on caring for the whole patient,
22 improving the efficiency -- improving efficiencies
23 and reducing costs.

24 We at the Dialysis Care Center have

1 developed innovative care models based on
2 coordinated patient-centered care, partnering with
3 nephrologists, dialysis nurses, and the patients
4 to oversee and monitor care of the ESRD patients
5 with the focus of reducing ER visits and
6 hospitalization, lessening the financial burden
7 which it poses to Medicare, Medicaid, and patients
8 without compromising the quality of their care.

9 Let me remind esteemed members, based on
10 the United States renal data alone in 2015,
11 approximately \$11 billion was spent on
12 hospitalizations, expenses of dialysis patients.

13 We at the Dialysis Care Center are
14 empowering patients to be active participants in
15 managing their disease along with their care
16 providers. Our philosophy and approach synergizes
17 completely with a value-based program, such as a
18 QiD, which was introduced by CMS to encourage the
19 dialysis companies and nephrologists taking care
20 of the dialysis patient to improve quality of care
21 of dialysis patients.

22 Among the wide array of indicators that we
23 were asked to monitor by CMS, special emphasis was
24 placed on reducing hospitalization and patient

1 satisfaction survey at dialysis centers.

2 Now I want to briefly inform the members
3 of our home dialysis. It is unfortunate that only
4 12 percent of the American dialysis patients
5 receive dialysis at home. The executive order
6 issued on July 19, 2019, has set forth the goal of
7 having 80 percent of the new end stage renal
8 dialysis patients by 2035 either receiving
9 dialysis at home or receiving a transplant. And
10 we, as a company, realized that years ago, and we
11 are well positioned to achieve that goal.

12 We at the Dialysis Care Center have
13 developed innovative programs to educate and
14 empower dialysis patients to choose home therapies
15 as against in-center, recognizing home therapies
16 offer better quality of life and save Medicare/
17 Medicaid billions of dollars.

18 It is, therefore, imperative that the
19 patient remains within our Dialysis Care Centers
20 so that our physicians, nurses, and staff can
21 follow these models and follow the patients to
22 reduce the cost, improve outcome, and encourage
23 patient to switch to home therapy.

24 We at the Dialysis Care Centers in our

1 clinics treat patients regardless of their
2 financial and insurance background.

3 You heard, all, the story of one of our
4 patients that we took care of at the Dialysis Care
5 Center in Olympia Fields. His journey started as
6 a home PD patient. He was switched to home hemo,
7 then he was switched to in-center, and eventually
8 he received a transplant and leading a healthy
9 life.

10 That's what DCC is all about, helping and
11 empowering patients to lead a better life and make
12 better decisions about their health.

13 As noted earlier, the current DCC clinic
14 in the area has reached their maximum utilization
15 capacity. That is 101 percent, DCC Olympia
16 Fields, in record 1 1/2-year time.

17 This is -- I want Board members to
18 recognize this unique need of Dialysis Care Center
19 to serve patients in innovative ways to improve
20 their quality of life and to avoid sending these
21 patients into other clinics belonging to large
22 LDOs where the focus and management does not match
23 the preferences and standard set by a small
24 company like us.

1 Thank you very much.

2 DR. SALAKO: I'd like to share two posters
3 with the members of the Board, please.

4 So when Dr. Shafi talks about continuum of
5 care -- can you hear me?

6 THE COURT REPORTER: Not very well.
7 Sorry.

8 MS. AVERY: Just bring it up a bit and
9 then you can.

10 DR. SALAKO: When Dr. Shafi talks about
11 continuum of care, you know, from a care
12 coordination perspective, what we wanted to also
13 show you from a physical client perspective --
14 these are things that the agency report will not
15 be able to capture.

16 This is our unit in Olympia Fields.
17 Right? We opened this unit January of 2018.

18 This is our home dialysis clinic where
19 we're treating, you know, tens of patients. This
20 is the physician office, right in the middle.
21 This is the dialysis clinic, at the end of it.

22 So we have patients being seen by the
23 nephrologist. If they are home, they go to the
24 left of the door. If they are in-center patients,

1 they go to the right of the door.

2 In the -- the kind of seamless care they
3 get here is a model that the LDOs don't have.
4 It's a model that our patient -- it allows us to
5 give really excellent care to our patients.

6 You know, Dr. Shafi also talked about a
7 model we've been saying for a few years here with
8 the Board, an emphasis on home. The national
9 average is 12 percent of patients on home.

10 With our organization it's well over
11 35 percent, and it's because we can do something
12 like this. We can provide patients seamless care,
13 either from home to in-center, in-center back to
14 home, with their physicians being there, next to
15 them, all the time.

16 That kind of -- this kind of picture, very
17 difficult to see unless you go to one of our
18 facilities, unless you're one of our patients, and
19 you feel totally, totally comfortable in knowing
20 that your caregivers are right there next to you
21 all the time.

22 Dialysis Care Center has opened three
23 clinics in this HSA in the last 20 months. We
24 opened DCC Oak Lawn. Today we are at over

1 90 percent utilization. It's an 11-station
2 clinic.

3 In January 2018 -- DCC Olympia Fields,
4 January 2018. We have over a hundred percent.
5 This particular clinic that's about 5 miles away
6 from where we're asking for this new CON, actually
7 has a fourth shift opened. We have a fourth shift
8 opened MWF; we have a fourth shift opened TTS.

9 That means the dialysis patient -- because
10 they truly desire to stay in our unit -- are
11 having to dialyze as late as 10:00 p.m. Winter is
12 coming. That's a problem, you know.

13 We don't -- the patients -- I wouldn't
14 like to get to dialysis at 5:00 p.m. in the
15 evening and then, you know, leave the dialysis
16 clinic at 10:00 at night when it's dark, when it's
17 cold.

18 This is -- and our last clinic we opened
19 just in March of this year. DCC Beverly is
20 already at 55 percent capacity -- utilization. We
21 expect that this clinic, based on our internal
22 data, will be at about 80 percent capacity before
23 the end of the year.

24 So there is a need for our own patients to

1 stay in our own network because they truly believe
2 that they will get the best care when they stay in
3 our network.

4 Thank you.

5 CHAIRMAN SEWELL: All right.

6 Are there any questions of the Applicant?

7 MEMBER SLATER: Yes.

8 CHAIRMAN SEWELL: Yes. Go ahead.

9 MEMBER SLATER: The one thing that you
10 never really addressed is that we've got a whole
11 bunch of beds, apparently, available within
12 the area.

13 So if that's the case, why do we need this
14 facility?

15 DR. SHAFI: I'll address that.

16 And that's part of my testimony -- which
17 I said earlier -- was that every dialysis company
18 is developing their own unique model of this
19 continuum of care, reducing hospitalization, and
20 reducing -- so within our own company that's --
21 that's a job I'm doing also -- that we identify
22 patients in our network, we try to keep them
23 within our own network so that we can deploy those
24 models, you know, by reducing hospitalization,

1 improving their quality numbers.

2 So once they leave our network, we really
3 don't -- we cannot exercise that kind of authority
4 on those patients.

5 So I think as -- Dr. Saragough also,
6 I think, would like to answer that because he's
7 also part of the DCC organization; he's the
8 medical director.

9 So I think we like to keep these patients
10 within the DCC network so that all the efficiency
11 models that we are developing we can do better.

12 DR. SARAGOUGH: I'd like to add to what
13 Dr. Shafi just mentioned.

14 From personal experience -- I've been
15 practicing in that area for the last four years
16 now. And the transition from PD to hemo or back
17 to PD, if it needs to be done, is just seamless if
18 these patients are part of our network.

19 It's just easier for me, as a physician,
20 who I know to transfer a patient from PD to hemo
21 with a seamless transition, within hours if it has
22 to be done that way.

23 If it's a patient that's in a different
24 unit, the transition is not as simple as it would

1 be if it's somebody who's part of our network.

2 It's just an easier transition.

3 DR. SALAKO: One other thing.

4 The gentleman that spoke earlier today,
5 one of our patients, he was a home dialysis
6 patient of ours, and he -- he was a home dialysis
7 patient of ours, and then he needed to go
8 in-center.

9 And when he went in-center, our clinic
10 hadn't opened at that time, and he went to one of
11 the LDOs, and he had a very torrid time, repeated
12 hospitalizations. He was very unhappy with his
13 experience there.

14 When he -- when our clinic opened, he did
15 come back to us because he was familiar with the
16 caregivers, he was familiar -- he was familiar
17 with his physicians, and he felt very happy to
18 come back to us. And, of course, we're happy to
19 report today he got a transplant.

20 So when you start to look at the
21 availability of chairs, there's also choice for
22 the patients. You know, these patients that are
23 dialyzing until 10:00 p.m. at night or -- they
24 could very well go to another dialysis clinic, but

1 they choose to stay where they are. They choose
2 to stay with this team that's looking after them.

3 You know, when you're a dialysis patient,
4 you get to a point where it's about
5 trustworthiness. It's about who do I -- who can
6 I entrust my care to? With whom do I feel most
7 comfortable? With whom do I -- who do I believe
8 is really on my side?

9 And these patients want to stay within our
10 network, and that's why our clinics are always
11 heavily utilized, because those patients want to
12 stay and other patients that they care about want
13 to come into our network.

14 CHAIRMAN SEWELL: Mike, the Applicant has
15 talked about -- I think they have an estimate of
16 how many pre-ESRD patients there are in the area,
17 and then I guess they have a projection about how
18 many of those will later -- I think it's after
19 two years of completion of the project -- will
20 require care.

21 That concept and that methodology, that's
22 not the one used by the State agency, is it?

23 MR. CONSTANTINO: No. We use historic
24 utilization.

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1 CHAIRMAN SEWELL: I see. Okay.

2 MR. CONSTANTINO: And population.

3 CHAIRMAN SEWELL: And then, you know, you
4 mentioned that you have these facilities operating
5 at target utilization. But in the State agency
6 report -- your facility at Olympia Fields is at
7 target occupancy but the one -- the others are
8 averaging about 70 percent collectively.

9 DR. SALAKO: Yeah.

10 CHAIRMAN SEWELL: And then you've got
11 one -- Hazel Crest -- that's not -- is that not
12 yet operational?

13 MR. SHAZZAD: It's not certified yet,
14 correct.

15 CHAIRMAN SEWELL: Oh, it's not certified
16 yet?

17 MR. SHAZZAD: Right.

18 CHAIRMAN SEWELL: But it will come online
19 at some point?

20 MR. SHAZZAD: Yes. But that's a different
21 market area.

22 CHAIRMAN SEWELL: I see. That's not in
23 this plan?

24 MR. SHAZZAD: No.

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1 CHAIRMAN SEWELL: Okay.

2 DR. SHAFI: That 70 percent utilization is
3 not our clinic. That's collectively, other
4 clinics.

5 CHAIRMAN SEWELL: That's all of them, yes.

6 DR. SHAFI: Yes.

7 CHAIRMAN SEWELL: Okay. Other questions
8 by Board members?

9 MEMBER MURRAY: I have a question for
10 staff.

11 So there's a lot of demographic changes.
12 When you evaluate need, do you look at the change
13 in the population in this area?

14 MR. CONSTANTINO: We will be. You will
15 approve that today. We did another -- we do it
16 every two years.

17 MEMBER MURRAY: Oh, every two years?

18 MR. CONSTANTINO: Yeah. That -- the
19 number of stations will be approved today by this
20 Board. We have to get your approval.

21 MEMBER MURRAY: And what is your
22 recommendation going to be?

23 MS. AVERY: We can't do it.

24 MEMBER MURRAY: We can't do it ahead of

1 time? That means you want me to vote without
2 information.

3 Okay.

4 MS. AVERY: Well, we were asked -- to be
5 clear, we were asked but we don't -- it
6 wouldn't -- Mike and George wouldn't have had a
7 chance to approve -- analyze the numbers, the new
8 numbers.

9 MEMBER MURRAY: I understand that. But --

10 CHAIRMAN SEWELL: Without them being --

11 MS. AVERY: Yeah.

12 MEMBER MURRAY: I just want to be clear
13 because this is an area that has seen a big
14 influence, especially of populations that,
15 unfortunately, will use dialysis. So that's why
16 I'm asking about it.

17 And I understand that you might not be
18 able to use a new recommendation on this
19 application. All right.

20 DR. SARAGOUGH: Dr. Murray, I can't
21 specifically give you numbers, but just from my
22 personal experience in the last four years, we've
23 seen tremendous increase in the number of CKD
24 patients that we see in our clinic -- you know, in

1 our outpatient clinics -- which is why -- that
2 center between the two dialysis units that was
3 just mentioned by Dr. Shafi.

4 So we have personally seen an increase in
5 the number of CKD patients that we've been seeing
6 over the last couple of years.

7 MEMBER MARTELL: What is the projection in
8 home dialysis? Is that -- considering the office
9 based.

10 So we know that there's a small percentage
11 using home right now, but how would that impact
12 this?

13 DR. SALAKO: May I -- we -- our numbers on
14 home dialysis -- our percentage, penetration of
15 home dialysis -- is one of the highest in the
16 United States today. We have 35 percent of our
17 patients on home. Okay?

18 This number has held steadfast for the
19 last three years. So we are very bullish. We
20 continue to believe that, inasmuch as we are
21 opening in-centers, we are able to bring patients
22 at home because we have those in-centers.

23 And when patients have to start dialysis
24 at in-center and crash into it -- and Ms. Therese

1 O'Donnell, she can talk more about it. But
2 patients get into our in-center clinics because
3 they crash into dialysis. Our nurses are
4 extremely proactive. They have a lot of programs
5 in which they still encourage those patients to go
6 home.

7 DR. SARAGOUGH: And adding to what
8 Dr. Salako just said, we have a dedicated nurse
9 who rounds at our in-center clinics, educating
10 patients on different modality options.

11 So every patient that goes in-center gets
12 a modality education about their choices and
13 preferences by a dedicated person who rounds on
14 these patients every week.

15 And I've personally had two patients last
16 week that switched over from hemo to PD because
17 they preferred PD or home options just by talking
18 to a dedicated educator.

19 DR. SHAFI: I think -- I just would like
20 to add to my answer earlier that, you know, once
21 these patients go to other dialysis clinics, we
22 cannot exercise that influence for them because
23 our staff is not there to change their modality.

24 So that's the reason it becomes so much

1 important for us to keep these patients within our
2 network.

3 So thank you.

4 CHAIRMAN SEWELL: Other questions?

5 (No response.)

6 CHAIRMAN SEWELL: All right. Roll call.

7 MR. ROATE: Thank you.

8 Motion made by Ms. Savage; seconded by
9 Dr. Murray.

10 Senator Demuzio.

11 MEMBER DEMUZIO: Yes, based upon the
12 testimony I've heard today and the staff report.

13 MR. ROATE: Thank you.

14 Dr. Martell.

15 MEMBER MARTELL: No. I have concerns
16 about the capacity issues in the region.

17 MR. ROATE: Thank you.

18 Dr. Murray.

19 MEMBER MURRAY: I'm going to reluctantly
20 have to vote no based on the information we have
21 today.

22 But let me make a comment that if I'm --
23 I mentioned this in one of my earlier questions.
24 This is an area that's changing very fast. It's

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1 increasing in African-American population, who,
2 unfortunately, desperately need dialysis.

3 And so I hope we reconsider this once our
4 new stuff comes out, whatever that is, on our
5 estimates.

6 MR. ROATE: Thank you.

7 Ms. Savage.

8 MEMBER SAVAGE: And I have to sadly vote
9 no, as well, based on what was just said.

10 MR. ROATE: Thank you.

11 Mr. Slater.

12 MEMBER SLATER: I vote no. It appears to
13 me that there's an unnecessary duplication and the
14 result would be an excess supply of facilities.

15 MR. ROATE: Thank you.

16 Chairman Sewell.

17 CHAIRMAN SEWELL: Yeah, I vote no. It
18 doesn't meet the criteria in our planning area
19 need.

20 MR. ROATE: 1 vote in the affirmative,
21 5 votes in the negative.

22 MS. AVERY: The motion has failed. You
23 will receive an intent to deny. Thank you.

24 DR. SARAGOUGH: Thank you.

1 THE COURT REPORTER: Please leave your
2 remarks for me at the table. Your written
3 remarks, please leave them.

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DIALYSIS CARE CENTER, LLC
15801 S. Bell Road
Homer Glen, IL 60491
PH: 708-645-1000
FAX: 931-484-4701

June 1, 2020

VIA Email and Federal Express

Ms. Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761

Re: Additional information - Dialysis Care Center Chicago Heights project #19-015
Transitional Care Unit Statement (TCU)

Dear Ms. Savage:

As the global effect of the coronavirus (COVID-19) continues to evolve, Dialysis Care Center remains firmly committed to the health and safety of our patients and employees while we focus on better serving our communities.

While we are closely monitoring the changing situation and its effect on our patients, we are happy to report that none of our patients on Home Therapies (i.e. Peritoneal Dialysis and Home-Hemo Dialysis) have tested positive for Covid-19 in comparison to patients in the traditional In-center dialysis setting. Current research has shown that patients dialyzing at home have a reduced risk of contracting COVID-19 as well as other infections.

As a result, we have made the decision to amend our current project, Dialysis Care Center Chicago Heights #19-015 to be a Transitional Care Unit (TCU). With this change, we commit to dedicating at least eight (8) of the dialysis chairs for Transitional Care in furtherance of our commitment to keep our patients and staff safe during these trying times.

At Dialysis Care Center, we have always been committed to providing a better healthcare experience and improving a patient's experience and quality of life. We look forward for the Board to approve this project so we can have the opportunity to provide Transitional Care services to the Chicago Heights and surrounding communities.

Sincerely,

Asim Shazzad
Chief Operating Officer



150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312.819.1900

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JUL 16 2019

HEALTH FACILITIES &
SERVICES REVIEW BOARD

July 15, 2019

Anne M. Cooper
(312) 873-3606
(312) 276-4317 Direct Fax
acooper@polsinelli.com

Via Federal Express

Courtney Avery
Administrator
IL Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Opposition to Dialysis Care Center Chicago Heights (Proj. No. 19-015)

Dear Ms. Avery:

Polsinelli PC represents DaVita Inc. (“DaVita”) and, on behalf of DaVita, writes this letter to document DaVita’s strong objection to the above referenced Dialysis Care Center (“DCC”) Chicago Heights facility proposal (the “Proposed Facility”) based on the following key issues:

- There is no need for the Proposed Facility in the DCC Chicago Heights geographic service area or in the planning area as a whole. HSA 7 has an excess of 56 stations, the second largest excess in the State. Of the ten dialysis facilities within five miles of the proposed facility site, only one exceeds the Illinois Health Facilities and Services Review Board’s (“State Board”) target utilization of 80%.
- The referral letter supplied by Dr. Suresh Samson in support of DCC’s application does not contain sufficient patient data from the geographic service area to justify the proposed facility site.
- DCC does not bring a different product to the market nor does it address a unique issue with the application for the Proposed Facility. Their attempts to differentiate themselves from existing quality dialysis providers are misleading and appear to be designed to divert the dialogue away from the key consideration - demand for the service.

It would be unwarranted to approve this facility with these defects combined with an excess of stations in the planning area.

Ms. Courtney Avery
 July 15, 2019
 Page 2

1. No Need for an 11th Facility within Five Miles of the DCC Hazel Crest Facility in HSA 7

There is no need for the Proposed Facility in the DCC Chicago Heights geographic service area. Of the ten dialysis facilities located within that five mile area, only one facility exceeded the Board’s target utilization of 80% as of March 31, 2019. See Table 1. Importantly, on October 30, 2018, the State Board approved DCC’s application for a 12 station dialysis facility in Hazel Crest (approximately 3.5 miles from the proposed Chicago Heights dialysis facility). In dismissing utilization of existing dialysis facilities in the area, DCC states, “there are no physician-owned ESRD facilities in the area”¹ but failed to address why its own recently approved physician-owned dialysis facility is not an option. As noted above, of the eight operational dialysis facilities, seven were below target utilization, averaging 60.5% and creating an excess of 24 stations. Adding 14 stations will reduce utilization of existing facilities and increase the excess of stations in the geographic service area.

Table 1 March 31, 2019 Utilization of Existing Facilities within 5 Miles				
Facility	Straight-Line Distance (Miles)	Number of Stations 03/31/2019	Number of Patients 03/31/19	Utilization % 03/31/19
Chicago Heights Renal Care	0.65	16	71	74.0%
Fresenius Medical Care South Suburban	1.87	27	111	68.5%
Fresenius Medical Care Chicago Heights	1.87	12	36	50.0%
Dialysis Care Center of Olympia Fields	2.08	11	67	101.5%
RCG Hazel Crest	3.04	20	0	0.0%
Fresenius Medical Care Hazel Crest	3.41	16	70	72.9%
Dialysis Care Center Hazel Crest	3.52	12	0	0.0%
Olympia Fields Dialysis Center	4.00	24	112	77.8%
Davita - Harvey Dialysis	4.24	18	57	52.8%
Fresenius Medical Care Steger	4.36	18	59	54.6%
Total		174	583	55.8%

¹ Dialysis Care Center Chicago Heights Certificate of Need Application 105 (Mar. 22, 2019) available at <https://www2.illinois.gov/sites/hfsrb/Projects/ProjectDocuments/2019/19-015/2019-03-21%2019-015%20application.pdf> (last visited Jul. 10, 2019).

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July 15, 2019

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2. Insufficient Patient Demand in the Geographic Service Area to Justify a New Facility Site

While Dr. Samson projects 77 patient referrals in his letter, 59% of the projected referrals are currently CKD Stage 3 patients. If these patients are properly managed, such patients can stay at Stage 3 indefinitely. The referral letter notably does not include any Stage 5 CKD patients, for which dialysis treatment would be imminent. Presumably there will not be sufficient patients to justify a new facility site absent poaching patients from other existing facility sites. The data in the referral letter simply does not support the position that a new dialysis facility is required to support patient needs within the specific market area.

Further, the growth in patient census over the past four years does not justify additional stations in this area at this time. Over the past four years, patient census has increased by 40 patients (or 1.6% annually). This does not justify the 14 station dialysis facility DCC proposes.

3. Home Dialysis is a Viable Option for Many Patients on a Long Term Basis

DCC has made multiple statements in hearings, most recently at the June 4, 2019 meeting, that it is primarily a home dialysis company, seeking unwarranted recognition for an emphasis on this care modality to the exclusion of other providers that place a strong emphasis on the home modalities.² Within the immediate geographic service area (five mile area), DCC operates home programs in Matteson and Flossmoor, which are among its 44 home programs

² DaVita is the largest provider of home dialysis in the United States. From 2017 to 2019, DaVita's home program has grown 10.3% in the Chicagoland area. DaVita works closely with patients to promote home dialysis modalities. Education is important to slow the progression of kidney disease. DaVita patients who attend Kidney Smart[®], DaVita's kidney care education program, are six times more likely to choose home dialysis as a treatment option. Further, all DaVita dialysis clinics 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. It appropriately trains patients who select a home modality in order to maximize their long-term chance of success and to avoid the most significant issues patients have with continuing this modality.

Ms. Courtney Avery

July 15, 2019

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across Chicago. Collectively, these programs can absorb at least 90 more patients for home dialysis training and support. Despite its assertion that DCC stands out as a home dialysis provider, over the past three years in Illinois, DCC has filed NINE in-center hemodialysis applications to provide dialysis services in the institutional setting, NOT in the home setting. Over this time, the DCC rationale for overlooking its non-compliance with the State Board's rules has morphed. Some months ago, its rationale was that it needed in-center services to provide a location for temporary dialysis for special circumstances (such as respite or a clinical, but not permanent issue with peritoneal dialysis) notwithstanding the fact other providers willingly accept the Kidney Care Center physicians' patients and maintain those physicians as members of their medical staff. DCC has also touted to the State Board a model of staff-assistance at home as unique. After DaVita refuted the facts relating to those assertions, DCC changed its rationale for shifting its focus to the in-center treatment modality rationalizing that patients on home dialysis were consistently failing on that modality after 30 months.³ Although DCC stated in its June 4, 2019 presentation that patients "will look to going in center" after failing on a home modality, this does not have to be the case. With improvements in the home hemodialysis treatment modality to make it more safe and effective at home, DaVita has recently modified its care transition protocol to re-educate home peritoneal dialysis patients who fail on that modality to the home hemodialysis modality rather than automatically transitioning them to an in-center hemodialysis program.⁴

* * * * *

In sum, based on the foregoing DaVita opposes the Proposed Facility to establish a 14 station dialysis facility in Chicago Heights, Illinois, which is not needed as multiple other dialysis facilities within the service area are under-utilized. Current patient needs do not merit

³ Ironically, good hygiene and nutrition and techniques to ensure adequacy of dialysis reinforced by effective training and monthly visits should significantly reduce home dialysis failure rates.

⁴ DaVita delivers innovative technologies like home remote monitoring on a telehealth platform to make it easier for patients to be treated at home. Home remote monitoring allows clinicians to interact with their patients on a regular basis, particularly high risk patients and patients that are within the first 90 days of home dialysis. Vital signs, e.g., blood pressure and weight, are transmitted to clinicians who can supervise patients dialyzing at home. With this monitoring, if vital stats trigger an alert, the clinician will be notified and DaVita will implement interventions to reduce the likelihood of treatment complications or failure, thereby allowing patients to continue to do self-care at home. Further, a caregiver, which is a frequent barrier to home modalities, is no longer mandatory for patients who dialyze with HHD at home.



Ms. Courtney Avery
July 15, 2019
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additional stations. Further, DCC Chicago Heights will not provide new or innovative care to the area.

Sincerely,

A handwritten signature in blue ink that reads "Anne M. Cooper".

Anne M. Cooper



150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606 • (312) 819-1900

June 10, 2020

Anne M. Cooper
(312) 873-3606
(312) 276-4317 Direct Fax
acooper@polsinelli.com

Via E-Mail

Courtney Avery
Administrator
IL Health Facilities & Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Opposition to Dialysis Care Center Chicago Heights (Proj. No. 19-015)

Dear Ms. Avery:

Polsinelli PC represents DaVita Inc. (“DaVita”) and, on behalf of DaVita, writes this letter as an update to its July 15, 2019 letter, which documented DaVita’s objection to the above referenced Dialysis Care Center (“DCC”) Chicago Heights facility proposal (the “Proposed Facility”). Since DaVita submitted the July 15, 2019 letter, a few key factors have changed that further demonstrate that a new DCC dialysis facility in Chicago Heights is not warranted.

- On September 18, 2019, the Illinois Health Facilities and Services Review Board (“State Board”) released its 2019 Inventory for the In-Center Hemodialysis Category of Service. Importantly, the number of excess stations increased by nearly 125% from the prior month (from an excess of 57 stations as of August 8, 2019, to an excess of 127 stations as of September 18, 2019).
- There is no need for the Proposed Facility in the DCC Chicago Heights geographic service area or in the planning area as a whole. HSA 7 has an excess of 128 stations as of March 5, 2020, the largest excess in the State. Of the ten dialysis facilities within five miles of the proposed facility site, only one exceeds State Board’s target utilization of 80%.

There is no need for the Proposed Facility in the DCC Chicago Heights geographic service area. Of the ten dialysis facilities located within that five mile area, only one facility exceeded the Board’s target utilization of 80% as of March 31, 2020. See Table 1. Further, 45 of the excess stations in HSA can be attributed to the nine underutilized facilities in the DCC Chicago Heights geographic service area. Adding 14 stations will reduce utilization of existing facilities and increase the excess of stations in the geographic service area.

Ms. Courtney Avery
 June 10, 2020
 Page 2

Table 1 March 31, 2020 Utilization of Existing Facilities within 5 Miles				
Facility	Straight-Line Distance (Miles)	Number of Stations 03/31/2020	Number of Patients 03/31/20	Utilization % 03/31/20
Chicago Heights Renal Care	0.68	16	56	58.3%
Fresenius Medical Care South Suburban	1.86	27	97	59.9%
Fresenius Medical Care Chicago Heights	1.90	12	50	69.4%
Dialysis Care Center of Olympia Fields	2.05	12	70	97.2%
RCG Hazel Crest	3.01	20	77	64.2%
Fresenius Medical Care Hazel Crest	3.39	16	68	70.8%
Dialysis Care Center Hazel Crest	3.49	12	31	43.1%
Olympia Fields Dialysis Center	3.98	24	80	55.6%
DaVita - Harvey Dialysis	4.23	18	46	42.6%
Fresenius Medical Care Steger	4.38	18	46	42.6%
Total		175	621	59.1%

In sum, based on the foregoing DaVita opposes the Proposed Facility to establish a 14 station dialysis facility in Chicago Heights, Illinois, which is not needed as multiple other dialysis facilities within the service area are under-utilized. Current patient needs do not merit additional stations.

Sincerely,



Anne M. Cooper