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Sent: Tuesday, July 26, 2011 7:10 PM
To: Constantino, Mike
Subject: U.S. Renal Care Streamwood Dialysis Support Letter and Prepared Testimony
Attachments: USRC Streamwood Testimony - P. O'Connor.pdf; USRC Streamwood Patient Support Letter.pdf; USRC Streamwood ESRD Patient Growth and Utilization.pdf

Good Afternoon Mike,

Please find the attached PDF copies of a letter written in support of the U.S. Renal Care Streamwood Dialysis certificate of need application and testimony prepared by Philip O'Connor in preparation for the Streamwood Public Hearing, which he was unable to attend. Lastly, please also find the attached letter providing a focused analysis on the service area of the proposed U.S. Renal Care Streamwood Dialysis facility. These materials are submitted in support of application number 11-026.

Please feel free to contact me with any questions or comments.

Thanks,

Shawn

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TESTIMONY OF PHILIP R. O'CONNOR, Ph.D.
TO THE ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
IN THE MATTER OF U.S. RENAL CARE STREAMWOOD DIALYSIS

Introduction and Background

My name is Philip R. O'Connor. I am testifying in support of the application submitted by the limited liability company applicant associated with U.S. Renal Care, Inc. ("U.S. Renal") to the Illinois Health Facilities and Services Review Board for a Certificate of Need ("CoN") for the U.S. Renal Care Streamwood Dialysis facility to be located in Streamwood, Illinois.

At the request of the legal representatives for U.S. Renal, I have examined a number of related topics with respect to the CoN application. My conclusion is that there are compelling reasons for approval of the application.

My views on this matter are informed by my background in economic regulation and by my lengthy experience related to health insurance as well as life, property and casualty insurance. I have served as Illinois Director of Insurance, the State's chief insurance regulator and as Chairman of the Illinois Commerce Commission, the State's utility regulatory agency. I hold a doctorate in Political Science from Northwestern University and have had an extensive consulting career involving economic competition in regulated industries. A copy of my resume is attached to this testimony as Appendix 1.

During my tenure as Illinois Director of Insurance, I was deeply involved in some of the earliest efforts to adjust medical insurance reimbursement methods to encourage improved utilization and to support development of lower cost treatment venues. As an insurance and utility regulator, as well as in my consulting and other professional business endeavors, I have been actively involved with market and competitive assessments in regulated industries.

Framework for Consideration of a Certificate of Need

The standards for consideration by the Board of CoN applications stand in a middle ground between the sort of exclusive utility service territories or so-called "first-in-the-field" doctrine¹ that partially governs the granting or denial by the Illinois Commerce Commission of applications for certificates of public convenience and necessity on the one hand and on the other hand the granting or denial by the Department of Insurance of licenses for insurance companies to enter one or more lines of business and to operate within the State. In the utility situation, the focus is on preventing a costly and unnecessary duplication of fixed, non-mobile capital assets in an industry that is highly capital intensive. In the insurance regulatory situation, by contrast, the focus is mainly on the financial solidity of the applicant insurance company and its record of performance in other markets or lines of business, including their conduct with respect to policyholders. There is not an assessment of need or demand in the market, the assumption being that entry into the market should be a function of an individual insurer's perceptions of the market.

The Board, while taking into consideration its estimates of likely patient populations and the potential adverse impact of an excess of service providers on investment in localized health care assets and operations, is not in the business of single-mindedly protecting incumbent providers from competitive entry by other care providers. Rather, the Board takes into account a variety of factors and ultimately and most importantly, the needs of a local population for accessible and reliable medical and other health services.

Therefore, the Board is in the position of considering U.S. Renal's application in terms of what it means for people requiring renal dialysis for a range of renal conditions. The Board is in a position to consider issues of access and availability in specific locations within the planning areas. What is the meaning for access, for convenience, for treatment options and for the prospects for the costs to these

patients and the entities that participate in paying for these services, whether it is the State, the Federal government, insurance companies and also charitable care.

Key Issues to Consider

I see four key issues that, when considered together, result in a compelling argument for approval of U.S. Renal's CoN application.

These issues are:

- The highly likely increase in demand for dialysis in Health Service Areas ("HSA") 7 and 9, due in great part to rapid, ongoing demographic changes.
- Ease and convenience of patient access to dialysis modalities in HSAs 7 and 9 which are fast growing areas of Illinois and which are increasingly traffic congested.
- Implications for cost levels and cost displacement or shifting in the wider health care system in HSAs 7 and 9 to the extent that accessibility and reliability of dialysis treatment are less than optimal.
- Treatment options for patients are adversely affected to the extent that providers of dialysis do not readily offer home-based, self-administered care as well as care based in renal dialysis centers.

With respect to all four of these issues, outcomes are likely to be better if U.S. Renal is allowed to enter the market in HSAs 7 and 9.

Patient Demand

It is appropriate for the Board to treat its own service needs estimates and projections as guidelines and as one of a number of important factors to consider rather than as a solely determinative factor. Quite properly the Board exercises its expert discretion in reviewing CoN application. One important reason for

doing so is the value of flexibility in addressing the differences across demographic groups in rates for such conditions as renal failure. The intersection of two important facts strongly suggests that that future incidence rate of chronic kidney disease in HSAs 7 and 9 may rise beyond that contemplated in current need estimates.

First, a comparison of census data for 2000 and 2010 indicates that the Chicago metropolitan areas covered by HSAs 7 and 9 have experienced substantial growth, not only in population generally, but also in terms of African-American and Hispanic populations. The combined general population growth in HSAs 7 and 9 between the 2000 and 2010 censuses was 7%, most of which occurred in HSA 9, at 37% compared to HSA 7 at less than 1%. In contrast, the combined increase in African-American and Hispanic portions of the population increased by nearly a third, or nearly five times the general population increase of 7%. The African-American portion of the combined HSA 7 and 9 total population grew from 10.7% in 2000 to 12.4% in 2010 while the Hispanic portion grew from 11.1% in 2000 to 16.6% in 2010. Thus, the combined percentage of the African-American and Hispanic populations grew from 21.8% to 29%.

The 2000 to 2010 growth in the Hispanic portion of the population has been dramatic, with the change in HSA 7 expanding nearly by half from 11.8% to 17.2%. In HSA 9, the portion of total population classified as Hispanic nearly doubled, from 7.8% in 2000 to 14.4% in 2010. Appendix 2 contains a spreadsheet with data underlying these figures.

Second, it is well understood, for example, that end stage renal disease ("ESRD") rates are considerably higher among African-American and Hispanic demographic segments than among non-Hispanic white demographic segments. The African-American ESRD rate has been reported to be 3.6 times that among whites in the United States and among Hispanics to be 1.5 times higher than that of non-Hispanics.²

The rapid growth in the African-American and Hispanic portions of the HSA 7 and 9 populations could have profound implications over time for the need for dialysis

services. Approval of U.S. Renal's application would represent a prudent step anticipating a reasonable expectation of higher incidence rates in the future than might be indicated by past rates in the two planning areas.

Patient Access

Beyond the basic issue of increased incidence rates that may be correlated with and increased portions of the HSA 7 and 9 populations that are African-American and Hispanic, there is the question of ease, convenience and certainty of timely access to dialysis services. Patient access is also closely related to cost issues, as addressed below.

A key principle in the creation of dialysis centers was that such centers could provide a combination of better, easier, more convenient access for patients trying to lead normal lives in contrast to the higher-cost, less "user-friendly" hospital setting. Indeed, the Board's mission includes helping to better assure access to lower cost yet high quality services.

There are various ways to consider improvements in patient access.

First, the Chicago metropolitan area, of which HSA 7 and 9 are included, is experiencing increased traffic congestion due to the inherent lag in road and public transit improvements in line with population growth. For example, Chicago area drivers are tied for "worst place" with drivers in the Washington D.C. area for time wasted due to traffic congestion.³

It is customary to focus on expressway congestion that contributes to the City of Chicago having the most acute congestion and lost time calculations. However, two facts should attract our interest in considering the nature of congestion as it relates to the issue of dialysis dispersion and accessibility in the suburban areas that comprise HSAs 7 and 9. First, many of the drivers losing time and being delayed by expressway traffic congestion within the City of Chicago are commuters who reside or work in the suburban areas. These drivers will include

people who require dialysis services themselves or are responsible for transportation of family or friends to dialysis centers. Second, in contrast to the Chicago Central Business District and balance of the City where 61% and 49% of congestion occur, respectively, on arterial roadways rather than on expressways, the figure for the remainder of the 6-county area is a far higher 93%.⁴

Most dialysis centers are located on or proximate to arterial roadways in the suburban areas that are the main sources of congestion. While dialysis center locations relative to arterials is not susceptible to much change, the placement of additional centers in HSA 7 and 9 will certainly facilitate patient access.

Second, it would be unrealistic to believe that patterns of seeking access to health care services are identical across demographic groups. The increase in African-American and Hispanic populations in HSAs 7 and 9 necessarily raises the question of what should be done to better assure that the many new residents accounting for this demographic change will have sufficient information, language skills, social networks, transport and, perhaps most importantly, other medical care such as pre-dialysis treatment by a nephrologist. For example, among new entrants to ESRD treatment, there was a marked difference between African-American and white patients who had not had prior nephrologist care, those figures being 47% and 41.4% respectively.⁵

To the extent that outreach and other programs either succeed or fail to largely close the gap described above as well as others, there will be varying impacts on dialysis demand and utilization.

Third, there is the question of whether the configuration of dialysis centers in HSAs 7 and 9 is fully adequate to accommodate existing demand for center-based dialysis. To the extent that there is population expansion in specific areas, such as in Bolingbrook, but where there appears are few dialysis stations, situations could easily develop in which physicians may find it necessary to delay discharging patients from hospitals due to difficulties in arranging close-to-home, near-term appointments for patients at dialysis centers.

Patient Costs and Cost Shifting

One of the central questions facing public policy makers, health system regulators, service providers, medical care payers and, of course, patients, is the cost of health care services. It is not the purpose of this testimony to delve into the complexities and intricacies of the health care finance system or of the particulars of medical economics. Rather, the focus is on features of the specific situation facing the Board with respect to dialysis services in HSAs 7 and 9.

Approval of the U.S. Renal CoN application would help to address several inter-related factors that likely are contributing to higher than necessary overall costs for dialysis services in HSAs 7 and 9 taken together.

First, the market for dialysis services is highly concentrated. The level of concentration in HSA 7 is about twice that in HSA 9, but with both markets being highly concentrated. The Herfindahl-Hirschman Index ("HHI") is a standard initial antitrust analysis screen used by the United States Department of Justice. The HHI is a simple calculation that adds up the squares of the values of percentage market shares (with the decimals ignored) of competitors in a market.⁶ Any result over 1,800 is considered highly concentrated. HSA 7 has an HHI of 5,232 while that of HSA 9 is 2,439.

The dialysis service providers in HSA 7 account for 1,056 approved stations and the providers in HSA 9 account for 217. In HSA 9 the four largest providers account for 84% of the just over two hundred approved stations while in HSA 7 just the top two providers account for 83% of the more than one thousand approved stations. Appendix 3 contains a spreadsheet upon which these various calculations are based.

It is noteworthy that the localized dialysis concentration level is higher than that in the dialysis sector nationally. According to the 2007 Economic Census, nationally the top four firms accounted for 76.7% of the market. The top eight

firms accounted for 81.6% of the national market, in stark contrast to the 83% of the market in HSA 7 accounted for by just the top two providers.⁷

In terms of comparison with other industries with which we are all familiar, the dialysis market in HSAs 7 and 9 must be regarded as highly concentrated. For example, in the entire financial and insurance services sector nationally, only government central banking entities and highly specialized entities referred to as "other depository credit intermediation" have concentration levels as high as those seen in HSAs 7 and 9 for dialysis.⁸ Similarly, in the information sector nationally, only in the greeting card and directory publishing sector are there concentration levels comparable to those for dialysis in HSAs 7 and 9, while other sectors in the information industry such as software and book publishing and even motion pictures are far less concentrated.⁹

Second, the high market concentration necessarily raises the prospect of the dampening of price competition. To the extent that there is a dearth of pressure to restrain prices, costs for service may be higher than would otherwise be the case, thus fueling the potential for excessive rates of reimbursement. Such a situation would also be likely accompanied by cost shifting or cost displacement in which the rates set by Medicare and Medicaid will be seriously deficient, placing upward pressure on prices for other patients that are already insufficiently restrained by competition.

Third, to the extent that an existing lack of competitive pressure raises prices above levels that would otherwise prevail, but new providers are denied entrance to the market, then the situation is exacerbated. Part of that exacerbation is the problem presented by an insufficient volume of services tied to the access problem described above that potentially requires extension of high-cost stays for hospital in-patients who could otherwise be served on an out-patient basis in the lower cost setting of a dialysis center.

Fourth, the changing demographics discussed above may also have important implications for cost shifting. To the extent that these demographic changes imply greater difficulties in securing reimbursement from the Federal

Government for patients who may be ineligible due to their immigration status, there will be cost shift implications. Nationally, about 70% of ESRD patients are covered exclusively or by some combination of Medicare and Medicaid while only about 15% have some form of private or other insurance coverage.¹⁰ However, the uninsured rate among Hispanics, the fastest growing demographic in HSA 7 especially is on the order of one-third. That is roughly three times the uninsured rate among non-Hispanic whites.¹¹

Overall, the problem of cost levels and cost displacement are unlikely to be addressed any time soon through changes to reimbursement mechanisms or rates of insurance coverage in salient population segments. Rather, the problem is one that underscores the importance of accommodating entry in order to stimulate development of pressure to offer lower cost alternatives, especially ones that patients may find attractive for reasons of convenience and comfort, as discussed below.

Patient Options

The U.S. Renal CoN application offers an opportunity to increase treatment modality options for patients in several respects. Importantly, these options ought to result in greater opportunities for more patients to access dialysis treatment that is both lower cost and more satisfying to them in terms of their life-style, work-life and other needs.

The 2010 USRDS Annual Report has sounded the alarm in noting that while the dialysis patient population has grown many-fold in the past three decades, the peritoneal dialysis population, that is served at lower cost, has grown much more slowly.¹² In the highly concentrated dialysis market in HSAs 7 and 9, there will be a natural and understandable lack of incentive for incumbent providers to actively promote treatment alternatives that would detract from control over patient flow and utilization. Thus, even though peritoneal dialysis is found by many patients to be a satisfying alternative and even preferable to hemodialysis,¹³ and the

convergence of patient outcomes of the two modalities,¹⁴ it does represent a challenge to in-center hemodialysis. There could be inherent disincentives for center-based dialysis services that manufacture dialysis-related supplies and equipment to offer or promote alternatives if those alternatives require less in the way of supplies and equipment.

U.S. Renal is specifically proposing as part of its plan the offering of in-home peritoneal dialysis when appropriate for the patient. The new competitive pressure brought to the market by U.S. Renal would help orient all providers toward patient satisfaction, whether through conventional hemodialysis or peritoneal methods. U.S. Renal will not suffer from any disincentive that could be related to an economic interest in the manufacturing of dialysis supplies and equipment or any other product related to dialysis services. It is solely in the business of operating dialysis services.

Conclusion

The Board has before it for consideration an application that, in light of the conditions in the dialysis market is HSA 7 and 9, should be given favorable review. To the extent that the focus is on patients and their needs, then the arguments in favor of approval should be regarded as compelling.

ENDNOTES

¹ For a discussion of the "first-in-the-field" doctrine see *Fountain Water District v. Illinois Commerce Commission* No. 5-96-0531, Appellate Court of Illinois, Fifth District <http://law.justia.com/cases/illinois/court-of-appeals-fifth-appellate-district/1997/5960531.html>.

² See page 255 United States Renal Data Service 2010 Annual Report Volume 2 "Atlas of End Stage Renal Disease", http://www.usrds.org/2010/pdf/v2_02.pdf.

³ See *Urban Mobility Report 2010*, Texas Transportation Institute, Texas A&M University, December 2010 http://tti.tamu.edu/documents/mobility_report_2010.pdf.

⁴ See page 10, *Moving at the Speed of Congestion: The True Cost of Traffic in the Chicago Metropolitan Area*, Metropolitan Planning Council, August 2008, <http://www.movingbeyondcongestion.org/downloads/MPC%20-%20Moving%20at%20the%20Speed%20of%20Congestion.pdf>.

⁵ See page 270 United States Renal Data Service 2010 Annual Report Volume 2 "Atlas of End Stage Renal Disease", http://www.usrds.org/2010/pdf/v2_03.pdf.

⁶ See the U.S. Department of Justice explanation of the Herfindahl-Hirschman Index, <http://www.justice.gov/atr/public/testimony/hhi.htm>.

⁷ See "Sector 62: Health Care and Social Assistance: Subject Series – Estab and Firm Size: Concentration by Largest Firms for the United States: 2007", U.S. Census Bureau, 2007 Economic Census, December 2010, http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=&-ds_name=EC0762SSSZ6&-lang=en.

⁸ See "Sector 52: Finance and Insurance: Subject Series - Estab & Firm Size: Summary Statistics by Concentration of Largest Firms for the United States: 2007", U.S. Census Bureau, 2007 Economic Census, November 2010, http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=&-ds_name=EC0752SSSZ6&-lang=en.

⁹ See "Sector 51: Information: Subject Series - Estab & Firm Size: Concentration by Largest Firms for the United States: 2007", U.S. Census Bureau, 2007 Economic Census, November 2001, http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=&-ds_name=EC0751SSSZ6&-lang=en.

¹⁰ See Wetmore, James B., et al "Considering Health Insurance: How Do Dialysis Initiates with Medicaid Coverage Differ from Persons without Medicaid Coverage?", *Nephrology Dialysis Transplantation*, September 2009, <http://ndt.oxfordjournals.org/content/25/1/198.full.pdf+html?sid=6be19b69-fc4f-4c29-a794-b5dc29e3ab80>.

¹¹ See: "Table HI09A. Health Insurance Coverage Status by Nativity, Citizenship, and Duration of Residence for Hispanic Population: 2009", Current Population Survey, U.S. Census Bureau, Annual Social and Economic Supplement, http://www.census.gov/hhes/www/cpstable/032010/health/h09a_000.htm.

Shah, N. Sarita and Carrasquillo, Olveen, "Twelve-Year Trends in Health Insurance Coverage among Latinos, by Subgroup and Immigration Status", *Health Affairs*, 25, no. 6 (2006): 1612-1619, <http://content.healthaffairs.org/content/25/6/1612.full.pdf+html>.

"Health Insurance Status of Hispanic Subpopulations in 2004: Estimates for the U.S. Civilian Noninstitutionalized Population under Age 65, *Medical Expenditure Panel Survey*, Agency for Healthcare Research and Quality, Statistical Brief #143, September 2006, http://www.meps.ahrq.gov/mepsweb/data_files/publications/st143/stat143.pdf.

¹² See page 278 United States Renal Data Service 2010 Annual Report Volume 2 "Atlas of End Stage Renal Disease", http://www.usrds.org/2010/pdf/v2_03.pdf.

¹³ See Rubin, Haya R. et al, "Patient Ratings of Dialysis Care with Peritoneal Dialysis vs. Hemodialysis" *Journal of the American Medical Association*, February 11, 2004, Vol. 291, No. 6.

¹⁴ See "PD and HD Outcomes and Associated Clinical Factors", Advanced Renal Education, Fresenius Medical Care North America, 2010.

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Dr. O'Connor is a recognized expert on the development and implementation business strategies in network and other regulated industries. He has been a frequent speaker, both nationally and internationally, on utility and insurance issues and has authored numerous articles in professional trade journals. He opened the office of NewEnergy Ventures in Chicago with two employees in 1998 and by 2007 the Great Lakes Region of Constellation NewEnergy had achieved nearly \$1 billion in retail electricity revenues. He was a principal with Coopers & Lybrand Consulting, into which he had merged his own firm, Palmer Bellevue Corporation, in 1994. Dr. O'Connor also served as Illinois' chief utility regulator, chairing the Illinois Commerce Commission, and as Director of the Illinois Department of Insurance and has been appointed to boards and commissions by five consecutive Illinois Governors. From March 2007 to March 2008 he served in the U.S. Embassy in Baghdad as an advisor to the Iraqi Ministry of Electricity.

Employment:

President, PROactive-Strategies, Inc, (1998-Present)

Vice President, Constellation NewEnergy, Inc. (2002-2008)
Senior VP & Illinois Market Leader, AES NewEnergy, Inc. (1998-2002)

Ministerial Advisor (Electricity), U.S. Embassy, Baghdad, Iraq (2007-8) through Parsons-Brinckerhoff under contract to the U.S. Army Corps of Engineers.

Principal/Partner, Coopers & Lybrand Consulting/Palmer Bellevue (1995-1998)

Managing Director, Palmer Bellevue, a Division of Coopers & Lybrand (1994-1995)
President and Chairman, Palmer Bellevue Corporation (1986-1993)

Chairman, Illinois Commerce Commission (1983 - 1985)
• Member, National Association of Regulatory Commissioners (1983-1985)

Director, Illinois Department of Insurance (1979 - 1982)

Assistant to the Director and Deputy Director for Research and Urban Affairs,
Illinois Department of Insurance (1977 - 1979)

Administrative Assistant to U.S. Representative George Miller (7th-CA) (1974-1977)

Assistant to California Senate Majority Leader, George Moscone (1973 - 1974)

Administrative Aide to Illinois Governor Richard B. Ogilvie (1969 - 1973)

Public & Political Service, Corporate Boards (partial list)

- Political Director, Citizens for Governor Thompson (1982)
- Chairman, U.S. Environmental Protection Agency Allowance Tracking & Trading Subcommittee of the Acid Rain Advisory Committee (1991-1992)
- General Chairman, Citizens for Governor Edgar (1994)
- Chairman of the Illinois Health Care Reform Task Force (1993-1994)
- Chairman, Illinois Task Force on Human Services Consolidation (1996-1998)
- Member, Illinois State Board of Elections (1998-2004)
- Member, Children & Families Transition Committee to Governor-Elect George H. Ryan (1998)
- Chairman, Interim Board of the Illinois Insurance Exchange (1998)
- Illinois Commerce Commission Millennium Review Committee (2000-2001)
- Member, Bush-Cheney Transition Advisory Committee on Energy (2001)
- Member of the Board, Irish Life of North America (ILoNA Financial) (1992-2002)
- Chairman, Illinois Inter-Departmental Insurance Tax Task Force (2000-2004)
- Loyola University of Chicago Rome Center Alumni Board (1998-2004)
- Member of the Advisory Board, Loyola University Museum of Art (2004-Present)
- Member of the Board, Delphi Financial Group (NYSE:DFG) (2003-Present)
- Member of the Board Reliance Standard Life Insurance (1993-Present)
- Member, Illinois Carbon Capture and Sequestration Commission (2009-Present)
- Member, Board of Haymarket Center of Chicago (2011-present)

Education

- 1966 - 1968 University of San Francisco
1968 - 1969 Loyola University of Chicago, Rome Center for Liberal Arts
1969 - 1970 Loyola University of Chicago, A.B. *Magna cum laude*
1971 Northwestern University, Graduate School, Political Science M.A. *Co-optation: A Re-definition and the Case of Chicago*
1979 Ph.D. Political Science Dissertation: *Metrosim: A Computer Simulation Model of U.S. Urban Systems*

Academic

- 1973 North Atlantic Treaty Organization (NATO) Advanced Study Institute
Summer Fellow – Polytechnic of Central London
- 1997 & 1998 Co-Instructor with Professor Alan Gitelson, *Political Science Money, Media, Message, Measurement & Motivation: Political Campaigns in the 90s*, an upper division undergraduate course, Loyola University of Chicago
- 1998 & 1999 Instructor, *The Politics of Deregulation*, Kellogg Graduate School of Management, Northwestern University, Evanston, Illinois

Appendix 2

HSA 7 Population by Race (2000 Census data)

	Cook County	City of Chicago	Suburban Cook County*	DuPage County	Total
Hispanic or Latino	1,071,740	753,644	318,096	81,366	399,462
Black or African American alone	1,405,361	1,065,009	340,352	27,600	367,952
Total Population	5,376,741	2,896,014	2,480,727	904,161	3,384,888

HSA 7 Population by Race (2010 Census data)

	Cook County	City of Chicago	Suburban Cook County*	DuPage County	Total
Hispanic or Latino	1,244,762	778,862	465,900	121,506	587,406
Black or African American alone	1,287,767	887,608	400,159	42,346	442,505
Total Population	5,194,675	2,695,598	2,499,077	916,924	3,416,001

HSA 7 Population by Race (2000-2010 Change)

	2000 Total Population	% Total	2010 Total Population	% Total	% Change
Hispanic or Latino	399,462	11.8%	587,406	17.2%	5.4%
Black or African American alone	367,952	10.9%	442,505	13.0%	2.1%
Total Population	3,384,888		3,416,001		

*Cook County Excluding City of Chicago

HSA 9 Population by Race (2000 Census data)

	Grundy County	Kankakee County	Kendall County	Will County	Total Population
Hispanic or Latino	1,552	4,959	4,086	43,768	54,365
Black or African American alone	71	16,065	718	52,509	69,363
Total:	37,535	103,833	54,544	502,266	698,178

HSA 9 Population by Race (2010 Census data)

	Grundy County	Kankakee County	Kendall County	Will County	Total Population
Hispanic or Latino	4,096	10,167	17,898	105,817	137,978
Black or African American alone	605	17,187	6,585	75,743	100,120
Total:	50,063	113,449	114,736	677,560	955,808

HSA 9 Population by Race (2000-2010 Change)

	2000 Total Population	% Total	2010 Total Population	% Total	% Change
Hispanic or Latino	54,365	7.8%	137,978	14.4%	6.6%
Black or African American alone	69,363	9.9%	100,120	10.5%	0.5%
Total:	698,178		955,808		

HSA 7 and HSA 9 Combined Population by Race (2000-2010 Change)

	2000 Total Population	% Total	2010 Total Population	% Total	% Change
Hispanic or Latino	453,827	11.1%	725,384	16.6%	5.5%
Black or African American alone	437,315	10.7%	542,625	12.4%	1.7%
Total Population	4,083,066		4,371,809		

HSA7 HERFINDAHL-HIRSCHMAN INDEX CALCULATION

Facility	Ownership	Number of Stations 3/20/2011	Market Share %	HHI
ARA-South Barrington Dialysis	ARA	14		
	ARA Total	14	1.33	1.76
Olympia Fields Dialysis Center	Davita	24		
Chicago Heights Renal Care	Davita	16		
Sloney Creek Dialysis	Davita	12		
Big Oaks Dialysis	Davita	12		
Palos Park Dialysis	Davita	12		
	Davita Total	76	7.20	51.80
Neomedica Dialysis Ctrs - Evanston	DSI	18		
RCG-South Holland	DSI	20		
Dialysis Center of America - Markham	DSI	24		
RCG Hazel Crest	DSI	17		
RCG - Arlington Heights Northwest Kidney Center	DSI	18		
RCG-Buffalo Grove	DSI	16		
RCG - Schaumburg	DSI	14		
	DSI Total	127	12.03	144.64
Downers Grove Dialysis Center	Fresenius	19		
Oak Park Dialysis Center	Fresenius	12		
Elk Grove Dialysis Center	Fresenius	28		
Central Dupage Dialysis Center	Fresenius	16		
Dialysis Center of America - Olympia Fields	Fresenius	27		
LaGrange Dialysis Center	Fresenius	20		
Fresenius Medical Care Northwest	Fresenius	16		
Neomedica Dialysis Ctrs - Rolling Meadows	Fresenius	24		
West Suburban Hosp. Dialysis Unit	Fresenius	46		
Dialysis Center of America - Berwyn	Fresenius	26		
Dialysis Center of America - Crestwood	Fresenius	32		
Blue Island Dialysis Ctr	Fresenius	24		
Neomedica Dialysis Ctrs - Far South Holland	Fresenius	17		
Naperville Dialysis Center	Fresenius	15		
Neomedica Dialysis Ctrs - Evergreen Park	Fresenius	30		
Neomedica Dialysis Ctrs - Hoffman Estates	Fresenius	17		
Dialysis Center of America - Orland Park	Fresenius	18		
Glenview Dialysis Center	Fresenius	20		
Neomedica Dialysis Ctrs - Melrose Park	Fresenius	18		
Lutheran General - Neomedica	Fresenius	32		
North Avenue Dialysis Center	Fresenius	22		
Neomedica Dialysis Ctrs - Hazel Crest	Fresenius	16		
RCG Villa Park	Fresenius	24		
Glendale Heights Dialysis Center	Fresenius	17		
RCG Skokie	Fresenius	14		
RCG - Mid America Evanston	Fresenius	20		
Aisip Dialysis Center	Fresenius	16		
FMC Dialysis Services of Willowbrook	Fresenius	16		
FMC Dialysis Services - Burbank	Fresenius	22		
RCG-Merrionette Park	Fresenius	18		
Fresenius Medical Care of Naperville North	Fresenius	14		
Fresenius Medical Care of West Chicago	Fresenius	12		
Fresenius Medical Care of Deerfield	Fresenius	12		
Fresenius Medical Care -Lombard	Fresenius	12		
Fresenius Medical Care Palatine	Fresenius	12		
Fresenius Medical Care Steger	Fresenius	12		
Fresenius Medical Care Des Plaines	Fresenius	12		
Fresenius Medical Care River Forest	Fresenius	20		
	Fresenius Total	748	70.83	5,017.36
Loyola Dialysis Center	Independent 1	30		
	Independent 1 Total	30	2.84	8.07
Evanston Hospital	Independent 2	5		
	Independent 2 Total	5	0.47	0.22
Maple Avenue Kidney Center	Independent 3	18		
	Independent 3 Total	18	1.70	2.91
Direct Dialysis - Crestwood Care Centre	Independent 4	6		
	Independent 4 Total	6	0.57	0.32
Center for Renal Replacement	Independent 5	16		
	Independent 5 Total	16	1.52	2.30
Community Dialysis of Harvey	Independent 6	16		
	Independent 6 Total	16	1.52	2.30
	Grand Total	1,056	100.00	5,231.67

HSA9 HERFINDAHL-HIRSCHMAN INDEX CALCULATION

Facility	Ownership	Number of Stations 3/20/2011	Market Share %	HHI
Renal Care Group - Morris	Fresenius	9		
Bolingbrook Dialysis Center	Fresenius	24		
Fresenius Medical Care of Oswego	Fresenius	10		
Fresenius Medical Care of Mokena	Fresenius	12		
Fresenius Medical Care of Plainfield	Fresenius	12		
Fresenius Medical Care Joliet	Fresenius	16		
	Fresenius Total	83	38.25	1,462.97
Silver Cross Renal Center	Silver Cross	19		
Silver Cross Renal Center West	Silver Cross	29		
Silver Cross Renal Center Morris	Silver Cross	9		
	Silver Cross Total	57	26.27	689.97
Sun Health	Sun Health	17		
	Sun Health Total	17	7.83	61.37
Kankakee County Dialysis	Davita	12		
	Davita Total	12	5.53	30.58
Provena St. Mary's Hospital	Independent 1	25		
	Independent 1 Total	25	11.52	132.73
Manteno Dialysis Center	Independent 2	15		
	Independent 2 Total	15	6.91	47.78
Yorkville Dialysis Center	Independent 3	8		
	Independent 3 Total	8	3.69	13.59
	Grand Total	217	100.00	2,439.00

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UNGARETTI & HARRIS LLP
CHICAGO, ILLINOIS
SPRINGFIELD, ILLINOIS
WASHINGTON, D.C.

July 26, 2011

Mr. Dale Galassie
Chairman
Illinois Health Facility and Service Review Board
525 West Jefferson Street
Springfield, Illinois 62761

**Re: 2015 Projected ESRD Patient Volume Growth and 96% Utilization of Facilities
Surrounding U.S. Renal Care Streamwood Dialysis**

Dear Mr. Galassie,

According to the rules governing the calculation of end stage renal disease ("ESRD") station need for in-center hemodialysis facility certificate of need applications, the estimated need for ESRD stations is based upon an experienced ESRD rate projected forward using a one-time population estimate for the entire health service area ("HSA"). However, historic trending data by zip code can be used to calculate a more accurate prediction of the growth in ESRD patients residing in the service area of U.S. Renal Care Streamwood Dialysis. Applicants have consistently defined their service area to be within a seven mile radius around the proposed facility, as provided in Appendix A, projecting that a majority of their patients will reside in this area. Using this seven mile radius around the proposed facility, Applicants have identified the zip codes that will generate the primary patient base of the proposed facility. According to Renal Network data for Network 10 (Illinois), and as indicated in the attached Appendix B, the prevalence of end stage renal disease for patients residing in the thirteen zip codes comprising the service area of U.S. Renal Care Streamwood Dialysis has grown steadily in the past five years. By using the experienced growth in ESRD patient volume over the past five years, Applicants have calculated a cumulative aggregate growth rate "Growth Rate" of 3.3%. This historic Growth Rate over the preceding five year period, applied forward for the next five years, can be used to predict the volume of ESRD patients in the service area. As applied to the service area of U.S. Renal Care Streamwood Dialysis, this model predicts a total ESRD volume of nearly 408 patients in 2015, or 61 patients over the 2010 experienced volume, a dramatic increase in ESRD patients in the immediate future.

This prediction of the high growth in ESRD patients becomes even more alarming when the number of currently approved dialysis stations is used to project utilization over the next five years. As indicated in Appendix C, Applicant has identified the currently existing or approved stations within the seven mile radius service area of U.S. Renal Care Streamwood Dialysis. As demonstrated in Appendix B, when the maximum capacity of such stations are applied against

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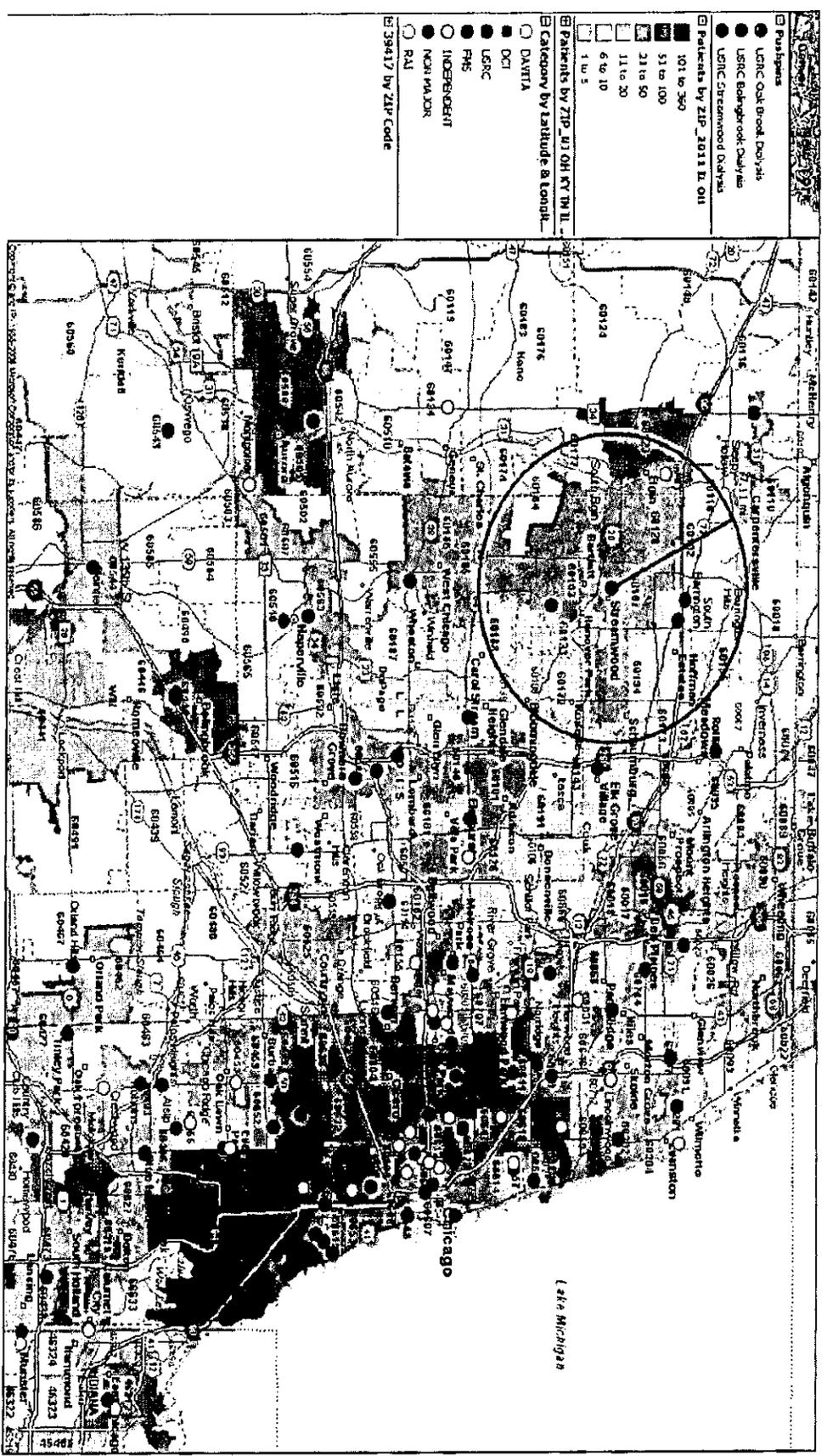
the predicted growth in ESRD patients, the utilization of such stations rapidly reaches total capacity over the next five years, with utilization in 2015 exceeding 96%. At such levels, it is inconceivable that patients requiring dialysis services could obtain timely dialysis treatment upon discharge from a hospital, let alone obtain such treatment at times that promote patient choice and consequently quality care. Furthermore, the realization of such levels of utilization would result in negative patient care issues including longer drive times, patients missing treatments due to the lack of shift availability or drive time issues, and additional shift creation leading to decreased dialysis treatment times or late night dialysis treatments.

The predictions of ESRD patient growth and utilization, calculated using recent historical data and applied in a systematic methodology, clearly demonstrate the need for an additional dialysis provider in the service area. As such, the Illinois Health Facilities and Services Review Board should recognize the dramatic need for additional dialysis stations in this area and approve the certificate of need application for U.S. Renal Care Streamwood Dialysis.

Sincerely,

A handwritten signature in black ink, appearing to read 'Shawn K. Moon', written over a horizontal line.

Shawn K. Moon



APPENDIX B

ZipCode	ESRD Network	State	County Name	City	Actual					Projected				
					Dec-05	Dec-06	Dec-07	Dec-09	Dec-10	Dec-11	Dec-12	Dec-13	Dec-14	Dec-15
60103	10 IL	DUPAGE	BARTLETT	42	40	35	34	28	29	30	31	32	33	
60133	10 IL	COOK	HANOVER PARK	18	18	27	39	33	34	35	36	38	39	
60108	10 IL	DUPAGE	BLOOMINGDALE	31	36	29	28	30	31	32	33	34	35	
60172	10 IL	DUPAGE	ROSELLE	16	21	24	24	22	23	23	24	25	26	
60120	10 IL	KANE	ELGIN	37	48	53	54	55	57	59	61	63	65	
60179	10 IL	COOK	HOFFMAN ESTATES	2	2	1	2	2	2	2	2	2	2	
60107	10 IL	COOK	HOFFMAN ESTATES	2	2	2	7	7	7	7	8	8	8	
60195	10 IL	COOK	STREAMWOOD	36	39	50	59	55	57	59	61	63	65	
60193	10 IL	COOK	SCHAUMBURG	26	25	21	15	17	18	18	19	19	20	
60169	10 IL	COOK	SCHAUMBURG	45	43	40	47	46	48	49	51	52	54	
60194	10 IL	COOK	SCHAUMBURG	37	29	22	20	23	24	25	25	26	27	
60173	10 IL	COOK	SCHAUMBURG	5	5	3	1	3	3	3	3	3	4	
				295	306	307	359	347	358	370	383	395	408	
						5 year CAGR >>	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	
						Licensed Stations >>	71	71	71	71	71	71	71	
						# of Shifts >>	6	6	6	6	6	6	6	
						Maximum Capacity >>	426	426	426	426	426	426	426	
						Utilization >>	84%	87%	90%	93%	96%			

USRC FACILITY	FACILITY NAME	CHAIN NAME	IDPH ADDRESS	IDPH CITY	MEDICARE ZIP	3-31-2011 STATIONS
US RENAL CARE STREAMWOOD	COBBLESTONE DIALYSIS		934 Center Street	LICIN	60120	14
US RENAL CARE STREAMWOOD	FRESNIUS MEDICAL CARE OF WEST CHICAGO	FRESNIUS MEDICAL CARE (FMC)	1859 N. MELTNER BLVD.	WEST CHICAGO	60185	12
US RENAL CARE STREAMWOOD	RCG - SCHUMBURG	NATIONAL RENAL INSTITUTES (NRI)	1156 S. ROSLIE RD.	SCHUMBURG	60139	14
US RENAL CARE STREAMWOOD	ABA-SOUTH BARRINGTON DIALYSIS	AMERICAN RENAL ASSOCIATES (ARA)	337 W. HIGGINS ROAD	S. BARRINGTON	60010	14
US RENAL CARE STREAMWOOD	NEOMEDICA DIALYSIS CTBS - HOFFMAN ESTATES	FRESNIUS MEDICAL CARE (FMC)	3150 WEST HIGGINS ROAD	HOFFMAN ESTATES	60195	12
						71

July 26, 2011

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

Dear Mr. Galassie,

I am writing to you in full support of the dialysis center proposed for Streamwood. Unfortunately, I know all too well how badly we need a dialysis center in the area.

My name is Mary Ann Foster and I am a resident at the Aiden Valley Ridge Nursing Home in Bloomingdale. I have been seeing my doctors for the last year for kidney issues and now it is has reached a point where I need to go on dialysis.

I was recently admitted to Glen Oaks hospital and when it came time to be discharged to a dialysis facility, there were no spots available to me at the centers close to where I live. When one did open up, it was at a place my doctor didn't have privileges so he wouldn't have been able to see me there. I trust my doctors and the wonderful care they have given me. I want them to remain a partner in my care. I don't want to be shuffled around to different facilities with different doctors.

Having to deal with health issues is bad enough, I shouldn't have to worry about not being able to access the care I so badly need. If there was a dialysis center in Streamwood, it would be much more convenient for me and I wouldn't have to worry about traveling far away from home to get dialysis.

Please approve the Streamwood dialysis center. Thank you for your time.

Sincerely,



Mary Ann Foster

275 E Army Trail Road
Bloomingdale, IL 60108