Fresenius Medical Care

August 21, 2012

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HEALTH FACILITIES &
SERVICES REVIEW BOARD

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62716

Re: Opposition - #12-052, DaVita Tazewell County

Dear Ms. Avery:

I am the Regional Vice President for Fresenius Medical Care with responsibility for the Central Illinois region, including Pekin and Peoria. The Pekin and Peoria facilities have served the area for 17 years.

When Fresenius submitted its application for North Pekin,it believed there was a need. This Board, however, determined that since its rules state there is a need for only three stations (now two given the addition of a station in the Service Area at Spoon River/Canton, Illinois), the nine stations proposed by us in North Pekin were not necessary. The Board also noted the excess capacity at our Peoria facilities. This excess exists primarily because we do not operate third shifts at these facilities. However, we can and will be responsive to the Board's concerns and begin operating these shifts. We also decided to relocate the Pekin Hospital clinic and add two stations - which is consistent with the Board's need criteria. We believe this will meet the need in the area. We respect the Board's decision and are glad to work within its framework.

However, Fresenius was troubled by the Board's comments on the North Pekin application regarding choice, competition and market share, since those are not relevant criteria for accepting or rejecting a CON application. This appears to be a recurring theme for the Board when confronted with Fresenius applications. I respectfully assert that the Board should not attempt to shape the market by denying Fresenius applications on the basis of excess capacity, while approving other non-Fresenius applications in the same health service area and thirty minute radius. The Board took this approach at the July 2012 meeting when it voted down the Fresenius Schaumburg application on the basis of excess capacity but approved the US Renal Villa Park application. These two projects were in the same Health Service Area, with the same need for the same number of stations and the exact maldistribution issue, i.e., 60% of facilities within 30 minutes were under-utilized in each SBR (Tab A - attached SBRs for both projects, and see also the Board Transcript for the July 24, 2012 Board meeting). The Board took a similar approach at the October 2011 meeting when it turned down Fresenius Naperbrook's application on the basis of excess capacity but approved the US Renal Bolingbrook application, which is one block from the existing Fresenius Bolingbrook facility (see attached Tab B which contains the

Fresenius Medical Services ♦ North Division
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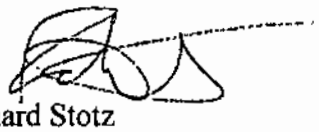
SBRs for these projects). The projects were in the same HSA and had the same findings on the maldisribution of services criteria (see Tab B, and also see the Board hearing transcripts from the October 2011 meeting when these projects were considered which is attached as Tab C).

In the instant case, DaVita proposes to build the Tazewell facility within 2 miles of the Fresenius North Pekin facility that was denied by the Board. Given the proximity of the two projects, the Tazewell facility would duplicate services and exceed the need in the area. The Board's concern about excess capacity in the Peoria facilities would remain. Thus, there does not appear to be any reason for the Board to approve DaVita's Tazewell application except to inject perceived competition against Fresenius into the market place. The Board's role in providing for proper health planning to adequately address need while not duplicating services so as to control health care costs does not require it to do this, and in fact there is nothing within the law and rules it works under that even reference this as a goal this Board is to address. As an example, competition is not likely to lower the price of dialysis services, since 80% of patients are on Medicare or Medicaid, which set standard reimbursement rates regardless of the provider. There is no evidence before this Board that Fresenius clinics provide poor quality in the area or that the DaVita/Usman clinic will provide better quality. In fact, the area Fresenius clinics exceed national and state norms for quality parameters, as evidenced by Pro Public data, an independent entity. (See attached).

As a result, I strongly urge you to disapprove the DaVita Tazewell application for the same reasons you denied Fresenius's North Pekin project. There is a need for two (2) stations not eight (8) stations, and there is excess capacity. You relied on those facts in denying our North Pekin application and we request you similarly deny the DaVita Tazewell County application.

Sincerely,



Richard Stotz
Regional Vice President

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO:	BOARD MEETING:	PROJECT NO:	PROJECT COST:
H-20	June 23-24, 2012	12-015	Original: $3,868,850
FACILITY NAME:		CITY:	
Fresenius Medical Care Schaumburg		Schaumburg	
TYPE OF PROJECT: Substantive			HSA: VII

PROJECT DESCRIPTION: Fresenius Medical Care Holdings, Inc., and Fresenius Medical Care Schaumburg, LLC d/b/a Fresenius Medical Care Schaumburg ("the applicants") are proposing the establishment of a 12-station End Stage Renal Dialysis (ESRD) facility located in 7,500 GSF of leased space in Schaumburg. The cost of the project is $3,868,850.

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EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The applicants (Fresenius Medical Care Holdings, Inc., and Fresenius Medical Care Schaumburg, LLC d/b/a Fresenius Medical Care Schaumburg) are proposing the establishment of a 12-station End Stage Renal Dialysis (ESRD) facility located in 7,500 GSF of leased space in Schaumburg. The cost of the project is $3,868,850.
- **The anticipated project completion date is September 30, 2014.**

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project proposes to establish a health care facility as defined by Illinois Health Facilities Planning Act.

PURPOSE OF THE PROJECT:

- The project seeks to address the calculated need for 92 stations by CY 2013 and the high utilization of existing facilities within 5 miles of the proposed facility.

NEED FOR THE PROJECT:

- To establish a dialysis service
  1. there must be a calculated need in the planning area;
  2. the proposed service must provide service to planning area residents;
  3. there must be a demand for the service in the planning area;
  4. the proposed service must improve access;
  5. the proposed service will not cause an unnecessary duplication of service or maldistribution of service; and,
  6. will not reduce the utilization of other area providers.

BACKGROUND/COMPLIANCE ISSUES

- Neither applicant has outstanding compliance issues with the State Board.

PUBLIC HEARING/COMMENTS

- No public hearing was requested and no letters of opposition have been received by the State Board Staff. Letters of support were submitted.

- **The President of St. Alexius Medical Center** stated *"Fresenius Medical Care provides services for both acute and chronic dialysis patients at St. Alexius Medical Center, allowing for continuity of care as the patient could then be assigned to receive ongoing treatment at the proposed Fresenius facility in Schaumburg."*

FINANCIAL AND ECONOMIC FEASIBILITY

- The entirety of the project will be funded through internal sources (Cash and Securities/Fair Market Value of the Leases and a review of the financial statements indicate sufficient cash is available to fund the project.

CONCLUSIONS:

- There is a calculated need for 92 ESRD stations in the HSA-VII planning area by CY 2013. The applicants have documented that the 100% of the patients will come from within the HSA-VII planning area and it appears there is sufficient patients to justify the new facility (83 pre ESRD patients). However there are 15 facilities within 30 minutes of the proposed facility; 9 facilities are not operating at the 80% target occupancy.

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1110.234 (c) Size of the Project	The facility size is in excess of the State Standard by 105 GSF per station *The applicants explain that the additional space is needed for a home dialysis department, administrative offices, and for future expansion.*
1110.1430 (b) Planning Area Need	9 of 15 facilities within 30 minutes are not operating at 80% target occupancy; therefore there it does not appear to be a service access issue in this market area nor a need for additional stations.
1110.1430 (e) Maldistribution/ Unnecessary Duplication of Service	9 of 15 facilities within 30 minutes are not operating at 80% target occupancy therefore it appears that an unnecessary duplication may result with the establishment of this facility.

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STATE BOARD STAFF REPORT
Fresenius Medical Care Schaumburg
PROJECT #12-015

Applicants	Fresenius Medical Care Holdings, Inc. Fresenius Medical Care Schaumburg, LLC
Facility Name	Fresenius Medical Care Schaumburg
Location	Schaumburg
Application Received	February 10, 2012
Application Deemed Complete	February 10, 2012
Review Period Ended	April 10, 2012
Review Period Extended by the State Board Staff	No
Public Hearing Requested	No
Applicants' Deferred Project	No
Can Applicants Request Another Deferral?	Yes
Applicants' Modified the Project	No

I. The Proposed Project

Fresenius Medical Care Holdings, Inc., and Fresenius Medical Care Schaumburg, LLC d/b/a Fresenius Medical Care Schaumburg ("the applicants") are proposing the establishment of a 12-station End Stage Renal Dialysis (ESRD) facility located 7,500 GSF of leased space in Schaumburg. The cost of the project is $3,868,850. **The anticipated project completion date is September 30, 2014.**

II. Summary of Findings

A. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1110.

B. The State Board Staff finds the proposed project appears to be in conformance with the provisions of Part 1120.

III. General Information

The applicants are Fresenius Medical Care Schaumburg, LLC d/b/a Fresenius Medical Care Schaumburg and Fresenius Medical Care Holdings, Inc. Fresenius Medical Care Holdings, Inc is the parent organization for all the entities. The proposed facility will be located at 815-825 W. West Wise Road, in Schaumburg. Schaumburg 1.0, LLC, owns the site. Fresenius Medical Care Schaumburg, LLC

d/b/a Fresenius Medical Care Schaumburg is the operating entity/licensee. The proposed facility will be located in Schaumburg in HSA VII. HSA VII is comprised of DuPage and Suburban Cook County. According to the June Update to IDPH Inventory of Health Care Facilities ("Inventory"), HSA VII there is a calculated need of 92 stations in the planning area by CY 2013.

Table One depicts the ESRD facilities in within 30 minutes of the proposed facility and their utilization. There are 15 facilities within 30 minutes of the proposed facility. Of the 15 facilities 9 are not at target occupancy (60%).

TABLE ONE
Facilities within 30 minutes of proposed facility

Name	City	Stations	Adjusted Time	Utilization	Met Occupancy?
USRC Streamwood Dialysis	Streamwood	13	9.7	0.00%	No
ARA-South Barrington Dialysis	Barrington	14	19	60.71%	No
FMC - Rolling Meadows	Rolling Meadows	24	19.5	71.53%	No
Davita - Arlington Heights	Arlington Heights	18	21.5	54.63%	No
FMC of West Chicago	West Chicago	12	23.5	40.28%	No
Fresenius Lombard	Lombard	12	24.5	29.17%	No
USRC Oak Brook Dialysis	Downers Grove	13	25.3	0.00%	No
Davita Cobblestone	Elgin	14	26	72.62%	No
Fresenius Des Plaines	Des Plaines	12	29.2	0.00%	No
Schaumburg Renal Center	Schaumburg	20	2	90.48%	Yes
FMC - Elk Grove	Elk Grove Village	28	11.2	90.48%	Yes
FMC - Hoffman Estates	Hoffman Estates	20	16.7	95.00%	Yes
FMC - Glendale Heights	Glendale Heights	17	21.2	92.16%	Yes
Fresenius Downers Grove	Downers Grove	19	26.7	87.82%	Yes
Fresenius Elmhurst	Elmhurst	24	29.2	85.42%	Yes

Sorted by Time, time determine by a travel time study that was performed in conformance with 1100.510 e. Travel Time Study
Utilization information taken from March 2012 Renal Network Data.

There is no land acquisition cost for this project. Start-Up Costs and Operating Deficit total $53,650. This is a substantive project subject to both a Part 1110 and

Part 1120 review. Project obligation will occur after permit issuance. **The anticipated project completion date is September 30, 2014.**

Summary of Support and Opposition Letters

No public hearing was requested. No letters of opposition were received by the State Board Staff. Letters of support were received from by the State Board Staff. A sample of support letter comments is below.

The President of St. Alexius Medical Center stated *"Fresenius Medical Care provides services for both acute and chronic dialysis patients at St. Alexian Medical Center, allowing for continuity of care as the patient could then be assigned to receive ongoing treatment at the proposed Fresenius facility in Schaumburg."*

IV. The Proposed Project - Details

The applicants propose to establish a 12 station ESRD facility housed in 7,500 Gross Square Feet ("GSF") of leased space in Schaumburg.

V. Project Costs and Sources of Funds

The total estimated project cost is $3,868,850. The proposed project is being funded with cash and securities totaling $1,619,075 and leases with a Fair Market Value of $2,249,775. Table Two outlines the project's costs and uses of funds. The State Board Staff notes all costs are classified as being clinical.

TABLE TWO
Project Uses and Sources of Funds

Uses of Funds	Clinical
Modernization Contracts	$1,065,000
Contingencies	$117,075
A & E Fees	$117,000
Moveable Equipment	$320,000
Fair Market Value of Leased Space & Equipment	$2,249,775
Total Uses of Funds	**$3,868,850**
Sources of Funds	**Clinical**

TABLE TWO Project Uses and Sources of Funds	
Uses of Funds	**Clinical**
Cash and Securities	$1,619,075
Leases (fair market value)	$2,249,775
Total Sources of Funds	**$3,868,850**

Itemization of the line item amounts above can be found at pages 32-33 of the application for permit.

VI. Cost/Space Requirements

Table Three displays the project's cost/space requirements for the project. The clinical portion comprises approximately 100% of the cost and GSF.

TABLE THREE Fresenius Medical Care Schaumburg Cost/Space Allocation							
Clinical Department	Cost	Existing GSF	Proposed GSF	New	Modernized	Vacated	As Is
ESRD	$3,868,850	0	7,500	0	7,500	0	0
Total	**$3,868,850**	**0**	**7,500**	**0**	**7,500**	**0**	**0**

VI I. Section 1110.230 - Project Purpose, Background and Alternatives

A. Criterion 1110.230(a) - Background of Applicant

The Criterion states:

"1) 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.* [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFPB shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. A health care facility is considered

"owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity (refer to 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

The applicant provided a list of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, a certified listing from the applicant of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application, and authorization permitting HFPB and Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted.

B. Safety Net Impact Statement/Charity Care

The establishment of the Fresenius Medical Care Schaumburg dialysis facility will not have any impact on safety net services in the community. Outpatient dialysis services are not typically considered "safety net" services, to the best of our knowledge. However, we do provide care for patients in the community who are economically challenged and/or who are undocumented aliens, who do not qualify for Medicare/Medicaid. We assist patients who do not have insurance in enrolling when possible in Medicaid and/or Medicaid as applicable, and also our social services department assists patients who have issues regarding transportation and/or who are wheel chair bound or have other disabilities which require assistance with respect to dialysis services and transport to and from the unit.

This particular application will not have an impact on any other safety net provider in the area, as no hospital within the area provides dialysis services on an outpatient basis.

Fresenius Medical Care is a for-profit publicly traded company and is not required to provide charity care, nor does it do so according to the Board's definition. However, Fresenius provides care to all patients regardless of

their ability to pay. There are a number of patients treated by Fresenius who either do not qualify for or will not seek any type of coverage for dialysis services. These patients are considered "self-pay" patients. These patients are invoiced as all patients are invoiced, however payment is not expected and Fresenius does not initiate any collections activity on these accounts. These unpaid invoices are written off as bad debt. Fresenius notes that as a for profit entity, it does pay sales, real estate and income taxes. It also does provide community benefit by supporting various medical education activities and associations, such as the Renal Network and National Kidney Foundation.

The table below shows the amount of "self-pay" care provided for the 3 fiscal years prior to submission of the application for **all Fresenius Medical Care facilities in Illinois** and the amount of care provided to Medicaid patients for the three fiscal years prior to submission of the application for all **Fresenius Medical Care facilities in Illinois.** This includes in-center hemodialysis, peritoneal dialysis, home hemodialysis & sub-acute hemodialysis.

TABLE FOUR SAFETY NET INFORMATION Fresenius Medical Care Facilities in Illinois			
NET REVENUE	$348,282,909	$364,295,636	$397,467,778
CHARITY CARE			
	2008	2009	2010
Charity (# of self-pay patients)	305	260	146
Charity (self-pay) Cost	$3,524,880	$3,642,751	$1,307,966
% of Charity Care to Net Rev.	1.01%	1.00%	0.33%
MEDICAID			
	2008	2009	2010
Medicaid (Patients)	1,626	1,783	1,828
Medicaid (Revenue)	$37,043,006	$40,401,403	$44,001,539
% of Medicaid to Net Revenue	10.64%	11.09%	11.07%

C. Criterion 1110.230(b) - Purpose of the Project

The Criterion states:

The applicant shall 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, per the applicant's definition.

1) The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of such information include:
   A) The area's demographics or characteristics (e.g., rapid area growth rate, increased aging population, higher or lower fertility rates) that may affect the need for services in the future;
   B) The population's morbidity or mortality rates;
   C) The incidence of various diseases in the area;
   D) The population's financial ability to access health care (e.g., financial hardship, increased number of charity care patients, changes in the area population's insurance or managed care status);
   E) The physical accessibility to necessary health care (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).
2) The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).
3) The applicant shall detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific time frames that relate to achieving the stated goals.
4) For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any

regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.

The project seeks to address the calculated need for 92 stations by CY 2013 and the high utilization of existing facilities within 5 miles of the proposed facility. The recent station additions in this market area are all projected to be at 80% within two years after completion. Dr. Wick the referring physician currently rounds at Davita Schaumburg and two Fresenius facilities in Elk Grove and Hoffman Estates. Currently these three facilities are operating at over 90%.

The applicants cited quantifiable goals as being the ability to improve access while monitoring patient demand, and that the facility will achieve quality outcomes as demonstrated by achieving 92% of patients having a URR greater than or equal to 65%, and 95% of patients having a Kt/V greater than or equal to 1.2.

D. Criterion 1110.230(c) - Alternatives to the Proposed Project

The Criterion states:

"The applicant shall 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.

1) Alternative options shall be addressed. Examples of alternative options include:
   - **A) Proposing a project of greater or lesser scope and cost;**
   - **B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;**
   - **C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and**
   - **D) Other considerations.**

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short

term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data,that verifies improved quality of care, as available."

The applicants propose a 12-station ESRD facility. The applicants considered the following alternatives:

1. **Proposing a project of greater or lesser scope**
2. **Pursuing a joint venture**
3. **Using other area facilities**

The applicants rejected these three alternatives because according to the applicants *"the physicians were already using other facilities, the business model preferred by the applicants is to wholly own their facility, and finally a project of lesser scope would not address the calculated station need in the planning area and the high utilization at the that three facilities in which patients were being referred."*

VI. Section 1110.234 - Project Scope and Size, Utilization and Unfinished/Shell Space – Review Criteria

A) Size of Project

The Criterion states:

"The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix B, unless the additional GSF can be justified by documenting one of the following:

1) Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
2) The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
3) The project involves the conversion of existing bed space that

results in excess square footage."

The applicants propose to establish a 12 station ESRD facility in 7,500 GSF of leased space. The State board standard is 360-520 GSF per station. The applicants note the project is allocating 625 GSF per station, which exceeds the standard. The applicants explain that the additional space is needed for a home dialysis department, administrative offices, and for future expansion. Table Five illustrates the spatial configuration, and the mentioned overage.

TABLE FIVE
SIZE OF PROJECT
12-015 FMC Schaumburg

Department/Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
ESRD Facility	7,500 GSF (12 Stations)	360-520 DGSF	105 GSF Over	No

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE SIZE OF PROJECT CRITERION (77 IAC 1110.234(a)).

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. If the applicant does not meet the utilization standards in Appendix B, or if service areas do not have utilization standards in 77 Ill. Adm. Code 1100, the applicant shall justify its own utilization standard by providing published data or studies, as applicable and available from a recognized source, that minimally include the following:

The applicants have documented by the second year after project completion they will be above the State Board's target occupancy of 80% (Application, P. 75).

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT

APPEARS TO BE IN CONFORMANCE WITH THE PROJECTED SERVICES UTILIZATION CRITERION (77 IAC 1110.234(b)).

IX. Section 1110.1430 - In-Center Hemodialysis Projects - Review Criteria

The criterion for establishing an ESRD facility reads as follows:

A) Criterion 1110.1430 (a) Planning Area Need

1) 77 Ill. Adm. Code 1100 (formula calculation)

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.

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.

B) Applicants proposing to add stations to an existing in-center hemodialysis service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing in-center hemodialysis service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

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 two-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).

A) Historical Referrals

i) If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.

ii) Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient facility.

B) Projected Referrals
The applicant shall provide physician referral letters that attest to:

i) The physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the

most recent three years and the end of the most recent quarter;

ii) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

iii) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iv) An estimated number of existing patients who are not expected to continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);

v) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty;

VI) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

VI i) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

4) Service Demand - Expansion of In-Center Hemodialysis Service
The number of stations to be added for each category of service is necessary to reduce the facility's experienced high utilization and

to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either (b)(4)(B) or (C):

A) Historical Service Demand

i) An average annual utilization rate that has equaled or exceeded utilization standards for in-center hemodialysis service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

ii) If patients have been referred to other facilities in order to receive the subject service, the applicant shall provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient facility, for each of the latest two years.

B) Projected Referrals

i) The applicant shall provide physician letters that attest to:

- the physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

- the number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

- an estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the

physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The anticipated number of referrals cannot exceed the physician's documented historical caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

ii) Each referral letter shall contain the physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty;

iii) The physician shall verify that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

iv) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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, indiVI duals 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 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.**

b) Planning Area Need Review Criterion

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 (formula calculation)

According to the June 2012 update to the IDPH Inventory of Health Care Facilities ("Inventory"), HSA-VII shows a calculated need for 92 stations in the planning area.

2) Service to Planning Area Residents

The primary purpose of this project is to provide in-center ESRD services to the residents of HSA-VII more specifically Schaumburg, The applicants

state that they anticipate 100% (83 pre ESRD patients) of their patient base originating from the planning area.

3) Service Demand

The applicants submitted a referral letter from Dr. Wick, the referring physician for the proposed facility; that of the 118 pre ESRD patients, 83 pre ESRD patients will be provided service at the proposed Schaumburg facility.

4) Service Accessibility

There is no absence of dialysis service within the planning area, nor access limitations due to payor status of patients or restrictive admission policies at other area facilities and 9 of 15 facilities within 30 minutes are not at target occupancy; therefore it does not appear to be a service access issue in the planning area.

While there is a calculated need for a 92 stations by CY 2013, there are 9 of 15 stations within 30 minutes not operating at the State Board's target occupancy therefore a positive finding cannot be made.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE PLANNING AREA NEED CRITERION (77 IAC 1110.1430(b)).

B) Criterion 1110.1430 (c) - 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 30 minutes normal travel time 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 30 minutes normal travel time from the project site that provide 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.**

The applicant provided a list of all zip code areas that are located within 30 minutes of the proposed site as required. The applicants' state that the ratio of ESRD stations to population is 1 station per 5,930 individuals based upon the 2010 census and within 30 minutes radius of the proposed

facility. As of the June 2012 Inventory, and the 2010 population census, the State ratio is 1 station per 3,371 individuals.

The State Board Staff notes 9 of the 15 facilities within 30 minutes of the proposed site are not operating at the target occupancy of 80% (See Table One), with an average occupancy of 56.66%. The applicants state that the project will not have an adverse impact on area providers due to the 83 patients that are new pre-ESRD patients. In addition the referring physicians will continue their current referral patterns to the other area facilities. Because there are existing facilities not at target occupancy it appears a duplication of service may result from the establishment of this facility.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE UNNECESSARY DUPLICATION MALDISTRIBUTION OF SERVICE CRITERION (77 IAC 1110.1430 (c).

C) Criterion 1110.1430 (e) - Staffing Availability

The Criterion states:

"The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO 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 210 ILCS 62, 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 Dietetic and Nutrition Services Practice Act [225 ILCS 30]) 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's of Social Work and meet the State of Illinois requirements (see 225 ILCS 20, the Clinical Social Work and Social Work Practice Act)."

The applicants are proposing to establish a 12-station ESRD facility and have provided the necessary information as required by this criterion on pages 91 of the application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE STAFFING CRITERION (77 IAC 1110.1430 (e)(1)).

D) Criterion 1110.1430(f) - Support Services

The Criteria states:

"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 are proposing to establish a 12-station ESRD facility and have provided the necessary documentation as required by this criterion at page 92 of the application for permit. The applicants note St. Alexius Medical Center, will provide back up services for the facility.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH THE SUPPORT SERVICES CRITERION (77 IAC 1110.1430 (f)).

E) **Criterion 1110.1430 (g) - Minimum Number of Stations**

The minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

1) **Four dialysis stations for facilities outside an MSA;**

2) **Eight dialysis stations for a facility within an MSA.**

The proposed 12 station ESRD facility will be located in an MSA. The applicants have met the requirements of this criterion

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE MINIMUM NUMBER OF STATIONS CRITERION (77 IAC 1110.1430 (g)).

F) **Criterion 1110.1430(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 are proposing to establish a 12-station ESRD facility and have provided the necessary documentation as required by this criterion at page 102 of the application for permit. The applicants note St. Alexius Medical Center will provide Blood bank, Rehabilitation, and Psychiatric

services.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH THE SUPPORT SERVICES CRITERION (77 IAC 1110.1430 (f)).

G) **Criterion1110.1430 (j) - Assurances**

The Criterion states:

"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 area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas .1.2."

The applicants provided the required certification information on page 94 of the application for permit as required of the criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE ASSURANCES CRITERION (77 IAC 1110.1430 (j)).

X. <u>1120.120 - Availability of Funds</u>

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable:

a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:

1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and

2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;

b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience. Provide a list of confirmed pledges from major donors (over $100,000);

c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;

d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:

1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;

2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;

3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;

4) **For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;**

e) **Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;**

f) **Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;**

g) **All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.**

The applicants are funding the project with cash and securities of $1,619,075 and the FMV of the lease of $2,249,775. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE AVAILABILITY OF FUNDS CRITERION (77 IAC 1120.120 (a)).

XI. 1120.130 - Financial Feasibility

Financial Viability Waiver
The applicant is NOT required to submit financial viability ratios if:

1) **all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or**

HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.

2) the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA), or its equivalent; or

HFSRB NOTE: MBIA Inc is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.

3) the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.

b) Viability Ratios

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards. The latest three years' audited financial statements shall consist of:

1) Balance sheet;

2) Revenues and expenses statement;

3) Changes in fund balance; and

4) Changes in financial position.

HFSRB NOTE: To develop the above ratios, facilities shall use and submit audited financial statements. If audited financial statements are

not available, the applicant shall use and submit Federal Internal Revenue Service tax returns or the Federal Internal Revenue Service 990 report with accompanying schedules. If the project involves the establishment of a new facility and/or the applicant is a new entity, supporting schedules to support the numbers shall be provided documenting how the numbers have been compiled or projected.

c) **Variance**

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

The applicants have qualified for the financial waiver because the project is being funded with internal sources including capital expended through a lease The applicants are funding the project with cash and securities of $1,619,075 and the FMV of the lease of $2,249,775. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project.

Table Six outlines Fresenius Medical Care credit rating from all three credit rating agencies. These credit ratings are **opinions** of the three rating agencies on the ability of a corporation to meet its financial obligation on time and in full.

TABLE SIX
Fresenius Credit Rating

	Standard & Poor's	Moody's	Fitch
Corporate Credit Rating	BB	Ba1	BB
Outlook	positive	stable	positive

BB—Less vulnerable in the near-term but faces major ongoing uncertainties to adverse business, financial and economic conditions.
Ba1-Speculative investment. Occurs often in deteriorated circumstances, usually problematic to predict future development
'BB'- ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time; however, business or financial flexibility exists which supports the servicing of financial commitments

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE FINANCIAL FEASIBILITY CRITERION (77 IAC 1120.130 (a)).

XII. Section 1120.140 - Economic Feasibility

A. Criterion 1120.140(a) - Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

The applicants are funding the project with cash and securities of $1,619,075 and the FMV of the lease of $2,249,775. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project. The applicants have provided the necessary attestation that borrowing (leasing) is less costly than the liquidation of existing investments. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF FINANCING ARRANGEMENTS CRITERION (77 IAC 1120.140(a)).

B. **Criterion 1120.140(b) - Terms of Debt Financing**

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

The applicants are funding the project with cash and securities of $1,619,075 and the FMV of the lease of $2,249,775. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project. The applicants have attested that the selected form of debt financing (leasing) will be at the lower net cost available to the applicants. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TERMS OF DEBT FINANCING CRITERION (77 IAC 1120.140(b)).

C. **Criterion 1120.140(c) - Reasonableness of Project Cost**

The applicant shall document that the estimated project costs are reasonable and shall document compliance with the State Board's standards as detailed in 77 IAC 1120.

Modernization Contracts and Contingencies - These costs total $1,182,075 or $157.61 per gross square feet. ($1,182,075/7,500 GSF = $157.61/GSF) This appears reasonable when compared to the State Board standard of $170.58/GSF.

Contingencies - These costs total $117,075. These costs are 9.99% of modernization costs. This appears reasonable when compared to the State Board standard of 10%-15% of modernization costs.

Architect and Engineering Fees - These costs total $117,000 or 9.9% of modernization and contingency costs. This appears reasonable when compared to the State Board standard of 6.90% -10.36% of modernization and contingency costs.

Moveable Equipment - These costs total $320,000 or $26,666 per station. This appears reasonable when compared to the State Board standard of $39,945.

Fair Market Value of Leased Space - These costs are $2,249,775. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF PROJECT COST CRITERION (77 IAC 1120.140 (c)).

D) Criterion 1120.140 (d) - Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

The applicants anticipate the direct operating costs per treatment to be $52.47. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECT DIRECT OPERATING COSTS CRITERION (77 IAC 1120.140 (d)).

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

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The applicants anticipate the total effect of the Project on Capital Costs per treatment to be $20.75. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS CRITERION (77 IAC 1120.140 (e)).

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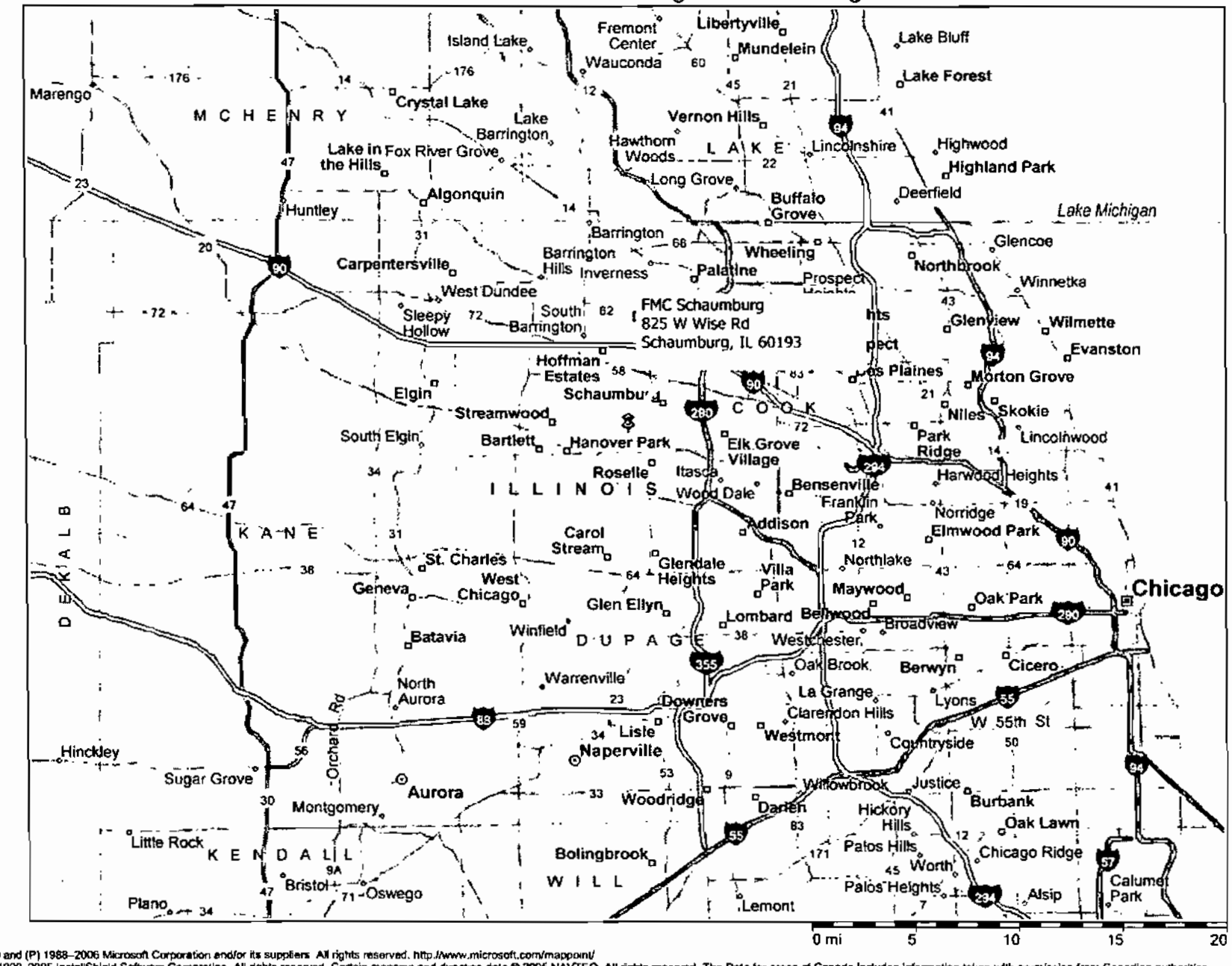

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO:	BOARD MEETING:	PROJECT NO:	PROJECT COST:
H-21	July 23-24, 2012	12-026	Original: $2,943,783
FACILITY NAME: US Renal Care Villa Park Dialysis		CITY: Villa Park	
TYPE OF PROJECT: Substantive			HSA: VII

PROJECT DESCRIPTION: USRC Villa Park, LLC, USRC Alliance, LLC, and US Renal Care, Inc. (the applicants) are proposing to establish a 13-station End Stage Renal Dialysis (ESRD) facility located in 6,612 GSF of leased space in Villa Park. The cost of the project is $2,943,783.

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EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

U.S. Renal Care, Inc., USRC Alliance, LLC, and US RC Villa Park, LLC (the applicants) are proposing to establish a 13-station End Stage Renal Dialysis (ESRD) facility in 6,612 GSF of leased space in Villa Park. The cost of the project is $2,943,783. **The anticipated project completion date is February 28, 2013.**

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- To establish a health care facility as defined by Illinois Health Facilities Planning Act.

PURPOSE OF THE PROJECT:

- To keep dialysis services accessible to a growing ESRD population in DuPage County (HSA-07).
- To accommodate 80 pre-ESRD patients identified by the applicant, needing ESRD services in the 24 months following project completion, and meet a current need for 92 ESRD stations in HSA-07.

NEED:

- To establish a dialysis service
  1. there must be a calculated need in the planning area;
  2. the proposed service must provide service to planning area residents;
  3. there must be a demand for the service in the planning area;
  4. the proposed service must improve access;
  5. the proposed service will not cause an unnecessary duplication of service or maldistribution of service; and,
  6. will not reduce the utilization of other area providers.

- HSA-VII currently has a calculated need for 92 ESRD stations.
- It appears that the proposed facility will provide service to planning area residents as 100% of the pre-ESRD patients reside in the planning area.
- There appears to be demand for this service in the planning area as 80 pre-ESRD patients have been identified that will need dialysis care within the next 1-3 years.
- There are existing providers within 30 minutes (18) that are currently not at the target occupancy of 80%

BACKGROUND/COMPLIANCE ISSUES

- The applicants have previously been approved for their first three Illinois dialysis facilities: Permit #11-024 US Renal Care Oak Brook Dialysis, Permit #11-025 US Renal Care Bolingbrook Dialysis, and Permit #11-026 US Renal Care Streamwood Dialysis.
- No charity care information has been provided for the applicants because the facilities

identified above have not been completed. Expected completion date for all three permits is December 31, 2012. Once these facilities are operating Net Revenue, Charity Care, and Medicaid information will required to be provided.

- Neither applicant has outstanding compliance issues with the State Board.

PUBLIC HEARING/COMMENT

- A Public Hearing was conducted on May 4, 2012, at the Villa Park Village Hall. No attendees registered as being opposed to the proposed project; and 26 attendees registered their support. The State Board Staff has received a number of support letters and no letters of opposition to the proposed project.

  Fresenius Medical Care Holdings, Inc. stated *"although Fresenius does believe that U.S Renal Villa Park will adverse impact its Elmhurst facility, (that was clear at the public hearing) we are not opposing the application. Fresenius believes the Health Facilities Services and Review Board's process is appropriate for addressing the establishment of facilities and that opposition to projects is warranted only in rare circumstances."*

FINANCIAL AND ECONOMIC FEASIBILITY

- The entirety of the project will be funded through internal sources (Cash and Securities/Fair Market Value of the Leases and a review of the financial statements indicate sufficient cash is available to fund the project.

CONCLUSIONS:

- There is a calculated need for 92 stations in the HSA-7 ESRD service area and the applicants justify this project based upon this calculated need. Of the 30 facilities located within 30 minutes 18 are currently not operating at the target occupancy of 80%. Average utilization of the 30 facilities is 75.30%. The applicants addressed a total of 16 criteria and failed to meet the following:

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1110.1430 - Planning Area Need	There are 30 facilities located within 30 minutes of the proposed facility of these 30 facilities 18 facilities (60%) are currently not operating at the target occupancy of 80%.
1110.1430 - Unnecessary Duplication of Service/Maldistribution	There are 30 facilities located within 30 minutes of the proposed facility of these 30 facilities 18 facilities (60%) are currently not operating at the target occupancy of 80%.

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STATE BOARD STAFF REPORT
US Renal Care Villa Park Dialysis, Villa Park
PROJECT #12-026

Applicants	USRC Villa Park, LLC USRC Alliance, LLC US Renal Care, Inc.
Facility Name	US Renal Care Villa Park Dialysis
Location	Villa Park
Application Received	March 12, 2012
Application Deemed Complete	March 13, 2012
Review Period Ended	July 11, 2012
Review Period Extended by the State Board Staff	No
Public Hearing Requested	Yes
Applicants' Deferred Project	No
Can Applicants Request Another Deferral?	Yes
Project Completion Date	February 28, 2013

I. The Proposed Project

The State Board is being asked to consider the establishment of a 13-station ESRD facility in Villa Park. The proposed facility will be located in 6,612 GSF of leased space, and the cost of the project is $2,943,783. **The anticipated project completion date is February 28, 2013.**

II. Summary of Findings

A. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1110.

B. The State Board Staff finds the proposed project appears to be in conformance with the provisions of Part 1120.

III. General Information

The proposed facility will be located at 200 East North Avenue, Villa Park. The applicants are USRC Villa Park, LLC, USRC Alliance, LLC, and US Renal Care, Inc. US Renal Care, Inc is the parent organization for all the entities and Royal Plaza Management, LLC owns the site. USRC Villa Park, LLC is the operating entity/licensee. The proposed facility will be located in HSA VII. HSA VII is comprised of DuPage and Suburban Cook Counties. The June 2012 update to the

IDPH Inventory of Health Care Facilities ("Inventory") shows a computed need for 92 ESRD stations in HSA-07.

There is no land acquisition cost for this project, as the proposed facility will be leased space with the interior being built out by the applicant. This is a substantive project subject to both a Part 1110 and Part 1120 review. Project obligation will occur after permit issuance. **The anticipated project completion date is February 28, 2013.**

IV. The Proposed Project - Details

The applicants propose to establish a 13 station ESRD facility in 6,612 Gross Square Feet ("GSF") of leased space. The proposed facility will be located in Villa Park (HSA-07), and the applicants note that it will build out the interior of the leased space. The total estimated project cost is $2,943,783.

V. Project Costs and Sources of Funds

The total estimated project cost is $2,943,783. The proposed project is being funded with cash and securities totaling $1,316,057, leases with a Fair Market Value of $1,627,726. Table One outlines the project's costs and uses of funds.

TABLE ONE
Project Uses and Sources of Funds

Uses of Funds	Clinical	Non-Clinical	Total
Modernization Contracts	$991,800	$0	$991,800
A & E Fees	$42,000	$0	$42,000
Consulting & Other Fees	$30,000	$0	$30,000
Moveable or Other Equipment	$62,412	$98,601	$161,013
FMV of Leased Space Equipment	$1,627,726	$0	$1,627,726
Other Costs to be Capitalized	$91,244	$0	$91,244
Total Uses of Funds	**$2,845,182**	**$98,601**	**$2,943,783**
Sources of Funds	**Clinical**	**Non-Clinical**	**Total**
Cash and Securities	$1,217,456	$98,601	$1,316,057
Leases (fair market value)	$1,627,726	$0	$1,627,726

TABLE ONE Project Uses and Sources of Funds			
Uses of Funds	Clinical	Non-Clinical	Total
Total Sources of Funds	$2,845,182	$98,601	$2,943,783

VI. Cost/Space Requirements

Table Two displays the project's cost/space requirements for the project. The clinical portion comprises approximately 100% of the cost and GSF.

TABLE TWO US Renal Care Villa Park Dialysis-Cost/Space Allocation							
Clinical Department	Cost	Existing GSF	Proposed GSF	New	Modernized	Vacated	As Is
ESRD	$2,943,783	0	6,612	0	6,612	0	0
Total	$2,943,783	0	6,612	0	6,612	0	0

VII. Section 1110.230 - Project Purpose, Background and Alternatives

A. Criterion 1110.230(a) - Background of Applicant

The Criterion states:

"1) 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.* [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFPB shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. A health care facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity (refer to 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

The applicant provided a list of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, a certified statement from the applicant that no adverse action has been taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application, and authorization permitting HFPB and Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted. The applicants appear fit, willing and able and have the qualifications, background and character to adequately provide a proper standard of healthcare service for the community.

B. Safety Net Impact Statement/Charity Care

The applicants note this particular project will actually have a positive impact on the ability of other providers and health care systems to cross-subsidize safety net services in the community and service area. As the availability of outpatient dialysis services become scarce, hospitals are sometimes forced to delay patient discharges while attempting to procure necessary dialysis services in the community. The proposed project seeks to make additional outpatient dialysis services available it will help facilitate more timely hospital discharges and will result in greater opportunities for hospitals to provide additional safety net and charity care services.

The applicants currently do not have any facilities operating in Illinois. The applicants have been approved for 3 projects (#11-024, #11-025, #11-026) and these three projects are scheduled to be completed in December 2012. At that time they will be required to report Net Revenue information, Charity Care and Medicaid information as required for all dialysis facilities.

C. Criterion 1110.230(b) - Purpose of the Project

The Criterion states:

The applicant shall 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, per the applicant's definition.

1) **The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of such information include:**
   A) **The area's demographics or characteristics (e.g., rapid area growth rate, increased aging population, higher or lower fertility rates) that may affect the need for services in the future;**
   B) **The population's morbidity or mortality rates;**
   C) **The incidence of various diseases in the area;**
   D) **The population's financial ability to access health care (e.g., financial hardship, increased number of charity care patients, changes in the area population's insurance or managed care status);**
   E) **The physical accessibility to necessary health care (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).**
2) **The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).**
3) **The applicant shall detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific time frames that relate to achieving the stated goals.**
4) **For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.**

The applicants state that the purpose of the proposed project is keep dialysis services accessible to a growing ESRD population in DuPage County (HSA-07), and address a need for 92 additional ESRD stations. The proposed project is also needed to accommodate 80 ESRD patients in the service area expected to require dialysis in the next 24 months

following project completion.

Table Three identifies facilities within a 30-minute time frame and their utilization as supplied by the applicants. As seen in the Table, 18 (60%) of the 30 facilities within a 30-minute travel radius are below the State Standard (80%), for utilization. Average utilization of these 30 facilities is 75.30%.

TABLE THREE

Facilities within 30 minutes of US Renal Care Villa Park Dialysis (1)

Facility	City	Adjusted Minutes (1)	Stations	March 2012 Utilization	Met 80% Standard
RCG Villa Park	Elmhurst	6	24	85.4%	Yes
FMC Glendale Heights	Glendale Heights	9	17	92.1%	Yes
FMC Westchester	Westchester	15	20	69.1%	No
FMC Dialysis of Willowbrook	Willowbrook	15	16	94.7%	Yes
USRC Oak Brook Dialysis	Downers Grove	15	13	0.0%*	No*
FMC Downers Grove	Downers Grove	16	19	87.7%	Yes
FMC Elk Grove	Elk Grove Village	16	28	90.4%	Yes
FMC North Avenue	Melrose Park	17	24	91.6%	Yes
FMC Lombard	Lombard	17	12	29.1%	No
FMC West Chicago	West Chicago	18	12	40.2%	No
Loyola Dialysis Ctr.	Maywood	18	30	77.2%	No
FMC Melrose Park	Melrose Park	20	18	55.5%	No
Oak Park Kidney Ctr.	Oak Park	21	18	62%	No
DSI Schaumburg	Schaumburg	21	14	82.1%	Yes
DSI Arlington Heights	Arlington Heights	22	18	42.5%	No
FMC Des Plaines	Des Plaines	23	12	0.0%*	No*
FMC River Forest	River Forest	23	20	2.5%	No
FMC Oak Park Dialysis	Oak Park	24	12	177.7%	Yes
FMC Rolling Meadows	Rolling Meadows	25	24	71.5%	No
FMC Northwest	Norridge	25	16	69.7%	No
Dialysis Management Svcs.	Chicago	26	14	65.4%	No

TABLE THREE

Facilities within 30 minutes of US Renal Care Villa Park Dialysis (1)

Facility	City	Adjusted Minutes (1)	Stations	March 2012 Utilization	Met 80% Standard
FMC West Suburban Dialysis	Oak Park	26	46	85.5%	Yes
FMC Berwyn	Berwyn	26	26	102.5%	Yes
FMC Central DuPage	West Chicago	28	16	73.9%	No
DaVita Monteclare Dialysis	Chicago	28	16	89.5%	Yes
FMC Dialysis Congress Pkwy.	Chicago	28	30	67.2%	No
Cook County Hospital Dialysis	Chicago	30	9	148.1%	Yes
Rush University Dialysis	Chicago	30	5	13.3%	No
FMC Austin	Chicago	30	16	66.6%	No
USRC Streamwood Dialysis	Streamwood	30	13	0.0%*	No*

1. Mileage calculated using MapQuest. Time calculated per 77 IAC 1100.510 (d)
2. *Recently approved facility, no data available.

The applicants cited quantifiable goals as being the ability to improve access while monitoring patient demand, and that the facility will achieve quality outcomes as demonstrated by achieving 92% of patients having a URR greater than or equal to 65%, and 92% of patients having a Kt/V greater than or equal to 1.2.

D. Criterion 1110.230(c) - Alternatives to the Proposed Project

The Criterion states:

"The applicant shall 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.

1) Alternative options shall be addressed. Examples of alternative options include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended

purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Other considerations.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available."

The applicants propose a 13-station ESRD facility. The applicants considered the following alternatives:

1. <u>Utilize Other Health Care Resources</u>

The applicants note the patient's options are limited in regard to utilizing other ESRD facilities. Due to the high frequency and length of required treatments, patients must have convenient and immediate access to dialysis facilities. It is noted that 3 of the 4 closest ESRD facilities are currently operating in excess of the State standard (80%). This, combined with the current need for 92 additional ESRD stations, makes this alternative infeasible. **The applicants identified no project costs with this alternative.**

2. <u>Propose a Project of Greater or Lesser Scope</u>

The applicants considered projects of this nature during the planning stages of the proposed project, and note a project of lesser scope would not sufficiently meet the need for ESRD services in the area. This, combined with the 80 pre-ESRD patients anticipated to require dialysis in the next two years, make a project of lesser scope infeasible. **The applicants identified no costs with this alternative.**

3. <u>Pursue a Joint Venture with Another Provider</u>

The applicants rejected this alternative, based on their business model. The applicants feel the pursuit of this alternative would negate this proven model, and/or compromise the benefits realized by patients of US Renal Care, Inc. **The applicants identified costs associated with this alternative as being similar to the project as proposed ($2,943,783).**

VIII. Section 1110.234 - Project Scope and Size, Utilization and Unfinished/Shell Space – Review Criteria

A) Size of Project

The Criterion states:

"The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix B, unless the additional GSF can be justified by documenting one of the following:

1) **Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;**
2) **The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;**
3) **The project involves the conversion of existing bed space that results in excess square footage."**

The applicants propose to establish a 13 station ESRD facility in 6,612 GSF of leased space. The State board standard is 360-520 GSF per station. The applicants note the project is allocating 508.6 GSF per station, which is within the standard. The proposed project meets the spatial standards established by the State Board, and a positive finding can be made.

TABLE FOUR
SIZE OF PROJECT
12-026 US Renal Care, Villa Park Dialysis

Department /Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
ESRD Facility	6,612 GSF (13 Stations)	360-520 DGSF (508.6 GSF/Station)	11.4 DGSF Under per station	Yes

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE SIZE OF PROJECT CRITERION (77 IAC 1110.234(a)).

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. If the applicant does not meet the utilization standards in Appendix B, or if service areas do not have utilization standards in 77 Ill. Adm. Code 1100, the applicant shall justify its own utilization standard by providing published data or studies, as applicable and available from a recognized source, that minimally include the following:

The applicants supplied a referral letter from Drs. Martin Kittaka, M.D. and Michael Cohan, M.D., identifying 80 pre-ESRD patients who would be referred to the applicant's facility within two years after project completion (application p. 236). The applicants have documented by the second year after project completion (2014), they will be above the State Board's target occupancy of 80% (Application, P. 72).

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECTED SERVICES UTILIZATION CRITERION (77 IAC 1110.234(b)).

IX. <u>Section 1110.1430 - In-Center Hemodialysis Projects – Review Criteria</u>

A) The criterion for establishing an ESRD facility reads as follows:

1) 77 Ill. Adm. Code 1100 (formula calculation)

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.

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.

B) Applicants proposing to add stations to an existing in-center hemodialysis service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing in-center hemodialysis service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

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 two-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).

A) Historical Referrals

i) If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.

ii) Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient facility.

B) Projected Referrals
The applicant shall provide physician referral letters that attest to:

i) The physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

ii) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

iii) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iv) An estimated number of existing patients who are not expected to continue requiring in-center

hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);

v) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty;

VI) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

VI i) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

b) Planning Area Need Review Criterion

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 (formula calculation)

According to the June 2012 update to the IDPH Inventory of Health Care Facilities ("Inventory"), HSA-07 shows a computed need for 92 ESRD stations by the year 2013. This project is requesting to establish a 13-station ESRD facility in 6,612 GSF of leased space in Villa Park.

2) Service to Planning Area Residents

The primary purpose of this project is to provide in-center ESRD services to the residents of Villa Park, Addison, Lombard, and Elmhurst (HSA-07). The applicants identified the 120 referral patients (40 patients annually) originating from the 135 zip codes in the service area. The applicants also note 100% of the pre-ESRD patients reside in HSA-07.

3) Service Restrictions

The applicants identified a service area encompassing Villa Park, Addison, Lombard, and Elmhurst, in HSA-07, DuPage County. The applicants note the current need for 92 additional ESRD stations in the HSA, the high occupancy rates at facilities proximal to the proposed facility.

4) Service Accessibility

There is no absence of service within the planning area, no access limitation due to payor status, no restrictive admission policies of existing providers, nor does the area population and existing care system exhibit medical care problems.

Conclusion

The applicants state the proposed facility will be located in Villa Park (HSA-07). The proposed facility will serve a patient population that is more prevalent to hypertension and diabetes, the Elderly and Hispanic population. However, the applicants identified 30 facilities within 30 minutes of the proposed location, with 18 (60%), reporting operational capacities less than the target occupancy.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE PLANNING AREA NEED CRITERION (77 IAC 1110.1430(b)).

B) Unnecessary Duplication / Maldistribution Review Criterion/Impact of Project on Other Area Providers

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 is located, in total or in part, within 30 minutes normal travel time 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 30 minutes normal travel time from the project site that provide 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.

The applicants identified 30 existing facilities within 30 minutes, and Board Staff concurs with these findings (See Table 3). Board Staff found 18 (60%) of the facilities are operating beneath the target occupancy of 80%, and average utilization of the 53 facilities is 75.3%. The June 2012 Update to the ESRD Station Inventory shows a need for 92 additional ESRD stations in the service area. The applicants also predict the proposed project will result in a maximum decrease of 1% utilization at other area facilities, after project completion. However with all facilities currently not operating at 80% there appears the approval of this facility could result in a duplication of service in the area.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE UNNECESSARY DUPLICATION/MALDISTRIBUTION/IMPACT OF PROJECT ON OTHER AREA PROVIDERS CRITERIA (77 IAC 1110.1430 (c) (1) (2)(3)).

C) Staffing - Availability

The Criterion states:

"The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO 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 210 ILCS 62, 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 Dietetic and Nutrition Services Practice Act [225 ILCS 30]) 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's of Social Work and meet the State of Illinois requirements (see 225 ILCS 20, the Clinical Social Work and Social Work Practice Act)."

The applicants are proposing to establish a 13-station ESRD facility and have provided the necessary information as required by this criterion on pages 116-137 of the application for permit. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE STAFFING CRITERION (77 IAC 1110.1430 (e) (1)).

D) Support Services

The Criteria states:

"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 are proposing to establish a 13-station ESRD facility and have provided the necessary documentation as required by this criterion on page 138 of the application for permit. The applicants note Alexian Brothers Medical Center, Elk Grove Village, will provide Blood bank, Rehabilitation, and Psychiatric services.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH THE SUPPORT SERVICES CRITERION (77 IAC 1110.1430 (f)).

E) **Minimum Number of Stations**
The minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

1) **Four dialysis stations for facilities outside an MSA;**

2) **Eight dialysis stations for a facility within an MSA.**

The proposed 13-station ESRD facility will be located in an MSA. The applicants have met the requirements of this criterion

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE MINIMUM NUMBER OF STATIONS CRITERION (77 IAC 1110.1430 (g)).

F) **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 the required affiliation agreement on pages 141-145 of the application for permit. The transfer agreement is with Alexian Brothers Medical Center, Elk Grove Village. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE CONTINUITY OF CARE CRITERION (77 IAC 1110.1430 (h)).

G) **Assurances**

The Criterion states:

"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 area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas .1.2."

The applicants provided the required certification information on page 146 of the application for permit as required of the criterion. The applicants note USRC patients have achieved the following clinical outcomes in the past year, and expect the same to occur with patients at US Renal Care Villa Park Dialysis.

- 85% of patients had a URR ≥ 65%
- 85% of patients had a Kt/V ≥ 1.2

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE ASSURANCES CRITERION (77 IAC 1110.1430 (j)).

X. 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources.

The applicants are funding the project with cash and securities totaling $1,316,057, and the FMV of the leases totaling $1,627,726. A review of audited financial statements supplied by the applicants indicates sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE AVAILABILITY OF FUNDS CRITERION (77 IAC 1120.120 (a)).

XI. 1120.130 - Financial Feasibility

A. Criterion 1120.130 - Financial Viability

Financial Viability Waiver
The applicant is NOT required to submit financial viability ratios if:

1) **all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or**

   HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.

2) **the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA), or its equivalent; or**

   HFSRB NOTE: MBIA Inc is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.

3) **the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.**

The applicants have qualified for the financial waiver because the project is being funded with internal sources including capital expended through a lease. The applicants are funding the project with cash and securities of $1,316,057, and the FMV of the lease of $1,627,726. A review of the applicants' audited financial statements indicates that sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE FINANCIAL FEASIBILITY CRITERION (77 IAC 1120.130 (a)).

XII. Section 1120.140 - Economic Feasibility

A. Criterion 1120.140(a) - Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

The applicants are funding the project with cash and securities of $1,316,057, and the FMV of the lease of $1,627,726. The applicants have provided documentation of internal funding sources for the proposed project, and this criterion is inapplicable.

THE STATE BOARD STAFF FINDS THE REASONABLENESS OF FINANCING ARRANGEMENTS CRITERION IS INAPPLICABLE TO THE PROPOSED PROJECT (77 IAC 1120.140(a)).

B. Criterion 1120.140(b) - Terms of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

The applicants are funding the project with cash and securities of $1,316,057, the FMV of the lease of $1,627,726. The applicants have provided documentation of internal funding sources for the proposed project, and this criterion is inapplicable

THE STATE BOARD STAFF FINDS THE TERMS OF DEBT FINANCING CRITERION IS INAPPLICABLE TO THE PROPOSED PROJECT (77 IAC 1120.140(b)).

C. Criterion 1120.140(c) - Reasonableness of Project Cost

The applicant shall document that the estimated project costs are reasonable and shall document compliance with the State Board's standards as detailed in 77 IAC 1120.

Modernization Contracts and Contingencies – These costs total $991,800 or $150.00 per gross square feet. ($991,800/6,612 GSF = $150.00/GSF) This appears **reasonable** when compared to the State Board standard of $154.28/GSF.

Contingencies – The applicants report no planned contingencies costs for this project.

Architect and Engineering Fees – These costs total $42,000 or 4.2% of modernization and contingency costs. This appears reasonable when

compared to the State Board standard of 7.08-10.62 % of modernization and contingency costs.

Moveable Equipment - These costs total $62,412 or $4,800 per station. This appears reasonable when compared to the State Board standard of $39,945.

Consulting & Other Fees - These costs total $30,000. The State Board does not have a standard for these costs.

Other Costs to be Capitalized - These costs total $91,244. The State Board does not have a standard for these costs.

Fair Market Value of Leased Space/Equipment - These costs are $1,627,726. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF PROJECT COST CRITERION (77 IAC 1120.140 (c)).

D) Criterion 1120.140 (d) - Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

The applicants anticipate the direct operating costs per treatment to be $228.95. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECT DIRECT OPERATING COSTS CRITERION (77 IAC 1120.140 (d)).

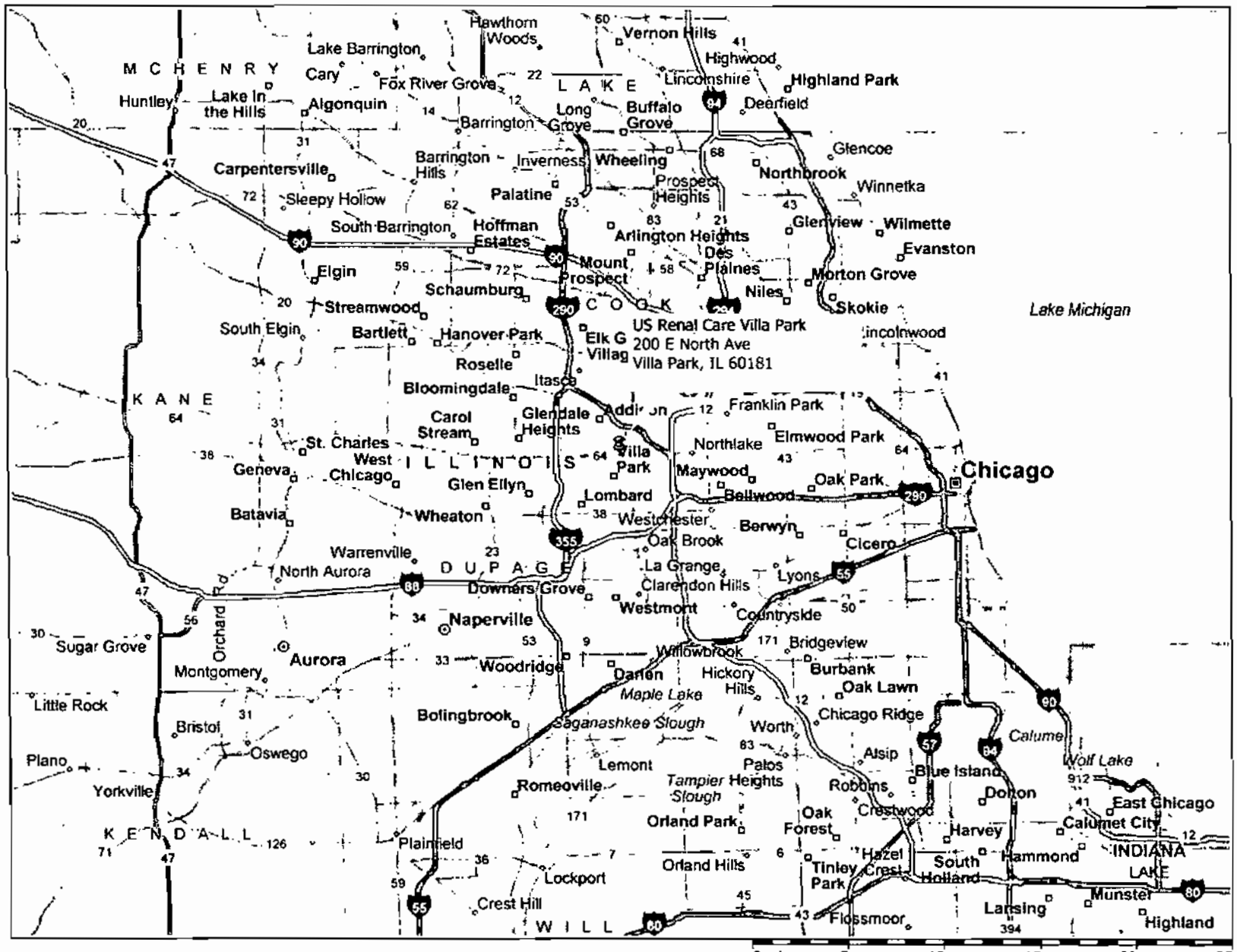
E) Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The applicants anticipate the total effect of the Project on Capital Costs per treatment to be $43.99. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS CRITERION (77 IAC 1120.140 (e)).

12-026 US Renal Care Villa Park - Villa Park



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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO:	BOARD MEETING:	PROJECT NO:	PROJECT COST:
H-20	October 12-13, 2011	11-038	Original: $4,920,300
FACILITY NAME: Fresenius Medical Care Naperbrook		CITY: Naperville	
TYPE OF PROJECT: Substantive			HSA: IX

PROJECT DESCRIPTION: Fresenius Medical Care Holdings, Inc., and Fresenius Medical Care Naperbrook, LLC (the applicants) are proposing the establishment of a 16-station End Stage Renal Dialysis (ESRD) facility located 10,000 GSF of leased space in Naperville. The cost of the project is $4,920,300. **The anticipated project completion date is December 31, 2013.**

The State Board Staff Notes there are three projects on the October Agenda proposing to establish dialysis facilities in the HSA IX planning area. The projects are as follows:

- Project #11-025 - USRC Bolingbrook Dialysis (13 stations)
- Project #11-038 - FMC Naperbrook (12 stations)
- Project #11-004 - Crest Hill Dialysis (12 stations)
- A fourth Project #11-058 - FMC Plainfield is proposing to add four stations to an existing 12 station facility.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- Fresenius Medical Care Holdings, Inc., and Fresenius Medical Care Naperbrook, LLC (the applicants) are proposing the establishment of a 16-station End Stage Renal Dialysis (ESRD) facility located 10,000 GSF of leased space in Naperville. The cost of the project is $4,920,300. **The anticipated project completion date is December 31, 2013.**

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project proposes to establish a health care facility as defined by Illinois Health Facilities Planning Act.

PURPOSE OF THE PROJECT:

- The proposed project seeks to establish an ESRD facility and ESRD services in Naperville, and to keep dialysis services accessible to a growing ESRD population in HSA-09. The proposed facility will also serve to provide access to patients of the FMC Naperville facility when the lease at the FMC Naperville facility expires in 2014. The applicants are requesting shell space as part of this application to accommodate this growth.

NEED:

- To establish a dialysis service
  1. there must be a calculated need in the planning area;
  2. the proposed service must provide service to planning area residents;
  3. there must be a demand for the service in the planning area;
  4. the proposed service must improve access;
  5. the proposed service will not cause an unnecessary duplication of service or maldistribution of service.

- HSA-IX currently has a calculated excess **of 55 ESRD stations.** 50.5% of the patients will reside from within the planning area and the remainder (49.5%) will reside in the HSA VII planning area. The applicants have identified 210 pre ESRD patients that will need dialysis in the next 1-3 years. There are 11 facilities within 30 minutes. Of these 11 facilities, 7 are operating above the State Board Standard of 80% and four are operating below the State Board standard of 80%. **See Table Five below.**

BACKGROUND/COMPLIANCE ISSUES

- Neither applicant has outstanding compliance issues with the State Board.

PUBLIC HEARING/COMMENT

- No public hearing was requested and no letters of opposition or support for this project

were received by the State Board Staff.

FINANCIAL AND ECONOMIC FEASIBILITY

- The entirety of the project will be funded through internal sources (Cash and Securities/Fair Market Value of the Leases and a review of the financial statements indicate sufficient cash is available to fund the project.

CONCLUSIONS:

- The State Board Staff notes there is a calculated excess of 55 stations in the HSA-09 ESRD service area and the applicants justify this project based upon this over-utilization of existing facilities and the need to accommodate the pre-ESRD patients served by Nephrology Associates of Northern Illinois (NANI), who will require dialysis services in the next 1-3 years. There are 11 facilities within 30 minutes operating at an average occupancy rate of 77%. Of these 11 facilities, 7 are operating **above** the State Board Standard of 80%, and **four** are operating below the State standard of 80%. **See Table Five below.**

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1110.1430(b) - Planning Are Need	Per the September 2011 Inventory Update, HSA-09 has a calculated excess of 55 ESRD stations, and four of the eleven (37%) ESRD facilities in a 30-minute drive radius are operating below the occupancy target of 80%.
1110. 1430 (c) - Unnecessary Duplication/Mal distribution of Service	37% (4 of 11 facilities) of the ESRD facilities within a 30-minute drive radius are operating beneath the 80th percentile.

Fresenius Medical Care Naperbrook
PROJECT #11-038

Applicants	Fresenius Medical Care Holdings, Inc. Fresenius Medical Care Naperbrook, LLC
Facility Name	Fresenius Medical Care Naperbrook
Location	Naperville
Application Received	June 28, 2011
Application Deemed Complete	June 29, 2011
Review Period Ended	August 28, 2011
Review Period Extended by the State Board Staff	No
Public Hearing Requested	No
Applicants' Deferred Project	No
Can Applicants Request Another Deferral?	Yes
Applicants' Modified the Project	No

I. The Proposed Project

The State Board is being asked to consider the establishment of a 16-station ESRD facility in Naperville. The proposed facility will be located in 10,000 GSF of leased space, and the cost of the project is $4,920,300. **The anticipated project completion date is December 31, 2013.**

II. Summary of Findings

A. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1110.

B. The State Board Staff finds the proposed project appears to be in conformance with the provisions of Part 1120.

III. General Information

The proposed facility will be located at 2451 South Washington Street, Naperville. The applicants are Fresenius Medical Care Naperbrook, LLC, and Fresenius Medical Care Holdings, Inc. Fresenius Medical Care Holdings, Inc is the parent organization for all the entities and Brushy Creek, LLC, owns the site. Fresenius Medical Care Naperbrook, LLC d/b/a Fresenius Medical Care Naperbrook is the operating entity/licensee. The proposed facility will be located in HSA IX. HSA IX is comprised of Will, Kendall, Kankakee, and

Grundy counties in Illinois. The September 2011 update to the IDPH Inventory of Health Care Facilities ("Inventory") shows a computed excess of 55 ESRD stations in HSA IX.

Table One lists the ESRD facilities in HSA IX and their utilization.

TABLE ONE
Facilities within the HSA IX ESRD Service Area

Facility	Ownership	City	Stations	Utilization	Met Occupancy?
FMC Morris	Fresenius	Morris	9	77.78%	No
Silver Cross Renal Ctr.	Silver Cross	Morris	9	38.89%	No
Yorkville Dialysis Ctr.	Renaissance	Yorkville	8	37.50%	No
FMC of Oswego	Fresenius	Oswego	10	88.33%	Yes
FMC of Plainfield	Fresenius	Plainfield	12	90.28%	No
Silver Cross Renal Ctr. West	Silver Cross	Joliet	29	88.51%	Yes
Sun Health	Sun Health	Joliet	17	56.86%	No
FMC Bolingbrook	Fresenius	Bolingbrook	24	79.86%	No
FMC Joliet	Fresenius	Joliet	16	0.00%*	No
Silver Cross Renal Ctr.	Silver Cross	New Lenox	19	74.56%	No
Provena St. Mary's Hospital	Provena	Kankakee	25	68.0%	No
Kankakee County Dialysis	Davita	Bourbonnais	12	56.94%	No
Manteno Dialysis Ctr.	Provena	Manteno	15	40.00%	No
FMC of Mokena	Fresenius	Mokena	12	69.44%	No

*Facilities recently approved by the State Board not yet operational
Utilization data taken from June 2011 Renal Network Data

There is no land acquisition cost for this project, as the proposed facility will be leased space with the interior being built out by the applicant. This is a substantive project subject to both a Part 1110 and Part 1120 review. Project obligation will occur after permit issuance. **The anticipated project completion date is December 31, 2013.**

A public hearing was offered on this project; however, no hearing was requested. The State Board Staff received no public comments regarding this project.

IV. The Proposed Project - Details

The applicants propose to establish a 16 station ESRD facility housed in 8,000 Gross Square Feet ("GSF") of leased space. The proposed facility will be housed in a 10,000 GSF building, leaving 2,000 GSF as shell space to be built out at a later date. The proposed facility will be located in Naperville, and the total estimated project cost is $4,920,300.

V. Project Costs and Sources of Funds

The total estimated project cost is $4,920,300. The proposed project is being funded with cash and securities totaling $1,851,500, and leases with a Fair Market Value of $3,068,800. Table Two outlines the project's costs and uses of funds. The State Board Staff notes all costs are classified as being clinical.

TABLE TWO
Project Uses and Sources of Funds

Uses of Funds	Clinical
Modernization Contracts	$1,044,100
Contingencies	$104,400
A & E Fees	$103,000
Moveable Equipment	$600,000
Fair Market Value of Leased Space & Equipment	$3,068,800
Total Uses of Funds	**$4,920,300**
Sources of Funds	**Clinical**
Cash and Securities	$1,851,500
Leases (fair market value)	$3,068,800
Total Sources of Funds	**$4,920,300**

VI. Cost/Space Requirements

Table Three displays the project's cost/space requirements for the project. The clinical portion comprises approximately 100% of the cost and GSF. The State Board Staff notes the proposed project will also consist of 2,000 GSF of shell space to be built out by the applicant at a later date.

TABLE THREE Fresenius Medical Care Naperbrook Cost/Space Allocation							
Clinical Department	Cost	Existing GSF	Proposed GSF	New	Modernized	Vacated	As Is
ESRD	$4,920,300	0	8,000	0	8,000	0	0
Total	$4,920,300	0	8,000	0	8,000	0	0

VI I. Section 1110.230 - Project Purpose, Background and Alternatives

A. Criterion 1110.230(a) - Background of Applicant

The Criterion states:

"1) 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.* [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFPB shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. A health care facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity (refer to 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

2) Examples of facilities owned or operated by an applicant include:

A) The applicant, Partnership ABC, owns 60% of the shares of Corporation XYZ, which manages the Good Care Nursing Home under a management agreement. The applicant, Partnership ABC, owns or operates Good Care Nursing Home.

B) The applicant, Healthy Hospital, a corporation, is a subsidiary of Universal Health, the parent corporation of Healthcenter Ambulatory Surgical Treatment Center (ASTC), its wholly-owned subsidiary. The applicant, Healthy Hospital, owns and operates Healthcenter ASTC.

C) Dr. Wellcare is the applicant. His wife is the director of a corporation that owns a hospital. The applicant, Dr. Wellcare, owns or operates the hospital.

D) Drs. Faith, Hope and Charity own 40%, 35% and 10%, respectively, of the shares of Healthfair, Inc., a corporation, that is the applicant. Dr. Charity owns 45% and Drs. Well and Care each own 25% of the shares of XYZ Nursing Home, Inc. The applicant, Healthfair, Inc., owns and operates XYZ Nursing Home, Inc.

3) The applicant shall submit the following information:

A) A listing of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, as applicable;

B) A certified listing from the applicant of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application;

C) Authorization permitting HFPB and Illinois Department of Public Health (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 HFPB.

4) If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed to update and/or clarify data.

The applicant provided a list of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and

accreditation identification numbers, a certified statement from the applicant that no adverse action has been taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application, and authorization permitting HFPB and Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted. The applicants appear fit, willing and able and have the qualifications, background and character to adequately provide a proper standard of healthcare service for the community.

B. Safety Net Impact Statement/Charity Care

The establishment of the Fresenius Medical Care Naperbrook dialysis facility will not have any impact on safety net services in the community. Outpatient dialysis services are not typically considered "safety net" services, to the best of our knowledge. However, we do provide care for patients in the community who are economically challenged and/or who are undocumented aliens, who do not qualify for Medicare/Medicaid. We assist patients who do not have insurance in enrolling when possible in Medicaid and/or Medicaid as applicable, and also our social services department assists patients who have issues regarding transportation and/or who are wheel chair bound or have other disabilities which require assistance with respect to dialysis services and transport to and from the unit.

This particular application will not have an impact on any other safety net provider in the area, as no hospital within the area provides dialysis services on an outpatient basis.

Fresenius Medical Care is a for-profit publicly traded company and is not required to provide charity care, nor does it do so according to the Board's definition. However, Fresenius provides care to all patients regardless of their ability to pay. There are a number of patients treated by Fresenius who either do not qualify for or will not seek any type of coverage for dialysis services. These patients are considered "self-pay" patients. These patients are invoiced as all patients are invoiced, however payment is not expected and Fresenius does not initiate any collections activity on these accounts. These unpaid invoices are written off as bad debt. Fresenius notes that as a for profit entity, it does pay sales, real estate and income taxes. It also does provide community benefit by supporting various medical education activities and associations, such as the Renal Network and National Kidney Foundation.

The table below shows the amount of "self-pay" care provided for the 3 fiscal years prior to submission of the application for **all Fresenius Medical Care facilities in Illinois** and the amount of care provided to Medicaid patients for the three fiscal years prior to submission of the application for all **Fresenius Medical Care facilities in Illinois.** This includes in-center hemodialysis, peritoneal dialysis, home hemodialysis & sub-acute hemodialysis. The application also includes a complete listing by facility of Medicaid revenue and unreimbursed care by facility in the State of Illinois. **See pages 85-88 of the application for permit.**

TABLE FOUR SAFETY NET INFORMATION Fresenius Medical Care facilities in Illinois			
CHARITY CARE			
	2008	2009	2010
Charity (# of self-pay patients)	305	260	146
Charity (self-pay) Cost	$ 3,524,880	$ 3,642,751	$ 1,307,966
MEDICAID			
	2008	2009	2010
Medicaid (Patients)	1,626	1,783	1,828
Medicaid (Revenue)	$ 37,043,006	$ 40,401,403	$ 44,001,539

C. **Criterion 1110.230(b) - Purpose of the Project**

The Criterion states:

The applicant shall 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, per the applicant's definition.

1) **The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of such information include:**
   A) **The area's demographics or characteristics (e.g., rapid area**

growth rate, increased aging population, higher or lower fertility rates) that may affect the need for services in the future;

B) The population's morbidity or mortality rates;

C) The incidence of various diseases in the area;

D) The population's financial ability to access health care (e.g., financial hardship, increased number of charity care patients, changes in the area population's insurance or managed care status);

E) The physical accessibility to necessary health care (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).

2) The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).

3) The applicant shall detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific time frames that relate to achieving the stated goals.

4) For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.

The applicants propose to establish a 16-station ESRD facility in 8,000 gross square feet of modernized, leased space. The proposed facility on a whole encompasses 10,000 GSF of space, and will contain 2,000 GSF of shell space to be built out by the applicants at a later date. The applicants state that the purpose of the proposed project is to keep dialysis services accessible to a rapidly growing ESRD population in HSA-09, more specifically, the Naperville/Bolingbrook area. This market area is situated on the border of DuPage (HSA-09) and Will (HSA-07) counties, and the applicants contend the existing ESRD facilities in this area are highly utilized and unable to expand/add extra stations. The applicants identified a service area in a 30-minute travel radius, encompassing most of DuPage, and portions of Kane, Will, and Kendall counties.

The applicants identified facilities within a 30-minute timeframe and their utilization as supplied by the Renal Network. As seen in the table below, 7 of the 11 (64%), facilities within a 30-minute travel radius are above the State Standard (80%), and four are operating below the State standard. Average utilization for these 11 facilities is 77% (See Table 5).

TABLE FIVE

Facilities within 30 minutes of the FMC Naperbrook (1)

Facility	Ownership	City	Minutes (1)	Miles	Stations	June 2011 Utilization	Met 80% Standard
FMC Naperville	Fresenius	Naperville	9	3.7	15	88.89%	Yes
FMC Bolingbrook	Fresenius	Bolingbrook	10	5.1	24	79.86%	No
FMC Naperville North	Fresenius	Naperville	13	5.2	14	86.90%	Yes
Fox Valley Dialysis Ctr.	Fox Valley	Aurora	17	9.5	26	88.46%	Yes
FMC Willowbrook	Fresenius	Willowbrook	24	13	16	86.46%	Yes
FMC Downers Grove	Fresenius	Downers Grove	26	14.2	19	96.49%	Yes
FMC Plainfield*	Fresenius	Plainfield	27	14	12	90.28%	Yes
FMC Lombard	Fresenius	Lombard	27	14.2	12	8.33%	No
Silver Cross Renal Ctr. West	Silver Cross	Joliet	27	14.4	29	88.51%	Yes
FMC Central DuPage	Fresenius	West Chicago	28	14.6	16	75.00%	No
Sun Health	Sun Health	Joliet	29	14.2	17	56.86%	No

1. Mileage calculated using MapQuest. Time calculated per 77 IAC 1100.510 (d)
2. *Adding 4 Stations to an existing 12-station facility.

The applicants cited quantifiable goals as being the ability to improve access while monitoring patient demand, and that the facility will achieve quality outcomes as demonstrated by achieving 96% of patients having a URR greater than or equal to 65%, and 99% of patients having a Kt/V greater than or equal to 1.2.

D. Criterion 1110.230(c) - Alternatives to the Proposed Project

The Criterion states:

"The applicant shall 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.

1) Alternative options shall be addressed. Examples of alternative options include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Other considerations.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data, that verifies improved quality of care, as available."

The applicants propose to establish a 16-station ESRD facility. The applicants considered the following alternatives:

1. <u>Utilize Other Health Care Resources</u>

The option of sending pre-ESRD patients to underutilized facilities in the area was determined to be unreasonable by the applicants, because of over-utilization at area facilities. The applicants note the existence of over-utilized facilities in the 30 minute area as illustrated in Table 5. The applicants also note the option of sending pre-ESRD patients from NANI to underutilized facilities would result in excessive travel and create hardship on behalf of the patient. **The applicants identified no cost with this alternative.**

2. <u>Propose a Project of Greater or Lesser Scope</u>

The applicants state an alternative of this nature was considered, but deemed it infeasible because the only option under this criterion would be to do nothing. The applicants identified a need for dialysis services in the market area, an area that is experiencing a significant increase in ESRD patients, and high utilization figures.

3. Pursue a Joint Venture with Another Provider

The applicants rejected this alternative, based on their business model which is to be wholly owned. The applicants have entered in to joint ventures in the past, but feel this option would be imprudent in this situation.

4. Project as Proposed

The applicants chose this alternative, based on the need to keep access to dialysis in the Naperville/Bolingbrook area. The applicants anticipate significant growth in the identified service area, and a need for local ESRD services. **Cost of the proposed alternative: $4,920,300.**

VI. Section 1110.234 - Project Scope and Size, Utilization and Unfinished/Shell Space - Review Criteria

A) Size of Project

The Criterion states:

"The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix B, unless the additional GSF can be justified by documenting one of the following:

1) **Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;**
2) **The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;**
3) **The project involves the conversion of existing bed space that**

results in excess square footage."

The applicants propose to establish a 16 station ESRD facility in 8,000 GSF of leased space. The State board standard is 360-520 GSF per station. The applicants note the project is allocating 500 GSF per station, which is in compliance with the State standard. The applicants explain that the proposed project will entail an additional 2,000 GSF of shell space that will be utilized for clinical services in the future. The applicants have addressed this criterion in section 1110.234 of this application.

TABLE SIX SIZE OF PROJECT 11-038 FMC Naperbrook				
Department /Service	**Proposed BGSF/DGSF**	**State Standard**	**Difference**	**Met Standard?**
ESRD Facility	8,000 GSF (16 Stations)	360-520 DGSF (500GSF/Station)	20 DGSF Under	Yes

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE SIZE OF PROJECT CRITERION (77 IAC 1110.234(a)).

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. If the applicant does not meet the utilization standards in Appendix B, or if service areas do not have utilization standards in 77 Ill. Adm. Code 1100, the applicant shall justify its own utilization standard by providing published data or studies, as applicable and available from a recognized source, that minimally include the following:

The applicants have identified 210 pre-ESRD patients from NANI who are expected to be referred to the proposed facility, once completed. The applicants have documented by the second year after project completion (2015), they will be above the State Board's target occupancy of 80% (Application, P. 45).

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECTED SERVICES UTILIZATION CRITERION (77 IAC 1110.234(b)).

d) 1110.234(c) - Unfinished Shell Space

Unfinished or Shell Space – Review Criterion

If the project includes unfinished space (i.e., shell space) that is to meet an anticipated future demand for service, the applicant shall document that the amount of shell space proposed for each department or clinical service area is justified, and that the space will be consistent with the standards of Appendix B as stated in subsections (a) and (b). The applicant shall provide the following information:

1) The total gross square footage of the proposed shell space;

2) The anticipated use of the shell space, specifying the proposed SF to be allocated to each department, area or function;

3) Evidence that the shell space is being constructed due to:

A) Requirements of governmental or certification agencies; or

B) Experienced increases in the historical occupancy or utilization of those departments, areas or functions proposed to occupy the shell space. The applicant shall provide the historical utilization for the department, area or function for the latest five-year period for which data are available, and, based upon the average annual percentage increase for that period, project the future utilization of the department, area or function through the anticipated date when the shell space will be placed into operation.

e) Assurances

The applicant shall submit the following:

1) **The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the end of the second year of operation after the project completion, the applicant will meet or exceed the utilization standards specified in Appendix B.**

2) **For shell space, the applicant shall submit the following:**

   A) **Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at that time or the categories of service involved;**

   B) **The anticipated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and**

   C) **The estimated date when the shell space will be completed and placed into operation.**

The applicants identified 2,000 GSF of shell space, which will be used for clinical purposes at a later date. The applicants propose to relocate 15 ESRD stations from FMC Naperville, and plan to use the noted shell space to accommodate this move in 2014, when the lease at the Naperville facility expires. The applicants supplied a notarized statement of assurance to have the shell space utilized by 2014, and will file a Certificate of Need application to accomplish the proposed project by January 2013 (application, p. 47).

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE UNFINISHED SHELL SPACE/ASSURANCES CRITERION (77 IAC 1110.234(d)(e)).

IX. Section 1110.1430 - In-Center Hemodialysis Projects – Review Criteria

The criterion for establishing an ESRD facility reads as follows:

1) **77 Ill. Adm. Code 1100 (formula calculation)**

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.

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.

B) Applicants proposing to add stations to an existing in-center hemodialysis service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing in-center hemodialysis service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

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 two-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).

A) Historical Referrals

i) If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.

ii) Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient facility.

B) Projected Referrals
The applicant shall provide physician referral letters that attest to:

i) The physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

ii) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

iii) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The

anticipated number of referrals cannot exceed the physician's documented historical caseload;

iv) An estimated number of existing patients who are not expected to continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);

v) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty;

VI) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

VI i) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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, indiVI duals 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 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.**

b) **Planning Area Need Review Criterion**

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 (formula calculation)**

According to the September 2011 update to the IDPH Inventory of Health Care Facilities ("Inventory"), HSA-09 shows a **computed excess of 55 ESRD stations**. This project is requesting 16 stations in 8,000 GSF of leased space in Naperville.

2) **Service to Planning Area Residents**

The primary purpose of this project is to provide in-center ESRD services to the residents of HSA-09, and more specifically, Naperville and Bolingbrook. The applicants state that they anticipate 50.48% of their patient base originating from Will County (HSA-09), and 49.52% originating from DuPage County (HSA-07) (Application, p. 49).

3) **Service Demand**

The applicants submitted a referral letter from Dr. David Schlieben, M.D., Medical Director of Fresenius Bolingbrook Dialysis, and an associate nephrologist with NANI, identifying 210 pre-ESRD patients that the doctors and their other practicing colleagues at NANI will refer to the proposed facility within 24 months of project completion (Application, pgs. 50-56).

4) Service Accessibility

The applicants state that the issue of access is problematic due to current facilities operating at high utilization levels and several facilities identified in the service area still being constructed. The State Board Staff identified 11 ESRD facilities in a 30 minute drive radius. Of these facilities, 7 (64%), were operating above the 80% occupancy target and four are operating below the State Standard of 80% (See Table 5).

The applicants cited high utilization and a growing service demand in the service area as basis for the proposed project. The State Board Staff notes the following: there is no absence of the proposed service within the planning area; no access limitations due to payor status of patients and there has been no evidence of restrictive admission policies at other area providers. In addition the area population and existing care system do not exhibit indicators of medical care problems and the State Board Staff has identified 4 area facilities performing below the State Occupancy target (80%). The State Board Staff is unable to make a positive finding regarding this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE PLANNING AREA NEED CRITERION (77 IAC 1110.1430(b)).

c) Unnecessary Duplication / Maldistribution Review Criterion

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 30 minutes normal travel time 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 30 minutes normal travel time from the project site that provide 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.

The applicants provided a list of all zip code areas that are located within 30 minutes of the proposed site as required. The applicants state that the ratio of ESRD stations to population is 1 per 5,917 according to the 2000 census in this 30 minute area. The State of Illinois ESRD stations to population is 1 station for every 3,398 individuals based upon the 2000 census. The applicants state that Will County, according to the 2010 census, has increased its population by 37%, and should result in a projected station to population ratio that exceeds allowable standards.

The applicants acknowledge that all facilities in the 30-minute drive radius are not operating in excess of the operating standard of 80%, and that an excess of 55 ESRD stations exist in HSA-09. However, the applicants identified 210 pre-ESRD patients and the fact that the service area is experiencing tremendous growth, presents itself as evidence for a future shortage of ESRD services in the area.

The applicants state that the project will not have an adverse impact on area providers, based on the number of pre-ESRD patients currently under the care of NANI physicians. It is noted that these physicians will be referring these patients to the proposed facility and other facilities in the area as well. However, Table Five does show that four of the eleven facilities in the 30-minute drive radius are operating below the 80th percentile for capacity. Based upon the underutilization of existing facilities, a positive finding cannot be made for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT <u>DOES NOT</u> APPEAR TO BE IN CONFORMANCE WITH THE UNNECESSARY DUPLICATION/MALDISTRIBUTION CRITERION (77 IAC 1110.1430 (b)).

C) Staffing - Availability

The Criterion states:

"The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that

licensure and JCAHO 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 210 ILCS 62, 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 Dietetic and Nutrition Services Practice Act [225 ILCS 30]) 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's of Social Work and meet the State of Illinois requirements (see 225 ILCS 20, the Clinical Social Work and Social Work Practice Act)."

The applicants are proposing to establish a 16-station ESRD facility and have provided the necessary information as required by this criterion on pages 61-64 of the application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE STAFFING CRITERION (77 IAC 1110.1430 (e)(1)).

D) Support Services

The Criteria states:

"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 are proposing to establish a 16-station ESRD facility and have provided the necessary documentation as required by this criterion on page 65 of the application for permit. The applicants note Edward Hospital, Naperville, will provide Blood Bank, Rehabilitation, and Psychiatric services.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH THE SUPPORT SERVICES CRITERION (77 IAC 1110.1430 (f)).

E) Assurances

The Criterion states:

"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 area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas .1.2."

The applicants provided the required certification information on page 70 of the application for permit as required of the criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE ASSURANCES CRITERION (77 IAC 1110.1430 (j)).

g) **Minimum Number of Stations**
The minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

1) **Four dialysis stations for facilities outside an MSA;**

2) **Eight dialysis stations for a facility within an MSA.**

The proposed 16 station ESRD facility will be located in an MSA. The applicants have met the requirements of this criterion

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE MINIMUM NUMBER OF STATIONS CRITERION (77 IAC 1110.1430 (g)).

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 the required affiliation agreement on page 67 of the application for permit. The transfer agreement is with Edward Hospital, Naperville. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT

APPEARS TO BE IN CONFORMANCE WITH THE CONTINUITY OF CARE CRITERION (77 IAC 1110.1430 (h)).

X. **1120.120 - Availability of Funds**

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources.

The applicants are funding the project with cash and securities of $1,851,500 and the FMV of the lease of $3,068,800. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE AVAILABILITY OF FUNDS CRITERION (77 IAC 1120.120 (a)).

XI. **1120.130 - Financial Feasibility**

A. **Criterion 1120.130 - Financial Viability**

Financial Viability Waiver
The applicant is NOT required to submit financial viability ratios if:

1) **all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or**

   HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.

2) **the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA), or its equivalent; or**

   HFSRB NOTE: MBIA Inc is a holding company whose subsidiaries provide financial guarantee insurance for municipal

bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.

3) **the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.**

The applicants have qualified for the financial waiver because the project is being funded with internal sources including capital expended through a lease. The applicants are funding the project with cash and securities of $1,851,500 and the FMV of the lease of $3,068,800. A review of the applicants' audited financial statements indicates that sufficient cash is available to fund the project.

Table Six outlines Fresenius Medical Care credit rating from all three credit rating agencies. These credit ratings are **opinions** of the three rating agencies on the ability of a corporation to meet its financial obligation on time and in full.

TABLE SIX
Fresenius Credit Rating

	Standard & Poor's	Moody's	Fitch
Corporate Credit Rating	BB	Ba1	BB+
Outlook	positive	stable	stable
Secured Debt	BBB-	Baa3	BBB
Unsecured Debt	BB	Ba2	BB+

BB—Less vulnerable in the near-term but faces major ongoing uncertainties to adverse business, financial and economic conditions.
Ba1-Speculative investment. Occurs often in deteriorated circumstances, usually problematic to predict future development
'BB'- ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time; however, business or financial flexibility exists which supports the servicing of financial commitments

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE FINANCIAL FEASIBILITY CRITERION (77 IAC 1120.130 (a)).

XII. Section 1120.140 - Economic Feasibility

A. Criterion 1120.140(a) - Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

The applicants are funding the project with cash and securities of $1,851,500 and the FMV of the lease of $3,068,800. The applicants have provided the necessary attestation that borrowing (leasing) is less costly than the liquidation of existing investments. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF FINANCING ARRANGEMENTS CRITERION (77 IAC 1120.140(a)).

B. Criterion 1120.140(b) - Terms of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are

reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

The applicants are funding the project with cash and securities of $1,851,500 and the FMV of the lease of $3,068,800. The applicants have attested that the selected form of debt financing (leasing) will be at the lower net cost available to the applicants. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TERMS OF DEBT FINANCING CRITERION (77 IAC 1120.140(b)).

C. Criterion 1120.140(c) - Reasonableness of Project Cost

The applicant shall document that the estimated project costs are reasonable and shall document compliance with the State Board's standards as detailed in 77 IAC 1120.

Modernization Contracts and Contingencies - These costs total $1,148,500 or $143.56 per gross square feet. ($1,148,500/8,000 GSF = $143.56/GSF) This appears reasonable when compared to the State Board standard of $149.35/GSF.

Contingencies - These costs total $104,400. These costs are 10% of modernization costs. This appears reasonable when compared to the State Board standard of 10%-15% of modernization costs.

Architect and Engineering Fees - These costs total $103,000 or 8.9% of modernization and contingency costs. This appears reasonable when compared to the State Board standard of 7.08% to 10.62% of modernization and contingency costs.

Moveable Equipment - These costs total $600,000 or $37,500 per station. This appears reasonable when compared to the State Board standard of $39,945.

Fair Market Value of Leased Space - These costs are $3,068,800. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF PROJECT COST CRITERION (77 IAC 1120.140 (c)).

D) Criterion 1120.140 (d) - Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

The applicants anticipate the direct operating costs per treatment to be $75.59. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECT DIRECT OPERATING COSTS CRITERION (77 IAC 1120.140 (d)).

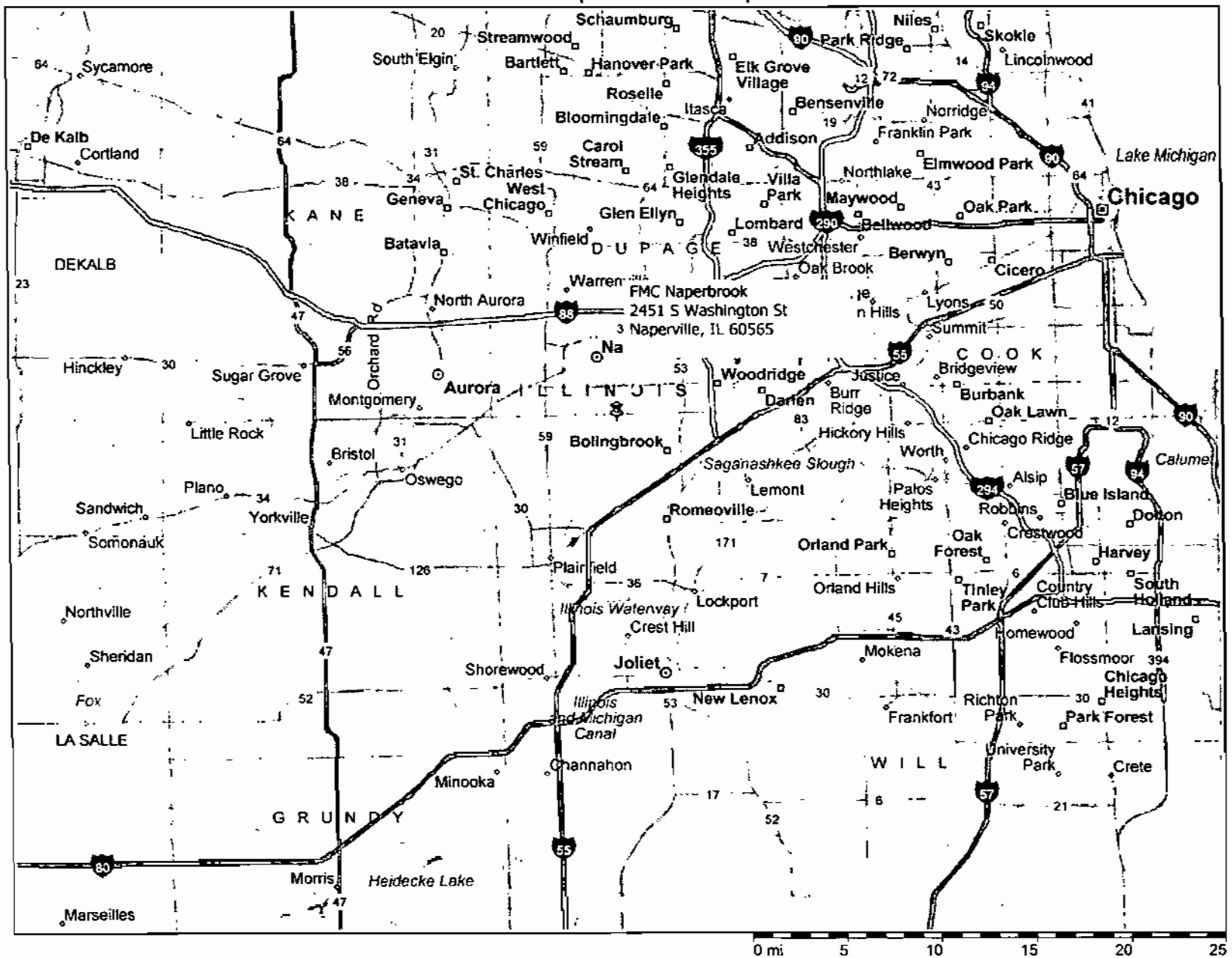
E) Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The applicants anticipate the total effect of the Project on Capital Costs per treatment to be $11.93. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS CRITERION (77 IAC 1120.140 (e)).

11-038 FMC Naperbrook - Naperville



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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 •(217) 782-3516 FAX: (217) 785-4111

DOCKET NO:	BOARD MEETING:	PROJECT NO:	PROJECT COST:
H-02	October 12-13, 2011	11-025	Original: $2,486,029
FACILITY NAME: U.S Renal Care Bolingbrook Dialysis		CITY: Bolingbrook	
TYPE OF PROJECT: Substantive			HSA: IX

PROJECT DESCRIPTION: USRC Alliance, LLC USRC Bolingbrook LLC and US Renal Care, Inc. (the applicants) are proposing the establishment of a 13-station End Stage Renal Dialysis (ESRD) facility located 7,219 GSF of leased space in Bolingbrook. The cost of the proposed project is $2,486,029.

This project was modified on July 28, 2011. This was considered a Type A Modification. US Renal Care, Inc. was added as a coapplicant requiring the publication of a notice of an opportunity for a public hearing.

The State Board Staff Notes there are three projects on the October Agenda proposing to establish dialysis facilities in the HSA IX planning area. The projects are as follows:

- Project #11-025 USRC - Bolingbrook Dialysis (13 stations)
- Project #11-038 FMC - Naperbrook (12 stations)
- Project #11-004 - Crest Hill Dialysis (12 stations)
- A fourth Project #11-058 - FMC Plainfield is proposing to add four stations to an existing 12 station facility.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- USRC Alliance, LLC, USRC Bolingbrook, LLC, and US Renal Care, Inc. (the applicants) are proposing the establishment of a 13-station End Stage Renal Dialysis (ESRD) facility located in 7,219 GSF of leased space in Bolingbrook. The cost of the project is $2,486,029. **The anticipated project completion date is August 1, 2012.**

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project proposes to establish a health care facility as defined by Illinois Health Facilities Planning Act.

PURPOSE OF THE PROJECT:

- The proposed project seeks to establish an ESRD facility and ESRD services in Bolingbrook. The purpose of the project is to relieve overcrowding at existing ESRD facilities in the service area, and to keep dialysis services accessible to a growing ESRD population in Will County.

NEED:

- To establish a dialysis service
  1. there must be a calculated need in the planning area;
  2. the proposed service must provide service to planning area residents;
  3. there must be a demand for the service in the planning area;
  4. the proposed service must improve access;
  5. the proposed service will not cause an unnecessary duplication of service or maldistribution of service.

- HSA-IX currently has a **calculated excess of 55 ESRD stations,** 100% of the pre ESRD patients will come from within HSA IX ESRD planning area and the applicants have identified 106 pre ESRD patients that will need care within the next 1 to 3 years. There is no lack of service within 30 minutes of the proposed facility as there are existing facilities operating below target occupancy. Average utilization of the facilities within 30 minutes is 76%. No access issues were identified within the planning area. The proposed facility would appear to result in unnecessary duplication of service because 3 of 10 (30%) facilities within 30 minutes are operating below target occupancy.

BACKGROUND/COMPLIANCE ISSUES:

- Neither applicant has outstanding compliance issues with the State Board.

PUBLIC HEARING/COMMENTS:

- A public hearing was held regarding this project on July 11, 2011. The hearing took place at the Village Hall for the Village of Bolingbrook. The State Board Staff registered

23 individuals in attendance, with 12 individuals speaking in support of the proposed project. One individual registered their opposition but did not speak in opposition to the proposed project. The Project file contains a "cease and desist" letter from Clare Connor Ranalli, of Holland & Knight, LLP, Legal Counsel for Fresenius, and a response for Ed Clancy, Ungaretti & Harris, LLP. Legal Counsel for the applicants.

- **Clare Connor Ranalli, Holland & Knight, LLP stated:** *"US Renal Care seeks to support its requests for permits to build dialysis centers by making material representations about Fresenius and its business practices, disparaging Fresenius Illinois' facilities and the services offered by them, and generally painting Fresenius in a potentially false light. We demand that U.S. Renal Care cease and desist in making defamatory and/or disparaging statements about Fresenius, modify the applications to remove untrue statements about Fresenius, and refrain from making or publishing further defamatory statements to the Board, whether by application, written or oral communication, at public hearing or otherwise".*

- **Edward Clancy, Ungaretti and Harris, LLP, Legal Counsel to the Applicant, stated:** *"The CON application demonstrates the need for proposed facilities, due to lack of patient choice in dialysis providers, and the changing population demographics in the proposed Health Service Areas (HSAs). The Cease and Desist Letter, however, misconstrues several statements made in the CON Application and threatens the applicants with litigation, unless they withdraw these statements. US Renal Care submits this letter to add clarification. We assume the Illinois Health Facilities and Services Review Board will note that our attempt to provide it with information directly related to its mission and purpose has been met with the threat of potential litigation. Please accept this letter in support of the CON application".*

FINANCIAL AND ECONOMIC FEASIBILITY:

- The entirety of the project will be funded through internal sources (Cash and Securities), and a review of the financial statements indicate sufficient cash is available to fund the project.

CONCLUSIONS:

- There is a **calculated excess of 55 stations in the HSA-09 ESRD service area**. There are 10 facilities within 30 minutes with 4 of the 10 facilities (40%) operating below the target occupancy of 80%. See Table Five below.

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
1110.234(a) Size of Project	The gross square footage (GSF) for the proposed project is 35 GSF in excess of the State Standard.
1110.1430(b) Planning Area Need	30% (3 of 10 facilities) of the ESRD facilities

State Board Standards Not Met	
Criteria	**Reasons for Non-Compliance**
	within a 30-minute drive radius are operating beneath the 80th percentile.
1110. 1430 (c) - Unnecessary Duplication /Mal distribution of Service	30% (3 of 10 facilities) of the ESRD facilities within a 30-minute drive radius are operating beneath the 80th percentile.
1120.140(c) Reasonableness of Project and Related Costs	The applicants were above the allowable percentile for Architect and Engineering Fees. These costs total $42,000 or 19.3% of modernization and contingency costs. This appears **high** when compared to the State Board standard of 8.80% to 13.2% of modernization and contingency costs.

U.S. Renal Care Bolingbrook Dialysis
PROJECT #11-025

Applicants	US Renal Care, Inc. USRC Bolingbrook, LLC USRC Alliance, LLC
Facility Name	U.S. Renal Care, Bolingbrook Dialysis
Location	Bolingbrook
Application Received	May 24, 2011
Application Deemed Complete	May 24, 2011
Review Period Ended	July 23, 2011
Review Period Extended by the State Board Staff	No
Public Hearing Requested	Yes
Applicants' Deferred Project	No
Can Applicants Request Another Deferral?	Yes
Applicants' Modified the Project	No

I. The Proposed Project

The State Board is being asked to consider the establishment of a 13-station ESRD facility in Downers Grove. The proposed facility will be located in 7,219 GSF of leased space, and the cost of the project is $2,486,029.

II. Summary of Findings

A. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1110.

B. The State Board Staff finds the proposed project does **not** appear to be in conformance with the provisions of Part 1120.

III. General Information

The proposed facility will be located at 396 Remington Boulevard, in Bolingbrook. The applicants are USRC Alliance, LLC, USRC Bolingbrook, LLC and US Renal Care, Inc. US Renal Care, Inc. is the parent organization for all the entities and PHT Bolingbrook, MOB d/b/a Partners Health Trust owns the site. USRC Bolingbrook, LLC is the operating entity/licensee. The proposed facility will be located in HSA IX. HSA IX is comprised of Will, Kendall, Grundy, and Kankakee counties in Illinois. The September 2011 update to the IDPH Inventory of Health Care Facilities ("Inventory") shows a computed excess of 55 ESRD

stations in HSA IX.

TABLE ONE
Facilities within the HSA IX ESRD Service Area

Facility	Ownership	City	Stations	Utilization	Met Occupancy?
Provena St. Mary's Hospital	Provena	Kankakee	25	64.67%	No
Silver Cross Renal Center	Silver Cross	New Lenox	19	78.07%	No
Sun Health	Sun Health	Joliet	17	52.94%	No
Renal Care Group	DaVita	Morris	9	74.07%	No
Bolingbrook Dialysis		Bolingbrook	24	79.17%	No
Manteno Dialysis Center	Provena	Manteno	15	43.33%	No
FMC Oswego	Fresenius	Oswego	10	88.33%	Yes
Kankakee County Dialysis		Bourbonnais	12	54.17%	No
FMC Mokena	Fresenius	Mokena	12	72.22%	No
FMC Plainfield	Fresenius	Plainfield	12	90.28%	No
Yorkville Dialysis Center		Yorkville	8	27.08%	No
Silver Cross Renal Center West		Joliet	29	85.06%	Yes
Silver Cross Renal Center Morris		Morris	9	38.89%	No
FMC Joliet*	Fresenius	Joliet	16	0.00%	No

*Facilities recently approved by the State Board not yet operational
Utilization data taken from June 2011 Renal Network Data

There is no land acquisition cost for this project, as the proposed facility will be leased space in a single-tenant building. This is a substantive project subject to both a Part 1110 and Part 1120 review. Project obligation will occur after permit issuance. **The anticipated project completion date is August 1, 2012.**

A public hearing was held regarding this project on July 11, 2011. The hearing took place at the Village Hall for the Village of Bolingbrook. The State Board Staff registered 23 individuals in attendance, with 12 individuals speaking in support of the proposed project. One individual registered their opposition but did not speak in opposition to the proposed project. The State Board Staff received support and opposition letters.

Rick D. Mace CEO Adventist Bolingbrook stated *"we anticipate the volume of patients requiring dialysis services increasing and wish to ensure that adequate resources*

to meet the needs of these patients. As such I strongly support this project and ask the Board to approve the Certificate of Need U. S. Renal Care Bolingbrook Dialysis facility."

IV. The Proposed Project - Details

The applicants propose to establish a 13 station ESRD facility housed in 7,219 Gross Square Feet ("GSF") of leased space. The proposed facility will be located at 396 Remington Boulevard, Bolingbrook. The applicants note that they will build out the interior of the leased space, and the total estimated project cost is $2,486,029.

V. Project Costs and Sources of Funds

The total estimated project cost is $2,486,029, and the entire project cost is being funded internally with cash and securities. Table Two outlines the project's costs and uses of funds. The State Board Staff notes all costs are classified as being both clinical and non-clinical.

TABLE TWO
Project Uses and Sources of Funds

Uses of Funds	Non-Clinical	Clinical	Total
Modernization Contracts		$216,570	$216,570
A & E Fees		$42,000	$42,000
Moveable Equipment	$98,601	$70,157	$168,757
Fair Market Value of Leased Space & Equipment		$1,967,457	$1,967,457
Other Costs to be Capitalized		$91,244	$91,244
Total Uses of Funds	**$98,601**	**$2,387,428**	**$2,486,029**
Sources of Funds	**Non-Clinical**	**Clinical**	**Total**
Cash and Securities	$98,601	$2,387,428	$2,486,428
Total Sources of Funds	**$98,601**	**$2,387,428**	**$2,486,428**

VI. Cost/Space Requirements

Table Three displays the project's cost/space requirements for the project. The clinical portion comprises approximately 96% of the cost and GSF.

TABLE THREE US Renal Care Bolingbrook Cost/Space Allocation							
Clinical Department	Cost	Existing GSF	Proposed GSF	New	Modernized	Vacated	As Is
ESRD	$2,387,428	0	7,219	0	7,219	0	0
Total	$2,387,428	0	7,219	0	7,219	0	0

VI I. Section 1110.230 - Project Purpose, Background and Alternatives

A. Criterion 1110.230(a) - Background of Applicant

The Criterion states:

"1) 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.* [20 ILCS 3960/6] In evaluating the qualifications, background and character of the applicant, HFPB shall consider whether adverse action has been taken against the applicant, or against any health care facility owned or operated by the applicant, directly or indirectly, within three years preceding the filing of the application. A health care facility is considered "owned or operated" by every person or entity that owns, directly or indirectly, an ownership interest. If any person or entity owns any option to acquire stock, the stock shall be considered to be owned by such person or entity (refer to 77 Ill. Adm. Code 1100 and 1130 for definitions of terms such as "adverse action", "ownership interest" and "principal shareholder").

2) Examples of facilities owned or operated by an applicant include:

A) The applicant, Partnership ABC, owns 60% of the shares of Corporation XYZ, which manages the Good Care Nursing Home under a management agreement. The applicant, Partnership ABC, owns or operates Good Care Nursing Home.

B) The applicant, Healthy Hospital, a corporation, is a subsidiary of Universal Health, the parent corporation of Healthcenter Ambulatory Surgical Treatment Center (ASTC), its wholly-owned subsidiary. The applicant, Healthy Hospital, owns and operates Healthcenter ASTC.

C) Dr. Wellcare is the applicant. His wife is the director of a

corporation that owns a hospital. The applicant, Dr. Wellcare, owns or operates the hospital.

D) Drs. Faith, Hope and Charity own 40%, 35% and 10%, respectively, of the shares of Healthfair, Inc., a corporation, that is the applicant. Dr. Charity owns 45% and Drs. Well and Care each own 25% of the shares of XYZ Nursing Home, Inc. The applicant, Healthfair, Inc., owns and operates XYZ Nursing Home, Inc.

3) The applicant shall submit the following information:

A) A listing of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, as applicable;

B) A certified listing from the applicant of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application;

C) Authorization permitting HFPB and Illinois Department of Public Health (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 HFPB.

4) If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed to update and/or clarify data.

The applicant provided a list of all health care facilities currently owned and/or operated by the applicant, including licensing, certification and accreditation identification numbers, a certified statement from the

applicant that no adverse action has been taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application, and authorization permitting HFPB and HFPB Staff access to any documents necessary to verify the information submitted. The applicants appear fit, willing and able and have the qualifications, background and character to adequately provide a proper standard of healthcare service for the community.

B. Safety Net Impact Statement/Charity Care

The applicants provided a Safety Net Impact Statement *that says the proposed project seeks to expand scarce outpatient dialysis services, which, in the past, has forced some hospitals to delay patient discharges in an effort to secure necessary dialysis services. The applicants plan to make additional outpatient services available to facilitate more timely hospital discharges, resulting in greater opportunities for hospitals to provide additional safety net and charity care services. The applicants also state they currently maintain a working relationship with Access DuPage, a unique partnership of hospitals, physicians, local government, human service agencies, and community groups working together to address access to medical services to the county's low-income, medically uninsured residents.* The table below shows the amount of charity care provided for the 3 fiscal years prior to submission of the application, and the amount of care provided to Medicaid patients for the three fiscal years prior to submission of the application for US Renal Care, Inc. nationally.

TABLE FOUR SAFETY NET INFORMATION US Renal Care, Inc			
CHARITY CARE			
	2008	2009	2010
Outpatient	1,075	1,056	1,922
Total	1,075	1,056	1,922
Charity (Cost)			
Outpatient	$280,941	$281,536	$521,535
Total	$280,941	$281,536	$521,535
MEDICAID			
Number of Treatments	2008	2009	2010

Outpatient	14,761	17,967	29,744
Medicaid Revenue			
Outpatient	$3,221,097	$3,956,318	$6,740,875

C. Criterion 1110.230(b) - Purpose of the Project

The Criterion states:

The applicant shall 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, per the applicant's definition.

1) The applicant shall address the purpose of the project, i.e., identify the issues or problems that the project is proposing to address or solve. Information to be provided shall include, but is not limited to, identification of existing problems or issues that need to be addressed, as applicable and appropriate for the project. Examples of such information include:
   A) The area's demographics or characteristics (e.g., rapid area growth rate, increased aging population, higher or lower fertility rates) that may affect the need for services in the future;
   B) The population's morbidity or mortality rates;
   C) The incidence of various diseases in the area;
   D) The population's financial ability to access health care (e.g., financial hardship, increased number of charity care patients, changes in the area population's insurance or managed care status);
   E) The physical accessibility to necessary health care (e.g., new highways, other changes in roadways, changes in bus/train routes or changes in housing developments).
2) The applicant shall cite the source of the information (e.g., local health department Illinois Project for Local Assessment of Need (IPLAN) documents, Public Health Futures, local mental health plans, or other health assessment studies from governmental or academic and/or other independent sources).
3) The applicant shall detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being. Further, the applicant shall provide goals with quantified and measurable objectives with specific

time frames that relate to achieving the stated goals.

4) **For projects involving modernization, the applicant shall describe the conditions being upgraded. For facility projects, the applicant shall include statements of age and condition and any regulatory citations. For equipment being replaced, the applicant shall also include repair and maintenance records.**

The applicants propose to establish a 13-station ESRD facility in 7,219 gross square feet of modernized, leased space.

The applicants state the purpose of the proposed project is to ease the high utilization currently reported at area ESRD facilities, allowing patients convenient and timely access to dialysis services. The applicants have also identified 106 pre-ESRD patients who are anticipated to require dialysis services in the next 1-3 years, based on current population data. The applicants note the Bolingbrook/Will County area has experienced a significant increase in its Hispanic population, which is reported to have 1.5 time higher incidence of kidney disease than non-Hispanic whites. These data, combined with the projected 106 pre-ESRD patients will create a need for dialysis services that outweighs the current offerings in HSA-IX.

Table Five identifies facilities within a 30-minute timeframe and their utilization as supplied by the applicants. As seen in Table Five, 3 (30%) of the 10 facilities within a 30-minute travel radius are do not meet the State Board Standard (80%), for utilization.

TABLE FIVE
Facilities within 30 minutes of USRC Bolingbrook Dialysis [1]

Facility	City	Adjusted Minutes [1]	Miles	Stations	June 2011 Utilization	Met 80% Standard
FMC Bolingbrook	Bolingbrook	1	0.53	24	79.86%	No
FMC Willowbrook	Willowbrook	18	11.4	16	86.46%	Yes
FMC Naperville	Naperville	20	8.6	15	88.89%	Yes
FMC Naperville-North	Naperville	25	10	14	86.90%	Yes
FMC Plainfield	Plainfield	25	13.2	12	90.28%	Yes
Fox Valley Dialysis Ctr.	Aurora	25	14	26	88.46%	Yes

TABLE FIVE

Facilities within 30 minutes of USRC Bolingbrook Dialysis [1]

Facility	City	Adjusted Minutes [2]	Miles	Stations	June 2011 Utilization	Met 80% Standard
Silver Cross Renal Ctr. West	Joliet	26	13.5	29	88.51%	Yes
FMC Lombard	Lombard	26	15.3	12	8.33%	No
FMC Downers Grove	Downers Grove	26	15.4	19	96.49%	Yes
Sun Health	Joliet	27	13.3	17	56.86%	No

1. Mileage calculated using MapQuest. Time calculated per 77 IAC 1100.510 (d)
2. *Recently approved facility, no data available.

The applicants also noted that they would like to provide dialysis patients with another choice in the provision of dialysis services, and identified the top three dialysis providers as having control of approximately 72% of the dialysis stations in HSA-09.

D. Criterion 1110.230(c) - Alternatives to the Proposed Project

The Criterion states:

"The applicant shall 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.

1) Alternative options shall be addressed. Examples of alternative options include:
   - **A) Proposing a project of greater or lesser scope and cost;**
   - **B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;**
   - **C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and**
   - **D) Other considerations.**

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short

term (within one to three years after project completion) and long term. This may vary by project or situation.

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available."

The applicants propose a 13-station ESRD facility. The applicants considered the following alternatives:

1. **Utilize Other Health Care Resources**

The applicants claim that patients who require dialysis treatment are limited in their options to utilize other health care resources, based on frequency and length of treatments, and access/effectiveness of facilities. The applicants note the top three providers control 72% of the dialysis services in the area, and it is the applicants' intent to provide service alternatives to patients who cannot or will not obtain services from these. No costs were identified with this alternative.

2. **Propose a Project of Greater or Lesser Scope**

The applicants' state alternatives of this nature were initially considered, but rejected due to their inability to sufficiently meet the ESRD service needs in HSA-09. The applicants identified 106-pre-ESRD patients that are anticipated to be in need of dialysis services in the next 1-3 years, based on population projections, and feel that the proposed project is the best alternative to serve this population. The applicants identified no costs with this alternative.

3. **Pursue a Joint Venture with Another Provider**

The applicants rejected this alternative, based on their business model to provide quality patient care while controlling costs. The applicants feel this option has the potential to compromise their proven operating model, and dilute the benefits of patient care realized by patients of U.S. Renal Care. The applicant identified no costs with this alternative.

VI. Section 1110.234 - Project Scope and Size, Utilization and Unfinished/Shell Space – Review Criteria

A) Size of Project

The Criterion states:

"The applicant shall document that the amount of physical space proposed for the project is necessary and not excessive. The proposed gross square footage (GSF) cannot exceed the GSF standards of Appendix B, unless the additional GSF can be justified by documenting one of the following:

1) **Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;**
2) **The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;**
3) **The project involves the conversion of existing bed space that results in excess square footage."**

The applicants propose to establish a 13 station ESRD facility in 7,219 GSF of leased space. The State board standard is 360-520 DGSF per station. The applicants note the project is allocating 555 GSF per station, which exceeds State standards. Table Six illustrates the spatial configuration, and the mentioned overage.

TABLE SIX
SIZE OF PROJECT
11-025 U.S. Renal Care Bolingbrook Dialysis

Department /Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
ESRD Facility	7,219 GSF (13 Stations)	360-520 DGSF (500GSF/Station)	555 DGSF/Station 35 DGSF Over	No

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE SIZE OF PROJECT CRITERION (77 IAC 1110.234(a)).

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or

equipment shall meet or exceed the utilization standards specified in Appendix B. The number of years projected shall not exceed the number of historical years documented. If the applicant does not meet the utilization standards in Appendix B, or if service areas do not have utilization standards in 77 Ill. Adm. Code 1100, the applicant shall justify its own utilization standard by providing published data or studies, as applicable and available from a recognized source, that minimally include the following:

The applicants have documented by the second year after project completion the proposed facility will exceed the State Board's target occupancy of 80% (Application, P. 55).

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECTED SERVICES UTILIZATION CRITERION (77 IAC 1110.234(b)).

IX. <u>Section 1110.1430 - In-Center Hemodialysis Projects – Review Criteria</u>

The criterion for establishing an ESRD facility reads as follows:

1) 77 Ill. Adm. Code 1100 (formula calculation)

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.

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.

B) Applicants proposing to add stations to an existing in-center hemodialysis service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

C) Applicants proposing to expand an existing in-center hemodialysis service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

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 two-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).

A) Historical Referrals

i) If the applicant is an existing facility, the applicant shall document the number of referrals to other facilities, for each proposed category of service, for each of the latest two years.

ii) Documentation of the referrals shall include: patient origin by zip code; name and specialty of referring physician; name and location of the recipient facility.

B) Projected Referrals
The applicant shall provide physician referral letters that attest to:

i) The physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent three years and the end of the most recent quarter;

ii) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;

iii) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The anticipated number of referrals cannot exceed the physician's documented historical caseload;

iv) An estimated number of existing patients who are not expected to continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);

v) The physician's notarized signature, the typed or printed name of the physician, the physician's office address and the physician's specialty;

VI) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services; and

VI i) Each referral letter shall contain a statement attesting that the information submitted is true and correct, to the best of the physician's belief.

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, indiVI duals 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 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

b) **Planning Area Need Review Criterion**

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 (formula calculation)**

According to the September 2011 update to the IDPH Inventory of Health Care Facilities ("Inventory"), HSA-09 shows a **computed excess of 55 ESRD stations.** This project is requesting 13 stations in 7,219 GSF of leased space in Bolingbrook.

2) **Service to Planning Area Residents**

The primary purpose of this project is to provide in-center ESRD services to the residents of HSA-09, and offer service-based alternatives for these patients in an area where existing facilities are experiencing high utilization (See Table 5). HSA-09 and the Bolingbrook area have experienced a significant increase in its Hispanic population, based on 2010 census data. The applicants note that Bolingbrook maintains a 24.5% Hispanic population, exceeding similar demographic populations for Will County and the State of Illinois. It is noted earlier in this report that the Hispanic population has a 1.5 times greater incidence of chronic kidney disease, requiring dialysis services, and the current excess of ESRD stations in HSA-09 inaccurately represents the needs of a service area with changing demographics.

3) **Service Demand**

The applicants submitted a referral letter from Drs. Anis Rauf, M.D. and Mohammed Ahmed, M.D., identifying 106 pre-ESRD patients that will be referred to ESRD facilities within the next two years (Application, p. 210). The applicants furnished zip codes of patient origin which indicate these patients reside in suburban Cook and Will counties.

4) **Service Accessibility**

The applicants state that the issue of access is problematic due to market dominance of three corporate entities that limit the availability of ESRD services to those who cannot or will not obtain services from them. These facilities are reported to own 72% of the dialysis facilities in HSA-09. The applicants have supplied a letter from Dr. Ahmed, (application, pgs. 72-73), which describes 3 patient accounts with area facilities that resulted in patient encounters that has a negative impact on the patient.

Summary

There is a calculated excess of 55 stations within the HSA IX planning area and the State Board Staff has found 3 (30%) of the 10 facilities in the 30-minute drive radius are operating under the State occupancy target of 80%(See Table 5). Therefore, a positive finding cannot be made.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE PLANNING AREA NEED CRITERION (77 IAC 1110.1430(b)).

c) Unnecessary Duplication / Maldistribution Review Criterion

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 is located, in total or in part, within 30 minutes normal travel time 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 30 minutes normal travel time from the project site that provide 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.

The applicants provided a list of all zip code areas that are located within 30 minutes of the proposed site as required. The applicants note the calculated station to population ratio is 1 station per 4,576 persons, within this 30 minute radius while the 2000 Census statistics identified a State station-to-Population ratio of 1 station per 3,408.

30% of the facilities within 30 minutes are operating at less than the target occupancy of 80% and there is an calculated excess of 55 ESRD stations in the IX planning area, based on the September 2011 Inventory Update. A positive finding cannot be made for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT <u>DOES NOT</u> APPEAR TO BE IN CONFORMANCE WITH THE

MALDISTRIBUTION/IMPACT ON AREA PROVIDERS CRITERION (77 IAC 1110.1430 (c)).

C) Staffing - Availability

The Criterion states:

"The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO 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 210 ILCS 62, 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 Dietetic and Nutrition Services Practice Act [225 ILCS 30]) 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's of Social Work and meet the State of Illinois requirements (see 225 ILCS 20, the Clinical Social Work and Social Work Practice Act)."

The applicants are proposing to establish a 13-station ESRD facility and have provided the necessary information as required by this criterion on pages 82-107 of the application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE STAFFING CRITERION (77 IAC 1110.1430 (e) (1)).

D) Support Services

The Criteria states:

"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 are proposing to establish a 13-station ESRD facility and have provided the necessary documentation as required by this criterion on page 109 of the application for permit. The applicants note Adventist Bolingbrook Hospital, Bolingbrook, will provide Blood bank, Rehabilitation, and Psychiatric services, while US Renal Care, Oak Brook, will provide training and instruction.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH THE SUPPORT SERVICES CRITERION (77 IAC 1110.1430 (f)).

E) Assurances

The Criterion states:

"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 area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas .1.2."

The applicants provided the required certification information on page 119 of the application for permit as required of the criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE ASSURANCES CRITERION (77 IAC 1110.1430 (j)).

g) **Minimum Number of Stations**
The minimum number of in-center hemodialysis stations for an End Stage Renal Disease (ESRD) facility is:

1) **Four dialysis stations for facilities outside an MSA;**

2) **Eight dialysis stations for a facility within an MSA.**

The proposed 13 station ESRD facility will be located in an MSA. The applicants have met the requirements of this criterion

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE MINIMUM NUMBER OF STATIONS CRITERION (77 IAC 1110.1430 (g)).

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 the required affiliation agreement on pages 112-117 of the application for permit. The transfer agreement is with Adventist Bolingbrook Hospital, Bolingbrook. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE CONTINUITY OF CARE CRITERION (77 IAC 1110.1430 (h)).

X. 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources.

The applicants are funding the project in its entirety with cash and securities of $2,486,029. A review of the applicants' financial statements indicates that sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE AVAILABILITY OF FUNDS CRITERION (77 IAC 1120.120 (a)).

XI. 1120.130 - Financial Feasibility

A. Criterion 1120.130 - Financial Viability

Financial Viability Waiver
The applicant is NOT required to submit financial viability ratios if:

1) **all project capital expenditures, including capital expended through a lease, are completely funded through internal resources (cash, securities or received pledges); or**

HFSRB NOTE: Documentation of internal resources availability shall be available as of the date the application is deemed complete.

2) the applicant's current debt financing or projected debt financing is insured or anticipated to be insured by Municipal Bond Insurance Association Inc. (MBIA), or its equivalent; or

HFSRB NOTE: MBIA Inc is a holding company whose subsidiaries provide financial guarantee insurance for municipal bonds and structured financial projects. MBIA coverage is used to promote credit enhancement as MBIA would pay the debt (both principal and interest) in case of the bond issuer's default.

3) the applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor (insurance company, bank or investing firm) guaranteeing project completion within the approved financial and project criteria.

The applicants have qualified for the financial waiver because the project is being funded with internal sources. The applicants are funding the project in its entirety with cash and securities of $2,486,029. A review of the applicants' audited financial statements indicates that sufficient cash is available to fund the project.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE FINANCIAL FEASIBILITY CRITERION (77 IAC 1120.130 (a)).

XII. Section 1120.140 - Economic Feasibility

A. Criterion 1120.140(a) - Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment

securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

The applicants are funding the project with cash and securities of $2,486,029. The applicants have provided the necessary attestation that borrowing (leasing) is less costly than the liquidation of existing investments. The applicants have met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF FINANCING ARRANGEMENTS CRITERION (77 IAC 1120.140(a)).

B. Criterion 1120.140(b) - Terms of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

The applicants are funding the project with cash and securities of $2,486,029; therefore, this criterion is not applicable.

THE STATE BOARD STAFF FINDS THE TERMS OF DEBT FINANCING CRITERION DOES NOT APPLY TO THE PROPOSED PROJECT (77 IAC 1120.140(b)).

C. Criterion 1120.140(c) - Reasonableness of Project Cost

The applicant shall document that the estimated project costs are reasonable and shall document compliance with the State Board's standards as detailed in 77 IAC 1120.

Modernization Contracts - These costs total $216,570 or $30.02 per gross square feet. ($216,570/7,219 GSF = $30.02/GSF) This appears reasonable when compared to the State Board standard of $149.35/GSF.

Architect and Engineering Fees - These costs total $42,000 or 19.3% of modernization and contingency costs. This appears **high** when compared to the State Board standard of 8.80% to 13.2% of modernization and contingency costs.

Moveable Equipment - These costs total $70,157 or $5,396.69 per station. This appears reasonable when compared to the State Board standard of $39,945.

Fair Market Value of Leased Space - These costs are $1,967,457. The State Board does not have a standard for these costs.

Other Costs to be Capitalized - These costs are $91,244. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE

REASONABLENESS OF PROJECT COST CRITERION (77 IAC 1120.140 (c)).

D) **Criterion 1120.140 (d) - Projected Operating Costs**

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

The applicants anticipate the direct operating costs per treatment to be $222.00. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECT DIRECT OPERATING COSTS CRITERION (77 IAC 1120.140 (d)).

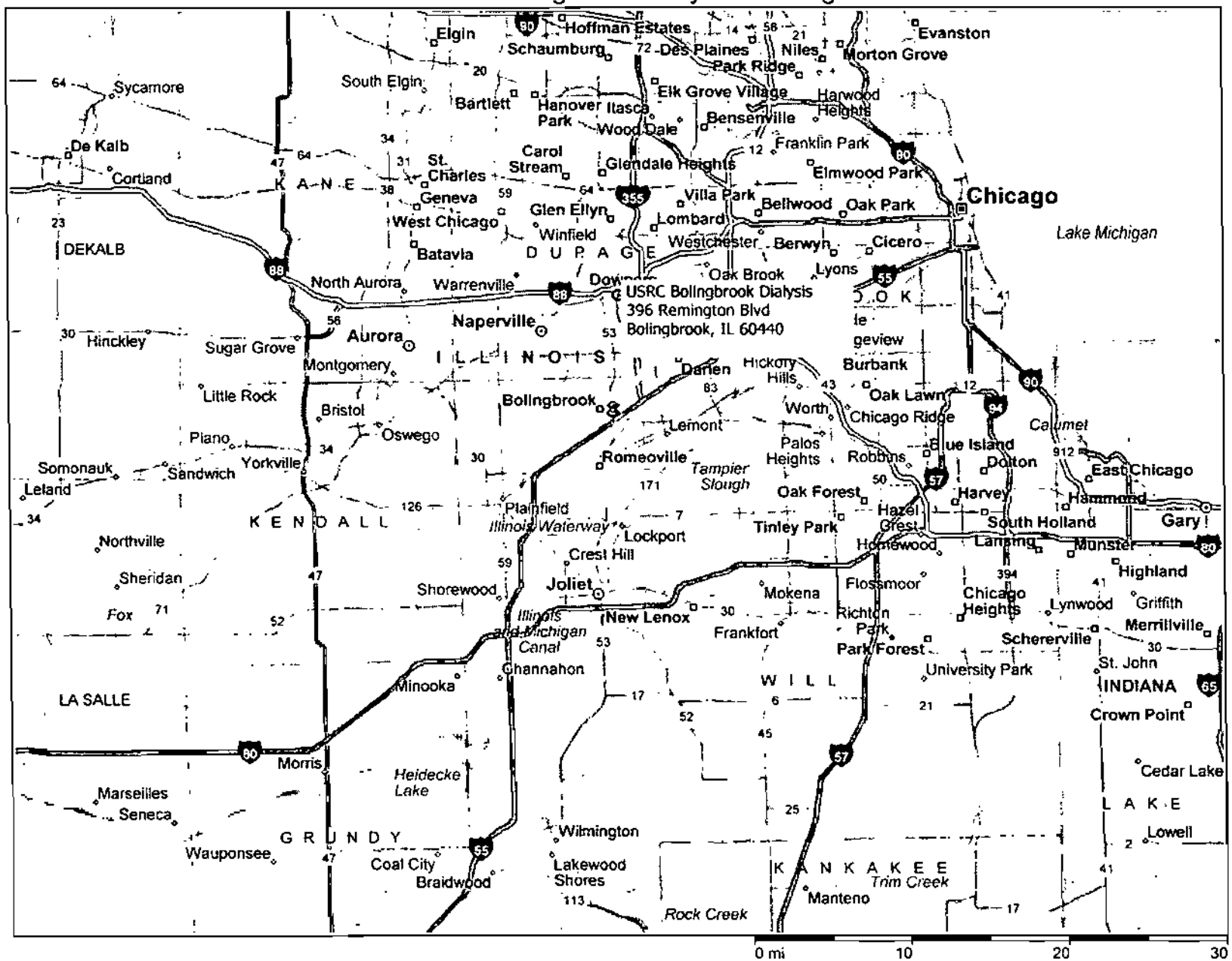
E) **Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs**

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The applicants anticipate the total effect of the Project on Capital Costs per treatment to be $21.68. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS CRITERION (77 IAC 1120.140 (e)).

11-025 USRC Bolingbrook Dialysis - Bolingbrook



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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

OCTOBER 12, 2011

DAY 1

ORIGINAL

1 STATE OF ILLINOIS

2 HEALTH FACILITIES AND SERVICES REVIEW BOARD

3 525 West Jefferson Street, 2nd Floor

4 Springfield, Illinois 62761

5 217-782-3516

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9 OPEN SESSION

10 DAY 1 -- OCTOBER 12, 2011

11 Regular session of the meeting of the State of

12 Illinois Health Facilities and Services Review Board was

13 held on October 12 & 13, 2011, at the Bolingbrook Golf

14 Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

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1 PRESENT:
2 Dale Galassie - Chairman
3 Ronald Eaker
4 John Hayes
5 John Burden
6 Alan Greiman
7 Kathy Olson
8 Richard Sewell
9 Rob Hilgenbrink
10
ALSO PRESENT:
11 Courtney Avery - Administrator
12 Cathy Clarke - Assistant
13 Frank Urso - General Counsel
Juan Morado - Assistant Counsel
14
Michael Constantino - IDPH Staff
15
Bill Dart - IDPH Staff
16
Claire Berman - IDPH Staff
17
David Carvalho - Deputy Director, IDPH
18
Michael C. Jones - IDFS
19
20
21
Reported by:
22 Karen K. Keim
CRR, RPR, CSR-IL, CRR-MO
23 Midwest Litigation Services
401 N. Michigan Avenue
24 Chicago, IL 60611

1 START TIME: 10:06 a.m.

2

3 CHAIRMAN GALASSIE: Good morning, ladies and

4 gentlemen, and welcome. We hope you'll be comfortable here

5 this morning. It's a beautiful day.

6 Let me start out by welcoming a class we have

7 here -- I'm not sure if it's undergraduate or graduate --

8 from Governor State University, a planning class. If

9 anyone is here, would you rise, any students, please.

10 (Applause)

11 CHAIRMAN GALASSIE: Welcome here. You'll see

12 government in action today, hopefully. That's our plan.

13 Okay. I will ask to call the meeting to order and ask

14 for a roll call by Staff, please.

15 MR. DART: Chairman Galassie?

16 CHAIRMAN GALASSIE: Here.

17 MR. DART: Member Hayes?

18 MR. HAYES: Here.

19 MR. DART: Dr. Burden?

20 MR. BURDEN: Here.

21 MR. DART: Mr. Eaker?

22 MR. EAKER: Present.

23 MR. DART: Justice Greiman?

24 MR. GREIMAN: Here.

1 MR. DART: Mr. Hilgenbrink?

2 MR. HILGENBRINK: Here.

3 MR. DART: Ms. Olson?

4 MS. OLSON: Here.

5 MR. DART: Mr. Penn?

6 (No response)

7 MR. DART: Mr. Sewell?

8 MR. SEWELL: Here.

9 CHAIRMAN GALASSIE: For the record, Mr. Penn

10 advised us he would not be present today.

11 MR. DART: That's eight answering.

12 CHAIRMAN GALASSIE: Thank you.

13 Can I have a motion to approve the agenda,

14 with a subsequent roll call vote, please?

15 MS. OLSON: So moved.

16 MR. SEWLL: Second.

17 CHAIRMAN GALASSIE: Moved and seconded. Roll

18 call.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Here -- yes. Sorry.

21 MR. DART: Member Hayes?

22 MR. HAYES: Yes.

23 MR. DART: Dr. Burden?

24 MR. BURDEN: Yes.

1 think something is being offered to the community that
2 responds to some of the things we heard in testimony, and
3 until we, as a board, have either a retreat or a
4 subcommittee to look at the ESRD in terms of
5 population-based need and take more things into
6 consideration, I'm reluctant to vote against it. So, I'm
7 going to abstain.
8 MR. DART: Chairman Galassie?
9 CHAIRMAN GALASSIE: Thank you, Mr. Sewell.
10 Chairman votes yes.
11 MR. DART: That's 8 votes in the
12 affirmative -- I'm sorry, 7 votes.
13 (Applause)
14 CHAIRMAN GALASSIE: That applause was for the
15 Staff report.
16 MR. CONSTANTINO: Thank you very much.
17 (Laughter)
18 CHAIRMAN GALASSIE: Now we're going to Item
19 11-025. However, I need to stop for a moment. We have
20 eight public comments requested for this item, and we have
21 two public comments following on the next item, 11-026.
22 So, bear with me. I need to ask the Board, do you need a
23 10-minute stretch? Lunch is at 12:30. Or are we able to
24 forge ahead? We are at 11:45.

1 (Discussion held off the record.)

2 CHAIRMAN GALASSIE: We will come back in ten

3 minutes.

4 (Recess)

5 CHAIRMAN GALASSIE: Thank you for being

6 reasonably timely. I will be pulling this back together.

7 And we're moving to Item H-2, 11-025, USRC

8 Bolingbrook Dialysis. We have eight individuals who have

9 signed up for comment. All but one are in support. I

10 would just ask, if you would like to testify in support, so

11 be it. If you feel your comments have been absorbed by the

12 previous presenters, you're not required to present,

13 obviously, but we're happy to have you, if you so choose.

14 We'll call your name, and if you would like to come up and

15 present, please do so. Again we will ask for a

16 three-minute duration, if possible, on public comment.

17 MS. AVERY: Roger Claar, John Rangel, and

18 Ricardo Morales.

19 CHAIRMAN GALASSIE: Good morning.

20 MR. CLAAR: Good morning. I've been honored

21 to have been mayor of Bolingbrook for the past 25 years.

22 I'd like to welcome you, first of all, to Bolingbrook, and,

23 secondly, to the Bolingbrook Golf Club, which is owned by

24 the Village of Bolingbrook, and we still have tee times

1 this afternoon.

2 (Laughter)

3 MR. CLAAR: Anyway, first of all, I'll be

4 brief, because I've been through many, many meetings like

5 this myself. Rick Mace, our hospital administrator of

6 Bolingbrook Hospital attests to the fact that the hospital

7 is experiencing a significant increase in patients

8 requiring dialysis services. At the same time, the

9 availability of these services at existing facilities

10 become limited, which causes delays in patient discharge

11 and increases the patient's length of stay. Many patients

12 are currently being sent out of town, requiring the burden

13 of gas expense, enormous amount of time, commuting three

14 times weekly to maintain their health.

15 Bolingbrook, according to the 2010 census, is

16 over 73,000 people. We saw a significant increase in our

17 African American and Hispanic population, which is almost

18 half of our population. This, of course, results in

19 disproportionate incidents of diabetes and high blood

20 pressure, which are leading causes of kidney failure. Lack

21 of access to dialysis care will continue to increase

22 without additional chairs available. We anticipate the

23 volume of patients requiring the service to increase and

24 wish to assure there are adequate resources to meet the

1 needs of the patients in the Bolingbrook community. As
2 such, as Mayor, I strongly support this project and ask the
3 Board to approve the Certificate of Need for the U.S. Renal
4 Care facility in Bolingbrook.
5 Thank you.
6 CHAIRMAN GALASSIE: Thank you, Mayor, and
7 thank you for hosting us today. We appreciate that very
8 much.
9 MR. MORALES: Good afternoon. My name is
10 Ricardo Morales (spells name), and I, too, have been
11 privileged to serve the Village of Bolingbrook as a Trustee
12 for the past 10 years. Like Mayor Claar, I see a need in
13 our town. As a community leader, it is my responsibility
14 to do what is best for our residents and our surrounding
15 communities. I see a need that needs to be addressed by
16 you, the Board, and we thank you for taking the time and
17 your concern in listening to us.
18 As Mayor Claar stated, we have a diverse
19 community, but for what I know about the illness that
20 affects the kidneys, it is not selective about race, color
21 or creed. Yes, there is specifically more of a need now,
22 as stated, for the minorities, but I think this is going to
23 serve all the people of our area, not just our town but the
24 surrounding areas. Again, our town specifically is over

1 73,000, over 45 percent being minorities. But, again, the
2 other part of the population deserve just as much care as
3 well. As a Mexican American myself, I do have slight
4 concern more than others, I guess, but again, as a
5 community leader, I'm more concerned with the residential
6 needs, and I ask that you approve this petition today.
7 Thank you.
8 CHAIRMAN GALASSIE: Thank you, Trustee
9 Morales.
10 Good morning.
11 MR. RANGEL: Good morning, Mr. Chairman,
12 members of the Board. Thank you once again for having me
13 here. My name is Juan Rangel again, CEO of UNO.
14 (Applause)
15 MR. GALASSIE: Looks like you're buying
16 lunch, Juan.
17 (Laughter)
18 MR. RANGEL: Just to kind of place some
19 context to my earlier comments this morning regarding
20 Hispanic representation on the Board, and in spite of the
21 opposition to the proposal before you for additional
22 dialysis facilities in the area before you, the Members of
23 the Health Facilities and Services Review Board have the
24 unique opportunity today to ensure critical healthcare to

1 this region's growing Hispanic community. I want to thank
2 this Board for your support of the Oak Brook dialysis
3 station, and I'm here also to speak on behalf of not only
4 the Oak Brook facility but that of Bolingbrook and
5 Streamwood.
6 I certainly urge this Board to approve the
7 facilities that will be greatly helping the Latino
8 community and, as you may know, with greater choice and
9 competition, costs will be lowered for all, not just for
10 the Hispanic community. The strength of this region will
11 be determined about how well our government can adapt to
12 meet the changing needs of this community. It will also be
13 determined by the support that our leaders have for it
14 today. The recent endorsement by Mayor Claar, as you
15 heard, and Trustee Morales, as well as Representative --
16 State Representative Linda Chapa LaVia are evidence that
17 our leaders see the need to adapt with the ever-changing
18 healthcare needs in this area. I urge this Board to also
19 lead the way and approve all three proposals for additional
20 dialysis facilities.
21 Thank you.
22 (Applause)
23 CHAIRMAN GALASSIE: Thank you very much.
24 MS. AVERY: Next we have David Dreyfus, Pastor

1 Calvin Quarles, and Avtar Dhindsa.

2 CHAIRMAN GALASSIE: Good morning.

3 MR. DREYFUS: Good morning. My name is Dave

4 Dreyfus (spells name), no relation to the actor nor the

5 mutual fund.

6 (Laughter)

7 MR. DREYFUS: I am a transplant education

8 coordinator and outreach coordinator for the University of

9 Illinois Medical Center, Division of Transplant. I've been

10 involved in transplantation for 15 years, with the last 6

11 years being involved with outreach and education. I come

12 before you today because I support U.S. Renal Care's

13 application to establish dialysis centers in Bolingbrook,

14 Oak Brook, and Streamwood.

15 My responsibilities as an outreach coordinator

16 and educator is to go to the dialysis units to talk to

17 patients on dialysis. My heart goes out to the people with

18 end-stage renal disease, because they basically have three

19 choices: They either go on dialysis and stay on dialysis;

20 go on dialysis and hopefully get a transplant; or do

21 nothing and die a very quick and painful death. The

22 difference that I see in a lot of the dialysis areas --

23 it's really fulfilling -- is getting these people listed

24 for transplant, and it's very important about education. I

1 think transplantation needs education, education,
2 education.
3 I know Dr. Rauf and Dr. Ahmed. We've gotten a
4 few patients from their facilities listed on our Transplant
5 Center. Their patients are well-educated about transplant.
6 They're given many options of what they can do. Dr. Rauf
7 and Dr. Ahmed also are there for them. They're very
8 knowledgeable of their patients, and they stay in close
9 contact with the Transplant Center. Even after patients
10 transplant, they want to be involved in the patient's
11 follow-up care, which a lot of the Transplant Centers --
12 I'm sorry -- dialysis centers say, "Once a patient is
13 transplanted, they're your ball of wax," and they basically
14 are done with them. But not Dr. Ahmed or Dr. Rauf. They
15 truly want to follow up and be part of the transplant team
16 within individual transplant centers.
17 Transplantation itself people wait anywhere
18 from 5 to 7 years. So, another thing, too, is living
19 donation is down. You know, living donation -- out of all
20 of the people that Dr. Burden mentioned that are on
21 dialysis for end-stage renal disease there's only probably
22 20 percent that are eligible or have a donor or a family
23 member or friend that are either willing as well as able to
24 donate.

1 So, a lot of people are on dialysis. Diabetes
2 and hypertension is growing at an epidemic rate.
3 Dr. Crawford, one of the esteemed nephrologists in Chicago,
4 did a talk not too long ago and said they are two most
5 silent killers before us now. With that increasing amount
6 of people with hypertension, diabetes, there's also more
7 need for dialysis and transplantation.
8 CHAIRMAN GALASSIE: Thirty seconds, please.
9 MR. DREYFUS: I ask you to approve the U.S.
10 Renal Care's applications to bring needed dialysis
11 facilities to this region, provided by these doctors, who
12 make the right decisions for these patients.
13 Thank you.
14 CHAIRMAN GALASSIE: Thank you very much.
15 MR. BURDEN: Mr. Chair, can I ask one question
16 of this gentleman?
17 CHAIRMAN GALASSIE: Certainly.
18 MR. BURDEN: I'm glad you were here to present
19 what you did. My question is clearly, what one-word or
20 two-word answer -- do you get the same feeling with the
21 competing dialysis, mega, large companies I won't mention
22 by name -- you know who I am talking about -- that
23 follow-up and care for patients who present and get the
24 adequate information necessary to be a candidate for a

1 transplant? That's one of my big things I'd like to see,
2 more transplants done. I'm asking. You can answer as you
3 see fit. I'd like to know what you just said regarding
4 this applicant's interest in seeing patients evaluated more
5 completely and being referred for transplant, does this
6 exist, to your mind, with the competitor institutions?
7 MR. DREYFUS: In the six years that I've been
8 an outreach person and involved in terms of getting people
9 to the transplant centers, we're seeing a lot more of
10 doctors basically referring them and being out of the loop
11 until they get the transplant done. Dr. Rauf, Dr. Ahmed,
12 and the few patients that we have vested, they are in on
13 all times of how -- what tests are being done. They want
14 the results as well, not that it would pertain to them,
15 because they're in for a transplant. So, there should
16 be -- I agree with you, I think more nephrologists should
17 be more involved in the actual work-up. But, then again,
18 you have so many patients that are on dialysis, it is
19 really, really hard to comprehend and take in how many
20 patients a nephrologist has to follow.
21 CHAIRMAN GALASSIE: I take that as a yes.
22 MR. DREYFUS: Yes. Thank you.
23 CHAIRMAN GALASSIE: Thank you.
24 If you would introduce yourself, sir, spell

1 your name, please.

2 MR. QUARLES: My name is Calvin Quarles, and

3 I'm the pastor of the Bolingbrook Community Church.

4 (Spells name.)

5 I want to take this opportunity to thank the

6 Planning Board for this moment to come in and share. First

7 of all, as a pastor we are typically accused of being

8 long-winded. You guys got me beat by a long shot. We

9 don't get to take lunch breaks in the middle of our

10 sermons. So I'll go on with this.

11 (Laughter)

12 MR. QUARLES: I am, as I said, the Senior

13 Pastor of the Bolingbrook Community Church, which I

14 consider to be a real labor of love and a real blessing to

15 me. I've been doing that for the past 9 years, have really

16 had a great opportunity here in the Bolingbrook community.

17 Lived in Bolingbrook for the past 16 years. As a Christian

18 minister, I've had the opportunity to serve as the leader

19 of the Bolingbrook Clergy Association and have been

20 involved pretty much throughout the community, doing

21 whatever projects need to be done for the benefit of our

22 schools, for the benefit of our children primarily, and

23 just really have a real heart for our community.

24 One of the things that I know is that there's

1 some increasing issues and problems in Bolingbrook
2 particularly in the health arena, which is why I was
3 certainly honored and pleased to see that the Bolingbrook
4 Hospital did come to this community. We knew that that was
5 something that we wanted to see take place, and I was glad
6 when it did. So, I certainly was encouraged when I heard
7 there was another opportunity for a medical facility to
8 come to Bolingbrook.
9 As you know and you've heard it said, our
10 village is growing. Over the past decade, it has certainly
11 increased significantly. Having been here for the past 16
12 years, I've seen the number of minorities to come into this
13 community to increase significantly. I think I've heard
14 numbers in the area of 44, 45 percent, what have you. I
15 know that's a significant number. I know that this issue
16 of dealing with high blood pressure or hypertension is
17 something that is personal to me, being one who takes high
18 blood pressure or hypertension medication on a daily basis.
19 I know the significance of it. I know the impact it has on
20 my family and on my community. So, I'm certainly here not
21 only because I want to support this effort, but also
22 because I have a personal interest and want to see things
23 changed, want to see things done at what I would consider a
24 much better way than I've heard described in the past.

1 I don't know a whole lot about the industry.
2 I've never sat through a meeting of this nature before.
3 I'm not so sure I want to go through this again. But I
4 will say this: I do believe that there is a need in this
5 community for a facility of this nature, increased ability
6 for those who are dealing with these particular issues.
7 So, I want to once again encourage you to consider
8 approving the request that has been made by U.S. Renal, and
9 I'm going to ask that you would do that, and I thank you
10 very much for this time.
11 CHAIRMAN GALASSIE: Thank you, Pastor
12 Quarles, and you're welcome to come back tomorrow, if you'd
13 like to.
14 MR. QUARLES: Not unless I can bring my
15 congregation and get applause like the others did.
16 (Laughter)
17 MS. AVERY: I'm assuming that Dr. Dhindsa is
18 no longer with us.
19 AUDIENCE MEMBER: He had to go to a surgery.
20 MS. AVERY: Next we have Cartrell Collins,
21 Pedro Anaya, and Brian Brandenburg.
22 (Pause)
23 CHAIRMAN GALASSIE: Good morning, sir.
24 MR. COLLINS: Good morning.

1 CHAIRMAN GALASSIE: Just introduce yourself,
2 and spell your name for the Recorder.
3 MR. COLLINS: My name is Cartrell Collins.
4 I'm presently a patient of Dr. Rauf and Ahmed, and
5 thankfully, I have just received a kidney transplant, so
6 I'm one of their success stories.
7 CHAIRMAN GALASSIE: Congratulations.
8 MR. COLLINS: Thank you. And I just really
9 would like to let the Board know that these doctors really
10 helped me, really, in terms of knowledge and information,
11 from the start of this whole process to where I am now
12 today, and I think it would be an injustice if the
13 application had any kind of problems, because there is a
14 need, there's a great need, and these doctors can
15 facilitate that need. So, I won't go into any other
16 details. I think it's been spoken of throughout this whole
17 Board forum. But, again, just really would like to let
18 this Board know that these are some good doctors, who have
19 their personal interest in their patients, and they really
20 showed it to me, and if I had to go to ten of these to make
21 the point clear that these doctors are well worth their
22 salt for any community, that would be it.
23 Thank you.
24 CHAIRMAN GALASSIE: Thank you, Mr. Collins.

1 MR. BRANDENBURG: Good afternoon. I will just
2 reintroduce myself. Brian Brandenburg from Fresenius
3 Medical Care, Regional Vice-President.
4 Just a couple of comments, the first being
5 about -- in response to some of the comments about quality.
6 I do take exception to the fact that it's been stated that
7 Fresenius and other large dialysis providers provide
8 substandard care, and I would say that from personal
9 experience, I do know that we do provide exceptional care
10 and we are very focused on things like catheter reduction
11 and home therapies, transplantation, and working with the
12 patients to improve the quality of their care.
13 Secondly, I'd like to make the comment that I
14 would ask the Board apply its rules consistently. We've
15 been presenting in front of the Board for many years, and
16 one of the things that we do appreciate is the consistent
17 nature in which you do apply and grant projects.
18 Next thing I'd like to speak about is
19 regarding the physical site that's been chosen by U.S.
20 Renal for the Bolingbrook facility. It is just across from
21 our Bolingbrook facility and it would seem, to provide
22 optimal access to the residents in Bolingbrook, a different
23 location would have been chosen to create an equal
24 distribution in stations.

1 We also question the referral information
2 provided by the physicians. Over the past three and a half
3 years, approximately 79 patients were referred by the
4 physicians supporting the proposed Bolingbrook facility, to
5 a total of twelve Fresenius facilities spanning
6 Chicagoland. This does not correlate to the number of
7 patients they claim will be referred to the three proposed
8 U.S. Renal facilities. For example, as of the second
9 quarter, they only had 10 patients at our Bolingbrook
10 facility, and yet state they would refer one in six
11 patients in the next two years to the proposed facility.
12 We are also concerned that in an attempt to
13 gain favor with this Board, a new provider to Illinois
14 would also make inaccurate and misleading statements about
15 other providers of dialysis, as opposed to addressing the
16 Board's criteria. U.S. Renal and its physicians cite three
17 patient care accounts, claiming that Fresenius restricts
18 admissions to patients with a central venous catheter for
19 dialysis access. All three examples were refuted by
20 Fresenius and by the physicians involved in these patients'
21 care. In fact, over the last two years, 20 patients, all
22 with central venous catheters, have been admitted to the
23 Bolingbrook facilities by Doctors Rauf and Ahmed.
24 We also note that Doctors Rauf and Ahmed have

1 never once attended a quality, monthly meeting at any of
2 the Fresenius clinics they admit to. If they had issues
3 about Fresenius admissions or quality, it would seem
4 logical that they would have attended at least one of those
5 meetings to voice their concerns. In reality, they are
6 making these allegations opportunistic now to gain approval
7 for their clinics.
8 In sum, we encourage the Board to look at the
9 referral information carefully, consider the location for
10 the proposed site, and finally, we ask the Board to
11 discourage the type of disparaging remarks made in its
12 application and ask that the applicants focus on the
13 Board's review criteria.
14 CHAIRMAN GALASSIE: Thank you,
15 Mr. Brandenburg.
16 Any other public comments on item 11-025?
17 (Pause)
18 CHAIRMAN GALASSIE: Hearing none, the
19 representatives are here in the room, though not at the
20 table. Are there any questions from the Board for them?
21 (Pause)
22 CHAIRMAN GALASSIE: Mike, would you give your
23 presentation, please?
24 MR. CONSTANTINO: Thank you, Mr. Chairman.

1 The applicants are proposing the establishment
2 of a 13-station ESRD facility, located in approximately
3 7,200 gross square feet of leased space in Bolingbrook,
4 Illinois. The anticipated cost of the project is $2.5
5 million. This project was modified on July 28th when the
6 applicants added a co-applicant. A public hearing was also
7 held on this project, and we have received -- the State
8 Board Staff -- both support and opposition comments
9 regarding this project. Currently, there's a calculated
10 excess of 55 ESRD stations in this planning area. We also
11 note that average utilization for the facilities within 30
12 minutes is 76 percent, and there are 3 of the 10
13 facilities, or 30 percent, within 30 minutes that are
14 operating below target occupancy.
15 Thank you, Mr. Chairman.
16 CHAIRMAN GALASSIE: Thank you, Mike.
17 Is the Board ready to vote on this matter?
18 (Pause)
19 CHAIRMAN GALASSIE: I'll entertain a motion
20 to approve Project 11-025 to establish a 13-station ESRD
21 facility in Bolingbrook, Illinois.
22 MR. BURDEN: So moved.
23 MR. GREIMAN: Seconded.
24 CHAIRMAN GALASSIE: Moved and seconded.

1 MR. DART: The motion was made by Dr. Burden,
2 seconded by Justice Greiman. Dr. Burden?
3 MR. BURDEN: I am moved by the fact that the
4 applicants appear to be generating, indeed, an element of,
5 shall we say, competition, but I have to look also at the
6 fact that we are 55 beds in excess currently in HSA 9.
7 There also is a 30 percent, shall we say -- 30 percent of
8 the facilities are operating below target occupancy. I
9 would have to say that I would vote against this applicant
10 at this particular time because of that, because I what I
11 mentioned.
12 MR. DART: Mr. Eaker?
13 MR. EAKER: I vote yes.
14 MR. DART: Justice Greiman?
15 MR. GREIMAN: Aye.
16 MR. DART: Mr. Hayes?
17 MR. HAYES: Yes.
18 MR. DART: Mr. Hilgenbrink?
19 MR. HILGENBRINK: Yes.
20 MR. DART: Ms. Olson?
21 MS. OLSON: Yes.
22 MR. DART: Mr. Sewell?
23 MR. SEWELL: No, for the same reasons as --
24 much more excess capacity in HSA 9.

1 MR. DART: Chairman Galassie?

2 CHAIRMAN GALASSIE: Yes.

3 MR. DART: That's six votes in the

4 affirmative, two negative.

5 CHAIRMAN GALASSIE: Motion passes.

6 Moving on then to Item 11-026, USRC Streamwood

7 Dialysis. We have two public comments, if these

8 individuals are still here.

9 MS. AVERY: Clare Ranalli and Brian

10 Brandenburg.

11 MR. BRANDENBURG: Hello, again. Regarding the

12 U.S. Renal Streamwood project, I just want to make clear

13 that we're not opposing the application on the basis of

14 need, as Fresenius has always promoted access to dialysis

15 services. In addition, we believe the Board is best

16 situated to determine where access is available based on

17 unique circumstances of each application.

18 We are concerned that in an attempt to gain

19 favor with the Board, the provider stated inaccurate and

20 misleading statements about other providers in dialysis, as

21 opposed to addressing the Board's criteria. U.S. Renal

22 questions Fresenius surveys show extremely high rates of

23 patient satisfaction overall in our clinics. U.S. Renal

24 claims that Fresenius' admission policies negatively impact

1 patients and raise healthcare costs. Fresenius same
2 standards that all other dialysis providers are subject to
3 and which U.S. Renal is. Also, many of those admission
4 requirements are mandated by CMS, such as the requirement
5 of a recent hepatitis screen. Patients' insurance must
6 also be verified. Fresenius Care makes every attempt to
7 admit a patient within 24 hours. However, if we do not
8 have the required information for CMS, there may be a
9 delay, as we cannot violate those regulations.
10 In sum, while not provided as comment on this
11 particular application, prior comments on the U.S. Renal
12 Bolingbrook and Oak Brook projects do apply and should be
13 considered as well.
14 CHAIRMAN GALASSIE: Thank you again.
15 Do the Board members have any questions
16 regarding this applicant and application?
17 (Pause)
18 CHAIRMAN GALASSIE: Michael, would you give
19 the presentation first?
20 MR. CONSTANTINO: Yes, sir. Thank you,
21 Mr. Chairman.
22 The applicants are proposing the establishment
23 of a 13-station ESRD facility, located in approximately
24 5,800 gross square feet of leased space in Streamwood,

1 Illinois. The anticipated cost of the project is
2 approximately $1.7 million. This project was modified also
3 on July 28th, when the applicants added a co-applicant. A
4 public hearing was held on this project, and we have
5 received both support and opposition letters regarding this
6 project. This is a second application by this applicant
7 within the HSA 7 Planning Area. Project 11-024 was
8 approved by the Board, and now this planning area shows an
9 excess of 5 stations. We also note there is no lack of
10 service within 30 minutes of the proposed facilities, as
11 there are existing facilities operating below target
12 occupancy. Average utilization within 30 minutes is 67
13 percent. 9 of the 13 facilities within 30 minutes are
14 operating below target occupancy.
15 Thank you, Mr. Chairman.
16 CHAIRMAN GALASSIE: Thank you. Appreciate
17 that.
18 Any questions by Board members?
19 MR. HAYES: Mr. Chairman, I'd like to ask them
20 specifically if someone could describe, why is there a need
21 or why is this facility needed in Streamwood?
22 CHAIRMAN GALASSIE: Whoever is responding, if
23 you would please come up to the mic. Thank you.
24 MR. URSO: You've already been sworn in.

1 MR. VINSON: Mr. Chairman, Sam Vinson on
2 behalf of U.S. Renal, and I'm going to make a very brief
3 comment on that and then turn the presentation over to Dr.
4 Lang, who knows the area extremely well.
5 I would make the point that in this particular
6 planning area, there's been an enormous change in
7 population between the 2000 and 2010 census. What that
8 population change demonstrates is that there has been a
9 substantial increase in persons of Hispanic, African
10 American, and aged background. Each of those groups has an
11 enormously higher incident rate of end-stage renal disease
12 than the general population. As a matter of fact, when you
13 look at the numbers, the average rate is somewhere around 3
14 to 1. So, as a consequence, this substantial change in
15 population mix has created a situation where there is far
16 more demand, far more need than you might expect from a
17 comparable population.
18 Now, one of the things that your criteria
19 takes into account is the general increase in the whole
20 population and the prevalence of the disease. It doesn't
21 take into account the subgroups within the population that
22 have particularly high incidences, African Americans,
23 Hispanic; also in this situation, Asians of Indian
24 background and, finally, the Asian. So as a consequence,

1 what your formula fails to do in predicting need is to deal
2 with the high incidence of those subgroups that has
3 dramatically grown in the planning area.
4 I could go on at some length, but that is
5 generally the point, sir, that I would make. Now, Dr.
6 Lang, I think can deal with it much more directly.
7 MR. LANG: I think the reason I picked
8 Streamwood is if I looked around where the dialysis units
9 were and where this older population that's aging has to
10 drive, there are a large number of patients who are from
11 Streamwood, and these are specifically patients that are
12 admitted both to St. Alexius Medical Center and Alexian
13 Brothers, but more so St. Alexius. And for that reason --
14 it's much easier for them in bad weather and in the winter
15 to get to a unit that's closer to their home, and that
16 reason is one of the reasons I picked Streamwood, and U.S.
17 Renal agreed.
18 I think it's important to recognize that
19 people who get dialysis usually need help after dialysis,
20 unless they're very young. They feel kind of worn out,
21 because you've done in nearly 3 to 4 hours what normally
22 your kidney would do in 24 hours. So, if we're taking off
23 3 liters of fluid, because they've gained that much, they
24 don't feel perky. They're not going to go out and play a

1 round of golf on this beautiful course here. So, I think
2 that's the reason Streamwood was picked.
3 And the other thing I wanted to point out, on
4 those facilities that are not functioning at 80 percent --
5 I mentioned this before -- one doctor who admits to one of
6 the units -- and I'm not going to name the unit -- he lost
7 two partners. So, obviously, the patients who he was
8 seeing or who his partners were seeing go to other doctors
9 who are admitting to another unit. Another doctor that I
10 know, basically where I had my problems with, he is hardly
11 ever in the unit. He's moved his practice to I think up in
12 McHenry County and he goes to various hospitals and I think
13 has a chauffeur to drive him around. So, for that reason,
14 if you're not at the hospital, relating to the primary care
15 physicians, you don't get the referrals. So, because his
16 facility is not filled, it means he's not doing his job.
17 It's not the facility's fault. In fact, one of the
18 facilities has a sign up on 79, advertising for patients.
19 That's because the doctor is never around. So, I don't
20 think it's my fault that the facility is not full.
21 And the point is, I want to have it closer to
22 where the patients live. That's my reason. My brother was
23 on dialysis. He got a transplant. So I know what these
24 people go through. So thank you for hearing me again.

1 CHAIRMAN GALASSIE: Thank you.

2 MR. CARVALHO: Mr. Chairman?

3 CHAIRMAN GALASSIE: Yes, Mr. Carvalho.

4 MR. CARVALHO: Thank you, Mr. Chair.

5 Something about what I heard this morning

6 didn't quite make sense, so I checked with our person who

7 does the inventory. The thing that didn't make sense is

8 the demographic differences in this planning area today are

9 not something that is as historical in Africanism. In

10 other words, there are different demographics in the state,

11 and there have been forever. So, I never heard this

12 discussion before, that our analysis of need is incorrect

13 because it doesn't take into account the demographic

14 difference. So, I checked with the person who put the

15 inventory together and said, "Has this ever come up before

16 about the fact that the need adjustment ought to be

17 disregarded because it's not accurately reflected in the

18 demographics of an area?" And the thing is, the -- let me

19 make two different points.

20 The need determination might be a little

21 out-of-date because of the passage of time, but, in fact,

22 the use rate of the area is the use rate that's used to

23 calculate need, which is to say if you're in an area that

24 demographically has a population that has a high

1 utilization, then that utilization will be the utilization
2 used to calculate need. If the area is one that is at the
3 State average or lower, then the State average will be
4 used. So, for example, any existing population that has a
5 high user of end-stage renal dialysis, their high use will
6 affect the need calculation.
7 Having said that, if the demographics have
8 changed dramatically from the time that our inventory was
9 calculated, then our inventory could be out-of-date. So,
10 the first point is our need analysis does take into account
11 demographics. But the second point is there's a time lag
12 if you have a demographic change in area. So, for example,
13 the demographics of the south side of Chicago are pretty
14 steady, so those use rates have taken into account the
15 historically high African American population there. If
16 you have an area that is demographically changed from our
17 base of calculation, then the use rate would not take into
18 account any increase.
19 So, for purposes of your consideration, the
20 need calculations that you have in front of you are based
21 on 2008. So, the applicants can inform us of any
22 demographic changes from 2008, but it is not the case that
23 demographics are not taken into account in the need
24 calculation. They are.

1 MR. SEWELL: I guess I'm a simple person,
2 unlike counsel over there. I think another way to say this
3 is we don't have a need-base formula. We have a
4 demand-base formula.
5 MR. CARVALHO: A utilization-based.
6 MR. SEWELL: Same thing. So, if the
7 demographics were working in favor of higher utilization,
8 it would be reflected. The only difference from making
9 that point, of course, would be the time lag, you know, and
10 what -- is it 2008 when we did this?
11 CHAIRMAN GALASSIE: Yeah.
12 MR. SEWELL: That I don't know. I don't know
13 how much has changed since 2008.
14 CHAIRMAN GALASSIE: Yes, sir.
15 MR. VINSON: Mr. Chairman, Member Sewell, the
16 point that I would make is you're right to think about
17 2008. We're in 2011. If you were to approve this
18 application, it would take a year to build the facility,
19 and the utilization rate that you would apply would be the
20 utilization rate two years later. So, you would be dealing
21 with a six-year period of time, and if the population
22 trends continue to occur as they have in the past decade
23 between 2000 and 2010 census, that's where you're fishing
24 behind the net.

1 MR. LANG: Mr. Chairman could I add one more
2 point?
3 CHAIRMAN GALASSIE: Sure.
4 MR. LANG: The other thing I don't like to do
5 is send patients to a fourth shift, and I'll just mention,
6 Fresenius runs a fourth shift at Hoffman Estates, and I
7 think that's not good for the patients. And the other
8 thing that -- talking about need, with the clinic that I
9 started many years ago, Rolling Meadows, it's below 75
10 percent, and Fresenius opened a clinic recently in
11 Palatine, which I'm sure took some of the patients from
12 there. So, I think you can skew the statistics, the use,
13 by doing various things. So, that's why I still think we
14 need one in Streamwood.
15 CHAIRMAN GALASSIE: Thank you, Doctor.
16 I think we're ready for a vote on this issue.
17 May I have a motion to approve Project 11-026 to establish
18 a 13-station ESRD facility in Streamwood, Illinois.
19 MR. HILGENBRINK: So moved.
20 MR. BURDEN: Second.
21 CHAIRMAN GALASSIE: Moved and seconded. Roll
22 call, please.
23 MR. DART: Motion made by Mr. Hilgenbrink,
24 seconded by Dr. Burden.

1 Dr. Burden?

2 MR. BURDEN: We're faced with the aspect of

3 need. I've listened to the explanations presented by the

4 applicants, and I am going to vote for this application for

5 the reasons that I alluded to.

6 MR. DART: Mr. Eaker?

7 MR. EAKER: Yes.

8 MR. DART: Justice Greiman?

9 MR. GREIMAN: Aye.

10 MR. DART: Mr. Hayes?

11 MR. HAYES: Yes.

12 MR. DART: Mr. Hilgenbrink?

13 MR. HILGENBRINK: Yes.

14 MR. DART: Ms. Olson?

15 MS. OLSON: Yes.

16 MR. DART: Mr. Sewell?

17 MR. HILGENBRINK: I abstain for the same

18 reason I did on the other HSA 7 application.

19 MR. DART: Chairman Galassie?

20 CHAIRMAN GALASSIE: Yes.

21 MR. DART: That's 7 votes in the affirmative.

22 CHAIRMAN GALASSIE: Motion passes.

23 Congratulations. Good luck. Someone should share that

24 chart with the UNO organization that was here this morning,

1 (Applause)

2 CHAIRMAN GALASSIE: I'm going to recommend

3 that we take a ten-minute break, come back, and we'll be

4 going into some Board business. We're on break for --

5 until quarter to.

6 (Recess)

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8 EXECUTIVE SESSION HELD

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10 MEETING RECESSED AT 3:48 P.M.

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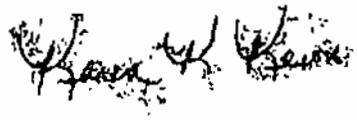
1 CERTIFICATE OF REPORTER

2

3 I, KAREN K. KEIM, CRR, RPR, a Certified Court
4 Reporter in the States of Illinois and Missouri, do hereby
5 certify that the proceedings in the above-entitled cause
6 were taken by me to the best of my ability and thereafter
7 reduced to writing; that I am neither counsel for, related
8 to, nor employed by any of the parties to the action, and
9 further that I am not a relative or employee of any
10 attorney or counsel employed by the parties thereto, nor
11 financially or otherwise interested in the outcome of the
12 action.

13

14 

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16 KAREN K. KEIM

17 CRR, RPR, CSR-IL, CCR-MO

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

OPEN SESSION

OCTOBER 13, 2011

DAY 2

ORIGINAL

1 STATE OF ILLINOIS

2 HEALTH FACILITIES AND SERVICES REVIEW BOARD

3 525 West Jefferson Street, 2nd Floor

4 Springfield, Illinois 62761

5 217-782-3516

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9 OPEN SESSION

10 DAY 2 -- OCTOBER 13, 2011

11 Regular session of the meeting of the State of

12 Illinois Health Facilities and Services Review Board was

13 held on October 12 & 13, 2011, at the Bolingbrook Golf

14 Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

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1 PRESENT:
2 Dale Galassie - Chairman
3 Ronald Eaker
4 John Hayes
5 John Burden
6 Alan Greiman
7 Kathy Olson
8 Richard Sewell
9 Rob Hilgenbrink
10
ALSO PRESENT:
11 Courtney Avery - Administrator
12 Cathy Clarke - Assistant
13 Frank Urso - General Counsel
Juan Morado - Assistant Counsel
14
Michael Constantino - IDPH Staff
15
Bill Dart - IDPH Staff
16
Claire Berman - IDPH Staff
17
David Carvalho - Deputy Director, IDPH
18
Michael C. Jones - IDFS
19
20
21
Reported by:
22 Karen K. Keim
CRR, RPR, CSR-IL, CRR-MO
23 Midwest Litigation Services
401 N. Michigan Avenue
24 Chicago, IL 60611

1 START TIME: 10:06 A.M.

2

3 CHAIRMAN GALASSIE: Good morning, ladies and

4 gentlemen. Welcome. The meeting is called to order -- or

5 reorder -- from our recess of yesterday, and we will be

6 starting with Item No. 11-038, Fresenius Medical Care of

7 Naperbrook. If representatives from there would please

8 come up to the front table, introduce yourselves, spell

9 your names for our Recorder, and we will have you sworn in.

10 While you're doing that, we will do roll call.

11 Bill, if you wouldn't mind.

12 MR. DART: Certainly.

13 Dr. Burden?

14 MR. BURDEN: Yes.

15 MR. DART: Mr. Eaker?

16 MR. EAKER: Here.

17 MR. DART: Justice Greiman?

18 MR. GREIMAN: Here.

19 MR. DART: Mr. Hayes?

20 MR. HAYES: Here.

21 MR. DART: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Here.

23 MR. DART: Ms. Olson?

24 MS. OLSON: Here.

1 MR. DART: Mr. Penn?
2 (No response)
3 MR. DART: Mr. Sewell?
4 MR. SEWELL: Here.
5 MR. DART: Chairman Galassie?
6 CHAIRMAN GALASSIE: Here.
7 Thank you very much. If you folks would
8 introduce yourselves.
9 MS. RANALLI: Certainly. Good morning. Thank
10 you. My name is Clare Ranalli (spells name). To my left
11 is Lori Wright (spells name). To her left is Coleen
12 Muldoon (spells name), and to her left is Terri Gurchiek
13 (spells name).
14 CHAIRMAN GALASSIE: Michael, can we have a
15 State Agency Report, please?
16 MR. CONSTANTINO: Thank you, Mr. Chairman.
17 The applicants are proposing the establishment
18 of a 16-station ESRD facility, located in approximately
19 10,000 gross square feet of leased space in Naperville,
20 Illinois. The cost of the project is approximately $5
21 million.
22 The State Board Staff would like to note that
23 the applicants are requesting shell space as part of this
24 application, in the words of the applicants, to accommodate

1 additional growth, and have committed to coming back to the
2 Board for the additional stations. The anticipated project
3 completion date is December 31st, 2013. No public hearing
4 was requested, and no letters of support or opposition were
5 received by the State Board Staff.
6 Thank you, Mr. Chairman.
7 CHAIRMAN GALASSIE: Thank you.
8 And who will speak to the Board?
9 MS. RANALLI: Thank you. I'm going to turn
10 things over to Ms. Muldoon, but I did want to ask the Board
11 and hope that this would be appropriate, that similarly
12 with the applications yesterday, as Fresenius has five
13 applications up in a row, if some of the comments that we
14 make might be able to be addressed or flow to those
15 applications, and as we move on, we could address the
16 specifics. That would save time.
17 CHAIRMAN GALASSIE: Sure.
18 MS. MULDOON: My name is Coleen Muldoon. I'm
19 a regional Vice-President of Fresenius Medical Care, and I
20 just wanted to comment on a few things before we got
21 started.
22 First of all, I want to give a little history
23 of myself and how I work with the company. I have been in
24 dialysis for over thirty years. I was a Clinical Manager

1 for 10 years in one of our other facilities in Oak Park,
2 which borders the City. I've always been quality-driven,
3 and that has been my goal working with Fresenius. I worked
4 with a small company when I started out, and I was the
5 Clinical Manager, and now I'm working with Fresenius, which
6 acquired that company. The company I worked for was
7 quality -- completely driven by quality and as is
8 Fresenius. I would not be working for them today if I did
9 not believe that they were driven by quality. The
10 difference between working with a large company -- I did
11 hear that the quality might be compromised because it was a
12 large company. If anything, I've seen things completely
13 different. I feel the resources I have to do my job by
14 working with a large company are endless. If I ever have a
15 problem or concern, I know I can go to somebody and there
16 is a completely dedicated resource at my availability at
17 all times.
18 On the local level how we operate, considering
19 the size of our company, I'm the Regional Vice-President.
20 I have 45 facilities that I'm responsible for. I have 8
21 Area Managers who report to me and have responsibility for
22 those facilities under them, and monthly we have quality
23 meetings at all of our facilities, which our Medical
24 Directors are very active and take the lead role in those

1 discussions. We have Quality Regional Managers, who come
2 into our facilities a couple times a year to evaluate where
3 we are. We're highly regulated, dialysis highly regulated.
4 I don't think there is a dialysis company in existence
5 today who isn't all about quality. We would not be -- we
6 could not function if we didn't drive the quality in our
7 facilities.
8 The Area Managers meet with their Clinical
9 Managers on a monthly basis and also in their units two to
10 three times a month, just to make sure things are going
11 okay. When we identify problems in our facilities, we do
12 action plans, we put plans in place, and we do follow-up to
13 make sure that we adhere to those policies and everybody is
14 functioning at the same level in all of our facilities.
15 We all have problems in our facilities. We
16 address those immediately and work very closely with them
17 to turn that around. We have multiple resources at our
18 hand. Education, we have a huge Education Department, and
19 we train -- we put many weeks of training into our
20 employees, and we do ongoing education with our educators
21 coming into our facilities and working directly with our
22 facilities. So between our Quality Managers, the Area
23 Managers who audit, myself, the physicians who have
24 oversight, the Clinical Managers who have direct oversight

1 of the facility, there is many, many levels that take care
2 of what goes on in our facilities.
3 We are a large company, but that only provides
4 us the additional resources we need to function in a very
5 highly regulated, very competitive field of dialysis. So,
6 I feel very strongly about some of the comments that were
7 made about Fresenius, because as a nurse, I would not be
8 working for this company if I thought in any way our
9 quality was compromised by the size of our company, and I
10 do not believe that for a minute. I feel we have best
11 practice that we share with facilities.
12 We picked up a New Jersey algorithm from our
13 New Jersey people that completely turned around how we were
14 treating our patients and meeting the needs of our
15 patients, and that was because we shared best practice
16 between our facilities. We do that constantly.
17 Dr. Hakim is head of our company. He is
18 world-known and he drives quality. He drives it down to
19 the region. We are measured as Regional Vice-Presidents
20 against our quality. A leader board comes out, and we are
21 ranked by our quality, and Corporate will come in and
22 intervene if they don't think that we are functioning at
23 that level. So, there's a lot of oversights and a lot of
24 things in place, because of our size, to make sure that

1 those things are in place. So, when people say that a
2 smaller company can provide better care, I don't agree with
3 that at all. I think everybody wants to provide good care.
4 But as a large company, we are at a huge advantage,
5 state-of-the-art equipment, and our units are -- we are
6 always upgrading our units, our water systems. Our
7 machines are used by every dialysis company. Our
8 education, as I said, is beyond anyone's. We often have
9 our employees approached by other companies because they
10 know that we have the best Education Department in the
11 Chicagoland area.
12 So, I just wanted everyone to be aware of
13 that. I don't say much at these meetings. I come to a lot
14 of them. I support this. We talk much before we come in.
15 I feel we are very well prepared. I don't have to add
16 anything at the time, unless you ask questions that might
17 need to be added. But I think our projects are solid.
18 Every project I've ever heard in my region -- I have 45
19 clinics. My average utilization is 83 percent. So, the
20 units that we are building we are filling, and the reason
21 we fill those units is because of our affiliation with our
22 physicians, who have growing practices. They want to work
23 with us. They want to come in to our facilities, and
24 that's what drives our growth, is our relationship and our

1 strong relationship with our physicians.

2 So, I know we're big, but because of that --

3 and these physicians are in pockets. This isn't one, big

4 Fresenius family. These are practices that are set out

5 throughout Chicago, and then we partner with those, and as

6 they grow, we have to add stations or facilities to

7 accommodate that, and our size dictates that. So, I think

8 if we brought in every one of our physicians, you'd get

9 very positive comments. In fact, one of the other

10 applications that was opposed, there was many letters that

11 came in from our physicians. I don't know if you took the

12 time to read them or have the time to read them, because

13 the applications are pretty cumbersome. But they were

14 pretty extensive and they were very supportive of Fresenius

15 and what it offers them as a physician.

16 So, just wanted to share --

17 CHAIRMAN GALASSIE: We appreciate that, and

18 we appreciate your comments as well. To the application,

19 please.

20 MS. GURCHIEK: I just wanted to introduce

21 myself real quickly, as well. My name is Terri Gurchiek,

22 and I am an Area Manager in the Chicagoland area, and my

23 territory covers nine facilities. I am based out of a

24 facility, so I do interact with our patients every day. My

1 role is to support our nurses and our Clinical Managers
2 from an operation standpoint, making sure that they have
3 everything that they need to do their job, to continue to
4 take care of our patients.
5 I have worked as a nurse for years. I've been
6 doing this for 21 years. I was also Clinical Manager at
7 the Naperville facility for years, and actually that
8 facility was running with four shifts for almost two years
9 because of the high utilization, and that was very
10 difficult for our patients and for our staff to do that.
11 And I also just wanted to, real quickly,
12 mention, kind of saddling on what Coleen said, that I
13 know -- I'm not at all of these hearings --
14 CHAIRMAN GALASSIE: I'm sorry to interrupt,
15 but what is the relevance of you running four shifts? I
16 don't understand that part.
17 MS. GURCHIEK: I'm going to talk to the
18 quality. That does affect quality, running patients four
19 shifts a day. These patients aren't leaving until eleven,
20 11:30, twelve o'clock at night, and in terms of quality, we
21 do have -- and I am on our QA committee in every one of the
22 facilities that I cover. So, we do have to meet monthly,
23 and we go through every facility each month and go through
24 their quality indicators. The physicians are there, and

1 actually, all the physicians are invited and encouraged to
2 attend, and we go through every indicator for our patients,
3 and I know that over the past few months -- and even
4 yesterday -- there were physicians making statements they
5 were concerned about the quality. Those same physicians
6 admit patients to these clinics and have never once
7 attended one quality meeting regarding the patients, and
8 they do admit patients to all of the facilities that I
9 cover. The Medical Directors ultimately are responsible
10 for those patients. So, when those physicians don't come,
11 it is their responsibility to work towards setting up
12 action plans to improve the quality.
13 And I just wanted to point out that in that
14 market, my area, which is all I can speak to, they are
15 providing exceptional quality in some of these facilities.
16 Bolingbrook and Naperville have even received awards from
17 the Renal Network because of the quality achievement that
18 they have had. So, I just wanted to mention that, because
19 it's very disheartening to hear that there were statements
20 made by these physicians in these facilities about the poor
21 quality, because it certainly is not, not true.
22 CHAIRMAN GALASSIE: The Board is -- hears
23 your message, and we understand your message. And
24 understand, we have very little control over what people

1 say. But the more we hear, it filters, I think, within a
2 reasonable amount, what people say. We are not interested
3 in having A talk about B. That's counter-productive for
4 everyone in this room. So thank you.
5 MS. RANALLI: Thank you, Chairman Galassie.
6 And Ms. Wright is going to speak to the specifics of the
7 application. But one thing you asked was about the
8 Naperville clinic running four shifts. Part of the reason
9 for the Naperbrook proposed facility in front of you is
10 because of over utilization in Naperville, which was
11 running four shifts, which is not a positive or optimal way
12 to run a clinic, because of its high utilization. So, that
13 Naperville clinic's utilization is relevant to this
14 Naperbrook facility.
15 CHAIRMAN GALASSIE: So, is the point that if
16 Naperbrook is approved, Naperville will no longer run four
17 shifts.
18 MS. WRIGHT: They are not currently. They're
19 at 89 percent utilization. Once they hit 100 percent and
20 go over, then we do have to add a fourth shift.
21 I'm just going to talk to you about the
22 project itself.
23 CHAIRMAN GALASSIE: Please do.
24 MS. WRIGHT: The City of Naperville -- I'm

1 sure some of you are familiar with it -- lies in DuPage
2 County. However, there is a very small portion of it that
3 lies over the border into Will County and is actually where
4 we are putting the facility. So, it is serving Naperville,
5 but it's in Will County. The project is going -- it is on
6 the border. It is going to serve HSA 7 and 9 almost
7 equally. If you have the application in front of you on
8 your computers, there's a map on page 48 that shows where
9 the facility is located in relationship to the two counties
10 and the two HSA's. Given this, we think that while we are
11 aware there is no need currently in HSA 9 or 7, that -- I
12 know the new inventory is going to being coming out
13 shortly -- we expect that there will be a need. We think
14 the combined need should be considered on this project.
15 The proposed Naperbrook facility is going to
16 serve a two-fold purpose. The first one is to meet current
17 need. As we have just said, the Naperville facilities are
18 both -- we have two of them there, at Naperville and
19 Naperville North -- are both pushing 90 percent
20 utilization, 88.89 and 86.90. And, like we said before,
21 once a facility reaches 100 percent, then we do have to add
22 a fourth shift, which is really hard on the patients,
23 because they are dialyzing until midnight, and they're
24 elderly, they're ill, and this is just really hard on them.

1 CHAIRMAN GALASSIE: You have to add that one
2 shift because there's no other options?
3 MS. WRIGHT: Yeah. Otherwise they would have
4 to drive out of their area for dialysis.
5 CHAIRMAN GALASSIE: Thank you.
6 MS. WRIGHT: The Bolingbrook facility is
7 essentially at 80 percent. It's 79.86, and we -- as far as
8 Naperville and Bolingbrook, we have already expanded all of
9 our facilities there as far as we can expand them at this
10 time. There is no more room. So, we're really out of
11 places to put these patients who are going to be pushing
12 towards 100 percent probably in the next year, and we are
13 going to need places for these patients to go.
14 If you look at the table, Table Five on page
15 12 of the State Agency Report, you will see that the
16 overall utilization of the facilities within 30 minutes is
17 at 77 percent, and as of yesterday, there were two projects
18 approved, the Oak Brook project -- the overall utilization
19 of those facilities was 78 percent -- and the Bolingbrook
20 project, and the overall utilization of those facilities
21 was at 76 percent. If you look further, the facilities
22 within 25 minutes travel are at a average of 86 percent
23 utilization. This shows that the high utilization is
24 closer to the Naperville, Bolingbrook area. It's not in

1 the outlying areas. The only facilities on the list that
2 really have any excess capacity are the Fresenius Lombard
3 facility and Sun Health in Joliet. These facilities are
4 near 30 minutes away, and they do not serve the residents
5 of Naperville.
6 It's in the best interests, as we have talked
7 about this, and many other providers have to have a
8 facility close to the patient's home, because
9 transportation is a hardship for these patients. As well,
10 on page 46 of the application, there's a chart.
11 Bolingbrook, Downers Grove, Naperville, Plainfield,
12 facilities that Nephrology Associates admit to, have seen
13 an average of 10 percent growth in their practice at these
14 facilities in the past five years. If you look at this
15 rate and apply it to future, the Naperbrook facility -- the
16 area facility -- the utilization of area facilities is
17 going to be at 122 percent in a little over two years, if
18 the Naperbrook facility is not approved.
19 The second purpose for this project is
20 planning for the future. Our current Naperville facility
21 is on the campus of Edward Hospital. It's in leased space.
22 Our lease is going to be up in a little over two and a half
23 years, in 2014. At that time, we are going to have to
24 vacate the premises there. Those patients will need a

1 place to go. The Naperbrook facility has 2,000 gross
2 square feet of unfinished, shell space that's going to be
3 ready to cost-effectively, quickly be built into
4 dialysis -- availability to put extra stations in there.
5 So, what we hope to do at that time is relocate the
6 patients in the dialysis stations from Naperville to the
7 Naperbrook site. It's already there. This will be more
8 cost effective. We're going to lock into the current lease
9 price, and, also, we're not going to have to pay real
10 estate brokers to go out and find us another building.
11 The other advantage to this is this is just an
12 ideal site and has easy access, ample parking. There's
13 room there for expansion. Much of the property that we
14 have looked at in the last several months, either there was
15 an existing site, it was too small, there wasn't ample
16 parking, it was on the second floor of a building, which is
17 not good for dialysis, because we use a lot of water. And
18 any vacant land that we found that we thought would be a
19 good site, also we found that we could not get medical
20 zoning for it.
21 So, we found an ideal site. We would like to
22 have it for the current need and also the future need for
23 our Naperville facility. Thank you.
24 CHAIRMAN GALASSIE: Thank you. We appreciate

1 that.

2 MS. RANALLI: We just open up questions to the

3 Board at this point.

4 CHAIRMAN GALASSIE: Questions from Board

5 members?

6 MR. GREIMAN: I have a question, Mr. Chairman.

7 CHAIRMAN GALASSIE: Yes, Judge.

8 MR. GREIMAN: This is a little different. You

9 have a lot of projects, and I notice that you say, for

10 example, this project, that you have cash and securities of

11 a million eight. The next project you have cash securities

12 of a million three. So -- and you have a million something

13 on all of the projects. So, the question I have is what do

14 you do internally? Do you separate those funds and say

15 this goes to the Naperville one and this goes to such and

16 such, or are we just talking about your bank account?

17 MS. RANALLI: I believe that the cash and

18 securities that are reported for each application depends

19 upon the timing, when the application is submitted, and as

20 you said, it ebbs and flows. So, it just reflects the time

21 the information is provided by the Treasurer, what that

22 figure would be.

23 MR. GREIMAN: So, we don't have security set

24 aside then? We just have a bank account of the company?

1 MS. RANALLI: That's right. They're not
2 security set aside for each project. However, each project
3 has a cost associated with it. Almost -- most of the
4 project costs relate to the lease for the space, and that,
5 of course, is segregated cash that is dedicated to pay for
6 those leases for the project separately.
7 CHAIRMAN GALASSIE: Other questions?
8 Dr. Burden?
9 MR. BURDEN: I apologize once again for
10 returning to something I read yesterday. I listened to
11 what I thought was Knute Rockne at halftime when they were
12 losing in the first half. I don't want you to take this
13 personally, but perhaps you will.
14 I am aware that we made statements yesterday,
15 and I look forward to a retreat where we can resolve some
16 of the issues that I continue to have. You represent one
17 of the two corporate chains that have been consistently
18 profitable, together making $2 billion in operating profits
19 a year. I am hung up on that. When I listen to your
20 accolades about how well you're taking care of patients, I
21 won't go into this, but there are many opinions that would
22 challenge that. I don't want to make another speech about
23 this, but I think we're going to have to address it.
24 I really feel that I would -- leaning more

1 comfortably towards recognizing the fact that you, as a
2 company, are doing so well, if I heard some interesting
3 comments regarding maybe making contributions, economic
4 contributions to the areas that you're caring for -- I'm
5 not looking at charity care per se, but I'm looking at a
6 thought that might influence some of the negatives that I
7 read regarding the whole operation that you represent and
8 claim to be so ethical about. I worked for 40 years in
9 this community. I worked with several dialysis units, and
10 I'm well aware of what's going on, so I don't need to be
11 told by somebody who represents the company about how great
12 they are, about how ethical they are and how honest you are
13 and giving such wonderful care, when I recognize -- and
14 I'll read from this.
15 "As the United States moves to expand access
16 to healthcare, dialysis offers potent lessons." And this
17 is the big picture I'm looking at. "Its story expresses
18 the fears of both ends of the ideological spectrum about
19 what can happen when the doors to care are thrown wide
20 open. Neither government controls nor market forces have
21 kept costs from ballooning or ensured highest-quality
22 care," which you dispute, of course. "Almost every key
23 assumption about how the program would unfold has proved
24 wrong." When we have our little get-together, I will fully

1 expect and listen to what you just said repeated, so you
2 can challenge this stuff. But this is well documented,
3 with a bibliography of two pages. I'm a little upset to be
4 lectured to when I know damn right well that some of what
5 you said is very self-serving.
6 Let me hear more about how interested you are
7 in making sure that the poorer communities -- this whole
8 system -- I'll read this. "One reason this system's
9 problems have evolved out of the health care spotlight is
10 that kidney failure disproportionately affects minorities
11 and the dispossessed. But given a patient pool growing by
12 3 percent a year and the outside 6 percent bite that the
13 kidney program takes from the Medicare budget, we ignore
14 dialysis at our own risk. More and more leaders in the
15 field, he said, are starting to say this isn't sufficient."
16 We really -- I have some problems with the
17 whole area, and I hope to resolve them to the benefit of
18 you. The patients primarily. Look forward to hearing more
19 about what you might do for these people that you seem to
20 be caring so diligently for and you claim to be doing such
21 a marvelous job. I hope that's true. That's what I'm
22 saying. I would like to see more evidence from it, and I
23 would be impressed if somebody from your company would step
24 forward and say, "We're going to make a contribution

1 economically to these poor people, poor communities that
2 are looking in a bad climate." We've got a horrible
3 economy going on right now, and we're reading about all the
4 amount of money that goes to this area, and I don't know of
5 any dialysis unit right now in the City that's suffering
6 economically, although I do know how well you're doing in
7 terms of care and treatment.
8 That's enough of my speech. It has nothing to
9 do with how I look at your application. I try to be honest
10 and open, but I could not listen to what you said and not
11 feel we've got to come back with something. My opinion is
12 my opinion, not the rest of the Board. They vote for
13 themselves. But I'd like to hear some of what I said, look
14 forward to hearing -- let's put it that way -- and maybe
15 when we have our retreat, which we're planning on in 90
16 days, you'll step forward and prove me wrong.
17 CHAIRMAN GALASSIE: I'd like to continue with
18 more questions rather than a response.
19 MS. OLSON: I have a question. If I'm doing
20 my math right, we're now -- HSA 7, plus 18 stations, and
21 HSA 9, plus 68?
22 MR. CONSTANTINO: Excess of 68, yes. I have
23 to point out that your rules require us to look at the
24 station need in the planning area where the facility is

1 located.

2 MS. OLSON: And this one is physically

3 located --

4 MR. CONSTANTINO: Physically located in HSA 9,

5 yes.

6 MS. OLSON: Thank you.

7 CHAIRMAN GALASSIE: Member Sewell?

8 MR. SEWELL: I have a question, just for my

9 own education. I don't know whether it's for you or for

10 the Staff. But I'm on page 12 of the Staff Report, and I

11 see a couple of quality measures, and I guess I want to

12 understand what those are. Something called URR. What is

13 URR?

14 MS. MULDOON: It's the Urea Reduction Rate,

15 and we test the patients. It shows from when they start

16 dialysis to the end, when they end the dialysis, that

17 actual treatment, the clearances, how well do we clean

18 their blood. So, that measures that.

19 MR. SEWELL: And the benchmark should be equal

20 to or greater than 65 percent?

21 MS. MULDOON: Correct.

22 MR. SEWELL: And the other is Kt/V. What is

23 that?

24 MS. MULDOON: It's another way of measuring

1 the adequacy of dialysis. URR just measures that snapshot,
2 and then the Kt/V measures the -- it's the actual dialysis,
3 just two different ways of measuring adequacy of dialysis.
4 CHAIRMAN GALASSIE: I have a question, and I
5 promise, Miss Ranalli, I'll let you speak to the issue. I
6 don't pretend to fully understand your business model,
7 though I think I'm learning more and more about it. But I
8 think there tends to be agreement that fourth shift service
9 is less desirable by everyone. When you close Naperville
10 and you move to Naperbrook, is there a possibility that
11 expansion could occur to absorb that population without
12 having to automatically go to a fourth shift?
13 MS. RANALLI: Yes. That's the anticipated
14 plan.
15 CHAIRMAN GALASSIE: Would you accept that as
16 a contingency of approving this, based upon that?
17 MS. RANALLI: Yes, absolutely.
18 MR. URSO: Not to have a fourth shift.
19 MS. RANALLI: No, we would not run a fourth
20 shift. When Edward -- we've been working with Edward, but
21 they want that space back. As we work that out, we would
22 not start a fourth shift at the Naperbrook facility.
23 CHAIRMAN GALASSIE: Okay. I heard that.
24 MS. OLSON: So, Chairman Galassie, you're

1 suggesting that they would be closing stations in order to
2 make up these stations they're opening?
3 CHAIRMAN GALASSIE: I'm not sure I understand
4 your question, but I'm suggesting that would they agree to
5 once Naperville is closed and that population is moved to
6 Naperbrook, that Naperbrook would either absorb it without
7 a fourth shift or they would expand it so they wouldn't
8 have to establish a fourth shift.
9 MS. RANALLI: Yes.
10 CHAIRMAN GALASSIE: Again, the point being,
11 we all want to try to avoid a fourth shift, if at all
12 possible.
13 Ms. Ranalli, you had a comment.
14 MS. RANALLI: I'll be as brief as possible,
15 but I do feel, just for the record, we need to respond to a
16 couple of things.
17 The quality -- I'm glad you brought up the
18 quality matrix that are in the application and that are
19 part of the Board's review criteria. Fresenius has for 15
20 years I've been working with them always met this Board's
21 matrix. Also, with respect to the quality issues that were
22 raised by the ProPublica article, et cetera, I think those
23 are all important things for everyone to talk about, but
24 one thing I think is important -- at least to me, maybe

1 just because I'm a lawyer -- is sort of looking at things
2 from an evidentiary standpoint.
3 Fresenius facilities have served the residents
4 and the patients in the state of Illinois for at least over
5 15 years, and if you go down to southern Illinois, where
6 the BMA facilities are, possibly 20 to 30 years. They have
7 never had any quality issues at all with the Illinois
8 Department of Public Health or otherwise. When they are
9 surveyed, if there are deficiencies, they are never being
10 what, level A or 3, the high-level deficiencies where there
11 are significant issues. They are all minor issues.
12 I work with Fresenius on some of those
13 regulatory issues as well. They immediately address those,
14 and again, they've always been minor level deficiencies.
15 So, there's a history of our partnering with the State of
16 Illinois and providing good quality.
17 And then on the charity or community benefit
18 point, Fresenius has clinics throughout many neighborhoods
19 in metropolitan Chicago and outside of it that are
20 economically-challenged, probably more than any other
21 provider, because it's largest, but also because it does go
22 to those communities, and I think you bring up a very good
23 point. As a for-profit entity -- and, also, any entity
24 that provides dialysis struggles with charity care, as you

1 define it. Community benefit is important, and I think
2 there are things we can do and are committed to do, and
3 maybe even firmly commit, as we move further and dialogue
4 with this Board, particularly in those communities like
5 Humboldt Park, South Loop, where there are issues that we
6 might be able to address regarding diabetes care,
7 prevention, some of the underlying problems that cause
8 end-stage renal disease, so those patients don't even
9 arrive at our facility requiring dialysis.
10 And, lastly, I received approval from a friend
11 of mine who has private insurance. So, a patient that is
12 extensively in need of a dialysis clinic, would want to
13 keep dialyzing there. She is my age, so a very young lady.
14 (Laughter)
15 MS. RANALLI: She has had three transplants.
16 She dialyzes at Fresenius. She has lupus. She has had
17 three transplants. She said they worked with her. After
18 the first two, it was a challenge for her to get a third,
19 but she finally was able to get a family member as a donor,
20 because she rejected the first two kidneys, and it
21 really -- it's heartening to hear that story, since I don't
22 hear from the patients' perspective. But that's what she
23 told me, and she was very pro-Fresenius and, again, a
24 private insurance patient and yet was very much encouraged

1 to get her current transplant, which she's had in place for
2 a year and is doing very well.
3 MR. HAYES: Mr. Chairman, I have some
4 questions.
5 Mike, can you go over -- you mentioned earlier
6 yesterday that you would update the Board exactly for
7 these -- the amount of stations that -- when we approved,
8 that you would update the need or the excess for the
9 different areas, and I think you just did that with Kathy
10 Olson's, Member Olson's question there. So, could you go
11 over that again?
12 MR. CONSTANTINO: Yeah. HSA 9, the planning
13 area in which your rules require us to review this project,
14 has an excess of 68 stations.
15 MR. HAYES: Okay.
16 MR. CONSTANTINO: HSA 7, by my count they have
17 an excess of 21 stations.
18 MR. HAYES: Okay. The other question that
19 came up at the last meeting from Member Penn, I think, even
20 the Judge as well, concerning revenue per facility in the
21 state of Illinois, and did you provide that information?
22 MS. RANALLI: No, we have not. We've been
23 talking with Mr. Constantino about providing that
24 information and how it -- what exactly you're looking at,

1 net revenue by clinic, et cetera, and we had hoped that we
2 might have the meeting that has been discussed sooner, but
3 apparently, that's been delayed, and we wanted to talk
4 about that then and figure out exactly what it was you were
5 looking for. We also have concern -- well, maybe. It
6 depends exactly what the information is you want. But we
7 have concerns about the proprietary nature of the
8 information, and right now, if we were certain what you
9 wanted, we could provide it, if it would be maintained in a
10 confidential way, but we don't know that your process
11 allows for that. And so, I think, we don't want to
12 prohibit you from having that information and we're not
13 objecting necessarily to providing it. We want to figure
14 out more what that is, what you're looking for and how we
15 can provide it to you, and, depending on what you're
16 looking for, whether it is proprietary. So, the net
17 revenue I know for hospitals. I think you asked for that
18 information, also --
19 CHAIRMAN GALASSIE: Right.
20 MS. RANALLI: -- in the application, and
21 hospitals file a form with the State, providing net revenue
22 by facilities, providing the net revenue by clinics.
23 Depending on what you're looking for, again, could reveal,
24 again, proprietary information to our competitors, to

1 payors, et cetera, and that's the concern. Plus, we're not
2 even sure exactly what you're looking for. So, we had
3 hoped to dialogue with you about that, if that's allowed by
4 you.
5 CHAIRMAN GALASSIE: I don't -- if you're
6 suggesting the retreat that we're planning to have on this
7 issue, I don't believe that's the place for this dialogue.
8 MS. RANALLI: Okay. Well, then any
9 appropriate --
10 CHAIRMAN GALASSIE: If there is confusion for
11 what it is we're requesting, then I think we better
12 articulate that. If someone can articulate that -- I don't
13 think I can.
14 MR. EAKER: I can speak to part of it. I've
15 been concerned that with every Fresenius application, you
16 use the same safety net information, which is a national
17 thing for three years. Is that correct? I'm looking at
18 2008, 2009, 2010 charity care. It's the information on
19 Table Four. I had asked for information regarding charity
20 care on a local level. What -- is it an across-the-board
21 thing? The response, if I remember right, from the past
22 was that "Well, no one ever gets turned away." But that
23 really doesn't answer the concern that I have. Most of the
24 time you relate self-pay as charity care, and I don't quite

1 understand that, because there could possibly be some very
2 wealthy self-pay people who doesn't need charity care. So,
3 I was looking for information that would break down those
4 categories.
5 MS. RANALLI: We have -- and thank you.
6 That's helpful, and we have changed the way we provide the
7 data in response to the question for net revenue by clinic.
8 Self-pay patients are patients that -- it's uncompensated
9 care. So, what we've done to try and provide more specific
10 information to the Board is we've provided the number of
11 uncompensated treatments that we -- each clinic and each
12 facility, and this is for Illinois, by the way. We provide
13 the number of Medicaid treatments that are provided at all
14 of the various clinics. So, that -- and, of course, the
15 Medicare percentage of treatment. So, that's the
16 information, how we're breaking it down now. The
17 uncompensated treatments are treatments, again, that we
18 just are not paid for, and that, honestly, doesn't occur
19 that frequently, because most patients are entitled to
20 obtain coverage which goes back to what was being discussed
21 yesterday about this being sort of a socialized medicine
22 experience, which was -- happened a long time ago, to make
23 sure patients weren't dying who shouldn't be dying because
24 they couldn't afford treatment or treatment wasn't

1 available. That's why the community benefit issue -- not
2 to change the subject, because we want to give you the
3 information you want on the uncompensated care and the
4 charity care, but I'd like to see a dialogue with the
5 dialysis industry that also addresses its ability to
6 provide community benefit, since charity care and the way
7 you think about it for a not-for-profit hospital that might
8 actually provide free care, promote free care, advertise
9 free care, provide free care is a little bit different. We
10 can't do that because of Medicare rules, et cetera, because
11 we are a for-profit company.
12 MR. HAYES: Mr. Chairman?
13 CHAIRMAN GALASSIE: Yes, Mr. Hayes.
14 MR. HAYES: The revenue by clinic, is that
15 readily available information?
16 MS. RANALLI: No.
17 MR. HAYES: Could that be -- from publicly
18 available information from the financial statements, you
19 have revenue per clinic or revenue per day, per -- revenue
20 per treatment, as well as the number of treatments at the
21 facility, and could that be calculated that way?
22 MS. RANALLI: Revenue per treatment, like
23 broken down by Medicaid and uncompensated care? Is that
24 what you're asking?

1 MR. HAYES: Well, let's start out with the
2 gross number here, because that was a concern, and the
3 revenue by clinic. Is the revenue per treatment and then
4 the number of treatments at a facility -- and that would
5 calculate pretty close to revenue, even though this is all
6 over the United States.
7 MS. RANALLI: That's what we're doing now.
8 And, also, the numbers in our application are Illinois.
9 Those are not national numbers. That is the state of
10 Illinois. And we're doing that now, very recently. In
11 response to the dialogue I've had with Mr. Constantino on
12 this issue, we have broken down those numbers. The
13 applications before you today may not have that, because
14 they were filed a couple of months ago, but the
15 applications filed very recently do have what you're
16 requesting.
17 MR. HAYES: But they don't have revenue by
18 clinic, a total revenue by clinic.
19 MS. RANALLI: A total number, like the
20 Naperville clinic's net revenue is X?
21 MR. HAYES: What kind of revenue per year does
22 Naperville generate?
23 MS. RANALLI: No, I don't believe the
24 applications include that. Instead, for, say, the

1 Naperville clinic, they would break down the revenue by
2 uncompensated treatment, Medicaid treatment, et cetera, but
3 the net revenue number is not there, other than for the
4 entire state of Illinois.
5 CHAIRMAN GALASSIE: Let me make a -- I'm
6 sorry, John.
7 MR. HAYES: You know, I think we'd like to see
8 that. If you were able to do it by the different
9 categories here and your Medicare and Medicaid and self-pay
10 and then charity care, you then would be able to come up
11 pretty close to your total revenue for a clinic. Do you
12 have to do that for CMS and other reporting to other
13 government agencies?
14 MS. RANALLI: No.
15 MR. HAYES: Do you have to do that for the
16 Illinois Department of Public Health and Medicaid?
17 MS. RANALLI: No.
18 MR. HAYES: Okay. Well, could that be done by
19 publicly-available information? It would take -- I don't
20 think it would take too long, an Excel spreadsheet with
21 that.
22 MS. RANALLI: I think we could. Hearing what
23 you're saying, I think we could look into that and maybe
24 present something to Mike that he could then share with the

1 Board and see if it's what you're looking for. I mean,
2 that would at least get us beyond the current place where
3 we are in dialogue.
4 CHAIRMAN GALASSIE: John, can I ask you a
5 question? Rather than trying to, perhaps, ask them for
6 every facility in Illinois -- and I think they get the gist
7 of what we're asking for -- I think it would be better for
8 them to voluntarily supply it than we making it a
9 contingency. Could we start with a sample and give us a
10 sample of facilities from the four quadrants of the state,
11 maybe -- how many facilities do you have in the state?
12 MS. RANALLI: I think close to 100.
13 CHAIRMAN GALASSIE: By the HSA or something
14 like that, as opposed to all 100, initially, and if that
15 doesn't satisfy where you're coming from, please say so.
16 That's just a thought.
17 MR. HAYES: Well, I would agree with starting
18 out with a sample. I wouldn't have any problem with that.
19 CHAIRMAN GALASSIE: Let them send that to
20 Mike.
21 MR. HAYES: And then we could start from
22 there, and I think that would answer some of the Board
23 member's questions associated with this issue.
24 CHAIRMAN GALASSIE: We respect the

1 proprietary aspect of it. We'd like to have information
2 for our knowledge of how the system is working. And,
3 again, perhaps my ignorance, but the only charity care must
4 be non-Medicare and non-Medicaid person who walks in the
5 door, right, because everybody else is covered.
6 MS. MULDOON: Right. As we said, we still get
7 -- we take undocumented patients also, but they also can
8 get coverage in the state of Illinois. So there really
9 isn't anybody in -- I mean, in our other states we do a lot
10 of charity care, but in the state of Illinois, usually we
11 have coverage. It's very rarely that we can't get a
12 patient covered.
13 CHAIRMAN GALASSIE: If we're coming to a
14 concensus -- unless Dr. Burden's issue is to this, if we're
15 coming to a concensus, then rather than a contingency on
16 this, we would be asking for you in the spirit of this
17 dialogue to give us a sampling of whatever the number --
18 how many HSA's are there, eight, eleven?
19 MR. CONSTANTINO: Eleven.
20 CHAIRMAN GALASSIE: So, if you give us one in
21 each, that's ten percent.
22 MR. BURDEN: I want to read something briefly
23 that addresses this. "ProPublica first asked CMS for
24 clinic-specific outcome data it collects, at taxpayer

1 expense, two years ago under the Freedom of Information
2 Act. The agency" -- that's CMS -- "declined to say whether
3 it would release the material until last week, as this
4 story neared publication. It subsequently has provided
5 reports for all clinics" -- all U.S -- "from 2002 to 2010.
6 ProPublica is reviewing this data and plans to make it
7 available for patients, researchers and the general
8 public."
9 I think that answers your question.
10 MS. RANALLI: That's quality data, not
11 financial.
12 MR. BURDEN: That's right.
13 MS. RANALLI: When you asked the question, I
14 was responding to financial.
15 MS. MULDOON: I think it would be good, when
16 we do do this, we put the number of facilities that are
17 treated in that HSA, because you're going to see that the
18 majority of our patients are in inner city facilities, in
19 HSA's with reduced revenue.
20 MR. SEWELL: I don't know who I want to ask
21 this, but revenue per facility -- don't you file Medicare
22 cost reports?
23 MS. MULDOON: Yes.
24 MR. SEWELL: It's got to be in there.

1 MS. MULDOON: It is.

2 MR. SEWELL: Okay.

3 CHAIRMAN GALASSIE: So, if you're filing it

4 with Medicare, what's the hesitation in filing it with this

5 Board? We just spent 20 minutes talking about whether to

6 put a contingency on this and that the Board wants this

7 information. If they're giving it to Medicare, they should

8 be giving it to us.

9 MS. RANALLI: The cost reports, I believe, are

10 public. So, why don't we then provide cost reports, as you

11 suggested -- well, we'll break it down in an Excel

12 spreadsheet and, we could provide a cost report for a

13 sampling of clinics, and, hopefully, if that answers your

14 question, then -- and that is the data you're looking

15 for --

16 CHAIRMAN GALASSIE: That's acceptable, but,

17 again, because we've had this dialogue, if you're

18 submitting it on all clinics to Medicare, what's the point?

19 Why aren't we submitting it? Then we want to see all

20 hundred. Yeah, of course, it's public information. Why is

21 there reluctance to give public information to a public

22 body?

23 MS. RANALLI: We have to see what information

24 is on the cost report. I'm not sure it's exactly what

1 Mr. Penn and Mr. Hayes and others have asked for.
2 MS. MULDOON: We'll pull the cost reports.
3 MS. RANALLI: Absolutely. But we've been
4 told -- that's the reason -- back in my mind, I'm concerned
5 that it may not be exactly what you're looking for, but
6 that's a good start.
7 CHAIRMAN GALASSIE: That's right. Appreciate
8 it, Ms. Ranalli. It would be a good start.
9 Now, Members, it's your decision. I'm going
10 to be making a motion here. If you want a contingency on
11 this motion, you have every right to. I will be making
12 a -- recommending a contingency on this motion that when --
13 if approved, when the Naperville facility closes and moves
14 to Naperbrook, that there will not be a fourth shift opened
15 in order to accomplish that.
16 MR. SEWELL: May I ask a question?
17 CHAIRMAN GALASSIE: Yes, sir.
18 MR. SEWELL: Okay. I'm confused by your
19 references to Naperbrook. That's the -- isn't that a
20 corporate name? That's a place too?
21 CHAIRMAN GALASSIE: Yeah.
22 MR. SEWELL: There's a place in the world
23 called Naperbrook? I shouldn't say "world".
24 MS. MULDOON: Actually, it's the name of the

1 dialysis facility.

2 MR. SEWELL: But it's not a geopolitical unit.

3 CHAIRMAN GALASSIE: No.

4 MR. SEWELL: When you say move to that --

5 MS. WRIGHT: The site is halfway between

6 Naperville and Bolingbrook, thus Naperbrook.

7 MR. URSO: Mr. Sewell, the application is

8 titled "Naperbrook," but they list the city as Naperville,

9 but I guess it's actually Bolingbrook.

10 MS. WRIGHT: It's actually in Naperville, but

11 it lies in Will County. It's kind of confusing.

12 CHAIRMAN GALASSIE: I'm going to recommend a

13 motion. Do we have a motion to approve Project 11-038 for

14 the establishment of a 12-stage ESRD facility in

15 Naperville, Illinois, with the condition that when the

16 Naperville facility closes and that population shifted to

17 Naperbrook, the Naperbrook facility, that a fourth shift

18 will not be added to accommodate, and that a report would

19 come back to the Board a year later.

20 MS. RANALLI: To confirm that fact, yes.

21 MS. WRIGHT: We will be filing a CON

22 application at that point to discontinue the Naperville

23 facility.

24 MR. URSO: Do you have an anticipated date

1 when you are going to do that?

2 MS. WRIGHT: Probably in mid to the end of

3 2013.

4 CHAIRMAN GALASSIE: We have a lengthy motion

5 on the floor. If it's working, I'll ask for a motion and a

6 second. Let me just get a motion and a second.

7 MR. BURDEN: So moved.

8 MR. HILGENBRINK: Seconded.

9 CHAIRMAN GALASSIE: Moved and seconded. Thank

10 you very much.

11 Comment, Mr. Carvalho?

12 MR. CARVALHO: The apparent life cycle of

13 these facilities is that they open up, they're

14 underutilized, utilization builds, and then it ultimately

15 goes to a situation where they go to a fourth shift and

16 then they seek an additional. So, was your motion

17 intending to never allow the facility to go to a fourth

18 shift, or just stop the fourth shift until some future time

19 when the demand changes?

20 CHAIRMAN GALASSIE: My motion was to

21 eliminate the fourth shift.

22 MR. CARVALHO: Forever?

23 CHAIRMAN GALASSIE: Correct.

24 MS. RANALLI: Right, because within one year,

1 we probably wouldn't even be admitting patients yet. So, I
2 understood it to never operate a fourth shift.
3 CHAIRMAN GALASSIE: Right. We have a motion
4 and a second. Roll call, please.
5 MR. SEWELL: Excuse me, Mr. Chairman, but the
6 motion is to approve with that condition?
7 CHAIRMAN GALASSIE: Correct.
8 MR. SEWELL: Okay. I never heard "approve".
9 CHAIRMAN GALASSIE: Okay. Motion to approve.
10 MR. DART: Motion made by Dr. Burden, seconded
11 by Mr. Hilgenbrink.
12 Dr. Burden?
13 MR. BURDEN: Did I understand, Mike, that you
14 said the number of beds excess in HSA 9, subsequent to the
15 approval of yesterday's Bolingbrook dialysis, is now what?
16 MR. CONSTANTINO: 68.
17 MR. BURDEN: 68?
18 MR. CONSTANTINO: Yes, sir.
19 MR. BURDEN: I vote no.
20 CHAIRMAN GALASSIE: Mr. Eaker?
21 MR. EAKER: I'm going to abstain.
22 MR. DART: Justice Greiman?
23 MR. GREIMAN: Aye.
24 MR. DART: Mr. Hayes?

1 MR. HAYES: Well, because of the excess beds
2 in the HSA 9 of 68 and the excess beds in HSA 7 of 18 now,
3 I'm going to vote no.
4 MR. DART: Mr. Hilgenbrink?
5 MR. HILGENBRINK: Yes.
6 MR. DART: Ms. Olson?
7 MS. OLSON: No, for the same reasons just
8 stated.
9 MR. DART: Mr. Sewell?
10 MR. SEWELL: No, due to excess capacity.
11 MR. DART: Chairman Galassie?
12 CHAIRMAN GALASSIE: The Chair intended to
13 vote no on this subject until the dialogue took place this
14 morning and a commitment to avoid a fourth shift. The
15 chair votes yes.
16 MR. DART: That's three votes yes and four no.
17 CHAIRMAN GALASSIE: Motion does not pass.
18 MR. DART: And one abstention.
19 MR. URSO: You'll have another opportunity to
20 come before the Board and also submit additional
21 information, if you so desire.
22 CHAIRMAN GALASSIE: And you folks are going
23 to remain for our following items. Thank you very much.
24 Significant dialogue, as we have four more applications

1 you.

2 CHAIRMAN GALASSIE: Thank you.

3 Ladies and gentlemen, I would ask that you be

4 timely in emptying the room. We're going to go into

5 Executive Session. Everyone other than Board members,

6 please take off.

7

8 EXECUTIVE SESSION HELD

9

10 MEETING ADJOURNED AT 3:36 P.M.

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1 CERTIFICATE OF REPORTER

2

3 I, KAREN K. KEIM, CRR, RPR, a Certified Court
4 Reporter in the States of Illinois and Missouri, do hereby
5 certify that the proceedings in the above-entitled cause
6 were taken by me to the best of my ability and thereafter
7 reduced to writing; that I am neither counsel for, related
8 to, nor employed by any of the parties to the action, and
9 further that I am not a relative or employee of any
10 attorney or counsel employed by the parties thereto, nor
11 financially or otherwise interested in the outcome of the
12 action.

13

14 Karen K. Keim

15

16 KAREN K. KEIM

17 CRR, RPR, CSR-IL, CCR-MO

18

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Pro Publica Data

Summary of Top Quality Markers
Dialysis Compare Data 2010 per
ProPublica Dialysis Facility Tracker
Central Illinois Market

	Fresenius Medical Care								DaVita								
Quality Marker	Peoria DT	Peoria No	East Peoria	Champaign	Pekin	McLean Co	Decatur	FMC Avg %	Lincoln	Decatur E Wood	Macon Co	Spgfield Montvale	Spgfield Ctrl	Urbana	DAV Avg %	State Avg	Natl Avg
Anemia Control	94%	82%	80%	91%	94%	91%	90%	**88%**	96%	78%	52%	92%	94%	77%	**82%**	**86%**	**86%**
Dialysis Adequacy	97%	92%	96%	95%	100%	96%	97%	**96%**	87%	98%	96%	98%	98%	69%	**91%**	**96%**	**97%**

Full reports on following pages.

FMC Decatur

DIALYSIS CENTERS OF AMERICA-ILLINOIS, Decatur, Ill.

	This Facility	State Average	National Average
Details	**(217) 423-6760** 1830 SOUTH 44TH STREET DECATUR, ILL. 62521 map »		
Stations	**12**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**23%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**7%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**21%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**32%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**5%** higher than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**29%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**6%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**6%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**13%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**90%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**97%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**47%** higher than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**16%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**10%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**71%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**8%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**1**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	June 10, 2009		

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FMC - MCLEAN COUNTY, Bloomington, Ill.

	This Facility	State Average	National Average
Details	**(309) 663-7165** 1505 EASTLAND MEDICAL PLAZA BLOOMINGTON, ILL. 61701 map »		
Stations	**20**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**25%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**10%** higher than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**25%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**9%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**21%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**48%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**10%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**8%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**17%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**91%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**96%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**46%** higher than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**26%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**7%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**67%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**13%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**2**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Oct. 29, 2010		

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FMC - CENTRAL ILLINOIS PEKIN, Pekin, Ill.

	This Facility	State Average	National Average
Details	**(309) 353-7629** 600 S 13TH ST PEKIN, ILL. 61554 map »		
Stations	**9**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**26%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**8%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**13%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**66%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**26%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**30%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**4%** lower than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**11%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**23%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**94%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**100%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**8%** lower than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**30%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	1%	11%	9%
Fistula Percent of patients with a fistula, 2010.	65%	63%	64%
Care Before Dialysis			
Not Treated by Nephrologist	20%	32%	30%
Clinic Conditions			
Standard Deficiencies Lower level problems with care	4		
Major Deficiencies Widespread or serious problems with care	0		
Date of Last Inspection	Jan. 19, 2011		

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FMC - CHAMPAIGN - URBANA DIALYSIS CENTER, Urbana, Ill.

	This Facility	State Average	National Average
Details	**(217) 328-4100** 1405 W PARK STREET URBANA, ILL. 61801 map »		
Stations	**25**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**22%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**4%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**36%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**14%** higher than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**5%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**34%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**32%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**12%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**23%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**91%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**95%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**1%** higher than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**19%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**14%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**64%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**41%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**2**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Sep. 10, 2008		

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FMC- EAST PEORIA DIALYSIS, East Peoria, Ill.

	This Facility	State Average	National Average
Details	**(309) 698-8322** 3300 NORTH MAIN EAST PEORIA, ILL. 61611 map »		
Stations	**24**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**25%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**6%** higher than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**28%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**13%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**9%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**23%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**5%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**9%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**22%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**80%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**96%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**72%** better than expected		
Wait List Percent of patients on transplant wait list, 2010.	**37%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**8%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**55%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**27%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**17**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Jan. 6, 2011		

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FMC - PEORIA NORTH, Peoria, Ill.

	This Facility	State Average	National Average
Details	**(309) 243-2200** 10405 N. JULIET COURT PEORIA, ILL. 61615 map »		
Stations	**17**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**23%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**1%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**26%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**9%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**25%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**28%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**16%** lower than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**7%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**14%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**82%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**92%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**33%** higher than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**43%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**6%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**62%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**0%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**9**		
Major Deficiencies Widespread or serious problems with care	**0**		
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FMC - PEORIA DOWNTOWN, Peoria, Ill.

	This Facility	State Average	National Average
Details	**(309) 637-4100** 410 W ROMEO B GARRETT AVE. PEORIA, ILL. 61605 map »		
Stations	**32**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**19%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**3%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**22%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**2%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**1%** higher than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**25%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**33%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**9%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**11%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**94%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**97%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**18%** lower than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**35%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**5%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**55%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**26%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**11**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Feb. 11, 2010		

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DAVITA - ILLINI RENAL DIALYSIS, Champaign, Ill.

	This Facility	State Average	National Average
Details	**(217) 378-7800** 507 E UNIVERSITY AVENUE CHAMPAIGN, ILL. 61820 map »		
Stations	**10**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**23%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**4%** higher than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**28%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**0%** as expected		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**6%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**27%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**4%** lower than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**8%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**14%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**77%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**69%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**163%** better than expected		
Wait List Percent of patients on transplant wait list, 2010.	**23%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**6%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**72%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**16%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**2**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Feb. 10, 2010		

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DAVITA - SPRINGFIELD CENTRAL DIALYSIS, Springfield, Ill.

	This Facility	State Average	National Average
Details	**(217) 788-3688** 932 N RUTLEDGE STREET SPRINGFIELD, ILL. 62702 map »		
Stations	**21**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**20%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**2%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**31%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**14%** higher than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**14%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**23%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**21%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**10%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**13%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**94%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**98%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**56%** better than expected		
Wait List Percent of patients on transplant wait list, 2010.	**20%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**6%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**65%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**18%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**1**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Oct. 29, 2009		

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SPRINGFIELD MONTVALE DIALYSIS, Springfield, Ill.

	This Facility	State Average	National Average
Details	**(217) 793-2781** 2930 S MONTVALE DRIVE STE A SPRINGFIELD, ILL. 62704 map »		
Stations	**17**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**22%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**4%** higher than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**30%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**1%** higher than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**7%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**22%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**19%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**13%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**20%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**92%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**98%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**8%** lower than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**34%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**3%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**78%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**4%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**0**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Dec. 8, 2009		

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MACON COUNTY DIALYSIS, Decatur, Ill.

	This Facility	State Average	National Average
Details	**(217) 877-9351** 1090 W MCKINLEY DECATUR, ILL. 62526 map »		
Stations	**21**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**26%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**11%** higher than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**31%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**15%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**16%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**35%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**21%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**12%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**6%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**52%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**96%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**55%** lower than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**34%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**7%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**71%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**42%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**2**		
Major Deficiencies Widespread or serious problems with care	**0**		
Date of Last Inspection	Jan. 29, 2010		

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DECATUR EAST WOOD DIALYSIS, Decatur, Ill.

	This Facility	State Average	National Average
Details	**(217) 425-6403** 794 EAST WOOD STREET DECATUR, ILL. 62523 map »		
Stations	**16**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**16%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**3%** lower than expected (This figure could be statistically invalid.)		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**23%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**2%** lower than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**7%** lower than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**34%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**30%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**10%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**20%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**78%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**98%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.	**9%** lower than expected (This figure could be statistically invalid.)		
Wait List Percent of patients on transplant wait list, 2010.	**26%**	**27%**	**24%**

	This Facility	State Average	National Average
Vascular Access			
Catheter Percent of patients with a catheter, 2010.	**4%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**73%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**25%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**13**		
Major Deficiencies Widespread or serious problems with care	**0**		
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DAVITA - LINCOLN DIALYSIS, Lincoln, Ill.

	This Facility	State Average	National Average
Details	**(217) 732-6798** 2100 WEST FIFTH ST LINCOLN, ILL. 62656 map »		
Stations	**14**		
Survival			
Mortality Deaths per 100 patient years, 2007-2010.	**40%**	**20%**	**20%**
Mortality vs. Expected Patient death rate versus expected death rate, 2007-2010.	**49%** worse than expected		
First Year Mortality Deaths during first year of treatment per 100 patient years, 2007-2009.	**50%**	**30%**	**27%**
First Year Mortality vs. Expected First year death rate versus expected death rate, 2007-2009.	**79%** higher than expected (This figure could be statistically invalid.)		
Hospitalization			
Hospital Admissions Hospital admissions versus expected admissions, 2007-2010.	**4%** higher than expected		

	This Facility	State Average	National Average
Days in Hospital Days in hospital versus expected days in hospital, 2007-2010.	**10%** lower than expected		
Emergency room visits vs. Expected Emergency room visit rate vs. expected, 2007-2009	**24%** higher than expected		
Infection			
Septicemia Percent hospitalized with a blood infection, 2007-2010.	**11%**	**13%**	**11%**
Access-Related Infections Percent with vascular access infection, 2009.	**25%**	**20%**	**19%**
Clinical Benchmarks			
Anemia Control Percent of patients with healthy hemoglobin levels, 2010.	**96%**	**86%**	**86%**
Dialysis Adequacy Percent of patients with adequate urea removal, 2010.	**87%**	**96%**	**97%**
Transplants			
Transplants vs. Expected Transplant rate versus expected transplant rate, 2007-2010.			
Wait List Percent of patients on transplant wait list, 2010.	**29%**	**27%**	**24%**
Vascular Access			

	This Facility	State Average	National Average
Catheter Percent of patients with a catheter, 2010.	**8%**	**11%**	**9%**
Fistula Percent of patients with a fistula, 2010.	**72%**	**63%**	**64%**
Care Before Dialysis			
Not Treated by Nephrologist	**0%**	**32%**	**30%**
Clinic Conditions			
Standard Deficiencies Lower level problems with care	**4**		
Major Deficiencies Widespread or serious problems with care	**1**		
Date of Last Inspection	Feb. 11, 2009		

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