



STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 FAX: (217) 785-4111

May 31, 2016

CERTIFIED LETTER
RETURN RECEIPT REQUESTED

Asim Shazzad
Administrator
Dialysis Care Center
15786 S Bell Rd
Homer Glen, IL, 60491

Re: Additional Information Project #16-020

Mr. Shazzad:

We are in the process of reviewing your application and we need additional information in order to complete our review. Please provide the following information for Application for Permit#16-020.

1. Please provide a copy of the admission and charity care policy for the proposed facility.
2. Please provide the names of the members and their percentage of ownership of Dialysis Care Center Oak Lawn, LLC, and Dialysis Care Center Holdings LLC.
3. The letter from Chase Bank dated May 17, 2016 refers to Kidney Care Center's accounts. Kidney Care Center will need to be a co-applicant on this application for permit because it appears Kidney Care Center will be providing the cash for this project. This is a Type A Modification and we will need
 - a. Page one of the application for permit completed for Kidney Care Center
 - b. Current Certificate of Good Standing
 - c. Signed certification page
4. We are going to need a schematic of the proposed facility indicating the location of all 11 dialysis stations, patient exam and training area, support area, water treatment, nurse station, lobby, reception area, administrative space, areas for staff i.e. locker room, toilets, and storage.
5. Permit #14-024 discontinued the facility at 9155 South Cicero Avenue, Oak Lawn, that stated *"there were multiple physical plant upgrades needed to plumbing, HVAC, and flooring. The patients do not have access to a clean sink on the treatment floor and need to rely on the use of alcohol wipes to clean their vascular access site. The RN station is too small to adequately prep medications. The water treatment room is outdated and in need of a complete overhaul. The Existing Facility houses 12 dialysis stations in*

approximately 4,000 GSF, or 333,3 GSF per station, which is below the Board's minimum standard for in-center hemodialysis stations. As a result, the space is inadequate to store medical supplies, office supplies, and biohazard waste. The facility has no dedicated conference room. The lobby/patient seating area is too small by DaVita standards to appropriately accommodate patients in a 12-station dialysis unit. The mechanical room and the computer/server room for all of the neighboring medical businesses are housed inside the Existing Facility. There is no way to access the server/computer room without going through the treatment floor, creating a potential infection control concern, Additionally, the patient treatment floor configuration prohibits the viewing of all patients from the nursing station, resulting in an overall concern for patient safety based on inadequate sight-lines.” The material you have submitted does not address any of these issues. We need a complete explanation of how these issues are going to be addressed.

6. We need for the applicants to 1. define the market area to be served, 2. the area's demographics or characteristics, 3. the goal of the project. [Page 82 of the application for permit]
7. We need for the applicants to compare the project's alternative options as it relates to issues of cost patient access, quality and financial benefits in the both the short and long term. [Page 84 of the Application for Permit]
8. We need revised referral letters for each physician.The letters need to provide the following:
 - a. The physician's total number of patients [by facility and zip code of residents] who have received care at existing facilities in the area for the most recent 3 years [2013, 2014, 2015]. It must be in this format

Zip Code of Patient	Name of Facility Referred	Number of Patients Referred
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- b. The number of new patients [by facility and zip code] located in the area that the physician referred for in-center hemo-dialysis for the most recent year.
 - c. The estimated number of patients [transfers from existing facilities and pre ESRD as well as respective zip code of residence that the physician will refer annually to the proposed facility within a 24-month period after project completion.
 - d. The referral letter must state that the referrals have not been used to support any other CON project pending or approved.
 - e. The statement that the information is true and correct to the best of the physicians' belief.
 - f. We need this information for each physician who is going to refer patients to the proposed facility. The letter needs to signed, dated and notarized.
9. Unnecessary Duplication of Service We need all facilities within 30 minutes identified. This information must be provided in this format:

Name of Facility	Map Quest Time	MapQuest Distance	Number of Stations	Number of Patients	Utilization
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10. We need for you to address Mal-distribution of Service 1110.1430 (c) (2)

11. It is unclear to us how an eleven [11] station ESRD facility can be established for \$762,000. Your project's uses and sources of funds statement does not have a line amount for architectural and engineering costs. We are assuming that an architect that is current with the Illinois Department of Public Health [IDPH] certification standards has not reviewed the proposed location of this facility before submittal of the application for permit. The proposed facility is required to meet current IDPH standards. Please explain why there are no costs for architectural and engineering fees.
12. Please provide an explanation of how the fair market value of the space and the fair market value of the dialysis machines were determined.
13. Please provide the expected payor mix of the proposed facility.

Payor Mix	# of Patients	Percentage of Revenue
Medicare Revenue		
Medicaid Revenue		
Private Pay Revenue		
Self Pay Revenue		
Charity Care		

14. One of the purposes of the Act is to assure the applicants have the financial resources to provide a proper standard of health care to the residents of the community. We need for you to complete the Tables below for the proposed project. We also need the assumptions that were used to calculate the projected information. Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

TABLE ONE Dialysis Care Center Oak Lawn, LLC Projected [Facility]			
	Year 1	Year 2	Year 3
# of Stations			
# of Treatments			
# of Patients			
Utilization Rate			
Net Patient Revenue			
Total Operating Expenses			
Net Profit or (Loss)			

TABLE TWO Projected Dialysis Care Center Oak Lawn, LLC			
	Year 1	Year 2	Year 3
Current Ratio			
Net Margin Percentage			
Percent Debt to Total Capitalization			
Projected Debt Service Coverage			
Days Cash on Hand			
Cushion Ratio			

TABLE THREE Projected Dialysis Care Center Holdings, LLC			
	Year 1	Year 2	Year 3
Current Ratio			
Net Margin Percentage			
Percent Debt to Total Capitalization			
Projected Debt Service Coverage			
Days Cash on Hand			
Cushion Ratio			

TABLE FOUR Projected Kidney Care Center			
	Year 1	Year 2	Year 3
Current Ratio			
Net Margin Percentage			
Percent Debt to Total Capitalization			
Projected Debt Service Coverage			
Days Cash on Hand			
Cushion Ratio			

Should you have any questions or concerns please contact Mike Constantino or George Roate at Mike.Constantino@illinois.gov or George.Roate@illinois.gov or 217.782.3516.

Sincerely,



Mike Constantino
Project Reviewer