STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

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

MEMO

RE: Public Hearing Report for Project #11-024 US Renal Care – Oak Brook

Date: July 11, 2011

Time: 1:30 PM

Place: Village of Downers Grove
801 Burlington Avenue Briarcliff
Downers Grove, Illinois

Public Hearing Officers: Courtney Avery, Administrator IHFSRB
Catherine Clark, Administrative Assistant IHFSRB

- 20 Individuals were attendance
- 10 Individuals did not provide testimony, 9 Individuals indicated support for the project, 1 individual did not provide a preference
- 10 Individuals spoke in support
- No One spoke in opposition

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) JENNIFER LINSNER

Address 4328 FOREST AVE.

City BROOKFIELD State IL Zip 60513

Signature Jennifer Linsner

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care) ADVANCED RENAL CARE

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

CRA

Name (*Please Print*) ANIS A. RAUF

Address 105 Covington i

City Oakbrook. State IL Zip 60523

Signature

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) Carrie L. Kopala PA-C (CRP)

Address 2340 S. Highland Ave #160

City Lombard State IL Zip 60148

Signature CKopala PA-C

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

Advanced Renal Care

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) Mohamed Ahmed

Address 333 Chestnut Street

City Hinsdale State IL Zip 60521

Signature

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

CRA

Name (*Please Print*) Debra Englen

Address 701 Indian Way

City St. Charles State IL Zip 60174

Signature Debra Englen

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) LAURA REGIS (CHA)

Address 1141 VINE ST

City NEW LENOX State IL Zip 60451

Signature LRegis

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

US RENAL CARE

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) Jeanne Petty

Address 6 Penny Royal Place

City Woodridge State IL Zip 60517

Signature Jeanne Petty

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

In Support/Testimony For U.S. Renal.

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) Amy B. Reab CNA

Address 2202 Brown Ct.

City Naperville State IL Zip 60565

Signature Amy Reab, RN, MS

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

CPA

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) Victoria Tucker

Address 305 E. Naperville RD

City Westmont State IL Zip 60559

Signature Victoria Tucker

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

US Renal Care

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STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

Public Hearing Form

Facility or Project Name: US Renal Care Oak Brook Dialysis

Project Number: 11-024

Date: July 11, 2011 **Time:** 1:30PM

TESTIMONY TO SUPPORT PROJECT

I. IDENTIFICATION

Name (*Please Print*) PHILIP R. O'CONNOR, PH.D (CRA)

Address 30 S. MICHIGAN AVE 7th Floor

City CHICAGO State IL Zip 60603

Signature Philip R. O'Connor

II. REPRESENTATION (*This section is to be filled if the witness is appearing on behalf of any group, organization or other entity.*)

Entity, Organization, etc. represented in this appearance (i.e., ABC Concerned Citizens for Health Care)

ILLINOIS HEALTH FACILITIES and SERVICES REVIEW BOARD
Public Hearing Register

Project: US Renal Care – Oak Brook Dialysis #11-024
Location: Village of Downers Grove, 801 Burlington Avenue

Date: July 11, 2011
Time: 1:30 PM

ATTENDANCE/NO TESTIMONY ON PROJECT

✓	#	NAME (PLEASE PRINT)	AGENCY, ORGANIZATION OR INSTITUTION REPRESENTED OR RESIDENT (PLEASE PRINT)	CITY (PLEASE PRINT)	(S) SUPPORT (O) OPPOSSED (N) NEUTRAL (PLEASE PRINT)
	1	Kathryn Stalmack	Polsinelli Shughart	Chicago	N
	2	Heather Zygadlo	Advanced Renal Care	Hinsdale	S
	3	Mayra Maldonado	Advanced Renal Care	Hinsdale	S
	4	Amanda Hunter	Advanced Renal Care	Hinsdale	S
	5	Elizabeth Lange	Advanced Renal Care	Hinsdale	S
	6	Humera Yousaf	Advanced Renal Care	Lombard	S
	7	Nancy Brizek			
	8	~~Melissa Hunt~~	~~Attorney~~		
	9	SHAWN MOON	U.S. RENAL	CHICAGO	S
	10	Michele Hoshall	US Renal	Chicago	S
	11	Rick MANISCALCO	US RENAL	"	S
	12				
	13				
	14				

Dr. Rauf Public Hearing Transcript

I am Dr. Anis Rauf. I am a native Chicagoan who grew up in the Chicago public school system. With hard work and dedication I was class valedictorian and was given an opportunity to train at Northwestern University in BME with a full scholarship where I first understood the concept of dialysis and developed a strong interest in the medical sciences. I completed medical school locally in Downers Grove at MWU. I completed my undergraduate training at UIC and then was fortunate enough to spend a year at the Mayo Clinic in Rochester, MN in the area of Critical Care. At Mayo Clinic I learned how the needs of the patient do truly come first as I personally observed how every single individual from the custodian to the world renown cardiovascular surgeon, Dr. Schaff always strive for true excellence in clinical medicine. The Mayo brother's frequently quote that "The best interest of the patient is the only interest to be considered." Because of strong family commitments and responsibilities I returned to the western suburbs of Chicago to pursue my dream of becoming a Nephrologist. After completing training, I tried very hard to secure a position in the area and I quickly learned that there was only one group in town and at that time they weren't looking to bring on another associate, because there was not a need. I felt that the community needed a choice for nephrology care and I went out and started my own clinical practice to bring the Mayo model of Care to the Western Suburbs in June of 2007. It was extremely difficult to obtain hospital privileges as well as dialysis unit privileges as a de novo nephrologist because of coverage issues and support from other physicians. However, I worked very hard and brought a choice to the area for nephrology services with a special skill set in critical care. I would say the wait times to see a nephrologist quickly diminished and overall quality improved as patients were attended to in an expedited fashion at all hours of the day or night. I quickly experienced first hand the explosive growth of my practice across several

hospital systems. I opened my first office in Lombard and quickly opened second and third offices in Hinsdale and Bolingbrook. As Adventist Bolingbrook Hospital opened its doors in early 2008, I was ready for my partner Dr. Mohammed Ahmed who joined me in June 2008. We have noted an explosive growth in the need for dialysis services, in part due to general population health characteristics, aging population, as well as better awareness for kidney disease and GFR. We also noted that many of our patients are of African Americans and Hispanics who have a different epidemiology for chronic kidney disease and end stage renal disease than the traditional North American populations. Peer reviewed literature demonstrates that Hispanic end stage renal disease rates are 130% that of Caucasian North Americans. African American rates are even higher. Diabetes prevalence is a major factor in these rates, but heart disease also contributes. We have led several discussions in community awareness seminars, CME events for primary care physicians as well as leading the National Kidney Foundation Kidney Mobile program in Bolingbrook in 2009.

I have witnessed the explosive growth in the need for dialysis services in our practice. In the past three years, our practice has grown nearly six fold from 322 patients in early 2007 to nearly 2,000 patients in 2010 and over 3,000 patients in early 2011, with the greatest areas of growth occurring in the Bolingbrook and Downers Grove communities. This explosive demand for nephrology services has caused my partner, Dr. Ahmed, and I to hire two additional health care professionals in order to provide the care our community requires. We hired Carrie Kapola PAC in late 2010 who round on all of our dialysis patients all over the area and we have recently hired Dr. Suneel Udani in 2011 who is a very well trained nephrologist from University of Chicago. Dr. Udani has a Masters in Public Health and we intend to incorporate his expertise to perform outcomes research in chronic kidney disease. I anticipate that we will hire at least 1-2

more nephrologists over the next year to keep up with all of the hospital and clinic area's we cover.

Over the past years, I have personally encountered several problems with access to the existing dialysis facilities. As our practice spans up to 7 hospitals and 8 dialysis units it is unusually difficult to keep our patients together on similar shifts because of chair availability. I have personally spoken with social workers who have been very frustrated with the difficulties associated with discharging patients from hospitals because of dialysis chair availabilities. Oftentimes, I have experienced that patients are denied access because they do not have working AV Fistula especially in Bolingbrook. Oftentimes many of these patients simply cannot sustain the AV Fistula procedure for a period of time or are too sick to get one and as a result stay longer in the hospital while they try to secure dialysis treatment. They often get put in farther away dialysis units which compromise patient choice and quality. We have documented the detailed steps it takes to admit a patient to the existing units as an outpatient and often times we are forced to admit these patients to the hospital unnecessarily. I believe all of these problems could be remedied if there was a choice in dialysis provider in the area. In the communities I serve, there is limited patient choice as to the provider of their dialysis services. In an area approximately 18 square miles, which includes 6 hospitals where we practice, there are about 14 dialysis centers. However, an overwhelming majority of those centers are operated by one dialysis provider, therefore limiting a patient's ability to choose between different providers. I feel that providing a second alternative to nephrology in this community has only improved patient and physician choice and I think a second dialysis provider in the area will do the same. My partner and I have met with several different providers over the past 4 years and believe that US Renal will bring quality, comfort and choice to our patients.

I believe it is critical that any nephrology practice or dialysis center place the patient and his informed freedom of choice as the paramount priority. Peer reviewed literature demonstrates that patients are much more satisfied with peritoneal dialysis than hemodialysis. Our group believes that every patient should have all options of dialysis that suit each patient's livelihood. I have personally witnessed that several of our patients were inappropriately solicited by dialysis staff while being dialyzed. I think under no circumstances should a provider try to disrupt the relationship between a physician and his patient and tell a patient to see another nephrologist that is more aligned with the dialysis center. Unfortunately, our group has had first hand experiences of this occurring in our area. We are proposing one out of three such centers to be established in Bolingbrook, the second to be in Downers Grove area and the third to be in Streamwood. This would easily provide a choice for patients and physicians to choose their preferred dialysis provider and ultimately quality of care will improve.

It is important for decision makers who have not been close to a friend or relative who is in a dialysis protocol to recognize the intrusive nature of the protocol. Patients go to a dialysis center three times a week. If the center is thirty minutes away that means a drive time of three hours per week and dialysis time of ten to twelve hours per week. If someone in the family must drive them, it is equally intrusive for the driver. It is a situation unlike most health care events; consequently convenience should be a factor. Our decision to locate our dialysis centers near our nephrology practices and nearby hospitals is related to providing this convenience to our patients and also for promoting quality care in our community. The close proximity of the proposed dialysis centers to our own practices will allow us to closely monitor the care of our patients and to be by their side quickly, should the need arise. By placing these dialysis centers near hospitals, we hope to provide a timely transition for patients from the inpatient setting to a more

convenient outpatient setting. Facilities in the Bolingbrook and Downers Grove areas are operating at near capacity for the past several months and we have personally experienced difficulty in placing our patients at these facilities when these are full. Oftentimes patients are put in alternative sites which are further away from their primary hospital and residences and further away from us making it much more difficult for us to round on them.

This will allow patients to get back to their lives more quickly and to start a routine and sustainable schedule of treatment. In promoting these quicker transitions from the inpatient to outpatient setting, we also hope to help the hospitals that serve our communities. Through my experience with my patients, I have seen the difficulty in scheduling inpatients for their outpatient dialysis services, which is required for their discharge from the hospital. By reducing the lengths of stay of individual patients, these hospitals will be able to provide their limited resources to a greater number of patients. We have support from the local hospitals for this project and I urge the board to approve this project.

Jennifer Linsner
Dialysis Patient

Testimony in support of Oak Brook facility

Good afternoon. I am here today to support U.S. Renal Care's application to build a dialysis center in Oak Brook. I urge this board to also support what is a much-needed critical project for dialysis patients like me in the area.

My name is Jennifer Linsner, and I have needed dialysis therapy since December when I became sick with a life-threatening illness. I feel fortunate and grateful to have had Dr. Ahmed's and Dr. Rauf's care and compassion during that very difficult time. From the beginning, they treated me with respect and made me feel well cared for. They discussed every step of my care and even took extra time to re-explain things I didn't understand. I have always felt valued as a patient in their care, and will continue seeing these very talented physicians.

The dialysis treatment I received at Fresenius, however, was a different experience. I didn't feel as if the nurses and technicians were on my team. I wasn't treated with respect or care, and they created an environment of negativity and stress that was not conducive to dialysis therapy. I was very unhappy and, like anyone in that situation, I looked for a different place to seek my treatment.

Sadly, there was not a single alternative. Even now when I look back, I get frustrated and disappointed that I did not have a choice as to where I sought dialysis. Because I am young and active, I have the benefit of dialyzing at home. But I think of the many, many other patients who are elderly or ill. They are truly stuck because they do not have a single alternative when it comes to where they dialyze. There is a growing need for the kind of alternative that U.S. Renal Care has proposed. Patients deserve – at the very least – a choice of where they seek treatment. That they don't have that choice now is a travesty.

I urge this board to approve U.S. Renal Care's application to open a dialysis center in Oak Brook. My experience with these doctors has been nothing but positive, and I am thrilled that I would be able to continue my care with them at this facility. Thank you for the opportunity to publicly support this important project.

Dr. Ahmed Public Hearing Transcript

My name is Dr. Mohammed Ahmed. I grew up in the Chicagoland area. I did my undergraduate work at the University of Chicago and medical school at Midwestern University, Chicago College of Osteopathic Medicine. I completed my General Medicine and Nephrology training at the Loyola University in Maywood. To further my understanding of caring for the critically ill pt, I embarked on a second fellowship at the Mayo Clinic in Rochester Minnesota. It is here that I learned that what enables Mayo Clinic perform world-class medicine having a passion for delivering the utmost care to each patient and to treat each patient how you would like to be treated. I have attempted to embody this philosophy in each of my patient interactions over the last three years. The last three years of Dr. Rauf and I embarking on the impossible feat of creating a successful practice from scratch have been the most challenging three years of my life. I have been through the most academically rigorous college experience in the US at the University of Chicago, completed two rigorous fellowships, and I must say these last three years have taken a profound toll on my personal and social lives. What has fueled my drive is knowing that each patient is getting the best care I can possibly provide. In every hospital where Dr. Rauf and I practice, there has been only one nephrology provider. Our entry into the DuPage county now provides a choice to patients; and with competition, the benefactors are the referring doctors and most importantly the patient. As outlined by Dr. Rauf, our practice has seen an explosive growth, not only because of the additional training we bring to the area, also due to the substantial demographic change in the community. The number of African Americans and Hispanic populations have grown substantially and the increased prevalence of diseases associated with end stage renal disease among those populations is causing very rapid growth in end stage renal disease service needs.

In putting together a plan for a facility to help deal with this issue, I have spent extensive time talking about those dialysis problems with other physicians, nurses, hospital discharge planners, patients and hospital management groups.

Several patients and social workers have reported access problems to me. Many of those problems probably relate to the robust need for existing station use. This growing, I might truly use the term exploding, need creates a situation where facility managers or owners establish rules for access that have a tragic effect on some patients. I cite three examples:

In May of 2011, I accepted into my care a patient with end stage COPD who requires a high amount continuous oxygen. Due to health related reasons, she recently moved to the Bolingbrook area to live under the care of her sister. This patient had multpile previous unsuccessful attempts to establish an AV Fistula, and at this time due to her advanced COPD, surgeons consider her to be a high surgical risk. The patient had requested to be transferred to a local dialysis provider and after several attempts for placement by a social worker, the patient herself, and my personal family members, was informed by the facility head nurse/manager that the medical director will not accept patients without an AV access. For this patient, this means that her sister must drive her thirty miles round trip thrice weekly and either wait four and a half hours for the duration of her treatment, or double her mileage by returning home for the wait. If this patient becomes sick on dialysis, she will be admitted to Silver Cross Hospital where I do not practice, and continuity of care is lost.

Another patient who has encountered similar difficulties suffers from Type II Diabetes Mellitus, peripheral vascular disease, hypertension and end stage renal disease. This patient has had multiple podiatric procedures for necrosis of the foot requiring several hospitalizations. This

patient had the surgical procedure for an AV Fistula with two subsequent revisions, all of which failed and is currently dialyzed with a permanent catheter at a dialysis facility requiring a drive of approximately twenty six miles round trip three times weekly for his dialysis treatments, again relying on a the help of a friend or family member due to his failing eye sight secondary to diabetes. Over the past two years, this patient has made multiple attempts for placement at a local dialysis facility to ease this burden, only to be turned away due to lack of an AV Fistula access. Again, when this patient has become ill on dialysis, he has been admitted to Edward Hospital, losing continuity of care of most of his Bolingbrook doctors which include such essential specialists as a cardiologist and his pulmonologis.

My last illustration is a patient with a diagnosis of end stage diabetic kidney disease. This patient lives in the Bolingbrook area and with difficulty commutes to a dialysis facility which is over twenty mile round trip drive. Over the past year and a half, this patient has unfortunately suffered from a recurrant severe abdominal pain associated with uncontrolled HTN and leaves her debilitated. She has had this pain during dialysis and dialysis has been cut short during these episodes. She has required to be admitted to the local hospital where she dialyses and has had multiple tests repeated and she has lost continuity with her primary care provider, her stomach specialist and her nephrologist. Furthermore, during when she has these episodes, she cannot drive the lengthy distance to be dialyzed at her current facility. Hence, she has missed dialysis for this reason and unfortunately has needed to dialyzed urgently at the Bolingbrook hospital, which is her community hospital. Although venous mapping has been completed and several attempts have been made to schedule surgery for an AV Fistula, to date this has not been possible due to the instability of the patient resulting in over twenty hospital admissions managing malignant hypertension and abdominal pain and urgent dialysis. These issues have

been addressed with the local dialysis provider to no avail, she is still not able to be transferred to the local dialysis facility because she does not have the desired dialysis access which this particular unit requires before a patient is transferred over to the facility, an AV fistula

My co-applicants and I have had discussions with hospital management both in Bolingbrook and throughout Health Service Area 7 where we practice. Physician based outpatient facilities do not often get widespread hospital support. In our case, we have found enthusiastic hospital support from several hospitals including Adventist Bolingbrook Hospital, Advocate Good Samaritan Hospital and St. Alexius Medical Center. I have no doubt that this support is based on the need for greater access. Delayed discharges, re-hospitalizations for dialysis, and loss of continuity for medically complex patients drive up hospital costs, place patients at risk for the management of resulting complications and potentially demean the self confidence level of patients. None of these are desirable; none are how medicine should be practiced. These are a few reasons why I believe our patients, our referring doctors, our nurses, and our growing community deserve a choice for a dialysis provider.

Carrie Kopala
Physician Assistant
Advanced Renal Care

Testimony in support of Oak Brook facility

Hello. My name is Carrie Kopala and I have been a physician assistant for 6 years, most recently at Advanced Renal Care. I am here to voice my support for a new U.S. Renal Care dialysis center in Oak Brook.

I have had the opportunity to work with a range of patients in need of dialysis therapy. Dialysis therapy, as you may know, is critical life-sustaining care that requires significant time and energy from patients. Patients typically visit a dialysis center three times a week, with each visit lasting three or four hours. For many, it truly becomes their second home. This treatment is also very intimate. That is why, as a care giver, patient comfort and care is my highest priority.

I am happy to support U.S. Renal Care's proposal to add a dialysis facility in Oak Brook. I believe that every patient should have a choice of where they dialyze, and too often they don't. Proximity to treatment is particularly important for dialysis patients. Many times they are elderly or ailing, and the frequent transportation takes a heavy toll on them. Introducing a closer, more convenient or simply preferred option would drastically improve patients' experience during their dialysis therapy.

I am encouraged by the proposal to open a dialysis treatment center in Oak Brook. Expanding options for treatment will truly give patients the choice they need. I urge this board to approve U.S. Renal Care's proposal for an Oak Brook facility. This new facility will expand access and provide patients a much-needed choice when it comes to the critical and life-sustaining care that so many people require. Thank you.

Debbie Engler
Registered Nurse
USRC

Testimony in support of Oak Brook facility

Hi, my name is Debbie Engler. I am a registered nurse employed by U.S. Renal Care in their Home Therapies program. I want to thank you for the opportunity to speak today. I have been a nurse for 20 years and have been in dialysis for the past eight years. I began the dialysis part of my career at a Davita unit in the small northwestern Illinois community of Freeport. I moved to the suburbs in 2005 when my husband was downsized from his engineering job at Honeywell. Why does the move to the suburbs matter?

Well, I have been looking for a place where the patient matters, where the patients were the most important part of the picture, and where we could give the care that we would want for our parents, grandparents or other people we genuinely cared about. I have worked at different companies in the area and have run into companies that don't put patients as the top priority. This goes from the top executives down to the personal caregivers.

I believe I have found the company where the patient really does come first. Dr. Rauf and Dr. Ahmed both work 24/7 and often give their personal cell phone numbers to patients and encourage them to call them directly. When was the last time your doctor did this for you? So, when they decided to open their units, I jumped at the chance to be part of their dreams of providing this type of personalized care.

This comes to the need for a U.S. Renal Care unit in the Oak Brook area. I believe our patients deserve the ability to choose where they want to get their dialysis care without the need to travel a significant distance from their homes. The only choice that they now have is a Fresenius Medical Care unit. I see no other choices for my patients other than to travel out of their communities. Dialysis care is very demanding of patients, and long travel times can be major barriers to wellness. I believe the patients in the Oak Brook area deserve a choice within their community.

Again, I want to thank you for the opportunity to speak to you regarding this matter. I urge you to approve USRC's application to open an Oak Brook dialysis facility.

Laura Regis
Registered Nurse
USRC Advanced Home Therapies

Testimony in support of Oak Brook facility

My name is Laura Regis. Thank you for the opportunity to support publicly U.S. Renal Care's application for an Oak Brook facility. As a registered nurse, I have had the opportunity to see first-hand what quality of care means to dialysis patients. I am also on the front lines, watching the demand for this kind of care grow. In order to meet this demand and provide a quality option to current patients, I believe an Oak Brook facility is the right choice.

An Oak Brook location would provide a convenient option for a countless number of patients. As you know, dialysis doesn't mean a clinic visit just once in a while. Patients come in three days a week and each visit they spend four or more hours there. Many times patients are elderly or very ill. Kidney failure does not discriminate. Although it occurs most frequently in the elderly, it can also happen to persons very young and persons at the prime of their lives. The needs of dialysis patients do not fit into a mold; all are as unique as the individuals affected by kidney disease. Dialysis patients in this area are seeking a choice in dialysis provider; one that offers treatment times that allows them to restore or maintain an acceptable quality of life. Many require treatment hours that will enable them to return to work to provide for families and remain productive members of society. The proposed US Renal Care Oak Brook facility would offer patients that choice.

As an adjunct faculty member of Lewis University's nursing program, I teach a workshop on Quality Improvement in Health Care. In this workshop we learn that quality is defined by the consumer. Insurance companies, doctors and patients alike are informed consumers looking at data regarding patient outcomes. US Renal Care data compares favorably to the higher quality performers in the dialysis industry. But the informed patients in this area that I have come to know are most concerned with customer service. They want to be treated as an individual with respect to their individual needs. US Renal Care and its' physicians are dedicated to the needs of our patients with customer service being our number one initiative. Without competition, quality and customer service stagnates. Our patients deserve a choice.

The dialysis population is growing, and I don't believe this community is currently prepared to manage that demand. With the existing provider offering limited choice of appointment times and many times documented prolonged hospital stays while patients await placement, our informed consumers are asking for dialysis provider choice.

Thank you for the opportunity to support this very important project. I urge the Illinois Health Care Planning Board to approve U.S. Renal Care's application to provide quality dialysis care in this Oak Brook location. Thank you.

Jeanne Petty
Registered Nurse

Testimony in support of Oak Brook facility

Good afternoon. Thank you for the opportunity to voice my support for a U.S. Renal Care facility in Oak Brook.

My name is Jeanne Petty, and I have been a registered nurse for 16 years. I have such a passion for providing quality care to people, and I am a staunch patient advocate. I am here today because, in my opinion, dialysis patients in the area are in desperate need of another option.

I am very concerned that there is not enough access for the many different kinds of dialysis patients in the region. Limited access to dialysis not only limits patient choice in dialysis provider but often delays the hospital discharge process which leaves ill patients' waiting until a dialysis clinic has room for them. This causes additional strain on the health care system as precious Medicare dollars are spent waiting for placement.

Patients have little choice of where they dialyze and when they have issues with customer service or they aren't able to get the quality of care they desire, their only option may be to travel outside of their community. With only one provider of dialysis service in the western suburbs, patient choice is sorely limited. Dialysis does not happen just once. Patients dialyze three times a week, and can be at a dialysis center for up to four hours each visit. For patients, traveling outside of their community, a distance can take a great toll on them, physically and financially.

Health care should be about the people we treat – not about the dollars they generate. I am very troubled by the detrimental impact the limited access has on patients. Introducing another option for patients will expand the access they have and improve the quality of care they receive. I see a real demand for this with my patients, and I am confident that they would utilize a new Oak Brook facility.

Again, thank you for the opportunity to voice my support for what I believe to be a crucial project. I am confident that the Illinois Health Care Planning Board will make the right decision by approving U.S. Renal Care's application to open an Oak Brook facility. Thank you.

Amy Reeb, RN, MS
Registered Nurse at Advocate Good Samaritan Hospital
Testimony in Support of Oak Book Dialysis Facility

Good afternoon. My name is Amy Reeb and I am a registered nurse at Advocate Good Samaritan Hospital in Downers Grove. I am here today because I sincerely support U.S. Renal's planned Oak Brook dialysis facility. This facility will help meet the growing dialysis need in the area. It will also provide options for patients needing dialysis.

Working at Good Samaritan Hospital for the past 6 years, I have witnessed first-hand the growing demand for patients needing dialysis in the area. Unfortunately, we as Americans are not getting any healthier. Diabetes is the leading cause of kidney disease, and it's impacting more and more people each year. Hypertension is an additional cause of kidney disease, and the rate of Americans being diagnosed each year continues to increase. We have to be able to keep up with this increased need by offering additional dialysis facilities to help accommodate patients.

Another important aspect of this project is that it will introduce another provider to the community which will give patients a choice about where and how they want to receive their treatment. Currently, patients don't have a choice in provider and they absolutely should. If you only have one option-it is not a true option.

In closing, I wish to reiterate my strong support for U.S. Renal's Oak Brook dialysis facility. There is clearly a growing need for more dialysis services in the area. The proposed facility would also give patients choice about where they receive care.

I encourage the state board to approve the application. Thank you for your time.

Vikki Tulcus
Dialysis Patient

Testimony in support of Oak Brook facility

My name is Vikki Tulcus, and I am here to testify in strong support of U.S. Renal Care's application to open a dialysis treatment facility in Oak Brook. Thank you for the opportunity to support this very important project.

For years, I have had the pleasure of working with Illinois Secretary of State Jesse White to promote organ and tissue donation in communities throughout the state. I have always been passionate about increasing awareness around this important issue, but it wasn't until several years ago when I became gravely ill, and as a result became a dialysis patient, that I understood first-hand what it is like to need life-sustaining care.

It was then that I realized how very limited the options are for dialysis care in the Chicago area. I am grateful to those who provided care in the months that I received in-center dialysis care. However, I quickly became dissatisfied with the quality of care available. I found that the clinic was frequently running late, that I would have to wait to be seen, and that there was a general lack of follow-through among the staff. More frustrating was that there was no other option.

I know that if there had been an alternative for me, I absolutely would have sought it out. It isn't right that dialysis patients, who are often already very sick, do not have the ability to choose where they dialyze. Before I was able to dialyze at home, I would spend a dozen hours or more a week at the dialysis center. That didn't include the time it took to also juggle a job and family life. Dialysis takes a toll on patients, and it is appalling to me that we do not have basic control over our own care due to the lack of options in the area. Everyone should have access to quality care, and right now dialysis patients don't.

Not only would a U.S. Renal Care facility in Oak Brook provide a quality option, but for me – and many others – it would also provide a much more convenient option. I currently live in Westmont, so my trips to see Dr. Ahmed and Dr. Rauf in Oak Brook would be a great help. I will be forever grateful to these two doctors who did nothing short of save my life. I am thrilled that I would be able to continue seeing them for care at the new U.S. Renal Care facility in Oak Brook.

Again, thank you for the opportunity to voice my support for what I believe to be a critical project. I urge you to approve U.S. Renal Care's application to open an Oak Brook facility. Thank you.

TESTIMONY OF PHILIP R. O'CONNOR, Ph.D.

TO THE ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

IN THE MATTER OF U.S. RENAL CARE OAK BROOK DIALYSIS

Introduction and Background

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

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

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

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

Framework for Consideration of a Certificate of Need

The standards for consideration by the Board of CoN applications stand in a middle ground between the sort of exclusive utility service territories or so-called "first-in-the-field" doctrine[1] that partially governs the granting or denial by the Illinois Commerce Commission of applications for certificates of public convenience and necessity on the one hand and on the other hand the granting or denial by the Department of Insurance of licenses for insurance companies to enter one or more lines of business and to operate within the State. In the utility situation, the focus is on preventing a costly and unnecessary duplication of fixed, non-mobile capital assets in an industry that is highly capital intensive. In the insurance regulatory situation, by contrast, the focus is mainly on the financial solidity of the applicant insurance company and its record of performance in other markets or lines of business, including their conduct with respect to policyholders. There is not an assessment of need or demand in the market, the assumption being that entry into the market should be a function of an individual insurer's perceptions of the market.

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

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

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

Key Issues to Consider

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

These issues are:

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

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

Patient Demand

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

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

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

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

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

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

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

Patient Access

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

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

There are various ways to consider improvements in patient access.

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

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

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

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

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

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

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

Patient Costs and Cost Shifting

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

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

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

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

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

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

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

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

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

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

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

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

Patient Options

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

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

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

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

Conclusion

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

ENDNOTES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1

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Phil.OConnor@PROactive-Strategies.net

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

Employment:

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

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

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

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

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

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

Director, Illinois Department of Insurance (1979 - 1982)

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

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

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

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

Public & Political Service, Corporate Boards (partial list)

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

Education

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

Academic

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

Appendix 2

HSA 7 Population by Race (2000 Census data)

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

HSA 7 Population by Race (2010 Census data)

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

HSA 7 Population by Race (2000-2010 Change)

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

*Cook County Excluding City of Chicago

HSA 9 Population by Race (2000 Census data)

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

HSA 9 Population by Race (2010 Census data)

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

HSA 9 Population by Race (2000-2010 Change)

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

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

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

Appendix 3

HSA7 HERFINDAHL-HIRSCHMAN INDEX CALCULATION

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

HSA9 HERFINDAHL-HIRSCHMAN INDEX CALCULATION

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