

STATE OF ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

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DOCKET NO: I-05	BOARD MEETING: October 30, 2018	PROJECT NO: 17-070	PROJECT COST:
FACILITY NAME: Dialysis Care Center Rockford		CITY: Rockford	Original: \$1,390,266 Modification:\$1,330,266
TYPE OF PROJECT:	Substantive		HSA: I

PROJECT DESCRIPTION: The Applicants (Dialysis Care Center Rockford, LLC and Dialysis Care Center Holdings, LLC) propose to establish a 12-station ESRD facility in 5,350 GSF of lease space at a cost of \$1,330,266. The expected completion date is December 30, 2019.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The Applicants propose to establish a 12-station ESRD facility in 5,350 GSF of lease space at a cost of \$1,330,266. The expected completion date is December 30, 2019.
- This project was deemed complete (December 8, 2017) before the new distance requirements (77 ILAC 1100.510(d)) became effective (March 7, 2018). Therefore, this Application is being reviewed with a Geographic Service Area (GSA) of 30 minutes, adjusted based on the location of the project.
- This project was modified on May 11, 2018 to remove the contingency cost from the cost of the project. Contingency costs are only applicable to projects that have new construction and/or modernization costs. This change is considered a Type B Modification that would not require a Notice for an Opportunity for a Public Hearing.
- This project was deferred from the June 5, 2018 State Board Meeting and received an Intent to Deny at the July 2018 State Board Meeting. At the July 2018 Meeting, the State Board requested the Applicants provide a Financial Audit of the DCC Holdings, LLC. That audit has been provided and is included at the end of this report.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- The applicants are proposing to establish a health care facility as defined by the Illinois Health Facilities Planning Act. (20 ILCS 3960/3)
- One of the objectives of the Health Facilities Planning Act is "to assess the financial burden to patients caused by unnecessary health care construction and modification. Evidence-based assessments, projections and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois. Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process." [20 ILCS 3960/2]

PUBLIC HEARING/COMMENT:

- A public hearing was offered in regard to the proposed project, but none was requested.
- Letters of support were received from Thomas P. McNamara, Mayor of Rockford and Alderman Joseph Chiarelli both stating in part:
 - "It is my understanding that the new facility will help address the growing need for dialysis services in the area, easing the burden on staff at existing clinics that are currently operating at or above capacity and make it easier for area patients to get the appropriate treatment options. Studies have also shown that access and continuity of care are especially important for chronic care patients, and that having a medical "home" helps reduce health care costs as well as medical complications. There is an urgent need of the dialysis services to this area as most of the area's population lack proper health insurance. This center will accommodate all patients regardless of their insurance status. Access to care is an important issue for me and my constituents. I am very attuned to our area's health care issues and dedicated to providing our community with sufficient medical access and, when possible, a better quality of life. I believe local, community-based medical facilities are vital as they allow residents to be near their homes and spend more time at work, with their loved ones or otherwise enjoying productive lives."
- One letter of opposition was received from DaVita Inc. that stated in part: "Dialysis Care Centers has presented five projects before the HFSRB. In its presentations, its representatives position its projects as "respite" facilities needed for patients who nearly exclusively use a home modality but need in-center care for limited reasons, noting "[a]t our core

we're a PD company; we're a home dialysis company." They claim a specialty dedicated facility is

needed when their home peritoneal patients require in-center hemodialysis for a period of time whether due to infection or a home hemodialysis care giver needs a break. Further, they assert when temporarily placed at in-center dialysis facility their patients are told they cannot return to a home modality. This is patently false. DaVita embraces home modalities as optimal therapies both in terms of quality of care and life and cost. It is committed to home modalities and increasing the number of patients on peritoneal dialysis ("PD") and home hemodialysis. In 2017, DaVita served over 23,000 home hemodialysis and PD patients, more than any other provider in the United States."...."Dialysis Care Centers is rapidly expanding in Illinois representing that it offers a unique method and high quality services. In fact, throughout its application, Dialysis Care Centers states that quality care is its first priority. Neither the application for DCC Rockford or the information on its website, however, discusses quality or innovative care models for in-center dialysis. The company's public information is limited to the descriptions of types of machines used for the various dialysis modalities, function of the kidneys and why they fail, what is chronic kidney disease, signs of ESRD, and when dialysis is needed. DCC Rockford also suggests that it has a special mode of care called Staff Enhanced home hemodialysis. First, as indicated by its name the model is for home dialysis which Dialysis Care Centers already offers in Rockford. Further, staff assistance in the home is not covered by government payors and 90% of patients listed for HSA I in 2016 am covered by government sponsored insurance products."

SUMMARY:

- The State Board has estimated an <u>excess of 4 ESRD stations in the HSA I ESRD Planning Area</u>, per the September 2018 ESRD Inventory Update.
- The Applicants identified 58 patients that are currently on home dialysis. In accordance with the rules, the State Board Staff did not accept these patients as historical referrals and these patients have not been considered when evaluating the need for this project.
- The applicants addressed a total of twenty one (21) criteria and have failed to adequately address the following:

Criteria	Reasons for Non-Compliance
77 ILAC 1110.234 (b) Projected Utilization	The Applicants project 58 patients will utilize the
	proposed facility within two years after project
	completion. However, the historical referrals (19
	patients) do not justify the number of stations being
	requested by the Applicants. [By rule the number of
	projected referrals cannot exceed the number of
	historical referrals. [77 ILAC 1110.1430 (c)] The Board
	Staff notes the Applicants did not provide the zip code
	of residence for the projected referrals as required.
77 ILAC 1110.234(e) – Assurances	While the Applicants did provide the necessary
77 ILAC 1110.1430(j) - Assurances	attestation that the proposed facility will be at target
3,	occupancy within two years after project completion as
	required the Applicants historical referrals did not
	support the Applicants reaching target occupancy within
	2-years after project completion.

Criteria	Reasons for Non-Compliance
77 ILAC 1110.1430(c) (1), (2), (3) & (5) - Planning	An excess of 4 ESRD stations exist in the HSA-I
Area Need	planning area and there is not a service access issue in
	this planning area as the five of the seven facilities
	within 30 minutes are not at target occupancy with the
	seven facilities averaging approximately 65%
	utilization. Additionally, the number of projected
	referrals exceeds the number of historical referrals of the
	two nephrologists identified to refer patients to the
	proposed facility. Based upon the historical referrals it
	does not appear that the Applicants have a sufficient
	number of patients to justify the number of stations
	requested.
77 ILAC 1110.1430(d)(1), (2), (3) – Unnecessary	There are seven facilities within 30 minutes and all have
Duplication of Service-Mal-distribution of Service	been operating for two years or more. Of these seven
Impact on Other	facilities two facilities are at the target occupancy of
•	80%. Average utilization of these seven facilities is
	approximately 65%.

STATE BOARD STAFF REPORT

Project 17-070

Dialysis Care Center Rockford

APPLICATION/CHRONOLOGY/SUMMARY			
Applicants(s)	Dialysis Care Center Rockford, LLC,		
	Dialysis Care Center Holdings, LLC		
Facility Name	Dialysis Care Center Rockford		
Location	657 Highgrove Place, Rockford, Illinois		
Permit Holder	Dialysis Care Center Rockford, LLC,		
	Dialysis Care Center Holdings, LLC		
Operating Entity	Dialysis Care Center Rockford, LLC		
Owner of Site	Perryville Center, LLC		
Total GSF	5,350 GSF		
Application Received	December 5, 2017		
Application Deemed Complete	December 8, 2017		
Review Period Ends	April 7, 2018		
Financial Commitment Date	October 30, 2019		
Project Completion Date	December 30, 2019		
Review Period Extended by the State Board Staff?	No		
Can the applicants request a deferral?	Yes		
Received an Intent to Deny?	Yes		

I. Project Description

The Applicants propose to establish a 12-station ESRD facility in 5,350 GSF of lease space at a cost of \$1,330,266. The expected completion date is December 30, 2019.

II. Summary of Findings

- **A.** State Board Staff finds the proposed project does <u>not</u> appear to be in conformance with the provisions of 77 ILAC 1100 (Part 1110).
- **B.** State Board Staff finds the proposed project appears to be in conformance with the provisions of 77 ILAC 1120 (Part 1120).

III. General Information

Dialysis Care Center Rockford, LLC and Dialysis Care Center Holdings, LLC are both 100% physician owned and operated. The two physicians below equally own the two entities:

- 1. Morufu Alausa M.D.
- 2. Sameer M. Shafi M.D.

Financial commitment will occur after permit issuance. This project is a substantive project subject to a Part 1110 and 1120 review.

Dialysis Care Center Holdings, LLC has been approved by the State Board for the following dialysis projects:

- In October of 2016, the State Board approved Permit #16-020 Dialysis Care Center Oak Lawn to establish an 11-station ESRD facility at a cost of the \$762,000. Dialysis Care Center Oak Lawn just had an Illinois Department of Health (IDPH) survey sent to Medicare for approval January of 2018.
- In October of 2016, the State Board approved Permit #16-022 Dialysis Care Center Olympia Fields to establish an 11-station ESRD facility at a cost of \$992,000. Dialysis Care Center Olympia Fields had an IDPH survey awaiting Plan of Correction before recommending to Medicare.
- **In June of 2017**, the State Board approved Permit #16-058 Dialysis Care Center McHenry to establish a 14-station ESRD facility at a cost of \$1,215,000.
- **In February of 2018**, the State Board approved Permit #17-052 Dialysis Care Center Beverly to establish a 12-station ESRD facility at a cost of \$1,609,752.
- **In June of 2018**, the State Board approved Permit #17-061 to establish a 14-station ESRD facility in Elgin at a cost of \$1,459,570.

As of December 2017 <u>Dialysis Care Center Holdings LLC</u> provided dialysis through 29 independent dialysis clinics in 9 different states (Illinois, Indiana, Ohio, Tennessee, Pennsylvania, Missouri, Kansas, and Michigan). Nineteen of these clinics are under the Home Dialysis Services, LLC brand and 10 are under the Dialysis Care Center brand.

IV. <u>Health Planning Area</u>

The proposed facility will be located in the HSA I ESRD Planning Area. This planning area includes the counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, and Winnebago. As of <u>September 2018 the State Board is estimating an excess of 4 stations in the planning area.</u>

The five-year need determination is a <u>short-term assessment</u> that applies to the planning area need requirements in the 77 Ill. Adm. Code 1110 category of service review criteria. The in-center hemodialysis or end stage renal disease (ESRD) station need is a five-year projection from the base year. The need for additional treatment stations is projected utilizing the following methodology. [77 ILAC 1100.630 - In-Center Hemodialysis Category of Service]

TABLE ONE				
Need Methodology HSA XI ESRD Planning Area				
Planning Area Population – 2015	673,500			
In Station ESRD patients -2015	694			
Area Use Rate 2015 (1)	.975			
Planning Area Population – 2020 (Est.)	711,700			
Projected Patients – 2020 (2)	694			
Adjustment	1.33x			
Patients Adjusted	923			
Projected Treatments – 2020 (3)	143,991			
Existing Stations	196			
Stations Needed-2020	192			
Number of Stations in Excess	4			

- Usage rate determined by dividing the number of in-station ESRD patients in the planning area by the 2015 planning area population per thousand.
- 2. Projected patients calculated by taking the 2020 projected population per thousand x the area use rate. Projected patients are increased by 1.33 for the total projected patients.
- 3. Projected treatments are the number of patients adjusted x 156 treatments per year per patient

V. Project Costs and Sources of Funds

The Applicants are funding the project with cash of \$496,000 and the FMV of leased space in the amount of \$865,266. The operating deficit and start-up costs are approximately \$834,644.

TABLE TWO
Project Costs and Sources of Funds

	Reviewable	Total	% of Total	Reviewable	Total	% of Total
	Orig	ginal Applicatio	n	N	Modification	
Contingencies	\$60,000	\$60,000	4.30%	\$0	\$0	0.00%
Architectural and Engineering Fees	\$45,000	\$45,000	3.30%	\$45,000	\$45,000	3.30%
Movable or Other Equipment	\$420,000	\$420,000	30.20%	\$420,000	\$420,000	30.20%
FMV of Leased Space	\$865,266	\$865,266	62.20%	\$865,266	\$865,266	62.20%
Total	\$1,390,266	\$1,390,266	100.00%	\$1,330,266	\$1,330,266	100.00%
Cash		\$556,000	39.90%		\$496,000	39.90%
FMV of Leased Space		\$865,266	60.10%		\$865,266	60.10%
Total		\$1,421,266	100.00%		\$1,361,266	100.00%

State Board Staff Notes: Of the 62 facilities approved by the State Board for years 2014-2018 the average project cost was \$4.3 million. The average cost for the six facilities submitted by the Applicants (Permit #16-020, #16-022 #16-058, #17-052, #17-061, and #17-070) was \$1,232,598. On average over the past four years (2014-2018) the cost per station of the 62 ESRD facilities approved to be established was approximately \$309,000 per station. The Applicants six facilities are not included in the cost per station for the 62 facilities. For the Applicants' six facilities, the average cost per station was \$41,652.

VI. Background of the Applicants

A) Criterion 1110.1430 (b) (1) & (3) – Background of the Applicants

An applicant must demonstrate that it is fit, willing and able, and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. To demonstrate compliance with this criterion the applicants must provide:

- A) A listing of all health care facilities currently owned and/or operated by the applicant in Illinois or elsewhere, including licensing, certification and accreditation identification numbers, as applicable;
- B) A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility;
- C) Authorization permitting HFSRB and IDPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide the authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.
- D) An attestation that the applicants have not had *adverse action*¹ taken against any facility they own or operate or a listing of all adverse action taken.
 - 1. The applicants attested that there has been no adverse action taken against any of the facilities owned or operated by Dialysis Care Center Rockford, LLC and Dialysis Care Center Holdings, LLC during the three (3) years prior to filing the application. [Application for Permit page 83-86]
 - 2. The applicants authorized the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to have access to any documents necessary to verify information submitted in connection to the applicants' certificate of need to establish a twelve-station ESRD facility. The authorization includes, but is 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. [Application for Permit pages 85-86]
 - 3. The site is owned by Perryville Center, LLC and evidence of this can be found at page 31-71 of the application for permit in the Letter of Intent to lease the property at 657 Highgrove Place, Rockford, Illinois.
 - 4. The applicants provided evidence that they were in compliance with Executive Order #2006-05 that requires all State Agencies responsible for regulating or <u>permitting development</u> within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order. State Agencies engaged in planning

¹ "Adverse action is defined as a disciplinary action taken by IDPH, CMMS, or any other State or federal agency against a person or entity that owns or operates or owns and operates a licensed or Medicare or Medicaid certified healthcare facility in the State of Illinois. These actions include, but are not limited to, all Type "A" and Type "AA" violations." (77 IAC 1130.140)

programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order.

5. The proposed location of the ESRD facility is in compliance with the Illinois State Agency Historic Resources Preservation Act which requires all State Agencies in consultation with the Director of Historic Preservation, institute procedures to ensure that State projects consider the preservation and enhancement of both State owned and non-State owned historic resources (20 ILCS 3420/1).

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION BACKGROUND OF THE APPLICANTS (77 ILAC 1110.1430 (b) (1) & (3))

VII. Purpose of the Project, Safety Net Impact, Alternatives to the Proposed Project

These three (3) criteria are for informational purposes only.

A) Criterion 1110.230 (a) – Purpose of the Project

To demonstrate compliance with this criterion the applicants must document that the project will provide health services that improve the health care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other area, per the applicant's definition.

"The purpose of this project is to create more life-sustaining dialysis accessibility to the large, growing population of ESRD patients in the HSA 1 market area - specifically, Rockford and Winnebago County residents. The sole provider of dialysis in Rockford, IL is DaVita Dialysis. Specifically considering the location we are proposing in central Rockford, there are no providers other than DaVita within a 30-minute drive. This monopoly in the Rockford area prevents dialysis-dependent individuals any agency in their healthcare. As most patients spend 12 hours per week on average dialyzing in-center, this restriction is significant as it denies patients a choice in where they are receiving treatment that will determine their quality and longevity of life. To allow this monopoly to continue in the Rockford area will negatively affect the health and wellness of this community. The addition of Dialysis Care Center Rockford in this community will provide additional treatment options for patients in the specific market area, as well as for patients in Winnebago County overall, and other surrounding cities. The market area to be served by the applicant is approximately within a 20-mile radius of the proposed facility location. [Application for Permit page 87]

B) Criterion 1110.230 (b) - Safety Impact Statement

To demonstrate compliance with this criterion the applicants must document the safety net impact if any of the proposed project. Safety net services are the services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. [20 ILCS 3960/5.4]

A Safety Impact Statement was provided as required. [See end of this report]

C) Criterion 1110.230(c) – Alternatives to the Proposed Project

To demonstrate compliance with this criterion the applicants must document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

The Applicants considered three alternatives to the proposed project.

- 1. Project of Greater or Lesser Size/Scope/Cost
- 2. Pursuing a joint venture for the establishment of a new facility
- 3. Using existing facilities
- 1) The option of a project of lesser scope/cost was initially considered, but was later rejected because of its inability to address the over-utilization of existing facilities in the Rockford area. This option would cause the existing facilities to reach and eventually exceed their operational capacities, resulting in access issues in the service area. The proposed facility is a shell ready facility. By using this site, the costs for the project is significantly lowered compared to other ESRD projects brought before the Board.
- 2) The ownership of the proposed facility is structured to accommodate the option of joint ownership/joint venture in the future. The proposed facility will be owned/operated in its entirety by physicians practicing in the service area.
- 3) The option of utilizing existing facilities was determined to be the least feasible alternative, with no possible outcomes to improve patient access/service. The growing ESRD population in the Rockford/HSA-01 service area requires the introduction of additional ESRD stations/facilities. There are no physician-owned ESRD facilities in the area where the physicians have the independence they need. It is expected that the facility will exceed the clinical outcomes that meet all network Centers for Medicare and Medicaid Services clinical goals established.

Although the applicants gave equal consideration to the alternatives mentioned above, it was determined that the establishment of an additional 12-station ESRD facility (project cost: \$1,330,266), is the most practical and economical alternative for the service area. The applicants identified no project costs with the above-mentioned alternatives.

VIII. Size of the Project, Projected Utilization, and Assurances

A) Criterion 1110.234(a) –Size of the Project

To demonstrate compliance with this criterion the applicants must document that the size of the project is in conformance with State Board Standards published in Part 1110 Appendix B.

The applicants are proposing a 12-station ESRD facility in 5,350 GSF of space or approximately 446 GSF per station. This is within the State Board Standard of 650 GSF per station or a total of 7,800 GSF.

The State Board Staff would expect to see a 12-station facility with the following:

Reception Area
Patient Area
Support Area
Staff and Administrative Area
Total
500 GSF
2,960 GSF
2,100 GSF
1,440 GSF
Total

Source: (US Department of Veterans Affairs Office of Construction & Facilities Management)

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION SIZE OF THE PROJECT (77 ILAC 1110.234(a))

B) Criterion 1110.234(b) – Projected Utilization

To demonstrate compliance with this criterion the applicants must 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 Part 1110 Appendix B. The number of years projected shall not exceed the number of historical years documented.

The Applicants have identified 94 Stage IV pre-ESRD patients with lab values indicative of active kidney failure who live in the Rockford/HSA-01 service areas. The Applicants project that approximately 58 of these individuals will require dialysis services in the first two years after the Dialysis Care Center Rockford facility begins operations. However, the Applicants projected referrals exceed the historical referrals of 11 patients (see Table Five below). The Applicants have not met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT <u>NOT</u> IN CONFORMANCE WITH CRITERION PROJECTED UTILIZATION (77 ILAC 1110.234(b))

C) Criterion 1110.234 (e) - Assurances

To demonstrate compliance with this criterion the applicants must 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.

The necessary attestation has been provided at page 145 of the application for permit. However, the State Board Staff was unable to accept the attestation as the number of historical referrals does not support the number of projected referrals.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS <u>NOT</u> IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.234(e))

IX. In-Center Hemodialysis Projects

A) Criterion 1110.1430 (b) (1) (2) (3) (5) - Planning Area Need

To demonstrate compliance with this criterion the applicants must document that the number of stations to be established or added is necessary to serve the planning area's population.

1) 77 Ill. Adm. Code 1100 (Formula Calculation)

To demonstrate compliance with this sub-criterion the applicants must document that the number of stations to be established is in conformance with the projected station need.

The State Board is estimating <u>an excess of 4 ESRD stations by 2020 in the HSA-01</u> ESRD Planning Area per the September 2018 Inventory Update.

2) Service to Planning Area Residents

To demonstrate compliance with this sub-criterion the applicants must document that the primary purpose is to serve the residents of the planning area.

The Applicants have stated: "Dialysis Care Center Rockford will be located in HSA-01, the sole provider of dialysis in Rockford, IL is DaVita Dialysis. Specifically considering the location we are proposing in central Rockford, there are no providers other than DaVita within a 30-minute drive. This monopoly in the Rockford area prevents dialysis-dependent individuals any agency in their healthcare. As most patients spend 12 hours per week on average dialyzing in-center, this restriction is significant as it denies patients a choice in where they are receiving treatment that will determine their quality and longevity of life. To allow this monopoly to continue in the Rockford area will negatively affect the health and wellness of this community."

3) Service Demand – Establishment of In-Center Hemodialysis Service To demonstrate compliance with this sub-criterion the applicants must document that there is sufficient demand to justify the twelve stations being proposed.

The State Board requires that the projected referrals include the following information

- 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

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

The Applicants submitted one referral letter signed by Dr. Talal Mahmood, M.D., containing referral information for both himself and his colleague, Dr. Krishna Manda M.D., attesting to the provision of care to 94 Stage 4 pre-ESRD patients through the Kidney Care Center, Rockford. Dr. Mahmood estimates that approximately 58 of these patients will require in-center hemodialysis services by project completion (December 2019). Additional information provided shows the Applicants have referred patients to these facilities. As stated above, the projected referrals cannot exceed the historical referrals. For this Application for Permit, the projected referrals exceed the historical referrals.

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<u>State Board Staff Notes:</u> The Applicants identified 58 patients that are currently on Home Dialysis. The State Board Staff could not accept these patients as historical referrals and these patients have not been considered when evaluating the need for this project.

5) Service Accessibility

To demonstrated compliance with this sub-criterion the applicants must document that 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 must document one of the following:

- 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;
- iv) For purposes of this subsection (c) (5) only, all services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100.

- 1. There is no absence of the proposed service within the planning area as there are 15 existing dialysis facilities in the HSA I ESRD Planning Area.
- 2. There has been no evidence of the access limitations due to payor status of the patients.
- 3. There has been no evidence of restrictive admission policies of existing providers.
- 4. There has been no evidence that the area population and existing care system exhibits indicators of medical care problems.
- 5. There are 7 facilities within 30 minutes of the proposed facility (See Table at the end of this report)

In summary, the State Board has <u>estimated an excess of 4 stations in the HSA I ESRD Planning Area by 2020.</u> Additionally the Applicants have not documented sufficient historical referrals to warrant the number of stations being requested. Based on the State Board Staff's review of the information provided by the Applicants, it appears that the need for additional stations is based on the need to provide a choice of dialysis service providers in a perceived monopolized market held by DaVita. Because of the excess of stations and the lack of historical referrals, the Applicants have not met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT <u>NOT</u> IN CONFORMANCE WITH CRITERION PLANNING AREA NEED (77 ILAC 1110.1430 (b) (1), (2), (3) and (5))

TABLE FOUR				
Facilities with	in 30 minutes of	f proposed facility		

Facility	Ownership	City	Adjusted Time (1)	Stations (2)	Occupancy (3)	Star Rating ⁽⁴⁾	Met Standard?
Churchview Dialysis	Davita	Rockford	3.45	24	59.72%	4	No
Roxbury Dialysis	Davita	Rockford	4.6	16	89.58%	5	Yes
Belvidere Dialysis	Davita	Belvidere	11.5	12	45.83%	3	No
Stonecrest Dialysis	Davita	Rockford	12.65	12	97.22%	5	Yes
Machesney Park Dialysis	Davita	Machesney Park	16.1	12	61.11%	N/A	No
Rockford Memorial Hospital	DaVita	Rockford	23	22	70.45%	5	Yes
Forest City Rockford	DaVita	Rockford	28.75	12	27.78%	N/A	No
				110	64.58%		

- 1. Time determined by MapQuest and adjusted per 1.15 times.
- 2. Stations as of September 2018
- 3. Occupancy as of June 30, 2018

B) Criterion 1110.1430 (c) - Unnecessary Duplication/Mal-distribution

To demonstrate compliance with this criterion the applicants must document that the proposed project will not result in:

- 1. An unnecessary duplication of service
- 2. A mal-distribution of service
- 3. An impact on other area providers
- 1. To determine if there is an unnecessary duplication of service the State Board identifies all facilities within thirty (30) minutes and determines if there is existing capacity to accommodate the demand identified in the application for permit. There are seven facilities within 30 minutes of the proposed facility (See Table Above). Of these seven facilities two are at the target occupancy of 80% and the average utilization is 65%.
- 2. To determine a mal-distribution (i.e. surplus) of stations in the thirty (30) minute service area the State Board compares the ratio of the number of stations per population in the thirty (30) minute service area to the ratio of the number of stations in the State of Illinois to the population in the State of Illinois. To determine a surplus of stations the number of stations per resident in the thirty-minute service area must be 1.5 times the number of stations per resident in the State of Illinois.

	Population	Stations	Ratio
30 Minute Service Area	295,594	110	1 Station per every 2,687 residents
State of Illinois (2015 est.)	12,978,800	4,850	1 Station per every 2,676 residents

The population in the 30-minute service area is 295,594 residents. The number of stations in the 30-minute service area is 110. The ratio of stations to population is one (1) station per every 2,687 residents in this 30-minute service area. The number of stations in the State of Illinois is 4,850 stations (as of June 2018). The 2015 estimated population in the State of Illinois is 12,978,800 residents (Illinois Department of Public Health Office of Health Informatics Illinois Center for Health Statistics -

2014 Edition). The ratio of stations to population in the State of Illinois is one (1) station per every 2,676 residents. To have a surplus of stations in this thirty (30) minute service area the number of stations per population would need to be one (1) station per every 1,784 residents. Based upon this methodology there is no surplus of stations in this service area.

3. The applicants stated the following regarding the **impact on other facilities**. "The proposed dialysis facility will not have an adverse impact on existing facilities in the proposed geographic service area. All the identified patients will be referrals from identified physicians and are on pre-ESRD list. No patients will be transferred from other existing dialysis facilities. The proposed dialysis facility will not lower utilization of other area providers that are operating below the target utilization standard." Board Staff reiterates that the facility will be in HSA-01 where there is an excess of four stations based on the monthly updates to the Inventory of Health Care Facilities and Services as of April, 2018.

There are seven facilities within 30 minutes of the proposed facility (See Table Above). Of these seven facilities two are at the target occupancy of 80% and the average utilization is 65%. Based upon the State Board's methodology there is no surplus of stations in this 30-minute service area. Based upon the information provided and reviewed by the State Board Staff, the Applicants have not met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS NOT IN CONFORMANCE WITH CRITERION UNNECESSARY DUPLICATION OF SERVICE, MALDISTRIBUTION OF SERVICE IMPACT ON OTHER FACILITIES (77 ILAC 1110.230 (c) (1) (2) and (3))

C) Criterion 1110.230 (e) - Staffing

To demonstrate compliance with this criterion the applicants must document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and Joint Commission staffing requirements can be met.

The proposed facility will be staffed in accordance with all State and Medicare staffing requirements. Dr. Talal Mahmood M.D. will serve as the Medical Director for Dialysis Care Center Rockford, with Dr. Krishna Manda serving as staff physician. Physician curriculum vitas for both physicians were provided as required.

The Applicants stated the following:

"Upon opening, the facility will hire a Clinic Manager who is a Registered Nurse (RN). This nurse will have at least a minimum of twelve months experience in a hemodialysis center. Additionally, we will hire one Patient Care Technician (PCT). After we have more than one patient, we will hire another RN and another PCT. All personnel will undergo an orientation process, led by the Medical Director and experienced members of the nursing staff prior to participating in any patient care activities.

Upon opening we will also employ:

Part-Time Registered Dietician
Part-Time Registered Master Level Social Worker (MSW)

Part-Time Equipment Technician Part-Time Secretary

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

One Clinic Manager Four Registered Nurses Ten Patient Care Technicians

All patient care staff and licensed/registered professionals will meet the State of Illinois requirements. Any additional staff hired must also meet these requirements along with completing an orientation training program. Annually all clinical staff must complete OSHA training, compliance training, CPR certification, skills competency, CVC competency, water quality training and pass the competency exam. Dialysis Care Center Rockford will maintain at least a 4 to 1 patient-staff ratio at all times on the treatment floor. A RN will be at the facility at all times when the facility is operational."

<u>DaVita Inc. expressed concern</u> with this staffing plan and stated the following:

"The Medicare Conditions of Participation requires registered nurses to have "at least 12 months of experience in facility nursing, and [at least] an additional 3 months of experience in providing nursing care to patients on maintenance dialysis. Dialysis Care Centers has no in-center dialysis presence within Rockford or anywhere in Winnebago County. The only meaningful option to comply with the Medicare Conditions of Participation would be to recruit registered nurses from existing clinics in the area. In fact, Dialysis Care Center has already contacted DaVita teammates in the Rockford area about working at the proposed DCC Rockford facility."

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

D) Criterion 1110.1430(f) - Support Services

To demonstrate compliance with this criterion the applicants 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
- Provision of training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training provided at the proposed facility or the existence of a signed, written agreement for provision of these services with another facility.

The applicants provided the necessary attestation as required at page 120 of the application for permit.

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

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

To demonstrate compliance with this criterion the applicants must document that 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 facility will be located in the Rockford metropolitan statistical area ("MSA"). The applicants have met the requirements of this criterion.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION MINIMUM NUMBER OF STATIONS (77 ILAC 1110.230(g))

F) Criterion 1110.1430(h) - Continuity of Care

To demonstrate compliance with this criterion the applicants 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 provided a signed transfer agreement with Swedish American Hospital, Rockford. A positive finding results for this criterion

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

G) Criterion 1110.1430(j) - Assurances

To demonstrate compliance with this criterion the representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that:

- 1) By the second year of operation after the project completion, the applicant will achieve and maintain the utilization standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal; and
- 2) An applicant proposing to expand or relocate in-center hemodialysis stations will achieve and maintain compliance with the following adequacy of hemodialysis outcome measures for the latest 12-month period for which data are available: ≥ 85% of hemodialysis patient population achieves urea reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II 1.2.

The necessary attestation has been provided at page 145 of the application for permit. However, the State Board Staff was unable to accept the attestation as the number of historical referrals does not support the number of projected referrals.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT <u>NOT</u> IN CONFORMANCE WITH CRITERION ASSURANCES (77 ILAC 1110.230(j))

X. Financial Viability

A) Criterion 1120.120 – Availability of Funds

To demonstrate compliance with this criterion the applicants must document that the resources are available to fund the project.

The applicants are funding the project with cash of \$496,000 and the FMV of leased space in the amount of \$865,266. The lease is an operating lease to be paid over the life of the facility. At the July 2018 State Board Meeting, the Applicants were asked to provide an audited financial statement for DCC Holdings, LLC. That report is attached at the end of this report. Based upon that report the Applicants have in excess of \$11,000,000 in cash as of December 31, 2017. The Applicants have sufficient resources to fund this project.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IS IN CONFORMANCE WITH CRITERION AVAILABILITY OF FUNDS (77 ILAC 1120.120)

B) Criterion 1120.130 - Financial Viability

To document compliance with this criterion the applicants must document that they have a Bond Rating of "A" or better, they meet the State Board's financial ratio standards for the past three (3) fiscal years or the project will be funded from internal resources.

The applicants are funding the project with cash of \$496,000 and the FMV of leased space in the amount of \$865,266. The Applicants stated that approximately 64% of the revenue for this facility will come from Medicare, 3% from Medicaid and the balance from commercial insurance (33%).

Previously the Applicants provided projected financial ratios for the new entity (DCC-Rockford) and the historical information for DCC – Holdings, Inc. as required as well as supporting information. That information was not audited. As stated above, the Applicants provided a Financial Audit as requested by the State Board. Based upon this Audit the Applicants have qualified for the financial waiver².

The Board Staff notes that Medicare and Medicaid patients typically make up the largest percentage of patients served by a dialysis facility. CMS implemented an ESRD Prospective Payment System (PPS). Under the new ESRD PPS, Medicare pays dialysis facilities a bundled rate per treatment. The rate is not the same for each facility. Each facility, within a given geographic area, may receive the same base rate. However, there are a number of adjustments both at the facility and at patient-specific level that affects the

²Financial Viability Waiver

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

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.

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.

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.

final reimbursement rate each facility will receive. What a dialysis facility receives from its commercial payers will also vary. Even if two different dialysis providers billed the same commercial payer the same amount, the actual payment to each facility will depend on the negotiated discount rate obtained by the commercial payer from each individual provider. [Source CMS Website]

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

XI. Economic Feasibility

- A) Criterion 1120.140(a) Reasonableness of Financing Arrangements
- B) Criterion 1120.140(b) Terms of Debt Financing

To demonstrate compliance with these criteria the applicants must document that leasing of the space is reasonable. The State Board considers the leasing of space as debt financing.

The Applicants are funding the project with cash of \$496,000 and the FMV of leased space in the amount of \$865,266. The operating lease³ is considered debt financing under current State Board rule. The term of the lease is for ten years with no renewal options stated. The base rent is \$23.95 for the first year, with annual 2.5% increases for years six thru ten. The lease terms appears reasonable.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERIA REASONABLENESS OF FINANCING ARRANGEMENTS AND TERMS OF DEBT FINANCING (77 ILAC 1120.140 (a) & (b))

C) Criterion 1120.140(c) – Reasonableness of Project Costs

To demonstrate compliance with this criterion the applicants must document that the project costs are reasonable by the meeting the State Board Standards in Part 1120 Appendix A.

Some State Board Standards are not applicable to this project. The Applicants have submitted an Application for Permit that did not include costs for new construction or modernization. Contingency and Architectural and Engineering Fees are a percentage of new construction and modernization costs, and their applicability to the State Board standard is contingent upon New Construction/Modernization costs.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION REASONABLENESS OF PROJECT COSTS (77 ILAC 1120.140(c))

D) Criterion 1120.140(d) – Projected Operating Costs

To demonstrate compliance with this criterion the applicants must document that the projected direct annual operating costs for the first full fiscal year at target utilization but no more than two years

³ There are two ways of accounting for leases. In an <u>operating lease</u>, the lessor (or owner) transfers only the right to use the property to the lessee. At the end of the lease period, the lessee returns the property to the lessor. Since the lessee does not assume the risk of ownership, the lease expense is treated as an operating expense in the income statement and the lease does not affect the balance sheet. In a <u>capital lease</u>, the lessee assumes some of the risks of ownership and enjoys some of the benefits. Consequently, the lease, when signed, is recognized both as an asset and as a liability (for the lease payments) on the balance sheet. The firm gets to claim depreciation each year on the asset and also deducts the interest expense component of the lease payment each year. In general, capital leases recognize expenses sooner than equivalent operating leases.

following project completion. Direct costs mean the fully allocated costs of salaries, benefits and supplies for the service.

The applicants are projecting \$248.05 operating expense per treatment.

STATE BOARD STAFF FINDS THE PROPOSED PROJECT IN CONFORMANCE WITH CRITERION PROJECTED OPERATING COSTS (77 ILAC 1120.140(d))

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

To demonstrate compliance with this criterion the applicants must provide the total projected annual capital costs for the first full fiscal year at target utilization but no more than two years following project completion. Capital costs are defined as depreciation, amortization and interest expense.

The applicants are projecting capital costs of \$6.38 per treatment.

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

SAFETY NET IMPACT STATEMENT

The establishment of Dialysis Care Center Rockford will not have any impact on safety net services in the Rockford area. Outpatient dialysis facilities services are not typically considered or viewed as "safety net" services. As a result, the presence of Dialysis Care Center Rockford as a provider is not expected to alter the way any other healthcare providers function in the community.

Dialysis Care Center Rockford has no reason to believe that this project would have any adverse impact on any provider or health care system to cross-subsidize safety net services.

Dialysis Care Center Rockford will be committed to providing ESRD services to all patients with or without insurance or patients to no regards for source of payment. Dialysis Care Center Rockford will not refuse any patients. Medicaid patients wishing to be served at Dialysis Care Center Rockford will not be denied services. Because of the Medicare guidelines for qualification for ESRD, a few patients with ESRD are left uninsured for their care.

The policy of Dialysis Care Center Rockford is to provide services to all patients regardless of race, color, or national origin. Dialysis Care Center Rockford will provide services to patients with or without insurance, as well as to patients who may require assistance in determining source of payment. Dialysis Care Center will not refuse any patient. Medicaid patients wishing to be served will not be denied services. Through Medicare guidelines, patients who are prequalified for ESRD or for the few that are currently ESRD status and are left uninsured, Dialysis Care Center will be committed to providing continued care.

Dialysis Care Center Rockford will be committed to work with any patient to try and find any financial resources and any programs for which they may qualify for. Dialysis Care Center will be an "open dialysis unit" meaning through our policy, any nephrologists will be able to refer their patients and apply for privileges to round at the facility, if they desire. Dialysis Care Center will participate in American Kidney Fund (AKF) to assist patients with insurance premiums which will be at no cost to the patient. Currently, as Dialysis Care Center Rockford will be a new entity. There is no current charity documentation that can be provided to the board; however the charity policy has been provided.

The Applicants were asked to provide an update to concerns expressed at the April 17, 2018 State Board Meeting regarding their contract status with the following State of Illinois Managed Care Providers: [Applicants response in Italics]

For Option A – Statewide

- Blue Cross Blue Shield of Illinois Yes, Contracted with both Medicaid and dual eligible
- Harmony Health Plan Yes, submitted contracting application on 3/29/18; awaiting on approval from plan
- IlliniCare Health Plan Yes, submitted contracting application on 3/26/18; awaiting on approval from plan
- Meridian Health Yes, submitted contracting application on 3/28/18; awaiting on approval from plan
- Molina Healthcare of IL Yes, submitted contracting application on 3/29/18; awaiting on approval from plan

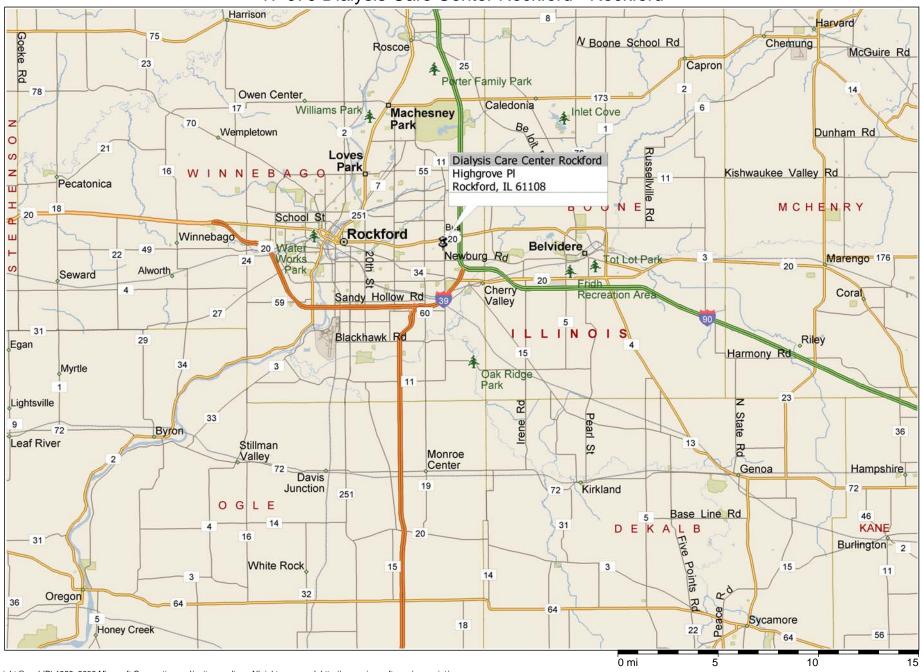
For Option B - Cook County Only

- CountyCare Health Plan Yes, submitted contracting application on 5/7/18; awaiting on approval from plan
- NextLevel Health. Yes, submitted contracting application on 3/27/18; awaiting on approval from plan

For DCFS Youth

• IlliniCare Health Plan – N/A as we do not currently accept Pediatric patients

17-070 Dialysis Care Center Rockford - Rockford



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DIALYSIS CARE CENTER HOLDINGS LLC & Subsidiaries

RECEIVED

OCT 02 2018

HEALTH FACILITIES & SERVICES REVIEW BOARD

Consolidated Financial Statements
For the year ended December 31, 2017
with
Report of Independent Auditor

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Member: IL CPA Society

INDEPENDENT AUDITOR'S REPORT

The Management
Dialysis Care Center Holdings LLC. & subsidiaries
15786 S Bell Rd
Homer Glen, IL 60491

We have audited the accompanying consolidated financial statement of Dialysis Care Center Holdings and subsidiaries which comprise the consolidated balance sheets as of December 31, 2017 and the related consolidated statements of operations, change in partnership capital, and cash flow for the year ended and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement; whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risk of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessment, the auditor considers internal control relevant to the entity's preparation of and fair presentation of the financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control.

Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the Consolidated financial position of Dialysis Care Center Holdings LLC and subsidiaries at December 31, 2017, and the consolidated results of their operations and their cash flows for the year then ended in conformity with United States generally accepted accounting principles.

Bashir Bello

Bashir Bello C.P.A. October 1, 2018

Dialysis Care Center Holdings LLC & Subsidiaries Consolidated Balance Sheets

For the Period Ended

1.0.	the remode and		
		Decembe	er 31, 2017
CURRENT ASSETS			
Cash & cash equivalent		\$ 11,053,394	
Prepaid expenses		79,033	
Account Receivable less allowar	ice for	. 5,555	
uncollectible accounts of \$535,6		4,365,160	
			\$ 15,497,587
FIXED ASSETS			
Property and equipment	Note	3,786,467	
Less: Accum Depreciation		(662,267)	
			3,124,200
OTHER ASSETS			
Deposit		43,355	
Due from related parties		4,742,411	
			4,785,766
TOTAL ASSETS			\$ 23,407,553
CURRENT LIABILITIES			
Account Payable		\$ 2,078,980	
Tax Payable		64,378	
			2,143,358
NONCURRENT LIABILITIES			
Due to third party payor		14,412,461	
Due to related parties		<u> </u>	
DADTHERS CARITAL			14,412,461
PARTNERS' CAPITAL			
Capital - Controlling Entity		(16,536,929)	
Capital - Non Controlling Entitle		(3,378,035)	
Retained Earnings	:5	23,594,345	
Net Income		3,172,353	
Net meome		3,172,333	6,851,734
			0,031,734
TOTAL LIABILITIES & PARTNERS	S' CAPITAI		\$ 23,407,553
. w read air in an ready the 1 2 to 1 1 Thilly			+ 10,101,000

Dialysis Care Center Holdings LLC & Subsidiaries Consolidated Statement of Operations

For the Period Ended

	December 31, 2017		
REVENUE			
Service revenue net of contractual allowance, discounts	\$	26,783,558	101%
Provision for uncollectible accounts		(321,403)	-1%
Total Income	\$	26,462,155	100%
EXPENSES			
Compensation, Related Taxes & Benefits		9,349,654	35%
Medical supplies & related cost		7,544,954	29%
Professional fees		229,637	1%
Rent and utilities		1,696,748	6%
Insurance		107,112	0%
Sales, general & administration		3,644,461	14%
Depreciation		226,302	1%
Total Expenses		22,798,868	86%
EARNINGS BEFORE TAXES		3,663,287.30	14%
State Corporation Tax		105,077	0%
CONSOLIDATED NET INCOME		3,558,210	13%
Non-Controlling Interest		385,857	1%
PROFIT ATTRIBUTABLE TO HOLDINGS	\$	3,172,353	12%

Home Dialysis Services Holdings LLC & Subsidiaries Consolidated Statement of Cash Flows

For the Year Ended December 31, 2017

Operating Activities:	
Net Income	\$ 3,172,353
Adjustments to reconcile changes in Net Income	
to net cash provided by operations:	
Tax payable	64,378
Depreciation	226,302
Due to/from related parties	(4,175,106)
Due to third party payor	14,414,360
Account payables	1,578,980
Accounts Receivable increase	(4,405,160)
Net cash provided by Operating Activities	10,876,107
Investing Activities:	
Purchase of property & equipment	(2,065,000)
Net cash provided (used) by Investing Activities	(2,065,000)
Financing Activities:	
Non controlling interest payment	(395,857)
Partners distribution	(2,542,165)
Net cash provided by Financing Activities	(2,938,022)
Net cash increase for the period	5,873,085
Cash at the beginning of period	5,180,309
Cash at the end of period	\$ 11,053,394

Note 1 - Nature of Business

As at December 2017 Dialysis Care Center Holdings LLC (DCC) provided medicare dialysis through 29 independent dialysis clinics/entities in 9 different states across USA (IL, IN, OH, TN, PA, MO, KS & MI).

19 of these clinics are under the Home Dialysis Services LLC (HDS) brand whilst 10 are under the newer Dialysis Care Center brand.

Additionally, Dialysis Care Center Holdings LLC (DCC) have morphed from a small dialysis provider to a rapidly growing mid-sized national dialysis company employing over 300 people.

Many diseases can lead to chronic kidney failure, particularly diabetes, chronic nephritis, and high blood pressure. There are currently two treatment options for chronic kidney failure - kidney transplant and dialysis. Dialysis Care Center Holdings LLC (DCC) is a kidney dialysis provider.

There are two types of dialysis treatments available & Dialysis Care Center Holdings LLC (DCC) handle both Hemodialysis and Peritoneal dialysis. In the case of Hemodialysis (HD), a hemodialysis machine controls the flow of blood from the patient through a special filter; the dialyzer while in the case of Peritoneal dialysis (PD), the patient's peritoneum is used as the dialyzing membrane.

Dialysis treatments are offered as Homedialysis treatments in specialized clinics for a vast majority of dialysis 88% globally. It requires the use of special products, hemodialysis machines and dialyzers (artificial kidneys) and is usually performed three times a week over a period of several hours by trained medical staff.

Today, Dialysis Care Center Holdings LLC (DCC) is the largest provider of staff assisted Home hemodialysis (HHD) in the midwestern part of the United States and the largest independent PD provider in the State of Illinois. In addition to dialysis treatments, Dialysis Care Center Holdings LLC (DCC) provide ESRD related laboratory services through a vendor - Ascend Laboratories for all their dialysis patients. Dialysis Care Center Holdings LLC (DCC) anticipate further growth in their business and plan to open and certify several new clinics before the end of 2018. Dialysis Care Center Holdings LLC (DCC) also remain on course to becoming one of the top providers of dialysis therapy in the United States by 2020.

Note 2 - Revenue Growth

Management believe that the key to continue growing revenue is to increase the number of treatments per clinic per year. Management have robustly developed their credentialing and contracting department which resulted in several in-network contracts executed by several payors.

PAYOR MIX ANALYSIS

Payor Type	% of Tmt	
Medicare	59%	
Commercial - (PPO, HMO, Others)	10%	
Medicaid	17%	
Medicare Advantage	9%	
Self Pay	5%	
Grand Total	100%	

Note 3 - Summary of Significant Accounting Principles

The following significant accounting policies have been followed in the preparation of the financial statements.

Accounting Standards

During 2009, the Financial Accounting Standards Board (FASB) Accounting Standard Codification (ASC), became effective and superceded prior existing financial accounting standards and is now the single source of authoritative US generally accepted accounting principles (GAAP). The codification does not change previous GAAP and accordingly, its adoption did not have a material impact on the Organization's consolidated financial statements.

Principles of Consolidation

The Consolidated financial statements as presented include all material intercompany accounts and transactions and this has been eliminated in consolidation as required by accounting principles generally accepted in the United States of America (GAAP). The scope of the elimination process includes both Dialysis Care Center Holdings LLC (DCC) and all subsidiaries intercompany balance while balance remaining relates to other Entities.

Variable Interest Entity

By design, the business template for Dialysis Care Center Holding LLC (DCC) expansion involves other Physicians as Joint Venture (JV) Partners. Therefore, each Partner qualify as a Variable Interest Entity (VIE) as defined by the Financial Accounting Standards Board (FASB). For 2017, the Net Profit attribtable to the VIE was \$0.386MM.

Income Taxes

The LLC is a for profit organization and recognized by the Internal Revenue Service as a Partnership Corporation. Therefore, it is not subject to Federal Income tax on entity level. However, all Net Income are deemed distributed to the Partners whether collected or not and are taxed at the Partner's level. In addition, the Holding LLC company is subject to State Corporate tax wherever the entity operates. A tax provision of \$0.105MM is estimated in 2017.

Use of Estimates

The preparation of consolidated financial statements in comformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures of assets and liabilities at the date of the consolidated financial statements and revenue and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

Accounts Receivable

Account receivable reflects the Net realisable amount after all contractual adjustments. In 2017, Adjusted AR is \$4.37MM. This amount reflects the balance after contractual and allowance adjustment.

The Company bills third-party payors or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed and patients are billed for deductibles. The carrying amounts of gross receivables are reduced by allowances that reflect management's estimate of the amounts that may not be collected.

Management estimates the collectibility of patient accounts receivable based on established contractual rates and on prior experience. Payors regularly review and updates their allowable payment levels, which can results in adjustments to amounts already billed.

The allowance for uncollectible accounts covers significant portion of the self pay accounts receivables.

Provision for Bad Debt

The Company provides for uncollectible amounts especially for uninsured patients through a bad debt adjustment. Based on their experience curve, Management allocates certain % to each type of out-of-network Insurance & Self-pay. A credit is recorded to the allowance for uncollectible accounts and a debit to Provision for Bad Debt Expense. Any collection efforts that results into cash payment usually go towards reducing the AR. The Billing Team regularly undertake AR review according to Company policy.

Due to Third Party Payor

Service Revenue is recognised when fully completed and recorded as Income.

BCBS of Illinois pays its contracted providers full billed charged for their services and then requires the provider to repay the excess typically within 30 days. This scenario results in HDS typically having several \$million in BCBS overpayments on hand on a monthly basis. These monies are paid back to BCBS and the real contracted dollars kept as revenue.

Related Party Transactions

There exist intra-party and inter-party transactions amongst related entities of the Consolidated Entities. In view of the interactions between JV Entities in terms of staff, materials & cashflow, there are related inter company transactions. For example, payroll processing is centralized under DCC Management LLC and reimbursable payroll cost distributed to each entity within the Consolidated Group.

Bank Loan - Line of Credit

The Company do not have any outstanding Loan or Line of Credit in effect.

Note Payable

The Company do not have any Note Payable or collaterized Account Receivable.

Retirement Plans

The Company operates a 401K Plan being adminstered by third party. Wells Fargo is the Investing entity. Each member may opt for self investing actions on stocks to buy & sell based on experience.

Capital Stocks/Units

Partnership Units are owned by all JV Parties while Holdings holds the controlling share in the Consolidated Entities.

Medical & Ancillary Supplies

Dialysis Care Center Holdings LLC (DCC) is able to provide dialysis treatments and laboratory services by partnering and securing contractual agreements with key suppliers in the industry.

The Company suppliers include Henry Schein, Fresenius, NXStage, Baxter, Ascend Labs and Tablo.

Management continue to negotiate the best possible and most competitive terms and prices from vendors with a view to providing affordable and sustainable quality care.

Building, Property and Equipments

Fixed assets are recorded at cost. 2017 Depreciation was \$226k.

Significant cost of improvement are capitalized as Building Improvement and repair cost are expensed as incurred. The cost of assets sold, retired or abandoned and the related accumulated depreciation and amortization (if intangible) are removed from the Assets List and any resulting gain or loss included in the Net Income.

Table of Property and Equipment

	Balance			Balance
	01-Jan-17	Additions	Write-offs	31-Dec-17
Leasehold Imp.	1,100,271	1,883,588	(1,899)	2,981,960
Furniture	152,819	17,114	-	169,933
Medical Equip	59,984	47,442	-	107,426
Computers	410,292	116,856	-	527,148
Total	1,723,366	2,065,000	(1,899)	3,786,467
Less: Accumulated Depreciation	(437,864)	(226,302)	1,899	(662,267)
Net Property and Equipment	1,290,401	1,833,799	_	3,124,200

Subsequent Events

Management evaluated subsequent events up to October 01, 2018, the date the financial statement were available to be issued. Events or transactions occuring after December 2017 but prior to October 01, 2018 that provided additional evidence about conditions that existed at December 31, 2017 have been recognized in the financial statement for the year ended.

Events or transactions that provided evidence about conditions that did not exist at December 31, 2017 but arose before the financial statements was available to be issued have not been recognized in the financial statement for the year ended. December 31, 2017.



Transcript of Open Session - Meeting

Date: July 24, 2018

Case: State of Illinois Health Facilities and Services Review Board

Planet Depos

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www.planetdepos.com

1	MR. MOUKHEIBER: Well, this shouldn't
2	happen, you guys. And I hope that you guys
3	approve the Geneva Commons [sic] dialysis center.
4	CHAIRMAN SEWELL: Thank you.
5	THE COURT REPORTER: Please leave your
6	remarks.
7	MS. MITCHELL: The last one for Geneva
8	Crossing Dialysis I apologize for this one
9	being out of order is Tara Kamradt. And for
10	Project 17-066 is Salima Din, Leon Sujata
11	Sujata. My apologies. Lynanne Hike for
12	Project 17-070 and, for Project 17-070, as well,
13	Charles Sweeney.
14	Since Ms. Kamradt's not here yet, Megan
15	Wilson, you may come up and speak, as well,
16	Project 17-070.
17	CHAIRMAN SEWELL: You may begin.
18	Anyone, go ahead.
19	DR. SWEENEY: I am Dr. Charles Sweeney.
20	I'm a nephrologist practicing in Rockford,
21	Illinois.
22	I oppose the DCC Rockford application,
23	Project 17-70. My colleague, Dr. Stim, presented
24	a dialysis clinic proposal for Rockford at your

1 last meeting in April. Our clinic proposal was 2 superior to the current DCC proposal before you 3 today in many respects, but it was denied due to 4 capacity at other clinics and an excess of 5 stations in the planning area. 6 I want to rebut three false narratives you 7 are hearing from DCC in marketing their company to 8 Number one, DCC is not unique in any way 9 because it promotes home dialysis. Number two, 10 respite dialysis is not administered in an outpatient dialysis clinic. It's provided in the 11 12 home training and support clinic, and DCC already offers this service in their Rockford clinic. 13 14 Number three, we do not solicit patients away from 15 DCC. We -- under any circumstances. 16 Over the past several months, DCC has held 17 itself out as having a care model that relies 18 primarily on home modalities. There is no doubt 19 among the members of the nephrology community that 20 home dialysis is a preferred modality to in-center 2.1 dialysis due to the quality of life and other 22 benefits. 23 DaVita Dialysis is an industry leader in 24 promoting home dialysis. DaVita's clinical

1	outcomes are at the top of the industry, as well;
2	however, many patients are incapable, unwilling,
3	or clinically ineligible for home dialysis.
4	Despite these barriers our care team is
5	committed to educating patients and encouraging
6	those who are clinically eligible and have the
7	requisite support and home environment to select a
8	home modality. Do not believe for a minute that
9	we, as nephrologists, prefer anything other than
10	home modalities.
11	As a DaVita medical staff member,
12	Dr. Mahmood currently already admits patients to
13	DaVita Dialysis units in Rockford for temporary
14	in-center dialysis. DCC nephrologists with
15	privileges continue to treat their patients there.
16	MR. ROATE: Two minutes.
17	DR. SWEENEY: Please oppose this proposal.
18	It is not needed and would provide duplication of
19	services already available.
20	Thank you.
21	CHAIRMAN SEWELL: Thank you.
22	DR. DIN: Good morning. My name is
23	Dr. Salima Din, and I'm a nephrologist with NANI
24	and the medical director of the DaVita Waukegan

1	CHAIRMAN SEWELL: Next is Item H-02,
2	Dialysis Care Center Rockford, to establish a
3	12-station ESRD facility in Rockford, HSA 1,
4	Project 17-070.
5	Is there a motion?
6	MEMBER JOHNSON: So moved.
7	CHAIRMAN SEWELL: Is there a second?
8	MEMBER MURPHY: Second.
9	CHAIRMAN SEWELL: Okay. Thank you.
10	Mr. Constantino.
11	MR. CONSTANTINO: Thank you, sir.
12	The Applicants propose to establish a
13	12-station ESRD facility in approximately
14	5400 gross square feet of leased space at a cost
15	of approximately \$1.3 million. The expected
16	completion date is December 30th, 2019.
17	This project was deferred from the
18	June 5th State Board meeting to this meeting
19	today. This project has been modified where the
20	cost of the project was reduced by approximately
21	\$60,000.
22	A public hearing was offered in regard to
23	this project but none was requested. We did
24	receive letters of support and, also, one letter

1 We do have findings related to of opposition. 2 this project. 3 I will note for the Board there is an 4 excess of four ESRD stations in HSA 1 planning 5 area per the June 2018 ESRD inventory update. We 6 also note that the Applicants are projecting 7 58 patients will be utilizing the proposed 8 facility within two years; however, they were unable to provide sufficient historical referrals 9 10 to justify that 58-patient number. 11 I would like to make a comment on the 12 financial viability. The Applicants did provide projected financial ratios for the new entity at 13 DCC Rockford, LLC, and historical financial 14 15 information for DCC Holdings, Inc., as required, 16 as well as supporting information. 17 They did provide a letter from a bank, and the State Board staff did discuss with the banker 18 19 at Chase Bank the amount of money that was in the 20 DCC Holdings, Inc., account, and it was in excess of \$10 million at that time. That was in 2.1 22 February of 2019 when we had the discussion with 2.3 Chase Bank. 2.4 MEMBER JOHNSON: 2018?

1	
1	MS. AVERY: 2018.
2	MR. CONSTANTINO: Sorry.
3	Thank you, sir.
4	CHAIRMAN SEWELL: All right. Thank you.
5	Would you state your name for the record,
6	and then they should be sworn in.
7	DR. SALAKO: Dr. Babajide Salako, CEO.
8	MR. SHAZZAD: Asim Shazzad, COO.
9	DR. MAHMOOD: Talal Mahmood, physician.
10	MR. SNOWWHITE: My name is John Snowwhite.
11	I'm the clinic manager and nurse.
12	MS. SMITH: Melissa Smith, area manager.
13	THE COURT REPORTER: Would you raise your
14	right hands, please.
15	(Five witnesses sworn.)
16	THE COURT REPORTER: Thank you. And
17	please print your names on the sheet.
18	Thank you.
19	CHAIRMAN SEWELL: All right.
20	Ms. Mitchell.
21	MS. MITCHELL: I just have a question.
22	I want to make sure it's a little
23	difficult to make out what's on there, so I want
24	to make sure it's not new information.

1	What exactly is on this?
2	MR. SHAZZAD: Oh, this is the most recent
3	HSA data that was sent June 30th by Mike
4	Constantino. It's just an update of the HSA data.
5	MS. MITCHELL: So this is something that's
6	already in the report?
7	MR. SHAZZAD: It's already in the report.
8	MS. MITCHELL: Okay. All right.
9	MR. SHAZZAD: It's not new.
10	MS. MITCHELL: Okay.
11	MR. SHAZZAD: Thank you.
12	MS. MITCHELL: Thank you.
13	CHAIRMAN SEWELL: Any comments for the
14	Board?
15	DR. SALAKO: Good morning, members of the
16	Board. Thank you for allowing us to speak.
17	You've heard a lot today about our project
18	in Rockford and the findings on the State agency
19	report. DaVita has come here today and made a lot
20	of opposition about our clinic, about our
21	business, and I think it is imperative for me to
22	clarify some of the nuances and innuendos that
23	they are suggesting.
24	One of the and I actually want

1 everybody to have an understanding of the dialysis 2 market in Illinois and nationwide. If you look at 3 the Rockford area, DaVita is the monopoly in the 4 Rockford area. It's a \$10 billion company. They 5 have seven clinics in Rockford. 6 We want to put a clinic in Rockford. 7 have strong physician support. We believe we 8 should be able to offer opposite -- we should give 9 the patients choice to be able to go to another 10 provider other than a DaVita clinic in Rockford, and that's why you see this fervent opposition to 11 12 our project and all these things about respite care and -- you know, we know -- everybody knows 13 14 that if you have respite care in the state of 15 Illinois, you have to go to an in-center. 16 can't do it at home. You know, we've had guidance 17 from the State before on this subject matter. You 18 have to go to the in-center. 19 So here we are. We have had previous 20 applications approved in this state. DaVita 2.1 hasn't opposed us but they've opposed us 22 vehemently in this particular project because they want to maintain their 100 percent monopoly in 23 2.4 Rockford. And I think we shouldn't take a

1 business competitive decision in front of the 2 Board. I think businesses should be able to 3 compete fairly and not use the Board as a tool to 4 be anticompetitive. 5 Now, with regards to the cost of our 6 projects, one of the things we have done -- we 7 hate to share our business strategies in public, 8 but I think we have to seek to come up here and 9 let everybody know. Most of the LDLs have a lot 10 of money. They have a way of getting the doctors 11 to be owners of their buildings and to build these 12 expensive clinics. 13 We don't build new things from the ground We rent space. We talk to our landlords to 14 up. 15 say, "Hey, listen. Can you do the capital 16 improvement on this project and amortize it in our 17 rent over 15 years?" So we don't have this huge 18 capital outlay to do a project at the beginning, 19 spending \$2 million to buy the land, to build it, the brick and mortar. We don't do that. 20 2.1 We get -- "You have the space; we'll rent 22 If you do the build-out for this it from you. project, we will -- you'll increase the rent by so 23 24 many basis points, and we'll" -- so it -- we're

1 able to save a ton of money. Okay? 2 We have cash. Even -- either way, a privately held company, we're willing to escrow 3 4 the money into different accounts for each project 5 so the State can see that the money's there to be 6 spent on these projects. We have \$10 million to 7 spend on five projects this year. It's money from 8 our other profitable businesses we'll put in a 9 bank account. We don't want to come here to discuss our 10 business strategy. We want to be able to prove to 11 12 the State that we're capable of running dialysis clinics. Our clinics are opened; they've been 13 certified by the State. You will hear about the 14 15 costs today. Most of our clinics that are already 16 open within six months have 80 percent 17 utilization. We're doing something right. 18 And I think it's -- it's very unnerving and really unsettling that a \$10 billion company 19 20 is going to come here and try to bully, 2.1 misrepresent a small, growing, Illinois-owned, 22 physician-owned and -managed company. And you can see from the board DaVita owns the Rockford area. 2.3 2.4 They run seven clinics there.

1	We want the patients to have choices. My
2	physicians, my staff will talk about the other
3	things that are related to this project, but
4	I think it's fair for everybody to understand
5	where this is coming from. In other areas where
6	they did not have a monopoly in our other
7	projects, you didn't hear DaVita coming here
8	saying, "Oh, their projects are cheaper; oh, their
9	projects are this; oh, their projects are that."
10	In Rockford they want to maintain 100 percent
11	monopoly, and it is just it just doesn't make
12	any sense.
13	So I'll hand it over to Dr. Talal Mahmood.
14	He's going to be my medical director.
15	DR. MAHMOOD: Thank you very much.
16	Good morning, everybody.
17	So I want to basically emphasize the fact
18	from the patient aspect. So, you know, patient,
19	if they are not satisfied with the care they're
20	getting through a medical, you know, facility,
21	they lose their ability to you know, for
22	compliance, their you know their lifestyle,
23	their well-being, overall well-being.
24	So there have been instances where

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1
    patients were not happy with the care DaVita is
2
    providing so -- you know, as Dr. Salako said,
    DaVita is the sole provider in the Rockford area,
3
4
    and patients had to travel an hour one way to a
5
    different facility -- let's say in Elgin.
6
    a Fresenius facility over there to do dialysis.
7
            So imagine, you know, there is already a
8
    burden of doing dialysis three times a week, and
9
    you have to travel roughly two hours for those
10
     three times a week to get the care you -- you
    know, you can get locally if -- but you are not
11
12
    happy with the care, another instance where a
    patient was not happy with the care and he was
13
14
    missing treatment. So if you are not happy with
15
    the care, you're missing treatments, you are
16
    basically -- it can be life-threatening, you know.
17
    So that will be the basic, you know, emphasis from
18
    the patient aspect.
19
            Now, from the physician aspect, you
20
    know -- DaVita is a big company.
2.1
    physician -- the physician voice not heard over
22
    there. If I work with a company which is
23
    physician-owned and -managed, you have a say in
24
    hiring the staff; you have a say in, you know,
```

1 quality and day-to-day operations of the facility; 2 and you can provide better care to the patients. 3 And, lastly, you know, as we have a robust 4 home care program, there have been instances 5 where, if I have to transfer the patient to a 6 DaVita facility temporarily for hemodialysis, 7 I have lost patients from home care because, you 8 know, they don't get the acknowledgement, the 9 support they have, you know, in the home program. 10 So with this facility we will be able to get the patients back in home care. You know, as 11 12 we all know, home care is better for lifestyle. 13 They're -- you know, they can continue doing their jobs, you know, so it will be better for overall 14 15 patient care. 16 MR. SNOWWHITE: We have a very robust home 17 dialysis program in Rockford, and over the last 18 2 1/2 years our census has grown over 150 percent. 19 Providing a continuum of care is vital to 20 the dialysis patient. It takes time to develop a 2.1 trust in the health care team for these patients. 22 Many dialysis patients will at some point in time 23 choose in-center hemodialysis either out of 24 necessity or for convenience. For these patients

1 to truly exercise their autonomy, they should have 2 the opportunity to continue their relationships 3 with their health care team. Rockford is the third largest city in 4 5 Illinois. DaVita has a monopoly on in-center 6 dialysis in Rockford. There simply are no other 7 choices for in-center dialysis in the Rockford 8 area. Dialysis patients deserve to have a voice 9 in who provides their ongoing care. 10 CHAIRMAN SEWELL: All right. MR. SHAZZAD: I'm just going to address 11 12 the SAR report a little bit. The first finding was the project 13 utilization. It said that we did not meet that 14 criteria. I believe we did. A lot of our 15 16 patients are home-based, as discussed throughout, 17 so the State does not take any home dialysis 18 referrals or does not count those. They only take 19 in-center referrals, so that's the reason why we didn't meet that criteria. We have a lot of 20 patients in Rockford. We're the third largest 2.1 22 home dialysis provider in the state of Illinois. 23 The second thing is the access in HSA 1. 2.4 There were four excess stations. I understand

1	that. HSA 1 is almost 90 percent dominated by
2	DaVita, as you see on the board. There are no
3	other options. DaVita is running a monopoly in
4	HSA 1, and we just want to offer patient choices
5	and a different option.
6	And that's about it. I think Mike
7	answered the financial viability.
8	DR. SALAKO: And I want to say that we've
9	shown in our clinics that are already open, that
10	opened earlier this year and in our other records,
11	that when we opened and several of our new
12	clinics that are coming up as other people see
13	that there's a new provider in town, folks are
14	coming there and saying, "Listen. When are you
15	going to open?"
16	When we talk about the other projects
17	later today, you'll see that we've been able to
18	aggressively get people who have wanted other
19	options, shifts that make sense for them, to come
20	work to dialyze in our clinics. And I truly
21	believe that this is an opportunity for us to,
22	once again, be of service to the community.
23	CHAIRMAN SEWELL: Okay. Thank you.
24	Mr. Constantino, on the 1120 criteria, the

1	financial viability
2	MR. CONSTANTINO: Yes.
3	CHAIRMAN SEWELL: the State agency
4	report says that the Applicant felt that they
5	didn't have to provide audited financial
6	statements because they had no debt.
7	MR. CONSTANTINO: That's yes. That was
8	the response we received from the Applicants.
9	CHAIRMAN SEWELL: Is that supported in our
10	rules? If you don't have any debt, you don't have
11	to have audited financial statements?
12	MR. CONSTANTINO: No. Our 1120 rules
13	require audited financial statements or a
14	performance bond or an escrow account.
15	And we've been reluctant to ask for a
16	performance bond because of the cost, and in this
17	situation they said they did not have audited
18	financials.
19	So we have discussed with them, if this
20	project should be approved, they would set up an
21	escrow account for this project, and they were
22	agreeable to that.
23	MR. SHAZZAD: And we will do that
24	immediately if it was approved.

1	CHAIRMAN SEWELL: Also, for the Applicant,
2	the State agency report cites this excess of
3	four stations in HSA 1 and also says that the
4	number of referrals it exceeds the number of
5	historical referrals of the two nephrologists that
6	you've identified to be referring.
7	DR. SALAKO: So this is so here's what
8	we we don't we can always I know it's
9	possible to find out the number of home patients
10	we have. We have a lot of home patients. As
11	I said, we have a very robust home program there
12	in Rockford.
13	Here's what typically happens: You know,
14	home patients after about 30 months typically
15	between 30 and we have 30 to 30 to
16	40 months your home patients will eventually
16 17	40 months your home patients will eventually fail at home therapies. Now, we've had a home
17	fail at home therapies. Now, we've had a home
17 18	fail at home therapies. Now, we've had a home therapy clinic there for about four years. That
17 18 19	fail at home therapies. Now, we've had a home therapy clinic there for about four years. That census in the clinic is enough in the 10s.
17 18 19 20	fail at home therapies. Now, we've had a home therapy clinic there for about four years. That census in the clinic is enough in the 10s. So our concern is this: As those
17 18 19 20 21	fail at home therapies. Now, we've had a home therapy clinic there for about four years. That census in the clinic is enough in the 10s. So our concern is this: As those patients and they will; it will happen. These

1 our network, the same care team, the same set of 2 nurses, the same set of physicians, the same set 3 of standards. 4 That is why, inasmuch as we do not do a 5 lot of in-center at the moment, we know that our 6 home therapy patients are going to come off 7 therapy. And it's happened to us in other places, 8 and we would rather keep those patients within our 9 network. 10 So that's the reason why you see those numbers the way we are. Do we have a lot of CKD 11 12 patients that we progress into ESRD? Absolutely. But we have a lot of home therapy patients that 13 14 eventually will fail on home therapies, yes. 15 And by the natural growth of our clinic 16 the last four years, we are beginning to get to 17 that sweet spot where we believe, in the next 6 to 18 12 months, a significant number of patients are 19 going to fail home therapies and will need to go to the in-center. 20 2.1 Why should they -- why should their only 22 option in Rockford be a DaVita clinic? You know, 23 it's a monopoly. 2.4 CHAIRMAN SEWELL: Board members have

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1
    questions?
2
            Yes.
3
            MEMBER MC NEIL: Okay. I have a series of
4
    questions.
5
            DR. SALAKO: Yes, sir.
6
            MEMBER MC NEIL: Mr. Constantino reported
7
    you at $10 million cash in the bank as of
8
    February 2018.
9
            DR. SALAKO: Yes.
10
            MEMBER MC NEIL: Has that changed
11
    dramatically?
12
            DR. SALAKO: We have two projects that
    we -- we are -- in February 2018 we had
13
     $10 million to fund five projects. One of those
14
    projects is about to open, DCC Beverly. It should
15
16
    open in the next month.
17
            We have another project, DCC Elgin, that
     is funded through that. We will probably have a
18
19
    balance in that account now of about $7.8 million.
20
    Okay? Roughly, if I can recall.
2.1
            But as we told the State, we are willing
22
    to escrow for each of these projects going
     forward -- "This is the money for this project."
23
2.4
    We will escrow it; we will put it aside. We will
```

1 provide evidence to the State that we have the 2 resources. And going forward for each of these 3 projects, "This is the cache of money." The State 4 will have access to it. 5 So we're willing to do that. 6 MEMBER MC NEIL: Okay. We've talked about 7 money now. Let's talk about number of treatments 8 per week. 9 Do home patients go through dialysis more 10 often? Is three the magic number? Or is four 11 better? Or is five better? Or is seven better? 12 And tell me about that because we've used this three as a magic number. And what's the 13 difference in outcome if you look at medical 14 15 records and journal articles, things like that? 16 DR. MAHMOOD: So, basically, there are two 17 home therapies. There is peritoneal dialysis and 18 there is home hemodialysis. So peritoneal 19 dialysis is daily, and most of the patients do it 20 nightly for convenience. And the benefits for 2.1 those is, you know, people have issues with their 22 blood pressure, you know, when they are removing the fluids, so it is slow fluid removal. 23 2.4 Lifestyle. They can work during the day

```
and do their dialysis at night. You know, when
1
2
    you're going at a certain time in a dialysis unit,
    you don't have the option of working most of the
3
4
           And then mortality benefits are actually
    time.
5
    the same, but their lifestyle is better.
6
            Now, home hemodialysis is different.
7
    a different machine than is used in in-center, and
8
    it depends on the patient -- basically, volume
9
    status, how much clearance they require -- and it
10
    can be three times a week, up to five times a
11
    week, so it depends on --
12
            MEMBER MC NEIL: Is there a difference in
    cost if it's three versus five?
13
14
            DR. SALAKO: Yes.
                               Yes --
15
            DR. MAHMOOD: Yes.
            DR. SALAKO: -- difference in cost.
16
17
            MEMBER MC NEIL: What if it's Medicaid?
     It's going to pay you 97-eight -- whatever it
18
19
     is -- a year?
20
            DR. SALAKO: And typically, you know, the
2.1
    home patients, we'll get paid three times a week
22
     if there's medical justification for it. We'll
23
    send the paperwork in; if it's approved, we get
24
    paid for it.
```

Now -- you know, just -- historically the 1 2 whole concept of three-times-a-week dialysis was 3 based on a study done in the late '70s at the 4 University of Michigan commissioned by CMS. 5 at that time they tried to look at the sweet 6 I mean, the government was not getting to 7 the whole ESRD as an entitlement, and they tried 8 to look at the sweet spot between outcomes and 9 financial reimbursement from government. 10 So that's how they got into using Kt over V as an indicator, but it was a huge study done by 11 12 the University of Michigan. And that's where we are today, and it's a model that's been around for 13 14 over 30 years, up to 40 years now. 15 Do we see it changing? Probably not. 16 whole business of dialysis is built around that, 17 and I think we all have to kind of live with that 18 until some kind of earth-changing technology advancement comes in, like a wearable kidney or 19 20 something. 2.1 I just don't see that changing anytime 22 It's an old study done in the late '70s by 23 the University of Michigan, and it looked at a 24 sweet spot between outcomes, frequency of

```
1
    dialysis, and looking at the cost of government
2
    going to pay for dialysis -- looking at a model
3
    where it becomes financially viable and
4
    sustainable for the government to do that.
5
            Well, 40 years and who knew we were going
6
    to have half a million dollars budgeted in the
7
    United States?
8
            MEMBER MC NEIL: But it's a follow-up
9
    question to that. You used the term "a lot" of
10
    patients are home care. What is "a lot"
11
    percentagewise?
12
            DR. SALAKO: What do you mean by that?
            MEMBER MC NEIL: Of your patients for home
13
    care. What's "a lot"?
14
15
            DR. SALAKO: In my company today we
16
    have -- well, I don't -- this is business again --
17
    today we have 50 percent of our patients --
18
     I cannot give absolute numbers. It's a -- it's a
19
    strategic business number for us but -- no --
20
            MEMBER MC NEIL: Plus or minus 10 percent
2.1
    works.
22
            DR. SALAKO: -- no -- I don't want to give
23
    absolute numbers of the number of patients we have
24
    in our network. We are present in a few more
```

```
1
    states now, but 50 percent of our patients today
2
    are in home therapies. We are still a heavy home
    therapies company. It's in our DNA.
3
4
            50 percent of our patients, in our --
    across all our network -- are still on home
5
6
    therapies.
7
            MEMBER MC NEIL: Now, we've heard the
8
    payment for home patients -- by Medicare,
9
    Medicaid, whatever -- is different than in
    clinic --
10
11
            DR. SALAKO: Yes.
12
            MEMBER MC NEIL: -- and we've heard that
     90 percent, approximately, of patients are on
13
    Medi- -- how do you work on that range?
14
            DR. SALAKO: It's the same across the
15
16
    board for all of us.
17
            So we -- 90 percent of our patients
    typically have Medicare or Medicaid. The -- from
18
19
    a business perspective, typically patients who
20
    choose home therapies are working, so their
2.1
    commercial needs tend to be higher.
22
            So if a patient -- if, God forbid,
     I became a dialysis patient today, I would have to
23
24
    take a home therapy. I'll continue to work. My
```

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1
    employer is not going to be terribly happy if
2
     I had to go to dialysis three times a week, either
3
     first thing in the morning -- the flexibility is
4
     lost.
5
            So the concept of home therapy is care,
6
    convenience, freedom -- which is our mantra -- is
7
    to allow folks who are on home therapies -- who
8
    need dialysis -- to stay at home and to be able to
9
    have a flexible lifestyle. So from a business
10
    perspective, what that means is that patients who
    are employed continue to stay employed. If they
11
12
    continue to stay employed, they're more likely
13
     than not to be on a private pay insurance.
14
            MEMBER MC NEIL: Okay. Now, in follow-up
15
     to that, what percentage of your patients get
16
    kidney transplants -- which is the real solution
17
    to the problem -- and how do you deal with that?
            DR. SALAKO: You know, we looked at our
18
    data for 2017, and I believe it was about
19
20
    7 percent of our -- I don't -- I believe it was
2.1
    but I can't say for certain.
22
            However, we do get upwards of 50 percent
23
    of our patients to register in a transplant
24
    program. They will go through a transplant
```

1	program in the state. We're registered with many
2	centers here. We have a good relationship with
3	Loyola; we have a good relationship with
4	Northwestern and Christ Hospital.
5	We send our patients to get evaluated and
6	by and large in fact, in the Rockford area,
7	several of our patients actually get their life in
8	Wisconsin in Wisconsin; right?
9	DR. MAHMOOD: Yeah. So most of the
10	patients get basically, through the University
11	of Wisconsin for transplant in the Rockford area.
12	DR. SALAKO: I think we actually get more
13	transplants
14	DR. MAHMOOD: They're higher than
15	THE COURT REPORTER: Wait, wait, wait.
16	What did you say?
17	DR. SALAKO: I said we actually get a
18	some of we actually get a higher transplant
19	rate in Wisconsin than we get in Illinois.
20	DR. MAHMOOD: The wait list is smaller
21	than in Chicago.
22	MEMBER MC NEIL: What is the wait list?
23	Timewise.
24	DR. MAHMOOD: I don't have the

```
1
            MEMBER MC NEIL: Approximately. I mean,
2
    we're --
           MR. SNOWWHITE: I would say maybe two to
3
4
     four, three to five years, somewhere.
5
            MEMBER MC NEIL: 3.1 is average.
6
    somewhere in that range?
7
           MR. SNOWWHITE: Yeah. And longer than
8
    that in the Chicagoland area.
9
            CHAIRMAN SEWELL: Okay.
10
            Ms. Mitchell.
11
           MS. MITCHELL: I just want to say
12
     something about the escrow account.
13
            What we've done recently is, when an
    Applicant said "We're going to provide -- put
14
15
    money in an escrow account," we put that as a
16
    condition on the permit.
17
            So would you be agreeable to that?
            MR. SHAZZAD: Yes.
18
19
            MS. MITCHELL: And there would also be a
20
    condition that you provide monthly -- well,
2.1
     I don't know what the project date is -- maybe
22
    quarterly reports since this is a little far
23
    out -- saying that the funds have been -- what
2.4
     funds are still in the account and what the monies
```

1	have been used for.
2	DR. SALAKO: We're agreeable to that.
3	MR. SHAZZAD: Yes.
4	DR. SALAKO: We're agreeable to that.
5	CHAIRMAN SEWELL: Other questions by Board
6	members?
7	Yes, ma'am.
8	MEMBER HEMME: I would really like to
9	discuss your financial statements
10	THE COURT REPORTER: Could you use your
11	microphone, please?
12	MEMBER HEMME: Is this one on? Yeah.
13	I would really like to discuss your
14	financial statements, which I don't believe are in
15	proper order, and there are several reasons for my
16	concerns.
17	First of all, on in regards to your
18	provision for bad debt, in 2016 your financial
19	statements showed that you have .2 percent. In
20	2017 of your fees for service. In 2017 you are
21	showing 34 percent bad debt.
22	This is an outrageous percentage, and I'm
23	wondering if you can explain.
24	DR. SALAKO: That's an easy one.

So what happens, if you -- the two ways we get paid for commercial insurance, you can either be in network -- all right? So we have the big commercial payers, Blue Cross Blue Shield, United, CIGNA, AETNA. You can either be in network or be out of network.

2.1

So if you are in network, obviously, you have a contracted rate. We have contracts with United; we have some -- yes, with United -- and Blue Cross Blue Shield.

With the other providers you are out of network so -- and you've -- you've heard this at this hearing several times where the people quote outrageous numbers that go -- they bill \$4500 per treatment.

Every dialysis company, that's our usual and customary rate of what gets billed out, and then you get paid the contracted rate. But if you bill it out and you don't receive that money back, it is a lot of money you're not receiving back and which you're out of network, so you have a high -- so I could have, for instance, a patient -- three patients. Let me give you the example of three patients.

```
I have three patients. One is a Medicare
1
2
    patient. At the end of the month I get paid
3
    $3,000 for dialysis. Okay? I billed out
4
    $105,000. Medicare will send me a check for
5
    $3,000. That's my payment. Okay?
6
            The next patient is a contracted patient.
7
    Okay? I am in a contract with an insurance
8
    company. I billed out $105,000; I will get back
9
    $15,000. Times three means the Medicare payment.
10
    That's why 10 percent commercial is where our
11
    profit is on the whole dialysis industry. So
12
    you'll get back -- you had a contract; you get
13
    $15,000. Okay? So you will accept the cash.
           My last patient, I was out of network.
14
    I billed out $105,000. Okay? They said, "You
15
16
    guys are out of network; we're not going to pay
17
    you any money." That's a -- that's something
18
    that's going to sit in my collections. Okay?
19
    That's going to be a bad debt. It's going to sit
20
    in my collections.
2.1
            So it doesn't affect my business -- you
22
    know, the reality is -- but I have to account
    for it.
2.3
2.4
           MEMBER HEMME: I understand that. But why
```

1	did your percentage change from .2 to 34 percent?
2	Are you seeing more write-offs?
3	DR. SALAKO: Yes. Because this week we
4	admitted patients that we were out of network and
5	we didn't get collections on.
6	So what we've done at the company by
7	the end of 2018 you'll see that now we're
8	contracted with everybody. So now we know we're
9	going to get our United money; we're going to get
10	our CIGNA money; we're going to get our AETNA
11	money; we're going to get our Blue Cross money.
12	The uncertainty you're going to get in out of
13	network, we don't have that anymore.
14	MEMBER HEMME: My other question relates
15	to your balance sheet and the fact that these are
16	unaudited.
17	You're showing accounts receivable of
18	14-seven; you're showing long-term liabilities of
19	almost the same and strictly from Blue Cross
20	Blue Shield, which means that you're basically at
21	zero. So all you have is the 10 million cash in
22	the bank compared to long-term liabilities.
23	DR. SALAKO: Yes.
24	MEMBER HEMME: I am seriously concerned

1	about these numbers that in a normal situation,
2	had they been audited, we would have had
3	commentary from the accountants that would tell
4	us would give us some explanations, and I feel
5	like I'm missing a lot of information.
6	I understand you don't have to be audited, but
7	I think you're missing a lot of valuable
8	information because you weren't audited according
9	to what we require.
10	DR. SALAKO: Fair point. And we can we
11	have since secured the services of an auditor, and
12	we are now our books are being audited, so it's
13	something we can always send we can send back
14	to the State, within the next week or two weeks,
15	audited statements for 2016, 2017.
16	However, let me point out that when you
17	see that liability to Blue Cross Blue Shield
18	everybody who's here in the state of Illinois
19	knows that there's an overpayment from Blue Cross
20	Blue Shield that's paid back on a monthly basis.
21	We have to account for it. We have to account for
22	it. That's what you see there. Okay?
23	You get an overpayment from Blue Cross
24	Blue Shield; you have to pay it back. If you

```
1
    don't pay it back, you will -- you -- Blue Cross
2
    Blue Shield will essentially suspend you. We have
3
    a lot of Blue Cross Blue Shield patients. We're
4
     in good standing with them. We pay back that
5
     liability on a monthly basis.
6
            So we have to account for that. Even
7
    though those are not audited statements, but we
8
    have to put them there. I think we're being
9
    transparent in showing that.
10
            CHAIRMAN SEWELL: Other -- yes, Dr. Goyal.
11
           MEMBER GOYAL: Thank you, Mr. Chairman.
12
            Again, my name hasn't changed. I'm still
    Arvind Goyal and I represent Medicaid.
13
14
            (Laughter.)
15
           MEMBER GOYAL: So three very small
16
     questions: Do you do any live donor referrals for
17
    kidney transplant?
18
            DR. MAHMOOD: Yes, we do.
19
           MEMBER GOYAL: And what's your rate? You
20
    get 7 percent or something on the --
2.1
            DR. MAHMOOD: Live? I don't exactly know,
22
    but it will be lower, I think, because -- it
23
    depends on if they have a donor or not.
2.4
           MEMBER GOYAL: Okay. Number two, most
```

1	Medicaid managed care plans are where 80 percent
2	of our patients reside today, my understanding
3	and I stand corrected because I don't have data on
4	each of the plans at this moment. Most of our
5	managed care plans are paying for three times a
6	week, from my understanding, for home dialysis, as
7	well.
8	Do you have issues with that if you are
9	spending a lot of your resources supporting
10	five days or seven days?
11	DR. SALAKO: Let me add that, by and
12	large, the bulk of our home patients are
13	peritoneal dialysis patients. You know, home
14	hemodialysis is something we do, but the bulk of
15	our dialysis patients are peritoneal dialysis
16	patients.
17	So it's very challenging, even in the
18	best-case scenarios, to have patients who will do
19	home hemodialysis. It requires a kind of level of
20	support for the patient. The patient selection
21	criteria there is pretty stringent.
22	So we really, by and large, don't have
23	that many. And if you have a patient the
24	demographics of the patient that would be on an

```
1
     independent home hemo patient will be slightly
2
    different.
3
            MEMBER GOYAL: Thank you.
4
            And, finally, do you have any
5
    relationships for home dialysis for a patient
6
    who's confined to a long-term care or nursing
7
    home?
8
            DR. SALAKO: For --
9
            MEMBER GOYAL: In Rockford area.
10
    I'm sorry.
11
            MS. SMITH: We don't have any current
12
    contracts with long-term care. We have had a very
    difficult time procuring them. Across the board,
13
    I have met with several long-term care facilities.
14
15
    Most facilities will only accept patients for
16
    short-term peritoneal dialysis care.
17
            MEMBER GOYAL:
                           Thank you.
18
            CHAIRMAN SEWELL: Other questions?
19
            (No response.)
20
            CHAIRMAN SEWELL: Would any Board member
2.1
    like to amend the motion for approval to add the
22
    condition of the establishment of an escrow
23
    account --
2.4
            MS. MITCHELL: And reports.
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1	CHAIRMAN SEWELL: and reports?
2	MEMBER JOHNSON: So moved.
3	MEMBER MC NEIL: Seconded.
4	CHAIRMAN SEWELL: All right. Motion is
5	amended the motion and the second, do they
6	accept that? Who made the motion to approve?
7	MR. ROATE: Motion made by Mr. Johnson;
8	seconded by Ms. Murphy.
9	CHAIRMAN SEWELL: Well, he does because he
10	made the motion for the amendment.
11	MEMBER JOHNSON: I accept.
12	CHAIRMAN SEWELL: All right. So I think
13	we're ready to vote.
14	Roll call.
15	MR. ROATE: Okay. So
16	CHAIRMAN SEWELL: On the amended on the
17	amended motion.
18	MR. ROATE: Okay. And the amended motion
19	was with Mr. Johnson and Dr. McNeil.
20	CHAIRMAN SEWELL: That's right.
21	MR. ROATE: Very good. Thank you.
22	Ms. Hemme.
23	MEMBER HEMME: Yes, on the amended motion.
24	MR. ROATE: Thank you.

1	Mr. Johnson.
2	MEMBER JOHNSON: Yes.
3	MS. MITCHELL: Please remember to state
4	your reason for your vote.
5	MR. ROATE: Thank you.
6	MS. MITCHELL: This is just the amendment.
7	My apologies.
8	MR. ROATE: Mr. McGlasson.
9	MEMBER MC GLASSON: Yes. It's become
10	apparent to me in my short time on this Board that
11	the payment model for dialysis must be seriously
12	flawed. But I don't see any way that solving that
13	problem is
14	MS. MITCHELL: Sorry, Mr. McGlasson. This
15	is just on the amendment itself, not on we're
16	not taking a vote on the project yet
17	MEMBER MC GLASSON: Oh, I'm sorry.
18	I apologize.
19	MS. MITCHELL: just the amendment.
20	MEMBER MC GLASSON: Yes on the amendment.
21	MR. ROATE: Okay.
22	Dr. McNeil.
23	MEMBER MC NEIL: Yes on the amendment.
24	MR. ROATE: Thank you.

1	Ms. Murphy.
2	MEMBER MURPHY: Yes on the amendment.
3	MR. ROATE: Chairman Sewell.
4	CHAIRMAN SEWELL: Yes on the amendment,
5	essentially because we don't have audited
6	financial statements.
7	MR. ROATE: Okay.
8	That's 6 votes in the affirmative on the
9	amendment.
10	CHAIRMAN SEWELL: So now we'll take a vote
11	on the project itself.
12	Can I have a roll call on that?
13	MR. ROATE: Same motion?
14	CHAIRMAN SEWELL: Yes.
15	MR. ROATE: Very good.
16	Ms. Hemme.
17	MEMBER HEMME: No, until we've received a
18	lot more information.
19	MR. ROATE: Thank you.
20	Mr. Johnson.
21	MEMBER JOHNSON: I'm going to vote no, as
22	well. The State Board report I haven't heard
23	enough here today that would convince me that
24	we've overcome the noncompliance.

1	MR. ROATE: Thank you.
2	Mr. McGlasson.
3	MEMBER MC GLASSON: I'm voting yes
4	because, as I started to say, I think there are
5	flaws in our payment system, and denying this
6	motion will only make that more difficult to
7	solve.
8	MR. ROATE: Thank you.
9	Dr. McNeil.
10	MEMBER MC NEIL: This is one where it
11	could go either way.
12	And meetings come up. They can reapply
13	with the data at the next meeting that we asked
14	for, and that can be done where it's fair to
15	everybody.
16	So I reluctantly vote no based on all of
17	those factors and the conversation.
18	MR. ROATE: Thank you.
19	Ms. Murphy.
20	MEMBER MURPHY: I had concerns about the
21	financial issues raised here among my fellow Board
22	members and in the report. But based on the
23	assurances given today of the escrow account and
24	the reporting and the explanation offered today of

1	the business model and the financials, I'm going
2	to vote yes.
3	MR. ROATE: Thank you.
4	Chairman Sewell.
5	CHAIRMAN SEWELL: I vote no. While this
6	Applicant desires to retain patients in their
7	system who currently are their patients who are on
8	home dialysis, we don't have a provision in our
9	rules that allow for that if there's enough
10	capacity in the system. So I don't think that the
11	planning area need and the assurances have been
12	provided. And then I'm equally concerned about
13	the financial viability.
14	So I vote no.
15	MR. ROATE: Thank you, sir.
16	That's 2 votes in the affirmative, 4 votes
17	in the negative.
18	MS. MITCHELL: That's you've received
19	an intent to deny. You'll receive a letter in the
20	mail telling you that you received an intent to
21	deny and what the next steps are for pursuing
22	further options.
23	DR. SALAKO: Thank you.
24	CHAIRMAN SEWELL: Okay. We're going to

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1
     take a 10-minute break, and we'll resume at 11:32.
2
             (A recess was taken from 11:23 a.m. to
3
     11:34 a.m.)
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