ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Horizon Health Dialysis
Street Address: 721 E. Court St STE B
City and Zip Code: Paris 61944
County: Edgar Health Service Area: 4 Health Planning Area:

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Hospital & Medical Foundation of Paris, Inc.
Street Address: 721 E. Court St
City and Zip Code: Paris 61944
Name of Registered Agent: Richard L James
Registered Agent Street Address: 328 N. Central PO BOX 820
Registered Agent City and Zip Code: Paris 61944
Name of Chief Executive Officer: Oliver Smith
CEO Street Address: 721 E. Court St
CEO City and Zip Code: Paris 61944
CEO Telephone Number: 217-465-4141

Type of Ownership of Applicants

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Bryan Niehaus
Title: Vice President
Company Name: Advis
Address: 7840 Graphics Dr STE 100 Tinley Park, IL 60477
Telephone Number: 708-478-7030
E-mail Address: bniehaus@advis.com
Fax Number: 708-478-7094

Additional Contact [Person who is also authorized to discuss the application for permit]

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Kym Pfrank
Title: Director of Strategic Development
Company Name: Horizon Health
Address: 721 E. Court St.
Telephone Number: (217) 465-4141
E-mail Address: KPfrank@myhorizonhealth.org
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Hospital & Medical Foundation of Paris, Inc.
Address of Site Owner: 721 E. Court St. Paris, IL 61944
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Hospital & Medical Foundation of Paris, Inc.
Address: 721 E. Court St., STE B, Paris, IL 61944

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (**http://www.hfsrb.illinois.gov**). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Hospital & Medical Foundation of Paris, Inc. d/b/a Horizon Health proposes to establish an 8-station in-center hemodialysis facility located at 721 E. Court St. STE B, Paris, IL 61944. The facility will be in space owned by the applicant. This project is proposing the same service and location as Project #16-042, which was approved by the HFSRB but abandoned by the former applicant on October 6, 2020.

The site is located in HSA 4.

This project is "substantive" under the planning board rules as it entails the establishment of a health facility that will provide in-center chronic renal dialysis services.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$568,698	$379,132	$947,830
Contingencies	$39,809	$26,539	$66,348
Architectural/Engineering Fees	$40,093	$26,729	$66,822
Consulting and Other Fees	$40,000	$0	$40,000
Movable or Other Equipment (not in construction contracts)	$285,550	$0	$285,550
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$859,930	$546,620	$1,406,550
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$859,930	$546,620	$1,406,550
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs
Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 96,628 .

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): 18-months after Project Approval

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?
☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
In-Center Hemodialysis	$974,150		3,000		3,000		
Total Clinical	$974,150		3,000		3,000		
NON-REVIEWABLE							
Non-Clinical	$432,400		2,000		2,000		
Total Non-clinical	$432,400		2,000		2,000		
TOTAL	**$1,406,550**		**5,000**		**5,000**		

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Hospital & Medical Foundation of Paris, Inc. in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Oliver M Smith
SIGNATURE

Oliver M. Smith
PRINTED NAME

Pres + CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of March 2021

Kimberly A Calvert
Signature of Notary

Seal

KIMBERLY A CALVERT
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 12, 2023

Martin D Adams
SIGNATURE

Martin D. Adams
PRINTED NAME

VP of Finance & CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 8 day of March 2021

Kimberly A Calvert
Signature of Notary

Seal

KIMBERLY A CALVERT
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 12, 2023

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility or the discontinuation of more than one category of service in a 6-month period. If the project is solely for a discontinuation of a health care facility the **Background of the Applicant(s) and Purpose of Project MUST** be addressed. **A copy of the Notice to the Local Media MUST be submitted with this Application for Discontinuation (20 ILCS 3960/8.7).**

Criterion 1110.290 – Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. Provide copies of the notices that were provided to the local media that would routinely be notified about facility events.
7. For applications involving the discontinuation of an entire facility, provide copies of the notices that were sent to the municipality in which the facility is located, the State Representative and State Senator of the district in which the health care facility is located, the Director of Public Health, and the Director of Healthcare and Family Services. These notices shall have been made at least 30 days prior to filing of the application.
8. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.290(b) for examples.

IMPACT ON ACCESS

1. Document whether the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within the **geographic service area**.

Or

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. 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.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH 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 such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

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

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

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

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

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

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

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

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

    c. The project involves the conversion of existing space that results in excess square footage.

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Criterion 1110.230 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☒ **In-Center Hemodialysis**	**0**	**8**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.230(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.230(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.230(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.230(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2300(b)(5) - Planning Area Need - Service Accessibility	X		
1110.230(c)(1) - Unnecessary Duplication of Services	X		
1110.230(c)(2) - Maldistribution	X		
1110.230(c)(3) - Impact of Project on Other Area Providers	X		
1110.230(d)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.230(e) - Staffing	X	X	
1110.230(f) - Support Services	X	X	X
1110.230(g) - Minimum Number of Stations	X		
1110.230(h) - Continuity of Care	X		
1110.230(I) - Relocation (if applicable)	X		
1110.230(j) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. **Projects for relocation** of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 1110.230(i) - Relocation of an in-center hemodialysis facility.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VI. 1120.120 - AVAILABILITY OF FUNDS

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

$1,406,550	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all

	terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$1,406,550	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

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

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:	**All the project's capital expenditures are completely funded through internal sources**			
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

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

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ESRD		$189.57			3000			$568,698	$568,698
Contingency		$13.27			3000			$39,809	$39,809
Total Clinical		$202.84			3000			$608,507	$608,507
Non clinical		$189.57			2000			$379,132	$379,132
Contingency		$13.27			2000			$26,539	$26,539
Total Non-clinical		$202.84			2000			$405,671	$405,671
Totals		$202.84			5000			$1,014,178	$1,014,178

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 37.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2017**	**2018**	**2019**
Inpatient	0	0	248
Outpatient	112	148	179
Total	**112**	**148**	**427**
Charity (cost in dollars)			
Inpatient	0	0	77,831
Outpatient	133,293	72128	629,722
Total	**133,293**	**72,128**	**707,553**
MEDICAID			
Medicaid (# of patients)	**2017**	**2018**	**2019**
Inpatient	61	73	115
Outpatient	10,603	17,815	29,842
Total	10,664	17,888	29,957
Medicaid (revenue)			
Inpatient	640,367	830,632	-967,967
Outpatient	3,294,437	5,313,372	6,221,924
Total	3,934,804	6,144,004	5,253,957

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	2017	**2018**	**2019**
Net Patient Revenue	**35,428,817**	**43,063,146**	**58,716,135**
Amount of Charity Care (charges)	133,293	72,128	707,553
Cost of Charity Care	133,293	72,128	707,553

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification

Applicants

A Certificate of Good Standing for Hospital & Medical Foundation of Paris, Inc. d/b/a Horizon Health (the "Applicant") is attached at Attachment – 1.

File Number 3835-894-4

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 30, 1958, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* FEBRUARY *A.D.* 2021 .

Authentication #: 2105703328 verifiable until 02/26/2022
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

Section I, Identification, General Information, and Certification

Site Ownership

The location is owned by the applicant Hospital & Medical Foundation of Paris, Inc. 721 E. Court Street St. Paris, IL 61944.

">

Edgar County ATAS Web Portal (https://il1349.cichosting.com/atasportal/parcelSearch.asp

Property Search

Property 1 of 1

Print Friendly Version (printParcelOverview.asp

Home (Default.aspx)
Parcel Search (parcelSearch.aspx)
Search Results (propertySearchResults.aspx)
Parcel Overview (parcelOverview.aspx)
Assessment (assessmentOverview.aspx)
Farmland (farmlandOverview.aspx)
Exemptions (homesteadExemptionOverview.aspx)
Transfer History (transferHistoryOverview.aspx)
Taxes (taxInformation.aspx)
Redemption (Redemption.aspx)
Property Card (http://il-edgar-publicaccessnow.cichosting.com/?p=09-19-06-300-039)
GIS Site (http://edgar.ilcounties.com/)
County Web Site (https://www.edgarcountyillinois.com)

Parcel Overview

Tax Year	Parcel Number	Alternate Parcel Number	Date of Data
2019	09-19-06-300-039	19-6F	3/4/2021 1:23:50 AM

Parcel Address
E COURT , PARIS, IL 61944

Property Owner
HOSPITAL & MEDICAL FOUNDATION; OF PARIS INC

Mailing Address
[redacted] ST PARIS IL 61944 Owner

Township	Taxing Code	Property Class
PARIS TOWNSHIP	09001	RI - Residential Improved

Short Legal Description

Sec	Twp	Rng
[redacted]		

[redacted] & S OF TOBIAS SD. /E COURT_.88A_

Land / Lot Information

Total Acres	0.88	Total SF	0
Non-Farm Acres	0.88	Frontage	0.00
Farm Acres	0.00	Depth	0.00

Lot Size

Subdivision

Lot Neighborhood 920-ORIGINAL PARIS

Genealogy

No activity was located for the selected range.

Section I, Identification, General Information, and Certification

Operating Entity/Licensee

The Illinois Certificate of Good Standing for Hospital & Medical Foundation of Paris, Inc. is attached at Attachment – 3.

File Number 3835-894-4

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON DECEMBER 30, 1958, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 26TH *day of* FEBRUARY *A.D.* 2021 .

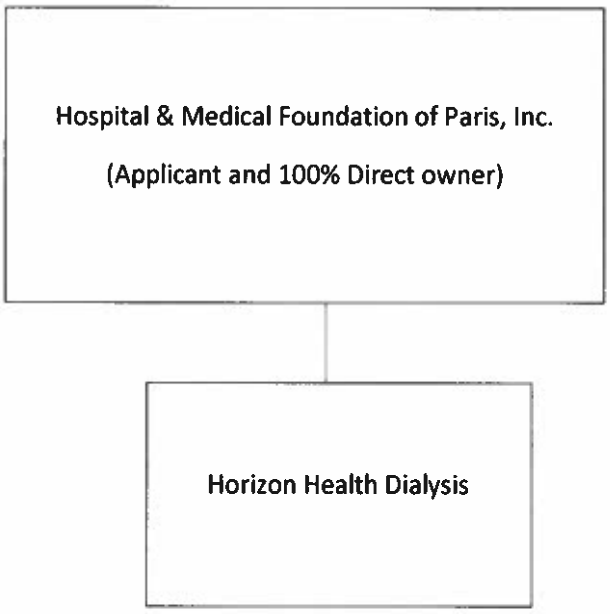
Authentication #: 2105703328 verifiable until 02/26/2022
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

Section I, Identification, General Information, and Certification

Organizational Relationships

The organizational chart for Hospital & Medical Foundation of Paris, Inc. is included below.



Section I, Identification, General Information, and Certification

Flood Plain Requirements

The site of the proposed dialysis facility complies with the requirements of Illinois Executive Order #2005-5. The proposed dialysis facility will be located at 721 E. Court Street St, STE B Paris, IL 61944. As shown on the FEMA flood plain map attached at Attachment – 5, the site of the proposed dialysis facility is located outside of a flood plain. Also see section XI.

National Flood Hazard Layer FIRMette

FEMA

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) *Zone A, V, A99*
- With BFE or Depth *Zone AE, AO, AH, VE, AR*
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile *Zone X*
- Future Conditions 1% Annual Chance Flood Hazard *Zone X*
- Area with Reduced Flood Risk due to Levee. See Notes. *Zone X*
- Area with Flood Risk due to Levee *Zone D*

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard *Zone X*
- Effective LOMRs
- Area of Undetermined Flood Hazard *Zone D*

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 / 17.5 Cross Sections with 1% Annual Chance / Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 2/26/2021 at 3:04 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

#21-009

Section I, Identification, General Information, and Certification

Historic Resources Preservation Act Requirements

The Historic Preservation Act determination from the Illinois Historic Preservation Agency is attached at Attachment – 6.

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov
Mailing Address: 1 Old State Capitol Plaza, Springfield, IL 62701

JB Pritzker, Governor
Colleen Callahan, Director

FAX (217) 524-7525

Edgar County
Paris
CON - Rehabilitation to Establish an In-center Hemodialysis Facility
721 E. Court St., Suite B
SHPO Log #009012721

February 9, 2021

Jake Beechy
The Advis Group
7840 Graphics Dr., Suite 100
Tinley Park, IL 60477

Dear Mr. Beechy:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please call 217/782-4836.

Sincerely,

Robert F. Appleman
Deputy State Historic
Preservation Officer

Section I, Identification, General Information, and Certification

Project Costs and Sources of Funds

Table 1120.110

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$568,698	$379,132	$947,830
Contingencies	$39,809	$26,539	$66,348
Architectural/Engineering Fees	$40,093	$26,729	$66,822
Consulting and Other Fees	$40,000	$0	$40,000
Movable or Other Equipment (not in construction contracts)	$285,550	$0	$285,550
Moveable or Other Equipment	$21,551		
Dialysis Chairs	$26,939		
Clinical Furniture and Equipment	$26,939		
Water Treatment	$129,306		
TVs and Accessories	$21,551		
Telephones	$16,163		
Generator	$10,775		
Facility Automation	$21,551		
Other miscellaneous	$10,775		
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)	$859,930	$546,620	$1,406,550
TOTAL USES OF FUNDS			
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$859,930	$546,620	$1,406,550
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			

Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$859,930	$546,620	$1,406,550

Section I, Identification, General Information, and Certification

Project Status and Completion Schedules

The Applicants anticipate project completion within 18 months of project approval.

Financial Commitment will occur after permit issuance.

Section I, Identification, General Information, and Certification

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
In-Center Hemodialysis	$974,150		3,000		3,000		
Total Clinical	$974,150		3,000		3,000		
NON REVIEWABLE							
Non-Clinical	$432,400		2,000		2,000		
Total Non-clinical	$432,400		2,000		2,000		
TOTAL	**$1,406,550**		**5,000**		**5,000**		

Section III, Project Purpose, Background and Alternatives – Information Requirements

Criterion 1110.110(a), Project Purpose, Background and Alternatives

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. This project is for the establishment of an 8-station in-center hemodialysis facility to be located at 721 E. Court Street St, STE B Paris, IL 61944. This project is anticipated to replace the project that was initially approved by the Board in 2016 (Proj. No.: 16-042), but was abandoned by Fresenius. There are very slight changes to the anticipated intent of the project, as it shall be located at the same location, seek to treat the same patient population, and shall partner with the same group of physicians, but with a different physician from within the group taking charge as the Medical Director.

Horizon Health is a full-service community healthcare provider with in the County of Edgar and located in Paris, Illinois. The area has been designated by the federal government as a medically underserved area ("MUA"). Horizon consists of serval healthcare providers, including Paris Community Hospital (a critical access hospital), Paris Clinic, Chrisman Clinic, Oakland Clinic, Senior Care, and EZ Care. The hospital and Horizon health has been serving the community for 50 years and is seeking to expand its care continuum and provide for additional resources for its patient population.

Quality

Paris Community Hospital was recently rated a 5-star hospital by CMS due to its high-quality commitment to its patient population, per the result of a recent patient survey. In addition to its 5-star overall rating, Horizon Health earned a 5-star rating for each of the following survey questions:

- **Communication with Nurses** – 91 percent of respondents said their nurses always communicated well. That compares to 81 percent, both statewide and nationally.
- **Communication with Doctors** – 89 percent of respondents said their doctors always communicated well. That compares to 81 statewide and 82 percent nationally.
- **Communication About Medicines** – 70 percent of respondents said staff always explained medicines before giving them. That compares to 66 percent, both statewide and nationally.
- **Discharge Information** – 93 percent of respondents said they were given information about what to do during their recovery at home. That compares to 87 percent, both statewide and nationally.

The ratings program is called the HCAHPS Summary Star Rating system. HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems. Results can be evaluated comparatively to other area hospitals, state averages, or national averages at Medicare.gov.

To further this continuum of care and to ensure the hospital continues to provide the best care to its community, the hospital is seeking approval for this project to establish an 8 bed ESRD facility. The hospital's patient population being managed today by the proposed medical director, Dr. Gaurav, would benefit greatly from receiving quality dialysis care in the community, rather than driving miles to other facilities in surrounding communities or in Indiana.

In keeping with best practices, the facility will track key quality measures on all ESRD patients, including:

- eKdrt/V – tells us if the patient is getting an adequate treatment
- Hemoglobin – monitors patients for anemia
- Albumin – monitors the patient's nutrition intake
- Phosphorus -monitors patient's bone health and mineral metabolism
- Catheters – tracks patients access for treat, with a goal of no catheters

Under the direction of Dr. Gaurav, these quality measures and other patient characteristics and clinical operations will be discussed by the inter-disciplinary team of nephrologists, clinical managers, nurses, social works, dieticians, and referring nephrologists during Quality Assessment Performance Improvement (QAPI) meetings.

Improving Patient Care

An optimal care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Early identification of CKD and deliberate treatment of ESRD by multidisciplinary teams leads to improved disease management and care, mitigating the risk of disease advancement and patient mortality.

Accordingly, timely referral to and treatment by a multidisciplinary clinical team may improve patient outcomes and reduce cost. Indeed, research has found that late referral and suboptimal care result in higher mortality and hospitalization rates. Deficient knowledge about appropriate timing of patient referrals and poor communication between PCPs and nephrologists have been cited as key contributing factors.[1]

Critically, addressing the failure of communication and coordination among primary care physicians ("PCPs"), nephrologists, and other specialists may alleviate a systemic barrier to mitigating the risk of patient progression from CKD to ESRD, and to effective care of patients with ESRD. With Paris Community Hospital offering the dialysis facility services to community members already served by the hospital, patients will receive care closer to home with improved access to their dialysis results amongst their other providers.

Awards

Paris Community Hospital was rated a top 100 Critical Access Hospital by the Chartis Center for Rural Health in 2019.

Paris Community Hospital is a top hospital in the nation for patient satisfaction, according to newly released survey data for 2019. The hospital received a "5-star" rating by the US Centers for Medicare & Medicaid Services.

[1] Navaneethan SD, Aloudat S, Singh S. A systematic review of patient and health system characteristics associated with late referral in chronic kidney disease. BMC Nephrol. 2008; 9:3.

Service to the Community

Horizon Health also runs and supports a Health foundation to support its community. The Horizon Health Foundation invests in healthcare for Edgar County and surrounding communities.

The foundation has provided funding for the following projects:

- EZ Care/NAL Health Clinic – EZ Care is a convenient walk-in clinic located off Route 1 South across from the Paris industrial park. The NAL Health Clinic, located inside the EZ Care building, is a primary healthcare clinic for North American Lighting employees and their family members who are covered by NAL's health insurance.
- Phipps Fund – This special fund was established in memory of the late Dr. Leland Phipps, one of the founders of our foundation. The fund is used for health services and resources that were important to Dr. Phipps. These include recruiting talented physicians and other healthcare professionals, providing special resources for the care of families and children, and providing long-term financial stability of locally-managed healthcare services.
- Reach Out and Read Program – The foundation is a proud sponsor of this program, which provides free books to children (infants to age 5) at well-child visits. This nationwide initiative is supported at a local level with funding from the foundation and emphasizes the importance of reading and language in early childhood development.

1. **A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.**

Please see attached relevant licensure documents are included following attachment-11.

2. **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.**

Please see attached relevant licensure documents are included following attachment-11.

3. **For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.**
    a. **A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.**

None.

    b. **A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.**

None

c. **A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.**

None.

d. **A certified listing of each applicant with one or more unsatisfied judgements against him or her.**

None.

e. **A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.**

None.

4. **Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH 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 such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

See attached authorized included following attachment-11.

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

N/A

HORIZON HEALTH

Paris Community Hospital
721 East Court Street
Paris, IL 61944
(217) 465-4141

Paris Clinic
727 East Court Street
Paris, IL 61944
(217) 465-8411

Chrisman Clinic
112 West Madison Ave.
Chrisman, IL 61924
(217)269-2394

Oakland Clinic
5 South Walnut Street
Oakland, IL 61943
(217) 346-2353

Senior Care
745 East Court Street
Paris, IL 61944
(217) 466-4170

EZ Care
1 Phipps Lane
Paris, IL 61944
(217) 463-4340

EZ Care— Marshall
1602 N. IL Hwy 1
Marshall, IL 62441

NAL Health Clinic
1 Phipps Lane
Paris, IL 61944
(217) 463-4901

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 IAC 1130.140 has been taken against any in-center dialysis facility owned or operated by Horizon Health in the State of Illinois during the three year period prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.230(a)(3)(C), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,

Oliver M. Smith
Horizon Health President & CEO

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements

Criterion 1110.110(b) – Background, Purpose of the Project, and Alternatives

Purpose of Project

1. **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 purpose of this project is to provide access to dialysis services to Edgar County, in HSA 4, where there are no dialysis facilities and no Illinois dialysis facilities located within 19 miles of Paris, where the proposed facility will be located. Importantly, the HFSRB has already recognized and approved this facility in early 2017 under Project #16-042 filed by Fresenius Kidney Care with the support of Paris Community Hospital. We supported that filing for the same reasons we are now coming before the Board to seek approval for what Fresenius failed to complete.

The primary purpose of this filing is to provide improved and convenient access to dialysis services for our community, within the community. A secondary benefit is to maintain greater continuity of care within the hospital system for our patients.

Horizon provides many patients with ongoing and underlying care and treatment, but does not have a local option for patient requiring dialysis services. Currently, Horizon patients from the surrounding areas who require dialysis services are removed from the hospital's continuum of care, as there are no nearby ESRD facilities that allow for convenient site of care for the Horizon patient population. Most of the patients requiring renal care are forced to drive 40 minutes or more for the closest care, which in most circumstances takes them outside of the State lines.

Studies show that hospitals can play an important role in transitional care interventions and the coordination of chronic care with better outcomes for the patients by taking a leading role in integrated care programs. The studies show that specialized care settings also invest in the coordination of these processes.[2] Dialysis patients are 8.5 times more likely to visit the ED compared to the general population.[3] Allowing for the hospital to be able to seamlessly oversee all aspects of the patient care will allow for this number to be reduced.

In addition to research emphasizing the value of care coordination among providers, research has generally displayed that the more information on a single EHR, the better the outcomes are for patient care. Patients receiving care on a single integrated EHR often experience reduced clinical errors and better outcomes as a result.[4] With the development of the proposed facility, patient data generated at the dialysis facility will be migrated to the EHR systems accessible by all Horizon providers, the largest care provider in the county.

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[2] De Regge, M., De Pourcq, K., Meijboom, B., Trybou, J., Mortier, E., & Eeckloo, K. (2017). The role of hospitals in bridging the care continuum: a systematic review of coordination of care and follow-up for adults with chronic conditions. BMC health services research, 17(1), 550. https://doi.org/10.1186/s12913-017-2500-0

[3] Komenda, P., Tangri, N., Klajncar, E., Eng, A., Di Nella, M., Hiebert, B., Strome, T., Lobato de Faria, R., Zacharias, J. M., Verrelli, M., Sood, M. M., & Rigatto, C. (2018). Patterns of emergency department utilization by patients on chronic dialysis: A population-based study. PloS one, 13(4), e0195323. https://doi.org/10.1371/journal.pone.0195323

[4] Nir Menachemi, Taleah H Collum, Risk Management Healthcare Policy. 2011; 4: 47–55. May 11, 2011.

This data integration ensures their PCP, nephrologist, and other clinical specialists can access the patient dialysis records, along with recent ED visits, on demand throughout the patients care program. This removes administrative burden and alleviates risks that a patient's PCP or specialist is missing information regarding their care, including dialysis treatments.

Patients served within the proposed facility will receive the excellent standard of care they have come to expect from Horizon facilities. The integration of the facility with the hospital's administrative services will keep patients within Horizons continuum of care, enabling efficient communications and coordinating the care of patients to address known barriers to effective CKD and ESRD treatment.

Paris, IL is also a Federally Designated Medically Underserved Area ("MUA"). This is no more evident than in the current lack of ESRD services within the county. The residents of the county also experience low income and have high Medicaid eligibility rates. Horizon is dedicated to providing services to all patients regardless of their ability to pay.

2. **Define the planning area or market area, or other relevant area, per the applicant's definition.**

The market to be served by the proposed dialysis facility is primarily Edgar County and Clark County, a rural area along the Indiana/Illinois border of central Illinois.

3. **Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.**

Currently, dialysis patients living in this area are travelling well over 40 minutes to dialyze in Indiana, the next closest ESRD facility. These patients would be better served by a facility in Paris, Illinois where they see their nephrologist and utilize other healthcare services at Paris Community Hospital.

The closest dialysis facilities to the Paris location are 45 minutes away for most patients whether in Illinois or Indiana. ESRD patients in the Paris area do not have reasonable access to dialysis services.

The purpose of this project is to improve access to life sustaining dialysis to residents of Edgar County and the immediately surrounding areas.

4. **Source Information**

US Renal Data System, USRDS 2018 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases (2018).

US Renal Data System, USRDS 2019 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD (2019).

5. **Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.**

The proposed facility will bring services to a medically underserved area where residents experience low income and high rates of Medicaid eligibility as well as lack of any insurance coverage. Horizon treats all

patients regardless of ability to pay and assists patients in securing some type of coverage. The goal of Horizon is to establish dialysis services in an area where there currently is no access within a reasonable distance.

As noted above, distance to ESRD facilities has been linked to a lower quality of life and increased mortality. Accordingly, the proposed location would serve the local populations health and well-being by providing them with the access to care that can dramatically improve these metrics.

6. **Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.**

The Applicant anticipates the proposed facility will have quality outcomes comparable to other facilities. Additionally, in an effort to better serve all kidney patients, Horizon believes in requiring all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers -1) dialysis adequacy; 2) fistula use rate; 3) nutrition; and 4) bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations.

original article

http://www.kidney-international.org

Higher mortality among remote compared to rural or urban dwelling hemodialysis patients in the United States

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Living far away from specialized care centers is a potential barrier to the delivery of quality health care and has been associated with adverse outcomes. To assess mortality as a function of distance from the closest hemodialysis unit, and as a function of rural rather than urban residence, we analyzed prospectively collected data on 726,347 adults initiating chronic hemodialysis in the United States over a 13-year period. Participants were classified into categories of 0–10 (referent), 11–25, 26–45, 46–100, and remote living over 100 miles from the closest hemodialysis unit. After a median follow-up of 2.7 years (range 0 to 12.7 years), 368,569 patients died. Compared to the referent group, the adjusted hazard ratio of death was 1.01, 0.99, 0.96, and 1.21, respectively. When residence location was classified using rural–urban commuter areas, 16.5, 66.8, and 16.7% of patients lived in urban, micropolitan, and metropolitan areas, respectively. Compared with those living in metropolitan areas, the adjusted hazard ratio of mortality among patients residing in micropolitan and rural communities was 1.02 and 1.01, respectively. Thus, remote but not rural residence was associated with increased mortality among patients initiating chronic hemodialysis treatment in the United States.

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KEYWORDS: epidemiology and outcomes; hemodialysis; mortality risk; Renal Data System; United States

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Several recent studies suggest that health outcomes are worse for remote-dwelling patients with chronic kidney disease and kidney failure, compared with otherwise similar patients living closer to specialist care.[1–3] Potential inequities in access to health care as a result of remote residence location are particularly relevant for patients treated with hemodialysis—which for most patients requires travel to a treatment facility three times per week. The burden of travel to dialysis has been associated with a lower health-related quality of life and an increased risk of mortality for patients with longer travel times to hemodialysis compared with those with shorter travel times.[4]

Rural vs. urban place of dwelling is an alternative measure of geographical access and is often used to evaluate accessibility to health care. Reported outcomes for urban- vs. rural-dwelling patients with chronic kidney disease have varied.[5,6] In one large study from the United States, survival was comparable for rural- and urban-dwelling hemodialysis patients, although the distance or travel time to the nearest hemodialysis center was not evaluated.[7] A large US population-based study reported that the likelihood of receiving a kidney transplant (when adjusted for factors including distance from care) was slightly higher for rural compared urban dwellers.[8] An estimated one-third of dialysis units in the United States are located in rural areas.[7] As distance to specialist care may differ substantially between rural dialysis units, classifying location as rural vs. urban may not adequately capture access to care. How travel distance to the nearest hemodialysis center and urban vs. rural dwelling is related to the risk of mortality in hemodialysis patients in the United States is unknown.

Ensuring equitable access to high-quality health care for patients with kidney failure is an important objective. To achieve this objective, further examination of the association between residence location and outcomes is required. We evaluated the association between place of residence and mortality among incident hemodialysis patients in the United States using (1) the shortest driving distance to the closest hemodialysis center as determined by patient zip code

and geographic information systems software and (2) the rural–urban commuting area (RUCA) code to classify the degree to which the residence location of each patient was rural or urban. We hypothesized that the risk of mortality would be higher for patients living further away from their dialysis center and for rural vs. urban dwellers.

RESULTS

Patient characteristics

Among the 747,150 patients who initiated chronic hemodialysis during the study period, information on the distance between residence location and the closest hemodialysis center could be determined for 726,347 (97.2%). The 20,803 (2.8%) patients with missing or invalid zip codes were excluded. Patients who lived further away from the closest dialysis center were less likely to be black or have hypertension as a cause of end-stage renal disease (ESRD) than patients living closer ($P<0.0001$; Table 1). When compared with patients living closest to their dialysis unit, patients living >100 miles away had lower rates of coronary disease, peripheral vascular disease, congestive heart failure, and chronic obstructive pulmonary disease. Patients residing further from the hemodialysis center were more likely to live in a rural area. However, among patients residing in a rural area, a substantial proportion, 80.2%, lived within 25 miles of the closest hemodialysis center.

Overall, 127,605 (17.6%) of patients received a kidney transplant during follow-up. Although 26.7% of the study population changed residence location during follow-up, most patients (90.8%) remained in the same distance category throughout the study. Of the 9.2% of patients who changed distance categories during follow-up, 53.0 and 92.6% remained within 10 and 25 miles of the closest hemodialysis center, respectively. Of the 714 remote-dwelling patients, the state of residence was known for all but one patient (0.14%). The highest proportion (84.0%) lived in the West (46.5% lived in California and 13.2% resided in Nevada). Of the remaining remote dwellers, 6.7% lived in the South (Texas and Oklahoma) and 7.6% in the Midwest (Kansas, Minnesota, and North Dakota). Remote dwellers in the Northeastern region resided in Massachusetts (1.5%).

Likelihood of mortality by distance category

During the median follow-up period of 2.7 years, and 368,569 (50.7%) patients died. Table 2 shows the adjusted time to death by distance from the closest hemodialysis center. In the fully adjusted model, patients living >100 miles from the closest dialysis center had an increased hazard of death, 1.21 (1.08, 1.37), compared with the referent group (0–10 miles). When follow-up was not censored at kidney transplantation, the increased risk of mortality in the remote-dwelling group was attenuated, although the test for trend remained statistically significant ($P<0.0001$). The risk of death was 1.00 (0.99–1.01), 0.97 (0.95–0.99), 0.94 (0.90–0.98), and 1.07 (0.96–1.20) for distances of 11–25 miles, 26–45 miles, 46–100 miles, and >100 miles, respectively (all compared with the referent of 0–10 miles).

In an additional analysis, we included with the main cohort the 401,184 dialysis patients who were over 70 years of age and initiated dialysis during the study period. All compared with the referent group of 0–10 miles; the risk of death for 18- to >70-year-olds was 0.99 (0.97–1.00), 0.98 (0.96–0.99), 0.96 (0.93–0.98), and 1.11 (1.02–1.21) for distances of 11–25 miles, 26–45 miles, 46–100 miles, and >100 miles, respectively (P for trend <0.0001). When analyzed separately, patients aged >70 years and living more than 100 miles from the closest hemodialysis center had a hazard ratio for the risk of death of 1.01 (0.89, 1.14) compared with those living within 10 miles.

Tests for interaction demonstrated that age ($P<0.0001$), race ($P<0.0001$), diabetes ($P=0.0149$), cause of ESRD ($P<0.0001$), median income ($P<0.0001$), and insurance status ($P<0.0001$), but not sex ($P=0.057$), all significantly modified the relationship between distance from the hemodialysis center and the likelihood of death. Therefore, we performed analyses that examined the association between time to death and distance from the closest hemodialysis center, and stratified on these potential confounders (Figure 1). The point estimate for mortality in the patients living furthest from the hemodialysis center (>100 miles; as compared with those living <10 miles) was only significant in the 18- to 39- and 60- to 70-year-old age categories: 1.57 (95% confidence interval 1.04–2.37) and 1.36 (1.16–1.60), respectively. Despite the positive test for interaction, the hazard ratio for mortality for those living furthest away was similar among those with (1.23 (1.06–1.44)) and without (1.24 (1.10–1.40)) diabetes as the cause of ESRD. For those with private insurance, the hazard ratio for higher mortality was 1.28 (1.01–1.63) and 1.30 (1.10–1.52) for those insured solely by Medicare.

Likelihood of mortality by rural vs. urban location of residence

After adjustment for distance from the closest hemodialysis center, there was no association between rural residence location and the risk of death (Table 3). A borderline interaction between rural location of residence and the distance from the closest hemodialysis center was noted ($P=0.052$). However, the risk of death was not appreciably increased among rural dwellers than among those living in metropolitan areas within any of the distance categories (Table 4). The analysis including the patients >70 years old showed no association between rural residence location and the risk of death—1.02 (1.02, 1.03) and 1.01 (1.00, 1.02) for patients residing in micropolitan and rural communities, respectively, compared with patients residing in metropolitan areas (data not shown).

DISCUSSION

To our knowledge, this is the first study to evaluate survival for a large population of hemodialysis patients in the United States

Table 1 | Demographics and clinical characteristics among patients initiating chronic hemodialysis, by distance to the closest hemodialysis center

	0–10 Miles, N=558,127	11–25 Miles, N=135,889	26–45 Miles, N=26,171	46–100 Miles, N=5446	>100 Miles, N=714	P-value
*Age**						
Mean (s.d.)	53.44 (12.05)	54.27 (11.84)	54.93 (11.60)	55.42 (11.48)	53.32 (12.17)	<0.0001
18–39 N (%)	85,740 (15.4)	18,508 (13.6)	3237 (12.4)	611 (11.2)	111 (15.6)	<0.0001
40–59	269,160 (48.2)	64,002 (47.1)	12,080 (46.2)	2479 (45.5)	344 (48.2)	<0.0001
60–70	203,227 (36.4)	53,379 (39.3)	10,854 (41.5)	2356 (43.3)	259 (36.3)	<0.0001
Female	250,663 (44.9)	60,006 (44.2)	11,721 (44.8)	2452 (45.0)	268 (37.5)	<0.0001
Race						
White	306,978 (55.0)	96,068 (70.7)	20,702 (79.1)	4659 (85.6)	604 (84.6)	<0.0001
Black	216,915 (38.9)	33,558 (24.7)	3582 (13.7)	142 (2.6)	38 (5.3)	<0.0001
American Indian	5532 (0.99)	3329 (2.4)	1588 (6.1)	591 (10.9)	54 (7.6)	<0.0001
Other	28,702 (5.1)	3024 (2.2)	299 (1.1)	54 (1.0)	18 (2.5)	<0.0001
Cause of ESRD						
Diabetes	264,296 (47.4)	66,818 (49.2)	13,651 (52.2)	3053 (56.1)	362 (50.7)	<0.0001
Glomerulonephritis	57,916 (10.4)	14,624 (10.8)	2705 (10.3)	600 (11.0)	87 (12.2)	0.0002
Hypertension	122,685 (22.0)	25,835 (19.0)	4319 (16.5)	670 (12.3)	99 (13.9)	<0.0001
Other	113,230 (20.3)	28,612 (21.1)	5496 (21.0)	1123 (20.6)	166 (23.3)	<0.0001
BMI > 30 kg/m^2	165,379 (29.6)	43,370 (31.9)	8476 (32.4)	1563 (28.7)	193 (27.0)	<0.0001
Comorbidities						
CAD	101,044 (18.1)	29,423 (21.7)	6185 (23.6)	1200 (22.0)	115 (16.1)	<0.0001
PVD	60,668 (10.9)	17,773 (13.1)	3793 (14.5)	736 (13.5)	74 (10.4)	<0.0001
CVD	39,741 (7.1)	10,709 (7.9)	2190 (8.4)	380 (7.0)	54 (7.6)	<0.0001
CHF	140,188 (25.1)	36,504 (26.9)	7241 (27.7)	1366 (25.1)	140 (19.6)	<0.0001
Cancer	21,322 (3.8)	6196 (4.6)	1240 (4.7)	229 (4.2)	33 (4.6)	<0.0001
COPD	28,780 (5.2)	9683 (7.1)	2128 (8.1)	347 (6.4)	33 (4.6)	<0.0001
History of drug or alcohol abuse	19,324 (3.5)	3462 (2.6)	594 (2.3)	133 (2.4)	25 (3.5)	<0.0001
Smoker	36,476 (6.5)	10,582 (7.8)	2341 (9.0)	429 (7.9)	60 (8.4)	<0.0001
Nonambulatory	20,520 (3.7)	5165 (3.8)	1111 (4.3)	147 (2.7)	23 (3.2)	<0.0001
eGFR* at the time of dialysis initiation (s.d.)	8.84 (4.36)	9.09 (4.39)	9.14 (4.43)	8.85 (4.35)	8.68 (4.46)	<0.0001
Insurer						
Medicare	248,170 (46.1)	60,801 (46.2)	13,321 (52.5)	2686 (51.4)	299 (43.3)	<0.0001
Private	162,197 (30.1)	42,344 (32.2)	6421 (25.3)	1235 (23.6)	215 (31.1)	<0.0001
Veterans'	7926 (1.5)	2037 (1.6)	494 (2.0)	109 (2.1)	23 (3.3)	<0.0001
Other/none	120,567 (22.4)	26,518 (20.1)	5156 (20.3)	1201 (23.0)	154 (22.3)	<0.0001
RUCA score						
1.0–3.9	109,355 (20.1)	6199 (4.7)	306 (1.2)	0 (0.00)	125 (19.3)	<0.0001
4.0–6.0	397,192 (73.1)	67,260 (51.3)	5519 (22.2)	1161 (22.6)	222 (34.2)	<0.0001
>6.0	36,901 (6.8)	57,688 (44.0)	19,063 (76.6)	3972 (77.4)	302 (46.5)	<0.0001
Median annual income						
$0–28,999	134,392 (24.2)	24,593 (18.3)	9559 (37.2)	2279 (42.3)	107 (15.1)	<0.0001
$29,000–35,999	127,817 (23.1)	35,401 (26.3)	10,068 (39.1)	2327 (43.2)	141 (19.8)	<0.0001
$36,000–45,999	143,388 (25.9)	38,570 (28.7)	5037 (19.6)	584 (10.8)	339 (47.7)	<0.0001
$46,000+	148,778 (26.8)	35,880 (26.7)	1063 (4.1)	200 (3.7)	124 (17.4)	<0.0001

Abbreviations: BMI, body mass index; CAD, coronary artery disease; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; CVD, cerebrovascular disease; eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; PVD, peripheral vascular disease; RUCA, rural–urban commuting area.
Data expressed as *N* (%), except * mean (standard deviation). Totals do not always add to 100% because of rounding.
Communities were classified as: metropolitan (RUCA 1.0–3.9; cities with population of >50,000 and their associated suburban areas); micropolitan (RUCA 4.0–6.0; towns or cities with population of 10,000 to 50,000); or rural (RUCA >6.0; towns with population of <10,000).
Data on eGFR, RUCA score, insurer, and median annual income were available for *n*=667,330, *n*=726,347, *n*=692,779, *n*=705,265, and *n*=720,647 of the study population, respectively.

as a function of distance to the nearest hemodialysis center while also accounting for urban–rural status. Evaluation of both of these factors is potentially significant given the decentralization of dialysis services in the United States; rural status alone may not adequately measure access to care.

Patients who lived the furthest from the closest hemodialysis center (>100 miles) had a 21% increased risk of death compared with those living within 10 miles of the closest center. Although patients living further away from the closest dialysis center were more likely to live in a rural area than those living closer, 53.5% of patients living more than 100 miles from the closest dialysis unit lived in either a metropolitan (population >50,000) or a micropolitan (population 10,000–50,000) area. Furthermore, when adjusted

Table 2 | Relation between distance to the closest hemodialysis center and time to mortality

	Proportion who died	Model 1: adjusted for age, sex, race	Model 2: Model 1 with adjustment for clinical characteristics[a]	Model 3: Model 2 with adjustment for socioeconomic characteristics[b]
0–10 Miles	281,655/558,127 (50.5%)	1.00	1.00	1.00
11–25 miles	69,929/135,889 (51.5%)	1.04 (1.03, 1.05)	1.03 (1.02, 1.04)	1.01 (1.00, 1.02)
26–45 Miles	13,841/26,171 (52.9%)	1.04 (1.02, 1.06)	1.01 (1.00, 1.03)	0.99 (0.97, 1.01)
46–100 Miles	2790/5446 (51.2%)	0.94 (0.90, 0.98)	0.95 (0.92, 0.99)	0.96 (0.92, 1.00)
>100 Miles	354/714 (49.6%)	1.10 (0.99, 1.23)	1.13 (1.01, 1.26)	1.21 (1.08, 1.37)

Results are expressed as hazard ratios with 95% confidence intervals. Models are censored at the time of kidney transplantation.
[a]Cause of end-stage renal disease, body mass index, comorbidities, smoking, drug/alcohol use, nonambulatory status, diabetes, estimated glomerular filtration rate.
[b]Insurance status, median neighborhood household income, rural-urban commuting area.

for distance, rural–urban status was not significantly associated with survival. These findings suggest that remote distance (>100 miles) from the closest dialysis unit, rather than rural–urban status, better reflects the increased risk of mortality associated with residence location in US hemodialysis patients. The magnitude of the increased risk among remote dwellers was relatively small, and was attenuated when follow-up time after kidney transplantation was included. This attenuated association was anticipated given the previous information that remote dwellers (albeit evaluated as distance from a transplant center) have a higher likelihood of transplantation than those living closer, and outcomes are better following transplantation as compared with dialysis.[8]

We attempted to identify factors that influenced the association between remote residence location and the risk of mortality. Despite positive tests for interaction, visual inspection of the hazards by distance category suggests that the relationship was similar in groups defined by such factors. Although we did not find an increased risk of death among remote dwellers with certain characteristics (such as diabetes; age 40–59 years; or with hypertension as the underlying cause of ESRD), it is unclear whether this represents a true difference or is due to residual confounding by unmeasured characteristics such as patient or physician preferences. The risk of death by distance from the closest dialysis center was not consistently related to age. Furthermore, we did not find that inclusion of elderly dialysis patients in the study population (age more than 70 years old) influenced the relationship between remote residence location and the risk of mortality. The inclusion of this elderly group of dialysis patients also did not increase mortality in the rural-dwelling group. It is possible that, irrespective of location, patients over the age of 70 years who initiate dialysis are a highly selected group with a lower comorbid disease burden that is unaccounted for in our analysis despite adjustment for comorbid conditions in multivariate models. In a smaller study from England, the risk of mortality was higher for incident dialysis patients over 80 years of age; however, comorbidity was a more significant predictor of outcome than age.[9] Future studies should collect detailed information on clinical characteristics such as the severity of comorbid conditions and markers of quality of care for hemodialysis patients by residence location.

Our results are in keeping with a previously published study evaluating the association between remote dwelling and survival in Canadian hemodialysis patients,[2] which found a marked increase in the risk of death from infectious causes for patients living more than 300 km away. It is possible that remote-dwelling patients in that study had higher rates of catheter use and catheter complications, which might have increased mortality; however, data regarding vascular access type were not available. Our results regarding remote-dwelling status and the likelihood of kidney transplantation are consistent with another large study based on United States Renal Data System (USRDS) data showing that remote dwellers (remote from a transplant center) had a similar or higher likelihood of transplantation compared with patients living within 15 miles of the kidney transplant center.[8] We speculate that the higher likelihood of transplantation among remote dwellers from a dialysis center in the current study may be related to lower comorbid disease burden in this group, which was not accounted for in our multivariate analysis, or a higher motivation to pursue transplantation among remote dwellers because of the travel burden of dialysis.

Studies based on rural vs. urban residence have reported equivocal,[7] superior,[10] or inferior[3,6] outcomes for rural dwellers with chronic kidney disease, compared with otherwise similar urban dwellers. A British study of 2548 dialysis patients analyzed by health authority reported the lowest mortality for rural and urban residence and highest mortality in industrial or mining health authorities.[5] The disparity in survival was not explained by other factors, including distance to dialysis center. However, this study did not censor at transplantation, and the majority of patients were treated with peritoneal dialysis rather than in-center hemodialysis. Our study included all adult patients starting hemodialysis over a 12-year period in the United States. We adjusted for a number of patient and socioeconomic factors and RUCA score, and also accounted for any potential disparities in access to transplant by censoring at transplantation.

It is possible that hemodialysis patients living far from their dialysis unit have a higher burden of comorbid conditions than those living closer. However, in our study, patients living the furthest away had the lowest rates of

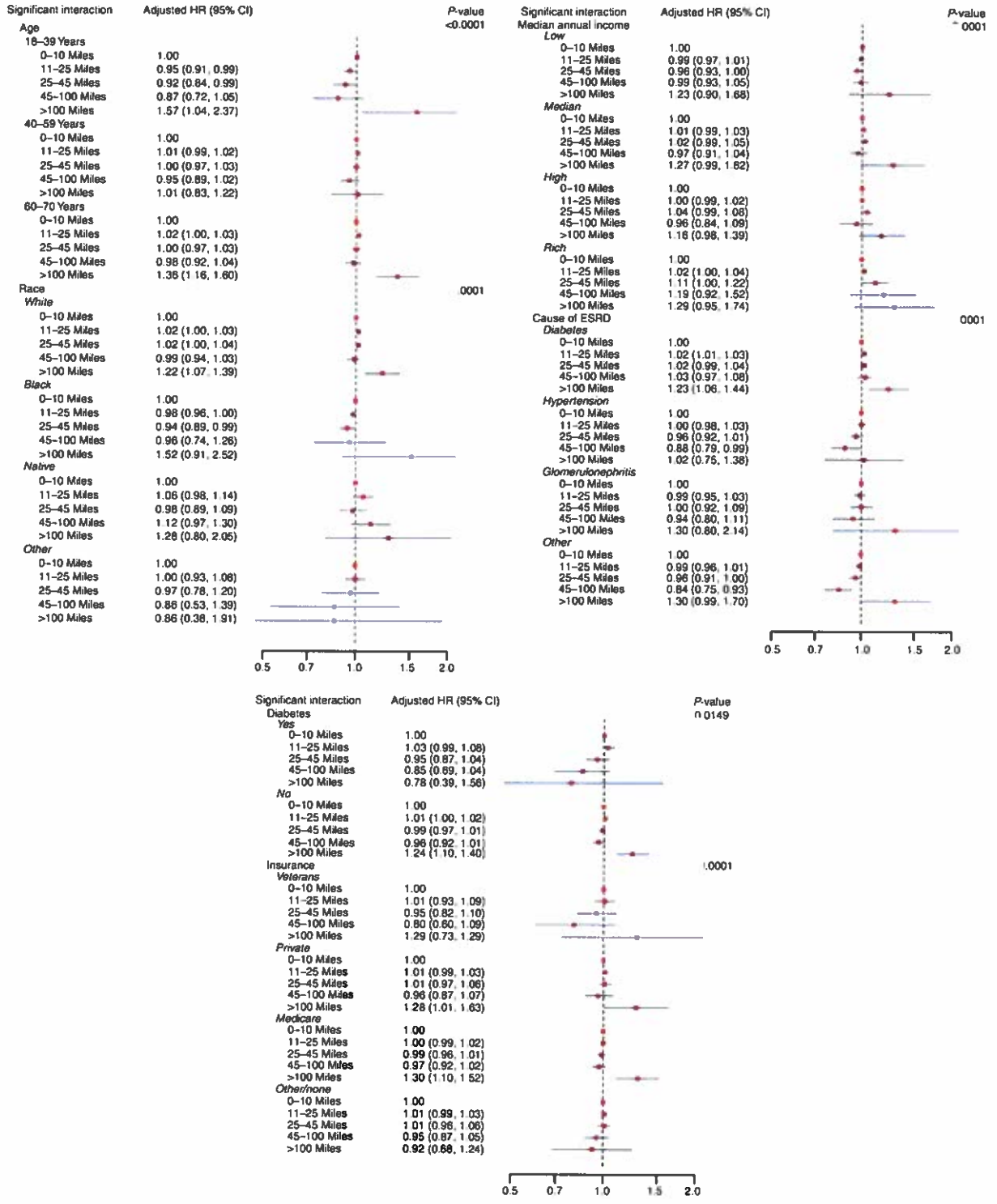

Figure 1 | The figure shows the adjusted hazard ratios (HRs) and 95% confidence intervals (CIs) associated with the likelihood of mortality by distance to the closest hemodialysis center (all compared with the referent group of those living within 10 miles). Models are censored at the time of kidney transplantation and adjusted for patient age, gender, race, cause of end-stage renal disease (ESRD), diabetic status, median within-neighborhood household income, insurance status, current smoking status, ambulatory status, comorbid conditions (coronary artery disease, peripheral vascular disease, cerebrovascular disease, congestive heart failure, malignancy, chronic obstructive pulmonary disease, alcohol or drug dependence), body mass index, and estimated glomerular filtration rate at dialysis initiation. Tests for interaction were significant at $P < 0.0001$ for age, race, insurance status, median annual income, cause of ESRD, and at $P = 0.0149$ for diabetic status.

Table 3 | Likelihood of mortality, by rurality of residence location

	Proportion who received a kidney transplant	Time to death, with censoring at the time of kidney transplantation	Proportion who died	Time to death, uncensored
Metropolitan (RUCA 1.0–3.9)	18,493/115,985 (15.9%)	1.00	55,940/115,985 (48.2%)	1.00
Micropolitan (RUCA 4.0-6.0)	84,874/471,354 (18.0%)	1.02 (1.01, 1.03)	238,317/471,354 (50.6%)	1.01 (1.00, 1.02)
Rural (RUCA >6.0)	21,316/117,926 (18.1%)	1.00 (0.99, 1.02)	62,655/117,926 (53.1%)	0.99 (0.97, 1.00)

Abbreviation: RUCA, rural-urban commuting area.
Results are expressed as hazard ratios with 95% confidence intervals.
Communities were classified as: metropolitan (RUCA 1.0–3.9; cities with population of >50,000 and their associated suburban areas); micropolitan (RUCA 4.0-6.0; towns or cities with population of 10,000 to 50,000); or rural (RUCA >6.0; towns with population of <10,000).
All analyses were adjusted for age, sex, race, cause of end-stage renal disease, body mass index, comorbidities, smoking, drug/alcohol use, nonambulatory status, median household income, insurance status, estimated glomerular filtration rate and distance from the closest dialysis center.

Table 4 | Relation between RUCA and time to mortality, in strata defined by distance from the closest hemodialysis center

	0–10 Miles	11–25 Miles	26–45 Miles	46–100 Miles	>100 Miles
Metropolitan (RUCA 1.0–3.9)	1	1	1	1	1
Micropolitan (RUCA 4.0-6.0)	1.01 (1.00, 1.02)	1.01 (0.97, 1.05)	0.98 (0.82, 1.17)	[a]	1.21 (0.79, 1.87)
Rural (RUCA >6.0)	0.99 (0.97, 1.01)	0.98 (0.94, 1.02)	0.97 (0.81, 1.15)	1.02 (0.91, 1.14)	0.97 (0.55, 1.72)

Abbreviation: RUCA, rural-urban commuting area.
Results are expressed as hazard ratios with 95% confidence intervals. Data was censored at the time of transplantation.
Communities were classified as: metropolitan (RUCA 1.0–3.9; cities with population of >50,000 and their associated suburban areas); micropolitan (RUCA 4.0-6.0; towns or cities with population of 10,000 to 50,000); or rural (RUCA >6.0; towns with population of <10,000).
All analyses were adjusted for age, sex, race, cause of end-stage renal disease, body mass index, comorbidities, smoking, drug/alcohol use, nonambulatory status, median household income, insurance status, estimated glomerular filtration rate and distance from the closest dialysis center.
[a]Insufficient observations in this cell to compute an estimate.

measured comorbid conditions. There was a modest increase in the risk of mortality for remote-dwelling patients with ESRD secondary to diabetes compared with those patients living closest to their dialysis center, suggesting that the higher mortality could be related to decreased physician or health-service access. Yet, just over half of the patients in this category lived in either a micropolitan or metropolitan area where better access to physicians and health services would be expected, as compared with rural areas. A potential explanation for our results is that the longer distance to travel to a dialysis center may cause patients to miss or shorten a dialysis session. Moist *et al.*[4] reported a 20% greater risk of death for patients with a travel time to dialysis greater than 60 min compared with those patients with a travel time of 15 min or less. Among patients with longer travel times, transportation issues were identified as a frequent reason to skip or shorten a dialysis session. Both skipping[11] and shortening[12] dialysis sessions have been associated with increased mortality.

Our study has several limitations. The distance calculations are based on zip codes and only approximate the true distance; to minimize bias, we used broad distance categories. We excluded people without a valid zip code, although this group accounted for less than 3% of the study population. We used each patient's zip code at the time of dialysis initiation to classify residence location, and this method could misclassify patients who moved during the study. However, at follow-up, 90.8% of the patients had remained in the same distance category. Given that a minority of patients move further away from specialty care once starting dialysis,[2] the true risk of death among remote-dwelling patients would therefore be expected to underestimate mortality in this group. Remote residence location has been associated with a lower risk of initiating dialysis, although we would that expect this effect would also bias the results toward the null—with only healthier remote-dwelling patients initiating dialysis.[3] We were unable to reliably identify patients' performing their own dialysis at home, and such patients were therefore included in the analysis. However, as the number of such patients in the United States is low (1756 at the approximate middle point of our study period), this is unlikely to have affected our conclusions.[13] Our analysis did not account for changes in dialysis modality that may have occurred after the initiation of hemodialysis. However, on the basis USRDS data, the probability of a change in modality does not differ significantly by rural–urban location.[14] We did not have individual-level data on socioeconomic status, and because our primary geolocalizing variable was based on zip code we could not use more precise methods such as block area addresses to categorize participants with respect to socioeconomic status. However, results were similar when an alternative method of adjusting for income (based on zip code tabulation areas) was used instead (data not shown). We did not evaluate travel time as a geographical barrier to access, and it is possible that patients using public transportation to travel to a dialysis unit would require a

similar amount of travel time as remote-dwelling patients using private transportation. Although the optimal method of measuring geographical access is unknown, we evaluated distance by road to the closest dialysis center as it is an objective determination of geographical access, which is highly correlated with travel time.[15] Finally, we did not have information on the actual dialysis unit at which patients received care, and therefore assumed that patients attended the closest dialysis center.

In conclusion, we found that mortality was higher for hemodialysis patients living more than 100 miles from the closest dialysis center compared with those living closer. In contrast, there was no evidence that the likelihood of death was higher among rural-dwelling compared with urban-dwelling patients. Although the number of remote-dwelling hemodialysis patients in the United States is relatively small, our results indicate that future studies should evaluate the specific factors that are related to travel distance, such as cost, time, and access to transportation—as well as assessing the quality of care in these patients.

MATERIALS AND METHODS

Study population and data sources

Data from the USRDS were used for this study, which was approved by the local research ethics review board at the University of Alberta. We studied incident adult patients, aged 18 to 70 years, who initiated chronic hemodialysis between 1 January 1995 and 30 September 2007 in the continental United States. The USRDS provides the zip code for each patient's residence location at the time of first renal replacement (dialysis or transplantation), as well as a listing of centers providing chronic hemodialysis and their zip codes. The population of each zip code was obtained using data from the 2000 US census and mapped onto zip-code tabulation areas.[16]

Estimation of distance

The geographic coordinates for each five-digit zip code were determined using the USA 5-digit ZIP Code Database (ZIP Code Download, Provo, Utah). These coordinates were entered into the ArcGIS 9.2 software (ESRI Incorporated, Redlands, CA) to determine the shortest distance by road (in miles) between the closest hemodialysis center and the residence of each patient at initiation of hemodialysis.[17–19] Distance to the closest hemodialysis center was categorized corresponding to the 0–75th >75–95th >95–99th >99–99.9th > and >99.9th percentiles. To assess the impact of changes in residence location over time, patients were categorized into distance categories as above using the zip code associated with their residence at the time of the last follow-up. Patient residence data were only available at the zip-code level, and thus a change in residence location was defined as a move to another zip code.

Classification of rural status

We used the RUCA code to classify the extent to which the residence location of each patient was rural or urban.[20] RUCA codes are assigned to each US zip code based on markers of population density, with values ranging from 1.0 (most urban) to 10.6 (most rural). Information on population density is supplemented by data on employment commuting to ensure that suburban areas with low population density in which many residents work in nearby large urban areas are classified as urban. As in previous work,[20] we classified each patient in the current analysis as belonging to 1 of 3 mutually exclusive RUCA groups: metropolitan (RUCA 1.0–3.9; cities with population of >50,000 and their associated suburban areas); micropolitan (RUCA 4.0–6.0; towns or cities with population of 10,000 to 50,000; and rural (RUCA >6.0; towns with population of <10,000).

Statistical analyses

Time to mortality was determined from the date of first renal replacement using the Kaplan–Meier method, and group differences were compared with the log-rank test. Patients were followed up until death or until the end of follow-up (30 September 2007) and censored after time of kidney transplantation. To evaluate the effect of transplantation on survival according to patient location, we conducted a sensitivity analysis that did not censor participants at kidney transplantation. Cox multivariate regression analysis was performed to determine the likelihood of mortality among patients in the different distance categories after adjustment for the following potential confounders: patient age, gender, race (as submitted to the USRDS on the initial Medical Evidence form: white, Black, American Indian, other), cause of ESRD (diabetes, glomerulonephritis, hypertension, other causes), median within-neighborhood household income (determined by linkage of patient zip codes to data from the 2000 US census), insurance status (Medicare only; private insurance only; insured by Department of Veterans' Affairs, other or no insurance), current smoking status, ambulatory status, comorbid conditions (coronary artery disease, peripheral vascular disease, cerebrovascular disease, congestive heart failure, malignancy, chronic obstructive pulmonary disease, alcohol or drug dependence), body mass index, and estimated glomerular filtration rate at dialysis initiation. In cases in which data were missing, a category of unknown was created and entered into the model. To assess the influence of clinically relevant patient characteristics on the risk of mortality by distance, we repeated analyses in subgroups defined by combinations of age <50 years, absence of diabetes, insurance status, and rural–urban residence location.

Tests for interaction were performed using cross-product terms in the Cox proportional hazards models. The proportional hazards assumption was tested using log-negative log plots of the within-group survivorship probabilities vs. log-time as well as time-dependent covariates in the Cox model. Statistical significance was set at $P<0.05$, and all statistical tests were two sided. Analyses were performed with SAS version 9.1 (SAS Institute, Cary, NC) and S-PLUS version 7.0 (TIBCO Software, Palo Alto, CA).

DISCLOSURE

All the authors declared no competing interests.

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Travel Time to Dialysis as a Predictor of Health-Related Quality of Life, Adherence, and Mortality: The Dialysis Outcomes and Practice Patterns Study (DOPPS)

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Background: Longer travel time to the dialysis unit creates a substantial burden for many patients. This study evaluated the effect of self-reported 1-way travel time to hemodialysis on mortality, health-related quality of life (HR-QOL), adherence, withdrawal from dialysis therapy, hospitalization, and transplantation.

Study Design: Prospective observational cohort.

Setting & Participants: Patients enrolled in the Dialysis Outcomes and Practices Patterns Study who completed a patient questionnaire (n = 20,994).

Predictor: One-way travel time to hemodialysis treatment, categorized as 15 or less, 16 to 30, 31 to 60, and longer than 60 minutes. Covariates included demographics, comorbid conditions, serum albumin level, time on dialysis therapy, and country.

Outcome & Measurement: HR-QOL was examined by using a linear mixed model. Cox proportional hazards regression was used to examine associations with mortality, withdrawal from dialysis therapy, hospitalization, and transplantation.

Results: Longer travel time was associated with greater adjusted relative risk (RR) of death ($P = 0.05$ for overall trend). Adjusted HR-QOL subscales were significantly lower for those with longer travel times compared with those traveling 15 minutes or less. There were no associations of travel time with withdrawal from dialysis therapy ($P = 0.6$), hospitalization ($P = 0.4$), or transplantation ($P = 0.7$).

Limitations: The questionnaire nonresponse rate was substantial, and nonresponders were older, with more comorbid conditions. Travel time was assessed by using a single nonvalidated question.

Conclusions: Longer travel time is associated significantly with greater mortality risk and decreased HR-QOL. Exploring opportunities to decrease travel time should be incorporated into the dialysis clinical routine.

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INDEX WORDS: Hemodialysis; travel time; distance; health-related quality of life; hospitalization; mortality; transportation; end-stage renal disease.

Although advances in hemodialysis treatment contribute to improved survival,[1] patients continue to have markedly impaired health-related quality of life (HR-QOL).[2-5] Many of the contributing factors are difficult to modify, including age, sex, multiple comorbidities, low albumin level, low income, educational status, and mental illness.[6] A smaller number of modifiable variables have been identified, such as early referral,[7,8] correction of anemia,[9] exercise,[10] and, possibly, treatment of depression.[11] Recent qualitative studies of patient experiences showed a frequent and recurring theme: time involved with both the dialysis treatment and travel affected HR-QOL.[12] Personal perspectives included: "I feel as if it rules all of my time,"[13] "time is the worst part,"[14] "it ties you to a certain place and time,"[15] and "one has to live close to the unit."[15,16]

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Travel burden has been a key element in conceptualizing geographic access to health care. During the 1960s, dialysis most commonly was provided by a small number of renal units based out of academic teaching facilities. Many countries have since decentralized the provision of dialysis therapy, with a resultant decrease in travel time and increase in accessibility.[17] Despite both the acknowledgement of travel issues for patients and changes in the dialysis delivery system, there is scant literature about the effect of distance and travel time on HR-QOL, mortality, or other outcomes in the hemodialysis population. The objective of this report is to evaluate the effect of 1-way travel time to hemodialysis therapy on mortality, HR-QOL, adherence, withdrawal from dialysis therapy, and transplantation. We also examined the association between travel time and predialysis care and performance targets on dialysis therapy.

METHODS

Study Sample

This study used a sample of 20,994 hemodialysis patients from the Dialysis Outcomes and Practices Patterns Study (DOPPS I, 10,775 patients; DOPPS II, 10,219 patients) who completed a patient questionnaire. These prospective observational studies involve adult hemodialysis patients randomly selected from 307 representative dialysis facilities in 7 countries (France, Germany, Italy, Japan, Spain, United Kingdom, and United States) for DOPPS I and 319 dialysis facilities in 12 countries (DOPPS I countries plus Australia, Belgium, Canada, New Zealand, and Sweden) for DOPPS II. In each study, a nationally representative sample was obtained by using randomized patient selection, with ongoing longitudinal patient and facility data collection. Data from DOPPS I were collected from 1996 to 2001, and data from DOPPS II were collected from 2002 to 2004. The sampling plan and study methods for the DOPPS are described elsewhere.[18] Institutional review boards approved the DOPPS in each country or facility, as required. Informed patient consent was obtained in accordance with the requirements of each country, review board, and dialysis center. Data collection was performed in a fashion that maintained patient anonymity at the coordinating center.

Travel Time to Dialysis

Data for travel time were extracted from 1 of 88 questions completed as part of a patient questionnaire. The following single question was asked: "How long does it take you to get to your dialysis unit or center (1 way)?" Response options included 15 or less, 16 to 30, 31 to 60, and longer than 60 minutes.

Quality-of-Life Questionnaire

Patient responses to the Kidney Disease Quality of Life Short Form were used to determine scores of 3 summary measures of HR-QOL: Mental Component Summary, Physical Component Summary, and Kidney Disease Component Summary. Scales for the Mental Component Summary and Physical Component Summary were derived from 8 different subscales originally developed for the 36-Item Short Form Health Survey: Physical Functioning, Role–Physical, Bodily Pain, General Health, Vitality, Social Functioning, Role–Emotional, and Mental Health. The scale for the Kidney Disease Component Summary is derived from 11 subscales: (1) symptoms/problems, (2) effects of kidney disease on daily life, (3) burden of kidney disease, (4) work status, (5) cognitive function, (6) quality of social interaction, (7) sexual function, (8) sleep, (9) social support, (10) dialysis staff encouragement, and (11) patient satisfaction. For all scales, higher scores represent better HR-QOL.

Additional questions included: "How do you usually get to dialysis?" Participants responded "yes" or "no" to the following questions: "In the past month of dialysis, have transportation problems caused you to shorten a hemodialysis session?" and "In the past month of dialysis, have transportation problems caused you to skip or miss a hemodialysis treatment?" A question from the unit practice survey (completed by the nurse manager) also was examined: "In general, when a patient is late for a scheduled treatment, we cannot provide a full treatment," with responses that ranged from strongly disagree to strongly agree.

Statistical Analysis

Univariate statistics were used to describe study patients versus those who did not complete the patient questionnaire. Descriptive statistics were used to examine the distribution of travel time and its correlation with predialysis care characteristics and hemodialysis performance measures. Overall trend P values were determined by means of type 3 contrasts for the travel-time effect using the score statistic.

The association between travel time and HR-QOL was examined by using linear mixed models and adjusted for age, sex, race, time on dialysis therapy, albumin level, 14 summary comorbid conditions (coronary heart disease, congestive heart failure, other cardiac conditions, hypertension, peripheral vascular disease, cerebrovascular disease, diabetes, lung disease, cancer [other than skin], human immunodeficiency virus/acquired immunodeficiency syndrome, gastrointestinal bleeding, neurological disease, psychiatric disorders, and recurrent cellulitis), phase of study, and country. Skewness of the HR-QOL variables was assessed, and log transformations were used when the skewness factor was greater than 0.6 to confirm P values. The association between travel time and all-cause mortality, withdrawal from dialysis therapy, first hospitalization, and transplantation were examined by using Cox proportional hazards regression. These models used the same variables listed for the linear models, but stratified by phase of study and country. Patients were censored if they did not attain the outcome by the end of the study or left the study for other reasons. Interactions between travel time and country were analyzed. All models accounted for facility clustering. In the linear

Table 1. Patient Characteristics by Treatment Time

Characteristic	≤15 Min	16-30 Min	31-60 Min	>60 Min	Nonresponders
No. of patients	8,197	7,390	4,405	1,002	7,347
Age (y)	60.2 ± 15.0	61.2 ± 14.7	60.9 ± 14.7	60.9 ± 14.2	62.8* ± 15.6
Men (%)	56.9	58.8	59.0	57.2	57.1
Black (%)	15.0	10.4	12.5	9.5	19.8*
Cause of ESRD (%)					
Diabetes mellitus	27.5	26.1	23.0	24.6	35.0
Hypertension	18.1	16.5	16.8	15.7	20.6
Glomerulonephritis	21.6	23.0	21.3	21.5	13.8
Other	33.9	34.4	38.9	38.3	30.6
Comorbid conditions (%)					
Coronary heart disease	40.1	39.6	38.2	38.9	46.8*
Congestive heart failure	29.7	29.3	27.6	31.4	41.2*
Other cardiac condition	31.2	32.4	32.2	31.8	33.2
Hypertension	79.1	76.5	76.2	77.2	76.0†
Peripheral vascular disease	21.9	22.7	22.2	21.2	27.8*
Cerebrovascular disease	14.6	14.6	14.0	13.4	20.9*
Diabetes	35.3	34.3	32.2	34.6	45.3*
Lung disease	9.7	9.5	10.4	12.9	12.7*
Cancer (other than skin)	10.0	10.8	10.8	10.5	11.7†
HIV/AIDS	0.7	0.3	0.5	0.7	1.1*
Gastrointestinal bleeding	6.1	6.0	5.4	6.2	8.2*
Neurological disease	7.7	7.4	7.8	6.4	14.5*
Psychiatric disorders	18.5	17.9	18.3	20.9	25.3*
Recurrent cellulitis	6.6	6.3	6.2	6.0	10.2*
Depression					
CES-D score > 10	41.2	43.9	48.1	45.2	—
Physician diagnosis	14.1	13.7	14.1	16.5	19.7*
Employment status (%)					
Employed full- or part-time or self employed (<60 y)	27.7	29.9	26.9	20.4	20.5*
Family support (%)					
Living with friends/family	79.6	81.1	79.8	81.3	72.0*
Married	58.4	62.3	59.0	61.3	51.4*
Prior peritoneal dialysis	6.2	6.9	8.6	8.5	7.5
Prior kidney transplant	5.9	6.2	6.7	7.7	4.3*
On transplant waiting list	14.9	14.9	15.4	16.0	8.3*
Time with ESRD (y)	1.61 (0.06-4.6)	1.54 (0.07-5.0)	1.46 (0.04-4.5)	1.12 (0.02-4.3)	0.39* (0.01-3.0)

Note: Values expressed as mean ± SD, percent, or median (25th to 75th percentile).

Abbreviations: ESRD, end-stage renal disease; HIV/AIDS, human immunodeficiency virus/acquired immunodeficiency disease; CES-D, Center for Epidemiological Studies Depression Scale.

*$P < 0.0001$ versus responders.

†$0.0001 < P < 0.05$ versus responders.

mixed models, facility was treated as a random effect and the covariance structure assumed was variance components, which models a different variance component for each random effect. The sandwich estimator, a robust covariance matrix estimator, was used to account for facility clustering in Cox models. It provides consistent estimates of the covariance matrix for parameter estimates, even when a parametric model fails to hold or is not even specified.[19]

Hemodialysis patients with longer travel times may represent a select group who have either failed or were ineligible for transplantation and/or peritoneal dialysis therapy. A sensitivity analysis was performed, restricted to patients without a history of peritoneal dialysis therapy or transplantation. More patients relied on transportation sent from the facility or ambulance in the longer-than-60-minute group. The sensitivity analysis was repeated restricted to participants who did not travel by ambulance or transportation sent by the facility. Also, to ensure that the associations were consistent across countries, interactions were examined with travel-time groups.

RESULTS

Of 28,323 DOPPS patients, 25.9% did not complete the patient questionnaire and thus were ineligible for this study. Table 1 lists the distribu-

Table 2. Distribution of Travel Time and Percentage of Nonresponders on the Patient Questionnaire by Country

Country	No. of Responders	Patients (% of responders)				Nonresponders (% of total)
		≤15 Min	16-30 Min	31-60 Min	>60 Min	
Australia and New Zealand	615	28.8	36.7	28.2	6.3	10.2
Belgium	666	38.0	38.0	20.9	3.1	14.7
Canada	665	31.4	32.2	27.4	9.0	17.2
France	659	31.9	33.1	29.1	5.9	12.6
Germany	734	45.6	41.1	12.9	0.4	9.3
Italy	759	41.2	35.2	20.6	3.0	6.7
Japan	1,901	36.7	40.9	19.3	3.1	13.2
Spain	803	30.6	27.6	30.0	11.8	7.8
Sweden	671	29.4	30.8	29.2	10.6	16.4
United Kingdom	606	25.2	35.6	30.2	8.9	15.3
United States	2,140	46.6	32.9	17.2	3.2	33.3
Overall	10,219	37.1	35.3	22.4	5.2	18.3

Note: Data from Dialysis Outcomes and Practices Patterns II.

tion of patient characteristics for the study population by travel time and for those who did not complete the patient questionnaire. Ineligible nonresponders were significantly older, more likely to be black, had a greater prevalence of several comorbid conditions, had a shorter time since starting dialysis therapy, and were less likely to be employed, married, living with family or friends, previously have undergone transplantation, or be on the transplant list. Characteristics of study patients were similar across travel-time categories, with the exception of fewer blacks and employed patients and more patients with a history of lung disease, physician-diagnosed depression, and prior peritoneal dialysis therapy and transplantation in the longer-travel-time categories.

Distribution of travel time and percentage of nonresponders are listed by country in Table 2. The percentage of patients traveling longer than 60 minutes was 5.2% and ranged from 0.4% in Germany to 11.8% in Spain. In the United States, 33.3% of patients did not complete the questionnaire, with a range of 6.7% to 17.2% for the other countries.

Outcome Measures by Travel Time

Crude rates per 100 patient-years and adjusted relative risks (RRs) for all-cause mortality, hospitalization, withdrawal from dialysis therapy, and transplantation are shown in Fig 1.

Mortality by Travel Time

The crude mortality rate increased from 12.0/100 patient-years in patients traveling 15 minutes or less to 15.0/100 patient-years in those traveling longer than 60 minutes ($P < 0.01$). After adjustment for factors listed in Table 1, patients traveling longer than 60 minutes had a 20% greater risk of death compared with those traveling 15 minutes or less (RR, 1.20; $P = 0.05$), with a significant trend across all time categories ($P = 0.05$). This effect persisted after adjustment for type of vascular access and adherence measures. Because there were more patients relying on ambulance or transportation sent from the hospital in the group traveling longer than 60 minutes, we repeated the analysis excluding patients using an ambulance or transportation sent from the hospital; the effect persisted in the longer-than-60-minute group (RR, 1.44; $P < 0.01$). No significant interactions were seen between treatment-time categories and country.

Hospitalization by Travel Time

After adjustment, there was a nonsignificant 5% increase in risk of hospitalization for patients traveling longer than 60 minutes versus those traveling 15 minutes or less (RR, 1.05; $P = 0.4$) and a nonsignificant overall trend across all time categories ($P = 0.3$).

Withdrawal by Travel Time

After adjustment, traveling longer than 60 minutes had a 10% greater risk of withdrawal compared with those traveling 15 minutes or less, which was nonsignificant ($P = 0.6$), as was the overall trend ($P = 0.5$).

Table 3. Adjusted HR-QOL Scores by Travel Time to Dialysis

HR-QOL Scale	≤15 Min (reference)	16-30 Min	31-60 Min	>60 Min
PCS	36.1	35.1*	34.6*	34.5*
Physical Functioning	39.4	37.1*	36.3*	36.6†
Role–Physical	30.0	26.4*	23.9*	23.9*
General Health	42.6	40.6*	39.2*	38.4*
Pain	62.0	59.6*	57.3*	56.1*
MCS	45.5	44.9†	43.6*	41.6*
Mental Health	62.9	61.8†	60.3*	58.8*
Role–Emotional	50.0	48.1†	44.5*	43.2*
Social Functioning	60.4	59.1†	57.0*	55.7*
Vitality	35.9	33.9*	33.2*	33.2†
Burden of Disease	38.9	36.9*	34.9*	32.0*
Effects of Disease	63.3	61.6*	60.6*	61.0†
Symptoms of Disease	72.9	71.8*	70.3*	69.3*
Quality of Social Interactions‡	74.1	73.7	72.2†	70.1*
Sexual Functioning‡	63.8	60.3†	60.6†	58.0†
Work Status‡	26.2	26.2	22.7*	21.7†
Sleep‡	59.6	58.2†	57.1*	55.5*
Cognitive‡	77.2	76.7	74.9*	72.1*
Social Support‡	74.0	73.7	72.5†	71.5†
Staff Encouragement‡	81.4	81.1	80.8	80.1
Satisfaction With Care‡	73.7	73.1	73.2	72.8

Note: Scores adjusted to average age, sex, race, 14 summary comorbid conditions, albumin level, time on dialysis therapy, country, and phase and accounted for facility clustering. The overall trend for each QOL score was significant for all scales except Staff Encouragement and Satisfaction With Care.

Abbreviations: HR-QOL, health-related quality of life; PCS, Physical Component Summary of Kidney Disease Quality of Life Short Form; MCS, Mental Component Summary of Kidney Disease Quality of Life Short Form.

*Significant in adjusted model, <0.001 compared with 15 minutes or less.

†Significant in adjusted model, <0.05 compared with 15 minutes or less.

‡Denotes measures available for only the Dialysis Outcomes and Practices Patterns I sample.

Transplantation by Travel Time

There was no difference in either crude rates or adjusted RRs for transplantation during the study observation period across travel-time categories, with a nonsignificant overall trend ($P = 0.7$).

Sensitivity Analyses

Excluding patients with previous peritoneal dialysis therapy or transplantation gave consistent results with the previous analysis, with a 21% greater associated risk of mortality in those traveling longer than 60 minutes (RR, 1.21; $P = 0.04$). After adjustment for type of vascular access in use at study entry, the greater mortality risk persisted (RR, 1.26; $P = 0.01$), although the significance of the overall trend decreased ($P = 0.08$). When travel time to the facility was examined as a facility characteristic (percentage of patients traveling > 60 minutes), results were consistent with the patient models. The risk of mortality for patients at a facility was 11% greater ($P = 0.02$) for every 10% more patients in the facility who traveled longer than 60 minutes. Death in the hospital was not significantly different across travel time categories; 65.0% for those traveling less than 15 minutes and 64.7% for those traveling longer than 60 minutes (odds ratio, 1.17; $P = 0.3$).

HR-QOL Scores by Travel Time to Dialysis

Adjusted HR-QOL scores were significantly lower for many of the HR-QOL subscales in those with longer travel times compared with those traveling 15 minutes or less, as listed in Table 3. Only satisfaction with care and dialysis staff encouragement did not show a significant association with travel time to dialysis. Comparing those traveling longer than 60 minutes with those traveling 15 minutes or less, lower scores were seen for 15 of the 19 questions, in most cases differing by more than 3 points, which is considered clinically significant.[20,21] Six scales

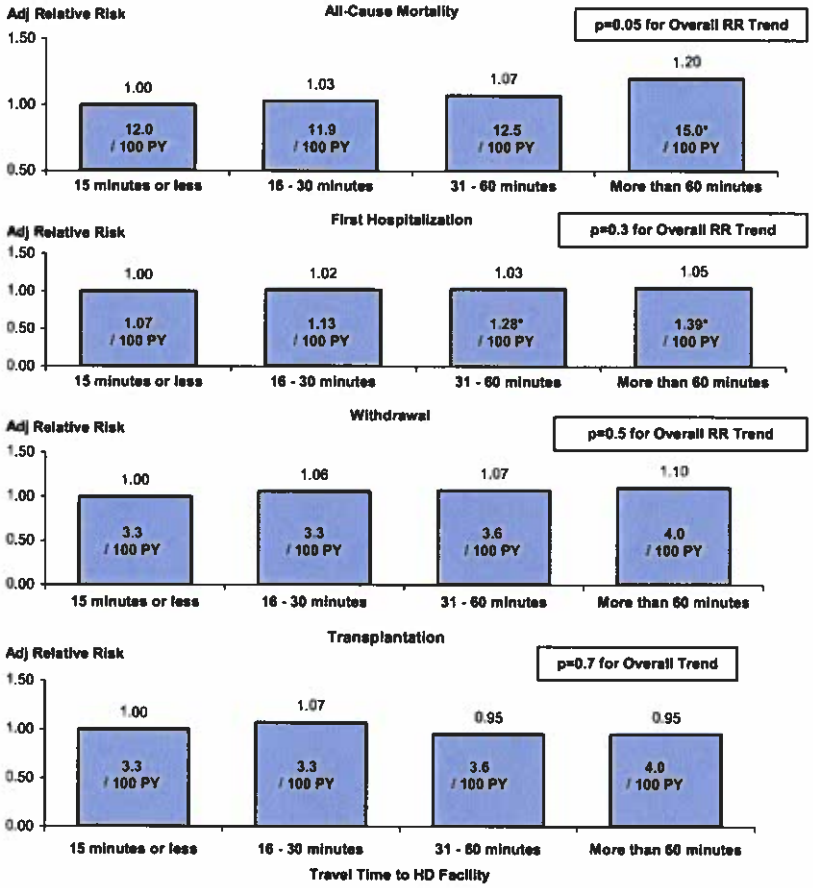

Figure 1. Rates of specific outcomes by travel-time category. Bars represent relative risk (RR) adjusted (Adj) for age, sex, race, 14 summary comorbid conditions, albumin level, and time on dialysis therapy stratified by country and phase and accounts for facility clustering. Numbers within bars are crude rates per 100 patient-years (PY). Asterisk denotes $P < 0.05$ versus 15-minute-or-less category. The overall trend was significant for increased all-cause mortality with increasing time on dialysis therapy. None of the comparisons for first hospitalization, withdrawal, or transplantation were significant after adjustment. Abbreviation: HD, hemodialysis.

had skewness measures greater than 0.6 (Cognitive Reasoning, Physical Role, Social Support, Staff Encouragement, Symptoms, and Work Status), for which log transformation was used. This transformation did not affect associations between travel time and HR-QOL measure.

Adherence Rates by Travel Time to Dialysis

The prevalence of skipping or shortening a dialysis session did not differ significantly across travel time to dialysis categories. However, in those with longer travel times, a problem with transportation was a significantly more frequent reason to either skip or shorten a dialysis session. Patients with longer travel times relied more on public and private transportation (Table 4). In a facility report question, 17% of nurses agreed or strongly agreed that a full dialysis treatment was not provided to patients who arrived late.

There was no difference in measures of predialysis care across travel time to dialysis categories (Table 5). Hemodialysis performance targets were similar, except fewer patients had a serum albumin level of 4.0 g/dL or greater (≥40 g/L) and fewer dialyzed with a fistula in the longer-than-60-minute travel category (Table 5). Normalized protein catabolic rates were similar in all groups (data not shown).

DISCUSSION

In this large international study, longer travel time to dialysis therapy was associated with lower HR-QOL and a significantly greater risk of mortality. These observations remained large and significant after controlling for possible confounders and in all sensitivity analyses. Furthermore, problems with transportation contributing to both skipped and shortened treatments were more common in those with the longest travel times. These results highlight travel time as a potentially modifiable variable affecting both mortality and HR-QOL. Specific efforts to decrease

Table 4. Adherence by Travel Time and Mode of Transportation

Measure	Patients (% yes)				
	≤15 Min	16-30 Min	31-60 Min	>60 Min	*P* for Overall Trend
Adherence					
Skipped ≥1 treatment in last 30 d	4.4	4.1	3.7	4.4	0.6
Skipped or missed treatment due to transportation problem	1.5	1.7	2.8	3.6	<0.001
Shortened session by at least 10 min	10.1	9.6	10.8	11.4	0.2
Shortened treatment due to transportation problem	2.9	3.3	5.1	8.6	<0.001
Mode of transportation					
Walk or drive myself	35.7	29.5	20.4	12.4	<0.001
Car driven by someone else	27.3	26.1	22.7	20.4	<0.01
Taxi/bus/underground train	16.6	20.7	25.9	28.5	<0.001
Dialysis/hospital sends transportation or ambulance	20.4	23.6	31.1	38.7	<0.001

travel time can be incorporated into routine clinical dialysis practice in an attempt to decrease the burden of end-stage renal disease, as well as improve survival.

Patient demographics and most characteristics were similar across travel times, with no indication that those with longer travel times were younger or fitter. Predialysis care and performance measures used in the Centers for Medicare and Medicaid Services End-Stage Renal Disease Clinical Performance Measures Projects[22] were similar across travel-time categories, except for lower serum albumin levels and less fistula use in those with longer travel times.

We initially hypothesized that patients with longer travel time would have greater rates of withdrawal from dialysis therapy, which would account for the greater mortality, but this was not shown. Similar percentages of patients died in the hospital, suggesting equal access to some health care. It is possible that patients living at a distance were hospitalized in primary or secondary level care centers without full resuscitation facilities or those with longer travel time died during transit to or from the dialysis unit. However, this could not be assessed in our study. It is interesting that facilities with greater percentages of patients traveling longer than 60 minutes also had significantly greater mortality. This finding provides strong corroboration of the adjusted patient-level model because it suggests that patient selection does not have a major role.

Travel time to dialysis showed a strong and robust association with HR-QOL. For the majority of HR-QOL subscales, a greater than 3-point lower score was seen for patients with travel times longer than 60 minutes compared with 15 minutes or less, which is considered clinically significant.[20,21] The subscale of burden of kidney disease had the greatest differentiation in score over travel time categories. Those who spent longer than 60 minutes traveling to dialysis each way would consume greater than 18 hours each week in travel time and time at the dialysis facility combined, as many hours as a half-time job. Nephrologists and dialysis nurses will agree that the most common question posed by patients is "Can I reduce my time?" The recent evidence supporting longer treatment times[23,24] may not permit a decrease in dialysis time, but every effort should be made to decrease patient travel time.

Nonadherence to the many elements of end-stage renal disease treatment was associated with increased mortality in some studies.[25] Although there are no standards to measure compliance,[26] skipping and shortening dialysis sessions are easy to monitor and quantify.[25,27,28] Patients with the longest travel times were more reliant on others for transportation, and transportation problems contributed substantially to shortened and skipped treatments. Furthermore, some facilities reported shortening prescribed dialysis treatment time if a patient arrived late for dialysis. Greater flexibility to accommodate patients with long travel times and assist patients with the mode and reliability of transportation are all potentially modifiable variables. Addressing these issues could result in improved adherence and HR-QOL.

Table 5. Predialysis Care and Performance Targets by Travel Time

Measure	Patients (%)				*P* for Overall Trend
	≤15 Min	16-30 Min	31-60 Min	>60 Min	
Pre-ESRD practice*					
Saw nephrologist >1 mo before dialysis start	74.3	72.6	73.7	71.3	0.01
Access functioning at time of dialysis start	48.6	50.2	47.6	49.2	0.2
Received erythropoietin predialysis	30.8	33.3	33.0	32.9	0.05
Performance target (%)					
Kt/V ≥ 1.2	70.1	70.3	68.6	72.9	0.1
Hemoglobin ≥ 11 g/dL	44.2	43.2	45.1	45.4	0.7
Albumin ≥ 4.0 g/dL	28.6	28.1	28.0	25.4	0.3
Calcium × phosphate ≤ 55 mg^2/dL^2	59.5	59.8	59.7	59.6	0.9
Dialysis using a fistula	51.3	55.0	54.1	46.4	0.01

Note: To convert hemoglobin and albumin in g/dL to g/L, multiply by 10.
Abbreviation: ESRD, end-stage renal disease.
*In patients new to dialysis therapy (n = 9,623 patients starting dialysis within 90 days).

Patients on hemodialysis therapy with long travel times should be identified and, if eligible, be educated regarding peritoneal dialysis or home hemodialysis therapy options. Although patient relocation to a closer or more accessible location should be considered, it is not always possible or desirable for the patient.[29]

Mode of transportation also needs to be examined. Patients with longer travel times frequently depend on transportation sent from the dialysis center. Distance contributes to travel time, but delays in pick up and drop off may also increase time. Although travel time and distance are highly correlated in hemodialysis patients traveling to satellite units,[30] travel time was a more accurate measure of access for peripheral and rural areas.[31] Time to dialysis therapy may be the more reliable marker because it includes delays in getting to dialysis, such as waiting for transportation, differences in traffic patterns, and mode of transportation.

Improved geographic access to health care has been an identified principle of health planning for decades. Regional or satellite units have increased access to care,[17] have decreased travel time,[17] are as effective as centralized hemodialysis units, and are more acceptable to patients.[30,32] Centralized units with a significant proportion of patients with long travel times may now argue for satellite expansion based on results of this study. However, close proximity may also mean long travel time if patients are dependent on public transportation or nonurgent ambulances; thus, it is incumbent that travel time be addressed for all patients.

We did not identify an association between travel time to dialysis and rate of transplantation. This is similar to Canadian data that showed no association between distance to the renal center and rate of transplantation.[33]

The relationship between travel time and patient outcomes was explored in other patient populations. Centralization of cancer services enhances expertise and availability of specialized equipment, but results in longer travel time. A recent review of this population indicated that distance to treatment centers influenced mastectomy rates and access to radiation therapy[34,35] and contributed to hardship and burden, although no firm conclusion was drawn regarding HRQOL.[36] However, in a cohort of patients referred with head-and-neck cancer, those living more than 15 miles from the treatment center had one third the hazard of death of those living closer.[37] In a community population, the adjusted rate ratio for hospitalization decreased by 15% in those living more than 30 minutes from the hospital, although mortality rates were not different.[38] It appears that travel time and/or distance from the care center may be capturing prognostic significance beyond those currently measured and/or represent a referral bias. Additional study into the effect of travel time and distance is warranted.

In this study, travel time was determined by the patient, at 1 time point and without valida-

tion. Neither patient address nor postal codes are captured in the DOPPS data; therefore, we were not able to identify whether the patient was living in an urban or rural area. However, patients dialyzing in rural areas were shown to have similar, if not improved, outcomes compared with urban centers.[39] The nonresponse rate was substantial in this study, and nonresponders were older and had a greater prevalence of comorbidity. It is possible that longer travel time may have an even greater effect on their HR-QOL and mortality, but this remains unknown.

In conclusion, the time required to travel to dialysis therapy adds considerable burden to hemodialysis patients, and longer travel time is associated significantly with greater mortality risk and decreased HR-QOL. Exploring opportunities to decrease travel time should be incorporated into the dialysis clinical routine.

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Section III, Background, Purpose of the Project, and Alternatives

Criterion 1110.110(d) – Background, Purpose of the Project, and Alternatives

Alternatives

1. The Applicants considered two options prior to determining to establish an 8-station dialysis facility. The options considered are as follows:
   a. Utilize Existing Facilities.
   b. Pursuing a joint venture
   c. Establish a new facility.

2. After exploring these options, which are discussed in more detail below, the Applicants determined to establish an 8-station dialysis facility. A review of each of the options considered and the reasons they were rejected follows.

Utilize Existing Facilities

There are no Illinois dialysis facilities within 19 miles of the proposed Dialysis Center. As a result, patients are forced to drive unnecessarily long distance for their treatment options, adding over an hour to the already time-consuming dialysis procedure. Distance has been directly linked to quality of care.[5] The U.S. Centers for Disease Control and Prevention estimates 10% of American adults have some level of CKD. Further, the National Kidney Fund of Illinois estimates over 1 million Illinoisans have CKD and most do not know it. Kidney disease is often silent until the late stages when it can be too late to head off kidney failure. As more working families obtain health insurance through the Affordable Care Act (or ACA) and 1.5 million Medicaid beneficiaries' transition from traditional fee for service Medicaid to Medicaid managed care, more individuals in high-risk groups will have better access to primary care and kidney screening. As a result of these health care reform initiatives, there will likely be tens of thousands of newly diagnosed cases of CKD in the years ahead. Once diagnosed, many of these patients will be further along in the progression of CKD due to the lack of nephrologist care prior to diagnosis. It is imperative that enough stations are available to treat this new influx of ESRD patients, who will require dialysis in the next couple of years.

In the last 12 months, Dr. Gaurav, treated 202 CKD patients that reside within 19 miles of the proposed site for Paris Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, return of function, or relocation, Dr. Gaurav anticipates that at least 20 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. Further, another 23 patients currently receiving dialysis in Indiana reside close to the proposed facility, and it is expected 20 of them would transfer to the proposed facility. There remains no option for these patients but to drive long distances to receive their care multiple times a week.

As a result of the need for services within the proposed planning area, Horizon rejected this option. There is no capital cost with this alternative.

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Pursue a Joint Venture

Horizon Health sought to work with a partner in the area, as demonstrated by the recent CON approval (16 042). However, Fresenius failed to complete this project on time and after over four years was forced to abandon the project by the HFSRB due to non-compliance with their rules.

As a result of the recent abandonment of the project, we have forgone the potential to pursue this option. The proposed project, as discussed below, does not change the intended patient population or location and seeks to replace the recently abandoned project.

Establish a New Facility

As noted above, there are no Illinois facilities within the proposed Dialysis Center's 19-mile GSA. The establishment of an 8-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the greater Paris area who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being. As a result, Horizon chose this option. This will allow for access to dialysis services within Paris and Edgar county. As a result, patients will have greatly reduced travel time while still obtaining the same high-quality care they are accustomed to. Therefore, patient satisfaction and quality of like will improve with access to the dialysis near their homes and within their state of residence.

The cost of this alternative is $1,406,550.

3. There is no direct empirical evidence relating to this project other than that when chronic care patients have improved access to services, it tends to reduce overall healthcare costs and results in less complications.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Criterion 1110.120, Size of the Project

The Applicants propose to establish an 8-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 450-650 gross square feet per dialysis station for a total of 3,600 – 5,200 gross square feet for 8 dialysis stations. The total gross square footage of the clinical space of the proposed center is 3,000 gross clinical square feet (or 625 GSF per station). Accordingly, the proposed facility meets the State standard per station.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD In-Center Hemodialysis	3,000 (8-stations)	3,600-5,200	None	Yes
Non-Clinical	2,000	N/A	N/A	N/A

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Criterion 1110.120(b), Project Services Utilization

By the second year of operation, annual utilization at the proposed facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.120 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Dr. Gaurav is treating 202 pre-ESRD patients and is treating 23 hemodialysis patients who reside within 19 miles of the proposed site. See Appendix – 1.

Conservatively, based upon attrition due to patient death, transplant, return of function, or relocation, Dr. Gaurav anticipates that approximately 20 of the ESRD patients currently dialyzing in Indiana will transfer to the Paris facility upon its opening, as it is closer to their homes and their other healthcare services. He also expects that approximately 20 of his patients with CKD will require dialysis and be referred to the proposed Paris facility within its first 2 years of operations.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ESRD	N/A	63% (30 patients)	80%	No
YEAR 2	ESRD	N/A	83% (40 patients)	80%	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Unfinished or Shell Space

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Assurances

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

Not Applicable

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

Not Applicable

3. **The anticipated date when the shell space will be completed and placed into operation.**

Not Applicable

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(b), In-Center Hemodialysis Projects – Review Criteria

1. Planning Area Need

The Applicants propose to establish an 8-station dialysis facility to be located at 721 E. Court Street STE B, Paris, IL 61944. As shown in Attachment – 23A, there are no in-center hemodialysis facilities in Illinois within 19 miles of the proposed location, demonstrating a drastic restriction to service access in keeping with 77 ILADC 1110.230. Furthermore, the location is designated as a Medically Underserved Area by HRSA. This project will address both gaps in access to care.

Although there is currently a proposed excess of stations within the Health Service Area, the projections include the recently terminated Fresenius project that was expected to be established at this same location and areas well beyond the drive time that patients would typically be expected to drive to receive dialysis care multiple times a week. In addition, the hospital has referred 151 patients to Dr. Gaurav's practice in CY20, 125 in CY19, and 109 in CY18. As seen, there is an increasing need for nephrology services and patients with CKD in the current area. Furthermore, Dr. Gaurav is currently treating twenty-three (23) patients with ESRD, with an addition 202 patients with CKD level 3, 4 or 5 within the service area that we anticipate will need ESRD in the coming two years.

Based on data from the Dr. Gaurav there were 202 CKD patients within the service area. The Renal Network is restricted to existing ESRD facilities, accordingly, as a new provider we have no way to access the data. The U.S. Centers for Disease Control and Prevention estimates 10% of American adults have some level of CKD. Further, the National Kidney Fund of Illinois estimates over 1 million Illinoisans have CKD and most do not know it. Kidney disease is often silent until the late stages when it can be too late to head off kidney failure.

Once diagnosed, many of these patients will be further along in the progression of CKD due to the lack of nephrologist care prior to diagnosis. It is imperative that enough stations are available to treat this new influx of ESRD patients, who will require dialysis in the next couple of years. Between 2017 and 2019 the number of new incident cases of patients with ESRD increased 7.2% from 124,500 new cases to 133,405 cases. This brought the total number of patients living with ESRD within the United States to 802,759 by the second quarter of 2020, the most recent data available.[5]

Related to the absence of in-county dialysis facilities, rural ESRD patients were estimated to travel farther for care than urban residents. Research has linked increased travel time and distance to decreased quality of life and increased mortality among these patients. It is estimated that patients living 26-45 miles away from the closest ESRD facility had a 2.4% higher likelihood of mortality compared to those living 0-10 miles and a 1.5% higher likelihood of mortality compared to those patients living 11-25 miles away.[6]

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[5] ESRD Quarterly Update. https://www.usrds.org/esrd-quarterly-update/

[6] Thompson S, Gill J, Wang X, Padwal R, Pelletier R, Bello A, Klarenbach S, Tonelli M. Higher mortality among remote compared to rural or urban dwelling hemodialysis patients in the United States. Kidney Int. 2012 May 16. doi: 10.1038/ki.2012.167

Furthermore, several areas of patient quality of life decreased in a clinically significant manner, as defined by the study, for patients traveling 15 minutes or less compared to those traveling 30 minutes or more, including: physical functioning, general health, emotional well-being, social functioning, burden and effects of the disease, and work status. As noted, there is not another ESRD facility within 19 miles or 45 minutes of the proposed facility. In addition to increasing the patient mortality, closer ESRD facilities have also been shown to dramatically improve the patient's quality of life.[7]

The proposed location seeks to reduce the mortality rate, increase access to care, and improve the overall quality of life of its patient population.

2. Service to Planning Area Residents

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of the greater Paris area. As evidenced in the physician referral letter attached at Appendix - 1, Dr. Gaurav has treated 202 pre-ESRD patients residing within 19 miles of the proposed facility in CY2020, and this number is expected to continue to grow. This number of patients is equal to the number of expected patients anticipated to be referred by the same practice Dr. Gaurav is associated with. However, as seen by our data, the physician group is currently treating more pre-ESRD patients than the original 2016 application, which was approved by this board for the service location in the exact some spot.

3. Service Demand

Attached at Appendix - 1 is a physician referral letter from Dr. Gaurav and a schedule of pre-ESRD and current patients by zip code. A summary of CKD patients projected to be referred to the proposed dialysis facility within the first two years after project completion is provided in Table 1110.230(b)(3)(B) below. The data present by Dr. Gaurav is limited to the service area rather than every zip code the practice treats patient from in Illinois / Indiana due to EHR reporting challenges. Further, as previously noted, the applicant lacks access to The Renal Network data as it is not a current ESRD facility. The applicants attempt to request data has proven unsuccessful. However, a reference to the 2016 filing by Fresenius shows the significant volume of patient treated by the physicians in Indiana facilities.

Table 1110.230(b)(3)(B) Projected Pre-ESRD Patient Referrals by Zip Code

5. Service Accessibility

The proposed Paris Community dialysis facility will be located in Paris, Edgar County in HSA 4 where there is an excess of 7 ESRD stations according to the January 2021 monthly inventory update. However, there are no dialysis clinics within 19 miles of Paris in Illinois, which is in a Federally Designated Medically Underserved Area. This HSA is comprised of the counties of Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby, and Vermillion along the central Illinois/Indiana border. This project will establish access to dialysis services in an area where there is an absence of the service.

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[7] Moist LM, Bragg-Gresham JL, Pisoni RL, Saran R, Akiba T, Jacobson SH, Fukuhara S, Mapes DL, Rayner HC, Saito A, Port FK. Travel time to dialysis as a predictor of health-related quality of life, adherence, and mortality: the Dialysis Outcomes and Practice Patterns Study (DOPPS). Am J Kidney Dis. 2008 Apr;51(4):641-50. doi: 10.1053/j.ajkd.2007.12.021. Epub 2008 Mar 3. PMID: 18371540.

Besides being a medically underserved area and the absence of dialysis services within 19 miles of Paris, the area population has limitations due to payor status and high poverty rates. For example, 16% of the residents of Paris are living below the poverty level and approximately 6% have no health insurance. In addition, nearly half are covered by a public form of health insurance.

Section V, Service Specific Review Criteria

In-Center Hemodialysis

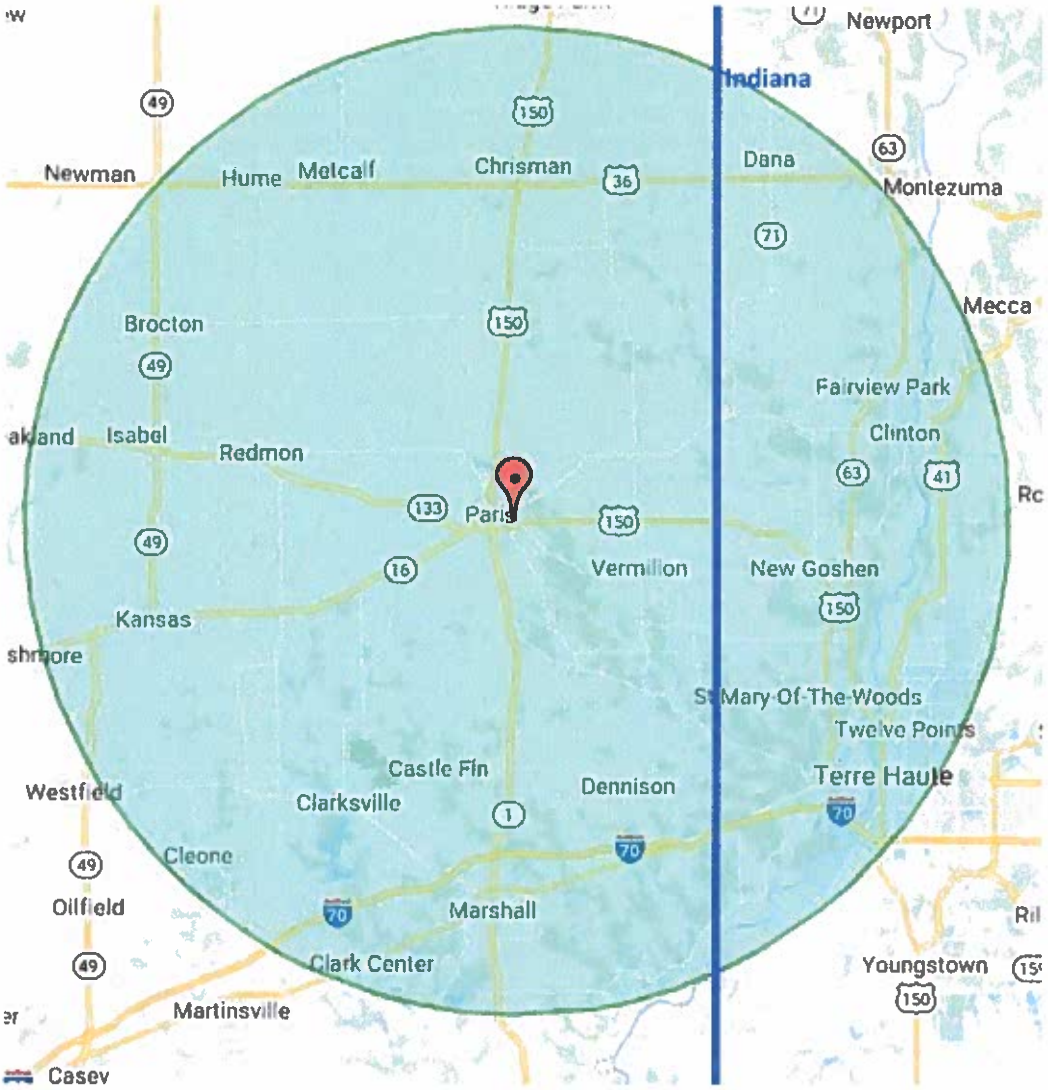
Criterion 1110.230(c), Unnecessary Duplication/Maldistribution

1. Unnecessary Duplication of Services

A-B) The proposed dialysis facility will be located at 721 E. Court Street St STE B, Paris, IL 61944. A map of the proposed facility's market area is attached at Attachment – 23A. A list of all zip codes located, in total or in part, within Illinois and 19 miles of the site of the proposed dialysis facility as well as 2018 census estimates for each zip code is provided in Table 1110.230(c)(1)(A).

Table 1110.230(c)(1)(A)

Zip Code	Population
61944	12,259
61955	189
61949	145
62423	485
61924	2,258
61933	901
61940	238
61917	771
62441	6,786
61932	439
Total	**24,471**



C) There are no dialysis facilities within Illinois located within 19 miles of the proposed dialysis facility is provided at Attachment – 23A.

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (A) ratio of stations to population exceeds one and one-half times the State Average; (B) historical utilization for existing facilities and services is below the HFSRB's utilization standard; or (C) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards.

As discussed, there is not an excess of stations within the service area because there are none within 19 miles in Illinois. Accordingly, the proposed dialysis facility will not result in a maldistribution of services.

A) Ratio of Stations to Population

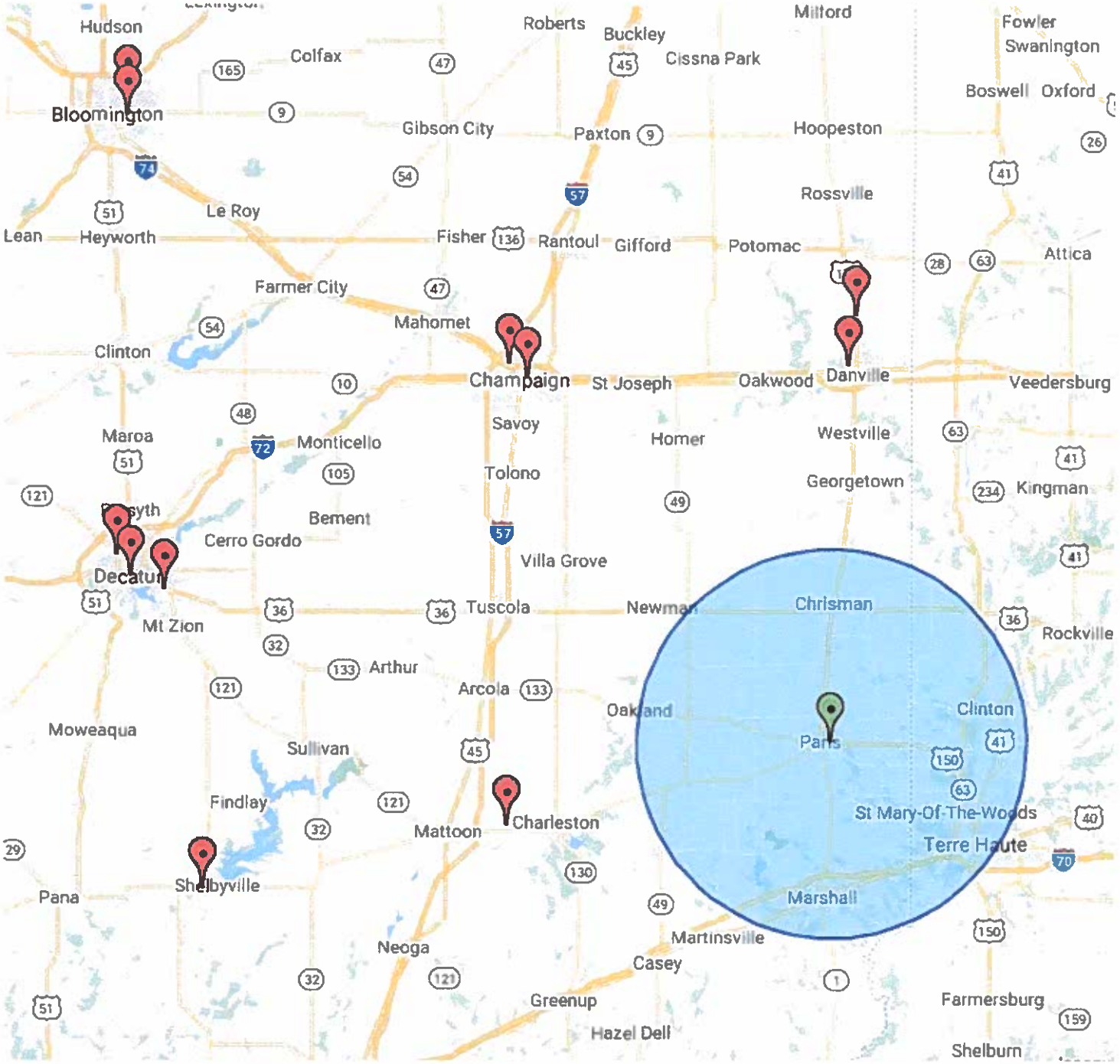
There are no stations in the planning area, therefore there is not an excess of stations.

3. Impact to Other Providers

A) The proposed dialysis facility will not have an adverse impact on existing facilities in the GSA, as there are currently no other dialysis facilities within 19 miles of the proposed location.

B) The applicant is the only hospital within Illinois that is located within the GSA, and does not currently offer in-center hemodialysis services. Therefore, it will not impact any area providers.

HSA 4 - ESRD FACILITIES



Red - Existing ESRD Facilities
Green - Proposed Facility
Blue Shade - 19 mile radius

#21-009

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(e), Staffing

1) The proposed facility will be staffed in accordance with all State and Medicare staffing requirements.

A) Medical Director: Kumar Gaurav, M.D. will serve as the Medical Director for the proposed facility.
B-E) Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

- Administrator (1 FTE)
- Registered Nurse (3 FTE)
- Dialysis Technician (6 FTE)
- Biomedical Technician (0.5 FTE)
- Social Worker (licensed MSW) (0.5 FTE)
- Registered Dietitian (0.5 FTE)
- Administrative Assistant (1 FTE)

C-A copy of Dr. Gaurav's curriculum vitae is attached at Attachment – 23B.

As patient volume increases, nursing and patient care technician staffing will increase accordingly to maintain a ratio of at least one direct patient care provider for every 4 ESRD patients. At least one registered nurse will be on duty while the facility is in operation.

3) All staff will be training under the direction of the proposed facility's Governing Body, utilizing Horizon Health's comprehensive training program. Horizon's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence.

4) At least one RN will be on duty when the unit is in operation and will maintain a ratio of at least one direct patient care provider to every 4 patients.

5) As set forth in the letter from Oliver Smith, President and CEO, included as an Attachment to this section, Horizon Health Dialysis will maintain an open medical staff.

Kumar Gaurav, MD 02/10/2021

Curriculum Vitae

Kumar Gaurav, MD, FNKF, FASN
1801 N 6th St.,
Suite 200
Terre Haute, IN 47802
Phone (812) 244 9104
kgauravmd@gmail.com

Work Experience:

02/2013-present	Kidney and Hypertension Center of Wabash Valley, LLC *Nephrology Private Practice*
02/2017-present	Ferne Dialysis, DaVita, Terre Haute Dialysis, Terre Haute, IN *Medical Director*
06/2014-04/2020	Silverwood Dialysis, DaVita, Indy East Clinic, Indianapolis, IN *Medical Director*
08/2016-12/2016	Providence Health Care, Terre Haute, IN *Facility Medical Director*
03/2016-12/2016	Kindred Transitional Care and Rehabilitation-Southwood, *Facility Medical Director*
10/2014-08/2016	Plasmacare, Grifols, Terre Haute, IN *Center Medical Director*
07/2010-03/2014	Internal Medicine Nephrology Inc. Terre Haute, IN *Nephrology Private Practice*

Training:

07/2008-06/2010	University of Virginia, Charlottesville, VA *Nephrology Fellowship*
07/2005-06/2008	University of Tennessee College of Medicine, Chattanooga, TN *Internal Medicine Residency*

Education:

08/1998-03/2004	University College of Medical Sciences (UCMS), University of Delhi, New Delhi, India *MBBS (Bachelor of Medicine and Bachelor of Surgery)*

Board Certifications:

- American Board of Internal Medicine – Internal Medicine (Valid until 2028)
- American Board of Internal Medicine – Nephrology (Valid until 2030)

Kumar Gaurav, MD 02/10/2021

Membership of professional societies:

- American Society of Nephrologists (ASN)
- National Kidney Foundation (NKF)
- Renal Physicians Association (RPA)
- Indiana State Medical Association (ISMA)

Medical Licensure:

- Indiana
- Illinois

Journal Reviewer

- Journal of General Internal Medicine (JGIM)
- Cases Journal

Academic Appointments

- Voluntary Assistant Professor, Indiana University School of Medicine 08/2011 – present
- Preceptor, Indiana State University Physician Assistant Studies Program 08/2011 – present

American Society of Nephrology (ASN) Appointments

- Member, ASN Practicing Nephrologists Advisory Group (PNAG) October 1, 2011 to September 30th, 2014

Renal Physicians Association (RPA) Appointment

- Member, RPA Healthcare Payment Committee, March 2012 - Present

Speakers Bureau

- Genzyme (2011)
- Sanofi US Renal (2012-2015)
- Otsuka America Pharmaceutical, Inc. (OAPI) (2012-2017)
- Questcor Pharmaceuticals (2012-2014)
- Mallinckrodt Pharmaceuticals (2015-2017)
- AbbVie Inc. (2013)
- Keryx Biopharmaceuticals (2017- 2018)

Advisory Board Meetings

- Alexion Pharmaceuticals
- Genentech USA, Inc.
- Keryx Biopharmaceuticals
- Relypsa, Inc.

Invited Guest Lectures

- Indiana State University Physician Assistant Studies Program

10/10/2017	Acute Kidney Injury
11/07/2016	Chronic Kidney Disease
10/31/2016	Acute Kidney Injury
02/11/2016	Chronic Kidney Disease
02/04/2016	Acute Kidney Injury
03/23/2015	Chronic Kidney Disease
03/23/2015	Acute Kidney Injury
02/26/2014	Chronic Kidney Disease
02/26/2014	Acute Kidney Injury
02/19/2014	Renal Physiology
11/25/2013	Acid Base Balance
11/18/2013	Acute Kidney Injury
10/31/2012	Acid Base Balance
10/24/2012	Acute Kidney Injury
11/04/2011	Acute Kidney Injury
11/02/2011	Acid Base Balance

- Indiana University School of Medicine at Indiana State University

09/25/2017	Tubular/Interstitial Diseases
09/26/2017	Acute Kidney Injury Cases
09/28/2017	Cases of Nephrotic Syndrome
11/08/2012	Chronic Kidney Disease
11/08/2012	Acute Kidney Injury
11/01/2012	Acid Base Balance

- Invited Medical School Interviewer Indiana University School of Medicine

10/12/2016	Interviewed candidates applying for admission to Indiana University School of Medicine

Invited Speaker Lectures/Programs

- Keryx Biopharmaceuticals

01/10/2018	Auryxia (ferric citrate) Clinical Review Magdy's Restaurant, Terre Haute, IN
12/15/2017	Keryx Speaker Training The Loews Chicago O'Hare Hotel, Chicago, IL

- Mallinckrodt Pharmaceuticals

12/12/2017	H.P. Acthar Gel therapy for proteinuria due to Nephrotic Syndrome Nephrology Associates of Northern Illinois and Indiana Marion, IN
10/17/2017	H.P. Acthar Gel therapy for proteinuria due to Nephrotic Syndrome Kidney and Hypertension Consultants Indianapolis, IN
03/29/2017	Acthar Gel in treatment of Nephrotic Syndrome Indiana Nephrology and Internal Medicine, Indianapolis, IN
09/21/2016	Acthar Gel in treatment of Nephrotic Syndrome J. Ford's Black Angus, Terre Haute, IN
06/16/2016	Acthar Gel in treatment of Nephrotic Syndrome Umi Grill, Terre Haute, IN
09/30/2015	Acthar Gel in treatment of Nephrotic Syndrome Vera Mae's Bistro, Muncie, IN
07/02/2015	Acthar Gel in treatment of Nephrotic Syndrome Community of Kokomo Nephrology, Kokomo, IN

- Questcor Pharmaceuticals

11/11/2014	Acthar Gel in treatment of Nephrotic Syndrome Café Navarre, South Bend, IN
10/14/2014	Acthar Gel in treatment of Nephrotic Syndrome Truffles Fine Cuisine, Bloomington, IN
09/10/2014	Acthar Gel in treatment of Nephrotic Syndrome McCormick and Schmick's, Indianapolis, IN
09/05/2014	Acthar Gel in treatment of Nephrotic Syndrome Café Navarre, South Bend, IN
07/22/2014	Acthar Gel in treatment of Nephrotic Syndrome Nicola's Restaurant, Cincinnati, OH
06/25/2014	Acthar Gel in treatment of Nephrotic Syndrome Mitchell's Ocean Club, Columbus, OH
05/19/2014	Acthar Gel in treatment of Nephrotic Syndrome The Landing at Fort Harrison Terre Haute, IN
04/02/2014	Acthar Gel in treatment of Nephrotic Syndrome UAP Clinic Terre Haute, IN
11/19/2013	Acthar Gel in treatment of Nephrotic Syndrome

	Hyde Park Prime Steakhouse, Columbus, OH
10/29/2013	H.P. Acthar Gel therapy for Proteinuria due To Nephrotic Syndrome Ivy Inn Restaurant, Charlottesville, VA
09/26/2013	H.P. Acthar Gel therapy for Proteinuria due To Nephrotic Syndrome Johnny's, Cleveland, OH
09/25/2013	Acthar Gel in treatment of Nephrotic Syndrome Kidney and Hypertension Consultants, Indianapolis, IN
09/25/2013	Acthar Gel in treatment of Nephrotic Syndrome Nephrology and Internal Medicine, Indianapolis, IN
07/25/2013	Acthar Gel in treatment of Nephrotic Syndrome Corndance Tavern, Mishawaka, IN
06/27/2013	Acthar Gel in treatment of Nephrotic Syndrome Zoes Restaurant, Virginia Beach, VA
05/30/2013	Acthar Gel in treatment of Nephrotic Syndrome Hyde Park Prime Steakhouse, Columbus, OH
04/29/2013	Acthar Gel in treatment of Nephrotic Syndrome Hickory Grille, Hermitage, PA
04/29/2013	Acthar Gel in treatment of Nephrotic Syndrome Bayview Nephrology, Erie, PA
04/25/2013	Acthar Gel in treatment of Nephrotic Syndrome Café Navarre, South Bend, IN
04/18/2013	Acthar Gel in treatment of Nephrotic Syndrome J. Ford's Black Angus Terre Haute, IN
02/20/2013	Acthar Gel in treatment of Nephrotic Syndrome Oceannaire Seafood Room, Indianapolis, IN
03/29/2013	Acthar Gel in treatment of Nephrotic Syndrome Acute Medical Care, Inc, Greencastle, IN
12/12/2012	Acthar Gel in treatment of Nephrotic Syndrome Acute Medical Care, Inc, Greencastle, IN
12/04/2012	Acthar Gel in treatment of Nephrotic Syndrome Umi Grill, Terre Haute, IN

- AbbVie, Inc

05/07/2013	Secondary Hyperparathyroidism, Northridge Medical Group Crawfordsville, IN
05/03/2013	Secondary Hyperparathyroidism, H.P.W. Center for Diabetes, Terre Haute, IN
02/05/2013	Secondary Hyperparathyroidism, J. Ford's Black Angus Terre Haute, IN

- Sanofi US Renal

09/10/2015	CKD-MBD: A look into Dysregulation and Strategies for Phosphorus Management RPM Italian, Chicago, IL
06/30/2015	CKD-MBD: A look into Dysregulation and Strategies for Phosphorus Management Catablu, West Jefferson Fort Wayne, IN
11/13/2014	Management of Phosphorus and the Bundling Horizon Ocean Prime Steakhouse, Indianapolis, IN
08/27/2014	Management of Phosphorus and the Bundling Horizon Stables Steakhouse, Terre Haute, IN
10/08/2013	Management of Phosphorus and the Bundling Horizon Stables Steakhouse, Terre Haute, IN
07/01/2013	Management of Phosphorus and the Bundling Horizon Indiana University Health, Lafayette, IN
02/28/2013- 03/01/2013	Sanofi Renal ESRD PPS Bundle, Speaker Training, W Atlanta-Buckhead Atlanta, GA
03/28/2012	The Importance of CKD-MBD Treatment Idle Creek Banquet Center, Terre Haute, IN

- Genzyme

10/20/2011	The Importance of CKD-MBD Treatment Umi Grill, Terre Haute, IN
10/06/2011	The Importance of CKD-MBD Treatment The Landing at Fort Harrison, Terre Haute, IN

Kumar Gaurav, MD 02/10/2021

- Otsuka America Pharmaceutical, Inc. (OAPI)

10/04/17	General Hyponatremia in SIADH Truffles Bloomington, IN
06/22/17	COMPASS: Hyponatremia case dialogues Ruth's Chris Steakhouse Cincinnati, OH
06/22/17	COMPASS: Hyponatremia case dialogues St Vincent Hospital Anderson, IN
06/13/17	Hyponatremia in Heart Failure and Hyponatremia in SIADH J Ford's Black Angus Terre Haute, IN
06/07/17	COMPASS: Hyponatremia case dialogues Deaconess Gateway Hospital Newburgh, IN
04/24/17	A Targeted Mechanism of Action for the Treatment of Hyponatremia in Patients with SIADH Ruth's Chris Steakhouse Clayton, MO
04/22/17	Samsca Speaker Training Orlando, FL
11/30/16	A Targeted Mechanism of Action for the Treatment of Hyponatremia in Patients with SIADH Ruth's Chris Steakhouse Indianapolis, IN
11/30/16	COMPASS: Hyponatremia Case Dialogues Hendricks regional Danville, IN
11/15/16	COMPASS: Hyponatremia Case Dialogues Corbett's Restaurant Louisville, KY
11/15/16	COMPASS: Hyponatremia Case Dialogues Deaconess Hospital Evansville, IN
09/27/16	A Targeted Mechanism of Action for the Treatment of Hyponatremia in Patients with SIADH Eddie Merlot's Columbus, OH
09/12/16	A Targeted Mechanism of Action for the Treatment of Hyponatremia in Patients with SIADH Putnam County Hospital Greencastle, IN
07/13/16	Evaluation and Management of Hyponatremia in the Hospital Setting J Ford's Black Angus Terre Haute, IN
07/09/16	Samsca Speaker Training WebExLyndhurst, NJ
04/27/16	Samsca Speaker Training

Kumar Gaurav, MD 02/10/2021

03/01/16	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Umi Grill Terre Haute, IN
08/04/15	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Smith's Row Food and Spirits Columbus, IN
06/16/15	Hyponatremia in Heart Failure: Treating Beyond the Initial Diagnosis The Landings Terre Haute, IN
06/09/15	Evaluation and Management of Hyponatremia in the Hospital Setting Ocean Prime Indianapolis, IN
05/18/15	Evaluation and Management of Hyponatremia in the Hospital Setting Franciscan Physician Network Nephrology Lafayette, IN
04/10/15	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis UAP Clinic Terre Haute, IN
02/26/15	Evaluation and Management of Hyponatremia in the Hospital Setting Umi Grill Sushi Bar Terre Haute, IN
08/26/14	Evaluation and Management of Hyponatremia in the Hospital Setting Sullivan Family Practice Office Sullivan, IN
08/07/14	Evaluation and Management of Hyponatremia in the Hospital Setting Umi Grill Sushi Bar Terre Haute, IN
08/06/14	Evaluation and Management of Hyponatremia in the Hospital Setting Clinton Medical Center Clinton, IN
07/31/14	Evaluation and Management of Hyponatremia in the Hospital Setting Community Rural Health Clinic Brazil IN
07/28/14	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment Missouri Baptist Cancer Center St. Louis, MO
07/17/14	Recognition and Treatment of Hyponatremia in the Hospital Setting Truffles Restaurant Bloomington, IN
06/10/14	Evaluation and Management of Hyponatremia in the Hospital Setting Amin Nephrology and Hypertension Specialists Farmington, MO
04/17/14	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis UAP Family Practice South Terre Haute, IN
04/16/14	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Cynthias Restaurant Paducah, KY
04/16/14	Recognition and Treatment of Hyponatremia in the Hospital Setting

The Baptist Heart Group
Paducah, KY

04/10/14 Recognition and Treatment of Hyponatremia in the Hospital Setting
Good Samaratin Hospital
Vincennes, IN

04/08/14 Recognition and Treatment of Hyponatremia in the Hospital Setting
Green County Health
Linton, IN

03/19/14 Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment
Umi Grill Sushi Bar
Terre Haute, IN

03/18/14 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
Esguerra Medical Practice
Linton, IN

03/12/14 Recognition and Treatment of Hyponatremia in the Hospital Setting
Truffles Restaurant
Bloomington, IN

02/18/14 Recognition and Treatment of Hyponatremia in the Hospital Setting
The Lake House at Spring Lake Woods
Madisonville, KY

02/18/14 Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment
Jeanie Stewart Medical Center
Hopkinsville, KY

01/23/14 Recognition and Treatment of Hyponatremia in the Hospital Setting
Arnett Hospital - IU
Lafayette, IN

01/22/14 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
UAP Family Practice
Terre Haute, IN

12/09/13 Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment
J. Hamman Prime
Indianapolis, IN

12/05/13 Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis
Stables Steakhouse
Terre Haute, IN

09/04/13 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
The Miller House
Owensboro, KY

09/04/13 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
Methodist Hospital - Boardroom
Henderson, KY

08/28/13 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
Umi Grill Sushi Bar
Terre Haute, IN

08/22/13 Understanding Hyponatremia: Treating Beyond the Primary Diagnosis
Fogo De Chao
Indianapolis, IN

08/22/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Marriott East - Emergency Nurses Association Indianapolis, IN
07/31/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Arnett Nephrology Lafayette, IN
07/23/13	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment Just Rennie's Evansville, IN
07/18/13	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Mountain Jacks Lafayette, IN
06/22/13	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment Taj Mahal Evansville, IN
06/18/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Good Samaritan Hospital Vincennes, IN
06/11/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Black & Tan Grille Green Bay, WI
05/29/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis The Landings Terre Haute, IN
05/28/13	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Mountain Jacks Lafayette, IN
05/23/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Steakhouse 9 Madisonville, KY
05/23/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Good Samaritan Hospital Vincennes, IN
05/22/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Family Medicine Center Terre Haute, IN
05/16/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Almost Home Greencastle, IN
05/08/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Dr. Black office Greencastle, IN
04/04/13	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Pea-Fections Vincennes, IN
04/02/13	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment KoFusion

	Champaign, IL
03/26/13	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment One Sixty Four North Kankakee, IL
03/14/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis J. Fords Black Angus Terre Haute IN
03/13/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Columbus Regional Hospital- Kroot Auditorium Columbus, IN
02/22/13	Live Speaker Training Hilton Americas Houston Houston, TX
01/31/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Umi Grill Sushi Bar Terre Haute, IN
01/30/13	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Tom's Place De Soto, IL
01/30/13	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Herrin Hospital- Pharmacy Department Herrin, IL
01/29/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Dr. Huh Office Terre Haute, IN
01/24/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Dr. Pittman's Office Terre Haute, IN
01/23/13	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Stone Creek Greenwood, IN
11/21/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Marion General Hospital Marion, IN
11/07/12	Understanding and Managing Hyponatremia: A Targeted Approach to Care Reid Hospital and Health Care Services Richmond, IN
10/25/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Truffles Restaurant Bloomington, IN
10/03/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Carnegie's Restaurant Greenfield, IN
09/13/12	Understanding and Managing Hyponatremia: A Targeted Approach to Care Ruth's Chris Steak House Portland, OR
09/12/12	Understanding and Managing Hyponatremia: A Targeted Approach to

	Care The Davis Restaurant Eugene, OR
09/12/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Salem Cardiovascular Salem, OR
09/10/12	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment The Landing at Fort Harrison Terre Haut, IN
08/30/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Community Hospital North Indianapolis, IN
08/28/12	Understanding and Managing Hyponatremia: A Targeted Approach to Care Carle Hospital Pharmacy Urbana, IL
08/27/12	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment UAP Pulmonology Terre Haute, IN
08/08/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis The Landings Terre Haute, IN
07/27/12	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment Reid Oncology Richmond, IN
07/26/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Cridersville Hall Cridersville, OH
07/25/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Umi Grill Sushi Bar Terre Haute, IN
07/18/12	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment J. Fords Black Angus Terre Haute, IN
07/11/12	Understanding and Managing Hyponatremia: A Targeted Approach to Care The Landing at Fort Harrison Terre Haute, IN
06/27/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Khoury's Mediterranean Island Indianapolis, IN
06/15/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Sigma Nephrology Lafayette, IN
06/12/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Del Alma Corvallis, OR

06/11/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Sigma Nephrology Lafayette, IN
05/23/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Sigma Nephrology Lafayette, IN
05/21/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis The Landing at Fort Harrison Terre Haute, IN
05/15/12	Hyponatremia in SIADH: A Targeted Mechanism of Action Approach to Treatment Umi Grill Sushi Bar Terre Haute, IN
05/08/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Vera Mae's Bistro Muncie, IN
05/07/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Union Hospital East Terre Haute, IN
04/23/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Terre Haute Regional Hospital Terre Haute, IN
04/19/12	Understanding Hyponatremia: Treating Beyond the Primary Diagnosis Umi Grill Sushi Bar Terre Haute, IN
03/29/12	Hyponatremia in Heart Failure: Treating Beyond the Primary Diagnosis Umi Grill Sushi Bar Terre Haute, IN
03/29/12	Hyponatremia in Cirrhosis: Treating Beyond the Primary Diagnosis UAP Gastroenterology Terre Haute, IN

Visiting Professor

- Meet The Nephrologist, Nephrology Core Training, November 22, 2013, San Francisco, CA, Genentech USA, Inc.

Local Appointments and Leadership Positions

- Chairman, Physicians Relations Committee, Department of Medicine, Terre Haute Regional Hospital, Terre Haute, 2021- present
- Member at Large, Medical Executive Relations Committee, Union Hospital, Terre Haute, 2017 - present
- Chairman, Department of Medicine, Terre Haute Regional Hospital, Terre Haute, 2017 - 2019
- President, Terre Haute Chapter of American Association of Physicians of Indian Origin (THAAPI) 2013-2014
- Chairman, Pharmacy and Therapeutics (P&T) Committee, Terre Haute Regional Hospital, Terre Haute, 2013 - 2016

- Chairman, Pharmacy and Therapeutics (P&T) Committee, Union Hospital, Terre Haute, 2012 – 2014
- Section Chief of Medicine, Union Hospital, Terre Haute, 2013 – 2014
- Vice President, Terre Haute Chapter of American Association of Physicians of Indian Origin (THAAPI) 2012-2013
- Treasurer, Terre Haute Chapter of American Association of Physicians of Indian Origin (THAAPI) 2011-2012
- Member, Critical Care Committee, Terre Haute Regional Hospital, Terre Haute, IN 2012- present
- Member, Physician Satisfaction Team, Union Hospital, 2011- 2013
- Member, Credentials Committee, Terre Haute Regional Hospital, Terre Haute, IN 2013- present

Research:

"A Rare Case of COVID 19 presenting as Rhabdomyolysis." Anup Trikannad, MD, Kumar Gaurav, MD, Girish Kunapareddy, MD, Sruthi Vellanki,MD, Andrew Gerard, Medical Student, Terre Haute, IN

- Poster presentation, 3rd Prize, ACP Indiana Poster Competition, November 2020,

"Immune deposits with ANCA related Glomerulonephritis: A diagnostic and management dilemma." Manish Gera, Kumar Gaurav, Internal Medicine Nephrology, Terre Haute, IN, Carrie Phillips, Indiana University, Indianapolis, IN

- Poster presentation, National Kidney Foundation (NKF) 2014 Spring Clinical Meetings, April, 2014, Orlando, FL

"Renal limited amyloidosis with apparent response, yet no response to treatment. A unique case and review of literature." Manish Gera, Kumar Gaurav, Internal Medicine Nephrology, Terre Haute, IN, Carrie Phillips, Indiana University, Indianapolis, IN

- Poster presentation, National Kidney Foundation (NKF) 2014 Spring Clinical Meetings, April, 2014, Orlando, FL

"Experience with Acthar® Gel for Treatment of Nephrotic range Proteinuria of different etiologies. A Case Series." Kumar Gaurav, Manish Gera, Internal Medicine Nephrology INC., Terre Haute, IN.

- Poster presentation, National Kidney Foundation (NKF) 2013 Spring Clinical Meetings, April, 2013, Orlando, FL

"Simplified Questionnaire versus SF 36 for Improving Quality of Life in Octogenarians and Nonagenarians on Dialysis" Manish Gera, Kumar Gaurav, Raj Jeevan. Nephrology, Internal Medicine Nephrology INC., Terre Haute, IN.

- Poster, National Kidney Foundation (NKF) 2012 Spring Clinical Meetings, May, 2012, Washington, DC

Kumar Gaurav, MD 02/10/2021

"Factors Affecting Quality of Life in Caucasian Octogenarians and Nonagenarians on Dialysis in Southern Indiana – A Cross Sectional Study." Manish Gera, Kumar Gaurav, Raj Jeevan. Nephrology, Internal Medicine Nephrology INC., Terre Haute, IN.

- American Society of Nephrology (ASN) 44th Annual Meeting, November, 2011, Philadelphia, PA
- Published abstract in the Journal of American Society of Nephrology (JASN) 22: 2011, 912A

"Monoclonal Immunoglobulin Deposition Disease without Evidence of Multiple Myeloma or Extra-Renal Involvement Treated with Bortezomib. Two Pilot Cases and Literature Review" Kumar Gaurav, Manish Gera, Raj Jeevan. Nephrology, Internal Medicine Nephrology Inc., Terre Haute, IN.

- American Society of Nephrology (ASN) 44th Annual Meeting, November, 2011, Philadelphia, PA
- Published abstract in the Journal of American Society of Nephrology (JASN) 22: 2011, 944A

"Kidney transplantation outcomes of crossmatch positive and ABO-incompatible patients. Single center experience" K. Gaurav, K. Brayman, T. Schmitt, C. Spencer, S. Sanoff, D. Keith, P. Lobo. University of Virginia, Charlottesville, VA

- Poster presentation at the XXIII International Congress of The Transplantation Society (TTS 2010), Vancouver, BC, Canada, August 16th 2010
- Poster Presentation at the American Society of Nephrology (ASN) 43rd Annual Meeting and Scientific Exposition, November, 19th 2010, Denver, CO
- Published abstract in Supplement to Transplantation July 27, 2010, Volume 90, Number 2 S

"Assessment of Target PTH and adherence to K/DOQI Guidelines" Kumar Gaurav, University of Virginia, Charlottesville, VA

- Chronic Hemodialysis Clinical Quality Improvement Project
- Presented at the Grand Rounds, University of Virginia, February 2009

"Milk-alkali syndrome in a middle-aged woman after ingesting large doses of calcium carbonate: a case report" Mandy Grubb, Kumar Gaurav, Mukta Panda

- Published in Cases Journal 2009 Sep 16;2:8198

"Non-healing painful ulcers in a patient with chronic kidney disease and role of sodium thiosulfate: a case report" Arshdeep Tindni, Kumar Gaurav, Mukta Panda

- Published in Cases Journal 2008 Sep 23;1(1):178

"Correlation between Renal Resistive Index (RRI) and Estimated Glomerular

Filtration Rate (eGFR)" Kumar Gaurav, Umesh Yalavarthy, Nathan Chamberlain, Sandra Pugh, Mukta Panda

- Oral presentation at Society for Vascular Ultrasound (SVU) Annual Meeting,

Baltimore, MD, June 2007

- Published in Journal for Vascular Ultrasound (JVU), Volume 32, Number 2, June 2008, 82-84(3)

"Dental Plaque As The Source Of Infection Of H.Pylori In Perforated Duodenal Ulcer Cases" Iqbal R Kaur, Kumar Gaurav & Sunil Gautam

- Poster presentation at Indian Association of Medical Microbiologists, Volume: XXVIII, November, 2004

Presentations:

"How much is too much?" Kumar Gaurav, Mandy Cincere, Mukta Panda

- Oral presentation at Society of General Internal Medicine (SGIM)- Southern Meeting, New Orleans, LA, February, 2008

"Disappearing amyloidosis" Kumar Gaurav, Arshdeep Tindni, Mukta Panda

- Poster presentation at SGIM- Southern Meeting, New Orleans, LA, February, 2008

"Unrelenting abdominal pain: Did you pull the right strings?" Arshdeep Tindni, Kumar Gaurav, Ann Rybolt, Mukta Panda

- Poster presentation at SGIM- Southern Meeting, New Orleans, February, 2008
- Oral presentation at American College of Physicians (ACP)- Tennessee chapter meeting, Chattanooga, TN, October, 2007

"How dangerous can the eosinophils be?" Kumar Gaurav, Arshdeep Tindni, Roger Jones

- Poster presentation at ACP- Tennessee Chapter meeting, Chattanooga, TN, October, 2007

"What is hiding behind the jiggling eyes?" Arshdeep Tindni, Kumar Gaurav, Mukta Panda

- Published abstract in the Journal of General Internal Medicine (JGIM) 2007, Apr; 22(s1):258
- Poster presentation at SGIM National meeting at Toronto, Canada, April, 2007

"An Intriguing Case of Fever Rash Arthritis and Proteinuria" Kumar Gaurav, Monica Gefter, Mukta Panda

- Poster Presentation at SGIM- Southern meeting, New Orleans, LA, February 2007

"Did You Think About Herpes?" Kumar Gaurav

- Oral presentation at Southern Medical Association's (SMA) 100th Annual Scientific Assembly in October, 2006

"Bilateral Pulmonary Nodules In A Smoker: What Would You Suspect?" Kumar Gaurav, Mukta Panda

- Published Case report in the JGIM 2007 Nov;22(11):1617-20

- Poster presentation at SGIM- Southern Meeting, Atlanta, GA, March, 2006 & at SGIM National Meeting. Los Angeles, CA, April, 2006

"Increased Frequency And Nocturia In An Middle Aged Male May Not Always Be Due To Benign Prostatic Hypertrophy (BPH)" Kumar Gaurav, Mukta Panda

- Published in Cases Journal 2009; 2: 9274
- Published abstract in the JGIM 2006; 21(s4):244
- Poster presentation at Society of SGIM- Southern Meeting, Atlanta, GA, March, 2006 & at SGIM National Meeting. Los Angeles, CA, April, 2006

"Dental Plaque As The Source Of Infection Of H.Pylori In Perforated Duodenal Ulcer Cases" Iqbal R Kaur, Kumar Gaurav & Sunil Gautam

- Poster presentation at Indian Association of Medical Microbiologists, Volume: XXVIII, November, 2004

Grand Round Lectures:

- COVID 19 Panel Discussion October, 1st, 2020
- Hyponatremia May, 29, 2014
- Fluid Management in Critically Ill Patients October, 10, 2013
- Vitamin D Metabolism: A Nephrologist's Perspective November 15, 2012
- Hyponatremia July 12, 2012
- Renal Replacement Therapies October 13, 2011
- Chronic Kidney Disease Chronic Kidney Disease: Coordinating Care for Improved Renal Disease Outcomes June 30, 2011
- Renal Artery Stenosis January 20, 2011
- Acute renal Failure September 16, 2010
- Indictaions for Plasmapheresis August 5, 2010

Invited Continuing Medical Education (CME) Lectures:

- Chronic Kidney Disease IAPA, Fall CME, November 4, 2016
- Albuminuria predictor of cardiovascular risks, Managing Clinical Risks, Fall CME, August 22, 2015
- Vitamin D for the Primary Care Provider, Managing Clinical Risks Spring CME, May 16, 2015
- Kidney Disease for the Primary Care Provider, Access2 MD Winter CME Conference, January 24, 2015
- Kidney Disease for the Primary Care Provider, Managing Clinical Risks CME, October 11, 2014

Invited Lectures as Volunteer Faculty at Union Hospital Family Medicine Residency Program:

- Acute Kidney Injury August 19th, 2020
- Vitamin D Metabolism November 2nd, 2016
- Acute Kidney Injury August 3rd, 2016
- Diabetic Nephropathy December 9th, 2015

Kumar Gaurav, MD 02/10/2021

- Renal Artery Stenosis — September 23rd, 2015
- Electrolyte and Fluid Management — July 22nd, 2015
- Chronic Kidney Disease — April 8th, 2015
- Fluid Management — July 10th, 2013
- Morbidity and Mortality Conference — May 31st, 2013
- Chronic Kidney Disease — May 22, 2013
- Diabetic Nephropathy — April 10th, 2013

Awards and accomplishments:

- Biography Published in Who's Who in America 2014 (68th Edition)
- Biography Published in Who's Who in America 2013 (67th Edition)
- Listed America's Top Physicians 2012: Nephrology. Consumers' Research Council of America
- Selected and Recognized, Peer Reviewed Physicians for Nephrology 2013
- Fellow of the American Society of Nephrology (FASN)
- Fellowship of the National Kidney Foundation (FNKF)
- Resident Research Award, June, 2008, University of Tennessee, School of Medicine, Chattanooga, TN
- First position in medical jeopardy at ACP - Tennessee chapter meeting, Chattanooga, TN, October, 2007
- Awarded Indian Council of Medical Research (ICMR) Short Term Studentship
- Awarded Merit certificate of National scholarships scheme from Central Board of Secondary Education, India

Volunteer Work:

- Organized and volunteered as a Physician, in association with the Terre Haute Chapter of American Association of Physicians of Indian Origin, in Health Fair and Screening participants for Hypertension and Proteinuria, September 2010, 2011, 2012, 2013
- Participated and volunteered as a Physician for Screening and counseling of participants in Terre Haute Community Health Fair Organized by Indiana University School of Medicine, in 2014, 2015 and 2016
- Screened participants for the KEEP Program of the National Kidney Foundation in the Health Fairs completed in 2010, 2011, 2012, 2013, 2014 and 2015
- Volunteered as a Physician for Dine with a Doc®, Rockville First United Methodist Church, Rockville, IN, March 3rd, 2016
- Volunteered as a Physician for Dine with a Doc®, Trinity United Methodist Church, Marshall, IL, February 12th, 2016

- Volunteered as a Physician for Dine with a Doc®, Wabash Activity Center, Terre Haute, IN, November, 18th, 2015
- Volunteered as a Physician for Dine with a Doc®, Toledo Christian Church, Toledo, IL, October, 30th, 2015
- Volunteered as a Physician for Dine with a Doc®, Casey Senior Social Center, Casey, IL, October, 20th, 2015
- Volunteered as a Physician for Dine with a Doc®, Clay County Citizen's Center, Brazil, IN, July 1st, 2015
- Volunteered as a Physician for Dine with a Doc®, Putnam County Hospital, Greencastle, IN, June, 22nd, 2015
- Volunteered as a Physician for Dine with a Doc®, Lawrenceville County Community Center, Lawrenceville, IL, April 30th, 2015
- Volunteered as a Physician for Dine with a Doc®, Providence Place, West Terre Haute, IN, April 14th, 2015
- Volunteered as a Physician for Dine with a Doc®, Community Center for seniors of Edgar County, Paris, IL, December 10th, 2014
- Volunteered as a Physician for Dine with a Doc®, The Life Center, Toledo, IL, October 31st, 2014
- Volunteered as a Physician for Dine with a Doc®, Victory Baptist Church, Clinton, IN, August 20th, 2014
- Participated in "Charlottesville Kidney Disease Screening" sponsored by University of Virginia and National Kidney Foundation on World kidney Day, March, 2009
- Organized voluntary health camp for uninsured people in Bathinda, PB, India, January 2008
- Participated in health fair for screening of minority population for Metabolic syndrome in a Minority Health Fair, August 2006, Chattanooga, TN
- Participated in "Komen Race for the Cure", Susan G. Komen Breast cancer foundation, September 2006 and 2007, Chattanooga, TN

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(f), Support Services

Included as an Attachment to this section is a letter from Oliver Smith, President and CEO, attesting that the proposed facility will participate in a dialysis data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(g), Minimum Number of Stations

The proposed dialysis facility is not located in a metropolitan statistical area ("MSA"). A dialysis facility located outside of an MSA must have a minimum of four dialysis stations. The Applicants propose to establish an 8-station dialysis facility. Accordingly, this criterion is met.

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(h), Continuity of Care

Hospital & Medical Foundation of Paris, Inc. d/b/a Horizon Health will be the owner and operator of the dialysis facility, ensuring each patient has full and ready access to all required hospital services within any barriers or interruptions in their care.

Section V, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.230(j), Assurances

Included as an Attachment to this section is a letter from Oliver Smith, President and CEO, certifying that the proposed facility will achieve target utilization by the second year of operation.

HORIZON HEALTH

Paris Community Hospital
721 East Court Street
Paris, IL 61944
(217) 465-4141

Paris Clinic
727 East Court Street
Paris, IL 61944
(217) 465-8411

Chrisman Clinic
112 West Madison Ave.
Chrisman, IL 61924
(217)269-2394

Oakland Clinic
5 South Walnut Street
Oakland, IL 61943
(217) 346-2353

Senior Care
745 East Court Street
Paris, IL 61944
(217) 466-4170

EZ Care
1 Phipps Lane
Paris, IL 61944
(217) 463-4340

EZ Care— Marshall
1602 N. IL Hwy 1
Marshall, IL 62441

NAL Health Clinic
1 Phipps Lane
Paris, IL 61944
(217) 463-4901

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: In-Center Hemodialysis Assurances

Dear Chair Savage:

Pursuant to 77 Ill. Admin. Code § 1110.230(e), I hereby certify the facility will maintain an open medical staff.

Further, pursuant to 77 Ill. Admin. Code § 1110.230(j), I hereby certify the following:

- By the second year after project completion, Horizon Health Dialysis expects to achieve and maintain 80% target utilization; and
- Horizon Health Dialysis also expects hemodialysis outcome measures will be achieved and maintained at the following minimums:
  - ≥ 85% of hemodialysis patient population achieves urea reduction ratio (URR) ≥ 65% and
  - ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II .1.2

Sincerely,

Oliver M. Smith

Oliver M. Smith
Horizon Health President & CEO

Subscribed and sworn to me

This 8 day of March, 2021

Kimberly A Calvert

Notary Public

KIMBERLY A CALVERT
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 12, 2023

HORIZON HEALTH

Paris Community Hospital
721 East Court Street
Paris, IL 61944
(217) 465-4141

Paris Clinic
727 East Court Street
Paris, IL 61944
(217) 465-8411

Chrisman Clinic
112 West Madison Ave.
Chrisman, IL 61924
(217)269-2394

Oakland Clinic
5 South Walnut Street
Oakland, IL 61943
(217) 346-2353

Senior Care
745 East Court Street
Paris, IL 61944
(217) 466-4170

EZ Care
1 Phipps Lane
Paris, IL 61944
(217) 463-4340

EZ Care— Marshall
1602 N. IL Hwy 1
Marshall, IL 62441

NAL Health Clinic
1 Phipps Lane
Paris, IL 61944
(217) 463-4901

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1110.230(f) that Horizon Health Dialysis will maintain an open medical staff.

I also certify the following with regard to needed support services:

- Horizon Health utilizes an electronic dialysis data system;
- Horizon Health Dialysis will have available all needed support services required by CMS, which may consist of clinical laboratory services, blood bank, nutrition, rehabilitation, psychiatric services, and social services; and
- Patients, either directly or through other area Horizon Health facilities, will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis.

Sincerely,

Oliver M. Smith
Horizon Health President & CEO

Subscribed and sworn to me
This 8 day of March, 2021

Kimberly A Calvert
Notary Public

KIMBERLY A CALVERT
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 12, 2023

Section VI, Financial Feasibility

Criterion 1120.120 Availability of Funds

See Attachment 33 – Exhibit 2 for the financial statements for the last three years for Horizon Health, which document sufficient internal cash funds for the project.

CONSOLIDATED FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITORS' REPORT

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC.
AND CONSOLIDATED SUBSIDIARY

December 31, 2018 and 2017

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC.
AND CONSOLIDATED SUBSIDIARY

December 31, 2018 and 2017

CONTENTS

Kerber, Eck & Braeckel LLP

CPAs and
Management Consultants
3401 Office Park Drive
Marion, IL 62959
ph 618.993.8724
fax 618.993.1903
www.kebcpa.com

INDEPENDENT AUDITORS' REPORT

Board of Directors
Hospital & Medical Foundation of Paris, Inc.
and Consolidated Subsidiary
Paris, Illinois

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary (the Hospital) (a nonprofit health care entity), which comprise the consolidated statements of financial position as of December 31, 2018 and 2017, and the related consolidated statements of activities, changes in financial position and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary as of December 31, 2018 and 2017, and the changes in its activities, changes in financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary taken as a whole. The accompanying supplementary information on pages 25 to 28 for the years ended December 31, 2018 and 2017 are presented for purposes of additional analysis and are not a required part of the basic consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Kerber, Eck + Braeckel, LLP

Marion, Illinois
May 28, 2019

CONSOLIDATED FINANCIAL STATEMENTS

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

December 31

ASSETS

	2018	2017
CURRENT ASSETS		
Cash and cash equivalents	$ 5,339,738	$ 9,864,711
Accounts receivable patient, less estimated uncollectibles of $ 8,039,629 in 2018 and $ 4,108,332 in 2017	9,149,470	6,597,420
Other receivables	1,040,021	586,292
Estimated third-party payor settlement receivable	1,182,000	234,085
Interest and dividends receivable	241	287
Supplies	1,617,010	1,277,683
Prepaid expenses and other	636,733	392,805
Total current assets	18,965,213	18,953,283
ASSETS WHOSE USE IS LIMITED		
Board designated funds (Note F)	21,014,136	23,721,356
Donor restricted funds	590,167	586,170
By bond covenants	-	364,094
Total assets whose use is limited	21,604,303	24,671,620
PROPERTY AND EQUIPMENT, AT COST (Note G)	25,001,570	15,055,987
OTHER ASSETS		
Pledges receivable, net (Note L)	-	100,498
Total other assets	-	100,498
Total assets	$ 65,571,086	$ 58,781,388

LIABILITIES AND NET ASSETS

	2018	2017
CURRENT LIABILITIES		
Accounts payable	$ 1,572,150	$ 1,225,240
Accrued payroll and other liabilities	3,083,560	2,638,695
Estimated third-party reimbursement programs	75,870	67,416
Current portion of long-term debt	550,990	350,888
Total current liabilities	5,282,570	4,282,239
LONG TERM DEBT (Note I)	5,854,494	1,907,571
Total liabilities	11,137,064	6,189,810
NET ASSETS		
With donor restrictions (Note N)	590,167	586,170
Without donor restrictions (Note N)	53,843,855	52,005,408
Total net assets	54,434,022	52,591,578
Total liabilities and net assets	$ 65,571,086	$ 58,781,388

The accompanying notes are an integral part of these statements.

#21-009

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF ACTIVITIES
(Unrestricted Funds)

Years ended December 31

	2018	2017
Unrestricted revenues, gains and other support		
Patient service revenue	$ 56,150,471	$ 43,848,605
Less: provision for bad debt	4,299,777	2,135,831
Net patient service revenue (Note D)	51,850,694	41,712,774
Other operating revenue	3,880,088	2,527,402
Total operating revenue	55,730,782	44,240,176
Operating expenses		
Salaries and wages	27,777,061	23,989,656
Employee benefits	6,983,545	5,316,124
Supplies and other	5,696,239	5,135,781
Physician fees	2,739,261	2,960,086
Professional services non-physician	948,620	745,818
Outside services	3,495,304	2,935,339
Depreciation	2,352,043	2,339,726
Utilities	643,560	474,684
Interest	101,644	94,376
Insurance	553,052	738,298
Other	1,418,174	1,505,381
Total operating expenses	52,708,503	46,235,269
Operating income (loss)	3,022,279	(1,995,093)
Nonoperating revenues (expenses)		
Contributions and grants received	28,072	161,718
Contribution expense	(20,963)	(11,940)
Investment income	2,668,091	1,721,530
Total nonoperating revenues (expenses)	2,675,200	1,871,308
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	5,697,479	(123,785)
Change in net unrealized gains and (losses) on other than trading securities	(3,986,633)	2,359,322
Net assets released from restrictions	127,601	150,309
INCREASE IN UNRESTRICTED NET ASSETS	$ 1,838,447	$ 2,385,846

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF CHANGES IN FINANCIAL POSITION

Years ended December 31

	2018	2017
Unrestricted net assets:		
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	$ 5,697,479	$ (123,785)
Net unrealized gains and (losses) on investments other than trading securities	(3,986,633)	2,359,322
Net assets released from restriction	127,601	150,309
INCREASE IN UNRESTRICTED NET ASSETS	1,838,447	2,385,846
Net assets with donor restrictions:		
Contributions	130,690	487,806
Investment income	908	868
Net assets released from restriction	(127,601)	(150,309)
Increase in restricted net assets	3,997	338,365
INCREASE IN NET ASSETS	1,842,444	2,724,211
Net assets, beginning of year	52,591,578	49,867,367
Net assets, end of year	$ 54,434,022	$ 52,591,578

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years ended December 31

	2018	2017
Cash flows from operating activities		
Change in financial position	$ 1,842,444	$ 2,724,211
Items not requiring (providing) cash		
Depreciation and amortization	2,352,043	2,339,726
Amortization of bond issue costs included in interest expense	19,404	3,279
Net unrealized gains and losses on investments other than trading securities	3,986,633	(2,359,322)
Changes in:		
Patient accounts receivable, net	(2,552,050)	1,871,928
Pledges receivable	100,498	(91,003)
Interest and dividends receivable	46	40,019
Estimated amounts due from and/to third-party payers	(939,461)	743,652
Supplies, prepaid expenses and other	(1,036,984)	926,486
Accounts payable and accrued expenses	791,775	(722,748)
NET CASH PROVIDED BY OPERATING ACTIVITIES	4,564,348	5,476,228
Cash flows from investing activities		
Cash (invested in) withdrawn from donor restricted funds	(3,997)	(321,272)
Purchase of investments	(12,739,726)	(10,903,161)
Proceeds from sale of investments	11,460,313	8,871,877
Purchase of property and equipment	(12,297,626)	(2,929,802)
NET CASH USED IN INVESTING ACTIVITIES	(13,581,036)	(5,282,358)
Cash flows from financing activities		
Cash (invested in) withdrawn from bond covenant funds	364,094	(13,204)
Proceeds from long-term debt	6,568,948	-
Principal payments on long-term debt	(2,441,327)	(338,162)
NET CASH PROVIDED BY/(USED IN) FINANCING ACTIVITIES	4,491,715	(351,366)
Decrease in cash and cash equivalents	(4,524,973)	(157,496)
Cash and cash equivalents at beginning of year	9,864,711	10,022,207
Cash and cash equivalents at end of year	$ 5,339,738	$ 9,864,711
SUPPLEMENTAL CASH FLOWS INFORMATION		
Interest paid	$ 82,240	$ 91,097

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2018 and 2017

NOTE A - SUMMARY OF ACCOUNTING POLICIES

1. Nature of Operations

Hospital & Medical Foundation of Paris, Inc. and it's consolidated subsidiary (the "Hospital"), located in Paris, Illinois, is a not-for-profit acute care hospital and clinical care facility. The Hospital primarily earns revenues by providing inpatient, outpatient, emergency care, and clinic services to patients in Paris, Illinois and the surrounding area.

Paris Community Hospital Foundation, Inc. (the Foundation) was established in 2015 as a supporting organization for the Hospital. The Foundation Board is appointed by the Hospital Board. The Hospital has the ability to control the activities of the Foundation.

2. Principles of Consolidation

The consolidated financial statements include the accounts of Hospital & Medical Foundation of Paris, Inc. ("HMFP") and Paris Community Hospital Foundation, Inc. (the "Foundation"). HMFP has both an economic interest in the Foundation and control of the Foundation. HMFP has the ability to control the activities of the Foundation through appointment of Foundation board members by HMFP life members. In addition, certain powers are reserved to HMFP per the Bylaws of the Foundation. All significant/material intercompany accounts and transactions have been eliminated in consolidation.

3. Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

4. Cash and Cash Equivalents

The Hospital considers all highly liquid investments, excluding assets whose use is limited, purchased with an initial maturity of three months or less to be cash equivalents.

5. Investments and Investment Return

Investments in marketable equity securities with readily determinable fair values and debt securities are carried at fair value. All other investments are carried at cost, which approximates fair value. Investment return which primarily consists of realized and unrealized gains and losses, interest income, and dividends is included in non-operating income (loss), unless the income or loss is restricted by donor or law or is classified as trading securities. The Hospital did not have any investments classified as trading securities at December 31, 2018 and 2017.

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

6. Assets Whose Use is Limited

Assets whose use is limited primarily include designated assets set aside by the Board of Directors for future capital improvements, (over which the Board retains control and may at its discretion subsequently use for other purposes) and bond reserve funds.

7. Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

8. Patient Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for Medicare, Medicaid, commercial, and self-pay in order to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely).

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. It is the Hospital's policy to charge off uncollectible accounts receivable when management determines the receivable will not be collected. No collection attempts are made on patients determined to qualify under the Hospital's financial assistance policy. The Hospital does not charge interest on outstanding balances.

9. Supplies

The Hospital states supply inventories at the lower of cost or net realizable value, determined using the first-in, first-out method.

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

10. Property, Equipment and Related Depreciation

Property and equipment acquisitions over $5,000 having a useful life of one year or more are recorded at cost. Assets acquired through lease agreements meeting requirements under generally accepted accounting principles in the U.S. that require capitalization are recorded at their fair market value as of the date of lease inception. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in the depreciation and amortization in the consolidated financial statements. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method with estimated lives of five to forty years. Assets acquired at less than $5,000 per item are treated as ordinary expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

11. Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payors.

Retroactively calculated contractual adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

12. Charity Care

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

13. Advertising

The Hospital is not involved in direct-response advertising. The Hospital's policy is to expense advertising costs as the costs are incurred. Advertising costs charged to operations for the years ended December 31, 2018 and 2017 amounted to $312,395 and $197,942, respectively.

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

14. Income Taxes

HMFP is a not-for-profit corporation and has been recognized as exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and a similar provision of state law. It qualifies for the charitable contribution deduction under Section 170(b)(1)(A) and has been classified as an organization other than a private foundation under Section 509(a)(2). There were no uncertain tax benefits or liabilities identified and recorded as of December 31, 2018.

The Foundation is a not-for-profit corporation and has been recognized as exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and a similar provision of state law. It qualifies for the charitable contribution deduction under Section 170(b)(1)(A) and has been classified as an organization other than a private foundation under Section 509(a)(2).

At December 31, 2018, no interest or penalties were attributed to HMFP or the Foundation. HMFP and the Foundation file income tax returns in the U.S. federal jurisdiction. Tax returns are no longer subject to U.S. federal examinations by tax authorities for years before 2015.

15. Donor-Restricted Gifts

All contributions are considered available for unrestricted use unless specifically restricted by the donor. Amounts received that are designated for future periods or restricted by the donor for specific purposes are reported as temporarily restricted or permanently restricted support that increases these net asset classes. However, if a restriction is fulfilled in the same time period in which the contribution is received, the Hospital reports the support as unrestricted.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in the contribution revenue. Conditional promises to give are not included as support until the conditions are substantially met.

16. Change in Net Assets

The consolidated statement of activities includes excess (deficiency) of revenues over expenses. Changes in net assets which are excluded from excess (deficiency) of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities.

17. Excess (Deficiency) of Revenue over Expenses

The performance indicator is the excess (deficiency) of revenue over expenses and that amount excludes changes in net assets with donor restrictions.

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

18. Subsequent Events

Subsequent events have been evaluated through May 28, 2019 which is the date the financial statements were available to be issued.

19. Change in Accounting Principle

The Hospital adopted ASU 2016-14 Presentation of Financial Statements of Not-for-Profit Entities for 2018 which changes presentation of net assets based on two classes. There was no effect to net income.

NOTE B - DEPOSITS

At December 31, 2018, the Hospital's deposits were covered by federal depository insurance up to $250,000 at each financial institution. The Hospital has not experienced any losses in such accounts and believes there is no significant risk with respect to these deposits.

At December 31, 2018, the Hospital had bank balances as follows:

	2018
Insured	$ 850,519
Uninsured, covered by repurchase agreements	3,298,095
Uninsured	2,377,851
Total bank balances	$ 6,526,465
Cash and cash equivalents	5,339,738
Donor restricted funds	590,167
By bond covenants	-
Carrying value	$ 5,929,905

NOTE C - UNCOMPENSATED CARE AND COMMUNITY BENEFIT

In support of its mission, the Hospital voluntarily provides care to patients at less than its established rates for patients that meet the Hospital's charity care criteria. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue. Charges excluded from revenue under the Hospital's charity care policy were approximately $540,000 and $700,000 for 2018 and 2017, respectively.

The Hospital uses an overall hospital cost to charge ratio to calculate the unpaid cost of charity care, uncollectable accounts and state Medicaid and other public aid programs. The following amounts reflect the quantifiable costs of the community benefit for the year ended December 31, 2018 and 2017 at cost:

NOTE C - UNCOMPENSATED CARE AND COMMUNITY BENEFIT - CONTINUED

	2018	2017
Benefits for the poor and the broader community		
Charity care	$ 260,000	$ 350,000
State Medicaid and other public aid programs	4,980,000	4,390,000
Medicare	870,000	2,660,000
Uncollectible accounts	2,080,000	1,050,000
Total community benefit	$ 8,190,000	$ 8,450,000

Benefits for the broader community represent the cost of services provided to other needy populations that may not qualify as poor, but still require special services and support. It also includes the cost of services for the general benefit of the communities in which the Hospital operates. Many programs are targeted toward populations that may be poor, but also include those areas that may need special health services and support. These programs are not financially self-supporting.

Benefits for the poor represent the cost of services provided to persons who cannot afford health care because of inadequate resources and who are uninsured or underinsured. Benefits for the broader community include cost of providing the following services: health screenings and other health-related services, training health professionals, educating the community with various seminars and classes, and subsidized costs of providing two rural clinics.

Charity care represents the cost (determined using a cost to charge ratio) of services provided to patients who cannot afford health care services due to inadequate resources. All or a portion of a patient's services may be considered charity care for which no payment is anticipated in accordance with the Hospital's established policies. Amounts classified as charity care are not reported as revenue in the statements of activities and changes in financial position.

Unpaid cost of Medicaid and other public programs represents the cost (determined using a cost to charge ratio) of providing services to beneficiaries of public programs, including state Medicaid and indigent care programs, in excess of payments for those services.

NOTE D - NET PATIENT SERVICE REVENUE

The Hospital has agreements with third-party payers that provide for payments to the Hospital at amounts different from its established rates. These payment arrangements include:

- Medicare - Inpatient acute care services and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Inpatient skilled nursing services are paid at prospectively determined per diem rates that are based on the patients' acuity. The Hospital is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary.

- Medicaid - Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates.

NOTE D - NET PATIENT SERVICE REVENUE - CONTINUED

Approximately 57% and 51% of net patient service revenues are from participation in the Medicare and state-sponsored Medicaid programs for the years ended December 31, 2018 and 2017. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Schedule of patient service revenue net of contractual allowances and discounts consist of the following for the year ended December 31, 2018:

	Medicare	Medicaid	Commercial and Other	Blue Cross	Self Pay	Total
Gross revenue	$ 47,603,281	$ 22,505,099	$ 15,764,905	$ 20,374,320	$ 2,536,859	$ 108,784,464
Less: contractual allowances/discounts	(24,307,622)	(16,580,582)	(4,280,525)	(5,222,689)	(1,701,096)	(52,092,514)
	$ 23,295,659	$ 5,924,517	$ 11,484,380	$ 15,151,631	$ 835,763	56,691,950
					Provision for Bad Debt	(4,299,777)
					Charity Care Adjustments	(541,479)
					Net Patient Service Revenue	$ 51,850,694

NOTE D - NET PATIENT SERVICE REVENUE - CONTINUED

Schedule of patient service revenue net of contractual allowances and discounts consist of the following for the year ended December 31, 2017:

	Medicare	Medicaid	Commercial and Other	Blue Cross	Self Pay	Total
Gross revenue	$ 36,486,194	$ 20,468,392	$ 16,605,297	$ 17,735,221	$ 2,377,258	$ 93,672,362
Less: contractual allowances/discounts	(21,136,115)	(14,751,223)	(8,936,206)	(4,250,935)	(49,078)	(49,123,557)
	$ 15,350,079	$ 5,717,169	$ 7,669,091	$ 13,484,286	$ 2,328,180	44,548,805
Provision for Bad Debt						(2,135,831)
Charity Care Adjustments						(700,200)
Net Patient Service Revenue						$ 41,712,774

Illinois Hospital Medicaid Assessment Program

The state of Illinois enacted legislation that provided for an assessment program intended to qualify for federal matching funds under the Illinois Medicaid program. Under the hospital assessment program, each hospital is assessed tax based on that hospital's adjusted gross hospital revenue. The assessments in part fund additional Medicaid payments. The legislation provides that none of the assessment funds are to be collected and no additional Medicaid payments are to be paid until the program receives the required federal government approval through the federal Center for Medicare and Medicaid Services.

The effect of this program in the statements of activities and changes in financial position for the years ended December 31, 2018 and 2017, is as follows:

	2018	2017
Additional Medicaid payments included in net patient service revenue	$ 382,056	$ 476,527
Hospital Access Improvement payment included in net patient service revenue	300,768	715,008
Affordable Care Act (ACA) Hospital Access payments included in net patient service revenue	326,613	461,751
Managed Care Organization - Hospital Access Program	1,846,157	701,415
Less payments paid to the program	(1,315,958)	(1,089,552)
	$ 1,539,636	$ 1,265,149

The provider assessment has been an important component in providing positive cash flows to support Hospital operations.

NOTE E - CONCENTRATION OF CREDIT RISK

The Hospital grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payer agreements. The mix of receivables from patients and third-party payers at December 31, 2018 and 2017 was:

	2018	2017
Medicare	19%	32%
Medicaid	36%	13%
Other third-party payers	18%	46%
Patients	27%	9%
	100%	100%

NOTE F - FAIR VALUE OF FINANCIAL INSTRUMENTS

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There are three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs supported by little or no market activity and that are significant to the fair value of the assets or liabilities

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies and inputs used for assets and liabilities measured at fair value on a recurring basis and recognized in the accompanying statements of financial position, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Cash Equivalents - Cash equivalents are comprised solely of money market funds, whose fair value are based on the value of the funds as provided by the fund manager.

Certificates of Deposit - The fair value of the CD's are based on cost plus accrued interest.

NOTE F - FAIR VALUE OF FINANCIAL INSTRUMENTS - CONTINUED

Fixed-Income Securities - The fair value of fixed-income securities is primarily determined with techniques consistent with the market approach. Significant observable inputs include benchmark ields, reported trades, observable broker/dealer quotes, issuer spreads, two-sided markets, benchmark securities, bids, offers, and reference data including market research publication.

	Fair Value Measurements at December 31, 2018			
	Total	Level 1	Level 2	Level 3
Investments at fair market value				
Cash and cash equivalents	$ 75,959	$ -	$ 75,959	$ -
Accrued income	38,498	-	38,498	-
Fixed-income securities				
Treasury and federal agencies	860,860	-	860,860	-
Corporate bonds	2,156,578	-	2,156,578	-
Foreign bonds	331,820	-	331,820	-
Pooled fixed income funds	5,041,689	5,041,689	-	-
Equity securities				
Common stocks	12,299,280	12,299,280	-	-
Pooled equity funds	209,452	209,452	-	-
Total investments	$ 21,014,136	$ 17,550,421	$ 3,463,715	$ -

	Fair Value Measurements at December 31, 2017			
	Total	Level 1	Level 2	Level 3
Investments at fair market value				
Cash and cash equivalents	$ 181,066	$ -	$ 181,066	$ -
Accrued income	41,406	-	41,406	-
Fixed-income securities				
Treasury and federal agencies	1,495,858	-	1,495,858	-
Corporate bonds	2,271,020	-	2,271,020	-
Foreign bonds	209,202	-	209,202	-
Pooled fixed income funds	215,717	215,717	-	-
Equity securities				
Common stocks	14,422,207	14,422,207	-	-
Pooled equity funds	4,884,880	4,884,880	-	-
Total investments	$ 23,721,356	$ 19,522,804	$ 4,198,552	$ -

Total investment return, which is comprised of realized and unrealized gains and losses, interest, and dividends net of custodial fees amounted to $(1,317,634) and $4,081,720 for the years ended December 31, 2018 and 2017, respectively. The investment advisory fees were $78,448 and $69,833 for the years ended December 31, 2018 and 2017, respectively.

NOTE G - PROPERTY AND EQUIPMENT

Property and equipment at December 31, 2018 and 2017 are as follows:

	2018	2017
Land improvements	$ 2,324,864	$ 2,324,864
Buildings and improvements	29,453,960	24,320,561
Equipment	18,775,493	17,113,271
Leasehold improvements	74,744	74,744
	50,629,061	43,833,440
Less accumulated depreciation	33,587,187	31,235,145
	17,041,874	12,598,295
Land	434,175	403,842
Investment Property	501,625	501,625
Construction in progress	7,023,896	1,552,225
	$ 25,001,570	$ 15,055,987

Construction in progress at December 31, 2018 represents amounts expended for costs related to expansion and renovation projects. A large portion of the balance represents costs expended for the new EZ Care facility, a surgery expansion project and PT complex. The projects are expected to be completed in 2019 with an estimated cost to complete of approximately $9,434,000.

NOTE H - LINE OF CREDIT

The Hospital has available an operating line of credit with Prospect Bank in Paris, Illinois in the amount of $2,500,000. At December 31, 2018, $0 was advanced on the line of credit.

NOTE I - LONG-TERM DEBT

A summary of long-term debt follows:

Bank loan, loan interest 4.125% variable, payable in monthly installments of $91,832 beginning November 2018 through October 2028	$ 6,405,484	$ -
Capital Improvement Revenue Bonds, Series 2003, 3.70%, with monthly payments of $35,772 including Interest.	-	2,277,863
	6,405,484	2,277,863
Less current maturities	550,990	350,888
Less deferred financing costs	-	19,404
Long-term portion	$ 5,854,494	$ 1,907,571

The following is a schedule of future maturities of long-term debt at December 31, 2018:

2019	$ 550,990
2020	556,411
2021	579,802
2022	604,176
2023	629,575
Thereafter	3,484,530
	$ 6,405,484

On December 1, 2003, the City of Paris issued Capital Improvement Revenue Bonds (Hospital & Medical Foundation of Paris, Inc. Project) Series 2003 in the amount of $6,060,000 in conjunction with the construction of additional facilities of the Hospital. The bonds are secured by all real and personal property of the Hospital, as defined in the bond documents, with the exception of Foundation assets. The revenue bonds are reported on the consolidated statement of financial position at their carrying value, net of unamortized debt issuance costs. The fair market value of the revenue bonds was determined to be equal to their carrying value by management with the assistance of the banks that own the bonds. The bond documents have restrictive covenants including expenditure of funds, insurance requirements, and reporting requirements. The bond documents specify certain covenants, which affect the consolidated financial statements. The Hospital complied with all of the covenants in 2018 and 2017. The Bonds were paid off in 2018.

Deferred financing costs associated with the Capital Improvement Revenue Bonds Series 2003 were being amortized by the debt outstanding method and were fully amortized upon the final pay off on the Bonds.

NOTE I - LONG-TERM DEBT - CONTINUED

On October 9, 2018 the Hospital obtained a bank note through Prospect Bank in the amount of $9,000,000 of which $6,568,798 was drawn as of December 31, 2018 for the purposes of paying off the Bonds and financing renovations and construction of facilities for the Hospital. The note is secured by mortgage on the property and all Hospital assets.

NOTE J - MEDICAL MALPRACTICE CLAIMS

The Hospital maintains claims made medical malpractice insurance from a commercial insurance company. The Hospital has a $7,500 per a claim and $30,000 per year deductible and is covered for up to one million per claim or occurrence with an aggregate of three million per policy year. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. The Hospital's management believes, after consultation with legal counsel, that the claims outstanding are without merit or that the ultimate liability, if any, resulting from them will not materially affect the Hospital's consolidated financial position.

NOTE K - EMPLOYEE HEALTH CLAIMS

Substantially all of the Hospital's employees are eligible to participate in the Hospital's health insurance plan. The Hospital is self-insured for health claims of participating employees and dependents up to limits provided for in an agreement with a third party stop-loss carrier which is $50,000 as of December 31, 2018. A provision is accrued for self-insured employee health claims including both claims reported and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Hospital's estimate will change by a material amount in the near term.

Employee health insurance liabilities were $179,704 and $160,000, at December 31, 2018 and 2017, respectively, and were recorded on an undiscounted basis in accrued payroll and other liabilities.

NOTE L - UNCONDITIONAL PLEDGES RECEIVABLE

	2018	2017
Promises receivable	$ -	$ 110,914
Less allowance for uncollectible promises receivable	-	10,416
Total unconditional promises to give	$ -	$ 100,498

NOTE M - PENSION PLANS

The Hospital sponsors a 403(b) Defined Contribution Plan (the Plan) covering substantially all full-time employees of the Hospital and Medical Foundation of Paris, Inc. The Hospital can make discretionary contributions up to 4.5% of each participant's compensation based on a predetermined rate schedule by years of service. Employer Pension contributions under this plan were $535,735 and $470,936 for 2018 and 2017, respectively.

NOTE N - NET ASSETS

The Hospital has received contributions, which are temporarily restricted, to provide services for the Meals on Wheels Program and various other areas of the Hospital. These contributions are included in temporarily restricted net assets.

Net assets with donor restrictions are available for the following purposes:

Donor restricted	2018	2017
Phipps Fund	$ 402,979	$ 352,203
Alzheimer's support group	13,107	13,107
Nursing scholarships	15,172	16,782
Employee scholarships	9,025	10,000
EZ Care Raidiology equipment	-	56,820
Ceiling lifts	20,823	25,027
Women's health	35,004	35,004
Garden of Hope	11,496	9,971
CARE	11,879	3,904
Miscellaneous	70,682	63,352
	$ 590,167	$ 586,170

Net assets without donor restrictions are as follows:

	2018	2017
Undesignated	$ 32,829,719	$ 27,919,958
Restricted - by bond covenants	-	364,094
Board designated	21,014,136	23,721,356
	$ 53,843,855	$ 52,005,408

NOTE N - NET ASSETS - CONTINUED

Net assets released from net assets with donor restrictions are as follows:

	2018	2017
Garden of Hope	$ -	$ 35,453
CARE	2,525	5,103
Ceiling lifts	4,204	-
Doc Acklin Scholarship	2,000	2,000
Employee Scholarships	1,000	-
EZ Care radiology equipment	59,720	-
Nursing scholarships	2,000	1,500
Swing bed	-	3,065
Rehab - underwater treadmill	51,400	
Meals on wheels	-	101,962
Miscellaneous	4,752	36,679
	$ 127,601	$ 150,309

NOTE O - FUNCTIONAL EXPENSES

The Hospital provides healthcare and related services to the residents of Paris, Illinois and the surrounding areas. The operating expenses included in the statements of activities primarily relates to providing these services.

NOTE P - MANAGEMENT SERVICES AGREEMENT

The Hospital has a consulting agreement with Blue Management Services, LLC d/b/a Alliant Management Services to advise on Hospital operations. The Hospital pays Alliant an annual fee for its management services. The agreement was terminated during 2018.

NOTE Q - RELATED PARTY TRANSACTIONS

The Hospital leases a portion of its medical office building to an S-Corporation, a shareholder of which is a member of the Board of Directors. The term of the lease began June 12, 2006 and ended June 11, 2011. The terms of the original lease are being continued on a month-to-month basis. The lessee agrees to pay the sum of $72,000, payable in 60 monthly installments of $1,200. The lessee also agrees to pay additional rent of $.25 for each prescription filled in excess of three thousand prescriptions per month. Total rent amounted to $20,400 and $19,964 for the years ended December 31, 2018 and 2017, respectively.

NOTE R - FOUNDATION SEPARATION AND CONSOLIDATION

During 2016, investment assets were transferred from HMFP to the Foundation. The Foundation is a legally separate entity that operates independently of HMFP. In 2015, these investment assets were reported as owned by HMFP. As of 2018, the investment assets are reported as owned by the Foundation. HMFP and the Foundation's financial statements have been consolidated in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 810; therefore, these investment assets are reported in the consolidated financial statements in 2018. Consolidation is required if the parent has a controlling financial interest in the subsidiary. The Hospital has the ability to control the activities of the Foundation through appointment of Foundation board members by HMFP life members. In addition, certain powers are reserved to HMFP per the Bylaws of the Foundation. In 2018 and 2017, consolidating schedules are included in supplementary information.

SUPPLEMENTARY INFORMATION

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF FINANCIAL POSITION

December 31, 2018

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 5,339,738	$ -	$ -	$ 5,339,738
Accounts receivable patient, net	9,149,470	-	-	9,149,470
Other receivables	1,040,021	-	-	1,040,021
Estimated third-party payor settlement receivable	1,182,000	-	-	1,182,000
Interest and dividends receivable	241	-	-	241
Supplies	1,617,010	-	-	1,617,010
Prepaid expenses and other	636,733	-	-	636,733
Total current assets	18,965,213	-	-	18,965,213
ASSETS WHOSE USE IS LIMITED				
Board designated funds	-	21,014,136	-	21,014,136
Donor restricted funds	590,167	-	-	590,167
By bond covenants	-	-	-	-
Total assets whose use is limited	590,167	21,014,136	-	21,604,303
PROPERTY AND EQUIPMENT, AT COST	25,001,570	-	-	25,001,570
OTHER ASSETS				
Beneficial interest in assets held by Foundation	21,014,136	-	(21,014,136)	-
Pledges receivable, net	-	-	-	-
Total other assets	21,014,136	-	(21,014,136)	-
Total assets	$ 65,571,086	$ 21,014,136	$ (21,014,136)	$ 65,571,086
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts payable	$ 1,572,150	$ -	$ -	$ 1,572,150
Accrued payroll and other liabilities	3,083,560	-	-	3,083,560
Estimated third-party reimbursement programs	75,870	-	-	75,870
Current portion of long-term debt	550,990	-	-	550,990
	5,282,570	-	-	5,282,570
LONG TERM DEBT	5,854,494	-	-	5,854,494
	11,137,064	-	-	11,137,064
NET ASSETS				
With donor restrictions	590,167	-	-	590,167
Without donor restrictions	53,843,855	21,014,136	(21,014,136)	53,843,855
	54,434,022	21,014,136	(21,014,136)	54,434,022
	$ 65,571,086	$ 21,014,136	$ (21,014,136)	$ 65,571,086

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF FINANCIAL POSITION

December 31, 2017

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc	Consolidating Entries	Consolidated Totals
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 9,864,711	$ -	$ -	$ 9,864,711
Accounts receivable patient, net	6,597,420	-	-	6,597,420
Other receivables	586,292	-	-	586,292
Estimated third-party payor settlement receivable	234,085	-	-	234,085
Interest and dividends receivable	287	-	-	287
Supplies	1,277,683	-	-	1,277,683
Prepaid expenses and other	392,805	-	-	392,805
Total current assets	18,953,283	-	-	18,953,283
ASSETS WHOSE USE IS LIMITED				
Board designated funds	-	23,721,356	-	23,721,356
Donor restricted funds	586,170	-	-	586,170
By bond covenants	364,094	-	-	364,094
Total assets whose use is limited	950,264	23,721,356	-	24,671,620
PROPERTY AND EQUIPMENT, AT COST	15,055,987	-	-	15,055,987
OTHER ASSETS				
Beneficial interest in assets held by Foundation	23,721,356	-	(23,721,356)	-
Pledges receivable, net	100,498	-	-	100,498
Total other assets	23,821,854	-	(23,721,356)	100,498
Total assets	$ 58,781,388	$ 23,721,356	$ (23,721,356)	$ 58,781,388
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts payable	$ 1,225,240	$ -	$ -	$ 1,225,240
Accrued payroll and other liabilities	2,638,695	-	-	2,638,695
Estimated third-party reimbursement programs	67,416	-	-	67,416
Current portion of long-term debt	350,888	-	-	350,888
	4,282,239	-	-	4,282,239
LONG TERM DEBT	1,907,571	-	-	1,907,571
	6,189,810	-	-	6,189,810
NET ASSETS				
With donor restrictions	586,170	-	-	586,170
Without donor restrictions	52,005,408	23,721,356	(23,721,356)	52,005,408
	52,591,578	23,721,356	(23,721,356)	52,591,578
	$ 58,781,388	$ 23,721,356	$ (23,721,356)	$ 58,781,388

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN FINANCIAL POSITION

FOR THE YEAR ENDED DECEMBER 31, 2018

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
Unrestricted revenues, gains and other support				
Patient service revenue	$ 56,150,471	$ -	$ -	$ 56,150,471
Less: provision for bad debt	4,299,777	-	-	4,299,777
Net patient service revenue (Note D)	51,850,694	-	-	51,850,694
Other operating revenue	3,880,088	-	-	3,880,088
Total operating revenue	55,730,782	-	-	55,730,782
Operating expenses				
Salaries and wages	27,777,061	-	-	27,777,061
Employee benefits	6,983,545	-	-	6,983,545
Supplies and other	5,696,239	-	-	5,696,239
Physician fees	2,739,261	-	-	2,739,261
Professional services non-physician	948,620	-	-	948,620
Outside services	3,495,304	-	-	3,495,304
Depreciation	2,352,043	-	-	2,352,043
Utilities	643,560	-	-	643,560
Interest	101,644	-	-	101,644
Insurance	553,052	-	-	553,052
Contributions	-	1,350,000	(1,350,000)	-
Other	1,418,174	-	-	1,418,174
Total operating expenses	52,708,503	1,350,000	(1,350,000)	52,708,503
Operating income (loss)	3,022,279	(1,350,000)	1,350,000	3,022,279
Nonoperating revenues (expenses)				
Contributions and grants received	1,378,072	-	(1,350,000)	28,072
Contribution expense	(20,963)	-	-	(20,963)
Investment income	38,678	2,629,413	-	2,668,091
Total nonoperating revenues (expenses)	1,395,787	2,629,413	(1,350,000)	2,675,200
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	4,418,066	1,279,413	-	5,697,479
Change in net unrealized gains and (losses) on other than trading securities	-	(3,986,633)	-	(3,986,633)
Net assets released from restrictions	127,601	-	-	127,601
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	4,545,667	(2,707,220)	-	1,838,447
Net assets with donor restrictions:				
Contributions	130,690	-	-	130,690
Investment income	908	-	-	908
Net assets released from restriction	(127,601)	-	-	(127,601)
Increase (decrease) in restricted net assets	3,997	-	-	3,997
INCREASE (DECREASE) IN NET ASSETS	$ 4,549,664	$ (2,707,220)	$ -	$ 1,842,444

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN FINANCIAL POSITION

FOR THE YEAR ENDED DECEMBER 31, 2017

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
Unrestricted revenues, gains and other support				
Patient service revenue	$ 43,848,605	$ -	$ -	$ 43,848,605
Less: provision for bad debt	2,135,831	-	-	2,135,831
Net patient service revenue (Note D)	41,712,774	-	-	41,712,774
Other operating revenue	2,527,402	-	-	2,527,402
Total operating revenue	44,240,176	-	-	44,240,176
Operating expenses				
Salaries and wages	23,989,656	-	-	23,989,656
Employee benefits	5,316,124	-	-	5,316,124
Supplies and other	5,135,781	-	-	5,135,781
Physician fees	2,960,086	-	-	2,960,086
Professional services non-physician	745,818	-	-	745,818
Outside services	2,935,339	-	-	2,935,339
Depreciation	2,339,726	-	-	2,339,726
Utilities	474,684	-	-	474,684
Interest	94,376	-	-	94,376
Insurance	736,474	1,824	-	738,298
Other	1,504,705	676	-	1,505,381
Total operating expenses	46,232,769	2,500	-	46,235,269
Operating income (loss)	(1,992,593)	(2,500)	-	(1,995,093)
Nonoperating revenues (expenses)				
Contributions and grants received	51,311	110,407	-	161,718
Contribution expense	(11,940)	-	-	(11,940)
Investment income	71,139	1,650,391	-	1,721,530
Total nonoperating revenues (expenses)	110,510	1,760,798	-	1,871,308
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	(1,882,083)	1,758,298	-	(123,785)
Change in net unrealized gains and (losses) on other than trading securities	-	2,359,322	-	2,359,322
Net assets released from restrictions	150,309	-	-	150,309
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(1,731,774)	4,117,620	-	2,385,846
Net assets with donor restrictions:				
Contributions	-	487,806	-	487,806
Investment income	868	-	-	868
Net assets released from restriction	(150,309)	-	-	(150,309)
Increase (decrease) in restricted net assets	(149,441)	487,806	-	338,365
INCREASE (DECREASE) IN NET ASSETS	$ (1,881,215)	$ 4,605,426	$ -	$ 2,724,211

CONSOLIDATED FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITORS' REPORT

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC.
AND CONSOLIDATED SUBSIDIARY

December 31, 2019 and 2018

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC.
AND CONSOLIDATED SUBSIDIARY

December 31, 2019 and 2018

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INDEPENDENT AUDITORS' REPORT

Board of Directors
Hospital & Medical Foundation of Paris, Inc.
and Consolidated Subsidiary
Paris, Illinois

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary (the Hospital) (a nonprofit health care entity), which comprise the consolidated statements of financial position as of December 31, 2019 and 2018, and the related consolidated statements of activities, changes in financial position, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary as of December 31, 2019 and 2018, and the changes in its activities, changes in financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements of Hospital & Medical Foundation of Paris, Inc. and Consolidated Subsidiary taken as a whole. The accompanying supplementary information on pages 29 to 32 for the years ended December 31, 2019 and 2018 are presented for purposes of additional analysis and are not a required part of the basic consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

Herbst, Eck + Braeckel, LLP

Marion, Illinois
May 14, 2020

CONSOLIDATED FINANCIAL STATEMENTS

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

December 31

ASSETS

	2019	2018
CURRENT ASSETS		
Cash and cash equivalents	$ 2,077,125	$ 5,339,738
Patient accounts receivable	9,242,497	9,149,470
Other receivables	1,137,399	1,040,021
Estimated third-party payor settlement receivable	1,954,870	1,182,000
Interest and dividends receivable	325	241
Supplies	1,700,683	1,617,010
Prepaid expenses and other	887,416	636,733
Total current assets	17,000,315	18,965,213
ASSETS WHOSE USE IS LIMITED		
Board designated funds (Note F)	25,611,053	21,014,136
Donor restricted funds	687,467	590,167
Total assets whose use is limited	26,298,520	21,604,303
PROPERTY AND EQUIPMENT, AT COST (Note G)	32,291,766	25,001,570
OTHER ASSETS		
Pledges receivable, net (Note L)	17,983	-
Total other assets	17,983	-
Total assets	$ 75,608,584	$ 65,571,086

LIABILITIES AND NET ASSETS

	2019	2018
CURRENT LIABILITIES		
Accounts payable	$ 1,550,524	$ 1,572,150
Accrued payroll and other liabilities	2,325,446	3,083,560
Estimated third-party reimbursement programs	70,216	75,870
Line of credit (Note H)	2,000,000	-
Current portion of long-term debt	759,713	550,990
Total current liabilities	6,705,899	5,282,570
LONG TERM DEBT (Note I)	7,168,597	5,854,494
Total liabilities	13,874,496	11,137,064
NET ASSETS		
With donor restrictions (Note N)	687,467	590,167
Without donor restrictions (Note N)	61,046,621	53,843,855
Total net assets	61,734,088	54,434,022
Total liabilities and net assets	$ 75,608,584	$ 65,571,086

The accompanying notes are an integral part of these statements.

#21-009

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF ACTIVITIES
(Unrestricted Funds)

Years ended December 31

	2019	2018
Net assets without donor restrictions:		
Unrestricted revenues, gains and other support		
Patient service revenue	$ 57,762,947	$ 56,150,471
Less: provision for bad debt	-	4,299,777
Net patient service revenue	57,762,947	51,850,694
Other operating revenue	5,710,233	3,880,088
Net assets released from restrictions	9,095	127,601
Total operating revenue	63,482,275	55,858,383
Operating expenses		
Salaries and wages	31,983,971	27,777,061
Employee benefits	7,499,131	6,983,545
Supplies and other	7,309,318	5,696,239
Physician fees	2,506,977	2,739,261
Professional services non-physician	1,111,747	948,620
Outside services	4,216,607	3,495,304
Depreciation	2,929,958	2,352,043
Utilities	615,764	643,560
Interest	395,512	101,644
Insurance	695,062	553,052
Other	1,726,867	1,418,174
Total operating expenses	60,990,914	52,708,503
Operating income	2,491,361	3,149,880
Nonoperating revenues (expenses)		
Contributions and grants received	25,223	28,072
Contribution expense	(25,739)	(20,963)
Investment income	1,342,536	2,668,091
Total nonoperating revenues (expenses)	1,342,020	2,675,200
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	3,833,381	5,825,080
Change in net unrealized gains and (losses) on investments	3,369,385	(3,986,633)
INCREASE IN UNRESTRICTED NET ASSETS	$ 7,202,766	$ 1,838,447

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF CHANGES IN FINANCIAL POSITION

Years ended December 31

	2019	2018
Net assets without donor restrictions (continued):		
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	$ 3,833,381	$ 5,825,080
Net unrealized gains and (losses) on investments	3,369,385	(3,986,633)
INCREASE IN UNRESTRICTED NET ASSETS	7,202,766	1,838,447
Net assets with donor restrictions:		
Contributions	105,830	130,690
Investment income	565	908
Net assets released from restriction	(9,095)	(127,601)
Increase in restricted net assets	97,300	3,997
INCREASE IN NET ASSETS	7,300,066	1,842,444
Net assets, beginning of year	54,434,022	52,591,578
Net assets, end of year	$ 61,734,088	$ 54,434,022

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATING SUBSIDIARY

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years ended December 31

	2019	2018
Cash flows from operating activities		
Increase in net assets	$ 7,300,066	$ 1,842,444
Items not requiring (providing) cash		
Depreciation and amortization	2,929,958	2,352,043
Amortization of bond issue costs included in interest expense	-	19,404
Net realized gains and losses and change in net unrealized gains and losses on investments	(3,369,385)	3,986,633
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(93,027)	(2,552,050)
Pledges receivable	(17,983)	100,498
Interest and dividends receivable	(84)	46
Estimated amounts due from and/to third-party payers	(778,524)	(939,461)
Supplies, prepaid expenses and other	(431,734)	(1,036,984)
Accounts payable and accrued expenses	(779,740)	791,775
NET CASH PROVIDED BY OPERATING ACTIVITIES	4,759,547	4,564,348
Cash flows from investing activities		
Purchases of investments	(13,168,021)	(12,739,726)
Proceeds from sales of investments	11,940,489	11,460,313
Purchases of property, plant and equipment and other assets	(10,220,154)	(12,297,626)
NET CASH USED IN INVESTING ACTIVITIES	(11,447,686)	(13,577,039)
Cash flows from financing activities		
Draws on line of credit	3,000,000	-
Payments on line of credit	(1,000,000)	-
Proceeds from issuance of long-term debt	2,431,202	6,568,948
Principal payments on long-term debt	(908,376)	(2,441,327)
NET CASH PROVIDED BY FINANCING ACTIVITIES	3,522,826	4,127,621
Net decrease in cash, cash equivalents and restricted cash	(3,165,313)	(4,885,070)
Cash, cash equivalents and restricted cash at beginning of year	5,929,905	10,814,975
Cash, cash equivalents and restricted cash at end of year	$ 2,764,592	$ 5,929,905
SUPPLEMENTAL CASH FLOWS INFORMATION		
Interest paid	$ 395,512	$ 82,240

The accompanying notes are an integral part of these statements.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE A - SUMMARY OF ACCOUNTING POLICIES

1. Nature of Operations

Hospital & Medical Foundation of Paris, Inc. and it's consolidated subsidiary (the "Hospital"), located in Paris, Illinois, is a not-for-profit acute care hospital and clinical care facility. The Hospital primarily earns revenues by providing inpatient, outpatient, emergency care, and clinic services to patients in Paris, Illinois and the surrounding area.

Paris Community Hospital Foundation, Inc. (the Foundation) was established in 2015 as a supporting organization for the Hospital. The Foundation Board is appointed by the Hospital Board. The Hospital has the ability to control the activities of the Foundation.

2. Principles of Consolidation

The consolidated financial statements include the accounts of Hospital & Medical Foundation of Paris, Inc. ("HMFP") and Paris Community Hospital Foundation, Inc. (the "Foundation"). HMFP has both an economic interest in the Foundation and control of the Foundation. HMFP has the ability to control the activities of the Foundation through appointment of Foundation board members by HMFP life members. In addition, certain powers are reserved to HMFP per the Bylaws of the Foundation. All significant/material intercompany accounts and transactions have been eliminated in consolidation.

3. Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

4. Cash and Cash Equivalents

The Hospital considers all highly liquid investments, excluding assets whose use is limited, purchased with an initial maturity of three months or less to be cash equivalents.

5. Investments and Investment Return

Investments in marketable equity securities with readily determinable fair values and debt securities are carried at fair value. All other investments are carried at cost, which approximates fair value. Investment return which primarily consists of realized and unrealized gains and losses, interest income, and dividends is included in non-operating income (loss), unless the income or loss is restricted by donor or law or is classified as trading securities. The Hospital did not have any investments classified as trading securities at December 31, 2019 and 2018.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

6. Assets Whose Use is Limited

Assets whose use is limited primarily include designated assets set aside by the Board of Directors for future capital improvements, (over which the Board retains control and may at its discretion subsequently use for other purposes) and bond reserve funds.

7. Net Assets with Donor Restrictions

Net assets with donor restrictions are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

8. Patient Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for Medicare, Medicaid, commercial, and self-pay in order to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely).

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. It is the Hospital's policy to charge off uncollectible accounts receivable when management determines the receivable will not be collected. No collection attempts are made on patients determined to qualify under the Hospital's financial assistance policy. The Hospital does not charge interest on outstanding balances.

9. Supplies

The Hospital states supply inventories at the lower of cost or net realizable value, determined using the first-in, first-out method.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

10. Property, Equipment and Related Depreciation

Property and equipment acquisitions over $5,000 having a useful life of one year or more are recorded at cost. Assets acquired through lease agreements meeting requirements under generally accepted accounting principles in the U.S. that require capitalization are recorded at their fair market value as of the date of lease inception. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in the depreciation and amortization in the consolidated financial statements. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method with estimated lives of five to forty years. Assets acquired at less than $5,000 per item are treated as ordinary expenses. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

11. Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payors.

Retroactively calculated contractual adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

12. Charity Care

The Hospital provides care to patients who meet certain criteria under its financial assistance policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

13. Advertising

The Hospital is not involved in direct-response advertising. The Hospital's policy is to expense advertising costs as the costs are incurred. Advertising costs charged to operations for the years ended December 31, 2019 and 2018 amounted to $322,139 and $312,395, respectively.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

14. Income Taxes

HMFP is a not-for-profit corporation and has been recognized as exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and a similar provision of state law. It qualifies for the charitable contribution deduction under Section 170(b)(1)(A) and has been classified as an organization other than a private foundation under Section 509(a)(2). There were no uncertain tax benefits or liabilities identified and recorded as of December 31, 2019.

The Foundation is a not-for-profit corporation and has been recognized as exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code and a similar provision of state law. It qualifies for the charitable contribution deduction under Section 170(b)(1)(A) and has been classified as an organization other than a private foundation under Section 509(a)(2).

The Hospital has recognized in the financial statements the effects of all tax positions and continually evaluates expiring statutes of limitations, audits, changes in tax law, and new authoritative rulings. The Hospital is not aware of any significant circumstances or events that make it reasonably possible that unrecognized tax benefits may increase or decrease within 12 months of the statement of financial position date. Penalties and interest assessed by taxing authorities are included in general and administrative expenses, if applicable. There were no interest or penalties paid during fiscal years 2019 and 2018.

15. Donor-Restricted Gifts

All contributions are considered available for unrestricted use unless specifically restricted by the donor. Amounts received that are designated for future periods or restricted by the donor for specific purposes are reported as net assets with donor restrictions. However, if a restriction is fulfilled in the same time period in which the contribution is received, the Hospital reports the support as unrestricted.

Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in the contribution revenue. Conditional promises to give are not included as support until the conditions are substantially met.

16. Change in Net Assets

The consolidated statement of activities includes excess (deficiency) of revenues over expenses. Changes in net assets which are excluded from excess (deficiency) of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments. The performance indicator is the excess (deficiency) of revenue over expenses and that amount excludes changes in net assets with donor restrictions.

17. Subsequent Events

Subsequent events have been evaluated through May 14, 2020 which is the date the financial statements were available to be issued.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE A - SUMMARY OF ACCOUNTING POLICIES - CONTINUED

18. Change in Accounting Principle

In May of 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The core principal of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for goods or services. The guidance in this update supersedes the revenue recognition requirements in Topic 605, Revenue Recognition, and most industry-specific guidance.

The Hospital adopted ASU 2014-09 as of January 1, 2019 using the modified retrospective transition approach. The Hospital has determined that there was no change in either the measurement or the timing of revenues recognized under ASU 2014-09 as compared to previous guidance. As a result, at the adoption of ASU 2014-09 the majority of what was previously classified as the provision for bad debts is now reflected as an implicit price concession and therefore is included as a reduction to net patient service revenue in the accompanying consolidated statement of operations. Bad debt expense is now considered a component of operating expenses in the accompanying consolidated statement of operations. ASU 2014-09 also requires certain additional disclosures reflected in Note B to these financial statements.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*. ASU 2016-01 amends guidance related to certain aspects of the recognition, measurement, presentation, and disclosure of financial instruments. The Hospital adopted the standard on January 1, 2019. Adoption did not have a material effect on the Hospital's results of operations, financial position, or cash flows.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*. The amendments in this update are to clarify cash flow issues with the objective of reducing the existing diversity in practice. The Hospital adopted the standard on January 1, 2019. Adoption did not have a material effect on the Hospital's results of operations, financial position, or cash flows.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*. The amendments in this update are to clarify cash flow issues regarding restricted cash with the objective of reducing the existing diversity in practice. The Hospital adopted the standard on January 1, 2019. Adoption did not have a material effect on the Hospital's results of operations, financial position, or cash flows.

In June 2018, the FASB issued ASU 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. The amendments in this update should assist entities in evaluating whether transactions should be accounted for as contributions or as exchange transactions, and determine with a contribution is conditional. The Hospital adopted the standard on January 1, 2019. Adoption did not have a material effect on the Hospital's results of operations, financial position, or cash flows.

19. Reclassifications

Certain reclassifications have been made to the 2018 balances previously reported in order to conform with the 2019 presentation.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE B - OPERATING REVENUES

The Hospital records revenue in three financial statement categories: Patient service revenues, other operating revenues and net assets released from restrictions. Performance obligations are identified based on the nature of the services provided.

Patient Service Revenues:

Effective January 1, 2019 upon the adoption of ASU 2014-09, net patient service revenue is reported at the amount that reflects the consideration for which the Hospital expects to be entitled in exchange for provided patient care. These amounts are due from patients, third-party payors (including health insurers and government payors), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed or the patient is discharged from the facility. Revenue is recognized as the performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Hospital believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services or patients receiving services at the Hospital on an outpatient basis. The Hospital measures the performance obligation from admission into the hospital, or the commencement of an outpatient service, to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. Revenue for performance obligations satisfied at a point in time is generally recognized when goods are provided to our patients and customers in a retail setting (for example, pharmaceuticals and medical equipment), and the Hospital does not believe it is required to provide additional goods or services related to that sale.

The Hospital determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, or implicit price concessions provided to uninured patients. The Hospital determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Hospital determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

The Hospital uses a portfolio approach as a practical expedient to account for categories of patient contracts as collective groups rather than recognizing revenue on an individual contract basis. The portfolio consists of major payor classes for inpatient revenue and outpatient revenue. Based on historical collection trends and other analyses, the Hospital believes that revenue recognized by utilizing the portfolio approach approximates the revenue that would have been recognized if an individual contract approach were used.

NOTE B - OPERATING REVENUES - CONTINUED

The Hospital has agreements with third-party payers that provide for payments to the Hospital at amounts different from its established rates. These payment arrangements include:

- Medicare - Inpatient acute care services and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Inpatient skilled nursing services are paid at prospectively determined per diem rates that are based on the patients' acuity. The Hospital is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary.

- Medicaid - Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates.

- Other – Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Approximately 53% and 56% of net patient service revenues are from participation in the Medicare and state-sponsored Medicaid programs for the years ended December 31, 2019 and 2018. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

Consistent with the Hospital's mission, care is provided to patients regardless of their ability to pay. Therefore, the Hospital has determined it has provided implicit price concessions to uninsured patients and other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represents the difference between amounts billed to patients and the amounts the Hospital expects to collect based on its collection history with those patients.

Patients who meet the Hospital's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Hospital also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, form standard charges. The Hospital estimates the transaction price for patients with deductibles and coinsurance and from those who are insured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE B - OPERATING REVENUES - CONTINUED

The nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement and payment methodologies
- Length of the patient's service or episode of care
- Geography of the service location
- Method of reimbursement (fee for service or cost based)
- Hospital's line of business that provided the service (for example, hospital inpatient, hospital outpatient, rural health clinic, and so on)

Schedule of net patient service revenue disaggregated by payor consists of the following for the year ended December 31, 2019:

Medicare	$ 25,079,038
Medicaid	5,738,341
Commercial and Other	12,526,850
Blue Cross	17,627,511
Self-Pay	2,247,369
Implicit price concessions	(5,456,162)
Net Patient Service Revenue	$ 57,762,947

At December 31, 2019, implicit price concessions included $4,052,122 provision for bad debt and $1,404,040 in charity care adjustments.

Schedule of patient service revenue net of contractual allowances and discounts consist of the following for the year ended December 31, 2018:

	Medicare	Medicaid	Commercial and Other	Blue Cross	Self Pay	Total
Gross revenue	$ 47,603,281	$ 22,505,099	$ 15,764,905	$ 20,374,320	$ 2,536,859	$ 108,784,464
Less: contractual allowances/discounts	(24,307,622)	(16,580,582)	(4,280,525)	(5,222,689)	(1,701,096)	(52,092,514)
	$ 23,295,659	$ 5,924,517	$ 11,484,380	$ 15,151,631	$ 835,763	56,691,950
					Provision for Bad Debt	(4,299,777)
					Charity Care Adjustments	(541,479)
					Net Patient Service Revenue	$ 51,850,694

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE B - OPERATING REVENUES - CONTINUED

Illinois Hospital Medicaid Assessment Program

The state of Illinois enacted legislation that provided for an assessment program intended to qualify for federal matching funds under the Illinois Medicaid program. Under the hospital assessment program, each hospital is assessed tax based on that hospital's adjusted gross hospital revenue. The assessments in part fund additional Medicaid payments. The legislation provides that none of the assessment funds are to be collected and no additional Medicaid payments are to be paid until the program receives the required federal government approval through the Center for Medicare and Medicaid Services.

The effect of this program in the statements of activities and changes in financial position for the years ended December 31, 2019 and 2018, is as follows:

	2019	2018
Additional Medicaid payments included in net patient service revenue	$ 300,923	$ 382,056
Hospital Access Improvement payment included in net patient service revenue	-	300,768
Affordable Care Act (ACA) Hospital Access payments included in net patient service revenue	183,570	326,613
Managed Care Organization – Hospital Access Program	2,857,147	1,846,157
Less payments paid to the program	(1,510,123)	(1,315,958)
	$ 1,831,517	$ 1,539,636

The provider assessment has been an important component in providing positive cash flows to support Hospital operations.

Other Operating Revenues:

The Hospital has additional revenue streams from the 340B program, cafeteria sales, rental properties and other miscellaneous sources. Revenue is recognized when obligations under the terms of the contract are satisfied. Revenues from these services are measured as the amount of consideration the Hospital expects to receive for those services.

Net Assets Released from Restrictions:

The Hospital receives contributions, of which all contributions are considered available for unrestricted use unless specifically restricted by the donor. Those contributions that are temporarily restricted are reflected in operating revenue once they have been used for their restricted purpose.

NOTE C - DEPOSITS

At December 31, 2019, the Hospital's deposits were covered by federal depository insurance up to $250,000 at each financial institution. The Hospital has not experienced any losses in such accounts and believes there is no significant risk with respect to these deposits.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE C – DEPOSITS - CONTINUED

At December 31, 2019, the Hospital had bank balances as follows:

	2019
Insured	$ 871,158
Uninsured, covered by pledged collateral	1,617,723
Uninsured, covered by repurchase agreements	266,150
Uninsured	205,971
Total bank balances	$ 2,961,002
Cash and cash equivalents	2,077,125
Donor restricted funds	687,467
Carrying value	$ 2,764,592

NOTE D - UNCOMPENSATED CARE AND COMMUNITY BENEFIT

In support of its mission, the Hospital voluntarily provides care to patients at less than its established rates for patients that meet the Hospital's charity care criteria. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue. Charges excluded from revenue under the Hospital's charity care policy were $1,404,040 and $541,479 for 2019 and 2018, respectively.

The Hospital uses an overall hospital cost to charge ratio to calculate the unpaid cost of charity care, uncollectable accounts and state Medicaid and other public aid programs. The following amounts reflect the quantifiable costs of the community benefit for the year ended December 31, 2019 and 2018 at cost:

	2019	2018
Benefits for the poor and the broader community		
Charity care	$ 700,000	$ 260,000
State Medicaid and other public aid programs	6,960,000	4,980,000
Medicare	2,190,000	870,000
Uncollectible accounts	2,030,000	2,080,000
Total community benefit	$ 11,880,000	$ 8,190,000

Benefits for the broader community represent the cost of services provided to other needy populations that may not qualify as poor, but still require special services and support. It also includes the cost of services for the general benefit of the communities in which the Hospital operates. Many programs are targeted toward populations that may be poor, but also include those areas that may need special health services and support. These programs are not financially self-supporting.

Benefits for the poor represent the cost of services provided to persons who cannot afford health care because of inadequate resources and who are uninsured or underinsured. Benefits for the broader community include cost of providing the following services: health screenings and other health-related services, training health professionals, educating the community with various seminars and classes, and subsidized costs of providing two rural clinics.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE D - UNCOMPENSATED CARE AND COMMUNITY BENEFIT - CONTINUED

Charity care represents the cost (determined using a cost to charge ratio) of services provided to patients who cannot afford health care services due to inadequate resources. All or a portion of a patient's services may be considered charity care for which no payment is anticipated in accordance with the Hospital's established policies. Amounts classified as charity care are not reported as revenue in the statements of activities and changes in financial position.

Unpaid cost of Medicaid and other public programs represents the cost (determined using a cost to charge ratio) of providing services to beneficiaries of public programs, including state Medicaid and indigent care programs, in excess of payments for those services.

NOTE E - CONCENTRATION OF CREDIT RISK

The Hospital grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payer agreements. The mix of receivables from patients and third-party payers at December 31, 2019 and 2018 was:

	2019	2018
Medicare	29%	19%
Medicaid	18%	36%
Other third-party payers	39%	18%
Patients	14%	27%
	100%	100%

NOTE F - FAIR VALUE OF FINANCIAL INSTRUMENTS

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There are three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices are available in active markets for identical assets or liabilities as of the measurement date.

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs supported by little or no market activity and that are significant to the fair value of the assets or liabilities

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE F - FAIR VALUE OF FINANCIAL INSTRUMENTS - CONTINUED

As of December 31, 2019 and 2018, the Level 2 instruments listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

Cash Equivalents - Cash equivalents are comprised solely of money market funds, whose fair value are based on the value of the funds as provided by the fund manager.

Fixed-Income Securities - The fair value of fixed-income securities is primarily determined with techniques consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, two-sided markets, benchmark securities, bids, offers, and reference data including market research publication.

The fair value of the Hospital's financial instruments at December 31, 2019 and 2018 are as follows:

	Fair Value Measurements at December 31, 2019			
	Total	Level 1	Level 2	Level 3
Investments at fair market value				
Cash and cash equivalents	$ 1,076,217	$ -	$ 1,076,217	$ -
Accrued income	40,907	-	40,907	-
Fixed-income securities				
Treasury and federal agencies	662,667	-	662,667	-
Corporate bonds	2,317,838	-	2,317,838	-
Foreign bonds	383,984	-	383,984	-
Pooled fixed income funds	367,153	367,153	-	-
Equity securities				
Common stocks	14,907,384	14,907,384	-	-
Pooled equity funds	5,854,903	5,854,903	-	-
Total investments	$25,611,053	$21,129,440	$ 4,481,613	-

	Fair Value Measurements at December 31, 2018			
	Total	Level 1	Level 2	Level 3
Investments at fair market value				
Cash and cash equivalents	$ 75,959	$ -	$ 75,959	$ -
Accrued income	38,498	-	38,498	-
Fixed-income securities				
Treasury and federal agencies	860,860	-	860,860	-
Corporate bonds	2,156,578	-	2,156,578	-
Foreign bonds	331,820	-	331,820	-
Pooled fixed income funds	5,041,689	5,041,689	-	-
Equity securities				
Common stocks	12,299,280	12,299,280	-	-
Pooled equity funds	209,452	209,452	-	-
Total investments	$21,014,136	$17,550,421	$ 3,463,715	-

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE F - FAIR VALUE OF FINANCIAL INSTRUMENTS - CONTINUED

Total investment return, which is comprised of realized and unrealized gains and losses, interest, and dividends net of custodial fees amounted to $4,712,486 and $(1,317,634) for the years ended December 31, 2019 and 2018, respectively. The investment advisory fees were $73,366 and $78,448 for the years ended December 31, 2019 and 2018, respectively.

As a result of Coronavirus Disease 2019, which was declared a pandemic on March 11, 2020, the United States Federal Government, State and Local Governments, and other countries around the world have taken measures that have suddenly limited economic output. This has caused market prices of various investment asset classes to significantly decline in value in 2020. As of the date of this report, the measures taken by the governments are expected to be short-term in nature. However, due to the uncertainty of the overall effects of the Coronavirus and the length of time of economic measures taken by Federal and State and Local Governments, there is also uncertainty on the value of the investment portfolio and its possible recovery as of the date of this report.

NOTE G - PROPERTY AND EQUIPMENT

Property and equipment at December 31, 2019 and 2018 are as follows:

	2019	2018
Land improvements	$ 2,523,630	$ 2,324,864
Buildings and improvements	41,195,475	29,453,960
Equipment	21,057,249	18,775,493
Leasehold improvements	74,744	74,744
	64,851,098	50,629,061
Less accumulated depreciation	36,420,813	33,587,187
	28,430,285	17,041,874
Land	324,175	434,175
Investment property	501,625	501,625
Construction in progress	3,035,681	7,023,896
	$ 32,291,766	$ 25,001,570

Construction in progress at December 31, 2019 represents amounts expended for costs related to expansion and renovation projects. A large portion of the balance represents costs expended for the new pain management and infusion service area, a surgery expansion project and the construction of the Horizon Health Life Center. The projects are expected to be completed in 2020 with an estimated cost to complete of approximately $2,500,000.

NOTE H - LINE OF CREDIT

The Hospital has available an operating line of credit with Prospect Bank in Paris, Illinois in the amount of $2,500,000. At December 31, 2019, $2,000,000 was advanced on the line of credit.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE I - LONG-TERM DEBT

A summary of long-term debt follows:

	2019	2018
Bank loan, loan interest 4.125% variable, payable in monthly installments of $91,832 beginning November 2018 through October 2028	$ 7,928,310	$ 6,405,484
Less current maturities	759,713	550,990
Long-term portion	$ 7,168,597	$ 5,854,494

The following is a schedule of future maturities of long-term debt at December 31, 2019:

2020	$ 759,713
2021	791,651
2022	824,931
2023	859,610
2024	895,747
Thereafter	3,796,658
	$ 7,928,310

On October 9, 2018 the Hospital obtained a bank note through Prospect Bank in the amount of $9,000,000 of which the full amount was drawn as of December 31, 2019 for the purposes of paying off the Bonds and financing renovations and construction of facilities for the Hospital. The note is secured by mortgage on the property and all Hospital assets.

NOTE J - MEDICAL MALPRACTICE CLAIMS

The Hospital maintains claims made medical malpractice insurance from a commercial insurance company. The Hospital has a $7,500 per a claim and $30,000 per year deductible and is covered for up to $1,000,000 per claim or occurrence with an aggregate of $3,000,000 per policy year. Accounting principles generally accepted in the United States of America require a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. The Hospital's management believes, after consultation with legal counsel, that the claims outstanding are without merit or that the ultimate liability, if any, resulting from them will not materially affect the Hospital's consolidated financial position.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE K - EMPLOYEE HEALTH CLAIMS

Substantially all the Hospital's employees are eligible to participate in the Hospital's health insurance plan. The Hospital is self-insured for health claims of participating employees and dependents up to limits provided for in an agreement with a third party stop-loss carrier which is $50,000 as of December 31, 2019. A provision is accrued for self-insured employee health claims including both claims reported, and claims incurred but not yet reported. The accrual is estimated based on consideration of prior claims experience, recently settled claims, frequency of claims and other economic and social factors. It is reasonably possible that the Hospital's estimate will change by a material amount in the near term.

Employee health insurance liabilities were $258,572 and $179,704, at December 31, 2019 and 2018, respectively, and were recorded on an undiscounted basis in accrued payroll and other liabilities.

NOTE L - UNCONDITIONAL PLEDGES RECEIVABLE

	2019	2018
Promises receivable	$ 19,981	$ -
Less allowance for uncollectable promises receivable	1,998	-
Total unconditional promises to give	$ 17,983	$ -

NOTE M - PENSION PLANS

The Hospital sponsors a 403(b) Defined Contribution Plan (the Plan) covering substantially all full-time employees of the Hospital and Medical Foundation of Paris, Inc. The Hospital can make discretionary contributions up to 4.5% of each participant's compensation based on a predetermined rate schedule by years of service. Employer Pension contributions under this plan were $616,314 and $535,735 for 2019 and 2018, respectively.

NOTE N - NET ASSETS

The Hospital has received contributions, which are temporarily restricted, to provide services for the Meals on Wheels Program and various other areas of the Hospital. These contributions are included in temporarily restricted net assets.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE N - NET ASSETS - CONTINUED

Net assets with donor restrictions are available for the following purposes:

	2019	2018
Phipps fund	$ 403,580	$ 402,979
Alzheimer's support group	13,107	13,107
Nursing scholarships	14,562	15,172
Employee scholarships	9,025	9,025
Ceiling lifts	20,823	20,823
Women's health	35,004	35,004
Garden of Hope	11,999	11,496
CARE	14,988	11,879
Sterotactic equipment	67,520	-
Miscellaneous	96,859	70,682
	$ 687,467	$ 590,167

Net assets without donor restrictions are as follows:

	2019	2018
Undesignated	$ 35,435,568	$ 32,829,719
Board designated	25,611,053	21,014,136
	$ 61,046,621	$ 53,843,855

Net assets released from net assets with donor restrictions are as follows:

	2019	2018
Garden of Hope	$ 2,454	$ -
CARE	830	2,525
Ceiling lifts	-	4,204
Doc Acklin scholarship	2,000	2,000
Employee scholarships	-	1,000
EZ Care radiology equipment	-	59,720
Nursing scholarships	1,000	2,000
Swing bed	500	-
Rehab – underwater treadmill	-	51,400
Miscellaneous	2,311	4,752
	$ 9,095	$ 127,601

NOTE O - FUNCTIONAL EXPENSES

The Hospital provides healthcare and related services to the residents of Paris, Illinois and the surrounding areas. The operating expenses included in the statements of activities primarily relates to providing these services.

For the year ended December 31, 2019:

	Program Services Patient Care	Management and General	Supporting Services	Fundraising	Scholarships	Total
Salaries and wages	$ 24,481,148	$ 3,285,587	$ 4,217,236	$ -	$ -	$ 31,983,971
Employee benefits	3,427,523	3,756,746	314,862	-	-	7,499,131
Supplies and other	6,071,247	554,571	683,500	-	-	7,309,318
Physicians' fees	2,487,859	19,118	-	-	-	2,506,977
Professional services non-physician	747,475	335,329	28,943	-	-	1,111,747
Outside services	1,424,169	1,318,821	1,473,617	-	-	4,216,607
Depreciation	2,929,958	-	-	-	-	2,929,958
Utilities	107,615	122,281	385,868	-	-	615,764
Interest	395,512	-	-	-	-	395,512
Insurance	285,080	409,982	-	-	-	695,062
Other	749,811	622,773	285,952	66,331	2,000	1,726,867
Total operating expenses	$ 43,107,397	$ 10,425,208	$ 7,389,978	$ 66,331	$ 2,000	$ 60,990,914

NOTE O - FUNCTIONAL EXPENSES - CONTINUED

For the year ended December 31, 2018:

	Program Services Patient Care	Management and General	Supporting Services	Fundraising	Scholarships	Total
Salaries and wages	$ 21,423,495	$ 2,803,064	$ 3,550,502	$ -	$ -	$ 27,777,061
Employee benefits	3,094,230	2,249,553	1,639,762	-	-	6,983,545
Supplies and other	4,932,382	322,435	441,422	-	-	5,696,239
Physicians' fees	2,739,261	-	-	-	-	2,739,261
Professional services non-physician	526,459	399,325	22,836	-	-	948,620
Outside services	1,107,833	1,140,314	1,247,157	-	-	3,495,304
Depreciation	2,352,043	-	-	-	-	2,352,043
Utilities	122,860	175,187	345,513	-	-	643,560
Interest	82,240	19,404	-	-	-	101,644
Insurance	225,110	327,942	-	-	-	553,052
Other	682,252	499,091	236,831	-	-	1,418,174
Total operating expenses	$ 37,288,165	$ 7,936,315	$ 7,484,023	$ -	$ -	$ 52,708,503

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE P - RELATED PARTY TRANSACTIONS

The Hospital leases a portion of its medical office building to an S-Corporation, a shareholder of which is a member of the Board of Directors. The term of the lease began June 12, 2006 and ended June 11, 2011. The terms of the original lease are being continued on a month-to-month basis. The lessee agrees to pay the sum of $72,000, payable in 60 monthly installments of $1,200. The lessee also agrees to pay additional rent of $.25 for each prescription filled in excess of three thousand prescriptions per month. Total rent amounted to $14,400 for each of the fiscal years ended December 31, 2019 and 2018.

NOTE Q - LIQUIDITY AND AVAILABILITY OF FINANCIAL ASSETS

As part of its liquidity management, the Hospital's strategy is to structure its financial assets to be available to satisfy general operating expenses, current liabilities, and other obligations as they come due. The Hospital's financial assets available within one year of the statement of financial position date for general expenditure are as follows.

	2019	2018
Cash and cash equivalents	$ 2,077,125	$ 5,339,738
Short-term investments	1,076,217	75,959
Accounts receivable	9,492,497	9,149,470
Financial assets available to meet cash needs for general expenditures within one year	$ 12,645,839	$ 14,565,167

To help manage unanticipated liquidity needs, the Hospital also has a line of credit (detailed in Note H), which it could draw upon if necessary. The board designated funds of $25,611,053 is generally used for capital improvements and other needs of the Hospital. Although the Hospital does not intend to spend from these funds (other than amounts appropriated for general expenditures as part of the boards annual budget and appropriation), these amounts could be made available if necessary.

As a result of Coronavirus Disease 2019, which was declared a pandemic on March 11, 2020, the United States, State and Local Governments, and other countries have taken measures that have suddenly limited economic output. Due to the decline in economic activity, the Hospital is faced with an uncertainty regarding its liquidity as revenue has significantly declined in the first quarter of 2020, and the decline in revenue may continue in the short-term in 2020. Management is working with its financial institutions to assist with liquidity needs. In addition, the United States government is developing policies and programs to assist businesses with short-term liquidity assistance. As of the date of these financial statements, the Hospital has applied for and received additional funding through the Paycheck Protection Program and Medicare Advanced Payments to help with liquidity. The short-term and long-term effects of the Coronavirus on the operations of the Hospital are uncertain as of the date of this report.

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2019 and 2018

NOTE R - FOUNDATION SEPARATION AND CONSOLIDATION

During 2016, investment assets were transferred from the Hospital to the Foundation. The Foundation is a legally separate entity that operates independently of the Hospital. In 2015, these investment assets were reported as owned by the Hospital. As of and beginning in 2017, the investment assets are reported as owned by the Foundation. The Hospital and the Foundation's financial statements have been consolidated in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 810; therefore, these investment assets are reported in the consolidated financial statements in 2019 and 2018. Consolidation is required if the parent has a controlling financial interest in the subsidiary. The Hospital has the ability to control the activities of the Foundation through appointment of Foundation board members by Hospital life members. In addition, certain powers are reserved to the Hospital per the Bylaws of the Foundation. In 2019 and 2018, consolidating schedules are included in supplementary information.

SUPPLEMENTARY INFORMATION

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF FINANCIAL POSITION

December 31, 2019

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 2,077,125	$ -	$ -	$ 2,077,125
Accounts receivable patient, net	9,242,497	-	-	9,242,497
Other receivables	1,692,471	-	(555,072)	1,137,399
Estimated third-party payor settlement receivable	1,954,870	-	-	1,954,870
Interest and dividends receivable	325	-	-	325
Supplies	1,700,683	-	-	1,700,683
Prepaid expenses and other	887,416	-	-	887,416
Total current assets	17,555,387	-	(555,072)	17,000,315
ASSETS WHOSE USE IS LIMITED				
Board designated funds	-	25,611,053	-	25,611,053
Donor restricted funds	687,467	-	-	687,467
Total assets whose use is limited	687,467	25,611,053	-	26,298,520
PROPERTY AND EQUIPMENT, AT COST	32,291,766	-	-	32,291,766
OTHER ASSETS				
Beneficial interest in assets held by Foundation	25,055,981	-	(25,055,981)	-
Pledges receivable, net	17,983	-	-	17,983
Total other assets	25,073,964	-	(25,055,981)	17,983
Total assets	$ 75,608,584	$ 25,611,053	$ (25,611,053)	$ 75,608,584
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts payable	$ 1,550,524	$ 555,072	$ (555,072)	$ 1,550,524
Accrued payroll and other liabilities	2,325,446	-	-	2,325,446
Estimated third-party reimbursement programs	70,216	-	-	70,216
Line of credit	2,000,000	-	-	2,000,000
Current portion of long-term debt	759,713	-	-	759,713
Total current liabilities	6,705,899	555,072	(555,072)	6,705,899
LONG TERM DEBT	7,168,597	-	-	7,168,597
Total liabilities	13,874,496	555,072	(555,072)	13,874,496
NET ASSETS				
With donor restrictions	687,467	-	-	687,467
Without donor restrictions	61,046,621	25,055,981	(25,055,981)	61,046,621
Total net assets	61,734,088	25,055,981	(25,055,981)	61,734,088
Total liabilities and net assets	$ 75,608,584	$ 25,611,053	$ (25,611,053)	$ 75,608,584

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF FINANCIAL POSITION

December 31, 2018

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	$ 5,339,738	$ -	$ -	$ 5,339,738
Accounts receivable patient, net	9,149,470	-	-	9,149,470
Other receivables	1,040,021	-	-	1,040,021
Estimated third-party payor settlement receivable	1,182,000	-	-	1,182,000
Interest and dividends receivable	241	-	-	241
Supplies	1,617,010	-	-	1,617,010
Prepaid expenses and other	636,733	-	-	636,733
Total current assets	18,965,213	-	-	18,965,213
ASSETS WHOSE USE IS LIMITED				
Board designated funds	-	21,014,136	-	21,014,136
Donor restricted funds	590,167	-	-	590,167
Total assets whose use is limited	590,167	21,014,136	-	21,604,303
PROPERTY AND EQUIPMENT, AT COST	25,001,570	-	-	25,001,570
OTHER ASSETS				
Beneficial interest in assets held by Foundation	21,014,136	-	(21,014,136)	-
Pledges receivable, net	-	-	-	-
Total other assets	21,014,136	-	(21,014,136)	-
Total assets	$ 65,571,086	$ 21,014,136	$ (21,014,136)	$ 65,571,086
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accounts payable	$ 1,572,150	$ -	$ -	$ 1,572,150
Accrued payroll and other liabilities	3,083,560	-	-	3,083,560
Estimated third-party reimbursement programs	75,870	-	-	75,870
Current portion of long-term debt	550,990	-	-	550,990
Total current liabilities	5,282,570	-	-	5,282,570
LONG TERM DEBT	5,854,494	-	-	5,854,494
Total liabilities	11,137,064	-	-	11,137,064
NET ASSETS				
With donor restrictions	590,167	-	-	590,167
Without donor restrictions	53,843,855	21,014,136	(21,014,136)	53,843,855
Total net assets	54,434,022	21,014,136	(21,014,136)	54,434,022
Total liabilities and net assets	$ 65,571,086	$ 21,014,136	$ (21,014,136)	$ 65,571,086

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN FINANCIAL POSITION

FOR THE YEAR ENDED DECEMBER 31, 2019

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
Net assets without donor restrictions:				
Unrestricted revenues, gains and other support				
Patient service revenue	$ 57,762,947	$ -	$ -	$ 57,762,947
Less: provision for bad debt	-	-	-	-
Net patient service revenue	57,762,947	-	-	57,762,947
Other operating revenue	5,710,233	-	-	5,710,233
Net assets released from restrictions	9,095	-	-	9,095
Total operating revenue	63,482,275	-	-	63,482,275
Operating expenses				
Salaries and wages	31,983,971	-	-	31,983,971
Employee benefits	7,499,131	-	-	7,499,131
Supplies and other	7,309,318	-	-	7,309,318
Physician fees	2,506,977	-	-	2,506,977
Professional services non-physician	1,111,747	-	-	1,111,747
Outside services	4,216,607	-	-	4,216,607
Depreciation	2,929,958	-	-	2,929,958
Utilities	615,764	-	-	615,764
Interest	395,512	-	-	395,512
Insurance	695,062	-	-	695,062
Contributions	-	475,276	(475,276)	-
Other	1,647,071	79,796	-	1,726,867
Total operating expenses	60,911,118	555,072	(475,276)	60,990,914
Operating income (loss)	2,571,157	(555,072)	475,276	2,491,361
Nonoperating revenues (expenses)				
Contributions and grants received	500,499	-	(475,276)	25,223
Contribution expense	(25,739)	-	-	(25,739)
Investment income	115,004	1,227,532	-	1,342,536
Total nonoperating revenues (expenses)	589,764	1,227,532	(475,276)	1,342,020
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	3,160,921	672,460	-	3,833,381
Change in interest in related organization	4,041,845	-	(4,041,845)	-
Change in net unrealized gains and (losses) on investments	-	3,369,385	-	3,369,385
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	7,202,766	4,041,845	(4,041,845)	7,202,766
Net assets with donor restrictions:				
Contributions	105,830	-	-	105,830
Investment income	565	-	-	565
Net assets released from restriction	(9,095)	-	-	(9,095)
Increase (decrease) in net assets with donor restrictions	97,300	-	-	97,300
INCREASE (DECREASE) IN NET ASSETS	$ 7,300,066	$ 4,041,845	$ (4,041,845)	$ 7,300,066

HOSPITAL & MEDICAL FOUNDATION OF PARIS, INC. AND CONSOLIDATED SUBSIDIARY

CONSOLIDATING STATEMENT OF ACTIVITIES AND CHANGES IN FINANCIAL POSITION

FOR THE YEAR ENDED DECEMBER 31, 2018

	Hospital & Medical Foundation of Paris, Inc.	Paris Community Hospital Foundation, Inc.	Consolidating Entries	Consolidated Totals
Net assets without donor restrictions:				
Unrestricted revenues, gains and other support				
Patient service revenue	$ 56,150,471	$ -	$ -	$ 56,150,471
Less: provision for bad debt	4,299,777	-	-	4,299,777
Net patient service revenue	51,850,694	-	-	51,850,694
Other operating revenue	3,880,088	-	-	3,880,088
Net assets released from restrictions	127,601	-	-	127,601
Total operating revenue	55,858,383	-	-	55,858,383
Operating expenses				
Salaries and wages	27,777,061	-	-	27,777,061
Employee benefits	6,983,545	-	-	6,983,545
Supplies and other	5,696,239	-	-	5,696,239
Physician fees	2,739,261	-	-	2,739,261
Professional services non-physician	948,620	-	-	948,620
Outside services	3,495,304	-	-	3,495,304
Depreciation	2,352,043	-	-	2,352,043
Utilities	643,560	-	-	643,560
Interest	101,644	-	-	101,644
Insurance	553,052	-	-	553,052
Contributions	-	1,350,000	(1,350,000)	-
Other	1,418,174	-	-	1,418,174
Total operating expenses	52,708,503	1,350,000	(1,350,000)	52,708,503
Operating income (loss)	3,149,880	(1,350,000)	1,350,000	3,149,880
Nonoperating revenues (expenses)				
Contributions and grants received	1,378,072	-	(1,350,000)	28,072
Contribution expense	(20,963)	-	-	(20,963)
Investment income	38,678	2,629,413	-	2,668,091
Total nonoperating revenues (expenses)	1,395,787	2,629,413	(1,350,000)	2,675,200
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	4,545,667	1,279,413	-	5,825,080
Change in net unrealized gains and (losses) on investments	-	(3,986,633)	-	(3,986,633)
INCREASE (DECREASE) IN NET ASSETS WITHOUT DONOR RESTRICTIONS	4,545,667	(2,707,220)	-	1,838,447
Net assets with donor restrictions:				
Contributions	130,690	-	-	130,690
Investment income	908	-	-	908
Net assets released from restriction	(127,601)	-	-	(127,601)
Increase (decrease) in net assets with donor restrictions	3,997	-	-	3,997
INCREASE (DECREASE) IN NET ASSETS	$ 4,549,664	$ (2,707,220)	$ -	$ 1,842,444

Section VII, Financial Feasibility

Criterion 1120.130 – Financial Viability

Not Applicable, as seen in Attachment 33, all of the project's capital expenditures are completely funded through internal sources.

Section VIII, Economic Feasibility Review Criteria

Criterion 1120.140(a), Reasonableness of Financing Arrangements

See Attachment 36-Exhibit 1 for a signed statement from a representative of Horizon Health that the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Section VIII, Economic Feasibility Review Criteria

Criterion 1120.140(b), Conditions of Debt Financing

Not Applicable, as seen in Attachment 33, all of the project's capital expenditures are completely funded through internal sources.

Section VIII, Economic Feasibility Review Criteria

Criterion 1120.140(c), Reasonableness of Project and Related Costs

The Cost and Gross Square Feet by Department is provided in the table below.

Department (list below)	A	B	C	D	E	F	G	H	Total Cost
	Cost/Square Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	(G + H)
	New	Mod.	New	Circ.*	Mod.	Circ.*	(A x C)	(B x E)	
ESRD		$189.57			3000			$568,698	$568,698
Contingency		$13.27			3000			$39,809	$39,809
Total Clinical		**$202.84**			**3000**			**$608,507**	**$608,507**
Non clinical		$189.57			2000			$379,132	$379,132
Contingency		$13.27			2000			$26,539	$26,539
Total Non-clinical		**$202.84**			**2000**			**$405,671**	**$405,671**
Totals		**$202.84**			**5000**			**$1,014,178**	**$1,014,178**

As shown in Table below, the project costs are below the State Standard.

	Application	State Standard	Above/Below State Standard
New Construction per GSF	N/A	$303.98	**Below State Standard**
Modernization Construction per GSF	$202.84	$219.32	**Below State Standard**
Equipment Per Station	$35,693.75	$60,420.40	**Below State Standard**
Contingencies	7%	7%-10%	**Below State Standard**
A/E Fees	7.05%	7.05-10.59%	**Below State Standard**
Site Survey + Site Prep	N/A	5% of Construction + Contingencies	**Below State Standard**
Pre-planning	N/A	1.8% of Construction + Contingencies + Equipment	**Below State Standard**

Section VIII, Economic Feasibility Review Criteria

Criterion 1120.140(d), Projected Operating Costs

Operating Expenses: $1,253,112

Treatments: 5,990

Operating Expense per Treatment: $209.2

Section VIII, Economic Feasibility Review Criteria

Criterion 1120.140(e), Total Effect of Project on Capital Costs

Capital Costs:

Depreciation/Amortization:	$117,265
Interest:	$0
Total Capital Costs:	$117,2656

Treatments: 5990

Capital Costs per Treatment: $19.58

HORIZON HEALTH

Paris Community Hospital
721 East Court Street
Paris, IL 61944
(217) 465-4141

Paris Clinic
727 East Court Street
Paris, IL 61944
(217) 465-8411

Chrisman Clinic
112 West Madison Ave.
Chrisman, IL 61924
(217)269-2394

Oakland Clinic
5 South Walnut Street
Oakland, IL 61943
(217) 346-2353

Senior Care
745 East Court Street
Paris, IL 61944
(217) 466-4170

EZ Care
1 Phipps Lane
Paris, IL 61944
(217) 463-4340

EZ Care— Marshall
1602 N. IL Hwy 1
Marshall, IL 62441

NAL Health Clinic
1 Phipps Lane
Paris, IL 61944
(217) 463-4901

Debra Savage
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded in total with cash and cash equivalents.

Sincerely,

Oliver M. Smith

Oliver M. Smith
Horizon Health President & CEO

Subscribed and sworn to me
This 8 day of March, 2021

Kimberly A Calvert

Notary Public

KIMBERLY A CALVERT
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 12, 2023

Section IX, Safety Net Impact Statement

20 ILCS 3960/5.4

1. This criterion is required for all substantive and discontinuation projects. Horizon Health is safety net providers to residents of the State of Illinois.

2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services, as there are no other dialysis service providers within the GSA.

3. The proposed project is for the establishment of an incenter hemodialysis center. As such, this criterion is not applicable.

A table showing the charity care and Medicaid care provided by the Applicants for the most recent three calendar years is provided below.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2017**	**2018**	**2019**
Inpatient	0	0	248
Outpatient	112	148	179
Total	**112**	**148**	**427**
Charity (cost in dollars)			
Inpatient	0	0	77,831
Outpatient	133,293	72128	629,722
Total	**133,293**	**72,128**	**707,553**
MEDICAID			
Medicaid (# of patients)	**2017**	**2018**	**2019**
Inpatient	61	73	115
Outpatient	10,603	17,815	29,842
Total	10,664	17,888	29,957
Medicaid (revenue)			
Inpatient	640,367	830,632	-967,967
Outpatient	3,294,437	5,313,372	6,221,924
Total	3,934,804	6,144,004	5,253,957

Section X, Charity Care Information

The table below provides charity care information for all facilities located in the State of Illinois that are owned or operated by the Applicant.

CHARITY CARE			
	2017	**2018**	**2019**
Net Patient Revenue	**35,428,817**	**43,063,146**	**58,716,135**
Amount of Charity Care (charges)	133,293	72,128	707,553
Cost of Charity Care	133,293	72,128	707,553

SECTION XI -Special Flood Hazard Area

The facility is not located in a flood zone.

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: Hospital & Medical Foundation of Paris, Inc. (Name) 721 E. Court St (Address)

Paris (City) IL (State) 61944 (ZIP Code) 217-465-4141 (Telephone Number)

2. Project Location: 721 E. Court St. STE B Paris, IL (Address) (City) (State)

Edgar (County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go To NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No X_

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

(City) (State) (ZIP Code) (Telephone Number)

Signature:_____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

National Flood Hazard Layer FIRMette

FEMA

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) Zone A, V, A99
- With BFE or Depth Zone AE, AO, AH, VE, AR
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
- Future Conditions 1% Annual Chance Flood Hazard Zone X
- Area with Reduced Flood Risk due to Levee. See Notes. Zone X
- Area with Flood Risk due to Levee Zone D

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard Zone X
- Effective LOMRs
- Area of Undetermined Flood Hazard Zone D

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 / 17.5 Cross Sections with 1% Annual Chance / Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 2/26/2021 at 3:04 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

#21-009

Appendix I – Physician Referral Letter

Attached as Appendix 1 is the letter from Dr. Gaurav projecting that 40 pre-ESRD patients will transfer to the proposed facility and/or will progress to ESRD and require dialysis treatment at Horizon Health Dialysis within 12 to 24 months of project completion.

Appendix 1

Kidney and Hypertension
Center of Wabash Valley, LLC

March 22, 2021

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I am a board certified and licensed nephrologist practicing in the Terre Haute and Clinton, IN area and serving the patients from the Paris, Illinois area.

In the past 12-months alone, Nephrologists here have seen 202 patients with CKD (Chronic Kidney Disease) who reside in the Paris, IL market area, and 23 patients with ESRD. I am requesting the Board to approve the dialysis clinic Horizon Health proposes to locate at Paris Community Hospital in Illinois to provide much improved access to dialysis services for these rural Illinois patients who will otherwise be required to travel out of state.

Our practice does not have access to the records of data reported to The Renal Network for the dialysis facilities our patients currently receive dialysis at in Terre Haute Indiana. However, in my opinion the volumes should be substantially similar to figures previously reported when Fresenius provided data to document seeing 170 in-center hemodialysis patients in 2013, 168 patients in 2014, 177 patients in 2015, and 178 patients at the end of June 2016. We have requested the same data for recent years from The Renal Network without success.

I expect that about 20 of the 23 ESRD patients currently dialyzing in Indiana may transfer to the Paris, IL facility upon its opening, as it is closer to their homes and their other healthcare services. I also expect that approximately 20 additional patients with CKD will require dialysis and be referred to the proposed Paris facility within its first 2 years of operations.

I respectfully request the Board approve the Horizon Health Dialysis CON application so that the facility can provide In-Center Hemodialysis services for the ESRD population in the community. Thank you for your consideration.

#21-009

Kidney and Hypertension Center of Wabash Valley, LLC

CERTIFICATION

I hereby attest that, to the best of my knowledge, all the information in this letter is true and correct and that these patient referrals have not been used to support another pending or approved CON application.

Sincerely,

Dr. Kumar Gaurav
Nephrologist
1801 N 6th St, Suite 200,
Terre Haute, IN 47803

Notarization:
Subscribed and sworn to me this 22 day of March, 2021.

Kimberly Gurchiek
Signature of Notary

SEAL

NOTARY PUBLIC SEAL INDIANA
KIMBERLY GURCHIEK
Notary Public
Vigo County, State of Indiana
Commission Expires May 3, 2024

Kidney and Hypertension
Center of Wabash Valley, LLC

Attachment 1

Historical Patient Utilization

Totals	2020	2019	2018
Pre-ESRD	202	205	108
ESRD	23	14	21

By Zip Code

61924	2020	2019	2018
Pre-ESRD	8	9	1
ESRD	0	0	1
61933	**2020**	**2019**	**2018**
Pre-ESRD	6	4	1
ESRD	1	1	1
61938	**2020**	**2019**	**2018**
Pre-ESRD	0	0	1
ESRD	0	0	0
61944	**2020**	**2019**	**2018**
Pre-ESRD	143	137	47
ESRD	16	9	13
61949	**2020**	**2019**	**2018**
CKD Stage 3	1	3	1
ESRD	1	1	0
62441	**2020**	**2019**	**2018**
CKD Stage 3	44	62	57
ESRD	5	3	6

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS