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: Quad Cities Kidney Center Rock Island, LLC
Street Address: 2623 17th Street
City and Zip Code: Rock Island 61201
County: Rock Island Health Service Area 10 Health Planning Area: C-5

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Quad Cities Kidney Center Rock Island, LLC
Address: 2623 17th Street, Rock Island, Illinois 61201
Name of Registered Agent: V.R. Alla, M.D.
Name of Chief Executive Officer: V.R. Alla, M.D.
CEO Address: 400 John Deere Road, Moline, Illinois 61265
Telephone Number: (309) 762-5570

Type of Ownership of Applicant/Co-Applicant

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ 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.

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 during the review period]

Name: V.R. Alla, M.D.
Title: Chief Executive Officer
Company Name: Quad Cities Kidney Center
Address: 400 John Deere Road, Moline, Illinois 61265
Telephone Number: (309) 762-5570
E-mail Address:
Fax Number: (309) 762-6194

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart P.C.
Address: 161 North Clark Street, Suite 4200
Telephone Number: (312) 873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number: (312) 873-2939

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: Quad Cities Kidney Center Rock Island, LLC
Street Address: 2623 17th Street
City and Zip Code: Rock Island 61201
County: Rock Island Health Service Area 10 Health Planning Area: C-5

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: United Dialysis Centers, LLC
Address: 400 John Deere Road, Moline, Illinois 61265
Name of Registered Agent: V.R. Alla, M.D.
Name of Chief Executive Officer: V.R. Alla, M.D.
CEO Address: 400 John Deere Road, Moline, Illinois 61265
Telephone Number: (309) 762-5570

Type of Ownership of Applicant/Co-Applicant

☐	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.

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 during the review period]

Name: V.R. Alla, M.D.
Title: Chief Executive Officer
Company Name: Quad Cities Kidney Center
Address: 400 John Deere Road, Moline, Illinois 61265
Telephone Number: (309) 762-5570
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Fax Number: (309) 762-6194

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

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart P.C.
Address: 161 North Clark Street, Suite 4200
Telephone Number: (312) 873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number: (312) 873-2939

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: V.R. Alla, M.D.
Title: Chief Executive Officer
Company Name: Quad Cities Kidney Center
Address: 400 John Deere Road, Moline, Illinois 61265
Telephone Number: (309) 762-5570
E-mail Address:
Fax Number: (309) 762-6194

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: R.R.S. Investments, LP
Address of Site Owner: 400 John Deere Road, Moline, Illinois 61265
Street Address or Legal Description of Site: 2623 17th Street, Rock Island, Illinois 61201 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, 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: Quad Cities Kidney Center Rock Island, LLC
Address: 2623 17th Street, Rock Island, Illinois 61201

☐	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 co-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 NOT APPLICABLE

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 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 #2005-5 (**http://www.hfsrb.illinois.gov**).

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

Historic Resources Preservation Act Requirements NOT APPLICABLE

[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 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
☒ Non-substantive	☒ Category A Project
	☐ Category B Project
	☐ DHS or DVA Project

2. Narrative Description

Provide in the space below, 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.

Quad Cities Kidney Center Rock Island, LLC and United Dialysis Centers, LLC (the "Applicants") propose to add six (6) stations to an existing twelve (12) station dialysis facility located at 2623 17th Street, Rock Island, Illinois 61201. Because this is an expansion of an existing dialysis facility, the project will involve no construction or modernization.

The project constitutes a non-substantive, category A project because it involves the in-center hemodialysis category of service and the total project cost is less than $2 million.

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 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			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)	$100,000	$0	$100,000
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	**$100,000**	**$0**	**$100,000**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$100,000	$0	$100,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$100,000**	**$0**	**$100,000**

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 $ N/A.

Project Status and Completion Schedules

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): December 31, 2011

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation 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

Are the following submittals up to date as applicable:

☐ Cancer Registry **NOT APPLICABLE**
☐ APORS **NOT APPLICABLE**
☒ 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 department/area **DGSF** or the building/area **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							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Facility Bed Capacity and Utilization NOT APPLICABLE

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are 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 manger 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 Quad Cities Kidney Center Rock Island, LLC* 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.

V.R. Alla, MD
SIGNATURE

V.R. ALLA, M.D
PRINTED NAME

PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of July 2010

Debora L Blaser
Signature of Notary

Seal
OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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 manger 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 United Dialysis Centers, LLC * **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.**

V.R. Alla, MD
SIGNATURE

V.R. Alla, M.D.
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20 day of July, 2010

Leslie Bobb
Signature of Notary

Seal

"OFFICIAL SEAL"
LESLIE BOBB
NOTARY PUBLIC STATE OF ILLINOIS
COMMISSION EXPIRES 08/16/10

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert EXACT legal name of the applicant

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.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

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 certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. 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.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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.

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, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as 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 age and condition and 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 Agency 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** of 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 1110.234 - 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.**

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;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

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

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	MET 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 of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF tot 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 are 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.

G. Criterion 1110.1430 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize In-Center Hemodialysis 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	12	6

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - Support Services	X	X	X
1110.1430(g) - Minimum Number of Stations	X		
1110.1430(h) - Continuity of Care	X		
1110.1430(j) - Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-26, 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 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

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)**

VIII. - 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:**

$100,000	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 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.
$100,000		**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 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. **All of the projects capital expenditures are completely funded through internal sources**
2. **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**
3. **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-40, 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.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
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.

2. 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 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* 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 -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

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 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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2	Site Ownership	25-26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	28-30
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Section I, Identification, General Information, and Certification
Applicants

The Illinois Certificates of Good Standing for Quad Cities Kidney Center Rock Island, LLC and United Dialysis Centers, LLC are attached at Attachment – 1.

Attachment – 1

File Number 0130639-1

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

QUAD CITIES KIDNEY CENTER ROCK ISLAND, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 30, 2004, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 23TH *day of* JUNE *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1017402162

Authenticate at: http://www.cyberdriveillinois.com

Attachment 1

File Number 0093573-5

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

UNITED DIALYSIS CENTERS, L.L.C., HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JUNE 05, 2003, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY 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* 23TH *day of* JUNE *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1017402140

Authenticate at: http://www.cyberdriveillinois.com

Section I, Identification, General Information, and Certification
Site Ownership

The dialysis facility lease between R.R.S. Investments, LP and Quad Cities Kidney Center Rock Island, LLC is attached at Attachment – 2.

Attachment – 2

LEASE AGREEMENT
MAY 1, 2009

Lesser:
RRS Investments, LP
400 John Deere Road
Moline, Illinois 61265

Lessee:
Quad Cities Kidney Center Rock Island, LLC
400 John Deere Road
Moline, Illinois 61265

Lease Premises
Quad Cities Kidney Center Rock Island, LLC
2623 17th Street
Rock Island, Illinois 61201

Lease Term
Initial term of ten (10) years, fixed with additional four (4) five-year options.

Base Rent, Expenses
The base rental rate for the initial term is at a commercially reasonable rate, not to exceed 20 dollars per square foot (approximately 6,000 square feet in total). The base rent shall remain fixed for the initial term of the lease, and the renewal term will be assessed according to the consumer price index. Quad Cities Kidney Center Rock Island, LLC shall pay all real estate taxes and utilities during the initial and renewal terms.

Other Terms
The lease agreement between the parties shall contain such other covenants, terms and conditions that are customarily found in a lease of this nature. This lease is subject to the approval of the certificate of need by the Illinois Health Facilities Planning Board.

Lessee:
COO

Quad Cities Kidney Center
Rock Island, LLC

Lesser:
V. A. Acla
General Partner
May 1, 2009

RRS Investments, LP

Attachment 2

Section I, Identification, General Information, and Certification
Operating Identity/Licensee

The Illinois Certificate of Good Standing for Quad Cities Kidney Center Rock Island, LLC is attached at Attachment – 1.

Attachment – 3

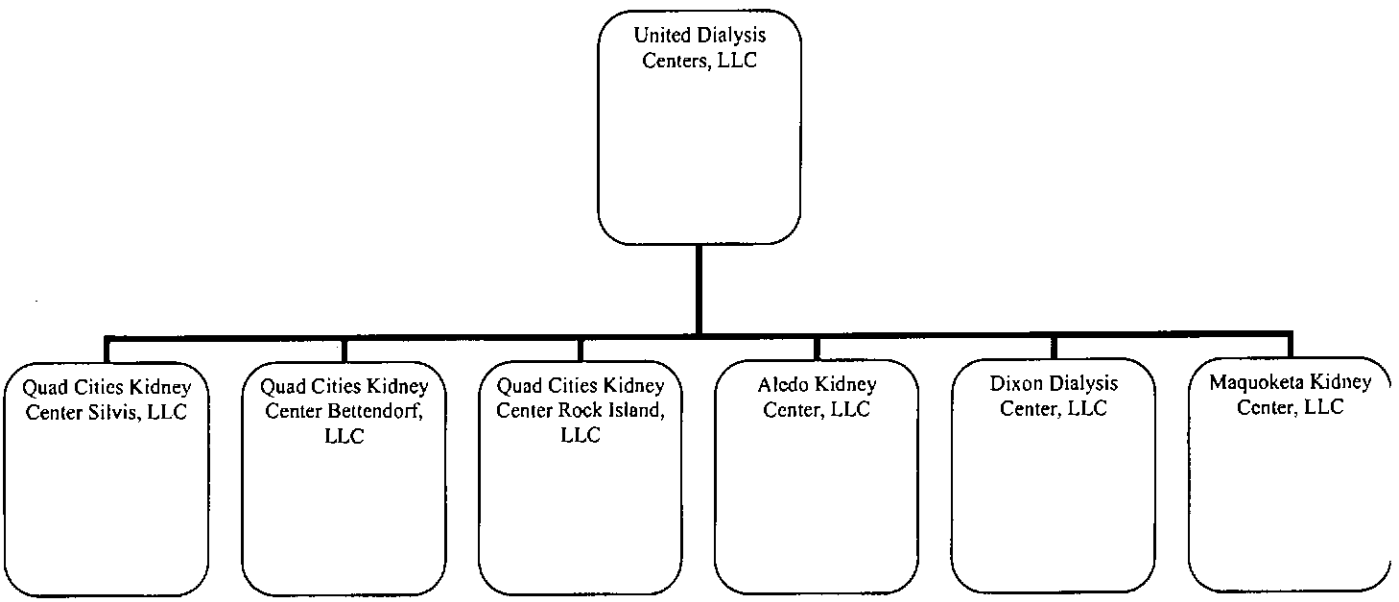
Section I, Identification, General Information, and Certification
Organizational Relationships

The organizational charts for Quad Cities Kidney Center Rock Island, LLC and United Dialysis Centers, LLC are attached at Attachment – 4A and 4B.

Attachment – 4

Organizational Relationships

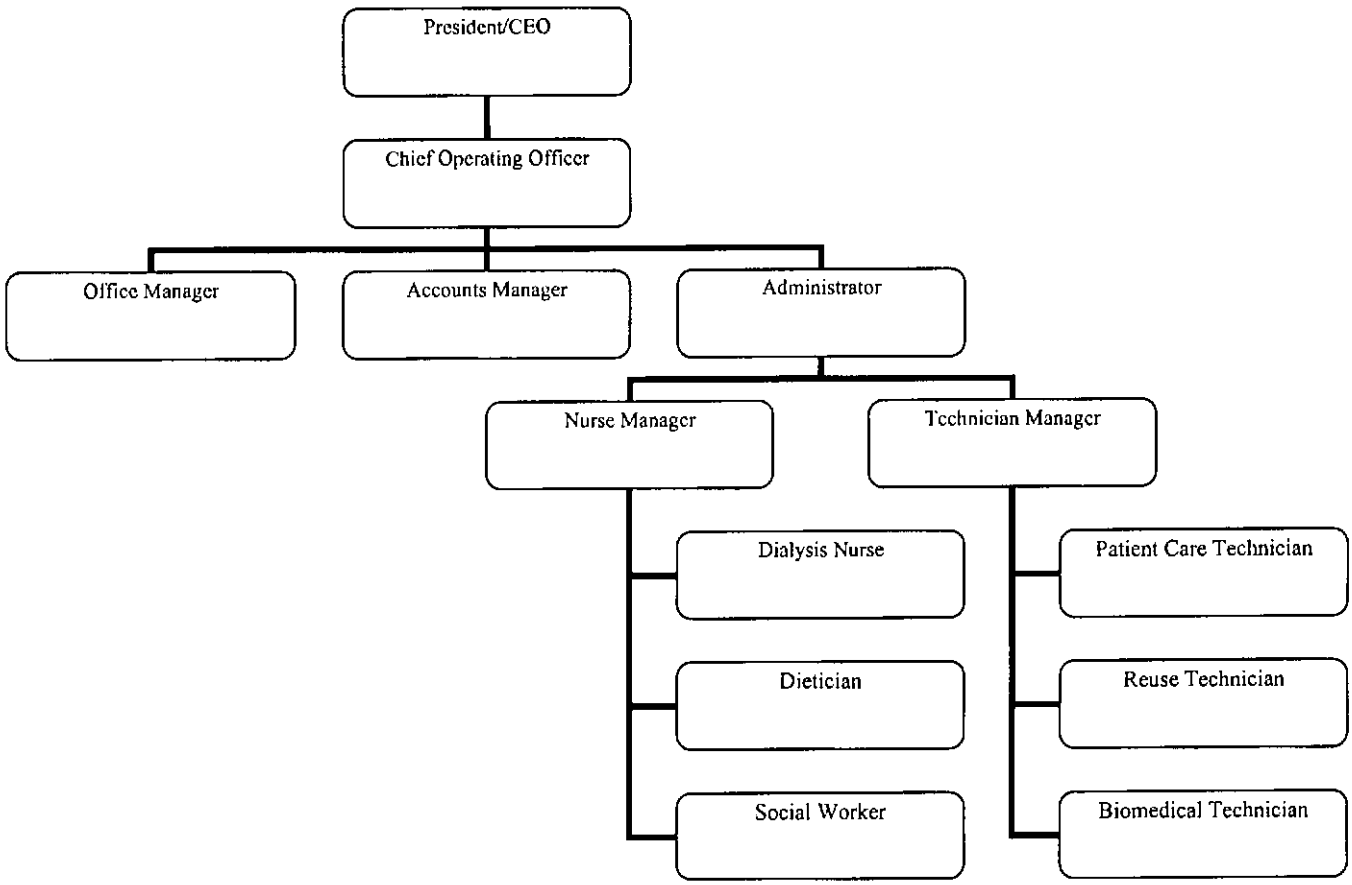
United Dialysis Centers, LLC is a holding company only. United Dialysis Centers, LLC does not conduct actual operations, but wholly owns six separate and distinct operating entities represented by the following organizational chart.



Attachment – 4A

Organizational Relationships

United Dialysis Centers, LLC is the parent company to Quad Cities Kidney Center Rock Island, LLC. Quad Cities Kidney Center Rock Island, LLC is a limited liability company with the following organizational structure.



Attachment –4B

Section I, Identification, General Information, and Certification
Flood Plain Requirements

The Applicants received a certificate of need permit for the establishment of a new dialysis facility in 2008. At that time, the Applicants received flood plain clearance from the Illinois State Water Survey Agency. The proposed project does not involve any construction or modification of the facility but merely an increase in the number of dialysis stations and related services. Therefore, this criterion is not applicable.

Section I, Identification, General Information, and Certification
Historic Resources Preservation Act Requirements

The Applicants received a certificate of need permit for the establishment of a new dialysis facility in 2008. At that time, the Applicants received a determination letter from the Illinois Historic Preservation Agency. The proposed project does not involve any construction or modification of the facility but merely an increase in the number of dialysis stations and related services. Therefore, this criterion is not applicable.

Section I, Identification, General Information, and Certification
Project Costs and Sources of Funds

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Moveable Equipment	$100,000	$0	$100,000
Total Project Costs	**$100,000**	**$0**	**$100,000**

Attachment – 7

Section I, Identification, General Information, and Certification

Cost Space Requirements

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	$100,000	6,000	0	0	0	6,000	0
Total Clinical	**$100,000**	**6,000**	**0**	**0**	**0**	**6,000**	**0**
NON CLINICAL							
Total Non-clinical	**$0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**$100,000**	**6,000**	**0**	**0**	**0**	**6,000**	**0**

Attachment –9

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230, Project Purpose, Background and Alternatives

Background of the Applicant

Quad Cities Kidney Center Rock Island, LLC and United Dialysis Centers, LLC 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. No adverse action has been taken against any of the applicants, or against any health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

1. Health care facilities owned or operated by the Applicants:

Quad Cities Kidney Center Rock Island, LLC

Health Care Facility	Identification Number
Quad Cities Kidney Center Rock Island, LLC	14-2703

United Dialysis Centers, LLC

Health Care Facility	Identification Number
Dixon Dialysis Center, LLC	14-2645
Aledo Kidney Center, LLC	14-2658
Quad Cities Kidney Center Silvis, LLC	14-2675
Quad Cities Kidney Center Rock Island, LLC	14-2703
Quad Cities Kidney Center Bettendorf, LLC	16-2530
Maquoketa Kidney Center, LLC	16-2327

Copies of the Medicare certification are attached at Attachment – 11A. Hemodialysis units are not subject to State licensure or Joint Commission accreditation.

2. Certification that no adverse action has been taken against any of the applicants, or against any health care facilities owned or operated by the applicants, directly or indirectly, within three years preceding the filing of this application is attached at Attachment – 11B.

3. An authorization permitting the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment – 11B.

4. The Applicants have not previously submitted an application for permit during this calendar year. Accordingly, this criterion is not applicable.

5. Information regarding the Alla Health Education Endowed Gift of $500,000 to Trinity Health Foundation to fund nursing scholarships, nursing continuing education, and community services and program about hypertension and kidney disease are attached at Attachment – 11C. Members of the Alla family own interests in the Applicants.

Illinois Department of
PUBLIC HEALTH

Rod R. Blagojevich, Governor
Eric E. Whitaker, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

March 26, 2004

Provider No.: 14-2645

V. R. Alla, M.D., Administrator
Dixon Dialysis Center, LLC
101 West 2nd Street
Dixon, Illinois 61021

Dear Dr. Alla:

The Centers for Medicare and Medicaid Services (CMS) has accepted your request for approval as a supplier of renal services in the Medicare program. **Your effective date of coverage is March 18, 2004.**

Your unit has been approved as a renal dialysis facility. This approval is for a total of 8 maintenance stations.

Your facility is approved to provide the following services:

- Hemodialysis

Your ESRD supplier identification number is shown above. The number should be entered on all forms and correspondence relating to the Medicare renal treatment program.

Your intermediary for reimbursement for renal treatment procedures will be AdminaStar, Federal, Inc. You must maintain separate cost centers for all renal services. Your intermediary will contact you shortly to explain the special reimbursement procedures.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to CMS within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the Illinois Department of Public Health if you wish to relocate your facility, change the services which you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact Rose Castleman of my staff at 217/782-7412. The Department's TTY number is 800/547-0466, for use by the hearing impaired.

Sincerely,

William A. Bell, Assistant Deputy Director
Bureau of Hospitals and Ambulatory Services

WAB/rsc

cc: Centers for Medicare and Medicare Services
Illinois Department of Public Aid
AdminaStar Federal
Richard Fox, Health Statistics
Field Operations Section

Midwestern Consortium
Division of Survey and Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

ESRD Number: 14-2658

February 1, 2005

Janice Kaszinski
Facility Manager
Aledo Kidney Center
409 NW 9th Avenue
Aledo, Illinois 61231

Dear Ms. Kaszinski:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program. Your effective date of Medicare coverage is December 21, 2004.

Your unit has been approved as a freestanding renal dialysis facility. This approval is for a total of six (6) hemodialysis maintenance stations. Your facility is approved to provide staff assisted hemodialysis only.

Your ESRD identification number is 14-2658. The number should be entered on all forms and correspondence relating to the Medicare renal treatment program. Your fiscal year end date is December 31. Your fiscal intermediary for reimbursement for renal treatment procedures will be AdminaStar Federal.

The facility phone number is (309) 582-2227. Your renal dialysis facility is owned by United Dialysis Centers.

Your renal network contact is as follows:

Susan Stark, Executive Director
Renal Network 9/10
911 East 86th Street, Suite 202
Indianapolis, IN 46240
(800) 456-6919
sstark2nw10esrd.net

233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601-5519

Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the Illinois Department of Public Health, if you wish to relocate your facility, change the services that you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact April Rush in our Chicago office at (312) 353-5184.

Sincerely,

Robert P. Daly, Manager
Non-Long Term Care Branch

cc: Illinois Department of Public Health
Illinois Department of Public Aid
AdminaStar Federal (IL)
Illinois Foundation for Quality Health Care
Renal Network 9/10
Office of Clinical Standards and Quality

Midwestern Consortium
Division of Survey and Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Supplier Number: 14-2675

July 7, 2006

V.R. Alla, M.D.
Medical Director
Quad Cities Kidney Center
880 Crosstown Avenue
Silvis, Illinois 61282

Dear Dr. Alla:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program. Your effective date of coverage is May 25, 2006.

Your unit has been approved as a renal dialysis facility. This approval is for a total of twelve (12) maintenance stations.

Your facility is approved to provide the following service:

-Staff Assisted Hemodialysis

Your ESRD supplier identification number is 14-2675. The number should be entered on all forms and correspondence relating to the Medicare renal treatment program.

Your intermediary for reimbursement for renal treatment procedures will be AdminaStar Federal of Illinois. You must maintain separate cost centers for all renal services. Your intermediary will contact you shortly to explain the special reimbursement procedures.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the Illinois Department of Public Health if you wish to relocate your facility, change the services which you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions about this letter, please contact Justin Pak of the Chicago office at (312) 353-0519.

Sincerely,

Douglas Wolfe
Program Representative
Non-Long Term Care Branch

cc: Illinois Department of Public Health
Illinois Department of Public Aid
AdminaStar Federal, Illinois
The Renal Network

Midwestern Consortium
Division of Survey and Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

National Provider Identifier (NPI): 1023262235
CMS Certification Number (CCN): 14-2703

June 5, 2009
(Via Certified Mail)

Venkateswararao Alla
Administrator
Quad Cities Kidney Center Rock Island, LLC
2623 17th Street
Rock Island, Illinois 61201

Dear Venkateswararao Alla:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program. Your effective date of coverage is May 11, 2009.

Your unit has been approved as a renal dialysis facility. This approval is for a total of twelve (12) maintenance stations.

Your facility is approved to provide the following service:

- Staff-assisted Hemodialysis

Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the CMS Certification Number (CCN) shown above; please provide it when contacting this office, when contacting the Illinois Department of Public Health (IDPH), or any time it is requested.

Your intermediary for reimbursement for renal treatment procedures will be National Government Services. You must maintain separate cost centers for all renal services. Your intermediary will contact you shortly to explain the special reimbursement procedures.

When you make general inquiries to your fiscal intermediary (FI) and/or Medicare Administrative Contractor (MAC), you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication

elements when inquiring about beneficiary and claim specific information. When prompted for your PTAN, give your CCN.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the IDPH if you wish to relocate your facility, change the services which you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact Mai Le-Yuen in the Chicago Regional Office at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

Heather Lang
Principal Program Representative
Non-Long Term Care Certification
& Enforcement Branch

cc: Illinois Department of Public Health
Illinois Department of Healthcare & Family Services
Illinois Foundation for Quality Health Care
National Government Services
Renal Network 9/10

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

STEVEN K. YOUNG, DIRECTOR

THOMAS J. VILSACK
GOVERNOR

SALLY J. PEDERSON
LT. GOVERNOR

January 4, 2005

Janice Kaszinski-Administrator
Quad Cities Kidney center-Bettendorf LLC
4480 Utica Ridge Road
Bettendorf, IA 52722

Initial Certification Number #16-2530.

Dear Ms Kaszinski:

We have carefully considered your request for approval as a supplier of renal services in the Medicare program under the long-term end-stage renal disease regulations and have determined that your facility meets program requirements and is eligible for reimbursement under Section 1881 of Title XVIII of the Social Security Act. Reimbursement for services rendered on or after **December 15, 2004** will be considered for payment by **CAHABA**.

Your facility has been approved as a renal dialysis facility to furnish the following services and number of stations:

Total approved stations: **9 (Nine)**

Services: **Staff Assisted Hemodialysis and Reuse**

Your intermediary for reimbursement of renal treatment procedures will be Cahaba . It will be necessary to maintain separate cost centers for all renal services. Your intermediary will contact you shortly to explain the special reimbursement procedures to be followed. Your ESRD identification number is #162530 the date of approval remains December 15, 2004. This number (162530) should be entered on all forms and correspondence relating to the Medicare renal treatment program.

According to your CMS-2567 form-your facility is in full compliance with the health and safety standards of the End- Stage Renal Disease (ESRD) regulations. A copy of this form is subject to public disclosure.

If you contemplate any expansions, relocations, change of ownership, or additions to your renal treatment services after the date of this approval, you should notify your ESRD Program Coordinator, as soon as possible.

Sincerely yours,

Kathy Sutton, RN
Medicare/Medicaid Bureau I

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
(515) 281-5457
FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
(515) 281-4843
FAX: (515) 281-4477

HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

Midwestern Consortium
Division of Survey and Certification

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

January 14, 2010

V. R. Alla, M.D.
Maquoketa Kidney Center, LLC
700 W. Grove Street
Maquoketa, Iowa 5260-2163

Re: Identification No. 16-2543
Telephone No. (563) 652-9674
Fax No. (563) 652-9679

Dear Dr. Alla:

We have been notified that you represent the new owner of Maquoketa Kidney Center, LLC (formerly Jackson County Regional Health Center Dialysis) effective November I, 2009.

Your facility is being issued a new identification number (shown above) due to its change from being a hospital-based facility to a freestanding facility. The new identification number should be entered on all forms and correspondence relating to the Medicare program. The identification number (16-2327) for Jackson County Regional Health Center Dialysis will be retired effective November 1, 2009.

Your facility is approved to furnish the following services and number of stations:

Total approved stations: (8)

Services: Hemodialysis
Automated Reuse

It is recognized that the facility has stations used for isolation purposes.

Your intermediary for reimbursement of renal treatment procedure will be Wisconsin Physician Services. Please contact your fiscal intermediary for any concerns or questions you may have regarding billing issues. We have forwarded a copy of this approval letter to their office.

If you contemplate any further expansion, relocation, change of ownership, or additions to your renal treatment services after the date of this approval, you should notify the State survey agency as soon as possible.

If you believe this determination is not correct in any respect, you may request that the decision be reconsidered. You may submit with the reconsideration request any additional information that you feel may have a bearing on the determination. The request must be submitted in writing to this office within 60 days of the date of this notice.

233 North Michigan Avenue
Suite 600
Chicago, Illinois 60601-5519

Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

Please feel free to contact Betty Snow, Health Insurance Specialist, in our Kansas City office at (816) 426-6471, if you have additional comments or concerns.

Sincerely,

Jennifer King, Branch Manager
Survey, Certification& Enforcement Branch II
Kansas City Regional Office

CC: SA / SSA
DQI
Network 12
WPS
CO ESRD Division
Medicare (LeAnn Robinson)

CMS:SCEB2:BSnow:n:shared:DSC:ESRD:IA:Maquoketa Kidney Center – _2543_2327:01_14_10 CHW.doc

Quad Cities Kidney Center

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapharesis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Out-Patient Clinics

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

600 North College Avenue
Geneseo, Illinois 61254
(309) 945-1787

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

4480 Utica Ridge Road
Bettendorf, Iowa 52722
(563) 344-9977

In-Patient Facilities

Trinity Medical Center
- West Campus
Rock Island, Illinois

- 7th Street Campus
Moline, Illinois

- Terrace Park Campus
Bettendorf, Iowa

Genesis Medical Center
- Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

July 28, 2010

Dale Galassie
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Adverse Action Certification and Access to Documents

Dear Mr. Galassie:

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 has been taken against any facility owned or operated by United Dialysis Centers, LLC or Quad Cities Kidney Center Rock Island, LLC during the three years 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,

V.R. Alla, MD

V.R. Alla, M.D.
Manager
United Dialysis Centers, LLC
Quad Cities Kidney Center Rock Island, LLC

Subscribed and sworn to me
This 28th day of July, 2010

Debora L Blaser
Notary Public

OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

104635.1

Quad-City Times

Alla family gives back

By Deirdre Cox Baker | Wednesday, November 26, 2008

The daunting financial situation facing many Americans these days hasn't prevented the Alla family from making a $500,000 donation to the Trinity Health Foundation. In fact, it helped prompt the decision.

"It's important to give, especially when the economy is so bad," family patriarch Dr. V.R. Alla said. A nephrologist, or kidney specialist, and the founder of the Quad-Cities Kidney Center facilities in the region, he said the gift was actually from the entire family.

The Allas have therefore been selected as the Trinity Health Foundation's Donor of the Year.

The family is in the habit of gathering each Friday night at the Rock Island home of Dr. V.R. and Nirmala Alla. They were around the dinner table one evening in the spring when the idea of the large contribution came up.

"When the economy is bad, people really need funds like these," Dr. Alla said.

The gift goes to three areas: Trinity's College of Nursing and Health Sciences, continuing education for nurses employed at Trinity Medical Center and to help support community services and programs about hypertension and kidney disease.

The Alla family certainly has shown that it values nursing, said Berlinda Tyler-Jamison, the president of the foundation.

"How do you thank someone for such a significant gift?" she said. "After searching for the correct words, I finally thought of my late great-grandmother's advice and simply said, 'Thank you.' "

Good education for nurses is critical for good outcomes, Dr. Alla said. The dialysis process that goes on in the kidney centers takes three to four hours for each patient, three times a week, and each one tends to develop a family-style relationship with the nurses and other health care providers.

One of the Alla couple's three sons, Rakesh Alla, is chief operating officer of the centers, which can be found in Moline, Silvis, Geneseo, Aledo and Dixon in Illinois, plus soon in Rock Island, as well as in Davenport and Bettendorf.

Money for scholarships at the Trinity school will ensure that there are open doors and opportunities for students, Rakesh Alla said, noting that it also will help encourage practicing nurses with continuing education possibilities.

The third emphasis, on community education, goes to the need in the Quad-Cities for dialysis services. "If we can put off or delay kidney failure through education, that's a win for everyone," he said.

In a way, a final benefit of the donation is to V.R. Alla himself, who was "welcomed with open arms" to the Quad-Cities as a kidney specialist in the 1970s. "It's a way to give back," he said.

His three sons include Rakesh, Dr. Rajesh Alla, who is also a nephrologist, and Suresh Alla, who is in a residency program at the University of Colorado near Denver.

Deirdre Cox Baker can be contacted at (563) 383-2492 or dbaker@qctimes.com. Comment on this story at qctimes.com.

P osted Online:

Kidney Center founder gives half a million to Trinity Foundation

Comment on this story

Jonathan Turner, jturner@qconline.com

MOLINE -- When Dr. V.R. Alla, his wife Nirmala and their two small boys settled in the Quad-Cities in 1980, he had little money.

More photos from this shoot

Photo: Gary Krambeck
Dr. V. R. Alla, who started the Quad Cities Kidney Center, and his family are donating $500,000 to the Trinity College of Nursing over several years.

Because of his perseverance and the growth of the Quad Cities Kidney Center, which he founded, that has changed. Now, to aid the community that welcomed and supported him, the 62-year-old India native and his family have pledged $500,000 to the Trinity Health Foundation.

"This community has been good to us," Dr. Alla said. "It greeted us with open arms when we came here. It gave me a chance. Now it's our time to give back."

"Building and accumulating wealth doesn't bring happiness," Rakesh Alla, the center's chief operating officer and one of his three sons, said. "If a community has been good to you, and if you can do something transformational and impactful for it, you should. Both our mother and father raised us to feel this way."

The Alla Family Health Education Endowed Gift will:

-- Provide scholarships for Trinity's College of Nursing and Health Sciences.

-- Provide continuing education to nurses.

-- Help support community services and education on hypertension and kidney disease prevention.

-- Help inspire others to contribute major gifts to Trinity Health Foundation

"There is a shortage of nurses anticipated in the very near future," Rakesh Alla said. "We are trying to do our part to make sure the Quad-Cities doesn't feel that, that patients don't feel the negative impact of that shortage."

Because medicine constantly is advancing, it's important to support continuing education, he said.

"I believe in education. Because of my education, I was able to come to this country and be

both current students and practicing nurses helps us provide the best patient care both now and in the future."

Trinity has about 200 nursing students and that number is certain to grow, she said. While the college currently offers $30,000 a year in total scholarships, it would like to use the Alla gift to increase that to $100,000 a year.

"It is a significant need for students," Ms. Dwyer said. "We want to reduce their burden once they graduate."

She said the gift also will "provide a great boost to the funds available for nurses to advance their careers and knowledge that helps them in their current practice."

successful," Dr. Alla said. "My success is dependent on my nurses providing the quality care. They make the Kidney Center successful."

Two of Dr. Alla's sons -- including Rajesh, a nephrologist -- came back to the Quad-Cities to work at the center, which will open its eighth clinic, in Rock Island, in January. His youngest, Suresh, also is a doctor and, after a fellowship, will return as well.

"We children have come back to ensure the second generation of service to the Quad-Cities community," Rajesh Alla said. "Our gift can help ensure ongoing service to patients for future generations through nursing and community education."

"We wanted to make a big impact on the community," he said, noting that the gift will be given over 20 years or less. "We hope to inspire others to do something in a similar way."

Dr. Alla came to the U.S. in 1974 to train at the University of Illinois-Chicago, and he worked at Cottage Hospital in Galesburg before coming to the Quad-Cities.

"I found there was no nephrologist for this big population," he said. "That was unusual."

At the time, there was a dialysis unit at St. Luke's Hospital in Davenport, but no stand-alone kidney center.

For those who need it, dialysis -- which replaces the blood-filtering function of the kidneys -- is required three times a week, often three to four hours at a time. Dr. Alla established the first Kidney Center in 1981 at 7th Street and 30th Avenue in Moline, but it outgrew that location within three years.

The current center at 400 John Deere Road, near Trinity's 7th Street Campus, was built in 1996. Since then, it's expanded to Davenport, Geneseo, Aledo, Silvis, Dixon, Bettendorf and the new clinic at Trinity West Campus in Rock Island.

"I go to their community to provide dialysis," Dr. Alla said, rather than making patients travel far for ongoing treatments. While it would have been more cost-effective to have one large center, "patient convenience, comfort and quality are most important," he said.

Dr. Alla's centers provide dialysis for 315 people in the region and other kidney services for about 800 more. The centers provide dialysis regardless of a patient's insurance status, he said.

Trinity Health Foundation president Berlinda Tyler-Jamison was tongue-tied at the family's generosity.

"How do you thank someone for such a significant gift?" she said, noting the donation will be "transformational" for Trinity and the area.

"We are so grateful to the Alla family for this long-lasting and significant gift," Trinity College president Carol Dwyer said. "Providing such meaningful educational resources to

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(b), Project Purpose, Background and Alternatives

Purpose of the Project

1. The purpose of this project is to expand access to needed dialysis services to the residents of Rock Island, particularly to the elderly and low-income populations who lack access to transportation. Access issues are particularly challenging for low income seniors and this problem is particularly acute in Rock Island County where the elderly population is 28.5% higher than the statewide average. Based upon the Illinois Department of Commerce and Economic Opportunity ("DCEO") 2010 population projections, the total population of Rock Island County is 151,651, of which 16% are residents over the age of sixty-five, compared to the statewide average of 12.5%. See Attachment - 12A. The prevalence of chronic kidney disease is greater among the elderly population than the general population.[1] This is important because the majority of patients receiving dialysis at Quad Cities Kidney Center Rock Island are over sixty-five years of age and are dependent on family members, public transportation, non-emergency transportation providers, or nursing home staff for transportation to medical appointments. Importantly, dialysis is scheduled three days per week (Monday, Wednesday, Friday or Tuesday, Thursday, Saturday) in four hour shifts. Nursing home and other third party transporters (e.g., medicar) almost exclusively transport patients for appointments Monday through Friday. For example, Trinity Express, operated by Trinity Health System, only provides transport from 7 a.m. to 7 p.m. Monday through Friday. As a result, nursing home patients and those dependent on a service for transport must schedule their dialysis Monday, Wednesday, and Friday between 9 a.m. and 5 p.m. As a result, only the second shift on Monday, Wednesday, and Friday is feasible for these patients. See Attachment – 12B letter from the Social Worker at Quad Cities Kidney Center Rock Island regarding scheduling issues.

   In addition to a large elderly population, the number of individuals in Rock Island living below the poverty level is higher than the statewide average. According to the most current U.S. Census Bureau estimates, approximately 16.7% of the residents of Rock Island live below the poverty level compared to 12.1% statewide. See Attachment – 12C. Like the elderly, the rate of chronic kidney disease is higher in the lower income population than the general population.[2] Additionally, these individuals are generally dependent on public transportation and must schedule their dialysis between 9 a.m. and 5 p.m., which means the second shift is the only option available.

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[1] U.S. Renal Data System, USRDS 2009 Annual 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 2009 *available at* http://www.usrds.org/atlas.htm (last visited Jul. 25, 2010); See also Manjula Kurella et al, Octogenairans and Nonagenarians Starting Dialysis in the United States, 146 ANNALS INTERNAL MED. 157, 177-83 (2007) *available at* http://annals.org/content/146/3/177.full.pdf+html (last visited Jul. 29, 2010).

[2] Monica Beaulieu & Andeera Levin, A Critical Evaluation of the Effects of Socioeconomic Status on Kidney Disease, 23 PORT. J. NEPHROLOGY & HYPERTENSION 215, 235-44, (2009) *available at* http://www.spnefro.pt/RPNH/PDFs/n3_2009/ artigo_004.pdf (last visited Jul. 25, 2010).

On February 26, 2006, Quad Cities Kidney Center Rock Island received a CON permit to establish a 12-station dialysis facility. The primary purpose of the facility is to provide outpatient dialysis services to residents of Rock Island at a more appropriate location to reduce the time and expense of travel for patients, many of whom do not drive, lack access to transportation, and depend on family or a service. Construction of the facility was completed and services initiated in May 2009. In only the first year of operation, the facility's census is already 42 patients, and it is operating at 58% capacity. While utilization has not yet reached the State Standard of 80%, the overall underutilization of the Rock Island Facility is due to patient scheduling issues that are beyond the facility's control. As previously discussed, a large percentage of the facility's patients are elderly or live below the poverty level and are dependent on third parties or public transportation to make their appointments. These individuals can only schedule their dialysis between 9 a.m. and 5 p.m., which means only the second shift is available.

Currently, the second shift is operating at the State Standard utilization rate of 80%. See Attachment – 26C. Importantly, it is nearly impossible for a dialysis facility to operate at capacity. Due to the reserved scheduling of patients, it is difficult to add new patients at the last minute when a patient is forced to cancel for medical reasons such as hospitalization or lack of vascular access patency or because transportation is unavailable. To accommodate demand for second shift services, an additional six dialysis stations is necessary.

Additionally, utilization has steadily increased since the facility's opening in May 2009. As shown in the physician referral letter attached at Attachment – 26B, Quad Cities Nephrology Associates is currently treating 88 Stage 4 and Stage 5 chronic kidney disease ("CKD") patients at its Rock Island office. Approximately 65% percent (or 57) of these CKD patients are projected to be referred to Quad Cities Kidney Center Rock Island within the next twelve months for dialysis. See Attachment – 12D describing Stage 4 and Stage 5 CKD. Without the addition of the six dialysis stations, there will not be capacity for all these patients as that rate of growth would provide for 100% utilization within 20 months, and additional patients could not be served unless an "adequate" number of patients die or receive transplants in that time. Given current patient attrition trends that the facility is experiencing, such attrition would not be sufficient to provide adequate patient treatment slots. As discussed above, the primary purpose for the establishment of the Quad Cities Kidney Center Rock Island is to provide access to life-sustaining dialysis to chronically-ill patients residing in the surrounding area who lack access to transportation. Therefore, referring these patients to more distant facilities would create an undue hardship for them.

2. A map of the Quad Cities Kidney Center Rock Island market area is attached at Attachment – 12E. The market area extends to U.S. Highway 67 to the East, Illinois 94 to the South, and to the Mississippi River to the West and North.

3. As set forth above, Rock Island has a higher percentage of elderly residents and residents living below the poverty level than the State average. According to a 2005 Centers for Disease Control and Prevention ("CDC") study, diabetes mellitus is the leading cause of

ESRD in the United States, accounting for 44% of new cases in 2002.[3] The rate of diabetes mellitus is greater among the elderly and low-income populations than the general public. Additionally, these groups are more reliant on public and government subsidized transportation and friends and family to make their dialysis treatment appointments. Due to transportation access issues, these patient groups can only regularly schedule their appointments between 9 a.m. and 5 p.m., or the second shift. Currently, the second shift at the Rock Island facility is operating at the State Standard utilization rate of 80% with demand expected to increase in the near future. Therefore, the only feasible option to accommodate increasing demand for second shift appointments is to add dialysis stations to the Rock Island facility.

4. Source Information

U.S. Renal Data System, USRDS 2009 Annual 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 2009 *available at* http://www.usrds.org/atlas.htm (last visited Jul. 25, 2010).

Manjula Kurella et al, Octogenairans and Nonagenarians Starting Dialysis in the United States, 146 ANNALS INTERNAL MED. 157, 177-83 (2007) *available at* http://annals.org/content/146/3/177.full.pdf+html (last visited Jul. 29, 2010).

Monica Beaulieu & Andeera Levin, A Critical Evaluation of the Effects of Socioeconomic Status on Kidney Disease, 23 Portuguese Journal of Nephrology Hypertension 235-44, May 14, 2009 *available at* http://www.spnefro.pt/RPNH/PDFs/n3_2009/artigo_004.pdf (last visited Jul. 25, 2010).

U.S. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, "Incidence of End-Stage Renal Disease Among Persons with Diabetes – United States, 1990 – 2002," Nov. 5, 2005 *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5443a2.htm (last visited Jul. 23, 2010).

Diabetes Complications Frequent in the Elderly, REUTERS HEALTH INFORMATION, May 24, 2007 *available at* http://www.medscape.com/viewarticle/557223.

Anthony J. Brown, M.D., *Prevalence of Kidney Failure in US Expected to Rise Markedly by 2020*, REUTERS HEALTH INFORMATION, November 7, 2007 *available at* http://www.medscape.com/viewarticle/ 56507_print.

Caroline Cassels, *Rapid Rise in Obesity Rates Found in ESRD Population*, MEDSCAPE MED. NEWS, April 18, 2006 *available at* http://www.medscape.com/viewarticle/539033_print.

[3] U.S. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Incidence of End-Stage Renal Disease Among Persons with Diabetes – United States, 1990 – 2002, Nov. 5, 2005 *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/_mm5443a2.htm (last visited Jul. 23, 2010).

Marlene Busko, *REGARDS: Nearly 1 in 10 Older Americans Has a Close Relative with ESRD*, MEDSCAPE MED. NEWS, March 20, 2007 *available at* http://www.medscape.com/viewarticle/553866_print.

Caroline Cassels, *Overweight/Obesity "Enormous" Risk Factor for ESRD*, MEDSCAPE MED. NEWS, January 9, 2006 *available at* http://www.medscape.com/viewarticle/538939_print.

Illinois Department of Economic Opportunity and Commerce, Population Projections *available at* http://www.commerce.state.il.us/dceo/Bureaus/Facts_Figures/Population_Projections/ (last visited Jul. 25, 2010).

U.S. Census Bureau, 2006 – 2008 American Community Survey 3-Year Estimates Data Profile Highlights *available at* http://www.census.gov/ (last visited Jul. 25, 2010).

5. The purpose of this project is to increase access to life-sustaining dialysis to the residents of Rock Island. As set forth above, a large percentage of dialysis patients in Rock Island are elderly and/or live below the poverty level and lack access to reliable transportation. Due to insufficient access to transportation, these patients must schedule dialysis between 9 a.m. and 5 p.m. Accordingly there is increasing demand for second shift appointments. In order to accommodate this increasing demand, the addition of six dialysis stations is necessary.

6. The Applicants will establish the following goals for Quad Cities Kidney Center Rock Island.

   Patient Satisfaction: The Applicants will continue to monitor patient satisfaction through their patient satisfaction survey. The results will be collected and summarized. A summary of the 2009 patient satisfaction surveys is attached at Attachment – 12G. Areas for improvement will be discussed a regularly scheduled meetings.

State/County	Race	Age Group	Sex	2000	2005	2010	2015	2020	2025	2030
Rock Island	All	All	Both Sexes	149,637	150,256	151,651	153,296	154,941	154,846	152,171
Rock Island	All	Total Male	M	72,671	72,832	73,394	74,017	74,589	74,201	72,480
Rock Island	All	Total Female	F	76,966	77,424	78,257	79,279	80,352	80,645	79,691
Rock Island	All	0-4	M	4,816	4,704	4,924	5,084	5,031	4,738	4,461
Rock Island	All	0-4	F	4,686	4,612	4,826	4,982	4,920	4,631	4,369
Rock Island	All	5-9	M	4,922	4,764	4,681	4,896	5,051	4,975	4,623
Rock Island	All	5-9	F	4,693	4,535	4,452	4,660	4,816	4,750	4,418
Rock Island	All	10-14	M	5,179	4,792	4,632	4,549	4,767	4,900	4,779
Rock Island	All	10-14	F	4,999	4,628	4,490	4,410	4,623	4,758	4,651
Rock Island	All	15-19	M	5,580	5,056	4,680	4,520	4,437	4,626	4,721
Rock Island	All	15-19	F	5,433	4,920	4,566	4,438	4,373	4,556	4,643
Rock Island	All	20-24	M	5,036	5,353	4,868	4,500	4,348	4,192	4,304
Rock Island	All	20-24	F	5,168	5,498	4,980	4,593	4,460	4,375	4,483
Rock Island	All	25-29	M	4,615	5,155	5,542	5,015	4,645	4,414	4,100
Rock Island	All	25-29	F	4,563	5,113	5,488	4,931	4,535	4,324	4,098
Rock Island	All	30-34	M	4,691	4,544	5,077	5,468	4,957	4,561	4,281
Rock Island	All	30-34	F	4,561	4,402	4,951	5,313	4,785	4,384	4,122
Rock Island	All	35-39	M	5,430	4,623	4,495	5,016	5,421	4,881	4,437
Rock Island	All	35-39	F	5,318	4,496	4,348	4,900	5,265	4,718	4,263
Rock Island	All	40-44	M	5,757	5,197	4,419	4,278	4,805	5,176	4,604
Rock Island	All	40-44	F	5,906	5,318	4,516	4,389	4,942	5,284	4,690
Rock Island	All	45-49	M	5,620	5,749	5,196	4,410	4,283	4,806	5,115
Rock Island	All	45-49	F	5,559	5,678	5,130	4,356	4,232	4,738	5,050
Rock Island	All	50-54	M	4,893	5,410	5,545	5,035	4,291	4,140	4,600
Rock Island	All	50-54	F	5,035	5,560	5,701	5,160	4,391	4,246	4,719
Rock Island	All	55-59	M	3,912	4,718	5,233	5,393	4,918	4,175	3,997
Rock Island	All	55-59	F	4,076	4,903	5,437	5,600	5,081	4,289	4,102
Rock Island	All	60-64	M	3,165	3,616	4,388	4,899	5,063	4,584	3,845
Rock Island	All	60-64	F	3,423	3,923	4,753	5,312	5,509	4,969	4,163
Rock Island	All	65-69	M	2,639	2,792	3,215	3,932	4,424	4,560	4,085
Rock Island	All	65-69	F	3,093	3,274	3,776	4,621	5,199	5,356	4,808
Rock Island	All	70-74	M	2,473	2,227	2,375	2,751	3,394	3,823	3,936
Rock Island	All	70-74	F	3,185	2,871	3,060	3,550	4,376	4,924	5,071
Rock Island	All	75-79	M	1,861	1,866	1,699	1,828	2,147	2,666	3,011
Rock Island	All	75-79	F	2,859	2,865	2,602	2,794	3,275	4,046	4,557
Rock Island	All	80-84	M	1,236	1,276	1,295	1,192	1,294	1,534	1,909
Rock Island	All	80-84	F	2,239	2,319	2,357	2,169	2,358	2,794	3,484
Rock Island	All	85+	M	846	990	1,130	1,251	1,313	1,450	1,672
Rock Island	All	85+	F	2,170	2,509	2,824	3,101	3,212	3,503	4,000

Σ_A 24,333

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Attachment 12A

Region	Race	Age Group	Gender	2000	2005	2010	2015	2020	2025	2030
Illinois	All	All	Both Sexes	12,440,846	12,875,035	13,279,091	13,748,695	14,316,487	14,784,968	15,138,849
Illinois	All	All	F	6,349,784	6,578,874	6,794,751	7,046,050	7,350,673	7,612,968	7,824,625
Illinois	All	All	M	6,091,062	6,296,161	6,484,340	6,702,645	6,965,814	7,172,000	7,314,224
Illinois	All	0-4	Both Sexes	878,370	895,172	901,561	938,500	982,388	990,626	983,535
Illinois	All	0-4	F	429,322	437,955	441,472	459,847	481,603	485,975	482,853
Illinois	All	0-4	M	449,048	457,217	460,089	478,653	500,785	504,651	500,682
Illinois	All	5-9	Both Sexes	931,392	876,171	892,052	900,728	941,367	981,418	986,246
Illinois	All	5-9	F	454,423	427,394	435,667	440,208	460,350	480,197	482,807
Illinois	All	5-9	M	476,969	448,777	456,385	460,520	481,017	501,221	503,439
Illinois	All	10-14	Both Sexes	906,606	929,728	873,339	890,967	903,105	940,037	976,799
Illinois	All	10-14	F	442,915	454,222	426,563	435,732	441,960	460,185	478,507
Illinois	All	10-14	M	463,691	475,506	446,776	455,235	461,145	479,852	498,292
Illinois	All	15-19	Both Sexes	895,527	914,638	935,783	882,797	905,894	912,257	943,983
Illinois	All	15-19	F	432,197	441,610	451,876	425,869	437,185	440,384	455,883
Illinois	All	15-19	M	463,330	473,028	483,907	456,928	468,709	471,873	488,100
Illinois	All	20-24	Both Sexes	852,322	919,076	935,870	962,151	917,582	931,646	929,886
Illinois	All	20-24	F	416,580	449,142	457,290	469,531	446,246	454,173	453,346
Illinois	All	20-24	M	435,742	469,934	478,580	492,620	471,336	477,473	476,540
Illinois	All	25-29	Both Sexes	893,308	909,001	971,564	996,854	1,036,890	977,400	977,799
Illinois	All	25-29	F	441,351	448,339	479,253	491,675	510,788	479,591	481,462
Illinois	All	25-29	M	451,957	460,662	492,311	505,179	526,102	497,809	496,337
Illinois	All	30-34	Both Sexes	921,511	902,328	916,777	981,838	1,011,587	1,046,892	983,591
Illinois	All	30-34	F	457,457	446,974	453,413	485,633	500,253	517,091	483,927
Illinois	All	30-34	M	464,054	455,354	463,364	496,205	511,334	529,801	499,664
Illinois	All	35-39	Both Sexes	998,606	916,612	896,496	913,795	983,226	1,008,179	1,039,236
Illinois	All	35-39	F	501,313	459,220	448,326	456,223	490,861	503,199	518,236
Illinois	All	35-39	M	497,293	457,392	448,170	457,572	492,365	504,980	521,000
Illinois	All	40-44	Both Sexes	988,686	985,437	903,521	886,195	907,527	972,689	994,263
Illinois	All	40-44	F	499,218	497,054	455,068	445,850	455,954	488,681	499,447
Illinois	All	40-44	M	489,468	488,383	448,453	440,345	451,573	484,008	494,816
Illinois	All	45-49	Both Sexes	875,299	972,715	969,342	891,047	877,826	895,801	957,563
Illinois	All	45-49	F	444,429	493,741	491,695	451,679	444,884	453,495	484,756
Illinois	All	45-49	M	430,870	478,974	477,647	439,368	432,942	442,306	472,807
Illinois	All	50-54	Both Sexes	754,231	848,305	943,854	943,967	871,819	855,339	869,976
Illinois	All	50-54	F	386,166	434,260	483,015	482,702	445,373	436,731	443,691
Illinois	All	50-54	M	368,065	414,045	460,839	461,265	426,446	418,608	426,285
Illinois	All	55-59	Both Sexes	578,752	718,043	809,601	906,658	912,642	838,803	819,677
Illinois	All	55-59	F	300,044	372,060	419,497	469,516	472,215	433,487	423,295
Illinois	All	55-59	M	278,708	345,983	390,104	437,142	440,427	405,316	396,382
Illinois	All	60-64	Both Sexes	463,686	537,528	671,302	763,509	863,173	866,384	792,825
Illinois	All	60-64	F	244,427	282,983	353,202	401,705	453,860	455,060	415,804
Illinois	All	60-64	M	219,259	254,545	318,100	361,804	409,313	411,324	377,021
Illinois	All	65-69	Both Sexes	398,111	416,208	485,988 B	615,644	708,480	800,667	802,797
Illinois	All	65-69	F	216,877	226,720	264,522	334,991	385,452	435,470	436,486
Illinois	All	65-69	M	181,234	189,488	221,466	280,653	323,028	365,197	366,311
Illinois	All	70-74	Both Sexes	375,451	349,546	367,492 B	434,042	556,236	641,708	727,510
Illinois	All	70-74	F	212,374	197,796	207,949	245,400	314,350	362,612	411,043
Illinois	All	70-74	M	163,077	151,750	159,543	188,642	241,886	279,096	316,467
Illinois	All	75-79	Both Sexes	317,487	312,631	293,230 B	312,061	373,707	481,852	559,060
Illinois	All	75-79	F	190,108	187,152	175,456	186,530	223,149	287,472	333,288
Illinois	All	75-79	M	127,379	125,479	117,774	125,531	150,558	194,380	225,772
Illinois	All	80-84	Both Sexes	219,155	241,894	241,369 B	229,888	248,702	300,745	391,792
Illinois	All	80-84	F	141,299	155,881	155,480	147,973	159,888	193,134	251,390
Illinois	All	80-84	M	77,856	86,013	85,889	81,915	88,814	107,611	140,402
Illinois	All	85+	Both Sexes	192,346	230,002	269,950 B	298,054	314,336	342,525	402,311
Illinois	All	85+	F	139,284	166,371	195,007	214,986	226,302	246,031	288,404
Illinois	All	85+	M	53,062	63,631	74,943	83,068	88,034	96,494	113,907

Σ_B 1,658,029

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Quad Cities Kidney Center

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapharesis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Out-Patient Clinics

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

600 North College Avenue
Geneseo, Illinois 61254
(309) 945-1787

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

4480 Utica Ridge Road
Bettendorf, Iowa 52722
(563) 344-9977

In-Patient Facilities

Trinity Medical Center
- West Campus
Rock Island, Illinois

- 7th Street Campus
Moline, Illinois

- Terrace Park Campus
Bettendorf, Iowa

Genesis Medical Center
- Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

July 27, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 62761

Dear Mr. Constantino,

I am a social worker for Quad Cities Kidney Center Rock Island, Moline, Silvis locations for more than 10 years. I also make arrangements for the ESRD patients social needs including the arrangements for their dialysis schedule and transportation.

The majority of the ESRD patients are elderly they require transportation through family members or public transportation. Some of the patients are in nursing homes and transported by nursing home van. Due to limited time of operation of transportation vehicles these patients need second shift of dialysis on Monday, Wednesday and Fridays. Even though I can arrange the first or third shift of dialysis they are not an ideal convenient time for these patients. We do have some patients on the waiting list for the second shift of dialysis on Monday, Wednesday and Friday.

Since it will not impact the other dialysis facilities in Moline or Silvis and does not require significant cost, I strongly support the expansion of six stations at Quad Cities Kidney Center Rock Island, LLC for the convenience of the dialysis patients.

Sincerely,

Linda Clark, MSW, LSW

Linda Clark, MSW, LSW
Social Services

U.S. Census Bureau

American FactFinder

FACT SHEET

Rock Island city, Illinois

2006-2008 American Community Survey 3-Year Estimates - what's this?
Data Profile Highlights:

NOTE: Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Social Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error
Average household size	2.32	(X)	2.61	+/-0.09
Average family size	3.10	(X)	3.20	+/-0.12
Population 25 years and over	24,581			+/-1,054
High school graduate or higher	(X)	84.3	84.5%	(X)
Bachelor's degree or higher	(X)	20.2	27.4%	(X)
Civilian veterans (civilian population 18 years and over)	3,327	11.4	10.1%	+/-401
With a Disability	(X)	(X)	(X)	(X)
Foreign born	1,908	5.0	12.5%	+/-452
Male, Now married, except separated (population 15 years and over)	6,759	47.1	52.2%	+/-490
Female, Now married, except separated (population 15 years and over)	6,787	41.5	48.2%	+/-564
Speak a language other than English at home (population 5 years and over)	N	N	19.6%	N
Household population	35,218			+/-1,405
Group quarters population	(X)	(X)	(X)	(X)

Economic Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error
In labor force (population 16 years and over)	19,205	63.6	65.2%	+/-1,117
Mean travel time to work in minutes (workers 16 years and over)	15.8	(X)	25.3	+/-0.9
Median household income (in 2008 inflation-adjusted dollars)	41,807	(X)	52,175	+/-3,406
Median family income (in 2008 inflation-adjusted dollars)	55,604	(X)	63,211	+/-4,042
Per capita income (in 2008 inflation-adjusted dollars)	22,136	(X)	27,466	+/-1,605
Families below poverty level	(X)	11.9	9.6%	(X)
Individuals below poverty level	(X)	16.7	13.2%	(X)

Housing Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error
Total housing units	16,867			+/-371
Occupied housing units	15,205	90.1	88.0%	+/-516
Owner-occupied housing units	10,385	68.3	67.1%	+/-475
Renter-occupied housing units	4,820	31.7	32.9%	+/-536
Vacant housing units	1,662	9.9	12.0%	+/-430
Owner-occupied homes	10,385			+/-475
Median value (dollars)	94,900	(X)	192,400	+/-3,141
Median of selected monthly owner costs				
With a mortgage (dollars)	1,055	(X)	1,508	+/-38
Not mortgaged (dollars)	369	(X)	425	+/-26

ACS Demographic Estimates - show more >>	Estimate	Percent	U.S.	Margin of Error
Total population	38,006			+/-1,634
Male	18,062	47.5	49.3%	+/-1,050

Female	19,944	52.5	50.7%	+/-897
Median age (years)	36.6	(X)	36.7	+/-2.6
Under 5 years	2,229	5.9	6.9%	+/-356
18 years and over	29,144	76.7	75.5%	+/-1,278
65 years and over	5,638	14.8	12.6%	+/-470
One race	37,153	97.8	97.8%	+/-1,578
White	28,600	75.3	74.3%	+/-1,602
Black or African American	6,598	17.4	12.3%	+/-775
American Indian and Alaska Native	115	0.3	0.8%	+/-100
Asian	446	1.2	4.4%	+/-284
Native Hawaiian and Other Pacific Islander	0	0.0	0.1%	+/-151
Some other race	1,394	3.7	5.8%	+/-623
Two or more races	853	2.2	2.2%	+/-311
Hispanic or Latino (of any race)	3,837	10.1	15.1%	+/-652

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Explanation of Symbols:
'***' - The median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
'******' - The estimate is controlled. A statistical test for sampling variability is not appropriate.
'N' - Data for this geographic area cannot be displayed because the number of sample cases is too small.
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U.S. Census Bureau

American FactFinder

FACT SHEET

Illinois

2006-2008 American Community Survey 3-Year Estimates - what's this?
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Social Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error	
Average household size	2.63	(X)	2.61	+/-0.01	map
Average family size	3.27	(X)	3.20	+/-0.01	
Population 25 years and over	8,336,919			+/-2,962	
High school graduate or higher	(X)	85.6	84.5%	(X)	map
Bachelor's degree or higher	(X)	29.5	27.4%	(X)	map
Civilian veterans (civilian population 18 years and over)	809,154	8.4	10.1%	+/-6,100	map
With a Disability	(X)	(X)	(X)	(X)	
Foreign born	1,763,185	13.7	12.5%	+/-13,615	map
Male, Now married, except separated (population 15 years and over)	2,569,004	51.7	52.2%	+/-10,954	
Female, Now married, except separated (population 15 years and over)	2,479,186	47.4	48.2%	+/-9,647	
Speak a language other than English at home (population 5 years and over)	2,589,373	21.7	19.6%	+/-13,440	map
Household population	12,485,179			*****	
Group quarters population	(X)	(X)	(X)	(X)	

Economic Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error	
In labor force (population 16 years and over)	6,704,699	67.0	65.2%	+/-13,016	map
Mean travel time to work in minutes (workers 16 years and over)	28.2	(X)	25.3	+/-0.1	map
Median household income (in 2008 inflation-adjusted dollars)	55,935	(X)	52,175	+/-225	map
Median family income (in 2008 inflation-adjusted dollars)	68,296	(X)	63,211	+/-310	map
Per capita income (in 2008 inflation-adjusted dollars)	28,820	(X)	27,466	+/-132	
Families below poverty level	(X)	8.9	9.6%	(X)	
Individuals below poverty level	(X)	12.1	13.2%	(X)	map

Housing Characteristics - show more >>	Estimate	Percent	U.S.	Margin of Error	
Total housing units	5,240,942			+/-932	
Occupied housing units	4,751,748	90.7	88.0%	+/-8,303	
Owner-occupied housing units	3,315,284	69.8	67.1%	3315284	
Renter-occupied housing units	1,436,464	30.2	32.9%	+/-9,974	
Vacant housing units	489,194	9.3	12.0%	+/-8,277	
Owner-occupied homes	3,315,284			+/-10,999	map
Median value (dollars)	208,000	(X)	192,400	+/-692	map
Median of selected monthly owner costs					
With a mortgage (dollars)	1,682	(X)	1,508	+/-5	map
Not mortgaged (dollars)	523	(X)	425	+/-2	

ACS Demographic Estimates - show more >>	Estimate	Percent	U.S.	Margin of Error
Total population	12,829,014			*****
Male	6,317,527	49.2	49.3%	+/-2,611

Female	6,511,487	50.8	50.7%	+/-2,611	
Median age (years)	35.9	(X)	36.7	+/-0.1	map
Under 5 years	886,427	6.9	6.9%	+/-1,040	
18 years and over	9,643,535	75.2	75.5%	+/-1,280	
65 years and over	1,551,226	12.1	12.6%	+/-867	
One race	12,621,354	98.4	97.8%	+/-5,695	
White	9,160,030	71.4	74.3%	+/-14,289	map
Black or African American	1,874,723	14.6	12.3%	+/-5,078	map
American Indian and Alaska Native	23,599	0.2	0.8%	+/-1,623	map
Asian	545,780	4.3	4.4%	+/-2,450	map
Native Hawaiian and Other Pacific Islander	4,763	0.0	0.1%	+/-638	map
Some other race	1,012,459	7.9	5.8%	+/-14,022	map
Two or more races	207,660	1.6	2.2%	+/-5,695	map
Hispanic or Latino (of any race)	1,910,423	14.9	15.1%	+/-691	

Source: U.S. Census Bureau, 2006-2008 American Community Survey

Explanation of Symbols:
'***' - The median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
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CKD Description

There are five stages of chronic kidney disease ("CKD") and patients with CKD are often referred to as pre-ESRD patients because their renal function is in decline and it is expected that they will eventually require dialysis or transplantation. The last two stages are the most acute and are described below.

Stage 4 (kidney function 15% - 29%)

Stage 4 is the stage of kidney disease where the estimated glomrular filtration rate (GFR) is 15-29mL/min and the serum creatinine may range up to around 800mol/L. People with this level of kidney function may have symptoms varying from almost unnoticeable to quite severe, often depending on the underlying cause of kidney failure and associated illnesses. The biochemistry shows typical changes of kidney failure: the serum potassium tends to rise and the blood becomes more acidic. In this stage, there is a greater risk of further rises in serum potassium from some 'potassium sparing' diuretics and blood pressure medications. There is a wide range of abnormalities of hormonal levels as well as routinely measured biochemistry. Anemia has usually (but not always) appeared and may become quite severe, requiring treatment.

Continued reduction of kidney function causes further rises in blood pressure, so good blood pressure control is very important to reduce the risk of cardiovascular diseases, including heart attacks and strokes. Treatment to prevent bone disease, usually with medications, is also very important at this time.

CKD - Stage 5 (kidney function less than 15%)

This is the stage of chronic kidney disease where kidney function is severely impaired. Estimated GFR is reduced to 15% of normal or less and serum creatinine can be above 800mol/L. The need for dialysis is approaching very fast.

Symptoms during this stage may still be almost negligible or be quite severe. They can include itch, nausea, loss of appetite, tiredness, pins and needles in the hands or feet and, at a late stage, chest pain due to pericarditis, which is inflammation of the lining around the outside of the heart. Bleeding and bruising become more prominent. Patients are often prone to infection and develop fluid retention with ankle swelling and shortness of breath. The aim is to commence dialysis before symptoms necessitating hospitalization arise and well before patients develop such severe symptoms. There is now a trend to start dialysis earlier e.g. at 10-15% of kidney function rather than 5-10% of kidney function.

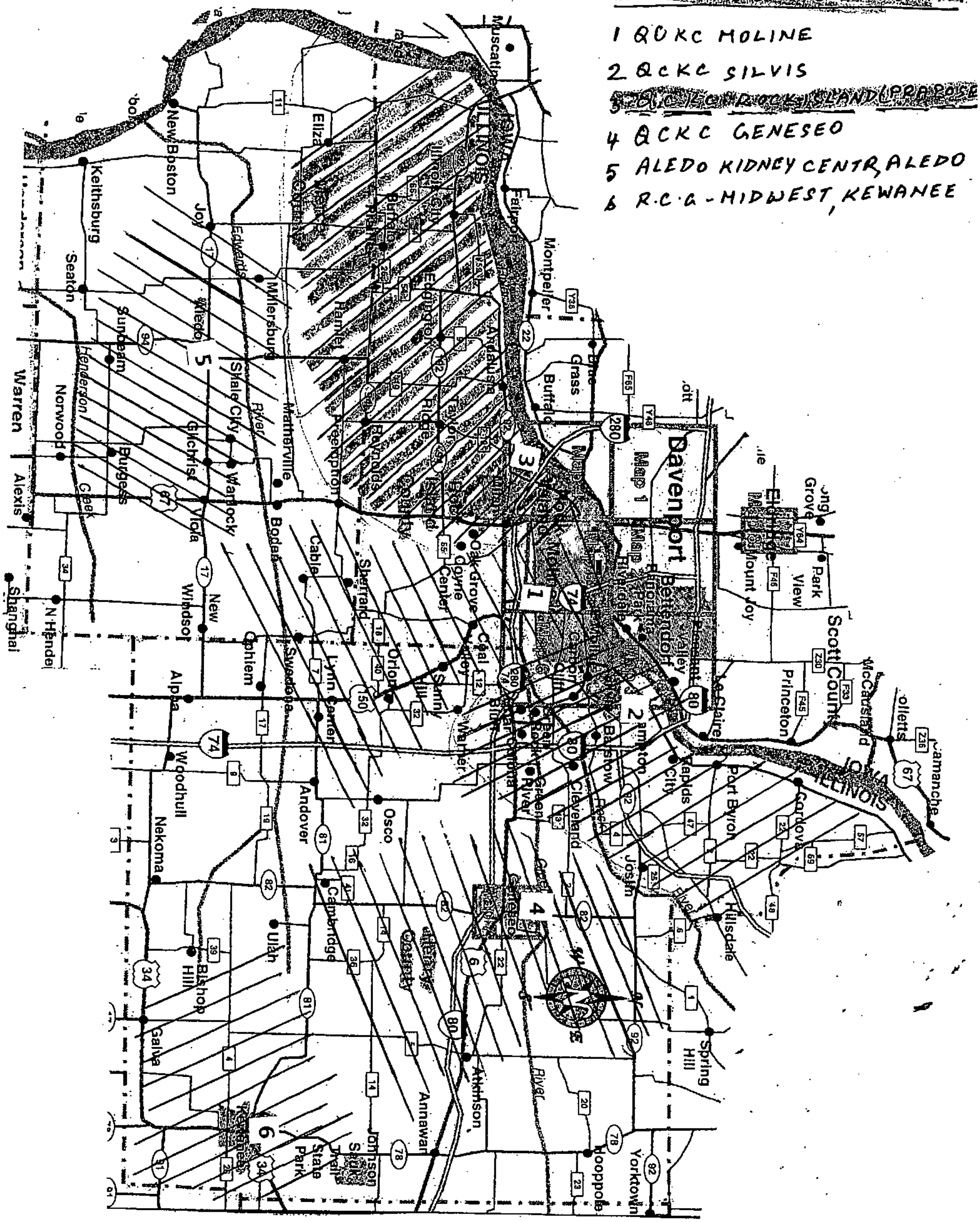
The rate of progress from one stage to the next may be unpredictable. Not all patients who lose some kidney function will progress to eventual loss of all kidney function. Progressive loss of function often depends on the extent of damage when a patient is first seen; for instance, the damage from an acute attack of glomerulonephritis, longstanding hypertension, from analgesics etc. Even in disorders where progression is usually inexorable, good blood pressure and biochemical control can delay the process, sometimes for years. Conversely, acute events such as severe infection, dehydration from vomiting or very high blood pressure can accelerate the progression of renal failure.

Renal replacement therapy has offered millions of patients an opportunity to prolong their lives. The success of the therapy has been undeniable, and outcomes continue to improve

PRIMARY SERVICE AREA OF EACH UNIT

~~DIALYSIS UNITS IN HSA 10.~~

1 QCKC MOLINE
2 QCKC SILVIS
~~3 QCKC ROCK ISLAND (PROPOSE~~
4 QCKC GENESEO
5 ALEDO KIDNEY CENTR, ALEDO
6 R.C.G - MIDWEST, KEWANEE



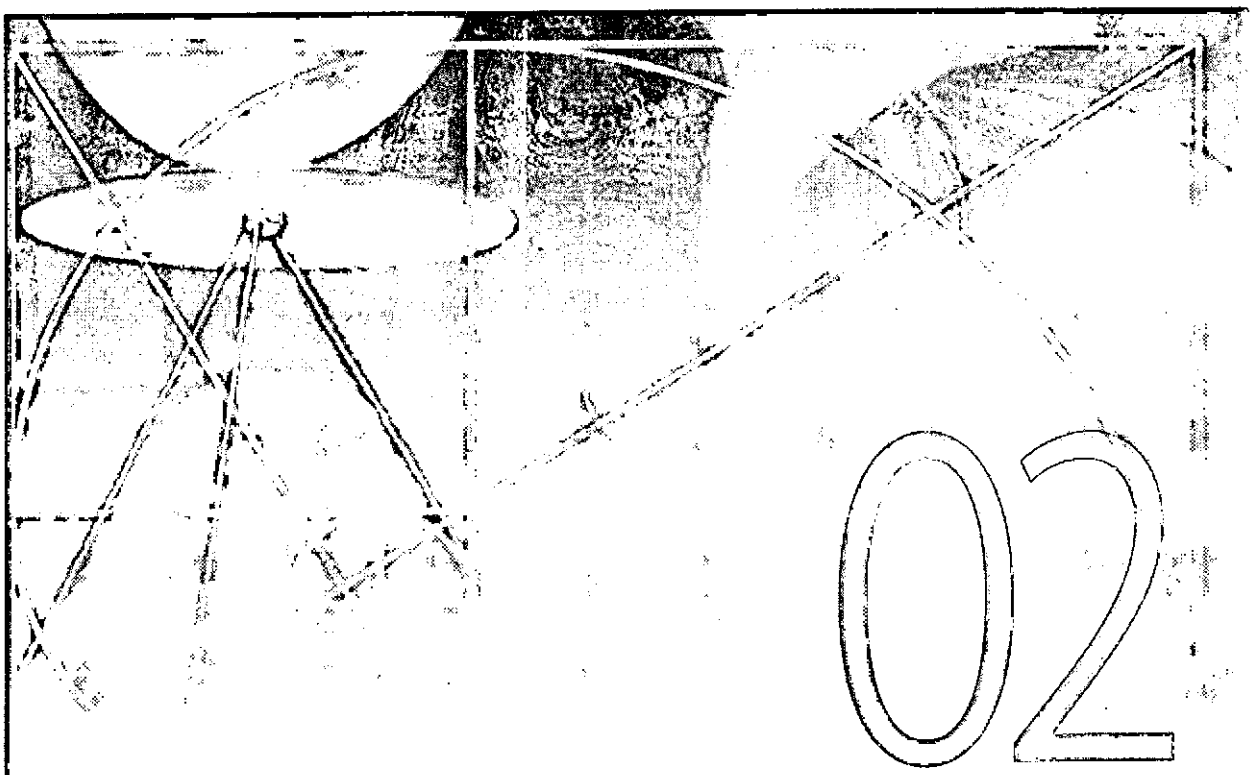
Attachment 12E

United States Renal Data System

2009 Annual Data Report

Volume Two

Atlas of End-Stage Renal Disease in the United States

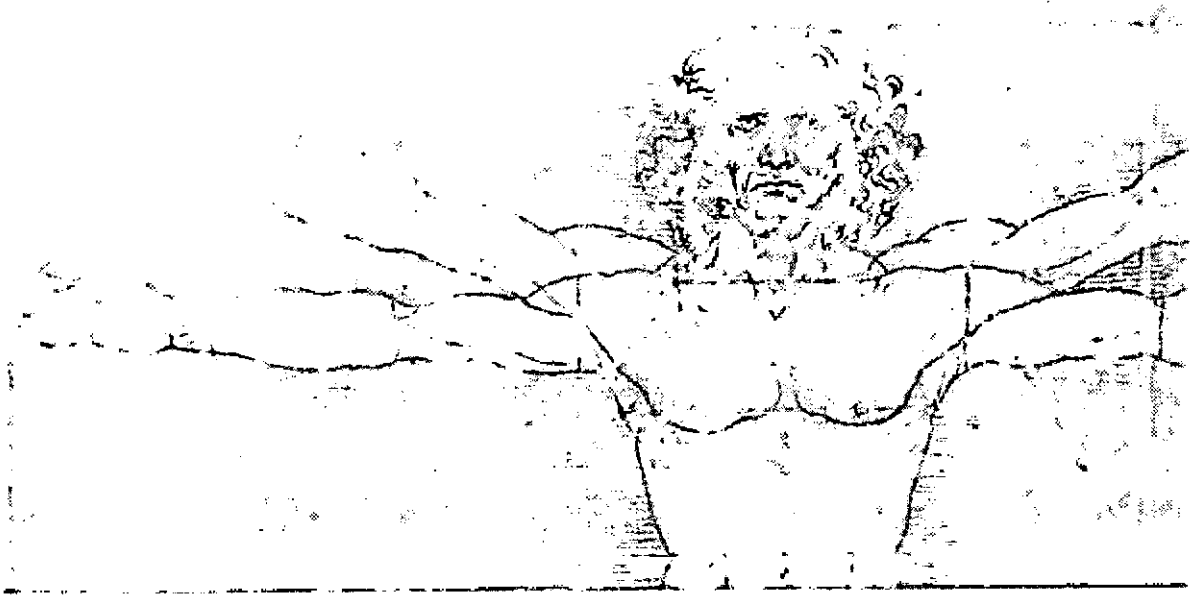


02

Chapter Two
Incidence & prevalence

Science is the observation of things possible, whether present or past. Prescience is the knowledge of things which may come to pass, though but slowly.

LEONARDO DA VINCI



Growth of the end-stage renal disease (ESRD) program is typically characterized by assessment of total patient counts at a single point in time (point prevalence), of new cases accepted for treatment (incidence), and of patients receiving kidney transplants. Disease rates are computed based on the number of patients per million people in the general population, and are adjusted for age, gender, and race. ¶ This year we update our projections using data available through December 31, 2007, and compare results for incidence, prevalence, and mortality both to projections presented in our 2005 JASN paper, which used data through 2000, and to those in the 2008 ADR, using data through 2006. Current projections are down slightly compared to those shown last year, and to results presented in the paper for 2015. The primary reason for these differences is a continued flattening of incident rates in most age and race groups. ¶ The 2006 growth in the incident population reversed in 2007, with rates returning to the flattened level seen since 2001. Although the incidence of ESRD due to diabetes has increased among younger minority patients, rates have been stable or falling in older populations and among whites (see Figure 1.21 in Chapter One), showing that a detailed assessment of subpopulations is required to determine whether trends are consistent across all groups defined by age, gender, race, ethnicity, and cause of ESRD. A new finding this year is that the number of elderly patients and those age 45–64 appears to have peaked, though this will require additional years of data to confirm. By race, data on incidence generally show the same flattening as the overall ESRD rates, though rates have been falling among Native Americans. This trend is not universal, however, as incidence among Native Americans younger than 40 has been on the rise. ¶ By primary cause, the adjusted rate of new ESRD cases due to diabetes fell 3.3 percent in 2007, to 155 per million population. The rate of ESRD due to glomerulonephritis continues to fall, returning to levels seen in the early 1990s. It is not clear if this finding is related to improved blood pressure control and greater use of ACE-Is or ARBs, or if hypertension and diabetes are now so common that there is some misclassification of primary diagnosis. Additional investigations will be needed to assess the care of these patients, and to determine if detection and treatment continue to improve. Data on the median age of incident patients show important trends; the slight decline in the age of white and Asian patients may illustrate an increasing number of patients age 45–64 entering ESRD, a reflection of the expanding number of post-war baby boomers reaching their middle years. In 2007, the adjusted incident rate for patients age 45–64 fell to the same level seen in 2000 — 611 per million population. The rate for those age 75 and older rose 10.4 percent during the same period, to 1,735, and that for patients age 20–44 grew 5.5 percent, to 126. ¶ Racial and ethnic discrepancies in ESRD persist, with 2007 incident rates in the African American and Native American populations 3.7 and 1.8 times greater, respectively, than the rate among whites, and the rate in the Hispanic population 1.5 times higher than that of non-Hispanics. ¶ Even after adjustments for age and gender, rates of ESRD continue

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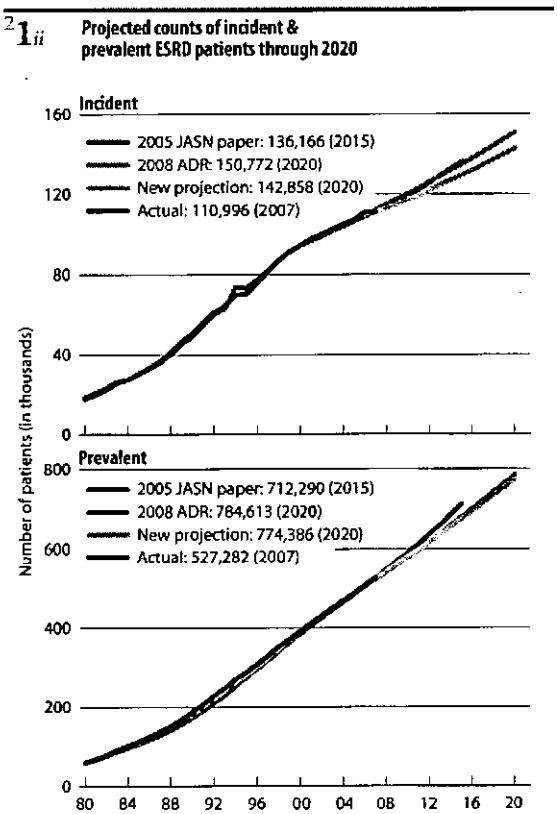
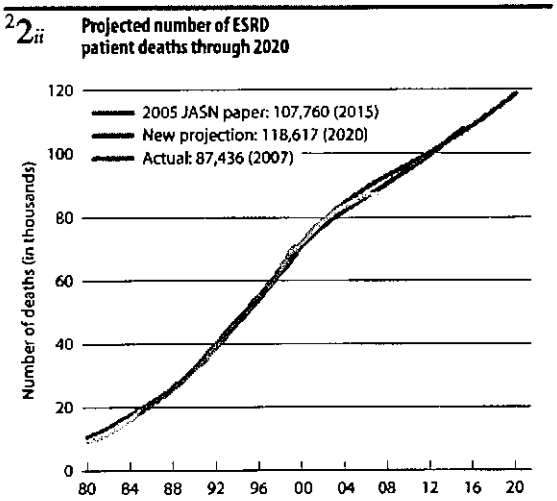
to vary widely across the U.S. This year we update our data on ESRD in the major metropolitan statistical areas (MSAs) of the United States. Among African Americans, for instance, the incidence of ESRD is greatest in the Denver, Colorado area, while for Hispanics it is highest in the MSA centered around Cincinnati, Ohio. These variations may reflect different burdens of chronic kidney disease, as well as regional differences in the use of detection efforts and treatment interventions in populations at risk for kidney failure. ¶ The prevalent population age 75 and older has nearly doubled since 1997, now reaching more than 81,000, while the number of patients age 45–64 has grown 82 percent. The population age 20–44, in contrast, is just 16.5 percent larger now than a decade ago. Prevalent rates per million population are growing most quickly among patients age 65 and older, with an overall increase of 24–28 percent since 2000, and of 42 and 57 percent for ages 65–74 and 75 and older, respectively, in the past decade. Regional variations in ESRD prevalence reflect differences in adjusted survival, in part related to higher rates of transplantation in certain areas of the U.S. ¶ Still to be determined is whether these data reflect short- or long-term trends, as the emergence of the baby boomers into a senior population will continue to contribute to the growth of the overall ESRD population, even with moderations in disease rates. The growth of diabetes in both the general Medicare population and among younger patients is a concern as well.

¶ FIGURES 2.1–2; see page 365 for analytical methods. *Counts projected using a Markov model.*



2.1ii Projected counts of incident & prevalent ESRD patients through 2020



2.2ii Projected number of ESRD patient deaths through 2020

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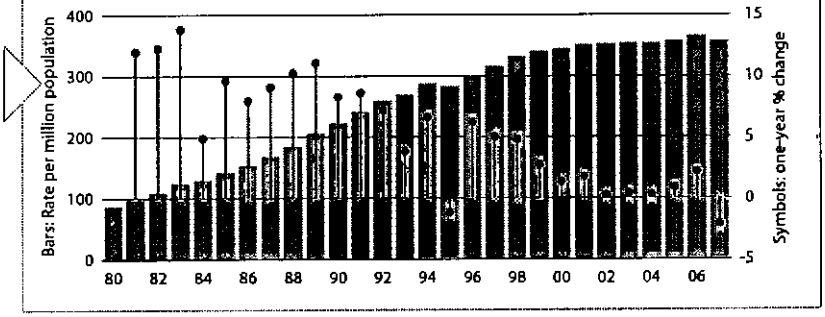
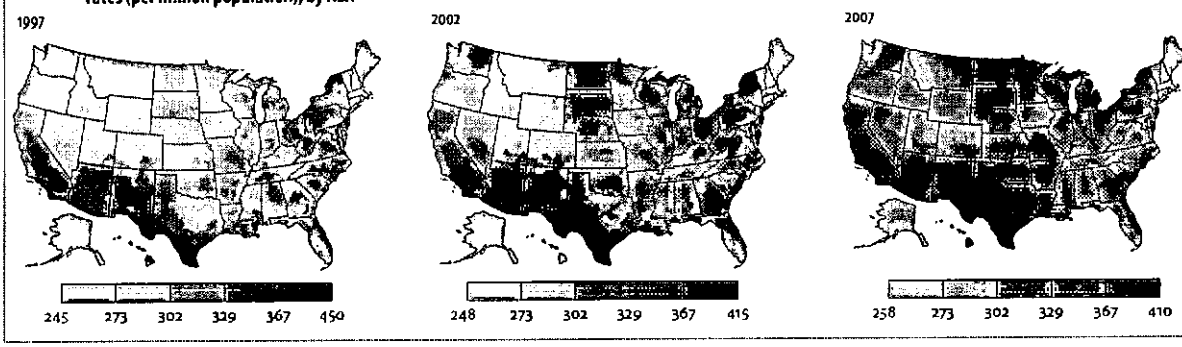
In 2007, the incident rate (adjusted for age, gender, and race) of end-stage renal disease fell 2.1 percent, to 354 per million population. This decline, the first since 1995, brought the rate of new ESRD cases back to that seen in 2005. ¶ FIGURE 2.3; see page 365 for analytical methods. *Incident ESRD patients.*

2.3ii Adjusted incident rates & annual percent change

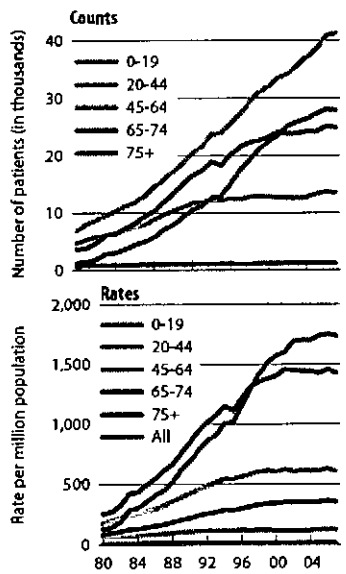


2.4ii Geographic variations in adjusted incident rates (per million population), by HSA

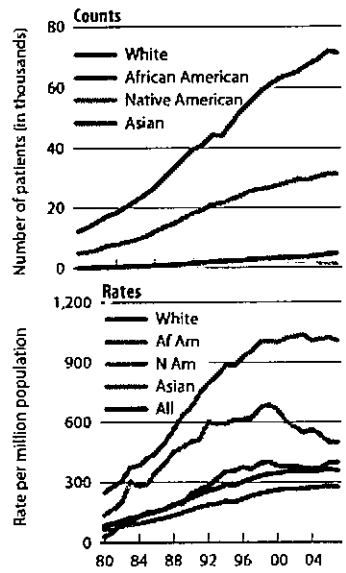


Incident counts & adjusted rates

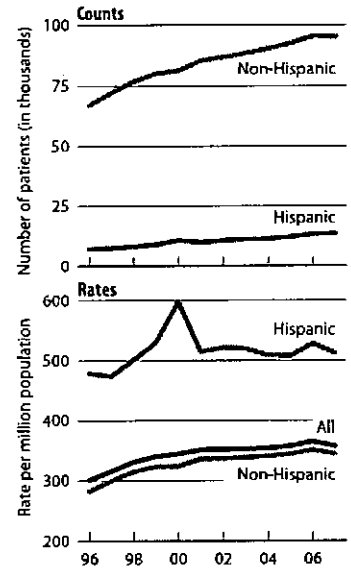
2.5ii Incident counts & adjusted rates, by age



2.6ii Incident counts & adjusted rates, by race



2.7ii Incident counts & adjusted rates, by Hispanic ethnicity

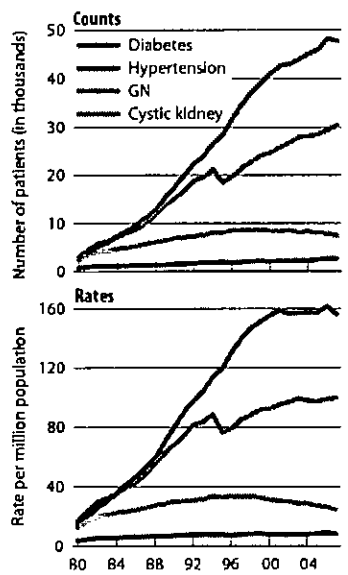


In 2007, the incident rate of ESRD was 354 per million population (see Table p.a), and geographically averaged 410 per million in the upper quintile — 8.9 percent lower than in 1997. The highest adjusted rates occur in the southern and southwestern portions of the country, in areas along the Mississippi River, and through the Ohio Valley. ❡ FIGURE 2.4; see page 365 for analytical methods. *Incident ESRD patients.*

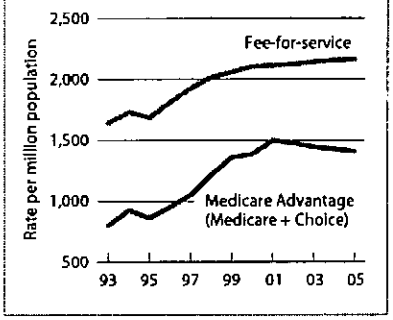
The incident rate among patients with Medicare Advantage (formerly Medicare + Choice) coverage peaked in 2001, and by 2005 had fallen 6 percent, reaching 1,407 per million population — 35 percent lower than the rate of 2,166 found in the fee-for-service population. More recent data are not yet available. ❡ FIGURE 2.9; see page 365 for analytical methods. *Incident ESRD patients.*

The median age of the incident ESRD population has changed little since the late 1990s, from a high of 65.0 in 2001 to 64.4 in 2007. By race and ethnicity, the median age ranges from 59.1 among African Americans to 66.8 among whites. ❡ FIGURE 2.10; see page 365 for analytical methods. *Incident ESRD patients.*

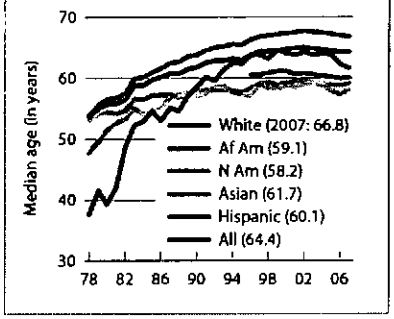
2.8ii **Incident counts & adjusted rates, by primary diagnosis**



2.9ii **Unadjusted incident rates, by payor**



2.10ii **Median age of incident patients, by race/ethnicity**



Since 2000, the adjusted incident rate of ESRD has grown 10.4 percent for patients age 75 and older, reaching 1,735 per million population in 2007, while the rate for those age 20–44 has increased 5.5 percent, to 126. In the remaining adult age groups, in contrast, the rate has remained quite stable, with 2007 levels 0.1 percent lower for those age 45–64, and 1.2 percent higher for those age 65–74.

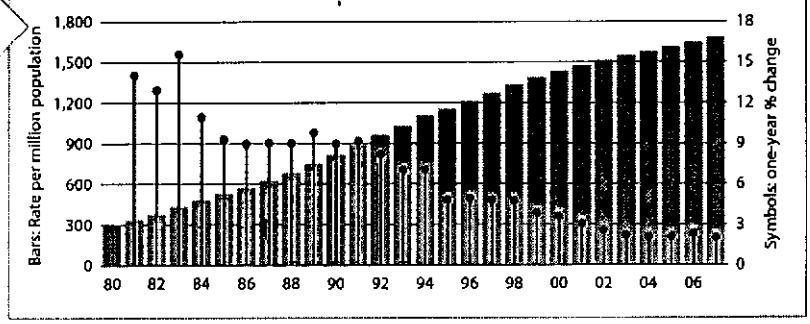
By race, incident rates for African Americans and Native Americans in 2007 reached 998 and 495 per million population, respectively — 3.7 and 1.8 times greater than the rate of 273 found among whites. Since 2000, the rate of new ESRD cases has grown 4.6–5.5 percent for Asians and whites; among African Americans, in contrast, it has remained stable.

Thirteen percent of new ESRD patients in 2007 were Hispanic. The incident rate in this population fell from that seen in 2006, to 508 per million population — 1.5 times greater than that found among non-Hispanics.

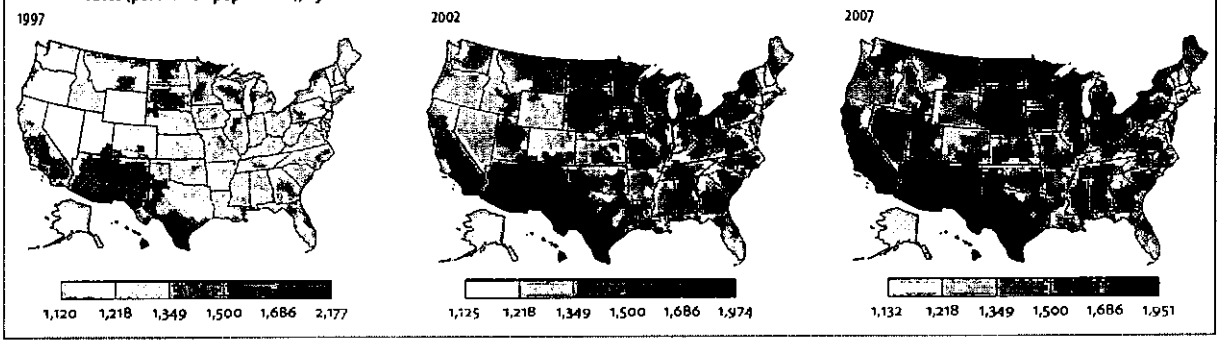
Diabetes was the primary cause of ESRD for 54 percent of new patients in 2007; one in three patients had a primary diagnosis of hypertension. The incident rate of diabetic ESRD fell 3.3 percent between 2006 and 2007, to 155 per million population — just 0.6 percent greater than the rate seen in 2000. The rate of ESRD caused by hypertension, in contrast, has grown 8.0 percent since 2000, to 99 per million population, while ESRD due to glomerulonephritis has fallen 21.3 percent, to 24.3. ❡ FIGURES 2.5–8; see page 365 for analytical methods. *Incident ESRD patients.*

Adjusted for age, gender, and race, the rate of prevalent ESRD cases rose 2.0 percent between 2006 and 2007, reaching 1,665 per million population. While this rate is nearly 18 percent greater than that seen in 2000, the annual rate of growth has remained between 2.0 and 2.3 percent since 2003. ◖ FIGURE 2.11; see page 365 for analytical methods. *December 31 point prevalent patients.*

2.11ii Adjusted prevalent rates & annual percent change

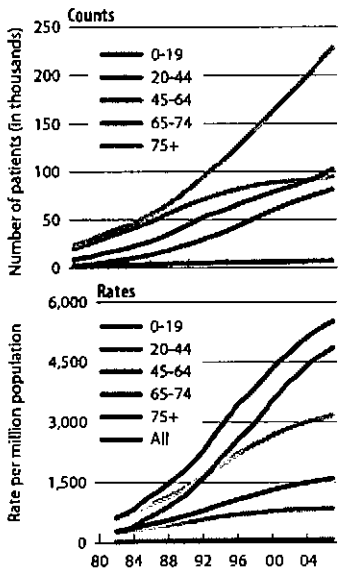


2.12ii Geographic variations in adjusted prevalent rates (per million population), by HSA

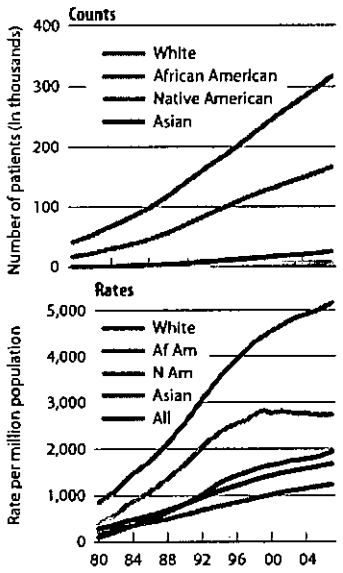


Prevalent counts & adjusted rates

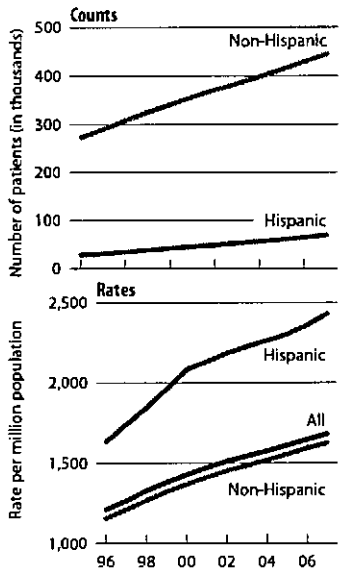
2.13ii Prevalent counts & adjusted rates, by age



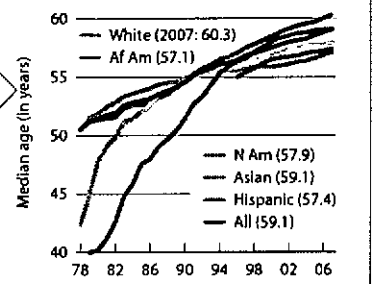
2.14ii Prevalent counts & adjusted rates, by race



2.15ii Prevalent counts & adjusted rates, by Hispanic ethnicity



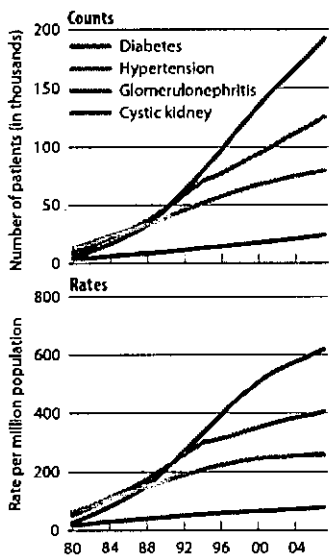
2.17ii Median age of prevalent patients, by race/ethnicity



The median age of the prevalent ESRD population has grown 2.7 percent since 2000, reaching 59.1 in 2007. By race and ethnicity, it varies from 57.1 in the African American population to 60.3 among whites. ❦ FIGURE 2.17; see page 365 for analytical methods. *December 31 point prevalent patients.*

In 2007, the prevalent rate of ESRD was 1,665 per million population (see Table p.a), and averaged 1,951 per million population in the upper quintile. With the addition of high rates in the Dakotas, geographic patterns generally parallel those found in the incident population; the highest rates occur in the south and southwestern portions of the country. ❦ FIGURE 2.12; see page 365 for analytical methods. *December 31 point prevalent patients.*

2.16ii Prevalent counts & adjusted rates, by primary diagnosis



By MSA, the greatest adjusted rate of prevalent ESRD for whites occurs in the Los Angeles area, at 1,542 per million population. For African Americans, rates of 6,000–7,400 are found in the St. Louis, Cincinnati, and Pittsburgh MSAs. The St. Louis MSA also has the highest prevalence among Hispanic patients, of 4,122. ❦ TABLE 2.A; see page 365 for analytical methods. *Incident & December 31 point prevalent patients, 2007. *Values for cells with ten or fewer patients are suppressed.*

2.aii Adjusted incident & prevalent rates per million population, by metropolitan statistical area (MSA) & race/ethnicity, 2007 (MSAs ranked by size; top three in each column highlighted in green)

	White		African American		Other race		Hispanic	
	Inc	Prev	Inc	Prev	Inc	Prev	Inc	Prev
New York, NY	298	1,221	864	4,080	312	1,402	400	1,786
Los Angeles, CA	350	1,542	842	3,860	352	1,645	529	2,496
Chicago, IL	296	1,286	946	4,758	342	1,489	503	2,297
Dallas-Fort Worth, TX	211	988	853	4,599	268	1,270	443	2,065
Philadelphia, PA	263	1,114	1,023	5,601	369	1,489	604	2,069
Houston, TX	261	1,120	949	4,305	260	1,051	453	2,040
Miami, FL	268	1,036	915	4,037	236	1,321	307	1,135
Washington, DC	175	789	789	4,282	278	1,354	244	1,273
Atlanta, GA	170	755	781	3,822	260	1,063	207	815
Boston, MA	227	1,050	708	4,094	337	1,657	376	1,862
Detroit, MI	270	1,169	1,078	5,561	349	1,607	325	1,948
San Fran.-Oakland, CA	244	1,191	945	5,027	395	2,031	439	2,054
Phoenix, AZ	271	1,123	826	3,471	667	3,471	588	2,446
Riverside-San Bern., CA	311	1,340	741	3,725	323	1,495	488	2,128
Seattle, WA	187	951	744	4,272	310	1,925	365	1,527
Minneapolis-St Paul, MN	184	1,002	825	5,264	635	3,101	485	2,276
San Diego, CA	249	1,223	822	4,079	379	1,916	514	2,578
St. Louis, MO	277	1,109	1,184	6,011	294	1,396	427	4,122
Tampa, FL	285	1,058	985	5,182	310	1,561	408	1,615
Baltimore, MD	248	1,038	1,018	5,167	409	1,341	482	1,828
Denver, CO	151	936	698	4,169	207	1,433	325	2,053
Pittsburgh, PA	407	1,537	1,481	7,329	930	1,962	*	1,157
Portland, OR	220	1,048	958	4,780	398	1,963	340	1,838
Cleveland, OH	279	1,199	993	5,659	*	1,197	*	1,020
Cincinnati, OH	318	1,348	1,101	6,221	397	1,709	615	2,120

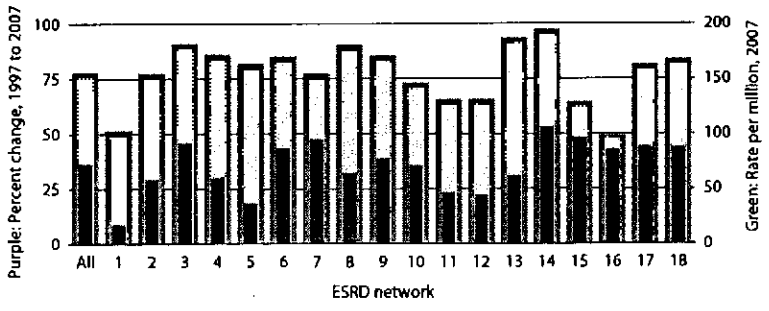
The adjusted rate of prevalent ESRD cases among patients age 65–74 reached 5,870 per million population in 2007 — nearly 24 percent greater than in 2000. For patients age 75 and older the rate is now 5,124, nearly 28 percent higher than in 2000. Overall growth in the rate during the same period has been just 17.5 percent.

By race, rates of prevalent ESRD continue to be highest in the African American and Native American populations, at 5,111 and 2,713 per million population, respectively, in 2007, compared to 1,222 and 1,911 among whites and Asians. The rate for Hispanic patients reached 2,408 in 2007, 1.5 times greater than the rate of 1,613 seen among non-Hispanics.

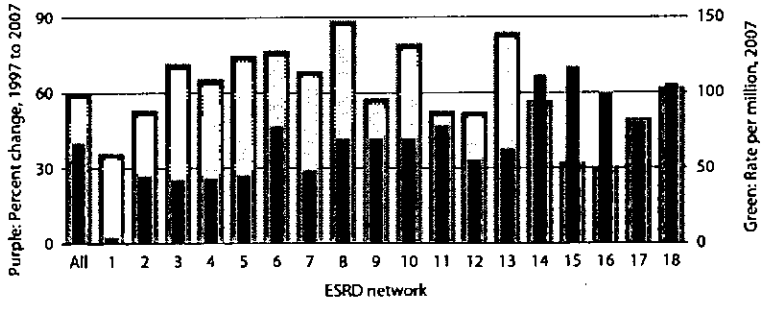
By primary diagnosis, annual growth in rates of existing ESRD cases continues to be relatively stable. In 2007, rates for ESRD caused by cystic kidney disease, glomerulonephritis, hypertension, and diabetes reached 79, 260, 407, and 619 per million population, respectively. ❦ FIGURES 2.13–16; see page 365 for analytical methods. *December 31 point prevalent patients.*

Growth in incident populations

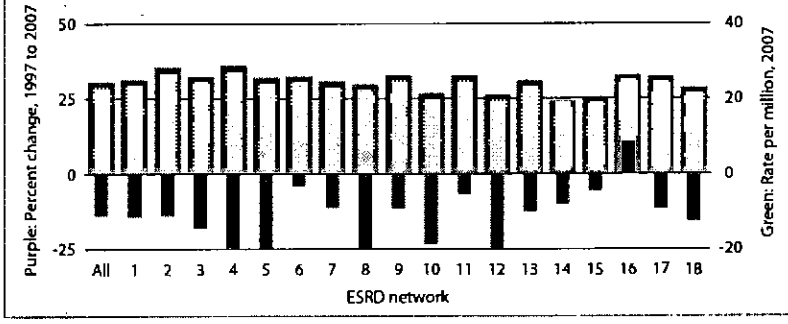
2.18ii Growth in incident ESRD due to diabetes, 1997–2007, by network (adjusted rates)

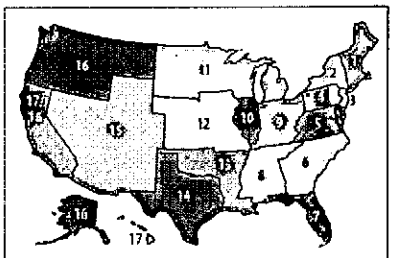


2.19ii Growth in incident ESRD due to hypertension, 1997–2007, by network (adjusted rates)



2.20ii Growth in incident ESRD due to glomerulonephritis, 1997–2007, by network (adjusted rates)

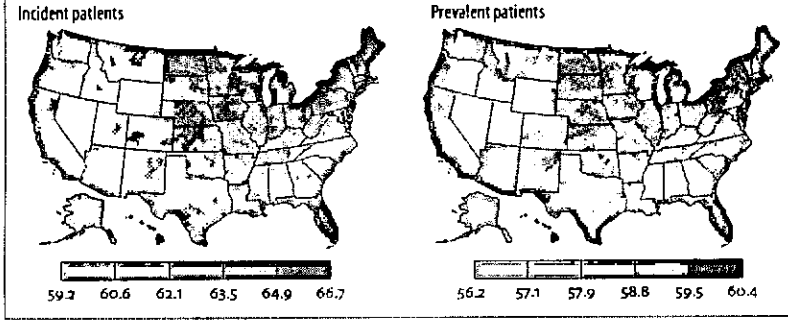




Network 1	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Network 2	New York
Network 3	New Jersey, Puerto Rico, Virgin Islands
Network 4	Delaware, Pennsylvania
Network 5	Maryland, Virginia, Washington D.C., West Virginia
Network 6	Georgia, North Carolina, South Carolina
Network 7	Florida
Network 8	Alabama, Mississippi, Tennessee
Network 9	Indiana, Kentucky, Ohio
Network 10	Illinois
Network 11	Michigan, Minnesota, North Dakota, South Dakota, Wisconsin
Network 12	Iowa, Kansas, Missouri, Nebraska
Network 13	Arkansas, Louisiana, Oklahoma
Network 14	Texas
Network 15	Arizona, Colorado, Nevada, New Mexico, Utah, Wyoming
Network 16	Alaska, Idaho, Montana, Oregon, Washington
Network 17	American Samoa, Northern California, Guam, Hawaii
Network 18	Southern California

The overall adjusted rate of ESRD due to diabetes was 155 per million population in 2007, 36 percent higher than a decade before. Both the highest rate and the greatest growth occurred in Network 14, at 193 per million and 53 percent, respectively. The rate of new ESRD cases due to hypertension rose only 2.6 percent in Network 1, but 70 percent in Network 15. And, with the exception of Network 16, rates of ESRD due to glomerulonephritis have fallen across the country. ❡ FIGURES 2.18–20; see page 365 for analytical methods. *Incident ESRD patients.*

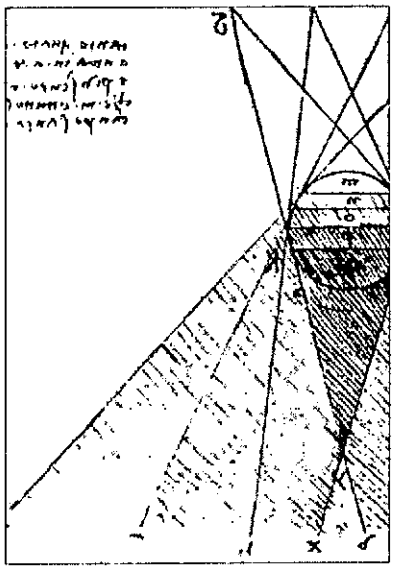
2.21ii Geographic variations in mean age, 2007, by HSA



The mean age of both the incident and prevalent ESRD populations is greatesr in areas of the Upper Midwest, the Northeast, and Florida. In the lower quintle, the mean age is 59.2 for incident patients, compared to 56.2 in rhe prevalent population. Means in the upper quintile are 66.7 and 60.4, respectively. ❡ FIGURE 2.21; see page 365 for analytical methods. *Incident & December 31 point prevalent patients.*

2b$_{ii}$ Patient demographics & adjusted rates, by ESRD network: Incident dialysis patients, 2007

	Total pts	% of total	Rate per million	Mean age	% DM	% White	% Af Am	% N Am	% Asian	% Hisp.
1	3,613	3.3	247.8	65.5	40.3	82.8	14.0	0.2	2.8	7.2
2	7,081	6.5	356.3	64.2	42.5	61.0	32.9	0.4	4.8	12.7
3	4,903	4.5	400.0	64.5	50.3	69.8	26.7	0.0	3.0	34.5
4	5,321	4.9	394.6	64.9	43.0	73.9	24.3	0.0	1.6	3.3
5	6,250	5.8	384.9	62.2	41.4	48.6	47.8	0.2	2.6	2.5
6	9,125	8.4	386.9	60.1	43.2	41.5	56.6	0.6	1.3	2.2
7	6,832	6.3	364.1	63.8	41.9	66.8	31.0	0.2	1.4	15.2
8	5,834	5.4	415.3	60.9	42.7	51.0	48.0	0.4	0.5	0.5
9	8,496	7.8	376.9	63.9	44.4	75.8	23.4	0.1	0.6	1.8
10	4,782	4.4	365.5	63.4	39.5	63.4	33.3	0.1	3.0	11.1
11	7,093	6.6	309.4	63.8	40.8	71.7	23.5	2.5	2.0	3.0
12	4,094	3.8	299.6	64.0	43.0	77.0	21.0	0.9	1.0	2.9
13	4,565	4.2	419.6	60.9	44.2	53.1	41.3	4.6	1.0	2.5
14	8,775	8.1	359.6	60.0	53.4	71.4	25.9	0.3	2.3	39.7
15	4,821	4.5	248.3	61.5	50.5	79.0	8.9	7.9	3.6	25.6
16	3,122	2.9	227.7	62.7	41.9	82.3	6.6	3.5	7.4	7.4
17	5,160	4.8	324.4	62.2	50.1	57.0	13.4	0.9	27.7	20.7
18	8,467	7.8	358.0	62.3	46.0	72.8	14.6	0.4	11.8	38.7
Unk.	*									
All	108,335	100.0	345.7	62.7	44.6	65.5	28.9	1.1	4.2	13.7



2c$_{ii}$ Patient demographics & adjusted rates, by ESRD network: December 31 point prevalent dialysis patients, 2007

	Total pts	% of total	Rate per million	Mean age	% DM	% White	% Af Am	% N Am	% Asian	% Hisp.
1	11,953	3.2	809	64.2	39.4	75.2	20.3	0.3	3.1	8.7
2	24,402	6.6	1,206	62.2	40.7	51.0	40.8	0.5	5.2	14.7
3	15,136	4.1	1,205	62.2	46.1	58.5	33.9	0.1	3.2	35.1
4	16,141	4.4	1,185	63.1	41.5	62.5	35.4	0.1	1.5	3.6
5	21,725	5.9	1,329	60.4	39.6	36.4	59.8	0.2	2.6	3.1
6	35,329	9.6	1,470	58.6	41.1	30.2	67.4	0.6	1.1	2.6
7	20,889	5.7	1,095	61.2	39.9	55.2	41.5	0.3	1.9	15.3
8	20,736	5.6	1,468	59.1	40.4	37.8	61.0	0.5	0.5	0.8
9	26,565	7.2	1,173	61.9	43.2	64.8	34.1	0.1	0.7	2.2
10	15,712	4.3	1,191	61.7	39.9	54.1	42.1	0.2	3.0	12.0
11	22,950	6.2	997	62.6	41.3	62.2	32.0	3.2	2.3	3.7
12	13,407	3.6	974	62.0	42.1	67.6	29.9	1.1	1.2	5.2
13	14,643	4.0	1,331	58.9	42.3	42.1	51.6	4.9	1.0	2.6
14	33,029	9.0	1,329	58.9	52.4	66.3	30.6	0.3	2.0	43.2
15	16,806	4.6	854	60.7	52.2	71.2	10.9	13.6	3.9	29.1
16	9,885	2.7	713	61.3	42.1	77.3	9.0	4.7	8.7	9.4
17	19,198	5.2	1,189	61.2	48.1	49.9	16.4	0.9	30.9	21.9
18	30,036	8.2	1,257	60.5	45.6	69.3	16.6	0.5	12.7	44.7
Unk.	*									
All	368,544	100.0	1,163	60.9	43.5	55.7	37.1	1.5	4.7	15.6

2d$_{ii}$ Patient demographics & adjusted rates, by ESRD network: December 31 point prevalent transplant patients, 2007

	Total pts	% of total	Rate per million	Mean age	% DM	% White	% Af Am	% N Am	% Asian	% Hisp.
1	7,801	4.9	521.9	51.4	20.1	82.9	11.8	0.3	3.9	7.4
2	10,095	6.4	496.1	50.6	19.0	67.4	22.4	0.8	6.5	16.8
3	4,454	2.8	405.4	50.8	22.2	71.4	20.4	0.2	4.8	30.1
4	9,432	5.9	677.2	51.6	22.2	73.4	21.0	0.2	3.4	3.0
5	9,776	6.2	592.7	51.1	22.0	57.5	35.5	0.3	4.8	4.7
6	9,267	5.8	389.9	49.8	22.6	58.2	38.3	0.8	2.3	2.1
7	8,007	5.0	419.0	52.0	21.5	72.3	22.5	0.5	3.5	16.9
8	7,371	4.6	524.2	49.4	20.8	65.0	32.9	0.3	1.4	1.0
9	11,389	7.2	499.8	50.4	25.8	80.3	16.6	0.1	2.0	1.6
10	6,907	4.4	507.7	49.7	22.6	67.0	25.4	0.3	4.6	13.7
11	17,415	11.0	757.9	51.2	28.4	82.1	12.4	1.8	3.1	3.2
12	7,344	4.6	533.7	50.7	22.7	82.8	13.8	0.8	2.2	4.8
13	4,793	3.0	435.9	49.9	23.6	63.1	31.4	3.2	1.8	2.4
14	10,747	6.8	424.2	49.6	24.6	77.8	16.4	0.4	3.9	36.8
15	8,037	5.1	413.1	50.3	28.1	84.3	5.1	6.0	4.1	20.4
16	5,937	3.7	432.3	51.3	24.9	83.9	5.4	2.8	7.6	6.8
17	8,310	5.2	528.6	50.4	20.9	65.1	8.8	0.9	23.0	20.3
18	11,415	7.2	476.5	49.3	19.9	73.2	11.1	0.6	13.9	37.2
Unk.	242	0.2		46.4	0.0	15.7	1.7	2.9	20.7	0.0
All	158,739	100.0	502.3	50.5	23.1	73.1	19.0	1.1	5.4	12.7

These tables present patient demographics and adjusted disease rates by modality and ESRD network. With an overall incident rate for dialysis patients of 346 per million population in 2007, rates by network range from 228 in Network 16 to 420 in Network 13. The distribution of patients by race continues to vary widely across the country. African Americans, for instance, constitute just 6.6 percent of the new ESRD population in Network 16, but 48–57 percent of patients in Networks 5, 6, and 8.

In the prevalent population, the overall rate for point prevalent dialysis patients in 2007 was 1,163 per million population. Network 1 has the lowest percentage of patients with diabetic ESRD, at 39.4, compared to 52 percent in Networks 14 and 15.

The rate of point prevalent ESRD patients with a transplant is lowest in Network 6, at 390 per million population. In Network 11, in contrast, the rate reaches 758 — 12 percent greater than the next highest rate, found in Network 4. One in nine transplant patients in the U.S. resides in one of the Upper Midwestern states covered by Network 11. ¶ TABLES 2.B–D; see page 365 for analytical methods. *Incident dialysis patients (2.b); December 31 point prevalent dialysis patients (2.c); December 31 point prevalent transplant patients (2.d). *Values for cells with ten or fewer patients are suppressed.*

chapter summary

In 2007, the adjusted rate of new ESRD cases was **354** per million population. • 2.3

The rate of new ESRD cases among African Americans reached **998** per million population in 2007 — **3.7 TIMES** greater than the rate of **273** among whites. • 2.6

HISPANICS accounted for **13%** of new ESRD patients in 2007. At 508 per million population, their rate was 1.5 times greater than that of non-Hispanics. • 2.7

In 2007, **DIABETES** was the cause of ESRD in 54% of new patients; one in three had ESRD caused by **HYPERTENSION**. • 2.8

The adjusted rate of prevalent ESRD cases reached **1,665** per million population in 2007. • 2.11

The rate of prevalent ESRD cases among patients **AGE 65–74** reached 5,879 in 2007 — nearly **24% GREATER** than in 2000. • 2.13

The rate of **5,111** prevalent ESRD cases per million population among African Americans is **4.2 TIMES** greater than the rate of **1,231** among whites. • 2.14

With an overall incident rate for dialysis patients of **346** per million population in 2007, rates by network range from **228** in Network 16 to **420** in Network 13. • 2.b

ONE IN NINE transplant patients in the U.S. resides in an Upper Midwestern state covered by Network 11. • 2.d

summary

Annals of Internal Medicine | ARTICLE

Octogenarians and Nonagenarians Starting Dialysis in the United States

Manjula Kurella, MD, MPH; Kenneth E. Covinsky, MD, MPH; Alan J. Collins, MD; and Glenn M. Chertow, MD, MPH

Background: The elderly constitute the fastest-growing segment of the end-stage renal disease (ESRD) population, but the epidemiology and outcomes of dialysis among the very elderly, that is, those 80 years of age and older, have not been previously examined at a national level.

Objective: To describe recent trends in the incidence and outcomes of octogenarians and nonagenarians starting dialysis.

Design: Observational study.

Setting: U.S. Renal Data System, a comprehensive, national registry of patients with ESRD.

Participants: Octogenarians and nonagenarians initiating dialysis between 1996 and 2003.

Measurements: Rates of dialysis initiation and survival.

Results: The number of octogenarians and nonagenarians starting dialysis increased from 7054 persons in 1996 to 13 577 persons in 2003, corresponding to an average annual increase in dialysis initiation of 9.8%. After we accounted for population growth, the rate of dialysis initiation increased by 57% (rate ratio, 1.57 [95% CI, 1.53 to 1.62]) between 1996 and 2003. One-year mortality for octogenarians and nonagenarians after dialysis initiation was 46%. Compared with octogenarians and nonagenarians initiating dialysis in 1996, those starting dialysis in 2003 had a higher glomerular filtration rate and less morbidity related to chronic kidney disease but no difference in 1-year survival. Clinical characteristics strongly associated with death were older age, nonambulatory status, and more comorbid conditions.

Limitations: Survival of patients with incident ESRD who did not begin dialysis could not be assessed.

Conclusions: The number of octogenarians and nonagenarians initiating dialysis has increased considerably over the past decade, while overall survival for patients on dialysis remains modest. Estimates of prognosis based on patient characteristics, when considered in conjunction with individual values and preferences, may aid in dialysis decision making for the very elderly.

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For author affiliations, see end of text.

The elderly constitute a substantial and growing fraction of the end-stage renal disease (ESRD) population. Data from the U.S. Renal Data System (USRDS) indicate that incidence rates of ESRD are no longer rising among persons younger than 65 years of age but have continued to increase among those 65 years of age and older (1). Researchers have speculated that more liberal acceptance of the very elderly (≥80 years) into dialysis programs has contributed to the increase in patients with ESRD (2, 3), yet little is known about how patient characteristics and incidence rates have changed over time in this population. The very elderly have a high prevalence of comorbid conditions, including dementia and disability, leading to some controversy about the appropriateness of dialysis initiation in these patients. Nonetheless, outcomes of the very elderly who are treated with dialysis have not been rigorously examined at a national level. Previous studies devoted to the very elderly with ESRD were single-center series. Most were of international ESRD populations with few minority patients, and several studies pooled data from different eras—during which time dialysis practices changed considerably (4–10).

We examined the epidemiology and outcomes of octogenarians and nonagenarians starting dialysis in the United States. Our goals were to describe recent trends in dialysis initiation and to describe differences in patient characteristics and outcomes over time.

METHODS

Analytic Cohort

We used data from the USRDS Standard Analysis Files from 1996 through 2003 for these analyses. The USRDS contains data on more than 99% of persons starting dialysis in the United States. We included all persons 65 years of age and older who began dialysis between 1 January 1996 and 31 December 2003 in the analytic cohort (n = 350 831). We followed patients until death or until 31 December 2004 to allow for at least 1 year of follow-up. The focus of these analyses was the very elderly; however, we included patients 65 to 79 years of age (the "young" elderly) in the analyses as a reference group. We excluded patients initiating dialysis after a failed kidney transplantation (n = 4693) because they may differ from patients with true incident ESRD in duration of kidney disease, timing of dialysis initiation, propensity to start (or return) to dialysis, and several other potential confounding factors. We also excluded 6 patients with missing demo-

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Conversion of figures and tables into slides

Context

Numbers of very elderly persons starting dialysis are increasing in the United States.

Contribution

This study, using national registry data of patients with end-stage renal disease, showed that octogenarians and nonagenarians starting dialysis increased from 7054 persons in 1996 to 13 577 persons in 2003. Patients starting dialysis in 2003 had higher estimated glomerular filtration rates and less morbidity related to chronic kidney disease, but no difference in 1-year mortality rate (approximately 50%), compared with those starting dialysis in 1996. Older age, nonambulatory status, and more comorbid conditions were strongly associated with an increased risk for death.

Implications

Increasing numbers of the very elderly are receiving dialysis, while overall survival remains low.

—The Editors

graphic data, leaving 346 132 persons in the analytic cohort. Because the current analyses used existing data without any patient identifiers, it received exempt certification from the University of California, San Francisco, Institutional Review Board, San Francisco, California.

Covariates

We obtained information or demographic characteristics, and comorbid conditions and selected laboratory data at the time of dialysis initiation from the Centers for Medicare & Medicaid Services (CMS) medical evidence form (CMS form 2728), which is typically completed by the attending nephrologist or other designated dialysis personnel. We analyzed age in 5-year increments (for example, 80 to 84 years, 85 to 89 years, and 90 years or more), except in the calculation of incidence rates because U.S. Census estimates are organized into 2 categories of persons older than age 80 years (80 to 84 years and 85 years or more). We categorized race as white, black, and other; the last category included Asians, Pacific Islanders, American Indians, and Alaskan Natives. We defined nonambulatory status as the inability to walk or the inability to transfer, underweight as a body mass index (BMI) less than 18.5 kg/m^2 (11), anemia as a hemoglobin concentration less than 100 g/L, and low serum albumin concentration as an albumin level less than 35 g/L. We calculated estimated glomerular filtration rate (GFR) at dialysis initiation by using the Modification of Diet in Renal Disease equation, incorporating age, sex, race, and serum creatinine concentration (12).

Statistical Analysis

We compared baseline characteristics over time by using analysis of variance for continuous variables and the chi-square test for categorical variables. We tabulated counts of patients starting dialysis and calculated the average annual increase in dialysis initiation by age group and compared this with the corresponding average annual increase in the U.S. population. We determined the unadjusted incidence of dialysis initiation within each age group by using census estimates based on counts from the bridged race dataset of the 2000 U.S. Census report from the U.S. Centers for Disease Control and Prevention for the denominator population (13). We modeled sex- and race-adjusted incidence rates and 95% CIs by using Poisson regression methods. We used similar methods to determine the relative risk, or rate ratio, of starting dialysis in 2003 versus in 1996. Survival curves as a function of clinical characteristics at the start of dialysis were computed by using Kaplan–Meier methods. We also used Cox proportional hazards models to examine the association of clinical characteristics with death. As a complementary approach, we determined the risk for death associated with the number rather than the type of comorbid condition. For the count of comorbid conditions, we included all conditions measured on the CMS medical evidence form that were statistically significantly associated with an increased risk for death in adjusted models.

Role of the Funding Sources

The funding sources had no role in the collection, analysis, or interpretation of the data or in the decision to submit this manuscript for publication. The authors had full access to the data for the study.

RESULTS

Trends in Dialysis Initiation among Octogenarians and Nonagenarians

Clinical characteristics of octogenarians and nonagenarians initiating dialysis from 1996 through 2003 are shown in Table 1. The adjusted mean estimated GFR at dialysis initiation and the percentage of patients initiating dialysis with an estimated GFR 15 mL/min per 1.73 m^2 or more (before stage 5 chronic kidney disease) increased over time. In parallel with the trend of dialysis initiation at a higher estimated GFR, most morbidity related to chronic kidney disease, such as anemia, underweight, and congestive heart failure, declined over time, as did the fraction of patients with 4 or more comorbid conditions. The prevalence of low serum albumin and nonchronic kidney disease–related morbidity remained stable or grew slightly over time.

Between 1996 and 2003, 78 419 octogenarians and 5577 nonagenarians initiated dialysis in the United States. The number of octogenarians and nonagenarians starting dialysis increased from 7054 persons in 1996 to 13 577 persons in 2003, corresponding to an average annual increase in dialysis initiation of 8.6% among those 80 to 84 years of age and 11.9% among those 85 years of age and older. The corresponding average annual increase in the

Table 1. **Change in Patient Characteristics at Dialysis Initiation among Octogenarians and Nonagenarians from 1996 to 2003***

Characteristic	1996–1997 (n = 15 206)	1998–1999 (n = 19 349)	2000–2001 (n = 22 599)	2002–2003 (n = 26 842)	P Value for Trend
Mean age (SD), y	84.0 (3.2)	84.2 (3.3)	84.3 (3.4)	84.3 (3.4)	<0.001
Female, %	49	48	49	48	0.03
Ethnicity, %					<0.001
White	77	79	78	80	
Black	19	17	18	16	
Other	4	4	4	4	
Mean estimated GFR (SD), *mL/min per 1.73 m²*	8.3 (3.7)	9.2 (4.3)	9.9 (4.8)	10.5 (4.9)	<0.001
Estimated GFR ≥15 mL/min per 1.73 m², %	5	8	12	15	<0.001
Anemia, %	59	53	48	44	<0.001
Congestive heart failure, %	48	46	45	44	<0.001
Underweight, %	21	16	9	8	<0.001
Serum albumin concentration < 35 g/L, %	72	76	77	76	<0.001
Nonambulatory, %	8	7	7	7	0.001
Diabetes, %	26	28	31	34	<0.001
Ischemic heart disease, %	34	35	36	36	<0.001
Chronic obstructive pulmonary disease, %	10	10	10	11	0.001
Cancer, %	8	9	10	10	<0.001
Peripheral vascular disease, %	17	17	17	18	0.76
Cerebrovascular disease, %	12	12	12	12	0.81
≥4 comorbid conditions, %	36	35	34	34	<0.001

* GFR = glomerular filtration rate.

U.S. population was 2.3% among those 80 to 84 years of age and 3.2% among those 85 years of age and older. For comparison, the average annual increase in dialysis initiation among patients 65 to 79 years of age was only 3.5%, while the U.S. population of persons 65 to 79 years of age did not substantially increase during this period.

Rates of dialysis initiation increased with age, peaking between age 75 and 84 years, and increased over time for each elderly age group (Figure 1). For persons older than 84 years of age, rates of dialysis initiation were dramatically lower than other elderly age groups; this effect persisted over time. After we accounted for population growth, rates of dialysis initiation increased by 57% (rate ratio, 1.57 [95% CI, 1.53 to 1.62]) among octogenarians and nonagenarians from 1996 to 2003 (Table 2). The rate of growth was similar among age and sex subgroups and among black and white patients. Rates of dialysis initiation declined slightly among other ethnic groups; however, these results should be interpreted with caution because of the relatively small number of nonblack and nonwhite patients in the study.

Survival of Octogenarians and Nonagenarians Starting Dialysis

The 1-year mortality rate for octogenarians and nonagenarians starting dialysis was 46% and did not materially change over the 7-year period. Median survival after dialysis initiation was 24.9 months (interquartile range, 8.3 to 51.8 months) for patients 65 to 79 years of age; 15.6 months (interquartile range; 4.8 to 35.5 months) for patients 80 to 84 years of age; 11.6 months (interquartile range, 3.7 to 28.5 months) for patients 85 to 89 years of age; and 8.4 months (interquartile range, 2.8 to 21.3 months) for patients 90 years of age or older. Similar to younger patients with ESRD, survival for octogenarians and nonagenarians starting dialysis was substantially lower than that of the age-matched general population. For example, the average life expectancy in the general population for persons 80 to 84 years of age is 105 months (89 months longer than that for patients 80 to 84 years of age who are starting dialysis), 78 months for persons 85 to 89 years of age (66 months longer than that for patients 85 to 89 years of age who are starting dialysis), and 57 months for persons 90 to 94 years of age (48 months longer than that for patients 90 years of age or older who are starting dialysis) (14).

Figure 2 shows survival after dialysis initiation by age and selected clinical characteristics. After adjustment for several demographic and clinical characteristics, older age

Figure 1. **Incidence of dialysis initiation from 1996 to 2003 by year and age group (per 100 000 persons in U.S. population), adjusted for sex and race.**

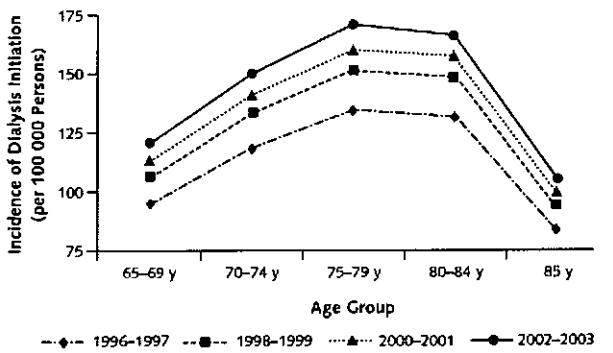

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Table 2. Incidence of Dialysis Initiation (per 100 000 Persons) among Octogenarians and Nonagenarians in 1996 and 2003 and Rate Ratio of Dialysis Initiation in 2003 versus 1996

Characteristic	1996			2003			2003 vs. 1996
	Persons Starting Dialysis, *n*	U.S. Population, *n*	Incidence of Dialysis Initiation (per 100 000 Persons)	Persons Starting Dialysis, *n*	U.S. Population, *n*	Incidence of Dialysis Initiation (per 100 000 Persons)	Rate Ratio (95% CI)
Overall	7054	8 414 873	84	13 577	10 134 662	134	1.57 (1.53–1.62)
Age							
80–84 y	4842	4 619 981	105	8716	5 416 415	161	1.50 (1.45–1.56)
≥85 y	2212	3 794 892	58	4861	4 718 247	103	1.72 (1.64–1.81)
Sex							
Male	3617	2 724 372	133	7110	3 498 567	203	1.54 (1.48–1.60)
Female	3437	5 690 501	60	6467	6 636 095	97	1.61 (1.54–1.67)
Ethnicity							
White	5458	7 652 210	71	10 838	9 135 456	119	1.64 (1.59–1.70)
Black	1293	618 045	209	2248	736 970	305	1.45 (1.36–1.56)
Other	303	144 618	210	491	262 236	187	0.90 (0.78–1.04)

remained strongly associated with an increased risk for death. The risk for death was 22% higher for patients 85 to 89 years of age (relative risk, 1.22 [CI, 1.20 to 1.24]) and was 56% higher for those 90 years of age or older (relative risk, 1.56 [CI, 1.51 to 1.61]) compared with patients 80 to 84 years of age. Among associated clinical characteristics, nonambulatory status (relative risk, 1.54 [CI, 1.49 to 1.58]), serum albumin concentration less than <35 g/L (relative risk, 1.28 [CI, 1.25 to 1.30]), congestive heart failure (relative risk, 1.21 [CI, 1.19 to 1.23]), and underweight (relative risk, 1.20 [CI, 1.18 to 1.23]) were most strongly associated with death. The number of comorbid conditions was also associated with death (comorbid conditions listed in Table 1 were included in the count). Compared with patients with 0 or 1 comorbid conditions, those with 2 to 3 comorbid conditions had a 31% increased risk for death (relative risk, 1.31 [CI, 1.28 to 1.33]), and those with 4 or more had a 68% increased risk for death (relative risk, 1.68 [CI, 1.64 to 1.72]).

Discussion

In this population-based study of patients with incident ESRD, we identified many important trends among the very elderly. Dialysis initiation among octogenarians and nonagenarians increased dramatically from 1996 to 2003, translating to a near doubling of the number of patients with incident ESRD who are older than 80 years of age. We observed this increase in dialysis initiation across most demographic subgroups, and it was approximately similar among men and women and among white and black patients. Survival after dialysis initiation was often poor among octogenarians and nonagenarians and was substantially lower than that of the age-matched population, as only 54% of the cohort was alive at 1 year. In addition to age, clinical characteristics, including nonambulatory status and the number of comorbid conditions, were associated with very high mortality rates after dialysis initiation.

Researchers have proposed several hypotheses to explain the growth in ESRD incidence in the United States, including an increase in chronic kidney disease prevalence, earlier initiation of dialysis, and more liberal acceptance into dialysis programs (2,3, 15, 16). Muntner and colleagues (2) examined the extent to which population growth, increasing diabetes prevalence, and improved survival after myocardial infarction and stroke explained the increase in new ESRD cases. They found that, in aggregate, these factors explained less than 50% of the observed increase in new ESRD cases from 1978 to 1991. In this study, similar results were seen in the subgroup of patients 75 years of age and older. Hsu and colleagues (15) concluded that the increase in new ESRD cases was not explained by an increased prevalence of chronic kidney disease, although their study did not include individuals 80 years of age and older. Of note, neither of these studies included data from the past decade.

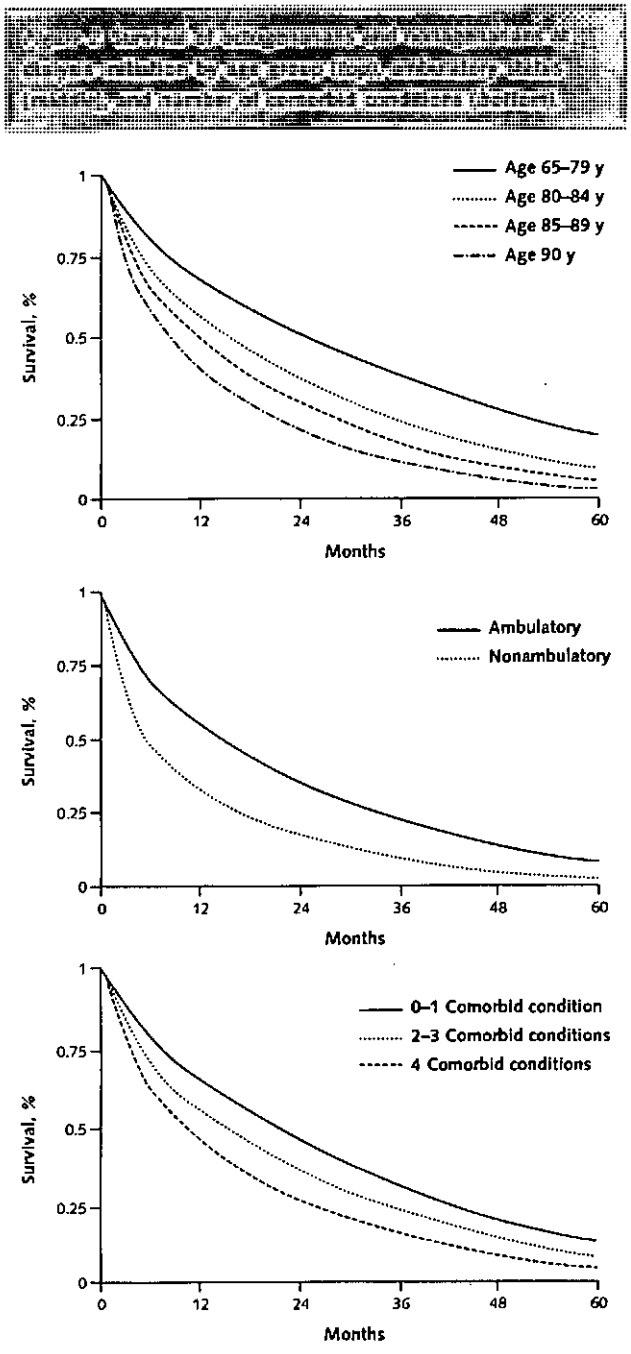
One would expect dialysis initiation at a higher estimated GFR to lead to a temporary increase in incidence rates (lead-time bias) as well as a permanent increase in incidence rates (length-time bias) because those who would otherwise have died from competing causes would now be counted as new ESRD cases (16). The latter effect, although difficult to quantify, may be particularly important among the very elderly for whom competing mortality risks are especially high. Researchers have also postulated that more liberal acceptance of the very elderly into dialysis programs and improved access to dialysis services, particularly in rural areas, contribute to the increase in the number of very elderly persons treated with dialysis. These effects are difficult to quantify and may be confounded by

the concurrent trend of dialysis initiation at a higher estimated GFR, improved predialysis care, or both.

Because it seems implausible that physiologic or "true" rates of ESRD could increase by 57% in just 7 years, these data together with those from previous studies suggest that dialysis initiation at a higher estimated GFR, more liberal admittance to dialysis programs, or both have played an important role in the recent increase in the number of elderly persons starting dialysis.

Congestive heart failure and malnutrition are frequently cited reasons for dialysis initiation at a higher GFR, particularly among elderly patients. Thus, it is somewhat surprising that while the frequency of dialysis initiation at a higher estimated GFR tripled over 7 years, the prevalence of low serum albumin concentration increased only modestly and the prevalence of congestive heart failure and underweight declined. These results suggest that dialysis initiation among the elderly is being driven by unmeasured factors or that clinicians may be using a preemptive approach to dialysis initiation in this population. Observational studies (17–19) of the timing of dialysis initiation have produced conflicting results about the benefits of early dialysis initiation (estimated GFR, approximately 10 to 14 mL/min per 1.73 m^2) versus late dialysis initiation (estimated GFR, approximately 5 to 8 mL/min per 1.73 m^2), partly because of confounding of estimated GFR by nutritional status, inadequate adjustment for comorbid conditions, and the effects of lead-time bias and survival bias. To our knowledge, there have been no published, randomized trials on the timing of dialysis initiation, although an international trial is currently in progress (20). Because the optimal timing for dialysis initiation has not been defined and because it is not clear that dialysis extends life for all elderly patients who reach ESRD, a strategy of dialysis initiation at a higher estimated GFR may result in growth of the ESRD population without accompanying increases in individual patient survival.

Regardless of the exact causes, the dramatic increase in dialysis initiation among octogenarians and nonagenarians has important implications for researchers, health care providers, and policymakers. Most current practice guidelines were derived from studies of younger patients; thus, their applicability to the very elderly is unclear. For example, the optimal management of renal osteodystrophy, modality of dialysis, and timing and type of vascular access placement in elderly patients remain unclear. As the population of very elderly dialysis patients grows, nephrologists must become more adept at addressing geriatric problems, such as dementia, falls, and depression, and the social and ethical challenges posed by the elderly. In general, the very elderly use far more health care resources and require more social support; and although explicit rationing does not exist in most developed nations, subtle social and financial pressures may lead to implicit dialysis rationing among the very elderly. The decline in treated incidence of ESRD for patients 85 years of age and older suggests some withholding



In the bottom panel, comorbid conditions include albumin concentration <35 g/L, anemia, underweight, congestive heart failure, diabetes, ischemic heart disease, chronic obstructive pulmonary disease, cancer, cerebrovascular disease, and peripheral vascular disease.

of dialysis therapy among the very elderly because other factors contributing to progressive chronic kidney disease would not be expected to stop as patients advance into the ninth decade.

Survival rates for octogenarians and nonagenarians starting dialysis in the United States are substantially lower than those previously reported (7–10). Median survival was less than 16 months for patients 80 to 84 years of age

and less than 12 months for patients 85 years of age or older. Several points are notable about these survival estimates. First, octogenarians and nonagenarians initiating dialysis are highly selected and probably represent a healthier group than the entire population of patients with ESRD, many of whom are not offered dialysis care. Second, our data report median survival from dialysis initiation and not the median *increase* in survival after dialysis initiation because the USRDS does not collect data on patients from whom dialysis was withheld. Observational data suggest that survival of elderly patients starting dialysis is 2 to 20 months longer than that of elderly persons patients from whom dialysis is withheld (10, 21, 22). Although such comparisons are inherently limited by differences in patient characteristics, these studies together with our findings emphasize the importance of distinguishing elderly persons who have ESRD that is going to be substantially life-shortening and may have increased survival with dialysis from those in whom the presence of ESRD is really a reflection of underlying multiorgan system dysfunction and whose illness may be better managed by a palliative approach.

In conjunction with the American Society of Nephrology, the Renal Physicians Association has issued guidelines that advocate for clear communication of prognosis and a time-limited trial of dialysis in patients for whom prognosis remains unclear (23). The findings of our study should serve as a guide for patients and clinicians deciding whether to initiate dialysis. Estimates of life expectancy are crucial for determining the relative benefits of therapy but should be interpreted in the context of other important factors, including patient preferences and expected quality of life. The decision-making process should begin early, and should be made on an individual basis. Timely discussion of these issues by primary care physicians, nephrologists, and other health care providers may allow elderly patients and their caregivers to address long-term care needs, advance directives, and treatment preferences well before the need for dialysis becomes imminent.

Our study has several strengths. We used contemporary data from a national database of patients with ESRD that has a more than 99% ascertainment of incident ESRD cases, and we controlled for many comorbid conditions. Thus, our findings are broadly generalizable to the U.S. population with ESRD. Nonetheless, our study has several important limitations. First, we did not have data on patients with incident ESRD who did not begin dialysis. Estimates of life expectancy in these patients would provide a more complete picture of the mortality associated with ESRD in the very elderly. Second, comorbid conditions may have been misclassified or underascertained on the basis of data reported on the CMS medical evidence form. Longenecker and colleagues (24) reported that the sensitivity of the form ranged from 23% to 75%, whereas specificity was generally more than 90% for the comorbid conditions included in our analyses (24). Misclassification of comorbid conditions would tend to reduce the discrimination of prediction but would not affect our estimates of life expectancy. Third, the Modification of Diet in Renal Disease equation used to estimate GFR may underestimate kidney function among the elderly, although we do not believe that the degree of misclassification would have changed substantially over time. Finally, although we considered nonambulatory status, we lacked more granular information on functional status and had no data on cognitive function, which are important determinants of mortality and morbidity among the very elderly (25).

The number of octogenarians and nonagenarians initiating dialysis has dramatically increased in the past decade. Although dialysis may increase life expectancy for selected octogenarians and nonagenarians, overall survival times remain modest. When considering dialysis initiation among the elderly, decision making should be individualized and realistic estimates of survival should be considered along with expected quality of life and the patient's values. Given the increase of very elderly patients with ESRD and the attendant morbidity, mortality, and costs, research priorities should include determining the reasons for the increasing incidence and development of risk stratification indices to aid in dialysis decision making. In the meantime, efforts to delay or prevent ESRD among the very elderly seem warranted.

From the University of California, San Francisco, and the San Francisco Veterans Affairs Medical Center, San Francisco, California, and the United States Renal Data System, Minneapolis, Minnesota.

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References

1. Collins AJ, Kasiske B, Herzog C, Chavers B, Foley R, Gilbertson D, et al. Excerpts from the United States Renal Data System 2004 annual data report: atlas of end-stage renal disease in the United States. Am J Kidney Dis. 2005;45: A5-7. [PMID: 15640975]
2. Muntner P, Coresh J, Powe NR, Klag MJ. The contribution of increased diabetes prevalence and improved myocardial infarction and stroke survival to the increase in treated end-stage renal disease. J Am Soc Nephrol. 2003;14:1568-77. [PMID: 12761257]
3. Port FK. The end-stage renal disease program: trends over the past 18 years. Am J Kidney Dis. 1992;20:3-7. [PMID: 1626554]
4. Chester AC, Rakowski TA, Argy WP Jr, Giacalone A, Schreiner GE. Hemodialysis in the eighth and ninth decades of life. Arch Intern Med. 1979;139: 1001-5. [PMID: 475517]
5. Vandelli L, Medici G, Perrone S, Lusvarghi E. Haemodialysis therapy in the elderly. Nephrol Dial Transplant. 1996;11 Suppl 9:89-94. [PMID: 9050041]
6. Röhrich B, Asmus G, von Herrath D, Schaefer K. Is it worth performing kidney replacement therapy on patients over 80? Nephrol Dial Transplant. 1996; 11:2412-3. [PMID: 9017613]
7. Lamping DL, Constantinovici N, Roderick P, Normand C, Henderson L, Harris S, et al. Clinical outcomes, quality of life, and costs in the North Thames Dialysis Study of elderly people on dialysis: a prospective cohort study. Lancet. 2000;356:1543-50. [PMID: 11075766]
8. Peri UN, Fenves AZ, Middleton JP. Improving survival of octogenarian patients selected for haemodialysis. Nephrol Dial Transplant. 2001;16:2201-6. [PMID: 11682668]
9. Munshi SK, Vijayakumar N, Taub NA, Bhullar H, Lo TC, Warwick G. Outcome of renal replacement therapy in the very elderly. Nephrol Dial Transplant. 2001;16:128-33. [PMID: 11209006]
10. Joly D, Anglicheau D, Alberti C, Nguyen AT, Touam M, Grünfeld JP, et al. Octogenarians reaching end-stage renal disease: cohort study of decision-making and clinical outcomes. J Am Soc Nephrol. 2003;14:1012-21. [PMID: 12660336]
11. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults—The Evidence Report. National Institutes of Health. Obes Res. 1998;6 Suppl 2:51S-209S. [PMID: 9813653]
12. Levey AS, Bosch JP, Lewis JB, Greene T, Rogers N, Roth D. A more accurate method to estimate glomerular filtration rate from serum creatinine: a new prediction equation. Modification of Diet in Renal Disease Study Group. Ann Intern Med. 1999;130:461-70. [PMID: 10075613]
13. Center for Disease Control and Prevention. National Center for Health Statistics (NCHS) Bridged-Race Estimates. Accessed at http://wonder.cdc.gov/population.html on 4 December 2006.
14. Arias E. United States life tables, 2002. Natl Vital Stat Rep. 2004;53:1-38. [PMID: 15580947]
15. Hsu CY, Vittinghoff E, Lin F, Shlipak MG. The incidence of end-stage renal disease is increasing faster than the prevalence of chronic renal insufficiency. Ann Intern Med. 2004;141:95-101. [PMID: 15262664]
16. McDonald S, McCredie M, Williams S, Stewart J. Factors influencing reported rates of treated end-stage renal disease. Adv Chronic Kidney Dis. 2005; 12:32-8. [PMID: 15719331]
17. Beddhu S, Samore MH, Roberts MS, Stoddard GJ, Ramkumar N, Pappas LM, et al. Impact of timing of initiation of dialysis on mortality. J Am Soc Nephrol. 2003;14:2305-12. [PMID: 12937307]
18. Korevaar JC, Jansen MA, Dekker FW, Jager KJ, Boeschoten EW, Krediet RT, et al. When to initiate dialysis: effect of proposed US guidelines on survival. Lancet. 2001;358:1046-50. [PMID: 11589934]
19. Traynor JP, Simpson K, Geddes CC, Deighan CJ, Fox JG. Early initiation of dialysis fails to prolong survival in patients with end-stage renal failure. J Am Soc Nephrol. 2002;13:2125-32. [PMID: 12138145]
20. Cooper BA, Branley P, Bulfone L, Collins JF, Craig JC, Dempster J, et al. The Initiating Dialysis Early and Late (IDEAL) study: study rationale and design. Perit Dial Int. 2004;24:176-81. [PMID: 15119639]
21. Burns A, Johnston S, Juszczak M, Powis S. Comparison of survival in elderly patients with end stage renal failure treated in a maximal conservative (no dialysis) programme compared with matched patients undergoing dialysis [Abstract]. Presented at the American Society of Nephrology's Renal Week 2005, Philadelphia, Pennsylvania, 8-13 November 2005. Abstract no. F-PO776.
22. Smith C, Da Silva-Gane M, Chandna S, Warwicker P, Greenwood R, Farrington K. Choosing not to dialyse: evaluation of planned non-dialytic management in a cohort of patients with end-stage renal failure. Nephron Clin Pract. 2003;95:c40-6. [PMID: 14610329]
23. Moss AH. Shared decision-making in dialysis: the new RPA/ASN guideline on appropriate initiation and withdrawal of treatment. Am J Kidney Dis. 2001; 37:1081-91. [PMID: 11325693]
24. Longenecker JC, Coresh J, Klag MJ, Levey AS, Martin AA, Fink NE, et al. Validation of comorbid conditions on the end-stage renal disease medical evidence report: the CHOICE study. Choices for Healthy Outcomes in Caring for ESRD. J Am Soc Nephrol. 2000;11:520-9. [PMID: 10703676]
25. Lee SJ, Lindquist K, Segal MR, Covinsky KE. Development and validation of a prognostic index for 4-year mortality in older adults. JAMA. 2006;295: 801-8. [PMID: 16478903]

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REVIEW ARTICLE

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A critical evaluation of the effects of socioeconomic status on kidney disease

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ABSTRACT

Socioeconomic status is known to impact on health outcomes in a number of different dimensions. Kidney disease outcomes are less frequent, and thus the relationship between chronic kidney disease (CKD), end-stage renal disease (ESRD) and socioeconomic status has been less well studied than other health outcomes. The current analysis systematically reviews the literature so as to describe the current knowledge state regarding the relationship between kidney disease and socioeconomic status (SES).

Methods: A search of two electronic databases (Medline 1950-April2008; EMBASE 1980-April2008) and the web based search engine Google Scholar identified 13 studies that met inclusion criteria. Seven studies looked at incidence of ESRD as the outcome of interest and all seven found an association between low SES and increased incidence of ESRD. Four studies looked at CKD as the outcome of interest, 2 examined prevalence and 2 examined progression.

Results: Despite the paucity of literature in this area, all 4 studies looking at the outcome of CKD demonstrate an inverse relationship between SES and CKD, supporting a significant association between low SES and kidney disease. However, the potential causal pathways are poorly explored. Given the prevalence of CKD in the population, the increasing understanding of CKD as a risk factor for a variety of other co-morbidities and mortality, and the findings of these studies, we recommend further research on understanding mechanisms by which SES impacts on CKD incidence, prevalence and progression.

Key-Words:
Chronic kidney disease; dialysis; progression; socioeconomic status; systematic review.

INTRODUCTION

Over the past 30 years, chronic kidney disease (CKD) and end-stage renal disease (ESRD) have become an epidemic. In Canada, the number of patients being treated for ESRD has increased 20% from 1997-2001 (13 per 100,000 to 16 per 100,000)[1]. The most common single cause of ESRD remains diabetes, representing 33% of new ESRD patients[1]. A diagnosis of ESRD not only portends a dismal prognosis for the patient if not transplanted (50% mortality at 5 years)[2], it also carries significant economic burden, estimated at $1.9 billion dollars per year in Canada in a recent study[3].

These profound costs to the patient and society have prompted the investigation of kidney dysfunction at an earlier stage. An estimated 600,000 people in Canada may have CKD[1], and recent attention has

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focused on preventing the onset and delaying the progression of this disease. Attention has turned to identifying and modifying risk factors such as diabetes and hypertension that contribute to both the development and progression of CKD.

Socioeconomic status (SES) has been identified as an important determinant of health and lower SES is associated with premature death[4-6]. The term SES encompasses more than just income or poverty; it represents an individual's social and economic standing or rank in a social group. There are several ways to measure SES, including income, education, occupation, location of residence and housing. Often a composite of several measures is used to determine a rank. SES may be measured at the individual or the area level, the latter providing further insights into the role of the socioeconomic environment that the individual lives in.

In most cases, kidney disease is a chronic, progressive condition that develops over a long period of time. Figure 1 describes a possible framework in which to link SES and kidney disease through a multitude of pathways. While traditionally SES is linked to many risk factors for diseases that cause or worsen kidney disease such as obesity[7] and smoking[7,8], it is becoming more evident that the relationship between social conditions and health is more than simply a proxy for these risk factors. Numerous authors and key thought leaders have been interested in describing and ensuring adequate focus on SES in clinical and health delivery research. As articulated by Link *et al.*[9] social conditions should be viewed as "fundamental causes of disease" and scientists should be urged to search for the "factors that put people at risk of risks"[9].

Most studies of the relationship between SES and kidney disease have focused on patients with ESRD, or dialysis dependent CKD. Individuals with lower SES appear to be at greater risk of ESRD when measured at both the individual and the area SES level[10-13]. These studies could not determine whether this finding was due to an increased incidence of the most common diseases that cause ESRD (diabetes or hypertension, which also track with low SES)[14,15] or represented an independent association.

Fewer studies have looked at the relationship between SES and CKD, before the progression to ESRD. As focus on determinants of progression increases, it is important to analyze this relationship more rigorously, as the focus on delaying progression may be impacted by this understanding. A recent study by Merkin *et al.*[16], examined the association of progressive CKD with area level SES, and found a strong association between low SES and progression of kidney disease. Of note,

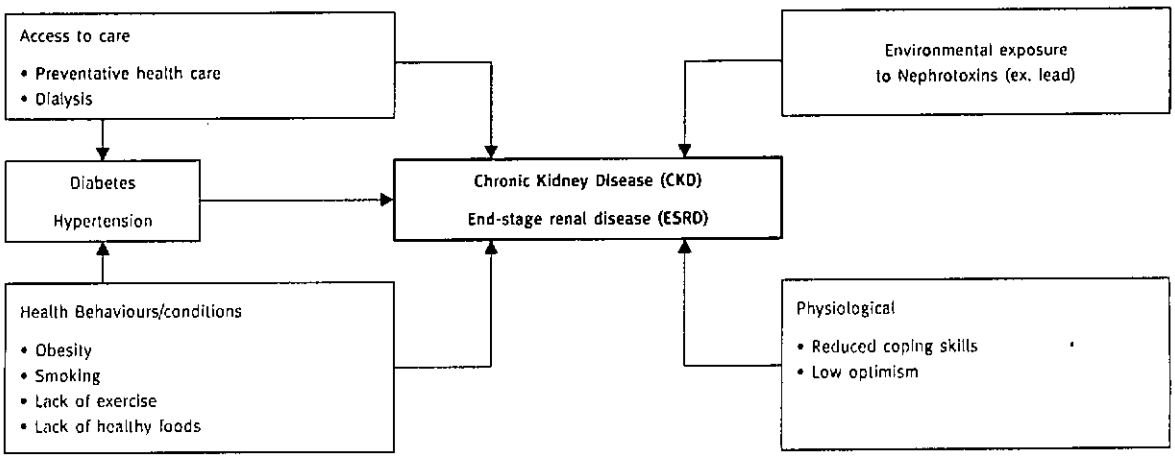

Figure 1

Possible relationship between SES and Kidney Disease

the study examined Caucasian middle aged males only.

This review offers a systematic evaluation of the current literature with respect to the relationship of SES and kidney disease. The objectives of this review are:

1. To examine the links between socioeconomic status and the incidence of CKD, including ESRD.

2. To examine the effect of socioeconomic status on the progression of kidney disease.

Although important, the relationship between socioeconomic status and access to (or outcomes after) renal transplantation is beyond the scope of this review but has been addressed extensively in recent publications[17,18].

METHODS

A systematic search of the literature was conducted to identify studies that evaluated:

a) The relationship between SES and the incidence of CKD (including ESRD).

b) The relationship between SES and progression of kidney disease.

Search Strategies

Two electronic databases (MEDLINE 1950-April 2008, and EMBASE 1980-April 2008) and one Web search engine (Google Scholar) were searched by one author (MB). The search terms for the exposure of interest included socioeconomic status; poverty; social class; occupation; education. The search terms for the outcome of interest included kidney; renal; hemodialysis; haemodialysis; predialysis; uremia; creatinine; kidney function tests; chronic kidney disease.

Articles published through April 2008 were considered. No language restrictions were placed. Reference lists of the articles retrieved as full text were also reviewed to identify if there were any gaps.

Inclusion/Exclusion criteria

Studies were included if they assessed the effects of SES on CKD/ESRD incidence or kidney function for all primary kidney diseases (including diabetes, Systemic Lupus Erythematosis (SLE), polycystic kidney disease (PCKD), hypertensive kidney disease). Studies that did not report the etiology of the kidney disease were still included in the analysis. No age restriction was placed.

Studies were excluded if they:

1. Examined the relationship between SES and hypertension or diabetes without mention of kidney disease

2. Assessed the relationship between SES and (a) access to kidney transplantation or outcomes of kidney transplantation, (b) renal cancers.

3. Assessed the relationship between SES and SLE severity including outcome measures other than kidney function or with kidney function included in a composite outcome.

Measures of individual level and area level SES were included. Measures of occupation, education and social class were included as long as specific definitions of these exposures were given in the study.

Cohort studies and case-control studies were included. Case-control studies were excluded if there was evidence of bias in control group selection or if exposure data was not available for >80% of cases and controls.

Scoring system

As the objective of this review was to examine the links between socioeconomic status and (1) the incidence of ESRD and (2) the incidence and progression of CKD, the following scoring system was used:

- Highest (Level A) – Cohort studies with population based design (i.e. not based on a convenience sample such as a clinic group or occupational cohort) to minimize selection bias. Outcome measure ESRD or CKD as identified by

well-defined criteria (defined serum creatinine measurement on more that one occasion).

- Moderate (Level B) – Cohort or Case-control studies with convenience sampling. Outcome measure ESRD or CKD as identified by well-defined criteria (defined serum creatinine measurement on more that one occasion). All other inclusion criteria met.

- Lowest (Level C) – Cohort or Case-control study with population based design or convenience sampling and outcome measure relied upon was an intermediate marker of kidney disease (such as proteinuria).

All studies were classified as Level A, B or C and the results of the individual studies found in the review were weighted according to their study classification.

Evaluation process

Once identified, the titles and abstracts of all studies identified by electronic searching were examined. Full papers were obtained for those studies that were thought to potentially meet the inclusion criteria.

Studies were grouped into those that evaluated (1) the relationship between SES and the incidence of ESRD and (2) the relationship between SES and the incidence and progression of CKD.

RESULTS

Search Results

A total of 190 studies were identified in the initial search. The titles and abstracts of these studies were examined. A total of 24 full papers that were thought to potentially meet inclusion criteria were retrieved and reviewed. This included 10 prospective, 8 retrospective and 6 case-control studies. Eleven studies were excluded: – 6 studies reported their outcome of interest as lupus progression (not kidney disease related to lupus), 3 studies did not define the method of measuring socioeconomic status, and 2 studies included deaths from renal cancers in their composite outcome measure of death from kidney disease. A summary of the results of the thirteen studies included in this report[10,11,19-28] is presented in Table I, arranged by study design and date of publication. This includes three prospective cohort[16,19,20], eight retrospective cohort[11,21-27], and two case-control studies[10,28].

Study settings, populations

The included studies were published between 1994 and 2008. All studies were conducted in the United States (12 studies, n = 1,237,648) except one study that was conducted in New Zealand[22] (n = 5013). All studies found a relationship between lower SES and risk of kidney disease, with two studies showing an effect in some groups but not others. In one study[27], a strong association between lower SES was found for kidney disease due to diabetes, but not for kidney disease due to polycystic kidney disease. In another study[28], the development of albuminuria (a marker of kidney damage) was related to lower household income but not education.

African Americans (AAs) have an increased incidence of CKD and ESRD compared to Caucasians[19]. Five of the studies were designed to evaluate the role that SES plays in explaining the increased incidence of kidney disease in AAs[10,11,19,24,26]. In all five studies, some of the excess risk for AAs could be explained by lower SES, but nearly half of the excess risk still remained unexplained.

Two studies specifically addressed patients over 65 years of age[20,24]. One study[20] examined the incidence of progressive CKD (pCKD) and found that elderly people living in the lowest SES areas experienced a 40% greater risk of pCKD compared to those living in the highest SES areas, even after accounting for individual level SES. The second study[24] included AA seniors and also noted an increased prevalence of kidney dysfunction in low-income (compared to high income) seniors (OR 3.2; 95% CI 1.1-9.4).

Definition and Measurement of SES

All studies used income in either their measure of SES, either alone[10,11,19,21,23,24,28] or in a composite

Table I

Summary of Included Studies

Study/Year of Publication/ Country	Type of Study	Number of People	Age Range/ Data Collection timeline/ Renal diagnosis	SES Criteria	Measure of kidney function	Relationship between SES and kidney function	Rank of Evidence
Tarver-Carr[19], 2002, United States	Prospective cohort	9,082 (90% Caucasian, 10% AA)	30-74 years 1976-1992 Renal diagnosis not specified	Poverty Income ratio (poor, near poor, not poor)	Incidence of ESRD or Death related to kidney disease	Incidence of ESRD 2.7 times higher among AA, adjusting for SES decreased RR to 2.49 (explaining 12% of excess risk)	Level A
Merkin[16], 2005, United States	Prospective cohort	12,856	45-64 years 1987-89 Renal diagnosis not specified	Area level SES (measures of income, wealth, education and occupation for 1990 US Census block groups of residence)	Progressive CKD (Creatinine elevation ≥35 umol/L) during 9 yr follow-up, hospitalization for CKD or death from renal disease	Individual SES associations stronger effect on kidney disease than area SES measures, weaker SES-ESRD disease association among AA	Level A
Merkin[20], 2007, United States	Prospective cohort	4,735 83.7% Caucasian, 16.3% AA	65 years and older Renal diagnosis not specified	Area level SES (measures of income, wealth, education, occupation for 1990 US Census block groups of residence)	Progressive CKD (Creatinine elevation ≥35 umol/L over 4-7 years or CKD hospitalization)	Elderly people living in lowest SES areas experienced 40% greater risk of pCKD compared to highest SES areas, adjusted for individual level SES measure, lifestyle factors, diabetes, hypertension associations	Level A
Young[21], 1994, United States	Retrospective cohort	80,172 patients (62% Caucasian, 38%, AA)	0-60 Renal diagnosis not specified	Average race specific, per capita income	Incidence of ESRD	Inverse association between ESRD and SES	Level A
Klag[11], 1997, United States	Retrospective cohort	332,544 90% Caucasian 7% AA	35-57 1973-1975 Renal diagnosis not specified	Area level SES based on income	Incidence of ESRD	Higher incidence of ESRD in both Caucasian and AA with lower income	Level A
Cass[22], 2001, Australia and New Zealand	Retrospective cohort	5,013	> 18 years 1993-1998 Renal diagnosis not specified	Index of Relative SE disadvantage (IRSD) derived from the 1996 Census.	Incidence of ESRD	Higher incidence of ESRD with greater disadvantage (significant correlation with r=-0.41, p=0.0003)	Level A
Martins[23], 2006, United States	Retrospective cohort	14,484	> 18 years 1988-1994 Renal diagnosis not specified	Poverty (<200% federal poverty level)	Albuminuria	Poverty associated with micro albuminuria (OR 1.18, 95% CI, 1.05 – 1.33) but not macroalbuminuria	Level C
Peralta[24], 2006, United States	Retrospective cohort	736 AA	> 65 years Renal diagnosis not specified	Individual income (3 levels, low, mid, high)	Glomerular filtration rate less that 60 mL/ min	Low income (compared to high income) strongly associated with prevalent kidney dysfunction (OR 3.2; 95% CI 1.1-9.4)	Level B
Shoham[25], 2007, United States	Retrospective cohort	12,631 AA/Caucasian	19 years + 2001 Renal diagnosis not specified	Social class (working/ not working at age 30,40,50 yrs Area level SES (composite of census scores)	Incidence of CKD defined by hospital discharge diagnosis and/or glomerular filtration rate <45 mL/ min	Adjusted OR of CKD for working class vs. non working class at age 30 was 1.4 (95% CI 1-2) in Caucasian and 1.9 (95% CI 1.1-3) in AA	Level A

Volkova[26], 2008, United States	Retrospective cohort	34,767	18yrs + 1998-2002 Renal diagnosis not specified	Neighbourhood poverty (proportion of census tract below poverty level)	ESRD Incidence	Neighbourhood poverty associated with higher ESRD incidence in non-Caucasian and Caucasian. Increased effect in non-Caucasian	Level A
Ward[27], 2008, United States	Retrospective cohort	747,556	19+ years 1996-2004 Renal diagnosis: Diabetes Mellitus SLE ADPKD	SES based on group of characteristics from patients ZIP code of residence	Incidence of ESRD	Strong SES-ESRD associations for ESRD due to DM, some association with ESRD due to lupus, no association due to ADPKD	Level A
Perneger[10], 1995, United States	Case-control	716 patients ESRD, 361 population controls	20-64 Renal diagnosis not specified	Household annual income, Yrs of Education Assessed by telephone interview	Incidence of ESRD	Categories of income (Odds ratio gradient 1-4.5; 95% CI 2.6-7.8. The proportion of ESRD incidence that could be attributed to income category was 53%	Level B
Kasike[28], 1998, United States	Case-control	1,376 American Indians from Great Lakes Region	25 years + 1992-1994 Renal diagnosis not specified	Household income by telephone interview, whether buying groceries was difficult, highest grade of school completed	Micro and macroalbuminuria	Lower household income (but not education) was a correlate of albuminuria in multivariate analysis	Level C

AA = African American
CKD = Chronic Kidney Disease
ESRD = End-Stage Renal Disease
SES = Socioeconomic status

measure of SES. All composite measures of SES used a combination of census-derived indicators of income, housing costs, education (high school, college) and education. Four of the studies used individual levels of SES[10,19,24,28]. In three of these studies, income level was assessed by phone interview[10,19,28]. The remaining nine studies used area level SES.

Only one study attempted to examine SES throughout the life course[25]. This study evaluated whether individual social class (measure by 5 pt questionnaire), education level, or area level SES status in childhood or adulthood are associated with increased risk of adult kidney disease. Social class was associated with CKD; even in early adult life (adjusted OR of CKD for persons belonging to the working class (*vs.* non-working class) at age 30) was 1.4 (95% CI 1.0-2.0). Class was associated with CKD more strongly than education. At later periods in the life course, area SES was associated with CKD.

■ ESRD incidence as an outcome

Seven studies[10,11,19,21,22,26,27] used ESRD as their outcome of interest. All of these studies found an association between lower SES and the development of ESRD. All studies adjusted for race, age and sex. Only one study looked at the association of SES and the incidence of ESRD by etiology of kidney disease[27]. This study, which was also the largest study in the review with 747,556 people, found that the incidence of ESRD caused by all primary renal diseases was greatest in those in the lowest SES score quartile and decreased progressively with higher SES. In Caucasian women, the incidence of ESRD was 388.9 per million in the lowest quartile of SES and 200.8 per million in the highest quartile of SES (RR 1.92, 95% CI 1.89-1.95). However, this association differed among patients with primary renal diseases. Strong SES-ESRD associations were found for ESRD due to diabetes, some association with ESRD due to lupus and no association due to Polycystic Kidney Disease (ADPKD).

CKD incidence/progression as an outcome

Four studies[16,20,24,25] used CKD as their outcome of interest. Two studies[24,25] looked at incidence of CKD and the other two[16,20] looked at progression of disease. These studies also adjusted for race, age, and sex. In the largest of these studies[16], Caucasian men in the lowest area level SES quartile had twice the risk for progressive CKD compared to those living in the highest quartile.

Summary description of scores assigned to eligible studies

Most studies (nine of thirteen – see Table I) were classified as Level A (Highest rank) studies. These were all cohort studies with a population-based design and evaluated both ESRD and CKD as well defined outcomes. Two studies[10,24] were considered Level B (Moderate rank). These included one case-control study[10] of 716 known ESRD patients with 361 population controls that looked at the incidence of ESRD by categories of income. This study showed the same inverse association between income and ESRD incidence, with an Odds ratio gradient of 1-4.5; 95% CI 2.6-7.8, representing a similar magnitude of effect to Level A studies measuring comparable outcomes. Two studies[23,28] were considered Level C (Lowest rank). One study[28] used a convenience sample for a case-control study that used albuminuria as the marker of kidney disease. The second study[23], although well designed, relied upon albuminuria as a marker of kidney disease.

DISCUSSION

This analysis represents a comprehensive review of the literature examining the relationship between SES and chronic kidney disease. All studies in this review reported an inverse association between socioeconomic status and kidney disease, even after controlling for possible confounders.

The majority of the studies define SES based on income, either alone or as part of a composite measure. Both area level and individual level SES is examined, which is important as neighbourhood or community socioeconomic characteristics may have important effects on individual health, independent of their individual SES[29]. Studies that examined area or individual SES characteristics separately reported consistent associations between SES and kidney disease. One study[20] examined area and individual SES characteristics together in an elderly cohort and found that low individual level SES was not associated with increased risk of progressive CKD after fully adjusting for all other SES indicators. However, elderly people living in the lowest SES area had a 40% increased risk of progressive CKD (compared to the highest SES area), even when adjusted for individual level SES. The effect of area level SES on health in the elderly has mixed results, with some studies finding greater health disparities by area level SES differentials in older patients, and other studies report increase differentials in the young[20].

Studies consistently show a gradient between SES levels and ESRD incidence (ESRD incidence increases as SES decreases), however there has been no determination to date as to whether there is a continuous or a threshold effect.

Twelve of the thirteen studies in this review looked at static measures of risk factor (SES) exposure, capturing only the current SES of the participant or their environment. One study[25] looked at a more robust measure, capturing information from childhood and early adulthood. Capturing a "life course" socioeconomic profile may provide insight into the potential contribution of this risk factor at critical periods in life. For example, there is mounting evidence that low birth weight and poor diet during pregnancy affects kidney function later in life[30]. At birth, the number of nephrons is fixed, and reduced nephron number, as observed in low birth weight babies, may predispose individuals to hypertension and kidney disease. A recent study found that babies born with a birth weight <2.5 kg were 65% more likely to develop adult CKD than those with a normal (3-4.5 kg) birth weight[30]. However, as the observation is limited to males, there continues to be a gap in our full understanding of the etiology of this association. Nonetheless the interaction of lower SES, probability of less robust prenatal care, leading to low birth weight and thus potential problems with kidney function in later years, warrants further study.

Another intriguing inter-relationship is that of SES and race. As is well known, there are differences in propensity to develop ESRD amongst different races/ethnic groups. AAs are over four times more likely to develop kidney disease than Caucasians[11]. Unfortunately, AAs are also more likely to have or be exposed to lower SES. Thus in an attempt to tease out the 2 variables, five of the studies cited in this review specifically examined the role that SES plays in explaining the increased incidence of kidney disease in AAs[10,11,19,24,26]. Although all studies at least partially adjusted for confounders, and found an inverse association between SES and kidney disease, a residual unexplained risk remained in AAs. Some studies[16,27] found weaker associations between SES and the occurrence of ESRD in non-Caucasians than Caucasians, which is yet unexplained but may speak to either un-captured but important components of SES (such as discrimination, differential access to care and referral) or physiological differences that predispose ESRD in AAs. Recent findings in demonstrating important genetic predictors of progression in AAs[31] may help by allowing further refinement of previously collected information. The developing world and developed areas in Asia (Japan, China) also have higher rates of ESRD and CKD, thus better understanding of the relationship between genetics and environment is important for future strategies in a variety of racial groups, exposed to different environments.

The majority of studies published to date have examined the SES association with ESRD incidence, and not necessarily the incidence of CKD and progression. While ESRD incidence is important, given the large amount of resources expended by any health care system, the more interesting question may be, in fact, the CKD incidence and how SES impacts it. The potential to better identify modifiable components within the "SES" risk factor association, may lead to the development of cogent arguments for improved support. The focus in the literature on ESRD is likely due to many factors, including the completeness and ease of data collection with ESRD (through national registries) compared to data obtained from CKD populations. Recent data from Barbour *et al.*[32] describes prevalence of laboratory abnormalities by stage of CKD in Caucasians, Asians, and South Asians living in a universal health care system. SES was not examined, but it does appear that non-Caucasians identified with CKD have a faster rate of progression to dialysis, although a lower probability of dying than Caucasians when treated within a universal well resources health care system. Further analysis of this cohort by SES or proxy may give interesting insights. Only one study[27] evaluated the association of SES on different causes of kidney disease. This study provided some insights into the pathway of the association between low SES and kidney disease. The study found a strong SES-ESRD association for ESRD due to diabetes, a condition that can often be controlled by effective treatment, and no SES association for ESRD due to autosomal dominant polycystic kidney disease, a condition that usually progresses to ESRD regardless of treatment. Potential SES related factors that may impede diabetic control include reduced access to care/medications and lower patient education.

The high recognized prevalence of CKD and the associated individual and economic costs, the accumulated data regarding SES in specific populations, and the increasing number of questions being raised about ethnicity and SES, suggest that there is a real need to better evaluate the independent impact of SES on CKD. Improved understanding of the interplay of these factors may lead to the development of interventions targeted to reduce the incidence and progression of CKD.

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

Given the current state of knowledge, it is premature to make policy recommendations to reduce socioeconomic disparities in kidney disease. These interventions and even the extent of the disparities are as yet unidentified and untested. However, from this review, several areas of future research can be identified. These include:

- Further studies exploring the association between SES and the different etiologies of kidney disease, in order to generate testable hypothesis about the role of SES in the development and progression of kidney disease.

- Studies evaluating the pathways of the association between low SES and kidney disease.

Specific questions should focus on how SES affects the development, progression and complications of kidney disease. This research should ideally be focused on pathways earlier in kidney disease to allow for interventions to be trialed that may prevent or delay the progression of kidney disease

- Further studies that evaluate the role of "life course" SES in the development of CKD to help evaluate the pathways of the association. In particular, the prenatal and early childhood socioeconomic environment should be further explored.

The results of this research will help further understand the pathways of the SES – kidney disease association. Ultimately, this knowledge will allow the development of interventions that can be trialed with more analytical study designs, in contrast to the observational research presented in this review. Although specific policy recommendations regarding interventions to reduce the SES association with kidney disease cannot be made, this does not negate the importance of general policy measures to help reduce the risk factors that contribute to diabetes and hypertension (i.e. obesity, smoking, inactivity, all of which are associated with lower SES and education levels).

Lower SES is associated with reduced kidney function. SES plays an important role at both the individual and area level. The majority of research in this field has focused on understanding the role of SES in explaining the increased risk that AAs have of developing kidney disease compared to Caucasians. Although reduced SES explains some of this racial variability, a large amount still remains unexplained. Further studies are needed to explore the pathways by which low SES may lead to kidney failure in a group of different racial backgrounds, in the context of different health care systems. Focus should be turned to CKD early in the disease course, to identifying the initiators and promoters of kidney disease that may then be the target of prevention strategies. The challenge remains to identify the components of SES that are most suitable for interventions.

Conflict of interest statement. None declared.

References

1. Canadian Institute for Health Information. Accessed online April 30,2008 at http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_21jan2004_2_e
2. United States Renal Data System. Excerpts from USRDS 2007 Annual Data Report. U.S. Department of Health and Human Services. The National Institute of Health, Diabetes and Digestive and Kidney Disease. Am J Kid Dis 2008; 1(Suppl1):S1
3. Zelmer JL. The economic burden of end-stage renal disease in Canada. Kidney International 2007;73:1122-1129
4. Krieger N. A glossary for social epidemiology. J Epidemiol Community Health 2001; 55:693-700
5. Adler NE, Boyce WT, Chesney MA, Folkman S, Syme SL. Socioeconomic inequalities in health: no easy solution. JAMA 1993;269:3140-5
6. Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. Health Aff(Millwood) 2002;21:60-76
7. Lantz PM, House JS, Lepkowski JM, Williams DR, Mero RP, Chen J. Socioeconomic factors, health behaviors and mortality. JAMA 1998;279:1703-1708
8. Bleyer AJ, Shemanski LR, Burke GL, Hansen KJ, Appel RG. Tobacco, hypertension and vascular disease: risk factors for renal function decline in an older population. Kidney Int 2000;57:2072-79
9. Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav 1995;35:80-94
10. Perneger TV, Whittle PK, Klag MJ. Race and end-stage renal disease. Socioeconomic status and access to health care as mediating factors. Arch Intern Med 1995;155:1202-1208
11. Klag MJ, Whelton PK, Randall BL, Neaton JD, Brancati FL, Stamler J. End-stage renal disease in African American and white men. 16-year MRFIT findings. JAMA 1997; 277:1293-1298
12. Li S, McAlpine DD, Liu J, Li S, Collins AJ. Differences between blacks and whites in the incidence of end stage renal disease and associated risk factors. Adv Ren Replace Ther 2004;11:5-13
13. Byrne C, Nedelman J, Luke RG. Race, socioeconomic status, and the development of end-stage renal disease. Am J Kidney Dis 1994;23:16-22
14. Scragg R, Baker J, Metcalf P, Dryson E. Prevalence of diabetes mellitus and impaired glucose tolerance in a New Zealand multiracial workforce. N Z Med J 1991;.104:395-397
15. Tyroler HA Socioeconomic status in the epidemiology and treatment of hypertension. Hypertension 1989;13:194-197
16. Merkin SS, Coresh J, Diez Roux A, Taylor HA, Powe NR. Area socioeconomic status and progressive CKD: The Atherosclerosis Risk in Communities (ARIC) Study. Am J Kid Disease 2005;46:203-213
17. Keith D, Ashby VB, Port FK, Leichtman AB. Insurance type and minority status associated with large disparities in prelisting dialysis among candidates for kidney transplantation. CJASN 2008;3:463-70
18. Goldfarb-Rumyantzev AS, Koford JK, Baird BC, *et al.* Role of socioeconomic status in kidney transplant outcome. CJASN 2006;1:313-322
19. Tarver-Carr ME, Powe N, Eberhardt MS, *et al.* Excess risk of chronic kidney disease among African American versus white subjects in the United States: A population-based study of potential explanatory variables. J Am Soc Nephrol 2002;13:2363-2370
20. Merkin SS, Diez Roux AV, Coresh J, *et al.* Individual and neighbourhood socioeconomic status and progressive chronic kidney disease in an elderly population: The Cardiovascular Health Study. Soc Sci Med 2007;65:809-821
21. Young EW, Mauger EA, Jiang K-H, Port FK, Wolfe RA. Socioeconomic status and end-stage renal disease in the United States. Kidney Int 1994;45:907-911

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22. Cass A, Cunningham J, Wang Z, Hoy W. Social disadvantage and variation in the incidence of end-stage renal disease in Australia capital cities. Aust N Z J Public Health 25:322-326,2001

23. Martins D, Tareen N, Zadshir A, *et al.* The association of poverty with the prevalence of albuminura: data from the third national health and nutrition examination survey (NHANES III) Am J Kid Dis 2006;47:965-971

24. Peralta, CA Ziv, E, Katz R, *et al.* African Ancestry, socioeconomic status, and kidney function in elderly African Americans: a genetic admixture analysis. J Am Soc Nephrol 2006;17:3491-96

25. Shoham D, Vupputuri S, Diz Roux A, *et al.* Kidney Disease in Life-Course Socioeconomic Context: The Atherosclerosis Risk in Communities (ARIC) Study. Am J Kid Dis 2007;49:217-226

26. Volkova N, McClellan W, Klein M, et al. Neighbourhood poverty and racial differences in ESRD incidence. JASN 2008;19:356-364

27. Ward MM. Socioeconomic Status and the Incidence of ESRD. Am J Kid Dis 2008; 51:563-572

28. Kasiske BL, Rith-Najarian S, Casper ML, Croft JB. American Indian heritage and risk factors for renal injury. Kidney Int 1998;54:1305-1310

29. Macintyre S, Maciver S, Sooman A. Area, class, and health: Should we be focusing on places or people? J Soc Policy 1993;22:213-234

30. Li S, Chen SC, Shlipak M, Bakris G, McCullough PA. Low birth weight is associated with CKD only in men. Kidney Int 2008;73:637-42

31. Rao M, Balakrishnan VS. The genetic basis of kidney disease risk in African Americans: MYH9 as a new candidate gene. Am J Kid Dis 2009;53:579-83

32. Barbour SJ, Er L, Djurdjev O, Karim MA, Levin A. The prevalence of hematologic and metabolic abnormalities during CKD stages in different ethnic groups. Kidney Int 2008;74:108-14

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Weekly

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Incidence of End-Stage Renal Disease Among Persons With Diabetes --- United States, 1990--2002

Diabetes mellitus is the leading cause of end-stage renal disease (ESRD) (i.e., kidney failure requiring dialysis or transplantation) in the United States, accounting for 44% of new cases of treated ESRD in 2002 (*1*). To examine trends in ESRD attributed to diabetes mellitus (ESRD-DM) in the United States, CDC analyzed 1990--2002 data from the United States Renal Data System (USRDS) and the National Health Interview Survey (NHIS). This report summarizes the findings of that analysis, which indicated that, although the number of new cases of ESRD-DM increased overall, the incidence of ESRD-DM among persons with diabetes is not increasing among blacks,* Hispanics, men, and persons aged 65--74 years, and is declining among persons aged <65 years, women, and whites. Continued interventions to reduce the prevalence of risk factors for kidney disease and improve diabetes care are needed to sustain and improve these trends.

USRDS, which is funded by the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health (NIH), collects, analyzes, and distributes information from clinical and claims data reports to the Centers for Medicare and Medicaid Services (CMS) regarding patients being treated for ESRD. With the ESRD entitlement program, the CMS Medicare program reimburses most of the total cost of ESRD treatment in the United States (*1*). USRDS collects demographic data and ESRD-related information, such as the date patients were first treated and the primary cause of their renal failure. CDC determined the number of persons who began treatment (i.e., dialysis or kidney transplantation) for ESRD in the United States during 1990--2002 for whom diabetes was the primary cause of renal failure. Incidence was calculated from 3-year moving averages of the annual number of U.S. residents with diabetes, as estimated by NHIS data for a weighted sample of the civilian noninstitutionalized population and age-adjusted on the basis of the 2000 U.S. standard population. In 1996, the NHIS estimate of the number of U.S. residents with diabetes was unusually low† (*2*), resulting in ESRD-DM incidence that was higher than expected. Beginning in 1997, data on Hispanics were collected, and the NHIS survey methodology was changed; instead of asking a one-sixth subsample of respondents whether (during the preceding 12 months) a family member had diabetes, all respondents were asked whether a health professional had ever told them they had diabetes (*3*). All analyses were conducted using statistical analysis software to account for the complex NHIS survey design. Regression analyses of annual data were used to test for trends; these analyses were performed both with and without the 1996 data.

The number of persons who began treatment for ESRD-DM increased 162%, from 16,649 in 1990 to 43,638 in 2002 (Figure 1). The age-adjusted incidence of ESRD-DM increased from 247 per 100,000

persons with diabetes in 1990 to 305 in 1996, before declining 21%, from 293 in 1997 to 232 in 2002 ($p<0.01$) (Figure 1). However, the magnitude of this decline in ESRD-DM incidence varied by age group (Figure 2). During 1997--2002, incidence decreased for persons aged <65 years (by 28% for those aged <45 years [$p<0.01$] and by 19% for those aged 45--64 years [$p<0.05$]); however, incidence did not change significantly for those aged 65--74 years, and increased 10% for those aged ≥75 years ($p<0.05$).

The magnitude of change in ESRD-DM incidence also differed by sex and by race/ethnicity (Figure 3). During 1990--2002, age-adjusted ESRD-DM incidence was greater among men than women and higher among blacks than whites. During 1997--2002, age-adjusted ESRD-DM incidence decreased significantly among women ($p<0.05$) but not among men. Incidence also decreased significantly among whites ($p<0.01$) but not among blacks; the trend among Hispanics did not change significantly.

Reported by: *NR Burrows, MPH, J Wang, LS Geiss, MA, KM Venkat Narayan, MD, MM Engelgau, MD, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note:

ESRD is a costly and disabling condition that disproportionately affects racial/ethnic minority populations and is associated with a high mortality rate (*1*). Risk factors for ESRD-DM include familial and genetic factors, the length of time a person has had diabetes, and hyperglycemia, hypertension, and hyperlipidemia (*4*). The findings in this report indicate encouraging trends in ESRD-DM incidence. After increasing from 1990 to 1996, ESRD-DM incidence decreased during 1997--2002 among persons aged <65 years, women, and whites; stopped increasing among persons aged 65--74 years, men, and blacks; and remained level among Hispanics. The reasons for improvement cannot be determined from these surveillance data; however, they might include a reduction in the prevalence of cardiovascular disease risk factors such as high blood pressure and high cholesterol (*5*), improvements in diabetes care practices (*6*), or development of new pharmacologic agents to reduce the prevalence of kidney disease risk factors (*7*). Continued interventions (e.g., blood sugar and blood pressure control [*8--10*]) to reduce the prevalence of these risk factors and improve care among persons with diabetes are needed to sustain and improve trends in ESRD-DM incidence.

During 1997--2002, ESRD-DM incidence among men, blacks, persons aged 65--74 years, and Hispanics did not decrease as it did among certain other populations; among persons aged ≥75 years, ESRD-DM incidence increased during 1990--2002. Additional strategies are needed to reduce these disparities. Reducing incidence of ESRD-DM among persons aged ≥75 years likely will be difficult because persons with diabetes are surviving longer and ESRD typically occurs 15--20 years after onset of diabetes (*4*). Moreover, the number of ESRD cases in the United States is likely to continue to increase as the U.S. population ages and the number of persons with diabetes continues to increase. The downward trend in ESRD incidence in the population with diabetes might reverse if persons have diabetes at younger ages or live with the disease for a longer time, thus increasing their risk for developing ESRD.

The findings in this report are subject to at least four limitations. First, data were collected for patients whose ESRD treatment was reported to CMS and do not include patients who died from ESRD before receiving treatment, persons who refused treatment, or patients whose treatment was not reported to CMS. Second, the 1996 NHIS estimate of the number of U.S. residents with diabetes

was unusually low (*2*); however, exclusion of 1996 data did not substantially affect incidence trends. Third, because incidence of ESRD-DM was defined as the percentage of persons with diabetes who began ESRD treatment in a given year, changes in incidence might have been caused by other factors, such as changes in diabetes treatment and care practices, greater recognition of the etiologic role of diabetes in ESRD, changes in access to treatment or acceptance of ESRD treatment, or a combination of these factors. Finally, the correlation between the length of time diabetes patients had the disease and their risk for developing ESRD-DM was not assessed because of a lack of data on duration of diabetes.

CDC provides resources and technical assistance to state and territorial diabetes-control programs to help them 1) educate persons regarding diabetes, 2) improve and monitor the quality of diabetes care, and 3) promote early detection of diabetic complications. The National Diabetes Education Program (NDEP), sponsored by CDC and NIH, aims to educate the public about controlling diabetes and preventing its complications. The NDEP campaign, "Know your ABCs,"[§] addresses risk factors for ESRD-DM, such as hyperglycemia, hypertension, and hyperlipidemia. In addition, the National Kidney Disease Education Program,[¶] sponsored by NIH, seeks to raise public awareness about the seriousness of kidney disease, the importance of testing for kidney disease among those at risk, and the availability of treatment to prevent or slow kidney failure. Similarly, the National Kidney Foundation offers the Kidney Early Evaluation Program,** a free health-screening program for persons at increased risk for kidney disease.

CDC will continue to work with public and private partners to reduce rates of diabetes and other risk factors for kidney disease and to improve care for persons with diabetes. Continued surveillance of ESRD-DM, its risk factors, and the level of care received by patients with diabetes will help public health officials monitor and assess progress in reducing the incidence of this serious complication of diabetes.

References

1. United States Renal Data System. Annual data report, 2004. Minneapolis, MN: USRDS Coordinating Center; 2004. Available at http://www.usrds.org/adr_2004.htm.
2. Engelgau MM, Geiss LS, Saaddine JB, et al. The evolving diabetes burden in the United States. Ann Intern Med 2004;140:945--50.
3. CDC. 1997 National Health Interview Survey (NHIS) public use data release: NHIS survey description. Hyattsville, MD: US Department of Health and Human Services, CDC; 2000. Available at ftp://ftp.cdc.gov/pub/health_statistics/nchs/dataset_documentation/nhis/1997/srvydesc.pdf.
4. Nelson RG, Knowler WC, Pettitt DJ, Bennett PH. Kidney diseases in diabetes. In: Diabetes in America. 2nd ed. Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, eds. Washington, DC: US Department of Health and Human Services, National Institutes of Health; 1995. DHHS publication no. (NIH)95-1468; 361--6.
5. Imperatore G, Cadwell BL, Geiss L, et al. Thirty-year trends in cardiovascular risk factor levels among US adults with diabetes: National Health and Nutrition Examination Surveys, 1971--2000. Am J Epidemiol 2004;160:531--9.
6. Geiss L, Engelgau M, Pogach L, et al. A national progress report on diabetes: successes and challenges. Diabetes Technol Ther 2005; 7:198--203.
7. Parving HH, Lehnert H, Brochner-Mortensen J, Gomis R, Andersen S, Arner P; Irbesartan in Patients with Type 2 Diabetes and Microalbuminuria Study Group. The effect of irbesartan on the development of diabetic nephropathy in patients with type 2 diabetes. N Engl J Med 2001;345:870--8.

8. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. N Engl J Med 1993;329:977--86.
9. UK Prospective Diabetes Study Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998;352:837--53.
10. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes (UKPDS 38). BMJ 1998;317:703--13.

* For this report, race and ethnicity were considered independently. The only racial populations considered were black and white; persons who identified themselves as black or white might be Hispanic or non-Hispanic. Persons who identified themselves as Hispanic might be of any race.

† Relative to 1995, the 1996 NHIS sample size was reduced by approximately 25% in the first and second quarters and by approximately 50% in the third and fourth quarters.

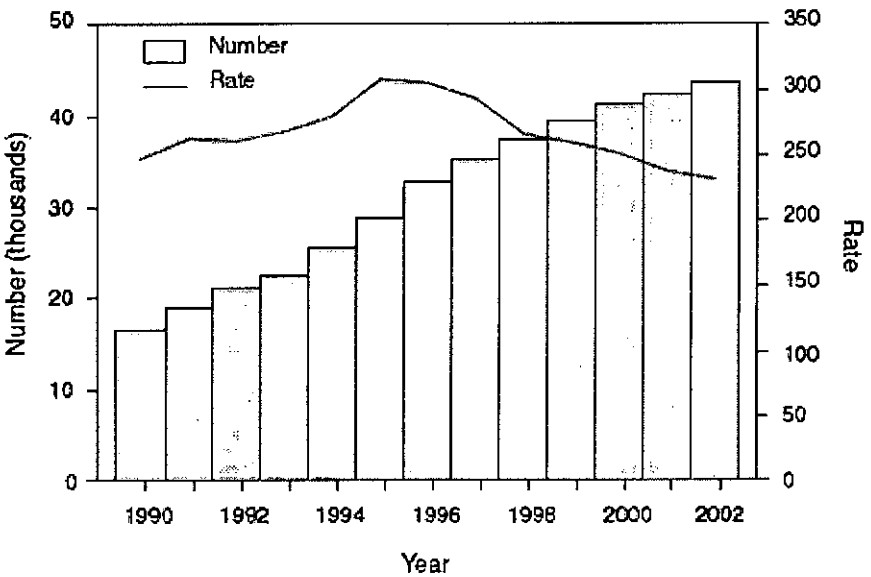
§ Available at http://www.cdc.gov/diabetes/ndep/campaigns.htm.

¶ Available at http://www.nkdep.nih.gov.

** Available at http://www.kidney.org/keep.

Figure 1

FIGURE 1. Number of persons who began treatment for end-stage renal disease associated with diabetes mellitus (ESRD-DM) and age-adjusted rate* of ESRD-DM among persons with diabetes — United States Renal Data System, 1990–2002



*Per 100,000 persons with diabetes, age-adjusted on the basis of the 2000 U.S. standard population.

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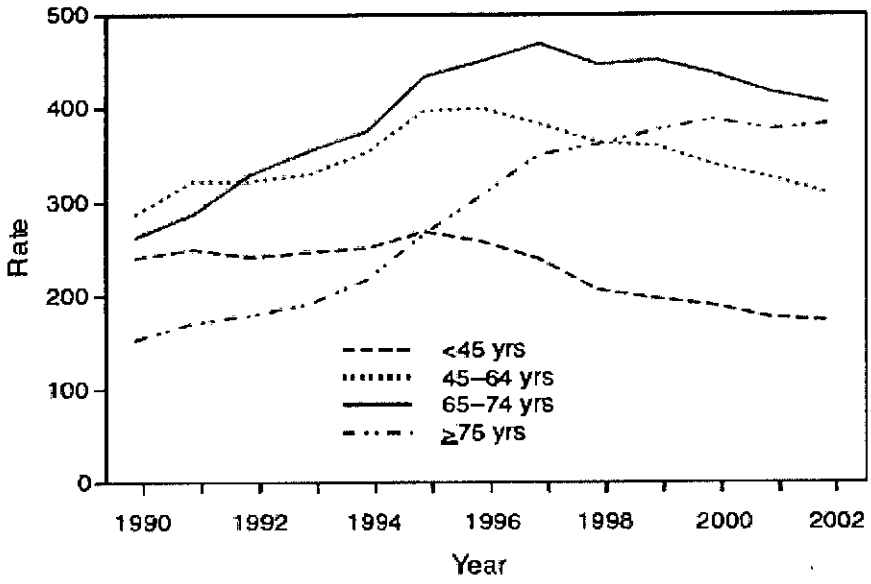
Figure 2

FIGURE 2. Rate* of end-stage renal disease associated with diabetes mellitus among persons with diabetes, by age group — United States Renal Data System, 1990–2002



*Per 100,000 persons with diabetes.

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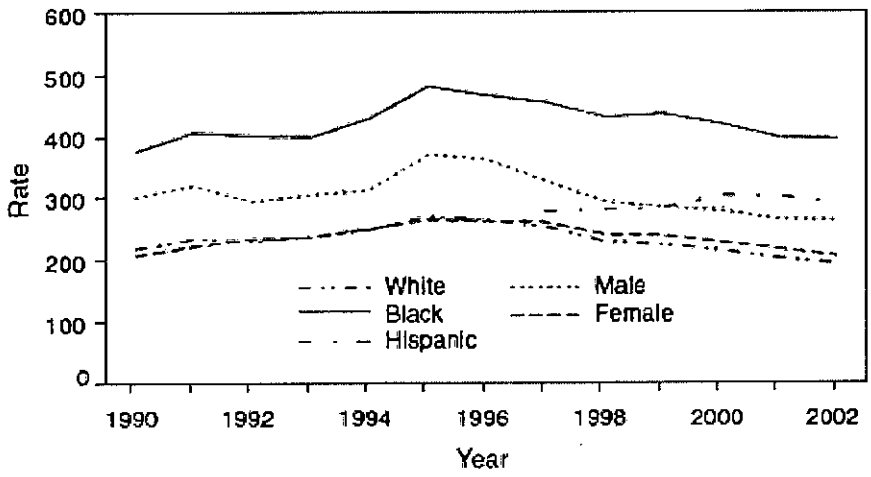
Figure 3

FIGURE 3. Age-adjusted rate* of end-stage renal disease associated with diabetes mellitus among persons with diabetes, by sex and race/ethnicity† — United States Renal Data System, 1990–2002



* Per 100,000 persons with diabetes, age-adjusted on the basis of the 2000 U.S. standard population.

† Race and ethnicity were considered independently. The only racial populations considered were black and white; persons who identified themselves as black or white might be Hispanic or non-Hispanic. Persons who identified themselves as Hispanic might be of any race.

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Diabetes Complications Frequent in the Elderly

NEW YORK (Reuters Health) May 24 - The results of a study published in the May 14th issue of the Archives of Internal Medicine suggest that patients diagnosed with diabetes mellitus late in life have a reduced life expectancy and increased rates of disease-related complications compared with nondiabetic individuals of the same age.

The investigators, Dr. Frank A. Sloan, of Duke University Center for Health Policy in Durham, North Carolina, and colleagues point out that "although increasing age is a risk factor for the development and progression of the microvascular and macrovascular complications of diabetes mellitus, little is known about the impact of diabetes mellitus in elderly populations."

In a national longitudinal analysis (January 1, 1991, to December 31, 2004), the researchers examined morbidity and mortality rates in 33,772 Medicare beneficiaries with diabetes mellitus and in 25,563 controls.

By 2004, patients with diabetes had an excess mortality of 9.2% compared with the control patients ($p < 0.001$). Being newly diagnosed as diabetic translated into a loss of life expectancy of just over 2 years.

Overall, 92% of the diabetes group experienced an adverse outcome by 2004, compared with 72% of the control group. The prevalence and incidence of microvascular and macrovascular complications were higher in diabetic patients at all time points.

The risk for all lower extremity complications was increased among patients with diabetes, especially complications associated with surgery.

Cardiovascular complications were a leading cause of morbidity in the study population. Overall, 58% of those in the diabetes group were diagnosed with heart failure, compared with 34% of the control group. While nephropathy and retinopathy complications were less common, both increased markedly in the diabetic group.

"The present findings demonstrate that for several complications, including myocardial infarction, CHF, and stroke, the incidence decreased after the date of diagnosis of diabetes mellitus," Dr. Sloan's team writes. They attribute this to the enhanced emphasis and lower thresholds for glucose, lipid and blood pressure control.

"However, for other important complications, in particular chronic renal failure and ESRD, the incidence increased," they note.

"The increased mortality risk during 10-year follow-up of the diabetes mellitus group is modest relative to the 2-fold increase attributed to diabetes mellitus elsewhere," the authors point out.

"Although the present data provide no insight into the cause of these patterns, the burden of diabetes mellitus complications on the individual and on the health care system is enormous."

Arch Intern Med 2007;167:921-927.

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REUTERS
HEALTH INFORMATION

Prevalence of Kidney Failure in US Expected to Rise Markedly by 2020

By Anthony J. Brown, MD

NEW YORK (Reuters Health) Nov 07 - Researchers predict the prevalence of end-stage renal disease (ESRD) in the US will rise over 60% from 2005 to 2020, a change that will have important ramifications for the delivery of healthcare to this population.

"Our biggest finding is that even with flattening ESRD incidence rates, expected counts are still going to increase dramatically. The baby boomers are the major driver, but also diabetes, obesity, and improved care of patients on dialysis and prior to kidney failure," lead researcher Dr. David T. Gilbertson, from the US Renal Data System in Minneapolis, told Reuters Health.

The findings are concerning because they suggest that "there may not be enough health care providers to care for this population in the future," he added. "Other options besides hemodialysis will need to be considered, including more kidney transplants, and more home-based therapy options such as peritoneal dialysis and home hemodialysis."

Dr. Gilbertson presented his team's findings on Saturday at the annual meeting of the American Society of Nephrology in San Francisco.

Based on data available through 2005, the researchers estimate that there will be 135,000 new cases of ESRD in the US in 2015. This figure is actually about 3000 cases lower than the estimate made in an earlier study using data through 2000, which is consistent with other reports showing a drop in ESRD incidence in recent years. The reason for this trend, however, is unclear.

Still, as Dr. Gilbertson noted, a pronounced increase in the prevalence of ESRD is expected. The 485,000 figure noted in 2005 is predicted to swell to 680,000 in 2015 and to 785,000 in 2020.

Dr. Gilbertson said that future research efforts "will attempt to include the chronic kidney disease population prior to kidney failure into the model, to assess expected future growth in that population."

Medscape www.medscape.com

Medscape Medical News

Rapid rise in obesity rates found in ESRD population

Caroline Cassels

April 18, 2006

Maywood, IL - Obesity rates in US patients with end-stage renal disease (ESRD) are rising more rapidly than those in the general population, a new study has shown [1].

Principal investigator **Dr Holly Kramer** (Loyola University Medical Center, Maywood, IL) and colleagues found that over an eight-year period, the rate of change in body-mass index (BMI) was twofold higher in the incident ESRD population compared with the US general population for all age groups. However, overall obesity trends among ESRD patients mirror those in the general population.

"We found the rate of obesity is increasing faster in the dialysis population compared with the general US population. This mirrors what we have been seeing in our own practice, where, over the past number of years, we have noticed an increase in morbid obesity, particularly among young women," Kramer told **renal*wire***.

The study was published online April 5, 2006 in advance of publication in the *Journal of the American Society of Nephrology*.

Using data from the **United States Renal Data System** (USRDS), the researchers included all patients 20 years and older who had initiated permanent dialysis between 1995 and 2002 and had complete information on height and dry weight. A total of 615¿192 incident ESRD patients were included in the analysis, which examined total obesity (BMI ≥30), obesity stage 1 (BMI 30-34.9), and obesity stage 2 (BMI ≥35).

Trends in BMI and obesity prevalence in the incident ESRD population were compared with the total US population using data on 1¿259¿841 US adults aged 20 and older gathered from the **Behavioral Risk Factor Surveillance System**.

The study found significant trends in increasing obesity prevalence in ESRD patients. Over the eight-year period, the average BMI among incident ESRD patients increased from 25.7 to 27.5 kg/m^2 compared with 25.7 to 26.7 in the US general population.

Morbid obesity highest among diabetics

Among the ESRD population, obesity stage 1 increased by 32%, obesity stage ≥2 by 63%, and total obesity by 45%. Although these results paralleled trends in the general population, there was one notable exception. Among ESRD patients aged 65 to 74, the researchers found a 97% increase in obesity stage ≥2 compared with 69% in the US

general population.

According to the authors, both the prevalence and rate of increase in obesity stage ≥2 among incident ESRD patients were higher among all subgroups with diabetes compared with those without diabetes.

"The burden of obesity is much greater in patients with diabetes," Kramer noted "They have a higher rate of obesity at baseline and, although both diabetics and nondiabetics have an increase in BMI over time, it is higher in diabetic vs nondiabetic patients, as is the rate of change."

In addition, the study found women had higher rates of obesity stage ≥2 compared with men, and non-Hispanic blacks were more likely to be morbidly obese compared with all other ethnic groups. Both these trends were consistent regardless of diabetes status.

ESRD population explosion?

Unless this trend is curbed, said Kramer, rising obesity rates will have a dramatic impact on renal-replacement therapy?particularly dialysis. Most centers, she said, will not transplant patients with a BMI greater than 35.

This, coupled with the fact that previous research has shown overweight and obesity confers a survival advantage in ESRD patients, means the US is facing a substantial increase in the number of prevalent ESRD patients on permanent dialysis. According to the study, the total number of ESRD patients in the US is expected to reach 600¿000 by 2010, with annual costs in excess of $28 billion.

In addition, said Kramer, managing obese ESRD patients is challenging. "It can be very difficult with obese patients to obtain and maintain vascular access. In my experience, the heavier a patient is, the more difficult they are to manage," she said.

It is not enough, she said, for nephrologists simply to advise patients to "lose weight." What is needed is an integrated, multidisciplinary, and comprehensive approach that considers the physical as well as environmental barriers to weight loss. Kramer suggested that in some cases surgery such as gastric banding or bypass might be warranted.

At a macro level, she said the nephrology community should partner with other like-minded organizations such as the **American Heart Association** (AHA) to combat the obesity epidemic.

"We need to turn the lights on and recognize that obesity is a huge problem for the nephrology community. If we want to reduce the incidence of ESRD in the future, first and foremost we have to look at ways of combating the obesity epidemic in children and provide our existing patients with chronic kidney disease with things like nutrition counseling and strategies to help them become more physically active," she said.

Source

1. Kramer H, Saranathan A, Luke A, et al. Increasing body mass index and obesity in the incident ESRD population. *J Am Soc Nephrol* 2006; DOI:10.1681/ASN.20051111241. Available at: http://www.jasn.org. MEDLINE

Medscape from WebMD www.medscape.com

Medscape Medical News

REGARDS: Nearly 1 in 10 Older Americans Has a Close Relative with ESRD

Marlene Busko

March 20, 2007 — The renal cohort of the Reasons for Geographic and Racial Differences in Stroke (REGARDS), a population-based study, found that having a close relative with end-stage renal disease (ESRD) was common, especially among African Americans and people who were obese or had diabetes. Screening close relatives of patients with ESRD for early kidney disease and treating risk factors such as obesity and diabetes could perhaps prevent progression to more advanced kidney disease.

The study will be published in the April issue of *Journal of the American Society of Nephrology* and was available online March 9.

Lead author William McClellan, MD, from Emory University in Atlanta, Georgia, told Medscape: "Our main finding was that a family history of ESRD in a first-degree relative — a parent, sibling, or child — was actually quite frequent." He added that what is exciting is that "there are easy ways of reaching those [at-risk] families and their members and providing them with potential information that could be lifesaving."

Dr. McClellan explained that because kidney disease imposes a tremendous burden on society — not just from progression to ESRD but also from increased risk for cardiovascular disease, stroke, and premature death — there is a lot of interest in finding ways to improve early detection and management of injured kidneys or risk factors in susceptible individuals.

The group writes that a previous study in the southeastern United States showed that 23% of African Americans and 14% of white Americans starting dialysis had a first- or second-degree relative who was also being treated for ESRD. Paradoxically, recent reports showed that the prevalence of chronic kidney disease (CKD) is lower in African Americans than in white Americans. Studying these families might lead to a better understanding of this accelerated loss of kidney function and suggest ways to reduce the occurrence of ESRD, Dr. McClellan said.

The group aimed to investigate the prevalence of and characteristics of individuals in the general population who had a first-degree relative with ESRD. They performed a cross-sectional analysis of data from a renal cohort of REGARDS, which is a population-based sample of individuals in the United States who are age 45 years or older. Participants were asked in a telephone interview whether anyone in their immediate family had kidney failure (or dialysis or transplant).

A positive family history of ESRD, defined as having a first-degree relative with ESRD, was reported by 1145 (9.5%) of the 12,030 participants in renal REGARDS. More African American than white study participants (14% vs 6.4%, respectively; odds ratio, 2.38; 95% CI, 2.11 – 2.71) reported this positive family history; it was also independently linked with being female, having diabetes, being overweight or obese, or having elevated C-reactive protein (CRP) levels.

Characteristics Independently Linked With Having a Family History of ESRD

Characteristic	Odds Ratio (95%CI)*
African American	2.14 (1.82 – 2.53)
Female	1.28 (1.08 – 1.51)
Overweight	2.64 (0.82 – 8.42)
Obese	3.48 (1.09 – 11.10
Diabetes	1.23 (1.03 – 1.48)
1-SD change in log CRP	11.8 (11.5 – 12.1)

CRP = C-reactive protein.
SD = standard deviation.

High-Risk Group Might Benefit From Interventions

Dr. McClellan commented that the clinical implications are that primary-care physicians and others should obtain a family history of ESRD in their patients; family members of patients with ESRD should be carefully screened for abnormal kidney function and protein in the urine; and public health education programs should focus on family members who are at high risk of having ESRD. He added that patients on dialysis could be asked whether members of their family could be contacted to tell them about this familial risk. The Family Reunion Health Guide by the National Kidney Disease Education Program is a recent initiative aimed at reaching high-risk family members to increase the early detection of kidney disease.

The group concludes: "If confirmed, then these findings suggest that individuals with a family history of ESRD may benefit from interventions to improve the detection and treatment of chronic kidney disease risk factors such as diabetes and obesity."

J Am Soc Nephrol. Published online March 9, 2007. MEDLINE

Medscape Medical News

Overweight/obesity "enormous" risk factor for ESRD

Caroline Cassels

January 09, 2006

San Francisco, CA - A large observational study has found overweight and obesity increase the risk of end-stage renal disease (ESRD) by up to 700% [1].

These results mean overweight and obesity now qualify as a new risk factor for ESRD, researchers say; ESRD already affects more than 300¿000 Americans and is expected to double by 2010.

"We found a strikingly high risk of ESRD associated with overweight?up to 700% in the most obese group. This is a very large effect," lead investigator **Dr Chi-yuan Hsu** (University of California, San Francisco) told ***renalwire***. "Even when we adjusted for major risk factors such as diabetes and hypertension, the risk was still increased several hundred percent, and that's enormous."

Their report was published in the January 3, 2006 issue of the *Annals of Internal Medicine*.

Stepwise increase in risk

The study was conducted jointly with the division of research at Kaiser Permanente of Northern California, a large integrated healthcare delivery system that currently cares for more than 35% of the insured adult population in the greater San Francisco Bay area.

Researchers analyzed available data from June 1964 to March 1985 derived from the Multiphasic Health Checkup, a voluntary annual health assessment. Eligible subjects included those who were 18 years and older and who had at least one concurrent measure of height, weight, blood pressure, serum creatinine, and dipstick urinalysis.

Persons with a baseline serum creatinine level greater than 10 mg/dL were excluded from the study. The final, total study sample included 320¿252 subjects.

Using body-mass index (BMI), researchers divided participants into four weight categories ranging from overweight to extremely obese.

The mean BMI in the study sample was 24.5 kg/m^2, Of the total study group, 58% had normal weight and 39% had a BMI of 25.0 kg/m^2 or greater.

After adjusting for age, sex, race, education level, smoking status, history of myocardial infarction, serum cholesterol

level, urinalysis proteinuria, urinalysis hematuria, and serum creatinine, researchers found a stepwise increase in the rate of ESRD with higher BMI, which skyrocketed more than sevenfold in those with extreme obesity. Even in patients who were in the overweight class, the increased risk of ESRD was 87% compared with normal-weight subjects.

ESRD risk according to weight class vs normal-weight subjects

Weight class by BMI (kg/m^2)	Adjusted relative risk	95% CI
Overweight, 25.0-29.9	1.87	1.64-2.14
Class I obesity, 30.0-34.9	3.57	3.05-4.18
Class II obesity, 35.0-39.9	6.12	4.97-7.54
Class III obesity, >40.0	7.07	5.37-9.31

To download table as a slide, click on slide logo below

Previous studies looking at overweight and obesity as a potential risk factor for ESRD have yielded conflicting results. However, as the largest study to date, and with an average follow-up of 26 years, Hsu believes his group's results are conclusive in establishing overweight and obesity as a bona fide risk factor.

"This is an exciting finding because it potentially points to weight loss as another way of preventing kidney failure. Weight loss may slow kidney disease progression among those with mild to moderate kidney disease. In addition, it provides patients with one more important reason to achieve and maintain a healthy weight," said Hsu.

In light of this finding, said Hsu, an interventional study to determine whether weight loss improves the prognosis of patients with mild to moderate kidney disease is warranted.

According to the **Centers for Disease Control and Prevention**, 65% of American adults are currently either overweight or obese. Of these, 8 million are morbidly obese.

Download Powerpoint

Source

1. Hsu C, McCulloch CE, Iribarren C, et al. Body mass index and risk for end-stage renal disease. *Ann Intern Med* 2006; 144:21-28. MEDLINE

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Quad Cities Kidney Center Rock Island
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	4%	65%	31%
2. Our promptness in returning your phone call	0%	0%	12%	59%	29%
3. Our helpfulness on the telephone	0%	0%	4%	65%	31%

C. During Your Visit	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Cleanliness of our **lobby area**	0%	0%	4%	48%	48%
2. Cleanliness of our **restrooms**	0%	0%	12%	48%	40%
3. Cleanliness of our **dialysis treatment area**	0%	0%	0%	38%	62%
4. Comfort you feel in dialysis treatment area	0%	4%	4%	51%	41%
5. Safety you feel during dialysis treatment	0%	0%	0%	46%	54%

D. Patient Care Staff	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Friendliness/courtesy of our **Office Staff**	0%	0%	12%	58%	29%
2. Friendliness/courtesy of our **Technicians**	0%	0%	0%	31%	69%
3. Concern our **Technicians** show for your issues	0%	0%	0%	45%	55%
4. Care you receive from our **Technicians**	0%	0%	0%	40%	60%
5. Friendliness/courtesy of our **Nurses**	0%	0%	0%	44%	56%
6. Concern our **Nurses** show for your issues	0%	0%	4%	36%	60%
7. Care you receive from our **Nurses**	0%	0%	7%	33%	60%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	3%	38%	59%
9. Concern our **Dietitians** show for your issues	0%	0%	0%	46%	54%
10. Care you receive from our **Dietitians**	0%	0%	4%	43%	53%
11. Friendliness/courtesy of our **Social Worker**	0%	4%	0%	48%	48%
12. Concern our **Social Worker** shows for your issues	0%	8%	3%	48%	41%
13. Care you receive from our **Social Worker**	0%	8%	3%	48%	41%

E. Physicians	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Friendliness/courtesy of our **Physicians**	0%	4%	4%	32%	62%
2. Concern our **Physicians** show for your issues	0%	3%	3%	34%	60%
A. Care you receive from our **Physicians**	0%	4%	0%	36%	60%

Results may not add up to 100% do to rounding of results.

Aledo Kidney Center
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	6%	33%	60%
2. Our promptness in returning your phone call	0%	0%	40%	53%	6%
3. Our helpfulness on the telephone	0%	0%	7%	36%	57%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	0%	40%	60%
2. Cleanliness of our **restrooms**	0%	0%	0%	33%	67%
3. Cleanliness of our **dialysis treatment area**	0%	0%	0%	33%	67%
4. Comfort you feel in dialysis treatment area	0%	0%	0%	53%	47%
5. Safety you feel during dialysis treatment	0%	0%	0%	33%	67%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	7%	20%	73%
2. Friendliness/courtesy of our **Technicians**	0%	0%	0%	27%	73%
3. Concern our **Technicians** show for your issues	0%	0%	0%	40%	60%
4. Care you receive from our **Technicians**	0%	0%	0%	40%	60%
5. Friendliness/courtesy of our **Nurses**	0%	0%	0%	33%	67%
6. Concern our **Nurses** show for your issues	0%	0%	0%	40%	60%
7. Care you receive from our **Nurses**	0%	0%	0%	33%	67%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	7%	29%	64%
9. Concern our **Dietitians** show for your issues	0%	0%	7%	33%	60%
10. Care you receive from our **Dietitians**	0%	0%	7%	27%	66%
11. Friendliness/courtesy of our **Social Worker**	0%	0%	7%	27%	66%
12. Concern our **Social Worker** shows for your issues	0%	0%	7%	33%	60%
13. Care you receive from our **Social Worker**	0%	0%	7%	27%	66%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	0%	7%	20%	73%
2. Concern our **Physicians** show for your issues	0%	0%	7%	20%	73%
A. Care you receive from our **Physicians**	0%	0%	7%	27%	66%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Bettendorf
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	8%	31%	61%
2. Our promptness in returning your phone call	0%	0%	8%	25%	67%
3. Our helpfulness on the telephone	0%	0%	8%	33%	59%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	0%	23%	77%
2. Cleanliness of our **restrooms**	0%	0%	0%	15%	85%
3. Cleanliness of our **dialysis treatment area**	0%	0%	0%	8%	92%
4. Comfort you feel in dialysis treatment area	0%	0%	0%	15%	85%
5. Safety you feel during dialysis treatment	0%	0%	0%	23%	77%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	0%	15%	85%
2. Friendliness/courtesy of our **Technicians**	0%	0%	0%	15%	85%
3. Concern our **Technicians** show for your issues	0%	0%	0%	15%	85%
4. Care you receive from our **Technicians**	0%	0%	0%	15%	85%
5. Friendliness/courtesy of our **Nurses**	0%	0%	0%	15%	85%
6. Concern our **Nurses** show for your issues	0%	0%	0%	15%	85%
7. Care you receive from our **Nurses**	0%	0%	0%	15%	85%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	8%	15%	77%
9. Concern our **Dietitians** show for your issues	0%	0%	0%	33%	67%
10. Care you receive from our **Dietitians**	0%	0%	0%	31%	69%
11. Friendliness/courtesy of our **Social Worker**	0%	0%	15%	15%	70%
12. Concern our **Social Worker** shows for your issues	0%	0%	8%	23%	69%
13. Care you receive from our **Social Worker**	0%	0%	0%	46%	54%
E. Physicians	**Poor Excellen%t 1**	**Fair 2**	**Average 3**	**Good 4**	**5**
1. Friendliness/courtesy of our **Physicians**	0%	0%	0%	23%	77%
2. Concern our **Physicians** show for your issues	0%	0%	0%	46%	54%
A. Care you receive from our **Physicians**	0%	0%	0%	23%	77%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Davenport
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	13%	56%	31%
2. Our promptness in returning your phone call	0%	0%	19%	56%	25%
3. Our helpfulness on the telephone	0%	0%	19%	25%	56%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	6%	56%	37%
2. Cleanliness of our **restrooms**	0%	0%	7%	67%	27%
3. Cleanliness of our **dialysis treatment area**	0%	0%	6%	44%	50%
4. Comfort you feel in dialysis treatment area	0%	0%	6%	50%	44%
5. Safety you feel during dialysis treatment	0%	0%	24%	38%	38%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	6%	44%	50%
2. Friendliness/courtesy of our **Technicians**	0%	0%	12%	19%	69%
3. Concern our **Technicians** show for your issues	0%	0%	19%	31%	50%
4. Care you receive from our **Technicians**	0%	0%	12%	25%	63%
5. Friendliness/courtesy of our **Nurses**	0%	0%	6%	50%	44%
6. Concern our **Nurses** show for your issues	0%	0%	24%	38%	38%
7. Care you receive from our **Nurses**	0%	0%	19%	50%	31%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	13%	56%	31%
9. Concern our **Dietitians** show for your issues	0%	0%	19%	44%	37%
10. Care you receive from our **Dietitians**	0%	0%	12%	50%	38%
11. Friendliness/courtesy of our **Social Worker**	0%	0%	6%	56%	37%
12. Concern our **Social Worker** shows for your issues	0%	0%	6%	56%	37%
13. Care you receive from our **Social Worker**	0%	0%	6%	56%	37%
E. Physicians	**Poor Excellen%t 1**	**Fair 2**	**Average 3**	**Good 4**	**5**
1. Friendliness/courtesy of our **Physicians**	0%	0%	18%	38%	44%
2. Concern our **Physicians** show for your issues	0%	6%	12%	38%	44%
A. Care you receive from our **Physicians**	0%	6%	13%	31%	50%

Results may not add up to 100% do to rounding of results.

Dixon Dialysis Center
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	0%	20%	80%
2. Our promptness in returning your phone call	0%	0%	0%	36%	64%
3. Our helpfulness on the telephone	0%	0%	0%	36%	64%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	6%	31%	63%
2. Cleanliness of our **restrooms**	0%	0%	7%	33%	60%
3. Cleanliness of our **dialysis treatment area**	0%	0%	0%	19%	81%
4. Comfort you feel in dialysis treatment area	0%	0%	0%	31%	69%
5. Safety you feel during dialysis treatment	0%	0%	0%	44%	56%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	0%	17%	83%
2. Friendliness/courtesy of our **Technicians**	0%	0%	6%	13%	81%
3. Concern our **Technicians** show for your issues	0%	0%	6%	19%	75%
4. Care you receive from our **Technicians**	0%	6%	0%	13%	81%
5. Friendliness/courtesy of our **Nurses**	0%	0%	0%	12%	88%
6. Concern our **Nurses** show for your issues	0%	0%	0%	19%	81%
7. Care you receive from our **Nurses**	0%	0%	0%	6%	94%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	0%	27%	73%
9. Concern our **Dietitians** show for your issues	0%	0%	0%	33%	67%
10. Care you receive from our **Dietitians**	0%	0%	0%	40%	60%
11. Friendliness/courtesy of our **Social Worker**	0%	0%	0%	19%	81%
12. Concern our **Social Worker** shows for your issues	0%	0%	0%	19%	81%
13. Care you receive from our **Social Worker**	0%	0%	0%	19%	81%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	0%	0%	33%	67%
2. Concern our **Physicians** show for your issues	0%	0%	0%	27%	73%
A. Care you receive from our **Physicians**	0%	0%	7%	20%	73%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Geneseo
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	6%	6%	35%	53%
2. Our promptness in returning your phone call	0%	0%	0%	50%	50%
3. Our helpfulness on the telephone	0%	6%	0%	31%	63%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	12%	41%	47%
2. Cleanliness of our **restrooms**	7%	7%	0%	57%	29%
3. Cleanliness of our **dialysis treatment area**	0%	0%	0%	35%	65%
4. Comfort you feel in dialysis treatment area	6%	12%	0%	41%	41%
5. Safety you feel during dialysis treatment	0%	6%	0%	44%	50%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	0%	47%	53%
2. Friendliness/courtesy of our **Technicians**	0%	0%	0%	29%	71%
3. Concern our **Technicians** show for your issues	0%	0%	0%	29%	71%
4. Care you receive from our **Technicians**	0%	0%	0%	29%	71%
5. Friendliness/courtesy of our **Nurses**	0%	0%	0%	29%	71%
6. Concern our **Nurses** show for your issues	0%	0%	0%	35%	65%
7. Care you receive from our **Nurses**	0%	0%	6%	24%	70%
8. Friendliness/courtesy of our **Dietitians**	12%	0%	6%	35%	47%
9. Concern our **Dietitians** show for your issues	19%	0%	6%	25%	50%
10. Care you receive from our **Dietitians**	18%	0%	6%	35%	41%
11. Friendliness/courtesy of our **Social Worker**	0%	0%	0%	47%	53%
12. Concern our **Social Worker** shows for your issues	0%	0%	0%	41%	59%
13. Care you receive from our **Social Worker**	0%	0%	0%	41%	59%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	6%	0%	35%	59%
2. Concern our **Physicians** show for your issues	6%	0%	0%	35%	59%
A. Care you receive from our **Physicians**	6%	0%	0%	35%	59%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Moline
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	6%	7%	45%	42%
2. Our promptness in returning your phone call	2%	9%	9%	38%	41%
3. Our helpfulness on the telephone	5%	0%	7%	46%	41%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	2%	1%	11%	39%	48%
2. Cleanliness of our **restrooms**	0%	1%	7%	42%	50%
3. Cleanliness of our **dialysis treatment area**	0%	0%	6%	41%	53%
4. Comfort you feel in dialysis treatment area	3%	1%	9%	46%	41%
5. Safety you feel during dialysis treatment	0%	4%	6%	40%	50%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	1%	17%	32%	50%
2. Friendliness/courtesy of our **Technicians**	2%	0%	4%	29%	65%
3. Concern our **Technicians** show for your issues	2%	0%	8%	36%	54%
4. Care you receive from our **Technicians**	2%	0%	4%	37%	57%
5. Friendliness/courtesy of our **Nurses**	0%	2%	2%	37%	60%
6. Concern our **Nurses** show for your issues	2%	1%	5%	31%	59%
7. Care you receive from our **Nurses**	0%	2%	0%	34%	64%
8. Friendliness/courtesy of our **Dietitians**	0%	0%	2%	39%	59%
9. Concern our **Dietitians** show for your issues	0%	0%	1%	39%	60%
10. Care you receive from our **Dietitians**	0%	0%	3%	40%	57%
11. Friendliness/courtesy of our **Social Worker**	0%	1%	2%	53%	44%
12. Concern our **Social Worker** shows for your issues	0%	3%	6%	46%	45%
13. Care you receive from our **Social Worker**	0%	1%	13%	43%	43%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	1%	2%	42%	55%
2. Concern our **Physicians** show for your issues	0%	3%	3%	44%	50%
A. Care you receive from our **Physicians**	0%	3%	5%	35%	57%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Silvis
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	0%	3%	34%	63%
2. Our promptness in returning your phone call	0%	3%	10%	36%	51%
3. Our helpfulness on the telephone	0%	2%	2%	36%	60%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	2%	0%	5%	36%	57%
2. Cleanliness of our **restrooms**	0%	0%	7%	26%	67%
3. Cleanliness of our **dialysis treatment area**	0%	0%	7%	16%	77%
4. Comfort you feel in dialysis treatment area	2%	0%	2%	30%	66%
5. Safety you feel during dialysis treatment	0%	0%	0%	27%	73%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	3%	0%	34%	63%
2. Friendliness/courtesy of our **Technicians**	0%	0%	0%	18%	82%
3. Concern our **Technicians** show for your issues	0%	0%	4%	24%	72%
4. Care you receive from our **Technicians**	0%	0%	0%	20%	80%
5. Friendliness/courtesy of our **Nurses**	0%	0%	3%	16%	81%
6. Concern our **Nurses** show for your issues	0%	0%	3%	20%	77%
7. Care you receive from our **Nurses**	0%	0%	0%	25%	75%
8. Friendliness/courtesy of our **Dietitians**	0%	3%	5%	26%	66%
9. Concern our **Dietitians** show for your issues	0%	3%	7%	20%	70%
10. Care you receive from our **Dietitians**	0%	5%	2%	26%	67%
11. Friendliness/courtesy of our **Social Worker**	0%	2%	5%	31%	62%
12. Concern our **Social Worker** shows for your issues	0%	2%	10%	28%	60%
13. Care you receive from our **Social Worker**	0%	2%	8%	30%	60%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	0%	5%	36%	59%
2. Concern our **Physicians** show for your issues	0%	2%	5%	34%	59%
A. Care you receive from our **Physicians**	0%	0%	5%	30%	65%

Results may not add up to 100% do to rounding of results.

Quad Cities Kidney Center Summary All Clinics
Patient Satisfaction Survey
2009

B. Calling Our Office	Poor 1	Fair 2	Average 3	Good 4	Excellent 5
1. Courtesy of the person who answers the telephone	0%	1%	6%	40%	53%
2. Our promptness in returning your phone call	0%	2%	12%	44%	42%
3. Our helpfulness on the telephone	0%	1%	6%	39%	54%
C. During Your Visit	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Cleanliness of our **lobby area**	0%	0%	6%	39%	55%
2. Cleanliness of our **restrooms**	1%	1%	5%	40%	53%
3. Cleanliness of our **dialysis treatment area**	0%	0%	3%	29%	68%
4. Comfort you feel in dialysis treatment area	1%	2%	3%	40%	54%
5. Safety you feel during dialysis treatment	0%	2%	4%	37%	57%
D. Patient Care Staff	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Office Staff**	0%	0%	5%	34%	61%
2. Friendliness/courtesy of our **Technicians**	0%	0%	2%	23%	75%
3. Concern our **Technicians** show for your issues	0%	0%	5%	30%	65%
4. Care you receive from our **Technicians**	0%	1%	2%	27%	70%
5. Friendliness/courtesy of our **Nurses**	0%	0%	1%	30%	69%
6. Concern our **Nurses** show for your issues	0%	0%	4%	30%	66%
7. Care you receive from our **Nurses**	0%	0%	4%	27%	69%
8. Friendliness/courtesy of our **Dietitians**	1%	0%	6%	33%	60%
9. Concern our **Dietitians** show for your issues	3%	0%	5%	34%	58%
10. Care you receive from our **Dietitians**	3%	0%	4%	37%	56%
11. Friendliness/courtesy of our **Social Worker**	0%	1%	4%	37%	58%
12. Concern our **Social Worker** shows for your issues	0%	1%	5%	37%	57%
13. Care you receive from our **Social Worker**	0%	1%	5%	39%	55%
E. Physicians	**Poor 1**	**Fair 2**	**Average 3**	**Good 4**	**Excellent 5**
1. Friendliness/courtesy of our **Physicians**	0%	1%	5%	32%	62%
2. Concern our **Physicians** show for your issues	0%	2%	4%	35%	59%
A. Care you receive from our **Physicians**	0%	1%	5%	30%	64%

Results may not add up to 100% due to rounding of results.

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(c), Project Purpose, Background and Alternatives

Alternatives

The Applicants explored several options prior to determining to expand the existing facility. The options considered and rejected were as follows:

a. Do nothing;

b. Create a fourth shift;

c. Establish a new freestanding facility;

d. Expand the Rock Island facility.

After exploring these options, which are discussed in more detail below, the Applicants determined to move forward with their project to expand the existing facility by six dialysis stations. The capital costs associated with the project are nominal particularly when compared to the benefits of proceeding. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

Quad Cities Kidney Centers began providing outpatient hemodialysis services to chronically-ill patients suffering from co-morbid conditions in Planning Area HSA 10 in 1981. Since the program began, expansion has been in line with patient volume. The growth has been steady and consistent. The establishment and expansion of dialysis centers has reflected the home residence of the patient population served by the physicians affiliated with the centers.

The Rock Island facility opened in May 2009. In that short time, the census has grown to 42 hemodialysis patients. While overall utilization of the facility is below the State Standard of 80%, this is due primarily to scheduling and access issues, which are beyond the facility's control. A majority of the patients of the Rock Island facility are reliant upon public transportation to get them to and from scheduled appointments. Due to transportation access issues, these patients can only regularly schedule their dialysis during the second shift. With 12 dialysis stations, the Rock Island facility second shift is operating at 80% capacity. See Attachment – 13A. Importantly, with reserved scheduling of patients on designated days of the week (either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday) and four-hour shifts, operating at 100% capacity is nearly impossible. This is because patients cannot be added at the last minute when a patient is forced to cancel for medical reasons (typically hospitalization or vascular access occlusion) or other reasons such as lack of transportation. Given the invariable schedule of the dialysis patient, when a patient misses dialysis treatment, he or she becomes more symptomatic and more ill. The fluid retention alone (dialysis draws up to 15 pounds of fluid from the body in a treatment) creates medical concerns.

The short term benefit of this option would be some operating expense and capital expense savings ($100,000 in capital expense). The demand placed on patients' time and energy in seeking dialysis in a more distant facility is hard to measure quantitatively but qualitatively, patients and their families benefit from having services accessible in a location that is more proximate to their home. See Patient Support Letters attached at Attachments 26C and 26D. Sometimes when patients are not offered a practical alternative for dialysis services, they opt not to initiate dialysis. This choice is one to obtain only palliative care for the disease process and the patient will die rather soon after ESRD is withheld. Moreover, because government reimbursement for outpatient dialysis is based on a fixed composite rate payment, this is not a better option from the Centers for Medicare and Medicaid Services/Department of Healthcare and Family Services perspective.

Create a Fourth Shift

As set forth in Section 1110.230(b), utilization at Quad Cities Kidney Center Rock Island is project to exceed 100% by the end of 2011 if no new dialysis stations are added. Rather than adding stations when patient census demands more service availability, occasionally, a provider will stretch its service capacity by operating a fourth shift so that each station may be used four times per day rather than three. This would increase the capacity of a 12-station facility to 48 patients per day, compared to adding six stations which would increase capacity to 54 treatments per day. When a fourth shift is operated, the dialysis facility is operated nearly around the clock with staff opening the facility around 5:00 a.m. and closing it around midnight. Not only is staffing a fourth shift difficult for clinic personnel, it is also suboptimal for the patients themselves who are chronically ill and usually elderly. Patients, many of whom rely on assistive devices such as canes and walkers, are faced with additional safety hazards when arriving and departing the facility in the dark. Some of these hazards cannot be avoided in the winter but patients feel much more secure when coming and going in the daylight.

Adding a fourth shift would increase operating costs by adding additional staffing costs and utilities cost. The costs would be somewhat higher than the operating costs of adding stations. More importantly, requiring patients to dialyze at a time when most people would already be in bed is an affront to their personal integrity and counterproductive to improved health. Third-party transportation is rarely available at night.

Importantly, even if a fourth shift was added, excess demand for dialysis services would still exist. Given current utilization and patient attrition trends, the census at Quad Cities Kidney Center Rock Island is projected to be 99 patients by December 31, 2011. Adding a fourth shift will increase the number of treatments that could be performed annually at the facility to 14,976; however, demand is projected to be 15,444 treatments. Accordingly, adding a fourth shift would not fully address the increased demand and is not an option.

Establish a Freestanding Facility

While building a freestanding facility would allow further opportunities for future expansion, a freestanding facility is not typically financially viable unless it has a minimum of eight stations. At this point the Applicants project that a six-station expansion would

accommodate Rock Island patients for the next two years and that the additional expenditure involved in a freestanding facility (approximately $1,800,000) is not justified when there is a much lower cost alternative available in the community (expanding the Rock Island facility).

Expand the Rock Island Facility

The Rock Island facility is located adjacent to the Trinity Medical Center West campus. At this location, medical coverage and access to other health care services is more readily available for the patients, particularly in emergent situations. As the patient demographic is skewed toward an elderly population with co-morbidities, this access is particularly important. After carefully weighing this low cost option against others, it was determined that this option has the least cost with the most benefit to patient care and access.

Table 1110.230(c)
Alternatives to Proposed Project
Cost Benefit Analysis

Alternative	Community Need	Access	Cost	Status
Do Nothing	Not Met	Same Level	$0	Reject
Create a Fourth Shift	Partially Met	Partially Enhanced	$0	Reject
Establish Freestanding Facility	Met	Enhanced	$1,800,000	Reject
Expand Rock Island Facility	Met	Enhanced	$100,000	Accept

ESRD Patient's Currently Receiving Treatment on Second Shift

QCKC Rock Island Unit

Initials	City	Zip Code	
B.D.	Rock Island	61201	**
J.C.	Rock Island	61201	
V.H.	Rock Island	61201	***
M.L.	Rock Island	61201	***
L.R.	Rock Island	61201	***
K.W.	Rock Island	61201	***
A.K.	Rock Island	61201	**
I.H.	Rock Island	61201	***
C.G.	Rock Island	61201	***
K.Z.	Rock Island	61201	
F.H.	Rock Island	61201	**
H.D.	Rock Island	61201	***
A.C.	Rock Island	61201	
F.W.	Rock Island	61201	***
H.M.	Rock Island	61201	***
C.M.	Rock Island	61201	
V.T.	Rock Island	61201	***
L.A.	Rock Island	61201	***
M.G.	Rock Island	61201	***

QCKC Moline Unit

Initials	City	Zip Code	
R.A	Sherrard	61281	
J.G.	Moline	61265	***
P.L.	Silvis	61282	***
J.V.	Davenport	52806	
S.C.	Moline	61265	***
P.G	Moline	61265	**
M.K.	Bettendorf	52722	**
M.B	Muscatine	52761	**
J.L	Moline	61265	*
D.L.	Rock Island	61201	
M.H.	Moline	21265	
R.A	Sherrard	61281	
A.C	Milan	61264	**
F.F	Rock Island	61201	**
R.G.	East Moline	61244	***
A.W	Moline	61265	
F.H.	Rock Island	61201	***
C.T.	Moline	61265	**
B.H	Milan	61264	***
M.E	Moline	61265	**
J.S.	Rock Island	61201	***
J.P.	Rock Island	61201	
N.A	Moline	21265	**
V.R.	Moline	61265	**
I.J.	East Moline	61244	*
J.R.	Moline	61265	**
F.R.	East Molne	61244	***
L.B	East Moline	61244	*
G.S.	East Molne	61244	
T.L.	East Moline	61244	
J.H.	Carbon Cliff	61239	***
R.T.	Milan	61264	***
P.P.	Moline	61265	**
R.B.	East Moline	61244	***
F.M.	Moline	61265	**
J.D.	Sherrard	61281	**
W.M.	Moline	61265	*

QCKC Silvis Unit

Initials	City	Zip Code	
J.P.	East Moline	61244	***
O.V.	East Moline	61244	**
A.K.	East Moline	61244	
T.C.	Silvis	61282	
L.P.	Silvis	61282	**
R.W.	Barstow	61239	***
B.M.	Erie	61250	
M.T.	Barstow	61239	***
J.F.	Coal Valley	61240	***
D.D.	Silvis	61282	***
G.F.	Carbon Cliff	61239	
R.H.	East Moline	61244	***
D.G.	East Moline	61244	***
W.S.	East Moline	61244	
F.C.	East Moline	61244	***
S.R.	East Moline	61244	***
A.T.	East Moline	61244	***
B.H.	East Moline	61244	
R.J.	East Moline	61244	**
L.F.	Colona	61241	***
S.S.	Silvis	61282	***
L.W.	Hampton	61256	**
A.B	East Moline	61244	***
Y.S.	Port Byron	61275	***
L.C.	Moline	61265	**
S.S.	Colona	61241	**
R.V.	Silvis	61282	
R.M.	East Moline	61244	***
C.W	Silvis	61282	**
A.S.	East Moline	61244	**
J. F.	Silvis	61282	**

Patient drives	
Nursing Home Transport	*
Family Transport	**
Public Transportation	***

Attachment 13A

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(a), Size of the Project

The Applicants propose to add six dialysis stations to its existing twelve station dialysis facility. No additional physical space is proposed for this project. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360-520 gross square feet per dialysis station for a total of 6,480 to 9,360 gross square feet for eighteen dialysis stations. The total gross square footage of Quad Cities Kidney Center Rock Island is 6,000 gross square feet. Accordingly, Quad Cities Kidney Center Rock Island is below the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ESRD	6,000	6,480 – 9,360	-480 – -3,360	Below State Standard

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(b), Project Services Utilization

By the second year of operation, Quad Cities Kidney Center Rock Island's annual utilization shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 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.

In only its first year of operation, Quad Cities Kidney Center Rock Island has a current census of 42 patients. See Attachment – 26A. Since its opening in May 2009, Quad Cities Kidney Center Rock Island's utilization has steadily increased by approximately 3-4 patients per month. This historical utilization is projected to continue for the near future and reflects attrition due to transplant and death. Based upon the physician referral letter, Quad Cities Nephrology Associates is currently treating 88 Stage 4 and Stage 5 CKD patients at its Rock Island office. See Attachment – 26B. An average of 65% of the Quad Cities Nephrology Associates Rock Island Stage 4 and 5 CKD patients (or 57 patients) will be referred to Quad Cities Kidney Center Rock Island within the next twelve months, increasing the patient census to 99 ESRD patients (or 91.7% utilization) by the end of 2011. With an additional 250 Stage 3 CKD patients currently treated at the Quad Cities Nephrology Associates Rock Island location, this growth is projected to continue through the end of 2012, resulting in a projected patient census of 135 patients (or over 100% utilization). Accordingly, the projected services utilization for the first two years after project completion will exceed the HFSRB utilization standard.

Table 1110.234(b)
Utilization

	Dept./ Service	Historical Utilization (Treatments)[4]	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	3,759	15,444	13,478	Yes
Year 2	ESRD	2,494	21,060	13,478	Yes

[4]Quad Cities Kidney Center Rock Island commenced operations on May 11, 2009. Year 1 historical utilization based on treatments provided from May 11, 2009 – December 31, 2009; Year 2 historical utilization based on treatments provided from January 1, 2010 – May 31, 2010.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(c), 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
Criterion 1110.234(d), Assurances

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

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(b), Planning Area Need – Service to Planning Area Residents

1. As previously discussed in Criterion 1110.230(b), the primary purpose for adding six dialysis stations to the existing facility is to expand access to life-sustaining dialysis services to the residents of Rock Island, particularly to the elderly and low-income populations who lack access to transportation and other resources. While the Applicants acknowledge there is an excess of twenty-three dialysis stations in the planning area, many of Rock Island's dialysis patients lack reliable access to transportation and other resources.[4] Importantly, Medicare and Medicaid do not generally pay for transportation to and from dialysis appointments. Medicare only pays for non-emergency ambulance transportation if a beneficiary is bed confined and other methods of transport are contraindicated or transport by ambulance is medically necessary.[5] According to the Medicare Carriers Manual, most dialysis patients are not ordinarily ill enough to require an ambulance.[6] Medicaid may pay for non-emergency transportation to a dialysis appointment; however, a cost-free mode of transportation must be unavailable or inappropriate.[7] As a result, many of these patients rely on public transportation, their nursing home, or family members to transport them to and from their dialysis appointments and can only schedule their dialysis appointments during the second shift. As previously discussed, the second shift at the Rock Island facility is currently operating at 80% capacity.

   There are two dialysis facilities within thirty minutes normal travel time of Quad Cities Kidney Center Rock Island. Quad Cities Kidney Center Moline is approximately nine minutes and Quad Cities Kidney Center Silvis is approximately nineteen minutes from the Rock Island facility. While there is additional capacity at the Moline facility, it is important to reiterate the primary purpose for the establishment of the Rock Island facility was to provide life-sustaining dialysis closer to residents who need these services. As previously discussed, the Rock Island facility predominantly serves the elderly and low income populations who lack access to transportation. The frequency and length of dialysis treatment has made providing transportation a challenging process. Often the amount of time a patient receives treatment varies, and the unpredictable recovery time following treatment makes it difficult to schedule patient return trips. This makes it difficult for providers to assist other customers, or may cause exhausted patients to remain at the treatment facility far longer than in situations where pick-up time is predictable. In order to make use of available transportation services, certain patients have to sometimes reduce their treatment length, which can have a negative effect upon patients' health. Transferring these patients to the Moline facility will result in

[4] Ill. Health Facilities and Svcs. Review Bd, Ill. Dep't Pub. Health, Addendum to Inventory of Health Care Facilities, Oct. 1, 2008 – Jul. 20, 2010 5 (Jul. 20, 2010) *available at* http://www.hfsrb.illinois.gov/pdf/Other%20Services%20Update%207-20-2010.pdf (last visited Jul. 23, 2010).
[5] 42 C.F.R. § 410.40 (2009).
[6] Ctrs. for Medicare & Medicaid Svcs., CMS Pub. 14 § 2120.3(J).
[7] Ill. Dep't of Healthcare and Family Svcs., Handbook for Providers of Transportation Services, Chapter T-200 – Policies and Procedures, T-203 (Aug. 2008) *available at* http://www.hfs.illinois.gov/assets/t200.pdf (last visited Jul. 29, 2010).

significant hardship. Accordingly, additional stations are required to meet second shift demand.

Increasing the number dialysis stations at Quad Cities Kidney Center Rock Island will not impact other area facilities or health care systems. Quad Cities Kidney Center Rock Island shares common ownership with the only two facilities within a thirty minute radius of the facility, Quad Cities Kidney Center Moline and Quad Cities Kidney Center Silvis. Therefore, any impact would be to related facilities.

Finally, and as previously discussed, this project will involve no construction or modernization. Accordingly, the cost of the project is nominal ($100,000); however, access to residents of Rock Island is significantly improved.

2. Attached as Attachment 26-A is the patient origin information by zip code for the Rock Island facility. As shown on Attachment 26-A, forty-one of forty-two patients, or 98% of patients, are from Rock Island (zip code 61201).

3. As set forth throughout this application, the Applicants propose to add six dialysis stations to its existing twelve station dialysis facility to accommodate second shift demand. The Rock Island facility commenced operations in May 2009. In just over one year, utilization at the facility has grown to forty-two patients and it is operating at just under 60% capacity. More importantly and as discussed more fully in Criterion 1110.230(b), second shift utilization is approximately 80%, which is the State's target utilization level. While there appears to be additional capacity for second shift, reserved scheduling of patients makes it nearly impossible to operate at 100% capacity. This is because station slots are reserved for unique patients who each require 156 treatments per year. A replacement patient cannot be added at the last minute when another patient cancels for medical reasons or other reasons such as lack of transportation. Given the inflexibility of scheduling, additional stations are required to accommodate demand for the second shift.

Table 1110.1430(b)(4)

	Patients	**Stations**	**Utilization**
Second Shift	19	12	79.1%
First & Second Shift	23	12	47.9%
Total	42	12	58.3%

Additionally, utilization has steadily increased since the facility's opening in May 2009. As shown in the physician referral letter attached at Attachment – 26B, Quad Cities Nephrology Associates is currently treating 88 Stage 4 and Stage 5 CKD patients at its Rock Island office. Approximately 65% percent (or 57) of these CKD patients are projected to require dialysis within the next twelve months and will be referred to Quad Cities Kidney Center Rock Island. Without the addition of the six dialysis stations,

utilization will exceed 100% and capacity will be insufficient for patient demand. As discussed above, the primary purpose for the establishment of the Quad Cities Kidney Center Rock Island is to provide access to life-sustaining dialysis to patients residing in the surrounding area who lack access to transportation. Therefore, the additional six stations are necessary to improve unrestricted access to needed dialysis services.

4. Attached as Attachment – 26B is (i) the physician referral letter from Dr. V.R. Alla, (ii) schedules of ESRD patients by zip code who are receiving care at existing facilities and (iii) pre-ESRD patients by zip code. Attached at Attachment – 26C and 26D are patient support letters from 30 pre-ESRD patients and 33 dialysis patients currently treated at Quad Cities Kidney Center Rock Island.

5. As discussed throughout this application, the proposed project is for the addition of six dialysis stations to an existing twelve station dialysis facility. As shown in Attachment 11-A, the Rock Island facility is Medicare certified. It is fully-staffed with an administrator, nurse manager, four staff nurses, a technician manager, six patient care dialysis technicians, dietician, and social worker. Quad Cities Kidney Center Rock Island anticipates hiring two additional staff nurses and three patient care dialysis technicians if HFSRB approves the additional six dialysis stations.

6. Attached at Attachment – 26E is a letter from Dr. V.R. Alla attesting that Quad Cities Kidney Center Rock Island participates in a dialysis data system, makes support services available to patients, and provides training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training. Attached at Attachment – 26F is a letter from Michael Freda, Director of Operations, Robert Young Center regarding services offered to patients referred by Quad Cities Kidney Center Rock Island. Attached at Attachment – 26G is a letter from Sean Martin, Executive Vice President of Sales & Marketing for Nationwide Laboratory Services regarding extension of laboratory services to Quad Cities Kidney Center Rock Island.

7. Attached at Attachment – 26H is a letter from Dr. V.R. Alla certifying that Quad Cities Kidney Center Rock Island will achieve target utilization by the second year of operation and outcome measures will meet or exceed current standards, as well as copies of the Renal Network Compliancy Awards for the dialysis facilities owned and operated by the Applicants are attached at Attachment – 26I

ESRD Patient's Rock Island Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	L.A.	Rock Island	61201	Rock Island
2	R.A.	Rock Island	61201	Rock Island
3	A.A.	Rock Island	61201	Rock Island
4	L.C.	Rock Island	61201	Rock Island
5	J.C.	Rock Island	61201	Rock Island
6	A.C.	Rock Island	61201	Rock Island
7	J.C.	Rock Island	61201	Rock Island
8	H.D.	Rock Island	61201	Rock Island
9	F.D.	Rock Island	61201	Rock Island
10	S.D.	Rock Island	61201	Rock Island
11	J.D.	Rock Island	61201	Rock Island
12	D.F.	Rock Island	61201	Rock Island
13	L.G.	Rock Island	61201	Rock Island
14	C.G.	Rock Island	61201	Rock Island
15	M.G.	Rock Island	61201	Rock Island
16	F.H.	Rock Island	61201	Rock Island
17	I.H.	Rock Island	61201	Rock Island
18	V.H.	Rock Island	61201	Rock Island
19	J.H.	Milan	61264	Rock Island
20	M.J.	Rock Island	61201	Rock Island
21	P.J.	Rock Island	61201	Rock Island
22	W.J.	Rock Island	61201	Rock Island
23	M.J.	Rock Island	61201	Rock Island
24	J.K.	Rock Island	61201	Rock Island
25	A.K.	Rock Island	61201	Rock Island
26	M.L.	Rock Island	61201	Rock Island
27	C.L.	Rock Island	61201	Rock Island
28	H.M.	Rock Island	61201	Rock Island
29	C.M.	Rock Island	61201	Rock Island
30	M.M.	Rock Island	61201	Rock Island
31	A.M.	Rock Island	61201	Rock Island
32	E.P.	Rock Island	61201	Rock Island
33	M.R.	Rock Island	61201	Rock Island
34	P.R.	Rock Island	61201	Rock Island
35	L.R.	Rock Island	61201	Rock Island
36	A.S.	Rock Island	61201	Rock Island
37	K.S.	Rock Island	61201	Rock Island
38	V.T.	Rock Island	61201	Rock Island
39	J.V.	Rock Island	61201	Rock Island
40	F.W.	Rock Island	61201	Rock Island
41	K.W.	Rock Island	61201	Rock Island
42	K.Z.	Rock Island	61201	Rock Island

ESRD Patient's Moline Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	R.A	Sherrard	61281	Mercer
2	N.A	Moline	21265	Rock Island
3	L.A.	Orion	61273	Rock Island
4	J.A.	East Moline	61244	Rock Island
5	N.B.	Moline	61265	Rock Island
6	L.B	East Moline	61244	Rock Island
7	M.B	Muscatine	52761	Muscatine
8	C.B.	Colona	61241	Henry
9	R.B.	East Moline	61244	Rock Island
10	C.B.	Colona	61241	Rock Island
11	R.C.	Orion	61273	Rock Island
12	J.C	Coal Valley	61240	Rock Island
13	J.C	Rock Island	61201	Rock Island
14	S.C.	Moline	61265	Rock Island
15	A.C	Milan	61264	Rock Island
16	J.D.	Sherrard	61281	Rock Island
17	B.D.	Rock Island	61201	Rock Island
18	C.D	Andulusia	61232	Rock Island
19	M.E	Milan	61264	Rock Island
20	M.E	Moline	61265	Rock Island
21	F.F	Rock Island	61201	Rock Island
22	A.G.	Moline	61265	Rock Island
23	E.G.	Moline	61265	Rock Island
24	E.G.	Moline	61265	Rock Island
25	R.G.	Moline	61265	Rock Island
26	P.G	Moline	61265	Rock Island
27	R.G.	East Moline	61244	Rock Island
28	J.G.	Moline	61265	Rock Island
29	L.G.	Moline	61265	Rock Island
30	C.H.	East Moline	61244	Rock Island
31	M.H.	Moline	21265	Rock Island
32	B.H	Milan	61264	Rock Island
33	B.H.	Muscatine	52761	Muscatine
34	F.H.	Rock Island	61201	Rock Island
35	J.H.	Carbon Cliff	61239	Rock Island
36	I.J.	East Moline	61244	Rock Island
37	T.J.	Milan	61264	Rock Island
38	K.J.	Rock Island	61201	Rock Island
39	J.K.	Rock Island	61201	Rock Island
40	C.K.	Moline	61265	Rock Island
41	R.K.	Walcott	52773	Scott
43	A.K.	Moline	61265	Rock Island
44	B.K.	Milan	61264	Rock Island
45	L.K.	Rock Island	61201	Rock Island
46	K.K.	Milan	61264	Rock Island
47	T.L.	East Moline	61244	Rock Island
48	C.L.	Moline	61265	Rock Island

	Patient's Intials	City	Zip Code	County
49	J.L	Moline	61265	Rock Island
50	D.L.	Rock Island	61201	Rock Island
51	P.L.	Silvis	61244	Rock Island
52	R.M.	Moline	61265	Rock Island
53	F.M.	Moline	61265	Rock Island
54	F.M.	Moline	61265	Rock Island
55	R.M.	Moline	61265	Rock Island
56	J.M.	Coal Valley	61240	Rock Island
57	S.M.	Milan	61264	Rock Island
58	J.M.	Rock Island	61201	Rock Island
59	V.M.	Moline	61265	Rock Island
60	W.M.	Moline	61265	Rock Island
61	W.N.	Rock Island	61201	Rock Island
62	J.O.	Coal Valley	61240	Rock Island
63	R.P.	Moline	61265	Rock Island
64	J.P.	Rock Island	61201	Rock Island
65	A.P.	Rock Island	61201	Rock Island
66	P.P.	Moline	61265	Rock Island
67	H.P	Rock Island	61201	Rock Island
68	T.R.	Moline	61265	Rock Island
69	V.R.	Moline	61265	Rock Island
70	F.R.	East Molne	61244	Rock Island
71	L.R.	Rock Island	61201	Rock Island
72	R.R.	Milan	61264	Rock Island
73	J.R.	Moline	61265	Rock Island
74	J.R.	Moline	61265	Rock Island
75	P.S.	Geneseo	61254	Henry
76	G.S.	Coal Valley	61240	Rock Island
77	D.S.	Rock Island	61201	Rock Island
78	C.S.	Moline	61265	Rock Island
79	D.S.	Rock Island	61201	Rock Island
80	J.S.	Rock Island	61201	Rock Island
81	G.S.	East Molne	61244	Rock Island
82	P.S.	Rock Island	61201	Rock Island
83	W.T.	Rock Island	61201	Rock Island
84	R.T.	Milan	61264	Rock Island
85	C.T.	Moline	61265	Rock Island
86	M.T.	East Molne	61244	Rock Island
87	M.T.	Hillsdale	61257	Rock Island
88	J.V.	East Molne	61244	Rock Island
89	T.V.	Moline	61265	Rock Island
90	J.V.	Davenport	52806	Scott
91	K.V.	Moline	61265	Rock Island
92	F.V.	Moline	61265	Rock Island
93	B.W.	Moline	61265	Rock Island
94	L.W.	Muscatine	52761	Muscatine
95	J.W.	Moline	61265	Rock Island
96	A.W	Moline	61265	Rock Island
97	M.W.	Silvis	61244	Rock Island
98	G.W.	Rock Island	61201	Rock Island
99	B.Y.	Milan	61264	Rock Island

ESRD Patient's Silvis Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	J.A.	Silvis	61282	Rock Island
2	P.B.	East Moline	61244	Rock Island
3	R.B.	Geneseo	61254	Henry
4	D.B.	Orion	61265	Henry
5	K.B.	Moline	61265	Rock Island
6	A.B	East Moline	61244	Rock Island
7	M.B.	Port Byron	61275	Rock Island
8	A.B.	East Moline	61244	Rock Island
9	F.C.	East Moline	61244	Rock Island
10	L.C.	Moline	61265	Rock Island
11	J.C.	East Moline	61244	Rock Island
12	D.D.	Silvis	61282	Rock Island
13	L.D.	Moline	61265	Rock Island
14	L.F.	Colona	61241	Henry
15	R.F.	East Moline	61244	Rock Island
16	J.F.	Coal Valley	61240	Rock Island
17	G.F.	Carbon Cliff	61239	Rock Island
18	D.G.	East Moline	61244	Rock Island
19	R.G.	Silvis	61282	Rock Island
20	L.G.	Erie	61250	Whiteside
21	K.H.	Moline	61265	Rock Island
22	B.H.	East Moline	61244	Rock Island
23	R.H.	East Moline	61244	Rock Island
24	J.H.	East Moline	61244	Rock Island
25	J.J.	Port Byron	61275	Rock Island
26	M.J.	East Moline	61244	Rock Island
27	R.J.	East Moline	61244	Rock Island
28	C.J.	Port Byron	61275	Rock Island
29	D.K.	East Moline	61244	Rock Island
30	A.K.	East Moline	61244	Rock Island
31	W.K.	Cordova	61242	Rock Island
32	T.L.	Moline	61265	Rock Island
33	S.M.	East Moline	61244	Rock Island
34	B.M.	Erie	61250	Whiteside
35	R.M.	East Moline	61244	Rock Island
36	K.M.	East Moline	61244	Rock Island
37	J.P.	East Moline	61244	Rock Island
38	L.P.	Silvis	61282	Rock Island
39	R.P.	Colona	61241	Henry
40	S.R.	East Moline	61244	Rock Island
41	P.R.	Rapid City	61278	Rock Island
42	O.R.	Carbon Cliff	61239	Rock Island
43	T.R.	Colona	61241	Henry
44	G.S.	Silvis	61282	Rock Island

	Patient's Intials	City	Zip Code	County
45	A.S.	East Moline	61244	Rock Island
46	W.S.	East Moline	61244	Rock Island
47	S.S.	Colona	61241	Henry
48	S.S.	Silvis	61282	Rock Island
49	Y.S.	Port Byron	61275	Rock Island
50	A.T.	East Moline	61244	Rock Island
51	R.T.	Cordova	61242	Rock Island
52	C.T.	Silvis	61282	Rock Island
53	M.T.	Barstow	61239	Rock Island
54	O.V.	East Moline	61244	Rock Island
55	R.V.	Silvis	61282	Rock Island
56	L.W.	Hampton	61256	Rock Island
57	C.W	Silvis	61282	Rock Island
58	E.W.	Silvis	61282	Rock Island
59	R.W.	Barstow	61239	Rock Island
60				

ESRD Patient Census

July 6 2010

Aledo	11
Bettendorf	17
Davenport	38
Dixon	16
Geneseo	18
Maquoketa	6
Moline	99
Rock Island	42
Silvis	59
Total	306

Quad Cities Nephrology Associates P.L.C. L.L.C.

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapheresis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Office Locations

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

Hospitals

Trinity Medical Center
-Trinity Moline Campus
Moline, Illinois

-Trinity Rock Island Campus
Rock Island, Illinois

-Trinity Bettendorf Campus
Bettendorf, Iowa

-Trinity Muscatine Campus
Muscatine, Iowa

Genesis Medical Center
-Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

Mercer County Hospital
Aledo, Illinois

Jackson County
Regional Health Center
Maquoketa, Iowa

V. R. Alla, M.D. *Rajendra Dahal, M.D.* *Rajesh Alla, M.D.*
Anwar Ahmed, M.D. *Nicolas Forero, M.D.* *Chijioke Ogbu, M.D.*

July 20, 2010

Mike Constantino
Illinois Health Facilities Planning
525 W. Jefferson, 2nd Floor
Springfield, IL 62761

Re: Quad Cities Kidney Center Rock Island, LLC CON Application for expansion

Dear Mr. Constantino,

Quad Cities Nephrology Associates consists of six Nephrologists who provide care to the ESRD and Pre-ESRD patients. We have been providing care to 95% of the HSA-10 ESRD and Pre-ESRD population for the last 30 years. Our Nephrology group provides ESRD care to five of the six dialysis facilities in the HSA-10. Quad Cities Nephrology Associates has offices at the five Quad Cities Kidney Center facilities and provides care for the chronic kidney disease patients who are in different stages not yet on dialysis. Out of the six Nephrologists two are Interventional Nephrologists providing interventional vascular access procedures for the maintenance of the vascular access of the ESRD patients. So Quad Cities Nephrology Associates is providing the total care of the ESRD and Pre-ESRD patients in the HAS-10.

With Quad Cities Nephrology Associates having an office in all the Quad Cities Kidney Center facilities they do early diagnosing and management of their Pre-ESRD population. Quad Cities Nephrology Associates reviews annually and identifies where their Pre-ESRD growth is and recommends to Quad Cities Kidney Center the need for either expansion of their present centers or the establishing of a new facility based on where the need is. As we have submitted the Pre-ESRD list we have 401 pre-ESRD patients at the Rock Island location, 1,182 pre-ESRD patients at the Moline location and 620 pre-ESRD patients at the Silvis location of Quad Cities Kidney Center. All these patients will be referred to the respective dialysis center where the patients are located when they reach their ESRD.

Since the average age of our dialysis patients is greater than 65 and the majority of our patients requiring transportation to the dialysis facility by family members, public transportation or nursing home transportation, most of them prefer the second shift of dialysis. With the various transportation problems there is a great demand for the second shift which has forced a waiting list particularly at the Rock Island location.

There is a large population of Afro-American and Hispanic patients where the incidence of chronic kidney disease is three to four times higher respectfully living in Rock Island. Since the three dialysis facilities in Rock Island, Moline and Silvis are owned by the same company it will not impact their utilization. Moreover, the expansion of Rock Island will improve access for the ESRD patients of their desired time, shift and day to receive their dialysis treatments.

The Nephrologists of Quad Cities Nephrology Associates highly recommends the expansion of Quad Cities Kidney Center-Rock Island.

Sincerely,

V.R. Alla MD

V.R. Alla, M.D.

OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

State of Illinois
County of Rock Island
Signed before me this 22nd day of July, 2010
by V.R. Alla MD
Debora L Blaser
Notary Public

ESRD Patient's Rock Island Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	L.A.	Rock Island	61201	Rock Island
2	R.A.	Rock Island	61201	Rock Island
3	A.A.	Rock Island	61201	Rock Island
4	L.C.	Rock Island	61201	Rock Island
5	J.C.	Rock Island	61201	Rock Island
6	A.C.	Rock Island	61201	Rock Island
7	J.C.	Rock Island	61201	Rock Island
8	H.D.	Rock Island	61201	Rock Island
9	F.D.	Rock Island	61201	Rock Island
10	S.D.	Rock Island	61201	Rock Island
11	J.D.	Rock Island	61201	Rock Island
12	D.F.	Rock Island	61201	Rock Island
13	L.G.	Rock Island	61201	Rock Island
14	C.G.	Rock Island	61201	Rock Island
15	M.G.	Rock Island	61201	Rock Island
16	F.H.	Rock Island	61201	Rock Island
17	I.H.	Rock Island	61201	Rock Island
18	V.H.	Rock Island	61201	Rock Island
19	J.H.	Milan	61264	Rock Island
20	M.J.	Rock Island	61201	Rock Island
21	P.J.	Rock Island	61201	Rock Island
22	W.J.	Rock Island	61201	Rock Island
23	M.J.	Rock Island	61201	Rock Island
24	J.K.	Rock Island	61201	Rock Island
25	A.K.	Rock Island	61201	Rock Island
26	M.L.	Rock Island	61201	Rock Island
27	C.L.	Rock Island	61201	Rock Island
28	H.M.	Rock Island	61201	Rock Island
29	C.M.	Rock Island	61201	Rock Island
30	M.M.	Rock Island	61201	Rock Island
31	A.M.	Rock Island	61201	Rock Island
32	E.P.	Rock Island	61201	Rock Island
33	M.R.	Rock Island	61201	Rock Island
34	P.R.	Rock Island	61201	Rock Island
35	L.R.	Rock Island	61201	Rock Island
36	A.S.	Rock Island	61201	Rock Island
37	K.S.	Rock Island	61201	Rock Island
38	V.T.	Rock Island	61201	Rock Island
39	J.V.	Rock Island	61201	Rock Island
40	F.W.	Rock Island	61201	Rock Island
41	K.W.	Rock Island	61201	Rock Island
42	K.Z.	Rock Island	61201	Rock Island

ESRD Patient's Moline Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	R.A	Sherrard	61281	Mercer
2	N.A	Moline	21265	Rock Island
3	L.A.	Orion	61273	Rock Island
4	J.A.	East Moline	61244	Rock Island
5	N.B.	Moline	61265	Rock Island
6	L.B	East Moline	61244	Rock Island
7	M.B	Muscatine	52761	Muscatine
8	C.B.	Colona	61241	Henry
9	R.B.	East Moline	61244	Rock Island
10	C.B.	Colona	61241	Rock Island
11	R.C.	Orion	61273	Rock Island
12	J.C	Coal Valley	61240	Rock Island
13	J.C	Rock Island	61201	Rock Island
14	S.C.	Moline	61265	Rock Island
15	A.C	Milan	61264	Rock Island
16	J.D.	Sherrard	61281	Rock Island
17	B.D.	Rock Island	61201	Rock Island
18	C.D	Andulusia	61232	Rock Island
19	M.E	Milan	61264	Rock Island
20	M.E	Moline	61265	Rock Island
21	F.F	Rock Island	61201	Rock Island
22	A.G.	Moline	61265	Rock Island
23	E.G.	Moline	61265	Rock Island
24	E.G.	Moline	61265	Rock Island
25	R.G.	Moline	61265	Rock Island
26	P.G	Moline	61265	Rock Island
27	R.G.	East Moline	61244	Rock Island
28	J.G.	Moline	61265	Rock Island
29	L.G.	Moline	61265	Rock Island
30	C.H.	East Moline	61244	Rock Island
31	M.H.	Moline	21265	Rock Island
32	B.H	Milan	61264	Rock Island
33	B.H.	Muscatine	52761	Muscatine
34	F.H.	Rock Island	61201	Rock Island
35	J.H.	Carbon Cliff	61239	Rock Island
36	I.J.	East Moline	61244	Rock Island
37	T.J.	Milan	61264	Rock Island
38	K.J.	Rock Island	61201	Rock Island
39	J.K.	Rock Island	61201	Rock Island
40	C.K.	Moline	61265	Rock Island
41	R.K.	Walcott	52773	Scott
43	A.K.	Moline	61265	Rock Island
44	B.K.	Milan	61264	Rock Island
45	L.K.	Rock Island	61201	Rock Island
46	K.K.	Milan	61264	Rock Island
47	T.L.	East Moline	61244	Rock Island
48	C.L.	Moline	61265	Rock Island

	Patient's Intials	City	Zip Code	County
49	J.L	Moline	61265	Rock Island
50	D.L.	Rock Island	61201	Rock Island
51	P.L.	Silvis	61244	Rock Island
52	R.M.	Moline	61265	Rock Island
53	F.M.	Moline	61265	Rock Island
54	F.M.	Moline	61265	Rock Island
55	R.M.	Moline	61265	Rock Island
56	J.M.	Coal Valley	61240	Rock Island
57	S.M.	Milan	61264	Rock Island
58	J.M.	Rock Island	61201	Rock Island
59	V.M.	Moline	61265	Rock Island
60	W.M.	Moline	61265	Rock Island
61	W.N.	Rock Island	61201	Rock Island
62	J.O.	Coal Valley	61240	Rock Island
63	R.P.	Moline	61265	Rock Island
64	J.P.	Rock Island	61201	Rock Island
65	A.P.	Rock Island	61201	Rock Island
66	P.P.	Moline	61265	Rock Island
67	H.P	Rock Island	61201	Rock Island
68	T.R.	Moline	61265	Rock Island
69	V.R.	Moline	61265	Rock Island
70	F.R.	East Molne	61244	Rock Island
71	L.R.	Rock Island	61201	Rock Island
72	R.R.	Milan	61264	Rock Island
73	J.R.	Moline	61265	Rock Island
74	J.R.	Moline	61265	Rock Island
75	P.S.	Geneseo	61254	Henry
76	G.S.	Coal Valley	61240	Rock Island
77	D.S.	Rock Island	61201	Rock Island
78	C.S.	Moline	61265	Rock Island
79	D.S.	Rock Island	61201	Rock Island
80	J.S.	Rock Island	61201	Rock Island
81	G.S.	East Molne	61244	Rock Island
82	P.S.	Rock Island	61201	Rock Island
83	W.T.	Rock Island	61201	Rock Island
84	R.T.	Milan	61264	Rock Island
85	C.T.	Moline	61265	Rock Island
86	M.T.	East Molne	61244	Rock Island
87	M.T.	Hillsdale	61257	Rock Island
88	J.V.	East Molne	61244	Rock Island
89	T.V.	Moline	61265	Rock Island
90	J.V.	Davenport	52806	Scott
91	K.V.	Moline	61265	Rock Island
92	F.V.	Moline	61265	Rock Island
93	B.W.	Moline	61265	Rock Island
94	L.W.	Muscatine	52761	Muscatine
95	J.W.	Moline	61265	Rock Island
96	A.W	Moline	61265	Rock Island
97	M.W.	Silvis	61244	Rock Island
98	G.W.	Rock Island	61201	Rock Island
99	B.Y.	Milan	61264	Rock Island

ESRD Patient's Silvis Unit

July 6 2010

	Patient's Intials	City	Zip Code	County
1	J.A.	Silvis	61282	Rock Island
2	P.B.	East Moline	61244	Rock Island
3	R.B.	Geneseo	61254	Henry
4	D.B.	Orion	61265	Henry
5	K.B.	Moline	61265	Rock Island
6	A.B	East Moline	61244	Rock Island
7	M.B.	Port Byron	61275	Rock Island
8	A.B.	East Moline	61244	Rock Island
9	F.C.	East Moline	61244	Rock Island
10	L.C.	Moline	61265	Rock Island
11	J.C.	East Moline	61244	Rock Island
12	D.D.	Silvis	61282	Rock Island
13	L.D.	Moline	61265	Rock Island
14	L.F.	Colona	61241	Henry
15	R.F.	East Moline	61244	Rock Island
16	J.F.	Coal Valley	61240	Rock Island
17	G.F.	Carbon Cliff	61239	Rock Island
18	D.G.	East Moline	61244	Rock Island
19	R.G.	Silvis	61282	Rock Island
20	L.G.	Erie	61250	Whiteside
21	K.H.	Moline	61265	Rock Island
22	B.H.	East Moline	61244	Rock Island
23	R.H.	East Moline	61244	Rock Island
24	J.H.	East Moline	61244	Rock Island
25	J.J.	Port Byron	61275	Rock Island
26	M.J.	East Moline	61244	Rock Island
27	R.J.	East Moline	61244	Rock Island
28	C.J.	Port Byron	61275	Rock Island
29	D.K.	East Moline	61244	Rock Island
30	A.K.	East Moline	61244	Rock Island
31	W.K.	Cordova	61242	Rock Island
32	T.L.	Moline	61265	Rock Island
33	S.M.	East Moline	61244	Rock Island
34	B.M.	Erie	61250	Whiteside
35	R.M.	East Moline	61244	Rock Island
36	K.M.	East Moline	61244	Rock Island
37	J.P.	East Moline	61244	Rock Island
38	L.P.	Silvis	61282	Rock Island
39	R.P.	Colona	61241	Henry
40	S.R.	East Moline	61244	Rock Island
41	P.R.	Rapid City	61278	Rock Island
42	O.R.	Carbon Cliff	61239	Rock Island
43	T.R.	Colona	61241	Henry
44	G.S.	Silvis	61282	Rock Island

	Patient's Intials	City	Zip Code	County
45	A.S.	East Moline	61244	Rock Island
46	W.S.	East Moline	61244	Rock Island
47	S.S.	Colona	61241	Henry
48	S.S.	Silvis	61282	Rock Island
49	Y.S.	Port Byron	61275	Rock Island
50	A.T.	East Moline	61244	Rock Island
51	R.T.	Cordova	61242	Rock Island
52	C.T.	Silvis	61282	Rock Island
53	M.T.	Barstow	61239	Rock Island
54	O.V.	East Moline	61244	Rock Island
55	R.V.	Silvis	61282	Rock Island
56	L.W.	Hampton	61256	Rock Island
57	C.W	Silvis	61282	Rock Island
58	E.W.	Silvis	61282	Rock Island
59	R.W.	Barstow	61239	Rock Island
60				

ESRD Patient Census

July 6 2010

Aledo	11
Bettendorf	17
Davenport	38
Dixon	16
Geneseo	18
Maquoketa	6
Moline	99
Rock Island	42
Silvis	59
Total	306

Rock Island CKD patients

Totals: CKD Patients, Stages, County

County	Stage 5	Stage 4	Stage 3	Total Patients
Rock Island	8	79	248	335
Mercer	0	0	2	2
Scott	0	1	0	1
				338

6/25/2010

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
1	Int's	City	Zip	County	Sta.					
2	AB	Rock Island	61201	Rock Island	3					
3	AC	Rock Island	61201	Rock Island	4					
4	AD	Rock Island	61201	Rock Island	3					
5	AE	Rock Island	61201	Rock Island	4					
6	AH	Rock Island	61201	Rock Island	3					
7	AJ	Rock Island	61201	Rock Island	3					
8	AK	Rock Island	61201	Rock Island	3					
9	AL-G	Rock Island	61201	Rock Island	3					
10	AM	Rock Island	61201	Rock Island	3					
11	AM	Rock Island	61201	Rock Island	3					
12	AM	Rock Island	61201	Rock Island	3					
13	AM	Rock Island	61201	Rock Island	3					
14	AO	Rock Island	61201	Rock Island	4					
15	AS	Rock Island	61201	Rock Island	4					
16	AS	Rock Island	61201	Rock Island	3					
17	AW	Rock Island	61201	Rock Island	3					
18	BB	Rock Island	61201	Rock Island	3					
19	BC	Rock Island	61201	Rock Island	3					
20	BD	Rock Island	61201	Rock Island	3					
21	BE	Rock Island	61201	Rock Island	3					
22	BG	Rock Island	61201	Rock Island	4					
23	BL	Milan	61264	Rock Island	3					
24	BM	Rock Island	61201	Rock Island	4					
25	BM	Rock Island	61201	Rock Island	3					
26	BN	Rock Island	61201	Rock Island	3					
27	BN	Rock Island	61201	Rock Island	3					
28	BR	Rock Island	61201	Rock Island	4					
29	BS	Rock Island	61201	Rock Island	3					
30	BW	Rock Island	61201	Rock Island	4					
31	BW	Rock Island	61201	Rock Island	3					
32	BW	Rock Island	61201	Rock Island	3					
33	BW	Rock Island	61201	Rock Island	3					
34	BW	Rock Island	61201	Rock Island	3					
35	CB	Milan	61201	Rock Island	3					
36	CB	Rock Island	61201	Rock Island	3					
37	CB	Rock Island	61201	Rock Island	3					
38	CC	Rock Island	61201	Rock Island	3					
39	CD	Rock Island	61201	Rock Island	3					
40	CD	Rock Island	61201	Rock Island	3					
41	CH	Rock Island	61201	Rock Island	3					
42	CH	Rock Island	61201	Rock Island	3					
43	CH	Rock Island	61201	Rock Island	3					
44	CL	Rock Island	61201	Rock Island	4					
45	CL	Rock Island	61201	Rock Island	3					
46	CL	Rock Island	61201	Rock Island	3					
47	CM	Davenport	52802	Scott	4					
48	CM	Rock Island	61201	Rock Island	4					
49	CM	Rock Island	61201	Rock Island	3					
50	CM	Rock Island	61201	Rock Island	3					
51	CS	Andalusia	61232	Rock Island	3					
52	CT	Rock Island	61201	Rock Island	3					
53	DA	Rock Island	61201	Rock Island	4					
54	DB	Rock Island	61201	Rock Island	3					
55	DB	Rock Island	61201	Rock Island	3					
56	DB	Rock Island	61201	Rock Island	3					
57	DB	Rock Island	61201	Rock Island	3					

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
58	DB	Rock Island	61201	Rock Island	3					
59	DC	Milan	61264	Rock Island	4					
60	DC	Rock Island	61201	Rock Island	3					
61	DD	Rock Island	61201	Rock Island	4					
62	DF	Rock Island	61201	Rock Island	4					
63	DF	Rock Island	61201	Rock Island	3					
64	DG	Moline	61265	Rock Island	3					
65	DG	Rock Island	61201	Rock Island	4					
66	DH	Rock Island	61201	Rock Island	3					
67	DH	Rock Island	61201	Rock Island	3					
68	DH	Rock Island	61201	Rock Island	3					
69	DH	Rock Island	61201	Rock Island	3					
70	DH	Rock Island	61201	Rock Island	3					
71	DJ	Rock Island	61201	Rock Island	4					
72	DL	Rock Island	61201	Rock Island	5					
73	DL	Rock Island	61201	Rock Island	4					
74	DL	Rock Island	61201	Rock Island	3					
75	DM	Milan	61264	Rock Island	3					
76	DM	Rock Island	61201	Rock Island	3					
77	DN	Rock Island	61201	Rock Island	3					
78	DP	Rock Island	61201	Rock Island	3					
79	DR	Rock Island	61201	Rock Island	3					
80	DR	Taylor Ridge	61284	Rock Island	4					
81	DS	Milan	61264	Rock Island	5					
82	DS	Rock Island	61201	Rock Island	3					
83	DS	Rock Island	61201	Rock Island	3					
84	DT	Milan	61264	Rock Island	3					
85	DT	Rock Island	61201	Rock Island	4					
86	DT	Rock Island	61201	Rock Island	3					
87	DT	Rock Island	61201	Rock Island	3					
88	DV	Rock Island	61201	Rock Island	3					
89	DW	Rock Island	61201	Rock Island	3					
90	DW	Rock Island	61201	Rock Island	3					
91	DW	Rock Island	61201	Rock Island	3					
92	DW	Rock Island	61201	Rock Island	3					
93	DY	Rock Island	61201	Rock Island	3					
94	EB	Rock Island	61201	Rock Island	3					
95	EB	Rock Island	61201	Rock Island	3					
96	EF	Rock Island	61201	Rock Island	3					
97	EH	Milan	61264	Rock Island	4					
98	EJ	Rock Island	61201	Rock Island	3					
99	EL	Rock Island	61201	Rock Island	3					
100	EL	Rock Island	61201	Rock Island	3					
101	EM	Rock Island	61201	Rock Island	3					
102	EP	Rock Island	61201	Rock Island	3					
103	ES	Rock Island	61201	Rock Island	4					
104	ES	Rock Island	61201	Rock Island	3					
105	ES	Rock Island	61201	Rock Island	3					
106	ES	Rock Island	61201	Rock Island	3					
107	ET	Rock Island	61201	Rock Island	3					
108	EV	Rock Island	61201	Rock Island	3					
109	EW	Rock Island	61201	Rock Island	3					
110	EW	Rock Island	61201	Rock Island	3					
111	FG	Milan	61264	Rock Island	3					
112	FH	RI	61201	Rock Island	3					
113	FH	RI	61201	Rock Island	3					
114	FJ	Ri	61201	Rock Island	3					

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
115	FK	RI	61201	Rock Island	3					
116	FT	RI	61201	Rock Island	4					
117	FV	RI	61201	Rock Island	3					
118	GA	RI	61201	Rock Island	3					
119	GA	RI	61201	Rock Island	3					
120	GF	RI	61201	Rock Island	3					
121	GG	Milan	61264	Rock Island	3					
122	GH	Rock Island	61201	Rock Island	4					
123	GH	Rock Island	61201	Rock Island	3					
124	GH	Rock Island	61201	Rock Island	3					
125	GJ	Rock Island	61201	Rock Island	3					
126	GM	Rock Island	61201	Rock Island	4					
127	GM	Rock Island	61201	Rock Island	3					
128	GP	Rock Island	61201	Rock Island	3					
129	GP	Rock Island	61201	Rock Island	3					
130	GS	Rock Island	61201	Rock Island	4					
131	HB	Rock Island	61201	Rock Island	3					
132	HD	Milan	61264	Rock Island	3					
133	HF	Rock Island	61201	Rock Island	3					
134	HJ	Rock Island	61201	Rock Island	4					
135	HJ	Rock Island	61201	Rock Island	3					
136	HL	Moline	61265	Rock Island	3					
137	HM	Rock Island	61201	Rock Island	4					
138	HT	Rock Island	61201	Rock Island	4					
139	IB	Rock Island	61201	Rock Island	3					
140	IJ	Rock Island	61201	Rock Island	4					
141	IJ	Rock Island	61201	Rock Island	4					
142	JB	Rock Island	61201	Rock Island	4					
143	JB	Rock Island	61201	Rock Island	3					
144	JB	Rock Island	61201	Rock Island	3					
145	JB	Rock Island	61201	Rock Island	3					
146	JB	Rock Island	61201	Rock Island	3					
147	JB	Rock Island	61201	Rock Island	3					
148	JC	Rock Island	61201	Rock Island	5					
149	JC	Rock Island	61201	Rock Island	4					
150	JC	Rock Island	61201	Rock Island	3					
151	JC	Rock Island	61201	Rock Island	3					
152	JD	Rock Island	61201	Rock Island	3					
153	JE	Rock Island	61201	Rock Island	3					
154	JF	Rock Island	61201	Rock Island	3					
155	JF	Rock Island	61201	Rock Island	3					
156	JF	Rock Island	61201	Rock Island	3					
157	JH	Rock Island	61201	Rock Island	5					
158	JH	Rock Island	61201	Rock Island	4					
159	JH	Rock Island	61201	Rock Island	4					
160	JH	Rock Island	61201	Rock Island	3					
161	JK	Rock Island	61201	Rock Island	3					
162	JK	Rock Island	61201	Rock Island	3					
163	JK	Rock Island	61201	Rock Island	3					
164	JK	Rock Island	61201	Rock Island	3					
165	JL	Rock Island	61201	Rock Island	3					
166	JM	Rock Island	61201	Rock Island	4					
167	JM	Rock Island	61201	Rock Island	3					
168	JN	Rock Island	61201	Rock Island	4					
169	JN	Rock Island	61201	Rock Island	3					
170	JN	Rock Island	61201	Rock Island	3					
171	JP	Rock Island	61201	Rock Island	4					

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
172	JP	Rock Island	61201	Rock Island	3					
173	JP	Rock Island	61201	Rock Island	3					
174	JQ	Rock Island	61201	Rock Island	4					
175	JR	Rock Island	61201	Rock Island	3					
176	JS	Rock Island	61201	Rock Island	3					
177	JV	Rock Island	61201	Rock Island	4					
178	JW	Rock Island	61201	Rock Island	4					
179	JW	Rock Island	61201	Rock Island	3					
180	JW	Rock Island	61201	Rock Island	3					
181	KB	Rock Island	61201	Rock Island	3					
182	KC	Rock Island	61201	Rock Island	3					
183	KD	Moline	61265	Rock Island	3					
184	KF	Rock Island	61201	Rock Island	3					
185	KG	Rock Island	61201	Rock Island	3					
186	KH	Rock Island	61201	Rock Island	5					
187	KH	Rock Island	61265	Rock Island	3					
188	KL	Rock Island	61201	Rock Island	3					
189	KN	Rock Island	61201	Rock Island	3					
190	KS	Milan	61264	Rock Island	4					
191	KW	Milan	61201	Rock Island	3					
192	LB	Rock Island	61201	Rock Island	4					
193	LB	Rock Island	61201	Rock Island	4					
194	LB	Rock Island	61201	Rock Island	4					
195	LC	Rock Island	61201	Rock Island	3					
196	LD	Rock Island	61201	Rock Island	3					
197	LF	Rock Island	61201	Rock Island	3					
198	LG	Rock Island	61201	Rock Island	3					
199	LG	Rock Island	61201	Rock Island	3					
200	LH	Rock Island	61201	Rock Island	4					
201	LH	Rock Island	61201	Rock Island	3					
202	LI-S	Rock Island	61201	Rock Island	3					
203	LJ	Rock Island	61201	Rock Island	4					
204	LL	Rock Island	61201	Rock Island	3					
205	LL	Rock Island	61201	Rock Island	3					
206	LM	Rock Island	61201	Rock Island	3					
207	LO	Rock Island	61201	Rock Island	3					
208	LR	Rock Island	61201	Rock Island	4					
209	LR	Rock Island	61201	Rock Island	4					
210	LR	Rock Island	61201	Rock Island	4					
211	LR	Rock Island	61201	Rock Island	3					
212	LR	Rock Island	61201	Rock Island	3					
213	LR	Rock Island	61201	Rock Island	3					
214	LS	Rock Island	61201	Rock Island	4					
215	LS	Rock Island	61201	Rock Island	3					
216	LS	Rock Island	61201	Rock Island	3					
217	LS	Rock Island	61201	Rock Island	3					
218	MA	Rock Island	61201	Rock Island	3					
219	MB	Rock Island	61201	Rock Island	3					
220	MB	Rock Island	61201	Rock Island	3					
221	MC	Rock Island	61201	Rock Island	3					
222	MD	Rock Island	61201	Rock Island	3					
223	MG	Rock Island	61201	Rock Island	3					
224	MH	Rock Island	61201	Rock Island	4					
225	MH	Rock Island	61201	Rock Island	3					
226	MJ	Rock Island	61201	Rock Island	3					
227	MJ	Rock Island	60201	Rock Island	3					
228	ML	Sherrard	61281	Mercer	3					

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
229	ML	Rock Island	61201	Rock Island	4					
230	ML	Rock Island	61201	Rock Island	3					
231	MM	Rock Island	61201	Rock Island	4					
232	MM	Rock Island	61201	Rock Island	3					
233	MM	Rock Island	61201	Rock Island	3					
234	MM	Rock Island	61201	Rock Island	3					
235	MN	Rock Island	61201	Rock Island	4					
236	MN	Rock Island	61201	Rock Island	4					
237	MN	Rock Island	61201	Rock Island	3					
238	MR	Aledo	61231	Mercer	3					
239	MR	Rock Island	61201	Rock Island	3					
240	MS	Rock Island	61201	Rock Island	4					
241	MS	Rock Island	61201	Rock Island	3					
242	MS	Rock Island	61201	Rock Island	3					
243	MT	Rock Island	61201	Rock Island	3					
244	MW	Rock Island	61201	Rock Island	4					
245	MW	Rock Island	61201	Rock Island	3					
246	MW	Rock Island	61201	Rock Island	3					
247	NF	Rock Island	61201	Rock Island	3					
248	NM	Rock Island	61201	Rock Island	4					
249	NS	Rock Island	61201	Rock Island	3					
250	NV	Rock Island	61201	Rock Island	3					
251	NW	Rock Island	61201	Rock Island	3					
252	OB	Rock Island	61201	Rock Island	3					
253	OJ	Rock Island	61201	Rock Island	4					
254	PA	Rock Island	61201	Rock Island	3					
255	PC	Rock Island	61201	Rock Island	3					
256	PC	Rock Island	61201	Rock Island	3					
257	PD	Rock Island	61201	Rock Island	3					
258	PE	Rock Island	61201	Rock Island	3					
259	PG	Rock Island	61201	Rock Island	3					
260	PH	Rock Island	61201	Rock Island	4					
261	PH	Rock Island	61201	Rock Island	3					
262	PJ	Rock Island	61201	Rock Island	3					
263	PM	Rock Island	61201	Rock Island	3					
264	PR	Rock Island	61201	Rock Island	4					
265	PS	Rock Island	61201	Rock Island	4					
266	QB	Rock Island	61201	Rock Island	4					
267	RB	Moline	61265	Rock Island	4					
268	RB	Rock Island	61201	Rock Island	3					
269	RB	Rock Island	61201	Rock Island	3					
270	RC	Milan	61264	Rock Island	3					
271	RC	Rock Island	61201	Rock Island	4					
272	RD	Rock Island	61201	Rock Island	3					
273	RE	Rock Island	61201	Rock Island	3					
274	RF	Rock Island	61201	Rock Island	3					
275	RF	Rock Island	61201	Rock Island	3					
276	RG	Milan	61264	Rock Island	3					
277	RG	Rock Island	61201	Rock Island	4					
278	RG	Rock Island	61201	Rock Island	3					
279	RH	Rock Island	61201	Rock Island	4					
280	RJ	Milan	61264	Rock Island	3					
281	RL	Rock Island	61201	Rock Island	3					
282	RM	Rock Island	61201	Rock Island	3					
283	RP	Rock Island	61201	Rock Island	3					
284	RR	Rock Island	61201	Rock Island	3					
285	RS	Rock Island	61201	Rock Island	4					

Rock Island CKD patients

	A	B	C	D	E	F	G	H	I	J
286	RS	Rock Island	61201	Rock Island	4					
287	RT	Rock Island	61201	Rock Island	4					
288	RT	Rock Island	61201	Rock Island	3					
289	RT	Rock Island	61201	Rock Island	3					
290	RT	Rock Island	61201	Rock Island	3					
291	RT	Rock Island	61201	Rock Island	3					
292	RV	Rock Island	61201	Rock Island	4					
293	RW	Rock Island	61201	Rock Island	3					
294	RW	Rock Island	61201	Rock Island	3					
295	RW	Rock Island	61201	Rock Island	3					
296	RW	Rock Island	61201	Rock Island	3					
297	SA	Rock Island	61201	Rock Island	4					
298	SB	Rock Island	61201	Rock Island	4					
299	SC	Milan	61264	Rock Island	3					
300	SD	Rock Island	61201	Rock Island	3					
301	SG	Rock Island	61201	Rock Island	3					
302	SH	Milan	61264	Rock Island	3					
303	SH	Rock Island	61201	Rock Island	3					
304	SH	Rock Island	61201	Rock Island	3					
305	SJ	Rock Island	61201	Rock Island	5					
306	SL	Rock Island	61201	Rock Island	4					
307	SM	Rock Island	61201	Rock Island	3					
308	SM	Rock Island	61201	Rock Island	3					
309	SM	Rock Island	61201	Rock Island	3					
310	SS	Milan	61264	Rock Island	3					
311	SS	Rock Island	61201	Rock Island	3					
312	ST	Rock Island	61201	Rock Island	5					
313	ST	Rock Island	61201	Rock Island	4					
314	ST	Rock Island	61201	Rock Island	3					
315	TC	Rock Island	61201	Rock Island	3					
316	TM	Rock Island	61201	Rock Island	3					
317	TV	Rock Island	61201	Rock Island	3					
318	TY	Rock Island	61201	Rock Island	3					
319	VB	Rock Island	61201	Rock Island	5					
320	VL	Rock Island	61201	Rock Island	3					
321	VT	Rock Island	61201	Rock Island	4					
322	VW	Rock Island	61201	Rock Island	3					
323	WB	Rock Island	61201	Rock Island	4					
324	WB	Rock Island	61201	Rock Island	3					
325	WC	Milan	61264	Rock Island	3					
326	WE	Rock Island	61201	Rock Island	3					
327	WG	East Moline	61244	Rock Island	3					
328	WH	Rock Island	61201	Rock Island	3					
329	WH	Rock Island	61201	Rock Island	3					
330	WH	Rock Island	61201	Rock Island	3					
331	WR	Rock Island	61201	Rock Island	3					
332	WS	Rock Island	61201	Rock Island	4					
333	WS	Rock Island	61201	Rock Island	3					
334	WT	Rock Island	61201	Rock Island	4					
335	WT	Rock Island	61201	Rock Island	3					
336	WW	Rock Island	61201	Rock Island	3					
337	MV	Rock Island	61201	Rock Island	4					
338	PL	Rock Island	61201	Rock Island	3					
339	ZE	Rock Island	61201	Rock Island	3					
340										
341										
342										

Silvis CKD Patients

	E	F	G	H	I	J
468						
469		County	Stage 5	Stage 4	Stage 3	Total Patients
470		Rock Island	14	94	315	423
471		Henry	0	6	16	22
472		Mercer	0	1	0	1
473		Whiteside	0	2	7	9
474		Knox	0	0	1	1
475		Dupage	0	0	1	1
476		Scott	1	0	1	2
477		Muscatine	0	0	1	1
478						
479						
480						
481						460
482						

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
1		City	Zip	County	Sta.					
2	AL	East Moline	61244	Rock Island	3					
3	AA	East Moline	61244	Rock Island	3					
4	AD	East Moline	61244	Rock Island	3					
5	AB	Silvis	61282	Rock Island	3					
6	AD	Cordova	61242	Rock Island	3					
7	AJ	East Moline	61244	Rock Island	3					
8	AD	Port Byron	61275	Rock Island	3					
9	BJ	Silvis	61282	Rock Island	3					
10	BV	East Moline	61244	Rock Island	3					
11	BR	Colona	61244	Rock Island	3					
12	BR	East Moline	61244	Rock Island	3					
13	BM	East Moline	61244	Rock Island	4					
14	BB	East Moline	61244	Rock Island	3					
15	BB	Silvis	61282	Rock Island	4					
16	BJ	Moline	61265	Rock Island	3					
17	BA	Port Byron	61275	Rock Island	4					
18	BA	East Moline	61244	Rock Island	3					
19	BL	East Moline	61244	Rock Island	3					
20	BL	East Moline	61244	Rock Island	5					
21	BW	East Moline	61244	Rock Island	3					
22	BJ	Moline	61265	Rock Island	4					
23	BL	East Moline	61244	Rock Island	3					
24	BF	Fulton	61252	Whiteside	4					
25	BG	Orion	61273	Henry	3					
26	BM	Silvis	61282	Rock Island	4					
27	BM	East Moline	61244	Rock Island	3					
28	BE	East Moline	61244	Rock Island	3					
29	BL	East Moline	61244	Rock Island	3					
30	BJ	East Moline	61244	Rock Island	3					
31	BJ	East Moline	61244	Rock Island	3					
32	BR	Silvis	61282	Rock Island	3					
33	BM	East Moline	61244	Rock Island	4					
34	BJ	East Moline	61244	Rock Island	4					
35	BR	East Moline	61244	Rock Island	3					
36	BD	East Moline	61244	Rock Island	3					
37	BM	East Moline	61244	Rock Island	3					
38	BA	East Moline	61244	Rock Island	4					
39	BB	Colona	61241	Rock Island	3					
40	BJ	Silvis	61282	Rock Island	4					
41	BA	Hampton	61256	Rock Island	3					
42	BA	East Moline	61244	Rock Island	5					
43	BM	Silvis	61282	Rock Island	3					
44	BC	Hampton	61256	Rock Island	3					
45	BE	Silvis	61282	Rock Island	4					
46	BA	East Moline	61244	Rock Island	5					
47	BH	Silvis	61282	Rock Island	3					
48	BF	Colona	61241	Rock Island	4					
49	BC	East Moline	61244	Rock Island	3					
50	BD	East Moline	61244	Rock Island	4					
51	CS	East Moline	61244	Rock Island	4					
52	CV	Rapid City	61278	Rock Island	4					
53	CJ	Alpha	61413	Henry	3					
54	CE	East Moline	61244	Rock Island	3					
55	CR	Hampton	61253	Rock Island	3					
56	CR	Port Byron	61275	Rock Island	4					
57	CJ	East Moline	61244	Rock Island	5					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
58	CA	Colona	61241	Rock Island	3					
59	CE	Colona	61241	Rock Island	3					
60	CG	Silvis	61282	Rock Island	3					
61	CA	Rapid City	61278	Rock Island	3					
62	CA	Hampton	61256	Rock Island	4					
63	CC	East Moline	61244	Rock Island	3					
64	CD	Colona	61241	Rock Island	3					
65	CD	Moline	61265	Rock Island	3					
66	CR	East Moline	61244	Rock Island	5					
67	CS	East Moline	61244	Rock Island	3					
68	CE	Silvis	61282	Rock Island	3					
69	CA	Port Byron	61275	Rock Island	3					
70	CR	East Moline	61244	Rock Island	3					
71	CJ	Silvis	61282	Rock Island	3					
72	VK	Fenton	61251	Whiteside	3					
73	VM	Hampton	61256	Rock Island	4					
74	CL	Moline	61265	Rock Island	3					
75	CL	Erie	61250	Henry	3					
76	CE	East Moline	61244	Rock Island	3					
77	CD	Colona	61241	Rock Island	3					
78	CR	Colona	61241	Rock Island	4					
79	CM	Port Byron	61275	Rock Island	3					
80	CR	East Moline	61244	Rock Island	3					
81	CB	Silvis	61282	Rock Island	3					
82	CL	Silvis	61282	Rock Island	3					
83	CW	East Moline	61244	Rock Island	3					
84	CJ	Hampton	61256	Rock Island	4					
85	DJ	East Moline	61244	Rock Island	3					
86	DP	Silvis	61281	Rock Island	4					
87	DN	Silvis	61244	Rock Island	4					
88	DL	Silvis	61282	Rock Island	3					
89	DM	East Moline	61244	Rock Island	3					
90	DP	East Moline	61244	Rock Island	4					
91	DP	Milan	61264	Rock Island	3					
92	DA	Colona	61241	Rock Island	3					
93	DS	East Moline	61244	Rock Island	3					
94	DE	East Moline	61244	Rock Island	3					
95	DJ	East Moline	61244	Rock Island	3					
96	DM	Colona	61241	Rock Island	4					
97	DJ	East Moline	61244	Rock Island	3					
98	DD	East Moline	61244	Rock Island	3					
99	DR	Hampton	61256	Rock Island	3					
100	DC	Colona	61241	Rock Island	3					
101	DC	Moline	61265	Rock Island	4					
102	DL	Muscatine	52761	Muscatine	3					
103	DH	Port Byron	61275	Rock Island	3					
104	DL	Rapid City	61278	Rock Island	3					
105	DE	Moline	61265	Rock Island	4					
106	DB	Silvis	61282	Rock Island	3					
107	DB	Silvis	61282	Rock Island	3					
108	DM	East Moline	61244	Rock Island	4					
109	DP	Colona	61241	Rock Island	4					
110	DD	East Moline	61244	Rock Island	3					
111	DL	Silvis	61282	Rock Island	3					
112	DJ	East Moline	61244	Rock Island	3					
113	DK	East Moline	61244	Rock Island	4					
114	DP	Colona	61241	Rock Island	4					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
115	DF	East Moline	61244	Rock Island	3					
116	DM	East Moline	61244	Rock Island	3					
117	DM	East Moline	61244	Rock Island	3					
118	DA	East Moline	61244	Rock Island	3					
119	DD	Silvis	61282	Rock Island	3					
120	EK	New Windsor	61465	Mercer	4					
121	EC	Silvis	61282	Rock Island	3					
122	EC	East Moline	61244	Rock Island	3					
123	EK	Port Byron	61275	Rock Island	3					
124	EC	Hillsdale	61257	Rock Island	3					
125	EL	Silvis	61282	Rock Island	3					
126	EA	Hampton	61256	Rock Island	3					
127	EM	Silvis	61282	Rock Island	4					
128	ES	East Moline	61244	Rock Island	3					
129	EK	Silvis	61282	Rock Island	3					
130	ER	Bettendorf	52722	Scott	5					
131	EJ	Silvis	61282	Rock Island	3					
132	EB	East Moline	61244	Rock Island	3					
133	FB	Moline	61265	Rock Island	4					
134	FB	Port Byron	61275	Rock Island	3					
135	FD	East Moline	61244	Rock Island	3					
136	FE	Moline	61265	Rock Island	4					
137	FC	East Moline	61244	Rock Island	5					
138	FB	Osco	61274	Henry	4					
139	FL	Silvis	61282	Rock Island	4					
140	FR	Colona	61241	Rock Island	3					
141	FM	East Moline	61244	Rock Island	3					
142	FA	East Moline	61244	Rock Island	4					
143	FM	Barstow	61236	Rock Island	4					
144	FL	East Moline	61244	Rock Island	3					
145	FJ	East Moline	61244	Rock Island	3					
146	FC	East Moline	61244	Rock Island	3					
147	FR	Colona	61241	Rock Island	3					
148	FP	Milan	61264	Rock Island	3					
149	FC	Silvis	61282	Rock Island	3					
150	GC	Moline	61265	Rock Island	3					
151	GC	Geneseo	61254	Henry	3					
152	GL	Colona	61241	Rock Island	3					
153	GA	Geneseo	61254	Henry	3					
154	GO	Rock Island	61201	Rock Island	3					
155	GD	East Moline	61244	Rock Island	3					
156	GM	Moline	61265	Rock Island	3					
157	GC	Colona	61241	Rock Island	3					
158	GG	Morrison	61270	Whiteside	3					
159	GC	East Moline	61244	Rock Island	4					
160	GC	East Moline	61244	Rock Island	3					
161	GJ	East Moline	61244	Rock Island	3					
162	GK	East Moline	61244	Rock Island	3					
163	GE	East Moline	61244	Rock Island	3					
164	GV	East Moline	61244	Rock Island	3					
165	GH	Hampton	61265	Rock Island	3					
166	GD	East Moline	61244	Rock Island	3					
167	GR	Hampton	61256	Rock Island	4					
168	GK	Moline	61265	Rock Island	4					
169	GM	Port Byron	61275	Rock Island	3					
170	GL	Erie	61250	Henry	4					
171	GD	East Moline	61244	Rock Island	3					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
172	GC	Orion	61273	Henry	4					
173	GA	East Moline	61244	Rock Island	5					
174	GD	Silvis	61282	Rock Island	3					
175	HL	East Moline	61244	Rock Island	3					
176	HS	Port Byron	61275	Rock Island	3					
177	HN	MO	65778	Rock Island	3					
178	HE	Colona	61244	Rock Island	3					
179	HN	Port Byron	61275	Rock Island	3					
180	HV	Silvis	61282	Rock Island	3					
181	HE	Colona	61241	Rock Island	3					
182	HJ	East Moline	61244	Rock Island	3					
183	HF	Moline	61265	Rock Island	3					
184	HG	Silvis	61282	Rock Island	4					
185	HC	Albany	61230	Whiteside	3					
186	HL	Barstow	61236	Rock Island	4					
187	HR	Silvis	61282	Rock Island	3					
188	HG	East Moline	61244	Rock Island	3					
189	HJ	Colona	61241	Rock Island	3					
190	HB	Albany	61230	Whiteside	3					
191	HL	East Moline	61244	Rock Island	4					
192	HT	East Moline	61244	Rock Island	3					
193	HL	Port Byron	61275	Rock Island	3					
194	HW	Colona	61241	Rock Island	3					
195	HC	East Moline	61244	Rock Island	3					
196	HD	East Moline	61244	Rock Island	3					
197	HR	East Moline	61244	Rock Island	3					
198	HJ	East Moline	61244	Rock Island	5					
199	HS	Moline	61265	Rock Island	3					
200	HE	Cambridge	61238	Henry	3					
201	HB	Moline	61265	Rock Island	3					
202	HJ	East Moline	61244	Rock Island	4					
203	HK	Silvis	61282	Rock Island	4					
204	HR	Silvis	61282	Rock Island	3					
205	HJ	East Moline	61244	Rock Island	4					
206	HM	Silvis	61282	Rock Island	3					
207	HE	Cordova	61242	Rock Island	3					
208	HM	East Moline	61244	Rock Island	4					
209	HD	East Moline	61244	Rock Island	3					
210	HH	East Moline	61244	Rock Island	4					
211	HK	East Moline	61244	Rock Island	3					
212	HR	Colona	61241	Rock Island	4					
213	HB	Erie	61250	Henry	3					
214	HR	East Moline	61244	Rock Island	3					
215	HJ	East Moline	61244	Rock Island	4					
216	HD	Moline	61265	Rock Island	3					
217	JE	Silvis	61282	Rock Island	3					
218	JD	East Moline	61244	Rock Island	3					
219	JA	East Moline	61244	Rock Island	3					
220	JB	East Moline	61244	Rock Island	4					
221	JC	East Moline	61244	Rock Island	4					
222	JD	Port Byron	61275	Rock Island	3					
223	JE	Silvis	61282	Rock Island	3					
224	JE	East Moline	61244	Rock Island	3					
225	JL	Silvis	61282	Rock Island	4					
226	JR	Silvis	61282	Rock Island	3					
227	JM	Silvis	61282	Rock Island	4					
228	JG	Geneseo	61254	Henry	3					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
229	KH	Rio	61472	Knox	3					
230	KJ	East Moline	61244	Rock Island	3					
231	KW	Silvis	61282	Rock Island	3					
232	KK	Colona	61241	Rock Island	3					
233	KC	Silvis	61282	Rock Island	3					
234	KH	East Moline	61244	Rock Island	3					
235	KL	Geneseo	61254	Henry	3					
236	KB	East Moline	61244	Rock Island	3					
237	KW	Hampton	61256	Rock Island	3					
238	KM	Hampton	61256	Rock Island	3					
239	KM	East Moline	61244	Rock Island	3					
240	KS	Geneseo	61254	Henry	4					
241	KC	East Moline	61244	Rock Island	3					
242	KC	East Moline	61244	Rock Island	3					
243	KB	East Moline	61244	Rock Island	3					
244	KM	Silvis	61282	Rock Island	3					
245	KS	East Moline	61244	Rock Island	4					
246	KV	East Moline	61244	Rock Island	3					
247	LD	Erie	61250	Henry	4					
248	LP	East Moline	61244	Rock Island	3					
249	LM	Silvis	61282	Rock Island	3					
250	LC	Silvis	61282	Rock Island	3					
251	LD	East Moline	61244	Rock Island	3					
252	LM	East Moline	61244	Rock Island	3					
253	LC	East Moline	61244	Rock Island	3					
254	BL	Colona	61241	Rock Island	3					
255	LC	East Moline	61244	Rock Island	3					
256	LL	East Moline	61244	Rock Island	4					
257	LE	East Moline	61244	Rock Island	3					
258	LJ	East Moline	61244	Rock Island	3					
259	LL	Erie	61250	Henry	4					
260	LM	Silvis	61282	Rock Island	4					
261	LL	Colona	61241	Rock Island	3					
262	LS	Carbon Cliff	61239	Rock Island	4					
263	LM	East Moline	61244	Rock Island	3					
264	LD	East Moline	61244	Rock Island	3					
265	MC	Silvis	61282	Rock Island	3					
266	MH	Silvis	61282	Rock Island	3					
267	MJ	East Moline	61244	Rock Island	3					
268	MC	East Moline	61244	Rock Island	3					
269	MA	Moline	61265	Rock Island	3					
270	MJ	East Moline	61244	Rock Island	3					
271	ME	Silvis	61282	Rock Island	3					
272	MG	East Moline	61244	Rock Island	4					
273	MP	Prophestown	61277	Rock Island	3					
274	MW	Carbon Cliff	61239	Rock Island	4					
275	MB	Silvis	61282	Rock Island	3					
276	MV	East Moline	61244	Rock Island	4					
277	MT	Port Byron	61275	Rock Island	3					
278	MJ	East Moline	61244	Rock Island	4					
279	MT	Silvis	61282	Rock Island	3					
280	MG	Moline	61265	Rock Island	3					
281	MV	Davenport	52806	Scott	3					
282	ME	Hampton	61256	Rock Island	4					
283	MC	Silvis	61282	Rock Island	4					
284	MB	East Moline	61244	Rock Island	4					
285	MD	Colona	61241	Rock Island	4					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
286	MG	Hampton	61256	Rock Island	3					
287	MJ	East Moline	61244	Rock Island	3					
288	ME	East Moline	61244	Rock Island	3					
289	MO	Silvis	61282	Rock Island	3					
290	MJ	Colona	61241	Rock Island	3					
291	MG	Moline	61264	Rock Island	3					
292	MT	Port Byron	61275	Rock Island	3					
293	MM	Silvis	61282	Rock Island	3					
294	ME	Moline	61265	Rock Island	4					
295	MG	East Moline	61244	Rock Island	3					
296	MG	East Moline	61244	Rock Island	3					
297	MD	East Moline	61244	Rock Island	3					
298	MH	Silvis	61282	Rock Island	4					
299	MN	Silvis	612821	Rock Island	3					
300	MS	Cordova	61242	Rock Island	3					
301	ND	Carbon Cliff	61239	Rock Island	3					
302	NR	East Moline	61244	Rock Island	3					
303	NS	East Moline	61244	Rock Island	3					
304	NJ	Hillsdale	61257	Rock Island	3					
305	OB	Silvis	61282	Rock Island	4					
306	OK	East Moline	61244	Rock Island	3					
307	OM	East Moline	61244	Rock Island	3					
308	PR	Cambridge	61238	Henry	3					
309	PE	Silvis	61282	Rock Island	4					
310	PC	Silvis	61282	Rock Island	4					
311	PJ	Silvis	61282	Rock Island	3					
312	PD	Carbon Cliff	61239	Rock Island	3					
313	PR	Colona	61241	Rock Island	3					
314	PS	East Moline	61244	Rock Island	3					
315	PR	Silvis	61282	Rock Island	3					
316	PL	Albany	61230	Whiteside	3					
317	PC	East Moline	61244	Rock Island	3					
318	PS	East Moline	61244	Rock Island	3					
319	PP	Colona	61241	Rock Island	3					
320	PR	Silvis	61282	Rock Island	3					
321	PG	Coal Valley	61240	Rock Island	3					
322	PE	Hampton	61256	Rock Island	3					
323	PC	Silvis	61282	Rock Island	3					
324	PM	Colona	61241	Rock Island	3					
325	PS	Silvis	61282	Rock Island	3					
326	PE	Cordova	61242	Rock Island	3					
327	PD	Colona	61241	Rock Island	5					
328	PM	East Moline	61244	Rock Island	5					
329	PC	Moline	61265	Rock Island	3					
330	PA	East Moline	61244	Rock Island	5					
331	RR	Colona	61241	Rock Island	3					
332	RH	Colona	61241	Rock Island	3					
333	RA	East Moline	61244	Rock Island	4					
334	RA	East Moline	61244	Rock Island	3					
335	RG	East Moline	61244	Rock Island	3					
336	RL	East Moline	61244	Rock Island	3					
337	RE	East Moline	61244	Rock Island	5					
338	RJ	East Moline	61244	Rock Island	5					
339	RC	East Moline	61244	Rock Island	3					
340	RM	Colona	22540	Rock Island	3					
341	RJ	Colona	61241	Rock Island	3					
342	RR	East Moline	61244	Rock Island	4					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
343	RS	East Moline	61244	Rock Island	3					
344	RF	Silvis	61282	Rock Island	4					
345	RD	Silvis	61282	Rock Island	3					
346	RB	East Moline	61244	Rock Island	3					
347	RW	East Moline	61244	Rock Island	3					
348	RV	Carol Stream	60188	DuPage	3					
349	RR	Silvis	61282	Rock Island	3					
350	RM	East Moline	61244	Rock Island	5					
351	RA	Moline	61265	Rock Island	4					
352	RC	Cambridge	61238	Henry	3					
353	RB	East Moline	61244	Rock Island	3					
354	RF	Silvis	61282	Rock Island	3					
355	RM	East Moline	61244	Rock Island	3					
356	RD	Silvis	61282	Rock Island	3					
357	RL	East Moline	61244	Rock Island	3					
358	SC	East Moline	61244	Rock Island	3					
359	ST	East Moline	61244	Rock Island	3					
360	SC	Cordova	61242	Rock Island	3					
361	SA	Moline	61265	Rock Island	3					
362	SS	East Moline	61244	Rock Island	3					
363	SW	East Moline	61244	Rock Island	3					
364	SD	Colona	61241	Rock Island	3					
365	SA	East Moline	61244	Rock Island	3					
366	SD	East Moline	61244	Rock Island	3					
367	SJ	Silvis	61282	Rock Island	3					
368	SR	Moline	61265	Rock Island	4					
369	SV	Erie	61250	Henry	3					
370	ST	East Moline	61244	Rock Island	3					
371	SG	Andalusia	61233	Rock Island	4					
372	SB	East Moline	61244	Rock Island	4					
373	SN	Rapid City	61278	Rock Island	3					
374	SP	East Moline	61244	Rock Island	3					
375	SM	Colona	61241	Rock Island	4					
376	SN	East Moline	61244	Rock Island	4					
377	SB	East Moline	61244	Rock Island	3					
378	SD	Colona	61241	Rock Island	3					
379	SJ	Colona	61241	Rock Island	4					
380	ST	East Moline	61244	Rock Island	3					
381	SJ	Colona	61241	Rock Island	3					
382	SK	East Moline	61244	Rock Island	3					
383	SJ	Hillsdale	61257	Rock Island	3					
384	SH	East Moline	61244	Rock Island	3					
385	SL	East Moline	61244	Rock Island	4					
386	SE	East Moline	61244	Rock Island	3					
387	SM	Port Byron	61275	Rock Island	3					
388	SH	Silvis	61282	Rock Island	3					
389	SD	Colona	61241	Rock Island	4					
390	SJ	East Moline	61241	Rock Island	3					
391	ST	Colona	61241	Rock Island	3					
392	SR	Silvis	61282	Rock Island	3					
393	SJ	Rapid City	61278	Rock Island	3					
394	SC	East Moline	61241	Rock Island	3					
395	TD	Hampton	61256	Rock Island	3					
396	TJ	Colona	61241	Rock Island	3					
397	TO	Albany	61230	Whiteside	3					
398	TL	Moline	61265	Rock Island	3					
399	TR	Silvis	61282	Rock Island	4					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
400	TK	East Moline	61244	Rock Island	3					
401	TD	East Moline	61244	Rock Island	3					
402	TJ	East Moline	61244	Rock Island	3					
403	TR	East Moline	61244	Rock Island	4					
404	TM	Cordova	61242	Rock Island	3					
405	TB	Colona	61244	Rock Island	4					
406	TC	East Moline	61244	Rock Island	3					
407	TG	Colona	61241	Rock Island	3					
408	TR	East Moline	61244	Rock Island	3					
409	TP	East Moline	61244	Rock Island	3					
410	UW	East Moline	61244	Rock Island	3					
411	VM	Hampton	61256	Rock Island	3					
412	VV	East Moline	61244	Rock Island	3					
413	VM	Port Byron	61275	Rock Island	3					
414	VL	Moline	61265	Rock Island	3					
415	VD	East Moline	61244	Rock Island	3					
416	VF	East Moline	61244	Rock Island	4					
417	VK	Morrison	61270	Whiteside	4					
418	VR	Colona	61241	Rock Island	3					
419	VD	Barstow	61236	Rock Island	3					
420	VM	East Moline	61244	Rock Island	4					
421	VW	Silvis	61282	Rock Island	3					
422	VD	East Moline	61244	Rock Island	4					
423	WL	Moline	61244	Rock Island	3					
424	WB	Port Byron	61275	Rock Island	3					
425	WD	Geneseo	61254	Henry	3					
426	WM	Albany	61230	Whiteside	3					
427	WM	Prophestown	61277	Rock Island	3					
428	WC	Hampton	61256	Rock Island	3					
429	WR	East Moline	61244	Rock Island	3					
430	WJ	East Moline	61244	Rock Island	3					
431	WG	East Moline	61244	Rock Island	3					
432	WS	East Moline	61244	Rock Island	3					
433	WA	Erie	61250	Rock Island	3					
434	WM	East Moline	61244	Rock Island	5					
435	WR	Silvis	61282	Rock Island	4					
436	WD	East Moline	61244	Rock Island	3					
437	WJ	East Moline	61244	Rock Island	3					
438	WW	Cambridge	61238	Henry	3					
439	WM	Rapid City	61278	Rock Island	3					
440	WL	Silvis	61282	Rock Island	4					
441	WL	Silvis	61282	Rock Island	3					
442	WJ	East Moline	61244	Rock Island	3					
443	WV	East Moline	61244	Rock Island	3					
444	WA	East Moline	61244	Rock Island	3					
445	WD	Port Byron	61275	Rock Island	4					
446	WS	Silvis	61282	Rock Island	4					
447	WJ	East Moline	61244	Rock Island	4					
448	WL	Silvis	61282	Rock Island	3					
449	WB	Erie	61250	Henry	3					
450	WP	Moline	61265	Rock Island	3					
451	WT	East Moline	61244	Rock Island	3					
452	YR	East Moline	61244	Rock Island	3					
453	YD	East Moline	61244	Rock Island	3					
454	YJ	East Moline	61244	Rock Island	3					
455	YD	East Moline	61244	Rock Island	3					
456	YK	Silvis	61282	Rock Island	3					

Silvis CKD Patients

	A	B	C	D	E	F	G	H	I	J
457	YK	Erie	61250	Henry	3					
458	YD	Cordova	61242	Rock Island	3					
459	ZM	East Moline	61244	Rock Island	4					
460	ZD	Colona	61241	Rock Island	3					
461	ZM	Colona	61241	Rock Island	4					
462										
463										
464										
465										
466										
467										
468										

Moline CKD Patients

County	Stage 5	Stage 4	Stage 3	Total Patients
Rock Island-	22	217	508	747
Henry-	0	11	32	43
Mercer-	1	9	14	24
Warren-	0	1	0	1
Knox-	0	0	2	2
Lee-	0	0	1	1
Whiteside-	0	0	1	1
Scott-	0	7	8	15
Jackson-	0	1	0	1
Muscatine-	0	0	1	1
				836

Totals: CKD Patients, Stages, County

6/25/2010

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
1	Int.	City	Zip	County	Sta.					
2	AJ	Moline	61265	Rock Island	5					
3	AD	Moline	61265	Rock Island	5					
4	AD	Moline	61265	Rock Island	5					
5	BM	Moline	61201	Rock Island	5					
6	CS	Sherrard	61281	Mercer	5					
7	HB	Moline	61265	Rock Island	5					
8	HE	Rock Island	61201	Rock Island	5					
9	KW	Cordova	61242	Rock Island	5					
10	KV	Cambridge	61238	Rock Island	5					
11	LL	Moline	61265	Rock Island	5					
12	MA	East Moline	61244	Rock Island	5					
13	MM	Rock Island	61201	Rock Island	5					
14	NK	Milan	61264	Rock Island	5					
15	PP	Moline	61265	Rock Island	5					
16	RM	Moline	61265	Rock Island	5					
17	RM	East Moline	61244	Rock Island	5					
18	RH	Silvis	61282	Rock Island	5					
19	RJ	Moline	61265	Rock Island	5					
20	RJ	Moline	61265	Rock Island	5					
21	SD	Milan	61264	Rock Island	5					
22	SK	Milan	61264	Rock Island	5					
23	ST	Moline	61265	Rock Island	5					
24	TS	Rock Island	61201	Rock Island	5					
25	AC	Moline	61265	Rock Island	4					
26	AP	Moline	61265	Rock Island	4					
27	AE	Moline	61265	Rock Island	4					
28	AO	Moline	61265	Rock Island	4					
29	AE	Kewanee	61413	Henry	4					
30	BC	Rock Island	61201	Rock Island	4					
31	BR	Moline	61265	Rock Island	4					
32	BC	Moline	61265	Rock Island	4					
33	BL	Moline	61265	Rock Island	4					
34	BJ	Moline	61265	Rock Island	4					
35	BR	Rock Island	61201	Rock Island	4					
36	BL	Rock Island	61201	Rock Island	4					
37	BV	Milan	61264	Rock Island	4					
38	BG	Morrison	61270	Rock Island	4					
39	BD	Milan	61264	Rock Island	4					
40	BP	New Windsor	61465	Mercer	4					
41	BR	Moline	61265	Rock Island	4					
42	BS	Moline	61265	Rock Island	4					
43	BL	Matherville	61263	Mercer	4					
44	BC	East Moline	61244	Rock Island	4					
45	BA	Rock Island	61201	Rock Island	4					
46	BJ	Rock Island	61201	Rock Island	4					
47	BD	East Moline	61244	Rock Island	4					
48	CS	Moline	61265	Rock Island	4					
49	CB	Moline	61265	Rock Island	4					
50	CD	Moline	61264	Rock Island	4					
51	CM	Andalusia	61232	Rock Island	4					
52	CS	Matherville	61263	Mercer	4					
53	CC	Moline	61265	Rock Island	4					
54	CR	Moline	61265	Rock Island	4					
55	CM	Silvis	61282	Rock Island	4					
56	CV	Sherrard	61281	Mercer	4					
57	CD	Silvis	61282	Rock Island	4					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
58	CP	Moline	61265	Rock Island	4					
59	DJ	Moline	61265	Rock Island	4					
60	DM	East Moline	61244	Rock Island	4					
61	DJ	Sherrard	61281	Mercer	4					
62	DM	Moline	61265	Rock Island	4					
63	DR	Moline	61265	Rock Island	4					
64	DJ	Moline	61265	Rock Island	4					
65	DR	Moline	61265	Rock Island	4					
66	DM	Coal Valley	61240	Rock Island	4					
67	DH	Moline	61265	Rock Island	4					
68	DR	Moline	61265	Rock Island	4					
69	DG	Coal Valley	61240	Rock Island	4					
70	DL	Moline	61265	Rock Island	4					
71	DM	Moline	61265	Rock Island	4					
72	DH	Taylor Ridge	61284	Rock Island	4					
73	DD	Coal Valley	61240	Rock Island	4					
74	DR	Milan	61264	Rock Island	4					
75	ER	Milan	61264	Rock Island	4					
76	ET	Rock Island	61201	Rock Island	4					
77	FC	Moline	61265	Rock Island	4					
78	FB	Osco	61274	Henry	4					
79	FJ	Milan	61264	Rock Island	4					
80	FM	Milan	61264	Rock Island	4					
81	FM	Moline	61265	Rock Island	4					
82	FJ	Moline	61265	Rock Island	4					
83	FB	Moline	61265	Rock Island	4					
84	GJ	Moline	61265	Rock Island	4					
85	GJ	Moline	61265	Rock Island	4					
86	GK	Moline	61265	Rock Island	4					
87	GC	Moline	61265	Rock Island	4					
88	GW	Orion	61273	Henry	4					
89	GA	Moline	61265	Rock Island	4					
90	GA	Moline	61265	Rock Island	4					
91	GM	Moline	61265	Rock Island	4					
92	HG	Moline	61265	Rock Island	4					
93	HC	Rock Island	61201	Rock Island	4					
94	HE	Moline	61265	Rock Island	4					
95	HC	Moline	61265	Rock Island	4					
96	HP	Milan	61264	Rock Island	4					
97	HL	Taylor Ridge	61284	Rock Island	4					
98	HJ	Rock Island	61201	Rock Island	4					
99	HE	Milan	61264	Rock Island	4					
100	HM	Moline	61265	Rock Island	4					
101	HM	Rock Island	61201	Rock Island	4					
102	HD	Milan	61264	Rock Island	4					
103	HJ	East Moline	61244	Rock Island	4					
104	HB	Aledo	61231	Mercer	4					
105	HT	Moline	61265	Rock Island	4					
106	HD	Rock Island	61201	Rock Island	4					
107	HB	Rock Island	61265	Rock Island	4					
108	HL	Rock Island	61201	Rock Island	4					
109	HD	Moline	61265	Rock Island	4					
110	HS	Milan	61264	Rock Island	4					
111	HW	Moline	61265	Rock Island	4					
112	JM	Moline	61265	Rock Island	4					
113	JM	Rock Island	61201	Rock Island	4					
114	JW	Moline	61265	Rock Island	4					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
115	JC	Moline	61265	Rock Island	4					
116	JS	Rock Island	61201	Rock Island	4					
117	JA	Rock Island	61201	Rock Island	4					
118	JR	Moline	61265	Rock Island	4					
119	JR	Moline	61265	Rock Island	4					
120	JE	Moline	61265	Rock Island	4					
121	JI	Moline	61265	Rock Island	4					
122	KE	Moline	61265	Rock Island	4					
123	KC	Moline	61265	Rock Island	4					
124	KM	East Moline	61244	Rock Island	4					
125	KD	Milan	61264	Rock Island	4					
126	KB	Monmoth	61462	Warren	4					
127	KS	Moline	61265	Rock Island	4					
128	KJ	Erie	61250	Henry	4					
129	KJ	Moline	61265	Rock Island	4					
130	LB	Moline	61265	Rock Island	4					
131	LN	Rock Island	61201	Rock Island	4					
132	LF	Moline	61265	Rock Island	4					
133	LE	Moline	61265	Rock Island	4					
134	LR	Sherrard	61281	Mercer	4					
135	LS	Silvis	61282	Rock Island	4					
136	LM	Milan	61264	Rock Island	4					
137	LR	Moline	61265	Rock Island	4					
138	LJ	East Moline	61244	Rock Island	4					
139	LS	Rock Island	61201	Rock Island	4					
140	LT	Moline	61265	Rock Island	4					
141	LC	Geneseo	61254	Henry	4					
142	LW	Moline	61265	Rock Island	4					
143	MR	Moline	61265	Rock Island	4					
144	MB	East Moline	61244	Rock Island	4					
145	MS	Coal Vallery	61240	Rock Island	4					
146	MA	Moline	61265	Rock Island	4					
147	MR	Moline	61265	Rock Island	4					
148	MI	East Moline	61244	Rock Island	4					
149	MC	Moline	61265	Rock Island	4					
150	MH	Bettendorf	52722	Scott	4					
151	MG	Moline	61265	Rock Island	4					
152	MM	Orion	61273	Henry	4					
153	MB	East Moline	61244	Rock Island	4					
154	MJ	East Moline	61244	Rock Island	4					
155	ML	Milan	61264	Rock Island	4					
156	MM	Moline	61265	Rock Island	4					
157	MV	East Moline	61244	Rock Island	4					
158	MF	Moline	61265	Rock Island	4					
159	MW	Moline	61265	Rock Island	4					
160	MM	Milan	61241	Rock Island	4					
161	MB	Coal Vallery	61240	Rock Island	4					
162	MC	Rock Island	61201	Rock Island	4					
163	MJ	Colona	61241	Rock Island	4					
164	MJ	Colona	61241	Rock Island	4					
165	MR	Moline	61265	Rock Island	4					
166	MB	Rock Island	61201	Rock Island	4					
167	MC	Rock Island	61201	Rock Island	4					
168	MC	Rock Island	61201	Rock Island	4					
169	MP	Orion	61273	Henry	4					
170	ML	Blue Grass	52726	Scott	4					
171	NJ	Moline	61265	Rock Island	4					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
172	NM	Rock Island	61201	Rock Island	4					
173	NE	Rock Island	61201	Rock Island	4					
174	OS	Rock Island	61201	Rock Island	4					
175	OD	East Moline	61244	Rock Island	4					
176	OW	Moline	61265	Rock Island	4					
177	OR	Davenport	52806	Scott	4					
178	OM	Coal Vallery	61240	Rock Island	4					
179	PW	East Moline	61244	Rock Island	4					
180	PW	Moline	61265	Rock Island	4					
181	PP	Moline	61265	Rock Island	4					
182	PJ	Orion	61273	Henry	4					
183	PG	Milan	61264	Rock Island	4					
184	PE	Moline	61265	Rock Island	4					
185	PM	Rock Island	61201	Rock Island	4					
186	PH	Moline	61265	Rock Island	4					
187	PJ	Rock Island	61201	Rock Island	4					
188	PA	Coal Vallery	61240	Rock Island	4					
189	PM	Moline	61265	Rock Island	4					
190	PL	Rock Island	61201	Rock Island	4					
191	PP	Moline	61265	Rock Island	4					
192	RL	Moline	61265	Rock Island	4					
193	RS	Moline	61265	Rock Island	4					
194	RL	Moline	61265	Rock Island	4					
195	RF	Moline	61265	Rock Island	4					
196	RS	Rock Island	61201	Rock Island	4					
197	RN	Moline	61265	Rock Island	4					
198	RL	Moline	61265	Rock Island	4					
199	RR	Moline	61265	Rock Island	4					
200	RP	Rock Island	61201	Rock Island	4					
201	RG	Rock Island	61201	Rock Island	4					
202	RL	Rock Island	61201	Rock Island	4					
203	RD	Rock Island	61201	Rock Island	4					
204	RL	Moline	61265	Rock Island	4					
205	RB	Rock Island	61201	Rock Island	4					
206	R	Rock Island	61201	Rock Island	4					
207	RE	Geneseo	61254	Henry	4					
208	RR	Rock Island	61201	Rock Island	4					
209	RM	East Moline	61244	Rock Island	4					
210	SM	Moline	61265	Rock Island	4					
211	SB	Rock Island	61201	Rock Island	4					
212	SK	Bettendorf	52722	Scott	4					
213	SR	Moline	61265	Rock Island	4					
214	SJ	East Moline	61244	Rock Island	4					
215	SJ	Geneseo	61254	Henry	4					
216	SR	Moline	61265	Rock Island	4					
217	SV	Moline	61265	Rock Island	4					
218	SA	Rock Island	61201	Rock Island	4					
219	SR	Rock Island	61201	Rock Island	4					
220	SA	Aledo	61273	Mercer	4					
221	SC	Rock Island	61201	Rock Island	4					
222	SB	Rock Island	61201	Rock Island	4					
223	SG	Rock Island	61201	Rock Island	4					
224	SW	Moline	61265	Rock Island	4					
225	SE	Rock Island	61201	Rock Island	4					
226	SS	Coal Vallery	61201	Rock Island	4					
227	SV	Moline	61265	Rock Island	4					
228	SW	Moline	61265	Rock Island	4					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
229	SG	Moline	61265	Rock Island	4					
230	SC	Rock Island	61201	Rock Island	4					
231	SV	Rock Island	61201	Rock Island	4					
232	SB	Moline	61265	Rock Island	4					
233	SJ	Moline	61265	Rock Island	4					
234	SJ	Moline	61265	Rock Island	4					
235	SE	Andalusia	61232	Rock Island	4					
236	SC	Lynn Center	61262	Henry	4					
237	SJ	Moline	61265	Rock Island	4					
238	SN	Moline	20812	Rock Island	4					
239	TG	Coal Valley	61240	Rock Island	4					
240	TS	Rock Island	61201	Rock Island	4					
241	TR	Rock Island	61201	Rock Island	4					
242	TB	Moline	61265	Rock Island	4					
243	TB	Sherrard	61281	Mercer	4					
244	TN	Milan	61264	Rock Island	4					
245	UC	Moline	61265	Rock Island	4					
246	VM	Moline	61265	Rock Island	4					
247	VM	Moline	61265	Rock Island	4					
248	VF	East Moline	61244	Rock Island	4					
249	VR	Rock Island	61201	Rock Island	4					
250	WD	Rock Island	61201	Rock Island	4					
251	WE	Moline	61265	Rock Island	4					
252	WL	Moline	61265	Rock Island	4					
253	WA	Davenport	52803	Scott	4					
254	WB	Rock Island	61201	Rock Island	4					
255	WM	Rock Island	61201	Rock Island	4					
256	WL	Rock Island	61201	Rock Island	4					
257	WR	Rock Island	61201	Rock Island	4					
258	WR	Rock Island	61201	Rock Island	4					
259	WD	Moline	61265	Rock Island	4					
260	WL	Moline	61265	Rock Island	4					
261	WM	Moline	61265	Rock Island	4					
262	WM	Rock Island	61201	Rock Island	4					
263	WO	Cordova	61242	Rock Island	4					
264	WN	Taylor Ridge	61284	Rock Island	4					
265	WT	East Moline	61244	Rock Island	4					
266	YA	Coal Valley	61241	Rock Island	4					
267	YS	Rock Island	61201	Rock Island	4					
268	ZX	Davenport	52806	Scott	4					
269	ZJ	Davenport	52806	Scott	4					
270	AL	Taylor Ridge	61284	Rock Island	3					
271	AW	Moline	61265	Rock Island	3					
272	AS	Moline	61265	Rock Island	3					
273	AD	Moline	61265	Rock Island	3					
274	AP	Moline	61265	Rock Island	3					
275	AA	Moline	61265	Rock Island	3					
276	AM	Moline	61265	Rock Island	3					
277	AJ	Moline	61265	Rock Island	3					
278	AL	Rock Island	61201	Rock Island	3					
279	AR	Moline	61265	Rock Island	3					
280	AA	Moline	61265	Rock Island	3					
281	AD	Moline	61265	Rock Island	3					
282	AW	Moline	61265	Rock Island	3					
283	AJ	East Moline	61244	Rock Island	3					
284	AD	Port Byron	61275	Rock Island	3					
285	AM	Moline	61265	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
286	BD	Moline	61265	Rock Island	3					
287	BV	Moline	61201	Rock Island	3					
288	BM	Amboy	61310	Lee	3					
289	BC	Moline	61265	Rock Island	3					
290	BC	Moline	61265	Rock Island	3					
291	BC	Lynn Center	61262	Henry	3					
292	BR	Moline	61265	Rock Island	3					
293	BL	Moline	61265	Rock Island	3					
294	BB	Rock Island	61201	Rock Island	3					
295	BA	East Moline	61244	Rock Island	3					
296	BL	Moline	61265	Rock Island	3					
297	BJ	Moline	61201	Rock Island	3					
298	BN	Rock Island	61201	Rock Island	3					
299	BW	Moline	61265	Rock Island	3					
300	BR	Moline	61265	Rock Island	3					
301	BC	Moline	61265	Rock Island	3					
302	BM	Prophestown	61277	Rock Island	3					
303	BD	Milan	61264	Rock Island	3					
304	BR	East Moline	61244	Rock Island	3					
305	BK	Rock Island	61201	Rock Island	3					
306	BR	Coal Valley	61240	Rock Island	3					
307	BK	Moline	61265	Rock Island	3					
308	BR	Moline	61265	Rock Island	3					
309	BL	Taylor Ridge	61284	Rock Island	3					
310	BL	Orion	61273	Henry	3					
311	BG	Rock Island	61201	Rock Island	3					
312	BS	Sherrard	61281	Mercer	3					
313	BG	Taylor Ridge	61284	Rock Island	3					
314	BD	Moline	61201	Rock Island	3					
315	BK	Moline	61265	Rock Island	3					
316	BR	Moline	61265	Rock Island	3					
317	BV	Moline	61265	Rock Island	3					
318	BC	Milan	61264	Rock Island	3					
319	BK	Milan	61264	Rock Island	3					
320	BD	East Moline	61244	Rock Island	3					
321	BK	Sherrard	61281	Mercer	3					
322	BR	Milan	61264	Rock Island	3					
323	BJ	Moline	61265	Rock Island	3					
324	BA	East Moline	61244	Rock Island	3					
325	BW	Moline	61265	Rock Island	3					
326	BC	Silvis	61282	Rock Island	3					
327	CD	Moline	61265	Rock Island	3					
328	CJ	Silvis	61282	Rock Island	3					
329	CH	Rock Island	61201	Rock Island	3					
330	CD	Orion	61273	Henry	3					
331	CM	Moline	61265	Rock Island	3					
332	CR	Moline	61265	Rock Island	3					
333	CW	Milan	61264	Rock Island	3					
334	CD	Rock Island	61201	Rock Island	3					
335	CJ	Sherrard	61281	Mercer	3					
336	CJ	Moline	61265	Rock Island	3					
337	CC	Moline	61265	Rock Island	3					
338	CM	Moline	61265	Rock Island	3					
339	CG	Moline	61265	Rock Island	3					
340	CK	Moline	61265	Rock Island	3					
341	CJ	Galesburg	61401	Knox	3					
342	CD	Rock Island	61201	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
343	CC	Rock Island	61201	Rock Island	3					
344	CD	Colona	61241	Rock Island	3					
345	CR	Moline	61265	Rock Island	3					
346	CA	Rock Island	61201	Rock Island	3					
347	CD	Moline	61265	Rock Island	3					
348	CC	Moline	61265	Rock Island	3					
349	CD	Milan	61264	Rock Island	3					
350	CJ	Rock Island	61201	Rock Island	3					
351	CF	Moline	61265	Rock Island	3					
352	CR	Milan	61264	Rock Island	3					
353	CJ	Coal Vallery	61240	Rock Island	3					
354	CD	Moline	61265	Rock Island	3					
355	CA	Moline	61265	Rock Island	3					
356	CD	Moline	61265	Rock Island	3					
357	CA	Moline	61265	Rock Island	3					
358	CM	Orion	61273	Henry	3					
359	CD	Moline	61265	Rock Island	3					
360	CB	Milan	61264	Rock Island	3					
361	CB	Moline	61265	Rock Island	3					
362	CJ	Orion	61273	Henry	3					
363	CD	Coal Vallery	61240	Rock Island	3					
364	CM	Moline	61265	Rock Island	3					
365	CE	Moline	61265	Rock Island	3					
366	CJ	Rock Island	61201	Rock Island	3					
367	CM	Rock Island	61201	Rock Island	3					
368	CR	Reynolds	61279	Rock Island	3					
369	CM	Rock Island	61201	Rock Island	3					
370	DG	Rock Island	61201	Rock Island	3					
371	DP	Milan	61264	Rock Island	3					
372	DM	Moline	61265	Rock Island	3					
373	DE	East Moline	61244	Rock Island	3					
374	DH	Andalusia	61232	Rock Island	3					
375	DP	Illinois City	61259	Rock Island	3					
376	DC	Moline	61265	Rock Island	3					
377	DM	Moline	61265	Rock Island	3					
378	DR	Rock Island	61201	Rock Island	3					
379	DR	Moline	61265	Rock Island	3					
380	DH	Rock Island	61201	Rock Island	3					
381	DA	Moline	61244	Rock Island	3					
382	DL	Moline	61265	Rock Island	3					
383	DR	Moline	61265	Rock Island	3					
384	DL	Milan	61264	Rock Island	3					
385	DC	Moline	61265	Rock Island	3					
386	DL	Milan	61264	Rock Island	3					
387	DM	Moline	61265	Rock Island	3					
388	DL	Rock Island	61201	Rock Island	3					
389	DD	Moline	61265	Rock Island	3					
390	DJ	Moline	61265	Rock Island	3					
391	DR	Rock Island	61201	Rock Island	3					
392	DE	Moline	61265	Rock Island	3					
393	DM	East Moline	61244	Rock Island	3					
394	ER	Moline	61265	Rock Island	3					
395	ER	Moline	61265	Rock Island	3					
396	EM	Moline	61265	Rock Island	3					
397	EB	Reynolds	61279	Rock Island	3					
398	EJ	Orion	61273	Henry	3					
399	ED	GEN	61254	Henry	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
400	EG	Moline	61265	Rock Island	3					
401	FR	Moline	61265	Rock Island	3					
402	FR	East Moline	61244	Rock Island	3					
403	FN	Moline	61265	Rock Island	3					
404	FD	Milan	61264	Rock Island	3					
405	FL	Moline	61265	Rock Island	3					
406	FA	Moline	61265	Rock Island	3					
407	FW	Moline	61265	Rock Island	3					
408	FR	Moline	61265	Rock Island	3					
409	FD	Lynn Center	61262	Henry	3					
410	FD	Moline	61265	Rock Island	3					
411	FL	Milan	61264	Rock Island	3					
412	FM	Moline	61265	Rock Island	3					
413	FR	Rock Island	61201	Rock Island	3					
414	FJ	Moline	61265	Rock Island	3					
415	FD	Rock Island	61201	Rock Island	3					
416	FJ	Coal Vallery	61240	Rock Island	3					
417	FG	Moline	61265	Rock Island	3					
418	FK	Rock Island	61261	Rock Island	3					
419	FW	Moline	61265	Rock Island	3					
420	FR	Orion	61272	Henry	3					
421	FS	Sherrard	61281	Mercer	3					
422	GL	Alpha	61413	Henry	3					
423	GS	Carbon cliff	61239	Rock Island	3					
424	GV	Moline	61265	Rock Island	3					
425	GA	Moline	61265	Rock Island	3					
426	GW	Maquoketa	52060	Jackson	3					
427	GP	Moline	61265	Rock Island	3					
428	GM	Moline	61265	Rock Island	3					
429	GN	Milan	61264	Rock Island	3					
430	GD	East Moline	61244	Rock Island	3					
431	GD	Rock Island	61201	Rock Island	3					
432	GD	Moline	61265	Rock Island	3					
433	GL	Moline	61265	Rock Island	3					
434	GI	East Moline	61244	Rock Island	3					
435	GK	Silvis	61265	Rock Island	3					
436	GG	Illinois City	61265	Rock Island	3					
437	GR	Moline	61265	Rock Island	3					
438	GM	Moline	61265	Rock Island	3					
439	GD	Rock Island	61201	Rock Island	3					
440	GA	Taylor Ridge	61264	Rock Island	3					
441	HN		65778		3					
442	HH	Sherrard	61281	Mercer	3					
443	HK	Moline	61265	Rock Island	3					
444	HF	Moline	61265	Rock Island	3					
445	HF	Moline	61265	Rock Island	3					
446	HM	East Moline	61244	Rock Island	3					
447	HI	Aledo	61231	Mercer	3					
448	HM	Moline	61265	Rock Island	3					
449	HR	Moline	61265	Rock Island	3					
450	HS	Moline	61265	Rock Island	3					
451	HS	Rock Island	61201	Rock Island	3					
452	HJ	Milan	61264	Rock Island	3					
453	HM	Moline	61265	Rock Island	3					
454	HM	Moline	61443	Rock Island	3					
455	HF	Moline	61265	Rock Island	3					
456	HM	Rock Island	61201	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
457	HJ	Silvis	61282	Rock Island	3					
458	HS	Moline	61265	Rock Island	3					
459	HF	Rock Island	61201	Rock Island	3					
460	HG	Moline	61265	Rock Island	3					
461	HL	Rock Island	61201	Rock Island	3					
462	HN	Moline	61265	Rock Island	3					
463	HG	Moline	61265	Rock Island	3					
464	HK	Moline	61265	Rock Island	3					
465	HP	Rock Island	61201	Rock Island	3					
466	HJ	Rock Island	61201	Rock Island	3					
467	HJ	Moline	61265	Rock Island	3					
468	HE	Andalusia	61232	Rock Island	3					
469	HW	Milan	61264	Rock Island	3					
470	HW	Moline	61265	Rock Island	3					
471	HR	Morrison	61270	Rock Island	3					
472	HA	Rock Island	61201	Rock Island	3					
473	HR	Coal Valley	61240	Rock Island	3					
474	HA	Moline	61265	Rock Island	3					
475	HR	Moline	61265	Rock Island	3					
476	HJ	Moline	61265	Rock Island	3					
477	HR	Coal Valley	61240	Rock Island	3					
478	HC	Coal Valley	61240	Rock Island	3					
479	HL	Moline	61265	Rock Island	3					
480	HJ	Coal Valley	61240	Rock Island	3					
481	IS	Moline	61265	Rock Island	3					
482	IM	Taylor Ridge	61284	Rock Island	3					
483	JF	Silvis	61282	Rock Island	3					
484	JI	Rock Island	61201	Rock Island	3					
485	JT	Rock Island	61201	Rock Island	3					
486	JJ	Moline	61265	Rock Island	3					
487	JR	Orion	61273	Henry	3					
488	JE	Moline	61265	Rock Island	3					
489	JJ	Rock Island	61201	Rock Island	3					
490	JJ	Moline	61265	Rock Island	3					
491	JR	Moline	61265	Rock Island	3					
492	JS	Moline	61265	Rock Island	3					
493	JJ	Moline	61265	Rock Island	3					
494	JR	Moline	61265	Rock Island	3					
495	JB	Silvis	61282	Rock Island	3					
496	JG	Milan	61264	Rock Island	3					
497	KH	RIO	61472	Knox	3					
498	KH	Moline	61265	Rock Island	3					
499	KJ	Moline	61265	Rock Island	3					
500	KJ	Coal Valley	61240	Rock Island	3					
501	KR	Moline	61265	Rock Island	3					
502	KD	Moline	61265	Rock Island	3					
503	KL	Geneseo	61254	Henry	3					
504	KJ	Rock Island	61201	Rock Island	3					
505	KM	Moline	61265	Rock Island	3					
506	KD	Moline	61265	Rock Island	3					
507	KB	Moline	61265	Rock Island	3					
508	KT	Milan	61264	Rock Island	3					
509	KW	Reynolds	61279	Rock Island	3					
510	KP	Coal Valley	61240	Rock Island	3					
511	LE	Coal Valley	61240	Rock Island	3					
512	LB	Milan	61264	Rock Island	3					
513	LH	Moline	61265	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
514	LL	Moline	61265	Rock Island	3					
515	LJ	Moline	61265	Rock Island	3					
516	LK	Moline	61265	Rock Island	3					
517	LJ	Andalusia	61233	Rock Island	3					
518	LW	Moline	61244	Rock Island	3					
519	LR	Moline	61265	Rock Island	3					
520	LC	Milan	61264	Rock Island	3					
521	LB	Taylor Ridge	61284	Rock Island	3					
522	LC	Silvis	61282	Rock Island	3					
523	LD	Rock Island	61201	Rock Island	3					
524	LR	Moline	61265	Rock Island	3					
525	LE	Moline	61265	Rock Island	3					
526	LR	Moline	61265	Rock Island	3					
527	LB	Silvis	61244	Rock Island	3					
528	LE	Moline	61265	Rock Island	3					
529	LC	Rock Island	61201	Rock Island	3					
530	LM	Moline	61265	Rock Island	3					
531	LA	Moline	61265	Rock Island	3					
532	LF	Geneseo	61254	Henry	3					
533	LM	Moline	61265	Rock Island	3					
534	LB	Moline	61265	Rock Island	3					
535	LR	Moline	61265	Rock Island	3					
536	LJ	East Moline	61244	Rock Island	3					
537	LC	Milan	61264	Rock Island	3					
538	LD	Moline	61265	Rock Island	3					
539	LM	Milan	61264	Rock Island	3					
540	LD	Moline	61265	Rock Island	3					
541	LJ	Davenport	52807	Scott	3					
542	LA	Milan	61264	Rock Island	3					
543	MV	Orion	61273	Henry	3					
544	MJ	Coal Valley	61240	Rock Island	3					
545	MD	Moline	61265	Rock Island	3					
546	MG	Moline	61215	Rock Island	3					
547	MD	Moline	61265	Rock Island	3					
548	MR	Coal Valley	61240	Rock Island	3					
549	MG	Rock Island	61201	Rock Island	3					
550	MB	Moline	61265	Rock Island	3					
551	MJ	Moline	61265	Rock Island	3					
552	MV	East Moline	61244	Rock Island	3					
553	ML	Rock Island	61201	Rock Island	3					
554	MR	Milan	61264	Rock Island	3					
555	MK	Moline	61265	Rock Island	3					
556	MD	Milan	61264	Rock Island	3					
557	MG	Moline	61265	Rock Island	3					
558	MM	Rock Island	61201	Rock Island	3					
559	MT	Lynn Center	61262	Henry	3					
560	MD	Long Grove	52756	Scott	3					
561	MM	East Moline	61244	Rock Island	3					
562	MD	Moline	61265	Rock Island	3					
563	MF	Moline	61265	Rock Island	3					
564	MP	Taylor Ridge	61284	Rock Island	3					
565	MB	Moline	61265	Rock Island	3					
566	MG	Moline	61265	Rock Island	3					
567	MT	Rock Island	61201	Rock Island	3					
568	MA	Moline	61265	Rock Island	3					
569	MG	Rock Island	61201	Rock Island	3					
570	MB	Moline	61265	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
571	MD	Moline	61265	Rock Island	3					
572	MB	Moline	61265	Rock Island	3					
573	MC	Taylor Ridge	61264	Rock Island	3					
574	MD	Davenport	52801	Scott	3					
575	MM	Rock Island	61201	Rock Island	3					
576	MP	Rock Island	61201	Rock Island	3					
577	MR	Rock Island	61201	Rock Island	3					
578	MR	Moline	61265	Rock Island	3					
579	MR	Orion	61273	Henry	3					
580	MD	Sherrard	61281	Mercer	3					
581	ME	Muscatine	52761	Muscatine	3					
582	MJ	Rock Island	61201	Rock Island	3					
583	MJ	Rock Island	61201	Rock Island	3					
584	ML	Coal Vallery	61240	Rock Island	3					
585	MC	East Moline	61244	Rock Island	3					
586	MB	Milan	61254	Rock Island	3					
587	MG	Coal Vallery	61240	Rock Island	3					
588	ML	Taylor Ridge	61284	Rock Island	3					
589	MM	Coal Vallery	61240	Rock Island	3					
590	MJ	Moline	61265	Rock Island	3					
591	MP	Moline	61265	Rock Island	3					
592	MB	Rock Island	61201	Rock Island	3					
593	ML	Orion	61273	Henry	3					
594	MA	Moline	61265	Rock Island	3					
595	MD	Milan	61264	Rock Island	3					
596	ME	Moline	61265	Rock Island	3					
597	MM	Rock Island	61201	Rock Island	3					
598	NG	Andalusia	61232	Rock Island	3					
599	NJ	Rock Island	61201	Rock Island	3					
600	NJ	New Windsor	61465	Mercer	3					
601	NK	Moline	61265	Rock Island	3					
602	NG	Moline	61265	Rock Island	3					
603	NJ	Rock Island	61201	Rock Island	3					
604	NM	Moline	61265	Rock Island	3					
605	NJ	Rock Island	61201	Rock Island	3					
606	ND	Moline	61265	Rock Island	3					
607	NR	Moline	61265	Rock Island	3					
608	ND	Rock Island	61201	Rock Island	3					
609	OJ	Moline	61265	Rock Island	3					
610	OJ	Moline	61265	Rock Island	3					
611	OK	Davenport	52806	Scott	3					
612	OP	Moline	61265	Rock Island	3					
613	OC	Coal Vallery	61240	Rock Island	3					
614	OJ	Milan	61264	Rock Island	3					
615	OC	Moline	61265	Rock Island	3					
616	OC	Moline	61265	Rock Island	3					
617	OD	Moline	61265	Rock Island	3					
618	OT	Sherrard	61281	Mercer	3					
619	OL	Rock Island	61201	Rock Island	3					
620	PJ	Moline	61265	Rock Island	3					
621	PD	Rock Island	61201	Rock Island	3					
622	PR	Cambridge	61238	Henry	3					
623	PC	Sherrard	61281	Mercer	3					
624	PS	Moline	61265	Rock Island	3					
625	PH	Coal Vallery	61240	Rock Island	3					
626	PJ	Moline	61265	Rock Island	3					
627	PB	Moline	61265	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
628	PH	Moline	61265	Rock Island	3					
629	PS	Davenport	52803	Scott	3					
630	PG	Rock Island	61201	Rock Island	3					
631	PN	Milan	61264	Rock Island	3					
632	PJ	Moline	61265	Rock Island	3					
633	PJ	Moline	61265	Rock Island	3					
634	PE	Moline	61265	Rock Island	3					
635	PW	Taylor Ridge	61284	Rock Island	3					
636	PR	Moline	61265	Rock Island	3					
637	PJ	Rock Island	61201	Rock Island	3					
638	PB	Moline	61265	Rock Island	3					
639	PJ	Moline	61265	Rock Island	3					
640	PW	Moline	61265	Rock Island	3					
641	PJ	Moline	61265	Rock Island	3					
642	PK	Rock Island	61201	Rock Island	3					
643	PR	Milan	61264	Rock Island	3					
644	PJ	Moline	61265	Rock Island	3					
645	PL	Moline	61265	Rock Island	3					
646	PM	Rock Island	61201	Rock Island	3					
647	PR	Rock Island	61201	Rock Island	3					
648	PD	Sherrard	61281	Mercer	3					
649	PL	Moline	61265	Rock Island	3					
650	PN	Orion	61273	Henry	3					
651	PR	Moline	61265	Rock Island	3					
652	PR	Moline	61265	Rock Island	3					
653	PR	Milan	61264	Rock Island	3					
654	PC	East Moline	61244	Rock Island	3					
655	PP	Moline	61265	Rock Island	3					
656	PM	Moline	61265	Rock Island	3					
657	QJ	Moline	61265	Rock Island	3					
658	QV	Moline	61265	Rock Island	3					
659	QK	Milan	61264	Rock Island	3					
660	RC	Moline	61265	Rock Island	3					
661	RM	Andalusia	61232	Rock Island	3					
662	RF	Moline	61265	Rock Island	3					
663	RT	Moline	61265	Rock Island	3					
664	RC	Prophestown	61277	Rock Island	3					
665	RB	Moline	61265	Rock Island	3					
666	RE	Moline	61265	Rock Island	3					
667	RC	East Moline	61244	Rock Island	3					
668	S	Rock Island	61201	Rock Island	3					
669	RJ	Viola	61466	Mercer	3					
670	RT	Moline	61265	Rock Island	3					
671	RW	Moline	61265	Rock Island	3					
672	RM	Hillsdale	61257	Rock Island	3					
673	RJ	Milan	61264	Rock Island	3					
674	RP	Alpha	61413	Henry	3					
675	RC	Moline	61265	Rock Island	3					
676	RP	Rock Island	61201	Rock Island	3					
677	RL	Rock Island	61201	Rock Island	3					
678	RL	Rock Island	61201	Rock Island	3					
679	RA	Geneseo	61254	Henry	3					
680	RL	Moline	61201	Rock Island	3					
681	M	Rock Island	61201	Rock Island	3					
682	RL	Cambridge	61238	Henry	3					
683	RL	East Moline	61244	Rock Island	3					
684	RR	Moline	61265	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
685	RB	Moline	61265	Rock Island	3					
686	RM	Moline	61265	Rock Island	3					
687	RD	Rock Island	61201	Rock Island	3					
688	RM	Moline	61265	Rock Island	3					
689	ST	Moline	61265	Rock Island	3					
690	SL	Moline	61265	Rock Island	3					
691	SS	Moline	61265	Rock Island	3					
692	SE	Milan	61264	Rock Island	3					
693	SJ	Moline	61265	Rock Island	3					
694	SM	Moline	61265	Rock Island	3					
695	SB	Moline	61265	Rock Island	3					
696	SL	East Moline	61244	Rock Island	3					
697	SA	Moline	61265	Rock Island	3					
698	SS	Milan	61264	Rock Island	3					
699	SC	Milan	61264	Rock Island	3					
700	SA	Moline	61265	Rock Island	3					
701	SC	Rock Island	61201	Rock Island	3					
702	SM	Moline	61265	Rock Island	3					
703	SL	Moline	61265	Rock Island	3					
704	SM	Rock Island	61201	Rock Island	3					
705	SW	Cambridge	61238	Henry	3					
706	SJ	Moline	61265	Rock Island	3					
707	SC	Moline	61265	Rock Island	3					
708	SD	Moline	61265	Rock Island	3					
709	SF	Moline	61265	Rock Island	3					
710	SM	Moline	61265	Rock Island	3					
711	SC	Rock Island	61201	Rock Island	3					
712	SA	Milan	61264	Rock Island	3					
713	SD	Moline	61265	Rock Island	3					
714	ST	Sherrard	61281	Mercer	3					
715	SD	Moline	61265	Rock Island	3					
716	SD	Davenport	52806	Scott	3					
717	SL	Annawan	61234	Henry	3					
718	SD	Albany	61230	Whiteside	3					
719	SS	Rock Island	61201	Rock Island	3					
720	SV	Moline	61265	Rock Island	3					
721	SC	Moline	61265	Rock Island	3					
722	SK	Colona	61242	Rock Island	3					
723	SK	Orion	61273	Henry	3					
724	SD	Erie	61250	Henry	3					
725	SP	Moline	61265	Rock Island	3					
726	SD	Moline	61265	Rock Island	3					
727	SE	Moline	61265	Rock Island	3					
728	SK	Moline	61265	Rock Island	3					
729	ST	Moline	61265	Rock Island	3					
730	SJ	Colona	61241	Rock Island	3					
731	SR	Rock Island	61201	Rock Island	3					
732	SS	Orion	61273	Henry	3					
733	SC	Viola	61486	Rock Island	3					
734	SK	Moline	61265	Rock Island	3					
735	SD	Milan	61264	Rock Island	3					
736	SB	Moline	61265	Rock Island	3					
737	SK	LeClaire	52753	Scott	3					
738	SD	Moline	61265	Rock Island	3					
739	SL	Moline	61265	Rock Island	3					
740	SV	Moline	61265	Rock Island	3					
741	SN	Rock Island	61201	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
742	SR	Moline	61265	Rock Island	3					
743	SW	Milan	61264	Rock Island	3					
744	SE	Moline	61265	Rock Island	3					
745	SD	Coal Valley	61241	Rock Island	3					
746	SM	Moline	61265	Rock Island	3					
747	SM	Rock Island	61201	Rock Island	3					
748	SV	Andalusia	61233	Rock Island	3					
749	SJ	Moline	61265	Rock Island	3					
750	SC	Moline	61265	Rock Island	3					
751	SB	Moline	61265	Rock Island	3					
752	SR	Sherrard	61281	Mercer	3					
753	SJ	Moline	61265	Rock Island	3					
754	SB	Moline	61265	Rock Island	3					
755	SC	Monmoth	61462	Rock Island	3					
756	SA	Orion	61273	Henry	3					
757	SC	Moline	61265	Rock Island	3					
758	SD	Moline	61265	Rock Island	3					
759	SM	Orion	61273	Henry	3					
760	SN	Moline	61265	Rock Island	3					
761	TG	Moline	61265	Rock Island	3					
762	TA	Coal Valley	61240	Rock Island	3					
763	TE	Coal Valley	61240	Rock Island	3					
764	TR	Rock Island	61201	Rock Island	3					
765	TA	Rock Island	61201	Rock Island	3					
766	TL	Moline	61265	Rock Island	3					
767	TW	Moline	61265	Rock Island	3					
768	TB	Moline	61265	Rock Island	3					
769	TS	Moline	61265	Rock Island	3					
770	TV	Rock Island	61201	Rock Island	3					
771	TV	Port Byron	61275	Rock Island	3					
772	TS	Rock Island	61201	Rock Island	3					
773	TM	Moline	61265	Rock Island	3					
774	TG	Moline	61265	Rock Island	3					
775	TW	Coal Valley	61240	Rock Island	3					
776	TT	Milan	61264	Rock Island	3					
777	TR	Rock Island	61201	Rock Island	3					
778	UR	Moline	61265	Rock Island	3					
779	VD	Milan	61264	Rock Island	3					
780	VD	Rock Island	61201	Rock Island	3					
781	VS	Moline	61265	Rock Island	3					
782	VJ	Moline	61265	Rock Island	3					
783	VJ	Moline	61265	Rock Island	3					
784	VB	Moline	61265	Rock Island	3					
785	VF	Moline	61265	Rock Island	3					
786	VR	Moline	61265	Rock Island	3					
787	VB	Rock Island	61201	Rock Island	3					
788	VL	Moline	61265	Rock Island	3					
789	VR	Coal Valley	61240	Rock Island	3					
790	VL	Moline	61265	Rock Island	3					
791	VF	Rock Island	61201	Rock Island	3					
792	VV	Orion	61273	Henry	3					
793	VO	Moline	61265	Rock Island	3					
794	WL	Moline	61265	Rock Island	3					
795	WJ	Geneseo	61254	Henry	3					
796	WJ	Moline	61265	Rock Island	3					
797	WW	Rock Island	61201	Rock Island	3					
798	WC	Hampton	61256	Rock Island	3					

Moline CKD Patients

	A	B	C	D	E	F	G	H	I	J
799	WH	Moline	61265	Rock Island	3					
800	WC	Colona	61240	Rock Island	3					
801	WR	Davenport	52804	Scott	3					
802	WA	Taylor ridge	61284	Rock Island	3					
803	WC	Moline	61265	Rock Island	3					
804	WP	Coal Valley	61240	Rock Island	3					
805	WW	Milan	61264	Rock Island	3					
806	WJ	Milan	61264	Rock Island	3					
807	WR	Moline	61265	Rock Island	3					
808	WF	Moline	61265	Rock Island	3					
809	WC	Moline	61265	Rock Island	3					
810	WB	Rock Island	61201	Rock Island	3					
811	WB	Milan	61264	Rock Island	3					
812	WR	Moline	61265	Rock Island	3					
813	WM	Moline	61265	Rock Island	3					
814	WL	Andalusia	61232	Rock Island	3					
815	WJ	Moline	61265	Rock Island	3					
816	WC	Rock Island	61201	Rock Island	3					
817	WT	Moline	61265	Rock Island	3					
818	WJ	Coal Valley	61240	Rock Island	3					
819	WD	Illinois City	61259	Rock Island	3					
820	WJ	Milan	61264	Rock Island	3					
821	WJ	Moline	61265	Rock Island	3					
822	WF	Moline	61265	Rock Island	3					
823	WD	Moline	61265	Rock Island	3					
824	WR	Rock Island	61201	Rock Island	3					
825	WP	Moline	61265	Rock Island	3					
826	WJ	East Moline	61244	Rock Island	3					
827	WM	Moline	61265	Rock Island	3					
828	WM	Milan	61264	Rock Island	3					
829	WB	Moline	61265	Rock Island	3					
830	WD	Andalusia	61232	Rock Island	3					
831	WM	Moline	61265	Rock Island	3					
832	WH	Moline	61265	Rock Island	3					
833	WM	Moline	61265	Rock Island	3					
834	WR	Rock Island	61201	Rock Island	3					
835	YD	Rock Island	61201	Rock Island	3					
836	ZL	East Moline	61244	Rock Island	3					
837	ZB	Erie	61250	Henry	3					
838										
839										
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July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

C.L

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

B.W

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

CM

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

DA

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

B. G

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

B.R

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

D. C

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

DF

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

AC

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

D. O

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

H.T

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

JC

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

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Sincerely,

GS

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

HJ

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

DG

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

DR

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

D.S

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

FT

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

E.S

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

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Sincerely,

GH

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

EH

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

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Sincerely,

OT

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

DL

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

D.J

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

S. M

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

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Sincerely,

A.O

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

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Sincerely,

AE

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

I understand that Quad Cities Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a dialysis patient and currently receive dialysis treatments at the Quad Cities Kidney Center, LLC in Rock Island, Illinois. I have seen the growth of this facility over the last year. There are new patients being added weekly.

I support the expansion of the Quad Cities Kidney Center Rock Island, Illinois. As a patient with kidney disease who is on dialysis, it is reassuring to me and the other patients to have a dialysis facility that can provide the needed dialysis treatment closer to where we live and at a convenient time. The dialysis patients need to rely on family, transportation services, or Nursing home staff, to get them to and from their dialysis treatment. Transportation services are available during the day hours 9am to 4pm Monday thru Friday. It can be difficult to find transportation for a dialysis patient in the early morning, evenings or on Saturday.

I hope that you will approve the expansion of the Quad Cities Kidney Center Rock Island LLC, Rock Island Illinois. So these patients can benefit having a more flexible and convenient time for their dialysis treatment.

Sincerely,

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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Sincerely,

JTC

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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E W
Sincerely,

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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Sincerely, JMJ

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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Sincerely,

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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I hope that you will approve the expansion of the Quad Cities Kidney Center Rock Island LLC, Rock Island Illinois. So these patients can benefit having a more flexible and convenient time for their dialysis treatment.

Sincerely,

R A.

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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I hope that you will approve the expansion of the Quad Cities Kidney Center Rock Island LLC, Rock Island Illinois. So these patients can benefit having a more flexible and convenient time for their dialysis treatment.

Sincerely, JCH

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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I hope that you will approve the expansion of the Quad Cities Kidney Center Rock Island LLC, Rock Island Illinois. So these patients can benefit having a more flexible and convenient time for their dialysis treatment.

Sincerely, C L

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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Sincerely, MGM

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

I understand that Quad Cities Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a dialysis patient and currently receive dialysis treatments at the Quad Cities Kidney Center, LLC in Rock Island, Illinois. I have seen the growth of this facility over the last year. There are new patients being added weekly.

I support the expansion of the Quad Cities Kidney Center Rock Island, Illinois. As a patient with kidney disease who is on dialysis, it is reassuring to me and the other patients to have a dialysis facility that can provide the needed dialysis treatment closer to where we live and at a convenient time. The dialysis patients need to rely on family, transportation services, or Nursing home staff, to get them to and from their dialysis treatment. Transportation services are available during the day hours 9am to 4pm Monday thru Friday. It can be difficult to find transportation for a dialysis patient in the early morning, evenings or on Saturday.

I hope that you will approve the expansion of the Quad Cities Kidney Center Rock Island LLC, Rock Island Illinois. So these patients can benefit having a more flexible and convenient time for their dialysis treatment.

Sincerely, D. T.

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

Dear Mr. Constantino

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Sincerely,

July 12, 2010

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Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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July 12, 2010

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525 West Jefferson Street
Springfield, IL 6276

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Sincerely,

July 12, 2010

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Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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Sincerely, PJ

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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Sincerely,

MR

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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525 West Jefferson Street
Springfield, IL 6276

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Sincerely, A M

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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Springfield, IL 6276

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Springfield, IL 6276

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Sincerely,

A.C.

July 12, 2010

Mike Constantino
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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525 West Jefferson Street
Springfield, IL 6276

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Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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Sincerely, SH

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Illinois Health Facilities Planning Board
525 West Jefferson Street
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July 12, 2010

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Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, IL 6276

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Springfield, IL 6276

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Sincerely, V. H

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

Dear Mr. Constantino

I understand that Quad Cites Kidney Center Rock Island, LLC is planning to add 6 additional stations to their existing 12 station hemodialysis unit to accommodate their End Stage Renal Disease patient growth.

I am a Chronic Kidney Disease patient followed by the Nephrologists who practice at the Quad Cities Kidney Center Rock Island location. I am going to need dialysis treatment in the near future. Expanding the stations in the Rock Island facility is reassuring to me that they will be able to accommodate my dialysis treatments at a convenient day and time. It is difficult for my family and I to travel far away 3 times a week for treatments especially during the winter months. It would be time consuming and more expensive, especially with the present economic times. I may need to rely on a transportation service, or public transportation that is only available during the day.

I support the expansion of the Quad Cities Kidney Center Rock Island LCC in Rock Island Illinois. This dialysis unit would provide continuity of care with my Nephrologists. I hope you will approve the expansion of the dialysis center in Rock Island, Illinois.

Sincerely,

July 12, 2010

Mike Constantino
Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

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Sincerely,

C W. M.

July 12, 2010

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Executive Secretary
Illinois Health Facilities Planning Board
525 West Jefferson Street
Springfield, Il 62761

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Sincerely,

Quad Cities Kidney Center

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapharesis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Out-Patient Clinics

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

600 North College Avenue
Geneseo, Illinois 61254
(309) 945-1787

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

4480 Utica Ridge Road
Bettendorf, Iowa 52722
(563) 344-9977

In-Patient Facilities

Trinity Medical Center
- West Campus
Rock Island, Illinois

- 7th Street Campus
Moline, Illinois

- Terrace Park Campus
Bettendorf, Iowa

Genesis Medical Center
- Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

July 28, 2010

Dale Galassie
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Mr. Galassie:

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 § 1110.1430(f) the following:

- Quad Cities Kidney Center Rock Island participates in a dialysis data system;
- Support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric services, and social services are available; and
- Quad Cities Kidney Center Rock Island has an agreement with Quad Cities Kidney Center Moline to provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Sincerely,

V.R. Alla, MD

V.R. Alla, M.D.
Manager
United Dialysis Centers, LLC
Quad Cities Kidney Center Rock Island, LLC

Subscribed and sworn to me
This 28th day of July, 2010

Debora L Blaser
Notary Public

OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

104661.1

ROBERT
YOUNG CENTER
IOWA HEALTH SYSTEM

4600 3RD STREET
MOLINE, IL 61265-6199
309-779-2031
www.trinityqc.com/ryc

June 27, 2010

V.R. Alla, M.D.
Quad City Kidney Center
400 John Deere Road
Moline, IL 61265

RE: Quad City Kidney Center – Rock Island LLC Expansion

Dear Dr. Alla,

The Robert Young Center, a comprehensive Community Health Center, is dedicated to provide comprehensive mental health and substance abuse services in response to the community's needs. Patients referred to the Robert Young Center by the Quad City Kidney Center, and its Rock Island affiliate, will receive quality, accessible, practical care that is patient-centered with concern for the mind, body and spirit. We offer this care to all of your patients, regardless of their race, religion or socioeconomic status.

Please do not hesitate to contact me at (309) 779-2051 if I can be of any assistance to you.

Sincerely,

Michael Freda, LCSW
Director of Operations

Nationwide
LABORATORY SERVICES
Where Science Meets Technology

June 25, 2010

Dr. V.R. Alla
Quad Cities Kidney Center
400 John Deere Rd.
Moline, IL 61265

Dear Dr. Alla:

This letter confirms that your current Nationwide Laboratory Services laboratory services agreement has been amended to include the Quad Cities Kidney Center Rock Island LLC clinic located at 2623 17th Street, Rock Island, IL 61201.

All terms, rights, pricing and Nationwide Laboratory Services responsibilities and obligations will be accorded your new clinic effective immediately.

Nationwide Laboratory Services is honored to count you and your esteemed clinical management team as valued customers.

Best regards,

Sean E. Martin

Sean Martin
Executive VP of Sales & Marketing
Nationwide Laboratory Services

2030 West McNab Road, Fort Lauderdale, Florida 33309 • 954-633-3580 • Fax: 954-633-3582 • www.nationwidelab.com

Quad Cities Kidney Center

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapharesis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Out-Patient Clinics

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

600 North College Avenue
Geneseo, Illinois 61254
(309) 945-1787

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

4480 Utica Ridge Road
Bettendorf, Iowa 52722
(563) 344-9977

In-Patient Facilities

Trinity Medical Center
- West Campus
Rock Island, Illinois

- 7th Street Campus
Moline, Illinois

- Terrace Park Campus
Bettendorf, Iowa

Genesis Medical Center
- Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

July 28, 2010

Dale Galassie
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: In-Center Hemodialysis Assurances

Dear Mr. Galassie:

Pursuant to 77 Ill. Admin. Code § 1110.1430(j), I hereby certify the following:

- By the second year after project completion, Quad Cities Kidney Center Rock Island will achieve and maintain 80% target utilization as specified in 77 Ill. Admin. Code; and
- Hemodialysis outcome measures will be achieved and maintained as follows:
  - ≥ 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,

V.R. Alla, MD

V.R. Alla, M.D.
Manager
United Dialysis Centers, LLC
Quad Cities Kidney Center Rock Island, LLC

Subscribed and sworn to me
This 29th day of July, 2010

Marla S. Floyd
Notary Public

OFFICIAL SEAL
MARLA S. FLOYD
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 1-19-2011

104756.1

Attachment 26H

Data from 2009 Dialysis Facility Reports for 2010	QCKC Moline	QCKC Davenport	QCKC Silvis	QCKC Geneseo	QCKC Rock Island	QCKC Bettendorf	Aledo Kidney Center	Dixon Dialysis Center
URR > 65%	***98%***	***96%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
US Average	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%	96.1%
HGB <10	***2.8%***	***0.0%***	***0.0%***	***0.0%***	***3.8%***	***7.1%***	***0.0%***	***0.0%***
US Average	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
HGB 10-12	***87.7%***	***100.0%***	***96.0%***	***93.8%***	***84.6%***	***92.9%***	***100.0%***	***90.0%***
US Average	81.0%	81.0%	81.0%	81.0%	81.0%	81.0%	81.0%	81.0%
HGB >12	***9.4%***	***0.0%***	***4.0%***	***6.3%***	***11.5%***	***0.0%***	***0.0%***	***10.0%***
US Average	16.2%	16.2%	16.2%	16.2%	16.2%	16.2%	16.2%	16.2%
% Prevalent Pts with AVF	55.6%	64.6%	52.6%	45.2%	52.4%	44.3%	55.1%	87.3%
US Average	53.1%	53.1%	53.1%	53.1%	53.1%	53.1%	53.1%	53.1%
Standardized Mortality Ratio (SMR)	***0.88*** Below the National Average of 1	***0.72*** Below the National Average of 1	***1.01*** Above the National Average of 1	***0.66*** Below the National Average of 1	***1.34*** Above the National Average of 1	***1.15*** Above the National Average of 1	***0.98*** Below the National Average of 1	***1.15*** Above the National Average of 1
Standardized Total Days Hospitalized Ratio	***0.89***	***0.43***	***0.93***	***0.46***	***NA***	***1.16***	***1.04***	***0.72***
National Reference Value	*1*	*1*	*1*	*1*	*1*	*1*	*1*	*1*
Admission Rate Per PY	***2***	***1.2***	***2***	***0.9***	***NA***	***2.1***	***2.1***	***1.4***
US Average	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
Average Length Of Stay (per admission)	***5.2***	***5.5***	***4.4***	***7.5***	***NA***	***7.6***	***4.3***	***4***
US Average	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.7
Transplantation Rate Compared Nationally	***6%***	***6%***	***7%***	***NA***	***NA***	***NA***	***NA***	***NA***
	5%	***5%***	***5%***	***5%***	***5%***	***5%***	***5%***	***5%***
Transplant Wait List	***20%***	***32%***	***25%***	***14%***	***19%***	***20%***	***22%***	***30%***
Compared Nationally	***24%***	***24%***	***24%***	***24%***	***24%***	***24%***	***24%***	***24%***
Infection Rate	***11.0%***	***5.0%***	***10.0%***	***8.0%***	***13.6%***	***11.0%***	***12.0%***	***9.0%***
National Rate	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 142645

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

In September 2009, each state's surveyors will receive the DFR for all dialysis facilities in their state.

This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

Collaborators

CMS has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) and Arbor Research Collaborative for Health to produce the *2009 Dialysis Facility Reports.*

How to Submit Comments

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- **Dialysis Facility Compare:** Comment on the three DFC measures (see page 2) which will be reported on the DFC public website in November 2009. The comment period begins July 13, 2009 and ends September 8, 2009. Your comments will **not** appear on the DFC website.
- **State Surveyor:** Comment on your DFR for the state surveyors. The state surveyors will receive a copy of your DFR in September 2009 with your comments.
- **UM-KECC:** Submit questions about your DFR to UM-KECC. You can also submit your suggestions to improve the DFR.

Dear Dialysis Facility Director:

This report has been prepared for this facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from the Centers for Medicare & Medicaid Services (CMS). It is the fourteenth in a series of annual reports. This is one of 5,507 reports that have been sent to the ESRD Networks for distribution to ESRD providers in the U.S. Your state survey agency will receive this report in September 2009. Selected highlights from this report are given here. The information specific to this facility is printed in **bold type** for easy identification.

What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**100%**
	Number of patients included in calculation: 15	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**0%**
	with ESA-treated hemoglobin >12 g/dL	**22%**
	Number of patients included in calculation: 18	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 1.06	
	P-value: 0.86	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 142658

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

In September 2009, each state's surveyors will receive the DFR for all dialysis facilities in their state.

This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

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- **Dialysis Facility Compare:** Comment on the three DFC measures (see page 2) which will be reported on the DFC public website in November 2009. The comment period begins July 13, 2009 and ends September 8, 2009. Your comments will **not** appear on the DFC website.
- **State Surveyor:** Comment on your DFR for the state surveyors. The state surveyors will receive a copy of your DFR in September 2009 with your comments.
- **UM-KECC:** Submit questions about your DFR to UM-KECC. You can also submit your suggestions to improve the DFR.

Dear Dialysis Facility Director:

This report has been prepared for this facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from the Centers for Medicare & Medicaid Services (CMS). It is the fourteenth in a series of annual reports. This is one of 5,507 reports that have been sent to the ESRD Networks for distribution to ESRD providers in the U.S. Your state survey agency will receive this report in September 2009. Selected highlights from this report are given here. The information specific to this facility is printed in **bold type** for easy identification.

What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**100%**
	Number of patients included in calculation: 14	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**0%**
	with ESA-treated hemoglobin >12 g/dL	**27%**
	Number of patients included in calculation: 15	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 0.71	
	P-value: 0.34	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 142675

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

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This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

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How to Submit Comments

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- **Dialysis Facility Compare:** Comment on the three DFC measures (see page 2) which will be reported on the DFC public website in November 2009. The comment period begins July 13, 2009 and ends September 8, 2009. Your comments will **not** appear on the DFC website.

- **State Surveyor:** Comment on your DFR for the state surveyors. The state surveyors will receive a copy of your DFR in September 2009 with your comments.

- **UM-KECC:** Submit questions about your DFR to UM-KECC. You can also submit your suggestions to improve the DFR.

Dear Dialysis Facility Director:

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What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**100%**
	Number of patients included in calculation: 44	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**2%**
	with ESA-treated hemoglobin >12 g/dL	**35%**
	Number of patients included in calculation: 46	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 0.92	
	P-value: 0.74	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 142526

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

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This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

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Dear Dialysis Facility Director:

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What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**98%**
	Number of patients included in calculation: 105	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**4%**
	with ESA-treated hemoglobin >12 g/dL	**11%**
	Number of patients included in calculation: 111	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 0.84	
	P-value: 0.05	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 162507

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

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Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**100%**
	Number of patients included in calculation: 26	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**0%**
	with ESA-treated hemoglobin >12 g/dL	**26%**
	Number of patients included in calculation: 27	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 0.86	
	P-value: 0.56	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 142592

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

In September 2009, each state's surveyors will receive the DFR for all dialysis facilities in their state.

This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

Collaborators

CMS has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) and Arbor Research Collaborative for Health to produce the *2009 Dialysis Facility Reports.*

How to Submit Comments

Between July 13, 2009 and September 8, 2009, you may submit comments for CMS on the three DFC measures, for your state surveyor, or for UM-KECC. Please visit www.DialysisReports.org, log on to view your report, and click **Comments**.

- **Dialysis Facility Compare:** Comment on the three DFC measures (see page 2) which will be reported on the DFC public website in November 2009. The comment period begins July 13, 2009 and ends September 8, 2009. Your comments will **not** appear on the DFC website.
- **State Surveyor:** Comment on your DFR for the state surveyors. The state surveyors will receive a copy of your DFR in September 2009 with your comments.
- **UM-KECC:** Submit questions about your DFR to UM-KECC. You can also submit your suggestions to improve the DFR.

Dear Dialysis Facility Director:

This report has been prepared for this facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from the Centers for Medicare & Medicaid Services (CMS). It is the fourteenth in a series of annual reports. This is one of 5,507 reports that have been sent to the ESRD Networks for distribution to ESRD providers in the U.S. Your state survey agency will receive this report in September 2009. Selected highlights from this report are given here. The information specific to this facility is printed in **bold type** for easy identification.

What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%** *Number of patients included in calculation: 16*	**100%**
2.	**The percentage of Medicare patients treated in this facility during 2008** **with ESA-treated hemoglobin <10 g/dL** **with ESA-treated hemoglobin >12 g/dL** *Number of patients included in calculation: 16*	 **0%** **31%**
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility** *Standardized Mortality Ratio (SMR): 0.73* *P-value: 0.37*	**As Expected**

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

2009 Dialysis Facility Report

Purpose of the Report

Enclosed is the *2009 Dialysis Facility Report (DFR)* for this facility, based on data from the Centers for Medicare & Medicaid Services (CMS).

This DFR includes data specific to provider number(s): 162530

These data could be useful in quality improvement and assurance activities. The information contained in this report facilitates comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. Some of these comparisons account for the patient mix at this facility, including age, sex, race, and diabetic status. This report is provided as a resource for characterizing selected aspects of clinical experience at this facility relative to other caregivers in this state, ESRD Network, and across the United States.

In September 2009, each state's surveyors will receive the DFR for all dialysis facilities in their state.

This report also provides you with advance notice of the updated quality measures (urea reduction ratio, hemoglobin, and patient survival) for your facility that will be reported on the Dialysis Facility Compare (DFC) website in November 2009 (www.medicare.gov).

Collaborators

CMS has contracted with the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) and Arbor Research Collaborative for Health to produce the *2009 Dialysis Facility Reports.*

How to Submit Comments

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- **Dialysis Facility Compare:** Comment on the three DFC measures (see page 2) which will be reported on the DFC public website in November 2009. The comment period begins July 13, 2009 and ends September 8, 2009. Your comments will **not** appear on the DFC website.

- **State Surveyor:** Comment on your DFR for the state surveyors. The state surveyors will receive a copy of your DFR in September 2009 with your comments.

- **UM-KECC:** Submit questions about your DFR to UM-KECC. You can also submit your suggestions to improve the DFR.

Dear Dialysis Facility Director:

This report has been prepared for this facility by the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) with funding from the Centers for Medicare & Medicaid Services (CMS). It is the fourteenth in a series of annual reports. This is one of 5,507 reports that have been sent to the ESRD Networks for distribution to ESRD providers in the U.S. Your state survey agency will receive this report in September 2009. Selected highlights from this report are given here. The information specific to this facility is printed in **bold type** for easy identification.

What's New This Year: As part of a continuing effort to improve the quality and relevance of this report for your facility, the following changes have been incorporated into your 2009 DFR. The percent of cardiac related deaths has been added to Table 1. First year mortality statistics for new dialysis patients who started dialysis between January 1, 2005 and December 31, 2007 are calculated and reported in the second half of Table 1. Please refer to the section entitled "What's New" in Section I of the *Guide to the 2009 Dialysis Facility Reports* for greater detail on these changes.

Dialysis Facility Compare: Anemia management is reported as two measures: the percent of patients with hemoglobin values of less than 10 g/dL and the percent of patients with hemoglobin values greater than 12 g/dL. The URR and hemoglobin measures were calculated for Medicare approved dialysis facilities operating at any time during 2008. The hemoglobin measures were calculated only for patients treated with erythropoiesis stimulating agents (ESA). The patient survival measure was calculated for Medicare approved dialysis facilities operating at any time from 2005 through 2008. The following measures for this facility will appear on the DFC website:

	Measure Name	This Facility
1.	**The percentage of Medicare hemodialysis patients treated in this facility during 2008 with URR ≥ 65%**	**100%**
	Number of patients included in calculation: 16	
2.	**The percentage of Medicare patients treated in this facility during 2008**	
	with ESA-treated hemoglobin <10 g/dL	**6%**
	with ESA-treated hemoglobin >12 g/dL	**38%**
	Number of patients included in calculation: 16	
3.	**Patient survival reported as "as expected," "better than expected," or "worse than expected" for the time period 2005-2008 for this facility**	**As Expected**
	Standardized Mortality Ratio (SMR): 0.87	
	P-value: 0.79	

Please see Table 5 for more information on URR and ESA-treated hemoglobin for this facility. URR and ESA-treated hemoglobin measures based on 10 or fewer patients will be reported as "not available" on DFC. Table 1 provides additional information on patient survival. If the Standardized Mortality Ratio (SMR) is less than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Better than Expected" on DFC. If the facility SMR is greater than 1.00 and statistically significant ($p<0.05$), the patient survival classification is "Worse than Expected" on DFC. Otherwise, the patient survival classification is "As Expected" on DFC. Please note that the classification is not reported for a facility if the SMR is based on 3 or fewer expected deaths.

Overview: This report includes summaries of patient characteristics, treatment patterns, and patient outcomes for chronic dialysis patients who were treated in this facility between January 2005 and December 2008. Mortality, hospitalization, and transplantation statistics are reported for a three- or four-year period. Regional and national averages are included to allow for comparisons. Several of the summaries of patient mortality,

THE RENAL NETWORK COMPLIANCY AWARD
March 2008

DIXON DIALYSIS CENTER

This certificate is presented in recognition for achieving an overall compliancy rate of 95% or more for CMS forms submitted in 2007.

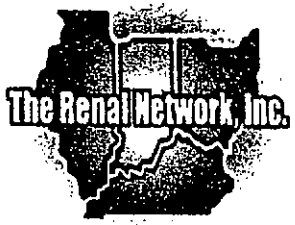
George R. Aronoff, M.D., President

Peter B. DeOreo, M.D., Chairman

Susan A. Stark, Executive Director

926

Attachment 26I



THE RENAL NETWORK
COMPLIANCY AWARD
March 2008

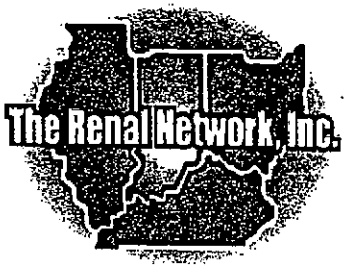
QUAD CITIES
KIDNEY CENTER LTD

This certificate is presented in recognition for achieving an overall compliancy rate of 95% or more for CMS forms submitted in 2007.

George R. Aronoff, M.D., President

Peter B. DeOreo, M.D., Chairman

Susan A. Stark, Executive Director



THE RENAL NETWORK QUALITY AWARD

March 2008

ALEDO KIDNEY CENTER

This certificate is presented in recognition for achievement of a Fistula rate ≥ 58%.

George R. Aronoff, M.D., President | Peter B. DeOreo, M.D., Chairman | Susan A. Stark, Executive Director

The Renal Network, Inc.
ESRD Network 9/10

March 5, 2008

BRENDA TEEL-LASH
DIXON DIALYSIS CENTER PH
101 WEST SECOND STREET
DIXON, IL 61021

Dear BRENDA,

I am pleased to recognize your hemodialysis program's achievement of a fistula rate above 50%.

A total of 183 hemodialysis programs (31% of Network facilities) had a fistula rate of 50% or greater this year, based on December 2007 data. Eighteen of these facilities have attained a fistula rate above 66%, the CMS goal for 2009. Eight facilities also had a catheter rate of no greater than 10%.

We will be recognizing the Quality Award facilities at the 2008 Network Council meeting on March 19, 2008 at the Westin River North in Chicago. You or a facility representative will be able to pick up your award at that time. No RSVP is necessary.

Congratulations and thank you for setting an example in quality patient care for all facilities.

Sincerely,

Susan A. Stark
Executive Director

2007 Vascular Access Quality Awards

Facilities Achieving a Fistula Rate >66%

Ball Dialysis – Winchester, Winchester, IN
FMC – Lexington South, Lexington, KY
FMC – Lutheran General- Advocate, Niles, IL
FMC – Skokie, Skokie, IL
MMB Dialysis LLC, Macomb, IL
Olney Dialysis Center, Olney, IL
Rushville Dialysis, Rushville, IL
VA Medical Center, Lexington, KY

Facilities Achieving a Fistula Rate 58-65.9%

Blue Ash Dialysis, Cincinnati, OH
CDC – Mentor, Mentor, OH
DCI – Frankfort, Frankfort, KY
DSI – Munroe Falls, Munroe Falls, OH
Davita – Churchview Dialysis, Rockford, IL
Davita – Parma, Parma, OH
Davita – Roxbury, Rockford, IL
Decatur East Wood Dialysis, Decatur, IL
Dialysis Center of Darke County, Greenville, OH
Dialysis Centers of Dayton – East, Dayton, OH
Dialysis Centers of Dayton – South, Moraine, OH
* *Dixon Dialysis Center, Dixon, IL*
FMC – Akron Canton Kidney Center, Uniontown, OH
FMC – Danville, Danville, KY
FMC – Madison, Madison, IN
FMC – Mansfield Kidney Center, Mansfield, OH
FMC – Medina County Kidney Center, Medina, OH
FMC – Merrillville Dialysis, Merrillville, IN
FMC – Pekin, Pekin, IL
FMC – Portsmouth, Portsmouth, OH
FMC – Richland County, Mansfield, OH
FMC – Streetsboro Kidney Center, Streetsboro, OH
FMC – Suburban, Louisville, KY
FMC – Villa Park, Villa Park, IL
Guernsey County Dialysis, Cambridge, OH

FMC Dialysis Services of Raytown
Southeastern Renal Dialysis, LC – Lee County
Renal Care Group – Hays
Southeastern Renal Dialysis, LC – Mt. Pleasant
Dialysis Clinics, Inc. – Bellevue
York General Dialysis Services
Jefferson County Dialysis Center
Gambro Healthcare – Hospital Hill
Renal Care Group – Great Bend
Ozarks Dialysis Services – South
Renal Care of Storm Lake, LLC
Dialysis Clinics, Inc. · Onawa
Gambro Healthcare – Omaha Central
Milton & Ethel Warner Dialysis Unit – Spencer
Hutchinson Dialysis, LLC
Harlan Dialysis
Renal Treatment Centers – Parsons
Renal Treatment Centers – Independence
Cherry County Hospital Dialysis Unit

TOPAZ LEVEL (40-49% AVF PERCENTAGE)

Dialysis Clinics, Inc – Jefferson City West
Renal Care Group – Mercy Des Moines, LLC
Renal Care Group- Wichita East
Renal Care Group – Wichita West
Creston Dialysis
NRI –Butler
Southeastern Renal Dialysis, LC – West Burlington
Gambro Healthcare – Rolla
Dialysis of Des Moines
Box Butte Dialysis Unit
Trinity Regional Medical Center
Carl T. Curtis Health Education Dialysis
Gambro Healthcare – Omaha South
Cedar Valley Dialysis Center –West Union
Fresenius Medical Care · Ottumwa
Siouxland Dialysis
Ozarks Dialysis Services – Monett
Metro Dialysis Center – North
Renal Care Group – Branson
Dialysis Center of Beatrice
Garden City Dialysis Center
* Quad Cities Kidney Center – Davenport
Gambro Healthcare – Omaha North
Dialysis Center of Lincoln
University of Kansas Medical Center – Dialysis
Saline County – Salina
University of Iowa – Grinnell
Kansas City Dialysis & Transplant Center
North Iowa Mercy Dialysis Center – Charles City
Dialysis Clinics, Inc – Clinton
Penn Valley Dialysis Center
RAI – Fremont
Dialysis Clinic, Inc – Saint Joseph
Saint Charles County Dialysis
Blessing Hospital ESRD Center
Dialysis Clinics, Inc – Omaha
Bio-Medical Applications of Lees Summit
Dialysis Clinic of Lincoln Northwest
Gambro Healthcare · Florissant
Affiliated Hospital Dialysis – Creve Coeur
Mercy Dialysis Center – Mason City
Affiliated Hospital Dialysis · South
RAI Care Center – Omaha (CKC Dialysis)
Capital City Dialysis
Dialysis Clinics, Inc · West Omaha
Dialysis Specialists of Topeka, Inc.
Renal Care Group · Mountain Grove
Northeast Nebraska Dialysis Center
Bluff City Dialysis
Barnes Jewish Medical Center
FMC Dialysis Services of Lincoln County
Grand Island Dialysis
NRI – Kansas City
Mary Greeley Medical Center – Ames
McCook Dialysis Center
Mary Greeley Medical Center – Marshalltown
Gambro Healthcare – Platte Woods
Gambro Healthcare · Hazelwood
Mercy Medical Center · Centerville
Gambro Healthcare – Council Bluffs

Fistula First Achievement

"Great things are not done by impulse, but by a series of small things brought together." ~ Vincent Van Gogh

Quad Cities Kidney Center - Davenport is recognized for achieving the mean Topaz level in the Fistula First Program from November 2004 - October 2005.

This facility is one of 57 facilities within Iowa, Kansas, Missouri & Nebraska receiving this honor.

Sarah Yelton, RN, CNN
QI Director

Cathy Long, BA, RHIT
QI Specialist

Katrina M. Dinkel, MA
Executive Director

FISTULAFIRST℠
National Vascular Access Improvement Initiative

THE RENAL NETWORK
QUALITY AWARD
June 2004

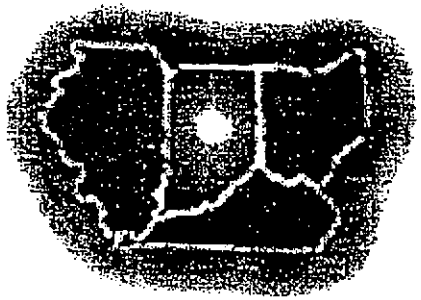
QUAD CITIES KIDNEY CENTER - GENESEO

This certificate is presented for achievement of Hemodialysis Adequacy goals. A Kt/V of ≥ 1.2 Daugirdas II was achieved by 95% or more patients.

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director



THE RENAL NETWORK QUALITY AWARD

June 2004

QUAD CITIES KIDNEY CENTER GENESEO

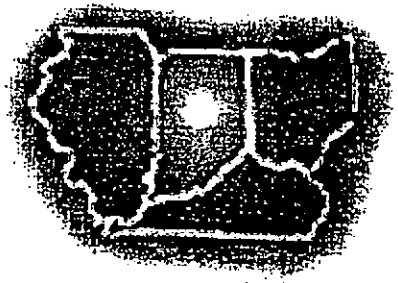
This certificate is presented in recognition for achievement as a Vascular Access Quality Performer. The percent of patients with fistulas was ≥ 40%.

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director

268



THE RENAL NETWORK QUALITY AWARD

June 2004

QUAD CITIES KIDNEY CENTER, LTD

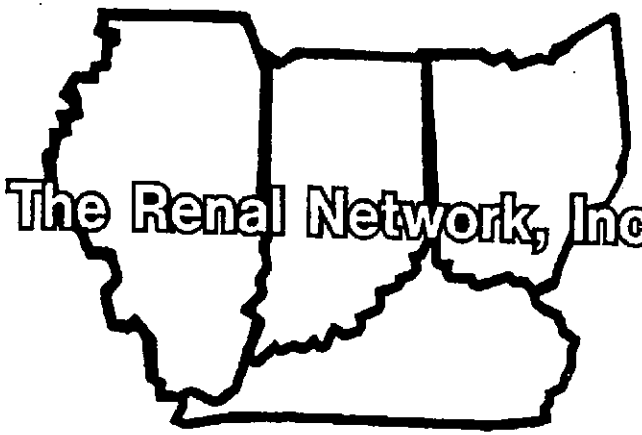
HEMODIALYSIS PROGRAM

This certificate is presented for achievement of Anemia Management goals. A hemoglobin level of 11 gm/dL was achieved by 85% or more patients.

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director



THE RENAL NETWORK QUALITY AWARD

May 2003

QUAD CITIES KIDNEY CENTER GENESEO

This certificate is presented for achievement of Anemia Management goals. A hemoglobin level of 11 gm/dL was achieved by 85% or more patients.

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director

The Renal Network, Inc.

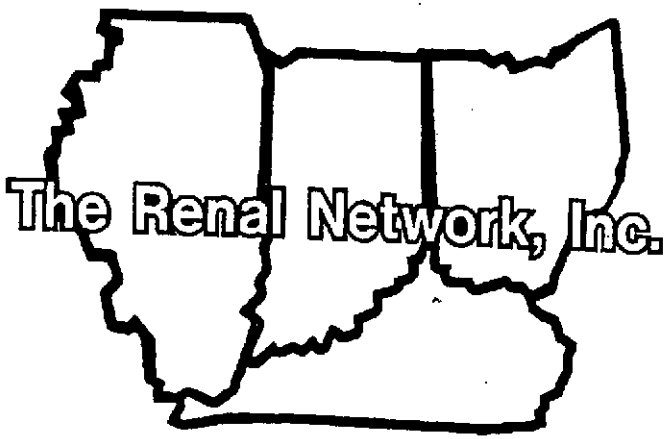
THE RENAL NETWORK QUALITY AWARD

May 2003

QUAD CITIES KIDNEY CENTER GENESEO

This certificate is presented in recognition for achievement as a Vascular Access Quality Performer. The percent of patients with fistulas was ≥ 40%.

Jay B. Wish, M.D., President	George R. Aronoff, M.D., Chairman	Susan A. Stark, Executive Director



THE RENAL NETWORK QUALITY AWARD

May 2003

QUAD CITIES KIDNEY CENTER GENESEO

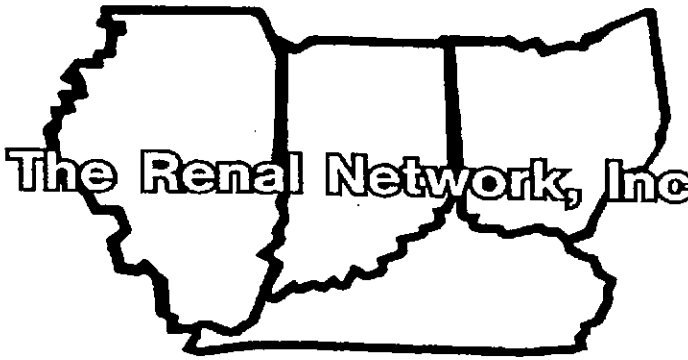
This certificate is presented for achievement of Hemodialysis Adequacy goals. A URR of ≥ 65% and a Kt/V of ≥ 1.2 Daugirdas II were achieved by 95% or more patients.

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director

378



QUAD CITIES KIDNEY CENTER
GENESEO

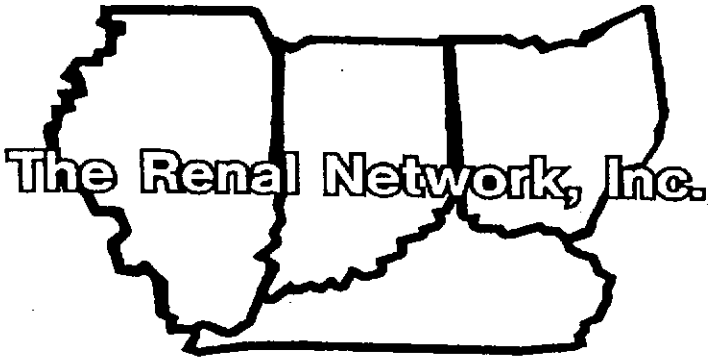
This certificate is presented for achievement of goals during the Hemodialysis Adequacy Quality Improvement Project

Jay B. Wish, M.D., President

George R. Aronoff, M.D., Chairman

Susan A. Stark, Executive Director

273



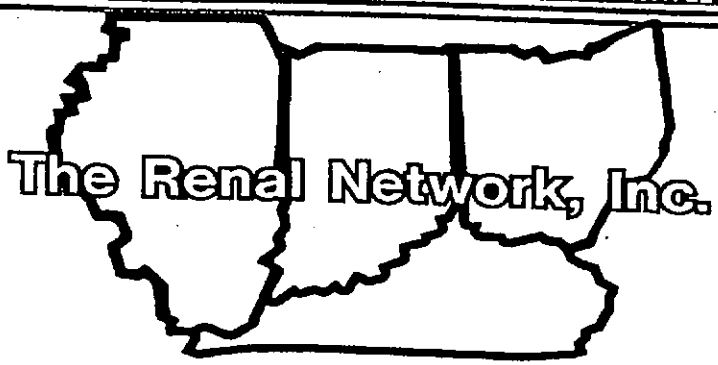
QUAD CITIES KIDNEY CENTER LTD

This certificate is presented for achievement of goals during the Hemodialysis Adequacy Quality Improvement Project

OCTOBER 2000 — DECEMBER 2001

Jay B. Wish, M.D., President	George R. Aronoff, M.D., Chairman	Susan A. Stark, Executive Director

274



Quad Cities Kidney Center LTD

Peritoneal Dialysis Program

Is awarded membership in the Clinical Performance Measures Project's

90% Club

May 2001

Jay B. Wish, M.D., President

Susan A. Stark, Executive Director

275

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

A letter from Blackhawk Bank and Trust attesting that Quad Cities Kidney Center Rock Island has sufficient internal financial resources to fund the project is attached at Attachment – 39.

Attachment – 39

Blackhawk Bank & Trust

We're Not For Sale.

July 9, 2010

Mike Constantino
Illinois Health Facilities Planning
525 W Jefferson, 2nd Floor
Springfield, IL 62761

RE: Quad Cities Kidney Center Rock Island, LLC CON Application for expansion

Dear Mr. Constantino:

This letter constitutes the written comments of Blackhawk Bank & Trust in support of the Quad Cities Kidney Center Rock Island, LLC certificate of need (CON) application for expansion.

Blackhawk Bank & Trust has a longstanding relationship with the principals and affiliates of Quad Cities Kidney Center Rock Island, LLC. Dr. V.R. Alla along with his medical practice, Quad Cities Kidney Center and the affiliated dialysis centers have been clients of Blackhawk Bank & Trust for over 25 years. They maintain significant accounts with our institution and have an excellent overall credit rating. There are no negative experiences to report, such as NSF instances. Currently, Blackhawk Bank & Trust has extended a $2,000,000 line of credit to this group which has always been in good standing under its lending arrangements paying any and all obligations in accordance with the terms or our arrangements. While I understand that the Quad Cities Kidney Center Rock Island will be funded by cash from its existing accounts which maintain balances in excess of $300,000.00 at all times and would not have any problem to use $100,000.00, Blackhawk Bank & Trust would be prepared to finance the expansion of an outpatient dialysis facility in Rock Island, Illinois. Dr Alla and his Quad Cities Kidney Center, United Dialysis Center and RRS Investments LP businesses are excellent customers. Given our longstanding relationship, Blackhawk Bank & Trust is intimately familiar with their financial standing and has confidence in any projects undertaken by these individuals.

Blackhawk Bank & Trust is a community bank in the Quad Cities area. It observes very sound, prudent financial policies and, therefore, consistently rates as one of

Rock Island - Lil' Hawk
38th Street & Blackhawk Road, Rock Island, IL 61201
P (309) 793-0926 F (309) 794-6237

the safest financial institutions in the United States. Blackhawk Bank & Trust's ability to maintain profitability and an adequate capital base is largely dependent on its ability to engage in profitable yet safe lending. This principal is at the core of the banking business. Thus, the processes undertaken by Blackhawk Bank & Trust in extending financing to Dr. Alla's businesses to evaluate and monitor its lending arrangements is of paramount importance.

In summary, I believe that the projected financial viability of Dialysis Access Center is strong and that it will have the continued ability to operate the dialysis program it contemplates over many years. I sincerely urge the Planning Board to approve this expansion project.

These comments are provided in accordance with Section 1130.630 of the rules of the Illinois Health Facilities Planning Board.

Thank you for your consideration.

Sincerely,

Christopher J. Lemon
Sr. Vice President

CJL/db

Subscribed & Sworn
Before me this 9th
Day of July, 2010

OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

Debora L. Blaser, Notary Public

My Commission expires on: 4-26-2011

Rock Island - Lil' Hawk
38th Street & Blackhawk Road, Rock Island, IL 61201
P (309) 793-0926 F (309) 794-6237
Member FDIC

Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

A letter from Blackhawk Bank and Trust attesting that Quad Cities Kidney Center Rock Island has sufficient internal financial resources to fund the project is attached at Attachment – 39.

Attachment – 40

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment 42-A is a letter from Dr. V.R. Alla attesting that the total estimated project costs and related costs will be funded in total with cash and cash equivalents.

Attachment – 42A

Quad Cities Kidney Center

"Dedicated to Compassionate and Quality Care"

- Provision of Peritoneal & Hemo Dialysis, CVVHD and Plasmapharesis
- Diagnosis of Kidney Disease and Administration of Biopsy Procedures
- Treatment & Management of Hypertension

Out-Patient Clinics

400 John Deere Road
Moline, Illinois 61265
(309) 762-5570

2623 17th Street
Rock Island, Illinois 61201
(309) 786-1400

880 Crosstown Avenue
Silvis, Illinois 61282
(309) 792-3517

600 North College Avenue
Geneseo, Illinois 61254
(309) 945-1787

120 West Locust Street
Davenport, Iowa 52803
(563) 323-3300

4480 Utica Ridge Road
Bettendorf, Iowa 52722
(563) 344-9977

In-Patient Facilities

Trinity Medical Center
- West Campus
Rock Island, Illinois

- 7th Street Campus
Moline, Illinois

- Terrace Park Campus
Bettendorf, Iowa

Genesis Medical Center
- Illini Campus
Silvis, Illinois

Hammond-Henry Hospital
Geneseo, Illinois

July 28, 2010

Dale Galassie
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Availability of Funds

Dear Mr. Galassie:

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, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Sincerely,

V.R. Alla, MD

V.R. Alla, M.D.
Manager
United Dialysis Centers, LLC
Quad Cities Kidney Center Rock Island, LLC

Subscribed and sworn to me
This 28th day of July, 2010

Debora L Blaser
Notary Public

OFFICIAL SEAL
DEBORA L. BLASER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-26-2011

104658.1

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(b), Conditions of Debt Financing

This project will be funded in total with cash and cash equivalents. Accordingly, this criterion is not applicable.

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(c), Reasonableness of Project and Related Costs

1. The Applicants propose to add six dialysis stations to their existing twelve station dialysis facility. There will be no construction or modernization associated with this project. Therefore this criterion is not applicable.

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	**State Standard**	**Above/Below State Standard**
Moveable Equipment	$100,000	$39,945 per station $39,945 x 6 = $239,670	Below State Standard

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(d), Projected Operating Costs

Operating Expenses: $863,587

Treatments: 15,444

Operating Expense per Treatment: $55.92

Attachment – 42D

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(e), Total Effect of Project on Capital Costs

Capital Costs:	$10,000
Treatments:	15,444
Capital Costs per Treatment:	$0.65 per procedure

Attachment – 42E

Section XI, Safety Net Impact Statement

1. Quad Cities Kidney Center Rock Island is a safety net provider of dialysis services to the residents of Rock Island. As discussed throughout this application, the primary purpose for the establishment of the Rock Island facility and the expansion is to increase access to life-sustaining dialysis treatment to residents who lack access to transportation, particularly the elderly, chronically-ill and low income populations. Importantly, the Applicants do not discriminate based on payor source. As set forth below, Quad Cities Kidney Center Rock Island provided a total of $80,490.64 in Medicaid and $51,394.68 in charity care during its first eight months of operation.

Charity & Medicaid Care		
	Charity Care	**Medicaid**
Patients	3	21
Charges	$51,394.68	$80,490.64
Total Charges	$51,394.68	$80,490.64

Moreover, the Applicants do not believe the addition of the six dialysis stations will have any impact on other safety net providers. As stated above, the purpose of this project is to improve access to essential safety net services to those members of the community, particularly the elderly and low income residents, who lack access to reliable transportation and would otherwise go without life-sustaining dialysis treatment.

2. The additional dialysis stations will not impact the ability of other providers or health care systems to cross-subsidize safety net services. As stated in Criterion 1110.1430(b), there are two dialysis facilities within thirty minutes normal drive time of the Rock Island facility. United Dialysis Centers, LLC, a co-applicant on this application, is the parent of both facilities, Quad Cities Kidney Center Moline, LLC and Quad Cities Kidney Center Silvis, LLC. Although the Applicants do not anticipate the additional dialysis stations will impact existing facilities, any impact will be to their own facilities and not other providers.

3. This project is for the proposed addition of six dialysis stations to an existing facility and will not result in the discontinuation of any facility or services. Accordingly, this criterion is not applicable.

Section XII, Charity Care

1. The table below provides charity care information for all facilities owned or operated by United Dialysis Centers, LLC and/or Quad Cities Kidney Center Rock Island for the latest three years.

CHARITY CARE		
	Amount of Charity Care (Charges)	Cost of Charity Care
Rock Island		
2009	$51,394.68	$51,394.68
Aledo		
2007	$4,199.52	$4,199.52
2008	$13,683.72	$13,683.72
2009	$10,149.88	$10,149.88
Dixon		
2007	$16,368.12	$16,368.12
2008	$5,599.72	$5,599.72
2009	$6,332.48	$6,332.48
Silvis		
2007	$142,817.24	$142,817.24
2008	$135,961.04	$135,961.04
2009	$123,697.18	$123,697.18
Total		
2007	$163,384.90	$163,384.90
2008	$155,244.50	$155,244.50
2009	$191,574.20	$191,574.20

2. Information regarding the Alla Health Education Endowed Gift of $500,000 to Trinity Health Foundation to fund nursing scholarships, nursing continuing education, and community services and program about hypertension and kidney disease are attached at Attachment – 11C. Members of the Alla family own interests in the Applicants.