

ORIGINAL

12-059

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT- May 2010 Edition

RECEIVED

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

JUN 19 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

HEALTH FACILITIES &
SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: U.S. Renal Care Plainfield Dialysis		
Street Address: 13717 U.S. Route 30, Units 111, 111-B, 113 and 113-B		
City and Zip Code: Plainfield, 60544		
County: Will County	Health Service Area: 9	Health Planning Area: 9

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: USRC Plainfield, LLC	
Address: 2400 Dallas Parkway, Suite 350, Plano, Texas 75093	
Name of Registered Agent: CT Corporation System	
Name of Chief Executive Officer: Stephen Pirri*	
CEO Address: 2400 Dallas Parkway, Suite 350, Plano, Texas 75093	
Telephone Number: 214.736.2700	

*Stephen Pirri acts as President and Manager of this entity.

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: Edward Clancy
Title: Attorney
Company Name: Ungaretti & Harris LLP
Address: 70 W. Madison, Suite 3500, Chicago, Illinois 60602
Telephone Number: 312.977.4487
E-mail Address: eclancy@uhlraw.com
Fax Number: 312.977.4405

Additional Contact

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

Name: Shawn Moon
Title: Attorney
Company Name: Ungaretti & Harris LLP
Address: 70 W. Madison, Suite 3500, Chicago, Illinois 60602
Telephone Number: 312.977.4342
E-mail Address: skmoon@uhlraw.com
Fax Number: 312.977.4405

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: USRC Alliance, LLC

Address: 2400 Dallas Parkway Suite 350, Plano, Texas 75093

Name of Registered Agent: CT Corporation System

Name of Chief Executive Officer: Stephen Pirri*

CEO Address: 2400 Dallas Parkway Suite 350, Plano, Texas 75093

Telephone Number: 214.736.2700

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Type of Ownership of Applicant/Co-Applicant

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

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- o 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.

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Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: U.S. Renal Care, Inc.

Address: 2400 Dallas Parkway Suite 350, Plano, Texas 75093

Name of Registered Agent: CT Corporation System

Name of Chief Executive Officer: Stephen Pirri*

CEO Address: 2400 Dallas Parkway Suite 350, Plano, Texas 75093

Telephone Number: 214.736.2700

*Stephen Pirri acts as President of this entity.

Type of Ownership of Applicant/Co-Applicant

- | | | | | |
|-------------------------------------|---------------------------|--------------------------|---------------------|--------------------------------|
| ☐ | Non-profit Corporation | ☐ | Partnership | |
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| ☐ | Limited Liability Company | ☐ | Sole Proprietorship | ☐ Other |

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o 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.

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: Thomas L. Weinberg
Title: Senior Vice President and General Counsel
Company Name: U.S. Renal Care, Inc.
Address: 2400 Dallas Parkway, Suite 350, Plano, Texas 75093
Telephone Number: 214.736.2700
E-mail Address: Tweinberg@usrenalcare.com
Fax Number: 214 736.2701

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Dayfield Properties, LLC
Address of Site Owner: 13717 U.S. Route 30, 111-B, Plainfield, Illinois 60544
Street Address or Legal Description of Site: 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: USRC Plainfield, LLC	
Address: 2400 Dallas Parkway, Suite 350, Plano, Texas 75093	
☐ 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. - 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.
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Flood Plain Requirements

[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

[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:

- ☒ Substantive
☐ Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- ☐ Part 1120 Not Applicable
☐ 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.

USRC Plainfield, LLC ("Applicant") proposes to establish a thirteen (13) station in-center hemodialysis facility at 13717 U.S. Route 30, Units 111, 111-B, 113 and 113-B, Plainfield, Illinois 60544 (the "Facility") located in Health Service Area ("HSA") 9. The Facility will utilize leased space to be built out by Applicant. The facility will provide both in-center hemodialysis and peritoneal dialysis for patients with End Stage Renal Disease ("ESRD").

This project is categorized as "substantive" under the Illinois Health Planning Act as it contemplates the establishment of an in-center hemodialysis facility.

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	\$714,230		\$714,230
Contingencies			
Architectural/Engineering Fees	\$55,000		\$55,000
Consulting and Other Fees	\$30,000		\$30,000
Movable or Other Equipment (not in construction contracts)	\$82,555	\$109,437	\$191,992
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	\$1,643,599		\$1,643,599
Other Costs To Be Capitalized	\$90,542		\$90,542
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$2,615,926	\$109,437	\$2,725,363
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$972,327	\$109,437	\$1,081,764
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	\$1,643,599		\$1,643,599
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$2,615,926	\$109,437	\$2,725,363
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 \$ (377,094).

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): April 1, 2013

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:

- N/A ☐ Cancer Registry
N/A ☐ APORS
N/A ☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
N/A ☐ 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.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		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 <u>ATTACHMENT-9</u> , 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.

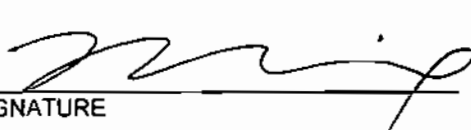
FACILITY NAME:		CITY:			
REPORTING PERIOD DATES: From: to:					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
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 U.S. Renal Care, Inc. *
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

Thomas L. Weinberg
PRINTED NAME

Senior Vice President & General Counsel
PRINTED TITLE

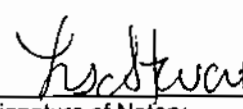

SIGNATURE

Stephen M. Pirri
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of June

Notarization:
Subscribed and sworn to before me
this 12th day of June


Signature of Notary

Seal




Signature of Notary

Seal



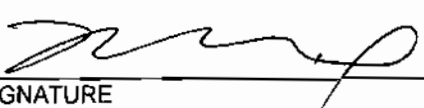
*Insert EXACT legal name of the applicant

CERTIFICATION

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

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This Application for Permit is filed on the behalf of USRC Alliance, 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.



SIGNATURE

Thomas L. Weinberg

PRINTED NAME

Manager

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 12th day of June



SIGNATURE

Stephen M. Pirri

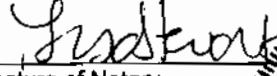
PRINTED NAME

President & Manager

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 12th day of June

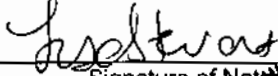


Signature of Notary

Seal



*Insert EXACT legal name of the Applicant



Signature of Notary

Seal

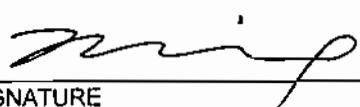


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This Application for Permit is filed on the behalf of USRC Plainfield, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and 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.


SIGNATURE

Thomas L. Weinberg

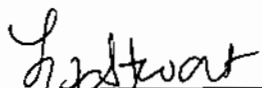
PRINTED NAME

Manager

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 12th day of June



Signature of Notary

Seal



*Insert EXACT legal name of the applicant


SIGNATURE

Stephen M. Piri

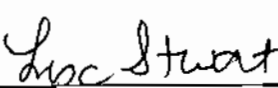
PRINTED NAME

President and Manager

PRINTED TITLE

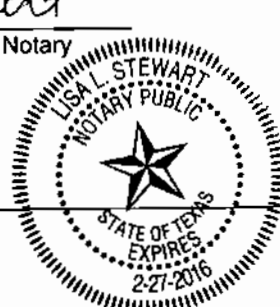
Notarization:

Subscribed and sworn to before me
this 12th day of June



Signature of Notary

Seal



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.

G. Criterion 1110.1430 - In-Center Hemodialysis

- Applicants proposing to establish, expand and/or modernize In-Center Hemodialysis must submit the following information:
- Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☒ In-Center Hemodialysis	0	13

- 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.

- 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:

\$1,081,764	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;
\$1,643,599	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.
\$2,725,363	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:	Not Applicable - Applicant qualifies for the financial viability waiver as all of the project's capital expenditures are completely funded through internal sources.	
Current Ratio		
Net Margin Percentage		
Percent Debt to Total Capitalization		
Projected Debt Service Coverage		
Days Cash on Hand		
Cushion Ratio		

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

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	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			

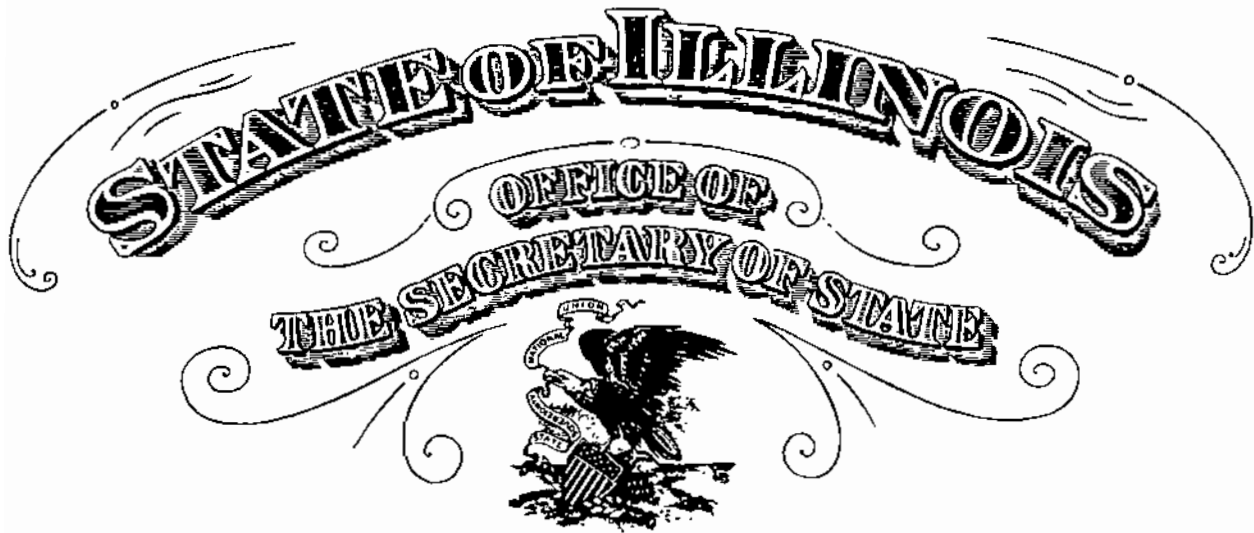
APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	24-27
2	Site Ownership	28-42
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	43-45
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	46
5	Flood Plain Requirements	47-48
6	Historic Preservation Act Requirements	49-50
7	Project and Sources of Funds Itemization	51
8	Obligation Document if required	N/A
9	Cost Space Requirements	53
10	Discontinuation	N/A
11	Background of the Applicant	54-64
12	Purpose of the Project	65
13	Alternatives to the Project	66-68
14	Size of the Project	69
15	Project Service Utilization	70
16	Unfinished or Shell Space	N/A
17	Assurances for Unfinished/Shell Space	N/A
18	Master Design Project	N/A
19	Mergers, Consolidations and Acquisitions	N/A
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
21	Comprehensive Physical Rehabilitation	N/A
22	Acute Mental Illness	N/A
23	Neonatal Intensive Care	N/A
24	Open Heart Surgery	N/A
25	Cardiac Catheterization	N/A
26	In-Center Hemodialysis	71-145
27	Non-Hospital Based Ambulatory Surgery	N/A
28	General Long Term Care	N/A
29	Specialized Long Term Care	N/A
30	Selected Organ Transplantation	N/A
31	Kidney Transplantation	N/A
32	Subacute Care Hospital Model	N/A
33	Post Surgical Recovery Care Center	N/A
34	Children's Community-Based Health Care Center	N/A
35	Community-Based Residential Rehabilitation Center	N/A
36	Long Term Acute Care Hospital	N/A
37	Clinical Service Areas Other than Categories of Service	N/A
38	Freestanding Emergency Center Medical Services	N/A
	Financial and Economic Feasibility:	
39	Availability of Funds	146-223
40	Financial Waiver	224
41	Financial Viability	225
42	Economic Feasibility	226-232
43	Safety Net Impact Statement	233-234
44	Charity Care Information	235

ATTACHMENT 1

TYPE OF OWNERSHIP – CERTIFICATE OF GOOD STANDING



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

U.S. RENAL CARE, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MAY 17, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1205402196

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

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 FEBRUARY A.D. 2012 .

Jesse White

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

USRC ALLIANCE, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON FEBRUARY 28, 2011, 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 FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



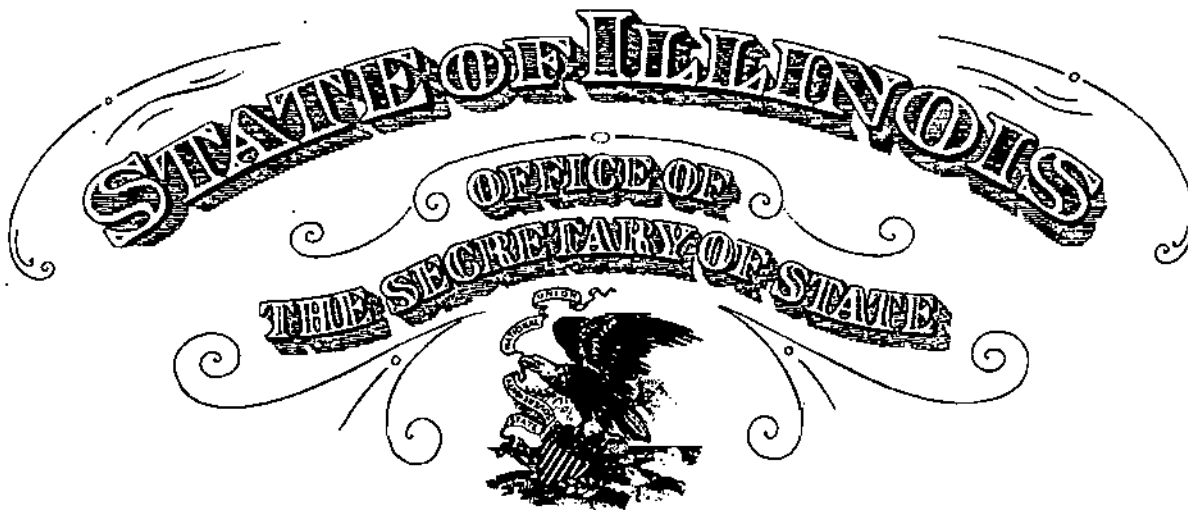
Authentication #: 1205402166

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

*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 FEBRUARY A.D. 2012 .*

Jesse White

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

USRC PLAINFIELD, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 16, 2012, 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.



Authentication #: 1216302060

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

*In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 11TH
day of JUNE A.D. 2012 .*

Jesse White

SECRETARY OF STATE

ATTACHMENT 2

SITE OWNERSHIP – PROOF OF OWNERSHIP



5001 Spring Valley Road
Suite 800W
Dallas, Texas 75244
Phone: 214-448-4525
Fax: 214-448-4571

Letter of Intent to Lease Space

May 25, 2012

Mr. Mark Batnick
Re/Max Commercial Consultants
24014 Renwick
Plainfield, IL 60544

**RE: REQUEST FOR PROPOSAL FOR PROPERTY LOCATED AT:
13713 N US ROUTE 30, PLAINFIELD, IL – SMALL BUSINESS PARK (“BUILDING”)
SUITE #TBD (THE “PREMISES”)**

Dear Mark:

USRC Plainfield, LLC (“Tenant”) has determined that the above referenced space meets its criteria for a possible clinic location. This proposed location will serve as a medical clinic for the Plainfield area.

Please reply by providing the requested information in the right column. If you are in agreement with the terms, please state “Agreed” in the column to the right

PREMISES / LEASE TERM:	Tenant will require approximately 6,500 square feet. Please propose an address, dedicated suite number and rentable square footage. Please propose a ten (10) year term with the right to terminate at any time after 60 months with 120-days written notice.	Address is 13717 US 30, Units 111, 111-B, 113, 113-B Plainfield, IL 60544 with 6,493 rentable sf. \$16.50 Net plus \$3.50 CAM or \$20.00 Gross. 3% escalator each year on base rent.
BUILDING:	1. Please provide the street address of the Building. 2. Please indicate the total rentable square footage of the Building.	13717 US 30, Plainfield, IL 60544 Approximately 57,000 sf
OWNERSHIP:	Please provide the full legal name, mailing address and social security number/federal tax identification number of the legal owner of the Building. If the owner is not an individual, please describe the type of entity (e.g. “an Ohio corporation...”).	Dayfield Properties, LLC (a Delaware Corporation) 13717 US 30, Unit 111-B Plainfield, IL 60544 FEIN – 61-146833

RENTAL RATE/ CONCESSIONS:	Please provide an aggressive, market sensitive rate with corresponding concessions on a ten (10) year term. Please indicate the structure of the rental rate (net, gross or full service) and all costs and/or services not included in the rent.	\$16.50 Net plus \$3.50 CAM or \$20.00 Gross. 3% escalator each year on base rent. Not included: gas, electric, data
LEASE COMMENCEMENT:	1. Landlord must deliver the Premises in warm shell condition per mutually acceptable specs within thirty (30) days from approval for a Certificate of Need from the State of Illinois. 2. Rent will commence one hundred twenty (120) days after issuance of a Certificate of Need by the State of Illinois.	Agreed. Agreed
RENEWAL OPTION:	Please propose two (2) consecutive, five (5) year lease renewal options at fixed rates.	Agreed with 3% escalator calculated annually
TENANT IMPROVEMENT ALLOWANCE (TENANT PERFORMS):	1. Landlord shall deliver the Premises in warm shell condition per Tenant's specs which have been listed in the section below. 2. Please provide a market sensitive Tenant Improvement Allowance for a ten (10) year term. 3. After delivery of the Premises, Tenant shall complete all necessary tenant improvements to the Premises pursuant to a space plan and specifications to be prepared by Tenant, approved by Landlord. 4. Tenant shall not be required to pay Landlord any construction management or supervisory fee for any tenant improvements.	Landlord will provide an as-is vanilla box.
RELOCATION	Landlord will agree not to relocate Tenant with the property.	OK



TENANT SPECS:	Tenant will require certain specifications listed below. If the specifications are not part of the base building package, please elaborate on how the specifications can be met. 1. 2" diameter incoming water line brought to the Premises that is dedicated, independent, and separately metered. 2. The presence of sewer service with no less than a 4" line into the premises of sufficient invert depth that will allow Tenant to install toilet fixtures at the farthest distance from the sewer line. 3. 208V 3Phase power panel with 600 amps with panel inside the Premises. 4. Gas line with separate meter running to the Premises. 5. HVAC to be installed per Tenant's engineered specifications. 6. Landlord will provide a smooth and clean concrete floor. 7. Current asbestos survey. 8. Fully engineered as built drawings of the Premises. 9. The subject property shall not be located within a 100 year flood plain. 10. The property shall not be located within 150 feet of easement boundaries or setbacks of hazardous underground locations including but not limited to liquid butane or propane, liquid petroleum or natural gas transmission lines, high pressure lines, and not within the easement of high voltage electrical lines. 11. Landlord grants Tenant the right to construct freight door and a freight drop off area.	OK to all.
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BASE YEAR / OPERATING EXPENSES:	Please provide a break-down of costs for all operating expenses for which Tenant will be responsible.	\$3.50 sf CAM includes water, garbage, real estate taxes, snow plowing, landscape and building maintenance.
SIGNAGE:	Please describe building standard signage rights along with any opportunities for Building signage and or monument signage.	1 sf of wall signage for every linear foot of frontage. Village Ordinance prevails when any discrepancy. Wall signage shall include a raceway. Existing monument signage is first come first serve (there are spots available).
PARKING:	Tenant will require 5 marked reserved handicapped spaces located at or near the entrance of the Premises, 10 marked reserved visitor spaces located near the entrance of the Premises, and 20 marked spaces which will be located in the Building parking area.	OK
RIGHT OF FIRST REFUSAL:	1. Tenant shall have a Right of First Refusal on any adjacent suite(s). 2. Tenant shall have 15 business days from receipt of written notice from Landlord to exercise its Right of First Refusal. 3. If Tenant exercises its Right of First Refusal, Tenant shall lease the additional space for a term that is coterminous with its Lease for the Premises and at the rental rate(s) and other Lease terms in effect, with a pro rated construction allowance.	OK OK OK



MISCELLANEOUS:	1. Tenant will require the right to allow a tractor trailer (18 wheeler) to deliver supplies in the delivery area located behind or in front of the Building. 2. If an awning doesn't currently exist, Landlord will allow Tenant, at its own expense to install an awning at the front of the Premises for a patient drop off/ pick up area.	OK Existing awning. If not suitable ok with Tenant installing additional with Landlord approval of design.
ASSIGNMENT OF LEASE:	Landlord shall provide automatic consent to an assignment if assignee has a net worth greater than or equal to assignor.	OK
TERMINATION OPTION:	Tenant shall have the right to terminate the Lease at any time after the fifth anniversary of the rent commencement date by providing written notice thereof at least 120 days prior to the date of termination.	OK
HOLDOVER:	Tenant shall have the right to holdover for three (3) months after term expiration at the same rate as the last month of the lease term. After the third month, the holdover rate shall increase to 125% of the rent for the last month of the lease term.	OK

HIPPA COMPLIANCE PROVISION:	Landlord acknowledges that Tenant is subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 and related regulations ("HIPAA"), and that HIPAA requires Tenant to ensure the safety and confidentiality of patient medical records. Landlord further acknowledges that, in order for Tenant to comply with HIPAA, Tenant must restrict access to the portions of the Property where patient medical records are kept or stored. Landlord hereby agrees that, notwithstanding the rights granted to Landlord, except when accompanied by an authorized representative of Tenant, neither Landlord nor its employees, agents, representatives or contractors shall be permitted to enter those areas of the Property designated by Tenant as locations where patient medical records are kept and/or stored or where such entry is prohibited by applicable state or federal health care privacy laws.	OK
BROKER / DISCLOSURE:	Both Landlord and Tenant recognize and acknowledge that the Tenant is represented by Howard Watkins with Transwestern as procuring Broker, in this transaction. Landlord agrees to pay a procuring brokerage a commission of \$1.25 per square foot per year.	Brokerage commission of \$1.00 sf per year paid annually.

Nothing contained herein shall be binding on either party unless and until actual lease documents are fully executed and exchanged by both parties.

DAYFIELD PROPERTIES, LLC

By: *Douglas Carroll*
Its: Director of Development
Print: Douglas Carroll

USRC PLAINFIELD, LLC

By: *Jack Harrington*
Its: SENIOR V.P.
Print: JACK HARRINGTON

LEASE AGREEMENT

TERM OF LEASE			
BEGINNING	ENDING		
01/01/13	12/31/22		
MONTHLY RENT	DATE OF LEASE		
See rent schedule below	6/12/12		
Security Deposit	\$10,821.67	PURPOSE	Dialysis center – Units 111, 111B, 113, 113B (6,493 sf)
** The Additional Rent (CAM) is the minimal amount with the actual amount calculated as provided in Paragraph 38 of the Lease Agreement.			
	<u>RENT</u>	<u>CAM</u>	<u>TOTAL</u>
01/01/13 – 12/31/13	\$8,927.88	+\$1,893.79	= \$10,821.67
01/01/14 – 12/31/14	\$9,195.72	+\$1,893.79	= \$11,089.51
01/01/15 – 12/31/15	\$9,471.59	+\$1,893.79	= \$11,365.38
01/01/16 – 12/31/16	\$9,755.74	+\$1,893.79	= \$11,649.53
01/01/17 – 12/31/17	\$10,048.41	+\$1,893.79	= \$11,942.20
01/01/18 – 12/31/18	\$10,349.86	+\$1,893.79	= \$12,243.65
01/01/19 – 12/31/19	\$10,660.36	+\$1,893.79	= \$12,554.15
01/01/20 – 12/31/20	\$10,980.17	+\$1,893.79	= \$12,873.96
01/01/21 – 12/31/21	\$11,309.58	+\$1,893.79	= \$13,203.37
01/01/22 – 12/31/22	\$11,648.87	+\$1,893.79	= \$13,542.66

NAME X USRC Plainfield, LLC

ADDRESS X

CITY X

NAME X Dayfield Properties, LLC

ADDRESS X 13717 South US Route 30
Unit 111

CITY X Plainfield, IL 60544

In consideration of the mutual covenants and agreements herein stated, Lessor hereby leases to Lessee and Lessee hereby leases from Lessor solely for the above purpose the premises designated above (the "Premises"), together with the appurtenances thereto, for the above Term.

LEASE COVENANTS AND AGREEMENTS

- 1. RENT.** Lessee shall pay Lessor or Lessor's agent as rent for the Premises the sum stated above, monthly in advance, until termination of this lease, at Lessor's address stated above or such other address as Lessor may designate in writing. Rent is due on the first of the month. Rent will increase at 3% per annum on the anniversary of the commencement of the lease. Rent shall begin one hundred twenty (120) days after issuance of a Certificate of Need by the State of Illinois.
- 2. GAS AND ELECTRIC CHARGES.** Lessee will pay, in addition to the rent above specified, all gas and electric light and power bills taxed, levied or charged for their unit, on the Premises, for and during the time for which this lease is granted and in case said for gas, electric light and power shall not be paid when due. Lessor shall have the right to pay the same, which amounts so paid, together with any sums paid by Lessor to keep the Premises in a clean and healthy condition, as herein specified, are declared to be so much additional rent and payable with the installment of rent next due thereafter.
- 3. SUBLETTING; ASSIGNMENT.** The Premises shall not be sublet in whole or in part to any person other than Lessee, and Lessee shall not assign this lease without, in each case, the consent in writing of Lessor first had and obtained; Lessor shall provide automatic consent to an assignment if assignee has a net worth greater than or equal to assignor. If Lessee, or any one or more of the Lessees, if there be more than one, shall make an assignment for the benefit of creditors, or shall be adjudged a

bankrupt, Lessor may terminate this lease, and in such event Lessee shall at once pay Lessor a sum of money equal to the entire amount of rent reserved by this lease for the then unexpired portion of the term hereby created, as liquidated damages.

4. **LESSEE NOT TO MISUSE.** Lessee will not permit any unlawful or immoral practice, with or without his knowledge or consent, to be committed or carried on in the Premises by himself or by any other person. Lessee will not allow the Premises to be used for any purpose that will increase the rate of insurance thereon, nor for any purpose other than that herein before specified. Lessee will not keep or use or permit to be kept or used in or on the Premises or any place contiguous thereto any flammable fluids or explosives, without the written permission of Lessor first hand and obtained. Lessee will not load floors beyond the floor load rating prescribed by applicable municipal ordinances. Lessee will not use or allow the use of the Premises for any purpose whatsoever that will injure the reputation of the Premises or of the building or which they are a part.
5. **CONDITION ON POSSESSION.** Lessee has examined and knows the condition of the Premises and has received the same in good order and repair, and acknowledges that no representations as to the condition and repair thereof, and no agreements or promises to decorate, alter, repair or improve the premises, have been made by Lessor or his agent prior to or at the execution of this lease that are not herein expressed.
6. **REPAIRS AND MAINTENANCE.** Lessee shall keep the Premises and appurtenances thereto in a clean, sightly and healthy condition, and in good repair, all according to the statutes and ordinances in such cases made and provided, and the directions of public officers thereunto duly authorized, all at his own expense, and shall yield the same back to Lessor upon the termination of this lease, whether such termination shall occur by expiration of the term, or in any other manner whatsoever, in the same condition of cleanliness, repair and sightliness as at the date of the execution hereof, loss by fire and reasonable wear and tear excepted. Lessee shall make all necessary repairs and renewals upon Premises and replace damaged, missing, burnt out, and broken lamps, globes, glass and fixtures with material of the same size and quality as that broken, damaged, missing, and burnt out and shall insure all glass in windows and doors of the Premises at his own expense. If, however, the Premises shall not thus be kept in good repair and in a clean, sightly and healthy condition by Lessee, as aforesaid, Lessor may enter the same, himself or by his agents, servants or employees, without such entering causing or constituting a termination of this lease or an interference with the possession of the Premises by Lessee, and Lessor may replace the same in the same condition of repair, sightliness, healthiness and cleanliness as existed at the date of execution hereof, and Lessee agrees to pay Lessor, in addition to the rent hereby reserved, the expenses of Lessor in thus replacing the Premises in that condition. Lessee shall not cause or permit any waste, misuse or neglect of the water, or of the water, gas or electric fixtures.
7. **ACCESS TO PREMISES.** Lessee shall allow Lessor or any person authorized by Lessor free access to the Premises for the purpose of examining or exhibiting the same, or to make any repairs or alterations thereof which Lessor may see fit to make, and Lessee will allow Lessor to have placed upon the Premises at all times notices of "For Sale" and "For Rent", and Lessee will not interfere with the same.

Lessor acknowledges that Lessee is subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 and related regulations ("HIPAA"), and that HIPAA requires Lessee to ensure the safety and confidentiality of patient medical records. Lessor further acknowledges that, in order for Tenant to comply with HIPAA, Lessee must restrict access to the portions of the Property where patient medical records are kept or stored. Lessor hereby agrees that, notwithstanding the rights granted to Lessor, except when accompanied by an authorized representative of Lessee, neither Lessor nor its employees, agents, representatives or contractors shall be permitted to enter those areas of the Property designated by Lessee as locations where patient medical records are kept and/or stored or where such entry is prohibited by applicable state or federal health care privacy laws.

8. **NON-LIABILITY OF LESSOR.** Except as provided by Illinois statute, Lessor shall not be liable to Lessee for any damage or injury to him or his property occasioned by the failure of Lessor to keep the Premises in repair, and shall not be liable for any injury done or occasioned by wind or by or from any defect of plumbing, electric wiring or of insulation thereof, gas pipes, water pipes, or from broken stairs, porches, railings or walks, or from the backing up of any sewer pipe or down-spout, or from the bursting, leaking or running of any tank, tub, washstand, water closet or waste pipe, drain, or any other pipe or tank in, upon or about the Premises or the building of which they are a part it being agreed that said radiators are under the control of Lessee, nor for any such damage or injury occasioned by water, snow or ice being upon or coming through the roof, skylight, trap-door, stairs, walks or any other place upon or near the Premises, or otherwise, nor for any such damage or injury done or occasioned by the falling of any fixture, plaster or stucco, nor for any damage or injury arising from any act, omission or negligence of co-tenants or of other persons, occupants of the same building or of adjoining or contiguous buildings or of owners of adjacent or contiguous property, or of Lessor's agents or Lessor himself, all claims for any such damage or injury being hereby expressly waived by Lessee.

9. **RESTRICTIONS (SIGNS, ALTERATIONS, FIXTURES).** Lessee shall not attach, affix or exhibit or permit to be attached, affixed or exhibited, except by Lessor or his agent, any articles or permanent character or any sign, attached or detached, with any writing or printing thereon, to any window, floor, ceiling, door or wall in any place in or about the Premises, or upon any of the appurtenances thereto, without in each case the written consent of Lessor first had and obtained; and shall not commit or suffer any waste in or about said premises; and shall make no changes or alterations in the Premises by the erection of partitions or the papering of walls, or otherwise, without the consent in writing of Lessor; and in case Lessee shall affix additional locks or bolts on doors or windows, or shall place in the Premises lighting fixtures or any fixtures of any kind, without the consent of Lessor first had and obtained, such locks, bolts and fixtures shall remain for the benefit of Lessor, and without expense of removal or maintenance to Lessor. Lessor shall have the privilege of retaining the same if he desires. If he does not desire to retain the same, he may remove and store the same, and Lessee agrees to pay the expense of removal and storage thereof. The provisions of this paragraph shall not however apply to Lessee's trade fixtures, equipment and movable furniture.
10. **FIRE AND CASUALTY.** In case the Premises shall be rendered untenable by fire, explosion or other casualty, Lessor may, at his option, terminate this lease or repair the Premises within sixty days. If Lessor does not repair the premises within said time, or the building containing the premises shall have been wholly destroyed, the term hereby created shall cease and terminate.
11. **TERMINATION; HOLDING OVER.** Tenant shall have the right to terminate the lease at any time after the fifth anniversary of the rent commencement date by providing written notice thereof at least 120 days prior to the date of termination. At the termination of the term of this lease, by lapse of time or otherwise, Lessee will yield up immediate possession of the Premises to Lessor, in good condition and repair, loss by fire and ordinary wear excepted, and will return the keys therefore to Lessor at the place of payment of rent. Tenant shall have the right to holdover for three (3) months after term expiration at the same rate as the last month of the lease term. After the third month, the holdover rate shall increase to 125% of the rent for the last month of the lease term. If Lessee retains possession of the Premises or any part thereof after the termination of the term by lapse of time or otherwise, then Lessor may at its option within thirty days after termination of the term serve written notice upon Lessee that such holding over constitutes either (a) renewal of this lease for one year, and from year to year thereafter, at double the rental (computed on an annual basis) specified in Section 1, or (b) creation of a month to month tenancy, upon the terms of this lease except at double the monthly rental specified in Section 1 for the time Lessee remains in possession. If no such written notice is served then a tenancy at sufferance with rental as stated at (c) shall have been created. Lessee shall also pay to Lessor all damages sustained by Lessor resulting from retention of possession by Lessee. The provisions of this paragraph shall not constitute a waiver by Lessor of any right of re-entry as hereinafter set forth; nor shall receipt of any rent or any other act in apparent affirmance of tenancy operate as a waiver of the right to terminate this lease for a breach of any of the covenants herein.
12. **LESSOR'S REMEDIES.** If Lessee shall vacate or abandon the Premises or permit the same to remain vacant or unoccupied for a period of ten days, or in case of the non-payment of the rent reserved hereby, or any part thereof, or of the breach of any covenant in this lease contained, Lessee's right to the possession of the Premises thereupon shall terminate with or (to the extent permitted by law) without any notice or demand whatsoever, and the mere retention of possession thereafter by Lessee shall constitute a forcible detainer of the Premises; and if the Lessor so elects, but not otherwise, and with or without notice of such election or any notice or demand whatsoever, this lease shall thereupon terminate, and upon the termination of Lessee's right of possession, as afore said, whether this lease be terminated or not, Lessee agrees to surrender possession of the Premises immediately, without the receipt of any demand for rent, notice to quit or demand for possession of the Premises whatsoever, and hereby grants to Lessor full and free license to enter into and upon the Premises or any part thereof, to take possession thereof with or (to the extent permitted by law) without process of law, and to expel and to remove Lessee or any other person who may be occupying the Premises or any part thereof, and Lessor may use such force in and about expelling and removing Lessee and other persons as may reasonably be necessary, and Lessor may re-possess himself of the Premises as of his former estate, but such entry of the Premises shall not constitute a trespass or forcible entry or detainer, nor shall it cause a forfeiture of rents due by virtue thereof, nor a waiver of any covenant, agreement or promise in this lease contained, to be performed by Lessee. Lessee hereby waives all notice of any election made by Lessor hereunder, demand for rent, notice to quit, demand for possession, and any and all notices and demand whatsoever, of any and every nature, which may or shall be required by any statute of this state relating to forcible entry and detainer, or to landlord and tenant, or any other statute, or by the common law, during the term of this lease or any extension thereof. The acceptance of rent, whether in a single instance or repeatedly, after it falls due, or after knowledge of any breach hereof by Lessee, or the giving or making of any notice or demand, whether according to any statutory provision or not, or any act or series of acts except an express written waiver, shall not be construed as a waiver of Lessor's rights to act without notice or demand or of any other right hereby given Lessor, or as an election not to proceed under the provisions of this lease.

13. **RIGHT TO RELET.** If Lessee's right to the possession of the Premises shall be terminated in any way, the Premises, or any part thereof, may, but need not (except as provided by Illinois statute), be relet by Lessor, for the account and benefit of Lessee, for such rent and upon such terms and to such person or persons and for such period or periods as may seem fit to the Lessor, but Lessor shall not be required to accept or receive any tenant offered by Lessee, nor to do any act whatsoever or exercise any diligence whatsoever, in or about the procuring of any care or diligence by Lessor in the reletting thereof; and if a sufficient sum shall not be received from such reletting to satisfy the rent hereby reserved, after paying the expenses of reletting and collection, including commissions to agents, and including also expenses of redecorating, Lessee agrees to pay and satisfy all deficiency; but the acceptance of a tenant by Lessor, in place of Lessee, shall not operate as a cancellation hereof, nor to release Lessee from the performance of any covenant, promise or agreement herein contained, and performance by any substituted tenant by the payment of rent, or otherwise, shall constitute only satisfaction pro tanto of the obligations of Lessee arising hereunder.
14. **COSTS AND FEES.** Lessee shall pay upon demand all Lessor's costs, charges and expenses, including fees of attorneys, agents and others retained by Lessor, incurred in enforcing any of the obligations of Lessee under this lease or in any litigation, negotiation or transaction in which Lessor shall, without Lessor's fault, become involved through or on account of this lease.
15. **LESSOR'S LIEN.** Lessor shall have a first lien upon the interest of Lessee under this lease, to secure the payment of all monies due under this lease, which lien may be foreclosed in equity at any time when money is overdue under this lease; and the Lessor shall be entitled to name a receiver of said leasehold interest, to be appointed in any such foreclosure proceeding, who shall take possession of said premises and who may relet the same under the orders of the court appointing him.
16. **REMOVAL OF OTHER LIENS.** In event any lien upon Lessor's title results from any act or neglect of Lessee, and Lessee fails to remove said lien within ten days after Lessor's notice to do so, Lessor may remove the lien by paying the full amount thereof or otherwise and without any investigation or contest of the validity thereof, and Lessee shall pay Lessor upon request the amount paid out by Lessor in such behalf, including Lessor's costs, expenses and counsel fees.
17. **REMEDIES NOT EXCLUSIVE.** The obligation of Lessee to pay the rent reserved hereby during the balance of the term hereof, or during any extension hereof, shall not be deemed to be waived, released or terminated, other notice to collect, demand for possession, or notice that the tenancy hereby created will be terminated on the date therein named, the institution of any action of forcible detainer or ejectment or any judgment for possession that may be rendered in such action, or any other act or acts resulting in the termination of Lessee's right to possession of the Premises. The Lessor may collect and receive any rent due from Lessee, and payment or receipt thereof shall not waive or affect any such notice, demand, suit or judgment, or in any manner whatsoever waive, affect, change, modify or alter any rights or remedies which Lessor may have by virtue hereof.
18. **NOTICES.** Notices may be served on either party, at the respective addresses given at the beginning of this lease, either (a) by delivering or causing to be delivered a written copy thereof, or (b) by sending a written copy thereof by United States certified or registered mail, postage prepaid, addressed to Lessor or Lessee at said respective addresses in which event the notice shall be deemed to have been served at the time the copy is mailed.
19. **MISCELLANEOUS.** (a) Provisions typed on this lease and all riders attached to this lease and signed by Lessor and Lessee are hereby made a part of this lease.
(b) Lessee shall keep and observe such reasonable rules and regulations now or hereafter required by Lessor, which may be necessary for the proper and orderly care of the building of which the Premises are a part.
(c) All covenants, promises, representations and agreements herein contained shall be binding upon, apply and inure to the benefit of Lessor and Lessee and their respective heirs, legal representatives, successors and assigns.
(d) The rights and remedies hereby created are cumulative and the use of one remedy shall not be taken to exclude or waive the right to the use of another.
(e) The words "Lessor" and "Lessee" wherever used in this lease shall be construed to mean Lessors or Lessees in all cases where there is more than one Lessor or Lessee, and to apply to individuals, male or female, or to firms or corporations, as the same may be described as Lessor or Lessee herein, and the necessary grammatical changes shall be assumed in each case as though fully expressed.
20. **SEVERABILITY.** If any clause, phrase, provision or portion of this lease or the application thereof to any person or circumstance shall be invalid, or unenforceable under applicable law, such event shall not affect, impair or render invalid or unenforceable the remainder of this lease nor any other clause, phrase, provision or portion hereof, nor shall it affect the application of any clause, phrase, provision or portion hereof to other persons or circumstances.
21. **INDEMNITY.** During the term of this Lease, Lessee covenants and agrees that he will protect, save and keep the Lessor harmless

and indemnified against and from any penalty, damages or charges imposed for any violation of any laws or ordinances, occasioned by the neglect of the Lessee or those holding under Lessee against and from any and all loss, cost, damage or expense, arising out of or from any accident or other occurrence on or about the Premises, causing injury to any person or property and will protect, indemnify and save and keep harmless the Lessor against and from any and all claims and against and from any and all loss, cost, damage or expense arising out of any failure of Lessee in any respect to comply with and perform all the requirements and provisions hereof.

22. **WATER USE.** Lessor is furnishing water for the use of toilets and wash sinks for Lessee's normal use. The water furnished to Lessee shall not be used by Lessee for any other use other than normal use of said toilets and wash sinks without the prior written permission of Lessor. For example, water cannot be used for washing or processing of any sort. Lessee will be billed their prorated share for water use costs as stated in Clause 38. Lessor reserves the right to monitor all water uses.
23. **PARKING.** Lessee shall be entitled to 5 marked reserved handicapped spaces located at or near the entrance of the Premises, 10 marked reserved visitor spaces located near the entrance of the Premises, and 20 marked spaces located in the building parking area. No abandoned, unlicensed, licensed, and junked vehicles shall be left overnight in the parking areas without permission of Lessor. Lessor reserves the right to tow vehicles left overnight on the property without further notification to Lessee, Lessee's employees, agents or customers.
24. **MUNICIPAL ORDINANCES.** Lessee agrees to abide by any and all Village Of Plainfield Ordinances as they apply to Lessee's business operations.
25. **SIGNS AND PICTURES.** No sign, picture, advertisement or notice shall be displayed, inscribed, painted or affixed on any part of the outside of the Premises without the prior written permission of Lessor. Any signs, pictures or any other item, which will be affixed to the outside of the premises, will be attached by a method reasonably described by the Lessor. Lessee shall not allow anything to be resting against any glass on the premises. Any sign, picture, advertisement or notice on the Premises shall satisfy the Sign Covenants of the Lessor and Village Of Plainfield's specifications and ordinances for sign advertising.
26. **SNOW REMOVAL.** Lessor will be responsible for plowing the snow in the parking lot and sidewalks after each snowfall. Lessee will be billed their prorated share for snow removal costs as stated in Clause 38.
27. **DANGEROUS CHEMICALS FLAMMABLE LIQUIDS.** Lessee will not keep or use or permit to be kept or used in or on the premises any dangerous chemicals, flammable liquids or explosives except that lessee may keep on the premises no more than 5 gallons of flammable liquid providing it is held in a self-closing can(s).
28. **PERMITTED USE OF PREMISES.** Lessee will only use the Premises for the purpose stated above.
29. **HVAC AND UTILITIES.** Lessor will provide heating and air conditioning equipment for the basic unit for the Premises. Lessor's HVAC contractor will perform the initial start up of the HVAC unit. Temperatures in the Premises will not be allowed to go below 50 degrees Fahrenheit. Lessee will be responsible for maintenance of HVAC units, Lessor will replace HVAC filters as needed and Lessee will be billed their prorated share as stated in Clause 38.
30. **NOTICE TO LESSOR.** All known malfunctions of water systems, gas systems, sewer systems, electrical systems, roofing systems, and plumbing systems provided by the Lessor must be reported to the Lessor within a reasonable time by Lessee. Lessor is to make repairs and maintain such systems in a timely manner except as stated in Clause 29.
31. **JANITORIAL SERVICES.** Lessee will provide all janitorial work for their basic unit. Lessee will pay their appropriate share of the common area maintenance as defined in clause #38.
32. **ANIMALS.** No dogs or other animals shall be allowed on the premises.
33. **HOURS OF OPERATION.** Lessee shall open and close the Premises as needed for proper operation of his business. A written list of his normal work hours shall be given to the Lessor.
34. **ALTERATION OF PREMISES.** Any alteration to the Premises as a result of business operations of Lessee after acceptance of this lease will be paid for by the Lessee. All alterations must be approved by Lessor. Approved alterations must meet the local and state building codes and the appropriate building permits and inspections must be obtained. Telephone service will be arranged for by Lessee and cable will be strung in conduit only. The basic conduit shall be provided by the Lessor and the cable shall be provided by Lessee. If additional conduit and telephone construction is needed such costs will be paid for by the Lessee.

35. **SECURITY.** Security as to locked Premises is the responsibility of the Lessee. All lock or key repairs and changes on the interior and exterior doors will be paid for by the Lessee. Initially, four keys will be provided for each entry door to the Premises. All lighting for the Premises as required by the City code for after closing hours will be paid for by the Lessee, provided such requirements are caused by Lessee's business operations.
36. **REFUSE CONTAINERS.** Refuse containers for private scavenger pickup and refuse removal will be the responsibility of the Lessor. Lessor will monitor those units to insure proper sanitary conditions. These containers will be placed only in areas reasonably designated by the Lessor. Placement of these containers shall not interfere with the business operations of Lessee or others. Lessee will be paying their share for refuse containers as stated in Clause 38.
37. **HALLWAYS.** The hallways and other common areas may not be used for storage, loitering, soliciting, or any other activity that may unnecessarily block or cause to inconvenience other tenants or that may create a violation in the local fire or building code.
38. **ADDITIONAL RENT.** In addition to the other amounts set forth in this lease, Lessee agrees to pay to Lessor as additional rent Lessee's prorata share of the Lessor's Real Estate Taxes, Insurance and Common Area Expenses incurred in each calendar year or portion thereof for the Building during the term of this lease. Lessee shall pay said share based on Lessor's estimates, as adjusted from time to time, in advance monthly with final adjustment for each year between Lessor and Lessee after the end of each calendar year. Commencing with the payment of rent set forth herein Lessee's initial minimum payment under this paragraph shall be \$ 1,893.79 per month. For purpose hereof Real Estate Taxes shall be defined as real estate taxes and special assessments and all other taxes which apply to or are assessed by the State, County or any municipality or taxing authority in which the Building is located on Lessor's land at the Property assessed with respect to any calendar year in which all or a portion of the term of this lease falls. Insurance shall be defined as Fire and Extended Coverage Insurance on Lessor's building on the property and Common Area Expenses shall be defined as all the Lessor's costs of operating, maintaining including cleaning and plowing, insuring (other than Fire and Extended Coverage), lighting, policing, repairing, restriping and replacing (including appropriate reserves), the sidewalks, parking areas, maintenance area, landscaping, drives and other common areas at the Building. Lessee's prorata share shall be based upon the percentage that the square foot area of the premises bears to the total square foot rentable area of Lessor's building on the Property which is 11 %. The additional rent obligation shall commence upon occupancy. Utilities shall commence upon occupancy.
39. **SUBORDINATION LEASE.** This lease is subject and subordinate to the lien of any mortgage or mortgages (or Trust indentures) now or hereafter enforced against the land and/or the Building, and to all renewals, modifications, consolidations, replacements and extensions thereof, and to all advances made or hereafter to be made upon the security thereof. In confirmation of such subordination, Lessee shall execute such further instruments as shall be requested by Lessor and Lessee hereby irrevocable appoints Lessor as attorney-in-fact for Lessee with full power and authority to execute and deliver in the name of Lessee any such instrument or instruments. Lessee covenants and agrees, in the event any proceedings are brought for the foreclosure of any such mortgage, to attorn to the purchaser upon any such foreclosure, upon any such foreclosure sale, and to recognize such purchaser as the Lessor under this lease or, in the event of the termination, for any reason whatsoever of any such underlying lease above referred to, that Lessee (at the option of the holder of the reversion under such underlying lease to be evidenced by written notice of election to Lessee) will attorn to and recognize such holder as the then Lessor under this lease to the same extent and effect as the original Lessor hereunder. The Lessee agrees to execute and deliver at any time from time to time, upon the request of the Lessor or of any such holder, any instrument, which in the sole judgement of Lessor, may be necessary or appropriate in any of such events to evidence such attornment. Lessee further waives the provisions of any statute or rule of law, now or hereafter in effect, which may give or purport to give Lessee any right or election to terminate or otherwise adversely affect this lease and the obligation of Lessee hereunder in the event any such foreclosure proceeding is brought, and agrees that this lease shall not be affected in any way whatsoever by any such foreclosure proceeding.
40. **LOST KEYS.** Lessor will provide new keys and locks in the event of lost keys for the Lessee's rental space. Lessee shall pay a \$20.00 fee.
41. **LATE PAYMENT RETURNED CHECK FEES.** The time of each and every payment of rent is of the essence of the Lease. The monthly rent set forth above shall be increased by 10% of said monthly rent (or 10% of said rent that remains unpaid if part of said monthly rent is paid) if paid after the 5th day of such month. Such monthly rent shall increase an additional 10% (or 10% of the unpaid rent if part of said monthly rent is paid) on the first day of each subsequent month until such monthly rent is paid in full. An additional charge of \$50.00 shall be added to said monthly rent should a check, submitted for payment of rent, or other obligation of Lessee, be returned unpaid by the bank for any reason. Upon notice to Lessee of a returned check, Lessee agrees to replace the funds within 24 hours of the notice with certified funds in the form of two certified or cashiers checks, one for the original check amount and one for the returned check fee of \$50.00.

42. In addition to the returned check fee, a rent check returned and unpaid constitutes non-payment of rent and late charges, if applicable, will be assessed in addition to the returned check fee.
43. **LIABILITY INSURANCE.** Lessee will secure and maintain general liability insurance designating Lessor as additional insured's from a financially responsible insurance company covering the premises and adjacent ways with limits of coverage of no less than \$1,000,000.00. Lessee shall furnish to Lessor customary certificates indicating that said policy of insurance required herein has been purchased and paid for by Lessee. Not less than 10 days prior to the expiration of each policy, a renewal policy or certificate shall be delivered to the Lessor, and not less than 10 days prior to the date any premium of each policy shall be due and payable there shall be delivered to the Lessor evidence of such payment satisfactory to the Lessor. Any such policy shall provide that same shall not be cancelable with less than 10 days notice to all insured's.
44. **LEASE HOLDER IMPROVEMENTS.** Lessor shall deliver the Premises a vanilla box per mutually agreeable specs within thirty (30) days from approval of a Certificate of Need from the State of Illinois. Lessor shall allow Lessee with prior written approval of Lessor and at Lessee's own expense, to install an awning at the front of the Premises for a patient drop off/pick up area.
45. **SECURITY DEPOSIT.** Lessee has deposited with Lessor a security deposit that is set forth above the performance of each and every covenant and agreement of this lease. Lessor shall have the right, but not the obligation, to apply the security deposit in whole or in part in payment of any unpaid rent or other amount due because of an unperformed covenant or agreement by Lessee. Lessor's right to possession of the Premises for nonpayment of rent or for any other reason shall not be affected by the fact that the Lessor holds security. Lessee's liability is not limited to the amount of the security deposit. On termination of the lease and full payment of all amounts due and performances of all Lessee's covenants and agreements, the security deposit or any portion thereof remaining unapplied shall be returned without interest to the Lessee.
46. **DELIVERIES.** Lessee shall be allowed tractor trailer delivery of supplies in the delivery area behind the building.
47. **OPTION TO RENEW.** Upon written notice provided by Lessee to Lessor within 90 days prior to the expiration date of this Lease and/or any then expiration date of any renewal term hereof, Lessee may renew this Lease for up to two (2) five-year renewal terms and the base rent shall increase 3% from the prior year's base rent. All other terms of this Lease shall continue in full force and effect.
48. **RIGHT OF FIRST REFUSAL.** Lessee has the right of first refusal to any adjacent suites. Lessee shall have fifteen (15) business days from receipt of written notice from Lessor to exercise its Right of First Refusal. If Lessee exercises its Right of First Refusal, Lessee shall lease the additional space for a term that is coterminous with its Lease for the Premises and at the rental rate(s) and other Lease terms in effect, with a pro rated construction allowance.

WITNESS the hands and seals of the parties hereto, as of the Date of Lease stated above.

Please print or type name(s) below signature(s).

LESSEE:

LESSOR:

BY: _____ (SEAL)

BY: _____ (SEAL)

BY: _____ (SEAL)

BY: _____ (SEAL)

ATTEST: _____

PERSONAL GUARANTEE

On this _____, 20____ in consideration of Ten Dollars (\$10.00) and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the undersigned Guarantor hereby guarantees the payment of rent and performance by Lessee, Lessee's heirs, executors, administrators, successors or assigns of all covenants and

agreements of the above Lease.

SIGNED:

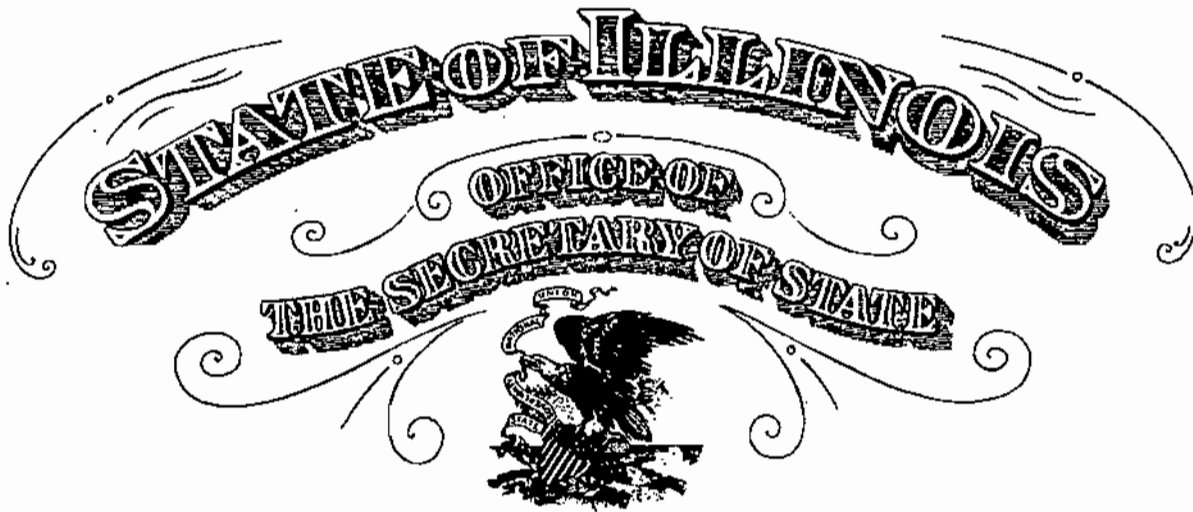
NAME	DATED

SIGNED:

NAME	DATED

ATTACHMENT 3

OPERATING IDENTITY/LICENSEE CERTIFICATE OF GOOD STANDING



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

USRC PLAINFIELD, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 16, 2012, 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.



Authentication #: 1216302060

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 11TH day of JUNE A.D. 2012 .

Jesse White

SECRETARY OF STATE

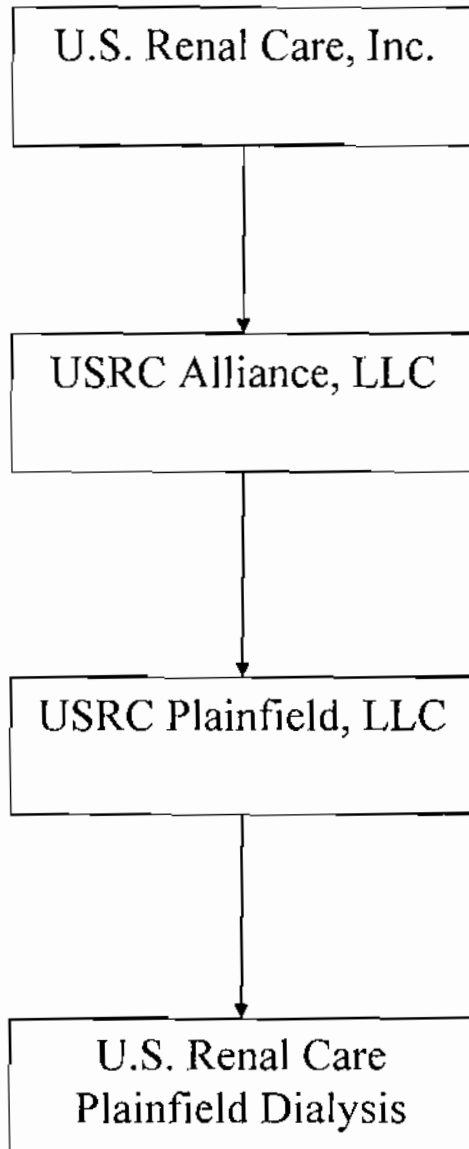
ATTACHMENT 3

PERSONS WITH 5% OR MORE OWNERSHIP INTEREST IN OPERATING ENTITY

Member	Direct/Indirect Ownership	Ownership Percentage
Naila I. Ahmed, M.D.	Indirect	8%
Aaron Gurfinchel, M.D.	Indirect	8%
Teresa Kravets, M.D.	Indirect	8%
Sandeep Mehta, M.D.	Indirect	8%
Preeti R. Nagarkatte, M.D.	Indirect	8%

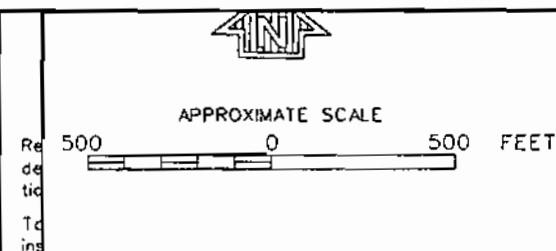
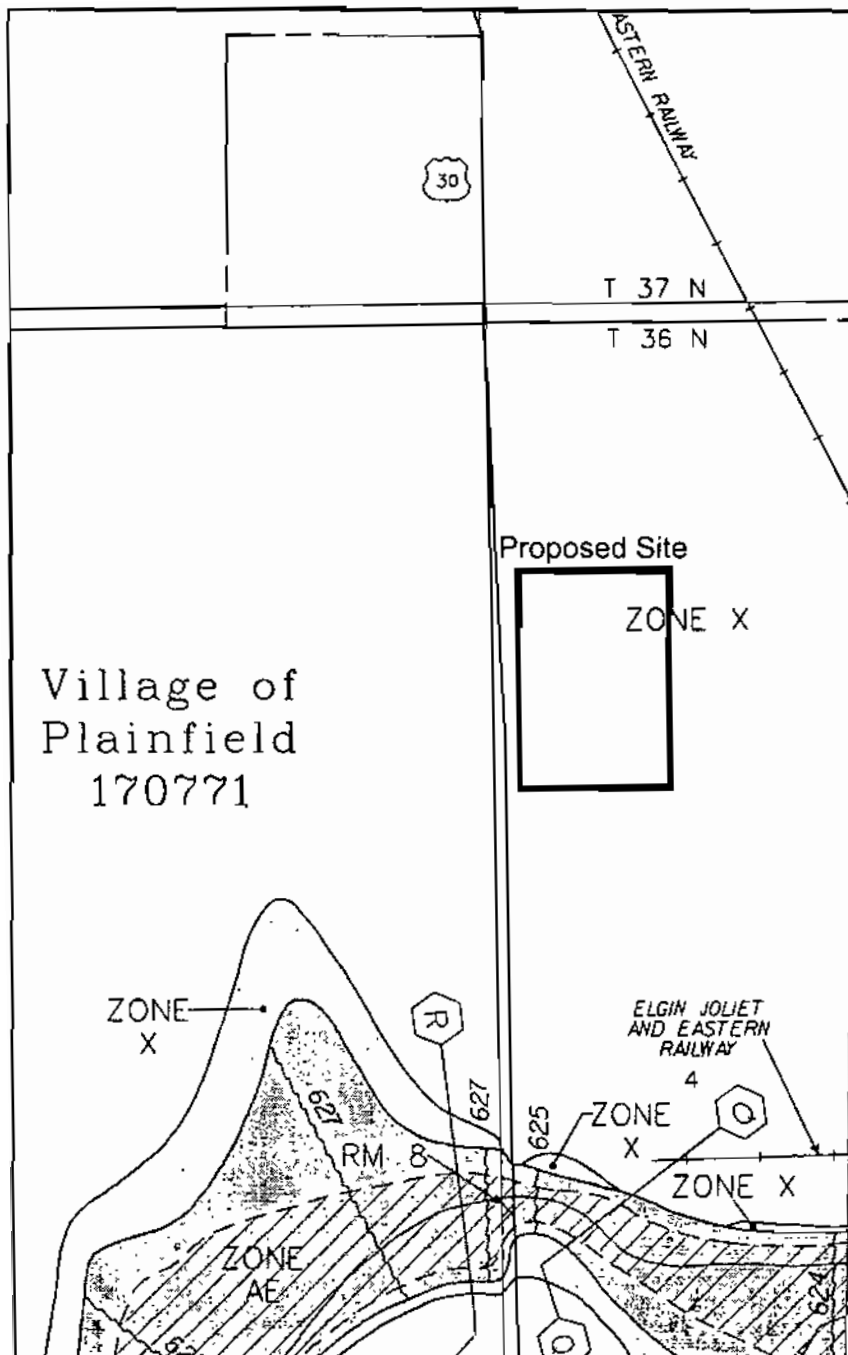
ATTACHMENT 4

ORGANIZATIONAL RELATIONSHIPS – ORGANIZATIONAL CHART



ATTACHMENT 5

FLOOD PLAIN REQUIREMENTS



NATIONAL FLOOD INSURANCE PROGRAM

FIRM
FLOOD INSURANCE RATE MAP
WILL COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 38 OF 585
(SEE MAP INDEX FOR PANELS NOT PRINTED)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
PLAINFIELD VILLAGE OF	1707	038	L
UNINCORPORATED AREAS	0000	000	L

Notice: In order for the MAP NUMBER shown herein should be used when placing map orders; the COMMUNITY NUMBER shown above should be used on insurance applications for the subject community.

MAP NUMBER
17197C0038 E

EFFECTIVE DATE:
SEPTEMBER 6, 1995

Federal Emergency Management Agency

This is an official copy of a portion of the above referenced flood map. It was extracted using F-MIT On-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For the latest product information about National Flood Insurance Program flood maps check the FEMA Flood Map Store at www.msc.fema.gov

ATTACHMENT 6

ILLINOIS HISTORIC PRESERVATION AGENCY LETTER



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Will County
Plainfield

CON - Lease to Establish a Dialysis Facility
13717 Route 30
IHPA Log #014051612

May 31, 2012

Shawn Moon
Ungaretti and Harris
Three First National Plaza
70 W. Madison - Suite 3500
Chicago, IL 60602-4224

Dear Mr. Moon:

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

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

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

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

ATTACHMENT 7

PROJECT COST/SOURCE OF FUNDS ITEMIZATION OF COSTS NOT OTHERWISE IDENTIFIED IN THE PROJECT COST/SOURCE OF FUNDS TABLE

Architect Fees	\$55,000
Computers & Wiring	\$48,913
Dialysis Chairs / Scales	\$20,497
Dialysis Machines	\$188,166
Building Lease	\$1,455,433
Leasehold Improvement	\$714,230
Medical / Biomed Equipment	\$13,145
Misc	\$9,582
Office Furniture / Equipment	\$109,437
Water Treatment	\$80,960

ATTACHMENT 8

OBLIGATION

Obligation will occur after permit issuance

ATTACHMENT 9

COST SPACE REQUIREMENTS

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
In-Center Hemodialysis	\$ 2,725,363	0	6,493		6,493		
Total Clinical	\$ 2,725,363	0	6,493		6,493		
NON REVIEWABLE							
Total Non-clinical							
TOTAL	\$ 2,725,363	0	6,493		6,493		

ATTACHMENT 11

BACKGROUND OF THE APPLICANT

Please find the attached list of facilities considered "owned or operated" by the Applicant and certification from the Applicant.

DCA of Adel, LLC d/b/a U.S. Renal Care
Adel Dialysis
203 Robinson St
Adel GA 31620
(220) 896-4529
EIN: 56-2335380
License No. ESRD001228
Medicare No. 112733

DCA of Ashland, LLC d/b/a U.S. Renal
Care Ashland Dialysis
113 N Washington St
Ashland VA 23005
(804) 752-3444
EIN: 27-0094841
License No. N/A
Medicare No. 492622

DCA of Barnwell, LLC d/b/a U.S. Renal
Care Barnwell Dialysis
10708 Marlboro Ave
Barnwell SC 29812
(803) 541-7225
EIN: 20-2131118
License No. ERD-0179
Medicare No. 422615

DCA of Calhoun, LLC d/b/a U.S. Renal
Care Calhoun Dialysis
105 Professional Pl
Calhoun GA 30701
(706) 624-4497
EIN: 20-4119620
License No. ESRD001266
Medicare No. 112770

DCA of Camp Hill, LLC d/b/a U.S. Renal
Care Camp Hill Dialysis
158 S 32nd St Suite 19
Camp Hill PA 17011
(717) 731-0506
EIN: 26-1554083
License No. N/A
Medicare No. 392750

DCA of Carlisle, Inc. d/b/a U.S. Renal Care
Carlisle Dialysis
101 Noble Blvd Suite 103
Carlisle PA 17013
(717) 258-3099
EIN: 23-2869880
License No. N/A
Medicare No. 392627

DCA of Central Valdosta, LLC d/b/a U.S.
Renal Care Central Valdosta Dialysis
506 N. Patterson St
Valdosta GA 31601
(229) 219-0099
EIN: 58-2617394
License No. ESRD001193
Medicare No. 112699

DCA of Chambersburg, Inc. d/b/a U.S.
Renal Care Chambersburg Dialysis
765 54th Ave, Park 5th Ave Professional
Center Suite A
Chambersburg PA 17201
(717) 263-9300EIN: 25-1810333
License No. N/A
Medicare No. 392648

DCA of Chesapeake, LLC d/b/a U.S. Renal
Care Chesapeake Dialysis
305 College Parkway
Arnold MD 21012
(410) 431-5106
EIN: 20-4373428
License No. E2619
Medicare No. 112619

DCA of Chevy Chase, LLC d/b/a U.S. Renal
Care Chevy Chase Dialysis
3 Bethesda Metro Center Suite B-005
Bethesda, MD 20814
(301) 652-3434
EIN: 75-2978031
License No. E2633
Medicare No. 21.2633

DCA of Cincinnati, LLC d/b/a U.S. Renal
Care Mt Healthy Dialysis
7600 Affinity Pl
Mt Healthy OH 45231
(513) 931-7900
EIN: 31-1810465
License No. 0684DC
Medicare No. 362655

DCA of Columbus, LLC d/b/a U.S. Renal
Care Columbus Dialysis
2360 Citygate Dr
Columbus OH 43219
(614) 428-4001
EIN: 20-8388926
License No. 0880DC
Medicare No. 362662

DCA of Delaware County, LLC d/b/a U.S.
Renal Care Delaware County Dialysis
1788 Columbus Pike
Delaware OH 43015
(740) 369-4870
EIN: 20-5799636
License No. 0871DC
Medicare No. 362713

DCA of Eastgate, LLC d/b/a U.S. Renal
Care Eastgate Dialysis
4600 Beechwood Rd Suite 900
Cincinnati OH 45244
(513) 528-3222
EIN: 26-4578574
License No. 0968DC
Medicare No. 362762

DCA of Edgefield, LLC d/b/a U.S. Renal
Care Edgefield Dialysis
306 Main St
Edgefield SC 29824
(803) 637-3225
EIN: 20-2131213
License No. ERD-0149
Medicare No. 422602

DCA of Fitzgerald, LLC d/b/a U.S. Renal
Care Fitzgerald Dialysis
402 S Grant St
Fitzgerald GA 31750
(229) 409-2221
EIN: 58-2596232
License No. ESRD001191
Medicare No. 112698

DCA of Hawkinsville, LLC d/b/a U.S.
Renal Care Hawkinsville Dialysis
292 Industrial Blvd Suite 100
Hawkinsville GA 31036
(478) 892-8008
EIN: 20-8548207
License No. ESRD001199
Medicare No. 112707

DCA of Hyattsville, LLC d/b/a U.S. Renal
Care Hyattsville Dialysis
4920 LaSalle Road
Hyattsville, MD 20782
(301) 277-0490
EIN: 26-3674421
License No. E2620
Medicare No. 212620

DCA of Kenwood, LLC d/b/a U.S. Renal
Care Kenwood Dialysis
5150 E Galbraith Rd
Cincinnati OH 45236
(513) 791-2698
EIN: 26-4578451
License No. 0956DC
Medicare No. 362759

DCA of Mechanicsburg, LLC d/b/a U.S.
Renal Care Mechanicsburg Dialysis
120 South Filbert St
Mechanicsburg PA 17055
(717) 790-6080
EIN: 23-3078802
License No. N/A
Medicare No. 392691

DCA of North Baltimore, LLC d/b/a U.S.
Renal Care North Baltimore Dialysis
2700 N Charles St Suite 102
Baltimore MD 21218
(410) 243-4193
EIN: 20-4373297
License No. E2577
Medicare No. 212577

DCA of Norwood, LLC d/b/a U.S. Renal
Care Norwood Dialysis
1721 Tennessee Ave
Cincinnati OH 45229
(513) 242-6733
EIN: 86-1117490
License No. 0773DC
Medicare No. 362681

DCA of Pottstown, LLC d/b/a U.S. Renal
Care Pottstown Dialysis
5 S Sunnybrook Rod Suite 500
Pottstown PA 19464
(610) 718-1127
EIN: 47-0924656
License No. N/A
Medicare No. 392707

DCA of Rockville, LLC d/b/a U.S. Renal
Care Rockville Dialysis
11800 Nebel St
Rockville MD 20852
(301) 468-3221
EIN: 06-1707727
License No. E2641
Medicare No. 212641

DCA of Royston, LLC d/b/a U.S. Renal
Care Royston Dialysis
611 Cook St
Royston GA 30662
(706) 2345-0817
EIN: 20-0546217
License No. ESRD001105
Medicare No. 112719

DCA of SO GA, LLC d/b/a U.S. Renal Care
South Georgia Dialysis
3564 N Crossing Cir
Valdosta GA 31602
(229) 249-3222
EIN: 22-3715287
License No. ESRD001180
Medicare No. 112688

DCA of South Aiken, LLC d/b/a U.S. Renal
Care South Aiken Dialysis
169 Crepe Myrtle Dr
Aiken SC 29803
EIN: 20-2130991
License No. ERD-0156
Medicare No. 422604

DCA of Toledo, LLC d/b/a U.S. Renal Care
Bowling Green Dialysis
1037 Conneaut Ave Suite 101
Bowling Green OH 43402
(419) 353-1080
EIN: 34-1933418
License No. 0631DC
Medicare No. 362630

DCA of Vineland, LLC d/b/a U.S. Renal
Care Vineland Dialysis
1450 East Chestnut Ave Bldg 2 Suite C
Vineland NJ 08361
(856) 692-9060
EIN: 52-2180919
License No. 22278
Medicare No. 312551

DCA of Warsaw, LLC d/b/a U.S. Renal
Care Warsaw Dialysis
4709 Richmond Rd
Warsaw VA 22572
(804) 333-4444
EIN: 13-4226110
License No. N/A
Medicare No. 492627

DCA of Wellsboro, Inc. d/b/a U.S. Renal
Care Wellsboro Dialysis
223 Tioga St
Wellsboro PA 16901
(570) 724-3188
EIN: 25-1762601
License No. N/A
Medicare No. 392602

DCA of West Baltimore, LLC d/b/a U.S.
Renal Care West Baltimore Dialysis
22 S Athol St
Baltimore MD 21229
(410) 947-3227
EIN: 75-3170570
License No. E2647
Medicare No. 112647

DCA of York, LLC d/b/a U.S. Renal Care
York Dialysis
1975 Kenneth Rd
York PA 174808
(717) 764-8322
EIN: 76-0792137
License No. N/A
Medicare No. 392731

Keystone Kidney Care, Inc d/b/a U.S. Renal
Care Bedford Dialysis
141 Memorial Dr
Everett PA 15537
(814) 623-2977
EIN: 25-1663054
License No. N/A
Medicare No. 392612

Keystone Kidney Care, Inc d/b/a U.S. Renal
Care Huntingdon Dialysis
820 Bryan St Suite 4
Huntingdon PA 16652
(814) 643-3600
EIN: 25-1663054
License No. N/A
Medicare No. 392656

Pine Bluff Dialysis, Inc. d/b/a Kidney
Center of McGehee
610 Holly St
Mc Gehee, AR 71654-2109
(870) 222-6700
EIN: 71-0855258
License No. N/A
Medicare No. 04-2565

Pine Bluff Dialysis, Inc. d/b/a Pine Bluff -
U.S. Renal Care
2800 W 28th Street
Pine Bluff, AR 71603
(870) 534-7400
EIN: 71-0855258
License No. N/A
Medicare No. 04-2564

U.S. Renal Care Boerne, LLC d/b/a U.S.
Renal Care Boerne Dialysis
1595 South Main Suite 107
Boerne, TX 78006
(830) 816-3030
EIN: 43-2099925
License No. 008371
Medicare No. 67-2563

U.S. Renal Care Home Therapies, LLC
1313 La Concha Ln
Houston, TX 77054-1809
(713) 668-2744
EIN: 32-0223510
License No. 008644
Medicare No. 45-2840

U.S. Renal Care of Northeast Arkansas LLC
d/b/a Paragould - U.S. Renal Care
901 W Kingshighway
Paragould, AR 72450
(870) 215-0187
EIN: 62-1826477
License No. N/A
Medicare No. 04-2562

USRC Advanced Home Therapies, LLC
396 Remington Blvd Suite 140
Bolingbrook IL 60440-4311
(630) 495-9356
EIN: 45-1627715
License No. N/A
Medicare No. Pending

USRC Altoona, LLC d/b/a U.S. Renal Care
Altoona Dialysis
118 E Chestnut Ave
Altoona PA 16601
(814) 942-2569
EIN: 27-3164836
License No. N/A
Medicare No. 39-2786

USRC Atascosa County Dialysis, LLC d/b/a
U.S. Renal Care Atascosa County Dialysis
1320 W Oaklawn Rd
SUITE G&H
Pleasanton, TX 78064-4304
(830) 569-3052
EIN: 26-1394783
License No. 008674
Medicare No. 672631

USRC Azle, LP d/b/a U.S. Renal Care
Tarrant Dialysis Azle
605 Northwest Parkway Suite 1
Azle TX 76020
(817) 406-4331
EIN: 26-4113763
License No. 110026
Medicare No. 672652

USRC Bellaire Dialysis, LLC d/b/a U.S.
Renal Care Bellaire Dialysis
7243 Bissonnet Dr Suite A
Houston TX 77074
(713) 988.7200
EIN: 26-1527679
License No. 110013
Medicare No. 67-2657

USRC Canton, LLC d/b/a U.S. Renal Care
Canton Dialysis
400 Highway 243 Suite 14
Canton TX 75103
(903) 567-2250
EIN: 26-2409182
License No. 008728
Medicare No. 672607

USRC Cheektowaga, Inc. d/b/a U.S. Renal
Care Cheektowaga Dialysis
2875 Union Rd Suite 13 C/D
Cheektowaga NY 14225
(716) 684-0276
EIN: 27-0789903
Medicare No. 33-2686

USRC Cleburne, LP d/b/a U.S. Renal Care
Tarrant Dialysis Cleburne
1206 W Henderson Suite A
Cleburne TX 76033
(817) 641-5530
EIN: 26-3465019
License No. 110025
Medicare No. 672650

USRC College Partnership, LP d/b/a Baylor
College of Medicine - Scott Street Dialysis
6120 Scott Street Ste F
Houston TX 77021
(713) 741-7059
EIN: 20-8317462
License No. 008624
Medicare No. 672605

USRC Dalton, LLC d/b/a U.S. Renal Care
Dalton Dialysis
1009 Professional Blvd
Dalton GA 30720-2506
(706) 278-1070
EIN: 27-3966564
License No. ESRD001109
Medicare No. 11-2524

USRC Delta, LP d/b/a U.S. Renal Care
Delta Dialysis
400 East Edinburg Blvd
Elsa, TX 78543
(956) 581-8489
EIN: 56-2584922
License No. 008419
Medicare No. 67-2557

USRC Downtown San Antonio, LLC d/b/a
U.S. Renal Care Downtown San Antonio
Dialysis
343 W Houston St Ste 209
San Antonio TX 78205
(210) 251-2824
EIN: 26-3721871
License No. 110024
Medicare No. 67-2672

USRC Eagle Pass, LLC d/b/a U.S. Renal
Care Maverick County Dialysis
3420 Amy Street
Eagle Pass, TX 78852
(830) 773-8878
EIN: 56-2533704
License No. 008305
Medicare No. 67-2534

USRC East Ft Worth LP d/b/a U.S. Renal
Care Tarrant Dialysis East Fort Worth
6450 Brentwood Stair Rd
Fort Worth Texas 76112
(817) 888-3015
EIN: 27-3360902
License No. 110078
Medicare No. Pending

USRC Edinburg, LP d/b/a U.S. Renal Care
Edinburg Dialysis
206 Conquest
Edinburg, TX 78539
(956) 383-8488
EIN: 41-2166757
License No. 008539
Medicare No. 45-2890

USRC Friendswood Dialysis, LLC d/b/a
U.S. Renal Care Friendswood Dialysis
3324 E FM 528
Friendswood TX 77546
(281) 993-5067
EIN: 26-1527903
License No. 008692
Medicare No. 672624

USRC Gateway Dialysis, LLC d/b/a U.S.
Renal Care Gateway Dialysis
7171 New Hwy 90 West Suite 101
San Antonio, TX 78227
(210) 673-9200
EIN: 26-2064040
License No. 008664
Medicare No. 45-2851

USRC Grove, LLC d/b/a U.S. Renal Care
Grove Dialysis
1200 NEO Loop Suite B&C
Grove OK 74344
(918) 787-2900
EIN: 27-2194282
License No. N/A
Medicare No. 37-2583

USRC Harlingen, LP d/b/a U.S. Renal Care
Harlingen Dialysis
4302 E. Sesame Drive
Harlingen, TX 78550
(956) 365-4103
EIN: 41-2166755
License No. 008196
Medicare No. 45-2817

USRC Kingwood, LP d/b/a U.S. Renal Care
Kingwood Dialysis
24006 Hwy 59 North
Kingwood TX 77339
(713) 741-7059
EIN: 20-8996067
License No. 008603
Medicare No. 672604

USRC Laredo South LP d/b/a U.S. Renal
Care Laredo South Dialysis
4602 Ben Cha Road
Laredo, TX 78041
(956) 668-8484
EIN: 20-5786850
License No. 008497
Medicare No. 67-2566

USRC Laredo, LP d/b/a U.S. Renal Care
Laredo Dialysis
6801 McPherson Road Suite 107
Laredo, TX 78041
(956) 725-1202
EIN: 41-2166761
License No. 008197
Medicare No. 45-2823

USRC McAllen, LP d/b/a U.S. Renal Care
McAllen Dialysis
1301 East Ridge Road Suite C
McAllen, TX 78503
(956) 668-8484
EIN: 41-2166763
License No. 008198
Medicare No. 45-2820

USRC Medina County Dialysis, LLC d/b/a
U.S. Renal Care Medina County Dialysis
3202 Avenue G
Hondo, TX 78861
(830) 426-3843
EIN: 26-2175292
License No. 007311
Medicare No. 45-2765

USRC Mid Valley Weslaco LP d/b/a U.S.
Renal Care Mid Valley Weslaco Dialysis
1005 South Airport Drive
Weslaco, TX 78596
(956) 581-8489
EIN: 41-2166767
License No. 008429
Medicare No. 45-2870

USRC Mineral Wells, LP d/b/a U.S. Renal
Care Tarrant Dialysis Mineral Wells
2611 Highway 180 West
Mineral Wells TX 76067
(940) 468-2704
EIN: 26-4113811
License No. 110043
Medicare No. 67-2660

USRC Mission, LP d/b/a U.S. Renal Care
Mission Dialysis
1300 S Bryan Rd Suite 107
Mission, TX 78572-6626
(956) 581-8489
EIN: 41-2166764
License No. 110005
Medicare No. 67-2502

USRC Murray County, LLC d/b/a U.S.
Renal Care Murray County Dialysis
108 Hospital Dr
Chatsworth GA 30705-2058
(706) 517-4818
EIN: 27-3989608
License No. ESRD001178
Medicare No. 11-2685

USRC N Richland Hills LP d/b/a U.S. Renal
Care Tarrant Dialysis North Richland Hills
6455 Hilltop Drive Suite 112
North Richland Hills, TX 76180-6039
(817) 877-3934
EIN: 16-1774637
License No. 008430
Medicare No. 67-2554

USRC Rio Grande LP d/b/a U.S. Renal Care
Rio Grande Dialysis
2787 Pharmacy Road
Rio Grande City, TX 78582
EIN: 41-2166762
(956) 487-2929
EIN: 41-2166762
License No. 008668
Medicare No. 45-2664

USRC SA Bandera Road LLC d/b/a U.S.
Renal Care Bandera Road Dialysis
7180 Bandera Road
San Antonio, TX 78238
(210) 403-9493
EIN: 90-0185327
License No. 008087
Medicare No. 45-2895

USRC SA Houston Street, LLC d/b/a U.S.
Renal Care Houston Street Dialysis
2011 East Houston Street Suite 102d
San Antonio, TX 78202
(210) 225-0004
EIN: 34-2011633
License No. 008134
Medicare No. 67-2506

USRC SA Pleasanton Road, LLC d/b/a U.S.
Renal Care Pleasanton Road Dialysis
1515 Pleasanton Road
San Antonio, TX 78221
(210) 922-6255
EIN: 20-8968868
License No. 008588
Medicare No. 67-2510

USRC SA Tri County LLC d/b/a U.S. Renal
Care Tri County Dialysis
14832 Main Street
Lytle, TX 78052
(830) 772-5784
EIN: 42-1639878
License No. 008135
Medicare No. 67-2507

USRC San Benito Dialysis Ltd d/b/a U.S.
Renal Care San Benito Dialysis
295 North Sam Houston
San Benito, TX 78586
(956) 668-8484
EIN: 41-2166758
License No. 008215
Medicare No. 67-2514

USRC SW Ft Worth LP d/b/a U.S. Renal
Care Tarrant Dialysis Southwest Fort Worth
5127 Old Granbury Road
Fort Worth, TX 76133-2017
(817) 877-3934
EIN: 16-1774638
License No. 008443
Medicare No. 67-2559

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis Central Fort Worth
4201 East Berry Street Suite 8
Fort Worth, TX 76105
(817) 531-0326
EIN: 87-0746621
License No. 008457
Medicare No. 45-2799

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis Fort Worth
501 College, Suite 100
Fort Worth, TX 76104
(817) 877-5907
EIN: 87-0746621
License No. 008467
Medicare No. 45-2579

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis Grand Prairie
1006 North Carrier Parkway
Grand Prairie, TX 75050
(972) 263-7202
EIN: 87-0746621
License No. 008468
Medicare No. 45-2855

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis Mansfield
1800 Hwy 157 North Suite 101
Mansfield, TX 76063-3930
(682) 518-0126
EIN: 87-0746621
License No. 008464
Medicare No. 45-2896

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis North Fort Worth
1978 Ephriham Avenue
Fort Worth, TX 76106-6670
(817) 624-7811
EIN: 87-0746621
License No. 008454
Medicare No. 45-2838

USRC Tarrant LP d/b/a U.S. Renal Care
Tarrant Dialysis South Fort Worth
12201 Bear Plaza
Burleson, TX 76028
(817) 293-1978
EIN: 87-0746621
License No. 110071
Medicare No. 45-2637

USRC Tarrant, LP d/b/a U.S. Renal Care
Tarrant Dialysis Arlington
203 West Randol Mill Road
Arlington, TX 76011
(817) 275-7787
EIN: 87-0746621
License No. 008463
Medicare No. 45-2580

USRC Tarrant, LP d/b/a U.S. Renal Care
Tarrant Dialysis Tarrant County
501 College, Suite 200
Fort Worth, TX 76104
(817) 877-1515
EIN: 87-0746621
License No. 008466
Medicare No. 45-2656

USRC Tonawanda, Inc. d/b/a U.S. Renal
Care Tonawanda Dialysis
3161 Eggert Rd
Tonawanda NY 14150
(716) 832-0159
EIN: 27-0789780
Medicare No. 33-2685

USRC Valley McAllen LP d/b/a U.S. Renal
Care Valley McAllen Dialysis
2000 S. Cynthia
McAllen, TX 78503
(956) 994-3374
EIN: 41-2166760
License No. 008199
Medicare No. 45-2872

USRC Weatherford LP d/b/a U.S. Renal
Care Tarrant Dialysis Weatherford
504 Santa Fe Drive
Weatherford, TX 76086-6503
(817) 594-2832
License No. 008567
Medicare No. 67-2543

USRC West Fort Worth Dialysis LP d/b/a
U.S. Renal Care Tarrant Dialysis West Fort
Worth
1704 S Cherry Lane Suite 200
White Settlement, TX 76108-3629
(817) 367-0822
EIN: 26-1527980
License No. 008649
Medicare No. 672637

USRC Westover Hills, LLC d/b/a U.S.
Renal Care Westover Hills Dialysis
11212 State Highway Building Two Suite
100
San Antonio TX 78216
(210) 521-5923
EIN: 27-3170218
License No. 110073
Medicare No. Pending

USRC Williamsville, Inc. d/b/a U.S. Renal
Care Williamsville Dialysis
7964 Transit Rd Suite 8-A
Williamsville NY 14221
(716) 634-1841
EIN: 27-0789979
Medicare No. Pending

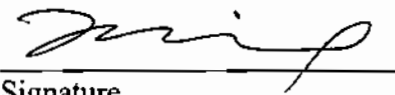
ATTACHMENT 11

BACKGROUND OF THE APPLICANT

USRC Plainfield, LLC

As required by 77 Ill. Admin. Code § 1110.230; I certify that no adverse actions have been taken against USRC Plainfield, LLC, or any facility owned or operated by the Applicant, by Medicare, Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of this Certificate of Need application; and

As required by 77 Ill. Admin. Code § 1110.230; I authorize the Illinois Health Facilities and Services Review Board and Illinois Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information related to this Certificate of Need application.



Signature

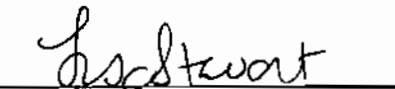
Thomas L. Weinberg

Printed Name

Manager

Title

Subscribed and sworn to before me this 12th day of June, 2012



Signature of Notary

Seal



ATTACHMENT 12

PURPOSE OF THE PROJECT

The purpose of this project is to keep dialysis services accessible to a growing ESRD population in Will County (HSA 9) and to ensure convenient access to dialysis services within HSA 9. The market area that U.S. Renal Care Plainfield Dialysis will serve is primarily a five mile radius around the facility. This facility is needed to accommodate the 54 ESRD patients that Applicant has identified from this area who will require dialysis services in the 24 months following project completion (approximately 27 patients annually). Applicant also anticipates that other physicians will refer ESRD patients for treatment at the proposed facility resulting in utilization of the facility in excess of the state standard. U.S. Renal Care Plainfield Dialysis will help alleviate this need by making 13 additional stations available to ESRD patients.

In addition, this increase in ESRD patients is based upon current patient populations and does not include future patients that present with diagnoses of CKD4 or CKD5. As such, additional dialysis stations are required to meet the needs of these patients. The goal of U.S. Renal Care Plainfield Dialysis is to keep dialysis access available to this patient population as we continue to monitor the growth and provide responsible health care planning for this area.

ATTACHMENT 13

ALTERNATIVES

Alternative Options

1. A project of greater or lesser scope and cost

Projects of greater and lesser scope were considered in the planning stages of this project. The alternative of a project of lesser scope would not sufficiently meet the ESRD station need identified by the Applicant. As indicated in the Purpose of the Project section, Applicant has identified 54 pre-ESRD patients that are anticipated to require dialysis services in the 24 months following project completion (approximately 27 patients annually) and anticipates that other physicians will also refer ESRD patients to the proposed facility. This increase in ESRD patients is based upon current patient populations and does not include future patients that may present with diagnoses of CKD4 or CKD5. As such, additional dialysis stations are required to meet the needs of these patients.

2. Pursuing an alternative 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

The operating model for this project is consistent with the standard that U.S. Renal Care has implemented in various states. This model allows U.S. Renal Care to provide the quality patient care services required by its patients while controlling costs. Pursuing an alternate arrangement for the provision of these services may negate this proven operating model or otherwise dilute the benefits realized by patients of U.S. Renal Care.

3. Utilizing other health care resources that are available to serve all or a portion of the population the Project proposes to serve

Patients who require dialysis treatment are limited in their options to utilize other health care resources. Due to the high frequency of required treatment (3 treatments per week) and length of treatment, patients must be able to access conveniently located and effective facilities. For example, an incremental increase in drive time of 10 minutes would result an annual drive time increase of 52 hours.

Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, 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. (See Attached Comparison Chart)

Comparison of Project to Alternative Options

Proposed Project	Alternative	Cost	Patient Access	Quality	Financial Benefits
Establish U.S. Renal Care Plainfield Dialysis	Project of Lesser Scope / No Project	Cost: \$0 Alternative Option presents less cost to Applicant but may result in additional costs to patients in the form of travel time and lack of access to the desired provider of dialysis services.	Alternative Option results in reduction in patient access as ESRD patient population growth exceeds Station growth.	Alternative Option results in reduction in quality as ESRD patient population growth exceeds Station growth.	Alternative Option does not result in greater financial benefit to any stakeholders (patients, the state, Applicant).
Establish U.S. Renal Care Plainfield Dialysis	Alternative Joint Venture or other Arrangement	Cost: $\approx$ \$2,725,363 Alternative Option would result in the same or similar total cost as the proposed project but distribute such costs among different parties.	Alternative Option would result in the same increased patient access as the proposed project.	Alternative Option would likely result in decreased quality as the provision of care through such an arrangement would represent a deviation from the proven model for the delivery of care established by Applicant.	Alternative Option does not result in greater financial benefit to any stakeholders (patients, the state, Applicant).
Establish U.S. Renal Care Plainfield Dialysis	Use Existing Resources	Cost: \$0 Alternative Option presents less cost to Applicant but may result in additional costs to patients in the form of travel time and lack of access to the desired provider of dialysis services.	Alternative Option results in reduction in patient access as ESRD patient population growth exceeds Station growth.	Alternative Option results in reduction in quality as ESRD patient population growth exceeds Station growth.	Alternative Option does not result in greater financial benefit to any stakeholders (patients, the state, Applicant).

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

Applicant maintains high levels of clinical quality for dialysis patients, on a corporate level U.S. Renal Care has accomplished a three month average patient outcomes of 95% of patients with a URR $\geq$ 65% and 97% of patients with Kt/V $\geq$ 1.2 for the period ending March 31, 2012. Applicant anticipates similar patient outcomes for the proposed project.

ATTACHMENT 14

SIZE OF THE PROJECT

Size of Project				
Department/Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
In-Center Hemodialysis	499 dgsf/Station	360-520 dgsf/Station	-21 dgsf/Station	Yes

The amount of physical space for the proposed project is necessary, and not excessive, for the provision of hemodialysis services. The 499 dgsf/station of the proposed project falls well within the state standard.

ATTACHMENT 15

PROJECT SERVICES UTILIZATION

Utilization					
	Dept/Service	Historical Utilization/Patient Days etc.	Projected Utilization	State Standard	Met Standard?
Year 1	In Center Hemodialysis	N/A	30 patients / 38%	80%	NO
Year 2	In Center Hemodialysis	N/A	63 patients / 81%	80%	YES

Applicant has identified 631 current patients in the area with diagnoses of CKD3, CKD4 or CKD5. Of these patients, Applicant estimates that approximately 54 patients will require dialysis services in the 24 months following project completion (approximately 27 patients annually). Based on Applicant's experience 10% of CKD 3, 50% of CKD 4 and 80% of CKD 5 will require dialysis services within 3 years. When this project is completed, most all of the patients Applicant has identified will require dialysis services within 2 years following project completion. Applicant also anticipates that other physicians will refer ESRD patients for treatment at the proposed facility resulting in utilization of the facility in excess of the state standard.

ATTACHMENT 26

PLANNING AREA NEED

As indicated in the Purpose of the Project section, Applicant has identified 54 pre-ESRD patients that are anticipated to require dialysis services in the 24 months following project completion (27 patients annually). This increase in ESRD patients is based upon current patient populations and does not include future patients that may present with diagnoses of CKD4 or CKD5. As such, additional dialysis stations are required to meet the needs of these patients.

ATTACHMENT 26

PLANNING AREA NEED – SERVICE TO PLANNING AREA RESIDENTS

USRC Plainfield, LLC proposes to establish a thirteen (13) station in-center hemodialysis and peritoneal dialysis facility at 13717 U.S. Route 30, Plainfield, Illinois 60544. The facility will utilize leased space to be built out by Applicant. The facility will provide both in-center hemodialysis and peritoneal dialysis for patients with End Stage Renal Disease to provide necessary health care to the residents of Will County and HSA 9, where the proposed project will be physically located. The market area that U.S. Renal Care Plainfield Dialysis will serve is primarily a five mile radius around the facility.

ATTACHMENT 26

PLANNING AREA NEED – SERVICE DEMAND – ESTABLISHMENT OF CATEGORY OF SERVICE

Projected Referrals – Attached in Appendix 1 are physician referral letters attesting to the physicians' total number of patients who have received care at existing facilities located in the area; the number of new patients located in the area that the physicians referred for in-center hemodialysis for the most recent year; and an estimated number of patients that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physicians' practice experience.

ATTACHMENT 26

PLANNING AREA NEED – SERVICE ACCESSIBILITY

The planning area for the proposed facility possesses several factors which contribute to service restrictions for patients in the area.

Observed ESRD Prevalence Rates in Certain Populations

ESRD differentially affects certain populations at rates higher than other populations. For example, ESRD prevalence rates are considerably higher among African-American and Hispanic demographic segments than among non-Hispanic white demographic segments. The African-American ESRD rate has been reported to be 3.6 times that among whites in the United States¹ at 5,205 per million population.² Similarly, peer reviewed academic articles demonstrate that ESRD prevalence among the Hispanic population, documented at a rate of 2,458 per million population, is materially higher than that of non-Hispanics.³ The clinical literature has noted:

a particularly rapid concomitant increase in the incidence and prevalence of end-stage renal disease (ESRD) in Hispanics observed in the United States during the last 2 decades. Compared with non-Hispanic whites, the incidence of ESRD in Hispanics is nearly 2-fold higher. Because of the high frequency of risk factors for ESRD in US Hispanics (eg, diabetes mellitus), it is anticipated that the Hispanic ESRD population will continue to undergo substantial growth.

Michael J. Fischer et al., CKD in Hispanics: Baseline Characteristics From the CRIC (Chronic Renal Insufficiency Cohort) and Hispanic-CRIC Studies, 58(2) Am. J. Kidney Dis. 214, at 214 (2011).

Obviously, if the 2-fold factor for incidence in this study is accurate, it contributes to the need determination issue, described below, in not taking into account any increased prevalence for Hispanics when the Hispanic population percentage grows. As a result, communities that demonstrate a growth in both the absolute number and percentage make-up of populations at higher risk for ESRD will experience a greater need for ESRD services.

In addition to ethnic prevalence rates, aging populations have also been associated with higher prevalence of ESRD. In 2008, populations aged 65 years and over experienced ESRD prevalence rates that were greater than 3.0 times the overall population.⁴ Specifically, the ESRD prevalence rate for populations aged 65 to 74 years was 5,940.9 per million population as compared to an overall ESRD prevalence rate of 1,698.6 per million population. Similarly, the ESRD prevalence rate for populations aged 75 years and greater was 5,266.4 per million

¹ U.S. Renal Data Service, 2010 Annual Data Report: Volume 2 Atlas of End Stage Renal Disease, at 255.

² *Id.* at 259.

³ U.S. Renal Data Service, 2010 Annual Data Report: Volume 2 Atlas of End Stage Renal Disease, at 255-259; Claudia M. Lora et al., Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem, 19 Ethnicity & Disease 466, at 466 (2009); Michael J. Fischer et al., CKD in Hispanics: Baseline Characteristics From the CRIC (Chronic Renal Insufficiency Cohort) and Hispanic-CRIC Studies, 58(2) Am. J. Kidney Dis. 214, at 214 (2011).

⁴ See U.S. Renal Data Service, 2010 Annual Data Report: Volume 2 Atlas of End Stage Renal Disease, at 258.
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population.⁵

These differential rates of ESRD prevalence related to both ethnicity and age result in greater need for ESRD services when populations are composed of greater numbers of individuals who experience higher rates of ESRD prevalence, as is demonstrated below for HSA 9.

Demographic Profile of HSA 9

The change in the demographic profile of HSA 9 requires additional stations to ensure that dialysis services are available to area residents. The Need Determination does not sufficiently take into account the demographic mix of the HSA population and may understate the need for ESRD stations in the relevant HSA.

Ethnic Profile

The changing ethnic profile of HSA 9 increases the need for ESRD services in this area. As described above, the prevalence of ESRD differs between various ethnic groups which will affect a population's overall ESRD rate as the ethnic mix of the population changes. The communities comprising HSA 9 have undergone significant changes in the ethnic mix between the years 2000 and 2010. As demonstrated in Table 1 below, HSA 9 has seen a dramatic increase in both the "Hispanic or Latino" and "Black or African American alone" populations as tabulated using Census 2000 and 2010 data. Between 2000 and 2010, the "Hispanic or Latino" and "Black or African American alone" populations grew by over 80,000 individuals and 30,000 individuals, or by 153.8% and 44.3%, respectively. As a result of this explosive diversification of HSA 9, the ethnic profile of this HSA has changed dramatically. In particular, the "Hispanic and Latino" segment of the total population has been significant, expanding from 7.8% to 14.4% in HSA 9. As the populations above suffer from a higher prevalence of ESRD, the increase in such populations and resulting changing ethnic profile of HSA 9 increases the need for ESRD services in this area.

Table 1

HSA 9 Population by Race (2000 Census data)

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

HSA 9 Population by Race (2010 Census data)

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

⁵U.S. Renal Data Service, 2010 Annual Data Report: Volume 2 Atlas of End Stage Renal Disease, Figure 2.12 available at www.usrds.org/2010/exe/v2_02.zip.
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HSA 9 Population by Race (2000-2010 Change)

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

The location of the proposed project, Plainfield, currently maintains a "Hispanic or Latino" population of 10.7% of the total population. In terms of the demographic make-up of this area, the Plainfield area has seen a dramatic increase in the population of Hispanic or Latino origin, increasing 743% from 504 individuals in 2000 to 4,247 individuals in 2010. This increase represents a change from 3.9% of the total Plainfield population in 2000 to 10.7% of the population in 2010. Similarly, the Plainfield area has seen a dramatic increase in the "Black or African American alone" population, which has seen an increase of 1,902% from 110 individuals in 2000 to 2,202 individuals in 2010. This increase represents a change from 0.8% of the total Plainfield population in 2000 to 5.6% of the population in 2010.

Age Profile

The changing age profile of HSA 9 also increases the need for ESRD services in this area. As discussed above, individuals 65 years of age and over experience prevalence of ESRD at a greater rate than those under 65 years of age. In HSA 9, this population has grown between 2000 and 2010 and now comprises a greater proportion of the overall population, as demonstrated in the Table 2 below. In HSA 9, the population 65 years of age and over has grown by 27,543 individuals, representing a growth of 42.7%. The growth in these populations represents a significant aging of these communities and will result in greater need for ESRD services.

Table 2**HSA 9 Population by Age Group (2000 Census Data)**

Age Group	Grundy County	Kankakee County	Kendall County	Will County	Total Population
64 and under	32,928	90,249	49,909	460,656	633,742
Between 65 and 74	2,292	6,996	2,474	22,690	34,452
75 and over	2,315	6,588	2,161	18,920	29,984
Total Population	37,535	103,833	54,544	502,266	698,178

HSA 9 Population by Age Group (2010 Census Data)

Age Group	Grundy County	Kankakee County	Kendall County	Will County	Total Population
64 and under	44,517	98,212	106,354	614,746	863,829
Between 65 and 74	3,117	7,952	5,115	36,418	52,602
75 and over	2,429	7,285	3,267	26,396	39,377
Total Population	50,063	113,449	114,736	677,560	955,808

Need Determination for the In-Center Hemodialysis Category of Service

The increased ESRD prevalence rate for certain populations and the demographic shift that has occurred within HSA 9 results in an increased demand for ESRD stations above and beyond the number of stations calculated by the Need Determination for the In-Center Hemodialysis

Category of Service (the "Need Determination"). The Need Determination, as currently formulated in 77 Ill. Admin. Code §1100.630, is based on the assumption that at the baseline time the existing rate of patients experiencing dialysis should determine future need. As such, if the population of the HSA increases, the need for stations increases proportionately (increased by a factor of 1.33 in the five year Need Determination). This approach may be reasonable if the demographic mix at the baseline time and predicted time are identical. But if the demographic mix changes and prevalence is not identical across population subgroups, it will not account for the change in mix. As such, variations in the demographic mix may result in increased station need.

An illustrative example of the effect of demographic mix changes can be provided through an examination of ESRD station need for incremental populations. As indicated in the following graphics, if a population increases by 100,000 individuals and the ESRD prevalence rate is assumed to be 1,699 per million population (representing the Overall Prevalence of ESRD as reported by the U.S. Renal Data Service), then the resulting station need to accommodate this population is 28 stations. If, however, the ESRD prevalence rate is adjusted to 4.718 per million population to account for populations with higher prevalence of ESRD (representing a mixed average of ESRD prevalence in high risk populations as reported by the U.S. Renal Data Service) then the resulting station need required to accommodate this incremental 100,000 individuals is 79 stations.

As a result, the failure of the Need Determination to take into account future variations in the demographic mix and the increased ESRD prevalence rate for certain populations renders the Need Determination insufficient to determine future need of ESRD stations.

CHRONIC KIDNEY DISEASE IN UNITED STATES HISPANICS: A GROWING PUBLIC HEALTH PROBLEM

Hispanics are the fastest growing minority group in the United States. The incidence of end-stage renal disease (ESRD) in Hispanics is higher than non-Hispanic Whites and Hispanics with chronic kidney disease (CKD) are at increased risk for kidney failure. Likely contributing factors to this burden of disease include diabetes and metabolic syndrome, both are common among Hispanics. Access to health care, quality of care, and barriers due to language, health literacy and acculturation may also play a role. Despite the importance of this public health problem, only limited data exist about Hispanics with CKD. We review the epidemiology of CKD in US Hispanics, identify the factors that may be responsible for this growing health problem, and suggest gaps in our understanding which are suitable for future investigation. (*Ethn Dis.* 2009;19:466-472)

Key Words: Chronic Kidney Disease, Hispanics, Health Care Disparities

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INTRODUCTION

Between 2004 and 2005, the number of Hispanic in the United States grew by 3.6 percent to reach a total of 42.7 million (representing nearly 15% of the total US population), making this the fastest growing segment of the population in the country.¹ A large increase has also occurred in the Hispanic end stage renal disease (ESRD) population. According to United States Renal Data System (USRDS), in 2005, there were 12,000 new cases of ESRD treated with dialysis or transplant in Hispanics, representing an increase of 63% since 1996. Hispanics have an incidence rate of ESRD which is 1.5 times greater than for non-Hispanic Whites.² This increase in ESRD cases not only translates into an increased burden to our health care system, but also emphasizes the importance of better understanding risk factors for chronic kidney disease (CKD) in Hispanics. In this review, we examine the epidemiology of CKD in US Hispanics, explore potential reasons for this growing public health problem, and highlight potential areas for future research.

METHODS

We performed a qualitative review of the literature utilizing a PubMed search for the following keywords: chronic kidney disease, Hispanics, Latinos, end stage renal disease, diabetes, dialysis, transplantation, and health care disparities. In addition, we reviewed data from the USRDS^{2,3} and the Organ Procurement and Transplantation Network.⁴ For the purpose of this review, the term Hispanic ethnicity refers to all

Hispanics have an incidence rate of ESRD which is 1.5 times greater than for non-Hispanic Whites.²

persons of Latin American origin living in the United States, unless indicated otherwise. Hispanics are culturally, socioeconomically, and genetically heterogeneous and represent a wide variety of national origins and social classes.⁵ In terms of ancestry, US Hispanics originate from three populations: European settlers, Native Americans, and West Africans. The breakdown for the US Hispanic population is as follows: 64% Mexican, 9% Puerto Rican, 3.5% Salvadoran and 2.7% Dominican.¹ The remainder is of Central American, South American or other Hispanic or Latino origin.

EPIDEMIOLOGY OF CKD IN HISPANICS

Glomerular filtration rate (GFR) estimating equations have been used to determine the prevalence of CKD in the United States. The abbreviated Modification of Diet in Renal Disease (MDRD) equation has been considered to be the most accurate available estimating equation for GFR and has been used widely in the literature and by a growing number of clinical laboratories.⁶ Though the equation has been demonstrated to have validity across a spectrum of different subgroups,⁷ there are no data regarding its validity in

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Hispanics. This is a relevant concern because the serum creatinine concentration, which is used in the MDRD equation to calculate estimated GFR (eGFR), has been demonstrated to differ by racial/ethnic groups. In an analysis of serum creatinine levels in the National Health and Nutrition Examination Survey (NHANES) III, Mexican Americans had lower mean serum creatinine levels than non-Hispanic Whites or non-Hispanic Blacks.⁸ The reasons for these differences are unknown. Similarly, a recent NHANES analysis of serum cystatin C, a potentially more sensitive marker of early kidney dysfunction than serum creatinine, reported lower levels of cystatin C in Mexican Americans compared with other racial/ethnic groups studied.⁹ These differences in the distribution of serum creatinine and cystatin C levels in Hispanics reinforce the importance of rigorously evaluating the accuracy of GFR estimating equations in Hispanics.¹⁰

INCIDENCE AND PREVALENCE OF CKD IN HISPANICS

Mild to Moderate CKD

Information regarding earlier stages of CKD in Hispanics is limited. Several investigators have reported a higher prevalence of microalbuminuria in Hispanics compared with non-Hispanic Whites.¹¹⁻¹³ In contrast to these findings, a recent analysis of NHANES III data suggests that the prevalence of CKD may be lower in Mexican Americans than in non-Hispanic Whites or non-Hispanic Blacks. In an analysis of NHANES III, moderately decreased kidney function (eGFR 30-59 mL/minute/1.73 m²) was most prevalent among non-Hispanic Whites (4.8%) and non-Hispanic Blacks (3.1%) and least prevalent in Mexican Americans (1.0%).¹⁴ Between NHANES 1988 to 1994 and 1994 to 2004, the prevalence of CKD rose among Mexican Americans but

continued to be lower than that observed in non-Hispanic Whites and Blacks.¹⁵

These data are not consistent with the higher prevalence rates of ESRD in Hispanics. One potential explanation is that Hispanics have a higher risk of ESRD because of more rapid progression of CKD after its onset, rather than simply a larger pool of individuals with CKD. The findings could also be related to methodological issues related to the sample size or sampling bias. Furthermore, as discussed earlier, the validity of the MDRD equation has not been established in Hispanics and utilizing the equation in Hispanics could be an important potential source of error. Lastly, NHANES includes only Mexican Americans and these findings may not be generalizable to other Hispanic subgroups.

End Stage Renal Disease (ESRD)

It is well established that Hispanics have a higher prevalence of ESRD than non-Hispanic Whites. The increased prevalence of treated ESRD in Hispanics was first recognized in the 1980s. Using data from the state of Texas, Mexican Americans were found to have an excess of ESRD compared with non-Hispanic Whites with an incidence ratio of 3.¹⁶ For diabetic ESRD, Mexican Americans had an incidence ratio of 6 compared with non-Hispanic Whites. The first study at a national level analyzed male Hispanics identified in Medicare ESRD program data files. Using common Spanish surnames to identify cases, it was found that Hispanics developed ESRD at a younger age than non-Hispanic Whites; and between 1980 and 1990, ESRD incidence rates increased more for Hispanics.¹⁷ In 1995, the USRDS began to acquire data regarding Hispanic ethnicity. In 2006, the adjusted incidence rate for ESRD in Hispanics was 1.5 times higher than for non-Hispanic Whites.² Furthermore, between 1996 and 2005, the incidence rate for Hispanics in-

Table 1. Leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites in 2000³

Primary disease	Hispanics	Non-Hispanic Whites
Diabetes	58.8%	38.8%
Hypertension/large vessel disease	16.2%	23.7%
Glomerulonephritis	9.1%	9.9%
Etiology uncertain	3.5%	4.0%
Other	12.4%	23.6%

creased by 63%.² In contrast, Burrows et al examined trends in age-adjusted ESRD rates and reported that the age-adjusted ESRD rate in Hispanics decreased by approximately 15%, from 2000 to 2005 (530.2 vs 448.9).¹⁸ However, there was an overall increase in the age-adjusted incidence rates in Hispanics in 2005 as compared with 1995 (448.9 vs 395.0). It is apparent that a longer period of follow-up time is needed to better characterize trends. The leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites are described in Table 1. Diabetes accounts for 59% of prevalent cases of ESRD in Hispanic compared with 39% of cases in non-Hispanic Whites.³ Unfortunately, data regarding causes of ESRD by Hispanic subgroup are not available.

The incidence and severity of diabetes are important factors in the excessive incidence of diabetic ESRD observed in Hispanics. The prevalence of diabetes in Hispanics has been estimated to be approximately 1.5 to 3 times that seen in the non-Hispanic White population and its incidence is rising.¹⁹ Moreover, Hispanics have been found to have lower rates of glucose self-monitoring and poorer glycemic control compared with non-Hispanic Whites.²⁰ Hispanics with diabetes may be at increased risk to develop diabetic nephropathy. Mexican American diabetics in San Antonio, Texas had a higher prevalence of proteinuria than non-Hispanic White diabetics from Wisconsin.²¹ However,

no such difference was observed in the San Luis Valley.²² The importance of non-diabetic CKD in Hispanics is not completely understood. Though hypertension is less prevalent in Hispanics, Mexican Americans had the highest rate of uncontrolled hypertension in NHANES III.²³ Data from Texas and the USRDS demonstrate a higher incidence of ESRD due to hypertension in Hispanics than in non-Hispanic Whites.^{16,24}

Progression of CKD in Hispanics

Only limited information is available regarding progression rates and risk factors for CKD in Hispanics. In a multivariable retrospective analysis of a cohort of 263 type 2 diabetic ESRD patients, Mexican ethnicity and female sex were found to hasten the decline of renal function.²⁵ A post hoc analysis of the Reduction of Endpoints in NIDDM with the Angiotensin II Antagonist Losartan Study (RENAAL) found that Hispanics had the highest risk for ESRD compared with Blacks and Whites.²⁶ However, the majority of Hispanics in this study were from Latin American countries and therefore, the findings may not be applicable to US Hispanics. A recent analysis of patients enrolled in Kaiser Permanente of Northern California, a large integrated healthcare delivery system, has clarified the risk of ESRD in US Hispanics with CKD.²⁷ In 39,550 patients with stage 3 to 4 CKD, Hispanic ethnicity was associated with almost a two-fold increased risk for ESRD when compared with non-Hispanic Whites. This increased risk was attenuated to 33% after adjustment for diabetes, medication use, and other characteristics. Thus, the risk for progression to ESRD in Hispanics is only partially explained by diabetes.

Even less is known about progression rates and risk factors for non-diabetic CKD in Hispanics. Some reports suggest that certain glomerular diseases may be more severe and

progress more often in Hispanics than in non-Hispanic Whites.²⁸⁻³⁰ In a recent examination of rates of progression in 128 patients with proliferative lupus nephritis, Barr et al. found that Hispanic ethnicity was independently associated with progression of CKD.³⁰ Another study examining patients with lupus found that Texan-Hispanic ethnicity was more likely to be associated with nephritis than Puerto Rican ethnicity.³¹ This suggests that outcomes can vary by Hispanic subgroup.

US Hispanics have been poorly represented in large prospective CKD studies. The ongoing NIDDK-sponsored Hispanic Chronic Renal Insufficiency Cohort Study (HCRIC) is investigating risk factors for CKD and cardiovascular disease (CVD) progression in a cohort of 326 Hispanics with CKD. This study is based at the University of Illinois at Chicago and is an ancillary study to the NIDDK-sponsored CRIC Study.³²

Metabolic Syndrome and CKD

Recent analyses of NHANES III data found that metabolic syndrome affects over 47 million Americans and that the problem is more pronounced in Hispanics.^{33,34} Mexican Americans have the highest age-adjusted prevalence of metabolic syndrome (31.9%) compared with non-Hispanic Whites (23.8%) and Blacks (21.6%).³³ There is now emerging evidence supporting a relationship between metabolic syndrome and CKD.³⁵⁻³⁸ In a prospective cohort study of Native Americans without diabetes, metabolic syndrome was associated with an increased risk for developing CKD.³⁹ In non-diabetic subjects with normal kidney function enrolled in the Atherosclerosis Risk in Communities Study (ARIC), investigators found an adjusted odds ratio of developing CKD in participants with metabolic syndrome of 1.43 compared with participants who did not have the syndrome.³⁸ These data suggest that metabolic syndrome could be an important factor in the Hispanic CKD population.

DISPARITIES IN HEALTH CARE AND PREVALENCE AND PROGRESSION OF CKD

The importance of healthcare disparities in CKD has received increased recognition,⁴⁰ but little is known regarding the impact of healthcare disparities on health outcomes in Hispanics with CKD. It is well substantiated that there are considerable disparities in health care for Hispanics.²⁰ According to a report by the Commonwealth Fund, nearly two-thirds (65%) of working-age Hispanics with low incomes were uninsured for all or part of the year in 2000.⁴¹ Using NHANES III data, Harris evaluated healthcare access and utilization, and health status and outcomes for patients with type 2 diabetes.²⁰ Mexican Americans below age 65 years had lower rates of health insurance coverage than non-Hispanic Whites and Blacks (66% vs 91% and 89%, respectively). Furthermore, Mexican Americans with private insurance or a high school education or more were more likely to have normoalbuminuria.²⁰ The quality of care received by Hispanics may also play a role in the progression of kidney disease. Hispanics with diabetes are less likely to report having had a foot exam or glycosylated hemoglobin testing.⁴² As noted earlier, Mexican American in NHANES III had the highest rate of uncontrolled hypertension.²³ Lastly, Ifudu et al reported that non-Whites, including Hispanics, are more likely to receive a late referral to a nephrologist for CKD management.⁴³ This study was limited by the low number of Hispanics in the analysis. These findings suggest that quality of care may play a role in the high prevalence of ESRD in this population.

Patient-centered factors may play a particularly important role for Hispanics include language, health care literacy, acculturation, social support, and trust in healthcare providers. Hispanics who are recent immigrants face a number of potential barriers to health care, includ-

ing lack of familiarity with the health-care system and language barriers. Spanish-speaking Hispanics are less likely to be insured, have access to care and use preventive health services.^{41,44} Trust in the healthcare system is another important factor because it has been found to be significantly related to adherence.⁴⁵ Doescher et al found that Hispanics reported significantly less trust in their physician than non-Hispanic Whites.⁴⁶ Finally, social support, defined as resources provided by a network of individuals or social groups, has been found to have direct effects on health status and health service utilization.⁴⁷ There have been no published studies to date focusing on patient-centered factors in Hispanics with CKD. However, it seems reasonable to speculate that these factors amplify CKD and associated CVD risk.

CARDIOVASCULAR DISEASE IN HISPANICS WITH ESRD AND EARLIER STAGES OF CKD

Several studies have found that Hispanics may have lower all-cause and CV mortality rates than non-Hispanic Whites.⁴⁸⁻⁵⁰ The term, Hispanic paradox, has been used to describe the lower than expected mortality rates despite the increased incidence of diabetes and obesity, lower socioeconomic status, and barriers to health care.⁵¹ A number of explanations have been proposed, including socio-cultural factors, ethnic misclassification, incomplete ascertainment of deaths, and the healthy migrant effect.^{36,52} In the ESRD population, Hispanics, Blacks, and Asians have a lower risk of death than non-Hispanic Whites, regardless of diabetes status.^{24,53-55} In a recent analysis of a national, random sample of hemodialysis patients, Hispanics had an adjusted 12-month mortality risk that was 25% lower than non-Hispanic Whites.⁵³ The reasons for the lower

ESRD mortality rates are not completely understood, but differences in survival have been noted among Hispanic subgroups with Mexican-Americans, Cuban Americans and Hispanic-other having an increased survival advantage compared with Puerto Rican Americans.⁵⁶ These findings suggest that sociocultural or genetic differences may play a role in these lower ESRD mortality rates and demonstrating the importance of examining health outcomes in subgroups of Hispanics.

Less is known regarding CVD risk and disease in Hispanics with earlier stages of CKD. An analysis of mortality rates of adults with CKD in NHANES found no difference in CVD or all-cause mortality in Mexican Americans compared with non-Hispanic whites.⁵⁷ In contrast, Hispanic veterans with diabetic CKD experienced a lower 18-month mortality rate than non-Hispanic Whites.⁵⁸ Though Hispanics in Kaiser Permanente of Northern California had an increased rate of ESRD, Hispanic ethnicity was associated with 29% lower adjusted mortality rate and 19% lower adjusted rate of CVD events as compared with non-Hispanic Whites, even after accounting for major cardiovascular risk factors, comorbidities and use of preventative therapies.²⁷ Again, the reasons for these differences are not known.

END-STATE RENAL DISEASE CARE IN US HISPANICS

Dialysis

Analysis of USRDS data reveals that Hispanics are 1.47 times more likely than non-Hispanic Whites to have late initiation of dialysis.⁵⁹ At the start of dialysis, Hispanics tend to have slightly lower hematocrit levels and are 13% less likely to be on erythropoiesis stimulating agents compared with non-Hispanic Whites.⁶⁰ An analysis of a random sample of Medicare eligible adults on hemodialysis in 1997 revealed that, compared with non-Hispanic Whites,

Hispanics on hemodialysis are more likely to be female, younger, and have diabetes.⁶¹ Hispanics tend to have higher albumin levels and similar hematocrit levels compared to non-Hispanic Whites.^{53,61,62}

Little is known about ESRD care in the United State for unauthorized immigrants. Of the 11.8 million unauthorized immigrants in the United States, more than 8.46 million are Hispanic.⁶³ The incidence rate for ESRD for this population is unknown. Many of these undocumented aliens do not receive systematic care before initiation of dialysis. The quality and availability of pre-ESRD care for unauthorized immigrants has not been systematically studied. A small study of undocumented ESRD patients initiating dialysis in New York City found that these patients had higher serum creatinine concentration and lower eGFR, higher systolic blood pressure, and greater costs for the hospitalization associated with the initiation of dialysis.⁶⁴ However, a limitation of this study was that it only included 33 Hispanics. An important issue regarding the dialysis of unauthorized immigrants is the compensation for dialysis, which varies by individual state and may limit the availability of long-term dialysis for undocumented aliens who are then forced to receive dialysis on an emergent basis only.⁶⁵ The cost of care for undocumented ESRD patients receiving dialysis on an emergent basis is 3.7 times higher than for those unauthorized immigrants receiving long-term maintenance dialysis.⁶⁶ End-stage renal disease in unauthorized immigrants is of great public health and economic concern and warrants future research and re-evaluation of current policies.

Transplantation

Limited data exist that suggest that Hispanics are equally likely to be referred for renal transplantation but are less likely to progress beyond the early stages of the transplant evaluation

with some of the reasons including financial concerns, fear of the surgery, and preference for dialysis.⁶⁷ Perhaps for this reason, Hispanics are underrepresented on kidney waiting lists relative to the prevalence of CKD in this population.⁶⁸ Once placed on the transplant wait list, Hispanics have a longer unadjusted median time to transplant than non-Hispanic Whites.⁴ Factors that potentially contribute to the longer time on the wait list include lower rates of organ donations in Hispanics relative to Whites,^{69,70} less knowledge and more fear-related barriers to living organ donation,⁷¹ and ethnic differences in the frequency of HLA alleles coupled with current allocation policies.⁷² Data regarding graft survival in Hispanics have not been uniform, with some studies suggesting that Hispanics and non-Hispanic Whites have similar rates of graft survival,^{73,74} while other studies have demonstrated poorer rates of graft survival in Hispanics.⁷⁵ More recently, Gordon et al found better patient and graft survival in Hispanics compared with non-Hispanics.⁷⁶ Further studies are needed to clarify whether Hispanic ethnicity influences post-transplant outcomes. In addition, policies are needed to address specific barriers within the transplant evaluation process for Hispanics to ensure appropriate access to this important therapy.

Compared with non-Hispanics Whites, Hispanics have an increased incidence of ESRD that appears independent of known clinical risk factors.

CONCLUSION

Chronic kidney disease is a growing and under-recognized health problem for US Hispanics. Compared with non-Hispanics Whites, Hispanics have an increased incidence of ESRD that appears independent of known clinical risk factors. Furthermore, among patients starting at the same level of CKD, Hispanics are at increased risk for progression to ESRD. Interestingly, data from NHANES suggest that the prevalence of CKD with decreased eGFR, at least in Mexican Americans, is lower than in non-Hispanic Whites. The reason for this discrepancy is unclear but could be related to more rapid progression of CKD. Many questions remain unanswered including: factors influencing CKD progression and CVD outcomes; the validity of current GFR estimating equations; insights into differences in outcomes among Hispanic subgroups; and the impact of health care disparities on CKD. For these reasons, future research is needed to better understand the epidemiology and complications of CKD in US Hispanics. Furthermore, it is essential that adequate numbers of US Hispanics are included in future interventional trials to provide the necessary evidence base to guide prevention and therapeutic strategies for CKD and ESRD.

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REFERENCES

1. U.S. Census. Nation's Population One-Third Minority. Available at: <http://www.census.gov/>

Press-Release/www/releases/archives/population/006808.html. 11-17-2008. Last accessed on 2-26-2009.

2. Collins AJ, Foley RN, Herzog C, et al. United States Renal Data System 2008 Annual Data Report Abstract. *Am J Kidney Dis*. 2009;53(1 Suppl):vi-374.
3. United States Renal Data Systems. Available at: http://www.usrds.org/adr_2000.htm. Last accessed on 8-25-2009.
4. Organ Procurement and Transplantation Network. Kidney Kaplan-Meier Median Waiting Times For Registrations Listed: 1999-2004. Available at: <http://www.optn.org/latest/Data/rptStrat.asp>. Last accessed on 8-27-2009.
5. Burchard EG, Borrell LN, Choudhry S, et al. Latino populations: A unique opportunity for the study of race, genetics, and social environment in epidemiological research. *Am J Public Health*. 2005;95(12):2161-2168.
6. Levey AS, Bosch JP, Lewis JB, et al. 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(6):461-470.
7. Stevens LA, Coresh J, Feldman HI, et al. Evaluation of the modification of diet in renal disease study equation in a large diverse population. *J Am Soc Nephrol*. 2007;18(10):2749-2757.
8. Jones CA, McQuillan GM, Kusek JW, et al. Serum creatinine levels in the US population: third National Health and Nutrition Examination Survey. *Am J Kidney Dis*. 1998;32(6):992-999.
9. Kottgen A, Selvin E, Stevens LA, et al. Serum cystatin C in the United States: the Third National Health and Nutrition Examination Survey (NHANES III). *Am J Kidney Dis*. 2008;51(3):385-394.
10. US Renal Data System. *Excerpt from the United States Renal Data System 2006 Annual Data Report*. *Am J Kidney Dis*. 2007;49(1 Suppl 1):A6-296.
11. Wachtell K, Olsen MH, Dahlöf B, et al. Microalbuminuria in hypertensive patients with electrocardiographic left ventricular hypertrophy: the LIFE study. *J Hypertens*. 2002;20(3):405-412.
12. Jones CA, Francis ME, Eberhardt MS, et al. Microalbuminuria in the US population: third National Health and Nutrition Examination Survey. *Am J Kidney Dis*. 2002;39(3):445-459.
13. Bryson CL, Ross HJ, Boyko EJ, Young BA. Racial and ethnic variations in albuminuria in the US Third National Health and Nutrition Examination Survey (NHANES III) population: associations with diabetes and level of CKD. *Am J Kidney Dis*. 2006;48(5):720-726.

14. Corresh J, Astor BC, Greene T, et al. Prevalence of chronic kidney disease and decreased kidney function in the adult US population: Third National Health and Nutrition Examination Survey. *Am J Kidney Dis*. 2003;41(1):1-12.
15. Corresh J, Selvin E, Stevens LA, et al. Prevalence of chronic kidney disease in the United States. *JAMA*. 2007;298(17):2038-2047.
16. Pugh JA, Stern MP, Haffner SM, et al. Excess incidence of treatment of end-stage renal disease in Mexican Americans. *Am J Epidemiol*. 1988;127(1):135-144.
17. Chiapella AP, Feldman HI. Renal failure among male Hispanics in the United States. *Am J Public Health*. 1995;85(7):1001-1004.
18. Burrows NR, Li Y, Williams DE. Racial and ethnic differences in trends of end-stage renal disease: United States, 1995 to 2005. *Adv Chronic Kidney Dis*. 2008;15(2):147-152.
19. Burke JP, Williams K, Gaskill SP, et al. Rapid rise in the incidence of type 2 diabetes from 1987 to 1996: results from the San Antonio Heart Study. *Arch Intern Med*. 1999;159(13):1450-1456.
20. Harris MI. Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes. *Diabetes Care*. 2001;24(3):454-459.
21. Haffner SM, Mitchell BD, Pugh JA, et al. Proteinuria in Mexican Americans and non-Hispanic whites with NIDDM. *Diabetes Care*. 1989;12(8):530-536.
22. Hamman RF, Franklin GA, Mayer EJ, et al. Microvascular complications of NIDDM in Hispanics and non-Hispanic whites. San Luis Valley Diabetes Study. *Diabetes Care*. 1991;14(7):655-664.
23. Hajjar I, Kotchen JM, Kotchen TA. Hypertension: trends in prevalence, incidence, and control. *Annu Rev Public Health*. 2006;27:465-490.
24. Excerpt from the United States Renal Data Systems 2002 annual report: Atlas of end-stage renal disease in the United States. *Am J Kidney Dis*. 2003;41(4 Suppl 2):v-254.
25. Garza R, Medina R, Basu S, Pugh JA. Predictors of the rate of renal function decline in non-insulin-dependent diabetes mellitus. *Am J Nephrol*. 1997;17(1):59-67.
26. de Zeeuw D, Ramjit D, Zhang Z, et al. Renal risk and renoprotection among ethnic groups with type 2 diabetic nephropathy: a post hoc analysis of RENAAL. *Kidney Int*. 2006;69(9):1675-1682.
27. Peralta CA, Shlipak MG, Fan D, et al. Risks for end-stage renal disease, cardiovascular events, and death in Hispanic versus non-Hispanic white adults with chronic kidney disease. *J Am Soc Nephrol*. 2006;17(10):2892-2899.
28. Ingulli E, Tejani A. Racial differences in the incidence and renal outcome of idiopathic focal segmental glomerulosclerosis in children. *Pediatr Nephrol*. 1991;5(4):393-397.
29. Bastian HM, Roseman JM, McGwin G, Jr., et al. Systemic lupus erythematosus in three ethnic groups. XII. Risk factors for lupus nephritis after diagnosis. *Lupus*. 2002;11(3):152-160.
30. Barr RG, Seliger S, Appel GB, et al. Prognosis in proliferative lupus nephritis: the role of socio-economic status and race/ethnicity. *Nephrol Dial Transplant*. 2003;18(10):2039-2046.
31. Fernandez M, Alarcon GS, Calvo-Alen J, et al. A multiethnic, multicenter cohort of patients with systemic lupus erythematosus (SLE) as a model for the study of ethnic disparities in SLE. *Arthritis Rheum*. 2007;57(4):576-584.
32. Feldman HI, Appel LJ, Chertow GM, et al. The Chronic Renal Insufficiency Cohort (CRIC) Study: Design and Methods. *J Am Soc Nephrol*. 2003;14(7 Suppl 2):S148-S153.
33. Ford ES, Giles WH, Dietz WH. Prevalence of the metabolic syndrome among US adults: findings from the third National Health and Nutrition Examination Survey. *JAMA*. 2002;287(3):356-359.
34. Park YW, Zhu S, Palaniappan L, et al. The metabolic syndrome: prevalence and associated risk factor findings in the US population from the Third National Health and Nutrition Examination Survey, 1988-1994. *Arch Intern Med*. 2003;163(4):427-436.
35. Chen J, Muntner P, Hamm LL, et al. The metabolic syndrome and chronic kidney disease in U.S. adults. *Ann Intern Med*. 2004;140(3):167-174.
36. Hunt KJ, Williams K, Resendez RG, et al. All-cause and cardiovascular mortality among diabetic participants in the San Antonio Heart Study: evidence against the "Hispanic Paradox". *Diabetes Care*. 2002;25(9):1557-1563.
37. Lucove J, Vupputuri S, Heiss G, et al. Metabolic syndrome and the development of CKD in American Indians: the Strong Heart Study. *Am J Kidney Dis*. 2008;51(1):21-28.
38. Kurella M, Lo JC, Chertow GM. Metabolic syndrome and the risk for chronic kidney disease among nondiabetic adults. *J Am Soc Nephrol*. 2005;16(7):2134-2140.
39. Norris K, Nissenson AR. Race, gender, and socioeconomic disparities in CKD in the United States. *J Am Soc Nephrol*. 2008;19(7):1261-1270.
40. Norris K, Nissenson A. Racial disparities in chronic kidney disease: tragedy, opportunity, or both? *Clin J Am Soc Nephrol*. 2008;3(2):314-316.
41. Commonwealth Fund. Quality of Health Care for Hispanic Populations: Findings from The Commonwealth Fund 2001 Health Care Quality Survey. Available at: <http://www.commonwealthfund.org/Content/Publications/Other/2002/Mar/Quality-of-Health-Care-for-Hispanic-Populations-A-Fact-Sheet.aspx>. Last accessed on 8-25-2009.
42. Mainous III AG, Diaz VA, Koopman RJ, Everett CJ. Quality of care for Hispanic adults with diabetes. *Fam Med*. 2007;39(5):351-356.
43. Ifuku O, Dawood M, Infel Y, et al. Delayed referral of black, Hispanic, and older patients with chronic renal failure. *Am J Kidney Dis*. 1999;33(4):728-733.
44. DuBard CA, Gizlice Z. Language spoken and differences in health status, access to care, and receipt of preventive services among US Hispanics. *Am J Public Health*. 2008;98(11):2021-2028.
45. Safran DG, Kosinski M, Tarlov AR, et al. The Primary Care Assessment Survey: tests of data quality and measurement performance. *Med Care*. 1998;36(5):728-739.
46. Doescher MP, Saver BG, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. *Arch Fam Med*. 2000;9(10):1156-1163.
47. Lee SY, Arozullah AM, Cho YI. Health literacy, social support, and health: a research agenda. *Soc Sci Med*. 2004;58(7):1309-1321.
48. Stern MP, Bradshaw BS, Eifler CW, et al. Secular decline in death rates due to ischemic heart disease in Mexican Americans and non-Hispanic whites in Texas, 1970-1980. *Circulation*. 1987;76(6):1245-1250.
49. Mitchell BD, Hazuda HP, Haffner SM, et al. Myocardial infarction in Mexican-Americans and non-Hispanic whites. The San Antonio Heart Study. *Circulation*. 1991;83(1):45-51.
50. Liao Y, Cooper RS, Cao G, et al. Mortality from coronary heart disease and cardiovascular disease among adult U.S. Hispanics: findings from the National Health Interview Survey (1986 to 1994). *J Am Coll Cardiol*. 1997;30(5):1200-1205.
51. Markides KS, Stroup-Benham CA, Goodwin JS, et al. The effect of medical conditions on the functional limitations of Mexican-American elderly. *Ann Epidemiol*. 1996;6(5):386-391.
52. Patel KV, Eschbach K, Ray LA, Markides KS. Evaluation of mortality data for older Mexican Americans: implications for the Hispanic paradox. *Am J Epidemiol*. 2004;159(7):707-715.
53. Frankenfield DL, Rocco MV, Roman SH, McClellan WM. Survival advantage for adult Hispanic hemodialysis patients? Findings from the end-stage renal disease clinical performance measures project. *J Am Soc Nephrol*. 2003;14(1):180-186.
54. Lopes AA, Bragg-Gresham JL, Satayathum S, et al. Health-related quality of life and associated outcomes among hemodialysis pa-

- rients of different ethnicities in the United States: the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney Dis.* 2003;41(3):605-615.
55. Young BA, Maynard C, Boyko EJ. Racial differences in diabetic nephropathy, cardiovascular disease, and mortality in a national population of veterans. *Diabetes Care.* 2003;26(8):2392-2399.
56. Frankenfield DL, Krishnan SM, Ashby VB, et al. Differences in mortality among Mexican-American, Puerto Rican, and Cuban-American dialysis patients in the United States. *Am J Kidney Dis.* 2009;53(4):647-657.
57. Mehrotra R, Kermah I, Fried L, et al. Racial differences in mortality among those with CKD. *J Am Soc Nephrol.* 2008;19(7):1403-1410.
58. Young BA, Maynard C, Reiber G, Boyko EJ. Effects of ethnicity and nephropathy on lower-extremity amputation risk among diabetic veterans. *Diabetes Care.* 2003;26(2):495-501.
59. Kausz AT, Obrador GT, Arora P, et al. Late initiation of dialysis among women and ethnic minorities in the United States. *J Am Soc Nephrol.* 2000;11(12):2351-2357.
60. Ward MM. Laboratory abnormalities at the onset of treatment of end-stage renal disease: are there racial or socioeconomic disparities in care? *Arch Intern Med.* 2007;167(10):1083-1091.
61. Frankenfield DL, Rocco MV, Frederick PR, et al. Racial/ethnic analysis of selected intermediate outcomes for hemodialysis patients: results from the 1997 ESRD Core Indicators Project. *Am J Kidney Dis.* 1999;34(4):721-730.
62. Morales LC, Burrows JD, Gizis F, Brommage D. Dietary adherence in Hispanic patients receiving hemodialysis. *J Ren Nutr.* 2007;17(2):138-147.
63. Chartier K. Illegal immigration: The impact on renal care. *Nephrol News Issues.* 2004;18(13):27-8, 30, 32.
64. Coritsidis GN, Khamash H, Ahmed SI, et al. The initiation of dialysis in undocumented aliens: the impact on a public hospital system. *Am J Kidney Dis.* 2004;43(3):424-432.
65. Hurley L, Kempe A, Crane LA, et al. Care of undocumented individuals with ESRD: a national survey of US nephrologists. *Am J Kidney Dis.* 2009;53(6):940-949.
66. Sheikh-Hamad D, Pajuk E, Wright AJ, et al. Care for immigrants with end-stage renal disease in Houston: a comparison of two practices. *Tex Med.* 2007;103(4):54-8, 53.
67. Sequist TD, Narva AS, Stiles SK, et al. Access to renal transplantation among American Indians and Hispanics. *Am J Kidney Dis.* 2004;44(2):344-352.
68. Higgins RS, Fishman JA. Disparities in solid organ transplantation for ethnic minorities: facts and solutions. *Am J Transplant.* 2006;6(11):2556-2562.
69. Breitkopf CR. Attitudes, beliefs and behaviors surrounding organ donation among Hispanic women. *Curr Opin Organ Transplant.* 2009;14(2):191-195.
70. Alvaro EM, Jones SP, Robles AS, Siegel JT. Predictors of organ donation behavior among Hispanic Americans. *Prog Transplant.* 2005;15(2):149-156.
71. Alvaro EM, Siegel JT, Turcotte D, et al. Living kidney donation among Hispanics: a qualitative examination of barriers and opportunities. *Prog Transplant.* 2008;18(4):243-250.
72. Roberts JP, Wolfe RA, Bragg-Gresham JL, et al. Effect of changing the priority for HLA matching on the rates and outcomes of kidney transplantation in minority groups. *N Engl J Med.* 2004;350(6):545-551.
73. Saunders PH, Banowsky LH, Reichert DF. Survival of cadaveric renal allografts in Hispanic as compared with Caucasian recipients. *Transplantation.* 1984;37(4):359-362.
74. Katznelson S, Gjertson DW, Cecka JM. The effect of race and ethnicity on kidney allograft outcome. *Clin Transpl.* 1995;379-394.
75. Press R, Carrasquillo O, Nickolas T, et al. Race/ethnicity, poverty status, and renal transplant outcomes. *Transplantation.* 2005;80(7):917-924.
76. Gordon EJ, Caicedo JC. Ethnic advantages in kidney transplant outcomes: the Hispanic Paradox at work? *Nephrol Dial Transplant.* 2009;24(4):1103-1109.

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CKD in Hispanics: Baseline Characteristics From the CRIC (Chronic Renal Insufficiency Cohort) and Hispanic-CRIC Studies

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Background: Little is known regarding chronic kidney disease (CKD) in Hispanics. We compared baseline characteristics of Hispanic participants in the Chronic Renal Insufficiency Cohort (CRIC) and Hispanic-CRIC (H-CRIC) Studies with non-Hispanic CRIC participants.

Study Design: Cross-sectional analysis.

Setting & Participants: Participants were aged 21-74 years with CKD using age-based estimated glomerular filtration rate (eGFR) at enrollment into the CRIC/H-CRIC Studies. H-CRIC included Hispanics recruited at the University of Illinois in 2005-2008, whereas CRIC included Hispanics and non-Hispanics recruited at 7 clinical centers in 2003-2007.

Factor: Race/ethnicity.

Outcomes: Blood pressure, angiotensin-converting enzyme (ACE)-inhibitor/angiotensin receptor blocker (ARB) use, and CKD-associated complications.

Measurements: Demographic characteristics, laboratory data, blood pressure, and medications were assessed using standard techniques and protocols.

Results: Of H-CRIC/CRIC participants, 497 were Hispanic, 1,650 were non-Hispanic black, and 1,638 were non-Hispanic white. Low income and educational attainment were nearly twice as prevalent in Hispanics compared with non-Hispanics ($P < 0.01$). Hispanics had self-reported diabetes (67%) more frequently than non-Hispanic blacks (51%) and whites (40%; $P < 0.01$). Blood pressure $> 130/80$ mm Hg was more common in Hispanics (62%) than blacks (57%) and whites (35%; $P < 0.05$), and abnormalities in hematologic, metabolic, and bone metabolism parameters were more prevalent in Hispanics ($P < 0.05$), even after stratifying by entry eGFR. Hispanics had the lowest use of ACE inhibitors/ARBs among the high-risk subgroups, including participants with diabetes, proteinuria, and blood pressure $> 130/80$ mm Hg. Mean eGFR was lower in Hispanics (39.6 mL/min/1.73 m²) than in blacks (43.7 mL/min/1.73 m²) and whites (46.2 mL/min/1.73 m²), whereas median proteinuria was higher in Hispanics (protein excretion, 0.72 g/d) than in blacks (0.24 g/d) and whites (0.12 g/d; $P < 0.01$).

Limitations: Generalizability; observed associations limited by residual bias and confounding.

Conclusions: Hispanics with CKD in the CRIC/H-CRIC Studies are disproportionately burdened with lower socioeconomic status, more frequent diabetes mellitus, less ACE-inhibitor/ARB use, worse blood pressure control, and more severe CKD and associated complications than their non-Hispanic counterparts.

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INDEX WORDS: Chronic kidney disease; Hispanics; epidemiology.

Hispanics are now the largest minority group in the United States.¹ Of interest, there also has been a particularly rapid concomitant increase in the incidence and prevalence of end-stage renal disease (ESRD) in Hispanics observed in the United States during the last 2 decades.² Compared with non-

Hispanic whites, the incidence of ESRD in Hispanics is nearly 2-fold higher.² Because of the high frequency of risk factors for ESRD in US Hispanics (eg, diabetes mellitus), it is anticipated that the Hispanic ESRD population will continue to undergo substantial growth.^{3,4}

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Despite the magnitude of this public health problem, little is known regarding earlier stages of chronic kidney disease (CKD) in Hispanics.⁵ A few prior reports have noted that although the prevalence of estimated glomerular filtration rate (eGFR) <60 mL/min/1.73 m² is similar in Hispanics and non-Hispanics, Hispanic ethnicity is associated with higher levels of microalbuminuria and proteinuria and an almost 2-fold higher risk of ESRD in comparison with non-Hispanic whites and blacks.⁶⁻¹⁰ Hispanics have not been well represented in most large prospective studies and clinical trials of CKD; therefore, our understanding of the risk factors, complications, and outcomes associated with CKD in Hispanics is limited.¹¹⁻¹⁵ One exception was a post hoc analysis of the RENAAL (Reduction in End Points in Non-Insulin-Dependent Diabetes With the Angiotensin II Antagonist Losartan) trial, which focused on the role of ethnicity and found that although baseline proteinuria and risk of ESRD were higher in Hispanics compared with non-Hispanic whites and blacks, all ethnic groups achieved renoprotection from losartan therapy after baseline differences in albuminuria were taken into account.¹⁶

The Hispanic Chronic Renal Insufficiency Cohort (H-CRIC) Study, an ancillary study to the multicenter National Institute of Diabetes and Digestive and Kidney Diseases-sponsored Chronic Renal Insufficiency Cohort (CRIC) Study, is the first prospective longitudinal study examining risk factors for the progression of CKD and cardiovascular disease in a sizable cohort of US Hispanics with a broad range of kidney dysfunction.^{17,18} The H-CRIC Study was initiated because of less-than-anticipated recruitment of Hispanics in the CRIC Study and was conducted at the University of Illinois at Chicago because of disproportionately successful Hispanic recruitment into the CRIC Study at this clinical site.¹⁸ In this article, we compare baseline characteristics between Hispanic and non-Hispanic participants in the CRIC and H-CRIC Studies, especially as they pertain to risk factors, complications, and management of CKD.

METHODS

Study Sample and Design

We conducted a cross-sectional comparative analysis of Hispanic and non-Hispanic participants at enrollment into the CRIC and H-CRIC Studies. CRIC is a prospective multicenter cohort study of adults with CKD. Details of the design and methods of the CRIC Study have been published previously.^{17,18} Major eligibility criteria for the CRIC Study included adults aged 21-74 years with mild to moderate CKD using age-based eGFR. Exclusion criteria included inability to consent, New York Heart Association class III or IV heart failure, cirrhosis, human immunodeficiency virus (HIV)/AIDS, polycystic kidney disease, prior dialysis therapy or transplant, immunosuppressive therapy within 6 months, or chemotherapy for cancer within 2 years. The H-CRIC Study adopted eligibility and exclusion criteria identical to the parent CRIC

Study. However, whereas CRIC included 169 Hispanics and 3,289 non-Hispanics recruited at 7 clinical centers from May 2003 through March 2007, H-CRIC included 327 Hispanics recruited at the University of Illinois at Chicago and Chicago metropolitan area from October 2005 through June 2008. Recruitment sites included university-based, community-based, and private health clinics. Both studies were approved by the institutional review boards of the participating centers, and the research was conducted in accordance with the principles of the Declaration of Helsinki. All study participants provided written informed consent.

Variables and Data Sources

H-CRIC Study participants underwent the same evaluation and test strategy as CRIC Study participants, which have been fully described previously,^{17,18} as well as additional evaluations (for only H-CRIC participants) focusing on primary language.¹⁹ Sociodemographic characteristics (eg, age, sex, race/ethnicity, education, annual household income, smoking, and health insurance) were self-reported and recorded at the baseline visit. Medical conditions (eg, hypertension, high cholesterol level, chronic heart failure, peripheral arterial disease, diabetes, myocardial infarction, or coronary revascularization) also were self-reported at baseline. Anthropometric measures (height, weight, body mass index, and waist circumference) were measured by trained study personnel and recorded. Current medications were reviewed and documented. As noted, blood pressure measurements and ankle-brachial indexes were obtained using standard and validated protocols.^{17,18} For each participant at baseline, urine creatinine and protein excretion were determined from a 24-hour urine collection, and eGFR was calculated using the CKD-EPI (CKD Epidemiology Collaboration) estimating equation, using a locally measured serum creatinine level calibrated to the Roche enzymatic method (Roche Diagnostics, Inc, www.roche-diagnostics.us).²⁰ GFR was assessed using renal clearance of 125-iodine iothalamate (measured GFR) in a select subcohort.^{17,18}

Statistical Analysis

Baseline participant characteristics were summarized using mean $\pm$ standard deviation or median and 25th-75th percentile for continuous variables and frequency distribution with percentage for categorical variables. Missing values occurred very infrequently and generally under the following circumstances: (1) a participant failed to answer a question on a reporting form, (2) a physical measure was not obtained, and (3) a laboratory test was not performed. The only variables with $>3\%$ missing values were primary language spoken (17% [percentage missing in Hispanics because language was assessed in only this group]), health insurance (12%), and urine studies (6%). Analyses for each variable included only observed values. Baseline participant characteristics were compared between groups using *t* tests, χ^2 tests, or analysis of variance, as appropriate. A 2-sided *P* < 0.05 was considered statistically significant. All statistical analyses were conducted using SAS, version 9.1 (SAS, www.sas.com).

RESULTS

Baseline Demographic and Clinical Characteristics

H-CRIC and Hispanic CRIC Participants

Of 497 H-CRIC and CRIC Hispanic participants, 69% were Mexican American, 16% were Puerto Rican, and 25% had other Latin American ancestry (Table 1). Proportions of participants with low annual household income ($< \$20,000$ /y), low educational attainment (less than high school diploma),

Table 1. Baseline Demographic and Clinical Characteristics of the H-CRIC and Hispanic CRIC Participants

Variable	Overall (N = 497)	Mexican American (n = 341)	Puerto Rican American (n = 81)	Other (n = 75)	P		
					Mexican vs Puerto Rican	Mexican vs Other	Overall
Age (y)	56.3 ± 11.7	56.0 ± 11.5	55.8 ± 13.4	58.1 ± 10.9	0.9	0.2	0.4
Men	288 (58)	194 (57)	50 (63)	44 (59)	0.4	0.8	0.7
Annual income					<0.01	<0.001	<0.001
≤\$20,000	313 (63)	234 (69)	42 (52)	37 (49)			
\$20,001-\$50,000	92 (19)	55 (16)	20 (25)	17 (23)			
\$50,001-\$100,000	24 (5)	8 (2)	5 (6)	11 (15)			
>\$100,000	12 (2)	4 (1)	4 (5)	4 (5)			
No response	56 (11)	40 (12)	10 (12)	6 (8)			
Education					<0.001	<0.001	<0.001
<7th grade	183 (37)	160 (47)	10 (13)	13 (17)			
7th-12th grade	110 (22)	75 (22)	26 (32)	9 (12)			
High school diploma	71 (14)	45 (13)	13 (16)	13 (17)			
Vocational degree	11 (2)	9 (3)	1 (1)	1 (1)			
Some college	67 (13)	29 (9)	20 (25)	18 (24)			
College graduate	35 (7)	17 (5)	5 (6)	13 (17)			
Graduate degree	20 (4)	6 (2)	6 (7)	8 (11)			
Health insurance					<0.001	0.01	<0.001
None	113 (23)	92 (27)	7 (9)	14 (19)			
Medicaid/public aid	80 (16)	61 (18)	10 (12)	9 (12)			
Any Medicare	119 (24)	80 (23)	24 (30)	15 (20)			
VA/military/Champus	9 (2)	1 (0)	6 (7)	2 (3)			
Private/commercial	67 (13)	40 (12)	8 (10)	19 (25)			
Unknown/incomplete	47 (9)	28 (8)	12 (15)	7 (9)			
Missing	62 (13)	39 (11)	14 (17)	9 (12)			
Primary language spoken					<0.001	<0.001	<0.001
English	86 (17)	56 (16)	21 (26)	9 (12)			
Spanish	327 (66)	260 (76)	33 (41)	34 (45)			
Missing	84 (17)	25 (7)	27 (33)	32 (43)			
Tobacco use							
Current smoker	29 (6)	19 (6)	9 (11)	1 (1)	0.07	0.1	0.03
>100 cigarettes	218 (44)	147 (43)	38 (47)	33 (44)	0.5	0.9	0.8
Medical history							
Hypertension	443 (89)	309 (91)	72 (89)	62 (83)	0.6	0.04	0.1
Diabetes	333 (67)	240 (70)	52 (64)	42 (56)	0.3	0.02	0.04
MI/prior revascularization	90 (18)	55 (16)	17 (21)	18 (24)	0.3	0.1	0.2
Heart failure	37 (7)	21 (6)	10 (12)	6 (8)	0.06	0.6	0.1
PVD	35 (7)	30 (9)	2 (2)	3 (4)	0.05	0.2	0.07
SBP (mm Hg)	136.0 ± 23.7	138.6 ± 24.4	130.5 ± 18.7	130.4 ± 23.6	0.01	0.01	0.01
DBP (mm Hg)	72.6 ± 12.8	73.2 ± 12.8	72.3 ± 12.6	70.2 ± 12.6	0.6	0.07	0.2
MAP (mm Hg)	93.7 ± 14.3	95.0 ± 14.6	91.7 ± 12.9	90.3 ± 13.8	0.07	0.01	0.02
BP >130/80 mm Hg	307 (62)	223 (66)	47 (59)	37 (49)	0.3	0.01	0.02
Weight (kg)	84.7 ± 20.1	84.6 ± 19.9	86.6 ± 23.8	82.9 ± 16.6	0.4	0.5	0.5
BMI (kg/m ²)	31.6 ± 6.6	31.9 ± 6.5	31.4 ± 7.4	30.6 ± 5.8	0.5	0.1	0.3
BMI category					0.5	0.9	0.9
<25 kg/m ²	58 (12)	37 (11)	12 (15)	9 (12)			
25-29.9 kg/m ²	170 (34)	116 (34)	29 (36)	25 (33)			
≥30 kg/m ²	268 (54)	187 (55)	40 (49)	41 (55)			
Waist circumference (cm)	102.7 ± 14.6	103.3 ± 14.5	102.1 ± 16.5	100.8 ± 12.6	0.5	0.2	0.4
Low ankle-brachial index ^a	72 (15)	46 (14)	15 (19)	11 (15)	0.3	0.9	0.5
Kidney function measures							
SCr (mg/dL)	1.88 ± 0.63	1.95 ± 0.65	1.78 ± 0.58	1.66 ± 0.54	0.03	<0.001	<0.001
eGFR (mL/min/1.73 m ²)	39.6 ± 14.9	37.4 ± 13.2	43.3 ± 17.5	45.6 ± 16.9	<0.001	<0.001	<0.001
eGFR category					0.03	<0.001	<0.001
<30 mL/min/1.73 m ²	135 (27)	105 (31)	19 (23)	11 (15)			
30-45 mL/min/1.73 m ²	205 (41)	149 (44)	29 (36)	27 (36)			
45-60 mL/min/1.73 m ²	114 (23)	67 (20)	22 (27)	25 (33)			
≥60 mL/min/1.73 m ²	43 (9)	20 (6)	11 (14)	12 (16)			

(Continued)

Table 1 (Cont'd). Baseline Demographic and Clinical Characteristics of the H-CRIC and Hispanic CRIC Participants

Variable	Overall (N = 497)	Mexican American (n = 341)	Puerto Rican American (n = 81)	Other (n = 75)	P		
					Mexican vs Puerto Rican	Mexican vs Other	Overall
SCysC (mg/L)	1.6 (1.3, 2.1)	1.7 (1.4, 2.1)	1.5 (1.2, 1.9)	1.3 (1.2, 1.7)	<0.001	<0.001	<0.001
Participants with mGFR tothalamate GFR	214 (43) 41.0 ± 18.8	145 (43) 37.1 ± 15.0	35 (43) 46.3 ± 22.0	34 (45) 52.2 ± 24.1	0.9 0.004	0.7 <0.001	0.9 <0.001
Urine studies							
24-h urine creatinine (g/d)	1.1 (0.8, 1.4)	1.1 (0.8, 1.4)	1.1 (0.9, 1.4)	1.1 (0.8, 1.3)	0.8	0.5	0.8
24-h urine protein (g/d)	0.72 (0.12, 3.25)	0.98 (0.19, 3.76)	0.39 (0.11, 1.90)	0.19 (0.07, 2.13)	0.06	0.08	0.05
Diabetics	1.10 (0.22, 4.32)	1.67 (0.26, 4.62)	0.67 (0.18, 2.16)	0.70 (0.13, 3.66)	0.2	0.6	0.4
Nondiabetics	0.26 (0.07, 1.17)	0.67 (0.10, 1.73)	0.12 (0.06, 0.41)	0.11 (0.05, 0.17)	0.1	0.1	0.07
UACR (mg/g) ^b	413.5 (29.8, 2,503.4)	659.9 (47.9, 2,635.8)	220.6 (24.6, 1,519.1)	73.6 (12.5, 1,692.3)	0.1	0.1	0.1
Diabetics	830.0 (70.1, 3,377.5)	1137.5 (77.2, 3,613.7)	363.7 (62.1, 2,309.0)	498.6 (64.0, 2,825.3)	0.2	0.4	0.3
Nondiabetics	85.7 (10.6, 826.8)	262.2 (21.2, 977.7)	43.1 (5.5, 423.7)	16.7 (8.8, 79.1)	0.7	0.4	0.7
Lipoproteins							
Total cholesterol (mg/dL)	189.5 ± 53.7	190.6 ± 53.9	186.8 ± 59.0	187.2 ± 47.0	0.6	0.6	0.8
LDL cholesterol (mg/dL)	103.7 ± 40.0	103.6 ± 40.9	103.6 ± 40.1	104.1 ± 36.2	0.9	0.9	0.9
HDL cholesterol (mg/dL)	43.1 ± 12.9	42.3 ± 12.6	44.9 ± 15.1	44.5 ± 11.3	0.1	0.2	0.2
Triglycerides (mg/dL)	158.0 (120.0, 229.0)	167.0 (124.0, 231.0)	136.0 (108.0, 201.0)	154.0 (115.0, 217.0)	0.05	0.1	0.05
Hemoglobin A _{1c} (%)	7.0 ± 1.7	7.0 ± 1.6	7.2 ± 2.0	6.8 ± 1.7	0.3	0.3	0.3
Hemoglobin (g/dL)	12.1 ± 1.9	11.9 ± 1.9	12.4 ± 1.6	12.6 ± 1.8	0.02	0.002	0.002
Bone metabolism parameters							
Calcium (mg/dL)	9.0 ± 0.5	8.9 ± 0.5	9.1 ± 0.6	9.1 ± 0.5	0.02	0.001	0.001
Phosphate (mg/dL)	4.0 ± 0.7	4.1 ± 0.7	3.7 ± 0.7	3.8 ± 0.7	<0.001	<0.001	<0.001
PTH (pg/mL)	62.0 (41.0, 102.0)	67.2 (46.0, 105.1)	54.0 (35.0, 89.0)	54.4 (35.0, 91.0)	0.1	0.008	0.02

Note: Continuous variables are represented by mean ± standard deviation or median (25th, 75th percentile); categorical variables are given as frequency (percentage). Conversion factors for units: SCr in mg/dL to mmol/L, ×88.4; total/LDL/HDL cholesterol in mg/dL to mmol/L, ×0.02586; hemoglobin in g/dL to g/L, ×10; calcium in mg/dL to mmol/L, ×0.2495; phosphate in mg/dL to mmol/L, ×0.3229; no conversion necessary for PTH in pg/mL and ng/L.

Abbreviations: BMI, body mass index; BP, blood pressure; CRIC, Chronic Renal Insufficiency Cohort; DBP, diastolic blood pressure; eGFR, estimated glomerular filtration rate; GFR, glomerular filtration rate; H-CRIC, Hispanic Chronic Renal Insufficiency Cohort; HDL, high-density lipoprotein; LDL, low-density lipoprotein; MAP, mean arterial pressure; mGFR, measured glomerular filtration rate; MI, myocardial infarction; PTH, parathyroid hormone; PVD, peripheral vascular disease; SBP, systolic blood pressure; SCr, serum creatinine; SCysC, serum cystatin C; UACR, urine albumin-creatinine ratio; VA, Veterans Administration.

^aAnkle-brachial index <0.9.

^bEight percent of values are missing.

and lack of health insurance were significantly higher for Mexican Americans than Puerto Rican Americans and other Latin Americans ($P < 0.02$). Mexican Americans more often spoke primarily Spanish (76%) relative to other Hispanic groups (~43%; $P < 0.001$). Compared with other Hispanic subgroups, prevalences of diabetes and blood pressure >130/80 mm Hg were more frequent in Mexican Americans. Mean eGFR was significantly lower in Mexican Americans (37.4 mL/min/1.73 m²) compared with Puerto Rican Americans (43.3 mL/min/1.73 m²) and other Latin Americans (45.6 mL/min/1.73 m²; $P < 0.001$), and measured GFR results for select participants were consistent with these findings. Median 24-hour urine protein and spot urine albumin-creatinine ratios were substantially higher in Mexican Americans compared with Puerto Rican Americans and other Latin Americans, and these trends persisted in both the diabetic and nondia-

betic subgroups. Compared with other Hispanic subgroups, Mexican Americans had significantly lower serum hemoglobin and calcium and higher serum phosphorus and total parathyroid hormone values ($P < 0.05$).

Comparison With Non-Hispanic White and Black CRIC Participants

Mean age was ~2 years younger in the 497 Hispanic H-CRIC/CRIC participants than in the 1,638 non-Hispanic white and 1,650 non-Hispanic black CRIC participants (Table 2). Compared with non-Hispanic whites and blacks, Hispanics more often had low annual household income, low educational attainment, lack of health insurance, and less current and former tobacco use ($P < 0.05$). The prevalence of diabetes was highest for Hispanics (67%), whereas self-reported history of myocardial infarction/prior revascularization was least prevalent for Hispanics

Table 2. Baseline Demographic and Clinical Characteristics of the H-CRIG/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants^b

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P	
				Hispanic vs White	Hispanic vs Black
Age (y)	56.3 ± 11.7	58.9 ± 11.0	58.1 ± 10.6	<0.001	0.001
Men	288 (58)	982 (60)	806 (49)	0.4	<0.001
Annual income				<0.001	<0.001
≤\$20,000	313 (63)	254 (16)	646 (39)		
\$20,001-\$50,000	92 (19)	416 (25)	417 (25)		
\$50,001-\$100,000	24 (5)	455 (28)	215 (13)		
>\$100,000	12 (2)	295 (18)	62 (4)		
No response	56 (11)	218 (13)	310 (19)		
Education				<0.001	<0.001
<7th grade	183 (37)	7 (0)	20 (1)		
7th-12th grade	110 (22)	83 (5)	417 (25)		
High school diploma	71 (14)	291 (18)	366 (22)		
Vocational degree	11 (2)	73 (4)	102 (6)		
Some college	67 (13)	394 (24)	465 (28)		
College graduate	35 (7)	429 (26)	180 (11)		
Graduate degree	20 (4)	361 (22)	100 (6)		
Health insurance				<0.001	<0.001
None	113 (23)	48 (3)	95 (6)		
Medicaid/public aid	80 (16)	95 (6)	317 (19)		
Any Medicare	119 (24)	561 (34)	488 (30)		
VA/military/Champus	9 (2)	73 (4)	110 (7)		
Private/commercial	67 (13)	290 (18)	190 (12)		
Unknown/incomplete	47 (9)	423 (26)	216 (13)		
Missing	62 (13)	148 (9)	234 (14)		
Primary language spoken				<0.001	<0.001
English	86 (17)				
Spanish	327 (66)				
Missing	84 (17)	1,638 (100)	1,650 (100)		
Tobacco use					
Current smoker	29 (6)	155 (9)	320 (19)	0.01	<0.001
>100 cigarettes	218 (44)	920 (56)	955 (58)	<0.001	<0.001
Medical history					
Hypertension	443 (89)	1,293 (79)	1,533 (93)	<0.001	0.008
Diabetes	334 (67)	649 (40)	848 (51)	<0.001	<0.001
MI/prior revascularization	90 (18)	376 (23)	361 (22)	0.02	0.07
Heart failure	37 (7)	117 (7)	217 (13)	0.8	<0.001
PVD	35 (7)	105 (6)	117 (7)	0.6	0.9
SBP (mm Hg)	136.0 ± 23.7	121.8 ± 18.6	132.9 ± 23.1	<0.001	0.009
DBP (mm Hg)	72.6 ± 12.8	69.0 ± 11.4	73.8 ± 13.8	<0.001	0.08
MAP (mm Hg)	93.7 ± 14.3	86.6 ± 11.8	93.5 ± 14.7	<0.001	0.8
BP >130/80 mm Hg	307 (62)	573 (35)	942 (57)	<0.001	0.05
Weight (kg)	84.7 ± 20.1	90.5 ± 22.7	95.8 ± 24.3	<0.001	<0.001
BMI (kg/m ²)	31.6 ± 6.6	31.2 ± 7.6	33.4 ± 8.3	0.2	<0.001
BMI category				<0.001	<0.001
<25 kg/m ²	58 (12)	310 (19)	217 (13)		
25-29.9 kg/m ²	170 (34)	517 (32)	378 (23)		
≥30 kg/m ²	268 (54)	809 (49)	1048 (64)		
Waist circumference (cm)	102.7 ± 14.6	105.4 ± 17.6	108.0 ± 18.2	0.003	<0.001
Low ankle-brachial index ^a	72 (15)	206 (13)	333 (20)	0.2	0.007

(Continued)

Table 2 (Cont'd). Baseline Demographic and Clinical Characteristics of the H-CRICH/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants^b

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P	
				Hispanic vs White	Hispanic vs Black
Kidney function measures					
SCr (mg/dL)	1.88 ± 0.63	1.59 ± 0.46	1.87 ± 0.63	<0.001	0.8
eGFR (mL/min/1.73 m ²)	39.6 ± 14.9	46.2 ± 14.7	43.7 ± 14.9	<0.001	<0.001
eGFR category				<0.001	<0.001
<30 mL/min/1.73 m ²	135 (27)	245 (15)	322 (20)		
30-<45 mL/min/1.73 m ²	205 (41)	570 (35)	607 (37)		
45-<60 mL/min/1.73 m ²	114 (23)	532 (32)	495 (30)		
≥60 mL/min/1.73 m ²	43 (9)	291 (18)	226 (14)		
SCysC (mg/L)	1.6 (1.3, 2.1)	1.3 (1.1, 1.7)	1.4 (1.1, 1.9)	<0.001	<0.001
Participants with mGFR	214 (43)	585 (36)	525 (32)	0.003	<0.001
Iothalamate GFR	41.0 ± 18.8	50.9 ± 20.3	47.1 ± 19.3	<0.001	<0.001
Urine studies					
24-h urine creatinine (g/d)	1.1 (0.8, 1.4)	1.3 (1.0, 1.7)	1.3 (0.9, 1.7)	<0.001	<0.001
24-h urine protein (g/d)	0.72 (0.12, 3.25)	0.12 (0.07, 0.51)	0.24 (0.08, 1.07)	<0.001	<0.001
Diabetics	1.10 (0.22, 4.32)	0.21 (0.08, 0.90)	0.42 (0.10, 1.63)	<0.001	<0.001
Nondiabetics	0.26 (0.07, 1.17)	0.09 (0.06, 0.28)	0.14 (0.07, 0.63)	<0.001	<0.001
UACR (mg/g) ^b	413.5 (29.8, 2,503.4)	24.5 (6.1, 208.1)	76.9 (11.4, 518.9)	<0.001	<0.001
Diabetics	830.0 (70.1, 3,377.5)	68.1 (14.4, 454.2)	174.9 (20.4, 975.2)	<0.001	<0.001
Nondiabetics	85.7 (10.4, 826.8)	13.2 (5.0, 98.2)	32.5 (7.7, 237.5)	<0.001	<0.001
Lipoproteins					
Total cholesterol (mg/dL)	189.5 ± 53.7	180.1 ± 41.9	185.6 ± 45.7	<0.001	0.1
LDL cholesterol (mg/dL)	103.7 ± 40.0	99.4 ± 32.1	106.1 ± 37.2	0.01	0.2
HDL cholesterol (mg/dL)	43.1 ± 12.9	47.1 ± 15.2	49.3 ± 16.1	<0.001	<0.001
Triglycerides (mg/dL)	158.0 (120.0, 229.0)	133.0 (91.5, 193.0)	112.0 (83.0, 160.0)	<0.001	<0.001
Hemoglobin A _{1c} (%)	7.0 ± 1.7	6.3 ± 1.3	6.9 ± 1.7	<0.001	0.3
Hemoglobin (g/dL)	12.1 ± 1.9	13.2 ± 1.7	12.2 ± 1.7	<0.001	0.2
Bone metabolism parameters					
Calcium (mg/dL)	9.0 ± 0.5	9.2 ± 0.5	9.2 ± 0.5	<0.001	<0.001
Phosphate (mg/dL)	4.0 ± 0.7	3.6 ± 0.6	3.8 ± 0.7	<0.001	<0.001
PTH (pg/mL)	62.0 (41.0, 102.0)	43.0 (30.4, 68.6)	67.2 (41.2, 114.8)	<0.001	0.01

Note: Continuous variables are represented by mean ± standard deviation or median (25th, 75th percentile); categorical variables are given as frequency (percentage). Conversion factors for units: SCr in mg/dL to mmol/L, ×88.4; total/LDL/HDL cholesterol in mg/dL to mmol/L, ×0.02586; hemoglobin in g/dL to g/L, ×10; calcium in mg/dL to mmol/L, ×0.2495; phosphate in mg/dL to mmol/L, ×0.3229; no conversion necessary for PTH in pg/mL and ng/L.

Abbreviations: BMI, body mass index; BP, blood pressure; CRIC, Chronic Renal Insufficiency Cohort; DBP, diastolic blood pressure; eGFR, estimated glomerular filtration rate; GFR, glomerular filtration rate; H-CRICH, Hispanic Chronic Renal Insufficiency Cohort; HDL, high-density lipoprotein; LDL, low-density lipoprotein; MAP, mean arterial pressure; mGFR, measured glomerular filtration rate; MI, myocardial infarction; PTH, parathyroid hormone; PVD, peripheral vascular disease; SBP, systolic blood pressure; SCr, serum creatinine; SCysC, serum cystatin C; UACR, urine albumin-creatinine ratio; VA, Veterans Administration.

^aAnkle-brachial index <0.9.

^bFour percent missing values.

(18%). The prevalence of self-reported hypertension for Hispanics (89%) was between that for non-Hispanic whites (79%) and blacks (93%), whereas blood pressure >130/80 mm Hg at cohort entry was more common for Hispanics (62%) than non-Hispanic whites (35%) and non-Hispanic blacks (57%; $P < 0.05$). Mean glycosylated hemoglobin level in Hispanics (7.0%) was significantly higher than in non-Hispanic whites (6.3%; $P < 0.05$) and similar to that in non-Hispanic blacks (6.9%; $P > 0.05$). Mean

eGFR was significantly lower in Hispanics (39.6 mL/min/1.73 m²) compared with non-Hispanic whites (46.2 mL/min/1.73 m²) and blacks (43.7 mL/min/1.73 m²; $P < 0.001$), and measured GFR results for select participants were consistent with these findings. Median 24-hour urine protein and spot urine albumin-creatinine ratios were substantially higher in Hispanics compared with non-Hispanic whites and blacks, and these trends persisted in both the diabetic and nondiabetic subgroups ($P < 0.001$). Lipoprotein lev-

Table 3. Baseline Frequency of ACEi/ARB Use in H-CRICH/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P		Overall
				Hispanic vs White	Hispanic vs Black	
Overall	67% (332/493)	67% (1,088/1,627)	71% (1,164/1,638)	0.8	0.1	0.03
Control of BP						
>130/80 mm Hg	62% (189/305)	70% (397/567)	70% (650/934)	0.02	0.01	0.03
≤130/80 mm Hg	76% (140/184)	65% (689/1,057)	73% (507/696)	0.004	0.4	<0.001
Presence of diabetes						
Yes	72% (238/331)	81% (524/645)	80% (678/843)	<0.001	0.001	0.001
No	58% (94/162)	57% (564/982)	61% (486/795)	0.9	0.5	0.3
Degree of proteinuria						
>0.3 g/d	67% (172/258)	78% (384/493)	73% (510/701)	<0.001	0.07	0.003
≤0.3 g/d	71% (110/154)	62% (671/1,087)	70% (574/822)	0.02	0.7	<0.001
eGFR level						
<30 mL/min/1.73 m ²	60% (81/135)	75% (183/244)	67% (215/322)	0.002	0.2	0.009
30-45 mL/min/1.73 m ²	74% (149/202)	73% (412/567)	74% (447/605)	0.8	0.9	0.9
45-60 mL/min/1.73 m ²	72% (81/113)	68% (358/526)	75% (367/489)	0.5	0.5	0.05
≥60 mL/min/1.73 m ²	49% (21/43)	47% (135/290)	61% (135/222)	0.8	0.1	0.01

Note: Statistical comparisons made within clinical subgroup strata (eg, eGFR level) across race/ethnicity.

Abbreviations: ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; BP, blood pressure; CRIC, Chronic Renal Insufficiency Cohort; eGFR, estimated glomerular filtration rate; H-CRICH, Hispanic Chronic Renal Insufficiency Cohort.

els, hemoglobin concentrations, and bone metabolism parameters were less favorable in Hispanics compared with non-Hispanic whites and similar to those in non-Hispanic blacks.

Baseline Frequency of ACE-I/ARB Use

Overall, use of angiotensin-converting enzyme (ACE)-inhibitor or angiotensin receptor blocker (ARB) medications was not significantly different among H-CRICH/CRIC participants (Table 3). However, for important subgroups, including those with blood pressure >130/80 mm Hg, diabetes, or urine protein excretion >0.3 g/d, Hispanics consistently had the lowest receipt of ACE-inhibitor/ARB therapy compared with non-Hispanic whites and blacks ($P < 0.05$).

Blood Pressure by eGFR and Albuminuria Strata

Across all eGFR categories and albuminuria strata, the proportion of participants with blood pressure >130/80 mm Hg was significantly higher for Hispanics compared with non-Hispanic white participants ($P < 0.05$; Table 4). However, only in eGFR <30 mL/min/1.73 m² strata was the percentage of Hispanics with blood pressure >130/80 mm Hg significantly higher than that of non-Hispanic blacks ($P < 0.05$), whereas this percentage was not significantly different between these 2 groups for all other eGFR strata. No significant differences were found between proportions of Hispanic and non-Hispanic blacks with blood pressure >130/80 mm Hg across albuminuria strata.

Laboratory Parameters by eGFR and Albuminuria Strata

Across all eGFR categories and albuminuria strata, Hispanic participants had significantly lower serum sodium and bicarbonate levels than non-Hispanic whites and blacks ($P < 0.05$), whereas less pronounced differences existed for serum potassium levels among these groups (Table 5). There were no significant differences in hemoglobin levels between Hispanics and non-Hispanic blacks, but levels were significantly lower in Hispanics compared with non-Hispanic whites across eGFR and albuminuria values ($P < 0.05$). Calcium levels were lower and serum phosphorus levels were higher in Hispanics versus non-Hispanics with eGFR <45 mL/min/1.73 m² or albumin-creatinine ratio ≥30 mg/g ($P < 0.05$). Total intact parathyroid hormone levels for Hispanics generally were significantly higher than for non-Hispanic whites, but lower than for non-Hispanic blacks across eGFR and albuminuria levels. Serum albumin level consistently was the lowest in Hispanics compared with non-Hispanics regardless of eGFR or albuminuria group.

DISCUSSION

We found that in participants with CKD in the CRIC and H-CRICH Studies, Hispanics were disproportionately burdened with lower socioeconomic status, more frequent diabetes mellitus, worse blood pressure control, lower receipt of ACE-inhibitor/ARB medications, and more severe CKD compared with non-Hispanic whites

Table 4. BP in H-CRICH/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P	
				Hispanic vs White	Hispanic vs Black
eGFR Strata					
eGFR <30 (n = 702)					
SBP (mm Hg)	142.3 ± 23.0	123.4 ± 20.4	135.0 ± 25.1	<0.001	0.004
DBP (mm Hg)	73.1 ± 12.7	66.4 ± 12.0	71.6 ± 14.0	<0.001	0.3
MAP (mm Hg)	96.2 ± 14.1	85.4 ± 12.7	92.7 ± 15.3	<0.001	0.03
BP >130/80 mm Hg	98 (73)	84 (35)	191 (60)	<0.001	0.006
eGFR 30-<45 (n = 1,382)					
SBP (mm Hg)	137.1 ± 24.3	123.8 ± 19.1	134.7 ± 23.8	<0.001	0.2
DBP (mm Hg)	72.0 ± 12.9	68.1 ± 11.1	73.1 ± 13.7	<0.001	0.4
MAP (mm Hg)	93.7 ± 14.5	86.6 ± 11.6	93.7 ± 15.1	<0.001	0.9
BP >130/80 mm Hg	126 (62)	216 (38)	349 (58)	<0.001	0.3
eGFR 45-<60 (n = 1,141)					
SBP (mm Hg)	130.8 ± 22.9	121.6 ± 18.4	131.7 ± 21.0	<0.001	0.7
DBP (mm Hg)	72.1 ± 13.3	70.2 ± 11.4	74.0 ± 13.2	0.1	0.2
MAP (mm Hg)	91.7 ± 14.4	87.4 ± 12.0	93.2 ± 13.6	<0.001	0.3
BP >130/80 mm Hg	62 (55)	192 (36)	291 (59)	<0.001	0.4
eGFR ≥60 (n = 560)					
SBP (mm Hg)	125.5 ± 18.8	116.9 ± 15.4	127.8 ± 22.0	0.001	0.5
DBP (mm Hg)	74.7 ± 11.4	70.6 ± 11.1	78.2 ± 14.2	0.02	0.1
MAP (mm Hg)	91.6 ± 12.9	86.0 ± 10.9	94.8 ± 15.5	0.002	0.2
BP >130/80 mm Hg	21 (49)	81 (28)	111 (50)	0.005	0.9
Albuminuria Strata					
UACR <30 mg/g (n = 1,564)					
SBP (mm Hg)	122.0 ± 20.6	118.0 ± 16.3	124.1 ± 19.4	0.02	0.3
DBP (mm Hg)	67.3 ± 12.1	67.8 ± 10.7	70.7 ± 12.5	0.7	0.009
MAP (mm Hg)	85.5 ± 13.2	84.5 ± 10.7	88.5 ± 13.0	0.3	0.03
BP >130/80 mm Hg	44 (38)	228 (27)	255 (42)	0.01	0.5
UACR 30-<300 mg/g (n = 955)					
SBP (mm Hg)	133.2 ± 20.0	122.9 ± 18.5	132.6 ± 22.2	<0.001	0.8
DBP (mm Hg)	69.6 ± 11.9	68.3 ± 11.4	73.6 ± 14.0	0.3	0.01
MAP (mm Hg)	90.8 ± 12.6	86.5 ± 11.6	93.2 ± 14.6	0.001	0.1
BP >130/80 mm Hg	51 (54)	148 (36)	247 (56)	0.001	0.7
UACR ≥300 mg/g (n = 1,110)					
SBP (mm Hg)	143.2 ± 22.9	129.8 ± 21.2	143.2 ± 23.1	<0.001	0.9
DBP (mm Hg)	76.0 ± 12.3	72.5 ± 12.2	77.2 ± 13.9	<0.001	0.3
MAP (mm Hg)	98.4 ± 13.1	91.6 ± 12.9	99.2 ± 14.2	<0.001	0.5
BP >130/80 mm Hg	186 (76)	183 (53)	395 (76)	<0.001	0.8

Note: Continuous variables are represented by mean ± standard deviation; categorical variables are given as frequency (percentage). eGFR given in mL/min/1.73 m².

Abbreviations: BP, blood pressure; CRIC, Chronic Renal Insufficiency Cohort; DBP, diastolic blood pressure; eGFR, estimated glomerular filtration rate; H-CRICH, Hispanic Chronic Renal Insufficiency Cohort; MAP, mean arterial pressure; SBP, systolic blood pressure; UACR, urine albumin-creatinine ratio.

and blacks. In particular, in the setting of CKD, Mexican Americans had especially unfavorable sociodemographic and clinical parameters relative to Puerto Rican Americans and other Latin Americans. Even when level of eGFR was taken into account, Hispanics with CKD more often had uncontrolled blood pressure, lower serum hemoglobin levels, and worse metabolic and bone metabolism parameters than non-Hispanic whites and blacks.

In contrast to prior reports and studies that focused chiefly on populations with ESRD,²⁻⁴ this work is one of the few systematic evaluations of CKD in Hispanics, who constitute a growing high-risk population well known to be affected by health disparities.²¹⁻²⁷ The CRIC and H-CRICH Studies were designed to examine prospectively risk factors for CKD progression and cardiovascular disease incidence and progression in a large diverse representative cohort of indi-

Table 5. Laboratory Parameters in H-CRIC/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P	
				Hispanic vs White	Hispanic vs Black
eGFR Strata					
eGFR <30 (n = 702)					
Sodium (mmol/L)	138.1 ± 2.9	139.8 ± 2.9	139.8 ± 3.1	<0.001	<0.001
Potassium (mmol/L)	4.6 ± 0.6	4.6 ± 0.5	4.5 ± 0.6	0.5	0.004
CO ₂ (mmol/L)	21.7 ± 3.5	23.0 ± 3.3	22.7 ± 3.4	<0.001	0.003
Hemoglobin (g/dL)	11.5 ± 1.8	12.3 ± 1.6	11.5 ± 1.6	<0.001	0.7
Calcium (mg/dL)	8.8 ± 0.6	9.2 ± 0.5	9.1 ± 0.6	<0.001	<0.001
Phosphate (mg/dL)	4.4 ± 0.7	4.0 ± 0.8	4.2 ± 0.7	<0.001	0.09
Total PTH (pg/mL)	102.7 (73.1, 171.3)	79.9 (50.6, 126.4)	133.6 (81.3, 212.6)	0.006	<0.001
Serum albumin (g/dL)	3.6 ± 0.5	4.0 ± 0.4	3.8 ± 0.5	<0.001	<0.001
eGFR 30-<45 (n = 1,382)					
Sodium (mmol/L)	137.9 ± 3.0	139.1 ± 2.9	140.0 ± 3.2	<0.001	<0.001
Potassium (mmol/L)	4.4 ± 0.5	4.5 ± 0.5	4.3 ± 0.5	0.2	0.04
CO ₂ (mmol/L)	22.8 ± 2.8	24.3 ± 2.8	24.5 ± 3.2	<0.001	<0.001
Hemoglobin (g/dL)	11.8 ± 1.7	13.0 ± 1.7	11.9 ± 1.6	<0.001	0.2
Calcium (mg/dL)	8.9 ± 0.5	9.2 ± 0.5	9.2 ± 0.5	<0.001	<0.001
Phosphate (mg/dL)	4.0 ± 0.7	3.7 ± 0.6	3.8 ± 0.6	<0.001	<0.001
Total PTH (pg/mL)	59.5 (44.0, 95.0)	48.0 (32.0, 76.0)	75.3 (48.9, 118.5)	0.09	<0.001
Serum albumin (g/dL)	3.6 ± 0.5	4.0 ± 0.4	3.9 ± 0.5	<0.001	<0.001
eGFR 45-<60 (n = 1,141)					
Sodium (mmol/L)	138.3 ± 3.1	139.3 ± 3.0	139.5 ± 3.1	0.002	<0.001
Potassium (mmol/L)	4.3 ± 0.5	4.3 ± 0.5	4.1 ± 0.5	0.4	0.002
CO ₂ (mmol/L)	24.0 ± 2.9	25.1 ± 2.8	25.7 ± 3.0	<0.001	<0.001
Hemoglobin (g/dL)	12.8 ± 2.1	13.4 ± 1.6	12.5 ± 1.6	<0.001	0.08
Calcium (mg/dL)	9.1 ± 0.5	9.3 ± 0.4	9.2 ± 0.5	0.01	0.08
Phosphate (mg/dL)	3.6 ± 0.6	3.5 ± 0.5	3.6 ± 0.6	0.09	0.8
Total PTH (pg/mL)	51.0 (37.0, 66.0)	38.0 (28.6, 54.0)	52.2 (36.0, 77.9)	<0.001	0.05
Serum albumin (g/dL)	3.8 ± 0.6	4.1 ± 0.4	4.0 ± 0.4	<0.001	0.008
eGFR ≥60 (n = 560)					
Sodium (mmol/L)	137.7 ± 2.5	138.7 ± 3.0	139.3 ± 2.6	0.04	<0.001
Potassium (mmol/L)	4.2 ± 0.5	4.2 ± 0.4	4.1 ± 0.4	0.3	0.3
CO ₂ (mmol/L)	24.8 ± 3.4	25.5 ± 3.0	25.6 ± 2.8	0.1	0.1
Hemoglobin (g/dL)	13.0 ± 1.6	13.7 ± 1.6	13.1 ± 1.6	0.003	0.8
Calcium (mg/dL)	9.1 ± 0.5	9.1 ± 0.4	9.3 ± 0.4	0.4	0.004
Phosphate (mg/dL)	3.7 ± 0.5	3.4 ± 0.5	3.5 ± 0.6	<0.001	0.09
Total PTH (pg/mL)	40.9 (27.0, 49.7)	35.0 (26.0, 45.0)	38.0 (28.5, 55.6)	0.3	0.4
Serum albumin (g/dL)	3.9 ± 0.6	4.0 ± 0.4	4.0 ± 0.4	0.02	0.02
Albuminuria Strata					
UACR <30 mg/g (n = 1,564)					
Sodium (mmol/L)	138.3 ± 2.9	139.1 ± 3.0	139.8 ± 3.3	0.005	<0.001
Potassium (mmol/L)	4.3 ± 0.5	4.3 ± 0.5	4.2 ± 0.5	0.5	0.03
CO ₂ (mmol/L)	23.9 ± 3.3	25.1 ± 2.9	25.4 ± 3.1	<0.001	<0.001
Hemoglobin (g/dL)	12.4 ± 1.5	13.4 ± 1.5	12.4 ± 1.6	<0.001	0.7
Calcium (mg/dL)	9.3 ± 0.4	9.3 ± 0.5	9.3 ± 0.5	0.7	0.2
Phosphate (mg/dL)	3.7 ± 0.5	3.5 ± 0.6	3.7 ± 0.6	0.004	0.9
Total PTH (pg/mL)	49.0 (35.0, 63.0)	38.0 (27.1, 54.1)	52.0 (35.0, 77.8)	0.1	0.03
Serum albumin (g/dL)	4.0 ± 0.4	4.1 ± 0.4	4.1 ± 0.4	0.04	0.4
UACR 30-<300 mg/g (n = 955)					
Sodium (mmol/L)	138.3 ± 2.7	139.3 ± 3.1	139.8 ± 3.0	0.005	<0.001
Potassium (mmol/L)	4.4 ± 0.6	4.4 ± 0.5	4.3 ± 0.5	0.4	0.06
CO ₂ (mmol/L)	23.1 ± 3.2	24.1 ± 3.0	24.4 ± 3.4	0.003	<0.001

(Continued)

Table 5 (Cont'd). Laboratory Parameters in H-CRICH/Hispanic CRIC Participants Compared With Non-Hispanic White and Black CRIC Participants

Variable	Hispanic (n = 497)	Non-Hispanic White (n = 1,638)	Non-Hispanic Black (n = 1,650)	P	
				Hispanic vs White	Hispanic vs Black
Hemoglobin (g/dL)	12.2 ± 2.0	13.1 ± 1.7	12.3 ± 1.8	<0.001	0.7
Calcium (mg/dL)	9.1 ± 0.5	9.2 ± 0.5	9.2 ± 0.5	0.01	0.008
Phosphate (mg/dL)	3.9 ± 0.7	3.6 ± 0.7	3.7 ± 0.6	<0.001	0.02
Total PTH (pg/mL)	57.7 (34.0, 90.0)	49.3 (32.0, 74.3)	69.4 (43.1, 125.0)	0.04	0.005
Serum albumin (g/dL)	3.9 ± 0.4	4.1 ± 0.4	4.0 ± 0.4	<0.001	0.02
UACR ≥300 mg/g (n = 1,110)					
Sodium (mmol/L)	137.9 ± 3.1	139.2 ± 2.8	139.5 ± 3.0	<0.001	<0.001
Potassium (mmol/L)	4.5 ± 0.6	4.5 ± 0.5	4.3 ± 0.5	0.09	0.001
CO ₂ (mmol/L)	22.5 ± 3.2	24.0 ± 3.1	24.0 ± 3.4	<0.001	<0.001
Hemoglobin (g/dL)	11.8 ± 2.0	12.7 ± 1.8	11.9 ± 1.7	<0.001	0.8
Calcium (mg/dL)	8.8 ± 0.5	9.1 ± 0.5	9.0 ± 0.5	<0.001	<0.001
Phosphate (mg/dL)	4.2 ± 0.8	3.8 ± 0.6	4.0 ± 0.7	<0.001	<0.001
Total PTH (pg/mL)	81.2 (50.5, 117.0)	60.1 (36.9, 98.4)	92.0 (55.7, 157.0)	0.06	<0.001
Serum albumin (g/dL)	3.5 ± 0.5	3.8 ± 0.5	3.7 ± 0.5	<0.001	<0.001

Note: Continuous variables are represented by mean ± standard deviation or median (25th, 75th percentile). eGFR given in mL/min/1.73 m². Conversion factors for units: hemoglobin in g/dL to g/L, ×10; calcium in mg/dL to mmol/L, ×0.2495; phosphate in mg/dL to mmol/L, ×0.3229; albumin in g/dL to g/L, ×10; no conversion necessary for PTH in pg/mL and ng/L.

Abbreviations: CO₂, carbon dioxide; CRIC, Chronic Renal Insufficiency Cohort; eGFR, estimated glomerular filtration rate; H-CRICH, Hispanic Chronic Renal Insufficiency Cohort; PTH, parathyroid hormone; UACR, urine albumin-creatinine ratio.

viduals with CKD.^{17,18} By capturing a wide array of data for a broad range of demographic factors and clinical exposures, the H-CRICH and CRIC Studies will further elucidate reasons for health disparities in Hispanics with CKD and inform clinical trials of therapeutic interventions that potentially may lead to improvements in clinical outcomes.²⁸

A few prior studies examined differences in the burden of CKD between Hispanics and non-Hispanics. Although analyses from NHANES (National Health and Nutrition Examination Survey) have found the prevalence of eGFR <60 mL/min/1.73 m² to be similar in Mexican Americans and non-Hispanic whites, they generally have noted a higher prevalence of micro- and macroalbuminuria.^{6,9,10} In a large cohort of adults with stages 3-4 CKD from Kaiser Permanente of Northern California, higher levels of proteinuria also were observed in Hispanics compared with non-Hispanic whites, which is consistent with our observations in the H-CRICH/CRIC Studies.⁷ Less is known about complications of CKD. Similar to our findings, a recent analysis from NHANES found that several metabolic abnormalities, including those involving hemoglobin, phosphorus, potassium, and bicarbonate, were more common in Hispanic than white adults with eGFR <60 mL/min/1.73 m².²⁹ Differences in socioeconomic status may explain some of these observed differences. For example, 2 recent studies found that low socioeconomic status was associated strongly with higher serum phosphorus levels in adults with CKD regardless of race/ethnic-

ity.^{30,31} The impact of these complications on health outcomes will be assessed in future longitudinal analyses.

Optimal control of blood pressure and use of renoprotective medications also were found to be inferior in Hispanics compared with non-Hispanic whites in H-CRICH/CRIC despite evidence supporting these measures to attenuate CKD progression.¹⁶ Similar patterns of greater uncontrolled blood pressure in Hispanics with and without CKD also have been observed in samples from NHANES^{29,32} and MESA (Multi-Ethnic Study of Atherosclerosis),³³ which appear due in part to socioeconomic differences. Only one prior study has examined the relationship between race/ethnicity and ACE-inhibitor/ARB use in individuals at high risk of progressive CKD. Of almost 40,000 diabetic adults in the Kaiser Permanente of Northern California Diabetes Registry, 59% of Latinos received an ACE inhibitor/ARB, including 54% with albuminuria, and this proportion was not significantly different from that observed for whites.³⁴ Although we observed a similar proportion of Hispanics receiving ACE inhibitors/ARBs in H-CRICH/CRIC overall, we found that Hispanics had significantly lower receipt of these medications in high-risk groups (eg, diabetes, proteinuria, and blood pressure >130/80 mm Hg) compared with non-Hispanic whites and blacks. In addition to local clinical practice patterns, the lower prevalence of health insurance in Hispanics in H-CRICH/CRIC likely contributes to these observed differences. Although not specifically evaluated in regard to categories of race and ethnic-

ity, lack of health insurance has been associated with decreased access to regular care, worse control of hypertension, and less receipt of ACE inhibitors/ARBs in adults with diabetes and CKD.^{35,36} Because of its robust data collection, future H-CRIC/CRIC analyses will delineate the relationships between race/ethnicity, socioeconomic status (eg, income, health insurance, and access to health care), risk factors for CKD, and CKD progression.

There is notable heterogeneity among Hispanics in the United States with regard to race, country of origin, language, health beliefs, and social customs.³⁷ The H-CRIC and CRIC Studies also afford an initial examination of differences among subgroups of Hispanics with CKD, finding that Mexican Americans had more severe CKD (ie, lower eGFRs and higher proteinuria), a disproportionate burden of unfavorable CKD risk factors, and a higher prevalence of CKD-related metabolic complications compared with Puerto Rican Americans and other Latin Americans. Only a few prior studies have investigated differences in CKD parameters and outcomes among Hispanic subgroups. In a prospective observational study of nearly 5,000 Hispanics receiving long-term dialysis therapy, Mexican Americans were found to have significantly lower mortality than their Puerto Rican American counterparts over 2 years.³⁸ Analysis of NHANES data showed that Cuban Americans were more likely to have an estimated creatinine clearance <60 mL/min/1.73 m² compared with Mexican Americans or Puerto Ricans.³⁹ Recently, findings from MESA showed that although Puerto Ricans had levels of albuminuria similar to non-Hispanic whites, Mexicans and Dominicans had much higher albuminuria than whites, which appeared to be related to the heterogeneity in genetic admixture between European, African, and Native American ancestry in these groups.⁴⁰ Further analyses are needed to better understand the diversity among Hispanic subgroups in the United States and delineate the clinical implications of these baseline findings.

The causes of racial and ethnic inequities among individuals with CKD are speculated to be of diverse origins, including patient- (eg, biological, socioeconomic, and environmental), provider- (eg, bias and communication), and health care system-related (eg, access to services) factors.^{22,23} Reasons for these reported disparities in Hispanics have been examined infrequently. Some have argued that differences in sociodemographic and recognized clinical factors account for much of observed disparities in health outcomes.²⁷ Others have contended that intrinsic biological and genetic predispositions toward CKD and its complications, along with differential responses to treatment, may contribute substantially to these disparities for Hispanics.⁷ Moreover, few studies have incor-

porated detailed data for socioeconomic status, health insurance, and access to care.^{3,8} Of those that did, the observed disparities in regard to higher rates of ESRD in Hispanics appear to be explained only partially by these factors.⁷ By virtue of their prospective longitudinal design and detailed collection of patient-level data, the H-CRIC and CRIC Studies are poised to identify additional genetic, biological, and sociocultural factors that contribute to racial/ethnic differences in CKD-related outcomes.

As in other observational analyses, inferences regarding causality are limited by residual bias and confounding. However, method strategies have been adopted to minimize these concerns.^{17,18} Another potential limitation pertains to the generalizability of findings from CRIC and H-CRIC participants. As previously described,^{17,18} the CRIC cohort oversampled certain subgroups (ie, African Americans) and recruited participants from select geographic sites and therefore is not a population-based sample like the NHANES CKD cohort. Similarly, most Hispanic participants in CRIC/H-CRIC were Mexican Americans (69%) and were recruited from the Chicago metropolitan area (85%). Although many characteristics of our Hispanic cohort, including country of origin, education, income, and primary language, are similar to representative samples, such as those in NHANES,^{21,41,42} it is important to recognize that our Hispanic cohort does not include robust representation from all Hispanic subgroups and geographic regions of the United States. Therefore, findings reported here may not fully generalize to all US Hispanics with CKD. Last, although a recent study has indicated that the CKD-EPI equation for eGFR is relatively accurate for Hispanics,⁴³ this equation has not been validated in large diverse samples of Hispanics. Hence, eGFR findings reported here across racial/ethnic groups may be subject to bias.

In conclusion, Hispanics with CKD in the CRIC/H-CRIC Studies are disproportionately burdened with lower socioeconomic status, more frequent diabetes mellitus, worse blood pressure control, lower receipt of ACE-inhibitor/ARB medications, and more severe CKD with disproportionate associated metabolic complications than their non-Hispanic white and black counterparts. The consequences of these observed differences across racial and ethnic groups are less clear. Although multiple studies have found an increased burden of adverse sociodemographic characteristics, clinical risk factors, and ESRD in Hispanics compared with whites,^{2-4,6-10,29} a decreased risk of cardiovascular events and death in Hispanics with CKD and ESRD has been observed,^{7,24-27} which is consistent with a phenomenon observed elsewhere

called the Hispanic paradox.⁴⁴ Therefore, longitudinal analyses are critically needed to fully examine the impact of these baseline health disparities as potential mediators of racial/ethnic variation in CKD-related clinical outcomes. Improving our understanding of the causes and consequences of health disparities in Hispanics with CKD has the potential to allow us to more effectively identify and address barriers to health care and improve outcomes for this population.^{22,23}

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REFERENCES

1. The Hispanic Population: Census 2000 brief. *US Census Bureau* [serial online]. 2004. <http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf>. Accessed December 1, 2010.
2. US Renal Data System. *USRDS 2009 Annual Data Report: Atlas of End-Stage Renal Disease in the United States*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2009.
3. Pugh JA, Stern MP, Haffner SM, Eifler CW, Zapata M. Excess incidence of treatment of end-stage renal disease in Mexican Americans. *Am J Epidemiol*. 1988;127:135-144.
4. Chiapella AP, Feldman HI. Renal failure among male Hispanics in the United States. *Am J Public Health*. 1995;85:1001-1004.
5. Lora CM, Daviglus ML, Kusek JW, et al. Chronic kidney disease in United States Hispanics: a growing public health problem. *Ethn Dis*. 2009;19:466-472.
6. Coresh J, Byrd-Holt D, Astor BC, et al. Chronic kidney disease awareness, prevalence, and trends among U.S. adults, 1999 to 2000. *J Am Soc Nephrol*. 2005;16:180-188.
7. Peralta CA, Shlipak MG, Fan D, et al. Risks for end-stage renal disease, cardiovascular events, and death in Hispanic versus non-Hispanic white adults with chronic kidney disease. *J Am Soc Nephrol*. 2006;17:2892-2899.
8. Young BA, Maynard C, Boyko EJ. Racial differences in diabetic nephropathy, cardiovascular disease, and mortality in a national population of veterans. *Diabetes Care*. 2003;26:2392-2399.
9. Jones CA, Francis ME, Eberhardt MS, et al. Microalbuminuria in the US population: Third National Health and Nutrition Examination Survey. *Am J Kidney Dis*. 2002;39:445-459.
10. Bryson CL, Ross HJ, Boyko EJ, Young BA. Racial and ethnic variations in albuminuria in the US Third National Health and Nutrition Examination Survey (NHANES III) population: associations with diabetes and level of CKD. *Am J Kidney Dis*. 2006;48:720-726.
11. Agodoa LY, Appel L, Bakris GL, et al. Effect of ramipril vs amlodipine on renal outcomes in hypertensive nephrosclerosis. *JAMA*. 2001;285:2719-2728.
12. Klahr S, Levey AS, Beck GJ, et al. The effects of dietary protein restriction and blood-pressure control on the progression of chronic renal disease. *N Engl J Med*. 1994;330:877-884.
13. Rahman M, Pressel S, Davis BR. Renal outcomes in high-risk hypertensive patients treated with an angiotensin-converting enzyme inhibitor or a calcium channel blocker vs a diuretic: a report from the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). *Arch Intern Med*. 2005;165(8):936-946.
14. Lewis EJ, Hunsicker LG, Clarke WR, et al. Renoprotective effect of the angiotensin-receptor antagonist irbesartan in patients with nephropathy due to type 2 diabetes. *N Engl J Med*. 2001;345(12):861-869.
15. Brenner BM, Cooper ME, De Zeeuw D, et al. Effects of losartan on renal and cardiovascular outcomes in patients with type 2 diabetes and nephropathy. *N Engl J Med*. 2001;345(12):861-869.
16. DeZeeuw D, Ramjit D, Zhang Z, et al. Renal risk and renoprotection among ethnic groups with type 2 diabetic nephropathy: a post hoc analysis of RENAAL. *Kidney Int*. 2006;69(9):1675-1682.
17. Feldman HI, Appel LJ, Chertow GM, et al. The Chronic Renal Insufficiency Cohort (CRIC) Study: design and methods. *J Am Soc Nephrol*. 2003;14(suppl 2):S148-S153.
18. Lash JP, Go AS, Appel LJ, et al. Chronic Renal Insufficiency Cohort (CRIC) Study: baseline characteristics and associations with kidney function. *Clin J Am Soc Nephrol*. 2009;4(8):1302-1311.
19. Marin G, Sabogal F, Marin BV, Oterosabogal R, Perezstabelle EJ. Development of a short acculturation scale for Hispanics. *Hispanic J Behav Sci*. 1987;9:183-205.
20. Levey AS, Stevens LA, Schmid CH, et al. CKD-EPI (Chronic Kidney Disease Epidemiology Collaboration). A new equation to estimate glomerular filtration rate. *Ann Intern Med*. 2009;150(9):604-612.
21. Mehrotra R, Kermah D, Fried L, Adler S, Norris K. Racial differences in mortality among those with CKD. *J Am Soc Nephrol*. 2008;19:1403-1410.
22. Powe NR. Let's get serious about racial and ethnic disparities. *J Am Soc Nephrol*. 2008;19:1271-1275.
23. Norris K, Nissenson AR. Race, gender, and socioeconomic disparities in CKD in the United States. *J Am Soc Nephrol*. 2008;19:1261-1270.
24. Frankenfield DL, Rocco MV, Roman SH, McClellan WM. Survival advantage for adult Hispanic hemodialysis patients? Findings from the End-Stage Renal Disease Clinical Performance Measures Project. *J Am Soc Nephrol*. 2003;14:180-186.
25. Murthy BVR, Molony DA, Stack AG. Survival advantage of Hispanic patients initiating dialysis in the United States is modified by race. *J Am Soc Nephrol*. 2005;16:782-790.
26. Lopes AA, Bragg-Gresham JL, Satayathum S, et al. Health-related quality of life and associated outcomes among hemodialysis patients of different ethnicities in the United States: the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney Dis*. 2003;41:605-615.
27. Robinson BM, Joffe MM, Pisoni RL, Port FK, Feldman HI. Revisiting survival differences by race and ethnicity among hemodialysis patients: the Dialysis Outcome and Practice Patterns Study. *J Am Soc Nephrol*. 2006;17:2910-2918.
28. Jager KJ, Stel VS, Wanner C, Zoccali C, Dekker FW. The valuable contribution of observational studies to nephrology. *Kidney Int*. 2007;72:671-675.
29. Foley RN, Wang C, Ishani A, Collins AJ. NHANES III: influence of race of GFR thresholds and detection of metabolic abnormalities. *J Am Soc Nephrol*. 2007;18:2575-2582.
30. Gutierrez OM, Isakova T, Einfeld G, Wolf M. Impact of poverty on serum phosphate concentrations in the Third National Health and Nutrition Examination Survey. *J Ren Nutr*. 2011;21(2):140-148.
31. Gutierrez OM, Anderson C, Isakova T, et al. Low socioeconomic status associates with higher serum phosphate irrespective of race. *J Am Soc Nephrol*. 2010;21(11):1953-1960.
32. Hajjar J, Kotchen TA. Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988-2000. *JAMA*. 2003;290:199-206.
33. Kramer H, Han C, Post W, et al. Racial/ethnic differences in hypertension and hypertension treatment and control in the Multi-Ethnic Study of Atherosclerosis (MESA). *Am J Hypertens*. 2004;17:963-970.
34. Rosen AB, Karter AJ, Liu JY, Selby JV, Schneider EC. Use of angiotensin-converting enzyme inhibitors and angiotensin receptor blockers in high-risk clinical and ethnic groups with diabetes. *J Gen Intern Med*. 2004;19:669-675.
35. Harris MI. Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes. *Diabetes Care*. 2001;24:454-459.
36. Hall YN, Rodriguez RA, Boyko EJ, Chertow GM, O'Hare AM. Characteristics of uninsured Americans with chronic kidney disease. *J Gen Intern Med*. 2009;24(8):917-922.

37. Burchard EG, Borrell LN, Choudhry S, et al. Latino populations: a unique opportunity for the study of race, genetics, and social environment in epidemiological research. *Am J Public Health*. 2005;95:2161-2168.
38. Frankenfield DL, Krishnan SM, Ashby VB, Shearon TH, Rocco MV, Saran R. Differences in mortality among Mexican-American, Puerto Rican, and Cuban-American dialysis patients in the United States. *Am J Kidney Dis*. 2009;53:647-657.
39. Rodriguez RA, Hernandez GT, O'Hare AM, Glidden DW, Perez-Stable E. Creatinine levels among Mexican Americans, Puerto Ricans, and Cuban Americans in the Hispanic Health and Nutrition Examination Survey. *Kidney Int*. 2004;66:2368-2373.
40. Peralta CA, Li Y, Wassel C, et al. Differences in albuminuria between Hispanics and whites: an evaluation by genetic ancestry and country of origin: the Multi-Ethnic Study of Atherosclerosis. *Circ Cardiovasc Genet*. 2010;3(3):240-247.
41. Sundquist J, Winkleby M. Country of birth, acculturation status and abdominal obesity in a national sample of Mexican-American women and men. *Int J Epidemiol*. 2000;29:470-477.
42. Hispanic Heritage Month 2009. *US Census Bureau* [serial online] 2009. http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb09-ff17.html. Accessed October 18, 2009.
43. Stevens LA, Claybon MA, Schmid CH, et al. Evaluation of the Chronic Kidney Disease Epidemiology Collaboration equation for estimating the glomerular filtration rate in multiple ethnicities. *Kidney Int*. 2011;279(5):555-562.
44. Franzini L, Ribic JC, Keddie AM. Understanding the Hispanic paradox. *Ethn Dis*. 2001;11:496-518.



DP-1

Profile of General Demographic Characteristics: 2000

Census 2000 Summary File 1 (SF 1) 100-Percent Data

NOTE: For information on confidentiality protection, nonsampling error, definitions, and count corrections see <http://factfinder.census.gov/home/en/data/notes/expsf1u.htm>.

Subject	Plainfield village, Illinois	
	Number	Percent
Total population	13,038	100.0
SEX AND AGE		
Male	6,537	50.1
Female	6,501	49.9
Under 5 years	1,248	9.6
5 to 9 years	1,276	9.8
10 to 14 years	1,101	8.4
15 to 19 years	800	6.1
20 to 24 years	551	4.2
25 to 34 years	2,023	15.5
35 to 44 years	2,696	20.7
45 to 54 years	1,725	13.2
55 to 59 years	506	3.9
60 to 64 years	294	2.3
65 to 74 years	427	3.3
75 to 84 years	295	2.3
85 years and over	96	0.7
Median age (years)	33.2	(X)
18 years and over	8,881	68.1
Male	4,367	33.5
Female	4,514	34.6
21 years and over	8,476	65.0
62 years and over	979	7.5
65 years and over	818	6.3
Male	327	2.5
Female	491	3.8
RACE		
One race	12,913	99.0
White	12,497	95.9
Black or African American	110	0.8
American Indian and Alaska Native	10	0.1
Asian	163	1.3
Asian Indian	31	0.2
Chinese	37	0.3
Filipino	38	0.3
Japanese	7	0.1
Korean	22	0.2
Vietnamese	1	0.0
Other Asian [1]	27	0.2
Native Hawaiian and Other Pacific Islander	1	0.0
Native Hawaiian	0	0.0
Guamanian or Chamorro	0	0.0
Samoan	0	0.0
Other Pacific Islander [2]	1	0.0

Subject	Plainfield village, Illinois	
	Number	Percent
Some other race	132	1.0
Two or more races	125	1.0
Race alone or in combination with one or more other races [3]		
White	12,613	96.7
Black or African American	126	1.0
American Indian and Alaska Native	50	0.4
Asian	201	1.5
Native Hawaiian and Other Pacific Islander	8	0.1
Some other race	170	1.3
HISPANIC OR LATINO AND RACE		
Total population	13,038	100.0
Hispanic or Latino (of any race)	504	3.9
Mexican	371	2.8
Puerto Rican	51	0.4
Cuban	16	0.1
Other Hispanic or Latino	66	0.5
Not Hispanic or Latino	12,534	96.1
White alone	12,144	93.1
RELATIONSHIP		
Total population	13,038	100.0
In households	12,967	99.5
Householder	4,315	33.1
Spouse	3,177	24.4
Child	4,826	37.0
Own child under 18 years	4,024	30.9
Other relatives	330	2.5
Under 18 years	97	0.7
Nonrelatives	319	2.4
Unmarried partner	166	1.3
In group quarters	71	0.5
Institutionalized population	69	0.5
Noninstitutionalized population	2	0.0
HOUSEHOLDS BY TYPE		
Total households	4,315	100.0
Family households (families)	3,522	81.6
With own children under 18 years	2,039	47.3
Married-couple family	3,177	73.6
With own children under 18 years	1,855	43.0
Female householder, no husband present	246	5.7
With own children under 18 years	139	3.2
Nonfamily households	793	18.4
Householder living alone	637	14.8
Householder 65 years and over	182	4.2
Households with individuals under 18 years	2,103	48.7
Households with individuals 65 years and over	545	12.6
Average household size	3.01	(X)
Average family size	3.37	(X)
HOUSING OCCUPANCY		
Total housing units	4,609	100.0
Occupied housing units	4,315	93.6
Vacant housing units	294	6.4
For seasonal, recreational, or occasional use	3	0.1
Homeowner vacancy rate (percent)	4.7	(X)
Rental vacancy rate (percent)	3.1	(X)
HOUSING TENURE		
Occupied housing units	4,315	100.0
Owner-occupied housing units	3,783	87.7
Renter-occupied housing units	532	12.3
Average household size of owner-occupied unit	3.12	(X)

Subject	Plainfield village, Illinois	
	Number	Percent
Average household size of renter-occupied unit	2.16	(X)

(X) Not applicable.

[1] Other Asian alone, or two or more Asian categories.

[2] Other Pacific Islander alone, or two or more Native Hawaiian and Other Pacific Islander categories.

[3] In combination with one or more other races listed. The six numbers may add to more than the total population and the six percentages may add to more than 100 percent because individuals may report more than one race.

Source: U.S. Census Bureau, Census 2000 Summary File 1, Matrices P1, P3, P4, P8, P9, P12, P13, P,17, P18, P19, P20, P23, P27, P28, P33, PCT5, PCT8, PCT11, PCT15, H1, H3, H4, H5, H11, and H12.



DP-1

Profile of General Population and Housing Characteristics: 2010

2010 Demographic Profile Data

NOTE: For more information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/doc/dpsf.pdf>.

Geography: Plainfield village, Illinois

Subject	Number	Percent
SEX AND AGE		
Total population	39,581	100.0
Under 5 years	3,477	8.8
5 to 9 years	4,335	11.0
10 to 14 years	4,092	10.3
15 to 19 years	2,936	7.4
20 to 24 years	1,464	3.7
25 to 29 years	1,584	4.0
30 to 34 years	2,655	6.7
35 to 39 years	4,114	10.4
40 to 44 years	4,250	10.7
45 to 49 years	3,338	8.4
50 to 54 years	2,257	5.7
55 to 59 years	1,623	4.1
60 to 64 years	1,377	3.5
65 to 69 years	778	2.0
70 to 74 years	491	1.2
75 to 79 years	293	0.7
80 to 84 years	243	0.6
85 years and over	274	0.7
Median age (years)	33.8	(X)
16 years and over	26,959	68.1
18 years and over	25,647	64.8
21 years and over	24,437	61.7
62 years and over	2,878	7.3
65 years and over	2,079	5.3
Male population	19,633	49.6
Under 5 years	1,769	4.5
5 to 9 years	2,285	5.8
10 to 14 years	2,058	5.2
15 to 19 years	1,502	3.8
20 to 24 years	768	1.9
25 to 29 years	763	1.9
30 to 34 years	1,206	3.0
35 to 39 years	1,934	4.9
40 to 44 years	2,069	5.2
45 to 49 years	1,738	4.4
50 to 54 years	1,179	3.0
55 to 59 years	815	2.1
60 to 64 years	665	1.7
65 to 69 years	362	0.9
70 to 74 years	231	0.6
75 to 79 years	119	0.3
80 to 84 years	89	0.2
85 years and over	81	0.2

Subject	Number	Percent
Median age (years)	33.1	(X)
16 years and over	13,176	33.3
18 years and over	12,492	31.6
21 years and over	11,853	29.9
62 years and over	1,265	3.2
65 years and over	882	2.2
Female population	19,948	50.4
Under 5 years	1,708	4.3
5 to 9 years	2,050	5.2
10 to 14 years	2,034	5.1
15 to 19 years	1,434	3.6
20 to 24 years	696	1.8
25 to 29 years	821	2.1
30 to 34 years	1,449	3.7
35 to 39 years	2,180	5.5
40 to 44 years	2,181	5.5
45 to 49 years	1,600	4.0
50 to 54 years	1,078	2.7
55 to 59 years	808	2.0
60 to 64 years	712	1.8
65 to 69 years	416	1.1
70 to 74 years	260	0.7
75 to 79 years	174	0.4
80 to 84 years	154	0.4
85 years and over	193	0.5
Median age (years)	34.4	(X)
16 years and over	13,783	34.8
18 years and over	13,155	33.2
21 years and over	12,584	31.8
62 years and over	1,613	4.1
65 years and over	1,197	3.0
RACE		
Total population	39,581	100.0
One Race	38,701	97.8
White	32,347	81.7
Black or African American	2,202	5.6
American Indian and Alaska Native	89	0.2
Asian	3,016	7.6
Asian Indian	1,183	3.0
Chinese	291	0.7
Filipino	731	1.8
Japanese	25	0.1
Korean	166	0.4
Vietnamese	131	0.3
Other Asian [1]	489	1.2
Native Hawaiian and Other Pacific Islander	16	0.0
Native Hawaiian	8	0.0
Guamanian or Chamorro	4	0.0
Samoan	0	0.0
Other Pacific Islander [2]	4	0.0
Some Other Race	1,031	2.6
Two or More Races	880	2.2
White; American Indian and Alaska Native [3]	68	0.2
White; Asian [3]	322	0.8
White; Black or African American [3]	184	0.5
White; Some Other Race [3]	134	0.3
Race alone or in combination with one or more other races: [4]		
White	33,115	83.7
Black or African American	2,453	6.2
American Indian and Alaska Native	199	0.5

Subject	Number	Percent
Asian	3,449	8.7
Native Hawaiian and Other Pacific Islander	61	0.2
Some Other Race	1,238	3.1
HISPANIC OR LATINO		
Total population	39,581	100.0
Hispanic or Latino (of any race)	4,247	10.7
Mexican	3,124	7.9
Puerto Rican	516	1.3
Cuban	88	0.2
Other Hispanic or Latino [5]	519	1.3
Not Hispanic or Latino	35,334	89.3
HISPANIC OR LATINO AND RACE		
Total population	39,581	100.0
Hispanic or Latino	4,247	10.7
White alone	2,932	7.4
Black or African American alone	47	0.1
American Indian and Alaska Native alone	43	0.1
Asian alone	23	0.1
Native Hawaiian and Other Pacific Islander alone	4	0.0
Some Other Race alone	969	2.4
Two or More Races	229	0.6
Not Hispanic or Latino	35,334	89.3
White alone	29,415	74.3
Black or African American alone	2,155	5.4
American Indian and Alaska Native alone	46	0.1
Asian alone	2,993	7.6
Native Hawaiian and Other Pacific Islander alone	12	0.0
Some Other Race alone	62	0.2
Two or More Races	651	1.6
RELATIONSHIP		
Total population	39,581	100.0
In households	39,472	99.7
Householder	11,920	30.1
Spouse [6]	8,842	22.3
Child	16,091	40.7
Own child under 18 years	13,349	33.7
Other relatives	1,686	4.3
Under 18 years	506	1.3
65 years and over	423	1.1
Nonrelatives	933	2.4
Under 18 years	77	0.2
65 years and over	42	0.1
Unmarried partner	506	1.3
In group quarters	109	0.3
Institutionalized population	109	0.3
Male	23	0.1
Female	86	0.2
Noninstitutionalized population	0	0.0
Male	0	0.0
Female	0	0.0
HOUSEHOLDS BY TYPE		
Total households	11,920	100.0
Family households (families) [7]	10,155	85.2
With own children under 18 years	6,602	55.4
Husband-wife family	8,842	74.2
With own children under 18 years	5,795	48.6
Male householder, no wife present	367	3.1
With own children under 18 years	201	1.7
Female householder, no husband present	946	7.9
With own children under 18 years	606	5.1

Subject	Number	Percent
Nonfamily households [7]	1,765	14.8
Householder living alone	1,365	11.5
Male	627	5.3
65 years and over	75	0.6
Female	738	6.2
65 years and over	269	2.3
Households with individuals under 18 years	6,870	57.6
Households with individuals 65 years and over	1,464	12.3
Average household size	3.31	(X)
Average family size [7]	3.62	(X)
HOUSING OCCUPANCY		
Total housing units	12,532	100.0
Occupied housing units	11,920	95.1
Vacant housing units	612	4.9
For rent	158	1.3
Rented, not occupied	2	0.0
For sale only	236	1.9
Sold, not occupied	29	0.2
For seasonal, recreational, or occasional use	35	0.3
All other vacants	152	1.2
Homeowner vacancy rate (percent) [8]	2.1	(X)
Rental vacancy rate (percent) [9]	11.7	(X)
HOUSING TENURE		
Occupied housing units	11,920	100.0
Owner-occupied housing units	10,732	90.0
Population in owner-occupied housing units	36,093	(X)
Average household size of owner-occupied units	3.36	(X)
Renter-occupied housing units	1,188	10.0
Population in renter-occupied housing units	3,379	(X)
Average household size of renter-occupied units	2.84	(X)

X Not applicable.

[1] Other Asian alone, or two or more Asian categories.

[2] Other Pacific Islander alone, or two or more Native Hawaiian and Other Pacific Islander categories.

[3] One of the four most commonly reported multiple-race combinations nationwide in Census 2000.

[4] In combination with one or more of the other races listed. The six numbers may add to more than the total population, and the six percentages may add to more than 100 percent because individuals may report more than one race.

[5] This category is composed of people whose origins are from the Dominican Republic, Spain, and Spanish-speaking Central or South American countries. It also includes general origin responses such as "Latino" or "Hispanic."

[6] "Spouse" represents spouse of the householder. It does not reflect all spouses in a household. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[7] "Family households" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couple households are included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present are tabulated in nonfamily households. "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

[8] The homeowner vacancy rate is the proportion of the homeowner inventory that is vacant "for sale." It is computed by dividing the total number of vacant units "for sale only" by the sum of owner-occupied units, vacant units that are "for sale only," and vacant units that have been sold but not yet occupied; and then multiplying by 100.

[9] The rental vacancy rate is the proportion of the rental inventory that is vacant "for rent." It is computed by dividing the total number of vacant units "for rent" by the sum of the renter-occupied units, vacant units that are "for rent," and vacant units that have been rented but not yet occupied; and then multiplying by 100.

Source: U.S. Census Bureau, 2010 Census.

NEED DETERMINATION—PREVALENCE RATES

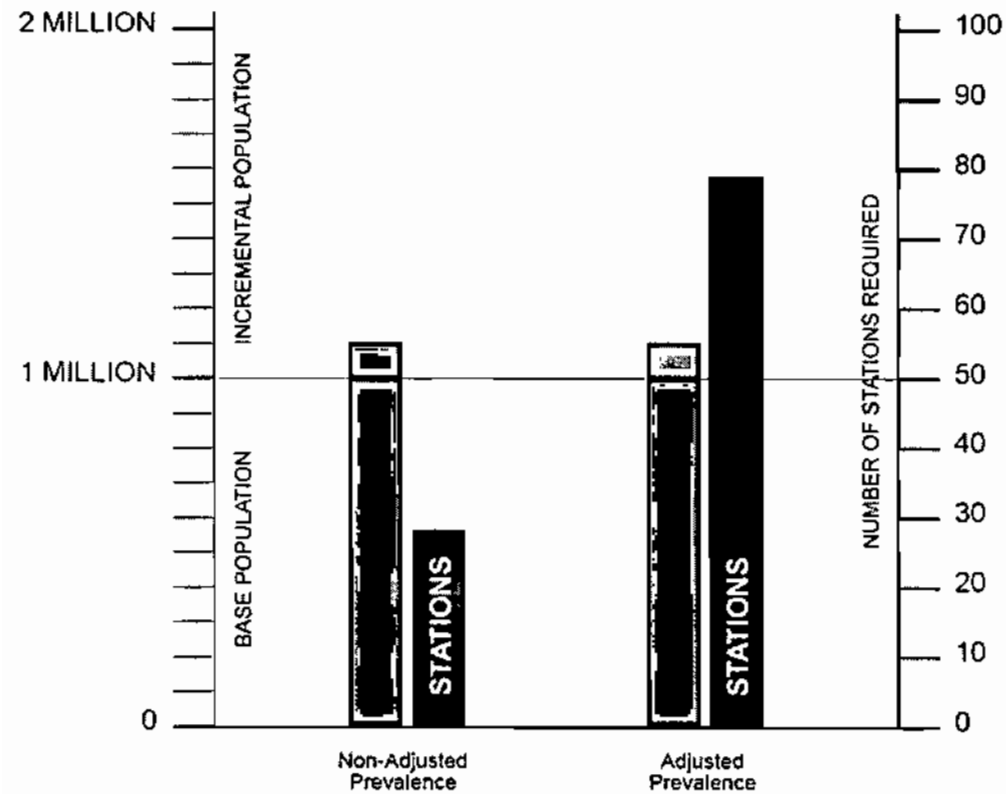
OVERALL PREVALENCE OF ESRD	1,699 per million population
Prevalence for Patients 65-74 years	5,941 per million population
Prevalence for Patients 75 years and over	5,266 per million population
Prevalence for African American Population	5,205 per million population
Prevalence for Hispanic Population	2,458 per million population
Average High Risk Prevalence (Mixed Average)	4,718 per million population

(Source: U.S. Renal Data Service, 2010 Annual Data Report: Volume 2 Atlas of End Stage Renal Disease, at 259)

APPLICATION OF ADJUSTED PREVALENCE

	Incremental Population	Prevalence Rate	Patients	Stations Required
Overall Prevalence	100,000	0.1699%	170	28
Average High Risk Prevalence	100,000	0.4718%	472	79

APPLICATION OF ADJUSTED PREVALENCE



ATTACHMENT 26

UNNECESSARY DUPLICATION OF SERVICES

The attached tables show the following information:

- A list of zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site; and
- The total population of the identified zip code areas (based upon the 2010 population numbers available for the State of Illinois population).

Zip Code	Total Population
60537	665
60450	20,332
60410	12,687
60421	3,968
60536	126
60541	3,148
60560	22,415
60545	12,940
60511	1,793
60512	1,111
60554	11,796
60447	13,709
60538	26,619
60506	53,013
60542	17,099
60539	341
60543	36,156
60503	16,717
60505	76,573
60519	88
60502	21,873
60510	28,897
60404	17,395
60586	46,251
60431	22,577
60544	25,959
60436	18,315
60435	48,899
60403	17,529
60446	39,807

Zip Code	Total Population
60585	22,311
60564	41,312
60504	37,919
60555	13,538
60563	35,922
60540	42,910
60490	20,463
60565	40,524
60440	52,911
60532	27,066
60433	17,160
60432	21,403
60441	36,869
60451	34,063
60491	22,743
60517	32,038
60515	27,503
60516	29,084
60559	24,852
60439	22,919
60561	23,115
60527	27,486
60185	36,527
60190	10,663
60189	30,472
60467	26,046
60480	5,246
60525	31,168
60458	14,428

ATTACHMENT 26

UNNECESSARY DUPLICATION OF SERVICES

The names and locations of all existing or approved health care facilities located within 30 minutes normal travel from the site that provide the dialysis services that are proposed by the project. This table indicates both facilities within an unadjusted 30 minute drive time and the 1.15 factor adjusted 30 minute drive time. Utilization data for these facilities is taken from the fourth quarter 2011 ESRD utilization .

Mapquest maps of driving times and distances are included in Appendix 2 in the order they appear in the facility table.

**U.S. RENAL CARE PLAINFIELD DIALYSIS UTILIZATION ANALYSIS
FACILITIES WITHIN A 30 MINUTE DRIVE TIME RADIUS (1.15 ADJUSTED)**

Name	Map Address	City	Zip Code	County	HSA	Stations	Patients	Drive Time	Adjusted Drive Time (1.15 X)	Included in Utilization Analysis	Utilization
Fresenius Medical Care of Oswego	6604 Mill Road	Oswego	60543	Kendall	9	10	41	18	20.7	Y	68.3%
Fox Valley Dialysis Center	1300 Waterford Drive	Aurora	60504	Kane	8	26	145	11	12.7	Y	92.9%
Fresenius Medical Center of Plainfield	24900 West Caton Farm Road	Plainfield	60544	Will	9	16	71	10	11.5	Y	74.0%
Silver Cross Renal Center West	1051 Essington Road	Joliet	60435	Will	9	29	147	18	20.7	Y	84.5%
Sun Health	2121 Oneida Street	Joliet	60435	Will	9	17	55	22	25.3	Y	53.9%
Fresenius Medical Care of Naperville-North	514 West 5th Avenue	Naperville	60563	DuPage	7	14	70	24	27.6	Y	83.3%
Fresenius Medical Care Naperbrook	2451 South Washington Street	Naperville	60565	Will	9	16	0	17	19.6	Y	0.0%
USRC Bolingbrook Dialysis	396 Remington Boulevard	Bolingbrook	60440	Will	9	13	0	18	20.7	Y	0.0%
FMC Bolingbrook	329 Remington Road	Bolingbrook	60440	Will	9	24	121	18	20.7	Y	84.0%
FMC - Naperville	100 Spalding Drive	Naperville	60566	Suburban Cook	7	15	81	22	25.3	Y	90.0%
Fresenius Medical Care Joliet	721 East Jackson Street	Joliet	60432	Will	9	16	0	28	32.2	N	0.0%
UTILIZATION CALCULATION FOR FACILITIES W/IN 30 MIN DRIVE TIME						196	731			11	62.2%
UTILIZATION CALCULATION FOR FACILITIES W/IN ADJUSTED 30 MIN DRIVE TIME						180	731			10	67.7%

ATTACHMENT 26

MALDISTRIBUTION

This Project will not result in maldistribution, because there is not a ratio of stations to population that exceeds one and one-half times the State average.

A ratio of stations to population that exceeds one and one-half times the State average:

The ratio of stations to population for within a 30 minute drive time of the proposed facility does not exceed one and a half times the State average. The State average, calculated from the most-recently available IDPH Revised Needs Determinations for ESRD Stations dated May 17, 2012 and 2010 census population statistics results in a state station to population ratio of 1 station per 3,346 persons. The calculated station to population ratio within the 30 minute drive time of the proposed facility is 1 station per 7,282 persons. Thus the station to population ratio within the 30 minute drive time of the proposed facility does not exceed one and one-half times the State average; in fact it is one-half the State average demonstrating that there is not a maldistribution of stations in the 30 minute drive time of the proposed facility.

The associated calculation of station to population ratios is included in this attachment. The calculation for the state station to population ratio utilizes 2010 Census data for the State of Illinois and the total station count as found on the IDPH Revised Needs Determinations for ESRD Stations dated May 17, 2012. The calculation of the station to population ratio for facilities within a 30 minute drive time is calculated using all facilities and zip codes identified in the Unnecessary Duplication of Services attachment.

13717 U.S. Route 30, Plainfield, Illinois 60544

Total Number of Stations for Facilities within a 30 Minute Drive Time	196
Total Population for Zip Codes within a 30 Minute Drive Time	1,427,459
Ratio of Stations to Population	7,282

State of Illinois

Total Number of Stations in the State of Illinois	3,834
Total Population in the State of Illinois	12,830,632
Ratio of Stations to Population	3,346

ATTACHMENT 26

IMPACT OF PROJECT ON OTHER AREA PROVIDERS

The addition of 13 ESRD stations at the U.S. Renal Care Plainfield Dialysis Facility would only account for 6.6% of the total shift capacity in the unadjusted 30-minute drive time area and 5.2% of the total shift capacity in HSA 9. Assuming 80% utilization (9,734 shifts per year) was achieved immediately, the facility would only make a 5.3% difference in the 30 minute drive time occupancy levels and less than a 4.2% difference in the total shift capacity of HSA 9. This increase in stations is fractional compared to the number of licensed stations in the area, thus it is unlikely that the addition of these stations will lower the utilization of other area providers, both those who are operating above 80% and those operating below 80%.

*This calculation is based on the HSA 9 approved stations of 250 as calculated on the IDPH Revised Needs Determinations for ESRD Stations dated May 17, 2012 and the 30 minute drive time facilities as identified in Attachment 26 Unnecessary Duplication of Services. Shift capacity of each station is calculated as 3 shifts per day, 6 days a week, 52 weeks a year.

ATTACHMENT 26

STAFFING AVAILABILITY

Medical Director

The curriculum vitae of the facility's Medical Director is included in this attachment.

Staff Recruitment

U.S. Renal Care, Inc. recruits facility personnel through the use of various job posting websites as well as a recruitment tool maintained on the corporate website (available at http://www.usrenalcare.com/us_renal_care_careers.htm).

Training

Applicant maintains rigorous orientation and training requirements for all staff of dialysis facilities. Clinical staff are subject to a comprehensive orientation regimen providing training for such personnel in multiple areas (policies related to orientation and competencies are included in this attachment). Such staff are also required to comply with any federal or state training requirements necessary for certification in their respective fields. In addition, U.S. Renal maintains both corporate and facility level training requirements for facility staff. For example, all staff are subject to corporate requirements for annual competency assessments and quarterly assignments provided through U.S. Renal Care's training tool, Health Streams (a copy of the schedule of assignments, email reminder and completion report are included in this attachment). Furthermore, dialysis staff are also required to comply with any facility required training programs as implemented by the governing body of the dialysis facility (see attached policy# EO-8002).

Staffing Plan

Applicant maintains staffing ratios in compliance with state requirements for the state in which Applicant maintains a dialysis facility. Included in this attachment is the U.S. Renal Care policy regarding staffing ratios which demonstrates the requirement for on duty RNs when the patients are present and maintenance of direct patient care providers in compliance with state regulations. In the case of Illinois Applicant will maintain a ratio of one direct patient care provider to every four patients.

Naila I Ahmed MD

9299 East Falling Water Drive
Burr Ridge, IL 60527

Phone (312) 560 1095 m (630) 8878005 Email: naila.ahmed@comcast.net

CLINICAL EXPERIENCE

Partner at Northeast Nephrology Associates 2002 – present. Working at St Joseph medical center, Silver Cross hospital and Morris hospital and take care of dialysis patients at outpatient centers including Silver Cross /Davita units, Fresenius, Nursing home etc.

Director at Silver Cross/ Davita East Hospital Unit.

Joliet home therapy: Director of Peritoneal dialysis Unit. Responsible for Building the PD program and supervision, management etc.

Clinical Instructor at Michael Reese Hospital, Chicago, Illinois, 2002 to 2005

Served as member of the Pharmacy Committee at ST. Joseph hospital medical center from 2005-2007

CHAIRMAN OF NEPHROLOGY, SILVER CROSS HOSPITAL, JOLIET, ILLINOIS FROM 5/07- present

Fellowship, Dept of Nephrology, University of Illinois at Chicago, 7/00 – 6/02

Residency, University of Illinois at Chicago, Dept. of Internal Medicine, Chicago, IL, 7/97 - 6/00

Externship, Veterans Affairs Medical Center/ George Washington University, Washington, D.C, 5/96 – 10/96

Lipid Clinic, George Washington University Hospital, Washington, D.C., 10/96- 2/97

Internship, Departments of Medicine & Surgery, Dhaka Medical College Hospital, Bangladesh, 2/94- 2/95. Completed training in General Medicine, Pediatrics and Psychiatry, General Surgery, Trauma (Casualty, Burn Unit, Neurosurgery), Orthopedics & Urology.

RESEARCH EXPERIENCE:

Research Fellow, Dept of Nephrology, University of Illinois at Chicago, 7/01- 6/02: As part of Nephrology Fellowship, worked at Cook County Hospital Research Lab on wound healing model, studying the role of Angiogenic factor such as Vascular Endothelial Growth Factor (VEGF), Angiopoietin, TIE 2 etc. In regulating Angiogenesis in Non Diabetic rat, PUBLISHED.

Research Assistantship, Department of Cardiology, George Washington University Hospital, Washington, D.C, 10/96-5/97. *Women's Health Initiative Study:* NIH funded research to evaluate the benefits and risks of estrogen replacement, low-fat diet and calcium supplement on overall morbidity and mortality of post-menopausal women.

Research Assistantship, Department of Neurology, and Veterans Affairs Medical Center, Washington, D.C, 9/96: *WARSS (Warfarin/Aspirin Recurrent Stroke Study):* NIH funded double blind, multicenter Trial.

Research Assistantship, United Nations Children's Fund (UNICEF), Bangladesh: Assisted in study on "Infant Feeding Practices in Bangladesh", breastfeeding vs. formula among women in Bangladesh.

EDUCATION:

Board Certified in Nephrology, 2002

The American Board of Internal Medicine Certification, 8/00

Educational Commission for Foreign Medical Graduates (ECFMG) Certification, 4/96

USMLE Step 1, 9/95: USMLE Step 2, 3/96: USMLE Step 3, 12/98

Certificate of Full Registration, Bangladesh Medical and Dental Council, 2/95

Bachelor of Science in Medicine & Surgery (M.B.B.S.), Dhaka Medical College, University of Dhaka, Bangladesh, 1994

HONORS:

- Ranked **9th** in Dhaka Regional Higher Secondary Certificate Exam. 1984
- Honors, 2nd M.B.B.S. Professional Exam; ranked **15th** in Bangladesh National Boards, 1988
- Consistently ranked among the top 5% of the class in Dhaka Medical College

SCHOLARSHIP:

Full scholarship to Medical School on the basis of National Boards rank in Higher Secondary Certificate School Exam.

PROFESSIONAL ORGANIZATIONS:

American College of Physicians

American Society of Internal Medicine

National Kidney Foundation

American Society of Nephrology

PERSONAL:

Foreign Languages: Fluent in Bengali, basic Urdu/Hindi

American Citizen

References Available Upon Request

1. DR. NAGARKATTE TEL 8157445550, NEPHROLOGY
2. DR. GAUTAM GUTTA INTERNAL MEDICINE, PROVENA ST JOSEPH HOSPITAL.
3. DR. NAZNEEN NOORANI 630-881-6506, INTERNAL MEDICINE
4. DR. AMAR GARAPATI, PULMONARY, SILVERCROSS HOSPITAL.

U.S. **RENAL CARE**

CONTINUING EDUCATION & IN-SERVICE PROGRAMS		EFFECTIVE DATE: 01/2011
POLICY # EO-8002	PAGE 1 OF 1	REVISION DATE: 01/2012

CONTINUING EDUCATION & IN-SERVICE PROGRAMS- **SEE STATE SPECIFIC ALSO**

PURPOSE: To provide guidelines on continuing education

POLICY:

All employees must have the opportunity for continuing education and related development activities. Continuing education and in-service programs are encouraged for all staff in the facility to continuously improve the quality of patient care by increasing staff knowledge.

PROCEDURE:

The governing body or designated persons are responsible for developing regularly scheduled monthly in-service programs that will meet the needs of the staff and the center.

Documentation of attendance at continuing education activities will be kept in the personnel file for each staff member. Continuing education activities may consist of, but are not limited to; seminars, lectures, and educational workshops for one-on-one training.

The Facility Administrator will maintain minutes of all such meetings, including attendance records. Out of center continuing education programs will be at the guidance of the Facility Administrator.

U.S. RENAL CARE		
Hemodialysis Charge Nurse Skills Checklist		EFFECTIVE DATE: 01/2011
POLICY # EO-1002		REVISION DATE: 04/2011

Employee: _____

Title: _____

Facility: _____

Date of Hire: _____

PA, VA, NY, GA a LPN maybe a charge nurse as long as dialysis RN is available in the building. The LPN may not supervise a RN

Charge Nurse, Administrator, or qualified designee may perform skills verification as preceptor

Objectives: To ensure proper orientation to the charge nurse position.

To provide a smooth transition from the clinical floor setting to the charge position

Expectations: The Charge Nurse will demonstrate ability to complete all charge nurse duties as per all facility protocols and procedures according to job description

Orientation Requirements	Date Completed	Preceptor Signature
Received a copy of the Federal/State Regulations and become familiar with the rule and regulations of the practicing state		
Understands and accepts expectations of job description		
Knows the facility's floor plan for emergency purposes and location of the equipment and supplies.		
Demonstrate knowledge of policies and procedures:		
a. Patients' Rights and Responsibilities	a.	a.
b. Patient's Grievance Procedure	b.	b.
c. Patient/Staff disaster plan, emergency evacuation and use of emergency supplies	c.	c.
d. Process for transferring patient to hospitals and other health care facilities	d.	d.
e. Patient Admissions and Discharges	e.	e.
f. Processing of the transient patient	f.	f.
g. Administration of medications and (count of narcotics) if required per facility procedure.	g.	g.
h. Administration of blood products (if provided) as per facility protocol	h.	h.
Demonstrates knowledge of the Electronic Medical Record(EMR)		
Pass a written comprehensive exam on Renal A&P, ESRD, and Hemodialysis with a score of 80% or better.		
Pass a written medication test as related to dialysis and other conditions related to renal failure		
Attend formal charge nurse education class contact educator.		
Daily Responsibilities	Date Completed	Preceptor Signature
Water Checks		
Veriflex Water testing is performed per policy,		
a. AM opening - Check all water parameters,	a.	a.
Pressure gauges, Softner and Carbon Tanks		
b. Checks Carbon tanks prior to start of each shift	b.	b.
c. End of the day checks - Softner tank	c.	c.
d. Ensures all logs are properly completed.	d.	c.
Clinical Checks		
Knows the location of the emergency cart, AED and suction equipment		
Ensures all equipment is functional and ready for use		
Verifies all daily checks are done, i.e.; glucometer, AED, crash cart, oxygen, suction supplies		
Assures drug counts are performed and accurate at start and end of day and documents on logs		
Verifies temperatures on medication and lab refrigerator are within established limits and documents on logs.		
Makes daily staff assignments based on patient needs		
Ensures staffing ratios do not exceed 4:1/PCT and 12:1/license nurse or as per state regs. FA is notified if not met		
Ensures staff maintains integrity of patient schedule. FA notified if not met		
Provides immediate supervision of patient care.		
Provides oversight and direction to PCTs and LVNs/LPNs		
Intervenes to changes in patient's condition		
Recommends changes in treatment based on patient's current needs		
Ensures patients are in view of staff during hemodialysis treatments.		

U.S. RENAL CARE		
Hemodialysis Charge Nurse Skills Checklist		EFFECTIVE DATE: 01/2011
POLICY # EO-1002		REVISION DATE: 04/2011

Ensures visualization of the patients, their access site, and their bloodline connections during the dialysis treatment		
Enforces staff compliance to personnel policies regarding breaks, lunch periods, etc.		
Efficiently manages staff hours and overtime - including sending staff home as needed when census is low.		
Ensures compliance with state and federal regulations - FA notified if not met		
References the Policy and Procedure manual to increase personal knowledge of P&P		
Practices according to company policies and procedures		
Verifies and corrects others to follow company P&P		
Follows proper infection control practices		
Monitors/corrects infection control practices for staff, patients and visitors - FA notified if not met		
Ensures biohazard waste is disposed of and stored properly		
Oversees the clinical floor is kept clean of debris/spills		
Ensures an unobstructed path to patient stations is maintained		
Ensures emergency exits are not obstructed		
Oversees that emergency procedures are followed		
Transcribes orders correctly onto Kardex, computer system, and/or methods as per facility protocol		
Verifies staff is transcribing/carrying out orders correctly		
Hospitalization of a patient: notifies physician, sends correct paperwork, proper documentation in progress notes.		
Proper documentation on return of hospitalized patient		
Conducts assessment of a patient when indicated by a question relating to a change in the patient's status, extended or frequent hospitalizations, or at the patient's request.		
Facilitates communication between the patient, patient's family or significant other		
Initiates and provide patient education and follow up as needed		
Participates in the interdisciplinary team review of a patient's progress		
Prepares for and assists with CIPA and POC completion as assigned		
Proper medication administration, including use of protocols for:		
a. Epogen	a.	a.
b. Vitamin D Analogs: Calcijex, Hectorol, Zemplar	b.	b.
c. Iron: Venfor, Fentecit	c.	c.
d. Oxygen	d.	d.
e. Hepatitis vaccine	e.	e.
f. TB Tuberculin Testing	f.	f.
g. Heparin	g.	g.
h. Lidocaine	h.	h.
i. Urokinase (Activase)	i.	i.
j. Antibiotics	j.	j.
k. Normal Saline	k.	k.
Manages complications during hemodialysis		
a. Hypotension	a.	a.
b. Hypertension	b.	b.
c. Cramps	c.	c.
d. Headaches	d.	d.
e. Pruritus	e.	e.
f. Nausea, vomiting	f.	f.
g. Fever, chills	g.	g.
h. Pyrogenic reaction	h.	h.
i. Chest pain	i.	i.
j. Seizures	j.	j.
k. Hypoglycemia	k.	k.
l. Hyperglycemia	l.	l.

U.S. RENAL CARE

Hemodialysis Charge Nurse Skills Checklist

EFFECTIVE DATE:
01/2011

POLICY # EO-1002

REVISION DATE:
04/2011

Oversees use and management of Reuse chemicals where applicable		
a. Approve sterilant	a.	a.
b. Signs and symptoms of reaction/exposure	b.	b.
Proper use of incident reports		
Verifies all ordered lab is drawn, processed, packaged and sent out		
Verifies staff perform pH/conductivity checks before treatment		
Recognizes machine problems, correctly handles machine problems, communicates with technical		
Communicates with physician, dietician, and social worker regarding patient needs		
Ensures charts are closed out prior to leaving and all paperwork communicated to business office as required (billing logs, etc.)		
Secures the building at the end of the day:		
a. makes sure all patients have left the facility	a.	a.
b. checks that water and acid valves have been turned off	b.	b.
c. checks that answering service has been activated	c.	c.
d. makes sure all doors have been locked	d.	d.
Weekly/Monthly/Quarterly Responsibilities	Date Completed	Preceptor Signature
Checks crash cart for adequacy of supplies, kind of supplies, and expiration dates, i.e.; meds, airway, lab tubes, misc.		
Checks to see what weekly labs need to be drawn		
Review of lab results and reports any critical abnormal results to the Physician		
Adjust patient treatment according to lab results following protocol		
Monthly Diabetic Foot Checks done		
Quarterly review of patient's home medication		
Treatment Initiation Responsibilities	Date Completed	Preceptor Signature
Conducts nursing rounds once all patients are undergoing treatment and		
a. reviews patient pre-treatment assessments and verifies accuracy and completeness	a.	a.
b. verifies all parameters are set to prescribed order.	b.	b.
c. verifies pre-treatments machine checks have been performed and documented	c.	c.
d. verifies treatment is initiated 3-5 minutes after heparin bolus is given according to documentation	d.	d.
Intradialytic Responsibilities	Date Completed	Preceptor Signature
Delegates administration of medications to licensed staff		
Verifies medications are prepared and labeled appropriately		
Adjusts medication doses based on lab per established protocol		
Reviews "routine" charting by nurses/PCTs		
Reviews "special situation" charting (acute problems, drug reactions, chest pain, fever, blood loss, etc.)		
Monitors machine alarms are answered in a timely manner		
Ensures 1/2 of all patient care staff are present on the clinical floor at all times.		
Turn-Around Responsibilities	Date Completed	Preceptor Signature
Orchestrates a smooth turnover by remaining on the dialysis floor during turnover, re-assigning staff as needed and troubleshooting problems		
Monitors sharps are disposed of properly		
Monitors trash is disposed of properly		
Ensures staff does not take breaks during turnover		
Ensures no personal phone calls are taken during turnover		
Physician Rounding Responsibilities	Date Completed	Preceptor Signature
Rounds with physicians and review labs, medications and other study results with MD. Updates MD to any new patient developments		
Receives new orders, transcribes them accurately, and carry them out in a time manner.		
Emergency Procedures	Date Completed	Preceptor Signature
Demonstrates Knowledge of Emergency Procedures		
a. Fire evacuation		
b. Loss of power		
c. Loss of water supply		
d. Natural disaster procedures		
Earthquake		
Tornado		
Hurricane		

US RENAL CARE	
Hemodialysis Charge Nurse Skills Checklist	EFFECTIVE DATE: 01/2011
POLICY # EO-1002	REVISION DATE: 04/2011

_____, has successfully completed the USRC Charge Nurse Skills Checklist to include successful return demonstrations and is competent to perform the clinical duties included on this checklist.

Employee Signature: _____

Date: _____

Reviewer Signature: _____

Date: _____

Medical Director Signature: _____

Date: _____

U.S. **RENAL CARE**

POLICY: RN / LPN / LVN ORIENTATION		EFFECTIVE DATE: 01/2011
POLICY # EO-1001	PAGE 1 OF 1	REVISION DATE:

RN/ LPN / LVN ORIENTATION

SCHEDULE FOR RN/LPN/LVN ORIENTATION AFTER ALL STEPS OF HEMODIALYSIS ORIENTATION ARE MET

(Ex. RN/LPN/LVN may only need 4 weeks to achieve Hemodialysis Orientation and then RN/LPN orientation can start)

- | | |
|----------------|---|
| Week I | Paperwork
Medication Administration and Documentation
Dressing Changes
IV Pump
Review of PD concepts- schedule with PD Nurse. Ultra Bag Competency and instillation of medications in PD bag.
Rounds with the physician
Transcribing orders
Evaluation |
| Week II | Charge Nurse Competency
Day I: Shadow the Charge Nurse
Day II-V: Charge Nurse role with Preceptor
Medication Test
Evaluation |

Reference: Core Curriculum for Nephrology Nursing

U.S. RENAL CARE

POLICY : PATIENT CARE TECHNICIAN CERTIFICATION		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0012	PAGE 1 OF 1	REVISION DATE:

POLICY:

All Patient Care Technicians (PCT's) shall be certified under a state or a nationally approved certification program as follows:

1. For newly employed patient care technicians, within 18 months of being hired as a dialysis patient care technician or
2. For patient Care technicians employed on October 14, 2008, within 18 months after this date (on or before April 14, 2010).
3. For current employees who transfer in to the patient care technician role from other jobs (reuse or water treatment technicians) certification will be obtained in 18 months from the date he/she started in the new PCT position

Ultimately US Renal Care (USRC) recognizes that certification of the PCT is an individual responsibility and a condition of continued employment in the dialysis industry. USRC will:

1. Offer review classes for voluntary attendance.
2. Offer copies of the "Amgen Care Curriculum for the Dialysis Technician" as a study guide.
3. Assist the employee with the application process to ensure completion and thoroughness of each application.
4. Pay initially for the first exam.
5. Reimburse for a second testing attempt once proof of a passing score is provided.
6. Encourage each PCT employed on October 14, 2008 to sit for the certification exam no later than the end of January 2010 to ensure adequate time to reschedule and retake the exam by the April deadline if necessary.

U.S. RENAL CARE

POLICY : NEW CLINICAL STAFF GUIDE		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0002	PAGE 1 OF 5	REVISION DATE: 1/2012

HEMODIALYSIS ORIENTATION FOR NEW CLINICAL STAFF

Also see State Specific

USRC definition of 'with experience' –employee has provided 6 months hands on dialysis patient care within the last 18 months.

The orientation period is approximately 6 – 8 weeks in length for non dialysis experienced staff. In order to meet the objective of the Orientation Checklist, and to allow for sufficient clinical practice, the following schedule is presented as a **guide**. Mastery of both theory and clinical skills is the responsibility of the student and no student may practice independently without demonstration and documentation of required skills. Until the individual has satisfied the training and competency requirements, the individual during the process of completing training shall be identified as a trainee when present in any patient area of the facility.

Prior to providing dialysis care, all nursing staff shall demonstrate satisfactory completion of either the training program or educational equivalency and the competency skills assessment checklist as required for the dialysis technicians.

Any registered nurse or licensed practical nurse who is employed without previous experience in the dialysis process, and who has not yet successfully completed the skills competency checklist, shall be directly supervised when engaged in dialysis treatment activities with patients by a staff member who has demonstrated skills competency for dialysis treatment as required by the State/Federal Regulations.

In addition to the Amgen and Nephrology Core Curriculums, the Employee Orientation Program Workbook is a good resource tool. Delivery of training material will be accomplished through a combination of lecture, video presentations and independent study.

WEEK 1:

Day 1: Facility tour and orientation

- Overview of the services provided by the facility
- Meet preceptor
- Meet the staff and physicians
- Review of Employee Handbook and Job Description
- Staff Roles and Responsibilities
- Overview of US Renal Care Philosophy
- Overview of P & P Manual
- Introduction of dialysis machine and dialysis prescription
- Reference Amgen Core Curriculum
- Read/review Module I and II (Today's Dialysis Environment/The Person with Kidney

Failure)

- Universal Precautions/OSHA Education
- HIPAA training
- Fire and Electrical Safety
- Professional education
- View state specific training videos

U.S. RENAL CARE

POLICY : NEW CLINICAL STAFF GUIDE		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0002	PAGE 2 OF 5	REVISION DATE: 1/2012

Testing: OSHA (TB, Blood borne pathogens, Universal Precautions, Hepatitis)

Day 2: Scavenger Hunt

Practice set up of dialysis machine with preceptor and removal of lines
 Observation of Hemodialysis procedure and orientation to clinic routines
 Proper cleaning of chairs, machines, clamps, and blood pressure cuffs
 Basic chemistry of body fluids and electrolytes
 History of Dialysis
 Legal and Ethical Issues
 Hygiene and Grooming
 Mobility and Positioning
 Read/review Module III (Principles of Dialysis)

Day 3: Practice set up of dialysis machine with preceptor

Introduction to screen of dialysis machine and machine components
 Reference Braun Operators Manual
 Vital signs
 Overview of the continuous quality improvement program
 Read/review Module IV (Hemodialysis Devices)
 Role of the dialysis technician in a dialysis setting: legal and ethical considerations and concepts of delegating.
 Communication and Team work Skills
 Pre and Post weights
 Machine testing PH/conductivity/temperatures

Day 4: Machine operation and introduction to problem solving with preceptor

Trouble shooting equipment – machine alarms
 Practices set up of the dialysis machine
 Policies and Procedures on Patients rights including Patient Bill of Rights
 Delivery of an adequate dialysis treatment and factors which may result in inadequate treatment
 Complications of dialysis and interventions
 Aseptic technique
 Education on the proper use of Safety Needles
 Education on accidental needle sticks (Issues and Prevention Strategies for Healthcare Workers)

Day 5: Preparation and use of dialysate baths

Practices set up of the dialysis machine
 Elder Abuse in the dialysis machine
 Testing: Module I (Today's Dialysis Environment)
 Identify allergies, patient chart (electronic medical record)
 Identify goal, treatment time, UFR, TMP
 Evaluation: Week 1

U.S. RENAL CARE

POLICY : NEW CLINICAL STAFF GUIDE		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0002	PAGE 3 OF 5	REVISION DATE: 1/2012

WEEK 2:

Continue practice set up and use of dialysis machine
 Residual testing for presence of bleach
 Introduction and education on access placement and taping access
 Review location and use of emergency equipment:
 (Oxygen, suction, crash cart, EKG, AED, Emergency box, fire drill & evacuation)
 Introduction to patient monitoring during treatment
 Introduction and education on documentation procedures and the HII system
 Theory and practice of conventional, high efficiency, and high flux dialysis
 Interpersonal Communication
 Read/review Module II and III (The Person with Kidney Failure/Principles of Dialysis)
 Evaluation: Week 2

WEEK 3:

Emergency Plans and Procedures
 Introduction to dialysis termination procedures
 Review and practice pre and post treatment procedures, patient monitoring
 Review clinic specific responsibilities and documentation
 Education on Transplants
 Review complication recognition and treatment
 Continue practice with machine set up and operation
 Read/review: Module V (Vascular Access)
 Testing: Module IV (Hemodialysis Devices)
 Evaluation: Week 3

WEEK 4:

Introduction to initiation of dialysis with catheters (as appropriate to job description)
 Review and educate on commonly used dialysis medications
 Medication Administration
 Continue supervised practice of dialysis termination
 Review P & P Manual
 Normal and abnormal lab values
 Pre and post dialysis blood draws
 Lab processing duties
 Orientation and competency for blood glucose monitoring equipment
 Supervised practice to incorporate pre and post dialysis procedures and patient
 Monitoring with machine operation, and documentation
 Introduction to initiation of dialysis by cannulation
 Introduction of materials used to create grafts, needle placement for access in a graft, and
 prevention of complications: and identification of signs and symptoms of complications
 when cannulating access
 Education on PD
 Renal Dietitian: Nutritional Considerations
 Read/review Module VI (Hemodialysis Procedures and Complications)
 Evaluation: Week 4

WEEK 5:

U.S. RENAL CARE

POLICY : NEW CLINICAL STAFF GUIDE		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0002	PAGE 4 OF 5	REVISION DATE: 1/2012

Cannulation of a patient with fistula needles
The orientee will incorporate trouble shooting and patient complications with all previously learned and practiced experience
Continue supervised practice of dialysis initiation via catheter, dialysis termination, and treatment procedures and monitoring
Incorporate machine problem solving and recognition and treatment of complications
Into practice
Education on monitoring of arterial and venous pressures
Renal Social Worker: Psychosocial issues
Read/review Module VII and VIII (Dialyzer Reprocessing/Water Treatment)
Testing: Module V (Vascular Access)
Evaluation: Week 5

WEEK 6:

Continue supervised practice of hemodialysis procedures
Competently complete a 1 – 2 patient assignment
Education on the management of adequacy outcomes
Technical Specialist: Water system, risks to patients of unsafe water, water checks, machine maintenance, trouble shooting machines and cleaning of machines
Evaluation: Week 6 (Preceptor/Orienteer/Administrator)

WEEK 7 & 8:

Competently complete assigned patient assignment
Testing: Module VII and VIII (Dialyzer reprocessing/Water Treatment)

This orientation program is based on the assumption that the orientee has no previous experience. Alterations/Adjustments in the orientation program will be made based on previous experience and proven clinical skills. During orientation the orientee will also receive theory training provided by the Clinical Services Department.

REFERENCES TO BE REVIEWED DURING ORIENTATION:

Core Curriculum for Dialysis Technicians
State Specific Educational Videos
Dialysis Training Manual
Dialysis Machine Manual
Dialysis Machine Trouble Shooting Guide

EVALUATION:

U.S. RENAL CARE

POLICY : NEW CLINICAL STAFF GUIDE		EFFECTIVE DATE: 01/2011
POLICY #: EO - 0002	PAGE 5 OF 5	REVISION DATE: 1/2012

All tests in the **Employee Education Manual** are to be passed with a score of 80% including the 'Knowledge Assessment Test'. Passing of the 'Knowledge Assessment Test' includes experience and non-experienced staff. If an experienced Care Giver does not pass the 'Knowledge Assessment Test' the first time – the employee needs to attend a theory class and retake the exam.

All employees (experience and non-experienced) may take the 'Knowledge Assessment Test' a maximum of three times. After third failure, the employee will be terminated.

Weekly evaluations with the orientation checklist will be filled out throughout the orientation process by the orientee, preceptor, and educator. The Administrator will evaluate all checklists weekly.

If at any time there are difficulties with the learning of the didactic material or inability to complete modules in the specified time period the Facility Administrator will be notified immediately. If at any time there are difficulties with the dialysis machine set-up, treatment monitoring, or termination of the treatment the Administrator will be notified. The Preceptor and Administrator will assess the training schedule orientee's progress and if needed will make changes in the orientation program.

U.S. RENAL CARE

POLICY : STAFFING POLICY		EFFECTIVE DATE: 01/2011
POLICY #: C-AD-0140	PAGE 1 OF 1	REVISION DATE: 09/2011

Staffing requirement for the ESRD facility include the coordination of personnel by the facility administrator to adequately staff for safe and effective provision of patient care.

The following guidelines will direct the staffing of each facility.

1. A fulltime supervising nurse shall be employed to manage the provision of patient care.
2. A nurse or nurses functioning in the charge role shall be on site and available to the treatment area to provide patient care during all dialysis treatments.
3. A registered nurse shall be in the facility when patients are present in the facility – if applicable.
4. Licensed nurse to patient ratio shall meet the required state regulations which govern the facility. If there are no state specific regulations, then the minimum requirement is to have one licensed nurse to every 12 patients.
5. Sufficient direct care staff shall be on-site to meet the needs of the patients. The ratio of direct care staff shall be one to four patients per shift, unless specified by state specific regulations. The staffing level shall not exceed that which is required by state specific regulations which govern the facility. See below for state specific staffing requirements.

State Specific Staffing Requirements

State	Licensed Staff to Patient Ratio	Direct Care Staff to Patient Ratio
Georgia	1 to 10	1 to 4
Maryland	1 to 9	1 to 3
New Jersey	1 to 9	1 to 3
Ohio	None	None
South Carolina	1 to 10	1 to 4
Texas	1 to 12	1 to 4
Pennsylvania	None	None
Arkansas	None	None
Oklahoma	None	None
New York	None	None
Illinois	None	None

U.S. RENAL CARE		
Clinical Annual Competency		EFFECTIVE DATE: 01/2011
POLICY # EO-9003		REVISION DATE:

Employee: _____
Title: _____
Date of Hire: _____

NOTE: Not All Skills May Be Required

Universal Precautions/Exposure Control	Date Completed	Preceptor Signature
Sterile Technique		
Aseptic Technique		
Machine Setup/Initiation of Treatment	Date Completed	Preceptor Signature
Hemodialysis Machine Set-Up		
Correct Bath		
Gather all Supplies		
Turn on Water		
Alarm Testing		
Line Placement/Connect Concentrate		
Peracetic Acid or other Residual Sterilant Testing (when applicable)		
Secures the Correct Dialyzer for the Patient		
Verification of Dialyzer		
Conductivity/pH Procedure		
Treatment Settings		
Treatment Procedure	Date Completed	Preceptor Signature
Initiation of Treatment		
Calculating Fluid Removal		
Setting UFR/Programs/Na Modeling/Coef		
Calculating Fluid Replacement		
Adjusts Blood Flow Rate to Patient's Prescription		
Ultrafiltrate Only		
Heparin Administration		
Patient Monitoring		
Vital Signs		
Fluid Replacement		
Complication Assessment and Treatment		
Reports unusual Findings to CN		
Oxygen Administration (if applicable)		
Verifies the Ordered Flow Rate from the CN		
Sets up Equipment Correctly		
Connects Tubing Correctly to Equipment and to Patient		
Complication Intervention	Date Completed	Preceptor Signature
Hypotension		
Hypertension		
Nausea/Vomiting		
Cramping		
Chest Pain		
SOB		
Seizures		
Cardiac/Respiratory Arrest		
Inform CN of any Unusual Findings		

U.S. RENAL CARE		
Clinical Annual Competency		EFFECTIVE DATE: 01/2011
POLICY # EO-9003		REVISION DATE:

Medication Administration	Date Completed	Preceptor Signature
Aseptic technique is used when preparing and administering intravenous medications from vials and ampules		
P.O.		
I.M.		
I.V. Push		
I. V. Drip		
Sub Q		
Labels Syringes Correctly		
Lidocaine Administration (if applicable)		
Checks Patient's Prescription		
Identifies the Correct Vial of Medication		
Prepares Dosage Correctly		
Administers the Dose Correctly		
Observes for and Understands Possible Complications		
Heparin Administration (if applicable)		
Describes Basics of Anticoagulation Therapy		
Assess Patient for and Reports Evidence of Active Bleeding		
Checks Patient's Prescription		
Identifies the Correct Vial of Medication		
Prepares Dosage Correctly		
Administers the Dose Correctly		
Observes for and Understands Possible Complications		
Monitors Appropriateness of Anticoagulation Throughout Treatment		
Normal Saline Administration (if applicable)		
Understand Facility Protocol		
Checks Patient's Prescription		
Recognizes Signs of Hypotension		
Notifies RN Appropriately		
Administers Normal Saline Correctly		
Treatment Termination	Date Completed	Preceptor Signature
Rinseback Procedure		
Removal of Fistula Needles		
Treatment of Post Treatment Bleeding		
Care of Catheters Post Treatment (if applicable)		
Discarding Supplies		
Reports Unusual Findings to CN		
Sanitizing equipment and treatment area		
Catheters (As Per State Regs)	Date Completed	Preceptor Signature
Assessment		
Pretreatment Preparation		
Initiation of Dialysis		
Accessing the Bloodstream		
Correcting Operational Problems:		
Poor Arterial Flow		
Poor Venous Flow		
Clotting in Catheter		
Elevated Arterial/Venous Pressures		
Site Infections/Cultures		
Take Off Preparation		
Rinseback Procedure		
Post Treatment Care of Catheter		
Dressing Change		

U.S. RENAL CARE		
Clinical Annual Competency		EFFECTIVE DATE: 01/2011
POLICY # EO-9003		REVISION DATE:

Fistula's/Grafts	Date Completed	Preceptor Signature
Assessment of Bruit and Thrill		
Pretreatment Preparation		
Cannulation		
Inspects the Access for Patency		
Prepares the Skin Using Aseptic Technique at all Times		
Calls for Assistance Appropriately		
Places Needles Correctly		
Replaces Needles Appropriately		
Secures Needles		
Accessing the Bloodstream		
Operational Problems and Corrections:		
Responds Appropriately to Machine Alarms		
Infiltration with Cannulation		
Infiltration During Treatment		
Arterial/Venous Spasms		
Arterial/Venous Pressure Problems		
Localized Bleeding		
Dislodged Needle		
Clotted Needle/Dialyzer		
Blood Leak into Dialysate		
Blood Leak Outside of Bloodpath		
Documentation	Date Completed	Preceptor Signature
Clinical Information System use		
Flowsheet		
Dialyzer and Patient Verification		
Machine Checks		
Vital Signs		
Medication Administration		
Pre and Post Assessments		
Treatment Complications		
Monthly Nursing Charting		
Admissions Charting		
Discharge Charting		
Patient Occurrence Charting		
Patient Assessment/Plan of Care		
Diagnostic Laboratory Testing	Date Completed	Preceptor Signature
Monthly and Other Labwork		
Blood/Wound Cultures		
Blood Glucose Testing		
Able to Describe Appropriate Response to Patient Emergencies	Date Completed	Preceptor Signature
Air Embolism		
Cardiac/Respiratory Arrest		
Unstable Angina		
Seizures		
Shock		
"New Dialyzer Reaction"		
Hemolysis		
Pyrogenic Reaction		
Chlorine in Dialysate		
Other		

U.S. RENAL CARE		
Clinical Annual Competency		EFFECTIVE DATE: 01/2011
POLICY # EO-9003		REVISION DATE:

Equipment and Building Emergencies	Date Completed	Preceptor Signature
Dialyzer Blood Leak		
Clotted Dialyzer and/or Lines		
Loss of Electrical Power		
Hand Crank Take-Off Procedure		
Fire or Flood		
Emergency Evacuation of Building		
Tornado/Hurricane/Blizzard Plans		
Knows Correct Procedure for Machine Failure		
Use of Emergency Equipment	Date Completed	Preceptor Signature
Oxygen		
Ambu Bag/Oral Airway		
Crash Cart		
Portable Suction		
Pt. Evacuation During an Emergency		
Education	Date Completed	Preceptor Signature
Fire Safety		
Back Safety		
Hazard Communication		
Electrical Safety		
US Renal Care Standards of Conduct & Compliance Program		
Prevention of Slips, Trips and Falls		
Emergency Preparedness		
Prevention of Needlesticks		
Additional competencies as required by state specific regulation, job role or needs assessment		
Complete Annual Competency Checklist - Clinical Employee (Technical Training Manual Section 9)		

_____, has successfully completed the USRC Clinical Annual Training Program to include successful return demonstrations and is competent to perform the clinical duties included on this checklist.

Employee Signature: _____

Date: _____

Preceptor Signature: _____

Date: _____

Medical Director Signature: _____

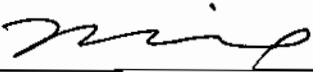
Date: _____

ATTACHMENT 26

STAFFING AVAILABILITY

USRC Plainfield, LLC

As required by 77 Ill. Admin. Code § 1110.1430(e)(5), Applicant certifies that U.S. Renal Care Plainfield Dialysis will maintain an open medical staff. Any board licensed nephrologist may apply for privileges at this facility.



Signature

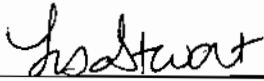
Thomas L. Weinberg

Printed Name

Manager

Title

Subscribed and sworn to before me this 12th day of June, 2012



Signature of Notary

Seal



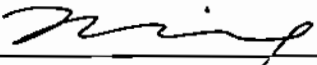
ATTACHMENT 26

SUPPORT SERVICES

USRC Plainfield, LLC

In accordance with 77 Ill. Admin. Code § 1110.1430(f) and with respect to the U.S. Renal Care Plainfield Dialysis facility, Applicant certifies that:

1. Applicant certifies that it will utilize the Health Informatics International system for the provision of care to its patients;
2. Applicant certifies that support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric and social services will be available to its patients; and
3. Applicant certifies that provision of training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training will be provided at the U.S. Renal Care Oak Brook Dialysis facility.



Signature
Thomas L. Weinberg

Printed Name
Manager

Title

Subscribed and sworn to before me this 12th day of June, 2012



Signature of Notary

Seal



ATTACHMENT 26

MINIMUM NUMBER OF STATIONS

The proposed U.S. Renal Care Plainfield Dialysis facility contemplates the establishment of 13 ESRD stations which meets the minimum station requirements for a metropolitan statistical area.

ATTACHMENT 26

CONTINUITY OF CARE

HOSPITAL TRANSFER AGREEMENT

THIS HOSPITAL TRANSFER AGREEMENT ("Agreement") is entered into effective the 14th day of June, 2012 (the **"Effective Date"**) by and between the **USRC Plainfield, LLC**, an Illinois limited liability company (the **"Center"**), and **Provena Saint Joseph Medical Center**, an operating unit of Provena Hospitals, an Illinois not-for-profit corporation (**"Hospital"**). (Center and Hospital may each be referred to herein as a **"Party"** and collectively as the **"Parties"**).

RECITALS

WHEREAS, the Center intends to submit to the Illinois Health Facilities Services and Review Board an application for a certificate of need permit to establish a free-standing renal dialysis center for treatment of patients with end-stage renal disease, which will be located in Lemont, Illinois; and

WHEREAS, patients of Center (**"Patients"**) may require transfer to a hospital for acute-inpatient or other emergency health care services; and

WHEREAS, Hospital owns and operates a licensed and Medicare certified acute care hospital in reasonable proximity to Center, which has a twenty-four (24) hour emergency room and provides emergency health care services; and

WHEREAS, the Parties desire to establish a transfer arrangement to ensure continuity of care for Patients and to specify the procedure for ensuring the timely transfer of patients to Hospital.

NOW, THEREFORE, in consideration of the foregoing, and the terms, conditions, covenants, agreements and obligations set forth herein, the Parties hereto agree as follows:

ARTICLE I **TRANSFER OF PATIENTS**

Upon recommendation of an attending physician and pursuant to the provisions of this Agreement, in the event that any Patient needs acute inpatient or emergency care and has either requested to be taken to Hospital, or is unable to communicate a preference for hospital services at a different hospital, and a timely transfer to Hospital would best serve the immediate medical needs of Patient, a designated staff member of Center shall contact the admitting office or emergency department of Hospital (the **"Emergency Department"**) to facilitate admission. Hospital shall accept, and as appropriate, admit a Patient as promptly as possible in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission (**"TJC"**) and any other applicable accrediting bodies, and reasonable policies and procedures of Hospital, and Hospital has the capacity to treat the Patient. After receiving a transfer request, Hospital shall give prompt confirmation of whether it can provide health care appropriate to the Patient's medical needs. Hospital's responsibility for patient care shall begin when Patient is admitted to Hospital.

ARTICLE II
RESPONSIBILITIES OF CENTER

Center shall be responsible for performing or ensuring the performance of the following:

- (a) Arranging, at no cost to Hospital, for ambulance service to Hospital;
- (b) Designating a person who has authority to represent Center and coordinate the transfer of Patient to Hospital ("**Transfer Coordinator**"). The Center will notify Hospital and keep it apprised of the name and contact information of the Transfer Coordinator;
- (c) Notifying Hospital's designated representative prior to transfer to alert him or her of the impending arrival of Patient and provide information on Patient to the extent allowed pursuant to Article IV. Such notice shall be as far in advance as possible and in any event prior to the Patient leaving the Center for transport, to allow the Hospital to determine whether it can provide the necessary Patient care;
- (d) Notifying Hospital of the estimated time of arrival of the Patient;
- (e) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to the care and transfer of individuals to Hospitals for emergency care;
- (f) The Patient's medical record shall contain a physician's order to transfer the Patient. The attending physician recommending the transfer shall communicate directly with Hospital's patient admissions, or, in the case of an emergency services patient who has been screened and stabilized for transfer, with the Hospital's Emergency Department.
- (g) In addition to a Patient's medical records and the physician's order to transfer, Center shall provide Hospital with all information regarding a Patient's medications, and clear direction as to who may make medical decisions on behalf of the Patient, with copies of any power of attorney for medical decision making or, in the absence of such document, a list of next of kin, if feasible, to assist the Hospital in determining appropriate medical decision makers in the event a Patient is or becomes unable to do so on his or her own behalf.
- (h) Personal effects of any transferred Patient shall be delivered to the transfer team or admissions department of the Hospital. Personal effects include, but are not limited to money, jewelry, personal papers and articles for personal hygiene.

ARTICLE III
RESPONSIBILITIES OF HOSPITAL

Hospital shall be responsible for performing or ensuring performance of the following:

- (a) Designating a person who has authority to represent and coordinate the transfer and receipt of Patients into the Emergency Department; and
- (b) Timely admission of Patient to Hospital when transfer of Patient is medically appropriate as determined by Hospital attending physician subject to hospital capacity and patient census issues provided, that all usual conditions of admission to Hospital are met; and
- (c) Recognizing and complying with the requirements of any federal and state law and regulations or local ordinances that apply to Patients who present at Emergency Departments.

ARTICLE IV
PATIENT INFORMATION

In order to meet the needs of Patients with respect to timely access to emergency care, Center shall provide information on Patients to Hospital, to the extent approved in advance or authorized by law and to the extent Center has such information available. Such information shall include: Patient Name, Social Security Number, Date of Birth, insurance coverage and/or Medicare beneficiary information (if applicable), current medical findings, diagnoses, known allergies or medical conditions, treating physician, contact person in case of emergency and any other relevant information Patient has provided Center in advance. The Center shall send a copy of all Patient medical records and information set forth in Section II(g) that are available at the time of transfer to the Hospital. Other records shall be sent as soon as practicable after the transfer. The Patient's medical record shall contain evidence that the Patient was transferred promptly, safely and in accordance with all applicable laws and regulations. Each Party shall and shall cause its employees and agents to protect the confidentiality of all Patient information (including, but not limited to, medical records, electronic data, radiology films, laboratory blocks, slides and billing information), and comply with all applicable state and federal laws and regulations protecting the confidentiality of Patients' records, including the Health Insurance Portability and Accountability Act of 1996 and the corresponding Standards for Privacy of Individually Identifiable Health Information regulations, each as amended from time to time (collectively, "HIPAA").

ARTICLE V
NON EXCLUSIVITY

This Agreement shall in no way give Hospital an exclusive right of transfer of Patients of Center. Center may enter into similar agreements with other acute-care hospitals, and Patients will continue to have complete autonomy with respect to choice of hospital service providers, as further described in **Article VI**.

ARTICLE VI
FREEDOM OF CHOICE

In entering into this Agreement, Center in no way is acting to endorse or promote the services of Hospital. Rather, Center intends to coordinate the timely transfer of Patients for medical care. Patients are in no way restricted in their choice of hospitals or medical care providers.

ARTICLE VII
BILLING AND COLLECTIONS

Each Party shall be responsible for billing the appropriate payer for the services it provides. Hospital shall be responsible for the billing and collection of all charges for professional services rendered at Hospital. Center shall in no way share in the revenue generated by professional services delivered to Patients at Hospital.

ARTICLE VIII
INDEPENDENT RELATIONSHIP

Section 8.1 In performing services pursuant to this Agreement, Hospital and all employees, agents or representatives of Hospital are, at all times, acting and performing as independent contractors and nothing in this Agreement is intended and nothing shall be construed to create an employer/employee, principal/agent, partnership or joint venture relationship. Center shall neither have nor exercise any direction or control over the methods, techniques or procedures by which Hospital or its employees, agents or representatives perform their professional responsibilities and functions. The sole interest of Center is to coordinate the timely transfer of Patients to Hospital for medical care.

Section 8.2 Each Party shall be solely responsible for the payment of compensation and benefits to its personnel and for compliance with any and all payments of all taxes, social security, unemployment compensation and worker's compensation.

Section 8.3 Notwithstanding the terms of this Agreement, in no event shall Hospital or any Hospital personnel be responsible for the acts or omissions of non-Hospital personnel.

ARTICLE IX **INSURANCE**

Both Parties shall maintain, at no cost to the other Party, professional liability insurance in an amount customary for its business practices. Each Party shall provide evidence of the coverage required herein to the other Party on an annual basis upon request. Each Party shall notify the other Party at least thirty (30) days prior to termination, lapse or loss of adequate insurance coverage as provided herein. In the event the form of insurance held by a Party is claims made, such Party represents and warrants that it will purchase appropriate tail coverage for claims, demands, or actions reported in future years for acts of omissions during the Term of this Agreement. In the event of insufficient coverage as defined in this **Article IX**, or lapse of coverage, the non-breaching Party reserves the right to immediately and unilaterally terminate this Agreement. Each Party shall notify the other in writing, by certified mail, of any action or suit filed and shall give prompt notice of any claim made against either by any person or entity that may result in litigation related in any way to this Agreement.

ARTICLE X **INDEMNIFICATION**

Each Party shall indemnify, defend and hold harmless the other Party together with its officers, directors, agents, employees, affiliates, successors and assigns from and against any and all liability, loss, claim, lawsuit, injury, cost, damage or expense whatsoever (including reasonable attorneys' fees and court costs), imposed by a third party and arising out of, incident to or in any manner occasioned by the performance or nonperformance of any duty or responsibility under this Agreement by such indemnifying Party, or any of its employees, agents, contractors or subcontractors. Provided, however, neither Party shall indemnify, defend or hold harmless the other Party from claims arising from the other Party's, or its officers, directors, agents, employees, affiliates, successors and assigns, gross negligence or willful misconduct.

ARTICLE XI **TERM AND TERMINATION**

Section 11.1 Term. The initial term of this Agreement shall commence on the Effective Date and shall continue in effect for a period of one (1) year (the "**Initial Term**"). Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless terminated pursuant to this Section. The Initial term and all renewal terms shall collectively be the "**Term**" of this Agreement.

Section 11.2 Events of Termination. Notwithstanding the foregoing, this Agreement may be terminated upon the occurrence of any one (1) of the following events:

- (a) Either Party may terminate this Agreement at any time upon sixty (60) days prior written notice to the other Party.
- (b) If either Party shall apply for or consent to the appointment of a receiver, trustee or liquidator of itself or of all or a substantial part of its assets, file a voluntary

petition in bankruptcy, or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if an order, judgment, or decree shall be entered by a court of competent jurisdiction or an application of a creditor, adjudicating such Party to be bankrupt or insolvent, or approving a petition seeking reorganization of such Party or appointing a receiver, trustee or liquidator of such Party or of all or a substantial part of its assets, and such order, judgment, or decree shall continue in effect and unstayed for a period of thirty (30) consecutive calendar days, then the other Party may terminate this Agreement upon ten (10) business days' prior written notice to such Party.

Section 11.3 Immediate Termination. Notwithstanding anything to the contrary herein, this Agreement will be terminated immediately upon the following events: (a) the suspension or revocation of a Party's license, certificate or other legal credential necessary to render patient care services and meet the terms and conditions of this Agreement; (b) termination of a Party's participation in or exclusion from any federal or state health care program for any reason; (c) the cancellation or termination of a Party's insurance required under Article IX of this Agreement without replacement coverage having been obtained; and (d) a Party determines that the continuation of this Agreement would endanger Patient care.

Section 11.4 Termination Due to Change in or Violation of Law. The Hospital shall have the unilateral right to terminate or amend this Agreement, without liability, to the extent necessary to comply with any legal order issued to the Hospital by a federal or state department, agency or commission, or TJC or any such accreditation organization by which the Hospital is then accredited, or if it is reasonably determined that continued participation in this Agreement would jeopardize the Hospital's status as a Medicare or Medicaid participant or would be inconsistent with its status as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. Prior to termination of this Agreement pursuant to this Section, Hospital shall first reasonably attempt to amend this Agreement in a manner that will achieve the business purposes hereof. If Hospital proposes an amendment to this Agreement pursuant to in order to comply with applicable law or accreditation standards, and such amendment is unacceptable to Center, either Party may choose to terminate this Agreement immediately upon notice at any time thereafter.

ARTICLE XII

MISCELLANEOUS PROVISIONS

Section 12.1 Entire Agreement. This Agreement constitutes the entire understanding between the Parties with respect to the subject matter hereof. This Agreement supersedes any and all other prior agreements either written or oral, between the Parties with respect to the subject matter hereof.

Section 12.2 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.

Section 12.3 Waiver. Any waiver of any terms and conditions hereof must be in writing, and signed by the Parties. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other terms and conditions hereof.

Section 12.4 Severability. The provisions of this Agreement shall be deemed severable, and, if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the Parties.

Section 12.5 Headings. All headings herein are inserted only for convenience and ease of reference and are not to be considered in the construction or interpretation of any provision of this Agreement.

Section 12.6 Assignment. This Agreement, being intended to secure the services of Hospital, shall not be assigned, delegated or subcontracted by Hospital without prior written consent of Center.

Section 12.7 Governing Law. This Agreement shall be construed under the laws of the state of Illinois, without giving affect to choice of law provisions.

Section 12.8 Notices. Any notice herein required or permitted to be given shall be in writing and shall be deemed to be duly given on the date of service if served personally on the other Party, or on the fourth (4th) day after mailing, if mailed to the other Party by certified mail, return receipt requested, postage pre-paid, and addressed to the Parties as follows:

To Center

USRC Plainfield, LLC

To Hospital

Provena Saint Joseph Medical Center
333 North Madison Street
Joliet, IL 60435
Attn: CEO

Copy to:

Presence Health
7435 West Talcott Ave., Suite 461
Chicago, IL 60631
Attention: Chief Legal Officer and
General Counsel

or such other place or places as either Party may designate by written notice to the other.

Section 12.9 Amendment. This Agreement may be amended upon mutual, written agreement of the Parties.

Section 12.10 Regulatory Compliance. The Parties agree that nothing contained in this Agreement shall require Center to refer patients to Hospital for emergency care services or to

purchase goods and services. Notwithstanding any unanticipated effect of any provision of this Agreement, neither Party will knowingly and intentionally conduct its behavior in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs.

Section 12.11 Access to Books and Records. If applicable, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States, or any of their duly authorized representatives, Hospital shall make available to the Secretary or to the Comptroller General those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing its services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such service. This Section is included pursuant to and is governed by the requirements of Public Law 96-499 and Regulations promulgated thereunder. The Parties agree that any attorney-client, accountant-client or other legal privileges shall not be deemed waived by virtue of this Agreement.

IN WITNESS THEREOF, the Parties have caused this Agreement to be executed by their duly authorized officers hereto setting their hands to be effective as of the Effective Date.

CENTER
USRC Plainfield, LLC

HOSPITAL
Provena Saint Joseph Medical Center,
an operating unit of Provena Hospitals

Signature: P. NAGARKATTE
Printed Name: P. NAGARKATTE
Title: Partner
Date: 6/14/12

Signature: Beth Hughes
Printed Name: Beth Hughes
Title: President/CEO
Date: 6/14/12

ATTACHMENT 28

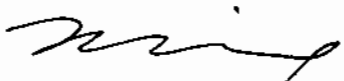
ASSURANCES

USRC Plainfield, LLC

In accordance with 77 Ill. Admin. Code § 1110.1430(j), and with respect to the U.S. Renal Care Plainfield Dialysis facility, Applicant certifies the following:

1. By the second year of operation after the project completion, the Applicant will achieve and maintain the 80% utilization standards as specified in 77 Ill. Adm. Code § 1100; and
2. That Applicant will achieve and maintain compliance with the following adequacy of hemodialysis outcome measures for the latest 12-month period for which data are available:

≥ 85% of hemodialysis patient population achieves area reduction ratio (URR) ≥ 65% and ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II
.1.2.



Signature

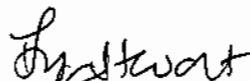
Thomas L. Weinberg

Printed Name

Manager

Title

Subscribed and sworn to before me this 12th day of June, 2012



Signature of Notary

Seal



ATTACHMENT 39

AVAILABILITY OF FUNDS

Applicant documents 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 cash and securities. Applicant will fund the project through capital contributions from its members. In the event that such contributions are insufficient to cover the costs associated with this project, U.S. Renal Care, Inc. will provide funding to Applicant through USRC Alliance, LLC by way of a revolving promissory note. As evidence of U.S. Renal Care, Inc.'s financial viability, we have included audited financials for 2009-2011. In addition, included in Attachment 42 is a certification from U.S. Renal Care, Inc. attesting to the reasonableness of the financing arrangement. Lastly, the master lease for dialysis equipment is also included in this attachment. The lessee contemplated by the master lease is a wholly owned subsidiary of U.S. Renal Care, Inc. and the equipment will be subsequently leased to USRC Plainfield, LLC.



U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2011 and 2010

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 3100
717 North Harwood Street
Dallas, TX 75201-6585

Independent Auditors' Report

The Board of Directors
U.S. Renal Care, Inc.:

We have audited the accompanying consolidated balance sheets of U.S. Renal Care, Inc. and subsidiaries (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of operations, changes in equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of U.S. Renal Care, Inc. and subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

Dallas, Texas
April 6, 2012

KPMG LLP is a Delaware limited liability partnership,
the U.S. member firm of KPMG International Cooperative
("KPMG International"), a Swiss entity.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2011 and 2010

Assets	2011	2010
Cash and cash equivalents	\$ 28,171,825	9,537,107
Accounts receivable, net of allowances of \$11,410,941 and \$13,458,494	48,222,030	48,449,631
Inventories	10,507,508	3,100,193
Other receivables	11,034,880	9,994,938
Deferred tax asset	3,613,197	6,215,457
Other current assets	3,166,263	2,636,244
Total current assets	104,715,703	79,933,570
Property and equipment, net	45,902,288	46,781,941
Amortizable intangibles, net	21,617,610	27,349,714
Trade names	859,000	859,000
Goodwill	195,591,363	195,575,023
Other long-term assets	706,982	470,902
Total assets	\$ 369,392,946	350,970,150
Liabilities and Equity		
Accounts payable	\$ 13,818,397	9,045,119
Accrued expenses	23,353,925	23,443,871
Current portion of long-term debt and capital lease obligations	3,805,921	2,924,662
Current portion of related-party notes payable	—	125,000
Total current liabilities	40,978,243	35,538,652
Long-term debt and capital lease obligations, net of current portion	317,654,880	181,723,922
Other long-term liabilities	1,394,929	1,245,591
Deferred tax liability	2,449,302	11,198,031
Preferred stock accrued dividends	—	19,831,208
Total liabilities	362,477,354	249,537,404
Commitments and contingencies		
U.S. Renal Care, Inc. equity:		
Preferred stock A (\$0.01 par value. Authorized shares 12,825,000; issued and outstanding 12,725,000 and 12,350,000 shares)	127,250	123,500
Preferred stock B and B-1 (\$0.01 par value. Authorized shares 1,600,000; issued and outstanding 1,431,666 shares)	14,317	14,317
Preferred stock C (\$0.01 par value. Authorized shares 25,000,000; issued and outstanding 24,500,962 shares)	245,010	245,010
Preferred stock D (\$0.01 par value. Authorized shares 8,333,333; issued and outstanding 8,333,333 shares)	83,333	83,333
Common stock (\$0.01 par value. Authorized shares 57,237,646 and 56,910,159; issued and outstanding 7,736,754 and 7,074,324 shares)	77,368	70,744
Additional paid-in capital	(50,804,776)	38,667,471
Retained earnings	—	8,624,492
Total U.S. Renal Care, Inc. stockholders' equity	(50,257,498)	47,828,867
Noncontrolling interests (including redeemable interests with redemption values of \$46,149,160 and \$40,999,428)	57,173,090	53,603,879
Total equity	6,915,592	101,432,746
Total liabilities and equity	\$ 369,392,946	350,970,150

See accompanying notes to consolidated financial statements.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Net operating revenues	\$ 309,643,779	237,606,328
Operating expenses:		
Patient care costs	186,090,458	154,284,195
General and administrative	25,301,516	20,165,850
Provision for doubtful accounts	9,117,119	6,898,682
Legal cost/settlement	77,943	(352,334)
Transaction costs	3,131,507	9,076,731
Depreciation and amortization	18,451,254	14,655,411
Loss on disposal of fixed assets	406,832	41,711
Gain on acquisition of controlling interest	—	(5,050,261)
Total operating expenses	<u>242,576,629</u>	<u>199,719,985</u>
Operating income	67,067,150	37,886,343
Interest expense, net	22,251,290	10,192,698
Loss on early retirement of debt	<u>4,801,472</u>	<u>—</u>
Income before income taxes	40,014,388	27,693,645
Income tax provision	<u>8,389,946</u>	<u>7,543,219</u>
Net income	31,624,442	20,150,426
Less net income attributable to noncontrolling interests	<u>17,113,167</u>	<u>13,023,628</u>
Net income attributable to U.S. Renal Care, Inc.	<u>\$ 14,511,275</u>	<u>7,126,798</u>

See accompanying notes to consolidated financial statements.

U.S. Patent Copyright, 1996, Strategic Business Systems, Inc.

For immediate release to news media only.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Cash flows from operating activities:		
Net income	\$ 31,624,442	20,150,426
Adjustments to reconcile net income to cash provided by operating activities:		
Depreciation and amortization	18,822,885	14,655,411
Noncash dispute settlement	—	450,000
Lease agreement intangible amortization included in rent	(9,936)	31,337
Provision for doubtful accounts	9,117,119	6,898,682
Deferred income taxes	855,742	4,646,303
Equity investment income	—	(805,801)
Stock compensation expense	136,340	102,652
Loss on disposal of fixed assets	406,832	41,711
Gain on acquisition of controlling interest	—	(5,050,261)
Loss on early retirement of debt	4,801,472	—
Loss on derivatives	434,083	—
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:		
Accounts receivable	(8,889,518)	(11,223,175)
Inventories	(7,407,314)	1,065,325
Other receivables	(1,039,942)	(2,773,018)
Other current assets	(530,021)	(326,422)
Other long-term assets	(236,080)	(1,049,343)
Accounts payable and accrued expenses	5,663,597	585,137
Other noncurrent liabilities	320,512	331,317
Net cash provided by operating activities	<u>54,070,213</u>	<u>27,730,281</u>
Cash flows from investing activities:		
Acquisitions, net of cash acquired	(1,275,000)	(116,523,175)
Sale of property and equipment	2,579,801	3,172,324
Additions of property and equipment, net	(15,377,075)	(18,394,835)
Purchase of noncontrolling interests	(465,001)	(18,991,500)
Investment in affiliate	—	101,335
Net cash used in investing activities	<u>(14,537,275)</u>	<u>(150,635,851)</u>
Cash flows from financing activities:		
Proceeds from long-term debt borrowings	278,827,099	181,952,491
Payments on long-term debt and related-party notes payable	(144,767,068)	(73,000,188)
Deferred financing costs	(5,149,293)	(7,938,537)
Proceeds from capital leases	3,696,968	3,260,343
Capital lease payments	(2,070,576)	(1,243,894)
Net proceeds from issuance of preferred stock	375,000	25,015,999
Proceeds from issuance of common stock	318,073	43,648
Repurchase of preferred stock	—	—
Contributions from noncontrolling interests	1,439,500	695,750
Distributions to noncontrolling interests	(16,067,923)	(11,668,292)
Dividends paid to shareholders	(137,500,000)	—
Net cash provided by (used in) financing activities	<u>(20,898,220)</u>	<u>117,117,320</u>
Net increase/decrease in cash and cash equivalents	18,634,718	(5,788,250)
Cash and cash equivalents at beginning of year	9,537,107	15,325,357
Cash and cash equivalents at end of year	\$ <u>28,171,825</u>	<u>9,537,107</u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2011 and 2010

	<u>2011</u>	<u>2010</u>
Supplemental cash flow information:		
Cash paid for interest	\$ 20,292,064	8,474,494
Cash paid for taxes	9,296,414	4,814,265
Supplemental disclosures of noncash investing and financing activities:		
Cumulative preferred dividends	\$ 2,601,976	5,094,782
Capital lease financing	398,676	99,126

See accompanying notes to consolidated financial statements.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

(1) Organization and Significant Accounting Policies

(a) *Organization and Business*

U.S. Renal Care, Inc. (the Company) was formed in June 2000 and provides dialysis services to patients who suffer from chronic kidney failure, also known as end stage renal disease (ESRD). ESRD is the stage of advanced kidney impairment that requires continual dialysis treatments, or a kidney transplant, to sustain life. Patients suffering from ESRD generally require dialysis three times per week for the rest of their lives. The Company primarily provides these services through the operation of outpatient kidney dialysis clinics. As of December 31, 2011, the Company operated 86 outpatient dialysis clinics in Texas, Arkansas, Georgia, Maryland, New Jersey, Ohio, Pennsylvania, Virginia, South Carolina, New York, Oklahoma and Illinois. In addition to its outpatient dialysis center operations, as of December 31, 2011, the Company provides acute dialysis services through contractual relationships with hospitals and dialysis to patients in their homes.

(b) *Principles of Consolidation*

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned and majority-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in consolidation.

(c) *Use of Estimates*

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities, and the disclosure of contingent assets and liabilities, at the date of the consolidated financial statements, as well as the reported amounts of revenues and expenses during the reporting period.

Although actual results in subsequent periods will differ from these estimates, such estimates are developed based upon the best information available to management and management's best judgments at the time made. The most significant estimates and assumptions involve revenue recognition, provisions for uncollectible accounts, determination of the fair value of assets and liabilities acquired, impairments and valuation adjustments, and accounting for income taxes.

(d) *Cash and Cash Equivalents*

Cash includes cash and highly liquid investments with a maturity of ninety days or less at date of purchase. Cash and cash equivalents at times may exceed the FDIC limits. The Company believes no significant concentration of credit risk exists with respect to these cash investments.

(e) *Accounts Receivable and Allowance for Doubtful Accounts*

Substantially all of the Company's accounts receivable are related to providing healthcare services to its patients and are due from the Medicare program, state Medicaid programs, managed care health plans, commercial insurance companies and individual patients. The estimated provision for doubtful accounts is recorded to the extent it is probable that a portion or all of a patient balance will not be collected. The Company considers a number of factors in evaluating the collectibility of accounts

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

receivable including the age of the accounts, collection patterns and any ongoing disputes with payors.

(f) Amounts Due from Third-Party Payors

The amount due from third-party payors, which is included in other receivables, represents balances owed to the Company by the Medicare program for reimbursable bad debts related to Medicare beneficiaries. These reimbursements are part of the Company's annual cost report filings and as such, the actual payments may be delayed or subsequently adjusted pending review and audit by the Medicare program fiscal intermediaries.

(g) Amounts Due from Drug Rebates

The amount due from drug rebates, which is included in other receivables, represents balances owed to the Company by various pharmaceutical vendors for Epogen (EPO), vitamin D and iron. During 2011 and 2010, the Company had incentive contracts that reduced the invoice price based upon volume purchased. This incentive was payable to the Company on a quarterly basis. In addition, there was an additional annual incentive based on volume that was payable to the Company annually.

(h) Inventories

Inventories consist primarily of pharmaceuticals and dialysis-related supplies and are stated at the lower of cost or market. Cost is determined using the first-in, first-out method. Market is determined on the basis of estimated realizable values.

(i) Property and Equipment

Property and equipment is carried at cost less accumulated depreciation. Property under capital lease agreements is stated at the present value of minimum lease payments less accumulated depreciation. Depreciation is computed using the straight-line method over the estimated useful lives of the assets or the term of the lease as appropriate. The general range of useful lives is as follows:

Buildings	39 years
Leasehold improvements	Life of lease
Furniture and equipment	5 years
Computers	3 years

Capital lease assets are amortized over the shorter of the lease term or the estimated useful life of the improvement. Property and equipment acquired in acquisitions is recorded at fair value. The cost of improvements that extend asset lives is capitalized. Other repairs and maintenance charges are expensed as incurred.

Fully depreciated assets are retained in property and depreciation accounts until they are removed from service. When sold or otherwise disposed of, assets and related depreciation are removed from the accounts and the net amounts, less proceeds from disposal, are included in income.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

(j) Concentration of Credit Risk

The Company's primary concentration of credit risk exists within accounts receivable, which consist of amounts owed by various governmental agencies, insurance companies, and private patients. Receivables from the Medicare program and various state Medicaid programs were approximately 56% and 57% of gross accounts receivable at December 31, 2011 and 2010, respectively. Concentration of credit risk relating to remaining accounts receivable is limited to some extent by the diversity of the number of patients and payors.

(k) Amortizable Intangible Assets

Amortizable intangible assets and liabilities include noncompetition and similar agreements, lease agreements, and deferred debt issuance costs. Noncompetition and similar agreements are amortized over the terms (five to ten years) of the agreements using the straight-line method. Lease agreement intangibles for favorable and unfavorable leases are amortized on a straight-line basis over the term of the lease.

Deferred debt issuance costs are amortized using the effective interest method as an adjustment to interest expense over the term of the related debt. In the case of debt repayments prior to the end of the term, the Company adjusts the amount of deferred financing costs at the date of repayment, which is included in interest expense.

(l) Goodwill

Goodwill is recorded when the consideration paid for an acquisition exceeds the fair value of net tangible assets and identifiable intangible assets acquired. Goodwill and other indefinite-lived intangible assets are not amortized, but are instead tested for impairment at least annually. The annual evaluation for 2011 and 2010 resulted in no impairment charges.

(m) Impairment of Long-Lived and Indefinite-Lived Assets

The Company evaluates long lived-assets and identifiable intangibles for impairment whenever events or changes in circumstances indicate that an asset's carrying amount may not be recoverable or the useful life has changed. When undiscounted future cash flows are not expected to be sufficient to recover an asset's carrying amount, a loss is recognized and the asset is written down to its fair value.

(n) Fair Value of Financial Instruments

U.S. GAAP describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets and liabilities.
- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

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

The Company's interest rate swap is remeasured to fair value on a recurring basis. At December 31, 2011 and 2010, the fair value of the interest rate swap was an unfavorable \$434,083 and \$0, respectively. The fair value of the interest rate swap is determined using quoted market prices for similar swap agreements and is considered to be Level 2 measurement. The fair value of the interest rate swap is included as a component of other long-term liabilities at fair value.

At December 31, 2011 and 2010, the carrying amount of the senior secured credit facility was \$314.5 million and \$178.9 million as compared to fair values of \$323.3 million and \$189.6 million, respectively. The estimates of the fair value of the Company's senior secured credit facility are based upon a discounted present value analysis of future cash flows and are considered to be Level 3 financial measures. Due to the existing uncertainty in the capital and credit markets, the actual rates that would be obtained to borrow under similar conditions could materially differ from the estimates the Company has used.

For the Company's other financial instruments, including the Company's cash and cash equivalents, accounts receivable, accounts payable, and accrued expenses the Company estimates the carrying amounts approximate fair value due to their short-term maturity.

(o) Net Operating Revenues and Accounts Receivable

Net operating revenue is recognized in the period services are provided. Revenue consists primarily of reimbursements from Medicare, Medicaid and commercial health plans for dialysis services provided to patients. A usual and customary fee schedule is maintained for the Company's dialysis treatment and other patient services. However, actual collected revenue is normally at a discount to this fee schedule. Contractual adjustments represent the differences between amounts billed for services and amounts paid by third-party payors.

The Company's dialysis facilities are certified to participate in the Medicare program. Revenues reimbursed by the Medicare program are recognized primarily on a prospective payment system for dialysis services (ESRD Program). Prior to January 2011, dialysis providers operating under the Medicare ESRD program received a composite payment rate to cover routine dialysis treatments and certain supplies. There was a separate payment for laboratory testing and pharmaceuticals such as EPO, vitamin D and iron supplements that were not included in the composite rate. However, beginning January 2011, Medicare implemented a new payment system in which all ESRD payments are now made under a single bundled payment rate that provides for an annual inflation adjustment based upon a market basket index, less a productivity improvement factor. The bundled payment rate provides a fixed rate to encompass goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers. Most lab services that were previously paid directly to laboratories are also included in the new payment bundle. Now, as a result of the bundled payment system, the dialysis providers are at risk of variations in pharmaceutical utilization since reimbursement is set at a fixed average reimbursement rate.

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As of November 1, 2010, dialysis providers were required to make an election as to which clinics would be fully reimbursed as of January 1, 2011 under the new bundled payment system or phased into the new system over a four year period. The Company elected to have approximately 72% of its clinics be reimbursed fully under the new bundled reimbursement system beginning January 1, 2011. Once this election was made, it could not be revoked. All clinics that receive Medicare certification subsequent to November 1, 2010 will be reimbursed under the new bundled reimbursement system.

The initial 2011 bundled payment rate includes reductions to conform to the provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) and to establish budget neutrality. Further, there is a 5.94% reduction tied to an expanded list of case mix adjusters which can be earned back upon the presence of these certain patient characteristics and co-morbidities at the time of treatment. Historically, dialysis providers have not had to track certain of the case-mix adjusters and these adjusters may be difficult to capture initially. There are also other provisions which may impact reimbursement including an outlier adjustment and a low volume facility adjustment.

On April 1, 2011, CMS released an interim final rule correcting the 3.1% transition adjustment factor to properly update the number of ESRD facilities that elected to opt fully into the new Prospective Payment System (PPS). This new rule was prospective and as a result, effective April 1, 2011 the Company began recognizing revenues in accordance with the new rule, which resulted in an increase in Medicare revenue per treatment of approximately 3.1% in comparison to levels recorded in the first quarter of 2011.

On November 1, 2011, CMS issued the final ESRD PPS rule for 2012. The base rate for 2012 increased by 2.1%, representing a market basket increase of 3.0% less a productivity adjustment of 0.9%.

Also, beginning in 2012, the rule provides for up to a 2% annual payment withhold that can be earned back by the facilities that meet certain defined clinical performance standards under a quality incentive program built into the bundled system. Thus, the quality incentive program could result in decreased payments if a dialysis facility fails to meet the standards.

Medicare presently pays 80% of the established payment rates for dialysis treatment furnished to patients. The remaining 20% may be paid by Medicaid if the patient is eligible, from private insurance funds, or from the patient's personal funds. If there is no secondary payor to cover the remaining 20%, and if the Company demonstrates prescribed collection efforts, Medicare may reimburse the Company for part of that balance as part of the Company's annual cost report filings subject to individual center Medicare economics. As a result, billing and collection of Medicare bad debt claims are often delayed significantly, and final payments are subject to audit.

Medicaid programs are administered by state governments and are partially funded by the federal government. In addition to providing primary coverage for patients whose income and assets fall below state defined levels and are otherwise insured, Medicaid serves as a supplemental insurance program for the co-insurance portion not paid by Medicare. Medicaid reimbursement varies by state but is typically reimbursed pursuant to a prospective payment system for dialysis services rendered.

Revenues associated with commercial health plans are estimated based upon patient-specific contractual terms between the Company and health plans for the patients with which the Company

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has formal agreements, upon commercial health plan coverage terms if known, or otherwise upon historical collection experience adjusted for refund and payment adjustment trends. Commercial revenue recognition involves substantial judgment. With several commercial insurers, the Company has multiple contracts with varying payment arrangements, and these contracts may include only a subset of the Company's dialysis centers. In addition, for services provided by noncontracted centers, final collection may require specific negotiation of a payment amount. Generally, payments for a dialysis treatment from commercial payors are greater than the corresponding amounts received from Medicare and Medicaid.

(p) Share-Based Compensation

The Company recognizes compensation expense, for all share-based awards, including stock option grants to employees, using a fair-value measurement method. Under the fair-value method, the estimated fair value of awards that are expected to vest is recognized over the requisite service period, which is generally the vesting period.

Prior to 2006, the Company accounted for its equity compensation using the intrinsic value-based method of accounting. The Company did not recognize compensation expense before 2006 because the exercise price of stock options granted was not less than the estimated value of the underlying stock on the date of grant. The Company continues to account for equity compensation based shares granted prior to 2006 using the intrinsic value method until such time as shares are modified, canceled, or repurchased.

The Company estimates the fair value of awards on the date of grant, using the Black-Scholes option pricing model. The weighted average fair value of options granted during the years ended December 31, 2011 and 2010 are calculated based on the following assumptions: expected volatility of 30% and 22%, respectively, expected dividend yield of 0%, expected life of 3.75 years, and risk-free interest rates of 0.69% to 1.97%. Expected volatility was derived using data drawn from public dialysis company comparables. The expected life was computed utilizing the simplified method as permitted by the Securities and Exchange Commission's Staff Accounting Bulletin, *Share Based Payment*. The expected forfeiture rate is 20% based upon a review of the Company's recent history and expectations as segregated between the Company's board of directors, senior officers, and other grantees. The risk-free interest rate is based on the approximate average yield on three and five year United States Treasury Bonds as of the date of grant. There were 146,987 and 352,000 options granted during the years ended December 31, 2011 and 2010, respectively (see note 10).

(q) Noncontrolling Interest

In December 2007, the FASB issued an accounting standard, *Noncontrolling Interests in Consolidated Financial Statements* (ASC 810), which gives guidance on the presentation and disclosure of noncontrolling interests (previously known as minority interests) of consolidated subsidiaries. This statement requires the noncontrolling interest to be included in the equity section of the balance sheet, requires disclosure on the face of the consolidated statement of operations of the amounts of consolidated net income attributable to the consolidated parent and the noncontrolling interest, and expands disclosures.

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Consolidated income (loss) is reduced (increased) by the proportionate amount of income or loss accruing to noncontrolling interests. Noncontrolling interest represents the equity interest of third-party owners in consolidated entities that are not wholly owned.

(r) *Income Taxes*

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to the differences between the financial statement carrying amount of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. A valuation allowance is established when it is more likely than not that the deferred tax assets will not be realized.

The Company recognizes the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For tax positions meeting the more-likely-than-not threshold, the amount recognized in the financial statements is the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement with the relevant tax authority. The amount of unrecognized tax benefits as of December 31, 2011 and 2010 was \$0.

The Company is subject to income taxes in the U.S. federal jurisdiction and various states. Tax regulations within each jurisdiction are subject to the interpretation of the related tax laws and regulations and require significant judgment to apply. The Company is no longer subject to U.S. federal or state or local income tax examinations by tax authorities for the years before 2006. In 2011, the Internal Revenue Service finalized its examination of the Company's 2007 U.S. income tax returns. The resolution of this examination resulted in no additional tax payment.

The Company recognizes interest accrued related to unrecognized tax benefits in interest expense and penalties in operating expenses for all periods presented.

The Company's consolidated LLC and L.P. subsidiaries do not incur federal income taxes. Instead, their earnings and losses are included in the returns of, and taxed directly to, the members and partners of these subsidiaries.

(s) *Derivative Instruments and Hedging Activities*

The Company has entered into interest rate swap and cap agreements as a means of hedging its exposure to and volatility from variable-based interest rate change. These agreements are designed as cash flow hedges and are not held for trading or speculative purposes. The swap agreement has the economic effect of converting portions of the Company's variable rate debt to fixed rates.

In 2011, the Company adopted the provisions of FASB Statement No. 161, *Disclosures about Derivative Instruments and Hedging Activities* (included in FASB ASC Topic 815, *Derivatives and Hedging*), which amends the disclosure requirements for derivative instruments and hedging

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activities. The amended disclosure require entities to provide information to enable users of the financial statements to understand how and why an entity uses derivative instruments, how derivative instruments and related hedged items are accounted for, and how derivative instruments are related hedged items affect an entity's financial position, financial performance, and cash flows (see note 6).

(i) Recently Issued Accounting Pronouncements

In July 2011, the FASB issued ASU No. 2011-07, *Health Care Entities-Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*. This standard amends the current presentation and disclosure requirements for health care entities that recognize significant amounts of patient service revenue at the time the services are rendered even though they do not assess the patient's ability to pay. This standard requires health care entities to reclassify the provision for bad debts from an operating expense to a deduction from patient service revenues in certain circumstances. Additionally, this standard requires enhanced disclosures on the policies for recognizing revenue, assessing bad debts, as well as quantitative and qualitative information regarding changes in the allowance for bad debts. This standard is applied retrospectively to all prior periods presented and is effective for the first annual period ending after December 15, 2012 with early adoption permitted. The adoption of this standard will not have a material impact on the Company's consolidated financial statements.

In September 2011, the FASB issued ASU No. 2011-08, *Intangibles-Goodwill and Other*. This standard simplifies the goodwill impairment assessment by allowing a company to first review qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount to determine if the two-step impairment test is necessary. If it is determined that certain events and circumstances prove that it is more likely than not that the fair value of a reporting unit is less than its carrying amount then an entity is required to proceed to step one of the two-step goodwill impairment test. This standard is effective for the first annual period ending after December 15, 2011 with early adoption permitted. The adoption of this standard will not have a material impact on the Company's consolidated financial statements.

(u) Reclassifications

Certain reclassifications have been made to the 2010 consolidated financial statement balances to conform with the 2011 presentation. Such reclassifications have no effect on earnings or stockholders' equity.

(v) Correction of Immaterial Error

In 2011, the Company identified an error in recording the purchase of an additional interest in a facility in 2010, that resulted in the Company gaining control of the facility that was previously accounted for as an equity method investment. The effect of this change increased goodwill and income before income taxes by \$5.1 million, increased income tax expense and deferred tax liabilities by \$1.8 million and increased net income by \$3.3 million. The allocation of the purchase price including this gain follows. The Company has included this adjustment in the 2010 financial statements as a correction of an immaterial error (see note 3(b)).

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(2) Fixed Assets

At December 31, 2011 and 2010, property and equipment consists of the following:

	<u>2011</u>	<u>2010</u>
Facility equipment, furniture, and information systems	\$ 46,577,947	42,891,347
Land and buildings	3,745,050	6,747,940
Leasehold improvements	30,638,531	21,493,319
New center construction in progress	863,043	778,865
	<u>81,824,571</u>	<u>71,911,471</u>
Less accumulated depreciation and amortization	<u>(35,922,283)</u>	<u>(25,129,530)</u>
	<u>\$ 45,902,288</u>	<u>46,781,941</u>

	<u>Year ended December 31</u>	
	<u>2011</u>	<u>2010</u>
Depreciation and amortization expense on property and equipment	\$ 12,880,752	9,304,459

Net book value of equipment under capital leases at December 31 was as follows:

	<u>2011</u>	<u>2010</u>
Equipment	\$ 14,073,859	10,671,572
Less accumulated depreciation	<u>(8,361,068)</u>	<u>(6,099,837)</u>
	<u>\$ 5,712,791</u>	<u>4,571,735</u>

(3) Acquisitions/Disposition

The Company has acquired various dialysis businesses, as described further below. The assets and liabilities for all acquisitions were recorded at their estimated fair values as of the effective acquisition date based upon the best available information.

Amortizable intangible assets consist primarily of noncompete agreements. Goodwill is recorded when the consideration paid for an acquisition exceeds the fair value of identifiable net tangible assets and identifiable intangible assets acquired.

The results of operations for the acquired companies are included in the Company's financial statements beginning on the effective acquisition date.

(a) *Dialysis Corporation of America, Inc. Acquisition*

On June 3, 2010, the Company acquired all the outstanding common shares of Dialysis Corporation of America, Inc. (DCA) for \$11.25 per share. DCA provides outpatient dialysis, in-home dialysis and

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acute services in Georgia, Maryland, New Jersey, Ohio, Pennsylvania, Virginia and South Carolina. The results of operations for DCA are included in the Company's financial statements beginning June 1, 2010.

The DCA acquisition cost of approximately \$110 million and costs related thereto were funded from the proceeds of the Company's senior secured and subordinated loan agreements (see note 6) and the issuance of Series D Preferred Stock (see note 8).

The estimated fair values of the assets acquired and liabilities assumed at the acquisition date are as follows:

Assets:	
Cash	\$ 1,294,958
Net accounts receivable	17,072,334
Inventory	2,684,480
Other receivables	1,280,382
Other current assets	<u>2,257,895</u>
Total current assets	24,590,049
Property and equipment, net	20,526,500
Amortizable intangibles, net	12,957,381
Goodwill	113,828,342
Other long-term assets	<u>863,600</u>
Total assets	<u>\$ 172,765,872</u>
Liabilities:	
Accounts payable	\$ 4,958,871
Accrued expenses	<u>6,177,187</u>
Total current liabilities	11,136,058
Long-term debt	9,586,971
Other long-term liabilities	(326,883)
Deferred tax liability	<u>3,808,826</u>
Total liabilities	<u>\$ 24,204,972</u>
Equity:	
Minority interest	<u>\$ 38,310,900</u>
Total equity	<u>\$ 38,310,900</u>

(b) San Antonio

On July 1, 2010, the Company purchased an additional 40% interest in one of its joint venture entities which it previously had a 40% noncontrolling ownership interest for \$7.2 million. The acquisition was funded by borrowing under the Company's revolving credit facility (see note 6) and cash on hand. The consolidated results of operation for this facility are included in the Company's financial statements beginning July 1, 2010. Previously, the Company's investment was recorded

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using the equity method of accounting. The investment balance at June 30, 2010 was approximately \$922,000.

Subsequent to the issuance of the December 31, 2010 financial statements, the Company concluded that the purchase of an additional 40% interest in the San Antonio joint venture on July 1, 2010, should have resulted in a gain to be included in the December 31, 2010 financial statements. At the date of the transaction, the Company did not remeasure the previously held noncontrolling interest of 40% at fair value and recognize the resulting gain or loss. As a result of this adjustment, a gain on acquisition of controlling interest of \$5.1 million is included in the December 31, 2010 financial statements. The effect of this change increased goodwill and income before income taxes by \$5.1 million, increased income tax expense and deferred tax liabilities by \$1.8 million and increased net income by \$3.3 million. The allocation of the purchase price including this gain follows. The Company has included this adjustment in the 2010 financial statements as a correction of an immaterial error.

Assets:	
Cash	\$ 671,969
Net accounts receivable	1,151,930
Inventory	22,726
Other receivables	7,724
Other current assets	24,742
Total current assets	1,879,091
Property and equipment, net	974,832
Goodwill	13,476,227
Total assets	\$ 16,330,150
Liabilities:	
Accounts payable	\$ 25,983
Accrued expenses	145,888
Total liabilities	\$ 171,871
Equity:	
Minority interest	\$ 2,986,200
Total equity	\$ 2,986,200

(c) December Acquisition

On December 1, 2010, the Company acquired two outpatient dialysis clinics, an acute program and a home program (December Acquisition). This transaction included purchasing a 51% majority interest in the assets of one of the clinics and a 100% interest in the assets of the other clinic. The results of operations for these services are included in the Company's financial statements beginning December 1, 2010. The December Acquisition cost of approximately \$1 million was funded from operating cash flow.

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The estimated fair values of the assets acquired at the acquisition date are as follows:

Assets:	
Inventory	\$ 89,114
Other current assets	26,017
Fixed assets	416,000
Goodwill	869,546
Total assets	<u>\$ 1,400,677</u>
Liabilities:	
Accrued expenses	\$ 357,713
Total liabilities	<u>\$ 357,713</u>

(d) *Medicore Disposition*

On November 30, 2010, the Company sold 100% of the net assets of its medical products business that was acquired in the DCA acquisition. The Company sold, assigned and transferred certain assets for approximately \$535,000 resulting in no gain or loss.

(e) *Advanced Home Therapies Acquisition*

On May 16, 2011, the Company acquired home dialysis programs providing services at two locations in Illinois. The transaction included purchasing a 51% majority interest in the assets. The results of operations for these services are included in the Company's financial statements beginning May 16, 2011. The Advanced Home Therapies Acquisition cost of approximately \$1.2 million was funded from operating cash flow.

The estimated fair value of the assets acquired at the acquisition date are as follows:

Assets:	
Fixed assets	\$ 9,320
Goodwill	2,452,430
Amortizable intangibles, net	38,250
Total assets	<u>\$ 2,500,000</u>
Equity:	
Minority interest	\$ 1,225,000
Total equity	<u>\$ 1,225,000</u>

(4) *Noncontrolling Interests*

The Company engages in the purchase and sale of equity interests with respect to its consolidated subsidiaries that do not result in a change of control. These transactions are accounted for as equity transactions, as they are undertaken among the Company, its consolidated subsidiaries, and noncontrolling interests, and their cash flow effect is classified within financing activities.

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As of December 31, 2011, the Company was the majority owner in 66 joint ventures. Of the noncontrolling interests in those 66 joint ventures, 23 have put rights generally at fair value as defined in the agreement that are either currently exercisable or become exercisable at various future dates. The carrying amount of these redeemable noncontrolling interests totaled \$9.1 million and \$7.3 million as compared to redemption values of \$46.1 million and \$41.0 million at December 31, 2011 and 2010, respectively. The redemption value is calculated at the current value of the put payment that would be required to redeem the interest if the put is exercised regardless of whether such interest is currently exercisable. As of December 31, 2011, \$7.4 million of put rights are currently exercisable and the remaining \$38.7 million generally become exercisable over the next three to five years.

(5) Intangible Assets

At December 31, 2011 and 2010, amortizable intangible assets consisted of the following:

	2011	2010
Noncompetition agreements	\$ 31,858,689	31,836,273
Lease agreements	580,106	580,106
Deferred debt issuance costs	7,768,556	7,939,537
Licenses	359,000	359,000
	<u>40,566,351</u>	<u>40,714,916</u>
Less accumulated amortization	<u>(18,948,741)</u>	<u>(13,365,202)</u>
Net amortizable intangible assets	<u>\$ 21,617,610</u>	<u>27,349,714</u>

Amortizable intangible liabilities, which are included in other long-term liabilities, consisted of lease agreements as follows:

	2011	2010
Lease agreements	\$ 1,894,040	1,894,040
Less accumulated amortization	<u>(933,193)</u>	<u>(648,449)</u>
Net amortizable intangible liabilities	<u>\$ 960,847</u>	<u>1,245,591</u>

Amortization of intangible assets and liabilities over the next five years is as follows:

	Noncompetition agreements	Deferred debt issuance costs	Lease agreements, net	Licenses
2012	\$ 4,508,985	1,267,449	(114,102)	71,800
2013	4,421,133	1,263,680	(66,168)	71,800
2014	4,324,487	1,263,680	(95,728)	71,800
2015	1,288,439	1,263,680	(106,751)	29,917
2016	164,805	1,150,451	(98,458)	—

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Changes in the value of goodwill were as follows:

	2011	2010
Balance at January 1	\$ 195,575,023	67,922,354
Goodwill adjustments	(2,436,090)	(521,626)
Goodwill acquired	2,452,430	128,174,295
Balance at December 31	\$ 195,591,363	195,575,023

The fair value of the identifiable intangibles acquired and the amount of goodwill recorded as a result of acquisitions are determined based upon independent third-party valuations and the Company's estimates. Amortization expense for the Company's intangible assets relates to the value associated with the noncompete and lease agreements. The noncompete intangible assets are amortized over the term of the noncompete agreements executed in connection with the acquisition transactions or the medical agreements entered into with certain physicians and the lease agreement intangibles are amortized over the term of the lease.

The Company recorded \$2.4 million to goodwill related to deferred tax adjustments in relation to the acquisition of DCA (see note 3(a)).

(6) Long-Term Debt

On June 9, 2011, the Company entered into an Amendment Agreement to amend and restate the Company's senior credit agreement entered into on May 24, 2010 (as amended, the Amended Agreement). The Amended Agreement consists of: (a) a \$215 million senior secured term loan (Term Loan) and (b) a \$40 million senior secured revolving credit facility (Revolver). Also on June 9, 2011, the Company entered into an Amendment Agreement to amend and restate the senior subordinated loan agreement entered into on May 24, 2010 to allow the Company to borrow an additional \$60 million (Additional Subordinated Loan), for an aggregate principle amount of \$100 million (Subordinated Loan). The additional proceeds obtained under the Term Loan and the Additional Subordinated Loan along with available cash on hand were utilized to (a) to fund a one time dividend payment to the Company's shareholders in the amount of \$137.5 million (see note 9), and (b) pay expenses and fees associated with the amended senior secured and subordinated loan agreements.

Borrowings under the Term Loan and Revolver (collectively Senior Secured Loans) bear interest based upon a spread in excess of LIBOR (floor of 1.50%) or the U.S. prime rate, as the benchmark, as adjusted, in the case of the interest rate applicable to the Revolver, based upon the Company's leverage ratio. The Amended Agreement also provides for an annual unused commitment fee of 0.75% based upon the average revolving credit commitment less outstanding borrowings on the Revolver and letters of credit, as adjusted based upon the Company's leverage ratio. As of December 31, 2011, borrowings under the Senior Secured Loans bore interest at 5.50%. The Subordinated Loan accrues interest at 13.25% with 11.25% paid in cash per annum. The remaining 2% of interest on the Subordinated Loan (PIK Interest) will be capitalized and accrued for until it becomes due upon the maturity of the loan.

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The Term Loan requires quarterly principal payments of \$537,500 in each year from 2011 through 2016 with the balance of \$204,787,500 due in 2016. The Subordinated Loan requires a one-time payment of \$100 million principal balance due in 2017, in addition to outstanding PIK Interest.

The Revolver, Term Loan, and Subordinated Loan mature on June 9, 2016, December 9, 2016, and June 2, 2017, respectively. The subordinated loan agreement provides for prepayment penalties if it is repaid within the first three years subsequent to June 2, 2011.

Commencing with the fiscal year ended December 31, 2011, the Company is required to prepay its outstanding Senior Secured Loan balances with 50% of excess cash flow as defined in the credit agreement. The Company is also required to prepay senior secured loan balances with: (a) 100% of the proceeds of asset sales or the proceeds received from casualty event settlements that are not reinvested or permitted pursuant to the terms of the credit agreement, and (b) 100% of the proceeds of indebtedness that is incurred and not permitted pursuant to the credit agreement. Following satisfaction of any prepayment under the Senior Secured Loans, the Company is required to prepay the Subordinated Loan balances with 100% of the proceeds of asset sales or the proceeds received from a casualty event settlement that are not reinvested or permitted pursuant to the terms of the credit agreement.

The Senior Secured Loans and the Subordinated Loan are guaranteed, on a joint and several basis, by each of the Company's subsidiaries, subject to certain exceptions. Borrowings under the credit agreements are collateralized by substantially all of the Company's and its subsidiaries' assets, including accounts receivable, inventory, and fixed assets not subject to permitted capital leases. The Subordinated Loan is subordinated to the repayment of the Senior Secured Loans. The Senior Secured and Subordinated Loan agreements include various events of default and contain certain restrictions on the operations of the business, including restrictions on certain cash payments, including capital expenditures, investments and the payment of dividends. These loan agreements also include covenants pertaining to interest coverage and total debt leverage, as well as other customary covenants and events of defaults.

The Company believes it is in compliance with all covenants under the Senior Secured Loan and Subordinated Loan agreements and has met all debt payment obligations. At December 31, 2011, approximately \$40 million of commitments were unused and available under the Revolver.

At December 31, 2011 and 2010, long-term debt and capital lease obligations consisted of the following:

	2011	2010
Senior secured credit facility:		
Term loan	\$ 213,387,500	131,506,250
Revolver	—	7,000,000
Subordinated loan	101,137,105	40,410,549
Other notes payable	—	23,305
Capital lease obligations	6,936,196	5,708,480
	321,460,801	184,648,584
Less current portion	(3,805,921)	(2,924,662)
	<u>\$ 317,654,880</u>	<u>181,723,922</u>

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Scheduled maturities of long-term debt and capital lease obligations at December 31, 2011 were as follows:

	Long-term debt	Capital lease obligations
2012	\$ 2,150,000	2,130,273
2013	2,150,000	1,890,004
2014	2,150,000	1,669,552
2015	2,150,000	1,296,580
2016	204,787,500	426,856
Thereafter	101,137,105	799,864
	<u>\$ 314,524,605</u>	<u>8,213,129</u>
Less interest portion at 5.040% – 8.561%		<u>(1,276,933)</u>
Total		<u>\$ 6,936,196</u>

Due to the Amended Agreement, the Company recognized a loss on early retirement of debt of \$4.8 million primarily related to a write-off of previously existing deferred finance costs.

According to the senior secured loan agreement dated as of May 24, 2010, the Company was required to enter into an interest rate hedging agreement, no later than 90 days following the closing date. The Company entered into a three year Hedge Agreement on September 1, 2010 which consists of an interest rate cap on the LIBOR floating rate of the senior secured loans at 1.75% until August 31, 2011. Additionally the Company entered into a swap from September 1, 2011 to September 1, 2013 effectively fixing the base rate at 2.32%. The notional amount of the swap is \$46.375 million, which is equivalent to 22% of the Term Loan amount borrowed. The fair value of the interest rate swap is \$434,083 at December 31, 2011 and is included as a component of other long-term liabilities. The swap is not being accounted for as an effective hedge and all adjustments to fair value are recorded to the statement of operations as interest expense. Interest expense for the year ended December 31, 2011 includes \$434,083 of net losses, representing the adjustment of the interest rate swap to fair value.

(7) **Income Taxes**

Income tax expense (benefit) consisted of the following:

	2011	2010
Current:		
Federal	\$ 4,726,167	1,652,164
State	2,812,966	1,244,752
Deferred:		
Federal	1,437,172	4,803,175
State	<u>(586,359)</u>	<u>(156,872)</u>
	<u>\$ 8,389,946</u>	<u>7,543,219</u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

The difference between the expected tax expense based on the federal statutory rate of 34% is primarily Texas gross margin tax, which is not based on pre-tax income and income tax attributable to noncontrolling interest.

Deferred tax assets and liabilities arising from temporary differences were as follows:

	<u>2011</u>	<u>2010</u>
Deferred tax assets:		
Accrued expenses and other liabilities for financial accounting purposes not currently deductible	\$ 6,486,955	5,776,527
Net operating loss carryforwards and contribution limitation	1,190,622	858,471
Flow through entities	9,852,665	4,328,310
Property plant and equipment	—	197,679
Other	<u>1,737,710</u>	<u>151,589</u>
Total deferred tax assets	<u>19,267,952</u>	<u>11,312,576</u>
Deferred tax liabilities:		
Property and equipment and intangibles, principally due to differences in depreciation and amortization	(2,234,567)	(3,546,732)
Goodwill	(11,328,149)	(11,031,330)
Other	<u>(4,541,341)</u>	<u>(1,717,088)</u>
Total deferred tax liabilities	<u>(18,104,057)</u>	<u>(16,295,150)</u>
Net deferred tax assets (liabilities)	\$ <u>1,163,895</u>	<u>(4,982,574)</u>

The Company fully utilized all net operating loss carryforwards at December 31, 2010 of approximately \$1,285,316. The Company has not recorded a valuation allowance for any of its deferred tax assets at December 31, 2011 as it expects to generate future taxable income sufficient to realize such deferred tax assets.

(8) Preferred Stock

Under the Company's Fifth Amended and Restated Certificate of Incorporation, as amended, 105,995,979 total shares are authorized to issue, comprised of 57,237,646 shares of common stock and 48,758,333 shares of preferred stock. Preferred stock is issuable in series under terms and conditions determined by the Company's Board of Directors.

(a) Series A Preferred Stock

During 2011, upon the exercise of warrants by certain warrant holders, 375,000 shares of Series A Preferred stock were issued at a price of \$1 per share for total net proceeds of approximately \$375,000. As of December 31, 2011 and 2010, there were 12,725,000 and 12,350,000 shares, respectively, of Series A Preferred stock outstanding.

(b) Series B Preferred Stock

As of December 31, 2011 and 2010, there were 545,000 shares of Series B Preferred stock outstanding.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

(c) Series B-1 Preferred Stock

As of December 31, 2011 and 2010, there were 886,666 shares of Series B-1 Preferred stock outstanding.

(d) Series C Preferred Stock

As of December 31, 2011 and 2010, there were 24,500,962 shares of Series C Preferred stock outstanding.

(e) Series D Preferred Stock

As of December 31, 2011 and 2010, there were 8,333,333 shares of Series D Preferred stock outstanding.

(f) Dividends

Following the payment by the Company of a cash dividend on June 9, 2011 (the 2011 Dividend) (see note 9), Series D Preferred stockholders are entitled to receive cash dividends at the rate of 8% per annum calculated on the base price per share of \$0.95, which are cumulative from June 9, 2011, but shall be paid only (a) upon a liquidation event; (b) upon a redemption of the Series D Preferred stock; or (c) if declared by the Board of Directors of the Company. Accumulations of dividends on shares of Series D Preferred stock do not bear interest. Series A, Series B, Series B-1 and Series C Preferred stockholders and common stockholders are entitled to receive dividends, when and if declared by the Board of Directors out of the Company's assets legally available. If Series A, Series C and Series D Preferred shares are outstanding, no dividend may be declared with respect to Series B or Series B-1 Preferred stock or common stock unless all declared Series A and Series C Preferred dividends and cumulative Series D Preferred dividends have been paid and a similar dividend is declared on Series A, Series C and Series D Preferred stock. Cumulative dividends with respect to all outstanding shares of Preferred Stock were \$359,305 and \$19,831,208 at December 31, 2011 and 2010, respectively.

(g) Redemption

Each share of Series A, Series C, and Series D Preferred stock is redeemable beginning on September 1, 2020, if approved by at least 60% of the then-outstanding shareholders of Series A, Series C, and Series D Preferred, voting as a single class. Series B and Series B-1 Preferred stock is redeemable, beginning on September 1, 2012 only subject to and after redemption of the Series A, Series C, and Series D Preferred Stock, or if approved by at least 60% of the then-outstanding shares of Series A, Series C, and Series D Preferred, voting as a single class, and if also approved by at least 60% of the then-outstanding shares of Series B and Series B-1 Preferred, voting as a single class.

Any such redemption would be payable in three equal annual installments and the redemption price per share would be calculated using the sum of the original issue price (\$1 per share for Series A and Series B Preferred, \$1.50 for Series C and Series B-1 Preferred, and \$3 per share for Series D Preferred) plus all related accrued and unpaid dividends, minus, in the case of Series A, Series C and Series D Preferred shares only, the amount of the 2011 Dividend paid in respect of such share (but not less than \$0).

U.S. RENAL CARE, INC. AND SUBSIDIARIES

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(h) Conversion Rights

Each share of Series A, Series B, Series B-1, Series C and Series D Preferred stock is currently convertible at any time, at the option of the holder, into the same number of shares of common stock. Each share of Series A, Series B, Series B-1, Series C, and Series D converts automatically upon (i) the approval of at least 60% of the shares of Series A, Series B and Series D Preferred stock, voting as a single class, or (ii) a qualified public offering. Upon such automatic conversion, any related declared and unpaid dividend becomes due.

(i) Liquidation Preference

Upon liquidation or dissolution, and after payment or provision for payment of all debts and liabilities, stockholders of the Company will receive proceeds, to the extent available, as follows: (a) first, to the holders of Series A, Series C and Series D Preferred stock, amounts per share equal to (i) the original issue price, plus (ii) accrued and unpaid dividends, minus (iii) the amount of the 2011 Dividend paid in respect of such share (but not less than \$0); (b) second, to the holders of Series B and Series B-1 Preferred stock, amounts per share equal to (i) the original issue price, plus (ii) accrued and unpaid dividends, (c) third, ratably to the holders of common stock, and Series A, Series B, Series B-1, Series C, and Series D Preferred stock on an as-if-converted to common stock basis until (i) the holders of Series A and Series C Preferred stock shall have received, in total including the payment under (a) above, an amount per share equal to three (3) times the difference between (A) the original issue price less (B) any amount by which the amount of the 2011 Dividend received in respect of such share exceeded the sum of the original issue price plus accrued and unpaid dividends, and (ii) the holders of Series D Preferred Stock shall have received, in total including the payment under (a) above, an amount per share equal to two (2) times the difference between (A) the original issue price less (B) any amount by which the amount of the 2011 Dividend received in respect of such share exceeded the sum of the original issue price plus accrued and unpaid dividends; and (d) fourth, to the holders of common stock, any remaining available amounts.

(j) Voting Rights

Each share of Series A, Series C and Series D Preferred stock issued and outstanding is entitled to the number of votes equal to the number of shares of common stock into which it is convertible. For various defined events, Series A, Series C and Series D Preferred stockholders vote together as a separate class. In those circumstances, 60% or more of the outstanding Series A, Series C and Series D Preferred stockholders must approve the event.

Each share of common stock is entitled to one vote. As long as Series A, Series C and Series D Preferred stock is outstanding, and except for various defined events, Series A, Series C and Series D Preferred stockholders vote together with common stockholders as a single class on an as-if-converted to common stock basis.

The Series B and Series B-1 Preferred stockholders have no voting rights and their consent is not required to take any corporate action.

The number of authorized shares outstanding can only be changed upon the affirmative vote of (i) a majority of the Company's stockholders, voting together on an as-if-converted to common stock

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

basis, and (ii) at least 60% of the Series A, Series C and Series D Preferred stock, voting both as separate classes and together as a single class.

(k) Other Terms

All stockholders are obligated to participate in a sale of the Company approved by at least 60% of the Series A, Series C and Series D Preferred stockholders, voting together as a single class, and the board of directors.

Series A, Series C and Series D Preferred stockholders have the right to purchase any new securities on a proportionate basis, and also have the right of over-allotment if any other Series A, Series C or Series D Preferred shareholder fails to purchase a full proportionate share of the any new securities. Series B Preferred, Series B-1 Preferred, and common stockholders do not have preemptive rights.

The Company and the Series A, Series B, Series C and Series D Preferred stockholders have the right to purchase shares from Series B Preferred, Series B-1 Preferred and common stockholders who wish to transfer their shares to a nonpermitted transferee.

(9) Shareholder Dividend

On June 9, 2011, the Company's Board of Directors authorized the payment of the 2011 Dividend in the amount of \$137.5 million to all common and preferred stockholders. The 2011 Dividend was paid using proceeds from the Company's Term Loan and Additional Subordinated Loan (see note 6). The Company's preferred shares are convertible and the 2011 Dividend was paid ratably to all outstanding shares on an as-if-converted basis. Of the total 2011 Dividend, \$117.4 million and \$20.1 million were paid to preferred and common stockholders, respectively. As of the date of the 2011 Dividend, there were \$22.4 million of cumulative dividends related to the Company's Series A, Series C and Series D Preferred stockholders. The 2011 Dividend constituted the payment of all such cumulative dividends to these stockholders. The remainder of the 2011 Dividend reduced retained earnings by \$11.9 million and additional paid-in capital by \$103.2 million. It is the Company's policy to reduce retained earnings subsequent to the dividend payment up to the amount of the current deficit in additional paid-in capital.

(10) Stock Compensation Plans

The Company's 2005 Stock Incentive Plan (the 2005 SIP) provides stock options and restricted stock grants, and other share-based incentives, primarily to employees and directors. In March 2009, the Company authorized an additional 500,000 shares available for grant. In May 2010, the Company authorized an additional 600,000 shares available for grant. In 2011, the Company authorized an additional 327,487 shares for grant. There were 6,327,487 and 6,000,000 shares available for grant as of December 31, 2011 and 2010, respectively, under the amended 2005 SIP.

(a) Stock Option Plan

Awards granted under the 2005 SIP are for incentive stock options with a five year term, an exercise price at least equal to the market value on the date of grant, and which vest 25% after one year of service and then monthly in equal amounts over the next three years of service. Income for the years ended December 31, 2011 and 2010 included \$(2,131) and \$70,744 respectively, of pretax compensation costs related to stock options granted. As of December 31, 2011, there was \$14,806 of

U.S. RENAL CARE, INC. AND SUBSIDIARIES

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total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a period of approximately four years. At December 31, 2011, the weighted average remaining contractual life of outstanding options was 2.82 years.

The table below summarizes activity in the Company's stock option plan:

	Year ended December 31			
	2011		2010	
	Awards	Weighted average exercise price	Awards	Weighted average exercise price
Outstanding at beginning of year	1,076,594	\$ 0.18	1,016,066	\$ 0.14
Granted	146,987	1.70	352,000	0.26
Exercised	(662,430)	0.48	(291,472)	0.15
Canceled	(128,250)	0.17	—	—
Outstanding at end of year	<u>432,901</u>	0.25	<u>1,076,594</u>	0.18
Awards exercisable at year-end	78,068	0.21	380,742	0.14

(b) Restricted Stock

The Company issued restricted stock to certain employees in 2010 and in prior years. Restricted stock awards vest 25% after one year of service and then monthly in equal amounts over the next three years of service, subject to continued employment and other plan terms and conditions. Holders of restricted stock are not allowed to sell, transfer, pledge, or otherwise encumber their restricted shares, but such holders are allowed to vote and their shares accrue dividends when and if declared. The Company may, but is not obligated to, repurchase vested restricted stock from employees at fair market value upon termination of the recipient's employment.

Expense for restricted stock is recognized over the vesting period. The noncash compensation expense associated with restricted stock awards was \$138,471 in 2011 and \$31,908 in 2010. The following table summarizes restricted stock award activity:

	2011	2010
Outstanding balance at beginning of year	\$ 3,961,558	3,401,558
Granted	—	560,000
Exercised	—	—
Forfeited	—	—
Repurchased	—	—
Balance at December 31, 2011	<u>\$ 3,961,558</u>	<u>3,961,558</u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES

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The following table summarizes the nonvested restricted stock activity:

	2011	2010
Outstanding balance at beginning of year	\$ 712,753	641,122
Granted	—	560,000
Vested	(339,420)	(488,369)
Forfeited	—	—
Repurchased	—	—
Balance at December 31, 2011	\$ 373,333	712,753

At December 31, 2011, 3,588,225 of the outstanding restricted shares were vested. As of December 31, 2011, there was approximately \$217,000 of total unrecognized compensation costs related to restricted stock awards. These costs are expected to be recognized over a remaining vesting period of approximately four years.

(11) Related-Party Transactions

Participation in the Medicare ESRD program requires that treatment at a dialysis center be under the general supervision of a director who is a physician. The Company has engaged physicians or groups of physicians to serve as medical directors for each of its centers. The Company has contracts with approximately 59 individual physicians and physician groups to provide medical director services. The compensation of medical directors is negotiated individually and depends in general on local factors such as competition, the professional qualifications of the physician, their experience and their tasks as well as the workload at the clinic.

An ESRD patient generally seeks treatment at a dialysis center near his or her home and at which his or her treating nephrologist has practice privileges. Additionally, many physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical directors to the centers. As a result, and as is typical in the dialysis industry, the primary referral source for most of the Company's centers is often the physician or physician group providing medical director services to the center.

The Company's medical director agreements generally include covenants not to compete. Also, when the Company acquires a center from one or more physicians, or where one or more physicians owns interests in centers as co-owners with the Company, these physicians have agreed to refrain from owning interests in competing centers within a defined geographic area for various time periods. These agreements not to compete restrict the physicians from owning or providing medical director services to other dialysis centers. Most of these agreements not to compete continue for a period of time beyond expiration of the corresponding medical director agreements.

The Company leases space for 35 of its centers in which physicians and/or employees hold ownership interests, and subleases space to referring physicians and/or employees at 16 centers. Future minimum lease payments payable under these leases is approximately \$23 million at December 31, 2011, exclusive of maintenance and other costs, and is subject to escalation. For 2011 and 2010, total lease payments under these leases were approximately \$3.9 million and \$2.9 million, respectively. On June 21, 2010, the

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

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Company entered into a ten year corporate office lease agreement with an entity owned by two of its employees. The lease commenced on August 1, 2011. The future lease payments payable under this lease are approximately \$1.1 million. For 2011, total lease payments under this lease were approximately \$49,678.

The Company's York, Pennsylvania dialysis center is leased from a limited liability partnership in which the Company has a 60% ownership interest with the remaining 40% owned by two doctors one of whom serves as the medical director for that facility. These doctors are also affiliated with the entity that owns a 40% minority ownership in the subsidiary that operates the facility.

Some medical directors and other referring physicians own Series B, Series B-1, Series C and Series D Preferred stock, which they purchased from the Company. Some of the Company's medical directors also own equity interests in entities that operate the Company's dialysis centers.

The Company believes that the leases and equity purchases are no less favorable to the Company and no more favorable to such physicians than would have been obtained in arm's-length bargaining between independent parties.

The Company has one promissory note obligation owed a noncontrolling interest holder in one of its subsidiaries. The note obligation was in an original amount of \$750,000, of which \$0 and \$125,000 was outstanding at December 31, 2011 and 2010, respectively. At December 31, 2011 and 2010, \$0 and \$125,000 of the amount outstanding was classified in the accompanying consolidated balance sheet as a current liability. The note bore interest at 7% and principal was due in six annual installments from May 1, 2006 through May 1, 2011.

During the years ended December 31, 2011 and 2010, the Company paid a related party affiliated through common ownership \$461,342 and \$461,011, respectively, for the usage of an airplane.

A member of the Company's board of directors provides consulting services primarily related to regulatory and reimbursement matters. The total expenses incurred by the Company related to these services were approximately \$100,000 in 2011 and 2010, respectively.

(12) Legislation, Regulations, and Market Conditions

The Company's dialysis operations are subject to extensive federal, state, and local government regulations. These regulations require the Company to meet various standards relating to, among other things, the operation of dialysis clinics, the provision of quality healthcare for patients, maintenance of proper ownership and records, quality assurance programs, and occupational, health, safety and environmental standards, and the provision of accurate reporting and billing to government and private payment programs. These laws are extremely complex, and in many instances, providers do not have the benefit of significant regulatory or judicial interpretation as to how to interpret and apply these laws and regulations in the normal course of conducting their business. Healthcare providers that do not comply with these laws and regulations may be subject to civil or criminal penalties, the loss of their licenses, or restriction in their ability to participate in various federal and state healthcare programs. The Company endeavors to conduct its business in compliance with applicable laws and regulations.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

The Company's dialysis centers are certified (or are pending certification) by the Centers for Medicare and Medicaid Services, as is required for the receipt of Medicare payments, and are licensed and permitted by state authorities.

The Medicare and Medicaid Fraud and Abuse Amendments of 1977, as amended, generally referred to as the "anti-kickback statute," imposes sanctions on those who, among other things, offer, solicit, make or receive payments in return for referral of a Medicare or Medicaid patient for treatment. The federal False Claims Act imposes penalties on those who, among other things, knowingly present a false or fraudulent claim for payment to the federal government. Another federal law, commonly referred to as the "Stark Law," prohibits physicians, with certain exceptions, from referring Medicare patients to entities with which the physician has a financial relationship, states have analogous statutes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), among other things, includes provisions relating to the privacy of medical information and prohibits inducements to patients to select a particular healthcare provider. Congress, states and regulatory agencies continue to consider modifications to federal and state healthcare laws. The Company's dialysis centers are also subject to various state hazardous waste and nonhazardous medical waste disposal laws.

Sanctions for violations of these statutes could result in the imposition of significant fines and penalties, repayments for patient services previously billed, expulsion from government healthcare programs, and other civil or criminal penalties. Management believes that the Company is in material compliance with applicable government laws and regulations.

(13) Profit-Sharing Plan

The Company has a savings plan for employees who meet certain criteria that have been established pursuant to the provisions of Section 401(k) of the Internal Revenue Code. The plan allows employees to contribute a defined portion of their compensation on a tax-deferred basis. Since January 1, 2005, the plan allows for defined matching Company contributions for eligible employees. The plan was amended effective January 1, 2006 to allow vesting credit for prior years of service for employees of certain acquired businesses. For the years ending December 31, 2011 and 2010, respectively, the Company made matching contributions to the plan of \$674,250 and \$386,328.

The Company may also make discretionary profit-sharing contributions to the plan if approved by the board of directors. No such contributions were made in 2011 or 2010.

(14) Commitments and Contingencies

The Company may be subject to claims and suits in the ordinary course of business, including contractual disputes and professional and general liability claims.

On February 15, 2007, the previous owners of the acquired San Antonio facilities brought suit against the Company. In the lawsuit, the plaintiffs alleged that the Company had failed to pay amounts due to the sellers of Rencare Ltd. (Rencare) concerning accounts receivable that arose prior to the close of the Rencare acquisition. A trial was held in November 2008 and judgment was entered in favor of the plaintiff seller. Both sides appealed, and the Company prevailed in the appeal. The Texas Court of Appeals held that the plaintiff should receive nothing and directed entry of judgment in the Company's favor. In

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

January of 2012, the Texas Supreme Court declined review, and the judgment in favor of the Company is now final. The Company incurred legal and other professional fees related to this litigation. These expenses aggregated \$62,791 and \$27,208 in 2011 and 2010, respectively. In 2010, the Company reversed a \$1.1 million reserve related to this litigation that it recorded in 2008.

In February, 2010, and prior to the Company's acquisition, DCA received a subpoena from the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) with respect to an investigation relating to EPO utilization at certain DCA clinics. The Company has been fully cooperating with the inquiry and has produced the requested documents to date. While there is no indication of such at this time, any negative findings could result in: (a) substantial monetary penalties; (b) excluding certain facilities from participation in the Medicare and Medicaid programs; and (c) the Company incurring legal expenses and management time, any or all of which could have a material adverse effect on the Company's revenues, earnings and cash flows. The Company incurred legal fees related to this investigation of \$271,377 and \$389,741 in 2011 and 2010, respectively, subsequent to its acquisition of DCA. In December 2010, the Company received a Civil Investigative Demand (CID) from the U.S. Attorney for the District of New Jersey requesting documents relating to laboratory tests performed on patients of the Company at two of its North Texas clinics. The Company gathered and produced the required documents and performed its own review of such documents. While the Company believes that it is not the subject of the government's investigation, the outcome of this matter is uncertain and the Company has risk of an adverse outcome that could result in substantial monetary penalties.

The Company has obligations to purchase the third-party interests in several of its joint ventures. These obligations are in the form of put provisions in joint venture agreements, and are exercisable at the third-party owners' discretion with some timing limitations. If these put provisions are exercised, the Company would be required to purchase the third-party owners' interests at fair market value (see note 4).

The Company rents office space, medical facilities, and medical equipment under lease agreements that are classified as operating leases for financial reporting purposes. At December 31, 2011, the future minimum rental payments under noncancelable operating leases with terms of one year or more consist of the following:

2012	\$ 10,318,246
2013	9,531,848
2014	8,200,747
2015	7,153,231
2016	6,812,937
Thereafter	10,753,819

Rent expense was \$10,976,315 and \$8,129,164 for the years ended December 31, 2011 and 2010, respectively.

(15) Subsequent Events

The Company evaluated events subsequent to December 31, 2011 and through April 6, 2012, the date on which the financial statements were issued.



U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2010 and 2009

(With Independent Auditors' Report Thereon)



KPMG LLP
Suite 3100
717 North Harwood Street
Dallas, TX 75201-6585

Independent Auditors' Report

The Board of Directors
U.S. Renal Care, Inc.:

We have audited the accompanying consolidated balance sheets of U.S. Renal Care, Inc. and subsidiaries (the Company) as of December 31, 2010 and 2009, and the related consolidated statements of operations, changes in equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of U.S. Renal Care, Inc. and subsidiaries as of December 31, 2010 and 2009, and the results of their operations and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

KPMG LLP

Dallas, Texas
April 27, 2011

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2010 and 2009

Assets	2010	2009
Cash and cash equivalents	\$ 9,537,107	15,325,357
Accounts receivable, net of allowances of \$13,458,494 and \$8,460,232	48,449,631	25,900,874
Inventories	3,100,193	1,369,198
Other receivables	9,994,938	4,863,513
Deferred tax asset	6,215,457	904,600
Other current assets	2,636,244	1,429,165
Total current assets	79,933,570	49,792,707
Property and equipment, net	46,781,941	19,251,600
Amortizable intangibles, net	27,349,714	12,241,011
Trade names	859,000	—
Investment in affiliate	—	217,670
Goodwill	190,524,762	67,922,354
Other long-term assets	470,902	238,961
Deferred taxes	—	906,459
Total assets	\$ 345,919,889	150,570,762
Liabilities and Equity		
Accounts payable	\$ 9,045,119	5,675,616
Accrued expenses	24,248,618	16,485,807
Current portion of long-term debt and capital lease obligations	2,924,662	1,447,595
Current portion of related-party notes payable	125,000	125,000
Total current liabilities	36,343,399	23,734,018
Long-term debt and capital lease obligations, net of current portion	181,723,922	62,010,592
Related-party notes payable	—	125,000
Other long-term liabilities	440,844	532,982
Deferred tax liability	9,480,942	—
Preferred stock accrued dividends	19,831,208	14,736,426
Total liabilities	247,820,315	101,139,018
Commitments and contingencies		
U.S. Renal Care, Inc. equity:		
Preferred stock A (\$0.01 par value. Authorized shares 20,325,000; issued and outstanding 12,350,000 and 12,350,000 shares)	123,500	123,500
Preferred stock B and B-1 (\$0.01 par value. Authorized shares 1,600,000; issued and outstanding 1,431,666 and 1,415,666 shares)	14,317	14,157
Preferred stock C (\$0.01 par value. Authorized shares 25,000,000; issued and outstanding 24,500,962 and 24,500,962 shares)	245,010	245,010
Preferred stock D (\$0.01 par value. Authorized shares 8,333,333; issued and outstanding 8,333,333 and 0 shares)	83,333	—
Common stock (\$0.01 par value. Authorized shares 53,525,000 and 52,525,000; issued and outstanding 7,074,324 and 7,074,324 shares)	70,744	62,229
Additional paid-in capital	38,667,471	36,454,222
Retained earnings	5,291,320	1,497,694
Total U.S. Renal Care, Inc. stockholders' equity	44,495,695	38,396,812
Noncontrolling interests (including redeemable interests with redemption values of \$40,999,428 and \$23,600,000)	53,603,879	11,034,932
Total equity	98,099,574	49,431,744
Total liabilities and equity	\$ 345,919,889	150,570,762

See accompanying notes to consolidated financial statements.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
Net operating revenues	\$ 237,606,328	153,164,637
Operating expenses:		
Patient care costs	154,284,195	98,842,829
General and administrative	20,207,561	15,601,927
Provision for doubtful accounts	6,898,682	4,585,251
Legal cost/settlement	(352,334)	286,647
Transaction costs	9,076,731	460,465
Depreciation and amortization	14,655,411	7,957,301
Total operating expenses	<u>204,770,246</u>	<u>127,734,420</u>
Operating income	32,836,082	25,430,217
Interest expense, net	<u>10,192,698</u>	<u>2,923,456</u>
Income before income taxes	22,643,384	22,506,761
Income tax provision (benefit)	<u>5,826,130</u>	<u>(3,191,190)</u>
Net income	16,817,254	25,697,951
Less net income attributable to noncontrolling interests	<u>13,023,628</u>	<u>10,103,151</u>
Net income attributable to U.S. Renal Care, Inc.	\$ <u><u>3,793,626</u></u>	<u><u>15,594,800</u></u>

See accompanying notes to consolidated financial statements.

U.S. REYNOLDS CABLE INC. AND SUBSIDIARIES

Consolidated Statement of Changes in Equity
Years ended December 31, 2010 and 2009

	U.S. Reynold Cable Inc. (referred to as "the company")										
	Preferred stock, A		Preferred stock, B and B-1		Preferred stock, C		Preferred stock, D		Common stock		Retained earnings/ (accumulated deficit)
	Shares	Amount	Shares	Amount	Shares	Amount	Shares	Amount	Shares	Amount	
Balance at December 31, 2008	12,350,000	\$ 123,500	1,415,666	\$ 14,157	24,300,962	\$ 243,010	—	\$ —	6,014,122	\$ 60,141	36,318,365
Issuance of preferred stock	—	—	16,000	160	—	—	—	—	—	—	—
Accumulated preferred dividend	—	—	(50,000)	(700)	—	—	—	—	—	—	—
Repurchase of preferred stock	—	—	—	—	200,000	2,000	—	—	—	—	—
Stock options exercised	—	—	—	—	—	—	—	—	—	—	—
Stock options forfeited	—	—	—	—	—	—	—	—	—	—	—
Exercise of restricted stock	—	—	—	—	—	—	—	—	258,730	2,587	—
Restricted stock expense	—	—	—	—	—	—	—	—	—	—	—
Capital contribution by noncontrolling interests	—	—	—	—	—	—	—	—	—	—	—
Dividends to noncontrolling interests	—	—	—	—	—	—	—	—	—	—	—
Net income	—	—	—	—	—	—	—	—	—	—	267,750
											(9,463,972)
											25,854,393
Balance at December 31, 2009	12,350,000	\$ 123,500	1,415,666	\$ 14,157	24,500,962	\$ 245,010	—	\$ —	6,272,852	\$ 62,729	25,854,393
Issuance of preferred stock	—	—	16,000	160	—	—	8,333	83,333	—	—	—
Accumulated preferred dividend	—	—	—	—	—	—	—	—	—	—	—
Stock options exercised	—	—	—	—	—	—	—	—	—	—	—
Stock options forfeited	—	—	—	—	—	—	—	—	—	—	—
Exercise of restricted stock	—	—	—	—	—	—	—	—	291,472	2,915	—
Restricted stock expense	—	—	—	—	—	—	—	—	—	—	—
Exercise of noncontrolling interest and options	—	—	—	—	—	—	—	—	560,000	5,600	—
Capital contribution by noncontrolling interests	—	—	—	—	—	—	—	—	—	—	—
Dividends to noncontrolling interests	—	—	—	—	—	—	—	—	—	—	—
Noncontrolling interest acquired in purchase business combination	—	—	—	—	—	—	—	—	—	—	—
Net income	—	—	—	—	—	—	—	—	—	—	—
Balance at December 31, 2010	12,350,000	\$ 123,500	1,431,666	\$ 14,317	24,500,962	\$ 245,010	8,333	\$ 83,333	7,874,324	\$ 78,743	25,854,393

See accompanying notes to consolidated financial statements

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows
Years ended December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
Cash flows from operating activities:		
Net income	\$ 16,817,254	25,697,951
Adjustments to reconcile net income to cash provided by operating activities:		
Depreciation and amortization	14,655,411	7,957,301
Noncash dispute settlement	450,000	—
Lease agreement intangible amortization included in rent	31,337	(83,399)
Provision for doubtful accounts	6,898,682	4,585,251
Deferred income taxes	2,929,214	(4,794,034)
Equity investment income	(805,801)	(17,646)
Stock compensation expense	102,652	55,096
Loss on disposal of fixed assets	41,711	—
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:		
Accounts receivable	(11,223,175)	(9,500,021)
Inventories	1,065,325	1,046,906
Other receivables	(2,773,018)	(529,248)
Other current assets	(326,422)	(93,041)
Other long-term assets	(1,049,343)	7,176
Accounts payable and accrued expenses	585,137	(5,143,239)
Other noncurrent liabilities	331,317	(12,936)
Net cash provided by operating activities	<u>27,730,281</u>	<u>19,176,117</u>
Cash flows from investing activities:		
Acquisitions, net of cash acquired	(116,523,175)	(386,762)
Sale of property and equipment	3,172,324	—
Additions of property and equipment, net	(18,394,835)	(7,431,804)
Purchase of noncontrolling interests	(18,991,500)	—
Investment in affiliate	101,335	(200,024)
Net cash used in investing activities	<u>(150,635,851)</u>	<u>(8,018,590)</u>
Cash flows from financing activities:		
Proceeds from long-term debt borrowings	181,952,491	8,750,000
Payments on long-term debt and related-party notes payable	(73,000,188)	(600,224)
Deferred financing costs	(7,938,537)	(7,424)
Proceeds from capital leases	3,260,343	336,118
Capital lease payments	(1,243,894)	(799,901)
Net proceeds from issuance of preferred stock	25,015,999	316,000
Proceeds from issuance of common stock	43,648	29,823
Repurchase of preferred stock	—	(75,000)
Contributions from noncontrolling interests	695,750	267,750
Distributions to noncontrolling interests	(11,668,292)	(9,463,932)
Net cash provided by (used in) financing activities	<u>117,117,320</u>	<u>(1,246,790)</u>
Net (decrease)/increase in cash and cash equivalents	<u>(5,788,250)</u>	<u>9,910,737</u>
Cash and cash equivalents at beginning of year	<u>15,325,357</u>	<u>5,414,620</u>
Cash and cash equivalents at end of year	\$ <u>9,537,107</u>	<u>15,325,357</u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
Supplemental cash flow information:		
Cash paid for interest	\$ 8,474,494	2,780,464
Cash paid for taxes	4,814,265	1,260,000
Supplemental disclosures of noncash investing and financing activities:		
Accrual of cumulative preferred dividends	\$ 5,094,782	3,924,249
Capital lease financing	99,126	463,783

See accompanying notes to consolidated financial statements.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

(1) Organization and Significant Accounting Policies

(a) Organization and Business

U.S. Renal Care, Inc. (the Company) was formed in June 2000 and provides dialysis services to patients who suffer from chronic kidney failure, also known as end stage renal disease (ESRD). ESRD is the stage of advanced kidney impairment that requires continual dialysis treatments, or a kidney transplant, to sustain life. Patients suffering from ESRD generally require dialysis three times per week for the rest of their lives. The Company primarily provides these services through the operation of outpatient kidney dialysis clinics. As of December 31, 2010, the Company operated 84 outpatient dialysis clinics in Texas, Arkansas, Georgia, Maryland, New Jersey, Ohio, Pennsylvania, Virginia and South Carolina. In addition to its outpatient dialysis center operations, as of December 31, 2010, the Company provides acute dialysis services through contractual relationships with 21 hospitals and dialysis to patients in their homes.

(b) Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned and majority-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in consolidation.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities, and the disclosure of contingent assets and liabilities, at the date of the consolidated financial statements, as well as the reported amounts of revenues and expenses during the reporting period.

Although actual results in subsequent periods will differ from these estimates, such estimates are developed based upon the best information available to management and management's best judgments at the time made. The most significant estimates and assumptions involve revenue recognition, provisions for uncollectible accounts, determination of the fair value of assets and liabilities acquired, impairments and valuation adjustments, and accounting for income taxes.

(d) Cash and Cash Equivalents

Cash includes cash and highly liquid investments with a maturity of ninety days or less at date of purchase. Cash and cash equivalents at times may exceed the FDIC limits. The Company believes no significant concentration of credit risk exists with respect to these cash investments.

(e) Accounts Receivable and Allowance for Doubtful Accounts

Substantially all of the Company's accounts receivable are related to providing healthcare services to its patients and are due from the Medicare program, state Medicaid programs, managed care health plans, commercial insurance companies and individual patients. The estimated provision for doubtful

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

accounts is recorded to the extent it is probable that a portion or all of a patient balance will not be collected. The Company considers a number of factors in evaluating the collectibility of accounts receivable including the age of the accounts, collection patterns and any ongoing disputes with payors.

(f) Amounts Due from Third-Party Payors

The amount due from third-party payors, which is included in other receivables, represents balances owed to the Company by the Medicare program for reimbursable bad debts related to Medicare beneficiaries. These reimbursements are part of the Company's annual cost report filings and as such, the actual payments may be delayed or subsequently adjusted pending review and audit by the Medicare program fiscal intermediaries.

(g) Amounts Due from Drug Rebates

The amount due from drug rebates, which is included in other receivables, represents balances owed to the Company by various pharmaceutical vendors for Epogen (EPO), vitamin D and iron. During 2010 and 2009, the Company had incentive contracts that reduced the invoice price based upon volume purchased. This incentive was payable to the Company on a quarterly basis. In addition, there was an additional annual incentive based on volume that was payable to the Company annually.

(h) Inventories

Inventories consist primarily of pharmaceuticals and dialysis-related supplies and are stated at the lower of cost or market. Cost is determined using the first-in, first-out method. Market is determined on the basis of estimated realizable values.

(i) Property and Equipment

Property and equipment is carried at cost less accumulated depreciation. Property under capital lease agreements is stated at the present value of minimum lease payments less accumulated depreciation. Depreciation is computed using the straight-line method over the estimated useful lives of the assets or the term of the lease as appropriate. The general range of useful lives is as follows:

Buildings	39 years
Leasehold improvements	Life of lease
Furniture and equipment	5 years
Computers	3 years

Capital lease assets are amortized over the shorter of the lease term or the estimated useful life of the improvement. Property and equipment acquired in acquisitions is recorded at fair value. The cost of improvements that extend asset lives is capitalized. Other repairs and maintenance charges are expensed as incurred.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

Fully depreciated assets are retained in property and depreciation accounts until they are removed from service. When sold or otherwise disposed of, assets and related depreciation are removed from the accounts and the net amounts, less proceeds from disposal, are included in income.

(j) *Concentration of Credit Risk*

The Company's primary concentration of credit risk exists within accounts receivable, which consist of amounts owed by various governmental agencies, insurance companies, and private patients. Receivables from the Medicare program and various state Medicaid programs were approximately 57% and 55% of gross accounts receivable at December 31, 2010 and 2009, respectively. Concentration of credit risk relating to remaining accounts receivable is limited to some extent by the diversity of the number of patients and payors.

(k) *Amortizable Intangible Assets*

Amortizable intangible assets and liabilities include noncompetition and similar agreements, lease agreements, and deferred debt issuance costs. Noncompetition and similar agreements are amortized over the terms (five to ten years) of the agreements using the straight-line method. Lease agreement intangibles for favorable and unfavorable leases are amortized on a straight-line basis over the term of the lease.

Deferred debt issuance costs are amortized using the effective interest method as an adjustment to interest expense over the term of the related debt. In the case of debt repayments prior to the end of the term, the Company adjusts the amount of deferred financing costs at the date of repayment, which is included in interest expense.

(l) *Goodwill*

Goodwill is recorded when the consideration paid for an acquisition exceeds the fair value of net tangible assets and identifiable intangible assets acquired. Goodwill and other indefinite-lived intangible assets are not amortized, but are instead tested for impairment at least annually. The annual evaluation for 2010 and 2009 resulted in no impairment charges.

(m) *Impairment of Long-Lived and Indefinite-Lived Assets*

The Company evaluates long lived-assets and identifiable intangibles for impairment whenever events or changes in circumstances indicate that an asset's carrying amount may not be recoverable or the useful life has changed. When undiscounted future cash flows are not expected to be sufficient to recover an asset's carrying amount, a loss is recognized and the asset is written down to its fair value.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

(n) Fair Value of Financial Instruments

The following table details the Company's financial instruments where the carrying value and fair value differ (amounts in millions):

Financial instrument	Carrying value as of December 31, 2010	Fair value at reporting date using		
		Quoted prices in active markets for identical items (Level 1)	Significant other observable inputs (Level 2)	Significant other unobservable inputs (Level 3)
Senior secured credit facility	\$ 178,917	—	—	189,632

The estimates of the fair value of the Company's senior secured credit facility are based upon a discounted present value analysis of future cash flows. Due to the existing uncertainty in the capital and credit markets, the actual rates that would be obtained to borrow under similar conditions could materially differ from the estimates the Company has used.

The fair value of the interest rate swaps are determined using quoted market prices for similar swap agreements and were nominal at December 31, 2010.

U.S. GAAP describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets and liabilities.
- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities.

For the Company's other financial instruments, including the Company's cash and cash equivalents, accounts receivable, accounts payable, and accrued expenses the Company estimates the carrying amounts approximate fair value due to their short-term maturity.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

(o) Net Operating Revenues and Accounts Receivable

Net operating revenue is recognized in the period services are provided. Revenue consists primarily of reimbursements from Medicare, Medicaid and commercial health plans for dialysis services provided to patients. A usual and customary fee schedule is maintained for the Company's dialysis treatment and other patient services. However, actual collected revenue is normally at a discount to this fee schedule. Contractual adjustments represent the differences between amounts billed for services and amounts paid by third-party payors.

The Company's dialysis facilities are certified to participate in the Medicare program. Revenues reimbursed by the Medicare program are recognized primarily on a prospective payment system for dialysis services (ESRD Program). Prior to January 2011, dialysis providers operating under the Medicare ESRD program received a composite payment rate to cover routine dialysis treatments and certain supplies. There was a separate payment for laboratory testing and pharmaceuticals such as EPO, vitamin D and iron supplements that were not included in the composite rate. However, beginning January 2011, Medicare implemented a new payment system in which all ESRD payments are now made under a single bundled payment rate that provides for an annual inflation adjustment based upon a market basket index, less a productivity improvement factor. The bundled payment rate provides a fixed rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers. Most lab services that were previously paid directly to laboratories are also included in the new payment bundle. Now, as a result of the bundled payment system, the dialysis providers are at risk of variations in pharmaceutical utilization since reimbursement is set at a fixed average reimbursement rate.

The initial 2011 bundled payment rate includes reductions of 2% and 0.8%, respectively, to conform to the provisions of MIPPA and to establish budget neutrality. Further, there is a 5.94% reduction tied to an expanded list of case mix adjusters which can be earned back upon the presence of these certain patient characteristics and co-morbidities at the time of treatment. Historically, dialysis providers have not had to track certain of the case-mix adjusters and this may be difficult to capture initially. There are also other provisions which may impact reimbursement including an outlier adjustment and a low volume facility adjustment.

As of November 1, 2010, dialysis providers were required to make an election as to which clinics would be fully reimbursed as of January 1, 2011 under the new bundled payment system or phased into the new system over a four year period. The Company elected to have approximately 72% of its clinics be reimbursed fully under the new bundled reimbursement system beginning January 1, 2011. Once this election was made, it may not be revoked. All clinics that receive Medicare certification subsequent to November 1, 2010 will be reimbursed under the new bundled reimbursement system. Beginning in 2012, dialysis providers will also be subject to a 2% annual Medicare payment withholding that can be earned back by facilities that meet certain defined clinical performance standards.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

Medicare presently pays 80% of the established payment rates for dialysis treatment furnished to patients. The remaining 20% may be paid by Medicaid if the patient is eligible, from private insurance funds, or from the patient's personal funds. If there is no secondary payor to cover the remaining 20%, and if the Company demonstrates prescribed collection efforts, Medicare may reimburse the Company for part of that balance as part of the Company's annual cost report filings subject to individual center profitability. As a result, billing and collection of Medicare bad debt claims are often delayed significantly, and final payment is subject to audit.

Medicaid programs are administered by state governments and are partially funded by the federal government. In addition to providing primary coverage for patients whose income and assets fall below state defined levels and are otherwise insured, Medicaid serves as a supplemental insurance program for the co-insurance portion not paid by Medicare. Medicaid reimbursement varies by state but is typically reimbursed pursuant to a prospective payment system for dialysis services rendered.

Revenues associated with commercial health plans are estimated based upon patient-specific contractual terms between the Company and health plans for the patients with which the Company has formal agreements, upon commercial health plan coverage terms if known or otherwise upon historical collection experience adjusted for refund and payment adjustment trends. Commercial revenue recognition involves substantial judgment. With several commercial insurers, the Company has multiple contracts with varying payment arrangements, and these contracts may include only a subset of the Company's dialysis centers. In addition, for services provided by noncontracted centers, final collection may require specific negotiation of a payment amount. Generally, payments for a dialysis treatment from commercial payors are greater than the corresponding amounts received from Medicare and Medicaid.

(p) Share-Based Compensation

The Company recognizes compensation expense, for all share-based awards, including stock option grants to employees, using a fair-value measurement method. Under the fair-value method, the estimated fair value of awards that are expected to vest is recognized over the requisite service period, which is generally the vesting period.

Prior to 2006, the Company accounted for its equity compensation using the intrinsic value-based method of accounting. The Company did not recognize compensation expense before 2006 because the exercise price of stock options granted was not less than the estimated value of the underlying stock on the date of grant. The Company continues to account for equity compensation based shares granted prior to 2006 using the intrinsic value method until such time as shares are modified, canceled, or repurchased.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

The Company estimates the fair value of awards on the date of grant, using the Black-Scholes option pricing model. The weighted average fair value of options granted during the years ended December 31, 2010 and 2009 are calculated based on the following assumptions: expected volatility of 22%, expected dividend yield of 0%, expected life of 3.75 years, and risk-free interest rates of 1.08% to 1.97%. Expected volatility was derived using data drawn from two public dialysis companies. The expected life was computed utilizing the simplified method as permitted by the Securities and Exchange Commission's Staff Accounting Bulletin, *Share Based Payment*. The expected forfeiture rate is 20% based upon a review of the Company's recent history and expectations as segregated between the Company's board of directors, senior officers, and other grantees. The risk-free interest rate is based on the approximate average yield on five year United States Treasury Bonds as of the date of grant. There were 352,000 and 195,000 options granted during the years ended December 31, 2010 and 2009, respectively (see note 9).

(q) *Noncontrolling Interest*

In December 2007, the FASB issued an accounting standard, *Noncontrolling Interests in Consolidated Financial Statements* (ASC 810), which gives guidance on the presentation and disclosure of noncontrolling interests (previously known as minority interests) of consolidated subsidiaries. This statement requires the noncontrolling interest to be included in the equity section of the balance sheet, requires disclosure on the face of the consolidated statement of operations of the amounts of consolidated net income attributable to the consolidated parent and the noncontrolling interest, and expands disclosures.

Consolidated income (loss) is reduced (increased) by the proportionate amount of income or loss accruing to noncontrolling interests. Noncontrolling interest represents the equity interest of third-party owners in consolidated entities that are not wholly owned.

(r) *Income Taxes*

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to the differences between the financial statement carrying amount of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. A valuation allowance is established when it is more likely than not that the deferred tax assets will not be realized.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

The Company adopted the accounting standard update ASC 740, *Accounting for Uncertainty in Income Taxes*, on January 1, 2009. Previously, the Company had accounted for tax contingencies under ASC 450, *Accounting for Contingencies*. As required by ASC 740, the Company recognizes the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For tax positions meeting the more-likely than-not threshold, the amount recognized in the financial statements is the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement with the relevant tax authority. At the adoption date, the Company applied ASC 740 to all tax positions for which the statute of limitations remained open. As a result of the implementation of ASC 740, the Company did not recognize an increase in the liability for unrecognized tax benefits. The amount of unrecognized tax benefits as of December 31, 2010 and 2009 was \$0.

The Company is subject to income taxes in the U.S. federal jurisdiction and various states. Tax regulations within each jurisdiction are subject to the interpretation of the related tax laws and regulations and require significant judgment to apply. The Company is no longer subject to U.S. federal or state or local income tax examinations by tax authorities for the years before 2006. In 2010, the Internal Revenue Service finalized its examination of the Company's 2007 U.S. income tax returns. The resolution of this examination resulted in no additional tax payment.

The Company recognizes interest accrued related to unrecognized tax benefits in interest expense and penalties in operating expenses for all periods presented.

The Company's consolidated LLC and L.P. subsidiaries do not incur federal income taxes. Instead, their earnings and losses are included in the returns of, and taxed directly to, the members and partners of these subsidiaries.

(s) *Derivative Instruments and Hedging Activities*

The Company has entered into an interest rate swap agreement as a means of hedging its exposure to and volatility from variable-based interest rate change. These agreements are designed as cash flow hedges and are not held for trading or speculative purposes. The swap agreement has the economic effect of converting portions of the Company's variable rate debt to fixed rates.

In 2010, the Company adopted the provisions of FASB Statement No. 161, *Disclosures about Derivative Instruments and Hedging Activities* (included in FASB ASC Topic 815, *Derivatives and Hedging*), which amends the disclosure requirements for derivative instruments and hedging activities. The amended disclosure require entities to provide information to enable users of the financial statements to understand how and why an entity uses derivative instruments, how derivative instruments and related hedged items are accounted for, and how derivative instruments are related hedged items affect an entity's financial position, financial performance, and cash flows (see note 6).

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

(i) *Recently Issued Accounting Pronouncements*

Effective January 1, 2009, the Company adopted the provisions of FASB ASC 820 relating to fair value measurements and disclosures with respect to nonfinancial assets and nonfinancial liabilities that are not permitted or required to be measured at fair value on a recurring basis. The adoption had no impact on the Company's consolidated financial statements.

Although the adoption of FASB ASC 820 had no direct impact on the Company's consolidated financial statements, additional disclosures are required under FASB ASC 820 indicating the fair value hierarchy of the valuation techniques utilized to determine fair value measures. The Company has included appropriate disclosures herein.

Effective December 31, 2009, the Company adopted FASB ASC 855, *Subsequent Events*, which establishes principles and requirements for subsequent events and applies to accounting for and disclosure of subsequent events not addressed in other applicable generally accepted accounting principles. The Company evaluated events subsequent to December 31, 2010 and through April 27, 2011, the date on which the financial statements were issued.

(u) *Reclassifications*

Certain reclassifications have been made to the 2009 consolidated financial statement balances to conform with the 2010 presentation. Such reclassifications have no effect on earnings or stockholders' equity.

(2) **Fixed Assets**

At December 31, 2010 and 2009, property and equipment consists of the following:

	<u>2010</u>	<u>2009</u>
Facility equipment, furniture, and information systems	\$ 42,891,347	22,202,152
Land and buildings	6,747,940	—
Leasehold improvements	21,493,319	9,731,329
New center construction in progress	778,865	2,829,967
	<u>71,911,471</u>	<u>34,763,448</u>
Less accumulated depreciation and amortization	<u>(25,129,530)</u>	<u>(15,511,848)</u>
	<u>\$ 46,781,941</u>	<u>19,251,600</u>
	<u>Year ended December 31</u>	
	<u>2010</u>	<u>2009</u>
Depreciation and amortization expense on property and equipment	\$ 9,304,459	5,355,638

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

Net book value of equipment under capital leases at December 31 was as follows:

	<u>2010</u>	<u>2009</u>
Equipment	\$ 10,671,572	7,312,321
Less accumulated depreciation	<u>(6,099,837)</u>	<u>(4,092,015)</u>
	<u>\$ 4,571,735</u>	<u>3,220,306</u>

(3) Acquisitions/Disposition

The Company has acquired various dialysis businesses, as described further below. The assets and liabilities for all acquisitions were recorded at their estimated fair values as of the effective acquisition date based upon the best available information.

Amortizable intangible assets consist primarily of noncompete agreements. Goodwill is recorded when the consideration paid for an acquisition exceeds the fair value of identifiable net tangible assets and identifiable intangible assets acquired.

The results of operations for the acquired companies are included in the Company's financial statements beginning on the effective acquisition date.

(a) *Dialysis Corporation of America, Inc. Acquisition*

On June 3, 2010, the Company acquired all the outstanding common shares of Dialysis Corporation of America, Inc. (DCA) for \$11.25 per share. DCA provides outpatient dialysis, in-home dialysis and acute services in Georgia, Maryland, New Jersey, Ohio, Pennsylvania, Virginia and South Carolina. The results of operations for DCA are included in the Company's financial statements beginning June 1, 2010.

The DCA acquisition cost of approximately \$110 million and costs related thereto were funded from the proceeds of the Company's senior secured and subordinated loan agreements (see note 6) and the issuance of Series D Preferred Stock (see note 8). All purchase accounting adjustments are final except for certain deferred tax calculations primarily related to flow-through entities.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

The estimated fair values of the assets acquired and liabilities assumed at the acquisition date are as follows:

Assets:	
Cash	\$ 1,294,958
Net accounts receivable	17,072,334
Inventory	2,684,480
Other receivables	1,280,382
Other current assets	<u>2,257,895</u>
Total current assets	24,590,049
Property and equipment, net	20,526,500
Amortizable intangibles, net	12,957,381
Goodwill	113,828,342
Other long-term assets	<u>863,600</u>
Total assets	<u><u>\$ 172,765,872</u></u>
Liabilities:	
Accounts payable	\$ 4,958,871
Accrued expenses	<u>6,177,187</u>
Total current liabilities	11,136,058
Long-term debt	9,586,971
Other long-term liabilities	(326,883)
Deferred tax liability	<u>3,808,826</u>
Total liabilities	<u><u>\$ 24,204,972</u></u>
Equity:	
Minority interest	<u>\$ 38,310,900</u>
Total equity	<u><u>\$ 38,310,900</u></u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES**Notes to Consolidated Financial Statements**

December 31, 2010 and 2009

(b) San Antonio

On July 1, 2010, the Company purchased an additional 40% interest in one of its joint venture entities which it previously had a 40% noncontrolling ownership interest for \$7.2 million. The acquisition was funded by borrowing under the Company's revolving credit facility (see note 6) and cash on hand. The consolidated results of operation for this facility are included in the Company's financial statements beginning July 1, 2010. Previously, the Company's investment was recorded using the equity method of accounting. The investment balance at June 30, 2010 was approximately \$922,000.

Assets:	
Cash	\$ 671,969
Net accounts receivable	1,151,930
Inventory	22,726
Other receivables	7,724
Other current assets	24,742
Total current assets	1,879,091
Property and equipment, net	974,832
Goodwill	8,426,146
Total assets	\$ 11,280,069
Liabilities:	
Accounts payable	\$ 25,983
Accrued expenses	145,888
Total liabilities	\$ 171,871
Equity:	
Minority interest	\$ 2,986,200
Total equity	\$ 2,986,200

(c) December Acquisition

On December 1, 2010, the Company acquired two outpatient dialysis clinics, an acute program and a home program (December Acquisition). This transaction included purchasing a 51% majority interest in the assets of one of the clinics and a 100% interest in the assets of the other clinic. The results of operations for these services are included in the Company's financial statements beginning December 1, 2010. The December Acquisition cost of approximately \$1 million was funded from operating cash flow.

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The estimated fair values of the assets acquired at the acquisition date are as follows:

Assets:	
Inventory	\$ 89,114
Other current assets	26,017
Fixed assets	416,000
Goodwill	<u>869,546</u>
Total assets	<u>\$ 1,400,677</u>
Liabilities:	
Accrued expenses	<u>\$ 357,713</u>
Total liabilities	<u>\$ 357,713</u>

(d) *Medicore Disposition*

On November 30, 2010, the Company sold 100% of the net assets of its medical products business that was acquired in the DCA acquisition. The Company sold, assigned and transferred certain assets for approximately \$535,000 resulting in no gain or loss.

(4) **Noncontrolling Interests**

The Company engages in the purchase and sale of equity interests with respect to its consolidated subsidiaries that do not result in a change of control. These transactions are accounted for as equity transactions, as they are undertaken among the Company, its consolidated subsidiaries, and noncontrolling interests, and their cash flow effect is classified within financing activities.

As of December 31, 2010, the Company was the majority owner in 48 joint ventures. Of the noncontrolling interests in those 48 joint ventures, 17 have put rights generally at fair value as defined in the agreement that are either currently exercisable or become exercisable at various future dates. The carrying amount of these redeemable noncontrolling interests totaled \$7.3 million and \$3.8 million as compared to redemption values of \$41.0 million and \$23.6 million at December 31, 2010 and 2009, respectively. The redemption value is calculated at the current value of the put payment that would be required to redeem the interest if the put is exercised regardless of whether such interest is currently exercisable. As of December 31, 2010, \$7.0 million of put rights are currently exercisable and the remaining \$34.0 million become exercisable at future dates.

During the year, there were nine time-based puts exercised in the Company's South Texas region and one in the San Antonio region. The Company paid \$18.4 million relating to these puts. As a result of the DCA acquisition, there was one change of control put that was partially exercised at one clinic for \$600,000.

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Notes to Consolidated Financial Statements

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(5) Intangible Assets

At December 31, 2010 and 2009, amortizable intangible assets consisted of the following:

	2010	2009
Noncompetition agreements	\$ 31,836,273	20,132,544
Lease agreements	580,106	76,221
Deferred debt issuance costs	7,939,537	1,910,489
Licenses	359,000	—
	<u>40,714,916</u>	<u>22,119,254</u>
Less accumulated amortization	<u>(13,365,202)</u>	<u>(9,878,243)</u>
Net amortizable intangible assets	<u>\$ 27,349,714</u>	<u>12,241,011</u>

Amortizable intangible liabilities, which are included in other long-term liabilities, consisted of lease agreements as follows:

	2010	2009
Lease agreements	\$ 1,089,293	1,089,293
Less accumulated amortization	<u>(648,449)</u>	<u>(556,311)</u>
Net amortizable intangible assets	<u>\$ 440,844</u>	<u>532,982</u>

Amortization of intangible assets and liabilities over the next five years is as follows:

	Noncompetition agreements	Deferred debt issuance costs	Lease agreements	Licenses
2011	\$ 4,564,626	1,323,090	396,359	71,800
2012	4,492,939	1,323,090	307,657	71,800
2013	4,418,857	1,323,090	227,206	71,800
2014	4,322,211	1,323,090	183,663	71,800
2015	1,281,681	1,323,090	149,418	29,917

Changes in the value of goodwill were as follows:

	2010	2009
Balance at January 1	\$ 67,922,354	67,559,887
Goodwill adjustments	(521,626)	362,467
Goodwill acquired	<u>123,124,034</u>	<u>—</u>
Balance at December 31	<u>\$ 190,524,762</u>	<u>67,922,354</u>

U.S. RENAL CARE, INC. AND SUBSIDIARIES

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The fair value of the identifiable intangibles acquired and the amount of goodwill recorded as a result of acquisitions are determined based upon independent third-party valuations and the Company's estimates. Amortization expense for the Company's intangible assets relates to the value associated with the noncompete and lease agreements. The noncompete intangible assets are amortized over the term of the noncompete agreements executed in connection with the acquisition transactions or the medical agreements entered into with certain physicians and the lease agreement intangibles are amortized over the term of the lease.

(6) Long-Term Debt

On June 3, 2010, the Company entered into a new senior credit agreement that consists of: (a) a \$132.5 million senior secured term loan (Term Loan) and (b) a \$40 million senior secured revolving credit facility (Revolver). Also on June 3, 2010, the Company entered into a \$40 million senior subordinated loan agreement (the Subordinated Loan). The proceeds of the Term Loan and the Subordinated Loan along with available cash on hand were utilized to: (a) pay off the Company's existing CIT Term Loan B and Revolver (which bore interest at 4.25% at December 31, 2009), (b) pay expenses and fees associated with the new senior secured and subordinated loan agreements, and (c) to fund the DCA acquisition (see note 3) including cost and fees related thereto.

Borrowings under the Term Loan and Revolver (collectively Senior Secured Loans) bear interest based upon a spread in excess of LIBOR (floor of 1.75%) or the U.S. prime rate, as the benchmark, as adjusted based upon the Company's leverage ratio. The new Senior Secured Loan also provides for an annual unused commitment fee of 0.75% based upon the average revolving credit commitment less outstanding borrowings on the Revolver and letters of credit issued. As of December 31, 2010, borrowings under the Senior Secured Loans bore interest at 6.25%. The Subordinated Loan accrues interest at 13.25% with 11.25% paid in cash per annum. The remaining 2% of interest on the Subordinated Loan (PIK Interest) will be capitalized and accrued for until it becomes due upon the maturity of the loan.

The Term Loan requires quarterly principal payments of \$331,250 in each year from 2011 through 2015 with the balance of \$124,881,250 due in 2016. The Subordinated Loan requires a one-time payment of \$40 million principal balance due in 2017, in addition to outstanding PIK Interest.

The Revolver, Term Loan, and Subordinated Loan mature on June 2, 2015, June 2, 2016 and June 2, 2017, respectively. The subordinated loan agreement provides for prepayment penalties if it is repaid within the first four years subsequent to June 3, 2010.

Commencing with the fiscal year ended December 31, 2011, the Company is required to prepay its outstanding Senior Secured Loan balances with 50% of excess cash flow as defined in the credit agreement. The Company is also required to prepay senior secured loan balances with: (a) 50% of the net proceeds of certain capital contributions as defined in the credit agreement, (b) 100% of the proceeds of asset sales or the proceeds received from casualty event settlements that are not reinvested or permitted pursuant to the terms of the credit agreement, and (c) 100% of the proceeds of indebtedness that is incurred and not permitted pursuant to the credit agreement. Following satisfaction of any prepayment under the Senior Secured Loans, the Company is required to prepay the Subordinated Loan balances with 100% of the proceeds of asset sales or the proceeds received from a casualty event settlement that are not reinvested or permitted pursuant to the terms of the credit agreement.

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The Senior Secured Loans and the Subordinated Loan are guaranteed, on a joint and several basis, by each of the Company's subsidiaries. Borrowings under the credit agreements are collateralized by most of the Company's assets, including accounts receivable, inventory, and fixed assets not subject to permitted capital leases. The Subordinated Loan is subordinated to the repayment of the Senior Secured Loans. The Senior Secured and Subordinated Loan agreements include various events of default and contain certain restrictions on the operations of the business, including restrictions on certain cash payments, including capital expenditures, investments and the payment of dividends. These loan agreements also include covenants pertaining to fixed charge coverage, interest coverage, and total debt leverage, as well as other customary covenants and events of defaults.

The Company believes it is in compliance with all covenants under the Senior Secured Loan and Subordinated Loan agreements and has met all debt payment obligations. At December 31, 2010, approximately \$33.0 million was unused and available under the Revolver.

At December 31, 2010 and 2009, long-term debt and capital lease obligations consisted of the following:

	<u>2010</u>	<u>2009</u>
Senior secured credit facility:		
CIT term loan B	\$ —	34,873,000
CIT revolver	—	24,968,762
Term loan	131,506,250	—
Revolver	7,000,000	—
Subordinated loan	40,410,549	—
Other notes payable	23,305	23,532
Capital lease obligations	<u>5,708,480</u>	<u>3,592,893</u>
Less current portion	184,648,584	63,458,187
	<u>(2,924,662)</u>	<u>(1,447,595)</u>
	<u>\$ 181,723,922</u>	<u>62,010,592</u>

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Scheduled maturities of long-term debt and capital lease obligations at December 31, 2010 were as follows:

	Long-term debt	Capital lease obligations
2011	\$ 1,346,461	1,964,299
2012	1,326,844	1,402,897
2013	1,325,000	1,208,797
2014	1,325,000	988,427
2015	8,325,000	486,895
Thereafter	<u>165,291,799</u>	<u>809,975</u>
	\$ <u>178,940,104</u>	6,861,290
Less interest portion at 5.719% – 8.561%		<u>(1,152,810)</u>
Total		\$ <u><u>5,708,480</u></u>

According to the senior secured loan agreement, the Company was required to enter into an interest rate hedging agreement, no later than 90 days following the closing date. The Company entered into a three year Hedge Agreement on September 1, 2010 which consists of an interest rate cap on the LIBOR floating rate of the senior secured loans at 1.75% until August 31, 2011. Additionally the Company entered into a swap from September 1, 2011 to September 1, 2013 effectively fixing the base rate at 2.32%. The notional amount of the swap is \$46.375 million, which is equivalent to 35% of the Term Loan amount borrowed. The fair values of the interest rate cap and swap are insignificant at December 31, 2010 and are not being accounted for as an effective hedge resulting in no adjustment to fair value being recorded to the statement of operations as interest expense.

(7) Income Taxes

Income tax expense (benefit) consisted of the following:

	2010	2009
Current:		
Federal	\$ 1,652,164	678,126
State	1,244,752	924,717
Deferred:		
Federal	3,086,086	(4,783,401)
State	<u>(156,872)</u>	<u>(10,632)</u>
	\$ <u><u>5,826,130</u></u>	<u><u>(3,191,190)</u></u>

The difference between the expected tax expense based on the federal statutory rate of 34% is primarily Texas gross margin tax, which is not based on pre-tax income and income tax attributable to noncontrolling interest.

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Deferred tax assets and liabilities arising from temporary differences were as follows:

	<u>2010</u>	<u>2009</u>
Deferred tax assets:		
Accrued expenses and other liabilities for financial accounting purposes not currently deductible	\$ 5,776,527	765,594
Net operating loss carryforwards and contribution limitation	858,471	1,345,244
Flow through entities	4,328,310	3,671,996
Property plant and equipment	197,679	236,104
Other	151,589	332,312
Total deferred tax assets	<u>11,312,576</u>	<u>6,351,250</u>
Deferred tax liabilities:		
Property and equipment and intangibles, principally due to differences in depreciation and amortization	(3,546,732)	(25,657)
Goodwill	(11,031,330)	(4,514,534)
Total deferred tax liabilities	<u>(14,578,062)</u>	<u>(4,540,191)</u>
Net deferred tax assets (liabilities)	<u>\$ (3,265,486)</u>	<u>1,811,059</u>

The valuation allowance consisted of the following:

	<u>2010</u>	<u>2009</u>
Balance at January 1	\$ —	6,149,048
Increase (decrease) during the year	—	(6,149,048)
Balance at December 31	<u>\$ —</u>	<u>—</u>

The Company had net operating loss carryforwards of approximately \$205,000 as of December 31, 2009, which were utilized in 2010. The Company has not recorded a valuation allowance for any of its deferred tax assets at December 31, 2010 as it expects to generate future taxable income sufficient to realize such deferred tax assets.

(8) Preferred Stock

Under the Company's Third Amended and Restated Certificate of Incorporation, 108,783,333 total shares are authorized to issue, comprising 53,525,000 shares of common stock and 55,258,333 shares of preferred stock. Preferred stock is issuable in series under terms and conditions determined by the Company's board of directors.

(a) Series A Preferred Stock

As of December 31, 2009 and 2010, there were 12,350,000 shares of Series A Preferred outstanding.

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(b) Series B Preferred Stock

The Series B redeemable convertible preferred stock (Series B Preferred) shares were sold, primarily to related-party physicians, at an original issue price of \$1 per share. During 2010 and 2009, the Company issued 16,000 shares to a related-party physician at a price of \$1.00 per share. As of December 31, 2010 and 2009, there were 545,000 and 529,000 shares, respectively, of Series B Preferred outstanding.

(c) Series B-1 Preferred Stock

As of December 31, 2010 and 2009, there were 886,666 shares of Series B-1 Preferred outstanding.

(d) Series C Preferred Stock

As of December 31, 2010 and 2009, there were 24,500,962 shares of Series C Preferred outstanding.

(e) Series D Preferred Stock

During 2010, 8,333,333 shares of Preferred D Stock were issued at a price of \$3 per share for total net proceeds of approximately \$25.0 million in connection with the acquisition of DCA. As of December 31, 2010, there were 8,333,333 shares of Series D Preferred outstanding.

(f) Dividends

Series A Preferred, Series C Preferred, and Series D Preferred stockholders are entitled to receive cash dividends at the rate of 8% per annum calculated on the original issue prices. Dividends are cumulative from the date of original issuance and accrue quarterly. Accumulations of dividends on shares of Series A, Series C and Series D Preferred stock do not bear interest and are payable generally at the time of a liquidating event as defined in the agreement. Series B Preferred, Series B-1 Preferred, and common stockholders are entitled to receive dividends, when and if declared by the board of directors out of the Company's assets legally available therefore, so long as all accrued dividends on then outstanding Series A, Series C, and Series D Preferred stock have been paid or declared and set apart.

(g) Redemption

Each share of Series A, Series C, and Series D Preferred stock is redeemable beginning on September 1, 2020, if approved by 60% of the then-outstanding shareholders of Series A, Series C, and Series D Preferred. Series B and Series B-1 Preferred stock is redeemable, beginning on September 1, 2012 only subject to and after redemption of the Series A, Series C, and Series D Preferred Stock and if approved by 60% of the then-outstanding shares of Series A, Series C, and Series D Preferred, voting as a single class, and if also approved by 60% of the then-outstanding shares of Series B and Series B-1 Preferred, voting as a single class.

Any such redemption would be payable in three equal annual installments calculated using the sum of the original issue prices (\$1 per share for Series A, Series C, and Series D Preferred, and \$1.50 for Series B and Series B-1 Preferred) plus all related accrued and unpaid dividends.

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(h) Conversion Rights

Each share of Series A, Series B, Series B-1, Series C and Series D Preferred stock is convertible at any time, at the option of the holder, into the same number of shares of common stock. Each share of Series A, Series B, Series B-1, Series C, and Series D converts automatically upon a qualified public offering. Upon such automatic conversion, any related declared and unpaid dividend becomes due.

(i) Liquidation Preference

Upon liquidation or dissolution, and after payment or provision for payment of all debts and liabilities, stockholders of the Company will receive proceeds, to the extent available, as follows: (a) first, to the holders of Series A, Series C and Series D Preferred Stock, amounts per share equal to their original share purchase prices, plus accrued and unpaid dividends (as adjusted for past dividends, combinations, splits, recapitalizations, and the like); (b) second, to the holders of Series B and Series B-1 Preferred Stock, amounts per share equal to their original share purchase prices, plus any accrued and unpaid dividends, (as adjusted for past dividends, combinations, splits, recapitalizations, and the like); (c) third, ratably to the holders of Common Stock, and Series A Preferred Stock, Series C Preferred Stock and Series D Preferred Stock on an as-if converted to Common Stock basis until the holders of Series A, Series C and Series D Preferred Stock shall have received, in total including the payment under (a) above, an amount equal to three (3) times the Series A and Series C and two (2) times the Series D original issue price, respectively; and (d) fourth, to the holders of Common Stock, any remaining available amounts.

(j) Voting Rights

Each share of Series A, Series C and Series D Preferred stock issued and outstanding is entitled to the number of votes equal to the number of shares of common stock into which it is convertible. For various defined events, Series A, Series C and Series D Preferred stockholders vote together as a separate class. In those circumstances, 60% or more of the outstanding Series A, Series C and Series D Preferred stockholders must approve the event.

Each share of common stock is entitled one vote. As long as Series A, Series C and Series D Preferred stock is outstanding, and except for various defined events, Series A, Series C and Series D Preferred stockholders vote together with common stockholders as a single class on an as-if-converted to common stock basis.

The Series B and Series B-1 Preferred stockholders have no voting rights and their consent is not required to take any corporate action.

A majority of the Company's stockholders, voting together on an as-if-converted to common stock basis, can change the number of authorized shares outstanding.

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(k) Other Terms

If Series A, Series C and Series D Preferred shares are outstanding, no dividend may be declared, and no shares shall be redeemed, on Series B or Series B-1 Preferred stock unless all accrued Series A, Series C and Series D Preferred dividends have been paid and a similar dividend is declared on Series A, Series C and Series D Preferred stock.

All stockholders are obligated to participate in a sale of the Company approved by 60% of the Series A, Series C and Series D Preferred stockholders, voting together as a single class, and the board of directors.

Series A, Series C and Series D Preferred stockholders have the right to purchase any new securities on a proportionate basis, and also have the right of over-allotment if any other Series A, Series C or Series D Preferred shareholder fails to purchase a full proportionate share of the any new securities. Series B Preferred, Series B-1 Preferred, and common stockholders do not have preemptive rights.

The Company and the Series A and Series B Preferred stockholders have the right to purchase shares from Series B Preferred, Series B-1 Preferred and common stockholders who wish to transfer their shares to a nonpermitted transferee.

(9) Stock Compensation Plans

The Company's 2005 Stock Incentive Plan (the 2005 SIP) provides stock options and restricted stock grants, and other share-based incentives, primarily to employees and directors. In March 2009, the Company authorized an additional 500,000 shares available for grant. In May 2010, the Company authorized an additional 600,000 shares available for grant. There were 6,000,000 and 5,400,000 shares available for grant as of December 31, 2010 and 2009, respectively, under the amended 2005 SIP.

(a) Stock Option Plan

Awards granted under the 2005 SIP are for incentive stock options with a five year term, an exercise price at least equal to the market value on the date of grant, and which vest 25% after one year of service and then monthly in equal amounts over the next three years of service. Income for the years ended December 31, 2010 and 2009 included \$70,744 and \$13,271 respectively, of pretax compensation costs related to stock options granted. As of December 31, 2010, there was \$22,072 of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a period of approximately four years. At December 31, 2010, the weighted average remaining contractual life of outstanding options was 2.37 years.

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The table below summarizes activity in the Company's stock option plan:

	Year ended December 31			
	2010		2009	
	Awards	Weighted average exercise price	Awards	Weighted average exercise price
Outstanding at beginning of year	1,016,066	\$ 0.14	1,061,692	\$ 0.14
Granted	352,000	0.26	195,000	0.15
Exercised	(291,472)	0.15	(208,751)	0.14
Canceled	—	—	(31,875)	0.11
Outstanding at end of year	<u>1,076,594</u>	<u>\$ 0.18</u>	<u>1,016,066</u>	<u>\$ 0.14</u>
Awards exercisable at year-end	<u>380,742</u>	<u>\$ 0.14</u>	<u>412,941</u>	<u>\$ 0.14</u>

(b) Restricted Stock

The Company issued restricted stock to certain employees in 2010 and in prior years. Restricted stock awards vest 25% after one year of service and then monthly in equal amounts over the next three years of service, subject to continued employment and other plan terms and conditions. Holders of restricted stock are not allowed to sell, transfer, pledge, or otherwise encumber their restricted shares, but such holders are allowed to vote and their shares accrue dividends when and if declared. The Company may, but is not obligated to, repurchase vested restricted stock from employees at fair market value upon termination of the recipient's employment.

Expense for restricted stock is recognized over the vesting period. The noncash compensation expense associated with restricted stock awards was \$31,908 in 2010 and \$41,825 in 2009. The following table summarizes restricted stock award activity:

	2010	2009
Outstanding balance at beginning of year	\$ 3,401,558	3,401,558
Granted	560,000	—
Exercised	—	—
Forfeited	—	—
Repurchased	—	—
Balance at December 31, 2010	<u>\$ 3,961,558</u>	<u>3,401,558</u>

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The following table summarizes the nonvested restricted stock activity:

	2010	2009
Outstanding balance at beginning of year	\$ 641,122	1,384,334
Granted	560,000	—
Vested	(488,369)	(743,212)
Forfeited	—	—
Repurchased	—	—
Balance at December 31, 2010	\$ 712,753	641,122

At December 31, 2010, 3,248,805 of the outstanding restricted shares were vested. As of December 31, 2010, there was approximately \$320,471 of total unrecognized compensation costs related to restricted stock awards. These costs are expected to be recognized over a remaining vesting period of approximately four years.

(10) Related-Party Transactions

Participation in the Medicare ESRD program requires that treatment at a dialysis center be under the general supervision of a director who is a physician. The Company has engaged physicians or groups of physicians to serve as medical directors for each of its centers. The Company has contracts with approximately 59 individual physicians and physician groups to provide medical director services. The compensation of medical directors is negotiated individually and depends in general on local factors such as competition, the professional qualifications of the physician, their experience and their tasks as well as the workload at the clinic.

An ESRD patient generally seeks treatment at a dialysis center near his or her home and at which his or her treating nephrologist has practice privileges. Additionally, many physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical directors to the centers. As a result, and as is typical in the dialysis industry, the primary referral source for most of the Company's centers is often the physician or physician group providing medical director services to the center.

The Company's medical director agreements generally include covenants not to compete. Also, when the Company acquires a center from one or more physicians, or where one or more physicians owns interests in centers as co-owners with the Company, these physicians have agreed to refrain from owning interests in competing centers within a defined geographic area for various time periods. These agreements not to compete restrict the physicians from owning or providing medical director services to other dialysis centers. Most of these agreements not to compete continue for a period of time beyond expiration of the corresponding medical director agreements.

The Company leases space for 44 of its centers in which physicians and/or employees hold ownership interests, and subleases space to referring physicians and/or employees at one center. Future minimum lease payments payable under these leases is approximately \$22 million at December 31, 2010, exclusive of maintenance and other costs, and is subject to escalation. For 2010 and 2009, total lease payments under these leases were approximately \$2.9 million and \$2.4 million, respectively. On June 21, 2010, the

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Company entered into a ten year corporate office lease agreement with an entity owned by two of its employees. The lease is expected to commence in 2011. The future lease payments payable under this lease are approximately \$1.5 million.

The Company's York, Pennsylvania dialysis center is leased from a limited liability partnership in which the Company has a 60% ownership interest with the remaining 40% owned by two doctors one of whom serves as the medical director for that facility. These doctors are also affiliated with the entity that owns a 40% minority ownership in the subsidiary that operates the facility.

Some medical directors and other referring physicians own Series B and Series B-I Preferred stock, which they purchased from the Company. Some of the Company's medical directors also own equity interests in entities that operate the Company's dialysis centers.

The Company believes that the leases and equity purchases are no less favorable to the Company and no more favorable to such physicians than would have been obtained in arm's-length bargaining between independent parties.

The Company has one promissory note obligation owed a noncontrolling interest holder in one of its subsidiaries. The note obligation was in an original amount of \$750,000, of which \$125,000 and \$250,000 was outstanding at December 31, 2010 and 2009, respectively. At December 31, 2010 and 2009, \$125,000 of the amount outstanding was classified in the accompanying consolidated balance sheet as a current liability. The note bears interest at 7% and principal is due in six annual installments from May 1, 2006 through May 1, 2011.

During the years ended December 31, 2010 and 2009, the Company paid a related party affiliated through common ownership \$461,011 and \$293,101, respectively, for the usage of an airplane.

A member of the Company's board of directors provides consulting services primarily related to regulatory and reimbursement matters. The total expenses incurred by the Company related to these services were approximately \$100,000 and \$108,333 in 2010 and 2009, respectively.

(11) Legislation, Regulations, and Market Conditions

The Company's dialysis operations are subject to extensive federal, state, and local government regulations. These regulations require the Company to meet various standards relating to, among other things, the operation of dialysis clinics, the provision of quality healthcare for patients, maintenance of proper ownership and records, quality assurance programs, and occupational, health, safety and environmental standards, and the provision of accurate reporting and billing to government and private payment programs. These laws are extremely complex, and in many instances, providers do not have the benefit of significant regulatory or judicial interpretation as to how to interpret and apply these laws and regulations in the normal course of conducting their business. Healthcare providers that do not comply with these laws and regulations may be subject to civil or criminal penalties, the loss of their licenses, or restriction in their ability to participate in various federal and state healthcare programs. The Company endeavors to conduct its business in compliance with applicable laws and regulations.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

The Company's dialysis centers are certified (or are pending certification) by the Centers for Medicare and Medicaid Services, as is required for the receipt of Medicare payments, and are licensed and permitted by state authorities.

The Medicare and Medicaid Fraud and Abuse Amendments of 1977, as amended, generally referred to as the "anti-kickback statute," imposes sanctions on those who, among other things, offer, solicit, make or receive payments in return for referral of a Medicare or Medicaid patient for treatment. The federal False Claims Act imposes penalties on those who, among other things, knowingly present a false or fraudulent claim for payment to the federal government. Another federal law, commonly referred to as the "Stark Law," prohibits physicians, with certain exceptions, from referring Medicare patients to entities with which the physician has a financial relationship, states have analogous statutes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), among other things, includes provisions relating to the privacy of medical information and prohibits inducements to patients to select a particular healthcare provider. Congress, states and regulatory agencies continue to consider modifications to federal and state healthcare laws. The Company's dialysis centers are also subject to various state hazardous waste and nonhazardous medical waste disposal laws.

Sanctions for violations of these statutes could result in the imposition of significant fines and penalties, repayments for patient services previously billed, expulsion from government healthcare programs, and other civil or criminal penalties. Management believes that the Company is in material compliance with applicable government laws and regulations.

(12) Profit-Sharing Plan

The Company has a savings plan for employees who meet certain criteria that have been established pursuant to the provisions of Section 401(k) of the Internal Revenue Code. The plan allows employees to contribute a defined portion of their compensation on a tax-deferred basis. Since January 1, 2005, the plan allows for defined matching Company contributions for eligible employees. The plan was amended effective January 1, 2006 to allow vesting credit for prior years of service for employees of certain acquired businesses. For the years ending December 31, 2010 and 2009, respectively, the Company made matching contributions to the plan of \$386,328 and \$391,053.

The Company may also make discretionary profit-sharing contributions to the plan if approved by the board of directors. No such contributions were made in 2010 or 2009.

(13) Commitments and Contingencies

The Company may be subject to claims and suits in the ordinary course of business, including contractual disputes and professional and general liability claims.

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

On February 15, 2007, the previous owners of the acquired San Antonio facilities brought suit against the Company. In the lawsuit, the plaintiffs alleged that the Company had failed to pay amounts due to the sellers of Rencare Ltd. (Rencare) concerning accounts receivable that arose prior to the close of the Rencare acquisition. The Company denied plaintiff's claims and, made counterclaims against plaintiffs and filed a third-party cross-claim against one of the other sellers of Rencare. In the Company's counterclaim and cross-complaint, the Company alleged, among other things, that Sellers breached the representations and warranties in the applicable Rencare acquisition documents by failing to disclose certain liabilities. A trial was held in November 2008 and judgment was entered in favor of plaintiff for \$750,000 plus \$300,000 in attorney fees. Both sides appealed and the Company fully prevailed in the appeal. The appellant court moved that the plaintiff should receive nothing. Plaintiff moved for reconsideration and the appellant court dismissed their motion. Plaintiffs are seeking further appellant review. At this time, the Company cannot determine what will be the ultimate resolution. The Company incurred legal and other professional fees related to this litigation. These expenses aggregated \$27,208 and \$286,647 in 2010 and 2009, respectively. In 2010, the Company reversed a \$1.1 million reserve related to this litigation that it recorded in 2008.

In February, 2010, and prior to the Company's acquisition, DCA received a subpoena from the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) with respect to an investigation relating to EPO utilization at certain DCA clinics. The Company has been fully cooperating with the inquiry and has produced the requested documents to date. While there is no indication of such at this time, any negative findings could result in: (a) substantial monetary penalties, (b) excluding certain facilities from participation in the Medicare and Medicaid programs, and (c) the Company incurring legal expenses and management time, any or all of which could have a material adverse effect on the Company's revenues, earnings and cash flows. The Company incurred legal fees related to this investigation of \$389,741 in 2010, subsequent to its acquisition of DCA.

In December 2010, the Company received a Civil Investigative Demand (CID) from the U.S. Attorney for the District of New Jersey requesting documents relating to laboratory tests performed on patients of the Company at two of its North Texas clinics. The Company is in the process of gathering the required documents and performing its own review of such documents. While the Company believes that it is not the subject of the government's investigation, the outcome of this matter is uncertain and the Company has risk of an adverse outcome that could result in substantial monetary penalties.

The Company has obligations to purchase the third-party interests in several of its joint ventures. These obligations are in the form of put provisions in joint venture agreements, and are exercisable at the third-party owners' discretion with some timing limitations. If these put provisions are exercised, the Company would be required to purchase the third-party owners' interests at fair market value (see note 4).

U.S. RENAL CARE, INC. AND SUBSIDIARIES

Notes to Consolidated Financial Statements

December 31, 2010 and 2009

The Company rents office space, medical facilities, and medical equipment under lease agreements that are classified as operating leases for financial reporting purposes. At December 31, 2010, the future minimum rental payments under noncancelable operating leases with terms of one year or more consist of the following:

2011	\$ 9,210,791
2012	8,665,034
2013	7,709,826
2014	6,288,782
2015	5,566,500
Thereafter	12,080,991

Rent expense was \$8,129,164 and \$6,290,202 for the years ended December 31, 2010 and 2009, respectively.



Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue, Suite 700
MAC #3206-070
Minneapolis, MN 55402

Master Lease

Master Lease Number 268280 dated as of November 2, 2010

Name and Address of Lessee:
US Renal Care Home Therapies LLC
1313 La Cooche Lane
Houston, TX 77054

Master Lease Provisions

1. **LEASE.** Lessor hereby agrees to lease to Lessee, and Lessee hereby agrees to lease from Lessor, the personal property described in a Supplement or Supplements to this Master Lease from time to time signed by Lessor and Lessee upon the terms and conditions set forth in this Master Lease and in the related Supplement (such property together with all replacements, substitutions, parts, improvements, repairs, and accessories, and all additions incorporated therein or attached thereto being referred to herein as the "Equipment"). Each Supplement shall constitute a separate lease incorporating the terms of this Master Lease. References in this Master Lease to "this Lease", "hereunder" and "herein" shall be construed to mean a Supplement which incorporates this Master Lease. Lessee's execution of a Supplement shall obligate Lessee to lease the Equipment described therein from Lessor. No Supplement shall be binding on Lessor unless and until executed by Lessor. Anything to the contrary notwithstanding, Lessor shall have no obligation to accept, execute or enter into any Supplement or to acquire or lease to Lessee any equipment. Title to all Equipment shall at all times remain in Lessor.
2. **TERM.** The term of this Lease shall begin on the rent commencement date shown in the applicable Supplement and shall continue for the number of consecutive months from the rent commencement date shown in such Supplement (the "Initial term") unless earlier terminated by Lessor as provided herein. The rent commencement date is the 15th day of the month in which all of the items of Equipment described in the related Supplement have been delivered and accepted by Lessee if such delivery and acceptance is completed on or before the 15th of such month, and the rent commencement date is the last day of such month if such delivery and acceptance is completed during the balance of such month. In the event Lessee executes the related Supplement prior to delivery and acceptance of all items of Equipment described therein, Lessee agrees that the rent commencement date may be left blank when Lessee executes the related Supplement and hereby authorizes Lessor to insert the rent commencement date based upon the date appearing on the delivery and acceptance certificate signed by Lessee. At the expiration of the Initial term, unless Lessee shall have renewed the Lease or purchased the Equipment from Lessor, as provided for in each Supplement, if Lessee does not return to Lessor all of the Equipment that is the subject of a Supplement in accordance with paragraph 14 below, Lessee shall pay to Lessor an amount equal to the monthly basic rental payment that was in effect during the last month of the Initial term for each month (or part of any month) as "Holdover Rent", and shall comply with all other provisions of this Lease, from the first day after the expiration of the Initial term until all such Equipment has been returned to Lessor in accordance with paragraph 14, provided however, that nothing contained herein and no payment of Holdover Rent shall relieve Lessee of its obligation to return the Equipment upon the expiration or earlier termination of the Lease. In addition, Lessee shall pay any applicable sales, use, and/or property taxes arising from this Lease.
3. **RENT.** Lessee shall pay as basic rent for the Initial term of this Lease the amount shown in the related Supplement as Total Basic Rent. The Total Basic Rent shall be payable in installments each in the amount of the basic rental payment set forth in the related Supplement plus sales and use tax thereon. Lessee shall pay advance installments and any security deposit, each as shown in the related Supplement, on the date it is executed by Lessee. Subsequent installments shall be payable on the first day of each rental payment period shown in the related Supplement beginning after the first rental payment period; provided, however, that Lessor and Lessee may agree to any other payment schedule, including irregular payments or balloon payments, in which event they shall be set forth in the Supplement. If the actual cost of the Equipment is more or less than the Total Cost as shown in the Supplement, the amount of each installment of rent will be adjusted up or down to provide the same yield to Lessor as would have been obtained if the actual cost had been the same as the Total Cost. Adjustments of 10% or less may be made by written notice from Lessor to Lessee. Adjustments of more than 10% shall be made by execution of an amendment to the Supplement reflecting the change in Total Cost and basic rental payment. In addition to basic rent, which is payable beginning on the rent commencement date, Lessee agrees to pay interim rent for the period beginning on the date the Equipment is delivered and accepted by Lessee to the rent commencement date at a daily rate equal to the percentage of Lessor's cost of the Equipment set forth in such Supplement. Interim rent shall be payable on the rent commencement date. Lessee agrees that if all of the items of Equipment covered by such Supplement have not been delivered and accepted thereunder before the date specified as the Cutoff Date in such Supplement, Lessor shall have no obligation to lease the Equipment to Lessee and Lessee shall purchase from Lessor the items of Equipment then subject to this Lease within five days after Lessor's request to do so for a price equal to Lessor's cost of such items plus all accrued but unpaid interim rent thereon. Lessee shall also pay any applicable sales and use tax on such sale.
4. **SECURITY DEPOSIT.** Lessor may apply any security deposit toward any obligation of Lessee under any Supplement and shall return any unapplied balance to Lessee without interest upon full satisfaction of all of Lessee's obligations.
5. **NO WARRANTIES.** Lessee agrees that it has selected each item of Equipment based upon its own judgment and disclaims any reliance upon any statements or representations made by Lessor. LESSEE ACKNOWLEDGES THAT: LESSOR IS NOT THE MANUFACTURER OF THE EQUIPMENT NOR THE MANUFACTURER'S AGENT NOR A DEALER THEREIN; THE EQUIPMENT IS OF A SIZE, DESIGN, CAPACITY, DESCRIPTION AND MANUFACTURE SELECTED BY THE LESSEE; LESSEE IS SATISFIED THAT THE EQUIPMENT IS SUITABLE AND FIT FOR ITS PURPOSES; AND LESSOR HAS NOT MADE AND DOES NOT MAKE ANY WARRANTY WITH RESPECT TO THE EQUIPMENT, EXPRESS OR IMPLIED, AND LESSOR SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR OF FITNESS FOR A PARTICULAR PURPOSE, OR AS TO THE QUALITY, CONDITION OR CAPACITY OF THE EQUIPMENT OR THE MATERIALS IN THE EQUIPMENT OR WORKMANSHIP OF THE EQUIPMENT. LESSOR'S TITLE TO THE EQUIPMENT, OR ANY OTHER REPRESENTATION OR WARRANTY WHATSOEVER. LESSOR SHALL NOT BE LIABLE TO LESSEE FOR ANY LOSS, DAMAGE, OR EXPENSE OF ANY KIND OR NATURE CAUSED, DIRECTLY OR INDIRECTLY, BY ANY EQUIPMENT OR THE USE OR MAINTENANCE THEREOF OR THE FAILURE OR OPERATION THEREOF, OR THE REPAIR, SERVICE OR ADJUSTMENT THEREOF, OR BY ANY DELAY OR FAILURE TO PROVIDE ANY SUCH MAINTENANCE, REPAIRS, SERVICE OR ADJUSTMENT, OR BY ANY INTERRUPTION OF SERVICE OR LOSS OF USE THEREOF OR FOR ANY LOSS OF BUSINESS HOWSOEVER CAUSED. LESSOR SHALL NOT BE LIABLE FOR DAMAGES OF ANY KIND, INCLUDING ANY LIABILITY FOR CONSEQUENTIAL DAMAGES, ARISING OUT OF THE USE OF OR THE INABILITY TO USE THE EQUIPMENT. No defect or condition of the Equipment and no failure on the part of the manufacturer or the shipper of the Equipment to deliver the Equipment or any part thereof to Lessee shall relieve Lessee of its obligation to pay rent or any other obligation hereunder. Lessor shall have no obligation in respect of the Equipment and shall have no

THIS AGREEMENT INCLUDES THE TERMS ON THE ATTACHED PAGE(S).

Lessor, Wells Fargo Equipment Finance, Inc.

U.S. Renal Care Home Therapies, LLC,
Lessee

By 
Title **Connie Longline**
Sr. Contract Administrator

By 
James D. Shelton, Manager

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obligation to install, erect, test, adjust or service the Equipment. Lessee shall look only to persons other than Lessor such as the manufacturer, vendor or carrier thereof should any item of Equipment for any reason and in any way be defective. To the extent permitted by the manufacturer and/or vendor and provided Lessee is not in default under the Lease, Lessor shall make available to Lessee all manufacturer and/or vendor warranties with respect to the Equipment.

6. **LESSEE COVENANTS, REPRESENTATIONS AND WARRANTIES.** (a) **Affirmative Covenants.** Lessee shall: (i) pay all shipping and delivery charges and other expenses incurred in connection with the Equipment and pay all legal claims, whether for labor, materials, supplies, rent or services, which might or could if unpaid become a lien on the Equipment; (ii) comply with all laws and regulations and rules, all manufacturer's instructions and warranty requirements, and with the conditions and requirements of all policies of insurance relating to the Equipment and its use; (iii) mark and identify the Equipment with all information and in such manner as Lessor or its assigns may request from time to time and replace promptly any such markings or identification which are removed, defaced or destroyed; (iv) at any and all times during business hours, grant Lessor free access to enter upon the premises wherein the Equipment shall be located or used and permit Lessor to inspect the Equipment and all applicable maintenance records; provided, however, that Lessor shall have no obligation to inspect any Equipment or records; (v) maintain a system of accounts established and administered in accordance with generally accepted accounting principles and practices consistently applied; and (vi) within thirty (30) days after the end of each fiscal quarter, deliver to Lessor a balance sheet as at the end of such quarter and statement of operations for such quarter, setting forth in comparative form the corresponding figures for the comparable period in the preceding fiscal year, within one hundred and twenty (120) days after the end of each fiscal year, deliver to Lessor a balance sheet as at the end of such year and statements of operations, income and retained earnings for such year, with accompanying footnotes, each setting forth in comparative form the corresponding figures for the preceding year, in each case prepared in accordance with generally accepted accounting principles and practices consistently applied and certified by Lessee's chief financial officer as fairly presenting the financial position and results of operations of Lessee, and, in the case of year end financial statements, certified by an independent accounting firm acceptable to Lessor, and with reasonable promptness, furnish Lessor with such other information, financial or otherwise, relating to Lessee or the Equipment as Lessor shall reasonably request.

(b) **Negative Covenants.** Lessee shall not: (i) voluntarily or involuntarily create, incur, assume or suffer to exist any mortgage, lien, security interest, pledge or other encumbrance or attachment of any kind whatsoever upon, affecting or with respect to the Equipment or this Lease or any of Lessee's interest thereunder; (ii) permit the name of any person, association or corporation other than the Lessor or Lessee to be placed on the Equipment; (iii) part with possession or control of or suffer or allow to pass out of its possession or control any item of the Equipment or change the location of the Equipment or any part thereof from the address shown in the applicable Supplement; (iv) ASSIGN OR IN ANY WAY TRANSFER OR DISPOSE OF ALL OR ANY PART OF THE EQUIPMENT; (v) change (a) its name or address from that set forth above, (b) the state under whose laws it is organized as of the date hereof, or (c) the type of organization under which it exists as of the date hereof unless it shall have given Lessor or its assigns no less than thirty (30) days' prior written notice of any such proposed change; (vi) permit the sale or transfer of any shares of its capital stock or of any ownership interest in the Lessee to any person, persons, entity or entities (whether in one transaction or in multiple transactions) which results in a transfer of a majority interest in the ownership and/or the control of the Lessee from the person, persons, entity or entities who hold ownership and/or control of the Lessee as of the date of this Master Lease; or (vii) consolidate with or merge into or with any other entity, or purchase or otherwise acquire all or substantially all of the assets or stock or other ownership interest of any person or entity or sell, transfer, lease or otherwise dispose of all or substantially all of Lessee's assets to any person or entity.

(c) **Representations and Warranties.** Lessee represents and warrants to Lessor, that effective on the date on which Lessee executes this Master Lease and each Supplement: (i) if Lessee is a partnership, corporation, limited liability company or other legal entity, the execution and delivery of this Master Lease and each Supplement and the performance of Lessee's obligations hereunder and thereunder have been duly authorized by all necessary action on the part of the Lessee and are not in contravention of, and will not result in a breach of, any of the terms of Lessee's charter, by-laws, articles of incorporation or other organic documents or any loan agreements or indentures of Lessee, or any other contract, agreement or instrument to which Lessee is a party or by which it is bound; (ii) the person signing the Master Lease and each Supplement on behalf of Lessee is duly authorized; (iii) Lessee's exact legal name as it appears on its charter or other organic documents, including as to punctuation and capitalization, and its principal place of business or chief executive office are as set forth in the heading of this Master Lease; (iv) Lessee is duly organized, validly existing and in good standing under the laws of the state of its incorporation or formation and is duly qualified and authorized to transact business in, and is in good standing under the laws of, each other state in which the Equipment is or will be located; (v) there has been no change in the name of the Lessee, or the name under which Lessee conducts business within the one year preceding the date hereof except as previously reported in writing to Lessor; (vi) Lessee has not moved its principal place of business or chief executive office, or has not changed the jurisdiction of its organization with the one year preceding the date hereof except as previously reported to Lessor in writing; (vii) this Master Lease and each Supplement constitute a legal, valid and binding obligation of Lessee, enforceable against Lessee in accordance with its terms; (viii) all information provided by Lessee to Lessor in connection with this Lease is true and correct; (ix) the Equipment will be used primarily for business purposes as opposed to personal, family or household purposes; and (x) there are no suits pending or threatened against Lessee or any guarantor which, if decided adversely, might materially adversely affect Lessee's or such guarantor's financial condition, the value, utility or remaining useful life of the Equipment, the rights intended to be afforded to Lessor hereunder or under any guarantor or the ability of Lessee or any guarantor to perform its obligations under the Lease or any document delivered in connection with the Lease.

7. **TAXES.** Lessee shall promptly pay when due, and indemnify and hold Lessor harmless, on an after-tax basis, from, all sales, use, property, excise and other taxes and all license and registration fees now or hereafter imposed by any governmental body or agency upon the Equipment or its use, purchase, ownership, delivery, leasing, possession, storage, operation, maintenance, repair, return or other disposition of the Equipment, or for titling or registering the Equipment, or upon the income or other proceeds received with respect to the Equipment or this Lease or the rentals hereunder; provided, however, that Lessee shall not be required to pay taxes on or measured by the net income of Lessor. Lessee shall prepare and file all tax returns relating to taxes for which Lessee is responsible hereunder which Lessee is permitted to file under the laws of the applicable taxing jurisdiction. Upon the expiration or earlier termination of the Lease, Lessee shall pay to Lessor any such taxes accrued or assessed but not yet due and payable.

8. **INDEMNITY.** Lessee hereby agrees to indemnify and hold Lessor harmless (on an after-tax basis) from and against any and all claims, losses, liabilities (including negligence, tort and strict liability), damages, judgments, obligations, actions, suits, and all legal proceedings, and any and all costs and expenses in connection therewith (including attorneys' fees) arising out of, or in any manner connected with, or resulting directly or indirectly from, the Equipment, including, without limitation, the manufacture, purchase, lease, financing, selection, ownership, delivery, rejection, non-delivery, transportation, possession, use, storage, operation, condition, maintenance, repair, return or other disposition of the Equipment or with this Lease, including without limitation, claims for injury to or death of persons and for damage to property, whether arising under the doctrine of strict liability, by operation of law or otherwise, and to give Lessor prompt notice of any such claim or liability.

9. **ASSIGNMENT.** Lessor may sell or assign any or all of its interest in this Lease or sell or grant a security interest in all or any part of the Equipment, without notice to or the consent of Lessee. Lessee agrees not to assert against any assignee of Lessor any title, recoupment, claim, counterclaim or defense Lessee may have against Lessor or any person other than such assignee. Lessee agrees that if it receives written notice of an assignment from Lessor, it will pay all Rent and other payments payable under each Supplement to such assignee or as instructed by Lessor or the assignee identified in the notice received from Lessor. An assignee of Lessor shall have all rights of Lessor under the applicable Lease, to the extent assigned, separately enforceable by such assignee independently of Lessor or any assignee with respect to other leases. Upon any such assignment and except as may otherwise be provided therein all references in this Master Lease to Lessor shall include such assignee.

10. **EQUIPMENT PERSONALTY.** The Equipment shall remain personal property regardless of its attachment to realty, and Lessee agrees to take such action at its expense as may be necessary to prevent any third party from acquiring any interest in the Equipment as a result of its attachment to realty. If requested by Lessor with respect to any item of the Equipment, Lessee will obtain and deliver to Lessor waivers of interest or liens in recordable form, satisfactory to Lessor, from all persons claiming any interest in the real property on or in which such item of the Equipment is installed or located.

11. **USE AND MAINTENANCE.** Lessee will use the Equipment with due care and only for the purpose for which it is intended. Lessee will, by qualified personnel, use, maintain, repair, modify (to the extent permitted or required herein) in accordance with prudent practices (but in no event less than the same extent to which Lessee maintains other similar equipment owned or leased by it) and for the purpose for which such Equipment was designed, in compliance with insurance policies, manufacturer's specified maintenance programs, warranties and applicable laws, and shall keep the Equipment in as good repair, condition

and working order as when originally received by Lessee, ordinary wear and tear excepted and will furnish and replace all parts of the Equipment as may from time to time become worn out, lost, stolen, destroyed or damaged or unfit for use, all at its expense. Lessee shall, at its expense, make all modifications and improvements to the Equipment required by law. Lessee may, at its sole cost and expense, make any modifications to the Equipment, provided that such modifications (a) are readily removable without causing damage to the Equipment, (b) do not reduce the value, utility, marketability or remaining useful life of the Equipment, and (c) are of a kind that customarily are made by lessees or purchasers of equipment similar to the Equipment. All parts, modifications and improvements to the Equipment shall, when installed or made, immediately become the property of Lessor and part of the Equipment for all purposes; provided, that any modification not required by law shall if requested by Lessor, be removed by Lessee and any damage to the Equipment resulting from such removal shall be repaired prior to the return of the Equipment to the Lessor. The Equipment shall not be used outside of the United States without Lessor's prior written consent.

12. LOSS OR DAMAGE. No loss or damage to the Equipment or any part thereof shall affect any obligation of Lessee under this Lease, which shall continue in full force and effect. Lessee shall advise Lessor in writing within five (5) days of any item of Equipment becoming lost, stolen or damaged and of the circumstances and extent of such damage. In the event any item of Equipment shall become lost, stolen, destroyed, damaged beyond repair or rendered permanently unfit for use for any reason, or in the event of condemnation or seizure of any item of Equipment, Lessee shall promptly pay Lessor, within ten (10) days after demand by Lessor, an amount equal to the greater of the fair market value of such item or the Lessor's Loss as defined in paragraph 18 below. Upon payment of such amount to Lessor, such item shall become the property of Lessee, Lessor will transfer to Lessee, without recourse or warranty, all of Lessor's right, title and interest therein, the rent with respect to such item shall terminate, and the basic rental payments on the remaining items shall be reduced accordingly. Lessee shall pay any sales and use taxes due on such transfer. Any insurance or condemnation proceeds received shall be paid to Lessor and credited to Lessee's obligation under this paragraph and Lessor shall be entitled to any surplus. Whenever the Equipment is damaged and such damage can be repaired, Lessee shall, at its expense, promptly effect such repairs as Lessor shall deem necessary for compliance with paragraph 11 above. Proceeds of insurance shall be paid to Lessor with respect to such repairable damage to the Equipment and shall, at the election of Lessor, be applied either to the repair of the Equipment by payment by Lessor directly to the party completing the repairs, or to the reimbursement of Lessee for the cost of such repairs; provided, however, that Lessor shall have no obligation to make such payment or any part thereof until receipt of such evidence as Lessor shall deem satisfactory that such repairs have been completed and further provided that Lessor may apply such proceeds to the payment of any rent or other sum due or to become due hereunder if at the time such proceeds are received by Lessor there shall have occurred any Event of Default or any event which with lapse of time or notice, or both, would become an Event of Default.

13. INSURANCE. Lessee shall obtain and maintain on or with respect to the Equipment at its own expense (a) comprehensive general liability insurance insuring against liability for bodily injury, and property damage with a minimum limit of \$1 million combined single limit per occurrence and (b) physical damage insurance insuring against loss or damage to the Equipment in an amount not less than the full replacement value of the Equipment. Lessee shall furnish Lessor with a certificate of insurance evidencing the issuance of a policy or policies to Lessee in at least the minimum amounts required herein naming Lessor as an additional insured thereunder for the liability coverage and as loss payee for the property damage coverage. Each such policy shall be in such form and with such insurances as may be satisfactory to Lessor, and shall contain a clause specifying that no action or misrepresentation by Lessee shall invalidate such policy and a clause requiring the insurer to give to Lessor at least thirty (30) days' prior written notice of (i) the cancellation or non-renewal of such policy or (ii) any amendment to the terms of such policy if such amendment would cause the policy no longer to conform to the policy requirements stated in this paragraph; and ten (10) days prior notice of cancellation for non-payment of premium. Lessee shall deliver, annually and at any time that there is a change in insurance carrier, to Lessor evidence satisfactory to Lessor of the required insurance coverage. Lessee hereby assigns to Lessor the proceeds of all such insurance and directs any insurer to make payments directly to Lessor. Lessor shall be under no duty to ascertain the existence of or to examine any such policy or to advise Lessee in the event any such policy shall not comply with the requirements hereof.

14. RETURN OF THE EQUIPMENT. Upon the expiration or earlier termination of this Lease by Lessor, Lessee will immediately deliver the Equipment to and in the manner designated by the Lessor in the same condition as when delivered to Lessee fully capable of performing all functions for which it was originally designed (or as upgraded during the Lease Term), ordinary wear and tear excepted, and in compliance with any additional return conditions set forth in the applicable Supplement, at such location within the continental United States as Lessor shall designate. Lessee shall pay all transportation and other expenses relating to such delivery. Lessee shall arrange for the disassembly and packing of the Equipment, together with all parts and pieces and then reassembly (including, if necessary, repair and overhaul) by an authorized representative of the manufacturer. Without limiting the generality of the foregoing, returned Equipment shall be in such condition to immediately qualify for (i) the manufacturer's (or other authorized service representative's) then available service contract or warranty, and (ii) all applicable licenses or permits necessary for its operation for its intended purposes and to comply with all specifications and requirements of applicable federal, state and local laws. The Equipment shall be returned with all related maintenance logs, operating manuals and other related materials and all such materials will be undamaged and contain all pages. Upon Lessor's request, Lessee shall, at Lessee's sole expense, provide storage acceptable to Lessor for a period of up to 90 days from the date of return and will assist Lessor in attempting to remarket the Equipment, including display and demonstration of the Equipment to prospective purchasers or lessees, and allowing Lessor to conduct any public or private sale or auction on Lessee's premises.

15. ADDITIONAL ACTION; EXPENSES. Lessee will promptly execute and deliver to Lessor such further documents and take such further action as Lessor may request in order to carry out more effectively the intent and purpose of this Lease, including the execution and delivery of appropriate financing statements to protect fully Lessor's interest hereunder in accordance with the Uniform Commercial Code or other applicable law. Lessor and any assignee of Lessor is authorized to file one or more Uniform Commercial Code financing statements without the signature of Lessee or signed by Lessor or any assignee of Lessor as attorney-in-fact for Lessee. Lessee hereby grants to Lessor a power of attorney in Lessee's name, to apply for a certificate of title for any item of Equipment that is required to be titled under the laws of any jurisdiction where the Equipment is or may be used and/or to transfer title thereto upon the exercise by Lessor of its remedies upon an Event of Default by Lessee under this Lease. Lessee acknowledges that Lessor may incur out-of-pocket costs and expenses in connection with the transactions contemplated by this Lease, and accordingly agrees to pay (or reimburse Lessor for) the reasonable costs and expenses related to (a) filing any financing, continuation or termination statements, (b) any title and lien searches with respect to this Lease and the Equipment, (c) documentary stamp taxes relating to the Lease, and (d) procuring certified charter documents and good standing certificates of Lessee and any guarantor of Lessee's obligations hereunder. Lessee will do whatever may be necessary to have a statement of the interest of Lessor and any assignee of Lessor in the Equipment noted on any certificate of title relating to the Equipment and will deliver said certificate to Lessor. If Lessee fails to perform or comply with any of its agreements, Lessor may perform or comply with such agreements in its own name or in Lessee's name as attorney-in-fact and the amount of any payments and expenses of Lessor incurred in connection with such performance or compliance, together with interest thereon at the rate provided below, shall be deemed rent payable by Lessee upon demand.

16. LATE CHARGES. If any payment, whether for rent or otherwise, is not paid when due, Lessor may impose a late charge of 5% of the amount past due (or the maximum amount permitted by applicable law if less). Payments thereafter received shall be applied first to delinquent installments and then to current installments.

17. DEFAULT. Each of the following events shall constitute an "Event of Default" hereunder: (a) Lessee shall fail to pay when due any installment of interim rent, basic rent or any other amount due hereunder; (b) any certificate, statement, representation, warranty or financial or credit information heretofore or hereafter made or furnished by or on behalf of Lessee or any guarantor of any of Lessee's obligations hereunder proves to have been false or misleading in any material respect or omitted any material fact, contingent or unliquidated liability or claim against Lessee or any such guarantor; (c) Lessee shall fail to observe or perform any other agreement to be observed or performed by Lessee hereunder and the continuance thereof for 10 calendar days following written notice thereof by Lessor to Lessee; (d) Lessee or any guarantor of this Lease or any partner of Lessee if Lessee is a partnership shall cause doing business as a going concern, make an assignment for the benefit of creditors, become insolvent, or engage in any dissolution or liquidation proceedings; (e) Lessee or any guarantor of this Lease or any partner of Lessee if Lessee is a partnership shall voluntarily file, or have filed against it involuntarily, a petition for liquidation, reorganization, adjustment of debt, or similar relief under the Federal Bankruptcy Code or any other present or future federal or state bankruptcy or insolvency law, or a trustee, receiver, or liquidator shall be appointed of it or of all or a substantial part of its assets; (f) Lessee or any guarantor of any of Lessee's obligations hereunder shall be in breach of or in default in the payment or performance of any material obligation, under any credit agreement, conditional sales contract, lease or other contract, however arising; (g) any individual Lessee, guarantor of this Lease, or partner of Lessee if Lessee is a partnership shall die; (h) an event of default

shall occur under any other obligation Lessee or any guarantor of Lessee's obligations hereunder owes to Lessor, (i) an event of default shall occur under any indebtedness Lessee may now or hereafter owe to any affiliate of Lessor, or (j) Lessee, or any guarantor of this Lease shall suffer an adverse material change in its financial condition from the date hereof, and as a result thereof Lessor deems itself or any of the Equipment to be insecure.

18. **REMEDIES.** Lessor and Lessee agree that Lessor's damages suffered by reason of an Event of Default are uncertain and not capable of exact measurement at the time this Lease is executed because the value of the Equipment at the expiration of this Lease is uncertain, and therefore they agree that for purposes of this paragraph 18 "Lessor's Loss" as of any date shall be the sum of the following: (1) the amount of all rent and other amounts payable by Lessee hereunder due but unpaid as of such date plus (2) the amount of all unpaid rent for the balance of the term of this Lease not yet due as of such date (including any renewal or purchase options which Lessee has contracted to pay) discounted from the respective dates installment payments would be due at the Discount Rate as defined below plus (3) 10% of the cost of the Equipment that is subject to this Lease as of such date (provided however, that with regard to any Supplement that expressly sets forth a "Final Purchase Payment" other than 10% of the cost of the Equipment, then the amount of such Final Purchase Payment shall be substituted in place of the 10% in this clause "(3)" for the purpose of calculating Lessor's Loss with regard to such Supplement.) "Discount Rate" means (i) the rate set forth for the Treasury Constant Maturities having the closest term to (but not longer than) the original term of the applicable Supplement, as set forth in the Federal Reserve Board H.15 Release (Selected Interest Rates) as of the Rent Commencement Date applicable to such Supplement, (ii) the rate set forth for the Treasury Constant Maturities having the closest term to (but not longer than) the remaining term of the applicable Supplement, as set forth in the Federal Reserve Board H.15 Release (Selected Interest Rates) as of the date of calculation of Lessor's Loss applicable to such Supplement, or (iii) 3%, whichever is lowest. If a rate referred to in the preceding clauses "(i)" or "(ii)" is not published in such publication referenced hereinabove, such rate shall be taken from a reputable source selected by Lessor.

Upon the occurrence of an Event of Default and at any time thereafter, Lessor may exercise any one or more of the remedies listed below as Lessor in its sole discretion may lawfully elect; provided, however, that upon the occurrence of an Event of Default specified in paragraph 17(e), an amount equal to Lessor's Loss as of the date of such occurrence shall automatically become due and payable without notice or demand of any kind. The exercise of any one remedy shall not be deemed an election of such remedy or preclude the exercise of any other remedy, and such remedies may be exercised concurrently or separately but only to the extent necessary to permit Lessor to recover amounts for which Lessee is liable hereunder.

a) Lessor may, by written notice to Lessee, terminate this Lease as to any or all of the Equipment subject hereto and declare an amount equal to Lessor's Loss as of the date of such notice to be immediately due and payable, as liquidated damages and not as a penalty, and the same shall thereupon be due and become immediately due and payable without further notice or demand, and all rights of Lessee to use the Equipment shall terminate but Lessee shall be and remain liable as provided in this paragraph 18. Lessee shall at its expense promptly deliver the Equipment to Lessor at a location or locations within the continental United States designated by Lessor. Lessor may also enter upon the premises where the Equipment is located and take immediate possession of and remove the same with or without instituting legal proceedings.

b) Lessor may proceed by appropriate court action to enforce performance by Lessee of the applicable covenants of this Lease or to recover, for breach of this Lease, Lessor's Loss as of the date Lessor's Loss is declared due and payable hereunder; provided, however, that upon recovery of Lessor's Loss from Lessee in any such action without having to repossess and dispose of the Equipment, Lessor shall tender the Equipment to Lessee at its then location upon payment of any additional amount due under clauses (e), (f) and (g) below.

c) In the event Lessor repossesses the Equipment, Lessor shall either retain the Equipment in full satisfaction of Lessee's obligation hereunder or sell or lease each item of Equipment in such manner and upon such terms as Lessor may in its sole discretion determine. The proceeds of any such sale or lease shall be applied to reimburse Lessor for Lessor's Loss and any additional amount due under clauses (f) and (g) below. Lessor shall be entitled to any surplus and Lessee shall remain liable for any deficiency. For purposes of this subparagraph, the proceeds of any lease of all or any part of the Equipment by Lessor shall be the amount reasonably assigned by Lessor as the cost of such Equipment in determining the rent under such lease.

d) Lessor may set off and apply against any Rent or other sums due hereunder any sums of money held by Lessor or any affiliate of Lessor for Lessee;

e) Lessor may recover interest on the unpaid balance of Lessor's Loss plus any amounts recoverable under clauses (f) and (g) of this paragraph 18 from the date it becomes payable until fully paid at the rate of the lesser of 12% per annum or the highest rate permitted by law.

f) In addition to any other recovery permitted hereunder or under applicable law, Lessor may recover from Lessee an amount that will fully compensate Lessor for any loss of or damage to Lessor's residual interest in the Equipment.

g) Lessor may exercise any other right or remedy available to it by law or by agreement, and may in any event recover legal fees and other costs and expenses incurred by reason of an Event of Default or the exercise of any remedy hereunder, including expenses of repossession, repair, storage, transportation, and disposition of the Equipment. Any payment received by Lessor may be applied to unpaid obligations as Lessor in its sole discretion determines.

If any Supplement is deemed at any time to be a lease intended as security, Lessee grants Lessor a security interest in the Equipment to secure its obligations under such Supplement, all other Supplements and all other indebtedness at any time owing by Lessee to Lessor. Lessee agrees that upon the occurrence of an Event of Default, in addition to all of the other rights and remedies available to Lessor hereunder, Lessor shall have all of the rights and remedies of a secured party under the Uniform Commercial Code.

No express or implied waiver by Lessor of any breach of Lessee's obligations hereunder shall constitute a waiver of any other breach of Lessee's obligations hereunder.

19. **NOTICES.** Any notice hereunder to Lessee or Lessor shall be in writing and shall be deemed to have been given when delivered personally or deposited with a nationally-recognized overnight courier service or in the United States mails, postage prepaid, addressed to recipient at its address set forth above or at such other address as may be last known to the sender.

20. **NET LEASE AND UNCONDITIONAL OBLIGATION.** This Lease is a completely net lease and Lessee's obligation to pay rent and all other amounts payable by Lessee hereunder is absolute, unconditional and irrevocable, and shall be paid without any abatement, reduction, setoff or defense of any kind.

21. **NON-CANCELABLE LEASE.** This Lease cannot be canceled or terminated except as expressly provided herein.

22. **SURVIVAL OF INDEMNITIES.** Lessee's obligations under paragraphs 7, 8, and 18 shall survive termination or expiration of this Lease.

23. **TAX INDEMNITY.** Lessor's loss of, or loss of the right to claim, or recapture of, all or any part of the federal or state income tax benefits Lessor anticipated as a result of entering into this Lease and owning the Equipment is referred to herein as a "Loss". If for any reason this Lease is not a true lease for federal or state income tax purposes, or if for any reason (even though this Lease may be a true lease) Lessor is not entitled to depreciate the Equipment for federal or state income tax purposes in the manner that Lessor anticipated when entering into this Lease, and as a result Lessor suffers a Loss, then Lessee agrees to pay Lessor, as additional basic rent, a lump-sum amount which, after the payment of all federal, state and local income taxes on the receipt of such amount, and using the same assumptions as to tax benefits and other matters Lessor used in originally evaluating and pricing this Lease, will in the reasonable opinion of Lessor maintain Lessor's net after-tax rate of return with respect to this Lease at the same level it would have been if such Loss had not occurred. The Lessor makes no representation with respect to the income tax consequences of this Lease or the Equipment. Lessor will notify Lessee of any claim that may give rise to indemnity hereunder. Lessor shall make a reasonable effort to contest any such claim but shall have no obligation to contest such claim beyond the administrative level of the Internal Revenue Service or other taxing authority. In any event, Lessor shall control all aspects of any settlement and contest.

Lessee agrees to pay the legal fees and other out-of-pocket expenses incurred by Lessor in defending any such claim even if Lessor's defense is successful. Notwithstanding the foregoing, Lessee shall have no obligations to indemnify Lessor for any Loss caused solely by (a) a casualty to the Equipment if Lessee pays the amount Lessee is required to pay as a result of such casualty, (b) Lessor's sale of the Equipment other than on account of an Event of Default hereunder, (c) failure of Lessor to have sufficient income to utilize its anticipated tax benefits or to timely claim such tax benefits, and (d) a change in tax law (including tax rates) effective after the Lease begins. For purposes of this paragraph 23, the term "Lessor" shall include any member of an affiliated group of which Lessor is (or may become) a member if consolidated tax returns are filed for such affiliated group for federal income tax purposes. Lessee's indemnity obligations under this paragraph 23 shall survive termination of this Lease.

24. **COUNTERPARTS.** There shall be one original of the Master Lease and of each Supplement and it shall be marked "Original." To the extent that any Supplement constitutes chattel paper (as that term is defined by the Uniform Commercial Code), a security interest may only be created in the Supplement marked "Original."

Ver. 0809

25. NON-WARRANTY. No course of dealing between Lessor and Lessee or any duty or omission on the part of Lessor in exercising any rights hereunder shall operate as a waiver or consent of Lessor. A waiver or consent shall be binding upon Lessor unless it is in writing and signed by Lessor. To the extent permitted by applicable law, Lessor hereby waives the benefit and advantage of, and covenants not to assert against Lessee, any violation, request, stay, appropriation, retention or redemption laws now existing or which may hereafter exist with, but for this provision, might be applicable to any sale or re-possessing made under the judgment, order or decree of any court or under the power of sale and red-emption conferred by this lease or otherwise. To the extent permitted by applicable law, Lessee hereby waives any and all rights and remedies conferred upon a Lessee by Article 2A-509 through 2A-522 of the Uniform Commercial Code, including but not limited to Lessee's right to: (i) cancel this Lease; (ii) repudiate this Lease; (iii) reject the Equipment; (iv) revoke acceptance of the Equipment; (v) recover damages from Lessor for any breach of warranty or for any other reason; (vi) claim a security interest in the Equipment in Lessee's possession or control for any reason; (vii) deduct all or any part of any claimed damages resulting from Lessor's default, if any, under this Lease; (viii) accept partial delivery of the Equipment; (ix) recover any general, special, incidental, or consequential damages, for any reason whatsoever, in substitution of Equipment identified to this Lease; (x) recover any general, special, incidental, or consequential damages, for any reason whatsoever, in application of law, Lessee also hereby waives any rights now or hereafter conferred by state or federal law or otherwise which may require Lessor to sell, lease or otherwise use any Equipment in mitigation of Lessor's damages as set forth in paragraph 18 or which may otherwise limit or modify any of Lessor's rights or remedies under paragraph 18.

26. MISCELLANEOUS. This Master Lease and related Supplement(s) constitute the entire agreement between Lessor and Lessee and may be modified only by a written instrument signed by Lessor and Lessee. Any provision of this Lease which is unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such unenforceability without rendering the remaining provisions of this Lease, and any such unenforceability in any jurisdiction shall not render unenforceable such provision in any other jurisdiction. Paragraph headings are for convenience only, and are not part of this Lease and shall not be deemed to effect the meaning or construction of any of the provisions hereof. In the event there is more than one Lessee named in this Master Lease and/or in any Supplement, the obligations or construction of any of the provisions hereof, in the event there is more than one Lessee named in this Master Lease and/or in any Supplement, shall be the joint and several obligation of each of the Lessees and Lessor may in its sole discretion, accept a photocopy, electronically transmitted facsimile or other reproduction of this Master Lease and/or a Supplement (a "Counterpart") as the binding and effective record of this Master Lease and/or a Supplement whether or not an ink signed copy hereof or thereof is also received by Lessor from Lessee, provided, however, that if Lessor accepts a Counterpart as the binding and effective record of this Master Lease or a Supplement, the Counterpart document received in writing by Lessor shall constitute the record hereof or thereof. Lessee agrees that a Counterpart of this Master Lease or a Supplement received by Lessor, shall, when acknowledged in writing by Lessor, constitute an original document for the purposes of establishing the provisions hereof and thereof and shall be legally admissible under the best evidence rule and binding on and enforceable against Lessee. If Lessor accepts a Counterpart of a Supplement as the binding and effective record thereof only such Counterpart acknowledged in writing by Lessor shall be marked "Original" and to the extent that a Supplement constitutes a chattel paper, a security interest may only be created in the Supplement that bears Lessor's ink signed acknowledgment and is marked "Original". This Lease shall in all respects be governed by, and construed in accordance with, the substantive laws of the state of Minnesota. LESSEE HEREBY WAIVES ANY RIGHT TO A JURY TRIAL WITH RESPECT TO ANY MATTER ARISING UNDER OR IN CONNECTION WITH THIS LEASE. TIME IS OF THE ESSENCE WITH RESPECT TO THE OBLIGATIONS OF LESSEE UNDER THIS LEASE.



Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue, Suite 700
MAC N9306-070
Minneapolis, MN 55402

Amendment to Master Lease

Wells Fargo Equipment Finance, Inc. ("Lessor") and U.S. Renal Care Home Therapies LLC ("Lessee") hereby amend the Master Lease Number 288280 dated as of November 2, 2010 (the "Lease") as follows:

1. Section 6(a)(vi) is amended by deleting it and replacing it in its entirety with the following: "keep accurate and complete records pertaining to Borrower's business and financial condition and submit to Lender such quarterly and annual reports concerning Borrower's business and financial condition Lender may from time to time reasonably request;"
2. Section 15 is amended by replacing words "Lessee will promptly execute and deliver to Lessor" with "Lessee will execute and deliver to Lessor within ten (10) days of Lessor's request"
3. Section 17(e) is amended by inserting "within (5) five business days of" before the words "when due".
4. Section 17(c) is amended by deleting "ten (10) calendar days" and replacing it with "20 calendar days".
5. Section 17(e) is amended by inserting "and, if such petition is involuntary, the same shall not be dismissed within 30 calendar days of its filing"
6. New clauses (k), (l) and (m) are hereby added as additional Events of Default in Section 17 of the Agreement to read as follows:

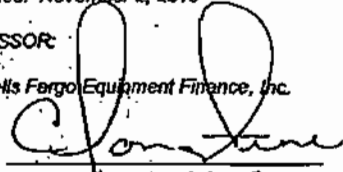
"(k) an event of default shall occur after giving effect to any provided cure period, of Lessee under that certain Credit Agreement dated as of May 24, 2010 among Lessee as Borrower, the Guarantors and Lenders identified therein Bank of America, N.A., as Syndication Agent, and Royal Bank of Canada, as Administrative Agent and as Collateral Agent, as such Credit Agreement may be amended from time to time (the "Credit Agreement"); (l) failure of Lessee to maintain at all times a minimum Fixed Charge Coverage Ratio as defined and set forth in the Credit Agreement; (m) failure to certify in writing to Lessor within sixty (60) days of the end of each fiscal quarter as to those matters pertaining to financial statements and Events of Default stated in the form for such certification attached hereto as Exhibit A."

Except as modified herein, the terms and conditions of the Lease remain the same and continue in full force and effect. In the event of a conflict between the terms of the Lease and this Amendment, the terms of this Amendment shall prevail.

Dated: November 2, 2010

LESSOR:

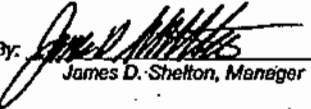
Wells Fargo Equipment Finance, Inc.

By: 

Title: Connie Longtine
Sr. Contract Administrator

LESSEE:

U.S. Renal Care Home Therapies, LLC

By: 

James D. Shelton, Manager

Revised U.S. Renal Care Inc amendment to ML (v2) (2).doc

Exhibit A
To Amendment to Master Lease dated as of November 2, 2010

To: Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue
Suite 700
Minneapolis, MN 55402
Attn: Senior Lending Manager, Healthcare

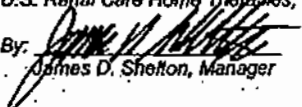
Re: Quarterly Compliance Certification of U.S. Renal Care Home Therapies, LLC ("Lessee")

The undersigned Lessee hereby certifies to Wells Fargo Equipment Finance, Inc. ("Lessor") that (a) the financial statement of Lessee dated as of June 30, 2010, heretofore or concurrently herewith delivered by Lessee to Lessor, is true and correct, and has been prepared in accordance with generally accepted accounting principals, and (b) as of the date hereof, there exists no default or defined Event of Default under any loan agreement, promissory note or other document in effect with respect to any credit accommodation granted by Lessor to Lessee.

Dated: November 2, 2010

LESSEE:

U.S. Renal Care Home Therapies, LLC

By: 
James D. Shelton, Manager



Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue, Suite 700
MAC N9306-070
Minneapolis, MN 55402

Amendment to Master Lease

Wells Fargo Equipment Finance, Inc. ("Lessor") and U.S. Renal Care Home Therapies, LLC ("Lessee") hereby amend the Master Lease Number 288280 dated as of November 2, 2010 (the "Lease") as follows:

1. Section 6(a)(vi) is amended by deleting it and replacing it in its entirety with the following: "keep accurate and complete records pertaining to Borrower's business and financial condition and submit to Lender such quarterly and annual reports concerning Borrower's business and financial condition Lender may from time to time reasonably request."
2. Section 15 is amended by replacing words "Lessee will promptly execute and deliver to Lessor" with "Lessee will execute and deliver to Lessor within ten (10) days of Lessor's request"
3. Section 17(b) is amended by inserting "within (5) five business days of" before the words "when due".
4. Section 17(c) is amended by deleting "ten (10) calendar days" and replacing it with "20 calendar days".
5. Section 17(v) is amended by inserting "and, if such petition is involuntary, the same shall not be dismissed within 30 calendar days of its filing"
6. New clauses (k), (l) and (m) are hereby added as additional Events of Default in Section 17 of the Agreement to read as follows:

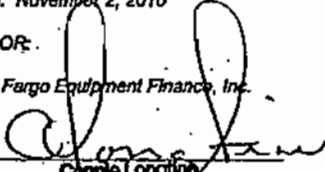
"(k) an event of default shall occur after giving effect to any provided cure period, of Lessee under that certain Credit Agreement dated as of July 5, 2006 among Lessee as Borrower, the Guarantors and Lenders identified therein, CapitalSource Finance LLC, as Syndication Agent; and CIT Healthcare LLC, as Administrative Agent and as Issuing Bank, as such Credit Agreement may be amended from time to time; (l) failure of Lessee to maintain at all times a minimum Fixed Charge Coverage Ratio (as defined below) of 1.20; (m) failure to certify in writing to Lessor within sixty (60) days of the end of each fiscal quarter as to those matters pertaining to financial statements and Events of Default stated in the form for such certification attached hereto as Exhibit A. "Fixed Charge Coverage Ratio" is defined as set forth in the attached Exhibit B, without regard to whether either of the two agreements from which the text of Exhibit B was taken is subsequently modified or terminated."

Except as modified herein, the terms and conditions of the Lease remain the same and continue in full force and effect. In the event of a conflict between the terms of the Lease and this Amendment, the terms of this Amendment shall prevail.

Dated: November 2, 2010

LESSOR:

Wells Fargo Equipment Finance, Inc.

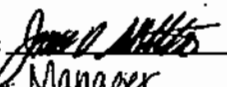
By: 

Title:

Carmie Longino
Sr. Contract Administrator

LESSEE:

U.S. Renal Care Home Therapies, LLC

By: 

Title:

Manager



Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue, Suite 700
MAC 18308-070
Minneapolis, MN 55402

Supplement to Master Lease Agreement of Sale

Supplement Number 0288280-400 dated as of November 2, 2010
to
Master Lease Number 288280 dated as of November 2, 2010

Name and Address of Lessee:
US Renal Care Home Therapies LLC
1313 La Concha Lane
Houston, TX 77054

Notice: Lessor reserves the right to withdraw the terms of this Supplement and issue a modified Supplement without notice to Lessee if Lessor is not in receipt of a fully executed original or facsimile of this document within five (5) business days of the date of this Supplement. However, in that event, no such modifications will be binding on Lessee unless and until Lessee executes the modified document containing all such modifications.

This is a Supplement to the Master Lease identified above between Lessor and Lessee (the "Master Lease"). Upon the execution and delivery by Lessor and Lessee of this Supplement, Lessor hereby agrees to lease to Lessee, and Lessee hereby agrees to lease from Lessor, the equipment described below upon the terms and conditions of this Supplement and the Master Lease. All terms and conditions of the Master Lease shall remain in full force and effect except to the extent modified by this Supplement. This Supplement and the Master Lease as it relates to this Supplement are hereinafter referred to as the "Lease".

Equipment Description:

The Equipment described on Schedule A attached hereto and made a part hereof

After Lessee signs this Lease, Lessee authorizes Lessor to insert any missing information or change any inaccurate information (such as the model year of the Equipment or its serial number or VIN) into this Equipment Description.

Equipment Location: 1313 La Concha Lane, Houston, TX 77054

SUMMARY OF PAYMENT TERMS	
Initial Term (Months): 60	Total Cost: \$108,892.77
Payment Frequency: Monthly	Total Basic Rent: \$123,592.80
Basic Rental Payment: \$2,059.88 plus applicable sales and use tax	Interim Rent Daily Rate: .014%
Number of Installments: 60	Cutoff Date: December 15, 2010
Advance Payments: First due on signing this Lease	Security Deposit: N/A

Additional Provisions: Total Finance Charges: \$14,700.03

End of Term Agreement:

1. In addition to paying the Total Basic Rent when and as due under the Lease, Lessee agrees to pay Lessor \$1.00 on the expiration date of the initial term of the Lease (the "Final Purchase Payment").
2. Upon receipt of the Total Basic Rent and the Final Purchase Payment by Lessor, the Equipment shall be deemed transferred to Lessee at its then location. Upon request by Lessee, Lessor will deliver a bill of sale transferring the Equipment to Lessee. Lessor hereby warrants that at the time of transfer the Equipment will be free of all security interests and other liens created by Lessor or in favor of persons claiming through Lessor. LESSOR MAKES NO OTHER WARRANTY WITH RESPECT TO THE EQUIPMENT, EXPRESS OR IMPLIED, AND SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY AND OF FITNESS FOR A PARTICULAR PURPOSE AND ANY LIABILITY FOR CONSEQUENTIAL DAMAGES ARISING OUT OF THE USE OF OR THE INABILITY TO USE THE EQUIPMENT.

THIS AGREEMENT INCLUDES THE TERMS ON THE ATTACHED PAGE(S).

Lessor: Wells Fargo Equipment Finance, Inc.

By: Kathleen Heide
VP

Title: December 31, 2010

Rent Commencement Date

Page 1 of 2

U.S. Renal Care Home Therapies, LLC,

By: James D. Shelton
James D. Shelton, Manager

SUP/SALE CAPP/CP1 00022010 1313 288280-400 281213 108213

3. Failure to pay the Final Purchase Payment when due shall constitute an "Event of Default" under the Lease.

4. Lessee agrees to pay all sales and use taxes arising on account of the sale of the Equipment to Lessee.

Lessor makes no representation with respect to the income tax consequences of the transaction evidenced by this Lease. Lessor will treat the lease as a sale regardless of how the Lease is treated by Lessee.

Modification to Master Lease: To be consistent with this Supplement the Master Lease is amended as follows:

1. The second paragraph of paragraph 2 (relating to automatic extension) is hereby deleted.

2. The third sentence of paragraph 12 covering casualty to the Equipment is amended to read as follows:

In the event any item of Equipment shall become lost, stolen, destroyed, damaged beyond repair, or rendered permanently unfit for use for any reason, or in the event of condemnation or seizure of any item of Equipment, Lessee shall promptly pay Lessor an amount equal to Lessor's Loss as defined in paragraph 18 with respect to such item at the time of payment based on the proportion that the original cost of such item bears to the Total Cost of all items of Equipment.

3. The sixth sentence of paragraph 12 is amended to read "Any insurance or condemnation proceeds received shall be credited to Lessee's obligation under this paragraph and Lessee shall be entitled to any surplus."

4. Paragraph 14 and 23 are deleted in their entirety.

5. The third sentence of paragraph 18(c) is amended to read "Lessee shall be entitled to any surplus and shall remain liable for any deficiency."

6. Clause (a) of the first sentence of paragraph 13 is amended to read as follows: "(a) comprehensive general liability insurance insuring against liability for bodily injury and property damage with a minimum limit of \$2,000,000.00 combined single limit per occurrence, and".

Ver. 1109



Wells Fargo Equipment Finance, Inc.
733 Marquette Avenue
Suite 700
Minneapolis, MN 55402

Schedule A

Contract No. 288280-400 dated as of November 2, 2010

Lessee: US Renal Care Home Therapies, LLC

Equipment Description: Dialysis, Computer and Computer Software systems equipment
together with all options, attachments and accessories as more fully described on the following Vendor Invoices

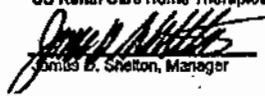
Asset ID	Description	Date	Asset Class ID	Vendor ID	Check #	Invoice #
10260	Red Pull Tight Lock	12/15/09	EQUIPMENT	METRO MEDICAL	7816 (22.00) 7940 (881.20) 8189 (261.08)	708146-00 708683-01 773474-01
10259	EPROM for upgrade to CRRT	12/15/09	EQUIPMENT	FRESENIUS USA	7779	94485260
10262	18 X 72 Adj. Shelf	01/08/10	EQUIPMENT	INTERMETRO	7800	10279213
10264	2008 K Dialysis Machine	02/10/10	EQUIPMENT	FRESENIUS USA	7958	94583144
10268	Marcor F801 RO System	03/18/10	EQUIPMENT	MAR COR	7942	0000159306
10297	90XL Meter Kit-CT	05/25/10	EQUIPMENT	MESA LABS	8247	0383636-IN

Equipment Originally located at: 1313 La Concha Lane
Houston, TX 77054

Dated: November 2, 2010

Lessee: US Renal Care Home Therapies, LLC

By:


James B. Shelton, Manager

ATTACHMENT 40

FINANCIAL VIABILITY WAIVER

The applicant is not required to submit financial viability ratios because all project capital expenditures are completely funded through internal resources.

ATTACHMENT 41

VIABILITY

The applicant is not required to submit financial viability ratios because all project capital expenditures are completely funded through internal resources as indicated in Attachment 40.

ATTACHMENT 42

REASONABLENESS OF PROJECT AND RELATED COSTS

A. Reasonableness of Financing Arrangements

See Attached Certifications

B. Conditions of Debt Financing

See Attached Certifications

C. Reasonableness of Project Costs

Department	A	B	C	D	E	F	G	H	Total Cost
	Cost/Square Foot		Gross Square Foot		Gross Square Foot		Const.		
	New	Mod	New	Circ	Mod	Circ			
In-Center Hemodialysis Contingencies	\$110				6,493			\$714,230	\$714,230
Totals	\$110				6,493			\$714,230	\$714,230

D. Projected Operating Costs

Projected Operating Costs	Total Cost	Treatments	Cost/Trmt
Labor	\$751,412	9,246	\$81
Medical supplies	\$194,787	9,246	\$21
Medications	\$553,127	9,246	\$60
Medical Director fees	\$60,000	9,246	\$6
Rent	\$110,381	9,246	\$12
Management Fee	\$250,166	9,246	\$27
Other	\$263,566	9,246	\$29
Total Projected Operating Costs	\$2,183,438	9,246	\$236

E. Total Effect of the Project on Capital Costs

	Total Cost	Treatments	Cost/Trmt
Total Effect of the Project on Capital Cost	\$318,950	9,246	\$34.50

ATTACHMENT 42

REASONABLENESS OF PROJECT AND RELATED COSTS

77 Ill. Admin. Code § 1120.140 Reasonableness of Financing Arrangements

U.S. Renal Care, Inc.

In accordance with 77 Ill. Admin. Code § 1120.140, I attest 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.

By: _____

Thomas L. Weinberg

By: _____

Stephen M. Pirri

Its: _____

Senior Vice President & General Counsel

Its: _____

President

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012

Signature of Notary



Notarization:

Subscribed and sworn to me this 12th day
of June, 2012

Signature of Notary



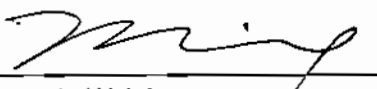
ATTACHMENT 42

REASONABLENESS OF PROJECT AND RELATED COSTS

77 Ill. Admin. Code § 1120.140 Conditions of Debt Financing

U.S. Renal Care, Inc.

In accordance with 77 Ill. Admin. Code § 1120.140, I attest that the conditions of debt financing are reasonable in that entering into a lease (borrowing) is less costly than the liquidation of existing investments which would be required for the applicant to construct a dialysis facility. Should the applicant be required to pay off the lease in full, its existing investments and capital retained could be converted to cash or used to retire the outstanding lease obligations within a sixty (60) day period.

By: 
Thomas L. Weinberg

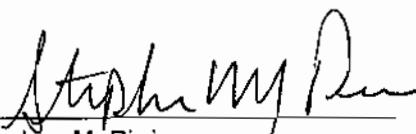
Its: Senior Vice President & General Counsel

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary

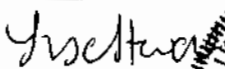


By: 
Stephen M. Pirri

Its: President

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary



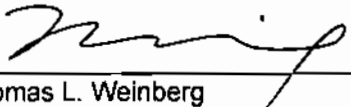
ATTACHMENT 42

REASONABLENESS OF PROJECT AND RELATED COSTS

77 Ill. Admin. Code § 1120.140 Reasonableness of Financing Arrangements

USRC Alliance, LLC

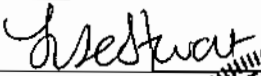
In accordance with 77 Ill. Admin. Code § 1120.140, I attest that the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

By: 
Thomas L. Weinberg

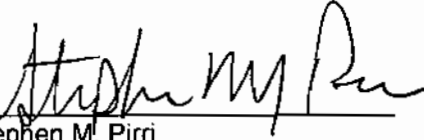
Its: Manager

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary

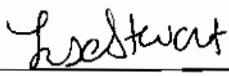


By: 
Stephen M. Pirri

Its: President & Manager

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary



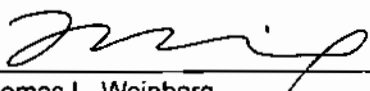
ATTACHMENT 42

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77 Ill. Admin. Code § 1120.140 Conditions of Debt Financing

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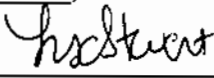
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By: 
Thomas L. Weinberg

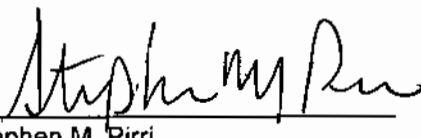
Its: Manager

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary

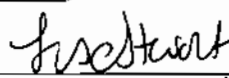


By: 
Stephen M. Pirri

Its: President & Manager

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary



ATTACHMENT 42

REASONABLENESS OF PROJECT AND RELATED COSTS

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USRC Plainfield, LLC

In accordance with 77 III. Admin. Code § 1120.140, I attest 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.

By: _____

Thomas L. Weinberg

By: _____

Stephen M. Pini

Its: _____

Manager

Its: _____

President and Manager

Notarization:

Subscribed and sworn to me this 12th day
of June, 2012

Signature of Notary



Notarization:

Subscribed and sworn to me this 12th day
of June, 2012

Signature of Notary



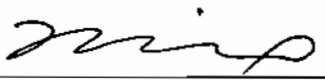
ATTACHMENT 42

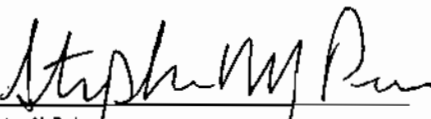
REASONABLENESS OF PROJECT AND RELATED COSTS

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USRC Plainfield, LLC

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By: 
Thomas L. Weinberg

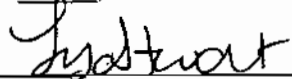
By: 
Stephen M. Pirt

Its: Manager

Its: President and Manager

Notarization:

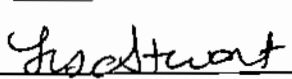
Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary



Notarization:

Subscribed and sworn to me this 12th day
of June, 2012


Signature of Notary



ATTACHMENT 43

SAFETY NET IMPACT

This project will result in a positive impact on the ability of other providers and health care systems to cross-subsidize safety net services. The capacity of hospitals and health systems to provide safety net and charity care services is impacted by their efficiency in discharging inpatients and transitioning their care from an inpatient setting to an outpatient setting. As the availability of outpatient dialysis services becomes more scarce, hospitals are sometimes forced to delay patient discharges while attempting to procure necessary dialysis services in the community. This delayed discharge and resulting increase in length of stay may unnecessarily consume hospital resources that could otherwise be directed to a patient in need of such resources. As the proposed project seeks to make additional outpatient dialysis services available it will help facilitate more timely hospital discharges and will result in greater opportunities for hospitals to provide additional safety net and charity care services.

With respect to the provision of dialysis services for Charity Care and Medicaid purposes, the Applicants do not operate facilities within Illinois and, as such, have provided Charity Care and Medicaid information at the corporate level for U.S. Renal Care, Inc. As such information is most accurately reported at the treatment level, due to the fact that patients receive multiple dialysis treatments which may qualify them as one or more patient types depending on their status at the time of treatment, this information is reported at the treatment level.

CHARITY CARE			
Charity (# of treatments)	2009	2010	2011
Inpatient	N/A	N/A	N/A
Outpatient	1,056	1,922	2,305
Total	1,056	1,922	2,305
Charity (cost in dollars)			
Inpatient	N/A	N/A	N/A
Outpatient	\$281,536	\$521,535	\$595,473
Total	\$281,536	\$521,535	\$595,473

MEDICAID			
Medicaid (# of treatments)	2009	2010	2011
Inpatient	N/A	N/A	N/A
Outpatient	17,967	29,744	40,586
Total	17,967	29,744	40,586
Medicaid (revenue)			
Inpatient	N/A	N/A	N/A
Outpatient	\$3,956,318	\$6,740,875	\$9,382,740
Total	\$3,956,318	\$6,740,875	\$9,382,740

ATTACHMENT 44

CHARITY CARE

Payor Mix	Year 1	Year 2	Year 3
Billed Govt Patients	29	57	59
Billed Commercial Patients	1	6	8
Billed Non Govt Low Patients	0	0	0
Total Patients	30	63	67

Charity Care Information	Year 1	Year 2	Year 3
Net Revenue	\$488,520	\$2,259,980	\$3,127,080
Bad Debt / Charity Care	\$15,144	\$70,059	\$96,939
Ratio of Bad Debt to Net Revenue	0.03	0.03	0.03

APPENDIX 1

PATIENT REFERRAL LETTERS

June 8, 2012

VIA FEDERAL EXPRESS

Mr. Dale Galassie
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Mr. Galassie:

On behalf of Northeast Nephrology Consultants, Ltd., comprised of Drs. Ahmed, Gurfinchel, Kravets, Mehta, and Nagarkatte, I am writing this letter in support of the certificate of need application for the proposed U.S. Renal Care Plainfield Dialysis facility.

Currently, we treat patients who receive their dialysis at the following facilities: Deerbrook Care Center, Fairview Care Center of Joliet, Fresenius Medical Care Plainfield, Silver Cross Renal Center – East, Silver Cross Renal Center – Morris, Silver Cross Renal Center – West or who receive their dialysis through home modalities. Based on our records, we treated 283 ESRD patients in 2011, 298 ESRD patients in 2010, 266 ESRD patients in 2009, and 231 ESRD patients through first quarter of 2012, as reported to the Renal Network. Included as Appendix A is the patient count organized by year, patient zip code, and dialysis facility for the years 2009, 2010, 2011, and first quarter 2012. We anticipate that 15% of our existing hemodialysis patients will not require in-center hemodialysis services within 1 year due to a change in health status.

With respect to new patients referred for dialysis, in the year 2011 we referred 86 patients for hemodialysis. Included as Appendix B is a patient count by facility and zip code of newly referred patients.

Based upon a review of our 631 Pre-ESRD patients that currently are in Chronic Kidney Disease (CKD) Stages 3, 4 and 5, we anticipate referring 54 patients to the proposed U.S. Renal Care Plainfield Dialysis facility for dialysis in the two years following project completion, as demonstrated in Appendix C. While these estimates are based on the zip code of the patient's residence, we will continue to respect a patient's choice in their dialysis provider.

We respectfully ask the Board to approve the U.S. Renal Care Plainfield Dialysis CON application to provide in center hemodialysis services for this growing ESRD population in Will County. Thank you for your consideration.

I attest to the fact that to the best of our knowledge, all the information contained in this letter is true and correct and that the projected referrals in this document were not used to support any other CON application.

Respectfully,

Signature:

Naila I Ahmed

Name:

NAILA I AHMED

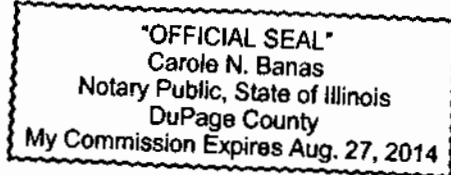
Title:

MD, PARTNER

SUBSCRIBED and SWORN TO before me
this 12 day of June, 2012

Carole N. Banas

Notary Public



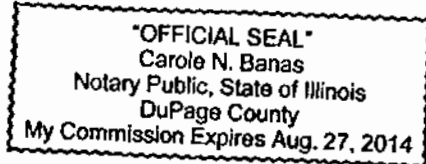
I attest to the fact that to the best of our knowledge, all the information contained in this letter is true and correct and that the projected referrals in this document were not used to support any other CON application.

Respectfully,

Signature: Naila I Ahmed
Name: NAILA I AHMED
Title: MD, PARTNER

SUBSCRIBED and SWORN TO before me
this 17 day of June, 2012

Carole N. Banas
Notary Public



APPENDIX A
ESRD PATIENTS BY PATIENT ZIP CODE 2009 – FIRST QUARTER 2012

Year	Physician	Patient Zip Code	Decbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
2009	Dr. Ahmed	60104					1			1
		60403							3	3
		60404					1		2	3
		60421					1			1
		60423					1		1	2
		60431							1	1
		60432					8		4	12
		60433					8	1	4	13
		60435				1	3		8	12
		60436					1		5	6
		60441					4		1	5
		60442							1	1
		60446					1			1
		60448					1			1
		60450						1	1	2
		60481							1	1
		60586							4	4
		60803							1	1
		61301							1	1
	Dr. Ahmed Total					1	30	2	38	71
	Dr. Gurfinkel	60436							1	1
		60451					1			1
	Dr. Gurfinkel Total						1		1	2
	Dr. Kravets	60403				2		2	3	7
		60404							1	1
		60408						2		2
		60410						1	2	3

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60416						3		3
		60420						2		2
		60421					1	1	1	3
		60431				1	2		5	8
		60432					8		3	11
		60433					6		3	9
		60434					1			1
		60435					2		16	18
		60436					3		2	5
		60441				1	4	1	2	8
		60442				1			1	2
		60446							5	5
		60447						1		1
		60448					1		1	2
		60450				1		4		5
		60451					3		3	6
		60464							1	1
		60477					1			1
		60481						1	1	2
		60544				1			5	6
		60586							1	1
		60840							1	1
		60920							1	1
		61341						3		3
		61354						1		1
	Dr. Kravets Total					7	32	22	58	119
	Dr. Nagarkatte	60403					2		4	6
		60404							3	3
		60406							1	1
		60407							1	1

APPENDIX 1

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total	
		60408							1	1	
		60421							3	3	
		60431					1			1	2
		60432						1		1	2
		60433						3		5	8
		60434								1	1
		60435						2		10	12
		60436						2		4	6
		60440								1	1
		60441					1	1		3	5
		60442						1			1
		60446								3	3
		60447								1	1
		60448						1		1	2
		60451					3	2			5
		60481								1	1
		60544					1			2	3
		60586								4	4
		60628								1	1
		60638						1			1
	Dr. Nagarkatte Total					6	16		52	74	
2009 Total						14	79	24	149	266	
2010	Dr. Ahmed	6043							1	1	
		6044					1			1	
		60403							2	2	
		60404					1		2	3	
		60416							1	1	
		60432			1	1	6		5	13	
		60433					9	2	2	13	
		60435						4		11	15

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60436					3		3	6
		60439					1			1
		60441					1		3	4
		60442							1	1
		60446					2			2
		60448					1			1
		60450						1		1
		60451							1	1
		60490							1	1
		60586				1			3	4
		60803							1	1
	Dr. Ahmed Total				1	2	29	3	37	72
	Dr. Gurfinchel	60404					1		1	2
		60432					2			2
		60433					1			1
		60435							2	2
		60436							1	1
		60440							1	1
		60441					1			1
		60451					1			1
		60479						1		1
	Dr. Gurfinchel Total						6	1	5	12
	Dr. Kravets	6043							1	1
		60403				2		1	1	4
		60404					1		3	4
		60408						2		2
		60410						2		2
		60416						2		2
		60420						2		2
		60421					1	1	3	5

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60423					1			1
		60431				2			5	7
		60432					5		1	6
		60433					9	1	5	15
		60434					1			1
		60435							17	17
		60436					2		1	3
		60439							1	1
		60441				1	3	1	1	6
		60442					1		1	2
		60446				1			5	6
		60447						1		1
		60448					1			1
		60450						8	1	9
		60451					2		2	4
		60464						1		1
		60467					1			1
		60474						1		1
		60481						2		2
		60491						1		1
		60544				1			5	6
		60586			1				1	2
		60840							1	1
		60920							1	1
		61341						3		3
		61350						1		1
		61354						1		1
	Dr. Kravets Total				1	7	28	31	56	123
	Dr. Mehta	60403							3	3
		60431							1	1

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60433							1	1
		60442					1			1
		60450				1				1
		60481							1	1
	Dr. Mehta Total					1	1		6	8
	Dr. Nagarkatte	6040							1	1
		6043							1	1
		6049					1			1
		60403					2		2	4
		60404							3	3
		60407							1	1
		60416				1				1
		60421					2		2	4
		60423					1			1
		60426							1	1
		60431						1	1	2
		60432				1	1		1	3
		60433					4		3	7
		60435					1	1	9	11
		60436					3		3	6
		60440							1	1
		60441				1	5		1	7
		60442					2			2
		60446							3	3
		60447							1	1
		60448					1		1	2
		60451				3	4		2	9
		60481							1	1
		60544				1			2	3
		60586							5	5

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60628							1	1
		61301							1	1
	Dr. Nagarkatte Total					7	27	2	47	83
2010 Total					2	17	91	37	151	298
2011	Dr. Ahmed	60403							2	2
		60404							2	2
		60410							1	1
		60416							1	1
		60431							1	1
		60432			1		5		6	12
		60433					8	1	1	10
		60435					2		9	11
		60436					1		5	6
		60439					1			1
		60441					3			3
		60446					1		1	2
		60447							1	1
		60544			1					1
		60586			1	1			2	4
		60803							1	1
	Dr. Ahmed Total				3	1	21	1	33	59
	Dr. Gurfinchel	60404							1	1
		60408							1	1
		60432					4			4
		60433					3		1	4
		60435							1	1
		60436					1		3	4
		60439					1			1
		60440							1	1
		60441		1			3			4

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60451					1			1
		60477					1			1
	Dr. Gurfinchel Total			1			14		8	23
	Dr. Kravets	25917					1			1
		60403				2			2	4
		60404							2	2
		60407						1		1
		60408					1	1		2
		60410						1		1
		60420						2		2
		60421					1	2	2	5
		60431				1			5	6
		60432					1		2	3
		60433					7		3	10
		60434					1			1
		60435	4	2		1	1		11	19
		60436					3		1	4
		60439							1	1
		60441				1	2		1	4
		60442				1	1		1	3
		60446					1		5	6
		60450						6		6
		60451					3			3
		60467					1			1
		60474						1		1
		60481						1	1	2
		60490							1	1
		60544				1			4	5
		60586			1				1	2
		60840							1	1

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60920							1	1
		61341						2		2
		61350						1		1
		61354						1		1
		61360						1		1
	Dr. Kravets Total		4	2	1	7	24	20	45	103
	Dr. Mehta	60403							3	3
		60404							1	1
		60416						1		1
		60431							1	1
		60432					1			1
		60433			1				1	2
		60435		1					3	4
		60436			1					1
		60442					1			1
		60446							1	1
		60450				1		1	1	3
		60481							1	1
	Dr. Mehta Total			1	2	1	2	2	12	20
	Dr. Nagarkatte	60403					2		3	5
		60404							2	2
		60410							1	1
		60416				1				1
		60421					1		2	3
		60423					1			1
		60426							1	1
		60431						1	3	4
		60432					3		1	4
		60433					3		4	7
		60435							10	10

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60436					3		4	7
		60441				1	4		2	7
		60442					2			2
		60446							2	2
		60447							1	1
		60448							1	1
		60450							1	1
		60451				4	4		1	9
		60481				1			1	2
		60491					1			1
		60544							1	1
		60586							4	4
		61301							1	1
	Dr. Nagarkatte Total					7	24	1	46	78
2011 Total			4	4	6	16	85	24	144	283
2012 1Q	Dr. Ahmed	60403							1	1
		60404							1	1
		60410						1	1	2
		60416							1	1
		60431							1	1
		60432			1		4		4	9
		60433					7		1	8
		60435					1		4	5
		60436					1		3	4
		60441					3			3
		60446							1	1
		60447				1				1
		60481				1				1
		60544			1				1	2
		60586				1			2	3

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
	Dr. Ahmed Total				2	3	16	1	21	43
	Dr. Gurfinkel	60404							1	1
		60423					1			1
		60432					4		1	5
		60433					1			1
		60435					1		3	4
		60436					1		3	4
		60441					2			2
		60451					1			1
		60481					2			2
	Dr. Gurfinkel Total						13		8	21
	Dr. Kravets	60401						1		1
		60403				1			2	3
		60404							2	2
		60407						1		1
		60408						1		1
		60420						2		2
		60421					1		2	3
		60431				2			5	7
		60432					4		1	5
		60433					8		2	10
		60435	2	1		1			9	13
		60436		1			2		1	4
		60439							1	1
		60441					2			2
		60442					1		1	2
		60446							2	2
		60448					1			1
		60450						3		3
		60451					3			3

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60467					1			1
		60477							1	1
		60481						1	1	2
		60544							3	3
		60560						1		1
		60586			1				1	2
		60920					1			1
		61341						1		1
		61350						1		1
		61354						1		1
	Dr. Kravets Total		2	2	1	4	24	13	34	80
	Dr. Mehta	60403							2	2
		60408					1			1
		60416						1		1
		60424						1		1
		60432					1		2	3
		60433			1				2	3
		60435		1					3	4
		60436			1					1
		60442					1			1
		60446							1	1
		60450				1		1		2
		60461							1	1
		60467					1			1
		60478							1	1
		60481							1	1
		60544							1	1
	Dr. Mehta Total			1	2	1	4	3	14	25
	Dr. Nagarkatte	60403				1	3		3	7
		60404							2	2

Year	Physician	Patient Zip Code	Deerbrook Care Center (Long-Term Care Facility)	Fairview Care Center of Joliet	Fresenius Medical Care Plainfield	Home Peritoneal Dialysis	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
		60410							1	1
		60417					1			1
		60421					2			2
		60426							1	1
		60431							2	2
		60432				1	2		1	4
		60433					4		1	5
		60435		1			1		7	9
		60436					1		3	4
		60440							1	1
		60441	3				4		2	9
		60442					1			1
		60446							2	2
		60447							1	1
		60448					2			2
		60450							1	1
		60451				1	1			2
		60481							1	1
		60491					1			1
		60544							1	1
		60586							1	1
		61301							1	1
	Dr. Nagarkatte Total		3	1		3	23		32	62
2012 1Q Total			5	4	5	11	80	17	109	231

APPENDIX B
2011 IN CENTER HEMODIALYSIS REFERRALS BY DIALYSIS FACILITY, PHYSICIAN AND PATIENT ZIP CODE

	Patient Zip Code	Fairview Care Center of Joliet	Silver Cross Renal Center - East	Silver Cross Renal Center - Morris	Silver Cross Renal Center - West	Grand Total
Dr. Ahmed	60433	1	1			2
	60435	4				4
	60436	1	1			2
	60441	1	1			2
Dr. Ahmed Total		7	3			10
Dr. Gurfinchel	60403				2	2
	60432		4			4
	60433		1			1
	60435				2	2
	60441	1	2			3
	60451		1			1
Dr. Gurfinchel Total		1	8		4	13
Dr. Kravets	60020				1	1
	60403				1	1
	60407			1		1
	60431				2	2
	60433		2			2
	60435				4	4
	60441		2			2
	60442		1			1
	60446				2	2
	60450			3	1	4
	60451		1			1
	60544				1	1
	61360			1		1
Dr. Kravets			6	5	12	23

Total						
Dr. Mehta	60403				1	1
	60404				1	1
	60410	1			1	2
	60416			1		1
	60423		1			1
	60431				1	1
	60433				1	1
	60435	1			3	4
	60446	1			1	2
	60447				1	1
	60450			1		1
Dr. Mehta Total		3	1	2	10	16
Dr. Nagarkatte	60403				1	1
	60408				1	1
	60421				3	3
	60431				2	2
	60432		1			1
	60435		1		4	5
	60436		1		3	4
	60439				1	1
	60441				1	1
	60446				1	1
	60451		1		1	2
	60481				1	1
	60544				1	1
Dr. Nagarkatte Total			4		20	24
Grand Total		11	22	7	46	86

APPENDIX C
ANTICIPATED REFERRALS IN THE TWO YEARS FOLLOWING PROJECT COMPLETION

We anticipate a total of 54 patient referrals to ESRD to the U.S. Renal Care Plainfield Dialysis Facility in the two years following project completion. We attribute these referrals to the following zip codes and physicians.

	Dr. Ahmed	Dr. Gurfinkel	Dr. Kravets	Dr. Mchta	Dr. Nagarkatte
60403	2	1	2	1	2
60432	1	1	1	1	1
60435	5	4	5	4	5
60544	2	1	2	2	2
60585	0	0	0	0	0
60586	2	1	2	2	2

APPENDIX 2

MAPQUEST MAPS OF FACILITIES

mapquest ^{ma}

Trip to:

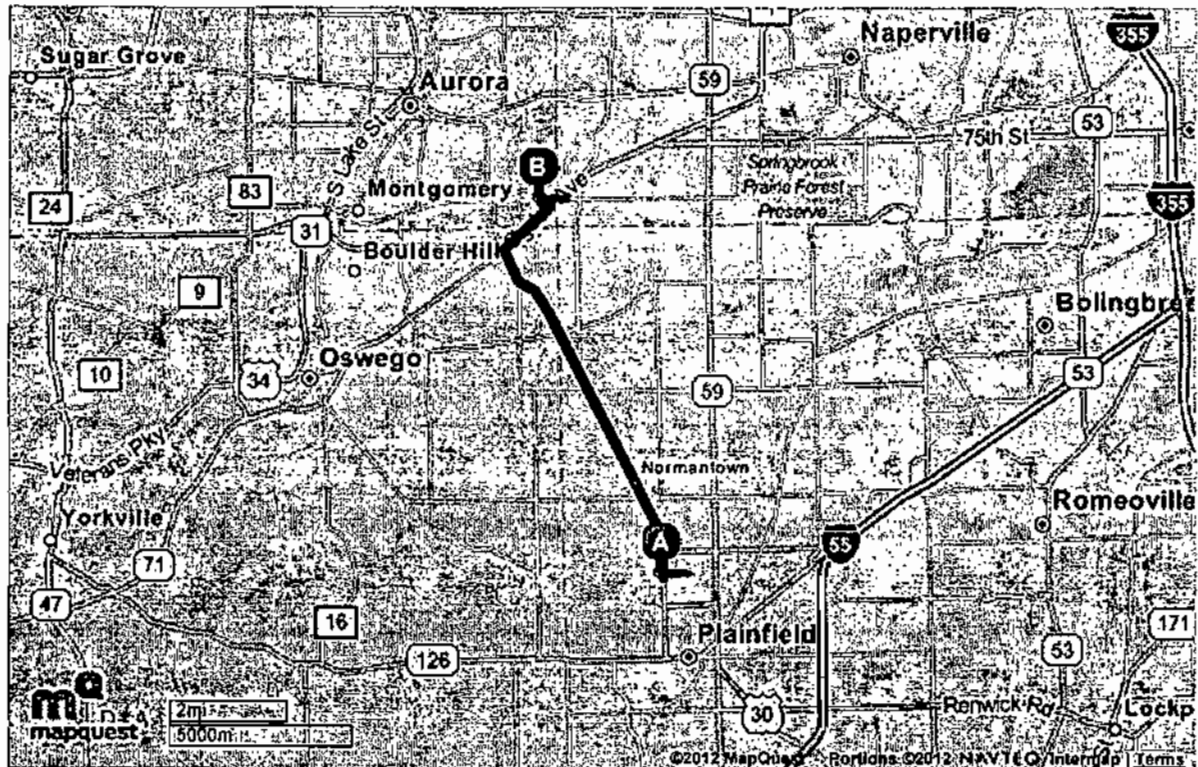
1300 Waterford Dr

Aurora, IL 60504-5502

8.45 miles / 11 minutes

Notes

Fox Valley Dialysis Center



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mapquest ^m

Trip to:

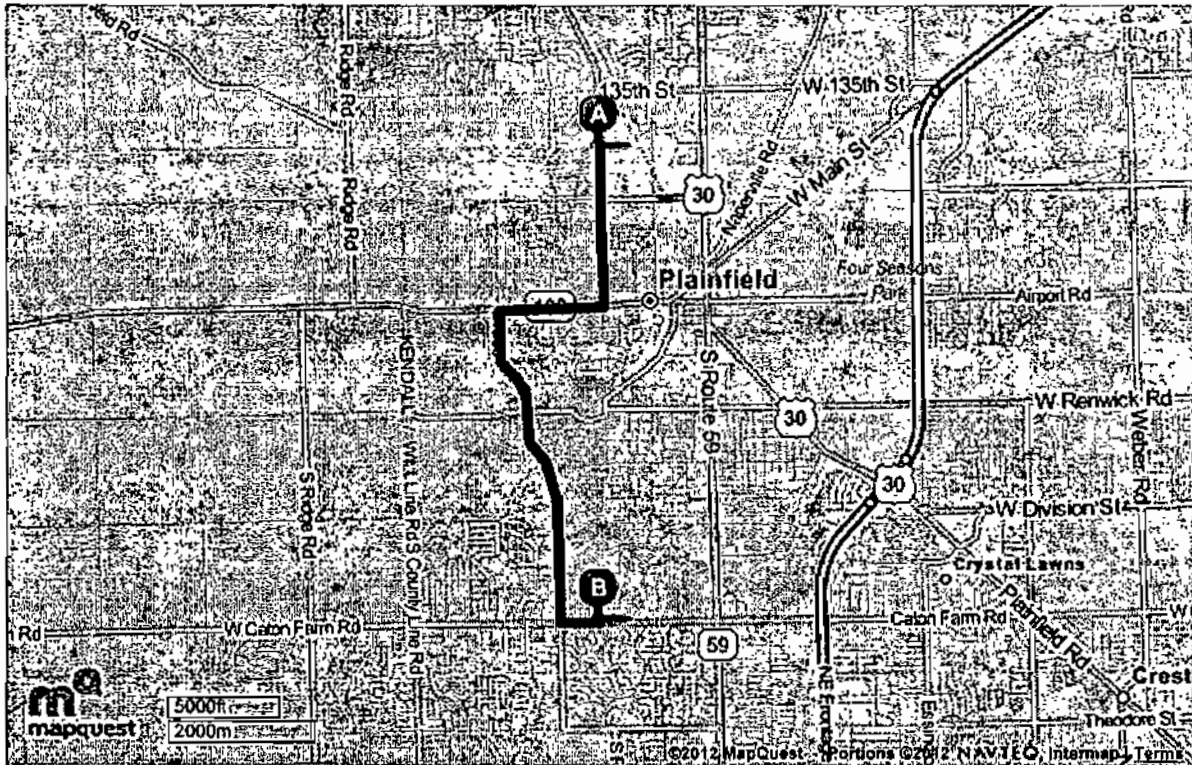
24900 W Caton Farm Rd

Plainfield, IL 60586

5.99 miles / 10 minutes

Notes

Fresenius Medical Center of Plainfield



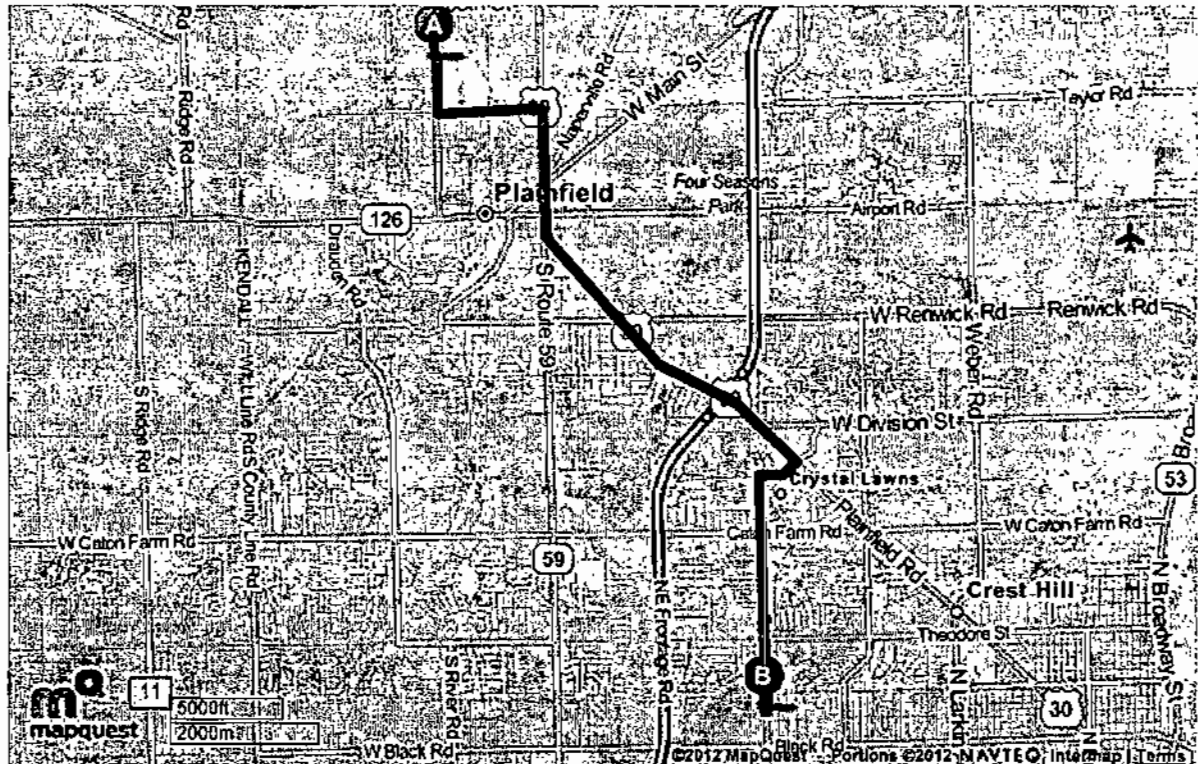
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Trip to:
1051 Essington Rd
Joliet, IL 60435-2801
8.53 miles / 18 minutes

Notes

Silver Cross Renal Center West



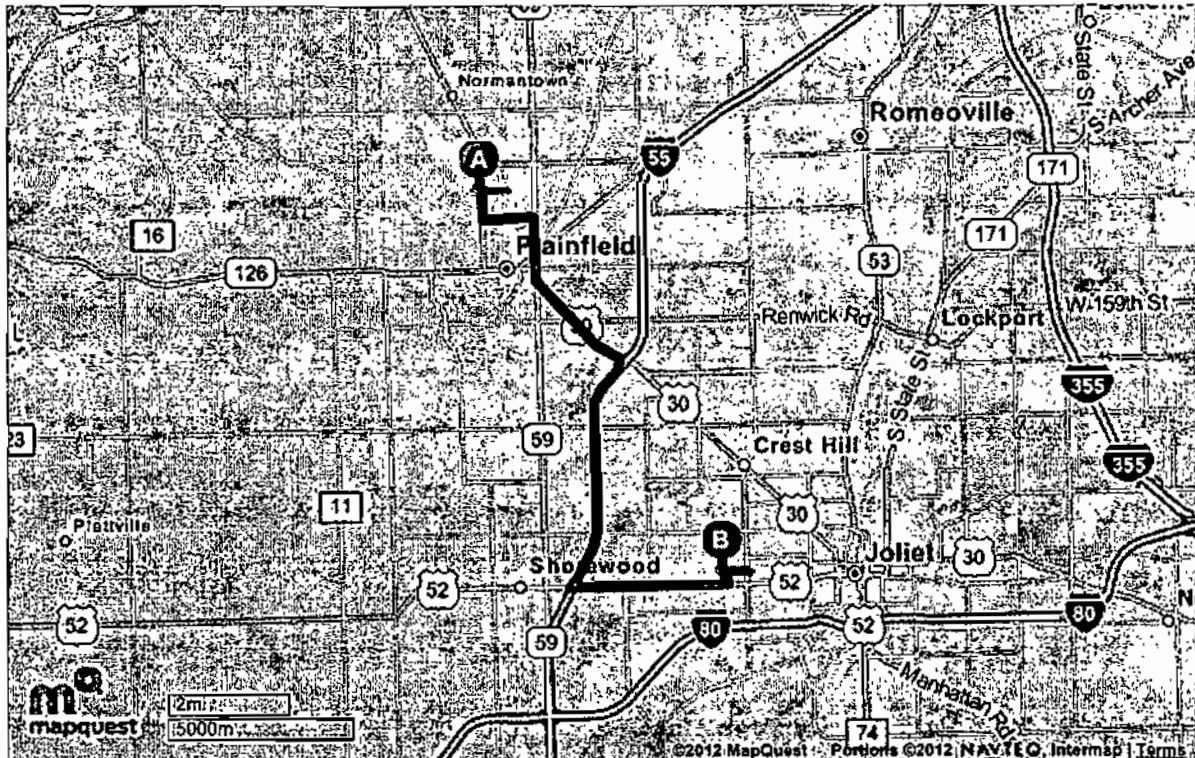
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mapquest m^o

Trip to:
2121 Oneida St
Joliet, IL 60435-6544
12.79 miles / 22 minutes

Notes

Sun Health



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mapquest m^Q

Trip to:

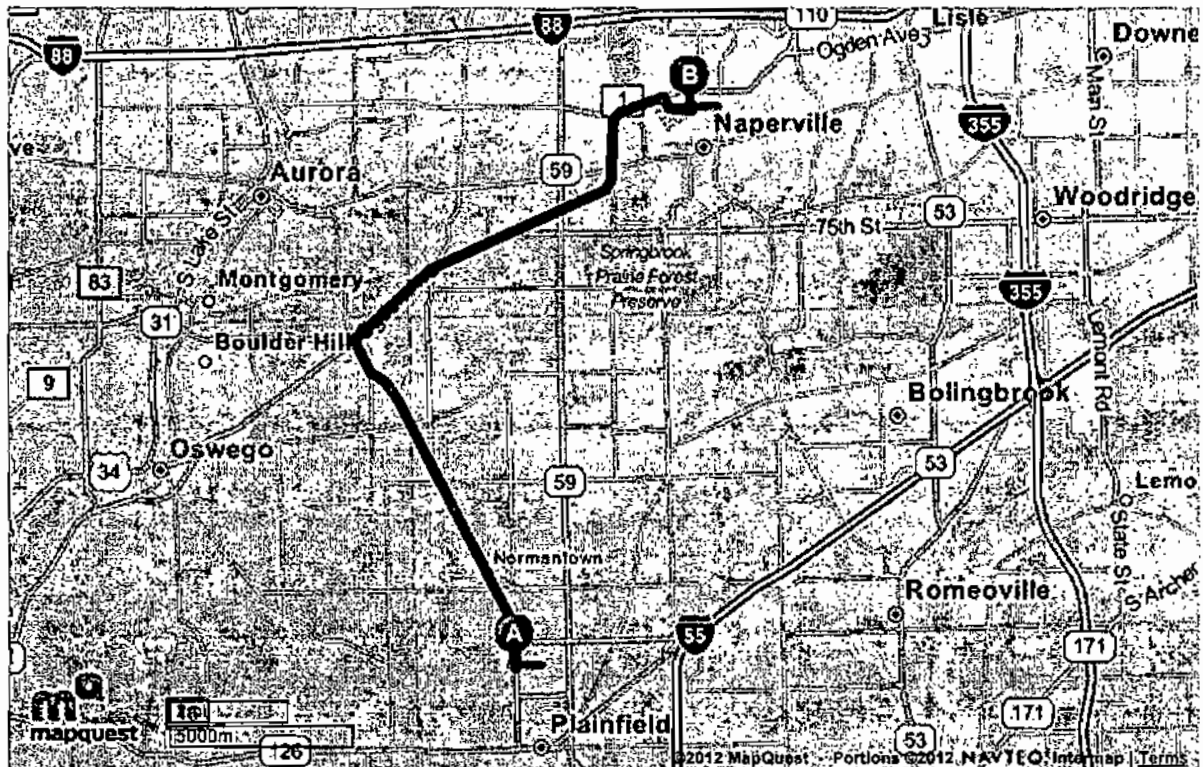
514 W 5th Ave

Naperville, IL 60563-2901

15.75 miles / 24 minutes

Notes

Fresenius Medical Care of Naperville - North



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mapquest m^q

Trip to:

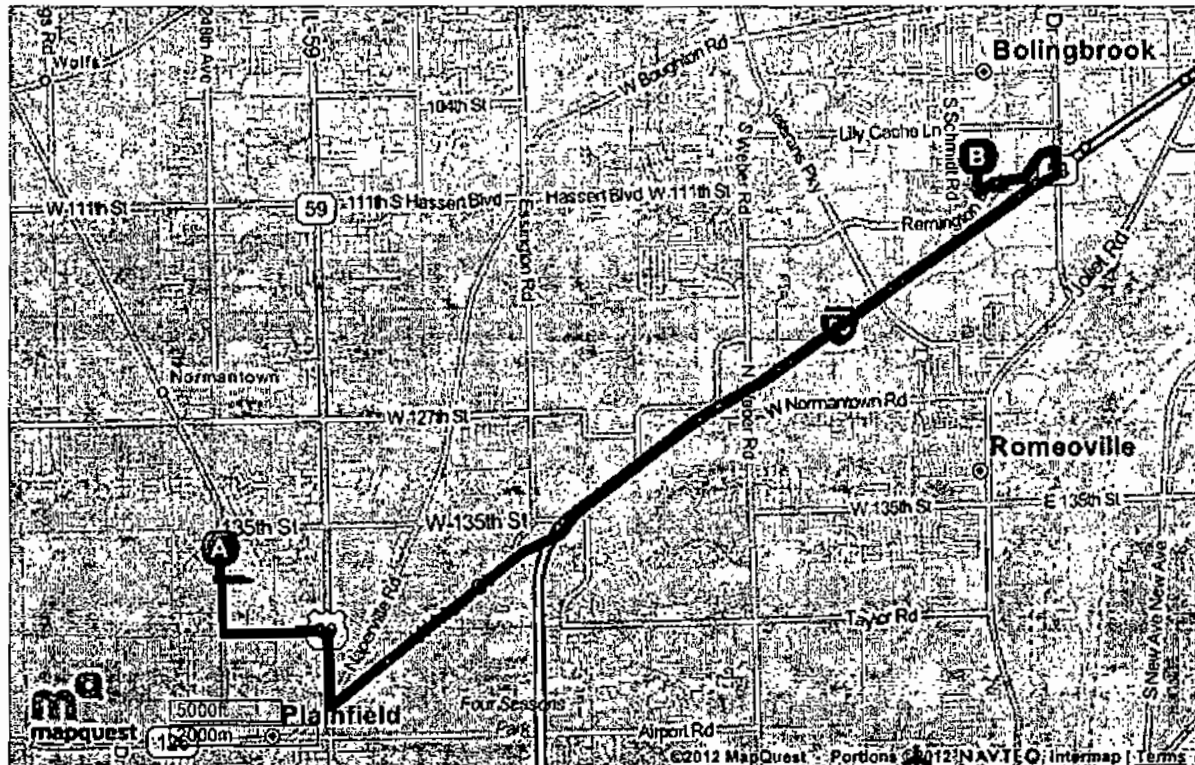
396 Remington Blvd

Bolingbrook, IL 60440-4302

11.89 miles / 18 minutes

Notes

USRC Bolingbrook Dialysis



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Trip to:

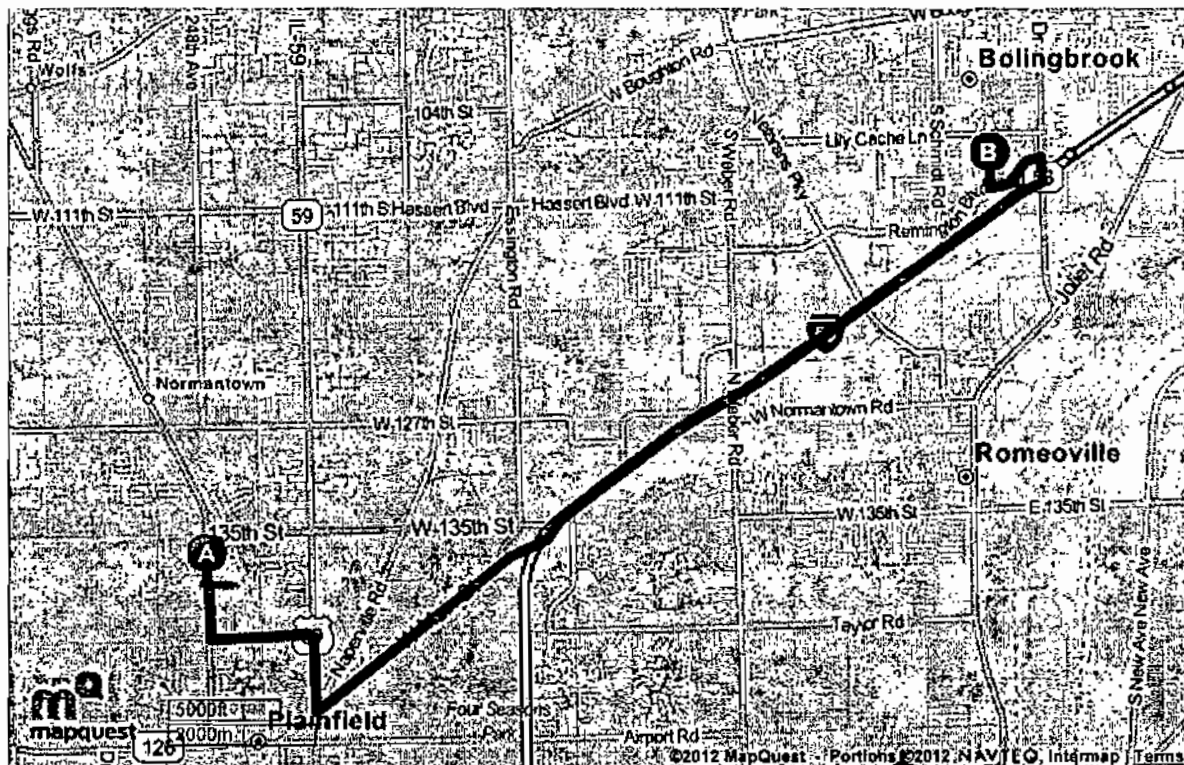
329 Remington Blvd

Bolingbrook, IL 60440-5827

11.67 miles / 18 minutes

Notes

FMC Bolingbrook



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mapquest m^o

Trip to:

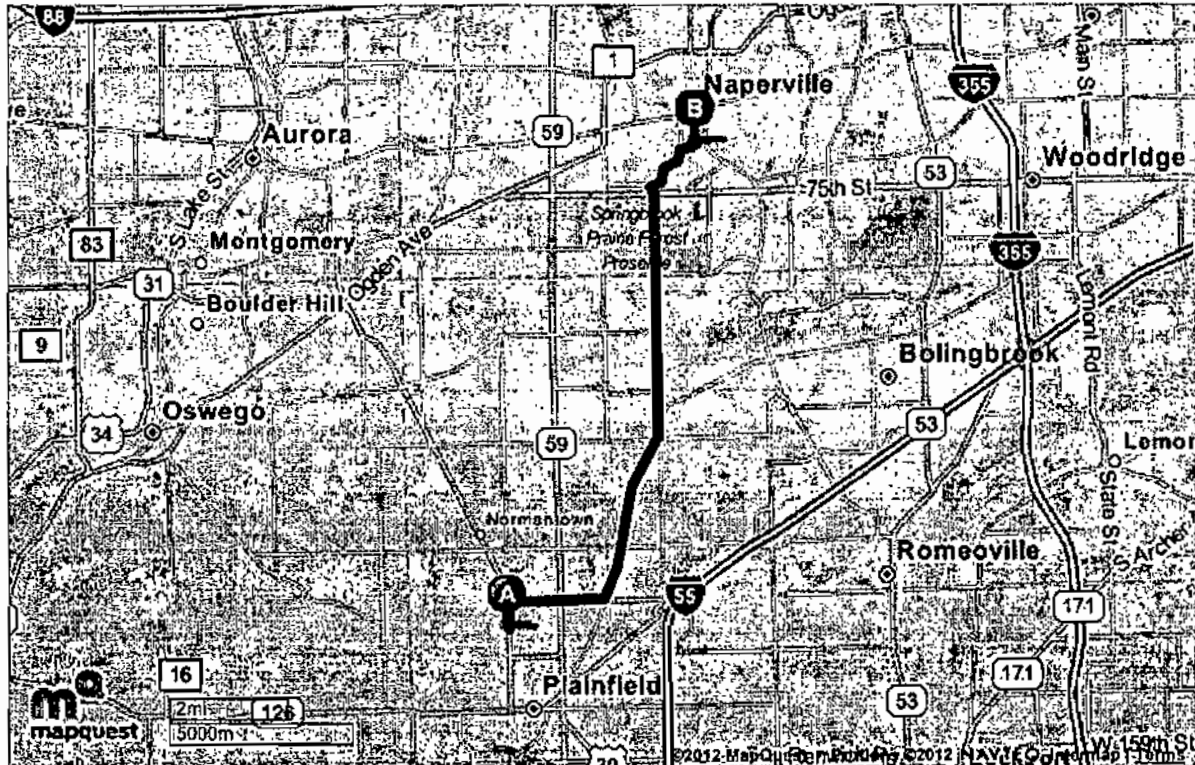
100 Spalding Dr

Naperville, IL 60540-6550

11.81 miles / 22 minutes

Notes

FMC - Naperville



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mapquest m^q

Trip to:

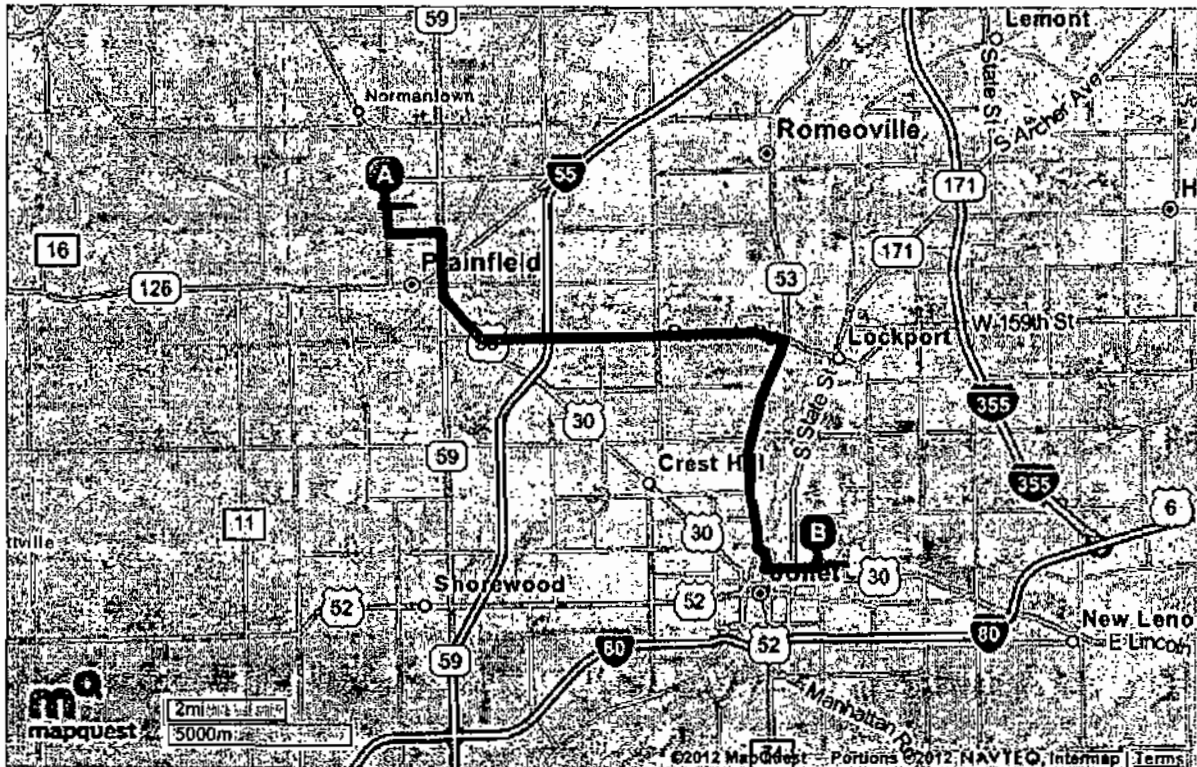
721 E Jackson St

Joliet, IL 60432-2560

15.21 miles / 28 minutes

Notes

Fresenius Medical Care Joliet



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