

Original

12-085

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

OCT 02 2012

This Section must be completed for all projects.

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name: Lawndale Dialysis		
Street Address: 3934 West 24 th Street		
City and Zip Code: Chicago, Illinois 60623		
County: Cook	Health Service Area 006	Health Planning Area:

Applicant /Co-Applicant Identification

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

Exact Legal Name: DaVita Inc.	
Address: 1551 Wewatta Street, Denver, CO 80202	
Name of Registered Agent: Illinois Corporation Service Company	
Name of Chief Executive Officer: Kent Thiry	
CEO Address: 1551 Wewatta Street, Denver, CO 80202	
Telephone Number: (303) 405-2100	

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: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart PC
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

Additional Contact

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

Name: Kelly Ladd
Title: Regional Operations Director
Company Name: DaVita Inc.
Address: 2659 N. Milwaukee Ave., 2 nd Floor, Chicago, Illinois 60647
Telephone Number: 815-459-4694
E-mail Address: kelly.ladd@davita.com
Fax Number: 866-366-1681

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT****SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

This Section must be completed for all projects.

Facility/Project Identification

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Street Address: 3934 West 24 th Street		
City and Zip Code: Chicago, IL 60623		
County: Cook	Health Service Area 006	Health Planning Area:

Applicant /Co-Applicant Identification

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

Exact Legal Name: Cowell Dialysis, LLC	
Address: 1551 Wewatta Street, Denver, CO 80202	
Name of Registered Agent: Illinois Corporation Service Company	
Name of Chief Executive Officer: Kent Thiry	
CEO Address: 1551 Wewatta Street, Denver, CO 80202	
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E-mail Address: kelly.ladd@davita.com
Fax Number: 866-366-1681

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: Kelly Ladd
Title: Regional Operations Director
Company Name: DaVita Inc.
Address: 2659 N. Milwaukee Ave., 2 nd Floor, Chicago, Illinois 60647
Telephone Number: 815-459-4694
E-mail Address: kelly.ladd@davita.com
Fax Number: 866-366-1681

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: SDO Development LLC
Address of Site Owner: 1149 West 175 th Street, Homewood, Illinois 60403
Street Address or Legal Description of Site: 3934 West 24th Street, Chicago, IL 60623
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: Cowell Dialysis, LLC	
Address: 1551 Wewatta Street, Denver, CO 80202	
☐ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☒ 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. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

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

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

Flood Plain Requirements

[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.

DaVita Inc. and Cowell Dialysis, LLC (the "Applicants") seek authority from the Illinois Health Facilities and Services Review Board (the "Board") to establish a 16-station dialysis facility located at 3934 West 24th Street, Chicago, Illinois. The proposed dialysis facility will include a total of 6,781 gross square feet.

This project has been classified as substantive because it involves the establishment of a health care 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	\$940,600		\$940,600
Contingencies	\$140,000		\$140,000
Architectural/Engineering Fees	\$52,800		\$52,800
Consulting and Other Fees	\$75,000		\$75,000
Movable or Other Equipment (not in construction contracts)	\$525,708		\$525,708
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	\$37,363		\$37,363
Fair Market Value of Leased Space or Equipment	\$1,374,469		\$1,374,469
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$3,145,940		\$3,145,940
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$487,715		\$487,715
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Loan	\$1,283,756		\$1,283,756
Leases (fair market value)	\$1,374,469		\$1,374,469
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$3,145,940		\$3,145,940
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 \$161,892_____.		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:
☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): December 31, 2015
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 <u>ATTACHMENT-8</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:
☐ Cancer Registry NOT APPLICABLE
☐ APORS NOT APPLICABLE
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert 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 manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of DaVita 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.

Martha Ha
SIGNATURE

Martha Ha
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 13th day of September, 2012

Linda N. O'Connell
Signature of Notary

Seal
LINDA N. O'CONNELL
NOTARY PUBLIC
STATE OF COLORADO
MY COMMISSION EXPIRES 06-08-2015

Arturo Sida
SIGNATURE

Arturo Sida
PRINTED NAME

Assistant Secretary
PRINTED TITLE

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

He attached
Signature of Notary

Seal

*Insert EXACT legal name of the applicant

CALIFORNIA JURAT WITH AFFIANT STATEMENT

- ☒ See Attached Document (Notary to cross out lines 1-6 below)
☐ See Statement Below (Lines 1-5 to be completed only by document signer[s], *not* Notary)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Signature of Document Signer No. 1 _____ Signature of Document Signer No. 2 (if any) _____

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me

on this 14 day of Sept, 2012
by _____
Date Month Year

(1) Arturo Silva
Name of Signer

proved to me on the basis of satisfactory evidence
to be the person who appeared before me (.) (✓)

(and

(2) _____
Name of Signer

proved to me on the basis of satisfactory evidence
to be the person who appeared before me.)

Signature Evette Tuana Johnson
Signature of Notary Public



Place Notary Seal and/or Stamp Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Further Description of Any Attached Document

Title or Type of Document: AFFIDAVIT FOR DEFENSE
Document Date: None Number of Pages: 1

Signer(s) Other Than Named Above: _____

RIGHT THUMBPRINT
OF SIGNER #1
Top of thumb here

RIGHT THUMBPRINT
OF SIGNER #2
Top of thumb here

CERTIFICATION

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- 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);
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- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Cowell Dialysis, 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.

Martha Ha

SIGNATURE

Martha Ha

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:

Subscribed and sworn to before me

this 13th day of September 2012

Linda N. O'Connell

Signature of Notary

Seal



Arturo Sida

SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:

Subscribed and sworn to before me

this _____ day of _____

Signature of Notary

Seal

See Attached

*Insert EXACT legal name of the applicant

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☐ See Statement Below (Lines 1-5 to be completed only by document signer[s], *not* Notary)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Signature of Document Signer No. 1 _____ Signature of Document Signer No. 2 (if any) _____

State of California

County of LOS ANGELES

Subscribed and sworn to (or affirmed) before me

on this 14 day of SEP, 2012
by _____

(1) ARTURO SILVA
Name of Signer

proved to me on the basis of satisfactory evidence
to be the person who appeared before me (.) ☒

(and

(2) _____
Name of Signer

proved to me on the basis of satisfactory evidence
to be the person who appeared before me.)

Signature Evette Tuana Johnson
Signature of Notary Public



Place Notary Seal and/or Stamp Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Further Description of Any Attached Document

Title or Type of Document: LEGAL FOR AFFIDAVIT
Document Date: CONVICTED 12/15/10 Number of Pages: 1

Signer(s) Other Than Named Above: _____

RIGHT THUMBPRINT
OF SIGNER #1
Top of thumb here

RIGHT THUMBPRINT
OF SIGNER #2
Top of thumb here

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate.**

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

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

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

G. Criterion 1110.1430 - In-Center Hemodialysis

- 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	16

- 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:**

\$487,715	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;
\$2,658,225	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.
\$3,145,940	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:	2009	2010	2011	
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)	Year	Year	Year
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.

Section I, Identification, General Information, and Certification
Applicants

Cowell Dialysis, LLC will operate Lawndale Dialysis, which shall be used as a trade name. DaVita Inc. is the entity that has final control over the proposed operator. Certificates of Good Standing for DaVita Inc., and Cowell Dialysis, LLC (collectively, the "Applicants") are attached at Attachment – 1. DaVita Inc. does not do business in the State of Illinois. A Certificate of Good Standing for DaVita Inc. from the state of its incorporation, Delaware is attached.

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE ELEVENTH DAY OF APRIL, A.D. 2012.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

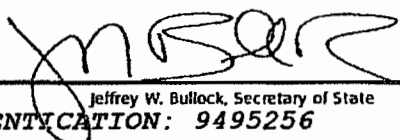
AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "DAVITA INC." WAS INCORPORATED ON THE FOURTH DAY OF APRIL, A.D. 1994.

2391269 8300

120417324

You may verify this certificate online
at corp.delaware.gov/authver.shtml




Jeffrey W. Bullock, Secretary of State
AUTHENTICATION: 9495256

DATE: 04-11-12



To all to whom these Presents Shall Come, Greeting:

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

COWELL DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON SEPTEMBER 15, 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 #: 1130801376

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 4TH
day of NOVEMBER A.D. 2011*

Jesse White

SECRETARY OF STATE

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

The letter of intent between SDO Development LLC and Total Renal Care, Inc. to lease the facility located at 3934 West 24th Street, Chicago, Illinois 60623 is attached at Attachment – 2.



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September 28, 2012

Emmett Purcell
Senior Vice President
USI Real Estate Brokerage Services Inc.
2215 York Road, Suite 110
Oak Brook, IL 60523

RE: REQUEST FOR PROPOSAL
NEC 24th Street & Pulaski Road
Chicago, IL

Dear Emmett:

Please allow this letter to serve as our response to enter into a binding lease with Total Renal Care, Inc.

LOCATION: NEC 24th Street & Pulaski Road, Chicago, IL (the "Premises")
3934 West 24th Street, Chicago, Illinois 60623

TENANT: Total Renal Care, Inc. or related entity to be named.

LANDLORD: SDO Development LLC, an Illinois limited liability company,
FEIN: 26-1207687

SPACE REQUIREMENTS: Approximately 6,781.1 contiguous useable square feet. Final SF and building layout to be mutually agreed to by the parties. Tenant shall have the right to measure the space based on the most recent BOMA standards. *Please indicate both rentable and useable square footage for the Premises.*

Landlord agrees to these terms and conditions. The square footage for the Premises is as follows:

Rentable: 6781.1 SF

Useable: 6444.25 SF

PRIMARY TERM: 15 YEAR LEASE
\$21.83/SF, with annual 3% increases after the Fifth Lease Year

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BASE RENT:*Please indicate the annual rate per rentable square foot.***15 YEAR TERM
LEASE YEAR****ANNUAL RENT**

1	\$ 148,031.41
2	\$ 148,031.41
3	\$ 148,031.41
4	\$ 148,031.41
5	\$ 148,031.41
6	\$ 152,472.35
7	\$ 157,046.53
8	\$ 161,757.92
9	\$ 166,610.66
10	\$ 171,608.98
11	\$ 176,757.25
12	\$ 182,059.97
13	\$ 187,521.76
14	\$ 193,147.42
15	\$ 198,941.84

*Please indicate the lease type. (i.e. FSG, MG, NNN).***NNN****ADDITIONAL EXPENSES:***Please provide an estimated annual cost per square foot for any and all additional operating expenses for which the Tenant will be responsible for paying including Taxes, Insurance and CAM.**Annual Estimated Cost/SF \$7.75 The taxes are being reassessed and we will receive a 2010 Tax statement in October, 2011. See Exhibit D.*

<i>Taxes</i>	<i>Insurance</i>	<i>CAM</i>
\$3.98	\$.49 cents	\$3.28

*Please provide Tenant's pro rata share percentage of operating expenses.***Tenant's pro rata share % is 44%**



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If operating expenses are based on a Base Year, please indicate the Base Year and expense stop.

N/A

Please indicate what, if any, utility costs Tenant will be responsible for paying that are not included in operating expenses or Base Rent.

Tenant shall be responsible for all separately-metered utility charges for the Premises.

Landlord to limit the cumulative operating expense costs to no greater than three percent (3%) increase annually.

Landlord agrees to these terms and conditions.

LANDLORD'S MAINTENANCE:

Landlord, at its sole cost and expense, shall be responsible for the structural and capitalized items (per GAAP standards) for the Property.

Landlord agrees to these terms and conditions.

**POSSESSION AND
COMMENCEMENT:**

Tenant shall take possession of the premises upon the later of completion of Landlord's required work (if any) or mutual lease execution. The rent commencement shall be the earlier of four (4) months from possession or until:

- a. Construction Improvements within the Premises have been completed in accordance with the final construction documents (except for nominal punch list items); and
- b. A Certificate of Occupancy for the Premises has been obtained from the City of Chicago, IL; and
- c. Tenant has obtained all necessary licenses and permits to operate its business.

Landlord will deliver the Premises in approximately four (4) months from the receipt of the Certificate of Need, or sooner, subject to Force Majeure and Governmental delays. Landlord requires Tenant to take possession of the Premises within thirty (30) days of said date and will provide for two (2) months of free base rent and CAM and Taxes upon delivery of possession.



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The Lease Term under shall begin upon Landlord's delivery of the vanilla box to Tenant. Landlord and Tenant shall work together to save time while Landlord is relocating Turner Acceptance Corporation and will consider any and all time saving methods for faster completion of the delivery of the space.

**FAILURE TO DELIVER
PREMISES:**

If Landlord has not delivered the premises to Tenant with all base building items substantially completed by two hundred seventy (270) days from receipt of the Certificate of Need, Tenant may elect to a) terminate the lease by written notice to Landlord or b) elect to receive two days of rent abatement for every day of delay beyond the two hundred seventy (270) day delivery period.

LEASE FORM:

Tenant's standard lease form.

Landlord agrees to these terms and conditions.

USE:

The use is for a Dialysis Clinic, related medical, office and distribution of pharmaceuticals. Tenant will require that the Landlord receive approval of the proposed building and use from the Alderman before a letter of intent can be finalized.

Landlord agrees to these terms and conditions. Please refer to

Exhibit F.

BASE BUILDING:

The following items must be delivered by the Landlord to the premises as part of the base building:

- A 2" dedicated water meter and line
- A 4" sewer line to a municipal sewer system
- Minimum 400 to 800, 120/208 volt 3 phase, 4 wire electrical service
- Gas service, at a minimum, will be rated to have 6" of water column pressure and supply 800,000-BTU's
- HVAC rooftop Units/Systems and all associated cost(s) with unit(s)



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Please refer to the attached Exhibit B regarding additional base building improvements and site development requirements.

Landlord agrees to these terms and conditions.

TENANT IMPROVEMENTS:

Please provide the tenant improvement allowance offered (psf).

None

OPTION TO RENEW:

Tenant shall receive three (3) five (5) year options to renew the lease. Option Rent shall be the lesser of 95% of fair market value.

Landlord agrees to these terms and conditions.

**RIGHT OF FIRST OPPORTUNITY
ON ADJACENT SPACE:**

Tenant shall have the on-going right of first opportunity on any adjacent space that may become available during the initial term of the lease and any extension thereof, under the same terms and conditions of Tenant's existing lease.

Landlord agrees to these terms and conditions.

HOLDING OVER:

Tenant shall be obligated to pay 125% for the then current rate.

PARKING:

Please indicate the number and location of parking spaces. Tenant requests one (1) dedicated stall per 1,000 rsf and (2) dedicated handicap stalls.

The parking ratio at 24th and Pulaski is 4.2 per 1000. Landlord will deliver to Tenant two (2) handicap spots directly in front of its space as well as two (2) other spots adjacent to the handicap for Tenants clients.

CONCESSIONS:

None.



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**COMMON AREA EXPENSES
AND REAL ESTATE TAXES:**

Please provide a detailed itemization and estimates of all common area operating expense components including real estate taxes and special assessments, insurance, landscape maintenance, exterior lighting, property management, maintenance, utilities, janitorial, security, etc., for which the client will be responsible to pay. If the lease provides for a base year for operating expenses, please indicate what the base year will be for a renewal.

Please see Exhibit D attached hereto.

TENANT SIGNAGE:

Tenant shall have the right to install building signage on the building, subject to Landlord's consent, which consent shall not be unreasonably withheld and subject to compliance by Tenant with all applicable laws and regulations. Landlord, at Landlord's expense, will furnish Tenant with any standard building directory signage.

Landlord agrees to these terms and conditions. Landlord will also deliver to Tenant signage rights on the Pylon on 24th in which Tenant will receive the second spot on the Pylon (replacing the Turner Acceptance Corporation sign) in accordance of all City of Chicago applicable laws.

BUILDING HOURS:

Tenant requires building hours of 24 hours a day, 7 days a week. Please indicate building hours for HVAC and utility services.

Landlord agrees to these terms and conditions.

SUBLEASE/ASSIGNMENT:

Tenant will have the right at any time to sublease or assign its interest in this Lease to any majority owned subsidiaries or related entities of DaVita Inc. without the consent of the Landlord or to unrelated entities with Landlord's reasonable approval.

Landlord agrees to these terms and conditions.

**GOVERNMENTAL
COMPLIANCE:**

Landlord shall represent and warrant to Tenant that Landlord, at Landlord's sole expense, will cause Tenant's Premises, the Building and parking facilities to be in full compliance with any governmental laws, ordinances, regulations or orders relating to, but not limited to, compliance with the Americans with Disabilities Act (ADA) and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or



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soil and ground water conditions, and shall indemnify and hold Tenant harmless from any claims, liabilities and cost arising from environmental conditions not caused by Tenant(s).

Landlord agrees to these terms and conditions.

ROOF RIGHTS:

If the building does not have cable television service, then Tenant will need the right to place a satellite dish on the roof at no additional fee.

Landlord agrees to these terms and conditions.

RADIUS RESTRICTION:

Landlord shall not lease space to another dialysis clinic or similar facility at the property or at any of the other properties Landlord controls within two (2) miles of the subject property.

Landlord agrees to these terms and conditions.

HVAC:

Please provide general description of HVAC systems (i.e. ground units, tonnage, age).

The HVAC units are brand new and the tonnage is 5 tons per unit.

DELIVERIES:

Landlord will provide Tenant with a dock door located on Harding Avenue per Tenant's specifications.

**EARLY TERMINATION
OPTION:**

After Tenant has completed Forty-eight (48) months of rent payments, Tenant shall have the one time right to terminate the Lease at any time with Two hundred seventy (270) days prior written notice before the expiration date along with a payment equal to one-quarter (1/4) of Tenant's monthly base rental obligations for the remaining portion of the current lease term and any unamortized transaction costs (brokerage commissions and tenant allowance).

SECURITY DEPOSIT:

None.

Landlord agrees to these terms and conditions.

CORPORATE GUARANTEE:

None.



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Landlord agrees to these terms and conditions.

CONTINGENCIES:

Tenant will need to apply for a Certificate of Need for the final location. If Tenant does not get the Certificate of Need by December 15, 2012 the Lease will be null and void. If they do get the Certificate of Need, then they will go forward with the lease based on satisfying the other contingencies that are in their standard Lease Document.

Tenant CON Obligation: Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a CON permit from the Illinois Health Facilities Planning Board (the "Planning Board"). Tenant agrees to proceed using its commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application to obtain the CON permit from the Planning Board. Based on the length of the Planning Board review process, Tenant does not expect to receive a CON permit prior to December 15, 2012. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit provided, however, the lease shall not be binding on either party prior to the approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective pending CON approval. Assuming CON permit approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the Planning Board does not award Tenant a CON permit to establish a dialysis center on the Premises by December 15, 2012, neither party shall have any further obligation to the other party with regard to the negotiations, lease or Premises contemplated by this Letter of Intent.

BROKERAGE FEE:

Landlord agrees that it recognizes USI Real Estate Brokerage Services Inc. as the client's sole representative and a brokerage fee equal to \$1.00/RSF per year of lease term shall be paid to USI, per separate commission agreement. Commissions to be paid 50% due within 30 days a fully executed lease and receipt



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of the CON and 50% within 30 days of lease commencement.
The client shall retain the right to offset rent for failure to pay the
Real Estate Commission.

PLANS:

*Please provide copies of site and construction plans or
drawings.*

*Please see Exhibit E attached hereto as well Landlord will
deliver a CAD file to Tenant.*

AGREED TO AND ACCEPTED THIS _____ DAY
OF _____, 2012

AGREED TO AND ACCEPTED THIS 28 DAY
OF September, 2012

By: _____

By: Penny Davis

SDO Development LLC, an Illinois limited
liability company, ("Landlord")

On behalf of Total Renal Care, Inc. a wholly
owned subsidiary of DaVita, Inc.
("Tenant")

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(708) 799 - 4949^F**EXHIBIT A****NON-BINDING NOTICE**

NOTICE: THE PROVISIONS CONTAINED IN THIS REQUEST FOR A PROPOSAL ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPERATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS REQUEST FOR A PROPOSAL, NEITHER TENANT NOR LANDLORD (OR USI) SHALL BE BOUND TO ENTER INTO ANY (GOOD FAITH OR OTHERWISE) NEGOTIATIONS OF ANY KIND WHATSOEVER. TENANT RESERVES THE RIGHT TO NEGOTIATE WITH OTHER PARTIES. NEITHER TENANT, LANDLORD OR USI INTENDS ON THE PROVISIONS CONTAINED IN THIS REQUEST FOR A PROPOSAL TO BE BINDING IN ANY MANNER, AS THE ANALYSIS FOR AN ACCEPTABLE TRANSACTION WILL INVOLVE ADDITIONAL MATTERS NOT ADDRESSED IN THIS LETTER, INCLUDING, WITHOUT LIMITATION, THE TERMS OF ANY COMPETING PROJECTS, OVERALL ECONOMIC AND LIABILITY PROVISIONS CONTAINED IN ANY LEASE DOCUMENT AND INTERNAL APPROVAL PROCESSES AND PROCEDURES. THE PARTIES UNDERSTAND AND AGREE THAT A CONTRACT WITH RESPECT TO THE PROVISIONS IN THIS REQUEST FOR A PROPOSAL WILL NOT EXIST UNLESS AND UNTIL THE PARTIES HAVE EXECUTED A FORMAL, WRITTEN LEASE AGREEMENT APPROVED IN WRITING BY THEIR RESPECTIVE COUNSEL. USI IS ACTING SOLELY IN THE CAPACITY OF SOLICITING, PROVIDING AND RECEIVING INFORMATION AND PROPOSALS AND NEGOTIATING THE SAME ON BEHALF OF OUR CLIENTS. UNDER NO CIRCUMSTANCES WHATSOEVER DOES USI HAVE ANY AUTHORITY TO BIND OUR CLIENTS TO ANY ITEM, TERM OR COMBINATION OF TERMS CONTAINED HEREIN. THIS REQUEST FOR A PROPOSAL IS SUBMITTED SUBJECT TO ERRORS, OMISSIONS, CHANGE OF PRICE, RENTAL OR OTHER TERMS; ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT NOTICE. WE RESERVE THE RIGHT TO CONTINUE SIMULTANEOUS NEGOTIATIONS WITH OTHER PARTIES ON BEHALF OF OUR CLIENT. NO PARTY SHALL HAVE ANY LEGAL RIGHTS OR OBLIGATIONS WITH RESPECT TO ANY OTHER PARTY, AND NO PARTY SHOULD TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION IN DETRIMENTAL RELIANCE ON THIS OR ANY OTHER DOCUMENT OR COMMUNICATION UNTIL AND UNLESS A DEFINITIVE WRITTEN LEASE AGREEMENT IS PREPARED AND SIGNED BY TENANT AND LANDLORD

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

Persons to own a 5% or greater ownership interest in Cowell Dialysis, LLC are listed in the table below.

Name	Address	City	State	Ownership Interest
DaVita Inc.	1551 Wewatta Street	Denver	CO	51%
Zoa Associates, Inc. (wholly owned by Ogbonnaya Aneziokoro, M.D.)	655 West Irving Park Road, Apt. 2101	Chicago	IL	27%
Sinai Health System	California Avenue at 15 th Street	Chicago	IL	22%

File Number 0365448-6



To all to whom these Presents Shall Come, Greeting:

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

COWELL DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON SEPTEMBER 15, 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 #: 1130801376

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 4TH day of NOVEMBER A.D. 2011

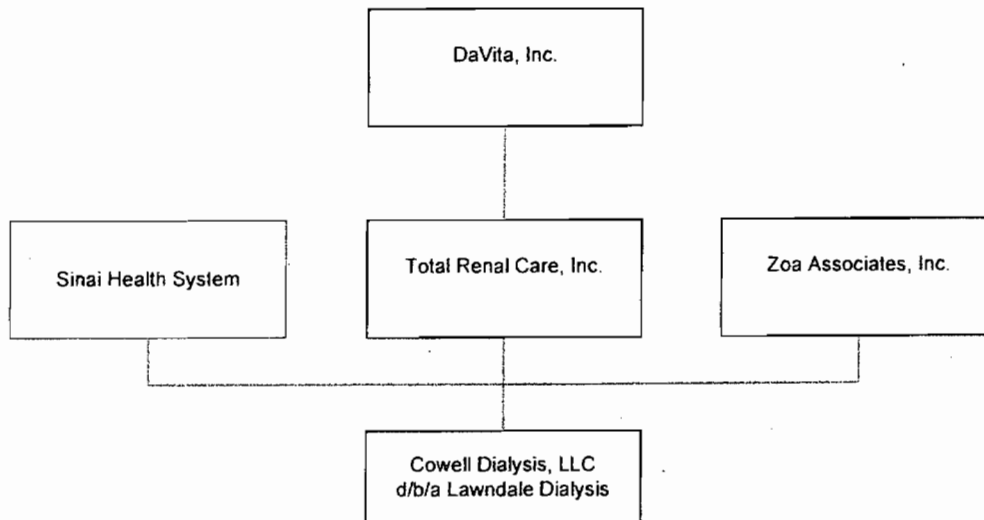
Jesse White

SECRETARY OF STATE

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

The organizational chart for DaVita Inc. and Cowell Dialysis, LLC is attached at Attachment – 4.

Lawndale Dialysis Organizational Chart

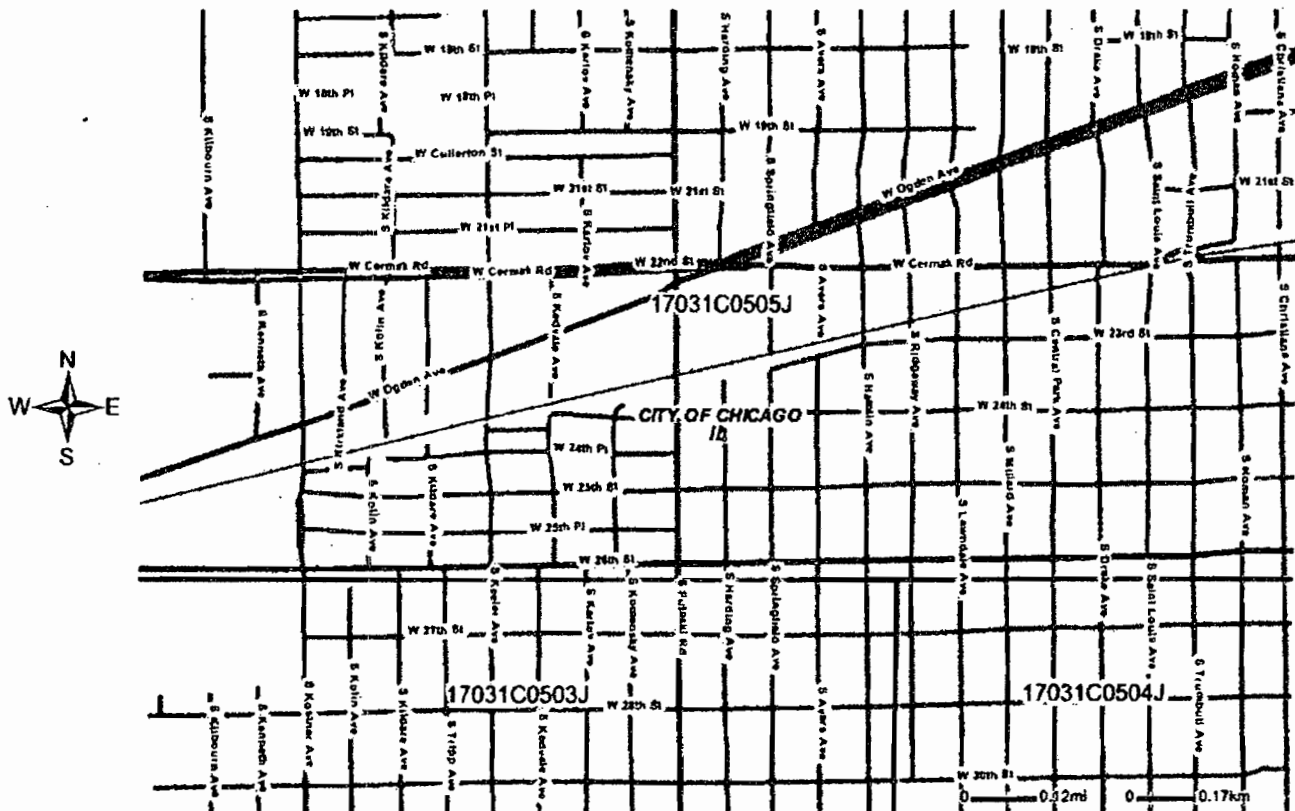


Section I, Identification, General Information, and Certification
Flood Plain Requirements

The site of the proposed dialysis facility complies with the requirements of Illinois Executive Order #2005-5. The proposed dialysis facility will be located at 3934 West 24th Street, Chicago, Illinois 60623. As shown on the FEMA Flood Insurance Rate Map, Map Index at Attachment – 5, this area is located on panel 17031C0505J. This is a non-printed panel with no special flood hazard area identified.

Mapping Information Platform

3934 W 24th St., Chicago, IL
60623



Legend

Cities Other Place Small Towns Small Cities State Largest Cities Major Cities Completed LOMBAs LOMBAs DP/RS Panels Bench Marks General Structures Coasts Four Bridges Dams Levees Wing Walls Base Flood Elevation (cont)	OFE with ROW/RS datum OFE with HANDS datum OFE with other datum Cross Section Lines Cross Section with ROW/RS datum Cross Section with HANDS datum Cross Section with other datum Political Jurisdiction DP/RS Streets PRIMARY ROAD SECONDARY ROAD RAILROAD OTHER ROAD Streams Water Body Floodways Flood Hazard Zones (cont)	Zone A Zone AE Zone AH Zone AO Zone AR Zone AS Zone V Zone VE Zone D GPM Annual Chance Flood Hazard Zone Streets Streets Major Roads Highways Major Highways Streets Lakes, Major Rivers	Land Areas US Other Countries
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Monday, 24 October 2011 21:38



FEMA

Attachment - 5



FEMA

Map Service Center

[Log on](#)

[Home](#) > [Map Search Results](#)

Map Search Results

Non-printed Panel(s)

17031C0505J

17031C

COOK CO UNINC %26 INC AREAS

FBMA Map Service Center, P.O. Box 3617 Oakton, Virginia 22124-9617 Phone: (877) 336-2627

Adobe Acrobat Reader required to view certain documents. [Click here to download.](#)

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

A copy of the determination that the proposed location is compliant with the Historic Resources Preservation Act from the Illinois Historic Preservation Agency is attached at Attachment – 6.



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

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

Cook County
Chicago

CON - Establish a 16-Station Dialysis Facility
3934 W. 24th St.
IHPA Log #004102611

RECEIVED

NOV 14 2011

HEALTH FACILITIES &
SERVICES REVIEW BOARD

November 9, 2011

Anne Cooper
Polsinelli Shughart
161 N. Clark St., Suite 4200
Chicago, IL 60601

Dear Ms. Cooper:

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

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

Table 1120.110			
Project Cost	Clinical	Non-Clinical	Total
Modernization Contracts	\$940,600		\$940,600
Contingencies	\$140,000		\$140,000
Architectural/Engineering Fees	\$52,800		\$52,800
Consulting and Other Fees	\$75,000		\$75,000
Moveable and Other Equipment			
Communications	\$64,125		\$64,125
Water Treatment	\$116,930		\$116,930
Bio-Medical Equipment	\$8,885		\$8,885
Clinical Equipment	\$250,535		\$250,535
Clinical Furniture/Fixtures	\$20,179		\$20,179
Lounge Furniture/Fixtures	\$2,815		\$2,815
Storage Furniture/Fixtures	\$5,359		\$5,359
Business Office Fixtures	\$22,925		\$22,925
General Furniture/Fixtures	\$21,455		\$21,455
Signage	\$12,500		\$12,500
Total Moveable and Other Equipment	\$525,708		\$525,708
Net Interest Expense During Construction (Project Related)	\$37,363		\$37,363
Fair Market Value of Leased Space	\$1,374,469		\$1,374,469
Total Project Costs	\$3,145,940		\$3,145,940

Section I, Identification, General Information, and Certification
Cost Space Requirements

Cost Space Table							
Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	\$3,145,940	6,781			6,781		
Total Clinical	\$3,145,940	6,781	0	0	6,781	0	0
NON REVIEWABLE							
Total Non-Reviewable	\$0	0	0	0	0	0	0
TOTAL	\$3,145,940	6,781	0	0	6,781	0	0

Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.230(a) – Background, Purpose of the Project, and Alternatives

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. For this project, DaVita has partnered with key stakeholders, Dr. Aneziokoro, who has committed his practice to the Little Village and Lawndale communities, and one of the anchor safety net hospitals in the community, Mt. Sinai Hospital. The proposed project involves the establishment of a 16-station dialysis facility to be located at 3934 West 24th Street, Chicago, IL 60624.

DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and empowering patients, and community outreach. A copy of DaVita's 2012 Community Care report, some of which is outlined below, details DaVita's commitment to quality, patient centric focus and community outreach is attached as Attachment – 11A.

Mt. Sinai Hospital is an integral safety net providers in the Lawndale community and the City of Chicago, annually providing over \$90 million in community benefits, including charity care, subsidized health services, language assistance, education, research, donations and volunteer services.

Mt. Sinai Hospital is a national and regional leader in innovative, community-based health improvement programs. Mt. Sinai Hospital is one of four designated Level I trauma (the highest level of care) centers in the City of Chicago. The Joint Commission recently designated Mt. Sinai Hospital as a Primary Stroke Center. Further, Mt. Sinai Hospital operates a Level III Neonatal Intensive Care Unit Center (the highest level of care for fragile newborns) and a Pediatric Intensive Care Unit, which provides specialized care for children with serious or life-threatening injuries or illnesses. In 2003, the State of Illinois recognized Mt. Sinai Hospital's pediatric services as a "Children's Hospital within a Hospital."

In addition to being a safety net provider of health care services to Chicago's West Side, Mt. Sinai Hospital also focuses on the needs of the surrounding community. It founded the Sinai Urban Health Institute (SUHI) in March 2000 to pursue its public health goals through data-driven evidence. SUHI's mission is to understand not only patients but the entire community to better serve its neighbors. Through this organization, Mt. Sinai Hospital has undertaken many local initiatives to confront several public health issues, including obesity and diabetes. SUHI has developed health profiles for the Lawndale communities in Chicago, which is a primary community that Mt. Sinai Hospital serves.

SUHI's Block by Block North Lawndale Diabetes Community Action Program focuses on building community strengths to increase early detection of diabetes and enhance self-management by those suffering from the disease. The program seeks to support residents in changing the culture within North Lawndale to make diabetes (and health in general) a neighborhood priority and to impact the environment to support healthier lifestyles. See Attachment – 11B.

The Humbolt Park Diabetes Task Force was developed to identify people with diabetes and effectively address diabetes prevalence in the Humbolt Park neighborhood.

West Rogers Park Obesity Intervention targets childhood obesity in the West Roger's Park neighborhood by awarding grants to schools to purchase physical education equipment and educational materials.

Preventive programs like these are vital to improving community health. Mt. Sinai Hospital and DaVita recognize, however, that it is equally important to ensure access to medical services for those individuals who can no longer benefit from preventive services.

DaVita has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and end stage renal disease ("ESRD"). These programs include the EMPOWER, IMPACT,

CathAway, and transplant assistance programs. Information on the EMPOWER, IMPACT and CathAway programs are attached at Attachment – 11C.

There are over 26 million patients with CKD and that number is expected to rise. Current data reveals two troubling trends which help explain the growing need for dialysis services:

- The prevalence of identified CKD stages 1 to 4 has increased from 10% to 15.1% between 1988 and 2008¹
- CKD affects approximately 1 in 10 people over the age of 20
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD²
 - 35.6% of U.S. adults are obese and this number is expected to grow to 42% by 2030.
 - 8.3% or 25.8 million people in the U.S. suffer from diabetes and another 79 million are pre-diabetic.
 - One third of U.S. adults have high blood pressure and another 30% have pre-hypertension.

Additionally, DaVita's EMPOWER program helps to improve intervention and education for pre-ESRD patients. Approximately 65-75% of CKD Medicare patients have never been evaluated by a nephrologist.³ Timely CKD care is imperative for patient morbidity and mortality. Adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may result in improved patient outcomes and reduce ESRD:

- Reduced GFR is an independent risk factor for morbidity and mortality,
- A reduction in the rate of decline in kidney function upon nephrologists referrals has been associated with prolonged survival of CKD patients,
- Late referral to a nephrologist has been correlated with lower survival during the first 90 days of dialysis, and
- Timely referral of CKD patients to a multidisciplinary clinical team may improve outcomes and reduce cost.

A care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Through the EMPOWER program, DaVita offers educational services to CKD patients that can help patients reduce, delay, and prevent adverse outcomes of untreated CKD. DaVita's EMPOWER program encourages CKD patients to take control of their health and make informed decisions about their dialysis care.

To extend DaVita's CKD education and awareness programs to the Spanish-speaking population, DaVita launched its Spanish-language website (DaVita.com/Espanol) in November 2011. Similar to DaVita's English-language website, DaVita.com/Espanol provides easy-to-access information for Spanish-speaking kidney care patients and their families, including educational information on kidney disease, treatment options, and recipes.

¹ US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011.

² Int'l Diabetes Found., *One Adult in Ten will have Diabetes by 2030* (Nov. 14, 2011), available at <http://www.idf.org/media-events/press-releases/2011/diabetes-atlas-5th-edition>.

³ US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011.

DaVita consistently raises awareness to community needs and makes cash contributions to organizations aimed at improving access to kidney care. In 2010, DaVita donated more than \$2 million to kidney disease- awareness organizations such as the Kidney TRUST, the National Kidney Foundation, the American Kidney Fund, and several other organizations. Its own employees, or members of the "DaVita Village," assisted in these initiatives by raising more than \$4.1 million through Tour DaVita and DaVita Kidney Awareness Run/Walks. Furthermore, DaVita committed \$1.5 million in 2011 for its teammates to put toward charitable donations in their communities.

DaVita does not limit its community engagement to the U.S. alone. It founded Bridge of Life, a 501(c)(3) nonprofit organization that operates on donations to bring care to those for whom it is out of reach. In addition to contributing Dialysis equipment to DaVita Medical Missions, Bridge of Life has accomplished 24 Missions since 2006, with more than 150 participating teammates spending more than 650 days abroad to increase capacity to provide dialysis to almost 700 individuals each year. It provided these desperately needed services in Cameroon, India, Ecuador, Guatemala, and the Philippines, and trained many health care professionals there as well.

Neither the Centers for Medicare and Medicaid Services or the Illinois Department of Public Health has taken any adverse action involving civil monetary penalties or restriction or termination of participation in the Medicare or Medicaid programs against any of the applicants, or against any Illinois health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

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

A list of health care facilities owned or operated by the Applicants in Illinois is attached at Attachment – 11D.

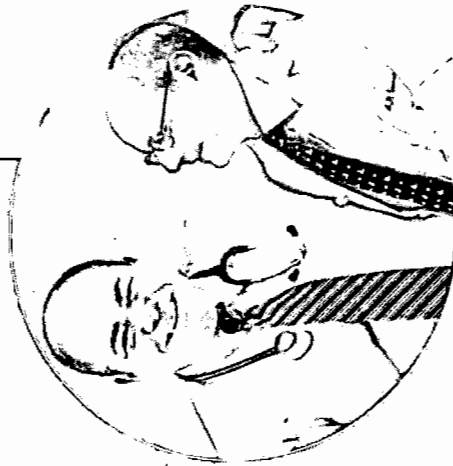
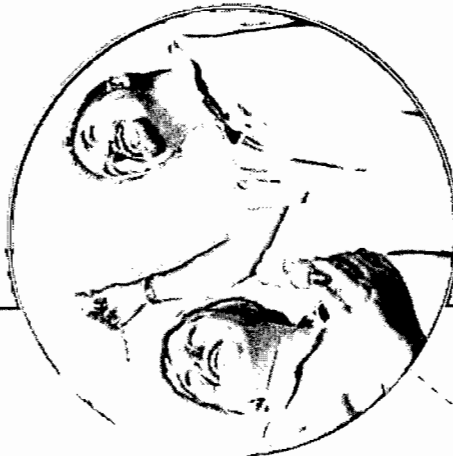
Dialysis facilities are currently not subject to State Licensure in Illinois.

2. Certification that no adverse action has been taken against either of the Applicants or against any health care facilities owned or operated by the Applicants in Illinois within three years preceding the filing of this application is attached at Attachment – 11E.
3. An authorization permitting the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment – 11E.



::: COMMUNITY CARE :::

The DaVita Vision for Social Responsibility



2011



:: OUR MISSION ::

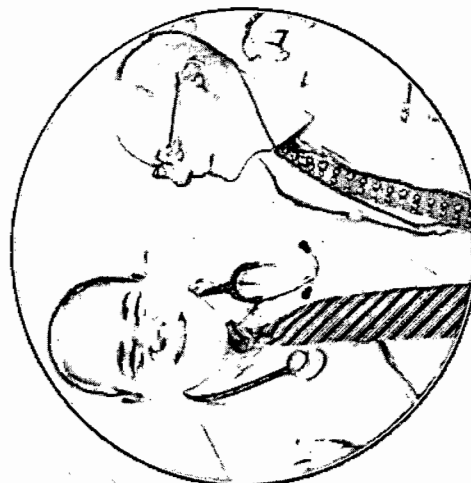
To be the Provider, Partner
and Employer of choice

:: OUR CORE VALUES ::

Service Excellence | Integrity | Team
Continuous Improvement | Accountability
Fulfillment | Fun

:: OUR VISION ::

To Build the Greatest Healthcare
Community the World Has Ever Seen



:: OUR TRILOGY OF CARE ::

CARING FOR OUR PATIENTS | CARING FOR EACH OTHER | CARING FOR OUR WORLD



bringing quality to life®



In 2011, after a yearlong process in which thousands of teammates (employees) discussed and voted on it, DaVita® unveiled its new vision of building the “Greatest Healthcare Community the World Has Ever Seen.” One year later, having launched dialysis centers in five new countries and as we look toward joining forces with Healthcare Partners, we are taking definitive steps toward achieving what we think that means—creating a distinctively positive model for integrated, accessible, sustainable and affordable healthcare.

The Community Care report, now in its fourth edition, reflects the groundwork we’re laying today to operate responsibly tomorrow, as the “DaVita Village” grows into new neighborhoods and touches more lives.

We strive to behave as a community first and a company second. That means creating a legitimately differentiated workplace where the mission and values live with unusual relevance and energy. We do this for many reasons; in particular, because we are unwilling to make the concession that the time that teammates spend at work should be less fulfilling and less satisfying than what they choose to do in their spare time. Just as important, we believe it has a powerful effect on the care we give to our 145,000-plus patients—and nearly 700,000 patients in the case of Healthcare Partners—and on how our teammates interact with the communities where they live and work.

Within the last year, we implemented several new social initiatives, including the DaVita Way of Giving, a nation-wide fund from which teammates can make charitable contributions in their local communities; a partnership with a major city school system, to design leadership-development programs for faculty; and the publication of DaVita’s environmental goals for our U.S. operations through the end of 2015. You can read more about these and other new and existing programs in these pages.

We are committed to building a sustainable global community and strive to improve the quality of every life we touch.

One for All, and All for One!

Kent J. Thiry
Chairman and CEO of DaVita Inc.
Mayor of the DaVita Village

::: COMMUNITY CARE :::

The DaVita Vision for Social Responsibility

☐ CARING FOR OUR PATIENTS

- :: Leading clinical outcomes & innovation
- :: Integrating care to treat the whole patient
- :: Empowering patients through education
- :: Appreciating our patients

8

☐ CARING FOR EACH OTHER

- :: Developing frontline leaders
- :: Building a culture of caring
- :: Encouraging diversity
- :: Listening to our teammates

18

☐ CARING FOR OUR WORLD

- :: Raising awareness
- :: Home-state community engagement
- :: Giving back
- :: Sending forth ripples: inspiring leadership
- :: Bringing dialysis to global communities
- :: Operating sustainably
- :: Generating taxpayer savings
- :: Pioneering governance & compliance standards

28

95% of waste at DaVita corporate headquarters is diverted through composting and recycling programs.

DaVita has achieved industry-leading clinical outcomes that have improved for 12 consecutive years. By doing so, we are helping our patients feel better and enabling them to live fuller lives.

The Women's Vision Foundation recognized DaVita with the 2011 Corporate Vision Award for our innovation and leadership in supporting and advancing women in their careers.

THE DAVITA STORY

We're a community first, and a company second—that's the foundation of our DaVita Village. We do dialysis, but we are not about dialysis. We are about the lives of our patients, teammates (employees) and partners, and the communities in which we operate.



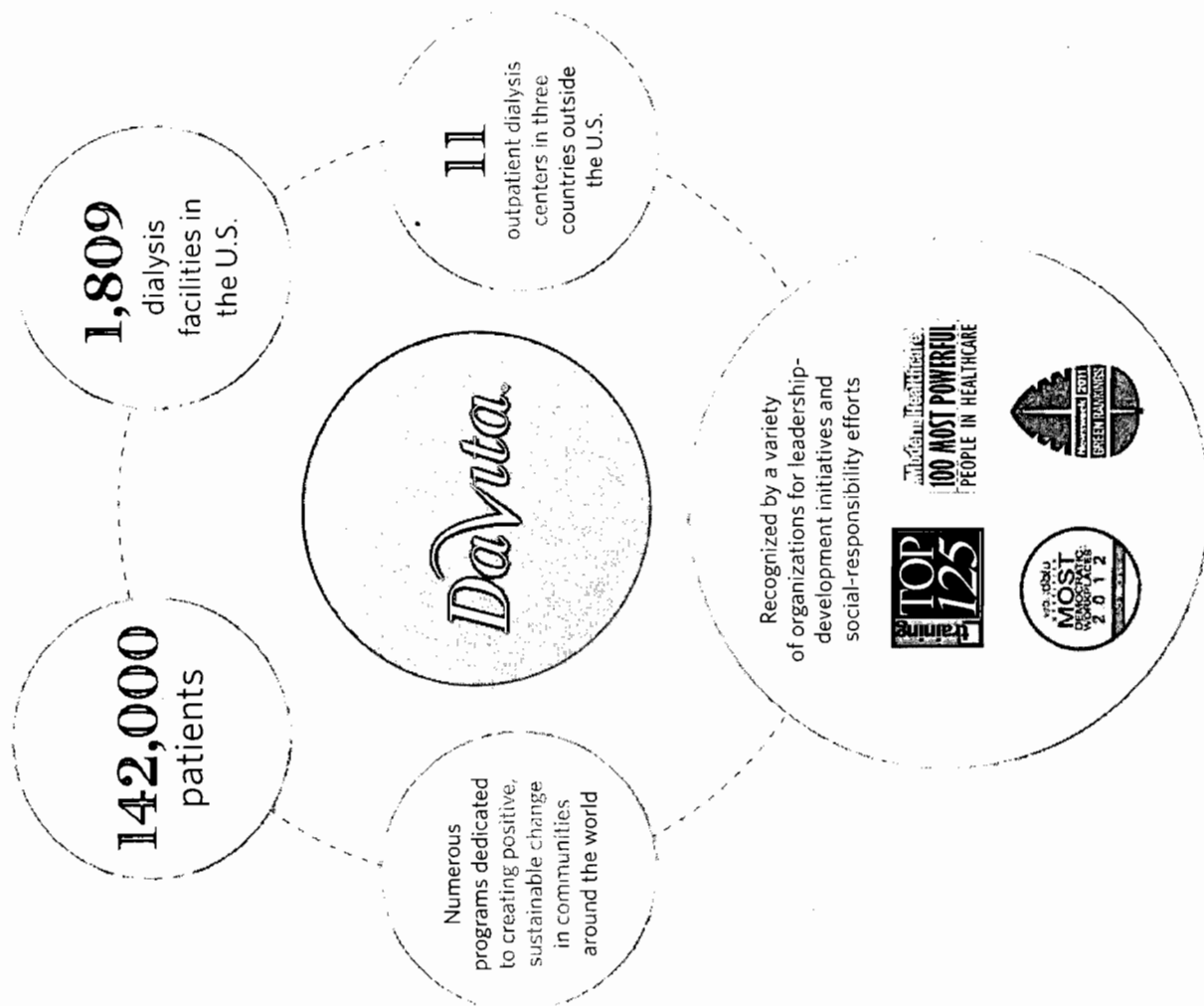
Our integrated approach to kidney care goes beyond delivering industry-leading clinical outcomes. We understand that quality kidney care also means providing multiple treatment options, educational tools, medication management tools and other value-added services that help patients live the best lives they can. We believe that this approach is helping shape the future of kidney care.

As a leading provider of kidney care services, DaVita aims to:

- Improve the quality of life for those diagnosed with chronic kidney disease (CKD)
- Innovate and add value to kidney care:
 - Raise awareness about kidney disease
 - Help to prevent or delay kidney failure
 - Increase access to care
- Be a role model for American healthcare:
 - Conserve healthcare dollars by developing models and systems for improvement that may be used in other chronic-disease populations
 - Offer convenient health-management services
 - Advance integrated care
 - Provide patients with personalized care teams
- Send out ripples of our community philosophy:
 - Develop charitable initiatives to benefit our local communities
 - Create positive, sustainable change in communities around the world
 - Promote both personal and professional leadership development within our organization and beyond

OUR TEAMMATES
WORKED DEMOCRATICALLY
TO NAME OUR COMPANY
AND DETERMINE OUR
CORE VALUES.

"DAVITA" IS DERIVED FROM THE
ITALIAN WORDS FOR "GIVING LIFE."



As of December 31, 2011

ABOUT CHRONIC KIDNEY DISEASE

A silent epidemic, chronic kidney disease (CKD) affects approximately one in 10 people over the age of 20 in the United States—yet most are unaware of their condition until it progresses to kidney failure, or end stage renal disease (ESRD).

58

ESRD occurs when kidneys are no longer able to perform their many important functions fully and require transplantation or dialysis to:

- Remove extra water and waste from the body
- Help control blood pressure
- Keep body chemicals in balance
- Maintain healthy bones
- Aid in making red blood cells

See page 30 for more information about how Tour DaVita® and DaVita Kidney Rock™ are raising awareness about kidney disease.

CKD affects
~20 million
U.S. residents.

Currently there are
approximately 400,000
individuals living in the
United States that have
been diagnosed with end
stage renal disease.*

The Centers for Disease
Control and Prevention
recognizes CKD as a major
public-health problem that
reduces the quality and
length of life.

2011 United States
Renal Data System
Annual Report (2009 data)

CKD RISK FACTORS

DIABETES AND
HYPERTENSION

#1 and #2
causes of kidney
disease, respectively.

LESS-COMMON CAUSES:
Polycystic kidney disease | Pylonephritis
Glomerulonephritis | Long-term use of
medicines that can damage the kidneys



AFRICAN
AMERICANS

2X

National surveys suggest that
over the past 35 years, the
occurrence of diabetes has
doubled in African Americans.

33%

African Americans make up only
about 13% of the U.S. population,
yet constitute 33% of patients
treated for kidney failure.

1 IN 3

One-third of the African
Americans with diabetes are
unaware they have the disease.



HISPANIC
AMERICANS

2X

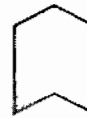
Hispanic American adults are
twice as likely as their non-Hispanic
white American counterparts to
develop type 2 diabetes.

1 IN 3

1 in 3 American Indians has
diabetes, which puts them at risk.



AMERICAN
INDIANS

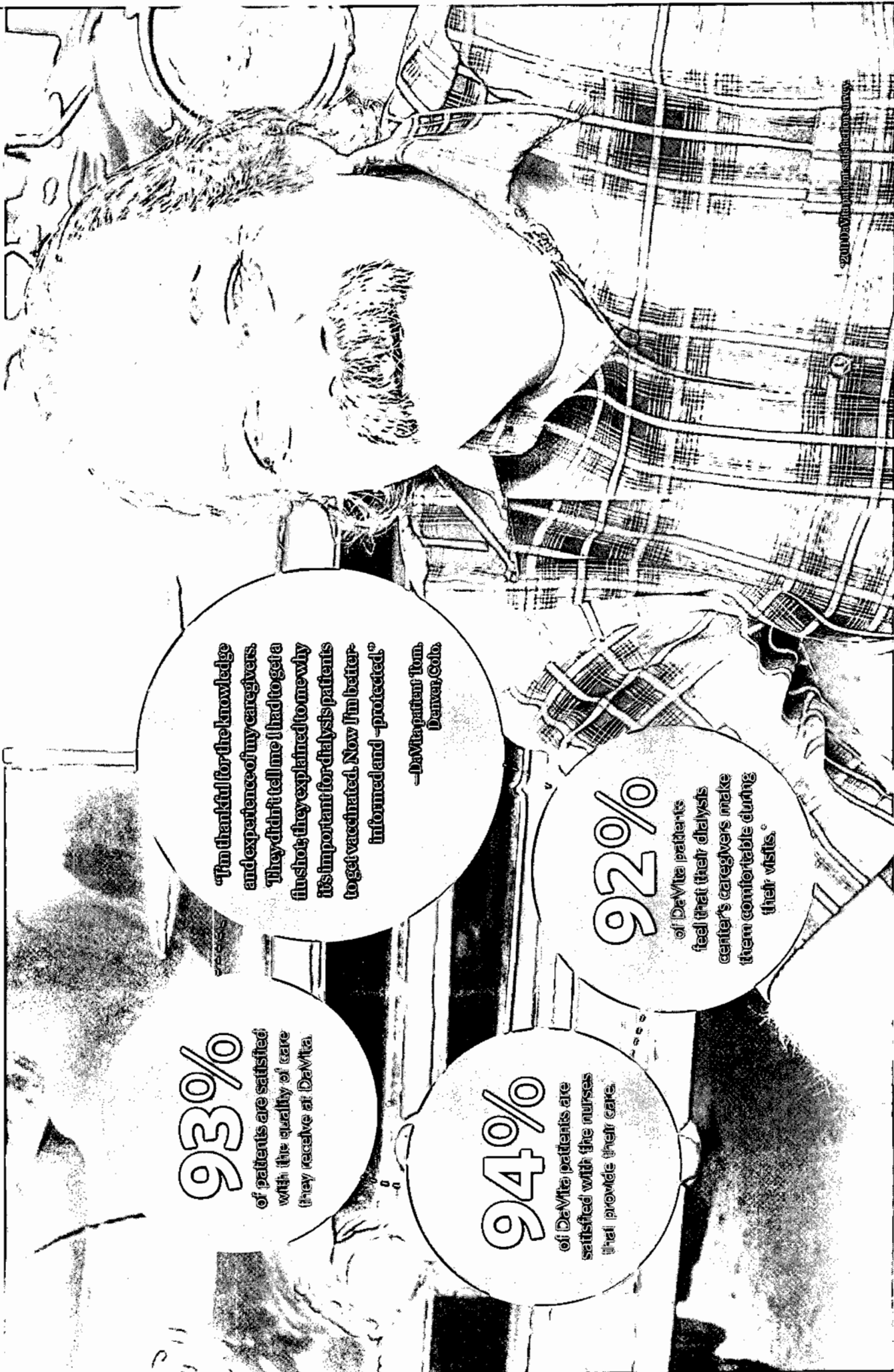


To learn your risk of CKD, visit DaVita.com/KidneyAware

:: CARING FOR OUR PATIENTS ::

DaVita takes an integrated and individualized approach to kidney care. Providing treatment options that offer choice, comfort and convenience helps patients continue to lead the lives they knew before dialysis.





93%

of patients are satisfied with the quality of care they receive at DaVita.

94%

of DaVita patients are satisfied with the nurses that provide their care.

92%

of DaVita patients feel that their dialysis center's caregivers make them comfortable during their visits.*

"I'm thankful for the knowledge and experience of my caregivers. They didn't tell me I had to get a flu shot; they explained to me why it's important for dialysis patients to get vaccinated. Now I'm better-informed and -protected."

-DaVita patient Tom,
Denver, Colo.

*2009 National Patient Satisfaction Survey



Leading Clinical Outcomes and Innovation

As a result of our continuous innovation, we achieve industry-leading clinical outcomes that have improved for 12 consecutive years. By doing so, we are helping our patients feel their best and enabling them to live fuller lives.

- **Anemia:** Our ability to manage patients' anemia has improved year over year and currently leads the industry.
- **Nutrition:** Our management of nutrition (albumin) and mineral and bone disease (calcium and phosphorus) leads the industry.
- **Vaccinations:** DaVita's pneumococcal pneumonia and influenza vaccination rates—both 91% in 2011—lead the industry.
- **Dialysis Adequacy:** Dialysis adequacy (Kt/V, the measure of how well toxins are removed from the blood) has improved by 60% in the last 12 years.
- **Overall Performance:** The Centers for Medicare & Medicaid Services ranked 76% of DaVita clinics in the top ESRD-performance tier, significantly better than the rest of the industry.*

Sources: National 2009 and Trends Plus Report, 2010 United States Renal Data System Annual Data Report (2008 data), Outcomes Plus, Angen

*Centers for Medicare & Medicaid Services (CMS) Quality Incentive Program Performance Measures

We have

improved our patients
fistula-adoption rate by

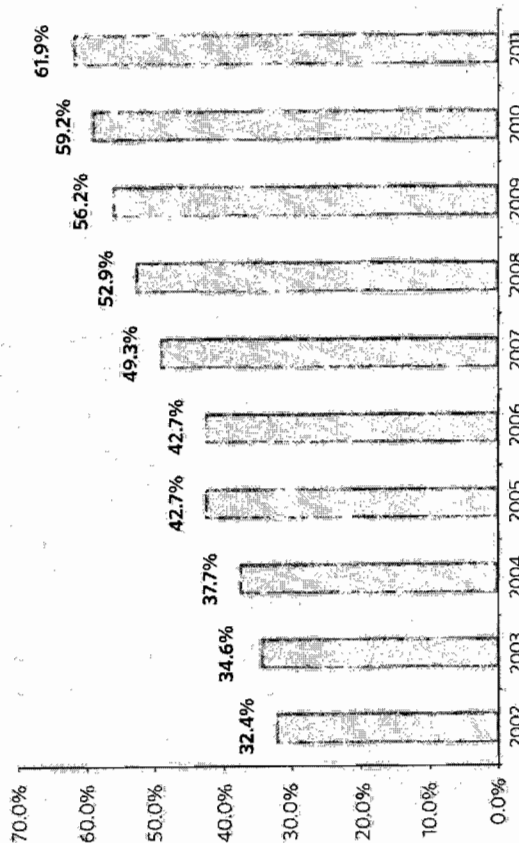
91%

over the last 10 years.

At the end of 2011, 61.9%
of DaVita patients were
using fistulas.

DaVita's CathAway™ program helps transition patients from catheters to fistulas, reducing the risk of hospitalization from infections and blood clots.

By the end of 2011, only 15.4% of DaVita patients who had been on dialysis for more than 90 days were still using their typically hospital-given catheters as their form of vascular access—our best outcomes to date.



FISTULAS IN USE

The DaVita Quality Index (DQI), a proprietary benchmarking tool that compares clinical performance among all DaVita facilities, has shown 12 consecutive years of improvement. As DQI scores have improved, mortality and hospitalizations have decreased.

DaVita Clinical Research® (DCR®) is one of the largest kidney-research networks in the U.S. and offers services across the entire drug-development life cycle, from Phase 1 clinical trials to health-economics and outcomes studies. In 2011, DCR had 1,900 patients enrolled in clinical trials to advance kidney care and save taxpayer dollars.

Our IMPACT™ care-management program for the first three months of dialysis, when patients are at highest risk for serious and potentially fatal complications, is improving outcomes and reducing mortality rates during this critical transition.

Integrating Care to Treat the Whole Patient

By advancing an integrated care model that treats patients' unique health conditions individually and holistically, DaVita aims to improve patients' total health and quality of life—not just replace kidney function.

MEDICATION MANAGEMENT

DaVita Rx®, DaVita's specialized pharmacy program, focuses on the unique needs of dialysis patients. The first and largest renal pharmacy, DaVita Rx was started in 2005 to improve patient access to medications and give clinicians information that allows for better patient care. DaVita Rx addresses common barriers to ESRD medication adherence. Multiple studies suggest that focused attention on medication management in the ESRD population can lower hospitalizations and reduce total care costs.

Compared to patients using other pharmacies, DaVita Rx patients experience*:

- 50% better adherence to their prescribed therapies.
- 40% fewer hospitalizations

LIFELINE VASCULAR ACCESS®

Lifeline Vascular Access, a DaVita affiliate, is the nation's leading provider of ESRD vascular access management. Managing ESRD patients' vascular access is critical to reducing hospitalization and mortality rates.

- Innovative early-intervention business model
- >500,000 procedures performed by physicians in more than 60 facilities across the U.S. and Puerto Rico
- Better clinical outcomes and increased patient satisfaction at lower costs than hospitals:
 - 98% overall procedure success rate in 2011
 - 93% of patients rated their overall experience as very good or excellent



DaVita Rx pharmacy works closely with physicians and coordinates with dialysis clinic care providers to develop comprehensive strategies for improving patient adherence to their prescribed regimen.

*Data is correlated based on a two-year study. National Renal Access Study (1981). Independent sample t-test and chi-square (42). Results are statistically significant at the p < 0.05 level.



DISEASE MANAGEMENT

In 2011, more than 6,600 CKD and ESRD patients relied on DaVita VillageHealth®—one of the nation's leading integrated kidney disease management organizations—to help manage their healthcare. VillageHealth has achieved:

↓ 15%
lower year-one mortality
rate over a three-year period*



90%
influenza vaccination
rates among members

↓ 14%
lower nondialysis costs
for ESRD care*

↓ 69%
reduction in catheter
(CVC) use in a patient's
first 12 months



91%
pneumococcal vaccination
rates among members

↓ 31%
fewer hospital readmissions
compared to the Medicare benchmark*

*Statistics are from the California ESRD Program.

Empowering Patients through Education

DaVita provides some of the most comprehensive kidney disease education tools available to help patients take control of their health and make better choices to enrich their lives.

DAVITA.COM

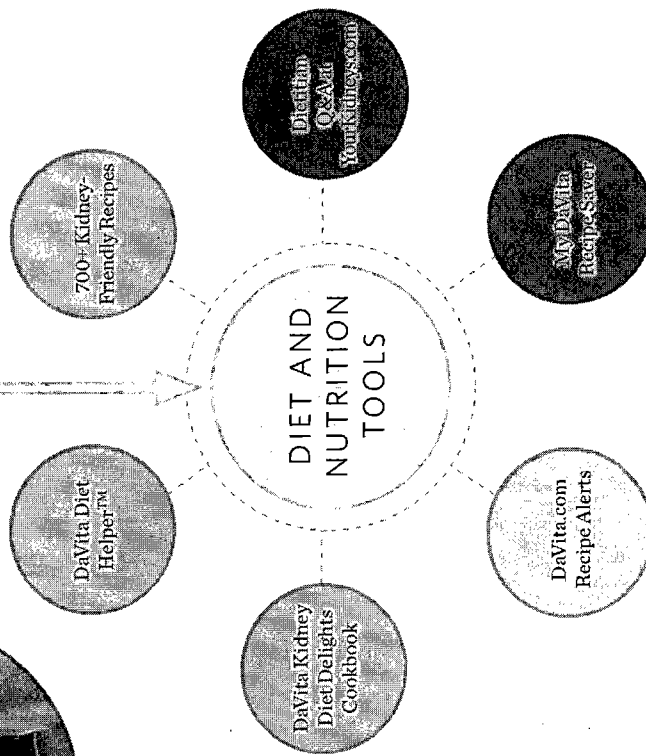
DaVita's award-winning website is one of the most popular online destinations for CKD education and resources. Redesigned in 2011 to be easier to navigate and more comprehensive than ever, it's an invaluable no-cost resource for kidney care patients (regardless of the provider they choose) and their caregivers.

DaVita's new Spanish-language website, DaVita.com/Espanol, provides easy-to-access information for Spanish-speaking patients and their families.

Hispanic populations have an increased risk of developing kidney disease and represent 11 percent of all new CKD patients in the U.S.



Following a kidney-friendly diet can help patients feel healthier, have fewer complications and slow the decline of residual kidney function.



MYDAVITA.COM

This robust social-networking component of DaVita.com encourages dialysis patients to connect with caregivers and fellow patients for friendship and support, to share personal stories about kidney health, and to save recipes and articles.

Go to MyDaVita.com to register.

DAVITA DIET HELPER™

This online kidney-related diet-management tool has empowered thousands of patients, healthcare professionals and care partners to:

- Plan meals according to patient prescriptions.
- Make shopping lists.
- Check daily nutritional levels.
- Print food records for dietitian visits.

DAVITA KIDNEY SMART™

In 2011, we revamped our longstanding CKD educational program to make it more accessible than ever. DaVita Kidney Smart aims to give people with CKD who have not yet started dialysis the information they need to make healthy choices and slow the progression of their disease, all at no cost to them.

- 1,000 instructor-led classes offered in neighborhoods across the country.
- Kidney Smart Magazine, a comprehensive overview of how kidneys function, choosing a healthcare team and diet and medication management.
- DaVita Kidney Diet Delights Cookbook.
- CKD videos at KidneySmart.org.

YOURKIDNEYS.COM

This user-friendly website answers questions and provides a community to patients newly diagnosed with CKD. The site's Expert Q&A gives visitors direct access to nurses, dietitians, social workers and physicians.



To help nephrologists stay informed and connected, DaVita launched NephLink™, a source for news, research and nephrology contacts.

Appreciating Our Patients

Dialysis patients have frequent contact with their healthcare providers, typically at least three times per week. Caring for our patients like family and making them feel at home while dialyzing at our centers is all part of how DaVita strives to improve their quality of life.

DAVITA VILLAGE GREETERS

More than 1,000 volunteers—often fellow patients or their family members—serve as Village Greeters to welcome patients entering our dialysis centers.

WALL OF FAME

Our annual Wall of Fame contest encourages patients and teammates to creatively showcase their pictures and fun facts. In 2011, more than 1,200 centers participated and more than 82,000 participants got to know each other a little better.

THE DAVITA CIRCLE OF LIFE

The DaVita Circle of Life program helps patients and teammates address life-planning and end-of-life issues, and honors deceased patients both locally and nationally.

- Centers perform memorial traditions when a patient from their center dies, and DaVita makes a donation to a nonprofit charity in honor of the deceased.
- DaVita holds an annual nationwide memorial service for patients who passed away during the year.



92%

of DaVita patients
feel that their dialysis
center's care team really
cares about them.*

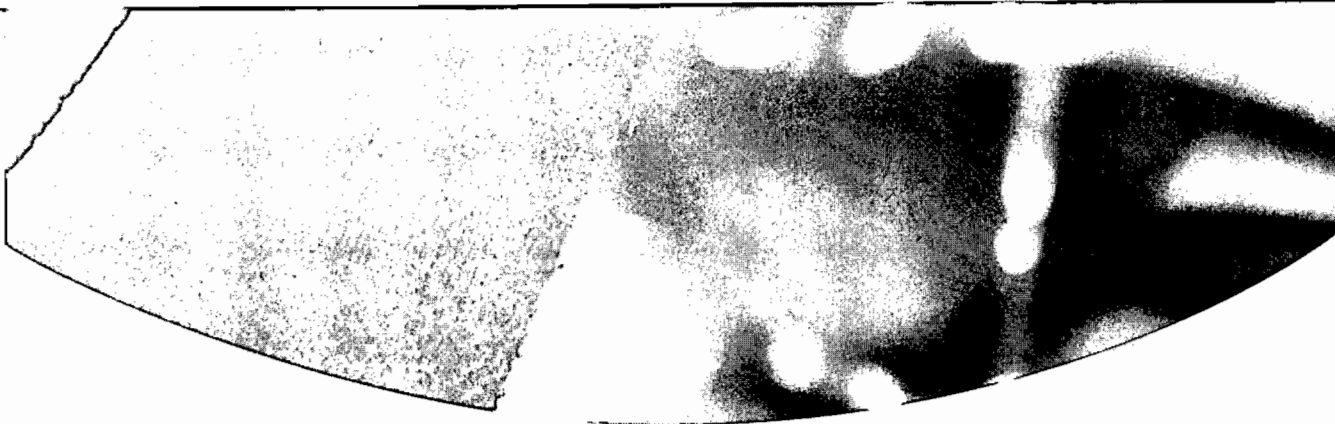
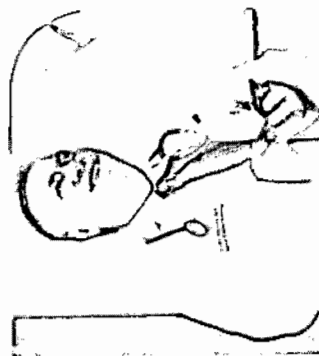
DaVita leads the industry
in offering home dialysis
options that can help
patients feel healthier,
keep their jobs and be
more active.

We offer secure Wi-Fi
at our clinics so patients
can stay connected
with the office and
their friends while
undergoing treatment.

© 2011 DaVita patient satisfaction survey

:: CARING FOR EACH OTHER ::

Nurturing ourselves better equips us to nurture our patients. This philosophy inspires our award-winning leadership-development programs, open communication channels, scholarships and financial assistance for teammates in times of need.



Daviita has been
recognized as the #1
national healthcare service
provider for employee
training programs
on Training Magazine's Top
125 list for eight consecutive
years (2005-2012).

Teammates voted
Daviita among the

**10 best
employers**

in Colorado, and among
the 10 Best Places to Work
in Denver, in 2010 and 2011.

Through teammate
payroll donations and
Daviita matching, the
Daviita Village Network
has awarded more than
\$1.9 million to 220
teammates in need.

Developing

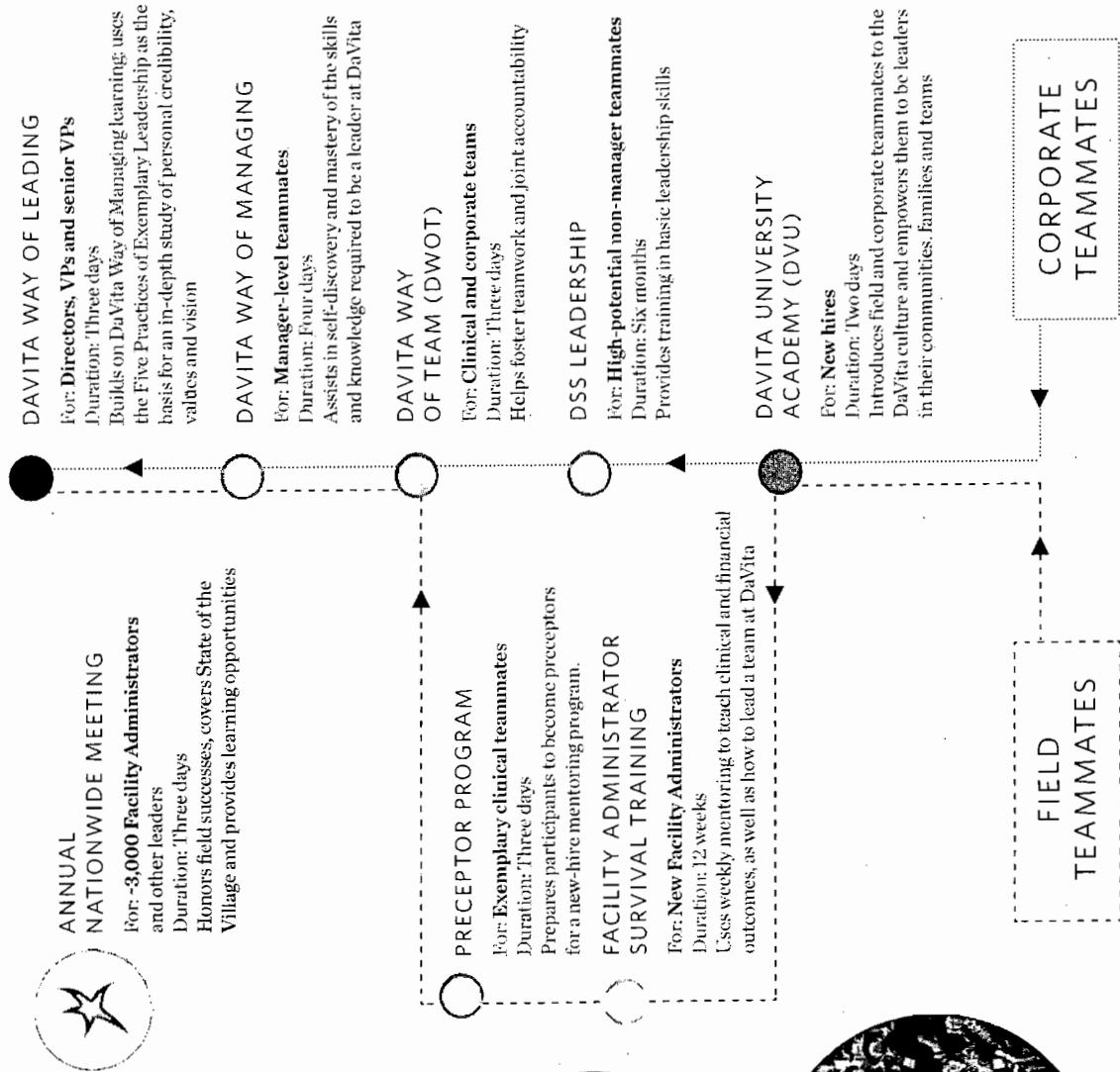
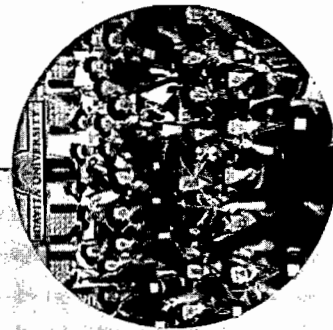
Frontline Leaders

We offer our teammates an array of opportunities to grow through DaVita University's multi-tiered training and advancement program.

Our training sequence encourages advancement throughout our Village—from new frontline teammates to seasoned leaders.

The results of our training program are dramatic: Over the years, attendees have had a 23% lower attrition rate than non-attendees.

DaVita's turnover rate fell 17% year over year, from 25% in 2010 to 19% in 2011.



Beyond the Classroom

Management is a business skill, but leadership is a human skill. One way we try to help our executives be better and more-compassionate leaders is through our Reality 101 clinic-immersion program. All new executives are required to attend Reality 101, which exposes them to the broad range of challenges our clinical teammates face on a daily basis.

immersion program. All new executives are required to attend Reality 101, which exposes them to the broad range of challenges our clinical teammates face on a daily basis.

- Illuminates the intellectual, physical and emotional demands faced by kidney care clinicians
- Gives insight into the rigors of the dialysis experience for patients
- Inspires a more empathetic—and therefore more effective—approach to leadership



In 2011, 32,000 teammates were trained in classrooms or online.

Including promotions and lateral moves, 5,850 teammates changed jobs within DaVita in 2011.



REDWOODS LEADERSHIP DEVELOPMENT PROGRAM

A leadership-oriented program recognized by top undergraduate and business schools around the country.

Nearly 500 teammates have used the Redwoods Leadership Development Program to grow within the company.

- MBA scholarships
- Internships
- Classroom training
- Intensive job-shadowing experiences

Building a Culture of Caring

In a community, citizens share each other's triumphs and struggles. Whether by helping a teammate's child through school, rewarding teammates' healthy choices, or being a safety net in times of crisis, DaVita invests in improving lives.

VILLAGE VITALITY

Dedicated to creating and sustaining a culture of health awareness and improvement among teammates, Village Vitality offers teammates:

- Free biometric screenings at work sites
- Stress-management courses
- Tobacco-use cessation programs
- Challenges such as Match the Mayor, a six-week program in which teammates try to match Chairman and CEO Kent Thiry in exercise minutes logged

More than 23,000 teammates know their body mass index (BMI) and other key health benchmarks because of the Village Vitality program.

More than 2,300 teammates participated in the Match the Mayor fitness program in 2011.

WE ARE WELL

The We Are Well award is presented to teammates who have made an outstanding commitment to achieving their health goals. Winners are selected based on:

- Committing deeply to achieving better health
- Fulfilling personal goals
- Overcoming challenging health or fitness obstacles
- Inspiring others to pursue health and fitness

Our teammate benefits include emergency child and elder care, and adoption assistance. DaVita reimburses full-time employees 100% of eligible expenses, up to \$5,000, for each adopted child.



VILLAGE CARE

Teammates who share a compelling story about doing the right thing for their health have the opportunity to earn free health insurance.

EDUCATIONAL ASSISTANCE

In addition to tuition reimbursement, we offer non-traditional forms financial support to DaVita teammates and their families to help them pursue their educational goals.

- Nurse Today and Nurse Tomorrow scholarship programs: up to an additional \$5,000 per year.
- Redwoods MBA-program scholarships.
- \$1,000-3,000 Scholarships for exceptional children and grandchildren of DaVita teammates.

Teammates and their families have been given \$5.7 million through DaVita's support programs. Together, the DaVita Children's Foundation and the KT Family Foundation have granted nearly \$1.4 million to 704 students.

Aid in Times of Crisis

The DaVita Village Network is a way for teammates to help each other during times of crisis, such as a natural disaster, accident or illness.

- Teammates contribute financial aid to others voluntarily through payroll deductions.
- DaVita's intention is to match every dollar donated by teammates with a dollar taken from company profits, up to \$250,000 each year.
- The DVN may provide limited assistance in certain situations of financial hardship, such as temporary living expenses that arise due to a fire or natural disaster or help defray high, out-of-pocket medical expenses not covered by insurance.



DaVita's commitment to supporting servicemembers is consistently recognized by:

- G.I. Jobs Top 100 Military Friendly Employers
- Military Times Edge Best for Vets Employers
- CivilianJobs.com Most Valuable Employers

SUPPORT FOR MILITARY FAMILIES

In addition to providing jobs and voicing our appreciation, we contribute funds to the teammates who serve our country.



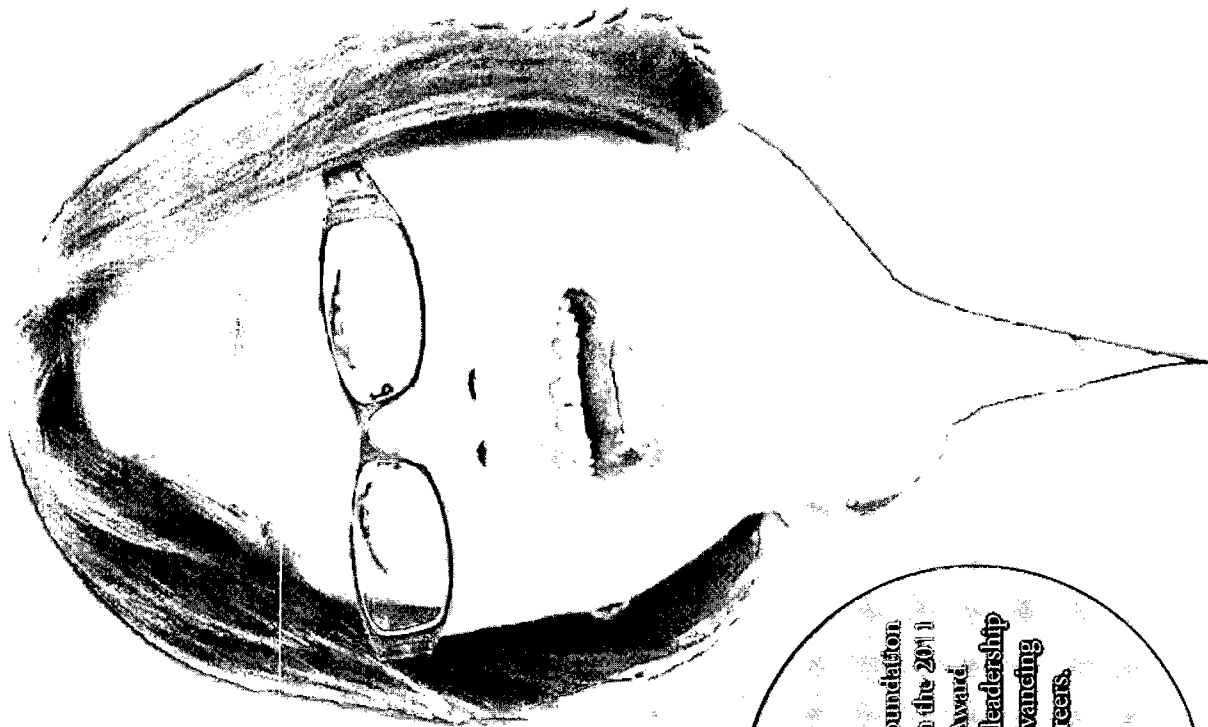
DaVita extends teammate and dependent healthcare coverage and life insurance during deployments lasting 30+ days.



Teammates have sent >1,400 letters and packages to active-duty teammates and family members through our Adopt-a-Troop program.



DaVita contributes \$5,000/year to each deployed teammate and offers paid, flexible scheduling upon return.



In 2011

41%

of hires and
57% of promotions
at the director level and
above were women and/or
ethnic minorities.

The Women's Vision Foundation
recognized DaVita with the 2011
Corporate Vision Award
for our innovation and leadership
in supporting and advancing
women in their careers.



Encouraging Diversity

We encourage diversity in our hiring to better serve our diverse patients. Additionally, we participate in and sponsor a number of diversity groups and events.

- Provide domestic-partner healthcare benefits, no matter the gender
- Invest \$3.2 million in community banks through our National Minority Bank Investment Initiative
- Sponsor nationwide kidney screenings and health seminars focused on the disparate impact of ESRD in African American, Hispanic and American Indian populations
- Participate in the Military Spouse Employment Partnership
- Actively recruit veterans from all five branches of the military



Listening to Our Teammates

We are deeply committed to engaging our 41,000 teammates in a dialogue about our company's objectives and their role in shaping the future of kidney care.

VOICE OF THE VILLAGE

Every eight weeks our CEO and other senior leaders invite teammates to participate in a Village phone call.

- On average, 2,000 to 3,000 teammates hear about the state of the company and ask questions about any subject they choose.
- Teammates may submit questions in advance to garner more-comprehensive answers.
- Post-call surveys ensure the betterment of future calls.

TOWN HALL MEETINGS

Held when one of our vice presidents visits a local center or business office, these meetings are an opportunity for teammates to communicate face-to-face with executives to:

- Showcase new programs.
- Recognize individual contributions.
- Share department updates.
- Ask questions about DaVita's business practices.

EUREKA!

Teammates provide feedback and share ideas via this online message board.

- Teammates submit ideas to improve patient care, enhance resource conservation and assist awareness-raising initiatives throughout the Village.
- Meaningful and implementable ideas are rewarded with recognition in Village-wide programs and occasional monetary prizes.
- Departments regularly solicit teammate feedback about specific business initiatives.

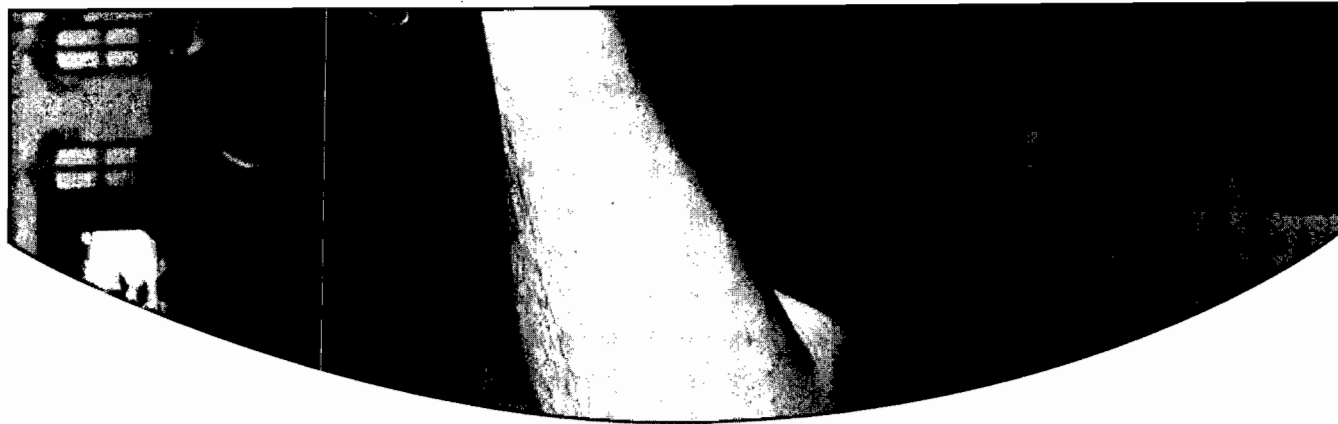
IT FORUM CALLS

These calls—made every six to eight weeks—provide teammates with important IT information.

- IT leadership creates a direct line of communication with field teammates.
- Teammates can ask questions of the IT team; typically 10 to 15 IT issues are resolved per call.

PEOPLE SERVICES FORUM CALLS

This call, held every six weeks, is a forum with senior leaders to discuss people-specific programs, including compensation, benefits, teammate engagement, internal mobility and many other topics.





Our name,
logo and Core
Values were
determined by
our teammates.

Teammates have voted
DaVita the only Fortune
500 company and only
healthcare company
among the World's Most
Democratic Workplaces
for five consecutive years
(2008-2012).

M
Marketers



:: CARING FOR OUR WORLD ::

In our relentless pursuit to build a healthy, caring culture, DaVita develops, participates in and donates to a variety of programs that work to transform communities and effect positive change for people and the environment.





DeVita committed

\$1.5 million

in 2011 for our teammates to put
toward charitable donations
to their communities.

Teammates and their
friends have participated in
321 community-service
projects totalling more than

28,000

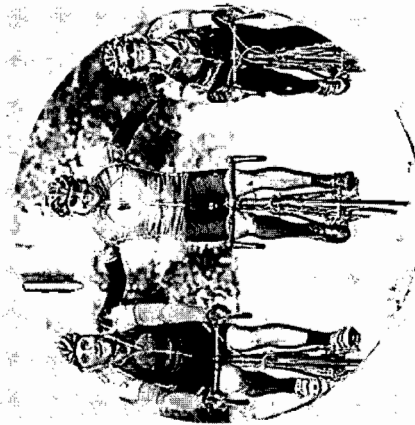
teammate hours.

**YAA for
Village Service**

Raising Awareness

TOUR DAVITA®

Tour DaVita is an annual 250-mile bicycle ride to raise awareness and funds to fight kidney disease. More than 1,600 teammates, physicians and friends have ridden a total of 350,000 miles to raise \$4.1 million thus far.



DAVITA KIDNEY ROCK™ 5K RUN/WALK

In 2011, the five-year tradition of holding run/walks across the country evolved into one megaweekend in Denver that provided no-cost kidney screenings to the community and raised \$500,000 for Bridge of Life—DaVita Medical Missions™. Bridge of Life supports improving kidney care in developing countries.



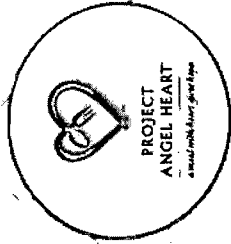
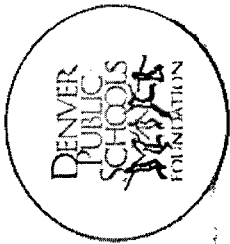
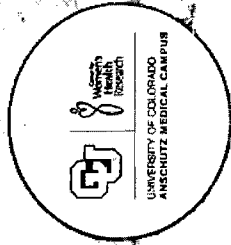
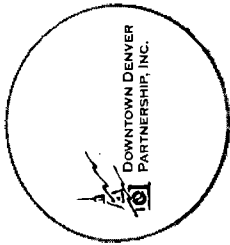
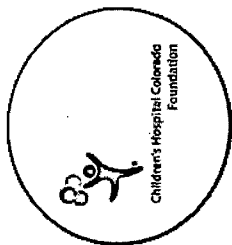
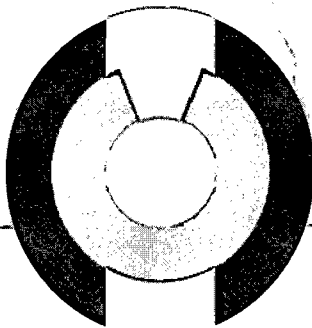
Why would a dialysis company focus so much on preventing or delaying the need for dialysis?

Because our bottom line will never take priority over the health and well-being of our community members.

Home-State Community Engagement

DaVita is passionate about community-enrichment initiatives in our home state of Colorado. We place a high value on engaging and making an impact on civic and charitable organizations. In 2011, DaVita:

- Provided financial support to more than two dozen charitable organizations in Denver.
- Volunteered throughout the year, preparing food, decorating delivery bags and delivering meals to chronically ill Denver-area residents through Project Angel Heart.
- Served on the boards of nearly 40 wide-ranging Colorado businesses and charitable organizations.
- Hosted numerous state and federal elected officials for thoughtful debate and civil discourse during Town Hall meetings at our interim headquarters.
- Actively engaged at the executive level in helping Denver and Colorado address public education, business development and recruitment, budget deficits and structural reform.



Giving Back

CONTRIBUTIONS TO RAISING CKD AWARENESS

Most people living with kidney disease don't know they have it until it's too late to slow its progression to kidney failure. We want to change that. In 2011, DaVita made cash contributions totaling more than \$2 million to the following kidney disease-awareness organizations and others:

- American Transplant Foundation
- Dialysis Scholarship Fund
- American Kidney Fund®
- Dialysis Patient Citizens
- The Kidney TRUST™
- National Kidney Foundation®
- Bridge of Life—DaVita Medical Missions™



VILLAGE SERVICE DAYS™

Over the last several years, more than 7,400 teammates and their friends around the country have launched a variety of local community-service projects, from preparing nutritious meals for people with restricted diets to delivering clothing and games to a VA rehab hospital.

As one example, in October 2011, more than 90 DaVita teammates helped renovate the Health Access Washoe County (HAWC) Health Center. The center treats more than 70,000 uninsured patients per year.

KT COMMUNITY FOUNDATION

Established in 2006 by Chairman and CEO Kent Thiry and his wife, Denise O'Leary, the KT Community Foundation has funded more than \$222,000 in teammate-led projects that make a difference in the communities where teammates live as well as overseas.



THE DAVITA WAY OF GIVING

In 2011, teammates at clinics across DaVita's 43-state footprint selected more than 600 charities, from Ronald McDonald House to small community-support entities in local areas, to receive ~\$1.5 million in contributions.

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"We wanted to empower everyone in the Village—especially our caregivers in the clinics—to make a difference through DaVita giving."

— Kent Thiry, Chairman, CEO
and DaVita Village "Mayor"



Sending Forth Ripples: Inspiring Leadership

We believe the key to building a successful organization is creating a democratic culture that allows people to explore their careers and themselves and become more effective leaders in the process. This is the DaVita Way of Leading. In 2011, we introduced the DaVita Way of Leading to several organizations and educational institutions. See page 20 for more information about DaVita's internal leadership development programs.

LEADERSHIP DEVELOPMENT PROGRAMS

In Denver, home to our corporate headquarters, DaVita is partnering with Denver Public Schools (DPS) to launch a personal and professional leadership program for educators based on the DaVita Way of Leading.

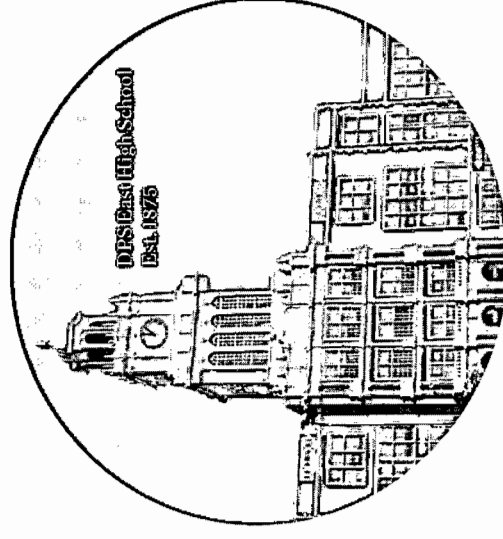
DPS executives, the Instructional Superintendent (IS) group and principals participate in individual-growth programs funded by DaVita and Piton-Foundation contributions. These initiatives include:

- Promoting reflection and team-building via a four-day off-site program
- Encouraging 360-degree feedback, leadership reflection, relationship-building with peers and having fun
- Incorporating superintendent-led Town Hall meetings into leadership programs
- Co-developing a leadership and personal/professional development program for teachers; to launch in 2013

BUILDING SHARED VALUES

DaVita is helping DPS honor and strengthen district-wide core values.

- Recruiting/evaluation process
- Ways to recognize, reward and honor commitment to democratic values
- An on-boarding program to introduce all district employees to the new DPS culture and help sustain momentum



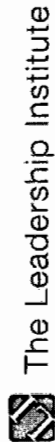
DIGITAL LITERACY & CITIZENSHIP

DaVita has partnered with Common Sense Media, which is supported by a \$250,000 pledge by DaVita Chairman and CEO Kent Thiry and his wife, Denise O'Leary, in launching a K-12 digital literacy and citizenship curriculum and a parent media education program in Colorado schools, starting with the Denver Public School system. To date, teachers have taught more than 21,000 hours of Common Sense curriculum and more than 600 students have participated in the "Magic of Smart and Safe Internet Use" program.



NATIONWIDE SPEAKING ENGAGEMENTS

The DaVita Way of Leading sends forth ripples of citizen leadership to other organizations as well. In the DaVita “Village” our citizens care for each other, sacrifice for each other, support each other, and—together—create meaning in our work and in our lives. Nationwide community groups and educational institutions such as Stanford University have invited DaVita representatives to speak about our corporate culture.



HARVARD | BUSINESS | SCHOOL



UCLAAnderson
School of Management



University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus



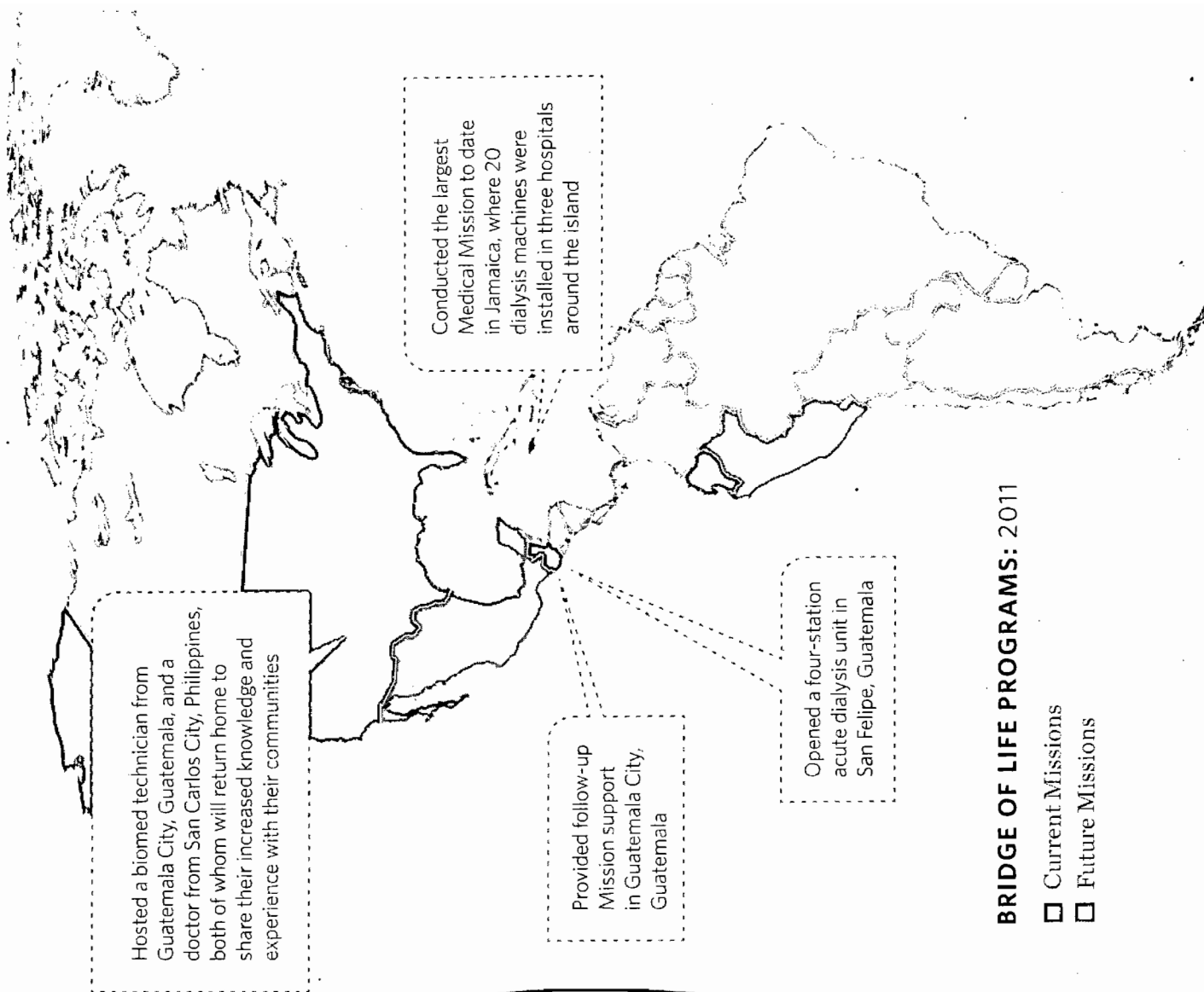
VANDERBILT UNIVERSITY
OWEN GRADUATE SCHOOL OF MANAGEMENT

Bringing Dialysis to Global Communities

Founded by DaVita, Bridge of Life—DaVita Medical Missions™ is an independent 501(c)(3) nonprofit organization that helps improve kidney health and save lives by bringing treatment, education and hope to developing countries. In support of Bridge of Life, DaVita does the following:

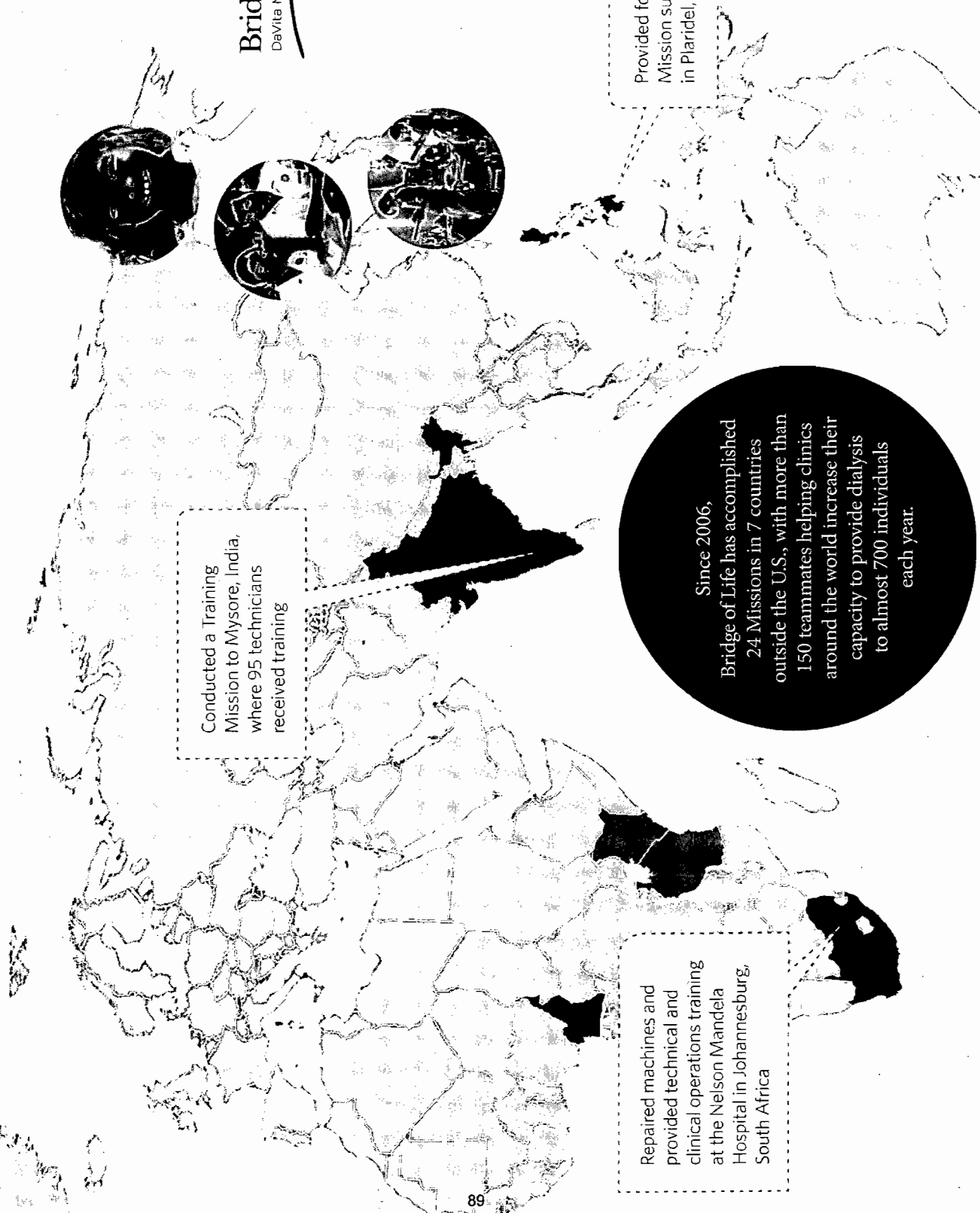
- Encourages teammates to volunteer to staff Missions and helps to cover their expenses.
- Increases the capacity to provide almost 71,000 desperately needed dialysis treatments each year.
- Contributes dialysis supplies and equipment to the Missions.
- Has trained more than 17 doctors, 87 nurses, 111 technicians and 16 biomedical technicians—all of whom have in turn touched the lives of thousands.
- Has installed or repaired 124 dialysis machines, providing the gift of life to approximately 682 additional individuals.
- Provides the equipment, start-up supplies and training to empower the medical personnel in local clinics to deliver kidney care services to the people within their country.

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BRIDGE OF LIFE PROGRAMS: 2011

- ☒ Current Missions
- ☐ Future Missions



Conducted a Training Mission to Mysore, India, where 95 technicians received training

Repaired machines and provided technical and clinical operations training at the Nelson Mandela Hospital in Johannesburg, South Africa

Since 2006, Bridge of Life has accomplished 24 Missions in 7 countries outside the U.S., with more than 150 teammates helping clinics around the world increase their capacity to provide dialysis to almost 700 individuals each year.

Provided follow-up Mission support in Plaridel, Philippines

Operating Sustainably

We strive to be an environmental leader in the healthcare industry by implementing conservation, stewardship and sustainability measures at our facilities. DaVita aggressively pursues innovative solutions to reduce our footprint while providing safe, effective care to our patients.

DaVita is the only kidney care company on the 2009, 2010 and 2011 EPA Green Power Partnership list of Fortune 500 companies that lead in purchasing green power.

BUILDING GREEN

- DaVita operates the only LEED® clinic in the country and are constantly incorporating our learnings into our other clinics.
- DaVita's first-ever dialysis clinic to use solar thermal technology, in Scottsburg, Indiana, showed a 44% reduction in natural-gas consumption versus comparable DaVita facilities.
- We are seeking LEED Gold certification for our new corporate headquarters in Denver. The building will feature the city's largest rooftop terrace and a next-generation, eco-friendly design that will incorporate state-of-the-art, high-efficiency mechanical, electrical and plumbing systems.
- We are testing energy-reduction technologies at our facilities, including a water turbine in San Francisco.



95% of waste at DaVita corporate headquarters is diverted through composting and recycling programs, and the 900 teammates in Tacoma are leading the way for the region by piloting commercial composting in our DaVita offices.

Single-use medical-sharps devices such as needles and syringes are collected, treated, processed and recycled to make new sharps containers for use in DaVita clinics.

DAVITA PURCHASING IN BULK IN 2011 SAVED

HAND SANITIZER 3,900 lbs. of plastic
DIALYSIS-MACHINE-CLEANING SUPPLIES 975,829 gallon jugs
LATEX GLOVES 355,574 lbs. of cardboard
BLOODLINES 1,348,000 lbs. of plastic and 246,000 lbs. of cardboard

OUR RECYCLING PROGRAM

DIALYZER COMPONENTS Saved 7,689,285 pounds of medical waste
RECYCLED SHARPS CONTAINERS Saved 650,976 lbs. of plastic
OFFICE/MANITORIAL PRODUCTS ~440 products contain recycled content
BUSINESS CARDS, LETTER-HEAD AND ENVELOPES 100% postconsumer paper

LEADING OUR INDUSTRY IN REDUCING, RECYCLING AND COMPOSTING

DaVita continues to partner with potential vendors to explore the feasibility of recycling medical waste such as dialyzers. In addition, new agreements with national solid-waste vendors brought new recycling opportunities to 400 clinics across the country.

In New York State, 37 DaVita clinics are preparing to pilot energy management systems that will control consumption through lighting and HVAC efficiencies.

Building on the success of our composting programs in our Denver-area business offices, our Tacoma office partnered with the City of Tacoma to pilot commercial composting applications. More than 900 teammates embraced the challenge and overcame hurdles to make the program a success.



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REDUCING GREENHOUSE-GAS EMISSIONS

- In 2012, for the fourth year in a row, DaVita offset 100% of the energy used at our corporate offices by purchasing green-power credits that generate a net zero increase in carbon dioxide emissions.
- We eliminated 6,100 medical-waste pickups, saving ~15,250 gallons of fuel annually.
- We are members of the Business Roundtable's Sustainable Growth and Climate RESOLVE initiatives to help reduce greenhouse-gas emissions.
- Teammates in our Denver and Tacoma offices receive complimentary annual passes for public transportation.

FINDING SUSTAINABLE SUPPLIERS

Our purchasing team is identifying vendors to support new sustainability initiatives, such as having ordered products delivered in reusable containers. In the first 90 days, we reduced cardboard waste at participating locations by more than 3,500 pounds!

Our biomedical technicians are developing protocols that could save 200 million gallons of water annually, without disrupting clinical operations or the delivery of patient care.

DaVita jumped 192 spots on Newsweek's U.S. Green Rankings list in 2011, our third consecutive year on the list.

In October 2011, 35 DaVita teammates joined with the Green Tacoma Partnership to plant trees, remove invasive weeds and clean up Garfield Gulch to help restore it to its native habitat.



SUSTAINABILITY GOALS

DaVita is committed to achieving the following environmental goals by 2015 (compared to 2011 figures):

Decrease water consumption by **10%**

Reduce energy consumption by **15%**

Increase environmentally preferable procurement by **15%**

Decrease office-paper consumption by **20%** and operate paperless clinics

Increase teammate awareness of sustainability initiatives by implementing **one new program per year**

Generating Taxpayer Savings

In the United States, most of the more than 397,000 people being treated for kidney failure*—including approximately 89% of DaVita's dialysis patients—are served through Medicare and other government programs funded by taxpayers. DaVita is committed to keeping costs low and improving access to care for all patients—not just our own.

DAVITA'S TAXPAYER COST-SAVING INITIATIVES

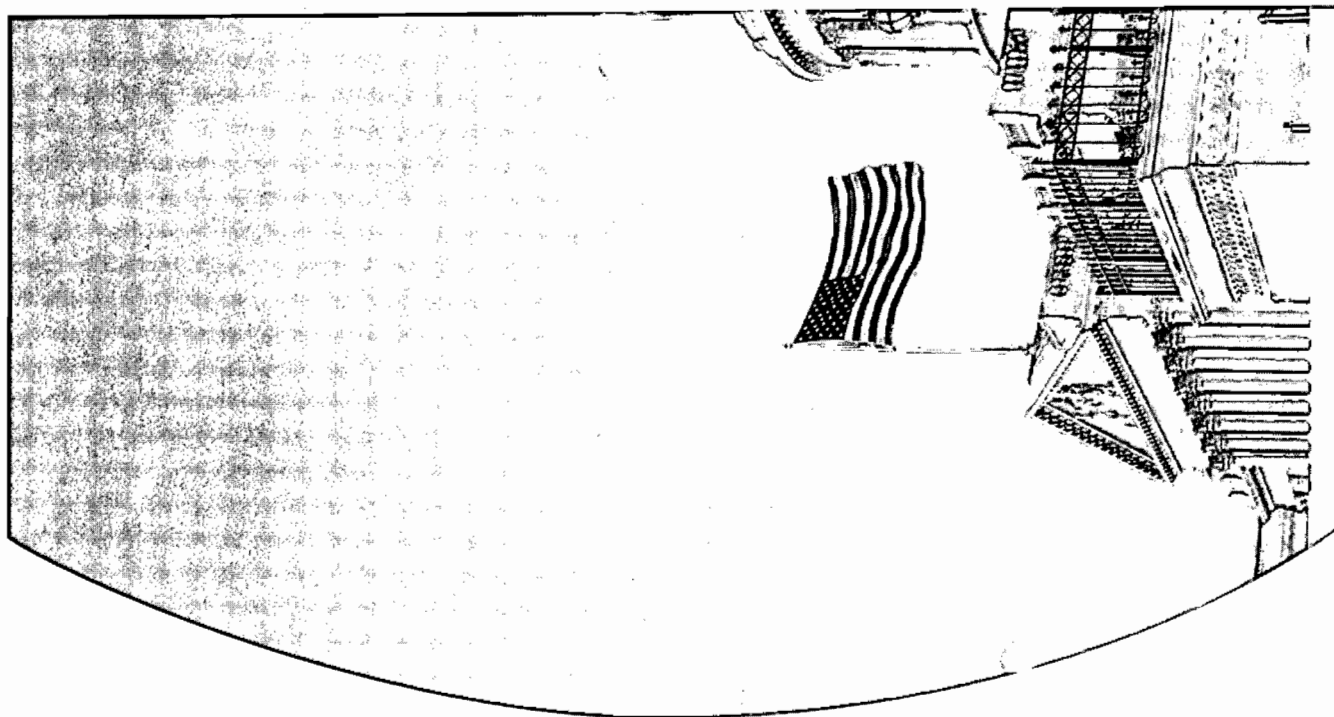
- Investing tens of millions of dollars over several years to experiment with, refine and roll out healthcare cost-savings measures
- Advancing more cost-effective treatment options to states for use in their Medicaid programs
- Managing patients' unique health conditions through related services
- Outpatient vascular access centers (Lifeline Vascular Access®)
- Pharmacy services within dialysis centers (DaVita Rx®)
- Disease-management assistance (DaVita VillageHealth®)
- Recognizing teammates who pursue innovative ways to reduce costs

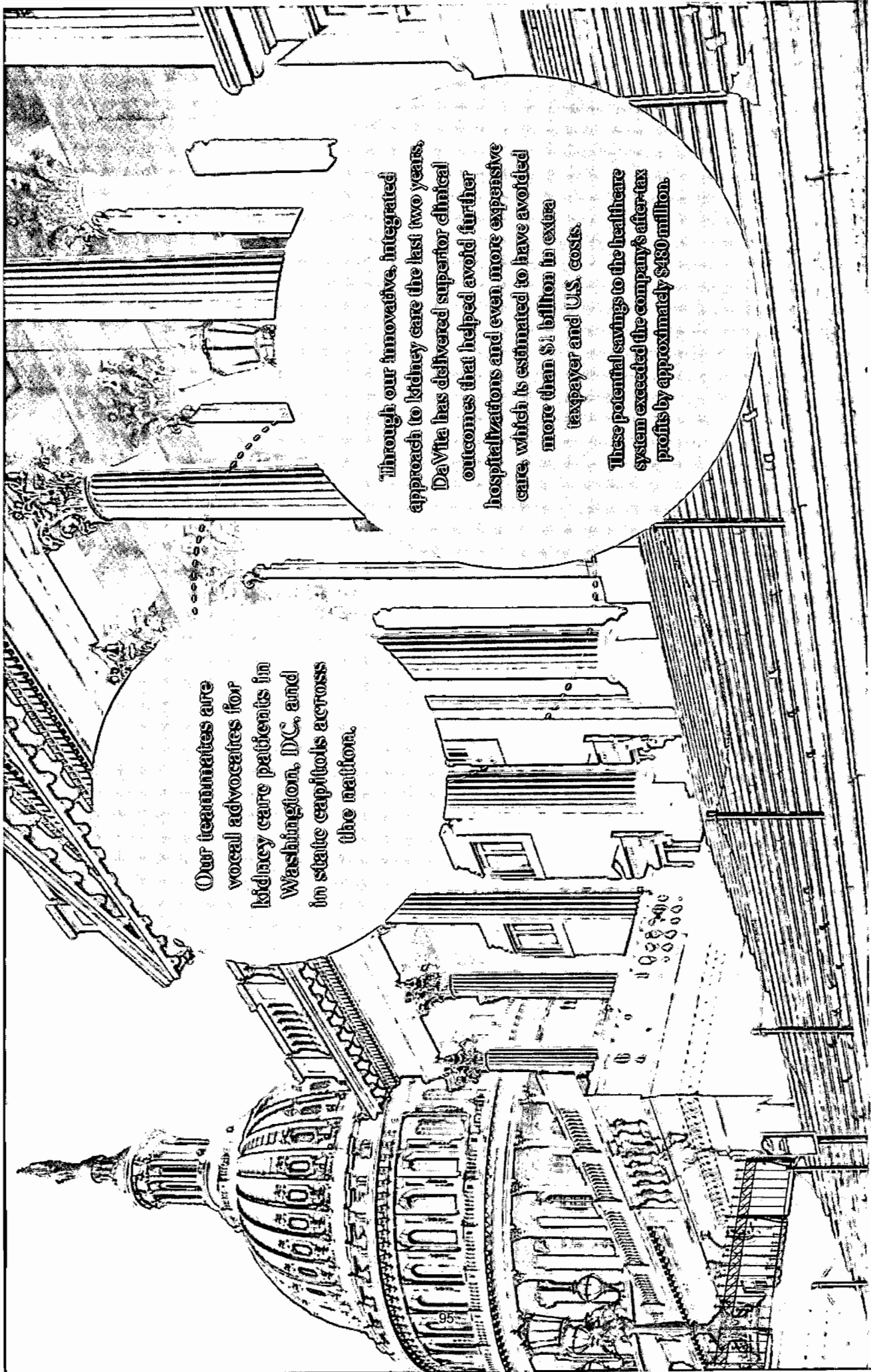
ADVOCATING FOR KIDNEY CARE PATIENTS

DaVita's commitment to social responsibility is demonstrated in our pioneering work in the complex arena of U.S. healthcare reform. In 2011, DaVita was a successful advocate for patients with chronic kidney disease.

- DaVita representatives met with officials at the Centers for Medicare and Medicaid Services (CMS) and with lawmakers in Congress to educate them about ESRD.
- Providers, patient groups, politically active teammates and many members of Congress engaged with CMS to advocate for changes that would benefit the kidney care community and ensure that access to high-quality care is preserved.

*2011 United States Renal Data System Annual Report





Our teammates are
vocal advocates for
kidney care patients in
Washington, DC, and
in state capitols across
the nation.

Through our innovative, integrated
approach to kidney care the last two years,
DaVita has delivered superior clinical
outcomes that helped avoid further
hospitalizations and even more expensive
care, which is estimated to have avoided
more than \$1 billion in extra
taxpayer and U.S. costs.

These potential savings to the healthcare
system exceeded the company's after-tax
profits by approximately \$480 million.

Chief Medical Officer
Allen R. Nissenson, MD, FACP

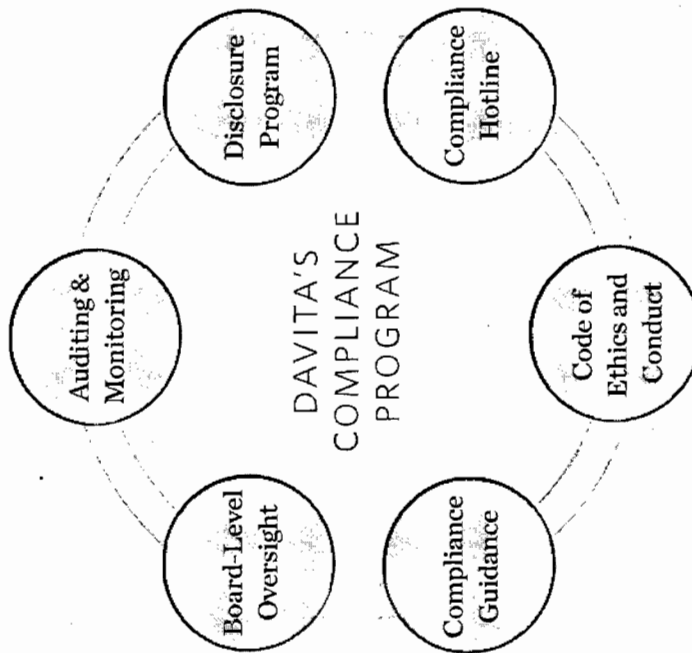
DaVita is the only kidney care company with a Clinical Performance Committee that advises the Board and management on results and proposed improvement measures relating to clinical performance.

Pioneering Governance and Compliance Standards

DaVita goes above and beyond industry requirements in hopes of being a role model for American healthcare.

- All but one member of the Board are required to be elected annually by a majority of votes cast by our stockholders.
- Most members of DaVita's Board of Directors are independent of the company and management.
- DaVita established and holds itself to the standards of Board-level committees on Audit, Compensation, Nominating and Governance, Compliance, Public Policy and Clinical Performance, each composed of independent Board members.
- Each committee's charter requires it to conduct an annual self-evaluation of the performance of the committee and each of its members.

DaVita's Compliance Program requires every teammate to complete annual Compliance training and provides these resources to ensure adherence to regulatory and ethical practices.



:: WHAT'S NEXT? ::

Each year is an opportunity for further growth. We are working on a variety of initiatives to build on last year's progress.

☐ CARING FOR OUR PATIENTS

☐ CARING FOR EACH OTHER

☐ CARING FOR OUR WORLD

Our sustainability team is continuing to track our solar-thermal-powered clinic, with hopes of expanding the use of this technology across the country.

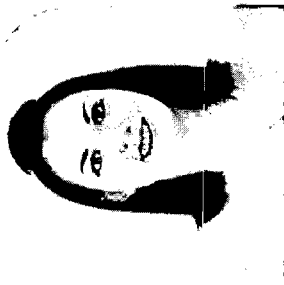
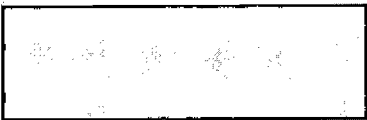
Through our regular engagement survey, we will continue to learn what motivates teammates to be the best they can be—and provide solutions to reinforce our world-class levels of engagement.

We will relaunch MyDaVita.com with better social networking and a new Health Portal for DaVita patients to access their lab results and medical records.

We will focus on improving the quality of infection reporting, in our efforts to find better ways to address a persistent threat to kidney care patients.

Our team of biomedical technicians is working on protocol changes that have the potential to save 200 million gallons of water annually.

We are bringing kidney care to more of the world, operating clinics in Malaysia and India and planning to open clinics in China.



We are also upgrading
our **DaVita Quality Index**
tool to allow teammates
to predict and track
their clinical outcomes and
course-correct earlier
in the process.

Thirty-seven clinics
in New York state will pilot
systems to **control energy**
consumption through
efficient lighting and
HVAC technologies.

We are investigating
technology that would allow
us to **create power from the**
water-discharge systems
in our dialysis facilities to offset
auxiliary power usage, such
as lighting in the
parking lots.

We will continue to expand
our **ROADMAPS program**,
offering teammates targeted
development opportunities
and experiences as they
continue to grow in
the Village.

In partnership with thought
leaders in healthcare,
we are **working to embrace**
a **"culture of safety"**
to promote industry-leading
safety and comfort for our
patients during
dialysis treatment.

DaVita®



Need a digital copy? Use this QR code.



GRI INDEX

The Global Reporting Initiative (GRI) is a network-based organization that pioneered the world's most widely used sustainability reporting framework. The reporting framework sets out the principles and performance indicators that organizations can use to measure and report their economic, environmental and social performance. Using the list of page numbers below, you can find examples of how DaVita follows the GRI framework's Sustainability Reporting Guidelines.

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Labor Practices and Decent Work	18-27
Human Rights	36-37
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Our patients inspire us to do great work in pursuit of improving their health and lives. We are honored that well-regarded publications and organizations recognize our achievements year after year, including Fortune, which named us among the World's Most Admired Companies for a seventh consecutive year in 2012.





:: ABOUT THIS REPORT ::

About kidney disease:

[DaVita.com](#)

[MyDaVita.com](#)

[DaVita.com/KidneyAware](#)

[YourKidneys.com](#)

To find a dialysis center near you:

[DaVita.com/find-a-center](#)

About DaVita's Trilogy of Care:

[DaVita.com/communitycare](#)

About Bridge of Life—DaVita Medical Missions:

[BridgeofLifeMM.org](#)

About career opportunities:

[Careers.DaVita.com](#)

About participating in the DaVita Kidney Rock™:

[DaVitaKidneyRock.org](#)

About participating in Tour DaVita®:

[TourDaVita.org](#)

Sustainable Printing

To help compensate for the printing of this report, approximately 150 trees were planted in areas of greatest need through the American Forests Global ReLeaf Fund. The report is printed with low-VOC, vegetable-based ink on FSC-certified recycled sources in the U.S.

Certain statements made in this report are "forward-looking statements" that include any statement that may predict, forecast, indicate, or imply future performance or achievements. These forward-looking statements are based on currently available information and are subject to a number of significant risks and uncertainties, which could cause our actual performance or achievements to differ materially from that projected in the forward-looking statements. Some of these uncertainties are described in DaVita's periodic filings with the Securities and Exchange Commission, including the "Risk Factors" section of our Annual Report on Form 10-K for the fiscal year ended December 31, 2011, as well as in our subsequently filed Quarterly Reports on Form 10-Q and other filings we make with the SEC from time to time. DaVita does not update forward-looking statements and expressly disclaims any obligation to do so.

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DaVita[®]

COMMUNITY CARE

The DaVita Vision for Social Responsibility

2011

DaVita.com/CommunityCare



DAVITA KIDNEY ROCK™ 5K RUN/WALK. AUGUST 11, 2012. DENVER, CO.

DAVITAKIDNEYROCK.ORG



WECHINK

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Research / Evaluation

Project: Block by Block North Lawndale Diabetes Community Action Program

Introduction:

North Lawndale has one of the highest rates of diabetes in the City of Chicago. It is estimated that the direct medical care costs per person per year with diabetes is 2.3 times higher than for the person without diabetes. Sinai Urban Health Institute (SUHI) was awarded a highly-competitive major grant by the National Institutes of Health (NIH) to undertake the Block by Block North Lawndale Diabetes Community Action Program. SUHI's proposal was ranked in the top 3% of requests received by NIH and will provide \$1 million over two years.

Project plan:

"It is unreasonable to expect that people will change behavior easily when so many forces in the social, cultural, and physical environment conspire against such change." Institute of Medicine

The growing prevalence of Type 2 diabetes in the US has been well documented. It is estimated that the direct medical care costs per person per year with diabetes is 2.3 times higher than for the person without diabetes. HbA1C has come to be used as a measure of diabetes management, self-care and risk for development of diabetes complications. It has been estimated that a one percent reduction in A1C values can reduce total healthcare costs for a patient with type 2 diabetes by up to \$950 per year. In another study managed care patients with type 2 diabetes who improved or achieved glycemic control saved \$369 per patient per year in total diabetes related costs as compared to those with higher A1C levels. Previous studies have demonstrated higher HbA1C levels and poorer glycemic control among African-Americans. This means that diabetes related healthcare costs for African-American pertaining to improved HbA1C levels are not being realized.

Although health professionals and demographers will describe the North Lawndale community on Chicago's west side as "extremely low socio-economic status" and "medically underserved," residents know their neighborhood has many strengths and assets. In fact, in 1966, Martin Luther King, Jr., picked North Lawndale as the base for the northern civil rights movement and moved his family there. Following

King's assassination, rioting, crime, unemployment and physical deterioration led to neighborhood decline. The North Lawndale Diabetes Community Action Project is driven by the residents, demanding improved diabetes outcomes and a share of health equity.

The North Lawndale Diabetes Community Action Project builds on community strengths to increase the early detection of diabetes and involves an entire neighborhood in efforts to enhance self-management by those with the disease. Our community-academic partnership proposes a neighborhood engagement approach to ameliorating the impact of diabetes on the lives of 10,000 adults living in a well-defined section of the North Lawndale neighborhood.

The Sinai Urban Health Institute, Sinai Health Systems, Rush University Medical Center and a community based organization (Family Focus North Lawndale) are proposing to develop and deliver a multilevel community intervention using a media campaign, community engagement, and individual self-managements training by "Diabetes Block Captains." Neighborhood residents working as Diabetes Block Captains will conduct household screenings for diabetes and then will engage their neighbors in activities that promote diabetes self-management. This Community Based Participatory Research (CBPR) approach seeks to support residents in changing the culture within the target community, to make diabetes a neighborhood priority, and to address the cultural and social environment to support healthier lifestyles.

OVERALL PURPOSE

To reduce the impact of type 2 diabetes mellitus on the health of residents of North Lawndale through a replicable multi-level strategy developed and implemented through a collaboration between the community and an academic health center.

PRIMARY AIM

1) To determine whether a multi-level community intervention, featuring an educational campaign, community engagement, and individual self-management training by a "Diabetes Block Captain" will result in a mean reduction of HbA1c greater than 0.5 among persons with type 2 diabetes mellitus living in a medically underserved urban neighborhood.

SECONDARY AIMS

2) To demonstrate the cost-effectiveness of a multi-level community intervention resulting from significant improvements in rates of diabetes self-management behaviors among persons with type 2 diabetes mellitus.

3) To determine whether this multi-level community intervention can improve early detection of diabetes in a medically underserved urban neighborhood by increasing the number of persons diagnosed by at least 25% over a one-year period.

The foundational bases for the Block by Block North Lawndale Diabetes Community Action Program are:

Awareness
Education
Self-Management
Community Engagement

Block by Block North Lawndale Diabetes Community Action Program has three (3) target audiences:

Persons who have been diagnosed with Type 2 Diabetes
Persons with multiple risk factors for developing type 2 Diabetes
The community-at-large

The Block by Block North Lawndale Diabetes Community Action Program seeks to support residents in changing the culture within North Lawndale to make diabetes (and health in general) a neighborhood priority and to impact the environment to support healthier lifestyles. Activities include an educational campaign, community engagement, and individual self-management support by Diabetes Block Captains to ultimately improve rates of diabetes self-management behaviors. Subsequently, through this multi-level community intervention, it is hoped that early detection of diabetes in North Lawndale will increase and people will live better and healthier lives.

Diabetes Block Captains will conduct 2,500 neighborhood household surveys to identify residents within North Lawndale who actually have or are at risk of developing Type 2 Diabetes. (Eligible persons who complete the survey will be mailed a \$15 gift card.) The project seeks to enroll 280 residents with Type 2 Diabetes into the intervention phase of project and will be assigned a Diabetes Block Captain who will make 4 home visits over 12-18 months, during which they will work with the individuals to develop action plans focused on small, consistent, lifestyle changes to improve self-management of the disease.

Poor self-management behaviors often lead to increased numbers of diabetes-related hospitalizations and emergency room visits. Those persons who have been diagnosed with Type 2 Diabetes will be educated (or re-educated) around the risks for short-term and long-term consequences of not managing the disease (e.g., amputations, dialysis, nerve damage, loss of vision, erectile dysfunction) and be encouraged to eat better, become more physically-active, take their medications, follow doctor's orders, undergo regular testing, and comply with foot care routines.

The major risk factors for developing Type 2 Diabetes include: having family members with the disease, being obese/overweight, not being physically active, having unhealthy eating habits, and being over age 45. Those North Lawndale residents with risk factors will be encouraged to participate in community-wide events related to the Block by Block North Lawndale Diabetes Community Action Program campaign messages that are intended to reduce their chances of developing the disease.

A particular emphasis for the community-at-large is the list of campaign messages and making small-but-consistent lifestyle changes to support those in their circle of influence who have or at risk of developing Type 2 Diabetes.

It is intended that formal and informal community partners will support North Lawndale residents and the Block by Block North Lawndale Diabetes Community Action Program by offering cooking classes and diabetes-friendly menus, hosting events, workshops, and meetings.

Block by Block North Lawndale Diabetes Community Action Program seeks to maximize attendance and participation in North Lawndale resources that are often underutilized, such as fitness classes and community gardens.

Project updates:

The Block by Block North Lawndale team presented on their research at this year's annual American Public Health Association (APHA) conference in Denver, Colorado. [Click here](#) to view the presentation.

The Lawndale Diabetes Project Kick-Off Press Conference

When: April 20, 2012, 10:00-11:30 a.m.

Where: Mount Sinai Hospital, Glasser Auditorium

Who: Elected officials, municipal leaders, community leaders and members

Why: Diabetes is exacting a terrible toll on our communities. Sinai Health System has teamed up with Blue Cross and Blue Shield of Illinois to address diabetes among North and South Lawndale residents.

[Click here](#) for event flyer.

Publications: West, J and Whitman S. [Block by Block North Lawndale Diabetes Community Action Program: Community Progress Report 2011](#)

Contact information: For more information regarding this project, please send an email to Joseph West, Sc.D., Program Director at joseph.west@sinai.org or to Avonella Rogers, Program Coordinator at avonella.rogers@sinai.org.

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[Margaret Shepard](#) Community Health Educator
[Katrina Sutton, AA](#) Community Health Educator
[Joseph F. West, ScD](#) Program Director.

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HEALTH INSTITUTE
SINAI URBAN
SUHI

A special branch of Social Health Agency

Introduction

North Lawndale has one of the highest diabetes rates in the city of Chicago (16%, twice the national rate). The North Lawndale Diabetes Community Action Project (NLCAP), also named Block by Block North Lawndale, aims to reduce the impact of type 2 diabetes mellitus on the health of residents of North Lawndale through a replicable multi-level strategy developed and implemented through community, medical and academic collaboration.

Block by Block North Lawndale builds on community strengths to increase the early detection of diabetes and involves an entire neighborhood in efforts to enhance self-management by those with the disease. Our community-academic partnership proposes to impact the lives of 10,000 adults living in the North Lawndale neighborhood one block at a time.

Objectives

1. Assess and explain the value of local health data in driving community-based interventions;
2. Demonstrate how community-based initiatives can address specific disparities in health; and
3. Highlight the implications of local data on eliminating disparities in other urban settings.
4. Explain the importance of neighborhood cohesion and coalition building in eliminating health inequalities and in key indicators
5. Demonstrate the evolving and important role of community health workers in eliminating health inequalities.
6. Discuss key actionable factors for improving neighborhood health and behavioral change through collective efficacy and coalition building.

Methods

The Sinai Urban Health Institute, Sinai Health Systems, Rush University Medical Center and a community based organization (Family Focus North Lauderdale) have developed a multilevel community intervention using a media campaign, community engagement, and individual self-management training by "Diabetes Block Captains." Neighborhood residents work as Diabetes Block Captains to conduct household screenings for diabetes and engage their neighbors in activities that promote diabetes self-management (e.g. walking classes, exercise classes, neighborhood walks, produce swap, etc.). This Community Based Participatory Research (CBPR) approach seeks to support residents in changing the culture within the community, to make diabetes a neighborhood priority, and to address the cultural and social environment to support healthier lifestyles.

Phase I of Block by Block focuses on a cluster of blocks in one segment of the community. Subsequent Phases will cover the remainder of the community. Block by Block encourages North Lawndale residents to know their diabetes status and to eat more fruits and vegetables, check blood sugar regularly, see a doctor often and exercise frequently. Block by Block wants friends and neighbors talking about diabetes and working to make the community safer, improve access to quality foods and increase social cohesion and collective efficacy.

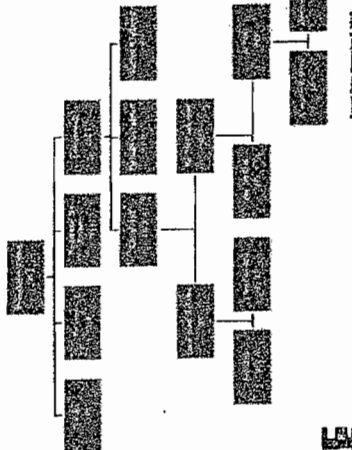
OVERALL PURPOSE: To reduce the impact of type 2 diabetes mellitus on the health of residents of North Lauderdale through a replicable multi-level strategy developed and implemented through collaboration between the community and an academic health center.

PRIMARY AIMS: To determine whether a multi-level community intervention, featuring an educational campaign, community engagement, and individual self-management training by a "Diabetes Block Captain" will result in a mean reduction of HbA1c greater than 0.5% among persons with type 2 diabetes mellitus living in a medically underserved urban neighborhood.

SECONDARY AIMS: 1) To demonstrate the cost-effectiveness of a multi-level community intervention resulting from significant improvements in rates of diabetes self-management (SDSC-A) behaviors among persons with Type 2 diabetes mellitus. 2) To determine whether this multi-level community intervention can improve early detection of diabetes in a medically underserved urban neighborhood by increasing the number of persons diagnosed by at least 25% over a one-year period.

Preliminary Results

Preliminary Data. Over a 6-month survey period NLCAP has interviewed 2,353 households, completed 1,123 interviews and enrolled 2,883 North Lawdle residents (Type 2 diabetes neighborhood prevalence of 26.7% [300/1,123]), which exceeds the prevalence in the North Lawdle found in our 2003 Community Survey of 10%. There are more than 3 times the U.S. rate. However, when you account for the CDC statement that one-third of persons with diabetes are unaware that they have the disease,³ this would elevate the actual neighborhood prevalence. Of residents surveyed 20% have been determined as high risk (26.5%), based on a standardized risk assessment. NLCAP has a health educator focused on helping those residents that are at risk for Type 2 diabetes receive a clinical consultation and a referral for services.



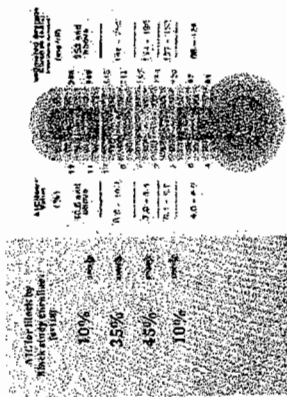
Sinai Health System has established a Diabetes Health Center staffed by three endocrinologists, diabetes nurse practitioners and a diabetes educator. NLCAP provides direct referrals and appointments for practitioners identified as at risk for diabetes, and for persons with diabetes that do not have a primary care provider. Comparing data collected in the community with that seen in the Health System and Center, 42% of patients with diabetes, identified at Sinai Health System have an average HbA1C of 9.0 or greater, indicating the need for tighter management. Baseline collection of HbA1C for NLCAP shows similar numbers of poorly controlled diabetes.

Discussion

The growing prevalence of Type 2 diabetes in the US has been well documented. It is estimated that the direct medical care costs per person per year with diabetes is 2.3 times higher than for the person without diabetes. Local survey data showed that North Lawndale, a poor African-American community and Humboldt Park, a poor Hispanic community had the highest diabetes rates in Chicago.

Employing well-trained community health workers the interventions aim to improve diabetes self-management in underserved areas of each community one block at a time. HbA_{1c} has come to be used as a measure of diabetes management, self-care and risk for development of diabetes complications. It has been estimated that a least a one percent change in HbA_{1c} levels can lead to significant healthcare cost savings. A primary outcome for both studies is a mean reduction HbA_{1c} levels of 0.5%.

North Lawndale is considered a "food desert" community. This means that there is a big imbalance or "food security" gap between grocery stores that provide quality food and the number of fast food outlets that provide foods high in fat, calories and sugar. Block by Block seeks to build community knowledge and establish a Community Wellness Coalition and Health Services Navigator in order to empower residents for activism to make North Lawndale healthier.



References

- Report 1. *Chicago Teen Health System, 2004*.
Whitman S, Williams C. *South At-Risk Health System's Improving Community Health Survey*.
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national estimates on diabetes in the United States, 2007. Atlanta, GA: US Department of Health
and Human Services, Centers for Disease Control and Prevention, 2008.

This research is funded by National Institutes of Health Grant: R01AID004946-01



Office of the Chief
Medical Officer (OCMO)
Allen R. Nissen, MD
Chief Medical Officer
Meredith Matthews, MD
Robert Provenzano, MD
John Robertson, MD
David S. Van Wyck, MD

April 30, 2009

Dear Physicians:

As your partner, DaVita® and OCMO are committed to helping you achieve unprecedented clinical outcomes with your patients. As part of OCMO's Relentless Pursuit of Quality™, DaVita will be launching our top two clinical initiatives; IMPACT and CathAway™, at our annual 2009 Nationwide Meeting. Your facility administrators will be orienting you on both programs upon their return from the meeting in early May.



IMPACT: The goal of IMPACT is to reduce incident patient mortality. IMPACT stands for Incident Management of Patients Actions Centered on Treatment. The program focuses on three components: patient intake, education and management and reporting. IMPACT has been piloting since October 2007 and has demonstrated a reduction in mortality. The study recently presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN. In addition to lower mortality rates, patient outcomes improved - confirming this vulnerable patient population is healthier under DaVita's relentless pursuit of quality care.



CathAway: Higher catheter use is associated with increased infection, morbidity, mortality and hospitalizations ^{(1) (2)}. The 7-step Cathaway Program supports reducing the number of patients with central venous catheters (CVCs). The program begins with patient education outlining the benefits of fistula placement. The remaining steps support the patient through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. For general information about the CathAway program, see the November 2008 issue of QUEST, DaVita's Nephrology Journal.

Here is how you can support both initiatives in your facilities:

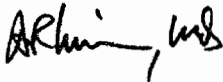
- **Assess incident patients regularly in their first 90 days:** Discuss patients individually and regularly. Use the IMPACT scorecard to prompt these discussions.
- **Adopt "Facility Specific Orders":** Create new facility specific orders using the form that will be provided to you.
- **Minimize the "catheter-removal" cycle time:** Review each of your catheter patients with your facility teammates and identify obstacles causing delays in catheter removal. Work with the team and patients to develop action plans for catheter removal.
- **Plan fistula and graft placements:** Start AV placement plans early by scheduling vessel mapping and surgery evaluation appointments for Stage 4 CKD patients. Schedule fistula placement surgery for those patients where ESRD is imminent in the next 3-6 months.

Launch Kits:

In May, Launch Kits containing materials and tools to support both initiatives will be arriving at your facilities. IMPACT kits will include a physician introduction to the program, step by step implementation plan and a full set of educational resources. FAs and Vascular Access Leaders will begin training on a new tool to help identify root-causes for catheter removal delays.

Your support of these efforts is crucial. As always, I welcome your feedback, questions and ideas. Together with you, our physician partners, we will drive catheter use to all-time lows and help give our incident patients the quality and length of life they deserve.

Sincerely,



Allen R. Nissenson, MD, FACP
Chief Medical Officer, DaVita

- (1) Dialysis Outcomes and Practice Patterns Study (DOPPS): 2 yrs/7 Countries / 10,000 pts.
- (2) Pastan et al: Vascular access and increased risk of death among hemodialysis patients.





Knowledge is power.

EMPOWER® is an educational program by DaVita®. The program includes a series of free community based classes for patients with chronic kidney disease (CKD). These classes encourage you to take control of your kidney disease and prepare for dialysis by making healthy choices about your kidney care

Taking Control Of Kidney Disease

Learn how to slow the progression of kidney disease.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Making Healthy Choices

Learn how to prepare for dialysis.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Treatment Choices

An in-depth look at all of your treatment choices.

- Kidney disease and related conditions
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

To register for a class, call 1-888-MyKidney (695-4363).

EMPOWER®
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DaVita®

DaVita, Inc. Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Adams County Dialysis	436 N 10TH ST		QUINCY	ADAMS	IL	62301-4152	14-2711
Alton Dialysis	3511 COLLEGE AVE		ALTON	MADISON	IL	62002-5009	14-2619
Barrington Creek	28160 W. Northwest Highway		Lake Barrington	Lake	IL	60010	
Benton Dialysis	1151 ROUTE 14 W		BENTON	FRANKLIN	IL	62812-1500	14-2608
Beverly Dialysis	8109 SOUTH WESTERN AVE		CHICAGO	COOK	IL	60620-5939	14-2638
Big Oaks Dialysis	5623 W TOUHY AVE		NILES	COOK	IL	60714-4019	14-2712
Centralia Dialysis	1231 STATE ROUTE 161		CENTRALIA	MARION	IL	62801-6739	14-2609
Chicago Heights Dialysis	177 W JOE ORR RD	STE B	CHICAGO HEIGHTS	COOK	IL	60411-1733	14-2635
Churchview Dialysis	5970 CHURCHVIEW DR		ROCKFORD	WINNEBAGO	IL	61107-2574	14-2640
Cobblestone Dialysis	934 CENTER ST	STE A	ELGIN	KANE	IL	60120-2125	14-2715
Crystal Springs Dialysis	720 COG CIRCLE		CRYSTAL LAKE	MCHENRY	IL	60014-7301	14-2716
Decatur East Wood Dialysis	794 E WOOD ST		DECATUR	MACON	IL	62523-1155	142599
Dixon Kidney Center	1131 N GALENA AVE		DIXON	LEE	IL	61021-1015	14-2651
DSI Arlington Heights Renal Center	17 West Golf Road		Arlington Heights	COOK	IL	60005-3905	14-2628
DSI Buffalo Grove Renal Center	1291 W. Dundee Road		Buffalo Grove	COOK	IL	60089-4009	14-2650
DSI Evanston Renal Center	1715 Central Street		Evanston	COOK	IL	60201-1507	14-2511
DSI Hazel Crest Renal Center	3470 West 183rd Street		Hazel Crest	COOK	IL	60429-2428	14-2622
DSI Loop Renal Center	1101 South Canal Street		Chicago	COOK	IL	60607-4901	14-2505
DSI Markham Renal Center	3053-3055 West 159th Street		Markham	COOK	IL	60428-4026	14-2575
DSI Schaumburg Renal Center	1156 S Roselle Rd		Schaumburg	COOK	IL	60193-4072	14-2654
DSI Scottsdale Renal Center	4651 West 79th Street	Suite 100	Chicago	COOK	IL	60652-1779	14-2518
DSI South Holland Renal Center	16136 South Park Avenue		South Holland	COOK	IL	60473-1511	14-2544
DSI Waukegan Renal Center	1616 North Grand Avenue	STE C	Waukegan	COOK	IL	60085-3676	14-2577
Edwardsville Dialysis	235 S BUCHANAN ST		EDWARDSVILLE	MADISON	IL	62025-2108	14-2701
Effingham Dialysis	904 MEDICAL PARK DR	STE 1	EFFINGHAM	EFFINGHAM	IL	62401-2193	14-2580

DaVita, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Emerald Dialysis	710 W 43RD ST		CHICAGO	COOK	IL	60609-3435	14-2529
Freeport Dialysis	1028 S KUNKLE BLVD		FREPORT	STEPHENSON	IL	61032-6914	14-2642
Granite City Dialysis Center	9 AMERICAN VLG		GRANITE CITY	MADISON	IL	62040-3706	14-2537
Illini Renal Dialysis	507 E UNIVERSITY AVE		CHAMPAIGN	CHAMPAIGN	IL	61820-3828	14-2633
Jacksonville Dialysis	1515 W WALNUT ST		JACKSONVILLE	MORGAN	IL	62650-1150	14-2581
Jerseyville Dialysis	917 S STATE ST		JERSEYVILLE	JERSEY	IL	62052-2344	14-2636
Kankakee County Dialysis	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	KANKAKEE	IL	60914-2439	14-2685
Lake County Dialysis Services	918 S MILWAUKEE AVE		LIBERTYVILLE	LAKE	IL	60048-3229	14-2552
Lake Park Dialysis	1531 E HYDE PARK BLVD		CHICAGO	COOK	IL	60615-3039	14-2717
Lake Villa Dialysis	37809 N IL ROUTE 59		LAKE VILLA	LAKE	IL	60046-7332	14-2666
Lincoln Dialysis	2100 WEST FIFTH		LINCOLN	LOGAN	IL	62656-9115	14-2582
Lincoln Park Dialysis	3157 N LINCOLN AVE		CHICAGO	COOK	IL	60657-3111	14-2528
Litchfield Dialysis	915 ST FRANCES WAY		LITCHFIELD		IL	62056-1775	14-2583
Little Village Dialysis	2335 W CERMAK RD		CHICAGO	COOK	IL	60608-3811	14-2668
Logan Square Dialysis	2659 N MILWAUKEE AVE	1ST FL	CHICAGO	COOK	IL	60647-1643	14-2534
Macon County Dialysis	1090 W MCKINLEY AVE		DECATUR	MACON	IL	62526-3208	14-2584
Marion Dialysis	324 S 4TH ST		MARION	WILLIAMSON	IL	62959-1241	14-2570
Maryville Dialysis	2130 VADALABENE DR		MARYVILLE	MADISON	IL	62062-5632	14-2634
Mattoon Dialysis	6051 Development Drive		Charleston	COLES	IL	61938-4652	14-2585
Metro East Dialysis	5105 W MAIN ST		BELLEVILLE	SAINT CLAIR	IL	62226-4728	14-2527
Montclare Dialysis Center	7009 W BELMONT AVE		CHICAGO	COOK	IL	60634-4533	14-2649
Mount Vernon Dialysis	1800 JEFFERSON AVE		MOUNT VERNON	JEFFERSON	IL	62864-4300	14-2541
Mt. Greenwood Dialysis	3401 W 111TH ST		CHICAGO	COOK	IL	60655-3329	14-2660
Olney Dialysis Center	117 N BOONE ST		OLNEY	RICHLAND	IL	62450-2109	14-2674

DaVita, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Olympia Fields Dialysis Center	4557B LINCOLN HWY	STE B	MATTESON	COOK	IL	60443-2318	14-2548
Pittsfield Dialysis	640 W WASHINGTON ST		PITTSFIELD	PIKE	IL	62363-1350	14-2708
Robinson Dialysis	1215 N ALLEN ST	STE B	ROBINSON	CRAWFORD	IL	62454-1100	14-2714
Rockford Dialysis	3339 N ROCKTON AVE		ROCKFORD	WINNEBAGO	IL	61103-2839	14-2647
Roxbury Dialysis Center	622 ROXBURY RD		ROCKFORD	WINNEBAGO	IL	61107-5089	14-2665
Rushville Dialysis	112 SULLIVAN DRIVE		RUSHVILLE	SCHUYLER	IL	62681-1293	14-2620
Sauget Dialysis	2061 GOOSE LAKE RD		SAUGET	SAINT CLAIR	IL	62206-2822	14-2561
Silver Cross Renal Center - New Lenox	1890 Silver Cross Boulevard		NEW LENOX	WILL	IL	60451	
Silver Cross Renal Center - West	1051 Essington Road		Joliet	WILL	IL	60435	
Silver Cross Renal Center - Morris	1551 Creek Drive		MORRIS	GRUNDY	IL	60450	
Springfield Central Dialysis	932 N RUTLEDGE ST		SPRINGFIELD	SANGAMON	IL	62702-3721	14-2586
Springfield Montvale Dialysis	2930 MONTVALE DR	STE A	SPRINGFIELD	SANGAMON	IL	62704-5376	14-2590
Springfield South	2930 South 6th Street		Springfield	SANGAMON	IL	62703	
Stoncrest Dialysis	1302 E STATE ST		ROCKFORD	WINNEBAGO	IL	61104-2228	14-2615
Stony Creek Dialysis	9115 S CICERO AVE		OAK LAWN	COOK	IL	60453-1895	14-2661
Stony Island Dialysis	8725 S STONY ISLAND AVE		CHICAGO	COOK	IL	60617-2709	14-2718
Sycamore Dialysis	2200 GATEWAY DR		SYCAMORE	DEKALB	IL	60178-3113	14-2639

DaVita, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Taylorville Dialysis	901 W SPRESSER ST		TAYLORVILLE	CHRISTIAN	IL	62568-1831	14-2587
TRC Children's Dialysis Center	2611 N HALSTED ST		CHICAGO	COOK	IL	60614-2301	14-2604
Vandalia Dialysis	301 MATTES AVE		VANDALIA	FAYETTE	IL	62471-2061	14-2693
Wayne County Dialysis	303 NW 11TH ST	STE 1	FAIRFIELD	WAYNE	IL	62837-1203	14-2688
West Lawn Dialysis	7000 S PULASKI RD		CHICAGO	COOK	IL	60629-5842	14-2719
Whiteside Dialysis	2600 N LOCUST	STE D	STERLING	WHITESIDE	IL	61081-4602	14-2648
Woodlawn Dialysis	1164 E 55TH ST		CHICAGO	COOK	IL	60615-5115	14-2310



2000 16th Street
Denver, CO 80202
(303) 405-2100
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September 13, 2012

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

Dear Chairman Galassie:

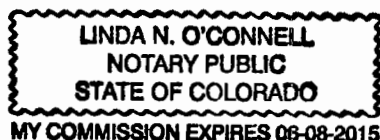
I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 IAC 1130.140 has been taken against any in-center dialysis facility owned or operated by DaVita Inc. or Cowell Dialysis, LLC in the State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

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

Sincerely,

Martha Ha
Assistant Secretary
DaVita Inc.

Subscribed and sworn to me
This 13th day of September, 2012

Notary Public

Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.230(b) – Background, Purpose of the Project, and Alternatives

Purpose of Project

1. The purpose of the project is to improve access to life sustaining dialysis services to the residents of Chicago, where there is a need for 78 additional dialysis stations. The area facilities have limited capacity and are not sufficient to meet patient demand particularly in light of the recent growth of ESRD patients in the geographic service area ("GSA"). In the most recently reported 12 month period from April 1, 2011 to March 31, 2012, there has been an increase of 180 dialysis patients in the area within 30 minutes of the proposed site. These patients alone require 30 stations operating at 100%.

ESRD patients are chronically ill individuals. In Chicago, these individuals are more often low-income, disabled, elderly, and members of minority groups. The City of Chicago's North and South Lawndale communities (collectively, "Lawndale") are comprised primarily of a Hispanic and African American population. South Lawndale is 83% Hispanic and 13% African American. North Lawndale is 94% African American and 5% Hispanic. Collectively, 98% of the Lawndale community is African American or Hispanic.

As shown in Attachment – 12A, there are currently 48 existing or approved dialysis facilities within 30 minutes travel time of the proposed dialysis facility (the "Geographic Service Area" or "GSA"). The average utilization of these facilities, as reported to The Renal Network (the "Renal Network Utilization Data") for the quarter ending March 31, 2012, is 78%. When excluding facilities that are not yet in operation, average utilization in the service area is 81%, above the State's standard.⁴ As such, the utilization within the service area will continue to meet or exceed the State's standard within 12 to 24 months.

The projected referrals from Dr. Aneziokoro, the primary referring physician for the proposed facility, confirm this. He is currently treating a large CKD patient-base, many of whom are advancing to ESRD and will likely require dialysis within the next 12 to 18 months. See Attachment – 12B. Conservatively, taking into account attrition due to patient death, transplant, return of function, or relocation, he projects that 74 of these patients will initiate dialysis within 12 to 18 months. Dr. Aneziokoro is also currently treating most of the patients at Little Village Dialysis, which is a local facility operating at 100% utilization, far above the state standard. Dr. Aneziokoro anticipates 14 of these patients will transfer to the proposed facility. Thus, approximately 88 patients will be referred to the proposed facility within 12 to 18 months.

Physicians affiliated with our joint-venture partner, Mt. Sinai Hospital, also are treating a large CKD patient population and those living Lawndale could also be referred to the proposed facility. Sinai nephrologists are treating 266 Stage 3, 4, and 5 CKD patients. Notably, 70% of these patients reside within 15 minutes normal travel time of the proposed facility. This fact coupled with Dr. Aneziokoro's large patient base also residing within 15 minutes, demonstrates adequate demand for the proposed facility.

These additional stations will also improve access to a community in need of these services most. If you compare the 2011 facility data for suburban Chicago (HSA 7) to the City of Chicago, you can see that the lower income parts of metro Chicago have reduced access to dialysis care. While patient numbers between these HSAs are virtually the same, with Chicago having slightly more, 4685 patients as of December 31, 2011 versus 4674 patients in the near suburbs, the

⁴ The Renal Network Utilization Data takes into account 2 facilities, FMC Cicero and FMC Chatham, which are not operating yet. The referring physicians for these facilities anticipate they will refer a sufficient number of patients to each facility to reach the State's 80% utilization standard by the second year of project completion.

suburban patients have better access to treatment with 990 stations for Chicago residents and 1065 stations for suburban Cook and DuPage counties.

Further, based upon the data gathered by the Board for 2011, of the patients treated in the City of Chicago for 2011, 21% were Hispanic and 67% were people of African American or non-White. This compares to a suburban population which is 13% Hispanic and 53% African American or non-White. Additionally, Medicaid accounted for only 10% of patients in HSAs 7 and 8, compared to 20% in HSA 6. The proposed Lawndale facility will be located in a community with a highly concentrated minority population and will provide improved access to necessary dialysis services for its residents.

Further, many dialysis patients often rely on public transit, Medicaid-sponsored transit, family members, and friends for transportation to and from dialysis treatment. Including transportation time and transition time, patients typically devote 15 to 20 hours for dialysis each week over three days. This inconvenience is exacerbated when patients require treatment during an evening or fourth shift. When facilities are operating at 80% utilization, it is often difficult for a patient to schedule dialysis during an optimal shift, which is generally the second shift. Dialysis patients are chronically ill and usually elderly. Patients, many of whom rely on assistive devices, such as canes and walkers, are faced with additional safety hazards when arriving and departing the facility in the dark. Some of these hazards cannot be avoided in the winter, but patients feel much more secure when coming and going in the daylight. The establishment of a 16-station dialysis facility will not only allow for safer and more convenient treatment times for patients, but will also help meet the 78-station need in the service area.

2. A map of the market area for the proposed facility is attached at Attachment – 12C. The market area encompasses approximately a 15 mile radius around the proposed facility. The boundaries of the market area of are as follows:
 - North approximately 30 minutes normal travel time to Skokie
 - Northeast approximately 22 minutes normal travel time to Belmont Ave. & Lake Shore Drive
 - East approximately 12 minutes normal travel time to South Lake Shore Drive
 - Southeast approximately 30 minutes normal travel time to South Deering
 - South approximately 30 minutes normal travel time to Crestwood
 - Southwest approximately 30 minutes normal travel time to Bolingbrook
 - West approximately 30 minutes normal travel time to Lombard
 - Northwest approximately 30 minutes normal travel time to Chicago O'Hare International Airport
3. The minimum size of a GSA is 30 minutes; however, most of the patients reside within the immediate vicinity of the proposed facility. A map of showing of the service area 15 minutes normal travel time surrounding the proposed facility is attached at Attachment – 12D. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.⁵ Due to socioeconomic conditions in the Chicago's Lawndale community, this population exhibits a higher prevalence of obesity, which is a driver of diabetes and hypertension. African Americans are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in the African American community, as are Hispanics. In fact, the ESRD incident rate among African Americans is 3.6 times greater than whites and the incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. See Attachment – 12E.

⁵ Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

As noted above, the Lawndale community is comprised of an approximately 98% African American and Hispanic population. Additionally, the median household income is \$26,090, which is barely above the poverty threshold for a family of four. Low-income, disabled, elderly, and members of minority groups are more likely to suffer from chronic kidney disease.⁶ This, coupled with the aging population, is expected to increase utilization.

As shown in Attachment – 12B, the projected referrals by Dr. Aneziokoro confirms this increasing demand. Dr. Aneziokoro expects approximately 88 of his current CKD and ESRD will be referred to the proposed Lawndale facility within the next 12 to 18 months.

4. Source Information

The Renal Network, Utilization Data for the Quarter Ending March 31, 2012.

U.S. Census Bureau, American FactFinder, Fact Sheet, available at http://factfinder.census.gov/home/saff/main.html?_lang=en (last visited Sept. 19, 2012).

U.S. Renal Data System, USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2010 available at <http://www.usrds.org/atlas.htm> (last visited Sept. 19, 2012).

U.S. Renal Data System, USRDS 2007 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2007 available at http://www.usrds.org/adr_2007.htm (last visited Sept. 19, 2012).

Sinai Urban Health Institute, Lawndale Diabetes Project: A Community-Based Collaboration Between Mt. Sinai Hospital and Blue Cross and Blue Shield of Illinois, available at <http://www.suhichicago.org/research-evaluation/lawndale-diabetes-project-a-community-based-collaboration-between-mount-sinai-hospital-and-blue-cross-and-blue-shield-of-illinois> (last visited Sept. 19, 2012).

Sinai Urban Health Institute, Block by Block North Lawndale Diabetes Community Action Program, <http://www.suhichicago.org/research-evaluation/block-by-block-north-lawndale-diabetes-community-action-program> (last visited Mar. 26, 2012).

5. The proposed facility will improve access to dialysis services to the residents of Lawndale and the surrounding area by establishing a 16-station dialysis facility in Lawndale. As a heavily Hispanic and African American community, Lawndale faces many challenges from a health disparities perspective and is considered a "food desert." There is a direct correlation between the lack of food choices and increases in obesity. In a 2009 survey conducted by Mt. Sinai Hospital, the North and South Lawndale communities were reported to have the highest obesity rates in the City of Chicago. In fact, Sinai Urban Health Institute ("SUHI") found that the diabetes mortality rate in Lawndale is 62% higher than national levels and 37% higher than the City of Chicago. It is estimated that the direct medical care costs per person per year with diabetes is 2.3 times higher than for the person without diabetes.

⁶ U.S. RENAL DATA SYSTEM, USRDS 2012 ANNUAL DATA REPORT: ATLAS OF CHRONIC KIDNEY DISEASE AND END-STAGE RENAL DISEASE IN THE UNITED STATES 183 (Nat'l Inst. of Health, & Nat'l Inst. of Diabetes & Digestive & Kidney Diseases 2011), available at http://www.usrds.org/2011/pdf/v2_ch01_11.pdf.

SUHI was awarded a highly-competitive major grant by the National Institutes of Health to undertake the Block by Block North Lawndale Diabetes Community Action Program.⁷ The primary aim of the program is the reduction in diabetes through community engagement of those in Lawndale, a "medically underserved urban neighborhood."⁸

Sinai's new program has the potential to have a positive impact on wellness and health care outcomes. However, the need for dialysis services in the Lawndale community is immediate. Given the expense and time of additional travel, patients may frequently miss treatments or forego dialysis altogether. This would significantly harm a patient's survival rate and exacerbate co-morbidities. By making dialysis services more accessible to the residents of Lawndale and the surrounding area, patients are more likely to adhere to their treatment protocols, which will result in better outcomes and survival rates.

6. The Applicants anticipate the proposed facility will have quality outcomes comparable to its other facilities. Additionally, in an effort to better serve all kidney patients, DaVita believes in requiring all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which was \$1 billion in hospitalization savings to the health care system and the American taxpayer in 2011.

⁷ SINAI URBAN HEALTH INSTITUTE, BLOCK BY BLOCK NORTH LAWDALE DIABETES COMMUNITY ACTION PROGRAM, <http://www.suhichicago.org/research-evaluation/block-by-block-north-lawndale-diabetes-community-action-program> (last visited Mar. 26, 2012).

⁸ *Id.*

Maple Avenue Kidney Center		Oak Park	7	6.22	16.25	18	67	62.04%
Loop Renal Center		Chicago	6	7.63	20	28	100*	59.52%
Fresenius Medical Care - Midway		Chicago	6	6.98	18.75	12	42	58.33%
Fresenius Medical Care Melrose Park		Melrose Park	7	9.31	23.75	18	60	55.56%
Fresenius Medical Care of Chicago - West		Chicago	6	3.24	11.25	31	99	53.23%
Grand Crossing Dialysis		Chicago	6	13.84	28.75	12	36*	50.00%
TRC Children's Dialysis		Chicago	6	9.95	27.5	6	17*	47.22%
West Lawn Dialysis		Chicago	6	5.79	18.75	12	30*	41.67%
Rush Univ. Med. Ctr.		Chicago	6	3.74	12.5	5	4	13.33%
Fresenius Medical Care West Willow		Chicago	6	9.3	21.25	12	5	6.94%
Fresenius Medical Care Chatham		Chicago	6	14.32	27.5	16	0	0.00%
Fresenius Medical Care Cicero		Cicero	7	1.8	6	16	0	0.00%
* Patient census as of 8/31/12 for DaVita facilities.								

Ogbonnaya Aneziokoro, M.D
655 West Irving Park Road
Suite 2101
Chicago 60613

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

Dear Chairman Galassie:

I am pleased to support the establishment of Lawndale Dialysis. As stated in my earlier support letters and testimony, the new 16-station chronic renal dialysis facility, to be located at 3934 West 24th Street, Chicago, IL 60623, will afford my growing patient-base access to excellent dialysis care.

The community surrounding the proposed facility, as well as the group of patients that I am treating, is a medically vulnerable, primarily African-American, Hispanic and low-income, patient population. The Lawndale community also has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). My patient population reflects the racial and ethnic health disparities in this community. So does the Board's own 78-station need projection and the state-wide ESRD data that it recently published which reflects the disparities in kidney health, and access to dialysis services and health insurance in the Hispanic and African American population.

In my last referral commitment letter, I identified 148 CKD patients whose condition is advancing to end stage renal disease (ESRD). Since that time, my colleagues and I experienced a loss – the very unfortunate death of Dr. Lillian Magana, who also treated CKD patients in the Lawndale and Little Village communities. After her untimely death, I took over substantially all of her patient load. Thus, my CKD patient population is now significantly larger.

Of these CKD patients, I project that I will refer 74 who will require dialysis within the next 12 to 18 months to the proposed Lawndale facility. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 96 patients at Little Village Dialysis, which is a nearby facility operating at 100% utilization, significantly higher than the state standard. I anticipate that 14 of these patients will transfer to the proposed facility. A list of the zip codes for these patients is attached at Attachment – 2. Thus, I project that I would refer a total of 88 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD at Attachment – 3.

Due to the large number of kidney disease patients my practice serves, the new facility is essential. I anticipate that my patient population, and the number of individuals suffering from CKD generally, will continue to increase. CKD is a growing public health problem in the United States. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and

ESRD. Not surprisingly, obesity, is linked to both diabetes and high blood pressure, is also one of driving factors for progressive CKD.

According to a recent study, the number of Americans with diabetes will double from 23.7 million in 2009 to 44.1 million in 2034. Because the average wait time for an ESRD patient for a kidney transplant is more than four years, and mortality rates among ESRD patients have improved significantly in recent years, during any given year, most of these patients become dependent on dialysis to survive. As such, demand for dialysis treatment is expected to continue to increase.

Further, as medical professionals and, more importantly, as humans, we have a responsibility to make a difference in our communities when we have the ability to do so. My partners, Mt. Sinai and DaVita, have demonstrated their willingness to furnish essential services in underserved and underprivileged communities. Due to local socioeconomic conditions, this community, in particular, needs these services, and they need them now.

This population exhibits a higher prevalence of obesity, which is a primary driver of diabetes and hypertension. Notably, the City of Chicago exhibits a much higher concentration of African Americans and Hispanics than the rest of the State. In fact, approximately 98% of the Lawndale community is either African American or Hispanic. These individuals are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in minority communities. In fact, the ESRD incident rate among African Americans is 3.6 times greater than the non-whites and the incident rate among Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to increase utilization.

My patients need this facility, and, as such, I fully support the proposed establishment of Lawndale Dialysis. The information in this letter is true and correct to the best of my knowledge.

Sincerely,

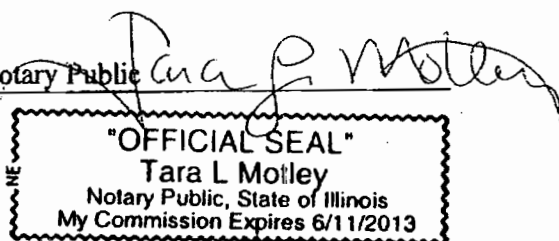


Ogbonnaya Aneziokoro, M.D.
Nephrologist

Subscribed and sworn to me

This 21st day of Sept., 2012

Notary Public



**ATTACHMENT 1
PRE-ESRD PATIENTS**

Zip	Patients
60804	8
60623	46
60624	5
60608	15
Total	74

**ATTACHMENT 2
CURRENT PATIENTS**

Zip	Patients
60608	1
60623	9
60629	3
Total	14

ATTACHMENT 3 HISTORICAL ESRD REFERRALS

Little Village Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60609	1	60402	1	60608	3
60629	3	60609	1	60609	1
60632	1	60623	6	60623	5
60651	1	60632	2	60632	2
		60638	1	60643	1
				60644	1

Lincoln Park Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60614	1	60609	1	60610	1
60624	1	60610	1	60614	1
60629	1	60614	3	60625	1
60639	1	60618	3	60657	2
60645	1	60645	1	91170	1
60653	1				
60659	1				

Logan Square Dialysis

2009		2011	
Zip Code	Patients	Zip Code	Patients
60614	2	60639	1

Emerald Dialysis

2011	
Zip Code	Patients
60621	1
60623	2
60632	2

[illegible]

Attachment - 12C

This is a detailed map of Chicago, Illinois, and its surrounding areas. The map shows the city's boundaries, major roads, and various landmarks. Key features include:

- Geography:** Lake Michigan is visible in the upper left corner. The city is situated on the southwestern shore of the lake.
- Major Roads:** The map displays a network of streets, including major highways like I-55 (Roosevelt Expressway) and I-90 (Dan Ryan Expressway). Other significant roads include W. Cermak Rd., W. 35th St., W. 47th St., and W. 55th St.
- Parks and Recreation:** Numerous parks are labeled, such as Lincoln Park, Grant Park, Jackson Park, and Forest Park. The map also shows various playgrounds and recreational areas.
- Neighborhoods and Districts:** The map identifies several neighborhoods, including Loop, South Loop, Little Italy, Greektown, and various suburban areas like Evanston, Skokie, and Oak Park.
- Landmarks:** The map includes labels for the Chicago River, the Chicago Midway Airport, and the Chicago skyline.
- Scale and Orientation:** A scale bar at the bottom indicates distances in miles (0 to 5) and kilometers (0 to 8). The map is oriented with North at the top.

Editorial Review

The obesity epidemics in ESRD: from wasting to waist?

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Keywords: CKD; ESRD; malnutrition; metabolic syndrome; obesity

During the last six decades, from the World War II years on, the phenotype of human beings has changed profoundly. The dominant slim, pale and light phenotype of the 1920s has gradually been overthrown by the heavy, large and ponderous phenotype of obese people. Obesity is rampant in the USA (<http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/>, accessed on 20th July 2008) and, even though to a lesser degree, most European countries share the same epochal evolution [1]. Type 2 diabetes and cardiovascular diseases are the two most important non-communicable disease outcomes of obesity. Abdominal obesity is strongly associated, and at least in part in a causal manner, with hypertension, dyslipidaemia and impaired insulin resistance [2]. Well beyond these complications, neoplasia [3], greater exposure to drugs of various sort, sterility [4], asthma [5], non-alcoholic liver disease [6] and osteoarthritis [7] are all much concerning sequelae of this epidemics. The risk of disease and disability attributable to overweight and obesity starts early, just when the upper limit of the ideal body mass index (BMI) (21–23 kg/m²) is trespassed and rises linearly at progressively higher BMI levels [8,9]. The burden of disease attributable to excess BMI among adults in the USA is enormous. Obesity at age 40 years reduced life expectancy by ~7 years in women and by ~6 years in men in the Framingham cohort [10]. In Europe, more than 1 million deaths and ~12 million life-years of ill health (disability adjusted life-years—DALYs) were counted in 2000 [9].

Obesity epidemics in the dialysis population

Until now the major focus of nutrition research in dialysis patients has been on low BMI and protein energy wasting

[11]. The identification and elucidation of this pervasive condition in the dialysis population has certainly been a major achievement of modern nephrology. However, a thorough refocusing of the problem is needed. In Western countries, overweight and obesity have now gained the ominous role of leading risk factors for chronic kidney disease (CKD) [12]. The pathophysiological underpinnings of obesity-related CKD are still unclear, but solid working hypothesis have been formulated and the issue is being intensively investigated in experimental models and in human studies [13]. From an epidemiologic point of view, the association between BMI and the incidence of ESRD has been convincingly established in population-based studies in Japanese men [14] and in American people [15]. Obesity is one of the most frequent risk factors for progressive CKD in the general population. For this reason, this condition has become highly prevalent in dialysis units (Figure 1). The problem was nicely described by Kramer *et al.*, in synchronic analyses based on the USRDS and on the Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention [16]. During a relatively brief period (just 8 years, from 1994 to 2002), the mean BMI increased from 25.7 kg/m² among incident patients in 1995 to 27.5 kg/m² in 2002 and from 25.7 to 26.7 kg/m² in the total US population (Figure 2). Overall in 2002, almost one-third of incident dialysis patients were obese and, worryingly so, the prevalence of patients with stage 2 obesity (BMI > 35 kg/m²) increased by 63%. As expected, the prevalence of obesity was higher in diabetics than in non-diabetics with a forecasted 2007 prevalence of total obesity in these patients as high as 44.6%. The predicted population average of BMI for 2007 (~28 kg/m²) clearly indicates that just a small fraction of dialysis patients in the USA have a normal or a low body weight. In a cohort of incident dialysis patients (1997–2004) in Europe (the Netherlands) [17], the average BMI was 25.3 kg/m² showing that in the other side of the Atlantic more than half of ESRD patients are overweight or obese. In brief, there is unmistakable evidence that the obese phenotype is at least as frequent in the dialysis population as it is in the general population. Thus, nutritional disorders in ESRD should be interpreted in a context that takes into appropriate account that fat excess rather than fat deficiency is the most common trait in dialysis patients.

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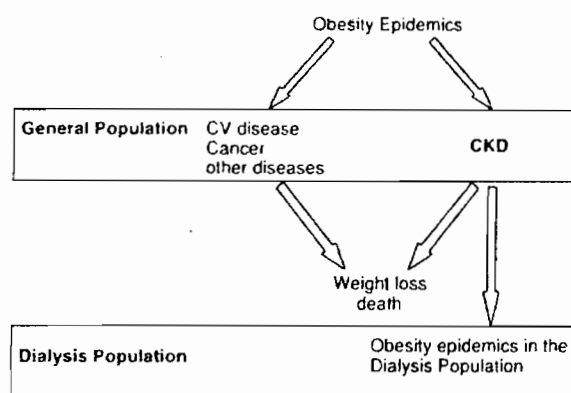


Fig. 1. Simple model whereby the obesity epidemics in the general population generate a parallel obesity epidemics in the dialysis population. Death and weight loss generated by CKD and other obesity-driven diseases represent competing risks that limit the rise in the prevalence of obesity in the dialysis population.

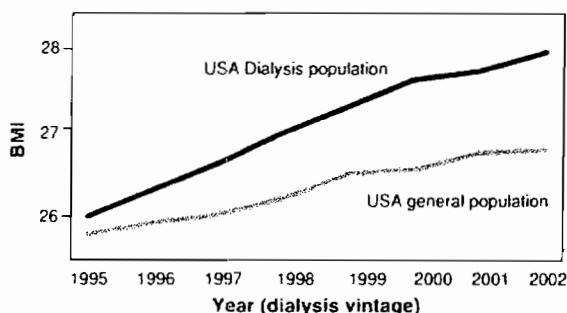


Fig. 2. Temporal trends in BMI (kg/m^2) among incident ESRD patients population by year of dialysis initiation and in the coeval general US population (Behavioral Risk Factor Surveillance System). Redrawn from Kramer HJ *et al.* [16].

Obesity and the reverse epidemiology conundrum in ESRD

The term 'reverse epidemiology' has been widely adopted to describe the apparently paradoxical inverse association between mortality and BMI and other risk factors in ESRD. Studies in renal registries [18], in clinical databases [19] and in large, international studies [20] have coherently shown that BMI is indeed inversely associated with death risk. This phenomenon is not typical of ESRD being common also to other chronic conditions, including cardiovascular disease [21,22]. The term 'reverse epidemiology' has fierce opponents [23]. It was emphasized that rules of epidemiology have not been reversed in dialysis patients, and recent data in a European dialysis cohort documented that the relationship between the BMI and mortality does not deviate from that of the coeval background population [17]. In addition, most studies did not adequately control for potential confounders such as cancer and CHF, and smoking. The main reason of concern with the term 'reverse' is that such a definition may distract from the complexity of the ESRD population and

may facilitate confusion between association and causation thus diverting clinical attention and scientific research from truly important issues related to risk factors modification in this population [23]. There is no question that obesity was a trait providing survival advantage to our ancestors at a time when famine and infectious diseases decimated the population and when the average duration of human life was 40 years or less [24]. The same survival advantage may apply to high-risk conditions such as cardiac disease, cancer and ESRD that are all characterized by a short life expectancy and by specific (non-Framingham) risk factors. Any case studying risk factors for survival in the dialysis population in no way imposes deviations from classic epidemiology principles. In this respect, there is absolutely no dissent on the fact that a high BMI *per se* should not be seen as a necessarily protective factor in ESRD. In fact, current guidelines in ESRD recommend a multidimensional assessment of nutritional status [25,26] both for prognosis and treatment while the very champions of the 'reverse epidemiology' concept accurately dissected the BMI-protein balance link when assessing the risk of malnutrition in this population [27].

How to measure the obesity burden in epidemiological studies

Defining obesity and how to measure it is of fundamental importance if we are to develop disease-specific studies in ESRD. However, in broad terms, the very essence of obesity and how it should be measured in population studies is an unsettled problem. This is so in epidemiological research in general and in research specific to ESRD as well. Most of the progress on the understanding of the detrimental effect of fat excess on human health was made in studies based on the BMI. In recent years, this time-honoured metric has been under intense scrutiny and, on the basis of a thorough meta-analysis, eminent epidemiologists came to the conclusion that the BMI is an inadequate metric for the cardiovascular risk of obesity [28]. Authoritative claims have been made that BMI should be abandoned straightaway [29]. Which is the best metric of this condition remains highly controversial. Proper positioning of the indicators of obesity may be obtained by studying the inter-correlation between the various metrics, their relationship with clinical outcomes and by cogent biological knowledge. Detailed analyses of the relationship between BMI, overall fat mass, waist circumference and abdominal visceral fat (as measured by computed tomography) in Caucasian and African American population samples have been made [30]. Collectively, the mean correlation between BMI and fat mass in these populations was very high ($r = 0.94$). Of note, waist circumference correlated very well both with BMI ($r = 0.93$) and overall fat mass ($r = 0.92$). Finally, BMI ($r = 0.72$) as well as the other metrics (fat mass $r = 0.73$; waist circumference $r = 0.77$) correlated equally well with abdominal visceral adiposity by CT. Since the major factor implicated in the health risks of obesity seems to be the excess adipose tissue and/or some aspects of cell biology, the data on the relationship between BMI and overall fat mass

would be against the contention that BMI is not a valid surrogate for fat mass, at least in apparently healthy adults in the community. The same reasoning applies to waist circumference. Since most of the variance in obesity-related anthropometrics is captured by BMI, some obesity experts see no reason to replace BMI by waist circumference or other metrics as a measure of obesity [30]. However, it has been argued that this position does not consider that analyses in apparently healthy subjects may not apply to patients with chronic conditions. Furthermore, simple analyses on inter-correlations between indicators of obesity in no way can surrogate the study of the relationship of these measurements with clinical outcomes, which is the ultimate, adjudicative criterion. In this respect, it is well demonstrated that waist circumference and the related metric waist hip ratio (WHR) add prognostic information at any level of BMI. In a large survey based on the III National Health and Examination survey within the three BMI categories of normal weight, overweight and class I obesity, a larger waist circumference coherently identified individuals at an increased health risk [31]. Likewise, the WHR was the strongest body size measure associated with myocardial infarction in the INTERHEART study, a world-wide extended case-control study [32]. Importantly, in this study, BMI lost substantial prognostic value in an analysis adjusting for WHR and other risk factors while the predictive power of WHR became stronger after these statistical adjustments, which is in line with biological evidence indicating that visceral fat is a relevant source of endogenous compounds impinging upon cardiovascular health. Whether metrics of waist circumference hold prognostic value for death and cardiovascular complications in patients with chronic diseases other than myocardial infarction is still unknown [33].

Obesity and protein energy wasting in ESRD: a two-dimensional problem

BMI is the most used anthropometric measure of overall body size in ESRD. The limitations of this metric are well known to nephrologists [11]. BMI does not distinguish between fat mass and lean mass. At similar BMI, percentage of body fat may differ considerably in people who exercise heavily and in sedentary people. Furthermore, in the elderly and non-Caucasian populations, the relationship between BMI and fat depots is different from that in the young and Caucasian populations [34]. Importantly, BMI does not give information on segmental fat distribution (abdominal versus peripheral fat), a phenomenon with metabolic and clinical bearings. Abdominal obesity is largely caused by the accumulation of visceral (or intra-abdominal) fat while peripheral obesity is mainly characterized by subcutaneous fat accumulation. Due to metabolic differences of the two fat depots, the two may differ in their role of predicting metabolic disturbances and clinical events. Although still not adequately emphasized, the notion that nutritional disorders in ESRD cannot be merely classified on the basis of BMI is well recognized. In 2003, Beddhu *et al.* [35] looked at the problem of which body component (increased

muscle mass or body fat) confers survival advantage in a large cohort of incident haemodialysis patients with high BMI. Twenty-four-hour urinary creatinine excretion prior entering regular dialysis treatment was used as a measure of muscle mass. Patients with high BMI had lower death risk than those with a normal or low BMI. However, high BMI patients with relatively low muscle mass (urinary creatinine ≤ 0.55 g/day) had higher risk of all-cause (HR, 1.14; $P < 0.001$) and cardiovascular (HR, 1.19; $P < 0.001$) deaths than patients with the same BMI but low muscle mass. Similarly, in a recent study by Honda in a relatively small cohort of ESRD patients in Sweden [36], protein-energy wasting (as measured by the subjective global assessment of nutrition) was equally prevalent in patients with low, normal and high BMI. In this cohort, BMI *per se* did not predict mortality. However, for each BMI group, protein-energy malnutrition was associated with increased death risk. Overall, these studies show that 'obese sarcopenia', i.e. a high body mass in the face of a low urinary creatinine or protein energy malnutrition, underlies a high death risk in ESRD patients thus indicating that the prognostic value of nutritional status in dialysis patients should be based on the BMI and on metrics of muscle mass and/or protein-energy balance.

Anthropometric measures of visceral fat accumulation such as waist circumference and the WHR are directly associated with all-cause and CV mortalities in the general population. Notwithstanding, ESRD is a chronic condition where nutrition disorders are exceedingly common, and no specific studies of these metrics are available in dialysis patients. Also in light of the rising tide of overweight and obesity in the ESRD population and of the adverse clinical outcomes observed in obese sarcopenia [35,36], the issue of simultaneously testing the prognostic value of metrics of overall body size (like the BMI) and segmental fat accumulation (waist circumference and WHR) in ESRD patients appears to be of major relevance. Very recently, relevant information on the validity of waist circumference as a measure of visceral fat accumulation has been gathered in patients with CKD [37]. In a series of 122 Brazilian patients with stage 3–5 CKD, this metric was strongly associated with visceral fat as measured by abdominal computed tomography and the association of this measurement with cardiovascular risk factors was of the same magnitude of that observed for visceral fat. These findings suggest that waist circumference is a simple and cheap instrument that may be applied for investigating the role of visceral fat on health outcomes in epidemiological studies in patients with renal diseases. In a combined cohort composed by patients enrolled in the Atherosclerosis Risk in Communities (ARIC) and the Cardiovascular Health Study (CHS), a larger waist hip ratio was associated with a 22% risk excess for incident CKD and a 12% risk excess for a combined outcome composed by incident CKD and death [38]. In the same study, BMI appeared protective for the composite outcome but did not predict the risk for CKD. Likewise, in another study in the same cohort [39], a large waist hip ratio was associated with an increased risk of cardiac events while obesity, defined on the basis of BMI > 30 kg/m², did not predict these events. Overall these analyses indicate that, like in the general population, measures of abdominal fat accumulation maintain a direct association with the

risk for CKD, cardiovascular events and death. Thus testing the value of these metrics in ESRD appears to be of foremost importance. This may be problematic in patients treated with peritoneal dialysis where other options for risk stratification can be envisaged [40]. Overall, combining estimates of overall body size such as the BMI and of abdominal fat accumulation such as waist circumference may indeed refine the prognostic power of these measurements and produce interesting hypotheses for future clinical trials in ESRD patients. For example, does weight loss confer a health benefit in patients with a high BMI and a high waist circumference? Conversely, does a relatively large waist circumference in the face of a normal or low BMI identify patients at the highest risk of adverse clinical outcomes? Does the relationship between waist circumference and the waist hip ratio with biomarkers of inflammation observed in the general population and in patients with cardiovascular diseases hold true in ESRD and is this relationship modified by the BMI in these patients? In light of the pervasiveness of the obesity epidemics (as defined on the basis of the BMI) in ESRD, studying anthropometric measurements of visceral obesity as related to health outcomes in this population appears to be an absolute research priority.

Conflict of interest statement. None declared.

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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-Hispanics 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-Hispanics 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

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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Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.230(c) – Background, Purpose of the Project, and Alternatives

Alternatives

The Applicants considered two options prior to determining to establish a 16-station dialysis facility. The options considered are as follows:

1. Maintain the status quo;
2. Establish a Wholly-Owned Facility; and
3. Joint Venture with Hospital and Physician Partners

After exploring these options, which are discussed in more detail below, the Applicants determined to partner with Mt. Sinai Hospital and Dr. Aneziokoro to establish a 16-station dialysis facility in Lawndale. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

Based upon the latest inventory data, there is a need for 78 dialysis stations in HSA 6, the service area where the proposed facility will be located. Average utilization of existing facilities is currently 81%. 20 of these facilities are operating above 90% utilization, which often requires the operation of a fourth shift. Patients receiving treatment during a fourth shift face additional safety hazards when arriving and departing the facility in the dark. As stated above, the community surrounding Lawndale is largely comprised of low-income, disabled, and vulnerable individuals who rely on wheelchairs and assistive devices such as canes and walkers. Patients are more secure when coming and going during the day.

The proposed project will improve access to dialysis services by adding a much needed dialysis facility to the Lawndale community. Importantly, approximately 98% of the area is African American or Hispanic. African Americans are at an increased risk of ESRD compared to the general population due to the higher prevalence of diabetes and hypertension, the two leading causes of CKD and ESRD in the African American community. In fact, the ESRD incident rate among African Americans is 3.6 times greater than whites and among the Hispanic population it is 1.5 times greater than the non-Hispanic population. As such, demand in the community will continue to increase. Dr. Aneziokoro projected referrals further demonstrate this increasing need.

Dr. Aneziokoro is currently treating a large CKD patient-base, many of which are advancing to ESRD and will likely require dialysis within the next 12 to 18 months. See Attachment – 13A. Conservatively, taking into account attrition due to patient death, transplant, return of function, or relocation, he projects that 74 of these patients will initiate dialysis within 12 to 18 months. Dr. Aneziokoro is also currently treating most of the patients at Little Village Dialysis, which is a local facility operating at 100% utilization, far above the state standard. Dr. Aneziokoro anticipates 14 of these patients will transfer to the proposed facility. Thus, approximately 88 patients will be referred to the proposed facility within 12 to 18 months. The establishment of a 16-station dialysis facility is necessary to meet the dialysis needs of these patients and will also help meet the 78-station need in the service area.

Health disparities are differences in health outcomes that are closely linked to social, economic and environmental disadvantage. There are many access to health care disparities which negatively affect the African American and Hispanic communities in the United States and locally in Chicago. As stated in other narratives in this application, this proposed facility will primarily serve African American and Hispanic patients. In recent years, both the federal and state governments as well as private sector initiatives are giving special attention to the health care access issues minorities in this country

face. At the federal level, there is an Office of Minority Health which has recently published the HHS Action Plan to Reduce Racial and Health Disparities. A copy of that Action Plan is attached as Attachment – 13B. At the federal level, the Federal Interagency Health Equity Team has federal with other public and private organizations to form the National Partnership for Action to End Health Disparities. In Illinois, there are 22 organizations that have become a part of this partnership to address health disparities here.

Despite medical advances and new technologies, well-documented health disparities exist between different racial and ethnic populations. Not only are these well-documented nationally but Statewide and area ESRD data bears out those health disparities as does research specifically targeting the Lawndale community which this project is intended to serve. Some data of particular note from the HHS Office of Minority Affairs includes:

- About 30 percent of Hispanic and 20 percent of black Americans lack a usual source of health care compared with less than 16 percent of whites.
- Hispanic children are nearly three times as likely as non-Hispanic white children to have no usual source of health care.
- African Americans and Hispanic are far more likely to rely on hospitals or clinics for their usual source of care than are white Americans (16 and 13 percent, respectively, v. 8 percent).

As discussed in other narratives to this application, the two institutional partners in this planned facility are working on many fronts to reduce health disparities in the communities they serve. But until the health of the community of Lawndale is improved and obesity, diabetes and hypertension rates are reduced to decrease the need for ESRD care, the option of not improving access to services for this needy population is one that was rejected.

There is no capital cost with this alternative.

Establish a Wholly-Owned Facility

As set forth above, there is currently a need for 78 dialysis stations in HSA 6, the service area where the proposed facility will be located. Average utilization of existing facilities is currently 81%, and 20 of these facilities are operating above 90% utilization, which often requires the operation of a fourth shift. Further, Dr. Aneziokoro is currently treating a large CKD patient-base, many of whom are advancing to ESRD and projects 74 patients will initiate dialysis within 12 to 18 months. Dr. Aneziokoro is also currently treating 96 patients at Little Village Dialysis, which is a local facility operating at 100% utilization, far above the state standard. Dr. Aneziokoro anticipates 14 of these patients will transfer to the proposed facility..

Further, the dialysis facility will be located in the Lawndale neighborhood, which is approximately 98% African-American and Hispanic. As set forth above, the ESRD incident rate among African Americans 3.6 times greater than that of whites and among Hispanics it is 1.5 times higher than the non-Hispanic population. Health disparities are differences in health outcomes that are closely linked to social, economic and environmental disadvantage. There are many health care access disparities which negatively affect the African American and Hispanic communities. As discussed throughout this application, DaVita and its two institutional partners are dedicated to community outreach and education to better educate, increase awareness, and improve ESRD intervention. While Mt. Sinai Hospital offers various innovative programs designed to improve the health of the Lawndale community, it currently provides no dialysis education programs similar to DaVita's IMPACT and EMPOWER programs.

Based upon the DaVita current utilization of the existing facilities and the projected number of CKD patients that will require in-center hemodialysis within the next 12 to 18 months DaVita considered establishing a wholly-owned 16-station dialysis facility. However, a wholly-owned facility would not

allow DaVita to leverage off Mt. Sinai Hospital's existing community outreach programs to improve CKD and ESRD education to the Lawndale community. Therefore, the option of establishing a wholly-owned facility was rejected.

The capital cost of this alternative is \$3,108,577.

Joint Venture with Hospital and Physician Partners

After vetting each parties' goals in the future delivery of health care, DaVita determined that it would be strategically, operationally and financially beneficial to collaborate with Mt. Sinai Hospital to offer dialysis services in the Lawndale community of Chicago. Dr. Aneziokoro is also a part of the joint venture. Dr. Aneziokoro also has a strong commitment to the community. He has dedicated his practice to the Little Village and Lawndale communities despite some of the financial challenges a private medical practice faces in a community that has a significant uninsured/underinsured population. Unlike the vast majority of hospitals that DaVita collaborates with in the delivery of dialysis services, Mt. Sinai Hospital is uniquely dedicated to providing a broad array of services to patients suffering from chronic kidney disease including ESRD. Typically, the relationships that DaVita has with its area hospitals involves DaVita supporting the hospital through the outsourcing of its acute dialysis services as well as being a provider of choice for outpatient dialysis services and other kidney disease support services. In the Lawndale community, however, Mt. Sinai Hospital is committed to a long term role as a dialysis provider and also employs several nephrologists to ensure access to physician care for a vulnerable population. Further, Mt. Sinai Hospital and DaVita share a common commitment to community outreach and education. While Mt. Sinai Hospital offers many diverse education programs, it currently provides no dialysis education programs similar to DaVita's IMPACT and EMPOWER programs. Leveraging on each provider's existing community programs, this partnership can better educate, increase awareness, and improve ESRD intervention in the Lawndale community.

The DaVita-Mt. Sinai Hospital-physician partnership provides the community an opportunity for better access to capital based on DaVita's strong financial position. Moreover, because Davita purchases large volumes of equipment and supplies, it can provide dialysis services at lower cost than smaller providers. These cost savings are invested in new technologies and quality initiatives to improve patient outcomes.

An expanded DaVita-Mt. Sinai Hospital partnership would also allow for greater economies of scale, integration of clinical, administrative and support functions, elimination of functional redundancies and redesign of patient care delivery. Further, the community will benefit from DaVita's infrastructure and processes and quality initiatives, which are proven to reduce patient mortality and morbidity.

The capital cost of this alternative is \$3,145,940.

Ogbonnaya Aneziokoro, M.D
655 West Irving Park Road
Suite 2101
Chicago 60613

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

Dear Chairman Galassie:

I am pleased to support the establishment of Lawndale Dialysis. As stated in my earlier support letters and testimony, the new 16-station chronic renal dialysis facility, to be located at 3934 West 24th Street, Chicago, IL 60623, will afford my growing patient-base access to excellent dialysis care.

The community surrounding the proposed facility, as well as the group of patients that I am treating, is a medically vulnerable, primarily African-American, Hispanic and low-income, patient population. The Lawndale community also has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). My patient population reflects the racial and ethnic health disparities in this community. So does the Board's own 78-station need projection and the state-wide ESRD data that it recently published which reflects the disparities in kidney health, and access to dialysis services and health insurance in the Hispanic and African American population.

In my last referral commitment letter, I identified 148 CKD patients whose condition is advancing to end stage renal disease (ESRD). Since that time, my colleagues and I experienced a loss – the very unfortunate death of Dr. Lillian Magana, who also treated CKD patients in the Lawndale and Little Village communities. After her untimely death, I took over substantially all of her patient load. Thus, my CKD patient population is now significantly larger.

Of these CKD patients, I project that I will refer 74 who will require dialysis within the next 12 to 18 months to the proposed Lawndale facility. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 96 patients at Little Village Dialysis, which is a nearby facility operating at 100% utilization, significantly higher than the state standard. I anticipate that 14 of these patients will transfer to the proposed facility. A list of the zip codes for these patients is attached at Attachment – 2. Thus, I project that I would refer a total of 88 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD at Attachment – 3.

Due to the large number of kidney disease patients my practice serves, the new facility is essential. I anticipate that my patient population, and the number of individuals suffering from CKD generally, will continue to increase. CKD is a growing public health problem in the United States. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and

ESRD. Not surprisingly, obesity, is linked to both diabetes and high blood pressure, is also one of driving factors for progressive CKD.

According to a recent study, the number of Americans with diabetes will double from 23.7 million in 2009 to 44.1 million in 2034. Because the average wait time for an ESRD patient for a kidney transplant is more than four years, and mortality rates among ESRD patients have improved significantly in recent years, during any given year, most of these patients become dependent on dialysis to survive. As such, demand for dialysis treatment is expected to continue to increase.

Further, as medical professionals and, more importantly, as humans, we have a responsibility to make a difference in our communities when we have the ability to do so. My partners, Mt. Sinai and DaVita, have demonstrated their willingness to furnish essential services in underserved and underprivileged communities. Due to local socioeconomic conditions, this community, in particular, needs these services, and they need them now.

This population exhibits a higher prevalence of obesity, which is a primary driver of diabetes and hypertension. Notably, the City of Chicago exhibits a much higher concentration of African Americans and Hispanics than the rest of the State. In fact, approximately 98% of the Lawndale community is either African American or Hispanic. These individuals are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in minority communities. In fact, the ESRD incident rate among African Americans is 3.6 times greater than the non-whites and the incident rate among Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to increase utilization.

My patients need this facility, and, as such, I fully support the proposed establishment of Lawndale Dialysis. The information in this letter is true and correct to the best of my knowledge.

Sincerely,



Ogbonnaya Aneziokoro, M.D.
Nephrologist

Subscribed and sworn to me

This 21st day of Sept., 2012

Notary Public



**ATTACHMENT 1
PRE-ESRD PATIENTS**

Zip	Patients
60804	8
60623	46
60624	5
60608	15
Total	74

**ATTACHMENT 2
CURRENT PATIENTS**

Zip	Patients
60608	1
60623	9
60629	3
Total	14

ATTACHMENT 3 HISTORICAL ESRD REFERRALS

Little Village Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60609	1	60402	1	60608	3
60629	3	60609	1	60609	1
60632	1	60623	6	60623	5
60651	1	60632	2	60632	2
		60638	1	60643	1
				60644	1

Lincoln Park Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60614	1	60609	1	60610	1
60624	1	60610	1	60614	1
60629	1	60614	3	60625	1
60639	1	60618	3	60657	2
60645	1	60645	1	91170	1
60653	1				
60659	1				

Logan Square Dialysis

2009		2011	
Zip Code	Patients	Zip Code	Patients
60614	2	60639	1

Emerald Dialysis

2011	
Zip Code	Patients
60621	1
60623	2
60632	2



HHS Action Plan to Reduce Racial and Ethnic Health Disparities

**A NATION FREE OF DISPARITIES
IN HEALTH AND HEALTH CARE**



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► INTRODUCTION AND BACKGROUND

Introduction and Background

Medical advances and new technologies have provided people in America with the potential for longer, healthier lives more than ever before. However, persistent and well-documented health disparities exist between different racial and ethnic populations and health equity remains elusive. Health disparities — differences in health outcomes that are closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play. This document provides a brief overview of racial and ethnic health disparities and unveils a Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities (“HHS Disparities Action Plan”).

“It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.”

– Kathleen G. Sebelius, Secretary,
Health & Human Services

The HHS Disparities Action Plan complements the 2011 National Stakeholder Strategy for Achieving Health Equity, a product of the National Partnership for Action (“NPA Stakeholder Strategy”). The NPA Stakeholder Strategy reflects the commitment of thousands of individuals across the country in almost every sector. It resulted from a public-private collaboration that solicited broad community input with the assistance of state and local government and Federal agencies. The NPA Stakeholder Strategy proposes a comprehensive, community-driven approach to reduce health disparities in the U.S. and achieve health equity through collaboration and synergy. Now, this first-ever HHS Disparities Action Plan and the NPA Stakeholder Strategy can be used together to coordinate action that will effectively address racial and ethnic health disparities across the country. Furthermore, the HHS Disparities Action Plan builds on national health disparities’ goals and objectives recently unveiled in *Healthy People 2020*, and leverages key provisions of the Affordable Care Act and other cutting-edge HHS initiatives.

With the HHS Disparities Action Plan, the Department commits to continuously assessing the impact of all policies and programs on racial and ethnic health disparities. Furthermore, the Department can now promote integrated approaches, evidence-based programs and best practices to reduce these disparities. Together, the HHS Disparities Action Plan and the NPA Stakeholder Strategy provide strong and visible national direction for leadership among public and private partners. While the Department respects and recognizes the critical roles other Federal departments play in reducing health disparities, this action plan focuses on HHS initiatives.

• INTRODUCTION AND BACKGROUND

Overview of Racial and Ethnic Health Disparities

The societal burden of health and health care disparities in America manifests itself in multiple and major ways. In one stark example, Murray et al show a difference of 33 years between the longest living and shortest living groups in the U.S.⁵ Another study, *The Economic Burden of Health Inequalities in the United States*, by the Joint Center for Political and Economic Studies, concludes that “the combined costs of health inequalities and premature death in the United States were \$1.24 trillion” between 2003 and 2006.⁶ Such health disparities arise from both biologic factors and social factors that affect individuals across their lifespan. Regarding the latter, the World Health Organization (WHO) defines these “social determinants of health” as the conditions in which people are born, grow, live, work and age that can contribute to or detract from the health of individuals and communities.⁷ Marked difference in social determinants, such as poverty, low socioeconomic status (SES), and lack of access to care, exist along racial and ethnic lines. These differences can contribute to poor health outcomes.⁸

Individuals, families and communities that have systematically experienced social and economic disadvantage face greater obstacles to optimal health. Characteristics such as race or ethnicity, religion, SES, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.⁹ While this HHS Disparities Action Plan focuses primarily on health disparities associated with race and ethnicity, many of the strategies can also apply across a wide array of population dimensions. For example, expanding healthcare access, data collection, and the use of evidence-based interventions will contribute to health equity for vulnerable populations that are defined by income, geography, disability, sexual orientation or other important characteristics.

The Burden of Racial and Ethnic Health Disparities: Major Dimensions

The leading health indicators have demonstrated little improvement in disparities over the past decade, according to recent analyses of progress on *Healthy People 2010* objectives. Significant racial and ethnic health disparities continue to permeate the major dimensions of health care, the health care workforce, population health, and data collection and research.

Disparities in Health Care: The Institute of Medicine’s (IOM) landmark 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, identifies the lack of insurance as a significant driver of healthcare disparities.¹¹ Lack of insurance, more than any other demographic or economic barrier, negatively affects the quality of health care received by minority populations. Racial and ethnic minorities are significantly less likely than the rest of the population to have health insurance.¹² They constitute about one-third of the U.S. population, but make up more than half of the 50 million people who are uninsured.¹³

► INTRODUCTION AND BACKGROUND

Members of racial and ethnic minority groups are also overrepresented among the 56 million people in America who have inadequate access to a primary care physician.¹⁴ Minority children are also less likely than non-Hispanic White children to have a usual source of care.¹⁵

Since 2002, the annual Agency for Healthcare Research and Quality (AHRQ) National Health Disparities Reports (NHDR) have documented the status of healthcare disparities and quality of care received by racial, ethnic and socio-economic groups in the United States.¹⁶ The NHDR documented that racial and ethnic minorities often receive poorer quality of care and face more barriers in seeking care including preventive care, acute treatment, or chronic disease management, than do non-Hispanic White patients.¹⁷ Minority groups experience rates of preventable hospitalizations that are, in some cases, almost double that of non-Hispanic Whites.¹⁸ African Americans have higher hospitalization rates from influenza than other populations.¹⁹ African American children are twice as likely to be hospitalized and more than four times as likely to die from asthma as non-Hispanic White children.²⁰

Major efforts to provide quality health care to racial and ethnic populations occur through both long-standing safety net programs, such as the Health Resources and Services Administration (HRSA)-funded Community Health Center Program, and new initiatives such as those aimed at increasing meaningful use of health information technology by primary care providers. The Community Health Center Program provides vulnerable populations access to comprehensive, culturally competent, quality primary healthcare services. Of the nearly 19 million patients currently served through these HRSA-funded community health centers, 63 percent are racial and ethnic minorities and 92 percent have incomes below the federal poverty level.²¹

Disparities in the Nation's Health and Human Services Infrastructure and Workforce: The 2004 IOM report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, underscores the significant differences in the racial and ethnic composition of the healthcare workforce compared to the U.S. population.²² More recently, the American Association of Medical Colleges reported that in 2008, Hispanics made up approximately 16 percent of the U.S. population, but accounted for less than 6 percent of all physicians.²³ African Americans accounted for a similar proportion of the U.S.'s population, but just over 6 percent of physicians²⁴.

Racial and ethnic minorities are more likely than non-Hispanic Whites to report experiencing poorer quality patient-provider interactions, a disparity particularly pronounced among the 24 million adults with limited English proficiency.²⁵ Diversity in the healthcare workforce is a key element of patient-centered care. The ability of the healthcare workforce to address disparities will depend on its future cultural competence and diversity.

In addition to cultural competency and diversity issues, shortages of physicians and other health professionals in underserved areas significantly affect the health of racial and ethnic minorities. HRSA's

National Health Service Corps (NHSC) invests in the healthcare workforce by placing health professionals in Health Professional Shortage Areas to care for underserved populations. Currently, 7,000 NHSC clinicians provide healthcare services in underserved areas in exchange for loan repayment or scholarships; approximately 33 percent of these clinicians are minorities and half serve in community health centers.²⁶

Disparities in the Health, Safety, and Well-Being of the American People: All people should have the opportunity to reach their full potential for health. Yet, those who live and work in low socioeconomic circumstances (which disproportionately include racial and ethnic minorities) often experience reduced access to healthy lifestyle options and suffer higher rates of morbidity and mortality as compared to their higher-income counterparts.²⁷ The recently released Centers for Disease Control and Prevention (CDC) report, *Health Disparities and Inequalities*, demonstrates that African American, Hispanic, Asian American and American Indian and Alaska Native populations suffer higher mortality rates than other populations.²⁸ Cardiovascular diseases, for example, account for the largest proportion of inequality in life expectancy between African American and non-Hispanic Whites. Childhood obesity affects racial and ethnic minority children at much higher rates than non-Hispanic Whites, driving up rates of associated diabetes.²⁹

Addressing disparities at the population level involves both new and well-established efforts. For the past decade, the CDC's Racial and Ethnic Approaches to Community Health (REACH) program has empowered residents to seek better health, helped change local healthcare practices, and mobilized communities to implement evidence-based public health programs to reduce health disparities across a broad range of health conditions. More recently, as part of the American Recovery and Reinvestment Act (ARRA) and with additional funds from the Affordable Care Act, the 50 CDC-funded Communities Putting Prevention to Work (CPPW) programs are supporting statewide and community-based policy and environmental changes in nutrition, physical activity, and tobacco control, directly targeting factors that may harm people's health.

These recent efforts join well-established programs to provide comprehensive child development services to economically disadvantaged children and families. Specifically, the Administration for Children and Families' (ACF) Head Start program promotes the social and cognitive development of children by providing educational, health, nutritional, social and other services to enrolled children and families. The Head Start program helps parents make progress toward their educational, literacy, and employment goals, and engages them in their children's learning. Most recent data indicate that racial and ethnic minorities make up 79 percent of the population served by Head Start, making this program a critical vehicle for addressing the social determinants of health disparities.³⁰ And the National Institutes of Health (NIH) has woven innovative pilot projects into the Healthy Start setting as a strategy to address the disproportionate burden of asthma among minority children and children living in poverty. These projects serve as models for developing healthy learning environments to introduce health and asthma self-management skills to children and their families.

• INTRODUCTION AND BACKGROUND

Disparities in Scientific Knowledge and Innovation: The recent IOM Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality report emphasizes that inadequate data on race, ethnicity, and language lowers the likelihood of effective actions to address health disparities.³¹ The Office of Management and Budget (OMB) has promulgated minimum standard categories for racial and ethnic data collection by federal agencies. The race categories include: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The ethnicity category includes Hispanic. Enhanced and standardized data on the race, ethnicity, and language spoken by patients and other users of the healthcare system would allow better understanding of the barriers faced by racial and ethnic minority populations. The lack of standards related to data collection remains a challenge for adequately collecting, reporting, and tracking data on health disparities.

► NEW OPPORTUNITIES

New Opportunities to Reduce Racial and Ethnic Health Disparities

The Affordable Care Act

This HHS Disparities Action Plan builds upon the Affordable Care Act – the landmark law signed by President Obama last year – that will bring insurance coverage to more than 30 million people. The Affordable Care Act not only includes provisions related broadly to health insurance coverage, health insurance reform, and access to care, but also provisions related to disparities reduction, data collection and reporting, quality improvement, and prevention. The Affordable Care Act will also reduce health disparities by investing in prevention and wellness, and giving individuals and families more control over their own care. Appendix A provides additional details on the provisions that will affect health disparities. Two important initiatives mandated by the Affordable Care Act are the National Strategy for Quality Improvement in Health Care, which will include priorities to improve the delivery of health care, and the National Prevention and Health Promotion Strategy, which aims to bring prevention and wellness to the forefront of national policy.

HHS Initiatives

In addition to the Affordable Care Act, the Department can leverage other key national initiatives in its effort to reduce racial and ethnic health disparities.

Healthy People 2020³²: One of the four overarching goals of the recently unveiled *Healthy People 2020* initiative is “to achieve health equity, eliminate disparities and improve the health of all groups.” Throughout the next decade, the *Healthy People 2020* initiative will assess health disparities in the U.S. population by tracking rates of death, chronic and acute diseases, injuries, and other health-related behaviors for sub-populations defined by race, ethnicity, gender identity, sexual orientation, disability status or special health care needs, and geographic location.

Let’s Move!³³: First Lady Michelle Obama launched the *Let’s Move!* initiative with the goal of solving the challenge of childhood obesity within a generation. The *Let’s Move!* initiative has five key pillars: (1) creating a healthy start in life for our children, from pregnancy through early childhood; (2) empowering parents and caregivers to make healthy choices for their families; (3) serving healthier food in schools; (4) ensuring access to healthy, affordable food; and (5) increasing physical activity. To bring this initiative to the local level, the Secretary, with the First Lady, called on mayors and other local officials to be public leaders of the *Let’s Move! Cities and Towns* initiative.

NEW OPPORTUNITIES

The National HIV/AIDS Strategy²⁴: Released by the President in July 2010, the National HIV/AIDS Strategy offers a vision that “the United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race and ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination.”

HHS Strategic Action Plan to End the Tobacco Epidemic²⁵: Released in November 2010 by the Secretary, this plan is anchored around the four pillars of (1) engaging the public; (2) supporting evidence-based tobacco control policies at the state and local levels; (3) having HHS lead by example; and (4) advancing research, especially in the context of new Food and Drug Administration (FDA) authority to regulate tobacco.

Efforts to Reduce Disparities in Influenza Vaccination²⁶: The HHS Seasonal Influenza Task Force has launched efforts to maximize vaccinations in targeted racial and ethnic minority groups through coordinated Departmental efforts as well as private-public partnerships.

Interagency Working Group on Environmental Justice²⁷: Executive Order 12898 directs each federal agency to make achieving environmental justice part of its mission. HHS and other participating agencies are committed to identifying and addressing disproportionately high adverse human health or environmental effects on minority and low-income populations.

HHS Infrastructure

Critical to the Department's success is strengthening its infrastructure to prioritize the challenges of reducing health disparities and to fully implement this HHS Disparities Action Plan. As mandated by the Affordable Care Act, HHS has not only established offices of minority health in six agencies (AHRQ, CDC, FDA, HRSA, Centers for Medicare and Medicaid Services [CMS], and Substance Abuse and Mental Health Services Administration [SAMHSA]), but also elevated the National Center on Minority Health and Health Disparities (now NIMHD) to an institute level at the NIH. Key action steps for these offices include:

1. Enhancing the integration of the missions of offices across the Department to avoid the creation of silos.
2. Aligning core principles and functions with the goals, strategies, and actions presented in the HHS Disparities Action Plan.

Collectively, these entities will improve coordination of health disparity efforts across HHS and build partnerships with public and private stakeholders. The directors of agency offices of minority health and

► NEW OPPORTUNITIES

senior staff in other key agencies will constitute the HHS Health Disparities Council overseen by the Assistant Secretary for Health. The Council will serve as the venue to share information, leverage HHS investments, coordinate HHS activities, reduce program duplication, and track progress on the strategies and actions of the HHS Disparities Action Plan.

In addition, HHS will reinvigorate and reaffirm its continuing commitment by:

- Promoting closer collaboration between operating and staff divisions to achieve a more coordinated national response to health disparities;
- Coordinating more effectively its investments in research, prevention, and health care among HHS agencies and across the federal government;
- Developing improved mechanisms to monitor and report on progress toward achieving the vision of the HHS Disparities Action Plan; and
- Facilitating public input and feedback on Departmental strategies and progress.

Partnerships with Other Federal Departments

To help ensure successful implementation of the HHS Disparities Action Plan, the Department will collaborate with the Federal Interagency Health Equity Team (FIHET). FIHET seeks to facilitate activities of the NPA between federal agencies to increase the efficiencies and effectiveness of policies and programs at the local, tribal, state and national levels. This team, which includes representatives of the Departments of Agriculture (USDA), Commerce (DOC), Education (ED), Housing and Urban Development (HUD), Labor (DOL), Transportation (DOT), and the Environmental Protection Agency (EPA), can collectively address the broad range of social determinants of health.

• VISION AND PURPOSE

Vision and Purpose

In November 2010, Secretary Kathleen Sebelius charged HHS with developing a Department-wide action plan for reducing racial and ethnic health disparities. This HHS Disparities Action Plan was developed through a collaborative, Department-wide process that actively engaged all HHS agencies. The action plan emphasizes approaches that are evidence-based and will achieve a large-scale impact. The action plan will be operational across HHS immediately.

The vision of the HHS Disparities Action Plan is:

"A nation free of disparities in health and health care."

The HHS Disparities Action Plan proposes a set of Secretarial priorities, pragmatic strategies, and high-impact actions to achieve Secretary Sebelius's strategic goals for the Department. The five goals from the HHS Strategic Plan for Fiscal Years (FY) 2010-2015 provide the framework for the HHS Disparities Action Plan.³⁸ They are:

- I. Transform health care;
- II. Strengthen the nation's Health and Human Services infrastructure and workforce;
- III. Advance the health, safety, and well-being of the American people;
- IV. Advance scientific knowledge and innovation; and
- V. Increase the efficiency, transparency, and accountability of HHS programs.

The actions presented in this HHS Disparities Action Plan represent mainly new efforts beginning in FY 2011 and beyond. The actions are also intended to be carried out with current agency resources, so that implementation can proceed without delay. This plan will also serve as guidance for future development, subject to the availability of resources. The following pages outline the strategies and actions, with further background provided in the two appendices. Appendix A highlights the new opportunities in the Affordable Care Act to reduce health disparities. Appendix B summarizes other relevant efforts begun prior to FY 2011 that also serve to create the strong foundation for the HHS Disparities Action Plan. Implementation of the actions will be led either by a single agency or co-led by agencies working in partnership.

This HHS Disparities Action Plan begins with the Secretarial priorities then presents the goals, strategies, and actions.

OVERARCHING SECRETARIAL PRIORITIES

Overarching Secretarial Priorities

Implementation of the HHS Disparities Action Plan will uphold four overarching Secretarial priorities to assure coordination and transformation of both existing programs and new investments. These priorities aim to:

1. **Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.** HHS leadership will assure that:
 - a. All staff and operating divisions will review their strategic plans, communications, programs, and regulations to assure that the goals, strategies, and actions in the HHS Disparities Action Plan are included to the fullest extent possible.
 - b. Every staff and operating division will assess its current and future capacity to support this HHS Disparities Action Plan, and will realign resources to best meet the goals.
 - c. Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.
2. **Increase the availability, quality, and use of data to improve the health of minority populations.** Strong surveillance systems must monitor trends in health and quality of care measures, as well as patient-centered research activities. HHS will:
 - a. Ensure that data collection standards for race, ethnicity, sex, primary language, and disability status are implemented throughout HHS-supported programs, activities, and surveys.
 - b. Assure public access to data that is appropriately disaggregated and de-identified in order to promote disparities research and assure that data on race and ethnicity in federally supported programs, activities, or surveys is routinely reported in a format that is available for external analysis. This is consistent with the HHS Open Government Initiative.
 - c. Identify and map high-need/disparity areas and align HHS investments to meet these needs. One example of this action is the Value-Driven Health Disparities Collaboration Project, which will use data to map and accelerate comprehensive planning to coordinate local disparities reduction activities. Working with

► OVERARCHING SECRETARIAL PRIORITIES

health plans and local health systems, this demonstration project will conduct local assessments and map “hot spots” of particular chronic conditions, health concerns, or factors known to contribute to ill health. The project will also identify gaps in services, programs, funds, and/or actions to effectively address the “hot spots” and take advantage of opportunities to promote healthier lifestyles. It will also establish ongoing partnerships with the community and private sector to reduce health disparities.

- d. Develop a system of public reporting of preventable hospital admissions by race and ethnicity (non-Hispanic White, African American, Hispanic) for dually eligible (Medicare/Medicaid) beneficiaries by hospital and state, with presentation of the data as unadjusted and adjusted relative risk ratios.
- e. Publicly display aggregately collected Medicaid and Medicare quality measurement data in new ways that call attention to racial and ethnic disparities.

3. **Measure and provide incentives for better healthcare quality for minority**

populations. Racial and ethnic minorities often receive poorer quality of care and face more barriers to seeking care than non-Hispanic Whites.³⁹ Providing incentives for quality care in these populations is critical for improving patient outcomes and creating a high-value healthcare system that promotes equity. HHS will:

- a. Implement through CMS an initiative that sets measures and provides incentives to improve health care quality, particularly for vulnerable populations. This effort will assess and refine current or new measures of chronic disease burdens for racial and ethnic minorities, such as heart attack, renal failure, stroke, hypertension, and diabetes. CMS will review current measures including those used in hospital value-based purchasing, Hospital Compare, Home Health Compare, Children’s Health Insurance Program (CHIP) Pediatric Quality Measures Programs, and other special payment models.
- b. Develop cross-departmental and inter-agency collaborations between CMS, HRSA, AHRQ, SAMHSA, and Indian Health Service (IHS) to provide incentives for improvements of health care quality. For example, SAMHSA will collaborate with CMS to support the development of measures and incentives related to the racial and ethnic health burden of depression.
- c. Expand health disparities projects, including a CMS initiative to reduce avoidable hospital admissions for people dually eligible for Medicare and Medicaid, racial and ethnic analyses of CMS Survey and Claims Data, and Quality Improvement Organization Disparities Special Initiatives addressing diabetes self management training, patient safety, and clinical pharmacy services.

• OVERARCHING SECRETARIAL PRIORITIES

4. **Monitor and evaluate the Department's success in implementing the HHS Disparities Action Plan.** HHS is committed to ensuring program integrity, effective program performance, and responsible stewardship of Federal funds. Regular reviews of progress will determine not only when goals are being reached, but also when refining or changing direction is necessary.
- a. Identify cross-cutting areas for collaboration across agencies and offices to conduct joint health and healthcare disparities research.
 - b. On a biannual basis, Office of the Assistant Secretary for Health/Office of Minority Health (OASH/OMH) and Assistant Secretary for Planning and Evaluation (ASPE) will review and report results of Agency Head progress made under this plan. Agencies and offices will refine strategies for improving the timeliness and quality of results.
 - c. On a biannual basis, review progress on Departmental efforts to improve coordination in the administration of grants, contracts, and intramural research that address reduction of disparities. Reduce duplication, align, or leverage resources where appropriate, and eliminate administrative burdens that limit efficient use of resources.

► GOAL I

Goal I: Transform Health Care

Transforming the current healthcare system and building a high-value healthcare system requires insuring the uninsured, making coverage more secure for those who have it, and improving quality of care for all. The 2010 Affordable Care Act offers the potential to meet these goals and address the needs of racial and ethnic minority populations. Specific provisions, such as those supporting improvements in primary care, creating linkages between the traditional realms of health and social services, as well as ongoing investments in health information technology, can transform health care and reduce disparities.

Strategy I.A: Reduce disparities in health insurance coverage and access to care. Racial and ethnic minorities have far lower rates of health insurance coverage than the national average, with approximately two of every five persons of Hispanic ethnicity and one of every five non-Hispanic African Americans uninsured.⁴⁰ Removing barriers to coverage based on health status through the Affordable Care Act will offer an unprecedented opportunity for access to care, particularly for racial and ethnic minorities who have disproportionately higher rates of chronic disease.

Actions:

- **I.A.1 Increase the proportion of people with health insurance and provide patient protections in Medicaid, CHIP, Medicare, Health Insurance Exchanges, and other forms of health insurance.** The Affordable Care Act: (1) allows those with pre-existing conditions (first children and eventually everyone) to gain and keep coverage; (2) ends lifetime limits on care; (3) covers preventive services recommended with an A or B by the U.S. Preventive Services Task Force (USPTF) in Medicare and private health plans; and (4) promotes coverage of preventive services recommended with an A or B by the USPTF in Medicaid.
 - Medicaid coverage will be expanded to individuals under age 65 with incomes up to 133 percent of the federal poverty level by 2014, including individuals who are not pregnant or are without dependent children. Grants to community-based and non-profit organizations, local governments, tribes, and states will support outreach activities and enrollment of children who are currently uninsured but eligible for Medicaid and CHIP. Such activities will have a focus on reducing disparities in coverage for racial and ethnic minorities and those experiencing language barriers.
 - Each Health Insurance Exchange will offer grants to organizations to establish navigator programs, which will raise awareness of the Health Insurance Exchange and draw diverse populations to gain access to coverage through the

GOAL I

Health Insurance Exchange. Navigators will provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served.

- Enrollment procedures will be streamlined to facilitate linkage of children and families to health insurance and human service programs by building on the existing Express Lane Eligibility. Linking enrollment of children and families in CHIP and Medicaid to enrollment in human service programs will improve the access and availability of both health care and human services for underserved populations. (Express Lane agencies are identified by a Medicaid or CHIP program as entities that have the authority to determine program eligibility).

Lead/Participating Agencies: CMS, ACF, HRSA, IHS, SAMHSA, USDA

Timeline: FY 2011-2014

Strategy I.B: Reduce disparities in access to primary care services and care coordination.

Access to timely and needed primary healthcare services continues to be a major challenge for racial and ethnic minorities.⁴¹ The actions below will expand primary care services and invest in training primary care providers. A special effort will be made to expand primary care and increase care coordination for migrant and seasonal farm workers, people experiencing homelessness, and residents of public housing.

Actions:

I.B.1 Increase the proportion of persons with a usual primary care provider and patient-centered health homes.

- HRSA will award 350 New Access Point grant awards to support new health center service delivery sites in medically underserved areas. Doing so will improve comprehensive, culturally competent, primary and preventive health care services. Funds will not only expand such services (including oral health, behavioral health, pharmacy, and/or enabling services) at existing health center sites, but will also support major construction and renovation projects at community health centers nationwide.
- HRSA will expand its NHSC by placing more primary care providers in communities with designated health professional shortage areas. Physicians, nurse practitioners, and dentists will receive payments that help satisfy their educational loans in return for providing health care in underserved communities.
- Community-based health teams will establish agreements with primary care physicians and other health care professionals to improve care coordination through patient-centered health homes. This involves coordination of disease

► GOAL I

prevention services, management of transitions between healthcare providers, and improvement of connectivity to a usual source of primary care.

- HRSA will expand its health center quality initiative that provides technical assistance and resources to health centers to: (1) become nationally recognized as health homes; (2) adopt and meaningfully use health information technology; (3) track clinical control of blood pressure and clinical management of diabetes; and (4) track reductions in racial and ethnic disparities in low birth weight child births.

Lead/Participating Agencies: HRSA/CMS, ACF, CDC, SAMHSA

Timeline: Starting in FY 2011

Strategy I.C: Reduce disparities in the quality of health care. The quality of care received by racial and ethnic minorities continues to be suboptimal, as demonstrated by the 2010 NHDR core indicators of quality care in preventive care, acute treatment, and chronic disease management.⁴² The actions below will enhance the quality of care provided to racial and ethnic minorities by removing barriers to the timeliness, patient-centeredness of care, and the equitable use of evidence-based clinical guidelines.

Actions:

- **I.C.1 Improve the quality of care provided in the Health Insurance Exchanges.** Health plans participating in the Health Insurance Exchanges, new private, competitive health insurance markets for individuals and small employers to be established by 2014, will implement a quality improvement strategy using financial and non-financial incentives to promote activities to reduce disparities in health and health care. Activities may include language services, community outreach, cultural competency training, health education, wellness promotion, and evidence-based approaches to manage chronic conditions.

Lead/Participating Agencies: CMS

Timeline: FY 2011-2014

- **I.C.2 Improve outreach for and adoption of certified electronic health record (EHR) technology to improve care through the Regional Extension Centers program and other federal grant programs.** Racial and ethnic minority communities will be specifically targeted for EHR outreach and adoption through federal and private sector partnerships with HHS agencies, the National Health Information Technology Collaborative, and other health organizations. The soon-to-be released "HHS Health Information Technology (HIT) Plan to End Health Disparities" will promote HIT interagency collaborations and disseminate best practices to improve care provided in underserved

► GOAL I

racial and ethnic communities through the use of technologies such as telehealth, electronic health records, clinical tools, and personal health records.

Lead/Participating Agencies: ONC, CMS, OASH/OMH, HRSA, NIH

Timeline: Starting in FY 2011

- **I.C.3 Develop, implement, and evaluate interventions to prevent cardiovascular diseases and their risk factors.** Heart attacks and strokes are the leading causes of premature death for racial and ethnic minorities. This initiative will focus multiple efforts on the prevention of cardiovascular diseases and their risk factors. HHS will implement interventions that will range from quality of care improvement opportunities to potential reimbursement incentives for policy and health system changes. This initiative will involve working both with minority providers and providers serving minority populations.

Lead/Participating Agencies: CDC, AHRQ, CMS, HRSA, NIH, OASH, ONC,

Timeline: Starting in 2011

- **I.C.4 Increase access to dental care for children in Medicaid and CHIP.** Given the relatively high percentage of racial and ethnic minority children (under the age of 19) with public insurance, this action will help to address disparities in coverage and access to oral health services. Specifically, this initiative seeks to increase by 10 percent the rate of children up to age 20 enrolled in Medicaid or CHIP who receive any preventive dental service and the rate of enrolled children ages six to nine who receive a dental sealant on a permanent molar tooth. The initiative includes working with states to develop oral health action plans, strengthening technical assistance to states and tribes, improving outreach to dental healthcare providers, increasing outreach to beneficiaries and partnering with other relevant governmental agencies and private sector organizations.

Lead/Participating Agencies: CMS, ACF, CDC, HRSA, OASH/OMH

Timeline: Starting in 2011

► GOAL II

Goal II: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Strengthening the nation's health and human services infrastructure involves addressing the critical shortage of primary care physicians, nurses, behavioral health providers, long-term care workers, and community health workers in the U.S. With growing national diversity, the disparity between the racial and ethnic composition of the healthcare workforce and that of the U.S. population widens as well.

Strategies to address the gaps in workforce diversity and shortages includes expanding the use of healthcare interpreters to overcome language barriers, improving the quality of patient-provider interactions in clinical settings, improving cultural competence education and training for health care professionals, and increasing racial and ethnic diversity in the healthcare workforce.⁴³

Strategy II.A: Increase the ability of all health professions and the healthcare system to identify and address racial and ethnic health disparities. Racial and ethnic minorities, and especially people whose primary language is not English, are more likely to report experiencing poorer quality patient-provider interactions than non-Hispanic Whites.⁴⁴ The actions below will address this disparity and optimize patient-provider interactions.

Actions:

- **II.A.1 Support the advancement of translation services.**
 - **Promote the healthcare interpreting profession as an essential component of the healthcare workforce to improve access and quality of care for people with limited English proficiency.** In partnership with national organizations for certification of interpreters, HHS will improve quality of care for people with limited English proficiency. This includes promoting the knowledge, skills, and abilities required for healthcare interpreting, educating individuals about the pathways into the healthcare interpreting profession, and establishing an accessible online national registry of certified interpreters to allow healthcare facilities and providers to quickly identify certified interpreters. Collaborations with community colleges will develop effective training programs that help build the profession of healthcare interpreters and deliver credentialing examinations for healthcare interpreters.
 - **Improve language access in Medicaid.** This initiative will pilot test software for a web-based enrollment system that enables Medicaid staff to interview non-English speaking or low-literacy applicants, and help those applicants to apply for Medicaid and

► GOAL II

CHIP benefits. This will allow a higher federal matching rate for state administrative costs dedicated to translation/interpretation services, including American Sign Language or Braille. This initiative will also encourage states to: employ staff members to provide translation or interpretation functions; pay for direct translator/interpreter support to medical providers; translate brochures, commercials, radio and newspaper advertisements, and other promotional material into other languages; and provide interpretation hotlines for Medicaid and CHIP recipients.

Lead/Participating Agencies: OASH/OMH, CMS, HRSA

Timeline: Starting in FY 2011

- **II.A.2 Collaborate with individuals and health professional communities to make enhancements to the current National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).** The CLAS Standards, released in 2000, represent the first national standards for culturally competent healthcare service delivery. These standards will be updated, via a CLAS Standards Enhancement Initiative. Improvements will be informed by the responses received throughout the recently ended public comment period and three previously held regional public meetings. HHS will maximize public input, stakeholder dialogue, and subject matter expertise to ensure that the enhanced CLAS Standards serve the health needs of populations experiencing health disparities.

Lead/Participating Agencies: OASH/OMH, SAMHSA

Timeline: Starting in FY 2011

Strategy II.B: Promote the use of community health workers and Promotoras. While Health Insurance Exchanges and expansions in Medicaid created by the Affordable Care Act offer much promise for racial and ethnic minorities, targeted efforts are necessary to ensure that they are enrolled and receive the health benefits for which they are eligible. Promotoras are individuals who provide health education and support to their community members. Community health workers and Promotoras can provide enrollment assistance and serve as critical liaisons between community members and health and human services organizations.⁴⁵

Actions:

- **II.B.1 Increase the use of Promotoras to promote participation in health education, behavioral health education, prevention, and health insurance programs.** This initiative includes: establishing a National Steering Committee for Promotoras; developing a national training curriculum and uniform national recognition for them; creating a

► GOAL II

national database system to facilitate recruitment and track training and certification of Promotoras; and supporting and linking Promotoras' networks across the Nation. As part of ACF's Head Start Program, Promotoras and community health workers can help parents effectively navigate the healthcare system and manage health care for their children.

Lead/Participating Agencies: OASH/OMH, ACF, CDC, CMS, HRSA, SAMHSA

Timeline: Starting in FY 2011

► **II.B.2 Promote the use of community health workers by Medicare beneficiaries.**

This initiative will promote the use of community health workers as members of interdisciplinary teams and multi-sector teams. Enabling payment of community health workers as members of diabetes self-management training teams, for example, improves the provision of health care, health education, disease prevention services, and connection to health homes will be enhanced. These workers will improve patients' diabetes self-management skills in many ways including the provision of plain language health-related information in non-clinical community settings.

Lead/Participating Agencies: CMS, CDC, HRSA, IHS, OASH

Timeline: Starting in FY 2011

Strategy II.C: Increase the diversity of the healthcare and public health workforces. Numerous studies have shown racial and ethnic minority practitioners are more likely to practice in medically underserved areas and provide health care to large numbers of racial and ethnic minorities who are uninsured and underinsured. This strategy includes actions to increase the diversity of the health care and public health workforces to address the compelling need for reductions in healthcare disparities.⁴⁶

Actions:

- **II.C.1 Create a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions.** Create an undergraduate pipeline program to increase racial and ethnic diversity in the health professions. This initiative will fund a national program to provide early educational opportunities for undergraduate students from health disparity populations to encourage careers in public health and biomedical sciences.

Lead/Participating Agencies: CDC, NIH

Timeline: Starting in FY 2011

- **II.C.2 Increase education and training opportunities for recipients of Temporary Assistance for Needy Families (TANF) and other low-income individuals**

► GOAL II

for occupations in healthcare fields through Health Profession Opportunity Grants (HPOG) program. HPOGs aim to improve the work readiness and employment outcomes for low-income workers and TANF beneficiaries. The ACF's Offices of Family Assistance and Refugee Resettlement will promote linkages between the HPOG grantees and refugee communities to offer the training programs. Training programs can include home care aides, certified nursing assistants, medical assistants, pharmacy technicians, emergency medical technicians, licensed vocational nurses, registered nurses, dental assistants, and health information technicians. Graduates of the training programs receive an employer- or industry-recognized certificate or degree.

Lead/Participating Agencies: ACF

Timeline: Starting in FY 2011

► II.C.3 **Increase the diversity and cultural competency of clinicians, including the behavioral health workforce.**

- HRSA will develop a plan for targeted recruitment of students from backgrounds that are underrepresented in the healthcare workforce. Activities will include implementing innovative strategies to encourage student interest in primary care and application to the NHSC scholarship program. In addition, HRSA will develop new approaches for reaching minority health professions students before they enter the job market through the loan repayment program. HRSA will assess the results of targeted efforts to expand outreach, mentorship, partnership, and recruitment practices.
- Through the newly funded Center for Integrated Health Solutions (CIHS) that works with higher-education institutes, SAMHSA will grow a diverse workforce to provide services in integrated primary care and behavioral health settings for vulnerable populations. CIHS will strengthen the capacity and skills of practitioners working in integrated care settings to better address the needs of racial and ethnic minority populations.
- Utilizing its National Network to Eliminate Disparities in Behavioral Health (NNED), SAMHSA will launch two new Communities of Practice for providers. This includes accessing virtual training and technical assistance to implement evidence-based behavioral health interventions focused on trauma and trauma-related disorders geared to minority populations.
- Through its Historically Black Colleges and Universities (HBCU) Center for Excellence, SAMHSA will increase the diversity of the workforce by training teams of clinicians, faculty, and students from HBCUs on best practices in behavioral health promotion, screening, and intervention. The Behavioral Health Policy Academy and related virtual events will serve as the primary venue for

► GOAL II

capacity development across 105 HBCUs.

Lead/Participating Agencies: HRSA, NIH, SAMHSA

Timeline: Starting in FY 2011

- **II.C.4 Increase the diversity of the HHS workforce.** The Office of Human Resources recently launched the Hispanic Initiative focused on the hiring, recruitment, and retention of Hispanics into the HHS workforce as the Department lags behind many agencies in the percentage of Hispanics that make up its workforce. Utilizing a multi-faceted approach, HHS will continually track Hispanic employment and recruitment efforts and conduct quarterly meetings to monitor progress. HHS is pursuing implementation of the Hispanic Serving Institution Fellowship Program, developed with the Hispanic Association of Colleges and Universities (HACU), which would provide HHS professional rotations for Hispanic academics working in the education and science field. HHS is also working with HACU to provide internships to college students in an effort to connect HHS with young Hispanic professionals at the start of their careers. HHS is also developing a Toolkit for managers and supervisors to provide guidance on methods of outreach, recruitment, and retention of Hispanics and other underrepresented populations in the HHS workforce. HHS recently signed a Memorandum of Understanding (MOU) with five Hispanic-serving organizations to establish a framework for cooperative initiatives. HHS and these organizations are phasing in a variety of programs over the coming year to increase Hispanic employment in HHS occupations.

Lead/Participating Agencies: ASA, all other HHS Agencies

Timeline: Starting in FY 2011

• GOAL III

Goal III: Advance the Health, Safety, and Well-Being of the American People

Advancing the health, safety, and well-being of the American people has special relevance for racial and ethnic minorities who fare far worse than their non-Hispanic White counterparts across a broad range of health indicators.⁴⁷ Creating environments that promote healthy behaviors to prevent and control chronic diseases and their risk factors requires renewed commitment to prevention, with an emphasis on strengthening community-based approaches to reduce high-risk behaviors.

Strategy III.A: Reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies. The actions under this strategy include the implementation of both universal and targeted interventions to close the modifiable gaps in health, longevity, and quality of life among racial and ethnic minorities.

Actions:

► **III.A.1 Build community capacity to implement evidence-based policies and environmental, programmatic, and infrastructure change strategies.**

- Through the Affordable Care Act, the CDC Community Transformation Grants Program will implement, evaluate, and disseminate evidence-based community preventive health activities. The goal is to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base for effective prevention programming. Funded communities will work across multiple sectors to reduce heart attacks, cancer, and strokes by addressing a broad range of risk factors and conditions including poor nutrition and physical inactivity, tobacco use, and others. While the program is designed to reach the entire population, special emphasis is placed on reducing health disparities and reaching rural and frontier areas.

Lead/Participating Agencies: CDC

Timeline: Starting in FY 2011

► **III.A.2 Implement an education and outreach campaign regarding preventive benefits.**

The campaign will be a national public-private partnership to raise public awareness of health improvement across the lifespan supported by the Affordable Care Act. The campaign will reach racial and ethnic minority populations with messages on the importance of accessing preventive services to relevant to nutrition, physical activity, and tobacco use.

Lead/Participating Agencies: CDC, CMS, HRSA, IHS, SAMHSA

Timeline: Starting in FY 2012

► GOAL III

► **III.A.3 Develop, implement, and evaluate culturally and linguistically appropriate evidence-based initiatives to prevent and reduce obesity in racial and ethnic minorities.**

- HRSA will sponsor a Healthy Weight Learning Collaborative to disseminate evidence-based and promising clinical and community practices to promote healthy weight in communities across the nation.
- The Childhood Obesity Research Demonstration Project, led by CDC, will develop, implement, and evaluate multi-sectoral and multi-level interventions for underserved children aged two to 12 years and their families. The project uses an integrated model of primary care and public health approaches to lower risk for obesity in racial and ethnic minority communities.

Lead/Participating Agencies: CDC, HRSA, ACF, AHRQ, CDC, NIH

Timeline: Starting in FY 2011

► **III.A.4 Reduce tobacco-related disparities through targeted evidence-based interventions in locations serving racial and ethnic minority populations.**

Reducing smoking prevalence among racial and ethnic minorities will require programs and interventions that are both culturally relevant and evidence based. Efforts will include tobacco-free policies, quitline promotion, and counseling and cessation services in sites such as public housing, community health centers, substance abuse facilities, mental health facilities, and correctional institutions.

Lead/Participating Agencies: OASH/OMH, CDC, FDA, ACF, HRSA, IHS, NIH, SAMHSA, OASH/OWH

Timeline: Starting in FY 2011

► **III.A.5 Increase education programs, social support, and home-visiting programs to improve prenatal, early childhood, and maternal health.** HRSA's Maternal, Infant, and Early Childhood Home Visitation program aims to meet the diverse needs of children and families in at-risk communities, particularly underserved minority women and their families with limited social support networks. Eligible entities can implement effective home-visiting services -- including coordination and referrals to other community services -- that can lead to improved outcomes in prenatal, maternal, newborn, and child health and development; parenting skills; school readiness; and family economic self sufficiency. These services can also lead to reductions in crime, domestic violence, and parental substance abuse.

Lead/Participating Agencies: ACF, HRSA, OASH/OPA, SAMHSA

Timeline: Starting in FY 2011

» GOAL III

- » **III.A.6 Implement targeted activities to reduce disparities in flu vaccination.** This initiative will improve vaccination rates in racial and ethnic minority communities. These activities, building on demonstration efforts in the 2010-2011 flu season, will include working with the private sector (pharmacy chains, health plans, and others), medical associations, community-based organizations, and state and local public health departments to increase the availability of flu vaccine and communicate a common set of messages about the seriousness of flu and the safety of the vaccine.
- Lead/Participating Agencies:** OASH/NVPO, OASH/OMH, CDC, ACF, CMS, FDA, HRSA
- Timeline:** Starting in FY 2011

- » **III.A.7 Implement targeted activities to reduce asthma disparities.**
- **Implement the Coordinated Federal Initiative to Reduce Asthma Disparities.** This interagency initiative, part of the President's Task Force on Environmental Health Risks and Safety Risks to Children, will promote best practices in asthma care to reduce disparities. These practices include: implement HHS clinical practice guidelines; link public and private stakeholders at the community level to deliver comprehensive, consistent, and integrated programs; optimize the tracking and targeting of populations disproportionately affected by childhood asthma; and develop a coordinated research agenda on asthma prevention and decreasing asthma severity.
 - Measure and promote better asthma care for racial and ethnic minorities through Medicaid and CHIP demonstration grants to states. Activities will support environmental interventions, nontraditional asthma educators, and testing of core asthma measures.
- Lead/Participating Agencies:** NIH, AHRQ, CDC, CMS, HRSA, and all other HHS agencies
- Timeline:** Starting in FY 2011

▶ GOAL III

Strategy III.B: Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.

Entities ranging from local health departments, national foundations, the World Health Organization, and several countries, are conducting health impact assessments on proposed policies and programs. Health disparity impact assessments have the potential to inform policymakers of likely impacts of proposed policies and programs on health and healthcare disparities among racial and ethnic minorities, and to reduce disparities through improving new policies and programs.

Actions:

- ▶ **III.B.1 Adopt a “health in all policies” approach.** Develop, implement, and monitor strategies addressing health disparities by engaging other key federal departments, the private sector, and community-based organizations to adopt a “health in all policies” approach, including a health impact assessment for key policy and program decisions.

Lead/Participating Agencies: OASH/OMH, All HHS Agencies

Timeline: Starting in FY 2012

- ▶ **III.B.2. Evaluate use of health disparity impact assessment for proposed policies and programs.** HHS will collaborate with national foundations to conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.

Lead/Participating Agencies: OASH/OMH, All HHS Agencies

Timeline: Starting in FY 2012

► GOAL IV

Goal IV: Advance Scientific Knowledge and Innovation

While scientific advances have improved the longevity and quality of life for people in America, these gains have not been experienced equally by racial and ethnic minorities.⁴⁶ Advancing scientific knowledge and innovation can improve patient-centered research in the areas of prevention, screening, diagnostic and treatment services, and strengthen existing information systems to reduce and improve the quality of health, public health, and biomedical research. These efforts must benefit all populations.

Strategy IV.A: Increase the availability and quality of data collected and reported on racial and ethnic minority populations. The capacity of HHS to identify disparities and effectively monitor efforts to reduce them is limited by a lack of specificity, uniformity, and quality in data collection and reporting procedures. Consistent methods for collecting and reporting health data by race, ethnicity, and language are essential.

Actions:

► **IV.A.1 Implement a multifaceted health disparities data collection strategy across HHS.** This initiative will:

- Establish data standards and ensure federally conducted or supported health care or public health programs, activities, or surveys collect and report data in five specific demographic categories: race, ethnicity, gender, primary language, and disability status as authorized in the Affordable Care Act;
- Oversample minority populations in HHS surveys;
- Develop other methods for capturing low-density populations (Native Americans, Asian Americans and Pacific Islanders) when oversampling is not fiscally feasible;
- Use analytical strategies and techniques, such as pooling data across several years, to develop estimates for racial and ethnic minority populations;
- Publish estimates of health outcomes for racial and ethnic minority populations and subpopulations on a regular, pre-determined schedule;
- Improve public access to HHS minority data and promotion of external analyses; and
- Develop and implement a plan for targeted special population studies, internally or through research grant funding announcements and contracts.

This initiative will also address gaps in subpopulations traditionally missed by standard HHS data collection activities.

Lead/Participating Agencies: ASPE/Data Council, AHRQ, CDC, CMS, OASH/OMH, all other HHS Agencies

Timeline: Starting in FY 2011

► GOAL IV

Strategy IV.B: Conduct and support research to inform disparities reduction initiatives. Health disparities research can inform initiatives to improve the health, longevity, and quality of life among racial and ethnic minorities by bridging the gap between knowledge and practice.

Actions:

- **IV.B.1 Develop and implement strategies to increase access to information, tools, and resources to conduct collaborative health disparities research across federal departments.** Bringing together various federal departments to pool government resources and expertise to utilize and disseminate health disparities research results will accelerate efforts to address social determinants of health in multiple settings. This initiative will develop coordinated research protocols and Memoranda of Agreement to facilitate collaboration across departments and agencies.

Lead/Participating Departments/Agencies: HHS/NIH, DOE, DOL, ED, EPA, USDA, VA

Timeline: Starting in FY 2011

- **IV.B.2 Develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations.** Patient-centered outcomes research informs healthcare decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. By working collaboratively with research and healthcare institutions, HHS can develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic minority populations. Targeted health conditions will include diabetes mellitus, asthma, arthritis, and cardiovascular diseases including stroke and hypertension.

Lead/Participating Agencies: NIH, AHRQ, ASPE, OASH/OMH

Timeline: Starting in FY 2011

- **IV.B.3 Promote community-based participatory research (CBPR) approaches to increase cancer awareness, prevention, and control to reduce health disparities.** The NIH is supporting various CBPR approaches that integrate the complex and multi-level determinants of health to reduce the burden of disease such as cancer, cardiovascular diseases, and diabetes within communities. This initiative will fund new cooperative agreements through the existing National Cancer Institute (NIH/NCI) Community Networks Program centers to increase knowledge of, access to, and utilization of biomedical and behavioral procedures for reducing cancer disparities. Such efforts range from prevention through early detection, diagnosis, treatment, and survivorship in

▶ GOAL IV

racial and ethnic minorities and other underserved populations. The Centers also provide an opportunity for training health disparity researchers (particularly new and early-stage investigators) in CBPR approaches and cancer health disparities.

Lead/Participating Agencies: NIH

Timeline: Starting in FY 2011

- ▶ **IV.B.4 Expand research capacity for health disparities research.** This initiative will support efforts to expand faculty-initiated health disparities research programs and improve the capacity for training future research scientists. Through extending infrastructure like the NIMHD Research Infrastructure in Minority Institutions Program, HHS will support researchers to study health disparities to improve the scientific infrastructure needed to find solutions.

Lead/Participating Agencies: NIH, HRSA, OASH/OMH

Timeline: Starting in FY 2011

- ▶ **IV.B.5 Leverage regional variation research in search of replicable success in health disparities.** Studies of systems where racial and ethnic minorities receive the highest quality of care and have the best health outcomes can reveal important tools to improve health disparities. Thorough research may reveal the specific mechanisms that solve this recalcitrant issue. HHS will support researchers who search for successful models and identify effective solutions to address health disparities.

Lead/Participating Agencies: NIH, AHRQ

Timeline: Starting in FY 2011

▶ GOAL V

Goal V: Increase Efficiency, Transparency, and Accountability of HHS Programs

Promoting better collaboration and streamlining efforts can improve the efficiency of HHS programs. Addressing racial and ethnic health disparities in an efficient, transparent, and accountable manner will require better coordination and integration of the minority health infrastructure and programs. Using transparent measures can help the Department hold itself accountable. Other HHS open-government activities such as the Community Health Data Initiative — a major new public-private effort to help people understand health and healthcare performance in their communities and to spark and facilitate action to improve performance — will promote local application of measures.

Streamline grant administration for health disparities funding. The Department will improve the coordination of the administration of grants that address health disparities by identifying effective ways to implement processes that simplify grant administrative activities for communities, community-based organizations, tribes, and states. This will include moving toward standardizing grantee reporting requirements, developing common metrics to reduce inefficiencies, and identifying opportunities to leverage investments.

Monitor and evaluate implementation of the HHS Disparities Action Plan. To assure accountability and a clear focus on performance and outcomes, HHS will employ a multi-level monitoring and evaluation approach to track progress on implementation and outcomes of the HHS Disparities Action Plan. Goal, strategy and action-level indicators will be assessed. At the **goal level**, HHS will monitor disparities data to assess the extent to which progress is being made in the five goals. At the **strategy level**, HHS will undertake program evaluations to assess the extent to which changes in strategy-level objectives are correlated with action steps. At the **action level**, HHS will track performance data to determine the extent to which actions are completed and assess the timeliness of completion. Collectively, these evaluation activities will help us to understand our progress toward achieving the vision of the HHS Disparities Action Plan.

Goal-Level Disparities Monitoring and Surveillance. To monitor the nation's overall progress toward achieving desired changes in disparities indicators, HHS will annually track progress on measures selected from multipurpose national data systems such as population-based surveys to track progress. These measures will reflect the goals of the HHS Disparities Action Plan, *Healthy People 2020* disparity objectives, and Affordable Care Act provisions. Measures will be publicly accessible and will provide timely updated information. HHS data systems will be used to provide data for these measures. Measures are listed in Appendix C.

GOAL V

Strategy-Level Evaluation. HHS will work with lead agencies to develop an evaluation plan for relevant actions within the HHS Disparities Action Plan. Evaluations will focus on the extent to which outcomes from implemented actions are correlated with desired strategies and changes. For example, HHS may conduct an evaluation to assess whether the creation of specific payment structure incentives by Health Insurance Exchanges have improved health outcomes among racial and ethnic and low-income populations.

These evaluation efforts will build upon existing monitoring and evaluation infrastructures. Each agency of the Department routinely conducts evaluations designed to assess the process, outcomes, and effectiveness of its own programs based on what aspects of disparity are targeted. Efforts are made to ensure all programs have measurable objectives that can be used to direct program activities and measure the benefits accruing to the target populations. To this end, the agency may directly collect data in the process of administering the program relating to performance. It may also conduct special evaluation studies to assess program outcomes and impacts. All monitoring and evaluation is designed in full recognition that in addition to actions outlined in the plan, changes in disparities are also related to ongoing efforts at various levels in government and private sector organizations, including efforts that address social determinants of health.

Action-Level Monitoring. HHS will routinely monitor agency and office progress in completing actions within the HHS Disparities Action Plan. As a part of this process, HHS will utilize existing performance measures, such as Government Performance and Results Act (GPRA) measures, and other program performance monitoring data systems. Additional performance metrics may be identified to allow HHS to identify barriers to action success and assess overall progress on HHS Disparities Action Plan implementation.

» CONCLUSION

Conclusion

This HHS Disparities Action Plan in support of the *National Stakeholder Strategy* will accelerate national momentum toward reducing racial and ethnic health care disparities. The Affordable Care Act represents the most significant federal effort to reduce disparities in the country's history. By building on the Affordable Care Act and shaping the Department's health disparities reduction activities around the Secretary's priorities, the Department will lead by example. Through the release of this Action Plan, the Department commits to the vision of a nation free from disparities in health and health care for racial and ethnic minority populations.

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

The Applicants propose to establish a 16-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360-520 gross square feet per dialysis station for a total of 5,760 to 8,320 gross square feet for 16 dialysis stations. The total gross square footage of the proposed dialysis facility is 6,781 gross square feet. Accordingly, proposed Facility meets the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD	6,781	5,760 – 8,320	0	Meets State Standard

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

By the second year of operation, annual utilization at the proposed facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Dr. Aneziokoro is currently treating a large CKD patient-base, many of which are advancing to ESRD and will likely require dialysis within the next 12 to 18 months. Conservatively, taking into account attrition due to patient death, transplant, return of function, or relocation, he projects that 74 of these patients will initiate dialysis within 12 to 18 months. Dr. Aneziokoro anticipates 14 of his patients at Little Village will transfer to the proposed facility. Thus, approximately 88 patients will be referred to the proposed facility within 12 to 18 months.

Table 1110.234(b)					
Utilization					
	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	N/A	13,728	11,980	Yes
Year 2	ESRD	N/A	13,728	11,980	Yes

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

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

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

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

Section VII, Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430, In-Center Hemodialysis Projects – Review Criteria

1. Planning Area Need

The Applicants propose to establish a 16-station dialysis facility to be located at 3934 West 24th Street, Chicago, Illinois 60623. The proposed facility will be located in HSA 6. Based upon the latest inventory data, there is a need for 78 dialysis stations in HSA 6, the service area where the proposed facility will be located. The proposed facility will address the need in HSA 6. As shown in Attachment – 26A, there are currently 48 dialysis facilities within 30 minutes normal travel time of the proposed facility. When excluding facilities that are not yet in operation, average utilization within 30 minutes normal travel time is 81%, above the State's standard. As ESRD prevalence increases, the utilization within the service area will continue to meet or exceed the State's standard.

Dr. Aneziokoro is currently treating a large CKD patient-base, many of which are advancing to ESRD and will likely require dialysis within the next 12 to 18 months. See Attachment – 13A. Conservatively, taking into account attrition due to patient death, transplant, return of function, or relocation, he projects that 74 of these patients will initiate dialysis within 12 to 18 months. Dr. Aneziokoro is also currently treating many patients at Little Village Dialysis, which is a local facility operating at 100% utilization, far above the state standard. Dr. Aneziokoro anticipates 14 of these patients will transfer to the proposed facility. Little Village Dialysis will continue operating above the State's 80% standard even after these patients transfer to the proposed facility. In total, approximately 88 patients will be referred to the proposed facility within 12 to 18 months. Accordingly, establishment of the proposed facility is necessary to maintain access to life-sustaining dialysis to residents of Lawndale.

2. Service to Planning Area Residents

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of Lawndale. As evidenced in the physician referral letter attached at Attachment – 26B, 14 of his current Little Village Dialysis patients and 78 of his pre-ESRD patients live within 15 minutes normal travel time of the proposed facility.

3. Service Demand

Attached at Attachment – 26B is physician referral letter from Dr. Aneziokoro and a schedule of pre-ESRD and current patients by zip code. A summary of CKD patients projected to be referred to the proposed dialysis facility within the first two years after project completion is provided in Table 1110.1430(b)(3)(B) below. A summary of patients Dr. Aneziokoro is currently treating at Little Village Dialysis is provided below.

Table 1110.1430(b)(3)(B) Projected Pre-ESRD Patient Referrals by Zip Code	
Zip	Patients
60804	8
60623	46
60624	5
60608	15
Total	74

Table 1110.1430(b)(3)(B) Current Patients by Zip Code	
Zip	Patients
60608	1
60623	9
60629	3
Total	14

4. Service Accessibility

As set forth throughout this application, the proposed facility is needed to maintain access to life-sustaining dialysis for residents of Lawndale. The average utilization of existing dialysis facilities within the GSA is 81%. Moreover, HFSRB currently identifies a need for 78 stations in HSA 6. Accordingly, a new dialysis facility is needed to improve access to dialysis services to residents of Chicago.

Table 110.230(b)(1) Facilities within 30 Minutes Driving Distance of Proposed Facility							
Facility	City	HSA	Distance	Adjusted Time	Stations	Patients (3/31/12)	Utilization (3/31/12)
Oak Park Dialysis Center	Oak Park	7	7.09	18.75	12	128	177.78%
John H. Stroger Jr. Hospital of Cook County	Chicago	6	3.48	11.25	9	80	148.15%
Beverly Dialysis	Chicago	6	9.17	28.75	12	79*	109.72%
Dialysis Center of America - Berwyn	Berwyn	7	4.7	16.25	26	160	102.56%
Little Village Dialysis	Chicago	6	2.38	8.75	16	96*	100.00%
North Avenue Dialysis Center	Melrose Park	7	10.31	26.25	22	132	100.00%
Garfield Kidney Center	Chicago	6	3.73	13.75	16	95	98.96%
West Metro Dialysis Center	Chicago	6	4.8	17.5	30	178	98.89%
Fresenius Medical Care Marquette Park	Chicago	6	7.43	25	16	94	97.92%
Midwest Renal Care - Chicago (Fresenius Ross-Englewood)	Chicago	6	12.18	25	16	94	97.92%
Stoney Creek Dialysis	Oak Lawn	7	9.14	26.25	12	70*	97.22%
Fresenius Medical Care Bridgeport	Chicago	6	6.37	17.5	27	154	95.06%
Woodlawn Dialysis	Chicago	6	12.2	26.25	20	114*	95.00%
FMC Dialysis Services of Willowbrook	Willowbrook	7	17.08	30	16	91	94.79%
FMC Dialysis Services - Burbank	Burbank	7	7.36	21.25	22	123	93.18%
Logan Square Dialysis	Chicago	6	6.5	23.75	20	111*	92.50%
Fresenius Medical Care West Belmont	Chicago	6	7.23	26.25	13	72	92.31%
University of Illinois Hospital	Chicago	6	3.43	11.25	26	143	91.67%
Lake Park Dialysis	Chicago	6	11.65	23.75	20	109*	90.83%
Emerald Dialysis	Chicago	6	11.83	25	24	130*	90.28%
West Suburban Hosp. Dialysis Unit	Oak Park	7	5.62	17.5	46	236	85.51%
Mt. Sinai Hospital Med Ctr	Chicago	6	2.02	6.25	15	76	84.44%
Lincoln Park Dialysis Center	Chicago	6	11.08	26.25	22	110*	83.33%
South Side Dialysis Center	Chicago	6	9.1	27.5	39	194	82.91%
RCG Garfield	Chicago	6	10.6	21.25	22	106	80.30%
Loyola Dialysis Center	Maywood	7	8.57	21.25	30	139	77.22%
Fresenius Medical Care Northcenter	Chicago	6	12.42	28.75	16	73	76.04%
RCG MidAmerica - Prairie	Chicago	6	8.1	18.75	24	108	75.00%
RCG-Scottsdale	Chicago	6	7.76	22.5	35	153	72.86%
Circle Medical Management	Chicago	6	4.24	15	27	113	69.75%
Northwestern Mem. Hosp. (Part of RCG Waukegan)	Chicago	6	9.13	22.5	44	183	69.32%
LaGrange Dialysis Center	Westchester	7	13.06	30	20	83	69.17%
Fresenius Medical Care Delaware	Chicago	6	6.58	16.25	24	99	68.75%
FMC Dialysis Services of Congress Parkway	Chicago	6	2.73	10	30	121	67.22%
Austin Community Kidney Center	Chicago	6	4.38	15	16	64	66.67%
Chicago Dialysis Center	Chicago	6	6.01	15	21	79	62.70%

Maple Avenue Kidney Center		Oak Park	7	6.22	16.25	18	67	62.04%
Loop Renal Center		Chicago	6	7.63	20	28	100*	59.52%
Fresenius Medical Care - Midway		Chicago	6	6.98	18.75	12	42	58.33%
Fresenius Medical Care Melrose Park		Melrose Park	7	9.31	23.75	18	60	55.56%
Fresenius Medical Care of Chicago - West		Chicago	6	3.24	11.25	31	99	53.23%
Grand Crossing Dialysis		Chicago	6	13.84	28.75	12	36*	50.00%
TRC Children's Dialysis		Chicago	6	9.95	27.5	6	17*	47.22%
West Lawn Dialysis		Chicago	6	5.79	18.75	12	30*	41.67%
Rush Univ. Med. Ctr.		Chicago	6	3.74	12.5	5	4	13.33%
Fresenius Medical Care West Willow		Chicago	6	9.3	21.25	12	5	6.94%
Fresenius Medical Care Chatham		Chicago	6	14.32	27.5	16	0	0.00%
Fresenius Medical Care Cicero		Cicero	7	1.8	6	16	0	0.00%
* Patient census as of 8/31/12 for DaVita facilities.								

Ogbonnaya Aneziokoro, M.D
655 West Irving Park Road
Suite 2101
Chicago 60613

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

Dear Chairman Galassie:

I am pleased to support the establishment of Lawndale Dialysis. As stated in my earlier support letters and testimony, the new 16-station chronic renal dialysis facility, to be located at 3934 West 24th Street, Chicago, IL 60623, will afford my growing patient-base access to excellent dialysis care.

The community surrounding the proposed facility, as well as the group of patients that I am treating, is a medically vulnerable, primarily African-American, Hispanic and low-income, patient population. The Lawndale community also has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). My patient population reflects the racial and ethnic health disparities in this community. So does the Board's own 78-station need projection and the state-wide ESRD data that it recently published which reflects the disparities in kidney health, and access to dialysis services and health insurance in the Hispanic and African American population.

In my last referral commitment letter, I identified 148 CKD patients whose condition is advancing to end stage renal disease (ESRD). Since that time, my colleagues and I experienced a loss – the very unfortunate death of Dr. Lillian Magana, who also treated CKD patients in the Lawndale and Little Village communities. After her untimely death, I took over substantially all of her patient load. Thus, my CKD patient population is now significantly larger.

Of these CKD patients, I project that I will refer 74 who will require dialysis within the next 12 to 18 months to the proposed Lawndale facility. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 96 patients at Little Village Dialysis, which is a nearby facility operating at 100% utilization, significantly higher than the state standard. I anticipate that 14 of these patients will transfer to the proposed facility. A list of the zip codes for these patients is attached at Attachment – 2. Thus, I project that I would refer a total of 88 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD at Attachment – 3.

Due to the large number of kidney disease patients my practice serves, the new facility is essential. I anticipate that my patient population, and the number of individuals suffering from CKD generally, will continue to increase. CKD is a growing public health problem in the United States. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and

ESRD. Not surprisingly, obesity, is linked to both diabetes and high blood pressure, is also one of driving factors for progressive CKD.

According to a recent study, the number of Americans with diabetes will double from 23.7 million in 2009 to 44.1 million in 2034. Because the average wait time for an ESRD patient for a kidney transplant is more than four years, and mortality rates among ESRD patients have improved significantly in recent years, during any given year, most of these patients become dependent on dialysis to survive. As such, demand for dialysis treatment is expected to continue to increase.

Further, as medical professionals and, more importantly, as humans, we have a responsibility to make a difference in our communities when we have the ability to do so. My partners, Mt. Sinai and DaVita, have demonstrated their willingness to furnish essential services in underserved and underprivileged communities. Due to local socioeconomic conditions, this community, in particular, needs these services, and they need them now.

This population exhibits a higher prevalence of obesity, which is a primary driver of diabetes and hypertension. Notably, the City of Chicago exhibits a much higher concentration of African Americans and Hispanics than the rest of the State. In fact, approximately 98% of the Lawndale community is either African American or Hispanic. These individuals are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in minority communities. In fact, the ESRD incident rate among African Americans is 3.6 times greater than the non-whites and the incident rate among Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to increase utilization.

My patients need this facility, and, as such, I fully support the proposed establishment of Lawndale Dialysis. The information in this letter is true and correct to the best of my knowledge.

Sincerely,

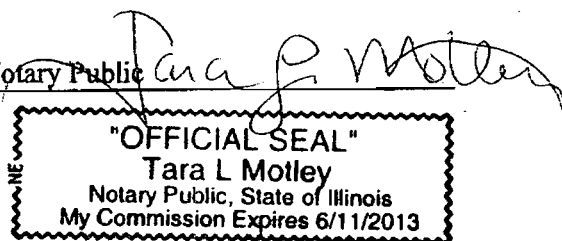


Ogbonnaya Aneziokoro, M.D.
Nephrologist

Subscribed and sworn to me

This 21st day of Sept., 2012

Notary Public



**ATTACHMENT 1
PRE-ESRD PATIENTS**

Zip	Patients
60804	8
60623	46
60624	5
60608	15
Total	74

**ATTACHMENT 2
CURRENT PATIENTS**

Zip	Patients
60608	1
60623	9
60629	3
Total	14

ATTACHMENT 3 HISTORICAL ESRD REFERRALS

Little Village Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60609	1	60402	1	60608	3
60629	3	60609	1	60609	1
60632	1	60623	6	60623	5
60651	1	60632	2	60632	2
		60638	1	60643	1
				60644	1

Lincoln Park Dialysis

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60614	1	60609	1	60610	1
60624	1	60610	1	60614	1
60629	1	60614	3	60625	1
60639	1	60618	3	60657	2
60645	1	60645	1	91170	1
60653	1				
60659	1				

Logan Square Dialysis

2009		2011	
Zip Code	Patients	Zip Code	Patients
60614	2	60639	1

Emerald Dialysis

2011	
Zip Code	Patients
60621	1
60623	2
60632	2

Section VII, Service Specific Review Criteria**In-Center Hemodialysis****Criterion 1110.1430(c), Unnecessary Duplication/Maldistribution****1. Unnecessary Duplication of Services**

- a. The proposed dialysis facility will be located at 3934 West 24th Street, Chicago, Illinois 60623. A map of the proposed facility's market area is attached at Attachment – 26C. A list of all zip codes located, in total or in part, within 30 minutes normal travel time of the site of the proposed dialysis facility as well as 2010 census figures for each zip code is provided in Table 1110.1430(c)(1)(A).

Table 1110.1430(c)(1)(A)		
Population of Zip Codes within 30 Minutes of Proposed Facility		
Zip	City	Population
60517	WOODRIDGE	32038
60515	DOWNERS GROVE	27503
60516	DOWNERS GROVE	29084
60559	WESTMONT	24852
60439	LEMONT	22919
60561	DARIEN	23115
60527	WILLOWBROOK	27486
60514	CLARENDON HILLS	9708
60521	HINSDALE	17597
60558	WESTERN SPRINGS	12960
60148	LOMBARD	51468
60191	WOOD DALE	14310
60523	OAK BROOK	9890
60181	VILLA PARK	28836
60126	ELMHURST	46371
60162	HILLSIDE	8111
60163	BERKELEY	5209
60164	MELROSE PARK	22048
60106	BENSENVILLE	20309
60463	PALOS HEIGHTS	14671
60445	MIDLOTHIAN	26057
60464	PALOS PARK	9620
60480	WILLOW SPRINGS	5246
60465	PALOS HILLS	17495
60457	HICKORY HILLS	14049
60455	BRIDGEVIEW	16446
60525	LA GRANGE	31168
60526	LA GRANGE PARK	13576
60458	JUSTICE	14428
60501	SUMMIT ARGO	11626
60513	BROOKFIELD	19047
60534	LYONS	10649

60482	WORTH	11063
60415	CHICAGO RIDGE	14139
60459	BURBANK	28929
60803	ALSIP	22285
60453	OAK LAWN	56855
60456	HOMETOWN	4349
60638	CHICAGO	55026
60402	BERWYN	63448
60655	CHICAGO	28550
60805	EVERGREEN PARK	19852
60652	CHICAGO	40959
60643	CHICAGO	49952
60620	CHICAGO	72216
60629	CHICAGO	113916
60632	CHICAGO	91326
60636	CHICAGO	40916
60621	CHICAGO	35912
60609	CHICAGO	64906
60628	CHICAGO	72202
60619	CHICAGO	63825
60617	CHICAGO	84155
60637	CHICAGO	49503
60653	CHICAGO	29908
60615	CHICAGO	40603
60649	CHICAGO	46650
60154	WESTCHESTER	16773
60155	BROADVIEW	7927
60104	BELLWOOD	19038
60165	STONE PARK	4946
60160	MELROSE PARK	25432
60153	MAYWOOD	24106
60141	HINES	224
60546	RIVERSIDE	15668
60130	FOREST PARK	14167
60305	RIVER FOREST	11172
60707	ELMWOOD PARK	42920
60131	FRANKLIN PARK	18097
60176	SCHILLER PARK	11795
60171	RIVER GROVE	10246
60634	CHICAGO	74298
60706	HARWOOD HEIGHTS	23134
60656	CHICAGO	27613
60631	CHICAGO	28641
60304	OAK PARK	17231
60301	OAK PARK	2539
60302	OAK PARK	32108
60804	CICERO	84573
60623	CHICAGO	92108

60644	CHICAGO	48648
60639	CHICAGO	90407
60651	CHICAGO	64267
60624	CHICAGO	38105
60641	CHICAGO	71663
60630	CHICAGO	54093
60646	CHICAGO	27177
60712	LINCOLNWOOD	12590
60077	SKOKIE	26825
60608	CHICAGO	82739
60647	CHICAGO	87291
60612	CHICAGO	33472
60622	CHICAGO	52548
60607	CHICAGO	23897
60616	CHICAGO	48433
60642	CHICAGO	18480
60614	CHICAGO	66617
60661	CHICAGO	7792
60654	CHICAGO	14875
60606	CHICAGO	2308
60602	CHICAGO	1204
60610	CHICAGO	37726
60618	CHICAGO	92084
60625	CHICAGO	78651
60659	CHICAGO	38104
60657	CHICAGO	65996
60613	CHICAGO	48281
60640	CHICAGO	65790
60605	CHICAGO	24668
60604	CHICAGO	570
60603	CHICAGO	493
60601	CHICAGO	11110
60611	CHICAGO	28718
Total		3,809,715

Source: U.S. Census Bureau, Census 2010, American Factfinder available at <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited Jul. 29, 2011).

- b. A list of existing and approved dialysis facilities located within 30 minutes normal travel time of the proposed dialysis facility is provided at Attachment – 26A.

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services but rather will improve access to low income residents in the City of Chicago. Currently, there is an inequitable allocation of dialysis facilities within the Chicago metropolitan area, with HSA 7, which comprises suburban Cook County and DuPage County and is more affluent, having better access to dialysis than HSA 6, which consists solely of the City of Chicago and includes larger low-income populations. As of March 31,

2012 there are slightly more dialysis patients in HSA 6 than HSA 7 with 4,769 dialysis patients in HSA 6 compared to 4,728 dialysis patients in HSA 7. Despite similar patient numbers, there is a significant disparity in the number of stations available in the two health service areas; HSA 6 had 1,075 stations as of March 31, 2012 to serve 4,769 patients (or 1 station for every 4.4 patients) and HSA 7 had 1,127 stations to serve 4,728 dialysis patients (or 1 stations for every 4.2 patients). This difference is significant because it means fewer stations are available and patients will likely have to travel farther for their dialysis. Dialysis patients are chronically ill and usually suffer from multiple comorbidities. Many patients are diabetic and elderly, have poor vision and/or rely on assistive devices such as canes and wheelchairs. Further, dialysis is very taxing to the body and there are many difficult side-effects to lost kidney function. As a result, many patients are reliant on friends or family members to transport them to and from their dialysis and must schedule their dialysis when transportation is available, which limits scheduling options. Patients with transportation access issues will often miss their dialysis treatments, which results in non-compliance with the treatment regimen. Studies have shown that skipping one or more dialysis sessions in a month has been associated with a 16% higher risk of hospitalization and 30% increased mortality risk compared to compliant patients. Traveling outside of their community for dialysis also puts a real strain on the pocket books of people living on fixed incomes and also is often unrealistic because of general socio-economic barriers.

Further, a maldistribution does not exist because the geographic service area has no excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (1) ratio of stations to population exceeds one and one-half times the State Average; (2) historical utilization for existing facilities and services is below the HFSRB's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more fully below, the ratio of stations to population in the GSA is 90% of the State average, the average utilization of existing facilities is 81%, and sufficient population exists to achieve target utilization. Accordingly, the proposed dialysis facility will not result in a maldistribution of services.

a. Ratio of Stations to Population

As shown in Table 1110.1430(c)(2)(A), the ratio of stations to population is 89% of the State Average.

Table 1110.1430(c)(2)(A)			
Ratio of Stations to Population			
	Population	Dialysis Stations	Stations to Population
Geographic Service Area	3,809,715	993	1:3,836
State	12,830,632	3,892	1:3,297

b. Historic Utilization of Existing Facilities

Additionally, the average utilization in the service area is 81%. Accordingly, there is sufficient patient population to justify the need for the proposed facility. There will be no maldistribution of services. Additional stations are necessary to adequately meet rising demand and a need of 78 additional dialysis stations, as identified by the HFSRB Inventory.

c. Sufficient Population to Achieve Target Utilization

The Applicants propose to establish a 16-station dialysis facility. To achieve the HFSRB's 80% utilization standard within the first two years after project completion, the Applicants would need 77 patient referrals. As set forth above in Table 1110.230(b)(2), Dr. Aneziokoro projects that approximately 74 of his current CKD patients will be referred to the proposed facility. Dr. Aneziokoro also anticipates referring 14 patients he is currently treating at Little Village Dialysis to the proposed facility. This results in 88 patient referrals within 12 to 18

months following project completion. Accordingly, there is sufficient volume to justify the proposed facility.

3. Impact to Other Providers

- a. The proposed dialysis facility will not have an adverse impact on existing facilities in the GSA. As discussed throughout this application, the average utilization among existing facilities is 81% and the HFSRB Inventory identifies a need of 78 additional stations. While Dr. Aneziokoro anticipates 14 of his patients he is currently at Little Village Dialysis will transfer to the proposed facility, Little Village Dialysis is currently operating at 100% utilization and will continue operating above the State's 80% standard even after 14 patients transfer to the proposed facility.
- b. The proposed facility will not lower the utilization of other area providers that are operating below the occupancy standards.

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Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(e), Staffing

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

a. Medical Director: Ogbonnaya Aneziokoro, M.D. will serve as the Medical Director for the proposed facility. A copy of Dr. Aneziokoro's curriculum vitae is attached at Attachment – 26D.

b. Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

Administrator
Registered Nurse (.5 FTE)
Patient Care Technician (1.2 FTE)
Biomedical Technician (0.2 FTE)
Social Worker (licensed MSW) (0.1 FTE)
Registered Dietitian (0.1 FTE)
Administrative Assistant (0.5 FTE)

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

c. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program is attached at Attachment – 26E.

d. As set forth in the letter from Martha Ha, Assistant Secretary of DaVita Inc. is attached at Attachment – 26F, Lawndale Dialysis will maintain an open medical staff.

Personal-Profile

1

Ogbonnaya Aneziokoro, M.D**Personal-Profile**

Ogbonnaya Aneziokoro M.D

Contact Information *655W Irving Park Road Apt 2101
Chicago Illinois 60613**Home 773-325-2533
Office 773-883-3639
Cell Phone - 630-667-5496
Business- 312-607-5496
E-Mail: oaneziok@nwmac.com***Visa Status** *US Citizen***Education***Fellowship - Nephrology
Section of Nephrology
Department of Medicine
University of Chicago
July 2003- July 2006**Nephrology Research
University of Chicago
2002**Chief Medical Resident
St Joseph Hospital Chicago Illinois
June 2001- June 2002**Residency, Internal Medicine
St Joseph Hospital Chicago Illinois
June 1998- June 2001**Internship
University College Hospital, Ibadan, Nigeria
1995- 1996*

Personal-Profile

2

Ogbonnaya Aneziokoro, M.D

*M.B.B.S., Bachelor of Medicine & Surgery
University College Hospital, Ibadan, Nigeria
1988 - 1995*

**Academic
Positions**

*Renal Clinical Pathophysiology Workshops: Taught renal
clinical Pathophysiology to groups of 20-30 4th year
medical students.*

*The University of Chicago
2003-2005*

*Attending Physician Labour Medicine Clinic
June 2001- June 2002*

*Member, Medical Education Committee
St Joseph Hospital, Chicago, IL
June 2001- June 2002*

*Member, Critical Care Committee
St Joseph Hospital, Chicago, IL
June 2001- June 2002*

*Member, Institutional Coordination Committee
St Joseph Hospital, Chicago, IL
June 2001- June 2002*

*Member Advisory Committee
Labour Outpatient Center
St Joseph Hospital, Chicago, IL
June 2001- June 2002*

Personal-Profile

3

Ogbonnaya Aneziokoro, M.D**Research/Publications**

Distinct and Separable Roles of the Complement in Factor H Deficient Bone Marrow Chimeric Mice with Immune complex Disease.

J Am Society of Nephrology 17:1354-1361, April 2006

Gene Expression Profile in Mesangial Cells Cultured from Streptozotocin Induced Diabetes in C57Bl6 Mice.

Vascular-Alergic Surveillance Monitoring of Chronic Hemodialysis Access With Radiological Determination of Venous Stenosis.

Clearance, Efficacy, and Safety of Pre-Filter Citrate during High Dose Continuous Venovenous Hemofiltration.

RAIL - 002: A Multi-center, Open-label Randomized Phase II Study to Assess Safety and Preliminary Efficacy with the Renal Assist Device (RAD) in Patients with Acute Renal Failure

Essentials of Patient Oriented Research - A yearlong course offered at the University of Chicago on Ethics of clinical research biostatistics and epidemiology and clinical investigation.

Schistosomiasis in adult Idere community establish a link between prevalence of schistosomiasis and habits of locals.
1998

Personal-Profile

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Ogbonnaya Aneziokoro, M.D**Presentations**

Epigenetic Effects In Diabetic Nephropathy
Midwest Nephrology Research Day
Chicago Illinois.
March 2006

Mesangial Cells Cultured From Diabetic Mice Have
Hyperglycemic Memory
Midwest Nephrology Research Day Indianapolis
Sponsored by University of Indiana and Renal Network Inc.
Indianapolis Indiana.
May 2005

Hepatorenal Syndrome and Current Concepts
November 2005

Idiopathic Membranous with FSGS a Poor Prognostic
Indicator
October 2005

Home Hemodialysis a More than Viable Option
September 2005

Monitoring, Surveillance and Diagnostic Testing For
Vascular Access
August 2005

Current concepts, Terminology and Management of
Peritoneal dialysis Infections.
March 2005

Vascular Access Steal Syndrome
February 2005

Diagnosis and Management of Central Venous Stenosis
November 2004

Personal-Profile

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Ogbonnaya Aneziokoro, M.D*Fistula Failure and Classification
September 2004**Pericardial Effusion and Pericarditis in Hemodialysis
Patients February 2004***Professional
Memberships***American Medical Association
American College of Physicians
American Society of Nephrology***Community
Service***Voluntary work for underserved population at the
Community health clinic in Chicago for 3 years
Jan 1999- June 2002***Work experience***Horizon Hospice, Chicago, IL Part time Internist
Nov 2000- July 2001**Internal medicine consultant for Hospital Care
Associates.
2001- 2002**House Physician St Anthony Hospital
2003- Present.**House Physician Lincoln Park Hospital
2005- Present.*

Personal-Profile

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Ogbonnaya Aneziokoro, M.D

References:

F. Gary Toback MD, PhD, Professor of Medicine, Section of Nephrology, University of Chicago - 773 702 1476

Patrick Murray MD, Professor of Medicine, Fellowship program Director, Section of Nephrology, University of Chicago - 773 702 3630

Mary S Hammes, Assistant Professor of Medicine, Director, Woodlawn Dialysis facility, University of Chicago - 773 702 9892

Pradeep Kadambi MD, Assistant Professor of Medicine, Transplant Nephrology, University of Chicago - 773 702 1323

PROGRAM DESCRIPTION

Introduction to Program

The Hemodialysis Education and Training Program is grounded in DaVita's Core Values. These core values include a commitment to providing *service excellence*, promoting *integrity*, practicing a *team* approach, systematically striving for *continuous improvement*, practicing *accountability*, and experiencing *fulfillment* and *fun*.

The Hemodialysis Education and Training Program is designed to provide the new teammate with the necessary theoretical background and clinical skills necessary to function as a competent hemodialysis patient care provider.

DaVita hires both non-experienced and experienced teammates.

A **non-experienced teammate** is defined as:

- A newly hired patient care teammate without prior dialysis experience.
- A rehired patient care teammate who left prior to completing the initial training.

An **experienced teammate** is defined as:

- A newly hired patient care teammate with prior dialysis experience as evidenced by successful completion of a competency exam.
- A rehired patient care teammate who left and can show proof of completing their initial training.

The curriculum of the Hemodialysis Education and Training Program is modeled after the American Nephrology Nurses Association Core Curriculum for Nephrology Nursing and the Board of Nephrology Examiners Nursing and Technology guidelines.

The program incorporates the policies, procedures, and guidelines of DaVita Inc.

The new teammate will be provided with a "StarTracker". The "StarTracker" is a tool that will help guide the training process while tracking progress. The facility administrator and preceptor will review the Star Tracker to plan and organize the training and professional development of the new teammate. The Star Tracker will guide the new teammate through the initial phase of training and then through the remainder of their first year with DaVita, thus increasing their knowledge of all aspects of dialysis. It is designed to be used in conjunction with the "My Learning Plan Workbooks."

Program Description

- The education program for the newly hired patient care provider teammate **without prior dialysis experience** is composed of at least (1) 120 hours didactic instruction and (2) 280 hours clinical practicum, unless otherwise specified by individual state regulations.

The **didactic phase** consists of instruction including but not limited to lectures, readings, self-study materials, on-line learning activities, specifically designed hemodialysis

workbooks for the teammate, demonstrations and observations. This education may be coordinated by the Clinical Services Specialist (CSS), the administrator, or the preceptor. This training includes introduction to the dialysis machine, components of the hemodialysis system, dialysis delivery system, principles of hemodialysis, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used, introduction to DaVita Policies and Procedures, and introduction to the Amgen Core Curriculum.

The **didactic phase** also includes classroom training with the Clinical Services Specialist, which covers more in-depth theory on structure and functions of the kidneys. This includes homeostasis, renal failure ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis, components of the hemodialysis system, water treatment, dialyzer reprocessing, hemodialysis treatment (which includes machine troubleshooting and patient complications), documentation, complication case studies, heparinization and anticoagulation, vascular access (which includes vascular access workshop), patient assessment (including workshop), fluid management with calculation workshop, nutrition, laboratory, adequacy, pharmacology, patient teaching/adult learning, service excellence (which includes professionalism, ethics and communications).

A final comprehensive examination score of $\geq 80\%$ must be obtained to successfully complete this portion of the didactic phase. If a score of less than 80% is attained, the teammate will receive additional appropriate remediation and a second exam will be given.

Also included in the **didactic phase** is additional classroom training covering Health and Safety Training, DaVita Virtual Training Program (which includes 21 hours of computer training classes), One For All orientation training, HIPAA training, LMS mandatory water classes, emergency procedures specific to facility, location of disaster supplies, and orientation to the unit.

Included in the **didactic phase** for nurses is additional classroom training. The didactic phase includes:

- The role of the dialysis nurse in the facility
- Pharmacology for nurses
- Outcomes management
- Patient assessment for the dialysis nurse.

The **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, a registered nurse, or the clinical services specialist (CSS). During this phase the teammate will demonstrate a progression of skills required to perform the hemodialysis procedures in a safe and effective manner. A *Procedural Skills Inventory Checklist* will be completed to the satisfaction of the preceptor and the administrator.

The clinical hemodialysis workbooks will also be utilized for this training and must be completed to the satisfaction of the preceptor and the administrator.

Those teammates who will be responsible for the Water Treatment System within the facility are required to complete the Mandatory LMS Educational Water courses and the corresponding skills checklists.

Both the didactic phase and/or the clinical practicum phase of a specific skill set will be successfully completed prior to the new teammate receiving an independent assignment for that specific skill set. The new teammate is expected to attend all training sessions and complete all assignments and workbooks.

- The education program for the newly hired patient care provider teammate **with previous dialysis experience** is individually tailored based on the identified learning needs. The initial orientation to the *Health Prevention and Safety Training* will be successfully completed prior to the new teammate working/receiving training in the clinical area. The *Procedural Skills Inventory Checklist* including verification of review of applicable policies and procedures will be completed by the preceptor, a registered nurse, and/or the clinical services specialist (CSS) and the new teammate upon demonstration of an acceptable skill-level. The new teammate will also utilize the hemodialysis training workbook and progress at their own pace. This workbook should be completed within a timely manner as to also demonstrate acceptable skill-level.

The *Initial Competency Exam* will be completed; a score of $\geq 80\%$ or higher is required prior to the new teammate receiving an independent patient-care assignment. If the new teammate receives a score of less than 80%, this teammate will receive theory instruction pertaining to the area of deficiency and a second competency exam will then be given. If the new teammate receives a score of less than 80% on the second exam, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate.

Following completion of the training, a *Verification of Competency* form will be completed (see forms TR1-06-05, TR1-06-06). In addition to the above, further training and/or certification will be incorporated as applicable by state law.

The goal of the program is for the trainee to successfully meet all training requirements. Failure to meet this goal is cause for dismissal from the training program and subsequent termination by the facility.

Process of Program Evaluation

The Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the, DaVita Prep Class Evaluation (TR1-06-08), the New Teammate Satisfaction Survey on the LMS and random surveys of facility administrators to determine satisfaction of the training program. To assure continuous



2000 16th Street
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(303) 405-2100
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September 13, 2012

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

Re: Certification of Support Services

Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1110.1430(f) that Lawndale Dialysis will maintain an open medical staff.

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

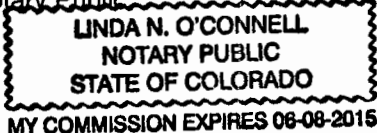
- DaVita utilizes an dialysis electronic data system;
- Lawndale Dialysis will have available all needed support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric services, and social services; and
- Patients, either directly or through other area DaVita facilities, will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis.

Sincerely,

Martha Ha
Assistant Secretary
DaVita Inc.

Subscribed and sworn to me
This 13th day of September, 2012

Notary Public



Service Excellence • Integrity • Team • Continuous Improvement • Accountability • Fulfillment • Fun

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(f), Support Services

Attached at Attachment – 26F is a letter from Martha Ha, Assistant Secretary, DaVita Inc. attesting that the proposed facility will participate in a dialysis data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(g), Minimum Number of Stations

The proposed dialysis facility will be located in the Chicago-Joliet-Naperville metropolitan statistical area ("MSA"). A dialysis facility located within an MSA must have a minimum of eight dialysis stations. The Applicants propose to establish a 16-station dialysis facility. Accordingly, this criterion is met.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(h), Continuity of Care

DaVita Inc. has an agreement with Northwester Memorial Hospital to provide inpatient care and other hospital services. Attached at Attachment – 26G is a copy of the service agreement with an area Northwestern Memorial Hospital.

TRANSFER AGREEMENT

This Transfer Agreement ("Agreement") is entered into as of November 14, 2011 ("Effective Date") by and between Northwestern Memorial Hospital, an Illinois corporation ("Receiving Hospital") and Total Renal Care, Inc. Total Renal Care, Inc. is entering into this Agreement for the benefit of itself and its affiliates operating in the City of Chicago (hereinafter "Transferring Provider"). The Receiving Hospital and Transferring Provider may be referred to individually as a "Party" and collectively the "Parties".

RECITALS

WHEREAS, Transferring Provider owns and operates outpatient dialysis facilities for the care and treatment of patients suffering from end-stage renal disease;

WHEREAS, from time to time, Transferring Provider treats patients who may require hospitalization and other services provided by Receiving Hospital which such services are not available at Transferring Provider, but are available at Receiving Hospital; and

WHEREAS, the Parties desire to establish a transfer arrangement to promote continuity of care and treatment appropriate to the needs of patients with end-stage renal disease.

NOW, THEREFORE, for and in consideration of the terms, conditions, covenants, agreements and obligations contained herein:

SECTION 1 PATIENT TRANSFERS

- 1.1 **Acceptance of Patients.** Upon recommendation of any attending physician who treats patients at one or more of the Transferring Provider dialysis units identified on Exhibit A, and pursuant to the provisions of this Agreement, Receiving Hospital agrees to accept the transfer of Transferring Provider patients requiring hospitalization and other services provided by Receiving Hospital (which may include inpatient dialysis from Transferring Provider *provided that* customary admission requirements, applicable State and Federal laws and regulations are met, and Receiving Hospital has the capacity and ability to treat the patient, as determined in its sole discretion. A request for a patient transfer shall be made by Transferring Provider as soon as possible once the need for a transfer has been identified. After receiving a transfer request, Receiving Hospital shall exercise its reasonable best efforts to promptly communicate whether it has the capacity to accept the transfer. Receiving Hospital further agrees to exercise its reasonable best efforts to provide for the prompt admission of transferred patients.
- 1.2 **Appropriate Transfer.** It shall be Transferring Provider's responsibility, at no cost to Receiving Facility, to arrange for appropriate and safe transportation and care of the patient during such transport. To the extent that the Transferring Provider has responsibilities under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Transferring Provider shall assure that the transfer is an "appropriate transfer" as defined in EMTALA and related regulations, and is carried out in accordance

with any other applicable laws and regulations. The Transferring Provider shall provide all available information regarding the patient when requesting a transfer, and shall comply with Section 2 below regarding the transmission of the patient's medical record to Receiving Hospital. Direct communication between the patient's attending physician from the Transferring Provider and an attending physician at the Receiving Hospital is required before Receiving Hospital will agree to accept the requested transfer.

- 1.3 **Standard of Performance.** Each Party shall, in performing its obligations under this Agreement, provide patient care services in accordance with the same standards as services provided under similar circumstances to all other patients of such Party, and as may be required by federal and state laws and Medicare/Medicaid certification standards. Each Party shall maintain all legally required certifications and licenses from all applicable governmental and accrediting bodies, and shall maintain full eligibility for participation in Medicare and Medicaid.
- 1.4 **Billing and Collections.** Each Party shall be entitled to bill patients and any third parties responsible for paying a patient's bill, for services rendered to patients by such Party and its employees, agents and representatives, and neither Party will have any liability to the other Party for such charges. Each Party shall be solely responsible for all matters pertaining to its billing and collection of such charges, including all forms, documentation, and insurance verification. The Parties shall reasonably cooperate with each other in the preparation and completion of all forms and documentation necessary for billing.

SECTION 2 MEDICAL RECORDS

Subject to applicable confidentiality requirements, the Parties shall exchange all information which may be necessary or useful in the care and treatment of a transferred patient, or which may be relevant in determining whether such patient can be adequately cared for by the Receiving Hospital. All such information shall be provided by the Transferring Provider in advance, where possible, and in any event, no later than at the time of the transfer. The Transferring Provider shall send a copy of all patient medical records that are available at the time of transfer to the Receiving Hospital, including documentation pertaining to the transfer. Any other patient records shall be sent as soon as practicable after the transfer. Each Party shall and shall cause its employees and agents to protect the confidentiality of all patient health information, and comply with all applicable state and federal laws and regulations protecting the confidentiality of patients' records, including the privacy and security regulations related to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

SECTION 3 TERM AND TERMINATION

- 3.1 **Term.** This Agreement shall be effective as of the Effective Date and shall remain in effect until terminated as provided herein.
- 3.2 **Termination.** This Agreement may be terminated as follows:

- (a) Termination by Mutual Consent. The Parties may terminate this Agreement at any time by mutual written consent, and such termination shall be effective upon the date stated in the consent.
- (b) Termination without Cause. Either Party may terminate this Agreement, without cause, upon thirty (30) days prior written notice to the other Party.
- (c) Termination for Cause. A party shall have the right to immediately terminate this Agreement for cause upon the happening of any of the following:
 - (i) If such Party determines that the continuation of this Agreement would endanger patient care.
 - (ii) Violation by the other Party of any material provision of this Agreement, which violation continues for a period of fifteen (15) days after receipt of written notice by the other Party specifying the violation and failure by the other Party to cure.
 - (iii) Exclusion of the other Party from participation in the Medicare or Medicaid programs or conviction of the other Party of a felony related to the provision of health care services.
 - (iv) Except with respect to a change from one accrediting organization to another, the other Party's loss or suspension of any certification, license, accreditation (including Health Facilities Accreditation Program ("HFAP") or Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") or other applicable accreditation), or other approval necessary to render acute patient care services.

SECTION 4 NON-EXCLUSIVE RELATIONSHIP

This Agreement shall be non-exclusive. Either Party shall be free to enter into similar arrangements at any time with other hospitals, or health care entities on either a limited or general basis while this Agreement is in effect. Neither Party shall use the other Party's name or marks in any promotional or advertising material without first obtaining the written consent of the other Party.

SECTION 5 LICENSURE AND INSURANCE

- 5.1 Licenses, Permits and Certification. Each party represents to the other Party that it and all of its employees, agents and representatives possess and shall maintain all required licenses, permits and certifications enabling such Party to provide the services referenced in this Agreement.
- 5.2 Notification of Claims. Each Party shall notify the other Party in writing of any action or suit filed, and shall give prompt notice of any claim made, against the Party by any person or entity that may result in litigation related to the subject of this Agreement.

SECTION 6 COMPLIANCE

- 6.1 **Compliance.** At all times, both Parties shall comply with all federal, state and local laws, rules and regulations now in effect or later adopted relating to the services to be provided hereunder. Each Party shall promptly notify the other Party if it receives notice of any actual or alleged infraction or violation of the same, or notice of any suit or action filed or claim made against a Party related to this Agreement.
- 6.2 **Mutual Representations and Warranties.** As of the date hereof and throughout the term of this Agreement, each Party represents and warrants to the other Party that it: (a) is licensed to operate a general acute care hospital in Illinois; (b) is participating provider in all federally funded health care programs, including Medicare and Medicaid; and (c) is accredited by the HFAP or Joint Commission. A Party shall promptly notify the other Party if it is no longer able to support any of the above representations and warranties.

SECTION 7 MISCELLANEOUS

- 7.1 **Non-Referral of Patients.** Neither Party is under any obligation to refer or transfer patients to the other Party. Neither Party will receive any payment for any patients referred or transferred to the other Party. A Party may refer or transfer patients to any facility based on the professional judgment of the treating physician(s) and the individual needs and wishes of the patient.
- 7.2 **Relationship of the Parties.** The Parties expressly acknowledge that, in performing their respective obligations under this Agreement, each is acting independently. The Parties are not, and shall not be considered to be, joint venturers or partners, and nothing herein shall be construed to authorize either Party to act as an agent for the other. Neither Party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other Party.
- 7.3 **Notices.** Any notice required to be given under this Agreement shall be in writing and shall be deemed given when personally delivered or sent by prepaid United States certified mail, return receipt requested, or by traceable one or two-day courier to each Party as follows:

To Receiving Hospital: Northwestern Memorial Hospital
251 E. Huron
Chicago, IL 60611
Attention: Chief Executive Officer

With a copy to: Northwestern Memorial Hospital
211 E. Ontario Street, Suite 1800
Chicago, IL 60611
Attention: Office of General Counsel

To Transferring Provider: Total Renal Care, Inc, Skyline Region 1
2659 N. Milwaukee Avenue, 2nd Floor
Chicago, Illinois 60647
Attention: Division Vice-President

With a copy to: Total Renal Care, Inc.
c/o DaVita Inc.
1551 Wewatta St.
Denver, CO 80202
Attention: Fusion Group General Counsel

or to such other address of which the receiving Party has given notice pursuant to this Section. All notices shall be considered given and received on the date actually received if given by personal delivery, or traceable courier service.

- 7.4 **Assignment.** Neither Party may assign its rights or delegate its obligations under this Agreement without the prior written consent of the other, except that either Party may assign all or part of its rights and delegate all or part of its obligations under this Agreement to any entity controlled by or under common control with such Party, or a successor in interest to substantially all of the assets of such Party.
- 7.5 **Entire Agreement; Amendment.** This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and may not be amended or modified except in a writing signed by both Parties. All continuing covenants, duties, and obligations contained herein shall survive the expiration or termination of this Agreement. Notwithstanding the foregoing, Transferring Provider may amend Exhibit A of this Agreement to add other dialysis facilities located within the City of Chicago by providing written notice to Receiving Hospital of any additions or deletions to Exhibit A it being understood that patients who require transfer who are being treated at dialysis units in near proximity to other hospitals with adequate capacity and capabilities may be the more appropriate options for certain patient transfers particularly when the need for hospitalization services are of an emergent nature.
- 7.6 **Governing Law.** This Agreement shall be governed by and construed according to the laws of the State of Illinois without regard to the conflict of laws provisions thereunder.
- 7.7 **Headings.** The headings of sections contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 7.8 **Non-discrimination.** Neither Party shall discriminate against any individuals on the basis of race, color, sex, age, religion, national origin, or disability while acting pursuant to this Agreement.
- 7.9 **Severability.** If any provision of this Agreement, or the application thereof to any person or circumstance, shall be held to be invalid, illegal or unenforceable in any respect by any court or other entity having the authority to do so, the remainder of this Agreement, or the application of such affected provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall be in no way affected, prejudiced or disturbed, and each provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

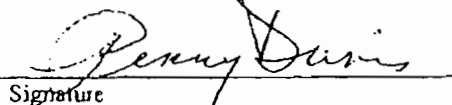
- 7.10 Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of the Parties hereto, their respective successors and permitted assigns.
- 7.11 Waiver. No failure by a Party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement, shall constitute a waiver of any such breach of such covenant, agreement, term or condition. Any Party may waive compliance by the other Party with any of the provisions of this Agreement if done so in writing. No waiver of any provision shall be construed as a waiver of any other provision or any subsequent waiver of the same provision.
- 7.12 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute one and the same instrument.
- 7.13 Approval by DaVita Inc. ("DaVita") as to form. The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita as to the form hereof.

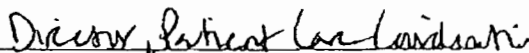
IN WITNESS WHEREOF, the Parties have executed this Agreement through their respective authorized officers, Effective Date.

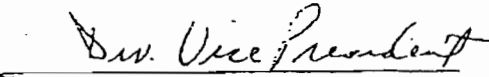
Northwestern Memorial Hospital

Total Renal Care, Inc.


Signature


Signature


Title


Title

APPROVED AS TO FORM ONLY:

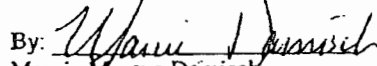
By: 
Marcie Marcus Damisch
Its: Group General Counsel

Exhibit A
Transferring Provider Dialysis Facilities

Beverly Dialysis
8109 South Western Ave.
Chicago, IL 60620

Children's Dialysis
2611 N. Halsted St.
Chicago, IL 60614

Emerald Kidney Center
710 W. 43rd St.
Chicago, IL 60609

Grand Crossing Dialysis
7319-7325 South Cottage Grove
Chicago, IL 60619

Lake Park Dialysis
1531 E. Hyde Park Blvd.
Chicago, IL 60615

Lawndale Dialysis
3934 West 24th Street
Chicago, IL 60623

Lincoln Park Dialysis
3157 N. Lincoln Ave.
Chicago, IL 60657

Little Village Dialysis
2335 W. Cermak Rd.
Chicago, IL 60608

Logan Square Dialysis
2659 N. Milwaukee Ave., 1st Fl.
Chicago, IL 60647

Loop Renal Center
1101 South Canal Street
Chicago, IL 60607

Montclare Dialysis
7009 Belmont Ave.
Chicago, IL 60634

Mount Greenwood Dialysis
3401 W. 111th St.
Chicago, IL 60665

Stony Island Dialysis
8725 S. Stony Island Ave.
Chicago, IL 60617

West Lawn Dialysis
7000 S. Pulaski Rd
Chicago, IL 60629

Woodlawn Dialysis
1164 E. 55th St.
Chicago, IL 60637

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(i), Relocation of Facilities

The Applicants propose the establishment of a 16-station dialysis facility. Thus, this criterion does is not applicable.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(j), Assurances

Attached at Attachment – 26H is a letter from Martha Ha, Assistant Secretary of DaVita Inc. certifying that the proposed facility will achieve target utilization by the second year of operation



2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

September 13, 2012

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

Re: In-Center Hemodialysis Assurances

Dear Chairman Galassie:

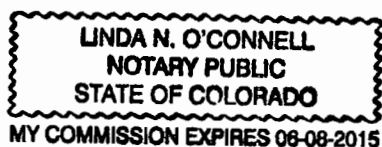
Pursuant to 77 Ill. Admin. Code § 1110.1430(j), I hereby certify the following:

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

Sincerely,

Martha Ha
Assistant Secretary
DaVita Inc.

Subscribed and sworn to me
This 13th day of September, 2012

Notary Public

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded with \$487,715 in cash and securities, a \$1,283,756 loan, and a lease with SDO Development LLC for \$1,374,469. A copy of DaVita's 2011 10-K Statement, evidencing sufficient funds to finance the proposed project was previously submitted with the application for Project No. 12-034, the letter of intent to lease the facility is on file for this project and attached is a letter from Blackhawk Bank indicating its interest in providing credit facilities to Cowell Dialysis including the proposed terms.

Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability

Financial viability ratios for the most recent three years are provided in the Table 1120.130 below.

Table 1120.130				
	DVA 2009	DVA 2010	DVA 2011	Projected 2015
Current Ratio	2.2	2.8	2.0	8.2
Net Margin Percentage	7.9%	7.5%	8.2%	15.1%
Percent Debt to Total Capitalization	37%	39%	39%	38%
Projected Debt Service Coverage	3.24	4.96	3.05	10.26
Days Cash on Hand	40 days	60 days	26 days	64 days
Cushion Ratio	2.0	4.7	1.1	6.8

Section X, Economic Feasibility Review Criteria

Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment – 42A is a letter from Martha Ha, Assistant Secretary of DaVita Inc. certifying the basis for partially financing the project with a line of credit.



2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

September 13, 2012

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

Re: Reasonableness of Financing Arrangements

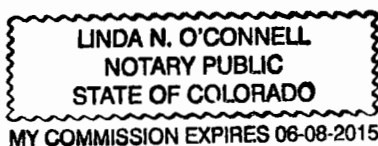
Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded, in part, by borrowing because DaVita has been advised by one of the joint venture partners that depleting its cash reserves beyond what is contemplated to fund the project will adversely affect its current ratio.

Sincerely,

Martha Ha
Assistant Secretary
DaVita Inc.

Subscribed and sworn to me
This 13th day of September, 2012

Notary Public

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(b), Conditions of Debt Financing

The proposed project will be funded in part by borrowing and the Applicants will obtain the most commercially reasonable rates.

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(c), Reasonableness of Project and Related Costs

1. The Cost and Gross Square Feet by Department is provided in the table below.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD		\$138.71			6,781			\$940,600	\$940,600
Contingency		\$20.65			6,781			\$140,000	\$140,000
TOTALS		\$159.36			6,781			\$1,080,600	\$1,080,600

* Include the percentage (%) of space for circulation

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	State Standard	Above/Below State Standard
Modernization Contracts	\$940,600	\$149.35 per gsf x 6,781 gsf = \$149.35 x 6,781 = \$1,012,742	Below State Standard
Contingencies	\$140,000	10-15% of Modernization Contracts = 10-15% x \$940,600 = \$94,060 - \$141,090	Meets State Standard
Architectural/Engineering Fees	\$52,800	6.77% - 10.17% x (Modernization Costs + Contingencies) = 6.77% - 10.17% x (\$940,600 + \$140,884) = 6.77% - 10.17% x \$1,080,600 = \$73,157 - \$109,897	Below State Standard
Consulting and Other Fees	\$75,000	No State Standard	No State Standard
Moveable Equipment	\$525,708	\$39,945 per station x 16 stations \$39,945 x 16 = \$639,120	Below State Standard

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(d), Projected Operating Costs

Operating Expenses: \$3,102,945

Treatments: 13,728

Operating Expense per Treatment: \$226.03

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(e), Total Effect of Project on Capital Costs

Capital Costs:

Interest	\$70,607
Depreciation:	\$120,121
Amortization:	\$4,342
Total Capital Costs:	\$195,070

Treatments: 13,728

Capital Costs per Treatment: \$14.21

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and empowering patients, and community outreach. A copy of DaVita's 2011 Community Care report, which details DaVita's commitment to quality, patient centric focus and community outreach is attached as Attachment – 11A. Because of the life sustaining nature of dialysis, federal government guidelines define renal failure as a condition that qualifies an individual for Medicare benefits eligibility regardless of their age and subject to having met certain minimum eligibility requirements including having earned the necessary number of work credits. Indigent ESRD patients who are not eligible for Medicare and who are not covered by commercial insurance are eligible for Medicaid benefits. If there are gaps in coverage under these programs during coordination of benefits periods or prior to having qualified for program benefits, grants are available to these patients from both the American Kidney Foundation and the National Kidney Foundation. If none of these reimbursement mechanisms are available for a period of dialysis, financially needy patients may qualify for assistance from DaVita in the form of free care. DaVita submits the following information regarding the amount of charity and Medicaid care provided over the most recent three years.

One of DaVita's partners in this facility, Mt. Sinai Hospital, is also a safety net provider serving predominantly African-American and Hispanic communities in Chicago's Lawndale neighborhood. Mt. Sinai Hospital is recognized nationally and regionally for quality patient care and innovative, community-based health improvement programs. Mt. Sinai Hospital is one of four Level I trauma centers in the City of Chicago. In 2011, Mt. Sinai Hospital provided over \$90 million in community benefits, which included charity care, subsidized health services, language assistance, education, research, donations and volunteer services. A copy of Sinai Health System's 2011 Annual Report, which further details Mt. Sinai Hospital's commitment to the Lawndale community is attached at Attachment – 43A.

Further, as part of its mission to improve the health of the communities it serves, Mt. Sinai Hospital has launched several initiatives to study and address specific health issues. The Sinai Urban Health Institute (SUHI) is a public health-focused entity made up of a diverse group of epidemiologists, research assistants and health educators who use data-driven research to study chronic disease prevalence that is unique to communities served by Sinai Health System. Sinai Community Institute (SCI) provides education, employment counseling, case management and nutrition services that address the social and economic factors affecting the health of the community's most vulnerable members – infants, children, adolescents and older adults. The Sinai Tomorrow Project, which is bringing innovative healthcare and new housing to the west side of Chicago, is yet another example of Mt. Sinai Hospital's commitment to the community's health.

Other than Mt. Sinai Hospital, no other safety net provider in the community and surrounding area offers in-center chronic dialysis services. Lawndale Dialysis is a partnership with Mt. Sinai Hospital in order to ensure that the business interests of DaVita and Mt. Sinai Hospital are aligned. DaVita does not otherwise compete with hospitals in the delivery of health care services. Accordingly, admissions to hospital programs and referral patterns to hospital clinics will not be affected by this project.

2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services because it won't divert patients away from safety net hospitals. Further, as shown in Table 1110.1430(b), average utilization at existing dialysis facilities within 30 minutes normal travel time of the proposed facility is currently 81%. Thus, the proposed facility is necessary to allow existing facilities to operate at their optimum capacity while at the same time accommodating the growing demand for dialysis services. Based upon the latest inventory data, there is a need for 78 dialysis stations in HSA 6, the service area where the proposed facility will be located. Accordingly, the proposed dialysis facility will not impact other general health care providers' ability to cross-subsidize safety net services.

3. The proposed project is for the establishment of Lawndale Dialysis. As such, this criterion is not applicable.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2009	2010	2011
Outpatient	124	66	96
	124	66	96
Charity (cost in dollars)			
Outpatient	\$597,263	\$957,867	\$830,580
Total	\$597,263	\$957,867	\$830,580
MEDICAID			
Medicaid (# of patients)	2009	2010	2010
Outpatient	445	563	729
Total	445	563	729
Medicaid (revenue)			
Outpatient	\$8,820,052	\$10,447,021	\$14,585,645
Total	\$8,820,052	\$10,447,021	\$14,585,645

Uniquely Committed to Our Community's Health



2011 ANNUAL REPORT

 **SINAI**
Sinai Health System

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- 31 Sinai's Strategy
- 32 Leadership Vision for Sinai's Future

MISSION — To improve the health of the individuals and communities we serve

VISION — To be the national model for the delivery of urban healthcare

VALUES — We do this with:

RESPECT

We create an atmosphere of mutual respect and fairness, treating each person with dignity, recognizing we all have unique talents.

INTEGRITY

We hold ourselves accountable for our actions and are honest and ethical in all our dealings.

QUALITY

We continuously improve our services as measured by the best practices in the industry.

SAFETY

We foster an environment that focuses on protecting our patients, visitors and caregivers from harm or injury.

TEAMWORK

We celebrate the opportunity to come together as caregivers in an inclusive workplace where diversity and open communication are valued.

MISSION — Mejorar la salud de los individuos y de las comunidades a las que servimos.

VISIÓN — Ser el modelo nacional para la entrega del cuidado de salud a nivel urbano.

VALORES — Haremos esto con:

RESPECTO

Crearemos una atmósfera de respeto mutuo y justicia, tratando a cada persona con dignidad, reconociendo que todos tenemos talentos excepcionales.

INTEGRIDAD

Nos hacemos responsables de que nuestras acciones sean honestas y éticas en todas nuestras relaciones.

CALIDAD

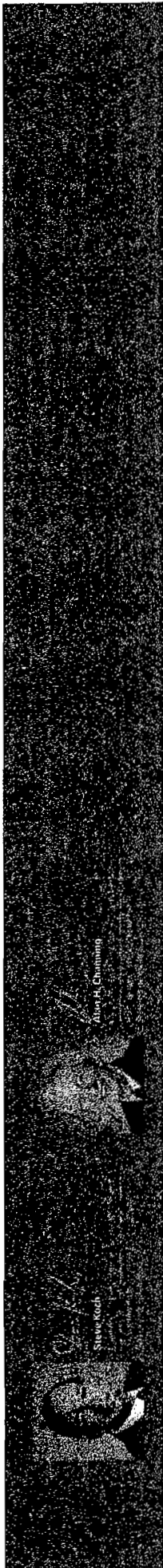
Mejoraremos continuamente nuestros servicios siguiendo las mejores prácticas de la industria.

SEGURIDAD

Fomentamos un ambiente que se enfoque en proteger nuestros pacientes, visitantes y cuidadores del daño o lesión.

TRABAJO EN EQUIPO

Celebramos la oportunidad de unirnos como cuidadores en un lugar de trabajo inclusivo, donde se valoran la diversidad y la comunicación abierta.



To Patients, Caregivers, Friends and Colleagues:

Whenever either of us is asked, "What makes Sinai special?" this is how we often respond. "Sinai is uniquely committed to our community's health. Unique commitment is the message underlying patient and caregiver stories highlighted in this year's annual report: using music to obtain unobtainable results for patients learning to walk again; reducing disparities in breast health among minority women and saving lives; managing dialysis with optimism; investing in the health of young lives through neonatal intensive care and nutrition programs.

Quality is an expression of Sinai's unique commitment to patients and to the communities we serve. Over the last six years Sinai has elevated attention to quality, systematically raising the bar. Our culture of quality has evolved and touches all 3,000 of our caregivers. As a result, Sinai has received national and regional recognition for quality patient care, quality programs and quality caregivers.

For example, this summer we earned The Gold Seal of Approval™ when a team of Joint Commission expert surveyors evaluated Mount Sinai Hospital (MSH) for compliance with standards of care specific to the needs of patients, including infection prevention and control, medication management and leadership. During the year, MSH was recognized for outstanding progress through the Surgical Care Improvement Project (SCIP), a quality program sponsored by the Centers for Medicare & Medicaid Services in collaboration with the American Hospital Association, Centers for Disease Control and Prevention, the Institute for Healthcare Improvement, The Joint Commission and others.

On September 20 the Illinois Hospital Association gave Sinai two awards: one for MSH's performance in a statewide campaign on elimination of hospital-acquired infections; and a second for breast cancer disparities community outreach (Sinai Urban Health Institute and MSH breast health imaging). Additionally, throughout the year MSH received recognition as a designated primary stroke center, an accredited chest pain center and an accredited obstetrical-gynecological ultrasound program.

Sinai's unique commitment to our community's health extends to The Sinai Tomorrow Project. Sinai's plan to bring innovative healthcare and new housing to the west side of Chicago. Sinai caregivers and members of the community have contributed to the first design phase for the planned outpatient and inpatient pavilions. The next phases are completion of detailed building designs, continuation of the funding campaign and the start of construction, pending federal, state and city approvals.

The Chicago Housing Authority (CHA), in collaboration with Sinai, has completed construction and received residents in Park Douglas, the 137-unit mixed-income housing development located adjacent to the north side of the outpatient pavilion site. Park Douglas is the first of 300 CHA units that will be constructed in our community over several years.

With your support, Sinai's unique commitment and dedicated caregivers will continue to have remarkable positive effects on our community's health in the years and decades to come.

Alan H. Chunhoo

Steve Koch

A los pacientes, cuidadores, amigos y colegas:

Cada vez que a alguno de nosotros se nos pregunta, "¿qué hace a Sinai especial?", así es como respondemos a menudo. "Sinai está excepcionalmente comprometido con la salud de nuestra comunidad. El compromiso excepcional es el mensaje esencial de las historias de los pacientes y cuidadores que se resaltarán en el reporte anual de este año: el uso de la música para obtener los resultados imposibles de conseguir en los pacientes que están aprendiendo a caminar de nuevo; reduciendo las disparidades en la salud del seno entre la minoría femenina y salvando vidas; manejando el diálisis con optimismo; invirtiendo en la salud de las vidas jóvenes a través del cuidado intensivo neonatal y programas de nutrición.

Calidad es una expresión del compromiso excepcional de Sinai a los pacientes y las comunidades que servimos. En los últimos seis años Sinai ha incrementado la atención a la calidad, sistemáticamente "exceder el precedente." Nuestra cultura de calidad ha evolucionado y toca a los 3,000 de nuestros cuidadores. Como resultado, Sinai ha recibido reconocimiento nacional y regional por la calidad en el cuidado del paciente, calidad de programas y calidad de cuidadores.

Por ejemplo, este verano nos ganamos "The Gold Seal of Approval™" cuando un equipo de expertos peritos de la Comisión Conjunta de Evaluación al Hospital Mount Sinai (MSH) por sus siglas en inglés en cumplimiento a la calidad del cuidado específico a las necesidades de los pacientes, incluyendo control y prevención de infecciones, manejo de los medicamentos y liderazgo. Durante el año, MSH fue reconocido por el progreso sobresaliente a través del proyecto perfeccionamiento en el cuidado quirúrgico (SCIP por sus siglas en inglés), un programa de calidad patrocinado por los centros de servicios de Medicare y Medicaid en colaboración con la Asociación Americana de Hospitales, centros para el control y prevención de las enfermedades, el Instituto para el mejoramiento de la salud, la Comisión Conjunta y otros.

En 20 de septiembre la asociación de hospitales de Illinois le concedió a Sinai dos premios: uno por su desempeño en una campaña a lo largo del estado en la eliminación de las infecciones adquiridas en los hospitales; y un segundo por las disparidades en el cáncer de seno premición comunitaria (Instituto urbano de salud Sinai y MSH diagnóstico por imágenes para la salud del seno). Adicionalmente, a través del año MSH recibió reconocimiento al designarlo como el centro de recuperación primario de accidentes cerebro vasculares, un acreditado centro de dolor torácico y un acreditado programa de ultrasonido obstétrico-ginecológico.

El compromiso excepcional de Sinai con nuestra comunidad se extiende al proyecto Sinai del mañana, un plan de Sinai para traer un cuidado de salud innovador y vivienda nueva al oeste de Chicago. Los cuidadores de Sinai y los miembros de la comunidad han contribuido con la primera etapa de diseño planeada para los pabellones de pacientes externos e internos. Las próximas etapas son la finalización de los diseños detallados del edificio, continuar con la campaña de financiación y el inicio de la construcción, en espera de la aprobación federal, estatal y de la ciudad.

La autoridad de vivienda de Chicago (CHA por sus siglas en inglés), en colaboración con Sinai, han terminado la construcción y recibirán inquilinos en el parque Douglas, la urbanización de 137 viviendas de ingreso mixto localizada contiguo al lado norte del pabellón de pacientes externos. El parque Douglas es el primero de 300 viviendas CHA que se construirán en nuestra comunidad a lo largo de varios años.

Con su apoyo, el compromiso excepcional de Sinai y sus dedicados cuidadores continuarán haciendo notables efectos positivos en la salud de nuestra comunidad en los años y décadas venideras.

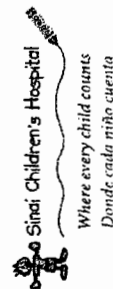
SINAI HEALTH SYSTEM

Located on the west side of Chicago, Sinai Health System (Sinai) is comprised of Mount Sinai Hospital, Sinai Children's Hospital, Schwab Rehabilitation Hospital, Sinai Medical Group, Sinai Community Institute and Sinai Urban Health Institute.

Sinai was established in 1919 to serve Eastern European Jewish immigrants in the area, and today Sinai Health System continues to focus on the needs of the surrounding community. Caregivers at Sinai are committed to the tradition of *tikkun olam*—a Hebrew phrase that means "repairing the world." Sinai's 3,000 caregivers believe that by their actions they offer a healing and caring presence for patients, families and the community.

Commitment to the Community

- Sinai provides over \$90 million a year in community benefits, including charity care, subsidized health services, language assistance, education, research, donations and volunteer services.
- With 3,000 caregivers, Sinai is among the largest employers and economic engines on Chicago's West Side.
- Through The Sinai Tomorrow Project, Sinai is bringing new and improved healthcare to the community, mixed-income housing in collaboration with the Chicago Housing Authority and a spirit of renewal to our community.



Sinai Health System
 675 North Dearborn Avenue
 Chicago, IL 60610
 (773) 542-2000
www.sinai.org

As a champion of urban health equality, Sinai Urban Health Institute (SUHI) has made it its mission to delve deeply into the "hows and whys" of diseases and health concerns that affect the people living in our community. Epidemiologists, research assistants and health educators at SUHI work together and with other health partners—like the Avon Foundation for Women—to study local and urban health trends, identify key health disparities and improve healthcare access among the people we serve.

"Helping Her Live" program Nurse Navigator Wendy Rodriguez and Angela Davis, MEd, meet with a patient.



"If I hadn't gone to the workshop, I probably wouldn't have had a mammogram and they may not have found my cancer on time. I'm so grateful to Sinai and the 'Helping Her Live' program."

Giving her help—and hope: Adela's story

Adela Prado is a 42-year-old mother and resident of Chicago's North Side. She is living proof of how the partnership with Avon and the "Helping Her Live" outreach program has not only touched, but saved the lives of women who may not have sought out health information and medical attention on their own.

"A friend asked me to go with her to a workshop given by Sinai at the Grand school in my neighborhood," says Adela. "I never wanted to get a mammogram, but the people there told me how important it is, so they made an appointment for me right then and there." Her first mammogram came back clear, but because of the education she received, Adela was able to recognize something wasn't right a few months later.

Her concern about a lump she felt during a self-exam brought her back to her primary doctor at Sinai, who immediately sent her for another mammogram. It indicated an abnormality that wasn't there just a few months before. Subsequent diagnostic tests revealed the unwanted news: Adela had Stage II breast cancer.

"The whole process went so fast and I started chemo shortly afterwards. I was glad the doctors here at Sinai didn't waste any time and everyone was so professional and helpful."

"The Sinai staff was so caring and compassionate. I never thought I'd be taken care of so well. They really lifted my spirits. I'm so grateful."

SUHI and Avon Foundation for Women Partnership: "Helping Her Live"

Through a number of grants from the Avon Foundation for Women totaling more than \$5 million, SUHI has developed the "Helping Her Live" (HHL) Program, an innovative breast health awareness and navigation program. Its goal is to bring education and community navigation to two communities in Chicago (North Lawndale and Humboldt Park) in an effort to eliminate racial and ethnic disparities in breast cancer morbidity and mortality.

Funding has allowed SUHI to install information kiosks in several locations throughout the community. At these kiosks, women can conduct a breast cancer risk self-assessment and call directly to a program coordinator who can schedule them for a mammogram.

The patient navigator program connects women to essential health services throughout the Sinai Health System and walks them through each step, providing social and emotional support as well.

In FY 2011 alone, more than 700 women were assisted through our navigator program and about 2,700 participated in more than 200 HHL community education and outreach events.

LEADING THE WAY

The Avon Foundation for Women has provided a multimillion-dollar grant to SUHI for "Helping Her Live," which funds our patient navigator program as well as a variety of outreach initiatives. Specially trained patient service advocates walk women like Adela through the system, ensuring that patients make and keep appointments and understand what is happening. Navigators also connect women with additional health or social services if necessary. Wanda Rodriguez was and continues to be Adela's navigator, advocate and friend.

"Wanda is just wonderful. She was there with me every step of the way. She called me constantly and held my hand through every chemo treatment and before and after my mastectomy. I wasn't as scared anymore."

Wanda acted as Adela's Spanish language interpreter as well, so that she and all of her caregivers could understand each other, which helped relieve some of Adela's fears and anxiety. From diagnosis and treatment to surgery and follow-up, Wanda guided and cheered Adela through every twist and turn.

"Adela was fearful that she wouldn't be around for her children," says Wanda, "but I was so impressed with how brave and strong she was throughout. She became my inspiration for doing my job and how I and other patient navigators can really make a difference. Sometimes just being there to listen and hold their hand is what patients need most."

Adela has finished her chemotherapy and radiation treatments and is awaiting reconstructive surgery. She has come a long way and, best of all, is cancer-free.

"I really thought I was going to die, but now I feel wonderful. I would like to help other women by being a 'testimony' for them. I would tell them that no matter how bad things are, there's always hope."



Uniquely Committed to Our Community's Health

HELPING HER LIVE

SINAI URBAN HEALTH INSTITUTE

Sinai Urban Health Institute (SUHI) is a public health-focused entity made up of a diverse group of epidemiologists, research assistants and health educators who use data-driven research to study chronic disease prevalence that is unique to the communities served by Sinai Health System. The mission of SUHI is grounded in the belief that in order to serve its neighbors well, it's important to understand not only patients, but the entire community. The results of research shape its programs so that better community engagement, disease prevention and treatment will help minimize disparities and bring greater North equality.

Extensive research has led to the development of some ambitious and successful community programs:

AT A GLANCE

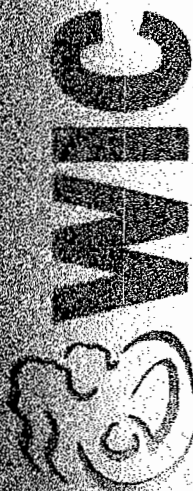
- **Avon "Helping Her Live" Breast Cancer Project**—Funded by Avon, this program provides breast health education outreach initiatives and patient navigator services. In FY 2011, SUHI made contact with more than 6,000 women, many of whom went on to have mammograms for the first time.
- **Chicago Westside Pediatric Asthma Intervention**—This home visit-based program is designed to ease the asthma burden experienced by many Westside Chicago families. It provides resources and support needed to more thoroughly address the issues that impede a family's ability to effectively manage a child's asthma.
- **North Lawndale Diabetes Intervention**—With one of the highest diabetes rates in the city of Chicago, North Lawndale has been selected for SUHI's diabetes outreach program, "Black by Block." Community health workers visit homes throughout the neighborhood with the goal of increasing early detection rates and encouraging better self-management of diabetes.
- **Humboldt Park Diabetes Intervention**—Diabetes prevalence and mortality among Puerto Rican in Humboldt Park is disproportionately higher than other communities in Chicago and the United States. A task force was developed to identify people with diabetes and effectively address diabetes prevalence in this neighborhood.
- **Avon Breast Cancer Navigator Project**—Specially trained patient navigators assist women through the Sinai system to obtain breast health services, including screening mammograms, follow-up to abnormal mammograms, services for women with breast symptoms and any treatment as needed.
- **West Rogers Park Obesity Intervention**—SUHI is fighting an increase in childhood obesity in the West Rogers Park area with programs that, for example, award grants to schools for the purchase of physical education equipment and educational materials.

Award in FY 2011

- Environmental Protection Agency's Leadership in Environmental Asthma Management Award
- American Hospital Association NOVA Award for excellent work in the area of Pediatric Asthma
- Premier Care Award Finalist (Asthma project)
- Greening of Paseo Bericua Award for support of the Greater Humboldt Park Community Health Initiative
- The Henry P. Rouse MD Citation for Exemplary Compassion in Healthcare from The Institute of Medicine of Chicago and Rush University Medical Center

SINAI COMMUNITY INSTITUTE

Reaching further to help those who need it most



(WOMEN, INFANTS AND CHILDREN PROGRAM)

AT
SINAI COMMUNITY INSTITUTE

Sinai Community Institute's (SCI's) programs are designed to meet the most challenging ongoing needs in a community where many people would not otherwise have access to key social, health and wellness services. The WIC (Women, Infants and Children) program is a particularly important and far-reaching service that helps feed some of the community's most vulnerable members.

Nourishing body, mind and soul

As a registered dietitian, professionally trained chef and ordained minister, Steven Foley is uniquely equipped to direct the WIC program at SCI, which provides nutrition education and access to healthy foods for pregnant and nursing women, infants and children up to five years old.

"I know for sure it's my mission in life to feed others—nutritionally and spiritually," Steven, who is the Director of Family Services and has been with SCI for 22 years, does just that and so much more. He and his staff look beyond the nutritional requirements of clients to assess their total needs.

Clients are connected with other integrated services throughout Sinai Health System like prenatal care, primary care or other SCI programs such as parenting education.

The Sinai WIC program's primary focus is ensuring that every infant receives the proper nutrition during that vital first year of life and then as a toddler. Taking a proactive approach, staff members visit new mothers in Mount Sinai Hospital's Mother-Baby unit to determine eligibility and enroll them in the program. Mothers are always encouraged to breastfeed and they can be connected easily to breastfeeding support services, if needed.

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"I feel I'm destined to give of myself.
The Sinai WIC program fits into that
mission perfectly."

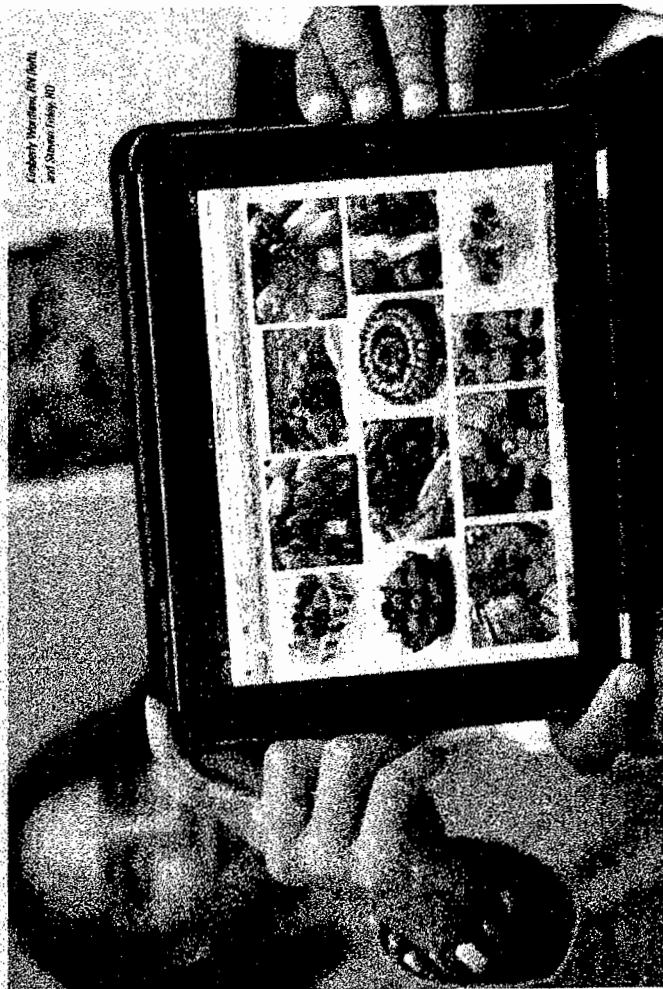
Steven Foley, RD, Dietitian, Sinai Health System

Sinai WIC Program

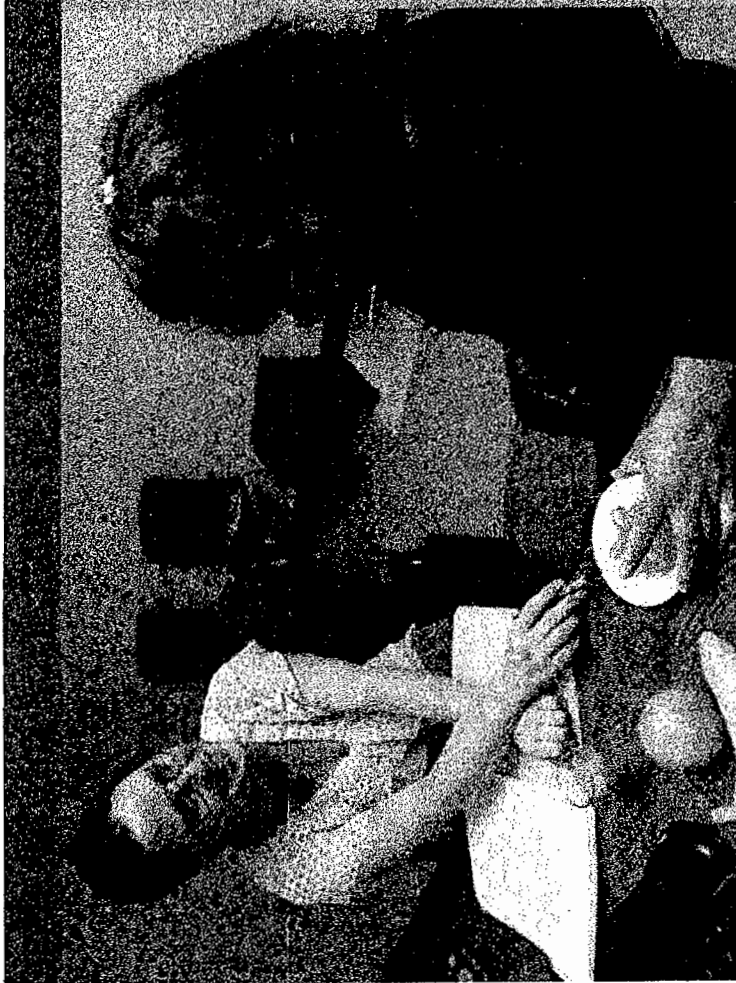
WIC is a federally funded program whose mission is to improve the health and nutritional status of women, infants and children; to reduce the incidence of infant mortality, premature births and low birth weight; to aid in the development of children; and to make referrals to other healthcare and social service providers. Sinai Community Institute's WIC program opened its doors to the surrounding community in 1986 and, because of the tremendous needs of its underserved population, has grown into an essential nutrition resource for young mothers and their children.

Currently, it provides nutrition education and access to nutrition services to more than 13,000 clients. That number is expected to increase to more than 18,000 with the addition of another site. Since Sinai WIC has become a successful, recognized model of WIC services, the State of Illinois often uses it as training location for many of its new staff members. Also, Sinai WIC has a location on the premises of a foreign consulate, the Chicago Mexican Consulate, a unique distinction among WIC programs in the United States.

Robert Hoffman, RD, Dietitian
and Steven Foley, RD



SINAI HEALTH SYSTEM | 2011 ANNUAL REPORT



WIC Health Educator Steven Duda and a client.

NUTRITION NOW AND FOR A LIFETIME

Steven and Assistant Director of Family Services Kimberly Wordlaw, RN, continually think about how the program can meet individual and community needs. Many innovative programs have been designed and implemented with that goal in mind.

One example of this community-centric thinking is the Smart Shopper program, in which once a month, a group of ten women are brought by bus to Whole Foods Market. There, a chef demonstrates how to cook healthy, cost-conscious meals, often introducing the women to different types of foods. Participants are also given tips on making better food choices while shopping and saving money.

"Since many of our clients are accustomed to shopping at small food markets where prices are high, we expose them to a supermarket where buying the store brand is often less expensive," says Steven. "There are simple things they can do to save money and eat better, so that's why it's important to teach them that they have choices."

SINAI COMMUNITY INSTITUTE

Sinai Community Institute (SCI) provides education, employment, training, case management and support services for men and women living in poverty in the community. SCI is a 501(c)(3) nonprofit organization that provides a wide range of services to its clients, including:

- Case management services
- Employment training and placement
- Financial counseling and budgeting
- Food bank services
- Housing assistance
- Job training and placement
- Legal services
- Life skills training
- Mental health services
- Physical therapy services
- Substance abuse treatment
- Supportive housing
- Transportation services
- Vocational training
- Wellness programs
- Youth services

ABOUT SINAI

- Founded in 1971 by a group of community leaders
- Provides services to over 10,000 clients annually
- Operates out of a 100,000 square foot facility in the heart of the city
- Has a long history of providing services to the community
- Is a member of the United Way
- Has received numerous awards for its services
- Is a 501(c)(3) nonprofit organization
- Has a board of directors consisting of community leaders
- Has a staff of over 100 employees
- Has a budget of over \$1 million
- Has a strong commitment to the community
- Has a long history of providing services to the community
- Is a member of the United Way
- Has received numerous awards for its services
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- Has a staff of over 100 employees
- Has a budget of over \$1 million
- Has a strong commitment to the community



A new, exciting program under development is a large teaching kitchen right on SCI's premises where a chef will conduct hands-on cooking classes. While participants are preparing their meal, they will be videotaped so that when they get home, they can watch what they were taught and replicate it in their own kitchen. Since some people have a limited supply of cooking equipment, there will be a class on cooking healthy with a Crock-Pot, for example, so that this program will be accessible for everyone interested.

Kimberly, who has been with the Sinai WIC program for more than ten years, prides herself on its innovative programs, but feels it's the one-on-one connection that really makes it all work.

"I'm the assistant director, but I'm also a registered nurse. It's in my nature to help and care for people, so that's why I love my job because it lets me do just that."

It's important for Kimberly to step out from behind her desk and be hands-on—literally. "Everyone here knows that when a mom comes in with a newborn, I have to hold the baby. I just have to."

Since we first opened our doors, we have served a population of great need—from Eastern European Jews in the early twentieth century to African Americans and Latinos today. The faces of our patients might have changed, but our commitment to help, heal and support has remained steadfast.

Today we are still a community-based hospital, but we have become so much more. We care for adults and children by providing exceptional medical, surgical, behavioral health, therapeutic and diagnostic services. Our patients come to us for routine preventive primary care as well as lifesaving therapies using leading-edge technologies.

Sinai's Level I Trauma Center, Level III Neonatal Intensive Care Unit (teach having the highest designation level there is) and our capabilities in stroke and chest pain care are validated by national accrediting organizations.

Yes, the challenges are great, but with forward thinking, skill, commitment and compassion, we will continue to deliver excellent healthcare to all our patients.

"The nurses in the NICU take the time to really want to be there. They are very professional about their jobs and take great care of the kids and the moms. I'm so glad they're here."

—A mother of a child in the NICU

"In our community, the challenges are great, but Sinai's commitment to service is even greater."

—A physician at Mount Sinai Hospital

MOUNT SINAI HOSPITAL

Founded in 1919 as a 60-bed hospital to serve the needs of Eastern European Jewish immigrants on the west side of Chicago, Mount Sinai Hospital today has grown to a 219-bed teaching, research and tertiary care facility serving predominantly African-American and Latino communities. Sinai has built on a legacy of serving the underserved and is proud to be a national model for the delivery of urban healthcare.

Mount Sinai Hospital is recognized nationally and regionally for quality patient care and innovative, community-based health improvement programs. Sinai's highly skilled physicians and caregivers consistently provide exceptional medical, surgical, behavioral health, therapeutic and diagnostic services to the thousands of patients who walk through its doors each year.

AT A GLANCE

- Level I Trauma Center for adult and pediatric emergencies—highest level of care (one of only four designated trauma centers in Chicago)
- Level III Neonatal Intensive Care Unit (NICU)—highest level of care for fragile newborns
- Pediatric Intensive Care Unit—specialized care for children with serious or life-threatening injuries or illnesses
- Sinai Children's Hospital (located within the hospital) includes pediatric cardiology, gastroenterology, hepatology, allergy, endocrinology, oncology, physical medicine and rehabilitation, and neurology
- Specialty services include cardiovascular services, cancer care center, stroke center, endocrinology, minimally invasive surgery, diabetes, geriatrics, and more
- Routine and innovative cardiology and cardiovascular surgery
- Cardiac Catheterization Laboratory
- Comprehensive Cancer Care Center provides integrated services to oncology patients
- Important and multidisciplinary behavioral health medicine and rehabilitation
- Advanced imaging technology includes 1.5T MRI, digital mammography and 64-slice CT
- Major teaching hospital that trains more than 700 healthcare professionals through undergraduate, graduate, residency and fellowship programs
- Sinai Interpreter Services, Dual Access Program and Illinois Video Interpreter Network (VIN) make health-minded communications available 24/7 for patients who are deaf or hard of hearing and patients who do not speak English

Uniquely Committed to Our Community's Health

Neonatal Intensive Care Unit

EXCEPTIONAL CARE FOR OUR TINIEST TREASURES
After having had two full-term, healthy babies in the last ten years, Avon Whitfield, 30, of DuPage County, never thought her third pregnancy would be any different. She couldn't have been more wrong.

In the 20th week of pregnancy, an ultrasound revealed that Avon had a short cervix—a condition that can lead to premature labor. She was immediately put on strict bed rest and prescribed medication to delay labor until closer to the baby's due date. The regimen worked for about six weeks, but then baby girl Lyric wouldn't wait any longer and arrived 14 weeks early, weighing in at approximately one and a half pounds.

"Her lungs were underdeveloped, which the doctors said is normal for a premature, but still, it's pretty frightening," says Avon. "I've never had experience with a premature before."

Lyric's nurses in Sinai's Neonatal Intensive Care Unit (NICU) tend to her around the clock, prepared to handle any situation. Avon says both the nurses and doctors prep her for everything that's going to happen and, as far as any questions she has, "they answer every last one."

Avon brings breast milk in every day and the nurses taught her how to do "kangaroo care," where she places little Lyric on her chest "skin-to-skin." This way of bonding also helps babies maintain body temperature, regulate heart and breathing rates, sleep more soundly and gain weight.

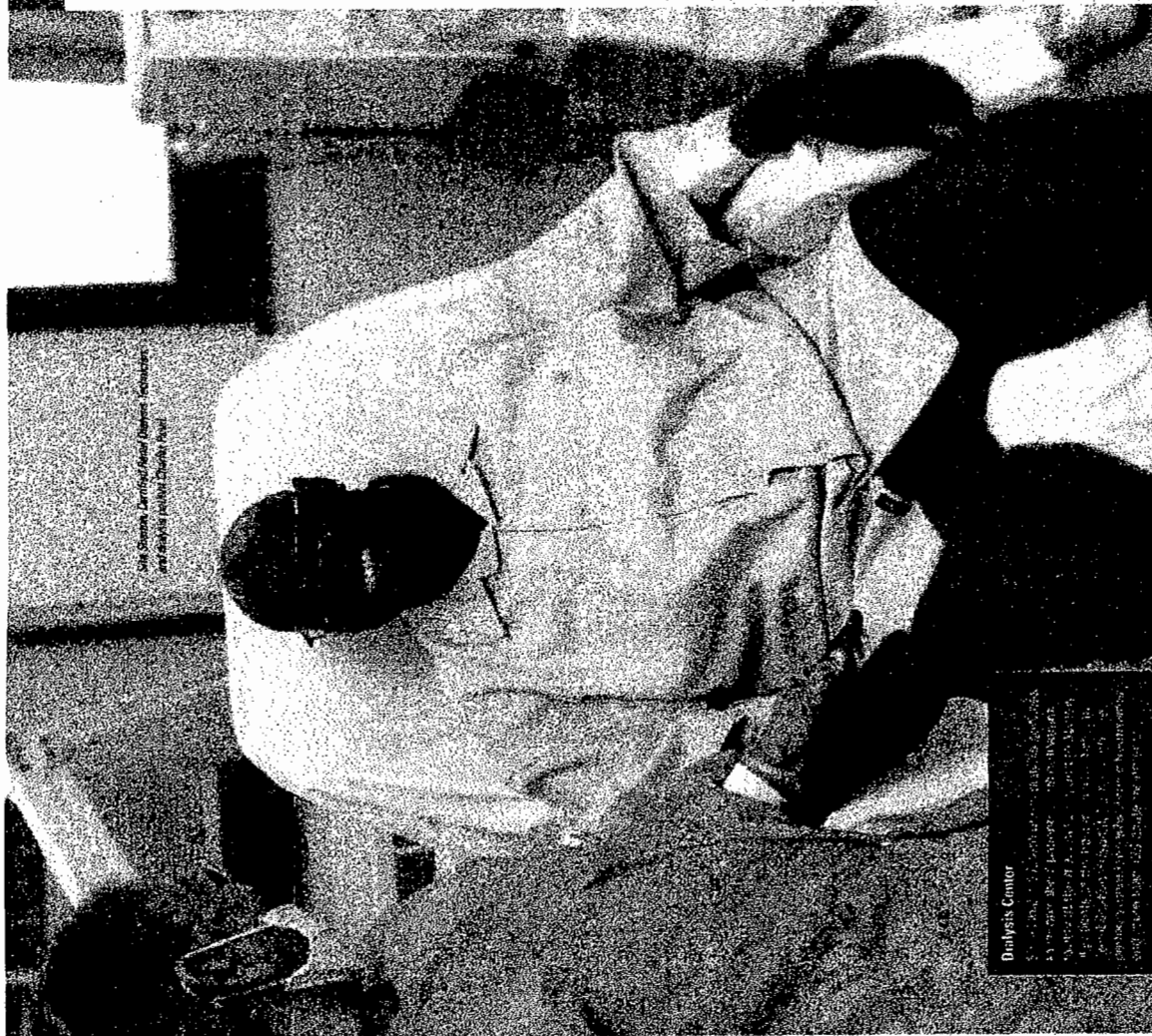
Avon is so grateful she's at such a top-notch NICU, even though she must travel an hour each way every day to see her daughter.

"I was seeing a doctor at the Lawndale Christian Health Center for prenatal care when I was living in the area. When he saw that the medication for my condition wasn't helping, he sent me right to Sinai. Now I live an hour away, but I don't mind driving the distance. I wouldn't want Lyric cared for anywhere else."

Avon and her family look forward to welcoming Lyric home, but that will still be awhile—she needs to be a healthy four and a half pounds before she can go home. In the meantime, Avon knows her little girl is in the best place she can be.

Neonatal Intensive Care

Mount Sinai Hospital's NICU is a true model of advanced healthcare for fragile newborns. Cutting-edge equipment and technology combined with highly trained doctors and nurses have earned the unit its designation as Level III—the highest possible level for a NICU. Licensed for 39 bassinets, the NICU cares for infants with the most complex of diagnoses.



Older patients, carrying food, dialysis machines and dialysis tubing, Charles Reed

Dialysis Center

Mount Sinai Hospital's Dialysis Center is a state-of-the-art facility that provides comprehensive dialysis services to our patients. The center is staffed by experienced nurses and technicians, and is equipped with the latest technology to ensure the highest quality of care.

Mount Sinai Hospital's Dialysis Services

FOCUSING ON LIFE, NOT KIDNEY DISEASE

One might expect that someone receiving dialysis treatment three days a week for end-stage kidney disease would be sad and depressed. Not so for Charles Reed, though, he's upbeat and appreciative.

"When people find out that I'm on dialysis, they usually feel sorry for me. But I tell them not to because I feel blessed that I can go to a place like Mount Sinai Hospital and get this treatment to help me. Not everyone has access to this kind of care and I'm really grateful for it."

Charles started receiving hemodialysis—a process that removes wastes and extra fluids from the blood—in November of 2009 and has kept his strict schedule of three days a week, four hours a day, ever since. He compares it to having a job—it's just something he's committed to doing and he makes it a priority.

Long-term high blood pressure, a heart arrhythmia and type II diabetes all contributed to his kidney disease, although the blood pressure and diabetes are well controlled now. Charles is awaiting treatment to correct his arrhythmia and then he can get on a kidney transplant waiting list. In the meantime, he'll continue to come to Mount Sinai Hospital's dialysis center because it keeps him feeling well and healthy.

"The nurses and technicians are great and the nephrologists I see each time I visit know everyone's story," says Charles. "The doctors keep up with me to make sure I stay on track with my diet. They all take great care of me."

Charles compares the atmosphere in the center to a work environment where you have "a really great group of co-workers." He appreciates the extra mile they go to make him feel welcome and comfortable.

"I know I'll be coming here for quite awhile since the average wait for a kidney transplant is five years. Until then, I know I can continue to live my life and be active with the help of Mount Sinai Hospital."

"There are dialysis centers that are closer and more convenient to my home, but I go to Mount Sinai Hospital because of the level of care of I receive. It's just a great place."

Accreditations and Certifications

- The Joint Commission Gold Seal of Approval™
Quality and safety are core values at MSH as evidenced through earning The Joint Commission Gold Seal of Approval and high national quality measure composite scores for fiscal year 2011.
 - Acute Myocardial Infarction: 99.4/100
 - Heart Failure: 99.5/100
 - Pneumonia: 99.3/100
- Surgical Care Improvement Project: 98.2/100
- Accreditation, College of American Pathologists; Certification, CMS Clinical Laboratory Improvement Amendments (CLIA)
- Emergency Department Approved for Pediatric Certification (EDAP)
- American College of Surgeons Commission on Cancer
- Ultrasound Practice Accreditation, American Institute of Ultrasound in Medicine
- Accredited Chest Pain Center by the Society of Chest Pain Centers
- Primary Stroke Center designation by The Joint Commission

Additional Quality Recognitions

- Surgical Care Improvement Project (SCIP)
- Innovation in Quality Award (Illinois Hospital Association)
- Illinois Hospital Association Pledge Quality Achievement Award

Mount Sinai Hospital
One St. Luke's Avenue
Chicago, IL 60608
(773) 542-5000
www.mssn.org

UNDER THE RAINBOW: LIGHTING THE WAY FOR CHILDREN IN NEED

Family crisis intervention and the diagnosis, treatment and prevention of child abuse and neglect have always been key services of Sinai's Child and Adolescent Behavioral Health (CABH) program, "Under the Rainbow." Today, we also offer a full range of outpatient services that address a variety of mental health issues that impact youth in the neighborhoods we serve.

Mirna Ballester, Psy.D., Clinical Psychologist and Manager of "Under the Rainbow," and her staff work together to treat children and families who face the daily challenges of chronic poverty, street violence, lower educational levels, substance abuse and domestic violence. She finds her interaction with the children both emotionally difficult and rewarding at the same time.

"Although it can be difficult to work with children who have been through painful experiences, I feel full of energy and passion when I interact with them," says Dr. Ballester.

"To have the opportunity to offer a child's different experience and open the window of it could be different to a child full of fear, anger and pain makes my day very meaningful."

"If I can provide them with my full attention, safety, care and advocacy, sometimes that's enough to make a 50-minute difference in a child's day and, thus, his or her life."

Through a variety of therapeutic interventions including art, play and talk therapies, Dr. Ballester and the clinical staff at "Under the Rainbow" provide different avenues for children to talk about or re-create the situations that may be negatively affecting their lives. Unique and skill-building methods are always welcome at "Under the Rainbow"—one of the staff clinicians developed a popular Tae Kwon Do therapy to help children with self-control, concentration and anxiety.

Although patients are seen in the office, case managers and counselors occasionally accompany children to court dates or meet with school administrators to ensure that the child is supported in all aspects of his or her life. "Under the Rainbow" staff members conduct group outreach workshops at schools and other community locations, educating and supporting the adults who can make a difference in the life of a child.

"The fact that the 'Under the Rainbow' program is part of a larger system—Sinai Psychiatry and Behavioral Health, which includes adult programs—gives us the capacity to help these families through many levels of care and makes our work more successful."

"Under the Rainbow"

"Under the Rainbow" evaluates and treats most children and adolescent psychological disorders and provides comprehensive mental health services for children, adolescents and young adults. Individual, family and group therapy is provided with ongoing support, are provided by psychologists, child psychiatrists, child and adolescent specialists, psychiatrists and graduate students.

Richard Allen-Brown, PhD
"Under the Rainbow" Child and Adolescent Behavioral Health Program Director

Mina Ballester, Psy.D.
"Under the Rainbow" Child and Adolescent Behavioral Health Program Manager

Tara Gill, Ph.D.
"Under the Rainbow" Child and Adolescent Behavioral Health Program Psychologist

SCHWAB REHABILITATION HOSPITAL

Making strides, one step at a time

As the first accredited rehabilitation hospital in the Midwest, Schwab Rehabilitation Hospital has become synonymous with exceptional, innovative care with a singular purpose: ensuring that every patient reaches his or her maximum potential. With that commitment in mind, Schwab has incorporated creative, expressive therapies like music and horticulture into some of its inpatient therapy sessions. These activities add a new dimension to traditional functional therapies by motivating, energizing and soothing patients at the same time.

HEALING THE WHOLE PERSON WITH EXPRESSIVE THERAPIES

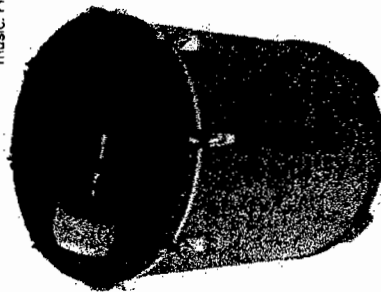
"Our bodies like rhythm. The brain uses it to send messages to its muscles to move in sequence. It also helps make connections in the brain that may have been damaged from stroke or another injury. Music is a perfect complement to neurologic rehabilitation therapies, especially," says Kristin Linderman, music therapist at Schwab Rehabilitation Hospital (SRH). She brought her knowledge of neurologic music therapy here in the spring of 2010 to establish another creative, effective expressive therapy, in addition to horticultural and recreational therapies.

With an autoharp in hand, Kristin is often seen walking backwards in front of a patient who is practicing walking—called gait training—with a physical therapist. Her music and beautiful singing provide structure for the patient, resulting in smoother steps, increased stamina and improved gait. "The rhythm of the music stimulates the brain to sequence the steps," says Kristin. "I also use a similar method in a group balance class to help time their movements. It's amazing how much better and longer they can do the exercises when they're following the rhythm of the music. Plus they simply enjoy the music."

The majority of the patients who participate in music therapy have sustained some degree of neurological and functional loss from a stroke, spinal injuries or brain injuries. However, music is an effective therapeutic tool for many types of disabilities.

"Schwab is truly an amazing rehabilitation hospital and we are proud of the unique therapies we offer along with the traditional ones. Our patients are very appreciative and they deserve it."

Kris Ventz, Director of Extended Services
including Expressive Therapies



Music Therapist Kristin Linderman
and rehab patient Jerry Knight

Physical Therapist Andrea Jensen
and rehab patient Jerry Knight

Schwab Rehabilitation Hospital
1401 South California Avenue
Chicago, IL 60608
(773) 872-7910
www.schwabrehab.com

Section XII, Charity Care Information

The table below provides charity care information for all dialysis facilities located in the State of Illinois that are owned or operated by the Applicants.

CHARITY CARE			
	2009	2010	2011
Net Patient Revenue	\$149,370,292	\$161,884,078	\$219,396,657
Amount of Charity Care (charges)	\$575,263	\$957,867	\$830,580
Cost of Charity Care	\$575,263	\$957,867	\$830,580

Appendix I – Time & Distance Determination

Attached as Appendix I are the distance and normal travel time from the proposed facility to all existing dialysis facilities in the GSA, as determined by MapQuest.



Notes

Trip to:

2611 N Halsted St
Chicago, IL 60614-2301
9.95 miles
22 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi	1.8 mi
	3. Turn right onto W Harrison St . <i>W Harrison St is just past W 5th Ave Mery's Restaurant is on the left If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 Mi	2.2 mi
	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 3.6 Mi	5.8 mi
	5. Merge onto I-90 W / I-94 W / Kennedy Expy W toward Wisconsin .	Go 0.9 Mi	6.7 mi
	6. Take the Lake St exit, EXIT 51A .	Go 0.1 Mi	6.8 mi
	7. Turn left onto W Lake St . <i>Lake & Union Restaurant is on the corner If you are on N Union Ave and reach W Walnut St you've gone a little too far</i>	Go 0.1 Mi	6.9 mi
	8. Turn right onto N Halsted St . <i>Northwestern Cutlery is on the corner If you reach N Green St you've gone a little too far</i>	Go 1.8 Mi	8.7 mi
	9. N Halsted St becomes N Halsted STS .	Go 0.05 Mi	8.8 mi
	10. N Halsted STS becomes N Halsted St .	Go 1.2 Mi	9.9 mi
	11. 2611 N HALSTED ST is on the right. <i>Your destination is just past W Wrightwood Ave If you reach W Schubert Ave you've gone about 0.1 miles too far</i>		9.9 mi

Appendix 1

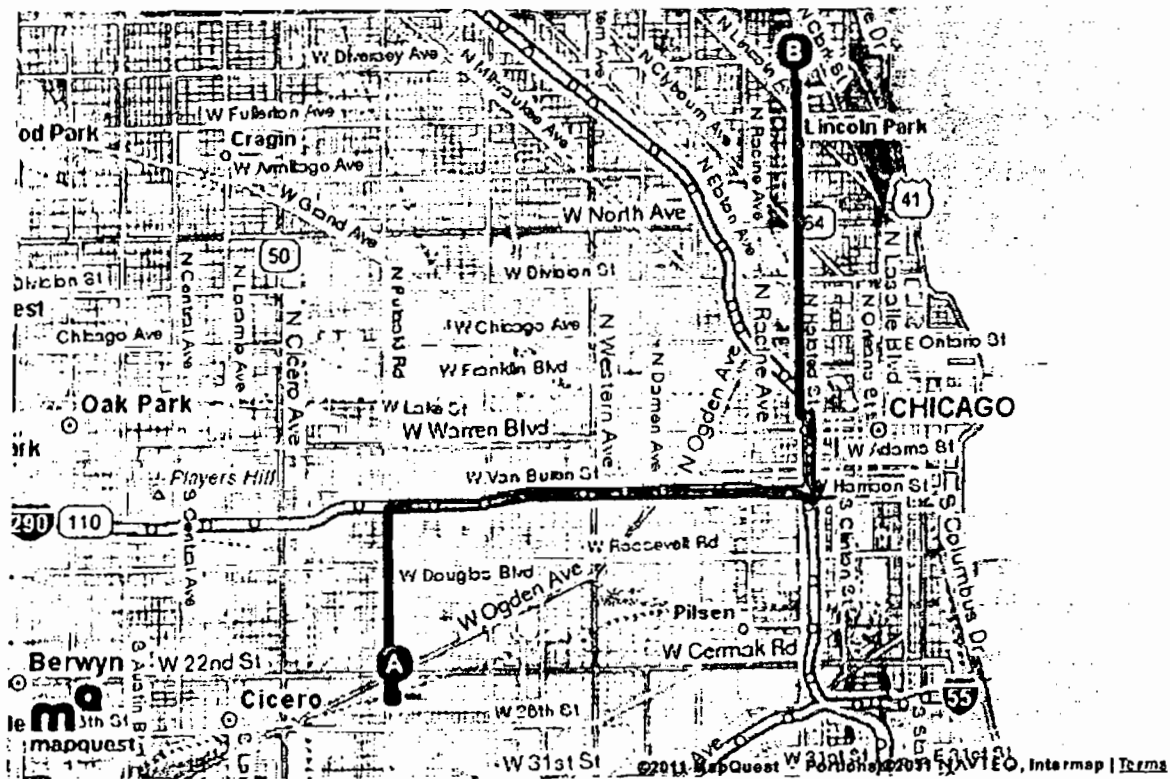


2611 N Halsted St
Chicago, IL 60614-2301

9.9 mi

9.9 mi

Total Travel Estimate: 9.95 miles - about 22 minutes



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Notes

Trip to:
1426 W Washington Blvd
Chicago, IL 60607-1821
4.24 miles
12 minutes



3934 W 24th St
Chicago, IL 60623-3371

**Miles Per
Section**

Miles Driven



1. Start out going **west** on **W 24th St** toward **S Pulaski Rd**.

Go 0.06 Mi

0.06 mi



2. Take the 1st **right** onto **S Pulaski Rd**.

Go 0.2 Mi

0.3 mi

*Las Islas Marias is on the corner
If you reach S Karlov Ave you've gone a little too far*



3. Take the 1st **right** onto **W Ogden Ave**.

Go 3.9 Mi

4.2 mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn **right** onto **W Washington Blvd / W Washington St**.

Go 0.08 Mi

4.2 mi

*W Washington Blvd is just past W Warren Blvd
If you reach W Randolph St you've gone about 0.1 miles too far*



5. **1426 W WASHINGTON BLVD** is on the left.

4.2 mi

*Your destination is just past N Bishop St
If you reach N Loomis St you've gone a little too far*

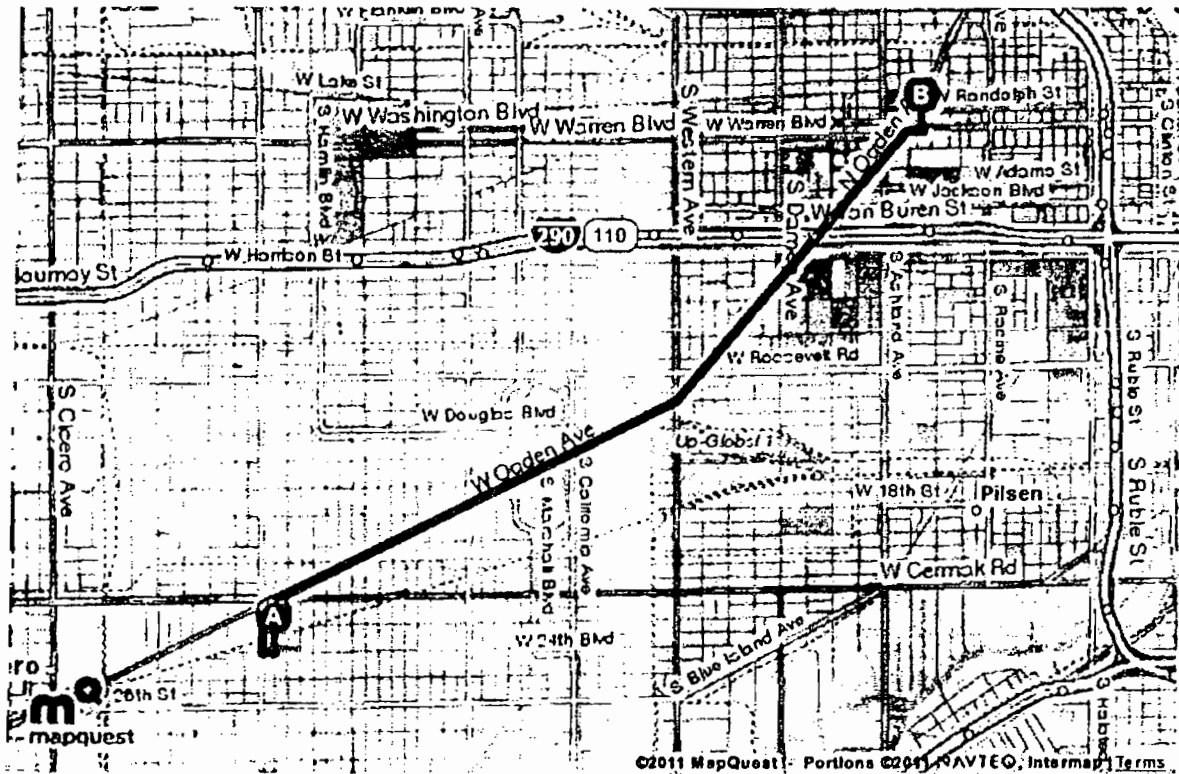


1426 W Washington Blvd
Chicago, IL 60607-1821

4.2 mi

4.2 mi

Total Travel Estimate: **4.24 miles - about 12 minutes**



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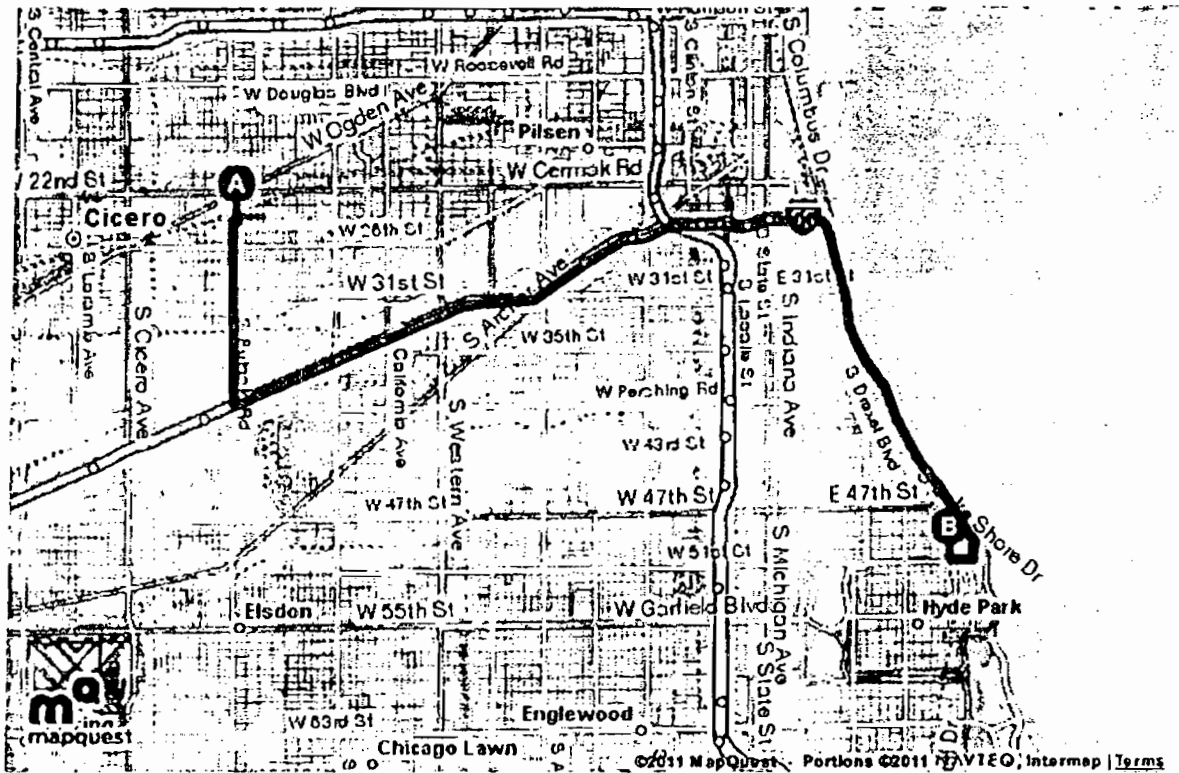
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Notes

Trip to:
1531 E Hyde Park Blvd
Chicago, IL 60615-3039
11.65 miles
19 minutes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
↩	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
↗		3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 6.0 Mi
↗		4. Merge onto S Lake Shore Dr / US-41 S.	Go 3.4 Mi
RAMP	5. Take the ramp toward Hyde Park Blvd.	Go 0.2 Mi	11.3 mi
↩	6. Turn left onto S Shore Dr / S Chicago Beach Dr. <i>If you are on E 50th St and reach S East End Ave you've gone a little too far</i>	Go 0.1 Mi	11.4 mi
↘	7. Turn right onto E Hyde Park Blvd / E 51st St.	Go 0.2 Mi	11.7 mi
■	8. 1531 E HYDE PARK BLVD is on the left. <i>If you reach S Lake Park Ave you've gone a little too far</i>		11.7 mi
B	1531 E Hyde Park Blvd Chicago, IL 60615-3039	11.7 mi	11.7 mi

Total Travel Estimate: 11.65 miles - about 19 minutes



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Notes

Trip to:
8721 S Stony Island Ave
Chicago, IL 60617-2709
19.53 miles
29 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd . <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 4.2 Mi	6.0 mi
	4. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana.	Go 0.8 Mi	6.7 mi
	5. Keep left to take I-94 Express Ln E / Dan Ryan Express Ln E toward Garfield Blvd .	Go 5.5 Mi	12.2 mi
	6. I-94 Express Ln E / Dan Ryan Express Ln E becomes I-94 E .	Go 4.8 Mi	17.0 mi
	7. Take the Stony Island Ave exit, EXIT 65 , toward 95th-103rd STS .	Go 0.8 Mi	17.8 mi
	8. Keep left to take the North Stony Island Ave ramp toward 95th St .	Go 0.5 Mi	18.3 mi
	9. Merge onto S Stony Island Ext .	Go 0.2 Mi	18.5 mi
	10. S Stony Island Ext becomes S Stony Island Ave .	Go 1.0 Mi	19.5 mi
	11. 8721 S STONY ISLAND AVE is on the right. <i>Your destination is just past E 88th St If you reach E 87th St you've gone a little too far</i>		19.5 mi

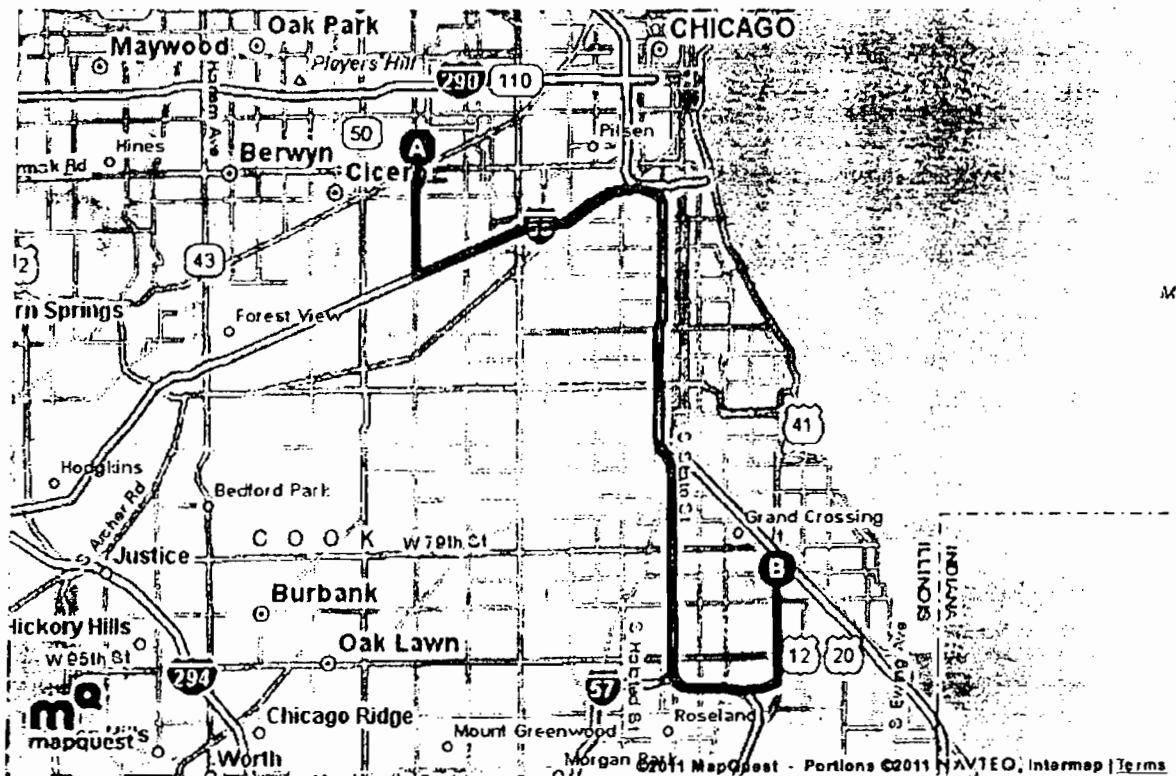


8721 S Stony Island Ave
Chicago, IL 60617-2709

19.5 mi

19.5 mi

Total Travel Estimate: **19.53 miles - about 29 minutes**



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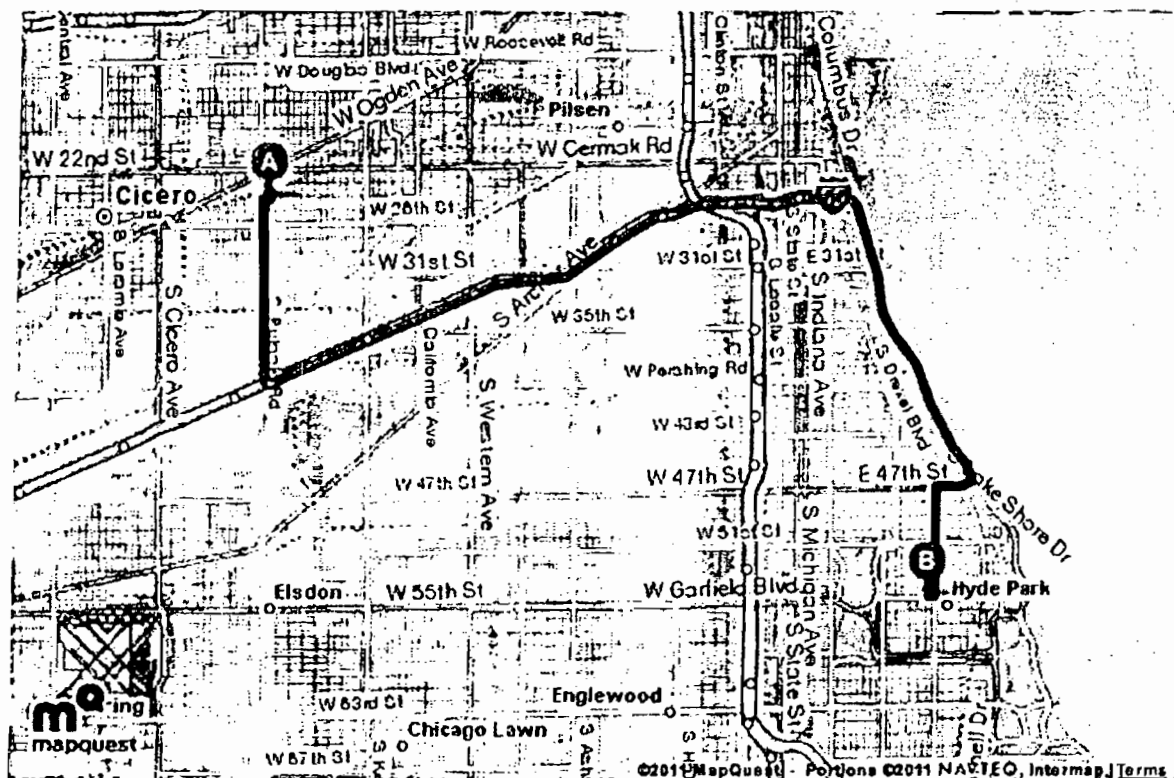
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Notes

Trip to:
1164 E 55th St
Chicago, IL 60615-5115
12.20 miles
21 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
 	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 6.0 Mi	7.7 mi
 	4. Merge onto S Lake Shore Dr / US-41 S .	Go 2.9 Mi	10.6 mi
	5. Take the 47th St ramp.	Go 0.2 Mi	10.8 mi
	6. Turn right onto E 47th St . <i>If you reach US-41 S you've gone about 0.1 miles too far</i>	Go 0.4 Mi	11.1 mi
	7. Turn left onto S Woodlawn Ave . <i>S Woodlawn Ave is 0.2 miles past S Lake Park Ave</i> <i>If you reach S Greenwood Ave you've gone about 0.1 miles too far</i>	Go 1.0 Mi	12.1 mi
	8. Turn right onto E 55th St . <i>E 55th St is 0.1 miles past E 54th Pl</i> <i>If you reach E 56th St you've gone about 0.1 miles too far</i>	Go 0.06 Mi	12.2 mi
	9. 1164 E 55TH ST is on the right. <i>If you reach S University Ave you've gone a little too far</i>		12.2 mi
	1164 E 55th St Chicago, IL 60615-5115	12.2 mi	12.2 mi

Total Travel Estimate: 12.20 miles - about 21 minutes



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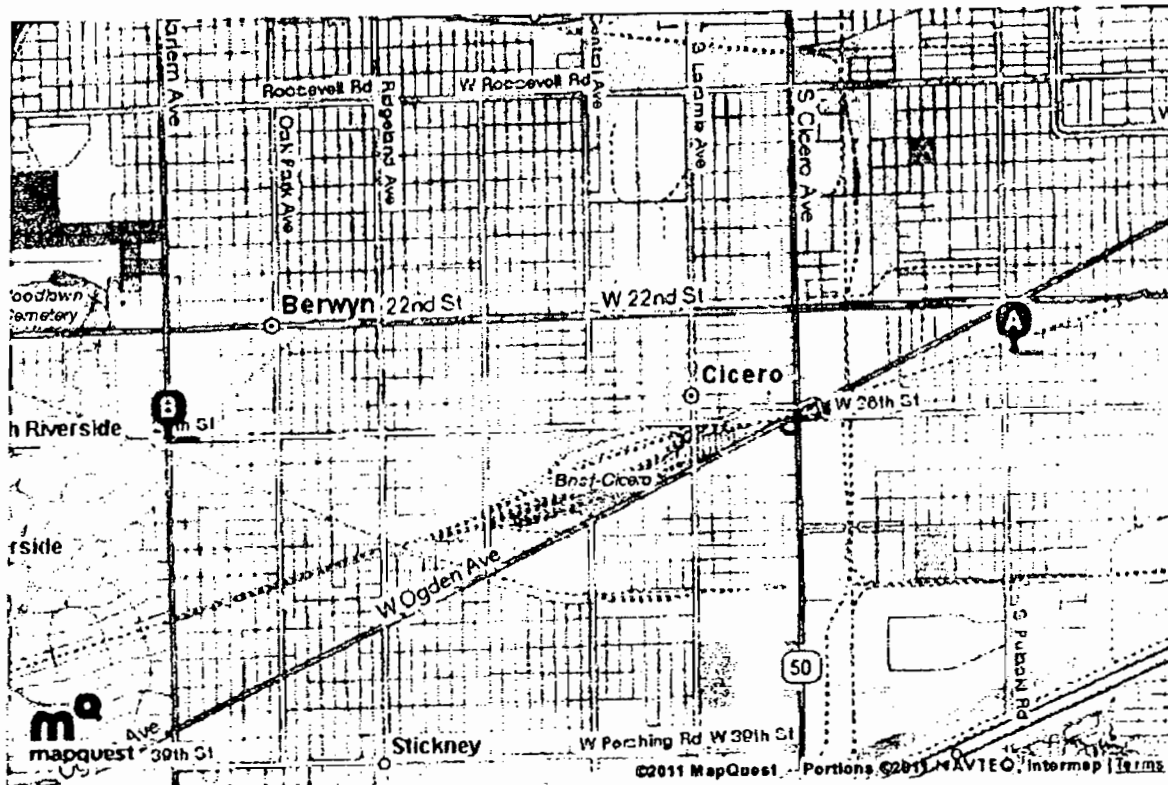
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Notes

Trip to:
2601 Harlem Ave
Berwyn, IL 60402-2100
4.70 miles
13 minutes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 MI	0.06 mi
➤	2. Take the 1st right onto S Pulaski Rd. <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 0.2 MI	0.3 mi
➤	3. Take the 1st left onto W Ogden Ave. <i>If you reach W Cermak Rd you've gone a little too far</i>	Go 1.0 MI	1.3 mi
➤	4. Turn right onto W 26th St / 35th Pl. Continue to follow W 26th St. <i>W 26th St is 0.3 miles past S Kenneth Ave If you are on W Ogden Ave and reach S 49th Ave you've gone about 0.3 miles too far</i>	Go 3.2 MI	4.5 mi
➤	5. Turn left onto Harlem Ave / IL-43. <i>Harlem Ave is 0.1 miles past Riverside Dr Citibank ATM is on the corner If you are on W 26th St and reach Veterans Dr you've gone about 0.3 miles too far</i>	Go 0.09 MI	4.6 mi
➤	6. Make a U-turn onto Harlem Ave / IL-43. <i>If you reach Riverside Dr you've gone a little too far</i>	Go 0.09 MI	4.7 mi
■	7. 2601 HARLEM AVE is on the right. <i>If you reach W 25th St you've gone about 0.2 miles too far</i>		4.7 mi
B	2601 Harlem Ave Berwyn, IL 60402-2100	4.7 mi	4.7 mi

Total Travel Estimate: **4.70 miles - about 13 minutes**



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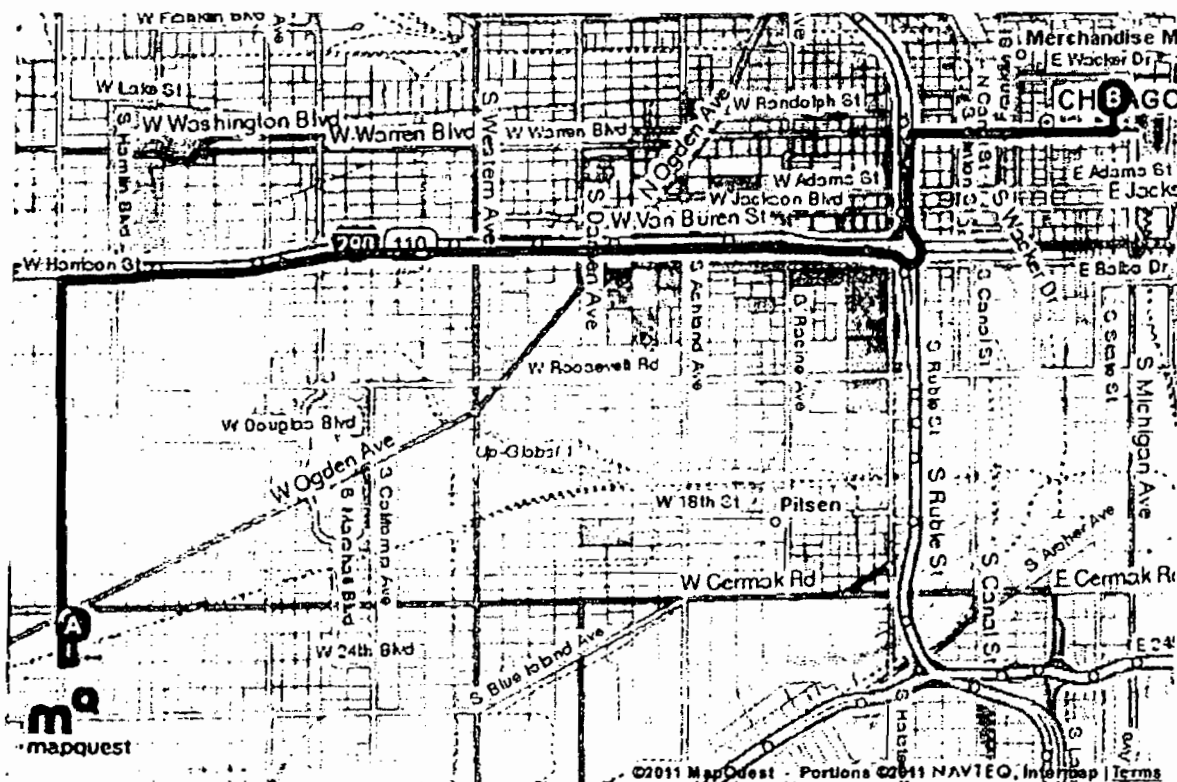


Notes

Trip to:
55 E Washington St
Chicago, IL 60602-2103
7.63 miles
16 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi	1.8 mi
	3. Turn right onto W Harrison St . <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 Mi	2.2 mi
	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 3.6 Mi	5.8 mi
	5. Merge onto I-90 W / I-94 W / Kennedy Expy W toward Wisconsin .	Go 0.7 Mi	6.5 mi
	6. Take EXIT 51C toward East Washington Blvd .	Go 0.1 Mi	6.6 mi
	7. Turn right onto W Washington Blvd . <i>Columbus Grill & Carryout is on the right</i>	Go 0.3 Mi	6.9 mi
	8. W Washington Blvd becomes W Washington St .	Go 0.7 Mi	7.6 mi
	9. 55 E WASHINGTON ST is on the right. <i>Your destination is just past N Wabash Ave</i> <i>If you reach N Garland Ct you've gone a little too far</i>		7.6 mi
	55 E Washington St Chicago, IL 60602-2103	7.6 mi	7.6 mi

Total Travel Estimate: 7.63 miles - about 16 minutes



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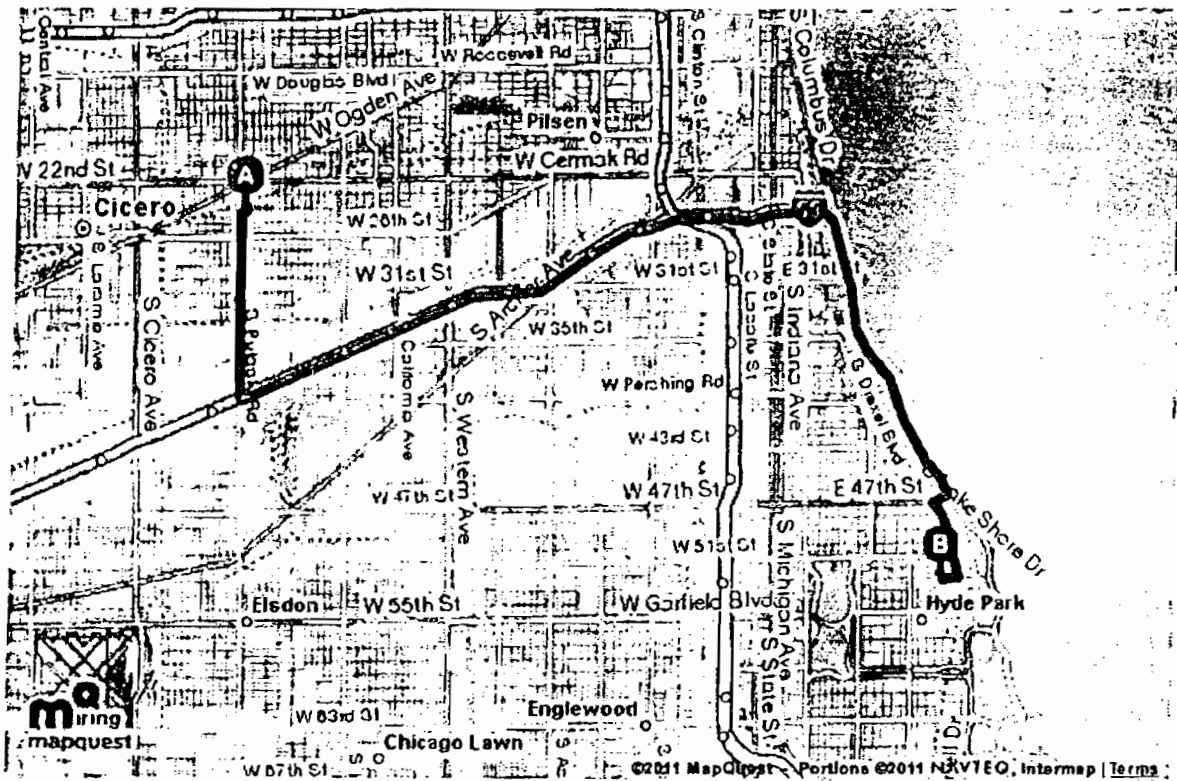
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Notes

Trip to:
1437 E 53rd St
Chicago, IL 60615-4513
11.83 miles
20 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 6.0 Mi	7.7 mi
	4. Merge onto S Lake Shore Dr / US-41 S.	Go 2.9 Mi	10.6 mi
	5. Take the 47th St ramp.	Go 0.2 Mi	10.8 mi
	6. Turn right onto E 47th St. <i>If you reach US-41 S you've gone about 0.1 miles too far</i>	Go 0.2 Mi	10.9 mi
	7. Turn sharp left onto S Lake Park Ave. <i>S Lake Park Ave is 0.1 miles past S Cornell Ave Italian Fiesta Pizzeria is on the right If you reach S Woodlawn Ave you've gone about 0.2 miles too far</i>	Go 0.8 Mi	11.7 mi
	8. Turn right onto E 53rd St. <i>E 53rd St is 0.1 miles past E 52nd St Borders is on the corner If you reach E 54th St you've gone about 0.1 miles too far</i>	Go 0.2 Mi	11.8 mi
	9. 1437 E 53RD ST is on the left. <i>Your destination is just past S Harper Ave If you reach S Blackstone Ave you've gone a little too far</i>		11.8 mi
	1437 E 53rd St Chicago, IL 60615-4513	11.8 mi	11.8 mi

Total Travel Estimate: 11.83 miles - about 20 minutes



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Notes

Trip to:

4811 W 77th St

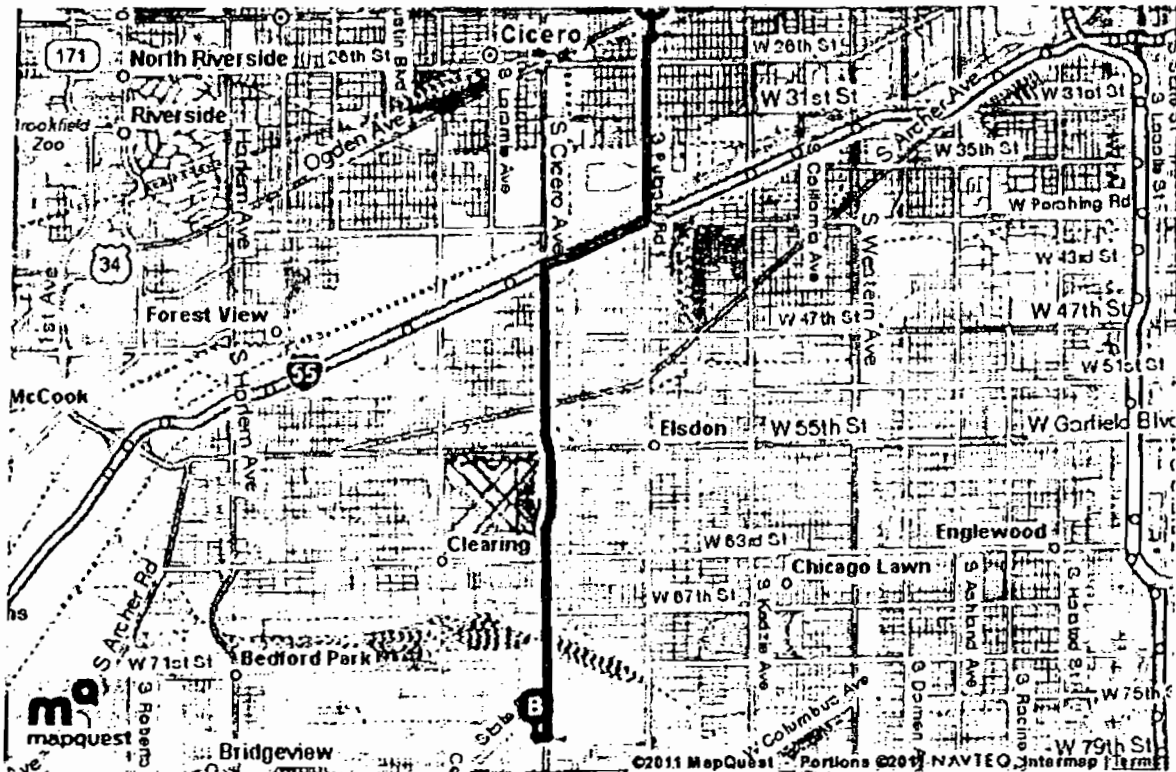
Burbank, IL 60459-1586

7.36 miles

17 minutes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
↩	2. Take the 1st left onto S Pulaski Rd . <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 MI	1.7 mi
↗	3. Merge onto I-55 S / Stevenson Expy S .	Go 0.8 MI	2.5 mi
EXIT 286	4. Take the IL-50 / Cicero Ave exit, EXIT 286 , toward Chicago Midway Airport .	Go 0.3 MI	2.8 mi
↩	5. Turn left onto IL-50 S / S Cicero Ave . Continue to follow IL-50 S . <i>If you reach I-55 S you've gone about 0.3 miles too far</i>	Go 4.4 MI	7.2 mi
↘	6. Turn right onto W 76th St / W 77th St . <i>W 76th St is 0.3 miles past S State Rd Olive Garden in Burbank Town Ctr is on the corner If you reach W 78th St you've gone about 0.2 miles too far</i>	Go 0.1 MI	7.3 mi
↩	7. Turn left . <i>Popeye's Chicken & Biscuits in Burbank Town Ctr is on the left</i>	Go 0.02 MI	7.4 mi
↘	8. Take the 1st right onto W 77th St . <i>Popeye's Chicken & Biscuits in Burbank Town Ctr is on the corner</i>		7.4 mi
■	9. 4811 W 77TH ST is on the left . <i>If you reach the end of W 77th St you've gone a little too far</i>		7.4 mi
B	4811 W 77th St Burbank, IL 60459-1586	7.4 mi	7.4 mi

Total Travel Estimate: 7.36 miles - about 17 minutes



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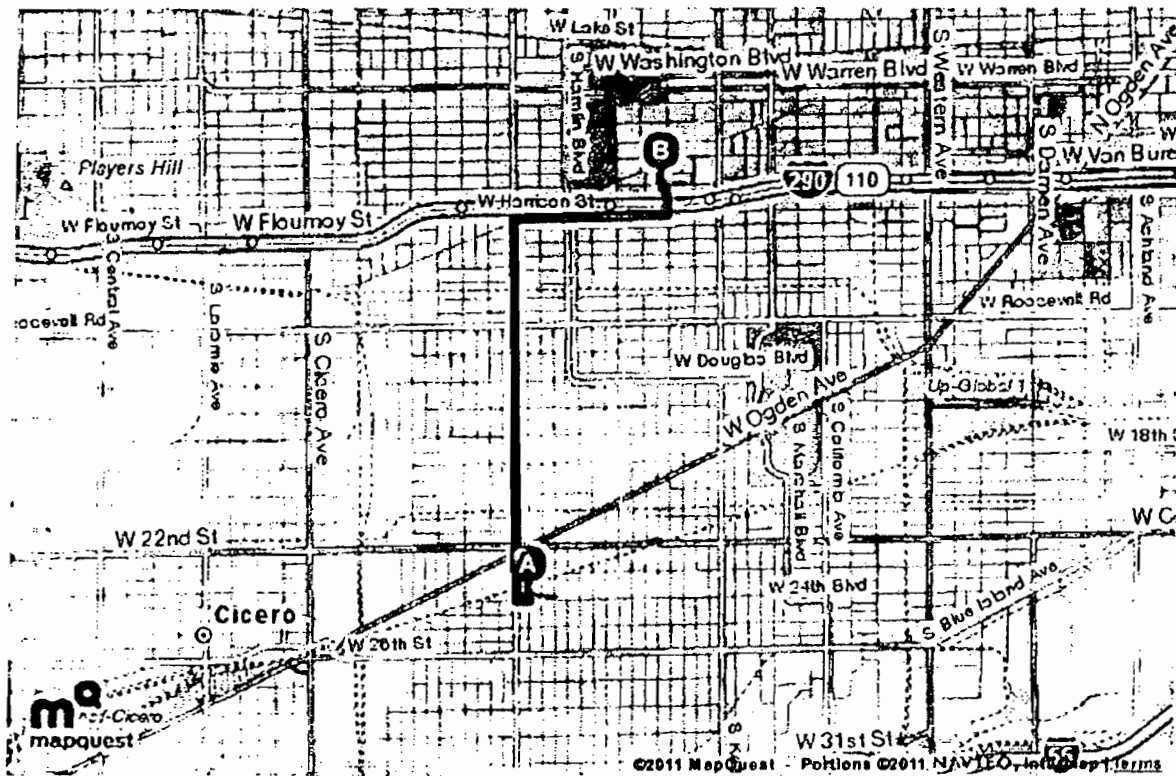


Notes

Trip to:
3410 W Van Buren St
Chicago, IL 60624-3358
2.73 miles
8 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi	1.8 mi
	3. Turn right onto W Harrison St . <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pky you've gone a little too far</i>	Go 0.8 Mi	2.6 mi
	4. Turn left onto S Homan Ave . <i>S Homan Ave is 0.1 miles past S St Louis Ave</i> <i>Murry's Fish & Chicken is on the corner</i> <i>If you reach I-290 E you've gone about 0.2 miles too far</i>	Go 0.1 Mi	2.7 mi
	5. Take the 2nd left onto W Van Buren St . <i>W Van Buren St is just past W Congress Pky</i> <i>If you reach W Gladys Ave you've gone a little too far</i>	Go 0.02 Mi	2.7 mi
	6. 3410 W VAN BUREN ST is on the right . <i>If you reach S Trumbull Ave you've gone a little too far</i>		2.7 mi
	3410 W Van Buren St Chicago, IL 60624-3358	2.7 mi	2.7 mi

Total Travel Estimate: 2.73 miles - about 8 minutes



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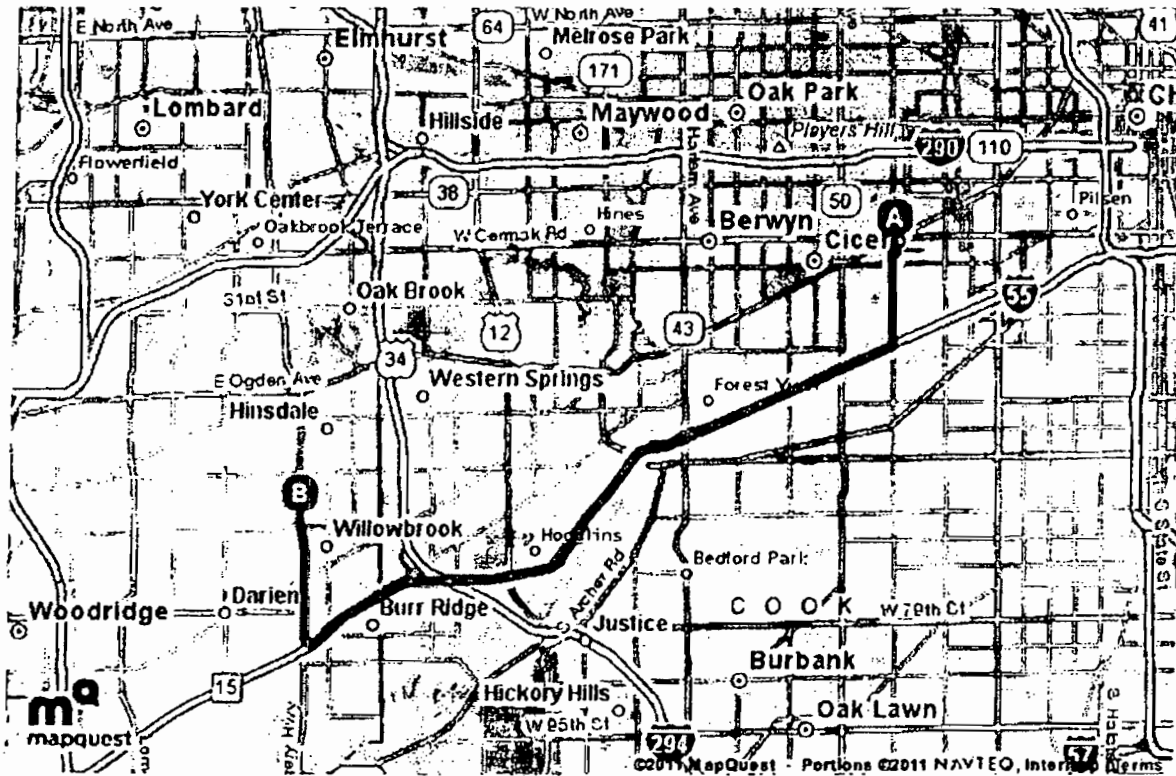
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Trip to:
6300 Kingery Hwy
Willowbrook, IL 60527-2248
17.08 miles
24 minutes

Notes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.7 mi
	3. Merge onto I-55 S . 	Go 12.9 Mi	14.6 mi
	4. Merge onto IL-83 N via EXIT 274 .  	Go 2.4 Mi	17.1 mi
	5. Turn left onto 63rd St . <i>63rd St is 0.2 miles past Ridgemoor Dr W</i> <i>Quiznos is on the corner</i>	Go 0.01 Mi	17.1 mi
	6. 6300 KINGERY HWY . <i>If you reach Americana Dr you've gone about 0.1 miles too far</i>		17.1 mi
	6300 Kingery Hwy Willowbrook, IL 60527-2248	17.1 mi	17.1 mi

Total Travel Estimate: 17.08 miles - about 24 minutes



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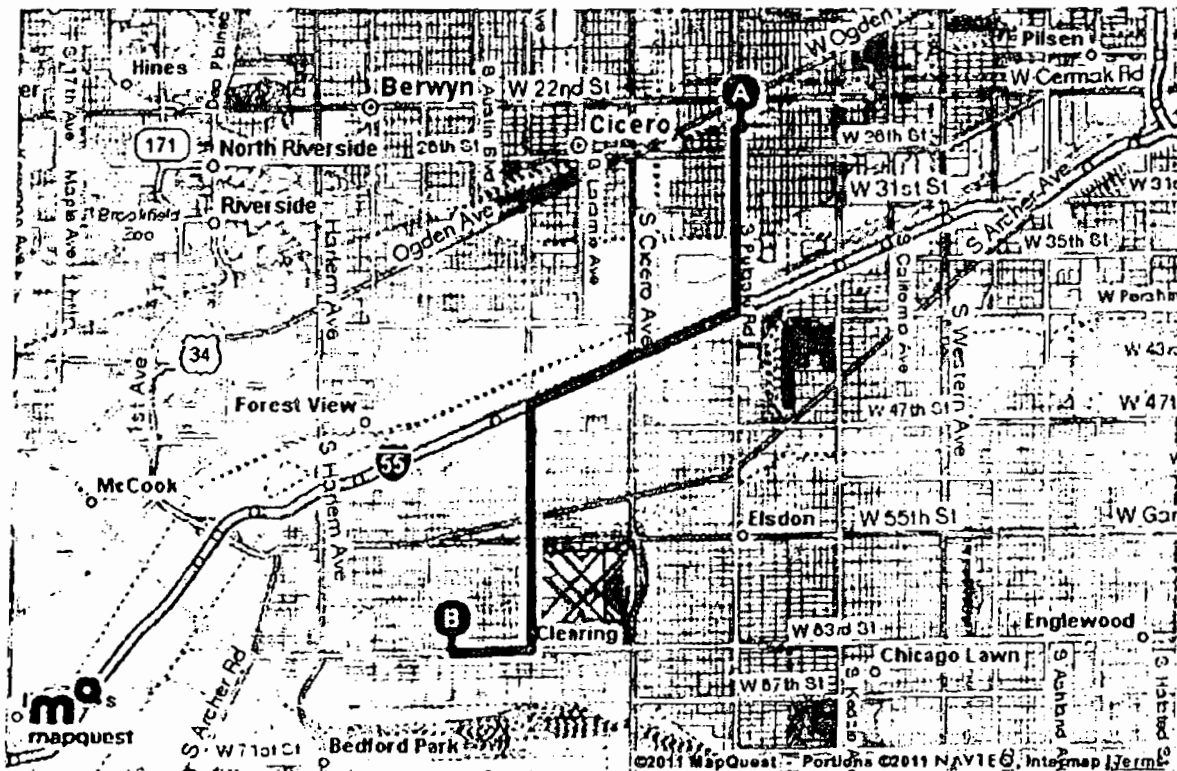
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Trip to:
6201 W 63rd St
Chicago, IL 60638-5009
6.98 miles
15 minutes

Notes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
↩	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.7 mi
↑	3. Merge onto I-55 S / Stevenson Expy S.	Go 1.9 Mi	3.6 mi
EXIT 285	4. Take the Central Ave exit, EXIT 285.	Go 0.3 Mi	3.9 mi
↩	5. Turn left onto S Central Ave. <i>If you reach I-55 S you've gone about 0.4 miles too far</i>	Go 2.3 Mi	6.2 mi
↪	6. Turn right onto W 63rd St. <i>W 63rd St is 0.1 miles past W 62nd St US Post Office is on the right If you reach W 63rd Pl you've gone a little too far</i>	Go 0.8 Mi	7.0 mi
■	7. 6201 W 63RD ST is on the left. <i>Your destination is just past S Melvina Ave If you reach S Merrimac Ave you've gone a little too far</i>		7.0 mi
B	6201 W 63rd St Chicago, IL 60638-5009	7.0 mi	7.0 mi

Total Travel Estimate: **6.98 miles - about 15 minutes**



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Notes

Trip to:
8315-8331 S Holland Rd
Chicago, IL 60620-1328
14.32 miles
22 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 4.2 Mi	6.0 mi
	4. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana .	Go 0.8 Mi	6.7 mi
	5. Keep left to take I-94 Express Ln E / Dan Ryan Express Ln E toward Garfield Blvd .	Go 5.5 Mi	12.2 mi
	6. I-94 Express Ln E / Dan Ryan Express Ln E becomes I-94 E / Dan Ryan Expy E .	Go 1.4 Mi	13.6 mi
	7. Take EXIT 61A toward 83rd St .	Go 0.2 Mi	13.7 mi
	8. Keep right at the fork in the ramp.	Go 0.2 Mi	13.9 mi
	9. Turn slight left onto S Lafayette Ave .	Go 0.08 Mi	14.0 mi
	10. Take the 1st right onto W 83rd St . <i>If you reach W 84th St you've gone about 0.1 miles too far</i>	Go 0.3 Mi	14.3 mi
	11. Turn left onto S Holland Rd . <i>S Holland Rd is just past S Princeton Ave</i> <i>If you reach S Stewart Ave you've gone about 0.1 miles too far</i>	Go 0.01 Mi	14.3 mi



12. 8315-8331 S HOLLAND RD

14.3 mi

If you reach W 85th St you've gone about 0.2 miles too far

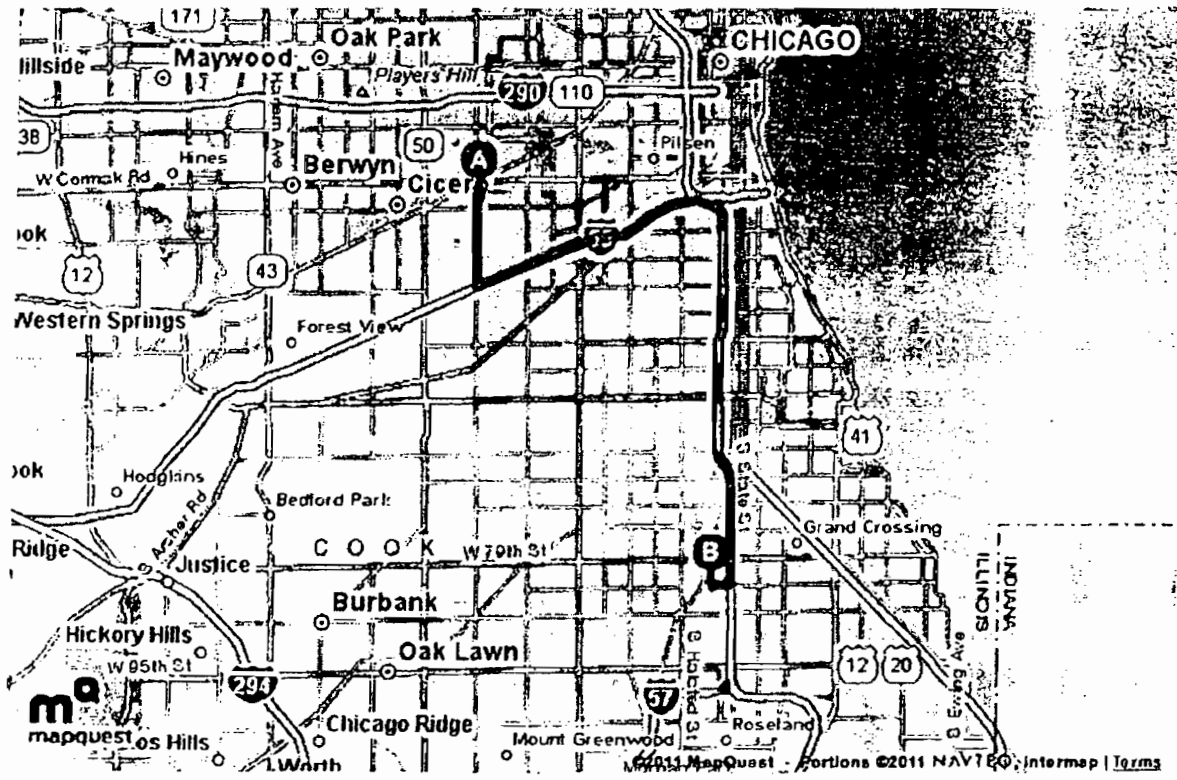


8315-8331 S Holland Rd
Chicago, IL 60620-1328

14.3 mi

14.3 mi

Total Travel Estimate: **14.32 miles - about 22 minutes**



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Notes

Trip to:
2620 W Addison St
Chicago, IL 60618-5905
12.42 miles
23 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd. <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi	1.8 mi
	3. Turn right onto W Harrison St. <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 Mi	2.2 mi
	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 3.6 Mi	5.8 mi
	5. Merge onto I-90 W / I-94 W / Kennedy Expy W toward Wisconsin.	Go 5.0 Mi	10.8 mi
	6. Take the Diversey Ave exit, EXIT 46B.	Go 0.3 Mi	11.0 mi
	7. Turn slight left onto W Diversey Ave.	Go 0.2 Mi	11.2 mi
	8. Turn right onto N California Ave. <i>Popeye's Chicken & Biscuits is on the corner</i> <i>If you reach N Mozart St you've gone a little too far</i>	Go 1.0 Mi	12.2 mi
	9. Turn right onto W Addison St. <i>W Addison St is 0.2 miles past W Roscoe St</i> <i>If you reach W Waveland Ave you've gone about 0.1 miles too far</i>	Go 0.2 Mi	12.4 mi
	10. 2620 W ADDISON ST is on the left. <i>Your destination is just past N Talman Ave</i> <i>If you reach N Campbell Ave you've gone about 0.1 miles too far</i>		12.4 mi
	2620 W Addison St Chicago, IL 60618-5905	12.4 mi	12.4 mi

Total Travel Estimate: 12.42 miles - about 23 minutes



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Notes

Trip to:

1340 S Damen Ave

Chicago, IL 60608-1169

3.24 miles

9 minutes



3934 W 24th St
Chicago, IL 60623-3371

**Miles Per
Section**

Miles Driven



1. Start out going **west** on **W 24th St** toward **S Pulaski Rd.**

Go 0.06 Mi

0.06 mi



2. Take the 1st **right** onto **S Pulaski Rd.**

Go 0.2 Mi

0.3 mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 1st **right** onto **W Ogden Ave.**

Go 2.4 Mi

2.7 mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn **right** onto **W Roosevelt Rd.**

Go 0.4 Mi

3.1 mi

If you reach W Taylor St you've gone about 0.2 miles too far



5. Take the 2nd **right** onto **S Damen Ave.**

Go 0.2 Mi

3.2 mi

S Damen Ave is 0.2 miles past S Hamilton Ave

If you reach S Wood St you've gone about 0.2 miles too far



6. **1340 S DAMEN AVE** is on the **right**.

3.2 mi

Your destination is just past W 13th St

If you reach W 14th St you've gone a little too far

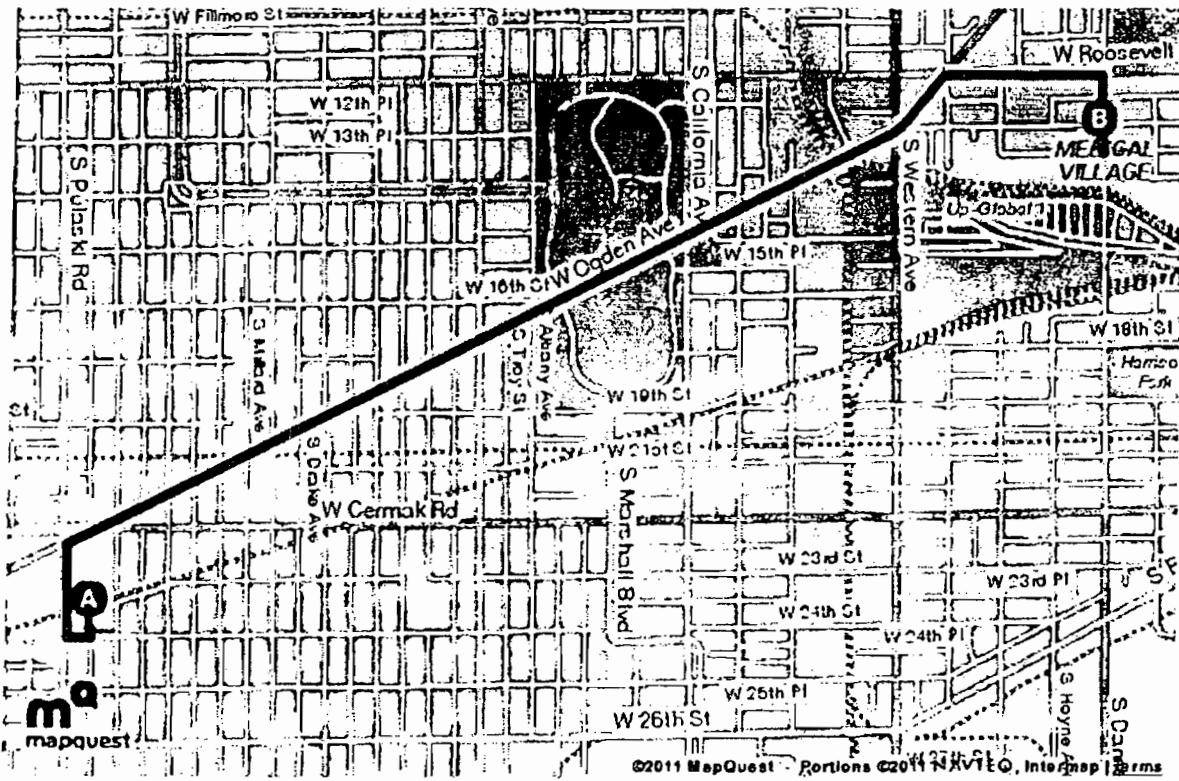


1340 S Damen Ave
Chicago, IL 60608-1169

3.2 mi

3.2 mi

Total Travel Estimate: **3.24 miles - about 9 minutes**



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Notes

Trip to:
1444-1454 W Willow St
Chicago, IL 60642-1524
9.30 miles
17 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd. <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi	1.8 mi
	3. Turn right onto W Harrison St. <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 Mi	2.2 mi
	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 3.6 Mi	5.8 mi
	5. Merge onto I-90 W / I-94 W / Kennedy Expy W toward Wisconsin.	Go 2.9 Mi	8.7 mi
	6. Take the IL-64 / North Ave exit, EXIT 48B.	Go 0.2 Mi	8.9 mi
	7. Turn right onto IL-64 / W North Ave. <i>If you reach I-90 W you've gone about 0.1 miles too far</i>	Go 0.1 Mi	9.0 mi
	8. Take the 2nd left onto N Elston Ave. <i>N Elston Ave is just past N Noble St</i> <i>North & Elston AMOCO is on the left</i> <i>If you reach N Ada St you've gone a little too far</i>	Go 0.2 Mi	9.2 mi
	9. Take the 3rd right onto W Willow St. <i>W Willow St is just past W Wabansia Ave</i> <i>If you reach W Cortland St you've gone about 0.2 miles too far</i>	Go 0.06 Mi	9.3 mi
	10. 1444-1454 W WILLOW ST. <i>If you reach W Wabansia Ave you've gone about 0.1 miles too far</i>		9.3 mi
	1444-1454 W Willow St Chicago, IL 60642-1524	9.3 mi	9.3 mi

Total Travel Estimate: **9.30 miles - about 17 minutes**



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Trip to:
W Franklin Blvd & N Spaulding Ave
Chicago, IL 60624
3.73 miles
11 minutes

Notes



3934 W 24th St
Chicago, IL 60623-3371

**Miles Per
Section**

Miles Driven



1. Start out going **west** on **W 24th St** toward **S Pulaski Rd**.

Go 0.06 Mi

0.06 mi



2. Take the 1st **right** onto **S Pulaski Rd**.

Go 0.2 Mi

0.3 mi

*Las Islas Marias is on the corner
 If you reach S Karlov Ave you've gone a little too far*



3. Take the 1st **right** onto **W Ogden Ave**.

Go 1.1 Mi

1.4 mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn **left** onto **S Kedzie Ave**.

Go 2.2 Mi

3.6 mi

*S Kedzie Ave is just past S Sawyer Ave
 Church of the Lord Jesus is on the corner
 If you reach S Albany Ave you've gone about 0.1 miles too far*



5. Turn **left** onto **W Franklin Blvd**.

Go 0.1 Mi

3.7 mi

*Gen Hoe Two Restaurant is on the corner
 If you reach W Ohio St you've gone about 0.1 miles too far*



6. Take the 1st **right** onto **N Spaulding Ave**.

Go 0.01 Mi

3.7 mi

If you reach N Homan Ave you've gone about 0.1 miles too far



7. W FRANKLIN BLVD & N SPAULDING AVE

3.7 mi

If you reach W Ohio St you've gone about 0.1 miles too far



W Franklin Blvd & N Spaulding Ave
Chicago, IL 60624

3.7 mi

3.7 mi

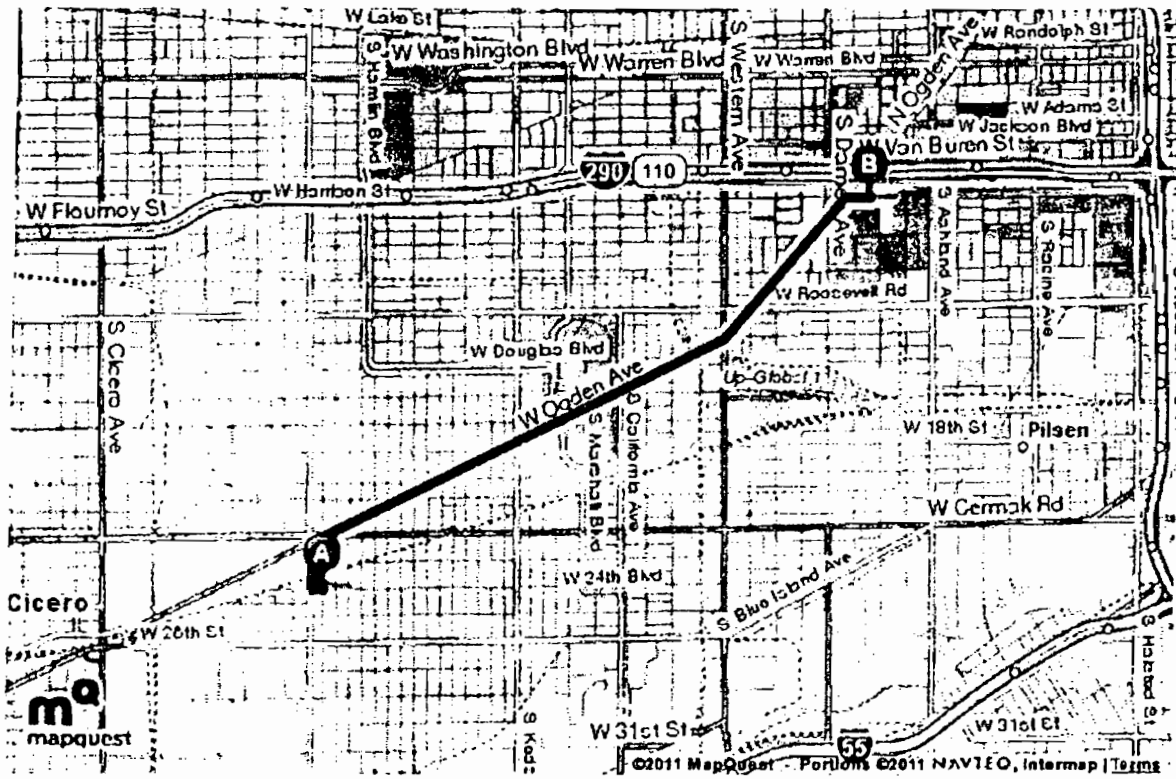
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Trip to:
1835 W Harrison St
Chicago, IL 60612-3771
3.48 miles
9 minutes

Notes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 MI	0.06 mi
↗	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 0.2 MI	0.3 mi
↗	3. Take the 1st right onto W Ogden Ave . <i>If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far</i>	Go 3.1 MI	3.4 mi
↗	4. Turn slight right onto W Harrison St . <i>W Harrison St is just past S Winchester Ave</i> <i>If you are on W Ogden Ave and reach S Wabash Ave you've gone a little too far</i>	Go 0.1 MI	3.5 mi
■	5. 1835 W HARRISON ST is on the right. <i>Your destination is just past S Wabash Ave</i> <i>If you reach S Wood St you've gone a little too far</i>		3.5 mi
B	1835 W Harrison St Chicago, IL 60612-3771	3.5 mi	3.5 mi

Total Travel Estimate: **3.48 miles - about 9 minutes**



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Trip to:
2400 Wolf Rd Ste 101
Westchester, IL 60154-5625
13.08 miles
24 minutes

Notes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 Mi	0.06 mi
	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 0.3 Mi	0.3 mi
	3. Take the 2nd left onto W Cermak Rd / W 22nd St . <i>W Cermak Rd is just past W Ogden Ave</i> <i>If you reach W 21st Pl you've gone a little too far</i>	Go 1.0 Mi	1.3 mi
	4. Turn right onto S Cicero Ave / IL-50 . <i>S Cicero Ave is just past S 47th Ct</i> <i>Walgreens is on the corner</i> <i>If you reach S 49th Ave you've gone about 0.1 miles too far</i>	Go 1.4 Mi	2.8 mi
	5. Turn left onto W Flournoy St . <i>W Flournoy St is just past W Lexington St</i> <i>If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i>	Go 0.04 Mi	2.8 mi
	6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left.	Go 7.6 Mi	10.4 mi
	7. Take EXIT 16 toward Wolf Rd .	Go 0.2 Mi	10.6 mi
	8. Stay straight to go onto Frontage Rd .	Go 0.08 Mi	10.7 mi
	9. Take the 1st left to stay on Frontage Rd . <i>If you reach N Jackson Blvd you've gone about 0.2 miles too far</i>	Go 0.06 Mi	10.7 mi
	10. Turn left onto S Frontage Rd .	Go 0.2 Mi	10.9 mi
	11. Turn right onto Harrison St . <i>300 Grill is on the corner</i>	Go 0.4 Mi	11.3 mi



12. Take the 1st left onto **S Wolf Rd.**

Go 1.8 Mi

13.1 mi

Hillside School is on the corner

If you reach N Elm St you've gone about 0.1 miles too far



13. **2400 WOLF RD STE 101** is on the right.

13.1 mi

Your destination is 0.1 miles past Westbrook Corporate Ctr

If you reach Summerdale St you've gone a little too far



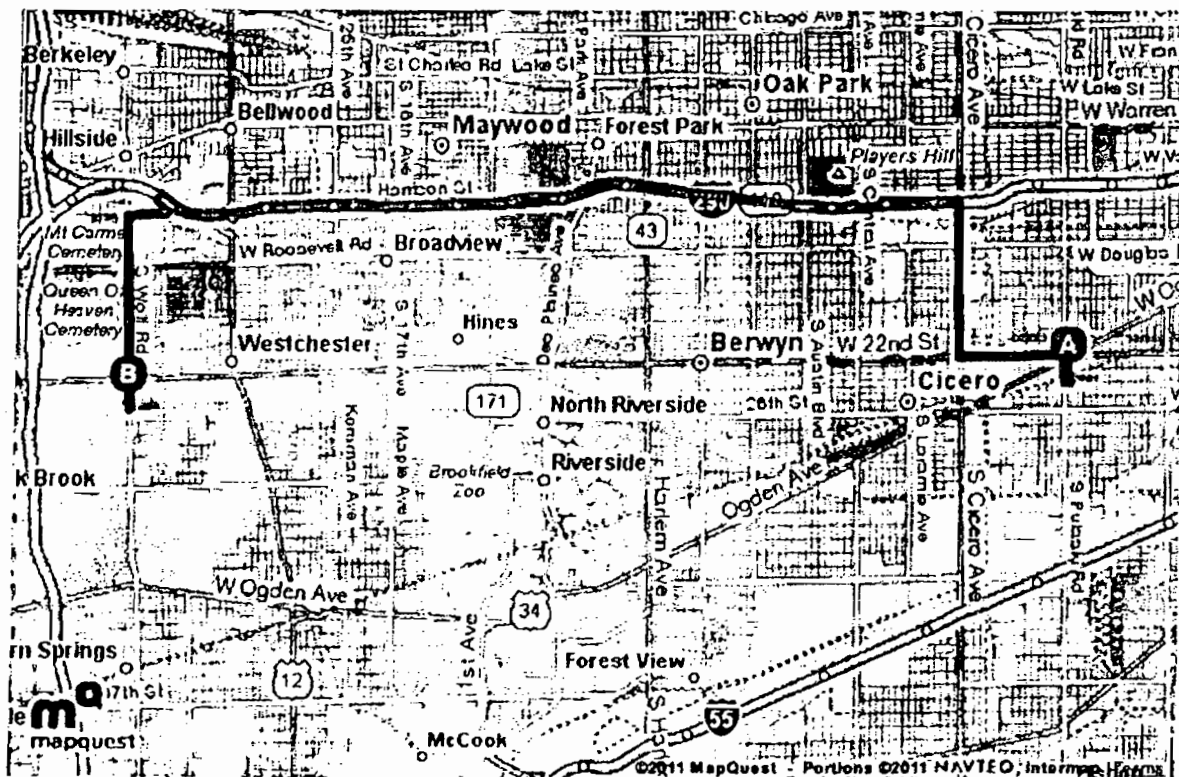
2400 Wolf Rd Ste 101

13.1 mi

13.1 mi

Westchester, IL 60154-5625

Total Travel Estimate: 13.06 miles - about 24 minutes



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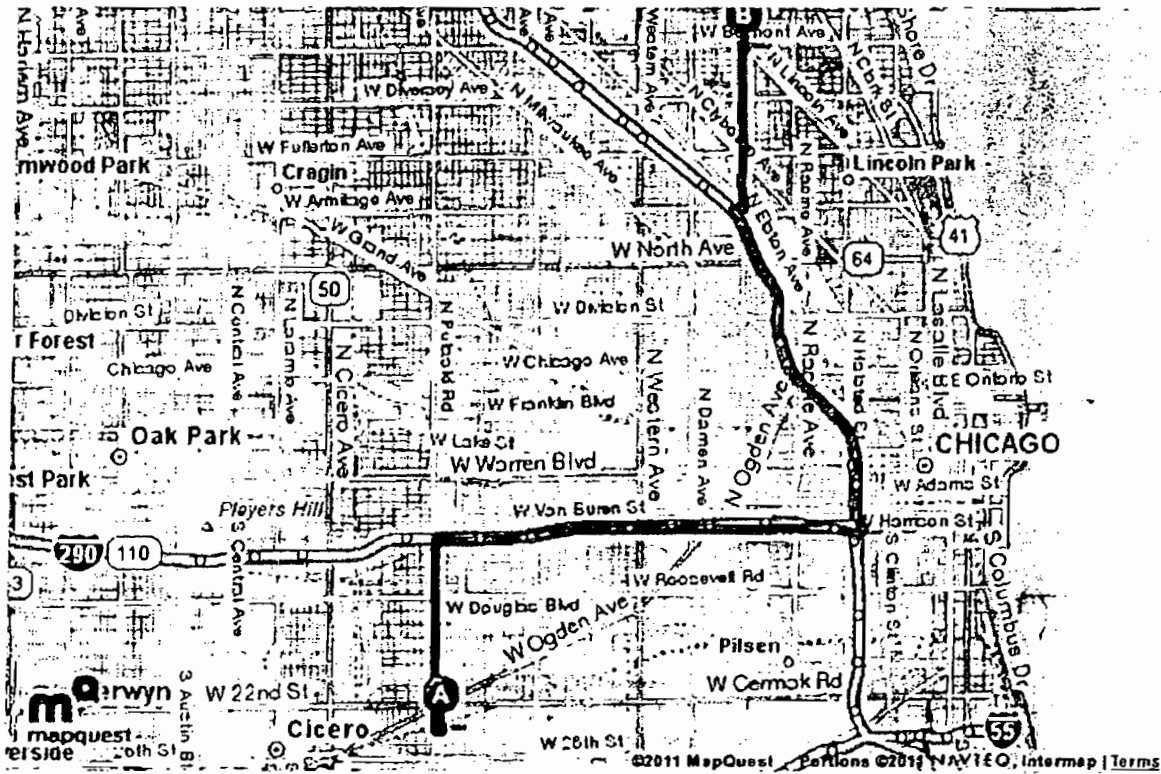
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Notes

Trip to:
3155 N Lincoln Ave # 57
Chicago, IL 60657-3111
11.08 miles
21 minutes

A	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
●	1. Start out going west on W 24th St toward S Pulaski Rd .	Go 0.06 MI	0.06 mi
➔	2. Take the 1st right onto S Pulaski Rd . <i>Las Islas Marias is on the corner If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 MI	1.8 mi
➔	3. Turn right onto W Harrison St . <i>W Harrison St is just past W 5th Ave Mary's Restaurant is on the left If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 MI	2.2 mi
➔		Go 3.6 MI	5.8 mi
➔		Go 3.5 MI	9.3 mi
	6. Take the Armitage Ave exit, EXIT 48A .	Go 0.2 MI	9.4 mi
➔	7. Turn sharp right onto W Armitage Ave . <i>If you reach I-90 W you've gone about 0.1 miles too far</i>	Go 0.09 MI	9.5 mi
➔	8. Take the 2nd left onto N Ashland Ave . <i>N Ashland Ave is just past N Holly Ave If you are on W Armitage Ave and reach N Elston Ave you've gone a little too far</i>	Go 1.5 MI	11.0 mi
➔	9. Turn sharp right onto N Lincoln Ave . <i>N Lincoln Ave is 0.1 miles past W Barry Ave Beckett's Public House is on the corner If you reach W Melrose St you've gone a little too far</i>	Go 0.04 MI	11.1 mi
■	10. 3155 N LINCOLN AVE # 57 is on the left . <i>If you reach N Greenview Ave you've gone about 0.1 miles too far</i>		11.1 mi
B	3155 N Lincoln Ave # 57 Chicago, IL 60657-3111	11.1 mi	11.1 mi

Total Travel Estimate: 11.08 miles - about 21 minutes



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Notes

Trip to:
2335 W Cermak Rd
Chicago, IL 60608-3811
2.38 miles
7 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

Las Islas Manas is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 2nd right onto W Cermak Rd / W 22nd St.

Go 0.7 Mi

W Cermak Rd is just past W Ogden Ave

If you reach W 21st St you've gone a little too far



4. Stay straight to go onto S Trumbull Ave.

Go 0.02 Mi



5. Turn slight left onto W Cermak Rd / W 22nd St. Continue to follow W Cermak Rd.

Go 1.3 Mi



6. 2335 W CERMAK RD is on the right.

Your destination is just past S Western Ave

If you reach S Oakley Ave you've gone a little too far



2335 W Cermak Rd
Chicago, IL 60608-3811

2.4 mi

A map of the area around W Germak Rd and W 16th St. The map shows a grid of streets including W 16th St, W 17th St, W 18th St, W 19th St, W 20th St, W 21st St, W 22nd St, W 23rd St, W 24th St, W 25th St, W 26th St, W 27th St, and W 28th St. Other streets shown are W 16th St, W 17th St, W 18th St, W 19th St, W 20th St, W 21st St, W 22nd St, W 23rd St, W 24th St, W 25th St, W 26th St, W 27th St, and W 28th St. Landmarks include a school (marked with a school icon) and a bus stop (marked with a bus icon). A scale bar indicates 2000ft and 500m. The map is credited to mapquest and NAVTEO.

308

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Notes

Trip to:
2659 N Milwaukee Ave
Chicago, IL 60647-1643
6.50 miles
19 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 1st right onto W Ogden Ave.

Go 1.1 Mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn left onto S Kedzie Ave.

Go 4.9 Mi

S Kedzie Ave is just past S Sawyer Ave

Church of the Lord Jesus is on the corner

If you reach S Albany Ave you've gone about 0.1 miles too far



5. Turn slight right onto W Logan Blvd.

Go 0.06 Mi

W Logan Blvd is just past N Linden Pl



6. Turn left onto N Milwaukee Ave.

Go 0.2 Mi

Dunlaps on the Square is on the right

If you reach N Albany Ave you've gone a little too far



7. 2659 N MILWAUKEE AVE is on the right.

Your destination is just past N Kedzie Ave

If you reach N Sawyer Ave you've gone a little too far



2659 N Milwaukee Ave
Chicago, IL 60647-1643

6.5 mi

310

Trip to:
1201 W Roosevelt Rd
Maywood, IL 60153-4046
8.57 miles
17 minutes

- | | | Miles Per Section |
|---|--|-------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Marias is on the corner</i>
<i>If you reach S Karlov Ave you've gone a little too far</i> | Go 0.3 Mi |
|  | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave</i>
<i>If you reach W 21st St you've gone a little too far</i> | Go 1.0 Mi |
|  | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th St</i>
<i>Walgreens is on the corner</i>
<i>If you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
|  | 5. Turn left onto W Floumoy St.
<i>W Floumoy St is just past W Lexington St</i>
<i>If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
|  | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 4.4 Mi |
|  | 7. Take the IL-171 / 1st Ave exit, EXIT 20. | Go 0.1 Mi |
|  | 8. Stay straight to go onto Harrison St. | Go 0.07 Mi |
|  | 9. Take the 1st left onto IL-171 / S 1st Ave.
<i>KFC is on the corner</i>
<i>If you reach S 2nd Ave you've gone a little too far</i> | Go 0.5 Mi |
|  | 10. Turn right onto W Roosevelt Rd.
<i>W Roosevelt Rd is 0.1 miles past Fillmore St</i>
<i>Burger King is on the right</i>
<i>If you are on S 1st Ave and reach 13th St you've gone about 0.1 miles too far</i> | Go 0.7 Mi |
| | 11. 1201 W ROOSEVELT RD is on the right. | |



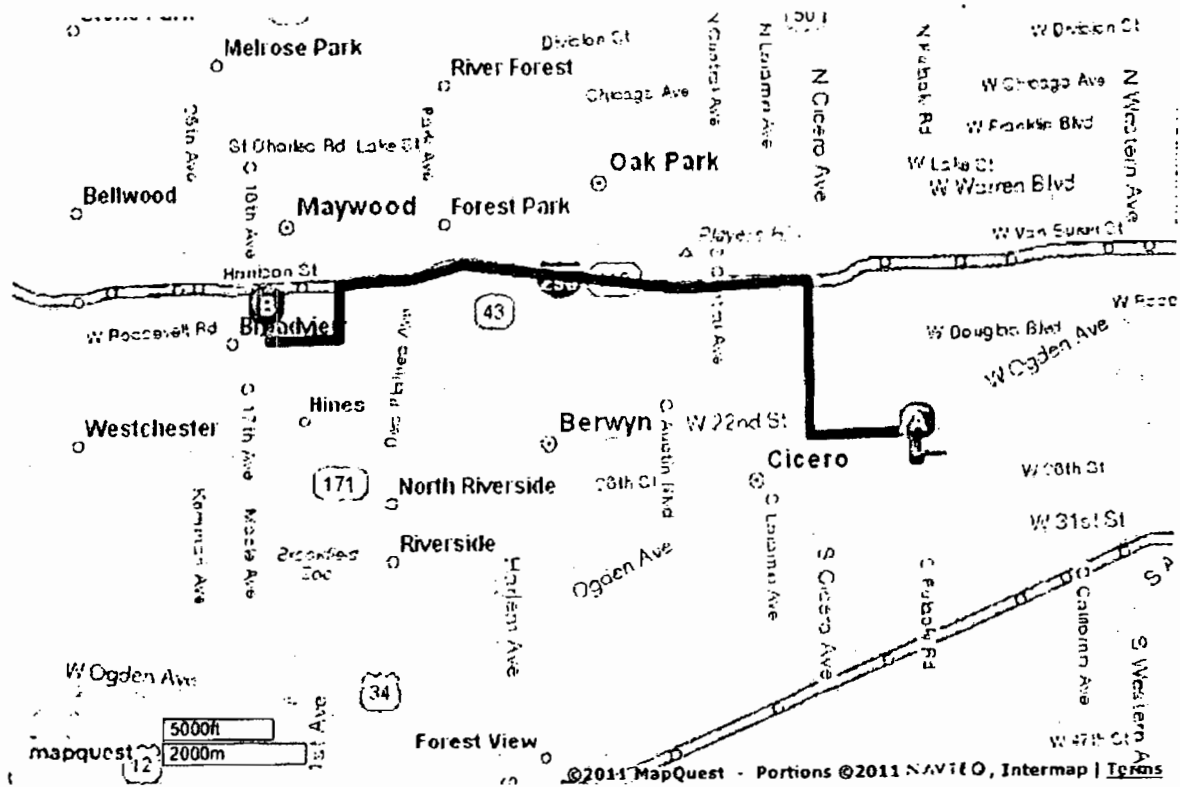
*Your destination is just past S 11th Ave
if you reach S 13th Ave you've gone a little too far*



**1201 W Roosevelt Rd
Maywood, IL 60153-4046**

8.6 mi

Total Travel Estimate: 8.57 miles - about 17 minutes



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Trip to:
610 S Maple Ave
Oak Park, IL 60304-1091
6.22 miles
13 minutes

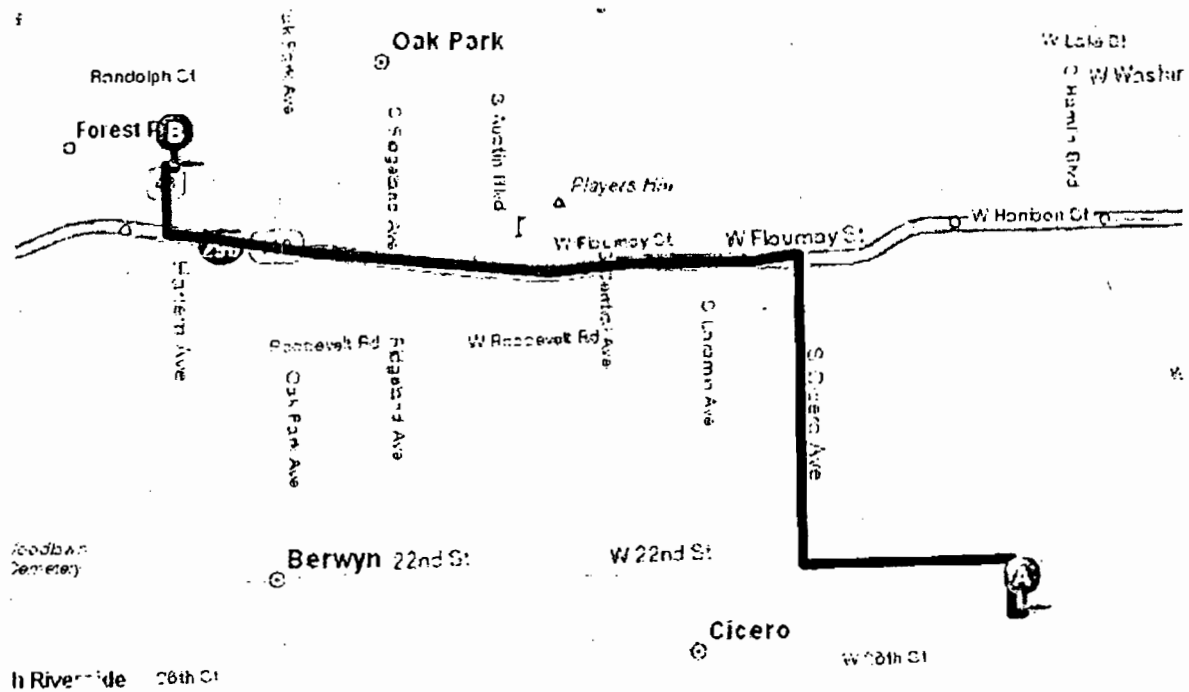
- | | | Miles Per Section |
|---|---|-------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Manas is on the corner</i>
<i>If you reach S Karlov Ave you've gone a little too far</i> | Go 0.3 Mi |
|  | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave</i>
<i>If you reach W 21st Pl you've gone a little too far</i> | Go 1.0 Mi |
|   | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th St</i>
<i>Walgreens is on the corner</i>
<i>If you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
|  | 5. Turn left onto W Floumoy St.
<i>W Floumoy St is just past W Lexington St</i>
<i>If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
|   | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 2.8 Mi |
|  | 7. Take the IL-43 / Harlem Ave exit, EXIT 21B, on the left. | Go 0.3 Mi |
|   | 8. Turn right onto IL-43 / Harlem Ave / S Harlem Ave. | Go 0.3 Mi |
|  | 9. Take the 2nd right onto Monroe St.
<i>Monroe St is just past Adams St</i>
<i>If you reach Madison St you've gone about 0.1 miles too far</i> | Go 0.05 Mi |
|  | 10. Turn right onto S Maple Ave. | Go 0.01 Mi |
|  | 11. 610 S MAPLE AVE is on the left.
<i>If you reach Adams St you've gone a little too far</i> | |



610 S Maple Ave
Oak Park, IL 60304-1091

6.2 mi

Total Travel Estimate: 6.22 miles - about 13 minutes



In Riverside 26th St

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Brightline

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Trip to:
6333 S Green St
Chicago, IL 60621-1943
12.18 miles
20 minutes

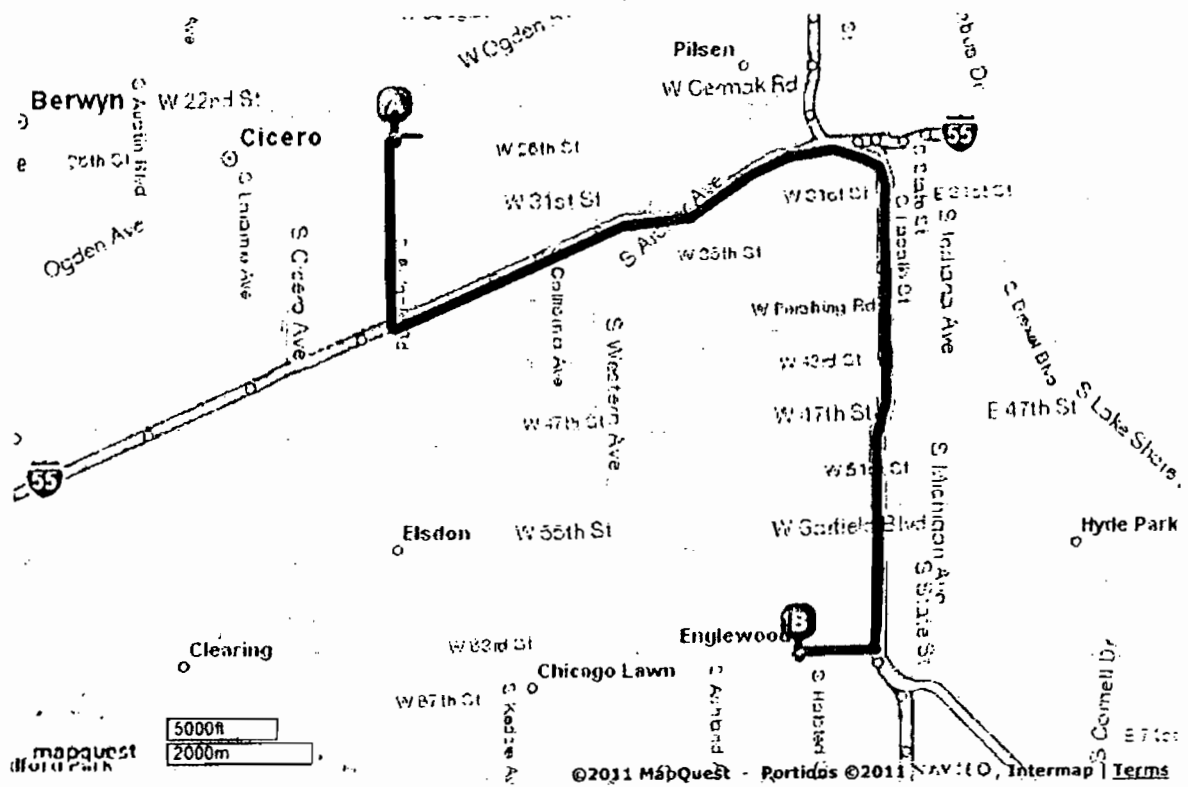
- | | | Miles Per
Section |
|---|--|----------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st left onto S Pulaski Rd.
<i>Las Islas Marias is on the corner
If you reach S Kerlov Ave you've gone a little too far</i> | Go 1.7 Mi |
|   | 3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left. | Go 4.2 Mi |
|   | 4. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana. | Go 0.8 Mi |
|  | 5. Keep left to take I-90 Express Ln E / I-94 Express Ln E / Dan Ryan Express Ln E toward Garfield Blvd. | Go 3.9 Mi |
|   | 6. Merge onto I-90 E / I-94 E / Dan Ryan Expy E toward Skyway / Indiana Toll Rd. | Go 0.5 Mi |
|  | 7. Take EXIT 58B toward 63rd St. | Go 0.2 Mi |
|  | 8. Turn slight left onto S Yale Ave. | Go 0.05 Mi |
|  | 9. Take the 2nd right onto W 63rd St.
<i>W 63rd St is just past W 62nd St
If you reach S Wells St you've gone a little too far</i> | Go 0.7 Mi |
|  | 10. Turn left onto S Green St.
<i>S Green St is just past S Halsted St
US Bank is on the left
If you reach S Peoria Dr you've gone a little too far</i> | Go 0.06 Mi |
|  | 11. 6333 S GREEN ST is on the left.
<i>If you are on S Peoria Dr and reach S Halsted St you've gone about 0.4 miles too far</i> | |



6333 S Green St
Chicago, IL 60621-1943

12.2 mi

Total Travel Estimate: 12.18 miles - about 20 minutes



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Notes

Trip to:
Mt Sinai Medical Center
15th & California St # L614
Chicago, IL 60608
(773) 257-6745
2.02 miles
5 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

Las Islas Manas is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 1st right onto W Ogden Ave.

Go 1.7 Mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn right onto S California Ave.

Go 0.08 Mi

S California Ave is 0.3 miles past S Sacramento Dr

If you reach S Fairland Ave you've gone a little too far



5. 15TH & CALIFORNIA ST # L614.

Your destination is just past W Ogden Ave

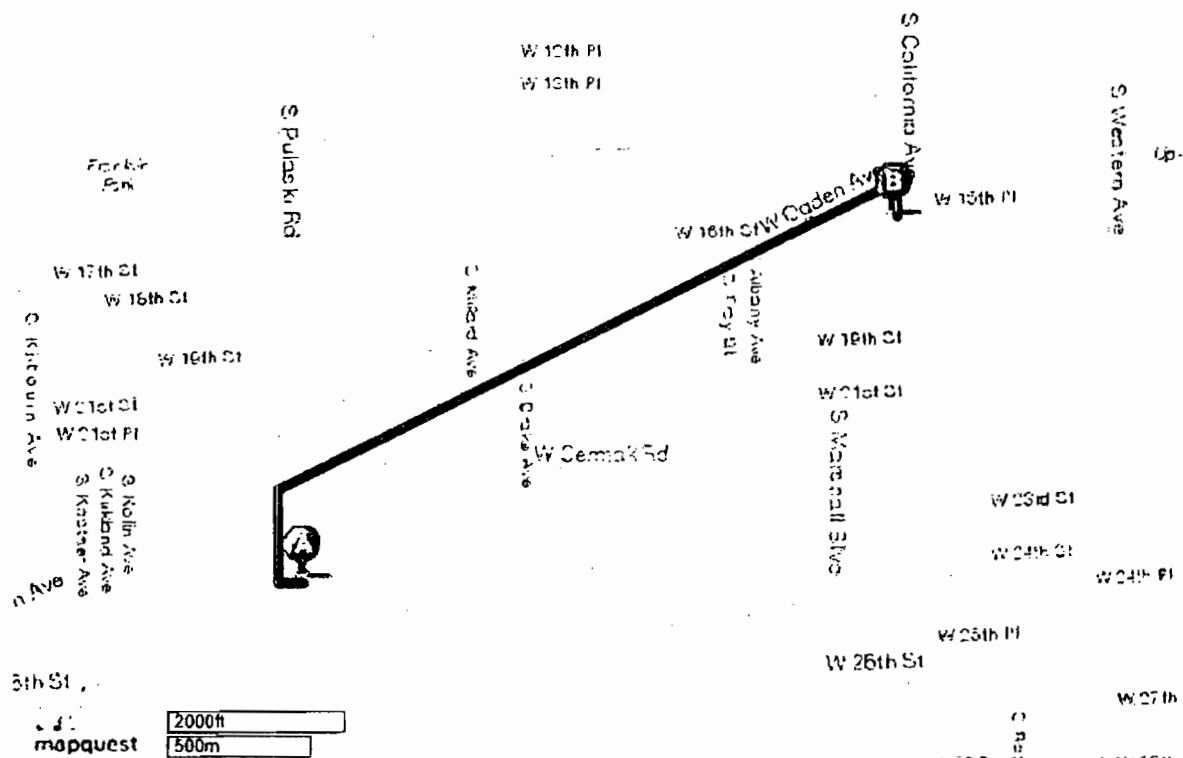
If you reach W 15th Pl you've gone a little too far



Mt Sinai Medical Center
15th & California St # L614, Chicago, IL 60608
(773) 257-6745

2.0 mi

Total Travel Estimate: 2.02 miles - about 5 minutes



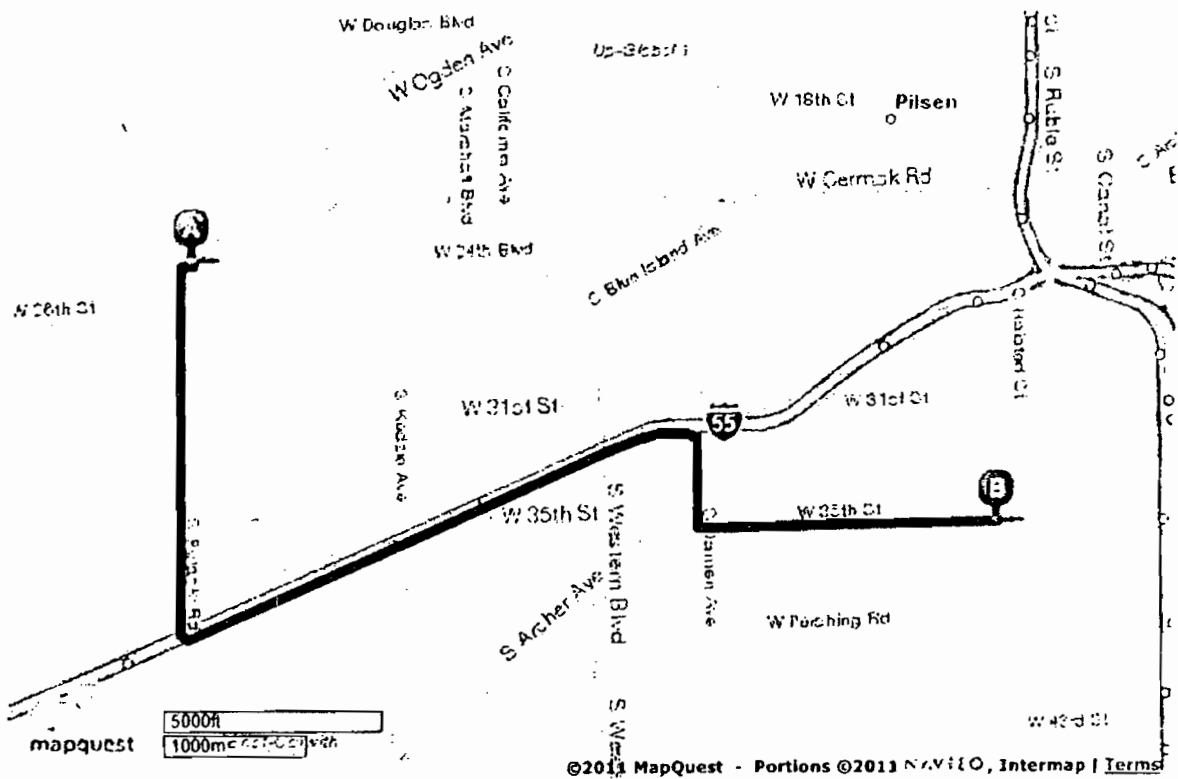
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Trip to:
825 W 35th St
Chicago, IL 60609-1511
6.37 miles
14 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Manas is on the corner</i> <i>If you reach S Kerlov Ave you've gone a little too far</i>	Go 1.7 Mi
 	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 2.2 Mi
	4. Take the Damen Ave exit, EXIT 290, toward Ashland Ave.	Go 0.2 Mi
	5. Keep left to take the Damen Ave ramp.	Go 0.2 Mi
	6. Keep right at the fork to go on S Damen Ave.	Go 0.5 Mi
	7. Turn left onto W 35th St. <i>W 35th St is just past W 34th St</i> <i>Papa Freddy's Pizza is on the corner</i> <i>If you reach W 36th St you've gone about 0.1 miles too far</i>	Go 1.5 Mi
	8. 825 W 35TH ST is on the right. <i>If you reach S Halsted St you've gone a little too far</i>	
	825 W 35th St Chicago, IL 60609-1511	6.4 mi

Total Travel Estimate: 6.37 miles - about 14 minutes



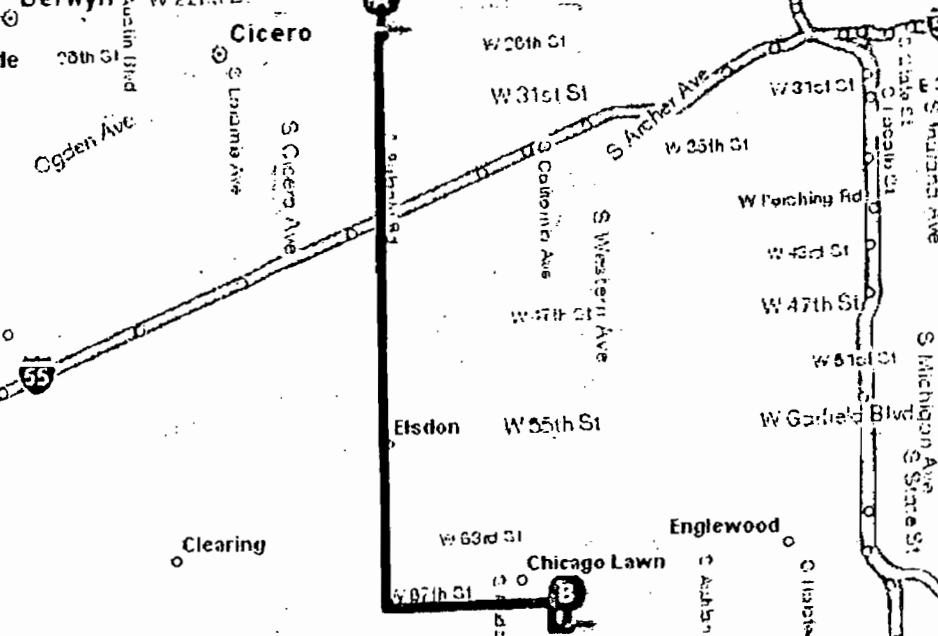
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Notes

Trip to:
2534 W 69th St
Chicago, IL 60629
7.43 miles
20 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 5.3 Mi
	3. Turn left onto W Marquette Rd / W 67th St <i>W Marquette Rd is just past W 66th Pl</i> <i>On the Go AMOCO is on the corner</i> <i>If you reach W 67th Pl you've gone a little too far</i>	Go 1.6 Mi
	4. Turn right onto S Washtenaw Ave. <i>S Washtenaw Ave is just past S Fairfield Ave</i> <i>If you reach S Talman Ave you've gone a little too far</i>	Go 0.3 Mi
	5. Take the 2nd left onto W 69th St / W Lithuanian Plaza Ct. <i>W 69th St is 0.1 miles past W 56th St</i> <i>Godley's Home Day Care is on the corner</i> <i>If you reach W 70th St you've gone about 0.1 miles too far</i>	Go 0.2 Mi
	6. 2534 W 69TH ST is on the left. <i>Your destination is just past S Rockwell St</i> <i>If you reach S Maplewood Ave you've gone a little too far</i>	
	2534 W 69th St Chicago, IL 60629	7.4 mi



325

Trip to:
1111 Superior St
Melrose Park, IL 60160-4138
9.31 miles
19 minutes

- | | | Miles Per
Section |
|---|---|----------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Marianas is on the corner.
If you reach S Karlov Ave you've gone a little too far</i> | Go 0.3 Mi |
|  | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave
If you reach W 21st Pl you've gone a little too far</i> | Go 1.0 Mi |
|   | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th Ct
Walgreens is on the corner
If you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
|  | 5. Turn left onto W Flournoy St.
<i>W Flournoy St is just past W Lexington St
If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
|   | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 4.4 Mi |
|  | 7. Take the IL-171 / 1st Ave exit, EXIT 20. | Go 0.1 Mi |
|  | 8. Stay straight to go onto Harrison St. | Go 0.07 Mi |
|   | 9. Take the 1st right onto S 1st Ave / IL-171.
<i>KFC is on the corner
If you reach S 2nd Ave you've gone a little too far</i> | Go 1.2 Mi |
|  | 10. Turn left onto Lake St.
<i>Lake St is just past Main St
Walgreens is on the left
If you reach Ohio St you've gone a little too far</i> | Go 0.7 Mi |
| | 11. Turn right onto N 11th Ave. | |



*N 11th Ave is just past N 10th Ave
if you reach N 12th Ave you've gone a little too far*

Go 0.08 Mi



12. Take the 1st left onto Superior St.

Go 0.01 Mi

*Medical Arts Pharmacy in Westlake Hospital Pro Bldg is on the left
if you reach Chicago Ave you've gone a little too far*



13. 1111 SUPERIOR ST is on the left.

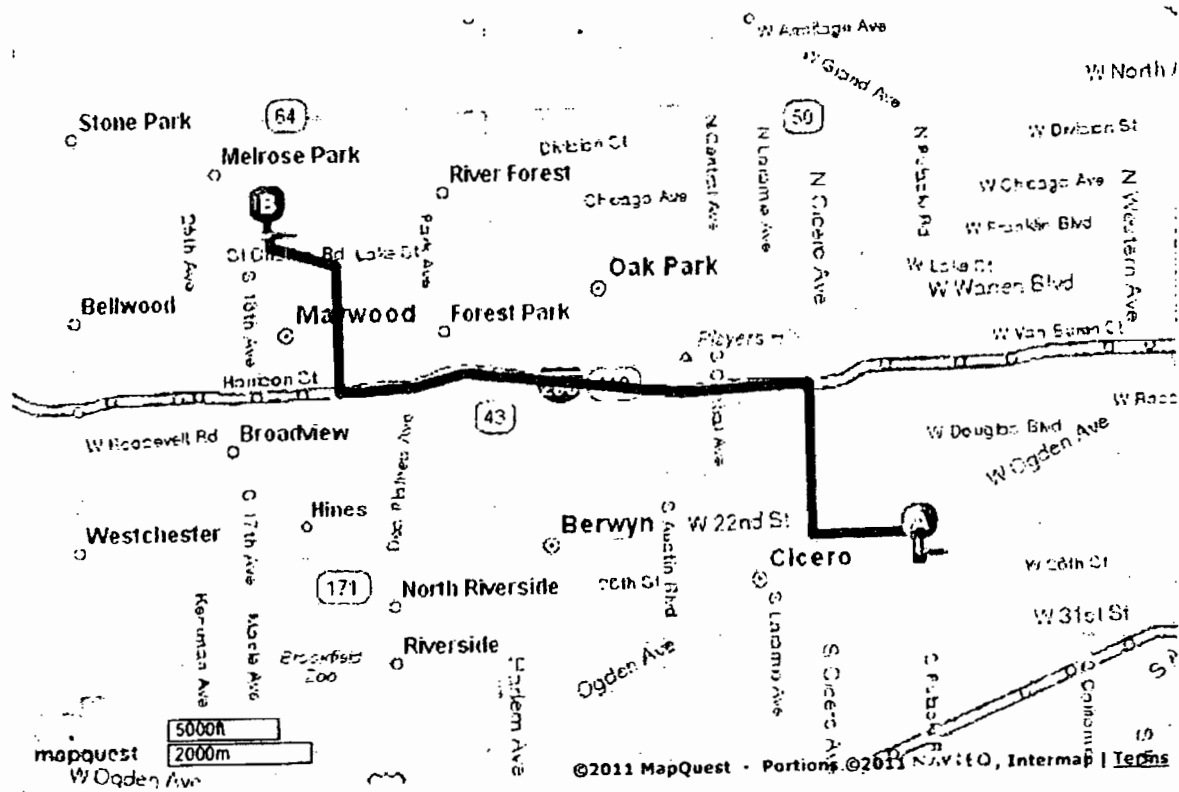
if you reach N 12th Ave you've gone a little too far



**1111 Superior St
Melrose Park, IL 60160-4138**

9.3 mi

Total Travel Estimate: 9.31 miles - about 19 minutes



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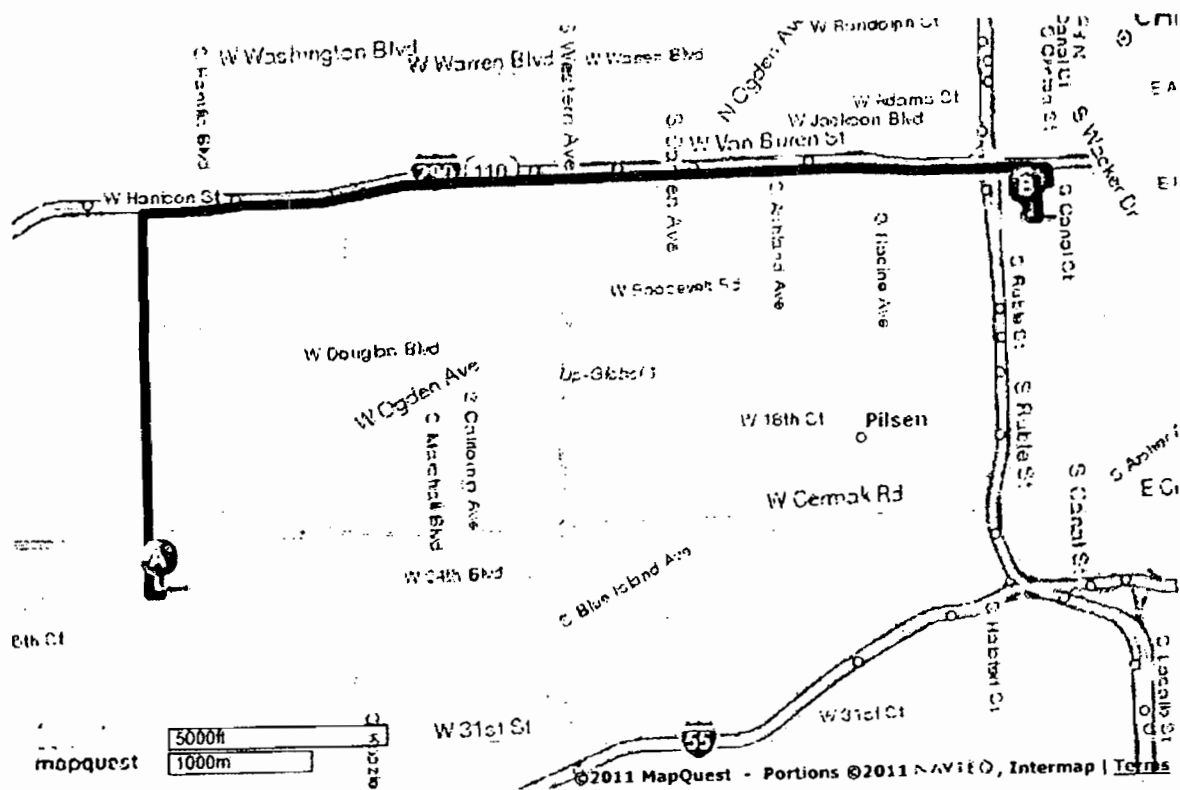
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Notes

Trip to:
557 W Polk St
Chicago, IL 60607-4388
6.58 miles
13 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st right onto S Pulaski Rd. <i>Las Islas Marías is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi
	3. Turn right onto W Harrison St. <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pkwy you've gone a little too far</i>	Go 0.3 Mi
 	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 4.0 Mi
	5. Take the exit toward Canal St.	Go 0.2 Mi
	6. Turn right onto W Harrison St. <i>Holiday Inn Hotel & Suites Chicago-Downtown is on the right</i>	Go 0.06 Mi
	7. Take the 1st left onto S Clinton St. <i>Harrison Grill is on the right</i> <i>If you reach S Jefferson St you've gone a little too far</i>	Go 0.2 Mi
	8. Take the 3rd right onto W Polk St. <i>W Polk St is just past W Lexington St</i> <i>Polk Street Pub is on the right</i> <i>If you reach W Cermak St you've gone a little too far</i>	Go 0.04 Mi
	9. 557 W POLK ST is on the left. <i>If you reach S Jefferson St you've gone a little too far</i>	6.6 mi

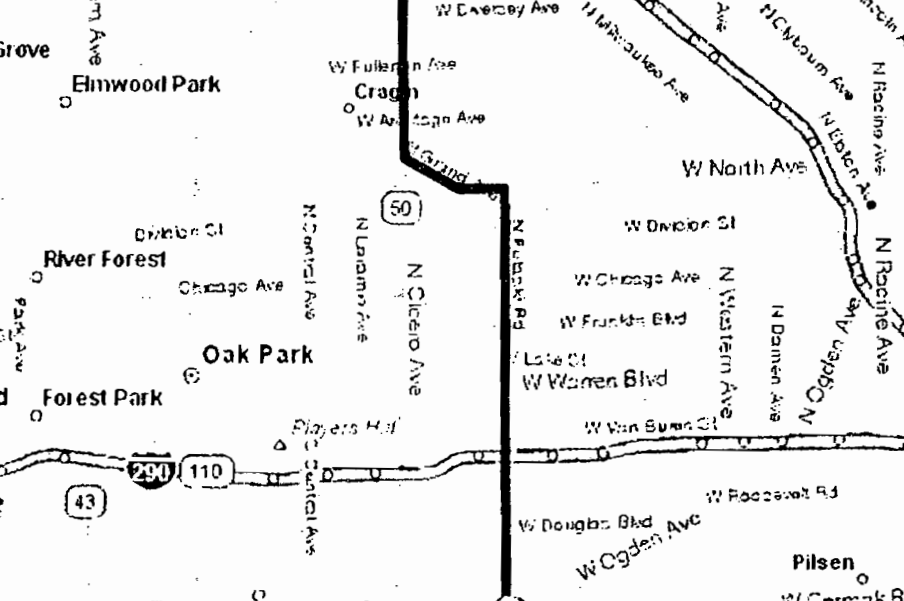
Total Travel Estimate: 6.58 miles - about 13 minutes



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Trip to:
4848 W Belmont Ave
Chicago, IL 60641-4329
7.23 miles
21 minutes

- | | | |
|---|---|------------------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | Miles Per
Section |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Manas is on the corner</i>
<i>If you reach S Karlov Ave you've gone a little too far</i> | Go 4.3 Mi |
|  | 3. Turn left onto W North Ave / IL-64.
<i>W North Ave is 0.1 miles past W Le Moyne St</i>
<i>Banco Popular is on the corner</i>
<i>If you reach W Wabansia Ave you've gone about 0.1 miles too far</i> | Go 0.5 Mi |
|  | 4. Turn slight right onto W Grand Ave.
<i>W Grand Ave is just past N Lowell Ave</i>
<i>Mc Donald's is on the corner</i> | Go 0.6 Mi |
|  | 5. Turn right onto N Cicero Ave / IL-50.
<i>N Cicero Ave is just past N Keating Ave</i>
<i>Las Islas Manas is on the right</i>
<i>If you reach N La Crosse Ave you've gone about 0.1 miles too far</i> | Go 1.7 Mi |
|  | 6. Turn left onto W Belmont Ave.
<i>W Belmont Ave is just past W Fletcher St</i>
<i>Deita Restaurant is on the corner</i>
<i>If you reach W Melrose St you've gone a little too far</i> | Go 0.07 Mi |
|  | 7. 4848 W BELMONT AVE is on the right.
<i>If you reach N Lamon Ave you've gone a little too far</i> | |
|  | 4848 W Belmont Ave
Chicago, IL 60641-4329 | 7.2 mi |



332

Trip to:
719 W North Ave
Melrose Park, IL 60160-1612
10.31 miles
21 minutes

- | | | Miles Per
Section |
|--|--|----------------------|
| | 3934 W 24th St
Chicago, IL 60623-3371 | |
| | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
| | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Marias is on the corner</i>
<i>If you reach S Kurlov Ave you've gone a little too far</i> | Go 0.3 Mi |
| | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave</i>
<i>If you reach W 21st St you've gone a little too far</i> | Go 1.0 Mi |
| | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th Ct</i>
<i>Walgreens is on the corner</i>
<i>If you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
| | 5. Turn left onto W Flournoy St.
<i>W Flournoy St is just past W Lexington St</i>
<i>If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
| | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 4.4 Mi |
| | 7. Take the IL-171 / 1st Ave exit, EXIT 20. | Go 0.1 Mi |
| | 8. Stay straight to go onto Harrison St. | Go 0.07 Mi |
| | 9. Take the 1st right onto S 1st Ave / IL-171.
<i>KFC is on the corner</i>
<i>If you reach S 2nd Ave you've gone a little too far</i> | Go 2.5 Mi |
| | 10. Turn left onto W North Ave / IL-64 W.
<i>W North Ave is 0.4 miles past Braddock Dr</i>
<i>If you are on N 1st Ave and reach N Des Plaines River Rd you've gone about 0.5 miles too far</i> | Go 0.4 Mi |
| | 11. 719 W NORTH AVE is on the left.
<i>Your destination is 0.1 miles past N 5th Ave</i> | |

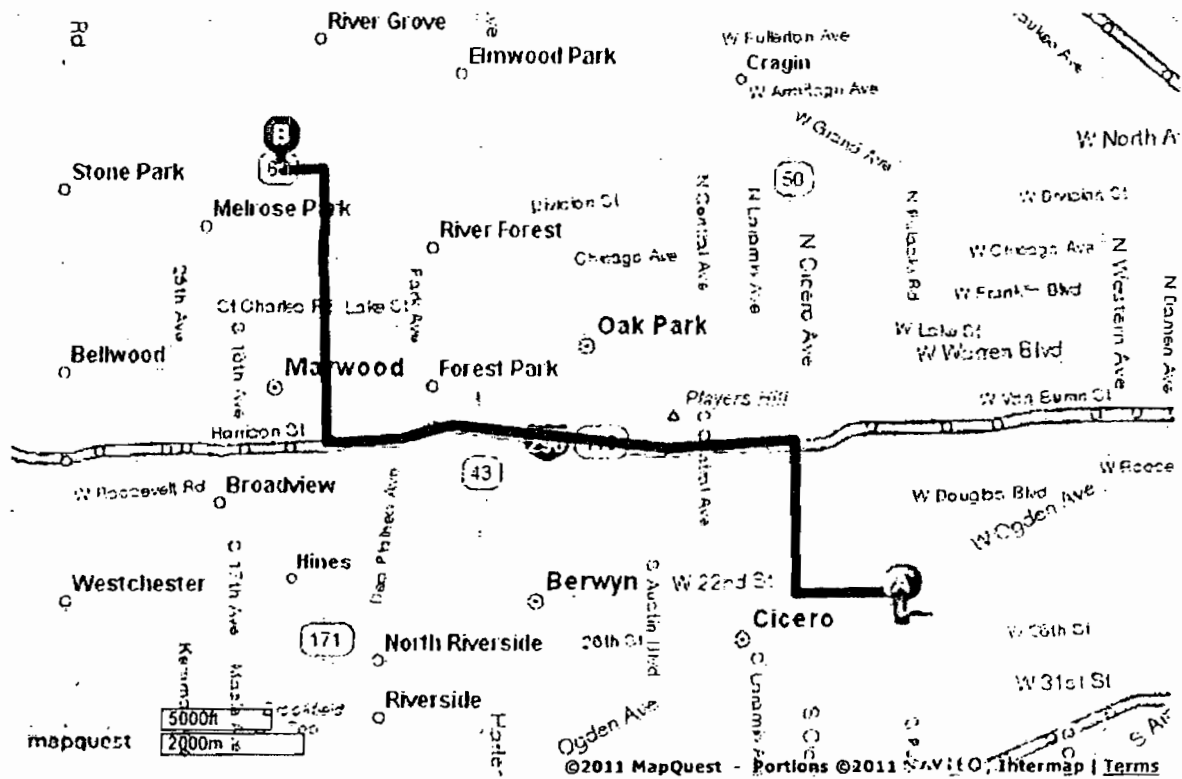
if you reach N 9th Ave you've gone about 0.1 miles too far



719 W North Ave
Melrose Park, IL 60160-1612

10.3 mi

Total Travel Estimate: 10.31 miles - about 21 minutes



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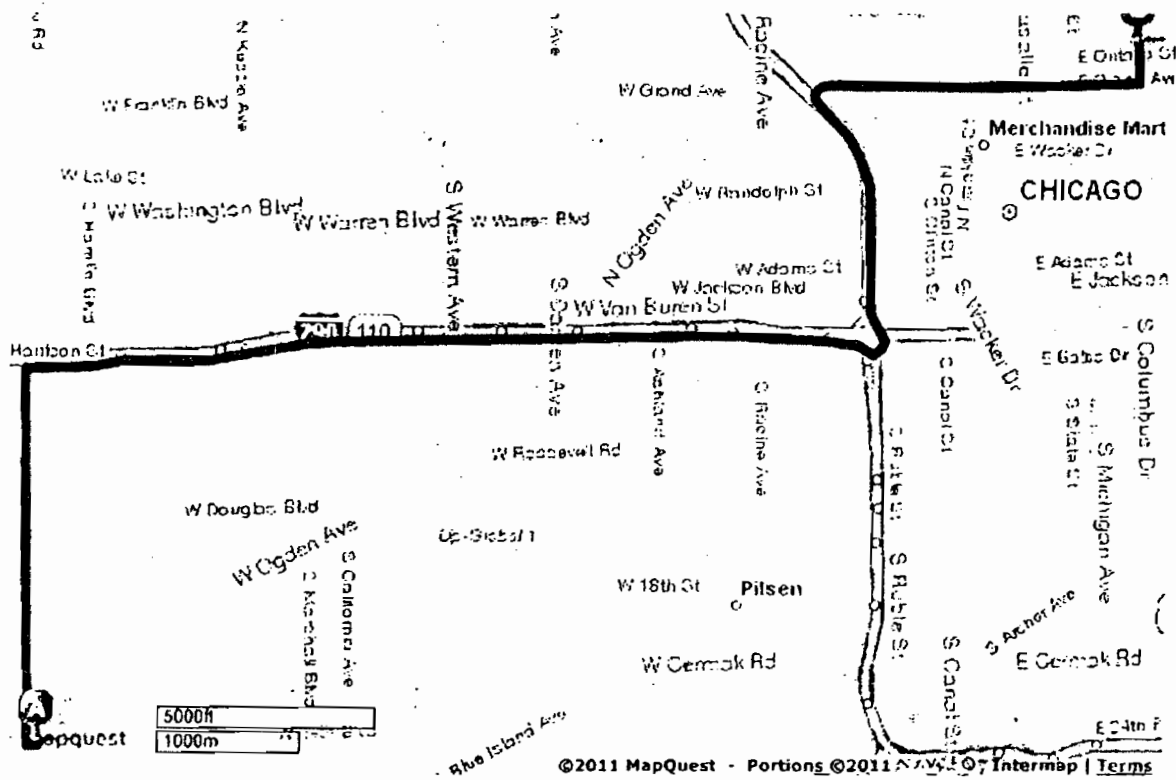
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Notes

Trip to:
710 N Fairbanks Ct
Chicago, IL 60611-3013
9.13 miles
18 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st right onto S Pulaski Rd. <i>Las Isles Marras is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.8 Mi
	3. Turn right onto W Harrison St. <i>W Harrison St is just past W 5th Ave</i> <i>Mary's Restaurant is on the left</i> <i>If you reach W Congress Pky you've gone a little too far</i>	Go 0.3 Mi
 	4. Merge onto I-290 E / IL-110 E / Chicago-Kansas City Expy / Eisenhower Expy E via the ramp on the left.	Go 3.6 Mi
 	5. Merge onto I-90 W / I-94 W / Kennedy Expy W toward Wisconsin.	Go 1.5 Mi
	6. Take EXIT 50B toward East Ohio St.	Go 0.8 Mi
	7. Stay straight to go onto W Ohio St.	Go 0.9 Mi
	8. Turn left onto N Fairbanks Ct. <i>N Fairbanks Ct is 0.1 miles past N St Clair St</i> <i>Doubletree Hotel is on the corner</i> <i>If you reach N McClurg Ct you've gone about 0.1 miles too far</i>	Go 0.2 Mi
	9. 710 N FAIRBANKS CT is on the left. <i>Your destination is just past E Huron St</i> <i>If you reach E Superior St you've gone a little too far</i>	
	710 N Fairbanks Ct Chicago, IL 60611-3013	9.1 mi

Total Travel Estimate: 9.13 miles - about 18 minutes



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Trip to:
733 Madison St
Oak Park, IL 60302-4419
7.09 miles
15 minutes

- | | 3934 W 24th St
Chicago, IL 60623-3371 | Miles Per
Section |
|---|---|----------------------|
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Marias is on the corner
if you reach S Karlov Ave you've gone a little too far</i> | Go 0.3 Mi |
|  | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave
if you reach W 21st St you've gone a little too far</i> | Go 1.0 Mi |
|   | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th Ct
Walgreens is on the corner
if you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
|  | 5. Turn left onto W Flournoy St.
<i>W Flournoy St is just past W Lexington St
if you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
|   | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 2.8 Mi |
|  | 7. Take the IL-43 / Harlem Ave exit, EXIT 21B, on the left. | Go 0.3 Mi |
|   | 8. Turn right onto IL-43 / Harlem Ave / S Harlem Ave. | Go 0.5 Mi |
|  | 9. Turn right onto Washington Blvd.
<i>Washington Blvd is 0.1 miles past Madison St
Fuji Grill is on the left
if you reach Randolph St you've gone about 0.1 miles too far</i> | Go 0.5 Mi |
|  | 10. Turn right onto S Oak Park Ave.
<i>S Oak Park Ave is just past S Grove Ave
if you reach S Euclid Ave you've gone a little too far</i> | Go 0.1 Mi |
| | 11. Take the 1st left onto Madison St. | |



if you reach Adams St you've gone about 0.1 miles too far

Go 0.05 Mi



12. 733 MADISON ST is on the right

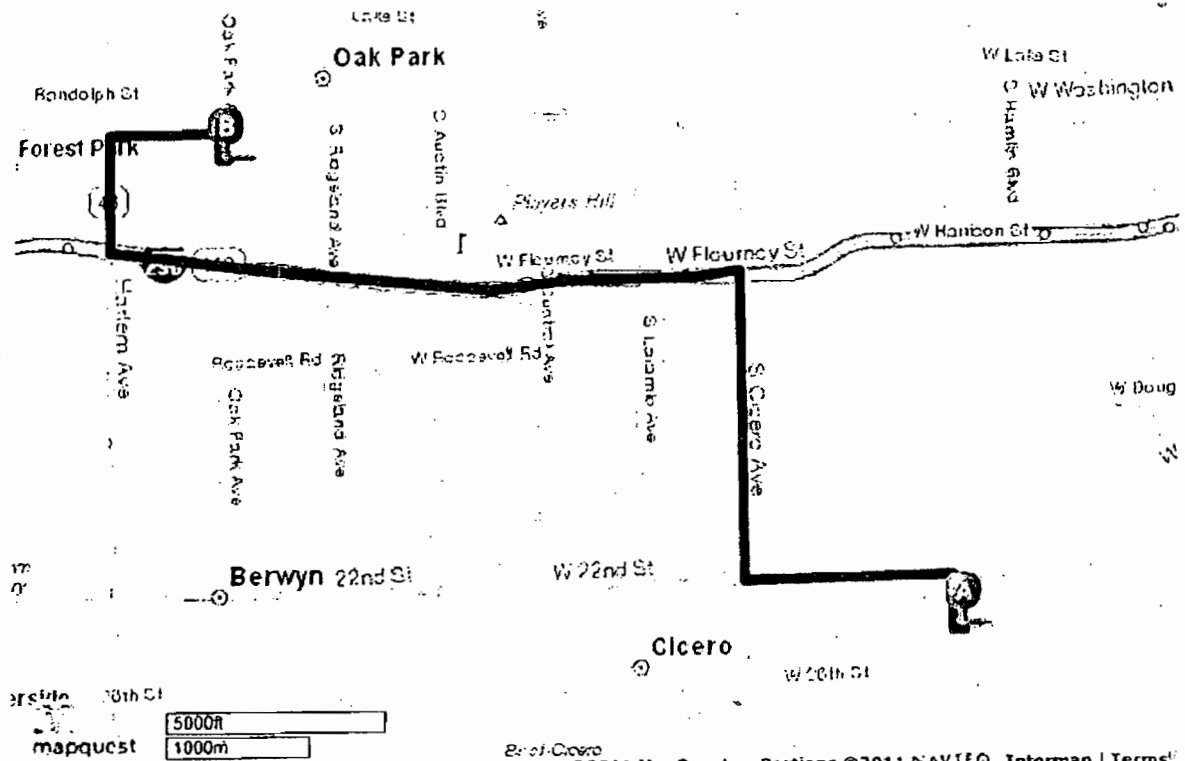
if you reach S Euclid Ave you've gone a little too far



**733 Madison St
Oak Park, IL 60302-4419**

7.1 mi

Total Travel Estimate: 7.09 miles - about 15 minutes



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Notes

Trip to:
5401 S Wentworth Ave
Chicago, IL 60609-6300
10.60 miles
17 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Marias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi
 	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 4.2 Mi
 	4. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana.	Go 0.8 Mi
	5. Keep left to take I-90 Express Ln E / I-94 Express Ln E / Dan Ryan Express Ln E toward Garfield Blvd.	Go 2.2 Mi
	6. Take the I-90-LOCAL / I-94-LOCAL exit.	Go 0.3 Mi
 	7. Merge onto I-90 E / I-94 E / Dan Ryan Expy E.	Go 0.8 Mi
	8. Take EXIT 57 toward Garfield Blvd.	Go 0.2 Mi
	9. Stay straight to go onto S Wells St.	Go 0.09 Mi
	10. Take the 1st left onto W Garfield Blvd / W 55th St. <i>Savik Mobil is on the corner</i> <i>If you reach W 57th St you've gone about 0.2 miles too far</i>	Go 0.07 Mi
	11. Take the 1st left onto S Wentworth Ave. <i>Chicago City Church AG is on the corner</i> <i>If you reach S Lashlie St you've gone a little too far</i>	Go 0.1 Mi



12. 5401 S WENTWORTH AVE is on the right.
If you reach W 53rd St you've gone about 0.1 miles too far



5401 S Wentworth Ave
Chicago, IL 60609-6300

10.6 mi

343

mapquest

Notes

Trip to:
[1600-1799] S Wabash Ave
Chicago, IL 60616
8.10 miles
15 minutes

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Islas Menas is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi
	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 4.9 Mi
	4. Take the Cermak Rd exit, EXIT 293A, toward Chinatown.	Go 0.7 Mi
	5. Turn right onto W Cermak Rd / W 22nd St. <i>If you are on W Cermak Rd and reach S Wentworth Ave you've gone a little too far</i>	Go 0.2 Mi
	6. Turn left onto S State St. <i>S State St is 0.1 miles past S Federal St</i> <i>Jerusalem Finest Inc is on the corner</i> <i>If you are on E Cermak Rd and reach S Wabash Ave you've gone a little too far</i>	Go 0.3 Mi
	7. Take the 3rd right onto E 18th St. <i>E 18th St is just past S Archer Ave</i> <i>If you reach W 17th St you've gone a little too far</i>	Go 0.08 Mi
	8. Take the 1st left onto S Wabash Ave. <i>If you reach S Michigan Ave you've gone a little too far</i>	Go 0.08 Mi
	9. [1600-1799] S WABASH AVE. <i>If you reach E 16th St you've gone a little too far</i>	
	[1600-1799] S Wabash Ave Chicago, IL 60616	8.1 mi

[illegible]

345

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Notes

Trip to:
4651 W 79th St
Chicago, IL 60652-1186
7.76 miles
18 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st left onto S Pulaski Rd.

Go 1.7 Mi

Las Islas Mangos is on the corner

If you reach S Kenoy Ave you've gone a little too far



3. Merge onto I-55 S / Stevenson Expy S.

Go 0.8 Mi



4. Take the IL-50 / Cicero Ave exit, EXIT 286, toward Chicago Midway Airport. Go 0.3 Mi



5. Turn left onto IL-50 S / S Cicero Ave. Continue to follow IL-50 S.

Go 4.8 Mi

If you reach I-55 S you've gone about 0.3 miles too far



6. Turn left onto W 79th St.

Go 0.2 Mi

W 79th St is 0.1 miles past W 76th St

Villas Bakery is on the corner

If you reach W 81st St you've gone about 0.2 miles too far



7. 4651 W 79TH ST is on the left.

Your destination is just past S Kipparick Ave

If you reach S Knox Ave you've gone a little too far

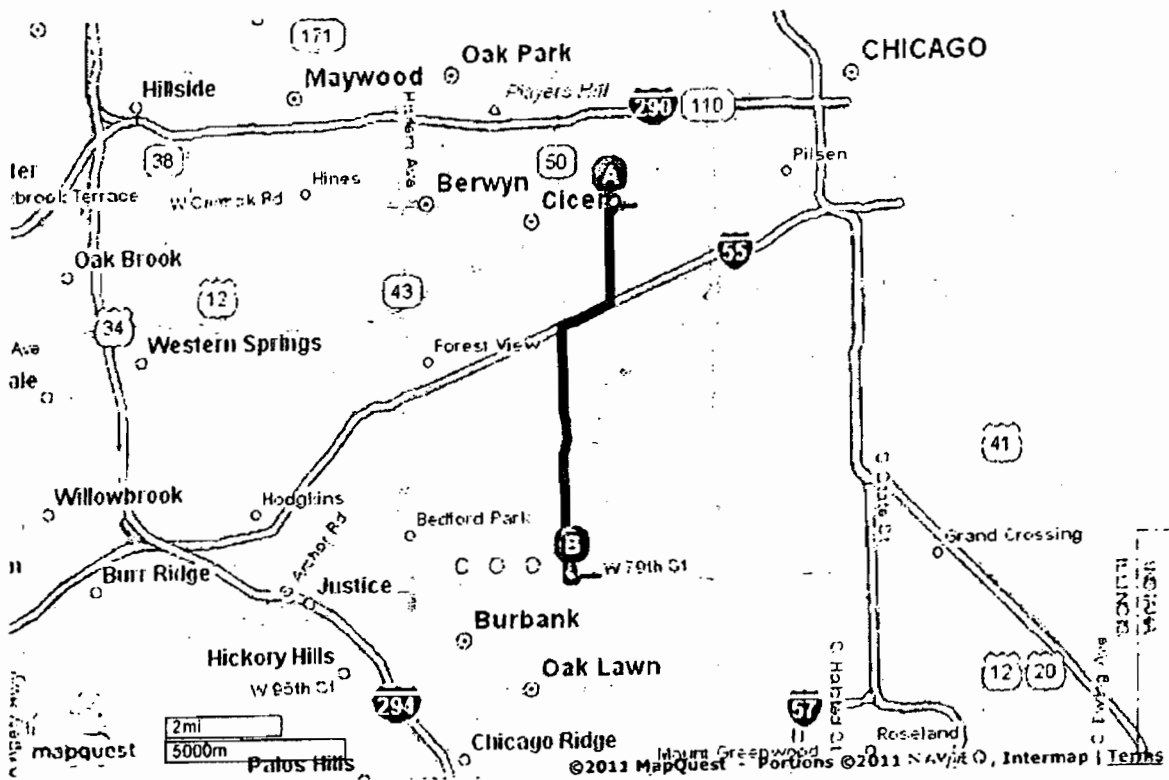


4651 W 79th St
Chicago, IL 60652-1186

7.8 mi

C

Total Travel Estimate: 7.76 miles - about 18 minutes



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Notes

Trip to:
1653 W Congress Pkwy
Chicago, IL 60612-3833
3.74 miles
10 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

Las Islas Manas is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 1st right onto W Ogden Ave.

Go 3.2 Mi

If you are on S Pulaski Rd and reach W Cermak Rd! you've gone a little too far



4. Turn slight right onto W Congress Pky.

Go 0.3 Mi

W Congress Pky is just past S Wolcott Ave

If you reach W Van Buren St you've gone about 0.1 miles too far



5. 1653 W CONGRESS PKWY.

Your destination is just past S Paulina St

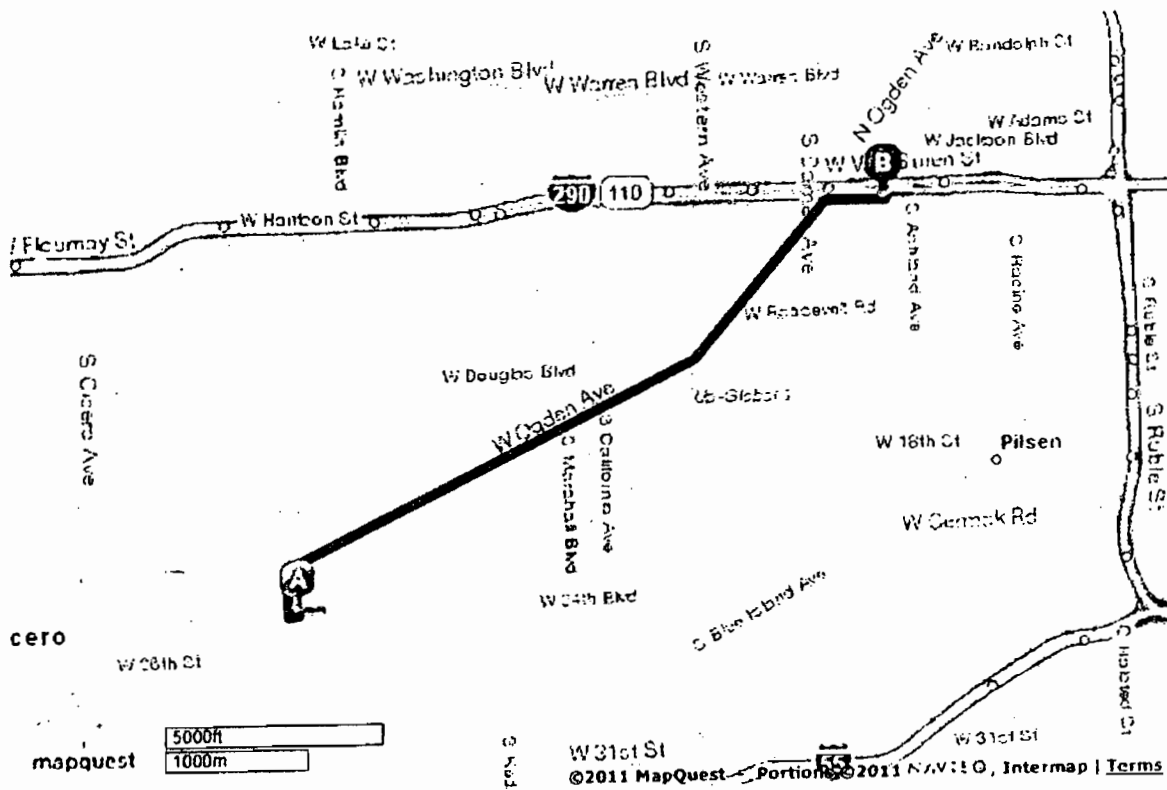
If you reach S Ashland Ave you've gone a little too far



1653 W Congress Pkwy
Chicago, IL 60612-3833

3.7 mi

Total Travel Estimate: 3.74 miles - about 10 minutes



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Notes

Trip to:
7721 S Western Ave
Chicago, IL 60620-5821
9.10 miles
22 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd. Go 0.06 Mi



2. Take the 1st left onto S Pulaski Rd.

Go 6.8 Mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Turn left onto W 79th St.

Go 2.0 Mi

W 79th St is 0.1 miles past W 78th St

White Castle is on the corner

If you reach W 80th St you've gone about 0.2 miles too far



4. Turn left onto S Western Ave.

Go 0.2 Mi

S Western Ave is just past S Artoisan Ave

Subway is on the corner

If you reach S Claremont Ave you've gone a little too far



5. 7721 S WESTERN AVE is on the right.

Your destination is just past W 78th St

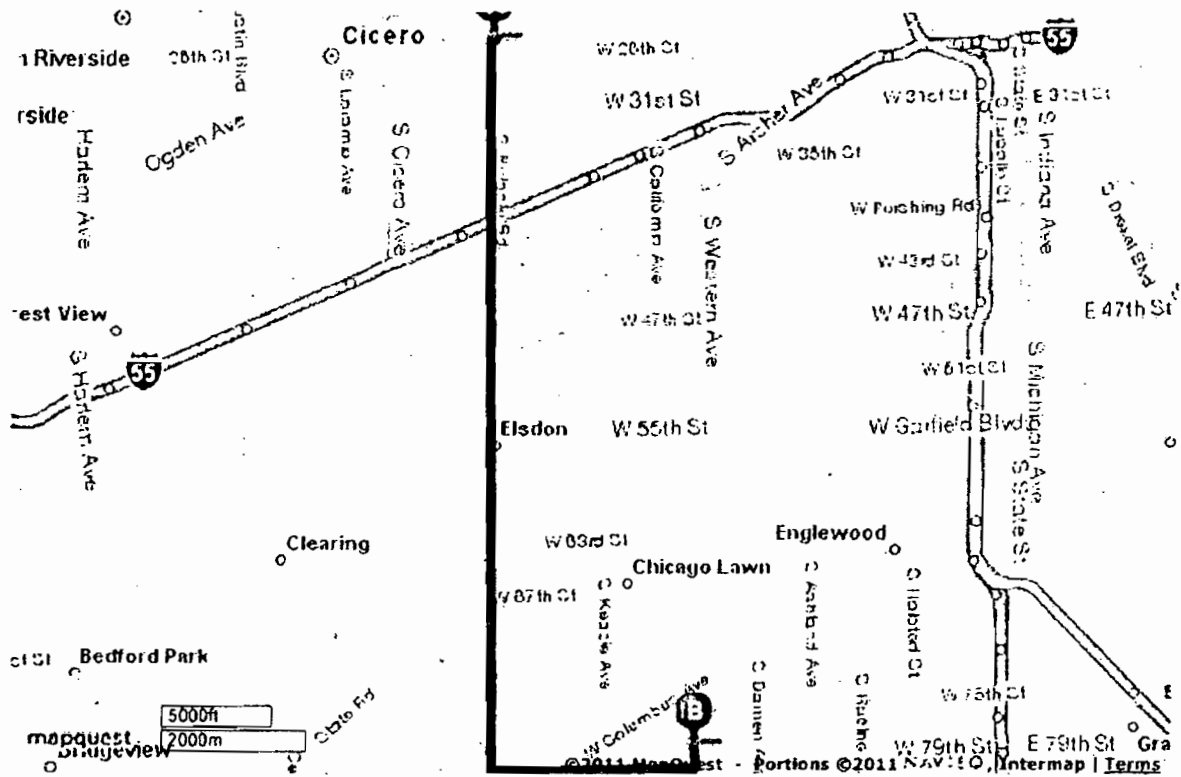
If you reach W 77th St you've gone a little too far



7721 S Western Ave
Chicago, IL 60620-5821

9.1 mi

Total Travel Estimate: 9.10 miles - about 22 minutes



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Trip to:
9115 S Cicero Ave
Oak Lawn, IL 60453-1895
9.14 miles
21 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st left onto S Pulaski Rd.

Go 1.7 Mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Merge onto I-55 S / Stevenson Expy S.

Go 0.8 Mi



4. Take the IL-50 / Cicero Ave exit, EXIT 286, toward Chicago Midway Airport. Go 0.3 Mi



5. Turn left onto IL-50 S / S Cicero Ave. Continue to follow IL-50 S.

Go 6.3 Mi

If you reach I-55 S you've gone about 0.3 miles too far



6. 9115 S CICERO AVE is on the left.

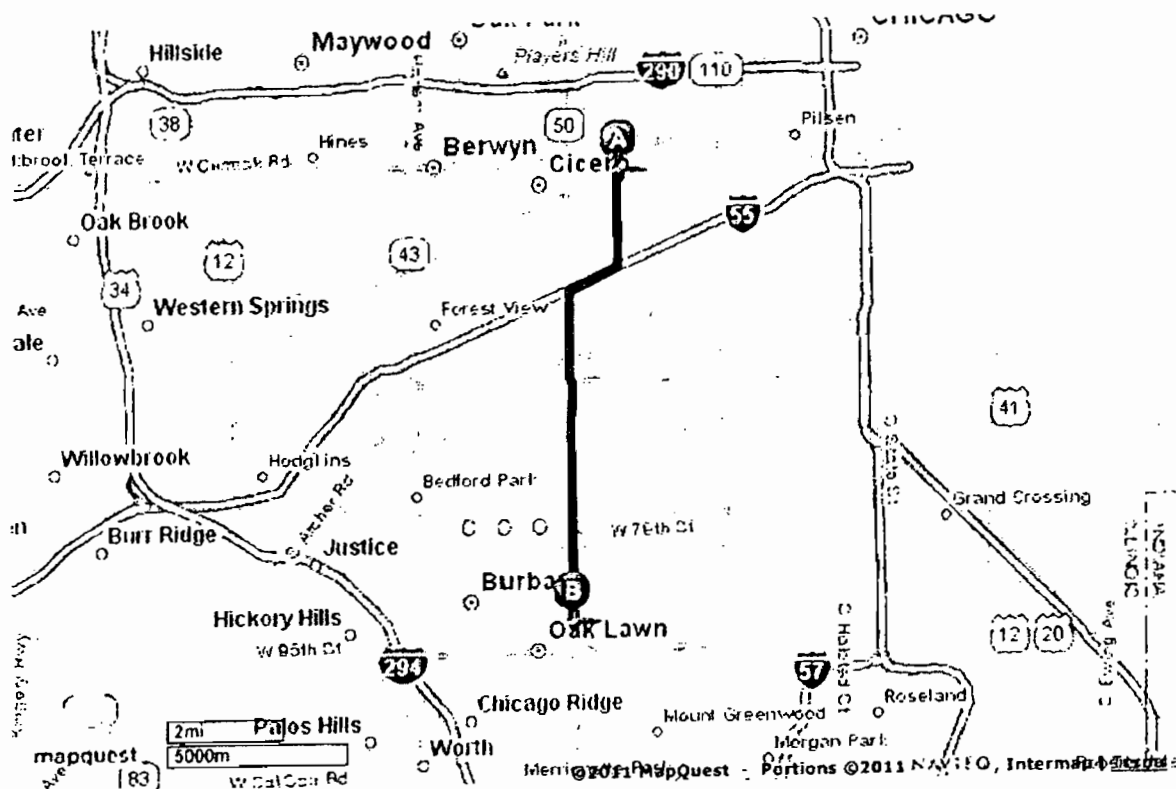
Your destination is just past W 91st St

If you reach W 91st St you've gone a little too far

9115 S Cicero Ave
Oak Lawn, IL 60453-1895

9.1 mi

Total Travel Estimate: 9.14 miles - about 21 minutes



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Trip to:
1740 W Taylor St
Chicago, IL 60612-7232
3.43 miles
9 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

Las Islas Marias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Take the 1st right onto W Ogden Ave.

Go 2.6 Mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn slight right onto W Taylor St.

Go 0.5 Mi

W Taylor St is 0.2 miles past W Roosevelt Rd

Lulu's Hot Dogs is on the corner

If you reach W Polk St you've gone about 0.2 miles too far



5. 1740 W TAYLOR ST is on the left.

Your destination is just past S Wood St

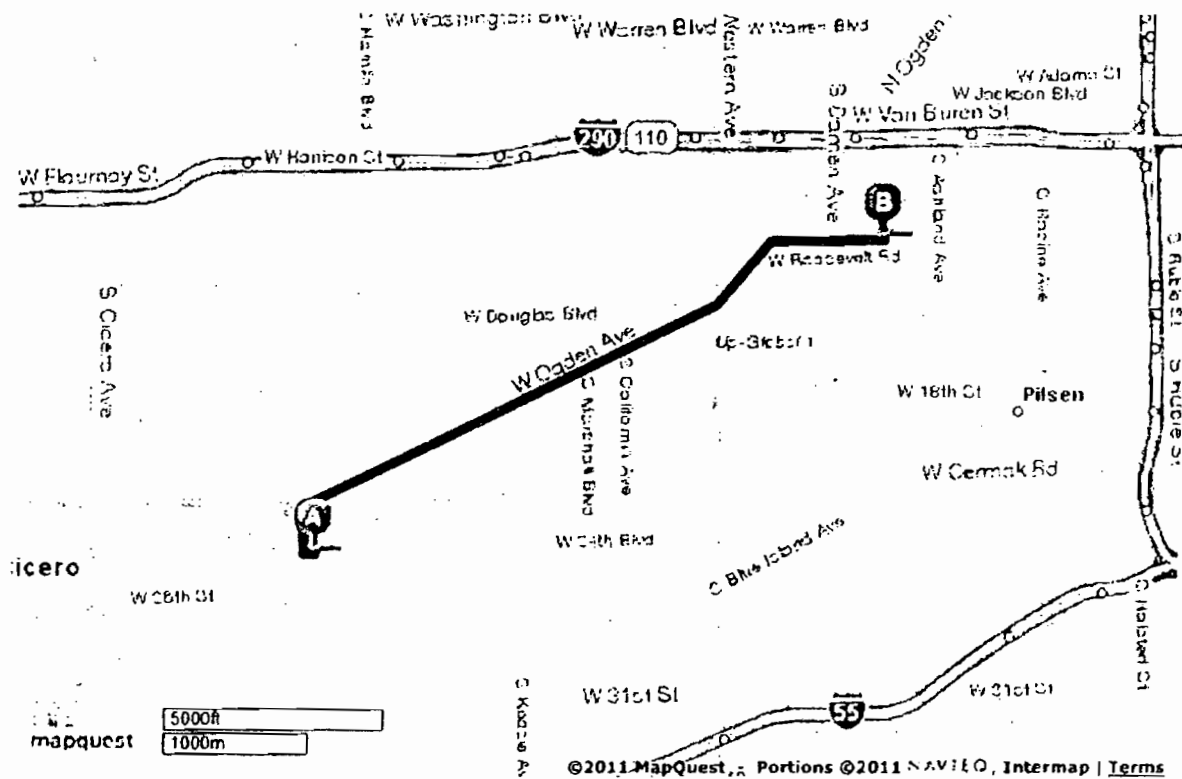
If you reach S Hermitage Ave you've gone a little too far



1740 W Taylor St
Chicago, IL 60612-7232

3.4 mi

Total Travel Estimate: 3.43 miles - about 9 minutes



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Notes

Trip to:
7000 S Pulaski Rd
Chicago, IL 60629-5842
5.79 miles
15 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd. Go 0.06 Mi



2. Take the 1st left onto S Pulaski Rd.

Go 5.7 Mi

Las Islas Martes is on the corner

If you reach S Karlov Ave you've gone a little too far



3. 7000 S PULASKI RD is on the right.

Your destination is just past W 70th St

If you reach W 70th Pl you've gone a little too far



7000 S Pulaski Rd
Chicago, IL 60629-5842

5.8 mi

The map shows a proposed rail line (indicated by a thick black line with a double line) running from Elsdon in the south to Cicero in the north. The line follows a path that is roughly parallel to I-55, which runs diagonally from the bottom left towards the top right. Key locations and streets shown include:

- Northwest:** Cicero, Berwyn, North Riverside, Riverside, Forest View, Forest View.
- Central:** Elsdon, Chicago Lawn, Englewood.
- Southeast:** Clearing, Bedford Park.
- Streets:** W 22nd St, W 28th St, W 31st St, W 35th St, W 40th St, W 47th St, W 55th St, W 67th St, W 78th St, W 81st St, W 84th St, W 87th St, W 90th St, W 93rd St, W 96th St, W 99th St, W 102nd St, W 105th St, W 108th St, W 111th St, W 114th St, W 117th St, W 120th St, W 123rd St, W 126th St, W 129th St, W 132nd St, W 135th St, W 138th St, W 141st St, W 144th St, W 147th St, W 150th St, W 153rd St, W 156th St, W 159th St, W 162nd St, W 165th St, W 168th St, W 171st St, W 174th St, W 177th St, W 180th St, W 183rd St, W 186th St, W 189th St, W 192nd St, W 195th St, W 198th St, W 201st St, W 204th St, W 207th St, W 210th St, W 213rd St, W 216th St, W 219th St, W 222nd St, W 225th St, W 228th St, W 231st St, W 234th St, W 237th St, W 240th St, W 243rd St, W 246th St, W 249th St, W 252nd St, W 255th St, W 258th St, W 261st St, W 264th St, W 267th St, W 270th St, W 273rd St, W 276th St, W 279th St, W 282nd St, W 285th St, W 288th St, W 291st St, W 294th St, W 297th St, W 300th St, W 303rd St, W 306th St, W 309th St, W 312nd St, W 315th St, W 318th St, W 321st St, W 324th St, W 327th St, W 330th St, W 333rd St, W 336th St, W 339th St, W 342nd St, W 345th St, W 348th St, W 351st St, W 354th St, W 357th St, W 360th St, W 363rd St, W 366th St, W 369th St, W 372nd St, W 375th St, W 378th St, W 381st St, W 384th St, W 387th St, W 390th St, W 393rd St, W 396th St, W 399th St, W 402nd St, W 405th St, W 408th St, W 411st St, W 414th St, W 417th St, W 420th St, W 423rd St, W 426th St, W 429th St, W 432nd St, W 435th St, W 438th St, W 441st St, W 444th St, W 447th St, W 450th St, W 453rd St, W 456th St, W 459th St, W 462nd St, W 465th St, W 468th St, W 471st St, W 474th St, W 477th St, W 480th St, W 483rd St, W 486th St, W 489th St, W 492nd St, W 495th St, W 498th St, W 501st St, W 504th St, W 507th St, W 510th St, W 513rd St, W 516th St, W 519th St, W 522nd St, W 525th St, W 528th St, W 531st St, W 534th St, W 537th St, W 540th St, W 543rd St, W 546th St, W 549th St, W 552nd St, W 555th St, W 558th St, W 561st St, W 564th St, W 567th St, W 570th St, W 573rd St, W 576th St, W 579th St, W 582nd St, W 585th St, W 588th St, W 591st St, W 594th St, W 597th St, W 600th St, W 603rd St, W 606th St, W 609th St, W 612nd St, W 615th St, W 618th St, W 621st St, W 624th St, W 627th St, W 630th St, W 633rd St, W 636th St, W 639th St, W 642nd St, W 645th St, W 648th St, W 651st St, W 654th St, W 657th St, W 660th St, W 663rd St, W 666th St, W 669th St, W 672nd St, W 675th St, W 678th St, W 681st St, W 684th St, W 687th St, W 690th St, W 693rd St, W 696th St, W 699th St, W 702nd St, W 705th St, W 708th St, W 711st St, W 714th St, W 717th St, W 720th St, W 723rd St, W 726th St, W 729th St, W 732nd St, W 735th St, W 738th St, W 741st St, W 744th St, W 747th St, W 750th St, W 753rd St, W 756th St, W 759th St, W 762nd St, W 765th St, W 768th St, W 771st St, W 774th St, W 777th St, W 780th St, W 783rd St, W 786th St, W 789th St, W 792nd St, W 795th St, W 798th St, W 801st St, W 804th St, W 807th St, W 810th St, W 813rd St, W 816th St, W 819th St, W 822nd St, W 825th St, W 828th St, W 831st St, W 834th St, W 837th St, W 840th St, W 843rd St, W 846th St, W 849th St, W 852nd St, W 855th St, W 858th St, W 861st St, W 864th St, W 867th St, W 870th St, W 873rd St, W 876th St, W 879th St, W 882nd St, W 885th St, W 888th St, W 891st St, W 894th St, W 897th St, W 900th St, W 903rd St, W 906th St, W 909th St, W 912nd St, W 915th St, W 918th St, W 921st St, W 924th St, W 927th St, W 930th St, W 933rd St, W 936th St, W 939th St, W 942nd St, W 945th St, W 948th St, W 951st St, W 954th St, W 957th St, W 960th St, W 963rd St, W 966th St, W 969th St, W 972nd St, W 975th St, W 978th St, W 981st St, W 984th St, W 987th St, W 990th St, W 993rd St, W 996th St, W 999th St, W 1002nd St, W 1005th St, W 1008th St, W 1011st St, W 1014th St, W 1017th St, W 1020th St, W 1023rd St, W 1026th St, W 1029th St, W 1032nd St, W 1035th St, W 1038th St, W 1041st St, W 1044th St, W 1047th St, W 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1281st St, W 1284th St, W 1287th St, W 1290th St, W 1293rd St, W 1296th St, W 1299th St, W 1302nd St, W 1305th St, W 1308th St, W 1311st St, W 1314th St, W 1317th St, W 1320th St, W 1323rd St, W 1326th St, W 1329th St, W 1332nd St, W 1335th St, W 1338th St, W 1341st St, W 1344th St, W 1347th St, W 1350th St, W 1353rd St, W 1356th St, W 1359th St, W 1362nd St, W 1365th St, W 1368th St, W 1371st St, W 1374th St, W 1377th St, W 1380th St, W 1383rd St, W 1386th St, W 1389th St, W 1392nd St, W 1395th St, W 1398th St, W 1401st St, W 1404th St, W 1407th St, W 1410th St, W 1413rd St, W 1416th St, W 1419th St, W 1422nd St, W 1425th St, W 1428th St, W 1431st St, W 1434th St, W 1437th St, W 1440th St, W 1443rd St, W 1446th St, W 1449th St

357

Trip to:
[1040-1099] N Mozart St
Chicago, IL 60622
4.80 miles
14 minutes



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi



2. Take the 1st right onto S Pulaski Rd.

Go 0.2 Mi

*Las Islas Marias is on the corner
if you reach S Karlov Ave you've gone a little too far*



3. Take the 1st right onto W Ogden Ave.

Go 1.3 Mi

If you are on S Pulaski Rd and reach W Cermak Rd you've gone a little too far



4. Turn left onto S Sacramento Dr.

Go 0.5 Mi

*S Sacramento Dr is just past S Albany Ave
if you reach S California Ave you've gone about 0.3 miles too far*



5. Turn left to stay on S Sacramento Dr.

Go 0.04 Mi

*S Sacramento Dr is 0.5 miles past W Ogden Ave
if you are on S Farrar Dr and reach S Thompson Dr you've gone a little too far*



6. S Sacramento Dr becomes S Sacramento Blvd.

Go 2.3 Mi



7. Turn right onto W Augusta Blvd.

Go 0.1 Mi

*W Augusta Blvd is 0.1 miles past W Grand Ave
if you are on N Humboldt Blvd and reach Luis Munoz Marin Dr you've gone a little too far*



8. Take the 2nd left onto N Richmond St.

Go 0.1 Mi

*N Richmond St is just past N Sacramento Ave
if you reach N Francisco Ave you've gone a little too far*



9. Turn right onto W Thomas St.

Go 0.1 Mi

*W Thomas St is just past W Cortez St
if you reach W Division St you've gone about 0.1 miles too far*



10. Take the 1st right onto N Mozart St.

Go 0.02 Mi

*N Mozart St is just past N Francisco Ave
if you reach N California Ave you've gone a little too far*



11. [1040-1099] N MOZART ST.

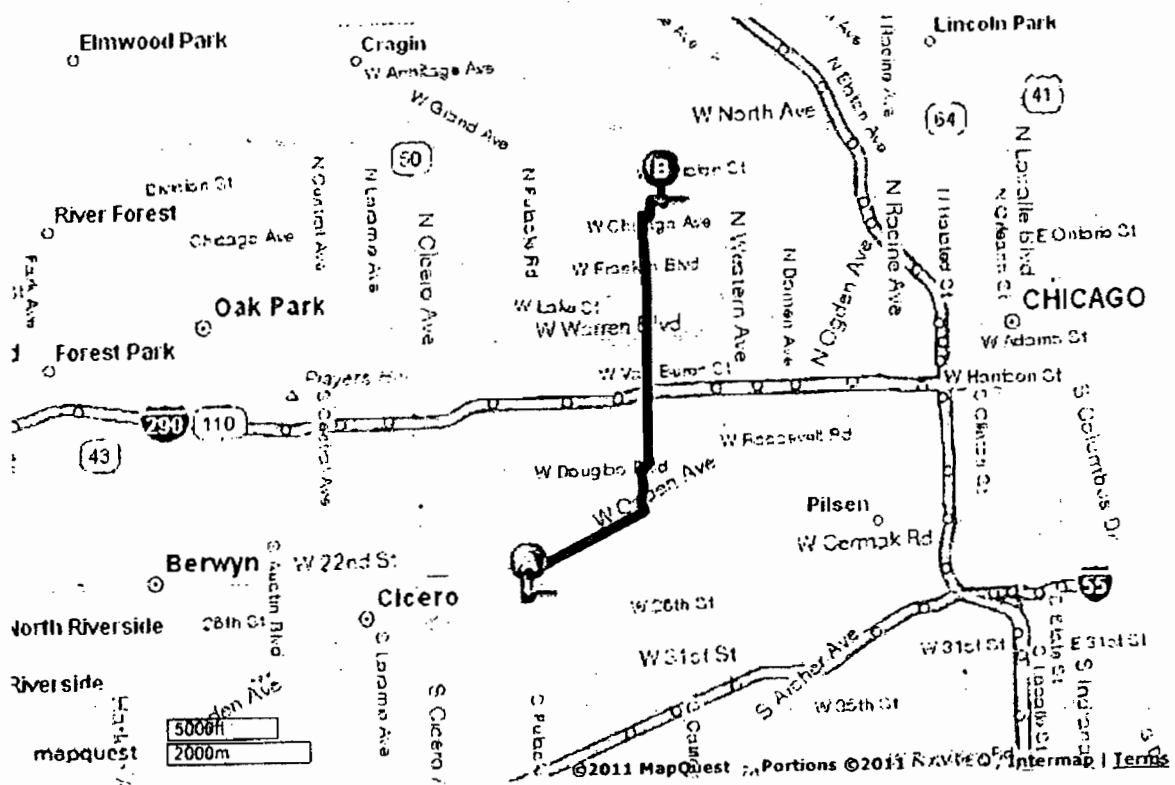
If you reach W Cortez St you've gone a little too far



[1040-1099] N Mozart St
Chicago, IL 60622

4.8 mi

Total Travel Estimate: 4.80 miles - about 14 minutes



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Trip to:
FMC West Suburban Dialysis Center
518 N Austin Blvd
Oak Park, IL 60644
(708) 386-5550
5.62 miles
14 minutes

- | | | Miles Per Section |
|---|---|-------------------|
|  | 3934 W 24th St
Chicago, IL 60623-3371 | |
|  | 1. Start out going west on W 24th St toward S Pulaski Rd. | Go 0.06 Mi |
|  | 2. Take the 1st right onto S Pulaski Rd.
<i>Las Islas Marias is on the corner</i>
<i>If you reach S Karlov Ave you've gone a little too far</i> | Go 0.3 Mi |
|  | 3. Take the 2nd left onto W Cermak Rd / W 22nd St.
<i>W Cermak Rd is just past W Ogden Ave</i>
<i>If you reach W 21st St you've gone a little too far</i> | Go 1.0 Mi |
|   | 4. Turn right onto S Cicero Ave / IL-50.
<i>S Cicero Ave is just past S 47th Ct</i>
<i>Walgreens is on the corner</i>
<i>If you reach S 49th Ave you've gone about 0.1 miles too far</i> | Go 1.4 Mi |
|  | 5. Turn left onto W Flournoy St.
<i>W Flournoy St is just past W Lexington St</i>
<i>If you are on S Cicero Ave and reach W Harrison St you've gone a little too far</i> | Go 0.04 Mi |
|   | 6. Merge onto I-290 W / IL-110 W / Chicago-Kansas City Expy / Eisenhower Expy W via the ramp on the left. | Go 1.2 Mi |
|  | 7. Take the Austin Blvd exit, EXIT 23A, on the left. | Go 0.3 Mi |
|  | 8. Turn right onto S Austin Blvd. | Go 1.3 Mi |
|  | 9. 518 N AUSTIN BLVD is on the left.
<i>Your destination is just past W Race Ave</i>
<i>If you reach W Ohio St you've gone a little too far</i> | |
|  | FMC West Suburban Dialysis Center
518 N Austin Blvd, Oak Park, IL 60644
(708) 386-5550 | 5.6 mi |

Mapquest map of Cicero, IL, showing Oak Park and Berwyn areas. The map includes major roads like I-290, I-110, and I-55, and local streets such as W Franklin Blvd, W Washington Blvd, W Flournoy St, W 22nd St, and W Ogden Ave. Landmarks like Oak Park and Berwyn are labeled. A scale bar indicates 5000 feet and 1000 meters. The map is credited to Mapquest and NAVTEQ.

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Trip to:
7319-7325 S Cottage Grove Ave
Chicago, IL 60619-1909
13.84 miles
23 minutes
Notes

To investors who want
to retire comfortably.

If you have a \$500,000 portfolio,
download the guide written by *Forbes*
columnist and money manager Ken
Fisher's firm. It's called "The 15-Minute
Retirement Plan." Even if you have
something else in place right now, it *still*
makes sense to request your guide!

[Click Here to Download Your Guide!](#)

FISHER INVESTMENTS

	3934 W 24th St Chicago, IL 60623-3371	Miles Per Section	Miles Driven
	1. Start out going west on W 24th St toward S Pulaski Rd.	Go 0.06 Mi	0.06 mi
	2. Take the 1st left onto S Pulaski Rd. <i>Las Blas Manias is on the corner</i> <i>If you reach S Karlov Ave you've gone a little too far</i>	Go 1.7 Mi	1.8 mi
 	3. Merge onto I-55 N / Stevenson Expy N via the ramp on the left.	Go 4.2 Mi	6.0 mi
 	4. Merge onto I-90 E / I-94 E / Dan Ryan Expy E via EXIT 292B toward Indiana.	Go 0.8 Mi	6.7 mi
	5. Keep left to take I-90 Express Ln E / I-94 Express Ln E / Dan Ryan Express Ln E toward Garfield Blvd.	Go 3.9 Mi	10.6 mi
	6. Take the I-90 E exit toward Skyway / Indiana Toll Rd.	Go 0.3 Mi	11.0 mi
 	7. Merge onto I-94 E / Dan Ryan Expy E.	Go 0.9 Mi	11.9 mi
	8. Take EXIT 59C toward 71st St.	Go 0.3 Mi	12.2 mi
	9. Keep right at the fork in the ramp.	Go 0.2 Mi	12.4 mi
	10. Turn slight left onto S Lafayette Ave.	Go 0.08 Mi	12.5 mi
	11. Take the 1st left onto W 71st St. <i>Holy Child Head Start is on the corner</i> <i>If you reach W 72nd St you've gone about 0.1 miles too far</i>	Go 1.1 Mi	13.6 mi
	12. Turn right onto S Cottage Grove Ave.	Go 0.3 Mi	13.8 mi



*S Cottage Grove Ave is 0.1 miles past S Langley Ave
If you reach S Drexel Ave you've gone about 0.1 miles too far*



13 7319-7325 S COTTAGE GROVE AVE.

13.8 mi

*Your destination is just past E 73rd St
If you reach E 74th St you've gone about 0.1 miles too far*

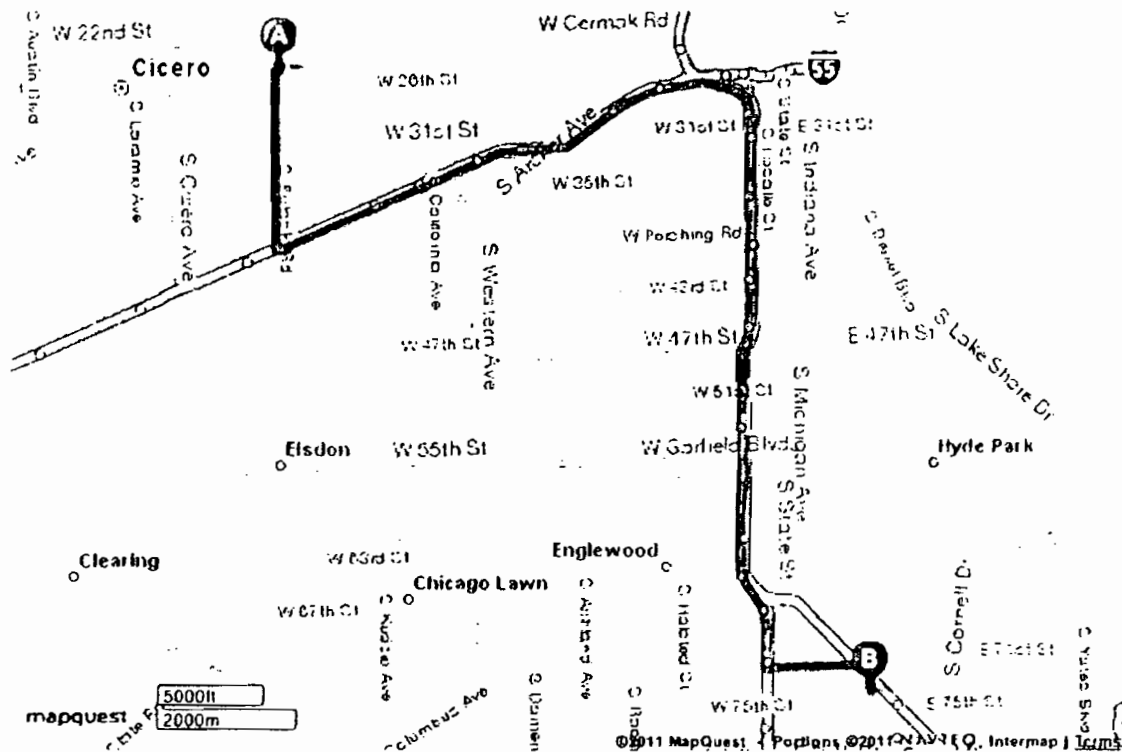


**7319-7325 S Cottage Grove Ave
Chicago, IL 60619-1909**

13.8 mi

13.8 mi

Total Travel Estimate: 13.84 miles - about 23 minutes



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Patch **DEALS**

\$10 for \$20 Worth of Food at Jullianni's Pizzeria & Pub on Evergreen Park Patch

mapquest

Trip to:
4800 W Chicago Ave
Chicago, IL 60651-3223
4.38 miles
12 minutes

Notes

To investors who want
to retire comfortably.

If you have a \$500,000 portfolio,
download the guide written by *Forbes*
columnist and money manager Ken
Fisher's firm. It's called "The 15-Minute
Retirement Plan." Even if you have
something else in place right now, it *still*
makes sense to request your guide!

[Click Here to Download Your Guide!](#)

FISHER INVESTMENTS



3934 W 24th St
Chicago, IL 60623-3371

Miles Per
Section

Miles Driven



1. Start out going west on W 24th St toward S Pulaski Rd.

Go 0.06 Mi

0.06 mi



2. Take the 1st right onto S Pulaski Rd.

Go 3.3 Mi

3.3 mi

Las Bris Manias is on the corner

If you reach S Karlov Ave you've gone a little too far



3. Turn left onto W Chicago Ave.

Go 1.0 Mi

4.4 mi

W Chicago Ave is 0.1 miles past W Hiram St

Phillips 66 is on the corner

If you reach W Iowa St you've gone about 0.1 miles too far



4. 4800 W CHICAGO AVE is on the right.

4.4 mi

Your destination is just past N Cicero Ave

If you reach N Lamon Ave you've gone about 0.1 miles too far

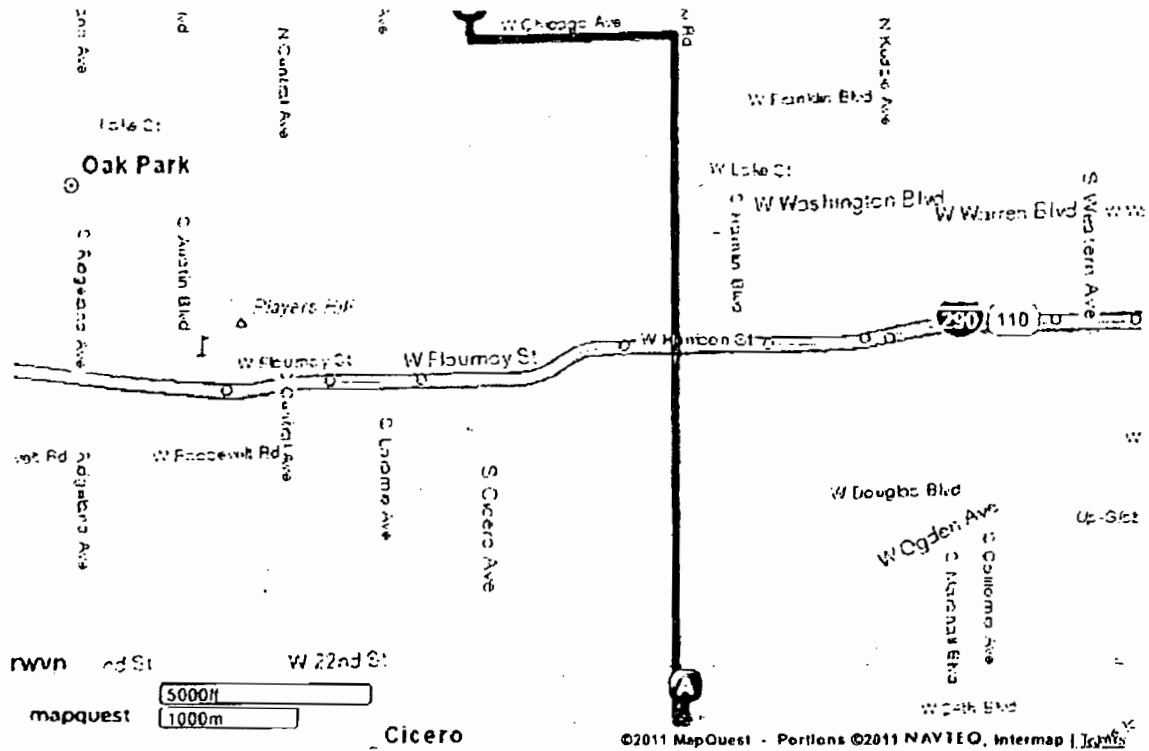


4800 W Chicago Ave
Chicago, IL 60651-3223

4.4 mi

4.4 mi

Total Travel Estimate: 4.38 miles - about 12 minutes



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50% Off Seasonal Furnace Maintenance from
Air-Smart (\$44.50 for \$89... on Elmhurst Patch

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

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