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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Churchview Dialysis
Street Address: 417 Ware Avenue
City and Zip Code: Rockford, Illinois 61107
County: Winnebago Health Service Area 001 Health Planning Area:

Applicant /Co-Applicant Identification

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

Exact Legal Name: Renal Treatment Centers - Illinois, 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
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

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

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

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: 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: Mary Anderson
Title: Division Vice President
Company Name: DaVita Inc.
Address: 1131 N. Galena, Dixon, Illinois 61021
Telephone Number: 815-284-0595
E-mail Address: mary.anderson@davita.com
Fax Number: 866-594-1131

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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E-mail Address: mary.anderson@davita.com
Fax Number: 866-594-1131

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: Mary Anderson
Title: Division Vice President
Company Name: DaVita Inc.
Address: 1131 N. Galena, Dixon, Illinois 61021
Telephone Number: 815-284-0595
E-mail Address: mary.anderson@davita.com
Fax Number: 866-594-1131

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Dyn 417, LLC

Address of Site Owner: 6801 Spring Creek Road, Rockford, IL 61114

Street Address or Legal Description of Site: 417 Ware Avenue, Rockford, Illinois 61107

Lot Ten (10) as designated upon Buckley Commercial Center Plat No. 2, being a Subdivision of the resubdivision of part of Lot 1 of Buckley Commercial Center Plat No. 1, Part of Lot No. 6 of Plat No. 3 of Crimson Ridge Estates Subdivision and part of the Southwest Quarter (1/4) of Section 23, Township 44 North, Range 2 East of the Third Principal Meridian, the Plat of which is recorded in Book 41 of Plats on Page 124B and Affidavit of Correction recorded as Document No. 0010455 in the Recorder's Office of Winnebago County, Illinois; EXCEPTING THEREFROM the East 37.00 feet of Lot Ten (10) as designated upon Buckley Commercial Center Plat No. 2, being a Subdivision of the resubdivision of part of Lot 1 of Buckley Commercial Center Plat No. 1, Part of Lot No. 6 of Plat No. 3 of Crimson Ridge Estates Subdivision and part of the Southwest Quarter (1/4) of Section 23, Township 44 North, Range 2 East of the Third Principal Meridian, the Plat of which is recorded in Book 41 of Plats on Page 124B and Affidavit of Correction recorded as Document No. 0010455 in the Recorder's Office of Winnebago County, Illinois, bounded and described as follows, to-wit: Beginning at the Northeast corner of said Lot Ten (10); thence South, 00 degrees 08'44" East, along the East line of said Lot, 215.00 feet to the Southeast corner of said Lot Ten (10); thence South, 89 degrees 51'16" West, along the South line of said Lot Ten (10), 37.00 feet; thence North, 00 degrees 08'44" West, parallel to the East line of said Lot Ten (10), 215.00 feet to a point in the North line of said Lot Ten (10); thence North, 89 degrees 51'16" East, along the North line of said Lot Ten (10), 37.00 feet to the point of beginning; situated in the County of Winnebago and State of Illinois.

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: Renal Treatment Centers - Illinois, Inc.

Address: 1551 Wewatta Street, Denver, CO 80202

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

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

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

Flood Plain Requirements

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

2. Narrative Description

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

Based on operational limitations at the current site, DaVita Inc. and Renal Treatment Centers - Illinois, Inc. (the "Applicants") seek authority from the Illinois Health Facilities and Services Review Board (the "Board") to relocate their existing 24-station dialysis facility located at 5970 Churchview Drive, East Rockford, Illinois 61114 to 417 Ware Avenue, Rockford, IL 61107 (the "Replacement Facility"). The proposed dialysis facility will include approximately 10,884 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	$1,545,904		$1,545,904
Contingencies	$216,427		$216,427
Architectural/Engineering Fees	$97,596		$97,596
Consulting and Other Fees	$87,500		$87,500
Movable or Other Equipment (not in construction contracts)	$737,849		$737,849
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,443,687		$1,443,687
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$4,128,963**		**$4,128,963**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$2,685,276		$2,685,276
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,443,687		$1,443,687
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$4,128,963**		**$4,128,963**

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 $0_____.

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 ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

☐ Cancer Registry **NOT APPLICABLE**
☐ APORS **NOT APPLICABLE**
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

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

Facility Bed Capacity and Utilization

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.**

SIGNATURE

James K. Hilger

PRINTED NAME

Chief Accounting Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of October, 2012

Linda N. O'Connell

Signature of Notary

Seal

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

SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of October, 2012

Linda N. O'Connell

Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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SIGNATURE

James K. Hilger

PRINTED NAME

Chief Accounting Office

PRINTED TITLE

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this 10th day of October, 2012

Signature of Notary

Seal

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

SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 11th day of October, 2012

Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

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

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

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

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

G. Criterion 1110.1430 - In-Center Hemodialysis

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

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

Category of Service	# Existing Stations	# Proposed Stations
☒ In-Center Hemodialysis	24	24

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

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

APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. Projects for relocation of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

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

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

VIII. - 1120.120 - Availability of Funds

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

$2,685,276	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$1,443,687 (FMV of Lease)	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.
$4,128,963	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const. $ (A x C)	Mod. $ (B x E)	
	New	Mod.	New	Circ.*	Mod.	Circ.*			
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

A table in the following format must be provided as part of Attachment 43.

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

A table in the following format must be provided for all facilities as part of Attachment 44.

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

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

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for DaVita Inc. and Renal Treatment Centers - Illinois, Inc. (collectively, the "Applicants" or "DaVita") are attached at Attachment – 1. Renal Treatment Centers - Illinois, Inc. is the operator of Churchview Dialysis. Churchview Dialysis is a trade name of Renal Treatment Centers - Illinois, Inc. and is not separately organized. As the person with final control over the operator, DaVita Inc. is named as an applicant for this CON application. 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.

Attachment – 1

Delaware

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.

Jeffrey W. Bullock, Secretary of State

2391269 8300

AUTHENTICATION: 9495256

120417324

DATE: 04-11-12

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

File Number 5819-656-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

RENAL TREATMENT CENTERS - ILLINOIS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 14, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 29TH *day of* OCTOBER *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1230301886

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

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

The letter of intent between Dya 417, L.L.C. and Renal Treatment Centers - Illinois, Inc. to lease the facility located at 417 Ware Avenue, Rockford, IL 61107 is attached at Attachment – 2A.

USI REAL ESTATE BROKERAGE SERVICES INC.

A USI COMPANY

2215 YORK RD. SUITE 110
OAKBROOK, IL 60523

TELEPHONE: 630-990-3658
FACSIMILE: 630-990-2300

September 13, 2012

Mr. Bharat Puri
First Rockford Group
6801 Spring Creek Road
Rockford, IL 61114

RE: **Request for Proposal**
417 Ware Avenue
Rockford, IL 61107

Dear Bharat:

USI Real Estate Brokerage Services Inc. has been exclusively authorized by Total Renal Care, Inc – a subsidiary of DaVita Inc. to assist in securing a lease requirement. DaVita Inc. is a Fortune 500 company with approximately 1,700 locations across the US and revenues of approximately $7 billion.

We are currently surveying the Rockford market area to identify all of the alternatives available that best suit DaVita's business and operational needs. Of the properties reviewed, your site has been identified as one that potentially meets the necessary requirements. We are requesting that you provide a written response to lease the above referenced Property. We request that you deliver your response no later than **September 18, 2012.** *Please prepare the proposal to respond to the following terms:*

PREMISES: **417 Ware Avenue, Rockford, IL 61107**

Lot Ten (10) as designated upon Buckley Commercial Center Plat No. 2, being a Subdivision of the resubdivision of part of Lot 1 of Buckley Commercial Center Plat No. 1, Part of Lot No. 6 of Plat No. 3 of Crimson Ridge Estates Subdivision and part of the Southwest Quarter (1/4) of Section 23, Township 44 North, Range 2 East of the Third Principal Meridian, the Plat of which is recorded in Book 41 of Plats on Page 124B and Affidavit of Correction recorded as Document No. 0010455 in the Recorder's Office of Winnebago County, Illinois; EXCEPTING THEREFROM the East 37.00 feet of Lot Ten (10) as designated upon Buckley Commercial Center Plat No. 2, being a Subdivision of the resubdivision of part of Lot 1 of Buckley Commercial Center Plat No. 1, Part of Lot No. 6 of Plat No. 3 of Crimson Ridge Estates Subdivision and part of the Southwest Quarter (1/4) of Section 23, Township 44 North, Range 2 East of the Third Principal Meridian, the Plat of which is recorded in Book 41 of Plats on Page 124B and Affidavit of Correction recorded as Document No. 0010455 in the Recorder's Office of Winnebago County, Illinois, bounded and described as follows, to-wit: Beginning at the Northeast corner of said Lot Ten (10); thence South, 00 degrees 08'44" East, along the East line of said Lot, 215.00 feet to the Southeast corner of said Lot Ten (10); thence South, 89 degrees 51'16" West, along the South line of said Lot Ten (10), 37.00 feet; thence North, 00 degrees 08'44" West, parallel to the East line of said Lot Ten (10), 215.00 feet to a point in the North line of said Lot Ten (10); thence North, 89 degrees 51'16" East, along the North line of said Lot Ten (10), 37.00 feet to the point of beginning; situated in the County of Winnebago and State of Illinois.

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

LANDLORD: **Dyn 417, L.L.C.**

SPACE REQUIREMENTS:	10,884 rentable square feet. As this proposal is based upon Tenant occupying the entire premises, this measurement is based on the total square footage of the building from the outside of outside walls and there is no distinction between usable and rentable square feet.
PRIMARY TERM:	Ten (10) years following rent commencement.
BASE RENT:	$15.75 psf NNN with 1.5% annual rent increases
ADDITIONAL EXPENSES:	Landlord's initial estimate of Common Area Maintenance, Insurance and Taxes for the Premises is $4.25 psf. Tenant's pro rata share will be 100%. Tenant will be responsible for the payment of all utility charges for the Premises.
LANDLORD'S MAINTENANCE:	Landlord, at its sole cost and expense, shall be responsible for the structural items for the Property.
POSSESSION AND RENT COMMENCEMENT:	Landlord shall deliver Possession of the Premises to the Tenant upon the later of substantial completion of Landlords required work (if any) or mutual lease execution. Rent Commencement shall be the earlier of five (5) 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 or county; and c. Tenant has obtained all necessary licenses and permits to operate its business.
LEASE FORM:	Tenant's standard lease form as the starting point for negotiations.
USE:	The Use is for a Dialysis Clinic, medical offices or other lawfully permitted use.
PARKING:	The property has four (4) parking spaces per 1,000 rsf with two (2) dedicated handicapped stalls. There is no patient drop off area provided.
BASE BUILDING:	Landlord shall deliver to the premises, the Base Building improvements included in the attached Exhibit B.
TENANT IMPROVEMENTS:	*N/A*
OPTION TO RENEW:	Tenant shall be entitled to two (2) , five (5) year options to renew the lease. Tenant's options to be exercised by providing notice to Landlord no less than 240 days prior to the end of the term. The Base Rent shall continue increasing annually at 1.5% through all Option Periods..

RIGHT OF FIRST OPPORTUNITY ON ADJACENT SPACE:	N/A
FAILURE TO DELIVER PREMISES:	If Landlord has not delivered the premises to Tenant with all base building items substantially completed by ninety (90) days from lease execution, Tenant may receive one day of rent abatement for every day of delay beyond the ninety (90) day delivery period through one hundred twenty (120) days and two days of rent abatement for every day of delay beyond one hundred twenty (120) days.
HOLDING OVER:	Tenant shall be obligated to pay 150% of the then current rate and no new tenancy shall be created.
TENANT SIGNAGE:	Tenant shall have the right to install building, monument and pylon signage at the Premises, subject to compliance with all applicable laws and regulations.
BUILDING HOURS:	Tenant shall have control over the building hours, HVAC and utility services.
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.
ROOF RIGHTS:	Tenant shall have the right to place a satellite dish on the roof at no additional fee, provided Tenant meets Landlord's requirements and no roof penetrations are made.
HVAC:	To be provided.
DELIVERIES:	Man-door access at rear of building
OTHER CONCESSIONS:	*N/A*
GOVERNMENTAL COMPLIANCE:	Landlord shall represent and warrant to Tenant that Landlord, at Landlord's sole expense, will cause the Premises, common areas, the building and parking facilities to be in full compliance with the Americans with Disabilities Act (ADA), and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or 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).
CERTIFICATE OF NEED:	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 Certificate of Need (CON) permit from the Illinois Health Facilities and Services Review Board (HFSRB). Based on the length of the HFSRB 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 approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective prior to CON permit approval. Assuming CON 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 HFSRB 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 recognizes as the Tenant's sole representatives USI Real Estate Brokerage Services Inc and shall pay a total brokerage fee equal to $115,000.00 per separate commission agreement. Tenant shall retain the right to offset rent for failure to pay the brokerage fee.

Please submit your response to this Request for Proposal via e-mail to:

John Steffens
USI Real Estate Brokerage Services Inc.
2215 York Road, Suite 110
Oak Brook, IL 60523
E-mail: john.steffens@jci.com

It should be understood that this Request For Proposal is subject to the terms of Exhibit A attached hereto. The information in this email is confidential and may be legally privileged. It is intended solely for the addressee. Access to this information by anyone but addressee is unauthorized.

Thank you for your time and consideration to partner with DaVita.

Sincerely,

JOHN STEFFENS

Cc: Edgar Levin
Christian Maese

LETTER OF INTENT: 417 WARE AVENUE, ROCKFORD, IL 61107

AGREED TO AND ACCEPTED THIS 12th DAY OF SEPTEMBER 2012

By: _____

("Landlord")

AGREED TO AND ACCEPTED THIS 13 DAY OF SEPTEMBER 2012

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

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

The Illinois Certificate of Good Standing for Renal Treatment Centers - Illinois, Inc. is attached at Attachment – 3.

Attachment – 3

File Number 5819-656-8

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

RENAL TREATMENT CENTERS - ILLINOIS, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 14, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 29TH *day of* OCTOBER *A.D.* 2012 .

Jesse White

SECRETARY OF STATE

Authentication #: 1230301886

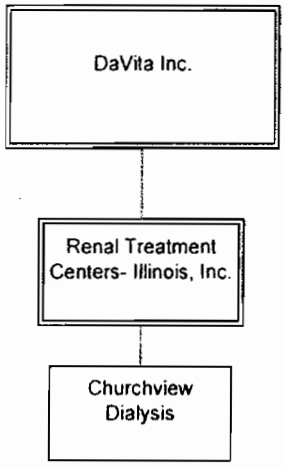
Authenticate at: http://www.cyberdriveillinois.com

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

The organizational chart for Davita Inc. and Renal Treatment Centers - Illinois, Inc. is attached at Attachment – 4.

Attachment – 4

Churchview Dialysis
Organizational Structure



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 417 Ware Avenue, Rockford, IL 61107. As shown on the FEMA flood plain map attached at Attachment – 5, the site of the proposed dialysis facility is located outside of a flood plain.

Attachment – 5

ational Flood Insurance Program at 1-800-638-6620.

MAP SCALE 1 " = 500 '

250 0 500 1000 FEET

NFIP

NATIONAL FLOOD INSURANCE PROGRAM

PANEL 0288D

FIRM

FLOOD INSURANCE RATE MAP

WINNEBAGO COUNTY, ILLINOIS

AND INCORPORATED AREAS

PANEL 288 OF 415

(SEE MAP INDEX FOR FIRM PANEL LAYOUT)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
CHERRY VALLEY, VILLAGE OF	170721	0288	D
ROCKFORD, CITY OF	170723	0288	D
WINNEBAGO COUNTY	170720	0288	D

Notice to User: The **Map Number** shown below should be used when placing map orders; the **Community Number** shown above should be used on insurance applications for the subject community.

MAP NUMBER
17201C0288D

EFFECTIVE DATE
SEPTEMBER 6, 2006

Federal Emergency Management Agency

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

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

The Applicants submitted a request for determination that the proposed location is compliant with the Historic Resources Preservation Act from the Illinois Historic Preservation Agency. A copy of the letter is attached at Attachment – 6.

Attachment – 6

Polsinelli Shughart PC

Joseph T. Van Leer

161 N. Clark Street, Suite 4200
Chicago, IL 60601
(312) 819-1900
Fax: (312) 819-1910
www.polsinelli.com

October 29, 2012

FEDERAL EXPRESS

Ms. Anne Haaker
Deputy State Historic Preservation Officer
Preservation Services Division
Illinois Historic Preservation Agency
1 Old State Capitol Plaza
Springfield, Illinois 62701

Re: Historic Preservation Act Determination – Churchview Dialysis

Dear Ms. Haaker:

This office represents DaVita Inc. ("Requestor"). Pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act, Requestor seeks a formal determination from the Illinois Historic Preservation Agency as to whether Requestor's proposed project to establish a dialysis facility to be located at 417 Ware Avenue, Rockford, IL 61107 ("Proposed Project") affects historic resources.

1. Project Description and Address

The Requestor is seeking a certificate of need from the Illinois Health Facilities and Services Review Board to establish a dialysis facility to be located at 417 Ware Avenue, Rockford, IL 61107. This project will involve the internal modernization of an existing building. No demolition or physical alteration of the exterior of any existing buildings will occur as a result of the Proposed Project.

2. Topographical or Metropolitan Map

A metropolitan map showing the location of the Proposed Project is attached at Attachment 1.

3. Historic Architectural Resources Geographic Information System

A map from the Historic Architectural Resources Geographic Information System is attached at Attachment 2. The property is not listed on the (i) National Register, (ii) within a local historic district, or (iii) within a local landmark.

4. Photographs of Standing Buildings/Structure

A photograph of the site of the proposed facility are attached at Attachment 3.

5. Addresses for Buildings/Structures

The Proposed Project will be located at 417 Ware Avenue, Rockford, IL 61107.

Thank you for your time and consideration of our request for Historic Preservation Determination. If you have any questions or need any additional information, please feel free to contact me at 312-873-3665 or jvanleer@polsinelli.com.

Sincerely,

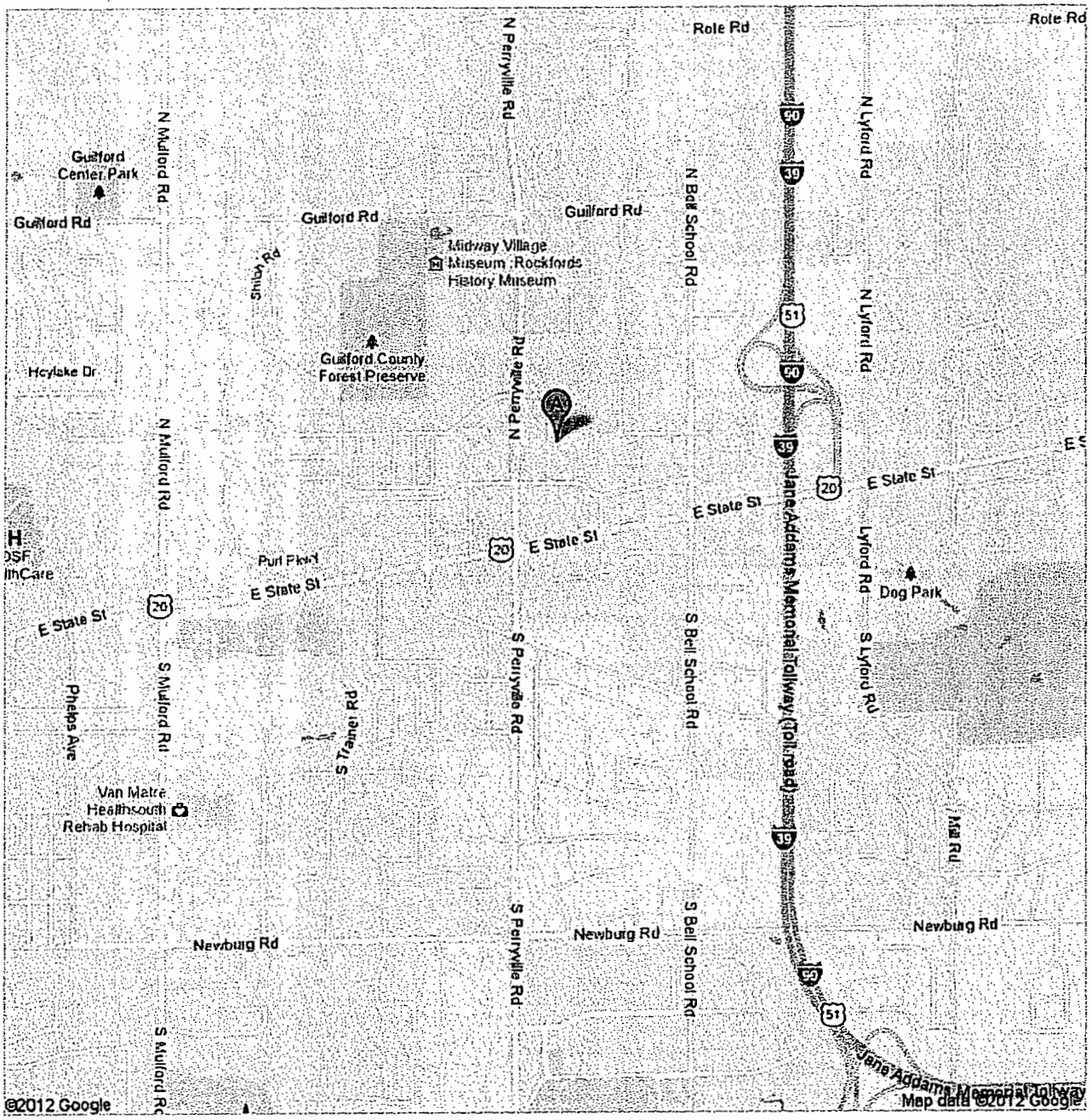
Joseph T. Van Leer

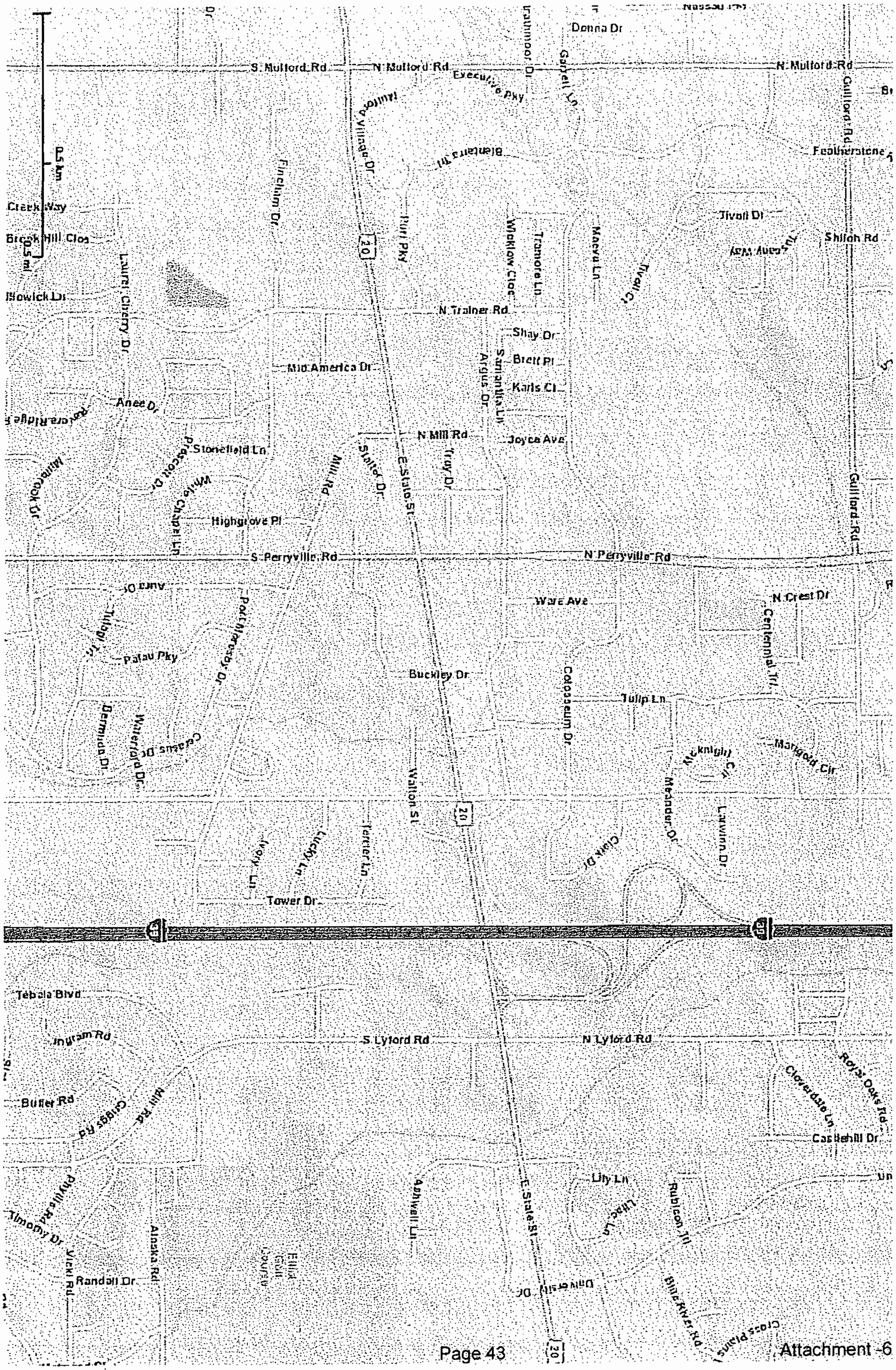
JTV:

Enclosure

Google

417 Ware Avenue, Rockford, IL 61107





Attachment -6

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

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Modernization Contracts	$1,545,904		$1,545,904
Contingencies	$216,427		$216,427
Architectural/Engineering Fees	$97,596		$97,596
Consulting and Other Fees	$87,500		$87,500
Moveable and Other Equipment			
Communications	$120,476		$120,476
Water Treatment	$125,385		$125,385
Bio-Medical Equipment	$12,485		$12,485
Reuse Equipment/Fixtures	$20,845		$20,845
Clinical Equipment	$362,409		$362,409
Clinical Furniture/Fixtures	$28,661		$28,661
Lounge Furniture/Fixtures	$4,415		$4,415
Storage Furniture/Fixtures	$8,023		$8,023
Business Office Fixtures	$14,250		$14,250
General Furniture/Fixtures	$28,100		$28,100
Signage	$12,800		$12,800
Total Moveable and Other Equipment	$737,849		$737,849
Fair Market Value of Leased Space	$1,443,687		$1,443,687
Total Project Costs	**$4,128,963**		**$4,128,963**

Section I, Identification, General Information, and Certification
Project Status and Completion Schedules

Although the Letter of Intent attached at Attachment – 2 provides for project obligation to occur after permit issuance, the Applicants will begin negotiations on a definitive lease agreement for the Replacement Facility, with the intent of project obligation being contingent upon permit issuance.

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

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	$4,128,963		10,884		10,884		
Total Clinical	$4,128,963		10,884		10,884		
NON CLINICAL							
Total Non-clinical							
TOTAL	$4,128,963		10,884		10,884		

Section II, Discontinuation
Criterion 1110.130(a), General

1. The Applicants seek authority from the Health Facilities and Services Review Board (the "Board") to relocate Churchview Dialysis's 24-station facility located at 5970 Churchview Drive, East Rockford, Illinois 61107 (the "Existing Facility") to 417 Ware Avenue, Rockford, IL 61107 (the "Replacement Facility"). The Replacement Facility will be operated as a 24-station unit.

2. No other clinical services will be discontinued as a result of this project.

3. Anticipated Discontinuation Date: November 13, 2013

4. The Applicants lease space for the Existing Facility from Rockford Health Physicians. As a result, the Applicants will have no control over the use of the space after discontinuation of the Existing Facility.

5. All medical records will be transferred to the Replacement Facility and/or be stored electronically in compliance with applicable law.

6. This project is a relocation of the Existing Facility and not a discontinuation in its entirety. Therefore, this criterion does not apply.

Section II, Discontinuation
Criterion 1110.130(b), Reasons for Discontinuation

The Existing Facility is located in a building that is old, poorly configured, and in need of repair. The Existing Facility presents numerous challenges, as there is limited clinical space and support space for the growing patient population of the nephrology group that utilizes the DaVita facilities in the area. Years ago, the facility was originally designed as a 12-station unit, but was later doubled in size by the prior operator. The revised configuration not only resulted in limited support space for nursing staff, but resulted in suboptimal sight-lines for monitoring of patients. Patients also face difficulties when entering and exiting the Existing Facility, as the unit is in the basement of the building. Finally, the capital costs for reconfiguring the Existing Facility exceed the cost of relocating to a modern facility, and will not address difficulties associated with the unit's location in the basement. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment.

Section II, Discontinuation
Criterion 1110.130(c), Impact on Access

1. The proposed project may technically be considered a discontinuation under the Board's rules, but there will be no reduction in services in the area and, thus, the discontinuation of the Existing Facility will not negatively impact access to care. On the contrary, it will improve access to life sustaining dialysis to residents of Rockford. The Applicants propose to discontinue the existing 24-station dialysis facility and establish a 24-station dialysis facility. The Replacement Facility will be located at 417 Ware Avenue, Rockford, IL 61107 approximately 2.6 miles, or 7 minutes, from the Existing Facility.

2. Documentation of the Applicant's request for an impact statement, which was sent to all non-DaVita in-center hemodialysis facilities within 45 minutes normal travel time of the Existing Facility is attached at Attachment – 10A. A list of facilities located within 45 minutes normal travel time is attached at Attachment – 10B. See Appendices – 1 and 2 for documentation that DaVita sent requests for an impact statement to all non-DaVita in-center hemodialysis facilities within 45 minutes travel time.

3. To date, the Applicants have not receive any impact statements regarding the discontinuation.

Churchview Dialysis Center
5970 Churchview Drive
East Rockford, Illinois 61107

October 29, 2012

FEDERAL EXPRESS

Quality Renal Care
910 Greenlee Unit #B
Marengo, IL 60152

To Whom It May Concern:

I am writing on behalf of DaVita Inc. and Renal Treatment Centers - Illinois, Inc. to inform you of the proposed relocation of Churchview Dialysis, a 24-station dialysis facility located at 5970 Churchview Drive, East Rockford, Illinois 61107 (the "Existing Facility"). DaVita plans to relocate the Existing Facility to a nearby location. Your facility is within 45 minutes travel time of the Existing Facility.

The estimated date of discontinuation and relocation is no later than November 13, 2013.

Over the past two years, the facility has served between 82 and 98 end-stage renal disease patients at any given time and the census at the end of September 2012 was 98. We expect all existing patients of the Existing Facility will be transferred to the replacement facility.

While we do not anticipate the project will impact access to care for residents of the area or area health care facilities because we will accommodate the Churchview Dialysis Center patient base at another nearby location, the Illinois Health Facilities and Services Review Board requires us to inform you of these plans to provide you an option to provide an impact statement from your facility.

If you choose to provide such a response, please detail whether your facility's admissions policies place any restrictions or limitations on providing service to residents of the market area and your capacity by shift. Please send any such response within fifteen days of receipt of this letter to Kara M. Friedman, Polsinelli Shughart, PC, 161 North Clark Street, Suite 4200, Chicago, Illinois 60601. If we do not receive a response from you within fifteen days, it will be assumed that you agree that the relocation of the Existing Facility will not affect your facility.

If you have any questions about DaVita's plans to relocate the facility, please feel free to contact Kara M. Friedman at kfriedman@polsinelli.com or 312-873-3639.

Sincerely,

On behalf of

DaVita Inc.
Renal Treatment Centers - Illinois, Inc.

Facilities within 45 Minutes Normal Travel Time						
Facility	**City**	**Distance**	**Time**	**Stations**	**Patients (9-30-2012)**	**Utilization (9-30-2012)**
Stonecrest Dialysis	Rockford	5.33	11	10	60	100.00%
Rockford Memorial Hospital	Rockford	8.48	17	20	110	91.67%
Roxbury Dialysis	Rockford	2.28	4	16	110	114.58%
Churchview Dialysis - East Rockford	East Rockford	2.72	5	24	98	68.06%
Quality Renal Care	Marengo	25.4	36	10	26	43.33%

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

Background of the Applicant

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. 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, some of which is outlined below, details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on October 2, 2012 as part of Applicants' application for Proj. No. 12-085. The proposed project involves the discontinuation of Churchview Dialysis's existing 24-station dialysis facility and the establishment of a 24-station Replacement Facility located at 417 Ware Avenue, Rockford, IL 61107.

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 – 11A.

There are over 26 million people in the U.S. suffering from CKD and few with mild to moderate disease are aware of that fact. Current data reveals two 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 2008[1]
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD[2]

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

[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.

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.

Patients can also access information to better understand and manage their kidney care through DaVita Health Portal on myDaVita.com. MyDaVita.com is an online patient social networking and virtual support center where dialysis patients can connect with other members of the kidney care community by sharing stories, meeting friends who are going through similar experiences, getting advice, and supporting and inspiring others. The website also includes other tools to help patients improve their quality of life and 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.

DaVita's IMPACT program seeks to reduce patient mortality rates during the first 90-days of dialysis through patient intake, education and management, and reporting. In fact, since piloting in October 2007, the program has not only shown to reduce mortality rates by 8 percent but has also resulted in improved patient outcomes.

DaVita's CathAway program seeks to reduce the number of patients with central venous catheters ("CVC"). Instead patients receive arteriovenous fistula ("AV fistula") placement. AV fistulas have superior patency, lower complication rates, improved adequacy, lower cost to the healthcare system, and decreased risk of patient mortality compared to CVCs. In July 2003, the Centers for Medicare and Medicaid Services, the End Stage Renal Disease Networks and key providers jointly recommended adoption of a National Vascular Access Improvement Initiative ("NVAII") to increase the appropriate use of AV fistulas for hemodialysis. The CathAway program is designed to comply with NAVII through patient education outlining the benefits for AV fistula placement and support through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. DaVita is an industry leader in the rate of fistula use and had the lowest day-90 catheter rates among large dialysis providers in 2010.

In an effort to reduce the length of hospital inpatient stays and readmissions, DaVita partners with hospitals to provide faster, more accurate ESRD patient placement through its Patient Pathways program. Importantly, Patient Pathways is not an intake program. An unbiased onsite liaison, who specializes in ESRD patient care, meets with both newly diagnosed and existing ESRD patients to assess their current ESRD care and provide information about insurance, treatment modalities, outpatient care, financial obligations before discharge, and grants available to ESRD patients. Patients choose a provider/center that best meets their needs for insurance, preferred nephrologists, transportation, modality and treatment schedule.

DaVita currently partners with over 300 hospitals nationwide through Patient Pathways, a provider-neutral discharge planning service. Patient Pathways, an unbiased liason that specializes in the complex case management and discharge planning of ESRD patients, has demonstrated benefits to hospitals, payors, and patients. Patients with renal conditions may account for only a fraction of overall hospitalizations, but they present unique and costly challenges to hospitals. Dialysis patients:

- Average 1.9 hospitalizations per year, totaling 12 days
- Stay 0.8 days longer and cost $1,848 more per hospital admission when compared to non-renal patients
- Present a higher risk for hospital readmissions due to multiple comorbidities

In an era of healthcare reform, hospitals will become increasingly responsible for these costs. The program has resulted in a 0.5 day reduction in average length of stay for both new admissions and readmissions and an 11% reduction in average acute dialysis treatments per patient. Moreover, patients are better educated and arrive at the dialysis center more prepared and less stressed. They have a better understanding of their insurance coverage and are more engaged and satisfied with their choice of dialysis facility. As a result, patients have higher attendance rates, are more compliant with their dialysis care, and have fewer avoidable readmissions.

DaVita's transplant referral and tracking program ensures every dialysis patient is informed of transplant as a modality option and promotes access to transplantation for every patient who is interested and eligible for transplant. The social worker or designee obtains transplant center guidelines and criteria for selection of appropriate candidates and assists transplant candidates with factors that may affect their eligibility, such as severe obesity, adherence to prescribed medicine or therapy, and social/emotional/ financial factors related to post-transplant functioning.

In an effort to better serve all kidney patients, DaVita believes in requiring that 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 is $509 million in savings to the health care system and the American taxpayer in 2010.

DaVita is also committed to sustainability and reducing its carbon footprint. In fact, it is the only kidney care company recognized by the Environmental Protection Agency for its sustainability initiatives. In 2010, DaVita opened the first LEED-certified dialysis center in the U.S. Furthermore, it saves approximately 8.5 million pounds of medical waste through dialyzer reuse and it also diverts 95% of its waste through composting and recycling programs. It has also undertaken a number of similar initiatives at its offices and is seeking LEED Gold certification for its corporate headquarters.

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 $3.4 million through Tour DaVita and DaVita Kidney Awareness Run/Walks.

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 18 Missions since 2006, with more than 75 participating teammates spending more than 650 days abroad. It provided these desperately needed services in Cameroon, India, Ecuador, Guatemala, and the Phillipines, 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 – 11B.

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 – 11C.

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 – 11C.

OCMO

Office of the Chief
Medical Officer (OCMO)
Alan S. Nissenson, MD
Chief Medical Officer
Meredith Mathews, MD
Robert Provenzano, MD
John Robertson, MD
David B. 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.

OCMO

DaVita.


TEAM IMPACT
FIRST
90
DAYS
INCIDENT MANAGEMENT OF PATIENTS ACTIONS CENTERED ON TREATMENT

DaVita®

OCMO
Relentless pursuit of quality

Dear Physician Partners:

IMPACT™ is an initiative focused on reducing incident patient mortality. The program provides a comprehensive onboarding process for incident patients, with program materials centered on four key clinical indicators—access, albumin, anemia, and adequacy.

Medical Directors: How can you support IMPACT in your facilities?

- Customize the new Standard Admission Order template into facility-specific orders. Drive use of the standard order with your attending physicians
- Review your facility IMPACT scorecard at your monthly QIFMM meeting
- Talk about IMPACT regularly with your attending physicians

Attending Physicians: How can you support IMPACT in your facilities?

- Use the IMPACT scorecard to assess incident patients
- Educate teammates about the risk incident patients face and how IMPACT can help

How was IMPACT developed? What are the initial results?
From October 2007 to April 2009, IMPACT was piloted in DaVita® centers. Early results, presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN this April, showed an 8% reduction in annualized mortality. In addition to lower mortality, IMPACT patients showed improvements in fistula placement rates and serum albumin levels. The results are so impressive that we are implementing this program throughout the Village.

Your support of this effort is crucial.
If you have not seen the IMPACT order template and scorecard by the end of June, or if you have additional questions about the program, email impact@davita.com. Together we can give our incident patients the quality and length of life they deserve.

Sincerely,

Dennis Kogod
Cheif Operating Officer

Allen R. Nissenson, MD, FACP
Chief Medical Officer

DaVita. Corporate Office | 601 Hawaii Street, El Segundo, CA 90245 | 1-800-313-1872 | DaVita.com/physicians

DaVita.

FOR IMMEDIATE RELEASE

DaVita's IMPACT Program Reduces Mortality for New Dialysis Patients

Study Shows New Patient Care Model Significantly Improves Patient Outcomes

El Segundo, Calif., (March, 29, 2009) – DaVita Inc., a leading provider of kidney care services for those diagnosed with chronic kidney disease (CKD), today released the findings of a study revealing DaVita's IMPACT™ (Incident Management of Patients, Actions Centered on Treatment) pilot program can significantly reduce mortality rates for new dialysis patients. The study presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN details how the IMPACT patient care model educates and manages dialysis patients within the first 90 days of treatment, when they are most unstable and are at highest risk. In addition to lower mortality rates, patient outcomes improved - confirming the health of this vulnerable patient population is better supported under DaVita's *Relentless Pursuit of Quality*™ care.

The pilot program was implemented with 606 patients completing the IMPACT program over a 12 month period in 44 DaVita centers around the nation. IMPACT focuses on patient education and important clinical outcomes - such as the measurement of adequate dialysis, access placement, anemia, and albumin levels - monitoring the patient's overall health in the first 90 days on dialysis. Data reflects a reduction in annualized mortality rates by eight percent for IMPACT patients compared with non-IMPACT patients in the DaVita network. Given that DaVita has roughly 28,000 new patients starting dialysis every year, this reduction affects a significant number of lives.

In addition, a higher number of IMPACT patients versus non-IMPACT patients had an arteriovenous fistula (AVF) in place. Research show that fistulas - the surgical connection of an artery to a vein - last longer and are associated with lower rates of infection, hospitalization and death compared to all other access choices.

Allen R. Nissenson, MD, Chief Medical Officer at DaVita says, "The IMPACT program is about quality patient care starting in the first 90 days and extending beyond. Improved outcomes in new dialysis patients translates to better long term results and healthier patients overall."

Researchers applaud the IMPACT program's inclusion of all patients starting dialysis, regardless of their cognitive ability or health status. Enrolling all patients at this early stage in their treatment allows them to better understand their disease and care needs while healthcare providers work to improve their outcomes. Through this program, DaVita mandates reporting on this particular population to better track and manage patients through their incident period.

Dennis Kogod, Chief Operating Officer of DaVita says, "We are thrilled by the promising results IMPACT has had on our new dialysis patients. DaVita continues to be the leader in the kidney care community, and we look forward to rolling out this program to all facilities later this year, to improve the health of all new dialysis patients."

Poster Presentation
NKF Spring Clinical Meeting
Nashville, TN
March 26-28, 2009

Incident Management of Hemodialysis Patients: Managing the First 90 Days

John Robertson[1], Pooja Goel[1], Grace Chen[1], Ronald Levine[1], Debbie Benner[1], and Amy Burdan[1]
[1]DaVita Inc., El Segundo, CA, USA

IMPACT (Incident Management of Patients, Actions Centered on Treatment) is a program to reduce mortality and morbidity in new patients during the first 3 months of dialysis, when these patients are most vulnerable. IMPACT was designed to standardize the onboarding process of incident patients from their 0 to 90-day period. We report on an observational (non-randomized), un-blinded study of 606 incident patients evaluated over 12 months (Oct77-Oct08) at 44 US DaVita facilities.

The study focused on 4 key predictive indicators associated with lower mortality and morbidity —anemia, albumin, adequacy and access (4As). IMPACT consisted of:

(1) Structured New Patient Intake Process with a standardized admission order, referral fax, and an intake checklist;
(2) 90-day Patient Education Program with an education manual and tracking checklist;
(3) Tools for 90-day Patient Management Pathway including QOL; and
(4) Data Monitoring Reports.

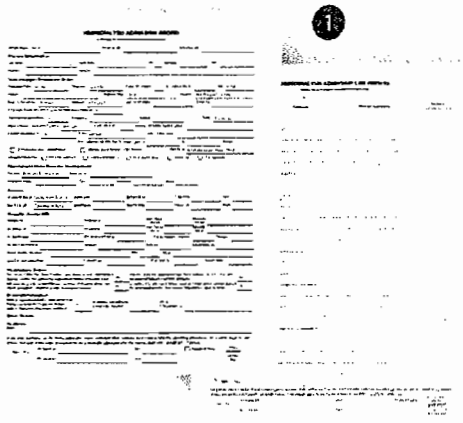
Data as of July, 2008 is reported. Patients in the IMPACT group were 60.6 3 15.1 years old (mean3SD), 42.8% Caucasian, 61% male with 25% having a fistula. Results showed a reduction in 90-day mortality almost 2 percentage points lower (6.14% vs. 7.98%; $p<0.10$) among IMPACT versus nonIMPACT patients. Changes among the 4As showed higher albumin levels from 3.5 to 3.6 g/dL (note that some IMPACT patients were on protein supplementation during this period) and patients achieving fistula access during their first 90-days was 25% vs. 21.4%, IMPACT and nonIMPACT, respectively ($p\leq0.05$). However, only 20.6% of IMPACT patients achieved Hct targets ($33\leq3xHb\leq36$) vs. 23.4% for controls ($p<0.10$); some IMPACT patients may still have >36-level Hcts. Mean calculated Kt/V was 1.54 for IMPACT patients vs. 1.58 for nonIMPACT patients ($p\leq0.05$).

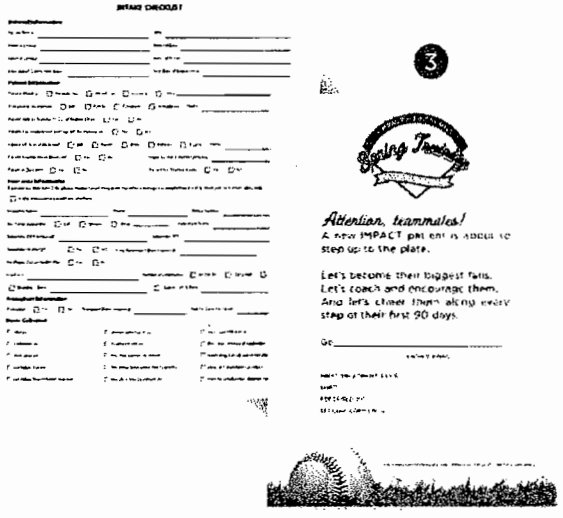
IMPACT is a first step toward a comprehensive approach to reduce mortality of incident patients. We believe this focus may help us to better manage CKD as a continuum of care. Long-term mortality measures will help determine if this process really impacts patients in the intended way, resulting in longer lives and better outcomes.

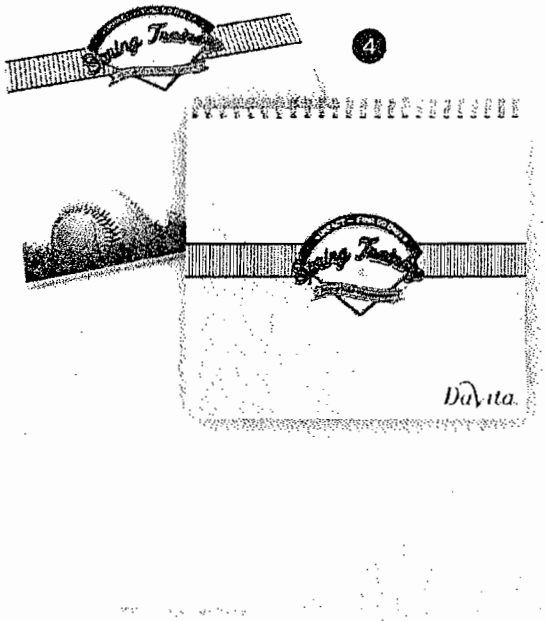
IMPACT Tools

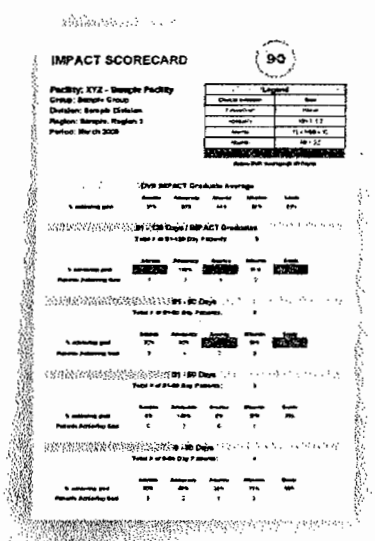
Here's how the IMPACT program will help the team record data, educate patients and monitor their progress in your facilities.

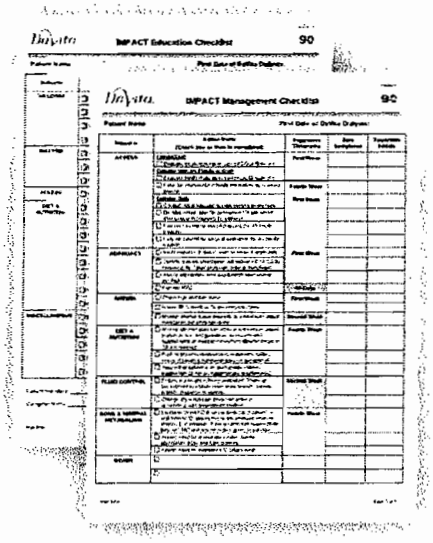
1. Standard Order Template, a two-page form with drop-down menus that can be customized into a center-specific template
2. Intake Checklist to gather registration and clinical data prior to admission
3. Patient Announcement to alert teammates about new incident patients
4. Patient Education Book and Flip Chart to teach patients about dialysis
5. Tracking Checklist for the team to monitor progress over the first 90 days
6. IMPACT Scorecard to track monthly center summary and patient level detail for four clinical indictors: access, albumin, adequacy, anemia

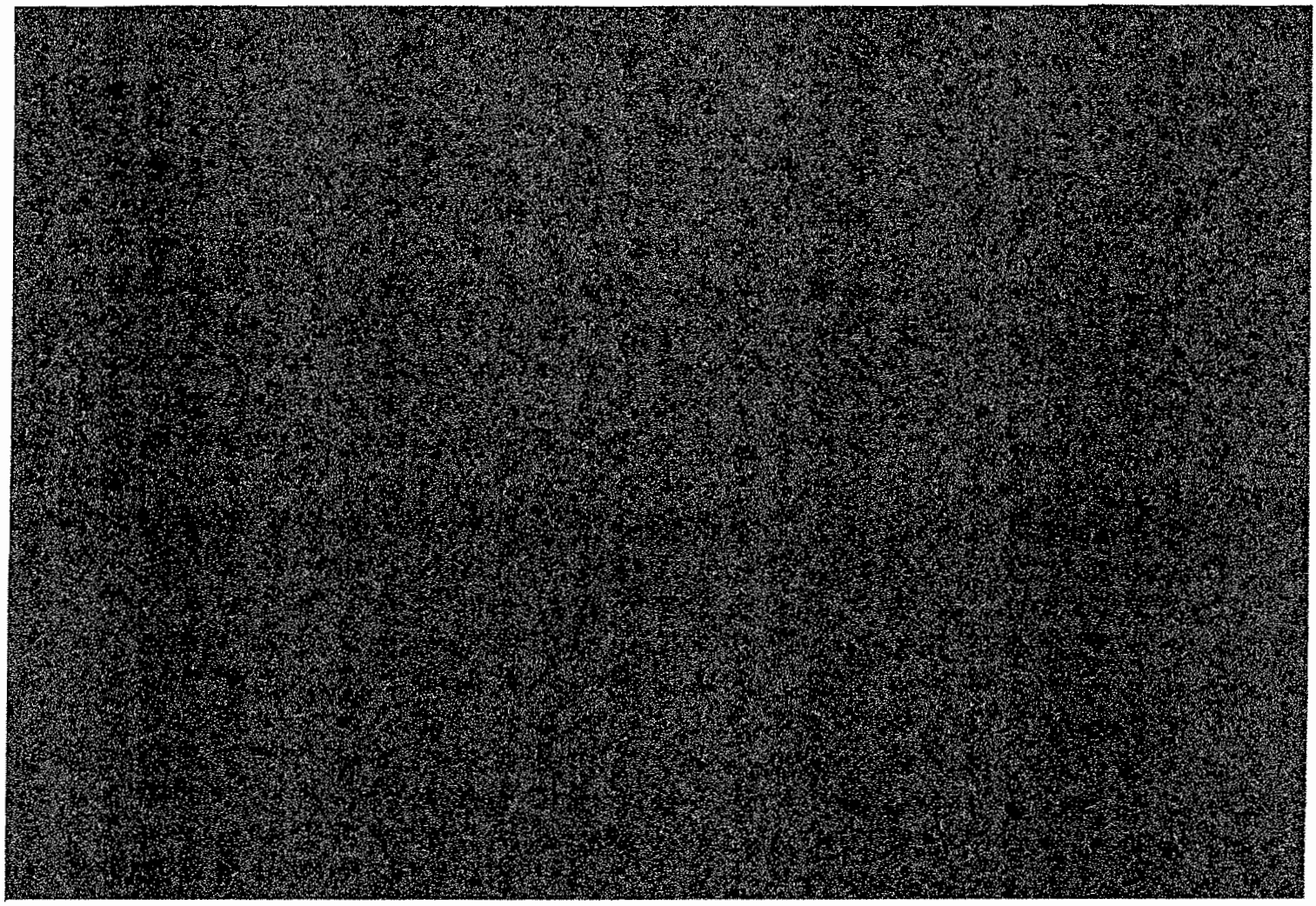












DaVita

Headquarters
1627 Cole Blvd, Bldg 18
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1-888-200-1041

IMPACT

For more information, contact
1-800-400-8331

DaVita.com

Our Mission
To be the Provider,
Partner and Employer
of Choice

Core Values
Service Excellence
Integrity
Team
Continuous Improvement
Accountability
Fulfillment
Fun

Printed with low-VOC, vegetable-based inks on recycled paper in the USA.

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		FREEPORT	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	
Stonecrest 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

DaVita.

2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

October 10, 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 Renal Treatment Centers – Illinois, Inc. 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,

James K. Hilger
Chief Accounting Officer
DaVita Inc.

Subscribed and sworn to me
This 10th day of October, 2012

Linda N. O'Connell
Notary Public

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

Attachment – 11C

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

Purpose of the Project

1. The Applicants propose to relocate the Existing Facility located at 5970 Churchview Drive, East Rockford, Illinois 61107 to 417 Ware Avenue, Rockford, IL 61107 (the "Replacement Facility") as a means of modernizing the existing service and to ensure the availability of dialysis services in HSA 1.

   The Existing Facility is suboptimal for both patients and staff. As the Applicant does not own the building and the lease term is nearing its end, it has determined that it will be better able to serve the needs of its patients if the service is relocated to a modernized facility. The Existing Facility is located in a building that is old, and poorly configured. The Existing Facility presents numerous challenges, as there is limited clinical space and support space for the growing patient population of the nephrology group that utilizes the DaVita facilities in the area. The origin of the configuration problems is the fact that the facility was originally designed by a prior operator as a 12-station unit, and was later doubled in size by the prior operator. The revised configuration not only resulted in limited support space for clinical staff, supplies, and equipment, but also resulted in suboptimal sight-lines for monitoring of patients. Work station design for patient and staff visibility is a fundamental in the design of any environment where caregivers must work as a team with groups of immobilized patients. Properly designed work stations and clinical areas allow clinicians to be aware of a patient's conditions, their presence, their actions and their needs. Similarly, patients are able to communicate efficiently with staff to get their attention to report problems and to request assistance. This is fundamental in care delivery relative to safety, efficiency and flexibility in the care environment. Obstructed sight lines can be significant issue in dialysis because of vascular access that occurs for dialysis and blood loss risks relating to needles potentially dislodging and because of the fact that patients are unable to leave their chairs without assistance. Finally, the capital costs for reconfiguring the Existing Facility exceed the cost of relocating to a modern facility, and will not address difficulties associated with the unit's location in the basement. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment.

   The proposed location is just 2.6 miles, or 7 minutes, from the Existing Facility, so the facility will continue to serve its current patients and meet the need for dialysis services in the area. The Replacement Facility is needed to serve the growing demand for dialysis services in Rockford. There is currently a need for 13 dialysis stations in HSA 1. Currently, the Existing Facility serves 98 ESRD patients. Charles Sweeney, M.D., the Medical Director for Churchview Dialysis, anticipates all 98 current patients will transfer to the Replacement Facility. Dr. Sweeney is currently treating 260 Stage 3, 4, and 5 CKD patients that reside in and around Rockford, 102 of which reside within 10 minutes normal travel time of the Replacement Facility. *See* Attachment – 12A. Based upon attrition due to patient death, transplant, or return of function, it is projected that 23 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. Thus, approximately 121 patients will receive treatment at the Replacement Facility within 12 to 18 months. This represents an 84% utilization rate, which exceeds the State's 80% standard.

   Furthermore, utilization of existing facilities to accommodate growing need for dialysis is not feasible. As shown in Attachment – 12B, there are currently 4 existing or approved dialysis facilities within 30 minutes normal travel time of Churchview Dialysis. As reported by the Renal Network (the "Renal Network Utilization Data") for the quarter ended September 30, 2012, average utilization of these facilities is 90**%** and each facility other than the Existing Facility is operating above the State's 80% standard. Furthermore, in the last year, utilization of the Existing Facility has increased by 15%. Thus, relocating to a modern space that can better accommodate this growing patient-base is necessary.

2. A map of the market area for the proposed facility is attached at Attachment – 12C. The market area encompasses a 19 mile radius around the proposed facility. The boundaries of the market area are as follows:

- North approximately 25 minutes normal travel time to South Beloit
- Northeast approximately 30 minutes normal travel time to Harvard
- East approximately 30 minutes normal travel time to Marengo
- Southeast approximately 30 minutes normal travel time to Kirkland
- South approximately 30 minutes normal travel time to Hillcrest
- Southwest approximately 30 minutes normal travel time to Byron
- West approximately 30 minutes normal travel time to Seward
- Northwest approximately 30 minutes normal travel time to Shirland

3. The minimum size of a GSA is 30 minutes; however, most of the patients reside within 15 minutes normal travel time of the proposed facility. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD. *See* Attachment 12D. African Americans are at an increased risk of ESRD compared to the general population due to the higher prevalence of diabetes and hypertension in the African American community. In fact, the incident rate among the African American population is 3.6 times greater than among whites. Notably, the City of Rockford has a higher concentration of African American individuals (approximately 20%) than the State average (approximately 15%). This, coupled with the aging population, is expected to increase the need for dialysis treatment.

4. Source Information

   The Renal Network, Utilization Data for the Quarter Ending September 30, 2011.

   U.S. Census Bureau, American FactFinder, Fact Sheet, *available at* http://factfinder.census.gov/home/saff/main.html?_lang=en (last visited Nov. 18, 2011).

   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/2010/view/default.asp (last visited Nov. 18, 2011).

   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/atlas07.aspx (last visited Nov. 18, 2011).

5. The Existing Facility is suboptimal and cannot meet the needs of patients and staff. It presents numerous challenges, as there is poorly configured clinical space for its growing patient population.

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.

RNA
Rockford Nephrology Associates

John C. Maynard, MD
Charles J. Sweeney, MD
Krishna Sankaran, MD
James A. Stim, MD
Michael Robertson, MD
Deane S. Charba, MD
David L. Wright, MD
Mashood Ahmad, MD
Joanna Niemiec, MD
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Jaqueline May, APN/CNP
Kathi Capriola, APN/CNS
Yvonne Schoonover, ANP-BC

Julie Ling, RN, CNN
Deb Musselman, MS, RD, CSR, LDN
Mary Jo Johnson, RN, CNN, Office Manager

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 relocation of Churchview Dialysis to 417 Ware Avenue, Rockford, IL 61107 to a modern facility. The updated building and services will afford my large patient-base continued access to excellent dialysis care.

The existing facility presents numerous challenges, as there is limited clinical space and support space for my growing patient population that utilizes the DaVita facilities in the area. Notably, the Rockford community has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). Due to the large number of CKD patients my practice serves, relocation into a modern space is essential.

Further, 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 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 is predicted to 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.

My patient-base further supports this. I am currently treating 260 Stage 3, 4, and 5 CKD patients whose condition is advancing to end stage renal disease (ESRD). 102 of these CKD patients reside within 10 minutes of the proposed facility. Based upon attrition due to patient death, transplant, or return of function, I anticipate that I will refer 23 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 98 patients at the existing facility. I anticipate that all of these patients will transfer to the proposed facility. Thus, I project that I would refer a total of 121 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD data at Attachment – 2.

612 Roxbury Road • Rockford, IL 61107 • Phone 815.227.8300 • Fax 815.227.8301
www.rockfordnephrology.org

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

Sincerely,

Charles J. Sweeney, M.D.
Nephrologist

Subscribed and sworn to me
This 26th day of October, 2012

Notary Public Tara J. Motley

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

ATTACHMENT 1
PRE-ESRD PATIENTS

Zip Code	Patients
61108	6
61107	10
61114	7
Total	**23**

ATTACHMENT 2
HISTORICAL ESRD REFERRALS

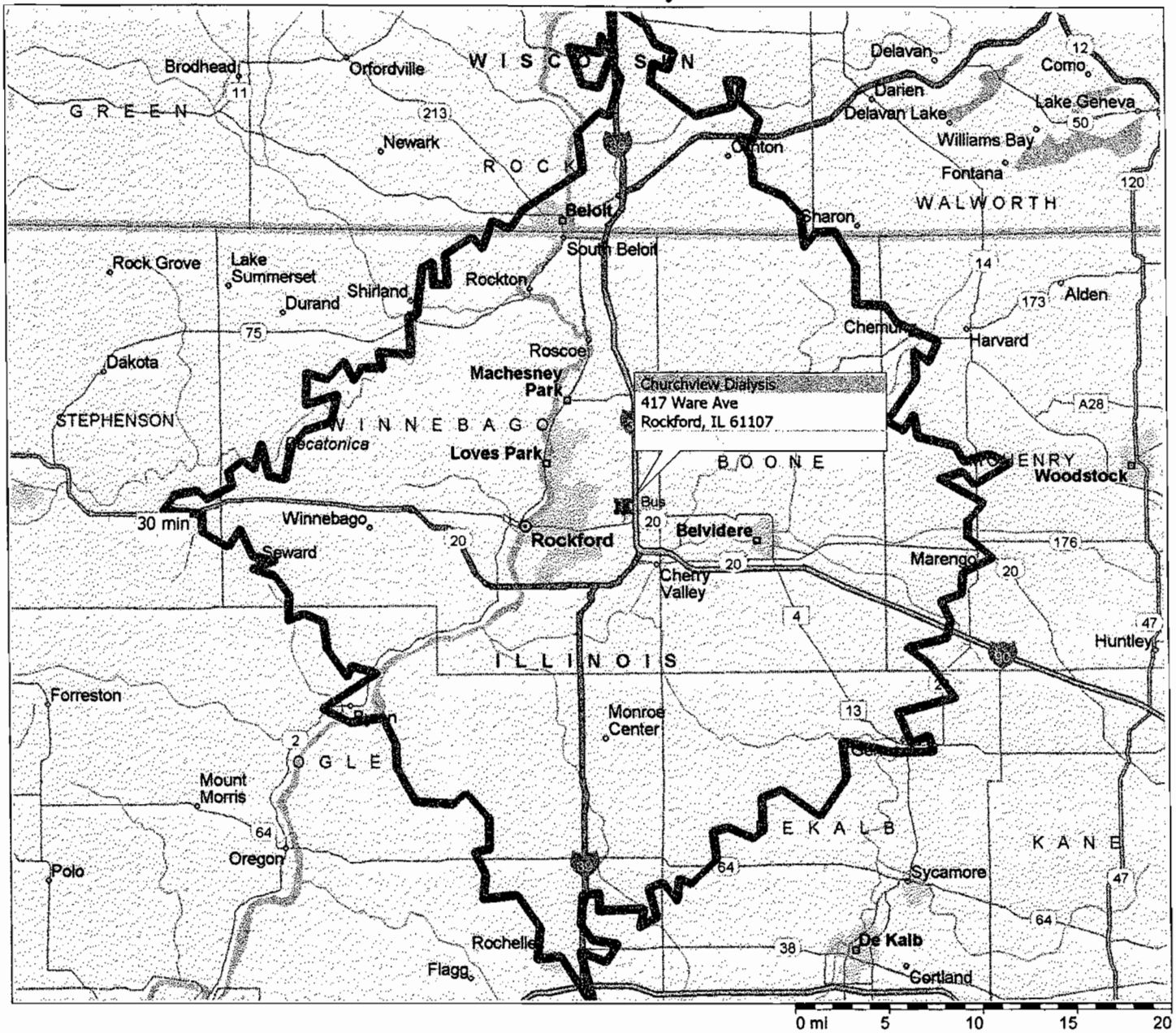
2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
34639	1	38583	1	32566	1
38305	1	43614	2	33441	1
38583	1	44109	1	33629	1
43614	1	45240	1	33952	1
44109	1	46410	1	39206	1
46410	1	48917	1	43614	1
49913	1	54824		44109	1
51433	1	55417	1	46410	1
54603	1	56003	1	51031	1
60033	2	60053	1	60033	1
60115	1	60102	1	60102	1
60152	2	60115	1	60619	1
61008	5	60152	1	60651	1
61016	1	60619	2	61008	5
61032	1	60950	1	61012	1
61036	1	61008	5	61032	2
61062	1	61012	1	61065	2
61068	1	61032	2	61073	4
61072	1	61054	1	61080	1
61073	2	61068	2	61084	1
61101	5	61071	1	61101	11
61102	2	61073	2	61102	11
61103	6	61101	3	61103	9
61104	4	61102	2	61104	10
61107	7	61103	6	61107	21
61108	16	61104	4	61108	16
61109	3	61107	6	61109	14
61111	8	61108	12	61111	3
61114	8	61109	2	61114	3
61115	9	61111	6	61115	11
75210	1	61114	7	61350	1
85204	1	61115	11	68022	1
85756	1	68022	1	85297	1
90807	1	90807	1	90746	1
91786	1	92262	1	90807	1

2012 YTD		
Initials	Zip Code	New Referral
AL	61107	Yes
AN	61111	No
AP	61107	Yes
AS	61008	No
AW	61107	No
BR	61073	Yes
BY	61107	No
CA	61107	No
CB	61104	No
CG	61101	No
CH	61108	No
CK	61115	Yes
DH	61073	No
DM	61115	No
DP	61109	No
DQ	61073	No
EA	61065	Yes
ED	61107	No
EE	61109	No
EG	61108	Yes
EG	61102	No
EH	60007	Yes
EP	61102	Yes
ES	61115	Yes
GA	61108	No
GC	61107	Yes
GP	51031	No
GT	61114	No
HM	61102	No
IK	61109	Yes
JB	61111	Yes
JC	61103	No
JD	61107	No
JH	39206	Yes
JH	38305	No
JL	61115	No
JM	61115	No
JP	61102	No

JS	61111	No
JW	61012	No
KB	61108	No
KP	61109	No
LC	61101	Yes
LG	61115	No
LJ	61114	No
LL	61108	No
LS	61108	No
MB	61080	No
MB	61065	Yes
MC	61103	No
MJ	61115	Yes
ML	61109	No
MM	61114	Yes
MR	61111	Yes
PA	61108	No
PK	61073	No
PM	61065	No
RA	61073	No
RC	61108	Yes
RG	61107	No
RM	61108	No
RM	54843	Yes
RP	61115	No
RP	61107	No
RS	61101	No
RS	85297	No
SC	61115	No
TB	60115	Yes
TB	74129	Yes
TD	61101	No
TD	61108	Yes
VH	61103	No
WB	44109	No
ZM	61115	No

Facilities within 30 Minutes Normal Travel Time						
Facility	**City**	**Distance**	**Time**	**Stations**	**Patients (9-30-2012)**	**Utilization (9-30-2012)**
Stonecrest Dialysis	Rockford	5.33	11	10	60	100.00%
Rockford Memorial Hospital	Rockford	8.48	17	20	110	91.67%
Roxbury Dialysis	Rockford	2.28	4	16	110	114.58%
Churchview Dialysis - East Rockford	East Rockford	2.72	5	24	98	68.06%

Churchview Dialysis



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Editorial Review

NDT
Nephrology Dialysis Transplantation

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/m^2) 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/m^2 among incident patients in 1995 to 27.5 kg/m^2 in 2002 and from 25.7 to 26.7 kg/m^2 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/m^2) 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/m^2) 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/m^2 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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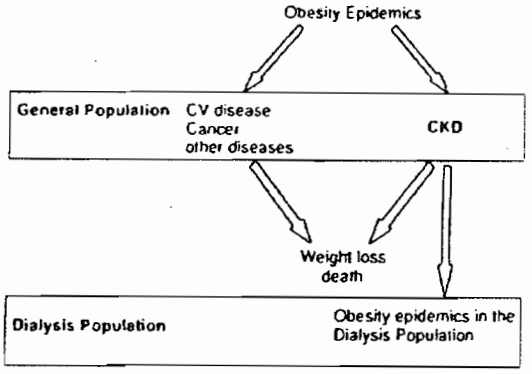

Fig. 1. Simple model whereby the obesity epidemics in the general population generate a parallel obesity epidemics in the dialysis population. Death and weight loss generated by CKD and other obesity-driven diseases represent competing risks that limit the rise in the prevalence of obesity in the dialysis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

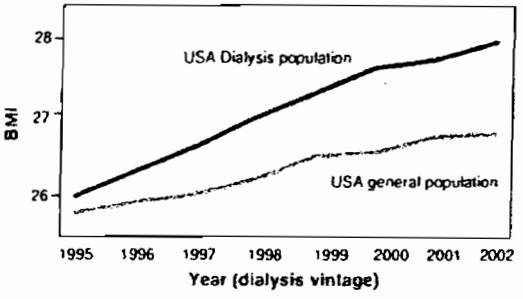

Fig. 2. Temporal trends in BMI (kg/m^2) among incident ESRD patients population by year of dialysis initiation and in the coeval general US population (Behavioral Risk Factor Surveillance System). Redrawn from Kramer HJ *et al.* [16].

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 $r = 77$) 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/m^2, 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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Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(c), Project Purpose, Background and Alternatives

Alternatives

The Applicants explored several options prior to determining to relocate Churchview Dialysis. After exploring the options below in detail, the Applicants determined to relocate its capacity in order to meet rising demand. A review of each of the options considered and the reasons they were rejected follows.

Utilize Existing Facilities

This is not a viable option. The Existing Facility is suboptimal for both patients and staff. As the Applicant does not own the building and the lease term is nearing its end, it has determined that it will be better able to serve the needs of its patients if the service is relocated to a modernized facility. The Existing Facility is located in a building that is old, poorly configured, and in need of repair. The Existing Facility presents numerous challenges, as there is limited clinical space and support space for the growing patient population of the nephrology group that utilizes the DaVita facilities in the area. Years ago, the facility was originally designed as a 12-station unit, but was later doubled in size by the prior operator. The revised configuration not only resulted in limited support space for clinical staff, but resulted in suboptimal sight-lines for monitoring of patients. Patients also face difficulties when entering and exiting the Existing Facility, as the unit is in the basement of the building. Finally, the capital costs for reconfiguring the Existing Facility exceed the cost of relocating to a modern facility, and will not address difficulties associated with the unit's location in the basement. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment.

There is no capital cost with this alternative.

Relocate Churchview Dialysis

DaVita determined that the most effective and efficient way to serve its patients and address the need for more stations in HSA 1 is to relocate the existing facility. The proposed site for the Replacement Facility is located just 2.35 miles from the current site, and will adequately serve Churchview Dialysis's current and projected patient-base.

Thus, the Applicants selected this option.

The cost associated with this option is $4,128,963.

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

Alternative	Community Need	Access	Capital Cost	Status
Utilize Existing Facilities	Not Met	Decreased	$0	Reject
Relocate Facility	Met	Increased	$4,128,963	Accept

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

The Applicants propose to relocate an existing dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard allows for a maximum of 12,480 gross square feet for 24 dialysis stations. The total gross square footage of the proposed dialysis facility is 10,884 gross square feet, meets the Board's standard.

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

By the second year of operation, the proposed facility's annual utilization shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week.

The proposed location is just 2.6 miles, or 7 minutes, from the Existing Facility, so the facility will continue to serve its current patients and meet the need for dialysis services in the area. The Replacement Facility is needed to serve the growing demand for dialysis services in Rockford. There is currently a need for 13 dialysis stations in HSA 1. Currently, the Existing Facility serves 98 ESRD patients. Dr. Charles Sweeney, M.D., the Medical Director for Churchview Dialysis, anticipates all 98 current patients will transfer to the Replacement Facility. Dr. Sweeney is also currently treating 260 pre-ESRD patients that reside in and around Rockford, 102 of which reside within 10 minutes normal travel time of the Replacement Facility. *See* Attachment – 15. Based upon attrition due to patient death, transplant, or return of function, it is projected that 24 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. Thus, approximately 121 patients will receive treatment at the Replacement Facility within 12 to 18 months. This represents an 84% utilization rate, which exceeds the State's 80% standard.

Table 1110.234(b)
Utilization

	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
2010	ESRD	12,150	N/A	17,972	Not Met
2011	ESRD	11,476	N/A	17,972	Not Met
2012 (Annualized)	ESRD	13,223	N/A	17,972	Yes
2013	ESRD	N/A	18,876	17,972	Yes
2014	ESRD	N/A	18,876	17,972	Yes

RNA
Rockford Nephrology Associates

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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 relocation of Churchview Dialysis to 417 Ware Avenue, Rockford, IL 61107 to a modern facility. The updated building and services will afford my large patient-base continued access to excellent dialysis care.

The existing facility presents numerous challenges, as there is limited clinical space and support space for my growing patient population that utilizes the DaVita facilities in the area. Notably, the Rockford community has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). Due to the large number of CKD patients my practice serves, relocation into a modern space is essential.

Further, 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 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 is predicted to 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.

My patient-base further supports this. I am currently treating 260 Stage 3, 4, and 5 CKD patients whose condition is advancing to end stage renal disease (ESRD). 102 of these CKD patients reside within 10 minutes of the proposed facility. Based upon attrition due to patient death, transplant, or return of function, I anticipate that I will refer 23 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 98 patients at the existing facility. I anticipate that all of these patients will transfer to the proposed facility. Thus, I project that I would refer a total of 121 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD data at Attachment – 2.

612 Roxbury Road • Rockford, IL 61107 • Phone 815.227.8300 • Fax 815.227.8301
www.rockfordnephrology.org

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

Sincerely,

Charles J. Sweeney, M.D.
Nephrologist

Subscribed and sworn to me
This 26th day of October, 2012

Notary Public Tara J. Motley

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

ATTACHMENT 1
PRE-ESRD PATIENTS

Zip Code	Patients
61108	6
61107	10
61114	7
Total	**23**

ATTACHMENT 2
HISTORICAL ESRD REFERRALS

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
34639	1	38583	1	32566	1
38305	1	43614	2	33441	1
38583	1	44109	1	33629	1
43614	1	45240	1	33952	1
44109	1	46410	1	39206	1
46410	1	48917	1	43614	1
49913	1	54824		44109	1
51433	1	55417	1	46410	1
54603	1	56003	1	51031	1
60033	2	60053	1	60033	1
60115	1	60102	1	60102	1
60152	2	60115	1	60619	1
61008	5	60152	1	60651	1
61016	1	60619	2	61008	5
61032	1	60950	1	61012	1
61036	1	61008	5	61032	2
61062	1	61012	1	61065	2
61068	1	61032	2	61073	4
61072	1	61054	1	61080	1
61073	2	61068	2	61084	1
61101	5	61071	1	61101	11
61102	2	61073	2	61102	11
61103	6	61101	3	61103	9
61104	4	61102	2	61104	10
61107	7	61103	6	61107	21
61108	16	61104	4	61108	16
61109	3	61107	6	61109	14
61111	8	61108	12	61111	3
61114	8	61109	2	61114	3
61115	9	61111	6	61115	11
75210	1	61114	7	61350	1
85204	1	61115	11	68022	1
85756	1	68022	1	85297	1
90807	1	90807	1	90746	1
91786	1	92262	1	90807	1

2012 YTD		
Initials	Zip Code	New Referral
AL	61107	Yes
AN	61111	No
AP	61107	Yes
AS	61008	No
AW	61107	No
BR	61073	Yes
BY	61107	No
CA	61107	No
CB	61104	No
CG	61101	No
CH	61108	No
CK	61115	Yes
DH	61073	No
DM	61115	No
DP	61109	No
DQ	61073	No
EA	61065	Yes
ED	61107	No
EE	61109	No
EG	61108	Yes
EG	61102	No
EH	60007	Yes
EP	61102	Yes
ES	61115	Yes
GA	61108	No
GC	61107	Yes
GP	51031	No
GT	61114	No
HM	61102	No
IK	61109	Yes
JB	61111	Yes
JC	61103	No
JD	61107	No
JH	39206	Yes
JH	38305	No
JL	61115	No
JM	61115	No
JP	61102	No

JS	61111	No
JW	61012	No
KB	61108	No
KP	61109	No
LC	61101	Yes
LG	61115	No
LJ	61114	No
LL	61108	No
LS	61108	No
MB	61080	No
MB	61065	Yes
MC	61103	No
MJ	61115	Yes
ML	61109	No
MM	61114	Yes
MR	61111	Yes
PA	61108	No
PK	61073	No
PM	61065	No
RA	61073	No
RC	61108	Yes
RG	61107	No
RM	61108	No
RM	54843	Yes
RP	61115	No
RP	61107	No
RS	61101	No
RS	85297	No
SC	61115	No
TB	60115	Yes
TB	74129	Yes
TD	61101	No
TD	61108	Yes
VH	61103	No
WB	44109	No
ZM	61115	No

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

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

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

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

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

1. Planning Area Need

The Applicants propose to relocate its existing 24-station dialysis facility located at 3053 West 159th Street Rockford, Illinois 60428 and to a new 24-station dialysis facility at 417 Ware Avenue, Rockford, IL 61107. The Existing Facility is suboptimal for both patients and staff. The Existing Facility is suboptimal for both patients and staff. As the Applicant does not own the building and the lease term is nearing its end, it has determined that it will be better able to serve the needs of its patients if the service is relocated to a modernized facility. The Existing Facility is located in a building that is old, poorly configured, and in need of repair. The Existing Facility presents numerous challenges, as there is limited clinical space and support space for the growing patient population of the nephrology group that utilizes the DaVita facilities in the area. Years ago, the facility was originally designed as a 12-station unit, but was later doubled in size by the prior operator. The revised configuration not only resulted in limited support space for nursing staff, but resulted in suboptimal sight-lines for monitoring of patients. Patients also face difficulties when entering and exiting the Existing Facility, as the unit is in the basement of the building. Finally, the capital costs for reconfiguring the Existing Facility exceed the cost of relocating to a modern facility, and will not address difficulties associated with the unit's location in the basement. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment.

The proposed location is just 2.6 miles, or 7 minutes, from the Existing Facility, so the facility will continue to serve its current patients and meet the need for dialysis services in the area. The Replacement Facility is needed to serve the growing demand for dialysis services in Rockford. There is currently a need for 13 dialysis stations in HSA 1. Currently, the Existing Facility serves 98 ESRD patients. Charles Sweeney, M.D., the Medical Director for Churchview Dialysis, anticipates all 98 current patients will transfer to the Replacement Facility. Dr. Sweeney is currently treating 260 Stage 3, 4, and 5 CKD patients that reside in and around Rockford, 102 of which reside within 10 minutes normal travel time of the Replacement Facility. *See* Attachment – 26A. Based upon attrition due to patient death, transplant, or return of function, it is projected that 24 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. Thus, approximately 121 patients will receive treatment at the Replacement Facility within 12 to 18 months. This represents an 84% utilization rate, which exceeds the State's 80% standard.

Furthermore, utilization of existing facilities to accommodate growing need for dialysis is not feasible. As shown in Attachment – 26B, there are currently 4 existing or approved dialysis facilities within 30 minutes normal travel time of Churchview Dialysis. Average utilization of these facilities is 90%, as of the quarter ended September 30, 2012, and each facility other than the Existing Facility is operating above the State's 80% standard. Furthermore, in the last year, utilization of the Existing Facility has increased by 15%. Thus, relocating to a modern space that can better accommodate this growing patient-base is necessary.

2. Service to Planning Area Residents

The primary purpose is to ensure the residents of Rockford have access to life sustaining dialysis. All of the current patients live in the service area.

3. Service Demand – Establishment of In-Center Hemodialysis Service

Currently, the Existing Facility serves 98 ESRD patients. Dr. Charles Sweeney, M.D., the Medical Director for Churchview Dialysis, anticipates all 98 current patients will transfer to the Replacement Facility. Dr. Sweeney is currently treating 260 Stage 3, 4, and 5 CKD patients that

reside in and around Rockford, 102 of which reside within 10 minutes normal travel time of the Replacement Facility. See Attachment – 26A. Based upon attrition due to patient death, transplant, or return of function, it is projected that 24 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. Thus, approximately 121 patients will receive treatment at the Replacement Facility within 12 to 18 months. This represents an 84% utilization rate, which exceeds the State's 80% standard.

4. Service Accessibility

As set forth throughout this application, the proposed relocation is needed to maintain access to life-sustaining dialysis for residents of Chicago. The Existing Facility is suboptimal for both patients and staff. The Existing Facility is suboptimal for both patients and staff. It presents numerous challenges, as there is limited clinical space for its growing patient population. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment

RNA
Rockford Nephrology Associates

John C. Maynard, MD
Charles J. Sweeney, MD
Krishna Sankaran, MD
James A. Slim, MD
Michael Robertson, MD
Deane S. Charba, MD
David L. Wright, MD
Mashood Ahmad, MD
Joanna Niemiec, MD
Bindu Pavithran, MD

Jaqueline May, APN/CNP
Kathi Capriola, APN/CNS
Yvonne Schoonover, ANP-BC

Julie Ling, RN, CNN
Deb Musselman, MS, RD, CSR, LDN
Mary Jo Johnson, RN, CNN, Office Manager

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 relocation of Churchview Dialysis to 417 Ware Avenue, Rockford, IL 61107 to a modern facility. The updated building and services will afford my large patient-base continued access to excellent dialysis care.

The existing facility presents numerous challenges, as there is limited clinical space and support space for my growing patient population that utilizes the DaVita facilities in the area. Notably, the Rockford community has a high concentration of patients suffering from diabetes, hypertension, and chronic kidney disease (CKD). Due to the large number of CKD patients my practice serves, relocation into a modern space is essential.

Further, 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 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 is predicted to 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.

My patient-base further supports this. I am currently treating 260 Stage 3, 4, and 5 CKD patients whose condition is advancing to end stage renal disease (ESRD). 102 of these CKD patients reside within 10 minutes of the proposed facility. Based upon attrition due to patient death, transplant, or return of function, I anticipate that I will refer 23 of these patients will be referred to the Replacement Facility within the next 12 to 18 months. A list of these pre-ESRD patients are provided at Attachment – 1. I am also currently treating 98 patients at the existing facility. I anticipate that all of these patients will transfer to the proposed facility. Thus, I project that I would refer a total of 121 patients within 12 to 18 months following project completion. Lastly, I have attached my historical ESRD data at Attachment – 2.

612 Roxbury Road • Rockford, IL 61107 • Phone 815.227.8300 • Fax 815.227.8301
www.rockfordnephrology.org

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

Sincerely,

Charles J. Sweeney, M.D.
Nephrologist

Subscribed and sworn to me
This 26th day of October, 2012

Notary Public Tara L. Motley

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

ATTACHMENT 1
PRE-ESRD PATIENTS

Zip Code	Patients
61108	6
61107	10
61114	7
Total	**23**

ATTACHMENT 2
HISTORICAL ESRD REFERRALS

2009		2010		2011	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
34639	1	38583	1	32566	1
38305	1	43614	2	33441	1
38583	1	44109	1	33629	1
43614	1	45240	1	33952	1
44109	1	46410	1	39206	1
46410	1	48917	1	43614	1
49913	1	54824		44109	1
51433	1	55417	1	46410	1
54603	1	56003	1	51031	1
60033	2	60053	1	60033	1
60115	1	60102	1	60102	1
60152	2	60115	1	60619	1
61008	5	60152	1	60651	1
61016	1	60619	2	61008	5
61032	1	60950	1	61012	1
61036	1	61008	5	61032	2
61062	1	61012	1	61065	2
61068	1	61032	2	61073	4
61072	1	61054	1	61080	1
61073	2	61068	2	61084	1
61101	5	61071	1	61101	11
61102	2	61073	2	61102	11
61103	6	61101	3	61103	9
61104	4	61102	2	61104	10
61107	7	61103	6	61107	21
61108	16	61104	4	61108	16
61109	3	61107	6	61109	14
61111	8	61108	12	61111	3
61114	8	61109	2	61114	3
61115	9	61111	6	61115	11
75210	1	61114	7	61350	1
85204	1	61115	11	68022	1
85756	1	68022	1	85297	1
90807	1	90807	1	90746	1
91786	1	92262	1	90807	1

2012 YTD		
Initials	Zip Code	New Referral
AL	61107	Yes
AN	61111	No
AP	61107	Yes
AS	61008	No
AW	61107	No
BR	61073	Yes
BY	61107	No
CA	61107	No
CB	61104	No
CG	61101	No
CH	61108	No
CK	61115	Yes
DH	61073	No
DM	61115	No
DP	61109	No
DQ	61073	No
EA	61065	Yes
ED	61107	No
EE	61109	No
EG	61108	Yes
EG	61102	No
EH	60007	Yes
EP	61102	Yes
ES	61115	Yes
GA	61108	No
GC	61107	Yes
GP	51031	No
GT	61114	No
HM	61102	No
IK	61109	Yes
JB	61111	Yes
JC	61103	No
JD	61107	No
JH	39206	Yes
JH	38305	No
JL	61115	No
JM	61115	No
JP	61102	No

JS	61111	No
JW	61012	No
KB	61108	No
KP	61109	No
LC	61101	Yes
LG	61115	No
LJ	61114	No
LL	61108	No
LS	61108	No
MB	61080	No
MB	61065	Yes
MC	61103	No
MJ	61115	Yes
ML	61109	No
MM	61114	Yes
MR	61111	Yes
PA	61108	No
PK	61073	No
PM	61065	No
RA	61073	No
RC	61108	Yes
RG	61107	No
RM	61108	No
RM	54843	Yes
RP	61115	No
RP	61107	No
RS	61101	No
RS	85297	No
SC	61115	No
TB	60115	Yes
TB	74129	Yes
TD	61101	No
TD	61108	Yes
VH	61103	No
WB	44109	No
ZM	61115	No

Facilities within 30 Minutes Normal Travel Time						
Facility	**City**	**Distance**	**Time**	**Stations**	**Patients (9-30-2012)**	**Utilization (9-30-2012)**
Stonecrest Dialysis	Rockford	5.33	11	10	60	100.00%
Rockford Memorial Hospital	Rockford	8.48	17	20	110	91.67%
Roxbury Dialysis	Rockford	2.28	4	16	110	114.58%
Churchview Dialysis - East Rockford	East Rockford	2.72	5	24	98	68.06%

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

1. Unnecessary Duplication

a. The proposed dialysis facility will be located at 417 Ware Avenue, Rockford, IL 61107. A map of the Churchview Dialysis 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) below.

Table 1110.1430(c)(1)(A)
Population of Zip Codes within 30 Minutes of Proposed Facility9

Zip Code	City	Population
61084	STILLMAN VALLEY	3175
60129	ESMOND	242
61043	HOLCOMB	131
61020	DAVIS JUNCTION	3108
61049	LINDENWOOD	585
61052	MONROE CENTER	1148
61016	CHERRY VALLEY	4837
60146	KIRKLAND	2713
60145	KINGSTON	2627
61088	WINNEBAGO	6020
61102	ROCKFORD	20538
61101	ROCKFORD	21593
61072	ROCKTON	11797
61104	ROCKFORD	19269
61109	ROCKFORD	28333
61103	ROCKFORD	24578
61108	ROCKFORD	28550
61112	ROCKFORD	86
61107	ROCKFORD	30439
61114	ROCKFORD	15776
61111	LOVES PARK	23492
61080	SOUTH BELOIT	10599
61115	MACHESNEY PARK	23180
61073	ROSCOE	20052
61008	BELVIDERE	34311
61011	CALEDONIA	2945
61065	POPLAR GROVE	11156
61038	GARDEN PRAIRIE	1354
61012	CAPRON	2175

Total	**354,809**

Source: U.S. Census Bureau, Census 2010, Zip Code Fact Sheet *available at* http://factfinder.census.gov/home/saff/main.html?_lang=en (last visited Oct. 12, 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 – 26C.

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (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 State Board'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 geographic service area is 65% of the State average, the average utilization of dialysis facilities within the GSA is 90%, 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 69% of the State Average.

Table 1110.1430(c)(2)(A)
Ratio of Stations to Population

	Population	Dialysis Stations	Stations to Population	Standard Met?
Geographic Service Area	354,809	70	1:5,069	Yes
State	12,830,632	3,892	1:3,297	

b. Historic Utilization of Existing Facilities

Average utilization of the Existing Facility is 68%, as of the quarter ended September 30, 2012. This is a 15% increase in the last year. Additionally, the average utilization in the service area is 90%. Accordingly, there is sufficient patient population to justify the need for the Replacement Facility. There will be no maldistribution of services. Additional stations are necessary to adequately meet rising demand identified by projected referrals from Dr. Sweeney.

c. Sufficient Population to Achieve Target Utilization

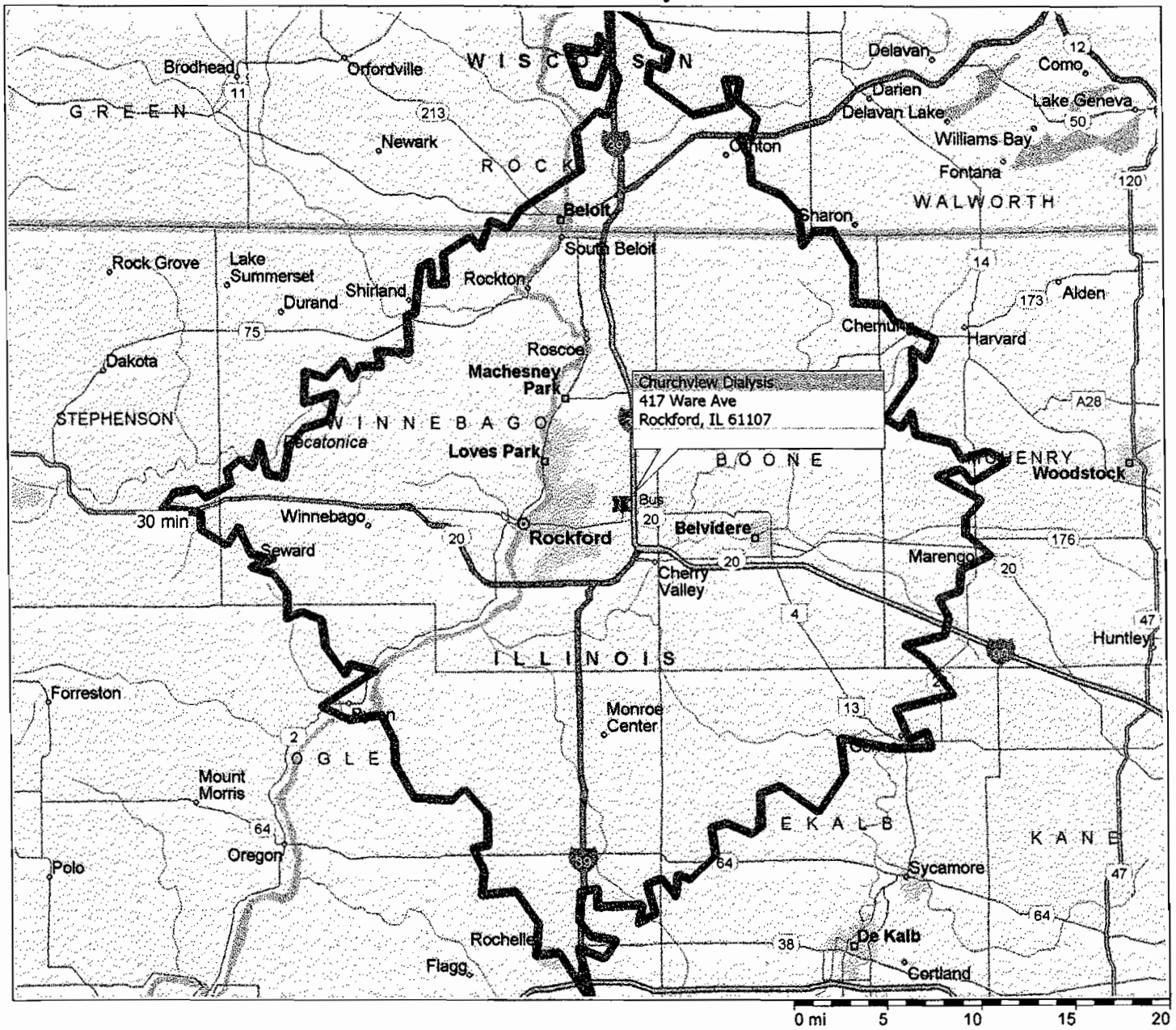
The Applicants propose to discontinue their existing 24-station facility and establish a 24-station facility. The Existing Facility currently treats 98 patients. To achieve the State Board's 80% utilization standard within the first two years after project completion, the Applicants would need 19 patient referrals. As stated in Attachment – 26A, Dr. Sweeney anticipates referring 24 patients within 12 to 18 months of project completion. Accordingly, there is sufficient population to achieve target occupancy.

3. Impact to Other Providers

a. The proposed dialysis facility will not have an adverse impact on existing facilities in the proposed geographic service area. All of the identified patients will either be transfers from the Existing Facility or referrals of pre-ESRD patients. No patients will be transferred from other existing dialysis facilities.

b. The proposed dialysis facility will not lower the utilization of other area providers that are operating below the occupancy standards.

Churchview Dialysis



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

   b. As discussed throughout this application, the Applicants seek authority to discontinue their existing 24-station dialysis facility and establish a 24-station dialysis facility. The Existing Facility is Medicare certified and fully staffed with a medical director, administrator, registered nurses, patient care technicians, social worker, and registered dietitian. Upon discontinuation of the Existing Facility, all current staff will be transferred to the Replacement Facility.

2. All staff will be training under the direction of the 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.

3. As set forth in the letter from James K. Hilger, Chief Accounting Officer of DaVita and Renal Treatment Centers - Illinois, Inc., attached at Attachment – 26F, the Replacement Facility will maintain an open medical staff.

CHARLES J. SWEENEY, M.D.
CURRICULUM VITAE

BIOGRAPHICAL INFORMATION:

Office Address: RNA of Rockford, LLC
612 Roxbury Road
Rockford, IL 61107

Date of Birth: 9/20/56

EMPLOYMENT:

05/08-present	RNA of Rockford, LLC Rockford, IL	M.D.
02/03-04/08	Nephrology Associates of Northern IL Rockford, IL	M.D.
1991-present	University of Illinois College of Medicine Department of Medicine Rockford, IL	Clinical Instructor
08/91-01/03	Rockford Health System Rockford, IL	M.D.
01/88-07/88	Victory Memorial Hospital Waukegan, IL	E.R. Physician

EDUCATION:

09/80-06/84	University of Illinois College of Medicine Rockford, IL	M.D.
09/78-06/80	University of Illinois at Chicago Departments of Biology and Chemistry Chicago, IL	Graduate Work

09/74-05/78	University of Notre Dame Notre Dame, IN	B.S.

POSTGRADUATE TRAINING:

07/88-06/91	University of Minnesota Hospitals and Clinics Minneapolis, MN	Nephrology Fellowship
07/84-12/87	University of Illinois Hospital West Side Veterans Hospital Chicago, IL	Internal Medicine Residency

CERTIFICATION AND LICENSURE:

Illinois License #036-072316
Wisconsin License #48933-020
Board Certified by American Board of Internal Medicine, 09/13/89
Board Certified by American Board of Internal Medicine, Subspecialty of Nephrology, 11/6/90

PROFESSIONAL ORGANIZATION MEMBERSHIPS:

American Society of Nephrology

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 ≥ 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 ≥ 80% or higher is required prior to the new teammate receives 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

DaVita.

2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

October 10, 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 Churchview 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;
- Churchview Dialysis will have available all needed support services required by CMS which may consist of clinical laboratory services, blood bank, nutrition, rehabilitation, psychiatric services, and social services; and
- Patients, either directly or through other area DaVita facilities, will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis.

Sincerely,

James K. Hilger
Chief Accounting Officer
DaVita Inc.

Subscribed and sworn to me
This 10th day of October, 2012

Notary Public

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

Attachment – 26F

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(f), Support Services

Attached at Attachment – 26F is a letter from James K. Hilger, Chief Accounting Officer of DaVita and Renal Treatment Centers - Illinois, 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 Rockford 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 24-station dialysis facility. Accordingly, this criterion is met.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(h), Continuity of Care

Included at Attachment – 26G is a copy of a letter agreement from OSF Saint Anthony Medical Center agreeing to accept the Applicants' ESRD patients for inpatient care and other hospital services when needed.

OSF
SAINT ANTHONY MEDICAL CENTER

December 29, 2004

Sue Chavez
DaVita Roxbury Dialysis
622 Roxbury Drive
Rockford, Illinois 61107

Re: Letter of Support

Dear Ms. Chavez:

This letter serves to affirm OSF Saint Anthony Medical Center's (Hospital) support of Renal Treatment Centers, Illinois, Inc. d/b/a Davita Roxbury Dialysis. Our Medical Center will provide the following services to you or your patients:

Blood Bank Services
General Acute Care Services
Rehabilitation Services
Emergency Services
Radiological Services
Emergency Lab Services

Transfer or referral of patients between the Hospital and the dialysis facility will be affected whenever such transfer or referral is determined as medically appropriate by the attending physician, with timely acceptance and admission. It is the Hospital's understanding that all information necessary for the care and treatment of these patients will also be transferred or referred between the facilities and that the dialysis facility will be fully accredited and approved by appropriate regulatory bodies.

Sincerely,

David A. Schertz, CHE
Administrator

kp

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(i), Relocation of Facilities

The Existing Facility is suboptimal for both patients and staff. The Existing Facility is suboptimal for both patients and staff. As the Applicant does not own the building and the lease term is nearing its end, it has determined that it will be better able to serve the needs of its patients if the service is relocated to a modernized facility. The Existing Facility is located in a building that is old, poorly configured, and in need of repair. The Existing Facility presents numerous challenges, as there is limited clinical space and support space for the growing patient population of the nephrology group that utilizes the DaVita facilities in the area. Years ago, the facility was originally designed as a 12-station unit, but was later doubled in size by the prior operator. The revised configuration not only resulted in limited support space for nursing staff, but resulted in suboptimal sight-lines for monitoring of patients. Patients also face difficulties when entering and exiting the Existing Facility, as the unit is in the basement of the building. Finally, the capital costs for reconfiguring the Existing Facility exceed the cost of relocating to a modern facility, and will not address difficulties associated with the unit's location in the basement. By relocating to a more modern space, the Applicants will ensure that patients receive access to modern, high quality dialysis treatment.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(j), Assurances

Attached at Attachment – 26H is a letter from James K. Hilger, Chief Accounting Officer of DaVita and Renal Treatment Centers - Illinois, Inc. certifying that the proposed facility will achieve target utilization by the second year of operation

DaVita.

2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

October 10, 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, Churchview Dialysis expects to achieve and maintain 80% target utilization; and
- Churchview Dialysis also expects hemodialysis outcome measures will be achieved and maintained at the following minimums:
  - ≥ 85% of hemodialysis patient population achieves urea reduction ratio (URR) ≥ 65% and
  - ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II .1.2

Sincerely,

James K. Hilger
Chief Accounting Officer
DaVita Inc.

Subscribed and sworn to me
This 10th day of October, 2012

Notary Public

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

Attachment – 26H

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded entirely with cash and cash equivalents, and a lease from Dyn 417, LLC. A copy of DaVita's 2011 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 12-034.

Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

The project will be funded entirely with cash. A copy of DaVita's 2011 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 12-034.

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment – 42A is a letter from James K. Hilger, Chief Accounting Officer of DaVita and Renal Treatment Centers - Illinois, Inc. attesting that the total estimated project costs will be funded entirely with cash.

Attachment – 42A

DaVita.

2000 16th Street
Denver, CO 80202
(303) 405-2100
www.davita.com

October 10, 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 total with cash and cash equivalents.

Sincerely,

James K. Hilger
Chief Accounting Officer
DaVita Inc.

Subscribed and sworn to me
This 10th day of October, 2012

Linda N. O'Connell
Notary Public

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

Attachment – 42A

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(b), Conditions of Debt Financing

This project will be funded in total with cash and cash equivalents. Accordingly, this criterion is not applicable.

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(c), Reasonableness of Project and Related Costs

1. The Cost and Gross Square Feet by Department is provided in the table below.

Table 1120.310(c)
COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
ESRD		142.03			10,884			$1,545,904	$1,545,904
Contingency		$19.88			10,884			$216,427	$216,427
TOTALS		$161.91			10,884			$1,762,331	$1,762,331

* 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 Costs	$1,545,904	$182.00 per gross square foot x 10,884 gross square feet = $1,980,888	Below State Standard
Contingencies	$216,427	10 - 15% of Modernization Costs = 10 – 15% x $1,545,904 = $154,590 - $231,886	Meets State Standard
Architectural/Engineering Fees	$97,596	6.22 – 9.34% x (Construction Costs + Contingencies) = 6.22 – 9.34% x ($1,545,904 + $216,427) = $1,762,331 6.22 – 9.34%% x $ = $109,617– $164,602	Below State Standard
Consulting and Other Fees	$87,500	No State Standard	No State Standard
Moveable Equipment	$737,849	$39,945 per station $39,945 x 24 = $958,680	Below State Standard

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(d), Projected Operating Costs

Operating Expenses: $4,454,128

Treatments: 18,876

Operating Expense per Treatment: $235.97

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(e), Total Effect of Project on Capital Costs

Capital Costs

Depreciation:	$257,293
Amortization:	$12,523
Total Capital Costs:	$269,816

Treatments: 18,876

Capital Costs per Treatment: $14.29

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita Inc. and its affiliates are safety net providers of dialysis services to residents of the State of Illinois. 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, was previously submitted on October 2, 2012 as part of Applicants' application for Proj. No. 12-085. 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.

2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. This project only involves the relocation of the Applicants' 24-station facility to address limitations at the current site. It will not involve an expansion of services, and will thus not impact other general health care providers' ability to cross-subsidize safety net services.

3. The proposed project is for the relocation of Churchview Dialysis and the addition of 2 stations at its new location located 2.35 miles from its current location. Patients currently treated at Churchview Dialysis will receive treatment at the new facility. As such, the discontinuation of service at the current location will not negatively impact the safety net.

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**

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 1 – Time & Distance Determination: Discontinuation

Attached as Appendix I is the list of all non-DaVita existing facilities within 45 minutes normal travel time from the Existing Facility and the distance and normal travel time determinations from MapQuest.

Facilities within 45 Minutes Normal Travel Time						
Facility	**City**	**Distance**	**Time**	**Stations**	**Patients (9-30-2012)**	**Utilization (9-30-2012)**
Stonecrest Dialysis	Rockford	5.33	11	10	60	100.00%
Rockford Memorial Hospital	Rockford	8.48	17	20	110	91.67%
Roxbury Dialysis	Rockford	2.28	4	16	110	114.58%
Churchview Dialysis - East Rockford	East Rockford	2.72	5	24	98	68.06%
Quality Renal Care	Marengo	25.4	36	10	26	43.33%

mapquest

Trip to:
2400 N Rockton Ave
Rockford, IL 61103-3655
5.84 miles / 13 minutes
Notes

This domain is b

The Polsinelli Shughart Communica access to this site.

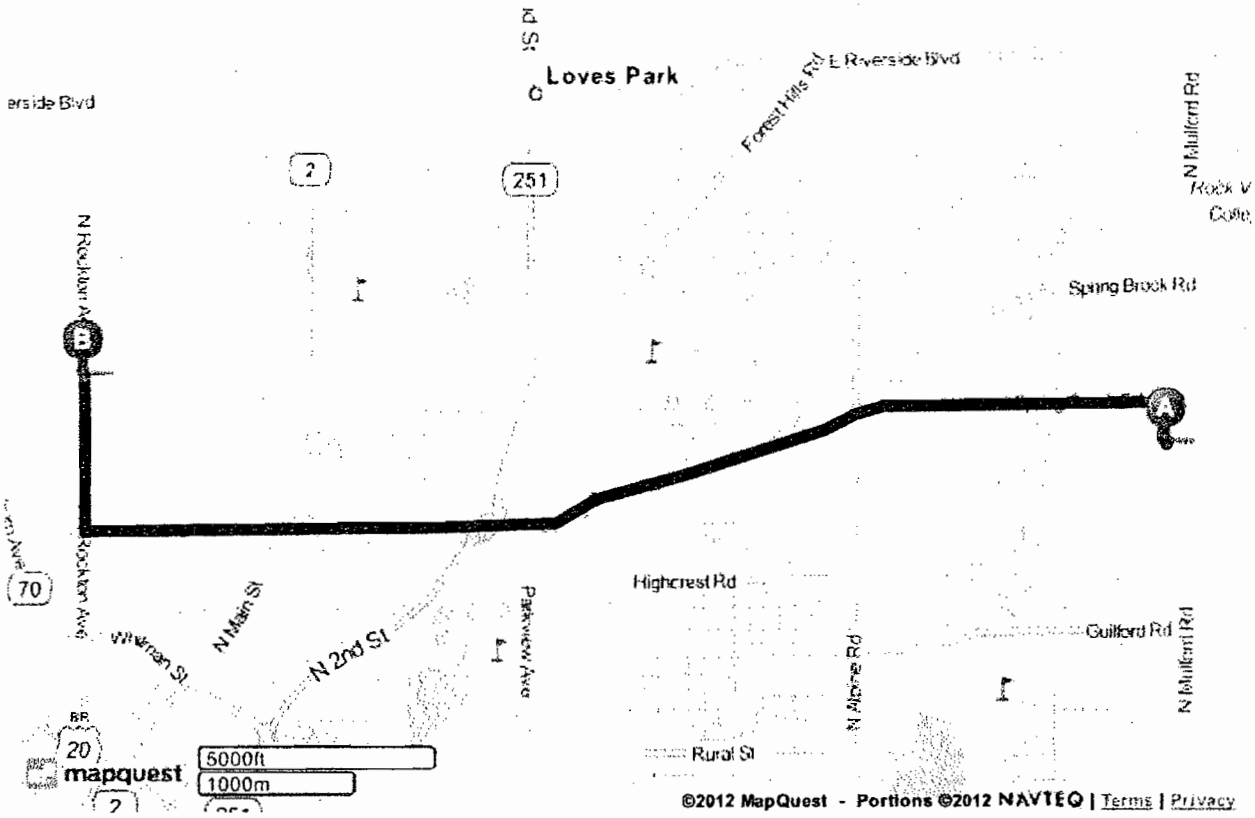
If you believe this is an error or have please contact the Support Center b

5970 Churchview Dr, Rockford, IL 61107-2574

1. Start out going **west** on **Churchview Dr** toward **Bellflower Ln.** Map	**0.01 Mi** *0.01 Mi Total*
2. Turn **right** to stay on **Churchview Dr.** Map	**0.2 Mi** *0.2 Mi Total*
3. Turn **left** onto **Spring Creek Rd.** Map	**3.4 Mi** *3.6 Mi Total*
4. **Spring Creek Rd** becomes **Auburn St.** Map	**1.6 Mi** *5.2 Mi Total*
5. Turn **right** onto **N Rockton Ave.** Map *N Rockton Ave is just past Tacoma Ave* *Pizza Hut is on the corner* *If you reach Auburn Ct you've gone a little too far*	**0.7 Mi** *5.8 Mi Total*
6. **2400 N ROCKTON AVE** is on the **left.** Map *Your destination is just past Fulton Ave* *If you reach Sharon Ave you've gone a little too far*	

2400 N Rockton Ave, Rockford, IL 61103-3655

Total Travel Estimate: **5.84 miles - about 13 minutes**



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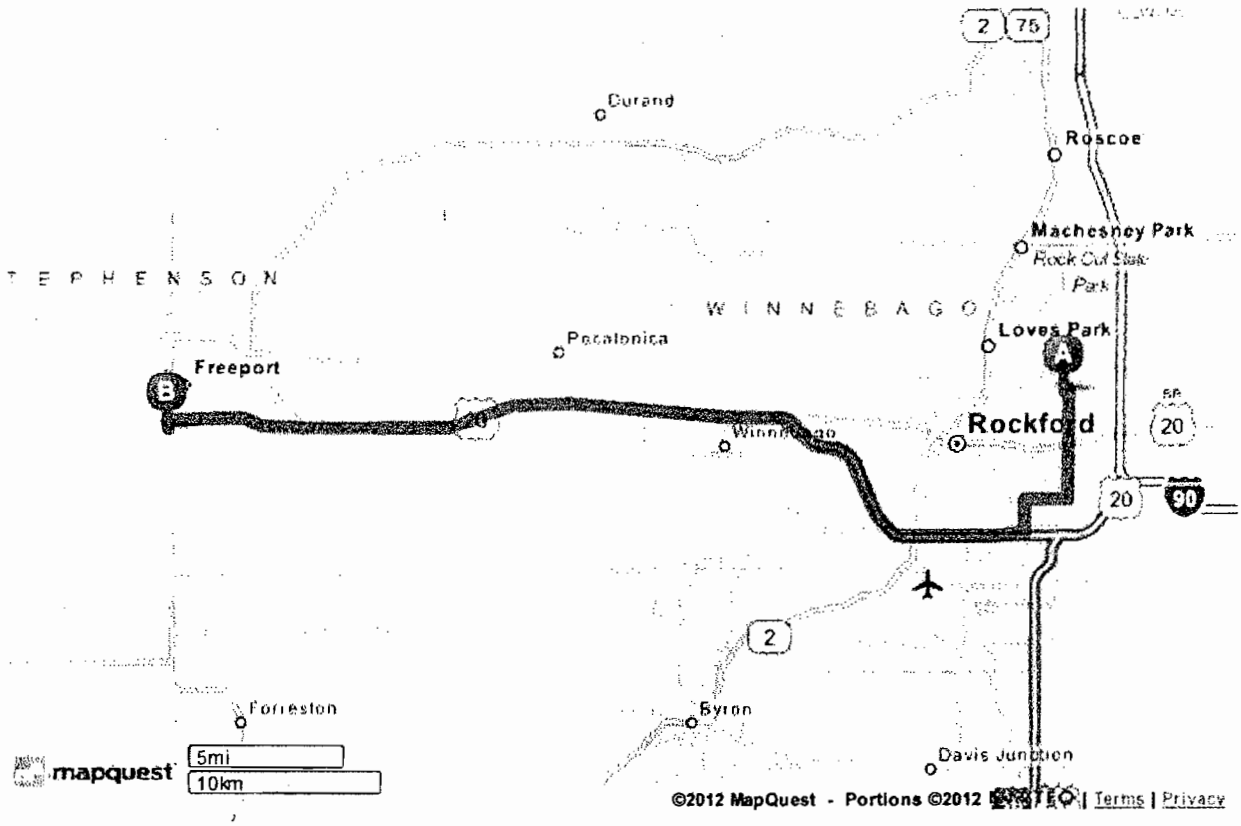
please contact the Support Center b
extension 4321 (816 360 4321)

5970 Churchview Dr, Rockford, IL 61107-2574

1. Start out going **northeast** on **Churchview Dr** toward **Bellflower Ln**. Map	**0.1 Mi** *0.1 Mi Total*
2. Turn **right** onto **N Mulford Rd**. Map	**3.9 Mi** *4.0 Mi Total*
3. Turn **right** onto **Harrison Ave**. Map *Harrison Ave is 0.2 miles past Columbine Blvd* *Angelo's Restaurant & Pizzeria is on the right* *If you reach Darlene Dr you've gone about 0.1 miles too far*	**1.5 Mi** *5.5 Mi Total*
4. Turn **left** onto **S Alpine Rd**. Map *S Alpine Rd is 0.1 miles past Holmes St* *Walgreens is on the corner* *If you are on Harrison Ave and reach Manchester Dr you've gone about 0.1 miles too far*	**1.2 Mi** *6.7 Mi Total*
5. Merge onto **US-20 W / Ulysses S Grant Memorial Hwy** toward **Freeport**. Map *If you reach Linden Rd you've gone about 0.3 miles too far*	**28.0 Mi** *34.6 Mi Total*
6. Merge onto **US-20-BR W** toward **Freeport**. Map	**3.6 Mi** *38.2 Mi Total*
7. **US-20-BR W** becomes **E South St**. Map	**1.7 Mi** *39.9 Mi Total*
8. Turn **left** onto **S West Ave / IL-26**. Map *S West Ave is 0.1 miles past Midwest Ct* *If you reach Willard Dr you've gone a little too far*	**0.3 Mi** *40.3 Mi Total*
9. **1808 S WEST AVE** is on the **right**. Map *Your destination is just past W Meadows Dr* *If you reach Woodside Dr you've gone about 0.3 miles too far*	

1808 S West Ave, Freeport, IL 61032-6712

Total Travel Estimate: **40.29 miles - about 48 minutes**



mapquest

Trip to:
612 Roxbury Rd
Rockford, IL 61107-5089
2.92 miles / 5 minutes
Notes

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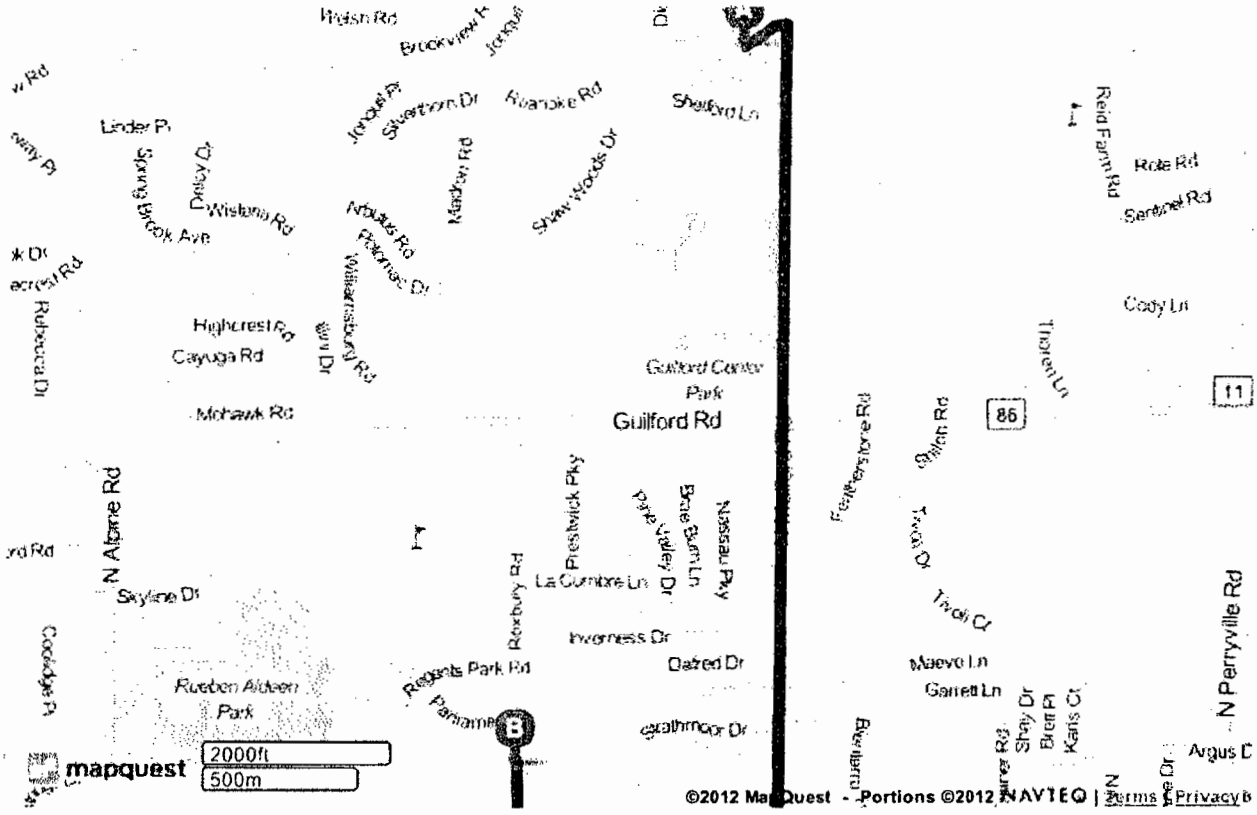
5970 Churchview Dr, Rockford, IL 61107-2574

1. Start out going **northeast** on **Churchview Dr** toward **Bellflower Ln.** Map	**0.1 Mi**	
	0.1 Mi Total	
2. Turn **right** onto **N Mulford Rd.** Map	**1.9 Mi**	
	2.0 Mi Total	
3. Turn **right** onto **E State St / US-20-BR.** Map *E State St is 0.1 miles past Mulford Village Dr* *Oscar's Pub & Grill is on the right* *If you are on S Mulford Rd and reach Fincham Dr you've gone about 0.1 miles too far*	**0.4 Mi** *2.5 Mi Total*	
4. Take the 2nd **right** onto **Roxbury Rd.** Map *Roxbury Rd is just past Justin Ct* *Lino's is on the left* *If you reach N Newtowne Dr you've gone about 0.3 miles too far*	**0.4 Mi** *2.9 Mi Total*	
5. **612 ROXBURY RD** is on the **left.** Map *Your destination is just past Strathmoor Dr* *If you reach Parliament Pl you've gone about 0.1 miles too far*		

612 Roxbury Rd, Rockford, IL 61107-5089

Total Travel Estimate: **2.92 miles - about 5 minutes**



mapquest

Trip to:
910 Greenlee St Unit B
Marengo, IL 60152-8200
25.40 miles / 36 minutes
Notes

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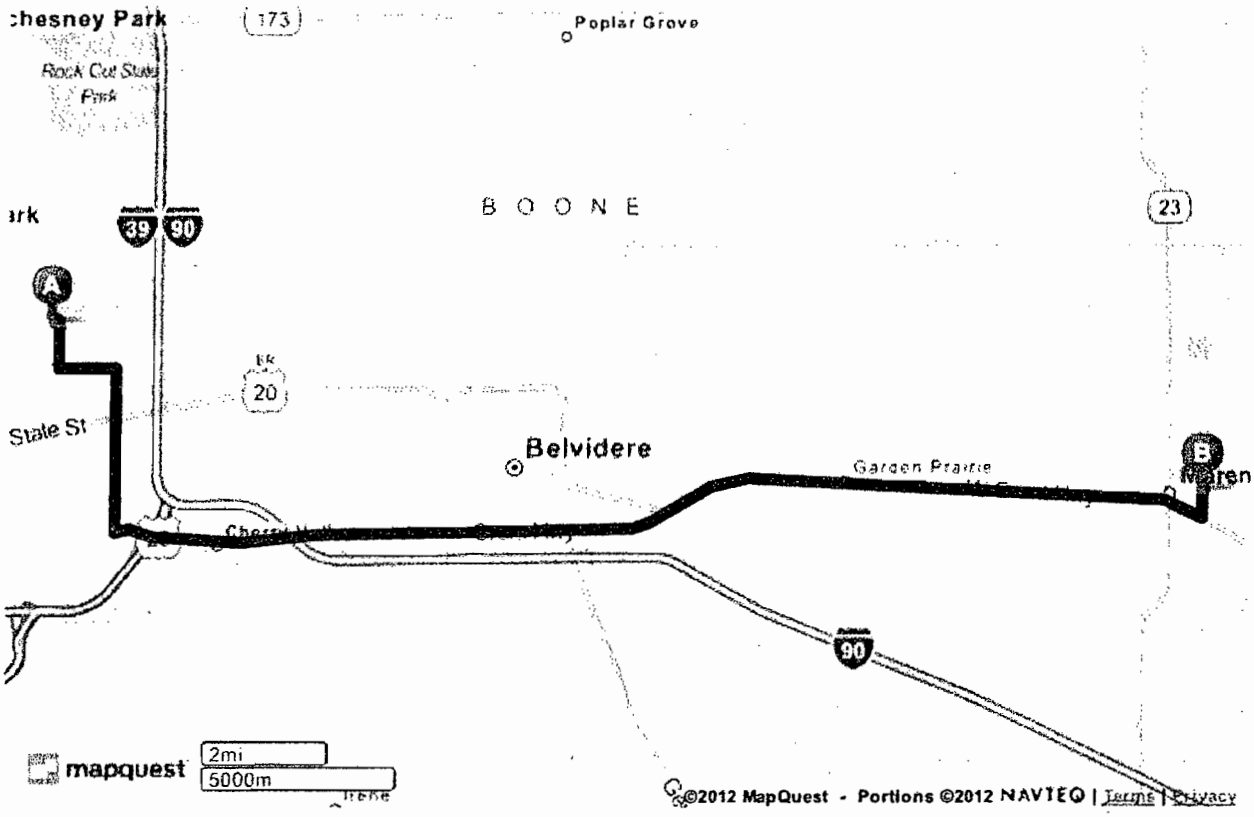
If you believe this is an error or have please contact the Support Center b

5970 Churchview Dr, Rockford, IL 61107-2574

1. Start out going **northeast** on **Churchview Dr** toward **Bellflower Ln.** Map	**0.1 Mi** *0.1 Mi Total*
2. Turn **right** onto **N Mulford Rd.** Map	**0.9 Mi** *1.0 Mi Total*
3. Take the 2nd **left** onto **Guilford Rd / CR-86.** Map *Guilford Rd is 0.1 miles past Thorngate Dr* *If you reach Vantage Pl you've gone about 0.1 miles too far*	**1.0 Mi** *2.0 Mi Total*
4. Turn **right** onto **N Perryville Rd / CR-11 S.** Map *N Perryville Rd is 0.1 miles past Derby Ln* *If you reach Red Oak Ln you've gone about 0.1 miles too far*	**2.9 Mi** *4.9 Mi Total*
5. Turn **left** onto **Harrison Ave.** Map *Harrison Ave is 0.1 miles past Griggs Crossing Rd* *If you reach Mill Rd you've gone about 1.0 mile too far*	**0.7 Mi** *5.6 Mi Total*
6. **Harrison Ave** becomes **US-20 W.** Map	**19.3 Mi** *24.9 Mi Total*
7. Turn **left** onto **S Prospect St.** Map *S Prospect St is 0.1 miles past Locust St* *Cafe 20 is on the left* *If you reach Riley Dr you've gone a little too far*	**0.5 Mi** *25.4 Mi Total*
8. Take the 1st **right** onto **Greenlee St.** Map *Greenlee St is 0.2 miles past E Prairie St* *If you reach Telegraph St you've gone about 0.3 miles too far*	**0.02 Mi** *25.4 Mi Total*
9. **910 GREENLEE ST UNIT B** is on the **right.** Map	

910 Greenlee St Unit B, Marengo, IL 60152-8200

Total Travel Estimate: **25.40 miles - about 36 minutes**



mapquest

Trip to:
1302 E State St
Rockford, IL 61104-2228
5.97 miles / 12 minutes
Notes

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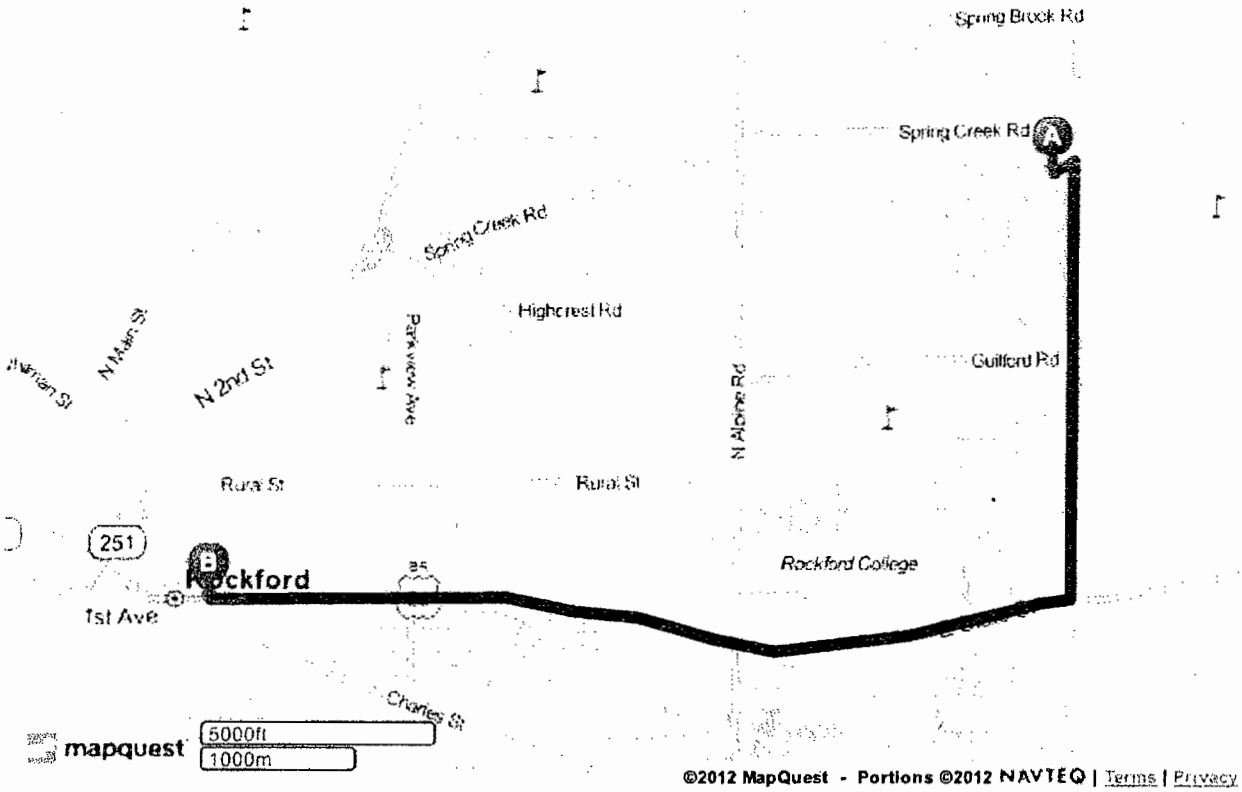
If you believe this is an error or have please contact the Support Center b

5970 Churchview Dr, Rockford, IL 61107-2574

1. Start out going **northeast** on **Churchview Dr** toward **Bellflower Ln.** Map	**0.1 Mi** *0.1 Mi Total*
2. Turn **right** onto **N Mulford Rd.** Map	**1.9 Mi** *2.0 Mi Total*
3. Turn **right** onto **E State St / US-20-BR.** Map *E State St is 0.1 miles past Mulford Village Dr* *Oscar's Pub & Grill is on the right* *If you are on S Mulford Rd and reach Fincham Dr you've gone about 0.1 miles too far*	**3.9 Mi** *6.0 Mi Total*
4. **1302 E STATE ST** is on the **right.** Map *Your destination is just past Summit St* *If you reach N 9th St you've gone a little too far*	

1302 E State St, Rockford, IL 61104-2228

Total Travel Estimate: **5.97 miles - about 12 minutes**



Appendix 2 – Discontinuation Impact Letters

Attached as Appendix II is documentation that Letters of Impact of Discontinuation and Relocation were sent to all non-DaVita existing dialysis within 45 minutes normal driving distance, as determined by MapQuest.

From: (312) 873-3665
Joseph T. Van Leer
Polsinelli Shughart PC
161 N. Clark Street
Suite 4200
Chicago, IL 60601

Origin ID: CHIA

FedEx Express

J1220121015032S

Ship Date: 29OCT12
ActWgt: 1.0 LB
CAD: 9383503/INET3300

Delivery Address Bar Code

Ref # 084628-435977
Invoice #
PO #
Dept #

SHIP TO: (847) 426-6456
Quality Renal Care

910 GREENLEE ST
UNIT B
MARENGO, IL 60152

BILL SENDER

TUE - 30 OCT A4
STANDARD OVERNIGHT

TRK# 7939 5585 3871
0201

79 RFDA

60152
IL-US
ORD

515G1/9CC8/AA44

After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.
Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

Churchview Dialysis Center
5970 Churchview Drive
East Rockford, Illinois 61107

October 29, 2012

FEDERAL EXPRESS

Quality Renal Care
910 Greenlee Unit #B
Marengo, IL 60152

To Whom It May Concern:

I am writing on behalf of DaVita Inc. and Renal Treatment Centers - Illinois, Inc. to inform you of the proposed relocation of Churchview Dialysis, a 24-station dialysis facility located at 5970 Churchview Drive, East Rockford, Illinois 61107 (the "Existing Facility"). DaVita plans to relocate the Existing Facility to a nearby location. Your facility is within 45 minutes travel time of the Existing Facility.

The estimated date of discontinuation and relocation is no later than November 13, 2013.

Over the past two years, the facility has served between 82 and 98 end-stage renal disease patients at any given time and the census at the end of September 2012 was 98. We expect all existing patients of the Existing Facility will be transferred to the replacement facility.

While we do not anticipate the project will impact access to care for residents of the area or area health care facilities because we will accommodate the Churchview Dialysis Center patient base at another nearby location, the Illinois Health Facilities and Services Review Board requires us to inform you of these plans to provide you an option to provide an impact statement from your facility.

If you choose to provide such a response, please detail whether your facility's admissions policies place any restrictions or limitations on providing service to residents of the market area and your capacity by shift. Please send any such response within fifteen days of receipt of this letter to Kara M. Friedman, Polsinelli Shughart, PC, 161 North Clark Street, Suite 4200, Chicago, Illinois 60601. If we do not receive a response from you within fifteen days, it will be assumed that you agree that the relocation of the Existing Facility will not affect your facility.

If you have any questions about DaVita's plans to relocate the facility, please feel free to contact Kara M. Friedman at kfriedman@polsinelli.com or 312-873-3639.

Sincerely,

On behalf of

DaVita Inc.
Renal Treatment Centers - Illinois, Inc.

Appendix 3 – Time & Distance Determination: Replacement Facility

Attached as Appendix III are the distance and normal travel time determinations from the proposed facility to all existing dialysis facilities within 30 minutes normal travel time as determined by MapQuest.

mapquest

Trip to:
612 Roxbury Rd
Rockford, IL 61107-5089
2.28 miles / 4 minutes
Notes

This domain is b

The Polsinelli Shughart Communica access to this site.

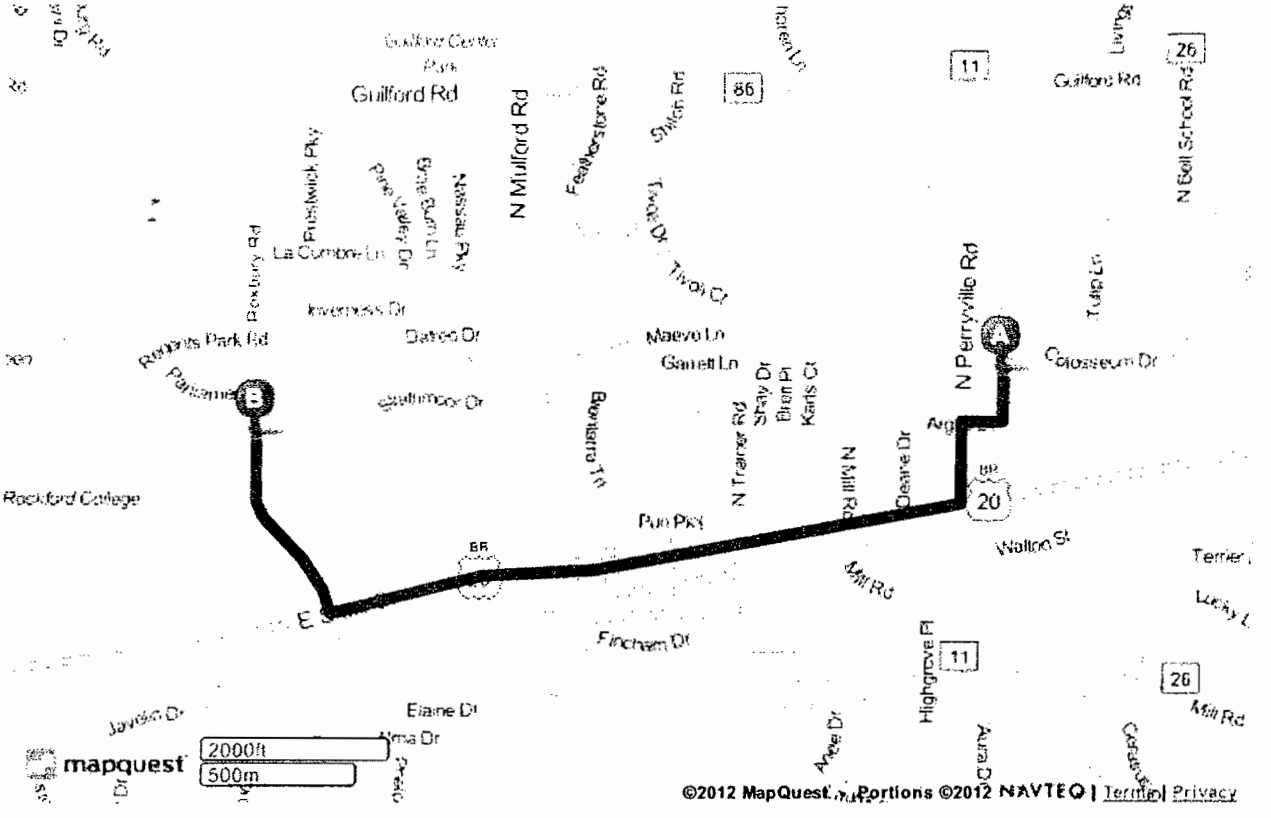
If you believe this is an error or have please contact the Support Center b

417 Ware Ave, Rockford, IL 61107-6413

1. Start out going **south** on **Ware Ave** toward **Argus Dr.** Map	**0.1 Mi**	
	0.1 Mi Total	
2. Turn **right** onto **Argus Dr.** Map	**0.09 Mi**	
	0.2 Mi Total	
3. Take the 1st **left** onto **N Perryville Rd / CR-11.** Map *If you reach Deane Dr you've gone about 0.1 miles too far*	**0.2 Mi**	
	0.4 Mi Total	
4. Take the 1st **right** onto **E State St / US-20-BR.** Map *If you are on S Perryville Rd and reach Walton St you've gone about 0.1 miles too far*	**1.4 Mi**	
	1.8 Mi Total	
5. Turn **right** onto **Roxbury Rd.** Map *Roxbury Rd is just past Justin Ct* *Lino's is on the left* *If you reach N Newtowne Dr you've gone about 0.3 miles too far*	**0.4 Mi**	
	2.3 Mi Total	
6. **612 ROXBURY RD** is on the **left.** Map *Your destination is just past Strathmoor Dr* *If you reach Parliament Pl you've gone about 0.1 miles too far*		

612 Roxbury Rd, Rockford, IL 61107-5089

Total Travel Estimate: **2.28 miles - about 4 minutes**



mapquest

Trip to:
5970 Churchview Dr
Rockford, IL 61107-2574
2.72 miles / 5 minutes
Notes

This domain is b

The Polsinelli Shughart Communica access to this site.

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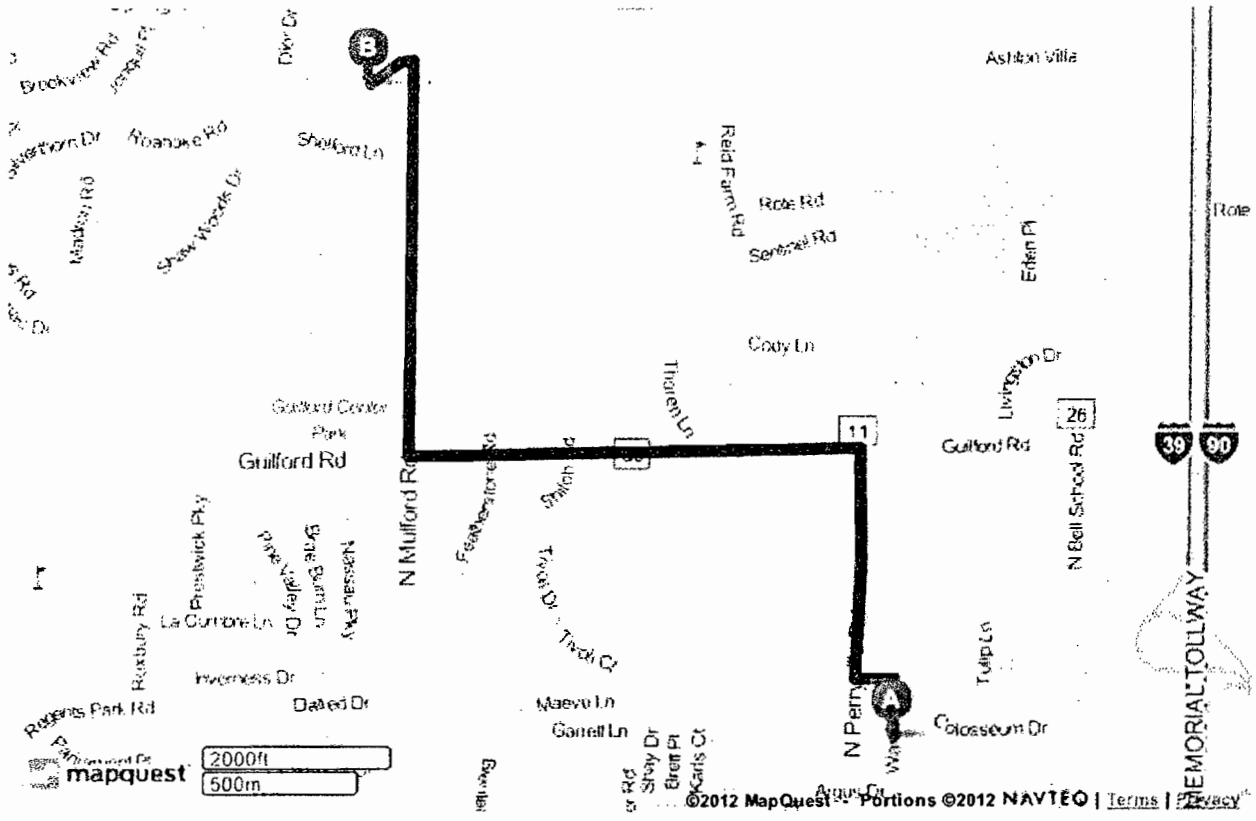
417 Ware Ave, Rockford, IL 61107-6413

1.	Start out going **north** on **Ware Ave** toward **Colosseum Dr.** Map	**0.1 Mi** *0.1 Mi Total*
2.	Turn **left** onto **Colosseum Dr.** Map	**0.09 Mi** *0.2 Mi Total*
3.	Take the 1st **right** onto **N Perryville Rd / CR-11 N.** Map *Heartland Community is on the right* *If you are on Garrett Ln and reach Joyce Ave you've gone about 0.2 miles too far*	**0.5 Mi** *0.7 Mi Total*
4.	Turn **left** onto **Guilford Rd.** Map *Guilford Rd is 0.3 miles past Crimson Ridge Dr* *If you reach Sentinel Rd you've gone about 0.4 miles too far*	**1.0 Mi** *1.7 Mi Total*
5.	Turn **right** onto **N Mulford Rd.** Map *N Mulford Rd is 0.1 miles past Featherstone Rd* *If you reach Mayfield Ct you've gone about 0.2 miles too far*	**0.9 Mi** *2.6 Mi Total*
6.	Take the 3rd **left** onto **Churchview Dr.** Map *Churchview Dr is 0.1 miles past Gale Ln* *If you reach Spring Creek Rd you've gone about 0.1 miles too far*	**0.1 Mi** *2.7 Mi Total*
7.	**5970 CHURCHVIEW DR** is on the **right.** Map *Your destination is just past Bellflower Ln* *If you reach Bellflower Ln you've gone a little too far*	

5970 Churchview Dr, Rockford, IL 61107-2574

Total Travel Estimate: **2.72 miles - about 5 minutes**



mapquest

Trip to:
1302 E State St
Rockford, IL 61104-2228
5.33 miles / 11 minutes
Notes

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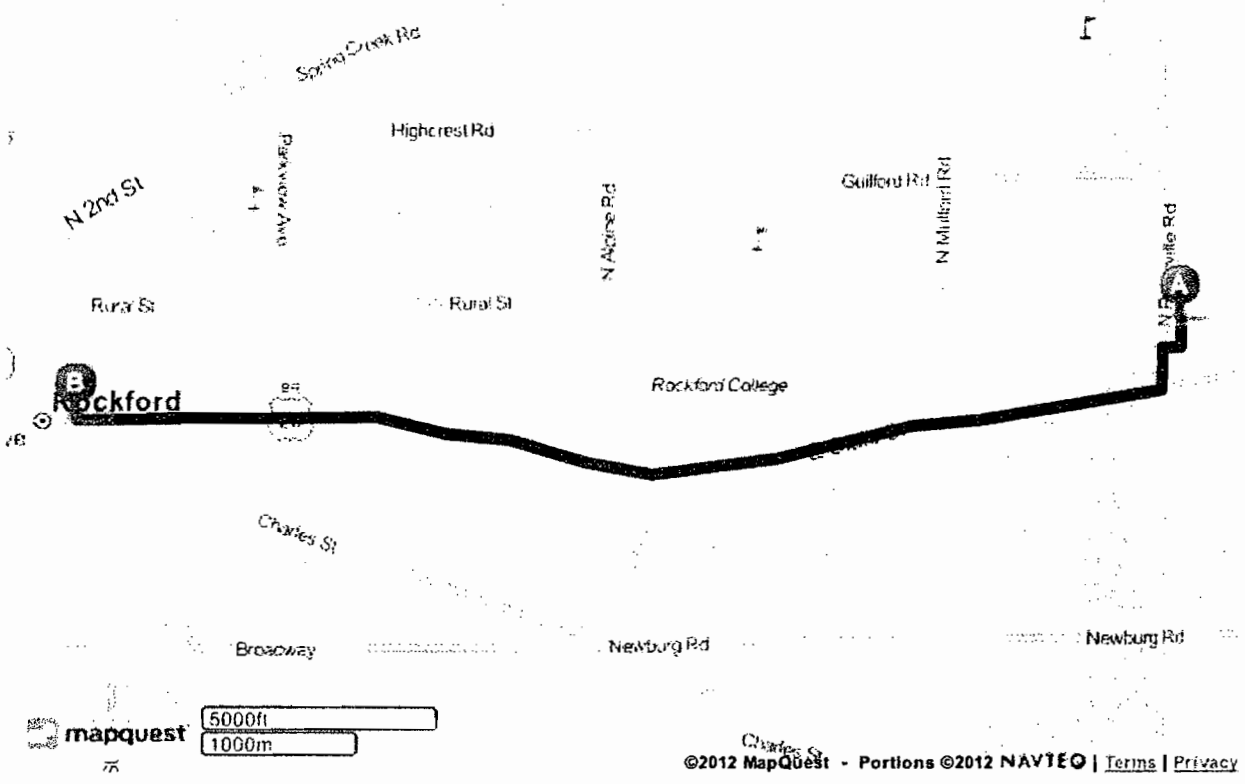
If you believe this is an error or have please contact the Support Center b

417 Ware Ave, Rockford, IL 61107-6413

1. Start out going **south** on **Ware Ave** toward **Argus Dr.** Map	**0.1 Mi**	*0.1 Mi Total*
2. Turn **right** onto **Argus Dr.** Map	**0.09 Mi**	*0.2 Mi Total*
3. Take the 1st **left** onto **N Perryville Rd / CR-11.** Map *If you reach Deane Dr you've gone about 0.1 miles too far*	**0.2 Mi**	*0.4 Mi Total*
4. Take the 1st **right** onto **E State St / US-20-BR.** Map *If you are on S Perryville Rd and reach Walton St you've gone about 0.1 miles too far*	**4.9 Mi**	*5.3 Mi Total*
5. **1302 E STATE ST** is on the **right.** Map *Your destination is just past Summit St* *If you reach N 9th St you've gone a little too far*		

1302 E State St, Rockford, IL 61104-2228

Total Travel Estimate: **5.33 miles - about 11 minutes**



mapquest

Trip to:
2400 N Rockton Ave
Rockford, IL 61103-3655
8.48 miles / 17 minutes
Notes

This domain is b

The Polsinelli Shughart Communica access to this site.

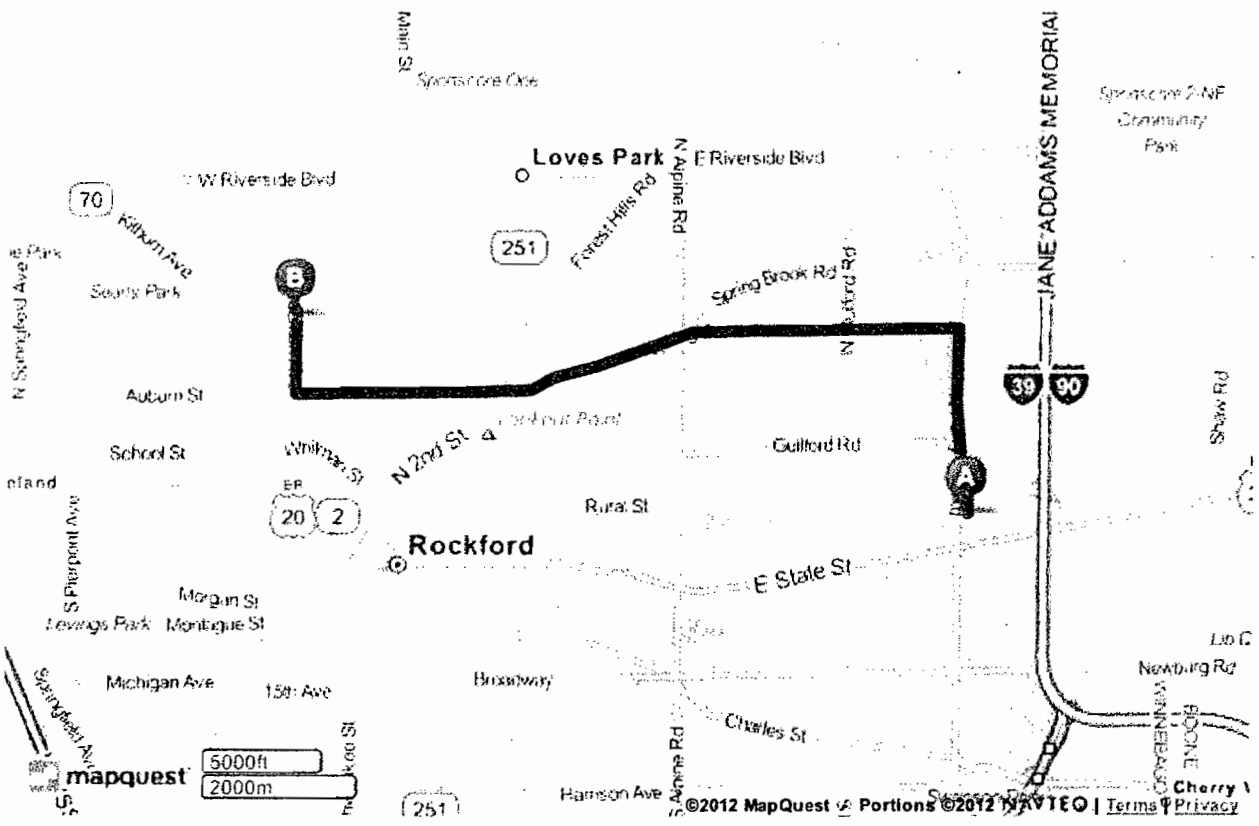
If you believe this is an error or have please contact the Support Center b

417 Ware Ave, Rockford, IL 61107-6413

1.	Start out going **north** on **Ware Ave** toward **Colosseum Dr.** Map	**0.1 Mi** *0.1 Mi Total*
2.	Turn **left** onto **Colosseum Dr.** Map	**0.09 Mi** *0.2 Mi Total*
3.	Take the 1st **right** onto **N Perryville Rd / CR-11 N.** Map *Heartland Community is on the right* *If you are on Garrett Ln and reach Joyce Ave you've gone about 0.2 miles too far*	**1.5 Mi** *1.7 Mi Total*
4.	Turn **left** onto **Spring Creek Rd / Perry Creek Pky.** Continue to follow **Spring Creek Rd.** Map *Spring Creek Rd is 0.4 miles past Rote Rd* *If you reach Olde Creek Rd you've gone about 0.5 miles too far*	**4.5 Mi** *6.2 Mi Total*
5.	**Spring Creek Rd** becomes **Auburn St.** Map	**1.6 Mi** *7.8 Mi Total*
6.	Turn **right** onto **N Rockton Ave.** Map *N Rockton Ave is just past Tacoma Ave* *Pizza Hut is on the corner* *If you reach Auburn Ct you've gone a little too far*	**0.7 Mi** *8.5 Mi Total*
7.	**2400 N ROCKTON AVE** is on the **left.** Map *Your destination is just past Fulton Ave* *If you reach Sharon Ave you've gone a little too far*	

2400 N Rockton Ave, Rockford, IL 61103-3655

Total Travel Estimate: **8.48 miles - about 17 minutes**



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

INDEX OF ATTACHMENTS