

Original

13-070

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

RECEIVED**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

DEC 13 2013

This Section must be completed for all projects.HEALTH FACILITIES &
SERVICES REVIEW BOARD**Facility/Project Identification**

Facility Name: Belvidere Dialysis		
Street Address: 1755 Beloit Road		
City and Zip Code: Belvidere, Illinois 61008		
County: Boone	Health Service Area: 1	Health Planning Area: 1

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

Exact Legal Name: DaVita HealthCare Partners Inc.
Address: 2000 16 th Street, Denver, CO 80202
Name of Registered Agent: Illinois Corporation Service Company
Name of Chief Executive Officer: Kent Thiry
CEO Address: 2000 16 th Street, Denver, CO 80202
Telephone Number: (303) 405-2100

Type of Ownership of Applicant/Co-Applicant

- | | |
|--|---|
| ☐ Non-profit Corporation | ☐ Partnership |
| ☒ For-profit Corporation | ☐ Governmental |
| ☐ Limited Liability Company | ☐ Sole Proprietorship ☐ Other |
- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
 - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact**[Person to receive ALL correspondence or inquiries]**

Name: Tim Tincknell
Title: Administrator, CON Projects
Company Name: DaVita HealthCare Partners, Inc.
Address: 2611 North Halsted Street, Chicago, Illinois 60614
Telephone Number: 773-549-9412
E-mail Address: timothy.tincknell@davita.com
Fax Number: 866-586-3214

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

Name: Mary J. Anderson
Title: Divisional Vice President
Company Name: DaVita HealthCare Partners Inc.
Address: 1131 North Galena, Dixon, Illinois 61021
Telephone Number: 815-284-0595, Ext 20
E-mail Address: mary.j.anderson@davita.com
Fax Number: 866-594-1131

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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Street Address: 1755 Beloit Road		
City and Zip Code: Belvidere, Illinois 61008		
County: Boone	Health Service Area: 1	Health Planning Area: 1

Applicant /Co-Applicant Identification

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

Exact Legal Name: Dialysis of Northern Illinois, LLC	
Address: 2000 16 th Street, Denver, CO 80202	
Name of Registered Agent: Illinois Corporation Service Company	
Name of Chief Executive Officer: Kent Thiry	
CEO Address: 2000 16 th 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.	
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E-mail Address: mary.j.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: Charles Sheets
Title: Attorney
Company Name: Polsinelli PC
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3605
E-mail Address: csheets@polsinelli.com
Fax Number: 312-873-3793

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Puri 2004 Dyn Trust
Address of Site Owner: 6801 Spring Creek Road, Rockford, Illinois 61114
Street Address or Legal Description of Site: Lot Five (5) as designated upon the Re-plat of Lot Four (4) of Plat Three (3) of Little Thunder Village Subdivision, being a Subdivision of part of the Southeast Quarter (1/4) of Section 22, Township 44 North, Range 3 East of the Third Principal Meridian, as the same is platted and recorded August 27, 2002, as Document Number 2002R9629 in Plat Index Envelope 270-B in the Recorder's Office of Boone County, Illinois; situated in the County of Boone and State of Illinois
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: Dialysis of Northern Illinois, LLC		
Address: 2000 16 th Street, Denver, CO 80202		
☐ Non-profit Corporation	☐ Partnership	
☒ For-profit Corporation	☐ Governmental	
☐ Limited Liability Company	☐ Sole Proprietorship	☐ Other
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☒ Substantive
☐ Non-substantive

2. Narrative Description

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

DaVita HealthCare Partners Inc. and Dialysis of Northern Illinois, LLC (the "Applicants") seek authority from the Illinois Health Facilities and Services Review Board (the "Board") to establish a 12-station dialysis facility located at 1755 Beloit Road, Belvidere, Illinois 61008. The proposed dialysis facility will include a total of 6,000 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	\$921,400		\$921,400
Modernization Contracts			
Contingencies	\$90,000		\$90,000
Architectural/Engineering Fees	\$75,000		\$75,000
Consulting and Other Fees	\$75,000		\$75,000
Movable or Other Equipment (not in construction contracts)	\$466,405		\$466,405
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	\$1,148,966		\$1,148,966
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$2,776,771		\$2,776,771
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$1,627,805		\$1,627,805
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	\$1,148,966		\$1,148,966
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$2,776,771		\$2,776,771
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 \$ 1,225,716.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): March 31, 2016

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
☐ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

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

Cost Space Requirements

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization

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 HealthCare Partners 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
Martha Ha

PRINTED NAME
Vice President, Assistant Corporate Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 6th day of September, 2013



Signature of Notary
SHANNA MARLENE RISEDORF
Seal NOTARY PUBLIC
STATE OF COLORADO

*Insert EXACT legal name of the applicant
MY COMMISSION EXPIRES 4/13/2015

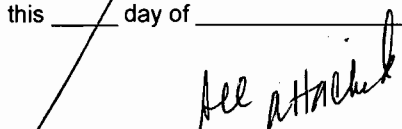


SIGNATURE
Arturo Sida

PRINTED NAME
Vice President, Asst Corporate Secretary

PRINTED TITLE

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


Signature of Notary

Seal

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public
(Here insert name and title of the officer)

personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public



(Notary Seal)

ADDITIONAL OPTIONAL INFORMATION

INSTRUCTIONS FOR COMPLETING THIS FORM

Any acknowledgment completed in California must contain verbiage exactly as appears above in the notary section or a separate acknowledgment form must be properly completed and attached to that document. The only exception is if a document is to be recorded outside of California. In such instances, any alternative acknowledgment verbiage as may be printed on such a document so long as the verbiage does not require the notary to do something that is illegal for a notary in California (i.e. certifying the authorized capacity of the signer). Please check the document carefully for proper notarial wording and attach this form if required.

DESCRIPTION OF THE ATTACHED DOCUMENT

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages _____ Document Date _____

(Additional information)

CAPACITY CLAIMED BY THE SIGNER

- ☐ Individual(s)
☐ Corporate Officer

(Title)

- ☐ Partner(s)
☐ Attorney-in-Fact
☐ Trustee(s)
☐ Other _____

- State and County information must be the State and County where the document signer(s) personally appeared before the notary public for acknowledgment.
- Date of notarization must be the date that the signer(s) personally appeared which must also be the same date the acknowledgment is completed.
- The notary public must print his or her name as it appears within his or her commission followed by a comma and then your title (notary public).
- Print the name(s) of document signer(s) who personally appear at the time of notarization.
- Indicate the correct singular or plural forms by crossing off incorrect forms (i.e. ~~he/she/they~~, is /are) or circling the correct forms. Failure to correctly indicate this information may lead to rejection of document recording.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different acknowledgment form.
- Signature of the notary public must match the signature on file with the office of the county clerk.
 - ❖ Additional information is not required but could help to ensure this acknowledgment is not misused or attached to a different document.
 - ❖ Indicate title or type of attached document, number of pages and date.
 - ❖ Indicate the capacity claimed by the signer. If the claimed capacity is a corporate officer, indicate the title (i.e. CEO, CFO, Secretary).
- Securely attach this document to the signed document

CERTIFICATION

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

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- 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);
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SIGNATURE
Martha Ha

PRINTED NAME
Vice President, Assistant Corporate Secretary

PRINTED TITLE



SIGNATURE
Arturo Sida

PRINTED NAME
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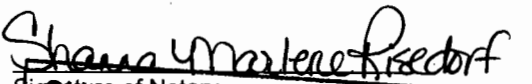
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 6th day of September, 2013

Notarization:

Subscribed and sworn to before me
this ____ day of ____


Signature of Notary
SHANNA MARLENE RISEDORF
Seal
NOTARY PUBLIC
STATE OF COLORADO

* Insert EXACT legal name of the applicant.
MY COMMISSION EXPIRES 4/13/2015

Signature of Notary
Seal

See attached

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public,
(Here insert name and title of the officer)

personally appeared Arturo Sida,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public

(Notary Seal)



ADDITIONAL OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages _____ Document Date _____

(Additional information)

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- ☐ Individual (s)
☐ Corporate Officer

(Title)

- ☐ Partner(s)
☐ Attorney-in-Fact
☐ Trustee(s)
☐ Other _____

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 - ❖ Indicate title or type of attached document, number of pages and date.
 - ❖ Indicate the capacity claimed by the signer. If the claimed capacity is a corporate officer, indicate the title (i.e. CEO, CFO, Secretary).
- Securely attach this document to the signed document

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 Board Report.

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

G. Criterion 1110.1430 - In-Center Hemodialysis

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	0	12

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:**

\$1,627,805	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;
\$1,148,966 (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.
\$2,776,771	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT-36, 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. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, 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 38, 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
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)
								Total Cost (G + H)
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 -39, 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-40, 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-41, 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 HealthCare Partners Inc. and Dialysis of Northern Illinois, LLC (collectively, the "Applicants" or "DaVita") are attached at Attachment – 1. Dialysis of Northern Illinois, LLC will be the operator of Belvidere Dialysis. Belvidere Dialysis is a trade name of Dialysis of Northern Illinois, LLC and is not separately organized. As the person with final control over the operator, DaVita HealthCare Partners Inc. is named as an applicant for this CON application. DaVita HealthCare Partners Inc. does not do business in the State of Illinois. A Certificate of Good Standing for DaVita HealthCare Partners Inc. from the state of its incorporation, Delaware is attached.

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA HEALTHCARE PARTNERS 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 TWELFTH DAY OF DECEMBER, A.D. 2012.

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

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

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

2391269 8300

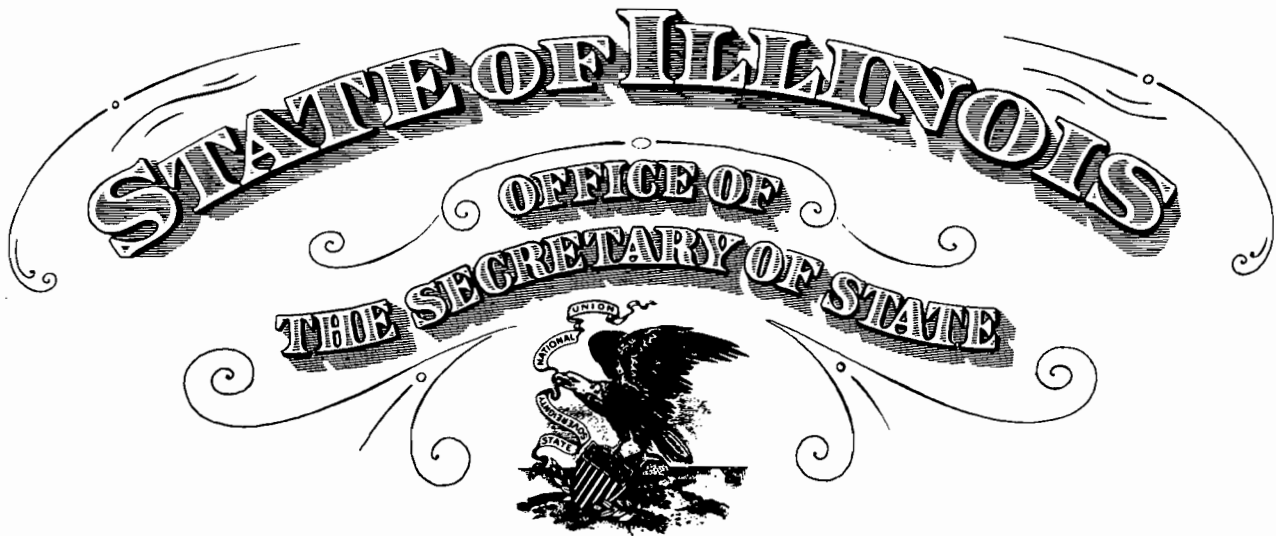
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You may verify this certificate online
at corp.delaware.gov/authver.shtml




Jeffrey W. Bullock, Secretary of State
AUTHENTICATION: 0060461

DATE: 12-12-12



To all to whom these Presents Shall Come, Greeting:

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

DIALYSIS OF NORTHERN ILLINOIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON AUGUST 14, 2003, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1215000762

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

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

Jesse White

SECRETARY OF STATE

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

The letter of intent between Puri 2004 Dyn Trust and Dialysis of Northern Illinois, LLC to lease the facility located at 1755 Beloit Road, Belvidere, Illinois 61008 is attached at Attachment – 2.



USI REAL ESTATE BROKERAGE SERVICES INC.

A USI COMPANY

2215 YORK RD, SUITE 110
OAKBROOK, IL 60523

TELEPHONE: 630-990-3638
FACSIMILE: 630-990-2300

November 19, 2013

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

RE: Request for Proposal
1755 Beloit Road, Belvidere, IL 61008

Dear Bharat:

USI Real Estate Brokerage Services Inc. has been exclusively authorized by Total Renal Care, Inc – a subsidiary of DaVita HealthCare Partners, Inc. ("DaVita") to assist in securing a lease requirement. DaVita is a Fortune 500 company with approximately 2,000 locations across the US and revenues in excess of \$8 billion.

We have been surveying the Belvidere 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 to be built by you through the DaVita Preferred Developer Program ("PDP"). We request that you deliver your response no later than **November 22, 2013**. *Please prepare the proposal to respond to the following terms:*

PREMISES:

Lot Five (5) as designated upon the Re-plat of Lot Four (4) of Plat Three (3) of Little Thunder Village Subdivision, being a Subdivision of part of the Southeast Quarter (1/4) of Section 22, Township 44 North, Range 3 East of the Third Principal Meridian, as the same is platted and recorded August 27, 2002, as Document Number 2002R9629 in Plat Index Envelope 270-B in the Recorder's Office of Boone County, Illinois; situated in the County of Boone and State of Illinois

TENANT:

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

LANDLORD:

Puri 2004 Dyn Trust or related entity to be named

SPACE REQUIREMENTS:

Premises will be approximately 6,000 rentable square feet.

PRIMARY TERM:

15 years

BASE RENT:

Years 1-5: \$20.77 per rsf
Years 6-10: \$22.85 per rsf
Years 11-15: \$25.13 per rsf

This lease is a NNN lease.

ADDITIONAL EXPENSES:

CAM is estimated to be \$1.50 psf
Taxes are estimated to be \$3.25 psf
Insurance is estimated to be \$0.25 psf.

As a single Tenant building, Tenant shall be responsible for 100% of the operating expenses.

Tenant will be responsible for all of its utilities (gas, electric, sewer, water, etc...). No utilities are included in the Base Rent.

Landlord to limit the controllable cumulative operating expense costs to no greater than three percent (3%) increase annually after the first fully stabilized year. Controllable operating expenses exclude real estate taxes, snow plowing and common area utilities.

LANDLORD'S MAINTENANCE:

Landlord, at its sole cost and expense, shall be responsible for the structural and capitalized items (per GAAP standards) for the Property. Notwithstanding the foregoing, the cost for capital expense items shall be amortized over their useful life and the annual amortized amount shall be reimbursed as part of CAM (subject to the annual cap).

**POSSESSION AND
RENT COMMENCEMENT:**

Landlord shall deliver Possession of the Premises to the Tenant upon the later of completion of Landlord's required work (if any) or mutual lease execution. Rent Commencement shall be the earlier of seven (7) 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 to match PDP requirements (as negotiated).

USE:

The Use is for a Dialysis Clinic, medical offices, distribution of pharmaceuticals to Tenant's patients and other lawfully permitted related uses.

Property is zoned General Business, which allow Medical Clinics as a permitted use.

The property is not encumbered by any CCR's that impact Tenant's tenancy.

PARKING:

Landlord will provide a minimum of four (4) parking spaces per 1,000 rsf and two (2) dedicated handicapped stalls.

Please indicate the number and location of parking spaces to be allocated to the Tenant, number of general handicap stalls, total reserved stalls, if there is a patient drop off area, and if the drop off area is covered. (See attached preliminary site plan)

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: Renewal terms to follow standard PDP requirements.

RIGHT OF FIRST OPPORTUNITY ON ADJACENT SPACE: N/A

FAILURE TO DELIVER PREMISES: Terms to match standard PD program.

HOLDING OVER: Terms to match standard PD program.

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 and approval of Landlord. Landlord, at Landlord's expense, will furnish Tenant with any standard building directory signage.

BUILDING HOURS: Tenant shall have access to the building 24 hours a day, 7 days a week.

As this is a single tenant building, there are no building hours for 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 HealthCare Partners, 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, but the location shall be subject to Landlord's approval and Tenant shall use Landlord's roofing contractor.

NON COMPETE: Landlord agrees not to lease space to another dialysis provider within a five (5) mile radius of Premises.

HVAC: New construction

DELIVERIES: Deliveries via man door at location identified in attached preliminary site plan.

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 any governmental laws, ordinances, regulations or orders relating to, but not limited to, compliance with the Americans with Disabilities Act (ADA), and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or 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 January 28, 2014. 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 January 28, 2014 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 brokerage fee in accordance with the PDP agreement. Tenant shall retain the right to offset rent for failure to pay the brokerage fee.

PLANS:

Please provide copies of site and construction plans or drawings.

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

Edgar Levin
edgar.l.levin@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,



Edgar Levin

Cc: John Steffens
Emmett Purcell

LETTER OF INTENT: 1755 BELOIT ROAD, BELVIDERE, IL 61008

AGREED TO AND ACCEPTED THIS 20th DAY OF NOVEMBER 2013

By: [Signature]
Puri 2004 Dyn Trust
("Landlord")

AGREED TO AND ACCEPTED THIS 21 DAY OF NOVEMBER 2013

By: [Signature]
On behalf of Total Renal Care, a wholly owned subsidiary of DaVita HealthCare Partners, Inc.
("Tenant")

EXHIBIT A**NON-BINDING NOTICE**

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

**Exhibit B -- MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS*****SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER*****SCHEDULE A - TO WORK LETTER****MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS**

At a minimum, the Lessor shall provide the following Base Building and Site Development Improvements to meet Lessee's Building and Site Development specifications at Lessor's sole cost:

All MBBi work completed by the Lessor will need to be coordinated and approved by the Lessee and their Consultants prior to any work being completed, including shop drawings and submittal reviews.

1.0 - Building Codes & Design

All Minimum Base Building Improvements (MBBI) and Site Development are to be performed in accordance with all current local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer and must be coordinated with the Lessee Improvement plans and specifications.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all permitting related to the base building and site improvements.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant for Life Safety per current federal, state and local code requirements.

4.0 Foundation and Floor

The foundation and floor of the building shall be in accordance with local code requirements. The foundation and concrete slab shall be designed by the Lessor's engineer to accommodate site-specific Climate and soil conditions and recommendations per Lessor's soil engineering and exploration report (To be reviewed and approved by Lessee's engineer).

Foundation to consist of formed concrete spread footing with horizontal reinforcing sized per geotechnical engineering report. Foundation wall, sized according to exterior wall systems used and to consist of formed and poured concrete with reinforcing bars or a running bond masonry block with proper horizontal and vertical reinforcing within courses and cells. Internal masonry cells to be concrete filled full depth entire building perimeter. Foundation wall to receive poly board R-10 insulation on interior side of wall on entire building perimeter (if required by code). Provide proper foundation drainage.

The floor shall be concrete slab on grade and shall be a minimum five-inch (5") thick with minimum concrete strength of 3,000-psi. It will include one of the following, wire mesh or fiber mesh, and/or rebar reinforcement

over a vapor barrier and granular fill per Lessor's soils and/or structural engineering team based on soil conditions and report from the Soils Engineer. Finish floor elevation to be a minimum of 8" above finish grade. Include proper expansion control joints. Floor shall be level (1/8" with 10' of run), smooth, broom clean with no adhesive residues, in a condition that is acceptable to install floor coverings in accordance with the flooring manufacturer's specifications. Concrete floor shall be constructed so that no more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results after 28 day cure time. Means and methods to achieve this level will be responsibility of the Lessor. Under slab plumbing shall be installed by Lessee's General Contractor in coordination with Lessor's General Contractor, inspected by municipality and Lessee for approval prior to pouring the building slab.

5.0 - Structural

Structural systems shall be designed to provide a minimum 13'-0" clearance (for 10'-0" finished ceiling height and 15' clearance for a 12" ceiling height) to the underside of the lowest structural member from finished slab and meet building steel (Type II construction or better) erection requirements, standards and codes. Structural design to allow for ceiling heights (as indicated above) while accommodating all Mechanical, Plumbing, Electrical above ceiling. Structure to include all necessary members including, but not limited to, columns, beams, joists; load bearing walls, and demising walls. Provide necessary bridging, bracing, and reinforcing supports to accommodate all Mechanical systems (Typical for flat roofs - minimum of four (4) HVAC roof top openings, one (1) roof hatch opening, and four (4) exhaust fans openings). Treatment room shall be column free.

The floor and roof structure shall be fireproofed as needed to meet local building code and regulatory requirements.

Roof hatch shall be provided and equipped with ladders meeting all local, state and federal requirements.

6.0 - Exterior walls

Exterior walls to be fire rated if required by local or State code requirements. If no fire rating is required, walls shall be left as exposed on the interior side of the metal studs or masonry/concrete with exterior insulation as required to meet code requirements and for an energy efficient building shell. Lessee shall be responsible for interior gyp board, taping and finish.

7.0 - Demising walls

All demising walls shall be a 1 or 2hr fire rated wall depending on local, state and/or regulatory (NFPA 101 - 2000) codes requirements whichever is more stringent. Walls will be installed per UL design and taped (Lessee shall be responsible for final finish preparation of gypsum board walls on Lessee side only). At Lessee's option and as agreed upon by Lessor, the interior drywall finish of demising walls shall not be installed until after Lessee's improvements are complete in the wall. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

8.0 - Roof Covering

The roof system shall have a minimum of a twenty (20) year life span with full (no dollar limit - NDL) manufacturer's warrantee against leakage due to ordinary wear and tear. Roof system to include a minimum of R-30 insulation. Ice control measures mechanically or electrically controlled to be considered in climates subject to these conditions. Downspouts to be connected into controlled underground discharge for the rain leaders into the storm system for the site or as otherwise required meeting local storm water treatment requirements. Storm water will be discharged away from the building, sidewalks, and pavement. Roof and all related systems to be maintained by the Lessor for the duration of the lease. Lessor to provide Lessee copy of material and labor roof warranty for record.

9.0 - Parapet

Lessor to provide a parapet wall based on building designed/type and wall height should be from the highest roof line. HVAC Rooftop units should be concealed from public view if required by local code.

10.0 - Façade

Lessor to provide specifications for building façade for lessee review and approval. All wall system to be signed off by a Lessor's Structural Engineer. Wall system "R" value must meet current Energy code. Wall system options include, but not limited to:

4" Face brick Veneer on 6" 16 or 18ga metal studs, R- 19 or higher batt wall insulation, on Tyvek (commercial grade) over 5/8" exterior grade gypsum board or Dens-Glass Sheathing.

Or

2" EIFS on 6" 16 or 18ga metal studs, R- 19 or higher batt wall insulation, on 1/2" cement board or equal.

Or

8" Split faced block with 3-1/2" to 6" 20ga metal stud furring, batt wall insulation to meet energy code and depth of mtl stud used.

11.0 - Canopy

Covered drop off canopy at Lessee's front entry door. Approximate size to be 16' width by 21' length with 10'-9" minimum clearance to structure with full drive thru capacity. Canopy to accommodate patient drop off with a level grade ADA compliant transition to the finish floor elevation. Canopy roof to be an extension of the main building with blending rooflines. Controlled storm water drainage requirements of gutters with downspouts connected to site storm sewer system or properly discharged away from the building, sidewalks, and pavement. Canopy structural system to consist of a reinforced concrete footing, structural columns and beam frame, joists, decking and matching roof covering. Canopy columns clad with EIFS and masonry veneer piers, matching masonry to main building. Steel bollards at column locations.

12.0 - Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to, Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

13.0 - Windows

Lessor to provide code compliant energy efficient windows and storefront systems to be 1" tinted insulated glass with thermally broken insulated aluminum mullions. Window size and locations to be determined by Lessee's architectural floor plan and shall be coordinate with Lessor's Architect.

14.0 - Thermal Insulation

All exterior walls to have a vapor barrier and insulation that meets or exceeds the local and national energy codes. The R value to be determined by the size of the stud cavity and should extend from finish floor to bottom of floor or ceiling deck. Roof deck to have a minimum R-30 insulation mechanically fastened to the underside of roof deck.

15.0 - Exterior Doors

All doors to have weather-stripping and commercial grade hardware (equal to Schlage L Series or better). Doors shall meet American Disability Act (ADA), and State Department of Health requirements. Lessor shall change the keys (reset tumblers) on all doors with locks after construction, but prior to commencement of the Lease, and shall provide Lessee with three (3) sets of keys. Final location of doors to be determined by Lessee architectural floor plan and shall be coordinate with Lessee's Architect. At a minimum, the following doors, frames and hardware shall be provided by the Lessor:

- Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.

- **Service Doors:** Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.
- **Fire Egress Doors:** Provide 36" wide door with 20 gauge insulated hollow metal door or Aluminum frame/glass door with panic bar hardware, lock, hinges, closer and painted with rust inhibiting paint. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

16.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee. Lessor is responsible for all tap/connection and impact fees for all utilities. All Utilities to be coordinated with Lessee's Architect. Lessor shall have contained within the building a common main room to accommodate the utility services which include, but not limited, to electrical, fire alarm, security alarm and fire riser if in a multi tenant building.

17.0 - Plumbing

Lessor to provide a segregated/dedicated potable water supply line that will be sized by Lessee's Engineer based on Lessee's water requirements (not tied-in to any other lessee spaces, fire suppression systems, or irrigation systems unless mandated by Local Building and or Water Dept). Water supply shall be provided with a shut off valve, 2 (two) reduced pressure zone (RPZ) backflow preventors arranged in parallel (with floor drain or open site drain under RPZ's), and meter. Water supply to provide a continuous minimum pressure of 50 psi, maximum 80psi, with a minimum flow rate of 50 gallons per minute to Lessee space. The RPZ's and the Meter will be sized to the incoming line, or per water provider or municipality standards. Lessor to provide Lessee with the most recent site water flow and pressure test results (gallons per minute and psi) for approval. Lessor shall perform water flow and pressure test prior to lease execution. Lessor shall stub the dedicated water line into the building per location coordinated by Lessee.

Provide exterior (anti-freeze when required) hose bibs (minimum of 2) in locations approved by Lessee.

Building sanitary drain size will be determined by Lessee's Mech Engineer based on total combined drainage fixture units (DFU's) for entire building, but not less than 4 inch diameter. The drain shall be stubbed into the building per location coordinated by Lessee at an elevation no higher than 4 feet below finished floor elevation, to a maximum of 10 feet below finished floor elevation. (Coordinate actual depth and location with Lessee's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Lessee's sanitary system design per Lessee's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

Sanitary sampling manhole to be installed by Lessor if required by local municipality.

Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies.

18.0 - Fire Suppression System

Single story stand alone buildings under 10,000sf will not require a Sprinkler System unless requested by Lessee, or if required by code or local authority. Single story stand alone buildings greater than 10,000 will require a sprinkler system. Lessor shall design and install a complete turnkey sprinkler system (less drops and heads in Lessee's space) that meets the requirements of NFPA #13 and all local building and life safety codes per NFPA 101-2000. This system will be on a dedicated water line independent of Lessee's potable water line requirements, or as required by local municipality or water provider. Lessor shall provide all municipal (or code authority) approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow

control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

19.0 - Electrical

Provide underground service with a dedicated meter via a new CT cabinet per utility company standards. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire to a distribution panelboard in the Lessee's utility room (location to be per Code and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include transformer coordination with utility company, transformer pad, grounding, and underground conduit wire sized for service inclusive of excavation, trenching and restoration, utility metering, distribution panelboard with main and branch circuit breakers, and electrical service and building grounding per NEC. Lessee's engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard.

If lease space is in a multi-tenant building then Lessor to provide meter center with service disconnecting means, service grounding per NEC, dedicated combination CT cabinet with disconnect for Lessee and distribution panelboard per above.

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

Lessor to provide main Fire Alarm Control panel that serves the Lessee space and will have the capacity to accommodate devices in Lessee space based on Fire Alarm system approved by local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide Fire Alarm panel to accommodate all tenants and locate panel in a common room with conduit stub into lessee space. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction.

Fire Alarm system equipment shall be equipped for double detection activation if required.

20.0 - Gas

Natural gas service, at a minimum, will be rated to have 6" water column pressure and supply 800,000-BTU's. Natural gas pipeline shall be stubbed into the building per location coordinated with Lessee and shall be individually metered and sized per demand. Additional electrical service capacity will be required if natural gas service is not available to the building.

21.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to be responsible for all costs for the HVAC system based on the below criteria.

Lessee will be responsible for the design, procurement and installation of the HVAC system.

The criteria is as follows:

- Equipment to be Carrier or Trane RTU's
- Supply air shall be provided to the Premises sufficient for cooling and ventilation at the rate of 275 to 325 square feet per ton to meet Lessee's demands for a dialysis facility and the base building Shell loads.
- Ductwork shall be extended 5' into the space for supply and return air.
- Provide 100% enthalpy economizer
- Units to include Power Exhaust
- Controls to be Programmable or DDC
- Provide high efficiency inverter rated non-overloading motors
- Provide 18" curbs, 36" in Northern areas with significant snow fall
- Units to have disconnect and service outlet

- System to be a fully ducted return air design
- All ductwork to be externally lined except for the drops from the units.
- Units will include motorized dampers for OA, RA & EA
- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

Equipment will be new and come with a full warranty on all parts including compressors (minimum of 5yrs) including labor. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat and or DDC controls (Note: The 5 zones of conditioning may be provided by individual constant volume RTU's, or by a VAV or VVT system of zone control with a single RTU). Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Lessee's design criteria and local and state codes.

Lessor to furnish steel framing members, roof curbs and flashing to support Lessee exhaust fans (minimum of 4) to be located by Lessee's architect.

22.0 - Telephone

Lessor shall provide a single 2" PVC underground conduit entrance into Lessee's utility room to serve as chase way for new telephone service. Entrance conduit location shall be coordinated with Lessee.

23.0 - Cable TV

Lessor shall provide a single 2" PVC underground conduit entrance into Lessee utility room to serve as chase way for new cable television service. Entrance conduit location shall be coordinated with Lessee.

Lessee shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee. Lessor shall reasonably cooperate and grant "right of access" with Lessee's satellite or cable provider to ensure there is no delay in acquiring such services.

24.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations handicap stalls inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Finish floor elevation is to be determined per Lessee's architectural plan in conjunction with Lessor's civil engineering and grading plans. If required, Lessor to construct concrete ramp of minimum 5' width, provide safety rails if needed, provide a gradual transitions from overhead canopy and parking lot grade to finish floor elevation. Concrete surfaces to be troweled for slip resistant finish condition according to accessible standards.

25.0 - Exiting

Lessor shall provide at the main entrance and rear doors safety lights, exterior service lights, exit sign with battery backup signs per doorway, in accordance with applicable building codes, local fire codes and other applicable regulations, ordinances and codes. The exiting shall encompass all routes from access points terminating at public right of way.

26.0 - Site Development Scope of Requirements

Lessor to provide Lessee with a site boundary and topographic ALTA survey, civil engineering and grading plans prepared by a registered professional engineer. Civil engineering plan is to include necessary details to comply with municipal standards. Plans will be submitted to Lessee Architect for coordination purposes. Site development is to include the following:

- Utility extensions, service entrance locations, inspection manholes;
- Parking lot design, stall sizes per municipal standard in conformance to zoning requirement;
- Site grading with Storm water management control measures (detention / retention / restrictions);
- Refuse enclosure location & construction details for trash and recycling;
- Handicap stall location to be as close to front entrance as possible;
- Side walk placement for patron access, delivery via service entrance;
- Concrete curbing for greenbelt management;
- Site lighting;
- Conduits for Lessee signage;
- Site and parking to accommodate tractor trailer 18 wheel truck delivery access to service entrance;
- Ramps and curb depressions.
- Landscaping shrub and turf as required per municipality;
- Irrigation system if Lessor so desires and will be designed by landscape architect and approved by planning department;
- Construction details, specifications / standards of installation and legends;
- Final grade will be sloped away from building.

27.0 - Refuse Enclosure

Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based on Lessee's requirements' and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

28.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

29.0 - Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, and building access points readied for connection into Lessee power panel. Location of pole fixtures per Lessor civil plan to maximize illumination coverage across site. Parking lot lighting to include timer (to be programmed per Lessee hours of operation) or a photocell. Parking lot lighting shall be connected to and powered by Lessor house panel (if in a Multi tenant building) and equipped with a code compliant 90 minute battery back up at all access points.

30.0 - Exterior Building Lighting

Lessor to provide adequate lighting and power per code and to illuminate the building main, exit and service entrance, landings and related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

31.0 - Parking Lot

Provide adequate amount of handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be firmly spike anchored in place onto the asphalt per stall alignment.

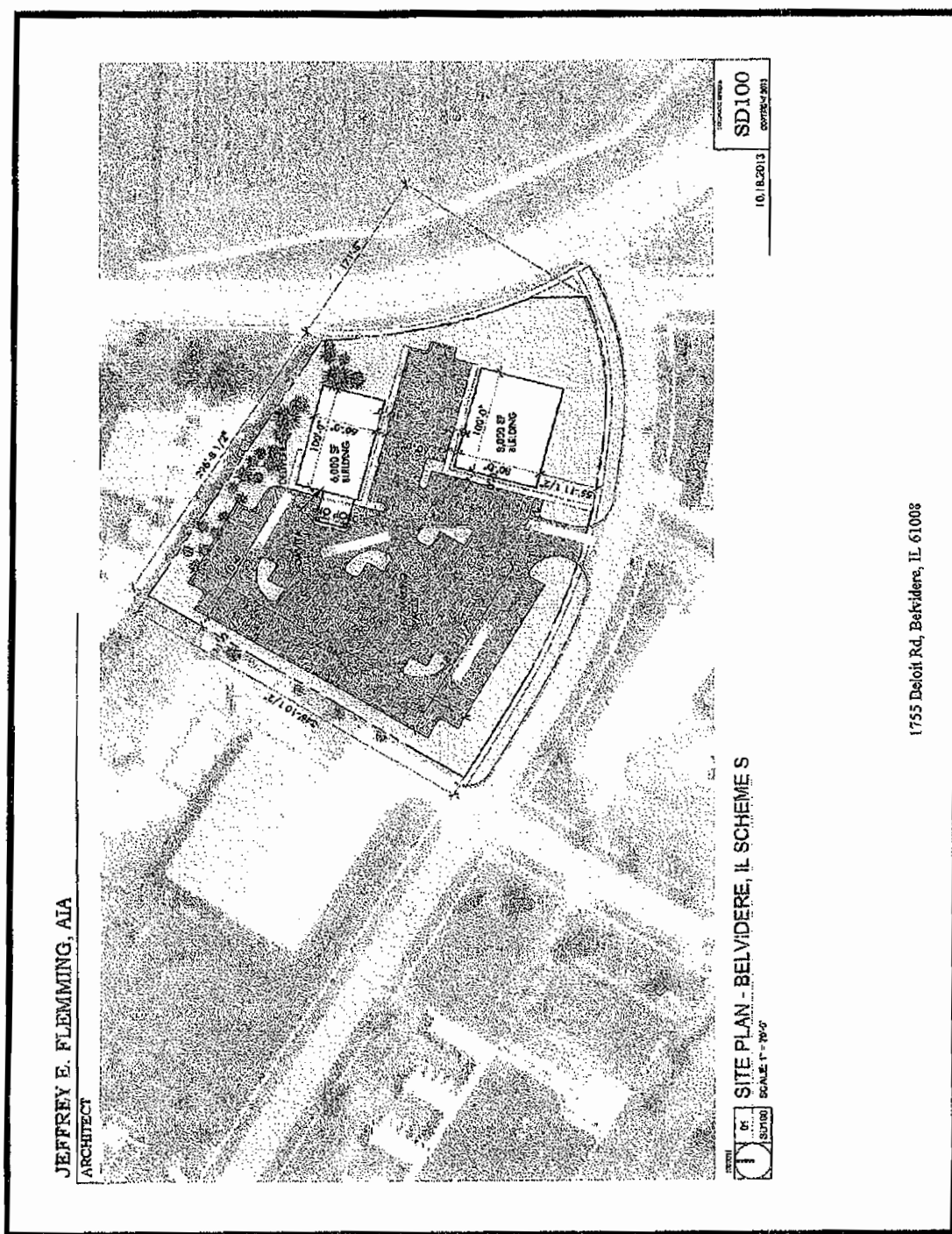
Asphalt wearing and binder course to meet geographical location design requirements for parking area and for truck delivery driveway.

Asphalt to be graded gradual to meet handicap and civil site slope standards, graded into & out of new patient drop off canopy and provide positive drainage to in place storm catch basins leaving surface free of standing water, bird baths or ice buildup potential.

32.0 - Site Signage

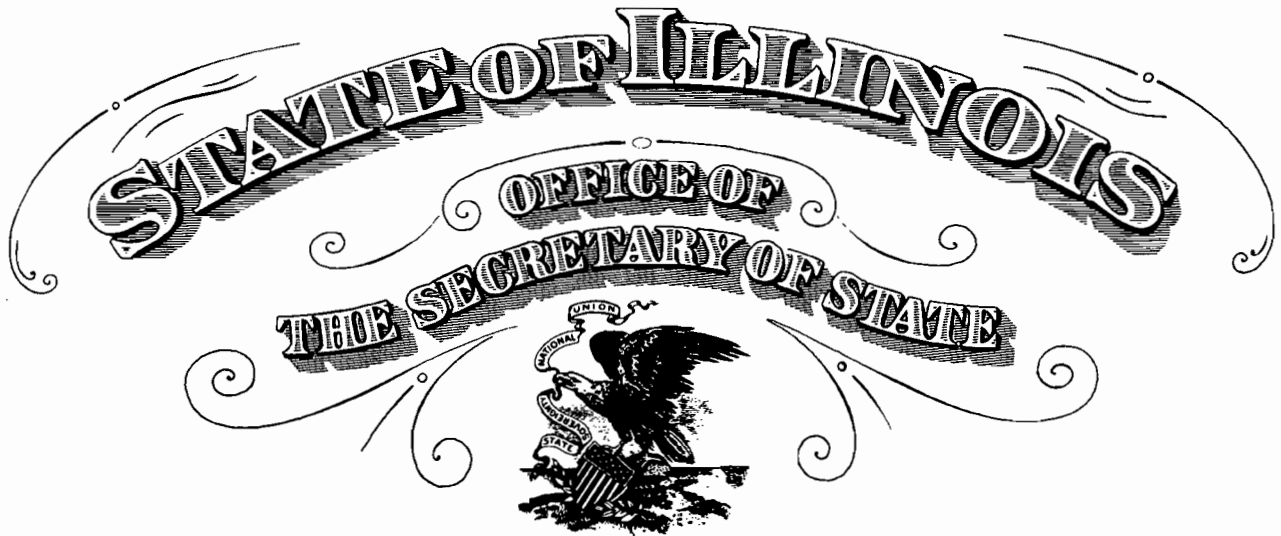
Lessor to allow for an illuminated site and/or façade mounted signs. A monument and/or the pylon structure to be provided by Lessor with power and a receptacle. Final sign layout to be approved by Lessee and the City.

Exhibit C – Preliminary Site Plan



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

The Illinois Certificate of Good Standing for Dialysis of Northern Illinois, LLC is attached at Attachment – 3.



To all to whom these Presents Shall Come, Greeting:

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

DIALYSIS OF NORTHERN ILLINOIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON AUGUST 14, 2003, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 1215000762

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

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

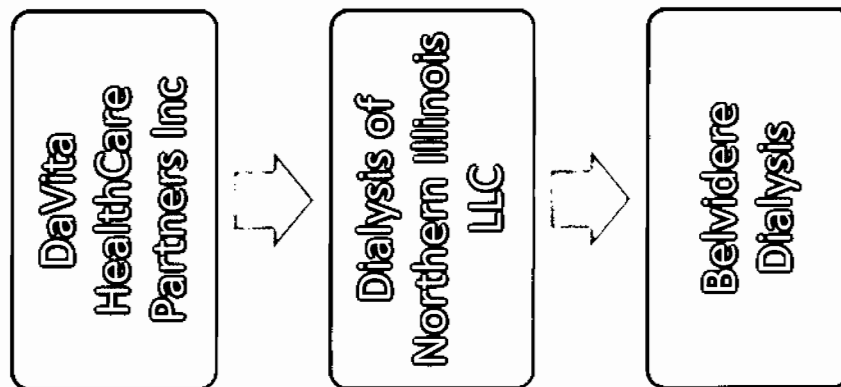
Jesse White

SECRETARY OF STATE

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

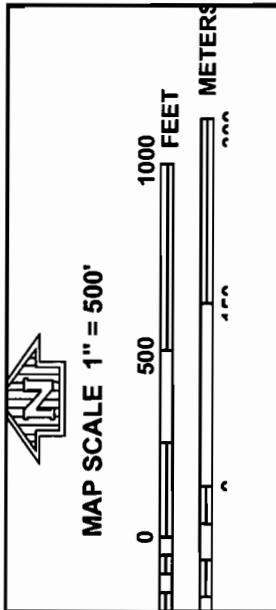
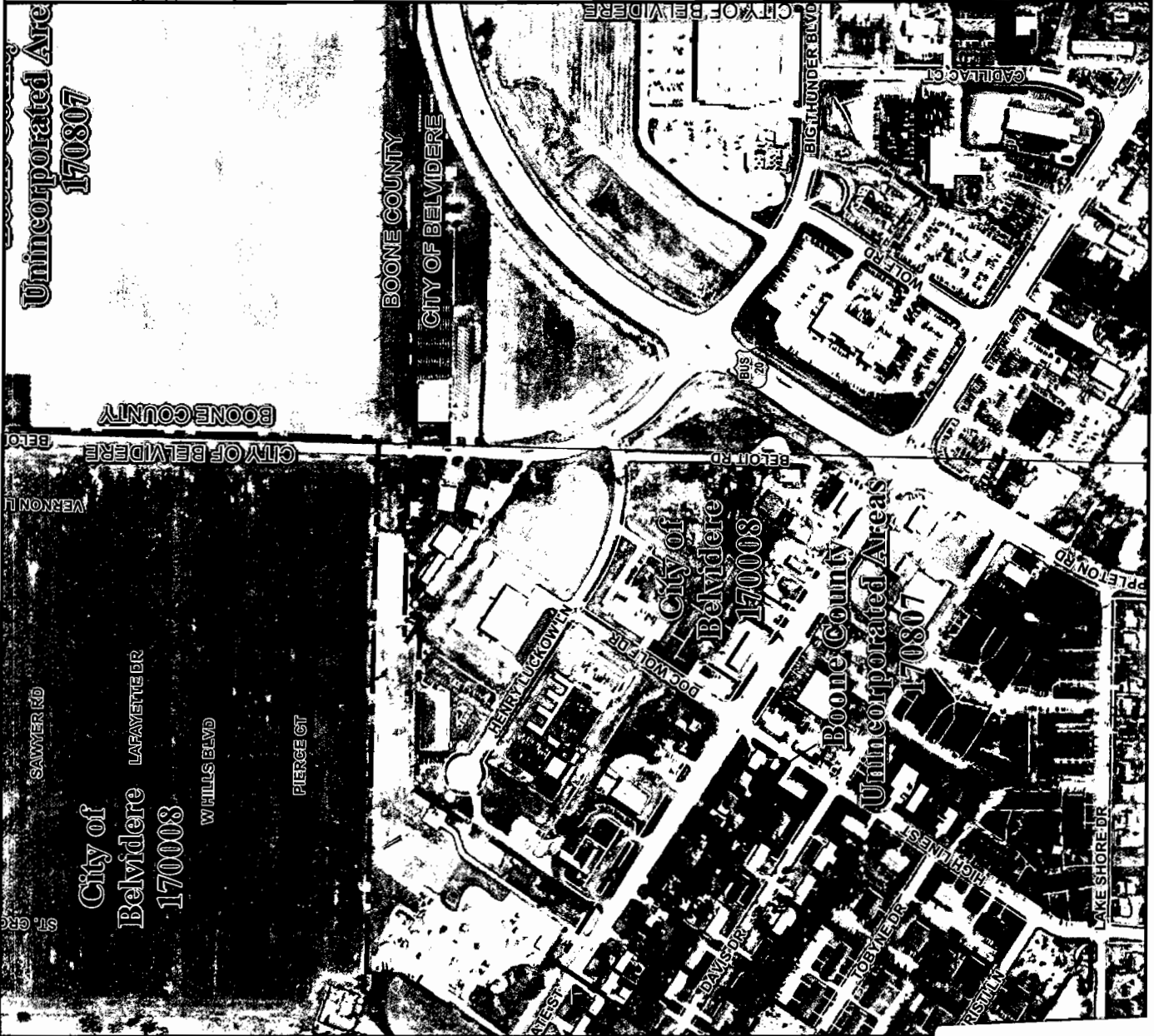
The organizational chart for DaVita HealthCare Partners Inc. and Dialysis of Northern Illinois, LLC is attached at Attachment – 4.

Belvidere Dialysis Organizational Chart



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

The site of the proposed dialysis facility complies with the requirements of Illinois Executive Order #2005-5. The proposed dialysis facility will be located at 1755 Beloit Road, Belvidere, Illinois 61008. 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.



NATIONAL FLOOD INSURANCE PROGRAM

PANEL 0113C	
FIRM FLOOD INSURANCE RATE MAP BOONE COUNTY, ILLINOIS AND INCORPORATED AREAS	
PANEL 113 OF 225 (SEE MAP INDEX FOR FIRM PANEL LAYOUT)	
CONTAINS:	NUMBER PANEL SUFFIX 170008 0113 C 170807 0113 C
COMMUNITY:	BELVIDERE, CITY OF BOONE COUNTY
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 17007C0113C	
EFFECTIVE DATE FEBRUARY 18, 2011	
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.



Timothy V Tincknell, FACHE
(773) 549-9412
timothy.tincknell@davita.com

2611 N Halsted St
Chicago, IL 60614
Fax: (866) 586-3214
www.davita.com

December 2, 2013

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

Dear Ms. Haaker:

Pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act, DaVita HealthCare Partners Inc. and Dialysis of Northern Illinois LLC ("Requestors") seek a formal determination from the Illinois Historic Preservation Agency as to whether their proposed project to establish a 12-station dialysis facility at 1755 Beloit Road, Belvidere, Illinois 61008 ("Proposed Project") affects historic resources. For reference, the legal description for this site is:

Lot Five (5) as designated upon the Re-plat of Lot Four (4) of Plat Three (3) of Little Thunder Village Subdivision, being a Subdivision of part of the Southeast Quarter (1/4) of Section 22, Township 44 North, Range 3 East of the Third Principal Meridian, as the same is platted and recorded August 27, 2002, as Document Number 2002R9629 in Plat Index Envelope 270-B in the Recorder's Office of Boone County, Illinois; situated in the County of Boone and State of Illinois

1. Project Description and Address

The Requestors are seeking a certificate of need from the Illinois Health Facilities and Services Review Board to establish a 12-station dialysis facility at 1755 Beloit Road, Belvidere, Illinois 61008.

2. Topographical or Metropolitan Map

Metropolitan maps showing the location of the Proposed Project are attached at Attachment 1.

3. Historic Architectural Resources Geographic Information System

Maps from the Historic Architectural Resources Geographic Information System are 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.



December 2, 2013

Page 2

4. Address for Building/Structure

The proposed project will be located at 1755 Beloit Road, Belvidere, Illinois 61008.

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 773-549-9412 or timothy.tincknell@davita.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Tincknell".

Timothy V Tincknell
Administrator, CON Projects

Enclosure

TVT:



Map Search

Enter an address or place:

1755 Beloit Road, Belvidere, Illinois 61008



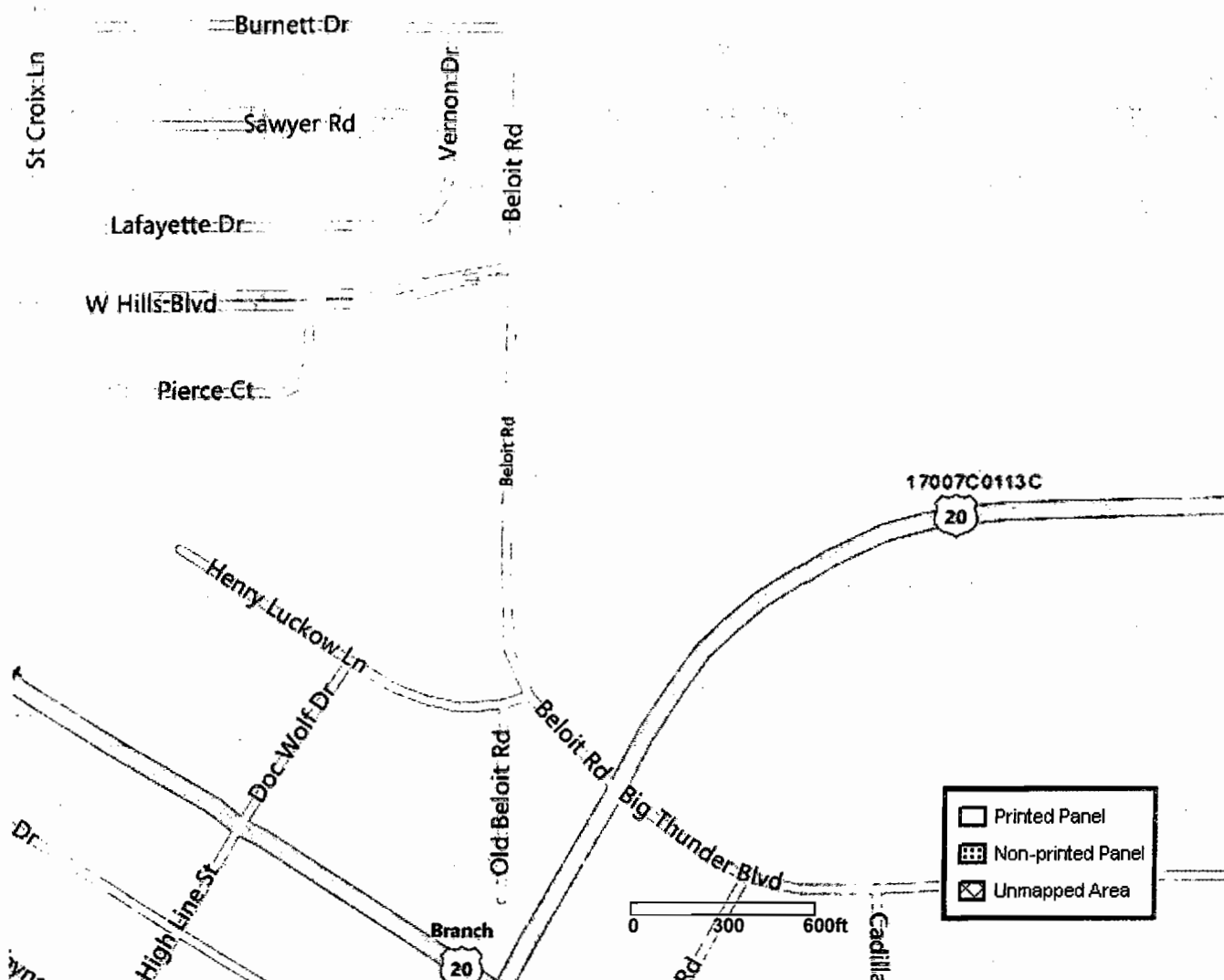
Use the select tool to choose a location or area of interest.

Base Map:

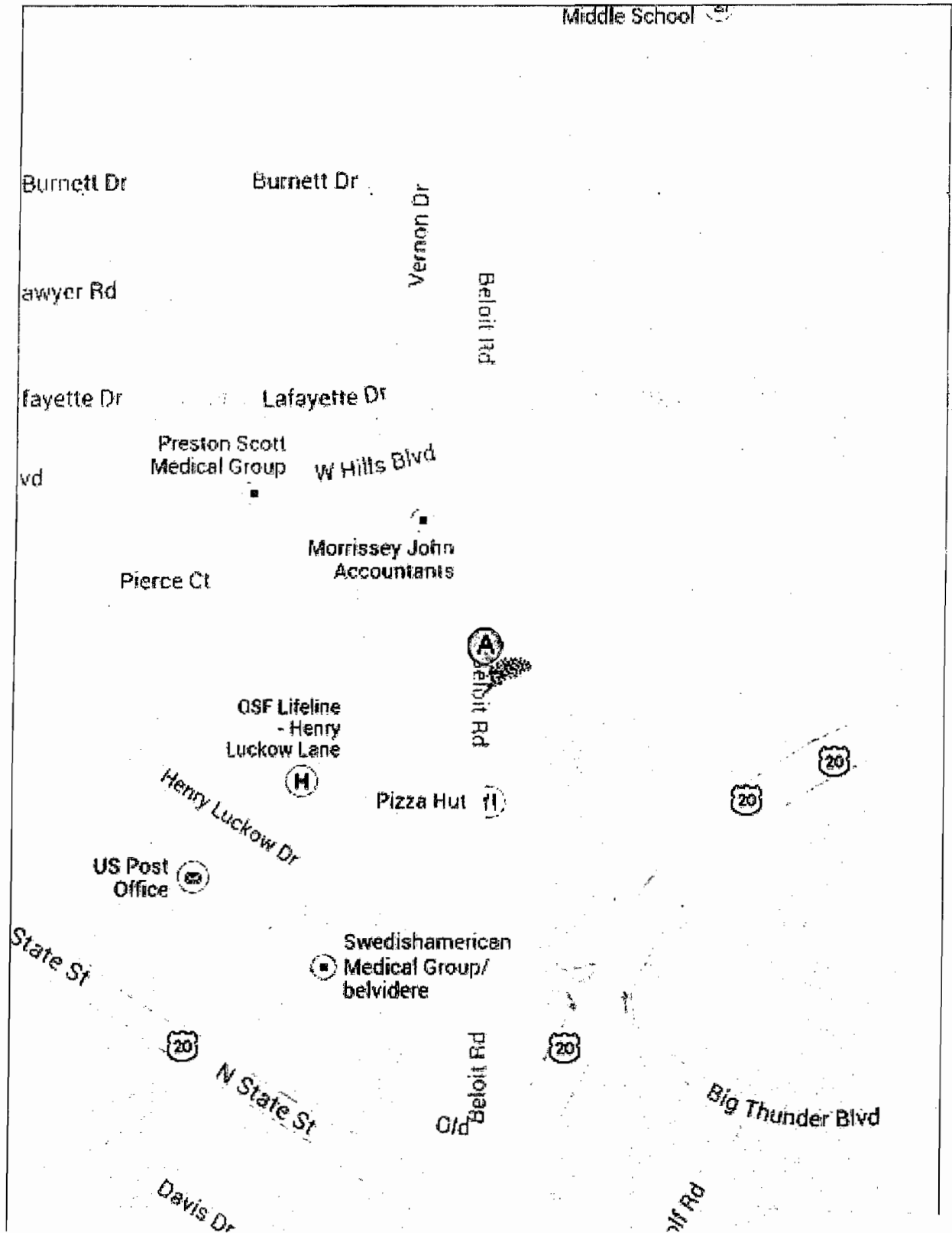
Road Map

Product Type:

Flood Maps



Google



Attachment - 6

53

Google

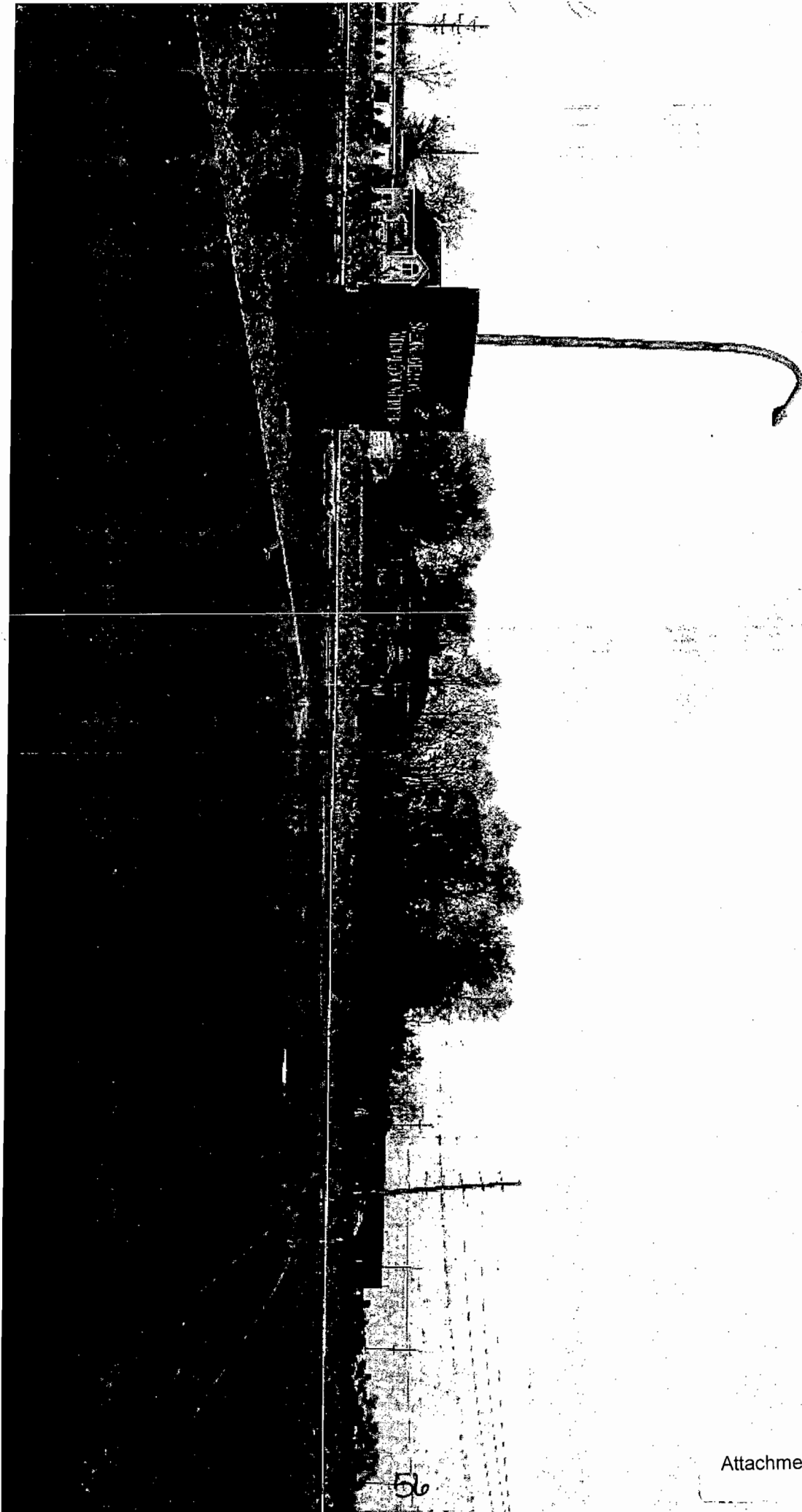
To see all the details that are visible on the screen, use the "Print" link next to the map.

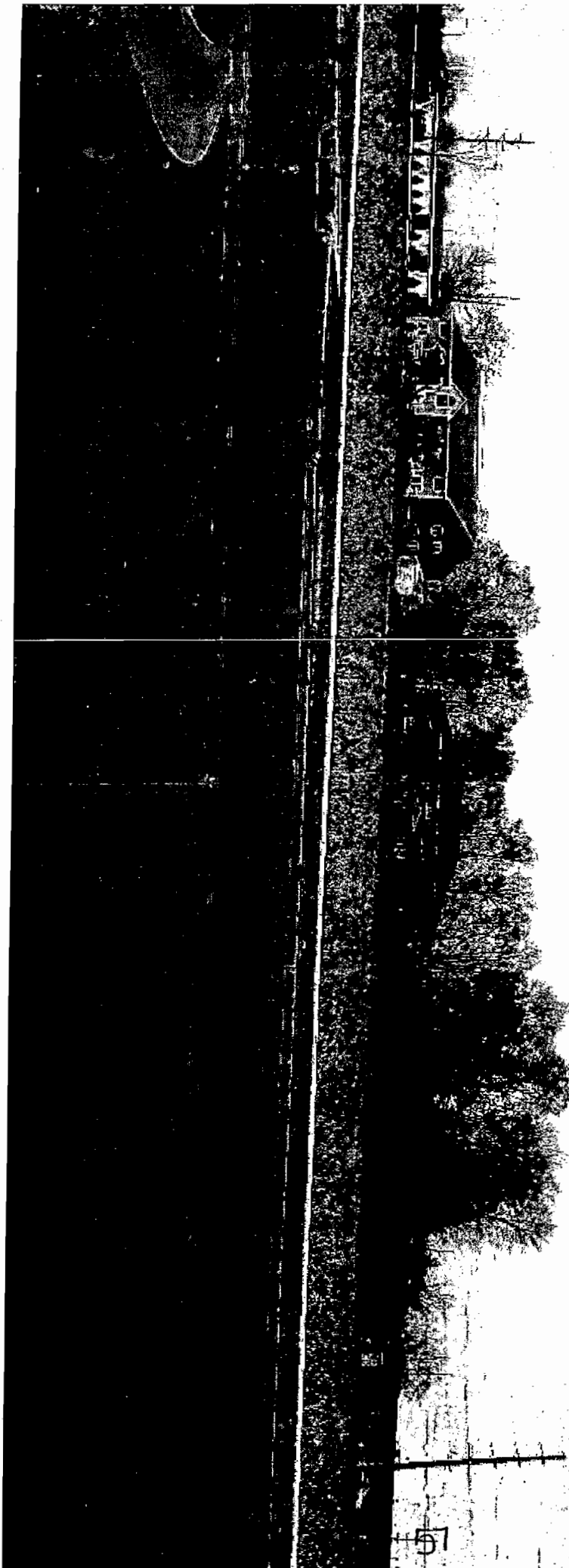


Attachment - 6

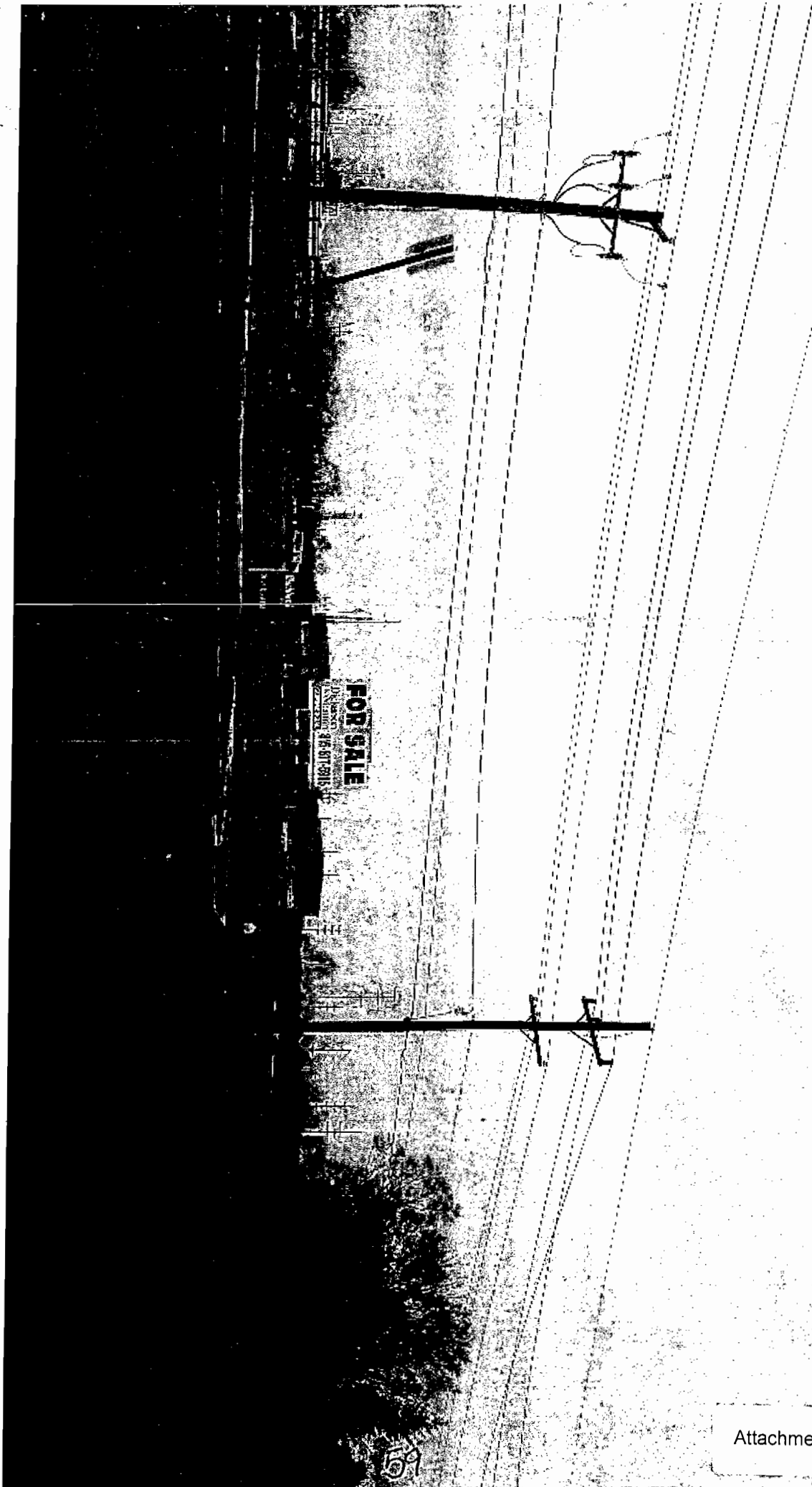
54







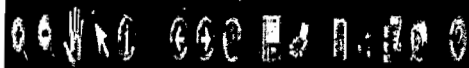
57



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UNIVERSITY 36-87-8015
20-22-23

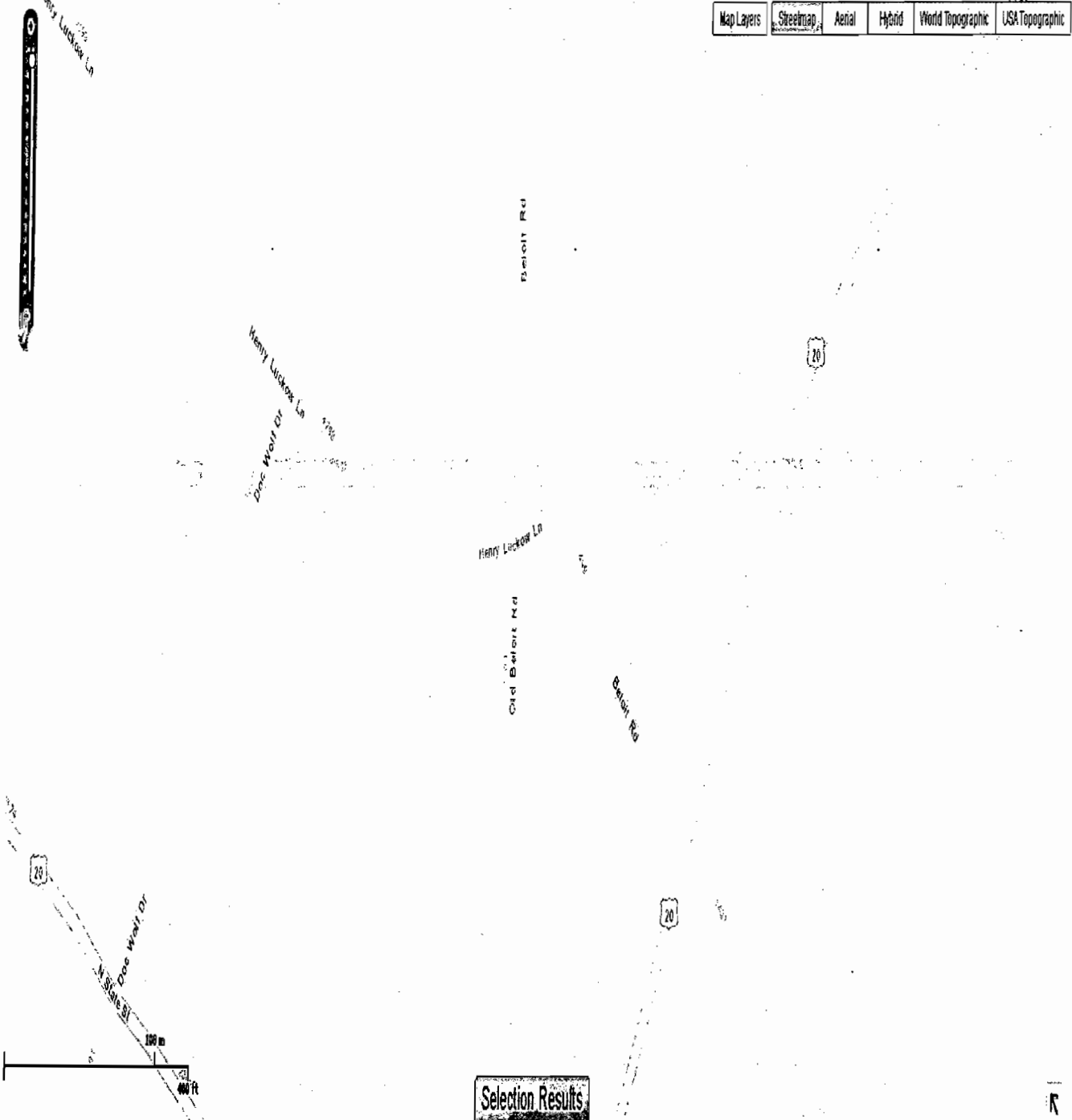
Historic Architectural Resources Geographic Information System

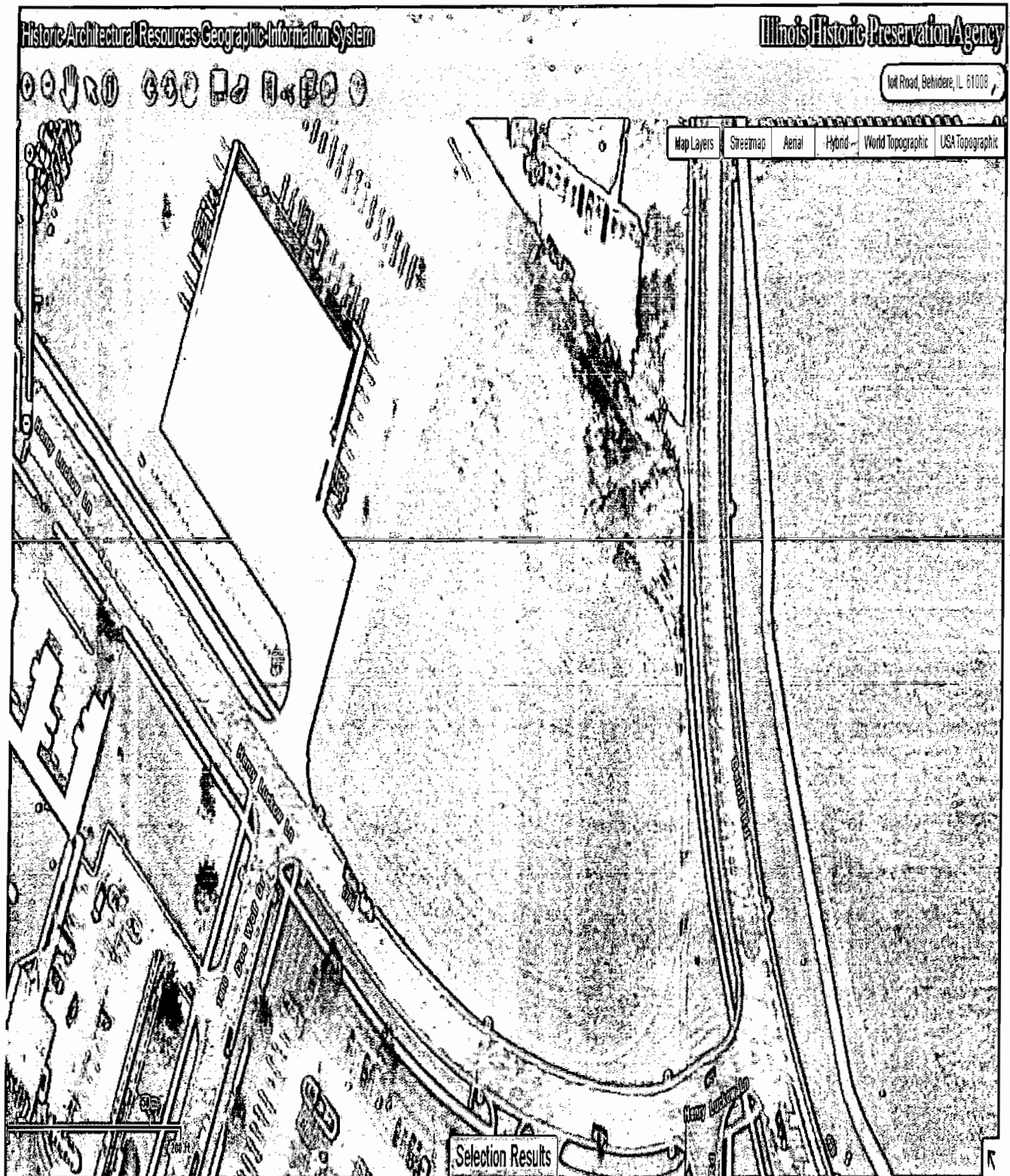
Illinois Historic Preservation Agency



1011 Road, Behind, IL 61008

Map Layers Streetmap Aerial Hybrid World Topographic USA Topographic





From: (773) 549-9412
 Tim Tincknell
 DaVita
 2611 N Halsted St
 Chicago, IL 60614

Origin ID: GYYA



Ship Date: 02DEC13
 ActWgt: 0.5 LB
 CAD: 104010597/INET3430

Delivery Address Bar Code



SHIP TO: (217) 785-5027

BILL SENDER

Ms. Anne Haaker
IL Historic Preservation Agency
1 Old State Capitol Plaza

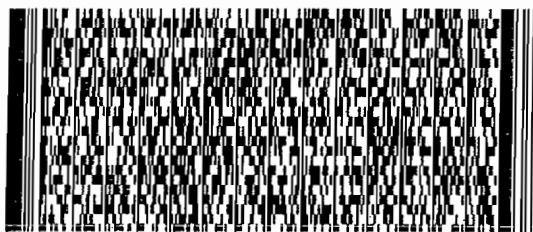
SPRINGFIELD, IL 62701

Ref #
 Invoice #
 PO #
 Dept #

TUE - 03 DEC 10:30A
PRIORITY OVERNIGHT

TRK# 7972 9105 4778
 0201

62701
 IL-US
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NA SPIA

51AG4/99D5/1A9E

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 Service Guide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

Attachment - 6

Timothy Tincknell

From: trackingupdates@fedex.com
Sent: Tuesday, December 03, 2013 11:11 AM
To: Timothy Tincknell
Subject: FedEx Shipment 797291054778 Delivered

This tracking update has been requested by:

Company Name: DaVita
Name: Tim Tincknell
E-mail: timothy.tincknell@davita.com

Our records indicate that the following shipment has been delivered:

Ship (P/U) date: Dec 2, 2013
Delivery date: Dec 3, 2013 11:07 AM
Sign for by: I.MILLS
Delivery location: SPRINGFIELD, IL
Delivered to: Receptionist/Front Desk
Service type: FedEx Priority Overnight
Packaging type: FedEx Envelope
Number of pieces: 1
Weight: 0.50 lb.
Special handling/Services: Deliver Weekday
Tracking number: [797291054778](#)

Shipper Information

Tim Tincknell
DaVita
2611 N Halsted St
Chicago
IL
US
60614

Recipient Information

Ms. Anne Haaker
IL Historic Preservation Agency
1 Old State Capitol Plaza
SPRINGFIELD
IL
US
62701

Please do not respond to this message. This email was sent from an unattended mailbox. This report was generated at approximately 11:10 AM CST on 12/03/2013.

To learn more about FedEx Express, please visit our website at fedex.com.

All weights are estimated.

To track the latest status of your shipment, click on the tracking number above, or visit us at fedex.com.

This tracking update has been sent to you by FedEx on the behalf of the

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

Table 1120.110			
Project Cost	Clinical	Non-Clinical	Total
New Construction Contracts	\$921,400		\$921,400
Contingencies	\$90,000		\$90,000
Architectural/Engineering Fees	\$75,000		\$75,000
Consulting and Other Fees	\$75,000		\$75,000
Moveable and Other Equipment			
Communications	\$75,713		\$75,713
Water Treatment	\$111,595		\$111,595
Bio-Medical Equipment	\$8,885		\$8,885
Clinical Equipment	\$199,991		\$199,991
Clinical Furniture/Fixtures	\$15,829		\$15,829
Lounge Furniture/Fixtures	\$2,815		\$2,815
Storage Furniture/Fixtures	\$5,362		\$5,362
Business Office Fixtures	\$13,260		\$13,260
General Furniture/Fixtures	\$21,455		\$21,455
Signage	\$11,500		\$11,500
Total Moveable and Other Equipment	\$466,405		\$466,405
Fair Market Value of Leased Space	\$1,148,966		\$1,148,966
Total Project Costs	\$2,776,771		\$2,776,771

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

The Applicants anticipate project completion within 24 months of project approval.

Further, 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 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							
Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	\$2,776,771		6,000	6,000			
Total Clinical	\$2,776,771		6,000	6,000			
NON REVIEWABLE							
Total Non-Reviewable							
TOTAL	\$2,776,771		6,000	6,000			

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(a), 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. For this project, DaVita HealthCare Partners Inc. has partnered with Dialysis of Northern Illinois, LLC in their commitment to the Belvidere community. The proposed project involves the establishment of a 12-station dialysis facility to be located at 1755 Beloit Road, Belvidere, Illinois 61008.

DaVita HealthCare Partners Inc is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and empowering patients, and community outreach. A copy of DaVita's 2012 Community Care report, some of which is outlined below, details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on July 15, 2013 as part of Applicants' application for Proj. No. 13-045.

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 Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Information on the Kidney Smart, IMPACT and CathAway programs as well as other DaVita initiatives was previously submitted on September 11, 2013, as part of the Applicants' application for Proj. No. 13-060.

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

- Between 1988-1994 and 2005-2010, the overall prevalence estimate for CKD rose from 12.3 to 14.0 percent. The largest relative increase, from 25.4 to 40.8 percent, was seen in those with cardiovascular disease.¹
- Many studies have shown that diabetes, hypertension, cardiovascular disease, higher body mass index, and advancing age are associated with the increasing prevalence of CKD.²
- Over five times the number of new patients began treatment for ESRD in 2011 (approximately 116,000) versus 1980 (approximately 20,000).³
- Over ten times more patients are now being treated for ESRD than in 1980 (approximately 615,000 versus approximately 60,000).⁴
- U.S. patients newly diagnosed with ESRD were 1 in 2,800 in 2011 versus 1 in 11,600 in 1980.⁵
- U.S. patients treated for ESRD were 1 in 526 in 2011 versus 1 in 3,400 in 1980.⁶
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD; 44% of new ESRD cases have a primary diagnosis of diabetes; 28% have a primary diagnosis of hypertension.⁷
- Nephrology care prior to ESRD continues to be a concern. Since the 2005 introduction of the new Medical Evidence form (2728), with fields addressing pre-ESRD care, there has been little progress made in this area (pre-ESRD data, however, should be interpreted with caution because of the potential for misreporting). Forty-two percent of new ESRD patients in 2011, for example, had not seen a nephrologist prior to beginning therapy. And among these patients, 51 percent of

¹ US Renal Data System, USRDS 2013 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, 44 (2013)

² Id. at 46

³ Id. at 158

⁴ Id.

⁵ Id. at 160

⁶ Id.

⁷ Id. at 161

those on hemodialysis began therapy with a catheter, compared to 19 percent of those who had received a year or more of nephrology care. Among those with a year or more of pre-ESRD nephrologist care, 30 percent began therapy with a fistula – five times higher than the rate among non-referred patients.⁸

Additionally, DaVita's Kidney Smart 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.⁹ Timely CKD care is imperative for patient morbidity and mortality. Adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may result in improved patient outcomes and reduce ESRD:

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

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

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

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 NVAII 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 has improved its patients' fistula-adoption rate by 91% between 2002 and 2011. At the end of 2012, 63.9% of DaVita patients were using fistulas, a 2.0% increase since 2011. In addition, only 13.9% of DaVita patients who had been on dialysis

⁸ Id. at 216-217

⁹ 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.

for more than 90 days were still using their typically hospital-given catheters as their form of vascular access – DaVita's best outcomes to date. DaVita is an industry leader in the rate of fistula use and has the lowest day-90 catheter rates among large dialysis providers.

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. Patient Pathways has demonstrated benefits to hospitals, patients, physicians and dialysis centers. 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 and was recently awarded Health Ethics Trust Best Practices Award for its compliance training program. (Attachment – 11A). Further, these quality measures have directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is more than \$1.5 billion in savings to the health care system and the American taxpayer since 2010.

DaVita Rx, the first and largest licensed, full-service U.S. renal pharmacy, focuses on the unique needs of dialysis patients. Since 2005, DaVita Rx has been helping improve outcomes by delivering medications to dialysis centers or to patients' homes, making it easier for patients to keep up with their drug regimens. As of 2012, DaVita Rx patients have an 82% adherence rate, compared to those who use chain pharmacies and have a 32% adherence rate, and those who use independent pharmacies and have a 36% adherence rate. In addition, better adherence may lead to fewer hospitalizations for patients using DaVita Rx versus those patients not on this service. Hospitalizations (per member per 1000) was 1.4 for Non-DaVita Rx patients versus 1.0 for DaVita Rx patients in 2012.

DaVita has been repeatedly recognized for its commitment to its employees (or teammates), particularly its more than 1,700 teammates who are reservists, members of the National Guard, military veterans, and military spouses. On September 16, 2013, DaVita received the prestigious Secretary of Defense Employer Support Freedom Award. Presented annually by the Employer Support of the Guard and Reserve ("ESGR"), an arm of the Department of Defense, the Freedom Award recognizes employers for outstanding support of employees who serve in the Guard and Reserve. It is the highest military-friendly award presented by the U.S. government. Nearly 3,000 employers were nominated for a Freedom Award

in 2013. An awards committee composed of senior Department of Defense officials, business leaders and prior honorees selected just 15 companies to receive the 2013 Freedom Award. DaVita also received the 2013 award for Best Military Recruiting Program from ERE Media and was recognized this year with Top 100 Military Friendly Employer and 2013 Top 100 Military Friendly Spouse Employer awards from GI Jobs, a Most Valuable Employers award from CivilianJobs.com and a "Best for Vets" award from Military Times EDGE.

In June 2013, DaVita was recognized as one of the best employers in four cities: Denver, Nashville, Philadelphia and the San Francisco Bay Area. For a second year in a row, WorkplaceDynamics recognized DaVita as one of the "Top Workplaces" in Denver, ranking 7th, up two positions from 2012. DaVita also debuted on the WorkplaceDynamics Top Workplaces lists in Philadelphia and the San Francisco Bay Area, ranking 14th out of 20 large companies in both cities. Finally, DaVita received Quantum Workplace's "Best Places to Work" in Nashville award for the second year in a row.

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 annually saves approximately 8 million pounds of medical waste through dialyzer reuse and it also diverts more than 85% 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. In addition, DaVita was also recognized as an "EPA Green Power Partner" by the U.S. Environmental Protection Agency.

DaVita consistently raises awareness of community needs and makes cash contributions to organizations aimed at improving access to kidney care. In 2011, DaVita donated more than \$2.5 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 and have raised approximately \$5 million, thus far, through the annual Tour DaVita bicycle ride, with \$1 million coming in 2013 alone. (Attachment – 11B). The Kidney Rock 5K Run/Walk raised an estimated \$1 million for Bridge of Life – DaVita Medical Missions in 2011 and 2012, combined. Starting in 2011, teammates at clinics across DaVita's 43-state footprint selected more than 600 charities from Ronald McDonald House to small community-support entities in their local areas, to receive approximately \$1.5 million in contributions. This new program titled "DaVita Way of Giving" continued in 2012.

DaVita does not limit its community engagement to the U.S. alone. It founded Bridge of Life, a 501(c)(3) nonprofit organization that operates on donations to bring care to those for whom it is out of reach. In addition to contributing Dialysis equipment to DaVita Medical Missions, Bridge of Life has accomplished 24 Missions between 2006--2011, with more than 150 participating teammates. It provided these desperately needed services in Cameroon, India, Ecuador, Guatemala, the Philippines, South Africa, and Jamaica, and trained many health care professionals there as well.

Neither the Centers for Medicare and Medicaid Services nor 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 – 11C.

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 – 11D.
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 – 11D.



DaVita Receives Best Practices Award for Compliance Training Program

Health Ethics Trust Recognizes DaVita for its Outstanding Compliance Program

DENVER--(BUSINESS WIRE)--Nov. 20, 2013-- DaVita®, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced the company has received Health Ethics Trust's Best Practice Award for its compliance training program.

Training is a foundational element of DaVita's compliance program. DaVita maintains an extensive training and education program that comprises a combination of in-person training sessions, automated online training tools, and ongoing real-time guidance and support from the company's compliance team.

"Compliance training and education empowers DaVita teammates to play an active role in reducing regulatory risk," said Jeanine Jiganti, chief compliance officer at DaVita. "By maintaining an environment of integrity through our compliance program, DaVita is able to provide quality care to our patients and be the employer of choice for our teammates."

All teammates are required to complete at least one compliance training course per year along with other various courses based on the teammate's role. The courses and supplemental messages ensure that teammates are consistently receiving timely guidance related to their work.

DaVita's compliance program follows a commitment to uphold the company's Code of Conduct, ensures teammates "do the right thing," and incorporates DaVita's Mission and Values. It also supports the organization's business objectives by:

- Collaborating with operators to assist with complex regulatory issues;
- Educating teammates about compliance in day-to-day activities; and
- Navigating health care laws and the regulatory environment.

DaVita's compliance program is essential to ensure ethical business practices that comply with guidelines from the Department of Health and Human Services Office of the Inspector General (OIG); federal, state and local laws; and DaVita policies.

The Health Ethics Trust was developed in response to growing ethics and compliance concerns in health care. The purpose of the trust is to assist health care organizations in ethical and legal conduct through educational programs, research and shared best practices.

DaVita and DaVita HealthCare Partners are trademarks or registered trademarks of DaVita HealthCare Partners Inc. All other trademarks are the property of their respective owners.

About DaVita

DaVita is the dialysis division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of kidney care in the United States, DaVita delivers dialysis services to patients with chronic kidney failure and end stage renal disease. DaVita strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of Sept. 30, 2013, DaVita operated or provided administrative services at 2,042 outpatient dialysis centers located in the United States serving approximately 166,000 patients. The company also operated 66 outpatient dialysis centers located in ten countries outside the United States. DaVita supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

Source: DaVita

DaVita
Ginger Pelz, 303-876-6611
Ginger.Pelz@DaVita.com



Tour DaVita Raises \$1 Million for The Kidney TRUST

Organization Will Use Funds to Support Kidney Screening Program

DENVER--(BUSINESS WIRE)--Oct. 15, 2013-- DaVita®, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced that the seventh annual Tour DaVita® raised \$1 million for The Kidney TRUST™.

Tour DaVita is a three-day, 220-mile bike ride to raise awareness and funds for the fight against kidney disease. This year's beneficiary, The Kidney TRUST, is a 501(c)(3) independent nonprofit organization that seeks to reduce the progression of chronic kidney disease through a no-cost, rapid screening in non-medical settings.

"The funds from this year's Tour DaVita will go a long way in supporting our mission," said Gloria Upchurch, program manager of The Kidney TRUST. "We will be able to continue helping communities around the country better understand their kidney health, including kidney disease risk factors."

More than 250 Tour DaVita participants had their kidneys screened at no cost by The Kidney TRUST during this year's event. It is estimated that one in 10 U.S. adults over the age of 20 has kidney disease, but may not be aware of it. In support of raising awareness, DaVita created an online risk quiz for people to learn about their kidney health.

Tour DaVita 2013 was held in upstate South Carolina with 570 participants cycling from Gaffney to Chester on day one; from Chester to Fountain Inn on day two; and from Fountain Inn to Seneca on day three.

To participate in Tour DaVita, riders each raised a minimum of \$750 in donations and paid their own travel expenses. Corporate sponsors also contributed to the fundraising efforts.

To date, Tour DaVita has helped raise more than \$5 million for nonprofits dedicated to raising awareness for kidney disease, providing kidney screenings and expanding access to dialysis care in developing countries. Participants have collectively ridden more than 533,000 miles over the course of seven years.

Corporate sponsors for this year's Tour DaVita included Amgen, ASD Healthcare, Baxter International Inc., Golden Construction Development Company, Inc. and NxStage Medical, Inc.

To find a no-cost screening near you, visit kidneytrust.org.

For more information about the seventh annual Tour DaVita, please visit tourdavita.org. For more information about The Kidney TRUST, please visit kidneytrust.org.

DaVita and Tour DaVita are registered trademarks of DaVita HealthCare Partners Inc. All other trademarks are the property of their respective owners.

About DaVita

DaVita is the dialysis division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of kidney care in the United States, DaVita delivers dialysis services to patients with chronic kidney failure and end stage renal disease. DaVita strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of June 30, 2013, DaVita operated or provided administrative services at 2,010 outpatient dialysis centers located in the United States serving approximately 159,000 patients. The company also operates 48 outpatient dialysis centers located in ten countries outside the United States. DaVita supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

About The Kidney TRUST

Attachment – 11B

Founded in 2006, The Kidney TRUST is a national non-profit organization dedicated to reducing the human and economic cost of kidney disease. The Kidney TRUST is focused on increasing awareness of chronic kidney disease (CKD) through public education and early-detection testing programs so that progression of CKD to kidney failure can be delayed or prevented. The Kidney TRUST is also developing innovative solutions to address the critical unmet needs of people with CKD. Visit www.kidneytrust.org for more information.

Source: DaVita

DaVita
Bianca Violante, 303-876-6614
bianca.violante@davita.com

DaVita HealthCare Partners, 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	
Arlington Heights Renal Center	17 WEST GOLF ROAD		ARLINGTON HEIGHTS	COOK	IL	60005-3905	14-2628	
Barrington Creek	28160 W. NORTHWEST HIGHWAY		LAKE BARRINGTON	LAKE	IL	60010	14-2736	
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	
Buffalo Grove Renal Center	1291 W. DUNDEE ROAD		BUFFALO GROVE	COOK	IL	60089-4009	14-2650	
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	14-2599	
Dixon Kidney Center	1131 N GALENA AVE		DIXON	LEE	IL	61021-1015	14-2651	
Driftwood Dialysis	1808 SOUTH WEST AVE		FREERPORT	STEPHENSON	IL	61032-6712	14-2747	
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	
Emerald Dialysis	710 W 43RD ST		CHICAGO	COOK	IL	60609-3435	14-2529	
Evanston Renal Center	1715 CENTRAL STREET		EVANSTON	COOK	IL	60201-1507	14-2511	
Grand Crossing Dialysis	7319 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60619-1909	14-2728	
Freeport Dialysis	1028 S KUNKLE BLVD		FREERPORT	STEPHENSON	IL	61032-6914	14-2642	
Granite City Dialysis Center	9 AMERICAN VLG		GRANITE CITY	MADISON	IL	62040-3706	14-2537	
Hazel Crest Renal Center	3470 WEST 183rd STREET		HAZEL CREST	COOK	IL	60429-2428	14-2622	
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	
Kenwood Dialysis	4259 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60653	14-2717	
Lake County Dialysis Services	565 LAKEVIEW PARKWAY	STE 176	VERNON HILLS	LAKE	IL	60061	14-2552	

DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Lake Villa Dialysis	37809 N IL ROUTE 59		LAKE VILLA	LAKE	IL	60046-7332	14-2666
Lawndale Dialysis	3934 WEST 24TH ST		CHICAGO	COOK	IL	60623	
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	MONTGOMERY	IL	62056-1775	14-2583
Little Village Dialysis	2335 W CERMAK RD		CHICAGO	COOK	IL	60608-3811	14-2668
Logan Square Dialysis	2838 NORTH KIMBALL AVE		CHICAGO	COOK	IL	60618	14-2534
Loop Renal Center	1101 SOUTH CANAL STREET		CHICAGO	COOK	IL	60607-4901	14-2505
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
Markham Renal Center	3053-3055 WEST 159th STREET		MARKHAM	COOK	IL	60428-4026	14-2575
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
Olympia Fields Dialysis Center	4557B LINCOLN HWY	STE B	MATTESON	COOK	IL	60443-2318	14-2548
Palos Park Dialysis	13155 S LaGRANGE ROAD		ORLAND PARK	COOK	IL	60462-1162	14-2732
Pittsfield Dialysis	640 W WASHINGTON ST		PITTSFIELD	PIKE	IL	62363-1350	14-2708
Red Bud Dialysis	LOT 4 IN 1ST ADDITION OF EAST INDUSTRIAL PARK		RED BUD	RANDOLPH	IL	62278	
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
Schaumburg Renal Center	1156 S ROSELLE ROAD		SCHAUMBURG	COOK	IL	60193-4072	14-2654

DaVita HealthCare Partners, Inc.									
Illinois Facilities									
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number		
Shiloh Dialysis	1095 NORTH GREEN MOUNT RD		SHILOH	ST CLAIR	IL	62269	14-2753		
Silver Cross Renal Center - Morris	1551 CREEK DRIVE		MORRIS	GRUNDY	IL	60450	14-2740		
Silver Cross Renal Center - New Lenox	1890 SILVER CROSS BOULEVARD		NEW LENOX	WILL	IL	60451	14-2741		
Silver Cross Renal Center - West	1051 ESSINGTON ROAD		JOLIET	WILL	IL	60435	14-2742		
South Holland Renal Center	16136 SOUTH PARK AVENUE		SOUTH HOLLAND	COOK	IL	60473-1511	14-2544		
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	14-2733		
Stoncrest Dialysis	1302 E STATE ST		ROCKFORD	WINNEBAGO	IL	61104-2228	14-2615		
Stony Creek Dialysis	9115 S CICERO AVE		OAK LAWN	COOK	IL	60453-1895	14-2661		
Stony Island Dialysis	8725 S STONY ISLAND AVE		CHICAGO	COOK	IL	60617-2709	14-2718		
Sycamore Dialysis	2200 GATEWAY DR		SYCAMORE	DEKALB	IL	60178-3113	14-2639		
Taylorville Dialysis	901 W SPRESSER ST		TAYLORVILLE	CHRISTIAN	IL	62568-1831	14-2587		
Tazewell Dialysis	1021 COURT STREET		PEKIN	TAZEWELL	IL	61554			
Timber Creek Dialysis	1001 S. ANNIE GLIDDEN ROAD		DEKALB	DEKALB	IL	60115			
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		
Waukegan Renal Center	1616 NORTH GRAND AVENUE	STE C	Waukegan	COOK	IL	60085-3676	14-2577		
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		
West Side Dialysis	1600 W 13TH STREET		CHICAGO	COOK	IL	60608			
Whiteside Dialysis	2600 N LOCUST	STE D	STERLING	WHITESIDE	IL	61081-4602	14-2648		
Woodlawn Dialysis	5060 S STATE ST		CHICAGO	COOK	IL	60609	14-2310		

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

Dear Chairwoman Olson:

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 HealthCare Partners Inc. or Dialysis of Northern Illinois LLC in the State of Illinois during the three year period prior to filing this application.

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

Sincerely,



Print Name: Arturo Sida

Its: Vice President and Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This 9th day of September, 2013

Notary Public

See attached

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public,
(Here insert name and title of the officer)

personally appeared Arturo Sida,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

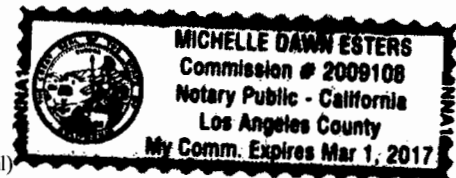
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public

(Notary Seal)



ADDITIONAL OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages _____ Document Date _____

(Additional information)

CAPACITY CLAIMED BY THE SIGNER

- ☐ Individual (s)
☐ Corporate Officer

(Title)

- ☐ Partner(s)
☐ Attorney-in-Fact
☐ Trustee(s)
☐ Other _____

INSTRUCTIONS FOR COMPLETING THIS FORM

Any acknowledgment completed in California must contain verbiage exactly as appears above in the notary section or a separate acknowledgment form must be properly completed and attached to that document. The only exception is if a document is to be recorded outside of California. In such instances, any alternative acknowledgment verbiage as may be printed on such a document so long as the verbiage does not require the notary to do something that is illegal for a notary in California (i.e. certifying the authorized capacity of the signer). Please check the document carefully for proper notarial wording and attach this form if required.

- State and County information must be the State and County where the document signer(s) personally appeared before the notary public for acknowledgment.
- Date of notarization must be the date that the signer(s) personally appeared which must also be the same date the acknowledgment is completed.
- The notary public must print his or her name as it appears within his or her commission followed by a comma and then your title (notary public).
- Print the name(s) of document signer(s) who personally appear at the time of notarization.
- Indicate the correct singular or plural forms by crossing off incorrect forms (i.e. ~~he/she/they~~, is ~~are~~) or circling the correct forms. Failure to correctly indicate this information may lead to rejection of document recording.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different acknowledgment form.
- Signature of the notary public must match the signature on file with the office of the county clerk.
 - ❖ Additional information is not required but could help to ensure this acknowledgment is not misused or attached to a different document.
 - ❖ Indicate title or type of attached document, number of pages and date.
 - ❖ Indicate the capacity claimed by the signer. If the claimed capacity is a corporate officer, indicate the title (i.e. CEO, CFO, Secretary).
- Securely attach this document to the signed document

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

Purpose of Project

1. The purpose of the project is to improve access to life sustaining dialysis services to the residents of the Belvidere community where the November 14, 2013 Inventory of Health Care Facilities and Services and Need Determination shows an excess of 16 dialysis stations through 2015. There are currently five existing or approved dialysis facilities within 30 minutes of the proposed Belvidere facility. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization of these facilities is 85.95%, which is above the State standard.

This is not surprising given the size of the facility's proposed medical director's practice. Dr. Mashood Ahmad's practice, Rockford Nephrology Associates is treating 544 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 102 Stage 4 and 5 CKD patients reside within 30 minutes of the proposed facility, and 81 of these same 102 patients reside within 20 minutes of the proposed facility. See Appendix 2. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Ahmad anticipates that approximately 64 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the current high utilization of these three facilities,¹⁰ many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's 80% utilization standard.

This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Ahmad's practice is currently treating ESRD patients at Churchview Dialysis, Rockford Dialysis, Roxbury Dialysis, Stonecrest Dialysis, and Sycamore Dialysis, which are collectively operating at an average of 93.70% utilization. Stonecrest Dialysis and Roxbury Dialysis are operating a fourth shift and Rockford Dialysis is nearly full. Operating four shifts per day is not a feasible alternative for many reasons. When a fourth shift is operated, the dialysis facility is operated nearly around the clock with staff opening the facility around 5:00 a.m. and closing it around midnight. Not only is staffing a fourth shift difficult for clinic personnel, it is also suboptimal for the patients themselves who are chronically ill and usually elderly. Patients, many of whom rely on assistive devices such as canes and walkers, are faced with additional safety hazards when arriving and departing the facility in the dark. Some of these hazards cannot be avoided in the winter but patients feel much more secure when coming and going in the daylight. Adding a fourth shift would increase operating costs by adding additional staffing costs and utilities cost. The costs would be somewhat higher than the operating costs of adding stations. As a result, a new dialysis facility is needed to accommodate Dr. Ahmad's already large, and growing, patient-base and lower utilization at over-utilized facilities in the GSA.

The establishment of a 12-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Belvidere community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

2. A map of the market area for the proposed facility is attached at Attachment – 12A. The market area encompasses an approximate 20 mile radius around the proposed facility. The boundaries of the market area of are as follows:

¹⁰ Per the June 30, 2013 ESRD utilization data, Stonecrest Dialysis was operating at 110% utilization, Rockford Dialysis was operating at 95% utilization, and Roxbury Dialysis was operating at 110% utilization.

- North approximately 30 minutes normal travel time to Wisconsin State Line.
- Northeast approximately 30 minutes normal travel time to Chemung, IL.
- East approximately 30 minutes normal travel time to Marengo, IL.
- Southeast approximately 30 minutes normal travel time to Genoa, IL.
- South approximately 30 minutes normal travel time to IL Route 64.
- Southwest approximately 30 minutes normal travel time to Davis Junction, IL.
- West approximately 30 minutes normal travel time to far west Rockford, IL (61102).
- Northwest approximately 30 minutes normal travel time to Roscoe, IL.

The purpose of this project is to improve access to life sustaining dialysis to residents of the community of Belvidere and the immediately surrounding areas. As discussed more fully above, there is not sufficient capacity within the GSA to accommodate all of Dr. Ahmad's projected referrals.

3. The minimum size of a GSA is 30 minutes; however, most of the patients reside within the immediate vicinity of the proposed facility. The proposed facility will be located in Belvidere, IL. There are currently five existing or approved dialysis facilities within 30 minutes of the proposed Belvidere facility. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization of these facilities is 85.95%. The surrounding community is comprised of approximately 26.1% Hispanic residents. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.¹¹ Due to socioeconomic conditions, this population exhibits a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in Hispanic communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. See Attachment – 12B. This, coupled with the aging population, is expected to further increase utilization at the existing dialysis facilities. As shown in Appendix - 2, the projected referrals by Dr. Ahmad confirm this. Dr. Ahmad expects approximately 64 of the current CKD patients to require dialysis within the next 12 to 24 months. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the high utilization of these three facilities, many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's 80% utilization standard.

4. Source Information

The Renal Network, Utilization Data for the Quarter Ending June 30, 2013.

U.S. Census Bureau, American FactFinder, Fact Sheet, available at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml> (last visited July 30, 2013).

US Renal Data System, USRDS 2013 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, (2013) available at <http://www.usrds.org/2013/view/Default.aspx> (last visited Dec. 6, 2013). available at

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 available at <http://www.usrds.org/atlas11.aspx> (last visited Dec. 6, 2013).

¹¹ Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

5. The establishment of the proposed facility will improve access to dialysis services to the residents of the Belvidere community and the surrounding area. Average utilization of the existing facilities is 85.95%, with two facilities operating four shifts per day. As set forth above operating four shifts is suboptimal for both patients and clinic staff. Establishment of a 12-station dialysis facility in Belvidere will not only alleviate high utilization at other facilities in the GSA, but will ensure Dr. Ahmad's increasing patient-base will have sufficient access to dialysis services in this community.
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 is more than \$1.5 billion in savings to the health care system and the American taxpayer since 2010.

[illegible]



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Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem

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University of Illinois at Chicago, Department of Medicine, Section of Nephrology (CML, AP, ACR, JPL); Division of Research, Kaiser Permanente of Northern California and University of California, San Francisco (ASG); Department of Preventive Medicine, Northwestern University Feinberg School of Medicine (MLD); National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health (JWK).

Abstract

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

Keywords

Chronic Kidney Disease; Hispanics; Health Care Disparities

Introduction

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

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AUTHOR CONTRIBUTIONS *Design concept of study:* Lora, Lash

Acquisition of data: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Data analysis and interpretation: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Manuscript draft: Lora, Lash

Administrative, technical, or material assistance: Lora, Daviglus, Kusek, Porter, Ricardo, Go, Lash

Supervision: Lora, Lash

for chronic kidney disease (CKD) in Hispanics. In this review, we examine the epidemiology of CKD in US Hispanics, explore potential reasons for this growing public health problem, and highlight potential areas for future research.

Methods

We performed a qualitative review of the literature utilizing a PubMed search for the following keywords: chronic kidney disease, Hispanics, Latinos, end stage renal disease, diabetes, dialysis, transplantation, and health care disparities. In addition, we reviewed data from the USRDS^{2,3} and the Organ Procurement and Transplantation Network.⁴ For the purpose of this review, the term Hispanic ethnicity refers to all persons of Latin American origin living in the United States, unless indicated otherwise. Hispanics are culturally, socioeconomically, and genetically heterogeneous and represent a wide variety of national origins and social classes.⁵ In terms of ancestry, US Hispanics originate from three populations: European settlers, Native Americans, and West Africans. The breakdown for the US Hispanic population is as follows: 64% Mexican, 9% Puerto Rican, 3.5% Salvadoran and 2.7% Dominican.¹ The remainder is of Central American, South American or other Hispanic or Latino origin.

Epidemiology of CKD in Hispanics

Glomerular filtration rate (GFR) estimating equations have been used to determine the prevalence of CKD in the United States. The abbreviated Modification of Diet in Renal Disease (MDRD) equation has been considered to be the most accurate available estimating equation for GFR and has been used widely in the literature and by a growing number of clinical laboratories.⁶ Though the equation has been demonstrated to have validity across a spectrum of different subgroups,⁷ there are no data regarding its validity in Hispanics. This is a relevant concern because the serum creatinine concentration, which is used in the MDRD equation to calculate estimated GFR (eGFR), has been demonstrated to differ by racial/ethnic groups. In an analysis of serum creatinine levels in the National Health and Nutrition Examination Survey (NHANES) III, Mexican Americans had lower mean serum creatinine levels than non-Hispanic Whites or non-Hispanic Blacks.⁸ The reasons for these differences are unknown. Similarly, a recent NHANES analysis of serum cystatin C, a potentially more sensitive marker of early kidney dysfunction than serum creatinine, reported lower levels of cystatin C in Mexican Americans compared with other racial/ethnic groups studied.⁹ These differences in the distribution of serum creatinine and cystatin C levels in Hispanics reinforce the importance of rigorously evaluating the accuracy of GFR estimating equations in Hispanics.¹⁰

Incidence and Prevalence of CKD in Hispanics

Mild to Moderate CKD

Information regarding earlier stages of CKD in Hispanics is limited. Several investigators have reported a higher prevalence of microalbuminuria in Hispanics compared with non-Hispanic Whites.^{11–13} In contrast to these findings, a recent analysis of NHANES III data suggests that the prevalence of CKD may be lower in Mexican Americans than in non-Hispanic Whites or non-Hispanic Blacks. In an analysis of NHANES III, moderately decreased kidney function (eGFR 30–59 mL/minute/1.73 m²) was most prevalent among non-Hispanic Whites (4.8%) and non-Hispanic Blacks (3.1%) and least prevalent in Mexican Americans (1.0%).¹⁴ Between NHANES 1988 to 1994 and 1994 to 2004, the prevalence of CKD rose among Mexican Americans but continued to be lower than that observed in non-Hispanic Whites and Blacks.¹⁵

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

End Stage Renal Disease (ESRD)

It is well established that Hispanics have a higher prevalence of ESRD than non-Hispanic Whites. The increased prevalence of treated ESRD in Hispanics was first recognized in the 1980s. Using data from the state of Texas, Mexican Americans were found to have an excess of ESRD compared with non-Hispanic Whites with an incidence ratio of 3.¹⁶ For diabetic ESRD, Mexican Americans had an incidence ratio of 6 compared with non-Hispanic Whites. The first study at a national level analyzed male Hispanics identified in Medicare ESRD program data files. Using common Spanish surnames to identify cases, it was found that Hispanics developed ESRD at a younger age than non-Hispanic Whites; and between 1980 and 1990, ESRD incidence rates increased more for Hispanics.¹⁷ In 1995, the USRDS began to acquire data regarding Hispanic ethnicity. In 2006, the adjusted incidence rate for ESRD in Hispanics was 1.5 times higher than for non-Hispanic Whites.² Furthermore, between 1996 and 2005, the incidence rate for Hispanics increased by 63%.² In contrast, Burrows et al examined trends in age-adjusted ESRD rates and reported that the age-adjusted ESRD rate in Hispanics decreased by approximately 15%, from 2000 to 2005 (530.2 vs 448.9).¹⁸ However, there was an overall increase in the age-adjusted incidence rates in Hispanics in 2005 as compared with 1995 (448.9 vs 395.0). It is apparent that a longer period of follow-up time is needed to better characterize trends. The leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites are described in Table 1. Diabetes accounts for 59% of prevalent cases of ESRD in Hispanic compared with 39% of cases in non-Hispanic Whites.³ Unfortunately, data regarding causes of ESRD by Hispanic subgroup are not available.

The incidence and severity of diabetes are important factors in the excessive incidence of diabetic ESRD observed in Hispanics. The prevalence of diabetes in Hispanics has been estimated to be approximately 1.5 to 3 times that seen in the non-Hispanic White population and its incidence is rising.¹⁹ Moreover, Hispanics have been found to have lower rates of glucose self-monitoring and poorer glycemic control compared with non-Hispanic Whites.²⁰ Hispanics with diabetes may be at increased risk to develop diabetic nephropathy. Mexican American diabetics in San Antonio, Texas had a higher prevalence of proteinuria than non-Hispanic White diabetics from Wisconsin.²¹ However, no such difference was observed in the San Luis Valley.²² The importance of non-diabetic CKD in Hispanics is not completely understood. Though hypertension is less prevalent in Hispanics, Mexican Americans had the highest rate of uncontrolled hypertension in NHANES III.²³ Data from Texas and the USRDS demonstrate a higher incidence of ESRD due to hypertension in Hispanics than in non-Hispanic Whites.^{16,24}

Progression of CKD in Hispanics

Only limited information is available regarding progression rates and risk factors for CKD in Hispanics. In a multivariable retrospective analysis of a cohort of 263 type 2 diabetic ESRD patients, Mexican ethnicity and female sex were found to hasten the decline of renal function.²⁵ A post hoc analysis of the Reduction of Endpoints in NIDDM with the Angiotensin II Antagonist Losartan Study (RENAAL) found that Hispanics had the highest

risk for ESRD compared with Blacks and Whites.²⁶ However, the majority of Hispanics in this study were from Latin American countries and therefore, the findings may not be applicable to US Hispanics. A recent analysis of patients enrolled in Kaiser Permanente of Northern California, a large integrated healthcare delivery system, has clarified the risk of ESRD in US Hispanics with CKD.²⁷ In 39,550 patients with stage 3 to 4 CKD, Hispanic ethnicity was associated with almost a two-fold increased risk for ESRD when compared with non-Hispanic Whites. This increased risk was attenuated to 33% after adjustment for diabetes, medication use, and other characteristics. Thus, the risk for progression to ESRD in Hispanics is only partially explained by diabetes.

Even less is known about progression rates and risk factors for non-diabetic CKD in Hispanics. Some reports suggest that certain glomerular diseases may be more severe and progress more often in Hispanics than in non-Hispanic Whites.^{28–30} In a recent examination of rates of progression in 128 patients with proliferative lupus nephritis, Barr et al. found that Hispanic ethnicity was independently associated with progression of CKD.³⁰ Another study examining patients with lupus found that Texan-Hispanic ethnicity was more likely to be associated with nephritis than Puerto Rican ethnicity.³¹ This suggests that outcomes can vary by Hispanic subgroup.

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

Metabolic Syndrome and CKD

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

Disparities in Health Care and Prevalence and Progression of CKD

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

the highest rate of uncontrolled hypertension.²³ Lastly, Ifudu et al reported that non-Whites, including Hispanics, are more likely to receive a late referral to a nephrologist for CKD management.⁴³ This study was limited by the low number of Hispanics in the analysis. These findings suggest that quality of care may play a role in the high prevalence of ESRD in this population.

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

Cardiovascular Disease in Hispanics with ESRD and Earlier Stages of CKD

Several studies have found that Hispanics may have lower all-cause and CV mortality rates than non-Hispanic Whites.^{48–50} The term, Hispanic paradox, has been used to describe the lower than expected mortality rates despite the increased incidence of diabetes and obesity, lower socioeconomic status, and barriers to health care.⁵¹ A number of explanations have been proposed, including socio-cultural factors, ethnic misclassification, incomplete ascertainment of deaths, and the healthy migrant effect.^{36,52} In the ESRD population, Hispanics, Blacks, and Asians have a lower risk of death than non-Hispanic Whites, regardless of diabetes status.^{24,53–55} In a recent analysis of a national, random sample of hemodialysis patients, Hispanics had an adjusted 12-month mortality risk that was 25% lower than non-Hispanic Whites.⁵³ The reasons for the lower ESRD mortality rates are not completely understood, but differences in survival have been noted among Hispanic subgroups with Mexican-Americans, Cuban Americans and Hispanic-other having an increased survival advantage compared with Puerto Rican Americans.⁵⁶ These findings suggest that sociocultural or genetic differences may play a role in these lower ESRD mortality rates and demonstrating the importance of examining health outcomes in subgroups of Hispanics.

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

End-State Renal Disease Care in US Hispanics

Dialysis

Analysis of USRDS data reveals that Hispanics are 1.47 times more likely than non-Hispanic Whites to have late initiation of dialysis.⁵⁹ At the start of dialysis, Hispanics tend to have slightly lower hematocrit levels and are 13% less likely to be on erythropoiesis stimulating agents compared with non-Hispanic Whites.⁶⁰ An analysis of a random sample of Medicare eligible adults on hemodialysis in 1997 revealed that, compared with non-Hispanic Whites, Hispanics on hemodialysis are more likely to be female, younger, and have diabetes.⁶¹ Hispanics tend to have higher albumin levels and similar hematocrit levels compared to non-Hispanic Whites.^{53,61,62}

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

Transplantation

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

Conclusion

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

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REFERENCES

1. U.S.Census. [11-17-2008. Last accessed on 2-26-2009] Nation's Population One-Third Minority. Available at: <http://www.census.gov/Press-Release/www/releases/archives/population/006808.html>
2. Collins AJ, Foley RN, Herzog C, et al. United States Renal Data System 2008 Annual Data Report Abstract. *Am J Kidney Dis.* 2009; 53(1 Suppl):vi-374.
3. United States Renal Data Systems. [Last accessed on 8-25-2009] Available at: http://www.usrds.org/adr_2000.htm
4. Organ Procurement and Transplantation Network. [Last accessed on 8-27-2009] Kidney Kaplan-Meier Median Waiting Times For Registrations Listed : 1999-2004. Available at: <http://www.optn.org/latestData/rptStrat.asp>
5. Burchard EG, Borrell LN, Choudhry S, et al. Latino populations: A unique opportunity for the study of race, genetics, and social environment in epidemiological research. *Am J Public Health.* 2005; 95(12):2161-2168. [PubMed: 16257940]
6. Levey AS, Bosch JP, Lewis JB, et al. A more accurate method to estimate glomerular filtration rate from serum creatinine: a new prediction equation. Modification of Diet in Renal Disease Study Group. *Ann Intern Med.* 1999; 130(6):461-470. [PubMed: 10075613]
7. Stevens LA, Coresh J, Feldman HI, et al. Evaluation of the modification of diet in renal disease study equation in a large diverse population. *J Am Soc Nephrol.* 2007; 18(10):2749-2757. [PubMed: 17855641]
8. Jones CA, McQuillan GM, Kusek JW, et al. Serum creatinine levels in the US population: third National Health and Nutrition Examination Survey. *Am J Kidney Dis.* 1998; 32(6):992-999. [PubMed: 9856515]
9. Kottgen A, Selvin E, Stevens LA, et al. Serum cystatin C in the United States: the Third National Health and Nutrition Examination Survey (NHANES III). *Am J Kidney Dis.* 2008; 51(3):385-394. [PubMed: 18295054]
10. US Renal Data System. Excerpts from the United States Renal Data System 2006 Annual Data Report. *Am J Kidney Dis.* 2007; 49(1 Suppl 1):A6-296. [PubMed: 17189040]

11. Wachtell K, Olsen MH, Dahlof B, et al. Microalbuminuria in hypertensive patients with electrocardiographic left ventricular hypertrophy: the LIFE study. *J Hypertens.* 2002; 20(3):405–412. [PubMed: 11875307]
12. Jones CA, Francis ME, Eberhardt MS, et al. Microalbuminuria in the US population: third National Health and Nutrition Examination Survey. *Am J Kidney Dis.* 2002; 39(3):445–459. [PubMed: 11877563]
13. Bryson CL, Ross HJ, Boyko EJ, Young BA. Racial and ethnic variations in albuminuria in the US Third National Health and Nutrition Examination Survey (NHANES III) population: associations with diabetes and level of CKD. *Am J Kidney Dis.* 2006; 48(5):720–726. [PubMed: 17059991]
14. Coresh J, Astor BC, Greene T, et al. Prevalence of chronic kidney disease and decreased kidney function in the adult US population: Third National Health and Nutrition Examination Survey. *Am J Kidney Dis.* 2003; 41(1):1–12. [PubMed: 12500213]
15. Coresh J, Selvin E, Stevens LA, et al. Prevalence of chronic kidney disease in the United States. *JAMA.* 2007; 298(17):2038–2047. [PubMed: 17986697]
16. Pugh JA, Stern MP, Haffner SM, et al. Excess incidence of treatment of end-stage renal disease in Mexican Americans. *Am J Epidemiol.* 1988; 127(1):135–144. [PubMed: 3276155]
17. Chiapella AP, Feldman HI. Renal failure among male Hispanics in the United States. *Am J Public Health.* 1995; 85(7):1001–1004. [PubMed: 7604897]
18. Burrows NR, Li Y, Williams DE. Racial and ethnic differences in trends of end-stage renal disease: United States, 1995 to 2005. *Adv Chronic Kidney Dis.* 2008; 15(2):147–152. [PubMed: 18334239]
19. Burke JP, Williams K, Gaskill SP, et al. Rapid rise in the incidence of type 2 diabetes from 1987 to 1996: results from the San Antonio Heart Study. *Arch Intern Med.* 1999; 159(13):1450–1456. [PubMed: 10399896]
20. Harris MI. Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes. *Diabetes Care.* 2001; 24(3):454–459. [PubMed: 11289467]
21. Haffner SM, Mitchell BD, Pugh JA, et al. Proteinuria in Mexican Americans and non-Hispanic whites with NIDDM. *Diabetes Care.* 1989; 12(8):530–536. [PubMed: 2776587]
22. Hamman RF, Franklin GA, Mayer EJ, et al. Microvascular complications of NIDDM in Hispanics and non-Hispanic whites. San Luis Valley Diabetes Study. *Diabetes Care.* 1991; 14(7):655–664. [PubMed: 1914815]
23. Hajjar I, Kotchen JM, Kotchen TA. Hypertension: trends in prevalence, incidence, and control. *Annu Rev Public Health.* 2006; 27:465–490. [PubMed: 16533126]
24. Excerpts from the United States Renal Data Systems 2002 annual report: Atlas of end-stage renal disease in the United States. *Am J Kidney Dis.* 2003; 41(4 Suppl 2):v–254. [PubMed: 12696022]
25. Garza R, Medina R, Basu S, Pugh JA. Predictors of the rate of renal function decline in non-insulin-dependent diabetes mellitus. *Am J Nephrol.* 1997; 17(1):59–67. [PubMed: 9057955]
26. de Zeeuw D, Ramjit D, Zhang Z, et al. Renal risk and renoprotection among ethnic groups with type 2 diabetic nephropathy: a post hoc analysis of RENAAL. *Kidney Int.* 2006; 69(9):1675–1682. [PubMed: 16572114]
27. Peralta CA, Shlipak MG, Fan D, et al. Risks for end-stage renal disease, cardiovascular events, and death in Hispanic versus non-Hispanic white adults with chronic kidney disease. *J Am Soc Nephrol.* 2006; 17(10):2892–2899. [PubMed: 16959827]
28. Ingulli E, Tejani A. Racial differences in the incidence and renal outcome of idiopathic focal segmental glomerulosclerosis in children. *Pediatr Nephrol.* 1991; 5(4):393–397. [PubMed: 1911111]
29. Bastian HM, Roseman JM, McGwin G Jr. et al. Systemic lupus erythematosus in three ethnic groups. XII. Risk factors for lupus nephritis after diagnosis. *Lupus.* 2002; 11(3):152–160. [PubMed: 12004788]
30. Barr RG, Seliger S, Appel GB, et al. Prognosis in proliferative lupus nephritis: the role of socioeconomic status and race/ethnicity. *Nephrol Dial Transplant.* 2003; 18(10):2039–2046. [PubMed: 13679478]

31. Fernandez M, Alarcon GS, Calvo-Alen J, et al. A multiethnic, multicenter cohort of patients with systemic lupus erythematosus (SLE) as a model for the study of ethnic disparities in SLE. *Arthritis Rheum.* 2007; 57(4):576–584. [PubMed: 17471524]
32. Feldman HI, Appel LJ, Chertow GM, et al. The Chronic Renal Insufficiency Cohort (CRIC) Study: Design and Methods. *J Am Soc Nephrol.* 2003; 14(7 Suppl 2):S148–S153. [PubMed: 12819321]
33. Ford ES, Giles WH, Dietz WH. Prevalence of the metabolic syndrome among US adults: findings from the third National Health and Nutrition Examination Survey. *JAMA.* 2002; 287(3):356–359. [PubMed: 11790215]
34. Park YW, Zhu S, Palaniappan L, et al. The metabolic syndrome: prevalence and associated risk factor findings in the US population from the Third National Health and Nutrition Examination Survey, 1988–1994. *Arch Intern Med.* 2003; 163(4):427–436. [PubMed: 12588201]
35. Chen J, Muntner P, Hamm LL, et al. The metabolic syndrome and chronic kidney disease in U.S. adults. *Ann Intern Med.* 2004; 140(3):167–174. [PubMed: 14757614]
36. Hunt KJ, Williams K, Resendez RG, et al. All-cause and cardiovascular mortality among diabetic participants in the San Antonio Heart Study: evidence against the “Hispanic Paradox”. *Diabetes Care.* 2002; 25(9):1557–1563. [PubMed: 12196427]
37. Lucove J, Vupputuri S, Heiss G, et al. Metabolic syndrome and the development of CKD in American Indians: the Strong Heart Study. *Am J Kidney Dis.* 2008; 51(1):21–28. [PubMed: 18155529]
38. Kurella M, Lo JC, Chertow GM. Metabolic syndrome and the risk for chronic kidney disease among nondiabetic adults. *J Am Soc Nephrol.* 2005; 16(7):2134–2140. [PubMed: 15901764]
39. Norris K, Nissenson AR. Race, gender, and socioeconomic disparities in CKD in the United States. *J Am Soc Nephrol.* 2008; 19(7):1261–1270. [PubMed: 18525000]
40. Norris K, Nissenson A. Racial disparities in chronic kidney disease: tragedy, opportunity, or both? *Clin J Am Soc Nephrol.* 2008; 3(2):314–316. [PubMed: 18287256]
41. Commonwealth Fund. [Last accessed on 8-25-2009] Quality of Health Care for Hispanic Populations: Findings from The Commonwealth Fund 2001 Health Care Quality Survey. Available at: <http://www.commonwealthfund.org/Content/Publications/Other/2002/Mar/Quality-of-Health-Care-for-Hispanic-Populations-A-Fact-Sheet.aspx>.
42. Mainous AG Iii, Diaz VA, Koopman RJ, Everett CJ. Quality of care for Hispanic adults with diabetes. *Fam Med.* 2007; 39(5):351–356. [PubMed: 17476609]
43. Ifudu O, Dawood M, Iofel Y, et al. Delayed referral of black, Hispanic, and older patients with chronic renal failure. *Am J Kidney Dis.* 1999; 33(4):728–733. [PubMed: 10196016]
44. DuBard CA, Gizlice Z. Language spoken and differences in health status, access to care, and receipt of preventive services among US Hispanics. *Am J Public Health.* 2008; 98(11):2021–2028. [PubMed: 18799780]
45. Safran DG, Kosinski M, Tarlov AR, et al. The Primary Care Assessment Survey: tests of data quality and measurement performance. *Med Care.* 1998; 36(5):728–739. [PubMed: 9596063]
46. Doescher MP, Saver BG, Franks P, Fiscella K. Racial and ethnic disparities in perceptions of physician style and trust. *Arch Fam Med.* 2000; 9(10):1156–1163. [PubMed: 11115223]
47. Lee SY, Arozullah AM, Cho YI. Health literacy, social support, and health: a research agenda. *Soc Sci Med.* 2004; 58(7):1309–1321. [PubMed: 14759678]
48. Stern MP, Bradshaw BS, Eifler CW, et al. Secular decline in death rates due to ischemic heart disease in Mexican Americans and non-Hispanic whites in Texas, 1970–1980. *Circulation.* 1987; 76(6):1245–1250. [PubMed: 3677349]
49. Mitchell BD, Hazuda HP, Haffner SM, et al. Myocardial infarction in Mexican-Americans and non-Hispanic whites. The San Antonio Heart Study. *Circulation.* 1991; 83(1):45–51. [PubMed: 1984897]
50. Liao Y, Cooper RS, Cao G, et al. Mortality from coronary heart disease and cardiovascular disease among adult U.S. Hispanics: findings from the National Health Interview Survey (1986 to 1994). *J Am Coll Cardiol.* 1997; 30(5):1200–1205. [PubMed: 9350915]
51. Markides KS, Stroup-Benham CA, Goodwin JS, et al. The effect of medical conditions on the functional limitations of Mexican-American elderly. *Ann Epidemiol.* 1996; 6(5):386–391. [PubMed: 8915469]

52. Patel KV, Eschbach K, Ray LA, Markides KS. Evaluation of mortality data for older Mexican Americans: implications for the Hispanic paradox. *Am J Epidemiol.* 2004; 159(7):707–715. [PubMed: 15033649]
53. Frankenfield DL, Rocco MV, Roman SH, McClellan WM. Survival advantage for adult Hispanic hemodialysis patients? Findings from the end-stage renal disease clinical performance measures project. *J Am Soc Nephrol.* 2003; 14(1):180–186. [PubMed: 12506150]
54. Lopes AA, Bragg-Gresham JL, Satayathum S, et al. Health-related quality of life and associated outcomes among hemodialysis patients of different ethnicities in the United States: the Dialysis Outcomes and Practice Patterns Study (DOPPS). *Am J Kidney Dis.* 2003; 41(3):605–615. [PubMed: 12612984]
55. Young BA, Maynard C, Boyko EJ. Racial differences in diabetic nephropathy, cardiovascular disease, and mortality in a national population of veterans. *Diabetes Care.* 2003; 26(8):2392–2399. [PubMed: 12882868]
56. Frankenfield DL, Krishnan SM, Ashby VB, et al. Differences in mortality among Mexican-American, Puerto Rican, and Cuban-American dialysis patients in the United States. *Am J Kidney Dis.* 2009; 53(4):647–657. [PubMed: 19150157]
57. Mehrotra R, Kermah D, Fried L, et al. Racial differences in mortality among those with CKD. *J Am Soc Nephrol.* 2008; 19(7):1403–1410. [PubMed: 18385428]
58. Young BA, Maynard C, Reiber G, Boyko EJ. Effects of ethnicity and nephropathy on lower-extremity amputation risk among diabetic veterans. *Diabetes Care.* 2003; 26(2):495–501. [PubMed: 12547888]
59. Kausz AT, Obrador GT, Arora P, et al. Late initiation of dialysis among women and ethnic minorities in the United States. *J Am Soc Nephrol.* 2000; 11(12):2351–2357. [PubMed: 11095658]
60. Ward MM. Laboratory abnormalities at the onset of treatment of end-stage renal disease: are there racial or socioeconomic disparities in care? *Arch Intern Med.* 2007; 167(10):1083–1091. [PubMed: 17533212]
61. Frankenfield DL, Rocco MV, Frederick PR, et al. Racial/ethnic analysis of selected intermediate outcomes for hemodialysis patients: results from the 1997 ESRD Core Indicators Project. *Am J Kidney Dis.* 1999; 34(4):721–730. [PubMed: 10516355]
62. Morales LC, Burrowes JD, Gizis F, Brommage D. Dietary adherence in Hispanic patients receiving hemodialysis. *J Ren Nutr.* 2007; 17(2):138–147. [PubMed: 17321954]
63. Chartier K. Illegal immigration. The impact on renal care. *Nephrol News Issues.* 2004; 18(13):27–8. 30, 32. [PubMed: 15643821]
64. Coritsidis GN, Khamash H, Ahmed SI, et al. The initiation of dialysis in undocumented aliens: the impact on a public hospital system. *Am J Kidney Dis.* 2004; 43(3):424–432. [PubMed: 14981600]
65. Hurley L, Kempe A, Crane LA, et al. Care of undocumented individuals with ESRD: a national survey of US nephrologists. *Am J Kidney Dis.* 2009; 53(6):940–949. [PubMed: 19327878]
66. Sheikh-Hamad D, Paiuk E, Wright AJ, et al. Care for immigrants with end-stage renal disease in Houston: a comparison of two practices. *Tex Med.* 2007; 103(4):54–8. 53. [PubMed: 17494250]
67. Sequist TD, Narva AS, Stiles SK, et al. Access to renal transplantation among American Indians and Hispanics. *Am J Kidney Dis.* 2004; 44(2):344–352. [PubMed: 15264194]
68. Higgins RS, Fishman JA. Disparities in solid organ transplantation for ethnic minorities: facts and solutions. *Am J Transplant.* 2006; 6(11):2556–2562. [PubMed: 16952299]
69. Breitkopf CR. Attitudes, beliefs and behaviors surrounding organ donation among Hispanic women. *Curr Opin Organ Transplant.* 2009; 14(2):191–195. [PubMed: 19469039]
70. Alvaro EM, Jones SP, Robles AS, Siegel JT. Predictors of organ donation behavior among Hispanic Americans. *Prog Transplant.* 2005; 15(2):149–156. [PubMed: 16013463]
71. Alvaro EM, Siegel JT, Turcotte D, et al. Living kidney donation among Hispanics: a qualitative examination of barriers and opportunities. *Prog Transplant.* 2008; 18(4):243–250. [PubMed: 19186576]
72. Roberts JP, Wolfe RA, Bragg-Gresham JL, et al. Effect of changing the priority for HLA matching on the rates and outcomes of kidney transplantation in minority groups. *N Engl J Med.* 2004; 350(6):545–551. [PubMed: 14762181]

73. Saunders PH, Banowsky LH, Reichert DF. Survival of cadaveric renal allografts in Hispanic as compared with Caucasian recipients. *Transplantation*. 1984; 37(4):359–362. [PubMed: 6369665]
74. Katznelson S, Gjertson DW, Cecka JM. The effect of race and ethnicity on kidney allograft outcome. *Clin Transpl*. 1995:379–394. [PubMed: 8794281]
75. Press R, Carrasquillo O, Nickolas T, et al. Race/ethnicity, poverty status, and renal transplant outcomes. *Transplantation*. 2005; 80(7):917–924. [PubMed: 16249739]
76. Gordon EJ, Caicedo JC. Ethnic advantages in kidney transplant outcomes: the Hispanic Paradox at work? *Nephrol Dial Transplant*. 2009; 24(4):1103–1109. [PubMed: 19075197]

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

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

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Table 1

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

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

Obesity and Risk for Chronic Renal Failure

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Few large-scale epidemiologic studies have quantified the possible link between obesity and chronic renal failure (CRF). This study analyzed anthropometric data from a nationwide, population-based, case-control study of incident, moderately severe CRF. Eligible as cases were all native Swedes who were aged 18 to 74 yr and had CRF and whose serum creatinine for the first time and permanently exceeded 3.4 mg/dl (men) or 2.8 mg/dl (women) during the study period. A total of 926 case patients and 998 control subjects, randomly drawn from the study base, were enrolled. Face-to-face interviews, supplemented with self-administered questionnaires, provided information about anthropometric measures and other lifestyle factors. Logistic regression models with adjustments for several co-factors estimated the relative risk for CRF in relation to body mass index (BMI). Overweight (BMI ≥ 25 kg/m²) at age 20 was associated with a significant three-fold excess risk for CRF, relative to BMI <25 . Obesity (BMI ≥ 30) among men and morbid obesity (BMI ≥ 35) among women anytime during lifetime was linked to three- to four-fold increases in risk. The strongest association was with diabetic nephropathy, but two- to three-fold risk elevations were observed for all major subtypes of CRF. Analyses that were confined to strata without hypertension or diabetes revealed a three-fold increased risk among patients who were overweight at age 20, whereas the two-fold observed risk elevation among those who had a highest lifetime BMI of >35 was statistically nonsignificant. Obesity seems to be an important—and potentially preventable—risk factor for CRF. Although hypertension and type 2 diabetes are important mediators, additional pathways also may exist.

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The number of patients with chronic renal failure (CRF) and ESRD is increasing steadily worldwide (1,2). Although the growing population with ESRD may be explained partly by more complete registration and better survival, a true rise in CRF incidence seems to be indisputable (3). This development parallels a rise in obesity prevalence of almost epidemic proportions.

Obesity has been implicated as a possible risk factor for microalbuminuria in individuals with hypertension and diabetes (4–6), and body mass index (BMI) was positively associated with progression of IgA glomerulonephritis in a cohort study (7). Studies from the general population suggest that obesity also may be harmful to the kidneys in individuals without hypertension, diabetes, or preexisting renal disease (8,9). In the Framingham Offspring cohort (10), body mass was positively related to the odds of having a GFR in the fifth or lower percentile after long-term follow-up. Similarly, follow-up among participants in health screening programs in the United States (11) and Japan (12) demonstrated a significant positive relationship between BMI and risk for ESRD, although this

association seemingly was confined to men in the Japanese study.

The aim of this study was to investigate the possible effects of body mass on the incidence of moderately severe CRF overall and by subtype. We obtained detailed anthropometric information in a nationwide, population-based, case-control study of incident prerenal CRF (13).

Materials and Methods

Study Participants

The study design has been described elsewhere (13). Briefly, the Swedish National Population Register provided a well-defined source population of 5.3 million native Swedes who were aged 18 to 74 yr and lived in Sweden during the ascertainment period, May 20, 1996, through May 31, 1998.

Eligible as cases were all men and women whose serum creatinine level, for the first time and permanently, exceeded 3.4 mg/dl (300 μ mol/L) and 2.8 mg/dl (250 μ mol/L), respectively. For ensuring complete case ascertainment, all medical laboratories that covered inpatient and outpatient care in Sweden provided monthly lists of patients who had undergone serum creatinine testing any time during the entire study period. A second creatinine measurement, 3 mo after the first, was done to verify the chronicity. Local physicians who treat patients with renal diseases determined patients' eligibility for the study by reviewing the medical records of patients with elevated serum creatinine levels. The diagnosis of underlying disease was based on the results of routine clinical evaluation. Patients with prerenal (e.g., severe heart failure) or postrenal (e.g., outlet obstruction) causes or with kid-

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ney transplants were ineligible. Of eligible cases, 16% refused or were too severely disabled to participate, and 6% had died, leaving 926 (78%) participants.

Control subjects, who were frequency-matched to cases according to age (± 10 yr) and gender, were randomly selected from the 5.3 million Swedes in the study base, using the nationwide National Population Register. The control selection was carried out on three occasions during the ascertainment period. Of 1330 selected control subjects, 998 (75%) participated, 17% refused, 4% could not be reached, and 4% were too sick to participate. All study participants provided informed consent, and the regional ethics committees and Swedish Data Inspection Board approved the study protocol.

Data Collection

Study participants completed a mailed questionnaire about anthropometric measures (height; current weight; weight at ages 20, 40, and 60; and highest weight during lifetime), education, alcohol consumption, and tobacco use. During a subsequent face-to-face interview, professional interviewers from Statistics Sweden double-checked the questionnaires and obtained information on medical history, occupation, and analgesic use. Although blinding of the interviewers to case/control status of the participants was impossible, the interviewers were instructed to interact similarly with case patients and control subjects in a standardized manner.

Data Analyses

Relative risk for CRF among groups with different anthropometric measures was estimated by odds ratios (OR) and 95% confidence intervals (CI) that were derived from unconditional logistic regression models. We analyzed data stratified by gender throughout, except in

analyses of disease-specific CRF, as a result of small sample sizes. Continuous variables (BMI [body weight divided by height raised to the second power, kg/m^2], cumulative number of cigarette pack-years, grams of alcohol per week) were categorized into quartiles according to the distribution among control subjects. In addition, BMI was categorized according to World Health Organization's (WHO's) definitions of overweight and obesity (14). Because few participants had a BMI $>30 \text{ kg}/\text{m}^2$ at age 20, BMI at that age was dichotomized into <25 and $\geq 25 \text{ kg}/\text{m}^2$. Level of education was categorized into ≤ 9 yr, 10 to 12 yr, and ≥ 13 yr. An indicator of regular use of aspirin and paracetamol was found to control sufficiently for confounding of nonnarcotic analgesic use. Adjustment for socioeconomic status instead of number of school years did not change the risk estimates. Always included as covariates in our models were age, cumulative cigarette pack-years, grams of alcohol consumed per week, ever/never regular use of paracetamol or aspirin, and number of years of formal education. We tested for interactions but did not include any interaction terms in the final models because they were statistically insignificant. Model fit was verified with the Hosmer and Lemeshow test (15).

Results

The participating case patients are characterized with regard to renal function and underlying disease in Table 1. A majority of the patients were in the preuremic stage: 80% had a creatinine level $<4.5 \text{ mg}/\text{dl}$ ($400 \mu\text{mol}/\text{L}$); only 6% had a predicted creatinine clearance (16) $<10 \text{ ml}/\text{min}$. Approximately one third of the patients had a diagnosis of diabetic nephropathy. The second largest group was patients with glomerulonephritis (28% of men and 16% of women), followed by renal vascular

Table 1. Participating case patients with CRF: Measures of renal function and underlying diagnosis^a

	Men (<i>n</i> = 597)	Women (<i>n</i> = 329)
Serum creatinine at inclusion (mg/dl ; median [range]) ^b	3.8 (3.4 to 28)	3.2 (2.8 to 19)
Creatinine clearance (ml/min ; median [range]) ^c	22 (2 to 53)	19 (3 to 35)
Diagnosis group		
diabetic nephropathy (<i>n</i> [%])	180 (30)	106 (32)
type 1 diabetes	75	46
type 2 diabetes	97	54
unknown	8	6
glomerulonephritis (<i>n</i> [%])	168 (28)	54 (16)
IgA nephropathy	55	8
no renal biopsy	40	14
unclassified on biopsy	27	15
proliferative	18	8
focal segmental sclerosis	13	3
crescentic glomerulonephritis	8	4
other	7	2
renal vascular disease (<i>n</i> [%])	100 (17)	39 (12)
other diagnosis (<i>n</i> [%])	149 (25)	130 (40)
hereditary disease	58	40
systemic disease or vasculitis	40	42
other diagnosis	23	32
unknown renal disease	28	16

^aCRF, chronic renal failure.

^bConversion factor for SI unit ($\mu\text{mol}/\text{L}$) is 88.4.

^cPredicted creatinine clearance (Cockcroft-Gault formula).

disease (17 and 12% of men and women, respectively). Mean age was 58 yr for men and 57 yr for women among both case patients and control subjects (Table 2). Compared with control subjects, case patients were on average less well educated, used more analgesics, and smoked more. The proportion of alcohol users was lower among case patients, but the mean consumption was somewhat higher. As expected, the prevalence of self-reported hypertension was high among case patients: 87% of men and 85% of women, compared with approximately 25% of male and female control subjects. Diabetes, present in slightly more than one third of the case patients, was reported by 7% of the control subjects (both genders). Current BMI was similar among case patients and control subjects, whereas mean of lifetime highest BMI was significantly higher among case patients, regardless of gender ($P < 0.001$).

OR for overall CRF in relation to BMI are presented sepa-

rately for men and women (Table 3), although no statistically significant effect modification by gender could be confirmed, neither when using quartiles as cut points for BMI categories nor when using the WHO's cut points for overweight and obesity ($P = 0.35$ and $P = 0.25$, respectively). We found a positive association of highest lifetime BMI with overall CRF risk, particularly among men (Table 3). Men in the highest quartile had a 2.3-fold increased risk (95% CI 1.6 to 3.3) compared with those in the lowest quartile. The corresponding OR was modest and statistically nonsignificant among women, but when using WHO's cut points (14), clear excesses of three-fold or greater were seen for BMI ≥ 35 kg/m² in both genders. Men and women who reported a BMI ≥ 25 kg/m² at age 20 had a significant three-fold elevated risk for CRF compared with patients with BMI < 25 kg/m². BMI at age 40 and at age 60 showed similar relationships with CRF risk as did highest

Table 2. Selected characteristics of case patients and control subjects^a

	Men		Women	
	Case Patients (<i>n</i> = 597)	Control Subjects (<i>n</i> = 653)	Case Patients (<i>n</i> = 329)	Control Subjects (<i>n</i> = 345)
Age at interview (yr; <i>n</i> [%])				
18 to 24	5 (1)	14 (2)	5 (2)	6 (2)
25 to 34	34 (6)	32 (5)	29 (9)	26 (8)
35 to 44	59 (10)	62 (9)	36 (11)	35 (10)
45 to 54	131 (22)	116 (18)	62 (19)	70 (20)
55 to 64	124 (21)	134 (21)	62 (19)	70 (20)
65 to 74	244 (41)	295 (45)	135 (41)	138 (40)
Education (yr; <i>n</i> [%])				
≤ 9	350 (59)	355 (54)	187 (57)	170 (49)
10 to 12	129 (22)	150 (23)	80 (24)	96 (28)
> 12	109 (18)	142 (22)	59 (18)	78 (23)
missing	9 (2)	6 (1)	3 (1)	1 (0)
Smoking (pack-years; <i>n</i> [%])				
never regular smokers ^b	216 (36)	252 (39)	156 (47)	188 (54)
≤ 6.6	61 (10)	94 (14)	18 (5)	44 (13)
6.7 to 15.9	86 (14)	85 (13)	55 (17)	47 (14)
16.0 to 27.3	96 (16)	101 (15)	60 (18)	41 (12)
> 27.3	130 (22)	117 (18)	37 (11)	24 (7)
missing	8 (1)	4 (1)	3 (1)	1 (0)
Diabetes (<i>n</i> [%])				
yes	206 (35)	45 (7)	123 (37)	23 (7)
no	391 (65)	608 (93)	206 (63)	322 (93)
missing	0 (0)	0 (0)	0 (0)	0 (0)
Hypertension (<i>n</i> [%])				
yes	518 (87)	160 (25)	279 (85)	88 (26)
no	77 (13)	488 (75)	49 (15)	257 (74)
missing	2 (0)	5 (1)	1 (0)	0 (0)
Height (cm; mean [SD])	176.9 (7.3)	177.7 (7.0)	163.8 (6.4)	164.4 (5.7)
Current BMI (kg/m ² ; mean [SD])	25.6 (4.2)	25.8 (3.5)	25.0 (5.0)	25.3 (4.1)
Highest BMI ^c (kg/m ² ; mean [SD])	28.5 (4.9)	26.8 (3.9)	28.3 (5.9)	26.7 (4.6)

^aBMI, body mass index.

^bLess than 6 mo of daily smoking in lifetime.

^cHighest BMI in lifetime.

Table 3. OR for CRF associated with BMI^a

	Men		Women	
	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)
Highest BMI (kg/m ²) ^c				
gender-specific quartiles ^d				
Q1 (lowest quartile)	101/158	1.0 (referent)	64/81	1.0 (referent)
Q2	113/160	1.1 (0.8 to 1.6)	56/85	0.8 (0.5 to 1.3)
Q3	136/158	1.4 (1.0 to 2.0)	81/82	1.2 (0.7 to 1.9)
Q4 (highest quartile)	230/157	2.3 (1.6 to 3.3)	107/84	1.3 (0.8 to 2.1)
cut points in accordance with WHO's definition of overweight and obesity				
<25.00	129/213	1.0 (referent)	96/136	1.0 (referent)
25.00 to 29.9	265/323	1.4 (1.0 to 1.9)	115/133	1.2 (0.8 to 1.8)
30.0 to 34.9	130/79	2.7 (1.9 to 4.0)	49/46	1.4 (0.8 to 2.4)
≥35.00	56/18	4.4 (2.4 to 8.2)	48/17	3.1 (1.6 to 6.1)
BMI at age 20 (kg/m ²) ^e				
gender-specific quartiles ^f				
Q1 (lowest quartile)	94/136	1.0 (referent)	55/68	1.0 (referent)
Q2	75/130	0.9 (0.6 to 1.4)	52/75	0.9 (0.5 to 1.5)
Q3	125/142	1.3 (0.9 to 1.9)	48/72	0.8 (0.5 to 1.5)
Q4 (highest quartile)	175/138	1.9 (1.3 to 2.8)	86/72	1.4 (0.8 to 2.3)
cut points in accordance with the WHO definition of overweight				
<25.0	377/506	1.0 (referent)	211/274	1.0 (referent)
≥25.0	92/40	3.1 (2.1 to 4.8)	30/13	3.0 (1.4 to 6.1)

^aCI, confidence interval; OR, odds ratio; Q, quartile; WHO, World Health Organization.

^bAdjusted for age, education, smoking, alcohol, and use of paracetamol and salicylates.

^cHighest BMI during lifetime. Because of missing information on ≥1 covariate, 46 case patients and 53 control subjects were excluded from analyses.

^dQ1: Men <24.4, women <23.6; Q2: men 24.4 to 26.4, women 23.6 to 25.8; Q3: men 26.5 to 28.8, women 25.9 to 28.9; Q4: men >28.8, women >28.9.

^eBecause of missing information on ≥1 covariate, 222 case patients and 183 control subjects were excluded from analyses.

^fQ1: men <20.5, women <19.0; Q2: men 20.6 to 21.7, women 19.1 to 20.5; Q3: men 21.8 to 23.4, women 20.6 to 21.9; Q4: men >23.4, women >21.9.

lifetime BMI, but the relative risk estimates were less precise as a result of the smaller number of patients who had attained these ages (data not shown). However, BMI at time of interview was not significantly associated with CRF risk: Men and women with BMI of 35 kg/m² or more had adjusted OR of 1.9 (95% CI 0.8 to 4.6) and 1.2 (95% CI 0.5 to 3.3), respectively, relative to patients with BMI <25.

In analyses stratified by the presence or absence of self-reported diabetes, the elevated CRF risk with increasing maximum BMI was more pronounced among individuals with than without diabetes. However, even for men and women without diabetes, a lifetime highest BMI of 35 kg/m² or more entailed a significant OR of 2.2, relative to those with BMI <25 kg/m² (Table 4). Likewise, obesity was associated with CRF also among patients who self-reported that they had no history of clinically known hypertension. The OR for CRF among these presumably nonhypertensive patients with highest BMI ≥35 kg/m² was 2.8 (95% CI 1.0 to 8.1), relative to patients with BMI

<25 kg/m². Analyses that were confined to individuals who reported neither diabetes nor hypertension produced point estimates of similar magnitude, albeit without statistical significance (Table 4). In contrast, a statistically significant three-fold risk increase was observed among those who did not have diabetes and hypertension and who reported overweight at age 20 (Table 4).

Lifetime highest BMI was dose-dependently associated with risk for all major CRF subtypes (Table 5). The highest risk was found for diabetic nephropathy: Having a BMI of 35 kg/m² or more entailed a more than seven-fold increase in risk relative to having a BMI <25 kg/m². The association was restricted essentially to nephropathy caused by type 2 diabetes, for which the OR was 6.4 (95% CI 3.5 to 11.7) among patients with a BMI of 30 to 34.9 kg/m² and 17.7 (95% CI 8.8 to 35.4) among those with a BMI of 35 kg/m² or more compared with nonoverweight individuals. A BMI of 30 kg/m² or more was associated with a significant 2.4-fold excess in risk also for nephrosclerosis and a

Table 4. OR for CRF associated with BMI^a

	No Diabetes		No Hypertension		No Diabetes or Hypertension	
	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)	No. of Case Patients/Control Subjects	OR ^b (95% CI)
Highest BMI in lifetime (kg/m ²) ^c						
<25	159/336	1.0 (referent)	37/293	1.0 (referent)	31/281	1.0 (referent)
25 to 29.9	274/434	1.3 (1.0 to 1.7)	58/347	1.3 (0.8 to 2.0)	44/335	1.1 (0.6 to 1.8)
30 to 34.9	104/105	2.0 (1.4 to 2.8)	19/72	1.8 (1.0 to 3.5)	10/65	1.2 (0.5 to 2.6)
≥35.0	37/28	2.2 (1.3 to 3.8)	7/13	2.8 (1.0 to 8.1)	4/11	2.1 (0.6 to 7.6)
BMI at age 20 (kg/m ²) ^d						
<25.0	413/728	1.0 (referent)	81/588	1.0 (referent)	62/559	1.0 (referent)
≥25.0	64/51	2.4 (1.6 to 3.6)	17/33	3.6 (1.8 to 7.1)	12/33	3.0 (1.4 to 6.4)

^aAnalyses are restricted to participants without self-reported diabetes and/or hypertension.

^bAdjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.

^cCut points in accordance with the WHO definition of overweight and obesity.

^dCut points in accordance with the WHO definition of overweight.

Table 5. OR among men and women for various subtypes of CRF associated with BMI

	No. of Control Subjects	Diabetic Nephropathy		Nephrosclerosis		Glomerulonephritis		Other	
		No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)	No. of Case Patients	OR ^a (95% CI)
Highest BMI in lifetime (kg/m ²) ^b									
<25	349	59	1.0 (referent)	30	1.0 (referent)	58	1.0 (referent)	78	1.0 (referent)
25 to 29.9	456	90	1.2 (0.8 to 1.7)	61	1.4 (0.8 to 2.2)	99	1.3 (0.9 to 1.9)	130	1.3 (1.0 to 1.9)
30 to 34.9	125	65	2.8 (1.8 to 4.4)	32	2.4 (1.4 to 4.3)	43	2.0 (1.2 to 3.2)	39	1.5 (0.9 to 2.4)
≥35.0	35	56	7.4 (4.2 to 13.0)	12	2.8 (1.2 to 6.2)	14	2.0 (1.0 to 4.2)	22	2.0 (1.1 to 3.9)
BMI at age 20 (kg/m ²) ^c									
<25.00	780	149	1.0 (referent)	95	1.0 (referent)	154	1.0 (referent)	190	1.0 (referent)
≥25.00	53	49	5.2 (3.2 to 8.4)	18	3.0 (1.6 to 5.5)	30	3.0 (1.8 to 4.9)	25	2.1 (1.2 to 3.6)

^aAdjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.

^bCut points in accordance with the WHO definition of overweight and obesity.

^cCut points in accordance with the WHO definition of overweight.

two-fold increase in risk for glomerulonephritis and “other renal disease.” Likewise, elevated BMI at age 20 yielded increases in risk for all major types of CRF (Table 5).

Discussion

In this population-based, case-control study of preuremic CRF, being overweight at age 20 or obese (for women being morbidly obese) at any later time was linked with an increased risk for CRF. In contrast, BMI at time of interview was not significantly related to CRF. The latter finding may be explained by weight loss among case patients as a consequence of morbidity related to the renal failure itself.

There is an accumulating body of clinical and experimental data implicating obesity as an important causative factor in renal disease (17,18), but epidemiologic data linking obesity to CRF have been scarce so far. Some studies have investigated the association between obesity and proteinuria in the general

population (8,9); however, few epidemiologic studies have quantified the possible link between obesity and established renal failure in population-based settings. Our study is one of the first large-scale, population-based investigations to identify obesity as an important risk factor in the development of renal failure. Relative risk estimates that were consistent with ours were reported in a cohort study with a smaller number of incident CRF cases (19). In a Japanese cohort that was assembled during a mass screening project in 1983, high BMI was associated with an increased risk for ESRD 17 yr later but only among men (12). There, the excess risk was comparable or slightly higher than in our study. A similar US cohort study among individuals who participated in a health testing program reported an even stronger and monotonic trend of increasing ESRD risk with increasing BMI among both men and women (11). Another US cohort study among men and women who were free of kidney disease at baseline noted a 23% in-

crease per unit BMI in the odds of falling below the fifth percentile of GFR after 18.5 yr of follow-up (10).

It is widely known that obesity markedly increases risk for diabetes and hypertension (20) and that both diabetes and hypertension are important contributors to ESRD (21,22). Not surprising, in analyses that estimated risks for specific renal diseases, we found the strongest positive association of high BMI with risk for diabetic nephropathy (related to type 2 diabetes) and the second strongest relationship with nephrosclerosis (almost all patients were reported to have hypertension as the underlying cause of this diagnosis). Nevertheless, two- to three-fold risk elevations also were observed for glomerulonephritis and "other renal diseases," although we cannot exclude some degree of misclassification because the renal diagnoses were based on biopsies in only 30%. As hypertension accompanies virtually all types of renal disease not only as a cause but also frequently as a consequence of the renal failure and because both hypertension and mild to moderate renal failure can pass unnoticed for several years, it is a limitation of our study that we were unable to establish whether any hypertension preceded the onset of the kidney disease. Specifically, we cannot exclude that some patients with glomerulonephritis and "other renal diseases" also had previous hypertension, potentially related to obesity. We chose not to adjust for hypertension in our modeling because hypertension frequently is a secondary effect of CRF, but in an attempt to elucidate further the effect of BMI on CRF risk, independent of hypertension and diabetes, we conducted analyses that were stratified on these conditions. We observed stronger associations among individuals with hypertension and/or diabetes, but excesses in risks also were seen among overweight individuals with a negative self-reported history of these conditions, at least among individuals who reported overweight at age 20. However, these analyses were based on small numbers, and the results must be interpreted cautiously. In addition, some of the patients may have had undiagnosed hypertension or diabetes.

We did not take preexisting proteinuria into consideration in this study, because confounding by proteinuria seems unlikely. It seems well established that leakage of proteins through the glomeruli, regardless of the cause, is harmful to the kidney (23,24). As obesity is the cause of glomerular leakage of proteins, proteinuria must be a link in one of the causal chains between obesity and CRF. Hence, proteinuria could be a true confounding factor only if it would be associated with obesity without being a consequence of it. It is conceivable that massive proteinuria of other causes than obesity could be associated with fluid retention, but it is inconceivable that such retention could result in BMI values of 30 or more. If proteinuria of other causes than obesity would result in reduced physical activity without a corresponding reduction in energy intake, then some weight gain also would be expected, but BMI values in excess of 30 seem implausible. Therefore, in our opinion, proteinuria is in the causal pathway between obesity and CRF and does not act as a confounder.

Focal segmental glomerulosclerosis (FSGS) and/or glomerulomegaly is seen commonly in renal biopsies from morbidly obese patients (25–27), and the development of these conditions

seems to be independent of hypertension and diabetes. The proportion of all renal biopsies that exhibited obesity-related FSGS or glomerulomegaly increased 10-fold from 1986 to 2000 in a New York clinicopathologic study (27). Although a low rate of renal biopsy may have entailed underascertainment, only 16 of our case patients had received a diagnosis of FSGS, and only one had a lifetime highest BMI that exceeded 35 kg/m².

Our finding that obesity was independently associated with increased risks for all major types of CRF agrees with the "multi-hit" hypothesis (28); that is, obesity entails an extra burden on the nephrons, which promotes the progression of renal failure. Obesity previously has been linked to the progression of existing renal disease, independent of other risk factors, but it also is an independent risk factor for proteinuria in the general population (8,9). In the latter case, obesity would act as an initiator of the process, although a preceding state of reduced number of nephrons as a result of congenital or unknown environmental and lifestyle factors cannot be excluded. Obese individuals, compared with lean, are at higher risk for developing proteinuria and CRF after unilateral nephrectomy (29). This supports the view that the coexistence of obesity and reduced number of functioning nephrons increases risk for CRF.

The BMI–CRF risk relationship seemed to be somewhat stronger—and evident in a lower BMI range—in men than in women. However, no BMI*gender interactions attained statistical significance. Therefore, the observed difference is likely to be a chance finding. However, the previous literature has provided some weak indications that a true gender difference might exist (11,12). The definition of ESRD in these studies was based mainly on the occurrence of renal replacement therapy (or death as a result of ESRD), so gender differences with regard to medical management could have introduced bias. In our study, the outcome classification was based on serum creatinine measurements in combination with evaluations by local specialists. Although different cut points were used for men and women, the inherent association among body weight, muscle mass, and serum creatinine warrants cautious interpretation of gender differences. In general, however, it seems that men have a more rapid progression rate of renal failure than women (30), possibly mediated by sex hormones, but one could speculate that differences in risk that is conferred by being overweight also may be important to this gender difference in progression rate.

The mechanisms that lead to renal damage in obesity are not completely understood. Suggested contributing factors include hyperlipidemia, hyperleptinemia, a state of low-grade inflammation, hyperfiltration caused by insulin resistance, increased sympathetic activity, and activated renin-angiotensin system (17,31).

The major strengths of our study include its population-based design deriving from a well-defined and continuously enumerated source population, the complete ascertainment of all incident CRF cases, and the relatively large sample size. Moreover, the vast majority of case patients had moderately severe renal failure, thus allaying some concern about recall

bias, reverse causation, and/or selective loss of cases with rapid disease progression. Important selection bias is unlikely owing to the fairly high and equal participation rates among case patients and control subjects. However, obese individuals, who experience considerable morbidity of various kinds, may undergo serum creatinine testing more often than the average person, raising some concern about possible detection bias. The creatinine levels that were chosen for our case definition are typically symptomatic. Therefore, the pool of asymptomatic prevalent cases that potentially could be recruited through more zealous creatinine testing is likely to be small.

Misclassification of the self-reported anthropometric measures could have influenced our results. Although self-reported information on height, current weight, weight at age 20, and birth weight is known to be relatively accurate overall (32–34), there is a systematic tendency for overweight individuals to underestimate their body size; conversely, very lean individuals tend to overestimate (35). Such misclassification of exposure, if nondifferential between case patients and control subjects, would bias estimates of associations toward null. The absence of any widespread preconceptions among the public about links between anthropometric measures and CRF lessens concern about reporting bias.

Conclusion

Taking experimental, clinical, and epidemiologic data together, obesity seems to be causally linked, directly or indirectly, to the development of CRF. Our results support that obesity contributes to the rapidly increasing burden of CRF in both men and women. The excess risk for CRF among obese people seems to be driven mainly by a high prevalence of hypertension and/or type 2 diabetes, but additional pathways cannot be ruled out. According to our data, the etiologic fraction (36) of all CRF that is attributable to obesity in the comparably lean Swedish population is 16% among men and 11% among women. This fraction is likely to be greater in the United States, where the general prevalence of obesity is higher. Hence, obesity probably should be put high on the list of potentially preventable causes of CRF. Moreover, promising results of weight reduction in patients with early-stage renal disease raise hopes for future secondary prevention (37).

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References

1. Svenskt Register för Aktiv Uremivård Socialstyrelsen: *Renal Replacement Therapy in Sweden 1991–2001* [in Swedish], 2002. Available at http://www.socialstyrelsen.se/Amnesord/halso_sjuk/kvalitetsregister/urin_konsorgen/kva023.htm. Accessed April 19, 2006
2. Lysaght MJ: Maintenance dialysis population dynamics: Current trends and long-term implications. *J Am Soc Nephrol* 13[Suppl]: S37–S40, 2002
3. Bommer J: Prevalence and socio-economic aspects of chronic kidney disease. *Nephrol Dial Transplant* 17: 8–12, 2002
4. Mimran A, Ribstein J, DuCailar G, Halimi JM: Albuminuria in normals and essential hypertension. *J Diabetes Complications* 8: 150–156, 1994
5. Esmatjes E, Castell C, Gonzalez T, Tresserras R, Lloveras G: Epidemiology of renal involvement in type II diabetics (NIDDM) in Catalonia. The Catalan Diabetic Nephropathy Study Group. *Diabetes Res Clin Pract* 32: 157–163, 1996
6. Spangler JG, Konen JC: Hypertension, hyperlipidemia, and abdominal obesity and the development of microalbuminuria in patients with non-insulin-dependent diabetes mellitus. *J Am Board Fam Pract* 9: 1–6, 1996
7. Bonnet F, Deprele C, Sassolas A, Moulin P, Alamartine E, Berthezene F, Berthouix F: Excessive body weight as a new independent risk factor for clinical and pathological progression in primary IgA nephritis. *Am J Kidney Dis* 37: 720–727, 2001
8. Cirillo M, Senigalliesi L, Laurenzi M, Alfieri R, Stamler J, Stamler R, Panarelli W, De Santo NG: Microalbuminuria in nondiabetic adults: Relation of blood pressure, body mass index, plasma cholesterol levels, and smoking: The Gubbio Population Study. *Arch Intern Med* 158: 1933–1939, 1998
9. Tozawa M, Iseki K, Iseki C, Oshiro S, Ikemiya Y, Takishita S: Influence of smoking and obesity on the development of proteinuria. *Kidney Int* 62: 956–962, 2002
10. Fox CS, Larson MG, Leip EP, Culleton B, Wilson PW, Levy D: Predictors of new-onset kidney disease in a community-based population. *JAMA* 291: 844–850, 2004
11. Hsu CY, McCulloch CE, Iribarren C, Darbinian J, Go AS: Body mass index and risk for end-stage renal disease. *Ann Intern Med* 144: 21–28, 2006
12. Iseki K, Ikemiya Y, Kinjo K, Inoue T, Iseki C, Takishita S: Body mass index and the risk of development of end-stage renal disease in a screened cohort. *Kidney Int* 65: 1870–1876, 2004
13. Ford CM, Ejerblad E, Lindblad P, Fryzek JP, Dickman PW, Signorello LB, Lipworth L, Elinder CG, Blot WJ, McLaughlin JK, Zack MM, Nyren O: Acetaminophen, aspirin, and chronic renal failure. *N Engl J Med* 345: 1801–1808, 2001
14. World Health Organization: Physical status: The use and interpretation of anthropometry. Report of a WHO Expert Committee. *World Health Organ Tech Rep Ser* 854: 1–452, 1995
15. Hosmer DW, Hosmer T, Le Cessie S, Lemeshow S: A comparison of goodness-of-fit tests for the logistic regression model. *Stat Med* 16: 965–980, 1997
16. Cockcroft D, Gault M: Prediction of creatinine clearance from serum creatinine. *Nephron* 16: 31–41, 1976
17. Praga M: Obesity: A neglected culprit in renal disease. *Nephrol Dial Transplant* 17: 1157–1159, 2002
18. Hall JE, Jones DW, Kuo JJ, da Silva A, Tallam LS, Liu J: Impact of the obesity epidemic on hypertension and renal disease. *Curr Hypertens Rep* 5: 386–392, 2003
19. Stengel B, Tarver-Carr ME, Powe NR, Eberhardt MS, Bran-

- cati FL: Lifestyle factors, obesity and the risk of chronic kidney disease. *Epidemiology* 14: 479–487, 2003
20. Mokdad AH, Ford ES, Bowman BA, Dietz WH, Vinicor F, Bales VS, Marks JS: Prevalence of obesity, diabetes, and obesity-related health risk factors, 2001. *JAMA* 289: 76–79, 2003
21. Brancati FL, Whelton PK, Randall BL, Neaton JD, Stamler J, Klag MJ: Risk of end-stage renal disease in diabetes mellitus: A prospective cohort study of men screened for MRFIT. Multiple Risk Factor Intervention Trial. *JAMA* 278: 2069–2074, 1997
22. Klag MJ, Whelton PK, Randall BL, Neaton JD, Brancati FL, Ford CE, Shulman NB, Stamler J: Blood pressure and end-stage renal disease in men. *N Engl J Med* 334: 13–18, 1996
23. Tryggvason K, Pettersson E: Causes and consequences of proteinuria: The kidney filtration barrier and progressive renal failure. *J Intern Med* 254: 216–224, 2003
24. Kriz W, LeHir M: Pathways to nephron loss starting from glomerular diseases: Insights from animal models. *Kidney Int* 67: 404–419, 2005
25. Kasiske BL, Crosson JT: Renal disease in patients with massive obesity. *Arch Intern Med* 146: 1105–1109, 1986
26. Praga M, Morales E, Herrero JC, Perez Campos A, Dominguez-Gil B, Alegre R, Vara J, Martinez MA: Absence of hypoalbuminemia despite massive proteinuria in focal segmental glomerulosclerosis secondary to hyperfiltration. *Am J Kidney Dis* 33: 52–58, 1999
27. Kambham N, Markowitz GS, Valeri AM, Lin J, D'Agati VD: Obesity-related glomerulopathy: An emerging epidemic. *Kidney Int* 59: 1498–1509, 2001
28. Nenov VD, Taal MW, Sakharova OV, Brenner BM: Multi-hit nature of chronic renal disease. *Curr Opin Nephrol Hypertens* 9: 85–97, 2000
29. Praga M, Hernandez E, Herrero JC, Morales E, Revilla Y, Diaz-Gonzalez R, Rodicio JL: Influence of obesity on the appearance of proteinuria and renal insufficiency after unilateral nephrectomy. *Kidney Int* 58: 2111–2118, 2000
30. Neugarten J: Gender and the progression of renal disease. *J Am Soc Nephrol* 13: 2807–2809, 2002
31. de Jong PE, Verhave JC, Pinto-Sietsma SJ, Hillege HL; PREVEND Study Group: Obesity and target organ damage: The kidney. *Int J Obes Relat Metab Disord* 26[Suppl 4]: S21–S24, 2002
32. Must A, Willett WC, Dietz WH: Remote recall of childhood height, weight, and body build by elderly subjects. *Am J Epidemiol* 138: 56–64, 1993
33. Troy LM, Michels KB, Hunter DJ, Spiegelman D, Manson JE, Colditz GA, Stampfer MJ, Willett WC: Self-reported birthweight and history of having been breastfed among younger women: An assessment of validity. *Int J Epidemiol* 25: 122–127, 1996
34. Tamakoshi K, Yatsuya H, Kondo T, Hirano T, Hori Y, Yoshida T, Toyoshima H: The accuracy of long-term recall of past body weight in Japanese adult men. *Int J Obes Relat Metab Disord* 27: 247–252, 2003
35. Kuskowska-Wolk A, Karlsson P, Stolt M, Rossner S: The predictive validity of body mass index based on self-reported weight and height. *Int J Obes* 13: 441–453, 1989
36. Miettinen O: Proportion of disease caused or prevented by a given exposure, trait or intervention. *Am J Epidemiol* 99: 325–332, 1974
37. Morales E, Valero MA, Leon M, Hernandez E, Praga M: Beneficial effects of weight loss in overweight patients with chronic proteinuric nephropathies. *Am J Kidney Dis* 41: 319–327, 2003

See related editorial, "The Enlarging Body of Evidence: Obesity and Chronic Kidney Disease," on pages 1501–1502.

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

Alternatives

The Applicants considered three options prior to determining to establish a 12-station dialysis facility. The options considered are as follows:

1. Do Nothing;
2. Utilize Existing Facilities; and
3. Establish a new facility.

After exploring these options, which are discussed in more detail below, the Applicants determined to establish a 12-station dialysis facility. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

Currently, there are five dialysis facilities within 30 minutes normal travel time of the proposed facility. Average utilization of the existing facilities is 85.95%, with two facilities operating at over 100% utilization and a third facility nearly full.

In fact, the average utilization has increased 4% annually at the existing facilities in the GSA over the last three years. The surrounding community is comprised of approximately 26.1% Hispanic residents. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.¹² Due to socioeconomic conditions, this population exhibits a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in Hispanic communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to further increase utilization in the area. Conservatively assuming historical growth rates remain unchanged, these facilities are projected to reach average utilization of 93% by the date the proposed Belvidere facility is operational.

In addition to the historical growth rate, Rockford Nephrology Associates is treating 544 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 102 Stage 4 and 5 CKD patients reside within 30 minutes of the proposed facility, and 81 of these same 102 patients reside within 20 minutes of the proposed facility. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Ahmad anticipates that approximately 64 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. Assuming utilization at the existing facilities remains unchanged, sufficient capacity does not exist in the GSA to accommodate all 64 patients.

While this alternative would result in no cost to the Applicants, it would not provide for sufficient access to life sustaining dialysis services to the residents of Belvidere. Accordingly, this alternative was rejected.

¹² Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

Utilize Existing Facilities

Based upon the latest inventory data, there is an excess of 16 dialysis stations in HSA 1. However, based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in operation for more than a year in the GSA is 85.95%, which is above the State standard. This is not surprising given the immense size of the facility's proposed medical director's practice. Dr. Ahmad's practice, Rockford Nephrology Associates, is treating 544 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 102 Stage 4 and 5 CKD patients reside within 30 minutes of the proposed facility, and 81 of these same 102 patients reside within 20 minutes of the proposed facility. See Appendix – 2. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Ahmad anticipates that approximately 64 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the high utilization of these three facilities, many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's 80% utilization standard.

This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Ahmad's practice is currently treating ESRD patients at Churchview Dialysis, Rockford Dialysis, Roxbury Dialysis, Stonecrest Dialysis, and Sycamore Dialysis, which are collectively operating at an average of 93.70% utilization. (Note: Sycamore Dialysis is just over 10 minutes outside of the GSA in consideration for the proposed facility.) Stonecrest Dialysis and Roxbury Dialysis are operating a fourth shift and Rockford Dialysis is nearly full. Operating four shifts per day is not a feasible alternative for many reasons. When a fourth shift is operated, the dialysis facility is operated nearly around the clock with staff opening the facility around 5:00 a.m. and closing it around midnight. Not only is staffing a fourth shift difficult for clinic personnel, it is also suboptimal for the patients themselves who are chronically ill and usually elderly. Patients, many of whom rely on assistive devices such as canes and walkers, are faced with additional safety hazards when arriving and departing the facility in the dark. Some of these hazards cannot be avoided in the winter but patients feel much more secure when coming and going in the daylight. Adding a fourth shift would increase operating costs by adding additional staffing costs and utilities cost. The costs would be somewhat higher than the operating costs of adding stations. A new dialysis facility is needed to accommodate Dr. Ahmad's already large, and growing, patient-base.

The establishment of a 12-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Belvidere community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

Further, the proposed project will improve access to dialysis services for the community at large by adding a much needed dialysis facility to the Belvidere community. Importantly, approximately 26.1% of this community is Hispanic. Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of diabetes and hypertension, the two leading causes of CKD and ESRD, in their communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. As such, demand in the community will continue to increase.

Thus, because utilization of existing facilities will not meet the needs of the community, DaVita rejected this option.

There is no capital cost with this alternative.

Establish a New Facility

Based upon current utilization of the existing facilities and the projected number of CKD patients that will require in-center hemodialysis within the next 12 to 24 months following project completion, the only feasible option is to establish a 12-station in-center hemodialysis facility. This alternative will ensure residents of the Belvidere community and the surrounding area have continued access to life sustaining dialysis treatment.

The cost of this alternative is \$2,776,771.

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

The Applicants propose to establish a 12-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 450-650 gross square feet per dialysis station for a total of 5,400 – 7,800 gross square feet for 12 dialysis stations. The total gross square footage of the proposed dialysis facility is 6,000 gross square feet (or 500 GSF per station). Accordingly, the proposed Facility meets the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD	6,000	5,400 – 7,800	N/A	State Standard Met

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

By the second year of operation, annual utilization at the proposed facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Dr. Ahmad is currently treating 102 CKD patients whose condition is advancing to ESRD. See Appendix – 2. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 64 of these patients will initiate dialysis within 12 to 24 months following project completion. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the high utilization of these three facilities, many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's standard of 80%.

Table 1110.234(b) Utilization					
	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	N/A	9,984	8,986	Yes
Year 2	ESRD	N/A	9,984	8,986	Yes

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

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

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

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

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430, In-Center Hemodialysis Projects – Review Criteria

1. Planning Area Need

The Applicants propose to establish a 12-station dialysis facility to be located at 1755 Beloit Road, Belvidere, Illinois to accommodate the growing need for dialysis in Belvidere and the surrounding communities. While the latest inventory data shows an excess of 16 dialysis stations in HSA 1, this is not an accurate reflection of the need for dialysis in Belvidere and the surrounding area. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in the GSA is 85.95%, with two facilities operating at 110% capacity and a third facility nearly full. (See Attachment – 26A). Further, average utilization of the facilities in the GSA has increased 4% annually over the past three years and is expected to continue for the foreseeable future. Belvidere and the surrounding community are comprised of approximately 26.1% Hispanic residents. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.¹³ Due to socioeconomic conditions, this population exhibits a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in Hispanic communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to further increase utilization in the area. Conservatively assuming historical growth rates remain unchanged, these facilities are projected to reach average utilization of 93% by the date the proposed Belvidere facility is operational.

Dr. Ahmad's physician referral letter supports this. Dr. Ahmad's practice, Rockford Nephrology Associates, is treating 544 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, 102 Stage 4 and 5 CKD patients reside within 30 minutes of the proposed facility, and 81 of these same 102 patients reside within 20 minutes of the proposed facility. Conservatively, based upon attrition due to patient death, transplant, return of function, or relocation, it is estimated that 64 of these patients will initiate dialysis within 12 to 24 months following project completion. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the current high utilization of these three facilities, many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's standard of 80%.

As ESRD prevalence increases, the utilization within the GSA will continue to meet or exceed the State's standard. Accordingly, establishment of the proposed facility is necessary to maintain access to life-sustaining dialysis to residents of Belvidere and the surrounding area.

2. Service to Planning Area Residents

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of the Belvidere community and the surrounding area. As evidenced in the physician referral letter attached at Appendix – 2, all 102 pre-ESRD patients reside within 30 minutes of the proposed facility.

3. Service Demand

Attached at Appendix – 2 is a physician referral letter from Dr. Ahmad and a schedule of pre-ESRD and current patients by zip code. A summary of CKD patients projected to be referred to the

¹³ Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

proposed dialysis facility within the first two years after project completion is provided in Table 1110.1430(b)(3)(B) below.

Table 1110.1430(b)(3)(B) Projected Pre- ESRD Patient Referrals by Zip Code	
Zip Code	Total Patients
60135	7
60145	2
60146	5
60152	4
61008	57
61011	5
61012	3
61016	5
61038	4
61065	10
Total	102

4. Service Accessibility

As set forth throughout this application, the proposed facility is needed to maintain access to life-sustaining dialysis for residents in the Belvidere community and the surrounding area. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in the GSA is 85.95%, with two facilities operating at 110% capacity and a third facility nearly full. Importantly, 57 of Dr Ahmad's 102 pre-ESRD patients and 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis reside in Belvidere. Accordingly, a new dialysis facility is needed to improve access to dialysis services to residents in the Belvidere community.

End Stage Renal Disease Facility	Address	City	County	Zip	Distance	Drive Time	Adjusted Drive Time	6/27/2013 Stations	6/30/2013 Patients	6/30/2013 Utilization
Stonecrest Dialysis	1302 East State Street	Rockford	Winnebago	61104	11.57	20	23.0	10	66	110.00%
Rockford Dialysis	3339 North Rockton Avenue	Rockford	Winnebago	61103	15.31	26	29.9	20	114	95.00%
Roxbury Dialysis Center	622 Roxbury Road	Rockford	Winnebago	61108	8.52	13	15.0	16	106	110.42%
Churchview Dialysis	5970 Churchview Drive	Rockford	Winnebago	61107	9.51	14	16.1	24	107	74.31%
QRC - Marengo	910 Greenlee Street	Marengo	Mc Henry	60152	16.19	24	27.6	10	24	40.00%
Total								80	417	85.95%

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

1. Unnecessary Duplication of Services

- a. The proposed dialysis facility will be located at 1755 Beloit Road, Belvidere, Illinois 61008. A map of the proposed facility's market area is attached at Attachment – 26B. A list of all zip codes located, in total or in part, within 30 minutes normal travel time of the site of the proposed dialysis facility as well as 2010 census figures for each zip code is provided in Table 1110.1430(c)(1)(A).

Table 1110.1430(c)(1)(A) Population of Zip Codes within 30 Minutes of Proposed Facility		
Zip Code	City	Population
61020	DAVIS JUNCTION	3,108
61052	MONROE CENTER	1,148
61016	CHERRY VALLEY	4,837
60146	KIRKLAND	2,713
60145	KINGSTON	2,627
60135	GENOA	7,248
61102	ROCKFORD	20,538
61104	ROCKFORD	19,269
61109	ROCKFORD	28,333
61103	ROCKFORD	24,578
61108	ROCKFORD	28,550
61112	ROCKFORD	86
61107	ROCKFORD	30,439
61114	ROCKFORD	15,776
61111	LOVES PARK	23,492
61080	SOUTH BELOIT	10,599
61115	MACHESNEY PARK	23,180
61073	ROSCOE	20,052
61008	BELVIDERE	34,311
61011	CALEDONIA	2,945
61065	POPLAR GROVE	11,156
61038	GARDEN PRAIRIE	1,354
60152	MARENGO	12,533
61012	CAPRON	2,175
Total		331,047

Source: U.S. Census Bureau, Census 2010, American Factfinder
available at
<http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited **October 25, 2013**).

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

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. 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 HFSRB's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more fully below, the ratio of stations to population in the GSA is 78.6% of the State average, the average utilization of existing facilities is 85.95%, 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 78.6% of the State Average.

Table 1110.1430(c)(2)(A)			
Ratio of Stations to Population			
	Population	Dialysis Stations	Stations to Population
Geographic Service Area	331,047	80	1:4,138
State	12,830,632	3,946	1:3,251

b. Historic Utilization of Existing Facilities

The average utilization for facilities in the service area operational for at least 2 years is 85.95%. Additionally, average utilization has increased 4% annually at these facilities over the last three years. The surrounding community is comprised of approximately 26.1% Hispanic residents. Diabetes and hypertension (high blood pressure) are the two leading causes of CKD and ESRD.¹⁴ Due to socioeconomic conditions, this population exhibits a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in Hispanic communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. This, coupled with the aging population, is expected to further increase utilization in the area. Conservatively assuming historical growth rates remain unchanged, these facilities are projected to reach average utilization of 93% by the date the proposed Belvidere facility is operational. Accordingly, there is sufficient patient population to justify the need for the proposed facility. There will be no maldistribution of services. Additional stations are necessary to adequately meet the rising demand of the pre-ESRD patient population in the area.

c. Sufficient Population to Achieve Target Utilization

The Applicants propose to establish a 12-station dialysis facility. To achieve the HFSRB's 80% utilization standard within the first two years after project completion, the Applicants would need 58 patient referrals. As set forth above in Table 1110.230(b)(2), Dr. Ahmad is currently treating 102 stage 4 & 5 CKD patients. Conservatively, based upon attrition due

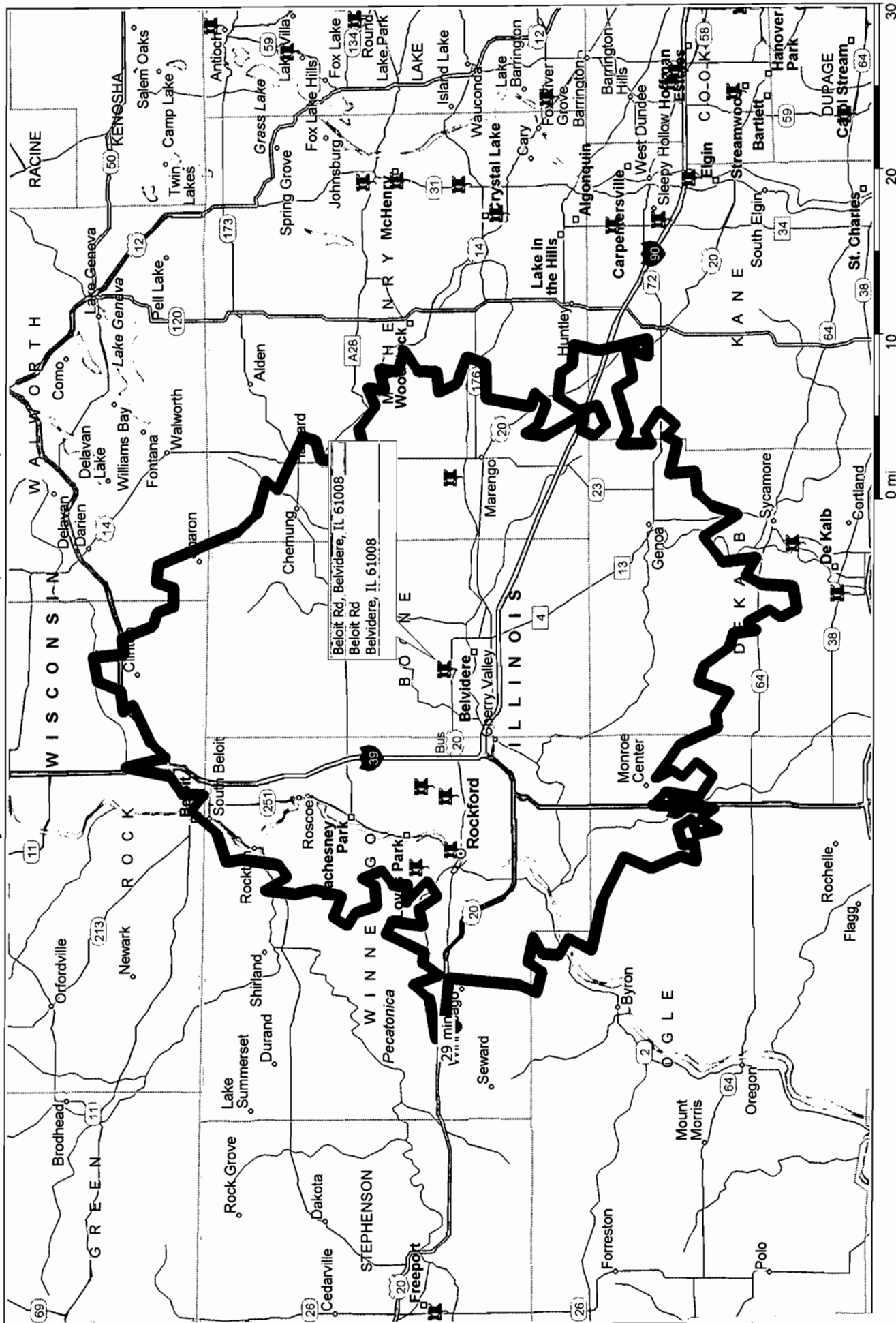
¹⁴ Michael F. Flessner, M.D., PhD et al., *Prevalence and Awareness of CKD Among African Americans: The Jackson Heart Study*, 53 Am. J. Kidney Dis. 183, 238-39 (2009), available at [http://www.ajkd.org/article/S0272-6386\(08\)01575-8/fulltext](http://www.ajkd.org/article/S0272-6386(08)01575-8/fulltext) (last visited Oct. 5, 2011).

patient death, transplant, return of function, or relocation, it is estimated that 64 of these patients will initiate dialysis within 12 to 24 months following project completion. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Dialysis, and Roxbury Dialysis live in Belvidere. Due to the high utilization of these three facilities, many of these patients may transfer to the proposed Belvidere facility without lowering utilization of any of the facilities below the State's 80% utilization standard.

3. Impact to Other Providers

- a. The proposed dialysis facility will not have an adverse impact on existing facilities in the GSA. As discussed throughout this application, the average utilization at the facilities within the service area in operation for at least one year is 85.95% with two facilities operating at 110% utilization and one facility nearly full. To proactively prepare for the needs of the community in the next 12-24 months, Dr Ahmad's large quantity of 544 pre-ESRD patients, with 102 of these patients at Stage 4 or 5 CKD, warrant the establishment of a new dialysis facility.
- b. The proposed facility will not lower the utilization of other area providers that are operating below the occupancy standards.

Belvidere Dialysis 1755 Beloit Road, Belvidere, IL 61008



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

1. The proposed facility will be staffed in accordance with all State and Medicare staffing requirements.
 - a. Medical Director: Mashood Ahmad, M.D. will serve as the Medical Director for the proposed facility. A copy of Dr. Ahmad's curriculum vitae is attached at Attachment – 26C.
 - b. Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

Administrator
Registered Nurse (2.3 FTE)
Patient Care Technician (5.2 FTE)
Biomedical Technician (0.3 FTE)
Social Worker (licensed MSW) (0.6 FTE)
Registered Dietitian (0.6 FTE)
Administrative Assistant (1 FTE)

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

- c. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program is attached at Attachment – 26D.
 - d. As set forth in the letter from Arturo Sida, Vice President and Assistant Corporate Secretary of DaVita HealthCare Partners Inc. and Dialysis of Northern Illinois, LLC, attached at Attachment – 26E, Belvidere Dialysis will maintain an open medical staff.

MASHOOD AHMAD, MD
CURRICULUM VITAE

BIOGRAPHICAL INFORMATION:

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

Date of Birth: 10/14/64

EMPLOYMENT:

12/08-present	RNA of Rockford, LLC Rockford, IL	M.D.
01/02-11/08	Northern Illinois Nephrology, S.C. Rockford, IL	M.D.
11/98-12/01	Elgin Clinic, Ltd. Elgin, IL	M.D.
01/97-10/98	Sinai Family Health System Chicago, IL	M.D. Assistant Director

EDUCATION:

07/82-04/89	Dow Medical College Karachi, Pakistan	M.D.
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POST GRADUATE TRAINING:

07/94-06/96	Westchester County Medical Center Valhalla, NY	Nephrology Fellowship
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MASHOOD AHMAD, M.D.
CURRICULUM VITAE
Page 2

07/91-06/94	Mount Vernon Hospital Mount Vernon, NY	Internal Medicine Residency
05/89-04/91	Civil Hospital Usman Memorial Hospital Karachi, Pakistan	Residency

CERTIFICATION AND LICENSURE:

Illinois License #036-094930
Wisconsin License #44412-020
Board Certified by American Board of Internal Medicine, Subspecialty
of Nephrology, 11/96

PROFESSIONAL ORGANIZATION MEMBERSHIPS:

American Medical Association
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, medications, 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 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), role of the Social Worker and conflict resolution. Additional topics are included as per specific state regulations.

A final comprehensive examination score of $\geq 80\%$ (unless state requires a higher score) 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, Systems/applications training on LMS, One For All orientation training in the facility or classroom, LMS Compliance training, LMS Diversity 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
- Critical thinking
- Hepatitis review
- Vascular access assessment
- Pharmacology for nurses
- Outcomes management
- CKD MBD
- Anemia
- Adequacy of dialysis

- Lab results
- Village initiatives
- Fluid management
- Developing plan of care
- Survey readiness
- Patient assessment

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 will be successfully completed prior to the new teammate receiving an independent assignment. The new teammate is expected to attend all training sessions and complete all assignments and workbooks.

- The education program for the newly hired patient care provider teammate **with previous dialysis experience** is individually tailored based on the identified learning needs. The initial orientation to the *Health Prevention and Safety Training* will be successfully completed prior to the new teammate working/receiving training in the clinical area. The *Procedural Skills Inventory Checklist* including verification of review of applicable policies and procedures will be completed by the preceptor, a registered nurse, and/or the clinical services specialist (CSS) and the new teammate upon demonstration of an acceptable skill-level. The new teammate will also utilize the hemodialysis training workbook and progress at their own pace. This workbook should be completed within a timely manner as to also demonstrate acceptable skill-level.

The *Initial Competency Exam* will be completed; a score of $\geq 80\%$ or higher is required prior to the new teammate receiving an independent patient-care assignment. If the new teammate receives a score of less than 80%, this teammate will receive theory instruction pertaining to the area of deficiency and a second competency exam will then be given. If the new teammate receives a score of less than 80% on the second exam, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate.

Following completion of the training, a *Verification of Competency* form will be completed (see forms TR1-06-05, TR1-06-06). In addition to the above, further training and/or certification will be incorporated as applicable by state law.

The goal of the program is for the trainee to successfully meet all training requirements. Failure to meet this goal is cause for dismissal from the training program and subsequent termination by the facility.

Process of Program Evaluation

The Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the, DaVita Prep Class Evaluation (TR1-06-08), the New Teammate Satisfaction Survey on the LMS and random surveys of facility administrators to determine satisfaction of the training program. To assure continuous improvement within the education program, evaluation data is reviewed for trends, and program content is enhanced when applicable to meet specific needs.

Program Content

The programs content for the new patient care provider teammate without previous dialysis experience incorporates content related to the following areas.

I. DaVita 101/DaVita Way

A. Behavioral objectives

1. State our mission
3. Describe our six core values
4. Describe the DaVita Way
5. List the team members in their local village

B. Content outline

1. DaVita Village and additional services
2. Our mission
3. Our core values
 - a. Service excellence
 - b. Integrity
 - c. Team
 - d. Continuous improvement
 - e. Accountability
 - f. Fulfillment
 - g. Fun
4. DaVita Way of Communication
 - a. Our language
 - b. VillageWeb
 - c. DaVita Village Voice
 - d. Computer systems
5. Teammate resources
6. One For All
 - a. Process review

II. Treatment Modalities

A. Behavioral objectives

1. Name four treatment options for patients with renal failure

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

Attached at Attachment – 26E is a letter from Arturo Sida, Vice President and Assistant Corporate Secretary of DaVita HealthCare Partners Inc. and Dialysis of Northern Illinois LLC 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.

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

Re: Certification of Support Services

Dear Chairwoman Olson:

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 Belvidere 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;
- Belvidere 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,


Print Name: Arturo Sida
Its: Vice President and Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This 9th day of September, 2013



Notary Public

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public
(Here insert name and title of the officer)

personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public



(Notary)

ADDITIONAL OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages _____ Document Date _____

(Additional information)

CAPACITY CLAIMED BY THE SIGNER

- ☐ Individual (s)
☐ Corporate Officer

(Title)

- ☐ Partner(s)
☐ Attorney-in-Fact
☐ Trustee(s)
☐ Other _____

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- State and County information must be the State and County where the document signer(s) personally appeared before the notary public for acknowledgment.
- Date of notarization must be the date that the signer(s) personally appeared which must also be the same date the acknowledgment is completed.
- The notary public must print his or her name as it appears within his or her commission followed by a comma and then your title (notary public).
- Print the name(s) of document signer(s) who personally appear at the time of notarization.
- Indicate the correct singular or plural forms by crossing off incorrect forms (i.e. he/she/~~they~~, is /~~are~~) or circling the correct forms. Failure to correctly indicate this information may lead to rejection of document recording.
- The notary seal impression must be clear and photographically reproducible. Impression must not cover text or lines. If seal impression smudges, re-seal if a sufficient area permits, otherwise complete a different acknowledgment form.
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 - ❖ Indicate title or type of attached document, number of pages and date.
 - ❖ Indicate the capacity claimed by the signer. If the claimed capacity is a corporate officer, indicate the title (i.e. CEO, CFO, Secretary).
- Securely attach this document to the signed document

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 12-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 – 26F 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 Applicants propose the establishment of a 12-station dialysis facility. Thus, this criterion is not applicable.

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

Attached at Attachment – 26G is a letter from Arturo Sida, Vice President and Assistant Corporate Secretary, DaVita HealthCare Partners Inc. certifying that the proposed facility will achieve target utilization by the second year of operation

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

Re: In-Center Hemodialysis Assurances

Dear Chairwoman Olson:

Pursuant to 77 Ill. Admin. Code § 1110.1430(j), I hereby certify the following:

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

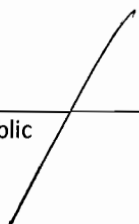
Sincerely,


Print Name: Arturo Sida
Its: Vice President and Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This 9th day of September, 2013

Notary Public

 *See Attached*

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public,
(Here insert name and title of the officer)

personally appeared Arturo Sida

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public

(Notary Seal)



ADDITIONAL OPTIONAL INFORMATION

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 - ❖ Indicate the capacity claimed by the signer. If the claimed capacity is a corporate officer, indicate the title (i.e. CEO, CFO, Secretary).
- Securely attach this document to the signed document

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 Puri 2004 Dyn Trust. A copy of DaVita's 2012 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 13-031. A letter of intent to lease the facility is attached at Attachment – 36A.



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

November 19, 2013

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

RE: Request for Proposal
1755 Beloit Road, Belvidere, IL 61008

Dear Bharat:

USI Real Estate Brokerage Services Inc. has been exclusively authorized by Total Renal Care, Inc – a subsidiary of DaVita HealthCare Partners, Inc. ("DaVita") to assist in securing a lease requirement. DaVita is a Fortune 500 company with approximately 2,000 locations across the US and revenues in excess of \$8 billion.

We have been surveying the Belvidere 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 to be built by you through the DaVita Preferred Developer Program ("PDP"). We request that you deliver your response no later than **November 22, 2013**. *Please prepare the proposal to respond to the following terms:*

PREMISES:

Lot Five (5) as designated upon the Re-plat of Lot Four (4) of Plat Three (3) of Little Thunder Village Subdivision, being a Subdivision of part of the Southeast Quarter (1/4) of Section 22, Township 44 North, Range 3 East of the Third Principal Meridian, as the same is platted and recorded August 27, 2002, as Document Number 2002R9629 in Plat Index Envelope 270-B in the Recorder's Office of Boone County, Illinois; situated in the County of Boone and State of Illinois

TENANT:

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

LANDLORD:

Puri 2004 Dyn Trust or related entity to be named

SPACE REQUIREMENTS:

Premises will be approximately 6,000 rentable square feet.

PRIMARY TERM:

15 years

BASE RENT:

Years 1-5: \$20.77 per rsf
Years 6-10: \$22.85 per rsf
Years 11-15: \$25.13 per rsf

This lease is a NNN lease.

ADDITIONAL EXPENSES:

CAM is estimated to be \$1.50 psf
Taxes are estimated to be \$3.25 psf
Insurance is estimated to be \$0.25 psf.

As a single Tenant building, Tenant shall be responsible for 100% of the operating expenses.

Tenant will be responsible for all of its utilities (gas, electric, sewer, water, etc...). No utilities are included in the Base Rent.

Landlord to limit the controllable cumulative operating expense costs to no greater than three percent (3%) increase annually after the first fully stabilized year. Controllable operating expenses exclude real estate taxes, snow plowing and common area utilities.

LANDLORD'S MAINTENANCE:

Landlord, at its sole cost and expense, shall be responsible for the structural and capitalized items (per GAAP standards) for the Property. Notwithstanding the foregoing, the cost for capital expense items shall be amortized over their useful life and the annual amortized amount shall be reimbursed as part of CAM (subject to the annual cap).

**POSSESSION AND
RENT COMMENCEMENT:**

Landlord shall deliver Possession of the Premises to the Tenant upon the later of completion of Landlord's required work (if any) or mutual lease execution. Rent Commencement shall be the earlier of seven (7) 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 to match PDP requirements (as negotiated).

USE:

The Use is for a Dialysis Clinic, medical offices, distribution of pharmaceuticals to Tenant's patients and other lawfully permitted related uses.

Property is zoned General Business, which allow Medical Clinics as a permitted use.

The property is not encumbered by any CCR's that impact Tenant's tenancy.

PARKING:

Landlord will provide a minimum of four (4) parking spaces per 1,000 rsf and two (2) dedicated handicapped stalls.

Please indicate the number and location of parking spaces to be allocated to the Tenant, number of general handicap stalls, total reserved stalls, if there is a patient drop off area, and if the drop off area is covered. (See attached preliminary site plan)

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: Renewal terms to follow standard PDP requirements.

RIGHT OF FIRST OPPORTUNITY ON ADJACENT SPACE: N/A

FAILURE TO DELIVER PREMISES: Terms to match standard PD program.

HOLDING OVER: Terms to match standard PD program.

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 and approval of Landlord. Landlord, at Landlord's expense, will furnish Tenant with any standard building directory signage.

BUILDING HOURS: Tenant shall have access to the building 24 hours a day, 7 days a week.

As this is a single tenant building, there are no building hours for 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 HealthCare Partners, 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, but the location shall be subject to Landlord's approval and Tenant shall use Landlord's roofing contractor.

NON COMPETE: Landlord agrees not to lease space to another dialysis provider within a five (5) mile radius of Premises.

HVAC: New construction

DELIVERIES: Deliveries via man door at location identified in attached preliminary site plan.

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 any governmental laws, ordinances, regulations or orders relating to, but not limited to, compliance with the Americans with Disabilities Act (ADA), and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or 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 January 28, 2014. 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 January 28, 2014 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 brokerage fee in accordance with the PDP agreement. Tenant shall retain the right to offset rent for failure to pay the brokerage fee.

PLANS:

Please provide copies of site and construction plans or drawings.

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

Edgar Levin
edgar.l.levin@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,



Edgar Levin

Cc: John Steffens
Emmett Purcell

LETTER OF INTENT: 1755 BELOIT ROAD, BELVIDERE, IL 61008

AGREED TO AND ACCEPTED THIS 20th DAY OF NOVEMBER 2013

By: [Signature]
Puri 2004 Dyn Trust
("Landlord")

AGREED TO AND ACCEPTED THIS 21 DAY OF NOVEMBER 2013

By: [Signature]
On behalf of Total Renal Care, a wholly owned subsidiary of DaVita HealthCare Partners, Inc.
("Tenant")

EXHIBIT A**NON-BINDING NOTICE**

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



Exhibit B -- MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER

SCHEDULE A - TO WORK LETTER

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

At a minimum, the Lessor shall provide the following Base Building and Site Development Improvements to meet Lessee's Building and Site Development specifications at Lessor's sole cost:

All MBBI work completed by the Lessor will need to be coordinated and approved by the Lessee and their Consultants prior to any work being completed, including shop drawings and submittal reviews.

1.0 - Building Codes & Design

All Minimum Base Building Improvements (MBBI) and Site Development are to be performed in accordance with all current local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer and must be coordinated with the Lessee Improvement plans and specifications.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all permitting related to the base building and site improvements.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant for Life Safety per current federal, state and local code requirements.

4.0 Foundation and Floor

The foundation and floor of the building shall be in accordance with local code requirements. The foundation and concrete slab shall be designed by the Lessor's engineer to accommodate site-specific Climate and soil conditions and recommendations per Lessor's soil engineering and exploration report (To be reviewed and approved by Lessee's engineer).

Foundation to consist of formed concrete spread footing with horizontal reinforcing sized per geotechnical engineering report. Foundation wall, sized according to exterior wall systems used and to consist of formed and poured concrete with reinforcing bars or a running bond masonry block with proper horizontal and vertical reinforcing within courses and cells. Internal masonry cells to be concrete filled full depth entire building perimeter. Foundation wall to receive poly board R-10 insulation on interior side of wall on entire building perimeter (if required by code). Provide proper foundation drainage.

The floor shall be concrete slab on grade and shall be a minimum five-inch (5") thick with minimum concrete strength of 3,000-psi. It will include one of the following, wire mesh or fiber mesh, and/or rebar reinforcement

over a vapor barrier and granular fill per Lessor's soils and/or structural engineering team based on soil conditions and report from the Soils Engineer. Finish floor elevation to be a minimum of 8" above finish grade. Include proper expansion control joints. Floor shall be level (1/8" with 10' of run), smooth, broom clean with no adhesive residues, in a condition that is acceptable to install floor coverings in accordance with the flooring manufacturer's specifications. Concrete floor shall be constructed so that no more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results after 28 day cure time. Means and methods to achieve this level will be responsibility of the Lessor. Under slab plumbing shall be installed by Lessee's General Contractor in coordination with Lessor's General Contractor, inspected by municipality and Lessee for approval prior to pouring the building slab.

5.0 - Structural

Structural systems shall be designed to provide a minimum 13'-0" clearance (for 10'-0" finished ceiling height and 15' clearance for a 12" ceiling height) to the underside of the lowest structural member from finished slab and meet building steel (Type II construction or better) erection requirements, standards and codes. Structural design to allow for ceiling heights (as indicated above) while accommodating all Mechanical, Plumbing, Electrical above ceiling. Structure to include all necessary members including, but not limited to, columns, beams, joists; load bearing walls, and demising walls. Provide necessary bridging, bracing, and reinforcing supports to accommodate all Mechanical systems (Typical for flat roofs - minimum of four (4) HVAC roof top openings, one (1) roof hatch opening, and four (4) exhaust fans openings). Treatment room shall be column free.

The floor and roof structure shall be fireproofed as needed to meet local building code and regulatory requirements.

Roof hatch shall be provided and equipped with ladders meeting all local, state and federal requirements.

6.0 - Exterior walls

Exterior walls to be fire rated if required by local or State code requirements. If no fire rating is required, walls shall be left as exposed on the interior side of the metal studs or masonry/concrete with exterior insulation as required to meet code requirements and for an energy efficient building shell. Lessee shall be responsible for interior gyp board, taping and finish.

7.0 - Demising walls

All demising walls shall be a 1 or 2hr fire rated wall depending on local, state and/or regulatory (NFPA 101 - 2000) codes requirements whichever is more stringent. Walls will be installed per UL design and taped (Lessee shall be responsible for final finish preparation of gypsum board walls on Lessee side only). At Lessee's option and as agreed upon by Lessor, the interior drywall finish of demising walls shall not be installed until after Lessee's improvements are complete in the wall. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

8.0 - Roof Covering

The roof system shall have a minimum of a twenty (20) year life span with full (no dollar limit - NDL) manufacturer's warranty against leakage due to ordinary wear and tear. Roof system to include a minimum of R-30 insulation. Ice control measures mechanically or electrically controlled to be considered in climates subject to these conditions. Downspouts to be connected into controlled underground discharge for the rain leaders into the storm system for the site or as otherwise required meeting local storm water treatment requirements. Storm water will be discharged away from the building, sidewalks, and pavement. Roof and all related systems to be maintained by the Lessor for the duration of the lease. Lessor to provide Lessee copy of material and labor roof warranty for record.

9.0 - Parapet

Lessor to provide a parapet wall based on building designed/type and wall height should be from the highest roof line. HVAC Rooftop units should be concealed from public view if required by local code.

10.0 - Façade

Lessor to provide specifications for building façade for lessee review and approval. All wall system to be signed off by a Lessor's Structural Engineer. Wall system "R" value must meet current Energy code. Wall system options include, but not limited to:

4" Face brick Veneer on 6" 16 or 18ga metal studs, R- 19 or higher batt wall insulation, on Tyvek (commercial grade) over 5/8" exterior grade gypsum board or Dens-Glass Sheathing.

Or

2" EIFS on 6" 16 or 18ga metal studs, R- 19 or higher batt wall insulation, on 1/2" cement board or equal.

Or

8" Split faced block with 3-1/2" to 6" 20ga metal stud furring, batt wall insulation to meet energy code and depth of mtl stud used.

11.0 - Canopy

Covered drop off canopy at Lessee's front entry door. Approximate size to be 16' width by 21' length with 10'-9" minimum clearance to structure with full drive thru capacity. Canopy to accommodate patient drop off with a level grade ADA compliant transition to the finish floor elevation. Canopy roof to be an extension of the main building with blending rooflines. Controlled storm water drainage requirements of gutters with downspouts connected to site storm sewer system or properly discharged away from the building, sidewalks, and pavement. Canopy structural system to consist of a reinforced concrete footing, structural columns and beam frame, joists, decking and matching roof covering. Canopy columns clad with EIFS and masonry veneer piers, matching masonry to main building. Steel bollards at column locations.

12.0 - Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to, Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

13.0 - Windows

Lessor to provide code compliant energy efficient windows and storefront systems to be 1" tinted insulated glass with thermally broken insulated aluminum mullions. Window size and locations to be determined by Lessee's architectural floor plan and shall be coordinate with Lessor's Architect.

14.0 - Thermal Insulation

All exterior walls to have a vapor barrier and insulation that meets or exceeds the local and national energy codes. The R value to be determined by the size of the stud cavity and should extend from finish floor to bottom of floor or ceiling deck. Roof deck to have a minimum R-30 insulation mechanically fastened to the underside of roof deck.

15.0 - Exterior Doors

All doors to have weather-stripping and commercial grade hardware (equal to Schlage L Series or better). Doors shall meet American Disability Act (ADA), and State Department of Health requirements. Lessor shall change the keys (reset tumblers) on all doors with locks after construction, but prior to commencement of the Lease, and shall provide Lessee with three (3) sets of keys. Final location of doors to be determined by Lessee architectural floor plan and shall be coordinate with Lessee's Architect. At a minimum, the following doors, frames and hardware shall be provided by the Lessor:

- Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.

- **Service Doors:** Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.
- **Fire Egress Doors:** Provide 36" wide door with 20 gauge insulated hollow metal door or Aluminum frame/glass door with panic bar hardware, lock, hinges, closer and painted with rust inhibiting paint. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

16.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee. Lessor is responsible for all tap/connection and impact fees for all utilities. All Utilities to be coordinated with Lessee's Architect. Lessor shall have contained within the building a common main room to accommodate the utility services which include, but not limited, to electrical, fire alarm, security alarm and fire riser if in a multi tenant building.

17.0 - Plumbing

Lessor to provide a segregated/dedicated potable water supply line that will be sized by Lessee's Engineer based on Lessee's water requirements (not tied-in to any other lessee spaces, fire suppression systems, or irrigation systems unless mandated by Local Building and or Water Dept). Water supply shall be provided with a shut off valve, 2 (two) reduced pressure zone (RPZ) backflow preventors arranged in parallel (with floor drain or open site drain under RPZ's), and meter. Water supply to provide a continuous minimum pressure of 50 psi, maximum 80psi, with a minimum flow rate of 50 gallons per minute to Lessee space. The RPZ's and the Meter will be sized to the incoming line, or per water provider or municipality standards. Lessor to provide Lessee with the most recent site water flow and pressure test results (gallons per minute and psi) for approval. Lessor shall perform water flow and pressure test prior to lease execution. Lessor shall stub the dedicated water line into the building per location coordinated by Lessee.

Provide exterior (anti-freeze when required) hose bibs (minimum of 2) in locations approved by Lessee.

Building sanitary drain size will be determined by Lessee's Mech Engineer based on total combined drainage fixture units (DFU's) for entire building, but not less than 4 inch diameter. The drain shall be stubbed into the building per location coordinated by Lessee at an elevation no higher than 4 feet below finished floor elevation, to a maximum of 10 feet below finished floor elevation. (Coordinate actual depth and location with Lessee's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Lessee's sanitary system design per Lessee's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

Sanitary sampling manhole to be installed by Lessor if required by local municipality.

Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies.

18.0 - Fire Suppression System

Single story stand alone buildings under 10,000sf will not require a Sprinkler System unless requested by Lessee, or if required by code or local authority. Single story stand alone buildings greater than 10,000 will require a sprinkler system. Lessor shall design and install a complete turnkey sprinkler system (less drops and heads in Lessee's space) that meets the requirements of NFPA #13 and all local building and life safety codes per NFPA 101-2000. This system will be on a dedicated water line independent of Lessee's potable water line requirements, or as required by local municipality or water provider. Lessor shall provide all municipal (or code authority) approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow

control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

19.0 - Electrical

Provide underground service with a dedicated meter via a new CT cabinet per utility company standards. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire to a distribution panelboard in the Lessee's utility room (location to be per Code and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include transformer coordination with utility company, transformer pad, grounding, and underground conduit wire sized for service inclusive of excavation, trenching and restoration, utility metering, distribution panelboard with main and branch circuit breakers, and electrical service and building grounding per NEC. Lessee's engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard.

If lease space is in a multi-tenant building then Lessor to provide meter center with service disconnecting means, service grounding per NEC, dedicated combination CT cabinet with disconnect for Lessee and distribution panelboard per above.

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

Lessor to provide main Fire Alarm Control panel that serves the Lessee space and will have the capacity to accommodate devices in Lessee space based on Fire Alarm system approved by local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide Fire Alarm panel to accommodate all tenants and locate panel in a common room with conduit stub into lessee space. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction.

Fire Alarm system equipment shall be equipped for double detection activation if required.

20.0 - Gas

Natural gas service, at a minimum, will be rated to have 6" water column pressure and supply 800,000-BTU's. Natural gas pipeline shall be stubbed into the building per location coordinated with Lessee and shall be individually metered and sized per demand. Additional electrical service capacity will be required if natural gas service is not available to the building.

21.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to be responsible for all costs for the HVAC system based on the below criteria.

Lessee will be responsible for the design, procurement and installation of the HVAC system.

The criteria is as follows:

- Equipment to be Carrier or Trane RTU's
- Supply air shall be provided to the Premises sufficient for cooling and ventilation at the rate of 275 to 325 square feet per ton to meet Lessee's demands for a dialysis facility and the base building Shell loads.
- Ductwork shall be extended 5' into the space for supply and return air.
- Provide 100% enthalpy economizer
- Units to include Power Exhaust
- Controls to be Programmable or DDC
- Provide high efficiency inverter rated non-overloading motors
- Provide 18" curbs, 36" in Northern areas with significant snow fall
- Units to have disconnect and service outlet

- System to be a fully ducted return air design
- All ductwork to be externally lined except for the drops from the units.
- Units will include motorized dampers for OA, RA & EA
- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

Equipment will be new and come with a full warranty on all parts including compressors (minimum of 5yrs) including labor. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat and or DDC controls (Note: The 5 zones of conditioning may be provided by individual constant volume RTU's, or by a VAV or VVT system of zone control with a single RTU). Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Lessee's design criteria and local and state codes.

Lessor to furnish steel framing members, roof curbs and flashing to support Lessee exhaust fans (minimum of 4) to be located by Lessee's architect.

22.0 - Telephone

Lessor shall provide a single 2" PVC underground conduit entrance into Lessee's utility room to serve as chase way for new telephone service. Entrance conduit location shall be coordinated with Lessee.

23.0 - Cable TV

Lessor shall provide a single 2" PVC underground conduit entrance into Lessee utility room to serve as chase way for new cable television service. Entrance conduit location shall be coordinated with Lessee.

Lessee shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee. Lessor shall reasonably cooperate and grant "right of access" with Lessee's satellite or cable provider to ensure there is no delay in acquiring such services.

24.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations handicap stalls inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Finish floor elevation is to be determined per Lessee's architectural plan in conjunction with Lessor's civil engineering and grading plans. If required, Lessor to construct concrete ramp of minimum 5' width, provide safety rails if needed, provide a gradual transitions from overhead canopy and parking lot grade to finish floor elevation. Concrete surfaces to be troweled for slip resistant finish condition according to accessible standards.

25.0 - Exiting

Lessor shall provide at the main entrance and rear doors safety lights, exterior service lights, exit sign with battery backup signs per doorway, in accordance with applicable building codes, local fire codes and other applicable regulations, ordinances and codes. The exiting shall encompass all routes from access points terminating at public right of way.

26.0 - Site Development Scope of Requirements

Lessor to provide Lessee with a site boundary and topographic ALTA survey, civil engineering and grading plans prepared by a registered professional engineer. Civil engineering plan is to include necessary details to comply with municipal standards. Plans will be submitted to Lessee Architect for coordination purposes. Site development is to include the following:

- Utility extensions, service entrance locations, inspection manholes;
- Parking lot design, stall sizes per municipal standard in conformance to zoning requirement;
- Site grading with Storm water management control measures (detention / retention / restrictions);
- Refuse enclosure location & construction details for trash and recycling;
- Handicap stall location to be as close to front entrance as possible;
- Side walk placement for patron access, delivery via service entrance;
- Concrete curbing for greenbelt management;
- Site lighting;
- Conduits for Lessee signage;
- Site and parking to accommodate tractor trailer 18 wheel truck delivery access to service entrance;
- Ramps and curb depressions.
- Landscaping shrub and turf as required per municipality;
- Irrigation system if Lessor so desires and will be designed by landscape architect and approved by planning department;
- Construction details, specifications / standards of installation and legends;
- Final grade will be sloped away from building.

27.0 - Refuse Enclosure

Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based on Lessee's requirements' and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

28.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

29.0 - Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, and building access points readied for connection into Lessee power panel. Location of pole fixtures per Lessor civil plan to maximize illumination coverage across site. Parking lot lighting to include timer (to be programmed per Lessee hours of operation) or a photocell. Parking lot lighting shall be connected to and powered by Lessor house panel (if in a Multi tenant building) and equipped with a code compliant 90 minute battery back up at all access points.

30.0 - Exterior Building Lighting

Lessor to provide adequate lighting and power per code and to illuminate the building main, exit and service entrance, landings and related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

31.0 - Parking Lot

Provide adequate amount of handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be firmly spike anchored in place onto the asphalt per stall alignment.

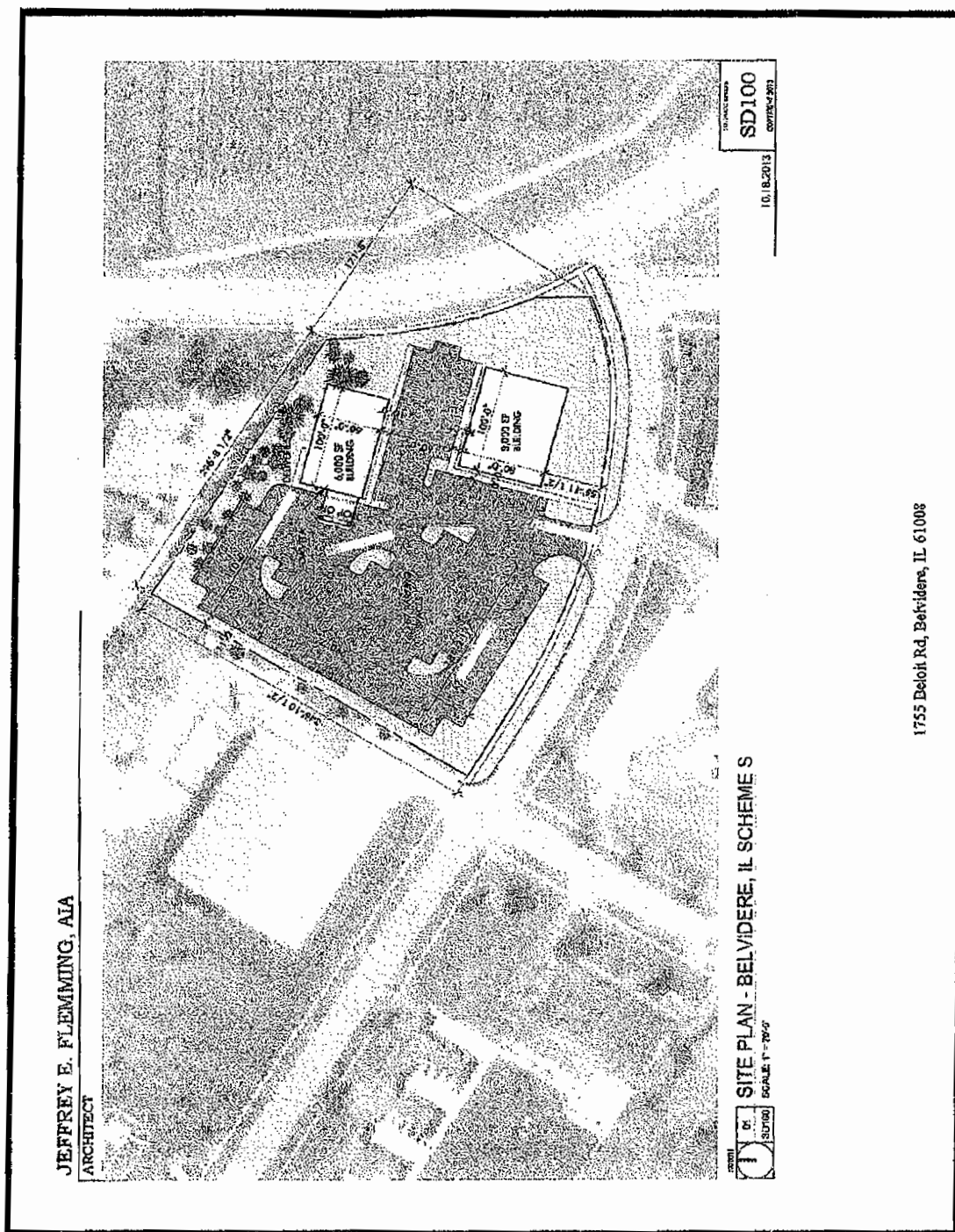
Asphalt wearing and binder course to meet geographical location design requirements for parking area and for truck delivery driveway.

Asphalt to be graded gradual to meet handicap and civil site slope standards, graded into & out of new patient drop off canopy and provide positive drainage to in place storm catch basins leaving surface free of standing water, bird baths or ice buildup potential.

32.0 - Site Signage

Lessor to allow for an illuminated site and/or façade mounted signs. A monument and/or the pylon structure to be provided by Lessor with power and a receptacle. Final sign layout to be approved by Lessee and the City.

Exhibit C – Preliminary Site Plan



Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

The project will be funded entirely with cash. A copy of DaVita's 2012 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 13-031.

Section X, Economic Feasibility Review Criteria

Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment – 39A is a letter from Arturo Sida, Vice President and Assistant Corporate Secretary of DaVita HealthCare Partners, Inc. attesting that the total estimated project costs will be funded entirely with cash.

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

Re: Reasonableness of Financing Arrangements

Dear Chairwoman Olson:

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,



Print Name: Arturo Sida
Its: Vice President and Assistant Corporate Secretary
DaVita HealthCare Partners Inc.

Subscribed and sworn to me

This 9th day of September, 2013

Notary Public

see attached

CALIFORNIA ALL-PURPOSE CERTIFICATE OF ACKNOWLEDGMENT

State of California

County of Los Angeles

On 9/9/13 before me, Michelle Dawn Esters, Notary Public
(Here insert name and title of the officer)

personally appeared Arturo Sola

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Michelle Dawn Esters

Signature of Notary Public

(Notary Seal)



ADDITIONAL OPTIONAL INFORMATION

DESCRIPTION OF THE ATTACHED DOCUMENT

(Title or description of attached document)

(Title or description of attached document continued)

Number of Pages _____ Document Date _____

(Additional information)

CAPACITY CLAIMED BY THE SIGNER

- ☐ Individual (s)
☐ Corporate Officer

(Title)

- ☐ Partner(s)
☐ Attorney-in-Fact
☐ Trustee(s)
☐ Other _____

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- Date of notarization must be the date that the signer(s) personally appeared which must also be the same date the acknowledgment is completed.
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- Print the name(s) of document signer(s) who personally appear at the time of notarization.
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- Securely attach this document to the signed document

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 1120.140(c), Reasonableness of Project and Related Costs

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD	153.57				6,000		\$921,400		\$921,400
Contingency	15.00				6,000		\$90,000		\$90,000
TOTALS	168.57				6,000		\$1,011,400		\$1,011,400

* 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
New Construction Contracts & Contingencies	\$1,011,400	\$254.58 per gsf x 6,000 gsf = \$254.58 x 6,000 = \$1,527,480	Below State Standard
Contingencies	\$90,000	10% of New Construction Contracts = 10% x \$921,400 = \$92,140	Below State Standard
Architectural/Engineering Fees	\$75,000	6.77% - 10.17% x (New Construction Costs + Contingencies) = 6.77% - 10.17% x (\$921,400 + \$90,000) = 6.77% - 10.17% x \$1,011,400 = \$68,472 - \$102,859	Meets State Standard
Consulting and Other Fees	\$75,000	No State Standard	No State Standard
Moveable Equipment	\$466,405	\$39,945 per station x 12 stations \$39,945 x 12 = \$479,340	Meets State Standard

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

Operating Expenses: \$1,826,297

Treatments: 9,984

Operating Expense per Treatment: \$182.92

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

Capital Costs:

Depreciation: \$106,159

Amortization: \$ 6,236

Total Capital Costs: \$112,395

Treatments: 9,984

Capital Costs per Treatment: \$11.26

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita HealthCare Partners 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 Kidney Smarting patients, and community outreach. A copy of DaVita's 2012 Community Care report, which details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on July 15, 2013 as part of Applicants' application for Proj. No. 13-045. DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Furthermore, 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. Its commitment to improving clinical outcomes directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which was \$1 Billion in savings to the health care system and the American taxpayer between 2010 - 2011.
2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. As shown in Table 1110.1430(b), average utilization at existing dialysis facilities within 30 minutes normal travel time of the Proposed Facility is currently 85.95% with two facilities operating at 110% utilization and a third facility nearly full. Further, Dr. Ahmad has identified 102 patients from his practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 30 minute commute of the proposed facility. Thus, approximately 64 patients will be referred to the Proposed Facility within 12 to 24 months. This represents an 89% utilization rate, which exceeds the State's 80% standard. As such, the proposed facility is necessary to allow existing facilities to operate at their optimum capacity while at the same time accommodating the growing demand for dialysis services. Accordingly, the proposed dialysis facility will not impact other general health care providers' ability to cross-subsidize safety net services.
3. The proposed project is for the establishment of Belvidere Dialysis. As such, this criterion is not applicable.

Safety Net Information per PA 96-0031			
CHARITY CARE			
	2010	2011	2012
Charity (# of patients)	66	96	152
Charity (cost in dollars)	\$957,867	\$830,580	\$1,199,657
MEDICAID			
	2010	2011	2012
Medicaid (# of patients)	563	729	651
Medicaid (revenue)	\$10,447,021	\$14,585,645	\$11,387,229

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		
	2010	2011	2012
Net Patient Revenue	\$161,884,078	\$219,396,657	\$228,403,979
Amount of Charity Care (charges)	\$957,867	\$830,580	\$1,199,657
Cost of Charity Care	\$957,867	\$830,580	\$1,199,657

Appendix I – Time & Distance Determination

Attached as Appendix I are the distance and normal travel time from the proposed facility to all existing dialysis facilities in the GSA, as determined by MapQuest.



Trip to:

[700-799] Beloit Rd

Belvidere, IL 61008

11.57 miles / 20 minutes

Notes

DaVita Stonecrest Dialysis to proposed location for
Belvidere Dialysis



1302 E State St, Rockford, IL 61104-2228

**Download
Free App**



1. Start out going **east** on **E State St / US-20-BR** toward **Regan St**. Continue to follow **US-20-BR**. [Map](#)

11.2 Mi

11.2 Mi Total



2. Turn **left** to stay on **US-20-BR**. [Map](#)

0.1 Mi

US-20-BR is 0.1 miles past Doc Wolf Dr

11.3 Mi Total

Taqueria El Torito is on the left

If you reach Wolf Rd you've gone a little too far



3. Take the 1st **left** onto **Beloit Rd**. [Map](#)

0.3 Mi

If you reach Fairgrounds Rd you've gone about 0.5 miles too far

11.6 Mi Total



4. **[700-799] BELOIT RD**. [Map](#)

Your destination is 0.1 miles past Henry Luckow Ln

If you reach W Hills Blvd you've gone a little too far



[700-799] Beloit Rd, Belvidere, IL 61008

1104

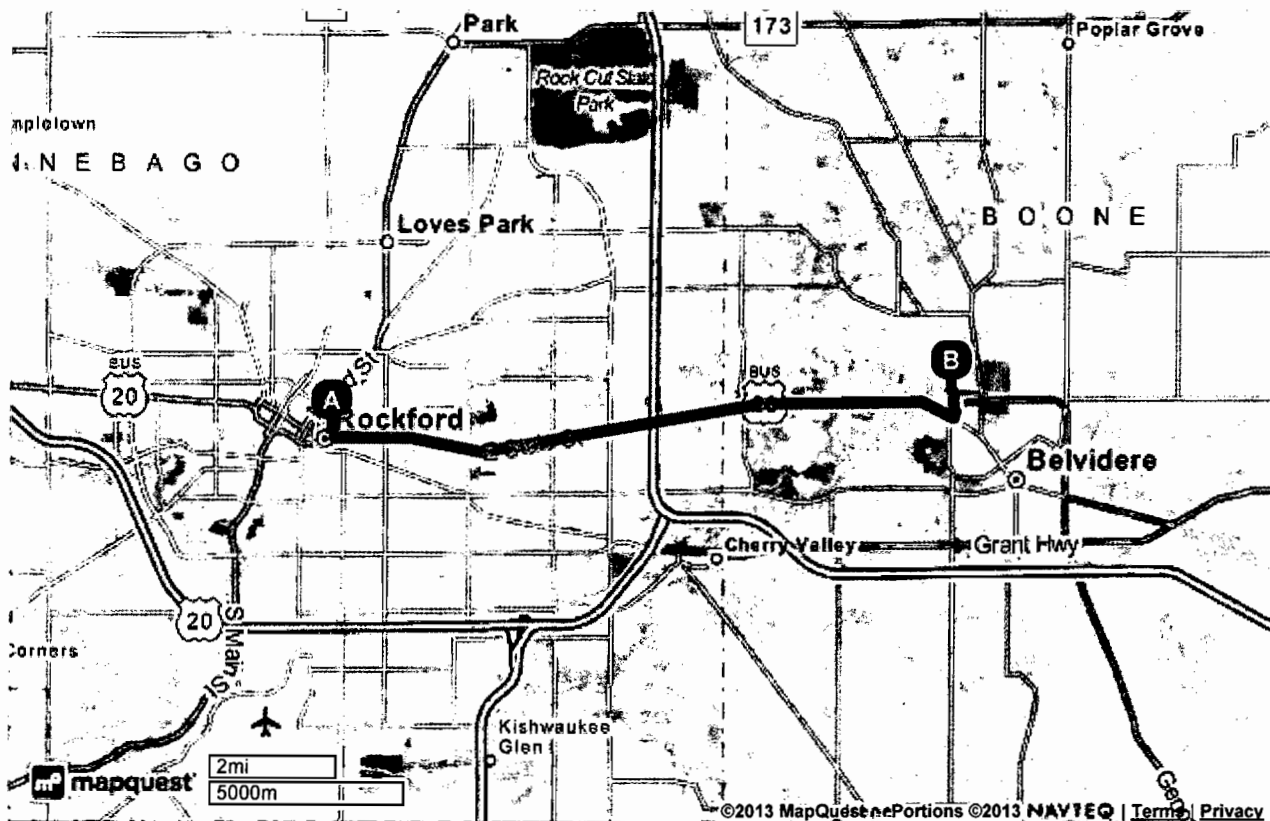
Total Travel Estimate: 11.57 miles - about 20 minutes

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Trip to:

[700-799] Beloit Rd

Belvidere, IL 61008

15.31 miles / 26 minutes

Notes

DaVita - Rockford Memorial Hospital to proposed location for Belvidere Dialysis



2400 N Rockton Ave, Rockford, IL 61103-3655

Download
Free App



1. Start out going **south** on **N Rockton Ave** toward **Bell Ave**. [Map](#)

0.7 Mi

0.7 Mi Total



2. Turn **left** onto **Auburn St**. [Map](#)

1.6 Mi

Auburn St is just past Vernon St

Pizza Hut is on the corner

If you reach Benderwirt Ave you've gone a little too far

2.3 Mi Total



3. **Auburn St** becomes **Spring Creek Rd**. [Map](#)

4.5 Mi

6.7 Mi Total



4. Turn **right** onto **N Perryville Rd**. [Map](#)

1.9 Mi

N Perryville Rd is 0.1 miles past Ashwin Blvd

If you reach McFarland Rd you've gone about 0.1 miles too far

8.7 Mi Total



5. Turn **left** onto **E State St / US-20-BR**. Continue to follow **US-20-BR**. [Map](#)

6.2 Mi

US-20-BR is 0.1 miles past Argus Dr

If you are on S Perryville Rd and reach Walton St you've gone about 0.1 miles too far

14.9 Mi Total



6. Turn **left** to stay on **US-20-BR**. [Map](#)

0.1 Mi

US-20-BR is 0.1 miles past Doc Wolf Dr

Taqueria El Torito is on the left

If you reach Wolf Rd you've gone a little too far

15.0 Mi Total



7. Take the 1st **left** onto **Beloit Rd**. [Map](#)

0.3 Mi

If you reach Fairgrounds Rd you've gone about 0.5 miles too far

15.3 Mi Total



8. **[700-799] BELOIT RD**. [Map](#)

Your destination is 0.1 miles past Henry Luckow Ln

If you reach W Hills Blvd you've gone a little too far



[700-799] Beloit Rd, Belvidere, IL 61008

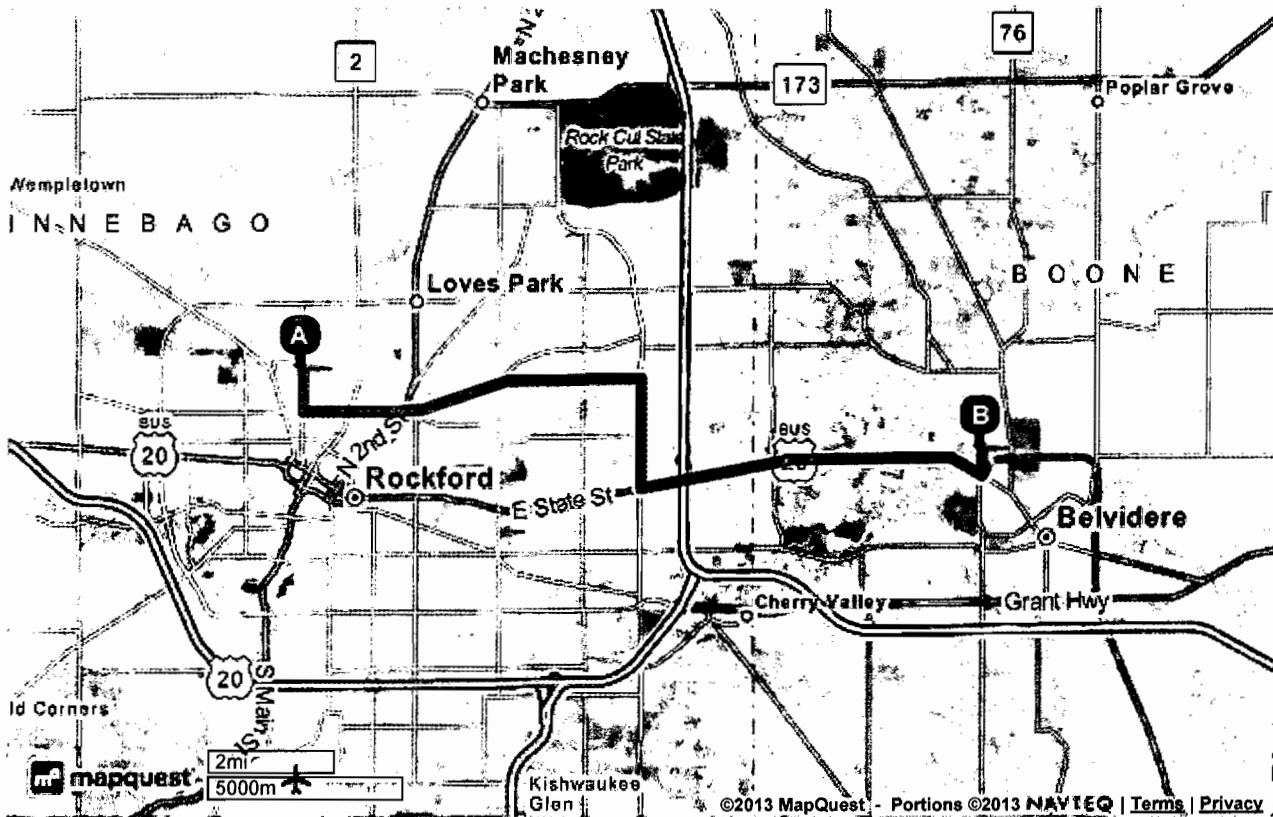
Total Travel Estimate: **15.31 miles - about 26 minutes**

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Appendix – 1



Trip to:

[700-799] Beloit Rd

Belvidere, IL 61008

8.52 miles / 13 minutes

Notes

DaVita Roxbury Dialysis to proposed location for Belvidere Dialysis



612 Roxbury Rd, Rockford, IL 61107-5089

Download
Free App



1. Start out going **south** on **Roxbury Rd** toward **Strathmoor Dr**. [Map](#)

0.4 Mi

0.4 Mi Total



2. Turn **left** onto **E State St / US-20-BR**. Continue to follow **US-20-BR**. [Map](#)

7.7 Mi

8.1 Mi Total

US-20-BR is 0.1 miles past Roxbury Rd

Lino's is on the corner

If you are on Arnold Ave and reach Justin Ct you've gone a little too far



3. Turn **left** to stay on **US-20-BR**. [Map](#)

0.1 Mi

8.3 Mi Total

US-20-BR is 0.1 miles past Doc Wolf Dr

Taqueria El Torito is on the left

If you reach Wolf Rd you've gone a little too far



4. Take the 1st **left** onto **Beloit Rd**. [Map](#)

0.3 Mi

8.5 Mi Total

If you reach Fairgrounds Rd you've gone about 0.5 miles too far



5. **[700-799] BELOIT RD**. [Map](#)

Your destination is 0.1 miles past Henry Luckow Ln

If you reach W Hills Blvd you've gone a little too far



[700-799] Beloit Rd, Belvidere, IL 61008

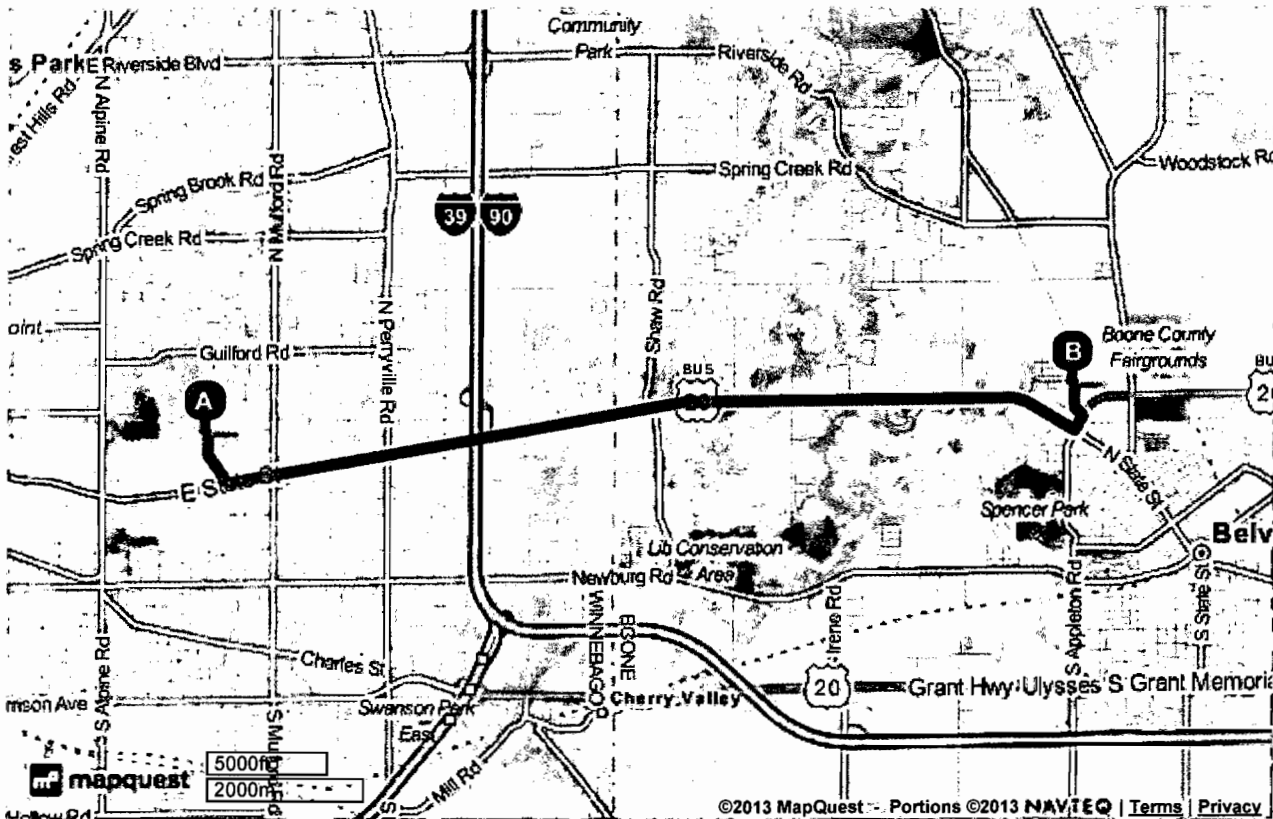
1168

Total Travel Estimate: **8.52 miles - about 13 minutes**

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1169

Appendix - 1



Trip to:

[700-799] Beloit Rd

Belvidere, IL 61008

9.51 miles / 14 minutes

Notes

DaVita Churchview Dialysis to proposed location for
Belvidere Dialysis**5970 Churchview Dr, Rockford, IL 61107-2574****Download
Free App**1. Start out going **northeast** on Churchview Dr toward Bellflower Ln. [Map](#)**0.07 Mi**

0.07 Mi Total

2. Turn **right** onto **N Mulford Rd.** [Map](#)**0.9 Mi**

0.9 Mi Total

3. Take the 2nd **left** onto **Guilford Rd.** [Map](#)**1.0 Mi***Guilford Rd is 0.1 miles past Thorngate Dr*

1.9 Mi Total

If you reach Vantage Pl you've gone about 0.1 miles too far4. Turn **right** onto **N Perryville Rd.** [Map](#)**0.9 Mi***N Perryville Rd is 0.1 miles past Derby Ln*

2.9 Mi Total

If you reach Red Oak Ln you've gone about 0.1 miles too far5. Turn **left** onto **E State St / US-20-BR.** Continue to follow **US-20-BR.** [Map](#)**6.2 Mi***US-20-BR is 0.1 miles past Argus Dr*

9.1 Mi Total

If you are on S Perryville Rd and reach Walton St you've gone about 0.1 miles too far6. Turn **left** to stay on **US-20-BR.** [Map](#)**0.1 Mi***US-20-BR is 0.1 miles past Doc Wolf Dr*

9.2 Mi Total

*Taqueria El Torito is on the left**If you reach Wolf Rd you've gone a little too far*7. Take the 1st **left** onto **Beloit Rd.** [Map](#)**0.3 Mi***If you reach Fairgrounds Rd you've gone about 0.5 miles too far*

9.5 Mi Total

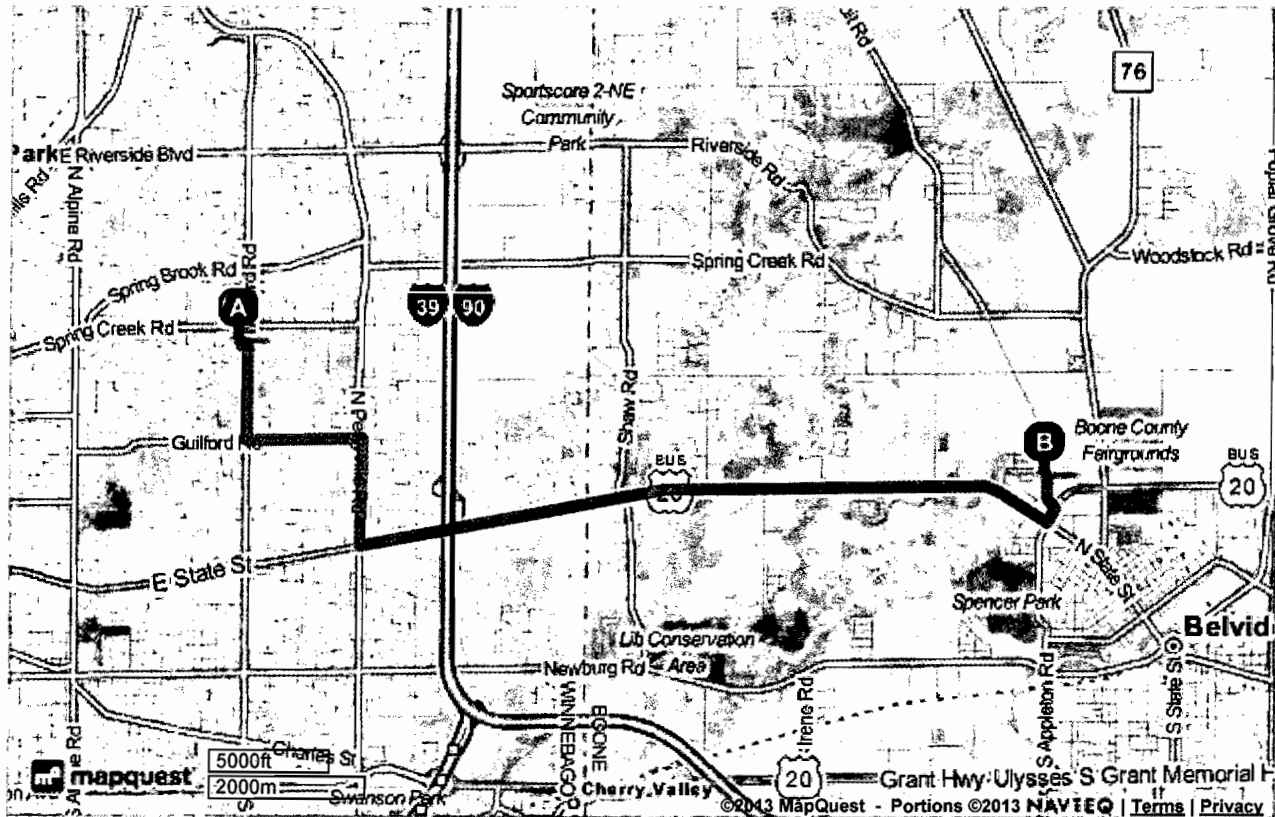
8. **[700-799] BELOIT RD.** [Map](#)*Your destination is 0.1 miles past Henry Luckow Ln**If you reach W Hills Blvd you've gone a little too far***[700-799] Beloit Rd, Belvidere, IL 61008**

Total Travel Estimate: **9.51 miles - about 14 minutes**

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Trip to:

[700-799] Beloit Rd

Belvidere, IL 61008

16.19 miles / 24 minutes

Notes

Quality Renal Care - Marengo to proposed location for Belvidere Dialysis

- | | | Download
Free App |
|----------|---|---------------------------------|
| A | 910 Greenlee St Unit B, Marengo, IL 60152-8200 | |
| ● | 1. Start out going west on Greenlee St toward N Prospect St . Map | 0.02 Mi
0.02 Mi Total |
| ↩ | 2. Turn left onto N Prospect St . Map
<i>Snap Fitness Marengo is on the corner</i> | 0.5 Mi
0.5 Mi Total |
| ➡ | 3. Turn right onto E Grant Hwy / US-20 / Ulysses S Grant Memorial Hwy . Continue to follow US-20 / Ulysses S Grant Memorial Hwy . Map
<i>Cafe 20 is on the right</i> | 9.9 Mi
10.4 Mi Total |
| ↗ | 4. Turn slight right onto Logan Ave . Map
<i>Logan Ave is 0.9 miles past Epworth Rd</i>
<i>If you are on US-20 and reach Farmington Way you've gone about 1.4 miles too far</i> | 1.9 Mi
12.3 Mi Total |
| ➡ | 5. Turn right onto US-20-BR . Map
<i>US-20-BR is 0.1 miles past Jamestown Ave</i>
<i>If you reach Biester Dr you've gone a little too far</i> | 3.6 Mi
15.9 Mi Total |
| ➡ | 6. Turn right onto Beloit Rd . Map
<i>Beloit Rd is 0.5 miles past IL-76</i>
<i>If you reach N State St you've gone about 0.1 miles too far</i> | 0.3 Mi
16.2 Mi Total |
| ■ | 7. [700-799] BELOIT RD . Map
<i>Your destination is 0.1 miles past Henry Luckow Ln</i>
<i>If you reach W Hills Blvd you've gone a little too far</i> | |
| B | [700-799] Beloit Rd, Belvidere, IL 61008 | |

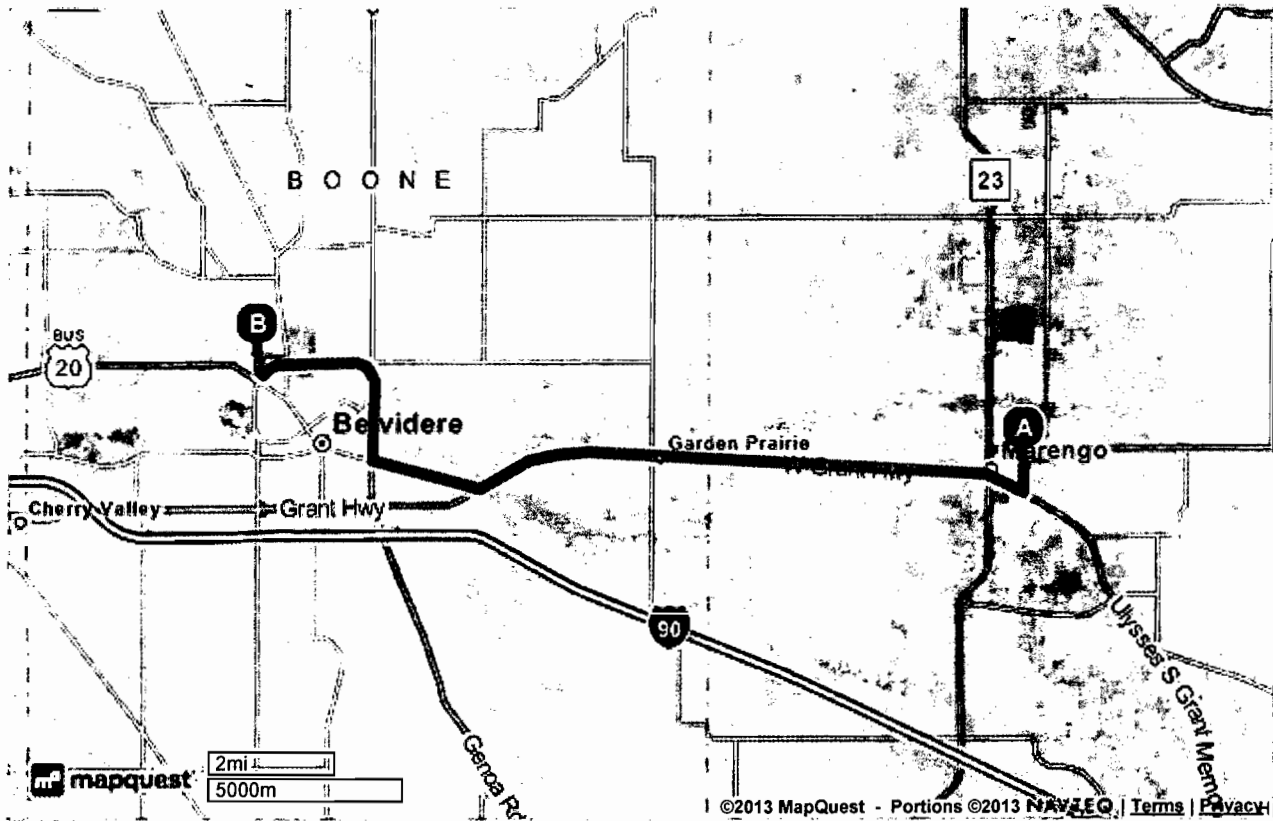
Total Travel Estimate: **16.19 miles - about 24 minutes**

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Appendix 2 – Physician Referral Letter

Attached as Appendix 2 is the physician referral letter from Dr. Mashood Ahmad.



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

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
Bindu Pavithran, MD
Charlene Murdakes, MD

Mashood Ahmad, M.D.
Rockford Nephrology Associates, LLC
612 Roxbury Road
Rockford, Illinois 61107

Kathryn J. Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson:

I am a nephrologist in practice with Rockford Nephrology Associates, LLC ("RNA"). I am writing on behalf of RNA in support of DaVita's establishment of Belvidere Dialysis, for which I will be the medical director. The proposed 12-station chronic renal dialysis Belvidere, Illinois 61008 will directly benefit our patients.

DaVita's proposed facility will improve access to necessary dialysis services in the greater Belvidere community. DaVita is well-positioned to provide these services, as it delivers life sustaining dialysis for residents of similar communities throughout the country and abroad. It has also invested in many quality initiatives to improve its patients' health and outcomes.

The site of the proposed facility is close to Interstate 90 (I-90) and will provide better access to patients residing east of the City of Rockford. Utilization of facilities in operation for more than a year within the 30 minute Geographic Service Area of the proposed facility was 85.95%, according to June 30, 2013 reported census data.

I have identified 102 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 30 minute commute of the proposed facility. (Of particular note, 57 of these 102 patients reside in Belvidere - the same city and same zip code of the proposed facility.) Conservatively, I predict at least 64 of these Stage 4 or 5 CKD patients will progress to dialysis within the next 12 to 24 months. Additionally, 26 of the existing ESRD in-center hemodialysis patients at Stonecrest Dialysis, Rockford Memorial Hospital, and Roxbury Dialysis live in Belvidere. Due to the current over utilization of these three facilities, I anticipate

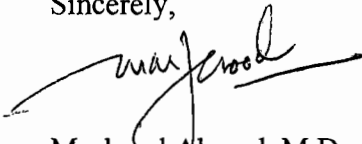
many of these patients will likely transfer to the proposed Belvidere facility without lowering utilization of any the facilities below the State's standard of 80%. My large patient base and the significant utilization at nearby facilities demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 3 ½ years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past year and a half is provided at Attachment – 2. The list of zip codes for the 102 pre-ESRD patients previously referenced is provided at Attachment – 3.

These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

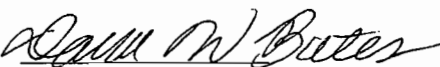
DaVita is a leading provider of dialysis services in the United States and I support the proposed establishment of Belvidere Dialysis.

Sincerely,



Mashood Ahmad, M.D.
Nephrologist
Rockford Nephrology Associates, LLC
612 Roxbury Road
Rockford, Illinois 61107

Subscribed and sworn to me
This 7th day of November, 2013

Notary Public: 



Attachment 1
Historical Patient Utilization

Churchview Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
SA	48917	PA	61108	PA	61108	BA	61114
PA	61108	CA	61107	CA	61107	PA	61108
GA	61108	RA	61073	RA	61073	CA	61107
KA	60135	GA	61108	GA	61108	RA	61073
RA	60132	EA	61065	EA	61065	GA	61108
JB	61071	JB	61071	TB	60135	EA	61065
GB	61114	SB	61107	JB	61071	SB	61107
WB	61114	LB	61109	SB	61107	TB	61107
CB	61104	TB	61107	TB	61107	BB	61103
KB	61108	CB	61104	CB	61104	CB	61104
EB	61115	MB	61080	MB	61080	CB	60637
LB	61108	KB	61108	KB	61108	CB	61008
SC	61115	VB	77018	JB	62069	MB	61080
WC	61008	JB	62069	SC	61115	JB	62069
CC	61008	WB	44109	CC	61008	MC	61111
VC	61038	SC	61115	VC	61038	SC	61115
JC	61103	CC	61008	JC	61103	RC	61108
MD	61107	VC	61038	LC	61101	SC	61107
SD	61107	JC	61103	MC	61103	CC	61008
TD	61101	LC	61101	GC	61107	VC	61038
ED	61107	MC	61103	GD	61063	DC	61115
EE	61104	JD	33629	SD	61107	JC	61103
BE	61115	SD	61107	TD	61101	GC	61107
AF	61102	TD	61101	ED	61107	RD	61111
DF	61112	ED	61107	EE	61104	TD	61101
TG	61103	EE	61104	BE	61115	EE	61104
RG	61107	BE	61115	AF	61102	BE	61115
CG	61101	AF	61102	AF	61114	JE	61073
JG	60102	RG	61107	RG	61107	LE	61108
EG	61102	CG	61101	CG	61101	FF	61107
LG	61115	EG	61108	EG	61108	GF	61008
JG	61115	EG	61102	EG	61102	EF	61008
VH	61115	LG	61115	LG	61115	AF	61102
FH	61008	JH	61008	JH	61008	LF	61111
HH	61109	FH	61008	FH	61008	RG	61107
CH	61108	MH	61102	MH	61102	BG	60102
DH	61103	JH	39206	JH	39206	CG	61111
VH	61101	HH	61109	HH	61109	MG	61114
RH	61103	CH	61108	CH	61108	GG	61107
PK	61073	VH	61101	VH	61101	EG	61102

Churchview Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
BK	61114	DH	61073	DH	61073	LG	61115
JL	61104	LJ	61114	LJ	61114	TG	61114
LL	61108	PK	61073	PK	61073	BH	61107
AL	61101	MK	61104	MK	61104	FH	61008
RL	61071	BK	61114	BK	61114	HH	61109
ML	61109	CK	61115	CK	61115	PH	61103
BM	61108	LL	61108	LL	61108	CH	61104
ZM	61115	ML	61114	ML	61114	CH	61108
JM	61115	ML	61109	ML	61109	VH	61101
DM	61114	JL	61115	JL	61115	VH	61108
HM	61102	PM	61065	PM	61065	DH	61073
JM	61102	ZM	61115	MM	61114	DH	61065
CM	61103	JM	61115	ZM	61115	MJ	61115
DM	61115	HM	61102	JM	61115	JJ	61115
DM	60163	RM	61104	HM	61102	KJ	61125
AN	61111	RM	61108	RM	61104	OJ	61115
DN	61104	SM	61008	SM	61008	PK	61073
HP	62711	CM	61103	CM	61103	MK	61104
JP	61102	CM	61108	CM	61108	BK	61114
HP	61008	DM	61115	DM	61115	AL	61107
KP	61109	AN	61111	AN	61111	LL	61008
JP	61101	JN	61101	JN	61101	ML	61114
DP	61115	DN	61104	DN	61104	ML	61109
RP	61103	VO	61111	VO	61111	ZM	61115
DQ	61073	HP	62711	HP	62711	HM	61102
MR	61065	JP	61102	JP	61102	RM	61104
AR	61109	DP	61109	DP	61109	JM	61080
RR	61032	KP	61109	KP	61109	SM	61008
MS	61108	JP	61101	JP	61101	CM	61103
AS	61008	AP	61107	AP	61107	CM	61108
JS	61111	RP	61107	RP	61107	DM	61115
GS	61114	DQ	61073	DQ	61073	AN	61111
DS	61111	MR	61065	MR	61065	DN	61104
LS	61108	AR	61109	AR	61109	EN	61107
JS	61111	MS	61108	MR	61107	VO	61111
RS	61114	RS	61101	BR	61073	JP	61102
RS	61108	GS	61114	RS	61101	DP	61109
GT	61107	DS	61111	GS	61114	AP	61065
NT	46410	LS	61108	DS	61111	EP	61107
MT	43614	JS	61111	LS	61108	AP	61114
GT	61114	MS	61107	JS	61111	CP	61107
JW	61012	CS	61103	MS	61107	EP	61065
GW	61114	MT	43614	CS	61103	KP	61109
AW	61107	GT	61114	PS	61114	JP	61101

Churchview Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
PW	61102	JW	61012	GT	61114	RP	61103
KW	61107	EW	61114	PT	61108	AP	61107
		AW	61107	JW	61012	RP	61107
		AW	61108	EW	61114	DQ	61073
		CY	61073	AW	61107	AR	61109
		BY	61107	CY	61073	MR	61107
				BY	61107	SR	61114
				MB	61065	GS	61114
				TD	61108	DS	61111
				AL	61107	JS	61111
				WB	44109	MS	61107
				RC	61108	AS	61107
				JD	61107	SS	33952
				JE	61073	CS	61103
				DG	60647	DS	61008
				MJ	61115	PS	61114
				WM	61108	AS	61008
				EP	61107	GT	61114
				ES	61032	JW	61012
				AS	61008	BW	61101
				EH	60007	DW	61114
				CH	63967	EW	61114
				OJ	61115	AW	61107
				RM	54843	TW	61104
				GP	51031	AW	61108
				MB	60178	JW	61008
				TB	74129	BY	61107
				JH	38305	RB	61111
				RS	85297	MH	61109
				JD	61111	LL	61011
				CG	61107	MW	61114
				KJ	61125	WB	44109
				DL	61114	CD	53711
				BM	61115	JD	61080
				AP	61114	CH	61073
				BG	60102	WH	61038
				JM	60180	EJ	61108
				LZ	61109	BM	61008
				LE	61108	GP	51031
				FF	61107	ER	34653
				GF	61008	TS	61101
				EF	61008	RS	85297
				GG	61107	DA	61008
				BH	61103	JB	61071

Churchview Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
				BH	61073	DL	61114
				CH	61104	CM	61114
				MK	61068	JN	61101
				EP	61065	RO	60652
				SR	61114	FS	61107
				BA	61114	DT	75089
				HB	35739	FV	61114
				VB	54481	JA	61114
				SH	61126	MB	61114
				VH	61108	MF	61114
				JS	61107	TF	61016
				DS	48221	AL	61101
				BB	61103	GO	55347
				CB	60637	DV	61068
				SC	61107	RW	61073
				DC	61115	LA	62226
				CG	61111	KB	61088
				DH	61065	AB	61102
				LL	61008	JC	61073
				KN	95901	JD	61107
				LR	61102	JH	38305
				CR	61073	LH	61101
				AS	61108	MJ	79605
				SW	60651	DM	61108
				CB	61008	CP	61115
				BF	61111	JR	61102
				LF	61111	JS	61101
				JG	64052	IT	61104
				AP	61065		
				CP	61107		
				CT	61104		
				CT	46320		
				BW	61101		
				DW	61114		
				PW	63112		
				TW	61104		
				EN	61107		
				DS	61008		

Historical Patient Utilization

Rockford Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
BA	61104	BA	61104	BA	61104	BA	61104
VA	61008	VA	61008	VA	61008	VA	61008
EA	61101	CA	61101	CA	61101	CA	61101
RB	61080	EA	61101	EA	61101	EA	61101
SB	61102	SB	61102	SB	61102	JA	61102
DB	61103	DB	61103	DB	61103	SB	61102
RB	61104	RB	61104	RB	61104	DB	61103
MB	61101	MB	61101	MB	61102	PB	61103
MB	61102	MB	61102	CB	61102	BB	61103
CB	61102	CB	61102	RB	61102	MB	61102
BB	61103	JB	61103	EB	61101	CB	61102
RB	61102	RB	61102	JC	61101	RB	61102
JC	61101	JC	61101	JC	61103	EB	61101
JC	61103	TC	53511	RC	61101	JC	61101
RC	61101	JC	61103	WC	61101	AC	61102
WC	61101	RC	61101	EC	61109	JC	61103
EC	61109	WC	61101	JC	61102	EC	61109
JC	61102	EC	61109	KC	61115	JC	61102
FC	61102	JC	61102	FC	61102	DC	61102
LC	61101	KC	61115	JC	61101	SC	61111
ZC	61108	FC	61102	FD	61115	FC	61102
JC	61101	JC	61101	BD	61104	JC	61101
BC	61084	FD	61115	LD	61101	TD	61108
EC	61103	BD	61104	ED	61102	BD	61104
JD	61107	LD	61101	AD	75056	LD	61101
FD	61115	ED	61102	JD	61105	ED	61102
BD	61104	AD	75056	KD	61103	KD	61103
LD	61101	JD	61105	LE	61108	ED	61111
ED	61102	KD	61103	KF	61101	LE	61102
AD	75056	LE	61108	PF	61102	PE	61010
JD	61105	KF	61101	DF	61109	ME	61101
KD	61103	PF	61102	CG	61101	KF	61101
LE	61108	DF	61109	PG	61101	PF	61102
PE	61010	CG	61101	EG	61102	GF	61101
DF	61088	NG	61108	CG	61072	DF	61109
PF	61102	EG	61102	DG	61101	RF	61103
JF	61104	CG	61072	JG	61103	VF	61101
DF	61109	DG	61101	DH	61101	PG	61101
PG	61102	JG	61103	HH	61101	JG	61104
NG	61108	DH	61101	BH	61103	EG	61102

Rockford Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
JG	60626	HH	61101	DH	61101	CG	61107
EG	61102	BH	61103	VH	61101	CG	61072
DG	61101	DH	61101	TH	61103	DG	61101
JG	61103	VH	61101	MH	61104	DH	61101
DH	61101	MH	61104	CH	32210	HH	61101
HH	61101	CH	32210	RH	61101	OH	61103
VH	61080	RH	61101	RH	62418	BH	61103
DH	61101	SH	61101	SH	61101	DH	61101
KH	61102	JH	61103	JH	61103	JH	61008
VH	61101	FH	61101	FH	61101	VH	61101
MH	61104	MI	61111	MI	61111	SH	64131
CH	32210	JJ	61102	MJ	61102	MH	61104
RH	61101	DJ	61107	JJ	61102	CH	61104
TH	61103	RJ	61103	DJ	61107	BH	61073
SH	61101	PK	61101	RJ	61103	PH	61103
JH	61103	ML	61114	PK	61101	SH	61101
DH	61101	KL	61101	KL	61101	JH	61103
FH	61101	FM	61107	FM	61107	FH	61101
JJ	61102	CM	61102	CM	61102	MJ	61102
KJ	61101	DM	61102	DM	61102	RJ	61103
MJ	61104	HM	61102	HM	61102	JJ	61102
CJ	61101	PM	61103	PM	61103	DJ	61107
DJ	61107	SM	61103	SM	61103	PK	61101
RJ	61103	AM	61101	AM	61101	DL	61103
PK	61101	JM	61103	JM	61103	SL	61103
EL	61073	RO	61104	RO	61104	FM	61107
JL	61080	HP	61101	HP	61101	CM	61102
SL	61101	KP	61103	KP	61103	DM	61102
FM	61107	AP	61102	AP	61102	HM	61102
NM	61103	GP	61111	GP	61111	PM	61103
CM	61102	JP	61103	JP	61103	SM	61109
HM	61102	JR	60625	BR	61111	SM	61104
PM	61103	BR	61111	JR	61101	SM	61103
GM	61107	JR	61101	RR	61103	SM	61102
SM	61103	RR	61103	JR	61101	JM	61102
AM	61101	JR	61101	ER	34653	AM	61101
JM	61103	ER	34653	BS	61104	JM	61103
RO	61104	BS	61104	BS	61108	JN	61101
HP	61101	BS	61108	CS	55404	FN	61102
AP	60084	CS	55404	KS	61063	LO	61108
GP	61111	KS	61063	RT	61107	RO	61104
JP	61103	RT	61107	RV	61103	KP	61103
JP	61103	RV	61103	MV	61101	GP	61111
JR	61101	EV	61073	EV	61073	JP	61103

Rockford Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RR	61103	EW	61073	JW	61107	BR	61111
JR	61101	PW	61102	PW	61102	JR	61101
JR	61104	SW	61102	SW	61102	RR	61103
BS	61108	JW	61080	JW	61080	JR	61101
TS	61101	LW	61104	LW	61104	BS	61104
CS	55404	LW	61102	LW	61102	RS	61103
MS	61108	AW	61101	JW	61101	JS	61115
KS	61063	FW	61101	AW	61101	CS	55404
SS	61108			FW	61101	TS	61107
JV	61102			ND	61108	KS	61063
RV	61103			PE	61010	RS	61073
EV	61073			WM	61111	SS	61108
EW	61073			FN	61102	DT	61114
SW	61102			EP	61102	LT	61103
JW	61080			MW	61047	RV	61103
LW	61104			LY	61103	MV	61101
LW	61102			TD	61108	EV	61032
WW	61072			HJ	61103	EV	61073
				DT	61114	EW	61103
				SW	46208	PW	61102
				DC	61103	SW	61102
				AC	61102	JW	61080
				ED	61111	LW	61104
				LE	61102	SW	61024
				JG	61108	LW	61102
				JH	61108	NW	61072
				CH	61104	WW	61101
				JN	61101	AW	61101
				GT	61107	FW	61101
				RV	61103	LY	61103
				JW	61107	NC	61103
				EW	61103	AF	61101
				SW	61102	DH	61115
				SC	61111	AL	61109
				GF	61101	RA	61072
				VF	61101	EM	61103
				JG	61104	RM	61101
				CG	61107	NR	61101
				AL	61109	KC	61101
				ML	33830	BH	61103
				LN	61114	RH	61103
				DP	61032	VR	61102
				SW	61024	KB	61054
				SA	61102	JB	61103

Rockford Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
				CD	61114	LC	61103
				SL	61103	JC	61101
				LM	61101	DH	61019
				JM	61080	RB	61101
				NB	61114	JW	61104
				ME	61101		
				BH	61073		
				BR	61111		
				SS	61108		
				PB	61103		
				AC	61102		
				OH	61103		
				RJ	61103		
				HL	61114		
				RS	61073		
				LI	61104		
				SM	61109		
				SM	61102		
				JS	61115		
				LT	61103		
				DC	61102		
				JC	61103		
				BF	61109		
				DH	45385		
				DL	61103		
				RS	61103		
				NW	61072		
				RF	61103		
				EH	61101		
				LO	61108		

Historical Patient Utilization

Roxbury Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
TA	61108	TA	61108	TA	61108	TA	61108
SA	61102	SA	61102	SA	61102	SA	61102
RA	61107	RA	61107	RA	61107	RA	61107
EB	61108	EB	61108	EB	61108	EB	61108
GB	61108	GB	61108	GB	61108	GB	61108
JB	61008	JB	61008	JB	61008	JB	61008
DB	61108	KB	61008	KB	61008	KB	61008
DB	61108	DB	61108	DB	61108	RB	61107
CB	61016	RB	61107	DB	61108	LB	61108
LB	61008	DB	61108	NB	61102	DB	61108
CB	61103	MB	61107	MB	61107	NB	61102
JC	61108	CB	61016	CB	61016	OB	60033
DC	61109	LB	61008	LB	61008	CB	61016
BC	61114	CB	61103	CB	61103	CB	61103
KC	61008	JC	61108	JC	61108	VD	61084
MC	61107	DC	61103	DC	61103	RD	61084
SC	61108	DC	61109	DC	61109	JD	61038
VD	61084	KC	61008	KC	61008	LE	61108
ID	61107	MC	61107	MC	61107	TE	61114
LE	61107	VD	61084	VD	61084	ME	61107
ME	61107	JD	61038	JD	61038	RF	61052
RF	61052	PE	61010	AD	61111	PF	61107
PF	61107	LE	61107	TE	61114	OF	61132
PF	61102	ME	61107	PE	61010	PF	61102
JF	61084	RF	61052	LE	61107	RF	61108
DF	61108	PF	61107	ME	61107	JF	61084
RF	61108	PF	61102	RF	61052	DF	61108
JG	61102	JF	61084	PF	61107	LF	61111
PG	61108	DF	61108	PF	61102	RF	61108
MG	61111	RF	61108	JF	61084	RG	61126
PG	60152	JG	61102	DF	61108	NG	61108
SG	61107	RG	61126	RF	61108	MG	61111
JG	61104	NG	61108	JG	61102	DG	61015
RH	61109	PG	61108	RG	61126	SG	61107
MH	61114	MG	61111	NG	61108	KH	61073
PH	61111	PG	61101	PG	61108	SH	61109
PJ	61114	SG	61107	MG	61111	RH	61109
YJ	61109	JG	61104	SG	61107	SH	61126
DK	61111	SH	61109	JG	61104	CH	61111
TK	61103	RH	61109	KH	61073	PH	61111

Roxbury Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
JK	61104	CH	61111	SH	61109	CJ	61102
RL	61103	PH	61111	RH	61109	SJ	61109
AL	61108	SJ	61109	CH	61111	YJ	61109
BM	61108	YJ	61109	PH	61111	DK	61111
BM	61008	DK	61111	SJ	61109	TK	61103
JM	61104	TK	61103	YJ	61109	JK	61104
LM	61073	JK	61104	DK	61111	TL	61115
RM	61008	RL	61103	TK	61103	RL	61115
JM	61108	AL	61108	JK	61104	AL	61108
RM	61101	AL	60014	RL	61103	SM	61114
LN	85373	JM	61108	AL	61108	JM	61108
CO	61073	KM	61065	AL	60014	JM	61011
MO	61109	JM	61108	JM	61108	KM	61065
LP	61109	DM	61109	MM	61114	JM	61108
VP	61114	BM	61008	KM	61065	DM	61109
RP	61103	JM	61104	JM	61108	RM	61111
BP	61107	LM	61073	DM	61109	BM	61008
NR	61108	RM	61008	BM	61008	JM	61020
WR	61020	JM	61108	JM	61104	JM	61104
FR	61108	RM	61101	LM	61073	LM	61073
GR	61008	GM	61008	RM	61008	RM	61008
CR	61108	AN	61109	JM	61108	JM	61108
HR	61104	CN	61008	RM	61101	RM	61101
AS	61111	CO	61073	GM	61008	GM	61008
JS	61008	MO	61109	AN	61109	AN	61109
JS	61008	CP	61084	JN	61108	JN	61108
PS	61108	LP	61109	CN	61008	CN	61008
HS	61107	VP	61114	CO	61073	GN	61102
DS	61008	BP	61107	MO	61109	RN	61104
BS	61114	RP	61108	CP	61084	JO	61109
AT	61109	NR	61108	LP	61109	CO	61073
MT	61107	WR	61020	VP	61114	MO	61109
JT	61108	GR	61008	BP	61107	CO	61108
PT	61107	VR	61111	RP	61108	LP	61109
PT	78216	CR	61108	NR	61108	VP	61107
WV	61101	HR	61104	WR	61020	VP	61114
VV	61114	CR	65788	FR	61108	JP	61108
FV	61114	DR	61109	GR	61008	BP	61107
DW	61008	RR	61108	CR	61108	RP	61108
MW	61114	JS	61114	HR	61104	NR	61108
CW	61101	TS	61101	DR	61109	WR	61020
FW	61108	JS	61008	RR	61108	BR	61111
CZ	61008	JS	61008	JS	61114	FR	61108
PZ	61072	AS	61107	TS	61101	GR	61008

Roxbury Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
BZ	61111	PS	61108	JS	61008	JR	61008
		HS	61107	JS	61008	CR	61108
		DS	61008	AS	61107	HR	61104
		CS	61109	HS	61107	DR	61109
		LS	61107	DS	61008	RR	61108
		PS	61114	CS	61109	TS	61101
		DS	61008	LS	61107	DS	61104
		BS	61114	PS	61114	JS	61008
		SS	61108	DS	61008	HS	61107
		GT	61107	BS	61114	DS	61008
		AT	61109	SS	61108	CS	61109
		MT	61107	GT	61107	LS	61107
		PT	61107	AT	61109	DS	61008
		PT	78216	PT	61107	PT	61107
		WV	61101	PT	78216	JT	61108
		VV	61114	WV	61101	FV	61114
		FV	61114	VV	61114	DW	61008
		DW	61008	FV	61114	VW	61109
		MW	61114	DW	61008	MW	61114
		CW	61101	MW	61114	CW	61101
		MW	61016	CW	61101	MW	61016
		DW	61008	MW	61016	DW	61008
		TW	61111	DW	61008	JW	61107
		TX	61109	TW	61111	TX	61109
		CZ	61008	TX	61109	CZ	61008
				CZ	61008	MZ	61008
				RB	61107	PH	61111
				NK	61114	GR	61115
				JM	61020	JB	61115
				KN	61032	JH	61008
				AE	61108	CR	65788
				RF	61108	RT	54235
				WM	61108	BO	53563
				RN	61104	MP	61008
				LB	61108	JR	61101
				RD	61084	DS	61107
				DS	48221	RC	33982
				TK	61114	RD	61108
				JO	61109	CW	61020
				JP	61108	HF	61008
				LA	62226	BN	61107
				DG	61015	RS	61108
				TL	61115		
				JM	61011		

Roxbury Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
				MM	61008		
				NP	75604		
				JR	61008		
				BR	61111		
				JT	61108		
				VW	61109		
				SW	60651		
				LF	61111		
				VP	61107		
				LE	61108		
				SH	61126		
				SM	61114		
				OF	61132		
				CJ	61102		
				MZ	61008		
				GN	61102		
				DS	61104		

Historical Patient Utilization

Stonecrest Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
NA	61104	AA	61108	AA	61108	AA	61108
AA	61108	AA	60133	AA	60133	AA	61104
CA	611067	LA	61103	LA	61103	LA	61103
AA	60133	AA	61104	AA	61104	AA	61104
LA	61103	SB	61103	SB	61103	SB	61103
JA	61103	VB	53224	VB	53224	OB	61101
AA	61104	IB	61104	IB	61104	PB	61104
KB	61103	FC	61109	FC	61109	JB	61020
VB	53224	WC	61109	WC	61109	IB	61104
IB	61104	NC	61103	NC	61103	JB	61108
WC	61109	DF	61107	LE	61102	WC	61109
NC	61103	EF	61104	DF	61107	NC	61103
DD	61084	IF	61104	EF	61104	DC	61107
SD	61104	MG	61102	IF	61104	MC	61109
EE	61108	LH	61102	MG	61102	DC	61010
DF	61107	WH	61103	JG	61008	LE	61102
EF	61104	TH	61103	LH	61102	JF	61102
IF	61104	BH	61109	WH	61103	DF	61107
MG	61102	GH	61101	BH	61109	EF	61104
PH	61102	LH	61102	GH	61101	IF	61104
TH	61103	BI	61102	LH	61102	MG	61102
JH	39206	BJ	61103	BI	61102	JG	61008
BJ	61103	MJ	61104	BJ	61103	LH	61102
RJ	61101	RJ	61101	MJ	61104	WH	61103
KL	61108	CJ	61101	RJ	61101	BH	61109
PM	61065	AL	61109	CJ	61101	LH	61102
JM	61108	KL	61108	AL	61109	BJ	61103
JM	60107	MM	61073	KL	61108	TJ	61104
SM	61108	GM	61102	MM	61073	GJ	61107
MM	61073	CM	61101	GM	61102	MJ	61104
CM	61101	AN	61102	CM	61101	RJ	61101
EP	61102	KO	61109	JM	61102	CJ	61101
AP	61103	JO	61102	AN	61102	DL	61104
AR	61104	BP	61109	JN	61107	KL	61108
AR	61108	EP	61102	KO	61109	MM	61073
TR	61008	MP	61101	JO	61102	GM	61102
JS	61115	PP	61104	BP	61109	CM	61101
ES	61102	AP	61103	EP	61102	JO	61102
RS	61107	AR	61108	MP	61101	KO	61109
CS	30067	JR	61104	PP	61104	BP	61109

Stonecrest Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
CS	61104	TR	61008	AP	61103	EP	61109
RS	61102	JS	61115	AR	61108	MP	61101
MW	61073	CS	61109	JR	61104	PP	61104
JW	61008	ES	61102	TR	61008	AP	61103
SW	60651	TS	61101	JS	61115	AR	61108
MW	61104	RS	61107	CS	61109	TR	61008
JW	61008	SS	61068	ES	61102	JR	61108
WW	61109	CS	61104	JS	61108	ES	61102
WZ	60156	RS	61102	TS	61101	TS	61101
		RW	61084	RS	61107	RS	61102
		JW	61104	SS	61068	CT	61104
		MW	61104	CS	61104	MW	61104
		JW	61008	RS	61102	JW	61008
		MZ	61108	RW	61084	MZ	61108
				JW	61104	LC	92557
				MW	61104	DJ	61111
				JW	61008	CM	61114
				WZ	60156	MP	61008
				MZ	61108	JS	61103
				AA	61104	BC	61108
				PB	61104	GJ	61102
				JF	61102	MK	61104
				TJ	61104	RR	61010
				JO	61102	TS	61107
				EP	61109	TW	61104
				AP	61102	DF	61109
				MG	61109	DS	61104
				AH	61108	KB	61073
				FL	61103	ML	61108
				DC	61107	RM	61104
				MC	61109		
				IH	61101		
				BM	61115		
				JB	61020		
				OB	61101		
				JB	61108		
				DC	61010		
				AR	95126		
				JR	61108		
				ST	60644		
				GJ	61107		
				RT	61109		
				DL	61104		
				CT	61104		

Stonecrest Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
				AV	61062		

Historical Patient Utilization

Sycamore Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
SA	60505	KA	60135	CA	61310	EA	60115
EA	60115	EA	60115	SA	60505	TB	60135
HB	60178	HB	60178	KA	60135	RB	60145
WB	60550	TB	60135	EA	60115	TB	61068
TB	60135	RB	60145	HB	60178	MC	60115
JB	60115	PB	60115	TB	60135	EC	60115
RB	60145	TB	61068	RB	60145	RE	60115
DB	61068	CC	60115	TB	61068	IF	60115
CC	60115	EC	60115	CC	60115	JF	60150
EC	60115	JC	60115	EC	60115	SF	60150
JC	60115	RE	60178	JC	60115	BH	60419
DE	60135	DF	60518	RE	60115	RH	60135
BE	61068	JF	60150	PF	60178	AH	60115
RE	60178	SF	60150	JF	60115	LH	60178
JF	60150	RG	60178	JF	60150	JJ	60115
SF	60150	EG	60115	SF	60150	LJ	60178
RG	60178	EH	60115	EG	60115	JL	61068
EG	60115	RH	60135	EH	60115	GM	60178
WG	61068	AH	60115	RH	60135	AM	60115
EH	60115	LH	60178	AH	60115	TM	60178
RH	60135	MH	60115	LH	60178	HM	60178
AH	60115	SH	60129	MH	60115	JN	60115
LH	60178	RH	60115	RH	60115	MO	60115
MH	60115	LJ	60178	JJ	60115	WO	60178
SH	60129	JK	60178	LJ	60178	DR	60115
RH	60115	MK	61068	JK	60178	JR	60115
LJ	60178	JL	60115	MK	61068	AS	60178
WJ	60178	CL	60115	JL	60115	DS	60178
MK	61068	JL	61068	CL	60115	GS	60115
JL	60115	GM	60178	ML	60115	RS	60178
CL	60115	TM	60178	JL	61068	BS	60178
JL	61068	CM	60178	GM	60178	RS	61043
HM	60178	HM	60178	TM	60178	BT	60178
HM	78570	HM	78570	CM	60178	KT	60115
JM	61068	JM	61068	HM	60178	RT	60115
MM	61068	MM	61068	HM	78570	CT	61068
PP	60115	JN	60115	MM	61068	RV	60552
RP	61068	WO	60178	JN	60115	KW	60115
NP	61068	PP	60115	WO	60178	KY	60178
KP	60112	NP	61068	NP	61068	SZ	60178

Sycamore Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
JP	60115	MP	60140	MP	60140	DZ	61068
NR	62665	RQ	60123	JR	60115	TB	60115
JR	60115	JR	60115	JS	60115	MB	60115
MS	30519	JS	60115	DS	60178	CK	60178
JS	60115	DS	60178	RS	60178	DR	60115
DS	60178	RS	60178	WS	60115	RT	60152
RS	60178	WS	60115	RS	61068	MM	61068
TS	60115	BS	60178	BS	60178	BB	60115
BS	60178	RS	61043	RS	61043	PB	60135
RS	61043	KT	60115	KT	60115	MP	60140
KT	60115	OT	60115	OT	60115	JR	60178
GT	61068	RT	60115	RT	60115	RT	60115
DV	61068	ST	60115	KW	60115	LW	55803
GW	60115	DV	61068	WB	60115	DZ	60115
RW	60145	KW	60115	BC	60178	DD	60115
KW	60115	NW	61107	SC	60150	PE	60109
NW	61107			CS	60553	KK	61020
				BT	60178	SH	60129
				LW	55803	DS	60115
				RF	60178		
				EK	61068		
				BH	99301		
				RJ	60178		
				MG	33073		
				CT	61068		
				KY	60178		
				WA	60113		
				MC	60115		
				JN	61068		
				AS	60178		
				SZ	60178		
				IF	60115		
				MO	60115		
				GS	60115		
				DZ	61068		
				GG	33782		

Attachment 2
New Patients

Churchview Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
MB	61065	RB	61111
TD	61108	MH	61109
AL	61107	LL	61011
WB	44109	MW	61114
RC	61108	WB	44109
JD	61107	CD	53711
JE	61073	JD	61080
DG	60647	CH	61073
MJ	61115	WH	61038
WM	61108	EJ	61108
EP	61107	BM	61008
ES	61032	GP	51031
AS	61008	ER	34653
EH	60007	TS	61101
CH	63967	RS	85297
OJ	61115	DA	61008
RM	54843	JB	61071
GP	51031	DL	61114
MB	60178	CM	61114
TB	74129	JN	61101
JH	38305	RO	60652
RS	85297	FS	61107
JD	61111	DT	75089
CG	61107	FV	61114
KJ	61125	JA	61114
DL	61114	MB	61114
BM	61115	MF	61114
AP	61114	TF	61016
BG	60102	AL	61101
JM	60180	GO	55347
LZ	61109	DV	61068
LE	61108	RW	61073
FF	61107	LA	62226
GF	61008	KB	61088
EF	61008	AB	61102
GG	61107	JC	61073
BH	61103	JD	61107
BH	61073	JH	38305
CH	61104	LH	61101
MK	61068	MJ	79605

Churchview Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
EP	61065	DM	61108
SR	61114	CP	61115
BA	61114	JR	61102
HB	35739	JS	61101
VB	54481	IT	61104
SH	61126		
VH	61108		
JS	61107		
DS	48221		
BB	61103		
CB	60637		
SC	61107		
DC	61115		
CG	61111		
DH	61065		
LL	61008		
KN	95901		
LR	61102		
CR	61073		
AS	61108		
SW	60651		
CB	61008		
BF	61111		
LF	61111		
JG	64052		
AP	61065		
CP	61107		
CT	61104		
CT	46320		
BW	61101		
DW	61114		
PW	63112		
TW	61104		
EN	61107		
DS	61008		

Rockford Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
ND	61108	NC	61103
PE	61010	AF	61101
WM	61111	DH	61115
FN	61102	AL	61109
EP	61102	RA	61072
MW	61047	EM	61103
LY	61103	RM	61101
TD	61108	NR	61101
HJ	61103	KC	61101
DT	61114	BH	61103
SW	46208	RH	61103
DC	61103	VR	61102
AC	61102	KB	61054
ED	61111	JB	61103
LE	61102	LC	61103
JG	61108	JC	61101
JH	61108	DH	61019
CH	61104	RB	61101
JN	61101	JW	61104
GT	61107		
RV	61103		
JW	61107		
EW	61103		
SW	61102		
SC	61111		
GF	61101		
VF	61101		
JG	61104		
CG	61107		
AL	61109		
ML	33830		
LN	61114		
DP	61032		
SW	61024		
SA	61102		
CD	61114		
SL	61103		
LM	61101		
JM	61080		
NB	61114		
ME	61101		
BH	61073		

Rockford Dialysis		
2012		2013 YTD 6/30
Initials	Zip Code	
BR	61111	
SS	61108	
PB	61103	
AC	61102	
OH	61103	
RJ	61103	
HL	61114	
RS	61073	
LI	61104	
SM	61109	
SM	61102	
JS	61115	
LT	61103	
DC	61102	
JC	61103	
BF	61109	
DH	45385	
DL	61103	
RS	61103	
NW	61072	
RF	61103	
EH	61101	
LO	61108	

Roxbury Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
RB	61107	PH	61111
NK	61114	GR	61115
JM	61020	JB	61115
KN	61032	JH	61008
AE	61108	CR	65788
RF	61108	RT	54235
WM	61108	BO	53563
RN	61104	MP	61008
LB	61108	JR	61101
RD	61084	DS	61107
DS	48221	RC	33982
TK	61114	RD	61108
JO	61109	CW`	61020
JP	61108	HF	61008
LA	62226	BN	61107
DG	61015	RS	61108
TL	61115		
JM	61011		
MM	61008		
NP	75604		
JR	61008		
BR	61111		
JT	61108		
VW	61109		
SW	60651		
LF	61111		
VP	61107		
LE	61108		
SH	61126		
SM	61114		
OF	61132		
CJ	61102		
MZ	61008		
GN	61102		
DS	61104		

Stonecrest Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
AA	61104	LC	92557
PB	61104	DJ	61111
JF	61102	CM	61114
TJ	61104	MP	61008
JO	61102	JS	61103
EP	61109	BC	61108
AP	61102	GJ	61102
MG	61109	MK	61104
AH	61108	RR	61010
FL	61103	TS	61107
DC	61107	TW	61104
MC	61109	DF	61109
IH	61101	DS	61104
BM	61115	KB	61073
JB	61020	ML	61108
OB	61101	RM	61104
JB	61108		
DC	61010		
AR	95126		
JR	61108		
ST	60644		
GJ	61107		
RT	61109		
DL	61104		
CT	61104		

Sycamore Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
WB	60115	TB	60115
BC	60178	MB	60115
SC	60150	CK	60178
CS	60553	DR	60115
BT	60178	RT	60152
LW	55803	MM	61068
RF	60178	BB	60115
EK	61068	PB	60135
BH	99301	MP	60140
RJ	60178	JR	60178
MG	33073	RT	60115
CT	61068	LW	55803
KY	60178	DZ	60115
WA	60113	DD	60115
MC	60115	PE	60109
JN	61068	KK	61020
AS	60178	SH	60129
SZ	60178	DS	60115
IF	60115		
MO	60115		
GS	60115		
DZ	61068		
GG	33782		

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60135	7
60145	2
60146	5
60152	4
61008	57
61011	5
61012	3
61016	5
61038	4
61065	10
Total	102

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