ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Rogers Park Dialysis		
Street Address: 1616 West Glenlake Avenue		
City and Zip Code: Chicago, Illinois 60660		
County: Cook	Health Service Area: 6	Health Planning Area:

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: DaVita Inc.
Street Address: 2000 16th Street
City and Zip Code: Denver, CO 80202
Name of Registered Agent: Illinois Corporation Service Company
Registered Agent Street Address: 801 Stevenson Drive
Registered Agent City and Zip Code: Springfield, IL 62703
Name of Chief Executive Officer: Javier J. Rodriguez
CEO Street Address: 2000 16th Street
CEO City and Zip Code: Denver, CO 80202
CEO Telephone Number: 303-405-2100

Type of Ownership of Applicants

- ☐ 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 they are 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: Kara Friedman
Title: Attorney
Company Name: Polsinelli PC
Address: 150 North Riverside Plaza, Suite 3000, Chicago, Illinois 60606-1599
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

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

Name: Josef Kaplan
Title: Regional Operations Director
Company Name: DaVita Inc.
Address:
Telephone Number: 516-297-2740
E-mail Address: josef.kaplan@davita.com
Fax Number:

Facility/Project Identification

Facility Name: Rogers Park Dialysis		
Street Address: 1616 West Glenlake Avenue		
City and Zip Code: Chicago, Illinois 60660		
County: Cook	Health Service Area: 6	Health Planning Area:

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Total Renal Care, Inc.
Street Address: 2000 16th Street
City and Zip Code: Denver, CO 80202
Name of Registered Agent: Illinois Corporation Service Company
Registered Agent Street Address: 801 Stevenson Drive
Registered Agent City and Zip Code: Springfield, IL 62703
Name of Chief Executive Officer: Javier J. Rodriguez
CEO Street Address: 2000 16th Street
CEO City and Zip Code: Denver, CO 80202
CEO Telephone Number: 303-405-2100

Type of Ownership of Applicants

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

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Name: Josef Kaplan
Title: Regional Operations Director
Company Name: DaVita Inc.
Address:
Telephone Number: 516-297-2740
E-mail Address: josef.kaplan@davita.com
Fax Number:

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: Kara Friedman
Title: Attorney
Company Name: Polsinelli PC
Address: 150 North Riverside Plaza, Suite 3000, Chicago, Illinois 60606-1599
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Stein Acquisitions/Cabanban Properties, LLC
Address of Site Owner: 980 North Michigan Avenue, Suite 1280, Chicago, Illinois 60611
Street Address or Legal Description of the Site: 1616 West Glenlake Avenue, Chicago, Illinois 60660 LOTS 6 TO 9, BOTH INCLUSIVE, IN THE SUBDIVISION OF THE SOUTH 148 FEET OF THE NORTH 296 FEET OF LOT 2 IN ROSEHILL CEMETERY COMPANY'S SUBDIVISION OF THE SOUTHEAST 'A OF THE NORTHEAST 'A OF SECTION 6, TOWNSHIP 40 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Total Renal Care, Inc.
Address: 2000 16th Street, Denver, Colorado 80202

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

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

Organizational Relationships

Provide (for each 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 #2006-5 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 #2006-5 **(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 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

DaVita Inc. and Total Renal Care, Inc., (collectively, the "Applicants" or "DaVita") seek authority from the Illinois Health Facilities and Services Review Board (the "State Board") to establish a 12-station dialysis clinic to be located at 1616 West Glenlake Avenue, Chicago, Illinois 60660. The proposed dialysis clinic will include approximately 7,410 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 be 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	$1,020,000	$396,000	$1,416,000
Modernization Contracts			
Contingencies	$102,000	$39,600	$141,600
Architectural/Engineering Fees	$93,684	$36,667	$130,351
Consulting and Other Fees	$57,816	$22,446	$80,262
Movable or Other Equipment (not in construction contracts)	$551,772	$95,662	$647,434
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,989,627	$781,639	$2,771,266
Other Costs To Be Capitalized	$63,128		$63,128
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$3,878,027**	**$1,372,014**	**$5,250,041**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$1,888,400	$590,375	$2,478,775
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,989,627	$781,639	$2,771,266
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$3,878,027**	**$1,372,014**	**$5,250,041**

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 $2,518,574.

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): October 31, 2021

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment 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 [Section 1130.620(c)]

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

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization NOT APPLICABLE

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of DaVita Inc.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Michael D. Staffieri	James K. Hilger
PRINTED NAME	PRINTED NAME
Chief Operating Officer, DaVita Kidney Care	Chief Accounting Officer
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 23rd day of October 2019	Notarization: Subscribed and sworn to before me this 24th day of October 2019
Signature of Notary	Signature of Notary
Seal: KATHY CONNOR NOTARY PUBLIC STATE OF COLORADO NOTARY ID 20064018112 MY COMMISSION EXPIRES APRIL 28, 2021	Seal: NICOLE BRUMMOND NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 10-07-23 155636

*Insert EXACT legal name of the applicant

CERTIFICATION

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

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole 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 Total Renal Care, Inc. * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Michael D. Staffieri	James K. Hilger
PRINTED NAME	PRINTED NAME
President	Chief Accounting Officer and Treasurer
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 23rd day of October 2019	Notarization: Subscribed and sworn to before me this 24th day of October, 2019
Signature of Notary	Signature of Notary
Seal	Seal

KATHY CONNOR
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20064018112
MY COMMISSION EXPIRES APRIL 29, 2021

NICOLE BRUMMOND
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
10-07-23
155636

*Insert EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.**

5. 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 that the information was 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.

Criterion 1110.110(b) & (d)

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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 Staff 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 1110.120 - 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 and it shall include the basis used for determining the space and the methodology applied.**

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 and certified by the facility's Medical Director.

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

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

   d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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	MEET 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 (GSF) 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 is 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.

SECTION V. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

F. Criterion 1110.230 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service 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
1110.230(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.230(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.230(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.230(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2300(b)(5) - Planning Area Need - Service Accessibility	X		
1110.230(c)(1) - Unnecessary Duplication of Services	X		
1110.230(c)(2) - Maldistribution	X		
1110.230(c)(3) - Impact of Project on Other Area Providers	X		
1110.230(d)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.230(e) - Staffing	X	X	
1110.230(f) - Support Services	X	X	X
1110.230(g) - Minimum Number of Stations	X		
1110.230(h) - Continuity of Care	X		
1110.230(i) - Relocation (if applicable)	X		
1110.230(j) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 23, 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 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 1110.230(i) - Relocation of an in-center hemodialysis facility.

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)**

VI. 1120.120 - AVAILABILITY OF FUNDS

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

$2,478,775	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$2,771,266	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.
$5,250,041	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 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 34, 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.

	Historical 3 Years			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.

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

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

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 37.

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 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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 39.

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

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for DaVita Inc. and Total Renal Care, Inc. (collectively, the "Applicants" or "DaVita") are attached at Attachment – 1.

Total Renal Care, Inc. will be the operator of Rogers Park Dialysis. Rogers Park Dialysis is a trade name of Total Renal Care, Inc. and is not separately organized.

As the person with final control over the operator, DaVita Inc. is named as an applicant for this CON application. DaVita Inc. does not do business in the State of Illinois. A Certificate of Good Standing for DaVita Inc. from the state of its incorporation, Delaware, is attached.

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SIXTEENTH DAY OF AUGUST, A.D. 2018.

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

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

Jeffrey W. Bullock, Secretary of State

2391269 8300

SR# 20186216280

Authentication: 203263018

Date: 08-16-18

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

Attachment - 1

File Number 5823-002-2

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

TOTAL RENAL CARE, INC., INCORPORATED IN CALIFORNIA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 10, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 19TH *day of* NOVEMBER *A.D.* 2019 .

Authentication #: 1932302458 verifiable until 11/19/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White
SECRETARY OF STATE

Attachment - 1

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

The letter of intent between Stein Acquisitions LLC/Cabanban Properties and Total Renal Care, Inc. to lease the property located at 1616 West Glenlake Avenue, Chicago, Illinois 60660 is attached at Attachment – 2.

CUSHMAN & WAKEFIELD
225 West Wacker Drive, Suite 3000
Chicago, IL 60606
Web: www.cushmanwakefield.com

November 6, 2019

Mr. Andy Stein
Clark Street Real Estate
980 N Michigan Ave Suite 1280
Chicago, IL 60611

RE: LOI – 1616 W Glenlake Ave, Chicago, IL 60660

Mr. Stein:

Cushman & Wakefield ("C&W") has been authorized by Total Renal Care, Inc. a subsidiary of DaVita, Inc. to assist in securing a lease requirement. DaVita, Inc. is a Fortune 200 company with revenues of approximately $13 billion. They operate 2,278 outpatient dialysis centers across the US and 124 in 10 countries outside the US.

Below is the proposal outlining the terms and conditions wherein the Tenant is willing to lease the subject premises:

PREMISES:	To be constructed building at 1616 W Glenlake Ave, Chicago, IL 60660
TENANT:	Total Renal Care, Inc. or related entity to be named
GUARANTY:	DaVita, Inc.
LANDLORD:	An entity that will be a joint venture between Stein Acquisitions LLC and Cabanban Properties
SPACE REQUIREMENTS:	Requirement is for approximately 7,410 SF of ground floor contiguous rentable square feet. Tenant shall have the right to measure space and final measurement standards will be agreed to by parties.
PRIMARY TERM:	15 years
BASE RENT:	$37.56 PSF, NNN with ten percent (10%) increases every 5 years during the term and any options.
ADDITIONAL EXPENSES:	It is the intention of the Landlord that this Lease is "absolute NNN" and accordingly Tenant shall be responsible for all charges related to the use and operation of the Premises during the term, including (without limitation) all utility charges, real estate taxes, assessments, maintenance charges for the premises, and liability/property insurance.
LANDLORD'S MAINTENANCE:	Landlord, at its sole cost and expense, shall be responsible for the structural components of the Property (to be further defined in lease). Tenant at its sole cost and expense shall maintain and keep in good order and repair (including sweeping, salting, snow, and ice removal) to the (i) parking areas, sidewalks, loading areas, and drive aisles serving the building and (ii)

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all landscaping locate on the premises and (iii) all common areas and (iv) alley's surrounding the site

POSSESSION AND RENT COMMENCEMENT: Landlord shall deliver Possession of the Premises to the Tenant upon the latter of: completion of Landlord's required work (if any) or mutual lease execution. Rent Commencement shall be the earlier of five (5) months from Landlord's substantial completion of the shell and MBBI. Landlord and Tenant shall work together to save time while Landlord is constructing the building shell and will consider any and all time saving methods for faster completion and delivery of the space to the Tenant.

LEASE FORM: Tenant's standard lease form that will conform to the Garfield Park lease as a starting point for negotiations.

USE: The operation of an outpatient renal dialysis clinic, renal dialysis home training, aphaeresis services and similar blood separation and cell collection procedures, general medical offices, clinical laboratory, including all incidental, related and necessary elements and functions of other recognized dialysis disciplines which may be necessary or desirable to render a complete program of treatment to patients of Tenant and related office and administrative uses or for any other lawful purpose.

The property is zoned B3-2 and medical is a permitted use in this zoning classification.

PARKING: Please see the attached Exhibit B site plan

BASE BUILDING: Landlord, at Landlord's expense, shall deliver to the premises the Base Building improvements included in the attached Exhibit C, subject to Tenant's architect and project manager approval.

Landlord will make reasonable efforts to coordinate early access for tenant improvements with Tenant's project manager once the building slab is poured, under roof, and exterior walls are up.

OPTION TO RENEW: Tenant desires two, five-year options to renew the lease. Option rent shall be increased by 10% after Year 15 of the initial term and following each successive five-year option periods, so long as tenant is not in default of the lease.

FAILURE TO DELIVER PREMISES: If Landlord has not delivered the premises to Tenant with all base building items substantially completed 270 days after Landlord acquires property and all necessary approvals and permits Tenant may receive one day of rent abatement for every day of delay beyond the 270 day delivery period.

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HOLDING OVER:	Tenant shall be obligated to pay 110% for the then current rate.
TENANT SIGNAGE:	Tenant shall have the right to install building and monument signage at the Premises at Tenant's cost, subject to compliance with all applicable laws and regulations.
SUBLEASE/ASSIGNMENT:	Tenant will have the right at any time to sublease or assign its interest in this Lease to any majority owned subsidiaries or related entities of DaVita, Inc. Inc. with the consent of the Landlord, whose consent shall not be unreasonably held or delayed.
ROOF RIGHTS:	Tenant shall have the right to place a satellite dish on the roof at no additional fee. Installation to be performed by mutually agreed upon contractor so as not damage roof or violate roof warranty. Tenant shall be responsible for its own permits.
NON-COMPETE:	Landlord agrees not to lease space to another dialysis provider within a five mile radius of Premises.
HVAC:	As part of Landlord's work, Landlord shall provide HVAC units meeting the specifications set forth in Exhibit C or provide an HVAC allowance.
DELIVERIES:	To be determined, see attached 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 seven (7) months from the latter of an executed LOI or subsequent filing date. 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

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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 within seven (7) months from the latter of an executed LOI or subsequent filing date 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 Cushman & Wakefield ("C&W") as the Tenant's local representative and shall pay a brokerage fee equal 2% of the base rent over the initial 10 year period, 50% shall be due upon receipt of a fully executed lease and satisfaction of all contingencies (including CON) and 50% payable upon Tenant's certificate of occupancy receipt and payment of first month's rent.

CONTINGENCIES: This proposal is subject to the Landlord securing and closing on the subject parcel and timing is subject to all necessary governmental approval.

In the event the Landlord is not successful in obtaining all necessary approvals including, but not limited to, zoning and use, the Tenant shall have the right, but not the obligation to terminate the lease.

It should be understood that this proposal is subject to the terms of Exhibit A attached hereto. Please complete and return the Potential Referral Source Questionnaire in Exhibit D. 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,

Matthew J. Gramlich
CC: DaVita Regional Operations

CUSHMAN & WAKEFIELD

SIGNATURE PAGE

LETTER OF INTENT: **1616 W GLENLAKE AVE, CHICAGO, IL 60660**

AGREED TO AND ACCEPTED THIS 14 DAY OF NOVEMBER 2019

By: _____

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

AGREED TO AND ACCEPTED THIS ____ DAY OF NOVEMBER 2019

By: _____

_____
("Landlord")

CUSHMAN & WAKEFIELD

SIGNATURE PAGE

LETTER OF INTENT: **1616 W GLENLAKE AVE, CHICAGO, IL 60660**

AGREED TO AND ACCEPTED THIS ____ DAY OF NOVEMBER 2019

By: _____

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

By: STEIN ACQUISITIONS / CABANBAN PROPERTIES LLC

AUTHORIZED SIGNATORY.

("Landlord")

CUSHMAN & WAKEFIELD

EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPERATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT NEITHER TENANT NOR LANDLORD (OR C&W) 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 C&W 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. C&W 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 C&W 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.

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EXHIBIT B – SITE PLAN

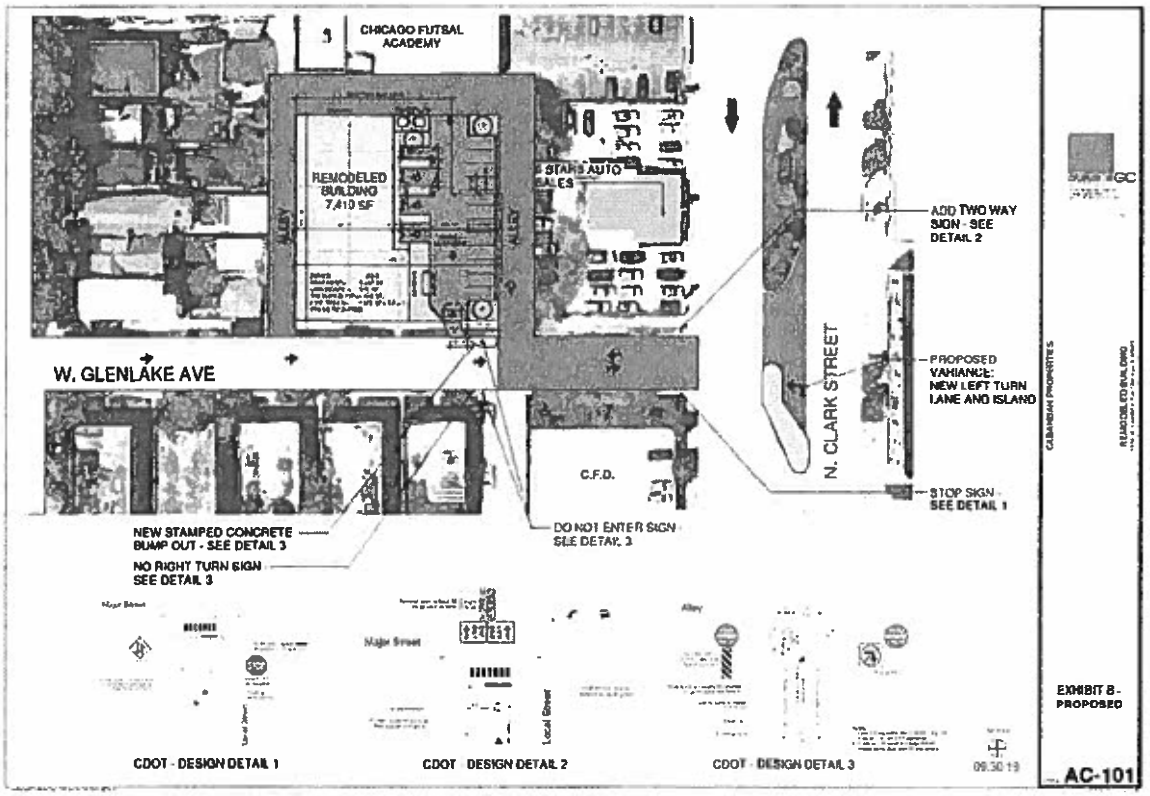

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EXHIBIT C – WORK LETTER

DaVita.

OPTION 1 FOR NEW BUILDING V5.1
[SUBJECT TO MODIFICATION BASED ON INPUT FROM TENANT'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

SCHEDULE A - TO WORK LETTER

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

(Note: Sections with an Asterisk (*) have specific requirements for T 1.2 in California and other select States – see end of document for changes to that section)

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

All MBBI work completed by the Landlord will need to be coordinated and approved by the Tenant 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, barrier-free regulations, energy codes, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Landlord'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 Tenant Improvement plans and specifications.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic without the need for special-use approval by the AHJ. Landlord to provide all permitting related to the base building and site improvements.

3.0 - Common Areas N/A

4.0 Foundation and Floor

The foundation and floor of the building is existing and will be modified to conform to the approved site plan in accordance with local code requirements. The foundation shall be designed by the Landlord's engineer to accommodate site specific climate and soil conditions and recommendations per the Landlord's soil engineering and exploration report (to be reviewed and approved by Tenant's engineer).

A new footing and foundation wall will be installed on the East side of the reconfigured building as reflected in the approved building and site plan. 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 up to finish floor at a minimum. 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 existing concrete floor shall be reutilized in the building. Patching of the existing slab by the Landlord at the new utility locations and at the reconfigured East building wall is anticipated. Patching will include one of the following, wire mesh or fiber mesh, and/or rebar reinforcement over a 10 mil minimum vapor barrier and granular fill per Landlord's soils and/or structural engineering team based on soil conditions and report from the Soils Engineer. Floor is existing with areas of new and old patching. Landlord will clean up the existing slab by disk sanding, filling and making the floor transitions smooth and broom clean with no adhesive residues, in a condition that is acceptable to install floor coverings in accordance with the flooring manufacturer's specifications. (NOTE: Recommend site meeting with Jim B. to review the existing floor slab conditions and to determine what repairs might be needed) – OK - Concrete floor shall be constructed so that no more 90% relative humidity 3lbs of moisture per 1,000 sf/24 hours is emitted per completed RH testing (ASTM F2170-11, 'Standard Test Method for Determining Relative Humidity in Concrete Floor Slabs Using in situ Probes') results after 28 day cure time. Relative humidity testing to be performed by Tenant at Tenant's sole cost. Methods to achieve this level will be responsibility of the Landlord and may preclude the requirement for Tenant's third party testing (TBD IF APPLICABLE). All utility trenches installed by Tenant's general contractor to be backfilled and compacted using approved granular material specification of the Landlord's general contractor testing consultant. Under slab plumbing shall be installed by Tenant's General Contractor

5.0 - Structural

The existing building structure is composed of bar joists, steel beams, and a gypsum deck roofing which is to remain in it's existing condition. The clear height to the bottom of the steel beams at 11'-5" above the existing concrete floor. The bottom of the gypsum deck is at approximately 13' above the floor. Existing columns will remain in their current condition and two columns will be added to eliminate the masonry bearing wall (running East/West) at the center point in the existing building. The existing building will be reduced in size to meet the new TI layout by demolishing the Eastern portion of the structure and adding a new footing, foundation, and exterior wall to re-enclose the building. 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 or 5) HVAC roof top openings, one (1) roof hatch opening, and four (4) exhaust fans openings).

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 code requirements. If no fire rating is required, interior of walls shall be left as exposed and until Tenants completes any and all work with-in walls on the interior side of the exterior walls. Landlord shall be responsible for interior metal stud furring/framing, mold- and

moisture-resistant glass mat board, mold- and moisture-resistant gypsum board, taping and finishing on the interior side of all exterior walls.

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. 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 Landlord for the duration of the lease. Landlord to provide Tenant copy of material and labor roof warranty for record.

9.0 – Parapet

Landlord to provide a parapet wall, if required by municipality, 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

Please see attached exhibit. Perimeter wall systems are existing except the proposed new East wall. The East wall to be signed off by a Landlord's Structural Engineer. The existing North, West, and South (Glenlake elevations) are existing. Landlord anticipates cosmetic improvements to the South wall to upgrade the appearance (NOTE: scope yet to be defined). The West and North walls face the existing alleys and will have joints repaired and walls painted. Wall system "R" value must meet current Energy code. Wall system options for the new East wall include, but not limited to:

Minimum 3-inch drainable exterior insulating fenestration system (EIFS) on water-vapor barrier on ¾-inch thick glass matt sheathing, AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring on continuous insulation/weather-barrier, system on 6" 16- or 18-ga metal stud framing

Or

Minimum 3-inch drainable exterior insulating fenestration system (EIFS), AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring on continuous insulation/weather-barrier system, on water-vapor barrier on 8-inch or 12-inch thick concrete masonry wall construction with 3½-inch 20-ga metal stud furring.
Or if required by local municipality

Brick or split face block Veneer on engineered 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.

11.0 - Canopy

Per a mutually agreeable design on the awning with an allowance being provided to the Tenant from the Landlord not to exceed $10,000.

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12.0 – Waterproofing and Weatherproofing

Landlord 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. Landlord 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. Landlord shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

13.0 - Windows

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

14.0 - Thermal Insulation

All new exterior walls to have a vapor barrier and insulation that meets or exceeds the local and national energy codes. Existing perimeter walls to have insulation installed to meet the current codes in the event that they do not comply. The R-value to be determined by the size of the stud cavity, if installed on the interior of the wall and should extend from finish floor to bottom of floor or ceiling deck. Should the insulation be installed on the exterior side of the wall sheathing, insulation shall extend from finish floor to the top of the parapet. 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 Yale 8800 Series, Grade 1 mortise lockset or better). Doors shall meet all barrier-free requirements including but not limited to American Disability Act (ADA), and State Department of Health requirements. Landlord shall change the keys (reset tumblers) on all doors with locks after construction, but prior to commencement of the Lease, and shall provide Tenant with a minimum of three (3) sets of keys. Final location of doors to be determined by Tenant architectural floor plan and shall be coordinate with Tenant's Architect. At a minimum, the following doors, frames and hardware shall be provided by the Landlord:

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

- Service Doors: Provide a 60" or 72"-inch wide double doors (with 1 - 24" and 1 - 36" leaf or 2- 36" leafs), b) 60" Roll up door,) with 20 gauge insulated hollow metal , painted with rust inhibiting paint, Flush bolts, T astragal, heavy duty aluminum threshold, continuous hinge each leaf, door viewer (peep), panic bar hardware (if required by code), push button programmable lockset,
- Teammate Entry Doors: Provide a minimum 36-inch wide, 20-ga, insulated, hollow metal door and thermally-broken, welded, 20-ga hollow-metal frame (both finished with rust-inhibiting paint) with programmable keypad lockset, heavy-duty hinges, aluminum threshold, surface closer, and concealed-overhead stop.

- Emergency Egress Doors: Provide minimum 42" wide door with 20 gauge insulated hollow metal door both painted with rust-inhibiting paint, AND/OR (where indicated by Lessee's Architect) a

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minimum 42-inch wide aluminum/glass door and aluminum storefront frame, with exit-only panic bar locking hardware, hinges, surface-closer and concealed-overhead stop.

16.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Tenant. Landlord is responsible for all tap/connection and impact fees for all utilities. All Utilities to be coordinated with Tenant's Architect.

17.0 - Plumbing

Landlord to provide a segregated/dedicated potable water supply line that will be sized by Tenant's Engineer based on Tenant's water requirements (not tied-in to any other Tenant 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 preventers 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 Tenant space. The RPZ's and the Meter will be sized to the incoming line, or per water provider or municipality standards. Landlord to provide Tenant with the most recent site water flow and pressure test results (gallons per minute and psi) for approval. Landlord shall perform water flow and pressure test prior to lease execution. Landlord shall stub the dedicated water line into the Tenant lease space per location coordinated by Tenant.
Provide exterior (anti-freeze when required) hose bibs (minimum of 2) in locations approved by Tenant.

Building sanitary drain size will be determined by Tenant'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 Tenant 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 Tenant's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Tenant's sanitary system design per Tenant's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

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

A Sprinkler System will be installed.. Landlord shall design and install a complete turnkey sprinkler system 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 Tenant's potable water line requirements, or as required by local municipality or water provider. Landlord shall provide all municipal (or code authority) approved shop drawings, service drops and sprinkler heads at heights per Tenant'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 Tenant's engineer dependent on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire to a distribution panel board in the Tenant's

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utility room (location to be per Code and coordinated with Tenant and their Architect) for Tenant's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Landlord'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 panel board with main and branch circuit breakers, and electrical service and building grounding per NEC. Tenant'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 panel board.

Landlord will provide up to 5 sub panels that can accommodate up to 42 circuits based on the Electrical Engineers design.

If Tenant so chooses to require an Emergency Transfer Switch hook-up for a temporary generator, Tenant will advise prior to completion of the bid documents and Landlord will provide one at Landlord costs per Tenants Electrical design.

Landlord to provide main Fire Alarm Control panel that serves the Tenant space and will have the capacity to accommodate devices in Tenant space based on Fire Alarm system approved by local authority having jurisdiction. Landlord'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 run to HVAC units per design drawings. Clinic shall be individually metered and sized per demand by Engineer. Additional electrical service capacity will be required if natural gas service is not available to the building.

21.0 - Mechanical /Heating Ventilation Air Conditioning

Landlord to be responsible for all costs for the HVAC system based on the below criteria. At Tenant's option, Landlord will provide an agreed upon allowance to the Tenant in the amount of $8.00/SF for the HVAC unit installation. Allowance to include installation of units, gas piping, electrical power wiring, and electrical control wiring. Landlord will install Tenant's HVAC curbing and steel support during the roofing installation and cap the openings until the Tenant contractor mobilizes on site.

Tenant will be responsible for the design, procurement and installation of the HVAC system.
The criteria is as follows:

- Equipment to be Lennox 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 Tenant's demands for a dialysis facility and the base building Shell loads.
- Units to include Power Exhaust
- Control system must be capable of performing all items outlined in the Sequence of Operations specification section
- RTU controller shall be compatible with a Building Management System

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- RTU Ductwork drops shall be concentric for air distribution until Tenant's General Contractor modifies distribution to align with Tenant's fit-out design criteria and layout and shall be extended 5' into the space for supply and return air. Extension of system beyond 5-feet shall be by Tenant's General Contractor.
- System to be a fully ducted return air design and will be by Tenant's General Contractor for the interior fit-out
- All ductwork to be externally lined except for the drops from the units.
- Provide 100% enthalpy economizer

using BACnet communication protocol.

- 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 at unit
- 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, coordination with Building Management System supplier, temporary construction thermostats, start-up and commissioning. 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). Tenant's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Tenant's design criteria and local and state codes.

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

22.0 - Telephone

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

23.0 - Cable TV

Landlord shall provide a single 2" PVC underground conduit entrance into Tenant utility room to serve as chase way for new cable television service. Entrance conduit location shall be coordinated with Tenant. Tenant 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. Landlord shall reasonably cooperate and grant "right of access" with Tenant'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. Landlord shall comply with all ADA regulations affecting the Building and entrance to Tenant space including, but not limited to exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, detectable warnings, parking lot striping for three (3)dedicated handicap stalls inclusive of pavement

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markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways. This will be approved along with final site plan.

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

25.0 - Exiting

Landlord shall provide at all exterior exit doors safety lights, exterior service lights, exit sign and emergency lights 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

Landlord to provide Tenant 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 Tenant 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 Tenant 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 Landlord 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

Landlord to provide a minimum 6" thick reinforced concrete pad approx. 100 to 150SF based on approved site plan and Tenant'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

Landlord to allow a generator to be installed onsite if required by code or Tenant chooses to provide one at Tenants costs. Tenant's cost to include Kirk key to be built into main electrical switch gear as required

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to allow generator to function. Tenant to advise if a generator will be desired for this location prior to the completion of the bid documents.

29.0 - Site Lighting

Landlord to provide adequate lighting per code and to illuminate all parking, pathways, and building access points readied for connection into Tenant power panel. Location of pole fixtures per Landlord civil plan to maximize illumination coverage across site. Parking lot lighting to include timer (to be programmed per Tenant hours of operation) or a photocell.

30.0 - Exterior Building Lighting

Landlord 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 Landlord 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 curbs or 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

Landlord will allow at Tenant's cost to install an illuminated monument site sign as well as facade mounted sign which will include electrical to both Final sign layout to be provided and approved by Landlord and City.

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

The Illinois Certificate of Good Standing for Total Renal Care, Inc. is attached at Attachment – 3.

File Number 5823-002-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

TOTAL RENAL CARE, INC., INCORPORATED IN CALIFORNIA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 10, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 19TH *day of* NOVEMBER *A.D.* 2019 .

Authentication #: 1932302458 verifiable until 11/19/2020
Authenticate at: http://www.cyberdriveillinois.com

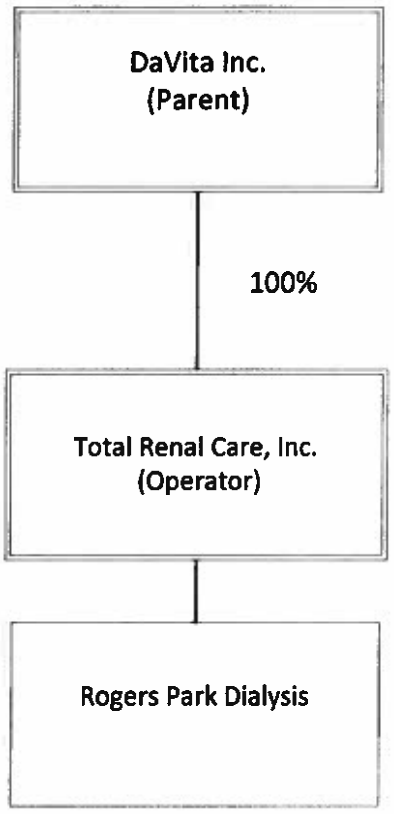
Jesse White

SECRETARY OF STATE

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

The organizational chart for DaVita Inc., Total Renal Care, Inc. and Rogers Park Dialysis is attached at Attachment – 4.

Rogers Park Dialysis
Organizational Chart



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

The site of the proposed dialysis clinic complies with the requirements of Illinois Executive Order #2006-5. The proposed dialysis clinic will be located at 1616 West Glenlake Avenue, Chicago, Illinois 60660. As shown in the documentation from the FEMA Flood Map Service Center attached at Attachment – 5. The interactive map for Panel 17031C0410J reveals that this area is not included in the flood plain.

National Flood Hazard Layer FIRMette

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) Zone A, V, A99
- With BFE or Depth Zone AE, AO, AH, VE, AR
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile Zone X
- Future Conditions 1% Annual Chance Flood Hazard Zone X
- Area with Reduced Flood Risk due to Levee. See Notes. Zone X
- Area with Flood Risk due to Levee Zone D

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard Zone X
- Effective LOMRs
- Area of Undetermined Flood Hazard Zone D

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 Cross Sections with 1% Annual Chance
- 17.5 Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 11/18/2019 at 10:23:03 AM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

Attachment - 5

#20-05

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

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

POLSINELLI

150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312.819.1900

November 26, 2019

Anne M. Cooper
(312) 873-3606
(312) 276-4317 Direct Fax
acooper@polsinelli.com

Via Federal Express

Robert F. Appleman
Deputy State Historic Preservation Officer
State Historic Preservation Office
Illinois Department of Natural Resources
Attn: Review & Compliance
1 Old State Capitol Plaza
Springfield, Illinois 62701

Re: Historic Preservation Act Determination – Rogers Park Dialysis

Dear Mr. Appleman:

This office represents DaVita Inc. and Tovell Dialysis, LLC (the "Requestors"). Pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act, Requestors seek a formal determination from the Illinois Historic Preservation Agency as to whether Requestors' proposed project to establish a twelve station dialysis clinic to be located at 480 – 490 North Independence Boulevard, Romeoville, Illinois 60446 (the "Proposed Project") affects historic resources.

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 twelve station dialysis clinic to be located at 480 – 490 North Independence Boulevard, Romeoville, Illinois 60446. The site of the Proposed Project will be located on a currently vacant lot and will involve construction of a new building that will house the dialysis center.

2. Topographical or Metropolitan Map

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

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3. Historic Architectural Resources Geographic Information System

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

4. Photographs of Standing Buildings/Structure

Photographs of the site of the proposed dialysis clinic are attached at Attachment 3.

5. Addresses for Buildings/Structures

The Proposed Project will be located at 480 – 490 North Independence Boulevard, Romeoville, Illinois 60446.

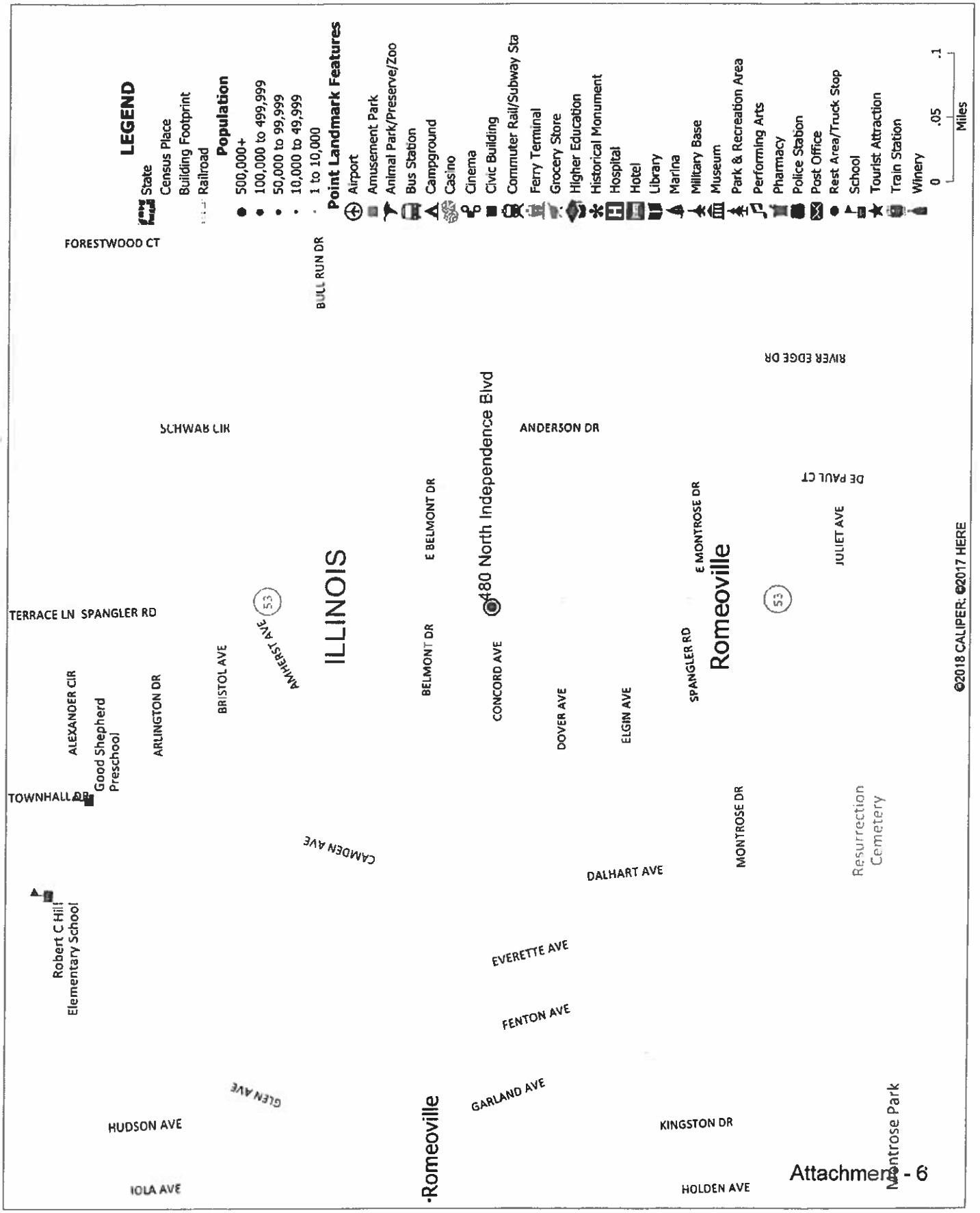
Thank you for your time and consideration of our request for Historic Preservation Determination. If you have any questions or need any additional information, please feel free to contact me at 312-873-3606 or acooper@polsinelli.com

Sincerely,

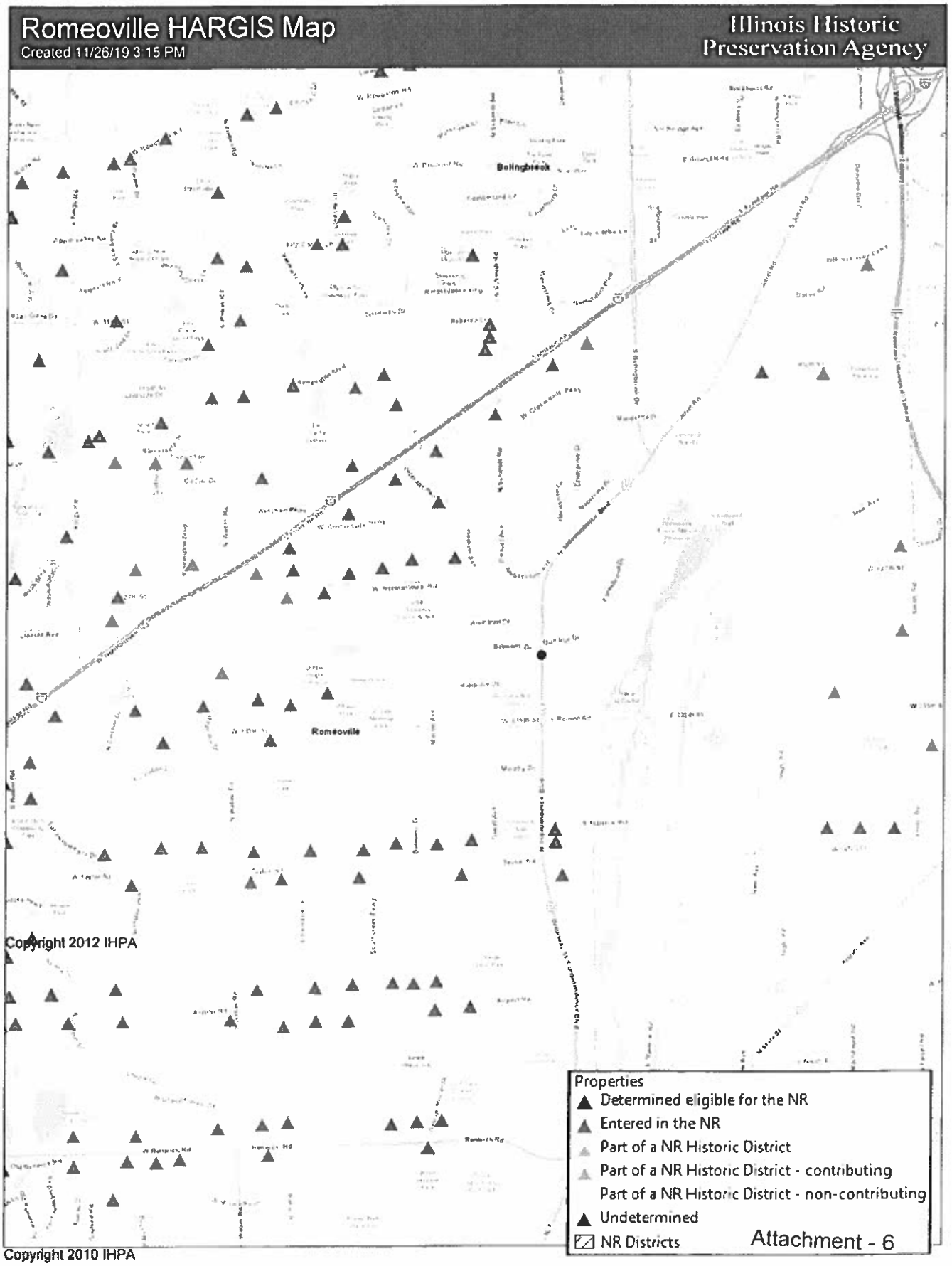
A. M. Cooper

Anne M. Cooper

Attachments



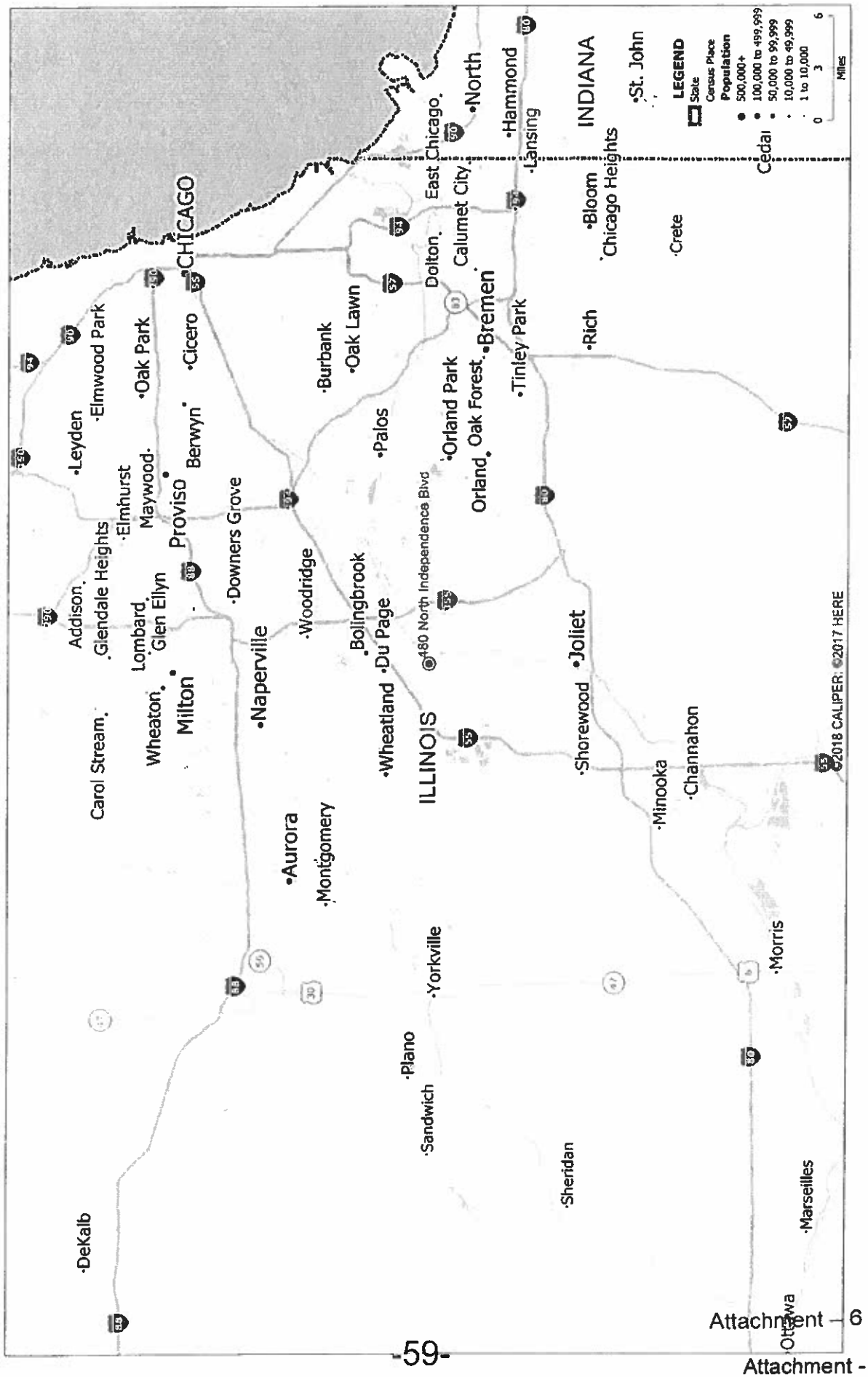
Attachment - 6



Attachment - 2

Attachment – 6

Attachment - 1



Attachment – 6

Attachment - 1

Google Maps 476 IL-53

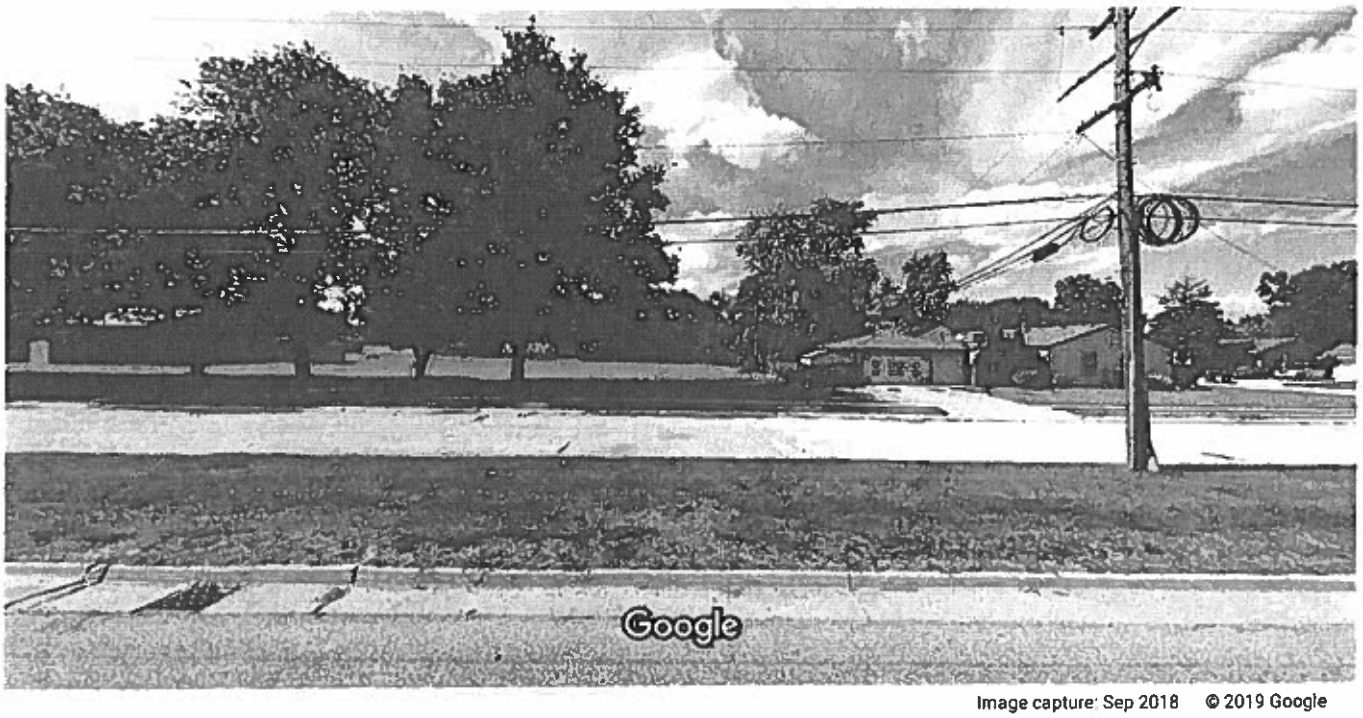


Image capture: Sep 2018 © 2019 Google

Romeoville, Illinois

Google

Street View - Sep 2018

Attachment – 6

Attachment - 3

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	$1,020,000	$396,000	$1,416,000
Contingencies	$102,000	$39,600	$141,600
Architectural/Engineering Fees	$93,684	$36,667	$130,351
Consulting and Other Fees	$57,816	$22,446	$80,262
Moveable and Other Equipment			
Communications	$104,157		$104,157
Water Treatment	$157,400		$157,400
Bio-Medical Equipment	$15,941		$15,941
Clinical Equipment	$247,624		$247,624
Clinical Furniture/Fixtures	$26,650		$26,650
Lounge Furniture/Fixtures		$3,855	$3,855
Storage Furniture/Fixtures		$7,162	$7,162
Business Office Fixtures		$35,645	$35,645
General Furniture/Fixtures		$33,800	$33,800
Signage		$15,200	$15,200
Total Moveable and Other Equipment	$551,772	$95,662	$647,434
Fair Market Value of Leased Space	$1,989,627	$781,639	$2,771,266
Other Costs to be Capitalized			
Back Up Generator	$15,000		$15,000
Life Safety Systems	$32,085		$32,085
Sprinkler System	$16,043		$16,043
Total Other Costs to be Capitalized	$63,128		$63,128
Total Project Costs	**$3,878,027**	**$1,372,014**	**$5,250,041**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$1,888,400	$590,375	$2,478,775
Fair Market Value of Leased Space	$1,989,627	$781,639	$2,771,266
Total Source of Funds	**$3,878,027**	**$1,372,014**	**$5,250,041**

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

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Modernization Contracts	$1,020,000	$396,000	$1,416,000
Contingencies	$102,000	$39,600	$141,600
Architectural/Engineering Fees	$93,684	$36,667	$130,351
Consulting and Other Fees	$57,816	$22,446	$80,262
Moveable and Other Equipment			
Communications	$104,157		$104,157
Water Treatment	$157,400		$157,400
Bio-Medical Equipment	$15,941		$15,941
Clinical Equipment	$247,624		$247,624
Clinical Furniture/Fixtures	$26,650		$26,650
Lounge Furniture/Fixtures		$3,855	$3,855
Storage Furniture/Fixtures		$7,162	$7,162
Business Office Fixtures		$35,645	$35,645
General Furniture/Fixtures		$33,800	$33,800
Signage		$15,200	$15,200
Total Moveable and Other Equipment	$551,772	$95,662	$647,434
Fair Market Value of Leased Space	$1,989,627	$781,639	$2,771,266
Other Costs to be Capitalized			
Back Up Generator	$15,000		$15,000
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Total Source of Funds	**$3,878,027**	**$1,372,014**	**$5,250,041**

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

The Applicants anticipate project completion within approximately **18** months of project approval.

Section I, Identification, General Information, and Certification
Current Projects

DaVita Current Projects			
Project Number	**Name**	**Project Type**	**Completion Date**
17-014	Rutgers Park Dialysis	Establishment	09/30/2020
17-016	Salt Creek Dialysis	Establishment	12/31/2019
17-029	Melrose Village Dialysis	Establishment	07/31/2020
17-049	Northgrove Dialysis	Establishment	07/31/2019
17-062	Auburn Park Dialysis	Establishment	02/29/2020
17-063	Hickory Creek Dialysis	Establishment	11/30/2019
17-068	Oak Meadows Dialysis	Establishment	04/30/2020
18-001	Garfield Kidney Center	Relocation	06/30/2020
18-017	Marshall Square Dialysis	Establishment	07/31/2020
18-037	Cicero Dialysis	Establishment	01/31/2021
18-048	Sauganash Dialysis	Establishment	04/30/2021
19-051	Driftwood Dialysis	Expansion	01/31/2021

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

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	$3,878,027	5,320			5,320		
Total Clinical	**$3,878,027**	**5,320**			**5,320**		
NON REVIEWABLE							
Administrative	$1,372,014	2,090			2,090		
Total Non-Reviewable	**$1,372,014**	**2,090**			**2,090**		
TOTAL	**$5,250,041**	**7,410**			**7,410**		

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.110(a), Project Purpose, Background and Alternatives

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. This project is for the establishment of Rogers Park Dialysis, 12-station in-center hemodialysis clinic to be located at 1616 West Glenlake Avenue, Chicago, Illinois.

DaVita 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 2018 Community Care report details DaVita's commitment to quality, patient centric focus and community outreach and was previously included in its Midway Dialysis CON application (Proj. No.19-027). Key initiatives of DaVita which are covered in that report are also outlined below.

Kidney Disease Statistics

37 million or 15% of U.S. adults are estimated to have CKD.[1] Current data reveals troubling trends, which help explain the growing need for dialysis services:

- Between 2016 and 2017, the proportion of Medicare patients with recognized CKD increased from 13.8 percent to 14.5 percent.[2]
- Many studies now show that diabetes, hypertension, cardiovascular disease, higher body mass index, and advancing age are associated with the increasing prevalence of CKD.[3]
- Nearly seven times the number of new patients began treatment for ESRD in 2017 (124,500) versus 1980 (17,901).[4]
- Over thirteen times more patients are now being treated for ESRD than in 1980 (746,557 versus 56,402).[5]
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD; 45% of new ESRD cases have a primary diagnosis of diabetes; 28% have a primary diagnosis of hypertension.[6]

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[1] Centers for Disease Control & Prevention, National Center for Chronic Disease Prevention and Health Promotion, National Chronic Kidney Disease Fact Sheet, 2019 (2019) *available at* https://www.cdc.gov/kidneydisease/pdf/2019_National-Chronic-Kidney-Disease-Fact-Sheet.pdf (last visiting Nov. 15, 2019)

[2] US Renal Data System, 2019 Annual Data Report: Epidemiology of Kidney Disease in the United States Executive Summary, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 7 (2019).

[3] US Renal Data System, 2018 Annual Data Report: Epidemiology of Kidney Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 10 (2018).

[4] US Renal Data System, 2019 Annual Data Report: Epidemiology of Kidney Disease in the United States Executive Summary, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 24 (2019).

[5] Id. at 28.

- Lack of access to nephrology care for patients with CKD prior to reaching end stage kidney disease which requires renal replacement therapy continues to be a public health concern. Timely CKD care is imperative for patient morbidity and mortality. Beginning in 2005, CMS began to collect CKD data on patients beginning dialysis. Based on that data, it appears that little progress has been made to improve access to pre-ESRD kidney care. For example, in 2016, 20.8% of newly diagnosed ESRD patients had not been treated by a nephrologist prior to beginning dialysis therapy. And among these patients who had not previously been followed by a nephrologist, 80% of those on hemodialysis began therapy with a catheter rather than a fistula. Comparatively, only 36% of those patients who had received a year or more of nephrology care prior to reaching ESRD initiated dialysis with a catheter instead of a fistula.[7]

- While the number of patients diagnosed with ESRD increases by 5% each year, mortality rates for ESRD have been declining in the United States over the last two decades, particularly when the changing demographic characteristics are taken into account. ESRD patients have lived well on dialysis for 5-10 years and as long as 20-30 years. Importantly, along with improvements in care of ESRD, hospitalization of ESRD patients is also declining.

DaVita's Quality Initiatives and Awards and Recognition

Quality Initiatives

DaVita has undertaken many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and ESRD. With the ongoing shift from volume to value in healthcare, providers—more than ever—are focusing their attention on generating optimal clinical outcomes in order to enhance patient quality of life. The extensive tools and initiatives that were built into the DaVita Patient-Focused Quality Pyramid help affiliated physicians succeed in this important undertaking. The pyramid serves as a framework for nephrologists to address the complex factors that impact patients, such as mortality, hospitalizations and the patient experience. Complex programs serve as an important tier in the DaVita Patient-Focused Quality Pyramid. They include:

- Clinical initiatives such as preventing missed treatments and managing vascular access, fluid, infection, medications and diabetes.

- Pneumococcal pneumonia and influenza initiatives: Increase pneumonia and influenza vaccination rates.

- Catheter removal: Help patients transition from central venous catheters (CVCs) to arteriovenous (AV) fistulas to reduce risk of hospitalization from infections and blood clots.

- Dialysis transition management: Support patients through any transition of care to improve outcomes and reduce mortality.

DaVita's patient centered quality programs also include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. These programs and others are described below.

Home Dialysis. As a national leader in home dialysis, DaVita continues to introduce initiatives to promote home modalities. DaVita supports patients in electing home dialysis by citing its flexibility and convenience, the ability to maintain employment, and its excellent outcomes. Additional benefits of home dialysis touted by DaVita to encourage patients to elect this modality include:

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[6] US Renal Data System, 2018 Annual Data Report: Epidemiology of Kidney Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 317 (2018).

[7] Id. at 322.

- Being able to dialyze at home
- Shorter dialysis treatment times for patients completing short daily home dialysis
- The ability to maintain an active lifestyle
- The potential for a more liberal diet
- Time saved by not travelling to a dialysis center three (3) days a week.

As evidence of its commitment to providing in-home care, DaVita reported in July 2019 that its peritoneal and home hemodialysis programs were growing at four (4) times the rate of its in-center treatment options.

In support of home care, DaVita instituted a comprehensive care program. The program helps ensure patients have a smooth transition into home dialysis and that they are supported through the process. Home care support includes:

- Extended support during a patient's first month of home dialysis.
- 24/7 nurse availability to help with any questions or concerns.
- Pre-arranged clinic visits for face-to-face meetings with a personalized care team.
- Continuing education reviewed on a regular basis.
- Arrangements for clinic treatment for patients that would like a break from in-home care.
- 24/7 technical support directly from the manufacturer for any machine related problems.
- Access to DaVita Digest, a home dialysis newsletter that's delivered monthly.
- A personalized care team which includes a nephrologist, a home training nurse, a registered dietitian and a social worker.

Prior to starting home dialysis DaVita provides patients with comprehensive, customized home dialysis training. Through this training patients work directly with a home dialysis nurse who provides education, tools and support including instruction on: the proper use of equipment; how to create and maintain a hygienic environment; how to manage supplies; how to handle needles; and how to keep an organized log of treatments. Length of the training program varies based on patient need but typically lasts between three (3) to five (5) weeks. DaVita recently implemented a training model for nurses to become comprehensive health managers for patients with typical co-morbid conditions like diabetes, cardiovascular disease and hypertension, improving patients' chances of continuing dialysis at home.

DaVita also invests in technology to support patients at home. One such example is Home Dialysis Connect™, a suite of technology innovations designed to improve the care experience and outcomes for patients on home dialysis, which includes the following components:

- Home Remote Monitoring, which uses Bluetooth technology to transmit patient vitals to help clinicians get ahead of destabilizing events.
- A telehealth platform, which allows DaVita to conduct online appointments with its patients in the comfort and convenience of their own home.
- DaVita's mobile app supports video visits, customized education, reminders, secure texting and image sharing, allowing consistent and immediate communications with its patients' care teams.

- DaVita uses predictive analytics to help avoid costly hospitalizations and allow patients to stay on home dialysis longer.

DaVita's innovations in supporting home patients shift more care to the home setting. Over the last year, DaVita's home program grew at four (4) times the rate of its outpatient program.

Vively Health. To advance comprehensive care to chronically ill patients, DaVita formed Vively Health (recently rebranded from DaVita Health Solutions). Vively Health provides in-home primary care to the highest risk, chronically ill patients – a group Vively refers to as the nation's Most Vulnerable Patients. (MVPs). MVPs are individuals with an interrelated set of chronic conditions who are frequent utilizers of the emergency room, hospital and greater health care system. Vively offers accessible, comprehensive and coordinated care for these individuals. Vively features include:

- Comprehensive house calls program, including in-home primary care, palliative care, mental and behavioral health support, medication managements and 24/7 clinical access
- Full risk medical group with no up-front or ongoing costs to health plans
- Sophisticated patient selection and predictive analytics to identify the right members based on their expected future condition-related costs
- Primary care physician and specialist friendly approach working alongside local providers to complement care delivery

Vively Health recently announced a five (5) year collaboration with Cerner Corporation in which it will utilize Cerner's technology, including its electronic health record, population health management platform and consumer framework. The single digital health record will be used to increase efficiencies within patients' homes, enhance a clinician's ability to issue spot prior to and during care visits, and provide a more comprehensive picture of an individual's health and financial information. The population health management platform will help providers know, predict and better understand the health of their populations. Use of the consumer framework will support interaction and engagement between patients, providers, and other health care organizations. It will also allow patients to access and have ownership over their health records to further active participation in their care.

To date, Vively Health has seen significant positive outcomes including:

- 91% satisfaction rating;
- 35-40% reduction in hospitalizations;
- 10-15% reduction in emergency room visits; and a
- 10-15% reduction in cost of care.

Improved Access to Kidney Care. To improve access to kidney care services, DaVita and Northwell Health in New York have joint ventured to serve thousands of patients in Queens and Long Island with integrated kidney care. The joint venture will provide kidney care services in a multi-phased approach, including:

- Physician education and support
- Chronic kidney disease education
- Network of outpatient centers
- Hospital services
- Vascular access
- Integrated care
- Clinical research
- Transplant services

The joint venture will encourage patients to better utilize in-home treatment options.

Kidney Smart. DaVita's Kidney Smart program helps to improve intervention and education for pre-ESRD patients. 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 improve patient outcomes and reduce ESRD as follows:

(i) 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,
(ii) Late referral to a nephrologist has been correlated with lower survival during the first 90 days of dialysis, and
(iii) 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. DaVita patients who have attended a Kidney Smart class have had 30 percent fewer hospitalizations and 38 percent fewer missed treatments in their first 90 days on dialysis and are six times more likely to start dialysis on a home modality.

DaVita Clinical Research. DaVita invests in innovation through its research arm, DaVita Clinical Research (DCR). DCR provides a spectrum of services for clinical drug research and device development. In November 2019, DCR presented ten (10) research abstracts at the American Society of Nephrology annual Kidney Week, which included:

- Associations between Body Mass Index, Kt/V and Outcomes among Patients Treated with Peritoneal Dialysis
- Patterns in Emergency Department Visits among American Dialysis Patients.

With access to over 90,000+ chronic kidney disease patients, 188,000+ hemodialysis patients, and 250+ research sites DCR is able to support research and provide meaningful insight aimed at improving clinical outcomes.

DaVita International. DaVita is committed to providing quality healthcare to patients around the world with operations in ten (10) countries.

DaVita Health Tour. On April 23, 2019, DaVita launched its DaVita Health Tour, which visited 18 communities to provide free health screenings and kidney education. The mobile health clinic included:

- Diabetes screenings, including a finger-stick glucose test;
- Biometrics, including blood pressure, height/weight/waist measurement and Body Mass Index (BMI) testing; and
- Personal and confidential patient results.

Access to free diabetes and blood pressure testing is critical to help identify individuals who may have or be at risk for developing CKD since diabetes and high blood pressure are two of the primary causes. CKD is often symptomless in its early stages, so this testing is essential to diagnose the disease early, when it may be possible to slow the progression of disease or stop it altogether.

Nephrology Care Alliance. The Nephrology Care Alliance (NCA) is a physician-led and physician-governed entity backed by DaVita. The alliance, which includes over 600 nephrologists nationally, seeks to reduce high-cost and high-risk incidences for chronic kidney disease patients. NCA has launched pilot programs with performance based incentives to reward high quality CKD care; is currently seeking value

based program partnerships with commercial and Medicare Advantage plans for 2020; and is reviewing CCMI demonstration programs to determine if viable models exist to support the goals of value based kidney care.

IMPACT. 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. Through IMPACT, DaVita's physician partners and clinical team have had proven positive results in addressing the critical issues of the incident dialysis patient. The program has helped improve DaVita's overall gross mortality rate, which has fallen 28% in the last 13 years.

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

Patient Pathways. For more than a decade, DaVita has been investing and growing its integrated kidney care capabilities. Through Patient Pathways, DaVita partners with hospitals to provide faster, more accurate ESRD patient placement to reduce the length of hospital inpatient stays and readmissions. Importantly, Patient Pathways is not an intake program. An unbiased onsite liaison, specializing in ESRD patient care, meets with both newly diagnosed and existing ESRD patients to assess their current ESRD care and provides 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 250 hospitals nationwide through Patient Pathways. Patient Pathways has demonstrated benefits to hospitals, patients, physicians and dialysis centers. Since its creation in 2007, Patient Pathways has impacted over 130,000 patients. The Patient Pathways program reduced overall readmission rates by 18 percent, reduced average patient stay by a half-day, and reduced acute dialysis treatments per patient by 11 percent. Moreover, patients are better educated and arrive at the dialysis clinic 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 clinic. As a result, patients have higher attendance rates, are more compliant with their dialysis care, and have fewer avoidable readmissions.

CKD EHR by Epic. On January 17, 2019, DaVita announced the successful implementation of CKD EHR by Epic. The CKD electronic health record (EHR) system was created alongside Epic, the most widely used and comprehensive health records system, to help improve patient care by transforming the physician information technology (IT) experience. The system was designed to enable better care coordination and increase practice efficiency. The system leverages Epic's interoperability network, Care Everywhere, to share clinical information across health care providers, regardless of which EHR systems other providers use. CKD EHR by Epic also delivers nephrology-specific functionality to support population health management, including a risk stratification model, workflow tools to help manage the progression of CKD and reporting capabilities to identify gaps of care.

Village Health. Since 1996, Village Health has innovated to become the country's largest renal National Committee for Quality Assurance accredited disease management program. VillageHealth's Integrated Care Management ("ICM") services partners with patients, providers and care team members to focus on the root causes of unnecessary hospitalizations such as unplanned dialysis starts, infection, fluid overload and medication management.

VillageHealth ICM services for payers and ACOs provide CKD and ESRD population health management delivered by a team of dedicated and highly skilled nurses who support patients both in the field and on the phone. Nurses use VillageHealth's industry-leading renal decision support and risk stratification software to manage a patient's coordinated needs. Improved clinical outcomes and reduced hospital readmission rates have contributed to improved quality of life for patients. As of 2014, VillageHealth ICM has delivered up to a 25 percent reduction in non-dialysis medical costs for ESRD patients, a 15 percent lower year-one mortality rate over a three-year period, and 48 percent fewer hospital readmissions compared to the Medicare benchmark. Applied to DaVita's managed ESRD population, this represents an annual savings of more than $30 million.

Transplant Education. On April 24, 2019, DaVita introduced its multi-media kidney transplant education resource, Transplant Smart. Transplant Smart is a comprehensive education and support program that includes:

- Motivating peer-to-peer videos intended to help patients learn from others who were once in their position. Topics include everything from "Why transplant?" to "How to find a living donor."
- Compelling animated videos created to inform patients and their loved ones about what to expect during each key step of the transplant process to help reduce their anxiety and increase their confidence.
- An illustrated handbook designed to educate DaVita patients about transplant and help them stay organized during their transplant journey.
- Enhanced guidance and support from a social worker throughout the journey.

DaVita expanded its emphasis on transplant education within its Kidney Smart® program, a no-cost chronic kidney disease education resource that is open to the community. Kidney Smart, which has educated more than 165,000 participants since 2012, now offers pre-emptive transplant education and will also offer post-class text messages with additional transplant education later this year.

On June 6, 2018, DaVita and the University of Chicago Medicine announced the successful implementation of the Transplant Waitlist Support Program. The program's purpose is to help waitlisted patients remain transplant ready by deploying a technology-enabled solution to proactively and electronically exchange patient information between DaVita and the transplant center. Outdated information can cause a patient to be passed over when a transplant opportunity arises.

Dialysis Quality Indicators. 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.

Pharmaceutical Compliance. 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 helped improve outcomes by delivering medications to dialysis centers or to patients' homes, making it easier for patients to keep up with their drug regimens. DaVita Rx patients have medication adherence rates greater than 80%, almost double that of patients who fill their prescriptions elsewhere, and are correlated with 40% fewer hospitalizations.

Awards and Recognition

- Five Star Quality Ratings. DaVita led the industry for the fourth year by meeting or exceeding Medicare standards in the Centers for Medicare and Medicaid Services ("CMS") Five-Star Quality Rating System ("Five Star"). DaVita had more three, four and five star clinics than it has ever had in the history of the program.

- Quality Incentive Program. DaVita ranked first in outcomes for the fourth straight year in the CMS end stage renal disease ("ESRD") Quality Incentive Program. The ESRD QIP reduces payments to dialysis clinics that do not meet or exceed CMS-endorsed performance standards. DaVita outperformed the other ESRD providers in the industry combined with only 11 percent of clinics receiving adjustments versus 23 percent for the rest of the industry.

- Coordination of Care. On September 5, 2018, America's Physician Groups (APG), formerly CAPG, the leading association in the country representing physician organizations practicing capitated, coordinated care, awarded two of DaVita's medical groups - HealthCare Partners in California and The Everett Clinic in Washington - its Standards of Excellence™ Elite Awards. The CAPG's Standards of Excellence™ survey is the industry standard for assessing the delivery of accountable and value based care. Elite awards are achieved by excelling in six domains including Care Management Practices, Information Technology, Accountability and Transparency, Patient-Centered Care, Group Support of Advanced Primary Care and Administrative and Financial Capability.

- Joint Commission Accreditation. In October 2018, DaVita Hospital Services, the first inpatient kidney care service to receive Ambulatory Health Care Accreditation from the Joint Commission, received its second reaccreditation. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Accreditation allows DaVita to monitor and evaluate the safety of kidney care and apheresis therapies against ambulatory industry standards. The accreditation allows for increased focus on enhancing the quality and safety of patient care; improved clinical outcomes and performance metrics, risk management and survey preparedness. Having set standards in place can further allow DaVita to measure performance and become better aligned with its hospital partners.

- Military Friendly Employer Recognition. DaVita has been repeatedly recognized for its commitment to its employees, particularly its more than 1,700 teammates who are reservists, members of the National Guard, military veterans, and military spouses. On July 16, 2018, the Disabled American Veterans recognized DaVita as the 2018 Outstanding Large Employer of the Year. Since 2010, DaVita has hired over 3,000 veteran teammates, offering transitional support for teammates with a military background. Veteran teammates vary from patient care technicians to the organization's current chief development officer. DaVita has long been committed to honoring retired and active-duty service members and works to help them feel welcome in the community and to transition from life in the military to life as teammates at DaVita.

- Workplace Awards. In April 2018, DaVita was certified by WorldBlu as a "Freedom-Centered Workplace." For the eleventh consecutive year, DaVita appeared on WorldBlu's list, formerly known as "most democratic" workplaces. WorldBlu surveys organizations' teammates to determine the level of democracy practiced. For the sixth consecutive year, DaVita was recognized as a Top Workplace by The Denver Post. In 2018, DaVita was recognized among *Training* magazine's Top 125 for its whole-person learning approach to training and development programs for the fourteenth year in a row. DaVita received a Gold LearningElite award from Chief Learning Officer Magazine, which recognized DaVita's exemplary learning and development programs. DaVita has been among the LearningElite for the past six years, and this was its first Gold level recognition. DaVita was one of more than 100 companies from ten industry sectors to join the inaugural 2018 Bloomberg Gender-Equality Index for creating a majority diverse Board of Directors. The index measures gender equality across internal company statistics, employee policies, external community support and engagement and gender-conscious product offerings. Finally, DaVita has been recognized as one of Fortune® Magazine's Most Admired Companies of 2019 – for the twelfth consecutive year and thirteenth year overall.

Service to the Community

- DaVita consistently raises awareness of community needs and makes cash contributions to organizations aimed at improving access to kidney care. DaVita provides significant funding to kidney disease awareness organizations such as the Kidney TRUST, the National Kidney Foundation, the American Kidney Fund, and several other organizations. DaVita Way of Giving program donated $2.1 million in 2018 to locally based charities across the United States. Its own employees, or members of the "DaVita Village," assist in these initiatives. In 2019, 541 riders participated in Tour DaVita, DaVita's annual charity bike ride, which raised $1.2 million to support Bridge of Life. Bridge of Life serves thousands of men, women and children around the world through kidney care, primary care, education and prevention and medically supported camps for kids.

- DaVita is committed to sustainability and reducing its carbon footprint. 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. Newsweek Green Rankings recognized DaVita as a 2017 Top Green Company in the United States, and it has appeared on the list every year since the inception of the program in 2009. In 2018, DaVita was recognized for the second time by the Dow Jones Sustainability Index (DJSI) as one of only seven U.S. based companies in the Health Care Providers and Services category on this year's DJSI World Index. Since 2013, DaVita has saved 645 million gallons of water through optimization projects. Through toner and cell phone recycling programs, more than $126,000 has been donated to Bridge of Life. In 2015, Village Green, DaVita's corporate sustainability program, launched a formal electronic waste program and recycled more than 558,000 pounds of e-waste since the program's inception. DaVita recently contracted with Longroad Energy on two virtual power purchase agreements facilitating the development of clean energy projects in Texas. DaVita's share of these projects, a wind farm and solar farm, will generate as much renewable energy as the amount of electricity used by DaVita's North American operations.

  In 2018, the U.S. Department of Energy ("DOE") recognized DaVita in its Advanced Rooftop Unit ("RTU") Campaign and awarded DaVita the Communities Award in the Excellence in Corporate Social Responsibility category. DaVita was honored for its leadership in installing more energy efficient RTUs (heating and cooling units) in commercial buildings. DaVita was recognized for the highest number of automated fault detection and diagnostic ("AFDD") installations on RTUs, having installed 4,889 AFDD systems. DaVita was recognized by the Communitas Awards in Communities Award in the Excellence in Corporate Social Responsibility for its sustainability efforts, which include, saving 643 million gallons of water since 2013 through conservation efforts at dialysis centers; diverting 354,610 pounds of electronic waste from landfills since 2016; and donating more than 34,000 meals to local shelters since 2016 through food waste recovery efforts.

- DaVita does not limit its community engagement to the U.S. alone. Since its inception in 2006, Bridge of Life, the primary program of DaVita Village Trust, an independent 501(c)(3) nonprofit organization, completed a total of 179 international medical missions in 30 countries and 310 domestic screenings. More than 1,300 DaVita volunteers supported these missions, impacting more than 118,000 men, women and children. In 2017, Bridge of Life established a Community Health Worker Program where they trained 13 individuals in Haiti and Nicaragua, allowing Bridge of Life to refer patients to local medical staff with their in-country partners and to ensure those patients receive continued follow-up care. It also developed an electronic medical record (EMR) system, allowing Bridge of Life to go paperless and to enter and maintain patient data more quickly and efficiently. In 2018, Bridge of Life partnered with the Syrian American Medical Society ("SAMS") to screen Syrian refugees in Irbid, Jordon for hypertension, diabetes and kidney disease and to provide health education. In 2019, Bridge of Life partnered with Global Livingston Institute to provide free health services, ongoing prevention education and recommended treatment plans to 3,000 Ugandans. Volunteer teammates from DaVita implemented a newly designed protocol for screening a younger population that focuses on behavioral health change of

high-risk habits such as tobacco and alcohol use, physical inactivity and diet. Volunteers screened adults in nearby communities for chronic kidney disease and its root causes such as hypertension and diabetes. The professionals from Bridge of Life use real-time, lab quality testing to identify individuals who have signs of chronic illnesses and offer health education to encourage patients to take a proactive role in their own health. They help ensure that high-risk patients receive the necessary care long-term by working with local clinics and hospitals to establish a referral process.

Other Section 1110.230(a) Requirements

Neither the Centers for Medicare and Medicaid Services nor the Illinois Department of Public Health ("IDPH") 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 clinics owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

A list of health care clinics owned or operated by the Applicants in Illinois is attached at Attachment – 11A. Dialysis clinics are currently not subject to State Licensure in Illinois.

Certification that no adverse action has been taken against either of the Applicants or against any health care clinics owned or operated by the Applicants in Illinois within three years preceding the filing of this application is attached at Attachment – 11B.

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

DaVita Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Adams County Dialysis	436 N 10TH ST		QUINCY	ADAMS	IL	62301-4152	14-2711
Alton Dialysis	3511 COLLEGE AVE		ALTON	MADISON	IL	62002-5009	14-2619
Arlington Heights Renal Center	17 WEST GOLF ROAD		ARLINGTON HEIGHTS	COOK	IL	60005-3905	14-2628
Auburn Park Dialysis	7939 SOUTH WESTERN AVENUE		CHICAGO	COOK	IL	60620	
Barrington Creek	28160 W. NORTHWEST HIGHWAY		LAKE BARRINGTON	LAKE	IL	60010	14-2736
Belvidere Dialysis	1755 BELOIT ROAD		BELVIDERE	BOONE	IL	61008	14-2795
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
Brickyard Dialysis	2640 NORTH NARRAGANSETT		CHICAGO	COOK	IL	60639	
Brighton Park Dialysis	**4729 SOUTH CALIFORNIA AVE**		CHICAGO	COOK	IL	60632	
Buffalo Grove Renal Center	1291 W. DUNDEE ROAD		BUFFALO GROVE	COOK	IL	60089-4009	14-2650
Calumet City Dialysis	1200 SIBLEY BOULEVARD		CALUMET CITY	COOK	IL	60409	14-2817
Carpentersville Dialysis	2203 RANDALL ROAD		CARPENTERSVILLE	KANE	IL	60110-3355	14-2598
Cicero Dialysis	6001 Ogden Avenue		Cicero	Cook	IL	60804	
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
Chicago Ridge Dialysis	10511 SOUTH HARLEM AVE		WORTH	COOK	IL	60482	14-2793
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
Collinsville Dialysis	101 LANTER COURT	BLDG 2	COLLINSVILLE	MADISON	IL	62234	
Country Hills Dialysis	4215 W 167TH ST		COUNTRY CLUB HILLS	COOK	IL	60478-2017	14-2575
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		FREEPORT	STEPHENSON	IL	61032-6712	14-2747
Edgemont Dialysis	8 VIEUX CARRE DRIVE		EAST ST. LOUIS	ST. CLAIR	IL	62203	
Edwardsville Dialysis	235 S BUCHANAN ST		EDWARDSVILLE	MADISON	IL	62025-2108	14-2701
Effingham Dialysis	904 MEDICAL PARK DR	STE 1	EFFINGHAM	EFFINGHAM	IL	62401-2193	14-2580

DaVita Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Emerald Dialysis	710 W 43RD ST		CHICAGO	COOK	IL	60609-3435	14-2529
Evanston Renal Center	1715 CENTRAL STREET		EVANSTON	COOK	IL	60201-1507	14-2511
Ford City Dialysis	8159 S CICERO AVENUE		CHICAGO	COOK	IL	60652	
Forest City Rockford	4103 W STATE ST		ROCKFORD	WINNEBAGO	IL	61101	
Glenview Dialysis	2601 Compass Road	Suite 145	Glenview	Cook	IL	60026	
Grand Crossing Dialysis	7319 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60619-1909	14-2728
Freeport Dialysis	1028 S KUNKLE BLVD		FREEPORT	STEPHENSON	IL	61032-6914	14-2642
Foxpoint Dialysis	1300 SCHAEFER ROAD		GRANITE CITY	MADISON	IL	62040	
Garfield Kidney Center	3250 WEST FRANKLIN BLVD		CHICAGO	COOK	IL	60624-1509	14-2777
Geneva Crossing Dialysis	540 South Schmale Road		Carol Stream	DuPage	IL	60188	
Granite City Dialysis Center	9 AMERICAN VLG		GRANITE CITY	MADISON	IL	62040-3706	14-2537
Harvey Dialysis	16641 S HALSTED ST		HARVEY	COOK	IL	60426-6174	14-2698
Hazel Crest Renal Center	3470 WEST 183rd STREET		HAZEL CREST	COOK	IL	60429-2428	14-2622
Hickory Crrek Dialysis	214 COLLINS STREET		JOLIET	WILL	IL	60432	
Huntley Dialysis	10350 HALIGUS ROAD		HUNTLEIY	MCHENRY	IL	60142	
Illini Renal Dialysis	507 E UNIVERSITY AVE		CHAMPAIGN	CHAMPAIGN	IL	61820-3828	14-2633
Irving Park Dialysis	4323 N PULASKI RD		CHICAGO	COOK	IL	60641	
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
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	14-2768
Lincoln Dialysis	2100 WEST FIFTH		LINCOLN	LOGAN	IL	62656-9115	14-2582
Lincoln Park Dialysis	2484 N ELSTON AVE		CHICAGO	COOK	IL	60647	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
Machesney Park Dialysis	7170 NORTH PERRYVILLE ROAD		MACHESNEY PARK	WINNEBAGO	IL	61115	14-2806

DaVita Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Macon County Dialysis	1090 W MCKINLEY AVE		DECATUR	MACON	IL	62526-3208	14-2584
Marengo City Dialysis	910 GREENLEE STREET	STE B	MARENGO	MCHENRY	IL	60152-8200	14-2643
Marshall Square Dialysis	2950-3010 West 26th Street		Chicago	COOK	IL	60623	
Maryville Dialysis	2130 VADALABENE DR		MARYVILLE	MADISON	IL	62062-5632	14-2634
Mattoon Dialysis	6051 DEVELOPMENT DRIVE		CHARLESTON	COLES	IL	61938-4652	14-2585
Melrose Village	1985 North Mannheim Road		Melrose Park	Cook	IL	60160	
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
Montgomery County Dialysis	1822 SENATOR MILLER DRIVE		HILLSBORO	MONTGOMERY	IL	62049	14-2813
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
North Dunes Dialysis	3113 North Lewis Avenue		Waukegan	Lake	IL	60087	
Northgrove Dialysiss	2491 INDUSTRIAL DRIVE		HIGHLAND	MADISON	IL	62249	
O'Fallon Dialysis	1941 FRANK SCOTT PKWY E	STE B	O'FALLON	ST. CLAIR	IL	62269	14-2818
Oak Meadows Dialysis	5020 West 95th Street		OAK LAWN	Cook	IL	60453	
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
Park Manor Dialysis	95TH STREET & COLFAX AVENUE		CHICAGO	COOK	IL	60617	
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	14-2772
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
Rutgers Park Dialysis	8455 WOODWARD AVENUE		WOODRIDGE	DUPAGE	IL	60517	
Salt Creek Dialysis	196 WEST NORTH AVENUE		VILLA PARK	DUPAGE	IL	60181	

DaVita Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Sauganash Dialysis	4054 WEST PETERSON AVENUE		CHICAGO	COOK	IL	60646	
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
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
Stonecrest Dialysis	1302 E STATE ST		ROCKFORD	WINNEBAGO	IL	61104-2228	14-2615
Stony Creek Dialysis	9115 S CICERO AVE		OAK LAWN	COOK	IL	60453-1895	14-2661
Stony Island Dialysis	8725 S STONY ISLAND AVE		CHICAGO	COOK	IL	60617-2709	14-2718
Sycamore Dialysis	2200 GATEWAY DR		SYCAMORE	DEKALB	IL	60178-3113	14-2639
Taylorville Dialysis	901 W SPRESSER ST		TAYLORVILLE	CHRISTIAN	IL	62568-1831	14-2587
Tazewell County Dialysis	1021 COURT STREET		PEKIN	TAZEWELL	IL	61554	14-2767
Timber Creek Dialysis	1001 S. ANNIE GLIDDEN ROAD		DEKALB	DEKALB	IL	60115	14-2763
Tinley Park Dialysis	16767 SOUTH 80TH AVENUE		TINLEY PARK	COOK	IL	60477	14-2810
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
Vermilion County Dialysis	22 WEST NEWELL ROAD		DANVILLE	VERMILION	IL	61834	14-2812
Washington Heights Dialysis	10620 SOUTH HALSTED STREET		CHICAGO	COOK	IL	60628	
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	14-2783
Whiteside Dialysis	2600 N LOCUST	STE D	STERLING	WHITESIDE	IL	61081-4602	14-2648

DaVita Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Woodlawn Dialysis	5060 S STATE ST		CHICAGO	COOK	IL	60609	14-2310

Attachment – 11A

63761192.1

#20-05

Richard Sewell
Vice Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Vice Chair Sewell:

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 Ill. Admin. Code § 1130.140 has been taken against any in-center dialysis clinic owned or operated by DaVita Inc. or Total Renal Care, Inc. in the State of Illinois during the three year period prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.110(a)(2)(J), 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: Michael D. Staffieri
Its: Chief Operating Officer, DaVita Kidney Care, DaVita Inc.
President, Total Renal Care, Inc.

Subscribed and sworn to me
This 23rd day of October, 2019

Notary Public

KATHY CONNOR
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20064018112
MY COMMISSION EXPIRES APRIL 28, 2021

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements
Criterion 1110.110(b) – Background, Purpose of the Project, and Alternatives

Purpose of Project

1. There is currently a need for 70 hemodialysis stations in the City of Chicago. This project is intended to address that need and will improve access to life sustaining dialysis services to the residents residing in the north side of Chicago. Rogers Park has a large and diverse immigrant and refugee population, and stands out among Chicago neighborhoods with its large foreign born population. The community is 26% African American, 22% Hispanic and 5% Asian.[8] Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications.[9] Limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians.[10] Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, the Health Resources & Services Administration ("HRSA") has designated this area as both a primary care Health Professional Shortage Area and a Medically Underserved Population. See Attachment – 12A.

   This project is intended to address the need for dialysis stations and will improve access to life sustaining dialysis services to the residents residing in the ethnically diverse Rogers Park neighborhood. As noted above Rogers Park is 26% African-American and 22% Hispanic. These are two minority groups that have a higher incidence and prevalence of kidney disease than the general population. The incidence of ESRD in the African-American and Hispanic populations is higher than in the general population. The ESRD incidence rate among African-Americans is 3.7 times greater than Caucasians, and the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this disease burden include diabetes and metabolic syndrome, both are common among African-American and Hispanic individuals. Other factors for these groups that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than the general population. Access to health care, the quality of care received, barriers due to language, and health literacy also play a role in the higher incident rates.[11]

   Given these factors, readily accessible dialysis services are imperative for the health of the residents living in Rogers Park. Excluding dialysis clinics that were recently approved or in ramp up, average

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[8] Chicago Metropolitan Agency for Planning (CMAP), Community Data Snapshot, Rogers Park, Chicago Community Area 3 (Jun. 2019) *available at* https://www.cmap.illinois.gov/documents/10180/126764/Rogers+Park.pdf (last visited Nov. 19, 2019).

[9] Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited Jul 9, 2018).

[10] Id. at 102-103.

[11] Claudia M. Lora, M.D. et al, *Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem,* Ethnicity Dis. 19(4), 466-72 (2009) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587111/ (last visited Sep. 29, 2017).

utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As noted above, patient census among the existing clinics in the Rogers Park GSA has increased 2% annually. As a result, the existing clinics will not have adequate capacity to treat Dr. Sprague's projected patients. The proposed Rogers Park Dialysis is needed to ensure ESRD patients on the Northside of Chicago have adequate access to dialysis services that are essential to their well-being.

2. A map of the market area for the proposed clinic is attached at Attachment – 12B. The market area encompasses an approximate 5 mile radius around the proposed clinic. The boundaries of the market area are as follows:

   - North approximately 5 miles to Evanston;
   - Northeast approximately 1 mile to Lake Michigan;
   - East approximately .75 miles to Lake Michigan;
   - Southeast approximately 1 mile to Lake Michigan;
   - South approximately 5 miles to Lincoln Park;
   - Southwest approximately 5 miles to Portage Park;
   - West approximately 5 miles to Jefferson Park; and
   - Northwest 5 miles to Skokie.

   The purpose of this project is to improve access to life sustaining dialysis to residents of Rogers Park and the surrounding area.

3. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

4. Source Information

   CENTERS FOR DISEASE CONTROL & PREVENTION, NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, National Chronic Kidney Disease Fact Sheet, 2017, (2017) available at https://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf (last visited May 28, 2019).

   US Renal Data System, USRDS 2018 Annual Data Report: Epidemiology of Kidney Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 10 (2018) available at https://www.usrds.org/2018/download/v1_c01_GenPop_18_usrds.pdf (last visited May 28, 2019).

   THE HENRY J. KAISER FAMILY FOUNDATION, MARKETPLACE EFFECTUATED ENROLLMENT, 2014-2019 *available at* https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 28, 2019).

Mohammed P. Hossian, M.D. et al., CKD AND POVERTY: A GROWING GLOBAL CHALLENGE, 53 AM. J. KIDNEY DISEASE 166, 167 (2009) available at http://www.ajkd.org/article/S0272-6386(08)01473-X/fulltext (last visited May 28, 2019).

Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited May 28, 2019).

5. The proposed clinic will improve access to dialysis services to the residents of Rogers Park and the surrounding area. Given the demographics of Rogers Park, this clinic is necessary to ensure sufficient access to dialysis services in the community.

6. DaVita anticipates the proposed clinic will have quality outcomes comparable to its other clinics. 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.

Hypertension Control Dashboard Released
data.HRSA.gov is excited to announce the release of the Hypertension Control Dashboard (/topics/health-centers/hypertension-control). The dashboard provides a multilevel view of hypertension control (high blood pressure control) in HRSA-funded health centers.

Health Resources & Services Administration (https://www.hrsa.gov)

Find Shortage Areas by Address

Enter an address to determine whether it is located in a shortage area: HPSA Geographic, HPSA Geographic High Needs, or Population Group HPSA or an MUA/P.

Note: This search will not identify facility HPSAs. To find these HPSAs, use the HPSA Find (/tools/shortage-area/hpsa-find) tool.

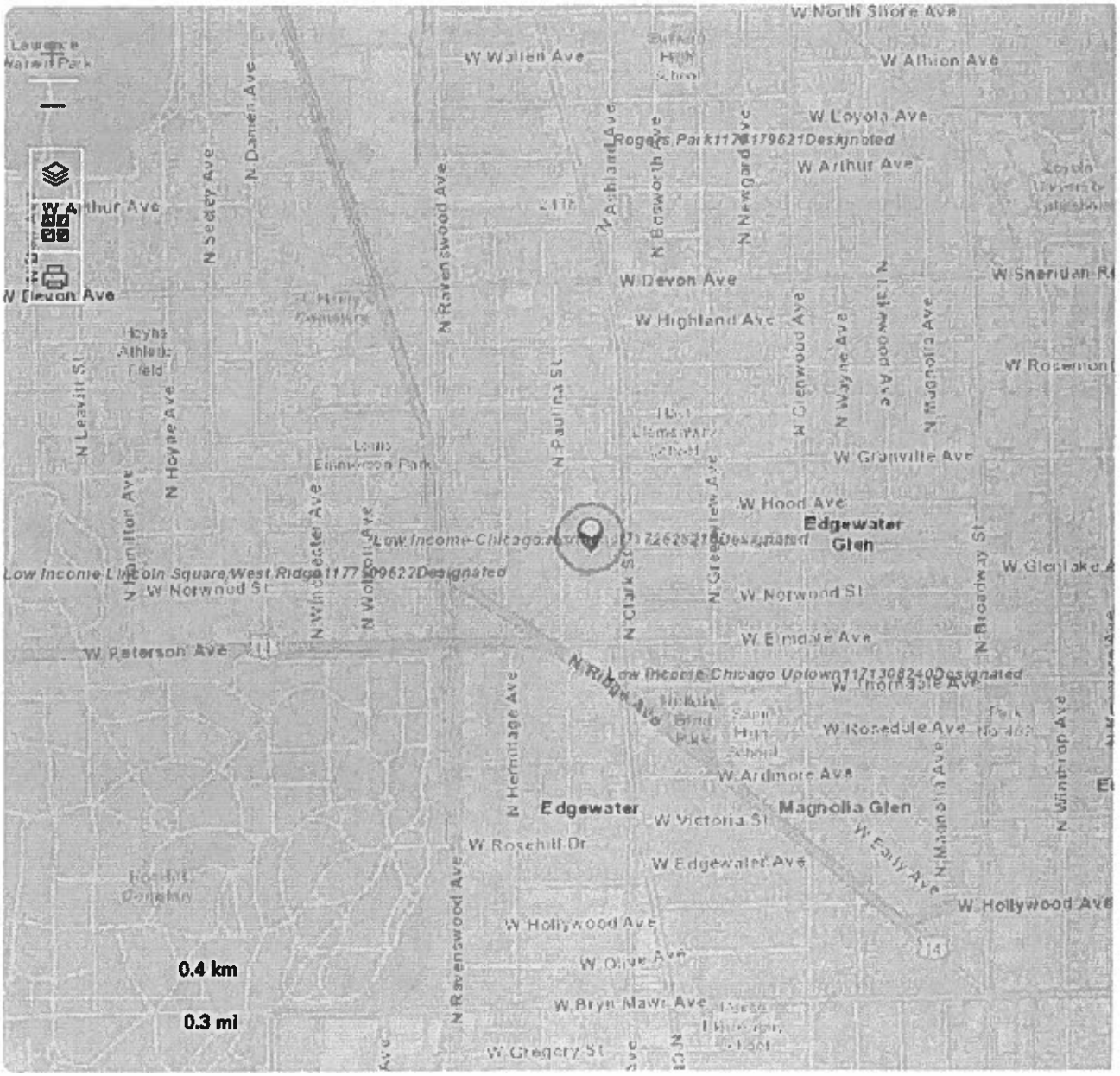
Start Over **Print**

HPSA Data as of 01/07/2020
MUA Data as of 01/07/2020

Address
1616 west glenlake avenue, chicago, IL, 60660

Standardized address

1616 W Glenlake Ave, Chicago, Illinois, 60660



Note: The address you entered is geocoded and then compared against the HPSA and MUA/P data in data.HRSA.gov. Due to geoprocessing limitations, the designation cannot be guaranteed to be 100% accurate and does not constitute an official determination.

[+] More about this address

In a Dental Health HPSA: ✗ No

In a Mental Health HPSA: ✔ **Yes**
HPSA Name: Low Income-Chicago Northeast
ID:7172628215
Designation Type:HPSA Population
Status: Designated
Score:17
Designation Date:01/15/2010
Last Update Date:12/31/2018

In a Primary Care HPSA: ✔ **Yes**
HPSA Name: Low Income-Chicago Uptown
ID:1171308240
Designation Type:HPSA Population
Status: Designated
Score:14
Designation Date:12/27/2018
Last Update Date:12/27/2018

In a MUA/P: ✔ **Yes**
Service Area Name: Communities Asian-American Population
ID:00801
Designation Type: Medically Underserved Population – Governor's Exception
Designation Date:03/31/1988
Last Update Date:03/31/1988

About HRSA

HRSA programs provide health care to people who are geographically isolated, economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access high quality health care. HRSA also supports access to health care in rural areas, the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery. Learn more about HRSA » (https://www.hrsa.gov)

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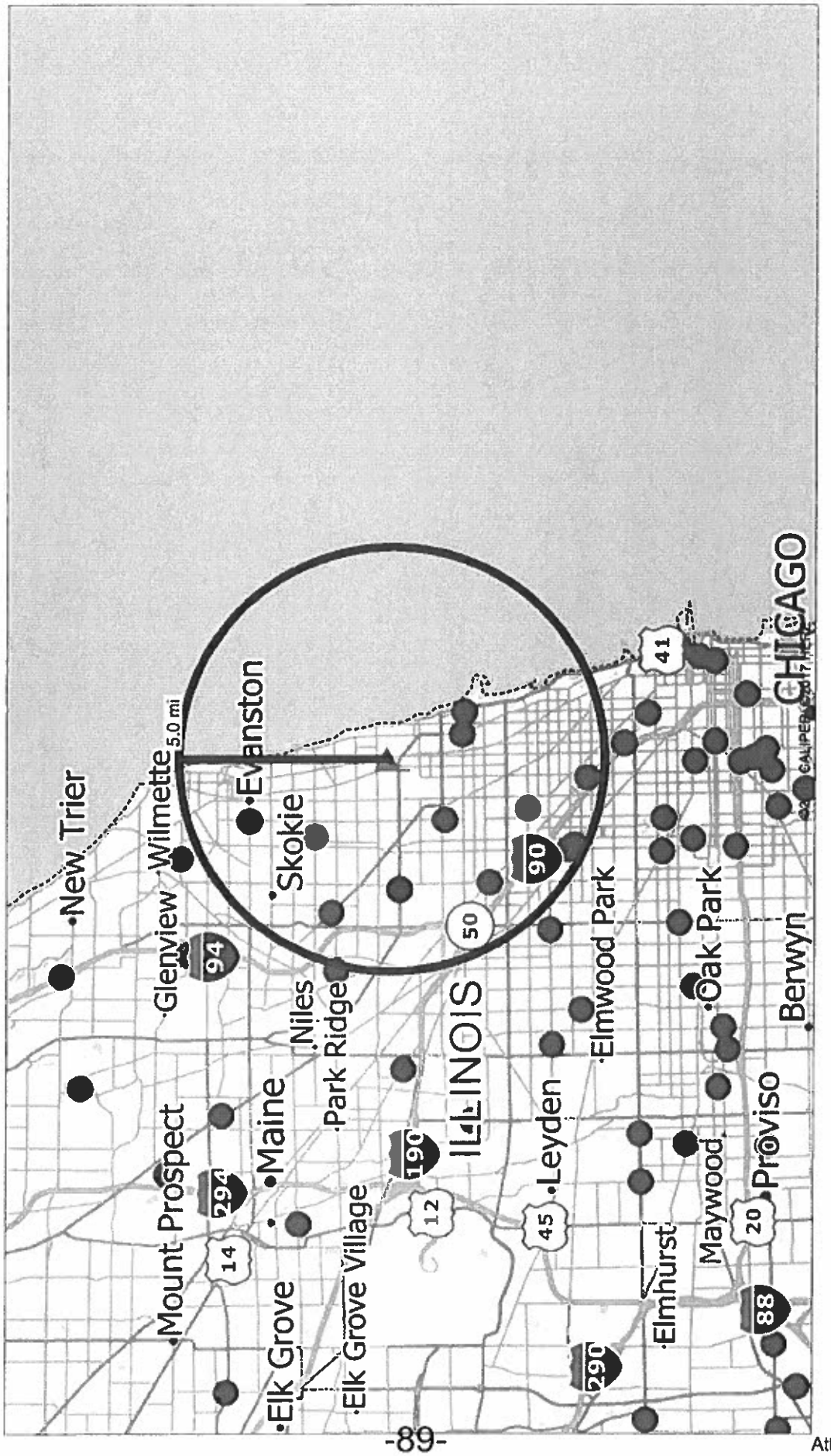
HRSA Data Warehouse (https://data.hrsa.gov/)

(https://www.hhs.gov)

Rogers Park 5 Mile Geographic Service Area



Attachment - 12B

Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.110(d) – Background, Purpose of the Project, and Alternatives

Alternatives

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

1. Maintain the Status Quo/Do Nothing

2. Utilize Existing Clinics.

3. Establish a new clinic.

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

Maintain the Status Quo/Do Nothing

The Applicants considered the option not to do anything. Rogers Park has a large and diverse immigrant and refugee population, and stands out among Chicago neighborhoods with its large foreign born population. The community is 26% African American, 22% Hispanic and 5% Asian.[12] Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications.[13] Limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians.[14] Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, HRSA has designated this area as both a primary care Health Professional Shortage Area and a Medically Underserved Population.

The incidence of ESRD in the African-American and Hispanic populations is higher than in the general population. The ESRD incidence rate among African-Americans is 3.7 times greater than Caucasians, and the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this disease burden include diabetes and metabolic syndrome, both are common among African-American and Hispanic individuals. Other factors for these groups that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than the general population. Access

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[12] Chicago Metropolitan Agency for Planning (CMAP), Community Data Snapshot, Rogers Park, Chicago Community Area 3 (Jun. 2019) *available at* https://www.cmap.illinois.gov/documents/10180/126764/Rogers+Park.pdf (last visited Nov. 19, 2019).

[13] Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited Jul 9, 2018).

[14] Id. at 102-103.

to health care, the quality of care received, barriers due to language, and health literacy also play a role in the higher incident rates.[15]

Given these factors, readily accessible dialysis services are imperative for the health of the residents living in Rogers Park. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As noted above, patient census among the existing clinics in the Rogers Park GSA has increased 2% annually As a result, the existing clinics will not have adequate capacity to treat Dr. Sprague's projected patients. The proposed Rogers Park Dialysis is needed to ensure ESRD patients on the Northside of Chicago have adequate access to dialysis services that are essential to their well-being.

There is no capital cost with this alternative.

Utilize Existing Clinics

DaVita considered utilizing existing facilities within the Rogers Park Dialysis GSA. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As noted above, patient census among the existing clinics in the Rogers Park GSA has increased 2% annually. As a result, the existing clinics will not have adequate capacity to treat Dr. Sprague's projected patients. The proposed Rogers Park Dialysis is needed to ensure ESRD patients on the Northside of Chicago have adequate access to dialysis services that are essential to their well-being.

There is no capital cost with this alternative.

Establish a New Clinic

Rogers Park has a large and diverse immigrant and refugee population, and stands out among Chicago neighborhoods with its large foreign born population. The community is 26% African

15 Claudia M. Lora, M.D. et al, *Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem,* Ethnicity Dis. 19(4), 466-72 (2009) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587111/ (last visited Sep. 29, 2017).

American, 22% Hispanic and 5% Asian.[16] Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications.[17] Limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians.[18] Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, HRSA has designated this area as both a primary care Health Professional Shortage Area and a Medically Underserved Population.

Further, the incidence of ESRD in the African-American and Hispanic populations is higher than in the general population. The ESRD incidence rate among African-Americans is 3.7 times greater than Caucasians, and the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this disease burden include diabetes and metabolic syndrome, both are common among African-American and Hispanic individuals. Other factors for these groups that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than the general population. Access to health care, the quality of care received, barriers due to language, and health literacy also play a role in the higher incident rates.[19]

Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As noted above, patient census among the existing clinics in the Rogers Park GSA has increased 2% annually. As a result, the existing clinics will not have adequate capacity to treat Dr. Sprague's projected patients.

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[16] Chicago Metropolitan Agency for Planning (CMAP), Community Data Snapshot, Rogers Park, Chicago Community Area 3 (Jun. 2019) *available at* https://www.cmap.illinois.gov/documents/10180/126764/Rogers+Park.pdf (last visited Nov. 19, 2019).

[17] Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited Jul 9, 2018).

[18] Id. at 102-103.

[19] Claudia M. Lora, M.D. et al, *Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem,* Ethnicity Dis. 19(4), 466-72 (2009) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587111/ (last visited Sep. 29, 2017).

The proposed Rogers Park Dialysis is needed to ensure ESRD patients on the Northside of Chicago have adequate access to dialysis services that are essential to their well-being. As a result, DaVita chose this option.

The cost of this alternative is **$5,250,041**.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(a), Size of the Project

The Applicants propose to establish a 12-station dialysis clinic. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360 - 520 gross square feet per dialysis station for a total of 4,320 – 6,240 gross square feet for 12 dialysis stations. The total gross square footage of the clinical space of the proposed Rogers Park Dialysis is 5,320 of gross square feet (or 443.33 GSF per station). Accordingly, the proposed clinic meets the State standard per station.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ESRD	5,320	4,320 – 6,240	N/A	Meets State Standard

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(b), Project Services Utilization

By the second year of operation, annual utilization at the proposed clinic shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.630 of the HFSRB's rules, clinics 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. NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion.

Table 1110.234(b)
Utilization

	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 2	ESRD	N/A	10,920	8,986	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(d), 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 1110.120(e), 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 1110.230, In-Center Hemodialysis Projects – Review Criteria

1. Planning Area Need

There is currently a need for 70 hemodialysis stations in the City of Chicago, one of the areas with the highest calculated need in the State. This project is intended to address that need and will improve access to life sustaining dialysis services to the residents residing in the Rogers Park neighborhood and surrounding areas. Rogers Park has a large and diverse immigrant and refugee population, and stands out among Chicago neighborhoods with its large foreign born population. The community is 26% African American, 22% Hispanic and 5% Asian.[14] Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications.[15] Limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians.[16] Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, HRSA has designated this area as both a primary care Health Professional Shortage Area and a Medically Underserved Population.

As noted above, Rogers Park has large African-American and Hispanic populations. These two minority groups have a higher incidence and prevalence of kidney disease than the general population. The incidence of ESRD in the African-American and Hispanic populations is higher than in the general population. The ESRD incidence rate among African-Americans is 3.7 times greater than Caucasians, and the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this disease burden include diabetes and metabolic syndrome, both are common among African-American and Hispanic individuals. Other factors for these groups that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than the general population. Access to health care, the quality of care received, barriers due to language, and health literacy also play a role in the higher incident rates.[17]

Given these factors, readily accessible dialysis services are imperative for the health of the residents living in Rogers Park. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three

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[14] Chicago Metropolitan Agency for Planning (CMAP), Community Data Snapshot, Rogers Park, Chicago Community Area 3 (Jun. 2019) *available at* https://www.cmap.illinois.gov/documents/10180/126764/Rogers+Park.pdf (last visited Nov. 19, 2019).

[15] Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited Jul 9, 2018).

[16] Id. at 102-103.

[17] Claudia M. Lora, M.D. et al, *Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem,* Ethnicity Dis. 19(4), 466-72 (2009) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587111/ (last visited Sep. 29, 2017).

years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As a result, the existing clinics will not have adequate capacity to treat NorthShore's projected patients. The proposed Rogers Park Dialysis is needed to ensure ESRD patients in Rogers Park and the surrounding area have adequate access to dialysis services that are essential to their well-being.

2. Service to Planning Area Residents

The proposed Rogers Park Dialysis is located in a community that is designated as a primary care HPSA and medically underserved population by HRSA. There is a need for 70 dialysis stations in the City of Chicago, one of the highest in the State. The purpose of the project is to meet this need and to ensure that the ESRD patient population in Rogers Park and the surrounding area has access to life sustaining dialysis. As evidenced in the physician referral letter attached at Appendix – 1, all 70 pre-ESRD patients anticipated to initiate dialysis within two years of project completion reside within 3 miles of Rogers Park Dialysis.

3. Service Demand

Attached at Appendix - 1 is a physician referral letter from Dr. Sprague and a schedule of CKD and current patients by zip code. A summary of CKD patients projected to be referred to the proposed dialysis clinic within the first two years after project completion is provided in Table 1110.230(b)(3)(B).

Table 1110.230(b)(3)(B) Projected Pre-ESRD Patient Referrals by Zip Code

Zip Code	Total Patients
60202	46
60625	3
60626	15
60640	6
60645	25
60559	9
60660	6
Total	**110**

4. Service Accessibility

As set forth throughout this application, the proposed clinic is needed to improve access to life-sustaining dialysis for residents of Rogers Park and the surrounding area. In collaboration with the NorthShore Medical Group, DaVita has identified the Rogers Park community as requiring additional access to in-center dialysis services. DaVita values its partnership in kidney care with the NorthShore Medical Group, which has dedicated resources to earlier intervention in kidney disease management, which, in turn, improves the quality of life after the onset of ESRD.

This project is intended to address the need for 70 dialysis stations in the City of Chicago and will improve access to life sustaining dialysis services to the residents residing in the ethnically diverse Rogers Park neighborhood. Rogers Park has a large and diverse immigrant and refugee population, and stands out among Chicago neighborhoods with its large foreign born population. The community is 26% African American, 22% Hispanic and 5% Asian.[18] Due to this large immigrant population, cultural barriers to access health care are high. These barriers include time and availability of providers, characteristics of healthcare personnel and patient-provider communications.[19] Limited communication and perceived lack of linguistic and cultural competence from providers can lead to mistrust of the health care system and make it difficult for immigrants to establish relationships with primary care physicians.[20] Provider communications and an ability to connect with your primary care provider are critical for optimal healthcare, particularly when treating complex chronic illnesses. Due to cultural and linguistic barriers faced by members of this community, HRSA has designated this area as both a primary care Health Professional Shortage Area and a Medically Underserved Population.

Rogers Park has large African-American and Hispanic populations. These two minority groups have a higher incidence and prevalence of kidney disease than the general population. The incidence of ESRD in the African-American and Hispanic populations is higher than in the general population. The ESRD incidence rate among African-Americans is 3.7 times greater than Caucasians, and the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population. Likely contributing factors to this disease burden include diabetes and metabolic syndrome, both are common among African-American and Hispanic individuals. Other factors for these groups that contribute to a higher disease burden are family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than the general population. Access to health care, the quality of care received, barriers due to language, and health literacy also play a role in the higher incident rates.[21]

Given these factors, readily accessible dialysis services are imperative for the health of the residents living in Rogers Park. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in

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[18] Chicago Metropolitan Agency for Planning (CMAP), Community Data Snapshot, Rogers Park, Chicago Community Area 3 (Jun. 2019) *available at* https://www.cmap.illinois.gov/documents/10180/126764/Rogers+Park.pdf (last visited Nov. 19, 2019).

[19] Joan Edward and Vicki Hines-Martin, Examining Perceived Barriers to Healthcare Access for Hispanics in a Southern Urban Community, 5 J of Hospital Administration 102, 104 (2016) *available at* https://www.researchgate.net/profile/Vicki_Hines-Martin/publication/291392351_Examining_perceived_barriers_to_healthcare_access_for_Hispanics_in_a_southern_urban_community/links/56ab9feb08ae8f386569c55b/Examining-perceived-barriers-to-healthcare-access-for-Hispanics-in-a-southern-urban-community.pdf?origin=publication_detail (last visited Jul 9, 2018).

[20] Id. at 102-103.

[21] Claudia M. Lora, M.D. et al, *Chronic Kidney Disease in United States Hispanics: A Growing Public Health Problem,* Ethnicity Dis. 19(4), 466-72 (2009) *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3587111/ (last visited Sep. 29, 2017).

consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. As a result, the existing clinics will not have adequate capacity to treat Dr. Sprague's projected patients. The proposed Rogers Park Dialysis is needed to ensure ESRD patients in Rogers Park and the surrounding area have adequate access to dialysis services that are essential to their well-being.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(c), Unnecessary Duplication/Maldistribution

1. Unnecessary Duplication of Services

a. The proposed dialysis clinic will be located at 1616 West Glenlake Avenue, Chicago, Illinois. A map of the proposed clinic's market area is attached at Attachment – 23A. A list of all zip codes located, in total or in part, within 5 miles of the site of the proposed dialysis clinic as well as 2017 population estimates for each zip code is provided in Table 1110.230(c)(1)(A).

Table 1110.230(c)(1)(A)
Population of Zip Codes within a 5 mile radius of Proposed Clinic

Zip Code	City	Population
60076	Skokie	32,093
60077	Skokie	28,470
60201	Evanston	42,880
60202	Evanston	32,677
60203	Evanston	4,199
60613	Chicago	50,553
60614	Chicago	70,225
60618	Chicago	95,218
60625	Chicago	80,676
60626	Chicago	49,416
60630	Chicago	57,531
60640	Chicago	68,258
60641	Chicago	69,954
60645	Chicago	48,269
60646	Chicago	27,865
60647	Chicago	87,707
60657	Chicago	70,103
60659	Chicago	40,442
60660	Chicago	42,068
60712	Lincolnwood	12,637
Total		**1,011,241**

Source: U.S. Census Bureau, Census 2017, American Factfinder *available at* https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml (last visited Nov. 18, 2019).

b. A list of existing and approved dialysis clinics located within a 5 mile radius of the proposed dialysis clinic is provided at Attachment – 23B.

2. Maldistribution of Services

The proposed dialysis clinic will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of clinics, 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 clinics 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.

a. Ratio of Stations to Population

As shown in Table 1110.230(c)(2)(A), the ratio of stations to population is 60% of the State Average

Table 1110.230(c)(2)(A)
Ratio of Stations to Population

	Population	Stations	Stations to Population	Standard Met
Rogers Park GSA	1,011,241	232	1:4,359	Yes
Illinois	12,854,526	4,946	1:2,600	

b. Historic Utilization of Existing Facilities

Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

c. Sufficient Population to Achieve Target Utilization

The Applicants propose to establish a 12-station dialysis clinic. To achieve the HFSRB's 80% utilization standard within the first two years after project completion, the Applicants would need 58 patient referrals. NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion.

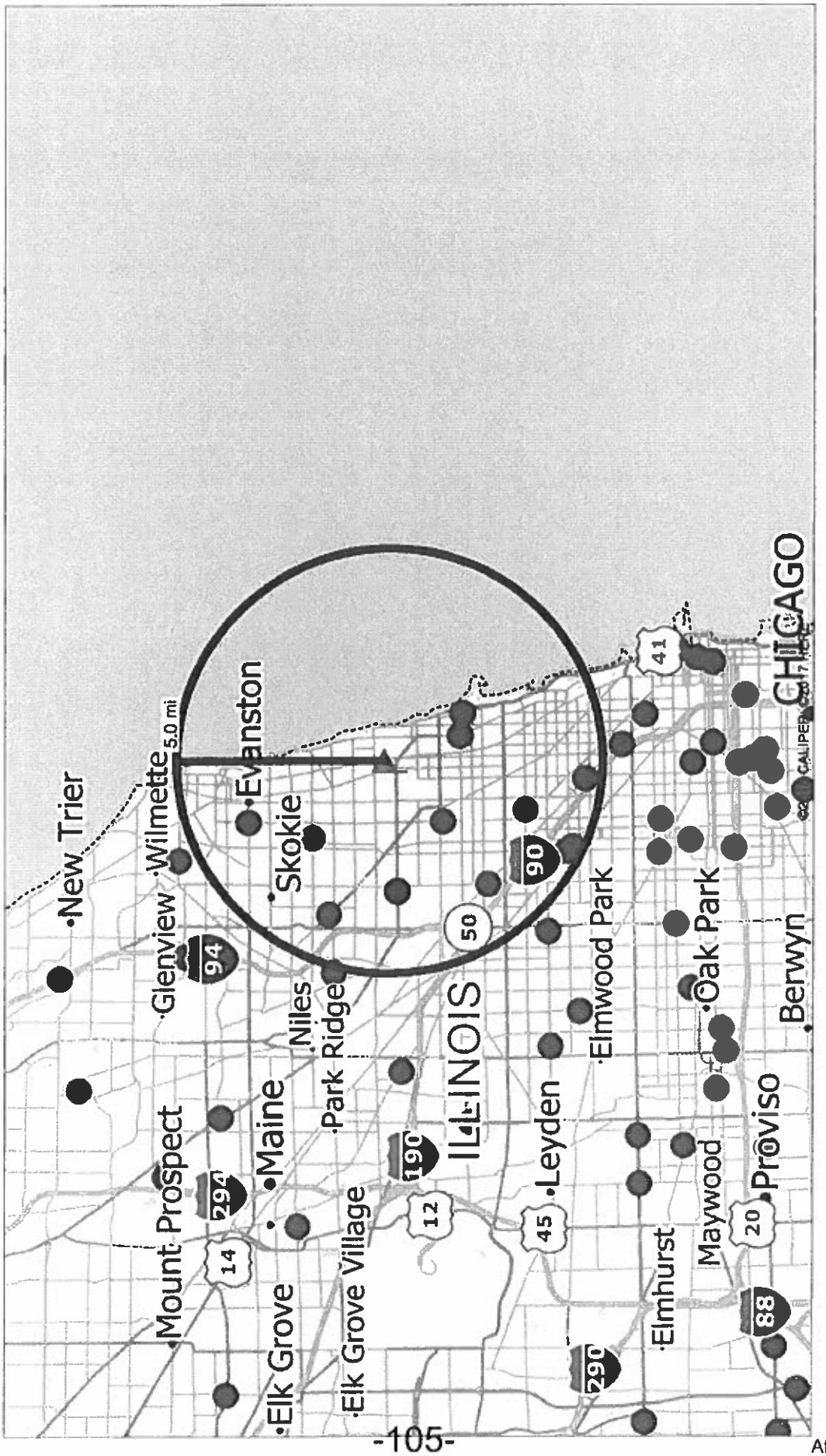
3. Impact to Other Providers

a. The proposed dialysis clinic will not have an adverse impact on existing clinics in the Rogers Park GSA. NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. No patients are expected to transfer from existing dialysis clinics.

b. The proposed dialysis clinic will not lower the utilization of other area clinics that are currently operating below HFSRB standards. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

Further, NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. No patients are expected to transfer from existing dialysis clinics.

Rogers Park 5 Mile Geographic Service Area



Attachment - 23A

Facility	Ownership	Address	City	Straight-Line Distance to Center (Miles)	HSA	Number of Stations 09/30/2019	Number of Patients 09/30/19	Utilization % 09/30/19	Projected Patients 09/30/22	Projected Utilization 09/30/22
Fresenius Medical Care of Lakeview	Fresenius	4800 N. Broadway	Chicago	1.75	6	14	68	81.0%	90	107.4%
Nephron Dialysis Ctr Swedish Covenant		5140 North California Ave.	Chicago	1.90	6	16	92	95.8%	88	91.8%
RCG - Uptown	Fresenius	4720 N. Marine Drive	Chicago	2.03	6	14	80	95.2%	90	107.6%
Dialysis Ctr of America - (Rogers Park)	Fresenius	2277 West Howard Street	Chicago	2.58	6	20	93	77.5%	102	84.7%
Sauganash Dialysis[1]	DaVita	4054 West Peterson Avenue	Chicago	3.20	6	12	0	0.0%	46	63.9%
Fresenius Medical Care Northcenter	Fresenius	2620 W. Addison	Chicago	3.39	6	16	68	70.8%	74	76.8%
Neomedica Dialysis Ctrs - Evanston	Davita	1922 Dempster Street	Evanston	3.63	7	20	103	85.8%	142	118.2%
Irving Park Dialysis[2]	Davita	4343 North Elston Avenue	Chicago	3.70	6	12	35	48.6%	67	93.1%
Center for Renal Replacement		7301 N. Lincoln Ave.	Lincolnwood	3.89	7	16	50	52.1%	33	33.9%
Fresenius Medical Care North Kilpatrick	Fresenius	4800 North Kilpatrick	Chicago	4.19	6	28	121	72.0%	100	59.3%
Lincoln Park Dialysis Center	Davita	2484 North Elston Avenue	Chicago	4.61	6	22	78	59.1%	60	45.4%
Logan Square Dialysis	Davita	2816 North kimball Avenue	Chicago	4.66	6	28	131	78.0%	128	76.4%
Fresenius Medical Care Logan Square	Fresenius	2721 N. Spaulding	Chicago	4.74	6	14	67	79.8%	96	114.8%
Total						**232**	**986**	**70.8%**	**1,116**	**80.2%**
Total (less clinics operational < 2 years						**208**	**951**	**76.2%**	**1,070**	**81.1%**

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(e), Staffing

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

    a. Medical Director: Stuart Sprague, D.O. will serve as the Medical Director for the proposed clinic. A copy of Dr. Sprague's curriculum vitae is attached at Attachment – 23C.

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

    Administrator (1.01 FTE)
    Registered Nurse (2.99 FTE)
    Patient Care Technician (3.94 FTE)
    Biomedical Technician (0.34 FTE)
    Social Worker (0.53 FTE)
    Registered Dietitian (0.54 FTE)
    Administrative Assistant (0.78 FTE)
    Other/Training (0.13 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 clinic is in operation.

    c. All staff will be training under the direction of the proposed clinic'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 – 23D.

    d. As set forth in the letter from Michael D. Staffieri, Chief Operating Officer of DaVita Inc. and Total Renal Care, Inc., attached at Attachment – 23E, Rogers Park Dialysis will maintain an open medical staff.

CURRICULUM VITAE

NAME: Stuart Michael Sprague, D.O., FACP, FASN, FNKF
Chief, Division of Nephrology and Hypertension
NorthShore University HealthSystem
Clinical Professor of Medicine
University of Chicago Pritzker School of Medicine

DATE AND PLACE OF BIRTH: August 31, 1955; Sturgis, Michigan

MARITAL STATUS: Married; Denise Lynn Olender

CHILDREN: Shoshana Faith, January 30, 1987
Ariella Maia, August 17, 1988
Nadav Lev, March 7, 1995

BUSINESS ADDRESS: Section of Nephrology and Hypertension
NorthShore University HealthSystem
2650 Ridge Avenue
Evanston, Illinois 60201
(847) 570-2512
Fax (847) 570-1696
E-mail stuartmsprague@gmail.com

HOME ADDRESS: 3650 North Magnolia
Chicago, Illinois 60613
(773) 975-9322

CERTIFICATION: National Board of Medical Examination
Diplomate, May 1983
American Board of Internal Medicine
Diplomate, September 1986
Subspecialty Nephrology
Diplomate, November 1988

EDUCATION:

UNDERGRADUATE: Michigan State University
East Lansing, Michigan
1977 with honors

PROFESSIONAL: Michigan State University
College of Osteopathic Medicine
East Lansing, Michigan, 1982

GRADUATE TRAINING: Research Nephrology Fellow
University of Chicago
Chicago, Illinois, 1987-1989

Clinical Nephrology Fellow
University of Chicago
Chicago, Illinois, 1986-1987

Medical Resident
Rush-Presbyterian-St. Lukes Medical Center, Chicago, Illinois, 1983-1986

Intern
Chicago College of Osteopathic Medicine
Chicago, Illinois, 1982-1983

APPOINTMENTS:

Chief
Division of Nephrology and Hypertension
NorthShore University HealthSystem
Evanston, Illinois, 2003-present

Professor (Clinical) of Medicine
Department of Medicine
University of Chicago Pritzker School of Medicine
Chicago, Illinois, 2009- present

Professor of Medicine
Department of Medicine
Feinberg School of Medicine
Northwestern University
Chicago, Illinois, 2004-2009

Associate Professor
Department of Medicine
Feinberg School of Medicine
Northwestern University
Chicago, Illinois, 1995-2004

Senior Attending Physician
Division of Nephrology
NorthShore University HealthSystem
Evanston, Illinois, 1995-present

Assistant Professor
Department of Medicine
University of Chicago
Pritzker School of Medicine
Chicago, Illinois, 1990-1995

Visiting Fulbright Professor
Department of Medicine
Hadassah-Hebrew University
Jerusalem, Israel, 1993-1994

Instructor
Department of Medicine
University of Chicago
Pritzker School of Medicine
Chicago, Illinois, 1989-1990

Teaching Assistant
College of Osteopathic Medicine
Michigan State University
East Lansing, Michigan, 1979-1980

Graduate Research Assistant
Department of Medicine
Michigan State University
East Lansing, Michigan, 1977-1979

HOSPITAL APPOINMENTS:

Evanston Hospital
Glenbrook Hospital
Highland Park Hospital
Skokie Hospital

ADMINISTRATIVE APPOINTMENTS AND COMMITTEES:

Chief, Division of Nephrology & Hypertension, NorthShore University HealthSystem, 2003-present
Director, Nephrology Research, NorthShore University HealthSystem, 1995-present
NorthShore's Committee on Appointments and Promotions (COAP), 2013- present
Medical Director
Fresenius Evanston Hemodialysis Unit, 2013-2017
Medical Director
Satellite Health Care Glenview Dialysis Unit, 2013-present
ERA-EDTA CKD-MBD Work Group, 2015-present
Internal Scientific Advisory Panel (ISAP) Scientific Committee, CTSA-Institute for Translational Medicine, The University of Chicago Biological Sciences, 2012-present
Board of Trustees Anshe Sholom B'nai Israel Congregation, 2012- present
Chairman of the Board 2014-present
Medical Advisory Board, National Kidney Foundation, 2012-present
Executive Committee, Scientific Advisory Board of the National Kidney Foundation of Illinois, 2011-present

International Federation of Clinical Chemistry and Laboratory Medicine-Work Group for Parathyroid Hormone, 2010-present
Kidney Research United Kingdom's External Referee Panel, 2010-present
American Society of Nephrology Conflict of Interest Management Committee, 2011- 2014
Data Safety Monitoring Board, Rockwell Medical CRUISE Study, 2011- 2013
Chairperson, End-Stage Renal Disease (ESRD) Quality Measure Development and Maintenance, Centers for Medicare & Medicaid Services, Technical Expert Panel (CMS-TEP), Mineral Metabolism, 2010
Co-Chair, Osteoporosis in Chronic Kidney Disease Group, Global Bone and Mineral Initiative, National Kidney Foundation and the European Renal Association, 2004-2013
Scientific Advisory Board, Litholink Corporation, 2008-present
Director, Metabolic Bone Disease Program and Renal Stone Disease Clinic, NorthShore University HealthSystem-Northwestern University, Chicago, Illinois, 1995-2009
Executive Committee, Scientific Advisory Board of the National Kidney Foundation of Illinois 2003-2009
Resident Recruitment Committee,
Evanston Northwestern Healthcare, 1995-2000
Program Committee, National Kidney Foundation 2008 Annual Meeting
Program Committee, National Kidney Foundation 2007 Annual Meeting
Community Leadership Award, National Kidney Foundation of Illinois, 2006
Chairperson, Executive Committee of the Medical Advisory Board of the National Kidney Foundation of Illinois 2003-2006
Scientific Advisory Board
Suntory Water Group, 1998-2005
Secretary-Treasurer, Post Transplantation Working Group of the American Society for Bone & Mineral Research, 2000-2004
Chairperson, Osteoporosis in Chronic Kidney Disease Group, Controversies in Mineral Metabolism and Bone Disease in Chronic Kidney Disease, National Kidney Foundation and the European Renal Association, 2003-2004
Research and Education Committee
Vice Chairman, 1998-2000
Evanston Northwestern Healthcare, 1997-2007
Postgraduate Education Committee, American Society of Nephrology, 2000-2003
Deputy Head, Division of Nephrology
Department of Medicine, Evanston Northwestern Healthcare, 1998-2003
Member, Advisory Committee of the International Working Group on Post Transplantation Bone Disease, 1999-2002
Medical Student Research Committee, Northwestern University Medical School, 1999-2002
Councilor
Midwestern American Federation for Medical Research, 1999-2001
Research Committee
Northwestern University Medical School, 1996-1997
Medical Review Board of the End Stage Renal Disease Network 10, Illinois, 1994-1996
Advisory Committee of the Clinical Research Center
University of Chicago, Chicago, Illinois, 1992-1995

Medical Director
University of Chicago Hospitals Chronic Hemodialysis Unit, Chicago, Illinois, 1991-1995
Director
Renal Bone Program, University of Chicago, Chicago, Illinois, 1989-1995
Board of Trustees
Anshe Emet Synagogue, 1991-1996
Scientific Advisory Board
United States-Israel BiNational Science Foundation, 1994
Medical Advisory Board
Home Intensive Care of Illinois, Inc., 1991-1993
College Advisory Committee
College of Osteopathic Medicine, Michigan State University, 1979-1980

DOCTORAL COMMITTEES:

Cynthia Daniels; Field of Interdepartmental Biological Sciences Program, Thesis "Developing and Characterization of Bioadsorbents for Extracorporeal Blood Purification", DOCTOR OF PHILOSOPHY awarded June 2007

PROFESSIONAL SOCIETIES:

American Association for the Advancement of Science
American College of Physicians
Fellow American College of Physicians
American Diabetes Association
American Federation for Medical Research
American Heart Association Council on Kidney Diseases
American Physicians Fellowship for Medicine in Israel
American Society for Bone and Mineral Research
American Society of Nephrology
Fellow American Society of Nephrology
Central Society for Clinical Research
International Society of Nephrology
International Bone and Mineral Society
Israel Medical Association
J. William Fulbright Alumni Association
National Kidney Foundation
Fellow National Kidney Foundation
National Kidney Foundation of Illinois
Physicians for Social Responsibility
Renal Physicians Association

EDITORIAL BOARDS:

American Journal of Nephrology
Associate Editor 2011-current

Clinical Journal of the American Society of Nephrology
Clinical Nephrology
Hemodialysis and Clinical Nephrology (electronic journal)
Journal of the American Society of Nephrology
Guest Associate Editor
Kidney International 1/2000-12/2012
WebMD-Nephrology

Web Community Leader
American Society of Nephrology Patient Care Questions and Answers

MANUSCRIPT REFEREE:

American Journal of Bone and Mineral Disease
American Journal of Kidney Diseases
American Journal of Nephrology
American Journal of Physiology - Renal Physiology
Annals of Internal Medicine
Archives of Internal Medicine
Calcified Tissue International
Clinical Journal of the American Society of Nephrology
Clinical Nephrology
Hemodialysis and Clinical Nephrology
Journal of the American Medical Association
Journal of the American Society of Nephrology
Journal of Bone and Mineral Research
Journal of Clinical Investigation
Journal of Clinical Endocrinology & Metabolism
Journal of Laboratory and Clinical Medicine
Journal of Pharmacology and Experimental Therapeutics
Kidney International
Nature Clinical Practice Endocrinology & Metabolism
Nephron
Nephrology Dialysis Transplantation
New England Journal of Medicine
Osteoporosis International
Peritoneal Dialysis International
Transplantation

PATENTS:

Receptor-based blood detoxification system. US Patent Application U50703392, February 15, 2006

CORPORATE POSITIONS:

Co-Founder, Vice-President and Chief Medical Officer. ProSorb BioTech, Inc, Evanston, Illinois. 2006-2013

HONORS:

Best Doctors, Chicago, 2000-2012, 2014, 2016
Teaching Service Award, Northwestern University Feinberg School of Medicine, 2005
Nephrology Faculty of the Year Award, University of Chicago Nephrology Fellows, 2012
Internal Medicine Teaching Service Award, NorthShore University HealthSystem, 2013
Nephrology Faculty of the Year Award, University of Chicago Nephrology Fellows, 2013
Nephrology Faculty of the Year Award, University of Chicago Nephrology Fellows, 2016

SCIENTIFIC SESSIONS CHAIRED:

Clinical Fluid and Electrolyte Disorders; 27th Annual Meeting of the American Society of Nephrology, Orlando, Florida, October 26-29, 1994.

Dialysis Amyloidosis; Renal Bone Disease, Parathyroid Hormone, and Vitamin D Satellite Symposium to the XIIIth International Congress of Nephrology, Seville, Spain, July 7-10, 1995.

Metabolic Bone Diseases; Xth International Workshop on Calcified Tissues, Jerusalem, Israel, March 10-14, 1996.

Post Transplant Bone Disease; 30th Annual Meeting of the American Society of Nephrology, San Antonio, Texas, November 2-5, 1997.

New Approaches to the Treatment of Parathyroid Disease in ESRD Patients; 8th Annual National Kidney Foundation Clinical Nephrology Meetings, Washington D.C., April 29-May 2, 1999.

Therapeutic Strategies; Transplant Bone Disease Meetings, Barcelona, Spain, August 25-26, 2000.

Post Transplantation Working Group of the American Society for Bone & Mineral Research, Toronto, Canada, September 22, 2000

Bone and Mineral Complications of Renal Transplantation: 33rd Annual Meeting of the American Society of Nephrology, Toronto, Ontario, Canada, October 10-16, 2000.

Basic Science for Clinical Nephrologists: Basic Concepts in Calcium Physiology and Pathophysiology: 34th Annual Meeting of the American Society of Nephrology, San Francisco, California, October 14-17, 2001.

Current Concepts in Vitamin D Therapy: 35th Annual Meeting of the American Society of Nephrology, Philadelphia, Pennsylvania, October 30-November 4, 2002.

Divalent Ions, Bones and Stones: Principles and Practices: Postgraduate Education Course of American Society of Nephrology, Philadelphia, Pennsylvania, October 30-31, 2002.

Old and New Optimal PTH Targets: Actions of the New PTH Inhibitor and Implications for its use in Guiding Vitamin D Therapy. 23rd Annual Dialysis Conference, Seattle Washington, March 2-4, 2003.

Vitamin D and the Prevention of Morbidity and Mortality in Dialysis Patients: 36th Annual Meeting of the American Society of Nephrology, San Diego, California, November 12-17, 2003.

Hormones, FGF23, and Fetuin in Mineral Metabolism: 36th Annual Meeting of the American Society of Nephrology, San Diego, California, Pennsylvania, November 12-17, 2003.

Vitamin D and the Prevention of Morbidity and Mortality in Dialysis Patients: 1st Annual Regional Meeting of the American Society of Nephrology, Chicago, Illinois February 7, 2004 and Los Angeles, California, February 21, 2004.

Modulation of PTH Synthesis, Secretion and Action. American Society of Nephrology Renal Week 2004, St. Louis , Missouri, October 27-November 1, 2004.

Chairperson of the 2nd Annual Regional Meeting of the American Society of Nephrology, Chicago, Illinois, February 11-13, 2005.

Managing Renal Osteodystrophy. Renal Week 2005 of the American Society of Nephrology, Philadelphia, Pennsylvania, November 8-13, 2005.

Controversies in Managing Hyperphosphatemia in CKD and ESRD. Renal Week 2005 of the American Society of Nephrology, Philadelphia, Pennsylvania, November 8-13, 2005.

Chairperson of the 3rd Annual Regional Meeting of the American Society of Nephrology, Chicago, Illinois, February 11-12, 2006.

Complications: Metabolic Disease. World Transplant Congress. The First Joint International Transplant Meeting, Boston, Massachusetts, July 2-27, 2006.

Nephrology in the 21st Century. National Kidney Foundation of Illinois, Chicago, Illinois, September 10, 2006.

Course Director, Clinical Application of Bone Biopsy. American Society of Nephrology, San Diego, California, November 15, 2006.

Vitamin D Deficiency and Early CKD. American Society of Nephrology, San Diego, California, November 16, 2006.

Literature review-The Year in Nephrology: Osteodystrophy and Vascular Calcification and Chronic Kidney Disease. American Society of Nephrology, San Diego, California, November 16, 2006.

Midwest Nephrology Fellows Research Day. Renal Network, ESRD Network 9/10. Chicago, Illinois, March 14, 2007.

Extending the Controversy: Answers to Managing Bone, Vascular and Mineral Metabolism in Chronic Kidney Disease. National Kidney Foundation 2007 Spring Clinical Meetings, Orlando, Florida, April 10-14, 2007.

Pleiotropic Actions of Vitamin D: Beyond Bone Disease. American Society of Nephrology Renal Week 2007. San Francisco, California, November 2, 2007.

Chairperson of the 2008 Renal Weekends of the American Society of Nephrology, Chicago, Illinois, March, 8-9, 2008.

Workshop: Management of Hyperphosphatemia Using Calcium vs. Non-Calcium Based Binders. National Kidney Foundation 2008 Spring Clinical Meetings, Gaylord, Texas, April 12-16, 2008.

Pathogenesis and Features of CKD Related Bone Disease. American Society of Nephrology, San Diego, California, October 31, 2009.

An Update on Vitamin D and Vitamin D Analogues: Rationale for Treatment. National Kidney Foundation 2011 Spring Clinical Meetings, Las Vegas, Nevada, April 28, 2011.

Abstract Chair: Mineral Disease: CKD-MBD. American Society of Nephrology Renal Week 2012, San Diego, California. October 30- November 4, 2012.

Stones and Bones: Pathogenesis and Treatment. American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 15, 2014.

Bone and Vascular Disease in CKD. American Society of Nephrology Renal Week 2015, San Diego, California, November 6, 2015.

Abstract Reviewer: 2016 American Transplant Congress, Boston, Massachusetts, June 11-16, 2016.

PUBLICATIONS

1. Mayor, G.H., Hook, J.B., Rech, R.H., Noordewier, B., Sprague, S.M., Keiser, J.A., McCormack, K.M.: Study of PTH, vitamin D, calcium and aluminum kinetics and dialysis encephalopathy. In: Proceedings of the 12th Annual Contractor's Conferences, Department of Health, Education and Welfare, Bethesda, Maryland, pp 36-40, 1978.

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12. Sprague, S.M.: Aluminum: Its measurement and metabolism. Seminars in Dialysis, 1:103-111, 1988.

13. Warren, G.V., Sprague, S.M., Corwin, H.L.: Sarcoidosis presenting as acute renal failure during pregnancy. American Journal of Kidney Diseases, 12:161-163, 1988.

14. Sprague, S.M., Corwin, H.L., Tanner, C.M., Wilson, R.S., Green, B.J., Goetz, C.G.: Relationship of aluminum to neurocognitive dysfunction in chronic dialysis patients. Archives of Internal Medicine, 148:2169-2172, 1988.

15. Corwin, H.L., Sprague, S.M., DeLaria, G.A., Norusis, M.J.: Acute renal failure associated with open heart surgery: A case-controlled study. Journal of Thoracic and Cardiovascular Surgery, 98:1107-1112, 1989.

16. Sprague, S.M., Bushinsky, D.A.: Mechanism of aluminum induced calcium efflux from cultured neonatal mouse calvariae. American Journal of Physiology 258 (Renal, Fluid and Electrolyte Physiology 27):F583-F588, 1990.

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18. Spiegel, D.M., Sprague, S.M.: Serum amyloid P component: A predictor of clinical β_2-microglobulin amyloidosis. American Journal of Kidney Diseases, 19:427-432, 1992.

19. Sprague, S.M., Moe, S.M.: Safety and efficacy of long-term treatment of secondary hyperparathyroidism by low-dose intravenous calcitriol. American Journal of Kidney Diseases, 19:532-539, 1992.

20. Moe, S.M., Sprague, S.M.: β_2-microglobulin induces calcium efflux from cultured neonatal mouse calvariae. American Journal of Physiology 263 (Renal, Fluid and Electrolyte Physiology 32):F540-F545, 1992.

21. Moe, S.M., Barrett, S.A., Sprague, S.M.: β_2-microglobulin stimulates osteoclastic mediated bone mineral dissolution from neonatal mouse calvariae. Calcium Regulating Hormones and Bone Metabolism, 11:302-306, 1992.

22. Josephson, M.A., Sprague, S.M., Thisthlethwaite, J.R., Stuart, F.P., Dasgupta, A.: Lipid peroxidation products in recipients of renal transplants. Transplant Monitoring, 10:56-60, 1992.

23. Sprague, S.M., Krieger, N.S., Bushinsky, D.A.: Aluminum inhibits formation of bone nodules *in vitro*. American Journal of Physiology 264 (Renal, Fluid and Electrolyte Physiology 33):F882-890, 1993.

24. Moe, S.M., Yu, B.O., Sprague, S.M.: Maintenance of bone mass in patients receiving dialytic therapy. American Journal of Kidney Diseases, 22:300-307, 1993.

25. Hammes, M., DeMory, A., Sprague, S.M.: Hypocalcemia in end stage renal disease: A consequence of spontaneous parathyroid gland infarction. American Journal of Kidney Diseases, 24:519-524, 1994.

26. Sprague, S.M., Krieger, N.S., Bushinsky, D.A.: Greater inhibition of *in vitro* bone mineralization with metabolic than respiratory acidosis. Kidney International, 46:1199-1206, 1994.

27. Moe, S.M., Sprague, S.M.: Uremic encephalopathy. Clinical Nephrology, 42:251-256, 1994.

28. Sprague, S.M., Popovtzer, M.M.: Is β_2-microglobulin a mediator of bone disease? Kidney International, 47:1-6, 1995.

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33. Sprague, S.M.: Amyloidosis in dialysis patients. Mediguide to Nephrology, 4:1-4, 1996.

34. Miyata, T., Sprague, S.M.: Advanced glycation of β_2-microglobulin in the pathogenesis of bone lesions in dialysis associated amyloidosis. Nephrology Dialysis Transplantation, 11:S86-S90, 1996.

35. Sprague, S.M., Moe, S.M.: Clinical manifestations and pathogenesis of dialysis-related amyloidosis. Seminars in Dialysis, 9:360-369, 1996.

36. Sprague, S.M., Popovtzer, M.M., Dranitzki-Elhalal, M., Wald, H.: Parathyroid hormone induced calcium efflux from cultured bone is mediated by protein kinase C translocation. American Journal of Physiology 271 (Renal, Fluid and Electrolyte Physiology 40):F1139-F1146, 1996.

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100. Quarles, L.D., Zeig, S., Spiegel, D.M., Silver, M.R., Vokes, T., Gokal, R., Ölgaard, K., Jadoul, M., Zani, V., Klassen, P., Olson, K.A., Turner, S.A., Sprague, S.M.: Cinacalcet HCl (AMG 073) controls secondary hyperparathyroidism (HPT) in dialysis patients regardless of disease severity. Presented to the 36th Annual Meeting of the American Society of Nephrology, San Diego, California, November 12-17, 2003.

101. Menaa, C., Corr, M., Froelich, C.J., Sprague, S.M.: NF-κB and P38 cross-talk is critical for osteoclast differentiation. Presented to the Combined Annual Meeting of the Central Society for Clinical Research and the Midwestern Section American Federation for Medical Research, Chicago, Illinois, April 14-15, 2004.

102. Frazão, J., Nicolini, M., Torregrossa, V., Kerr, P., Jaeger, P., Sprague, S.M., Jadoul, M., Mellotte, G., Neyer, U., Geiger, H., Hagen, E.C., McCary, L., Baker, N., Turner, S., Quarles, L.D.: Cinacalcet HCl Effectively Reduces Intact Parathyroid Hormone (iPTH) and Ca x P Irrespective of the Severity of Secondary Hyperparathyroidism (HPT). Presented to XLI Congress of the European Renal Association/European Dialysis and Transplantation Society, Lisbon, Portugal, May 15-18, 2004.

103. Menaa, C., Corr, M., Froelich, C.J. Sprague, S.M.: NF-κB and not p38 MAPK is essential for expression and secretion of osteoclastogenic factors by breast cancer cells. Presented to the 26th Annual Meeting American Society of Bone and Mineral Metabolism, Seattle, Washington, October 1-5, 2004.

104. Menaa, C., Corr, M., Froelich, C.J., Sprague, S.M.: NF-kappa B and p38 cross-talk is critical for osteoclast differentiation. Presented to the 26th Annual Meeting American Society of Bone and Mineral Metabolism, Seattle, Washington, October 1-5, 2004.

105. Tian, J., Moe, S.M., Dobrez, D., Amdahl, M., Melnick, J., Williams, L., Sprague, S.M.: The association of baseline lab values and hospitalization outcomes in hemodialysis patients receiving or not receiving vitamin D. Presented to the 37th Annual Meeting of the American Society of Nephrology, St. Louis Missouri, October 29- November 1, 2004.

106. Sprague, S.M., Nicolini, M., Evenepoel, P., Curzi, M., González, T., Husserl, F., Kopyt, N., Abboud, H., Culleton, B., Albizem, M.A., Zani, V., Guo, M.G., Klassen, P.S., Wong, G.K.T.: Maintenance of NKF-K/DOQI™ goals for parathyroid hormone and Ca x P with cinacalcet HCl. Presented to the 37th Annual Meeting of the American Society of Nephrology, St. Louis Missouri, October 29- November 1, 2004.

107. Marx, S.E., Brown, L.M., Ashraf, T., Amdahl, M., Melnick, J.Z., Williams, L.A., Sprague, S.M.: Evaluation of annualized dosing ratio of paricalcitol to calcitriol in hemodialyisis patients. Presented to the 37th Annual Meeting of the American Society of Nephrology, St. Louis Missouri, October 29- November 1, 2004.

108. Mittman, N., Finkelstein, F., Cullerton, B., Charytan, C., Agarwal, A., Albizem, M.A., Guo, M.G., Klassen, P.S., Sprague, S.M.: Cinacalcet HCl for the management of secondary hyperparathyroidism in patients receiving peritoneal dialysis. Presented to the 37th Annual Meeting of the American Society of Nephrology, St. Louis Missouri, October 29- November 1, 2004.

109. Coyne, D., Martin, K.J., Qui, P., Acharya, M., Batlle, D., Rosansky, S., Abboud, H., Fadem, S., Levine, L., Smolenski, O., Kaplan, M., Williams, L., Sprague, S.M.: Paricalcitol (Zemplar) Capsule Controls Secondary Hyperparathyroidism (SHPT) in Chronic Kidney Disease (CKD) Stages 3 and 4 Patients. Presented to the 37th Annual Meeting of the American Society of Nephrology, St. Louis Missouri, October 29- November 1, 2004.

110. Ghantous, W, Schinleber, P, Roberts, L, Sprague, SM.: Inhibition of parathyroid hormone: Dose equivalency study between paricalcitol and doxercalciferol. Presented to the National Kidney Foundation 2005 Spring Clinical Meetings, Washington, D.C., May 4-8, 2005.

111. Coyne, D., Melnick, J.Z., Tian, J., Williams, L.A., Andress, D., Sprague, S.M.: Paricalcitol therapy has no adverse effect on kidney function. Presented to the National Kidney Foundation 2005 Spring Clinical Meetings, Washington, D.C., May 4-8, 2005.

112. Josephson, M.A., Sprague, S.M.: Cinacalcet use after kidney transplant. Presented to the American Transplant Congress 2005, Seattle, Washington, May 21-25, 2005.

113. Coyne, D., Martin, K.J., Acharya, M., Andress, D., Qiu, P., Melnick, J.Z., Williams, L.A., Sprague, S.M.: Safety and efficacy of paricalcitol capsule for the treatment of secondary hyperparthyroidism in early stage CKD patients. Presented to the XLII ERA-EDTA Congress, Istanbul Turkey, June 4-7, 2005.

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115. Menaa, C., Abdouelaziz, A., Froelich, C.J., Sprague, S.M.: p65 subunit is essential for osteoclastogenic factors expression in breast cancer cells. Presented to the 27th Annual Meeting American Society of Bone and Mineral Metabolism, Nashville, Tennessee, September 23-27, 2005.

116. Pramanik, R., Asplin, J., Lindeman, C., Donahue, S., Sprague, S.M., Favus, M., Coe, F.: CSF-1R in the pathogenesis of osteoporosis in idiopathic hypercalciuria. Presented to the 27th Annual Meeting American Society of Bone and Mineral Metabolism, Nashville, Tennessee, September 23-27, 2005.

117. Tang, I., Josephson, M.A., Kopyt, N., Sprague, S.M.: Cinacalcet in Post-Transplant Hyperparathyroidism. Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

118. Moe, S.M., Goodman, W.G., Cunningham, J., Drueke, T., Adler, S., Rosansky, S.J., Albizem, M.B., Olson, K.A., Addison, J., Sprague, S.M.: Cinacalcet HCl Sustains Long-Term Control of Secondary Hyperparathyroidism. Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

119. Sprague, S.M., Nicolini, M., Evenepoel, P., Curzi, M., Gonzalez, T., Husserl, F., Kopyt, N., Abboud, H., Culleton, B., Albizem, M.B., Addison, J., Olson, K.A., Klassen, P.S., Wong, G.K.T.: Simultaneous Control of PTH and CA x P Is Sustained over 2 Years of Treatment with Sensipar®/Mimpara® (Cinacalcet HCL). Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

120. Shirsat, S., Josephson, M.A., Sprague, S.M.: Vitamin D deficiency following renal transplantation. Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

121. Hristova, M., Ho, L.T., Kim, E., Oliva, R., Sprague, S.M.: Prevalence of 25-Hydroxyvitamin D Insufficiency and Deficiency in CKD Patients. Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

122. Zisman, A., Hristova, M., Degraf, J., Ho, L.T., Sprague, S.M.: Effects of Treatment of 25-Hydroxyvitamin D Deficiency in CKD Patients. Presented to the American Society of Nephrology Renal Week 2005, Philadelphia, Pennsylvania, November 8-13, 2005.

123. Funes, I., Nash, K., Sprague S.M.: Improved health status in end-stage cardiac patients with congestive heart failure (CHF) using icodextrin. Presented to the Annual Conference on Dialysis. San Francisco, California, February 26-28, 2006.

124. Sprague, S., Charytan, C., Horowitz, J., Tucker, K., Tharpe, D., Lad, P., Wang, O., Turner, S., Block, G.: A prosepctive observational registry assessing the management and progression of secondary HPT in patients with chronic kidney disease (CKD): Methods and objectives. Presented to the National Kidney Foundation 2006 Spring Clinical Meetings, Chicago, Illinois, April 19-23, 2006.

125. Copley, J., Germain, M., Stern, L., Pankewyckz, O., Katznelson, S., Wang, O., Turner, S., Sprague, S.: Retrospective evaluation of cinacalcet HCl in subjects following renal transplantation. Presented to the XLIII Congress of the European Renal Association- European Dialysis and Transplant Association. Glasgow, United Kingdom, July 15-18, 2006.

126. Sprague, S.M., Germain, M., Stern, L., Pankewyckz, O., Katznelson, S., Wang, O., Turner, S., Copley, J.: Retrospective evaluation of cinacalcet HCl in patients following renal transplantation. Presented to the World Transplant Congress, Boston, Massachusetts, July 22-27, 2006.

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128. Gal-Moscovici, A., Menaa, C., Tarjan, S., Sprague, S.M.: The inhibitory effect of cyclosporine on osteoclast formation *in vitro* may be reversed by the in *vivo* production of osteoclastogenic factors. Presented to the American Society of Nephrology Renal Week 2006, San Diego, California, November 14-20, 2006.

129. Ross, E., Tian, J., Abboud, H., Hippensteel, R., Melnick, J.Z., Williams, L.A., Hamm, L.L., Sprague, S.M.: Paricalcitol Capsules for the Treatment of Secondary Hyperparathyroidism in Patients on HD or PD. Presented to the American Society of Nephrology Renal Week 2006, San Diego, California, November 14-20, 2006.

130. Shapiro, W., Martinez, C., Charytan, C., Horowitz, J., Tharpe, D., Droge, J., Ling, X., Belozeroff, V., Block, G., Sprague, S.M.: A Prospective Observational Registry Assessing the Management and Progression of Secondary Hyperparathyroidism (HPT) in Patients with Chronic Kidney Disease (CKD): Baseline Data. Presented to the American Society of Nephrology Renal Week 2006, San Diego, California, November 14-20, 2006.

131. Mehrotra, B., Martin, K., Fishbane, S., Sprague, S.M., Zeig, S.: Reformulated higher Dosage strength lanthanum carbonate demonstrates efficacy and tolerability. Presented to the Annual Conference on Dialysis. Denver, Colorado, February 18-20, 2007.

132. Floege, J., Sprague, S.M., Droge, J., Banos, A., Chertow, G.: Advance: the effect of cinacalcet plus low-dose vitamin d on vascular calcification in hemodialysis patients – methods. Presented to the National Kidney Foundation 2007 Spring Clinical Meetings, Orlando, Florida, April 10-15, 2007.

133. Mehrotra, R., Martin, K., Anger, M. , Fishbane, S., Sprague, S.M., Zeig, S.: Reformulated lanthanum carbonate: An analysis of efficacy and safety. Presented to the National Kidney Foundation 2007 Spring Clinical Meetings, Orlando, Florida, April 10-15, 2007.

134. Sprague, S.M., Melnick, J., Tian, J., Hippensteel, R.: Treatment with paricalcitol capsules reduces total and bone-specific alkaline phosphatase in dialysis patients. Presented to the National Kidney Foundation 2007 Spring Clinical Meetings, Orlando, Florida, April 10-15, 2007.

135. Ross, E., Abboud, H., Tian, J., Hippensteel, R., Melnick, J.Z., Hamm, L.L., Sprague, S.M.: Optimized dosing regimen of paricalcitol capsule for treatment of secondary hyperparathyroidism in dialysis patients. Presented to the XLIV ERA-EDTA Congress, Barcelona, Spain, June 21-24, 2007.

136. Shannon, Y.M., Khambati, N., Ho, L.T., Sprague, S.M.: Effects of Ergocalciferol on ESA Requirements in Non-dialysis CKD Patients. American Society of Nephrology Renal Week 2007, San Francisco, California, October 31-November 5, 2007.

137. Khambati, N., Ho, L.T., Sprague, S.M.: Treatment with ergocalciferol and active vitamin D for hyperparathyroidism in CKD. American Society of Nephrology Renal Week 2007, San Francisco, California, October 31-November 5, 2007.

138. Sprague, S.M., Finn, W.F., Qiu, P.: Hyperphosphatemia in chronic kidney disease stages 3 and 4: Findings from a randomized, multi-center trial. Presented at the American Society of Nephrology Renal Week 2007, San Francisco, California, October 31-November 5, 2007.

139. Sprague, S.M., Finn, W., Abboud, H., Qiu, P.: Lanthanum carbonate reduces phosphate burden in patients with CKD stages 3 and 4: Results from a randomized multicenter trial. Presented to the National Kidney Foundation 2008 Spring Clinical Meetings, Dallas, Texas, April 2-6, 2008.

140. Shapiro, W., Martinez, C., Charytan, C., Horowitz, J., Tharpe, D., Droge, J., Ling, X., Belozeroff, V., Goodman, W., Block, G., Sprague, S.M.: Treatment patterns in patients progressing through later-stage chronic kidney disease (CKD): Baseline data from a prospective observational registry. Presented to the National Kidney Foundation 2008 Spring Clinical Meetings, Dallas, Texas, April 2-6, 2008.

141. Shannon, Y., Khambati, N., Katsulis, Stutz, L., Ho, L.T., Sprague, S.M.: Effects of vitamin D on ESA requirements in CKD stage 3-4. Presented to the National Kidney Foundation 2008 Spring Clinical Meetings, Dallas, Texas, April 2-6, 2008.

142. Ho, L.T., Khambati, N., Sprague, S.M.: Ergocalciferol and active vitamin D for hyperparathyroidism in CKD. Presented to the National Kidney Foundation 2008 Spring Clinical Meetings, Dallas, Texas, April 2-6, 2008.

143. Zhang, E., Daniels, C., Ameer, G., Sprague, S.M.: Removal of advanced glycation end products with a novel extracorporeal bioadsorbent reduces the monocyte inflammatory response. Presented to the National Kidney Foundation 2008 Spring Clinical Meetings, Dallas, Texas, April 2-6, 2008.

144. Finn, W., Sprague, S.M., Abboud, H., Qiu, P.: 25-Hydroxyvitamin D and 1,25-dihydroxyvitamin D levels in patients with CKD stages 3 and 4 are not affected by lanthanum carbonate: Results from a randomized multicentre trial. Presented to the XLV ERA-EDTA Congress, Stockholm, Sweden, May 10-13, 2008.

145. Sprague, S.M., Finn, W., Abboud, H., Qiu, P.: Lanthanum carbonate reduces phosphate burden in patients with CKD stages 3 and 4: Results from a randomized multicentre trial. Presented to the XLV ERA-EDTA Congress, Stockholm, Sweden, May 10-13, 2008.

146. Belen, C., Amdahl, M., Weatherill, A.R., Andress, D., Sprague, S.M.: Treatment with oral paricalcitol reduces bone specific alkaline phosphatase and serum osteocalcin levels in CKD stage 3-5. Presented to the XIV International Congress on Nutrition and Metabolism in Renal Disease, Marseilles, France, June 11-15, 2008.

147. Rambod, M., Sprague, S.M., Kalantar-Zadeh, K.: Association of the marker of adynamic bone disease with malnutrition-inflammation complex in hemodialysis patients. Presented to the 30th American Society of Bone and Mineral Annual Research Meeting, Montreal, Quebec, Canada, September 12-16, 2008.

148. Rambod, M., Sprague, S.M., Kalantar-Zadeh, K.: Serum intact PTH of 100 to 150 pg/ml is associated with greatest survival in maintenance hemodialysis patients. Presented to the 30th American Society of Bone and Mineral Annual Research Meeting, Montreal, Quebec, Canada, September 12-16, 2008.

149. Shannon, Y., Du, H., Ho, L.T., Sprague, S.M.: The use of phosphate binders in non-dialysis CKD patients. Presented to the American Society of Nephrology Renal Week 2008, Philadelphia, Pennsylvania, November 4-9, 2008.

150. Gal-Moscovici, A., Frishman, M., Scherzer, P., Sprague, S.M.: Low turn-over bone disease in early CKD: A potential role of FGF-23. Presented to the American Society of Nephrology Renal Week 2008, Philadelphia, Pennsylvania, November 4-9, 2008.

151. Belen, C., Du, H., Ho, L.T., Sprague, S.M.: Calcium and Risk of Mortality in Chronic Kidney Disease. Presented to the American Society of Nephrology Renal Week 2008, Philadelphia, Pennsylvania, November 4-9, 2008.

152. Arora, A., Du, H., Ho, L.T., Sprague, S.M.: Association of ergocalciferol treatment and mortality in chronic kidney disease. Presented to the American Society of Nephrology Renal Week 2008, Philadelphia, Pennsylvania, November 4-9, 2008.

153. Huang, M., F., Du, H., Ho, L.T., Sprague, S.M., Kim, G., C.: Outcome differences in a chronic kidney disease management clinic. Presented to the American Society of Nephrology Renal Week 2008, Philadelphia, Pennsylvania, November 4-9, 2008.

154. Sprague, S.M., Zhang, P. Qiu, P.: Lanthanum carbonate vs. sevelamer hydrochloride for the reduction of serum phosphorus in patients on dialysis. Presented to the National Kidney Foundation 2009 Spring Clinical Meetings, Nashville, Tennessee, March 25-29, 2009.

155. Finn, W., Sprague, S.M., Abboud, H., Qiu, P.: Lanthanum carbonate treatment does not affect 25-hydroxyvitamin D (25-OH D) and 1,25-dihydroxyvitamin D ($1,25-(OH)_2$ D) levels in patients with CKD stages 3 and 4: A randomized trial. Presented to the National Kidney Foundation 2009 Spring Clinical Meetings, Nashville, Tennessee, March 25-29, 2009.

156. Krause, R., Sprague, S.M., Zhang, P., Qiu, P., Ross. E.: Lanthanum carbonate provides greater phosphate reduction than sevelamer hydrochloride over a 4 week treatment period in patients on dialysis. Presented to the World Congress of Nephrology 2009, Milan, Italy, May 22-26, 2009.

157. Fishbane, S., Sprague, S.M., Audhya, P., Andress, D.: A randomized controlled trial to evaluate survival benefits of paricalcitol compared to calcitriol in hemodialysis patients: Futility as a cause for early termination. Presented to the World Congress of Nephrology 2009, Milan, Italy, May 22-26, 2009.

158. Sprague, S.M., Poole, L., Smyth, M.: Greater reduction of serum phosphorus with lanthanum compared with sevelamer hydrochloride in hemodialysis patients. Presented to the American Society of Nephrology Renal Week 2009, San Diego, California, October 27- November 1, 2009.

159. Zhang, E., Lapidos, K., Ameer, G.A., Sprague, S.M.: A novel extracorporeal therapy approach to remove advanced glycation end products. Presented to the American Society of Nephrology Renal Week 2009, San Diego, California, October 27- November 1, 2009.

160. Streja, E., Kovesdy, C.P., Kim, Y., Rambod, M., Sprague, S.M., Nissenson, A.R., Kalantar-Zadeh, K.: Higher serum total alkaline phosphatase is associated with lower bone mineral density in hemodialysis patients. Presented to the American Society of Nephrology Renal Week 2009, San Diego, California, October 27- November 1, 2009.

161. DeGraf, J., Larson, D., Du, H., Kirshenbaum, S., Sprague, S.M., Khosla, N., Ho, L.T.: Effect of ergocalciferol treatment on mineral metabolism in chronic hemodialysis patients. Presented to

the National Kidney Foundation 2010 Spring Clinical Meetings, Orlando, Florida, April 13 - 17, 2010.

162. Larson, D., DeGraf, J., Du, H., Kirshenbaum, S., Sprague, S.M., Khosla, N., Ho, L.T.: Administration of oral 25-hydroxyvitamin D: Effects on anemia management in end stage renal disease. Presented to the National Kidney Foundation 2010 Spring Clinical Meetings, Orlando, Florida, April 13 - 17, 2010.

163. Knight, M., Du, H., Ho, L.T., Sprague, S.M.: Effects of IV iron use in non dialysis CKD. American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

164. Moe, S.M., Bellorin-Font, E.R., Carvalho, A.B., D'Haese, P.C., Drueke, T.B., Du H., Ferreira, M.A., Malluche, H.H., Sprague, S.M., Jorgetti, V.: Sensitivity and specificity of guideline PTH targets to differentiate high and low bone turnover. Presented to the American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

165. Sprague, S.M. Du, H., Manley, T.L., Carvalho, A.B., D'Haese, P.C., Drueke, T.B. Ferreira, M.A., Jorgetti, V., Moe, S.M., Malluche, H.H., Bellorin-Font, E.R: International assessment of TMV classification of bone biopsy in ESKD. Presented to the American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

166. Malluche, H.H, Bellorin-Font, E.R., Rojas, E., Carvalho, A.B., D'Haese, P.C., Drueke, T.B., Ferreira, M.A., Jorgetti, V., Moe, S.M., Sprague, S.M.: Predictive Value of Biomarkers for Bone Turnover in ESKD. Presented to the American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

167. Khosla, N., Degraf, J.D., Du, H., Sua, J.N., Ho, L.T., Sprague, S.M.: Effect of different ergocalciferol dosing on mineral metabolism and anemia management in end stage kidney disease. Presented to the American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

168. Khosla, N., Du, H., Patel, N.N., Ho, L.T., Degraf, J.D., Sprague, S.M.: Effect of ergocalciferol on anemia, management in end stage kidney disease. Presented to the American Society of Nephrology Renal Week 2010, Denver, Colorado, November 16 - 21, 2010.

169. Funes, I., Sprague, S.M., Khosla, N.: It can work: Daily hemodialysis in a rehabilitation facility. Presented to the Annual Dialysis Conference, Phoenix, Arizona, February 20-22, 2011.

170. Kirshenbaum, J., Du, H., Sprague, S.M.: Vitamin D status and calciuria in calcium oxalate nephrolithiasis. Presented to the National Kidney Foundation 2011 Spring Clinical Meetings, Las Vegas, Nevada, April 26-30, 2011.

171. Haquel, M.E., Bokhary, U., Fettman, S., Sprague, S.M., Prasad P.: Preliminary evaluation of renal BOLD MRI for monitoring progression in CKD patients. Submitted to the 19th Annual

Meeting of the International Society for Magnetic Resonance in Medicine, Montreal, Canada, May 7-13, 2011.

172. Khosla, N., Fettman, S., Sprague, S.M.: Impact of lanthanum carbonate on FGF23 in chronic kidney disease stages 3-5. Presented to the American Society of Nephrology Renal Week 2011, Philadelphia, Pennsylvania, November 8 - 13, 2011.

173. Prasad, P.V., Li, L., Agarwal, R., Sprague, S.M.: Blood oxygenation level dependent MRI in chronic kidney disease: A preliminary cross sectional study. Presented to the American Society of Nephrology Renal Week 2011, Philadelphia, Pennsylvania, November 8 - 13, 2011.

174. Goldberg, S., Faber, M., Ghossein, C., Sprague, S.M.: Update on the PACE Study: Randomized Controlled Trial of Paricalcitol and Calcitriol Endpoints. Presented to the American Society of Nephrology Renal Week 2011, Philadelphia, Pennsylvania, November 8 - 13, 2011.

175. Lazich, I., Alonzo, M., Donaldson, C., Sprague, S.M.: Ethanol injection for management of refractory hyperparathyroidism in CKD: Case reports. Presented to the National Kidney Foundation 2012 Spring Clinical Meetings. Washington, D.C. May 9-13, 2012.

176. Sprague, S.M., Al-Saghir, F., Sharma, A., Crawford, P., Zeig, S., Lee, S., Hootkins, R., Bushinsky, D., Green, R., Tabash, S., Melnick, J.: Safety and efficacy of CTAP101 capsules for SHPT and vitamin D insufficiency in stage 3 and 4 CKD. Presented to the National Kidney Foundation 2012 Spring Clinical Meetings. Washington, D.C. May 9-13, 2012.

177. Stobaugh, D.J., Deepak, P, Ehrenpreis, E.D., Sprague, S.M.: Predicting serum phosphate concentrations in patients undergoing chronic hemodialysis using a dynamic model. American Society of Nephrology Renal Week 2012, San Diego, California. October 30-November 4, 2012.

178. Ennis, J., Sprague, S.M., Worcester, E., Coe, F.: Association of Vitamin D Status and Secondary Hyperparathyroidism in CKD. Presented to the American Society of Nephrology Renal Week 2012, San Diego, California. October 30-November 4, 2012.

179. Khosla, N, Fettman, S., Gerseny, H., Sprague, S.M.: Impact of Lanthanum Carbonate on FGF23 in Chronic Kidney Disease Stages 3-5. Presented to the American Society of Nephrology Renal Week 2012, San Diego, California. October 30-November 4, 2012.

180. Floege, J., Ketteler, M., Rastogi, A., Covic, A.C., Chong, E.M.F., Lisk, L.J., Gaillard, S., Sprague, S.M.: Efficacy and safety of PA21 in hyperphosphatemic CKD patients on dialysis. Presented to the American Society of Nephrology Renal Week 2012, San Diego, California. October 30-November 4, 2012.

181. Sprague, S.M., Melnick, J., Tabash, S., Bishop, C., White, J., Epps, T., Rubison, R.M., Al-Saghir, F., Sharma, A.: Pharmacokinetic and pharmacodynamic profile of modified-release calcifediol in CKD Subjects with secondary hyperparathyroidism and vitamin D insufficiency. Presented to the National Kidney Foundation 2013 Spring Clinical Meetings, Orlando Florida. April 2-6, 2013.

182. Rastogi, A., Covic, A., Floege, J., Ketteler, M., Chong, E., Gaillard, S., Lisk, L., Sprague, S.M.: PA21 – A novel iron-based phosphate binder with a low pill burden: Tolerance in dialysis patients. Presented to the National Kidney Foundation 2013 Spring Clinical Meetings, Orlando Florida. April 2-6, 2013.

183. Floege, J., Covic, A., Ketteler, M., Rastogi, A., Chong, E., Lisk, L., Sprague, S.M.: Outcomes and regional analysis a phase 3 study of PA21, a novel iron-based phosphate binder. Presented to the 50th ERA-EDTA Annual Conference, Istanbul, Turkey, May 18-21, 2013.

184. Ketteler, M., Floege, J., Rastogi, A., Sprague, S.M., Gaillard, S., Löpfe, M., Wilhelm, M., Covic, A.: Analysis of fat-soluble vitamins in a phase 3 study of PA21, a novel iron-based phosphate binder. Presented to the 50th ERA-EDTA Annual Conference, Istanbul, Turkey, May 18-21, 2013.

185. Floege, J., Covic, A., Ketteler, M., Mann, J., Rastogi, A., Chong, E., Lisk, L., Sprague, S.M: Safety and efficacy of PA21, A novel iron-based phosphate binder, in patients with ESRD and hyperphosphatemia: A long-term phase 3 study. Presented to the 50th ERA-EDTA Annual Conference, Istanbul, Turkey, May 18-21, 2013.

186. Covic, A., Floege, J., Rastogi, A., Sprague, S.M., Levesque, V., Moneuse, P., Chong, E., Ketteler, M.: Novel iron-based phosphate binder PA21 effectively reduces serum phosphate in different subgroups of ESRD patients. Presented to the World Congress of Nephrology 2013, Hong Kong, May 31-June 4, 2013.

187. Floege, J., Covic, A.C., Ketteler, M., Mann, J., Rastogi, A., Spinowitz, B., Chong, E.M.F., Gaillard, S., Lisk, L.J., Sprague, S.M.: Efficacy and safety of novel iron-based phosphate binder PA21 in peritoneal- and haemodialysis-dependent CKD patients. Presented to the 11th European Peritoneal Dialysis Meeting, Masstricht, Netherlands, October 11-14, 2013.

188. Lazich, I., Alonzo, M., Donaldson, C., Sprague, S.M.: Ethanol injection for management of severe hyperparathyroidism: Case reports. American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

189. Wetmore, J., Gurevich, K., Sprague, S.M., Da Roza, G., Buerkert, J., Reiner, M., Goodman, W., Cooper, K.: The PARADIGM Trial: Impact of dialysate calcium and calcium based binders. Submitted to the American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

190. Sprague, S.M., Wetmore, J., Gurevich, K., Da Roza, G., Buerkert, J., Reiner, M., Goodman, W., Cooper, K.: The PARADIGM trial: Effects of cinacalcet and vitamin D as monotherapies on FGF-23 levels during treatment of secondary hyperparathyroidism in patients on dialysis. Submitted to the American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

191. Wetmore, J., Gurevich, K., Sprague, S.M., Da Roza, G., Buerkert, J., Reiner, M., Goodman, W., Cooper, K.: The PARADIGM trial: cinacalcet vs vitamin D as monotherapies for treatment of secondary hyperparathyroidism in patients on dialysis. Presented to the American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

192. Rawal, A., Sprague, S.M.: Weeping Kidney Syndrome. American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

193. Sprague, S.M., Floege, J., Covic, A., Ketteler, M., Rastogi, A., Chong, E.M.F., Spinowitz, B.S.: Efficacy of PA21, a novel iron-based phosphate binder, maintained to 52 weeks in dialysis patients with hyperphosphatemia. Presented to the American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

194. Sprague, S.M., Covic, A., Ketteler, M., Rastogi, A., Spinowitz, B.S., Floege, J.: Analysis of CKD-MBD Markers in a Phase 3 Study of PA21 and sevelamer in patients with hyperphosphatemia. Presented to the American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 5-10, 2013.

195. Rastogi, A., Covic, A., Floege, J., Ketteler, M., Spinowitz, B., Botha, J., Gaillard, S., Sprague, S.M.: No clinically relevant changes in vitamin D concentrations with PA21, a novel iron-based phosphate binder, over 52 weeks. Presented to the National Kidney Foundation 2014 Spring Clinical Meetings, April 22-26, 2014.

196. Sprague, S.M., Covic, A., Floege, J., Moneuse, P., Ketteler, M., Spinowitz, B., Gaillard, S., Rastogi, A.: Concomitant intravenous iron use drives changes in iron indices in a phase 3 study of PA21. Presented to the National Kidney Foundation 2014 Spring Clinical Meetings, April 22-26, 2014.

197. Coyne, D.W., Goldberg, S., Faber, M.D., Ghossein, C., Sprague, S.M.: Update on the PACE study: Randomized controlled trial of paricalcitol and calcitriol endpoints. Presented to the National Kidney Foundation 2014 Spring Clinical Meetings, April 22-26, 2014.

198. Ketteler, M., Covic, A., Rastogi, A., Sprague, S.M., Botha, J., Rakov, V., Flöege, J.: No decline in serum concentration of fat-soluble vitamins after one year of treatment with a new iron-based phosphate binder PA21 in phase 3 study. Presented to the 17th International Society for Renal Nutrition and Metabolism, Wurzburg, Germany, May 6-10, 2014.

199. Thacker, J., Tan, H., Li, L-P., Li, W., Sprague, S.M., Kohn, O., Lazich, I., Prasad, P.V.: ASL and BOLD MRI measurements in human kidneys. Presented to the Joint Annual Meeting of International Society for Magnetic Resonance in Medicine-European Society for Magnetic Resonance in Medicine and Biology, Milan, Italy, May 10-16, 2014.

200. Floege, J., Ketteler, M., Rastogi, A., Spinowitz, B., Sprague, S.M., Botha, J., Braunhofer, P., Covic, A.: Post hoc analysis of safety profiles by patient age in a phase 3 study of PA21 and sevelamer carbonate. Presented to the 51st ERA-EDTA Annual Conference, Amsterdam, Netherlands, May 31-June 3, 2014.

201. Covic, A., Ketteler, M., Rastogi, A., Spinowitz, B., Sprague, S.M., Botha, J., Rakov, V., Floege, J.: Efficacy and safety of PA21 and sevelamer carbonate in haemodialysis patients with or without diabetes: a post hoc analysis of a phase 3 study. Presented to the 51st ERA-EDTA Annual Conference, Amsterdam, Netherlands, May 31-June 3, 2014.

202. Covic, A., Ketteler, M., Rastogi, A., Spinowitz, B., Sprague, S.M., Botha, J., Braunhofer, P., Floege, J.: Comparison of safety profiles of PA21 and sevelamer carbonate in a post hoc analysis of a phase 3 study. Presented to the 51st ERA-EDTA Annual Conference, Amsterdam, Netherlands, May 31-June 3, 2014.

203. Floege, J., Botha, J., Chong, E., Sprague, S.M.: PA21 does not interact with oral vitamin D analogues: A post hoc analysis of a phase 3 study. Presented to the 51st ERA-EDTA Annual Conference, Amsterdam, Netherlands, May 31-June 3, 2014.

204. Floege, J., Covic, A.C., Ketteler, M., Rastogi, A., Chong, E.M.F., Gaillard, S., Lisk, L.J., Sprague, S.M.: Efficacy and safety of PA21, a novel iron-based phosphate binder in CKD patients on peritoneal and haemodialysis. Presented to the 15th Congress of the International Society for Peritoneal Dialysis, Madrid, Spain, September 7-10, 2014.

205. Thacker, J., Tan, H., Li, L-P., Li, W., Sprague, S.M., Kohn, O., Lazich, I., Prasad, P.V.: Human kidneys with diabetes and stage 3 CKD are ischemic and hypoxic as evaluated by MRI. Presented to the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

206. Sprague, S.M., Botha, J., Rakov, V., Floege, J.: Sucroferric oxyhydroxide does not affect oral vitamin D agonists: Post hoc analysis of phase 3 data. Presented to the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

207. Sprague, S.M., Covic, A., Ketteler, M., Rastogi, A., Spinowitz, B., Botha, J., Rakov, V., Floege, J.: Post hoc analysis of iron indices in dialysis patients with lower vs higher baseline ferritin in sucroferric oxyhydroxide study. Presented to the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

208. Sprague, S.M., Covic, A., Floege, J., Ketteler, M., Spinowitz, B., Gaillard, S., Moneuse, P., Rastogi, A.: Concomitant I.V. iron use drives change in iron indices across geographical regions in sucroferric oxyhydroxide study. Proceedings of the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

209. Goldberg, S., Coyne, D.W., Faber, M., Sprague, S.M.: Effects of active vitamin D on fibroblast growth factor-23 in patients with chronic kidney disease; Subgroup analysis of the PACE trial. Presented to the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

210. Sprague, S.M., Ali, S., Mangoo-Karim, R., Crawford, P.W., Pergola, P.E., Sindelar, L., Strugnell, S.A., Melnick, J., Z., White, J.A., Petkovich, M.P., Bishop, C.W.: Safety and efficacy of modified-release calcifediol for secondary hyperparathyroidism in patients with stage 3 or 4

CKD and vitamin D insufficiency. Presented to the American Society of Nephrology Renal Week 2014, Philadelphia, Pennsylvania, November 11-16, 2014.

211. Wooldridge, T.D., Sprague, S.M., Rakov, V., Botha, J., Rastogi, A.: Efficacy and safety of iron-based phosphate binder sucroferric oxyhydroxide in CKD patients on peritoneal dialysis (PD) or hemodialysis (HD). Presented to the 35th Annual Dialysis Conference, New Orleans, Louisiana, January 31- February 3, 2015.

212. Coyne, D., Sprague, S.M., Chong, E., Botha, J., Rastogi, A.: Sucroferric oxyhydroxide does not interact with oral vitamin D receptor agonists: a *post hoc* analysis of Phase 3 data. Presented to the 35th Annual Dialysis Conference, New Orleans, Louisiana, January 31- February 3, 2015.

213. McKiernan, F., Sprague, S.M., Binkley, N., Dharmanolla, S., White, J., Petkovich, M., Bishop, C.W., Melnick, J.: Modified-release calcifediol lowers iPTH, corrects 25(OH)D levels and reduces bone markers in CKD patients. Presented to the 97th Annual Meeting of the Endocrine Society, San Diego, California, March 5-8, 2015.

214. Ketteler, M., Sprague, S.M., Covic, A., Rastogi, A., Rakov, V., Chong, E., Floege, J.: Analysis of FGF-23 and other CKD-MBD markers in a phase 3 study of sucroferric oxyhydroxide in CKD patients on dialysis. Presented to ISN World Congress of Nephrology 2015, Cape Town, South Africa, March 13-17, 2015.

215. Sprague, S.M., Covic, A., Floege, J., Ketteler, M., Spinowitz, B., Rakov, V., Botha, J., Rastogi, A.: Post hoc analysis of antianemic product use over 1 year in a phase 3 study of sucroferric oxyhydroxide. Presented to the National Kidney Foundation 2015 Spring Clinical Meetings, Dallas, Texas, March 25-29, 2015.

216. Sprague, S.M., Shaukat, A., Mangoo-Karim, R., Crawford, P.: Modified-release calcifediol is effective for SHPT in both Stages 3 and 4 CKD. Presented to the National Kidney Foundation 2015 Spring Clinical Meetings, Dallas, Texas, March 25-29, 2015.

217. Covic, A., Sprague, S.M., Ketteler, M., Spinowitz, B., Rastogi, A., Botha, J., Rakov, V., Floege, J.: Post hoc analysis of IV iron and ESA use over 1 year in a phase 3 study of sucroferric oxyhydroxide. Presented to the 52nd ERA-EDTA Congress, London, United Kingdom, May 28-31, 2015.

218. Covic, A., Sprague, S.M., Ketteler, M., Rastogi, A., Spinowitz, B., Botha, J., Rakov, V., Floege, J.: Post Hoc analysis of iron indices in dialysis patients with lower verse higher baseline ferritin in a phase 3 study of sucroferric oxyhydroxide. Presented to the 52nd ERA-EDTA Congress, London, United Kingdom, May 28-31, 2015.

219. Sprague, S.M., Strugnell, S.A., Melnick, J.Z., White, J.A., Petkovich, M.P., Bishop, C.W.: Efficacy and safety of modified-release calcifediol in stage 3-4 CKD patients with secondary hyperparathyroidism and vitamin D insufficiency. Presented to the American Society of Nephrology Renal Week 2015, San Diego, California, November 3-8, 2015.

220. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Rakov, V., Samuels, L.A.: Efficacy and safety of sucroferric oxyhydroxide, an iron-based phosphate binder over 52 weeks in African American dialysis patients. Presented to the American Society of Nephrology Renal Week 2015, San Diego, California, November 3-8, 2015.

221. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Rakov, V., Samuels, L.A.: CKD-MBD indices after 52 weeks of sucroferric oxyhydroxide, and iron based phosphate binder, in African American dialysis patients. Presented to the American Society of Nephrology Renal Week 2015, San Diego, California, November 3-8, 2015.

222. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Rakov, V., Samuels, L.A.: Concomitant IV iron use drives changes in iron indices in African American dialysis patients over 52 weeks of sucroferric oxyhydroxide treatment. Presented to the American Society of Nephrology Renal Week 2015, San Diego, California, November 3-8, 2015.

223. Sprague, S.M., Strugnell, S., Melnick, J.Z., White, J., Petkovich, M., Bishop, C.W.: Treatment effects of modified release calcifediol on bone markers suggest higher 25-hydroxyvitamin D levels are needed for adequacy in patients with stage 3 or 4 CKD. Presented to the ENDO 2016, Boston, Massachusetts, April 1-4, 2016.

224. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Rakov, V., Samuels, L.A.: FGF-23 CKD-MBD indices after 1 year of treatment with sucroferric oxyhydroxide in African American dialysis patients. Presented to the National Kidney Foundation 2016 Spring Clinical Meetings, Boston, Massachusetts, April 27-May 1, 2016.

225. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Rakov, V., Samuels, L.A.: 1-Year efficacy and safety of sucroferric oxyhydroxide in a sub-population of African American dialysis patients. Presented to the National Kidney Foundation 2016 Spring Clinical Meetings, Boston, Massachusetts, April 27-May 1, 2016.

226. Sprague, S.M., Melnick, J.Z., Strugnell, S.A., Graces, C., Dharmanolla, S., Petkovich, M.P., Bishop, C.W: Efficacy of modified-release calcifediol for SHPT in CKD increases with dose. Presented to the National Kidney Foundation 2016 Spring Clinical Meetings, Boston, Massachusetts, April 27-May 1, 2016.

227. Prasad, P.V., Thacker, J., Tan, H., Li, L-P., Li, W., Zhou, Y., Kohn, O., Sprague, S.M.: Kidneys of subjects with chronic kidney disease (CKD) are ischemic but not necessarily hypoxic. Presented to the 24th Annual meeting for the International Society of Magnetic Resonance in Medicine, Singapore, May 7-13, 2016.

228. Li, L-P, Tan, H., Thacker, J., Li, W., Zhou, Y., Kohn, O., Sprague, S.M., Prasad, P.V.: Evaluation of renal blood flow in subjects with diabetic nephropathy using ASL perfusion MRI. Presented to the 24th Annual meeting for the International Society of Magnetic Resonance in Medicine, Singapore, May 7-13, 2016.

229. Floege, J., Sprague, S.M., Covic, A., Rastogi, A.,Spinowitz, B., Larroque, S., Rakov, V., Ketteler, M.: Sucroferric oxyhydroxide does not impact the iPTH-lowering effects of oral VDRAs or cinacalcet: A post hoc analysis of a phase 3 study. Presented to the 53rd ERA-EDTA Congress, Vienna, Austria, May, 21-24, 2016.

230. Floege, J., Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Rakov,V., Larroque, S., Pergola, P.: Characteristics of responders and non-responders to treatment with sucroferric oxyhydroxide: A *post hoc* analysis of a phase 3 study. Presented to the 53rd ERA-EDTA Congress, Vienna, Austria, May, 21-24, 2016.

231. Wall, J.V., Zierold, C., Olson, G., Blocki, F.A., Bonelli, F., Sprague, S.M., Martin, K.J.: Characterization of two parathyroid hormone (1-84) standard materials. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

232. Floege, J., Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Walpen, S., Rakov, V., Larroque, S., Pergola, P.: Characteristics of responders and non-responders to phosphate binder therapy: A post hoc analysis of a phase 3 study. Presented to the American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

233. Ketteler, M., Sprague, S.M., Covic, A., Rastogi, A., Spinowitz, B., Larroque, S., Rakov, V., Walpen, S., Floege, J: Effect of non-calcium phosphate binders on CKD-MBD indices in dialysis patients: A post hoc analysis of a phase 3 study. Presented to the American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

234. Prasad, P.V., Li, L-P., Thacker, J., Zhou, Y., Kohn, O.F., Sprague, S.M.: Apparent disparity between renal cortical blood flow and oxygenation in diabetic nephropathy as evaluated by magnetic resonance imaging. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

235. Prasad, P.V., Sprague, S.M., Li, W., Dunkle, E., and Combine Investigators: Magnetic resonance imaging sensitive to hypoxia and fibrosis in a multi-center study of chronic kidney disease. Presented to the American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

236. Sprague, S.M., Zhou, Y., Faber, M., Coyne, D.W.: Effect of vitamin D therapy on CKD-MBD biomarkers in CKD: A post hoc analysis of the PACE study. Presented to the American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

237. Sprague, S.M., Strugnell, S.A., Melnick, J.Z., Petkovich, M.P., Bishop, C.W.: Modified-release calcifediol is effective in African-American and non-African-American patients with stage 3-4 CKD, secondary hyperparathyroidism and vitamin D insufficiency. Presented to the American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

238. Sprague, S.M., Zierold, C., Blocki, F.A., Bonelli, F., Coyne, D.W.: Baseline levels of 1,25-dihydroxyvitamin D in CKD 3-4 patients may be associated with changes in serum calcium in patients receiving calcitriol. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 15-20, 2016.

239. Sprague, S.M., Strugnell, S.A., Laidlaw, D., Petkovich, M.P., Bishop, C.W.: Extended-release calcifediol is effective for secondary hyperparathyroidism in both African-American and non-African-American patients with stage 3-4 CKD. Presented to the 20th Workshop on Vitamin D, Orlando, Florida, March 28-31, 2017.

240. Sprague, S.M., Strugnell, S., Laidlaw, D., Petkovich, M., Bishop, C.W.: PTH-lowering efficacy of extended-release calcifediol is not affected by underlying diabetes in stage 3 or 4 CKD. Presented to Endo 2017, Orlando, Florida, April 1-4, 2017.

241. Sprague, S.M., Strugnell, S., Laidlaw, D., Petkovich, M., Bishop, C.W: The efficacy and safety of extended-release calcifediol in Hispanic Vs Non-Hispanic adult subjects with SHPT, stage 3-4 CKD and vitamin D insufficiency. Presented to the ISN World Congress of Nephrology 2017, Mexico City, Mexico, April 21-25, 2017.

242. Sprague, S.M., Parameswaran, V., Ficociello, L.H., Mullon, C., Kossmann, R.J.: Change in serum phosphorus and pill burden among hemodialysis patients switching from phosphate binder dual therapy to monotherapy with sucroferric oxyhydroxide. Presented to the National Kidney Foundation 2017 Spring Clinical Meetings, Orlando, Florida, April 18-22, 2017.

243. Sprague, S.M., Ficociello, L.H., Parameswaran, V., Mullon, C., Kossmann, R.J.: Phosphorus (P) control in patients prescribed sucroferric oxyhydroxide (SO) with and without baseline elevated parathyroid hormone (PTH). Presented to the National Kidney Foundation 2017 Spring Clinical Meetings, Orlando, Florida, April 18-22, 2017.

244. Sprague, S.M., Rastogi, A., Ketteler, M., Covic, A., Floege, J., Larroque, S., Walpen, S., Henriquez, M.: One year efficacy and safety of sucroferric oxyhydroxide in Hispanic dialysis patients. Presented to the National Kidney Foundation 2017 Spring Clinical Meetings, Orlando, Florida, April 18-22, 2017.

245. Sprague, S.M., Dean, P., Li, L., Thacker, J., Zhou, Y., Kohn, O., Prasad, P.: Apparent disparity between renal cortical blood flow and oxygenation in diabetic nephropathy as evaluated by magnetic resonance imaging. Presented to the National Kidney Foundation 2017 Spring Clinical Meetings, Orlando, Florida, April 18-22, 2017.

246. Sprague, S.M., Parameswaran,V., Ficociello, L.H., Ofsthun, N., Mullon, C., Kossmann, R.J., Coyne, D.W.: Two year follow up on chronic hemodialysis (HD) patients prescribed sucroferric oxyhydroxide (SO) as part of routine care. Presented to the American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October 31- November 5, 2017.

247. Coyne, D.W., Ficociello, L.H., Parameswaran,V., Ofsthun, N., Mullon, C., Kossmann, R.J., Sprague, S.M.: Effectiveness of sucroferric oxyhydroxide (SO) in lowering serum phosphorus (sP) in 4,925 chronic hemodialysis (HD) patients prescribed SO as part of routine care. Presented to the American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October 31- November 5, 2017.

248. Nickolas, T., Pereira, R.C., Coco, M., Ix, J.H., Chonchol, M., Pullman, J.M., Sprague, S.M., Salusky, I.B.: Relationships between vitamin D and bone formation and mineralization in adults and children with predialysis CKD. Presented to the American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October 31- November 5, 2017.

249. Sprague, S.M., Strugnell, S.A., Ashfaq, A., Petkovich, M.P., Bishop, C.W.: PTH suppression with extended-release calcifediol (ERC) is directly proportional to severity of secondary hyperparathyroidism (SHPT). Presented to the American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October 31- November 5, 2017.

250. Baied, E., Alonzo, M., Sprague, S.M.: Ultrasound guided ablation therapy for treatment of severe secondary hyperparathyroidism. American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October 31- November 5, 2017.

251. Sprague, S.M., Strugnell, S.A., Ashfaq, A., Bishop, C.W.: Extended-release calcifediol (ERC) improves bone marker levels in CKD patients with diabetes. Submitted to the National Kidney Foundation 2018 Spring Clinical Meetings, Austin, Texas, April 10-14, 2018.

252. Li, W., Isakova, T., Sprague, S.M., Prasad, P.V.: Renal BOLD and diffusion MRI in CKD: First application to a multi-center trial. Submitted to the Joint Annual Meeting of the International Society for Magnetic Resonance in Medicine-European Society for Magnetic Resonance in Medicine and Biology, Paris, France, June 16-21, 2018.

SELECTED INVITED SEMINARS

1. Aluminum Bone Disease. National Kidney Foundation of Illinois Annual Meeting, Chicago, Illinois, October 11, 1990.

2. Aluminum Toxicity Syndrome in Dialysis Patients. Medical Grand Rounds, University of Chicago, Chicago, Illinois, December 4, 1990.

3. Therapy of Secondary Hyperparathyroidism. Kansas City, Missouri, April 18, 1991.

4. Mechanism of Aluminum Associated Bone Mineral Dissolution. Northwestern University, Chicago, Illinois, September 5, 1991.

5. Pathologic Mechanisms in Aluminum Associated Bone Disease. Yale University, New Haven, Connecticut, October 18, 1991.

6. Low Dose Intravenous Calcitriol. Experts Roundtable on the Prevention and Management of Renal Osteodystrophy. Phoenix, Arizona, December 7, 1991.

7. Cellular Basis for Aluminum Associated Bone Disease. University of Chicago, Chicago, Illinois, December 10, 1991.

8. Overview of Renal Osteodystrophy. Renal Network of Illinois Annual Meeting, Chicago, Illinois, January 24, 1992.

9. Secondary Hyperparathyroidism. Medical Grand Rounds, Loyola University Medical School, Maywood, Illinois, February 26, 1992.

10. Bone Disease in Renal Failure. Lunch with the Experts session of the Clinical Nephrology Meetings of the National Kidney Foundation, Chicago, Illinois, April 10-12, 1992.

11. Renal Bone Disease. Medical Grand Rounds, Evanston Hospital, Evanston, Illinois, May 6, 1992.

12. Calcium Balance in Dialysis Patients. The 2nd Annual University of Wisconsin Nephrology Forum, Madison, Wisconsin, May 28, 1992.

13. Renal Osteodystrophy. The National Center for Advanced Medical Education. Specialty Review in Nephrology. Chicago, Illinois, September 13-17, 1992.

14. Long Term Complications of Renal Failure. Medical Grand Rounds, Christ Hospital and Medical Center, Oak Lawn, Illinois, October 15, 1992.

15. Bone Disease after Kidney Transplantation. National Education Meeting of the National Kidney Foundation of Illinois, Chicago, Illinois, October 17, 1992.

16. β_2-Microglobulin Amyloidosis Associated Bone Disease. Rush Presbyterian St. Lukes Medical Center, Chicago, Illinois, April 19, 1993.

17. Serum PTH: What Are We Aiming For and Why? Second Annual Spring Clinical Nephrology Meetings of The National Kidney Foundation, Inc., Chicago, Illinois, April 23, 1993.

18. Role of Bone Biopsy in Patients with Renal Failure. Lunch with the Experts session of the Second Annual Spring Clinical Nephrology Meetings of the National Kidney Foundation, Chicago, Illinois, April 22-25, 1993.

19. Mechanism of β_2-microglobulin Induced Bone Mineral Dissolution. Hebrew University-Hadassah Medical Center, Jerusalem, Israel, September 7, 1993.

20. Renal Osteodystrophy. The National Center for Advanced Medical Education. Specialty Review in Nephrology. Chicago, Illinois, September 25-29, 1994.

21. Overview of Renal Bone Disease. Medical Grand Rounds. Lutheran General Hospital, Park Ridge, Illinois, February 1, 1995.

22. The Role of β_2-Microglobulin in Dialysis Associated Amyloidosis. Advances In Mineral Metabolism, Snowmass, Colorado, April 2-6, 1995.

23. Bone Manifestations of Dialysis Amyloidosis; Renal Bone Disease, Parathyroid Hormone, and Vitamin Satellite Symposium to the XIIIth International Congress of Nephrology, Seville, Spain, July 7-10, 1995.

24. Pathogenesis of β_2-microglobulin Bone Disease. Hebrew University-Hadassah Medical Center, Jerusalem, Israel, July 17, 1995.

25. Bone Disease Post Transplantation. Xth International Workshop on Calcified Tissues, Jerusalem, Israel, March 11, 1996.

26. Renal Osteodystrophy. The National Center for Advanced Medical Education. Specialty Review in Nephrology. Chicago, Illinois, October 7-11, 1996.

27. Osteoporosis and Renal Disease. Saint Mary's Health Center-Michigan State University College of Human Medicine, Grand Rapids, Michigan, June 20, 1997.

28. Bone Effects of Immunosuppressive and Anti-Neoplastic Agents. Meet-The-Professor Session of the 19th Annual Meeting of the American Society for Bone and Mineral Research. Cincinnati, Ohio, September 10-14, 1997.

29. Dialysis Amyloidosis. Renal Grand Rounds, Loyola University Medical School, Maywood, Illinois, October 9, 1997.

30. β_2-Microglobulin Amyloidosis. Renal Grand Rounds, University of Michigan, Ann Arbor, Michigan, February 4, 1998.

31. Post-Transplant Bone Disease. Division of Nephrology, University of Michigan, Ann Arbor, Michigan, February 5, 1998.

32. Renal Osteodystrophy and Divalent Ion Metabolism. Clinical Nephrology Symposium, 31st Annual Meeting of the American Society of Nephrology, Philadelphia, Pennsylvania, October 27, 1998.

33. Mechanisms of Transplantation-Associated Bone Loss. The 6th Symposium on Growth and Development in Children with Chronic Renal Failure "Molecular Basis of Skeletal Growth" of the International Pediatric Nephrology Association, New York, New York, March 12, 1999.

34. Overview of Bone Disease in Dialysis Patients and Indications for Bone Biopsy. 8th Annual National Kidney Foundation Clinical Nephrology Meetings, Washington D.C., April 30, 1999.

35. Malignancies and Disorders of Divalent Cations. 4th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 1999.

36. Nephrolithiasis: Pathogenesis, Diagnosis and Treatment. 4th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 1999.

37. Advanced Issues in Nephrolithiasis. 4th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 1999.

38. Update on Disturbances of Calcium and Phosphorus and Renal Osteodystrophy. Italian Nephrological Congress, Chicago, Illinois October 4-7, 1999.

39. Post-Transplant Bone Disease. Clinical Nephrology Symposium, 32nd Annual Meeting of the American Society of Nephrology, Miami Beach, Florida, November 6, 1999.

40. Overview of Therapeutic Strategies for Transplant Bone Disease. Transplant Bone Disease Meeting, Barcelona, Spain, August 25-26, 2000.

41. Nephrolithiasis: Pathogenesis, Diagnosis and Treatment. 5th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 26 – September 1, 2000.

42. Advanced Issues in Nephrolithiasis. 5th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 26 – September 1, 2000.

43. Electrolyte Disturbances in the ICU: Calcium, Magnesium and Phosphate. Postgraduate Education Course of the 33rd Annual Meeting of the American Society of Nephrology, Toronto, Ontario, Canada, October 11-12, 2000.

44. Short and Long Term Histologic and Densitometric Abnormalities Post-Transplantation. Clinical Nephrology Symposium, 33rd Annual Meeting of the American Society of Nephrology, Toronto, Ontario, Canada, October 14, 2000.

45. Overview of transplant associated bone disease. Medical Grand Rounds, Loyola University Medical School, Maywood, Illinois, October 31, 2000.

46. Role of β_2-microglobulin in causing osteoarthropathy in dialysis amyloidosis. Nephrology Research Conference, University of Texas Southwestern Medical Center, Dallas, Texas, January 8, 2001.

47. Phosphate control: Achieving the right balance. NephroAsia, Singapore, June 15, 2001.

48. Role of phosphate binders and calcimimetics in renal osteodystrophy. NephroAsia, Singapore, June 16, 2001.

49. Healthy bones for a satisfying life. National Kidney Foundation of Illinois, Chicago, Illinois, June 21, 2001.

50. Nephrolithiasis: Pathogenesis, Diagnosis and Treatment. 6th Annual Board Review Course & Update. American Society of Nephrology, Chicago, Illinois, August 25 – 31, 2001.

51. Advanced Issues in Nephrolithiasis. 6th Annual Board Review Course & Update. American Society of Nephrology, Chicago, Illinois, August 25 – 31, 2001.

52. Low bone turnover. 34th Annual Meeting of the American Society of Nephrology, San Francisco, California, October 15, 2001.

53. Post transplant bone disease. Grand Rounds, University of Western Ontario, London, Ontario, Canada, December 4, 2001.

54. Bone disease in hypercalciuric stone formers. Clinical Nephrology Meetings 2002, National Kidney Foundation, Chicago, Illinois, April 17-21, 2002.

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67. Transplant bone disease. National Kidney Foundation 2004 Clinical Meetings, Chicago, Illinois, April 28-May 2, 2004.

68. Osteoporosis verse renal osteodystrophy. National Kidney Foundation 2004 Clinical Meetings, Chicago, Illinois, April 28-May 2, 2004.

69. Renal bone disease:A new paradigm. Medical Grand Rounds, Chicago Medical School, North Chicago, Illinois, May 12, 2004.

70. Vitamin D analogs and the treatment of secondary hyperparathyroidism. Presented to XLI Congress of the European Renal Association/European Dialysis and Transplantation Society, Lisbon, Portugal, May 17, 2004.

71. Management of secondary hyperparathyroidism. The Renal Network 2004 Nephrology Conference, Chicago, Illinois June 10-11, 2004.

72. Disorders of calcium and phosphorus metabolism. 9th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 2004.

73. Renal osteodystrophy. 9th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 2004.

74. Bone and mineral management following renal transplantation. Combined Renal and Endocrine Grand Rounds, Columbia University, College of Physicians & Surgeons, New York, New York, October 18, 2004.

75. Chronic Kidney Disease: Early diagnosis, staging and treatment. Illinois Primary Health Care Association 22nd Annual Leadership Conference. St. Louis, Missouri, November 5, 2004.

76. Review of disorders of bone and mineral metabolism. 2nd Annual Regional Meetings of the American Society of Nephrology, Washington DC, February 5-6, 2005, Chicago, Illinois, February 12-13, 2005 & Seattle, Washington, February 26-27, 2005.

77. Meeting therapeutic goals with vitamin D therapy. Annual Dialysis Conference. Tampa, Florida, February 28-March 2, 2005.

78. New Phosphate Binders. Dialysis Annual Dialysis Conference. Tampa, Florida, February 28-March 2, 2005.

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83. Which Vitamin D Metabolite. Workshop on Mineral Metabolism, Israel Society of Nephrology and Hypertension and Hadassah Hebrew University Medical Center, Tel Aviv, Israel, July 28-29, 2005.

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93. Mechanism of Transplant Associated Bone Disease. Renal Grand Rounds, University of Colorado Renal, February 28, 2006.

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96. New Approaches to Managing Secondary Hyperparathyroidism. Vitamin D Recpetor Activators: What is their Role in CKD. Prague, Czech Republic, May 13, 2006.

97. Management of Secondary Hyperparathyroidism. Royal Society of Medicine. London, England, June 26, 2006.

98. New Concepts in Renal Bone Disease. North West Kidney Club. Manchester, England, June 28, 2006.

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100. Cardiovascular Risks, Complications and Survival: Role of Vitamin D. Humber River Regional Medical Center Grand Rounds. Toronto, Ontario, October 31, 2006.

101. Bone and Mineral Metabolism in CKD: Medical Crossfire. American Society of Nephrology Renal Week, San Diego, California, November 16, 2006.

102. Review of Disorders of Bone and Mineral Metabolism. Annual Renal Weekends 2007 Meetings of the American Society of Nephrology, Chicago, Illinois, March 31-April 1, 2007.

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106. Management of Post-Transplant Renal Bone Disease. ENDO 2007, The Endocrine Society's 89th Annual Meeting, Toronto, Ontario, Canada, June 2-5, 2007.

107. Pathophysiology of Post-transplant Bone Disease. University of Alabama Medical Center., Birmingham, Alabama, October 8, 2007.

108. CKD and Osteoporosis. 2007 Chronic Kidney Disease Symposium. University of Minnesota, Minneapolis, Minnesota, November 27, 2007.

109. Renal Transplant Bone Disease. Spectrum of Renal Bone Disease. Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, November 28, 2007.

110. Review of Disorders of Bone and Mineral Metabolism. Annual Renal Weekends 2008 Meetings of the American Society of Nephrology, Washington, D.C., February 9-10, 2008.

111. Vitamin D and CKD. Annual Renal Weekends 2008 Meetings of the American Society of Nephrology, Chicago, March 8-9, 2008.

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115. Pathophysiology of Transplant Associated Bone Loss. University of Chicago, May 16, 2008.

116. Management of Transplant Associated Bone Disease. Bay State Medical Center, Springfield, Massachusetts, September 11, 2008.

117. Osteoporosis in Chronic Kidney Disease. University of Nebraska, Omaha, Nebraska, September 18, 2008.

118. Phosphorus Balance in Chronic Kidney Disease. Combined Renal and Endocrine Grand Rounds, Columbia University, College of Physicians & Surgeons, New York, New York, October 27, 2008.

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120. Disorders of Mineral Metabolism in Chronic Kidney Disease. Endocrine Grand Rounds, Medical College of Wisconsin, Milwaukee, Wisconsin, October 1, 2009.

121. Pathophysiology of Phosphate Retention in CKD: A Comparative Review of the Efficacy and Safety of Phosphate Binders. Cork University, Cork, Ireland, October 22, 2009.

122. Pathophysiology and Management of Phosphate Retention in CKD. Renal Grand Rounds, St. John Hospital & Medical Center, Detroit, Michigan, December 17, 2009.

123. Phosphate Binder Therapy: Making an Informed Choice. Royal College of Physicians. London, England, February 26, 2010.

124. CKD-MBD: A New Paradigm for 2010. Renal Grand Rounds, Henry Ford Hospital, Detroit, Michigan, May 5, 2010.

125. Improving Outcomes in CKD-MBD Through Current Treatments; Effects on Bone Parameters with Lanthanum Carbonate. 16th Pan Hellenic Nephrology Congress, Kos, Greece, June 2-5, 2010.

126. Treatment of Metabolic Bone Disease. 15th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 2010.

127. Renal Osteodystrophy. 15th Annual Board Review Course & Update. American Society of Nephrology, San Francisco, California, August 28 – September 3, 2010.

128. Atypical Fractures in Osteoporotic Patient. Medicine Grand Rounds. NorthShore University HealthSystem, Evanston, Illinois, October 8, 2010

129. Quality Indicators in Chronic Dialysis. First Annual Meeting of NxStage Users. Las Vegas, Nevada, October 10-12, 2010.

130. Management of Mineral and Bone Disorders in the Transplant Patient. American Society of Nephrology Renal Week 2010, Denver, Colorado, November 19, 2010.

131. The Evolution of Bone Disease in CKD-MBD. The 2010 Clinical Research Meeting of the Israeli Society of Nephrology and Hypertension. Jerusalem, Israel, December 9-11, 2010.

132. An Update on Vitamin D and Vitamin D Analogues: Rationale for Treatment: Case Studies. National Kidney Foundation 2011 Spring Clinical Meetings, Las Vegas, Nevada, April 26-30, 2011.

133. Diagnostic Approaches to Post-Transplant Bone Disease. American Transplant Congress, Philadelphia, Pennsylvania, May 4, 2011.

134. Regulating Mineral Disorders Post-transplant: Vitamin D, Calcium and Cinacalcet Use. American Transplant Congress, Philadelphia, Pennsylvania, May 4, 2011.

135. Renal Osteodystrophy. Board Review Course & Update 2011. American Society of Nephrology, San Francisco, California, August 27-September 2, 2011.

136. Treatment Options for Patients with Metabolic Bone Diseases. Annual Board Review Course & Update 2011. American Society of Nephrology, San Francisco, California, August 27 – September 2, 2011.

137. CKD-MBD: An update. American Society of Nephrology Kidney Week 2011. Philadelphia, Pennsylvania, November 8, 2011.

138. Pathogenesis of Post Kidney Transplant Bone Disease. Renal Grand Rounds. University of Chicago Pritzker School of Medicine. Chicago, Illinois. February 9, 2012.

139. Pathogenesis of Metabolic Bone Disease. Board Review Course & Update 2012. American Society of Nephrology, San Francisco, California, August 25 – August 31, 2012.

140. Treatment Options for Patients with Metabolic Bone Diseases. Annual Board Review Course & Update 2012. American Society of Nephrology, San Francisco, California, August 25 – August 31, 2012.

141. Bone Mineral Metabolism Fractures and their Associated Morbidity. 14th Congress of the International Society of Peritoneal Dialysis, Kuala Lumpur, Malaysia, September 11, 2012.

142. NephSAP: Renal Bone Disease, Disorders of Divalent Ions, and Nephrolithiasis. American Society of Nephrology Renal Week 2012, San Diego, California. October 31, 2012.

143. Management of Persistent Hyperparathyroidism after Kidney Transplantation. American Society of Nephrology Renal Week 2012, San Diego, California. November 3, 2012.

144. Overview of Post Kidney Transplant Bone Disease. Renal Grand Rounds. Drexel University Medical School, Philadelphia, Pennsylvania. November 20, 2012.

145. Non-Primary Hyperparathyroidism, Medical and Surgical Management. American Association of Clinical Endocrinology Annual Meeting. Phoenix, Arizona. May 3, 2013.

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147. Treatment Options for Patients with Metabolic Bone Diseases. Annual Board Review Course & Update 2013. American Society of Nephrology, Chicago, Illinois, August 10 – August 16, 2013.

148. Measuring PTH is Still Useful. American Society of Nephrology Renal Week 2013, Atlanta, Georgia, November 8, 2013.

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150. Integrating Dietary Restrictions and Therapeutic Agents to Control Phosphate. National Kidney Foundation 2014 Spring Clinical Meetings, Las Vegas, Nevada, April 23, 2014.

151. Use of Novel Phosphate Binders. Fresenius Medical Care North America 2014 Medical Directors' Symposium. Atlanta, Georgia, April 30, 2014.

152. Metabolic Bone Disease and Hyperparathyroidism of CKD and ESRD: Current Insights from Basic Science and Clinical Trials. 2nd Annual SUNY Downstate Dialysis Symposium. Emerging Trends in Dialysis Care: Novel Concepts. Brooklyn, New York, May 9, 2014

153. Pathogenesis of Metabolic Bone Disease. Board Review Course & Update 2014. American Society of Nephrology, Chicago, Illinois, August 2 – August 8, 2014.

154. Treatment Options for Patients with Metabolic Bone Diseases. Annual Board Review Course & Update 2014. American Society of Nephrology, Chicago, Illinois, August 2 – August 8, 2014.

155. Case-Based Workshop for Bone and Mineral Metabolism. Annual Board Review Course & Update 2014. American Society of Nephrology, Chicago, Illinois, August 2 – August 8, 2014.

156. Clinical Roundtable-Management of Bone Health in CKD-MBD. American Society of Bone and Mineral Research 2014 Annual Meeting, Houston, Texas, September 13, 2014.

157. Diagnosis and Management of Osteoporosis in Chronic Kidney Disease. Medical Grand Rounds, Rush University, Chicago, Illinois, October 8, 2014.

158. Is it Really Just Osteoporosis: The Evolution of CKD-MBD. Renal Grand Rounds, Northwestern University Feinberg School of Medicine, Chicago, Illinois, November 6, 2014.

159. Vitamin D and Bisphosphonate—Use it or Lose it. An Update in Internal Medicine for the Primary Care Practitioner. NorthShore University HealthSystem, Chicago, Illinois, December 5, 2014.

160. Pathogenesis of Osteoporosis in Chronic Kidney Disease-Mineral and Bone Disease. Renal Grand Rounds. BayState Medical Center, Springfield, Massachusetts, December 11, 2014.

161. Clinical Obstacles to Controlling Hyperphosphatemia. National Kidney Foundation 2015 Spring Clinical Meetings, Dallas, Texas, March 27, 2015.

162. Debate: Cinacalcet for CKD-MBD: Pro: Cinacalcet is an Important Option for CKD-MBD Treatment. National Kidney Foundation 2015 Spring Clinical Meetings, Dallas, Texas, March 29, 2015.

163. Osteoporosis in Patients with CKD. Renal Grand Rounds. Henry Ford Hospital. Detroit, Michigan, April 22, 2015.

164. Novel Iron-Containing Phosphate Binders: Dialysis Patients in Focus—Potential Added Benefits. 52nd European Renal Association-European Dialysis and Transplantation Association Congress, London, United Kingdom, May 30, 2015.

165. Improving Diagnostic Testing and Interpretation of Chronic Kidney Disease—Case Studies in using CKD Diagnostic Tools Effectively. 21st International Federation of Clinical Chemistry-EuroMedLab. Paris, France, June 22, 2015.

166. Pathogenesis of Metabolic Bone Disease. Board Review Course & Update 2015. American Society of Nephrology, Chicago, Illinois, July 28, 2015.

167. Treatment Options for Patients with Metabolic Bone Diseases. Annual Board Review Course & Update 2015. American Society of Nephrology, Chicago, Illinois, July 28, 2015.

168. Case-Based Workshop for Bone and Mineral Metabolism. Annual Board Review Course & Update 2015. American Society of Nephrology, Chicago, Illinois, July 28, 2015.

169. Chronic Kidney Disease-Mineral and Bone Disease—Role of Parathyroid Hormone. 2015 Annual Meeting of the American Association for Clinical Chemistry. Atlanta, Georgia, July 29, 2015.

170. Renal Osteodystrophy Treatment:Crosstalk Between Kidney and Bone: Bench to Bedside. American Society of Bone and Mineral Research 2015 Annual Meeting. Seattle, Washington, October 8, 2015.

171. The Rule Truth about Vitamin D. Updates in Internal Medicine for the Primary Care Practitioner. NorthShore University HealthSystem-University of Chicago Pritzker School of Medicine. Northbrook, Illinois, October 30, 2015.

172. Phosphorus Management in CKD: Patient Motivation and Self-Control. American Society of Nephrology Renal Week 2015, San Diego, California, November 6, 2015.

173. New Advances for Managing Phosphate in CKD-MBD. National Kidney Foundation of Singapore, Singapore, March 3, 2016.

174. Iron-Based Phosphate Binder: New Paradigm of Hyperphosphatemia Management in CKD. National University Hospital Singapore, Singapore, March 4, 2016

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177. Differences in Phosphate Binders. Royal Melbourne Hospital, Australia, March 10, 2016.

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179. Contemporary Management of CKD-MBD. Greenfield Health System Medical Directors Meeting, Detroit, Michigan, May 26, 2016.

180. Phosphate Pathophysiology and Management in CKD-MBD. Renal Grand Rounds. Cook County Stroger Hospital, Chicago, Illinois, October 11, 2016.

181. Update on Vitamin D and PTH. Maintenance Dialysis Program. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 16, 2016.

182. Therapeutic Goals for the Treatment of Vitamin D Insufficiency and CKD-MBD. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 18, 2016.

183. Treatment of Bone Disease in CKD. American Society of Nephrology Renal Week 2016, Chicago, Illinois, November 20, 2016.

184. Secondary Hyperparathyroidism in CKD: Issues and Challenges in Timely Management. Medscape Education—Nephrology Web Seminar, November 2016-2017, http://www.medscape.org/viewarticle/869645

185. Outcomes Associated with Vitamin D Deficiency: Skeletal. National Kidney Foundation Scientific Workshop: The Role of Vitamin D in Stage 3-4 CKD. Atlanta, Georgia, May 18, 2017.

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187. Therapeutic Approach to Chronic Kidney Disease-Mineral Bone Disorder. Medical Grand Rounds. Tulane Medical School. New Orleans, Louisiana, September 13, 2017.

188. Iron-Based Phosphate Binders: New Paradigm of Hyperphosphatemia Management in CKD. 47th Eastern Regional Meeting of the Japanese Society of Nephrology. Yokohama, Japan, October 28, 2017.

189. Update on Phosphate, Vitamin D and Parathyroid Hormone: Maintenance Dialysis. American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, October November 1, 2017.

190. Parathyroid Hormone and Bone Disease Following Kidney Transplantation. American Society of Nephrology Renal Week 2017, New Orleans, Louisiana, November 2, 2017.

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Training Program Manual **TR1-01-01**
Basic Training for In-center Hemodialysis
DaVita, Inc.

TITLE: BASIC TRAINING IN-CENTER HEMODIALYSIS PROGRAM OVERVIEW

Mission
DaVita's Basic Training Program for In-center Hemodialysis provides the instructional preparation and the tools to enable teammates to deliver quality patient care. Our core values of *service excellence, integrity, team, continuous improvement, accountability, fulfillment and fun* provide the framework for the Program. Compliance with State and Federal Regulations and the inclusion of DaVita's Policies and Procedures (P&P) were instrumental in the development of the program.

Explanation of Content
Two education programs for the new nurse or patient care technician (PCT) are detailed in this section. These include the training of new DaVita teammates **without** previous dialysis experience and the training of the new teammates **with** previous dialysis experience. A program description including specific objectives and content requirements is included.

This section is designed to provide a *quick reference* to program content and to provide access to key documents and forms.

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Revision Mar 2014, Sep 2015, Feb 2017

Training Program Manual **TR1-01-02**
Basic Training for In-center Hemodialysis
DaVita, Inc.

TITLE: BASIC TRAINING FOR IN-CENTER HEMODIALYSIS PROGRAM DESCRIPTION

Introduction to Program

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

DaVita hires both non-experienced and experienced teammates. Newly hired teammates must meet all applicable State requirements for education, training, credentialing, competency, standards of practice, certification, and licensure in the State in which he or she is employed. For individuals with experience in the armed forces of the United States, or in the national guard or in a reserve component, DaVita will review the individual's military education and skills training, determine whether any of the military education or skills training is substantially equivalent to the Basic Training curriculum and award credit to the individual for any substantially equivalent military education or skills training.

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

- A newly hired patient care teammate without prior in-center hemodialysis experience.
- A rehired patient care teammate who left prior to completing the initial training.
- A newly hired or rehired patient care teammate with previous incenter hemodialysis experience who has not provided at least 3 months of hands on dialysis care to patients within the past 12 months.
- A DaVita patient care teammate with experience in a different treatment modality who transfers to in-center hemodialysis. Examples of different treatment modalities include acute dialysis, home hemodialysis, peritoneal dialysis, and pediatric dialysis.

An **experienced teammate** is defined as:

- A newly hired or rehired teammate who is either certified in hemodialysis under a State certification program or a national commercially available certification program, or can show proof of completing an in-center hemodialysis training program,
- And has provided at least 3 months of hands on in-center hemodialysis care to patients within the past 12 months.

Note:

Experienced teammates who are rehired outside of a 90 day window must complete the required training as outlined in this policy.

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Training Program Manual **TR1-01-02**
Basic Training for In-center Hemodialysis
DaVita, Inc.

The curriculum of the Basic Training Program for In-center Hemodialysis is modeled after Federal Law and State Boards of Nursing requirements, the American Nephrology Nurses Association Core Curriculum for Nephrology Nursing, and the Board of Nephrology Examiners Nursing and Technology guidelines. The program also incorporates the policies, procedures, and guidelines of DaVita HealthCare Partners Inc.

"Day in the Life" is DaVita's learning portal with videos for RNs, LPN/LVNs and patient care technicians. The portal shows common tasks that are done throughout the workday and provides links to policies and procedures and other educational materials associated with these tasks thus increasing teammates' knowledge of all aspects of dialysis. It is designed to be used in conjunction with the "Basic Training Workbook."

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 a minimum of (2) 240 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 in-center hemodialysis workbooks for the teammate, demonstrations, and observations. This education may be coordinated by the Clinical Services Specialist (CSS), a nurse educator, the administrator, or the preceptor.

Within the clinic setting this training includes

- Principles of dialysis
- Water treatment and dialysate preparation
- Introduction to the dialysis delivery system and its components
- Care of patients with kidney failure, including assessment, data collection and interpersonal skills
- Dialysis procedures and documentation, including initiation, monitoring, and termination of dialysis
- Vascular access care including proper cannulation techniques
- Medication preparation and administration
- Laboratory specimen collection and processing
- Possible complications of dialysis
- Infection control and safety
- Dialyzer reprocessing, if applicable

The program also introduces the new teammate to DaVita Policies and Procedures (P&P), and the Core Curriculum for Dialysis Technicians.

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The **didactic phase** also includes classroom training with the CSS or nurse educator. Class builds upon the theory learned in the Workbooks and introduces the students to more advanced topics. These include:

- Acute Kidney Injury vs. Chronic Renal Failure
- Adequacy of Hemodialysis
- Complications of Hemodialysis
- Conflict Resolution
- Data Collection and Assessment
- Documentation & Flow Sheet Review
- Fluid Management
- Importance of P&P
- Infection Control
- Laboratory
- Manifestations of Chronic Renal Failure
- Motivational Interviewing
- Normal Kidney Function vs. Hemodialysis
- Patient Self-management
- Pharmacology
- Renal Nutrition
- Role of the Renal Social Worker
- Survey Savvy for Teammates
- The DaVita Quality Index
- The Hemodialysis Delivery System
- Vascular Access
- Water Treatment

Also included are workshops, role play, and instructional videos. Additional topics are included as per specific state regulations.

Theory class concludes with the *DaVita Basic Training Final Exam.* A comprehensive examination score of 80% (unless state requires a higher score) must be obtained to successfully complete this portion of the didactic phase.

The *DaVita Basic Training Final Exam* can be administered as a paper-based exam by the instructor in a classroom setting, or be completed online (DVU2069-EXAM) either in the classroom or in the facility. If the exam is completed in the facility, the new teammate's preceptor will proctor the online exam.

If a score of less than 80% is attained, the teammate will receive additional appropriate remediation and a second exam will be given. The second exam may be administered by the instructor in the classroom setting, or be completed online.

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Only the new teammate's manager will be able to enroll the new teammate in the online exam. The CSS or RN Trainer responsible for teaching Basic Training Class will communicate to the teammate's FA to enroll the teammate in DVU2069-EXAM. To protect the integrity of the online exam, the FA must enroll the teammate the same day he/she sits for the test and the exam must be proctored

Note:

- FA teammate enrollment in DVU2069-EXAM is limited to one time.

If the new teammate receives a score of less than 80% on the second attempt, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate. If it is decided that the teammate should be allowed a third attempt to pass the exam, the teammate should receive appropriate remediation prior to enrollment in the online exam. The enrollment will be done by the Clinical Education and Training Team after submission of the completed form TR1-01-02C DVU2069-EXAM Enrollment Request. Enrollment will be communicated to the FA and the teammate should sit for the exam on the same day he/she is enrolled. The facility preceptor must proctor the exam.

Also included in the **didactic phase** is additional classroom training covering Health and Safety Training, systems/applications training, One For All orientation training, Compliance training, Diversity training, mandatory water classes, emergency procedures specific to facility, location of disaster supplies, and orientation to the facility.

The **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, and/or a registered nurse. During this phase the teammate will demonstrate a progression of skills required to perform the in-center hemodialysis procedures in a safe and effective manner. A *Procedural Skills Verification Checklist* will be completed to the satisfaction of the preceptor, and a registered nurse overseeing the training. The Basic Training Workbook for In-center Hemodialysis will also be utilized for this training and must be completed to the satisfaction of the preceptor and the registered nurse.

Those teammates who will be responsible for the Water Treatment System within the facility are required to complete the Mandatory Educational Water courses and the corresponding skills checklists.

Both the didactic phase and/or the clinical practicum phase will be successfully completed, along with completed and signed skills checklists, 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 new teammate will utilize the Basic

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Training Workbook for In-center Hemodialysis and progress at his/her own pace under the guidance of the facility's preceptor. This workbook should be completed within a timely manner as to also demonstrate acceptable skill-level.

As with new teammates without previous experience, the **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, and/or a registered nurse. During this phase the teammate will demonstrate the skills required to perform the in-center hemodialysis procedures in a safe and effective manner and a *Procedural Skills Verification Checklist* will be completed to the satisfaction of the preceptor, and a registered nurse overseeing the training.

Ideally teammates with previous experience will also attend Basic Training Class, however, they may opt-out of class by successfully passing the *DaVita Basic Training Final Exam* with a score of 80% or higher. The new experienced teammate should complete all segments of the workbook including the recommended resources reading assignments to prepare for taking the *DaVita Basic Training Final Exam* as questions not only assess common knowledge related to the in-center hemodialysis treatment but also knowledge related to specific DaVita P&P, treatment outcome goals based on clinical initiatives and patient involvement in their care.

After the new teammate with experience has sufficiently prepared for the *DaVita Basic Training Final Exam,* the teammate's manager will enroll him/her in the online exam. To protect the integrity of the exam, the FA must enroll the teammate the same day he/she sits for the test and the exam must be proctored by the preceptor.

If the new teammate with experience receives a score of less than 80% on the *DaVita Basic Training Final Exam*, this teammate will be required to attend Basic Training Class. After conclusion of class, the teammate will then receive a second attempt to pass the Final Exam either as a paper-based exam or online as chosen by the Basic Training instructor and outlined in the section for inexperienced teammates of this policy.

If the new teammate receives a score of less than 80% on the second attempt, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate. If it is decided that the teammate should be allowed a third attempt to pass the exam, the teammate should receive appropriate remediation prior to enrollment in the online exam. This enrollment will be done by the Clinical Education and Training Team after submission of the completed form TR1-01-02C DVU2069-EXAM Enrollment Request. Enrollment will be communicated to the FA and the teammate should sit for the exam on the same day he/she is enrolled. The facility preceptor must proctor the exam.

The **didactic phase** for nurses regardless of previous experience includes three days of additional classroom training and covers the following topics:

- Nephrology Nursing, Scope of Practice, Delegation and Supervision, Practicing according to P&P

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- Nephrology Nurse Leadership
- Impact – Role of the Nurse
- Care Planning including developing a POC exercise
- Achieving Adequacy with focus on assessment, intervention, available tools
- Interpreting laboratory Values and the role of the nurse
- Hepatitis B – surveillance, lab interpretation, follow up, vaccination schedules
- TB Infection Control for Nurses
- Anemia Management – ESA Hyporesponse: a StarLearning Course
- Survey Readiness
- CKD-MBD – Relationship with the Renal Dietitian
- Pharmacology for Nurses – video
- Workshop
    - Culture of Safety, Conducting a Homeroom Meeting
    - Nurse Responsibilities, Time Management
    - Communication – Meetings, SBAR (Situation, Background, Assessment, Recommendation)
    - Surfing the VillageWeb – Important sites and departments, finding information

Independent Care Assignments
Prior to the new teammate receiving an independent patient-care assignment, the Procedural Skills Verification Checklist must be completed and signed and a passing score of the DaVita Basic Training Final Exam must be achieved.
Note:
Completion of the skills checklist is indicated by the new teammate in the LMS (RN: SKLINV1000, PCT: SKLINV2000) and then verified by the FA.

Following completion of the training, a *Verification of Competency* form will be completed (see forms TR1-01-05, TR1-01-06). 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.

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Process of Program Evaluation

The In-center Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the DaVita Basic Training Class Evaluation (TR1-01-08A) and Basic Training Nursing Fundamentals Evaluation (TR1-0108B), the New Teammate Satisfaction Survey 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.

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Richard Sewell
Vice Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Vice Chair Sewell:

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 § 1110.230(e) that Rogers Park Dialysis will maintain an open medical staff.

I also certify the following with regard to needed support services:

- DaVita utilizes an electronic dialysis data system;
- Rogers Park Dialysis will have available all needed support services required by the Centers for Medicare and Medicaid Services, 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: Michael D. Staffieri
Its: Chief Operating Officer, DaVita Kidney Care, DaVita Inc.
President, Total Renal Care, Inc.

Subscribed and sworn to me
This 23rd day of October, 2019

Notary Public

KATHY CONNOR
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20064018112
MY COMMISSION EXPIRES APRIL 28, 2021

Street, Denver, CO 80202 | P (800) 244-0680 | F (310) 536-2675 | DaVita.com

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(f), Support Services

Attached at Attachment – 23E is a letter from Michael D. Staffieri, Chief Operating Officer of DaVita Inc. and Total Renal Care, Inc. attesting that the proposed clinic will participate in a dialysis data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(g), Minimum Number of Stations

The proposed dialysis clinic will be located in the Chicago metropolitan statistical area ("MSA"). A dialysis clinic located within an MSA must have a minimum of eight dialysis stations. The Applicants propose to establish a 12-station dialysis clinic. Accordingly, this criterion is met.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(h), Continuity of Care

DaVita Inc. has an agreement with I to provide inpatient care and other hospital services. Attached at Attachment – 23F is a copy of the service agreement with this area hospital.

DaVita.

November 21, 2019

NorthShore University HealthSystem
Evanston Hospital
2650 Ridge Avenue
Evanston, Illinois 60201
Attn: President

Re: *Patient Transfer Agreement* (the "Agreement") by and among **Total Renal Care, Inc.** ("Facility") and **NorthShore University HealthSystem- Evanston Hospital** ("Hospital"), dated July 14, 2018, as amended and assigned, for Services at Company's free-standing dialysis center formerly known as "**Pratt Beach Dialysis**," and formerly located at 6418 North Sheridan Road, Chicago, 60626 ("Center").

To Whom It May Concern:

As of November 14, 2019 the Pratt Beach Dialysis facility name has been changed to Rogers Park Dialysis and has been relocated from 6418 North Sheridan Road, Chicago, IL 60626 to the following location 1616 West Glenlake Avenue, Chicago, IL 60660.

Please make sure that all future notices are mailed out to the correct address. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

DocuSigned by:
A9D36A72D795422...

Josef Kaplan
Regional Operations Director

TRANSFER AGREEMENT

This TRANSFER AGREEMENT (the "Agreement") is made as of the last date of signature hereto (the "Effective Date"), between **NorthShore University HealthSystem – Evanston Hospital** ("Hospital") and **Total Renal Care, Inc.**, a subsidiary of DaVita Inc. ("Facility").

WHEREAS. Facility desires to assure the availability of the Hospital's facilities for its patients who are in need of treatment at a hospital. and the Hospital is equipped and qualified to provide inpatient hospital care.

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Facility:

Pratt Beach Dialysis
6418 North Sheridan Rd.
Chicago. IL 60626

THEREFORE, the parties wish to enter into the Agreement set forth below as follows:

1. Hospital agrees to make the facilities and personnel of its routine emergency service available for the treatment of acute life-threatening emergencies, which may occur to any of Facility's patients. Hospital and its staff shall cooperate with Facility's staff to ensure the provision of safe and adequate care to Facility's patients who are transferred to Hospital to receive services in the case of an emergency. If, in the opinion of a member of Facility's medical staff, any patient requires emergency hospitalization. Hospital agrees to furnish all necessary medical services at its facility for such patient at the patient's expense. In the event of an emergency at Facility. the responsible physician shall notify the patient's physician of record. as indicated in Facility's files. and shall promptly notify the Emergency Room physician of the particular emergency. Facility shall be responsible for arranging to have the patient transported to the Hospital and shall send appropriate interim medical records. Facility shall provide for an interchange. within one working day. of the patient long term program and patient care plan. and of medical and other information necessary or useful in the care and treatment of patients referred to the Hospital from Facility, or in determining whether such patients can be adequately cared for otherwise than in either of the facilities. Admission to Hospital. and the continued treatment by Hospital. shall be provided regardless of the patient's race. color. creed, sex. age. disability, or national origin.

2. In the event the patient is transferred directly from Facility to Hospital. Facility shall provide for the security of, and be accountable for. the patient's personal effects during the transfer.

3. Facility shall keep medical records of all treatments rendered to patients by Facility. Such medical records shall conform to applicable standards of professional practice. If requested by Hospital, Facility shall provide complete copies of all medical records of a patient treated by Facility.

4. In addition to the services described above, the Hospital shall make the following services available to patients referred by Facility either at the Hospital or at an affiliated hospital:

   a. Inpatient care for any patient who develops complications or any conditions that require hospital admission:

   b. Blood Bank services to be performed by the Hospital.

5. With respect to all work, duties, and obligations hereunder, it is mutually understood and agreed that the parties shall own and operate their individual facilities wholly independent of each other. All patients treated at the facilities of Hospital or Facility shall be patients of that facility. Each party shall have the sole responsibility for the treatment and medical care administered to patients in their respective facilities.

6. Facility and Hospital shall each maintain in full force and effect throughout the term of this Agreement, at its own expense, a policy of comprehensive general liability insurance and professional liability insurance covering it and its respective staff and physicians each having a combined single limit of not less than $1,000,000 per occurrence, $3,000,000 annual aggregate for bodily injury and property damage to insure against any loss, damage or claim arising out of the performance of each party's respective obligations under this Agreement. Each will provide the other with certificates evidencing said insurance, if and as requested. Either party may provide for the insurance coverage set forth in this Section through self-insurance.

7. Each party agrees to indemnify and hold harmless the other, their officers, directors, shareholders, agents and employees against all liability, claims, damages, suits, demands, expenses and costs (including but not limited to, court costs and reasonable attorneys' fees) of every kind arising out of or in consequence of the party's breach of this Agreement, and of the negligent errors and omissions or willful misconduct of the indemnifying party, its agents, servants, employees and independent contractors (excluding the other party) in the performance of or conduct related to this Agreement.

8. The Parties expressly agree to comply with all applicable laws relating to the services provided hereunder or by such party.

9. Whenever under the terms of this Agreement, written notice is required or permitted to be given by one party to the other, such notice shall be deemed to have been sufficiently given if delivered in hand, overnight delivery, personal delivery or by registered or certified mail, return receipt requested, postage prepaid, to such party at the following address:

   To the Hospital:

   NorthShore University HealthSystem
   Evanston Hospital
   2650 Ridge Avenue
   Evanston, IL 60201
   Attn: President

To Facility:

Total Renal Care, Inc.
C/o: DaVita Inc.
5200 Virginia Way
Brentwood, TN 37027
Attn: Group General Counsel

With a copy to:

Pratt Beach Dialysis
C/o: DaVita Inc.
6418 North Sheridan Rd.
Chicago, IL 60626
Attn: Facility Administrator

10. If any provisions of this agreement shall, at any time, conflict with any applicable state or federal law, or shall conflict with any regulation or regulatory agency having jurisdiction with respect thereto, this Agreement shall be modified in writing by the parties hereto to conform to such regulation, law, guideline, or standard established by such regulatory agency.

11. This Agreement including any exhibits, schedules, or other attachments which are incorporated herein by reference and made a part hereof may not be amended, modified, or shall be binding unless agreed to in a written instrument signed by both parties.

12. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all negotiations, prior discussions, agreements or understandings, whether written or oral, with respect to the subject matter hereof, as of the Effective Date. This Agreement shall bind and benefit the parties, their respective successors and assigns. This Agreement shall not be assigned by either party without the other party's prior written consent.

13. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Illinois, without respect to its conflicts of law rules.

14. The term of this Agreement is for one (1) year, beginning on the Effective Date, and will automatically renew for successive one year periods unless either party gives the other notice prior to an expiration date. Either party may terminate this Agreement, at any time, with or without cause, upon thirty (30) days written notice to the non-terminating party.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their respective officers thereunto duly authorized as of the date below written.

NorthShore University HealthSystem – Evanston Hospital

By: _____

Name: DOUGLAS SILVERSTEIN

Title: PRESIDENT

Date: 7/11/18

Total Renal Care, Inc.

By: Brent Habitz

Name: Brent Habitz

Title: Regional Operations Director

Date: July 3, 2018

Approved by DaVita as to form only:

By: Kanika M. Rankin

Name: Kanika M. Rankin

Title: Senior Corporate Counsel - Operations

Date: July 14, 2018

DocuSign

Certificate Of Completion

Envelope Id: 6B82F8C4DD614BB887C4B101BC611BE7 — Status: Completed

Subject: Please DocuSign: DaVita - Sauganash Dialysis - Transfer Agreement - GENERAL SERVICES - JC.pdf, ...

Source Envelope:

Document Pages: 8	Signatures: 2	Envelope Originator:
Certificate Pages: 4	Initials: 0	Jennifer Schroeder
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Brent Habitz@davita.com		Viewed: 6/29/2018 3:48:20 PM
Regional Operations Director		Signed: 7/3/2018 5:22:08 AM
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Agent Delivery Events	Status	Timestamp
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Carbon Copy Events	Status	Timestamp
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Margaret.Enger@davita.com		Viewed: 7/3/2018 7:50:17 AM
Security Level: Email, Account Authentication (None)		

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Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/3/2018 5:22:07 AM
Certified Delivered	Security Checked	7/3/2018 5:22:07 AM
Signing Complete	Security Checked	7/3/2018 5:22:07 AM
Completed	Security Checked	7/3/2018 5:22:07 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

Electronic Record and Signature Disclosure created on 5/12/2014 11:08:39 AM
Parties agreed to: Brent Habitz

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. For such copies, as long as you are an authorized user of the DocuSign system you will have the ability to download and print any documents we send to you through your DocuSign user account for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of your DocuSign account. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use your DocuSign Express user account to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through your DocuSign user account all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact DaVita:
You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: emily.briggs@davita.com

To advise DaVita of your new e-mail address
To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..
In addition, you must notify DocuSign, Inc to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in DocuSign.
To request paper copies from DaVita
To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.
To withdraw your consent with DaVita
To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign account, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail, full name, IS Postal Address, telephone number, and account number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	•Allow per session cookies •Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

** These minimum requirements are subject to change. If these requirements change, we will provide you with an email message at the email address we have on file for you at that time providing you with the revised hardware and software requirements, at which time you will have the right to withdraw your consent.

Acknowledging your access and consent to receive materials electronically
To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I Agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and
- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and
- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

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2000 16th Street
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jennifer.schroeder@davita.com
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Holder: Jennifer Schroeder
jennifer.schroeder@davita.com

Location: DocuSign

Signer Events	Signature	Timestamp
Kanika M. Rankin Kanika.Rankin@davita.com Senior Corporate Counsel Security Level: Email, Account Authentication (None)	Kanika M. Rankin Using IP Address: 68.32.245.124 Signed using mobile	Sent: 7/12/2018 2:20:13 PM Resent: 7/13/2018 11:49:33 AM Viewed: 7/14/2018 6:26:29 AM Signed: 7/14/2018 6:26:44 AM
Electronic Record and Signature Disclosure: Accepted: 7/14/2018 6:26:29 AM ID: b3fe7aca-9c59-4c78-ba33-8a49486cda47		
In Person Signer Events	**Signature**	**Timestamp**
Editor Delivery Events	**Status**	**Timestamp**
Agent Delivery Events	**Status**	**Timestamp**
Intermediary Delivery Events	**Status**	**Timestamp**
Certified Delivery Events	**Status**	**Timestamp**
Carbon Copy Events	**Status**	**Timestamp**
Margaret Enger Margaret.Enger@davita.com Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered via DocuSign	COPIED	Sent: 7/14/2018 6:26:45 AM Viewed: 7/16/2018 8:33:04 AM
Notary Events	**Signature**	**Timestamp**

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/14/2018 6:26:45 AM
Certified Delivered	Security Checked	7/14/2018 6:26:45 AM
Signing Complete	Security Checked	7/14/2018 6:26:45 AM
Completed	Security Checked	7/14/2018 6:26:45 AM
Payment Events	**Status**	**Timestamps**

Electronic Record and Signature Disclosure

Attachment – 23F

Electronic Record and Signature Disclosure created on: 6/12/2014 12:08:39 PM
Parties agreed to: Kanika M. Rankin

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. For such copies, as long as you are an authorized user of the DocuSign system you will have the ability to download and print any documents we send to you through your DocuSign user account for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of your DocuSign account. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use your DocuSign Express user account to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through your DocuSign user account all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact DaVita:
You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: emily.briggs@davita.com

To advise DaVita of your new e-mail address
To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..
In addition, you must notify DocuSign, Inc to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in DocuSign.
To request paper copies from DaVita
To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.
To withdraw your consent with DaVita
To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign account, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail, full name, IS Postal Address, telephone number, and account number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	•Allow per session cookies •Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

** These minimum requirements are subject to change. If these requirements change, we will provide you with an email message at the email address we have on file for you at that time providing you with the revised hardware and software requirements, at which time you will have the right to withdraw your consent.

Attachment – 23F

Acknowledging your access and consent to receive materials electronically
To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I Agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(i), Relocation of Facilities

The Applicants propose the establishment of a 12-station dialysis clinic. Thus, this criterion is not applicable.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.230(j), Assurances

Attached at Attachment – 23G is a letter from Michael D. Staffieri, Chief Operating Officer of DaVita Inc. and Total Renal Care, Inc. certifying that the proposed clinic will achieve target utilization by the second year of operation.

Richard Sewell
Vice Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: In-Center Hemodialysis Assurances

Dear Vice Chair Sewell:

Pursuant to 77 Ill. Admin. Code § 1110.230(j), I hereby certify the following:

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

Sincerely,

Print Name: Michael D. Staffieri
Its: Chief Operating Officer, DaVita Kidney Care, DaVita Inc.
President, Total Renal Care, Inc.

Subscribed and sworn to me
This 23rd day of October, 2019

Kathy Connor
Notary Public

KATHY CONNOR
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20064018112
MY COMMISSION EXPIRES APRIL 28, 2021

P (800) 244-0680 | F (310) 536-2675 | DaVita.com

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded entirely with cash and cash equivalents. A copy of DaVita's 2018 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted on March 1, 2019. A real estate letter of intent to lease the clinic is attached at Attachment – 33.

Attachment – 33

CUSHMAN & WAKEFIELD
225 West Wacker Drive, Suite 3000
Chicago, IL 60606
Web: www.cushmanwakefield.com

November 6, 2019

Mr. Andy Stein
Clark Street Real Estate
980 N Michigan Ave Suite 1280
Chicago, IL 60611

RE: LOI – 1616 W Glenlake Ave, Chicago, IL 60660

Mr. Stein:

Cushman & Wakefield ("C&W") has been authorized by Total Renal Care, Inc. a subsidiary of DaVita, Inc. to assist in securing a lease requirement. DaVita, Inc. is a Fortune 200 company with revenues of approximately $13 billion. They operate 2,278 outpatient dialysis centers across the US and 124 in 10 countries outside the US.

Below is the proposal outlining the terms and conditions wherein the Tenant is willing to lease the subject premises:

PREMISES:	To be constructed building at 1616 W Glenlake Ave, Chicago, IL 60660
TENANT:	Total Renal Care, Inc. or related entity to be named
GUARANTY:	DaVita, Inc.
LANDLORD:	An entity that will be a joint venture between Stein Acquisitions LLC and Cabanban Properties
SPACE REQUIREMENTS:	Requirement is for approximately 7,410 SF of ground floor contiguous rentable square feet. Tenant shall have the right to measure space and final measurement standards will be agreed to by parties.
PRIMARY TERM:	15 years
BASE RENT:	$37.56 PSF, NNN with ten percent (10%) increases every 5 years during the term and any options.
ADDITIONAL EXPENSES:	It is the intention of the Landlord that this Lease is "absolute NNN" and accordingly Tenant shall be responsible for all charges related to the use and operation of the Premises during the term, including (without limitation) all utility charges, real estate taxes, assessments, maintenance charges for the premises, and liability/property insurance.
LANDLORD'S MAINTENANCE:	Landlord, at its sole cost and expense, shall be responsible for the structural components of the Property (to be further defined in lease). Tenant at its sole cost and expense shall maintain and keep in good order and repair (including sweeping, salting, snow, and ice removal) to the (i) parking areas, sidewalks, loading areas, and drive aisles serving the building and (ii)

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all landscaping locate on the premises and (iii) all common areas and (iv) alley's surrounding the site

POSSESSION AND RENT COMMENCEMENT: Landlord shall deliver Possession of the Premises to the Tenant upon the latter of: completion of Landlord's required work (if any) or mutual lease execution. Rent Commencement shall be the earlier of five (5) months from Landlord's substantial completion of the shell and MBBI. Landlord and Tenant shall work together to save time while Landlord is constructing the building shell and will consider any and all time saving methods for faster completion and delivery of the space to the Tenant.

LEASE FORM: Tenant's standard lease form that will conform to the Garfield Park lease as a starting point for negotiations.

USE: The operation of an outpatient renal dialysis clinic, renal dialysis home training, aphaeresis services and similar blood separation and cell collection procedures, general medical offices, clinical laboratory, including all incidental, related and necessary elements and functions of other recognized dialysis disciplines which may be necessary or desirable to render a complete program of treatment to patients of Tenant and related office and administrative uses or for any other lawful purpose.

The property is zoned B3-2 and medical is a permitted use in this zoning classification.

PARKING: Please see the attached Exhibit B site plan

BASE BUILDING: Landlord, at Landlord's expense, shall deliver to the premises the Base Building improvements included in the attached Exhibit C, subject to Tenant's architect and project manager approval.

Landlord will make reasonable efforts to coordinate early access for tenant improvements with Tenant's project manager once the building slab is poured, under roof, and exterior walls are up.

OPTION TO RENEW: Tenant desires two, five-year options to renew the lease. Option rent shall be increased by 10% after Year 15 of the initial term and following each successive five-year option periods, so long as tenant is not in default of the lease.

FAILURE TO DELIVER PREMISES: If Landlord has not delivered the premises to Tenant with all base building items substantially completed 270 days after Landlord acquires property and all necessary approvals and permits Tenant may receive one day of rent abatement for every day of delay beyond the 270 day delivery period.

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HOLDING OVER:	Tenant shall be obligated to pay 110% for the then current rate.
TENANT SIGNAGE:	Tenant shall have the right to install building and monument signage at the Premises at Tenant's cost, subject to compliance with all applicable laws and regulations.
SUBLEASE/ASSIGNMENT:	Tenant will have the right at any time to sublease or assign its interest in this Lease to any majority owned subsidiaries or related entities of DaVita, Inc. Inc. with the consent of the Landlord, whose consent shall not be unreasonably held or delayed.
ROOF RIGHTS:	Tenant shall have the right to place a satellite dish on the roof at no additional fee. Installation to be performed by mutually agreed upon contractor so as not damage roof or violate roof warranty. Tenant shall be responsible for its own permits.
NON-COMPETE:	Landlord agrees not to lease space to another dialysis provider within a five mile radius of Premises.
HVAC:	As part of Landlord's work, Landlord shall provide HVAC units meeting the specifications set forth in Exhibit C or provide an HVAC allowance.
DELIVERIES:	To be determined, see attached 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 seven (7) months from the latter of an executed LOI or subsequent filing date. 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

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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 within seven (7) months from the latter of an executed LOI or subsequent filing date 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 Cushman & Wakefield ("C&W") as the Tenant's local representative and shall pay a brokerage fee equal 2% of the base rent over the initial 10 year period, 50% shall be due upon receipt of a fully executed lease and satisfaction of all contingencies (including CON) and 50% payable upon Tenant's certificate of occupancy receipt and payment of first month's rent.

CONTINGENCIES: This proposal is subject to the Landlord securing and closing on the subject parcel and timing is subject to all necessary governmental approval.

In the event the Landlord is not successful in obtaining all necessary approvals including, but not limited to, zoning and use, the Tenant shall have the right, but not the obligation to terminate the lease.

It should be understood that this proposal is subject to the terms of Exhibit A attached hereto. Please complete and return the Potential Referral Source Questionnaire in Exhibit D. 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,

Matthew J. Gramlich
CC: DaVita Regional Operations

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SIGNATURE PAGE

LETTER OF INTENT: **1616 W GLENLAKE AVE, CHICAGO, IL 60660**

AGREED TO AND ACCEPTED THIS 14 DAY OF NOVEMBER 2019

By: _____

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

AGREED TO AND ACCEPTED THIS ____ DAY OF NOVEMBER 2019

By: _____

_____
("Landlord")

CUSHMAN & WAKEFIELD

SIGNATURE PAGE

LETTER OF INTENT: **1616 W GLENLAKE AVE, CHICAGO, IL 60660**

AGREED TO AND ACCEPTED THIS ____ DAY OF NOVEMBER 2019

By: _____

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

By: STEIN ACQUISITIONS / CABANA PROPERTIES, LLC

AUTHORIZED SIGNATORY.

("Landlord")

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EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPERATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT NEITHER TENANT NOR LANDLORD (OR C&W) 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 C&W 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. C&W 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 C&W 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.

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EXHIBIT B – SITE PLAN

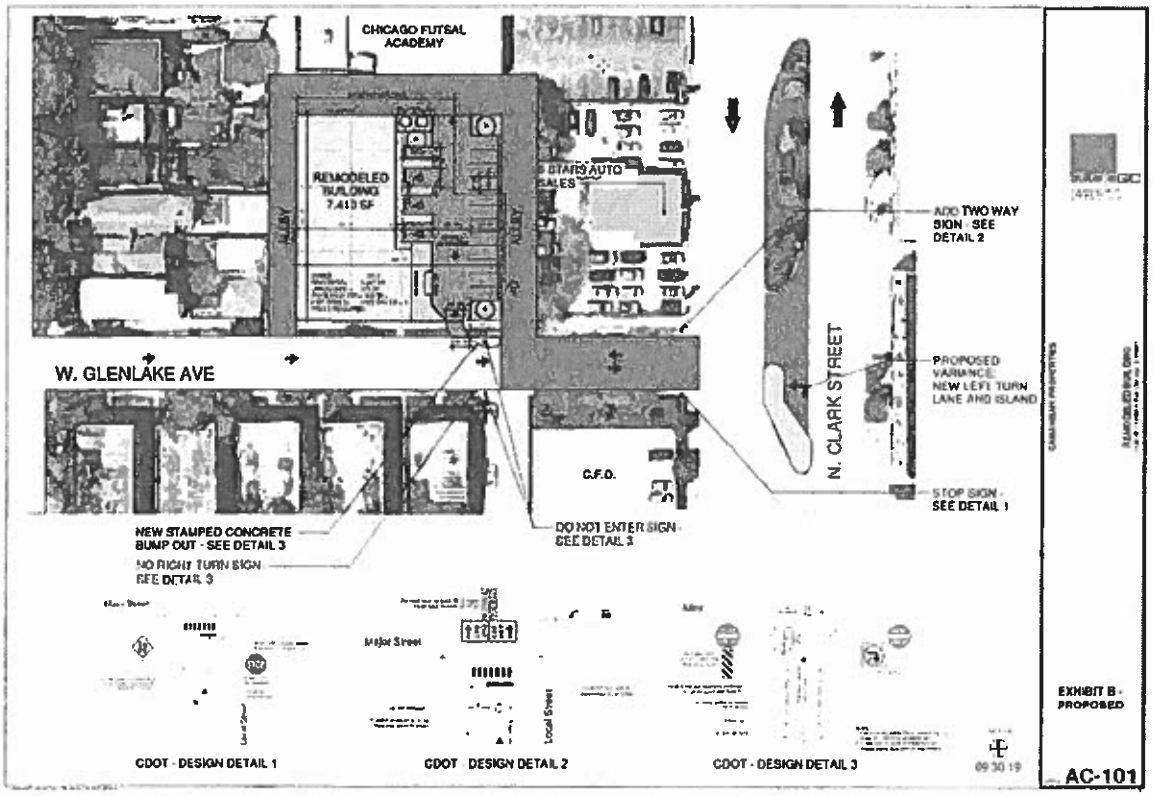

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EXHIBIT C – WORK LETTER

DaVita.

OPTION 1 FOR NEW BUILDING V5.1
[SUBJECT TO MODIFICATION BASED ON INPUT FROM TENANT'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

SCHEDULE A - TO WORK LETTER

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

(Note: Sections with an Asterisk (*) have specific requirements for I 1.2 in California and other select States – see end of document for changes to that section)

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

All MBBI work completed by the Landlord will need to be coordinated and approved by the Tenant 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, barrier-free regulations, energy codes, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Landlord'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 Tenant Improvement plans and specifications.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic without the need for special-use approval by the AHJ. Landlord to provide all permitting related to the base building and site improvements.

3.0 - Common Areas N/A

4.0 Foundation and Floor

The foundation and floor of the building is existing and will be modified to conform to the approved site plan in accordance with local code requirements. The foundation shall be designed by the Landlord's engineer to accommodate site specific climate and soil conditions and recommendations per the Landlord's soil engineering and exploration report (to be reviewed and approved by Tenant's engineer).

A new footing and foundation wall will be installed on the East side of the reconfigured building as reflected in the approved building and site plan. 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 up to finish floor at a minimum. 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 existing concrete floor shall be reutilized in the building. Patching of the existing slab by the Landlord at the new utility locations and at the reconfigured East building wall is anticipated. Patching will include one of the following, wire mesh or fiber mesh, and/or rebar reinforcement over a 10 mil minimum vapor barrier and granular fill per Landlord's soils and/or structural engineering team based on soil conditions and report from the Soils Engineer. Floor is existing with areas of new and old patching. Landlord will clean up the existing slab by disk sanding, filling and making the floor transitions smooth and broom clean with no adhesive residues, in a condition that is acceptable to install floor coverings in accordance with the flooring manufacturer's specifications. (NOTE: Recommend site meeting with Jim B. to review the existing floor slab conditions and to determine what repairs might be needed) – OK - Concrete floor shall be constructed so that no more 90% relative humidity 3lbs of moisture per 1,000 sf/24 hours is emitted per completed RH testing (ASTM F2170-11, 'Standard Test Method for Determining Relative Humidity in Concrete Floor Slabs Using in situ Probes') results after 28 day cure time. Relative humidity testing to be performed by Tenant at Tenant's sole cost. Methods to achieve this level will be responsibility of the Landlord and may preclude the requirement for Tenant's third party testing (TBD IF APPLICABLE). All utility trenches installed by Tenant's general contractor to be backfilled and compacted using approved granular material specification of the Landlord's general contractor testing consultant. Under slab plumbing shall be installed by Tenant's General Contractor

5.0 - Structural

The existing building structure is composed of bar joists, steel beams, and a gypsum deck roofing which is to remain in it's existing condition. The clear height to the bottom of the steel beams at 11'-5" above the existing concrete floor. The bottom of the gypsum deck is at approximately 13' above the floor. Existing columns will remain in their current condition and two columns will be added to eliminate the masonry bearing wall (running East/West) at the center point in the existing building. The existing building will be reduced in size to meet the new TI layout by demolishing the Eastern portion of the structure and adding a new footing, foundation, and exterior wall to re-enclose the building. 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 or 5) HVAC roof top openings, one (1) roof hatch opening, and four (4) exhaust fans openings).

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 code requirements. If no fire rating is required, interior of walls shall be left as exposed and until Tenants completes any and all work with-in walls on the interior side of the exterior walls. Landlord shall be responsible for interior metal stud furring/framing, mold- and

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moisture-resistant glass mat board, mold- and moisture-resistant gypsum board, taping and finishing on the interior side of all exterior walls.

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. 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 Landlord for the duration of the lease. Landlord to provide Tenant copy of material and labor roof warranty for record.

9.0 – Parapet

Landlord to provide a parapet wall, if required by municipality, 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

Please see attached exhibit. Perimeter wall systems are existing except the proposed new East wall. The East wall to be signed off by a Landlord's Structural Engineer. The existing North, West, and South (Glenlake elevations) are existing. Landlord anticipates cosmetic improvements to the South wall to upgrade the appearance (NOTE: scope yet to be defined). The West and North walls face the existing alleys and will have joints repaired and walls painted. Wall system "R" value must meet current Energy code. Wall system options for the new East wall include, but not limited to:

Minimum 3-inch drainable exterior insulating fenestration system (EIFS) on water-vapor barrier on ¾-inch thick glass matt sheathing, AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring on continuous insulation/weather-barrier, system on 6" 16- or 18-ga metal stud framing

Or

Minimum 3-inch drainable exterior insulating fenestration system (EIFS), AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring on continuous insulation/weather-barrier system, on water-vapor barrier on 8-inch or 12-inch thick concrete masonry wall construction with 3½-inch 20-ga metal stud furring.
Or if required by local municipality

Brick or split face block Veneer on engineered 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.

11.0 - Canopy

Per a mutually agreeable design on the awning with an allowance being provided to the Tenant from the Landlord not to exceed $10,000.

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12.0 – Waterproofing and Weatherproofing

Landlord 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. Landlord 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. Landlord shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

13.0 - Windows

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

14.0 - Thermal Insulation

All new exterior walls to have a vapor barrier and insulation that meets or exceeds the local and national energy codes. Existing perimeter walls to have insulation installed to meet the current codes in the event that they do not comply. The R-value to be determined by the size of the stud cavity, if installed on the interior of the wall and should extend from finish floor to bottom of floor or ceiling deck. Should the insulation be installed on the exterior side of the wall sheathing, insulation shall extend from finish floor to the top of the parapet. 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 Yale 8800 Series, Grade 1 mortise lockset or better). Doors shall meet all barrier-free requirements including but not limited to American Disability Act (ADA), and State Department of Health requirements. Landlord shall change the keys (reset tumblers) on all doors with locks after construction, but prior to commencement of the Lease, and shall provide Tenant with a minimum of three (3) sets of keys. Final location of doors to be determined by Tenant architectural floor plan and shall be coordinate with Tenant's Architect. At a minimum, the following doors, frames and hardware shall be provided by the Landlord:

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

- Service Doors: Provide a 60" or 72"-inch wide double doors (with 1 - 24" and 1 - 36" leaf or 2- 36" leafs), b) 60" Roll up door,) with 20 gauge insulated hollow metal , painted with rust inhibiting paint, Flush bolts, T astragal, heavy duty aluminum threshold, continuous hinge each leaf, door viewer (peep), panic bar hardware (if required by code), push button programmable lockset,
- Teammate Entry Doors: Provide a minimum 36-inch wide, 20-ga, insulated, hollow metal door and thermally-broken, welded, 20-ga hollow-metal frame (both finished with rust-inhibiting paint) with programmable keypad lockset, heavy-duty hinges, aluminum threshold, surface closer, and concealed-overhead stop.

- Emergency Egress Doors: Provide minimum 42" wide door with 20 gauge insulated hollow metal door both painted with rust-inhibiting paint, AND/OR (where indicated by Lessee's Architect) a

minimum 42-inch wide aluminum/glass door and aluminum storefront frame, with exit-only panic bar locking hardware, hinges, surface-closer and concealed-overhead stop.

16.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Tenant. Landlord is responsible for all tap/connection and impact fees for all utilities. All Utilities to be coordinated with Tenant's Architect.

17.0 - Plumbing

Landlord to provide a segregated/dedicated potable water supply line that will be sized by Tenant's Engineer based on Tenant's water requirements (not tied-in to any other Tenant 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 preventers 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 Tenant space. The RPZ's and the Meter will be sized to the incoming line, or per water provider or municipality standards. Landlord to provide Tenant with the most recent site water flow and pressure test results (gallons per minute and psi) for approval. Landlord shall perform water flow and pressure test prior to lease execution. Landlord shall stub the dedicated water line into the Tenant lease space per location coordinated by Tenant.
Provide exterior (anti-freeze when required) hose bibs (minimum of 2) in locations approved by Tenant.

Building sanitary drain size will be determined by Tenant'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 Tenant 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 Tenant's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Tenant's sanitary system design per Tenant's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

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

A Sprinkler System will be installed.. Landlord shall design and install a complete turnkey sprinkler system 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 Tenant's potable water line requirements, or as required by local municipality or water provider. Landlord shall provide all municipal (or code authority) approved shop drawings, service drops and sprinkler heads at heights per Tenant'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 Tenant's engineer dependent on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire to a distribution panel board in the Tenant's

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utility room (location to be per Code and coordinated with Tenant and their Architect) for Tenant's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Landlord'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 panel board with main and branch circuit breakers, and electrical service and building grounding per NEC. Tenant'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 panel board.

Landlord will provide up to 5 sub panels that can accommodate up to 42 circuits based on the Electrical Engineers design.

If Tenant so chooses to require an Emergency Transfer Switch hook-up for a temporary generator, Tenant will advise prior to completion of the bid documents and Landlord will provide one at Landlord costs per Tenants Electrical design.

Landlord to provide main Fire Alarm Control panel that serves the Tenant space and will have the capacity to accommodate devices in Tenant space based on Fire Alarm system approved by local authority having jurisdiction. Landlord'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 run to HVAC units per design drawings. Clinic shall be individually metered and sized per demand by Engineer. Additional electrical service capacity will be required if natural gas service is not available to the building.

21.0 - Mechanical /Heating Ventilation Air Conditioning

Landlord to be responsible for all costs for the HVAC system based on the below criteria. At Tenant's option, Landlord will provide an agreed upon allowance to the Tenant in the amount of $8.00/SF for the HVAC unit installation. Allowance to include installation of units, gas piping, electrical power wiring, and electrical control wiring. Landlord will install Tenant's HVAC curbing and steel support during the roofing installation and cap the openings until the Tenant contractor mobilizes on site.

Tenant will be responsible for the design, procurement and installation of the HVAC system.
The criteria is as follows:

- Equipment to be Lennox 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 Tenant's demands for a dialysis facility and the base building Shell loads.
- Units to include Power Exhaust
- Control system must be capable of performing all items outlined in the Sequence of Operations specification section
- RTU controller shall be compatible with a Building Management System

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- RTU Ductwork drops shall be concentric for air distribution until Tenant's General Contractor modifies distribution to align with Tenant's fit-out design criteria and layout and shall be extended 5' into the space for supply and return air. Extension of system beyond 5-feet shall be by Tenant's General Contractor.
- System to be a fully ducted return air design and will be by Tenant's General Contractor for the interior fit-out
- All ductwork to be externally lined except for the drops from the units.
- Provide 100% enthalpy economizer

using BACnet communication protocol.

- 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 at unit
- 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, coordination with Building Management System supplier, temporary construction thermostats, start-up and commissioning. 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). Tenant's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Tenant's design criteria and local and state codes.

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

22.0 - Telephone

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

23.0 - Cable TV

Landlord shall provide a single 2" PVC underground conduit entrance into Tenant utility room to serve as chase way for new cable television service. Entrance conduit location shall be coordinated with Tenant. Tenant 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. Landlord shall reasonably cooperate and grant "right of access" with Tenant'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. Landlord shall comply with all ADA regulations affecting the Building and entrance to Tenant space including, but not limited to exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, detectable warnings, parking lot striping for three (3)dedicated handicap stalls inclusive of pavement

markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways. This will be approved along with final site plan.

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

25.0 - Exiting

Landlord shall provide at all exterior exit doors safety lights, exterior service lights, exit sign and emergency lights 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

Landlord to provide Tenant 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 Tenant 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 Tenant 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 Landlord 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

Landlord to provide a minimum 6" thick reinforced concrete pad approx. 100 to 150SF based on approved site plan and Tenant'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

Landlord to allow a generator to be installed onsite if required by code or Tenant chooses to provide one at Tenants costs. Tenant's cost to include Kirk key to be built into main electrical switch gear as required

to allow generator to function. Tenant to advise if a generator will be desired for this location prior to the completion of the bid documents.

29.0 - Site Lighting

Landlord to provide adequate lighting per code and to illuminate all parking, pathways, and building access points readied for connection into Tenant power panel. Location of pole fixtures per Landlord civil plan to maximize illumination coverage across site. Parking lot lighting to include timer (to be programmed per Tenant hours of operation) or a photocell.

30.0 - Exterior Building Lighting

Landlord 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 Landlord 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 curbs or 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

Landlord will allow at Tenant's cost to install an illuminated monument site sign as well as facade mounted sign which will include electrical to both Final sign layout to be provided and approved by Landlord and City.

Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

The project will be funded entirely with cash. A copy of DaVita's 2018 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted on March 1, 2019.

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

Attached at Attachment – 36A is a letter from Michael D. Staffieri, Chief Operating Officer of DaVita Inc. and Total Renal Care, Inc. attesting that the total estimated project costs will be funded entirely with cash.

Richard Sewell
Vice Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Vice Chair Sewell:

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: Michael D. Staffieri
Its: Chief Operating Officer, DaVita Kidney Care, DaVita Inc.
President, Total Renal Care, Inc.

Subscribed and sworn to me
This 23rd day of October, 2019

Notary Public

KATHY CONNOR
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20064018112
MY COMMISSION EXPIRES APRIL 28, 2021

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) CLINICAL	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)	
CLINICAL									
ESRD	$191.73				5,320			$1,020,000	$1,020,000
Contingency	$19.17				5,320			$102,000	$102,000
TOTAL CLINICAL	**$210.90**				**5,320**			**$1,122,000**	**$1,122,000**
NON-CLINICAL									
Admin	$189.47				2,090			$396,000	$396,000
Contingency	$18.95				2,090			$39,600	$39,600
TOTAL NON-CLINICAL	**$208.42**				**2,090**			**$435,600**	**$435,600**
TOTAL	**$210.20**				**7,410**			**$1,557,600**	**$1,557,600**
* Include the percentage (%) of space for circulation									

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	**State Standard**	**Above/Below State Standard**
New Construction Contracts & Contingencies	$1,122,000	$303.99 x 5,320 GSF = $1,617,227	Below State Standard
Contingencies	$102,000	10% Modernization Contracts 10%-15% x $1,020,000 = $102,000 - $153,000	Meets State Standard

Table 1120.310(c)			
	Proposed Project	**State Standard**	**Above/Below State Standard**
Architectural/Engineering Fees	$93,684	6.22% - 9.34% of New New Construction Contracts + Contingencies) = 6.77% - 10.17% x ($1,020,000 + $102,000)= 6.77% - 10.17% x $1,122,000 = $75,959 - $114,107	Meets State Standard
Consulting and Other Fees	$57,816	No State Standard	No State Standard
Moveable Equipment	$551,772	$58,660.58 per station x 12 stations $58,660.58 x 12 = $703,926.95	Below State Standard
Fair Market Value of Leased Space or Equipment	$1,989,627	No State Standard	No State Standard
Other Costs to be Capitalized	$63,128	No State Standard	No State Standard

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

Operating Expenses	$984,333
Treatments	10,920
Capital Costs per Treatment	$90.14

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

Capital Costs	$228,608
Treatments	10,920
Capital Costs per Treatment	$20.93

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita Inc. and its affiliates are safety net providers of dialysis services to residents of the State of Illinois. DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and Kidney Smarting patients, and community outreach. A copy of DaVita's 2018 Community Care report, which details DaVita's commitment to quality, patient centric focus and community outreach and was previously included in its Midway Dialysis CON application (Proj. No.19-027). As referenced in the report, 91 percent of DaVita dialysis clinics are rated with three, four or five stars in the CMS Five Star Quality Rating Program. DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Furthermore, DaVita is an industry leader in the rate of fistula use in 2018, 75 percent of patients transitioned to dialysis with a permanent vascular access in place. DaVita outperformed the rest of the industry in early access placement by nearly 100 percent. Its commitment to improving clinical outcomes directly translated into a 25 percent lower hospitalization rate than the industry average and 48 percent lower hospital readmission rate.

   DaVita accepts and dialyzes Illinois patients with renal failure needing a regular course of hemodialysis without regard to race, color, national origin, gender, sexual orientation, age, religion, disability or payor source. Because of the life sustaining nature of dialysis, federal government guidelines define renal failure as a condition that qualifies an individual for Medicare benefits eligibility regardless of their age and subject to having met certain minimum eligibility requirements including having earned the necessary number of work credits. Indigent ESRD patients who are not eligible for Medicare and who are not covered by commercial insurance are typically eligible for Medicaid benefits. If there are gaps in coverage under these programs during coordination of benefits periods or prior to having qualified for program benefits, grants are available to these patients from both the American Kidney Fund and the National Kidney Foundation. If none of these reimbursement mechanisms are available for a period of dialysis, financially needy patients who meet certain objective criteria for financial assistance and otherwise cooperate with DaVita to fulfill documentation requirements may qualify for assistance from DaVita in the form of free care.

   A table showing the charity care and Medicaid care provided by the Applicants for the most recent three calendar years is provided on the following page.

2. The proposed Rogers Park Dialysis will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. Excluding dialysis clinics that were recently approved or in ramp up, average utilization of area dialysis clinics is 76% as of September 30, 2019. Further, over the past three years, patient census at the existing clinics has increased 2% annually and is anticipated to increase for the foreseeable future due to the demographics of the community and disease incidence and prevalence trend. Average utilization of these clinics is projected to exceed 80% by October 2022, the year Rogers Park completes its ramp up.

   NorthShore Medical Group is currently treating 110 Stage 4 and Stage 5 CKD patients, who reside within 3 miles of the proposed Rogers Park Dialysis. See Appendix – 1. Conservatively, based upon attrition due to patient death, transplant, stable disease, or relocation away from the area and in consideration of other treatment modalities (HHD and peritoneal dialysis), it is anticipated that at least 70 of these patients will initiate in-center hemodialysis within 12 to 24 months following project completion. No patients are expected to transfer from existing dialysis clinics. The proposed Rogers Park Dialysis clinic will not impact other general health care providers' ability to cross-subsidize safety net services.

3. The proposed project is for the establishment of Rogers Park Dialysis. As such, this criterion is not applicable.

4. A table showing the charity care and Medicaid care provided by the Applicants for the most recent three calendar years is provided below.

Safety Net Information per PA 98-0031			
CHARITY CARE			
	2016	2017	2018
Charity (# of patients)	110	98	126
Charity (cost in dollars)	$2,400,299	$2,818,603	$2,711,788
MEDICAID			
	2016	2017	2018
Medicaid (# of patients)	297	407	298
Medicaid (revenue)	$4,692,716	$9,493,634	$7,951,548

Section XII, Charity Care Information

The table below provides charity care information for all dialysis clinics located in the State of Illinois that are owned or operated by the Applicants.

CHARITY CARE			
	2016	2017	2018
Net Patient Revenue	$353,226,322	$357,821,315	$394,665,458
Amount of Charity Care (charges)	$2,400,299	$2,818,603	$2,711,788
Cost of Charity Care	$2,400,299	$2,818,603	$2,711,788

Appendix I – Physician Referral Letter

Attached as Appendix 1 is the physician referral letter from Dr. Stuart Sprague projecting 70 pre-ESRD patients will initiate dialysis within 12 to 24 months of project completion.

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

Dear Chair Savage:

I am a nephrologist in practice with NorthShore Medical Group ("NorthShore"). I am writing on behalf of NorthShore in support of the establishment of Rogers Park Dialysis a 12 station dialysis clinic to be located at 1616 West Glenlake Avenue, Chicago, Illinois 60660. The proposed 12 station chronic renal dialysis facility will directly benefit our patients.

The proposed dialysis clinic will improve access to necessary dialysis services in Rogers Park. 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 patients' health and outcomes.

NorthShore is currently treating 110 Stage 4 and Stage 5 chronic kidney disease ("CKD") patients that reside within three miles of the proposed Rogers Park Dialysis. Conservatively, I predict at least of the 70 CKD patients will progress to dialysis within 12 to 24 months of completion of Rogers Park Dialysis. NorthShore's large patient base demonstrates considerable demand for this clinic.

A list of patients who have received care at existing clinics in the area over the past 3 years is provided at Attachment – 1. A list of new patients we have referred for in-center hemodialysis in the past year is provided at Attachment – 2. The zip codes for the 70 CKD 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.

I support the proposed establishment of Rogers Park Dialysis.

Sincerely,

Stuart Sprague, D.O.
Nephrologist
NorthShore Medical Group
1000 Central Street, Suite 800
Evanston, Illinois 60201

Subscribed and sworn to me
This 6 day of January.
~~2019~~ 2020

Laura Kay Metz
Notary Public

LAURA KAY METZ
Official Seal
Notary Public - State of Illinois
My Commission Expires Jun 28, 2021

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Attachment - 1
Historical Patient Census

Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
33904	Affiliated Dialysis Center	0	1	0	0
60015	Affiliated Dialysis Center	1	1	0	0
60035	Affiliated Dialysis Center	0	1	0	0
60062	Affiliated Dialysis Center	2	2	0	0
60068	Affiliated Dialysis Center	0	1	0	0
60070	Affiliated Dialysis Center	1	1	0	0
60089	Affiliated Dialysis Center	0	1	0	0
60077	Center for Renal Replacement	1	0	0	0
60053	Center for Renal Replacement	2	2	2	2
60076	Center for Renal Replacement	1	1	1	0
60645	Center for Renal Replacement	1	1	1	0
60646	Center for Renal Replacement	1	1	0	0
60660	Center for Renal Replacement	1	1	0	0
60077	Concerto Dialysis	0	1	0	0
60025	Concerto Dialysis	0	1	0	0
60053	Concerto Dialysis	0	1	0	0
60077	DaVita Big Oaks	1	1	2	2
60053	DaVita Big Oaks	0	0	1	1
60626	DaVita Big Oaks	0	0	0	1
60659	DaVita Big Oaks	1	1	2	2
60712	DaVita Big Oaks	0	2	3	3
60090	DaVita Buffalo Grove	0	1	0	0
53115	DaVita Buffalo Grove	0	1	0	0
60015	DaVita Buffalo Grove	0	1	1	1
60041	DaVita Buffalo Grove	0	1	1	1
60089	DaVita Buffalo Grove	0	1	3	1
30328	DaVita Evanston	1	0	0	0
60016	DaVita Evanston	0	0	0	1
60025	DaVita Evanston	1	0	0	0
60053	DaVita Evanston	1	1	1	2
60076	DaVita Evanston	5	5	6	6
60077	DaVita Evanston	2	3	3	2
60087	DaVita Evanston	0	0	0	1
60169	DaVita Evanston	1	0	0	0
60201	DaVita Evanston	20	19	22	26
60201	DaVita Evanston	1	0	0	0
60202	DaVita Evanston	10	12	13	14
60202	DaVita Evanston	1	0	0	0

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Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60203	DaVita Evanston	1	1	1	1
60203	DaVita Evanston	1	0	0	0
60402	DaVita Evanston	1	1	1	1
60613	DaVita Evanston	1	1	1	1
60619	DaVita Evanston	1	1	0	0
60625	DaVita Evanston	1	0	0	0
60626	DaVita Evanston	8	12	9	11
60626	DaVita Evanston	2	0	0	0
60629	DaVita Evanston	1	0	0	0
60630	DaVita Evanston	1	1	1	1
60640	DaVita Evanston	1	1	1	1
60644	DaVita Evanston	1	1	1	1
60645	DaVita Evanston	1	2	5	7
60646	DaVita Evanston	1	2	2	2
60647	DaVita Evanston	1	1	1	1
60649	DaVita Evanston	1	0	0	0
60659	DaVita Evanston	1	0	0	0
60660	DaVita Evanston	1	1	1	2
60712	DaVita Evanston	2	3	3	3
60714	DaVita Evanston	2	1	1	1
60064	DaVita Lake County	1	1	0	0
60061	DaVita Lake County	0	0	0	1
60087	DaVita Lake County	0	0	1	0
60089	DaVita Lake County	1	1	1	1
60171	FMC Chicago	1	1	0	0
60656	FMC Chicago	1	0	0	0
10056	FMC Deerfield	1	0	0	0
60013	FMC Deerfield	0	1	0	0
60015	FMC Deerfield	2	5	4	3
60035	FMC Deerfield	4	3	4	8
60040	FMC Deerfield	3	3	3	3
60045	FMC Deerfield	2	2	1	3
60047	FMC Deerfield	2	1	1	1
60062	FMC Deerfield	4	3	4	3
60064	FMC Deerfield	1	2	2	2
60069	FMC Deerfield	1	2	1	0
60073	FMC Deerfield	1	0	0	0
60083	FMC Deerfield	1	1	1	1
60085	FMC Deerfield	0	1	2	2
60089	FMC Deerfield	1	3	1	1
60090	FMC Deerfield	4	3	3	4

Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60640	FMC Deerfield	1	0	0	0
60030	FMC Gurnee	2	1	2	2
60031	FMC Gurnee	4	6	1	3
60064	FMC Gurnee	0	1	3	6
60073	FMC Gurnee	0	2	1	0
60083	FMC Gurnee	1	1	2	2
60085	FMC Gurnee	1	6	8	8
60087	FMC Gurnee	2	2	2	5
60099	FMC Gurnee	1	1	0	1
60527	FMC Gurnee	0	0	1	0
60035	FMC Highland Park	18	1	0	0
33098	FMC Highland Park	0	0	1	0
60015	FMC Highland Park	4	5	6	7
60022	FMC Highland Park	2	2	3	2
60030	FMC Highland Park	1	1	2	1
60031	FMC Highland Park	1	0	0	0
60035	FMC Highland Park	0	19	16	11
60040	FMC Highland Park	10	2	0	0
60040	FMC Highland Park	0	8	8	6
60044	FMC Highland Park	0	0	0	1
60045	FMC Highland Park	4	4	1	2
60046	FMC Highland Park	0	0	1	0
60048	FMC Highland Park	0	0	0	1
60060	FMC Highland Park	0	0	0	1
60061	FMC Highland Park	1	3	0	0
60062	FMC Highland Park	1	0	0	0
60062	FMC Highland Park	2	4	3	3
60064	FMC Highland Park	3	3	3	3
60069	FMC Highland Park	3	5	4	3
60085	FMC Highland Park	6	5	4	5
60089	FMC Highland Park	2	1	1	0
60090	FMC Highland Park	1	1	1	0
60201	FMC Highland Park	0	0	1	0
60202	FMC Highland Park	0	1	0	0
60654	FMC Highland Park	1	1	0	0
60192	FMC Hoffman Estates	1	1	0	1
60045	FMC Lake Bluff	1	0	0	0
53144	FMC Lake Bluff	0	0	1	0
60030	FMC Lake Bluff	0	1	1	1
60031	FMC Lake Bluff	1	0	0	0
60044	FMC Lake Bluff	4	5	5	6

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Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60045	FMC Lake Bluff	2	2	6	6
60046	FMC Lake Bluff	1	1	0	0
60048	FMC Lake Bluff	1	1	1	1
60060	FMC Lake Bluff	1	1	1	0
60064	FMC Lake Bluff	8	8	7	8
60085	FMC Lake Bluff	2	4	5	2
60087	FMC Lake Bluff	2	2	2	1
60099	FMC Lake Bluff	3	2	2	2
60069	FMC Mundelein	1	0	0	0
46202	FMC Mundelein	0	0	1	0
60013	FMC Mundelein	1	0	0	0
60015	FMC Mundelein	1	1	0	0
60030	FMC Mundelein	3	2	2	5
60031	FMC Mundelein	0	0	0	1
60035	FMC Mundelein	0	0	1	0
60040	FMC Mundelein	1	0	0	0
60044	FMC Mundelein	1	0	0	0
60046	FMC Mundelein	1	3	3	2
60047	FMC Mundelein	2	3	2	3
60048	FMC Mundelein	0	0	0	1
60060	FMC Mundelein	4	6	5	4
60061	FMC Mundelein	4	4	5	7
60064	FMC Mundelein	3	3	4	2
60069	FMC Mundelein	1	0	1	0
60073	FMC Mundelein	0	0	1	0
60083	FMC Mundelein	0	0	1	1
60085	FMC Mundelein	3	2	1	1
60087	FMC Mundelein	4	3	3	0
60089	FMC Mundelein	0	0	1	1
60099	FMC Mundelein	1	1	1	1
60107	FMC Mundelein	0	0	0	1
60202	FMC Mundelein	1	1	0	0
62233	FMC Mundelein	1	0	0	0
91127	FMC Mundelein	0	0	0	0
98584	FMC Mundelein	0	1	0	0
33904	FMC Northfield	1	1	0	0
60004	FMC Northfield	0	1	0	0
60022	FMC Northfield	0	1	1	0
60035	FMC Northfield	0	1	1	0
60053	FMC Northfield	1	1	0	0
60062	FMC Northfield	0	1	2	1

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Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60091	FMC Northfield	0	0	1	1
60093	FMC Northfield	1	2	2	2
60067	FMC Palatine	1	0	0	0
60004	FMC Palatine	1	0	2	0
60074	FMC Palatine	0	0	0	1
60089	FMC Palatine	0	0	0	1
60090	FMC Palatine	0	1	1	1
60073	FMC Round Lake	5	4	5	10
60030	FMC Round Lake	1	1	0	0
60041	FMC Round Lake	0	0	0	1
60084	FMC Round Lake	1	1	0	0
60202	FMC Skokie	1	1	0	0
60064	FMC Waukegan Harbor	1	1	2	1
60085	FMC Waukegan Harbor	10	9	9	9
60087	FMC Waukegan Harbor	1	1	2	1
60099	FMC Waukegan Harbor	3	2	1	0
60035	FMC Waukegan Harbor	0	0	1	1
60018	DaVita Glenview	1	1	0	0
60004	DaVita Glenview	0	0	0	1
60008	DaVita Glenview	0	1	1	1
60010	DaVita Glenview	0	2	0	0
60015	DaVita Glenview	0	0	0	1
60016	DaVita Glenview	3	4	2	4
60022	DaVita Glenview	0	0	0	1
60025	DaVita Glenview	2	1	0	0
60025	DaVita Glenview	9	7	6	7
60026	DaVita Glenview	1	1	0	0
60026	DaVita Glenview	0	1	2	3
60035	DaVita Glenview	1	3	3	2
60045	DaVita Glenview	1	0	0	0
60046	DaVita Glenview	0	0	0	1
60047	DaVita Glenview	0	0	1	0
60048	DaVita Glenview	1	0	1	0
60053	DaVita Glenview	1	2	1	1
60056	DaVita Glenview	0	0	2	2
60061	DaVita Glenview	1	1	1	0
60062	DaVita Glenview	2	2	0	0
60062	DaVita Glenview	9	7	12	8
60065	DaVita Glenview	1	0	0	0
60067	DaVita Glenview	0	0	1	0
60068	DaVita Glenview	1	0	0	1

Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60070	DaVita Glenview	1	2	0	0
60070	DaVita Glenview	1	1	3	4
60074	DaVita Glenview	0	1	1	0
60076	DaVita Glenview	1	1	0	0
60076	DaVita Glenview	1	1	2	2
60077	DaVita Glenview	2	2	2	1
60089	DaVita Glenview	1	1	1	1
60090	DaVita Glenview	3	5	3	4
60091	DaVita Glenview	2	1	2	2
60093	DaVita Glenview	2	3	2	3
60201	DaVita Glenview	2	1	1	1
60202	DaVita Glenview	0	1	0	0
60203	DaVita Glenview	0	0	0	1
60714	DaVita Glenview	2	2	3	2
60025	FMC Glenview	1	1	0	0
60004	FMC Glenview	1	1	1	0
60005	FMC Glenview	0	0	1	1
60016	FMC Glenview	3	2	2	3
60025	FMC Glenview	2	3	4	3
60026	FMC Glenview	1	1	1	1
60056	FMC Glenview	2	2	2	3
60062	FMC Glenview	2	3	3	2
60067	FMC Glenview	0	0	0	1
60070	FMC Glenview	2	2	4	5
60090	FMC Glenview	2	1	2	1
60714	FMC Glenview	1	2	3	3
60091	FMC Evanston	2	0	0	0
60640	FMC Evanston	1	0	1	1
21076	FMC Evanston	1	1	0	0
60015	FMC Evanston	1	0	0	0
60016	FMC Evanston	0	0	1	1
60025	FMC Evanston	1	1	1	1
60030	FMC Evanston	1	1	1	0
60053	FMC Evanston	3	2	1	1
60056	FMC Evanston	1	1	1	1
60076	FMC Evanston	7	9	6	7
60077	FMC Evanston	2	5	5	7
60090	FMC Evanston	1	1	1	1
60091	FMC Evanston	2	4	1	2
60093	FMC Evanston	2	1	1	2
60099	FMC Evanston	1	1	1	0

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Zip Code	Dialysis Center	2016 Patients	2017 Patients	2018 Patients	2019 Patients
60201	FMC Evanston	18	18	15	14
60202	FMC Evanston	8	8	4	4
60203	FMC Evanston	4	3	2	1
60610	FMC Evanston	1	0	0	0
60626	FMC Evanston	3	4	0	3
60043	FMC Evanston	0	0	0	1
60045	FMC Evanston	4	4	4	2
60046	FMC Evanston	2	3	2	3
60660	FMC Evanston	1	0	0	0
60712	FMC Evanston	2	2	3	5
60707	FMC Evanston	0	1	1	0
60438	FMC Evanston	0	0	1	0
60626	FMC Evanston	0	0	4	0
60649	FMC Evanston	0	0	1	1
60714	FMC Evanston	0	0	1	1

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Attachment - 2
New Patients

Zip Code	Dialysis Center	2019 New Patients
60076	Davita Evanston	1
60077	Davita Evanston	1
60087	Davita Evanston	1
60091	Davita Evanston	1
60201	Davita Evanston	4
60202	Davita Evanston	4
60626	Davita Evanston	3
60645	Davita Evanston	4
60016	DaVita Glenview	2
60025	DaVita Glenview	2
60026	DaVita Glenview	1
60053	DaVita Glenview	1
60062	DaVita Glenview	5
60070	DaVita Glenview	1
60089	DaVita Glenview	1
60090	DaVita Glenview	3
60091	DaVita Glenview	1
60093	DaVita Glenview	1
60203	DaVita Glenview	1
60645	DaVita Glenview	1
60043	FMC Evanston	1
60062	FMC Evanston	1
60076	FMC Evanston	4
60077	FMC Evanston	1
60093	FMC Evanston	1
60201	FMC Evanston	4
60202	FMC Evanston	2
60626	FMC Evanston	2
60640	FMC Evanston	1
60646	FMC Evanston	1
60712	FMC Evanston	1
60714	FMC Evanston	1
60016	FMC Glenview	1
60025	FMC Glenview	2
60056	FMC Glenview	1
60070	FMC Glenview	1
60714	FMC Glenview	1

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Attachment - 3
CKD Patients

Zip Code	Patients
60202	46
60625	3
60626	15
60640	6
60645	25
60559	9
60660	6
Total	110

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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#20-05

POLSINELLI

ORIGINAL

150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312.819.1900

January 7, 2020

Anne M. Cooper
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(312) 819-1910 fax
acooper@polsinelli.com

FEDERAL EXPRESS

Michael Constantino
Supervisor, Project Review Section
Illinois Department of Public Health
Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

Re: Application for Permit – Rogers Park Dialysis

Dear Mr. Constantino:

I am writing on behalf of DaVita Inc, and Total Renal Care, Inc. (collectively, "DaVita") to submit the attached Application for Permit to establish a 12-station dialysis facility in Chicago, Illinois. For your review, I have attached an original and one copy of the following documents:

1. Check for $2,500 for the application processing fee;
2. Completed Application for Permit;
3. Copies of Certificate of Good Standing for the Applicants;
4. Authorization to Access Information; and
5. Physician Referral Letter.

Thank you for your time and consideration of DaVita's application for permit. If you have any questions or need any additional information to complete your review of the DaVita's application for permit, please feel free to contact me.

Sincerely,

Anne M. Cooper

Anne M. Cooper

Attachments