



DIALYSIS CARE CENTER, LLC
15801 S. Bell Road
Homer Glen, IL 60491
PH: 708-645-1000
FAX: 931-484-4701

September 2, 2021

VIA Federal Express

Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761
Attn: Michael Constantino

Re: Dialysis Care Center Rockford Expansion

Dear Ms. Avery,

I am submitting the enclosed application for consideration by the Illinois Health Facilities and Services Review Board. Please find the following:

1. An original and 1 copy of an application for permit to Expand Dialysis Care Center Rockford to 12 stations.
2. A filing fee of \$2,500.00 payable to Illinois Department of Public Health.

Thank you for your attention to this matter. Please do not hesitate to contact me if you have any questions regarding the proposed project to establish an in-center hemodialysis facility.

Sincerely,

A handwritten signature in black ink, appearing to read "Asim M. Shazzad", with a large, stylized flourish extending from the end of the signature.

Asim M. Shazzad
Chief Operating Officer

**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: Dialysis Care Center Rockford		
Street Address: 1007 W Riverside BLVD		
City and Zip Code: Rockford, IL, 61103-2158		
County: Winnebago County	Health Service Area: 1	Health Planning Area: 1

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

Exact Legal Name: Dialysis Care Center Rockford, LLC
Street Address: 15801 S. Bell Rd
City and Zip Code: Homer Glen, IL, 60491
Name of Registered Agent: Salman Azam, ESQ
Registered Agent Street Address: 333 N. Michigan Ave, Suite 1815
Registered Agent City and Zip Code: Chicago, IL, 60601
Name of Chief Executive Officer: Morufu O. Alausa M.D.
CEO Street Address: 15801 S. Bell Rd
CEO City and Zip Code: Homer Glen, IL, 60491
CEO Telephone Number: (708)645-1000

Type of Ownership of Applicants

☐ 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 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: Asim Shazzad
Title: Administrator
Company Name: Dialysis Care Center
Address: 15801 S. Bell Rd, Homer Glen, IL, 60491
Telephone Number: (630) 965-9007
E-mail Address: shazzad@kidneycares.com
Fax Number: (708) 645-1001

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

Name: Morufu Alausa M.D
Title: CEO
Company Name: Dialysis Care Center
Address: 15801 S. Bell Rd, Homer Glen, IL, 60491
Telephone Number: (708) 645-1000
E-mail Address: talausam@kidneycares.com
Fax Number: (708) 645-1001

**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.

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Street Address: 1007 W Riverside Blvd		
City and Zip Code: Rockford, IL, 61103-2158		
County: Winnebago County	Health Service Area: 1	Health Planning Area: 1

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

Exact Legal Name: Dialysis Care Center Holdings, LLC
Street Address: 15801 S. Bell Rd
City and Zip Code: Homer Glen, IL, 60491
Name of Registered Agent: Salman Azam, ESQ
Registered Agent Street Address: 333 N. Michigan Ave, Suite 1815
Registered Agent City and Zip Code: Chicago, IL, 60601
Name of Chief Executive Officer: Morufu O. Alausa M.D.
CEO Street Address: 15801 S. Bell Rd
CEO City and Zip Code: Homer Glen, IL, 60491
CEO Telephone Number: (708) 645-1000

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Title: CEO
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Address: 15801 S. Bell Rd, Homer Glen, IL, 60491
Telephone Number: (708) 645-1000
E-mail Address: talaus@kidneycares.com
Fax Number: (708)645-1001

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: Asim Shazzad
Title: Administrator
Company Name: Dialysis Care Center
Address: 15801 S. Bell Rd, Homer Glen, IL, 60491
Telephone Number: (630) 965-9007
E-mail Address: shazzad@kidneycares.com
Fax Number: (708)645-1001

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Meridian Investments Partners, LLC
Address of Site Owner: C/O General Counsel, 812 Campus Dr, Joliet, IL, 60435
Street Address or Legal Description of the Site: 1007 W Riverside Blvd, Rockford, IL, 61103-2158
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Dialysis Care Center Rockford, LLC			
Address: 15801 S. Bell Rd, Homer Glen, IL 60491			
☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☒	Limited Liability Company	☐	Sole Proprietorship
		☐	Other
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #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 1110.40 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.

Dialysis Care Center Rockford, LLC. ("Applicant") proposes to add 4 additional stations to its currently 8 approved stations. This will bring the total to a 12-stations, including 1 station as an isolation room.

The scale of impact of the COVID-19 pandemic on society and the economy globally provided a strong incentive for us to thoroughly analyze the efficiency of our dialysis units in dealing with the current pandemic and to obtain lessons to prepare for the future, and more overly to be better prepared for future pandemics. We used data envelopment analysis and data compiled from our clinics to analyze how efficient the use of our resources was. We at DCC implemented a 12-1 patient ratio for nurses and 4-1 Patient Care Technician ratio. The current chairs we have at the clinic do not meet the efficiency ratios and are not cost effective. We additionally have exceeded the admissions to Dialysis Care Center Rockford by our projections where if we continue at those projections, we will not have the dialysis chairs to meet the patients need.

The proposed request will not have any Construction costs or Modernization costs as the 4 stations are pre-existing.

This project is "non- substantive" under Planning Board rule 1110.10(c) as it entails the addition of ESRD stations to an existing 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			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	\$60,000.00		\$60,000.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$60,000.00		\$60,000.00
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	\$60,000.00		\$60,000.00
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$60,000.00		\$60,000.00
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 \$ <u>N/A</u>

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): <u>6 Months after approval for CMS Certification of Additional Stations – (July, 31, 2022)</u>
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 <u>ATTACHMENT 8</u>, 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 ☐ APORS ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.
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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.**

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

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

Facility Bed Capacity and Utilization**Section 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 representatives of the applicant entity. Authorized representatives 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 is filed on the behalf of **Dialysis Care Center Rockford, LLC *** in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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 fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

Morufu O Alausa MD

PRINTED NAME

CEO /President

PRINTED TITLE

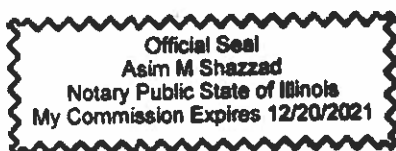
Notarization:

Subscribed and sworn to before me
this 2 day of September


Signature of Notary

Seal

*Insert the EXACT legal name of the applicant




SIGNATURE

Mohammad S. Shafi MD

PRINTED NAME

Vice President

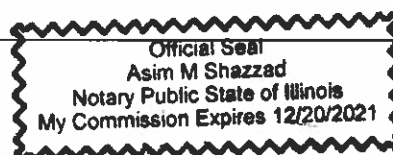
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 2 day of September


Signature of Notary

Seal



CERTIFICATION

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- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- 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 is filed on the behalf of **Dialysis Care Center Holdings, LLC *** in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application 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 fee required for this application is sent herewith or will be paid upon request.



SIGNATURE

Morufu O Alausa MD

PRINTED NAME

CEO /President

PRINTED TITLE

Notarization:

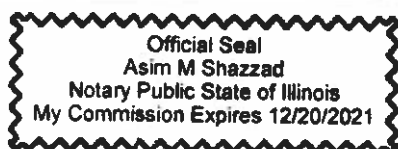
Subscribed and sworn to before me
this 2 day of September



Signature of Notary

Seal

*Insert the EXACT legal name of the applicant




SIGNATURE

Mohammad S. Shafi MD

PRINTED NAME

Vice President

PRINTED TITLE

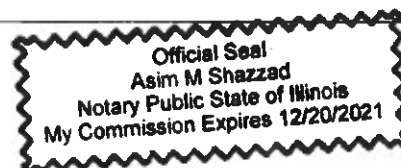
Notarization:

Subscribed and sworn to before me
this 2 day of September



Signature of Notary

Seal



SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency.

NOTE: If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 – Discontinuation (State-Owned Facilities and Relocation of ESRD's)

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document whether or not the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

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

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

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

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest 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 1110.230 – Purpose of the Project, and Alternatives

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (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 VI. SERVICE SPECIFIC REVIEW CRITERIA**F. Criterion 1110.1430 - 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	8	12

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(c)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(c)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(c)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(c)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(c)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(d)(1) - Unnecessary Duplication of Services	X		
1110.1430(d)(2) - Maldistribution	X		
1110.1430(d)(3) - Impact of Project on Other Area Providers	X		
1110.1430(e)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.1430(f) - Staffing	X	X	
1110.1430(g) - Support Services	X	X	X
1110.1430(h) - Minimum Number of Stations	X		
1110.1430(i) - Continuity of Care	X		
1110.1430(j) - Relocation (if applicable)	X		
1110.1430(k) - Assurances	X	X	
APPEND DOCUMENTATION AS ATTACHMENT 24, 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 1110.1430(j) - 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)**

VII. 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]:**

\$60,000.00 (FMV OF LEASE)	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; 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.
\$60,000.00	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 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 35**, 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 36**, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

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

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED 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 38.

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

SECTION XI. 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 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section 1, Identification, General Information, and certification

**Certificates of Good standing for Dialysis Care Center Rockford, LLC.
Dialysis Care Center Rockford will be the operating entity.**

Attachment 1**Applicant Identification**

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

Exact Legal Name: Dialysis Care Center Rockford, LLC.
Street Address: 15801 S. Bell Rd
City and Zip Code: Homer Glen, IL, 60491
Name of Registered Agent: Salman Azam, ESQ
Registered Agent Street Address: 333 N. Michigan Ave, Suite 1815
Registered Agent City and Zip Code: Chicago, IL, 60601
Name of Chief Executive Officer: Morufu O. Alausa M.D.
CEO Street Address: 15801 S. Bell Rd
CEO City and Zip Code: Homer Glen, IL, 60491
CEO Telephone Number: (708)645-1000

Type of Ownership of Applicants

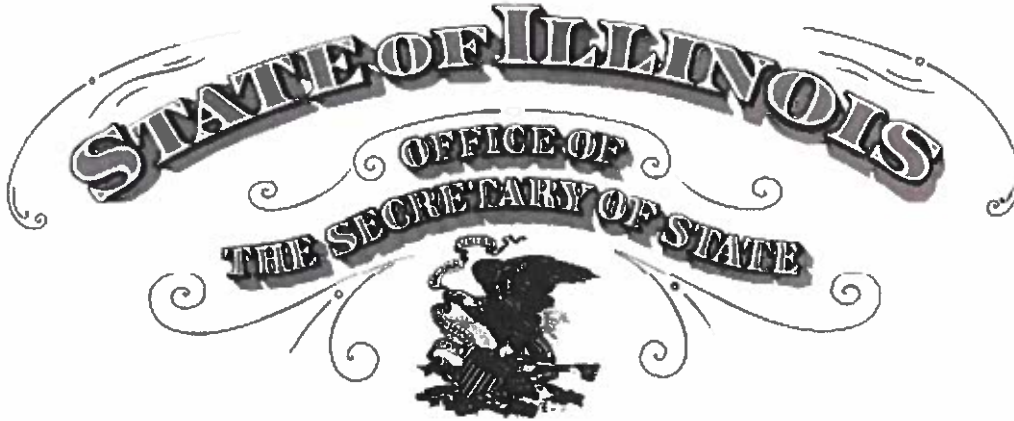
☐ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☒ Limited Liability Company	☐ Sole Proprietorship	☐ Other

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

Attachment 1

File Number

0653665-4



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

DIALYSIS CARE CENTER ROCKFORD LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 08, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 2124204036 verifiable until 08/30/2022
Authenticate at: <http://www.isos.gov>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 30TH
day of AUGUST A.D. 2021 .***

Jesse White

SECRETARY OF STATE

Attachment 1

Section 1, Identification, General Information, and certification

**Certificates of Good standing for Dialysis Care Center Holdings, LLC.
Dialysis Care Center Holdings will be the operator of the dialysis unit.**

Attachment 1**CO-Applicant(s)** [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Dialysis Care Center Holdings, LLC
Street Address: 15801 S. Bell Rd
City and Zip Code: Homer Glen, IL, 60491
Name of Registered Agent: Salman Azam, ESQ
Registered Agent Street Address: 333 N. Michigan Ave, Suite 1815
Registered Agent City and Zip Code: Chicago, IL, 60601
Name of Chief Executive Officer: Morufu O Alausa M.D.
CEO Street Address: 15801 S. Bell Rd
CEO City and Zip Code: Homer Glen, IL, 60491
CEO Telephone Number: (630)697-1414

Type of Ownership of Applicants

☐ 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.

Attachment 1

Section 1, Identification, General Information, and certification

File Number

0578210-4

***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

DIALYSIS CARE CENTER HOLDINGS LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 03, 2016, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



Authentication #: 2124204054 verifiable until 08/30/2022
Authenticate at: <http://www.ilsos.gov>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 30TH
day of AUGUST A.D. 2021 .***

Jesse White

SECRETARY OF STATE

Section 1, Identification, General Information, and certification**Site Ownership****Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Meridian Investment Partners, LLC.
Address of Site Owner: C/O General Counsel, 812 Campus Dr, Joliet, IL, 60435
Street Address or Legal Description of Site: 1007 W Riverside Blvd, Rockford, IL, 61103-2158

Attachment 2

Section 1, Identification, General Information, and certification
Operating Entity/Licensee

Operating Identity/Licensee

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

Exact Legal Name: Dialysis Care Center Rockford, LLC			
Address: 15801 S. Bell Rd, Homer Glen, IL 60491			
☐	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.			

Dialysis Care Center Rockford, LLC ("Operator") will operate the proposed facility. A copy of Certificate of Good Standing is attached on the following page.

Attachment 3

Section 1, Identification, General Information, and certification
Operating Entity/Licensee

File Number

0653665-4



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***

DIALYSIS CARE CENTER ROCKFORD LLC, HAVING ORGANIZED IN THE STATE OF
ILLINOIS ON OCTOBER 08, 2017, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS
OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS
IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF
ILLINOIS.



Authentication #: 1928100626 verifiable until 09/18/2020
Authenticate at: <http://www.cyberdriveillinois.com>

***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 18TH
day of SEPTEMBER A.D. 2019 .***

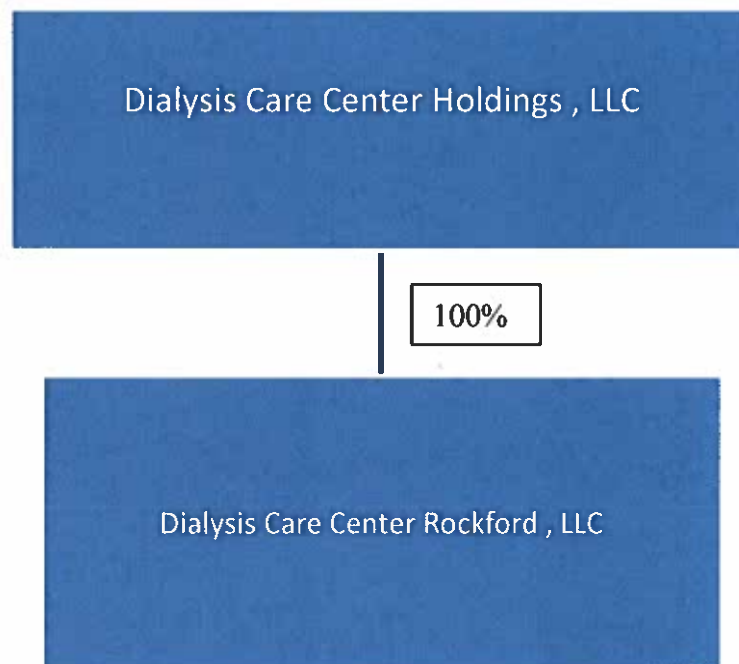
Jesse White

SECRETARY OF STATE

Attachment 3

Section 1, Identification, General Information, and certification
Organizational Relationships

The following organizational chart shows the organization of Applicant, Co-Applicants, and their related parties. Attachment 4:

**Attachment 4**

**Section 1, Identification, General Information, and certification
Flood Plain requirements**

NOT APPLICABLE- EXPANSION ONLY

**Section 1, Identification, General Information, and certification
Project Costs and sources of funds**

Table 1120.110

Project Costs	Clinical	Non-Clinical	Total
New Construction Contracts	-	-	-
Contingencies	-	-	-
Architectural/Engineering Fees	-	-	-
Moveable and Other Equipment			
Communications	-	-	-
Water Treatment	-	-	-
Clinical Furniture	-	-	-
Bio-Medical Equipment	-	-	-
Clinical Equipment	-	-	-
Office Furniture	-	-	-
Office Equipment	-	-	-
Total Moveable and Other Equipment	-	-	-
*Fair Market Value of Leased Space	60,000.00		60,000.00
*4 Dialysis Machines and 4 Dialysis Chairs			
Total Project Cost	60,000.00		60,000.00

**Section 1, Identification, General Information, and certification
Project Status and completion schedules**

The Applicants anticipate project completion within approximately 6 months of project approval.

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

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. This project is for the expansion of Dialysis Care Center Rockford, to a 12-station in-center hemodialysis.

Dialysis Care Center Rockford and Dialysis Care Center Holdings is 100% physician owned and operated. The two physicians below equally own the entities.

1. Morufu Alausa M.D.
2. Sameer M. Shafi M.D.

Both aforementioned physicians have earned recognition with America's Best Physicians for their excellence in providing care for ESRD patients and innovative contributions to the nephrology community overall.

Dialysis Care Center focuses on a 360-degree approach to improving patient health outcomes and providing a medical home for ESRD patients. Included in this care approach is an emphasis on one-on-one attention from our qualified medical staff and a cutting-edge educational program, known as Staff Enhanced Hemodialysis (SEH).

One-on-one attention from our CCHT and BONENT certified technicians and experienced dialysis nurses is achieved through maintaining facilities that have a lower number of stations. Such facilities create an environment for our medical staff to adequately and efficiently monitor patients throughout the entire hemodialysis treatment process. Additionally, such an atmosphere facilitates the creation of quality patient-provider relationships, contributing to construction of a medical home for ESRD patients.

Our continuing educational program, SEH, gives our medical staff, namely, our Clinical Certified Hemodialysis Technicians (CCHTs), more opportunity to connect with patients who visit our facilities for treatment. The program, which covers topics such as fluid management, vascular access management, anemia management, depression, dialysis adequacy and nutrition, is facilitated by our CCHTs, further allowing them to create these meaningful, improved outcome-driving relationships. Of course, this program also empowers patients with critical knowledge to help them better manage of their health, thus reducing hospitalizations and morbidity and mortality.

Attachment-11

With ESRD being the fastest growing cause of hospitalizations and the fifth leading cause of hospital readmissions, our care model additionally has carefully built-in patient interventions to reduce hospitalizations overall. Dialysis Care Center has been recognized by surrounding local hospitals in providing an excellent continuum of care to patients.

Dialysis Care Center provides:

- multiple physician visits within 30 days post-hospitalization,
- 100% medication reconciliation upon hospital discharge,
- renowned and open communication between our nursing/medical staff and hospital discharge planners,
- continuation of antibiotics and other hospital infusive therapies.

The addition of such interventions in Dialysis Care Center's in-center hemodialysis program have been shown to contribute to a strong, consistent, and community-based continuum of care.

Consistency is also implemented internally at Dialysis Care Center, using Clarity, an electronic health record (EHR) created specifically for dialysis clinics. Clarity allows all our medical staff an open line of communication regarding real-time progress to efficiently address patient needs.

**SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES -
INFORMATION REQUIREMENTS**
Certification and Authorization

Dialysis Care Center Rockford, LLC

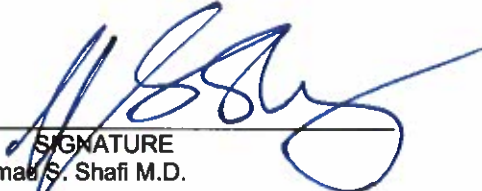
In accordance with section III, A (2) of the Illinois Health Facilities Planning Board Application for certificate Need; I do hereby certify that no adverse actions have been taken against Dialysis Care Center Rockford, LLC by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

In regards to section III, A (3) of the Illinois Health Facilities Planning Board Application for certificate Need; I do hereby authorize the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection.


SIGNATURE
Morufu O Alausa M.D.

PRINTED NAME
CEO /President

PRINTED TITLE


SIGNATURE
Mohammad S. Shafi M.D.

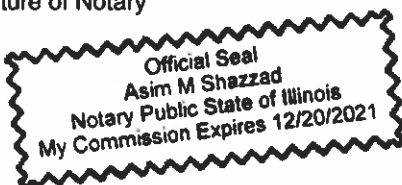
PRINTED NAME
Vice President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2 day of September


Signature of Notary

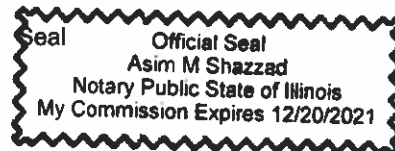
Seal



Notarization:
Subscribed and sworn to before me
this 2 day of September


Signature of Notary

Seal

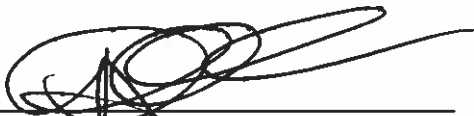


**SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES -
INFORMATION REQUIREMENTS
Certification and Authorization**

Dialysis Care Center Holdings, LLC

In accordance with section III, A (2) of the Illinois Health Facilities Planning Board Application for certificate Need; I do hereby certify that no adverse actions have been taken against Dialysis Care Center Rockford, LLC by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

In regards to section III, A (3) of the Illinois Health Facilities Planning Board Application for certificate Need; I do hereby authorize the State Board and Agency access to information in order to verify any documentation or information submitted in response to the requirements of this subsection or to obtain any documentation or information that the State Board or Agency finds pertinent to this subsection.



SIGNATURE
Morufu Alausa M.D.

PRINTED NAME
CEO /President

PRINTED TITLE



SIGNATURE
Mohammad S. Shafi MD

PRINTED NAME
Vice President

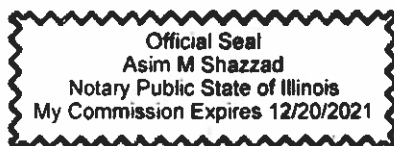
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2 day of September



Signature of Notary

Seal

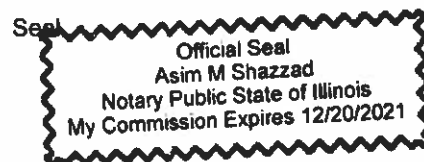


Notarization:
Subscribed and sworn to before me
this 2 day of September



Signature of Notary

Seal



Attachment-11

**SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES -
INFORMATION REQUIREMENTS****Purpose of the project**

The purpose of this project is to create additional life-sustaining dialysis accessibility to the large, growing population of ESRD patients in the HSA 1 market area specifically Rockford and Winnebago County residents.

Dialysis Care Center Rockford is proposing to add 4 additional hemodialysis stations

The scale of impact of the COVID-19 pandemic on society and the economy globally provided a strong incentive for us to thoroughly analyze the efficiency of our dialysis units in dealing with the current pandemic and to obtain lessons to prepare for the future, and more overly to be better prepared for future pandemics. We used data envelopment analysis and data compiled from our clinics to analyze how efficient the use of our resources was. We at DCC implemented a 12-1 patient ratio for nurses and 4-1 Patient Care Technician ratio. The current chairs we have at the clinic do not meet the efficiency ratios and are not cost effective. We additionally have exceeded the admissions to Dialysis Care Center Rockford by our projections where if we continue at those projections, we will not have the dialysis chairs to meet the patients need.

Increasing the station availability at the Dialysis Care Center Rockford facility will maintain access to dialysis services in an area of Winnebago County that has historically experienced high utilization rates. The additional stations will also provide patients with a choice of treatment shift times that would better coordinate with their home life, employment and transportation options and will ease over utilization at neighboring facilities.

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

Alternatives to the project

We have considered three options prior to adding 4 additional stations.

1. Increasing or reducing the scope and size of the project
2. Pursuing a joint venture for the establishment of a new facility
3. Using existing facilities

After exploring these options, which are discussed in more detail below, we determined to add the 4 additional stations to Dialysis Care Center Rockford. Discussed is a review of each of the options considered and the reasons they were rejected.

Proposing a project of greater or lesser scope and cost.

The only option other than what was proposed in the application, would entail a lesser scope and cost than the project proposed in this application would be to do nothing, which was considered. **This option, however, does not address Patient access issues in Rockford, IL.** To do nothing would cause existing area facilities to reach or exceed capacity as patient access declines in this HSA 1 defined zone. There is no cost to this alternative.

Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or portion of the projects intended purposes; developing alternative settings to meet all or a portion of the projects intended purposes.

The ownership of this facility is structured so later if there was the desire to form a joint venture with additional physicians, a partner would be able to invest in the facility. This facility is and will be owned 100% owned and operated directly by the physicians working in the area.

Utilizing other health care resources that are available to serve all or portion of the population proposed to be served by the project.

Utilizing other health care ESRD facilities was considered but there is no alternative. As mentioned there are no physician-owned ESRD facilities in the area where the physicians have the independence they need to improve the quality indicators set by the Board's criteria on quality. It is expected that the facility will exceed the clinical outcomes that meet all network, Centers for Medicare and Medicaid Services clinical goals established.

Reasons why the chosen alternatives were selected.

The project utilizes space that is pre-existing, the cost of the proposed 4 additional stations is a fraction of the cost of developing a new facility.

This we believe is the most efficient long-term solution to maintaining access to dialysis services in the Rockford area, and to accommodate the need of the growing population in HSA 1.

We believe that the proposed project meets the HFPB goals of providing health care services in the most cost effective manner.

Empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

There is no direct empirical evidence relating to this project other than that when chronic care patients have adequate access to services, it tends to reduce overall healthcare costs and results in less complications. It is expected that this facility will exceed the quality expectations set by the Board.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Size of Project**

As seen in the chart below, the state standard is 450-650 gross square feet per dialysis station for a total of 3,400-7,800 gross square feet for 12 stations. The project is being accomplished in leased space within the state guidelines,

Dept. / Service	Proposed BGSF/DGSF	State Standard	Difference	Met Standard?
ESRD In-center Hemodialysis	5,400 (12 Stations)	450- 650 DGSF	N/A	Yes

Size of Project
Attachment-14

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Project Service Utilization**

Clinic was Certified on July 19th, 2021, as of August 30, 2021, the clinic census is 15 patients within 1 month and 11 days. At this rate we will exceed 120% utilization Within 12 months. We are requesting the additional 4 stations To meet patients need. Please see attached CMS approval letter dated August 10, 2021.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
Less than 2 Months	IN-CENTER HEMODIALYSIS	15 PATEINTS		N/A	
YEAR 1	IN-CENTER HEMODIALYSIS		100%	80%	YES
YEAR 2	IN-CENTER HEMODIALYSIS		100%	80%	YES

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS - Chicago, Survey and Operations Group
259 N Michigan, Suite 600
Chicago, IL 60601



CMS Certification Number (CCN): 142875
National Provider Identifier (NPI): 1003498965

August 10, 2021

Administrator
Dialysis Care Center Rockford, LLC
1007 W. Riverside Blvd. Suite A
Rockford, IL 61103

Via Email: shazzad@dccdialysis.com

Dear Administrator:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program (Title XVIII of the Social Security Act). Your effective date of coverage is July 19, 2021.

Your unit has been approved as a renal dialysis facility. This approval is for a total of 8 maintenance stations.

Your facility is approved to provide the following services:

- In Center Hemodialysis

Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the CMS Certification Number (CCN) shown above; please provide it when contacting this office, when contacting the State agency, or any time it is requested.

Your Medicare Administrator Contractor (MAC) for reimbursement for renal treatment procedures will be NGS. You must maintain separate cost centers for all renal services. Your MAC will contact you shortly to explain the special reimbursement procedures.

When you make general inquiries to your MAC, you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary- and claim-specific information. When prompted for your PTAN, give your CCN.

We have certified your facility and assigned your CCN. However, this does not complete your Medicare enrollment. The MAC will now complete the final steps and will notify you of your enrollment or denial including the date when you may begin submitting claims for payment. Your provider agreement and CCN are contingent upon your enrollment into the Medicare program. If your enrollment is ultimately denied by the MAC, your agreement and/or CCN will be voided.

Page 2
Administrator

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the Illinois Department of Public Health if you wish to relocate your facility, change the services which you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact Kessa Frantz, Certification Specialist, in the Chicago Office at Kessa.Frantz@cms.hhs.gov.

Sincerely,



Maria Vergel De Dios
Principal Program Representative
Non-Long Term Care Certification & Enforcement Branch

cc: Illinois Department of Public Health
Illinois Department of Health Care and Family Services
NGS
Renal Network #10
Livanta

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

Attachment-16

**SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE
Assurances**

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

Attachment-17

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

In-Center Hemodialysis

Criterion 1110.1430(b)(1), Planning area need

The scale of impact of the COVID-19 pandemic on society and the economy globally provided a strong incentive for us to thoroughly analyze the efficiency of our dialysis units in dealing with the current pandemic and to obtain lessons to prepare for the future, and more overly to be better prepared for future pandemics. We used data envelopment analysis and data compiled from our clinics to analyze how efficient the use of our resources was. We at DCC implemented a 12-1 patient ratio for nurses and 4-1 Patient Care Technician ratio. The current chairs we have at the clinic do not meet the efficiency ratios and are not cost effective. We additionally have exceeded the admissions to Dialysis Care Center Rockford by our projections where if we continue at those projections, we will not have the dialysis chairs to meet the patients need.

The additional 4 dialysis chairs requested for Dialysis Care Center Rockford will grant patients the liberty to make choices about their care, and, ultimately, their health outcomes.

Planning Area Need
Attachment-24

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

In-Center Hemodialysis

Service to Planning area residents

The primary purpose of this project is to ensure that the ESRD patient population of the greater Rockford area, market area, and planning area of HSA 1 has access to life sustaining dialysis and have dialysis options.

We anticipate that well over 90% of Dialysis Care Center Rockford will be residents of the planning area HSA 1.

Planning Area Need
Attachment-24

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

In-Center Hemodialysis

Service Demand- Establishment of Category of services

Dialysis Care Center Rockford is located in HSA 1,

Attachment-24

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Planning area need – Service Accessibility

As set forth throughout this application, the proposed ESRD facility is needed to maintain access to life-sustaining dialysis for patients in the greater Rockford area. Dialysis Care Center Rockford is necessary to provide essential care to ESRD patients in the community. This facility will better accommodate the current and future demand for dialysis services and ensure dialysis services are accessible to the greater Rockford Community and HSA 1 area.

Attachment-24

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430(C) (2), Misdistribution

The 4 additional stations requested of Dialysis Care Center Rockford will not result in an unnecessary duplication of services or a service misdistribution. A misdistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (1) ratio of stations to population exceeds one and one-half times the state average; (2) historical utilization for existing facilities and services is below the State Boards utilization standard; or (3) insufficient population to provide the volume of caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more extensively below, the ratio of stations to population in the geographic area is above of the state average, and the average utilization of existing facilities within the geographic service area is more than 82%. Notably, average utilization of facilities within 30 minutes of the proposed site is about 70%. Sufficient population exists to achieve target utilization in the future.

Accordingly, the proposed dialysis facility will not result in a misdistribution of services.

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430(C) (3). Impact of project on other Area Providers

The proposed dialysis facility will not have an adverse impact on existing facilities in the proposed geographic service area. All the identified patients will be referrals from identified physicians and are on pre-ESRD list. No patients will be transferred from other existing dialysis facilities.

The proposed dialysis facility will not lower utilization of other area providers that are operating below the target utilization standard.

Attachment-24

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430(e) Staffing

Dialysis Care Center Rockford will be staffed in accordance with all state and Medicare staffing guidelines and requirements.

A. Medical Director:

Dr. Talal Mahmood will serve as the Medical Director for Dialysis Care Center Rockford. Attached is his curriculum vitae.

Additional staffed physician Dr. Krishna Manda. Attached please find his curriculum vitae.

B. All other personnel

Upon opening, the facility will hire a Clinic Manager who is a Registered Nurse (RN). This nurse will have at least a minimum of twelve months experience in a hemodialysis center. Additionally, we will hire one Patient Care Technician (PCT). After we have more than one patient, we will hire another RN and another PCT. All personnel will undergo an orientation process, led by the Medical Director and experienced members of the nursing staff prior to participating in any patient care activities.

Upon opening we will also employ:

- Part-Time Registered Dietician
- Part-Time Registered Master Level Social Worker (MSW)
- Part-Time Equipment Technician
- Part-Time Secretary

These positions will go full time as the clinic census increases. Additionally, the patient Care staff will increase to the following:

- One Clinic Manager –Registered Nurse
- Four Registered Nurses
- Ten Patient Care Technicians

Staffing
Attachment-24

All patient care staff and licensed / registered professionals will meet the State of Illinois requirements. Any additional staff hired must also meet these requirements along with completing an orientation training program.

Annually all clinical staff must complete OSHA training, Compliance training, CPR certification, Skills competency, CVC competency, Water quality training and pass the competency exam.

Dialysis Care Center Rockford will maintain at least a 4 to 1 patient-staff ratio at all times on the treatment floor. An RN will be at the facility at all times when the facility is operational.

TALAL MAHMOOD, M.D.
6940 Villagreen View
Rockford, IL 61107
779-774-9272

EDUCATION AND TRAINING:

7/12-6/14	Fellowship (Nephrology) University of Mississippi Medical Center – Jackson, MS
8/04-8/07	Residency (Internal Medicine) Michael Reese Hospital – Chicago, IL
5/01-11/01	Internship (Surgery) Jinnah Hospital – Lahore, Pakistan MBBS
11/00-5/01	Internship (Medicine) Jinnah Hospital – Lahore, Pakistan
1/95-10/00 Pakistan	Baqai Medical & Dental College – University of Karachi – Karachi, MBBS

EMPLOYMENT:

7/14-Present	Kidney Care Center Nephrologist
5/09-5/12	Inpatient Consultants (IPC) – The Hospitalist Company – Rockford, IL Swedish American Hospital Hospitalist (Internal Medicine)
9/7-4/09	Midwest Neoped Associates. Ltd.- Chicago Heights/Olympia Fields, IL St. James Hospital Hospitalist (Internal Medicine)
11/01-5/04	Bismillah Hospital – Lahore, Pakistan Medical Officer

GAPS:

5/12-7/12	Preparing for Fellowship to begin, relocating
5/04-8/04	Volunteer work in medicine, taking care of personal family matters and process of moving to the United States

KRISHNA KANTH REDDY MANDA

6940 Villagreen View

Rockford, IL 61107

779-774-9272

EDUCATION AND TRAINING:

12/96-7/02	Jawaharlal Nehru Medical College – Belgaum, India MBBS
2/04-7/04	Royal Hampshire County Hospital – Winchester, UK Intern – Orthopedics
8/04 -1/05	West Wales General Hospital, Carmarthen, UK Intern – General Medicine
2/5-7/05	West Wales General Hospital, Carmarthen, UK Resident – Emergency Medicine
8/05-7/06	West Wales General Hospital – Carmarthen, UK Resident – Chest Medicine, Emergency Medicine, Hematology/Oncology
8/06-7/07	West Wales General Hospital – Carmarthen, UK Senior Resident – Elderly Medicine and Diabetes & Endocrinology
8/07-7/08	University Hospital of Wales, Cardiff, UK Senior Resident – Gastroenterology and Nephrology
8/08-2/9	Prince Charles Hospital – Merthyr Tydfil, UK Registrar – Elderly Medicine and Respiratory Medicine
3/09-5/9	Chesterfield Royal Hospital – Chesterfield, UK Senior Resident – Cardiology and Stroke Medicine
7/09-6/12	Berkshire Medical College – Pittsfield, MA Resident – Internal Medicine
7/12-6/13	Berkshire Medical College – Pittsfield, MA Chief Resident – Internal Medicine
7/13-6/15	University of Massachusetts – Worcester, MA Fellowship – Nephrology

KRISHNA KANTH REDDY MANDA**Page 2****EMPLOYMENT:**

8/02-2/03	Tukkar Hospital – Belgum, India Medical Officer
7/15-Present	Kidney Care Center Rockford LLC Nephrologist

CERTIFICATIONS:

2004- Present	Basic Life Support
2004-Present	Advanced Cardiac Life Support
2012	Board Certified in Internal Medicine
2015	Board Certified in Nephrology

GAPS:

3/03	Mahavir Hospital & Research Centre – Hyderabad, India Clinical Observer in Critical Care Unit
4/03-6/03	Went to the UK and took the Professional and Linguistic Assessment Board (PLAB). Applied for Clinical Attachment Posts and clinical jobs
6/03-7/03	Milton Keynes General Hospital – Milton Keynes, MK6 5LD Clinical Attachment in Medicine
7/03-1/04	Poole Hospital – Poole, BH15 2JB Clinical Attachment in Cardiology and Geriatrics
6/09	Vacation

Attachment-24

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430(g) Minimum Number of stations

Dialysis Care Center Rockford will provide twelve ESRD stations, as identified in section 1110-1430g as the minimum number of eight dialysis stations to be provided at an ESRD facility to be located in a metropolitan statistical area ("MSA"). Accordingly, this criterion is met.

Attachment-24

Section VII. Service Specific Review Criteria

In-Center Hemodialysis

Criterion 1110.1430 (i) Relocation of facilities

Dialysis Care Center Rockford is proposing the establishment of an 12-station dialysis facility. Thus, the criterion is not applicable.

Section VIII. Financial and economic Feasibility
Criterion 1110.120 Availability of funds

Dialysis Care Center Rockford will be funded entirely with cash and cash equivalents,

SECTION X. SAFETY NET IMPACT STATEMENT

The expansion of Dialysis Care Center Rockford will not have any impact on safety net services in the Rockford area. Outpatient dialysis facilities services are not typically considered or viewed as "safety net" services. As a result the presence of Dialysis Care Center Rockford as a provider is not expected to alter the way any other healthcare providers function in the community.

Dialysis Care Center Rockford has no reason to believe that this project would have any adverse impact on any provider or health care system to cross-subsidize safety net services.

Dialysis Care Center Rockford will be committed to providing ESRD services to all patients with or without insurance or patients to no regards for source of payment. Dialysis Care Center Rockford will not refuse any patients. Medicaid patients wishing to be served at Dialysis Care Center Rockford will not be denied services. Because of the Medicare guidelines for qualification for ESRD, a few patients' with ESRD are left uninsured for their care.

SECTION XI. CHARITY CARE INFORMATION

The policy of Dialysis Care Center Rockford is to provide services to all patients regardless of race, color, national origin. Dialysis Care Center Rockford will provide services to patients with or without insurance and as well as patients who may require assistance in determining source of payment. Dialysis Care Center will not refuse any patient. Medicaid patients wishing to be served will not be denied services. Through Medicare guidelines, patients who are prequalified for ESRD or for the few that are currently ESRD status and are left uninsured, Dialysis Care Center will be committed to providing continued care.

Dialysis Care Center Rockford will be committed to work with any patient to try and find any financial resources and any programs for which they may qualify for.

Dialysis Care Center will be an "open dialysis unit" meaning through our policy, any nephrologist will be able to refer their patients and apply for privileges to round at the facility, if they desire.

Dialysis Care Center will participate in American Kidney Fund (AKF) to assist patients with insurance premiums which will be at no cost to the patient.

Currently as Dialysis Care Center Rockford will be a new entity there is no current Charity documentation that can be provided to the board, however the Charity policy is attached.

Please find attached our Admission Policy and Charity Policy.

DIALYSIS CARE CENTER ROCKFORD

Admission Policy

- I. Purpose: The purpose of this policy is to define requirements for admission to the Dialysis Care Center (DCC).
- II. Performed by: Medical Director, Program Manager, Program Nurse
- III. Overview: All patients must receive modality education by their referring physician prior to being admitted to the facility. The Program staff will further educate the patient on the modality he/she has chosen. The facility Patient Handbook will also include education on the different treatment modalities and instruct the patient on his/her right to change their treatment modality provided they meet the criteria for that modality and they have discussed this with their physician and the members of the interdisciplinary team (IDT).
- IV. Supplies:
 - A. Assignment of Benefits Form
 - B. Release of information Form
 - C. Admission Agreement
 - D. Consent for Dialysis
 - E. Patient Handbook
- V. Policy:
 - A. All patients referred to DCC will be treated regardless of race, creed, age, sex, color, disability, or national origin.
 - B. In order to develop the admission treatment orders and to identify and address any urgent medical needs prior to the completion of the comprehensive patient assessment by the IDT, the Medical Director, nephrologist or physician extender and the Program Registered Nurse will be responsible for an initial assessment before the initiation of the patient's first dialysis treatment in the facility.
 - C. The initial medical assessment may be completed by review of the patient's medical records or consultation with the referring physician and is not intended to require the medical staff physically see the patient in the facility prior to the first treatment.
 - D. Orders for treatment must be obtained prior to the initial dialysis treatment. The Registered Nurse will meet with the patient new to dialysis to

perform an initial nursing assessment prior to initiation of treatment. The minimum nursing evaluation prior to initiating treatment for a patient new to dialysis will include the following:

- Neurologic: level of alertness, orientation
- Subjective complaints
- Pain status
- Activity: ambulation status, support needs, falls risk
- Access assessment
- Respiratory: description of respirations and lung sounds
- Cardiovascular: heart rate and rhythm, blood pressure, any edema
- Fluid gains
- integumentary: skin color, temperature, and any type/location of wounds

E. All appropriate paperwork must be completed prior to admission and includes receipt of medical and financial record to allow enough time for review by the physician and clinical staff. The following forms must be signed before admission to the facility:

- Assignment of Benefits (AOB)
- Release of Information
- Admission Agreement

F. Hepatitis testing is required prior to admission.

G. Financial approval for the patient's admission will be granted based on the patient's insurance coverage the patient's intent to pursue other assistance programs if indicated. Any individual unable to obtain or ineligible for financial or insurance coverage, or refusing to disclose insurance information will not be granted financial clearance to be admitted to the Program.

H. Copies of insurance coverage are required prior to admission.

I. Prior to initiation of dialysis, a consent form for the specific dialysis treatment modality must be signed by the patient or authorized Caregiver.

VI. Procedure: Please follow the steps in the table below.

1	Review admission policy with appropriate staff to ensure admission process is understood and followed.
2	Obtain and review hepatitis status of patient with the Medical Director, physician or physician extender prior to admission.
3	Obtain patient or authorized caregiver signature on all admission documents including but not limited to the AOB, Release of Information and Consent

4	As certain that the patient has received financial and medical clearance and has been approved for admission to the Program/facility before accepting the patient for treatment.
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VII. References:

- Federal Register (April 2008). Centers for Medicare & Medicaid Services (CMS), Conditions for Coverage, 494.150 Medical Director.

VIII. Associate Policies:

- Hemodialysis Consent Policy



DIALYSIS CARE CENTER ROCKFORD

Charity Policy

- I. Purpose:** The purpose of this policy is to define requirements for admission to the Dialysis Care Center Rockford, LLC (DCC).
- II. Performed by:** Medical Director, Program Manager, Program Nurse
- III. Policy:**
 - A. Provide care for patients in the community who are economically challenged and/or who are undocumented aliens, who do not qualify for Medicare/Medicaid pursuant to an Indigent Waiver policy.
 - B. Assist patients who do not have insurance in enrolling when possible in Medicaid and/or Medicaid as applicable, and also our social services department assists patients who have issues regarding transportation and/or who are wheel chair bound or have other disabilities which require assistance with respect to dialysis services and transport to and from the unit.
 - C. Provides care to patients who do not qualify for any type of coverage for dialysis services. These patients are considered "self-pay" patients. They are billed for services rendered, and after three statement reminders the charges are written off as bad debt. Collection actions are not initiated unless the applicants are aware that the patient has substantial financial resources available and/or the patient has received reimbursement from an insurer for services we have rendered and has not submitted the payment for same to the applicants.
 - D. Provide community benefit by supporting various medical education activities and associations, such as the Renal Network and National Kidney Foundation