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 Olympia Fields
Street Address: 3322 Vollmer Rd
City and Zip Code: Olympia Fields, IL, 60461
County: Cook County Health Service Area: 7 Health Planning Area:7

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

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: 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: talausa@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.

Facility/Project Identification

Facility Name: Dialysis Care Center Olympia Fields
Street Address: 3322 Vollmer Rd
City and Zip Code: Olympia Fields, IL, 60461
County: Cook County Health Service Area: 7 Health Planning Area:7

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

Exact Legal Name: Meridian Investment Partners, 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
- ☐ 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: 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: talausa@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: 3322 Vollmer Rd, Olympia Fields, IL,60461
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 Olympia Fields, 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.**

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 1110.40 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 Olympia Fields, LLC. ("Applicant") proposes to add 12 additional stations to its currently 12 approved stations. This will bring the total to a 24-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 Olympia Fields by our projections where if we continue at those projections, we will not have the dialysis chairs to meet the patients need.

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	$540,000.00		$540,000.00
Contingencies			
Architectural/Engineering Fees	$12,000.00		$12,000.00
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	$400,000.00		$400,000.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$952,000.00		$952,000.00
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**$552,000.00**		**$552,000.00**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	**$400,000.00**		**$400,000.00**
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$952,000.00**		**$952,000.00**

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 operatin 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 $ N/A

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): 6 Months after approval for CMS Certification of Additional Stations – (Dec 31, 2022)

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
☐ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **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

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 Olympia Fields, 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 20th day of April, 2022

Signature of Notary

Seal

SIGNATURE

Mohammad S. Shafi MD

PRINTED NAME

Vice President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- 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.

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Morufu O Alausa MD

PRINTED NAME

CEO /President

PRINTED TITLE

Notarization:
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this 20th day of April, 2022

Signature of Notary

Seal

SIGNATURE

Mohammad S. Shafi MD

PRINTED NAME

Vice President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

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?

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	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 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	12	24

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(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]:**

$552,000.00	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;
$400,000.00 (FMV OF LEASE)	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;

	5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$952,000.00	**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	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 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 Olympia Fields, LLC.
Dialysis Care Center Olympia Fieldswill 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 Olympia Fields, 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.

File Number 0579050-6

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

DIALYSIS CARE CENTER OLYMPIA FIELDS LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 11, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 20TH *day of* APRIL *A.D.* 2022 .

Authentication #: 2211003632 verifiable until 04/20/2023
Authenticate at: http://www.ilsos.gov

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

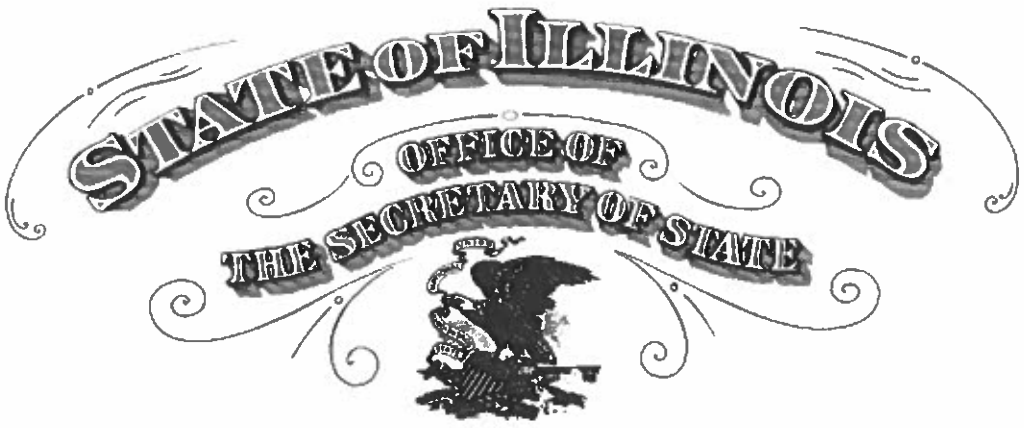
Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ 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.

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.

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 .

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

Jesse White
SECRETARY OF STATE

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: Meridian Investment Partners, 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.

File Number **0381617-6**

To all to whom these Presents Shall Come, Greeting:

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

MERIDIAN INVESTMENT PARTNERS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 13, 2012, 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 #: 2000301682 verifiable until 01/03/2021
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* **3RD** *day of* **JANUARY** ***A.D.*** **2020** .

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: 3322 Vollmer Rd, Olympia Fields, IL, 60805

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 Olympia Fields, 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 Olympia Fields, LLC ("Operator") is operating the 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 0579050-6

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

DIALYSIS CARE CENTER OLYMPIA FIELDS LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 11, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 20TH *day of* APRIL *A.D.* 2022 .

Jesse White
SECRETARY OF STATE

Authentication #: 2211003632 verifiable until 04/20/2023
Authenticate at: http://www.ilsos.gov

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
Modernization Contracts	540,000.00		540,000.00
Contingencies	-		-
Architectural/Engineering Fees	12,000.00		12,000.00
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	400,000.00		400,000.00
Total Project Cost	952,000.00		952,000.00

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 Olympia Fields, to a 24-station in-center hemodialysis.

Dialysis Care Center Olympia Fields 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 ERSD 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.

Attachment-11

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

Dialysis Care Center Olympia Fields, LLC

In accordance with section III, A (2) of the Illinois Health Facilities Planning Board Application for certificate Need; I do herby certify that no adverse actions have been taken against Dialysis Care Center Olympia Fields, 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 herby 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

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

SIGNATURE
Mohammad S. Shafi M.D.
PRINTED NAME
Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

Attachment-11

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 herby certify that no adverse actions have been taken against Dialysis Care Center Olympia Fields, 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 herby 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

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

SIGNATURE
Mohammad S. Shafi MD
PRINTED NAME
Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of April, 2022

Signature of Notary

Seal

OFFICIAL SEAL
JULIE WILLIAMSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES: 2/8/2026

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 7 market area specifically Olympia Fields and Cook County residents.

Dialysis Care Center Olympia Fields is proposing to add 12 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 Olympia Fields 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 Olympia Fields facility will maintain access to dialysis services in an area of Cook 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.

Purpose
Attachment-12

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

Alternatives to the project

We have considered three options prior to adding 12 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 12 additional stations to Dialysis Care Center Olympia Fields. 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 Olympia Fields, IL.** To do nothing would cause existing area facilities to reach or exceed capacity as patient access declines in this HSA 7 defined zone. There is no cost to this alternative.

Pursing 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 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 Olympia Fields area, and to accommodate the need of the growing population in HSA 7.

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 24 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	6,500 (24 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 January 19th, 2018 , please see attached CMS approval letter dated February 14th 2018 and has always been operating above 70% utilization.

Clinic As of April 1, 2022, has 71 patients at this rate without expansion the clinic will have over 100% utilization

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

Project Service Utilization
Attachment-15

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 142829
National Provider Identifier (NPI): 1003368440

February 14, 2018

Administrator
Dialysis Care Center Olympia Fields
3322 Vollmer Road, Suite 300
Olympia Fields, IL 60461

Dear Administrator:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program. Your effective date of coverage is January 19, 2018.

Your unit has been approved as a renal dialysis facility. This approval is for a total of twelve (12) 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 Administrative Contractor (MAC) for reimbursement for renal treatment procedures will be National Government Services. You must maintain separate cost centers for all renal services. Your intermediary 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.

The Medicare Administrative Contractor (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 CCN is contingent upon your enrollment into the Medicare program. If your enrollment is ultimately denied by the MAC, your CCN will be voided.

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 Olympia Fields by our projections where if we continue at those projections, we will not have the dialysis chairs to meet the patients need.

The additional 12 dialysis chairs requested for Dialysis Care Center Olympia Fields 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 Olympia Fields area, market area, and planning area of HSA 7 has access to life sustaining dialysis and have dialysis options.

We anticipate that well over 90% of Dialysis Care Center Olympia Fields will be residents of the planning area HSA 7.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

In-Center Hemodialysis
Service Demand- Establishment of Category of services

Dialysis Care Center Olympia Fields is located in HSA 7,

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 Olympia Fields area. Dialysis Care Center Olympia Fields 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 Olympia Fields Community and HSA 7 area.

Attachment-24

Section VII. Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(C) (2), Misdistribution

The 2 additional stations requested of Dialysis Care Center Olympia Fields 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.

Attachment-24

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 Olympia Fields will be staffed in accordance with all state and Medicare staffing guidelines and requirements.

A. Medical Director:

Dr. Tauseef Sarguroh is serving as the Medical Director for Dialysis Care Center Olympia Fields. Attached is his curriculum vitae.

B. All other personnel

The facility has a Clinic Manager who is a Registered Nurse (RN). This nurse has at least a minimum of twelve months experience in a hemodialysis center. Additionally, 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 Olympia Fields will always maintain at least a 4 to 1 patient-staff ratio on the treatment floor. An RN will be always at the facility when the facility is operational.

Sarguroh, Tauseef, M.D.

U. S. A. Mailing Address
2720 S. Highland Ave #132
Lombard, IL 60148
Contact no.: 718-710-1152
tauseef.sarguroh@gmail.com

Personal Information
Date of Birth: February 16,1984

Certifications

The American Board of Nephrology	09/2015
The American Board of Internal Medicine	09/2013
Education Commission for Foreign Medical Graduates	03/2008

Nephrology Fellowship

Organization	Position	Dates
Harlem Hospital Center affiliated with Columbia University College of Physicians and Surgeons, New York, New York.	Chief Nephrology Fellow	07/2013 - 06/2015

Internal Medicine Residency

Organization	Position	Dates
St. Barnabas Hospital, Bronx, New York.	Resident	07/2010 - 06/2013

Fellowship and Residency Awards

-Fellow of the year; Jun 2015
-Resident of the year for excellence in professionalism; Jun 2011.
-Resident of the year for excellence in communication skills; Jun 2011.

Medical Education

Institution & Location	Degree	Dates Attended	Degree Date
Dr. D. Y. Patil Medical College and Hospital, Navi Mumbai, India.	M. B. B. S. (Bachelor of Medicine, Bachelor of Surgery)	10/2001 - 02/2007	04/2007

Medical School Awards

-Certificate of excellence for having secured second rank in internal medicine in the final year of medicine; Mar 2006.
-Certificate of excellence for having secured distinction in ophthalmology; Mar 2005.

Exams

Examination	Status	Date
USMLE Step 3	Passed	04/2009
USMLE Step 2 CS (Clinical Skills)	Passed	11/2007
USMLE Step 2 CK (Clinical Knowledge)	Passed	11/2007
USMLE Step 1	Passed	05/2007

Work Experience

Organization	Position	Dates

1) Kidney Care Center	Attending Physician	06/2015 - Current
2) P.D.Hinduja National Hospital and Research Center, Mumbai, India.	Junior Medical Staff	12/2009 - 03/2010
3) P.D.Hinduja National Hospital and Research Center, Mumbai, India.	Junior Medical Staff	06/2008 - 08/2008
4) Dapoli Hospital, Dapoli, India.	House Officer	06/2007 - 08/2007

Observerships

Organization	Position	Dates
1) P.D.Hinduja National Hospital and Research Center, Mumbai, India.	I. C. U. Observer	03/2010 - 04/2010
2) Memorial Hermann: Heart and Vascular Institute, Houston, U. S. A.	International Observer	06/2009 - 07/2009

ACLS

Advanced Cardiac Life Support (ACLS) Exp. Date: 2020

Publications and Posters

-Poster presentation on a case of scleroderma and pauci immune glomerulonepritits as first author with Dr. Jeffrey Wallach at the ASN 2014.
-Poster presentation on a case of 5-oxoproline causing high anion gap metabolic acidosis as third author with Dr. Jeffrey Wallach at Harlem Hospital Center annual research day, New York. (5/2013)
-Publication in Hemeonc Today on Nephrotic Syndrome of unclear etiology hid two primary malignancies as second author with Dr. Fulger Illmana. (8/2013)
-Publication in Vol. 4 No. 5 of International Journal of Collaborative Research on Internal Medicine and Public Health (IJCRIMPH) on Acute Renal Failure and Fanconi's syndrome in an HIV Patient treated with tenofovir as second author with Dr. Muthyala Padmini. (4/2012)
-Poster presentation on "Spousal Renal Transplants" comparing the outcome of spousal renal transplants versus live related renal transplants as first author with Dr. Alan Almeida presented at the XXIII International Congress of the Transplantation Society, Vancouver. (4/2010)
-Poster presentation on a research study showing Hyponatremia with ACEi and ARBs as second author with Dr. James Croll at Einstein College of Medicine 9th Annual Doctors Recognition Day physicians expo poster presentations and symposium, Bronx NY. (4/2012)
-Poster presentation on a case of emphysematous pyelonephritis and concomitant emphysematous cystitis in a diabetic female as second author with Dr. Abdurrehman Ahmed at St. Barnabas Hospital annual research day, Bronx NY. (5/2012)
-Poster presentation on Vitamin D deficiency in HIV patients and co-relation with CD4 counts as fifth author with Dr. Victoria Bengualid at St. Barnabas Hospital annual research day, Bronx, NY. (5/2011)
-Poster presentation on a case of Candida meningitis as third author with Dr. Judith Berger at St. Barnabas Hospital annual research day, Bronx, NY. (5/2011)

Language Fluency

-Besides English I am able to speak basic conversational Spanish, which gives me more opportunity to interact with patients from varied ethnic backgrounds.

-I also speak Hindi and my mother tongue Marathi.

Other Career Accomplishments

-Conducted weekly lectures for nurses in the hemodialysis unit on topics related to CKD, ESRD and hemodialysis, 2014.
-Organized workshop on Cardio Pulmonary Cerebral Resuscitation, Dr. D.Y. Patil Medical College, (10/2006)
-Helped Organize a blood donation camp in BVIT Campus Khargar, Navi Mumbai. (02/2006)

Hobbies & Interests

-I enjoy playing soccer and have captained my high school and university soccer teams. In addition to the exercise, it helps me unwind from my usual routine.

-I am also a passionate aquarist and take active interest in tropical fish life.

Attachment-24

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

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761
Attn: Michael Constantino

Re: Dialysis Care Center Olympia Fields Expansion

I hereby certify under of perjury as provided in § 1-109 of the Illinois code of civil procedure, 735 ILCS 5/109 and pursuant to 77 III. Admin. Code § 1110-1430 (f) that Dialysis Care Center Olympia Fields will maintain an open medical staff.

I also certify the following with regards to need support services:

- Dialysis Care Center Olympia Field will utilize a dialysis electronic patient data tracking system
- Dialysis Care Center Olympia Fields will have available all needed support services required by CMS which may consist of nutritional counseling, clinical laboratory services, blood bank, rehabilitation, psychiatric services, and social services.
- Patients will have access to training for self-care dialysis, self-care instruction, and home hemodialysis and peritoneal dialysis

Sincerely,

Asim M Shazzad
Chief Operating Officer

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

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761
Attn: Michael Constantino

Re: Dialysis Care Center Olympia Fields Expansion

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

- By the second year after project completion, Dialysis Care Center Olympia Fields expects to achieve and maintain 80% target utilization
- Dialysis Care Center Olympia Fields 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 Daurgirdas II .1.2

Sincerely,

Asim M Shazzad
Chief Operating Officer

Section VII. Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(g) Minimum Number of stations

Dialysis Care Center Olympia Fields will provide sixteen 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 Olympia Fields is proposing to add an addition of 12 dialysis chairs, totaling 24-station dialysis facility. Thus, the criterion is not applicable.

Attachment-24

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

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

Attachment 3

SECTION X. SAFETY NET IMPACT STATEMENT

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

Dialysis Care Center Olympia Fields 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 Olympia Fields 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 Olympia Fields will not refuse any patients. Medicaid patients wishing to be served at Dialysis Care Center Olympia Fields 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 Olympia Fields is to provide services to all patients regardless of race, color, national origin. Dialysis Care Center Olympia Fields 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 Olympia Fields 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 Olympia Fields 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 OLYMPIA FIELDS

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.

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

Attachment 39

DIALYSIS CARE CENTER OLYMPIA FIELDS

Charity Policy

I. **Purpose:** The purpose of this policy is to define requirements for admission to the Dialysis Care Center Olympia Fields, 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

#22-013

KIDNEY CARE CENTER

April 20, 2022

VIA Federal Express and Email

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761
Attn: Michael Constantino

Re: Dialysis Care Center Olympia Fields Expansion
Supplemental Information for Expansion

Dear Ms. Savage,

I am a pleased to support Dialysis Care Center Olympia Fields expansion request of 12 additional stations. This will allow Dialysis Care Center Olympia Fields to improve access to necessary dialysis services in the Olympia Fields community.

My partners and I have witnessed extreme growth of both population and of ESRD patients in this area. We have many pre-ESRD patients in my practice that I anticipate referring to the Dialysis Care Center Evergreen Park. This facility will better serve the growing number of dialysis patients in my practice. Since Dialysis Care Center Olympia Fields opening, we have referred over 80 dialysis patients.

We currently have 171 CKD 4 pre-ESRD patients in my practice, this does not include any patients that are CKD 3. My partners and I will continue to refer patients to the other area facilities per the patient's place of residence and choice. We are also strong supporters of home dialysis through our Rockford home therapies programs and will continue to refer those patients who are good candidates for home dialysis services.

I respectfully ask you to consider the constant growth of ESRD in Olympia Fields and Cook County to approve the Dialysis Care Center Olympia Fields facility to maintain access for future dialysis patients.

I attest that to the best of my knowledge, all the information contained in this letter is true and correct.

Thank you for your consideration.

Sincerely,

Dr Tauseef Sarguroh

#22-013

KIDNEY CARE CENTER

April 20, 2022

VIA Federal Express and Email

Ms. Debra Savage, Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois, 62761
Attn: Michael Constantino

Re: Dialysis Care Center Olympia Fields Expansion
Supplemental Information for Expansion

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I respectfully ask you to consider the constant growth of ESRD in Olympia Fields and Cook County to approve the Dialysis Care Center Olympia Fields facility to maintain access for future dialysis patients.

I attest that to the best of my knowledge, all the information contained in this letter is true and correct.

Thank you for your consideration.

Sincerely,

Tauseef Sarguroh (Apr 20, 2022 16:46 CDT)

Dr Tauseef Sarguroh

Dr Tauseef letter

Final Audit Report 2022-04-20

Created:	2022-04-20
By:	Julie Williamson (jwilliamson@hdsdialysis.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAMXxElZmkMpqcUOJQjnoMzADbCJuX2pbC

"Dr Tauseef letter" History

Document created by Julie Williamson (jwilliamson@hdsdialysis.com)
2022-04-20 - 9:29:23 PM GMT

Document emailed to Tauseef Sarguroh (tsarguroh@kidneycares.com) for signature
2022-04-20 - 9:29:38 PM GMT

Email viewed by Tauseef Sarguroh (tsarguroh@kidneycares.com)
2022-04-20 - 9:33:12 PM GMT

Document e-signed by Tauseef Sarguroh (tsarguroh@kidneycares.com)
Signature Date: 2022-04-20 - 9:46:30 PM GMT - Time Source: server

Agreement completed.
2022-04-20 - 9:46:30 PM GMT

KIDNEY CARE CENTER OLYMPIA FIELDS CKD STAGE 4 PATIENTS

Patient Initials	Patient Zip Code	CKD Stage
AS	60443	Chronic Kidney Disease Stage 4
AW	60411	Chronic Kidney Disease Stage 4
AB	60443	Chronic Kidney Disease Stage 4
AW	60411	Chronic Kidney Disease Stage 4
AJ	60443	Chronic Kidney Disease Stage 4
AM	60422	Chronic Kidney Disease Stage 4
AP	60411	Chronic Kidney Disease Stage 4
AT	60411	Chronic Kidney Disease Stage 4
AD	60411	Chronic Kidney Disease Stage 4
AM	60411	Chronic Kidney Disease Stage 4
AC	60411	Chronic Kidney Disease Stage 4
BJ	60411	Chronic Kidney Disease Stage 4
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BG	60411	Chronic Kidney Disease Stage 4
CG	60411	Chronic Kidney Disease Stage 4
CT	60411	Chronic Kidney Disease Stage 4
CG	60411	Chronic Kidney Disease Stage 4
CB	60443	Chronic Kidney Disease Stage 4
CJ	60443	Chronic Kidney Disease Stage 4
CH	60461	Chronic Kidney Disease Stage 4
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CR	60443	Chronic Kidney Disease Stage 4
CY	60443	Chronic Kidney Disease Stage 4
CP	60411	Chronic Kidney Disease Stage 4
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CM	60443	Chronic Kidney Disease Stage 4
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DS	60411	Chronic Kidney Disease Stage 4
DG	60443	Chronic Kidney Disease Stage 4
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DV	60422	Chronic Kidney Disease Stage 4
DC	60461	Chronic Kidney Disease Stage 4
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DH	60411	Chronic Kidney Disease Stage 4
DM	60443	Chronic Kidney Disease Stage 4
DP	60422	Chronic Kidney Disease Stage 4

DJ	60411 Chronic Kidney Disease Stage 4
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DB	60443 Chronic Kidney Disease Stage 4
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DG	60443 Chronic Kidney Disease Stage 4
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DS	60443 Chronic Kidney Disease Stage 4
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ER	60411 Chronic Kidney Disease Stage 4
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FL	60411 Chronic Kidney Disease Stage 4
FB	60411 Chronic Kidney Disease Stage 4
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IB	60411 Chronic Kidney Disease Stage 4
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YO	60461 Chronic Kidney Disease Stage 4