Original

13-050

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: Chicago Ridge Dialysis			
Street Address: 10511 South Harlem Avenue			
City and Zip Code: Worth, Illinois 60482			
County: Cook	Health Service Area	007	Health Planning Area:

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

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

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

Name: Ronny Philip
Title: Regional Operations Director
Company Name: DaVita HealthCare Partners Inc.
Address: 8109 South Western Avenue, Chicago, Illinois 60620
Telephone Number: 773-778-0173
E-mail Address: ronny.philip@davita.com
Fax Number: 855-871-6348

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: Chicago Ridge Dialysis
Street Address: 10511 South Harlem Avenue
City and Zip Code: Worth, Illinois 60482
County: Cook Health Service Area 007 Health Planning Area: 006

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

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

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Fax Number: 855-871-6348

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name: Charles Sheets
Title: Attorney
Company Name: Polsinelli Shughart PC
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3605
E-mail Address: csheets@polsinelli.com
Fax Number: 312-873-3793

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Palestra Real Estate Partners, Inc.

Address of Site Owner: 808 Montparnasse Place, Newtown Square, PA 19073

Street Address or Legal Description of Site: This site is comprised of two tax parcels, as described on the legal descriptions set forth below.

Tax Parcel One:

The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

Tax Parcel Four:

Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridan, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Cagles Dialysis, LLC

Address: 2000 16th Street, Denver, CO 80202

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

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

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

Organizational Relationships

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

financial contribution.

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☒ Substantive	☐ Part 1120 Not Applicable
☐ Non-substantive	☐ Category A Project
	☒ Category B Project
	☐ DHS or DVA Project

2. Narrative Description

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

DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC (the "Applicants") seek authority from the Illinois Health Facilities and Services Review Board (the "Board") to establish a 16-station dialysis facility located at 10511 South Harlem Avenue, Worth, Illinois 60482. The proposed dialysis facility will include a total of 6,800 gross square feet.

This project has been classified as substantive because it involves the establishment of a health care facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$1,025,000		$1,025,000
Contingencies	$148,625		$148,625
Architectural/Engineering Fees	$86,000		$86,000
Consulting and Other Fees	$53,500		$53,500
Movable or Other Equipment (not in construction contracts)	$595,000		$595,000
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,453,509		$1,453,509
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$3,361,634**		**$3,361,634**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$1,908,125		$1,908,125
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,453,509		$1,453,509
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$3,361,634**		**$3,361,634**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 1,735,401.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): May 31, 2015

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

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

State Agency Submittals

Are the following submittals up to date as applicable:

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

Cost Space Requirements

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

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

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

Facility Bed Capacity and Utilization

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

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

CERTIFICATION

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

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

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

SIGNATURE

Javier Rodriguez

PRINTED NAME

President

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of July, 2013

Signature of Notary

Seal

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

SIGNATURE

Arturo Sida

PRINTED NAME

Assistant Secretary

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 3rd day of July, 2013

Signature of Notary

Seal

S. FINESTONE
COMM. #2001439
NOTARY PUBLIC • CALIFORNIA
LOS ANGELES COUNTY
Commission Expires JANUARY 15, 2017

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Javier Rodriguez
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2ND day of July, 2013

Signature of Notary

Seal

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

SIGNATURE

Arturo Sida
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 3rd day of July, 2013

Signature of Notary

Seal

S. FINESTONE
COMM. #2001439
NOTARY PUBLIC • CALIFORNIA
LOS ANGELES COUNTY
Commission Expires JANUARY 15, 2017

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

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

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

2. Define the planning area or market area, or other, per the applicant's definition.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

4. Cite the sources of the information provided as documentation.

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate.**

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

G. Criterion 1110.1430 - In-Center Hemodialysis

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

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

Category of Service	# Existing Stations	# Proposed Stations
☒ In-Center Hemodialysis	0	16

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

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

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

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

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

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

VIII. - **1120.120 - Availability of Funds**

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

$1.908.125	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$1,453,509 (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.
$3,361,634	**TOTAL FUNDS AVAILABLE**

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot 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 -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for DaVita HealthCare Partners, Inc. and Cagles Dialysis, LLC (collectively, the "Applicants") are attached at Attachment – 1. Cagles Dialysis, LLC will be the operator of Chicago Ridge Dialysis, and is not separately organized. As the person with final control over the operator, DaVita HealthCare Partners, Inc. is named as an applicant for this CON application.

Attachment - 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA HEALTHCARE PARTNERS INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWELFTH DAY OF DECEMBER, A.D. 2012.

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

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

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

Jeffrey W. Bullock, Secretary of State

2391269 8300

AUTHENTICATION: 0060461

121330793

DATE: 12-12-12

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

File Number 0439201-9

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

CAGLES DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JUNE 24, 2013, 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* 1ST *day of* JULY *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1318202452

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

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

The letter of intent between Palestra Real Estate Partners, Inc. and Cagles Dialysis, LLC to lease the facility located at 10511 South Harlem Avenue, Worth, Illinois 60482 is attached at Attachment – 2.

Attachment - 2

PALESTRA PROPERTIES, INC.

July 29, 2013

Mr. Edgar Levin
USI REAL ESTATE BROKERAGE SERVICES INC.
2215 YORK RD, SUITE 110
OAKBROOK, IL 60523

RE: ***RESPONSE v5 to Request for Proposal – former Aldi Store Redevelopment***
10511 South Harlem Avenue, Worth, IL

Dear Edgar:

Thank you for the Request for Proposal. Below please find our written response to lease the above-referenced Property to be redeveloped by Palestra Real Estate Partners, Inc. or its assigns through the DaVita Preferred Developer Program ("PDP").

DISCLOSURE:	USI Real Estate Brokerage Services Inc. discloses that this Request for Proposal is subject to the terms of Exhibit A attached hereto. The information in this email is confidential and may be legally privileged. It is intended solely for the addressee. Access to this email by anyone else is unauthorized.
PREMISES:	10511 South Harlem Avenue, Worth, IL
LEGAL DESCRIPTION:	See Exhibit C
TENANT (or "Lessee"):	Total Renal Care, Inc. or related entity to be named
LANDLORD (or "Lessor"):	Palestra Real Estate Partners, Inc. or its assigns
SPACE:	Approximately 6,800 contiguous rentable square feet (usable same).
PRIMARY TERM & BASE RENT:	Proposed Term and Base Rent is summarized here, and shall be per the Tenant PDP Lease form and the attached Prelim Budget. Years 1- 5: $227,209.62 per annum (~$23.18/Rsf) Years 6-10: $249,930.58 per annum (~$25.50/Rsf) Years 11-15: $274,923.64 per annum (~$28.05/Rsf)
ADDITIONAL EXPENSES:	Tenant shall pay additional expenses and additional rent according to the Tenant PDP Lease form. Tenant's pro rata share percentage of the Building shall be 73.35%, which equals 9,800 (total Tenant space) divided by the Building total square feet of 13,360.
LANDLORD'S MAINTENANCE:	Landlord shall be responsible as called for by the Tenant PDP Lease form.

POSSESSION AND RENT COMMENCEMENT:	Landlord shall deliver Possession of the Premises to the Tenant as called for by the Tenant PDP Lease form. Rent Commencement shall be as called for by the Tenant PDP Lease form.
USE:	The Tenant's Use is as called for by the Tenant PDP Lease form. The Tenant's Architect will verify that the Property's Zoning will allow the Tenant's dialysis use. The Tenant's Provisioning Team will determine the postal address it wants.
PARKING:	Preliminarily, from the Site Plan provided by the Seller, it appears the Property contains 87 total parking stalls (a Property ratio of 6.5 per 1000 Rsf). Tenant may have its pro rata share of the Property's parking stalls. Assuming 73.35% and 87, then Tenant may have the unreserved use of 64 parking stalls 6.5 per 1000 Rsf).
BASE BUILDING:	Landlord shall deliver to the Base Building as called for by the Tenant PDP Lease form and by the attached Exhibit B.
TENANT ALLOWANCE:	None.
OPTION TO RENEW:	As called for by the Tenant PDP Lease form.
RIGHT OF FIRST OPPORTUNITY ON ADJACENT SPACE:	Tenant shall have a one-time right of first opportunity, on the adjacent 3,560 Rsf space, such right expiring 12/31/2013. If Tenant leases this space, it shall be under the same terms and conditions of the Tenant PDP Lease form – and made coterminous and thus prorating any other items as necessary to make both Landlord and Tenant whole.
FAILURE TO DELIVER PREMISES:	As called for by the Tenant PDP Lease form.
HOLDING OVER:	As called for by the Tenant PDP Lease form.
TENANT SIGNAGE:	As called for by the Tenant PDP Lease form.
BUILDING HOURS:	As called for by the Tenant PDP Lease form.
SUBLEASE/ASSIGNMENT:	As called for by the Tenant PDP Lease form.
ROOF RIGHTS:	As called for by the Tenant PDP Lease form.
NON COMPETE:	As called for by the Tenant PDP Lease form.
HVAC:	As called for by the Tenant PDP Lease form and attached Exhibit B.
DELIVERIES:	As called for by the Tenant PDP Lease form.
OTHER CONCESSIONS:	As called for by the Tenant PDP Lease form.

GOVERNMENTAL COMPLIANCE: As called for by the Tenant PDP Lease form.

CONTINGENCIES: Tenant CON Obligation: Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities and Services Review Board (HFSRB). Based on the length of the HFSRB review process, Tenant does not expect to receive a CON permit prior to November 5, 2013. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit *provided, however, the lease shall not be binding on either party prior to approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective prior to CON permit approval.* Assuming CON approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the HFSRB does not award Tenant a CON permit to establish a dialysis center on the Premises by November 5, 2013 neither party shall have any further obligation to the other party with regard to the negotiations, lease, or Premises contemplated by this Letter of Intent.

BROKERAGE FEE: Landlord recognizes USI Real Estate Brokerage Services Inc. as the Tenant's sole representative and shall pay a brokerage fee, per the Tenant PDP, per separate commission agreement provided on May 1, 2013.

Thank you for the opportunity to respond to the Request for Proposal.

Sincerely,
Palestra Real Estate Partners, Inc.

Vincent Curran Jr., its President

AGREED TO AND ACCEPTED THIS 31st DAY OF JULY 2013

By: _____
Palestra Real Estate Partners, Inc.
("Landlord")

AGREED TO AND ACCEPTED THIS 31st DAY OF JULY 2013

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

EXHIBIT A

NON-BINDING NOTICE

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

DaVita.

Exhibit B

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost:

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

1.0 - Building Codes & Design

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

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

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

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement.

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessor attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4 bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition.

Existing Concrete floor shall not have more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 – Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or Insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

8.0 – Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 – 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

9.0- Roof Covering

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum

of R30 roof insulation at roof deck. If the R30 value is not meet, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

10.0 – Canopy

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

11.0 – Waterproofing and Weatherproofing

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

12.0 – Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

13.0 – Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation. Any new roof deck insulation is to be installed to the underside of the roof deck.

14.0 – Exterior Doors

All exterior doors shall meet American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

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

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

Any doors that are designated to be provided modified or prepared by Lessor; Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

15.0 – Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

16.0 – Plumbing

Lessor to provide a building water service sized to support Lesses's potable water demand, building fire sprinkler water demand (if applicable), and other tenant water demand (if applicable). Final size to be determined by building potable and sprinkler water combined by means of the total building water demand based on code derived water supply fixture unit method and the building fire sprinkler water hydraulic calculations, per applicable codes and in accordance to municipality and regulatory standards. Lessor to provide a minimum potable water supply to support 30 (60) GPM with a constant 50 PSI water pressure, or as determined by Lessee's Engineer based on Lessee's water demand. Maximum water pressure to Lessee space to not exceed 80 PSI, and where it does water supply to be provided with a pressure reducing valve. Lessor to provide Lessee with a current water flow test results (within current year) indicating pressure and flow, for Lessee's approval.

Where suitable building water already exists, Lessor to provide Lessee with a potable water supply to meet the above minimum requirements. Water flow and pressure to Lessee's space to be unaffected by any other building water requirements such as other tenant water requirements or irrigation systems. Lessor to bring water to Lessee's space, leaving off with a valve and cap for Lessee extension per Lessee direction or Lessee design plans.

Potable water supply to be provided with water meter and two (2) reduced pressure zone (RPZ) backflow devices arranged in parallel for uninterrupted service and sized to support required GPM demand. Backflow devices to be provided with adequate drainage per code and local authority. Meter to be per municipality or water provider standards.

Any existing hose bibs will be in proper working condition prior to Lessees possession of space.

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

Sanitary drain to be stubbed into Lessee's space with a minimum invert level of 42 inches below finished slab. Sanitary drain to be sized based on the calculated drainage fixture unit (DFU) method in accordance to code for both the Lessee's DFU's combined with any other tenant DFU's sharing the drain however, in no case less than 4 inch diameter. Ejectors or lift stations are prohibited. Lessor to clean, power jet and televise existing sanitary drain and provide Lessee with a copy of results. Any drains displaying disrepair or improper pitch shall be corrected by Lessor prior to acceptance by Lessee. Where existing conditions are not met, Lessor to provide new sanitary drain to meet such requirements at Lessor's cost and include all relevant Sanitary District and local municipality permit, tap and other fees for such work.

Lessor to provide a plumbing vent no less than 4 inch diameter stubbed into Lessee's space as high as possible with an elevation no less than the bottom of the lowest structural element of the framing to the deck above. Where deck above is the roof, Lessor to provide roof termination and all required roof flashing and waterproofing. Plumbing roof terminations to maintain a minimum separation of 15 feet, or

more if required by local code, from any mechanical rooftop equipment with fresh air intake. Where required separation does not exist, Lessor to relocate to be within compliance at Lessor's cost.

Sanitary sampling manhole if required by local municipality on new line.

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

17.0 - Fire Suppression and Alarm System

Fire Sprinkler Systems and building fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

Where Sprinkler System is not present and is required by Lessee usage based on local code or NFPA 101, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building, fire prevention and life safety codes for the entire building. This system to be on a dedicated water line independent of Lessee's potable water line requirements. Lessor to include all municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

18.0 – Electrical

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire derived from a single metered source and consisting of dedicated CT cabinet per utility company standards feeding a distribution panelboard in the Lessee's utility room (location to be per National Electrical Code (NEC) and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include utility metering, tenant service feeder, and distribution panelboard with main and branch circuit breakers. Lessee will not accept multiple services to obtain the necessary capacity. Should this not be available Lessor to upgrade electrical service to meet the following criteria:

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

Lessee's Engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term.

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

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

Existing electrical raceway, wire, and cable extending through the Lessee's space but serving areas outside the Lessee's space shall be re-routed outside the Lessee's space and reconnected as required at the Lessor's cost.

Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide an empty conduit stub in Lessee space from Lessor's Fire Alarm panel. If Fire Alarm system is unable to accommodate Lessee requirements and/or FA system is not within applicable code compliance, Lessor to upgrade panel at Lessor's cost.

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

19.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000-BTU's. Natural gas line shall be individually metered and sized per demand.

20.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units, components and equipment that Lessee intends to reuse shall be left in place 'as is' by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units, Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows:

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

- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

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

21.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

22.0 – Cable or Satellite TV

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

23.0 - Handicap Accessibility

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

Lessor shall provide pavement marking; curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

24.0 - Generator

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

25.0 – Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with a 90 minute battery back up at all access points.

26.0 – Exterior Building Lighting

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

27.0 – Parking Lot

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

28.0 – Refuse Enclosure

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

29.0 - Signage

Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Exhibit C – Legal Description, Tax & Survey Information

Tax Parcel One:

The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

Tax Parcel Four:

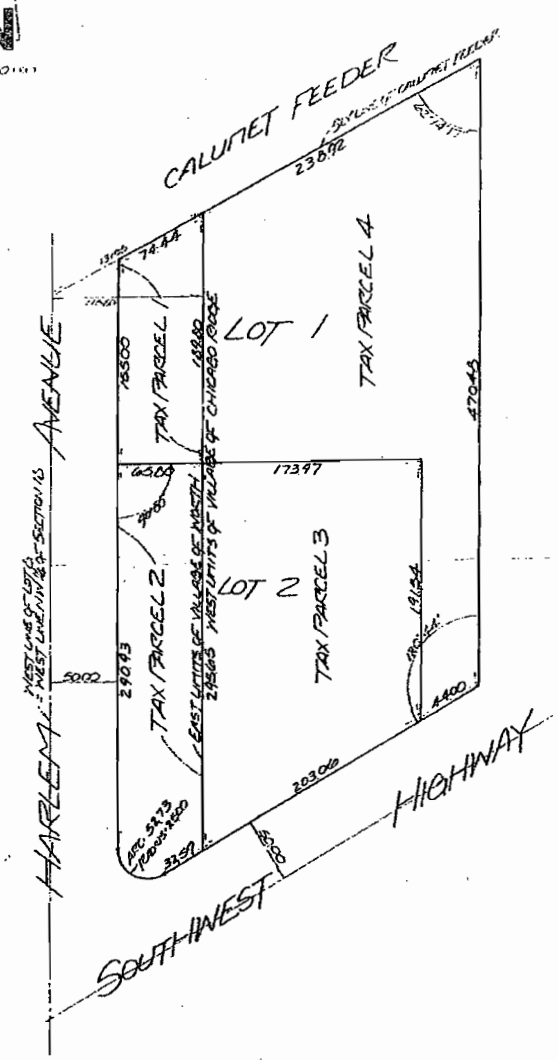
Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridan, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

PLAT OF SURVEY

TAX DIVISION MAP

#32

STONELAKE SURVEY CO., LTD.
REGISTERED LAND SURVEYORS
11659 S. MAYFIELD AVENUE
WORTH, ILLINOIS 60482
PHONE: 388-1010



TAX PARCEL ONE: THE WEST 65.00 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 1 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287597, IN COOK COUNTY, ILLINOIS.

TAX PARCEL TWO: THE WEST 65.00 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 2 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287597, IN COOK COUNTY, ILLINOIS.

TAX PARCEL THREE: LOT 2 (EXCEPT THE WEST 65.00 FEET, MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287597, IN COOK COUNTY, ILLINOIS.

TAX PARCEL FOUR: LOT 1 (EXCEPT THE WEST 65.00 FEET MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287597, IN COOK COUNTY, ILLINOIS.

AREAS OF TAX PARCELS

TAX PARCEL ONE	- 31,344 SQUARE FEET
TAX PARCEL TWO	- 28,305 SQUARE FEET
TAX PARCEL THREE	- 42,473 SQUARE FEET
TAX PARCEL FOUR	- 58,788 SQUARE FEET

STATE OF ILLINOIS }
COUNTY OF COOK } SS

STONELAKE SURVEY CO., LTD. HEREBY CERTIFIES THAT WE HAVE SURVEYED THE ABOVE DESCRIBED PROPERTY AND HAVE PREPARED THE HEREON DRAWN PLAT FOR TAX DIVISION PURPOSES. ALL DIMENSIONS ARE IN FEET AND DECIMAL PARTS THEREOF CORRECT AT 62° FAHRENHEIT.

DATED AT WORTH, ILLINOIS THIS 26 DAY OF June, 1990.

STONELAKE SURVEY CO., LTD.

ILLINOIS REGISTERED LAND SURVEYOR 01702

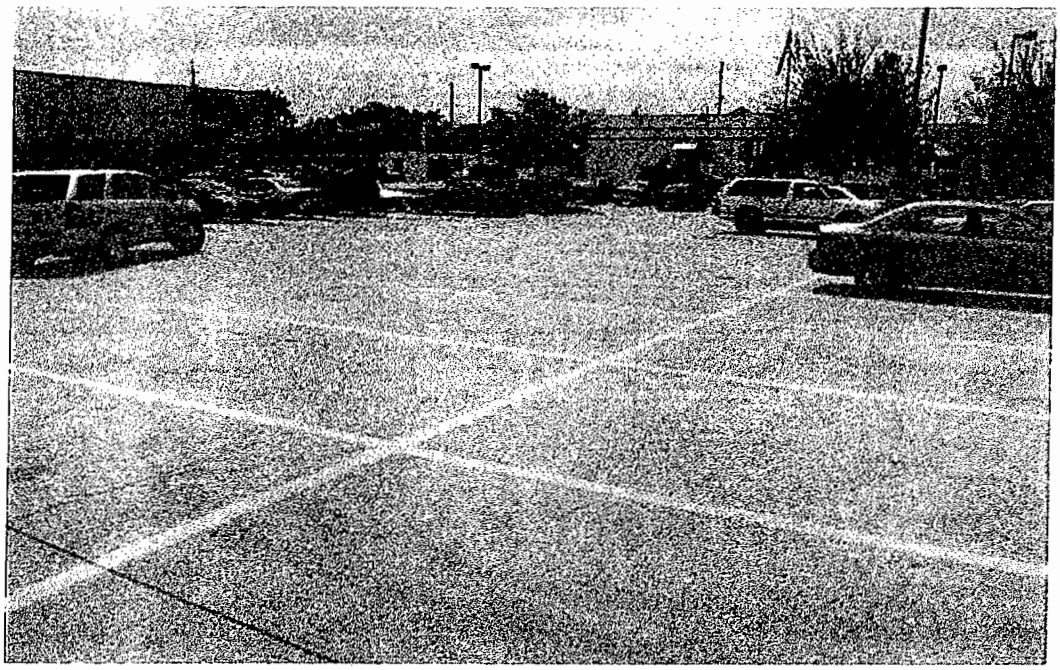
#32 Parcel 3

ADDRESS .....
SURVEYED FOR Joel Powell
ORDERED BY: .....
ORDER NO. 3442-90A

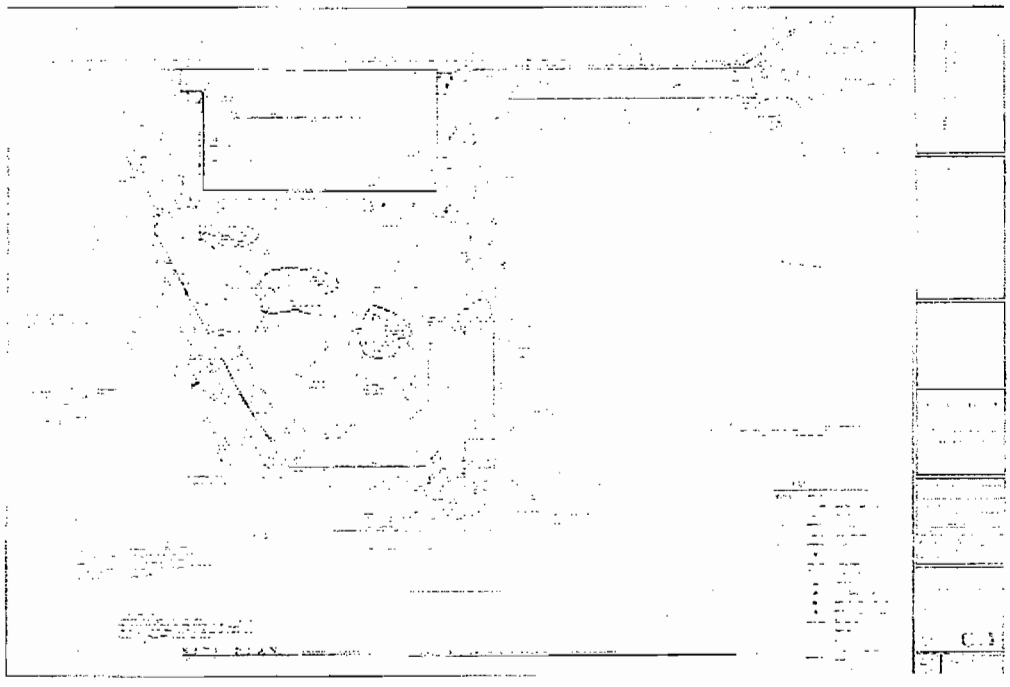
SCALE: 1 INCH = 100 FEET

NO MEASUREMENTS ARE TO BE ASSUMED BY SCALE

24181010980000 07/15/2007



24181011000000 07/16/2007



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

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

Attachment - 3

File Number 0439201-9

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

CAGLES DIALYSIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON JUNE 24, 2013, 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* 1ST *day of* JULY *A.D.* 2013 .

Jesse White

SECRETARY OF STATE

Authentication #: 1318202452

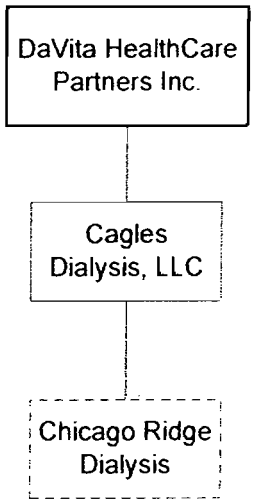
Authenticate at: http://www.cyberdriveillinois.com

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

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

Attachment - 4

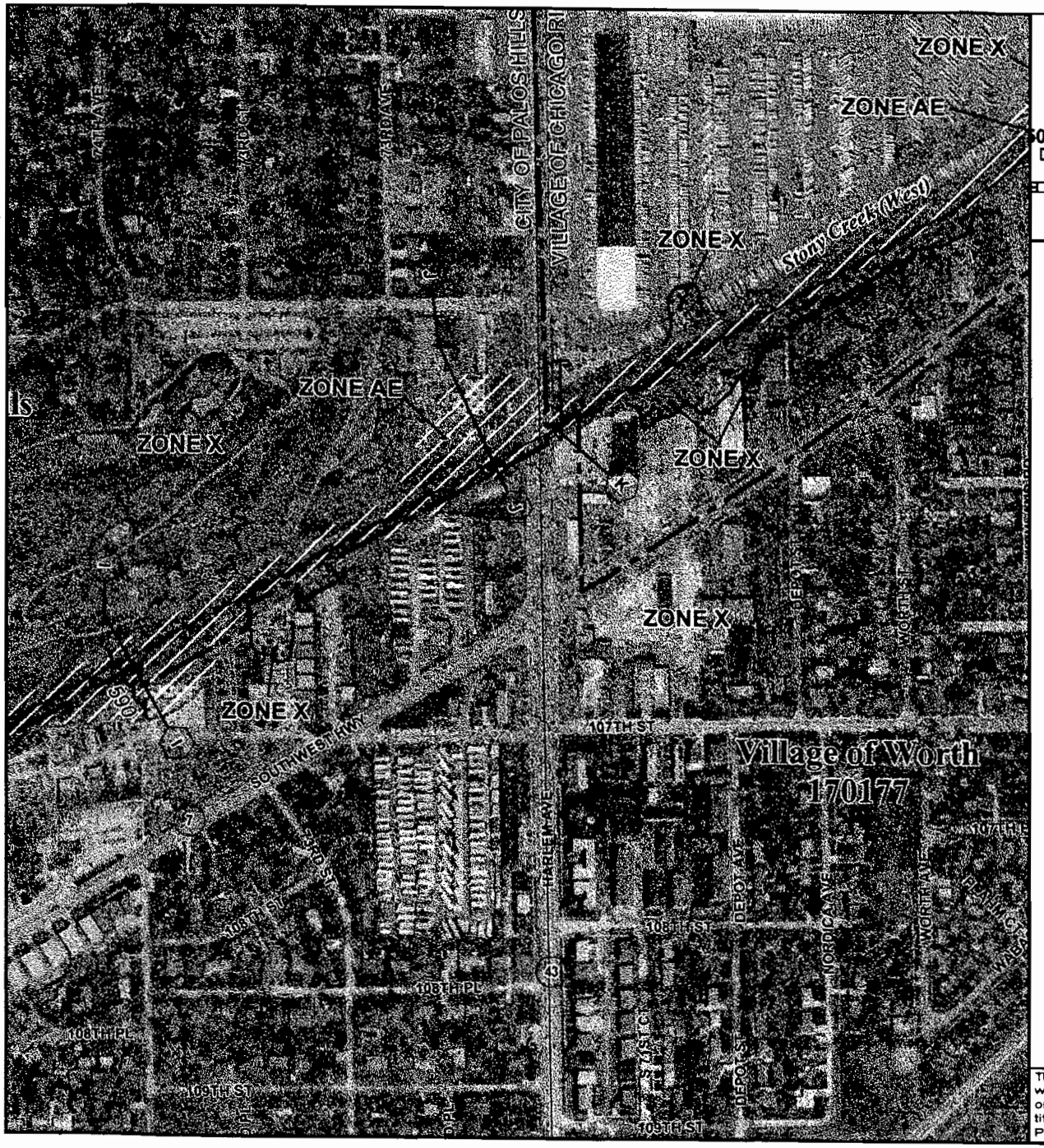
Chicago Ridge Dialysis Center
Organizational Structure



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

The site of the proposed dialysis facility complies with the requirements of Illinois Executive Order #2005-5. The proposed dialysis facility will be located at 10511 South Harlem Avenue, Worth, Illinois 60482. As shown on the FEMA flood plain map attached at Attachment – 5, the site of the proposed dialysis facility is located outside of a flood plain.

Attachment - 5



MAP SCALE 1" = 500'

0 500 1000 FEET

METE

NFIP

NATIONAL FLOOD INSURANCE PROGRAM

PANEL 0608J

FIRM

FLOOD INSURANCE RATE MAP

COOK COUNTY, ILLINOIS

AND INCORPORATED AREAS

PANEL 608 OF 832

(SEE MAP INDEX FOR FIRM PANEL LAYOUT)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
BRIDGEVIEW, VILLAGE OF	170065	0608	J
CHICAGO RIDGE, VILLAGE OF	170076	0608	J
COOK COUNTY	170054	0608	J
HICKORY HILLS, CITY OF	170103	0608	J
OAK LAWN, VILLAGE OF	170137	0608	J
PALOS HILLS, CITY OF	170143	0608	J
WORTH, VILLAGE OF	170177	0608	J

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

MAP NUMBER
17031C0608J

MAP REVISED
AUGUST 19, 2008

Federal Emergency Management Agency

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

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

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

Attachment - 6

DaVita.

Timothy V Tinckneil, FACHE
(773) 549-9412
timothy.tinckneil@davita.com

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

July 25, 2013

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

Re: Historic Preservation Act Determination

Dear Ms. Haaker:

Pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act, DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC ("Requestors") seek a formal determination from the Illinois Historic Preservation Agency as to whether their proposed project to establish a 16-station dialysis facility at 10511 South Harlem Avenue, Worth, Illinois 60482 ("Proposed Project") affects historic resources.

1. Project Description and Address

The Requestors are seeking a certificate of need from the Illinois Health Facilities and Services Review Board to establish a 16-station dialysis facility at 10511 South Harlem Avenue, Worth, Illinois 60482. No demolition or physical alteration of the existing building or construction of new buildings will occur as a result of the Proposed Project.

2. Topographical or Metropolitan Map

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

3. Historic Architectural Resources Geographic Information System

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

4. Address for Building/Structure

The proposed project will be located at 10511 South Harlem Avenue, Worth, Illinois 60482.

Thank you for your time and consideration of our request for Historic Preservation Determination. If you have any questions or need any additional information, please feel free to contact me at 773-549-9412 or timothy.tincknell@davita.com.

Sincerely,

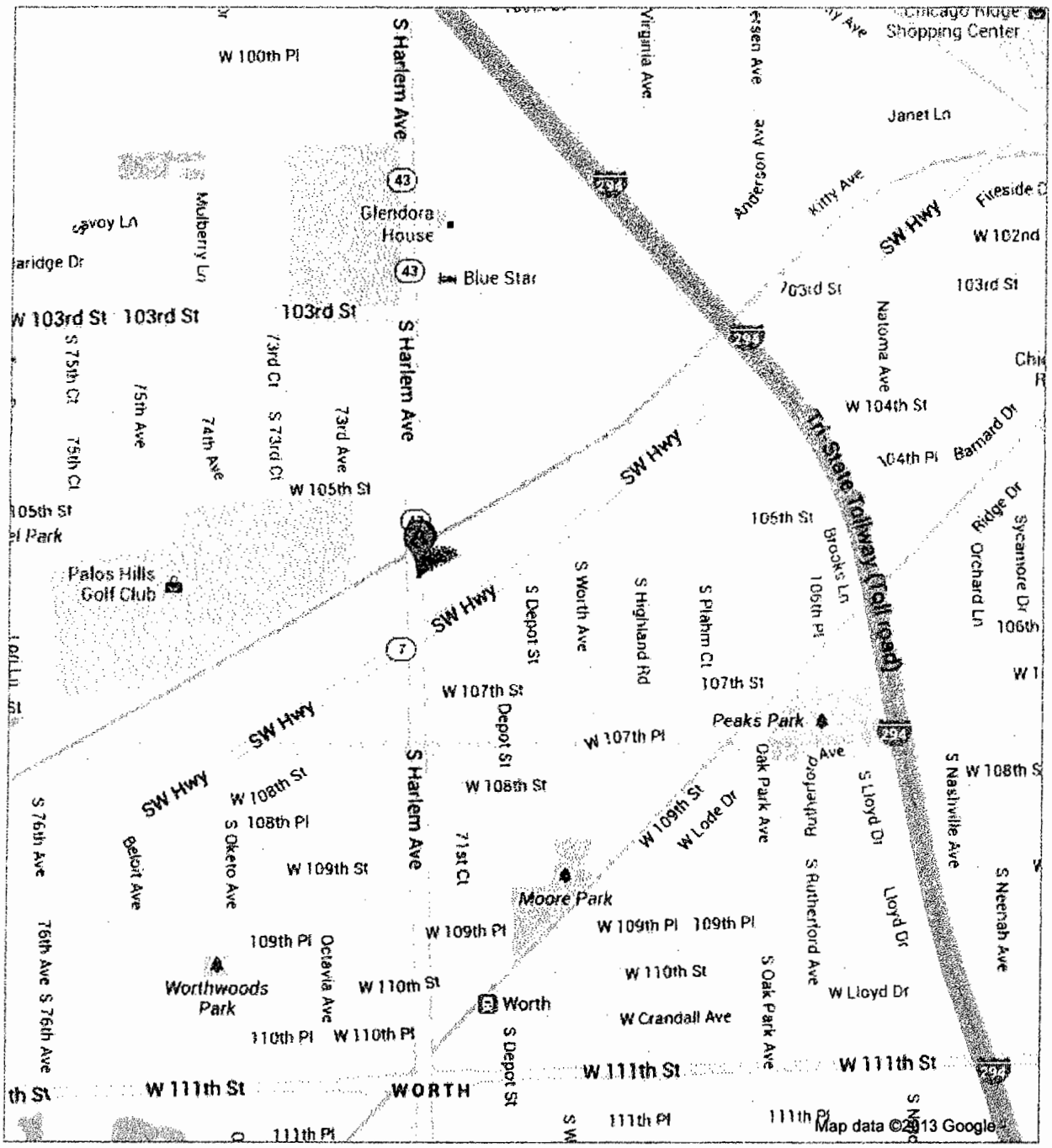
Timothy V Tincknell
Administrator, CON Projects

Enclosure

TVT:

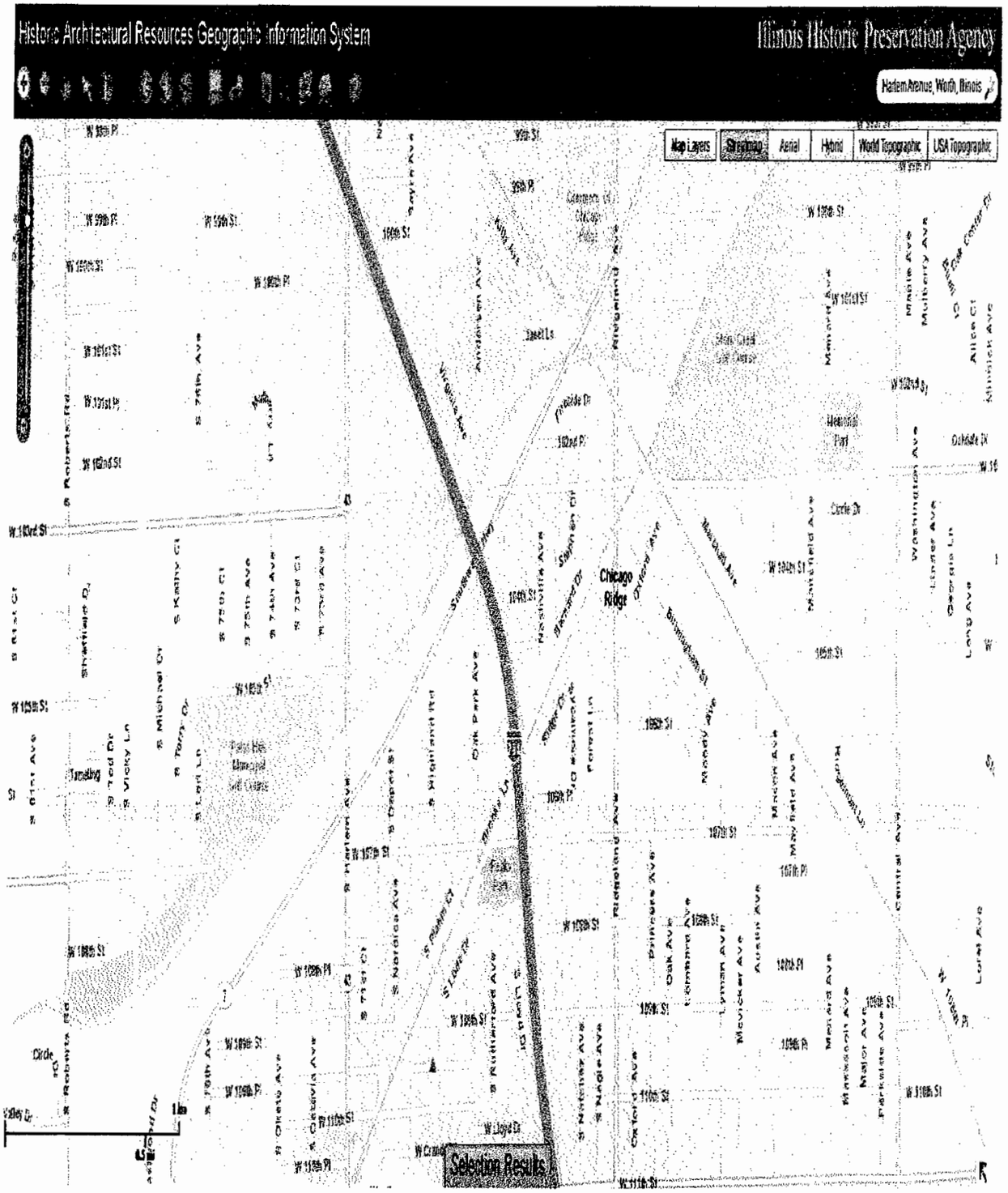
To see all the details that are visible on the screen, use the "Print" link next to the map.

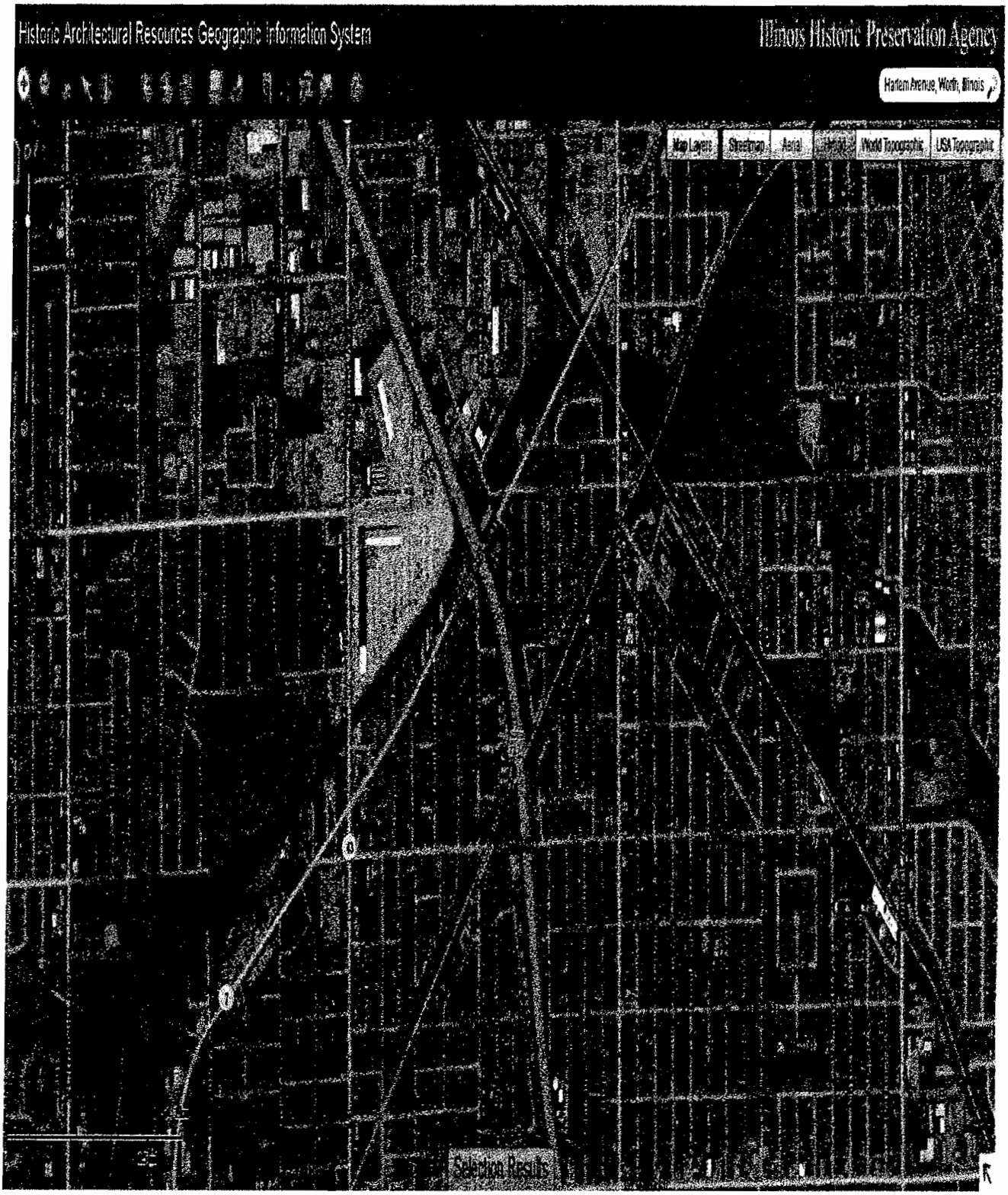
Google



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

Google


Historic Architectural Resources Geographic Information System
Illinois Historic Preservation Agency
Harlem Avenue, Worth, Illinois
Map Layers
Streets
Aerial
Hybrid
World Topographic
USA Topographic
Chicago Ridge
Selection Results


Historic Architectural Resources Geographic Information System
Illinois Historic Preservation Agency
Harlem Avenue, Worth, Illinois
Map Layers
Streetmap
Aerial
World Topographic
USA Topographic
Selection Results

Timothy Tincknell

From: trackingupdates@fedex.com
Sent: Friday, July 26, 2013 9:04 AM
To: Timothy Tincknell
Subject: FedEx Shipment 796318575177 Delivered

This tracking update has been requested by:

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

Our records indicate that the following shipment has been delivered:

Ship (P/U) date:	Jul 25, 2013
Delivery date:	Jul 26, 2013 9:03 AM
Sign for by:	J.DUCH
Delivery location:	SPRINGFIELD, IL
Delivered to:	Receptionist/Front Desk
Service type:	FedEx Priority Overnight
Packaging type:	FedEx Envelope
Number of pieces:	1
Weight:	0.50 lb.
Special handling/Services:	Deliver Weekday
Tracking number:	796318575177

Shipper Information	Recipient Information
Tim Tincknell	Ms. Anne Haaker
DaVita	IL Historic Preservation Agency
2611 N Halsted St	1 Old State Capitol Plaza
Chicago	SPRINGFIELD
IL	IL
US	US
60614	62701

Please do not respond to this message. This email was sent from an unattended mailbox. This report was generated at approximately 9:04 AM CDT on 07/26/2013.

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

All weights are estimated.

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

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

From: (773) 549-9412
Tim Tincknell
DaVita
2611 N Halsted St

Chicago, IL 60614

Origin ID: GYYA

FedEx Express

J13111302120326

Ship Date: 25JUL13
ActWgt: 0.5 LB
CAD: 104010597/INET3370

Delivery Address Bar Code

SHIP TO: (217) 785-5027 BILL SENDER

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

SPRINGFIELD, IL 62701

Ref #
Invoice #
PO #
Dept #

FRI - 26 JUL 10:30A
PRIORITY OVERNIGHT

TRK# 7963 1857 5177
0201

62701
IL-US
STL

NA SPIA

518G1/AA04/93A8

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

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

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

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Modernization Contracts	$1,025,000		$1,025,000
Contingencies	$148,625		$148,625
Architectural/Engineering Fees	$86,000		$86,000
Consulting and Other Fees	$53,500		$53,500
Moveable and Other Equipment			
Communications	$89,730		$89,730
Water Treatment	$127,391		$127,391
Bio-Medical Equipment	$9,964		$9,964
Clinical Equipment	$283,357		$283,357
Clinical Furniture/Fixtures	$21,878		$21,878
Lounge Furniture/Fixtures	$3,157		$3,157
Storage Furniture/Fixtures	$6,013		$6,013
Business Office Fixtures	$14,870		$14,870
General Furniture/Fixtures	$26,304		$26,304
Signage	$12,336		$12,336
Total Moveable and Other Equipment	$595,000		$595,000
Fair Market Value of Leased Space	$1,453,509		$1,453,509
Total Project Costs	**$3,361,634**		**$3,361,634**

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

The Applicants anticipate project completion within 18 months of project approval. Specifically, the timeline is as follows:

- 3 months for Schematics Design
- 6 months for Construction
- 3 months for Permit Approval
- 6 months for Completion of Medicare Enrollment

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

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

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	$3,361,634		6,800		6,800		
Total Clinical	$3,361,634		6,800		6,800		
NON REVIEWABLE							
Total Non-Reviewable							
TOTAL	$3,361,634		6,800		6,800		

Attachment - 9

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

Background of the Applicant

The Applicants are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. For this project, DaVita HealthCare Partners, Inc has partnered with Cagles Dialysis, LLC in their commitment to the Chicago Ridge community. The proposed project involves the establishment of a 16-station dialysis facility to be located at 15011 South Harlem Avenue, Worth, Illinois 60482.

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

DaVita has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and end stage renal disease ("ESRD"). These programs include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Information on the Kidney Smart, IMPACT and CathAway programs, in addition to two press releases: "DaVita Celebrates Extraordinary 2012" and "DaVita Celebrates Giving Back in 2012" are attached at Attachment – 11A.

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

- Between 1988-1994 and 2005-2010, the overall prevalence estimate for CKD rose from 12.3 to 14.0 percent. The largest relative increase, from 25.4 to 40.8 percent, was seen in those with cardiovascular disease.[4]
- Many studies have shown that diabetes, hypertension, cardiovascular disease, higher body mass index, and advancing age are associated with presence of CKD.[4]
- Nearly five times the number of new patients began treatment for ESRD in 2010 (approximately 117,000) versus 1980 (approximately 20,000).[4]
- Nearly ten times more patients are now being treated for ESRD than in 1980 (approximately 600,000 versus approximately 60,000).[4]
- U.S. patients newly diagnosed with ESRD was 1 in 2,900 in 2010 versus 1 in 11,600 in 1980.
- U.S. patients being treated for ESRD was 1 in 570 in 2010 versus 1 in 3,450 in 1980.[4]
- Increasing prevalence in the diagnosis of diabetes and hypertension, the two major causes of CKD; 44% of new ESRD cases have a primary diagnosis of diabetes; 28% have a primary diagnosis of hypertension.[4]
- Nephrology care prior to ESRD continues to be a concern. Since the 2005 introduction of the new Medical Evidence form (2728), with fields addressing pre-ESRD care, there has been little progress made in this area (pre-ESRD data, however, should be interpreted with caution because of the potential for misreporting). Forty-three percent of new ESRD patients in 2010, for example, had not seen a nephrologist prior to beginning therapy. And among these patients, 88 percent of those on hemodialysis began therapy with a catheter, compared to 54 percent of those who had received a year or more of nephrology care. Among those with a year or more of pre-ESRD nephrologist care, in contrast, 26 percent began therapy with a fistula – eight times higher than the rate among non-referred patients.[4]

Additionally, DaVita's Kidney Smart program helps to improve intervention and education for pre-ESRD patients. Approximately 65-75% of CKD Medicare patients have never been evaluated by a

nephrologist.[1] Timely CKD care is imperative for patient morbidity and mortality. Adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may result in improved patient outcomes and reduce ESRD:

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

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

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

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

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

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[1] US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011.

[2] Int'l Diabetes Found., *One Adult in Ten will have Diabetes by 2030* (Nov. 14, 2011), available at http://www.idf.org/media-events/press-releases/2011/diabetes-atlas-5th-edition.

[3] US Renal Data System, USRDS 2011 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2011.

[4] US Renal Data System, USRDS 2012 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2012.

surgery and maturation, first cannulation and catheter removal. DaVita has improved its patients' fistula-adoption rate by 91% between 2002 and 2011. At the end of 2012, 63.9% of DaVita patients were using fistulas, a 2.0% increase since 2011. In addition, only 13.9% of DaVita patients who had been on dialysis for more than 90 days were still using their typically hospital-given catheters as their form of vascular access – DaVita's best outcomes to date. DaVita is an industry leader in the rate of fistula use and has the lowest day-90 catheter rates among large dialysis providers.

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

DaVita currently partners with over 300 hospitals nationwide through Patient Pathways. Patient Pathways has demonstrated benefits to hospitals, patients, physicians and dialysis centers. The program has resulted in a 0.5 day reduction in average length of stay for both new admissions and readmissions and an 11% reduction in average acute dialysis treatments per patient. Moreover, patients are better educated and arrive at the dialysis center more prepared and less stressed. They have a better understanding of their insurance coverage and are more engaged and satisfied with their choice of dialysis facility. As a result, patients have higher attendance rates, are more compliant with their dialysis care, and have fewer avoidable readmissions.

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

In an effort to better serve all kidney patients, DaVita believes in requiring that all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is more than $1.5 billion in savings to the health care system and the American taxpayer since 2010.

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

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

U.S. government. Nearly 3,000 employers were nominated for a Freedom Award in 2013. An awards committee composed of senior Department of Defense officials, business leaders and prior honorees selected just 15 companies to receive the 2013 Freedom Award. DaVita also received the 2013 award for Best Military Recruiting Program from ERE Media and was recognized this year with Top 100 Military Friendly Employer and 2013 Top 100 Military Friendly Spouse Employer awards from GI Jobs, a Most Valuable Employers award from CivilianJobs.com and a "Best for Vets" award from Military Times EDGE.

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

DaVita is also committed to sustainability and reducing its carbon footprint. In fact, it is the only kidney care company recognized by the Environmental Protection Agency for its sustainability initiatives. In 2010, DaVita opened the first LEED-certified dialysis center in the U.S. Furthermore, it annually saves approximately 8 million pounds of medical waste through dialyzer reuse and it also diverts more than 85% of its waste through composting and recycling programs. It has also undertaken a number of similar initiatives at its offices and is seeking LEED Gold certification for its corporate headquarters. In addition, DaVita was also recognized as an "EPA Green Power Partner" by the U.S. Environmental Protection Agency.

DaVita consistently raises awareness of community needs and makes cash contributions to organizations aimed at improving access to kidney care. In 2011, DaVita donated more than $2.5 million to kidney disease- awareness organizations such as the Kidney TRUST, the National Kidney Foundation, the American Kidney Fund, and several other organizations. Its own employees, or members of the "DaVita Village," assisted in these initiatives and have raised approximately $5 million, thus far, through the annual Tour DaVita bicycle ride, with $900,000 coming in 2012 alone. The Kidney Rock 5K Run/Walk raised an estimated $1 million for Bridge of Life – DaVita Medical Missions in 2011 and 2012, combined. Starting in 2011, teammates at clinics across DaVita's 43-state footprint selected more than 600 charities from Ronald McDonald House to small community-support entities in their local areas, to receive approximately $1.5 million in contributions. This new program titled "DaVita Way of Giving" continued in 2012.

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

Neither the Centers for Medicare and Medicaid Services nor the Illinois Department of Public Health has taken any adverse action involving civil monetary penalties or restriction or termination of participation in the Medicare or Medicaid programs against any of the applicants, or against any Illinois health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

1. Health care facilities owned or operated by the Applicants:

   A list of health care facilities owned or operated by the Applicants in Illinois is attached at Attachment – 11B.

   Dialysis facilities are currently not subject to State Licensure in Illinois.

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

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

OCMO

Office of the Chief
Medical Officer (OCMO)
Allen R. Nissenson, MD
Chief Medical Officer
Meredith Mathews, MD
Robert Provenzano, MD
John Robertson, MD
David B. Van Wyck, MD

April 30, 2009

Dear Physicians:

As your partner, DaVita® and OCMO are committed to helping you achieve unprecedented clinical outcomes with your patients. As part of OCMO's Relentless Pursuit of Quality™, DaVita will be launching our top two clinical initiatives; IMPACT and CathAway™, at our annual 2009 Nationwide Meeting. Your facility administrators will be orienting you on both programs upon their return from the meeting in early May.

IMPACT: The goal of IMPACT is to reduce incident patient mortality. IMPACT stands for Incident Management of Patients Actions Centered on Treatment. The program focuses on three components: patient intake, education and management and reporting. IMPACT has been piloting since October 2007 and has demonstrated a reduction in mortality. The study recently presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN. In addition to lower mortality rates, patient outcomes improved - confirming this vulnerable patient population is healthier under DaVita's relentless pursuit of quality care.

CathAway: Higher catheter use is associated with increased infection, morbidity, mortality and hospitalizations [1] [2].The 7-step Cathaway Program supports reducing the number of patients with central venous catheters (CVCs). The program begins with patient education outlining the benefits of fistula placement. The remaining steps support the patient through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. For general information about the CathAway program, see the November 2008 issue of QUEST, DaVita's Nephrology Journal.

Here is how you can support both initiatives in your facilities:

- **Assess incident patients regularly in their first 90 days**: Discuss patients individually and regularly. Use the IMPACT scorecard to prompt these discussions.
- **Adopt "Facility Specific Orders"**: Create new facility specific orders using the form that will be provided to you.
- **Minimize the "catheter-removal" cycle time**: Review each of your catheter patients with your facility teammates and identify obstacles causing delays in catheter removal. Work with the team and patients to develop action plans for catheter removal.
- **Plan fistula and graft placements**: Start AV placement plans early by scheduling vessel mapping and surgery evaluation appointments for Stage 4 CKD patients. Schedule fistula placement surgery for those patients where ESRD is imminent in the next 3-6 months.

Launch Kits:

In May, Launch Kits containing materials and tools to support both initiatives will be arriving at your facilities. IMPACT kits will include a physician introduction to the program, step by step implementation plan and a full set of educational resources. FAs and Vascular Access Leaders will begin training on a new tool to help identify root-causes for catheter removal delays.

Your support of these efforts is crucial. As always, I welcome your feedback, questions and ideas. Together with you, our physician partners, we will drive catheter use to all-time lows and help give our incident patients the quality and length of life they deserve.

Sincerely,

Allen R. Nissenson, MD, FACP
Chief Medical Officer, DaVita

(1) Dialysis Outcomes and Practice Patterns Study (DOPPS): 2 yrs/7 Countries / 10,000 pts.
(2) Pastan et al: Vascular access and increased risk of death among hemodialysis patients.

OCMO

DaVita.

Knowledge is power.

EMPOWER® is an educational program by DaVita®. The program includes a series of free community based classes for patients with chronic kidney disease (CKD). These classes encourage you to take control of your kidney disease and prepare for dialysis by making healthy choices about your kidney care

Taking Control Of Kidney Disease

Learn how to slow the progression of kidney disease.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Making Healthy Choices

Learn how to prepare for dialysis.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Treatment Choices

An in-depth look at all of your treatment choices.

- Kidney disease and related conditions
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

To register for a class, call 1-888-MyKidney (695-4363).

EMPOWER®
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DaVita®


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

DaVita®

OCMO
Relentless pursuit of quality

Dear Physician Partners:

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

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

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

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

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

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

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

Sincerely,

Dennis Kogod
Cheif Operating Officer

Allen R. Nissenson, MD, FACP
Chief Medical Officer

DaVita.

FOR IMMEDIATE RELEASE

DaVita's IMPACT Program Reduces Mortality for New Dialysis Patients

Study Shows New Patient Care Model Significantly Improves Patient Outcomes

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

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

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

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

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

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

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

Incident Management of Hemodialysis Patients: Managing the First 90 Days

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

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

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

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

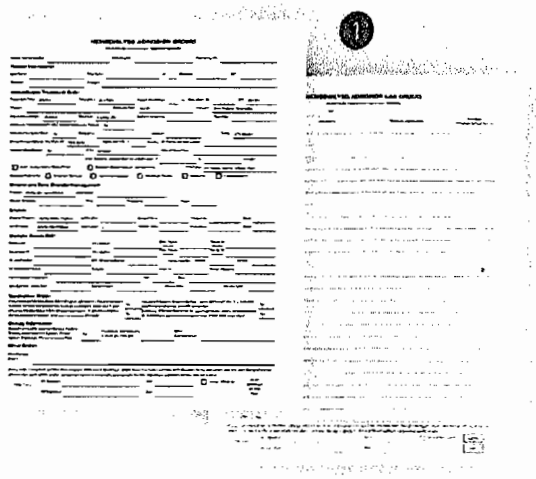
Data as of July, 2008 is reported. Patients in the IMPACT group were 60.6 3 15.1 years old (mean3SD), 42.8% Caucasian, 61% male with 25% having a fistula. Results showed a reduction in 90-day mortality almost 2 percentage points lower (6.14% vs. 7.98%; $p<0.10$) among IMPACT versus nonIMPACT patients.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

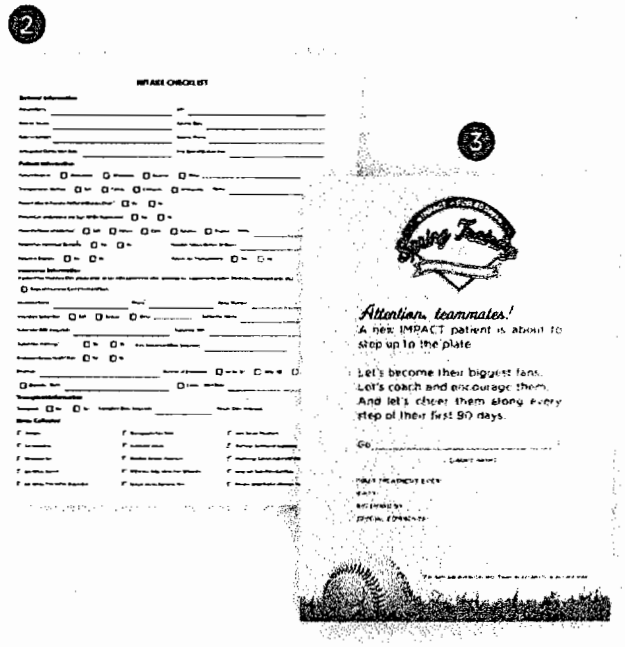
IMPACT is a first step toward a comprehensive approach to reduce mortality of incident patients. We believe this focus may help us to better manage CKD as a continuum of care. Long-term mortality measures will help determine if this process really impacts patients in the intended way, resulting in longer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

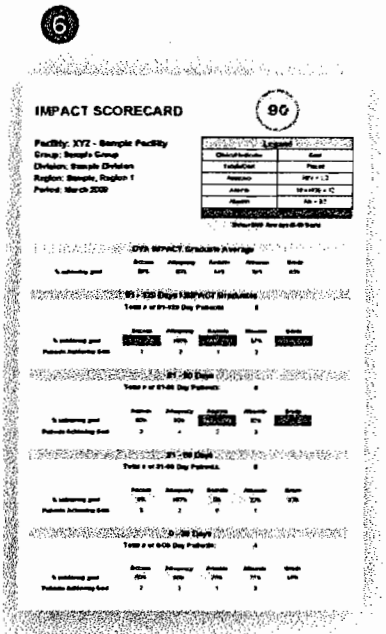
IMPACT Tools

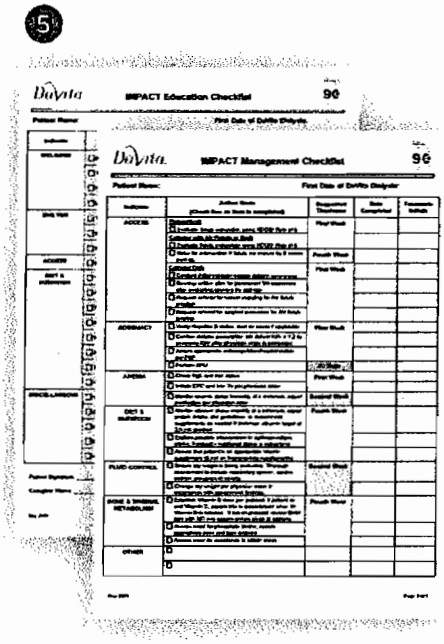
Here's how the IMPACT program will help the team record data, educate patients and monitor their progress in your facilities.

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









DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Adams County Dialysis	436 N 10TH ST		QUINCY	ADAMS	IL	62301-4152	14-2711
Alton Dialysis	3511 COLLEGE AVE		ALTON	MADISON	IL	62002-5009	14-2619
Arlington Heights Renal Center	17 WEST GOLF ROAD		ARLINGTON HEIGHTS	COOK	IL	60005-3905	14-2628
Barrington Creek	28160 W. NORTHWEST HIGHWAY		LAKE BARRINGTON	LAKE	IL	60010	14-2736
Benton Dialysis	1151 ROUTE 14 W		BENTON	FRANKLIN	IL	62812-1500	14-2608
Beverly Dialysis	8109 SOUTH WESTERN AVE		CHICAGO	COOK	IL	60620-5939	14-2638
Big Oaks Dialysis	5623 W TOUHY AVE		NILES	COOK	IL	60714-4019	14-2712
Buffalo Grove Renal Center	1291 W. DUNDEE ROAD		BUFFALO GROVE	COOK	IL	60089-4009	14-2650
Centralia Dialysis	1231 STATE ROUTE 161		CENTRALIA	MARION	IL	62801-6739	14-2609
Chicago Heights Dialysis	177 W JOE ORR RD	STE B	CHICAGO HEIGHTS	COOK	IL	60411-1733	14-2635
Churchview Dialysis	5970 CHURCHVIEW DR		ROCKFORD	WINNEBAGO	IL	61107-2574	14-2640
Cobblestone Dialysis	934 CENTER ST	STE A	ELGIN	KANE	IL	60120-2125	14-2715
Crystal Springs Dialysis	720 COG CIRCLE		CRYSTAL LAKE	MCHENRY	IL	60014-7301	14-2716
Decatur East Wood Dialysis	794 E WOOD ST		DECATUR	MACON	IL	62523-1155	14-2599
Dixon Kidney Center	1131 N GALENA AVE		DIXON	LEE	IL	61021-1015	14-2651
Driftwood Dialysis	1808 SOUTH WEST AVE		FREEPORT	STEPHENSON	IL	61032-6712	
Edwardsville Dialysis	235 S BUCHANAN ST		EDWARDSVILLE	MADISON	IL	62025-2108	14-2701
Effingham Dialysis	904 MEDICAL PARK DR	STE 1	EFFINGHAM	EFFINGHAM	IL	62401-2193	14-2580
Emerald Dialysis	710 W 43RD ST		CHICAGO	COOK	IL	60609-3435	14-2529
Evanston Renal Center	1715 CENTRAL STREET		EVANSTON	COOK	IL	60201-1507	14-2511
Grand Crossing Dialysis	7319 S COTTAGE GROVE AVENUE		CHICAGO	COOK	IL	60619-1909	14-2728
Freeport Dialysis	1028 S KUNKLE BLVD		FREEPORT	STEPHENSON	IL	61032-6914	14-2642
Granite City Dialysis Center	9 AMERICAN VLG		GRANITE CITY	MADISON	IL	62040-3706	14-2537
Hazel Crest Renal Center	3470 WEST 183rd STREET		HAZEL CREST	COOK	IL	60429-2428	14-2622
Illini Renal Dialysis	507 E UNIVERSITY AVE		CHAMPAIGN	CHAMPAIGN	IL	61820-3828	14-2633
Jacksonville Dialysis	1515 W WALNUT ST		JACKSONVILLE	MORGAN	IL	62650-1150	14-2581
Jerseyville Dialysis	917 S STATE ST		JERSEYVILLE	JERSEY	IL	62052-2344	14-2636
Kankakee County Dialysis	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	KANKAKEE	IL	60914-2439	14-2685
Lake County Dialysis Services	565 LAKEVIEW PARKWAY	STE 176	VERNON HILLS	LAKE	IL	60061	14-2552
Lake Park Dialysis	43RD & SOUTH COTTAGE GROVE		CHICAGO	COOK	IL	60653	14-2717

DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Lake Villa Dialysis	37809 N IL ROUTE 59		LAKE VILLA	LAKE	IL	60046-7332	14-2666
Lawndale Dialysis	3934 WEST 24TH ST		CHICAGO	COOK	IL	60623	
Lincoln Dialysis	2100 WEST FIFTH		LINCOLN	LOGAN	IL	62656-9115	14-2582
Lincoln Park Dialysis	3157 N LINCOLN AVE		CHICAGO	COOK	IL	60657-3111	14-2528
Litchfield Dialysis	915 ST FRANCES WAY		LITCHFIELD	MONTGOMERY	IL	62056-1775	14-2583
Little Village Dialysis	2335 W CERMAK RD		CHICAGO	COOK	IL	60608-3811	14-2668
Logan Square Dialysis	2838 NORTH KIMBALL AVE		CHICAGO	COOK	IL	60618	14-2534
Loop Renal Center	1101 SOUTH CANAL STREET		CHICAGO	COOK	IL	60607-4901	14-2505
Macon County Dialysis	1090 W MCKINLEY AVE		DECATUR	MACON	IL	62526-3208	14-2584
Marion Dialysis	324 S 4TH ST		MARION	WILLIAMSON	IL	62959-1241	14-2570
Markham Renal Center	3053-3055 WEST 159th STREET		MARKHAM	COOK	IL	60428-4026	14-2575
Maryville Dialysis	2130 VADALABENE DR		MARYVILLE	MADISON	IL	62062-5632	14-2634
Mattoon Dialysis	6051 DEVELOPMENT DRIVE		CHARLESTON	COLES	IL	61938-4652	14-2585
Metro East Dialysis	5105 W MAIN ST		BELLEVILLE	SAINT CLAIR	IL	62226-4728	14-2527
Montclare Dialysis Center	7009 W BELMONT AVE		CHICAGO	COOK	IL	60634-4533	14-2649
Mount Vernon Dialysis	1800 JEFFERSON AVE		MOUNT VERNON	JEFFERSON	IL	62864-4300	14-2541
Mt. Greenwood Dialysis	3401 W 111TH ST		CHICAGO	COOK	IL	60655-3329	14-2660
Olney Dialysis Center	117 N BOONE ST		OLNEY	RICHLAND	IL	62450-2109	14-2674
Olympia Fields Dialysis Center	4557B LINCOLN HWY	STE B	MATTESON	COOK	IL	60443-2318	14-2548
Palos Park Dialysis	13155 S LaGRANGE ROAD		ORLAND PARK	COOK	IL	60462-1162	14-2732
Pittsfield Dialysis	640 W WASHINGTON ST		PITTSFIELD	PIKE	IL	62363-1350	14-2708
Red Bud Dialysis	LOT 4 IN 1ST ADDITION OF EAST INDUSTRIAL PARK		RED BUD	RANDOLPH	IL	62278	
Robinson Dialysis	1215 N ALLEN ST	STE B	ROBINSON	CRAWFORD	IL	62454-1100	14-2714
Rockford Dialysis	3339 N ROCKTON AVE		ROCKFORD	WINNEBAGO	IL	61103-2839	14-2647
Roxbury Dialysis Center	622 ROXBURY RD		ROCKFORD	WINNEBAGO	IL	61107-5089	14-2665
Rushville Dialysis	112 SULLIVAN DRIVE		RUSHVILLE	SCHUYLER	IL	62681-1293	14-2620
Sauget Dialysis	2061 GOOSE LAKE RD		SAUGET	SAINT CLAIR	IL	62206-2822	14-2561
Schaumburg Renal Center	1156 S ROSELLE ROAD		SCHAUMBURG	COOK	IL	60193-4072	14-2654

DaVita HealthCare Partners, Inc.							
Illinois Facilities							
Regulatory Name	Address 1	Address 2	City	County	State	Zip	Medicare Certification Number
Shiloh Dialysis	1095 NORTH GREEN MOUNT RD		SHILOH	ST CLAIR	IL	62269	
Silver Cross Renal Center - Morris	1551 CREEK DRIVE		MORRIS	GRUNDY	IL	60450	14-2740
Silver Cross Renal Center - New Lenox	1890 SILVER CROSS BOULEVARD		NEW LENOX	WILL	IL	60451	14-2741
Silver Cross Renal Center - West	1051 ESSINGTON ROAD		JOLIET	WILL	IL	60435	14-2742
South Holland Renal Center	16136 SOUTH PARK AVENUE		SOUTH HOLLAND	COOK	IL	60473-1511	14-2544
Springfield Central Dialysis	932 N RUTLEDGE ST		SPRINGFIELD	SANGAMON	IL	62702-3721	14-2586
Springfield Montvale Dialysis	2930 MONTVALE DR	STE A	SPRINGFIELD	SANGAMON	IL	62704-5376	14-2590
Springfield South	2930 SOUTH 6th STREET		SPRINGFIELD	SANGAMON	IL	62703	14-2733
Stonecrest Dialysis	1302 E STATE ST		ROCKFORD	WINNEBAGO	IL	61104-2228	14-2615
Stony Creek Dialysis	9115 S CICERO AVE		OAK LAWN	COOK	IL	60453-1895	14-2661
Stony Island Dialysis	8725 S STONY ISLAND AVE		CHICAGO	COOK	IL	60617-2709	14-2718
Sycamore Dialysis	2200 GATEWAY DR		SYCAMORE	DEKALB	IL	60178-3113	14-2639
Taylorville Dialysis	901 W SPRESSER ST		TAYLORVILLE	CHRISTIAN	IL	62568-1831	14-2587
Tazewell Dialysis	1021 COURT STREET		PEKIN	TAZEWELL	IL	61554	
Timber Creek Dialysis	1001 S. ANNIE GLIDDEN ROAD		DEKALB	DEKALB	IL	60115	
TRC Children's Dialysis Center	2611 N HALSTED ST		CHICAGO	COOK	IL	60614-2301	14-2604
Vandalia Dialysis	301 MATTES AVE		VANDALIA	FAYETTE	IL	62471-2061	14-2693
Waukegan Renal Center	1616 NORTH GRAND AVENUE	STE C	Waukegan	COOK	IL	60085-3676	14-2577
Wayne County Dialysis	303 NW 11TH ST	STE 1	FAIRFIELD	WAYNE	IL	62837-1203	14-2688
West Lawn Dialysis	7000 S PULASKI RD		CHICAGO	COOK	IL	60629-5842	14-2719
Whiteside Dialysis	2600 N LOCUST	STE D	STERLING	WHITESIDE	IL	61081-4602	14-2648
Woodlawn Dialysis	1164 E 55TH ST		CHICAGO	COOK	IL	60615-5115	14-2310

DaVita | HealthCare Partners

July 2, 2013

John Hayes
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Acting Chairman Hayes:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 IAC 1130.140 has been taken against any in-center dialysis facility owned or operated by DaVita HealthCare Partners Inc. or Cagles Dialysis, LLC in the State of Illinois during the three year period prior to filing this application.

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

Sincerely,

Javier Rodriguez
President
DaVita HealthCare Partners Inc.

Subscribed and sworn to me
This 2ND day of July, 2013

Notary Public

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

2000 16th Street, Denver, CO 80202 | P (303) 405-2100 | F (303) 876-0963 | DaVitaHealthCarePartners.com

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

Purpose of Project

1. The purpose of the project is to improve access to life sustaining dialysis services to the residents of the Chicago Ridge community where there is a need for 40 additional dialysis stations. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in operation for more than a year in the GSA is 81%, which is above the State standard.

   This is not surprising given the immense size of the facility's proposed medical director's practice. Dr. Sreya Pallath's practice, J.R. Nephrology & Associates, P.C. is treating 791 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, approximately 137 Stage 4 and 5 CKD patients reside within 20 minutes of the proposed facility. *See* Attachment – 12A. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Pallath anticipates that approximately 87 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion.

   This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Pallath's practice is currently treating ESRD patients at Stoney Creek Dialysis, West Lawn Dialysis, and Beverly Dialysis, which are collectively operating at 94% utilization. As a result, without operating a fourth shift, these facilities cannot accommodate Dr. Pallath's already large, and growing, patient-base. This, coupled with high utilization in the service area, supports the need for a new 16-station facility.

   The establishment of a 16-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Chicago Ridge community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

2. A map of the market area for the proposed facility is attached at Attachment – 12B. The market area encompasses an approximate 15 mile radius around the proposed facility. The boundaries of the market area of are as follows:

   - North approximately 30 minutes normal travel time to Bellwood, IL
   - Northeast approximately 30 minutes normal travel time to 79th St & I-94, Chicago, IL
   - East approximately 30 minutes normal travel time to 103rd St & I-94, Chicago, IL
   - Southeast approximately 30 minutes normal travel time to South Holland, IL
   - South approximately 30 minutes normal travel time to Matteson, IL
   - Southwest approximately 30 minutes normal travel time to Lockport, IL
   - West approximately 30 minutes normal travel time to Bolingbrook, IL
   - Northwest approximately 30 minutes normal travel time to Downers Grove, IL

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

3. The minimum size of a GSA is 30 minutes; however, most of the patients reside within the immediate vicinity of the proposed facility. The proposed facility is located in Worth, IL on the immediate border of the City of Chicago Ridge. The surrounding community is comprised of approximately 30% African American and 25% Hispanic residents. Diabetes and hypertension

(high blood pressure) are the two leading causes of CKD and ESRD.[2] Due to socioeconomic conditions, these populations exhibit a higher prevalence of obesity, which is a driver of diabetes and hypertension. Hispanic and African Americans are at an increased risk of ESRD compared to the general population due to the higher prevalence of these conditions in the Hispanic and African American communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population, and the ESRD incident rate among African Americans is 3.6 times greater than the non-Hispanic white population *See* Attachment – 12C. This, coupled with the aging population, is expected to increase utilization. As shown in Attachment – 12A, the projected referrals by Dr. Pallath confirm this. Dr. Pallath expects approximately 87 of the current CKD patients to require dialysis within the next 12 to 18 months.

4. Source Information

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

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

U.S. Renal Data System, USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2010 *available at* http://www.usrds.org/2010/view/ (last visited July 30, 2013).

U.S. Renal Data System, USRDS 2007 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2007 *available at* http://www.usrds.org/atlas07.aspx (last visited July 30, 2013).

5. The proposed facility will improve access to dialysis services to the residents Chicago Ridge community and the surrounding area by establishing the proposed facility. Given the increasing size of Dr. Pallath's patient-base, this facility is necessary to ensure sufficient access to dialysis services in this community.

6. The Applicants anticipate the proposed facility will have quality outcomes comparable to its other facilities. Additionally, in an effort to better serve all kidney patients, DaVita believes in requiring all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is more than $1.5 billion in savings to the health care system and the American taxpayer since 2010.

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

Sreya Pallath, M.D.
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

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

Dear Vice Chairman Hayes:

I am pleased to support DaVita's establishment of Chicago Ridge Dialysis. The proposed 16-station chronic renal dialysis facility, to be located at 10511 South Harlem Avenue, Worth, Illinois 60482 will directly benefit my patients.

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

The site of the proposed facility is close to Interstate 294 (I-294) and will provide better access to patients residing in the south and southwest suburbs, as well as the far southwest area of the city of Chicago. Utilization of facilities in operation for more than a year within the 30 minute Geographic Service Area of the proposed facility was 79.0%, according to March 31, 2013 reported census data.

I have identified 137 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Conservatively, I predict at least 87 of these patients will progress to dialysis within the next 12 to 24 months. My large patient base, the significant utilization at nearby facilities, and the present 40-station need identified in Health Service Area 7 demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 3 ½ years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past year and a half is provided at Attachment – 2. The list of zip codes for the 137 pre-ESRD patients previously referenced is provided at Attachment – 3.

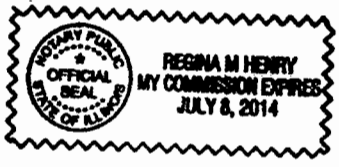
These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

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

Sincerely,

Sreya Pallath, M.D.
Nephrologist
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Subscribed and sworn to me
This 1st day of August, 2013



Notary Public: Regina M Henry

Attachment 1

Historical Patient Utilization

Stony Creek Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RA	60453	RA	60453	RA	60453	RA	60453
JA	60805	JA	60805	EA	60459	EA	60459
EA	60805	EA	60459	JA	60638	JA	60638
MA	60465	JA	60638	RB	60803	RB	60803
EA	60459	RB	60803	FB	60632	FB	60632
HB	60805	GB	60644	GB	60644	GB	60644
RB	60803	EC	60617	JC	60453	JC	60453
EC	60617	DD	60406	EC	60617	EC	60617
JC	60803	AA	60459	DD	60406	WD	60456
DC	60459	LB	60415	WD	60456	JB	60652
DD	60406	JB	60652	AA	60459	CB	60629
AA	60459	CB	60629	JB	60652	IB	60620
HA	60453	IB	60620	CB	60629	AB	60406
JB	60652	AB	60406	IB	60620	MC	60629
AB	60453	CB	46307	AB	60406	JD	60652
CB	60629	MC	60629	MC	60629	CD	60628
IB	60620	WC	60453	WC	60453	WD	60636
JB	60628	FC	60620	FC	60620	DD	60652
AB	60406	EC	60453	MD	60453	ZE	60629
LC	89107	MD	60453	JD	60652	JF	60457
MC	60629	JD	60652	CD	60628	PG	60629
JC	60803	CD	60628	DD	60406	EG	60482
WC	60453	DD	60406	WD	60636	RG	60632
DC	60459	WD	60636	BD	60463	BG	60453
FC	60620	DD	60652	DD	60652	RG	60620
EC	60453	ZE	60629	ZE	60629	JH	60620
JD	60652	NF	60629	DF	60459	LH	60453
LD	60803	OF	60638	JF	60457	RI	60652
MD	60638	DF	60459	PG	60629	JJ	60453
CD	60628	PG	60629	EG	60482	AJ	60652
DD	60406	LG	60487	RG	60632	JJ	60629
WD	60636	RG	60632	BG	60453	RK	60459
DD	60652	SG	60803	SG	60803	WK	60638
ZE	60629	RG	60465	VG	60453	HL	60453
OF	60638	VG	60453	RG	60620	GM	60453
DF	60459	JH	60620	JH	60620	FM	60457
PG	60629	WH	60453	JH	46405	YM	60632
LG	60652	SH	60620	SH	60620	DN	60453
LG	60487	LH	60453	LH	60453	EN	60455
RG	60632	RJ	60629	RI	60652	PO	60453

Stony Creek Dialysis, CONTINUED							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
VG	60453	JJ	60453	RJ	60629	KP	60456
MG	60453	AJ	60652	JJ	60453	SP	60455
MG	60652	JJ	60629	AJ	60652	AP	60455
JH	60620	RJ	60803	JJ	60629	GR	60459
WH	60453	EK	60453	RJ	60803	MR	60465
SH	60620	RK	60459	EK	60453	RS	60629
LH	60453	WK	60638	RK	60459	BS	60652
JJ	60453	DM	60459	AK	60465	AS	60456
JJ	60652	GM	60453	WK	60638	LS	60805
JJ	60629	FM	60457	HL	60453	RS	60491
RJ	60803	AM	60638	GM	60453	WS	60453
EK	60453	DM	60805	FM	60457	DT	60638
RK	60459	DN	60453	YM	60632	GV	60459
WK	60638	EN	60455	DM	60805	LW	60652
RK	60638	JN	60453	RM	60805	JW	60415
PL	60455	JO	60453	MM	60453	GW	60609
IL	60457	PO	60453	DN	60453	WW	60620
RL	60629	KP	60456	EN	60455	EW	60453
DM	60459	BP	60453	JO	60453	DW	60458
CM	60638	AP	60455	PO	60453	WY	60453
GM	60453	JR	60453	KP	60456	JZ	60459
KM	60636	RS	60629	SP	60455	JW	60428
LM	60803	BS	60652	AP	60455	IO	60453
FM	60457	AS	60456	GR	60459	MT	60652
DM	60805	ES	60629	JR	60453	GW	60620
HM	60463	LS	60805	MR	60465	MR	60619
JN	60459	RS	60491	RS	60629	JC	60458
DN	60453	WS	60453	BS	60652	DF	60655
JO	60643	GV	60459	AS	60456	MM	60459
JO	60453	RV	60453	SS	60453	AM	60455
JP	60453	LW	60652	CS	60453	MK	60453
BP	60453	JW	60415	LS	60805		
AP	60455	GW	60609	RS	60491		
JR	60453	WW	60620	WS	60453		
BS	60652	JW	60629	DT	60638		
AS	60456	MW	60085	GV	60459		
ES	60629	EW	60453	RV	60453		
LS	60805	DW	60458	LW	60652		
RS	60491	HY	60453	JW	60415		
WS	60453	JZ	60459	GW	60609		
MV	60403	KZ	60445	WW	60620		
RV	60453			EW	60453		
LW	60652			DW	60458		
GW	60609			WY	60453		

Stony Creek Dialysis, CONTINUED					
2010		2011	2012		2013 YTD 6/30
Initials	Zip Code		Initials	Zip Code	
JW	60453		JZ	60459	
WW	60620				
DW	60458				
HY	60453				
JZ	60459				
KZ	60445				

Beverly Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
LF	60628	LF	60628	RM	60620	SG	60629
OJ	60609	RM	60620	SG	60629	EC	60620
RM	60620	SG	60629	EC	60620	WG	60652
SG	60629	EC	60620	WG	60652	EH	60619
EC	60620	WG	60652	EH	60619	MH	60609
WG	60652	EH	60619	MH	60609	BH	60620
EH	60619	MH	60609	BH	60620	AJ	60620
MH	60609	BH	60620	AJ	60620	DR	60620
BH	60620	AJ	60620	DR	60620	AS	60620
AJ	60620	DR	60620	AS	60620	AF	60619
DR	60620	AS	60620	AF	60619	BA	60620
AS	60620	AF	60619	BA	60620	AB	60620
RB	60803	AH	60629	AB	60620	BG	60620
SC	60465	JM	60619	BG	60620	DG	60478
MC	60629	RR	60629	DG	60478	SM	60629
AF	60619	WS	60620	BG	60652	KM	60636
WG	60643	BA	60620	SM	60629	CR	60620
AH	60629	AB	60620	KM	60636	BT	60620
CL	60628	BG	60620	CR	60620	IW	60628
SM	60617	DG	60478	BT	60620	AB	60628
JM	60619	BG	60652	IW	60628	TB	60620
LM	60803	SM	60629	SA	60636	GC	60629
RR	60629	KM	60636	AB	60628	RJ	60620
GS	60617	CR	60620	TB	60620	SJ	60628
WS	60620	BT	60620	GC	60629	KP	60620
BA	60620	IW	60628	RJ	60620	ST	60620
AB	60620	SA	60636	SJ	60628	VB	60636
BG	60620	AB	60628	KP	60620	WK	60620
DG	60478	TB	60620	MR	60619	RL	60619
BG	60652	JC	60629	JS	60628	CM	60620
SM	60629	GC	60629	GS	60636	LN	60620
KM	60636	GH	60629	ST	60620	FP	60620
CR	60620	KH	60652	BD	60621	RP	60652
BT	60620	MJ	60619	VB	60636	GR	60643
IW	60628	RJ	60620	WK	60620	MR	60610
AH	60608	SJ	60628	RL	60619	ER	60628
BA	60649	WK	60628	CM	60620	JT	60620
EH	60629	WK	60629	LN	60620	WT	60620
AK	60617	ML	60652	FP	60620	RT	60629
DR	60620	LM	60803	RP	60652	CT	60620
		RN	60628	GR	60643	AW	60458
		PN	60643	MR	60610	TC	60652

Beverly Dialysis, CONTINUED						
2010	2011		2012		2013 YTD 6/30	
	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
	KP	60620	ER	60628	LG	60629
	CR	60643	RS	60620	AJ	60652
	LR	60628	LS	60805	SJ	60636
	MR	60619	JT	60620	MK	60453
	JS	60628	WT	60620	HM	60617
	GS	60636	RT	60629	LS	60620
	ST	60620	CT	60620	BT	60620
	MT	60652	AW	60458	BA	60649
	LW	60620	BA	60649	EH	60629
	BA	60649	EH	60629	AK	60617
	EH	60629	AK	60617	DR	60620
	AK	60617	DR	60620		
	DR	60620				

West Lawn Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
N/A	N/A	FB	60636	FB	60636	FB	60636
		EC	60637	EC	60637	EC	60637
		MG	60632	MG	60632	MG	60632
		RJ	60629	RJ	60629	RJ	60629
		MJ	60620	MJ	60620	MJ	60620
		WK	60629	WK	60629	WK	60629
		EM	60652	EM	60652	EM	60652
		MR	60652	MR	60652	MR	60652
		IS	60629	IS	60629	IS	60629
				MA	60629	MA	60629
				AB	60629	AB	60629
				AB	60629	AB	60629
				DB	60621	DB	60621
				MR	60632	MR	60632
				BD	60629	BD	60629
				MD	60501	MD	60501
				PF	60629	PF	60629
				GH	60629	GH	60629
				HJ	60636	HJ	60636
				MJ	60629	MJ	60629
				EN	60632	EN	60632
				RO	60632	RO	60632
				HR	60501	HR	60501
				MR	60632	MR	60632
				AR	60629	AR	60629
				NR	60652	NR	60652
				MT	60652	MT	60652
				CV	60629	CV	60629
				BZ	60629	BZ	60629
						JA	60638
						SA	60629
						JB	60629
						UC	60632
						ZC	60652
						BF	60629
						GG	60632
						HG	60629
						BG	60632
						JH	60629
						KH	60629
						AM	60453
						MM	60805

West Lawn Dialysis, CONTINUED				
2010	2011	2012	2013 YTD 6/30	
			Initials	Zip Code
			LM	60632
			JM	60629
			SP	60619
			CP	60620
			SR	60652

Attachment 2
New Patients

Stony Creek Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
FB	60632	JW	60428
BZ	60629	IO	60453
WD	60456	MT	60652
BD	60463	GW	60620
JF	60457	MR	60619
EG	60482	JC	60458
JC	60453	DF	60655
BG	60453	MM	60459
RG	60620	AM	60455
RI	60652	MK	60453
EK	60453		
AK	60465		
MM	60457		
RM	60805		
MM	60453		
SP	60455		
GR	60459		
SS	60453		
CS	60453		
HL	60411		
WY	60453		
HL	60453		
YM	60632		

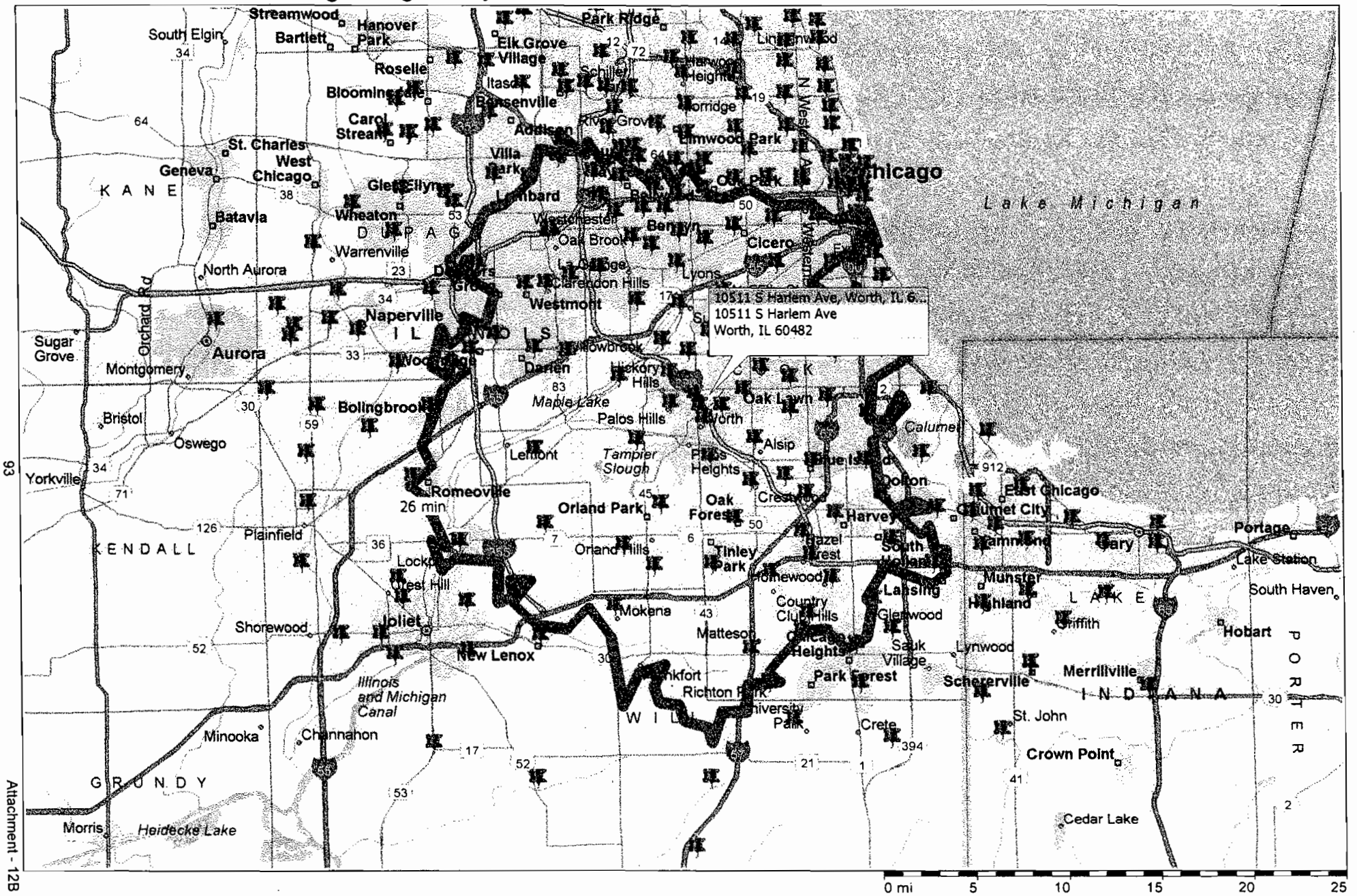
Beverly Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
BD	60621	TC	60652
VB	60636	LG	60629
WK	60620	AJ	60652
RL	60619	SJ	60636
CM	60620	MK	60453
LN	60620	HM	60617
FP	60620	LS	60620
RP	60652	BT	60620
GR	60643		
MR	60610		
ER	60628		
CT	60620		
AW	60458		

West Lawn Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
MA	60629	JA	60638
AB	60629	SA	60629
AB	60629	JB	60629
DB	60621	UC	60632
MR	60632	ZC	60652
BD	60629	BF	60629
MD	60501	GG	60632
PF	60629	HG	60629
GH	60629	BG	60632
HJ	60636	JH	60629
MJ	60629	KH	60629
EN	60632	AM	60453
RO	60632	MM	60805
HR	60501	LM	60632
MR	60632	JM	60629
AR	60629	SP	60619
NR	60652	CP	60620
MT	60652	SR	60652
CV	60629		
BZ	60629		

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60406	1
60415	2
60445	5
60452	2
60453	24
60455	9
60456	2
60457	4
60458	2
60459	6
60462	4
60463	5
60464	3
60465	4
60472	1
60477	4
60482	5
60501	1
60643	10
60652	15
60655	12
60803	9
60805	7
Total	**137**

Chicago Ridge Dialysis 10511 South Harlem Avenue, Worth, IL 60482



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

Hispanics are the fastest growing minority group in the United States. The incidence of end-stage renal disease (ESRD) in Hispanics is higher than non-Hispanic Whites and Hispanics with chronic kidney disease (CKD) are at increased risk for kidney failure. Likely contributing factors to this burden of disease include diabetes and metabolic syndrome, both are common among Hispanics. Access to health care, quality of care, and barriers due to language, health literacy and acculturation may also play a role. Despite the importance of this public health problem, only limited data exist about Hispanics with CKD. We review the epidemiology of CKD in US Hispanics, identify the factors that may be responsible for this growing health problem, and suggest gaps in our understanding which are suitable for future investigation. (*Ethn Dis.* 2009;19:466–472)

Key Words: Chronic Kidney Disease, Hispanics, Health Care Disparities

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Introduction

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

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

Methods

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

Epidemiology of CKD in Hispanics

Glomerular filtration rate (GFR) estimating equations have been used to determine the prevalence of CKD in the United States. The abbreviated Modification of Diet in Renal Disease (MDRD) equation has been considered to be the most accurate available estimating equation for GFR and has been used widely in the literature and by a growing number of clinical laboratories.[6] Though the equation has been demonstrated to have validity across a spectrum of different subgroups,[7] there are no data regarding its validity in

Hispanics. This is a relevant concern because the serum creatinine concentration, which is used in the MDRD equation to calculate estimated GFR (eGFR), has been demonstrated to differ by racial/ethnic groups. In an analysis of serum creatinine levels in the National Health and Nutrition Examination Survey (NHANES) III, Mexican Americans had lower mean serum creatinine levels than non-Hispanic Whites or non-Hispanic Blacks.[8] The reasons for these differences are unknown. Similarly, a recent NHANES analysis of serum cystatin C, a potentially more sensitive marker of early kidney dysfunction than serum creatinine, reported lower levels of cystatin C in Mexican Americans compared with other racial/ethnic groups studied.[9] These differences in the distribution of serum creatinine and cystatin C levels in Hispanics reinforce the importance of rigorously evaluating the accuracy of GFR estimating equations in Hispanics.[10]

INCIDENCE AND PREVALENCE OF CKD IN HISPANICS

Mild to Moderate CKD

Information regarding earlier stages of CKD in Hispanics is limited. Several investigators have reported a higher prevalence of microalbuminuria in Hispanics compared with non-Hispanic Whites.[11–13] In contrast to these findings, a recent analysis of NHANES III data suggests that the prevalence of CKD may be lower in Mexican Americans than in non-Hispanic Whites or non-Hispanic Blacks. In an analysis of NHANES III, moderately decreased kidney function (eGFR 30–59 mL/minute/1.73 m^2) was most prevalent among non-Hispanic Whites (4.8%) and non-Hispanic Blacks (3.1%) and least prevalent in Mexican Americans (1.0%).[14] Between NHANES 1988 to 1994 and 1994 to 2004, the prevalence of CKD rose among Mexican Americans but continued to be lower than that observed in non-Hispanic Whites and Blacks.[15]

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

End Stage Renal Disease (ESRD)

It is well established that Hispanics have a higher prevalence of ESRD than non-Hispanic Whites. The increased prevalence of treated ESRD in Hispanics was first recognized in the 1980s. Using data from the state of Texas, Mexican Americans were found to have an excess of ESRD compared with non-Hispanic Whites with an incidence ratio of 3.[16] For diabetic ESRD, Mexican Americans had an incidence ratio of 6 compared with non-Hispanic Whites. The first study at a national level analyzed male Hispanics identified in Medicare ESRD program data files. Using common Spanish surnames to identify cases, it was found that Hispanics developed ESRD at a younger age than non-Hispanic Whites; and between 1980 and 1990, ESRD incidence rates increased more for Hispanics.[17] In 1995, the USRDS began to acquire data regarding Hispanic ethnicity. In 2006, the adjusted incidence rate for ESRD in Hispanics was 1.5 times higher than for non-Hispanic Whites.[2] Furthermore, between 1996 and 2005, the incidence rate for Hispanics increased by 63%.[2] In contrast, Burrows et al examined trends in age-adjusted ESRD rates and reported that the age-adjusted ESRD rate in Hispanics decreased by approximately 15%, from 2000 to 2005 (530.2 vs 448.9).[18] However, there was an overall increase in the age-adjusted incidence rates in Hispanics in 2005 as compared with 1995 (448.9 vs 395.0). It is apparent that a longer period of follow-up time is needed to better characterize trends. The leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites are described in Table 1. Diabetes accounts for 59% of prevalent cases of ESRD in Hispanic compared with 39% of cases in non-Hispanic Whites.[3] Unfortunately, data regarding causes of ESRD by Hispanic subgroup are not available.

Table 1. Leading causes of ESRD requiring dialysis in Hispanics and non-Hispanic Whites in 2000[3]

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

The incidence and severity of diabetes are important factors in the excessive incidence of diabetic ESRD observed in Hispanics. The prevalence of diabetes in Hispanics has been estimated to be approximately 1.5 to 3 times that seen in the non-Hispanic White population and its incidence is rising.[19] Moreover, Hispanics have been found to have lower rates of glucose self-monitoring and poorer glycemic control compared with non-Hispanic Whites.[20] Hispanics with diabetes may be at increased risk to develop diabetic nephropathy. Mexican American diabetics in San Antonio, Texas had a higher prevalence of proteinuria than non-Hispanic White diabetics from Wisconsin.[21] However,

no such difference was observed in the San Luis Valley.[22] The importance of non-diabetic CKD in Hispanics is not completely understood. Though hypertension is less prevalent in Hispanics, Mexican Americans had the highest rate of uncontrolled hypertension in NHANES III.[23] Data from Texas and the USRDS demonstrate a higher incidence of ESRD due to hypertension in Hispanics than in non-Hispanic Whites.[16,24]

Progression of CKD in Hispanics

Only limited information is available regarding progression rates and risk factors for CKD in Hispanics. In a multivariable retrospective analysis of a cohort of 263 type 2 diabetic ESRD patients, Mexican ethnicity and female sex were found to hasten the decline of renal function.[25] A post hoc analysis of the Reduction of Endpoints in NIDDM with the Angiotensin II Antagonist Losartan Study (RENAAL) found that Hispanics had the highest risk for ESRD compared with Blacks and Whites.[26] However, the majority of Hispanics in this study were from Latin American countries and therefore, the findings may not be applicable to US Hispanics. A recent analysis of patients enrolled in Kaiser Permanente of Northern California, a large integrated healthcare delivery system, has clarified the risk of ESRD in US Hispanics with CKD.[27] In 39,550 patients with stage 3 to 4 CKD, Hispanic ethnicity was associated with almost a two-fold increased risk for ESRD when compared with non-Hispanic Whites. This increased risk was attenuated to 33% after adjustment for diabetes, medication use, and other characteristics. Thus, the risk for progression to ESRD in Hispanics is only partially explained by diabetes.

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

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

Metabolic Syndrome and CKD

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

Disparities in Health Care and Prevalence and Progression of CKD

The importance of healthcare disparities in CKD has received increased recognition,[40] but little is known regarding the impact of healthcare disparities on health outcomes in Hispanics with CKD. It is well substantiated that there are considerable disparities in health care for Hispanics.[20] According to a report by the Commonwealth Fund, nearly two-thirds (65%) of working-age Hispanics with low incomes were uninsured for all or part of the year in 2000.[41] Using NHANES III data, Harris evaluated healthcare access and utilization, and health status and outcomes for patients with type 2 diabetes.[20] Mexican Americans below age 65 years had lower rates of health insurance coverage than non-Hispanic Whites and Blacks (66% vs 91% and 89%, respectively). Furthermore, Mexican Americans with private insurance or a high school education or more were more likely to have normoalbuminuria.[20] The quality of care received by Hispanics may also play a role in the progression of kidney disease. Hispanics with diabetes are less likely to report having had a foot exam or glycosylated hemoglobin testing.[42] As noted earlier, Mexican American in NHANES III had the highest rate of uncontrolled hypertension.[23] Lastly, Ifudu et al reported that non-Whites, including Hispanics, are more likely to receive a late referral to a nephrologist for CKD management.[43] This study was limited by the low number of Hispanics in the analysis. These findings suggest that quality of care may play a role in the high prevalence of ESRD in this population.

Patient-centered factors may play a particularly important role for Hispanics include language, health care literacy, acculturation, social support, and trust in healthcare providers. Hispanics who are recent immigrants face a number of potential barriers to health care, includ-

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

CARDIOVASCULAR DISEASE IN HISPANICS WITH ESRD AND EARLIER STAGES OF CKD

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

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

END-STATE RENAL DISEASE CARE IN US HISPANICS

Dialysis

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

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

Transplantation

Limited data exist that suggest that Hispanics are equally likely to be referred for renal transplantation but are less likely to progress beyond the early stages of the transplant evaluation

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

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

CONCLUSION

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

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Obesity and Risk for Chronic Renal Failure

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

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

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

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

Materials and Methods

Study Participants

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

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

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

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

Data Collection

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

Data Analyses

Relative risk for CRF among groups with different anthropometric measures was estimated by odds ratios (OR) and 95% confidence intervals (CI) that were derived from unconditional logistic regression models. We analyzed data stratified by gender throughout, except in analyses of disease-specific CRF, as a result of small sample sizes. Continuous variables (BMI [body weight divided by height raised to the second power, kg/m^2], cumulative number of cigarette pack-years, grams of alcohol per week) were categorized into quartiles according to the distribution among control subjects. In addition, BMI was categorized according to World Health Organization's (WHO's) definitions of overweight and obesity (14). Because few participants had a BMI >30 kg/m^2 at age 20, BMI at that age was dichotomized into <25 and ≥25 kg/m^2. Level of education was categorized into ≤9 yr, 10 to 12 yr, and ≥13 yr. An indicator of regular use of aspirin and paracetamol was found to control sufficiently for confounding of nonnarcotic analgesic use. Adjustment for socioeconomic status instead of number of school years did not change the risk estimates. Always included as covariates in our models were age, cumulative cigarette pack-years, grams of alcohol consumed per week, ever/never regular use of paracetamol or aspirin, and number of years of formal education. We tested for interactions but did not include any interaction terms in the final models because they were statistically insignificant. Model fit was verified with the Hosmer and Lemeshow test (15).

Results

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

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

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

[a]CRF, chronic renal failure.
[b]Conversion factor for SI unit (μmol/L) is 88.4.
[c]Predicted creatinine clearance (Cockroft-Gault formula).

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

OR for overall CRF in relation to BMI are presented separately for men and women (Table 3), although no statistically significant effect modification by gender could be confirmed, neither when using quartiles as cut points for BMI categories nor when using the WHO's cut points for overweight and obesity ($P = 0.35$ and $P = 0.25$, respectively). We found a positive association of highest lifetime BMI with overall CRF risk, particularly among men (Table 3). Men in the highest quartile had a 2.3-fold increased risk (95% CI 1.6 to 3.3) compared with those in the lowest quartile. The corresponding OR was modest and statistically nonsignificant among women, but when using WHO's cut points (14), clear excesses of three-fold or greater were seen for BMI ≥35 kg/m^2 in both genders. Men and women who reported a BMI ≥25 kg/m^2 at age 20 had a significant three-fold elevated risk for CRF compared with patients with BMI <25 kg/m^2. BMI at age 40 and at age 60 showed similar relationships with CRF risk as did highest

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

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

[a]BMI, body mass index.
[b]Less than 6 mo of daily smoking in lifetime.
[c]Highest BMI in lifetime.

Table 3. OR for CRF associated with BMI[a]

	Men		Women	
	No. of Case Patients/Control Subjects	OR[b] (95% CI)	No. of Case Patients/Control Subjects	OR[b] (95% CI)
Highest BMI (kg/m2)[c]				
gender-specific quartiles[d]				
Q1 (lowest quartile)	101/158	1.0 (referent)	64/81	1.0 (referent)
Q2	113/160	1.1 (0.8 to 1.6)	56/85	0.8 (0.5 to 1.3)
Q3	136/158	1.4 (1.0 to 2.0)	81/82	1.2 (0.7 to 1.9)
Q4 (highest quartile)	230/157	2.3 (1.6 to 3.3)	107/84	1.3 (0.8 to 2.1)
cut points in accordance with WHO's definition of overweight and obesity				
<25.00	129/213	1.0 (referent)	96/136	1.0 (referent)
25.00 to 29.9	265/323	1.4 (1.0 to 1.9)	115/133	1.2 (0.8 to 1.8)
30.0 to 34.9	130/79	2.7 (1.9 to 4.0)	49/46	1.4 (0.8 to 2.4)
≥35.00	56/18	4.4 (2.4 to 8.2)	48/17	3.1 (1.6 to 6.1)
BMI at age 20 (kg/m^2)[e]				
gender-specific quartiles[f]				
Q1 (lowest quartile)	94/136	1.0 (referent)	55/68	1.0 (referent)
Q2	75/130	0.9 (0.6 to 1.4)	52/75	0.9 (0.5 to 1.5)
Q3	125/142	1.3 (0.9 to 1.9)	48/72	0.8 (0.5 to 1.5)
Q4 (highest quartile)	175/138	1.9 (1.3 to 2.8)	86/72	1.4 (0.8 to 2.3)
cut points in accordance with the WHO definition of overweight				
<25.0	377/506	1.0 (referent)	211/274	1.0 (referent)
≥25.0	92/40	3.1 (2.1 to 4.8)	30/13	3.0 (1.4 to 6.1)

[a]CI, confidence interval; OR, odds ratio; Q, quartile; WHO, World Health Organization.
[b]Adjusted for age, education, smoking, alcohol, and use of paracetamol and salicylates.
[c]Highest BMI during lifetime. Because of missing information on ≥1 covariate, 46 case patients and 53 control subjects were excluded from analyses.
[d]Q1: Men <24.4, women <23.6; Q2: men 24.4 to 26.4, women 23.6 to 25.8; Q3: men 26.5 to 28.8, women 25.9 to 28.9; Q4: men >28.8, women >28.9.
[e]Because of missing information on ≥1 covariate, 222 case patients and 183 control subjects were excluded from analyses
[f]Q1: men <20.5, women <19.0; Q2: men 20.6 to 21.7, women 19.1 to 20.5; Q3: men 21.8 to 23.4, women 20.6 to 21.9; Q4: men >23.4, women >21.9.

lifetime BMI, but the relative risk estimates were less precise as a result of the smaller number of patients who had attained these ages (data not shown). However, BMI at time of interview was not significantly associated with CRF risk: Men and women with BMI of 35 kg/m^2 or more had adjusted OR of 1.9 (95% CI 0.8 to 4.6) and 1.2 (95% CI 0.5 to 3.3), respectively, relative to patients with BMI <25.

In analyses stratified by the presence or absence of self-reported diabetes, the elevated CRF risk with increasing maximum BMI was more pronounced among individuals with than without diabetes. However, even for men and women without diabetes, a lifetime highest BMI of 35 kg/m^2 or more entailed a significant OR of 2.2, relative to those with BMI <25 kg/m^2 (Table 4). Likewise, obesity was associated with CRF also among patients who self-reported that they had no history of clinically known hypertension. The OR for CRF among these presumably nonhypertensive patients with highest BMI ≥35 kg/m^2 was 2.8 (95% CI 1.0 to 8.1), relative to patients with BMI <25 kg/m^2. Analyses that were confined to individuals who reported neither diabetes nor hypertension produced point estimates of similar magnitude, albeit without statistical significance (Table 4). In contrast, a statistically significant three-fold risk increase was observed among those who did not have diabetes and hypertension and who reported overweight at age 20 (Table 4).

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

Table 4. OR for CRF associated with BMI[a]

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

[a]Analyses are restricted to participants without self-reported diabetes and/or hypertension.
[b]Adjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.
[c]Cut points in accordance with the WHO definition of overweight and obesity.
[d]Cut points in accordance with the WHO definition of overweight.

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

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

[a]Adjusted for age, gender, education, smoking, alcohol, and use of paracetamol and salicylates.
[b]Cut points in accordance with the WHO definition of overweight and obesity.
[c]Cut points in accordance with the WHO definition of overweight.

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

Discussion

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

There is an accumulating body of clinical and experimental data implicating obesity as an important causative factor in renal disease (17,18), but epidemiologic data linking obesity to CRF have been scarce so far. Some studies have investigated the association between obesity and proteinuria in the general population (8,9); however, few epidemiologic studies have quantified the possible link between obesity and established renal failure in population-based settings. Our study is one of the first large-scale, population-based investigations to identify obesity as an important risk factor in the development of renal failure. Relative risk estimates that were consistent with ours were reported in a cohort study with a smaller number of incident CRF cases (19). In a Japanese cohort that was assembled during a mass screening project in 1983, high BMI was associated with an increased risk for ESRD 17 yr later but only among men (12). There, the excess risk was comparable or slightly higher than in our study. A similar US cohort study among individuals who participated in a health testing program reported an even stronger and monotonic trend of increasing ESRD risk with increasing BMI among both men and women (11). Another US cohort study among men and women who were free of kidney disease at baseline noted a 23% in-

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

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

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

Focal segmental glomerulosclerosis (FSGS) and/or glomerulomegaly is seen commonly in renal biopsies from morbidly obese patients (25–27), and the development of these conditions seems to be independent of hypertension and diabetes. The proportion of all renal biopsies that exhibited obesity-related FSGS or glomerulomegaly increased 10-fold from 1986 to 2000 in a New York clinicopathologic study (27). Although a low rate of renal biopsy may have entailed underascertainment, only 16 of our case patients had received a diagnosis of FSGS, and only one had a lifetime highest BMI that exceeded 35 kg/m^2.

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

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

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

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

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

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

Conclusion

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

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Excess Risk of Chronic Kidney Disease among African-American *versus* White Subjects in the United States: A Population-Based Study of Potential Explanatory Factors

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Abstract. African Americans experience higher rates of chronic kidney disease (CKD) than do whites. It was hypothesized that racial differences in modifiable factors would account for much of the excess risk of CKD. A cohort study of 9082 African-American and white adults of age 30 to 74 yr, who participated in the Second National Health and Nutrition Examination Survey in 1976 to 1980 and were monitored for vital status through 1992 in the Second National Health and Nutrition Examination Survey Mortality Study, was conducted. Incident CKD was defined as treated CKD cases (ascertained by linkage to the Medicare Registry) and deaths related to kidney disease. The incidence of all-cause CKD was 2.7 times higher among African Americans, compared with whites. Adjustment for sociodemographic factors decreased the relative risk (RR) to 2.49, explaining 12% of the excess risk of CKD among African Americans. Further adjustment for lifestyle factors explained 24% of the excess risk, whereas adjustment for clinical factors alone explained 32%. Simultaneous adjustment for sociodemographic, lifestyle, and clinical factors attenuated the RR to 1.95 (95% confidence interval, 1.05 to 3.63), explaining 44% of the excess risk. Although the excess risk of CKD among African Americans was much greater among middle-age adults (30 to 59 yr of age; RR = 4.23, statistically significant) than among older adults (60 to 74 yr of age; RR = 1.27), indicating an interaction between race and age, the same patterns of explanatory factors were observed for the two age groups. Nearly one-half of the excess risk of CKD among African-American adults can be explained on the basis of potentially modifiable risk factors; however, much of the excess risk remains unexplained.

Since the late 1970s, the incidence of end-stage renal disease (ESRD) has increased at a fourfold higher rate among African-American individuals, compared with white individuals (1). Suggested explanations for this racial disparity include lower socioeconomic status among African Americans (2–6), higher prevalence and greater severity of diabetes mellitus and hypertension among African Americans (7–11), and increased inherited susceptibility of African Americans to kidney damage (12–14). In the long term, identification of susceptibility genes might lead to the development of more preventive measures for African-American and white subjects; however, it is important to identify risk factors for African Americans that can be modified with current approaches. One set of potentially modifiable factors is represented by socioeconomic status, which is an indirect marker of suboptimal health behaviors, inadequate access to health care, and possible adverse environmental exposures (15–18). Another set of potentially modifiable factors includes complex traits such as BP and glycemic status, which are modifiable with behavior modification and pharmacotherapy.

Previous studies that sought to explain the African-American/white differences in chronic kidney disease (CKD) rates demonstrated several limitations. Some studies used case-control study designs, which limit causal inferences (4), or relied on ecologic exposure data for information that was not available at the individual level (3,7,19–21). Other studies either used study populations that were not typical of the United States (3,11,22–24) or relied on intermediate markers of kidney disease as outcomes (6). With these considerations in mind, we conducted a population-based, prospective study to determine how much of the excess risk of CKD among African Ameri-

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cans could be explained on the basis of racial disparities in potentially modifiable risk factors.

Materials and Methods

Study Design and Sample

This study was a national, nonconcurrent, population-based, cohort study, in which we analyzed how baseline risk factors in the Second National Health and Nutrition Examination Survey (NHANES II) were related to CKD in 12 to16 yr of passive follow-up monitoring. NHANES II was a cross-sectional, multistage, probability survey of noninstitutionalized American individuals (age, 6 mo to 74 yr) that was conducted by the National Center for Health Statistics from February 1976 to February 1980 (25,26). Details of the plan, complex sampling design, responses, and data collection procedures were previously described (25). The vital status of examined adults of age 30 to 74 yr was passively determined by matching to the National Death Index and the Social Security Administration Death Master Files, using a previously described algorithm (27). Participants were also linked (on the basis of their full name, race, and date of birth) to the Medicare Registry, to determine whether they had received renal replacement therapy (*i.e.*, dialysis or kidney transplantation).

This analysis included African-American and white subjects who were 30 to 74 yr of age at the time of the baseline evaluation. Of these 9087 individuals, five who were receiving renal replacement therapy (*i.e.*, listed in the Medicare Registry) at the time of the baseline examination were excluded, as were those with missing baseline data on family income (n = 369) or other key variables (n = 155). A similar percentage of those excluded developed CKD, compared with those included in the analysis (2.2% *versus* 1.3%, P = 0.16). After exclusions, 894 African-American and 7664 white adults remained for analysis.

Data Collection

The race of the participants in NHANES II was determined by the interviewers and was classified as "white," "African American," or "other races" (25). Questions regarding participant age, gender, marital status, education, and household income were also asked during the baseline interviews. To judge the resources available to families as a function of their total income, all household incomes (assessed using income categories, to increase the response likelihood) were expressed relative to the federal poverty thresholds for equally sized households. A poverty income ratio of <1.00 is below the federal poverty level ("poor"), a poverty income ratio of 1.00 to 1.99 is at or near the poverty level ("near poor"), and a poverty income ratio of ≥2.00 is 200% above the federal poverty level ("not poor") (28).

Participants were also asked two questions regarding their level of physical activity in leisure and nonleisure activities, *i.e.*, (*1*) whether they were getting "much," "moderate," or "little" exercise for recreation and (*2*) whether in their usual day, aside from recreation, they were "very active," "moderately active," or "quite inactive." Individuals reporting much exercise in recreation and/or a very physically active day were classified as being "very active." Those reporting little recreational exercise and a "quite inactive" daily routine were categorized as being "inactive." All other combinations were considered to be "moderately active." The frequency of beer, wine, and liquor consumption was obtained from a food frequency questionnaire and was categorized as never, seldom (<1 time/wk), weekly (1 to 6 times/wk), or daily (≥1 time/d). Smoking history at baseline was used to classify participants as never, former, or current smokers.

The body mass index was calculated from the measured height (in meters) and weight (in kilograms) and was categorized as not overweight (<25 kg/m^2), overweight (25 to 29.9 kg/m^2), or obese (≥30 kg/m^2) (29). BP was measured twice in the right arm, by using a standard mercury sphygmomanometer, with the subject seated. The mean of the two readings was used for analysis. Persons were considered hypertensive if they demonstrated a systolic BP of ≥140 mmHg or a diastolic BP of ≥90 mmHg or if they reported being told by a doctor that they had hypertension. Persons who responded affirmatively to the question, "Has a doctor ever told you that you had diabetes?" were classified as having diabetes mellitus. A history of cardiovascular disease (CVD) was defined on the basis of a self-report of previous heart failure, heart attack, or stroke.

Total serum cholesterol levels were measured according to the protocol described for the Lipid Research Clinics Program (30). Serum creatinine determinations were performed by using the Jaffe reaction, and GFR were estimated by using the Cockcroft-Gault creatinine clearance equation (31). Because the nonresponse rate for serum creatinine levels was 28%, these measurements were considered only in subsidiary analyses (25).

Ascertainment of Outcomes

Incident all-cause CKD was defined as either treatment for ESRD or death related to kidney disease. Treated ESRD cases from February 1976 through December 31, 1992, were ascertained from the Medicare ESRD Registry, by matching participants in NHANES II on the basis of their full name, birth date, gender, and race. Those who were matched to the registry perfectly or nearly perfectly with respect to all of the matching factors were classified as definite matches (n = 33), whereas those with slight differences with respect to any of the matching factors were classified as probable matches (n = 4). All those who did not match in multiple fields or who did not match with respect to race alone were classified as possible or poor matches (n = 46). In our analyses, only definite and probable matches were counted as treated ESRD events.

Kidney-related deaths were identified through 1992 in the NHANES II Mortality Study. Deaths were ascertained by using the National Death Index and the Social Security Administration Death Master Files. Decedents who were not listed in the Medicare ESRD Registry but for whom any of the following kidney-related *International Classification of Diseases* (9th Revision) codes designated the underlying or contributing cause of death were also counted as CKD events: 250.4 (diabetes mellitus with nephropathy), 274.1 (gouty nephropathy), 275.4 (nephrocalcinosis), 403 (hypertensive renal disease), 404 (hypertensive heart and renal disease), 580 to 589 (nephritis, nephrotic syndrome, or nephrosis), or 593.9 (renal disease not otherwise specified). This broad definition was used to include individuals who received Medicare-funded renal replacement therapy, those who might have received it before being enrolled in Medicare, and those who might have chosen not to initiate therapy.

Analyses

All statistical analyses accounted for the complex survey design, providing nationally representative estimates. By using weighted Poisson models in Stata 6.0 (32) and the age distribution of the entire NHANES II cohort, directly age-adjusted CKD incidence rates were calculated per 100,000 person-yr of risk. Cumulative lifetime CKD incidence rates were estimated by using a weighted life-table method, and the cumulative risks of the two race groups were compared by using log-rank tests. Baseline variables were grouped as (*1*) sociodemographic factors, including poverty status, educational attainment, and marital status; (*2*), lifestyle factors, including smoking status, physical activity, alcohol use, and body mass index; and (*3*) clinical

factors, including diabetes mellitus, hypertension, cardiovascular diseases, systolic BP, and serum cholesterol levels. To assess relative differences in CKD incidence rates for African Americans, compared with whites, we conducted a series of five Cox proportional-hazards model analyses with Sudaan 7.5 (33), adjusting for (*1*) age (continuously) and gender; (*2*) age, gender, and sociodemographic factors; (*3*) age, gender, and lifestyle factors; (*4*) age, gender, and clinical factors; and (*5*) all of the aforementioned variables simultaneously. The percentage of excess risk of CKD for African Americans that was explained by a set of risk factors was calculated by using the formula

$$\% \text{ excess risk} = \frac{RR_1 - RR_2}{RR_1 - 1}$$

where RR_1 is the relative risk (RR) of CKD for African Americans *versus* whites adjusted only for age and gender and RR_2 is the RR adjusted for age, gender, and the set of risk factors (34,35).

To test the robustness of the associations, three subsidiary analyses were performed. We first excluded individuals who developed CKD within the first 5 yr of follow-up monitoring, to determine whether the same associations between race and CKD were present. Next, we analyzed the subpopulation with serum creatinine measurements, adjusting for GFR. Finally, we limited the outcome to treated ESRD only. Because analyses performed with treated ESRD as the outcome yielded mostly similar results (data not shown), only analyses with the combined end point of CKD (defined as either treated ESRD or death related to kidney disease) are presented.

Results

Baseline Characteristics of the Cohort

Sociodemographic and clinical characteristics of the 8558 adults who were included in the analysis are presented in Table 1. Compared with white subjects, African-American adults were more likely to have less education, live below the federal poverty level, and be unmarried. They were also more likely to be current cigarette smokers, to be more obese, to be physically inactive, and to drink less alcohol than their white counterparts. In addition, African-American adults demonstrated higher prevalences of diabetes mellitus and hypertension than did white subjects, as well as higher mean systolic BP values and GFR.

Table 1. Baseline characteristics of 8558 adults of age 30 to 74 yr, in NHANES II, according to race[a]

Characteristic	African American (n = 894)	White (n = 7664)
Age (yr)[b]	48.2 ± 0.5	49.3 ± 0.3
Male (%)	45.1	47.4
Sociodemographic		
education (%)[c]		
1 to 8th grade	31.1	17.3
9 to 12th grade	52.4	51.9
college or more	16.5	30.8
poverty status (%)[c]		
poor	26.9	8.3
near poor	33.2	22.4
not poor	39.9	69.4
marital status (%)[c]		
never married	7.4	4.6
no longer married	34.0	15.9
currently married	58.6	79.5
Lifestyle		
smoking status (%)[d]		
never smoked	40.8	37.9
former smoker	19.2	26.6
current smoker	40.0	35.4
physical activity (%)[d]		
inactive	13.0	9.9
moderately active	56.2	62.6
highly active	30.7	27.6
alcohol use (%)[d]		
0	43.8	36.4
<1/wk	16.6	20.8
1 to 6/wk	28.4	27.9
≥1/d	11.2	14.9
obesity (%)[c]		
thin to normal (<25 kg/m^2)	36.9	49.2
overweight (25 to 29.9 kg/m^2)	36.1	35.2
obese (≥30 kg/m^2)	27.0	15.6
Clinical		
Hypertension (%)[c]	59.5	47.0
Diabetes mellitus (%)[c]	7.0	4.0
History of CVD (%)[c]	6.5	6.1
Systolic BP (mmHg)[b,c]	133.0 ± 0.9	129.0 ± 0.6
Serum cholesterol level (mg/dl)[b]	219.9 ± 3.1	223.4 ± 1.1
GFR (ml/min)[b,c,e]	90.8 ± 1.7	87.8 ± 0.8

[a] NHANES II, Second National Health and Nutrition Examination Survey; CVD, cardiovascular disease.
[b] Mean ± SEM.
[c] $P < 0.01$; all comparisons compare African Americans with whites.
[d] $P < 0.05$.
[e] Serum creatinine measurements were available for 6005 adults. GFR was calculated by using the Cockcroft-Gault equation.

Incident CKD

With a median follow-up period of 14 yr, we identified 172 cases of CKD. Of these, 37 patients entered the Medicare ESRD Registry and 135 died without receiving Medicare-funded renal replacement therapy. The age-adjusted incidences of all-cause CKD and treated ESRD were 2.7- and 8.9-fold higher, respectively, among African-American adults, compared with white adults (Table 2). Moreover, the age-adjusted incidence of kidney disease attributable to diabetes mellitus or hypertension was almost 12 times higher among African-American adults, compared with whites. Figure 1 presents the cumulative lifetime incidences of CKD for African Americans *versus* whites. African Americans demonstrated a higher cumulative risk of CKD for every age after 45 yr, compared with whites. By age 80 yr, African Americans who had not died as a result of other causes demonstrated a 9.4% cumulative risk of developing CKD, compared with 3.8% among whites ($P < 0.001$).

Explanatory Factors for Excess Risk

To determine how much of the excess risk of CKD among African-American adults was related to potentially modifiable factors, a series of multivariate proportional-hazard analyses were performed. The base model, adjusted for age and gender only, revealed that African Americans were more than two times more likely than whites to develop CKD [RR = 2.69; 95% confidence interval (CI), 1.55 to 4.51]. Further adjustment for sociodemographic variables reduced the RR to 2.49, corresponding to an 11.8% reduction in the excess risk of African

Table 2. Incident CKD among African-American and white adults of age 30 to 74 yr, in NHANES II[a]

Outcome	African Americans (n = 894)		Whites (n = 7664)	
	No. of Events	Incidence Rates (per 100,000 person-yr)[b]	No. of Events	Incidence Rates (per 100,000 person-yr)[b]
Treated ESRD[c]	12	97	25	11
Diabetic or hypertensive CKD[d]	13	83	28	7
All-cause CKD[e]	33	222	139	84

[a] CKD, chronic kidney disease, defined as receipt of renal replacement therapy or death with kidney disease; ESRD, end-stage renal disease.

[b] Weighted and age-adjusted using the direct method, with the NHANES II African-American and white populations combined as the standard.

[c] Entry into the Medicare ESRD registry.

[d] Entry into the Medicare ESRD registry with renal disease attributed to hypertension or diabetes mellitus or death resulting from hypertensive or diabetic renal disease.

[e] Entry into the Medicare ESRD registry or kidney-related death.

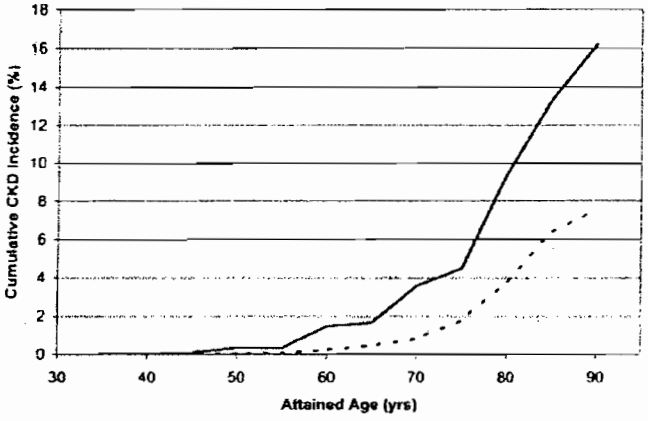

Figure 1. Cumulative incidence of chronic kidney disease (CKD), according to race and attained age, in the Second National Health and Nutrition Examination Survey (NHANES II), 1976 to 1992. Results are weighted to the general United States population. Solid line, African Americans; dashed line, whites. The cumulative incidence of CKD among African Americans was significantly higher than that among whites (log-rank test, $P < 0.001$).

Table 3. Excess risk of CKD among African Americans *versus* whites in relation to potentially modifiable risk factors[a]

Adjusted for	RR for African Americans (*versus* Whites)	Excess Risk Explained (%)[b]
Age and gender only	2.69 (1.50 to 4.82)	
Sociodemographic factors[c]	2.49 (1.33 to 4.67)	11.8
Lifestyle factors[d]	2.29 (1.31 to 4.01)	23.7
Clinical factors[e]	2.15 (1.18 to 3.92)	32.0
All risk groups[f]	1.95 (1.05 to 3.63)	43.8

[a] RR, relative risk. Values in parentheses are 95% confidence intervals. All models were adjusted for age and gender.

[b] Calculated using the formula $(RR_{age, gender} - RR_{age, gender, factor})/(RR_{age, gender} - 1)$.

[c] Sociodemographic factors include poverty status, education, and marital status.

[d] Lifestyle factors include smoking status, body mass index, alcohol use, and physical activity.

[e] Clinical factors include diabetes mellitus, hypertension, systolic BP, cardiovascular disease history, and serum cholesterol levels.

[f] Adjusted for lifestyle, clinical, and sociodemographic variables.

Americans developing CKD (Table 3). The addition of lifestyle variables to the base model reduced the excess risk by 23.7%, whereas the addition of clinical factors to the base model substantially reduced it by 32.0% (Table 3). In fact, simply adjusting for diabetes mellitus and hypertension in the base model reduced the excess risk by 35.3% (data not shown). Simultaneously controlling for all variables yielded a 43.8% reduction in the excess risk and attenuated the RR of CKD among African Americans; however, the excess risk remained statistically significant (RR = 1.95; 95% CI, 1.05 to 3.63).

Effect Modification by Age

Testing for possible interactions between race and other variables revealed age to be a significant modifier of the association between race and CKD ($P = 0.04$). African-American adults of age 30 to 59 yr at baseline demonstrated a 5.4-fold higher risk of CKD, compared with whites of similar ages, whereas those of age 60 to 74 yr at baseline exhibited a RR of 1.61 (95% CI, 1.04 to 2.49), after adjustment for age and gender (Figure 2). Compared with the overall population, adjustment for lifestyle or clinical factors explained similar proportions of the excess risk among African-American adults of age 30 to 59 yr or 60 to 74 yr. In contrast, sociodemographic factors attenuated the risk among African Americans of age 60 to 74 yr by 37.7% but did not account for any excess risk of CKD among African Americans of age 30 to 59 yr. Adjustment for lifestyle and clinical factors alone explained similar percentages of the excess risk of CKD among African Americans of age 30 to 59 yr and those of age 60 to 74 yr (40.9% *versus* 50.8%). Simultaneous adjustment for sociodemographic, lifestyle, and clinical factors decreased the RR among African

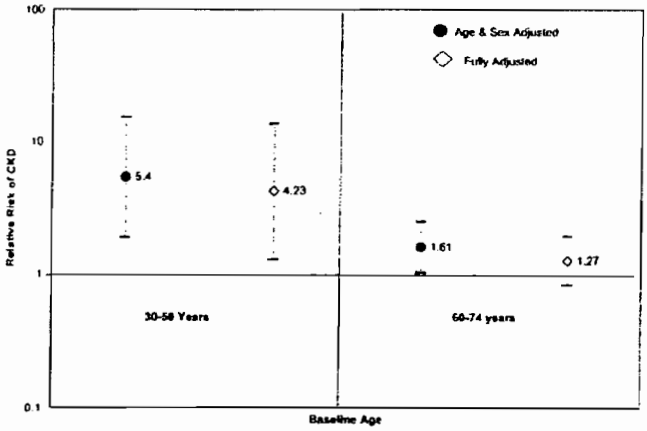

Figure 2. Adjusted relative hazard of CKD for African-American *versus* white adults in NHANES II, stratified according to age at baseline. All comparisons are African Americans *versus* whites. The fully adjusted model included age, gender, diabetes mellitus, hypertension, history of cardiovascular disease, serum cholesterol levels, smoking, poverty status, education, marital status, obesity, and alcohol use.

Americans in both age groups (Figure 2), with the racial disparity in CKD risk remaining statistically significant for the younger age group (RR = 4.23; 95% CI, 1.30 to 13.74).

Subsidiary Analyses

Further analyses of the entire cohort were performed by excluding individuals with <5 yr of follow-up monitoring, to assess the effects of early events on the observed associations between race and CKD. In these analyses, an almost identical attenuation of the excess risk among African Americans was observed after adjustment for all risk factors (39%). Finally, analyses limited to those without missing serum creatinine and urinalysis measurements, with adjustment for GFR, yielded similar patterns of percentages of excess risk explained by given sets of modifiable factors (as listed in Table 3), with the estimated risks explained being slightly higher (*i.e.*, 35% sociodemographic, 12% lifestyle, 35% clinical, and 51% all factors).

Discussion

Our results confirm that African-American adults in the United States develop CKD at rates far exceeding those for white adults, particularly during middle age. Much of the racial disparity in CKD in the United States is explained by potentially modifiable factors such as diabetes mellitus and hypertension. However, most of the excess risk of CKD experiences by African Americans remains unexplained by traditionally measured risk factors. Strengths of this study that lend weight to these conclusions include a nationally representative, population-based cohort, with comprehensive, individual-level, exposure measurements obtained before the development of CKD, and virtually complete outcome ascertainment.

Results of this study are consistent with previous findings of a higher risk of CKD among African Americans. Since 1977, when Easterling first documented a 3.8-fold higher risk of CKD among African Americans *versus* whites, using the Michigan ESRD registry, there have been many studies focusing on African-American/white differences in CKD (2–11,19,23). All of those studies have documented an excess risk for African Americans, compared with whites, with estimates of the association ranging from 1.9 to 7.4. Most of those studies have been limited by reliance on data from the United States Renal Data System or other ESRD registries, which lack information on potential explanatory factors (5,7,9,10,19,36–39).

Four prospective studies used geographically aggregated measures of exposure as indirect estimates of individual-level measures (2,3,8,11). For example, Whittle *et al.* (8) used prevalence estimates of explanatory factors (such as hypertension and diabetes mellitus) obtained from a regional survey to examine the racial differences in CKD risk. They observed that adjustment for age, prevalence and severity of hypertension, diabetes mellitus, and level of education in the population reduced the risk of hypertensive ESRD in African-American areas, but the racial association remained strong and statistically significant.

Although they had individual measurements of chronic medical conditions and behaviors at baseline, Brancati *et al.* (11) and Klag *et al.* (3) lacked individual measurements of income for Multiple Risk Factor Intervention Trial screenees, which hindered accurate quantification of the effects of socioeconomic factors on the individual risk of kidney disease. Nevertheless, those groups both concluded that higher BP, lower income, and higher prevalence of diabetes mellitus and hypertension among African-American adults explained some of the racial differences in CKD risk, with a significant amount remaining unexplained.

Like Rostand *et al.* (36) and Lopes *et al.* (20,37,38), we observed that racial differences in CKD risk were modified by age, with middle-age adults (30 to 59 yr) exhibiting a greater racial disparity than older adults (60 to 74 yr). The reasons for this age interaction are unclear; however, previous authors have speculated regarding accelerated kidney damage attributable to poorer control of BP, lower potassium intake, sustained higher levels of psychologic stress, and underdeveloped kidneys (38).

In our study, the large residual excess risk observed could possibly be explained on the basis of suboptimal measurement of exposures in NHANES II. In particular, factors such as BP were measured on only one occasion, which could result in an underestimation of the strength of the attenuation between race and CKD. Additionally, better characterization of potentially modifiable risk factors such as diabetes mellitus (*e.g.*, using hemoglobin A-1c levels) might have yielded greater reductions in the excess risk. By grossly assessing socioeconomic status (using education and poverty levels), we might have inadequately adjusted for the local environment or access to and quality of health care. It is possible that these factors in combination could account for all of the residual excess risk among African Americans.

Another potential explanation for the unexplained excess risk among African Americans might be unmeasured environmental, behavioral, sociocultural, or developmental factors that were beyond the scope of NHANES II data. Literature reports suggest that undernutrition in fetal life imparts a higher risk of CKD in adulthood (40,41). Because African Americans exhibit much higher rates of low birth weights, compared with whites (42), and low birth weights are associated with kidney underdevelopment, the low birth weight theory has been advanced to help explain the racial differences in CKD rates (13). Additionally, African Americans are more likely to be exposed to occupational and environmental toxins such as lead (43), to experience viral infections (44), and to have less access to preventive medical care, as well as being referred to treatment for CKD late in the course of their disease (45). Enhanced susceptibility of African-American kidneys to injury resulting from hypertension (46,47) and racial differences in renal vascular hemodynamics (48,49) have also been cited as explanations for the racial disparity in CKD risk.

In addition to previously mentioned limitations related to the assessment of exposures, other limitations deserve comment. First, because NHANES II was restricted to the noninstitutionalized population, the absolute risks of kidney disease among whites and especially African Americans were likely underestimated (15,50,51). Second, the NHANES II Mortality Study determined vital status only for adults of age 30 to 74 yr at baseline, limiting inferences to the middle-age United States population. Third, race was determined not by self-report but by interviewer assessment, leading to potential misclassification of African Americans, Hispanics, and Native Americans as whites. A number of studies have demonstrated discrepancies between the interviewer-observed race and the self-reported race, with approximately 6% of persons self-identifying as African American being classified as white (52,53). Fourth, renal function was not assessed at baseline times for all participants. Therefore, we could not completely establish whether renal insufficiency was already present in some of the subjects who later developed CKD.

Finally, the use of passive follow-up techniques without social security numbers to determine vital status and treatment for ESRD might have led to some misclassification of outcomes. Previous studies that evaluated the effectiveness of the National Death Index and the Social Security Administration Death Master Files suggested that underascertainment of vital status occurs more commonly for African Americans than for whites (27,54,55), whereas other work proposed that there is no racial difference in ascertainment (56). Additionally, whites are more likely to have multiple causes of death coded on their death certificates (57), which could increase the ascertainment of CKD events for whites while underestimating the number for African Americans. Because the majority of our events were deaths related to kidney disease, this differential ascertainment could significantly affect our results. In addition to deaths, only individuals treated through the Medicare program were included in our analyses. Therefore, possible racial differences in enrollment in Medicare *versus* private insurance could affect our findings. We might have underestimated the true racial disparity in CKD by relying on these methods. Lastly, our use of CKD attributable to any cause as the primary outcome instead of cause-specific CKD reduced the possibility of misclassification bias, which is known to be influenced by race (58,59).

In light of the exorbitant costs, to individuals and to society, of treatment for CKD, the identification of modifiable risk factors for CKD is an important public health priority, as indicated in Healthy People 2010. Our results suggest that interventions aimed at reducing the racial disparity in CKD risk should focus on primary prevention and improved treatment of diabetes mellitus and hypertension, lifestyle modification, and elimination of health disparities attributable to socioeconomic status. Our data further suggest that the benefits of these improvements might be greatest for middle-age adults. Further prospective studies are needed to identify novel environmental, developmental, and genetic causes of the large African-American/white disparity in the incidence of CKD.

Acknowledgments

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

Alternatives

The Applicants considered two options prior to determining to establish a 16-station dialysis facility. The options considered are as follows:

1. Utilize Existing Facilities.

2. Establish a new facility.

After exploring these options, which are discussed in more detail below, the Applicants determined to establish a 16-station dialysis facility. A review of each of the options considered and the reasons they were rejected follows.

Utilize Existing Facilities

Based upon the latest inventory data, there is a need for 40 dialysis stations in HSA 7. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in operation for more than a year in the GSA is 81%, which is above the State standard. This is not surprising given the immense size of the facility's proposed medical director's practice. Dr. Pallath's practice, J.R. Nephrology & Associates, P.C. is treating 791 Stage 3, 4 and 5 CKD patients. Nearly all of these patients reside within 30 minutes normal travel time of the proposed facility. In fact, approximately 137 Stage 4 and 5 CKD patients reside within 20 minutes of the proposed facility. See Attachment – 13A. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, Dr. Pallath anticipates that approximately 87 of these patients will initiate dialysis at the proposed facility within 12 to 24 months following project completion.

This facility is necessary to provide sufficient access to care for these CKD patients. Dr. Pallath's practice is currently treating ESRD patients at Stoney Creek Dialysis, West Lawn Dialysis, and Beverly Dialysis, which are collectively operating at 94% utilization. As a result, without operating a fourth shift, these facilities cannot accommodate Dr. Pallath's already large, and growing, patient-base. This, coupled with high utilization in the service area, supports the need for a new 16-station facility.

The establishment of a 16-station dialysis facility will improve access to necessary dialysis treatment for those individuals in the Chicago Ridge community who suffer from ESRD. ESRD patients are typically chronically ill individuals and adequate access to dialysis services is essential to their well-being.

Further, the proposed project will improve access to dialysis services for the community at large by adding a much needed dialysis facility to the Chicago Ridge community. Importantly, approximately 55% of this community is either African American or Hispanic. African Americans and Hispanics are at an increased risk of ESRD compared to the general population due to the higher prevalence of diabetes and hypertension, the two leading causes of CKD and ESRD, in their communities. In fact, the ESRD incident rate among the Hispanic population is 1.5 times greater than the non-Hispanic population, and the ESRD incident rate among African Americans is 3.6 times greater than the non-Hispanic white population. As such, demand in the community will continue to increase.

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

There is no capital cost with this alternative.

Establish a New Facility

Based upon current utilization of the existing facilities and the projected number of CKD patients that will require in-center hemodialysis within the next 12 to 24 months following project completion, the only feasible option is to establish a 16-station in-center hemodialysis facility. This alternative will ensure residents of the Chicago Ridge community and the surrounding area have continued access to life sustaining dialysis treatment.

The cost of this alternative is $3,361,634.

Sreya Pallath, M.D.
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

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

Dear Vice Chairman Hayes:

I am pleased to support DaVita's establishment of Chicago Ridge Dialysis. The proposed 16-station chronic renal dialysis facility, to be located at 10511 South Harlem Avenue, Worth, Illinois 60482 will directly benefit my patients.

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

The site of the proposed facility is close to Interstate 294 (I-294) and will provide better access to patients residing in the south and southwest suburbs, as well as the far southwest area of the city of Chicago. Utilization of facilities in operation for more than a year within the 30 minute Geographic Service Area of the proposed facility was 79.0%, according to March 31, 2013 reported census data.

I have identified 137 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Conservatively, I predict at least 87 of these patients will progress to dialysis within the next 12 to 24 months. My large patient base, the significant utilization at nearby facilities, and the present 40-station need identified in Health Service Area 7 demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 3 ½ years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past year and a half is provided at Attachment – 2. The list of zip codes for the 137 pre-ESRD patients previously referenced is provided at Attachment – 3.

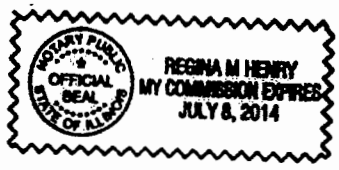
These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

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

Sincerely,

Sreya Pallath, M.D.
Nephrologist
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Subscribed and sworn to me
This 1st day of August, 2013



Notary Public: Regina M Henry

Attachment 1
Historical Patient Utilization

Stony Creek Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RA	60453	RA	60453	RA	60453	RA	60453
JA	60805	JA	60805	EA	60459	EA	60459
EA	60805	EA	60459	JA	60638	JA	60638
MA	60465	JA	60638	RB	60803	RB	60803
EA	60459	RB	60803	FB	60632	FB	60632
HB	60805	GB	60644	GB	60644	GB	60644
RB	60803	EC	60617	JC	60453	JC	60453
EC	60617	DD	60406	EC	60617	EC	60617
JC	60803	AA	60459	DD	60406	WD	60456
DC	60459	LB	60415	WD	60456	JB	60652
DD	60406	JB	60652	AA	60459	CB	60629
AA	60459	CB	60629	JB	60652	IB	60620
HA	60453	IB	60620	CB	60629	AB	60406
JB	60652	AB	60406	IB	60620	MC	60629
AB	60453	CB	46307	AB	60406	JD	60652
CB	60629	MC	60629	MC	60629	CD	60628
IB	60620	WC	60453	WC	60453	WD	60636
JB	60628	FC	60620	FC	60620	DD	60652
AB	60406	EC	60453	MD	60453	ZE	60629
LC	89107	MD	60453	JD	60652	JF	60457
MC	60629	JD	60652	CD	60628	PG	60629
JC	60803	CD	60628	DD	60406	EG	60482
WC	60453	DD	60406	WD	60636	RG	60632
DC	60459	WD	60636	BD	60463	BG	60453
FC	60620	DD	60652	DD	60652	RG	60620
EC	60453	ZE	60629	ZE	60629	JH	60620
JD	60652	NF	60629	DF	60459	LH	60453
LD	60803	OF	60638	JF	60457	RI	60652
MD	60638	DF	60459	PG	60629	JJ	60453
CD	60628	PG	60629	EG	60482	AJ	60652
DD	60406	LG	60487	RG	60632	JJ	60629
WD	60636	RG	60632	BG	60453	RK	60459
DD	60652	SG	60803	SG	60803	WK	60638
ZE	60629	RG	60465	VG	60453	HL	60453
OF	60638	VG	60453	RG	60620	GM	60453
DF	60459	JH	60620	JH	60620	FM	60457
PG	60629	WH	60453	JH	46405	YM	60632
LG	60652	SH	60620	SH	60620	DN	60453
LG	60487	LH	60453	LH	60453	EN	60455
RG	60632	RJ	60629	RI	60652	PO	60453

Stony Creek Dialysis, CONTINUED							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
VG	60453	JJ	60453	RJ	60629	KP	60456
MG	60453	AJ	60652	JJ	60453	SP	60455
MG	60652	JJ	60629	AJ	60652	AP	60455
JH	60620	RJ	60803	JJ	60629	GR	60459
WH	60453	EK	60453	RJ	60803	MR	60465
SH	60620	RK	60459	EK	60453	RS	60629
LH	60453	WK	60638	RK	60459	BS	60652
JJ	60453	DM	60459	AK	60465	AS	60456
JJ	60652	GM	60453	WK	60638	LS	60805
JJ	60629	FM	60457	HL	60453	RS	60491
RJ	60803	AM	60638	GM	60453	WS	60453
EK	60453	DM	60805	FM	60457	DT	60638
RK	60459	DN	60453	YM	60632	GV	60459
WK	60638	EN	60455	DM	60805	LW	60652
RK	60638	JN	60453	RM	60805	JW	60415
PL	60455	JO	60453	MM	60453	GW	60609
IL	60457	PO	60453	DN	60453	WW	60620
RL	60629	KP	60456	EN	60455	EW	60453
DM	60459	BP	60453	JO	60453	DW	60458
CM	60638	AP	60455	PO	60453	WY	60453
GM	60453	JR	60453	KP	60456	JZ	60459
KM	60636	RS	60629	SP	60455	JW	60428
LM	60803	BS	60652	AP	60455	IO	60453
FM	60457	AS	60456	GR	60459	MT	60652
DM	60805	ES	60629	JR	60453	GW	60620
HM	60463	LS	60805	MR	60465	MR	60619
JN	60459	RS	60491	RS	60629	JC	60458
DN	60453	WS	60453	BS	60652	DF	60655
JO	60643	GV	60459	AS	60456	MM	60459
JO	60453	RV	60453	SS	60453	AM	60455
JP	60453	LW	60652	CS	60453	MK	60453
BP	60453	JW	60415	LS	60805		
AP	60455	GW	60609	RS	60491		
JR	60453	WW	60620	WS	60453		
BS	60652	JW	60629	DT	60638		
AS	60456	MW	60085	GV	60459		
ES	60629	EW	60453	RV	60453		
LS	60805	DW	60458	LW	60652		
RS	60491	HY	60453	JW	60415		
WS	60453	JZ	60459	GW	60609		
MV	60403	KZ	60445	WW	60620		
RV	60453			EW	60453		
LW	60652			DW	60458		
GW	60609			WY	60453		

Stony Creek Dialysis, CONTINUED					
2010		2011	2012		2013 YTD 6/30
Initials	Zip Code		Initials	Zip Code	
JW	60453		JZ	60459	
WW	60620				
DW	60458				
HY	60453				
JZ	60459				
KZ	60445				

Beverly Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
LF	60628	LF	60628	RM	60620	SG	60629
OJ	60609	RM	60620	SG	60629	EC	60620
RM	60620	SG	60629	EC	60620	WG	60652
SG	60629	EC	60620	WG	60652	EH	60619
EC	60620	WG	60652	EH	60619	MH	60609
WG	60652	EH	60619	MH	60609	BH	60620
EH	60619	MH	60609	BH	60620	AJ	60620
MH	60609	BH	60620	AJ	60620	DR	60620
BH	60620	AJ	60620	DR	60620	AS	60620
AJ	60620	DR	60620	AS	60620	AF	60619
DR	60620	AS	60620	AF	60619	BA	60620
AS	60620	AF	60619	BA	60620	AB	60620
RB	60803	AH	60629	AB	60620	BG	60620
SC	60465	JM	60619	BG	60620	DG	60478
MC	60629	RR	60629	DG	60478	SM	60629
AF	60619	WS	60620	BG	60652	KM	60636
WG	60643	BA	60620	SM	60629	CR	60620
AH	60629	AB	60620	KM	60636	BT	60620
CL	60628	BG	60620	CR	60620	IW	60628
SM	60617	DG	60478	BT	60620	AB	60628
JM	60619	BG	60652	IW	60628	TB	60620
LM	60803	SM	60629	SA	60636	GC	60629
RR	60629	KM	60636	AB	60628	RJ	60620
GS	60617	CR	60620	TB	60620	SJ	60628
WS	60620	BT	60620	GC	60629	KP	60620
BA	60620	IW	60628	RJ	60620	ST	60620
AB	60620	SA	60636	SJ	60628	VB	60636
BG	60620	AB	60628	KP	60620	WK	60620
DG	60478	TB	60620	MR	60619	RL	60619
BG	60652	JC	60629	JS	60628	CM	60620
SM	60629	GC	60629	GS	60636	LN	60620
KM	60636	GH	60629	ST	60620	FP	60620
CR	60620	KH	60652	BD	60621	RP	60652
BT	60620	MJ	60619	VB	60636	GR	60643
IW	60628	RJ	60620	WK	60620	MR	60610
AH	60608	SJ	60628	RL	60619	ER	60628
BA	60649	WK	60628	CM	60620	JT	60620
EH	60629	WK	60629	LN	60620	WT	60620
AK	60617	ML	60652	FP	60620	RT	60629
DR	60620	LM	60803	RP	60652	CT	60620
		RN	60628	GR	60643	AW	60458
		PN	60643	MR	60610	TC	60652

Beverly Dialysis, CONTINUED						
2010	2011		2012		2013 YTD 6/30	
	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
	KP	60620	ER	60628	LG	60629
	CR	60643	RS	60620	AJ	60652
	LR	60628	LS	60805	SJ	60636
	MR	60619	JT	60620	MK	60453
	JS	60628	WT	60620	HM	60617
	GS	60636	RT	60629	LS	60620
	ST	60620	CT	60620	BT	60620
	MT	60652	AW	60458	BA	60649
	LW	60620	BA	60649	EH	60629
	BA	60649	EH	60629	AK	60617
	EH	60629	AK	60617	DR	60620
	AK	60617	DR	60620		
	DR	60620				

West Lawn Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
N/A	N/A	FB	60636	FB	60636	FB	60636
		EC	60637	EC	60637	EC	60637
		MG	60632	MG	60632	MG	60632
		RJ	60629	RJ	60629	RJ	60629
		MJ	60620	MJ	60620	MJ	60620
		WK	60629	WK	60629	WK	60629
		EM	60652	EM	60652	EM	60652
		MR	60652	MR	60652	MR	60652
		IS	60629	IS	60629	IS	60629
				MA	60629	MA	60629
				AB	60629	AB	60629
				AB	60629	AB	60629
				DB	60621	DB	60621
				MR	60632	MR	60632
				BD	60629	BD	60629
				MD	60501	MD	60501
				PF	60629	PF	60629
				GH	60629	GH	60629
				HJ	60636	HJ	60636
				MJ	60629	MJ	60629
				EN	60632	EN	60632
				RO	60632	RO	60632
				HR	60501	HR	60501
				MR	60632	MR	60632
				AR	60629	AR	60629
				NR	60652	NR	60652
				MT	60652	MT	60652
				CV	60629	CV	60629
				BZ	60629	BZ	60629
						JA	60638
						SA	60629
						JB	60629
						UC	60632
						ZC	60652
						BF	60629
						GG	60632
						HG	60629
						BG	60632
						JH	60629
						KH	60629
						AM	60453
						MM	60805

West Lawn Dialysis, CONTINUED				
2010	2011	2012	2013 YTD 6/30	
			Initials	Zip Code
			LM	60632
			JM	60629
			SP	60619
			CP	60620
			SR	60652

Attachment 2
New Patients

Stony Creek Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
FB	60632	JW	60428
BZ	60629	IO	60453
WD	60456	MT	60652
BD	60463	GW	60620
JF	60457	MR	60619
EG	60482	JC	60458
JC	60453	DF	60655
BG	60453	MM	60459
RG	60620	AM	60455
RJ	60652	MK	60453
EK	60453		
AK	60465		
MM	60457		
RM	60805		
MM	60453		
SP	60455		
GR	60459		
SS	60453		
CS	60453		
HL	60411		
WY	60453		
HL	60453		
YM	60632		

Beverly Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
BD	60621	TC	60652
VB	60636	LG	60629
WK	60620	AJ	60652
RL	60619	SJ	60636
CM	60620	MK	60453
LN	60620	HM	60617
FP	60620	LS	60620
RP	60652	BT	60620
GR	60643		
MR	60610		
ER	60628		
CT	60620		
AW	60458		

West Lawn Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
MA	60629	JA	60638
AB	60629	SA	60629
AB	60629	JB	60629
DB	60621	UC	60632
MR	60632	ZC	60652
BD	60629	BF	60629
MD	60501	GG	60632
PF	60629	HG	60629
GH	60629	BG	60632
HJ	60636	JH	60629
MJ	60629	KH	60629
EN	60632	AM	60453
RO	60632	MM	60805
HR	60501	LM	60632
MR	60632	JM	60629
AR	60629	SP	60619
NR	60652	CP	60620
MT	60652	SR	60652
CV	60629		
BZ	60629		

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60406	1
60415	2
60445	5
60452	2
60453	24
60455	9
60456	2
60457	4
60458	2
60459	6
60462	4
60463	5
60464	3
60465	4
60472	1
60477	4
60482	5
60501	1
60643	10
60652	15
60655	12
60803	9
60805	7
Total	**137**

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

The Applicants propose to establish a 16-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360-520 gross square feet per dialysis station for a total of 5,760 to 8,320 gross square feet for 16 dialysis stations. The total gross square footage of the proposed dialysis facility is 6,800 gross square feet (or 425 GSF per station). Accordingly, proposed Facility meets the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ESRD	6,800	5,760 – 8,320	0	State Standard Met

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

By the second year of operation, annual utilization at the proposed facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Dr. Pallath is currently treating 137 CKD patients whose condition is advancing to ESRD and who will likely require dialysis within the next 12 to 24 months following project completion. *See* Attachment – 15A. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 87 of these patients will initiate dialysis within 12 to 18 months.

Table 1110.234(b)
Utilization

	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	N/A	13,572	11,981	Yes
Year 2	ESRD	N/A	13,572	11,981	Yes

Sreya Pallath, M.D.
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

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

Dear Vice Chairman Hayes:

I am pleased to support DaVita's establishment of Chicago Ridge Dialysis. The proposed 16-station chronic renal dialysis facility, to be located at 10511 South Harlem Avenue, Worth, Illinois 60482 will directly benefit my patients.

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

The site of the proposed facility is close to Interstate 294 (I-294) and will provide better access to patients residing in the south and southwest suburbs, as well as the far southwest area of the city of Chicago. Utilization of facilities in operation for more than a year within the 30 minute Geographic Service Area of the proposed facility was 79.0%, according to March 31, 2013 reported census data.

I have identified 137 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Conservatively, I predict at least 87 of these patients will progress to dialysis within the next 12 to 24 months. My large patient base, the significant utilization at nearby facilities, and the present 40-station need identified in Health Service Area 7 demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 3 ½ years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past year and a half is provided at Attachment – 2. The list of zip codes for the 137 pre-ESRD patients previously referenced is provided at Attachment – 3.

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

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

Sincerely,

Sreya Pallath, M.D.
Nephrologist
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Subscribed and sworn to me
This 1st day of August, 2013

NOTARY PUBLIC OFFICIAL SEAL STATE OF ILLINOIS
REGINA M HENRY
MY COMMISSION EXPIRES
JULY 8, 2014

Notary Public: Regina M Henry

Attachment 1

Historical Patient Utilization

Stony Creek Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RA	60453	RA	60453	RA	60453	RA	60453
JA	60805	JA	60805	EA	60459	EA	60459
EA	60805	EA	60459	JA	60638	JA	60638
MA	60465	JA	60638	RB	60803	RB	60803
EA	60459	RB	60803	FB	60632	FB	60632
HB	60805	GB	60644	GB	60644	GB	60644
RB	60803	EC	60617	JC	60453	JC	60453
EC	60617	DD	60406	EC	60617	EC	60617
JC	60803	AA	60459	DD	60406	WD	60456
DC	60459	LB	60415	WD	60456	JB	60652
DD	60406	JB	60652	AA	60459	CB	60629
AA	60459	CB	60629	JB	60652	IB	60620
HA	60453	IB	60620	CB	60629	AB	60406
JB	60652	AB	60406	IB	60620	MC	60629
AB	60453	CB	46307	AB	60406	JD	60652
CB	60629	MC	60629	MC	60629	CD	60628
IB	60620	WC	60453	WC	60453	WD	60636
JB	60628	FC	60620	FC	60620	DD	60652
AB	60406	EC	60453	MD	60453	ZE	60629
LC	89107	MD	60453	JD	60652	JF	60457
MC	60629	JD	60652	CD	60628	PG	60629
JC	60803	CD	60628	DD	60406	EG	60482
WC	60453	DD	60406	WD	60636	RG	60632
DC	60459	WD	60636	BD	60463	BG	60453
FC	60620	DD	60652	DD	60652	RG	60620
EC	60453	ZE	60629	ZE	60629	JH	60620
JD	60652	NF	60629	DF	60459	LH	60453
LD	60803	OF	60638	JF	60457	RI	60652
MD	60638	DF	60459	PG	60629	JJ	60453
CD	60628	PG	60629	EG	60482	AJ	60652
DD	60406	LG	60487	RG	60632	JJ	60629
WD	60636	RG	60632	BG	60453	RK	60459
DD	60652	SG	60803	SG	60803	WK	60638
ZE	60629	RG	60465	VG	60453	HL	60453
OF	60638	VG	60453	RG	60620	GM	60453
DF	60459	JH	60620	JH	60620	FM	60457
PG	60629	WH	60453	JH	46405	YM	60632
LG	60652	SH	60620	SH	60620	DN	60453
LG	60487	LH	60453	LH	60453	EN	60455
RG	60632	RJ	60629	RI	60652	PO	60453

Stony Creek Dialysis, CONTINUED							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
VG	60453	JJ	60453	RJ	60629	KP	60456
MG	60453	AJ	60652	JJ	60453	SP	60455
MG	60652	JJ	60629	AJ	60652	AP	60455
JH	60620	RJ	60803	JJ	60629	GR	60459
WH	60453	EK	60453	RJ	60803	MR	60465
SH	60620	RK	60459	EK	60453	RS	60629
LH	60453	WK	60638	RK	60459	BS	60652
JJ	60453	DM	60459	AK	60465	AS	60456
JJ	60652	GM	60453	WK	60638	LS	60805
JJ	60629	FM	60457	HL	60453	RS	60491
RJ	60803	AM	60638	GM	60453	WS	60453
EK	60453	DM	60805	FM	60457	DT	60638
RK	60459	DN	60453	YM	60632	GV	60459
WK	60638	EN	60455	DM	60805	LW	60652
RK	60638	JN	60453	RM	60805	JW	60415
PL	60455	JO	60453	MM	60453	GW	60609
IL	60457	PO	60453	DN	60453	WW	60620
RL	60629	KP	60456	EN	60455	EW	60453
DM	60459	BP	60453	JO	60453	DW	60458
CM	60638	AP	60455	PO	60453	WY	60453
GM	60453	JR	60453	KP	60456	JZ	60459
KM	60636	RS	60629	SP	60455	JW	60428
LM	60803	BS	60652	AP	60455	IO	60453
FM	60457	AS	60456	GR	60459	MT	60652
DM	60805	ES	60629	JR	60453	GW	60620
HM	60463	LS	60805	MR	60465	MR	60619
JN	60459	RS	60491	RS	60629	JC	60458
DN	60453	WS	60453	BS	60652	DF	60655
JO	60643	GV	60459	AS	60456	MM	60459
JO	60453	RV	60453	SS	60453	AM	60455
JP	60453	LW	60652	CS	60453	MK	60453
BP	60453	JW	60415	LS	60805		
AP	60455	GW	60609	RS	60491		
JR	60453	WW	60620	WS	60453		
BS	60652	JW	60629	DT	60638		
AS	60456	MW	60085	GV	60459		
ES	60629	EW	60453	RV	60453		
LS	60805	DW	60458	LW	60652		
RS	60491	HY	60453	JW	60415		
WS	60453	JZ	60459	GW	60609		
MV	60403	KZ	60445	WW	60620		
RV	60453			EW	60453		
LW	60652			DW	60458		
GW	60609			WY	60453		

Stony Creek Dialysis, CONTINUED					
2010		2011	2012		2013 YTD 6/30
Initials	Zip Code		Initials	Zip Code	
JW	60453		JZ	60459	
WW	60620				
DW	60458				
HY	60453				
JZ	60459				
KZ	60445				

Beverly Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
LF	60628	LF	60628	RM	60620	SG	60629
OJ	60609	RM	60620	SG	60629	EC	60620
RM	60620	SG	60629	EC	60620	WG	60652
SG	60629	EC	60620	WG	60652	EH	60619
EC	60620	WG	60652	EH	60619	MH	60609
WG	60652	EH	60619	MH	60609	BH	60620
EH	60619	MH	60609	BH	60620	AJ	60620
MH	60609	BH	60620	AJ	60620	DR	60620
BH	60620	AJ	60620	DR	60620	AS	60620
AJ	60620	DR	60620	AS	60620	AF	60619
DR	60620	AS	60620	AF	60619	BA	60620
AS	60620	AF	60619	BA	60620	AB	60620
RB	60803	AH	60629	AB	60620	BG	60620
SC	60465	JM	60619	BG	60620	DG	60478
MC	60629	RR	60629	DG	60478	SM	60629
AF	60619	WS	60620	BG	60652	KM	60636
WG	60643	BA	60620	SM	60629	CR	60620
AH	60629	AB	60620	KM	60636	BT	60620
CL	60628	BG	60620	CR	60620	IW	60628
SM	60617	DG	60478	BT	60620	AB	60628
JM	60619	BG	60652	IW	60628	TB	60620
LM	60803	SM	60629	SA	60636	GC	60629
RR	60629	KM	60636	AB	60628	RJ	60620
GS	60617	CR	60620	TB	60620	SJ	60628
WS	60620	BT	60620	GC	60629	KP	60620
BA	60620	IW	60628	RJ	60620	ST	60620
AB	60620	SA	60636	SJ	60628	VB	60636
BG	60620	AB	60628	KP	60620	WK	60620
DG	60478	TB	60620	MR	60619	RL	60619
BG	60652	JC	60629	JS	60628	CM	60620
SM	60629	GC	60629	GS	60636	LN	60620
KM	60636	GH	60629	ST	60620	FP	60620
CR	60620	KH	60652	BD	60621	RP	60652
BT	60620	MJ	60619	VB	60636	GR	60643
IW	60628	RJ	60620	WK	60620	MR	60610
AH	60608	SJ	60628	RL	60619	ER	60628
BA	60649	WK	60628	CM	60620	JT	60620
EH	60629	WK	60629	LN	60620	WT	60620
AK	60617	ML	60652	FP	60620	RT	60629
DR	60620	LM	60803	RP	60652	CT	60620
		RN	60628	GR	60643	AW	60458
		PN	60643	MR	60610	TC	60652

Beverly Dialysis, CONTINUED						
2010	2011		2012		2013 YTD 6/30	
	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
	KP	60620	ER	60628	LG	60629
	CR	60643	RS	60620	AJ	60652
	LR	60628	LS	60805	SJ	60636
	MR	60619	JT	60620	MK	60453
	JS	60628	WT	60620	HM	60617
	GS	60636	RT	60629	LS	60620
	ST	60620	CT	60620	BT	60620
	MT	60652	AW	60458	BA	60649
	LW	60620	BA	60649	EH	60629
	BA	60649	EH	60629	AK	60617
	EH	60629	AK	60617	DR	60620
	AK	60617	DR	60620		
	DR	60620				

West Lawn Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
N/A	N/A	FB	60636	FB	60636	FB	60636
		EC	60637	EC	60637	EC	60637
		MG	60632	MG	60632	MG	60632
		RJ	60629	RJ	60629	RJ	60629
		MJ	60620	MJ	60620	MJ	60620
		WK	60629	WK	60629	WK	60629
		EM	60652	EM	60652	EM	60652
		MR	60652	MR	60652	MR	60652
		IS	60629	IS	60629	IS	60629
				MA	60629	MA	60629
				AB	60629	AB	60629
				AB	60629	AB	60629
				DB	60621	DB	60621
				MR	60632	MR	60632
				BD	60629	BD	60629
				MD	60501	MD	60501
				PF	60629	PF	60629
				GH	60629	GH	60629
				HJ	60636	HJ	60636
				MJ	60629	MJ	60629
				EN	60632	EN	60632
				RO	60632	RO	60632
				HR	60501	HR	60501
				MR	60632	MR	60632
				AR	60629	AR	60629
				NR	60652	NR	60652
				MT	60652	MT	60652
				CV	60629	CV	60629
				BZ	60629	BZ	60629
						JA	60638
						SA	60629
						JB	60629
						UC	60632
						ZC	60652
						BF	60629
						GG	60632
						HG	60629
						BG	60632
						JH	60629
						KH	60629
						AM	60453
						MM	60805

West Lawn Dialysis, CONTINUED				
2010	2011	2012	2013 YTD 6/30	
			Initials	Zip Code
			LM	60632
			JM	60629
			SP	60619
			CP	60620
			SR	60652

Attachment 2
New Patients

Stony Creek Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
FB	60632	JW	60428
BZ	60629	IO	60453
WD	60456	MT	60652
BD	60463	GW	60620
JF	60457	MR	60619
EG	60482	JC	60458
JC	60453	DF	60655
BG	60453	MM	60459
RG	60620	AM	60455
RI	60652	MK	60453
EK	60453		
AK	60465		
MM	60457		
RM	60805		
MM	60453		
SP	60455		
GR	60459		
SS	60453		
CS	60453		
HL	60411		
WY	60453		
HL	60453		
YM	60632		

Beverly Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
BD	60621	TC	60652
VB	60636	LG	60629
WK	60620	AJ	60652
RL	60619	SJ	60636
CM	60620	MK	60453
LN	60620	HM	60617
FP	60620	LS	60620
RP	60652	BT	60620
GR	60643		
MR	60610		
ER	60628		
CT	60620		
AW	60458		

West Lawn Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
MA	60629	JA	60638
AB	60629	SA	60629
AB	60629	JB	60629
DB	60621	UC	60632
MR	60632	ZC	60652
BD	60629	BF	60629
MD	60501	GG	60632
PF	60629	HG	60629
GH	60629	BG	60632
HJ	60636	JH	60629
MJ	60629	KH	60629
EN	60632	AM	60453
RO	60632	MM	60805
HR	60501	LM	60632
MR	60632	JM	60629
AR	60629	SP	60619
NR	60652	CP	60620
MT	60652	SR	60652
CV	60629		
BZ	60629		

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60406	1
60415	2
60445	5
60452	2
60453	24
60455	9
60456	2
60457	4
60458	2
60459	6
60462	4
60463	5
60464	3
60465	4
60472	1
60477	4
60482	5
60501	1
60643	10
60652	15
60655	12
60803	9
60805	7
Total	**137**

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

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

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

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

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

1. Planning Area Need

The Applicants propose to establish a 16-station dialysis facility to be located at 10511 South Harlem Avenue, Worth, Illinois 60482. There is currently a need for 40 dialysis stations, the service area where the proposed facility will be located. As shown in Attachment – 26A, there are currently 30 existing or approved facilities within 30 minutes normal travel time of the proposed facility, 28 of which have been in operation for over a year. The utilization of these facilities for the quarter ending June 30, 2013, is 77%. When excluding the two facilities that have not been in operation for two years, average utilization within 30 minutes normal travel time is 81%, which is above the State's standard. As ESRD prevalence increases, the utilization within the service area will continue to meet or exceed the State's standard.

Additionally, Dr. Pallath is currently treating 137 CKD patients whose condition is advancing to ESRD and who will likely initiate dialysis within the next 12 to 24 months. See Attachment – 26B. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 87 of these patients will initiate dialysis within 12 to 24 months following project completion. Accordingly, establishment of the proposed facility is necessary to maintain access to life-sustaining dialysis to residents of the Chicago Ridge community and the surrounding area.

2. Service to Planning Area Residents

The primary purpose of the proposed project is to maintain access to life-sustaining dialysis services to the residents of the Chicago Ridge community and the surrounding area. As evidenced in the physician referral letter attached at Attachment – 26B, all 137 pre-ESRD patients reside within 20 minutes of the proposed facility.

3. Service Demand

Attached at Attachment – 26B is a physician referral letter from Dr. Pallath and a schedule of pre-ESRD and current patients by zip code. A summary of CKD patients projected to be referred to the proposed dialysis facility within the first two years after project completion is provided in Table 1110.1430(b)(3)(B) below.

Table 1110.1430(b)(3)(B) Projected Pre-ESRD Patient Referrals by Zip Code

Zip Code	Total Patients
60406	1
60415	2
60445	5
60452	2
60453	24
60455	9
60456	2
60457	4
60458	2

60459	6
60462	4
60463	5
60464	3
60465	4
60472	1
60477	4
60482	5
60501	1
60643	10
60652	15
60655	12
60803	9
60805	7
Total	**137**

4. Service Accessibility

As set forth throughout this application, the proposed facility is needed to maintain access to life-sustaining dialysis for residents in the Chicago Ridge community and the surrounding area. Based upon the ESRD Utilization Data reported to the IDPH for the quarter ending June 30, 2013, the average utilization for facilities in operation for more than a year in the GSA is 81%. Moreover, HFSRB currently identifies a need for 40 stations in HSA 7. Accordingly, a new dialysis facility is needed to improve access to dialysis services to residents in the Chicago Ridge community.

Facility	City	Zip Code	HSA	Distance	Adjusted Drive Time	Stations	In-Center Patients	9-30-2012 Utilization	In-Center Patients	12-31-2012 Utilization	03-31-2013 Patients	03-31-2013 Utilization	06-30-2013 Patients	06-30-2013 Utilization
Palos Park Dialysis	Orland Park	60462	7	4.99	11.5	12	9	12.50%	12	16.7%	21	29.2%	19	26.4%
Dialysis Center of America - Crestwood	Crestwood	60445	7	5.08	11.5	24	122	84.72%	121	84.0%	111	77.1%	114	79.2%
Stoney Creek Dialysis	Oak Lawn	60453	7	4.03	11.5	12	70	97.22%	70	97.2%	73	101.4%	71	98.6%
Alsip Dialysis Center	Alsip	60803	7	5.58	13.8	20	87	90.63%	83	86.5%	80	66.7%	80	66.7%
RCG-Scottsdale	Chicago	60652	6	5.84	14.95	35	168	80.00%	161	76.7%	**161**	**76.7%**	151	**71.9%**
Mount Greenwood Dialysis	Chicago	60655	6	5.45	14.95	16	74	77.08%	78	81.3%	81	84.4%	81	84.4%
FMC Dialysis Services - Burbank	Burbank	60459	7	6.16	16.1	26	125	80.13%	126	80.8%	131	84.0%	134	85.9%
Direct Dialysis - Crestwood Care Centre	Crestwood	60445	7	6.56	16.1	6	97	269.44%	37	102.8%	36	100.0%	36	100.0%
Fresenius Medical Care - Midway	Chicago	60638	6	6.71	17.25	12	52	72.22%	58	80.6%	57	79.2%	55	76.4%
FMC - Merrionette Park	Merrionette Park	60803	7	6.42	17.25	18	97		105	97.2%	**105**	**97.2%**	99	**91.7%**
Dialysis Center of America - Orland Park	Orland Park	60462	7	8.89	19.55	18	83	76.85%	76	70.4%	75	69.4%	78	72.2%
West Lawn Dialysis	Chicago	60629	6	7.76	20.7	12	31	43.06%	36	50.0%	40	55.6%	54	75.0%
FMC - Southside	Chicago	60652	6	6.92	20.7	39	197		218	93.2%	212	90.6%	213	91.0%
FMC Dialysis Services of Willowbrook	Willowbrook	60527	7	13.13	21.85	20	94	78.33%	88	73.3%	79	65.8%	81	67.5%
Fresenius Medical Care Evergreen Park	Evergreen Park	60643	7	7.11	21.85	30	160	88.89%	150	83.3%	149	82.8%	154	85.6%
FMC - Blue Island Dialysis Ctr	Blue Island	60406	7	8.62	21.85	24	115		128	88.9%	128	88.9%	127	88.2%
Beverly Dialysis	Chicago	60620	6	7.85	21.85	12	79	109.72%	78	108.3%	76	105.6%	78	108.3%
Markham Renal Center	Markham	60428	7	11.11	23	24	90	62.50%	100	69.4%	96	66.7%	101	70.1%
LaGrange Dialysis Center	Westchester	60154	7	14.21	24.15	20	88	73.33%	89	74.2%	87	72.5%	92	76.7%
Fresenius Medical Care Cicero	Cicero	60804	7	11.68	25.3	16	0	0.00%	0	0.0%	2	2.1%	1	1.0%
FMC - Neomedica - Marquette Park	Chicago	60636	6	8.81	25.3	16	94		88	91.7%	87	90.6%	85	88.5%
FMC Elmhurst	Elmhurst	60125	7	16.2	26.45	24	117		132	91.7%	**132**	**91.7%**	119	**82.6%**
Dialysis Center of America - Berwyn	Berwyn	60402	7	10	26.45	26	162	103.85%	162	103.8%	168	107.7%	164	105.1%
Fresenius Medical Care of Mokena	Mokena	60448	9	13.21	27.6	12	45	62.50%	45	62.5%	42	58.3%	44	61.1%
Fresenius Medical Care Hazel Crest	Hazel Crest	60429	7	13.93	27.6	16	77	80.21%	76	79.2%	83	86.5%	85	88.5%
Fresenius Medical Care Chatham	Chicago	60620	6	9.77	28.75	16	4	4.17%	6	6.3%	28	29.2%	48	50.0%
Community Dialysis of Harvey	Harvey	60426	7	15.24	28.75	16	72	75.00%	64	66.7%	**64**	**66.7%**	71	**74.0%**
Fresenius Medical Care of Roseland	Chicago	60628	6	9.65	28.75	12	72	100.00%	71	98.6%	72	100.0%	71	98.6%
USRC Oak Brook	Downers Grove	60515	7	19.4	29.9	13	1	93.75%	4	5.1%	13	16.7%	22	28.2%
Bolingbrook Dialysis Center	Bolingbrook	60446	9	17.52	29.9	24	135	93.75%	132	91.7%	125	86.8%	122	84.7%

Attachment - 26A

Sreya Pallath, M.D.
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

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

Dear Vice Chairman Hayes:

I am pleased to support DaVita's establishment of Chicago Ridge Dialysis. The proposed 16-station chronic renal dialysis facility, to be located at 10511 South Harlem Avenue, Worth, Illinois 60482 will directly benefit my patients.

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

The site of the proposed facility is close to Interstate 294 (I-294) and will provide better access to patients residing in the south and southwest suburbs, as well as the far southwest area of the city of Chicago. Utilization of facilities in operation for more than a year within the 30 minute Geographic Service Area of the proposed facility was 79.0%, according to March 31, 2013 reported census data.

I have identified 137 patients from my practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Conservatively, I predict at least 87 of these patients will progress to dialysis within the next 12 to 24 months. My large patient base, the significant utilization at nearby facilities, and the present 40-station need identified in Health Service Area 7 demonstrate considerable demand for this facility.

A list of patients who have received care at existing facilities in the area over the past 3 ½ years is provided at Attachment – 1. A list of new patients my practice has referred for in-center hemodialysis for the past year and a half is provided at Attachment – 2. The list of zip codes for the 137 pre-ESRD patients previously referenced is provided at Attachment – 3.

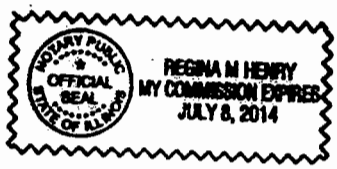
These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

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

Sincerely,

Sreya Pallath, M.D.
Nephrologist
J.R. Nephrology & Associates, P.C.
4542 W. 95th Street
Oak Lawn, Illinois 60453

Subscribed and sworn to me
This 1st day of August 2013



Notary Public: Regina M Henry

Attachment 1
Historical Patient Utilization

Stony Creek Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
RA	60453	RA	60453	RA	60453	RA	60453
JA	60805	JA	60805	EA	60459	EA	60459
EA	60805	EA	60459	JA	60638	JA	60638
MA	60465	JA	60638	RB	60803	RB	60803
EA	60459	RB	60803	FB	60632	FB	60632
HB	60805	GB	60644	GB	60644	GB	60644
RB	60803	EC	60617	JC	60453	JC	60453
EC	60617	DD	60406	EC	60617	EC	60617
JC	60803	AA	60459	DD	60406	WD	60456
DC	60459	LB	60415	WD	60456	JB	60652
DD	60406	JB	60652	AA	60459	CB	60629
AA	60459	CB	60629	JB	60652	IB	60620
HA	60453	IB	60620	CB	60629	AB	60406
JB	60652	AB	60406	IB	60620	MC	60629
AB	60453	CB	46307	AB	60406	JD	60652
CB	60629	MC	60629	MC	60629	CD	60628
IB	60620	WC	60453	WC	60453	WD	60636
JB	60628	FC	60620	FC	60620	DD	60652
AB	60406	EC	60453	MD	60453	ZE	60629
LC	89107	MD	60453	JD	60652	JF	60457
MC	60629	JD	60652	CD	60628	PG	60629
JC	60803	CD	60628	DD	60406	EG	60482
WC	60453	DD	60406	WD	60636	RG	60632
DC	60459	WD	60636	BD	60463	BG	60453
FC	60620	DD	60652	DD	60652	RG	60620
EC	60453	ZE	60629	ZE	60629	JH	60620
JD	60652	NF	60629	DF	60459	LH	60453
LD	60803	OF	60638	JF	60457	RI	60652
MD	60638	DF	60459	PG	60629	JJ	60453
CD	60628	PG	60629	EG	60482	AJ	60652
DD	60406	LG	60487	RG	60632	JJ	60629
WD	60636	RG	60632	BG	60453	RK	60459
DD	60652	SG	60803	SG	60803	WK	60638
ZE	60629	RG	60465	VG	60453	HL	60453
OF	60638	VG	60453	RG	60620	GM	60453
DF	60459	JH	60620	JH	60620	FM	60457
PG	60629	WH	60453	JH	46405	YM	60632
LG	60652	SH	60620	SH	60620	DN	60453
LG	60487	LH	60453	LH	60453	EN	60455
RG	60632	RJ	60629	RI	60652	PO	60453

Stony Creek Dialysis, CONTINUED							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
VG	60453	JJ	60453	RJ	60629	KP	60456
MG	60453	AJ	60652	JJ	60453	SP	60455
MG	60652	JJ	60629	AJ	60652	AP	60455
JH	60620	RJ	60803	JJ	60629	GR	60459
WH	60453	EK	60453	RJ	60803	MR	60465
SH	60620	RK	60459	EK	60453	RS	60629
LH	60453	WK	60638	RK	60459	BS	60652
JJ	60453	DM	60459	AK	60465	AS	60456
JJ	60652	GM	60453	WK	60638	LS	60805
JJ	60629	FM	60457	HL	60453	RS	60491
RJ	60803	AM	60638	GM	60453	WS	60453
EK	60453	DM	60805	FM	60457	DT	60638
RK	60459	DN	60453	YM	60632	GV	60459
WK	60638	EN	60455	DM	60805	LW	60652
RK	60638	JN	60453	RM	60805	JW	60415
PL	60455	JO	60453	MM	60453	GW	60609
IL	60457	PO	60453	DN	60453	WW	60620
RL	60629	KP	60456	EN	60455	EW	60453
DM	60459	BP	60453	JO	60453	DW	60458
CM	60638	AP	60455	PO	60453	WY	60453
GM	60453	JR	60453	KP	60456	JZ	60459
KM	60636	RS	60629	SP	60455	JW	60428
LM	60803	BS	60652	AP	60455	IO	60453
FM	60457	AS	60456	GR	60459	MT	60652
DM	60805	ES	60629	JR	60453	GW	60620
HM	60463	LS	60805	MR	60465	MR	60619
JN	60459	RS	60491	RS	60629	JC	60458
DN	60453	WS	60453	BS	60652	DF	60655
JO	60643	GV	60459	AS	60456	MM	60459
JO	60453	RV	60453	SS	60453	AM	60455
JP	60453	LW	60652	CS	60453	MK	60453
BP	60453	JW	60415	LS	60805		
AP	60455	GW	60609	RS	60491		
JR	60453	WW	60620	WS	60453		
BS	60652	JW	60629	DT	60638		
AS	60456	MW	60085	GV	60459		
ES	60629	EW	60453	RV	60453		
LS	60805	DW	60458	LW	60652		
RS	60491	HY	60453	JW	60415		
WS	60453	JZ	60459	GW	60609		
MV	60403	KZ	60445	WW	60620		
RV	60453			EW	60453		
LW	60652			DW	60458		
GW	60609			WY	60453		

Stony Creek Dialysis, CONTINUED					
2010		2011	2012		2013 YTD 6/30
Initials	Zip Code		Initials	Zip Code	
JW	60453		JZ	60459	
WW	60620				
DW	60458				
HY	60453				
JZ	60459				
KZ	60445				

Beverly Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
LF	60628	LF	60628	RM	60620	SG	60629
OJ	60609	RM	60620	SG	60629	EC	60620
RM	60620	SG	60629	EC	60620	WG	60652
SG	60629	EC	60620	WG	60652	EH	60619
EC	60620	WG	60652	EH	60619	MH	60609
WG	60652	EH	60619	MH	60609	BH	60620
EH	60619	MH	60609	BH	60620	AJ	60620
MH	60609	BH	60620	AJ	60620	DR	60620
BH	60620	AJ	60620	DR	60620	AS	60620
AJ	60620	DR	60620	AS	60620	AF	60619
DR	60620	AS	60620	AF	60619	BA	60620
AS	60620	AF	60619	BA	60620	AB	60620
RB	60803	AH	60629	AB	60620	BG	60620
SC	60465	JM	60619	BG	60620	DG	60478
MC	60629	RR	60629	DG	60478	SM	60629
AF	60619	WS	60620	BG	60652	KM	60636
WG	60643	BA	60620	SM	60629	CR	60620
AH	60629	AB	60620	KM	60636	BT	60620
CL	60628	BG	60620	CR	60620	IW	60628
SM	60617	DG	60478	BT	60620	AB	60628
JM	60619	BG	60652	IW	60628	TB	60620
LM	60803	SM	60629	SA	60636	GC	60629
RR	60629	KM	60636	AB	60628	RJ	60620
GS	60617	CR	60620	TB	60620	SJ	60628
WS	60620	BT	60620	GC	60629	KP	60620
BA	60620	IW	60628	RJ	60620	ST	60620
AB	60620	SA	60636	SJ	60628	VB	60636
BG	60620	AB	60628	KP	60620	WK	60620
DG	60478	TB	60620	MR	60619	RL	60619
BG	60652	JC	60629	JS	60628	CM	60620
SM	60629	GC	60629	GS	60636	LN	60620
KM	60636	GH	60629	ST	60620	FP	60620
CR	60620	KH	60652	BD	60621	RP	60652
BT	60620	MJ	60619	VB	60636	GR	60643
IW	60628	RJ	60620	WK	60620	MR	60610
AH	60608	SJ	60628	RL	60619	ER	60628
BA	60649	WK	60628	CM	60620	JT	60620
EH	60629	WK	60629	LN	60620	WT	60620
AK	60617	ML	60652	FP	60620	RT	60629
DR	60620	LM	60803	RP	60652	CT	60620
		RN	60628	GR	60643	AW	60458
		PN	60643	MR	60610	TC	60652

Beverly Dialysis, CONTINUED						
2010	2011		2012		2013 YTD 6/30	
	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
	KP	60620	ER	60628	LG	60629
	CR	60643	RS	60620	AJ	60652
	LR	60628	LS	60805	SJ	60636
	MR	60619	JT	60620	MK	60453
	JS	60628	WT	60620	HM	60617
	GS	60636	RT	60629	LS	60620
	ST	60620	CT	60620	BT	60620
	MT	60652	AW	60458	BA	60649
	LW	60620	BA	60649	EH	60629
	BA	60649	EH	60629	AK	60617
	EH	60629	AK	60617	DR	60620
	AK	60617	DR	60620		
	DR	60620				

West Lawn Dialysis							
2010		2011		2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code	Initials	Zip Code	Initials	Zip Code
N/A	N/A	FB	60636	FB	60636	FB	60636
		EC	60637	EC	60637	EC	60637
		MG	60632	MG	60632	MG	60632
		RJ	60629	RJ	60629	RJ	60629
		MJ	60620	MJ	60620	MJ	60620
		WK	60629	WK	60629	WK	60629
		EM	60652	EM	60652	EM	60652
		MR	60652	MR	60652	MR	60652
		IS	60629	IS	60629	IS	60629
				MA	60629	MA	60629
				AB	60629	AB	60629
				AB	60629	AB	60629
				DB	60621	DB	60621
				MR	60632	MR	60632
				BD	60629	BD	60629
				MD	60501	MD	60501
				PF	60629	PF	60629
				GH	60629	GH	60629
				HJ	60636	HJ	60636
				MJ	60629	MJ	60629
				EN	60632	EN	60632
				RO	60632	RO	60632
				HR	60501	HR	60501
				MR	60632	MR	60632
				AR	60629	AR	60629
				NR	60652	NR	60652
				MT	60652	MT	60652
				CV	60629	CV	60629
				BZ	60629	BZ	60629
						JA	60638
						SA	60629
						JB	60629
						UC	60632
						ZC	60652
						BF	60629
						GG	60632
						HG	60629
						BG	60632
						JH	60629
						KH	60629
						AM	60453
						MM	60805

West Lawn Dialysis, CONTINUED				
2010	2011	2012	2013 YTD 6/30	
			Initials	Zip Code
			LM	60632
			JM	60629
			SP	60619
			CP	60620
			SR	60652

Attachment 2
New Patients

Stony Creek Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
FB	60632	JW	60428
BZ	60629	IO	60453
WD	60456	MT	60652
BD	60463	GW	60620
JF	60457	MR	60619
EG	60482	JC	60458
JC	60453	DF	60655
BG	60453	MM	60459
RG	60620	AM	60455
RI	60652	MK	60453
EK	60453		
AK	60465		
MM	60457		
RM	60805		
MM	60453		
SP	60455		
GR	60459		
SS	60453		
CS	60453		
HL	60411		
WY	60453		
HL	60453		
YM	60632		

Beverly Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
BD	60621	TC	60652
VB	60636	LG	60629
WK	60620	AJ	60652
RL	60619	SJ	60636
CM	60620	MK	60453
LN	60620	HM	60617
FP	60620	LS	60620
RP	60652	BT	60620
GR	60643		
MR	60610		
ER	60628		
CT	60620		
AW	60458		

West Lawn Dialysis			
2012		2013 YTD 6/30	
Initials	Zip Code	Initials	Zip Code
MA	60629	JA	60638
AB	60629	SA	60629
AB	60629	JB	60629
DB	60621	UC	60632
MR	60632	ZC	60652
BD	60629	BF	60629
MD	60501	GG	60632
PF	60629	HG	60629
GH	60629	BG	60632
HJ	60636	JH	60629
MJ	60629	KH	60629
EN	60632	AM	60453
RO	60632	MM	60805
HR	60501	LM	60632
MR	60632	JM	60629
AR	60629	SP	60619
NR	60652	CP	60620
MT	60652	SR	60652
CV	60629		
BZ	60629		

Attachment 3
Pre-ESRD Patients

Zip Code	Total
60406	1
60415	2
60445	5
60452	2
60453	24
60455	9
60456	2
60457	4
60458	2
60459	6
60462	4
60463	5
60464	3
60465	4
60472	1
60477	4
60482	5
60501	1
60643	10
60652	15
60655	12
60803	9
60805	7
Total	**137**

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

1. Unnecessary Duplication of Services

a. The proposed dialysis facility will be located at 10511 South Harlem, Worth, Illinois 60482. A map of the proposed facility's market area is attached at Attachment – 26C. A list of all zip codes located, in total or in part, within 30 minutes normal travel time of the site of the proposed dialysis facility as well as 2010 census figures for each zip code is provided in Table 1110.1430(c)(1)(A).

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

Zip Code	City	Population
60446	ROMEOVILLE	39,807
60441	LOCKPORT	36,869
60491	HOMER GLEN	22,743
60517	WOODRIDGE	32,038
60515	DOWNERS GROVE	27,503
60516	DOWNERS GROVE	29,084
60559	WESTMONT	24,852
60439	LEMONT	22,919
60561	DARIEN	23,115
60527	WILLOWBROOK	27,486
60514	CLARENDON HILLS	9,708
60521	HINSDALE	17,597
60558	WESTERN SPRINGS	12,960
60523	OAK BROOK	9,890
60181	VILLA PARK	28,836
60126	ELMHURST	46,371
60162	HILLSIDE	8,111
60163	BERKELEY	5,209
60448	MOKENA	24,423
60487	TINLEY PARK	26,928
60467	ORLAND PARK	26,046
60462	ORLAND PARK	38,723
60477	TINLEY PARK	38,161
60443	MATTESON	21,145
60478	COUNTRY CLUB HILLS	16,833
60452	OAK FOREST	27,969
60463	PALOS HEIGHTS	14,671

60445	MIDLOTHIAN	26,057
60464	PALOS PARK	9,620
60480	WILLOW SPRINGS	5,246
60465	PALOS HILLS	17,495
60457	HICKORY HILLS	14,049
60455	BRIDGEVIEW	16,446
60525	LA GRANGE	31,168
60526	LA GRANGE PARK	13,576
60458	JUSTICE	14,428
60501	SUMMIT ARGO	11,626
60513	BROOKFIELD	19,047
60534	LYONS	10,649
60482	WORTH	11,063
60415	CHICAGO RIDGE	14,139
60459	BURBANK	28,929
60803	ALSIP	22,285
60453	OAK LAWN	56,855
60456	HOMETOWN	4,349
60638	CHICAGO	55,026
60402	BERWYN	63,448
60422	FLOSSMOOR	9,403
60430	HOMEWOOD	20,094
60429	HAZEL CREST	15,630
60428	MARKHAM	12,203
60472	ROBBINS	5,390
60469	POSEN	5,930
60406	BLUE ISLAND	25,460
60426	HARVEY	29,594
60425	GLENWOOD	9,117
60438	LANSING	28,884
60473	SOUTH HOLLAND	22,439
60419	DOLTON	22,788
60827	RIVERDALE	27,946
60655	CHICAGO	28,550
60805	EVERGREEN PARK	19,852
60652	CHICAGO	40,959
60643	CHICAGO	49,952
60620	CHICAGO	72,216
60629	CHICAGO	113,916
60632	CHICAGO	91,326
60636	CHICAGO	40,916

60621	CHICAGO	35,912
60628	CHICAGO	72,202
60619	CHICAGO	63,825
60154	WESTCHESTER	16,773
60155	BROADVIEW	7,927
60104	BELLWOOD	19,038
60153	MAYWOOD	24,106
60141	HINES	224
60546	RIVERSIDE	15,668
60130	FOREST PARK	14,167
60304	OAK PARK	17,231
60804	CICERO	84,573
60623	CHICAGO	92,108
60608	CHICAGO	82,739
60616	CHICAGO	48,433
Total		**2,392,989**

Source: U.S. Census Bureau, Census 2010, American Factfinder *available at* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited June 30, 2013).

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

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (1) ratio of stations to population exceeds one and one-half times the State Average; (2) historical utilization for existing facilities and services is below the HFSRB's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more fully below, the ratio of stations to population in the GSA is 77.6% of the State average, the average utilization of existing facilities is 71%, and sufficient population exists to achieve target utilization. Accordingly, the proposed dialysis facility will not result in a maldistribution of services.

a. Ratio of Stations to Population

As shown in Table 1110.1430(c)(2)(A), the ratio of stations to population is 77.6% of the State Average.

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

	Population	Dialysis Stations	Stations to Population
Geographic Service Area	2,392,989	571	1:4,191
State	12,830,632	3,946	1:3,251

b. Historic Utilization of Existing Facilities

Additionally, the average utilization for facilities in the service area operational for at least 2 years is 81%. Accordingly, there is sufficient patient population to justify the need for the proposed facility. There will be no maldistribution of services. Additional stations are necessary to adequately meet rising demand and a need of 40 additional dialysis stations, as identified by the HFSRB Inventory.

c. Sufficient Population to Achieve Target Utilization

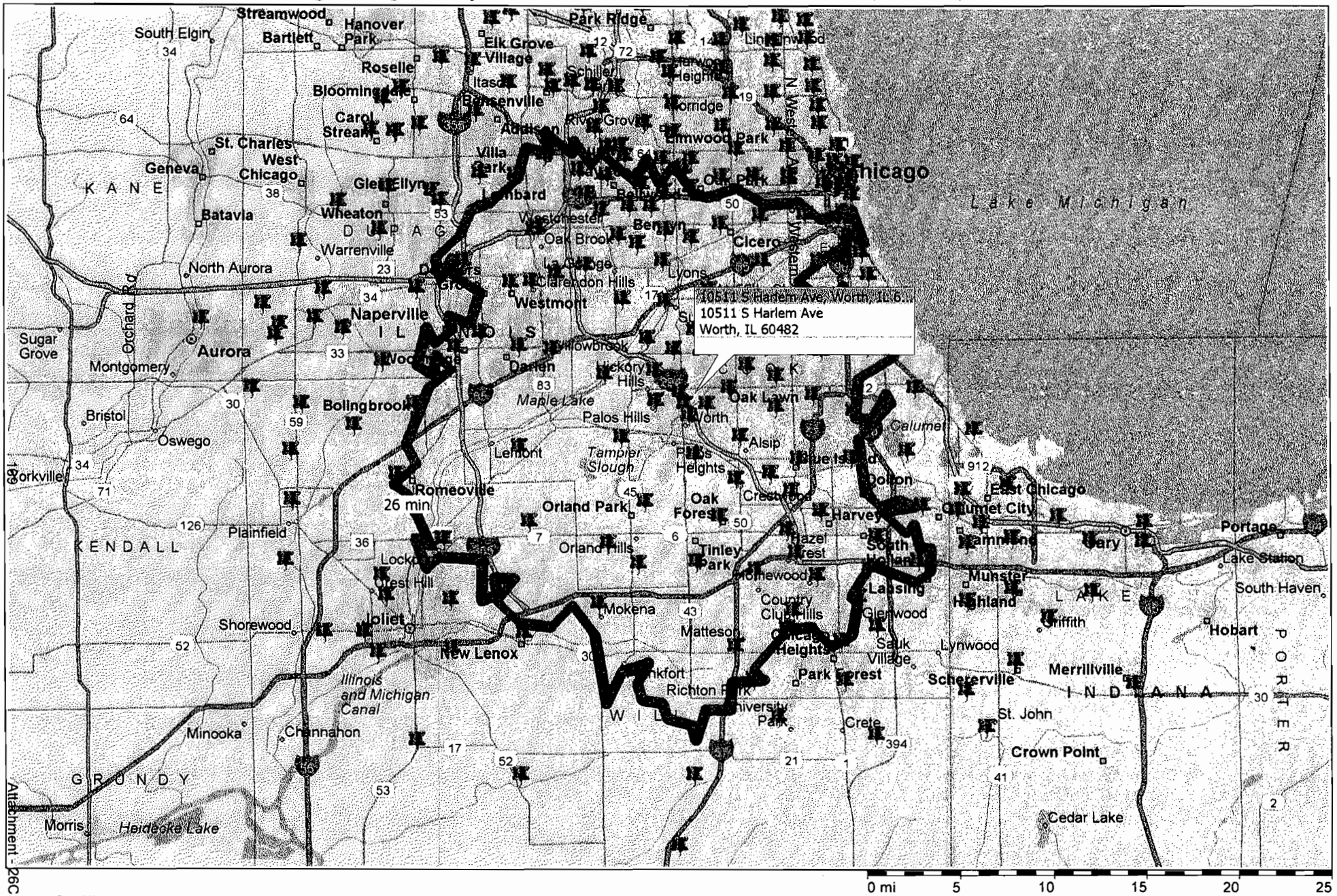
The Applicants propose to establish a 16-station dialysis facility. To achieve the HFSRB's 80% utilization standard within the first two years after project completion, the Applicants would need 77 patient referrals. As set forth above in Table 1110.230(b)(2), Dr. Pallath is currently treating 137 CKD patients. Conservatively, based upon attrition due patient death, transplant, return of function, or relocation, it is estimated that 87 of these patients will initiate dialysis within 12 to 24 months following project completion.

3. Impact to Other Providers

a. The proposed dialysis facility will not have an adverse impact on existing facilities in the GSA. As discussed throughout this application, the average utilization at the facilities within the service area in operation for at least one year is 81% and the HFSRB Inventory identifies a need of 40 additional stations.

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

Chicago Ridge Dialysis 10511 South Harlem Avenue, Worth, IL 60482



Attachment - 26C

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

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

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

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

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

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

    c. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program is attached at Attachment – 26E.

    d. As set forth in the letter from Javier Rodriguez, President of DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC is attached at Attachment – 26F, Chicago Ridge Dialysis will maintain an open medical staff.

Sreya Pallath, M.D.

Maiden Name
Sreya Patri
Home Address
1124 Covington Drive
Lemont, IL 60439
(H) 630/685-4049

Work Address
J. R. Nephrology & Associates, P.C.
4542 West 95th Street
Oak Lawn, Illinois 60453
Tel: 708/425-0522
Fax: 708/425-4505
Email: jrnephrology@sbcglobal.net

Medical Education & Training

Fellow, Department of Nephrology 2002-2004
University of Illinois at Chicago

- Inpatient services: nephrology consultation, transplant service, medical intensive care unit, coronary intensive care unit.
- Outpatient longitudinal clinics: hemodialysis shifts, peritoneal dialysis clinic.
- Teaching responsibilities: case presentations, topic reviews, journal clubs, all with literature review; formal lectures to medical students and internal medicine residents.

Hospital Affiliations

- University of Illinois Medical Center, Chicago, IL
- V.A. Chicago Health Care System, West Side Division, Chicago, IL
- Cook County Hospital, Chicago, IL

Resident, Department of Internal Medicine 1999-2002
University of Illinois at Chicago

Education

Doctorate of Medicine 1995-1999
Rush Medical College, Chicago

Bachelor of Science 1991-1995
University of Illinois at Urbana-Champaign

- Major: Biology, Honor's; GPA: 4.5/5.0
- Dean's List 1991-1995

Credentials

Diplomate, American Board of Internal Medicine 2002-2012
U.S. Medical Licensure Examinations, Steps I-III
Licensure: Illinois
Board Certified in Nephrology 2005-2015

Publications

Gordon Syndrome – New Insights into the Pathogenetic Mechanisms
Sreya Pallath, M.D.
Accepted for publication in: Kidney – A current survey of world literature

BK nephropathy in lung transplantation
Sreya Pallath, Shellee Grim, Nina Clark
Currently in writing

Research Experience

Role of angiogenesis factors on diabetic rats 2003
Mentors: Dr. A. K. Singh, Dr. J. A. Arruda
Department of Nephrology: Cook County Hospital, Chicago

- Prepared pathologic slides with staining and immunofluorescence of granulomas specimens of subcutaneous tissue obtained from diabetic and control rats exposed to various angiogenesis factors.
- Examined the effects of these angiogenesis factors on neovascularization.

Assessment of urinary albumin using a new non-immunologic fluorescent dye 2000
Mentors: Dr. A. K. Singh, Dr. J. A. Arruda
Department of Nephrology: Cook County Hospital, Chicago

- Collected urine samples of diabetic and non-diabetic patients and analyzed amount of proteinuria using a new non-immunologic immunofluorescent dye.
- Compared this technique with assessment of total urinary protein using radioimmunoassay.

Literature review on mechanisms of spore germination of Bacillus subtilis 1993
Mentor: Dr. H. Y. Cheung
Department of Biology and Chemistry; City University of Hong Kong

- Assisted in preparation of review article discussing recent world literature on mechanisms of protein recognition of DNA.

Immunohistochemical analysis of osteosarcoma 1992
Mentor: Dr. J. C. Lee
Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, Hong Kong

- Prepared pathologic slides of low grade osteosarcoma specimens and analyzed histology using immunohistochemistry.

Professional Activities

Reviewer 2004
American Journal of Nephrology

Service

Pilsen Homeless Shelter, Chicago, IL 1995-1996
Franciscan Homeless Shelter, Chicago, IL 1996-1997
Volunteer Illini Projects, Champaign, IL 1992-1994
Director of Blood Program

Employment History

Nephrologist, J.R. Nephrology & Associates, S.C. June 1,2005 - Present
Telemarketer, Ameritech; Champaign, IL 1994
Laboratory Assistant 1992-1993
Department of Plant Biology, University of Illinois at Urbana-Champaign

Attending Experience

Advocate Christ Hospital and Medical Center May 26, 2005 - Present
Little Company of Mary Hospital June 9, 2005 - Present
Holy Cross Hospital September 29, 2005 – June 30, 2008

Professional Societies

American Society of Nephrology; Member
National Kidney Foundation; Member, Volunteer
Renal Physicians Association; Member
American College of Physicians; Member
American Medical Association; Member

Personal Information

Date of Birth: July 28, 1973
Place of Birth: Hyderabad, India
Citizenship: U.S.A.

References

Malgorzata Gajda, M.D
Lawn Medical Center, S.C
4301 West 95th Street
Oak Lawn, IL 60453
Phone: 708/425-5500
Fax: 708/425-0771

Robert Chalupczak, M.D.
Lawn Medical Center, S.C
4301 West 95th Street
Oak Lawn, IL 60453
Phone: 708/425-5500
Fax: 708/425-0771

Beata Styka, M.D.
12050 S. Harlem Avenue
Palos Heights, IL 60463
Phone: 708/671-1500
Fax: 708/671-1535

Reference letters available on request.

PROGRAM DESCRIPTION

Introduction to Program

The Hemodialysis Education and Training Program is grounded in DaVita's Core Values. These core values include a commitment to providing *service excellence*, promoting *integrity*, practicing a *team* approach, systematically striving for *continuous improvement*, practicing *accountability*, and experiencing *fulfillment* and *fun*.

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

DaVita hires both non-experienced and experienced teammates.
A **non-experienced teammate** is defined as:

- A newly hired patient care teammate without prior dialysis experience.
- A rehired patient care teammate who left prior to completing the initial training.

An **experienced teammate** is defined as:

- A newly hired patient care teammate with prior dialysis experience as evidenced by successful completion of a competency exam.
- A rehired patient care teammate who left and can show proof of completing their initial training.

The curriculum of the Hemodialysis Education and Training Program is modeled after the American Nephrology Nurses Association Core Curriculum for Nephrology Nursing and the Board of Nephrology Examiners Nursing and Technology guidelines.

The program incorporates the policies, procedures, and guidelines of DaVita Inc.

The new teammate will be provided with a "StarTracker". The "StarTracker" is a tool that will help guide the training process while tracking progress. The facility administrator and preceptor will review the Star Tracker to plan and organize the training and professional development of the new teammate. The Star Tracker will guide the new teammate through the initial phase of training and then through the remainder of their first year with DaVita, thus increasing their knowledge of all aspects of dialysis. It is designed to be used in conjunction with the "My Learning Plan Workbooks."

Program Description

- The education program for the newly hired patient care provider teammate **without prior dialysis experience** is composed of at least (1) 120 hours didactic instruction and (2) 280 hours clinical practicum, unless otherwise specified by individual state regulations.

  The **didactic phase** consists of instruction including but not limited to lectures, readings, self-study materials, on-line learning activities, specifically designed hemodialysis

workbooks for the teammate, demonstrations and observations. This education may be coordinated by the Clinical Services Specialist (CSS), the administrator, or the preceptor. This training includes introduction to the dialysis machine, components of the hemodialysis system, dialysis delivery system, principles of hemodialysis, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used, introduction to DaVita Policies and Procedures, and introduction to the Amgen Core Curriculum.

The **didactic phase** also includes classroom training with the Clinical Services Specialist, which covers more in-depth theory on structure and functions of the kidneys. This includes homeostasis, renal failure ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis, components of the hemodialysis system, water treatment, dialyzer reprocessing, hemodialysis treatment (which includes machine troubleshooting and patient complications), documentation, complication case studies, heparinization and anticoagulation, vascular access (which includes vascular access workshop), patient assessment (including workshop), fluid management with calculation workshop, nutrition, laboratory, adequacy, pharmacology, patient teaching/adult learning, service excellence (which includes professionalism, ethics and communications).

A final comprehensive examination score of ≥ 80% must be obtained to successfully complete this portion of the didactic phase. If a score of less than 80% is attained, the teammate will receive additional appropriate remediation and a second exam will be given.

Also included in the **didactic phase** is additional classroom training covering Health and Safety Training, DaVita Virtual Training Program (which includes 21 hours of computer training classes), One For All orientation training, HIPAA training, LMS mandatory water classes, emergency procedures specific to facility, location of disaster supplies, and orientation to the unit.

Included in the **didactic phase** for nurses is additional classroom training. The didactic phase includes:

- The role of the dialysis nurse in the facility
- Pharmacology for nurses
- Outcomes management
- Patient assessment for the dialysis nurse.

The **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, a registered nurse, or the clinical services specialist (CSS). During this phase the teammate will demonstrate a progression of skills required to perform the hemodialysis procedures in a safe and effective manner. A *Procedural Skills Inventory Checklist* will be completed to the satisfaction of the preceptor and the administrator.

The clinical hemodialysis workbooks will also be utilized for this training and must be completed to the satisfaction of the preceptor and the administrator.

Those teammates who will be responsible for the Water Treatment System within the facility are required to complete the Mandatory LMS Educational Water courses and the corresponding skills checklists.

Both the didactic phase and/or the clinical practicum phase of a specific skill set will be successfully completed prior to the new teammate receiving an independent assignment for that specific skill set. The new teammate is expected to attend all training sessions and complete all assignments and workbooks.

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

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

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

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

Process of Program Evaluation

The Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the, DaVita Prep Class Evaluation (TR1-06-08), the New Teammate Satisfaction Survey on the LMS and random surveys of facility administrators to determine satisfaction of the training program. To assure continuous

DaVita | HealthCare Partners

July 2, 2013

John Hayes
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Acting Chairman Hayes:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1110.1430(f) that Chicago Ridge Dialysis will maintain an open medical staff.

I also certify the following with regard to needed support services:

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

Sincerely,

Javier Rodriguez
President
DaVita HealthCare Partners Inc.

Subscribed and sworn to me
This 2ND day of July, 2013

Notary Public

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

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

Attached at Attachment – 26F is a letter from Javier Rodriguez, President of DaVita HealthCare Partners Inc. and Cagles Dialysis, LLC attesting that the proposed facility will participate in a dialysis data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

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

The proposed dialysis facility will be located in the Chicago-Joliet-Naperville metropolitan statistical area ("MSA"). A dialysis facility located within an MSA must have a minimum of eight dialysis stations. The Applicants propose to establish a 16-station dialysis facility. Accordingly, this criterion is met.

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

DaVita HealthCare Partners Inc. has an agreement with Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center to provide inpatient care and other hospital services. Attached at Attachment – 26G is a copy of the service agreement with this area hospital.

TRANSFER AGREEMENT
BETWEEN
ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER
AND
STONY CREEK DIALYSIS CENTER

This Agreement is made and effective as of the **19th day of June, 2006**, between **Advocate Health and Hospitals Corporation d/b/a Advocate Christ Medical Center**, an Illinois not-for-profit corporation ("MEDICAL CENTER"), and **Stony Creek Dialysis Center, DaVita, Inc.**, a for-profit corporation ("FACILITY").

WHEREAS, both parties to this agreement desire to assure continuity of care and treatment appropriate to the needs of each patient in the MEDICAL CENTER and the FACILITY, and to use the skills, resources, and physical plant for patient care at both the acute and post-acute stages of illness.

NOW, THEREFORE, IN CONSIDERATION of the mutual advantage occurring to the parties hereto, the MEDICAL CENTER and FACILITY hereby covenant and agree with each other as follows:

1. Autonomy. The Board of Directors of the MEDICAL CENTER and the Board of Directors of the FACILITY shall continue to have exclusive control of the management, assets and affairs of their institutions, and neither party by virtue of this Agreement shall assume any liability for any debts or obligations which have been or which may be incurred by the other party to this Agreement.

2. Transfer of Patients. Whenever the attending physician of any patient confined in the MEDICAL CENTER or in the FACILITY shall determine that a transfer of such patient from one of these institutions to the other is medically appropriate, the parties shall take whatever steps may be necessary to effect such a transfer in their admissions policies to patients requiring such transfer, subject to availability of bed space, and provided that all the usual conditions for admission are met. Each party shall give notice to the other party, as far in advance as possible, of responsibility of the institution and attending physician initiating transfer to arrange for appropriate and safe transportation. Further, it shall be their responsibility for arranging for the care of the patient during transfer. These responsibilities will cease when the patient has been physically admitted at the designation designated.

3. Medical Center Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the FACILITY in accordance with Article II, the MEDICAL CENTER shall be guided by its usual admission requirements.

In accordance with criteria for admission:

A. Patients declared as emergencies by their attending physicians shall be admitted to the MEDICAL CENTER without delay, unless the MEDICAL CENTER is on emergency bypass and has notified applicable agencies of such.

B. Patients not strictly emergent, but requiring early admission to the MEDICAL CENTER shall be placed on the MEDICAL CENTER's urgent list.

C. Elective cases shall be booked for future admission to the MEDICAL CENTER, according to the established routine of the MEDICAL CENTER.

4. Facility Admissions Priority. In establishing its preference in admission policies for patients subject to transfer from the MEDICAL CENTER in accordance with Article II, the FACILITY shall be guided by the following plan:

A. To admit the patient from the MEDICAL CENTER as promptly as possible, provided general admission requirements established by the institution are met.

B. To give priority to re-admission of patients transferred from the FACILITY to the MEDICAL CENTER.

C. To accommodate weekend admissions, provided general admission requirements of the FACILITY are met

5. Interchange of Information. The parties shall interchange all pertinent medical records and other information which may be necessary or useful in the care and treatment of patients transferred between he parties or which may be revenant to determining whether such parties can be adequately cared for otherwise than in either the MEDICAL CENTER or FACILITY. All such information shall be provided by the transferring institution in advance, where possible, and in any event at the time of the transfer, and shall be recorded on a referral form which shall be mutually agreed upon by the parties.

6. Transfer of Personal Effects. Procedures for effecting the transfer of patients and their personnel effects and valuables shall be developed and adhered to by both parties. These procedures will include, but are not limited to, the provision of information concerning such valuables, money, and personal effects transferred with the patient so that a receipt may be given and received for same. The patient's personal effects will ordinarily be transferred with the patient. The transferring institution will assume responsibility for those personal effects transferred with the patient.

7. Final Financial Arrangements. Charges for services performed by either party for patients transferred from the other party pursuant to this Agreement shall be collected by the party rendering such services directly from the patient, third party payors or from other sources normally billed. Neither party shall have any liability to the other for such charges, except to the extent that such liability would exist separate and apart from the Agreement. Nor shall either party receiving a transferred patient be responsible for collecting any previously outstanding account receivable due the other party from such patient.

8. Insurance. Each party shall maintain professional and public liability insurance coverage in the amount of One Million Dollars ($1,000,000.000) per occurrence or claim made with respect to the actions of its employees and agents connected with or arising out of services provided under this Agreement.

9. Independent Contractor. Nothing contained in this Agreement shall constitute or be construed to create a partnership, joint venture, employment, or agency relationship between the parties and/or their respective successors and assigns, it being mutually understood and agreed that the parties shall provide the services and fulfill the obligations hereunder as independent contractors. Further, it is mutually understood and agreed that nothing in this Agreement shall in any way affect the independent operation of either the MEDICAL CENTER or the FACILITY. The governing body of the MEDICAL CENTER and the FACILITY shall have exclusive control of the management, assets, and affairs at their respective institutions. No party by virtue of this Agreement shall assume any liability for any debts or obligations of a financial or legal nature incurred by the other, and neither institution shall look to the other to pay for service rendered to a patient transferred by virtue of this Agreement.

10. Nondiscrimination. The parties agree to comply with Title VI of the Civil Rights Act of 1964, all requirements imposed by regulations issued pursuant to that title, section 504 of the Rehabilitation Act of 1973, and all related regulations, to insure that neither party shall discriminate against any recipient of services hereunder on the basis of race, color, sex, creed, national origin, age or handicap, under any program or activity receiving Federal financial assistance.

11. Term and Termination. This Agreement shall commence on **June 19, 2006**, and shall automatically be renewed annually for one year periods unless terminated according to this Section 10. This Agreement may be terminated by either party at any time upon the giving of at least sixty (60) day's prior written notice. Notwithstanding any notice which may have been given, however, this Agreement shall be automatically terminated whenever either party shall have its license to operate revoked, suspended or non-renewed.

12. Notices. All notices required to be served under this Agreement may be served on any of the parties hereto personally or may be served by sending a letter duly addressed by registered or certified mail. Notices to be served on the MEDICAL CENTER shall be served at or mailed to: Advocate Christ Medical Center, attention President, at 4440 West 95th Street, Oak Lawn, Illinois 60453 with a copy to Chief Legal Officer, Advocate Health and Hospitals Corporation at 2025 Windsor Drive, Oak Brook, Illinois 60521. Notices to be served on FACILITY shall be

served at or mailed to: Stony Creek Dialysis Center, attention Facility Administrator, at 9115 South Cicero Avenue, Oak Lawn, Illinois 60453, unless otherwise instructed.

13. Advertising and Publicity. Neither party shall use the name of the other party in any promotional or advertising material unless review and approval of those intended use shall be first be obtained from the party whose name is to be used.

14. Nonexclusive Clause. Nothing in this Agreement shall be construed as limiting the right of either party to affiliate or contract with any other MEDICAL CENTER or FACILITY, or either a limited or general basis, while this Agreement is in effect.

15. Amendment. This Agreement may be amended, modified, or supplemented by agreement of both parties, but no such modification, amendment, or supplement shall be binding on either party unless and until the same is attached hereto in writing and signed by authorized officials of both parties.

16. Governing Law. All questions concerning the validity or construction of this Agreement shall be determined in accordance with the laws of Illinois.

IN WITNESS WHEREOF, this Agreement has been executed by the MEDICAL CENTER and the FACILITY on the date first written above.

ADVOCATE HEALTH AND HOSPITALS CORPORATION
d/b/a ADVOCATE CHRIST MEDICAL CENTER

By: Kenneth W Kuhlmann
President

STONY CREEK DIALYSIS CENTER, DAVITA, INC.

By: M Bates
Facility Administrator

28943

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

The Applicants propose the establishment of a 16-station dialysis facility. Thus, this criterion does is not applicable.

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

Attached at Attachment – 26H is a letter from Javier Rodriguez, President, DaVita HealthCare Partners Inc. certifying that the proposed facility will achieve target utilization by the second year of operation

DaVita | HealthCare Partners

July 2, 2013

John Hayes
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: In-Center Hemodialysis Assurances

Dear Acting Chairman Hayes:

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

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

Sincerely,

Javier Rodriguez
President
DaVita HealthCare Partners Inc.

Subscribed and sworn to me
This 2ND day of July, 2013

Notary Public

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded entirely with cash and cash equivalents, and a lease from Palestra Real Estate Partners, Inc. A copy of DaVita's 2012 10-K Statement evidencing sufficient internal resources to fund the project was previously submitted with the application for Project No. 13-031. A letter of intent to lease the facility is attached at Attachment – 39A.

PALESTRA PROPERTIES, INC.

July 29, 2013

Mr. Edgar Levin
USI REAL ESTATE BROKERAGE SERVICES INC.
2215 YORK RD, SUITE 110
OAKBROOK, IL 60523

RE: RESPONSE v5 to Request for Proposal – former Aldi Store Redevelopment
10511 South Harlem Avenue, Worth, IL

Dear Edgar:

Thank you for the Request for Proposal. Below please find our written response to lease the above-referenced Property to be redeveloped by Palestra Real Estate Partners, Inc. or its assigns through the DaVita Preferred Developer Program ("PDP").

DISCLOSURE: USI Real Estate Brokerage Services Inc. discloses that this Request for Proposal is subject to the terms of Exhibit A attached hereto. The information in this email is confidential and may be legally privileged. It is intended solely for the addressee. Access to this email by anyone else is unauthorized.

PREMISES: 10511 South Harlem Avenue, Worth, IL

LEGAL DESCRIPTION: See Exhibit C

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

LANDLORD (or "Lessor"): Palestra Real Estate Partners, Inc. or its assigns

SPACE: Approximately 6,800 contiguous rentable square feet (usable same).

PRIMARY TERM & BASE RENT: Proposed Term and Base Rent is summarized here, and shall be per the Tenant PDP Lease form and the attached Prelim Budget.

Years 1- 5: $227,209.62 per annum (~$23.18/Rsf)
Years 6-10: $249,930.58 per annum (~$25.50/Rsf)
Years 11-15: $274,923.64 per annum (~$28.05/Rsf)

ADDITIONAL EXPENSES: Tenant shall pay additional expenses and additional rent according to the Tenant PDP Lease form. Tenant's pro rata share percentage of the Building shall be 73.35%, which equals 9,800 (total Tenant space) divided by the Building total square feet of 13,360.

LANDLORD'S MAINTENANCE: Landlord shall be responsible as called for by the Tenant PDP Lease form.

POSSESSION AND RENT COMMENCEMENT:	Landlord shall deliver Possession of the Premises to the Tenant as called for by the Tenant PDP Lease form. Rent Commencement shall be as called for by the Tenant PDP Lease form.
USE:	The Tenant's Use is as called for by the Tenant PDP Lease form. The Tenant's Architect will verify that the Property's Zoning will allow the Tenant's dialysis use. The Tenant's Provisioning Team will determine the postal address it wants.
PARKING:	Preliminarily, from the Site Plan provided by the Seller, it appears the Property contains 87 total parking stalls (a Property ratio of 6.5 per 1000 Rsf). Tenant may have its pro rata share of the Property's parking stalls. Assuming 73.35% and 87, then Tenant may have the unreserved use of 64 parking stalls 6.5 per 1000 Rsf).
BASE BUILDING:	Landlord shall deliver to the Base Building as called for by the Tenant PDP Lease form and by the attached Exhibit B.
TENANT ALLOWANCE:	None.
OPTION TO RENEW:	As called for by the Tenant PDP Lease form.
RIGHT OF FIRST OPPORTUNITY ON ADJACENT SPACE:	Tenant shall have a one-time right of first opportunity, on the adjacent 3,560 Rsf space, such right expiring 12/31/2013. If Tenant leases this space, it shall be under the same terms and conditions of the Tenant PDP Lease form – and made coterminous and thus prorating any other items as necessary to make both Landlord and Tenant whole.
FAILURE TO DELIVER PREMISES:	As called for by the Tenant PDP Lease form.
HOLDING OVER:	As called for by the Tenant PDP Lease form.
TENANT SIGNAGE:	As called for by the Tenant PDP Lease form.
BUILDING HOURS:	As called for by the Tenant PDP Lease form.
SUBLEASE/ASSIGNMENT:	As called for by the Tenant PDP Lease form.
ROOF RIGHTS:	As called for by the Tenant PDP Lease form.
NON COMPETE:	As called for by the Tenant PDP Lease form.
HVAC:	As called for by the Tenant PDP Lease form and attached Exhibit B.
DELIVERIES:	As called for by the Tenant PDP Lease form.
OTHER CONCESSIONS:	As called for by the Tenant PDP Lease form.

GOVERNMENTAL COMPLIANCE: As called for by the Tenant PDP Lease form.

CONTINGENCIES: Tenant CON Obligation: Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities and Services Review Board (HFSRB). Based on the length of the HFSRB review process, Tenant does not expect to receive a CON permit prior to November 5, 2013. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit *provided, however, the lease shall not be binding on either party prior to approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective prior to CON permit approval.* Assuming CON approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the HFSRB does not award Tenant a CON permit to establish a dialysis center on the Premises by November 5, 2013 neither party shall have any further obligation to the other party with regard to the negotiations, lease, or Premises contemplated by this Letter of Intent.

BROKERAGE FEE: Landlord recognizes USI Real Estate Brokerage Services Inc. as the Tenant's sole representative and shall pay a brokerage fee, per the Tenant PDP, per separate commission agreement provided on May 1, 2013.

Thank you for the opportunity to respond to the Request for Proposal.

Sincerely,
Palestra Real Estate Partners, Inc.

Vincent Curran Jr., its President

AGREED TO AND ACCEPTED THIS 31st DAY OF JULY 2013

By: _____
Palestra Real Estate Partners, Inc.
("Landlord")

AGREED TO AND ACCEPTED THIS 30th DAY OF JULY 2013

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

EXHIBIT A

NON-BINDING NOTICE

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

DaVita.

Exhibit B

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost:

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

1.0 - Building Codes & Design

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

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

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

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement.

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessor attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4 bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition.

Existing Concrete floor shall not have more than 3-lbs. of moisture per 1,000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 – Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or Insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

8.0 – Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 – 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

9.0- Roof Covering

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum

of R30 roof insulation at roof deck. If the R30 value is not meet, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

10.0 – Canopy

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

11.0 – Waterproofing and Weatherproofing

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

12.0 – Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

13.0 – Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation. Any new roof deck insulation is to be installed to the underside of the roof deck.

14.0 – Exterior Doors

All exterior doors shall meet American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

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

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

Any doors that are designated to be provided modified or prepared by Lessor; Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

15.0 – Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

16.0 – Plumbing

Lessor to provide a building water service sized to support Lesses's potable water demand, building fire sprinkler water demand (if applicable), and other tenant water demand (if applicable). Final size to be determined by building potable and sprinkler water combined by means of the total building water demand based on code derived water supply fixture unit method and the building fire sprinkler water hydraulic calculations, per applicable codes and in accordance to municipality and regulatory standards. Lessor to provide a minimum potable water supply to support 30 (60) GPM with a constant 50 PSI water pressure, or as determined by Lessee's Engineer based on Lessee's water demand. Maximum water pressure to Lessee space to not exceed 80 PSI, and where it does water supply to be provided with a pressure reducing valve. Lessor to provide Lessee with a current water flow test results (within current year) indicating pressure and flow, for Lessee's approval.

Where suitable building water already exists, Lessor to provide Lessee with a potable water supply to meet the above minimum requirements. Water flow and pressure to Lessee's space to be unaffected by any other building water requirements such as other tenant water requirements or irrigation systems. Lessor to bring water to Lessee's space, leaving off with a valve and cap for Lessee extension per Lessee direction or Lessee design plans.

Potable water supply to be provided with water meter and two (2) reduced pressure zone (RPZ) backflow devices arranged in parallel for uninterrupted service and sized to support required GPM demand. Backflow devices to be provided with adequate drainage per code and local authority. Meter to be per municipality or water provider standards.

Any existing hose bibs will be in proper working condition prior to Lessees possession of space.

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

Sanitary drain to be stubbed into Lessee's space with a minimum invert level of 42 inches below finished slab. Sanitary drain to be sized based on the calculated drainage fixture unit (DFU) method in accordance to code for both the Lessee's DFU's combined with any other tenant DFU's sharing the drain however, in no case less than 4 inch diameter. Ejectors or lift stations are prohibited. Lessor to clean, power jet and televise existing sanitary drain and provide Lessee with a copy of results. Any drains displaying disrepair or improper pitch shall be corrected by Lessor prior to acceptance by Lessee. Where existing conditions are not met, Lessor to provide new sanitary drain to meet such requirements at Lessor's cost and include all relevant Sanitary District and local municipality permit, tap and other fees for such work.

Lessor to provide a plumbing vent no less than 4 inch diameter stubbed into Lessee's space as high as possible with an elevation no less than the bottom of the lowest structural element of the framing to the deck above. Where deck above is the roof, Lessor to provide roof termination and all required roof flashing and waterproofing. Plumbing roof terminations to maintain a minimum separation of 15 feet, or

more if required by local code, from any mechanical rooftop equipment with fresh air intake. Where required separation does not exist, Lessor to relocate to be within compliance at Lessor's cost.

Sanitary sampling manhole if required by local municipality on new line.

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

17.0 - Fire Suppression and Alarm System

Fire Sprinkler Systems and building fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

Where Sprinkler System is not present and is required by Lessee usage based on local code or NFPA 101, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building, fire prevention and life safety codes for the entire building. This system to be on a dedicated water line independent of Lessee's potable water line requirements. Lessor to include all municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

18.0 – Electrical

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire derived from a single metered source and consisting of dedicated CT cabinet per utility company standards feeding a distribution panelboard in the Lessee's utility room (location to be per National Electrical Code (NEC) and coordinated with Lessee and their Architect) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Lessor's service provisions shall include utility metering, tenant service feeder, and distribution panelboard with main and branch circuit breakers. Lessee will not accept multiple services to obtain the necessary capacity. Should this not be available Lessor to upgrade electrical service to meet the following criteria:

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

Lessee's Engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panelboard. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term.

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

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

Existing electrical raceway, wire, and cable extending through the Lessee's space but serving areas outside the Lessee's space shall be re-routed outside the Lessee's space and reconnected as required at the Lessor's cost.

Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. Lessor's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction. If lease space is in a multi-tenant building then Lessor to provide an empty conduit stub in Lessee space from Lessor's Fire Alarm panel. If Fire Alarm system is unable to accommodate Lessee requirements and/or FA system is not within applicable code compliance, Lessor to upgrade panel at Lessor's cost.

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

19.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000-BTU's. Natural gas line shall be individually metered and sized per demand.

20.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units, components and equipment that Lessee intends to reuse shall be left in place 'as is' by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units, Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows:

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

- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

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

21.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

22.0 – Cable or Satellite TV

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

23.0 - Handicap Accessibility

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

Lessor shall provide pavement marking; curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

24.0 - Generator

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

25.0 – Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with a 90 minute battery back up at all access points.

26.0 – Exterior Building Lighting

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

27.0 – Parking Lot

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

28.0 – Refuse Enclosure

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

29.0 - Signage

Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Exhibit C – Legal Description, Tax & Survey Information

Tax Parcel One:

The west 65.80 feet (measured perpendicular to the west line) of Lot 1 in Aldi subdivision, being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridian, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

Tax Parcel Four:

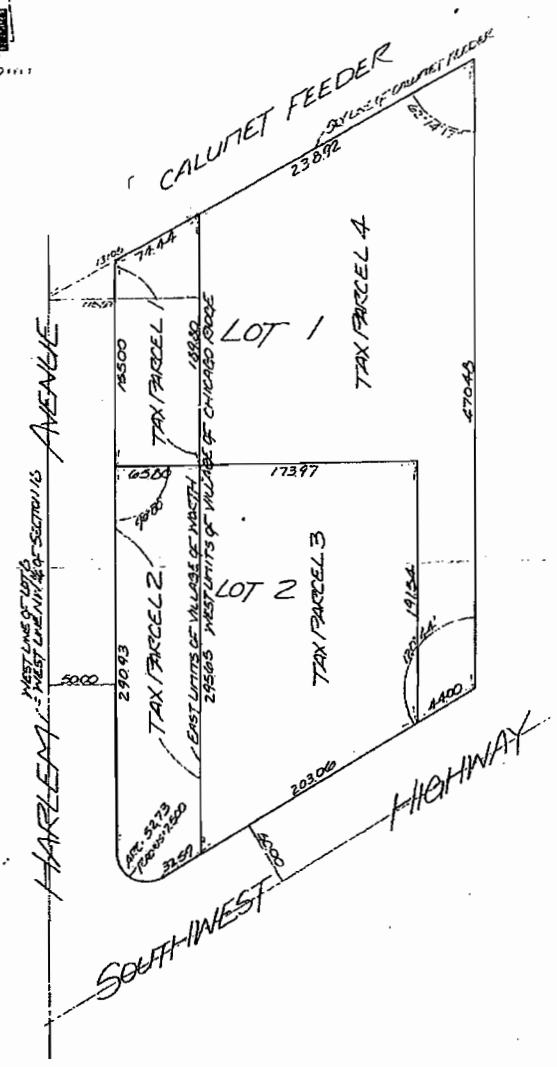
Lot 1 (except the west 65.80 feet measured perpendicular to the west line thereof) in Aldi subdivision being a subdivision of part of the northwest ¼ of Section 18, Township 37 North, Range 13, east of the Third Principal Meridan, according to the Plat thereof recorded June 18, 1990 as document number 90-287592, in Cook County, Illinois.

#32

PLAT OF SURVEY

TAX DIVISION MAP

STONELAKE SURVEY CO., LTD.
REGISTERED LAND SURVEYORS
11659 S. MAYFIELD AVENUE
WORTH ILLINOIS 60482
PHONE 388-1010



TAX PARCEL ONE: THE WEST 65.80 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 1 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL TWO: THE WEST 65.80 FEET (MEASURED PERPENDICULAR TO THE WEST LINE) OF LOT 2 IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL THREE: LOT 3 (EXCEPT THE WEST 65.80 FEET, MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287592, IN COOK COUNTY, ILLINOIS.

TAX PARCEL FOUR: LOT 1 (EXCEPT THE WEST 65.80 FEET MEASURED PERPENDICULAR TO THE WEST LINE THEREOF) IN ALDI SUBDIVISION, BEING A SUBDIVISION OF PART OF THE NORTHWEST ¼ OF SECTION 18, TOWNSHIP 37 NORTH, RANGE 13, EAST OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE PLAT THEREOF RECORDED JUNE 18, 1990 AS DOCUMENT NUMBER 90-287592, IN COOK COUNTY, ILLINOIS.

AREAS OF TAX PARCELS

TAX PARCEL ONE	= 31,344 SQUARE FEET
TAX PARCEL TWO	= 26,385 SQUARE FEET
TAX PARCEL THREE	= 42,433 SQUARE FEET
TAX PARCEL FOUR	= 58,760 SQUARE FEET

STATE OF ILLINOIS }
COUNTY OF COOK } SS

STONELAKE SURVEY CO., LTD. HEREBY CERTIFIES THAT WE HAVE SURVEYED THE ABOVE DESCRIBED PROPERTY AND HAVE PREPARED THE HEREON DRAWN PLAT FOR TAX DIVISION PURPOSES. ALL DIMENSIONS ARE IN FEET AND DECIMAL PARTS THEREOF CORRECT AT 62° FAHRENHEIT.

DATED AT WORTH, ILLINOIS THIS 26 DAY OF June, 1990.

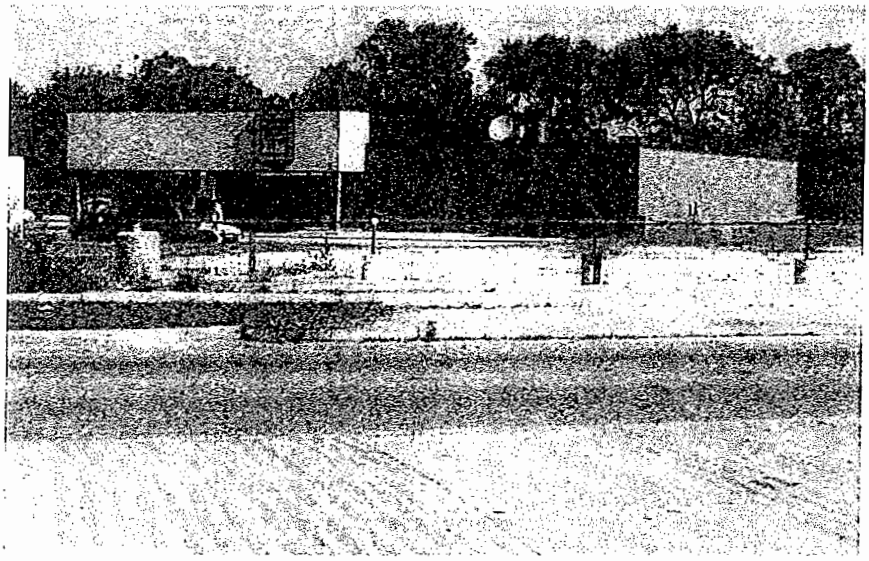
STONELAKE SURVEY CO., LTD.

ILLINOIS REGISTERED LAND SURVEYOR #1705

#32 Pack/3

ADDRESS _____
SURVEYED FOR 7011 EDWELL
ORDERED BY _____
ORDER NO. 3694-90K
BOOK _____ PAGE _____

NO MEASUREMENTS ARE TO BE ASSUMED BY SCALE



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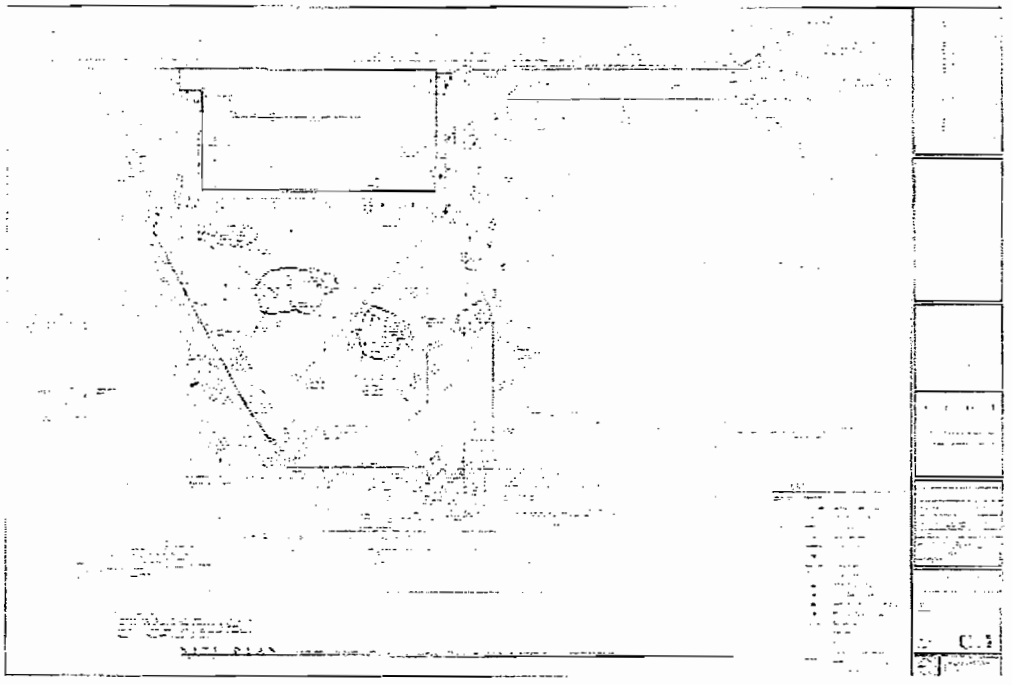


Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

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

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

Attached at Attachment – 42A is a letter from Javier Rodriguez, President of DaVita HealthCare Partners, Inc. attesting that the total estimated project costs will be funded entirely with cash.

Attachment – 42A

DaVita | HealthCare Partners

July 2, 2013

John Hayes
Acting Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Acting Chairman Hayes:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded in total with cash and cash equivalents.

Sincerely,

Javier Rodriguez
President
DaVita HealthCare Partners Inc.

Subscribed and sworn to me
This 2ND day of July, 2013

Notary Public

RHONDA R. CORRICK
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19964010321
MY COMMISSION EXPIRES NOVEMBER 13, 2016

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

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

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(c), Reasonableness of Project and Related Costs

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. $ (A x C)	Mod. $ (B x E)	
ESRD	150.74				6,800			$1,025,000	$1,025,000
Contingency	21.85				6,800			$148,625	$148,625
TOTALS	172.59				6,800			$1,173,625	$1,173,625
* Include the percentage (%) of space for circulation									

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)			
	Proposed Project	**State Standard**	**Above/Below State Standard**
Modernization Contracts & Contingencies	$1,173,625	$173.14 per gsf x 6,800 gsf = $173.14 x 6,800 = $1,177,352	Below State Standard
Contingencies	$148,625	10-15% of Modernization Contracts = 10-15% x $1,025,000 = $102,500 - $153,750	Meets State Standard
Architectural/Engineering Fees	$86,000	6.90% - 10.56% x (Modernization Costs + Contingencies) = 6.90% - 10.36% x ($1,025,000 + $148,625) = 6.90% - 10.36% x $1,173,625 = $80,980 - $121,588	Meets State Standard
Consulting and Other Fees	$53,500	No State Standard	No State Standard
Moveable Equipment	$595,000	$39,945 per station x 16 stations $39,945 x 16 = $639,120	Below State Standard

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

Operating Expenses: $3,592,114

Treatments: 13,572

Operating Expense per Treatment: $264.67

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

Capital Costs:

Depreciation:	$155,716
Amortization:	$ 10,088
Total Capital Costs:	$165,804

Treatments: 13,572

Capital Costs per Treatment: $12.22

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. DaVita HealthCare Partners Inc. and its affiliates are safety net providers of dialysis services to residents of the State of Illinois. DaVita is a leading provider of dialysis services in the United States and is committed to innovation, improving clinical outcomes, compassionate care, education and Kidney Smarting patients, and community outreach. A copy of DaVita's 2012 Community Care report, which details DaVita's commitment to quality, patient centric focus and community outreach, was previously submitted on July 15, 2013 as part of Applicants' application for Proj. No. 13-045. DaVita has taken on many initiatives to improve the lives of patients suffering from CKD and ESRD. These programs include the Kidney Smart, IMPACT, CathAway, and transplant assistance programs. Furthermore, DaVita is an industry leader in the rate of fistula use and had the lowest day-90 catheter rates among large dialysis providers in 2010. Its commitment to improving clinical outcomes directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which was $1 Billion in savings to the health care system and the American taxpayer between 2010 - 2011.

2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. As shown in Table 1110.1430(b), average utilization at existing dialysis facilities within 30 minutes normal travel time of the Proposed Facility is currently 81%. Dr. Pallath has identified 137 patients from her practice who are suffering from Stage 4 or 5 CKD, who all reside within an approximate 20 minute commute of the proposed facility. Thus, approximately 87 patients will be referred to the Proposed Facility within 12 to 24 months. This represents a 91% utilization rate, which exceeds the State's 80% standard. As such, the proposed facility is necessary to allow existing facilities to operate at their optimum capacity while at the same time accommodating the growing demand for dialysis services. Accordingly, the proposed dialysis facility will not impact other general health care providers' ability to cross-subsidize safety net services.

3. The proposed project is for the establishment of Chicago Ridge Dialysis. As such, this criterion is not applicable.

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

Section XII, Charity Care Information

The table below provides charity care information for all dialysis facilities located in the State of Illinois that are owned or operated by the Applicants.

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

Appendix I – Time & Distance Determination

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

Property Record for 10511 S Harlem Avenue, Worth, IL 60482

Information for the Retail property located at 10511 S Harlem Avenue, Worth, IL 60482 includes data gathered from Cook County tax records, public records data providers and LoopNet historical listing and sales records.

LoopNet Property Records X

LoopNet Property Records display available information such as historical listings, property details, property tax records, property deeds, owners, mortgages, tenants, and more. Information is aggregated from the LoopNet marketplace, LoopNet research, leading independent data providers, Cook County tax records, and LoopNet members.

Retail Property Record

10511 S Harlem Avenue, Worth, IL 60482

Summary Stats & Trends Property More

Summary

Become a Property Facts Subscriber to view all the information for this property. Learn More

Already a member? Log in

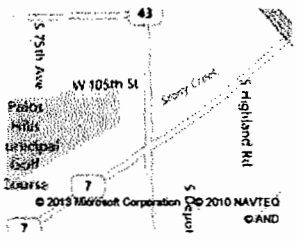
Get Featured Here

Update this property record to get your logo and profile link here – free. Submit a photo or image. LoopNet's Research Team reviews all submissions prior to publishing new information.

Property Details

View Details

Primary Property Type:	Retail
Property Sub-type:	Retail (Other)
Building Size:	



View Larger Maps

mapquest

Notes

FMC Bolingbrook Dialysis Center

Trip to:

538 E Boughton Rd
Bolingbrook, IL 60440-2181
17.52 miles / 26 minutes

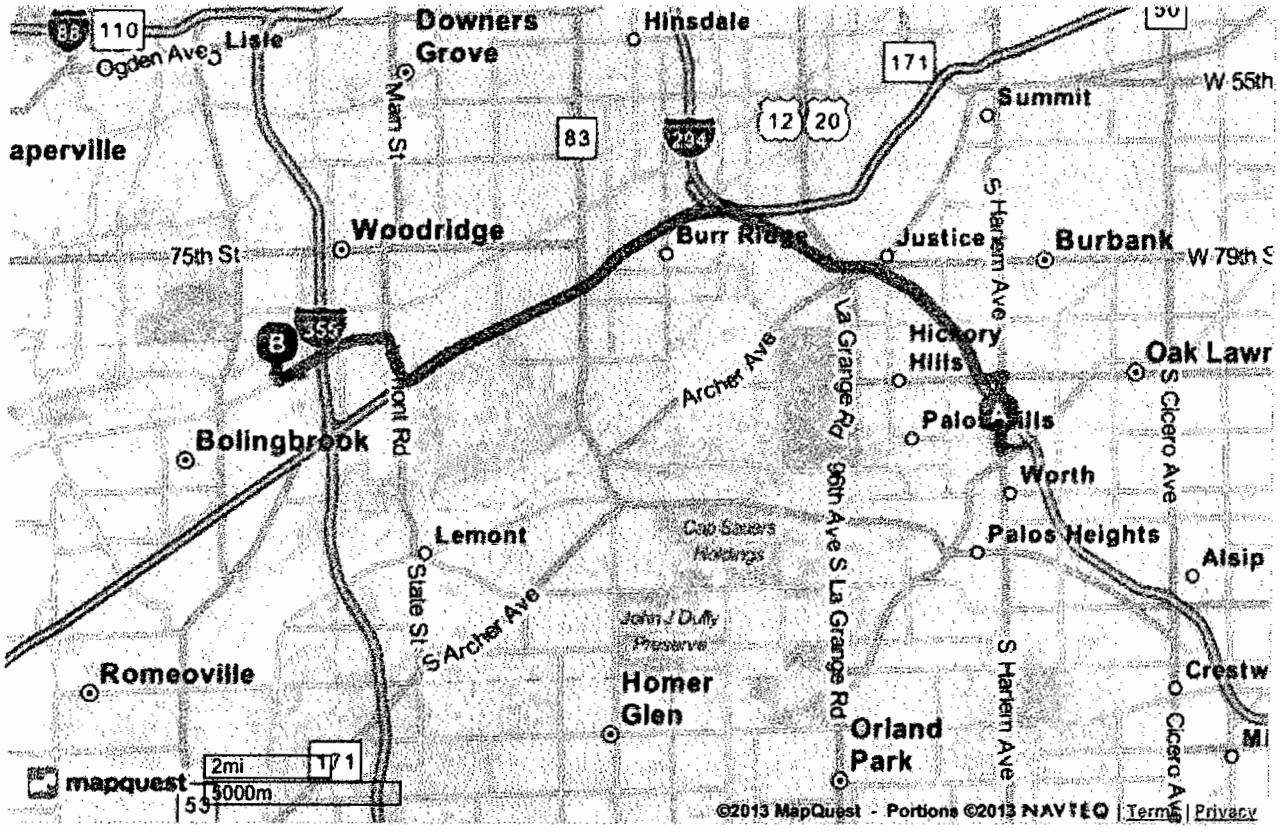
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**5.7 Mi** *7.5 Mi Total*
4. Merge onto **I-55 S** toward **St Louis**. Map	**6.9 Mi** *14.5 Mi Total*
5. Take the **North Lemont Rd** exit, **EXIT 271B**. Map	**0.3 Mi** *14.7 Mi Total*
6. Merge onto **Lemont Rd**. Map	**0.7 Mi** *15.4 Mi Total*
7. Take the 3rd **left** onto **87th St**. Map *87th St is 0.2 miles past Woodcrest Dr* *If you reach 86th St you've gone about 0.1 miles too far*	**1.0 Mi** *16.4 Mi Total*
8. **87th St** becomes **E Boughton Rd**. Map	**1.1 Mi** *17.5 Mi Total*
9. **538 E BOUGHTON RD** is on the **right**. Map *Your destination is just past Preston Dr* *If you reach Kildeer Dr you've gone a little too far*	

538 E Boughton Rd, Bolingbrook, IL 60440-2181

Total Travel Estimate: **17.52 miles - about 26 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Silver Cross Renal Center

Trip to:

1890 Silver Cross Blvd

New Lenox, IL 60451-9508

17.73 miles / 31 minutes

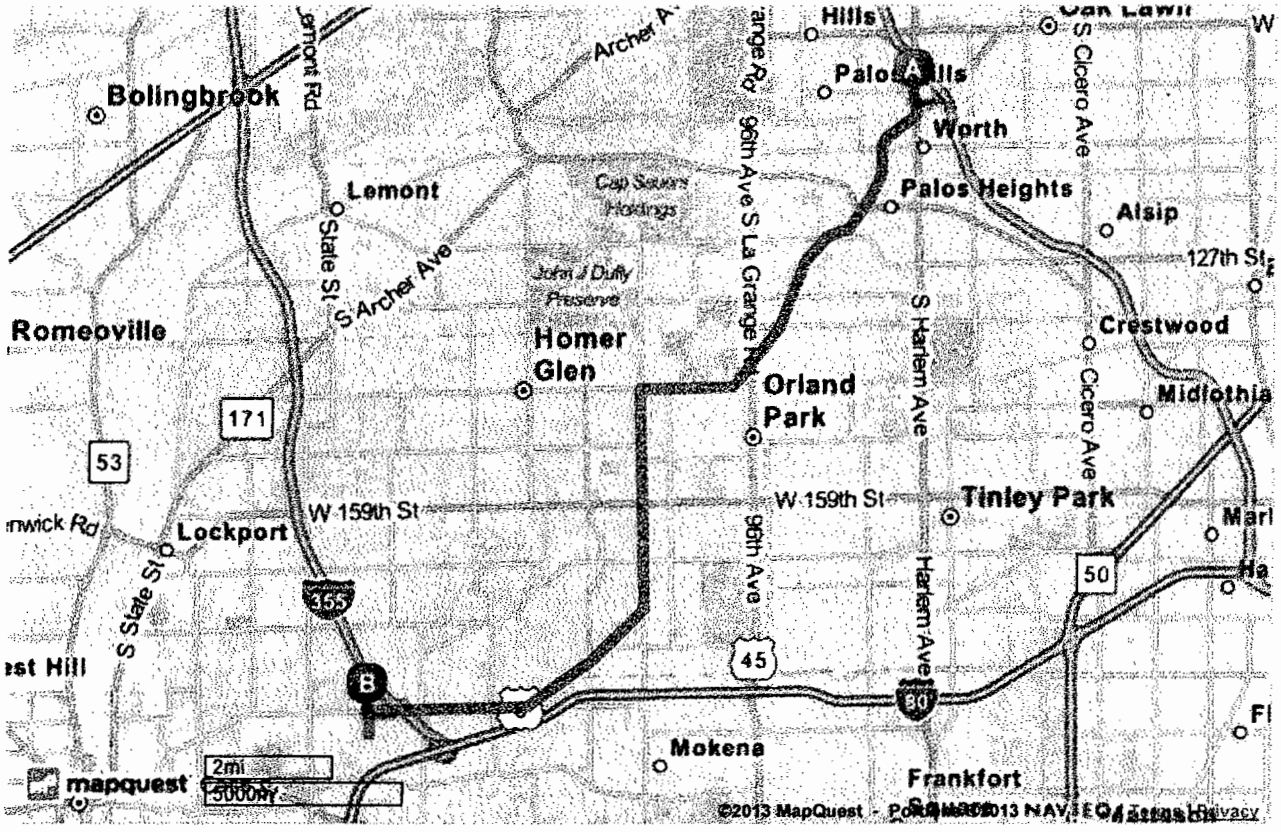
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. Map	**0.1 Mi**	
	0.1 Mi Total	
2. Take the 1st **right** onto **SouthWest Hwy / IL-7**. Map	**6.0 Mi**	
Brooklyn Pizza is on the corner	*6.1 Mi Total*	
If you are on S Harlem Ave and reach W 107th St you've gone a little too far		
3. Turn **slight right** onto **W 143rd St / IL-7**. Map	**1.6 Mi**	
The Irish Patriot is on the corner	*7.8 Mi Total*	
4. Turn **left** onto **Wolf Rd / IL-7**. Continue to follow **Wolf Rd**. Map	**3.9 Mi**	
Wolf Rd is 0.2 miles past Deer Haven Ln	*11.7 Mi Total*	
CVS Pharmacy is on the corner		
If you reach Compton Ct you've gone about 0.1 miles too far		
5. Turn **right** onto **US-6 / SouthWest Hwy**. Continue to follow **US-6 W**. Map	**5.6 Mi**	
US-6 W is 0.2 miles past Brook Hill Dr	*17.2 Mi Total*	
If you reach 175th St you've gone about 0.1 miles too far		
6. Turn **left** onto **Silver Cross Blvd**. Map	**0.4 Mi**	
Silver Cross Blvd is 1.0 mile past N Cedar Rd	*17.6 Mi Total*	
If you reach Spring Creek St you've gone about 0.2 miles too far		
7. Make a **U-turn** onto **Silver Cross Blvd**. Map	**0.2 Mi**	
If you reach Abraham Dr you've gone about 0.6 miles too far	*17.7 Mi Total*	
8. **1890 SILVER CROSS BLVD** is on the **right**. Map		
If you reach Maple Rd you've gone about 0.1 miles too far		

1890 Silver Cross Blvd, New Lenox, IL 60451-9508

Total Travel Estimate: **17.73 miles - about 31 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

USRC Oak Brook

Trip to:

1201 Butterfield Rd Ste B

Downers Grove, IL 60515-1074

19.40 miles / 26 minutes

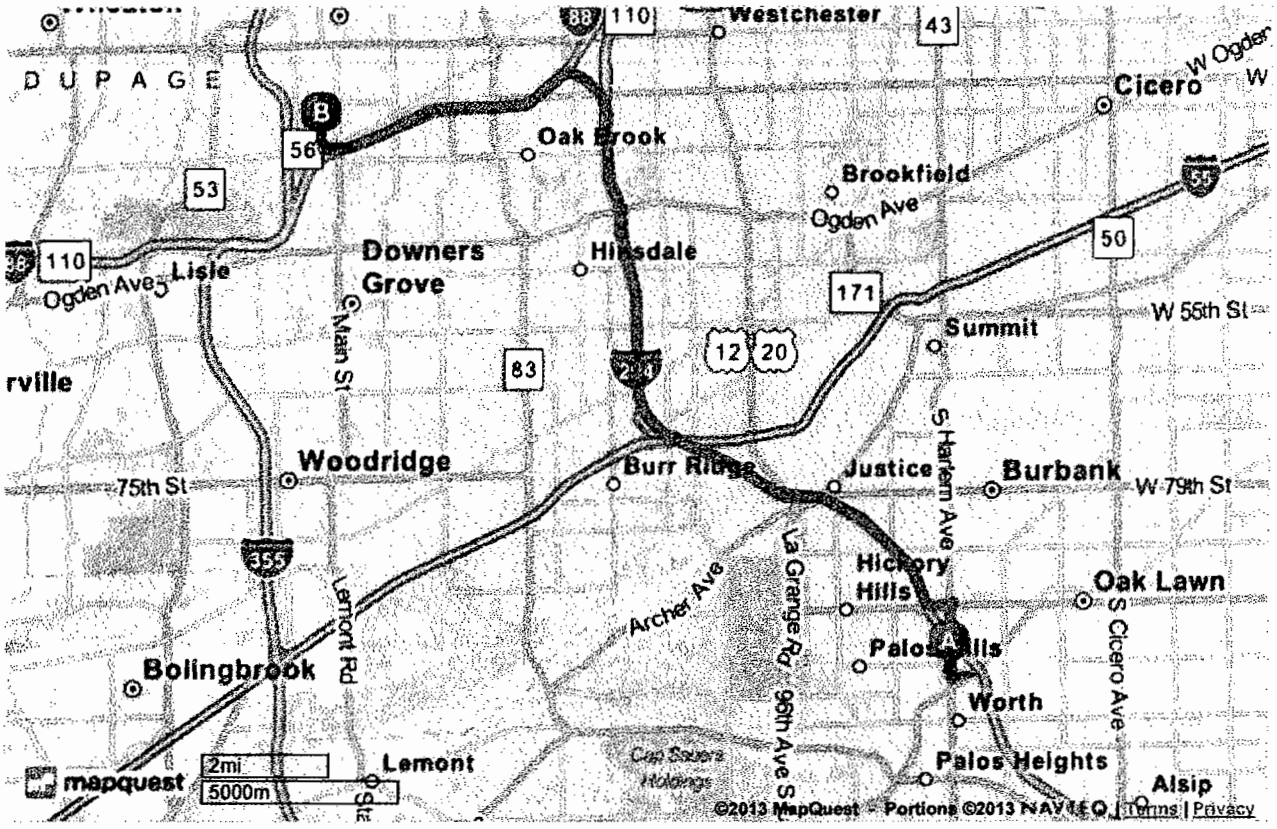
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**11.5 Mi** *13.3 Mi Total*
4. Merge onto **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** toward **Aurora** (Portions toll). Map	**5.5 Mi** *18.8 Mi Total*
5. Take the **Highland Ave** exit. Map	**0.2 Mi** *19.0 Mi Total*
6. Keep **left** to take the ramp toward **Downers Grove / Midwestern College / Keller College**. Map	**0.04 Mi** *19.1 Mi Total*
7. Stay **straight** to go onto **Butterfield Rd**. Map	**0.3 Mi** *19.4 Mi Total*
8. **1201 BUTTERFIELD RD STE B** is on the **left**. Map *Your destination is 0.3 miles past Highland Ave* *If you reach Downers Dr you've gone about 0.2 miles too far*	

1201 Butterfield Rd Ste B, Downers Grove, IL 60515-1074

Total Travel Estimate: **19.40 miles - about 26 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes
FMC Downers Grove

Trip to:
3825 Highland Ave
Downers Grove, IL 60515-1554
20.22 miles / 28 minutes

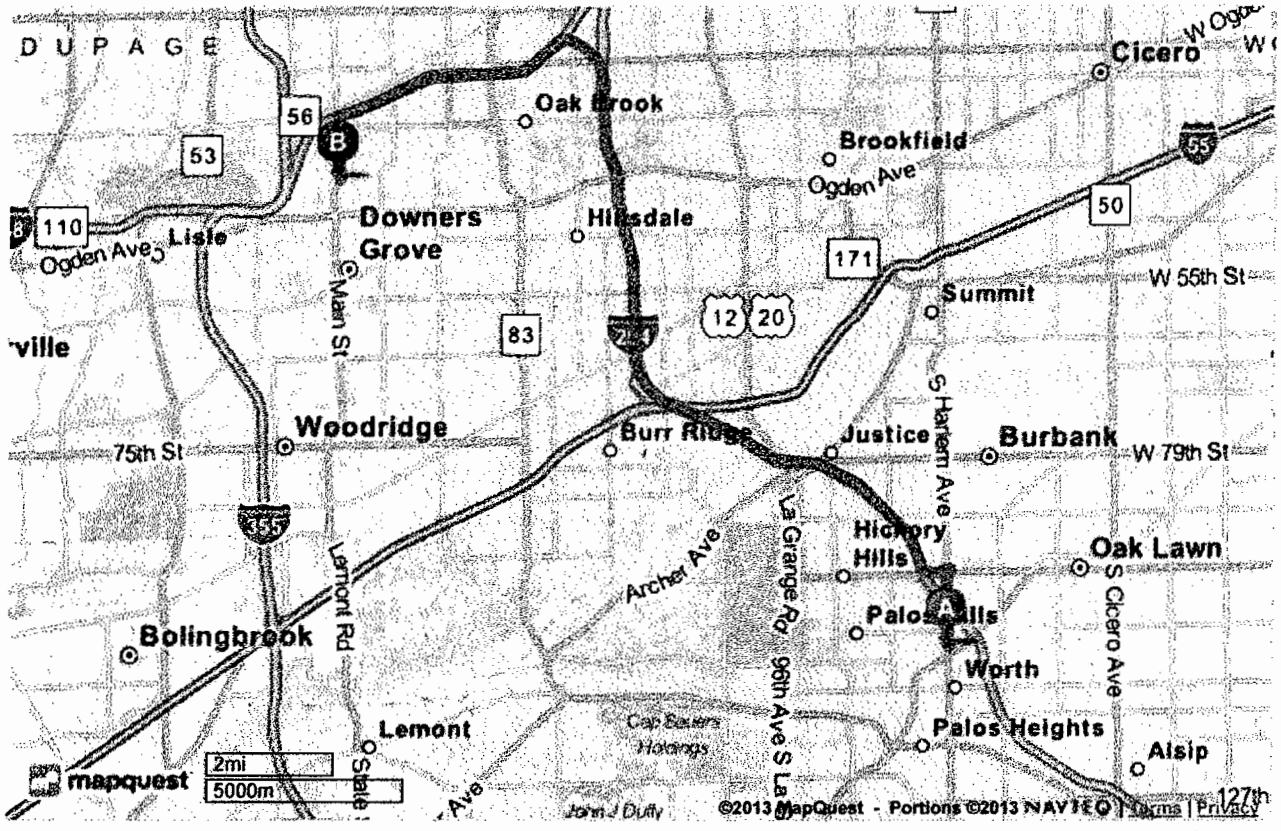
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**11.5 Mi** *13.3 Mi Total*
4. Merge onto **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** toward **Aurora** (Portions toll). Map	**5.5 Mi** *18.8 Mi Total*
5. Take the **Highland Ave** exit. Map	**0.2 Mi** *19.0 Mi Total*
6. Keep **left** to take the ramp toward **Downers Grove / Midwestern College / Keller College**. Map	**0.04 Mi** *19.1 Mi Total*
7. Turn **left** onto **Highland Ave**. Map	**1.1 Mi** *20.2 Mi Total*
8. **3825 HIGHLAND AVE** is on the **left**. Map *Your destination is just past Black Oak Dr* *If you reach 39th St you've gone about 0.1 miles too far*	

3825 Highland Ave, Downers Grove, IL 60515-1554

Total Travel Estimate: **20.22 miles - about 28 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC Dialysis Services of Willowbrook

Trip to:

6300 Kingery Hwy Ste 408

Willowbrook, IL 60527-2271

13.13 miles / 19 minutes

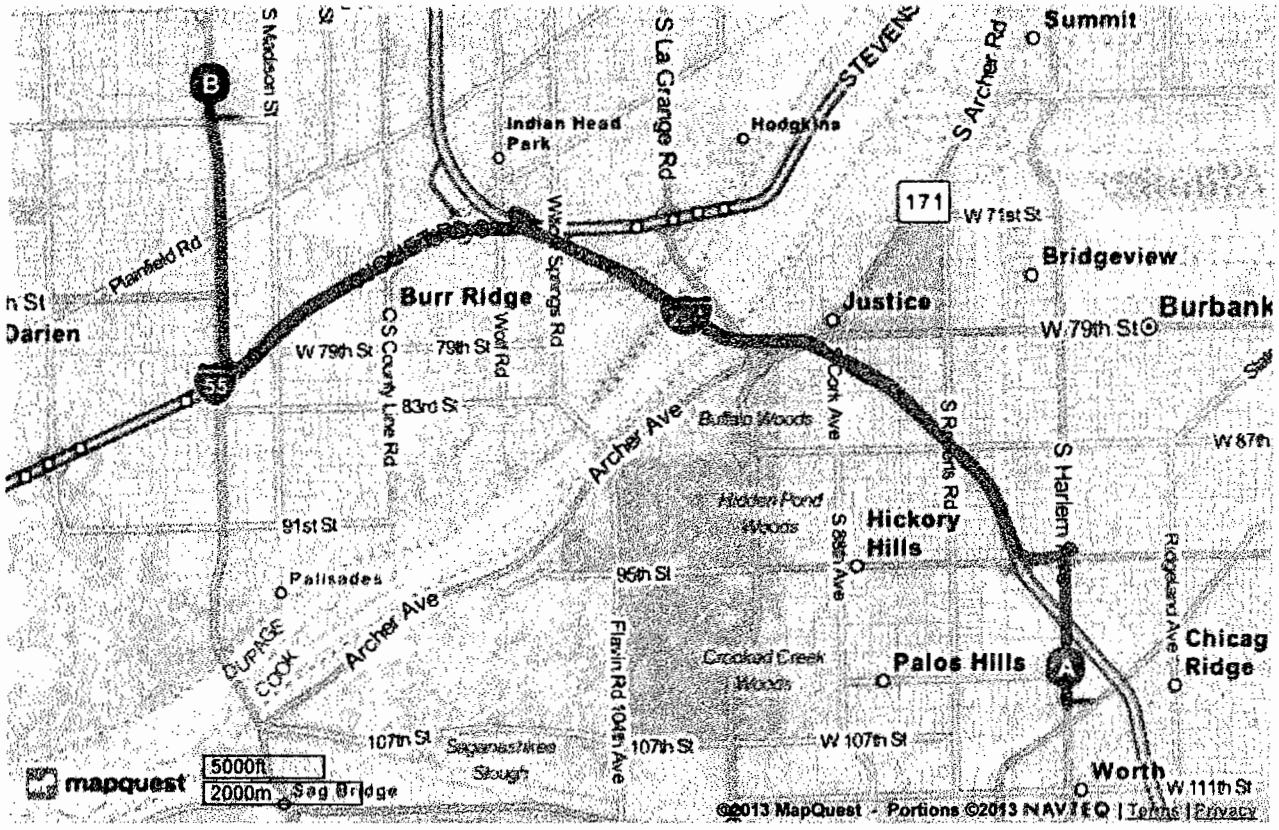
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**5.7 Mi** *7.5 Mi Total*
4. Merge onto **I-55 S** toward **St Louis**. Map	**3.1 Mi** *10.7 Mi Total*
5. Merge onto **IL-83 N** via **EXIT 274**. Map	**2.4 Mi** *13.1 Mi Total*
6. Turn **left** onto **63rd St**. Map *63rd St is 0.2 miles past Ridgemoor Dr W* *Bank of America Banking Center - Route 83/63rd Str is on the corner*	**0.01 Mi** *13.1 Mi Total*
7. **6300 KINGERY HWY STE 408**. Map *If you reach Americana Dr you've gone about 0.1 miles too far*	

6300 Kingery Hwy Ste 408, Willowbrook, IL 60527-2271

Total Travel Estimate: **13.13 miles - about 19 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care -Lombard

Trip to:

1940 Springer Dr
Lombard, IL 60148-6419
21.05 miles / 30 minutes

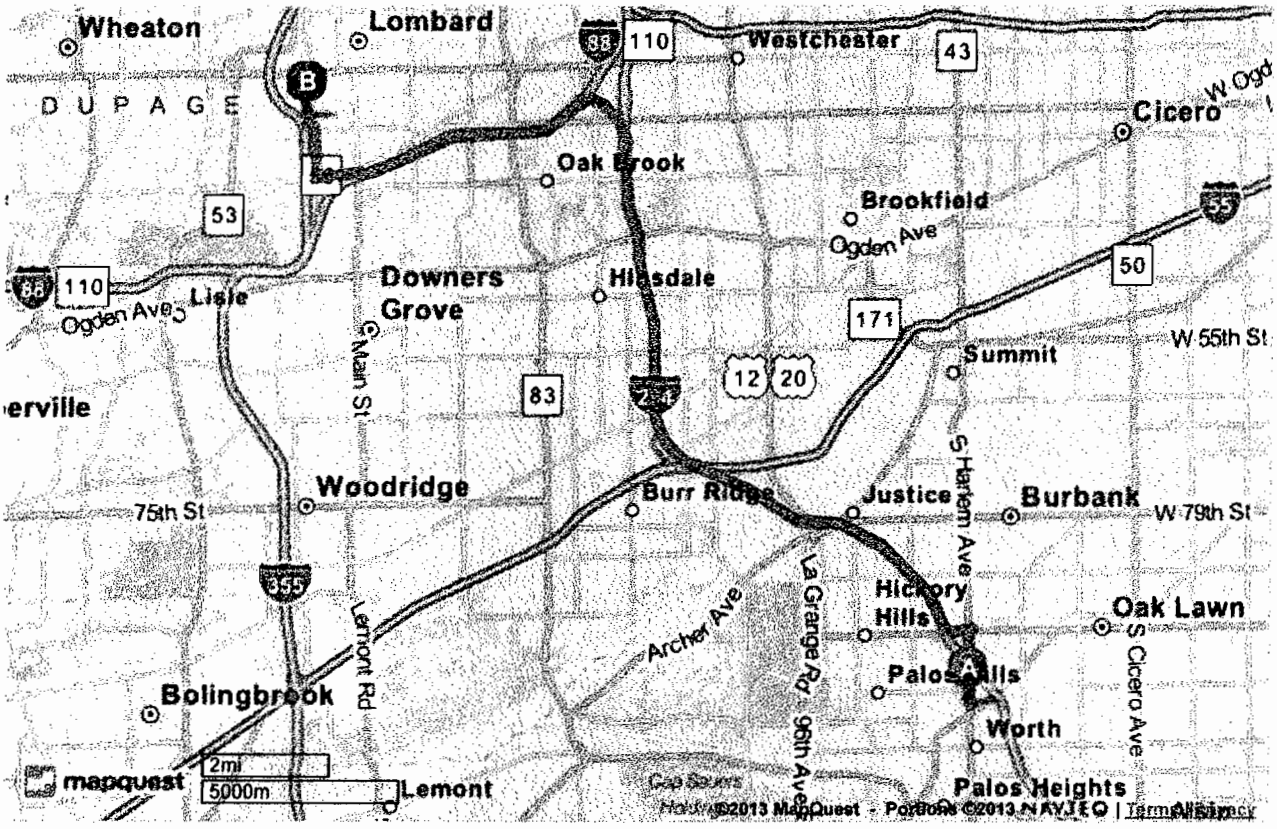
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**11.5 Mi** *13.3 Mi Total*
4. Merge onto **I-88 W / IL-110 W / Ronald Reagan Memorial Tollway** toward **Aurora** (Portions toll). Map	**5.5 Mi** *18.8 Mi Total*
5. Take the **Highland Ave** exit. Map	**0.2 Mi** *19.0 Mi Total*
6. Keep **right** to take the ramp toward **Lombard / Chiropractic College**. Map	**0.05 Mi** *19.1 Mi Total*
7. Turn **right** onto **Highland Ave**. Map	**0.03 Mi** *19.1 Mi Total*
8. Merge onto **Butterfield Rd / IL-56 W** via the ramp on the **left**. Map	**0.8 Mi** *19.9 Mi Total*
9. Turn **right** onto **Finley Rd**. Map *Finley Rd is 0.2 miles past Downers Dr*	**0.9 Mi** *20.8 Mi Total*
10. Turn **left** onto **Foxworth Blvd**. Map *Foxworth Blvd is 0.1 miles past 22nd St* *If you reach Oak Creek Dr you've gone about 0.2 miles too far*	**0.1 Mi** *20.9 Mi Total*
11. Turn **right** onto **Springer Dr**. Map	**0.1 Mi** *21.0 Mi Total*
12. **1940 SPRINGER DR** is on the **left**. Map *If you reach Oak Creek Dr you've gone about 0.1 miles too far*	

1940 Springer Dr, Lombard, IL 60148-6419

Total Travel Estimate: **21.05 miles - about 30 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes
FMC Elmhurst

Trip to:
133 E Brush Hill Rd
Elmhurst, IL 60126-5658
16.20 miles / 23 minutes

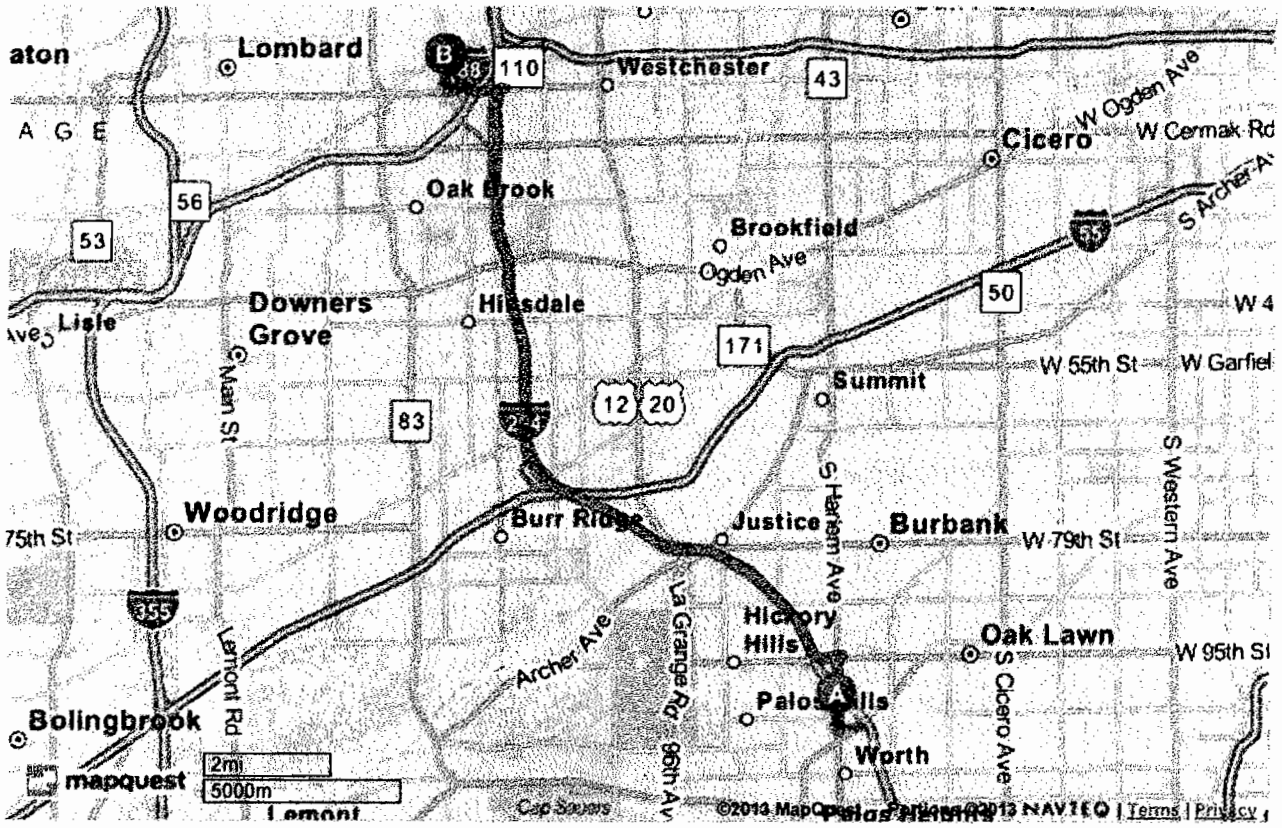
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**13.1 Mi** *15.0 Mi Total*
4. Merge onto **IL-38 W / Roosevelt Rd**. Map	**0.7 Mi** *15.7 Mi Total*
5. Take the **North York Road** ramp. Map	**0.3 Mi** *15.9 Mi Total*
6. Turn **slight left** onto **E Brush Hill Rd**. Map	**0.3 Mi** *16.2 Mi Total*
7. **133 E BRUSH HILL RD**. Map *Your destination is 0.2 miles past Fronza Pky* *If you reach S Euclid Ave you've gone about 0.1 miles too far*	

133 E Brush Hill Rd, Elmhurst, IL 60126-5658

Total Travel Estimate: **16.20 miles - about 23 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - LaGrange Dialysis Center

Trip to:

2400 Wolf Rd Ste 101a

Westchester, IL 60154-5635

14.21 miles / 21 minutes

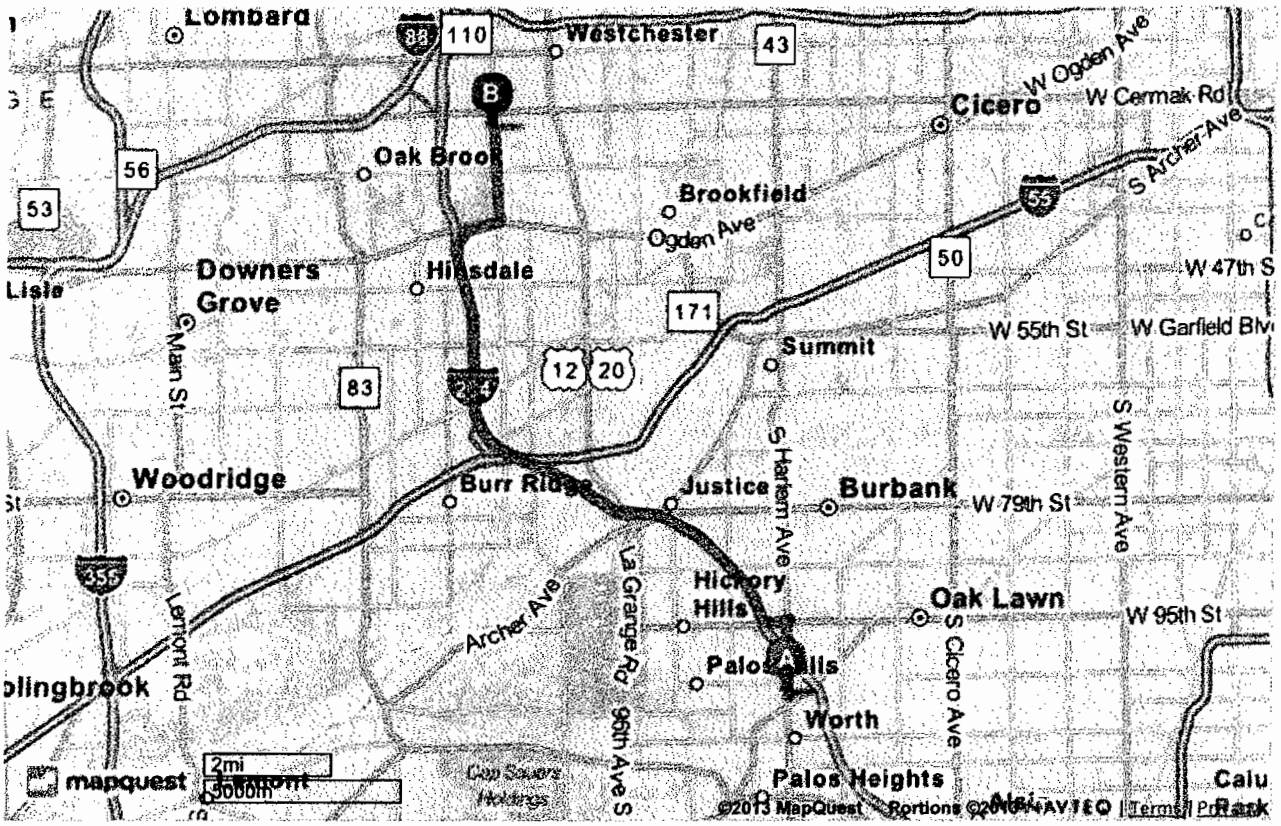
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi**	*1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi**	*1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**9.8 Mi**	*11.6 Mi Total*
4. Merge onto **US-34 E / Ogden Ave**. Map	**1.0 Mi**	*12.6 Mi Total*
5. Turn **left** onto **Wolf Rd**. Map *Wolf Rd is just past Lawn Ave* *If you reach Johnson Ave you've gone a little too far*	**1.6 Mi**	*14.2 Mi Total*
6. **2400 WOLF RD STE 101A** is on the **left**. Map *Your destination is just past Summerdale St* *If you reach Westbrook Corporate Ctr you've gone about 0.1 miles too far*		

2400 Wolf Rd Ste 101a, Westchester, IL 60154-5635

Total Travel Estimate: **14.21 miles - about 21 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care of Mokena

Trip to:

8910 W 192nd St
Mokena, IL 60448-8110
13.21 miles / 24 minutes

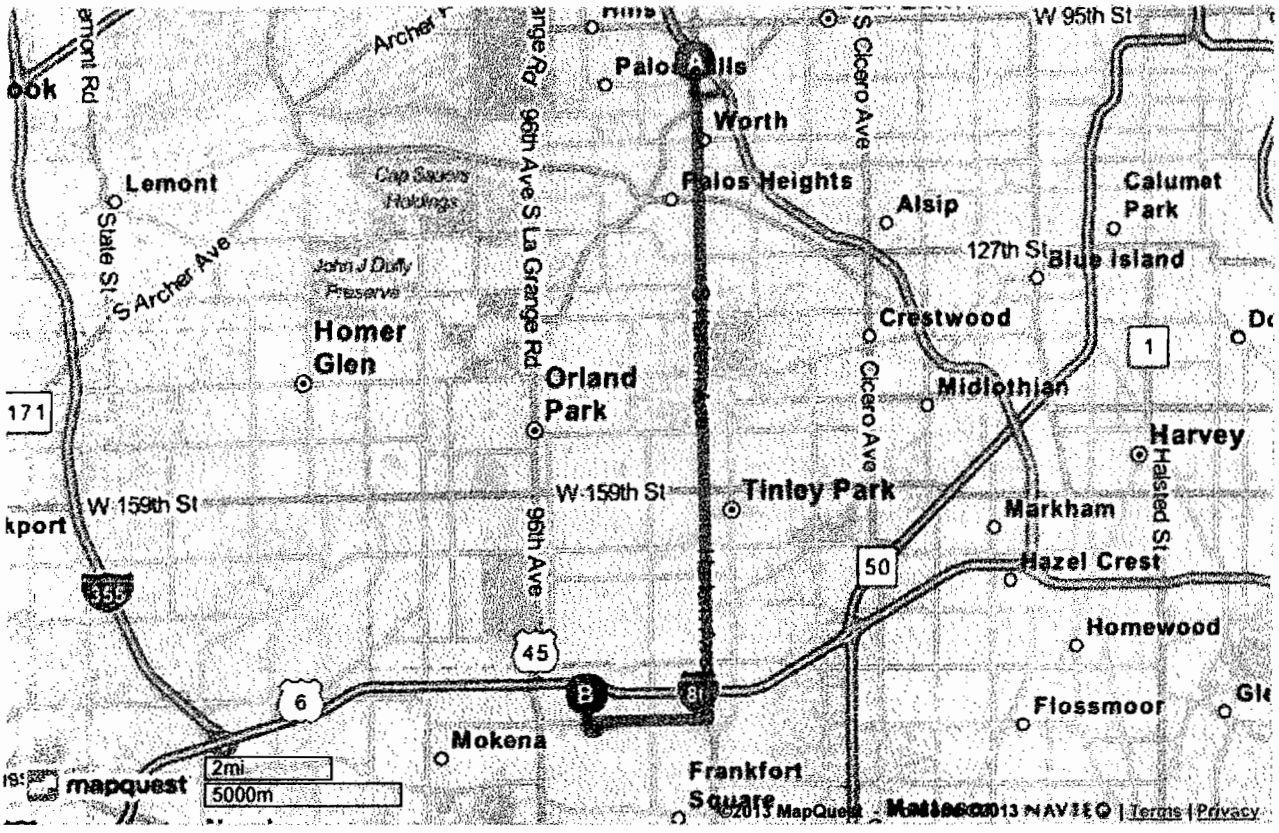
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1.	Start out going **south** on **S Harlem Ave / IL-43 S** toward **SouthWest Hwy / IL-7**. Map	**10.8 Mi** *10.8 Mi Total*
2.	Turn **right** onto **W 191st St**. Map *T.G.I. Friday's is on the right* *If you reach Oak Park Ave you've gone about 0.2 miles too far*	**2.0 Mi** *12.9 Mi Total*
3.	Turn **left** onto **S 88th Ave**. Map *S 88th Ave is 0.3 miles past 85th Ct* *If you reach Darvin Dr you've gone about 0.4 miles too far*	**0.2 Mi** *13.1 Mi Total*
4.	Take the 1st **right** onto **W 192nd St**. Map *The Breakfast Nook is on the right* *If you reach Clare Ave you've gone about 0.1 miles too far*	**0.2 Mi** *13.2 Mi Total*
5.	**8910 W 192ND ST** is on the **right**. Map *If you reach W 191st St you've gone about 0.4 miles too far*	

8910 W 192nd St, Mokena, IL 60448-8110

Total Travel Estimate: **13.21 miles - about 24 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes
Palos Park Dialysis

Trip to:
13155 S la Grange Rd
Orland Park, IL 60462-1162
4.99 miles / 10 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. Map	**0.1 Mi** *0.1 Mi Total*
2. Take the 1st **right** onto **SouthWest Hwy / IL-7**. Map *Brooklyn Pizza is on the corner* *If you are on S Harlem Ave and reach W 107th St you've gone a little too far*	**4.1 Mi** *4.3 Mi Total*
3. Turn **right** onto **W 131st St**. Map *W 131st St is 0.6 miles past W 126th St* *Murphys Pub is on the corner* *If you are on SouthWest Hwy and reach W 135th St you've gone about 0.5 miles too far*	**0.7 Mi** *4.9 Mi Total*
4. Turn **left** onto **S La Grange Rd / 96th Ave / US-45**. Map *S La Grange Rd is 0.2 miles past S 94th Ave* *It's Greek to Me is on the left* *If you reach S Mill Rd you've gone about 0.2 miles too far*	**0.05 Mi** *5.0 Mi Total*
5. **13155 S LA GRANGE RD** is on the **left**. Map *If you reach Southmoor Dr you've gone about 0.1 miles too far*	

13155 S la Grange Rd, Orland Park, IL 60462-1162

Total Travel Estimate: **4.99 miles - about 10 minutes**

BOOK TRAVEL with mapquest (877) 577-5766

mapquest

Notes
FMC - Dialysis Center of America - Orland Park

Trip to:
9160 W 159th St
Orland Park, IL 60462-5648
8.89 miles / 17 minutes

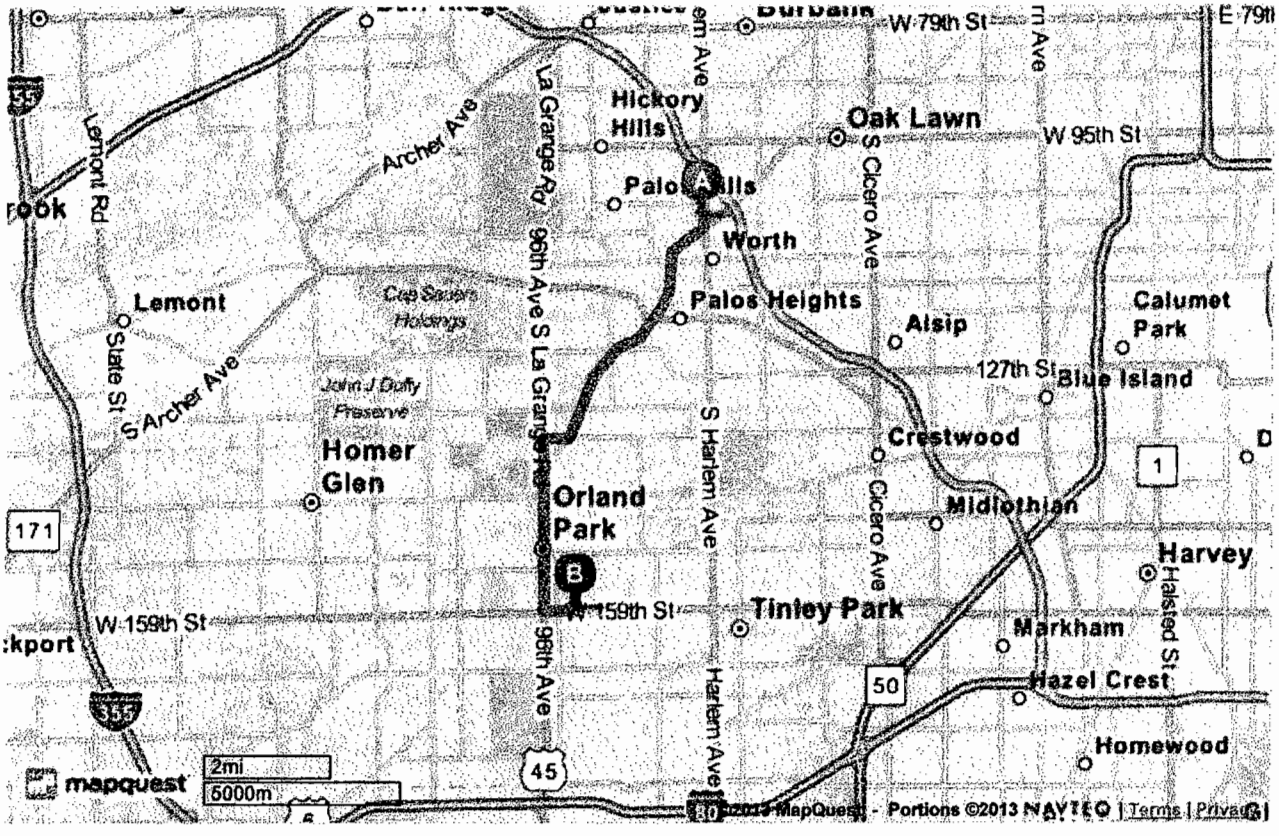
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy**. Map		**0.1 Mi** *0.1 Mi Total*
2. Take the **1st right** onto **SouthWest Hwy / IL-7**. Map *Brooklyn Pizza is on the corner* *If you are on S Harlem Ave and reach W 107th St you've gone a little too far*		**4.7 Mi** *4.8 Mi Total*
3. Turn **right** onto **W 135th St**. Map *W 135th St is 0.5 miles past W 131st St*		**0.5 Mi** *5.3 Mi Total*
4. Turn **left** onto **S La Grange Rd / 96th Ave / US-45**. Map		**3.0 Mi** *8.3 Mi Total*
5. Turn **left** onto **W 159th St / US-6**. Map *W 159th St is 0.3 miles past 156th Pl* *Fat Sam's Pub is on the right* *If you reach 163rd St you've gone about 0.5 miles too far*		**0.6 Mi** *8.9 Mi Total*
6. **9160 W 159TH ST** is on the **left**. Map *Your destination is 0.3 miles past S 94th Ave* *If you reach Parkhill Dr you've gone a little too far*		

9160 W 159th St, Orland Park, IL 60462-5648

Total Travel Estimate: **8.89 miles - about 17 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Olympia Fields Dialysis Center

Trip to:

4557 Lincoln Hwy Ste B

Matteson, IL 60443-2385

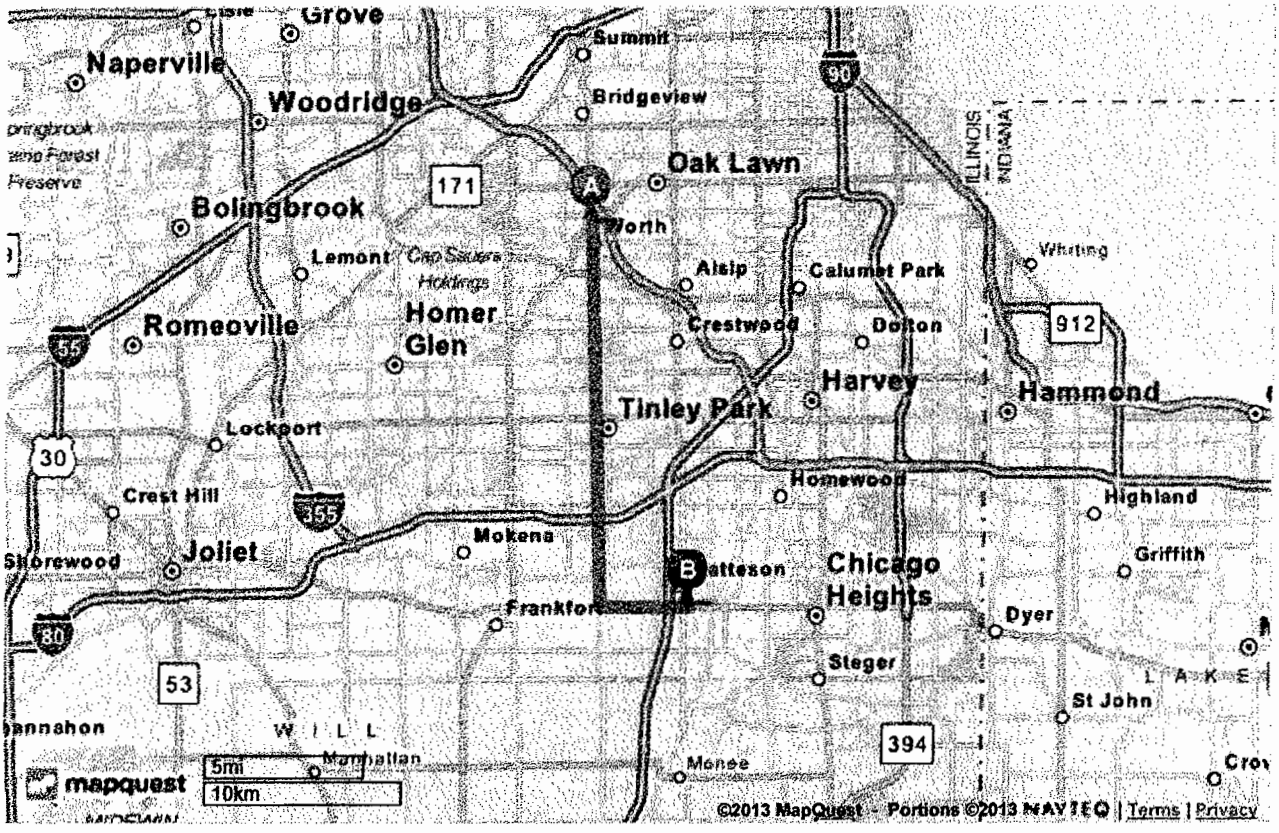
16.74 miles / 29 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43 S** toward **SouthWest Hwy / IL-7**. Map	**13.5 Mi** *13.5 Mi Total*
2. Turn **left** onto **211th St / Lincoln Hwy / W Lincoln Hwy / US-30 E**. Continue to follow **211th St / Lincoln Hwy / US-30 E**. Map *211th St is 0.4 miles past W Hickory Creek Dr* *If you reach Georgetown Commons you've gone about 0.3 miles too far*	**3.3 Mi** *16.7 Mi Total*
3. **4557 LINCOLN HWY STE B** is on the **right**. Map *Your destination is just past Lindenwood Dr* *If you reach Kostner Ave you've gone about 0.2 miles too far*	

4557 Lincoln Hwy Ste B, Matteson, IL 60443-2385

Total Travel Estimate: **16.74 miles - about 29 minutes**



mapquest

Notes

Direct Dialysis - Crestwood Care Centre

Trip to:

14255 Cicero Ave

Crestwood, IL 60445-2154

6.56 miles / 14 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi**	*1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi**	*4.2 Mi Total*
3. Stay **straight** to go onto **Cal Sag Rd**. Map	**0.9 Mi**	*5.2 Mi Total*
4. Turn **right** onto **IL-50 / Cicero Ave / IL-83**. Map *IL-50 is 0.3 miles past Rivercrest Dr* *Beds Beds Beds is on the corner* *If you reach Kolmar Ave you've gone about 0.5 miles too far*	**1.4 Mi**	*6.6 Mi Total*
5. **14255 CICERO AVE** is on the **left**. Map *Your destination is just past 142nd St* *If you reach 143rd St you've gone a little too far*		

14255 Cicero Ave, Crestwood, IL 60445-2154

Total Travel Estimate: **6.56 miles - about 14 minutes**

BOOK TRAVEL with mapquest (877) 577-5766

mapquest

Notes

FMC - Dialysis Center of America - Crestwood

Trip to:

4861 Cal Sag Rd # 73

Crestwood, IL 60445-4415

5.08 miles / 10 minutes

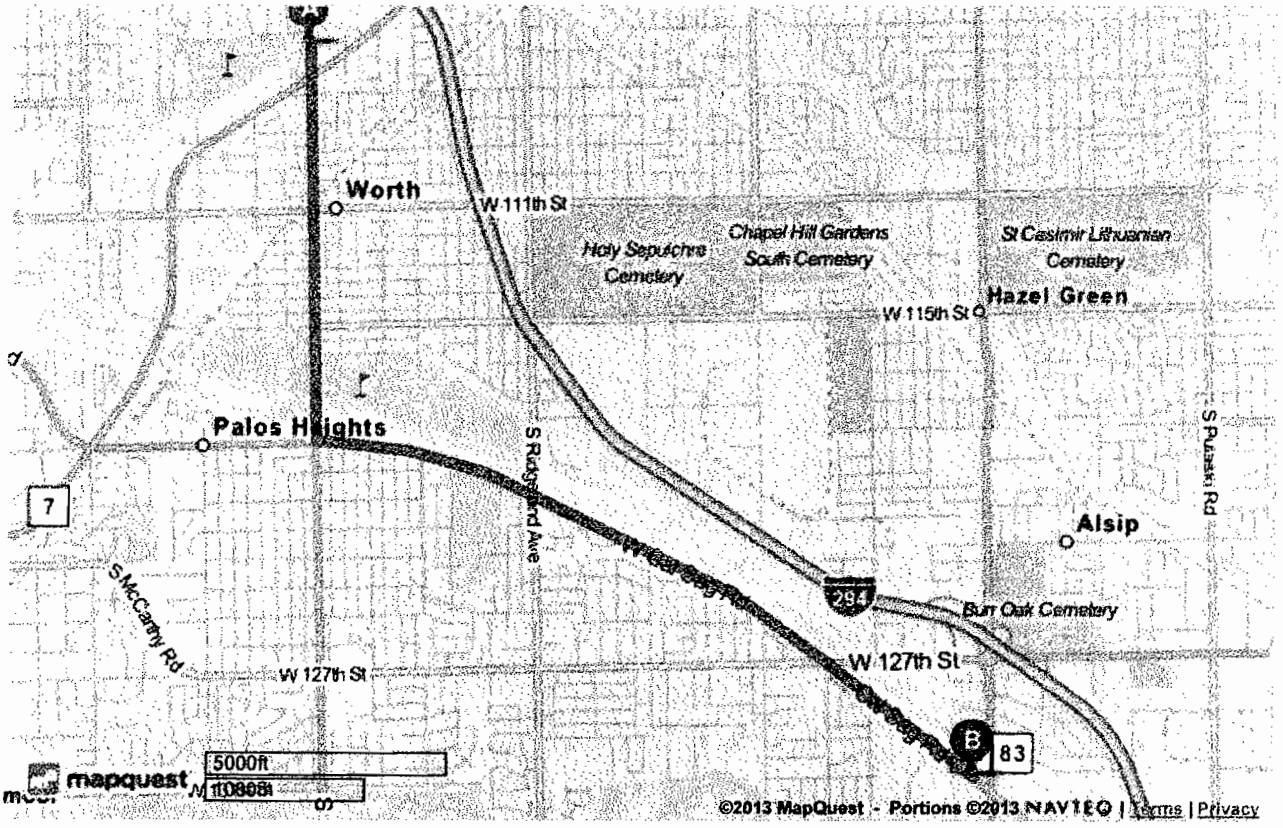
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi** *1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi** *4.2 Mi Total*
3. Stay **straight** to go onto **Cal Sag Rd**. Map	**0.8 Mi** *5.1 Mi Total*
4. **4861 CAL SAG RD # 73** is on the **right**. Map *Your destination is 0.2 miles past Rivercrest Dr* *If you reach IL-50 you've gone about 0.1 miles too far*	

4861 Cal Sag Rd # 73, Crestwood, IL 60445-4415

Total Travel Estimate: **5.08 miles - about 10 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes
FMC - Alsip Dialysis Center

Trip to:
12250 S Cicero Ave Ste 105
Alsip, IL 60803-2946
5.58 miles / 12 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map — **1.7 Mi** / *1.7 Mi Total*

2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map — **2.5 Mi** / *4.2 Mi Total*
IL-83 is 0.3 miles past W 116th St
Sherwin-Williams Paint Store is on the corner
If you reach W 119th Pl you've gone a little too far

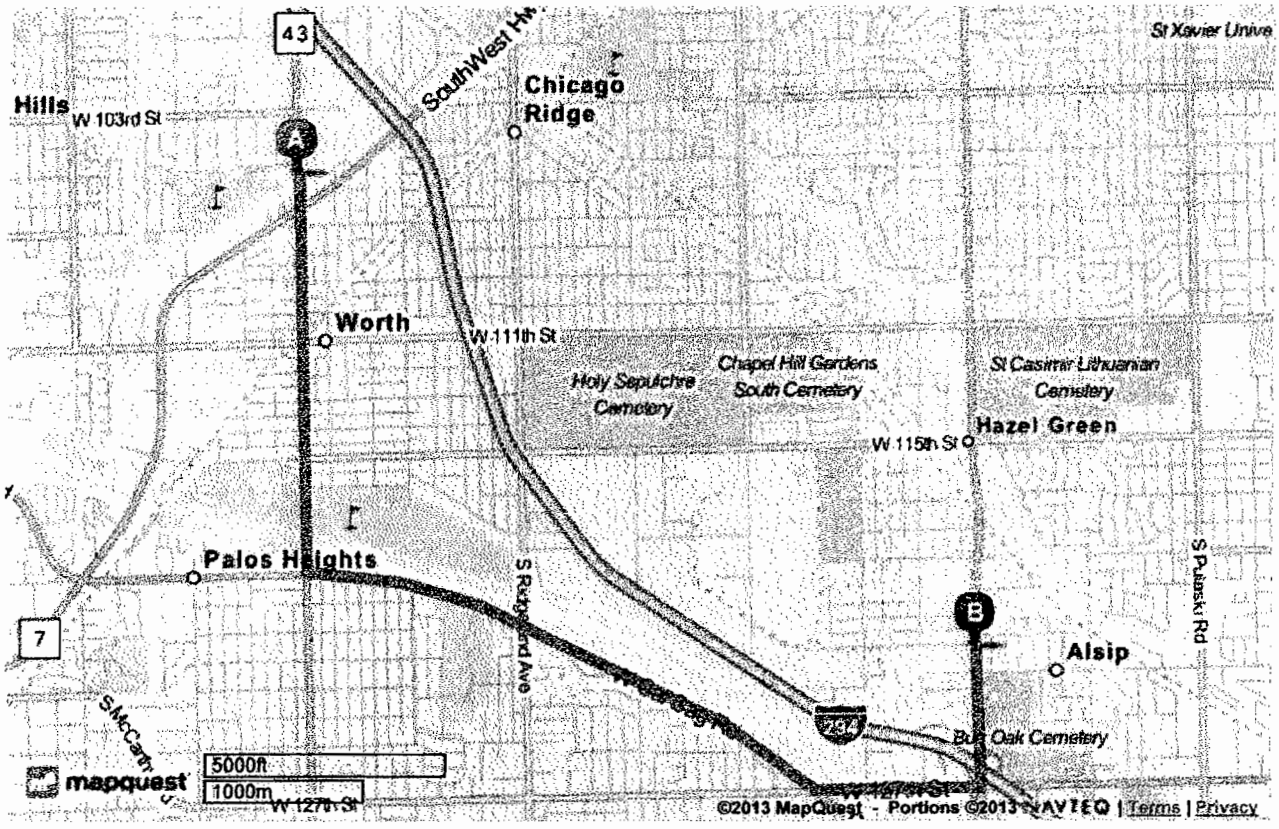
3. Turn **slight left** onto **W 127th St / IL-83**. Map — **0.7 Mi** / *5.0 Mi Total*
W 127th St is 0.3 miles past S Central Ave
SPEEDWAY #7750 is on the corner
If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far

4. Turn **left** onto **IL-50 N / S Cicero Ave**. Map — **0.6 Mi** / *5.6 Mi Total*
IL-50 N is 0.1 miles past S Laporte Ave
If you reach S Kostner Ave you've gone about 0.4 miles too far

5. **12250 S CICERO AVE STE 105** is on the **left**. Map
Your destination is just past W 123rd St
If you reach W 122nd St you've gone a little too far

12250 S Cicero Ave Ste 105, Alsip, IL 60803-2946

Total Travel Estimate: **5.58 miles - about 12 minutes**



mapquest

Notes

Stoney Creek Dialysis

Trip to:

9115 S Cicero Ave

Oak Lawn, IL 60453-1895

4.03 miles / 10 minutes

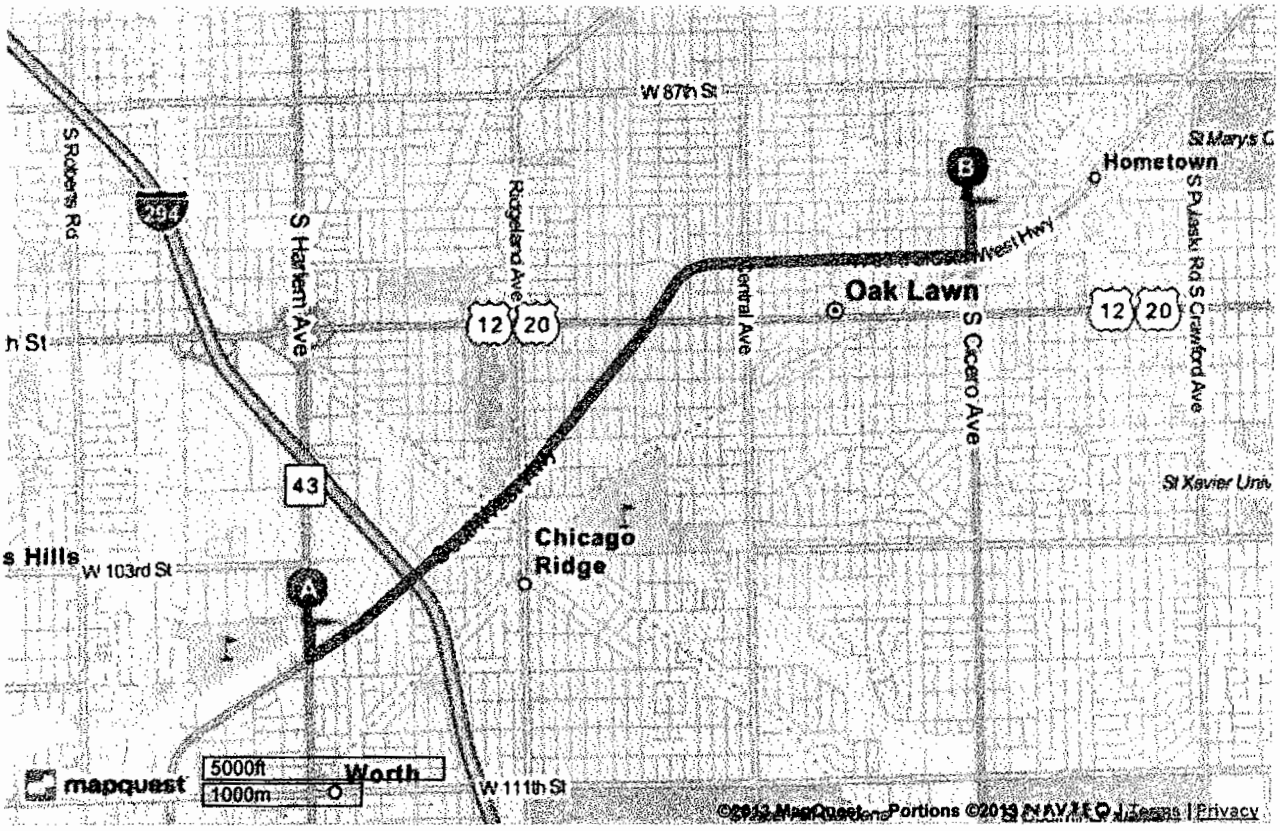
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi**	
	0.1 Mi Total	
2. Take the 1st **left** onto **SouthWest Hwy**. Map	**3.7 Mi**	
Brooklyn Pizza is on the corner	*3.8 Mi Total*	
If you reach W 107th St you've gone a little too far		
3. Turn **left** onto **S Cicero Ave / IL-50**. Map	**0.2 Mi**	
S Cicero Ave is just past S 48th Ct	*4.0 Mi Total*	
Boston Market is on the corner		
If you reach S Keating Ave you've gone a little too far		
4. **9115 S CICERO AVE** is on the **right**. Map		
Your destination is just past W 91st Pl		
If you reach W 91st St you've gone a little too far		

9115 S Cicero Ave, Oak Lawn, IL 60453-1895

Total Travel Estimate: **4.03 miles - about 10 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care - Midway

Trip to:

6201 W 63rd St

Chicago, IL 60638-5009

6.71 miles / 15 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map — **5.5 Mi**
   5.5 Mi Total

2. Turn **right** onto **W 63rd St**. Map — **1.3 Mi**
   6.7 Mi Total
   W 63rd St is just past W 63rd Pl
   SHELL is on the corner
   If you reach W 62nd St you've gone about 0.1 miles too far

3. **6201 W 63RD ST** is on the **right**. Map
   Your destination is just past S Merrimac Ave
   If you reach S Melvina Ave you've gone a little too far

6201 W 63rd St, Chicago, IL 60638-5009

Total Travel Estimate: **6.71 miles - about 15 minutes**

mapquest

Notes

FMC Dialysis Services - Burbank

Trip to:

4811 W 77th St

Burbank, IL 60459-1586

6.16 miles / 14 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map — **2.3 Mi** / *2.3 Mi Total*

2. Turn **right** onto **W 87th St**. Map — **1.0 Mi** / *3.3 Mi Total*
W 87th St is just past W 87th Pl
Circle K is on the corner
If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far

3. Turn **slight left** onto **State Rd**. Map — **1.5 Mi** / *4.8 Mi Total*
State Rd is just past Nagle Ave
Les Brothers Restaurant is on the corner
If you are on W 87th St and reach Mobile Ave you've gone a little too far

4. Turn **slight right** onto **W 79th St**. Map — **0.8 Mi** / *5.7 Mi Total*
W 79th St is just past Linder Ave
Best Taste Deli Inc is on the right
If you are on State Rd and reach Lotus Ave you've gone a little too far

5. Turn **left** onto **S Cicero Ave / IL-50**. Map — **0.4 Mi** / *6.0 Mi Total*
S Cicero Ave is just past La Crosse Ave
Dunkin Donuts is on the corner
If you reach S Keating Ave you've gone a little too far

6. Turn **left** onto **W 76th St / W 77th St**. Map — **0.1 Mi** / *6.1 Mi Total*
W 76th St is 0.2 miles past W 78th St
Olive Garden Italian Restaurant is on the left
If you reach S State Rd you've gone about 0.3 miles too far

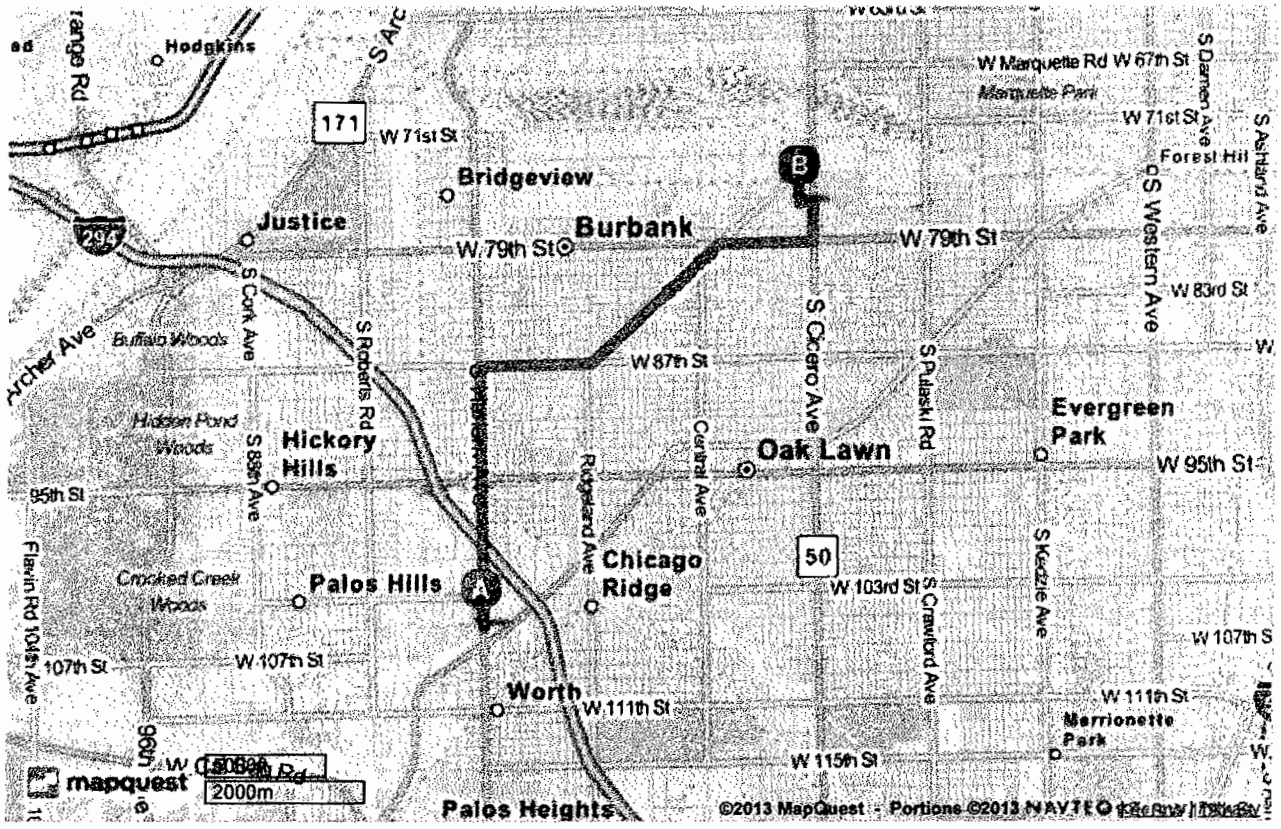
7. Turn **left**. Map — **0.02 Mi** / *6.2 Mi Total*
Popeyes Chicken & Biscuits is on the left

8. Take the **1st right** onto **W 77th St**. Map
Popeyes Chicken & Biscuits is on the corner

9. **4811 W 77TH ST** is on the **left**. Map
If you reach the end of W 77th St you've gone a little too far

4811 W 77th St, Burbank, IL 60459-1586

Total Travel Estimate: **6.16 miles - about 14 minutes**



mapquest

Notes

RCG-Scottsdale

Trip to:

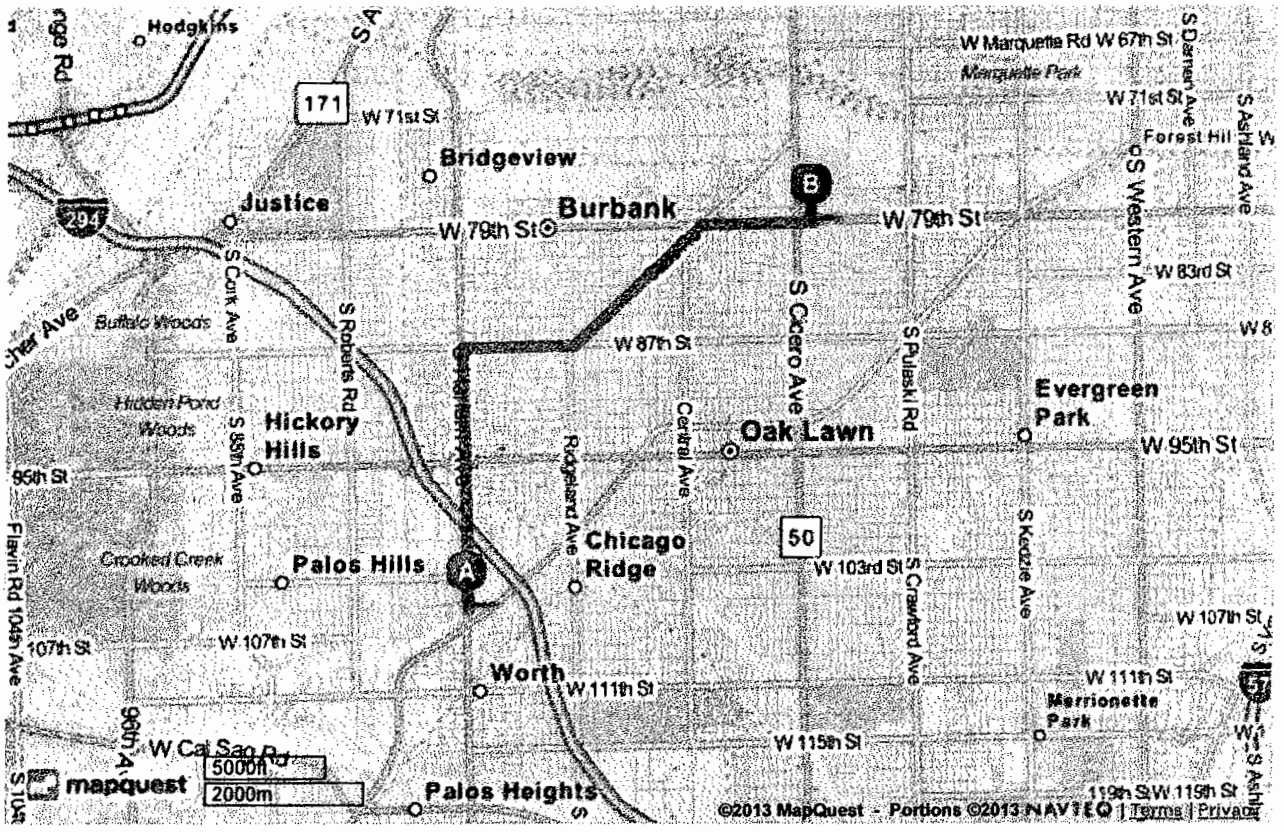
4651 W 79th St
Chicago, IL 60652-1186
5.84 miles / 13 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**2.3 Mi** *2.3 Mi Total*
2. Turn **right** onto **W 87th St**. Map *W 87th St is just past W 87th Pl* *Circle K is on the corner* *If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far*	**1.0 Mi** *3.3 Mi Total*
3. Turn **slight left** onto **State Rd**. Map *State Rd is just past Nagle Ave* *Les Brothers Restaurant is on the corner* *If you are on W 87th St and reach Mobile Ave you've gone a little too far*	**1.5 Mi** *4.8 Mi Total*
4. Turn **slight right** onto **W 79th St**. Map *W 79th St is just past Linder Ave* *Best Taste Deli Inc is on the right* *If you are on State Rd and reach Lotus Ave you've gone a little too far*	**1.0 Mi** *5.8 Mi Total*
5. **4651 W 79TH ST** is on the **right**. Map *Your destination is just past S Kilpatrick Ave* *If you reach S Knox Ave you've gone a little too far*	

4651 W 79th St, Chicago, IL 60652-1186

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



mapquest

Notes

West Lawn Dialysis

Trip to:

7000 S Pulaski Rd
Chicago, IL 60629-5842
7.76 miles / 18 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1.	Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**2.3 Mi** *2.3 Mi Total*
2.	Turn **right** onto **W 87th St**. Map *W 87th St is just past W 87th Pl* *Circle K is on the corner* *If you are on S Harlem Ave and reach W 86th St you've gone about 0.1 miles too far*	**1.0 Mi** *3.3 Mi Total*
3.	Turn **slight left** onto **State Rd**. Map *State Rd is just past Nagle Ave* *Les Brothers Restaurant is on the corner* *If you are on W 87th St and reach Mobile Ave you've gone a little too far*	**1.5 Mi** *4.8 Mi Total*
4.	Turn **slight right** onto **W 79th St**. Map *W 79th St is just past Linder Ave* *Best Taste Deli Inc is on the right* *If you are on State Rd and reach Lotus Ave you've gone a little too far*	**1.8 Mi** *6.7 Mi Total*
5.	Turn **left** onto **S Pulaski Rd**. Map *S Pulaski Rd is just past S Komensky Ave* *1326 4010 W 79 is on the corner* *If you reach S Springfield Ave you've gone a little too far*	**1.1 Mi** *7.8 Mi Total*
6.	**7000 S PULASKI RD** is on the **left**. Map *Your destination is just past W 70th Pl* *If you reach W 70th St you've gone a little too far*	

7000 S Pulaski Rd, Chicago, IL 60629-5842

Total Travel Estimate: **7.76 miles - about 18 minutes**

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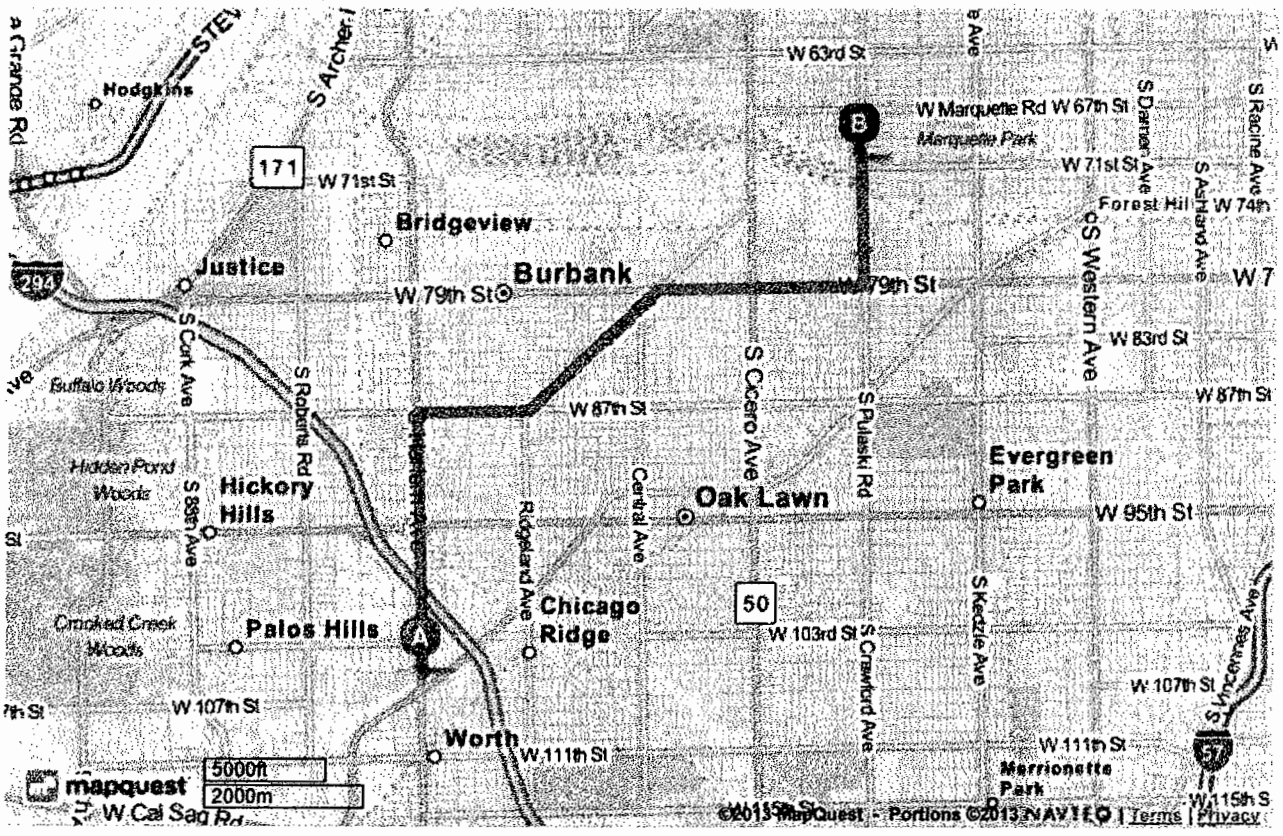


mapquest

Notes

FMC - Dialysis Center of America - Olympia Fields

Trip to:

2609 Lincoln Hwy

Olympia Fields, IL 60461-1801

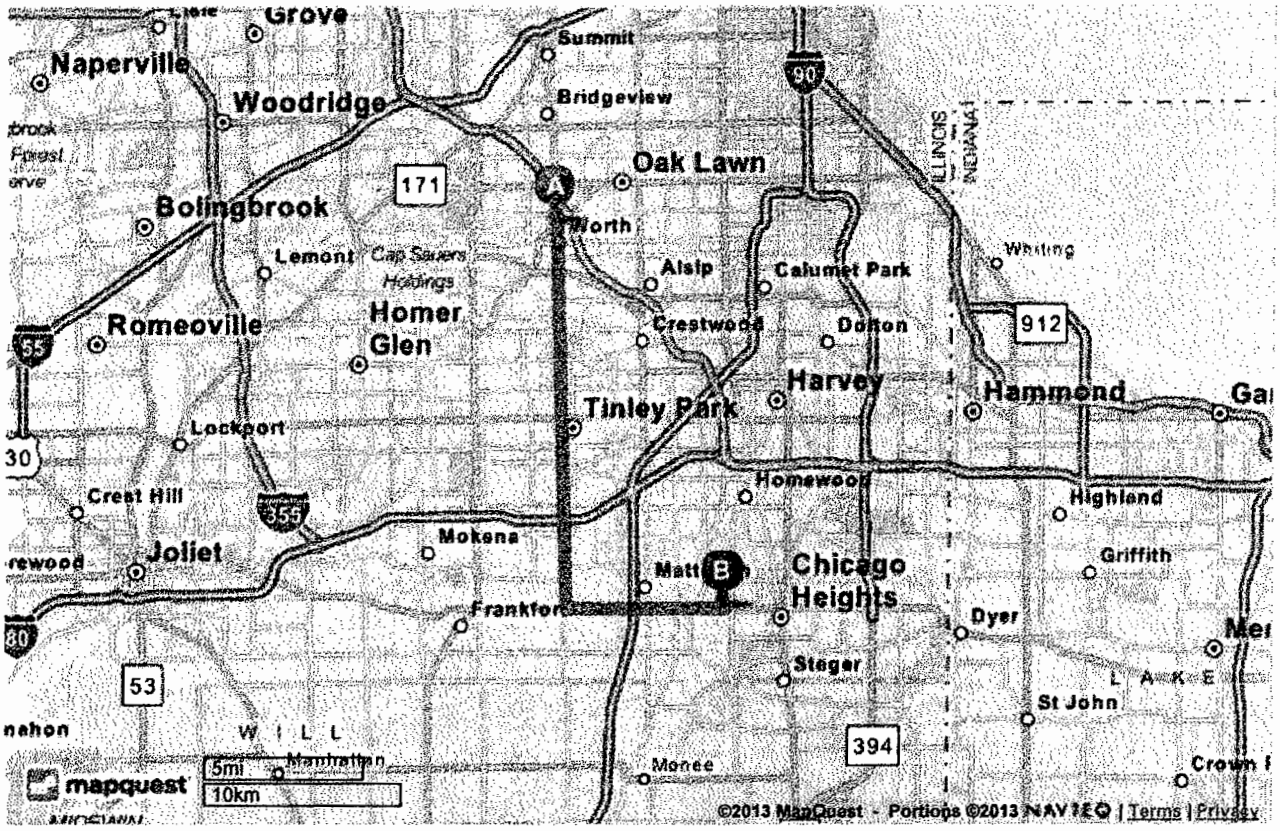
19.21 miles / 34 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43 S** toward **SouthWest Hwy / IL-7**. Map	**13.5 Mi** *13.5 Mi Total*
2. Turn **left** onto **211th St / Lincoln Hwy / W Lincoln Hwy / US-30 E**. Continue to follow **Lincoln Hwy / US-30 E**. Map *Lincoln Hwy is 0.4 miles past W Hickory Creek Dr* *If you reach Georgetown Commons you've gone about 0.3 miles too far*	**5.8 Mi** *19.2 Mi Total*
3. **2609 LINCOLN HWY** is on the **left**. Map *Your destination is 0.4 miles past Orchard Dr* *If you reach Brookwood Dr you've gone a little too far*	

2609 Lincoln Hwy, Olympia Fields, IL 60461-1801

Total Travel Estimate: **19.21 miles - about 34 minutes**



mapquest

Notes

Hazel Crest Renal Center

Trip to:

3470 W 183rd St
Hazel Crest, IL 60429-2428
13.52 miles / 27 minutes

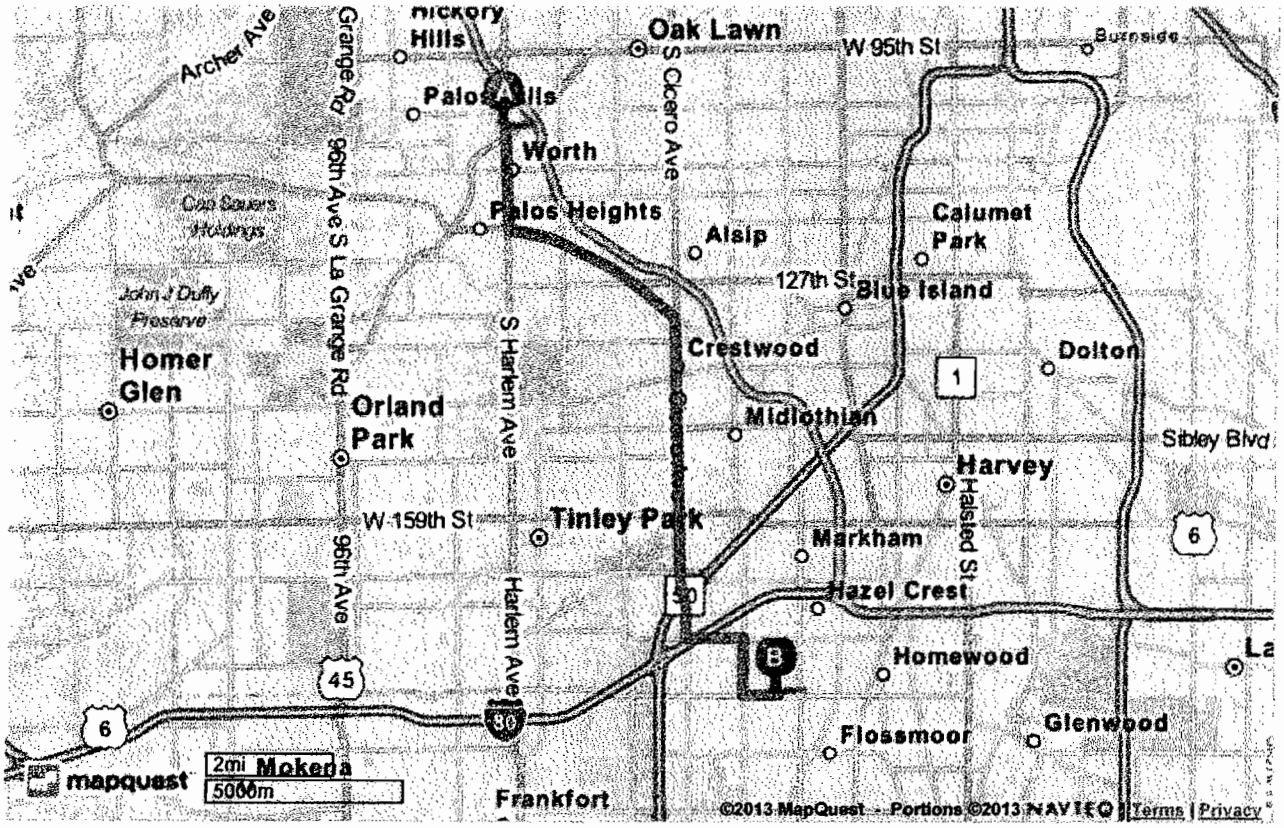
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi** *1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi** *4.2 Mi Total*
3. Stay **straight** to go onto **Cal Sag Rd**. Map	**0.9 Mi** *5.2 Mi Total*
4. Turn **right** onto **IL-50 / Cicero Ave / IL-83**. Continue to follow **IL-50 / Cicero Ave**. Map *IL-50 is 0.3 miles past Rivercrest Dr* *Beds Beds Beds is on the corner* *If you reach Kolmar Ave you've gone about 0.5 miles too far*	**5.7 Mi** *10.8 Mi Total*
5. Turn **left** onto **175th St**. Map *175th St is 0.3 miles past 173rd St* *If you reach Wilshire Blvd you've gone a little too far*	**1.0 Mi** *11.9 Mi Total*
6. Turn **right** onto **Pulaski Rd / Crawford Ave**. Map *Pulaski Rd is just past Eastgate Dr* *Docks Fish is on the corner* *If you reach Winston Dr you've gone a little too far*	**1.0 Mi** *12.9 Mi Total*
7. Turn **left** onto **183rd St**. Map *183rd St is 0.1 miles past Fairway Ter* *Walgreens is on the corner* *If you reach 40th Ct you've gone a little too far*	**0.7 Mi** *13.5 Mi Total*
8. **3470 W 183RD ST** is on the **left**. Map *Your destination is just past Village Dr* *If you reach Grenoble Dr you've gone a little too far*	

3470 W 183rd St, Hazel Crest, IL 60429-2428

Total Travel Estimate: **13.52 miles - about 27 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care Hazel Crest

Trip to:

Hazel Crest, IL 60429

13.93 miles / 24 minutes

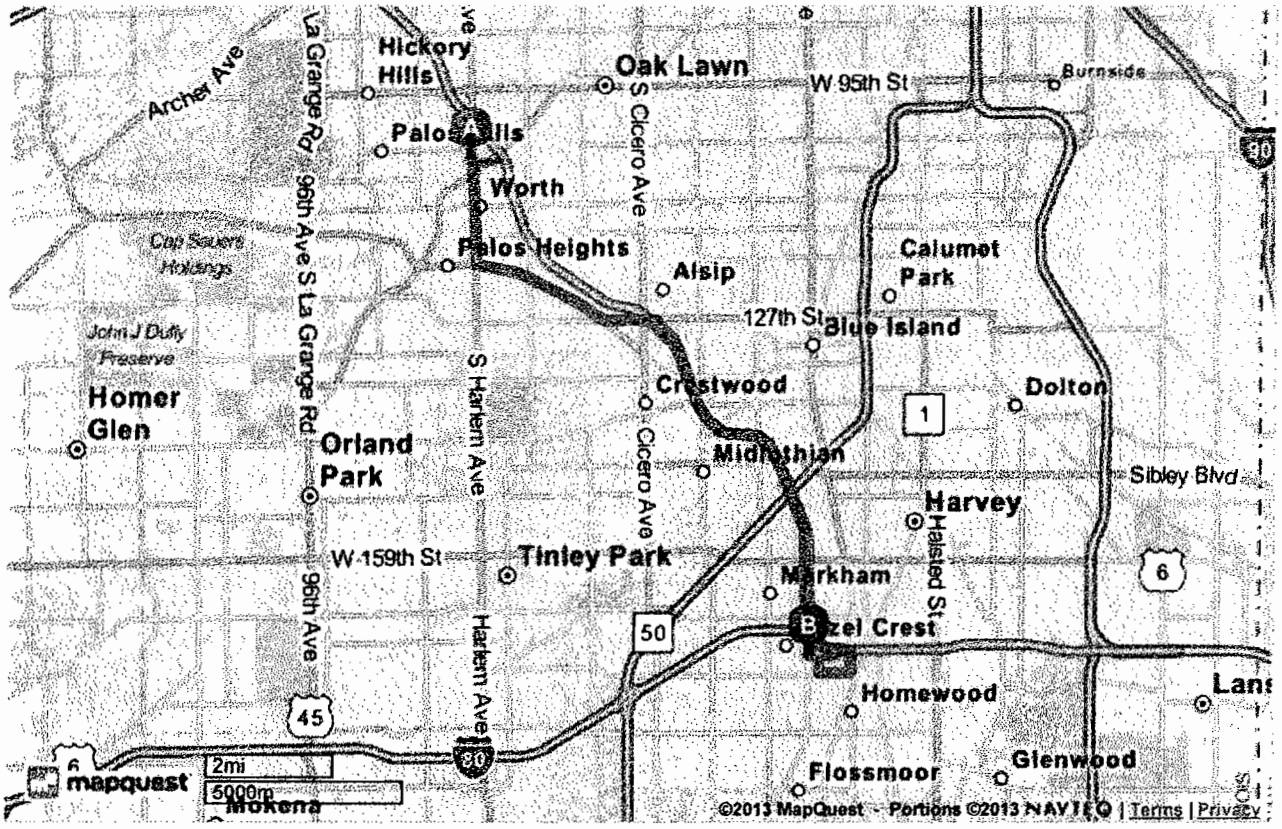
A [10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi**	*1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi**	*4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**1.0 Mi**	*5.2 Mi Total*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map *If you reach S Kostner Ave you've gone about 0.2 miles too far*	**6.8 Mi**	*12.1 Mi Total*
5. Merge onto **I-80 E** toward **Dixie Hwy**. Map	**0.6 Mi**	*12.7 Mi Total*
6. Take the **Dixie Hwy** exit. Map	**0.2 Mi**	*12.9 Mi Total*
7. Turn **right** onto **Dixie Hwy**. Map	**0.4 Mi**	*13.2 Mi Total*
8. Take the **1st right** onto **175th St**. Map *175th St is 0.1 miles past Cheker Sq* *MOBIL is on the right* *If you reach Spruce Rd you've gone a little too far*	**0.6 Mi**	*13.8 Mi Total*
9. Turn **right** onto **Jovanna Dr**. Map *Jovanna Dr is just past Western Ave* *If you reach Palmer Blvd you've gone a little too far*	**0.1 Mi**	*13.9 Mi Total*
10. Welcome to **HAZEL CREST, IL 60429**. Map *Your destination is at the end of Jovanna Dr*		

B Hazel Crest, IL 60429

Total Travel Estimate: **13.93 miles - about 24 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Chicago Heights Dialysis

Trip to:

177 W Joe Orr Rd

Chicago Heights, IL 60411-1733

18.89 miles / 32 minutes

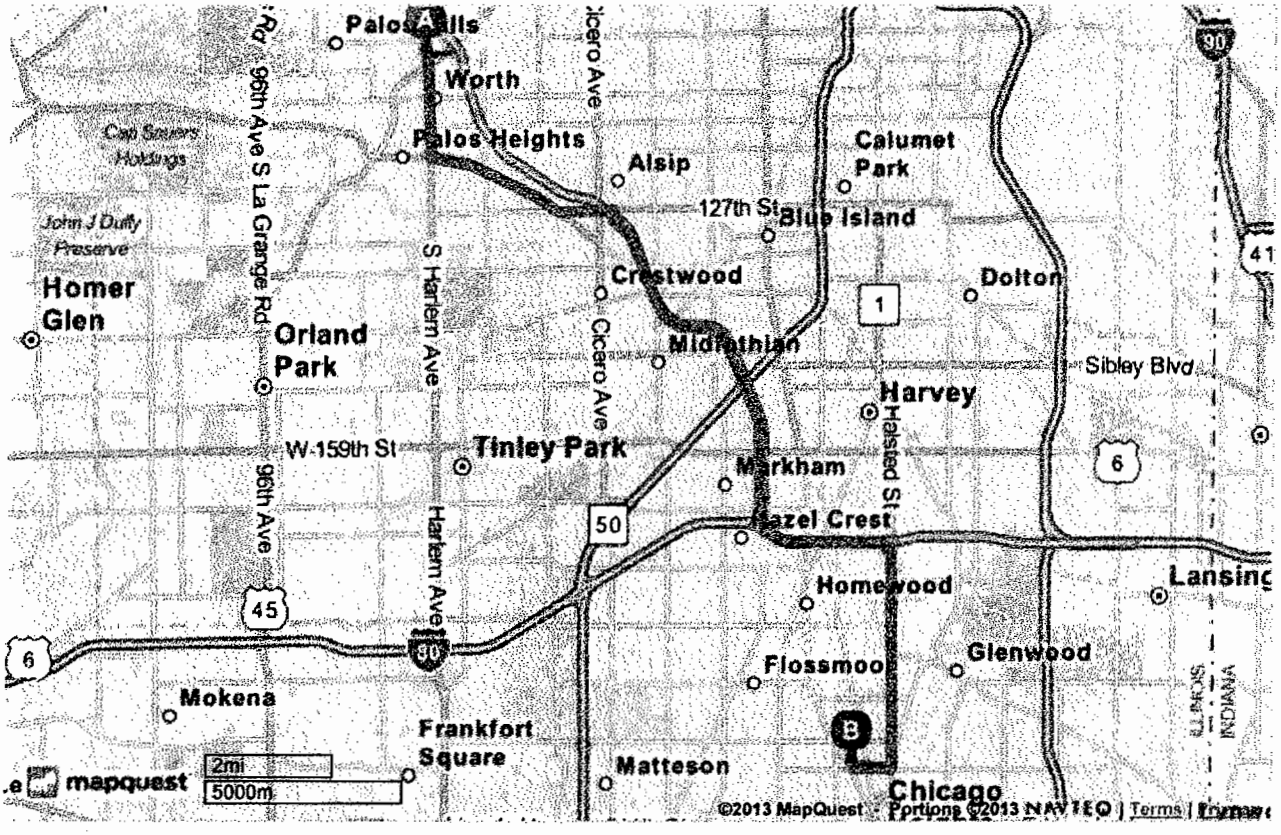
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi** *1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi** *4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**1.0 Mi** *5.2 Mi Total*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map *If you reach S Kostner Ave you've gone about 0.2 miles too far*	**8.6 Mi** *13.8 Mi Total*
5. Merge onto **IL-1 S**. Map	**4.4 Mi** *18.2 Mi Total*
6. Turn **right** onto **E Joe Orr Rd**. Map *E Joe Orr Rd is 0.1 miles past Eastgate Ave* *Brown's Chicken & Pasta is on the corner* *If you reach Southgate Ave you've gone about 0.1 miles too far*	**0.7 Mi** *18.9 Mi Total*
7. **177 W JOE ORR RD** is on the **right**. Map *Your destination is 0.2 miles past Chicago Rd* *If you reach Dixie Hwy you've gone a little too far*	

177 W Joe Orr Rd, Chicago Heights, IL 60411-1733

Total Travel Estimate: **18.89 miles - about 32 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Markham Renal Center

Trip to:

3053-3055 W 159th St

Markham, IL 60428-4003

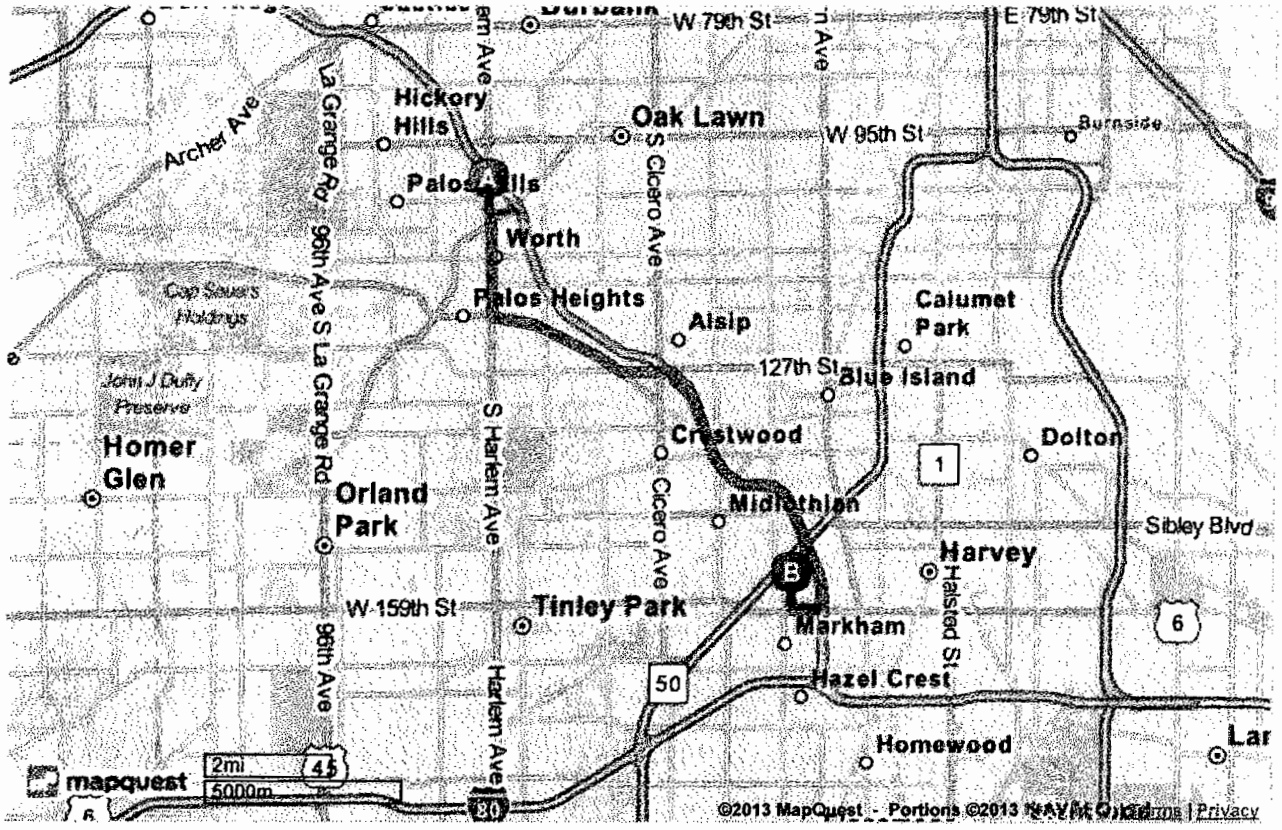
11.11 miles / 20 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi**	*1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi**	*4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**1.0 Mi**	*5.2 Mi Total*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map *If you reach S Kostner Ave you've gone about 0.2 miles too far*	**5.0 Mi**	*10.2 Mi Total*
5. Merge onto **W 159th St / US-6 W**. Map	**0.9 Mi**	*11.1 Mi Total*
6. **3053-3055 W 159TH ST**. Map *Your destination is just past Whipple Ave* *If you reach Albany Ave you've gone a little too far*		

3053-3055 W 159th St, Markham, IL 60428-4003

Total Travel Estimate: **11.11 miles - about 20 minutes**



mapquest

Notes

FMC - Blue Island Dialysis Ctr

Trip to:

12200 Western Ave

Blue Island, IL 60406-1398

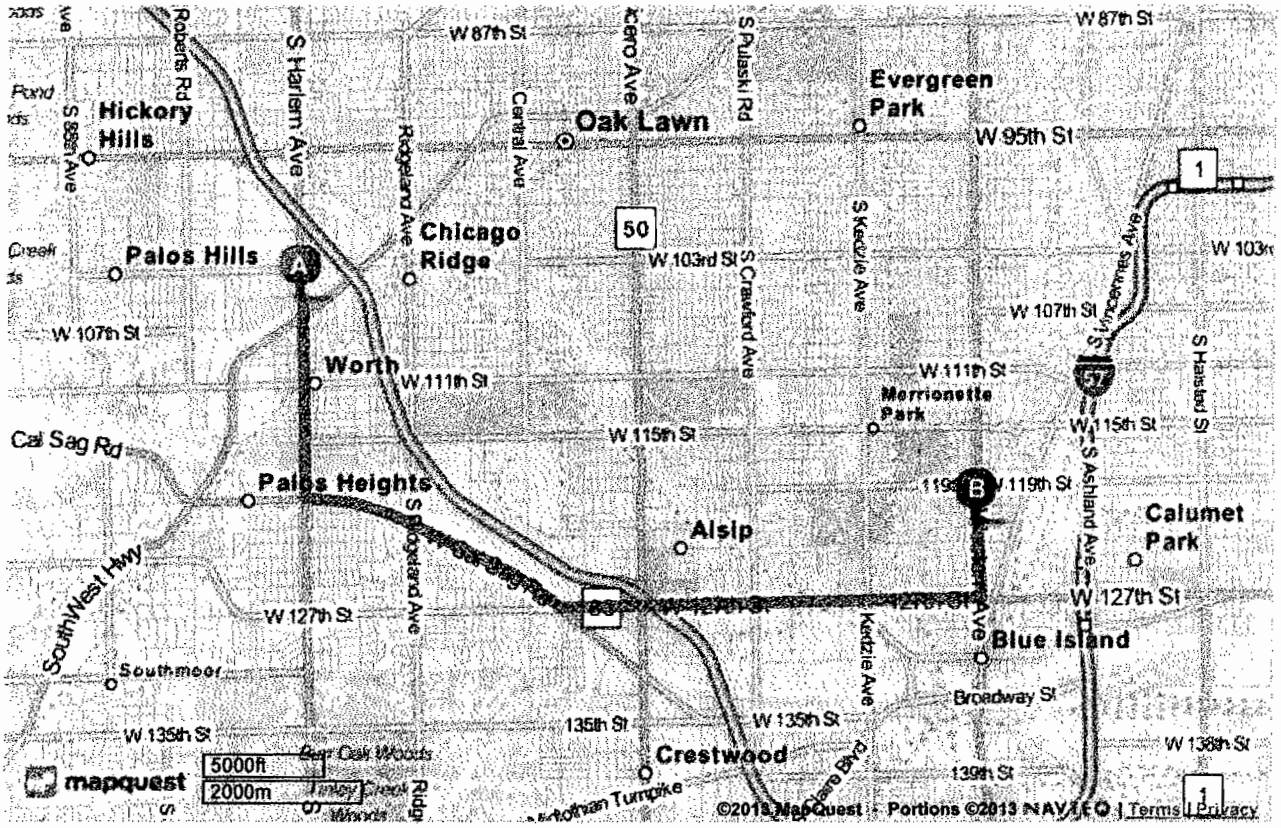
8.62 miles / 19 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi**	*1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi**	*4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**3.8 Mi**	*8.0 Mi Total*
4. Turn **left** onto **Western Ave**. Map *Western Ave is just past Artesian Ave* *Beggars Pizza is on the left* *If you reach Vincennes Rd you've gone about 0.1 miles too far*	**0.6 Mi**	*8.6 Mi Total*
5. **12200 WESTERN AVE** is on the **left**. Map *Your destination is 0.1 miles past 123rd St* *If you reach 122nd St you've gone a little too far*		

12200 Western Ave, Blue Island, IL 60406-1398

Total Travel Estimate: **8.62 miles - about 19 minutes**



mapquest

Notes

Community Dialysis of Harvey

Trip to:

16641 Halsted St Ste 1

Harvey, IL 60426-6174

15.24 miles / 25 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi** *1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi** *4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**1.0 Mi** *5.2 Mi Total*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map *If you reach S Kostner Ave you've gone about 0.2 miles too far*	**8.6 Mi** *13.8 Mi Total*
5. Take the **IL-1 / Halsted St** exit. Map	**0.3 Mi** *14.0 Mi Total*
6. Keep **left** to take the ramp toward **IL-1 N / Halsted St**. Map	**0.3 Mi** *14.4 Mi Total*
7. Merge onto **IL-1 N / Halsted St**. Map	**0.9 Mi** *15.2 Mi Total*
8. **16641 HALSTED ST STE 1** is on the **right**. Map *Your destination is just past E 167th St* *If you reach E 166th St you've gone a little too far*	

16641 Halsted St Ste 1, Harvey, IL 60426-6174

Total Travel Estimate: **15.24 miles - about 25 minutes**

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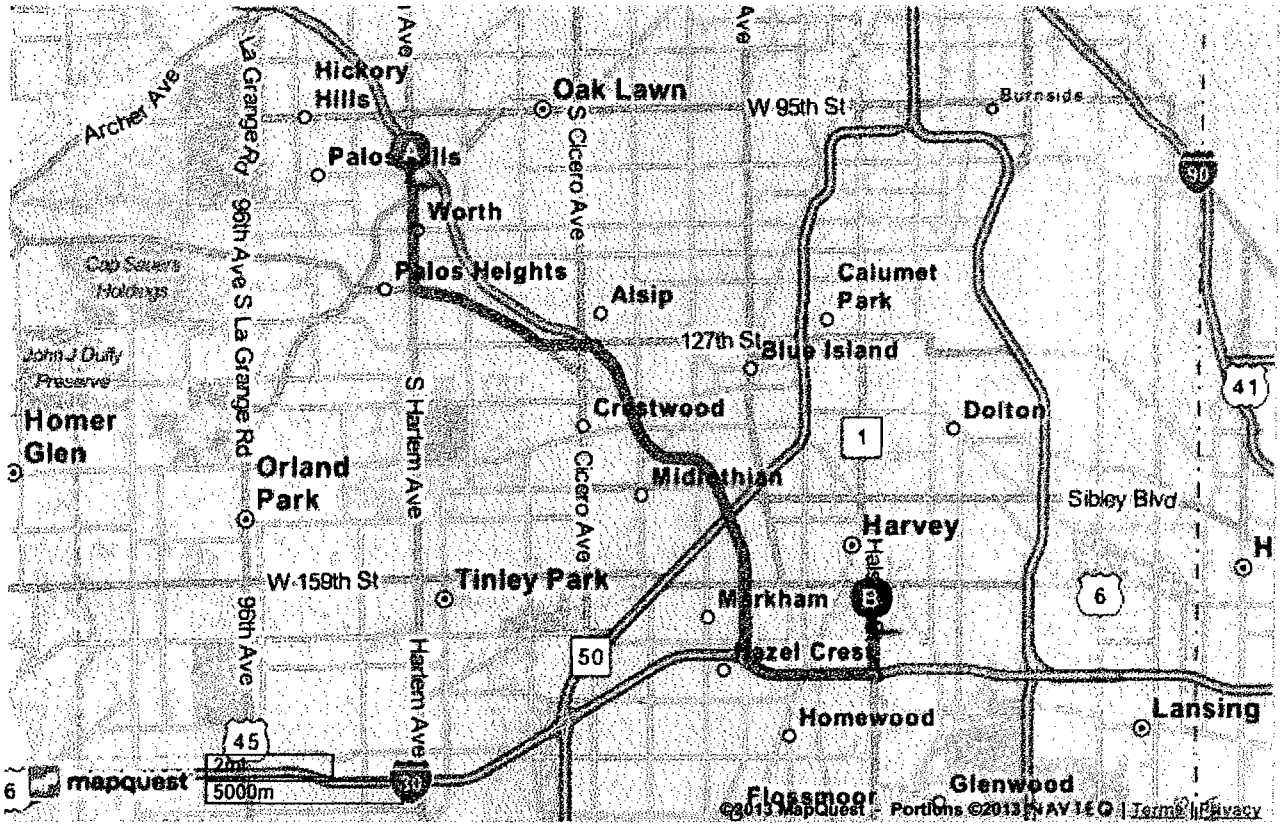


mapquest

Notes

South Holland Renal Center

Trip to:

16136 S Park Ave

South Holland, IL 60473-1511

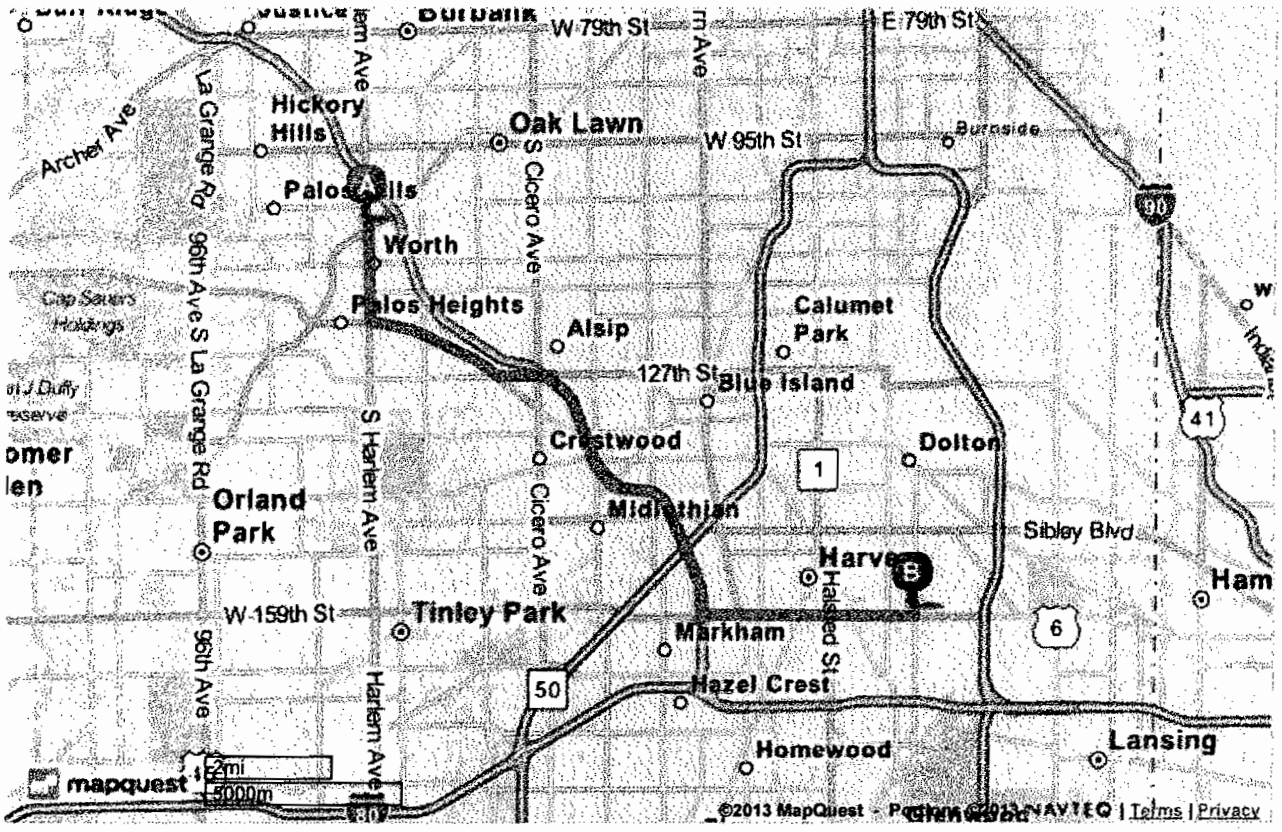
14.85 miles / 29 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**1.7 Mi** *1.7 Mi Total*
2. Turn **left** onto **W College Dr / IL-83**. Continue to follow **IL-83**. Map *IL-83 is 0.3 miles past W 116th St* *Sherwin-Williams Paint Store is on the corner* *If you reach W 119th Pl you've gone a little too far*	**2.5 Mi** *4.2 Mi Total*
3. Turn **slight left** onto **W 127th St / IL-83**. Continue to follow **W 127th St**. Map *W 127th St is 0.3 miles past S Central Ave* *SPEEDWAY #7750 is on the corner* *If you are on Cal Sag Rd and reach W Playfield Dr you've gone a little too far*	**1.0 Mi** *5.2 Mi Total*
4. Merge onto **I-294 S** toward **Indiana** (Portions toll). Map *If you reach S Kostner Ave you've gone about 0.2 miles too far*	**5.0 Mi** *10.2 Mi Total*
5. Take the exit. Map	**0.2 Mi** *10.4 Mi Total*
6. Merge onto **US-6** via the ramp on the **left**. Map	**4.4 Mi** *14.8 Mi Total*
7. Turn **left** onto **S Park Ave**. Map *S Park Ave is just past Louis Ave* *Chase Bank is on the left* *If you reach Claire Ln you've gone about 0.1 miles too far*	**0.08 Mi** *14.8 Mi Total*
8. **16136 S PARK AVE** is on the **left**. Map *Your destination is just past E 161st Pl* *If you reach E 161st St you've gone a little too far*	

16136 S Park Ave, South Holland, IL 60473-1511

Total Travel Estimate: **14.85 miles - about 29 minutes**



mapquest

Notes

FMC - Merrionette Park

Trip to:

11630 S Kedzie Ave

Merrionette Park, IL 60803-6302

6.42 miles / 15 minutes

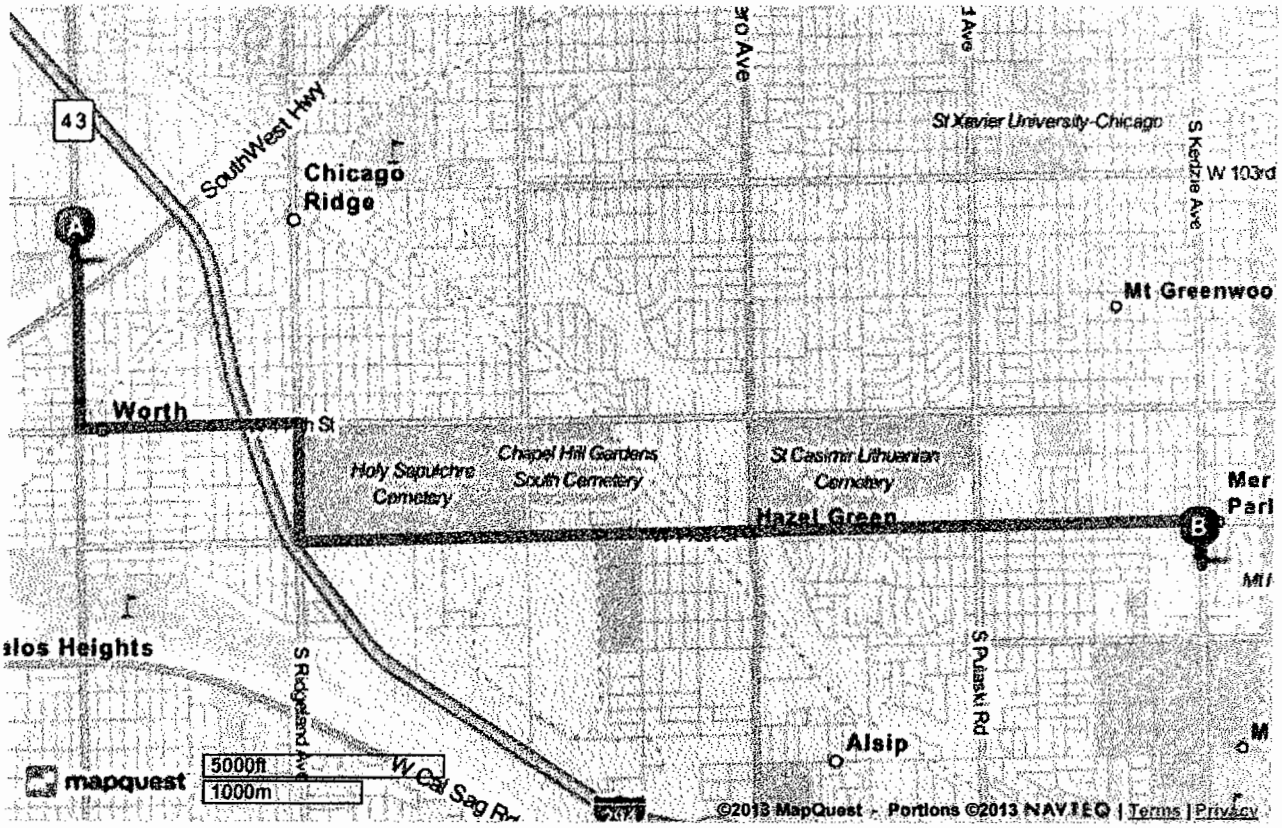
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

	1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
	2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**1.0 Mi** *1.7 Mi Total*
	3. Turn **right** onto **S Ridgeland Ave**. Map *S Ridgeland Ave is just past S Nagle Ave* *If you reach Oxford Ave you've gone a little too far*	**0.5 Mi** *2.2 Mi Total*
	4. Take the 1st **left** onto **W 115th St**. Map *W 115th St is 0.1 miles past W 114th St* *If you reach W Wood Ave you've gone about 0.1 miles too far*	**4.0 Mi** *6.2 Mi Total*
	5. Turn **right** onto **S Kedzie Ave**. Map *S Kedzie Ave is just past S La Salle St* *Mobil is on the corner* *If you reach S Troy St you've gone a little too far*	**0.2 Mi** *6.4 Mi Total*
	6. **11630 S KEDZIE AVE** is on the **right**. Map *Your destination is 0.1 miles past W Meadow Lane Dr* *If you reach W 116th Pl you've gone a little too far*	

11630 S Kedzie Ave, Merrionette Park, IL 60803-6302

Total Travel Estimate: **6.42 miles - about 15 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Mount Greenwood Dialysis

Trip to:

3401 W 111th St
Chicago, IL 60655-3329
5.45 miles / 13 minutes

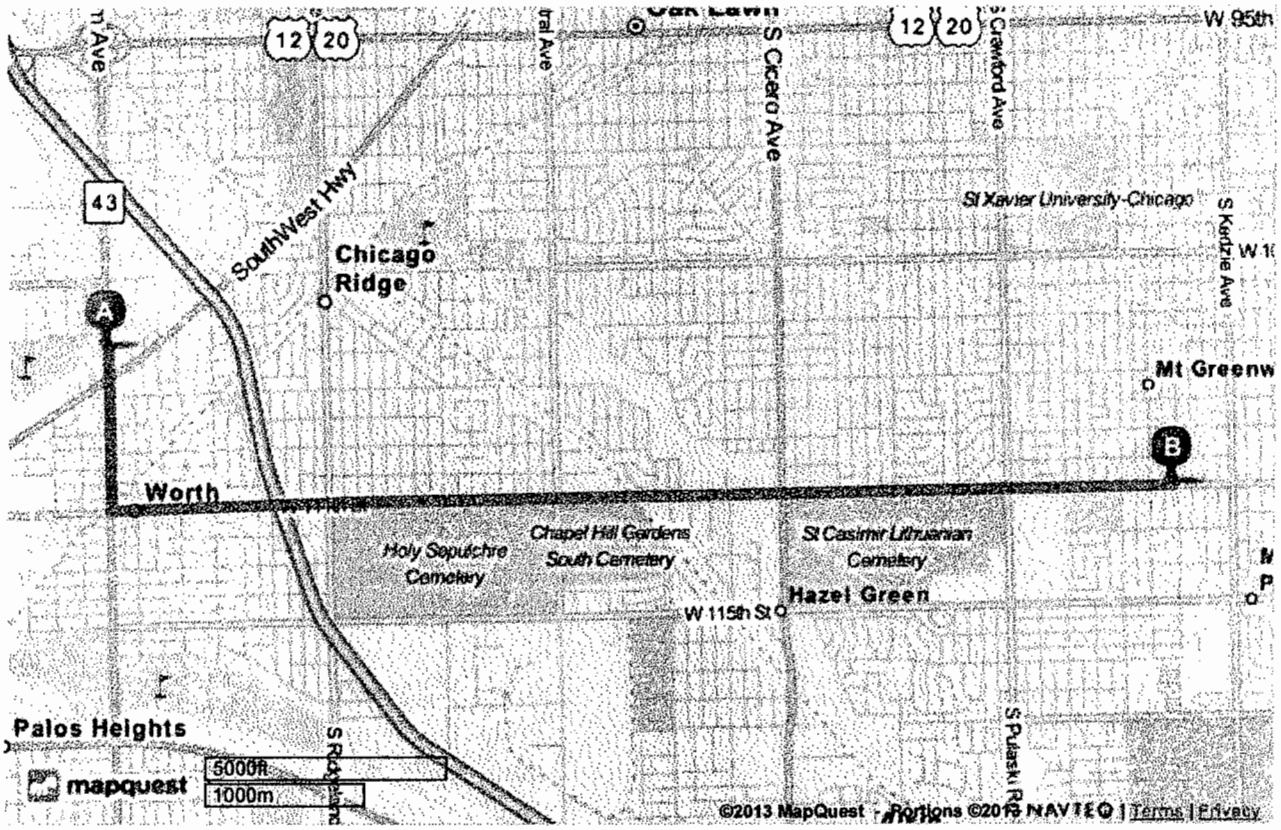
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**4.7 Mi** *5.4 Mi Total*
3. **3401 W 111TH ST** is on the **right**. Map *Your destination is just past S Trumbull Ave* *If you reach S Homan Ave you've gone a little too far*	

3401 W 111th St, Chicago, IL 60655-3329

Total Travel Estimate: **5.45 miles - about 13 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care Evergreen Park

Trip to:

9730 S Western Ave

Evergreen Park, IL 60805-2814

7.11 miles / 19 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi**	*0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**2.1 Mi**	*2.3 Mi Total*
3. Turn **right** onto **US-20 / US-12 / W 95th St**. Map *US-20 is 0.1 miles past Austin Ave* *Red Lobster is on the left* *If you reach W 93rd St you've gone about 0.2 miles too far*	**4.5 Mi**	*6.7 Mi Total*
4. Turn **right** onto **S Western Ave**. Map *S Western Ave is 0.1 miles past S Campbell Ave* *Applebee's is on the right* *If you reach S Claremont Ave you've gone a little too far*	**0.4 Mi**	*7.1 Mi Total*
5. **9730 S WESTERN AVE** is on the **right**. Map *Your destination is 0.1 miles past W 97th St* *If you reach W 99th St you've gone about 0.1 miles too far*		

9730 S Western Ave, Evergreen Park, IL 60805-2814

Total Travel Estimate: **7.11 miles - about 19 minutes**

mapquest

Notes
Beverly Dialysis

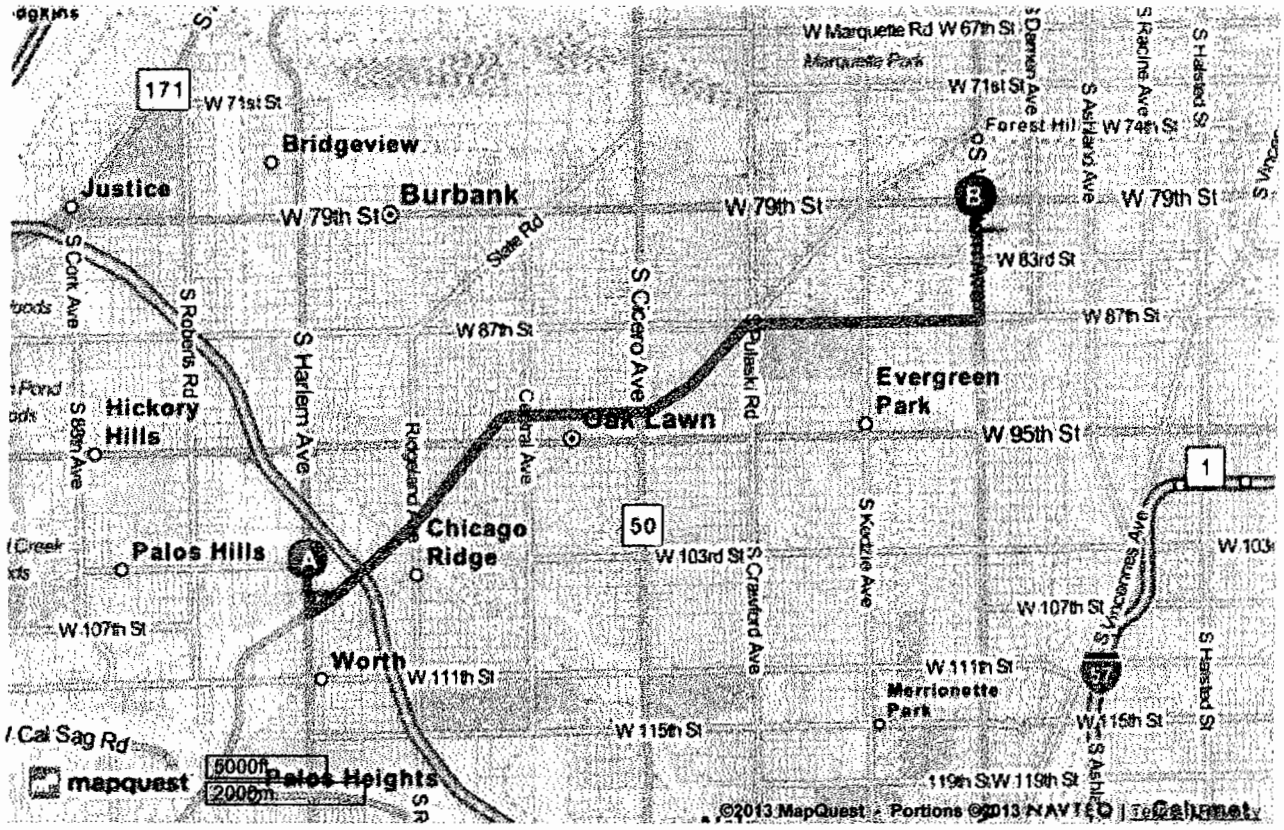
Trip to:
8111 S Western Ave
Chicago, IL 60620-5939
7.85 miles / 19 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi**	*0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi**	*5.1 Mi Total*
3. Turn **slight right** onto **W 87th St**. Map *W 87th St is 0.2 miles past S Merrion Ln* *If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far*	**2.1 Mi**	*7.1 Mi Total*
4. Turn **left** onto **S Western Ave**. Map *If you reach S Longwood Dr you've gone about 0.3 miles too far*	**0.7 Mi**	*7.9 Mi Total*
5. **8111 S WESTERN AVE** is on the **right**. Map *Your destination is just past W 81st Pl* *If you reach W 81st St you've gone a little too far*		

8111 S Western Ave, Chicago, IL 60620-5939

Total Travel Estimate: **7.85 miles - about 19 minutes**



mapquest

Notes

Fresenius Medical Care Chatham

Trip to:

8710 S Holland Rd

Chicago, IL 60620

9.77 miles / 25 minutes

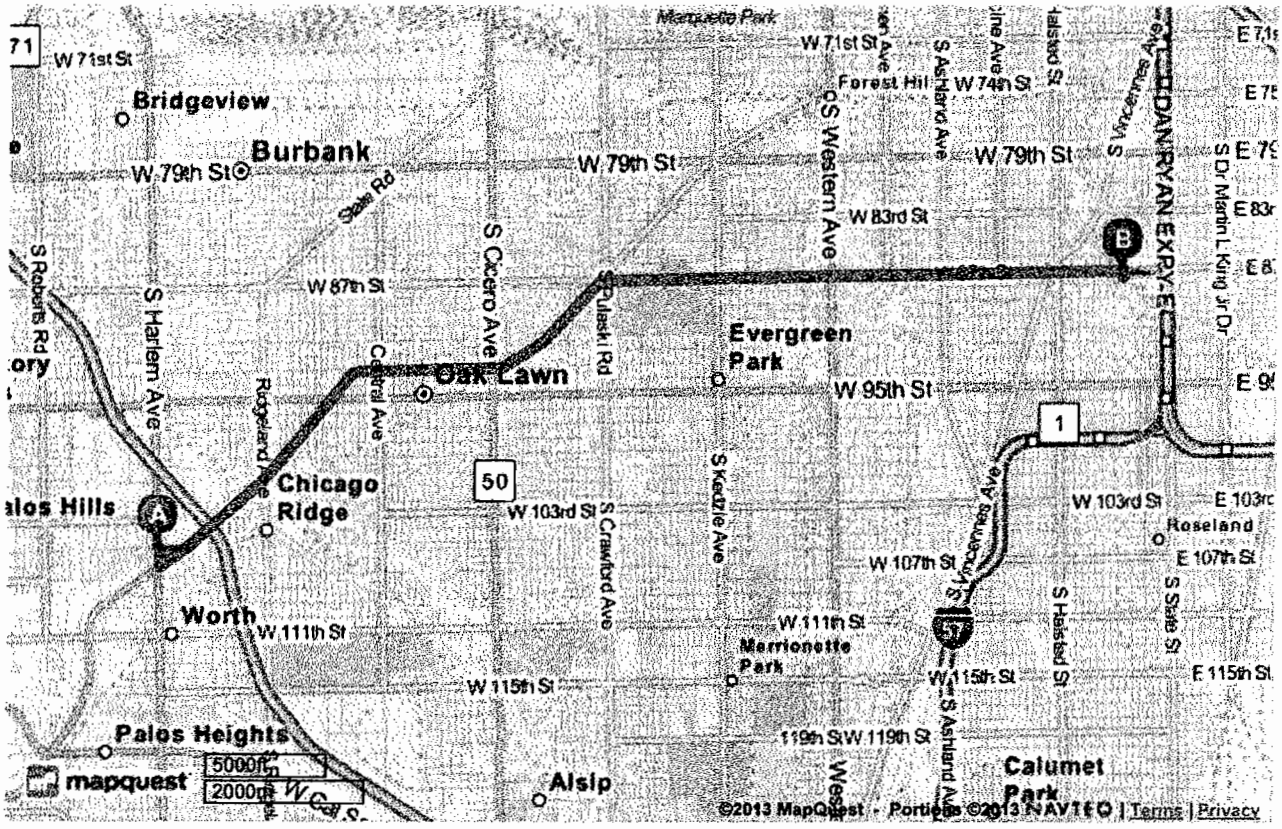
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
3. Turn **slight right** onto **W 87th St**. Map *W 87th St is 0.2 miles past S Merrion Ln* *If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far*	**4.6 Mi** *9.7 Mi Total*
4. Turn **slight right** onto **S Holland Rd**. Map *Reggio's Pizza is on the corner* *If you reach S Lafayette Ave you've gone about 0.3 miles too far*	**0.07 Mi** *9.8 Mi Total*
5. **8710 S HOLLAND RD** is on the **right**. Map *Your destination is just past S Princeton Ave* *If you reach W 88th St you've gone a little too far*	

8710 S Holland Rd, Chicago, IL 60620

Total Travel Estimate: **9.77 miles - about 25 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - Southside

Trip to:

3134 W 76th St

Chicago, IL 60652-1968

6.92 miles / 18 minutes

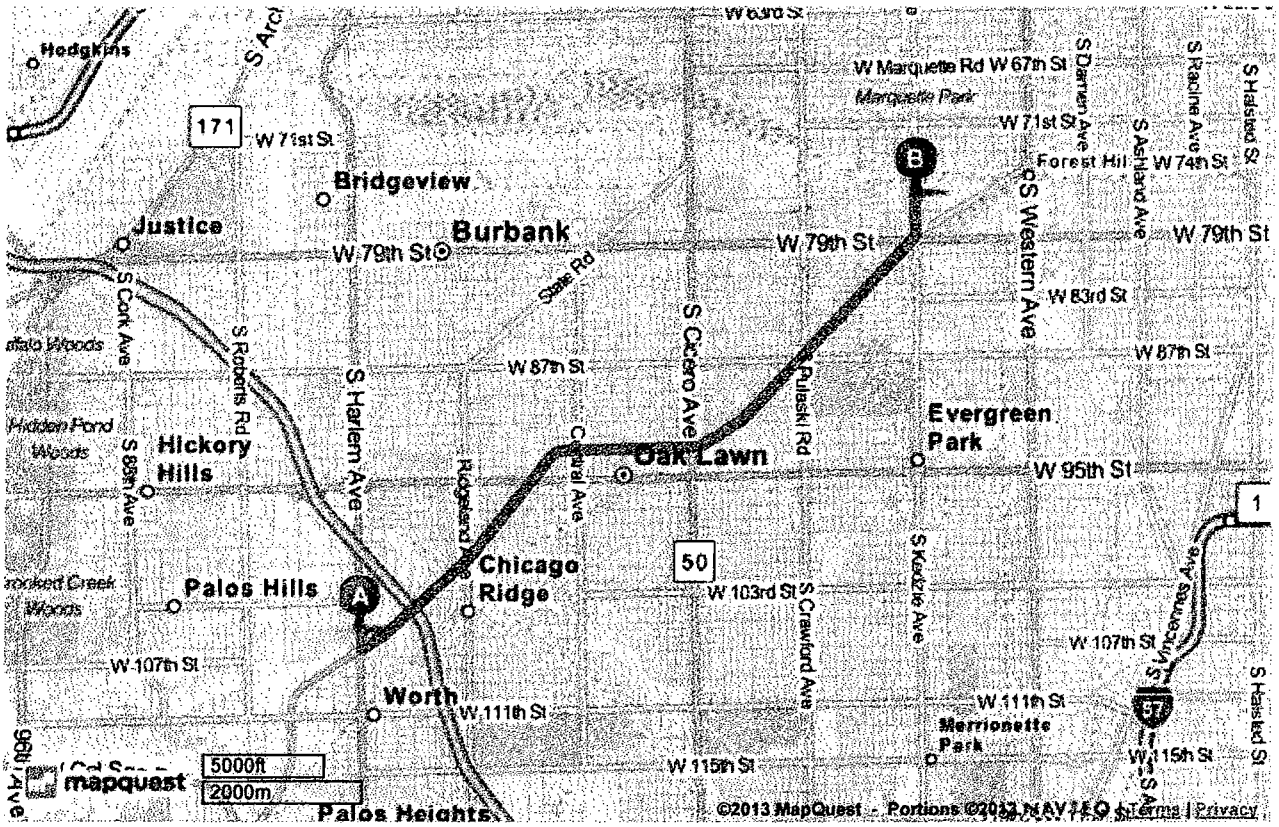
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
3. **SouthWest Hwy** becomes **W Columbus Ave**. Map	**1.5 Mi** *6.6 Mi Total*
4. Turn **left** onto **S Kedzie Ave**. Map *S Kedzie Ave is just past W 79th St* *If you reach S Troy St you've gone a little too far*	**0.3 Mi** *6.9 Mi Total*
5. Take the 2nd **right** onto **W 76th St**. Map *W 76th St is 0.1 miles past W 77th St* *If you reach W 73rd St you've gone about 0.3 miles too far*	**0.03 Mi** *6.9 Mi Total*
6. **3134 W 76TH ST** is on the **left**. Map *If you reach W 77th St you've gone about 0.1 miles too far*	

3134 W 76th St, Chicago, IL 60652-1968

Total Travel Estimate: **6.92 miles - about 18 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - Neomedica - Marquette Park

Trip to:

6535 S Western Ave
Chicago, IL 60636-2410
8.81 miles / 22 minutes

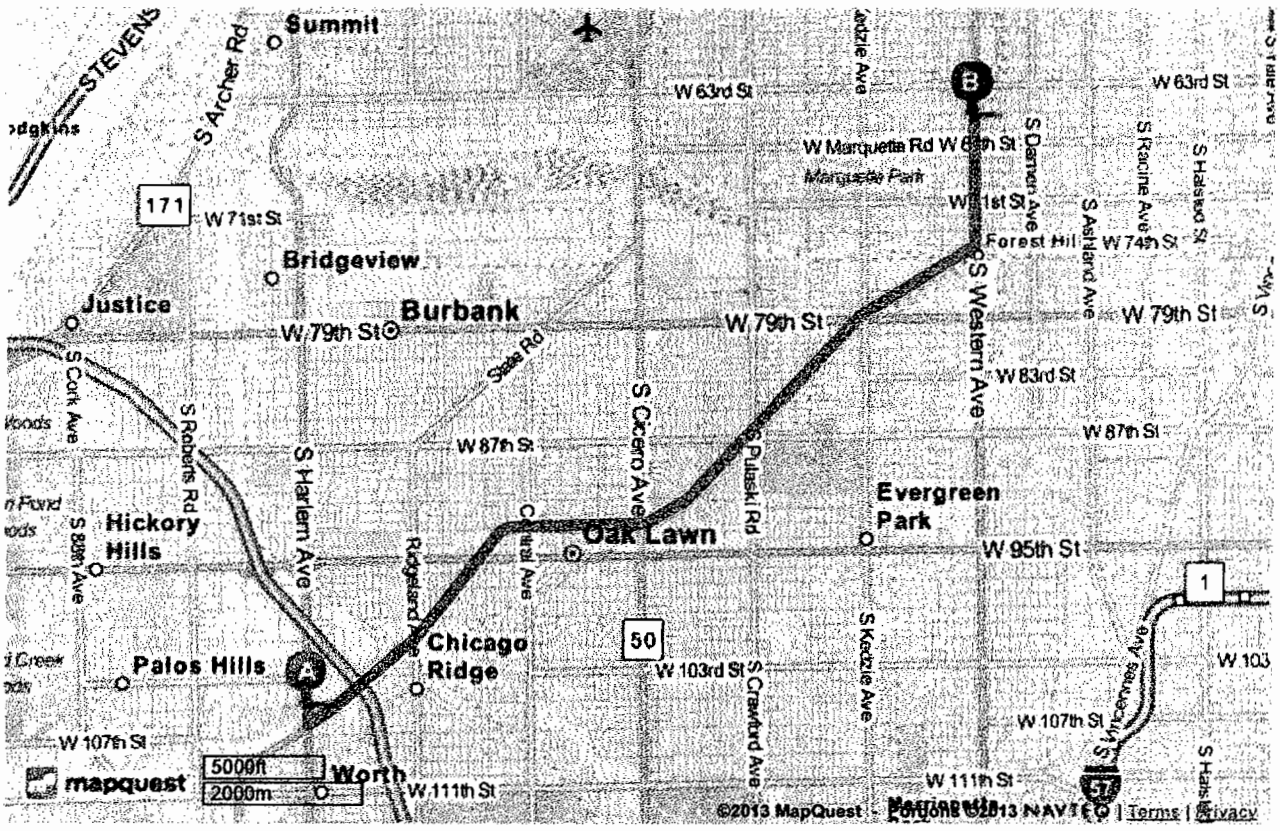
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
3. **SouthWest Hwy** becomes **W Columbus Ave**. Map	**2.7 Mi** *7.7 Mi Total*
4. Turn **left** onto **S Western Ave**. Map *Second Mt Calvary MB Church is on the corner*	**1.1 Mi** *8.8 Mi Total*
5. **6535 S WESTERN AVE** is on the **right**. Map *Your destination is just past W 66th St* *If you reach W 65th St you've gone a little too far*	

6535 S Western Ave, Chicago, IL 60636-2410

Total Travel Estimate: **8.81 miles - about 22 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - Ross Dialysis - Englewood

Trip to:

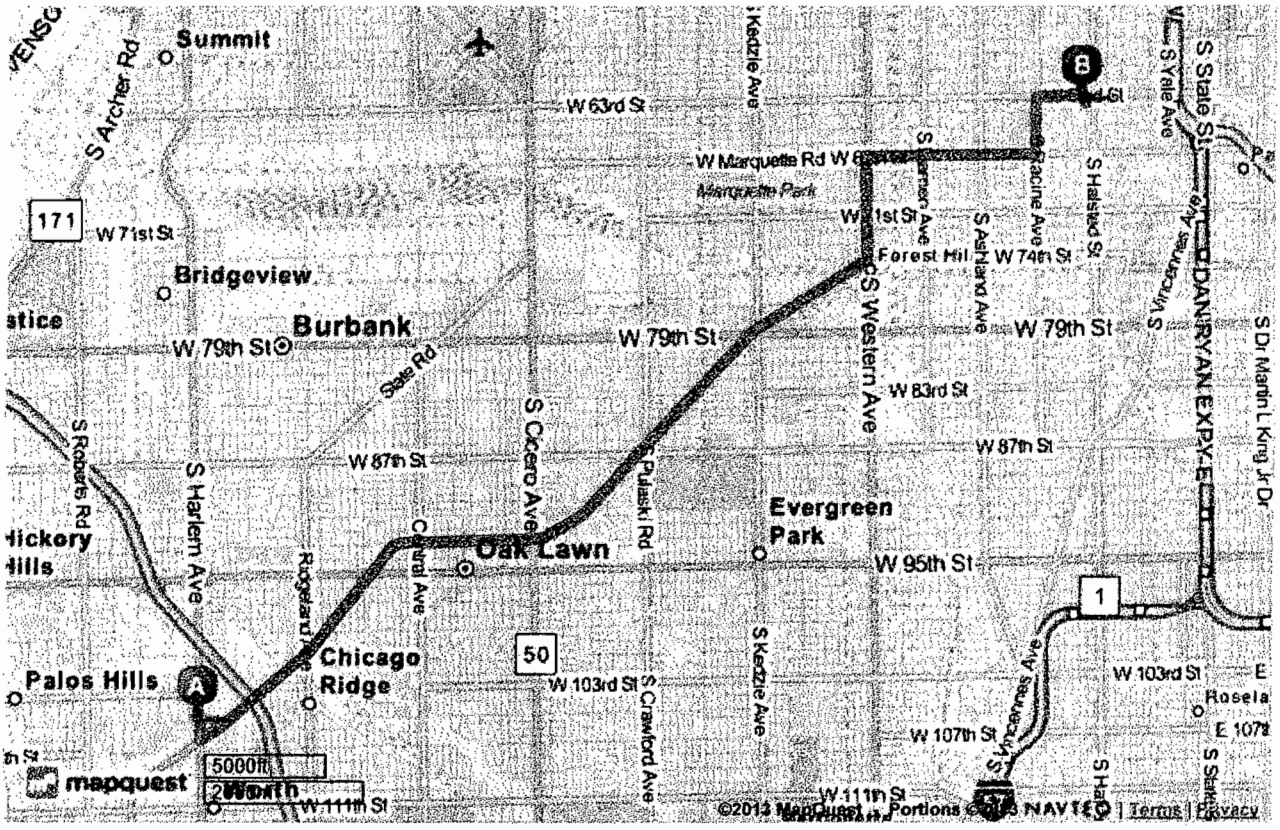
6333 S Green St
Chicago, IL 60621-1943
11.11 miles / 29 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
3. **SouthWest Hwy** becomes **W Columbus Ave**. Map	**2.7 Mi** *7.7 Mi Total*
4. Turn **left** onto **S Western Ave**. Map *Second Mt Calvary MB Church is on the corner*	**0.9 Mi** *8.6 Mi Total*
5. Turn **right** onto **W Marquette Rd / W 67th St**. Map *W Marquette Rd is 0.1 miles past W 68th St* *If you reach W 66th St you've gone about 0.1 miles too far*	**1.5 Mi** *10.1 Mi Total*
6. Turn **left** onto **S Racine Ave**. Map *S Racine Ave is just past S Elizabeth St* *Island Fish & Chicken is on the corner* *If you reach S May St you've gone a little too far*	**0.5 Mi** *10.6 Mi Total*
7. Turn **right** onto **W 63rd St**. Map *W 63rd St is 0.1 miles past W 64th St* *Brothers Submarine is on the corner* *If you reach W 62nd St you've gone about 0.1 miles too far*	**0.4 Mi** *11.0 Mi Total*
8. Turn **right** onto **S Green St**. Map *S Green St is just past S Peoria St* *U.S. Bank - Englewood IL Office is on the corner* *If you reach S Halsted St you've gone a little too far*	**0.06 Mi** *11.1 Mi Total*
9. **6333 S GREEN ST** is on the **left**. Map *If you are on S Peoria Dr and reach S Halsted St you've gone about 0.4 miles too far*	

6333 S Green St, Chicago, IL 60621-1943

Total Travel Estimate: **11.11 miles - about 29 minutes**



mapquest

Notes

FMC - Garfield

Trip to:

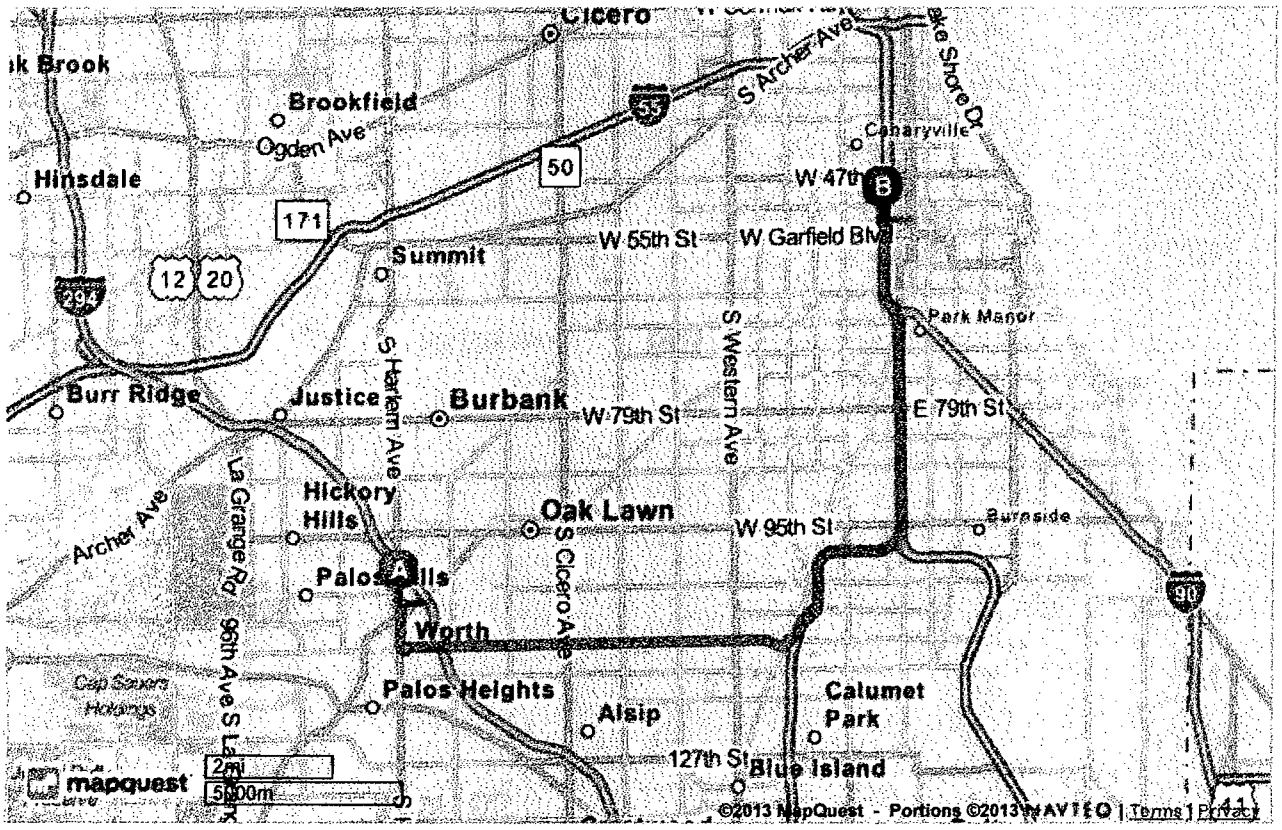
5401 S Wentworth Ave
Chicago, IL 60609-6300
16.60 miles / 32 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**6.6 Mi** *7.3 Mi Total*
3. **W 111th St** becomes **W Monterey Ave**. Map	**0.3 Mi** *7.6 Mi Total*
4. Turn **left** onto **S Vincennes Ave**. Map *S Vincennes Ave is just past S Church St* *Morgan Park Pentecostal Church is on the corner* *If you reach S Ashland Ave you've gone a little too far*	**0.2 Mi** *7.8 Mi Total*
5. Turn **right** onto **W 111th St**. Map *W 111th St is just past W Pryor Ave* *Church of Jesus Christ of Latter-Day Saints is on the right* *If you reach W Chelsea Pl you've gone a little too far*	**0.2 Mi** *8.0 Mi Total*
6. Merge onto **I-57 N** via the ramp on the **left** toward **Chicago Loop**. Map *If you reach S Bishop St you've gone a little too far*	**2.6 Mi** *10.6 Mi Total*
7. Merge onto **I-94 W / Dan Ryan Expy W** via the exit on the **left** toward **Chicago Loop**. Map	**4.0 Mi** *14.6 Mi Total*
8. Keep **right** to take **I-94 W / Dan Ryan Expy W**. Map	**1.5 Mi** *16.1 Mi Total*
9. Take **EXIT 57** toward **Garfield Blvd**. Map	**0.3 Mi** *16.4 Mi Total*
10. Stay **straight** to go onto **S Wentworth Ave**. Map	**0.2 Mi** *16.6 Mi Total*
11. **5401 S WENTWORTH AVE** is on the **right**. Map *Your destination is 0.1 miles past W Garfield Blvd* *If you reach W 53rd St you've gone about 0.1 miles too far*	

5401 S Wentworth Ave, Chicago, IL 60609-6300

Total Travel Estimate: **16.60 miles - about 32 minutes**



mapquest

Notes

Emerald Dialysis

Trip to:

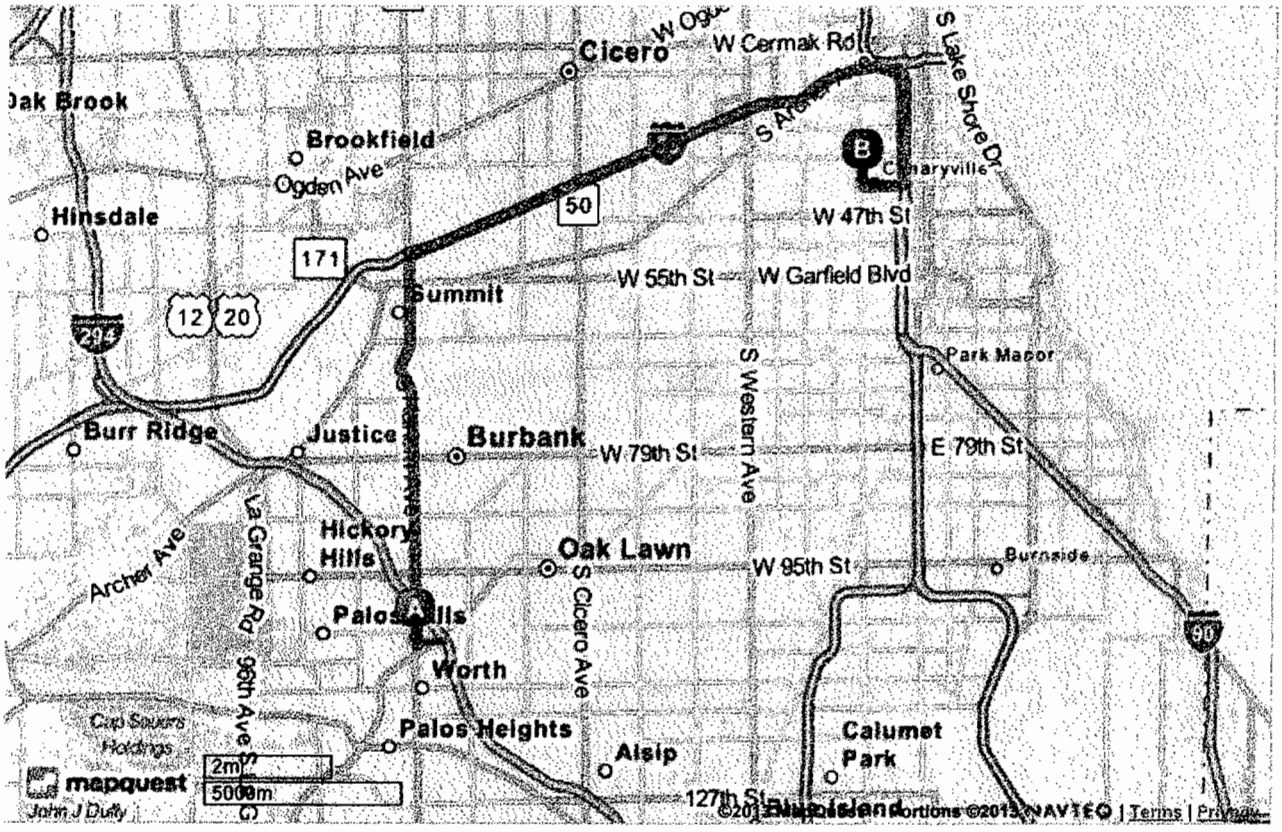
710 W 43rd St
Chicago, IL 60609-3435
18.96 miles / 32 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.6 Mi** *15.5 Mi Total*
3. Merge onto **I-90 E / I-94 E / Dan Ryan Expy E** via **EXIT 292B** toward **Indiana**. Map	**0.8 Mi** *16.2 Mi Total*
4. Keep **right** to take **I-90 E / I-94 E / Dan Ryan Expy E**. Map	**1.9 Mi** *18.1 Mi Total*
5. Take **EXIT 56A** toward **43rd St**. Map	**0.2 Mi** *18.3 Mi Total*
6. Turn **slight left** onto **S Wentworth Ave**. Map *Subway is on the corner*	**0.03 Mi** *18.3 Mi Total*
7. Take the 1st **right** onto **W 43rd St**. Map *DAN RYAN CITGO is on the corner* *If you reach W 43rd Pl you've gone a little too far*	**0.6 Mi** *19.0 Mi Total*
8. **710 W 43RD ST** is on the **right**. Map *Your destination is just past S Union Ave* *If you reach S Emerald Ave you've gone a little too far*	

710 W 43rd St, Chicago, IL 60609-3435

Total Travel Estimate: **18.96 miles - about 32 minutes**



mapquest

Notes

Fresenius Medical Care Bridgeport

Trip to:

825 W 35th St

Chicago, IL 60609-1511

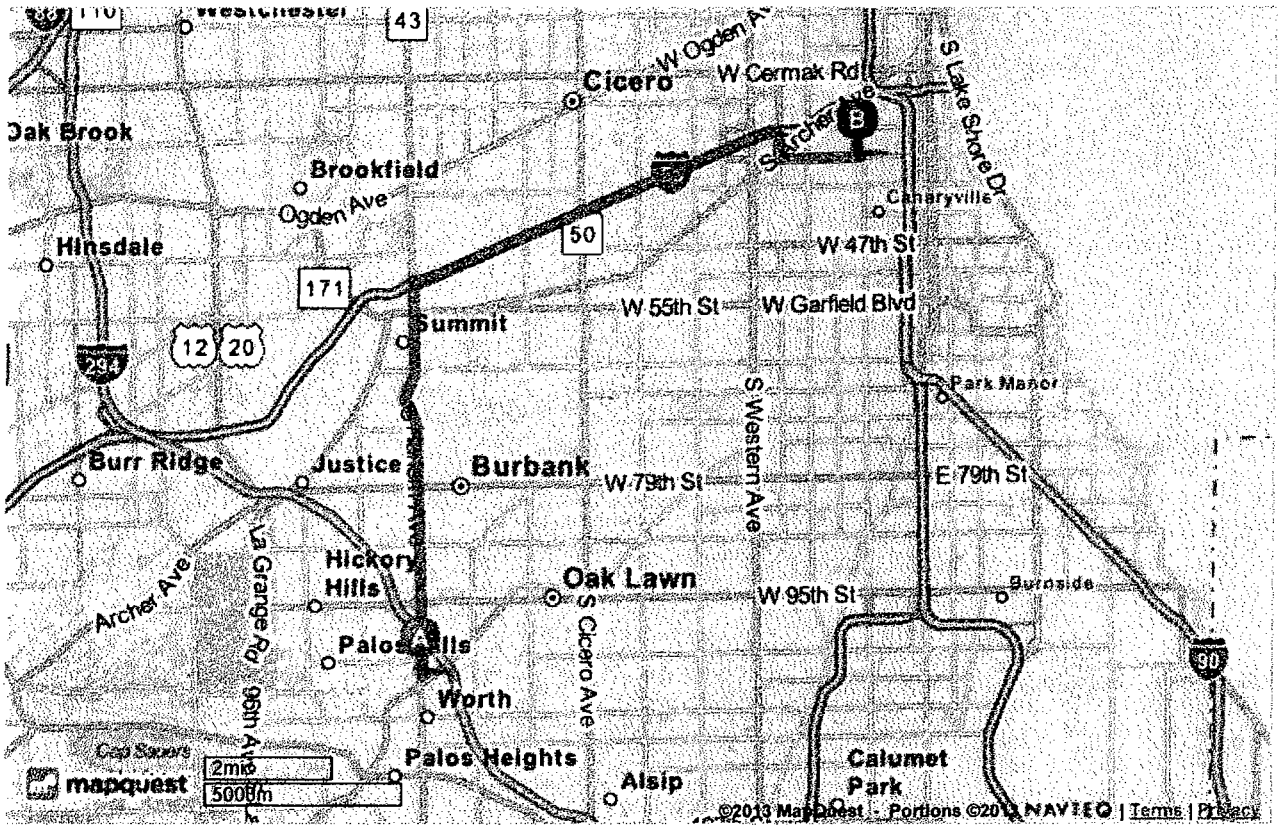
15.84 miles / 29 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**6.6 Mi** *13.5 Mi Total*
3. Take the **Damen Ave** exit, **EXIT 290**, toward **Ashland Ave**. Map	**0.2 Mi** *13.7 Mi Total*
4. Keep **left** to take the **Damen Ave** ramp. Map	**0.2 Mi** *13.9 Mi Total*
5. Keep **right** at the fork to go on **S Damen Ave**. Map	**0.5 Mi** *14.4 Mi Total*
6. Turn **left** onto **W 35th St**. Map *W 35th St is just past W 34th Pl* *China Wok is on the left* *If you reach W 36th St you've gone about 0.1 miles too far*	**1.4 Mi** *15.8 Mi Total*
7. **825 W 35TH ST** is on the **right**. Map *If you reach S Halsted St you've gone a little too far*	

825 W 35th St, Chicago, IL 60609-1511

Total Travel Estimate: **15.84 miles - about 29 minutes**



mapquest

Notes

Fresenius Medical Care of Roseland

Trip to:

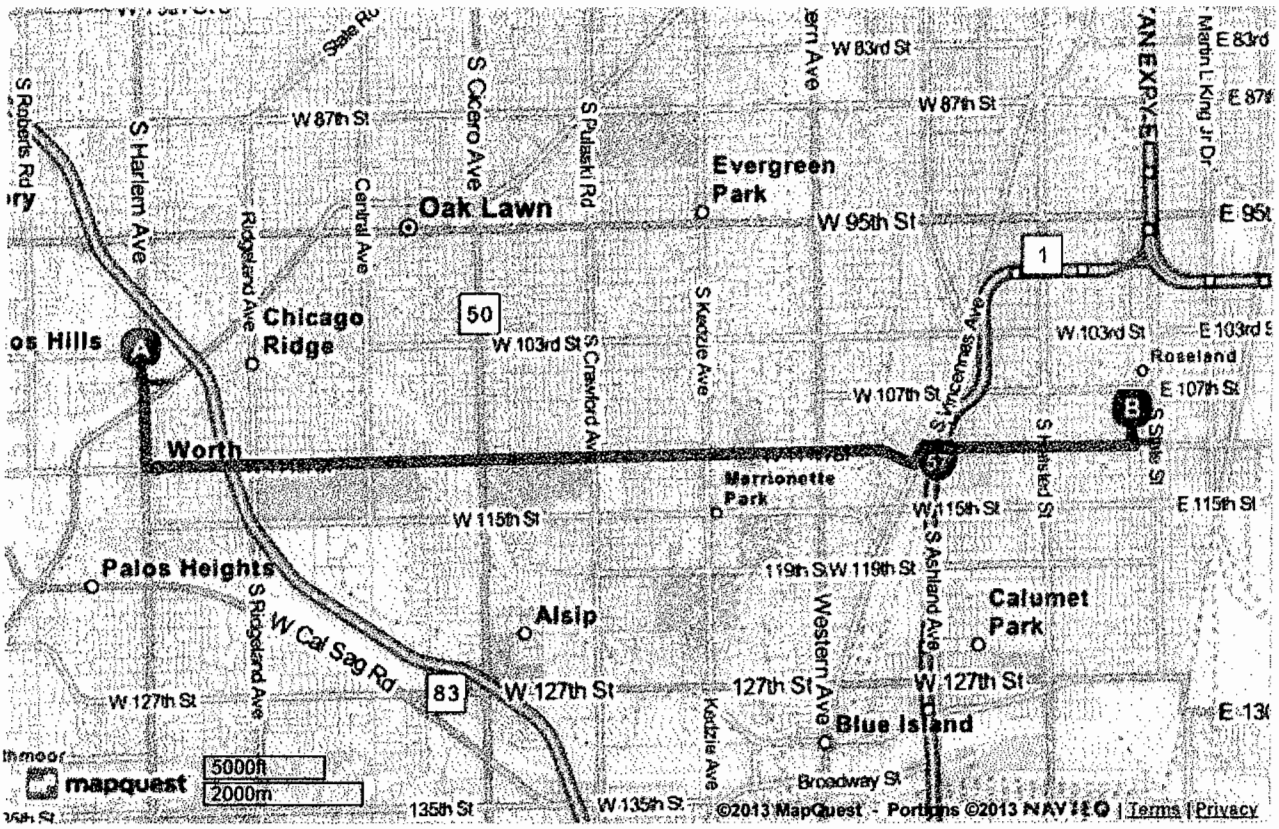
132 W 111th St
Chicago, IL 60628-4215
9.65 miles / 25 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**6.6 Mi** *7.3 Mi Total*
3. **W 111th St** becomes **W Monterey Ave**. Map	**0.3 Mi** *7.6 Mi Total*
4. Turn **left** onto **S Vincennes Ave**. Map *S Vincennes Ave is just past S Church St* *Morgan Park Pentecostal Church is on the corner* *If you reach S Ashland Ave you've gone a little too far*	**0.2 Mi** *7.8 Mi Total*
5. Turn **right** onto **W 111th St**. Map *W 111th St is just past W Pryor Ave* *Church of Jesus Christ of Latter-Day Saints is on the right* *If you reach W Chelsea Pl you've gone a little too far*	**1.9 Mi** *9.7 Mi Total*
6. **132 W 111TH ST** is on the **left**. Map *Your destination is just past S Wentworth Ave* *If you reach S Perry Ave you've gone a little too far*	

132 W 111th St, Chicago, IL 60628-4215

Total Travel Estimate: **9.65 miles - about 25 minutes**



mapquest

Notes

FMC - Greenwood Dialysis Center

Trip to:

1111 E 87th St Ste 700

Chicago, IL 60619-7038

11.52 miles / 30 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi**	*0.1 Mi Total*
2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi**	*5.1 Mi Total*
3. Turn **slight right** onto **W 87th St**. Map *W 87th St is 0.2 miles past S Merrion Ln* *If you are on W Columbus Ave and reach S Pulaski Rd you've gone a little too far*	**6.5 Mi**	*11.5 Mi Total*
4. **1111 E 87TH ST STE 700** is on the **right**. Map *Your destination is just past S Greenwood Ave* *If you reach S Avalon Ave you've gone about 0.1 miles too far*		

1111 E 87th St Ste 700, Chicago, IL 60619-7038

Total Travel Estimate: **11.52 miles - about 30 minutes**

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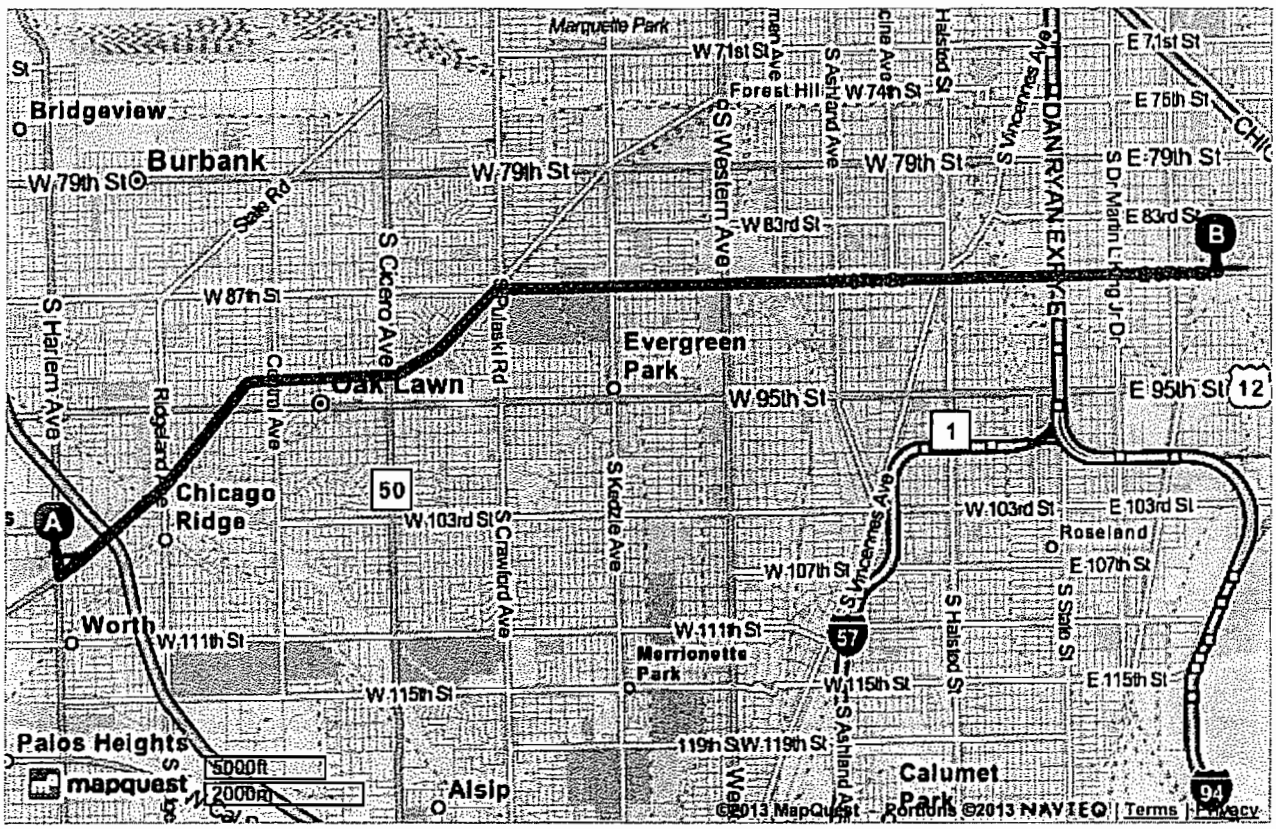


mapquest

Trip to:
8721 S Stony Island Ave
Chicago, IL 60617-2709
14.59 miles / 31 minutes

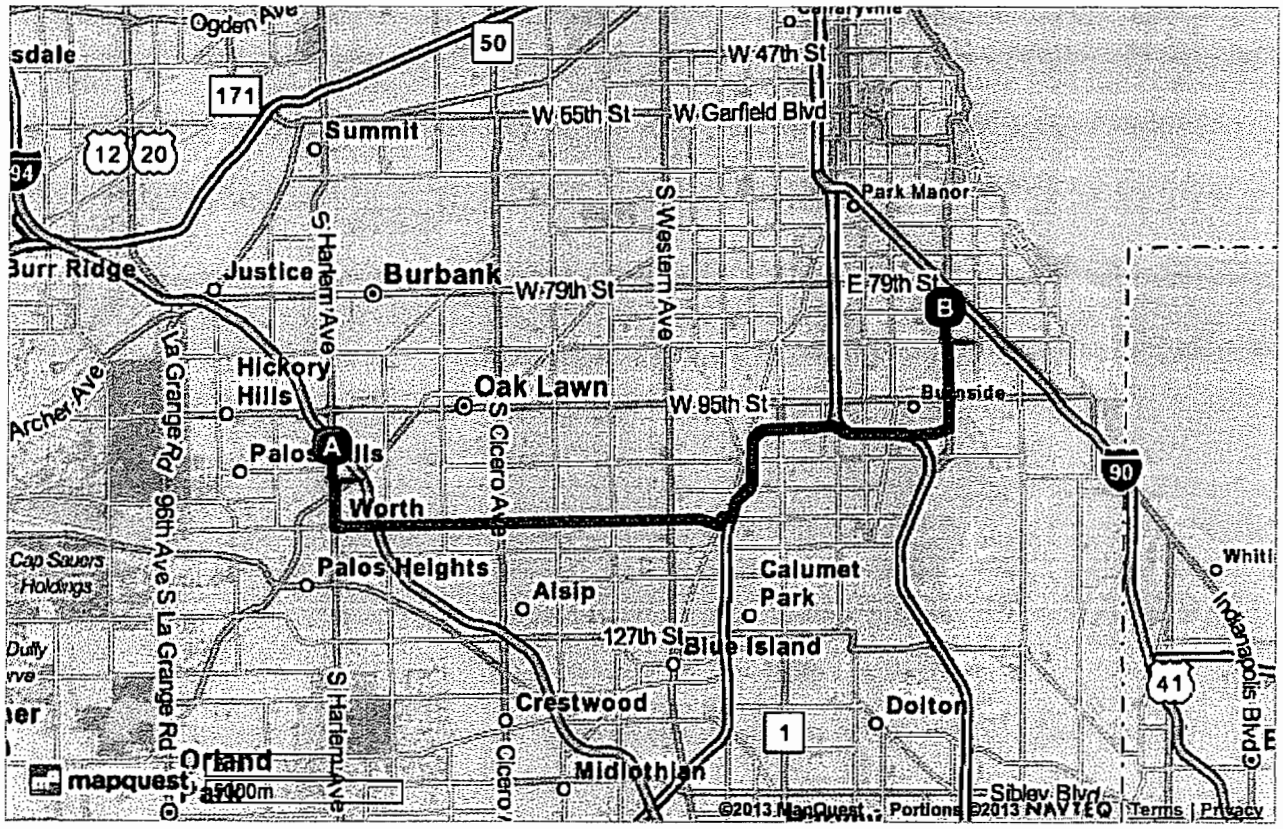
Notes
Stony Island Dialysis

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**6.6 Mi** *7.3 Mi Total*
3. **W 111th St** becomes **W Monterey Ave**. Map	**0.3 Mi** *7.6 Mi Total*
4. Turn **left** onto **S Vincennes Ave**. Map *S Vincennes Ave is just past S Church St* *Morgan Park Pentecostal Church is on the corner* *If you reach S Ashland Ave you've gone a little too far*	**0.2 Mi** *7.8 Mi Total*
5. Turn **right** onto **W 111th St**. Map *W 111th St is just past W Pryor Ave* *Church of Jesus Christ of Latter-Day Saints is on the right* *If you reach W Chelsea Pl you've gone a little too far*	**0.2 Mi** *8.0 Mi Total*
6. Merge onto **I-57 N** via the ramp on the **left** toward **Chicago Loop**. Map *If you reach S Bishop St you've gone a little too far*	**2.6 Mi** *10.6 Mi Total*
7. Merge onto **I-94 E / Bishop Ford Fwy** toward **Indiana**. Map	**1.5 Mi** *12.0 Mi Total*
8. Take the **Stony Island Ave** exit, **EXIT 65**, toward **95th-103rd STS**. Map	**0.8 Mi** *12.8 Mi Total*
9. Keep **left** to take the **North Stony Island Ave** ramp toward **95th St**. Map	**0.5 Mi** *13.4 Mi Total*
10. Merge onto **S Stony Island Ext**. Map	**0.2 Mi** *13.6 Mi Total*
11. **S Stony Island Ext** becomes **S Stony Island Ave**. Map	**1.0 Mi** *14.6 Mi Total*
12. **8721 S STONY ISLAND AVE** is on the **right**. Map *Your destination is just past E 88th St .* *If you reach E 87th St you've gone a little too far*	

8721 S Stony Island Ave, Chicago, IL 60617-2709

Total Travel Estimate: **14.59 miles - about 31 minutes**



mapquest

Notes

Fresenius Medical Care - Neomedica South

Trip to:

9200 S South Chicago Ave
Chicago, IL 60617-4512
15.81 miles / 34 minutes

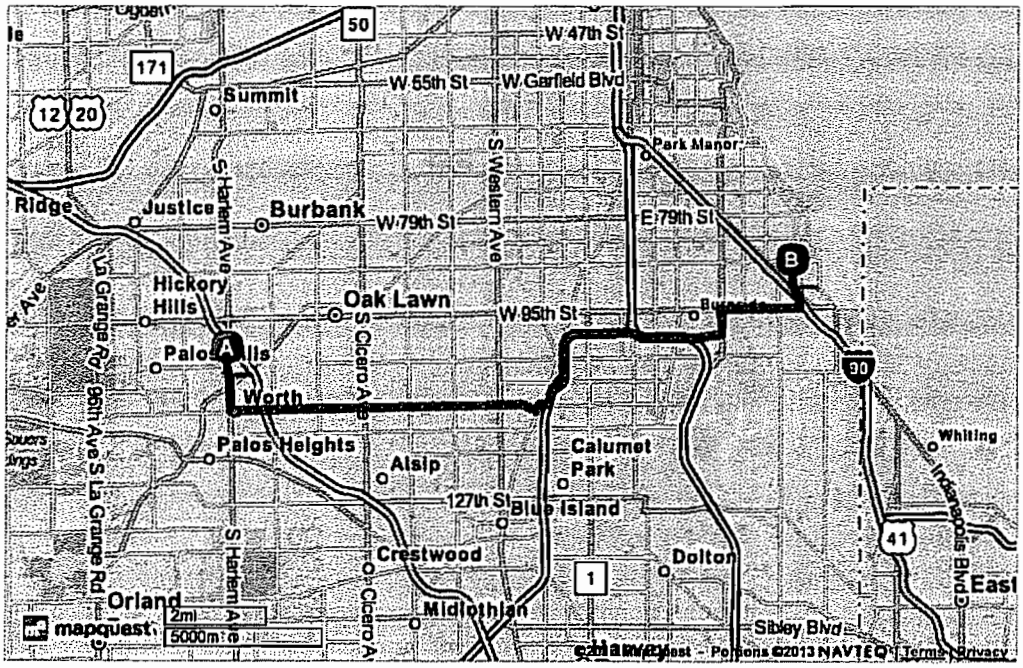
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.7 Mi** *0.7 Mi Total*
2. Turn **left** onto **W 111th St**. Map *W 111th St is just past W 110th Pl* *Post Office-Worth is on the corner* *If you reach W 111th Pl you've gone a little too far*	**6.6 Mi** *7.3 Mi Total*
3. **W 111th St** becomes **W Monterey Ave**. Map	**0.3 Mi** *7.6 Mi Total*
4. Turn **left** onto **S Vincennes Ave**. Map *S Vincennes Ave is just past S Church St* *Morgan Park Pentecostal Church is on the corner* *If you reach S Ashland Ave you've gone a little too far*	**0.2 Mi** *7.8 Mi Total*
5. Turn **right** onto **W 111th St**. Map *W 111th St is just past W Pryor Ave* *Church of Jesus Christ of Latter-Day Saints is on the right* *If you reach W Chelsea Pl you've gone a little too far*	**0.2 Mi** *8.0 Mi Total*
6. Merge onto **I-57 N** via the ramp on the **left** toward **Chicago Loop**. Map *If you reach S Bishop St you've gone a little too far*	**2.6 Mi** *10.6 Mi Total*
7. Merge onto **I-94 E / Bishop Ford Fwy** toward **Indiana**. Map	**1.5 Mi** *12.0 Mi Total*
8. Take the **Stony Island Ave** exit, **EXIT 65**, toward **95th-103rd STS**. Map	**0.8 Mi** *12.8 Mi Total*
9. Keep **left** to take the **North Stony Island Ave** ramp toward **95th St**. Map	**0.5 Mi** *13.4 Mi Total*
10. Merge onto **S Stony Island Ext**. Map	**0.2 Mi** *13.6 Mi Total*
11. **S Stony Island Ext** becomes **S Stony Island Ave**. Map	**0.08 Mi** *13.6 Mi Total*
12. Turn **right** onto **E 95th St / US-20 / US-12**. Map *Circle K is on the right* *If you reach E 93rd St you've gone about 0.2 miles too far*	**1.8 Mi** *15.4 Mi Total*
13. Turn **left** onto **S Commercial Ave**. Map *S Commercial Ave is just past S Exchange Ave* *Praise Tabernacle Center is on the corner* *If you reach S Houston Ave you've gone a little too far*	**0.3 Mi** *15.7 Mi Total*
14. Turn **slight left** onto **S South Chicago Ave**. Map *S South Chicago Ave is 0.1 miles past E 94th St* *If you reach E 92nd St you've gone about 0.1 miles too far*	**0.2 Mi** *15.8 Mi Total*
15. **9200 S SOUTH CHICAGO AVE** is on the **left**. Map *Your destination is just past S Exchange Ave* *If you reach E 92nd St you've gone a little too far*	

9200 S South Chicago Ave, Chicago, IL 60617-4512

Total Travel Estimate: **15.81 miles - about 34 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Grand Crossing Dialysis

Trip to:

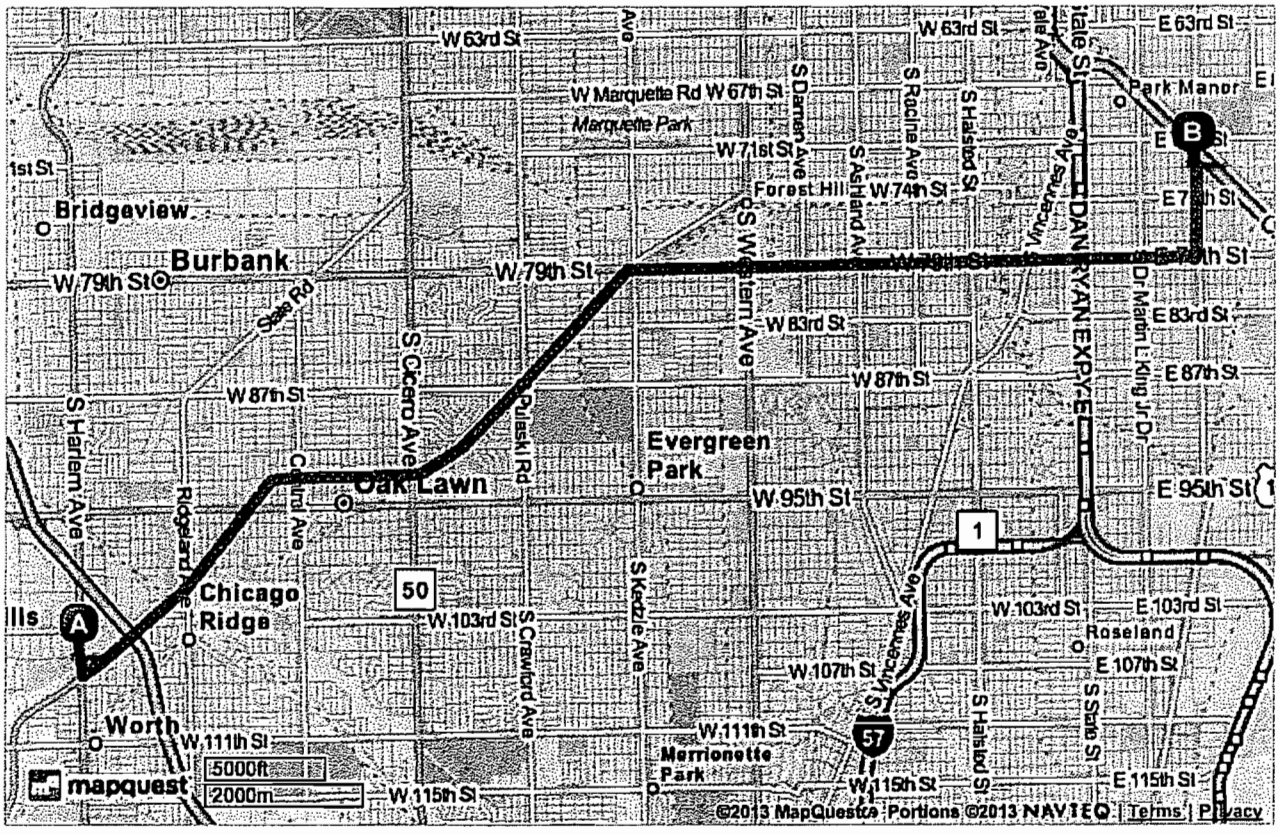
7319 S Cottage Grove Ave
Chicago, IL 60619-1909
12.29 miles / 31 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

●	1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7.** Map	**0.1 Mi** *0.1 Mi Total*
↰	2. Take the 1st **left** onto **SouthWest Hwy.** Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
↑	3. **SouthWest Hwy** becomes **W Columbus Ave.** Map	**1.4 Mi** *6.5 Mi Total*
↗	4. Turn **slight right** onto **W 79th St.** Map *W 79th St is 0.1 miles past S Christiana Ave* *Boones Funeral Services is on the corner* *If you are on W Columbus Ave and reach S Kedzie Ave you've gone a little too far*	**5.1 Mi** *11.6 Mi Total*
↰	5. Turn **left** onto **S Cottage Grove Ave.** Map *S Cottage Grove Ave is just past S Evans Ave* *Billy's Gyros Inc is on the corner* *If you reach S Maryland Ave you've gone a little too far*	**0.7 Mi** *12.3 Mi Total*
■	6. **7319 S COTTAGE GROVE AVE** is on the **right.** Map *Your destination is 0.1 miles past E 74th St* *If you reach E 73rd St you've gone a little too far*	

7319 S Cottage Grove Ave, Chicago, IL 60619-1909

Total Travel Estimate: **12.29 miles - about 31 minutes**



mapquest

Trip to:

7531 S Stony Island Ave
Chicago, IL 60649-3954
13.01 miles / 33 minutes

Notes

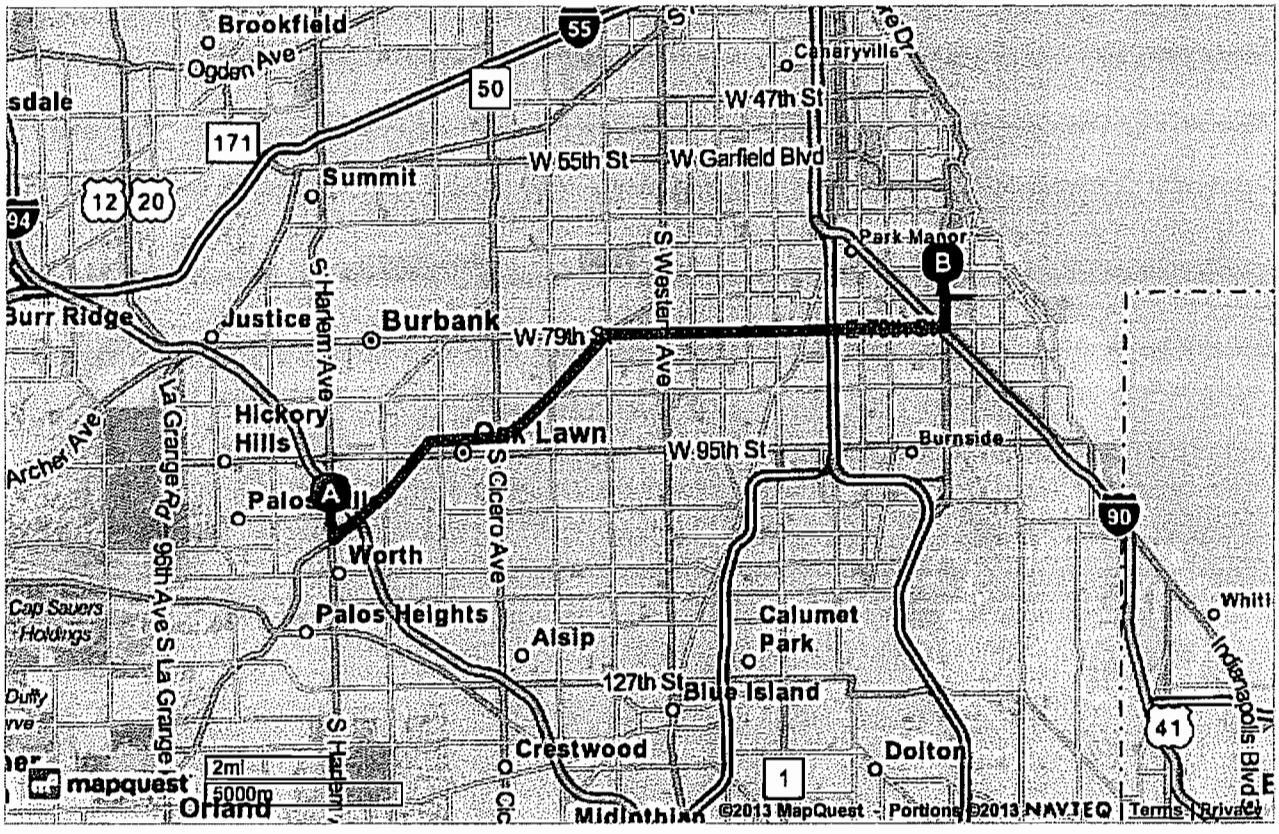
FMC - Jackson Park Dialysis

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

●	1. Start out going **south** on **S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
↰	2. Take the **1st left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
↑	3. **SouthWest Hwy** becomes **W Columbus Ave**. Map	**1.4 Mi** *6.5 Mi Total*
↗	4. Turn **slight right** onto **W 79th St**. Map *W 79th St is 0.1 miles past S Christiana Ave* *Boones Funeral Services is on the corner* *If you are on W Columbus Ave and reach S Kedzie Ave you've gone a little too far*	**6.1 Mi** *12.6 Mi Total*
↰	5. Turn **left** onto **S Stony Island Ave**. Map *Maxwell Street Grill is on the corner* *If you reach S Cornell Ave you've gone a little too far*	**0.4 Mi** *13.0 Mi Total*
■	6. **7531 S STONY ISLAND AVE** is on the **right**. Map *Your destination is just past E 76th St* *If you reach E 75th Pl you've gone a little too far*	

7531 S Stony Island Ave, Chicago, IL 60649-3954

Total Travel Estimate: **13.01 miles - about 33 minutes**



mapquest

Notes

Woodlawn Dialysis

Trip to:

5060 S State St
Chicago, IL 60609-5328
19.64 miles / 33 minutes

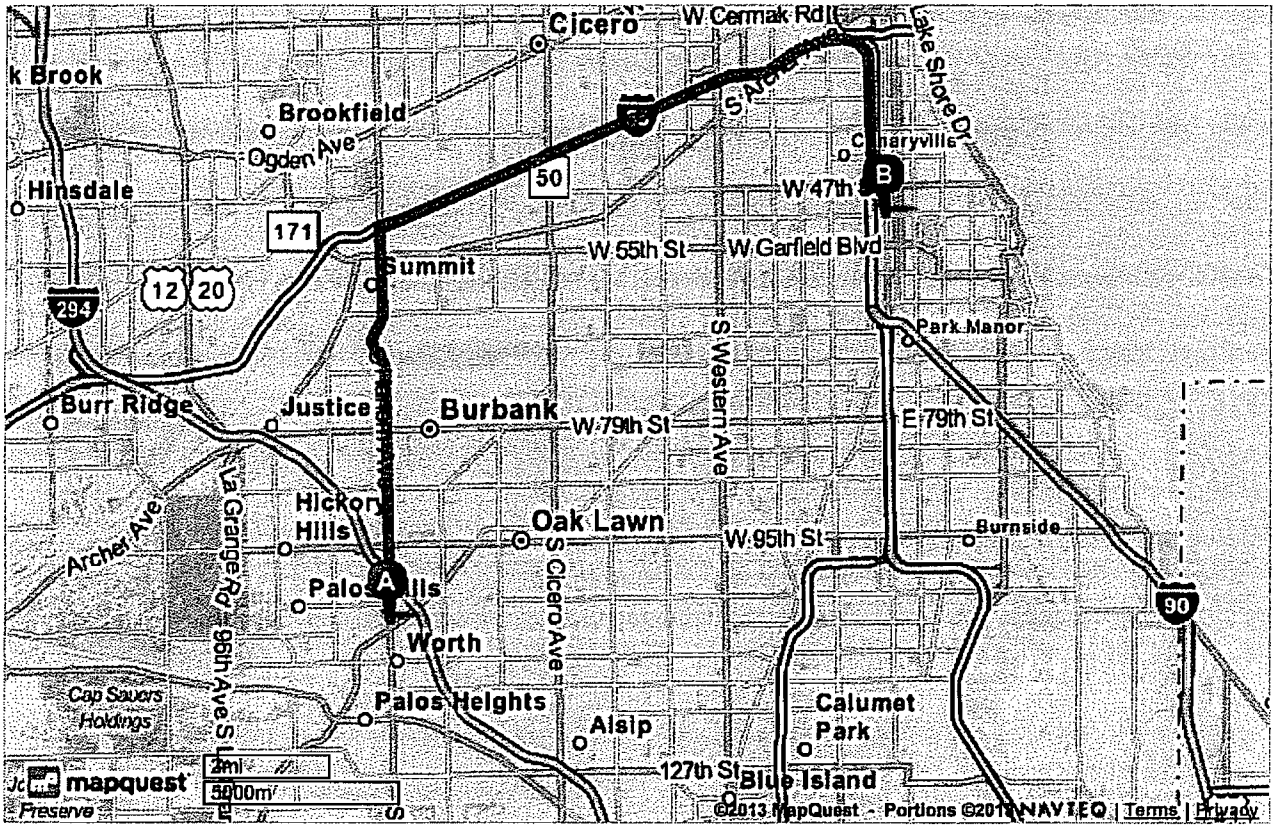
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.6 Mi** *15.5 Mi Total*
3. Merge onto **I-90 E / I-94 E / Dan Ryan Expy E** via **EXIT 292B** toward **Indiana.** Map	**0.8 Mi** *16.2 Mi Total*
4. Keep **right** to take **I-90 E / I-94 E / Dan Ryan Expy E.** Map	**2.3 Mi** *18.6 Mi Total*
5. Take **EXIT 56B** toward **47th St.** Map	**0.2 Mi** *18.8 Mi Total*
6. Turn **slight left** onto **S Wentworth Ave.** Map	**0.06 Mi** *18.8 Mi Total*
7. Take the **1st left** onto **W 47th St.** Map *Pappy's Restaurant is on the corner* *If you are on S Wells St and reach W 48th Pl you've gone about 0.2 miles too far*	**0.3 Mi** *19.2 Mi Total*
8. Turn **right** onto **S State St.** Map *S State St is just past S Dearborn St* *If you are on E 47th St and reach S Wabash Ave you've gone a little too far*	**0.5 Mi** *19.6 Mi Total*
9. **5060 S STATE ST** is on the **right.** Map *Your destination is 0.3 miles past E 48th St* *If you reach W 51st St you've gone a little too far*	

5060 S State St, Chicago, IL 60609-5328

Total Travel Estimate: **19.64 miles - about 33 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Kenwood Dialysis

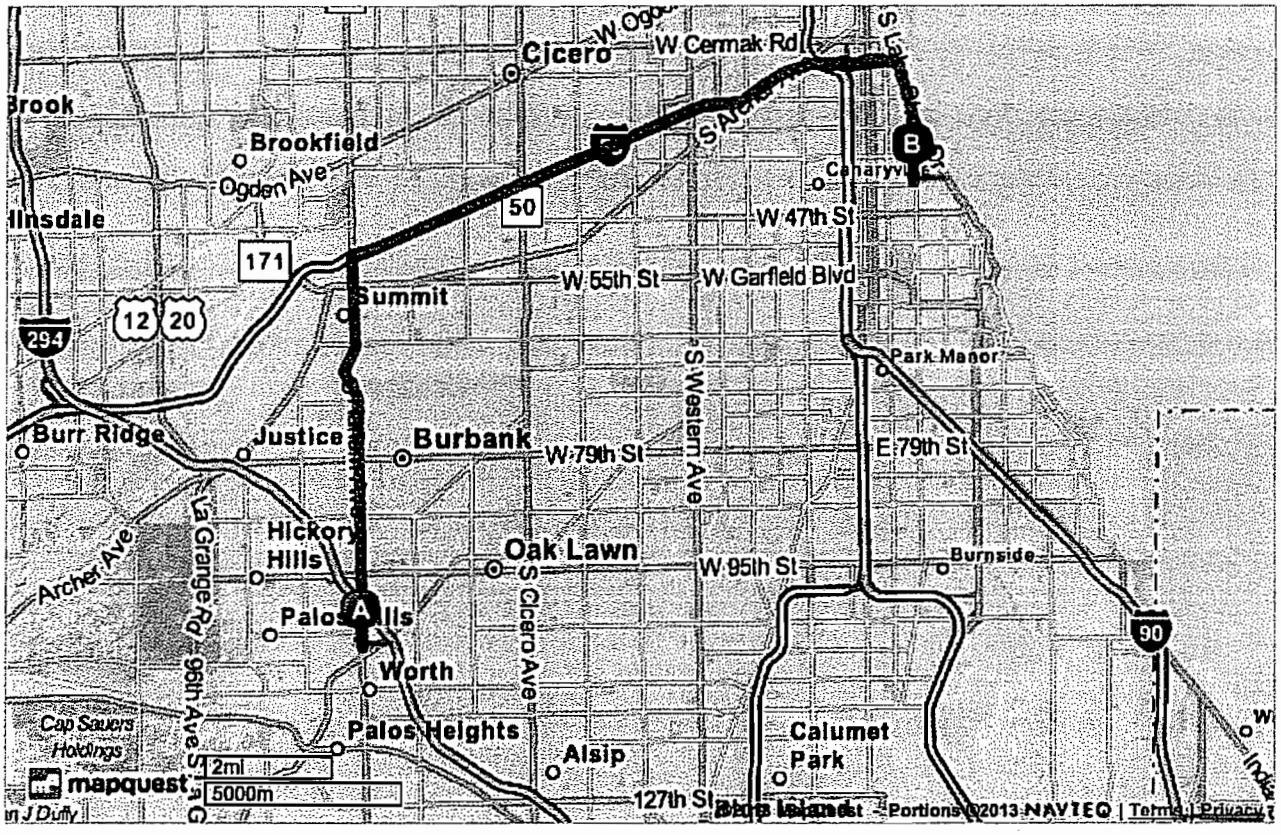
Trip to:

4253 S Cottage Grove Ave
Chicago, IL 60653-2929
19.82 miles / 33 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**10.3 Mi** *17.2 Mi Total*
SOUTH 41	3. Merge onto **S Lake Shore Dr / US-41 S.** Map	**1.7 Mi** *18.9 Mi Total*
RAMP	4. Take the **Oakwood Blvd** ramp. Map	**0.2 Mi** *19.1 Mi Total*
↱	5. Turn **right** onto **E Oakwood Blvd.** Map *If you reach US-41 S you've gone about 0.1 miles too far*	**0.2 Mi** *19.3 Mi Total*
↰	6. Turn **left** to stay on **E Oakwood Blvd.** Map *E Oakwood Blvd is just past S Lake Park Ave* *If you are on E Pershing Rd and reach S Ellis Ave you've gone a little too far*	**0.2 Mi** *19.5 Mi Total*
↰	7. Turn **left** onto **S Cottage Grove Ave.** Map *S Cottage Grove Ave is just past S Drexel Blvd* *If you reach S Langley Ave you've gone about 0.1 miles too far*	**0.4 Mi** *19.8 Mi Total*
■	8. **4253 S COTTAGE GROVE AVE.** Map *Your destination is just past E 42nd Pl* *If you reach E 43rd St you've gone a little too far*	
B	**4253 S Cottage Grove Ave**, Chicago, IL 60653-2929	

Total Travel Estimate: **19.82 miles - about 33 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Trip to:
2420 E 79th St
Chicago, IL 60649-5112
13.61 miles / 36 minutes

Notes
Fresenius Medical Care South Shore

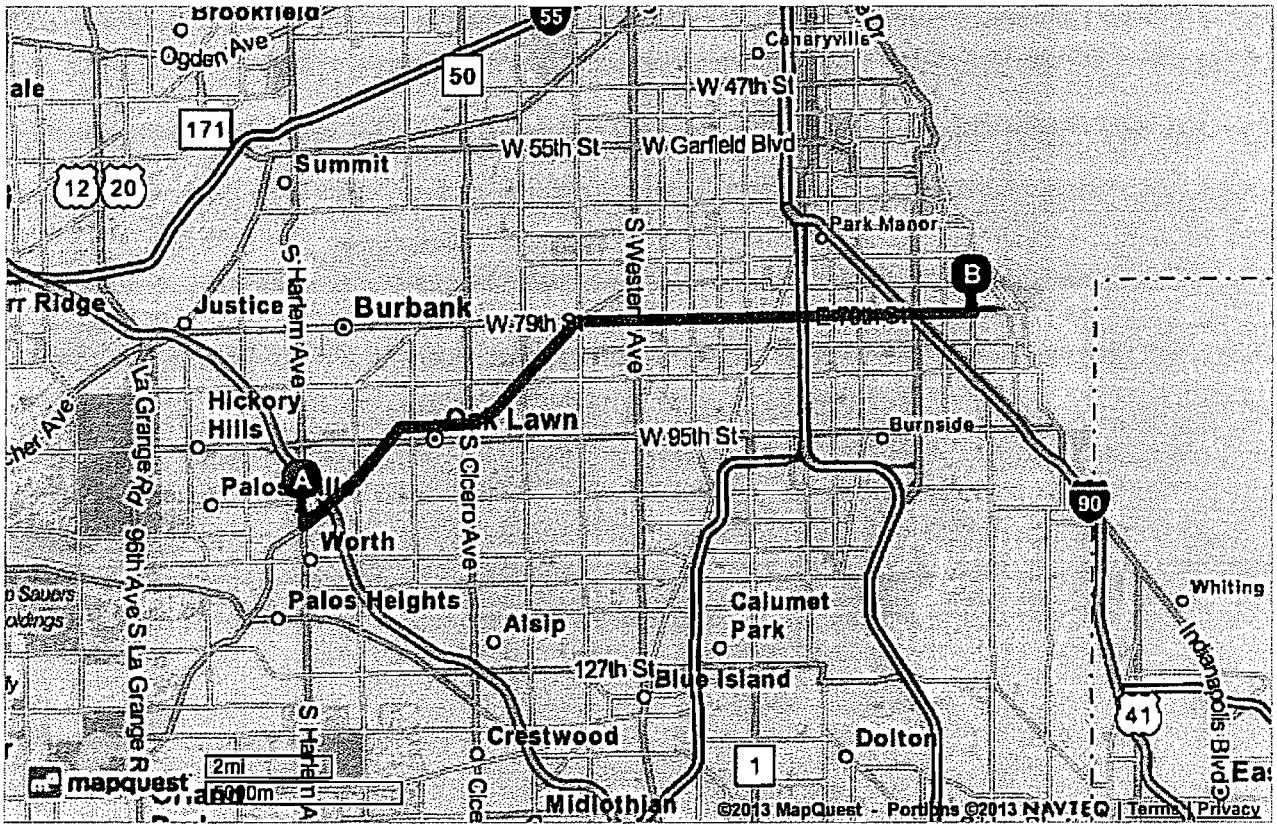
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

●	1. Start out going **south on S Harlem Ave / IL-43** toward **SouthWest Hwy / IL-7**. Map	**0.1 Mi** *0.1 Mi Total*
↰	2. Take the 1st **left** onto **SouthWest Hwy**. Map *Brooklyn Pizza is on the corner* *If you reach W 107th St you've gone a little too far*	**4.9 Mi** *5.1 Mi Total*
↑	3. **SouthWest Hwy** becomes **W Columbus Ave**. Map	**1.4 Mi** *6.5 Mi Total*
↗	4. Turn **slight right** onto **W 79th St**. Map *W 79th St is 0.1 miles past S Christiana Ave* *Boones Funeral Services is on the corner* *If you are on W Columbus Ave and reach S Kedzie Ave you've gone a little too far*	**7.1 Mi** *13.6 Mi Total*
■	5. **2420 E 79TH ST** is on the **left**. Map *Your destination is just past S Yates Blvd* *If you reach S Phillips Ave you've gone a little too far*	

2420 E 79th St, Chicago, IL 60649-5112

Total Travel Estimate: **13.61 miles - about 36 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Loyola Dialysis Center

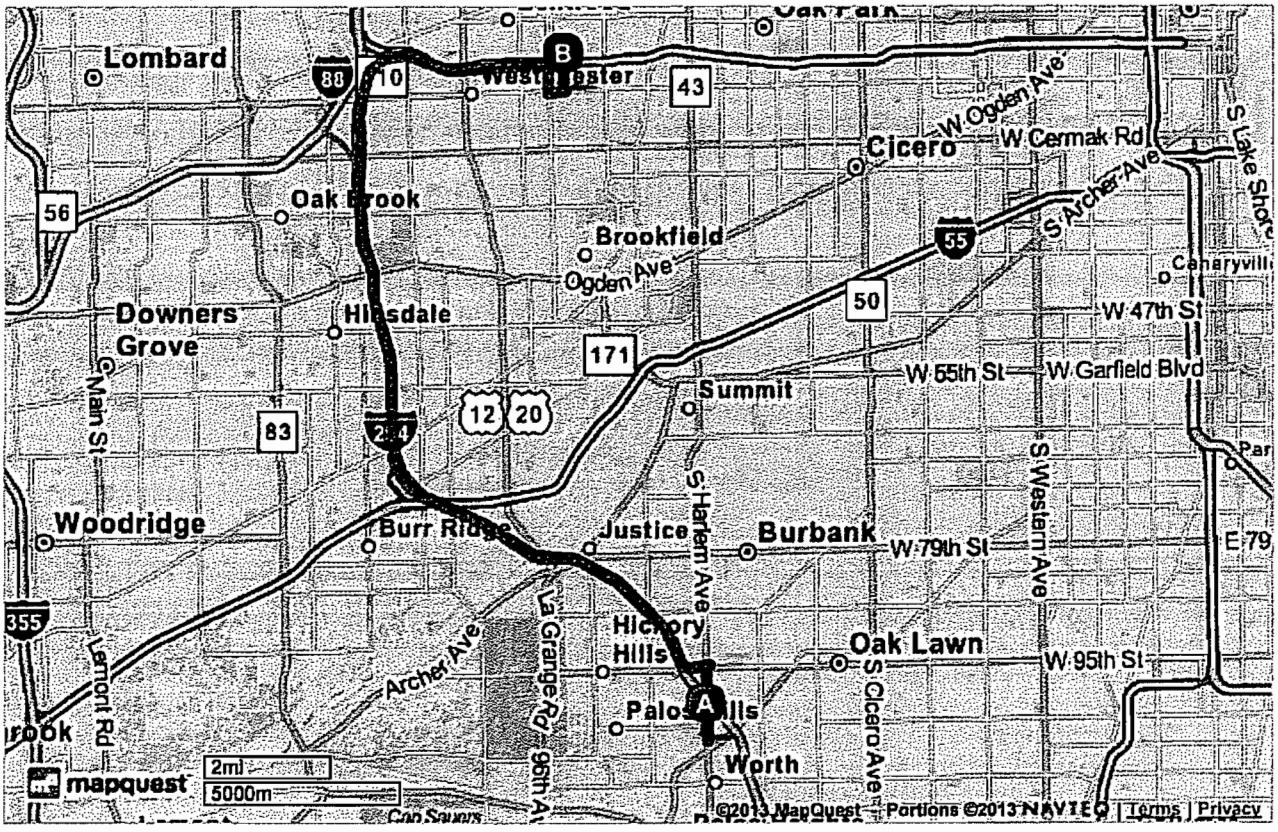
Trip to:

1201 W Roosevelt Rd
Maywood, IL 60153-4046
19.61 miles / 28 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St.** Map	**1.3 Mi** *1.3 Mi Total*
WEST 20	2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N.** Map	**0.5 Mi** *1.8 Mi Total*
NORTH 294	3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**13.3 Mi** *15.1 Mi Total*
EAST 290	4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** toward **Chicago.** Map	**0.7 Mi** *15.8 Mi Total*
EAST 290	5. Keep **left** to take **I-290 E / IL-110 E / Eisenhower Expy E.** Map	**2.9 Mi** *18.7 Mi Total*
19A EXIT	6. Take the **17th Ave** exit, **EXIT 19A.** Map	**0.2 Mi** *18.8 Mi Total*
↑	7. Stay **straight** to go onto **Bataan Dr.** Map	**0.03 Mi** *18.8 Mi Total*
↱	8. Take the **1st right** onto **S 17th Ave.** Map *MARATHON is on the corner* *If you reach S 16th Ave you've gone a little too far*	**0.5 Mi** *19.3 Mi Total*
↰	9. Turn **left** onto **W Roosevelt Rd.** Map *W Roosevelt Rd is 0.1 miles past Fillmore St* *If you reach 13th St you've gone about 0.1 miles too far*	**0.3 Mi** *19.6 Mi Total*
■	10. **1201 W ROOSEVELT RD** is on the **left.** Map *Your destination is just past S 13th Ave* *If you reach S 12th Ave you've gone a little too far*	
B	**1201 W Roosevelt Rd**, Maywood, IL 60153-4046	

Total Travel Estimate: **19.61 miles - about 28 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care Melrose Park

Trip to:

1111 Superior St

Melrose Park, IL 60160-4138

21.11 miles / 33 minutes

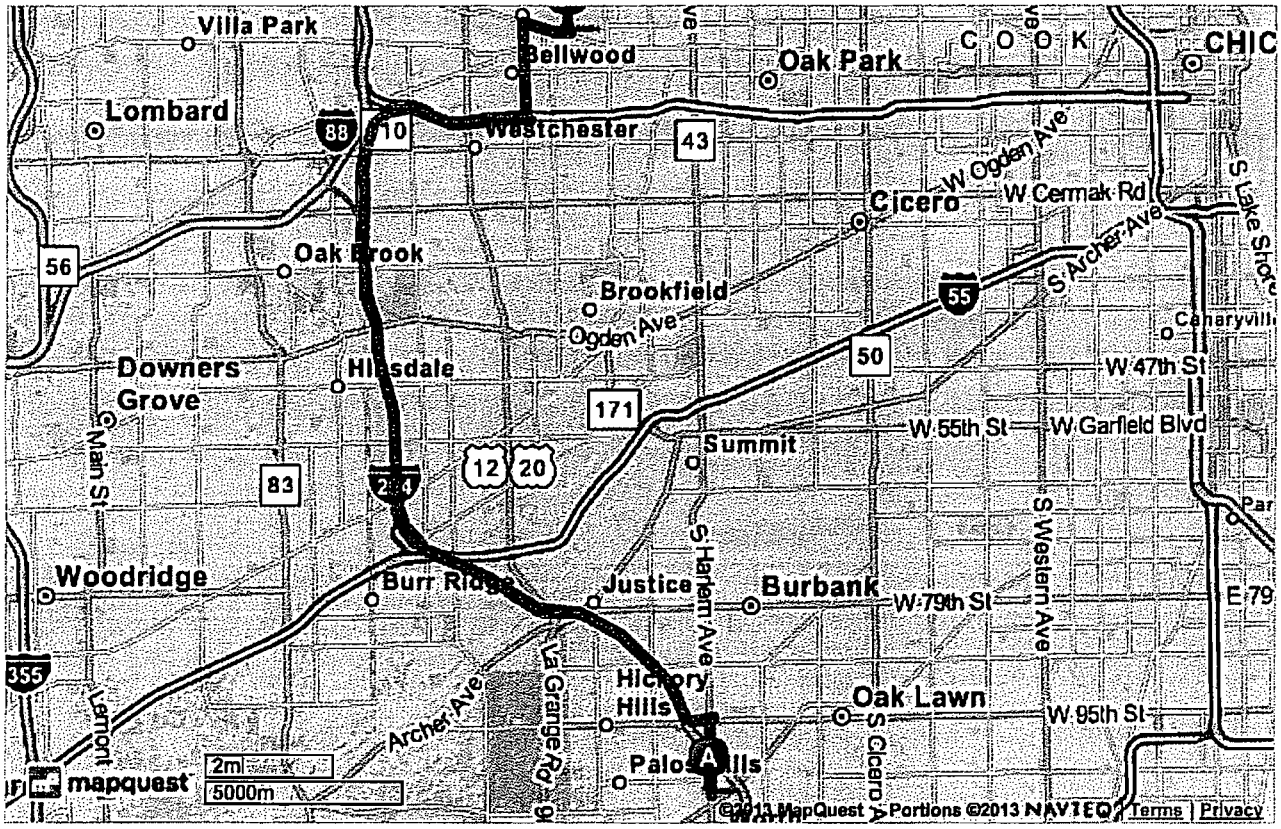
A [10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**13.3 Mi** *15.1 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy** E toward **Chicago**. Map	**0.7 Mi** *15.8 Mi Total*
5. Keep **left** to take **I-290 E / IL-110 E / Eisenhower Expy** E. Map	**2.6 Mi** *18.3 Mi Total*
6. Take the **North 25th Ave** exit, **EXIT 18B**. Map	**0.2 Mi** *18.5 Mi Total*
7. Turn **slight right** onto **25th Ave**. Map	**1.7 Mi** *20.2 Mi Total*
8. Turn **right** onto **W Lake St**. Map *W Lake St is 0.2 miles past Main St* *Carnita's & Alfredo is on the corner* *If you reach Walton St you've gone a little too far*	**0.7 Mi** *20.9 Mi Total*
9. Turn **slight left** onto **Superior St**. Map *Superior St is just past N 16th Ave* *El Anzuelo Restaurant is on the left*	**0.2 Mi** *21.1 Mi Total*
10. **1111 SUPERIOR ST** is on the **right**. Map *Your destination is just past N 12th Ave* *If you reach N 11th Ave you've gone a little too far*	

B 1111 Superior St, Melrose Park, IL 60160-4138

Total Travel Estimate: **21.11 miles - about 33 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - Dialysis Center of America - Berwyn

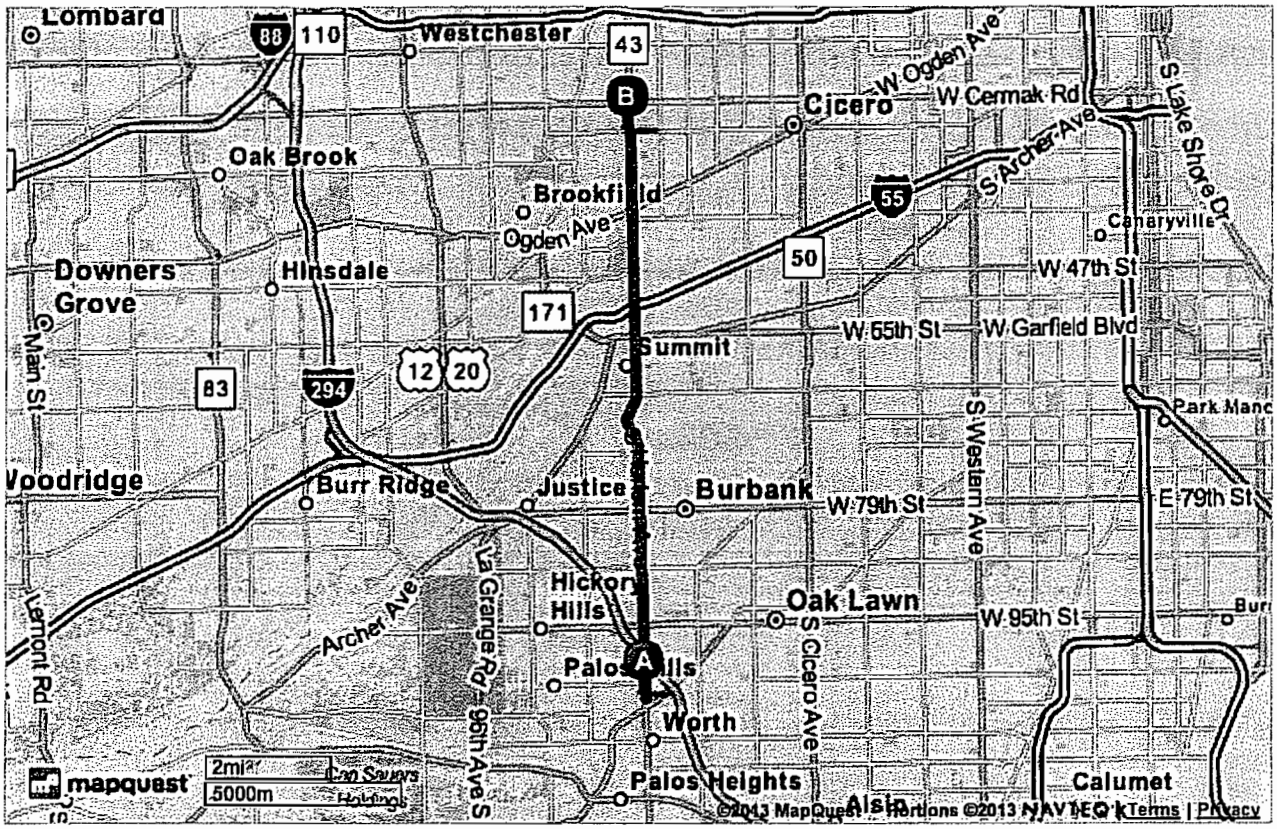
Trip to:

2601 Harlem Ave
Berwyn, IL 60402-2100
10.00 miles / 23 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**10.0 Mi** *10.0 Mi Total*
■	2. **2601 HARLEM AVE** is on the **right.** Map *Your destination is just past Berkeley Rd* *If you reach 26th St you've gone a little too far*	
B	**2601 Harlem Ave**, Berwyn, IL 60402-2100	

Total Travel Estimate: **10.00 miles - about 23 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Maple Avenue Kidney Center

Trip to:

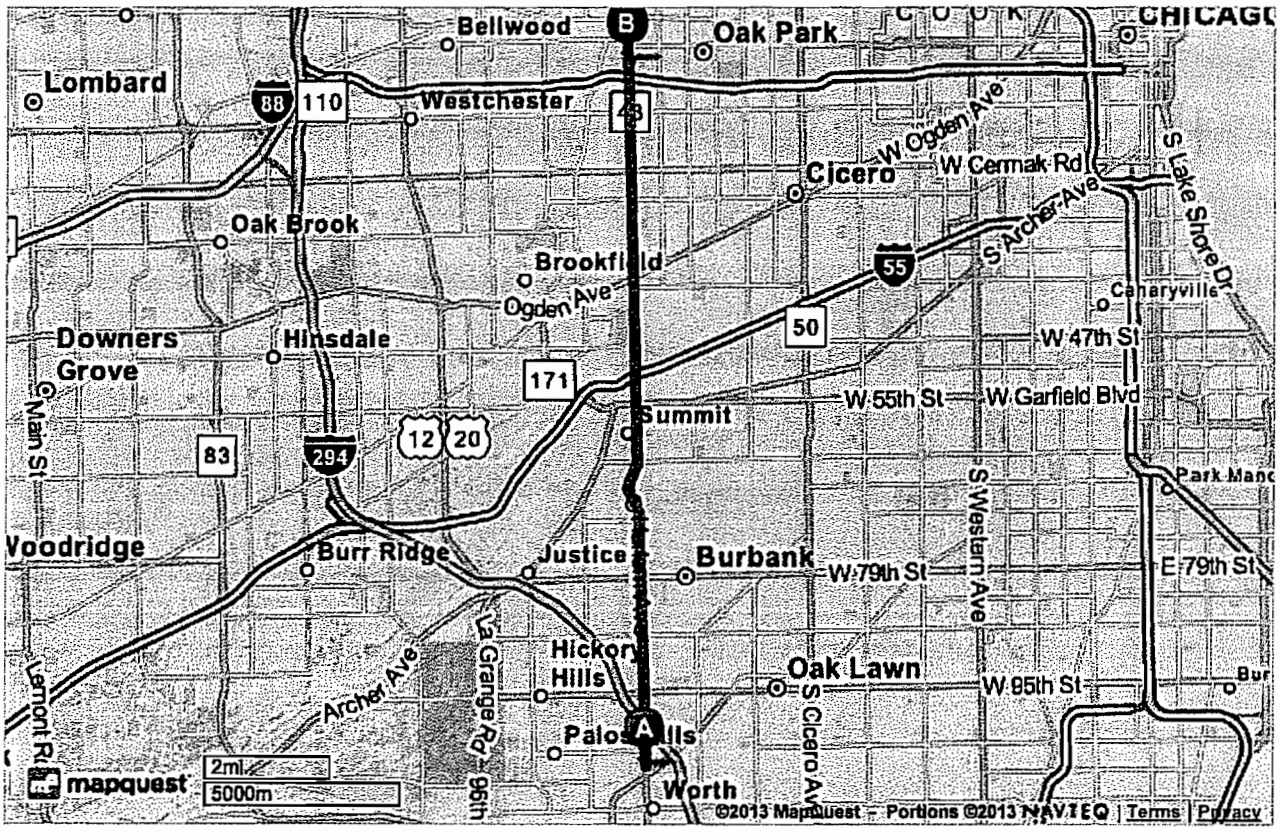
610 S Maple Ave
Oak Park, IL 60304-1091
12.49 miles / 29 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1.	Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**12.4 Mi** *12.4 Mi Total*
2.	Turn **right** onto **Monroe St.** Map *Monroe St is just past Adams St* *If you reach Madison St you've gone about 0.1 miles too far*	**0.05 Mi** *12.5 Mi Total*
3.	Turn **right** onto **S Maple Ave.** Map	**0.01 Mi** *12.5 Mi Total*
4.	**610 S MAPLE AVE** is on the **left.** Map *If you reach Adams St you've gone a little too far*	

610 S Maple Ave, Oak Park, IL 60304-1091

Total Travel Estimate: **12.49 miles - about 29 minutes**



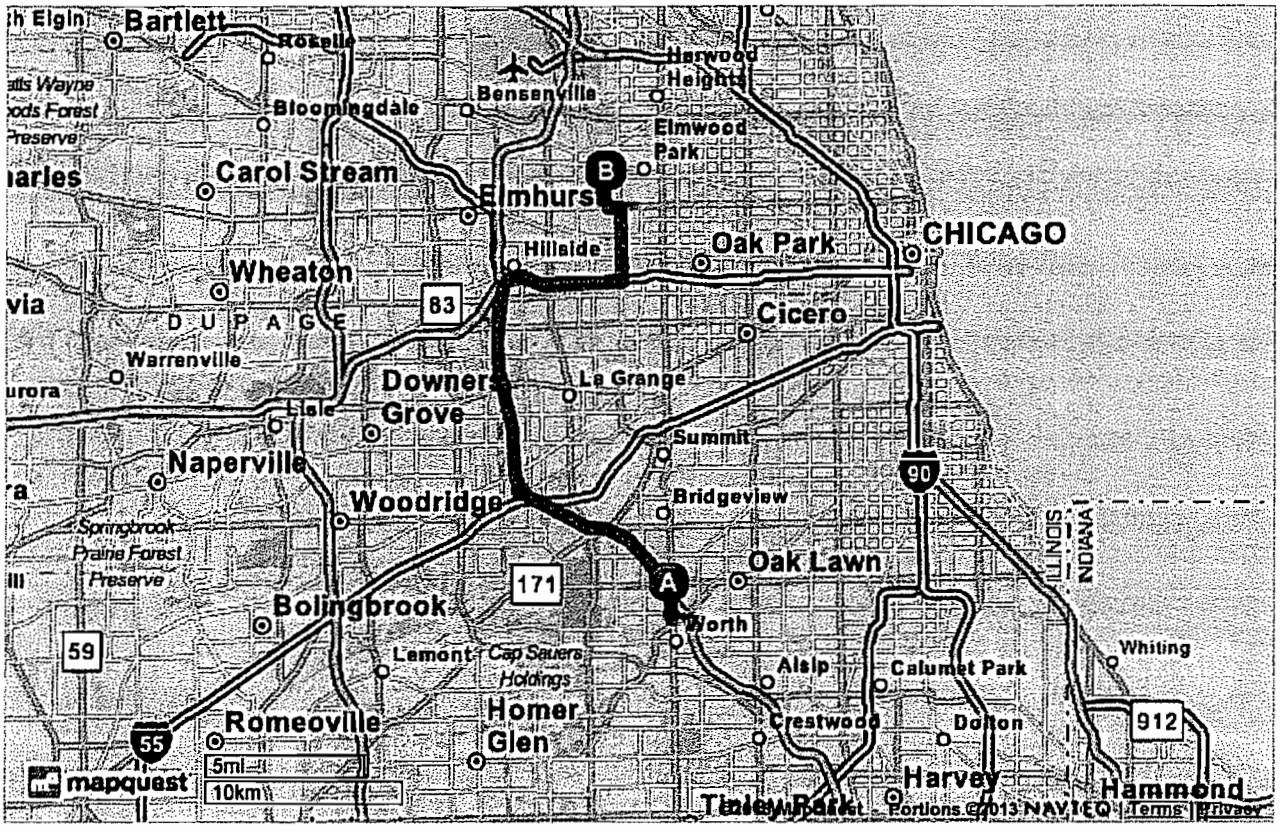
mapquest

Trip to:
719 W North Ave
Melrose Park, IL 60160-1612
22.84 miles / 34 minutes

Notes
FMC - North Avenue Dialysis Center

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St.** Map	**1.3 Mi** *1.3 Mi Total*
WEST 20	2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N.** Map	**0.5 Mi** *1.8 Mi Total*
NORTH 294	3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**13.3 Mi** *15.1 Mi Total*
EAST 290	4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** toward **Chicago.** Map	**0.7 Mi** *15.8 Mi Total*
EAST 290	5. Keep **left** to take **I-290 E / IL-110 E / Eisenhower Expy E.** Map	**3.9 Mi** *19.6 Mi Total*
20 EXIT	6. Take **EXIT 20** toward **IL-171 / 1st Ave.** Map	**0.2 Mi** *19.8 Mi Total*
↑	7. Stay **straight** to go onto **Bataan Dr.** Map	**0.06 Mi** *19.9 Mi Total*
171	8. Take the **1st left** onto **IL-171 / S 1st Ave.** Map *If you reach I-290 E you've gone about 0.1 miles too far*	**2.6 Mi** *22.4 Mi Total*
WEST 64	9. Turn **left** onto **W North Ave / IL-64 W.** Map *W North Ave is 0.4 miles past Braddock Dr* *If you are on N 1st Ave and reach N Des Plaines River Rd you've gone about 0.5 miles too far*	**0.4 Mi** *22.8 Mi Total*
■	10. **719 W NORTH AVE** is on the **right.** Map *Your destination is 0.1 miles past N 5th Ave* *If you reach N 9th Ave you've gone about 0.1 miles too far*	
B	**719 W North Ave**, Melrose Park, IL 60160-1612	

Total Travel Estimate: **22.84 miles - about 34 minutes**



mapquest

Trip to:
103 Forest Ave
River Forest, IL 60305-2003
21.42 miles / 31 minutes

Notes
Fresenius Medical Care River Forest

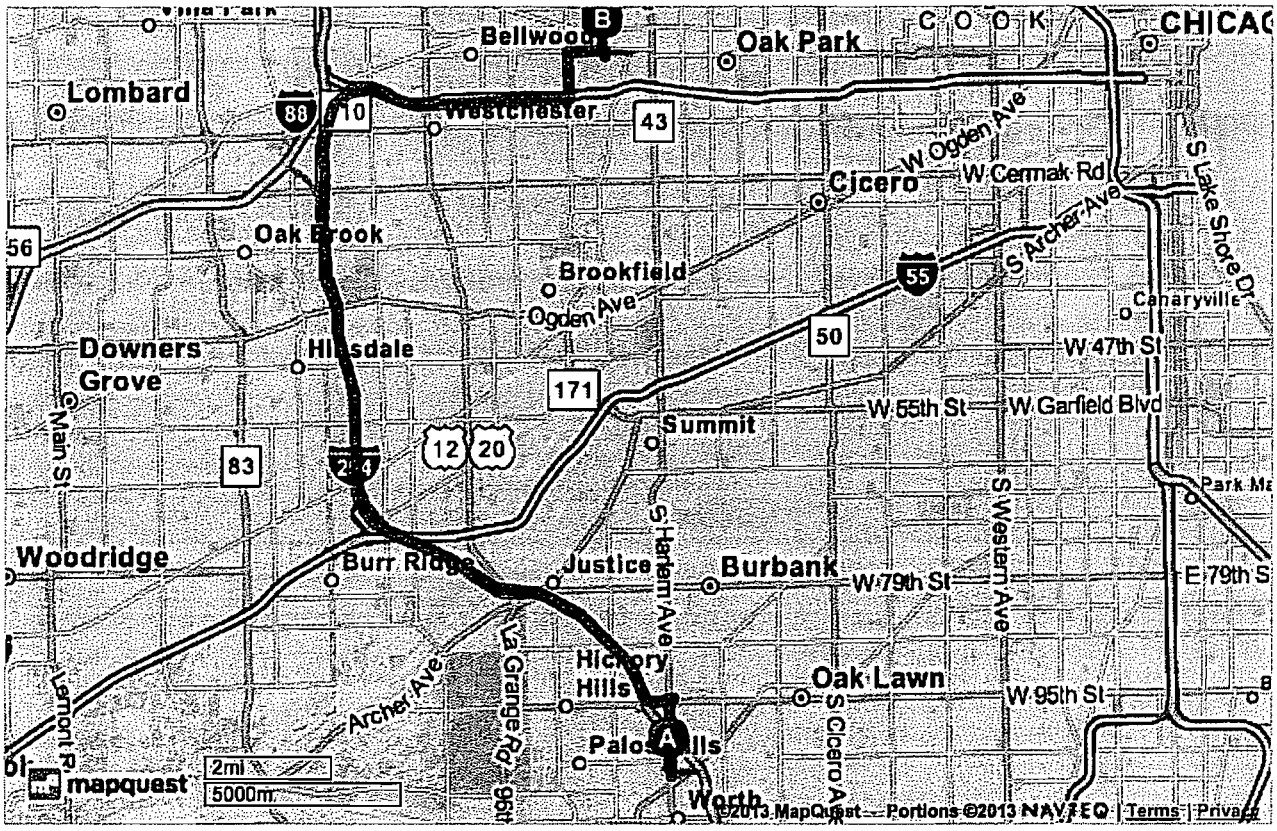
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43** toward **W 105th St**. Map	**1.3 Mi** *1.3 Mi Total*
2. Merge onto **US-20 W / US-12 W / W 95th St** toward **I-294-TOLL N**. Map	**0.5 Mi** *1.8 Mi Total*
3. Merge onto **I-294 N** toward **Wisconsin** (Portions toll). Map	**13.3 Mi** *15.1 Mi Total*
4. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E** toward **Chicago**. Map	**0.7 Mi** *15.8 Mi Total*
5. Keep **left** to take **I-290 E / IL-110 E / Eisenhower Expy E**. Map	**3.9 Mi** *19.6 Mi Total*
6. Take **EXIT 20** toward **IL-171 / 1st Ave**. Map	**0.2 Mi** *19.8 Mi Total*
7. Stay **straight** to go onto **Bataan Dr**. Map	**0.06 Mi** *19.9 Mi Total*
8. Take the 1st **left** onto **IL-171 / S 1st Ave**. Map *If you reach I-290 E you've gone about 0.1 miles too far*	**0.8 Mi** *20.7 Mi Total*
9. Turn **right** onto **Washington Blvd**. Map *Washington Blvd is 0.1 miles past Warren St* *If you reach Pine St you've gone a little too far*	**0.7 Mi** *21.3 Mi Total*
10. Turn **right** onto **Forest Ave**. Map *Forest Ave is just past Keystone Ave* *If you reach Park Ave you've gone a little too far*	**0.10 Mi** *21.4 Mi Total*
11. **103 FOREST AVE** is on the **left**. Map *If you reach Vine St you've gone a little too far*	

103 Forest Ave, River Forest, IL 60305-2003

Total Travel Estimate: **21.42 miles - about 31 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Trip to:
733 Madison St
Oak Park, IL 60302-4419
13.12 miles / 31 minutes

Notes
FMC - Oak Park Dialysis Center

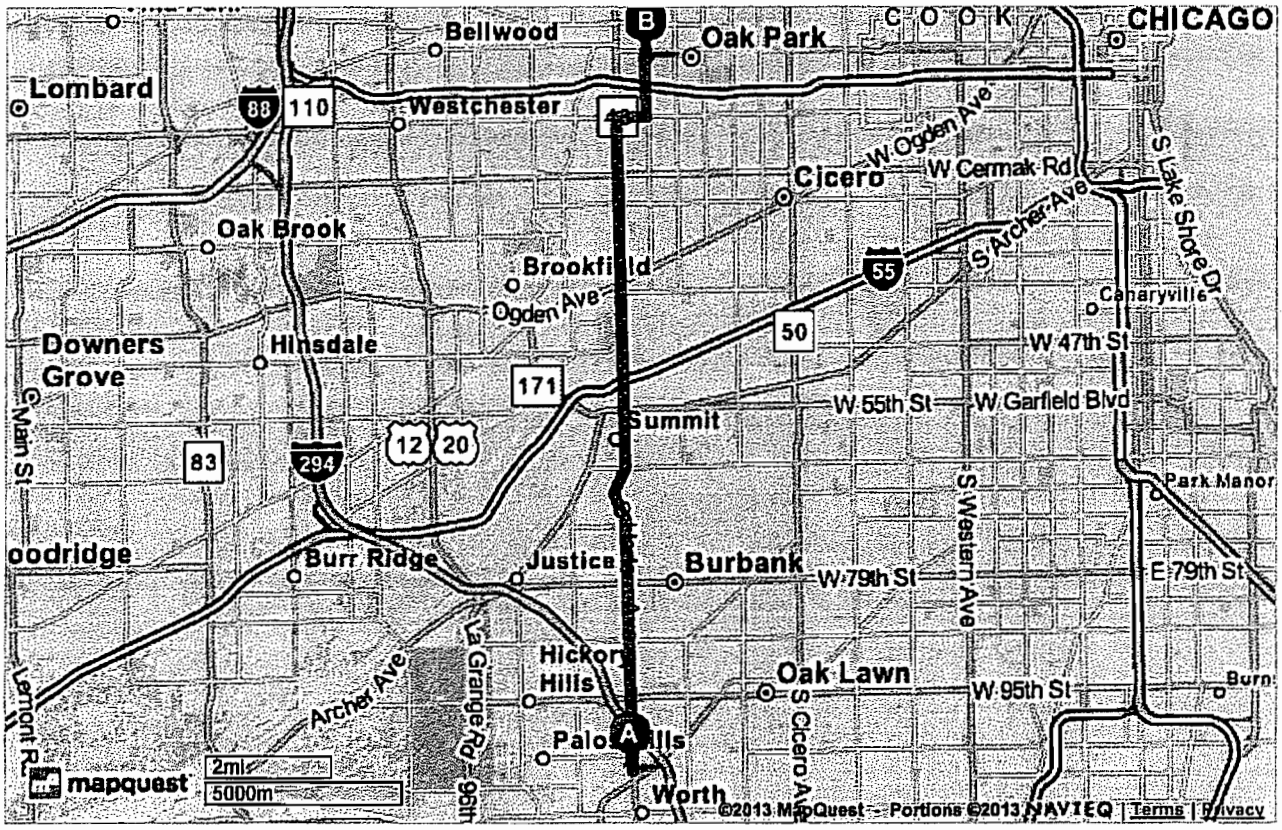
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**11.5 Mi** *11.5 Mi Total*
↱	2. Turn **right** onto **Roosevelt Rd.** Map *Roosevelt Rd is 0.1 miles past 13th St* *JOSHUAS OIL EXPRESS is on the right* *If you reach Fillmore St you've gone about 0.1 miles too far*	**0.5 Mi** *12.1 Mi Total*
↰	3. Turn **left** onto **S Oak Park Ave.** Map *S Oak Park Ave is just past S Grove Ave* *Buona is on the corner* *If you reach S Euclid Ave you've gone a little too far*	**1.0 Mi** *13.1 Mi Total*
↱	4. Turn **right** onto **Madison St.** Map *Madison St is 0.1 miles past Adams St* *Chase is on the corner* *If you reach Washington Blvd you've gone about 0.1 miles too far*	**0.05 Mi** *13.1 Mi Total*
■	5. **733 MADISON ST** is on the **right.** Map *If you reach S Euclid Ave you've gone a little too far*	

733 Madison St, Oak Park, IL 60302-4419

Total Travel Estimate: **13.12 miles - about 31 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Trip to:

[448-498] N Austin Blvd
Oak Park, IL 60302
14.96 miles / 34 minutes

Notes

FMC - West Suburban Hosp. Dialysis Unit

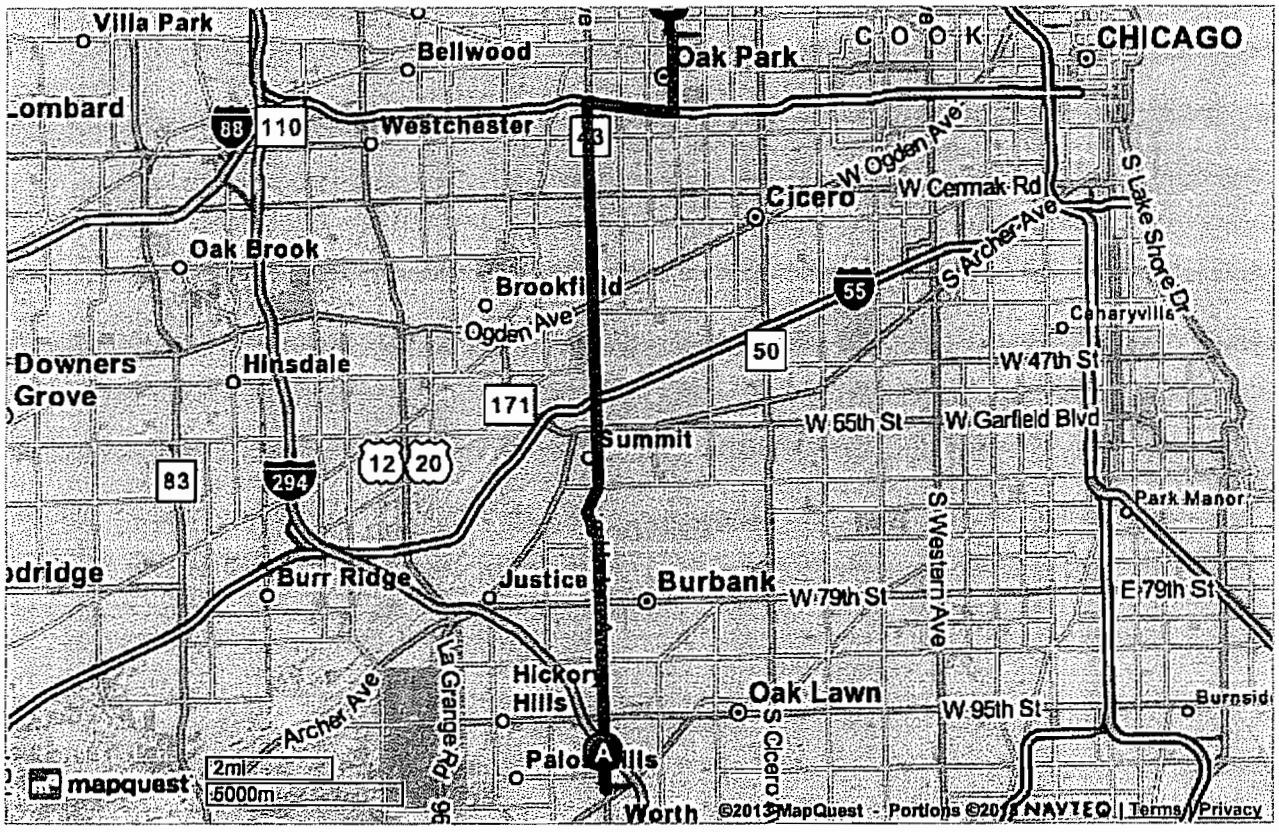
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**12.1 Mi** *12.1 Mi Total*
2. Merge onto **I-290 E / IL-110 E / Eisenhower Expy E.** Map *If you are on IL-43 and reach Jackson Blvd you've gone about 0.1 miles too far*	**1.3 Mi** *13.4 Mi Total*
3. Take the **Austin Blvd exit, EXIT 23A,** on the **left.** Map	**0.3 Mi** *13.7 Mi Total*
4. Turn **left** onto **S Austin Blvd.** Map	**1.3 Mi** *15.0 Mi Total*
5. **[448-498] N AUSTIN BLVD.** Map *Your destination is just past W Midway Park* *If you reach W Race Ave you've gone a little too far*	

[448-498] N Austin Blvd, Oak Park, IL 60302

Total Travel Estimate: **14.96 miles - about 34 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care Cicero

Trip to:

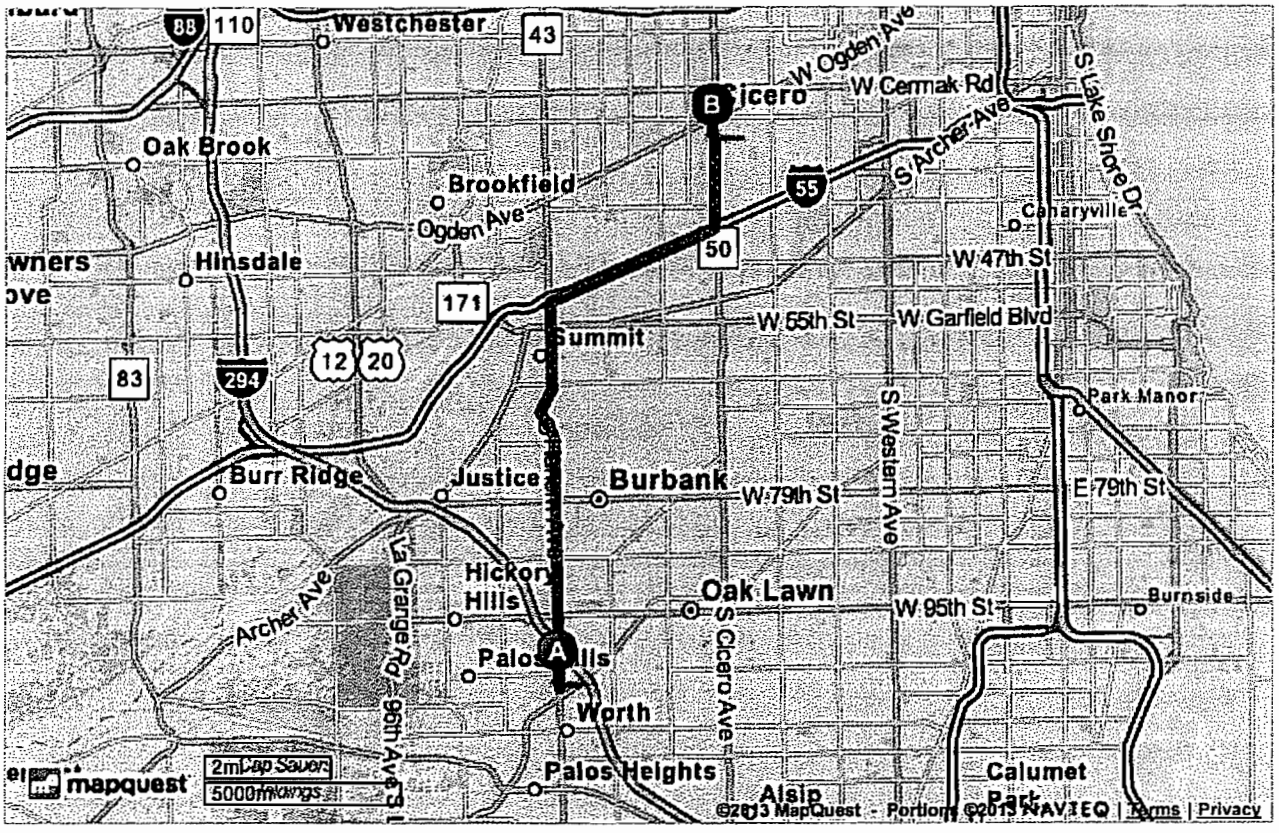
3000 S Cicero Ave
Cicero, IL 60804-3638
11.68 miles / 22 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**2.9 Mi** *9.8 Mi Total*
3. Take the **IL-50 / Cicero Ave** exit, **EXIT 286**, toward **Chicago Midway Airport**. Map	**0.3 Mi** *10.2 Mi Total*
4. Turn **left** onto **IL-50 / S Cicero Ave**. Map *If you reach I-55 N you've gone about 0.3 miles too far*	**1.5 Mi** *11.7 Mi Total*
5. **3000 S CICERO AVE** is on the **left**. Map *If you reach W 30th St you've gone a little too far*	

3000 S Cicero Ave, Cicero, IL 60804-3638

Total Travel Estimate: **11.68 miles - about 22 minutes**



mapquest

Notes

FMC - Austin Community Kidney Center

Trip to:

4800 W Chicago Ave

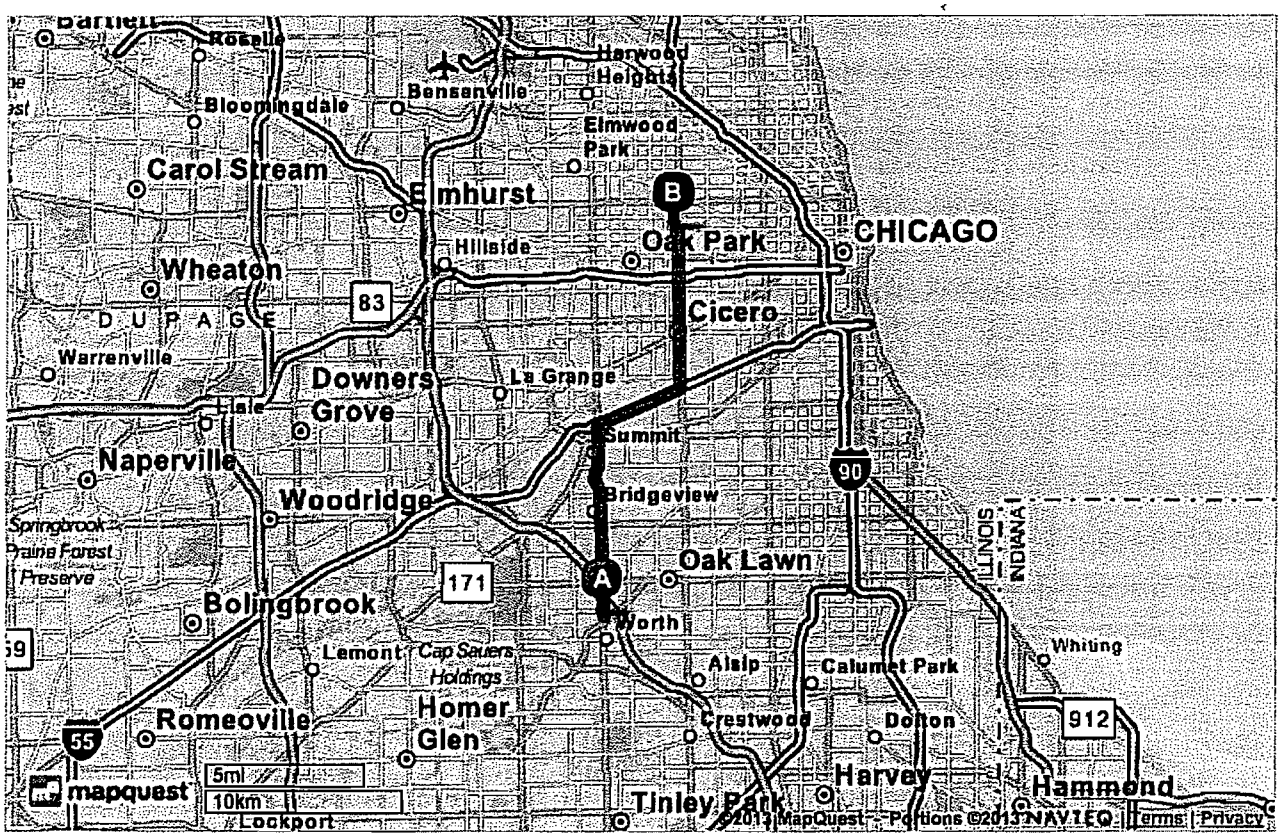
Chicago, IL 60651-3223

15.61 miles / 34 minutes

	[10451-10548] S Harlem Ave, Palos Hills, IL 60465	
	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**2.9 Mi** *9.8 Mi Total*
286 EXIT	3. Take the **IL-50 / Cicero Ave** exit, **EXIT 286**, toward **Chicago Midway Airport**. Map	**0.3 Mi** *10.2 Mi Total*
50	4. Turn **left** onto **IL-50 / S Cicero Ave**. Map *If you reach I-55 N you've gone about 0.3 miles too far*	**5.4 Mi** *15.6 Mi Total*
	5. Turn **left** onto **W Chicago Ave**. Map *W Chicago Ave is just past W Superior St* *Chicago Sub is on the left* *If you reach W Rice St you've gone a little too far*	**0.02 Mi** *15.6 Mi Total*
	6. **4800 W CHICAGO AVE** is on the **right**. Map *If you reach N Lamon Ave you've gone about 0.1 miles too far*	
	4800 W Chicago Ave, Chicago, IL 60651-3223	

Total Travel Estimate: **15.61 miles - about 34 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Trip to:
3410 W Van Buren St
Chicago, IL 60624-3358
15.66 miles / 33 minutes

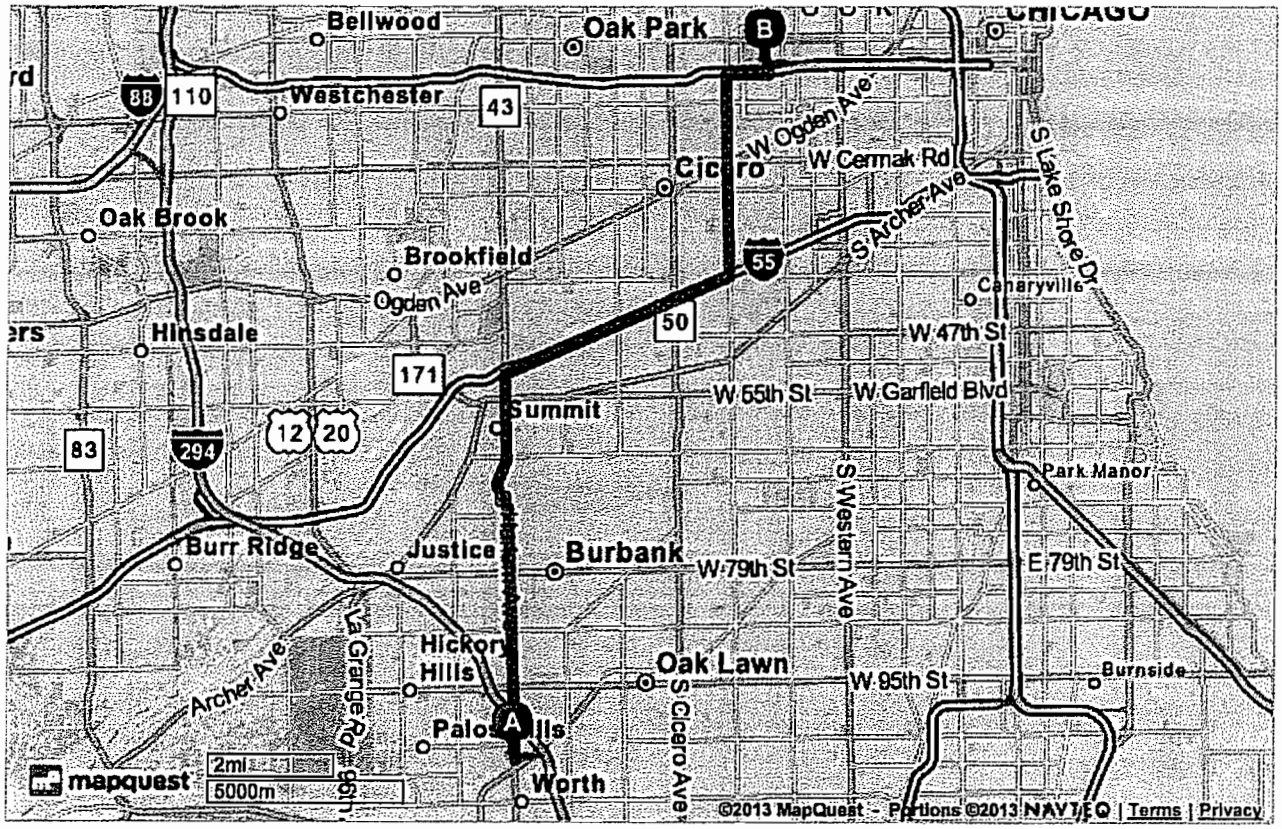
Notes
FMC Dialysis Services of Congress Parkway

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**4.1 Mi** *11.0 Mi Total*
3. Take the **Pulaski Rd** exit, **EXIT 287**. Map	**0.2 Mi** *11.2 Mi Total*
4. Keep **left** at the fork in the ramp. Map	**0.08 Mi** *11.3 Mi Total*
5. Turn **slight left** onto **S Pulaski Rd**. Map	**3.5 Mi** *14.8 Mi Total*
6. Turn **right** onto **W Harrison St**. Map *W Harrison St is just past W 5th Ave* *Mary's Restaurant is on the left* *If you reach W Congress Pky you've gone a little too far*	**0.8 Mi** *15.5 Mi Total*
7. Turn **left** onto **S Homan Ave**. Map *S Homan Ave is 0.1 miles past S St Louis Ave* *Murry's Fish & Chicken is on the corner* *If you reach I-290 E you've gone about 0.2 miles too far*	**0.1 Mi** *15.6 Mi Total*
8. Take the 2nd **left** onto **W Van Buren St**. Map *W Van Buren St is just past W Congress Pky* *If you reach W Gladys Ave you've gone a little too far*	**0.02 Mi** *15.7 Mi Total*
9. **3410 W VAN BUREN ST** is on the **right**. Map *If you reach S Trumbull Ave you've gone a little too far*	

3410 W Van Buren St, Chicago, IL 60624-3358

Total Travel Estimate: **15.66 miles - about 33 minutes**



mapquest

Notes

Mt. Sinai Hospital Med Ctr

Trip to:

1500 S California Ave

Chicago, IL 60608

14.94 miles / 28 minutes

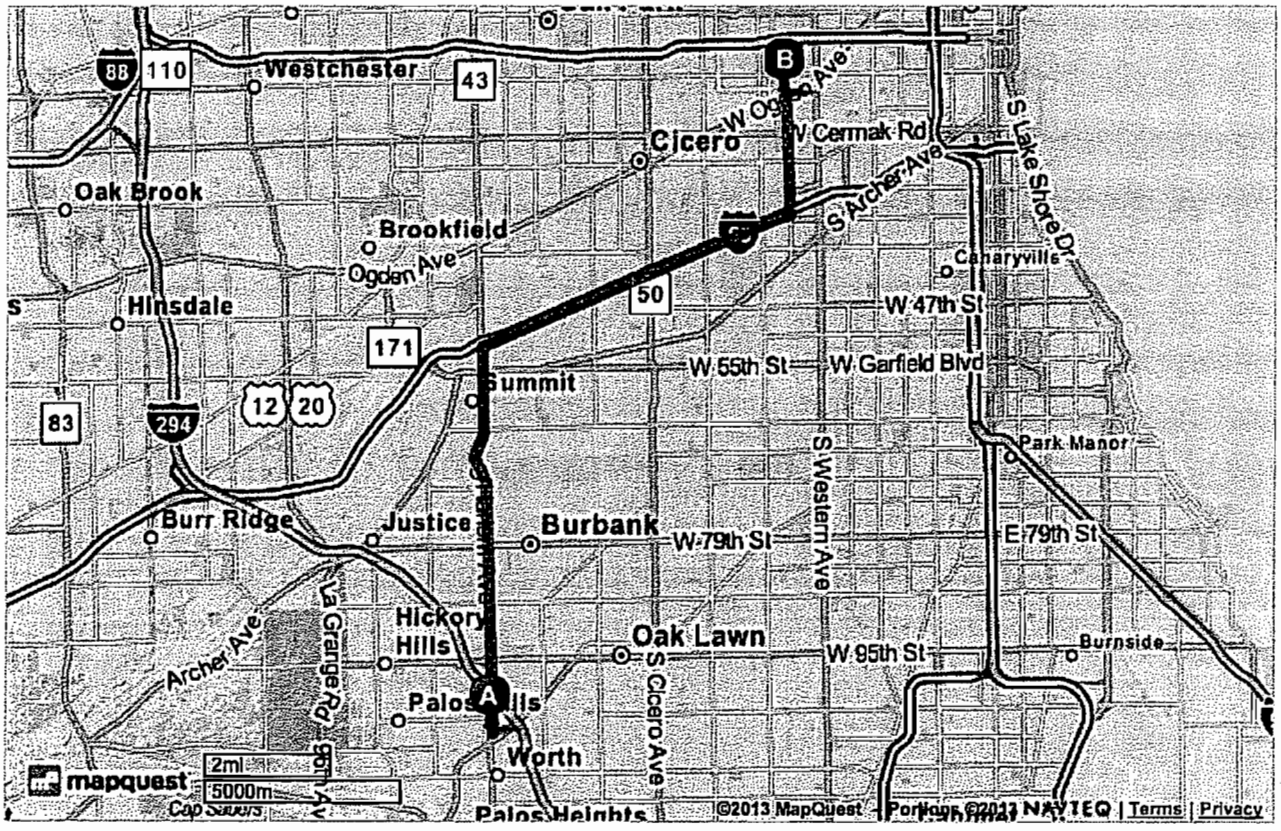
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**5.5 Mi** *12.4 Mi Total*
3. Take **EXIT 289** toward **California Ave.** Map	**0.2 Mi** *12.6 Mi Total*
4. Keep **right** to take the **California Ave** ramp. Map	**2.3 Mi** *14.9 Mi Total*
5. **1500 S CALIFORNIA AVE** is on the **left.** Map *Your destination is just past W 15th Place Dr* *If you reach W Ogden Ave you've gone a little too far*	

1500 S California Ave, Chicago, IL 60608

Total Travel Estimate: **14.94 miles - about 28 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

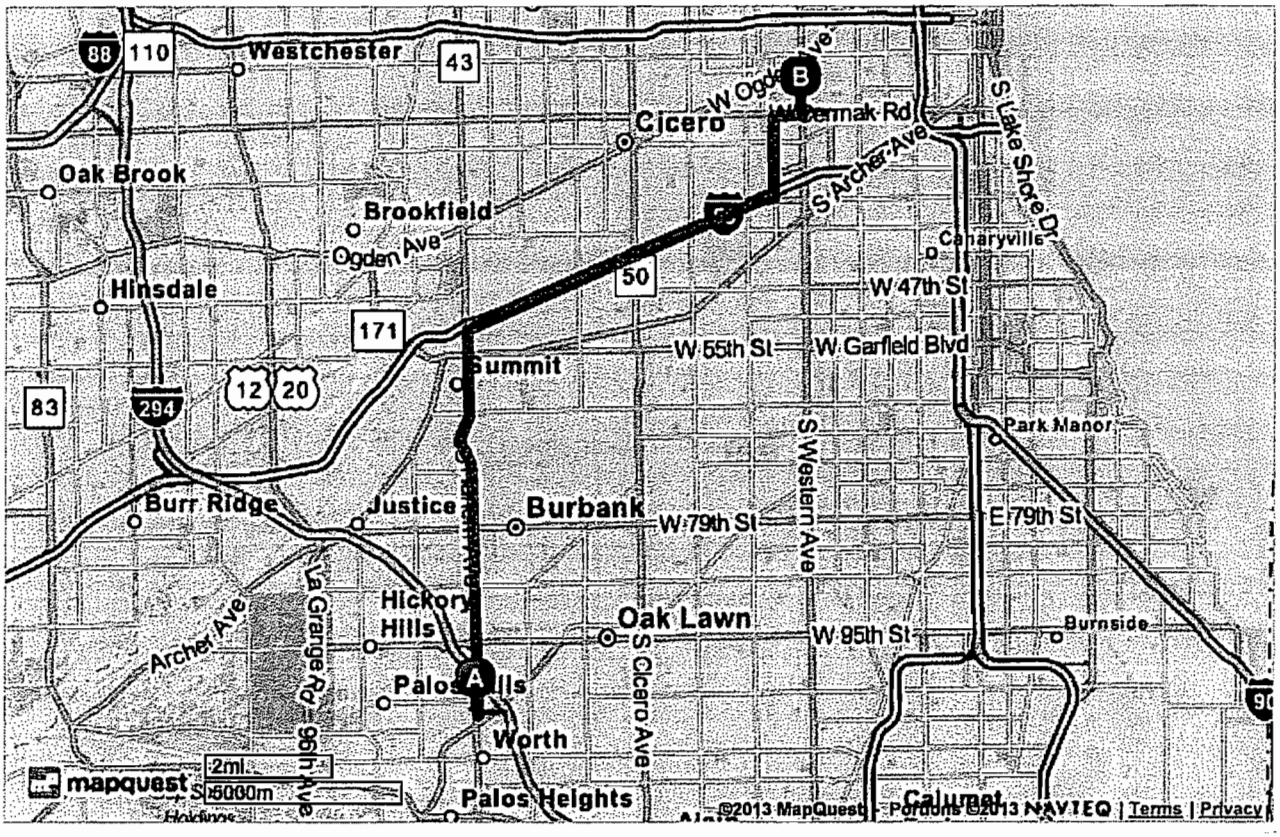
Little Village Dialysis

Trip to:

2335 W Cermak Rd
Chicago, IL 60608-3811
14.84 miles / 28 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**5.5 Mi** *12.4 Mi Total*
289 EXIT	3. Take **EXIT 289** toward **California Ave.** Map	**0.2 Mi** *12.6 Mi Total*
RAMP	4. Keep **right** to take the **California Ave** ramp. Map	**0.2 Mi** *12.9 Mi Total*
	5. Keep **left** at the fork to go on **S California Ave.** Map	**1.4 Mi** *14.3 Mi Total*
	6. Turn **right** onto **W Cermak Rd / W 22nd St.** Continue to follow **W Cermak Rd.** Map *W Cermak Rd is just past W 22nd Pl* *Cocula Restaurant is on the left* *If you reach W 21st Pl you've gone a little too far*	**0.5 Mi** *14.8 Mi Total*
■	7. **2335 W CERMAK RD** is on the **right.** Map *Your destination is just past S Western Ave* *If you reach S Oakley Ave you've gone a little too far*	
B	**2335 W Cermak Rd**, Chicago, IL 60608-3811	

Total Travel Estimate: **14.84 miles - about 28 minutes**



mapquest

Trip to:
2335 W Cermak Rd
Chicago, IL 60608-3811
14.84 miles / 28 minutes

Notes
Little Village Dialysis

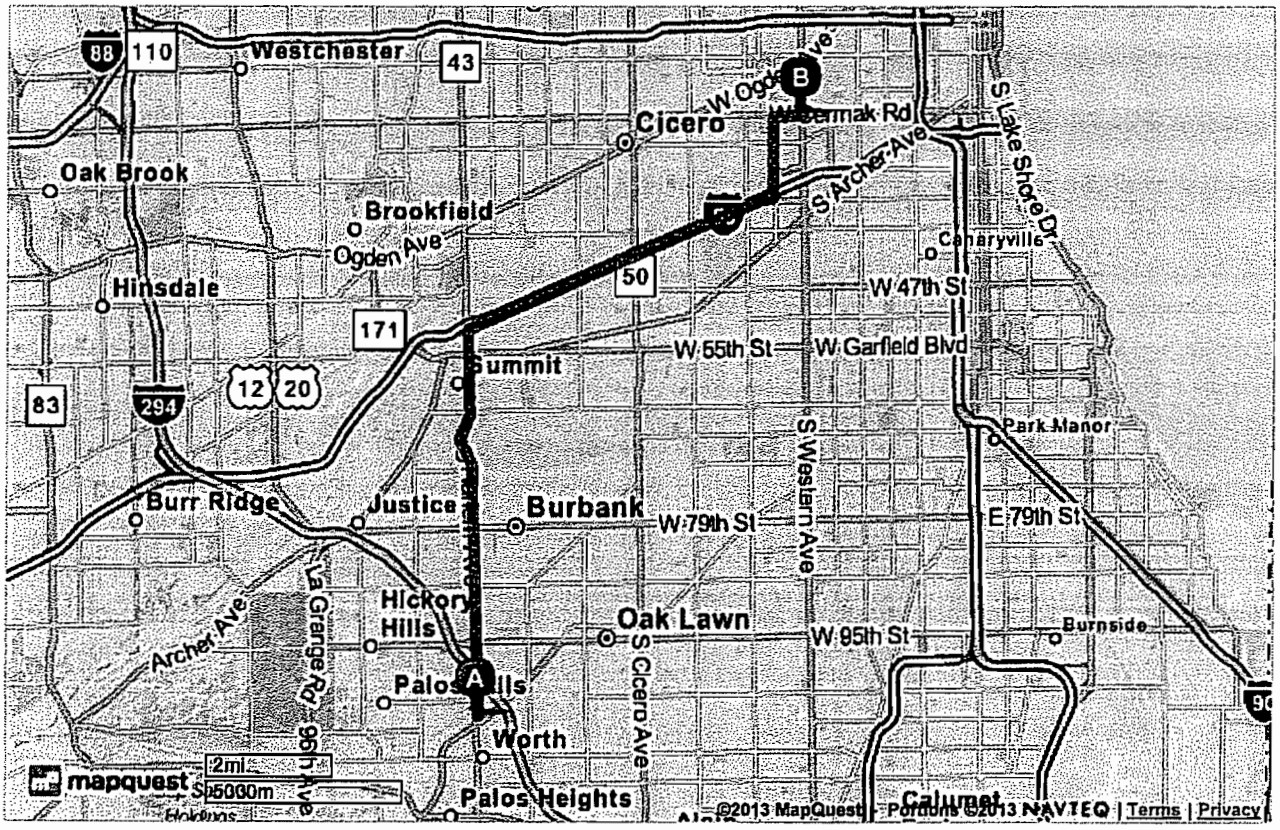
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**5.5 Mi** *12.4 Mi Total*
3. Take **EXIT 289** toward **California Ave.** Map	**0.2 Mi** *12.6 Mi Total*
4. Keep **right** to take the **California Ave** ramp. Map	**0.2 Mi** *12.9 Mi Total*
5. Keep **left** at the fork to go on **S California Ave.** Map	**1.4 Mi** *14.3 Mi Total*
6. Turn **right** onto **W Cermak Rd / W 22nd St.** Continue to follow **W Cermak Rd.** Map *W Cermak Rd is just past W 22nd Pl* *Cocula Restaurant is on the left* *If you reach W 21st Pl you've gone a little too far*	**0.5 Mi** *14.8 Mi Total*
7. **2335 W CERMAK RD** is on the **right.** Map *Your destination is just past S Western Ave* *If you reach S Oakley Ave you've gone a little too far*	

2335 W Cermak Rd, Chicago, IL 60608-3811

Total Travel Estimate: **14.84 miles - about 28 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Trip to:
1340 S Damen Ave
Chicago, IL 60608-1169
15.82 miles / 30 minutes

Notes
Fresenius Medical Care of Chicago - West

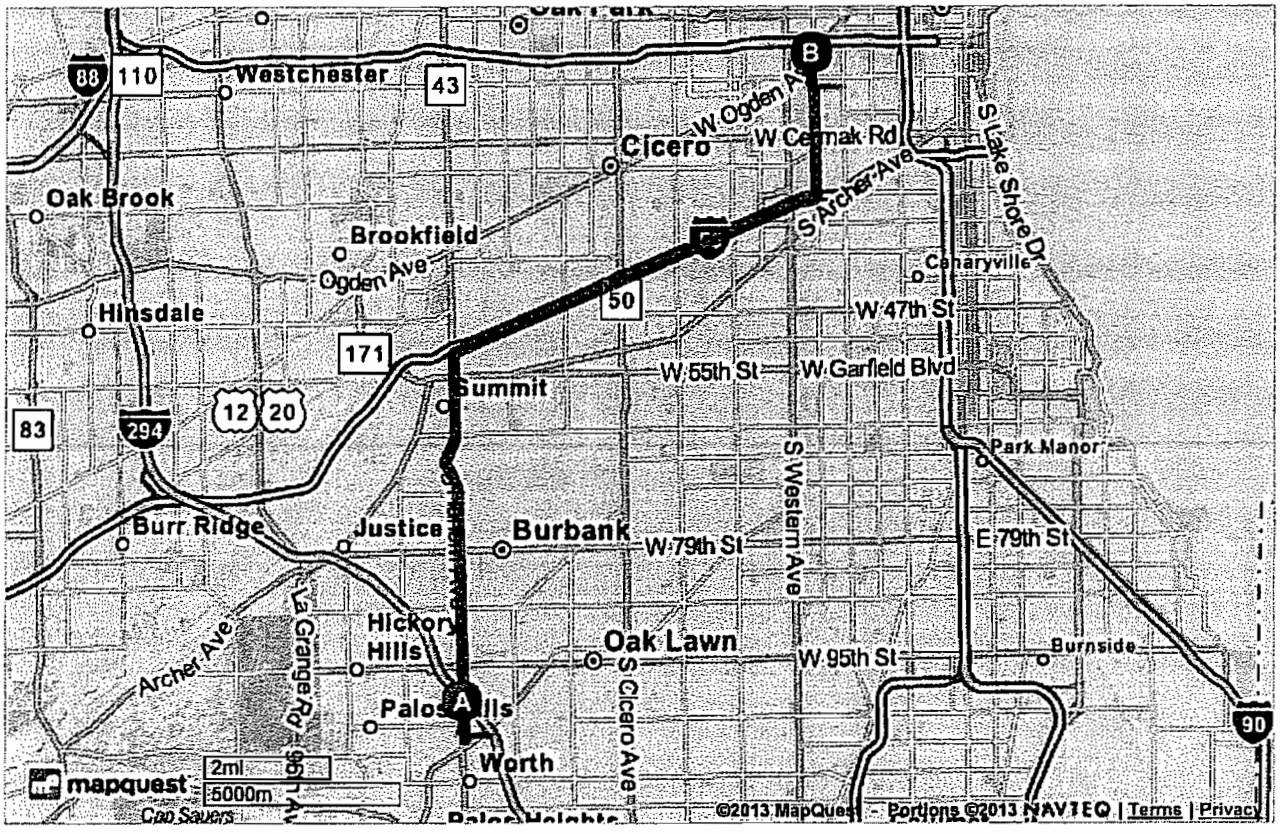
[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**6.6 Mi** *13.5 Mi Total*
3. Take the **Damen Ave** exit, **EXIT 290**, toward **Ashland Ave.** Map	**0.2 Mi** *13.7 Mi Total*
4. Keep **left** to take the **Damen Ave** ramp. Map	**0.2 Mi** *13.9 Mi Total*
5. Keep **left** at the fork in the ramp. Map	**0.06 Mi** *14.0 Mi Total*
6. Turn **slight left** onto **S Damen Ave.** Map	**1.9 Mi** *15.8 Mi Total*
7. **1340 S DAMEN AVE** is on the **left.** Map *Your destination is just past W 14th St* *If you reach W Hastings St you've gone a little too far*	

1340 S Damen Ave, Chicago, IL 60608-1169

Total Travel Estimate: **15.82 miles - about 30 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

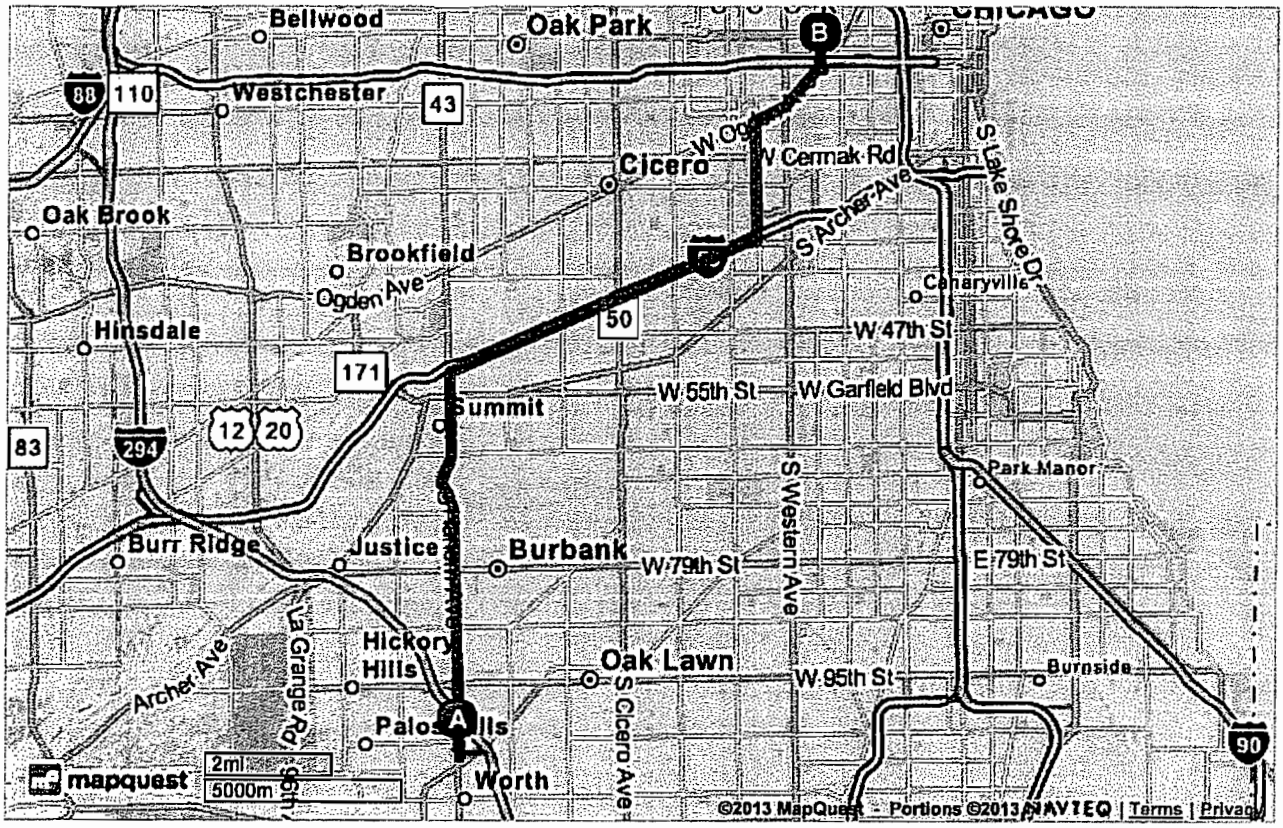
John H. Stroger Jr. Hospital of Cook County

Trip to:

1835 W Harrison St
Chicago, IL 60612-3771
16.49 miles / 33 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**5.5 Mi** *12.4 Mi Total*
289 EXIT	3. Take **EXIT 289** toward **California Ave**. Map	**0.2 Mi** *12.6 Mi Total*
RAMP	4. Keep **right** to take the **California Ave** ramp. Map	**0.2 Mi** *12.9 Mi Total*
	5. Keep **left** at the fork to go on **S California Ave**. Map	**2.1 Mi** *14.9 Mi Total*
	6. Turn **right** onto **W Ogden Ave**. Map *If you reach W 14th St you've gone a little too far*	**1.4 Mi** *16.4 Mi Total*
	7. Turn **slight right** onto **W Harrison St**. Map *W Harrison St is just past S Winchester Ave* *Medical Center Restaurant is on the corner* *If you are on W Ogden Ave and reach S Wolcott Ave you've gone a little too far*	**0.1 Mi** *16.5 Mi Total*
■	8. **1835 W HARRISON ST** is on the **right**. Map *Your destination is just past S Wolcott Ave* *If you reach S Wood St you've gone a little too far*	
B	**1835 W Harrison St**, Chicago, IL 60612-3771	

Total Travel Estimate: **16.49 miles - about 33 minutes**



mapquest

Trip to:
1859 W Taylor St Rm 1003
Chicago, IL 60612-4319
16.81 miles / 33 minutes

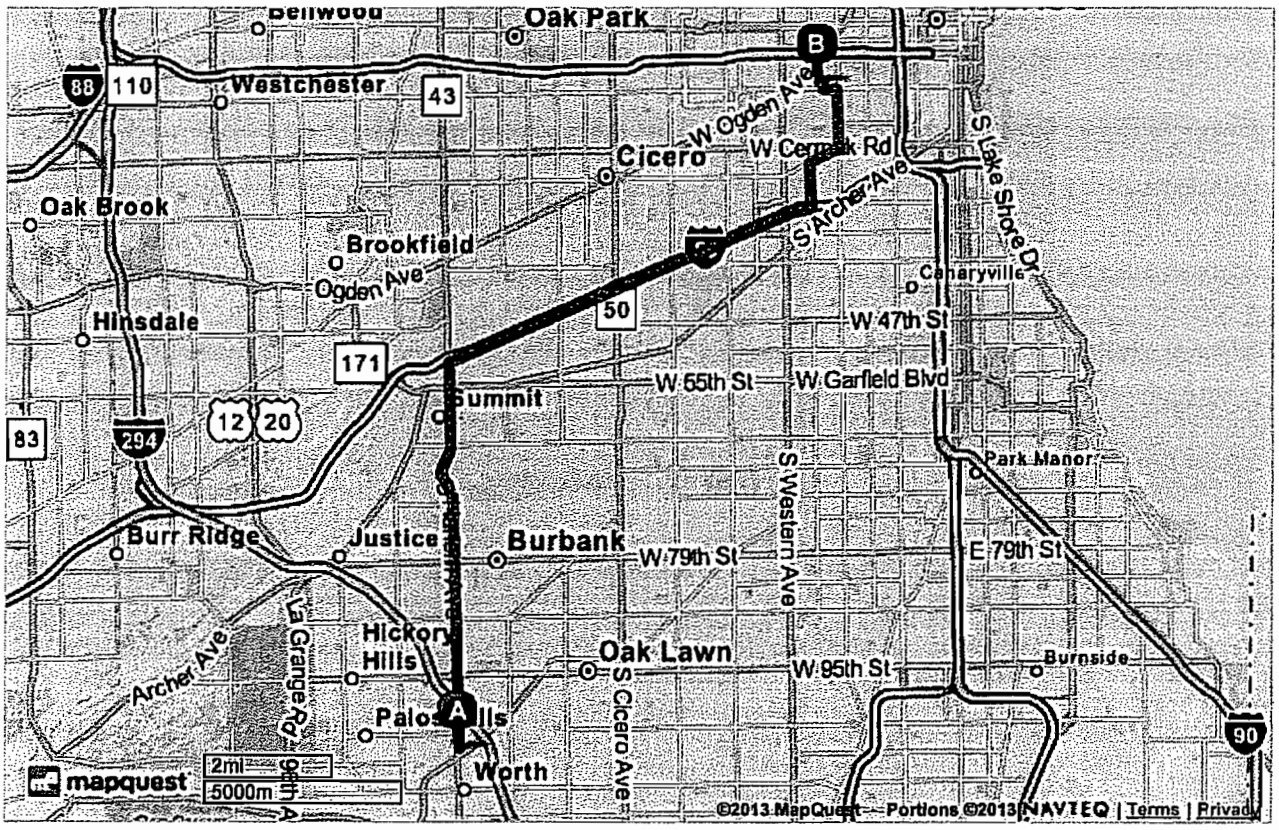
Notes
University of Illinois Hospital - Dialysis

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**6.6 Mi** *13.5 Mi Total*
3. Take the **Damen Ave** exit, **EXIT 290**, toward **Ashland Ave.** Map	**0.2 Mi** *13.7 Mi Total*
4. Keep **left** to take the **Damen Ave** ramp. Map	**0.2 Mi** *13.9 Mi Total*
5. Keep **left** at the fork in the ramp. Map	**0.06 Mi** *14.0 Mi Total*
6. Turn **slight left** onto **S Damen Ave.** Map	**0.8 Mi** *14.8 Mi Total*
7. Turn **right** onto **S Blue Island Ave.** Map *S Blue Island Ave is 0.6 miles past W Marketplace Access Rd* *SHELL is on the corner* *If you reach W Coulter St you've gone a little too far*	**0.6 Mi** *15.3 Mi Total*
8. Turn **left** onto **S Ashland Ave.** Map *S Ashland Ave is 0.1 miles past S Paulina St* *CERMAK BP is on the corner* *If you are on W Cermak Rd and reach S Laflin St you've gone about 0.1 miles too far*	**1.0 Mi** *16.3 Mi Total*
9. Turn **left** onto **W Roosevelt Rd.** Map *W Roosevelt Rd is just past W Washburne Ave* *Bank of America Banking Center - Ashland & Rooseve is on the corner* *If you reach W Taylor St you've gone about 0.1 miles too far*	**0.3 Mi** *16.6 Mi Total*
10. Turn **right** onto **S Wood St.** Map *S Wood St is just past S Hermitage Ave* *If you reach S Wolcott Ave you've gone about 0.1 miles too far*	**0.2 Mi** *16.7 Mi Total*
11. Turn **left** onto **W Taylor St.** Map *W Taylor St is just past W Fillmore St* *If you reach W Polk St you've gone about 0.1 miles too far*	**0.07 Mi** *16.8 Mi Total*
12. **1859 W TAYLOR ST RM 1003** is on the **left.** Map *If you reach S Wolcott Ave you've gone a little too far*	

1859 W Taylor St Rm 1003, Chicago, IL 60612-4319

Total Travel Estimate: **16.81 miles - about 33 minutes**



mapquest

Trip to:

1750 W Harrison St Ste 735
Chicago, IL 60612-3825
19.41 miles / 33 minutes

Notes

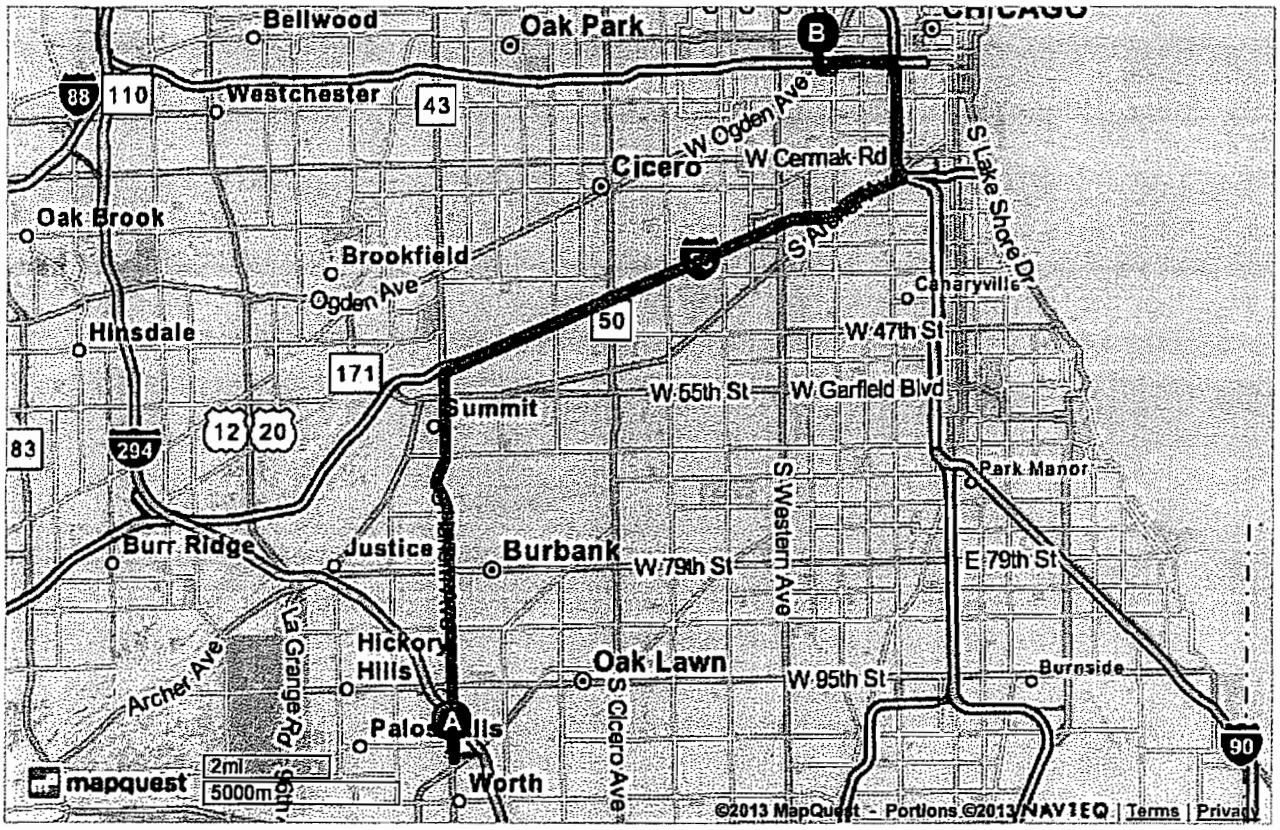
Rush University - St Luke's Medical Center

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.1 Mi** *15.0 Mi Total*
3. Merge onto **I-90 W / I-94 W / Dan Ryan Expy W** via **EXIT 292A** toward **Wisconsin**. Map	**2.2 Mi** *17.2 Mi Total*
4. Take the **I-290 W / Eisenhower Expy** exit, **EXIT 51H**, toward **West Suburbs**. Map	**0.5 Mi** *17.7 Mi Total*
5. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the exit on the **left** toward **West Surburbs**. Map	**1.2 Mi** *18.8 Mi Total*
6. Take **EXIT 28B** toward **Ashland Ave / Paulina St**. Map	**0.2 Mi** *19.0 Mi Total*
7. Turn **slight left** onto **W Van Buren St**. Map	**0.06 Mi** *19.1 Mi Total*
8. Turn **left** onto **S Ashland Ave**. Map *BP is on the corner* *If you reach N Marshfield Ave you've gone a little too far*	**0.1 Mi** *19.2 Mi Total*
9. Turn **right** onto **W Harrison St**. Map *W Harrison St is just past W Congress Pky* *Subway is on the corner* *If you reach W Flournoy St you've gone a little too far*	**0.2 Mi** *19.4 Mi Total*
10. **1750 W HARRISON ST STE 735** is on the **right**. Map *Your destination is just past S Paulina St* *If you reach S Wood St you've gone a little too far*	

1750 W Harrison St Ste 735, Chicago, IL 60612-3825

Total Travel Estimate: **19.41 miles - about 33 minutes**



mapquest

Notes

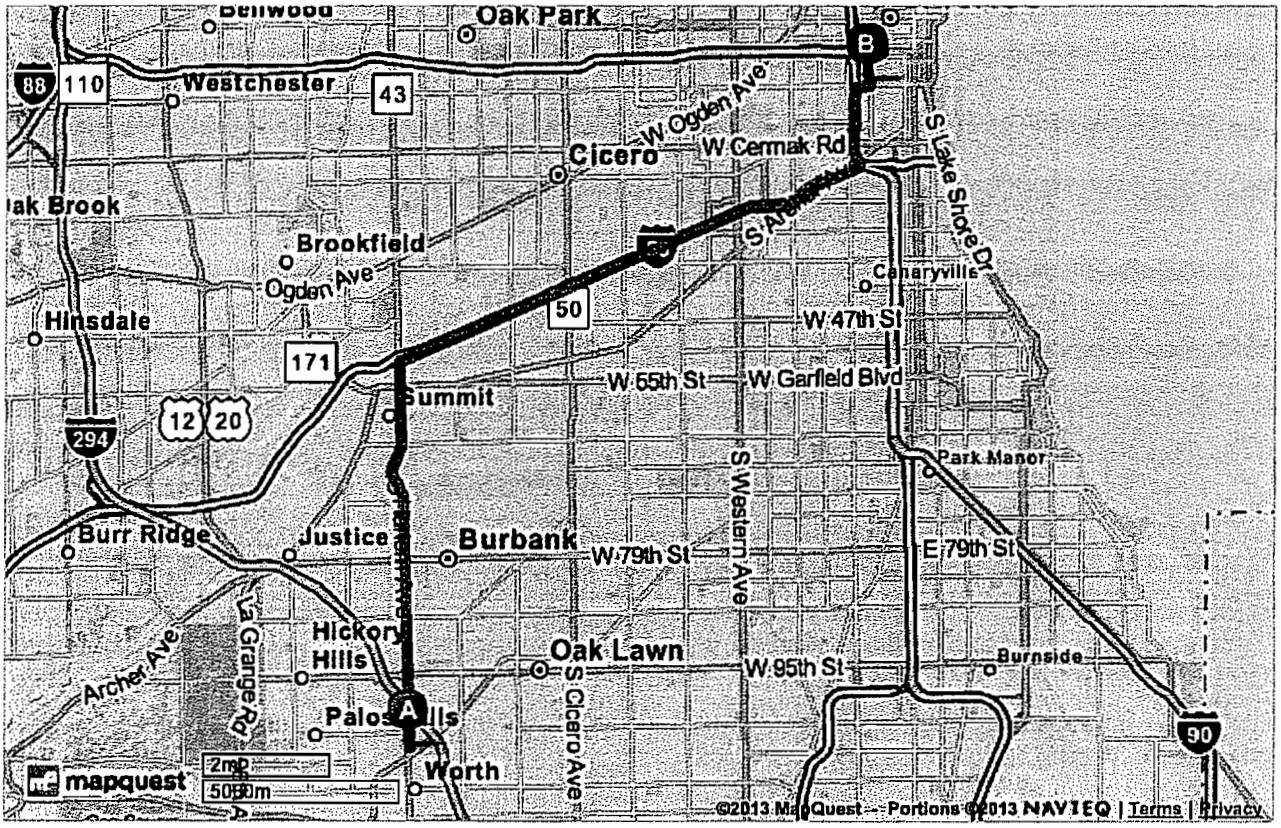
Loop Renal Center

Trip to:

1101 S Canal St
Chicago, IL 60607-4901
17.63 miles / 30 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.1 Mi** *15.0 Mi Total*
292A EXIT WEST 94	3. Merge onto **I-90 W / I-94 W / Dan Ryan Expy W** via **EXIT 292A** toward **Wisconsin.** Map	**2.1 Mi** *17.1 Mi Total*
52B EXIT	4. Take **EXIT 52B** toward **Roosevelt Rd / Taylor St.** Map	**0.1 Mi** *17.2 Mi Total*
↑	5. Stay **straight** to go onto **S Ruble St.** Map	**0.09 Mi** *17.3 Mi Total*
↱	6. Turn **right** onto **W Roosevelt Rd.** Map *W Roosevelt Rd is just past W 12th Pl* *If you reach W Taylor St you've gone about 0.1 miles too far*	**0.3 Mi** *17.5 Mi Total*
↰	7. Turn **left** onto **S Canal St.** Map *S Canal St is just past S Clinton St* *Catholic Charities is on the left* *If you reach S Delano Ct E you've gone about 0.3 miles too far*	**0.09 Mi** *17.6 Mi Total*
■	8. **1101 S CANAL ST** is on the **right.** Map *If you reach W Taylor St you've gone a little too far*	
B	**1101 S Canal St**, Chicago, IL 60607-4901	

Total Travel Estimate: **17.63 miles - about 30 minutes**



mapquest

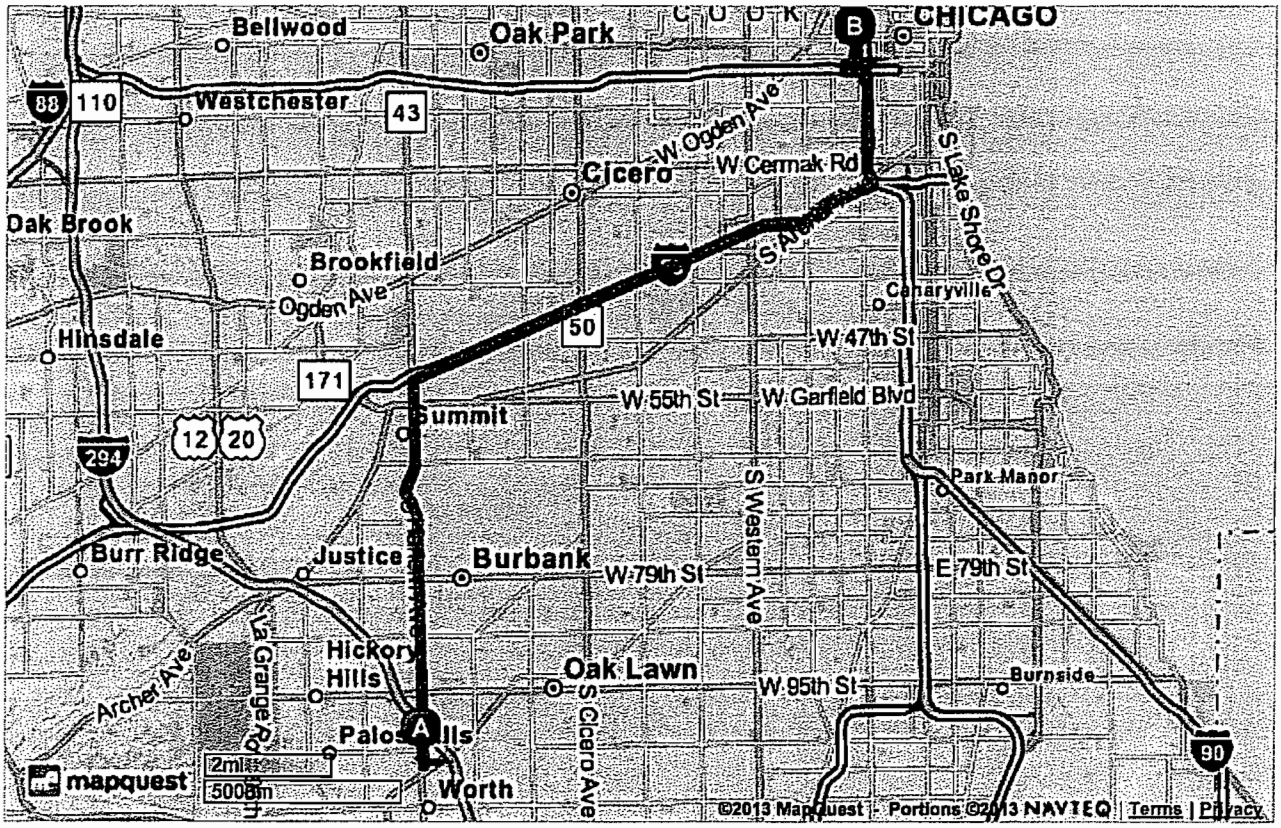
Trip to:
820 W Jackson Blvd
Chicago, IL 60607-3026
18.66 miles / 31 minutes

Notes
FMC - Chicago Dialysis Center

	[10451-10548] S Harlem Ave, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St**. Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N**. Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.1 Mi** *15.0 Mi Total*
292A EXIT WEST 94	3. Merge onto **I-90 W / I-94 W / Dan Ryan Expy W** via **EXIT 292A** toward **Wisconsin**. Map	**2.2 Mi** *17.2 Mi Total*
51H EXIT	4. Take the **I-290 W / Eisenhower Expy** exit, **EXIT 51H**, toward **West Suburbs**. Map	**0.5 Mi** *17.7 Mi Total*
WEST 290	5. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the exit on the **left** toward **West Surburbs**. Map	**0.5 Mi** *18.2 Mi Total*
29B EXIT	6. Take the **Morgan St** exit, **EXIT 29B**. Map	**0.1 Mi** *18.3 Mi Total*
↱	7. Turn **right** onto **S Morgan St**. Map	**0.1 Mi** *18.4 Mi Total*
↱	8. Take the 2nd **right** onto **W Jackson Blvd**. Map *W Jackson Blvd is just past W Van Buren St* *SHELL is on the corner* *If you reach W Adams St you've gone a little too far*	**0.2 Mi** *18.7 Mi Total*
■	9. **820 W JACKSON BLVD** is on the **left**. Map *Your destination is just past S Green St* *If you reach S Halsted St you've gone a little too far*	
	820 W Jackson Blvd, Chicago, IL 60607-3026	

Total Travel Estimate: **18.66 miles - about 31 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Fresenius Medical Care - Polk Street

Trip to:

557 W Polk St

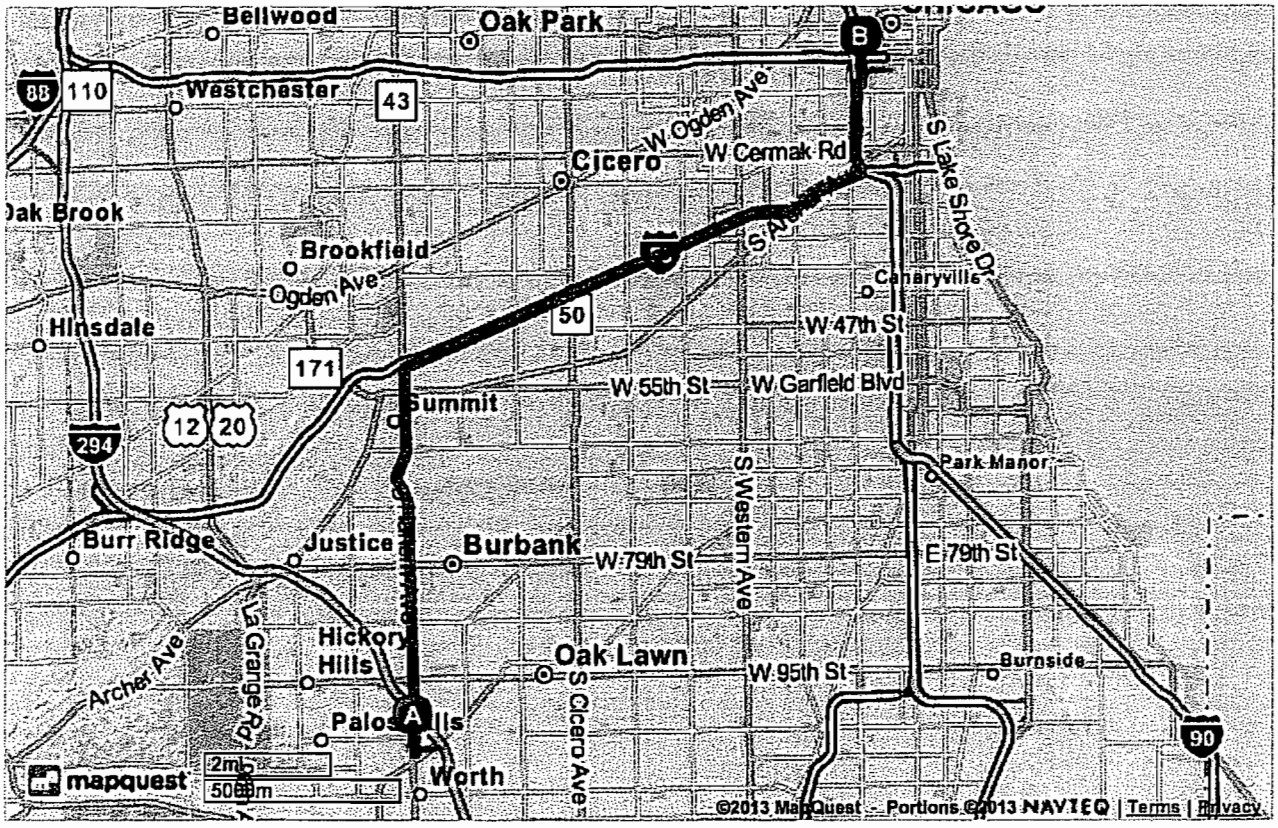
Chicago, IL 60607-4388

17.78 miles / 30 minutes

A	**[10451-10548] S Harlem Ave**, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.1 Mi** *15.0 Mi Total*
292A EXIT WEST 94	3. Merge onto **I-90 W / I-94 W / Dan Ryan Expy W** via **EXIT 292A** toward **Wisconsin.** Map	**2.1 Mi** *17.1 Mi Total*
52B EXIT	4. Take **EXIT 52B** toward **Roosevelt Rd / Taylor St.** Map	**0.1 Mi** *17.2 Mi Total*
↑	5. Stay **straight** to go onto **S Ruble St.** Map	**0.09 Mi** *17.3 Mi Total*
RAMP	6. Take the **I-90 W / I-94 W** ramp toward **Kennedy Expy / Wisconsin.** Map	**0.2 Mi** *17.5 Mi Total*
↱	7. Turn **right** onto **W Taylor St.** Map *If you reach I-90 W you've gone about 0.2 miles too far*	**0.1 Mi** *17.6 Mi Total*
↰	8. Turn **left** onto **S Jefferson St.** Map *S Jefferson St is just past S Desplaines St* *If you reach S Clinton St you've gone a little too far*	**0.2 Mi** *17.7 Mi Total*
↱	9. Take the 3rd **right** onto **W Polk St.** Map *W Polk St is just past W Cabrini St* *If you reach W Lexington St you've gone a little too far*	**0.04 Mi** *17.8 Mi Total*
■	10. **557 W POLK ST** is on the **right.** Map *If you reach S Clinton St you've gone a little too far*	
B	**557 W Polk St**, Chicago, IL 60607-4388	

Total Travel Estimate: **17.78 miles - about 30 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

Circle Medical Management

Trip to:

1426 W Washington Blvd

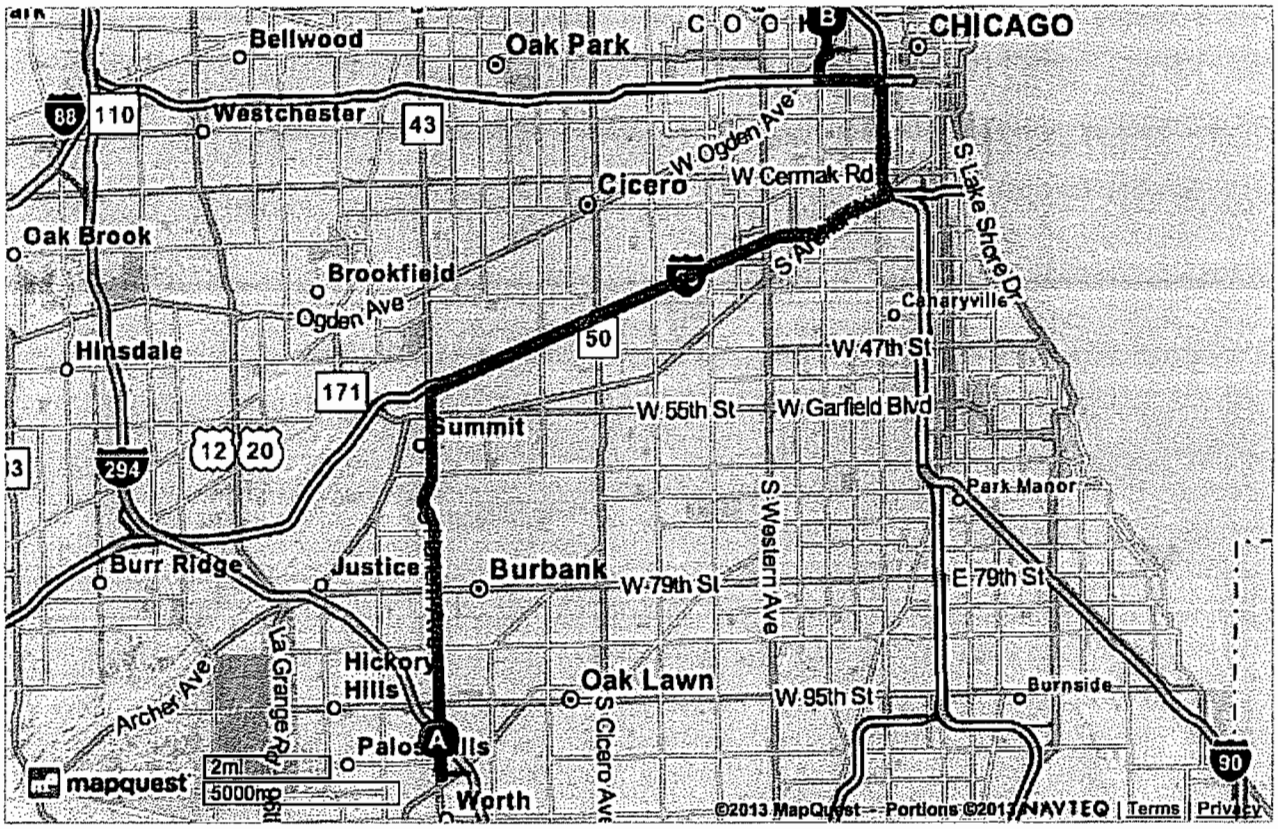
Chicago, IL 60607-1821

19.64 miles / 33 minutes

	[10451-10548] S Harlem Ave, Palos Hills, IL 60465	
●	1. Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
NORTH 55	2. Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**8.1 Mi** *15.0 Mi Total*
292A EXIT WEST 94	3. Merge onto **I-90 W / I-94 W / Dan Ryan Expy W** via **EXIT 292A** toward **Wisconsin.** Map	**2.2 Mi** *17.2 Mi Total*
51H EXIT	4. Take the **I-290 W / Eisenhower Expy** exit, **EXIT 51H**, toward **West Suburbs.** Map	**0.5 Mi** *17.7 Mi Total*
WEST 290	5. Merge onto **I-290 W / IL-110 W / Eisenhower Expy W** via the exit on the **left** toward **West Surburbs.** Map	**1.2 Mi** *18.8 Mi Total*
28B EXIT	6. Take **EXIT 28B** toward **Ashland Ave / Paulina St.** Map	**0.2 Mi** *19.0 Mi Total*
	7. Turn **slight left** onto **W Van Buren St.** Map	**0.06 Mi** *19.1 Mi Total*
	8. Turn **right** onto **S Ashland Ave.** Map *BP is on the corner* *If you reach N Marshfield Ave you've gone a little too far*	**0.3 Mi** *19.4 Mi Total*
	9. Turn **slight right** onto **W Ogden Ave.** Map *W Ogden Ave is just past W Monroe St* *Bombon Cafe is on the left* *If you are on S Ashland Ave and reach W Madison St you've gone a little too far*	**0.2 Mi** *19.6 Mi Total*
	10. Turn **right** onto **W Washington Blvd / W Washington St.** Map *W Washington Blvd is just past W Warren Blvd* *If you reach W Randolph St you've gone about 0.1 miles too far*	**0.08 Mi** *19.6 Mi Total*
■	11. **1426 W WASHINGTON BLVD** is on the **left.** Map *Your destination is just past N Bishop St* *If you reach N Loomis St you've gone a little too far*	
	1426 W Washington Blvd, Chicago, IL 60607-1821	

Total Travel Estimate: **19.64 miles - about 33 minutes**

BOOK TRAVEL with mapquest (877) 577-5766



mapquest

Notes

FMC - Prairie

Trip to:

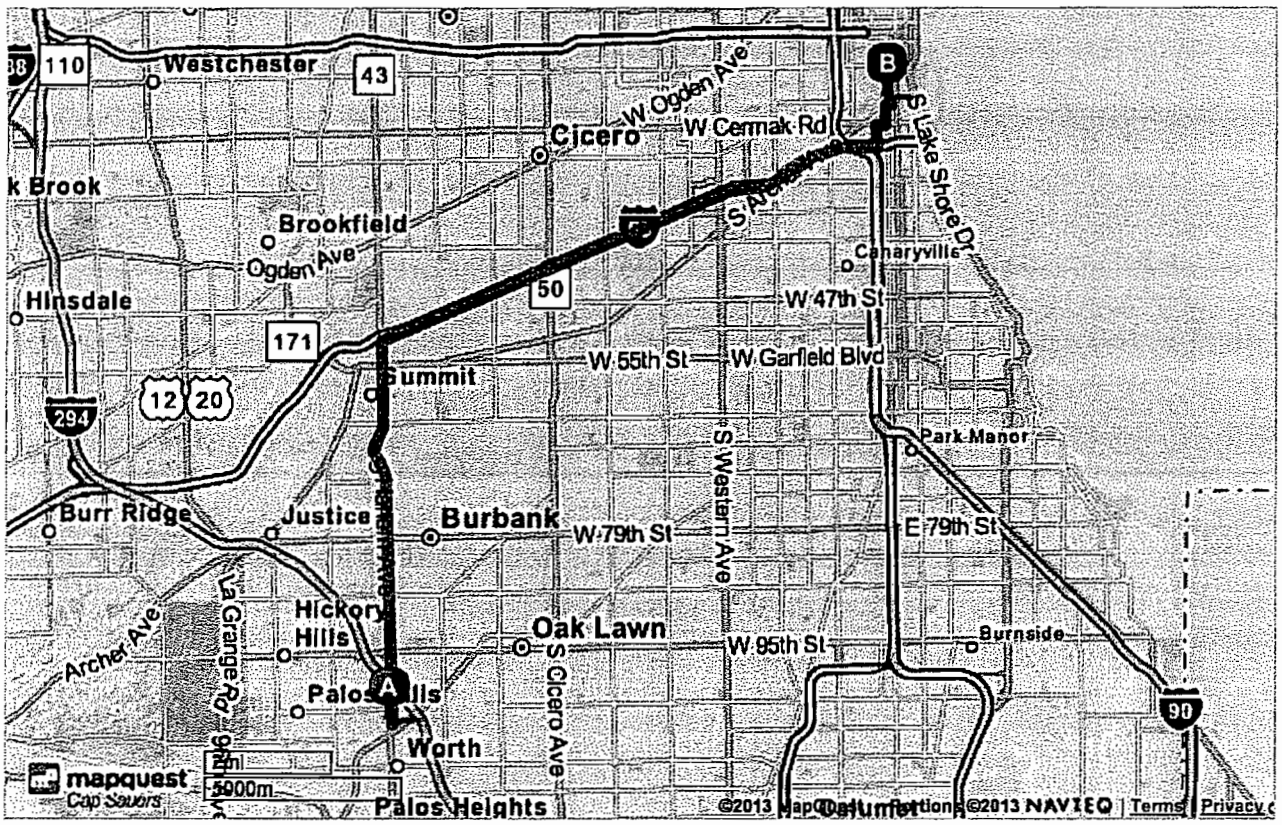
1717 S Wabash Ave
Chicago, IL 60616-1219
17.58 miles / 30 minutes

[10451-10548] S Harlem Ave, Palos Hills, IL 60465

1.	Start out going **north** on **S Harlem Ave / IL-43 N** toward **W 105th St.** Map	**6.9 Mi** *6.9 Mi Total*
2.	Merge onto **I-55 N / Stevenson Expy N.** Map *If you reach IL-43 S you've gone about 0.4 miles too far*	**9.3 Mi** *16.2 Mi Total*
3.	Take the **Cermak Rd** exit, **EXIT 293A**, toward **Chinatown.** Map	**0.7 Mi** *16.9 Mi Total*
4.	Turn **right** onto **W Cermak Rd / W 22nd St.** Map *If you are on W Cermak Rd and reach S Wentworth Ave you've gone a little too far*	**0.2 Mi** *17.1 Mi Total*
5.	Turn **left** onto **S State St.** Map *S State St is 0.1 miles past S Federal St* *Jamaica Jerk Villa is on the corner* *If you are on E Cermak Rd and reach S Wabash Ave you've gone a little too far*	**0.3 Mi** *17.4 Mi Total*
6.	Take the 3rd **right** onto **E 18th St.** Map *E 18th St is just past S Archer Ave* *Chicago City Police Department is on the corner* *If you reach W 17th St you've gone a little too far*	**0.08 Mi** *17.5 Mi Total*
7.	Take the 1st **left** onto **S Wabash Ave.** Map *Park Creperie Cafe is on the corner* *If you reach S Michigan Ave you've gone a little too far*	**0.07 Mi** *17.6 Mi Total*
8.	**1717 S WABASH AVE** is on the **right.** Map *If you reach E 16th St you've gone a little too far*	

1717 S Wabash Ave, Chicago, IL 60616-1219

Total Travel Estimate: **17.58 miles - about 30 minutes**



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

INDEX OF ATTACHMENTS