

19-022

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

MAY 21 2019

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Austin Dialysis at Loretto		
Street Address: 645 South Central Avenue, Suite 100		
City and Zip Code: Chicago, Illinois 60644		
County: Cook	Health Service Area: 6	Health Planning Area: A-02

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

Exact Legal Name: Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto		
Street Address: 645 South Central Avenue, Suite 100		
City and Zip Code: Chicago, Illinois 60644		
Name of Registered Agent: Sameer K. Suhail, M.D.		
Registered Agent Street Address: 155 North Michigan Avenue, Suite 634		
Registered Agent City and Zip Code: Chicago, Illinois 60601		
Name of Chief Executive Officer: Sameer K. Suhail, M.D.		
CEO Street Address: 645 South Central Avenue, Suite 100		
CEO City and Zip Code: Chicago, Illinois 60644		
CEO Telephone Number: (708) 653-6167		

Type of Ownership of Applicants

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Other

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Sameer K. Suhail, M.D.
Title: President & CEO
Company Name: Austin Dialysis Center LLC d/b/a Austin Dialysis at Loretto
Address: 155 North Michigan Avenue, Suite 634, Chicago, Illinois 60601
Telephone Number: (708) 626-4300
E-mail Address: dr.sameersuhail@gmail.com
Fax Number: N/A

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

Name: George N. Miller, Jr.
Title: President & Chief Executive Officer
Company Name: Loretto Hospital
Address: 645 South Central Avenue, Chicago, Illinois 60644
Telephone Number: (773) 626-4300
E-mail Address: george.miller@lorettoshospital.org
Fax Number: N/A

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

Name: Melinda Malecki
Title: Vice President & Chief Legal Counsel
Company Name: Loretto Hospital
Address: 645 South Central Avenue, Chicago, Illinois 60644
Telephone Number: (773) 626-4300
E-mail Address: melinda.malecki@lorettohospital.org
Fax Number: N/A

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

Name: Joseph Hylak-Reinholtz
Title: Legal Counsel for Applicant
Company Name: Hylak-Reinholtz Law Firm, LLC
Address: 601 West Monroe Street, Springfield, Illinois 62704
Telephone Number: (630) 464-4514
E-mail Address: JHRLaw2017@gmail.com
Fax Number: N/A

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

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Street Address: 645 South Central Avenue, Suite 100		
City and Zip Code: Chicago, Illinois 60644		
County: Cook	Health Service Area: 6	Health Planning Area: A-02

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

Exact Legal Name: Loretto Hospital
Street Address: 645 South Central Avenue
City and Zip Code: Chicago, Illinois 60644
Name of Registered Agent: George N. Miller, Jr.
Registered Agent Street Address: 645 South Central Avenue
Registered Agent City and Zip Code: Chicago, Illinois 60644
Name of Chief Executive Officer: George N. Miller, Jr.
CEO Street Address: 645 South Central Avenue
CEO City and Zip Code: Chicago, Illinois 60644
CEO Telephone Number: (773) 626-4300

Type of Ownership of Applicants

<input checked="" type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
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- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: George N. Miller, Jr.
Title: President & Chief Executive Officer
Company Name: Loretto Hospital
Address: 645 South Central Avenue, Chicago, Illinois 60644
Telephone Number: (773) 626-4300
E-mail Address: george.miller@lorettohospital.org
Fax Number: N/A

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

Name: Melinda Malecki
Title: Vice President & Chief Legal Counsel
Company Name: Loretto Hospital
Address: 645 South Central Avenue, Chicago, Illinois 60644
Telephone Number: (773) 626-4300
E-mail Address: melinda.malecki@lorettohospital.org
Fax Number: N/A

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: Anosh Ahmed, M.D.
Title: Chief Operating Officer
Company Name: Loretto Hospital
Address: 645 South Central Avenue, Suite 100, Chicago, Illinois 60644
Telephone Number: (773) 626-4300
E-mail Address: anosh@lorettohospital.org
Fax Number: N/A

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Loretto Hospital
Address of Site Owner: 645 South Central Avenue, Chicago, Illinois 60644
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto
Address: 645 South Central Avenue, Suite 100, Chicago, Illinois 60644
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>).

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

- Substantive
- Non-substantive

2. Narrative Description

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

The applicant, Austin Dialysis Center, LLC, an Illinois limited liability company, which upon CON approval will do business as Austin Dialysis at Loretto ("Applicant"), herein proposes the establishment of a 12-station end stage renal disease ("ESRD") facility to be located within leased space inside of Loretto Hospital ("Project"). The address of the project site is 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 ("Project Site").

The ESRD facility will be constructed in existing space, which will be converted into the dialysis center by the Applicant. The Project Site includes a total of 2,750 GSF. While the Project will be located within Loretto Hospital, the facility will seek licensure, accreditation, and Medicare certification as a freestanding facility (i.e., not as a hospital-based unit under the hospital's license). The interior of the leased space will be built out by the primary Applicant pursuant to a lease agreement.

The Project's total cost is \$1,961,169. Of that amount, \$720,169 represents the fair market value of two leases over a five (5) year term—the first, a real property lease valued at \$432,169 over the term, and the second, an equipment lease with a 5-year value of \$288,000. However, the first two years of the property lease rent will be waived by Loretto Hospital in exchange for securities (i.e., membership units) in the Applicant's limited liability company. The value of the securities totals \$167,750, which is the equivalent of the first two years of waived rent. The Applicant will take on a loan of \$1,119,500 to fund the balance of the Project's costs.

The ESRD facility will be in Health Service Area 6 (HSA 6), which, according to the most recent inventory of Health Care Services, presently has a need for five (5) additional ESRD stations and this Project will close that gap but also provide a vital healthcare service in an community with disproportional dialysis needs.

The Project is substantive because it proposes the establishment of a new healthcare facility under the in-center hemodialysis category of service.

The estimated project completion date is January 31, 2021.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$0	\$0	\$0
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$0	\$0	\$0
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$705,500.00	\$0	\$705,500.00
Contingencies	\$70,500.00	\$0	\$70,500.00
Architectural/Engineering Fees	\$71,500.00	\$0	\$71,500.00
Consulting and Other Fees	\$0	\$50,000.00	\$50,000.00
Movable/Other Equipment (not in construction contracts)	\$288,000.00	\$56,000.00	\$344,000.00
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space	\$432,169.00	\$0	\$432,169.00
Fair Market Value of Leased Equipment	\$288,000.00	\$0	\$288,000.00
Other Costs To Be Capitalized	\$0	\$0	\$0
Acquisition of Building or Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$1,855,169.00	\$106,000.00	\$1,961,169.00
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$71,500.00	\$50,000.00	\$121,500.00
Securities	\$167,750.00	\$0	\$167,750.00
Pledges	\$0	\$0	\$0
Gifts and Bequests	\$0	\$0	\$0
Bond Issues (project related)	\$0	\$0	\$0
Mortgages	\$0	\$0	\$0
Leases (fair market value) Space	\$264,419.00	\$0	\$264,419.00
Leases (fair market value) Equipment	\$288,000.00	\$0	\$288,000.00
Governmental Appropriations	\$0	\$0	\$0.00
Grants	\$0	\$0	\$0.00
Other Funds and Sources (loans)	\$1,063,500.00	\$56,000.00	\$1,119,500.00
TOTAL SOURCES OF FUNDS	\$1,855,169.00	\$106,000.00	\$1,961,169.00
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purchase Price: \$ _____ Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ _____ <u>167,750.00</u>

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

- | | |
|---|---|
| <input type="checkbox"/> None or not applicable | <input checked="" type="checkbox"/> Preliminary |
| <input type="checkbox"/> Schematics | <input type="checkbox"/> Final Working |

Anticipated project completion date (refer to Part 1130.140): _____ January 31, 2021

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

- Purchase orders, leases or contracts pertaining to the project have been executed.
- Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
- Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

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

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That IS:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ESRD (In-Center Dialysis)	\$1,855,169	2,750	2,750		2,750		
<i>Total Clinical</i>	<i>\$1,855,169</i>	<i>2,750</i>	<i>2,750</i>		<i>2,750</i>		
Non-Reviewable							
Non-Clinical Space (e.g., non-clinical space, such as administrative office space, waiting room and reception areas, medical record storage).	\$106,000	0	0		0		
<i>Total Non-clinical</i>	<i>\$106,000</i>	<i>0</i>	<i>0</i>		<i>0</i>		
TOTAL	\$1,961,169	2,750	2,750		2,750		
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization ← Not Applicable to In-Center Hemodialysis Project

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

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

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

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

SIGNATURE

George N. Miller, Jr.

PRINTED NAME

President & CEO, Loretto Hospital

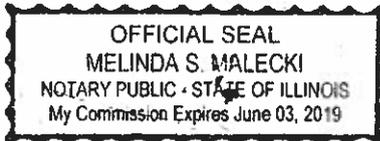
PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 9th day of May, 2019

Melinda S Malecki
Signature of Notary

Seal



SIGNATURE

Sameer K. Suhail, M.D.

PRINTED NAME

President & CEO, Austin Dialysis Center LLC

PRINTED TITLE

Notarization:

Subscribed and sworn to before me this 9th day of May, 2019

Melinda S Malecki
Signature of Notary

Seal



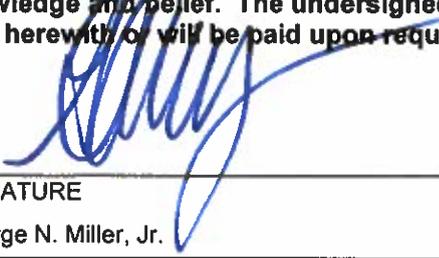
*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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- o 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);
- o 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);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Loretto Hospital, an Illinois not-for-profit corporation * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.



SIGNATURE

George N. Miller, Jr.

PRINTED NAME

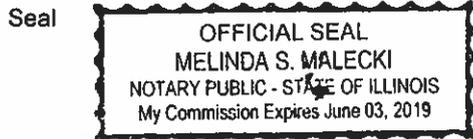
President & CEO, Loretto Hospital

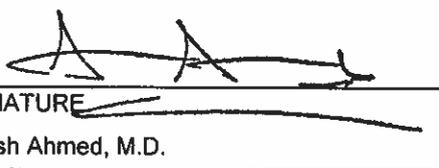
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of May, 2019



Signature of Notary





SIGNATURE

Anosh Ahmed, M.D.

PRINTED NAME

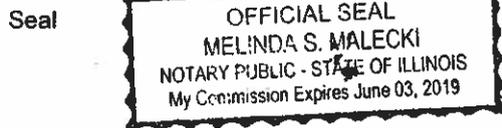
Chief Operating Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of May, 2019



Signature of Notary



*Insert the EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate.**

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

ASSURANCES:

Submit the following:

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

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

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

F. Criterion 1110.230 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service must submit the following information:
2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
<input checked="" type="checkbox"/> In-Center Hemodialysis	0	12

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.230(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.230(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.230(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.230(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.230(b)(5) - Planning Area Need - Service Accessibility	X		
1110.230(c)(1) - Unnecessary Duplication of Services	X		
1110.230(c)(2) - Maldistribution	X		
1110.230(c)(3) - Impact of Project on Other Area Providers	X		
1110.230(d)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.230(e) - Staffing	X	X	
1110.230(f) - Support Services	X	X	X
1110.230(g) - Minimum Number of Stations	X		
1110.230(h) - Continuity of Care	X		
1110.230(i) - Relocation (if applicable)	X		
1110.230(j) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. **Projects for relocation** of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 1110.230(i) - Relocation of an in-center hemodialysis facility.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

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

<u>\$289,250</u>	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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;
<u>\$1,119,500</u>	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: <ol style="list-style-type: none"> 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;
<u>\$552,419</u>	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
<u>\$1,961,169</u>	TOTAL FUNDS AVAILABLE

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

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

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

SECTION XI. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

A table in the following format must be provided for all facilities as part of Attachment 39.

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

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

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	25
2	Site Ownership	26
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	44
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	47
5	Flood Plain Requirements	48
6	Historic Preservation Act Requirements	56
7	Project and Sources of Funds Itemization	94
8	Financial Commitment Document if required	96
9	Cost Space Requirements	108
10	Discontinuation	N/A
11	Background of the Applicant	109
12	Purpose of the Project	117
13	Alternatives to the Project	150
14	Size of the Project	153
15	Project Service Utilization	154
16	Unfinished or Shell Space	155
17	Assurances for Unfinished/Shell Space	156
18	Master Design Project	N/A
	Service Specific:	
19	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
20	Comprehensive Physical Rehabilitation	N/A
21	Acute Mental Illness	N/A
22	Open Heart Surgery	N/A
23	Cardiac Catheterization	N/A
24	In-Center Hemodialysis	157
25	Non-Hospital Based Ambulatory Surgery	N/A
26	Selected Organ Transplantation	N/A
27	Kidney Transplantation	N/A
28	Subacute Care Hospital Model	N/A
29	Community-Based Residential Rehabilitation Center	N/A
30	Long Term Acute Care Hospital	N/A
31	Clinical Service Areas Other than Categories of Service	N/A
32	Freestanding Emergency Center Medical Services	N/A
33	Birth Center	N/A
	Financial and Economic Feasibility:	
34	Availability of Funds	259
35	Financial Waiver	280
36	Financial Viability	281
37	Economic Feasibility	308
38	Safety Net Impact Statement	318
39	Charity Care Information	325

ATTACHMENT 1

Applicant Ownership Information

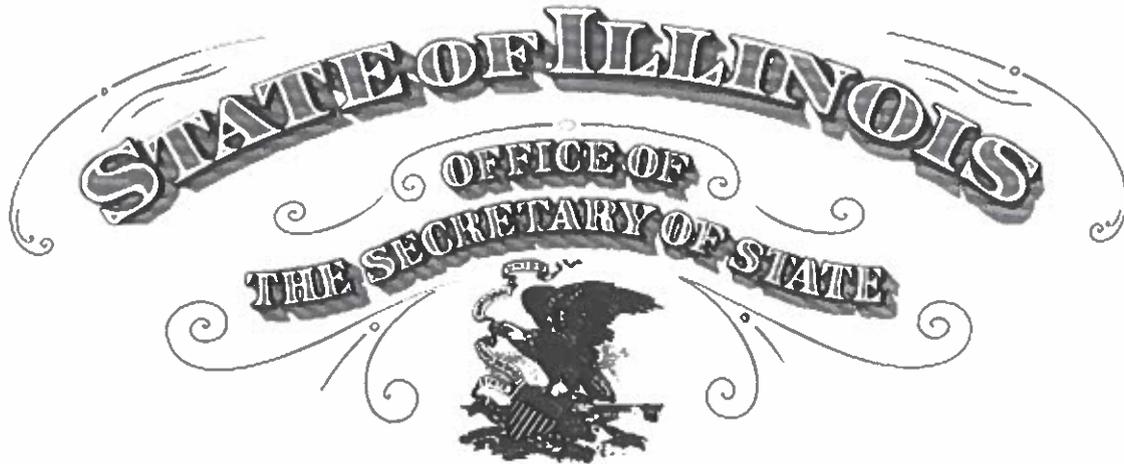
Please find attached a Certificate of Good Standing issued by the Illinois Secretary of State for Austin Dialysis Center, LLC, a domestic limited liability company (“Applicant”). Upon permit issuance, the Applicant will establish “Austin Dialysis at Loretto” as the official “doing business as” name of the company.

Austin Dialysis Center, LLC is the legal entity that will own, operate, manage, and control the proposed in-center hemodialysis facility. The Applicant’s company will also be the entity that will apply for and be certified as an end stage renal disease facility by the Centers for Medicare and Medicaid Services.

A Certificate of Good Standing issued by the Illinois Secretary of State for the co-applicant Loretto Hospital, an Illinois not-for-profit corporation (“Loretto”), is also attached. Loretto is a co-applicant because it will actively be involved in the operation and provision of care and will be in control of the use of capital assets that are components of the project, such as, but not limited to, fixed equipment, mobile equipment, and buildings.

File Number

0475545-6



To all to whom these Presents Shall Come, Greeting:

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

AUSTIN DIALYSIS CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 05, 2014, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1823802194 verifiable until 08/24/2019
Authenticate at: <http://www.cyberdriveillinois.com>

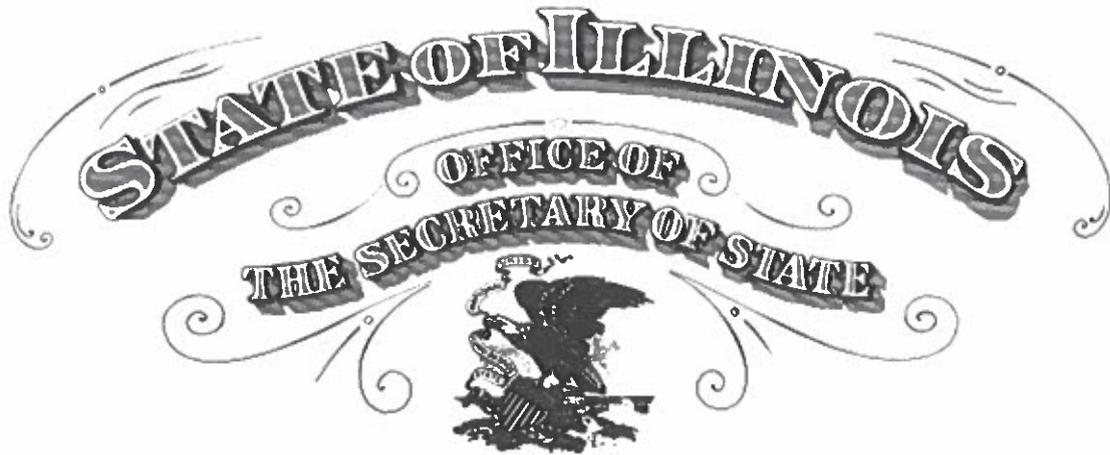
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2018 .

Jesse White

SECRETARY OF STATE

File Number

2629-280-8



To all to whom these Presents Shall Come, Greeting:

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

LORETTO HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 07, 1939, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1823602212 verifiable until 08/24/2019
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2018 .

Jesse White

SECRETARY OF STATE

ATTACHMENT 2

Site Ownership

The proposed ESRD facility will be established in leased space inside Loretto Hospital. The ESRD facility will be on the first floor of the hospital. The ESRD facility's address will be 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 ("Project Site").

Loretto Hospital ("Site Owner") owns the building in which the proposed ESRD facility will be located. The Site Owner provided confirmation of the title to the property as evidence of its ownership of the Project Site.

The Applicant will enter into a Lease Agreement with Loretto Hospital following permit issuance; however, a fully executed lease is not available at this time. Instead, a copy of a Letter of Intent to Lease between the Applicant and Site Owner is attached hereto.

PART I - EVIDENCE OF SITE OWNERSHIP

(see attached)

Loan

SCHEDULE A

OFFICE FILE NO.	POLICY NUMBER	DATE OF POLICY	AMOUNT OF INSURANCE
03030201	M-9994-5814182	August 08, 2003	\$ 2,000,000.00

1. Name of Insured Lender: Austin Bank of Chicago its successors and/or assigns, as their interests may appear.

2. Title to the estate or interest in the land is vested in:

Loretto Hospital, A Not-For-Profit Corporation of Illinois

3. The estate or interest in the land which is encumbered by the insured mortgage is:

Fee Simple

4. The insured security instrument and assignments thereof, if any, are described as follows:

Mortgage dated July 18, 2003 and recorded August 8, 2003 as document number 0322039012 made by Loretto Hospital, A Not-For-Profit Corporation of Illinois, to Austin Bank of Chicago to secure an indebtedness of \$2,000,000.00.

5. The land referred to in this Policy is described as follows:

See Exhibit A attached hereto and made part of.

File No: 03030201

EXHIBIT A - LEGAL DESCRIPTION

PARCEL A:

LOTS 1 TO 11, BOTH INCLUSIVE, IN DAVIS AND SONS SUBDIVISION OF LOTS 221 AND 222 IN SCHOOL TRUSTEES' SUBDIVISION OF THE NORTH PART OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL B:

LOTS 16 TO 22, BOTH INCLUSIVE, IN DAVIS AND SONS SUBDIVISION OF LOTS 221 AND 222 IN SCHOOL TRUSTEES' SUBDIVISION OF THE NORTH PART OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL C:

LOTS 8 TO 14, BOTH INCLUSIVE, IN DAVIS AND SONS SUBDIVISION OF LOT 229, IN SCHOOL TRUSTEES' SUBDIVISION OF THE NORTH PART OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL D:

LOTS 9 TO 16, BOTH INCLUSIVE IN FISHER'S SUBDIVISION OF LOT 230, IN SCHOOL TRUSTEES' SUBDIVISION OF THE NORTH PART OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL E:

THE EAST 4.42 FEET OF LOT 63 AND ALL OF LOT 64 IN BRITIGAN'S HARRISON STREET AND CENTRAL AVENUE SUBDIVISION OF LOTS 141, 142, 143, 144 (EXCEPT THE STREETS) IN SCHOOL TRUSTEES' SUBDIVISION OF THE NORTH PART OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

PARCEL F:

LOT 65 AND THE WEST 20.50 FEET OF LOT 66 IN BRITIGAN'S HARRISON STREET AND CENTRAL AVENUE SUBDIVISION OF LOTS 141 TO 144 BOTH INCLUSIVE (EXCEPT THE STREETS) IN SCHOOL TRUSTEES' SUBDIVISION IN THE NORTHWEST QUARTER OF SECTION 16, TOWNSHIP 39 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS.

Loan

Loan Policy Number: M-9994-5814182

SCHEDULE B

Agent's Order Number: 03030201

EXCEPTIONS FROM COVERAGE

This policy does not insure against loss or damage (and the Company will not pay costs, attorneys' fees or expenses) which arise by reason of:

Special Exceptions:

1. General Real Estate Taxes for the Years 2002 and 2003

Tax Number are as follows:

16-16-300-017-0000, LOTS 1, 2, AND 3 OF PARCEL A;
16-16-300-016-0000, LOTS 4, 5, 6, AND 7 OF PARCEL A;
16-16-300-039-0000, LOT 8 AND PART OF LOT 9 OF PARCEL A;
16-16-300-038-0000, PART OF LOT 9 IN PARCEL A;
16-16-300-036-0000, LOT 10 AND PART OF LOT 9 OF PARCEL A;
16-16-300-012-0000, LOT 11 OF PARCEL A;
16-16-300-024-0000, LOTS 16 AND 17 OF PARCEL B;
16-16-300-040-0000, LOTS 18, 19, AND 20 OF PARCEL B;
16-16-300-028-0000, LOTS 21 AND 22 OF PARCEL B;
16-16-300-019-0000, LOTS 8 AND 9 OF PARCEL C;
16-16-300-020-0000, LOT 10 AND PART OF LOT 11 OF PARCEL C;
16-16-300-021-0000, LOT 12 AND PART OF LOT 11 IN PARCEL C;
16-16-300-022-0000, LOT 13 OF PARCEL C;
16-16-300-023-0000, LOT 14 OF PARCEL C;
16-16-300-018-0000, PARCEL D;
16-16-120-035-0000, PARCEL E;
16-16-120-031-0000, PARCEL F.

Note: The 2003 and 2004 taxes are not yet due or payable.

2. Party Wall Agreement among Angelo Mouhelis, Eudokia Mouhelis, Elmer Jezek, and Helen Jezek recorded July 9, 1951 as document number 15118289 concerning a party wall along the east line of parcel F.
3. Covenants and restriction contained in deeds from Merchants Loan and Trust Company, as Trustee, recorded as document numbers 7319066, 67767072, 7587951, 7021036, 7277117, and 7974261 concerning minimum building cost, type of building to be constructed and use of the premises.

Note: Affects parcels E and F

4. Mortgage dated July 30, 1999 and recorded August 3, 1999 as document number 99734511 made by Loretto Hospital, a not-for-profit corporation of Illinois, to Austin Bank of Chicago to secure an indebtedness of \$5,440,000.00.
5. Assignment of leases and rents dated July 30, 1999 and recorded August 3, 1999 as document number 99734512, made by Loretto Hospital, a not-for-profit corporation of Illinois, to Austin

Continued on next page

POLICY NO.: M-9994-5814182

SCHEDULE B CONTINUED

Bank of Chicago.

6. Security interest of American National Bank and Trust Company of Chicago, secured party under a financing statement executed by Loretto Hospital, a not-for-profit corporation of Illinois Loretto Hospital, debtor and filed March 31, 2000 as document number 00225827.
7. Security interest of DVI Financial Services, Inc., secured party under a financing statement executed by Loretto Hospital, a not-for-profit corporation of Illinois DTC Corp., Loretto, debtor and filed November 13, 2000 as document number 00888083.
8. License Agreement dated July 2, 2001 and recorded July 13, 2001 as document number 0010621064 made between Assumption Greek Orthodox Church and Loretto Hospital.
9. License Agreement dated November 15, 2001 and recorded November 29, 2001 as document number 0011120055 between Loretto Hospital and Assumption Greek Orthodox Church.
10. Amendment to Security interest of US Bank, NA, secured party under a financing statement executed by Loretto Hospital, a not-for-profit corporation of Illinois, debtor and filed January 27, 2003 as document number 0030123229.
11. Subject to encroachments, overlaps, unrecorded easements and other adverse matters, which may be disclosed by an accurate survey of the land made in accordance with Illinois survey and alta/acsm survey standards.

ALTA Loan Policy

Policy Number: M- 9994-5814182
Order No: 03030201

SCHEDULE B - PART II

In addition to the matters set forth in Part I of this Schedule, the title to the estate or interest in the land described or referred to in Schedule A is subject to the following matters, if any be shown, but the Company insures that such matters are subordinate to the lien or charge of the insured mortgage upon said estate or interest:

ENDORSEMENT ATTACHED TO AND MADE A PART OF POLICY OF
TITLE INSURANCE SERIAL NUMBER M - 9994 1314182 ISSUED BY
Loretto Hospital, A Not-For-Profit Corporation of
FILE NO: 03030201

**STEWART TITLE
GUARANTY COMPANY**
HEREIN CALLED THE COMPANY

The Company hereby insures the Insured against loss or damage which the Insured shall sustain by reason of:

1. Any inaccuracies in the following assurances:

- (a) That there are no covenants, conditions or restrictions under which the lien of the mortgage referred to in Schedule A can be divested or subordinated or its validity, priority or enforceability otherwise impaired:
- (b) That unless otherwise expressly set forth or indicated to the contrary in Schedule B:
 - (1) There are no present violation on said land of any enforceable covenants, conditions or restrictions or plat building lines;
 - (2) Any instrument referred to in Schedule B as specifically containing "covenants and restrictions" affecting said land does not, in addition, establish an easement thereon or provide for either a lien for liquidated damages, a levy of a private charge or assessment, an option to purchase, or the prior approval of a future purchaser or occupant;
 - (3) There are no encroachments of existing improvements located on said land onto adjoining land, nor any encroachments unto said land of existing improvements located on adjoining land;
 - (4) There are no encroachments of existing improvements located on said land onto that portion of said subject to any easement shown in Schedule B.

2. Any future violations on said land of any covenants, conditions or restrictions occurring prior to the acquisition of title to said land by the Insured, provided such violations result in loss of the lien of the mortgage referred to in Schedule A or impair the validity, priority or enforceability of such lien, or result in loss of the title to said estate or interest if the Insured shall acquire title in satisfaction of the indebtedness secured by such mortgage.

3. The entry of any court order or judgment which constitutes a final determination and denies the right to maintain any existing improvements on said land because of any violation of any covenants, conditions or restrictions or plat building lines or because of any encroachment thereof over onto adjoining land.

Wherever in this endorsement any or all the words "covenants, conditions or restrictions" appear, they shall not be deemed to refer to or to include the terms, covenants, conditions or limitations contained in any lease or declaration of condominium referred to in Schedule A or relating to environmental protection.

This endorsement is made a part of the policy and is subject to all of the terms and provisions thereof and of any prior endorsements thereto. Except to the extent expressly stated, it neither modifies any of the terms and provisions of the policy and any prior endorsements, nor does it extend the effective date of the policy and any prior endorsements, nor does it increase the face amount thereof.

Signed under seal for the Company, but this Endorsement is to be valid only when it bears an authorized countersignature.


Chairman of the Board




President

Countersigned:

Authorized Countersignature
Stewart Title Guaranty Company

Chicago, IL
City, State
COMPREHENSIVE ENDORSEMENT

File No: 03030201

REVOLVING CREDIT ENDORSEMENT

Issued by

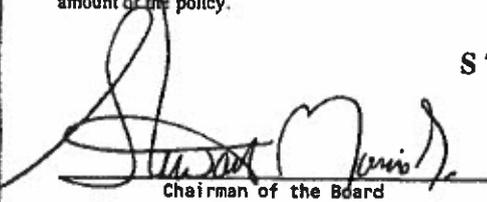
STEWART TITLE
GUARANTY COMPANY

Attached to and made a part of Stewart Title Guaranty Company Mortgagee Policy No. M-5894-5814182,
this 8th day of August, 2003.

Notwithstanding anything to the contrary contained in this policy, the following terms and provisions shall control and apply:

1. This policy insured only to, and liability hereunder is thereby limited to, the extent of the amount of proceeds of the loan secured by the lien instrument set forth under Schedule A hereof actually disbursed as of the date of this policy, but increases as each subsequent advance or disbursement of loan proceeds is made and decreases as repayment of all or a portion of the amount of loan proceeds disbursed is made from time to time, so that any loss payable hereunder shall be limited to the aggregate amount of loan proceeds actually disbursed less the aggregate of all repayments thereof existing at the time a loss occurs hereunder; provided, however, that each disbursement of loan proceeds is made in good faith and without knowledge of any defects in, or objections to, title; and further provided that in no event shall the liability of the Company hereunder exceed the face amount of this policy.
2. The Company hereby assures the Insured that any disbursements of such loan proceeds made subsequent to the date of this policy shall be deemed to have been made as of the date of this policy and shall have the same priority as any advances made as of the date of this policy, except as to (i) bankruptcies affecting the estate or interest described on Schedule "A" hereof prior to the date of any such advance or disbursement; and, (ii) taxes, costs, charges, damages and other obligations to the government secured by statutory liens arising or recorded subsequent to the date of the policy.

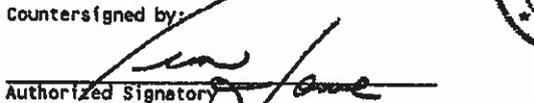
This endorsement when countersigned below by an Authorized Countersignature is made a part of said policy. Except as expressly modified by the provisions hereof, this endorsement is subject to the following policy matters: (i) Insuring Provisions; (ii) Exclusions from Coverage; (iii) Schedule "B" Exceptions; (iv) the Conditions and Stipulations; and, (v) any prior endorsements. Except as stated herein, this endorsement does not: (i) extend the effective date of the policy and/or any prior endorsements; or, (ii) increase the face amount of the policy.


Chairman of the Board

STEWART TITLE
GUARANTY COMPANY




President

Countersigned by: 
Authorized Signatory
Stewart Title Guaranty Company
Company
Chicago, IL
City, State

Serial No. E-58765814182

PART II - LOI TO LEASE

(see attached)



April 30, 2019

Austin Dialysis Center, LLC
155 North Michigan Avenue, Suite 634
Chicago, Illinois 60601
Attention: Sameer K. Suhail, M.D., President & CEO

RE: Healthcare Facility Space Lease

Dear Dr. Suhail:

This letter of intent (“Letter of Intent”) outlines the basic business terms and conditions upon which Loretto Hospital, an Illinois not-for-profit corporation (“Landlord”) would be willing to execute a lease (“Lease”) with Austin Dialysis Center, LLC (“Tenant”), whereby Tenant shall occupy the Premises (as defined below) to operate a Medicare-certified end stage renal disease (“ESRD”) facility, it being understood that additional terms and conditions remain to be negotiated between the parties and final approval is contingent upon the complete execution of the documents and transactions described in this Letter of Intent.

- | | |
|-----------------|---|
| Landlord | Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60601
Attention: George K. Miller, President/CEO |
| Tenant | Austin Dialysis Center, LLC
d/b/a Austin Dialysis at Loretto
155 North Michigan Avenue
Suite 634
Chicago, Illinois 60601
Sameer K. Suhail, M.D., President/CEO |
| Premises | Loretto Hospital
645 South Central Avenue
Suite 100
Chicago, Illinois 60644 |

Specifically, the “Premises” shall include Suite 100, which is the space in the lower level of Loretto Hospital, located on the east side of the building, and is presently occupied by the hospital’s physical therapy program. Access to the Premises will be through the hospital’s main entrance, into the lobby, past the security desk, and completed either by an elevator ride or a descent down a staircase, which is directly accessible from the hospital’s main lobby.

SQF of Premises The Premises shall consist of two thousand seven hundred and fifty (2,750) square feet of rentable space (“RSF”), which shall be identified and described in a Lease between Landlord and Tenant.

Equipment Lease Unless otherwise agreed to by the parties, Tenant will provide all medical and non-medical equipment for the complete operation of a 14-station ESRD facility. If necessary, Tenant will secure leased equipment in its name to ensure the ability to operate the facility.

Term of Lease The Lease shall have an initial term (“Initial Term”) of five (5) years, which shall commence thirty (30) days after Tenant obtains a certificate of need (“CON”) permit from the Illinois Health Facilities and Services Review Board (“State CON Board”). Thereafter, the Lease shall automatically renew for two (2) renewal terms (each a “Renewal Term”), each extending the Lease for an additional five (5) year period. The Initial Term along with any or all Renewal Terms shall collectively be referred to as the “Term” of the Lease.

Fair Market Value of Rent; Rent Escalation Landlord and Tenant concur that the direct fair market value rental range of \$28.00 to \$33.00 per square foot (“SQF”), net of the Premises’ net rentable area, as provided by Real Estate Counselors International, Inc. (“RECI”), is reasonable and consistent with fair market value (“FMV”). Based on this estimate, the initial amount for rent (“Rent”) shall be calculated at \$30.50/SQF net (“net” meaning the amount does not include the Tenant’s pro-rated responsibility of taxes or common area expenses).

Using \$30.50/SQF, the resulting monthly Rent will be \$83,875.00 per year ($\$30.50 \times 2,750$ SQF). Rent will be subject to a two and four tenths percent (2.4%) annual escalation starting on the twenty-fifth (25th) month of the Term and increase annually thereafter at the same rate. The Rent shall be prorated to account only for the days on which the Subtenant occupies the Premises.

Based on the foregoing, the Rent amounts for 2019 through 2024:

Year 1	\$83,875
Year 2	\$83,875
Year 3	\$85,972
Year 4	\$88,122
Year 5	\$90,325

Taxes and Common Area Expenses	Tenant and Landlord agree that Rent, calculated on a net basis, does not include the Tenant's pro-rated responsibility of taxes ("Taxes") or common area expenses ("CAM"). CAM includes any work that is completed in the hospital building's common area on behalf of the hospital and all of its tenants, including the Tenant. CAM includes, but is not limited to, snowplowing of the parking lot and sidewalks, landscaping of the exterior, insurance for the building, or the cleaning of common areas (lobbies, bathrooms, hallways, etc.). Each tenant, including the Tenant, is responsible for such charges, which are passed on by the Landlord.
Waiver of Rent, Taxes and CAM	Landlord and Tenant agree that Tenant will not pay Rent to the Landlord, or its pro-rated portion of Taxes and/or CAM costs, any month during the Term of the Lease in which Loretto Hospital has not fully compensated Tenant for the fair market value of fifteen (15) membership units in Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto. During any such month, Tenant shall credit Loretto Hospital for the full amount of Rent, pro-rated Taxes, and CAM costs, applying such amounts towards payment for the LLC membership units.
Improvements	Landlord will not provide an allowance towards improvements within the Premises. Tenant shall provide those alterations and improvements required such that the Premises comply with codes and regulations necessary for the use by Tenant as a Medicare certified ESRD facility.
Assignment & Sublease	Tenant shall not have the right to assign or sublet all or part of the Premises at any time during the Term of the Lease without first obtaining the Landlord's consent, which shall not be unreasonably withheld or delayed. No consent shall be required for an assignment or sublet to any subsidiary, affiliate, or company related to Tenant.
Real Estate Brokers; Commissions	It is represented that neither the Tenant nor the Landlord is represented by a real estate broker and no commission will be paid in connection with the Lease.
Government Approvals	Landlord and Tenant acknowledge and agree that the establishment of a Medicare certified ESRD 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, therefore, the Tenant cannot establish an ESRD facility within the Premises or execute a binding real estate Lease in connection therewith, unless the Tenant first obtains a CON permit from the State CON Board. Tenant agrees to proceed using commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application without undue delay in order to obtain a CON permit from the State CON Board as soon as possible.

In light of the foregoing facts, Landlord and Tenant agree that the Lease may only be executed after the Tenant has obtained a CON permit from the State CON Board, or alternatively, execute a Lease prior to CON approval, but such Lease shall include a provision that states the agreement, though executed, shall not be binding on either party unless the State CON Board grants a CON permit to the Tenant. If the Tenant fails to obtain a CON permit from the State CON Board, neither party shall have any further obligation to the other party with regard to the negotiations, Lease, or Premises contemplated by the parties in this Letter of Intent.

**Exclusive
Negotiations**

In consideration of each of the parties entering into this Letter of Intent, each party agrees to deal with the other in good faith while negotiating the terms set forth in this Letter of Intent and the transactions contemplated hereby, and Landlord agrees to negotiate exclusively with the Tenant with respect to these transactions for up to thirty (30) days after either: (1) a final decision is made by the State CON Board in connection with a CON permit application regarding the establishment of an ESRD facility within the Premises; or (2) the parties mutually agree to abandon all efforts to establish the ESRD facility before the State CON Board issues any decision on the matter.

Confidentiality

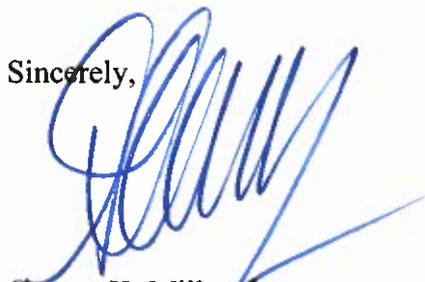
Subject to mandatory provisions of applicable law, the parties to this Letter of Intent hereby agree to preserve and maintain the confidentiality of any and all information (including, but not limited to, information gathered or exchanged during due diligence, except to the extent such information is already in the public domain) and negotiations relative to the transactions contemplated herein, including the existence of this Letter of Intent, and the fact that negotiations concerning a joint venture are taking place. Neither party hereto shall issue any press releases, nor disclose such information, without the prior written consent of the other party except: (1) where a party is required by applicable law or regulatory requirements to make a disclosure concerning the information or the proposed transactions; or (2) where a party makes disclosure to its employees, legal counsel, accountants, and agents who have a need to know such information in connection with the transactions contemplated hereby.

This Letter of Intent is not intended to be a binding agreement between the Landlord and Tenant; but, shall be the basis for negotiation going forward. There shall be no binding agreement between the Landlord and Tenant until a Lease is fully executed by all of the necessary parties, including, but not necessarily limited to, the Landlord and Tenant. Either party may withdraw from negotiations at any time for any reason, without liability to the other. The terms set forth in this Letter of Intent are being provided with confidentiality and must not be shared with any other parties not specifically identified herein.

If the terms described in this Letter of Intent are consistent with your understanding and approval, please sign and date below and return the executed document to the address provided below. Upon receipt of the signed offer and CON approval, we will prepare an executable Lease for your approval.

We look forward to working with you. Please free to contact me if you have any questions regarding this Letter of Intent.

Sincerely,

A handwritten signature in blue ink, appearing to read "G. Miller, Jr.", with a long horizontal flourish extending to the right.

George K. Miller, Jr.
President and Chief Executive Officer
Loretto Hospital
o/b/o Landlord

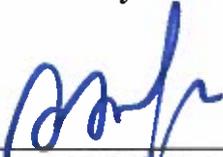
[signatures continue on following page]

AGREED AND ACCEPTED

Please indicate your acceptance of the above terms and conditions by executing below and returning an original signed copy to the address below.

TENANT:

Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto



Sameer K. Subail, M.D.
President and Chief Executive Officer

Date: 04/30/2019

Please return a signed copy of this Letter of Intent to:

Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60601
Attention: George K. Miller, Jr. President/CEO

ATTACHMENT 3

Operating Entity/Licensee Information

I. Certificate of Good Standing

Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto (“Applicant”) will be the legal entity responsible for operating the ESRD facility and will obtain Medicare certification as an ESRD facility. A Certificate of Good Standing issued by the Illinois Secretary of State for the Applicant is attached immediately following this page.

A Certificate of Good Standing issued by the Illinois Secretary of State for the co-applicant Loretto Hospital, an Illinois not-for-profit corporation (“Co-Applicant”), is also attached. The Co-Applicant is required to be a party to the CON permit application because the Co-Applicant will actively be involved in the operation and provision of care and will be in control of the use of capital assets that are components of the project, such as, but not limited to, fixed equipment, mobile equipment, and buildings.

II. Ownership Disclosures

The following persons hold a five percent (5%) or greater ownership interest in the Primary CON Applicant (i.e., the Company):

Name	Entity/Individual	Ownership %
Sameer K. Suhail, M.D.	Individual	100.0%
Loretto Hospital	Not-for-Profit Entity	0%
TOTAL		100.0%

Note, upon issuance of a CON permit for the Project, Loretto Hospital will acquire up to forty-nine percent (49%) ownership; however, Dr. Suhail will maintain control of the Applicant’s business.

File Number

0475545-6



To all to whom these Presents Shall Come, Greeting:

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

AUSTIN DIALYSIS CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 05, 2014, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1823602194 verifiable until 08/24/2019
Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 24TH day of AUGUST A.D. 2018 .

Jesse White

SECRETARY OF STATE

File Number

2629-280-8



To all to whom these Presents Shall Come, Greeting:

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

LORETTO HOSPITAL, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 07, 1939, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION 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 24TH day of AUGUST A.D. 2018 .

Jesse White

SECRETARY OF STATE

Authentication #: 1823602212 verifiable until 08/24/2019
Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 4

Organizational Relationship

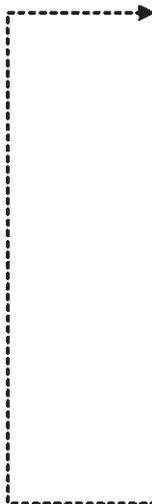
No Parent Company



Austin Dialysis Center, LLC an Illinois Limited Liability Company d/b/a Austin Dialysis at Loretto	
Sameer K. Suhail, M.D.	100.0%
Loretto Hospital	0.0% *
TOTAL:	100.0%



No Subsidiary Companies



ESRD Facility to be managed by Loretto Hospital.

* Upon issuance of a CON permit, Loretto Hospital will acquire up to forty-nine percent (49%) ownership interest.

ATTACHMENT 5

Flood Plain Requirements

The address of the project site is 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 ("Project Site"). The Project Site is not located within a flood plain, as evidenced by the attached flood plain maps obtained from the Federal Emergency Management Agency ("FEMA"). Accordingly, the project is in compliance with the requirements of Illinois Executive Order #2006-5.

FEMA-generated maps are attached after this page, which identify the Project Site and show that it is not located within or near a flood plain. A copy of Executive Order #2006-5 is provided after the FEMA maps.

Attachment 5

Flood Plain Maps

The maps provided below identify the Project Site, located at 645 South Central Avenue, Chicago, Illinois, and show any nearby flood plains, which have been officially identified by the Federal Emergency Management Agency (“FEMA”).



The map below provides a closer view of the Project Site, once again showing that the Project Site is not within a FEMA-designated flood plain (center of image reads “Area of Minimal Flood Hazard.”)



The map below provides another close-up view of the Project Site, once again showing that the Project Site is not within a FEMA-designated flood plain (center of image reads "Area of Minimal Flood Hazard."





2006-05

**CONSTRUCTION ACTIVITIES
IN SPECIAL FLOOD HAZARD AREAS**

WHEREAS, the State of Illinois has programs for the construction of buildings, facilities, roads, and other development projects and annually acquires and disposes of lands in floodplains; and

WHEREAS, federal financial assistance for the acquisition or construction of insurable structures in all Special Flood Hazard Areas requires State participation in the National Flood Insurance Program; and

WHEREAS, the Federal Emergency Management Agency has promulgated and adopted regulations governing eligibility of State governments to participate in the National Flood Insurance Program (44 C.F.R. 59-79), as presently enacted or hereafter amended, which requires that State development activities comply with specified minimum floodplain regulation criteria; and

WHEREAS, the Presidential Interagency Floodplain Management Review Committee has published recommendations to strengthen Executive Orders and State floodplain management activities;

NOW THEREFORE, by virtue of the authority vested in me as Governor of the State of Illinois, it is hereby ordered as follows:

I. For purpose of this Order:

- A. "Critical Facility" means any facility which is critical to the health and welfare of the population and, if flooded, would create an added dimension to the disaster. Damage to these critical facilities can impact the delivery of vital services, can cause greater damage to other sectors of the community, or can put special populations at risk. The determination of Critical Facility will be made by each agency.

Examples of critical facilities where flood protection should be required include:

Emergency Services Facilities (such as fire and police stations)

Schools

Hospitals

Retirement homes and senior care facilities

Major roads and bridges

Critical utility sites (telephone switching stations or electrical transformers)

Hazardous material storage facilities (chemicals, petrochemicals, hazardous or toxic substances)

Examples of critical facilities where flood protection is recommended include:

Sewage treatment plants

Water treatment plants

Pumping stations

- B. "Development" or "Developed" means the placement or erection of structures (including manufactured homes) or earthworks; land filling, excavation or other alteration of the ground surface; installation of public utilities; channel modification; storage of materials or any other activity undertaken to modify the existing physical features of a floodplain.
- C. "Flood Protection Elevation" means one foot above the applicable base flood or 100-year frequency flood elevation.
- D. "Office of Water Resources" means the Illinois Department of Natural Resources, Office of Water Resources.
- E. "Special Flood Hazard Area" or "Floodplain" means an area subject to inundation by the base or 100-year frequency flood and shown as such on the most current Flood Insurance Rate Map published by the Federal Emergency Management Agency.
- F. "State Agencies" means any department, commission, board or agency under the jurisdiction of the Governor; any board, commission, agency or authority which has a majority of its members appointed by the Governor; and the Governor's Office.

2. All State Agencies engaged in any development within a Special Flood Hazard Area shall undertake such development in accordance with the following:
 - A. All development shall comply with all requirements of the National Flood Insurance Program (44 C.F.R. 59-79) and with all requirements of 92 Illinois Administrative Code Part 700 or 92 Illinois Administrative Code Part 708, whichever is applicable.
 - B. In addition to the requirements set forth in preceding Section A, the following additional requirements shall apply where applicable:
 1. All new Critical Facilities shall be located outside of the floodplain. Where this is not practicable, Critical Facilities shall be developed with the lowest floor elevation equal to or greater than the 500-year frequency flood elevation or structurally dry floodproofed to at least the 500-year frequency flood elevation.
 2. All new buildings shall be developed with the lowest floor elevation equal to or greater than the Flood Protection Elevation or structurally dry floodproofed to at least the Flood Protection Elevation.
 3. Modifications, additions, repairs or replacement of existing structures may be allowed so long as the new development does not increase the floor area of the existing structure by more than twenty (20) percent or increase the market value of the structure by fifty (50) percent, and does not obstruct flood flows. Floodproofing activities are permitted and encouraged, but must comply with the requirements noted above.
3. State Agencies which administer grants or loans for financing development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.
4. State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.
5. State Agencies engaged in planning programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order.
6. The Office of Water Resources shall provide available flood hazard information to assist State Agencies in carrying out the responsibilities established by this Order. State Agencies which obtain new flood elevation, floodway, or encroachment data developed in conjunction with development or other activities covered by this Order shall submit such data to the Office of Water Resources for their review. If such flood hazard information is used in determining design features or location of any State development, it must first be approved by the Office of Water Resources.

7. State Agencies shall work with the Office of Water Resources to establish procedures of such Agencies for effectively carrying out this Order.
8. **Effective Date.** This Order supersedes and replaces Executive Order Number 4 (1979) and shall take effect on the first day of.

Rod R. Blagojevich, Governor

Issued by Governor: March 7, 2006
Filed with Secretary of State: March 7, 2006

ATTACHMENT 6

Illinois Historical Preservation Act Requirements and Clearance Letter Request

Please find attached immediately after this page a letter submitted to the Illinois Department of Natural Resources, Historic Preservation Division ("DNR-HPD") by Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto, LLC ("Applicant"). The letter explains why the proposed ESRD facility, which will be constructed within Loretto Hospital, does not adversely affect Illinois' historic resources. The Applicant asked the DNR-HPD to provide a "clearance letter" concluding the same.

Note: The Applicant will submit the clearance letter to the Illinois Health Facilities and Services Review Board once it is obtained from the HPD.



**HYLAK-REINHOLTZ
LAW FIRM, LLC**

601 West Monroe Street
Springfield, Illinois 62704

Joseph J. Hylak-Reinholtz
Attorney at Law
(217) 525-0700 ext. 114
JHRLaw2017@gmail.com

April 25, 2019

VIA U.S. MAIL

Illinois Department of Natural Resources
Historic Preservation Division
1 Natural Resources Way
Springfield, Illinois 62702
Attention: Valerie Spurgeon, Executive Secretary

Re: Illinois Certificate of Need Clearance Letter Request

Dear Secretary Spurgeon:

The Illinois State Agency Historic Resources Preservation Act, 20 ILCS 3420/1 et seq. ("Act"), provides that written notice of a proposed undertaking shall be given to the Executive Secretary of the Historic Preservation Division ("HPD") either by a State agency or a recipient of its funds, licenses or permits when the proposed undertaking might affect historic, architectural or archaeological resources. This letter hereby provides notice of an undertaking proposed by Loretto-Austin Community Dialysis Center ("Applicant"), under which the Applicant will establish an in-center hemodialysis facility in leased space within Loretto Hospital ("In-Center Dialysis Facility"). Specifically, the Applicant is planning to modernize existing space within the hospital to accommodate the proposed In-Center Dialysis Facility ("Project"). State law and regulations require the Applicant to obtain a certificate of need ("CON") permit from the Illinois Health Facilities and Services Review Board ("State Board") before starting the Project.

The Applicant provides, in this letter, all information necessary for the HPD to conduct a review of the Project, to determine whether any historic, architectural, or archaeological sites exist within the Project's area, and if the proposed undertaking will adversely affect such sites. Upon conclusion of the review by the HPD, the Applicant asks your agency to issue a written summary of its findings. As you may be aware, the Applicant must provide this letter to the State Board as a required component of a CON permit application.

Project Summary

In accordance with the requirements of the State Board, a CON permit applicant must submit the following information to the HPD: (1) a general project description and address; (2) a topographic or metropolitan map showing the general location of the project; (3) photographs of any standing buildings/structure within the project area; and (4) addresses for buildings/structures, if present.

The Applicant is proposing the establishment of an In-Center Dialysis Facility, which will be located within Loretto Hospital, 645 South Central Avenue, Chicago, Illinois 60644 (“Project Site”). The central complex of Loretto Hospital was built in 1923. At that time, the hospital was a proprietary institution owned by a group of physicians from the west side of Chicago. It was known then as Austin Hospital. Fifteen years later, the Sisters of Saint Casimir purchased the property in December 1938. After nearly one month of intense renovation and repairs, The Loretto Hospital opened its doors to the public on January 16, 1939 under the administration of the Sisters of Saint Casimir. In 1969, the Sisters of Saint Casimir added a new wing to the hospital. The new wing consisted of an eight-story bed tower and a new diagnostic and treatment building. In addition, a new Family Health Center (currently known as The Loretto Hospital’s Outpatient Center Clinic) was opened in the hospital to bring primary care to residents of the Austin community. It is the Applicant’s understanding that neither Loretto Hospital’s original building nor the 1969 addition have any recorded historical or architectural significance.

There are two historical sites worth noting that are near the Project Site. The first site is Columbus Park, which is listed on the National Register of Historic Places (“NRHP”). Columbus Park is directly to the west of the Project Site, across South Central Avenue. The second site is the Assumption Greek Orthodox Church and Plato School, which is immediately adjacent to the north side of Loretto Hospital. The church is eligible for listing in the NRHP under Criterion C and Criteria Consideration A (as an excellent example of the Byzantine architectural style applied to a religious building and designed by a local master architect); but, no such protection has been sought by the church. The building, encompassing both the church and the school, was constructed from 1937 until 1938. The church and school were designed by architect Peter E. Camburas.

The Project, however, will mostly involve interior construction. If changes to the exterior of the building are necessary, they will be minimal. The interior work will result in the modernization of existing space that is presently used as administrative and office space. There will be no changes to the hospital building that will affect the building itself and any exterior changes will not harm, in any way, adjacent historic structures such as the church and Columbus Park.

General Location and Description of the Project

As noted above, the Project Site is in Chicago, Illinois. Specifically, the In-Center Hemodialysis Facility will be located within Loretto Hospital, located at 645 South Central Avenue, Chicago, Cook County, Illinois 60644. A map showing the general location of the Project and photographs of the Project Site are attached hereto as Exhibit A.

Buildings/Structures Within the Project Area

The buildings immediately adjacent to the Project Site may, in some way, have historic or architectural significance; however, as of July 2018, none of these structures are officially listed on the National Register of Historic Places or are otherwise officially recognized as having historical or architectural significance. Immediately to the north of the Project Site is the Assumption Greek Orthodox Church and Plato School, 601 S Central Ave, Chicago, IL 60644. To the north of the church,

across West Harrison Street, is a parking lot, some deteriorating structures, and another insignificant building housing a small church and a Loretto health clinic.

Immediately to the south of the Project Site is Interstate 290. To the east of the Project Site is a hospital parking lot and a row of Chicago-style brownstone three-flats on the 5500 block of West Flournoy Street. Columbus Park is to the west of the Project Site across South Central Avenue. Columbus Park is registered on the NRHP. Photographs of the properties that are adjacent to the Project Site are attached hereto as Exhibit B.

Addresses for Buildings/Structures

The addresses for buildings/structures surrounding the Project Site are provided in the exhibits. However, the Project requires mostly interior construction; therefore, it will only have a minimal impact on the existing interior of Loretto Hospital.

Conclusion

The Applicant must obtain a CON permit from the State Board for the proposed Project. The State Board's rules require a CON permit applicant to obtain a clearance letter from the HPD, which must conclude that the proposed undertaking is not a project, activity, or program that will have an adverse impact on the character or use of designated historic properties and sites. In the present case, there will be no adverse affect on the hospital building constructed in 1923. There will also be no adverse affect on officially-recognized historic properties or sites near the Project Site, including, but not limited to, Assumption Greek Orthodox Church and Columbus Park. Therefore, the HPD should have no reason to determine that the Project has the potential to harm any of our State's historic properties or sites.

Please let me know if you have questions. Thank you for your attention to this matter.

Sincerely yours,

Joseph Hylak-Reinholtz

JHR/jhr

Enclosures

EXHIBIT A

Part 1 - General Location of the Project

Project Site: 645 South Central Avenue, Chicago, Illinois

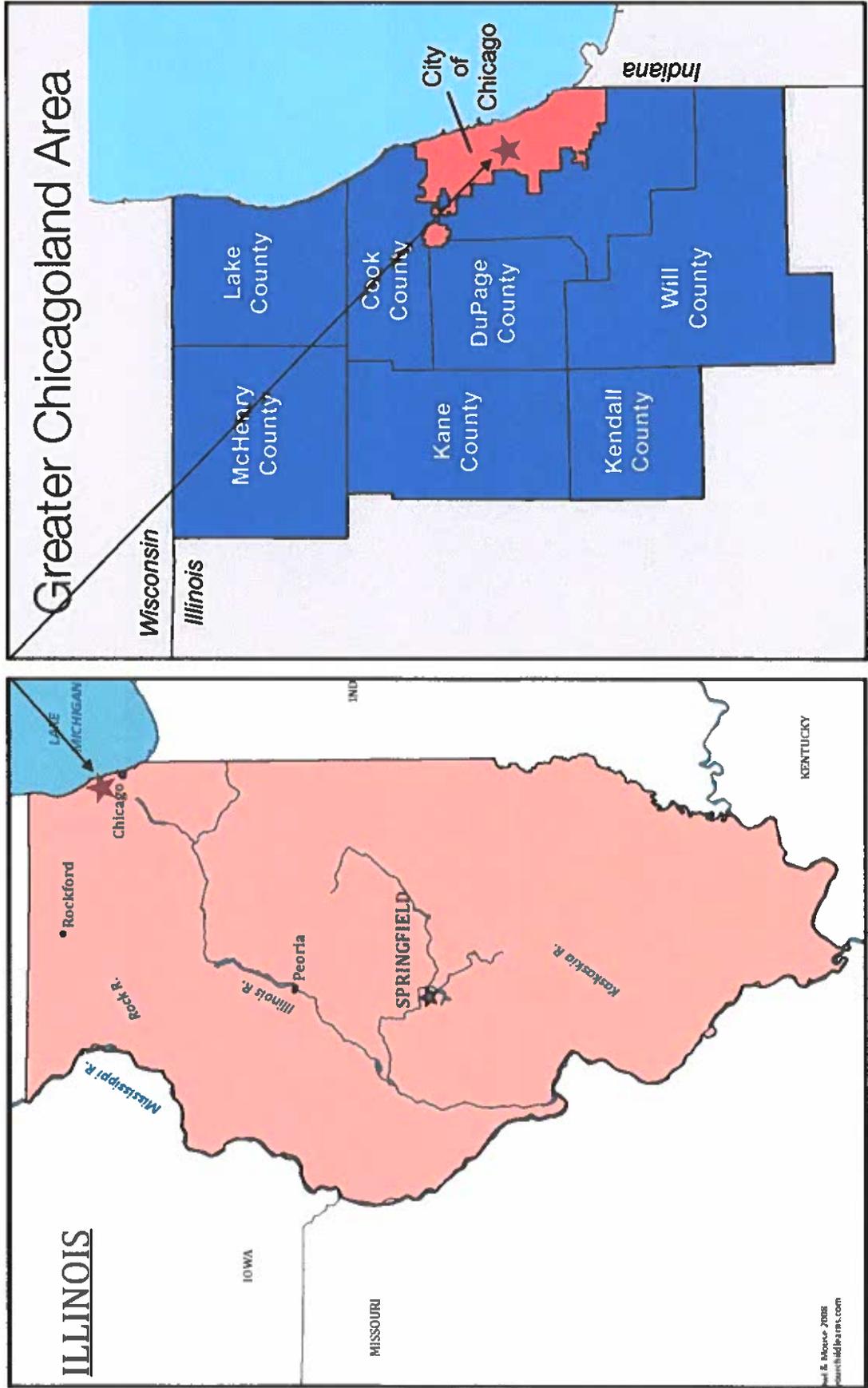


EXHIBIT A

Part 1 - General Location of the Project

Project Site: 645 South Central Avenue, Chicago, Illinois



EXHIBIT A

Part 1 - General Location of the Project

Project Site: 645 South Central Avenue, Chicago, Illinois

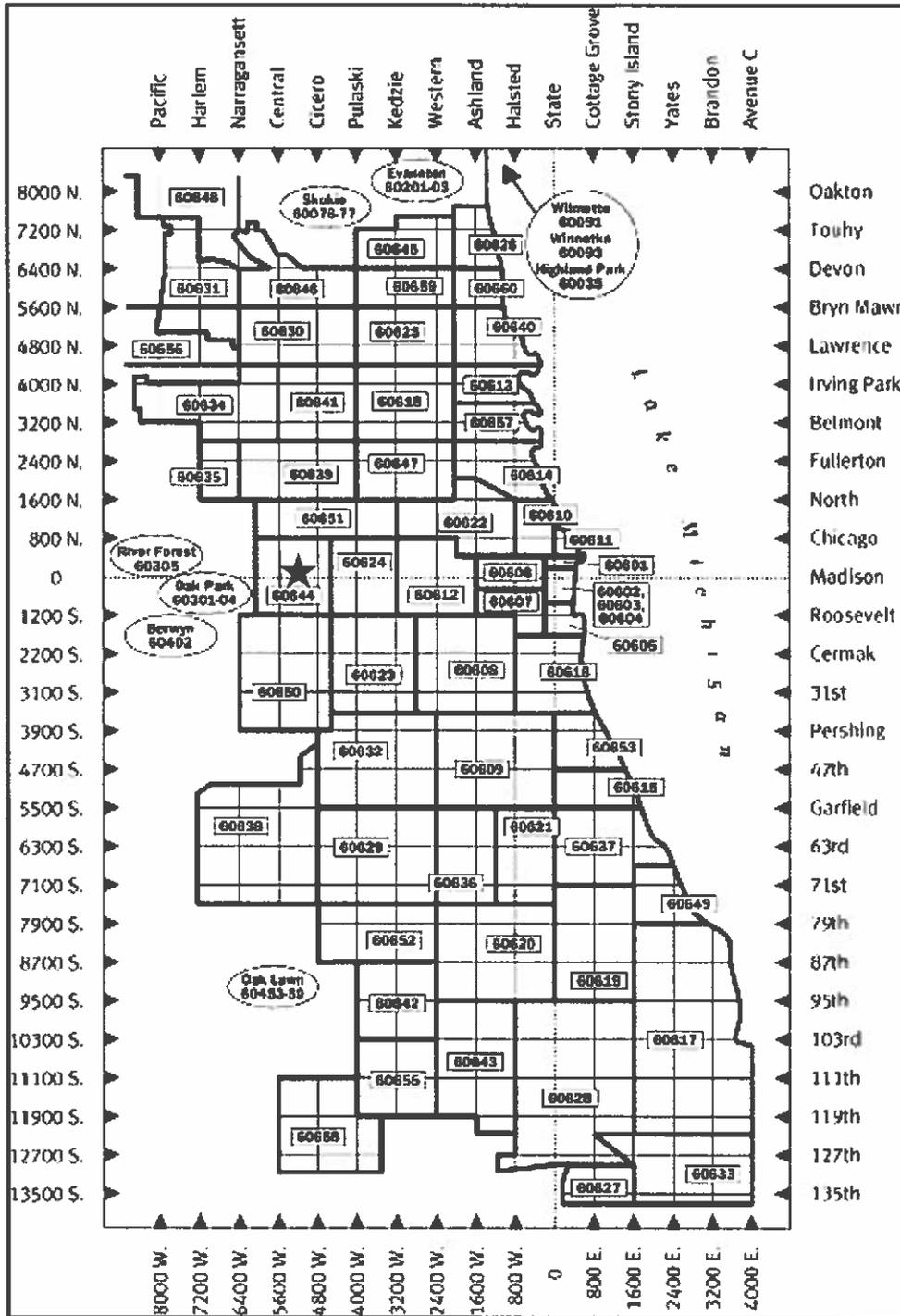


EXHIBIT A

Part 2 – General Description of Project

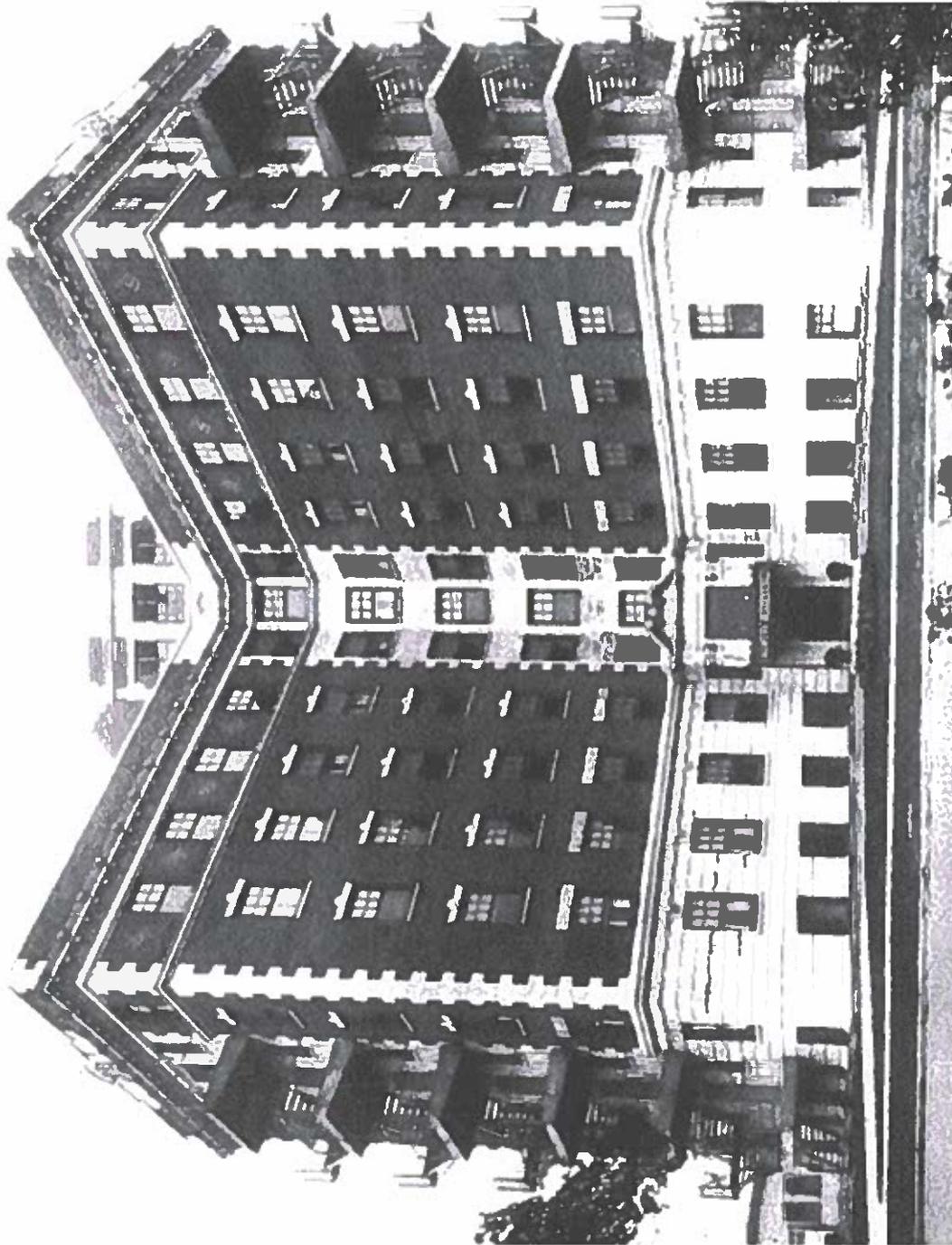
The Applicant will be constructing its In-Center Hemodialysis Facility in an existing space within Loretto Hospital. Photographs of the exterior of the Project Site are provided below.

Elevation: Facing East (2018)



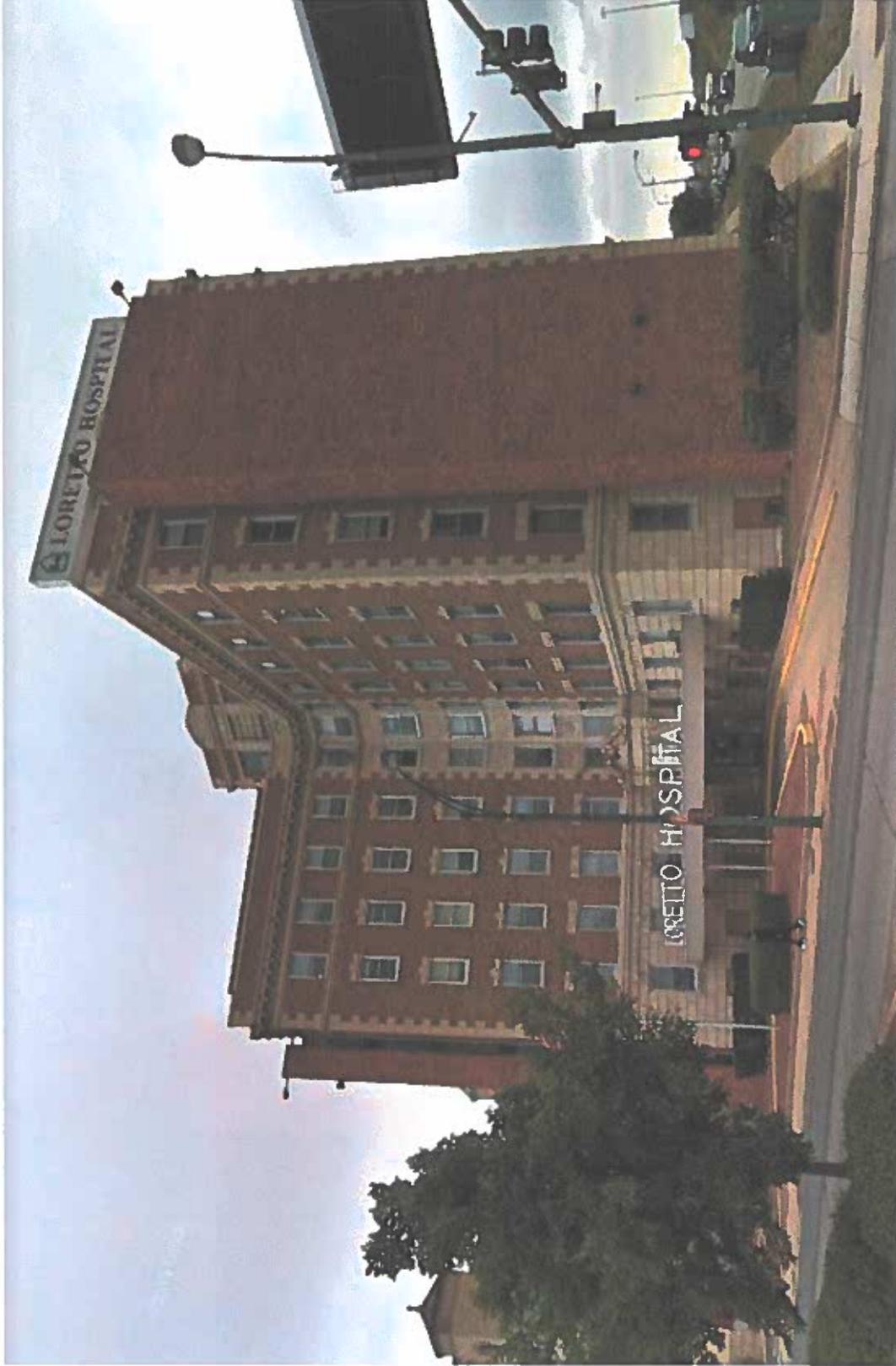
Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Elevation: Facing East (1923)



Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Elevation: Facing East/Northeast (2018)



Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Elevation: Facing West/Southwest



Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Note 2: If exterior changes are required, this side of the building would be the most likely location (i.e., off of Flournoy Street) to be modified for the proposed In-Center Hemodialysis Facility.

Elevation: Facing East/Northeast



Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Note 2: If exterior changes are required, this side of the building would be the most likely location (i.e., off of Flournoy Street) to be modified for the proposed In-Center Hemodialysis Facility.

Elevation: Facing South



Note: Minimal changes will be made to the exterior of this structure. The architect will match the existing building materials so that exterior changes will blend with the current image.

Note 2: The south elevation of Loretto Hospital is largely blocked by the Plato School.

EXHIBIT B

Photographs of Structures Adjacent to the Project Site

The buildings immediately adjacent to the Project Site may have historic or architectural significance; however, as of July 2018, none are officially listed on the National Register of Historic Places. Immediately to the North is the Assumption Greek Orthodox Church and Plato School, 601 S Central Ave, Chicago, IL 60644. To the north, across West Harrison Street, is a parking lot, some dilapidated structures, a small church, and Loretto's health clinic. Immediately to the South is Interstate 290. To the East is a parking lot and a row of Chicago-style brownstone three-flats. Columbus Park is to the West of the Project Site across South Central Avenue.

PROJECT SITE – AERIAL VIEW

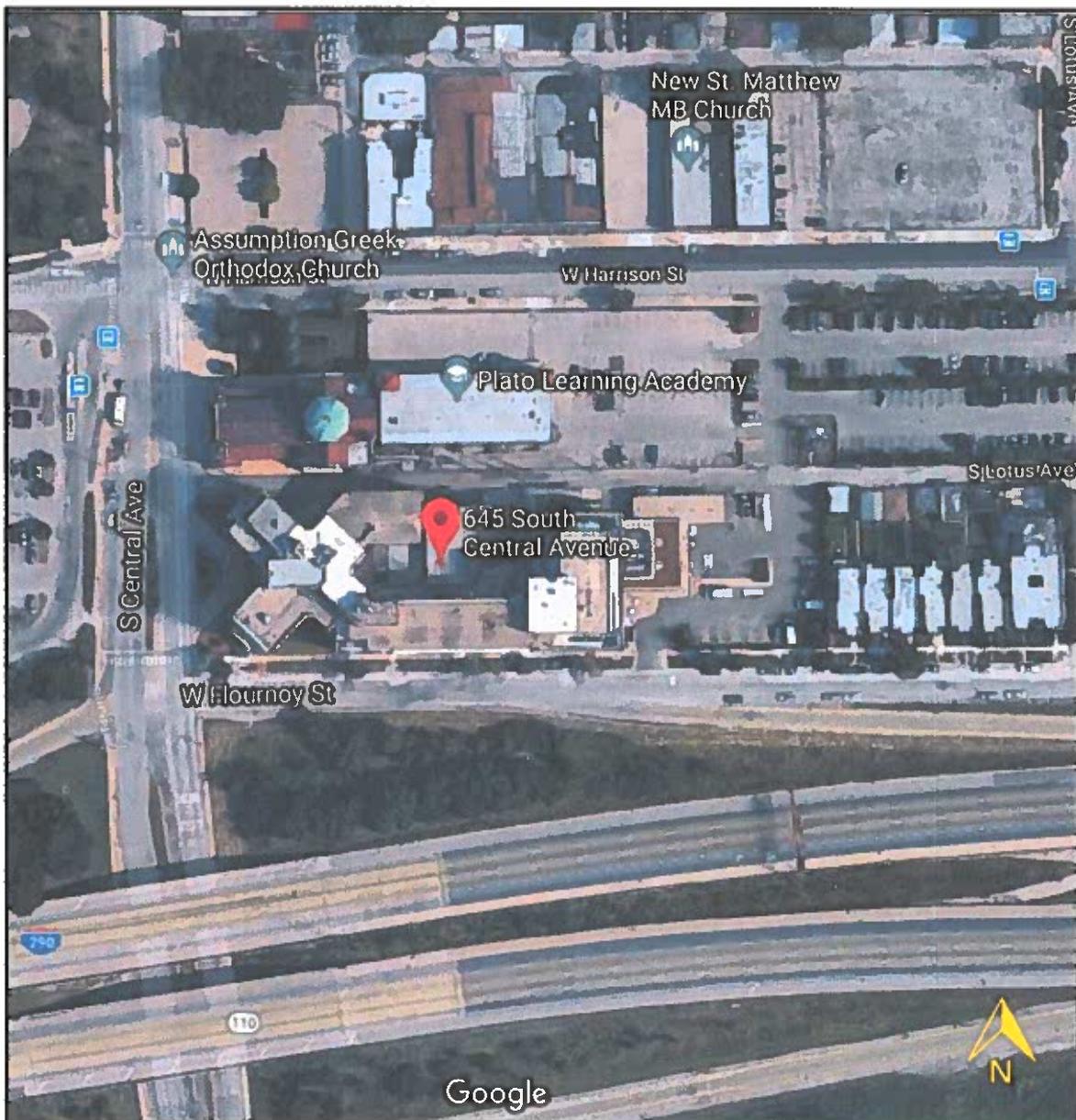


EXHIBIT B

Photographs of Structures Adjacent to the Project Site



1. Assumption Greek Orthodox Church
2. Plato School at Assumption GOC
3. Assumption GOC Parking Lot
4. Three-Story Building, 5558 W. Harrison St.
5. Empty Parking Lot (Buildings Razed)
6. New St. Matthew Church/Loretto Clinic
7. Chicago Brownstones
8. Interstate 290
9. Columbus Park

Note: The image to the left, and most of the following images, taken from Google Maps.

Note: Additional photographs of the adjacent structures immediately follows this page.

NORTH OF THE PROJECT SITE

Just north of the Project Site is the Assumption Greek Orthodox Church (“Church”). The Church is immediately adjacent to Loretto Hospital’s north wall and is separated only by a narrow alley. The Church is eligible for listing in the National Register of Historic Places (“NRHP”) under Criterion C and Criteria Consideration A as an excellent example of the Byzantine architectural style applied to a religious building and designed by a local master architect. The Church was constructed from 1937 until 1938 and was designed by architect Peter E. Camburas.

The Byzantine-style, three-story masonry structure has a cruciform footprint. Located within the residential Austin neighborhood in Chicago, the Church is oriented west across South Central Avenue toward Columbus Park. It has proximate southwest views toward I-290 from the west-facing façade, though they are partially obstructed by mature trees in Columbus Park, and the South Central Avenue bridge. Views directly south from the Church are blocked by the adjacent Loretto Hospital.

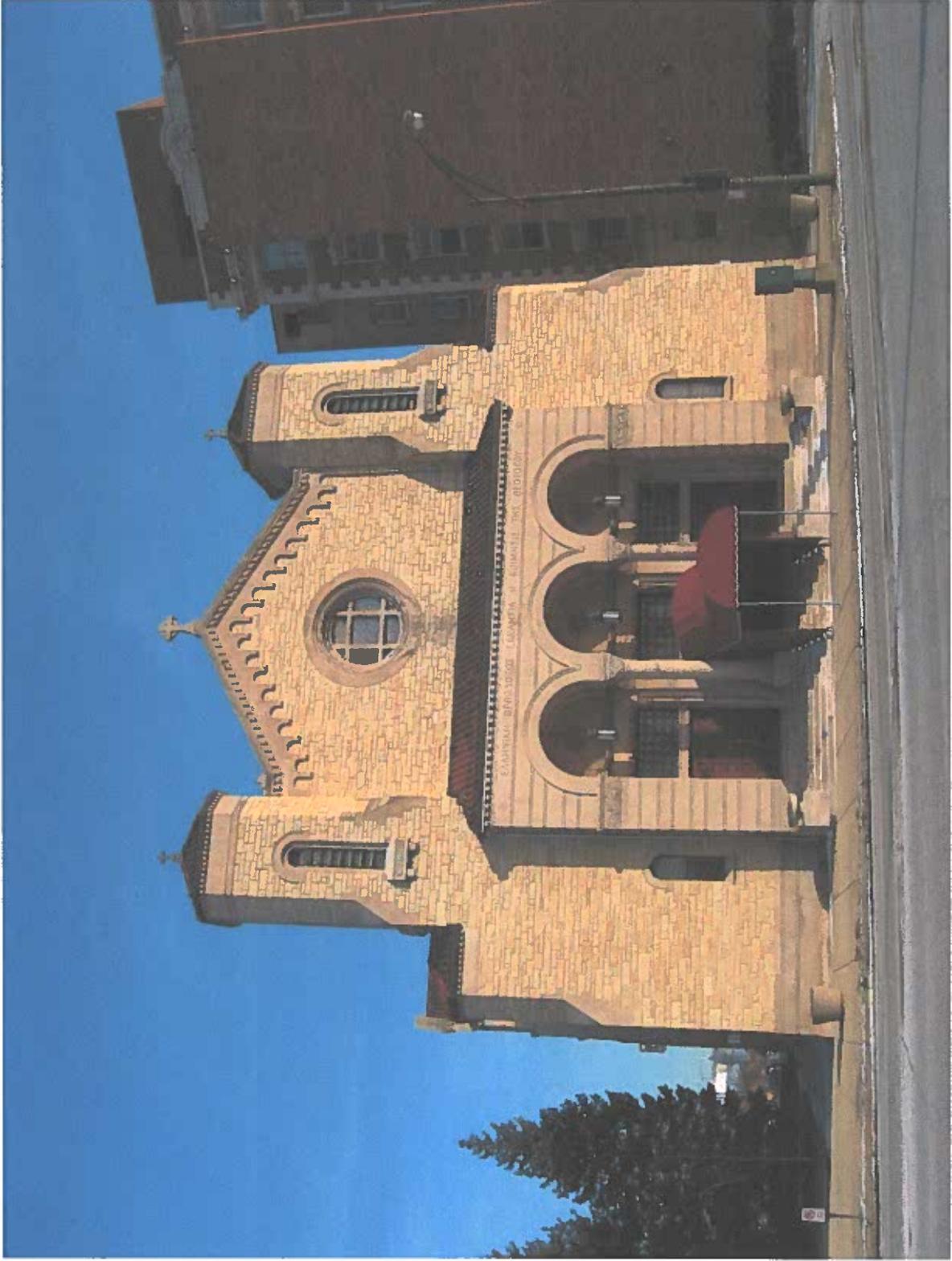
The Church building is historically significant for its design that exemplifies Byzantine design principles as applied to a religious building; however, the site only retains moderate integrity of setting due to changes in its western viewshed in Columbus Park and the construction of I-290 in the 1950s to the South of the Church, though views to I-290 are partially blocked by the adjacent Loretto Hospital.

If the Applicant is required to do work to the exterior of the hospital building, all of the work would likely be on the Hospital’s south side and out of the Church’s viewpoints. Importantly, all potential exterior work would occur on Flournoy Street, well outside of the Church’s NRHP boundary. The intervening, multi-story Loretto Hospital immediately to the Church’s south obstructs views between the building and also creates a substantial noise barrier.

The Project will likely involve minimal work to the Hospital’s exterior. Any exterior work that might be done will take place on the Hospital’s south side along Flournoy Street, which is well outside of the Church’s NRHP boundary, would be well-hidden from any viewsheds from the Church. Based on these facts, the Project would have no adverse effect to the historic property’s integrity of setting. Furthermore, no Project-related activity would alter the Church’s feeling as an excellent example of the Byzantine architectural style as applied to a religious building and designed by a local master architect or its association with that style or architect. Therefore, Project implementation would have no effect to the Church property’s integrity of feeling or association.

Based on this evaluation, the proposed Project would have no adverse effect to the Church.

The remaining structures to the North of the Project Site do not appear to have any architectural or historic significance.



Above: Assumption Greek Orthodox Church, 601 S. Central Avenue, Chicago, IL



Google

View of Church from Corner of S. Central Avenue & W. Harrison Street – Looking Southeast



View of Church and Loretto Hospital, Facing East, Showing the Alley Separating the Two Structures



Another View of Church/Plato School and Loretto Hospital, Facing West, Showing the Alley Separating the Two Structures



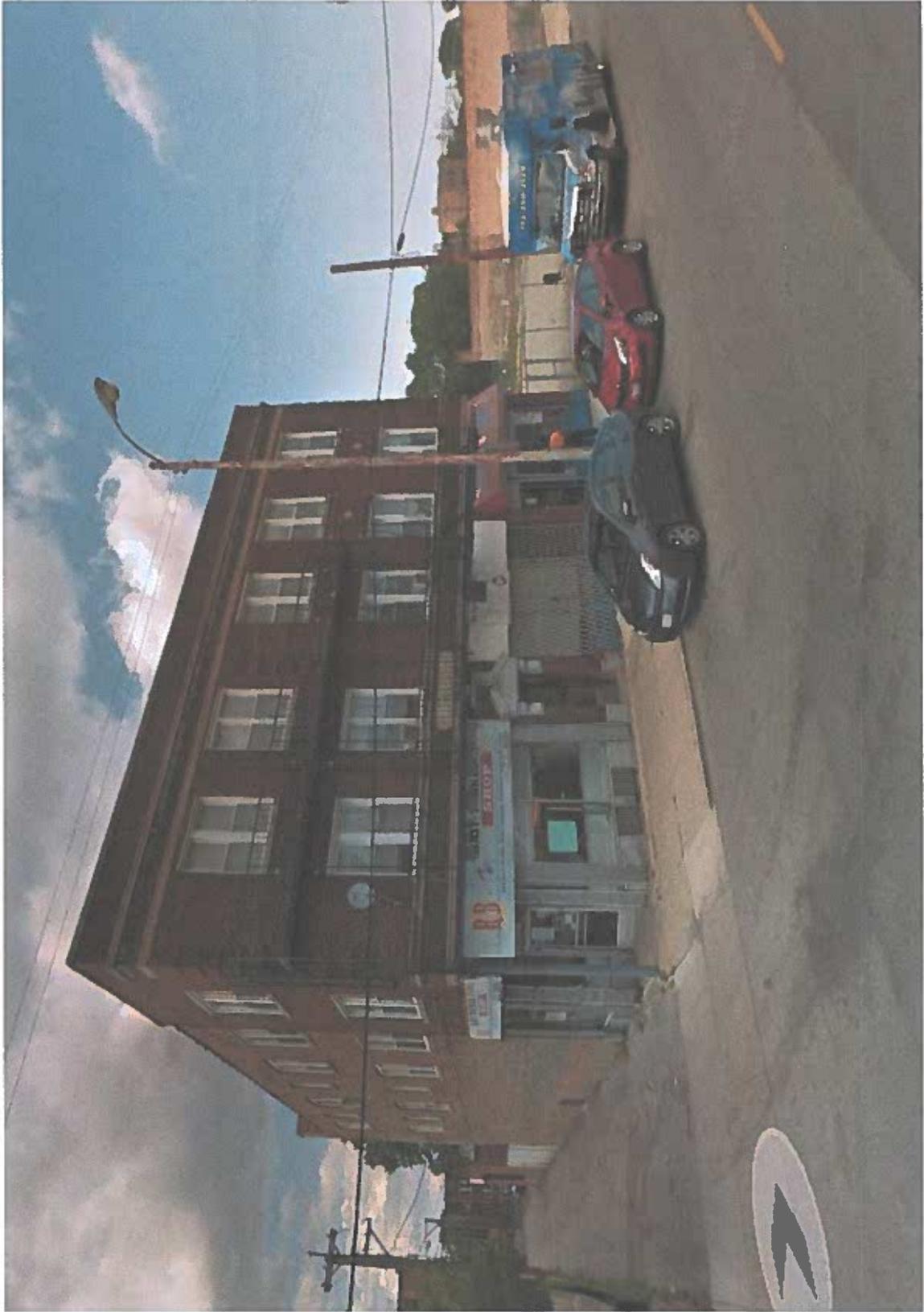
Another View of Church/Plato School (South Elevation)



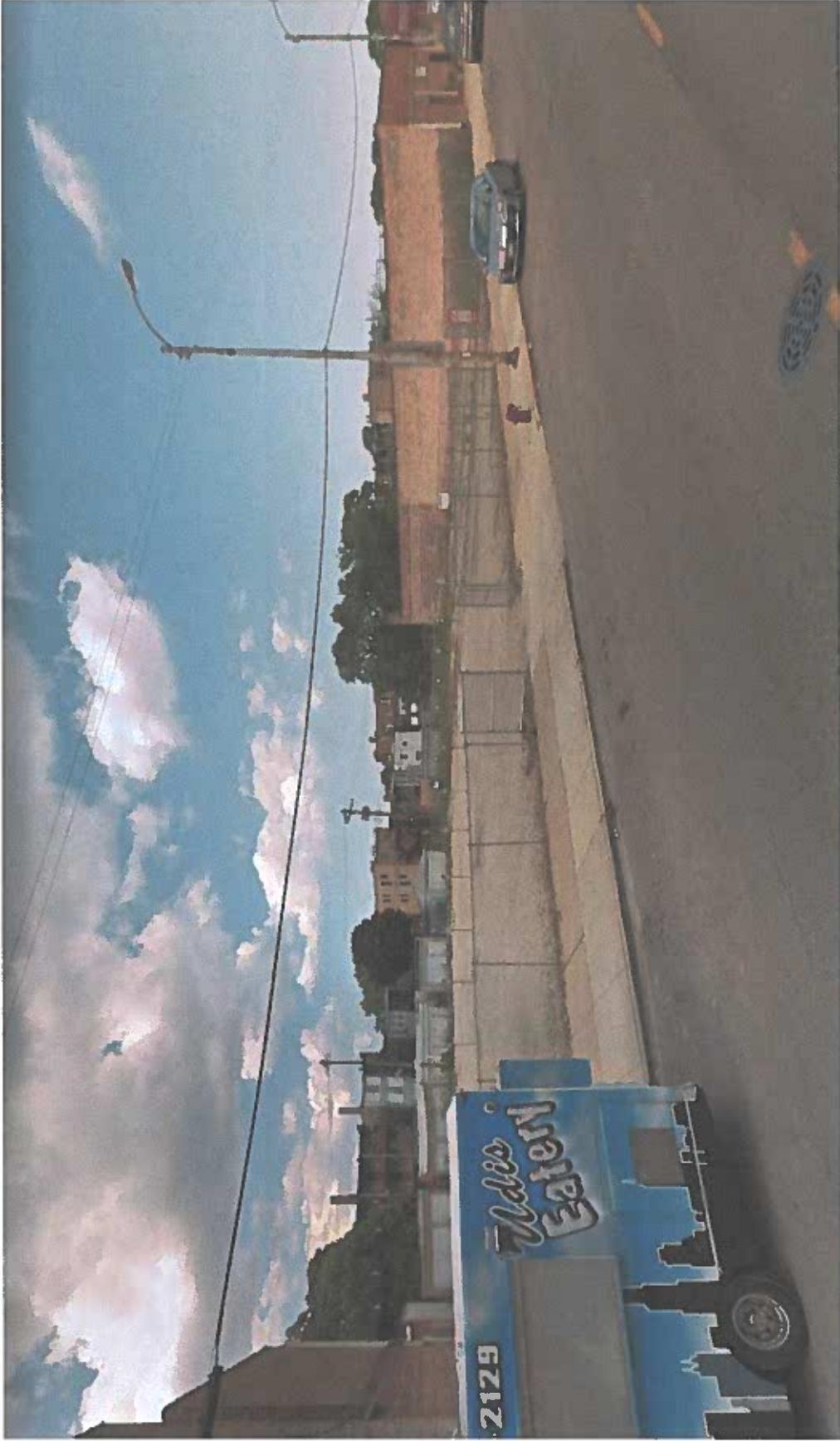
View of Plato School and Three-Story Building (5558 West Harrison Street), Church Parking Lot to the Left



View of the Northeast Corner of South Central Avenue & West Harrison Street, Showing Church Parking Lot



5558 West Harrison Street



Empty Parking Lot on North Side of West Harrison Street, between 5558 and 5530 West Harrison Street



5558 West Harrison Street
The New St. Matthew M.B. Church Occupies the Left Side of the Building;
Loretto Hospital Health Center Occupies the Right Side of the Building



View Down West Harrison Street, Facing West, Showing Loretto Clinic on Right. Hospital Parking Lot on the Left.



Loretto Hospital Parking Lot – To the East of the Hospital Building.



Loretto Hospital Parking Lot – To the East of the Hospital Building, Showing the Back of the Brownstones on Flourney.



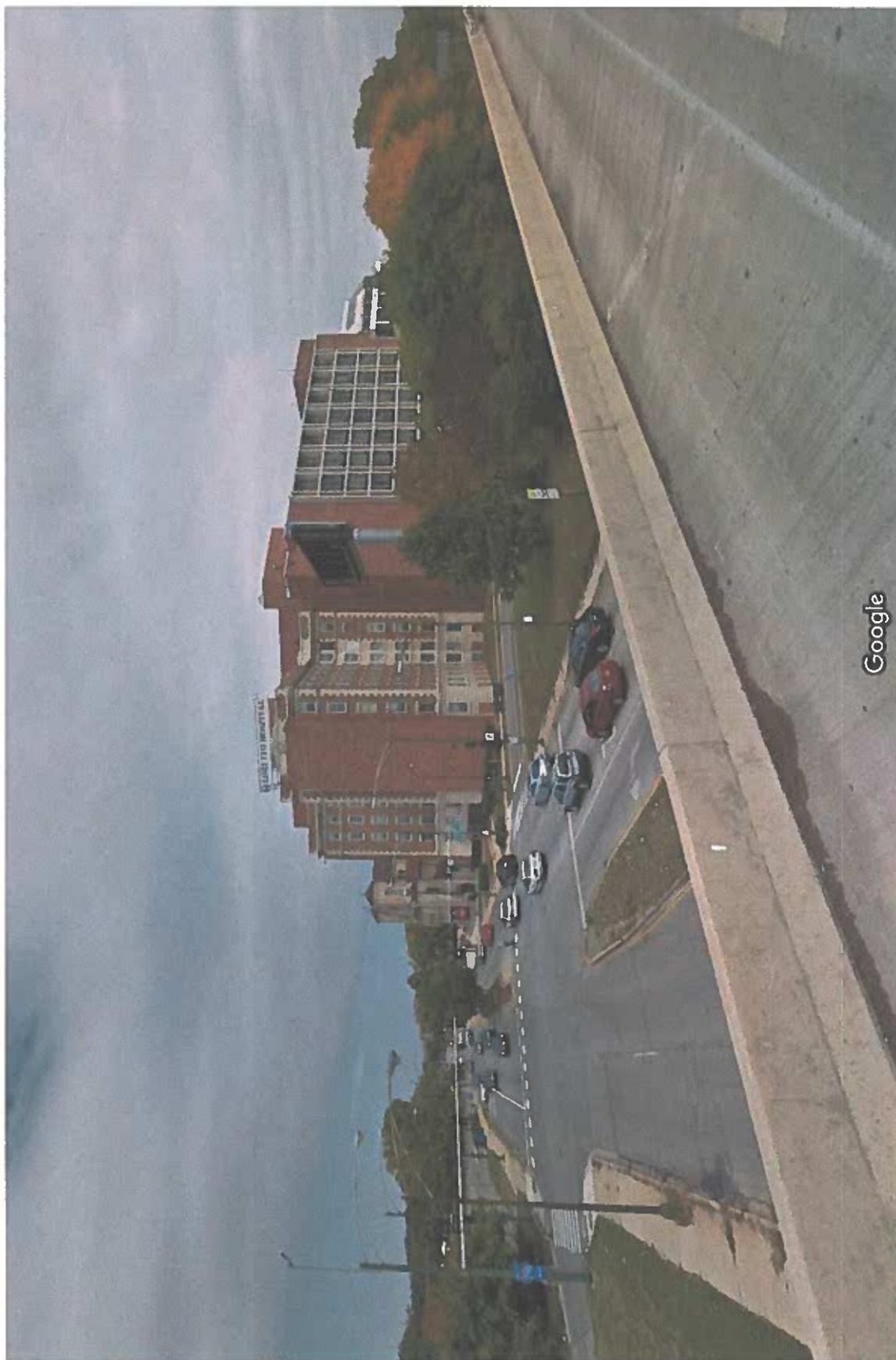
Loretto Hospital Parking Lot – To the East of the Hospital Building, Showing the Alley

SOUTH OF THE PROJECT SITE

There are no structures to the South of the Project Site. To the south of Loretto Hospital is Interstate 290.



View Looking West Down Flournoy Street



Google

View of Loretto Hospital From Interstate 290, Facing Northeast



View of Hospital's North Elevation, Facing Northwest on Flournoy Street.

EAST OF THE PROJECT SITE

The structures to the East of the Project Site also do not appear to have any historic or architectural significance. On Flourmoy Street, there are five three-flat brownstones. None of these structures appear to have any known historical significance.



5500 Block of West Flourmoy Street, Showing Chicago-Style Three-Flat Brownstones (None Appear to Have Historical Significance)



View Down West Flourney Street, Facing Northwest, Showing Loretto Hospital in Background

WEST OF THE PROJECT SITE

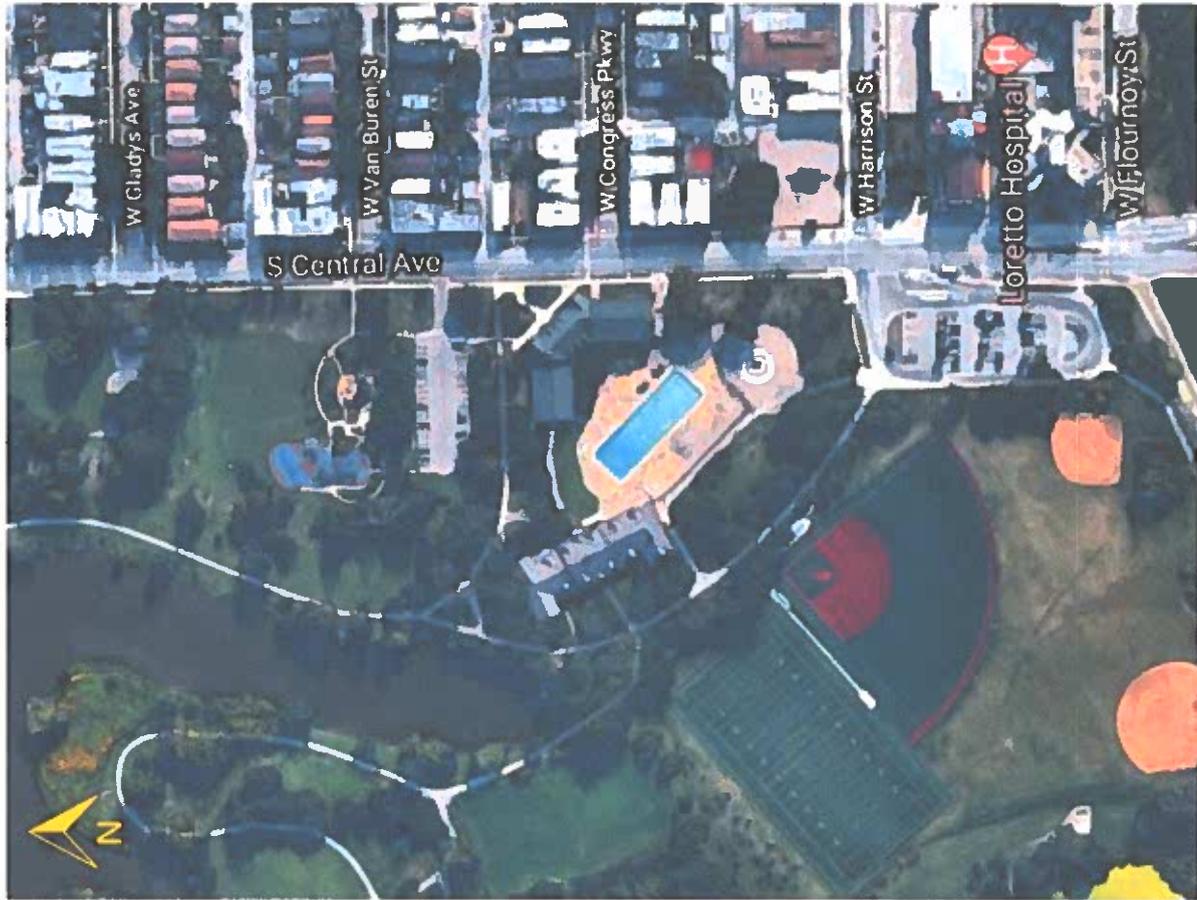
Immediately to the West of the Project Site, across South Central Avenue, is Columbus Park. Columbus Park is listed on the National Register of Historic Places. However, the Project will be mostly interior work and the Project Site will involve little to no exterior work. Furthermore, any work would likely be hidden by Assumption Greek Orthodox Church of by the hospital building.



A Parking Lot is Across South Central Avenue to the West of Loretto Hospital. View is Facing Northwest Across S. Central Ave.



Parking Lot to the West of Loretto Hospital, Across South Central Avenue. View Facing East Across South Central Ave.



Aerial View of Columbus Park, Bordering on South Central Avenue, Adjacent to Loretto Hospital

ATTACHMENT 7

Project Costs and Sources of Funds

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$0	\$0	\$0
Site Survey and Soil Investigation	\$0	\$0	\$0
Site Preparation	\$0	\$0	\$0
Off Site Work	\$0	\$0	\$0
New Construction Contracts	\$0	\$0	\$0
Modernization Contracts	\$705,500.00	\$0	\$705,500.00
Contingencies	\$70,500.00	\$0	\$70,500.00
Architectural/Engineering Fees	\$71,500.00	\$0	\$71,500.00
Consulting and Other Fees	\$0	\$50,000.00	\$50,000.00
Movable or Other Equipment (not in construction contracts)	\$288,000.00	\$56,000.00	\$344,000.00
Bond Issuance Expense (project related)	\$0	\$0	\$0
Net Interest Expense During Construction (project related)	\$0	\$0	\$0
Fair Market Value of Leased Space	\$432,169.00	\$0	\$432,169.00
Fair Market Value of Leased Equipment	\$288,000.00	\$0	\$288,000.00
Other Costs To Be Capitalized	\$0	\$0	\$0
Acquisition of Building or Other Property (excluding land)	\$0	\$0	\$0
TOTAL USES OF FUNDS	\$1,855,169.00	\$106,000.00	\$1,961,169.00
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash	\$71,500.00	\$50,000.00	\$121,500.00
Securities	\$167,750.00	\$0	\$167,750.00
Pledges	\$0	\$0	\$0
Gifts and Bequests	\$0	\$0	\$0
Bond Issues (project related)	\$0	\$0	\$0
Mortgages	\$0	\$0	\$0
Leases (fair market value) Space	\$264,419.00	\$0	\$264,419.00
Leases (fair market value) Equipment	\$288,000.00	\$0	\$288,000.00
Governmental Appropriations	\$0	\$0	\$0.00
Grants	\$0	\$0	\$0.00
Other Funds and Sources (loans)	\$1,063,500.00	\$56,000.00	\$1,119,500.00
TOTAL SOURCES OF FUNDS	\$1,855,169.00	\$106,000.00	\$1,961,169.00

ITEMIZED EQUIPMENT LIST

Fixtures, Furniture & Movable Equipment

<u>Item(s)</u>	<u>Cost</u>	<u>Purchase</u>	<u>Lease</u>
Dialysis Chairs (12) *	\$18,000	X	
Fresenius 2008T Dialysis Machines (12) *	\$288,000		X
Miscellaneous Clinical Equipment *	\$25,000	X	
Computers ♦	\$7,500	X	
Clinical Furniture & Equipment *	\$25,000	X	
Office Equipment & Other Furniture ♦	\$25,000	X	
Water Treatment *	\$135,000	X	
TVs and Accessories (12) ♦	\$6,000	X	
Telephones ♦	\$12,500	X	
Generator *	\$65,000	X	
Facility Automation *	\$20,000	X	
Other Miscellaneous Items ♦	\$5,000	X	
TOTAL	\$632,000	\$344,000	\$288,000

* clinical equipment

♦ non-clinical equipment

PURCHASED EQUIPMENT

<u>Clinical Equipment</u>	<u>Cost</u>	<u>Non-Clinical Equipment</u>	<u>Cost</u>
Dialysis Chairs	\$18,000	Computers	\$7,500
Misc. Clinical Equipment	\$25,000	Office Equipment/Furniture	\$25,000
Clinical Furniture/Equipment	\$25,000	TVs and Accessories	\$6,000
Water Treatment	\$135,000	Telephones	\$12,500
Generator	\$65,000	Other Misc. Items	\$5,000
Facility Automation	\$20,000		
TOTAL	\$288,000	TOTAL	\$56,000

LEASED EQUIPMENT

Fresenius Dialysis Machines	\$288,000
-----------------------------	-----------

ATTACHMENT 8

Project Status and Completion Schedules

- Architectural drawings are provided immediately following this page.
- The anticipated project completion date is January 31, 2021, which assumes CON approval at the August 6, 2019 State Board meeting. If the State Board does not grant a CON permit on this particular hearing date, it will become necessary to identify a later project completion date.
- Financial commitment will occur after permit issuance. The Project's funds will come from five sources: (1) cash; (2) securities; (3) the fair market value of a real property lease; (4) the fair market value of an equipment lease; and (5) a bank loan. The total project cost includes the fair market value of rent to be paid over the five (5) year term of the property lease and the five (5) year term of an equipment lease.

DEMOLITION LEGEND

DEMOLITION NOTES

1. ALL EXISTING WALLS, CEILING, FLOOR, AND MECHANICAL SYSTEMS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

2. ALL EXISTING PARTITIONS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

3. ALL EXISTING DOORS AND WINDOWS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

4. ALL EXISTING STAIRS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

5. ALL EXISTING ELEVATORS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

6. ALL EXISTING MECHANICAL SYSTEMS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

7. ALL EXISTING ELECTRICAL SYSTEMS TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

8. ALL EXISTING PIPING TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

9. ALL EXISTING ROOFING TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

10. ALL EXISTING EXTERIOR FINISHES TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

11. ALL EXISTING INTERIOR FINISHES TO BE DEMOLISHED UNLESS OTHERWISE NOTED.

12. ALL EXISTING PAINT TO BE REMOVED UNLESS OTHERWISE NOTED.

13. ALL EXISTING GLASS TO BE REMOVED UNLESS OTHERWISE NOTED.

14. ALL EXISTING METALS TO BE REMOVED UNLESS OTHERWISE NOTED.

15. ALL EXISTING WOOD TO BE REMOVED UNLESS OTHERWISE NOTED.

16. ALL EXISTING CONCRETE TO BE REMOVED UNLESS OTHERWISE NOTED.

17. ALL EXISTING BRICK TO BE REMOVED UNLESS OTHERWISE NOTED.

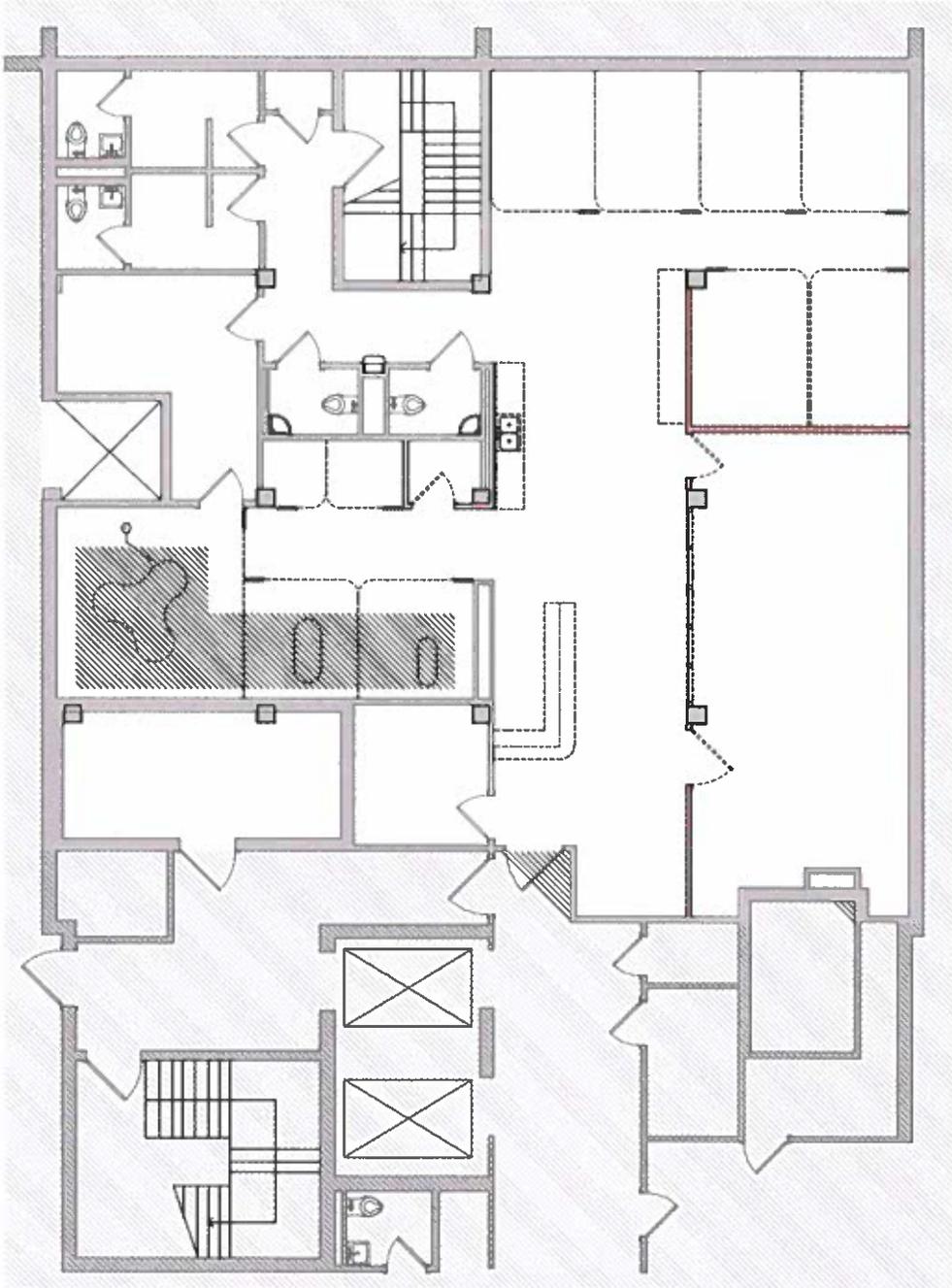
18. ALL EXISTING BLOCK TO BE REMOVED UNLESS OTHERWISE NOTED.

19. ALL EXISTING MASONRY TO BE REMOVED UNLESS OTHERWISE NOTED.

20. ALL EXISTING STRUCTURAL ELEMENTS TO BE REMOVED UNLESS OTHERWISE NOTED.

SHEET NOTES

1. SEE SHEET 01-100 FOR GENERAL NOTES.



1:00 Scale

Demolition Plan | AD-10
The Loretto Hospital
Osgood Dayton Treatment Center

ICEKHOFF SAUNDERS ARCHITECTS
© 2014 ICEKHOFF SAUNDERS ARCHITECTS

645 S Central Ave, Chicago, IL 60644 Project No: 14057 Date: 04/27/2014

ATTACHMENT 8
Project Status and Completion Schedules



Interior Views | A8.1
The Loretto Hospital
Outpatient Daycare Treatment Center
645 S Canal Ave, Chicago, IL 60644
Project No: 15207 Date: 06/07/2018

Interior Views | A8.1
KCEINHOF SAUNDERS ARCHITECTS

ATTACHMENT 8
Project Status and Completion Schedules



Interior Views | A3.2

The Loretto Hospital
Outpatient Diagnostic Treatment Center

645 S Central Ave. Chicago, IL 60644

Project No: 16037

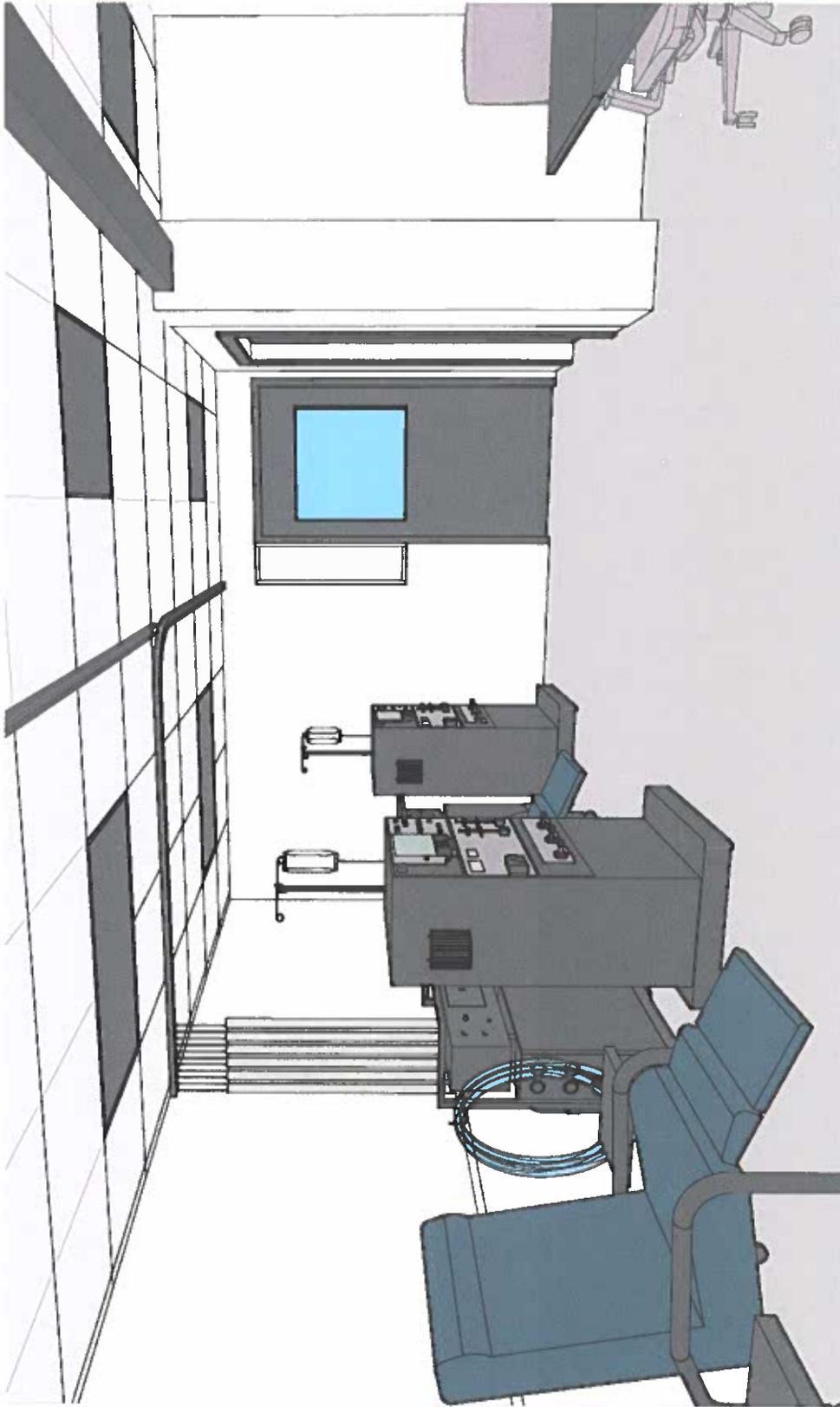
Date: 06/07/2010

Interior Views | A3.2

ECKINDIS SAUNDERS ARCHITECTS

© 2010 Eckindis Saunders Architects, Inc.

ATTACHMENT 8 Project Status and Completion Schedules



Interior Views - A3.3

The Lorain Hospital
Occupant Daycare Treatment Center

645 S Central Ave, Chicago, IL 60644

Project No: 10037

Date: 05/07/2019

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ATTACHMENT 8
Project Status and Completion Schedules



March 26th, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courney Avery, Administrator

**Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements
Austin Dialysis at Loretto Certificate of Need Permit Application**

Dear Ms. Avery:

It is my understanding that Austin Dialysis Center, LLC, an Illinois limited liability company doing business as Austin Dialysis at Loretto ("Applicant"), is applying for a certificate of need ("CON") permit to establish an in-center hemodialysis facility ("ESRD Facility") at 645 South Central Avenue, Chicago, Illinois 60644 ("Project"). In the CON permit application, the Applicant indicates that the total cost of the Project is \$1,000,000 ("Project Cost"). Of that amount, \$300,000 represents the fair market value of lease agreements and \$700,000 represents equipment and tenant improvements. Accordingly, the Applicant needs a bank loan for \$700,000 to fund the balance of the Project Cost.

I, Michael Gilbert, submit this letter for the Applicant, to certify that, as of March 26th, 2019, the Applicant and his accumulated business interests have a sufficient credit history and our bank will consider issuing a loan to the Applicant in the amount of \$700,000 to cover the balance of the total Project Cost. If you have questions, please do not hesitate to contact me at 815.751.3736. Thank you very much.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Michael Gilbert", with a long horizontal flourish extending to the right.

Michael Gilbert
Vice President
STC Capital Bank
St. Charles, IL 60174

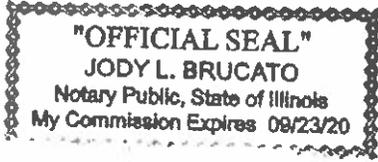
NOTARY:

Subscribed and sworn to me this 1st day of April, 2019

Jody L. Brucato

Notary Public

Seal:





March 26th, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courney Avery, Administrator

**Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements
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Dear Ms. Avery:

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Respectfully Submitted,

A handwritten signature in black ink, appearing to read "M Gilbert", written over a horizontal line.

Michael Gilbert
Vice President
STC Capital Bank
St. Charles, IL 60174

NOTARY:

Subscribed and sworn to me this _____ day of _____, 2019

Notary Public _____

Seal:

This proposal is intended as an outline only and does not purport to summarize all of the conditions, covenants, representations, warranties, and other provisions that would typically be contained in definitive legal documentation. Any commitment by STC Capital Bank, if and/or when issued, will be subject to negotiation and execution of definitive loan documents in form and substance satisfactory to the Borrower, STC Capital Bank, and their respective counsels.

FACILITY 1

Amount: \$700,000

Borrower: Austin Dialysis Center LLC, Dr. Sameer Suhail, Dr. Dena Suhail,, AICG

Purpose: Equipment and tenant improvement at 645 South Central Avenue Chicago, Illinois 60644

Rate: 6%

Term: 72-month term

Amortization: 12-months Interest only, 60 months Principal and Interest

Security: Blanket first lien on all assets. Specifically, Fresenius Dialysis Machines and future accounts receivable of Austin Dialysis and full guarantee of Dr. Sameer and Dena Suhail and also AICG.

Pre-Payment: No Pre-Payment Penalty

Repayment: Interest-only for 12 months then Principal and Interest Payments over the final 60 months.

Banking Relationship: The client will be required to maintain a full banking relationship with STC Capital Bank for the property and any reserve accounts.

Due Diligence: Purchase contract for new Kidney Dialysis Machines, contractors sworn statement of tenant improvements, documentation of other miscellaneous FF&E

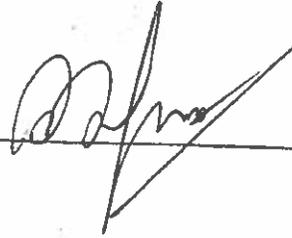
Origination Fee: 1%

Documentation Fee: \$500



ACCEPTANCE:

Dr. Sameer Suhail



Michael Gilbert
STC Capital Bank
460 South First Street
St. Charles, IL 60174



ATTACHMENT 9

Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That IS:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ESRD Facility (In-Center Dialysis)	\$1,855,169	2,750	2,750		2,750		
<i>Total Clinical</i>	<i>\$1,855,169</i>	<i>2,750</i>	<i>2,750</i>		<i>2,750</i>		
Non-Reviewable							
Non-Clinical Space (e.g., non-clinical space, such as administrative office space, waiting room and reception areas, medical record storage).	\$106,000	0	0		0		
<i>Total Non-clinical</i>	<i>\$106,000</i>	<i>0</i>	<i>0</i>		<i>0</i>		
TOTAL	\$1,961,169	2,750	2,750		2,750		

Notes:

- The entire ESRD facility proposed in this application should be considered clinical space. However, non-clinical expenses included in the project budget include consulting and related fees (e.g., attorney fees) and some non-clinical fixtures and furniture.
- There will be no co-mingling of clinical space between the Applicant and Loretto Hospital.
- Patients of the ESRD facility will gain access to the facility using Loretto Hospital's main lobby and certain elevator banks and stairwells. Loretto Hospital will not share patient registration space or waiting areas with the Applicant.
- While Loretto Hospital's main lobby and certain elevator banks and stairwells will be used by the Applicant's patients to gain access to the proposed ESRD facility, this non-clinical space will belong solely to the hospital.

ATTACHMENT 11

Background of Applicant

Criterion 1110.110(a) -- Background of Applicant

The primary CON permit applicant, Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto ("Applicant") is fit, willing, and able, and has the qualifications, background, character, and financial resources to adequately provide a proper service for the community. The Applicant also states that the project will promote the orderly and economic development of health care facilities or services in the State of Illinois.

(a) List of all Health Care Facilities Owned/Operated by the Applicant.

The Applicant is a newly-formed business and does not presently own or operate any health care facilities in Illinois.

(b) List of all Health Care Facilities Owned/Operated by Persons with Ownership of 5% or Greater or Persons Who Are Officers or Directors of the Applicant.

(1) Austin Dialysis at Loretto: Sameer K. Suhail, M.D.

None

(2) Loretto Hospital: Co-Applicant

The Immediate Care Center of Oak Park
1000 Madison Avenue
Oak Park, Illinois 60302

The Loretto Hospital Outpatient Mental Health Program at Symphony West
5130 West Jackson Blvd
Chicago, IL 60644

Loretto Primary/Immediate Care Berwyn
6905 Cermak Rd, Ste A
Berwyn, IL 60402

(c) Certifications

A certified letter is attached immediately following this Attachment 11. The certification provides as follows: (1) no adverse action has been taken against the Applicant or any facility, owner, or officer/director of the Applicant, nor does any such person have an adverse criminal or civil ruling, decision, etc. that would preclude them from owning and operating a health care facility; and (2) the Illinois Health Facilities and Services Review Board and the Illinois

Department of Public Health are authorized to obtain information regarding this CON permit application.

May 7, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

Re: Background of Applicant

Dear Ms. Avery:

Pursuant to State Board Review Criterion 1110.1540(b)(3), in regard to the background of the applicant Austin Dialysis Center, LLC (“Applicant”), I hereby certify that no adverse action has been taken against the Applicant or any facility owned and/or operated by the Applicant during the three year period before the date on which the Applicant will file its certificate of need permit application to establish an in-center hemodialysis facility at 645 South Central Avenue, Chicago, Illinois 60644. Furthermore, an exhibit is attached to this certification letter, which identifies each applicant, corporate officer, director, LLC member, partner, and owner of at least five percent (5.0%) of the entity that will own and operate the proposed health care facility.

I hereby certify that the individuals who have been identified on this list: (i) have not been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to: (a) the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or (b) been the subject of any juvenile delinquency or youthful offender proceeding; (ii) have not been charged with fraudulent conduct or any act involving moral turpitude; (iii) do not have any unsatisfied judgments against him or her; and (iv) is not in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order, or directive of any court or governmental agency.

Respectfully Submitted,

Sameer K. Suhail, M.D.
President & CEO
Austin Dialysis Center, LLC

NOTARY:

Subscribed and sworn to me this 9th day of May, 2019

Melinda S Malecki
Notary Public

Seal:

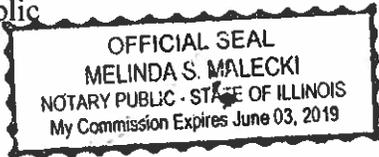


EXHIBIT A

Ownership Interests 5.0% or Greater

Name	Entity/Individual	Ownership %
Sameer K. Suhail, M.D.	Individual	100.0%
Loretto Hospital *	Not-for-Profit Entity	0.0%
TOTAL		100.0%

NOTE: Following the issuance of a CON permit, Loretto Hospital will acquire up to 49% of the membership units in the ESRD facility company.

May 7, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

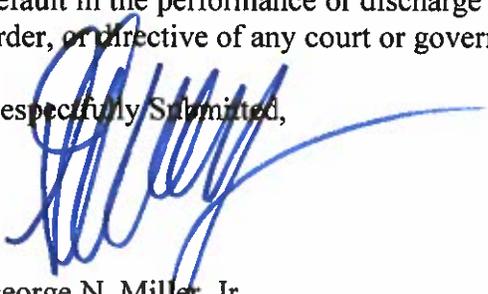
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I hereby certify that the individuals who have been identified on this list: (i) have not been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to: (a) the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or (b) been the subject of any juvenile delinquency or youthful offender proceeding; (ii) have not been charged with fraudulent conduct or any act involving moral turpitude; (iii) do not have any unsatisfied judgments against him or her; and (iv) is not in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order, or directive of any court or governmental agency.

Respectfully Submitted,


George N. Miller, Jr.
President & CEO
Loretto Hospital

NOTARY:

Subscribed and sworn to me this 9th day of May, 2019

Melinda S. Malecki
Notary Public

Seal:

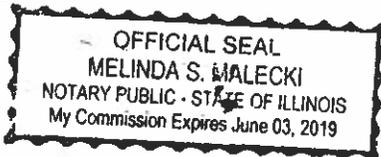


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Loretto Hospital *	Not-for-Profit Entity	0.0%
TOTAL		100.0%

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May 7, 2019

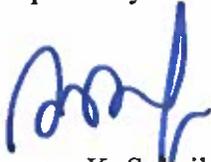
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

Re: Access to Documents and Records

Dear Ms. Avery:

The CON permit applicant Austin Dialysis Center, LLC (“Applicant”) hereby permits the Illinois Health Facilities and Services Review Board (“State Board”) and the Illinois Department of Public Health (“IDPH”) to have access to any documents necessary to verify the information submitted in the certificate of need permit application submitted by the Applicant, including, but not limited to: (i) official records of IDPH or other State of Illinois agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of nationally recognized accreditation organizations.

Respectfully Submitted,



Sameer K. Sultail, M.D.
President & CEO
Austin Dialysis Center, LLC

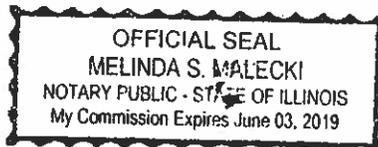
NOTARY:

Subscribed and sworn to me this 9th day of May, 2019



Notary Public

Seal:



May 7, 2019

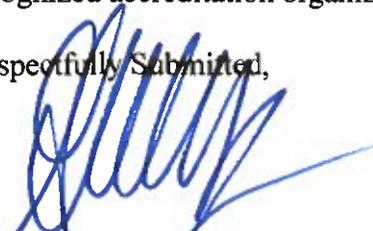
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Respectfully Submitted,

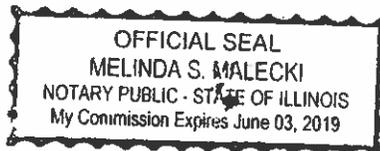

George N. Miller, Jr.
President & CEO
Loretto Hospital

NOTARY:

Subscribed and sworn to me this 9th day of May, 2019

Melinda S. Malecki
Notary Public

Seal:



ATTACHMENT 12

Criterion 1110.110(b) -- Purpose of the Project

1. The certificate of need permit applicant, Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto ("Applicant"), herein requests approval from the Illinois Health Facilities and Services Review Board ("State Board") to establish an in-center hemodialysis facility ("ESRD Facility"), which will be located in leased space inside Loretto Hospital ("Project"). The Project will involve the modernization of 2,750 SQF of existing space, which is presently occupied by the hospital's physical therapy department. The scope of services that will be provided at the proposed ESRD Facility will include in-center hemodialysis. The Applicant is seeking approval to establish a 12 station ESRD facility that will operate six days a week (Monday through Saturday) with three shifts each day.

The Project will accomplish three important objectives: (1) generally address a reported need for dialysis stations in the City of Chicago/Health Service Area 6 ("HSA 6") as reported in the State Board's most recent update to the Inventory of Other Health Care Services; (2) enhance access to high-quality dialysis care in the heart of Chicago's west side, an area centered among some of Chicago's most African American neighborhoods, helping a population group which is disproportionately affected by kidney disease; and (3) advance the charitable mission of Loretto Hospital in HSA 6.

The Applicant decided to seek a certificate of need ("CON") permit from the State Board is to enhance access to care for Loretto's patients who need dialysis care. The most recent inventory of healthcare services published by the State Board shows that the health service area has a need for an additional dialysis stations. The Applicant will close the need gap by establishing the ESRD Facility, which will serve a community that is largely African-American, a population group disproportionately affected by kidney disease.

Due to high rates of diabetes, high blood pressure and heart disease, African-Americans have an increased risk of developing kidney failure. African-Americans need to be aware of these risk factors and visit their doctor or clinic regularly to check their blood sugar, blood pressure, urine protein, and kidney function.

Notably,

- African-Americans suffer from kidney failure at a significantly higher rate than Caucasians - more than 3 times higher.
- African-Americans constitute more than 35% of all patients in the U.S. receiving dialysis for kidney failure, but only represent 13.2% of the overall U.S. population.
- Diabetes is the leading cause of kidney failure in African-Americans, a population group twice as likely to be diagnosed with diabetes when compared with Caucasians. Approximately 4.9 million African-Americans over 20 years of age are living with either diagnosed or undiagnosed diabetes.

ATTACHMENT 12

15 Criterion 1110.230(a) -- Purpose of the Project

- The most common type of diabetes in African-Americans is type 2 diabetes. The risk factors for this type of diabetes include: family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity, and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than Caucasians. African Americans are also more likely to develop serious complications such as heart disease and strokes.
- High blood pressure is the second leading cause of kidney failure among African-Americans and remains the leading cause of death due to its link with heart attacks and strokes.

While it is important to add the dialysis service line to meet the healthcare needs of African-Americans, it is equally important to ensure that these patients can afford to obtain dialysis treatments. Loretto Hospital, the Co-Applicant, is a not-for-profit community-based organization with a mission to serve the Austin neighborhood and surrounding Chicago communities. As a not-for-profit organization, Loretto is dedicated to providing care regardless of a patient's ability to pay. Loretto offers a variety of financial assistance programs to help those who have difficulty paying medical bills and plans to extend such benefits to the proposed ESRD Facility.

2. The proposed ESRD Facility will be located at 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 ("Project Site"). Because the Project Site is located within the city limits of the City of Chicago, the project is in Health Service Area 6 ("HSA 6"). The Project Site is located within Chicago's Austin community, placing the proposed ESRD Facility in Hospital Planning Area A-02.

Pursuant to the State Board's rules, 77 Ill. Adm. Code 1110.230(b)(5)(C)(i), the Applicant's geographic service area ("GSA") includes all zip codes within a five (5) mile drive time radius surrounding the Project Site.

Note: Several maps identifying the Project Site and the boundary of the proposed GSA and a list of all zip codes in the GSA are provided immediately following this Attachment 12.

3. The primary purpose of this project is to establish an ESRD facility to provide dialysis services and treatments to Loretto Hospital's existing patients as well as the residents of the Austin community and surrounding neighborhoods. It is very important to have adequate dialysis care at Loretto Hospital because the community has a large percentage of residents who are African-American, a demographic group that is at increased risk of developing chronic kidney disease (CKD), which often leads to dialysis and may require a kidney transplant.

Compared to other ethnic groups, the African American population has noticeably higher rates of diabetes and hypertension (i.e., high blood pressure), which are the two leading causes of kidney disease. Almost one in every three African Americans has high blood pressure. Because there are no warning signs, frequently people have high blood pressure or

kidney disease and don't even know they have a health problem. Even diabetes doesn't always have symptoms. Therefore, it is very important for persons in high-risk groups to have regular physicals or screening for high blood pressure and diabetes.

While many African Americans already know they have diabetes or high blood pressure, many are not aware they may also have kidney disease. They are shocked to be diagnosed with kidney failure and then immediately begin dialysis. Even though their kidney disease progressed over time to kidney failure, it's as if it happened all of a sudden. Advanced awareness is the key to better health. The Applicant not only wants to open an in-center hemodialysis facility at Loretto, the Applicant and Loretto Hospital want to work with the community to increase awareness of kidney health issues, encourage healthy eating and lifestyles, and hopefully close the health disparity gap that is rampant in minority communities like the Austin neighborhood.

Quick access to healthcare services results in the timely use of personal health services, which can help a patient achieve improved health outcomes. The proposed ESRD Facility will enhance access to outpatient health care services because it will fill a gap in care that exists in the community. According to the most recent update to the State CON Board's Inventory of Other Health Care Services, HSA 6 has a need for an additional 21 dialysis stations.

TABLE ONE
 Revised Need Determinations: ESRD Station Need HSA 6
 As of March 11, 2019

REVISED NEED DETERMINATIONS 3/11/2019 ESRD STATIONS				
ESRD SERVICE AREAS	APPROVED EXISTING STATIONS	CALCULATED STATION NEED 2020	ADDITIONAL STATIONS NEEDED 2020	EXCESS ESRD STATIONS 2020
HSA 1	196	192	0	4
HSA 2	188	159	0	29
HSA 3	182	155	0	27
HSA 4	202	186	0	16
HSA 5	195	166	0	29
HSA 6	1,348	1,353	5	0
HSA 7	1,486	1,430	0	56
HSA 8	492	427	0	65
HSA 9	308	301	0	7
HSA 10	96	78	0	18
HSA 11	260	212	0	48
ILLINOIS TOTAL	4,953	4,659	5	299

Joseph V. Nally, Jr., MD, Clinical Professor of Medicine at the Cleveland Clinic Lerner College of Medicine, has closely studied minority groups in regard to dialysis care and concluded in a recent article that African Americans have a greater burden of chronic kidney disease than whites. They are more than 3 times as likely as whites to develop end-stage renal disease, even after adjusting for age, disease stage, smoking, medications, and comorbidities. Why this is so has been the focus of much speculation and research.

An article attached with this Attachment 12, titled “Chronic Kidney Disease in African Americans: Puzzle Pieces Are Falling Into Place” reviews recent advances in the understanding of the progression of chronic kidney disease, with particular scrutiny of the disease in African Americans. Breakthroughs in genetics that help explain the greater disease burden in African Americans are also discussed, as well as implications for organ transplant screening.

The key points addressed in the Dr. Nally article are:

- Patients with chronic kidney disease are more likely to die than to progress to end-stage disease, and cardiovascular disease and cancer are the leading causes of death.
- As kidney function declines, the chance of dying from cardiovascular disease increases.
- African Americans tend to develop kidney disease at a younger age than whites and are much more likely to progress to dialysis.
- About 15% of African Americans are homozygous for a variant of the APOL1 gene. They are more likely to develop kidney disease and to have worse outcomes.

The Applicant also hired a dialysis consultant to conduct a market study, which examined the Austin neighborhood and surrounding communities’ health care needs.

4. Evidence to support the need for this project immediately follows this attachment. The information attached includes the following:

- Joseph V. Nally, Jr., M.D., Chronic Kidney Disease in African Americans: Puzzle Pieces Are Falling Into Place, Cleveland Clinic Journal of Medicine, Vol. 84, No. 11, Nov. 2017.
- National Kidney Foundation, African Americans and Kidney Disease, Fact Sheet.
- Mary Hoffman, Principal, Marython Associates, Inc., Dialysis Business Overview, May 2018.

5. This project's goals are as follows: (a) generally increase access to in-center hemodialysis treatment services for Loretto Hospital’s patients and to the surrounding community as a whole – an area with a reported need for additional in-center hemodialysis stations; (b) provide enhanced access to care for the area’s pre-ESRD patients, especially African

Americans who are at a much higher risk for developing significant health problems related to poor kidney function and/or failure; and (c) expand Loretto Hospital's charitable mission in the community. With a new in-center hemodialysis service created by this joint venture with the primary Applicant, Loretto Hospital will be able to support local education and awareness of kidney disease and work to reduce health disparities within the African American community. If Loretto Hospital is successful at achieving these goals, the hospital will be able to dramatically improve the lives of those living in the area with kidney disease, reduce health complications, and diminish the overall cost of healthcare to this population.

6. In addition to the foregoing, this project involves the modernization of existing space. The Applicant is proposing the establishment of an ESRD Facility, which will be located within an existing hospital. The address of the existing hospital is 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 ("Project Site").

The central complex of Loretto Hospital was built in 1923. At that time, the hospital was a proprietary institution owned by a group of physicians from the west side of Chicago. It was known then as Austin Hospital. Fifteen years later, the Sisters of Saint Casimir purchased the property in December 1938. After nearly one month of intense renovation and repairs, The Loretto Hospital opened its doors to the public on January 16, 1939 under the administration of the Sisters of Saint Casimir. In 1969, the Sisters of Saint Casimir added a new wing to the hospital. The new wing consisted of an eight-story bed tower and a new diagnostic and treatment building. In addition, a new Family Health Center (currently known as The Loretto Hospital's Outpatient Center Clinic) was opened in the hospital to bring primary care to residents of the Austin community. It is the Applicant's understanding that neither Loretto Hospital's original building nor the 1969 addition have any recorded historical or architectural significance.

There are two historical sites worth noting that are near the Project Site. The first site is Columbus Park, which is listed on the National Register of Historic Places ("NRHP"). Columbus Park is directly to the west of the Project Site, across South Central Avenue. The second site is the Assumption Greek Orthodox Church and Plato School, which is immediately adjacent to the north side of Loretto Hospital. The church is eligible for listing in the NRHP under Criterion C and Criteria Consideration A (as an excellent example of the Byzantine architectural style applied to a religious building and designed by a local master architect); but, no such protection has been sought by the church. The building, encompassing both the church and the school, was constructed from 1937 until 1938. The church and school were designed by architect Peter E. Camburas.

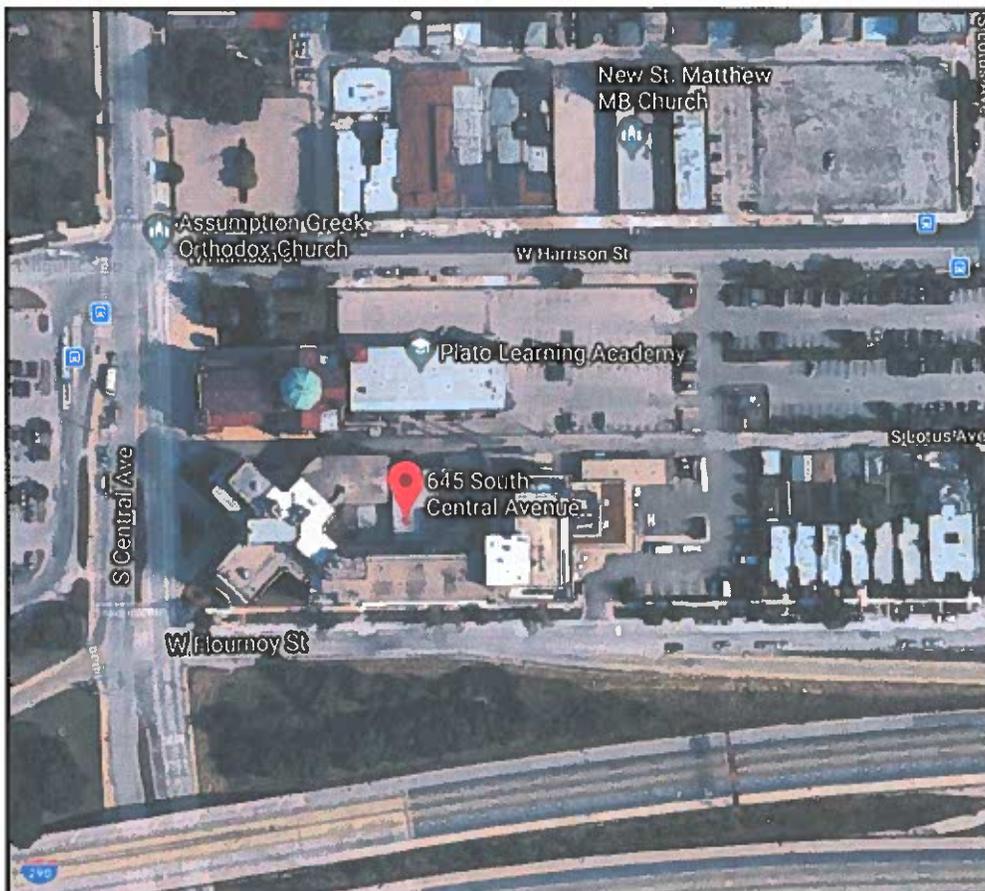
The Project, however, will mostly involve interior construction. If changes to the exterior of the building are necessary, they will be minimal. The interior work will result in the modernization of existing space that is presently used as administrative and office space. There will be no changes to the hospital building that will affect the building itself and any exterior changes will not harm, in any way, adjacent historic structures such as the church and Columbus Park.

Project Site: Loretto Hospital, 645 South Central Avenue, Chicago, Illinois



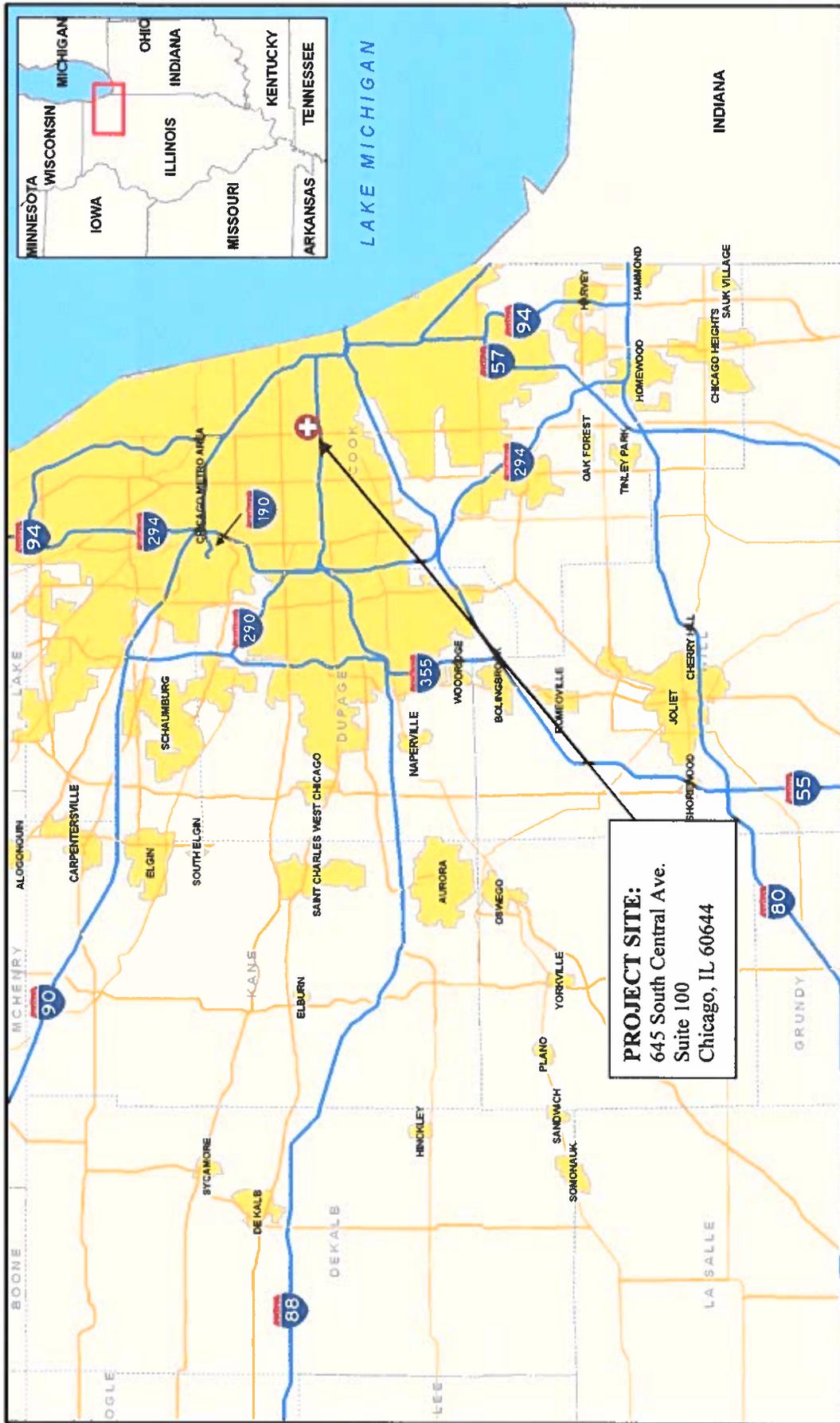


Aerial View

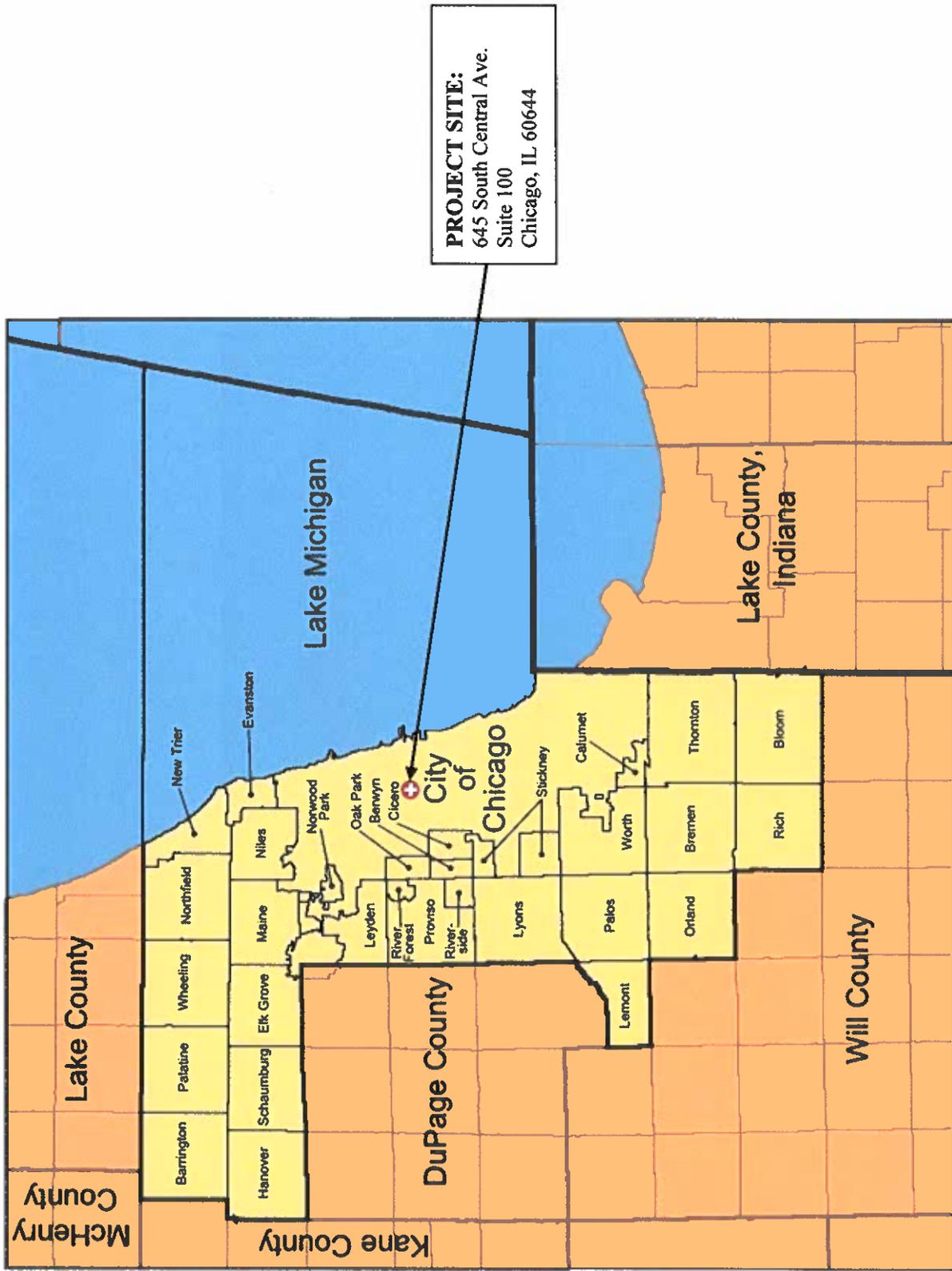


Geographic Service Area: Five (5) Mile Radius From Project Site

Project Site Identified Below



Project Site Identified Below

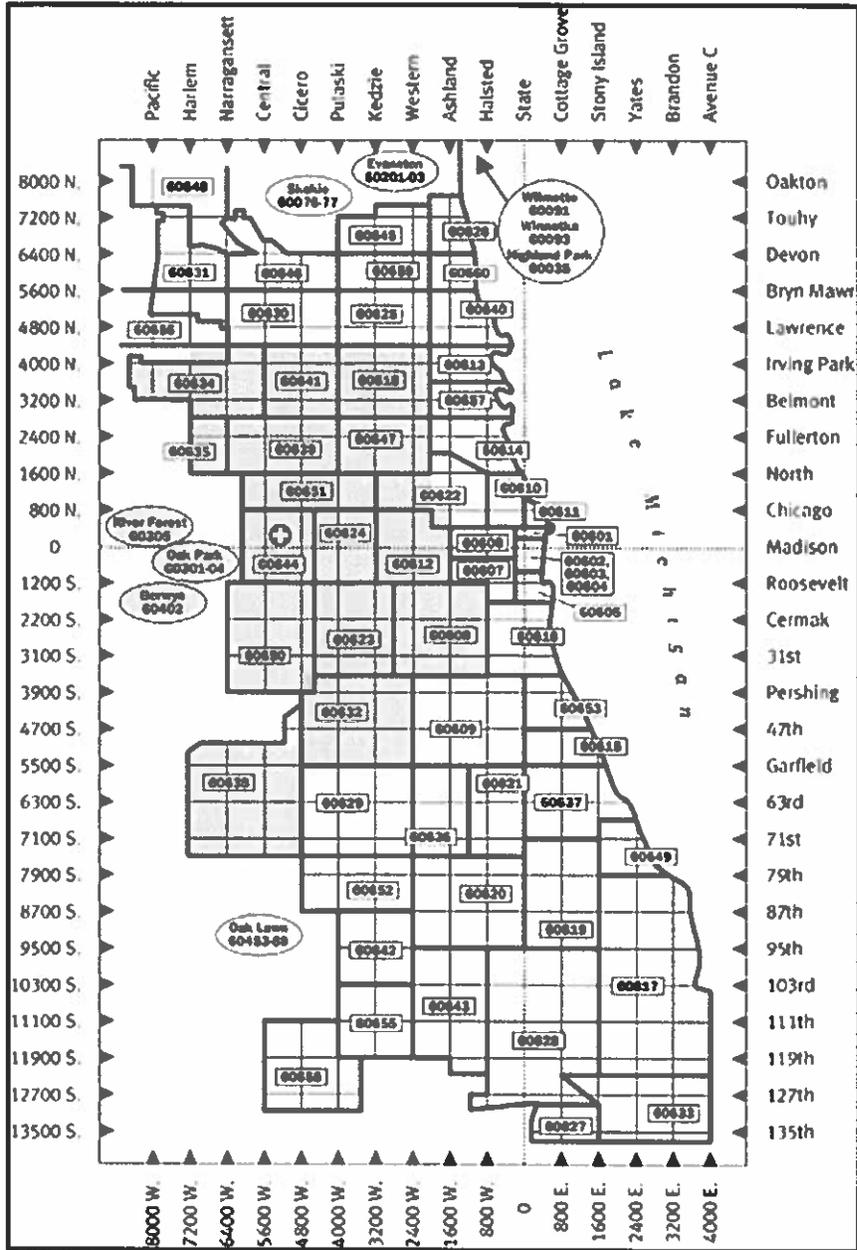


ATTACHMENT 12

Zip Codes

Zip Codes

- 60130
- 60153
- 60155
- 60160
- 60171
- 60302
- 60304
- 60305
- 60402
- 60513
- 60534
- 60546
- 60608
- 60612
- 60618
- 60622
- 60623
- 60624
- 60632
- 60634
- 60638
- 60639
- 60641
- 60644 *
- 60647
- 60651
- 60707
- 60804



* Location of Project Site

ESRD Patients by Zip Code in GSA

Zip Code	Population	ESRD Patients 2017-2019
60130	14,137	0
60153	24,029	1
60155	7,915	0
60160	25,534	0
60171	10,248	0
60302	32,258	0
60304	17,402	0
60305	11,217	0
60402	63,938	0
60513	18,966	0
60534	10,571	0
60546	15,837	0
60608	78,072	2
60612	35,559	2
60618	95,632	0
60622	54,467	1
60623	88,137	6
60624	38,134	6
60632	91,668	1
60634	73,382	0
60638	57,746	0
60639	90,211	0
60641	70,642	0
60644 *	49,645	70
60647	88,866	0
60651	61,759	7
60707	43,451	0
60804	83,972	1
TOTAL	1,353,395	97

The chart above shows the patients, by zip code, who have received hospital-based dialysis treatments in the past two years. Most of the patients originated from the same zip code of Loretto Hospital, showing how convenient this location is for these patients. Moreover, the number of patients in the past two years, that is 97 patients, is more than enough patients to significantly exceed the State Board’s target utilization of 80%.

ATTACHMENT 12

Other Supporting Documentation

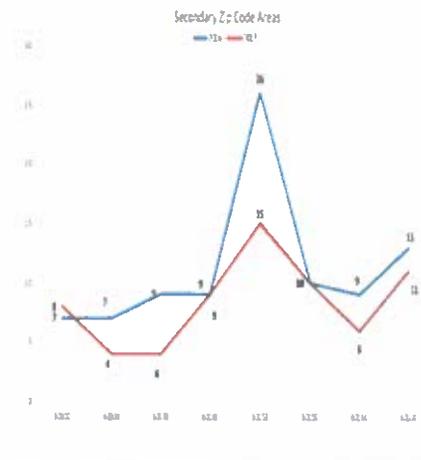
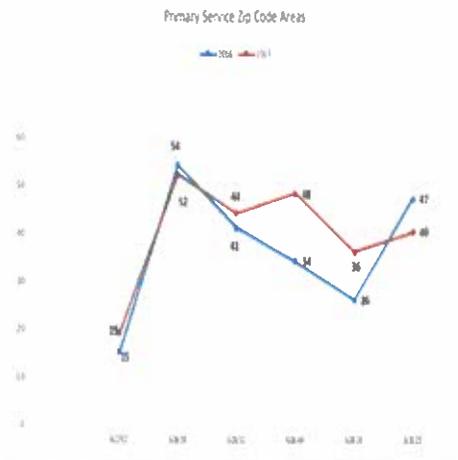
A market study concludes that the demand for dialysis services is growing in the GSA—a GSA with a large African American community (a racial demographic disproportionately affected by kidney disease).

The slide features a blue header with the Marython Associates, Inc. logo on the left and the text 'Loretto Hospital' on the right. Below the header, the main content area is white and contains the title 'Dialysis Business Overview' in a large, bold font. At the bottom center, the author's name 'Mary Hoffman', company 'Marython Associates, Inc', and date 'May 2018' are listed.

The slide features a blue header with the Marython Associates, Inc. logo on the left and the text 'The Market' on the right. Below the header, the main content area is white and contains a bulleted list of market insights. At the bottom right, there are two footnotes: '*AJKD Vol 71, January 2018' and '**The Big Business of Dialysis Care, June 9, 2016'.

- Dialysis demand (incidence rate) is growing in Loretto's primary/secondary market zip codes
 - Increase in obesity, diabetes, hypertension contributes to the trend
 - Lack of available donor kidneys for transplantation
 - Aging population
- Total population is ~527m residents to estimate ~1200- 1500 current dialysis patients (2284 per million population)
- Medicare pays 80%, co-insurance (Medicaid) pays 20%
 - <1% of CMS patients, 7% of expenditures
- Competition primarily from Fresenius (48%) and Davita (22%)
 - ~70% of the market, ~3,900 locations
 - Their profit is primarily from their private pay patients (10%)
- In U.S., 30% of incident HD patients 75-89 y/o die within 1 year*
- U.S. one-year mortality rates are among the highest in the world.**

ATTACHMENT 12



Source: ESRD Network 10
CROWNweb

- Demand is growing
- Competition is strong
- High patient turnover
- Pressure to keep costs in check while providing top quality care



Marython
ASSOCIATES, INC.

Loretto Hospital

AP vendor - L06326

MAPLE AVE KIDNEY CENTER

\$6Km Thru Dec 18 →

Dialysis Business Overview

Mary Hoffman
Marython Associates, Inc
May 2018

- **Dialysis demand (incidence rate) is growing in Loretto's primary/secondary market zip codes**
 - Increase in obesity, diabetes, hypertension contributes to the trend
 - Lack of available donor kidneys for transplantation
 - Aging population
- **Total population is ~527m residents to estimate ~1200- 1500 current dialysis patients (2284 per million population)**
- **Medicare pays 80%, co-insurance (Medicaid) pays 20%**
 - <1% of CMS patients, 7% of expenditures
- **Competition primarily from Fresenius (48%) and Davita (22%)**
 - ~70% of the market, ~3,900 locations
 - Their profit is primarily from their private pay patients (10%)
- **In U.S., 30% of incident HD patients 75-89 y/o die within 1 year***
- **U.S. one-year mortality rates are among the highest in the world.****

*AJKD Vol 71, January 2018

**The Big Business of Dialysis Care, June 9, 2016



- **Base payment in 2017 was \$231.55/treatment (subject to adjustments)***
 - **Average adjustment is ~6% higher****
- **Treatment rate includes:**
 - **All IV drugs given on dialysis and their oral equivalents**
 - **All antibiotics administered on dialysis for an ESRD-related infection**
 - **All ESRD-related lab tests whether or not they were drawn in the dialysis facility**
 - **Excludes all vaccines**
- **Dialysis patients are hospitalized on average 2x/year spending about 11 days in hospital*****
- **Occupancy rates of 85-90% are typically considered cost-effective. Most facilities are hard-pressed to run at >95% due to cancellations, illnesses or staff shortages.*****

*AJKD Vol 71, January 2018

**15th Annual Interdisciplinary Nephrology Conference – October 2014

***Dialysis and Transplantation August 2006

- G&A includes all hospital support:
 - Housekeeping
 - Billing
 - Quality
 - Infection control
 - Biomedical support
 - Human Resources
 - Overhead (utilities/space)
- Other
 - Transportation
 - Medical supplies
- NOT INCLUDED
 - Construction costs/debt repayment (~\$1.5 – 2.0 million+)
 - Legal Fees (CON + other) \$100,000+
 - Equipment (machines/furniture) \$300,000

Marathon

Unrealistic – Full capacity at 1 year

Year 1	Q1 new	Q1 total	Q2 new	Q2 total	Q3 new	Q3 total	Q4 new	Q4 total	YE total
Patients	25	25	25	50	25	75	21	96	96
Treatments	780	780	780	1755	780	2730	655	3580	8845

Optimistic – Full capacity at 1.5 years

Year 1	Q1 new	Q1 total	Q2 new	Q2 total	Q3 new	Q3 total	Q4 new	Q4 total	YE total
Patients	16	16	32	16	48	16	64	64	64
Treatments	499	499	1123	499	1747	499	2371	5741	5741
Year 2	Q5 new	Q5 total	Q6 new	Q6 total	Q7 total	Q8 total	YE total		
Patients	16	80	96	96	96	96	96	96	96
Treatments	499	2995	499	3619	3744	3744	3744	14102	14102

Realistic – Full capacity at 2 year

Year 1	Q1 new	Q1 total	Q2 new	Q2 total	Q3 new	Q3 total	Q4 new	Q4 total	YE total
Patients	\$ 12	\$ 12	\$ 12	\$ 24	\$ 12	\$ 36	\$ 12	\$ 48	\$ 48
Treatments	\$	\$ 374	\$ 374	\$ 842	\$ 374	\$ 1,310	\$ 374	\$ 1,778	\$ 4306
Year 2	Q1 new	Q1 total	Q2 new	Q2 total	Q3 new	Q3 total	Q4 new	Q4 total	YE total
Patients	\$ 12	\$ 60	\$ 12	\$ 72	\$ 12	\$ 84	\$ 12	\$ 96	\$ 96
Treatments	\$ 374	\$ 2,246	\$ 374	\$ 2,714	\$ 374	\$ 3,182	\$ 374	\$ 3,650	\$ 11,792

\$250/treatment
90% capacity

Realistic Pro forma

	Year 1	Year 2	Year 3	Year 4	Year 5
YR end Census	48	96	96	96	96
Total Treatments	4306	11,792	13,478	13,478	13,478
Income Statement	\$1,076,400	\$2,948,100	\$3,369,600	\$3,369,600	\$3,369,600
Full Salaries	\$504,828	\$822,548	\$927,328	\$955,148	\$983,802
Medical supplies	\$210,974	\$577,828	\$715,400	\$729,708	\$744,302
G&A	\$107,640	\$294,810	\$336,960	\$336,960	\$336,960
Med Director	\$85,000	\$85,000	\$85,000	\$85,000	\$85,000
Other	\$107,640	\$294,810	\$336,960	\$336,960	\$336,960
TOTAL Expenses	\$1,016,082	\$2,074,996	\$2,401,648	\$2,443,776	\$2,487,024
EBITDA	\$60,318	\$873,104	\$967,952	\$925,824	\$882,576
Depreciation	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000
EBIT	\$30,318	\$843,104	\$937,952	\$895,824	\$852,576

CMS administers the ESRD Quality Incentive Program to promote high-quality care at outpatient dialysis facilities

- Links a portion of payment directly to facilities' performance on quality care measures.
- CMS will reduce payments to facilities that do not meet or exceed certain performance standards

Quality measures include:

- Reduce hospitalizations
- Anemia management: Hgb > 12
- HD adequacy: minimum deliver hemodialysis dose (Kt/V)
- Bloodstream infection monitoring
- Vascular access maintenance
- Mineral metabolism management
- Hypercalcemia

Current national efforts to improve quality of care while reducing costs are particularly applicable to dialysis population:

- Patient Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACO)
- ESRD Seamless Care Organizations (ESCO)
- Development of Clinical Performance Measures



AFRICAN AMERICANS AND KIDNEY DISEASE

Due to high rates of diabetes, high blood pressure and heart disease, Blacks and African Americans have an increased risk of developing kidney failure. Blacks and African Americans need to be aware of these risk factors and visit their doctor or clinic regularly to check their blood sugar, blood pressure, urine protein and kidney function.

- Blacks and African Americans suffer from kidney failure at a significantly higher rate than Caucasians - more than 3 times higher.
- African Americans constitute more than 35% of all patients in the U.S. receiving dialysis for kidney failure, but only represent 13.2% of the overall U.S. population.
- Diabetes is the leading cause of kidney failure in African Americans. African Americans are twice as likely to be diagnosed with diabetes as Caucasians. Approximately 4.9 million African Americans over 20 years of age are living with either diagnosed or undiagnosed diabetes.
- The most common type of diabetes in African Americans is type 2 diabetes. The risk factors for this type of diabetes include: family history, impaired glucose tolerance, diabetes during pregnancy, hyperinsulinemia and insulin resistance, obesity and physical inactivity. African Americans with diabetes are more likely to develop complications of diabetes and to have greater disability from these complications than Caucasians. African Americans are also more likely to develop serious complications such as heart disease and strokes.
- High blood pressure is the second leading cause of kidney failure among African Americans and remains the leading cause of death due to its link with heart attacks and strokes.

Updated January 2016

Source: <https://www.kidney.org/news/newsroom/factsheets/African-Americans-and-CKD>

CME CREDIT **LEARNING OBJECTIVE:** Readers will recognize recent advances in the understanding of chronic kidney disease in African Americans

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Chronic kidney disease in African Americans: Puzzle pieces are falling into place

ABSTRACT

Recent decades have seen great advances in the understanding of chronic kidney disease, spurred by standardizing disease definitions and large-scale patient surveillance. African Americans are disproportionately affected by the disease, and recently discovered genetic variants in *APOL1* that protect against sleeping sickness in Africa provide an important explanation for the increased burden. Studies are now under way to determine if genetic testing of African American transplant donors and recipients is advisable.

KEY POINTS

Patients with chronic kidney disease are more likely to die than to progress to end-stage disease, and cardiovascular disease and cancer are the leading causes of death.

As kidney function declines, the chance of dying from cardiovascular disease increases.

African Americans tend to develop kidney disease at a younger age than whites and are much more likely to progress to dialysis.

About 15% of African Americans are homozygous for a variant of the *APOL1* gene. They are more likely to develop kidney disease and to have worse outcomes.

Medical Grand Rounds articles are based on edited transcripts from Medicine Grand Rounds presentations at Cleveland Clinic. They are approved by the authors but are not peer-reviewed.

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Editor's note: This Medical Grand Rounds was presented as the 14th Annual Lawrence "Chris" Crain Memorial Lecture, a series that has been dedicated to discussing kidney disease, hypertension, and health care disparities in the African American community. In 1997, Dr. Crain became the first African American chief medical resident at Cleveland Clinic, and was a nephrology fellow in 1998–1999. Dr. Nally was his teacher and mentor.

AFRICAN AMERICANS have a greater burden of chronic kidney disease than whites. They are more than 3 times as likely as whites to develop end-stage renal disease, even after adjusting for age, disease stage, smoking, medications, and comorbidities. Why this is so has been the focus of much speculation and research.

This article reviews recent advances in the understanding of the progression of chronic kidney disease, with particular scrutiny of the disease in African Americans. Breakthroughs in genetics that help explain the greater disease burden in African Americans are also discussed, as well as implications for organ transplant screening.

■ ADVANCING UNDERSTANDING OF CHRONIC KIDNEY DISEASE

In the 1990s, dialysis rolls grew by 8% to 10% annually. Unfortunately, many patients first met with a nephrologist on the eve of their first dialysis treatment; there was not yet an adequate way to recognize the disease earlier and slow its progression. And disease definitions were not yet standardized, which led to inadequate metrics and hampered the ability to move disease management forward.

CHRONIC KIDNEY DISEASE IN AFRICAN AMERICANS

				Albuminuria stages, description, and range (mg/g)				
				A1		A2	A3	
				Optimum and high-normal		High	Very high and nephrotic	
				< 10	0–29	30–299	300–1,999	≥ 2,000
GFR stages, descriptions, and range (mL/min/1.73 m ²)	G1	High and optimum	> 105	No CKD	No CKD	Moderate-risk CKD	High-risk CKD	Very high-risk CKD
			90–104	No CKD	No CKD	Moderate-risk CKD	High-risk CKD	Very high-risk CKD
	G2	Mild	75–89	No CKD	No CKD	Moderate-risk CKD	High-risk CKD	Very high-risk CKD
			60–74	No CKD	No CKD	Moderate-risk CKD	High-risk CKD	Very high-risk CKD
	G3a	Mild-moderate	45–59	Moderate-risk CKD	Moderate-risk CKD	High-risk CKD	Very high-risk CKD	Very high-risk CKD
	G3b	Moderate-severe	30–44	High-risk CKD	High-risk CKD	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD
	G4	Severe	15–29	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD
G5	Kidney failure	< 15	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD	Very high-risk CKD	

FIGURE 1. Prognosis of chronic kidney disease (CKD) by glomerular filtration rate (GFR) and albuminuria.

Reprinted from Levey AS, de Jong PE, Coresh J, et al. The definition, classification, and prognosis of chronic kidney disease: a KDIGO Controversies Conference report. *Kidney Int* 2011; 80:17–28; copyright 2011, with permission from Elsevier, www.sciencedirect.com/science/journal/00852538?sdsc=1.

Standardizing definitions

The situation improved in 2002, when the National Kidney Foundation published clinical practice guidelines for chronic kidney disease that included disease definitions and staging.¹ Chronic kidney disease was defined as a structural or functional abnormality of the kidney lasting at least 3 months, as manifested by either of the following:

- Kidney damage, with or without decreased glomerular filtration rate (GFR), as defined by pathologic abnormalities or markers of kidney damage in the blood, urine, or on imaging tests
- GFR less than 60 mL/min/1.73 m², with or without kidney damage.

A subsequent major advance was the recognition that not only GFR but also albuminuria was important for staging of chronic kidney disease (Figure 1).²

Developing large databases

Surveillance and monitoring of chronic kidney

disease have generated large databases that enable researchers to detect trends in disease progression.

US Renal Data System. The US Renal Data System has collected and reported on data for more than 20 years from the National Health and Nutrition Examination Survey and the Centers for Medicare and Medicaid Services about chronic and end-stage kidney disease in the United States.

Cleveland Clinic database. Cleveland Clinic has developed a validated chronic kidney disease registry based on its electronic health record.³ The data include demographics (age, sex, ethnic group), comorbidities, medications, and complete laboratory data.⁴

Alberta Kidney Disease Network. This Canadian research consortium links large laboratory and demographic databases to facilitate defining patient populations, such as those with kidney disease and other comorbidities.

TABLE 1

Causes of death in patients with non-dialysis-dependent chronic kidney disease

Cause of death, n (%)	Overall (n = 6,661)	eGFR 45–59 (n = 3,308)	eGFR 30–44 (n = 2,261)	eGFR < 30 (n = 1,092)
Cardiovascular disease	2,311 (34.7)	1,017 (30.7)	862 (38.1)	432 (39.6)
Ischemic heart disease	1,227 (18.4)	532 (16.1)	457 (20.2)	238 (21.8)
Heart failure	163 (2.4)	61 (1.8)	75 (3.3)	27 (2.5)
Cerebrovascular disease	255 (3.8)	123 (3.7)	94 (4.2)	38 (3.5)
Other cardiovascular disease	666 (10.0)	301 (9.1)	236 (10.4)	129 (11.8)
Malignant neoplasm	2,117 (31.8)	1,282 (38.8)	616 (27.2)	219 (20.1)
Other cause	2,233 (33.5)	1,009 (30.5)	783 (34.7)	441 (40.3)

eGFR = estimated glomerular filtration rate

Adapted from reference 9.

Kaiser Permanente Renal Registry. Kaiser Permanente of Northern California insures more than one-third of adults in the San Francisco Bay Area. The renal registry includes all adults whose kidney function is known. Data on age, sex, and racial or ethnic group are available from the health-plan databases.

DEATHS FROM KIDNEY DISEASE

The mortality rate in patients with end-stage renal disease who are on dialysis has steadily fallen over the past 20 years, from an annual rate of about 25% in 1996 to 17% in 2014, suggesting that care improved during that time. Patients with transplants have a much lower mortality rate: less than 5% annually.⁵ But these data also highlight the persistent risk faced by patients with chronic kidney disease; even those with transplants have death rates comparable to those of patients with cancer, diabetes, or heart failure.

Death rates correlate with GFR

After the publication of definitions and staging by the National Kidney Foundation in 2002, Go et al⁶ studied more than 1 million patients with chronic kidney disease from the Kaiser Permanente Renal Registry and found that the rates of cardiovascular events and death from any cause increased with decreasing estimated GFR. These findings were

confirmed in a later meta-analysis, which also found that an elevated urinary albumin-to-creatinine ratio (> 1.1 mg/mmol) is an independent predictor of all-cause mortality and cardiovascular mortality.⁷

Keith et al⁸ followed nearly 28,000 patients with chronic kidney disease (with an estimated GFR of less than 90 mL/min/1.73 m²) over 5 years. Patients with stage 3 disease (moderate disease, GFR = 30–59 mL/min/1.73 m²) were 20 times more likely to die than to progress to end-stage renal disease (24.3% vs 1.2%). Even those with stage 4 disease (severe disease, GFR = 15–29 mL/min/1.73 m²) were more than twice as likely to die as to progress to dialysis (45.7% vs 19.9%).

Heart disease risk increases with declining kidney function

Navaneethan et al⁹ examined the leading causes of death between 2005 and 2009 in patients with chronic kidney disease in the Cleveland Clinic database, which included more than 33,000 whites and 5,000 African Americans. During a median follow-up of 2.3 years, 17% of patients died, with the 2 major causes being cardiovascular disease (35%) and cancer (32%) (Table 1). Interestingly, patients with fairly well-preserved kidney function (stage 3A) were more likely to die of cancer than heart disease. As kidney function de-

African Americans are more than 3 times likelier than whites to develop end-stage renal disease

CHRONIC KIDNEY DISEASE IN AFRICAN AMERICANS

Hazard ratios for blacks compared with whites

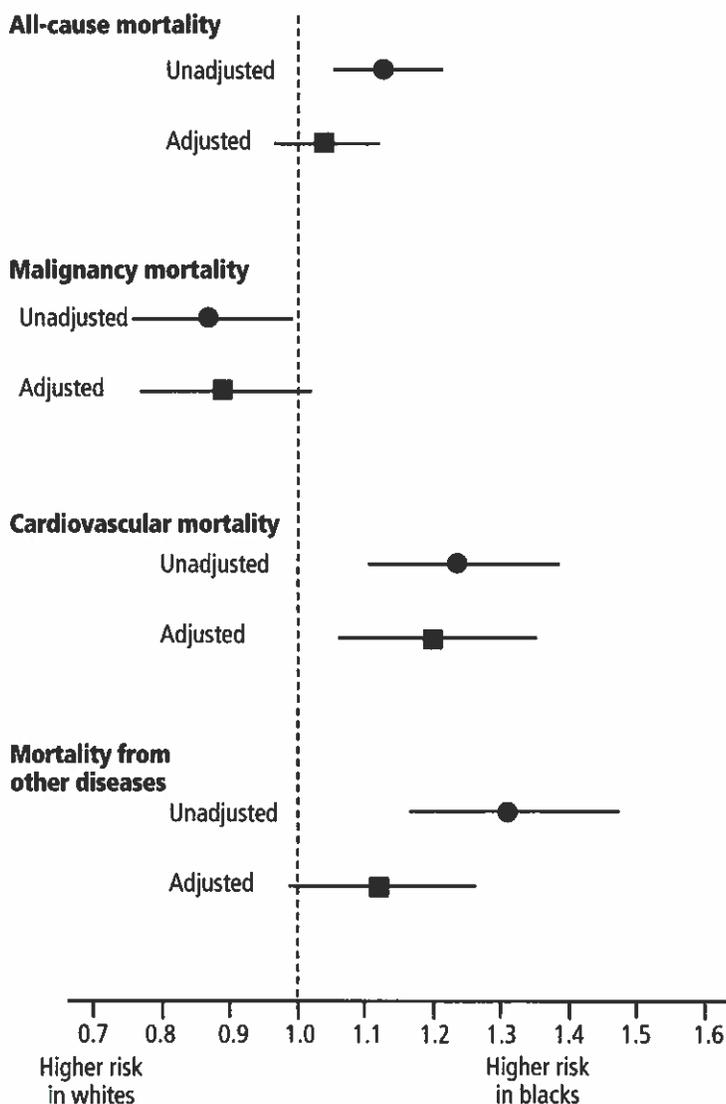


FIGURE 2. Risk for all-cause and major cause-specific death in black vs white patients.

Adapted from Navaneethan SD, Schold JD, Arrigain S, Jolly SE, Nally JV Jr. Cause-specific deaths in non-dialysis-dependent CKD. *J Am Soc Nephrol* 2015; 26:2512–2520.

clined, whether measured by estimated GFR or urine albumin-to-creatinine ratio, the chance of dying of cardiovascular disease increased.

Similar observations were made by Thompson et al¹⁰ based on the Alberta Kidney Disease Network database. They tracked cardiovascular causes of death and found that regardless of estimated GFR, cardiovascular deaths were most often attributed to ischemic

heart disease (about 55%). Other trends were also apparent: as the GFR fell, the incidence of stroke decreased, and heart failure and valvular heart disease increased.

AFRICAN AMERICANS WITH KIDNEY DISEASE: A DISTINCT GROUP

African Americans constitute about 12% of the US population but account for:

- 31% of end-stage renal disease
- 34% of the kidney transplant waiting list
- 28% of kidney transplants in 2015 (12% of living donor transplants, 35% of deceased donor transplants).

In addition, African Americans with chronic kidney disease tend to be:

- Younger and have more advanced kidney disease than whites¹¹
- Much more likely than whites to have diabetes, and somewhat more likely to have hypertension
- More likely than whites to die of cardiovascular disease (37.4% vs 34.2%) (Figure 2).⁹

Overall, the prevalence of chronic kidney disease is slightly higher in African Americans than in whites. Interestingly, African Americans are slightly less likely than whites to have low estimated GFR values (6.2% vs 7.6% incidence of < 60 mL/min/1.73 m²) but are about 50% more likely to have proteinuria (12.3% vs 8.4% incidence of urine albumin-to-creatinine ratio ≥ 30 mg/g).

More likely to be on dialysis, but less likely to die

Although African Americans have only a slightly higher prevalence of chronic kidney disease (about 15% increased prevalence) than whites,¹² they are 3 times more likely to be on dialysis.

Nevertheless, for unknown reasons, African American adults on dialysis have about a 26% lower all-cause mortality rate than whites.⁵ One proposed explanation for this survival advantage has been that the mortality rate in African Americans with chronic kidney disease before entering dialysis is higher than in whites, leading to a “healthier population” on dialysis.¹³ However, this theory is based on a small study from more than a decade ago and has not been borne out by subsequent investigation.

African Americans with chronic kidney disease: Death rates not increased

African Americans over age 65 with chronic kidney disease have all-cause mortality rates similar to those of whites: about 11% annually. Breaking it down by disease severity, death rates in stage 3 disease are about 10% and jump to more than 15% in higher stages in both African Americans and whites.⁵

However, African Americans with chronic kidney disease have more heart disease and much more end-stage renal disease than whites.

Disease advances faster despite care

The incidence of end-stage renal disease is consistently more than 3 times higher in African Americans than in whites in the United States.^{5,14}

Multiple investigations have tried to determine why African Americans are disproportionately affected by progression of chronic kidney disease to end-stage renal disease. We recently examined this question in our Cleveland Clinic registry data. Even after adjusting for 17 variables (including demographics, comorbidities, insurance, medications, smoking, and chronic kidney disease stage), African Americans with chronic kidney disease were found to have an increased risk of progressing to end-stage renal disease compared with whites (subhazard ratio 1.38, 95% confidence interval 1.19–1.60).

We examined care measures from the Cleveland Clinic database. In terms of the number of laboratory tests ordered, clinic visits, and nephrology referrals, African Americans had at least as much care as whites, if not more. Similarly, African Americans' access to renoprotective medicines (angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, statins, beta-blockers) was the same as or more than for whites.

Although the frequently attributed reasons surrounding compliance and socioeconomic issues are worthy of examination, they do not appear to completely explain the differences in incidence and outcomes. This dichotomy of a marginally increased prevalence of chronic kidney disease in African Americans with mortality rates similar to those of whites, yet with a 3 times higher incidence of end-stage

renal disease in African Americans, suggests a faster progression of the disease in African Americans, which may be genetically based.

GENETIC VARIANTS FOUND

In 2010, two variant alleles of the *APOL1* gene on chromosome 22 were found to be associated with nondiabetic kidney disease.¹⁵ Three nephropathies are associated with being homozygous for these alleles:

- **Focal segmental glomerulosclerosis**, the leading cause of nephrotic syndrome in African Americans
- **Hypertension-associated kidney disease** with scarring of glomeruli in vessels, the primary cause of end-stage renal disease in African Americans
- **Human immunodeficiency virus (HIV)-associated nephropathy**, usually a focal segmental glomerulosclerosis type of lesion.

The first two conditions are about 3 to 5 times more prevalent in African Americans than in whites, and HIV-associated nephropathy is about 20 to 30 times more common.

African sleeping sickness and chronic kidney disease

The *APOL1* variants have been linked to protection from African sleeping sickness caused by *Trypanosoma brucei*, transmitted by the tsetse fly (Figure 3).¹⁶ The pathogen can infect people with normal *APOL1* using a serum resistance-associated protein, while the mutant variants prevent or reduce protein binding. Having one variant allele confers protection against trypanosomiasis without leading to kidney disease; having both alleles with the variants protects against sleeping sickness but increases the risk of chronic kidney disease. About 15% of African Americans are homozygous for a variant.¹⁷

Retrospective analysis of biologic samples from trials of kidney disease in African Americans has revealed interesting results.

The African American Study of Kidney Disease and Hypertension (AASK) trial¹⁸ evaluated whether tighter blood pressure control would improve outcomes. Biologic samples were available for DNA testing for 693 of the 1,094 trial participants. Of these, 23% of African Americans were found to be homozy-

Cardiovascular events and deaths from any cause increase with decreasing GFR

CHRONIC KIDNEY DISEASE IN AFRICAN AMERICANS

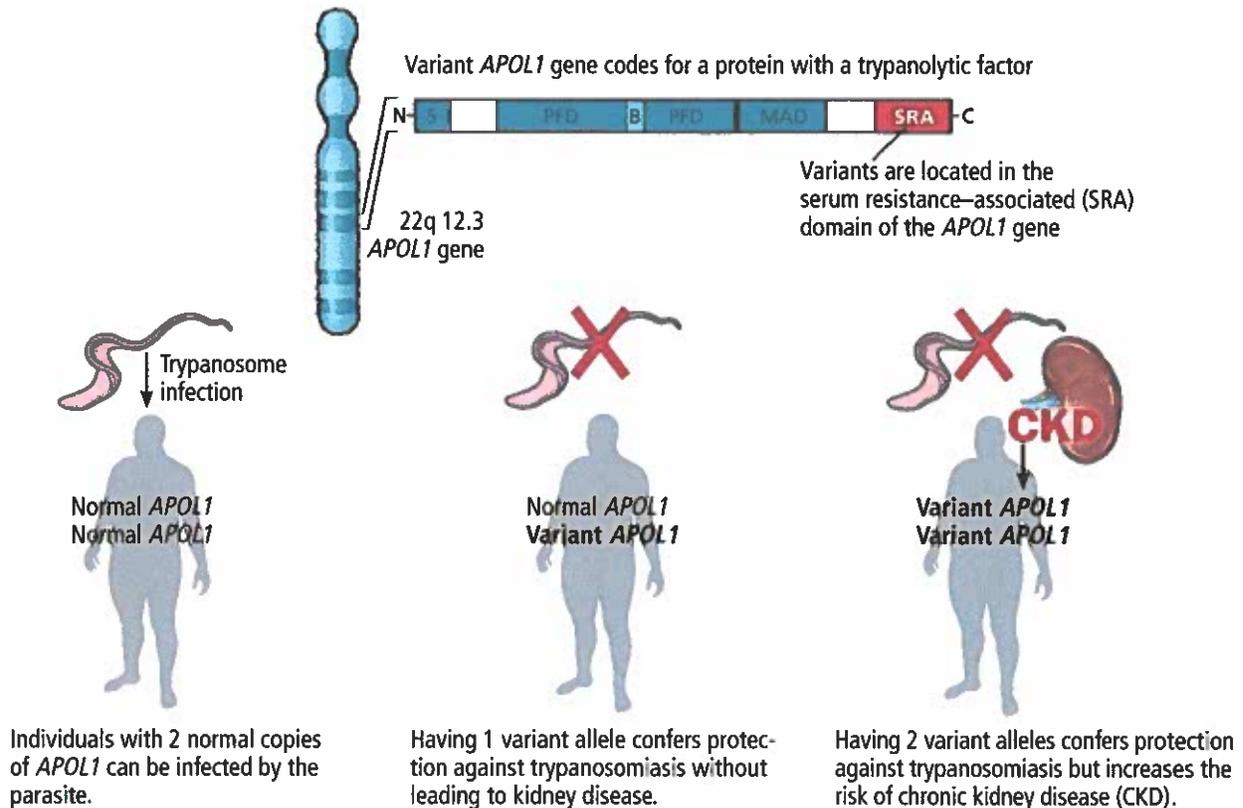


FIGURE 3. Variants in the *APOL1* gene that are common in sub-Saharan Africa protect against African sleeping sickness, but homozygosity for these variants increases the risk of chronic kidney disease.

gous for a high-risk allele, and they had dramatically worse outcomes with greater loss of GFR than those with one or no variant allele (Figure 4). However, the impact of therapy (meeting blood pressure targets, treatment with different medications) did not differ between the groups.

The Chronic Renal Insufficiency Cohort (CRIC) observation study¹⁸ enrolled patients with an estimated GFR of 20 to 70 mL/min/1.73 m², with a preference for African Americans and patients with diabetes. Nearly 3,000 participants had adequate samples for DNA testing. They found that African Americans with the double variant allele had worse outcomes, whether or not they had diabetes, compared with whites and African Americans without the homozygous gene variant.

Mechanism not well understood

The mechanism of renal injury is not well understood. Apolipoprotein L1, the protein

coded for by *APOL1*, is a component of high-density lipoprotein. It is found in a different distribution pattern in people with normal kidneys vs those with nondiabetic kidney disease, especially in the arteries, arterioles, and podocytes.^{19,20} It can be detected in blood plasma, but levels do not correlate with kidney disease.²¹ Not all patients with the high-risk variant develop chronic kidney disease; a “second hit” such as infection with HIV may be required.

Investigators have recently developed knockout mouse models of *APOL1*-associated kidney diseases that are helping to elucidate mechanisms.^{22,23}

■ EFFECT OF GENOTYPE ON KIDNEY TRANSPLANTS IN AFRICAN AMERICANS

African Americans receive about 30% of kidney transplants in the United States and represent about 15% to 20% of all donors.

Lee et al²⁴ reviewed 119 African American recipients of kidney transplants, about half of whom were homozygous for an *APOL1* variant. After 5 years, no differences were found in allograft survival between recipients with 0, 1, or 2 risk alleles.

However, looking at the issue from the other side, Reeves-Daniel et al²⁵ studied the fate of more than 100 kidneys that were transplanted from African American donors, 16% of whom had the high-risk, homozygous genotype. In this case, graft failure was much likelier to occur with the high-risk donor kidneys (hazard ratio 3.84, $P = .008$). Similar outcomes were shown in a study of 2 centers²⁶ involving 675 transplants from deceased donors, 15% of which involved the high-risk genotype. The hazard ratio for graft failure was found to be 2.26 ($P = .001$) with high-risk donor kidneys.

These studies, which examined data from about 5 years after transplant, found that kidney failure does not tend to occur immediately in all cases, but gradually over time. Most high-risk kidneys were not lost within the 5 years of the studies.

The fact that the high-risk kidneys do not all fail immediately also suggests that a second hit is required for failure. Culprits postulated include a bacterial or viral infection (eg, BK virus, cytomegalovirus), ischemia or reperfusion injury, drug toxicity, and immune-mediated allograft injury (ie, rejection).

Genetic testing advisable?

Genetic testing for *APOL1* risk variants is on the horizon for kidney transplant. But at this point, providing guidance for patients can be tricky. Two case studies^{27,28} and epidemiologic data suggest that donors homozygous for an *APOL1* variant and those with a family history of end-stage kidney disease are at increased risk of chronic kidney disease. Even so, most recipients even of these high-risk organs have good outcomes. If an African American patient needs a kidney and his or her sibling offers one, it is difficult to advise against it when the evidence is weak for immediate risk and when other options may not be readily available. Further investigation is clearly needed into whether *APOL1* variants and other biomarkers can predict an organ's success as a transplant.

APOL1 variants increase the risk of chronic kidney disease

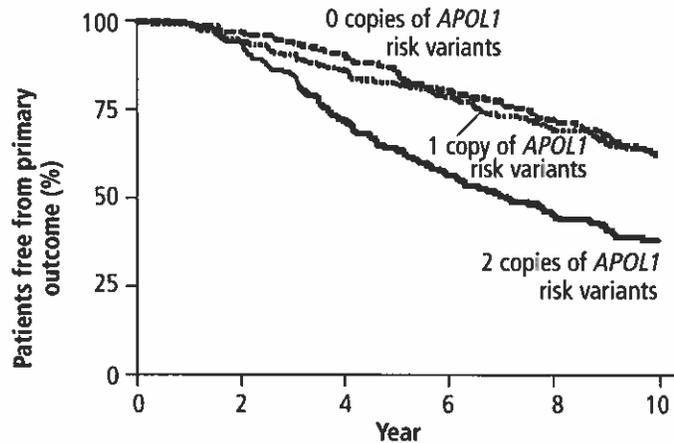


FIGURE 4. Proportion of patients free from progression of chronic kidney disease, according to *APOL1* genotype, in the African American Study of Kidney Disease and Hypertension. The primary outcome was reduction in the glomerular filtration rate (as measured by iothalamate clearance) or incident end-stage renal disease.

From Parsa A, Kao WH, Xie D, et al; AASK Study Investigators; CRIC Study Investigators. *APOL1* risk variants, race, and progression of chronic kidney disease. *N Engl J Med* 2013; 369:2183–2196. Reprinted with permission from Massachusetts Medical Society.

The National Institutes of Health are currently funding prospective longitudinal studies with the *APOL1* Long-term Kidney Transplantation Outcomes Network (APOLLO) to determine the impact of *APOL1* genetic factors on transplant recipients as well as on living donors. Possible second hits will also be studied, as will other markers of renal dysfunction or disease in donors. Researchers are actively investigating these important questions.

KEEPING SCIENCE RELEVANT

In a recent commentary related to the murine knockout model of *APOL1*-associated kidney disease, O'Toole et al offered insightful observations regarding the potential clinical impact of these new genetic discoveries.²³

As we study the genetics of kidney disease in African American patients, we should keep in mind 3 critical questions of clinical importance:

Will findings identify better treatments for chronic kidney disease? The AASK trial found that knowing the genetics did not affect

African Americans: 12% of the US population, but 31% of patients with end-stage renal disease

CHRONIC KIDNEY DISEASE IN AFRICAN AMERICANS

outcomes of routine therapy. However, basic science investigations are currently underway targeting *APOL1* variants which might reduce the increased kidney disease risk among people of African descent.

Should patients be genotyped for *APOL1* risk variants? For patients with chronic kidney disease, it does not seem useful at this time. But for renal transplant donors, the answer is

probably yes.

How does this discovery help us to understand our patients better? The implications are enormous for combatting the assumptions that rapid chronic kidney disease progression reflects poor patient compliance or other socioeconomic factors. We now understand that genetics, at least in part, drives renal disease outcomes in African American patients. ■

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ATTACHMENT 13

Criterion 1110.230(c) -- Alternatives

Pursuant to 77 Ill. Adm. Code § 1110.230(c), the CON permit applicant, Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto (“Applicant”), considered the following alternatives before committing to the proposed project:

1. Do Nothing/Maintain Status Quo.

The first alternative considered by the Applicant was to maintain the status quo and forgo the establishment of a new ESRD Facility in Chicago, Illinois.

Total Project Cost: \$0

Reason(s) for Rejecting Alternative:

The Applicant rejected this alternative because it fails to address the growing need for dialysis treatments in the Applicant’s GSA. As noted above in Attachment 12, Loretto Hospital served nearly 100 dialysis patients in the past two years. Most of these patients live in close proximity to the hospital, so an ESRD facility located within the hospital would be preferred by the patients and also centralize their access to healthcare services.

2. Propose a Project of Lesser Scope.

Another alternative considered by the Applicant was seeking a CON permit for an ESRD facility with less than 12 stations.

Total Project Cost: \$1.29 million (8 station ESRD facility)

Reason(s) for Rejecting Alternative:

State Board criterion 1110.230(g) provides that the smallest ESRD facility that can be proposed within a metropolitan statistical area (“MSA”) is eight (8) stations. When the Applicant first considered establishing an ESRD facility at Loretto Hospital, HSA 6 had a need of 21 dialysis stations. Since that time, the number of needed stations has fallen; however, a need still exists in the GSA. Prior to submitting this CON permit application, the Applicant considered the minimum number of stations for an MSA. The Applicant realized that both an 8-station and a 12-station dialysis clinic would exceed the 5 station need in HSA 6. But, a 12 station ESRD facility would best meet the needs of Loretto Hospital’s existing dialysis patient base. As a result, the Applicant concluded that a 12-station ESRD facility was the best allowable size to meet anticipated service demand.

3. Utilizing Other Healthcare Resources in the GSA.

The Applicant also considered utilizing other healthcare resources in the GSA, such as referring dialysis patients to other ESRD service providers.

Total Project Cost: \$0

Reason(s) for Rejecting Alternative:

The Applicant rejected the alternative of utilizing other healthcare providers in the GSA because Loretto Hospital was already doing this approach and was not satisfied with sending its patients to other facilities further away from their homes. As noted above, 70 of the 97 dialysis patients served by Loretto Hospital over the past two years live in zip code 60644—the same area as the hospital. Consequently, nearly seventy percent (70%) of the hospital's patients were required to seek dialysis treatments further from their home. In a generally low-income community, the Applicants did not want to see its patients continue to seek care further away, increasing their travel time to receive services, but also having to seek a new nephrologist for their care. Nearby ESRD facilities are closed shops, meaning that if you go to a Fresenius or DaVita ESRD facility, you end up using their nephrologists because Loretto Hospital's nephrologists are either not affiliated with these other providers or their locations are too far away from the hospital for Loretto's nephrologists to do rounds at all of the surrounding ESRD facilities. In sum, Loretto's dialysis patients are presently losing continuity of care.

It is in the patients' best interest to be able to receive dialysis treatments in their own community, at a location where they receive most of their other healthcare services, and to be able to stick with one nephrologist from the inception of ESRD services.

Documentation

As discussed in alternatives narrative provided above, the Applicant considered several alternative options before submitting the present CON permit application. The narrative above compares the various alternatives considered by the Applicant and, pursuant to the State Board's rules, each one considered the costs and other necessary factors relevant to each alternative. In cases where the Applicant was not able to determine the cost of a stated alternative option, "undetermined" is provided next to the project cost for the given alternative.

ATTACHMENT 13

Alternatives – Documentation

There is no direct empirical evidence relating to this project that concludes better health outcomes result from the proximity of your healthcare provider. However, generally, when chronic care patients have adequate or improved access to healthcare services, it tends to reduce overall costs of care, results in less complications, and reduces the stress of traveling longer distances in an urban area often bogged down in time-consuming rush hour traffic, which can arise at any time of day along the Interstate 290 corridor.

It is expected that the Applicant's ESRD facility will meet or exceed the same quality outcomes as other ESRD facilities in HSA 6, such as:

- 90-95% of patients will have a URR \geq 65%
- 90-95% of patients will have a KtV \geq 1.2

ATTACHMENT 14

Criterion 1110.234 -- Project Scope: Size of Project

Size of Project				
Department/ Service	Proposed DGSF	State Standard Per Station	Difference	Met Standard?
In-Center Hemodialysis	2,750 DGSF	360-520 DGSF	(130)	YES

Conclusion

As noted above, the State Board’s standard for a 12 station ESRD facility is calculated by total departmental square footage (“DGSF”). Accordingly, for a 12-station facility, the maximum size is 6,240 DGSF, or 520 DGSF maximum per station. The proposal submitted by the applicant, Austin Dialysis Center, LLC (“Applicant”), totals 2,750 DGSF, which is well below the maximum DGSF. While this per-station DGSF is lower than the standard’s minimum threshold, a smaller facility neither conflicts with any federal ESRD regulation or condition nor violates any state standard set by the Illinois Department of Public Health. The Applicant admits that the space might be tight, but it is very workable based on the architect’s design.

ATTACHMENT 15

Criterion 1110.234 -- Project Services Utilization

Utilization					
	Dept./ Service	Historical Utilization (Patient Days) (Treatments) Etc.	Projected Utilization	State Standard	Met Standard?
Year 1 (2019-20)	In-Center Hemo	36	50%	80%	NO
Year 2 (2020-21)	In-Center Hemo	60	83%	80%	YES

Summary

An ESRD Facility applicant must document that, by the end of the second year of operation, the annual utilization of the clinical service areas shall meet or exceed the applicable utilization standards. For the proposed ESRD Facility, with 12 stations operating at three shifts per day, six days per week, the Applicant must demonstrate 80% utilization by the end of the second year of operation, or at least 58 patients.

As the chart above illustrates, the Applicant will meet this state standard by the end of the second year of operation following the date of project completion.

The Applicant understands that some dialysis patients may choose to seek dialysis care at another location and the two-year projections account for nearly 40% of the hospital's 2018 dialysis patients seeking ESRD treatments at another location. Even with this extremely conservative projection, the Applicant will easily go beyond the 80% utilization standard.

ATTACHMENT 16

Unfinished or Shell Space

This attachment is not applicable. The Applicant's project does not include any unfinished or shell space.

ATTACHMENT 17

Assurances

The Applicant's project does not include any unfinished or shell space. As a result, this attachment is not applicable.

ATTACHMENT 24(a)

Criterion 1110.230(b)(1) – Planning Area Need: Formula Calculation

The Applicant is requesting approval for a 12-station in-center hemodialysis facility. Each station will operate with three shifts a day, six days a week. The proposed facility will be in HSA 6, which according to the March 2019 revised need determinations, presently has a need for an additional 5 dialysis stations. The following table shows the most current need data.

ESRD Service Areas	Approved Existing Stations	Calculated Station Need 2020	Additional Stations Needed 2020	Excess ESRD Stations 2020
HSA 1	196	192	0	4
HSA 2	188	159	0	29
HSA 3	182	155	0	27
HSA 4	202	186	0	16
HSA 5	195	166	0	29
HSA 6	1,348	1,353	5	0
HSA 7	1,486	1,430	0	56
HSA 8	492	427	0	65
HSA 9	308	301	0	7
HSA 10	96	78	0	18
HSA 11	260	212	0	48
State Total	4,953	4,659	5	299

Analysis

The Applicant’s proposal will eliminate the calculated need for dialysis stations in HSA 6 but will also create a surplus of 7 stations. However, a 7-station surplus in the second largest HSA is not egregious by any means, especially when compared to the excess number of ESRD stations in much smaller HSAs. For example, HSA 8 has a calculated station need of 427 stations, 492 stations have been approved by the State Board, thereby creating a surplus of 65 stations. The Applicant’s proposed GSA is within HSA 6, centered among some of Chicago’s poorest communities with residents who disproportionately suffer from kidney disease.

ATTACHMENT 24(b)

Criterion 1110.230(b)(2) – Planning Area Need: Service to GSA Residents

(a) Number of ESRD Stations to be Established

The Applicant is requesting approval for a 12-station in-center hemodialysis facility. Each station will be assigned three shifts a day, six days a week. The proposed ESRD facility will be in HSA 6.

(b) Purpose of the Project: Meet Unmet Need for Dialysis Care on Chicago’s West Side

The Applicant’s proposal will eliminate the calculated need for dialysis stations in HSA 6 but will also create a surplus of 7 stations. However, a 7-station surplus in the second largest HSA is not egregious by any means, especially when compared to the excess number of ESRD stations in much smaller HSAs. For example, HSA 8 has a calculated station need of 427 stations, 492 stations have been approved by the State Board, thereby creating a surplus of 65 stations. The Applicant’s proposed GSA is within HSA 6, centered among some of Chicago’s poorest communities with residents who disproportionately suffer from kidney disease.

Sufficient Patient Base

Based on historical patient data provided by Loretto Hospital, the proposed ESRD facility is expected to reach and possibly exceed the State Board’s 80% utilization standard for ESRD facilities at the end of the second full year of operation.

Loretto Hospital Historic ESRD Patients by GSA Zip Code

Zip Code	Population	ESRD Patients 2017-2019
60153	24,029	1
60608	78,072	2
60612	35,559	2
60622	54,467	1
60623	88,137	6
60624	38,134	6
60632	91,668	1
60644 *	49,645	70
60651	61,759	7
60804	83,972	1
TOTAL		97

The chart above identifies the patients, by zip code, who have received hospital-based dialysis treatments in the past two years at Loretto Hospital. Most notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for

ATTACHMENT 24(b)

most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board's target utilization standard of 80% without adversely impacting nearby ESRD providers.

Less Travel

As noted above, 70 of the 97 dialysis patients served by Loretto Hospital over the past two years live in zip code 60644—the same area as the hospital. Consequently, nearly seventy percent (70%) of the hospital's patients were required to seek dialysis treatments further from their home. In a generally low-income community, it is not best to make people seek dialysis care further away from their home, increasing their travel time to receive services, but also increasing their out-of-pocket costs via more costly public transportation fares or more gas.

Continuity of Care

The proposed ESRD facility will improve continuity of care. At present, a person who obtains dialysis care at Loretto Hospital will be treated by a hospital physician who likely has no ties to outside dialysis providers like Fresenius or DaVita. When a hospital patient transfers to one of these nearby facilities, they often have to select a new nephrologist since the hospital nephrologist is not affiliated with these other providers or their locations are too far away from the hospital for Loretto's nephrologists to do rounds at all of the surrounding ESRD facilities. In sum, Loretto's dialysis patients are presently losing continuity of care when they switch between inpatient and outpatient dialysis. Thus, it is in the patients' best interest to be able to receive dialysis treatments in their own community, at a location where they receive most of their other healthcare services, and to be able to stick with one nephrologist from the inception of ESRD services.

Combating Racial Disparities

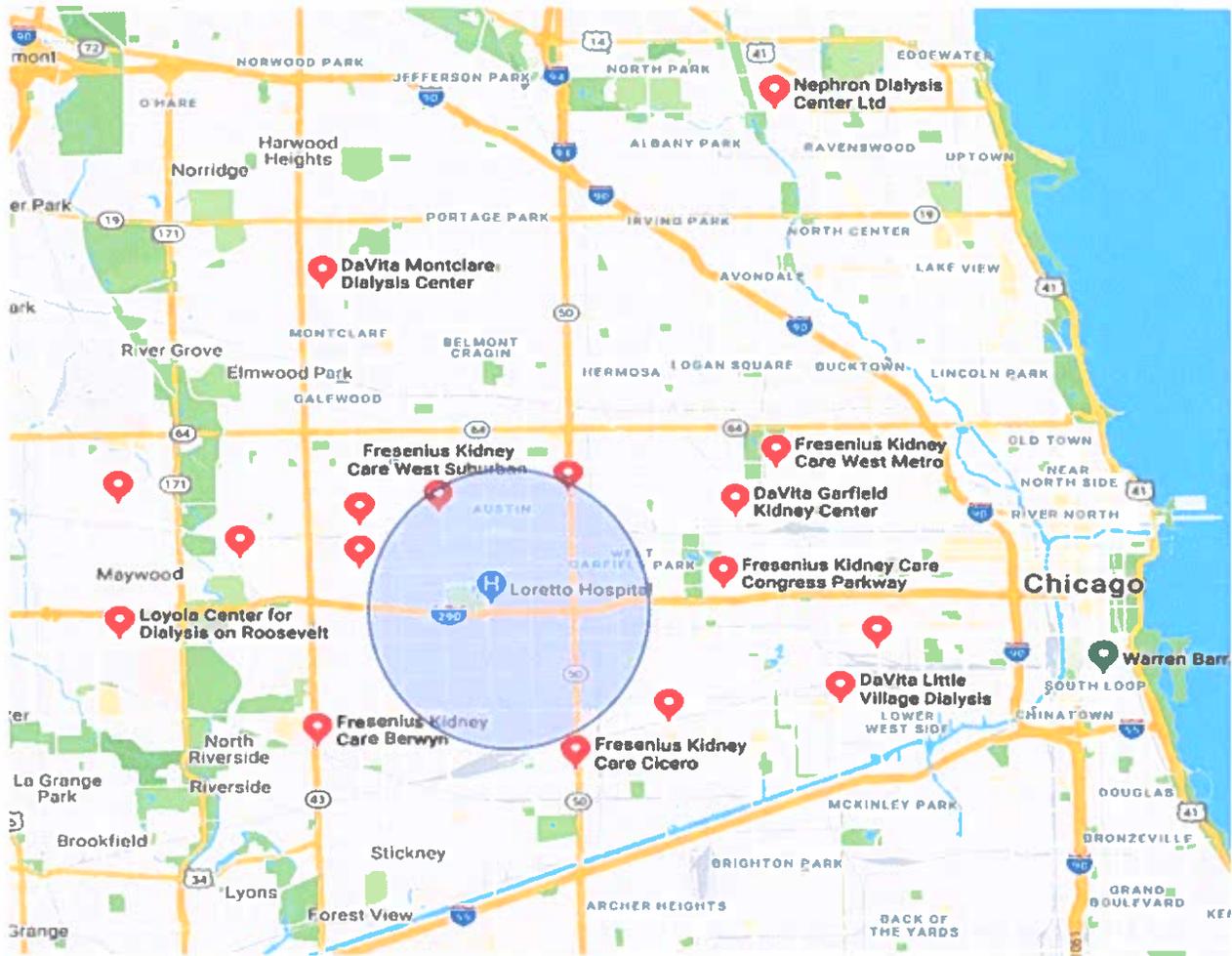
A 2017 report, entitled [A Tale of Three Cities: The State of Racial Justice in Chicago](#), highlighted certain communities in the City of Chicago that continue to suffer from disparities in economic status, life expectancy, and health outcomes. The Westside of Chicago, not surprisingly, was included in the list of Chicago's most vulnerable neighborhoods.

The report reached three significant conclusions:

- Health outcomes are improving across Chicago, but inequalities between blacks and whites are either stagnant or widening on major indicators of mortality like heart disease, stroke, obesity, diabetes, and kidney disease.
- Healthcare providers and pharmacies are dispersed throughout the city in patterns that mirror Chicago's segregation, being concentrated in the city center and white neighborhoods but sparse in black and Latin neighborhoods.
- Further, data from the Chicago Department of Public Health indicates that significant health disparities exist with regards to disease prevalence in Chicago, with black and

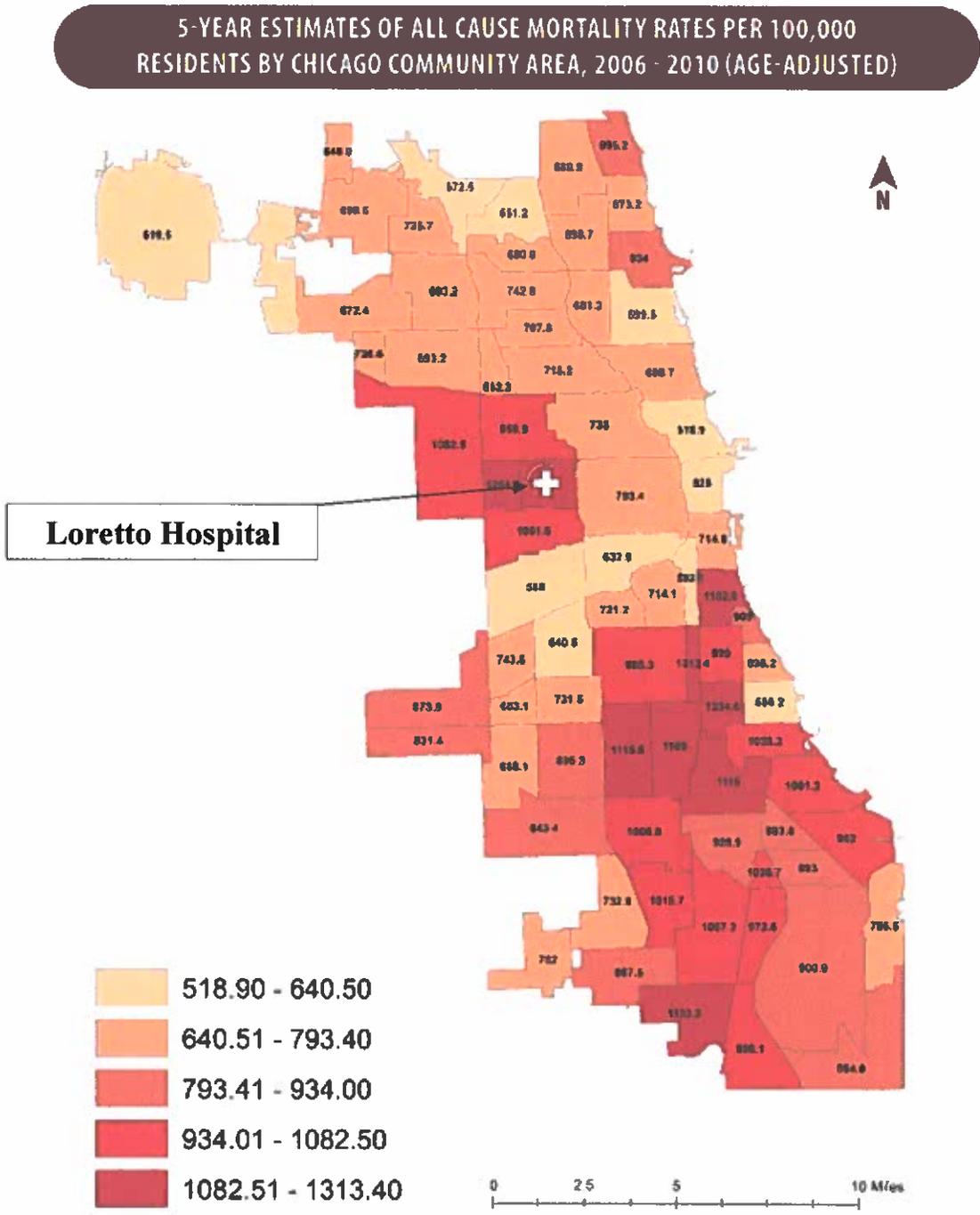
Latin Chicagoans having higher rates of heart disease, cancer, stroke, diabetes, and homicide as compared their white counterparts.

When it comes to in-center hemodialysis facilities, the community in which Loretto Hospital is based does not have a centrally-located ESRD facility. Loretto Hospital also happens to be located among some of Chicago’s largest African American majority neighborhoods—a racial demographic shown to suffer disproportionately from diabetes and kidney disease when compared with Caucasians.



The 2017 *Tale of Three Cities Report* also examined mortality rates by neighborhood. In the report, the author states that “one can see that these racial disparities in mortality map directly onto Chicago’s patterns of segregation, with predominantly black neighborhoods on the South and West Sides suffering the highest death rates in the city. In fact, 17 community areas have mortality rates of over 1,000 deaths per 100,000 residents. Of these communities, all have black majorities and 16 have black populations of 85% or greater.”

The following map shows that Loretto Hospital is located in or near three of the communities with the highest mortality rates in the City of Chicago:



Data: Chicago Department of Public Health

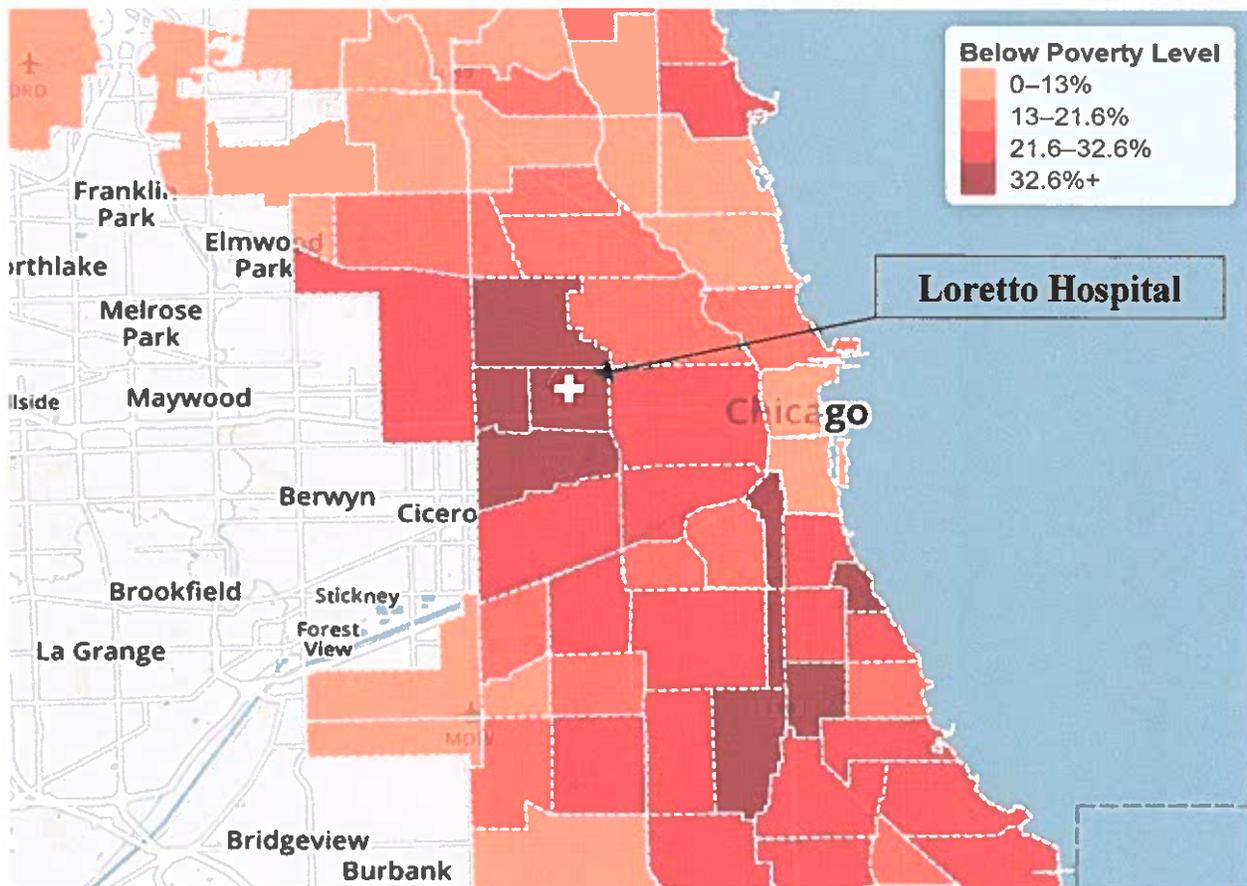
Dr. Derek Robinson, a physician involved with the creation of the following map, created what he called “The Chicago Life Expectancy Map.” He developed the map to raise public awareness of how health is shaped by social and environmental factors - illustrating that for babies born in certain communities, opportunities to lead a long and healthy life can vary dramatically depending by which “L” Stop is closest to your house. The following map shows where Loretto Hospital is located.



Loretto Hospital is also located within an area designated by the federal government as a Medically Underserved Area (“MUA”). The following chart shows that the Austin Community Service Area has been designated as an MUA by Health Resources Services Administration (“HRSA”) under the Department of Health and Human Services.

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
07323	Brighton Park / Gage Park Service Area	Medically Underserved Area	Illinois	61.6	Designated	Non-Rural	2003/04/07	2011/01/12
	CT 8351.00							
	CT 8428.00							
07335	Humboldt Park Service Area	Medically Underserved Area	Illinois	60.7	Designated	Non-Rural	2003/05/14	2003/05/14
	CT 2312.00							
	CT 2315.00							
	CT 8366.00							
	CT 8421.00							
07336	Austin Community Service Area	Medically Underserved Area	Illinois	51.0	Designated	Non-Rural	2003/05/22	2003/05/22

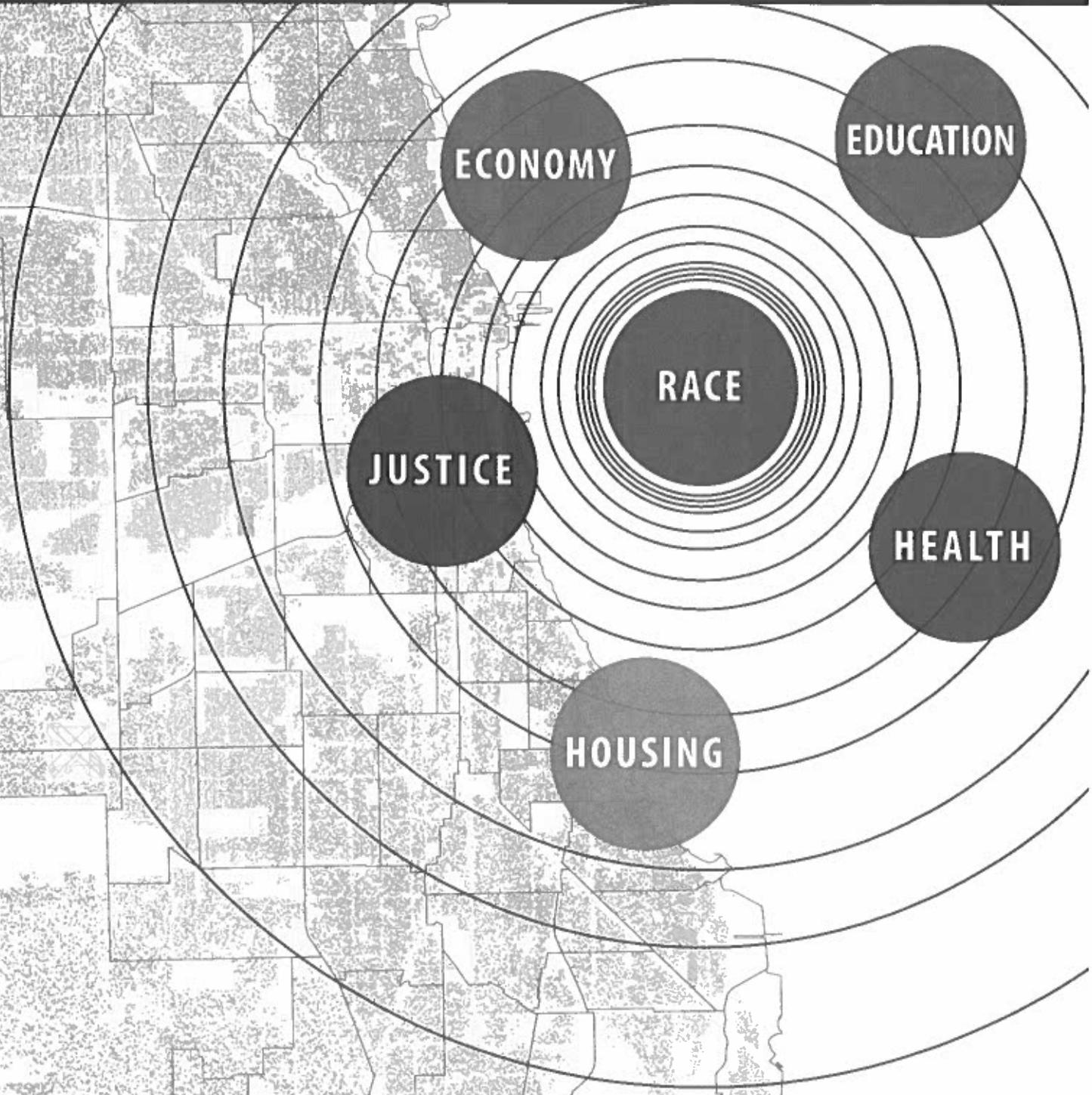
Medically Underserved Areas are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population.



As shown in the map above, Loretto Hospital is also located in or near several communities that have the highest number of families living below the poverty level, which only complicates their ability to obtain affordable health care. These families could benefit greatly from an in-center ESRD facility located in the center of their community.

INSTITUTE FOR RESEARCH ON RACE & PUBLIC POLICY

A Tale of Three Cities: The State of Racial Justice in Chicago Report



Institute for Research on Race and Public Policy

Research that Makes a Difference

Chicago's racial / ethnic self-identification in 2010 U.S. Census.
Each dot represents 25 people. Dot-map created by William Rankin.

- white ●
- black ●
- hispanic ●
- asian ●
- other ●

A Tale of Three Cities: The State of Racial Justice in Chicago is dedicated to all in Chicago who struggle daily to transform the hard realities of racial and ethnic inequalities in the service of more just futures.

report authored by Kasey Henricks, Amanda E. Lewis, Iván Arenas, and Deana G. Lewis and published May 19, 2017



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- Chicago Community Trust
- Great Cities Institute, University of Illinois at Chicago
- Health & Medicine Policy Research Group
- Institute on Government and Public Affairs
- Institute on Policy and Civic Engagement, University of Illinois at Chicago
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EXECUTIVE SUMMARY: STATE OF RACIAL JUSTICE IN CHICAGO¹

Chicago's largest racial and ethnic groups—blacks, Latinxs, and whites—each makes up roughly one-third of the city's population. As this report reveals, these groups generally live in separate neighborhoods and have divergent experiences when it comes to housing, economics, education, justice, and health. Capturing life in Chicago today is in many ways a tale of three cities.

The central finding of this report is that racial and ethnic inequities in Chicago remain *pervasive, persistent, and consequential*. These inequities affect the lives of Chicagoans in every neighborhood; they have not just spatial but also deep historical roots and are embedded in our social, economic, political, and cultural institutions; and they have powerful effects on the experiences and opportunities of all Chicagoans. The patterns described herein are stark, if not entirely surprising. Chicagoans of all racial and ethnic groups want to live in safe and healthy communities where they don't just subsist or survive but also thrive, but not all have equal access.

For example, in the realm of economic outcomes, we find that black and Latinx Chicagoans on average have far more precarious employment options, declining or stagnating wages, higher rates of unemployment and poverty, and fewer opportunities to generate wealth. Large racial and ethnic inequalities in resources persist at all class levels. For instance, education attainment does not alleviate racial inequalities in unemployment or income. While Chicago overall has enjoyed more prosperity over the past half century, much of this boon has been disproportionately distributed to whites, causing economic disparities among racial and ethnic groups to be wider today than in the Civil Rights Era. Over 30% of black Chicago families and around 25% of Latinx Chicago families live under the poverty line. Meanwhile, the city's poverty rate is less than 10% for white families.

There is no way to understand Chicago today without acknowledging our long collective racial history. That long history is reflected not only in patterns of homeownership and in the demographics of our neighborhoods, but in the placement of freeways and public housing, and in the organization of our schools and health care systems. Across the sections of the report, we discover again and again that present day challenges we face stem in part from our failure to address the long-term consequences of decades of formal and widespread private and public discrimination along with continuing forms of entrenched but subtle institutional and interpersonal forms of discrimination.

A Tale of Three Cities: The State of Racial Justice in Chicago attempts to step beyond the competing public narratives about Chicago to assess—in evidence-based, concrete terms—what the challenges and opportunities are for its residents today.

HOUSING

Key Point #1: *Today, nearly 50 years after the Fair Housing Act, Chicago remains among the most segregated cities in the nation and almost as segregated as it was a half-century ago.*

- Black, Latinx, and white Chicagoans live in distinct and distant communities.
- Black-white segregation levels persist even among the city's most affluent households. Black households earning over \$100,000 are just as likely as black households earning less than \$25,000 annually to be segregated from whites.
- Latinx-white segregation levels are significant, though not as extreme as black-white segregation, and those levels drop significantly as Latinx household income rises.

Key Point #2: *Historical housing policies combined with lending and real-estate practices have generated many of the patterns of neighborhood segregation that we see today. These discriminatory policies and practices also contribute to unequal rates of homeownership and home value in Chicago proper and the entire metro region.*

- A slight majority of white Chicagoans currently own their homes. Only 43% of Latinx and 35% of black Chicagoans are homeowners.
- The white-black homeownership gap in the larger metro area sits at nearly 2:1.
- Largely because of patterns of segregation, Chicagoans of color own homes that appreciate at slower rates and peak at lower values than their white counterparts.
- The typical white household in Chicago owns a home that is worth \$275,000. The typical black and Latinx households own homes worth \$145,000 and \$180,000 respectively.

Key Point #3: *Today's two-tiered lending market (prime vs. subprime) causes Chicagoans of color to pay more for less. Even when they possess equivalent measures of creditworthiness compared to whites, black and Latinx households are more likely to secure mortgages that have high interest rates, ballooning payment schedules, and numerous extra fees.*

- When applying for conventional loans in the Chicago metro area, whites have a 77% approval rate, Latinxs have a 67% rate, and blacks have a 59% rate.

- White home-seekers are approved for \$12.4 billion in total annual mortgages compared to \$1 billion for Latinx home-seekers and \$569 million for black home-seekers.
- Because home-seekers of color are often locked out of the prime lending market, they are more likely to turn to costlier alternatives. Black and Latinx home-seekers apply for home-purchase loans from the Federal Housing Authority, Farm Service Agency/Rural Housing Service, or Veterans Administration at 172% and 122% the rate that they apply for prime mortgages. White home-seekers apply for these mortgages at a third of the rate that they apply for prime mortgages.

Key Point #4: *Pervasive and persistent segregation, historical legacies of housing discrimination, and a two-tiered lending market set the preconditions for a mid-2000s housing collapse that was amplified along lines of race and ethnicity. Those communities most devastated were communities of color.*

- Between 2008 and 2015, 128,839 foreclosures were filed in Chicago. Most occurred in a handful of predominantly black and Latinx communities, especially Austin (5,746), Belmont Cragin (4,455), and West Lawn (4,065).
- Large portions of some minority neighborhoods have experienced long-term vacancies since the foreclosure crisis, with as much as 10-to-25% of housing stock being abandoned in places like Englewood and Riverdale.
- Between 2009 and 2013, 22,674 apartment buildings containing 68,300 units entered foreclosure. Of the 18 community areas that lost the high proportions of rental stock, 17 have black and/or Latinx populations of 85% or more.

Key Point #5: *The aftermath of the Great Recession, compounded with broader long-term shifts of economic restructuring and uneven urban development, has left many families in Chicago unable to afford housing in the city. Such a trend is pronounced among the city's black and Latinx residents.*

- About half the black and Latinx homeowners in the Chicago metro area are cost-burdened, spending 30% or more of their income on monthly housing costs. Only about one-third of white homeowners are cost-burdened.
- About two-thirds of black renters and more than half the Latinx renters are cost-burdened by monthly rental costs. The same is true for only about four in ten white renters.

ECONOMICS

Key Point #1: *Over the past half century, Chicago has transitioned from an industrial to service economy. This shift translates into the widespread loss of well-paying, semiskilled manufacturing jobs, and higher levels of underemployment and unemployment.*

- Latinx workers have been most severely impacted by the economic restructuring. About 56% of Latinxs worked manufacturing jobs in 1960 compared to only 16% in 2015.
- Though the national unemployment rate peaked at 10% during the Great Recession, the unemployment rate for black Chicagoans has not fallen below this threshold since at least 1960. Standing at nearly 20% today, the black unemployment rate is over four times the city's white unemployment rate. The unemployment rate for Chicago's Latinxs is about 10% or about double the white rate.
- Higher levels of education do not eliminate racial and ethnic disparities in joblessness. Even black Chicagoans with advanced degrees are more likely to be unemployed than whites who have only a bachelor's degree.

Key Point #2: *Levels of income inequality among blacks, Latinxs, and whites are worse in Chicago than in the nation overall, and they are worsening over time.*

- In Chicago, over 30% of black families and around 25% of Latinx families live below the poverty line. The poverty rate is less than 10% for white families.
- About one-half of Latinx workers and one-third of black workers do not earn a living wage, defined as earning at least \$15 per hour. This is true for only 15% of white workers.
- Chicago's median family income is \$36,720 for blacks, \$47,308 for Latinxs, and \$81,702 for whites.
- Whereas the typical white family earned 1.6 and 1.4 times more income than the typical black and Latinx family in 1960, today the typical white family earns 2.2 and 1.7 times more income than the typical black and Latinx families.

Key Point #3: *Racial and ethnic gaps in wealth are more dramatic than racial and ethnic gaps in income. Even when black and Latinx households have assets, the amounts are often minuscule and not enough to weather financial instability.*

- Nationally the black-white gap is 1:20, while the Latinx-white gap is 1:18.
- One-third of Chicago's black and Latinx households possess either zero or negative net worth compared to only 15% of white households.

- For those households that do possess wealth, 48% and 42% of black and Latinx households are asset poor. This means that they lack sufficient net worth to subsist above poverty for at least three months without income. Only 20% of white households fall under this threshold.

Key Point #4: *Not only do Chicagoans of color face higher levels of unemployment and poverty as well as have less income and wealth than their white peers, but they are geographically removed from the city's job centers and have fewer transit options.*

- Black Chicagoans have the longest commute-to-work times in the city. On average, it takes them 38 minutes to get to work compared to 34 minutes for Latinxs and 32 minutes for whites.

EDUCATION

Key Point #1: *Chicago's schools have gone through a dramatic demographic change over the past forty years. White student enrollment in the city's public schools has dropped dramatically since 1970 mainly due to suburbanization and enrollment shifts to private schools.*

- Chicago public schools today are a majority Latinx (46.6%) and black (37.8%). White students comprise less than 10% of the district enrollment. Nearly half of all CPS schools (309 of 676) have student bodies that are at least 85% black or 85% Latinx.
- CPS schools are segregated by race and ethnicity as well as poverty. About 91% of black students and 89% of Latinx students attend schools where 75% or more of the student population are eligible for free or reduced lunch.

Key Point #2: *Educational opportunities and resources in Chicago's public schools are unevenly distributed along lines of race and ethnicity. Struggling schools are concentrated in communities of color, while white students are overrepresented in the district's most advantaged educational environments.*

- CPS schools with 85% or more black students are just as likely to be on academic probation as they are in good standing. Black CPS students comprise over 60% of students at schools that do not offer AP/IB, Calculus, and/or Physics. They are also nearly seven times more likely than other groups to attend a school without art or music classes.
- White students comprise a quarter of all students at selective enrollment high schools. They are overrepresented in the district's advanced courses and gifted programs. They make up anywhere from 32% to 40% of the student body at the district's top five nationally ranked high schools even though they comprise less than 10% of the CPS student body.

- Of the \$650 million put toward new schools or school additions by CPS during the past six years, about three-fourths has gone toward schools where white students are overrepresented by at least twice their representation in the district overall.

Key Point #3: *Racial and ethnic disparity in the quality of educational experiences defines the schools not only within the district but between CPS, surrounding districts, and the state.*

- In terms of teacher qualifications, CPS has fewer high school teachers with a Master's degree or higher (60%) than surrounding districts in Cook County as well as the state overall.
- The average class size in CPS (25 students) is larger than surrounding districts in Cook County and 25% higher than the state average.
- State investment in education has an inverse relationship with poverty. The poorest districts like CPS get nearly \$2,500 less per pupil from the state than do the state's wealthiest districts.

Key Point #4: *CPS students lack teachers who look like them. With recent school closures concentrated in communities of color, this disparity has deepened over time.*

- Only 17% of CPS teachers are Latinx even though Latinx youth comprise about half the district's enrollment. Only one of every five teachers are black even though black students make up more than a third of all CPS students.
- Between 1980 and 2015, more than 250 CPS schools closed their doors. The lion's share of closures has been concentrated in the city's South and West Sides.
- In 2013, 35 of the 43 public school closings occurred in neighborhoods with majority-black or majority-Latinx residents. Only seven were located in white-majority areas. Taken together, nearly 47,000 youth were impacted. About 90% of these students were black.
- Black teachers accounted for 51% of mass layoffs in 2012 and another 29% in 2015.

Key Point #5: *A large majority of CPS 9th graders say they want a college degree (75%), but obstacles and barriers prevent them from achieving this goal.*

- About 62% of CPS alumni enroll in a 2- or 4-year college within 12 months of their high school graduation.
- Of the nearly 4,000 CPS high school graduates that annually enroll in an Illinois community college, about 70% cannot begin with entry-level coursework and must take at least one remedial course.
- Only 14 out of 100 CPS 9th graders graduate college within ten years of beginning high school. Of these college graduates, 36% are white women, 27% are white men, 16% are Latinx women, 13% are black women, 11% are Latino men, and 6% are black men.

Key Point #6: *Rates of school punishment—which include actions such as suspension, expulsion, and police notification—among CPS students are generally on the decline. However, deep racial and ethnic differences remain in student discipline.*

- Far fewer youth are suspended today than were suspended five years ago, 55,270 compared to 101,174.
- Black students are suspended, both in school (24.2 per 100 students) and out of school (16.1 per 100 students), at double the district rate.
- Black students are expelled at four times the rate of Latinxs and twenty-three times the rate of whites.
- Black youth are more likely to have student misconduct escalated to the attention of the Chicago Police Department. For every 2.1 police notifications black youth receive per 100 students, their Latinx and white counterparts receive 0.7 and 0.3 notifications.

JUSTICE

Key Point #1: *Stories about rampant crime and violence in Chicago have taken center stage in national media. These stories provide a narrative of a violent Chicago that is not in line with the data.*

- Aside from the exceptional year of 2016, Chicago's homicide rates have generally declined over the past two decades. At its high-water mark, Chicago had 924 murders in 1994.
- Similar to national trends, both violent (e.g., aggravated assault, robbery) and property (e.g., burglary, larceny-theft) crimes in Chicago have been on the decline for the past thirty years, with both crime rates at their lowest points since 1985.

Key Point #2: *Crime has gone down, but incarceration has boomed. Incarceration rates have skyrocketed due to a variety of "tough on crime" policy shifts, including the "War on Drugs," aggressive policing strategies, and mandatory minimum sentencing.*

- Imprisonment rates in the State of Illinois have grown by 450% since 1980.
- With an imprisonment rate of 1,533 per 100,000, black Illinois residents are nine times more likely than whites to go to prison. Latinxs are more than one-and-a-half times more likely than whites to be imprisoned.
- Illinois prisons are operating at 150% their maximum capacity, and the state has among the most overcrowded prison systems in the nation.
- At the local level, about two-thirds of all those admitted to the Cook County Jail are black. Over half of them are from majority black neighborhoods, with one in three coming from South Side neighborhoods and one in five from the West Side.

Key Point #3: *The prison boom is expensive. As the Illinois prison population has grown, so have corrections costs.*

- Currently the state spends \$1.35 billion annually on direct expenditures on corrections—a growth rate of 232% since 1977. In addition, \$411 million annually is spent on police and protection, and \$375 million is annually spent on judicial courts.
- The state spending growth rate on corrections between 1977 and 2012 is 2.5 times higher than the growth rate of state spending on higher education.
- For every \$1 annually spent on libraries, the state spends \$224 on corrections.
- At the local level, spending on incarceration is densely concentrated among Chicago’s black and Latinx neighborhoods. The mostly black neighborhood of Austin accounts for about \$110 million in state imprisonment spending per year.

Key Point #4: *Mass incarceration and the geographic distribution of state prisons has consequences for political districting in the State of Illinois. Because most state prisoners are from Cook County but are enumerated as residents in the county where their prisons are located, the population counts of certain districts are inflated and, by extension, so is their voting power.*

- About 60% of prisoners in Illinois are from Cook County, and about 90% of all state prisoners are incarcerated downstate.
- About 95% of state prison cells are located in districts that are predominantly white.
- Nearly a quarter of the residents counted towards the 4th District’s population (Lee County) are in prison. This permits every 75 residents in this district to have voting power equivalent to 100 residents in other districts.

Key Point #5: *Because of aggressive policing strategies and the implicit biases that undergird them, Chicagoans of color are subject to considerably more police surveillance, suspicion, and intervention than their white counterparts.*

- Prior to the formal end of “stop-and-frisk” in 2016, black Chicagoans accounted for 72% of all police stops even though they comprise only one-third of the city’s population.
- Police stops are concentrated geographically, with predominantly black police districts like Englewood logging 226 stops per 1,000 residents. In comparison, the predominantly white police district of Lincoln has five times fewer stops (43 per 1,000 residents).

- Black Chicagoans are more likely to be stopped even in predominantly white neighborhoods. In the Town Hall district, for instance, blacks make up only 6.6% of the population but account for 51% of all police stops.
- Blacks and Latinxs are more likely to be searched during vehicular stops. Although blacks and Latinx are searched at four times the rate of their white counterparts, they are half as likely to be in possession of illegal contraband or a controlled substance.

Key Point #6: *Even though Chicagoans of color bore the brunt of police misconduct and use of force, they are less likely than white Chicagoans to have their complaints against CPD officers sustained. This remains true even as the city has the highest number of fatal police-involved-shootings in the nation and has doubled its police misconduct payouts over the past ten years.*

- Black Chicagoans are subjected to 76% of all use-of-force incidents documented by the CPD. They are nine-and-a-half times more likely than their white counterparts to experience the use of force. Of use-of-force incidents that involve the CPD and Chicago youth, 83% of the children are black and 14% are Latinx.
- Chicago leads the nation in fatal police-involved-shootings. Between 2010 and 2014, a total of 70 deaths resulted from CPD shootings. Two-thirds of these involved black residents.
- Less than 2% of all filed complaints against CPD Officers result in disciplinary action. About 30% of complaints are filed against just 10% of the police force. Black Chicagoans file 61% of all complaints but see only a quarter of these sustained. Whites file 21% of all complaints but see 58% of these sustained.
- Over the last decade, financial compensation for cases of police misconduct, including false arrest, injuries from police car chases or shootings, police brutality, excessive use of force, and wrongful death has cost Chicago taxpayers \$424,574,589.

HEALTH

Key Point #1: *Health outcomes are improving across Chicago, but inequalities between blacks and whites are either stagnant or widening on major indicators of mortality like heart disease, stroke, and mortality in general.*

- During the past three decades, the black mortality rate has been 130% times the white rate. Black Chicagoans die younger too. Because many of these deaths are preventable, health experts refer to them as “premature.” The black premature mortality rate is 13,642 years of potential life lost per 100,000 residents, three times the white rate of 5,698.

- Seventeen community areas have mortality rates of over 1,000 deaths per 100,000 residents. Of these communities, all have majority black populations and 16 have black populations of 85% or greater.
- Heart disease and stroke are number one and number three on the list of causes of death in Chicago. Black residents are 2.9 times more likely to die from stroke than their white counterparts and 2.1 times as likely to die from heart disease.
- Though black women die from breast cancer at higher rates than their white counterparts, they have lower rates of incidence than white women (155.2 diagnoses per 100,000 residents versus 166.5 diagnoses per 100,000 residents).

Key Point #2: *Whereas Latinx Chicagoans tend to be positioned in the middle or bottom on many measures of the racial and ethnic inequity, they fare better than both whites and blacks on measures like mortality rates and incidence of certain cancers. That said, Latinxs are uninsured at twice the rate of their black and white counterparts and may be underreported in some areas.*

- About 8.6% of Latinx Chicagoans have been diagnosed with diabetes compared to 12.3% of blacks and 8.6% of whites.
- About 32.1% of Latinx Chicagoans have been diagnosed with obesity compared to 37.8% of blacks and 23.7% of whites.
- Latinxs die from heart disease and stroke at 50% and 70% the rate of their white peers, with a heart disease mortality rate of 549 deaths per 100,000 people and a stroke mortality rate of 84 deaths per 100,000 people.
- While Latinxs are among the least likely of Chicago's three main racial and ethnic groups to die from cancer, they are actually faring worse today than in the past for some cancer types like female breast cancer. Breast cancer mortality rates have declined for black (14%) and white (27%) women over the past decade. They have increased for Latinas by 33%.

Key Point #3: *Healthcare providers and pharmacies are dispersed throughout the city in patterns that mirror Chicago's segregation, being concentrated in the city center and white neighborhoods but sparse in black and Latinx neighborhoods.*

- Those living on the North Side of Chicago, or in the Loop, routinely have about ten times as many health care provider options located in or adjacent to their neighborhood than do predominantly black communities of the Far South Side.

- As many as 1 million residents on Chicago’s South and West Sides live in areas without a drug store within a half-mile radius.
- Chicago’s food deserts cluster in almost exclusively black census tracts. As many as 183,200 Chicagoans live in a low-income census tract that is at least one mile away from a supermarket or large grocery store.

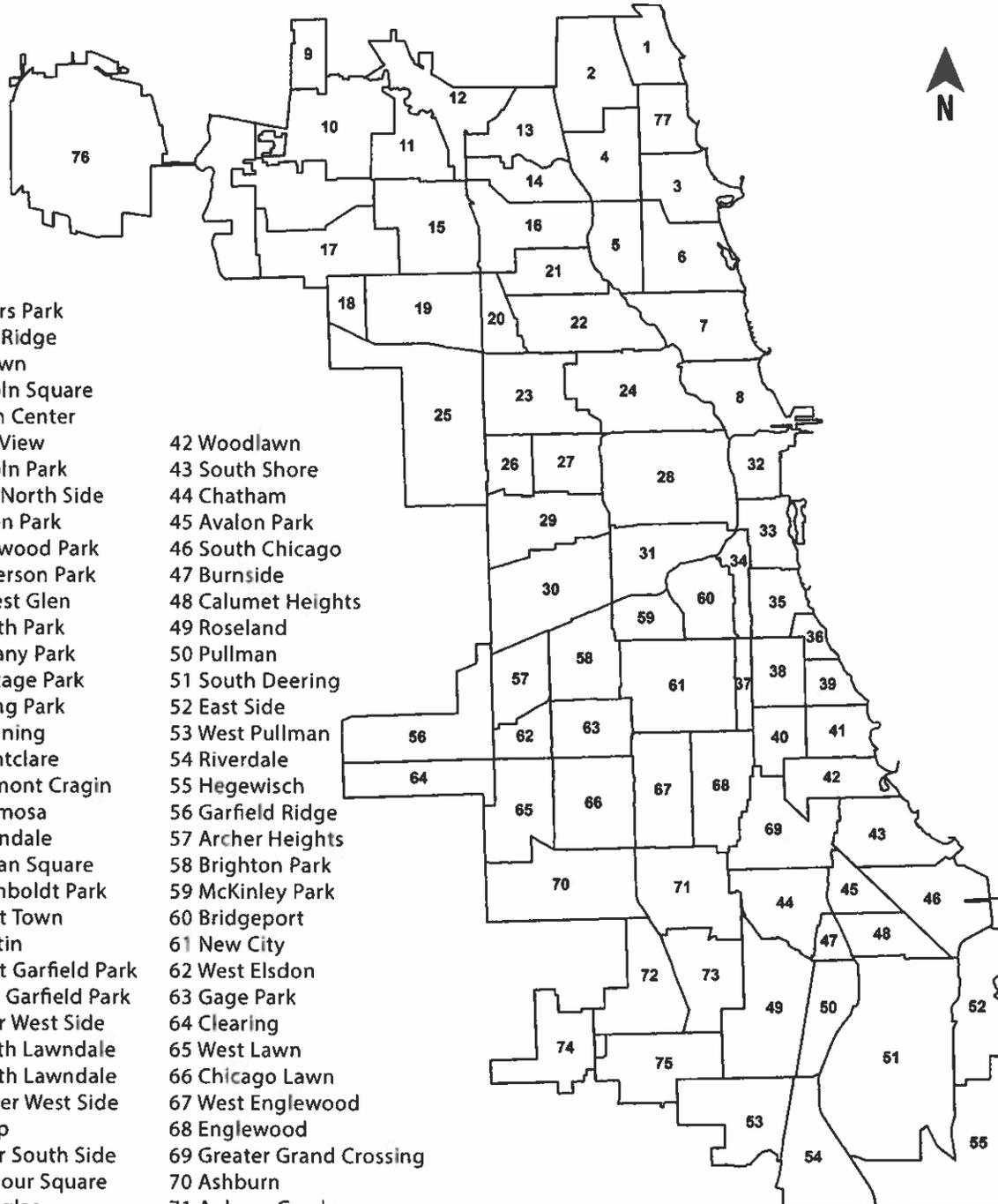
Key Point #4: *Health inequalities begin at birth in Chicago. Racial and ethnic disparities persist in infant mortality and low birthweight, two outcomes often associated with socioeconomic status and access to prenatal care.*

- The number of infant deaths per 1,000 live births is almost three times higher for black Chicagoans than white Chicagoans (11.6 versus 4.3). The mortality rate for Latinx infants is 1.4 times higher than for white infants (5.9 versus 4.3).
- Three neighborhoods, South Chicago, Washington Park, and Grand Boulevard, with black populations of 90% or more suffer infant mortality rates more than two or more times the city rate.
- About 15% of black infants in Chicago are considered to have low birthweight, or less than 5 lbs., 8 oz. (or <2,500 grams). This is more than double the rates for white and Latinx infants.
- In 13 of Chicago’s 77 community areas, at least 15% of all infants are born with low birthweights. All of these 13 communities have black populations of 90% or higher.

ENDNOTE

- 1 Complete references and citations are available in the full report. Unless otherwise specified, all evidence-driven references in the Executive Summary draw from recent data collected between 2010 and 2016.

CHICAGO COMMUNITY AREA MAP



- 1 Rogers Park
- 2 West Ridge
- 3 Uptown
- 4 Lincoln Square
- 5 North Center
- 6 Lake View
- 7 Lincoln Park
- 8 Near North Side
- 9 Edison Park
- 10 Norwood Park
- 11 Jefferson Park
- 12 Forest Glen
- 13 North Park
- 14 Albany Park
- 15 Portage Park
- 16 Irving Park
- 17 Dunning
- 18 Montclare
- 19 Belmont Cragin
- 20 Hermosa
- 21 Avondale
- 22 Logan Square
- 23 Humboldt Park
- 24 West Town
- 25 Austin
- 26 West Garfield Park
- 27 East Garfield Park
- 28 Near West Side
- 29 North Lawndale
- 30 South Lawndale
- 31 Lower West Side
- 32 Loop
- 33 Near South Side
- 34 Armour Square
- 35 Douglas
- 36 Oakland
- 37 Fuller Park
- 38 Grand Boulevard
- 39 Kenwood
- 40 Washington Park
- 41 Hyde Park
- 42 Woodlawn
- 43 South Shore
- 44 Chatham
- 45 Avalon Park
- 46 South Chicago
- 47 Burnside
- 48 Calumet Heights
- 49 Roseland
- 50 Pullman
- 51 South Deering
- 52 East Side
- 53 West Pullman
- 54 Riverdale
- 55 Hegewisch
- 56 Garfield Ridge
- 57 Archer Heights
- 58 Brighton Park
- 59 McKinley Park
- 60 Bridgeport
- 61 New City
- 62 West Elsdon
- 63 Gage Park
- 64 Clearing
- 65 West Lawn
- 66 Chicago Lawn
- 67 West Englewood
- 68 Englewood
- 69 Greater Grand Crossing
- 70 Ashburn
- 71 Auburn Gresham
- 72 Beverly
- 73 Washington Heights
- 74 Mount Greenwood
- 75 Morgan Park
- 76 O'Hare
- 77 Edgewater

0 2.5 5 10 Miles

INTRODUCTION

Over the years, Chicago has had many nicknames:

The Windy City

The City of Big Shoulders (via Carl Sandburg)

The Second City

“Chicago: a city that works.”

Today a more accurate label might be “Chicago: A city that works . . . for some.”

In fact, trying to make sense of the different realities of people’s lives in Chicago today can feel like a tale of three cities. There is not one Chicago. New high-rise luxury condo and apartment buildings rise throughout downtown, the west loop, and along the riverfront. On sunny days, the magnificent mile teems with visitors and locals moving through shops and restaurants. The lakefront nearly sparkles with runners, bikers, walkers, tourists on Segways, boats, swimmers, and jet skis moving through the water while cars stream by on Lake Shore Drive. And yet, local and national news stories document dramatic rates of gun violence, with headlines suggesting, for example, that trauma room medical personnel see so much gun violence that they suffer from “compassion fatigue” having become almost numb to the consequences.¹

Even within communities, the realities of Chicagoans’ daily lives are far more complex than the picture of supposedly violent communities described in national news stories. In every neighborhood, we find friends and families barbequing, hard-working young people trudging off to school with heavy backpacks, and parks filled with residents walking, playing, and exercising. We find communities full of immigrants working overtime to make ends meet.

A Tale of Three Cities: The State of Racial Justice in Chicago attempts to step beyond the competing public narratives about Chicago to assess—in evidence-based, concrete terms—what the challenges and opportunities are for its residents today. Specifically, we examine a wide range of indicators within the domains of housing, economics, education, justice, and health to provide a snapshot of how conditions vary for Chicago residents along racial and ethnic lines.

ABOUT THE REPORT

As the Institute for Research on Race and Public Policy, one of our central aims is to increase our knowledge about the experiences and conditions of racial and ethnic groups nationally, but especially locally, in the City of Chicago. We undertook this project in part to fill a need we identified in our own search for recent, comprehensive data on the conditions of different groups in the city. When we looked, we found that many centers, scholars, or other policy organizations had produced important work on specific aspects of inequality. However, nowhere could we find a source that brought together information about multiple dimensions of inequality in one place. Working with limited resources, we tried not to duplicate efforts that researchers and colleagues had already completed. Thus, we cite that important work throughout the report. Where information was not readily available, we committed ourselves to a challenging but necessarily limited agenda: we would not collect new data but instead would draw on available secondary sources. In doing so, we pursued a dual goal of locating information about racial and ethnic inequality on multiple indicators in one central place and making this information as accessible as possible.

While we recognize there is much diversity of experience and social standing within each racial and ethnic group, our analysis primarily documents between-group differences among blacks, Latinxs, and whites. We are building on decades of scholarship within the social sciences that recognizes race and ethnicity to be categories of social life that fundamentally shape our identities, interactions, and experiences in the world. Race and ethnicity are social categories—they are not biological or permanent—that have played an important role in organizing social relations nationally and within the city of Chicago for a long time.

We began the task of bringing together wide-ranging information by seeking out the counsel of a number of experts at the University of Illinois at Chicago, across the city of Chicago, and around the country asking, “What are the key indicators that capture the conditions of racial and ethnic groups today and what is the best available data on these indicators?” The answers we received form a list that serves as the backbone of our report. While we successfully managed to find high quality data on many of these indicators, we recognize some shortcomings in the data available, some gaps in knowledge that we were not able to fill and some clear drawbacks in a solely quantitative exploration of conditions of social life. In the section that follows we acknowledge in detail the scope and limitations of this report.

Despite some limitations, the report provides a far-reaching picture of the changing conditions of racial and ethnic groups in Chicago during the last half century. It offers data and analysis on how racial and ethnic groups in Chicago

are faring in relation to housing, economics, education, justice, and health. In highlighting intersections between these thematic areas, we hope to encourage public officials, policy makers, philanthropists, advocates, organizers, direct service providers, and residents to work beyond their particular domains—for example, to see that the challenges of housing impact educational opportunities; that justice and health are inextricably linked; and that economic constraints permeate the social lives of Chicagoans of different racial and ethnic groups in ways both obvious and subtle. Understanding these and many other intersections is key to addressing the disparities that adversely affect so many in our divided city and society.

“Not everything that is faced can be changed, but nothing can be changed until it is faced.”

— James Baldwin

Our audience for this report is not just other policy makers, philanthropists, scholars, public officials, non-profit organizations, or community organizers but any and all Chicagoans who are concerned about the state of our city and concerned that young people growing up here are facing such dramatically different odds of success. We do not imagine that the data in this report will serve as a revelation. The facts are not new, but we have made the effort to collect them here because they are necessary. These are not easy truths. As James Baldwin once said, “Not everything that is faced can be changed, but nothing can be changed until it is faced.”²

HOW INEQUALITIES ENDURE

While we do not have space in this report to detail the history of racial dynamics in the city (and that work is done brilliantly elsewhere)³, there is no way to understand where we are today without acknowledging that history. Segregated communities emerged in the 20th century as a result of federal, state, and local policies. As Richard Rothstein, author of the new book *The Color of Law*, recently put it, segregation is not “the unintended effect of benign policies. It was an explicit, racially purposeful policy that was pursued at all levels of government.”⁴ “Redlining” is just one oft-cited example which had the consequence, in practice, of making black neighborhoods ineligible for FHA (Federal Housing Administration) loans (along with private mortgages and insurance) at precisely the time that the federal government was making the largest push in history to make homeownership possible for working Americans. Consequently, black Americans were for all practical purposes “locked out of the greatest mass-based opportunity for wealth accumulation in American history.”⁵

That long history is embedded not only in patterns of homeownership and in the demographics of our neighborhoods, but in the placement of freeways and public housing, and in the organization of our schools and health care systems. Across the sections of the report, we discover again and again that present day challenges we face stem in part from our failure to address the long-term consequences of decades of formal and widespread private and public discrimination. Inequity is not merely an inherited legacy of the past, however. We still contend with many forms of entrenched but subtle institutional and interpersonal forms of discrimination.

The central finding in this report is that racial and ethnic inequities in Chicago remain pervasive, persistent, and consequential: these inequities affect the lives of Chicagoans in every neighborhood; they have not just spatial but also deep historical roots and are embedded in our social institutions;⁶ and they have powerful effects on the lived experiences and opportunities of all Chicagoans. While it is impossible to ignore the devastating impact of gun violence, the other hard truth we must face is that far more Chicagoans die early today from the effects of structural violence than they do from interpersonal violence. As health scholar Paul Farmer and his colleagues describe:

The central finding in this report is that racial and ethnic inequities in Chicago remain pervasive, persistent, and consequential.

“The term ‘structural violence’ is one way of describing social arrangements that put individuals and populations in harm’s way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities).”⁷

When we consider the deep levels of Chicago’s segregation, we are concerned because where people live shapes their proximity to quality public education, the availability and variety of public amenities, their access to quality healthcare facilities and social services, their exposure to or insulation from pollutants and other environmental hazards, and their immediate access to jobs, among other factors associated with well-being and social mobility. Advantages or disadvantages people have in one area often translate into parallel advantages or disadvantages in another. Chicagoans of all racial and ethnic groups want to live in safe and healthy communities where they don’t just subsist or survive but also thrive, but not all have equal access.

The reverberations of our collective racial history, along with persistent patterns of racism today, yield stark patterns of inequity we cannot ignore. In many ways, Dr. Martin Luther King, Jr.'s description of racial dynamics fifty years ago remains as relevant today as they did during the years of struggle for civil rights:

“Of the good things in life, the Negro has approximately one-half those of whites; of the bad things of life, he has twice those of whites. Thus, half of all Negroes live in substandard housing, and Negroes have half the income of whites. When we turn to the negative experiences of life, the Negro has a double share. There are twice as many unemployed; the rate of infant mortality (widely accepted as an accurate index of general health) among Negroes is double that of whites.”⁸

This was Chicago in 1967. This is Chicago in 2017. Black and Latinx Chicagoans tend to be overrepresented on the bottom-end of most every indicator of inequality available while white Chicagoans tend to be overrepresented at the top. To be sure, considerable changes have transpired in the city's racial and ethnic landscape over the past half-century, from the election of Chicago's first black mayor to major demographic transformations to recent affirmations of being a “sanctuary city,” but levels of inequality among Chicago's major racial and ethnic groups remain pervasive, persistent, and consequential. It begs the question, in this city of broad shoulders, why are some shouldering a far greater burden than others?

We can all do better. And, in fact, it will take significant effort by many of us to make real headway on the challenges described herein. Good intentions are not enough, apathy is not an option.⁹ We all need to feel a much greater collective sense of responsibility and take action to ensure that our neighbors near and far have the opportunity to live full, healthy, and dignified lives.

ENDNOTES

- 1 More on the subject is available in "Inundated with gunshot victims, Chicago doctors and nurses face 'compassion fatigue'" by Marwa Eltagouri.
- 2 Baldwin, James. 1962. "As Much Truth As One Can Bear." *The New York Times Book Review*. BR:11
- 3 There are too many examples to name them all but just a few include: Moore, Natalie. 2016. *Southside: A Portrait of Chicago and American Segregation*. New York, NY: St. Martin's Press; Hirsch, Arnold. 1998. *Making the Second Ghetto: Race and Housing in Chicago 1940-1960*. Chicago, IL: University of Chicago Press; Drake, St. Claire and Horace Cayton. [1945] 2015. *Black Metropolis: A Study of Negro Life in a Northern City*. Chicago, IL: University of Chicago Press; Wilkerson, Isabel. 2010. *The Warmth of Other Suns: The Epic Story of America's Great Migration*. New York, NY: Random House.
- 4 Rothstein, Richard. 2017. *The Color of Law: A Forgotten History of How Our Government Segregated America*. New York, NY: Liveright Publishing. See also "Historian Says Don't 'Sanitize' How Our Government Created Ghettos" by Terry Gross.
- 5 Oliver, Melvin and Thomas Shapiro. 1995. *Black Wealth/White Wealth: A New Perspective on Racial Inequality*. New York, NY: Routledge.
- 6 Reskin, Barbara. 2012. "The Race Discrimination System." *Annual Review of Sociology* 38:17-35; see also Feagin, Joe R. and Douglas Lee Eckberg. 1980. "Discrimination: Motivation, Action, Effects, and Context." *Annual Review of Sociology* 6:1-20.
- 7 Farmer, Paul E., Bruce Nizeye, Sara Stulac, and Salmaan Keshavjee. 2006. "Structural Violence and Clinical Medicine." *PLoS Medicine* 3(10):1686-1691.
- 8 King, Jr., Martin Luther. 1967. *Where Do We Go from Here? Chaos or Community?* Boston, MA: Beacon Press.
- 9 Forman, Tyrone A. 2004. "Color-Blind Racism and Racial Indifference: The Role of Racial Apathy in Facilitating Enduring Inequalities." Pp. 43-66 in *The Changing Terrain of Race and Ethnicity*, edited by Maria Krysan and Amanda E. Lewis. New York, NY: Russell Sage.

SCOPE OF THE REPORT

While we strove to make *A Tale of Three Cities* as comprehensive as possible, we had to limit its scope because of constraints in available data and resources. We list some of the resulting shortcomings here in the spirit of encouraging ourselves and others to continue the effort and fill in the gaps.

First, we were surprised to discover how many gaps there are in existing data. As we discuss more fully in the methodological appendix, we regularly came up against important limitations in *how* data are currently collected, organized, and/or tallied. One example is that racial and ethnic categories are not consistent across datasets. This makes some comparisons challenging and also raised questions about what racial/ethnic labels to use and whether to allow variation or impose consistency in our use. Racial and ethnic categories are inherently social and political. And they change over time. As we discuss more fully in the methodological appendix, the labels we use are themselves subject to much debate (e.g., Hispanic vs. Latinx) and vary across datasets.

We also were challenged by gaps in *what kinds* of data are readily available. For instance, when we began to pull together existing data on educational experiences in the city, we found extensive research and data on educational *outcomes* but not as much on differences in educational *inputs* within and across schools in the city. Researchers in other cities and states urged us to include measures of educational equity used in their localities (e.g., data on the availability of textbooks and supplies, teacher preparation, etc.). But these data were not readily available for the city of Chicago. Similarly, with regard to health data, we found ourselves challenged about how to address gaps between the extensive data available on *illness* and *death* but the lack of available indicators that tap into opportunities for *wellness* (e.g., community access to affordable health and fitness programs).

We also recognize that the report is not truly a report on the conditions of all racial and ethnic groups in the City of Chicago. Having to rely upon secondary sources meant that data across many indicators was either unreliable or unavailable for numerically smaller but important communities within the city: Asians, Pacific Islanders, Native Americans, and Arab Americans. To this end, we hope that the report can be used (by us and others) as a spur for new research. To at least partially fill this gap, we have included short qualitative commentaries by scholars in their areas of expertise that capture some of the key challenges facing some of these communities today.

We hope that the report can be used as a spur for new research.

Another important limitation in the report stems from the fact that any effort to understand how life experiences vary along racial and ethnic lines will, by its nature, be incomplete. What we are capturing here are meaningful but inherently limited average differences between groups. However, it is important to remember the small scope of such averages—not every white family in the city is thriving just as not every black family is struggling. We also recognize that we are much more than just our racial/ethnic identity. Race/ethnicity always intersects with other categories of human difference (e.g., class, religion, sexuality, gender). Data limitations, and the scope of this report, make it impossible to fully attend to these intersections. We do not, for example, disaggregate data by ethnicity or nationality within categories; and we only attend to gender differences in limited ways. While we incorporate class variation where possible, we give almost no attention to sexuality or religious differences.

Another constraint of the report stems from the kind of data we are drawing upon. This report is quantitative, not qualitative—therefore we necessarily miss some of the nuances of how the disparities revealed by numerical differences affect how people experience these disparities. The kinds of quantitative data we draw on are crucial for capturing social patterns but miss the different ways people have organized their families, neighborhoods, and communities to not only survive but hopefully overcome these challenges and thrive. Chicago is full of stories of engaged people organizing to improve their communities, provide better education to their young people, make streets and parks safer, build new businesses and expand job opportunities, and provide healthcare to all.

KEY TAKEAWAYS FROM THIS SECTION

- Health outcomes are improving across Chicago, but inequalities between blacks and whites are either stagnant or widening on major indicators of mortality like heart disease, stroke, and mortality in general.
- Whereas Latinx Chicagoans tend to be positioned in the middle or bottom on many measures of the racial and ethnic inequity, they fare better than both whites and blacks on measures like mortality rates and incidence of certain cancers. That said, Latinxs are uninsured at twice the rate of their black and white counterparts and may be underreported in some areas.
- Healthcare providers and pharmacies are dispersed throughout the city in patterns that mirror Chicago's segregation, being concentrated in the city center and white neighborhoods but sparse in black and Latinx neighborhoods.
- Health inequalities begin at birth in Chicago. Racial and ethnic disparities persist in infant mortality and low birthweight, two outcomes often associated with socioeconomic status and access to prenatal care.

WHAT DOES HEALTH EQUITY LOOK LIKE IN CHICAGO?

with Faith E. Fletcher and Meredith Buchberg

Widespread health disparities persist across the country and locally in Chicago. Importantly, while most of the nation has made some progress toward the reduction of health inequalities among racial and ethnic groups, these inequalities are actually growing worse in Chicago.¹ In 2014, the Chicago Department of Health (CDPH) launched the first Healthy Chicago Survey to gain a better understanding of health behaviors, health outcomes, and access to health services among Chicago residents.² Results from the survey indicate that black and Latinx Chicagoans are less

CHICAGO NUMBERS THAT COUNT

A Comparison of the Leading Causes of Death by Race / Ethnicity in the U.S. and Chicago

United States				City of Chicago					
	All Persons	Black	Latinx	White		All Persons	Black	Latinx	White
1	Heart Disease	Heart Disease	Cancer	Heart Disease	1	Heart Disease	Heart Disease	Cancer	Heart Disease
2	Cancer	Cancer	Heart Disease	Cancer	2	Cancer	Cancer	Heart Disease	Cancer
3	Chronic Lower Respiratory Diseases	Stroke	Accidents	Stroke	3	Stroke	Stroke	Accidents	Stroke
4	Accidents	Accidents	Stroke	Accidents	4	Accidents	Accidents	Diabetes	Chronic Lower Respiratory Diseases
5	Stroke	Homicide	Diabetes	Pulmonary Diseases	5	Chronic Lower Respiratory Diseases	Homicide	Stroke	Accidents
6	Alzheimers	Conditions Originating in Perinatal Period	Liver Disease	Influenza and Pneumonia	6	Diabetes	Diabetes	Homicide	Influenza and Pneumonia
7	Diabetes	Influenza and Pneumonia	Alzheimers	Diabetes	7	Kidney Disease	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	Diabetes
8	Influenza and Pneumonia	Diabetes	Chronic Lower Respiratory Diseases	Atherosclerosis	8	Septicemia	Kidney Disease	Kidney Disease	Septicemia
9	Kidney Disease	Liver Disease	Influenza and Pneumonia	Liver Disease	9	Influenza and Pneumonia	Septicemia	Septicemia	Alzheimers
10	Suicide	Kidney Disease	Kidney Disease	Suicide	10	Homicide	Influenza and Pneumonia	Influenza and Pneumonia	Kidney Disease

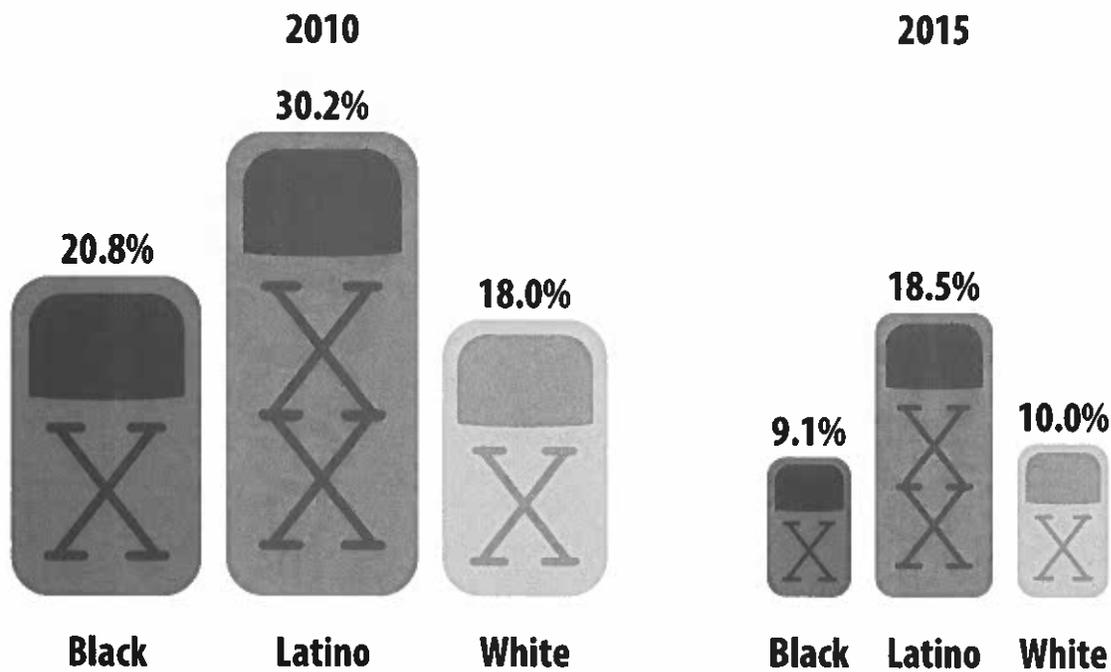
Source: Centers for Disease Control and Prevention; Chicago Department of Public Health

likely than white Chicagoans to have health insurance, more likely to be current cigarette smokers, and less likely to meet recommendations for physical activity as well as for fruit and vegetable consumption.³ Further, data from the CDPH indicate that significant health disparities exist with regards to disease prevalence in Chicago, with black and Latinx Chicagoans having higher rates of heart disease, cancer, stroke, diabetes, and homicide as compared their white counterparts.

Latinx Chicagoans are twice as likely as blacks or whites to be uninsured.

Access to and availability of high-quality education, nutritious food, safe and affordable housing, affordable and reliable public transportation, health care providers and adequate insurance, as well as clean water and air are important for health outcomes and have been and continue to be distributed unequally in Chicago.¹⁶ For example, despite reductions in the number of uninsured individuals in Chicago, due largely in part to the Affordable Care Act, data from the American Community Survey show that Latinx Chicagoans are twice as likely as blacks or whites to be uninsured.

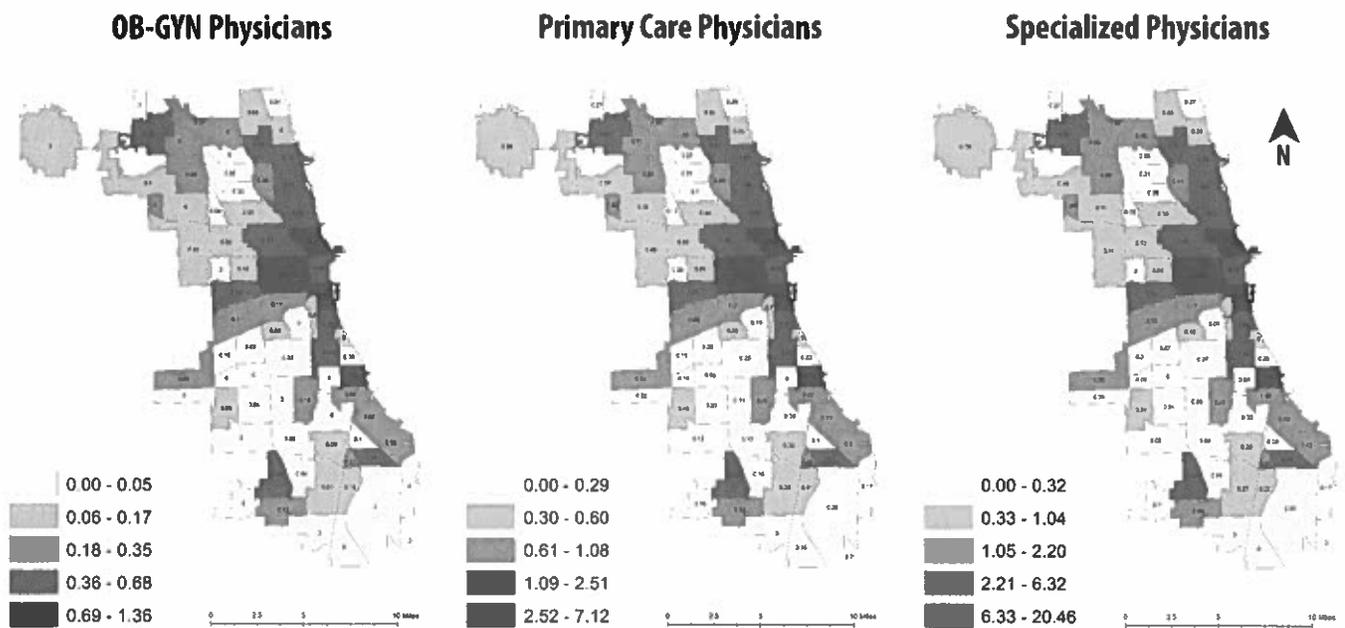
5-YEAR ESTIMATES OF UNINSURED CHICAGOANS BY RACE AND ETHNICITY, 2010 - 2015



Data: American Community Survey

Elsewhere, data from the Primary Care Service Area Project show us that the availability of healthcare providers, from OB-GYN physicians to primary care doctors to specialist physicians, are dispersed throughout the city in ways that mirror the city's patterns of segregation. Most doctors are concentrated in the city center and in neighborhoods that are predominantly white. Meanwhile, many black neighborhoods located on the city's South and West Sides can be considered "healthcare provider deserts." That is, many cannot access healthcare conveniently due to location and the dearth of options in their communities.

HEALTHCARE PROVIDER RATES PER 1,000 RESIDENTS BY COMMUNITY AREA, 2010



Data: Primary Care Service Area Project

A lack of options extends beyond medical providers and includes pharmacy options too. More than 1 million people on the South and West Sides live in "pharmacy deserts."⁴ That is, they have no drug store within a half-mile radius of their communities—communities that are often low income and cannot access convenient transportation. Perhaps what makes this trend all the more disturbing is that as many as 70% of Americans have at least one medical prescription. Consequently, this likely means that many people of color are not getting the medicine they need simply because of where they live.

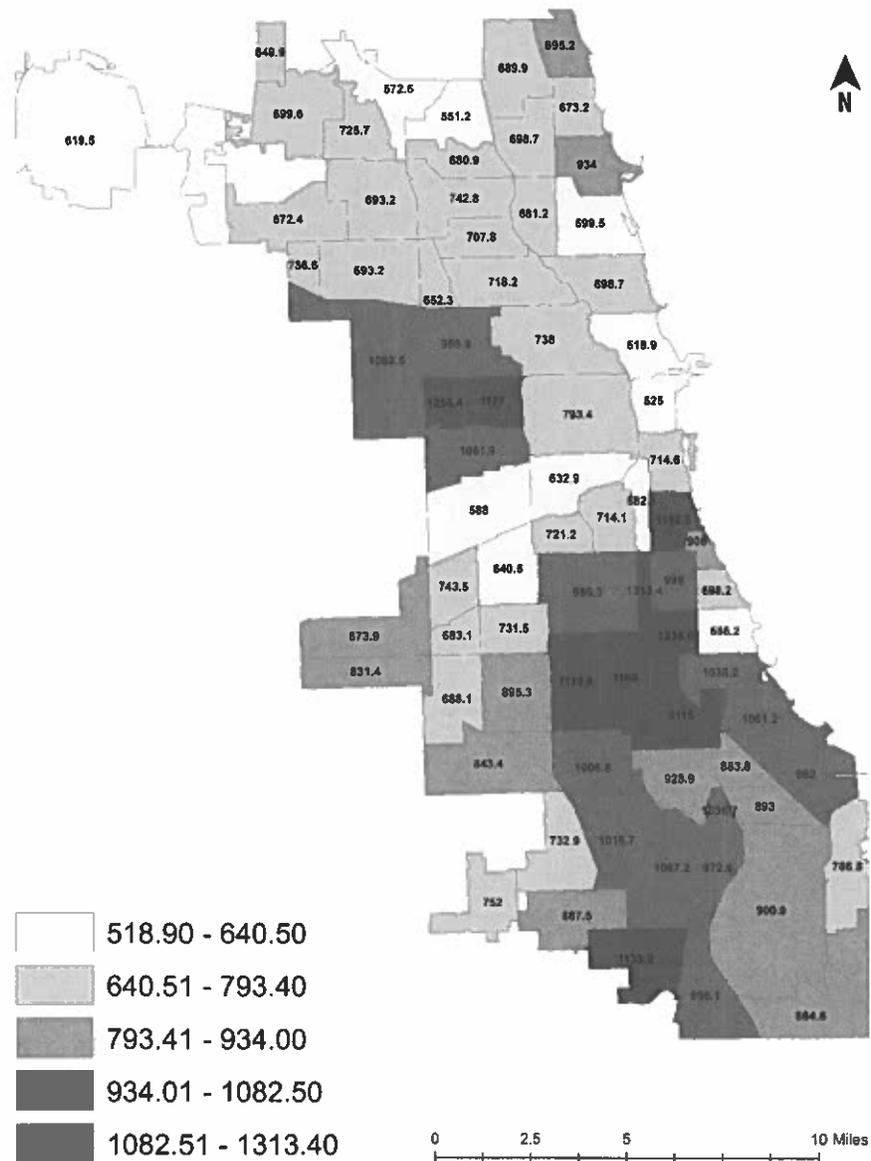
More than 1 million people on the South and West Sides live in pharmacy deserts.

MORBIDITY, MORTALITY, AND PREMATURE DEATH

According to CDPH data, age-adjusted all-cause mortality in the city has declined by about 20% over the past decade to our current rate of about 800 deaths per 100,000 residents. The decline has not, however, translated into parity among racial and ethnic groups. Black Chicagoans are dying at rates that outpace those of their white peers. During the past three decades, for example, the black mortality rate has hovered around 130% of the white rate.⁵

Looking at mortality rates by neighborhood, one can see that these racial disparities in mortality map directly onto Chicago's patterns of segregation, with predominantly black neighborhoods on the South and West Sides suffering the highest death rates in the city. In fact, 17 community areas have mortality rates of over 1,000 deaths per 100,000 residents. Of these communities, all have black majorities and 16 have black populations of 85% or greater. Studying Chicago recently, Bijou Hunt and colleagues found a statistically significant negative correlation between the proportion of black residents in a community and life expectancy.⁶

5-YEAR ESTIMATES OF ALL CAUSE MORTALITY RATES PER 100,000 RESIDENTS BY CHICAGO COMMUNITY AREA, 2006 - 2010 (AGE-ADJUSTED)



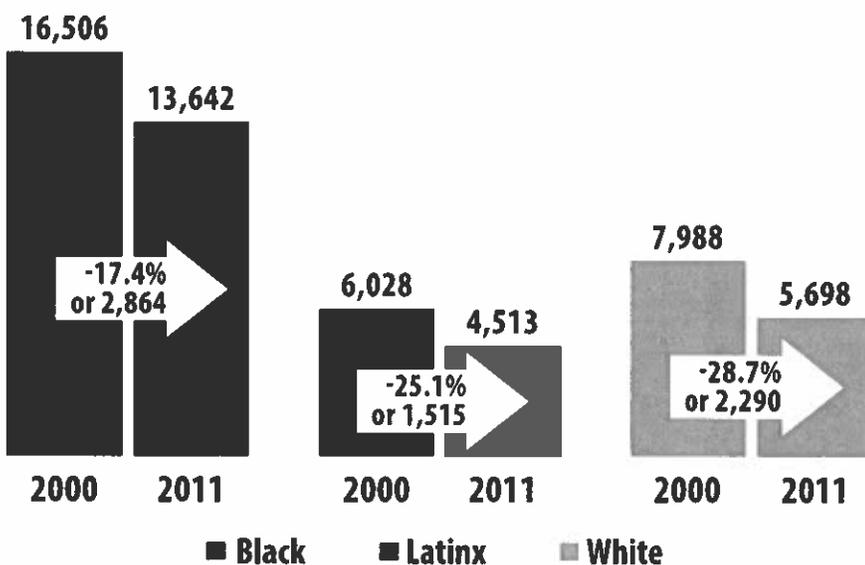
Data: Chicago Department of Public Health

Not only do black Chicagoans die at higher rates, but they tend to die at younger ages. Because many of these deaths are preventable, health experts refer to them as premature. Premature deaths simply refer to deaths that occur before someone reaches 75 years of age, and the premature mortality rate is calculated by the number of potential years of life lost.⁷ As of 2011, Chicago's premature mortality rate was 7,720 years of potential life lost per 100,000 residents.⁸ Breaking these numbers down by racial and ethnic group, the black premature mortality rate was 13,642 years of potential life lost. The Latinx rate was 4,513 years. And the white rate was 5,698. This means that black Chicagoans are suffering premature death at 2.4 to 3 times the rate of whites and Latinxs.

Not only do black Chicagoans die at higher rates, but they tend to die at younger ages.

Interestingly, premature deaths for Chicago's Latinxs have declined between 2000 and 2011 at similar rates as for whites (28.7% versus 25.1%). Given that Latinxs fare worse than whites on many indicators of inequality, this finding may seem counterintuitive. Researchers dubbing this phenomenon as the "Hispanic Paradox" have suggested several explanations: first, that Latinxs who immigrate are more likely to remain in better health than those who do not; second, that Latinx immigrants who are in poor health may not contribute to the death rate because they return to their home country before death;⁹ and third, that Latinxs smoke at lower rates than other groups.¹⁰

COMPARE: PREMATURE MORTALITY RATES PER 100,000 RESIDENTS, 2000 - 2011



Data: Chicago Department of Public Health

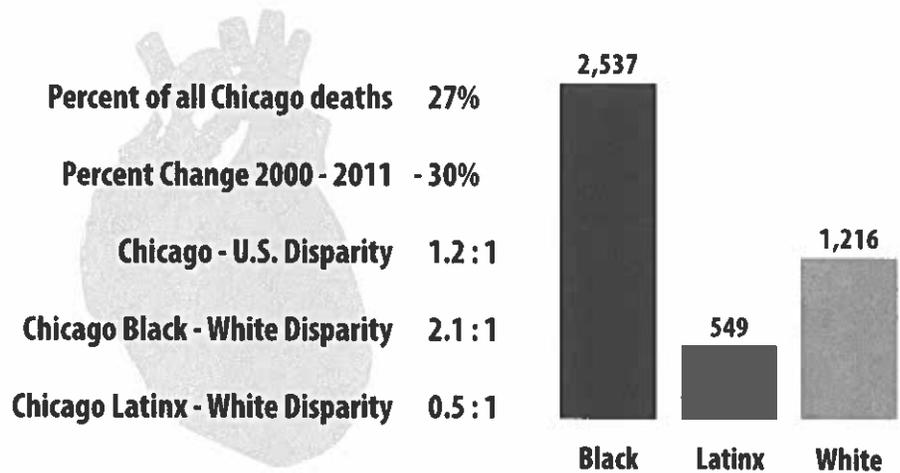
While the deaths of individuals over age 75 can largely be attributed to chronic conditions associated with aging, deaths of individuals under 75 are more likely to be attributed to preventable causes. Scholars recently have written about the role that the persistent and cumulative effects of discrimination and other upstream factors can play in premature death.¹¹ Allostatic load, for instance, which refers to the physiological effects one experiences due to the accumulation

of chronic life stressors, has been shown to partially explain racial disparities in mortality (independent of socioeconomic status and individual health behaviors).¹² In Chicago, these disparities persist in mortality rates for cardiovascular disease, cancer, homicide, diabetes, and infant mortality.

CARDIOVASCULAR DISEASE AND STROKE

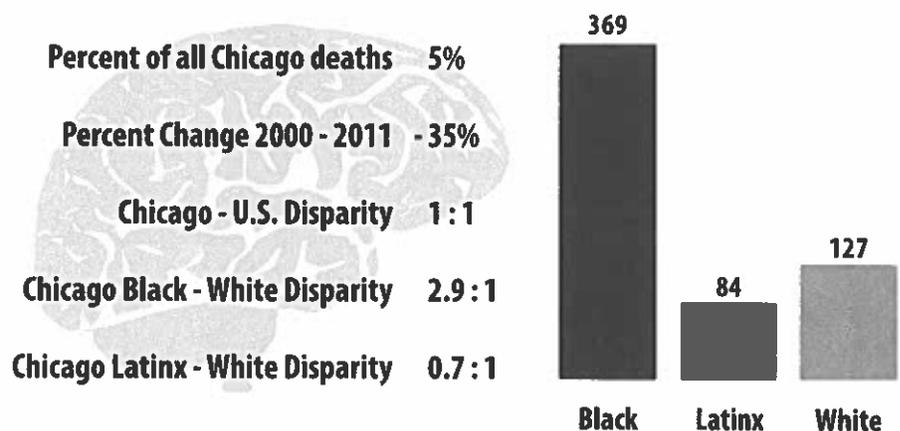
Deaths from heart disease and stroke have declined significantly over the last 30 years due to advances in medications and treatments, lower rates of smoking, and increased awareness and education about risk factors.¹³ However, heart disease and stroke are still the number one and number three causes of death for Chicago residents. Together, they account for over one-third of all the city's deaths. Significant black-white disparities persist here too. Black Chicagoans are about 2.9 times more likely to die from stroke and 2.1 times as likely to die from heart disease compared to white Chicagoans.

HEART DISEASE MORTALITY PER 100,000 RESIDENTS (AGE-ADJUSTED), 2011



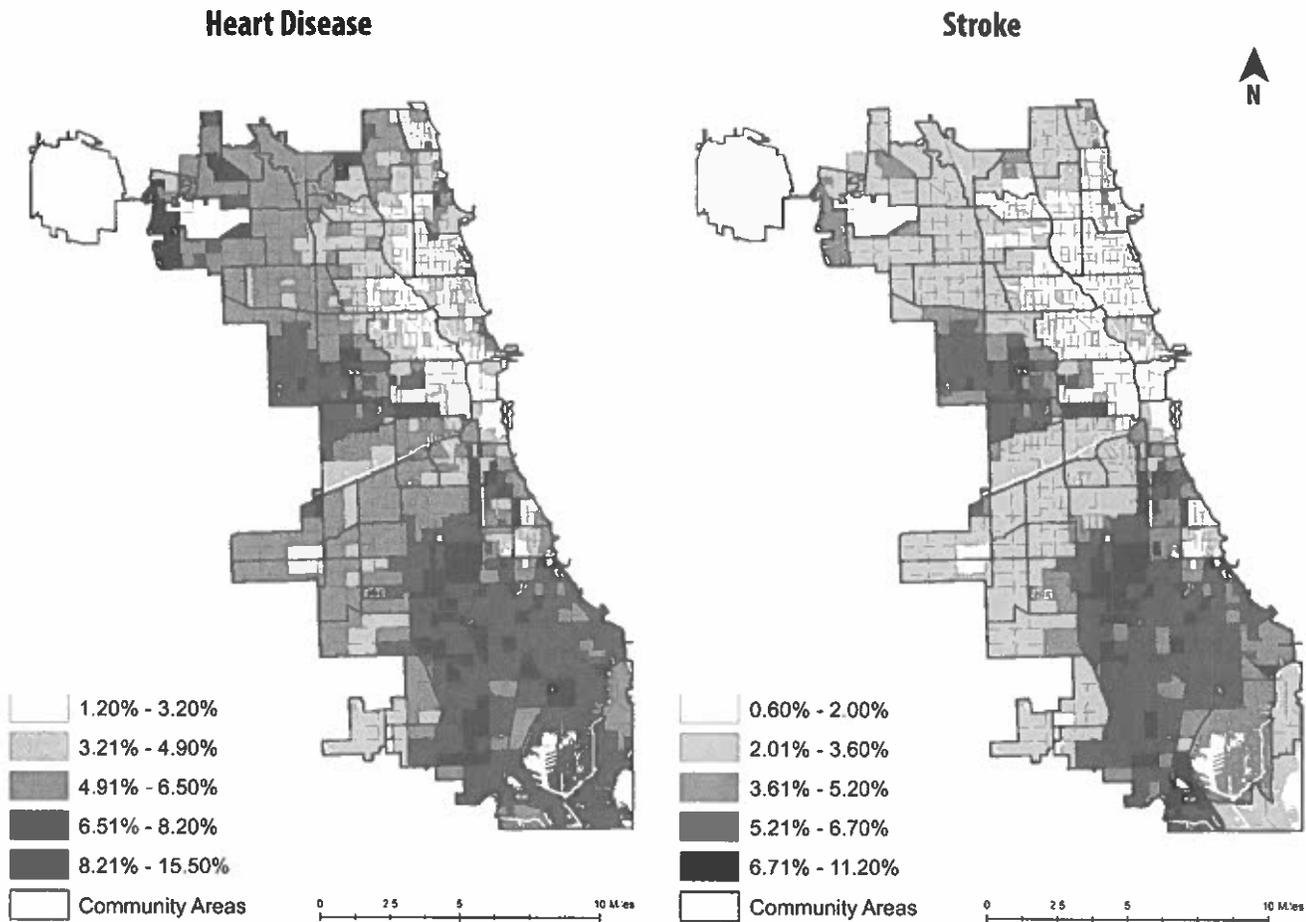
Data: Chicago Department of Public Health

STROKE MORTALITY PER 100,000 RESIDENTS (AGE-ADJUSTED), 2011



Data: Chicago Department of Public Health

PERCENTAGE OF THE POPULATION IN CHICAGO DIAGNOSED WITH HEART DISEASE OR STROKE IN 2014 BY CENSUS TRACT

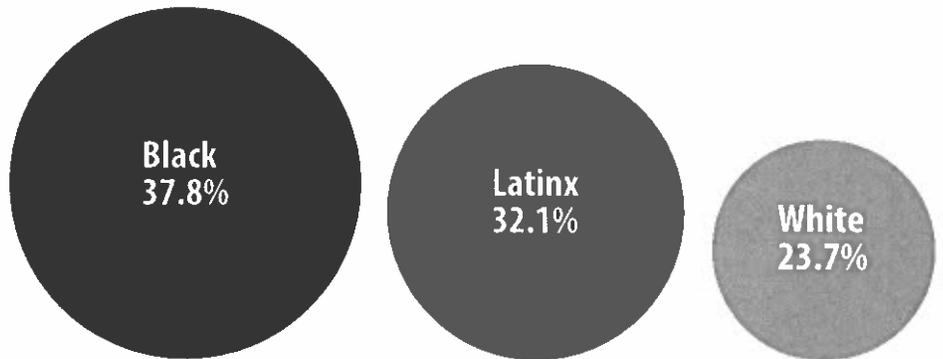


Data: 500 Cities: Local Data for Better Health

Again, those communities suffering most from heart disease and stroke are located in predominantly black neighborhoods on the South and West Sides of the city. Looking at the dataset "500 Cities: Local Data for Better Health," we see that some of these communities have over 10 times the rate of heart disease and stroke as the surrounding neighborhoods. The communities hardest hit have populations where over 10% of their entire population has been diagnosed with heart disease or experienced a stroke; 9 census tracts in the city surpass this threshold.

Compared to white Chicagoans, their black and Latinx counterparts exhibit substantially higher rates of important risk factors for heart disease, including hypertension, obesity, lack of physical activity, smoking, and diabetes. For example, the rate of hypertension is almost twice as high for blacks than for whites (39.3% versus 23.6%).¹⁴

OBESITY RATES IN CHICAGO BY RACE AND ETHNICITY, 2014



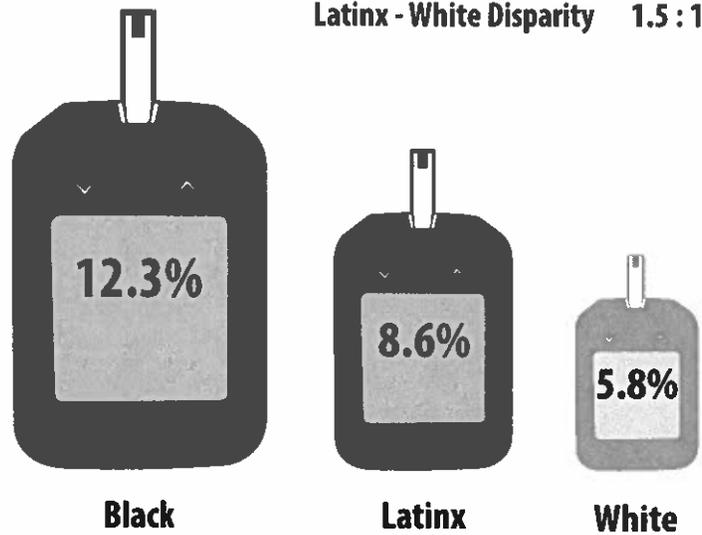
Data: Healthy Chicago Survey

Looking at the prevalence of diabetes among Chicago’s racial and ethnic groups, about 12.3% of black residents have been diagnosed with it compared to 8.6% of Latinxs and 5.8% of whites. This means that the prevalence of diabetes is about 210% higher for blacks than whites and about 150% higher for Latinxs than whites. What are some of the factors that contribute to these racial and ethnic disparities in disease rates?

PREVALENCE OF DIABETES, 2014

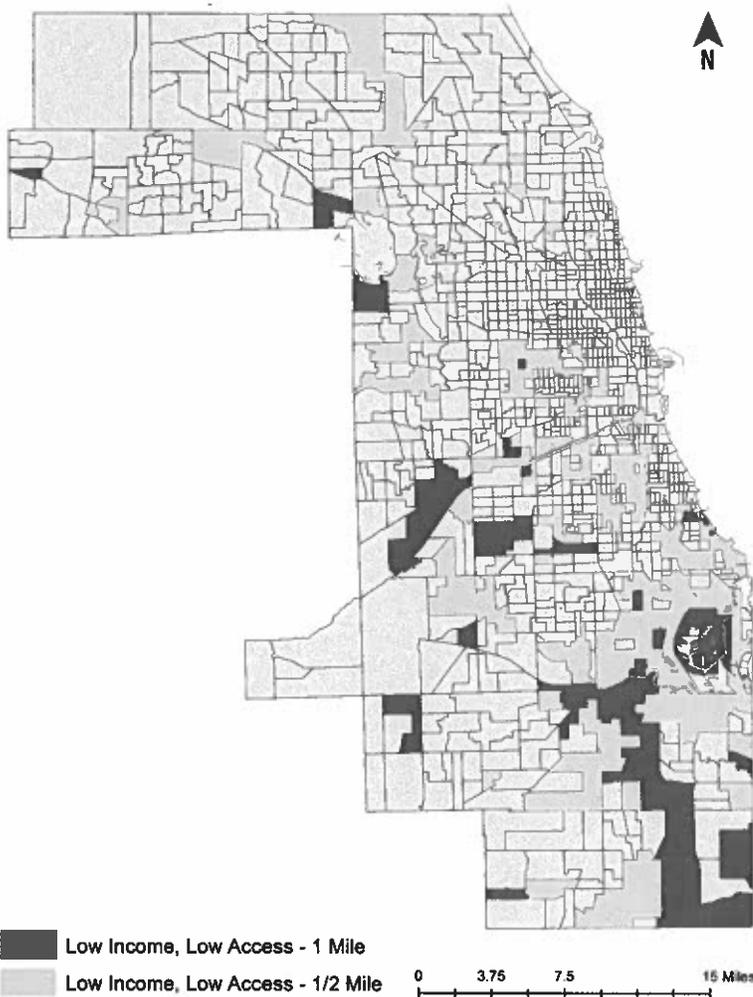
Black - White Disparity 2.1 : 1
 Latinx - White Disparity 1.5 : 1

The prevalence of diabetes is about 210% higher for blacks than whites and about 150% higher for Latinxs than whites.



Data: Chicago Department of Public Health

**LOW-INCOME COOK COUNTY CENSUS TRACTS LOCATED
0.5-TO-1 MILE FROM A SUPERMARKET, 2015**



Data: Food Access Research Atlas

black Chicagoans were most disadvantaged among their options for balanced food choices.¹⁸ More specifically, their findings show that poor black folks traveled farther to any type of grocery store compared to other Chicagoans and that food deserts cluster, in a strikingly obvious fashion, in exclusively black communities.¹⁹ This important study remains relevant still today as food deserts continue to disproportionately impact these same communities.²⁰

Food deserts continue to disproportionately impact black communities.

FOOD DESERTS IN COOK COUNTY

One contributing factor to higher diabetes rates, as well as other disparate health outcomes among people of color, is “food deserts.”¹⁵ Food deserts, as defined by the U.S. Department of Agriculture, refer to census tracts where a significant share of residents have either no or low access to a supermarket or large grocery store.¹⁶ By this definition, corner stores that often sell processed foods, which are high in sugar and low in nutritional value, are systematically omitted. Remaining are the Jewel-Oscos and Mariano’s of Cook County, places that offer fuller sections of fresh produce and have their own delis. Census tracts qualify as “low access” if they have at least 500 residents or one-third of their population living more than one mile from a supermarket or large grocery store.¹⁷

Over a decade ago, the Mari Gallagher Research and Consulting Group found that low-income

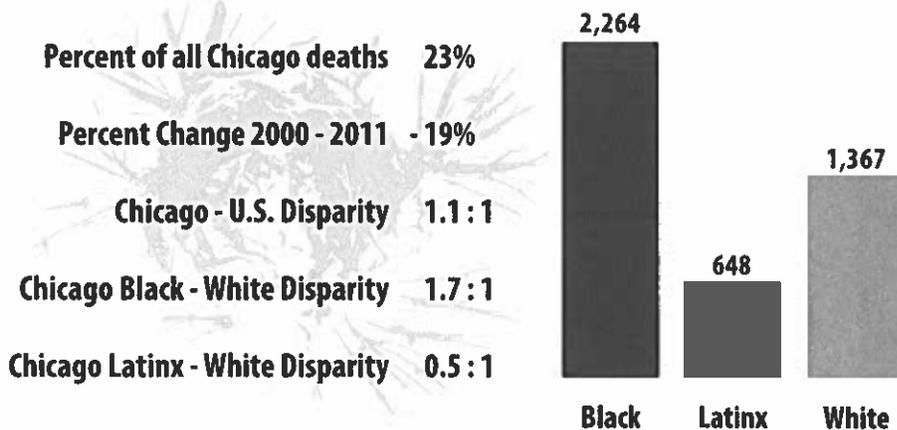
Data from the Food Access Research Atlas show that 183,200 Chicagoans live within a low-income census tract that is located at least one mile away from a supermarket or large grocery store. That adds up to 44 low-income census tracts. By “low-income,” we borrow the U.S. Department of Agriculture’s definition to mean those tracts that have either: 1) 20% or more of their families with incomes at or below the federal poverty line or, 2) 80% or more of families with a median income that is at or below the surrounding area’s median income. The vast majority of these food deserts are located in segregated black neighborhoods on the South and West Sides.

When we look at those low-income tracts that are located at least a half mile from a supermarket or large grocery store, the number of communities grows exponentially to 302 census tracts. That is 1,176,894 Chicagoans in total. While this half-mile threshold falls under the distance of what constitutes a food desert, let us point out that half a mile to a supermarket or large grocery store is still a sizeable distance—one that may require traveling through concentrated areas of crime or spaces underserved by public transit. Most of these low-income tracts also cluster in segregated black neighborhoods.

CANCER MORTALITY AND INCIDENCE

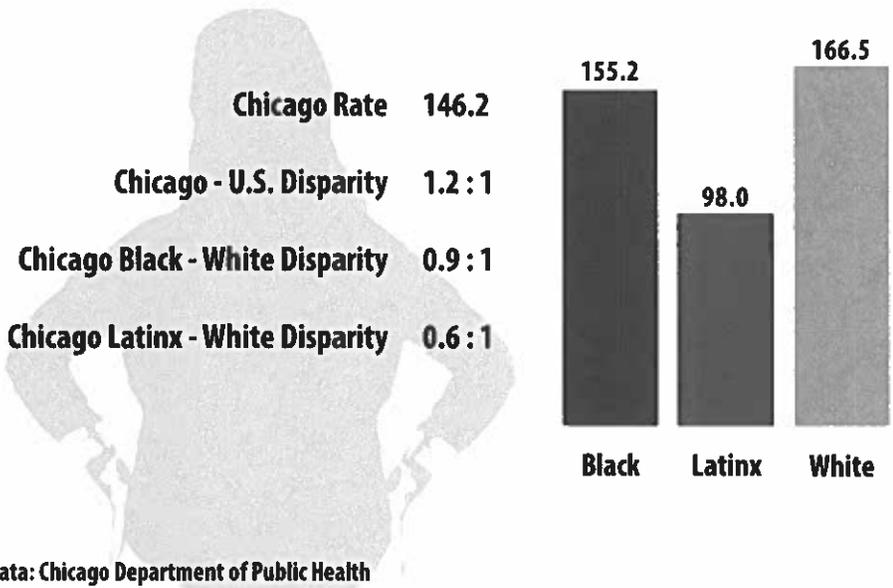
Even though Chicago’s cancer mortality rates have declined by 19% over the past decade, cancer still accounts for 1 in 4 deaths among Chicagoans. Black Chicagoans, in particular, are vulnerable. With a cancer mortality rate of 2,264 deaths per 100,000, they are 1.3 times more likely than white Chicagoans to die from cancer. Meanwhile, white Chicagoans are twice as likely as their Latinx counterparts to die from cancer. While Latinxs are the least likely of Chicago’s three main racial and ethnic groups to die from cancer, it is worth noting that they are actually faring worse now than in the past for some cancer types.

CANCER MORTALITY PER 100,000 RESIDENTS (AGE-ADJUSTED), 2011



Data: Chicago Department of Public Health

BREAST CANCER INCIDENCE PER 100,000 RESIDENTS, 2011



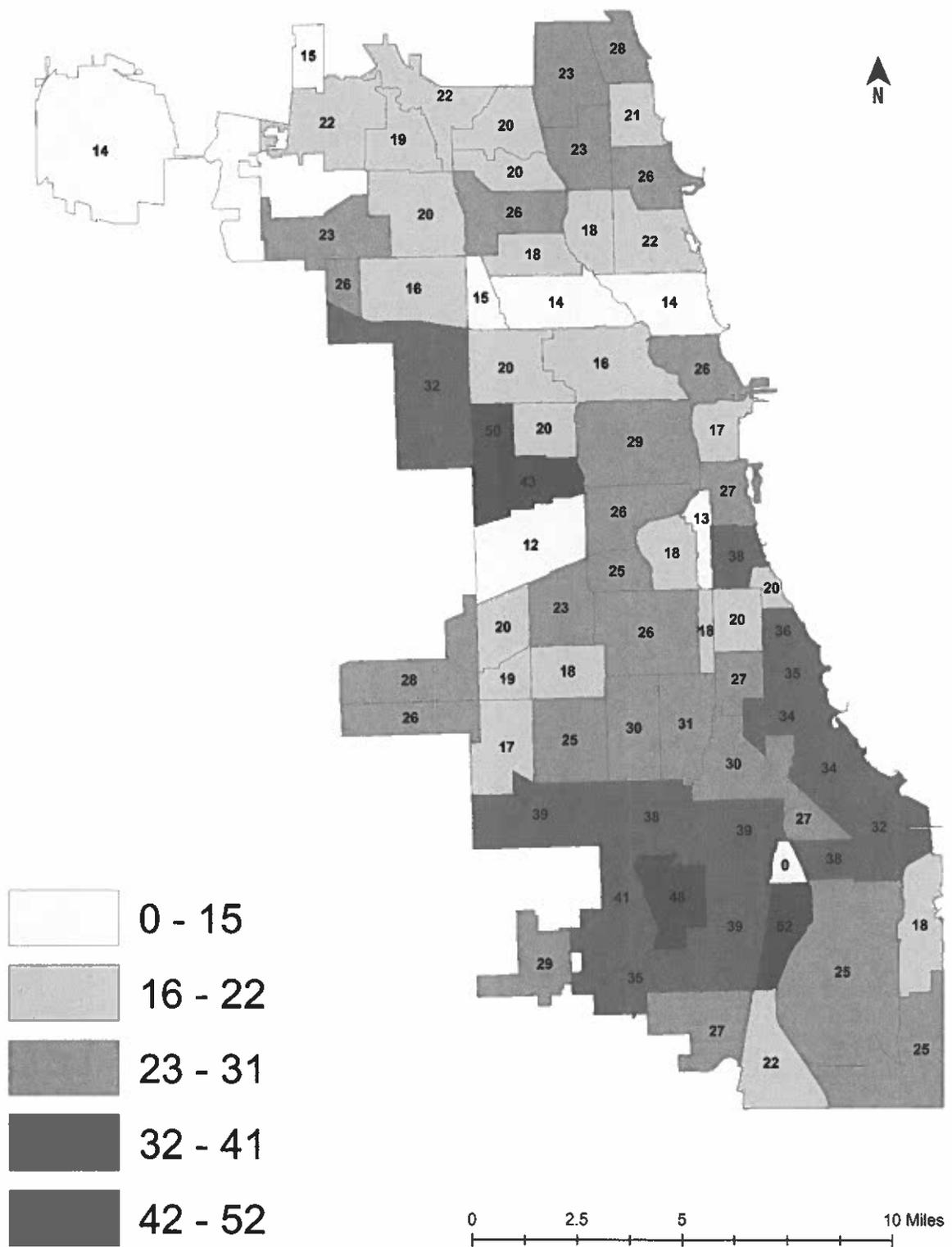
Consider mortality rates for female breast cancer in Chicago. During the 2000s, data from the Illinois Department of Public Health show that the breast cancer mortality rate declined for black and white women by 14.0% and 26.5%, respectively.²¹ Meanwhile, the breast cancer mortality rate for Latinas trended in the opposite direction, increasing by 33.3% over the same timeline.

In Chicago, the female breast cancer mortality rate is 1.5 times higher for black women than for white women.²² The rate for black women is 37 deaths per 100,000 residents. Though black women die at higher rates than their white counterparts, it is worth noting that they have lower rates of incidence than white women (155.2 diagnoses per 100,000 residents versus 166.5 diagnoses per 100,000 residents). That is, white women have higher incidence but lower mortality than their black counterparts, suggesting that many black women in Chicago are not getting a breast cancer diagnosis in time to save their life.

As with other disease patterns, Chicagoan’s breast cancer mortality rates have a spatial dimension to it also, with mortality rates much higher in some neighborhoods than others. Four out of the five worst-off neighborhoods are comprised of populations that are 90% or more black residents. The highest mortality rates are in Pullman (51.5), West Garfield Park (49.7), Washington Heights (48.5), North Lawndale (43.4), and Beverly (41.4). Scholars argue that these kinds of disparities result from a myriad of barriers that minorities face, including poverty, lack of access to health care, lack of health insurance, language and literacy barriers, and poor expectations about the results of cancer treatments and the healthcare system.²³

In Chicago, the female breast cancer mortality rate is 1.5 times higher for black women than for white women.

5-YEAR ESTIMATES OF FEMALE BREAST CANCER MORTALITY RATES PER 100,000 RESIDENTS BY CHICAGO COMMUNITY AREA, 2006-2010 (AGE-ADJUSTED)



Data: Chicago Department of Public Health

INFANT MORTALITY AND LOW BIRTHWEIGHT

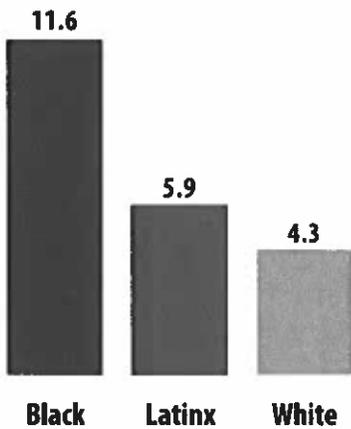
INFANT MORTALITY RATE PER 1,000 BIRTHS, 2010

Percent Change 2000 - 2010 - 30%

Chicago - U.S. Disparity 1 : 1

Chicago Black - White Disparity 2.7 : 1

Chicago Latinx - White Disparity 1.4 : 1



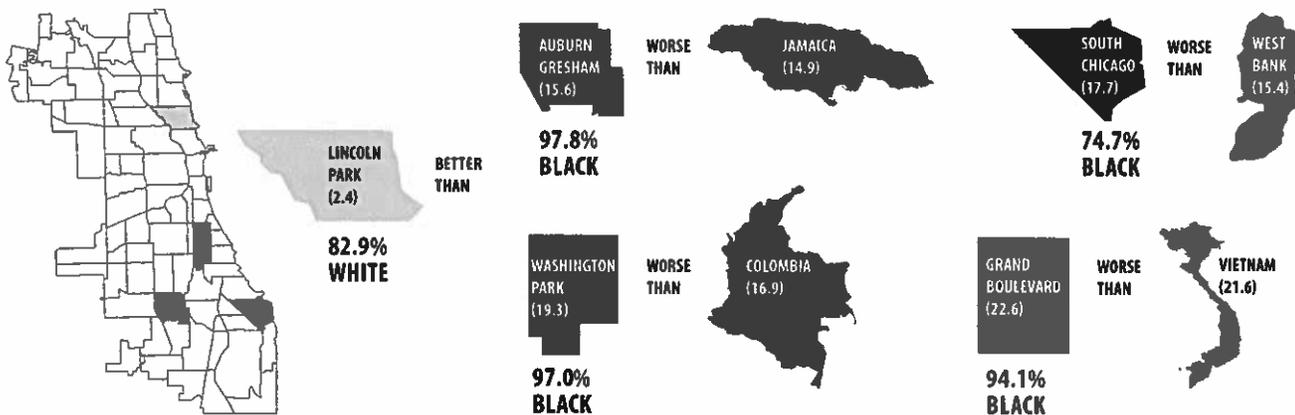
Data: Chicago Department of Public Health

Although infant mortality rates in Chicago have decreased approximately 30% since 2000, they are markedly different between racial and ethnic groups. The infant mortality rate, defined as the number of infant deaths per 1,000 live births,²⁴ is almost 3 times higher for black Chicagoans than white Chicagoans (11.6 versus 4.3). Meanwhile, the mortality rate for Latinx infants is 1.4 times higher as compared to Whites (5.9 versus 4.3).

In Chicago, three predominantly black neighborhoods suffer infant mortality rates that are about 2 or more times greater than the city rate (9.0 infant deaths per 1,000 live births). In fact, their infant mortality rates are on par with nation-states often thought of as “developing.”

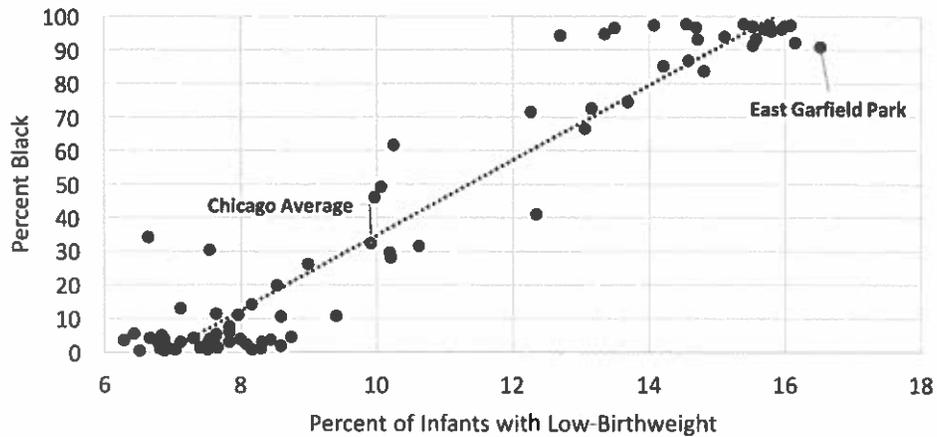
Low birthweight is one of the most significant risk factors for infant mortality. By low birthweight, we mean less than 5 pounds, 8 ounces (< 2,500 grams). In Chicago, about 15% of black infants are considered low birthweight.²⁵ This is more than double the white and Latinx rates, both of which are 7%. In fact, 13 of Chicago’s 77 community areas have at least 15% of all infants being born with a low birthweight. All of these community areas have black populations of 90% or more.

A COMPARISON OF INTERNATIONAL INFANT MORTALITY RATES PER 1,000 BIRTHS TO CHICAGO COMMUNITY AREA RATES AND THEIR RACIAL AND ETHNIC COMPOSITION, 2010



Data: Chicago Department of Public Health; CIA World Factbook

5-YEAR ESTIMATES OF THE PERCENT OF INFANTS BORN WITH LOW-BIRTHWEIGHT AND PERCENT BLACK BY COMMUNITY AREA, 2005-2009

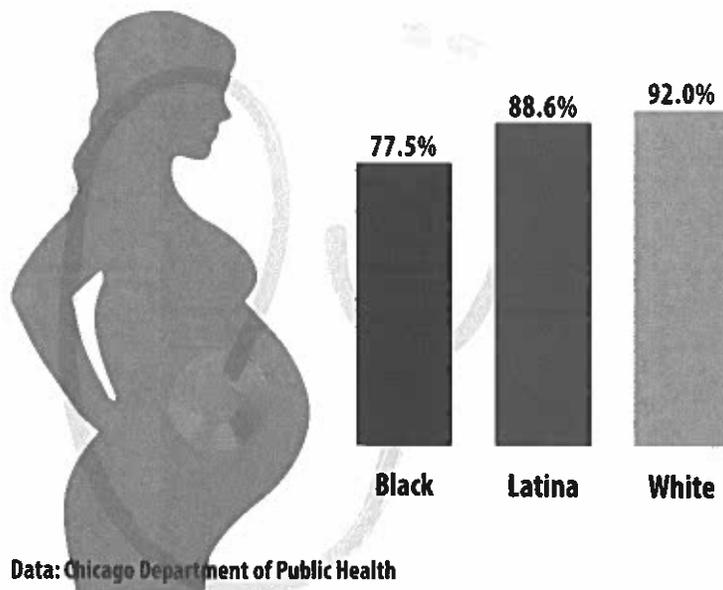


Data: Chicago Department of Public Health

In understanding how these unequal outcomes occur, Michael Lu and Neal Hafon call for a “life course” approach.²⁶ They suggest that birth outcomes like low birthweight are associated with the entire life course of the mother and the cumulative effect of her experiences, not only the months that she is pregnant. For example, black mothers in Chicago are less likely to be insured, and they disproportionately lack access to prenatal healthcare.²⁷ About 92% of white women receive prenatal care compared to 88.6% and 77.5% of Latina and black women, respectively. While low birthweight is largely preventable with proper prenatal care, structural barriers stand in the way of resolving this social problem.

WHO RECEIVED PRENATAL CARE IN 2008?

Although infant mortality rates in Chicago have decreased about 30% since 2000, they are markedly different between racial and ethnic groups.

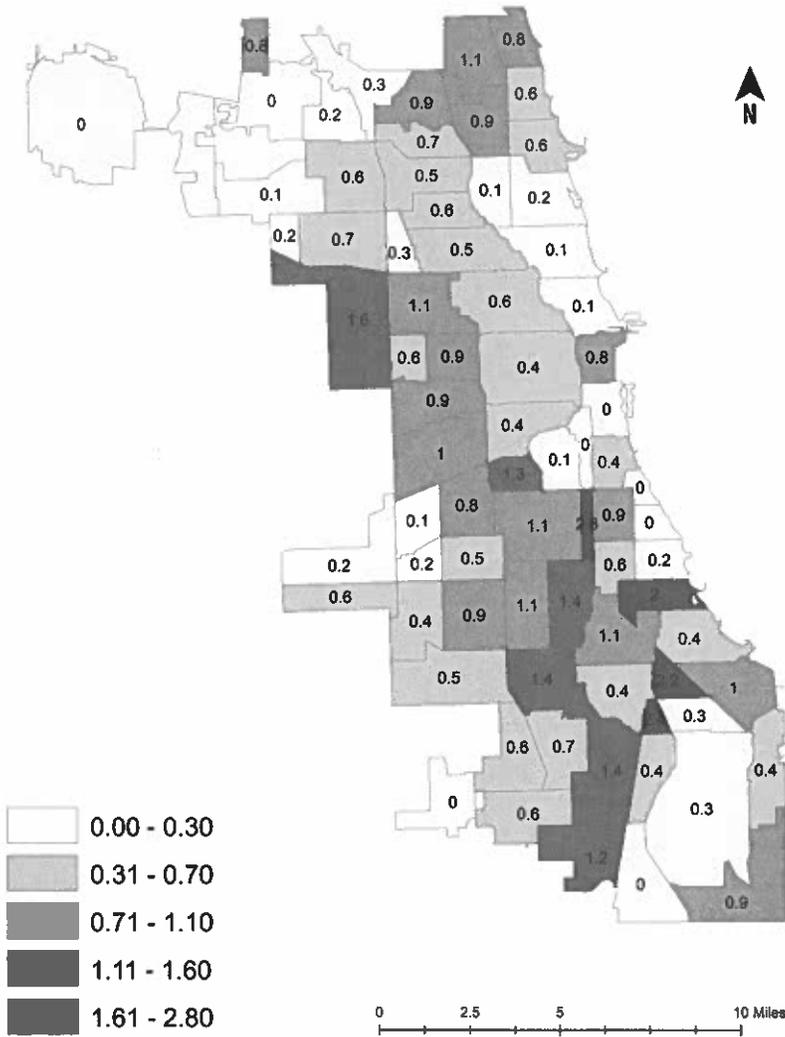


Data: Chicago Department of Public Health

THE SEGREGATION OF LEAD EXPOSURE AND ITS CONSEQUENCES

That elevated lead levels in Chicago map onto the city's patterns of segregation means that more communities of color are exposed. They are exposed to a toxin linked to a reduction in intellectual ability and to worse academic performance.²⁸ Even the smallest amounts of exposure can leave permanent scarring, meaning that racial and ethnic inequality for minority students comes with exposure to an element so toxic it invades the body and destroys brain development.²⁹ Recent studies have even linked exposure to lead toxicity with community problems of higher crime, violence in general, and homicide in particular.³⁰

ESTIMATED PERCENT OF CHILDREN BETWEEN 0 - 6 YEARS WITH ELEVATED BLOOD LEAD LEVELS BY CHICAGO COMMUNITY AREA, 2013



In the average community area of Chicago, data from the Chicago Department of Public Health show that 0.7% of children between 0-6 years of age have elevated blood lead levels. Eight predominantly black neighborhoods have percentages at two times the city average or greater: Fuller Park (2.8%), Burnside (2.4%), Avalon Park (2.2%), Woodlawn (2%), Austin (1.6%), Roseland (1.4%), Englewood (1.4%), and Auburn Gresham (1.4%). In contrast, predominantly white neighborhoods like North Center (0.1%) and Lincoln Park (0.1%) have lead exposure levels of near zero.

Data: Chicago Department of Public Health

EXPERT COMMENTARY: HEALTH



Faith Fletcher, PhD is an Assistant Professor in Community Health Sciences and a faculty member with the Center of Excellence in Maternal and Child Health at the University of Illinois at Chicago (UIC). Her primary areas of research focus on disparities in cervical cancer screening, smoking cessation, and reproductive health among HIV-positive women with attention to the ethics of research on stigmatized populations. Dr. Fletcher is a UIC Building Interdisciplinary Research Careers in Women's Health K12 Fellow.



Meredith Buchberg is a Senior Research Area Specialist at the University of Texas Health Science Center at San Antonio. She has worked as a research coordinator and consultant for numerous research studies investigating health disparities, minority health outcomes, smoking cessation, oral health and health behaviors among people living with HIV/AIDS.

"Every seven minutes, a black person dies prematurely in the United States. That is, over 200 black people die every single day who would not die if the health of blacks and whites were equal."³¹ Here, David Williams, renowned Harvard public health scholar, is capturing in lay terms what public health scholars typically characterized as "health disparities."

In a 1966 speech to the Medical Committee for Human Rights, Dr. Martin Luther King Jr. declared such inequalities and disparities in health and health care as "most shocking and inhuman." He declared access to healthcare as a civil rights issue, and purported that structural racism and poverty contributed to staggering health disparities among African Americans in particular. Over five decades later, we continue to grapple with understanding and addressing the role and complexity of the "interrelated set of individual, provider, health

system, societal, and environmental factors that lead to disparities in health and health care,” particularly, among communities of color.³²

The National Institutes of Health defines “health disparities” as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”³³ What we know from decades of well-documented research and reporting is that despite noteworthy advances in medicine, medical care, and public health in the U.S., significant health disparities persist, with racial/ethnic minority populations shouldering a greater burden of morbidity, mortality and “unequal treatment” across the board.

As described in the *2015 Kelly Report: Health Disparities in America*:

“America cannot truly be a healthy nation until we cure our nation of health disparities and address the underlying social determinants that cause them. Many of the gaps that exist in public health are shaped by generations of cultural bias, injustice, and inequality.”³⁴

The disparities between groups in Chicago are, similarly, vast and consequential, and are shaped by multiple influences, including historic injustice. Although health disparities data tell us important information about dimensions of disease and “adverse health conditions” between groups, we are attempting to understand more deeply how and why race and ethnicity are so consequential for health outcomes—how they are related to racial/ethnic differences in access to medical care, in equality of treatment within medical settings,³⁵ as well as to all the social, economic, and/or environmental resource differences captured in other sections of this report.³⁶

Scholars are mapping out in ever more detail the multiple dimensions of how racial and ethnic dynamics today shape our access to medical facilities, our experience with medical personnel, our level of stress, the safety of our community, the amount of toxins in our air and water, how much we have to pay for health clubs or organic food, and so on. This scholarly discourse is not new. In his classic 1899 book, *The Philadelphia Negro*, W.E.B. Du Bois described stark disparities in health stating that “bad ventilation, lack of outdoor life for women and children, poor protection against dampness and cold are undoubtedly the chief causes of the excessive death rate.”³⁷ In this way, the health outcomes documented here for Chicago residents are deeply connected to the parameters and, in fact, exacerbated by the historical and current racial and ethnic inequality discussed in previous sections of this report.

While this section on health focuses primarily on the kinds of health outcomes recognized as key measures of health disparities within the field of public health, it is important to emphasize that these disease and mortality rates are connected to what health professionals call the “social determinants of health.” Examples of social determinants include: access to educational, economic, and employment opportunities; access to health care services; social support; residential segregation; literacy; exposure to crime and violence; and discrimination. These factors directly or indirectly influence the accessibility, availability, and affordability of the conditions for optimal health.³⁸ That is, health outcomes are shaped not only by personal behavior and one’s immediate access to medical care but also by the environmental conditions of one’s neighborhood (e.g., air quality), the exposure to important stressors (e.g., discrimination), and access to wellness (e.g., availability of fresh fruit and vegetables, availability and affordability of exercise and wellness facilities). Recognizing that health outcomes are contextually influenced by the complex interplay between environmental, social, personal, and behavioral factors involves a shift in focus in where we locate the source of health problems.³⁹ Although downstream determinants such as medical care and personal behaviors have a direct impact on health, these determinants themselves are shaped by upstream determinants such as living and working conditions as well as economic and social opportunities and resources.

In recent years, health equity has gained new attention and support. The U.S. Department of Health and Human Service’s Office of Disease Prevention and Health Promotion introduced the Healthy People initiative to provide evidence-based priorities, objectives, and benchmarks for the country.⁴⁰ Healthy People 2000 set forth goals to reduce health disparities, while Healthy People 2010 sought to eliminate health disparities. Healthy People 2020’s priority is to move one-step further to not only eliminate health disparities, but to achieve health equity for all individuals in the U.S.—“the highest level of health for all individuals.”⁴¹ The report recognized that achieving health equity requires implementing systemic and ongoing community, institutional, and public policy strategies to address “inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”⁴² Thus, reducing health disparities will require turning our attention beyond individual decision-making or behavior to the contexts and constraints of those choices as well as to the availability of resources and opportunities for health. As stated by Kathleen G. Sebelius, former U.S. Secretary of Health and Human Services, “it is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.”

ENDNOTES

- 1 Silva, Abigail, Steven Whitman, Helen Margellos, and David Ansell. 2001. "Evaluating Chicago's Success in Reaching the Healthy People 2000 Goal of Reducing Health Disparities." *Public Health Review* 116(5):484-494.
- 2 See the Chicago Department of Public Health's Healthy Chicago Survey.
- 3 "Chicago Department of Public Health." 2015. *Measuring Chicago's Health: Findings from the 2014 Healthy Chicago Survey*. Chicago, IL: Chicago Department of Public Health.
- 4 Qato, Dima, Martha L. Daviglius, Jocelyn Wilder, Todd Lee, Danya Qato, and Bruce Lambert. 2014. "Pharmacy Deserts' Are Prevalent in Chicago's Predominantly Minority Communities, Raising Medication Access Concerns." *Health Affairs* 33(11):1958-1965.
- 5 Orsi, Jennifer M., Helen Margellos-Anast, and Steven Whitman. 2010. "Black-White Health Disparities in the United States and Chicago: A 15-Year Progress Analysis." *American Journal of Public Health* 100(2):349-356. See also Silva et al. 2001.
- 6 Hunt, Bijou R., Gary Tran, and Steven Whitman. 2015. "Life Expectancy Varies in Local Communities in Chicago: Racial and Spatial Disparities and Correlates." *Journal of Racial and Ethnic Health Disparities* 2(4):425-433.
- 7 The Illinois Department of Public Health (IDPH) calculates premature mortality as the number of years of potential life lost before being 75 years of age. This definition is different from how the Centers for Disease Control and Prevention calculates premature mortality. The CDC uses 65 years of age as a threshold, making the IDPH premature mortality rate a more conservative indicator. Like the all-cause mortality rate, premature mortality rates are expressed in units per 100,000 people. The units, however, are the number of years lost, not deaths. Premature mortality is a supplemental indicator to the general mortality rate since the latter is age-adjusted and does not account for "early" death.
- 8 "Chicago Department of Public Health" 2015.
- 9 Markides, Kyriakos S. and Karl Eschbach. 2005. "Aging, Migration, and Mortality: Current Status of Research on the Hispanic Paradox." *The Journals of Gerontology, Series B* 60(2):S68-S75.
- 10 "Chicago Department of Public Health" 2015.
- 11 Borrell, Luisa N., Florence J. Dallo, Norma Nguyen. 2010. "Racial/Ethnic Disparities in All-Cause Mortality in US Adults: The Effect of Allostatic Load." *Public Health Reports* 125(6):810-816.
- 12 Duru, O. Kenrik, Nina T. Harawa, Dulcie Kermah, and Keith C. Norris. 2012. "Allostatic Load Burden and Racial Disparities in Mortality." *Journal of the National Medical Association* 104(1-2):89-95.
- 13 See the American Heart Association's "Heart Disease Death Rates Continue to Drop."

- 14 "Chicago Department of Public Health" 2015.
- 15 "Illinois State Advisory Committee." 2011. *Food Deserts in Chicago: A Report of the Illinois Advisory Committee to the United States Commission on Civil Rights*. Springfield, IL: State of Illinois.
- 16 The U.S. Department of Agriculture goes on to elaborate that a large supermarket is defined as a food store that sells all major categories of food and has annual sales of more than \$2 million.
- 17 For rural areas, in order to qualify as "low access," the census tract must be located more than 10 miles from a supermarket or large grocery store.
- 18 Mari Gallagher Research and Consulting Group. 2006. *Good Food: Examining the Impact of Food Deserts on Public Health in Chicago*. Chicago, IL: Mari Gallagher Research and Consulting Group.
- 19 See also Zenk, Shannon N., Amy J. Schulz, Barbara A. Israel, Sherman A. James, Shuming Bao, and Mark L. Wilson. 2005. "Neighborhood Racial Composition, Neighborhood Poverty, and the Spatial Accessibility of Supermarkets in Metropolitan Detroit." *American Journal of Public Health* 95(4):660-667.
- 20 It is worth noting that the number of Chicagoans residing within food deserts has been cut by nearly half during the past decade. Still, racial and ethnic disparities remain. See Mari Gallagher Research and Consulting Group. 2011. *The Chicago 2011 Food Desert Drilldown: 5th Anniversary Edition*. Chicago, IL: Mari Gallagher Research and Consulting Group.
- 21 "Chicago Department of Public Health." 2012. *The Chicago Plan for Public Health System Improvement, 2012 - 2016: A Five-Year Plan for Strengthening the Health of the City*. Chicago, IL: Chicago Department of Public Health.
- 22 "Chicago Department of Public Health" 2012.
- 23 Mead, Holly, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel. 2008. *Racial and Ethnic Disparities in US Health Care: A Chartbook*. New York, NY, The Commonwealth Fund.
- 24 Unlike most other mortality rates which express the number of deaths per 100,000 people, infant mortality rates express the number of deaths per 1,000 live births.
- 25 "Chicago Department of Public Health" 2012.
- 26 Lu, Michael C. and Neil Halfon. 2003. "Racial and Ethnic Disparities in Birth Outcomes: A Life-course Perspective." *Maternal and Child Health Journal* 7(1):13-30. See also Lu, Michael C., Milton Kotelchuck, Vijaya Hogan, Loretta Jones, Kynna Wright, and Neal Halfon. 2010. "Closing the Black-White Gap in Birth Outcomes: A Life-course Approach." *Ethnicity & Disease* 20(102):S2-62-76.
- 27 "Chicago Department of Public Health." 2011. *Transforming the Health of Our City: Chicago Answers the Call*. Chicago, IL: Chicago Department of Public Health.

- 28 Evens, Anne, Daniel Hryhorczuk, Bruce P Lanphear, Kristin M Rankin, Dan A. Lewis, Linda Forst, and Deborah Rosenberg. 2015. "The Impact of Low-level Lead Toxicity on School Performance among Children in the Chicago Public Schools: A Population-based Retrospective Cohort Study." *Environmental Health* 14:1-9.
- 29 See also Sampson, Robert J. and Alix S. Winter. 2016. "The Racial Ecology of Lead Poisoning: Toxic Inequality in Chicago Neighborhoods, 1995-2013." *Du Bois Review* 13(2): 261-283.
- 30 Stretesky, Paul B., and Michael J. Lynch. 2001. "The Relationship between Lead Exposure and Homicide." *Archives of Pediatrics and Adolescent Medicine* 155(5):579-582.
- 31 See "How Racism Makes Us Sick" by David Williams.
- 32 Ubrri, Petry and Samantha Artiga. 2016. *Disparities in Health and Health Care: Five Key Questions and Answers*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
- 33 Minority Health and Health Disparities Research and Education Act of 2000. 42 U.S.C. §§ 106-525 (2000).
- 34 Kelly, Robin L. 2015. *The Kelly Report: Health Disparities in America*. Washington, D.C.: U.S. House of Representatives.
- 35 Braveman, Paula, Susan Egerter, and David R. Williams. 2011. "The Social Determinants of Health: Coming of Age." *Annual Review of Public Health* 32:381-398. See also Matthew, Dayna. 2015. *Unjust Medicine: A Cure for Racial Inequality in American Health Care*. New York, NY: NYU Press.
- 36 "U.S. Department of Health and Human Services, Office of Minority Health." 2013. *National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2013*. Washington, D.C.: U.S. Department of Health and Human Services, Office of Minority Health. See also "U.S. Department of Health and Human Services." 2008. *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020*. Washington, D.C.: U.S. Department of Health and Human Services.
- 37 Du Bois, W.E.B. 1899. *The Philadelphia Negro*. Philadelphia, PA: University of Pennsylvania Press.
- 38 See Healthy People 2020's Social Determinants of Health; Blankenship, Kim M., Sarah J. Bray, and Michael H. Merson. 2000. "Structural Interventions in Public Health." *AIDS* 14 (1):S11-S21.
- 39 Blankenship et al. 2000.
- 40 Updated every 10 years, Healthy People is intended to increase the public's awareness of important social determinants of health, provide measurable objectives, and encourage collaboration among local, state, and national groups. See Healthy People 2020's About Healthy People.
- 41 See Healthy People 2020's Disparities.
- 42 Ibid.

ATTACHMENT 24(c)

Criterion 1110.230(b)(3) – Planning Area Need: Service Demand - Establish ESRD Facility

Historic Referrals

The 12 dialysis stations proposed by the Applicant to establish a new in-center hemodialysis service is necessary to accommodate the service demand in Health Service Area 6 and, specifically, the service demand experienced annually by Loretto Hospital over the latest 2-year period, as evidenced by projected referrals. The projected referrals are based on historical patient history since 2017, which shows that the Applicant will have enough patients to reach the 80% utilization standard by the end of the second year of operation.

The following chart shows that Loretto Hospital has treated 97 patients in the Geographic Service Area (“GSA”) in the past two years.

Loretto Hospital Historic ESRD Patients by GSA Zip Code

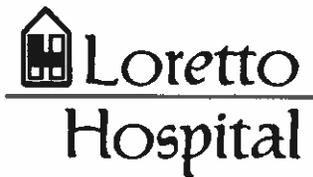
Zip Code	Population	ESRD Patients 2017-2019
60153	24,029	1
60608	78,072	2
60612	35,559	2
60622	54,467	1
60623	88,137	6
60624	38,134	6
60632	91,668	1
60644 *	49,645	70
60651	61,759	7
60804	83,972	1
TOTAL		97

The chart above identifies the patients, by zip code, who have received hospital-based dialysis treatments in the past two years at Loretto Hospital. Most notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board’s target utilization standard of 80% without adversely impacting nearby ESRD providers.

Projected Referrals

The Applicant provides, immediately following this page, provides a physician referral letter, which attests that:

- (1) The referring physician's total number of patients (by facility and zip code of residence) who have received care at existing facilities located in the area, as reported to The Renal Network at the end of the year for the most recent 3 years and the end of the most recent quarter;
- (2) The number of new patients (by facility and zip code of residence) located in the area, as reported to The Renal Network, that the physician referred for in-center hemodialysis for the most recent year;
- (3) An estimated number of patients (transfers from existing facilities and pre-ESRD, as well as respective zip codes of residence) that the physician will refer annually to the applicant's facility within a 24-month period after project completion, based upon the physician's practice experience. The anticipated number of referrals cannot exceed the physician's documented historical caseload;
- (4) An estimated number of existing patients who are not expected to continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received kidney transplants or expired);
- (5) The physician's notarized signature, the typed or printed name of the physician, the physician's office address, and the physician's specialty;
- (6) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services; and
- (7) The referral letter contains a statement attesting that the information submitted is true and correct, to the best of the physician's belief.



VIA OVERNIGHT DELIVERY

May 8, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

RE: ESRD Facility Proposed by Austin Dialysis at Loretto, Chicago, Illinois

Dear Ms. Avery:

I am a nephrologist practicing in the City of Chicago. I submit this letter in support of the in-center hemodialysis facility (“ESRD Facility”) proposed by Austin Dialysis at Loretto (“Applicant”). The Applicant’s proposal will enhance access to critical care for end stage renal disease (“ESRD”) patients living in Chicago’s Austin neighborhood and other at-risk communities near the Loretto Hospital campus.

Based on hospital records, 97 ESRD patients were treated at Loretto Hospital since 2017. I have included with this letter patient origin information for 2017 through the most recent quarter, separated out by zip code, a copy of which is attached to this letter as Exhibit A. I anticipate that these historical patterns will continue for 2019 and beyond. ESRD patient projections are attached hereto as Exhibit B.

Upon review of the hospital’s records, Loretto Hospital has historically treated many pre-ESRD patients who currently have Chronic Kidney Disease (“CKD”), Stage 3-5. I estimate that a small number of these patients, approximately 10%, would not continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received a kidney transplant). This estimate is small because, based on experience at Loretto Hospital, I have found that a significant number of minorities are not approved for kidney transplants and therefore they need to begin and remain on dialysis for the remainder of their lives.

In regard to patients beginning dialysis, based on historical trends, I estimate that at least 36 patients who live within five miles of Loretto Hospital will be treated through the hospital, develop ESRD, require in-center hemodialysis within the proposed ESRD facility’s first year of operation, and such patients will choose the proposed ESRD facility for their treatments. I estimate that 60 patients will choose the proposed ESRD facility within the first 24 months of operation. I anticipate referring all 60 of these patients to the proposed ESRD facility within the first two years following project completion. This information is attached as Exhibit B.

Based on foregoing, I certify that: (1) the patients choosing the proposed facility will reside within the Applicant's five-mile geographic service area; (2) the anticipated number of patients does not exceed the hospital’s documented historical caseload; (3) I have not used the

aforementioned referrals to support another pending or approved certificate of need permit application; and (4) the information provided in this letter is true and correct to the best of my knowledge.

Respectfully submitted,



Rajani Kosuri, M.D.
Nephrologist
Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60644

NOTARY

Subscribed and sworn to me this 9th day of May, 2019.



Notary Public

Seal:

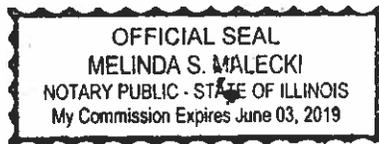


EXHIBIT A

Historical Patient Origin Data

Historical patient information, by zip code, is provided below. The information reflects patient information for the referring physician identified in the letter accompanying this exhibit.

Loretto Hospital Historic ESRD Patients by GSA Zip Code

Zip Code	Population	ESRD Patients 2017	ESRD Patients 2018	ESRD Patients 2019
60153	24,029	0	1	0
60608	78,072	0	2	0
60612	35,559	0	2	0
60622	54,467	0	1	0
60623	88,137	0	5	1
60624	38,134	0	5	1
60632	91,668	0	1	0
60644	49,645	13	47	10
60651	61,759	2	4	1
60804	83,972	0	1	0
TOTAL		15	69	13

The chart above identifies the patients who have received hospital-based dialysis treatments in the past two years at Loretto Hospital (2017 through March 31, 2019). Most notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board's target utilization standard of 80% without adversely impacting nearby ESRD providers.

EXHIBIT B

ESRD Projected Referrals

TOTAL POPULATION/TOTAL ESRD PATIENTS IN APPLICANT'S GSA			
** Patients Beginning Dialysis Treatments Within 24 Months **			
Zip Code	Total Population	Pre-ESRD Patients Begin Dialysis < 12 Months	Pre-ESRD Patients Begin Dialysis 12-24 Months
60153	24,029	1	1
60608	78,072	1	1
60612	35,559	1	1
60622	54,467	1	1
60623	88,137	3	3
60624	38,134	3	3
60632	91,668	1	1
60644	49,645	21	15
60651	61,759	3	1
60804	83,972	1	1
TOTAL	1,353,395	36	65

ATTACHMENT 24(d)

Criterion 1110.230(b)(4) – Planning Area Need: Service Demand – Expansion of Existing Category of Service

This section is not applicable to an in-center hemodialysis project.

ATTACHMENT 24(e)

Criterion 1110.230(b)(5) – Planning Area Need: Service Accessibility

The proposed 12-station in-center hemodialysis facility (“Facility”), which will treat patients with End Stage Renal Disease (“ESRD”) residing in the geographic service area (“GSA”) (i.e., a five-mile radius around the Facility), will improve access to care for planning area residents. The following narrative explains why the proposed Facility is needed.

SERVICE RESTRICTIONS

The Applicant will demonstrate need for the Facility by showing that:

- (a) Health Service Area 6 (“HSA 6”) has a need for additional dialysis stations;
- (b) The location of Loretto Hospital shows a notable gap of dialysis service in its immediate vicinity; and
- (c) The GSA population and existing care system exhibit indicators of medical care problems, including an average family income below the poverty level, high mortality rates, designation as a Medically Underserved Area by the federal Health Resources Services Administration (“HRSA”), and a number of other health disparities that directly affect kidney health and often lead to a need for ongoing dialysis treatments.

HSA 6 Needs Additional Dialysis Stations

The Applicant is requesting approval for a 12-station in-center hemodialysis facility. Each station will be assigned three shifts a day, six days a week. The proposed ESRD facility will be in HSA 6, which according to the March 2019 revised need determinations, presently has a need for an additional 5 dialysis stations. The following table shows the most current need data.

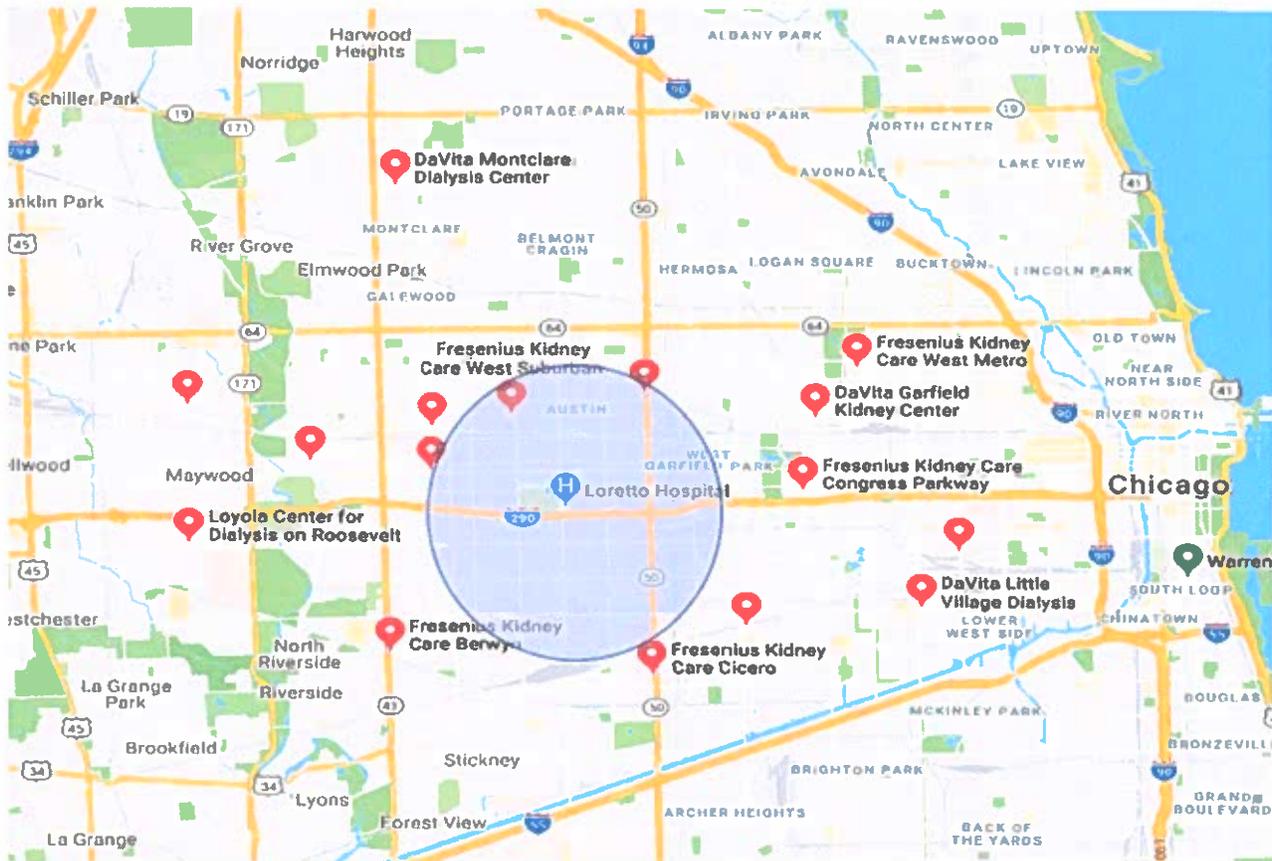
ESRD Service Areas	Approved Existing Stations	Calculated Station Need 2020	Additional Stations Needed 2020	Excess ESRD Stations 2020
HSA 1	196	192	0	4
HSA 2	188	159	0	29
HSA 3	182	155	0	27
HSA 4	202	186	0	16
HSA 5	195	166	0	29
HSA 6	1,348	1,353	5	0
HSA 7	1,486	1,430	0	56
HSA 8	492	427	0	65
HSA 9	308	301	0	7
HSA 10	96	78	0	18
HSA 11	260	212	0	48
State Total	4,953	4,659	5	299

The Applicant’s proposal will eliminate the calculated need for dialysis stations in HSA 6 but will also create a surplus of 7 stations. However, a 7-station surplus in the second largest HSA is not egregious by any means, especially when compared to the excess number of ESRD stations in much smaller HSAs. For example, HSA 8 has a calculated station need of 427 stations but 492 stations have been approved by the State Board, thereby creating a surplus of 65 stations. The Applicant’s proposed GSA is within HSA 6, centered among some of Chicago’s poorest communities with residents who disproportionately suffer from kidney disease.

Loretto Hospital is Center of Hemodialysis Service Gap

When it comes to in-center hemodialysis facilities, the communities immediately surrounding Loretto Hospital do not have a centrally-located ESRD facility. The lack of a centrally-located in-center hemodialysis facility creates a gap in health care services that are vital to the health of the hospital’s patient base. Loretto Hospital is located among some of Chicago’s largest African American majority neighborhoods—a racial demographic shown to suffer disproportionately from diabetes and kidney disease when compared with Caucasians. This factor is discussed in greater detail in the following section.

The following map shows the existing gap in hemodialysis services around Loretto Hospital, evidenced by the lack of existing ESRD facilities within the radius surrounding the hospital campus.

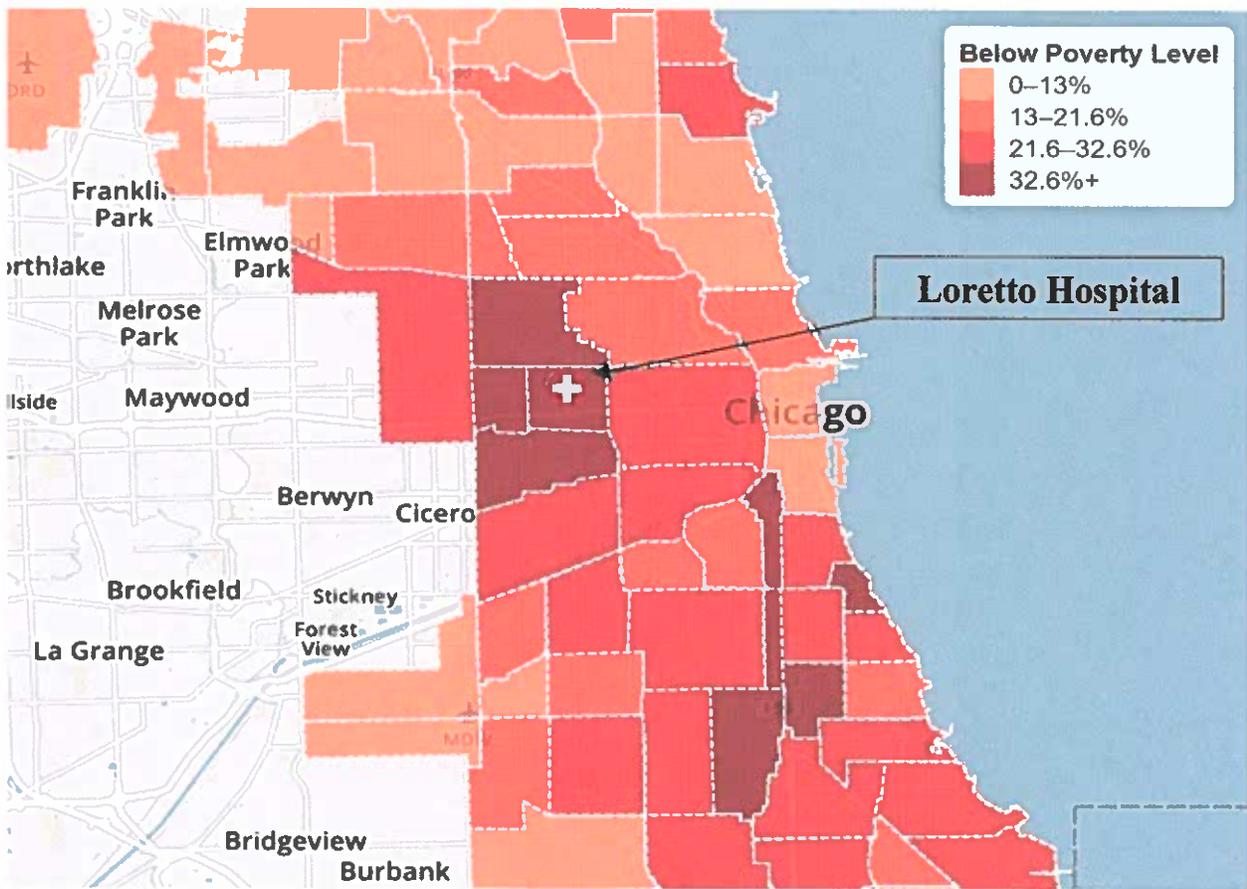


Community Affected by Many Medical Care Problems

The area population and existing care system exhibit indicators of medical care problems, such as an average family income level below the State average poverty level, high infant mortality, or designation by the Secretary of Health and Human Services as a Health Professional Shortage Area, a Medically Underserved Area, or a Medically Underserved Population.

(1) Low Income Community

As shown in the map below, Loretto Hospital is also located in or near several communities that have the highest number of families living below the poverty level, which only complicates their ability to obtain affordable health care. These families could benefit greatly from an in-center ESRD facility located in the center of their community.

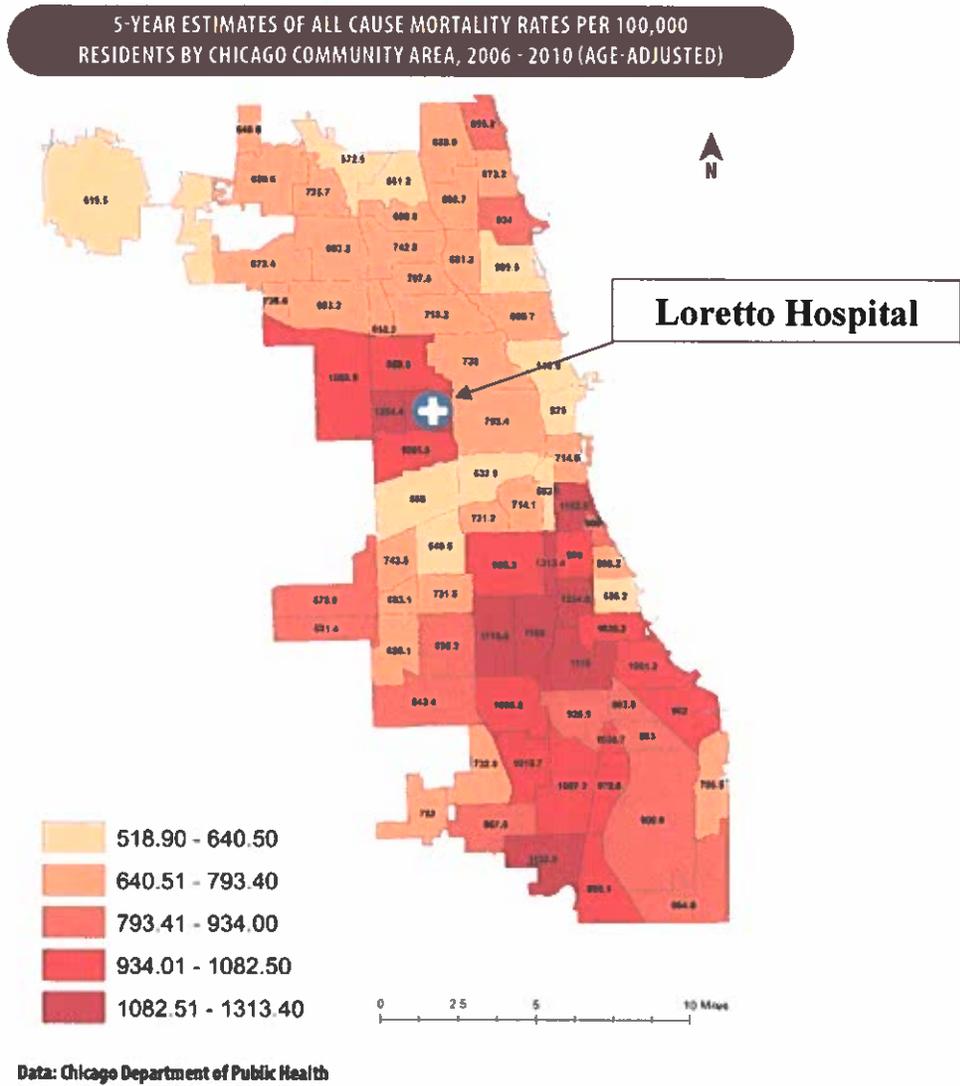


(2) High Mortality Rates

The *2017 Tale of Three Cities Report* also examined mortality rates by neighborhood. In the report, the author states that “one can see that these racial disparities in mortality map directly onto Chicago’s patterns of segregation, with predominantly black neighborhoods on the South and West Sides suffering the highest death rates in the city. In fact, 17 community areas have

mortality rates of over 1,000 deaths per 100,000 residents. Of these communities, all have black majorities and 16 have black populations of 85% or greater.”

The following map shows that Loretto Hospital is located in or near three of the communities with the highest mortality rates in the City of Chicago:



Note that Loretto Hospital campus is located in one of the census tracts with the highest rates of mortality, and three other surrounding census tracts to the west also indicate the highest mortality rates.

(3) HRSA Medically Underserved Area

Loretto Hospital is also located within an area designated by the federal government as a Medically Underserved Area (“MUA”). The following chart shows that the Austin Community Service Area has been designated as an MUA by Health Resources Services Administration

(“HRSA”) under the Department of Health and Human Services. *Medically Underserved Areas are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population.*

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
07323	Brighton Park / Gage Park Service Area	Medically Underserved Area	Illinois	61.6	Designated	Non-Rural	2003/04/07	2011/01/12
CT 8351.00								
CT 8428.00								
07335	Humboldt Park Service Area	Medically Underserved Area	Illinois	60.7	Designated	Non-Rural	2003/05/14	2003/05/14
CT 2312.00								
CT 2315.00								
CT 8366.00								
CT 8421.00								
07336	Austin Community Service Area	Medically Underserved Area	Illinois	51.0	Designated	Non-Rural	2003/05/22	2003/05/22

(4) Other Relevant Factors Affecting Kidney Disease and Dialysis Treatments

The GSA has a number of other health disparities that directly affect kidney health and often lead to a need for ongoing dialysis treatments, all of which strongly suggest additional sites for dialysis treatments are needed now.

SUPPORTING DOCUMENTATION

The following report is attached after this page, which supplements the narrative provided above.

- *2017 Tale of Three Cities*

ATTACHMENT 24(f)

Criterion 1110.230(c)(1) – Unnecessary Duplication/Maldistribution of Services

The ESRD Facility proposed by the Applicant will not result in an unnecessary duplication of services. To support this conclusion, the Applicant provides the following information:

Geographic Service Area: Zip Codes, Population Data

The following chart includes all of the zip codes in the geographic service area (“GSA”) proposed by the Applicant. The GSA, by regulation, is a five (5) mile radius surrounding the project site. Along with the zip code data, the most current population data is provided.

Proposed GSA: Zip Codes & Corresponding Population

Zip Code	Population
60130	14,137
60153	24,029
60155	7,915
60160	25,534
60171	10,248
60302	32,258
60304	17,402
60305	11,217
60402	63,938
60513	18,966
60534	10,571
60546	15,837
60608	78,072
60612	35,559
60618	95,632
60622	54,467
60623	88,137
60624	38,134
60632	91,668
60634	73,382
60638	57,746
60639	90,211
60641	70,642
60644 *	49,645
60647	88,866
60651	61,759
60707	43,451
60804	83,972
TOTAL	1,353,395

Health Care Facilities in the GSA

The names and locations of all existing or approved health care facilities (i.e., ESRD facilities) located within the proposed 5-mile radius GSA is provided below.

Existing Health Care Facilities Within Proposed GSA

Facility & City	Miles	Drive Time	Ownership	Stations	Occupancy %	Met Occupancy Standard?
Fresenius Kidney Care Oak Park 733 Madison, Oak Park	2.4	9.0	Fresenius	12	93.06%	Yes
Maple Ave. Kidney Center 610 S. Maple Street, Oak Park	2.6	5.0	Independent	18	N/A	N/A
Fresenius Kidney Care Austin 4800 W. Chicago Ave., Chicago	2.6	9.0	Fresenius	16	67.71%	No
Fresenius Kidney Care Congress 3410 W. Van Buren, Chicago	3.1	6.0	Fresenius	30	56.11%	No
Fresenius Kidney Care Cicero 3000 S. Cicero Ave., Cicero	3.5	9.0	Fresenius	20	80.83%	Yes
Fresenius Kidney Care River For. 103 Forest Ave., River Forest	3.7	9.0	Fresenius	24	69.44%	No
Lawndale Dialysis 3934 W. 24 th Street, Chicago	3.9	13.0	DaVita	16	105.21%	Yes
DaVita Garfield Kidney Center 3250 W. Franklin Blvd., Chicago	4.9	11.0	DaVita	24	61.11%	No
Fresenius Kidney Care Berwyn 2601 Harlem Ave., Berwyn	4.9	11.0	Fresenius	30	76.67%	No
Loyola Center for Dialysis 1201 W. Roosevelt Rd., Maywood	5.0	8.0	Independent	30	N/A	N/A
Fresenius Medical Care Humboldt 3520 W. Grand Ave., Chicago	5.0	14.0	Fresenius	34	70.59%	No

While all of the existing ESRD facilities in the GSA are not at capacity according to the State Board’s 80% utilization standard, the Applicant points out four important facts:

- Two of the facilities have not reported data and therefore cannot be factored into the equation.
- Of the six facilities that are not at capacity, five are owned by Fresenius. When Fresenius comes before the State Board, they always claim that their centers will achieve capacity. Perhaps Fresenius’ inability to achieve the 80% utilization rate is the result to overly aggressive expansion when the State Board’s need data showed over an 80 station need in 2017 or maybe Fresenius simply built centers too large for the particular community (e.g., Fresenius Kidney Care Congress has 30 stations, presently utilized at 56%). The Applicant asks the State Board to hold this against Fresenius and not the Applicant when considering underutilization of existing ESRD facilities in the GSA.
- Of the six facilities not at capacity, two are over 70% utilized and two more have utilization rates in the 60th percentile. Thus, these four centers appear to be approaching

the State Board's 80% utilization standard.

- Both DaVita and Fresenius previously asked Loretto Hospital to be a partner in an ESRD facility joint venture.

ATTACHMENT 24(g)

Criterion 1110.230(c)(2) – Maldistribution

(a) Population of Geographic Service Area by Zip Code

The following chart shows the total population of the GSA by zip code and reflects the most recent population numbers available for the State of Illinois.

GSA Population by Zip Code	
Zip Code	Population
60130	14,137
60153	24,029
60155	7,915
60160	25,534
60171	10,248
60302	32,258
60304	17,402
60305	11,217
60402	63,938
60513	18,966
60534	10,571
60546	15,837
60608	78,072
60612	35,559
60618	95,632
60622	54,467
60623	88,137
60624	38,134
60632	91,668
60634	73,382
60638	57,746
60639	90,211
60641	70,642
60644 *	49,645
60647	88,866
60651	61,759
60707	43,451
60804	83,972
TOTAL	1,353,395

NOTE: The above-referenced census data was obtained from the U.S. Census Bureau, using American Fact Finder, available at <http://factfinder2.census.gov> on the web. The census data is the most recent data available for the State of Illinois by zip code. The data is from the most recent American Community Survey – Five Year Population Estimates.

(b) Discussion

The Applicant hereafter documents that the proposed project will not result in maldistribution of services.

Need for Additional Stations in the Health Service Area

Maldistribution does not exist because there is a need for additional dialysis stations in Health Service Area 6 (“HSA 6”). The proposed ESRD facility will be in HSA 6, which according to the March 2019 revised need determinations, presently has a need for an additional 5 dialysis stations.

The following table shows the most current need data.

ESRD Service Areas	Approved Existing Stations	Calculated Station Need 2020	Additional Stations Needed 2020	Excess ESRD Stations 2020
HSA 1	196	192	0	4
HSA 2	188	159	0	29
HSA 3	182	155	0	27
HSA 4	202	186	0	16
HSA 5	195	166	0	29
HSA 6	1,348	1,353	5	0
HSA 7	1,486	1,430	0	56
HSA 8	492	427	0	65
HSA 9	308	301	0	7
HSA 10	96	78	0	18
HSA 11	260	212	0	48
State Total	4,953	4,659	5	299

The Applicant’s proposal will eliminate the calculated need for dialysis stations in HSA 6 but will also create a surplus of 7 stations. However, a 7-station surplus in the second largest HSA is not egregious by any means, especially when compared to the excess number of ESRD stations in much smaller HSAs. For example, HSA 8 has a calculated station need of 427 stations but 492 stations have been approved by the State Board, thereby creating a surplus of 65 stations. The Applicant’s proposed GSA is within HSA 6, centered among some of Chicago’s poorest communities with residents who disproportionately suffer from kidney disease.

Utilization of Existing Providers

Moreover, a maldistribution does not exist because a handful of existing providers, mainly Fresenius, should achieve target utilization soon. For example, Fresenius, the largest provider that holds a controlling share of the west-side market, has two facilities in the 70th percentile and two more in the upper 60th percentile. When Fresenius came before the State Board for a CON permit each time for these four ESRD facilities, it had to commit to referrals to achieve the standard. The Applicant believes that Fresenius will eventually reach 80% utilization at each of

these facilities. However, if Fresenius fails to achieve 80% utilization at these centers (as promised to the State Board), it will likely be the result of overbuilding for the particular community and overly-aggressive expansion into the west-side market.

The names and locations of all existing or approved health care facilities (i.e., ESRD facilities) located within the proposed 5-mile radius GSA is provided below.

Existing Health Care Facilities Within Proposed GSA

Facility & City	Miles	Drive Time	Ownership	Stations	Occupancy %	Met Occupancy Standard?
Fresenius Kidney Care Oak Park 733 Madison, Oak Park	2.4	9.0	Fresenius	12	93.06%	Yes
Maple Ave. Kidney Center 610 S. Maple Street, Oak Park	2.6	5.0	Independent	18	N/A	N/A
Fresenius Kidney Care Austin 4800 W. Chicago Ave., Chicago	2.6	9.0	Fresenius	16	67.71%	No
Fresenius Kidney Care Congress 3410 W. Van Buren, Chicago	3.1	6.0	Fresenius	30	56.11%	No
Fresenius Kidney Care Cicero 3000 S. Cicero Ave., Cicero	3.5	9.0	Fresenius	20	80.83%	Yes
Fresenius Kidney Care River For. 103 Forest Ave., River Forest	3.7	9.0	Fresenius	24	69.44%	No
Lawndale Dialysis 3934 W. 24 th Street, Chicago	3.9	13.0	DaVita	16	105.21%	Yes
DaVita Garfield Kidney Center 3250 W. Franklin Blvd., Chicago	4.9	11.0	DaVita	24	61.11%	No
Fresenius Kidney Care Berwyn 2601 Harlem Ave., Berwyn	4.9	11.0	Fresenius	30	76.67%	No
Loyola Center for Dialysis 1201 W. Roosevelt Rd., Maywood	5.0	8.0	Independent	30	N/A	N/A
Fresenius Medical Care Humboldt 3520 W. Grand Ave., Chicago	5.0	14.0	Fresenius	34	70.59%	No

While all of the existing ESRD facilities in the GSA are not at capacity according to the State Board’s 80% utilization standard, the Applicant points out four important facts:

- Two of the facilities have not reported data and therefore cannot be factored into the equation.
- Of the six facilities that are not at capacity, five are owned by Fresenius. When Fresenius comes before the State Board, they always claim that their centers will achieve capacity. Perhaps Fresenius’ inability to achieve the 80% utilization rate is the result to overly aggressive expansion when the State Board’s need data showed over an 80 station need in 2017 or maybe Fresenius simply built centers too large for the particular community (e.g., Fresenius Kidney Care Congress has 30 stations, presently utilized at 56%). The Applicant asks the State Board to hold this against Fresenius and not the Applicant when considering underutilization of existing ESRD facilities in the GSA.

- Of the six facilities not at capacity, two are over 70% utilized and two more have utilization rates in the 60th percentile. Thus, these four centers appear to be approaching the State Board’s 80% utilization standard.
- Both DaVita and Fresenius previously asked Loretto Hospital to be a partner in an ESRD facility joint venture.

Loretto Hospital Has Sufficient Case Loads to Sustain its Own ESRD Facility

Historical data submitted by Loretto Hospital’s nephrologist Dr. Kosuri shows that the hospital has a patient case history and projected referrals to support a fully utilized ESRD facility. Historical patient information, by zip code, is provided below.

Loretto Hospital Historic ESRD Patients by GSA Zip Code

Zip Code	Population	ESRD Patients 2017	ESRD Patients 2018	ESRD Patients 2019
60153	24,029	0	1	0
60608	78,072	0	2	0
60612	35,559	0	2	0
60622	54,467	0	1	0
60623	88,137	0	5	1
60624	38,134	0	5	1
60632	91,668	0	1	0
60644	49,645	13	47	10
60651	61,759	2	4	1
60804	83,972	0	1	0
TOTAL		15	69	13

The chart above identifies the number of patients who have received hospital-based dialysis treatments in the past two years at Loretto Hospital (2017 through March 31, 2019). Notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board’s target utilization standard of 80% without adversely impacting nearby ESRD providers.

ESRD Projected Referrals

TOTAL POPULATION/TOTAL ESRD PATIENTS IN APPLICANT'S GSA			
** Patients Beginning Dialysis Treatments Within 24 Months **			
Zip Code	Total Population	Pre-ESRD Patients Begin Dialysis < 12 Months	Pre-ESRD Patients Begin Dialysis 12-24 Months
60153	24,029	1	1
60608	78,072	1	1
60612	35,559	1	1
60622	54,467	1	1
60623	88,137	3	3
60624	38,134	3	3
60632	91,668	1	1
60644	49,645	21	15
60651	61,759	3	1
60804	83,972	1	1
TOTAL	1,353,395	36	65

Conclusion

At present, not all of the existing ESRD facilities are at the State Board's 80% utilization standard. However, most of these facilities are performing well and have utilization rates in the 60th and 70th percentiles. Moreover, these facilities promised the State Board in their CON applications that they would achieve the utilization standard and the Applicant believes they will because of the health status of people living on the west-side of Chicago and the growing demand for dialysis services.

ATTACHMENT 24(h)

Criterion 1110.230(c)(3) – Impact of Project on Other Area Providers

The Applicant hereafter documents that the proposed project will not adversely affect existing ESRD facilities in the proposed GSA.

Need for Additional Stations in the Health Service Area

Maldistribution does not exist because there is a need for additional dialysis stations in Health Service Area 6 (“HSA 6”). The proposed ESRD facility will be in HSA 6, which according to the March 2019 revised need determinations, presently has a need for an additional 5 dialysis stations.

The following table shows the most current need data.

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The Applicant’s proposal will eliminate the calculated need for dialysis stations in HSA 6 but will also create a surplus of 7 stations. However, a 7-station surplus in the second largest HSA is not egregious by any means, especially when compared to the excess number of ESRD stations in much smaller HSAs. For example, HSA 8 has a calculated station need of 427 stations but 492 stations have been approved by the State Board, thereby creating a surplus of 65 stations. The Applicant’s proposed GSA is within HSA 6, centered among some of Chicago’s poorest communities with residents who disproportionately suffer from kidney disease.

Utilization of Existing Providers

Moreover, a maldistribution does not exist because a handful of existing providers, mainly Fresenius, should achieve target utilization soon. For example, Fresenius, the largest provider that holds a controlling share of the west-side market, has two facilities in the 70th percentile and two more in the upper 60th percentile. When Fresenius came before the State Board for a CON

permit each time for these four ESRD facilities, it had to commit to referrals to achieve the standard. The Applicant believes that Fresenius will eventually reach 80% utilization at each of these facilities. However, if Fresenius fails to achieve 80% utilization at these centers (as promised to the State Board), it will likely be the result of overbuilding for the particular community and overly-aggressive expansion into the west-side market.

The names and locations of all existing or approved health care facilities (i.e., ESRD facilities) located within the proposed 5-mile radius GSA is provided below.

Existing Health Care Facilities Within Proposed GSA

Facility & City	Miles	Drive Time	Ownership	Stations	Occupancy %	Met Occupancy Standard?
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Fresenius Kidney Care Berwyn 2601 Harlem Ave., Berwyn	4.9	11.0	Fresenius	30	76.67%	No
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considering underutilization of existing ESRD facilities in the GSA.

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60623	88,137	0	5	1
60624	38,134	0	5	1
60632	91,668	0	1	0
60644	49,645	13	47	10
60651	61,759	2	4	1
60804	83,972	0	1	0
TOTAL		15	69	13

The chart above identifies the number of patients who have received hospital-based dialysis treatments in the past two years at Loretto Hospital (2017 through March 31, 2019). Notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board’s target utilization standard of 80% without adversely impacting nearby ESRD providers.

ESRD Projected Referrals

TOTAL POPULATION/TOTAL ESRD PATIENTS IN APPLICANT'S GSA			
** Patients Beginning Dialysis Treatments Within 24 Months **			
Zip Code	Total Population	Pre-ESRD Patients Begin Dialysis < 12 Months	Pre-ESRD Patients Begin Dialysis 12-24 Months
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60608	78,072	1	1
60612	35,559	1	1
60622	54,467	1	1
60623	88,137	3	3
60624	38,134	3	3
60632	91,668	1	1
60644	49,645	21	15
60651	61,759	3	1
60804	83,972	1	1
TOTAL	1,353,395	36	65

Conclusion

At present, not all of the existing ESRD facilities are at the State Board's 80% utilization standard. However, most of these facilities are performing well and have utilization rates in the 60th and 70th percentiles. Moreover, these facilities promised the State Board in their CON applications that they would achieve the utilization standard and the Applicant believes they will because of the health status of people living on the west-side of Chicago and the growing demand for dialysis services. Thus, the proposed ESRD facility should not adversely affect existing providers.

ATTACHMENT 24(i)

Criterion 1110.230(d)(1) through (3) – Deteriorated Facilities

The permit applicant is proposing to establish an in-center hemodialysis facility. Thus, the project does not involve the modernization of an existing dialysis center. Accordingly, this criterion is not applicable to this project.

ATTACHMENT 24(j)

Criterion 1110.230(e) – Staffing

Staffing Availability

The proposed ESRD Facility will ensure that all clinical and professional staffing needs will be met in accordance with federal and state law, regulations, and policies. All personnel will be appropriately licensed, trained, and credentialed. Staffing levels will also be consistent with any applicable accreditation standards.

The Applicant will ensure that all necessary staff are hired or contracted with before the ESRD Facility becomes operational. The appropriate levels of staff will be achieved by following industry guidelines.

Medical Director

The ESRD Facility will be under the direction of a Medical Director. The Medical Director will be Rajani Kosuri, M.D.

Note: Additional documentation and information about Dr. Kosuri, the project's lead nephrologist, immediately follows this page.

Other Staff

Loretto Hospital will ensure that the ESRD Facility is properly staffed in accordance with the federal Conditions for Coverage governing dialysis facilities and all other staffing laws and requirements.

The ESRD Facility will employ or contract with:

- One or more registered nurse(s) with experience in dialysis care;
- Several dialysis technicians;
- A Dietitian; and
- A Social Worker.

Staffing Plan

Upon opening the ESRD facility, a Clinical Manager who is a registered nurse (RN) will be named and several dialysis technicians will be hired. Initially, the facility will employ or contract with a part-time dietitian and part-time social worker with appropriate training and expertise. These two positions will go to full time as the facility's census increases.

Eventually, the Applicant anticipates that its patient care staff will increase to include the aforementioned Clinical Manager (RN), up to four additional RN's, and around ten dialysis

technicians. The Applicant expects its staffing model to maintain a 3 to 1 or lower patient-staff ratio at all times.

All patient care staff and other licensed/registered professionals employed by or engaged with the ESRD facility will meet all State of Illinois employment, licensure, and/or certification requirements, as applicable. Any additional staff hired by the ESRD facility will also meet these requirements. All RNs and dialysis technicians must obtain certification in nephrology as soon as eligible to maintain employment.

Training

The Applicant will ensure that, at least annually, all clinical staff complete OSHA training, regulatory compliance training, CPR certification, skills competency, CVC competency, quality assurance training, and pass a skills competency program. Learning goals will be established based on the results of annual testing. In addition, the Applicant intends to implement mock surveys at the ESRD facility at least annually to ensure regulatory compliance with State of Illinois and federal review standards.

Medical Staff

The medical staff at the ESRD facility will be closed. Only nephrologists employed by or affiliated with Loretto Hospital, and who meet all of the hospital's physician credentialing requirements, will be allowed to oversee and treat patients at the ESRD facility.

A certification of this process is attached following this attachment.

MEDICAL DIRECTOR DOCUMENTATION

RAJANI KOSURI, MD

Address: 2052 Shady Grove Ct, Naperville, IL 60565
Phone: 219.299.3388 • E-mail: rkosuri26@yahoo.com

~ INTERNAL MEDICINE/ NEPHROLOGY ~

Highly talented and dedicated medical professional with in-depth commitment to provide safe, efficient, and patient-centered care

- Vast knowledge of evidence based medicine underscored with excellent diagnostic and treatment planning capabilities.
- Abreast with current research inventions and properly implement these practices in patient care settings.
- Comfortable interacting with patient and their family members and other physicians and medical staff involved in the patient care.
- Possess outstanding communication and interpersonal skills.

EDUCATION & CREDENTIALS

Medical School / Residency / Fellowship

Nephrology Fellowship

Loyola University Medical Center, Maywood, IL

Jul 2009-June 2011

Internal Medicine Residency

William Beaumont Hospital, Royal Oak, MI

Jul 2005-Jul 2008

Bachelor of Medicine, Bachelor of Surgery (MBBS)

Andhra Medical College, Visakhapatnam, India

Oct 1996-Jun 2002

Medical Licensure

- Physician Permanent License (Indiana – 01071807A; Illinois – 036123880; Michigan – 4301086504)

Board Certifications

- American Board of Internal Medicine (October 2018) / Nephrology (October 2011)
- American Board of Internal Medicine (August 2008)
- ECFMG Certification (USMLE Step1-94, USMLE Step2 CK-96, USMLE Step2 CS-Passed, USMLE Step3-86)

CLINICAL EXPERIENCE

Internal Medicine/ Nephrology ▪ Self employed

Aug 2015 – Present

Nephrologist (Part-time) ▪ Dr. Oswaldo Wagener, Oak Park, IL

Dec 2013 – Present

Internal Medicine/ Nephrology ▪ Datta Sambare S.C., Oak Park, IL

Dec 2013 – July 2015

Nephrologist ▪ Northwest Indiana Nephrology, Munster, IN

Nov 2012 - Oct 2013

Nephrologist ▪ Optimum Kidney Care, Chicago, IL

Aug 2011 - Oct 2012

Hospitalist ▪ William Beaumont Hospital, Royal Oak, MI

Jul 2008 - Jun 2009

RAJANI KOSURI, MD

Address: 2052 Shady Grove Ct, Naperville, IL 60565
Phone: 219.299.3388 • E-mail: rkosuri26@yahoo.com

Hospital AFFILIATIONS

- Loretto Hospital
- Gottlieb Memorial Hospital
- Westlake Hospital
- West Suburban Hospital
- Norwegian American Hospital

PROFESSIONAL AFFILIATIONS

- American Society of Nephrology
- American Society of Internal Medicine

PUBLICATIONS

- The RIFLE Criteria as a Predictor of Mortality in Geriatric Patients Admitted to a Medical Intensive Care Unit
Francis Dumler, **Rajani Kosuri**; Hemodialysis International, Vol. 14 No. 1, 2010
- Anemia Management With Darbepoetin-Alfa in Outpatient Hemodialysis Patients Switched from Epoetin-Alfa: A Community Hospital Experience
Agrawal, Varun MD; Mukherjee, Sudipto MD, PhD, MPH; Kosuri, **Rajani, MD**; Dumler, Francis MD; American Journal of Therapeutics: 29 September 2009
- Minimal Coronary Artery Calcium Score Alone Fails to Reliably Detect Significant Lesions in Acute Chest Pain Patients
JACC February 21, 2006; Michael J. Gallagher, Gilbert Raff, James A. Goldstein, Michael A. Ross, Brian O'Neil, James Wegner, Aparna Balichetty, **Rajani Kosuri**, William W. O'Neil
- Coronary 64-slice Computed Tomographic Angiography Models Employing Aortic Root and Selective Catheter Directed Contrast Enhancement in Swine: Technical Feasibility and Preliminary Results Using 3D and 4D Reconstructions
Int J Cardiovasc Imaging 2006 Mar 15; Kostaki Bis , Anil Shetty, Stacy Brewington, Paul Arpasi, **Rajani Kosuri**, Wendy Stein, Michael Lauer, William O'Neil
- Atypical Chest Pain: Coronary, Aortic, and Pulmonary Vasculature Enhancement at Biphasic Single-Injection 64-Section CT Angiography
Radiology 2007 243: 368-376; Thomas G. Vrachliotis, MD; Kostaki G. Bis, MD; Ahmad Haidary, MD; **Rajani Kosuri**, MD; Mamtha Balasubramaniam, MS; Michael Gallagher, MD; Gilbert Raff, MD; Michael Ross, MD; Brian O'Neil, MD; and William O'Neil, MD
- Comparison of a Biphasic Single Injection 64-slice CT-Angiography Protocol to Current Standard Protocols Used for Evaluation of Aortic and Pulmonary Vasculature
AJROnline.org, Apr 2006; 186:A83-A96; Haidary A.F.1; Bis K.G.1; Vrochliotis T.G.1; **Kosuri R.1**; Balasubramanian M.1; Ross M.1; O'Neil, B.1; O'Neil, W.

PRESENTATIONS

- Case report of Wegner's Granulomatosis superimposed on IgA Nephropathy at ACP-ASIM
- Case report of Multiorgan failure associated with serotonin syndrome after a suicide attempt at ACP-ASIM

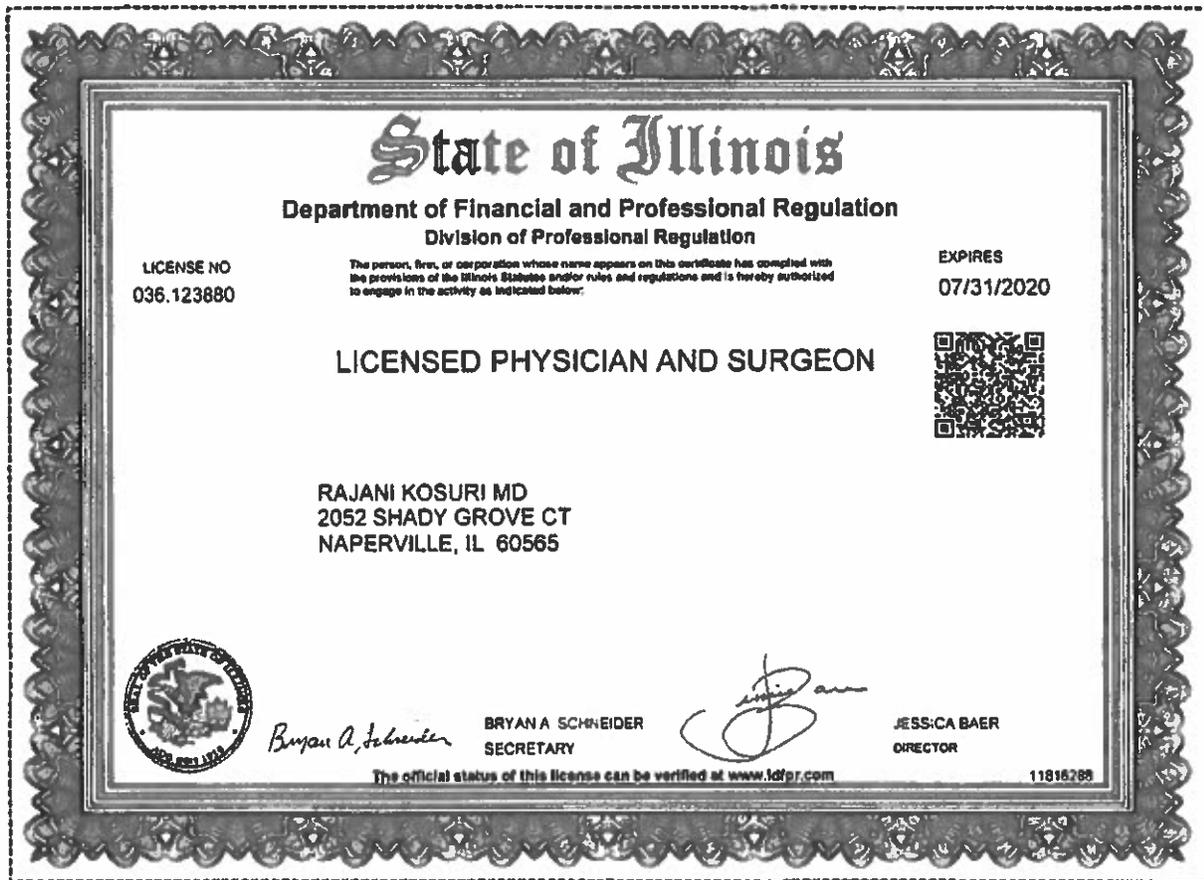
RAJANI KOSURI, MD

Address: 2052 Shady Grove Ct, Naperville, IL 60565
Phone: 219.299.3388 • E-mail: rkosuri26@yahoo.com

- Submitted a case report of Immune mediated mesangioproliferative glomerulonephritis triggered by cytomegalovirus to ACP
- Submitted a case report of Pheochromocytoma presenting with myocardial infarction and Tako-tsubo like ventricular dysfunction to ACP

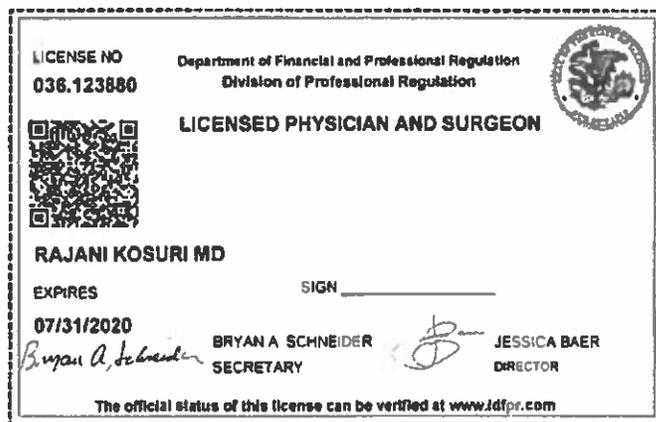
LANGUAGE SKILLS

- Proficient in English, Hindi, and Telugu



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For future reference, IDFPR is now providing each person/business a unique identification number, 'Access ID', which may be used in lieu of a social security number, date of birth or FEIN number when contacting the IDFPR. Your Access ID is: 3481109

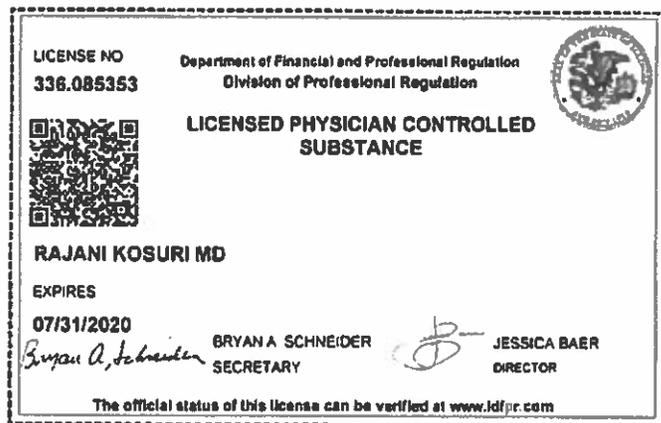


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THE AMERICAN BOARD OF INTERNAL MEDICINE
 INCORPORATED 1936

ATTESTS THAT

Rajani Kozuri

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY

CERTIFIED FOR THE PERIOD 2008 THROUGH 11 2018

AS A DIPLOMATE IN

INTERNAL MEDICINE

Harold J. Simon
 Robert J. Johnson
 John J. Kilgus
 David S. Cooper
 Bryan
 John S. Harold
 K P Hild



George H. Karon
 Ernest Keefe
 Richard J. ...
 Suzanne McKeep ...
 Stuart S. Kinas
 Philip R.
 Sam A. ...
 W J B ...
 Christine ...
 Thomas ...

MEDICAL STAFF CERTIFICATION

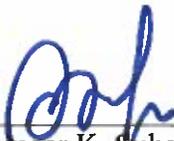
May 5, 2019

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Medical Staff Certification Letter

Dear Ms. Avery:

Pursuant to 77 Ill. Adm. Code § 1110.230(e)(5), an applicant is required to provide a letter certifying whether a proposed dialysis facility will or will not maintain an open medical staff. On behalf of the Applicant, Austin Dialysis Center, LLC, in consultation with project co-applicant Loretto Hospital, I submit this certified letter, which hereby attests that the proposed dialysis facility will maintain a closed medical staff. Only nephrologists employed by or affiliated with Loretto Hospital will staff the proposed ESRD facility. However, the hospital will be open to allowing any qualified nephrologist to affiliate with the hospital.



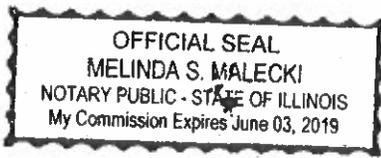
Sameer K. Suhail, M.D.
President & CEO
Austin Dialysis Center, LLC

Subscribed and sworn to before me this 9th day of May, 2019.



Signature of Notary Public

Seal



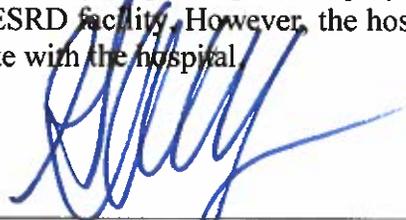
May 5, 2019

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Medical Staff Certification Letter

Dear Ms. Avery:

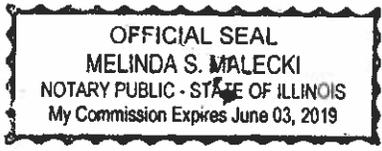
Pursuant to 77 Ill. Adm. Code § 1110.230(e)(5), an applicant is required to provide a letter certifying whether a proposed dialysis facility will or will not maintain an open medical staff. On behalf of the Applicant, Austin Dialysis Center, LLC, in consultation with project co-applicant Loretto Hospital, I submit this certified letter, which hereby attests that the proposed dialysis facility will maintain a closed medical staff. Only nephrologists employed by or affiliated with Loretto Hospital will staff the proposed ESRD facility. However, the hospital will be open to allowing any qualified nephrologist to affiliate with the hospital.



George N. Miller, Jr.
President & CEO
Loretto Hospital

Subscribed and sworn to before me this 9th day of May, 2019.

Melinda S Malecki
Signature of Notary Public

Seal 

ATTACHMENT 24(k)

Criterion 1110.230(f) – Support Services

The support services certification, required by 77 Ill. Adm. Code § 1110.230(f), is attached immediately after this page.

May 5, 2019

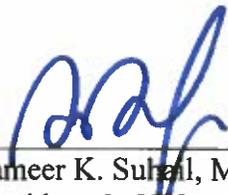
Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Support Services Certification Letter
Austin Dialysis Center, LLC

Dear Ms. Avery:

Pursuant to 77 Ill. Adm. Code § 1110.230(f), a certificate of need permit applicant is required to provide a letter certifying its support services plan. On behalf of the applicant Austin Dialysis Center, LLC ("Applicant"), in consultation with project co-applicant Loretto Hospital, I hereby certify to the following:

1. The ESRD facility proposed by the Applicant will utilize a patient tracking system to record the provision of dialysis care to its patients;
2. Applicant certifies that the following support services will be available to the ESRD facility's patients: clinical laboratory services; nutritional counseling; and psychiatric/social services; and
3. Applicant certifies that the following support services will be available to the ESRD facility's patients by way of referral: blood bank services; rehabilitation services; and home dialysis services.



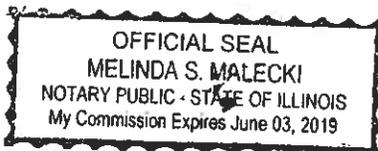
Sameer K. Suhail, M.D.
President & CEO
Austin Dialysis Center, LLC

Subscribed and sworn to before me this 9th day of May, 2019.



Signature of Notary Public

Seal



ATTACHMENT 24(I)

Criterion 1110.230(g) – Minimum Number of Stations

The in-center hemodialysis facility (“ESRD Facility”) proposed by Austin Dialysis Center, LLC (“Applicant”) will be located in the City of Chicago, Illinois. The city is a Metropolitan Statistical Area (“MSA”) as such term is defined by the State Board. A minimum of eight (8) dialysis stations is required to establish an in-center hemodialysis center in an MSA. The Applicant is seeking approval for a twelve (12) station ESRD Facility thereby meeting this requirement.

ATTACHMENT 24(m)

Criterion 1110.230(h) – Continuity of Care

A certificate of need (“CON”) permit applicant proposing to establish an in-center hemodialysis category of service shall document that a signed, written affiliation agreement or arrangement is in effect for the provision of inpatient care and other hospital services. Documentation shall consist of copies of all such agreements.

Accordingly, a letter of agreement covering patient transfers is attached immediately following this page. This transfer agreement, however, is contingent upon CON approval.

AUSTIN DIALYSIS CENTER

April 30, 2019

Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60644
Attention: George Miller, President & CEO

RE: Letter Agreement for Backup Dialysis Services

Dear Mr. Miller:

This letter, when signed by an authorized representative of Loretto Hospital, an Illinois not-for-profit corporation ("Hospital"), shall be an agreement (the "Agreement") by and between Hospital and Austin Dialysis Center, LLC, an Illinois limited liability company ("Austin Dialysis"), for emergency back-up dialysis services for patients being served by Austin Dialysis at the end stage renal disease ("ESRD") facility located at 645 South Central Avenue, Suite 100, Chicago, Illinois 60644 (the "ESRD Facility"). This Agreement shall be effective on the first date that Austin Dialysis provides at least one hemodialysis treatment to a patient at the ESRD Facility (the "Effective Date").

Patient Transfer Agreement

On the Effective Date, Austin Dialysis will provide in-center hemodialysis treatments for patients at its ESRD Facility. Austin Dialysis understands that Hospital owns and operates an acute care hospital/dialysis center located at located at 645 South Central Avenue, Chicago, Illinois 60644.

Hospital agrees to provide hospital-based hemodialysis services to patients from the ESRD Facility who need emergency dialysis services and, if necessary, inpatient hospitalization, which may or may not include inpatient dialysis care. These services shall be available to the ESRD Facility's patients twenty-four (24) hours a day, seven (7) days a week.

In the event that any patient from the ESRD Facility requires hospitalization, whether or not the patient's illness is associated with ESRD, such patient may be transferred by a method of transportation appropriate to the patient's clinical condition to the Hospital for treatment in accordance with the Hospital's admission policies and procedures. In the event of an admission to the Hospital, Austin Dialysis understands that the patient shall no longer be under the care of the ESRD Facility.

Hospital requests notification from Austin Dialysis as far in advance as possible of an impending transfer of an ESRD Facility patient. With respect to any transfer, Austin Dialysis will formally discharge the patient from its care and will provide to Hospital, within one (1) working day of the transfer, all medical and administrative records and information necessary or useful for the care and treatment of the transferred patient. This information includes, but is not limited to: (i) a reason or reasons for the transfer; (ii) current medical findings; (iii) the patient's diagnosis and rehabilitation potential; (iv) a brief summary of the course of treatment followed to date; (v) nursing and dietary information; (vi) pertinent administrative and social information; and (vii) information related to the patient's plan of care.

If the transfer is necessary for the patient's welfare, Austin Dialysis will ensure that the patient's medical record includes documentation of the medical need and reasons why the ESRD Facility was no longer able to meet the transferred patient's needs.

The patient shall be solely responsible for transportation to the accommodating hospital. Hospital is not responsible for patient care at any time the ESRD Facility patient is not under its direct control including, but not limited to, the period of time when the patient is being transported by Austin Dialysis to the Hospital. Within the Hospital, a transfer shall occur when the Hospital's staff assumes control over the care and welfare of the transferred patient by taking the patient into their custody.

It is the policy of Hospital to admit and treat all patients at the Hospital equally, without regard to race, color, national origin, ancestry, sex, age, religious creed, disability, handicap or any other protected status. Hospital will not reject a transfer of any such person. Hospital will honor a transferred patient's advanced directives, if any, when an ESRD Facility patient is transferred to the Hospital by Austin Dialysis.

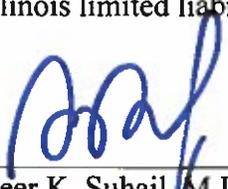
Nothing in this agreement shall in any way affect the autonomy of either Austin Dialysis or Hospital. Their respective governing bodies shall have exclusive control over the management and affairs of each provider's respective organizations. Hospital does not assume by virtue of this letter any liabilities for any debts or obligations of Austin Dialysis or the ESRD Facility. Nothing in this letter precludes the right of patients or physicians from obtaining services from another hospital or ESRD facility of their choice.

* * * *

If you agree with the terms of this agreement for routine and emergency dialysis services and, if necessary, inpatient hospitalization, made between Hospital and Austin Dialysis, please sign and return an original copy of this letter to Austin Dialysis Center, LLC, 155 North Michigan Avenue, Chicago, Illinois 60601. Please contact me if you have questions. Thank you very much.

Respectfully submitted,

AUSTIN DIALYSIS CENTER, LLC,
an Illinois limited liability company



Sameer K. Suhail, M.D.
President & CEO

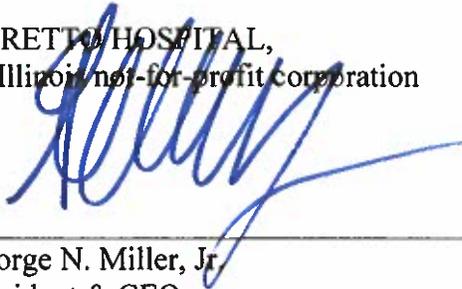
5-9-19

Date

[continued on following page]

ACCEPTED AND AGREED:

LORETTO HOSPITAL,
an Illinois not-for-profit corporation



George N. Miller, Jr.
President & CEO

4-30-19

Date

ATTACHMENT 24(n)

Criterion 1110.230(i) – Relocation

This review criterion is not applicable to the proposed project.

ATTACHMENT 24(o)

Criterion 1110.230(j) – Assurances

The assurances certification, required by 77 Ill. Adm. Code § 1110.230(j), is attached immediately after this page.

May 5, 2019

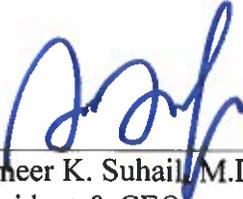
Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Assurances Certification Letter
Austin Dialysis Center, LLC

Dear Ms. Avery:

Pursuant to 77 Ill. Adm. Code § 1110.230(f), a certificate of need permit applicant is required to provide a letter certifying its assurances pertaining to quality measures. On behalf of the applicant Austin Dialysis Center, LLC ("Applicant"), in consultation with project co-applicant Loretto Hospital, I hereby certify to the following:

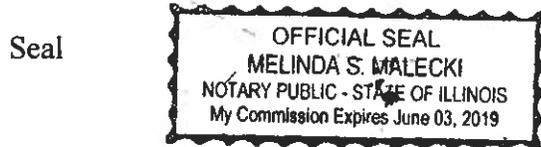
1. By the second year of operation after the project has been completed, the ESRD facility will achieve and maintain the State Board's utilization standards applicable to the In-Center Hemodialysis Category of Service; and
2. That the ESRD facility intends to achieve and maintain compliance with hemodialysis quality measures. The following data shows the Applicant's goals in relation to quality of care.
 - o 90% of patients have urea reduction ratio (URR) \geq 65%
 - o 90% of patients have Kt/V \geq 1.2
 - o Fistula prevalence goal: \geq 80%



Sameer K. Suhail, M.D.
President & CEO
Austin Dialysis Center, LLC

Subscribed and sworn to before me this 9th day of May, 2019.

Melinda S Malecki
Signature of Notary Public



ATTACHMENT 34

**Criterion 1120.120
Availability of Funds**

The Project’s total cost is \$1,961,169. Of that amount, \$720,169 represents the fair market value of two leases over a five (5) year term—the first, a real property lease valued at \$432,169 over the term, and the second, an equipment lease with a 5-year value of \$288,000. However, the first two years of the property lease rent will be waived by Loretto Hospital in exchange for the purchase of securities (i.e., membership units) in the Applicant’s limited liability company. Loretto Hospital will acquire up to 49% of the membership units in the LLC. The value of the securities totals \$167,750, which is the equivalent of the first two years of waived rent. The Applicant will take on a loan of \$1,119,500 to fund the balance of the Project’s costs.

AVAILABILITY OF FUNDS	
<u>\$289,250</u>	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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;
<u>\$1,119,500</u>	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: <ol style="list-style-type: none"> 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.
<u>\$552,419</u>	
\$1,961,169	TOTAL FUNDS AVAILABLE

Discussion: Availability of Funds

The Project's funds will come from five sources: (1) cash; (2) securities; (3) the fair market value of a real property lease; (4) the fair market value of an equipment lease; and (5) a bank loan. The total project cost includes the fair market value of rent to be paid over the five (5) year term of the property lease and the five (5) year term of an equipment lease. Each of these are discussed below in greater detail.

(a) Cash & Securities

(1) Cash

A few of the project costs are being paid in cash. Of these costs, most have already been incurred in the process leading up to the certificate of need ("CON") permit application submission to the State Board. These costs include \$121,500 to cover legal, consulting, and architecture fees.

(2) Securities

Co-applicant Loretto Hospital will not charge the applicant Austin Dialysis Center, LLC ("Applicant") rent during the first two years of occupancy. In lieu of rent, the Applicant will credit the waived rent amount towards the purchase of membership units in the Applicant's limited liability company. Loretto Hospital has the ability to acquire up to 49% of the membership units.

The initial credit of waived rent over the first two years will total \$167,500. The Applicant and Loretto Hospital have not yet determined the ownership percentage that this amount equals. However, the ownership percentage given to this dollar amount will be determined using a pre-CON valuation of the business. The Applicant and Loretto Hospital may agree to additional years of waived rent based on the result of ongoing negotiations concerning the pre-CON value of the Applicant's business.

(b) Debt

(1) Bank Loan

The majority of the project costs, or \$1,119,500, will come from a bank loan. The Applicant has a loan commitment from STC Capital Bank to cover this amount. A copy of the letter is provided below.

(2) Property Lease (Fair Market Value)

The Applicant and Loretto Hospital executed a Letter of Intent to Lease on December 14, 2018 ("LOI"). The LOI provides the terms of a five (5) year property lease for the 2,750 square foot space that will house the proposed hemodialysis facility ("Property Lease"). The LOI further provides that the five-year value of the rent shall be \$432,169.

The Property Lease will include the following rent amounts for 2019 through 2024:

Year 1	\$83,875
Year 2	\$83,875
Year 3	\$85,972
Year 4	\$88,122
Year 5	\$90,325

During the first two years, there will be no increase in the rent amount. However, in years 3 through 5, the rent will increase with a 2.5% upward adjustment each year.

(3) Equipment Lease (Fair Market Value)

The project budget includes \$288,000 to lease equipment from Fresenius (“Equipment Lease”). The amount of the lease is consistent with market value. A sample lease agreement is provided below.

Documentation

The following documents are attached immediately following this page, providing the evidence needed to comply with this review criterion:

- Bank Letter re: Loan
- Letter of Intent to Lease (Property)
- Sample Lease Agreement (Equipment)



March 26th, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courney Avery, Administrator

**Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements
Austin Dialysis at Loretto Certificate of Need Permit Application**

Dear Ms. Avery:

It is my understanding that Austin Dialysis Center, LLC, an Illinois limited liability company doing business as Austin Dialysis at Loretto ("Applicant"), is applying for a certificate of need ("CON") permit to establish an in-center hemodialysis facility ("ESRD Facility") at 645 South Central Avenue, Chicago, Illinois 60644 ("Project"). In the CON permit application, the Applicant indicates that the total cost of the Project is \$1,000,000 ("Project Cost"). Of that amount, \$300,000 represents the fair market value of lease agreements and \$700,000 represents equipment and tenant improvements. Accordingly, the Applicant needs a bank loan for \$700,000 to fund the balance of the Project Cost.

I, Michael Gilbert, submit this letter for the Applicant, to certify that, as of March 26th, 2019, the Applicant and his accumulated business interests have a sufficient credit history and our bank will consider issuing a loan to the Applicant in the amount of \$700,000 to cover the balance of the total Project Cost. If you have questions, please do not hesitate to contact me at 815.751.3736. Thank you very much.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'Michael Gilbert', with a long horizontal flourish extending to the right.

Michael Gilbert
Vice President
STC Capital Bank
St. Charles, IL 60174

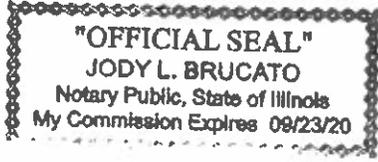
NOTARY:

Subscribed and sworn to me this 1st day of April, 2019

Jody L. Brucato

Notary Public

Seal:





March 26th, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attention: Courney Avery, Administrator

**Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements
Austin Dialysis at Loretto Certificate of Need Permit Application**

Dear Ms. Avery:

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I, Michael Gilbert, submit this letter for the Applicant, to certify that, as of March 26th, 2019, the Applicant and his accumulated business interests have a sufficient credit history and our bank will consider issuing a loan to the Applicant in the amount of \$700,000 to cover the balance of the total Project Cost. If you have questions, please do not hesitate to contact me at 815.751.3736. Thank you very much.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "M Gilbert", written over a horizontal line.

Michael Gilbert
Vice President
STC Capital Bank
St. Charles, IL 60174

NOTARY:

Subscribed and sworn to me this _____ day of _____, 2019

Notary Public

Seal:

This proposal is intended as an outline only and does not purport to summarize all of the conditions, covenants, representations, warranties, and other provisions that would typically be contained in definitive legal documentation. Any commitment by STC Capital Bank, if and/or when issued, will be subject to negotiation and execution of definitive loan documents in form and substance satisfactory to the Borrower, STC Capital Bank, and their respective counsels.

FACILITY 1

Amount: \$700,000

Borrower: Austin Dialysis Center LLC, Dr. Sameer Suhail, Dr. Dena Suhail,, AICG

Purpose: Equipment and tenant improvement at 645 South Central Avenue Chicago, Illinois 60644

Rate: 6%

Term: 72-month term

Amortization: 12-months Interest only, 60 months Principal and Interest

Security: Blanket first lien on all assets. Specifically, Fresenius Dialysis Machines and future accounts receivable of Austin Dialysis and full guarantee of Dr. Sameer and Dena Suhail and also AICG.

Pre-Payment: No Pre-Payment Penalty

Repayment: Interest-only for 12 months then Principal and Interest Payments over the final 60 months.

Banking Relationship: The client will be required to maintain a full banking relationship with STC Capital Bank for the property and any reserve accounts.

Due Diligence: Purchase contract for new Kidney Dialysis Machines, contractors sworn statement of tenant improvements, documentation of other miscellaneous FF&E

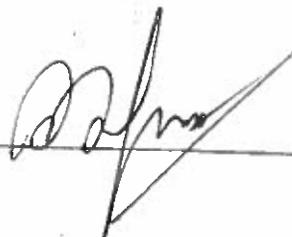
Origination Fee: 1%

Documentation Fee: \$500



ACCEPTANCE:

Dr. Sameer Suhail



Michael Gilbert
STC Capital Bank
460 South First Street
St. Charles, IL 60174





April 30, 2019

Austin Dialysis Center, LLC
155 North Michigan Avenue, Suite 634
Chicago, Illinois 60601
Attention: Sameer K. Suhail, M.D., President & CEO

RE: Healthcare Facility Space Lease

Dear Dr. Suhail:

This letter of intent ("Letter of Intent") outlines the basic business terms and conditions upon which Loretto Hospital, an Illinois not-for-profit corporation ("Landlord") would be willing to execute a lease ("Lease") with Austin Dialysis Center, LLC ("Tenant"), whereby Tenant shall occupy the Premises (as defined below) to operate a Medicare-certified end stage renal disease ("ESRD") facility, it being understood that additional terms and conditions remain to be negotiated between the parties and final approval is contingent upon the complete execution of the documents and transactions described in this Letter of Intent.

Landlord	Loretto Hospital 645 South Central Avenue Chicago, Illinois 60601 Attention: George K. Miller, President/CEO
Tenant	Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto 155 North Michigan Avenue Suite 634 Chicago, Illinois 60601 Sameer K. Suhail, M.D., President/CEO
Premises	Loretto Hospital 645 South Central Avenue Suite 100 Chicago, Illinois 60644

Specifically, the "Premises" shall include Suite 100, which is the space in the lower level of Loretto Hospital, located on the east side of the building, and is presently occupied by the hospital's physical therapy program. Access to the Premises will be through the hospital's main entrance, into the lobby, past the security desk, and completed either by an elevator ride or a descent down a staircase, which is directly accessible from the hospital's main lobby.

SQF of Premises The Premises shall consist of two thousand seven hundred and fifty (2,750) square feet of rentable space (“RSF”), which shall be identified and described in a Lease between Landlord and Tenant.

Equipment Lease Unless otherwise agreed to by the parties, Tenant will provide all medical and non-medical equipment for the complete operation of a 14-station ESRD facility. If necessary, Tenant will secure leased equipment in its name to ensure the ability to operate the facility.

Term of Lease The Lease shall have an initial term (“Initial Term”) of five (5) years, which shall commence thirty (30) days after Tenant obtains a certificate of need (“CON”) permit from the Illinois Health Facilities and Services Review Board (“State CON Board”). Thereafter, the Lease shall automatically renew for two (2) renewal terms (each a “Renewal Term”), each extending the Lease for an additional five (5) year period. The Initial Term along with any or all Renewal Terms shall collectively be referred to as the “Term” of the Lease.

Fair Market Value of Rent; Rent Escalation Landlord and Tenant concur that the direct fair market value rental range of \$28.00 to \$33.00 per square foot (“SQF”), net of the Premises’ net rentable area, as provided by Real Estate Counselors International, Inc. (“RECI”), is reasonable and consistent with fair market value (“FMV”). Based on this estimate, the initial amount for rent (“Rent”) shall be calculated at \$30.50/SQF net (“net” meaning the amount does not include the Tenant’s pro-rated responsibility of taxes or common area expenses).

Using \$30.50/SQF, the resulting monthly Rent will be \$83,875.00 per year ($\$30.50 \times 2,750$ SQF). Rent will be subject to a two and four tenths percent (2.4%) annual escalation starting on the twenty-fifth (25th) month of the Term and increase annually thereafter at the same rate. The Rent shall be prorated to account only for the days on which the Subtenant occupies the Premises.

Based on the foregoing, the Rent amounts for 2019 through 2024:

Year 1	\$83,875
Year 2	\$83,875
Year 3	\$85,972
Year 4	\$88,122
Year 5	\$90,325

Taxes and Common Area Expenses	Tenant and Landlord agree that Rent, calculated on a net basis, does not include the Tenant's pro-rated responsibility of taxes ("Taxes") or common area expenses ("CAM"). CAM includes any work that is completed in the hospital building's common area on behalf of the hospital and all of its tenants, including the Tenant. CAM includes, but is not limited to, snowplowing of the parking lot and sidewalks, landscaping of the exterior, insurance for the building, or the cleaning of common areas (lobbies, bathrooms, hallways, etc.). Each tenant, including the Tenant, is responsible for such charges, which are passed on by the Landlord.
Waiver of Rent, Taxes and CAM	Landlord and Tenant agree that Tenant will not pay Rent to the Landlord, or its pro-rated portion of Taxes and/or CAM costs, any month during the Term of the Lease in which Loretto Hospital has not fully compensated Tenant for the fair market value of fifteen (15) membership units in Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto. During any such month, Tenant shall credit Loretto Hospital for the full amount of Rent, pro-rated Taxes, and CAM costs, applying such amounts towards payment for the LLC membership units.
Improvements	Landlord will not provide an allowance towards improvements within the Premises. Tenant shall provide those alterations and improvements required such that the Premises comply with codes and regulations necessary for the use by Tenant as a Medicare certified ESRD facility.
Assignment & Sublease	Tenant shall not have the right to assign or sublet all or part of the Premises at any time during the Term of the Lease without first obtaining the Landlord's consent, which shall not be unreasonably withheld or delayed. No consent shall be required for an assignment or sublet to any subsidiary, affiliate, or company related to Tenant.
Real Estate Brokers; Commissions	It is represented that neither the Tenant nor the Landlord is represented by a real estate broker and no commission will be paid in connection with the Lease.
Government Approvals	Landlord and Tenant acknowledge and agree that the establishment of a Medicare certified ESRD 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, therefore, the Tenant cannot establish an ESRD facility within the Premises or execute a binding real estate Lease in connection therewith, unless the Tenant first obtains a CON permit from the State CON Board. Tenant agrees to proceed using commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application without undue delay in order to obtain a CON permit from the State CON Board as soon as possible.

In light of the foregoing facts, Landlord and Tenant agree that the Lease may only be executed after the Tenant has obtained a CON permit from the State CON Board, or alternatively, execute a Lease prior to CON approval, but such Lease shall include a provision that states the agreement, though executed, shall not be binding on either party unless the State CON Board grants a CON permit to the Tenant. If the Tenant fails to obtain a CON permit from the State CON Board, neither party shall have any further obligation to the other party with regard to the negotiations, Lease, or Premises contemplated by the parties in this Letter of Intent.

**Exclusive
Negotiations**

In consideration of each of the parties entering into this Letter of Intent, each party agrees to deal with the other in good faith while negotiating the terms set forth in this Letter of Intent and the transactions contemplated hereby, and Landlord agrees to negotiate exclusively with the Tenant with respect to these transactions for up to thirty (30) days after either: (1) a final decision is made by the State CON Board in connection with a CON permit application regarding the establishment of an ESRD facility within the Premises; or (2) the parties mutually agree to abandon all efforts to establish the ESRD facility before the State CON Board issues any decision on the matter.

Confidentiality

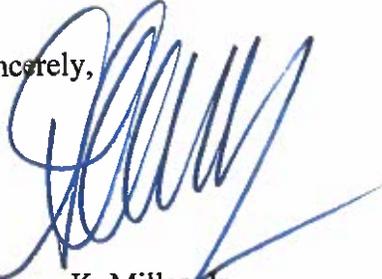
Subject to mandatory provisions of applicable law, the parties to this Letter of Intent hereby agree to preserve and maintain the confidentiality of any and all information (including, but not limited to, information gathered or exchanged during due diligence, except to the extent such information is already in the public domain) and negotiations relative to the transactions contemplated herein, including the existence of this Letter of Intent, and the fact that negotiations concerning a joint venture are taking place. Neither party hereto shall issue any press releases, nor disclose such information, without the prior written consent of the other party except: (1) where a party is required by applicable law or regulatory requirements to make a disclosure concerning the information or the proposed transactions; or (2) where a party makes disclosure to its employees, legal counsel, accountants, and agents who have a need to know such information in connection with the transactions contemplated hereby.

This Letter of Intent is not intended to be a binding agreement between the Landlord and Tenant; but, shall be the basis for negotiation going forward. There shall be no binding agreement between the Landlord and Tenant until a Lease is fully executed by all of the necessary parties, including, but not necessarily limited to, the Landlord and Tenant. Either party may withdraw from negotiations at any time for any reason, without liability to the other. The terms set forth in this Letter of Intent are being provided with confidentiality and must not be shared with any other parties not specifically identified herein.

If the terms described in this Letter of Intent are consistent with your understanding and approval, please sign and date below and return the executed document to the address provided below. Upon receipt of the signed offer and CON approval, we will prepare an executable Lease for your approval.

We look forward to working with you. Please free to contact me if you have any questions regarding this Letter of Intent.

Sincerely,

A handwritten signature in blue ink, appearing to read "G. Miller, Jr.", with a long horizontal stroke extending to the right.

George K. Miller, Jr.
President and Chief Executive Officer
Loretto Hospital
o/b/o Landlord

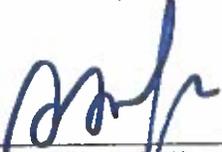
[signatures continue on following page]

AGREED AND ACCEPTED

Please indicate your acceptance of the above terms and conditions by executing below and returning an original signed copy to the address below.

TENANT:

Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto



Sameer K. Subail, M.D.
President and Chief Executive Officer

Date: 04/30/2019

Please return a signed copy of this Letter of Intent to:

Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60601
Attention: George K. Miller, Jr. President/CEO

EQUIPMENT RENTAL AND SUPPLY PURCHASE AGREEMENT

This Agreement, dated _____, 2019 ("EFFECTIVE DATE"), is made by and between Fresenius USA Marketing, Inc., a Delaware corporation ("FUSA") with its principal office located at 95 Hayden Avenue, Lexington, Massachusetts 02420-9192, and Austin Dialysis Center, LLC, an Illinois limited liability company, with its principal office located at 155 N. Michigan Avenue, Suite 634, Chicago, Illinois 60601 ("LESSEE" or "PURCHASER" as applicable).

Section 1.0 Definitions.

The following definitions apply within this Equipment Rental and Supply Purchase Agreement. PRODUCT(S) shall mean EQUIPMENT and DISPOSABLES. DISPOSABLES shall mean any hemodialysis product other than EQUIPMENT. EQUIPMENT shall mean hemodialysis machines and other related equipment.

Section 2.0 Term and Termination

2.1 Unless earlier terminated pursuant to Section 2.2 below, this Agreement shall be for a term of five (5) years, commencing on the EFFECTIVE DATE.

2.2 If either party fails to meet any of its material obligations or otherwise materially breaches this Agreement, the other party may, at its option, terminate this Agreement and any other Agreement between FUSA and LESSEE/PURCHASER with sixty (60) days written notice, if the failure to meet the obligation or cure the breach of either party is unable to be remedied in that timeframe.

Section 3.0 Reserved

Section 4.0 Order/Delivery Policy

4.1 LESSEE/PURCHASER agrees to abide by the Order/Delivery Policy described on Attachment 1.0.

4.2 All orders shall be subject to the terms and conditions of this Agreement and shall not be subject to the terms, conditions, or provisions of any order confirmation, except to the extent that such confirmation specifies quantities.

Section 5.0 Return Goods Policy

5.1 Due to the nature of FUSA's PRODUCTS, the contents are subject to damage in transit to LESSEE/PURCHASER. All orders must be counted and inspected for damage prior to acceptance from carrier. Exceptions must be reported within two (2) business days to the designated Customer Service representative in order to receive all authorized credits.

5.2 All returns must be arranged through FUSA's Customer Service Department. LESSEE must ensure that PRODUCTS are packed for shipment. All PRODUCTS returned to FUSA must have a Returned Goods Authorization ("RGA") number. Any PRODUCT returned to FUSA without a corresponding RGA number shall not be credited.

5.3 DISPOSABLES

5.3a This policy applies to all DISPOSABLES originally delivered to hospitals, centers, or home patients unless otherwise indicated. DISPOSABLES must be returned in the original, unopened container.

5.3b DISPOSABLES that have not been stored in a sanitary manner or in accordance with PRODUCT(S) storage statements cannot be returned or credited. Verification of proper storage may be required for credit.

5.3c DISPOSABLES provided at no charge are not eligible for credit, but are still subject to the terms of this Agreement.

5.3d [reserved]

5.3e [reserved]

5.3f All returns must be arranged through FUSA's Customer Service Department. LESSEE/PURCHASER must ensure that DISPOSABLES are packed for shipping.

5.3g DISPOSABLES shipped in error by FUSA must be reported within two (2) business days and returned within thirty (30) days of shipment.

5.3h DISPOSABLES ordered in error by LESSEE must be reported within two (2) business days and returned within thirty (30) days of shipment. All such returns must be arranged through FUSA's Customer Service Department, and LESSEE/PURCHASER if fully responsible for all associated costs.

5.3i [reserved]

5.3j EXCESS STOCK [reserved].

5.4 EQUIPMENT

5.4a Purchased EQUIPMENT is not returnable unless SHIPPED IN ERROR BY FUSA or ORDERED IN ERROR BY LESSEE. Leased, rental, trade-in, and/or evaluation equipment may be returned as governed by the terms of the applicable agreement.

5.4b All EQUIPMENT returns are at LESSEE/PURCHASER's expense, and EQUIPMENT must be in the same condition as when delivered to LESSEE/PURCHASER, normal wear and tear excepted. LESSEE/PURCHASER shall deliver the EQUIPMENT to such place or on board such carrier, packed for shipping, as FUSA may specify. LESSEE/PURCHASER is fully responsible for return of EQUIPMENT including all associated charges with the exception of return due to equipment shipped in error by FUSA. LESSEE/PURCHASER shall give FUSA prior written notice that it is returning EQUIPMENT.

5.4c Due to the nature of FUSA's PRODUCTS, the contents are subject to damage in transit [omitted].

5.4d Exchangeable parts [omitted].

5.4e Warranty parts [omitted].

5.4f Each part returned to FUSA must have a corresponding Material Travel Tag completed and attached securely to the part. If either the Material Travel Tag or the RGA form is not enclosed with the replacement part(s), LESSEE/PURCHASER must contact the Parts Customer Service Department to obtain the RGA number to be recorded on the Material Travel Tag.

5.4g Spare parts ordered by LESSEE/PURCHASER [omitted]. Return freight charges [omitted].

Section 6.0 FUSA Performance

6.1 FUSA shall use commercially reasonable efforts to fill orders, but FUSA shall not be liable for non-performance or delays caused by a supply shortage of raw materials, manufacturing problems, delivery or labor problems, acts of regulatory agencies, discontinuation of a product line, Acts of God, or causes beyond its control.

Section 7.0 Warranty

7.1 FUSA warrants that the PRODUCT(S) manufactured by Fresenius Medical Care North America, when used in accordance with the directions on the labeling, is fit for the purposes and indications described on the labeling. The applicable manufacturer under the manufacturer's warranty will cover PRODUCTS not manufactured by Fresenius Medical Care North America, and FUSA provides no warranty for PRODUCTS not manufactured by Fresenius Medical Care North America.

7.2 [omitted].

7.3 All warranties in this Agreement shall be construed to comply with the warranty Safe Harbor found at 42 C.F.R. 1001.952(g).

7.4 [omitted].

7.5 EQUIPMENT

7.5a FUSA warrants to LESSEE/PURCHASER that EQUIPMENT delivered is free from defects in material or workmanship for the periods specified in the appropriate Operator's Manual (which outlines the complete warranty), provided the EQUIPMENT is used and maintained in accordance with the manufacturer's operating instructions. Parts installed which have been purchased from vendors other than FUSA shall void all applicable warranties.

7.5b The Warranty does not apply to any EQUIPMENT that is misused, abused, neglected, tampered with, damaged by accident, flood, water, fire, or other hazard, subjected to abnormal or unusual electrical or fluid stress, improperly installed or operated, or not maintained in accordance with the routine maintenance schedule set forth in the Operator's and Technician's manual for the EQUIPMENT. Periodic preventative maintenance required to maintain proper machine operation is not covered under the Warranty. Warranty does not provide replacement dialyzers or any other compensation during the period that PURCHASER's EQUIPMENT is inoperative.

7.5c FUSA shall repair or replace, at its option, using new or reconditioned parts and/or subassemblies, any parts subject to this Warranty that are proven defective in materials or workmanship. Such repair or replacement shall be made without cost to PURCHASER and FUSA reserves the right to determine the location at which the repair or replacement will be accomplished.

7.5d Warranty parts [reserved].

7.5e All leased EQUIPMENT shall be set forth hereto on Exhibit A.

Section 8.0 Confidentiality

8.1 All information in this Agreement relating to [omitted] is confidential and, except as provided in Section 3.0, [omitted] required prior written consent.

Section 9.0 General Provisions

9.1 This Agreement contains the entire agreement between FUSA and LESSEE/PURCHASER and supersedes all prior understandings or agreements of the parties, whether written or oral. No modification of, nor amendment to, this Agreement shall be effective unless in writing and signed by FUSA and LESSEE/PURCHASER. The Attachments, Schedules, and Exhibits attached are incorporated herein.

9.2 The rights and obligations of the parties shall inure to the benefit of, and shall be binding upon the parties hereto and their respective successors and assigns, provided that neither party shall assign its rights and obligations hereunder without the prior written consent of the other. The sale or transfer of substantially all of the assets of LESSEE/PURCHASER, the sale or transfer of more than fifty percent (50%) of the outstanding stock of LESSEE/PURCHASER, and the merger of LESSEE/PURCHASER into another entity constitute an assignment for which this section applies. LESSEE/PURCHASER expressly acknowledges that any assignment to entities controlled by, controlling, or under common ownership with FUSA or originating out of any merger or consolidation of FUSA shall not require the consent of LESSEE/PURCHASER.

9.3 Either party may terminate this Agreement, effective immediately with written notice if: The other shall file for bankruptcy, or shall be adjudicated bankrupt, or shall take advantage of any applicable insolvency law, or shall make an assignment for the benefit of creditors, or shall be dissolved, or shall have a receiver appointed for its property.

9.4 This Agreement is deemed to be executed in, shall be governed by and construed according to the laws of the Commonwealth of Massachusetts without reference to conflict of law principles. Each party agrees to submit to the jurisdiction of the courts of Massachusetts for the purpose of resolving any dispute hereunder. If particular portions of this Agreement are ruled unenforceable, such portions shall be deemed modified to the extent necessary to render such portions enforceable and to preserve to the fullest extent permissible the intent and agreement of the parties herein set forth. In the event that any future changes in federal or state law or regulations applicable to the performance of this Agreement shall, in the reasonable opinion of legal counsel for either party, make any portion of this Agreement invalid or illegal, either party may terminate this Agreement upon thirty (30) days written notice to the other, if within said thirty (30) day period the parties are not able to agree on a mutually acceptable addendum to the Agreement.

9.5 FUSA's failure to insist on performance of any of the terms or conditions herein, or to exercise any right, or privilege, or FUSA's waiver of any breach hereunder shall not thereafter waive any other term, condition, right, or privilege.

9.6 Upon request, LESSEE/PURCHASER shall supply the following financial information certified by an independent certified public accountant: Complete fiscal financial statements (within ninety (90) days of the close of the LESSEE/PURCHASER's fiscal year) and quarterly unaudited balance sheet and income statement (within forty-five (45) days of LESSEE/PURCHASER's quarterly close).

9.7 Any notice required to be given under this Agreement shall be given by certified mail, return receipt requested, postage prepaid, or by nationally recognized overnight courier service, to the appropriate party at its address first set forth above or to any other address subsequently provided. A required copy of any notice to FUSA should be sent to the Law Department, RPT/FUSA, Fresenius Medical Care North America, Inc., 95 Hayden Avenue, Lexington, Massachusetts 02420-9192.

FUSA shall notify LESSEE/PURCHASER of the EFFECTIVE DATE of this Agreement.

PURCHASER does have _____ does not have _____ tax-exempt status.

PURCHASER'S fiscal year is reported as: January 1 to December 31

[remainder of page intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

Fresenius USA Marketing, Inc.
Lexington, Massachusetts

LESSEE/PURCHASER: Austin Dialysis Center, LLC
Chicago, Illinois

By: _____

By: _____

(print name)

(print name)

(print title)

(print title)

(date)

(date)

EXHIBIT A

LEASED EQUIPMENT

<u>Item(s)</u>	<u>Cost</u>	<u>Purchase</u>	<u>Lease</u>
Fresenius 2008T Dialysis Machines (12) *	\$288,000		X

ATTACHMENT 35

**Criterion 1120.130
Financial Viability Waiver**

The Project's funds will come from five sources: (1) cash; (2) securities; (3) the fair market value of a real property lease; (4) the fair market value of an equipment lease; and (5) a bank loan. The total project cost includes the fair market value of rent to be paid over the five (5) year term of the property lease and the five (5) year term of an equipment lease.

As the project involves financing other than cash or equivalents, and the Applicant does not have an A bond rating, therefore the projected viability ratios for the ESRD facility are provided below as Attachment 36.

ATTACHMENT 36

Criterion 1120.130 Viability Ratios

The Project's funds will come from five sources: (1) cash; (2) securities; (3) the fair market value of a real property lease; (4) the fair market value of an equipment lease; and (5) a bank loan. The total project cost includes the fair market value of rent to be paid over the five (5) year term of the property lease and the five (5) year term of an equipment lease.

As a new business entity, the Applicant has provided information below to justify the calculations. The ratios contained therein are calculated in accordance with the requirements of Section 1120, Appendix A.

CALCULATIONS

The *projected* viability ratios for the proposed ESRD facility are provided below. As a new entity, the Applicant is providing information to support the financial projections showing how each ratio was calculated. The ratios are calculated in accordance with Section 1120, Appendix A requirements.

FINANCIAL VIABILITY RATIOS

Current Ratio

Formula: Current Assets/Current Liabilities

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥ 1.5	1.96	1.88	1.82	Yes

The Applicant will be able to meet the standard for Current Ratio in all three years.

Net Margin Percentage

Formula: (Net Income/Net Operating Revenues) x 100

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥ 3.5%	5.60%	29.62%	28.73%	Yes

The Applicant will be able to meet the standard for Net Margin Percentage in all three years.

Long-Term Debt to Capitalization

Formula: (Long-Term Debt/Long-Term Debt + Net Assets) x 100

State Standard	Year 1	Year 2	Year 3	Met Standard?
≤ 80%	2.64%	1.41%	1.27%	Yes

The Applicant will be able to meet the standard for Long-Term Debt to Capitalization in all three years.

Project Debt Service Coverage

Formula: Net Income + (Depreciation + Interest + Amortization)/Principal Payments plus Interest Expense for the Year of Maximum Debt Service after Project Completion.

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥ 1.75	TBD	TBD	TBD	TBD

It is presently unclear if the Applicant will be able to meet the standard for Projected Debt Service Coverage. Once loan information is obtained from the bank, the Applicant will submit the information for this ratio.

Days of Cash-on-Hand

Formula: (Cash plus Investments plus Board Designated Funds)/(Operating Expense less Depreciation Expense)/365 days.

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥ 45 days	TBD	TBD	TBD	TBD

It is presently unclear if the Applicant will be able to meet the standard for Cash on Hand. Once loan information is obtained from the bank, the Applicant will submit the information for this ratio.

Cushion Ratio

Formula: (Cash plus Investments plus Board Designated Funds)/(Principal Payments plus Interest Expense) for the year of maximum debt service after project completion.

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥ 3.0	TBD	TBD	TBD	TBD

It is presently unclear if the Applicant will be able to meet the standard for Cushion Ratio. Once loan information is obtained from the bank, the Applicant will submit the information for this ratio.

Projected Financial Statement

	Projected Year 1	Projected Year 2	Projected Year 3
Revenue:			
In-center hemodialysis treatment reimbursements	\$1,076,400	\$2,948,100	\$3,369,600
Total Income	\$1,076,400	\$2,948,100	\$3,369,600
Expenses:			
Salaries	\$504,828	\$822,548	\$927,328
Supplies	\$210,974	\$577,828	\$715,400
G&A	\$107,640	\$294,810	\$336,960
Med. Director	\$85,000	\$85,000	\$85,000
Other	\$107,640	\$294,810	\$336,960
Total Expenses	\$1,016,082	\$2,074,996	\$2,401,648
Net Income	\$60,318	\$873,104	\$967,952

Projected Balance Sheet

	Projected Year 1	Projected Year 2	Projected Year 3
ASSETS			
Current Assets			
Checking/Savings	\$25,000	\$50,000	\$75,000
Accounts Receivable	\$1,076,400	\$2,948,100	\$3,369,600
Total Current Assets	\$1,101,400	\$2,998,100	\$3,444,600
Fixed Assets			
CapEx	\$705,500	\$705,500	\$705,500
FF&E	\$344,000	\$344,000	\$344,000
Accumulated Depreciation	-\$30,000	-\$30,000	-\$30,000
Total Fixed Assets	\$1,019,500	\$1,019,500	\$1,019,500
TOTAL ASSETS	\$2,120,900	\$4,017,600	\$4,464,100
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities			
Liabilities	\$1,016,082	\$2,074,996	\$2,401,648
Total Current Liabilities	\$1,016,082	\$2,074,996	\$2,401,648
Long-Term Liabilities			
Equipment Lease	\$57,600	\$57,600	\$57,600
	\$57,600	\$57,600	\$57,600
Total Liabilities	\$1,073,682	\$2,132,596	\$2,459,248
Equity			
Building & Equipment	\$344,000	\$344,000	\$344,000
Retained Earnings	0	0	0
Capital Contribution	\$5,000	\$5,000	\$5,000
Total Equity	\$349,000	\$349,000	\$349,000
TOTAL LIABILITIES & EQUITY	\$2,120,900	\$4,017,600	\$4,464,100

LORETTO HOSPITAL
Chicago, Illinois

CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2017 and 2016

LORETTO HOSPITAL
Chicago, Illinois

CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2017 and 2016

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INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Loretto Hospital
Chicago, Illinois

Report of the Financial Statements

We have audited the accompanying consolidated financial statements of Loretto Hospital which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Westside Insurance Company, a wholly owned subsidiary, which statements reflect total assets of 31% and 25%, respectively, and revenue constituting 2%, for the years ended June 30, 2017 and 2016 of the related consolidated totals. Those statements were audited by other auditors, whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for Westside Insurance Company is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

(Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Loretto Hospital as of June 30, 2017 and 2016 and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Crowe LLP

Crowe LLP

Chicago, Illinois
October 12, 2018

LORETTO HOSPITAL
CONSOLIDATED BALANCE SHEETS
June 30, 2017 and 2016

	<u>2017</u>	<u>2016</u>
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 3,635,397	\$ 5,223,294
Patient accounts receivable, net of allowance for uncollectible accounts of \$5,111,274 in 2017 and \$5,057,643 in 2016	4,154,207	5,034,081
Inventories	479,348	423,952
Estimated third-party payor settlements	951,223	1,342,105
Prepaid expenses and other current assets	<u>1,430,756</u>	<u>3,453,436</u>
Total current assets	10,650,931	15,476,868
Assets whose use is limited by board designation; for capital improvements of \$752,464 in 2017 and \$752,499 in 2016 and insurance claims of \$12,397,303 in 2017 and \$10,663,765 in 2016		
	13,149,767	11,416,264
Estimated insurance recoveries	6,373,984	5,433,015
Property and equipment, net	<u>25,395,993</u>	<u>24,352,498</u>
Total noncurrent assets	<u>44,919,744</u>	<u>41,201,777</u>
 Total assets	 <u>\$ 55,570,675</u>	 <u>\$ 56,678,645</u>
LIABILITIES AND NET ASSETS		
Current liabilities:		
Line of credit	\$ 1,012,016	\$ -
Accounts payable	4,401,110	4,691,771
Accrued expenses and other liabilities	5,161,717	3,482,874
Estimated third-party payor settlements	-	284,882
Accrued liabilities for self-insurance	<u>2,609,231</u>	<u>939,066</u>
Total current liabilities	13,184,074	9,398,593
Asset retirement obligation	1,028,382	1,028,382
Accrued liabilities for self-insurance, net of current portion	<u>7,845,778</u>	<u>7,689,043</u>
Total long-term liabilities	<u>8,874,160</u>	<u>8,717,425</u>
Total liabilities	22,058,234	18,116,018
Net assets:		
Unrestricted	33,326,226	38,126,412
Temporarily restricted	<u>186,215</u>	<u>436,215</u>
Total net assets	<u>33,512,441</u>	<u>38,562,627</u>
 Total liabilities and net assets	 <u>\$ 55,570,675</u>	 <u>\$ 56,678,645</u>

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years ended June 30, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Unrestricted revenue:		
Patient service revenue, net of contractual allowances and discounts	\$ 63,067,790	\$ 60,462,021
Provision for bad debts	<u>(5,485,792)</u>	<u>(5,317,887)</u>
Net patient service revenue, less provisions for bad debts	57,581,998	55,144,134
Other operating revenue	1,198,652	3,561,384
Net assets released from restrictions	<u>250,000</u>	<u>5,077</u>
Total revenue	59,030,650	58,710,595
Expenses:		
Salaries, wages, and benefits	34,032,024	33,475,534
Professional fees	3,569,001	2,644,001
Provider assessment	7,426,529	6,428,759
Supplies	5,190,673	6,388,410
Purchased services	5,415,205	4,823,999
Insurance	2,992,008	1,388,827
Depreciation and amortization	2,411,265	2,186,229
Other	<u>3,528,080</u>	<u>2,664,253</u>
Total expenses	64,564,785	60,000,012
Operating loss	(5,534,135)	(1,289,417)
Nonoperating gains (losses):		
Gain on sale of accountable care entity investment	-	3,243,590
Investment income	28,411	307,560
Unrealized gain from investments	733,537	237,281
Realized loss from investments	<u>(27,999)</u>	<u>(307,107)</u>
	<u>733,949</u>	<u>3,481,324</u>
Excess (deficit) of revenue over expenses	(4,800,186)	2,191,907
Temporarily restricted net assets:		
Net assets released from restriction	(250,000)	(5,077)
Contributions	<u>-</u>	<u>294,847</u>
	<u>(250,000)</u>	<u>289,770</u>
Increase (decrease) in net assets	(5,050,186)	2,481,677
Net assets at beginning of year	<u>38,562,627</u>	<u>36,080,950</u>
Net assets at end of year	<u>\$ 33,512,441</u>	<u>\$ 38,562,627</u>

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATED STATEMENTS OF CASH FLOWS
Years ended June 30, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Operating activities:		
Increase (decrease) in net assets	\$ (5,050,186)	\$ 2,481,677
Adjustments to reconcile increase (decrease) in net assets to net cash from operating activities:		
Depreciation and amortization	2,411,265	2,186,229
Unrealized gain on investments	(733,537)	(237,281)
Provision for bad debts	5,485,792	5,317,887
Gain on sale of accountable care entity investment	-	(3,243,590)
Change in assets and liabilities:		
Patient accounts receivable	(4,605,918)	(5,555,924)
Inventories	(55,396)	2,324
Prepaid expenses and other current assets	668,497	238,803
Due to(from) third-party payors, net	106,000	(11,668)
Estimated insurance recoveries	(940,969)	1,910,636
Accounts payable	(290,661)	1,552,412
Accrued expenses and other liabilities	1,678,843	(289,727)
Accrued liabilities for self insurance	<u>1,826,900</u>	<u>(3,031,633)</u>
Net cash provided by operating activities	500,630	1,320,145
Investing activities:		
Purchase of property and equipment	(3,454,760)	(2,090,819)
Proceeds from sale and maturities of investments	50,035	2,618,060
Proceeds from sale of accountable care entity investment	1,354,183	1,909,407
Purchase of investments	<u>(1,050,001)</u>	<u>(2,560,000)</u>
Net cash used in investing activities	<u>(3,100,543)</u>	<u>(123,352)</u>
Cash flows from financing activities		
Line of credit borrowing	<u>1,012,016</u>	-
Net cash from financing activities	<u>1,012,016</u>	-
Net change in cash and cash equivalents	(1,587,897)	1,196,793
Cash and cash equivalents at beginning of year	<u>5,223,294</u>	<u>4,026,501</u>
Cash and cash equivalents at end of year	<u>\$ 3,635,397</u>	<u>\$ 5,223,294</u>
Supplemental disclosures of cash flow information		
Cash paid during the year for interest	\$ 23,094	\$ -

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATING BALANCE SHEETS
 June 30, 2017

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
ASSETS					
Current assets:					
Cash and cash equivalents	\$ 3,195,827	\$ 143,772	\$ 295,798	\$ -	\$ 3,635,397
Patient accounts receivable, net	4,143,352	1,679	9,176	-	4,154,207
Inventories	479,348	-	-	-	479,348
Estimated third-party payor settlements	951,223	-	-	-	951,223
Other assets	-	650,001	-	(650,001)	-
Prepaid expenses and other current assets	1,240,978	184,043	5,735	-	1,430,756
Total current assets	<u>10,010,728</u>	<u>979,495</u>	<u>310,709</u>	<u>(650,001)</u>	<u>10,650,931</u>
Assets whose use is limited	752,464	12,397,303	-	-	13,149,767
Estimated insurance recoveries	2,438,062	3,935,922	-	-	6,373,984
Property and equipment, net	25,395,993	-	-	-	25,395,993
Investment in wholly-owned subsidiary	9,064,830	-	-	(9,064,830)	-
Interest in affiliated not-for-profit entity	306,709	-	-	(306,709)	-
Total noncurrent assets	<u>37,958,058</u>	<u>16,333,225</u>	<u>-</u>	<u>(9,371,539)</u>	<u>44,919,744</u>
Total assets	<u>\$ 47,968,786</u>	<u>\$ 17,312,720</u>	<u>\$ 310,709</u>	<u>\$ (10,021,540)</u>	<u>\$ 55,570,675</u>
LIABILITIES AND NET ASSETS					
Current liabilities:					
Line of credit	\$ 1,012,016	-	-	-	\$ 1,012,016
Accounts payable	5,001,935	49,176	-	(650,001)	4,401,110
Accrued expenses and other liabilities	4,549,384	608,333	4,000	-	5,161,717
Accrued liabilities for self-insurance	209,899	2,399,332	-	-	2,609,231
Total current liabilities	<u>10,773,234</u>	<u>3,056,841</u>	<u>4,000</u>	<u>(650,001)</u>	<u>13,184,074</u>
Asset retirement obligation	1,028,382	-	-	-	1,028,382
Accrued liabilities for self-insurance, net of current portion	2,654,729	5,191,049	-	-	7,845,778
Total long-term liabilities	<u>3,683,111</u>	<u>5,191,049</u>	<u>-</u>	<u>-</u>	<u>8,874,160</u>
Total liabilities	<u>14,456,345</u>	<u>8,247,890</u>	<u>4,000</u>	<u>(650,001)</u>	<u>22,058,234</u>
Net assets:					
Unrestricted	33,326,226	9,064,830	155,493	(9,220,323)	33,326,226
Temporarily restricted	186,215	-	151,216	(151,216)	186,215
Total net assets	<u>33,512,441</u>	<u>9,064,830</u>	<u>306,709</u>	<u>(9,371,539)</u>	<u>33,512,441</u>
Total liabilities and net assets	<u>\$ 47,968,786</u>	<u>\$ 17,312,720</u>	<u>\$ 310,709</u>	<u>\$ (10,021,540)</u>	<u>\$ 55,570,675</u>

LORETTO HOSPITAL
CONSOLIDATING BALANCE SHEETS
 June 30, 2016

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
ASSETS					
Current assets:					
Cash and cash equivalents	\$ 4,539,283	\$ 401,583	\$ 282,428	\$ -	\$ 5,223,294
Patient accounts receivable, net	5,024,786	-	9,295	-	5,034,081
Inventories	423,952	-	-	-	423,952
Estimated third-party payor settlements	1,342,105	-	-	-	1,342,105
Other assets	-	433,334	-	(433,334)	-
Prepaid expenses and other current assets	3,250,838	179,523	23,075	-	3,453,436
Total current assets	<u>14,580,964</u>	<u>1,014,440</u>	<u>314,798</u>	<u>(433,334)</u>	<u>15,476,868</u>
Assets whose use is limited	752,499	10,663,765	-	-	11,416,264
Estimated insurance recoveries	3,031,024	2,401,991	-	-	5,433,015
Property and equipment, net	24,352,498	-	-	-	24,352,498
Investment in wholly-owned subsidiary	8,135,823	-	-	(8,135,823)	-
Interest in affiliated not-for-profit entity	302,026	-	-	(302,026)	-
Total noncurrent assets	<u>36,573,870</u>	<u>13,065,756</u>	<u>-</u>	<u>(8,437,849)</u>	<u>41,201,777</u>
Total assets	<u>\$ 51,154,834</u>	<u>\$ 14,080,196</u>	<u>\$ 314,798</u>	<u>\$ (8,871,183)</u>	<u>\$ 56,678,645</u>
LIABILITIES AND NET ASSETS					
Current liabilities:					
Accounts payable	\$ 5,078,621	\$ 41,212	\$ 5,272	\$ (433,334)	\$ 4,691,771
Accrued expenses and other liabilities	2,875,374	600,000	7,500	-	3,482,874
Estimated third-party payor settlements	284,882	-	-	-	284,882
Accrued liabilities for self-insurance	293,924	645,142	-	-	939,066
Total current liabilities	<u>8,532,801</u>	<u>1,286,354</u>	<u>12,772</u>	<u>(433,334)</u>	<u>9,398,593</u>
Asset retirement obligation	1,028,382	-	-	-	1,028,382
Accrued liabilities for self-insurance, net of current portion	3,031,024	4,658,019	-	-	7,689,043
Total long-term liabilities	<u>4,059,406</u>	<u>4,658,019</u>	<u>-</u>	<u>-</u>	<u>8,717,425</u>
Total liabilities	<u>12,592,207</u>	<u>5,944,373</u>	<u>12,772</u>	<u>(433,334)</u>	<u>18,116,018</u>
Net assets:					
Unrestricted	38,126,412	8,135,823	150,811	(8,286,634)	38,126,412
Temporarily restricted	436,215	-	151,215	(151,215)	436,215
Total net assets	<u>38,562,627</u>	<u>8,135,823</u>	<u>302,026</u>	<u>(8,437,849)</u>	<u>38,562,627</u>
Total liabilities and net assets	<u>\$ 51,154,834</u>	<u>\$ 14,080,196</u>	<u>\$ 314,798</u>	<u>\$ (8,871,183)</u>	<u>\$ 56,678,645</u>

LORETTO HOSPITAL
CONSOLIDATING STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Year ended June 30, 2017

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
Unrestricted revenue:					
Patient service revenue, net of contractual allowances and discounts	\$ 63,067,790	-	-	-	\$ 63,067,790
Provision for bad debts	(5,485,792)	-	-	-	(5,485,792)
Net patient service revenue, less provisions for bad debts	57,581,998	-	-	-	57,581,998
Other operating revenue	1,130,158	1,300,000	163,522	(1,395,028)	1,198,652
Net assets released from restrictions	250,000	-	-	-	250,000
Total revenue	<u>58,962,156</u>	<u>1,300,000</u>	<u>163,522</u>	<u>(1,395,028)</u>	<u>59,030,650</u>
Expenses:					
Salaries, wages, and benefits	34,026,169	-	100,883	(95,028)	34,032,024
Professional fees	3,569,001	-	-	-	3,569,001
Provider assessment	7,426,529	-	-	-	7,426,529
Supplies	5,190,673	-	-	-	5,190,673
Purchased services	5,415,205	-	-	-	5,415,205
Insurance	3,409,962	882,046	-	-	2,992,008
Depreciation and amortization	2,411,265	-	-	(1,300,000)	2,411,265
Other	3,247,228	222,896	57,956	-	3,528,080
Total expenses	<u>64,696,032</u>	<u>1,104,942</u>	<u>158,839</u>	<u>(1,395,028)</u>	<u>64,564,785</u>
Operating income (loss)	<u>(5,733,876)</u>	<u>195,058</u>	<u>4,683</u>	<u>-</u>	<u>(5,534,135)</u>
Nonoperating gains (losses):					
Net income from wholly-owned subsidiary	929,007	-	-	(929,007)	-
Net income from affiliated not-for-profit entity	4,683	-	-	(4,683)	-
Investment income	-	28,411	-	-	28,411
Unrealized gain from investments	-	733,537	-	-	733,537
Realized loss on investments	-	(27,999)	-	-	(27,999)
	<u>933,690</u>	<u>733,949</u>	<u>-</u>	<u>(933,690)</u>	<u>733,949</u>
Excess (deficit) of revenue over expenses	<u>(4,800,186)</u>	<u>929,007</u>	<u>4,683</u>	<u>(933,690)</u>	<u>(4,800,186)</u>
Temporarily restricted net assets:					
Net assets released from restriction	(250,000)	-	-	-	(250,000)
Contributions	(250,000)	-	-	-	(250,000)
Increase (decrease) in net assets	<u>(5,050,186)</u>	<u>929,007</u>	<u>4,683</u>	<u>(933,690)</u>	<u>(5,050,186)</u>
Net assets at beginning of year	38,562,627	8,135,823	302,026	(8,437,849)	38,562,627
Net assets at end of year	<u>\$ 33,512,441</u>	<u>\$ 9,064,830</u>	<u>\$ 306,709</u>	<u>\$ (9,371,539)</u>	<u>\$ 33,512,441</u>

LORETTO HOSPITAL
CONSOLIDATING STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Year ended June 30, 2016

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
Unrestricted revenue:					
Patient service revenue, net of contractual allowances and discounts	\$ 60,462,021	-	-	-	\$ 60,462,021
Provision for bad debts	(5,317,887)	-	-	-	(5,317,887)
Net patient service revenue, less provisions for bad debts	55,144,134	-	-	-	55,144,134
Other operating revenue	3,485,386	1,300,000	158,517	(1,382,519)	3,561,384
Net assets released from restrictions	5,077	-	5,077	(5,077)	5,077
Total revenue	<u>58,634,597</u>	<u>1,300,000</u>	<u>163,594</u>	<u>(1,387,596)</u>	<u>58,710,595</u>
Expenses:					
Salaries, wages, and benefits	33,471,534	-	96,366	(92,366)	33,475,534
Professional fees	2,644,001	-	-	-	2,644,001
Provider assessment	6,428,759	-	-	-	6,428,759
Supplies	6,388,410	-	-	-	6,388,410
Purchased services	4,823,999	-	-	-	4,823,999
Insurance	2,369,416	319,411	-	(1,300,000)	1,388,827
Depreciation and amortization	2,186,229	-	-	-	2,186,229
Other	2,343,116	237,753	83,384	-	2,664,253
Total expenses	<u>60,655,464</u>	<u>557,164</u>	<u>179,750</u>	<u>(1,392,366)</u>	<u>60,000,012</u>
Operating income (loss)	<u>(2,020,867)</u>	<u>742,836</u>	<u>(16,156)</u>	<u>4,770</u>	<u>(1,289,417)</u>
Nonoperating gains (losses):					
Gain on sale of accountable care entity investment	3,243,590	-	-	-	3,243,590
Net income from wholly-owned subsidiary	980,570	-	-	(980,570)	-
Net loss from affiliated not-for-profit entity	(11,386)	-	-	11,386	-
Investment income	-	307,560	-	-	307,560
Unrealized gain from investments	-	237,281	-	-	237,281
Realized loss from investments	-	(307,107)	-	-	(307,107)
	<u>4,212,774</u>	<u>237,734</u>	<u>-</u>	<u>(969,184)</u>	<u>3,481,324</u>
Excess (deficit) of revenue over expenses	<u>2,191,907</u>	<u>980,570</u>	<u>(16,156)</u>	<u>(964,414)</u>	<u>2,191,907</u>
Temporarily restricted net assets:					
Net assets released from restriction	(5,077)	-	(5,077)	5,077	(5,077)
Contributions	294,847	-	9,847	(9,847)	294,847
	<u>289,770</u>	<u>-</u>	<u>4,770</u>	<u>(4,770)</u>	<u>289,770</u>
Increase (decrease) in net assets	<u>2,481,677</u>	<u>980,570</u>	<u>(11,386)</u>	<u>(969,184)</u>	<u>2,481,677</u>
Net assets at beginning of year	<u>36,080,950</u>	<u>7,155,253</u>	<u>313,412</u>	<u>(7,468,665)</u>	<u>36,080,950</u>
Net assets at end of year	<u>\$ 38,562,627</u>	<u>\$ 8,135,823</u>	<u>\$ 302,026</u>	<u>\$ (8,437,849)</u>	<u>\$ 38,562,627</u>

LORETTO HOSPITAL
Chicago, Illinois
CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2018 and 2017

DRAFT 11/21/2018

LORETTO HOSPITAL
Chicago, Illinois

CONSOLIDATED FINANCIAL STATEMENTS
June 30, 2018 and 2017

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INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Loretto Hospital
Chicago, Illinois

Report of the Financial Statements

We have audited the accompanying consolidated financial statements of Loretto Hospital which comprise the consolidated balance sheets as of June 30, 2018 and 2017, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Westside Insurance Company, a wholly owned subsidiary, which statements reflect total assets of 33% and 31%, respectively, and revenue constituting 2%, for the years ended June 30, 2018 and 2017 of the related consolidated totals. Those statements were audited by other auditors, whose reports have been furnished to us, and our opinion, insofar as it relates to the amounts included for Westside Insurance Company is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

(Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Loretto Hospital as of June 30, 2018 and 2017 and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheets and consolidating statements of operations and changes in net assets are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.



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LORETTO HOSPITAL
CONSOLIDATED BALANCE SHEETS
June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 2,483,786	\$ 3,635,397
Patient accounts receivable, net of allowance for uncollectible accounts of \$ _____ in 2018 and \$5,111,274 in 2017	4,781,829	4,154,207
Inventories	366,865	479,348
Estimated third-party payor settlements	842,061	951,223
Prepaid expenses and other current assets	<u>925,955</u>	<u>1,430,756</u>
Total current assets	9,400,496	10,650,931
Assets whose use is limited by board designation; for capital improvements of \$754,791 in 2018 and \$752,464 in 2017 and insurance claims of \$8,209,397 in 2018 and \$12,397,303 in 2017		
	8,964,188	13,149,767
Estimated insurance recoveries	10,455,772	6,373,984
Property and equipment, net	23,934,199	25,395,993
Other assets	<u>541,667</u>	<u>-</u>
Total noncurrent assets	<u>43,895,826</u>	<u>44,919,744</u>
Total assets	<u>\$ 53,296,322</u>	<u>\$ 55,570,675</u>
LIABILITIES AND NET ASSETS		
Current liabilities:		
Line of credit	\$ 1,906,045	\$ 1,012,016
Accounts payable	3,777,691	4,401,110
Accrued expenses and other liabilities	5,566,611	5,161,717
Accrued liabilities for self-insurance	<u>824,356</u>	<u>2,609,231</u>
Total current liabilities	12,074,703	13,184,074
Asset retirement obligation	1,028,382	1,028,382
Accrued liabilities for self-insurance, net of current portion	<u>12,087,161</u>	<u>7,845,778</u>
Total long-term liabilities	<u>13,115,543</u>	<u>8,874,160</u>
Total liabilities	25,190,246	22,058,234
Net assets:		
Unrestricted	27,919,861	33,326,226
Temporarily restricted	<u>186,215</u>	<u>186,215</u>
Total net assets	<u>28,106,076</u>	<u>33,512,441</u>
Total liabilities and net assets	<u>\$ 53,296,322</u>	<u>\$ 55,570,675</u>

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years ended June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Unrestricted revenue:		
Patient service revenue, net of contractual allowances and discounts	\$ 63,710,976	\$ 63,067,790
Provision for bad debts	<u>(5,945,755)</u>	<u>(5,485,792)</u>
Net patient service revenue, less provisions for bad debts	57,765,221	57,581,998
Other operating revenue	2,465,625	1,198,652
Net assets released from restrictions	<u>-</u>	<u>250,000</u>
Total revenue	<u>60,230,846</u>	<u>59,030,650</u>
Expenses:		
Salaries, wages, and benefits	36,097,221	34,021,484
Professional fees	3,820,136	3,569,001
Provider assessment	7,683,703	7,426,529
Supplies	5,116,395	5,190,673
Purchased services	5,675,080	5,425,745
Insurance	2,765,157	2,992,008
Depreciation	2,657,413	2,411,265
Interest	129,023	-
Other	<u>2,010,618</u>	<u>3,528,080</u>
Total expenses	<u>65,954,746</u>	<u>64,564,785</u>
Operating loss	(5,723,900)	(5,534,135)
Nonoperating gains (losses):		
Investment income	1,108,585	28,411
Unrealized gain from investments	312,094	733,537
Realized loss on investments	<u>(1,108,524)</u>	<u>(27,999)</u>
	<u>312,155</u>	<u>733,949</u>
Deficit of revenue over expenses	(5,411,745)	(4,800,186)
Temporarily restricted net assets:		
Net assets released from restriction	-	(250,000)
Contributions	<u>5,380</u>	<u>-</u>
	<u>5,380</u>	<u>(250,000)</u>
Decrease in net assets	(5,406,365)	(5,050,186)
Net assets at beginning of year	<u>33,512,441</u>	<u>38,562,627</u>
Net assets at end of year	<u>\$ 28,106,076</u>	<u>\$ 33,512,441</u>

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATED STATEMENTS OF CASH FLOWS
Years ended June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
Operating activities:		
Decrease in net assets	\$ (5,406,365)	\$ (5,050,186)
Adjustments to reconcile decrease in net assets to net cash from operating activities:		
Depreciation	2,657,413	2,411,265
Unrealized gain from investments	(312,094)	(733,537)
Provision for bad debts	5,945,755	5,485,792
Change in assets and liabilities:		
Patient accounts receivable	(6,573,377)	(4,605,918)
Inventories	112,483	(55,396)
Prepaid expenses and other current assets	(36,866)	668,497
Due to third-party payors, net	109,162	106,000
Estimated insurance recoveries	(4,081,788)	(940,969)
Accounts payable	(623,419)	(290,661)
Accrued expenses and other liabilities	404,894	1,678,843
Accrued liabilities for self insurance	<u>2,456,508</u>	<u>1,826,900</u>
Net cash provided by (used in) operating activities	(5,347,694)	500,630
Investing activities:		
Purchase of property and equipment	(1,195,619)	(3,454,760)
Proceeds from sale and maturities of investments	4,647,673	50,035
Proceeds from sale of accountable care entity investment	-	1,354,183
Purchase of investments	<u>(150,000)</u>	<u>(1,050,001)</u>
Net cash provided by (used in) investing activities	<u>3,302,054</u>	<u>(3,100,543)</u>
Cash flows from financing activities		
Line of credit borrowing	<u>894,029</u>	<u>1,012,016</u>
Net cash from financing activities	<u>894,029</u>	<u>1,012,016</u>
Net change in cash and cash equivalents	(1,151,611)	(1,587,897)
Cash and cash equivalents at beginning of year	<u>3,635,397</u>	<u>5,223,294</u>
Cash and cash equivalents at end of year	<u>\$ 2,483,786</u>	<u>\$ 3,635,397</u>
Cash paid during the year for interest	\$ 129,023	\$ 23,094

See accompanying notes to consolidated financial statements.

LORETTO HOSPITAL
CONSOLIDATING BALANCE SHEETS
 June 30, 2018

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
ASSETS					
Current assets:					
Cash and cash equivalents	\$ 1,532,974	\$ 668,476	\$ 282,336	\$ -	\$ 2,483,786
Patient accounts receivable, net	4,729,269	-	52,560	-	4,781,829
Inventories	366,865	-	-	-	366,865
Estimated third-party payor settlements	842,061	-	-	-	842,061
Prepaid expenses and other current assets	729,051	190,899	6,005	-	925,955
Total current assets	<u>8,200,220</u>	<u>859,375</u>	<u>340,901</u>	<u>-</u>	<u>9,400,496</u>
Assets whose use is limited	754,791	8,209,397	-	-	8,964,188
Estimated insurance recoveries	2,214,474	8,241,298	-	-	10,455,772
Property and equipment, net	23,934,199	-	-	-	23,934,199
Other assets	-	541,667	-	-	541,667
Investment in wholly-owned subsidiary	6,702,729	-	-	(6,702,729)	-
Interest in affiliated not-for-profit entity	329,539	-	-	(329,539)	-
Total noncurrent assets	<u>33,935,732</u>	<u>16,992,362</u>	<u>-</u>	<u>(7,032,268)</u>	<u>43,895,826</u>
Total assets	<u>\$ 42,135,952</u>	<u>\$ 17,851,737</u>	<u>\$ 340,901</u>	<u>\$ (7,032,268)</u>	<u>\$ 53,296,322</u>
LIABILITIES AND NET ASSETS					
Current liabilities:					
Line of credit	\$ 1,906,045	-	-	-	\$ 1,906,045
Accounts payable	3,689,702	83,277	4,712	-	3,777,691
Accrued expenses and other liabilities	4,959,961	600,000	6,650	-	5,566,611
Accrued liabilities for self-insurance	231,312	593,044	-	-	824,356
Total current liabilities	<u>10,787,020</u>	<u>1,276,321</u>	<u>11,362</u>	<u>-</u>	<u>12,074,703</u>
Asset retirement obligation	1,028,382	-	-	-	1,028,382
Accrued liabilities for self-insurance, net of current portion	2,214,474	9,872,687	-	-	12,087,161
Total long-term liabilities	<u>3,242,856</u>	<u>9,872,687</u>	<u>-</u>	<u>-</u>	<u>13,115,543</u>
Total liabilities	<u>14,029,876</u>	<u>11,149,008</u>	<u>11,362</u>	<u>-</u>	<u>25,190,246</u>
Net assets:					
Unrestricted	27,919,861	8,702,729	172,943	(8,875,672)	27,919,861
Dividend paid to Hospital	-	(2,000,000)	-	2,000,000	-
Temporarily restricted	186,215	-	156,596	(156,596)	186,215
Total net assets	<u>28,106,076</u>	<u>6,702,729</u>	<u>329,539</u>	<u>(7,032,268)</u>	<u>28,106,076</u>
Total liabilities and net assets	<u>\$ 42,135,952</u>	<u>\$ 17,851,737</u>	<u>\$ 340,901</u>	<u>\$ (7,032,268)</u>	<u>\$ 53,296,322</u>

LORETTO HOSPITAL
CONSOLIDATING BALANCE SHEETS
 June 30, 2017

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
ASSETS					
Current assets:					
Cash and cash equivalents	\$ 3,195,827	\$ 143,772	\$ 295,798	\$ -	\$ 3,635,397
Patient accounts receivable, net	4,143,352	1,679	9,176	-	4,154,207
Inventories	479,348	-	-	-	479,348
Estimated third-party payor settlements	951,223	-	-	-	951,223
Other assets	-	650,001	-	(650,001)	-
Prepaid expenses and other current assets	1,240,978	184,043	5,735	-	1,430,756
Total current assets	<u>10,010,728</u>	<u>979,495</u>	<u>310,709</u>	<u>(650,001)</u>	<u>10,650,931</u>
Assets whose use is limited	752,464	12,397,303	-	-	13,149,767
Estimated insurance recoveries	2,438,062	3,935,922	-	-	6,373,984
Property and equipment, net	25,395,993	-	-	-	25,395,993
Investment in wholly-owned subsidiary	9,064,830	-	-	(9,064,830)	-
Interest in affiliated not-for-profit entity	306,709	-	-	(306,709)	-
Total noncurrent assets	<u>37,958,058</u>	<u>16,333,225</u>	<u>-</u>	<u>(9,371,539)</u>	<u>44,919,744</u>
Total assets	<u>\$ 47,968,786</u>	<u>\$ 17,312,720</u>	<u>\$ 310,709</u>	<u>\$ (10,021,540)</u>	<u>\$ 55,570,675</u>
LIABILITIES AND NET ASSETS					
Current liabilities:					
Line of credit	\$ 1,012,016	-	-	-	\$ 1,012,016
Accounts payable	5,001,935	49,176	-	(650,001)	4,401,110
Accrued expenses and other liabilities	4,549,384	608,333	4,000	-	5,161,717
Accrued liabilities for self-insurance	209,899	2,399,332	-	-	2,609,231
Total current liabilities	<u>10,773,234</u>	<u>3,056,841</u>	<u>4,000</u>	<u>(650,001)</u>	<u>13,184,074</u>
Asset retirement obligation	1,028,382	-	-	-	1,028,382
Accrued liabilities for self-insurance, net of current portion	2,654,729	5,191,049	-	-	7,845,778
Total long-term liabilities	<u>3,683,111</u>	<u>5,191,049</u>	<u>-</u>	<u>-</u>	<u>8,874,160</u>
Total liabilities	<u>14,456,345</u>	<u>8,247,890</u>	<u>4,000</u>	<u>(650,001)</u>	<u>22,058,234</u>
Net assets:					
Unrestricted	33,326,226	9,064,830	155,493	(9,220,323)	33,326,226
Temporarily restricted	186,215	-	151,216	(151,216)	186,215
Total net assets	<u>33,512,441</u>	<u>9,064,830</u>	<u>306,709</u>	<u>(9,371,539)</u>	<u>33,512,441</u>
Total liabilities and net assets	<u>\$ 47,968,786</u>	<u>\$ 17,312,720</u>	<u>\$ 310,709</u>	<u>\$ (10,021,540)</u>	<u>\$ 55,570,675</u>

LORETTO HOSPITAL
CONSOLIDATING STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Year ended June 30, 2018

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
Unrestricted revenue:					
Patient service revenue, net of contractual allowances and discounts	\$ 63,710,976	-	-	-	\$ 63,710,976
Provision for bad debts	(5,945,755)	-	-	-	(5,945,755)
Net patient service revenue, less provisions for bad debts	57,765,221	-	-	-	57,765,221
Other operating revenue	2,334,519	1,300,000	221,608	(1,390,502)	2,465,625
Total revenue	60,099,740	1,300,000	221,608	(1,390,502)	60,230,846
Expenses:					
Salaries, wages, and benefits	36,097,221	-	90,502	(90,502)	36,097,221
Professional fees	3,820,136	-	-	-	3,820,136
Provider assessment	7,683,703	-	-	-	7,683,703
Supplies	5,116,395	-	-	-	5,116,395
Purchased services	5,675,080	-	-	-	5,675,080
Insurance	2,336,487	1,728,670	-	(1,300,000)	2,765,157
Depreciation	2,657,413	-	-	-	2,657,413
Interest	129,023	-	-	-	129,023
Other	1,651,376	245,586	113,656	-	2,010,618
Total expenses	65,166,834	1,974,256	204,158	(1,390,502)	65,954,746
Operating income (loss)	(5,067,094)	(674,256)	17,450	-	(5,723,900)
Nonoperating gains (losses):					
Net income from wholly-owned subsidiary	(362,101)	-	-	362,101	-
Net income from affiliated not-for-profit entity	22,830	-	-	(22,830)	-
Investment income	-	1,108,585	-	-	1,108,585
Unrealized gain from investments	-	312,094	-	-	312,094
Realized loss from investments	(339,271)	(1,108,524)	-	-	(1,108,524)
	(339,271)	312,155	-	339,271	312,155
Excess (deficit) of revenue over expenses	(5,406,365)	(362,101)	17,450	339,271	(5,411,745)
Temporarily restricted net assets:					
Net assets released from restriction	-	-	5,380	-	5,380
Contributions	-	-	5,380	-	5,380
Decrease in net assets	(5,406,365)	(362,101)	22,830	339,271	(5,406,365)
Net assets at beginning of year	33,512,441	9,064,830	306,709	(9,371,539)	33,512,441
Net assets at end of year	\$ 28,106,076	\$ 8,702,729	\$ 329,539	\$ (9,032,268)	\$ 28,106,076

LORETTO HOSPITAL
CONSOLIDATING STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Year ended June 30, 2017

	<u>Hospital</u>	<u>Westside</u>	<u>Foundation</u>	<u>Eliminations</u>	<u>Loretto Hospital</u>
Unrestricted revenue:					
Patient service revenue, net of contractual allowances and discounts	\$ 63,067,790	\$ -	\$ -	\$ -	\$ 63,067,790
Provision for bad debts	(5,485,792)	-	-	-	(5,485,792)
Net patient service revenue, less provisions for bad debts	57,581,998	-	-	-	57,581,998
Other operating revenue	1,130,158	1,300,000	163,522	(1,395,028)	1,198,652
Net assets released from restrictions	250,000	-	-	-	250,000
Total revenue	<u>58,962,156</u>	<u>1,300,000</u>	<u>163,522</u>	<u>(1,395,028)</u>	<u>59,030,650</u>
Expenses:					
Salaries, wages, and benefits	34,015,629	-	100,883	(95,028)	34,021,484
Professional fees	3,569,001	-	-	-	3,569,001
Provider assessment	7,426,529	-	-	-	7,426,529
Supplies	5,190,673	-	-	-	5,190,673
Purchased services	5,425,745	-	-	-	5,425,745
Insurance	3,409,962	882,046	-	(1,300,000)	2,992,008
Depreciation	2,411,265	-	-	-	2,411,265
Other	3,247,228	222,896	57,956	-	3,528,080
Total expenses	<u>64,696,032</u>	<u>1,104,942</u>	<u>158,839</u>	<u>(1,395,028)</u>	<u>64,564,785</u>
Operating income (loss)	<u>(5,733,876)</u>	<u>195,058</u>	<u>4,683</u>	<u>-</u>	<u>(5,534,135)</u>
Nonoperating gains (losses):					
Net income from wholly-owned subsidiary	929,007	-	-	(929,007)	-
Net loss from affiliated not-for-profit entity	4,683	-	-	(4,683)	-
Investment income	-	28,411	-	-	28,411
Unrealized gain from investments	-	733,537	-	-	733,537
Realized loss on investments	-	(27,999)	-	-	(27,999)
	<u>933,690</u>	<u>733,949</u>	<u>-</u>	<u>(933,690)</u>	<u>733,949</u>
Excess (deficit) of revenue over expenses	<u>(4,800,186)</u>	<u>929,007</u>	<u>4,683</u>	<u>(933,690)</u>	<u>(4,800,186)</u>
Temporarily restricted net assets:					
Net assets released from restriction	(250,000)	-	-	-	(250,000)
Decrease in net assets	<u>(5,050,186)</u>	<u>929,007</u>	<u>4,683</u>	<u>(933,690)</u>	<u>(5,050,186)</u>
Net assets at beginning of year	<u>38,562,627</u>	<u>8,135,823</u>	<u>302,026</u>	<u>(8,437,849)</u>	<u>38,562,627</u>
Net assets at end of year	<u>\$ 33,512,441</u>	<u>\$ 9,064,830</u>	<u>\$ 306,709</u>	<u>\$ (9,371,539)</u>	<u>\$ 33,512,441</u>

ATTACHMENT 37

**Criterion 1120.140
Economic Feasibility**

The Project's funds will come from five sources: (1) cash; (2) securities; (3) the fair market value of a real property lease; (4) the fair market value of an equipment lease; and (5) a bank loan. The total project cost includes the fair market value of rent to be paid over the five (5) year term of the property lease and the five (5) year term of an equipment lease. Each of these are discussed below in greater detail.

A. Reasonableness of Financing Arrangements

A significant portion of the project budget, \$1,119,500 out of \$1,961,169, will be financed through a traditional bank loan. Immediately following this attachment, the Applicant provides a notarized statement signed by an authorized representative attesting that \$1,119,500 will be funded through borrowing because 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

A significant portion of the project budget, \$1,119,500 out of \$1,961,169, involves debt financing. Immediately following this attachment, the Applicant provides a notarized document signed by an authorized representative attesting that: (1) the selected form of debt financing for the project will be at the lowest net cost available; and (2) the project involves (in part) the leasing of equipment and facilities and that the expenses incurred with leasing a facility and the equipment are less costly than constructing a new facility and purchasing new equipment.

C. Reasonableness of Project and Related Costs

The following chart identifies the department impacted by the proposed project (the entire healthcare facility as proposed) and provides a cost and square footage allocation related to this project.

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)	
ESRDF (Clinical & Non-Clinical)		\$687.52		2,750				\$687.52	\$687.52
Contingency		\$25.64		2,750				\$25.64	\$25.64
TOTAL		\$713.16		2,750				\$713.16	\$713.16

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The following information represents the projected direct annual operating costs for the first full year operating at target utilization, but no more than two years following the date of project completion:

<u>Year 2020</u>	
Operating Expenses:	\$1,200,000
<i>Salaries</i>	<i>\$400,000</i>
<i>Benefits</i>	<i>\$200,000</i>
<i>Supplies</i>	<i>\$600,000</i>
Procedures (Treatments)	9,360 *
Operating Expense/Procedure:	\$128.21

E. Total Effect of the Project on Capital Costs

The following information represents the total projected annual capital costs for the first full year operating at target utilization, but no more than two years following the date of project completion:

<u>Year 2020</u>	
Capital Costs:	\$290,000
<i>Interest</i>	<i>\$40,000</i>
<i>Dep./Amort.</i>	<i>\$250,000</i>
Procedures (Treatments)	9,360 *
Capital Costs/Procedure:	\$30.98

* Treatments assumes: 60 patients x 52 weeks/year x 3 treatments/week = 9,360 treatments/year

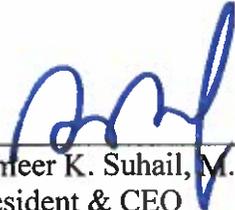
May 5, 2019

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Criterion 1120.140
Reasonableness of Financing Arrangements
Austin Dialysis Center, LLC

Dear Ms. Avery:

A significant portion of the project budget, \$1,119,500 out of \$1,961,169, will be financed through a traditional bank loan. As the authorized representative acting on behalf of Austin Dialysis Center, LLC ("Applicant"), I hereby provide this notarized statement attesting that \$1,119,500 will be funded through borrowing because taking on a bank loan 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.



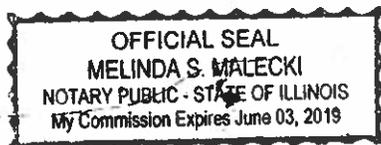
Sameer K. Suhail, M.D.
President & CEO
Austin Dialysis Center, LLC

Subscribed and sworn to before me this 9th day of May, 2019.



Signature of Notary Public

Seal



May 5, 2019

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Criterion 1120.140
Conditions of Debt Financing
Austin Dialysis Center, LLC

Dear Ms. Avery:

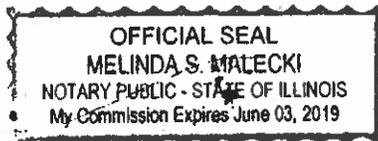
A significant portion of the project budget, \$1,119,500 out of \$1,961,169, will be financed through a traditional bank loan. As the authorized representative acting on behalf of Austin Dialysis Center, LLC ("Applicant"), I hereby provide this notarized statement attesting that: (1) the selected form of debt financing for the project will be at the lowest net cost available; and (2) the project involves (in part) the leasing of equipment and facilities and that the expenses incurred with leasing a facility and the equipment are less costly than constructing a new facility and purchasing new equipment.

Sameer K. Suhali, M.D.
President & CEO
Austin Dialysis Center, LLC

Subscribed and sworn to before me this 9th day of May, 2019.

Signature of Notary Public

Seal





April 30, 2019

Austin Dialysis Center, LLC
155 North Michigan Avenue, Suite 634
Chicago, Illinois 60601
Attention: Sameer K. Suhail, M.D., President & CEO

RE: Healthcare Facility Space Lease

Dear Dr. Suhail:

This letter of intent ("Letter of Intent") outlines the basic business terms and conditions upon which Loretto Hospital, an Illinois not-for-profit corporation ("Landlord") would be willing to execute a lease ("Lease") with Austin Dialysis Center, LLC ("Tenant"), whereby Tenant shall occupy the Premises (as defined below) to operate a Medicare-certified end stage renal disease ("ESRD") facility, it being understood that additional terms and conditions remain to be negotiated between the parties and final approval is contingent upon the complete execution of the documents and transactions described in this Letter of Intent.

Landlord	Loretto Hospital 645 South Central Avenue Chicago, Illinois 60601 Attention: George K. Miller, President/CEO
Tenant	Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto 155 North Michigan Avenue Suite 634 Chicago, Illinois 60601 Sameer K. Suhail, M.D., President/CEO
Premises	Loretto Hospital 645 South Central Avenue Suite 100 Chicago, Illinois 60644

Specifically, the "Premises" shall include Suite 100, which is the space in the lower level of Loretto Hospital, located on the east side of the building, and is presently occupied by the hospital's physical therapy program. Access to the Premises will be through the hospital's main entrance, into the lobby, past the security desk, and completed either by an elevator ride or a descent down a staircase, which is directly accessible from the hospital's main lobby.

SQF of Premises The Premises shall consist of two thousand seven hundred and fifty (2,750) square feet of rentable space (“RSF”), which shall be identified and described in a Lease between Landlord and Tenant.

Equipment Lease Unless otherwise agreed to by the parties, Tenant will provide all medical and non-medical equipment for the complete operation of a 14-station ESRD facility. If necessary, Tenant will secure leased equipment in its name to ensure the ability to operate the facility.

Term of Lease The Lease shall have an initial term (“Initial Term”) of five (5) years, which shall commence thirty (30) days after Tenant obtains a certificate of need (“CON”) permit from the Illinois Health Facilities and Services Review Board (“State CON Board”). Thereafter, the Lease shall automatically renew for two (2) renewal terms (each a “Renewal Term”), each extending the Lease for an additional five (5) year period. The Initial Term along with any or all Renewal Terms shall collectively be referred to as the “Term” of the Lease.

Fair Market Value of Rent; Rent Escalation Landlord and Tenant concur that the direct fair market value rental range of \$28.00 to \$33.00 per square foot (“SQF”), net of the Premises’ net rentable area, as provided by Real Estate Counselors International, Inc. (“RECI”), is reasonable and consistent with fair market value (“FMV”). Based on this estimate, the initial amount for rent (“Rent”) shall be calculated at \$30.50/SQF net (“net” meaning the amount does not include the Tenant’s pro-rated responsibility of taxes or common area expenses).

Using \$30.50/SQF, the resulting monthly Rent will be \$83,875.00 per year (\$30.50 x 2,750 SQF). Rent will be subject to a two and four tenths percent (2.4%) annual escalation starting on the twenty-fifth (25th) month of the Term and increase annually thereafter at the same rate. The Rent shall be prorated to account only for the days on which the Subtenant occupies the Premises.

Based on the foregoing, the Rent amounts for 2019 through 2024:

Year 1	\$83,875
Year 2	\$83,875
Year 3	\$85,972
Year 4	\$88,122
Year 5	\$90,325

**Taxes and
Common Area
Expenses**

Tenant and Landlord agree that Rent, calculated on a net basis, does not include the Tenant's pro-rated responsibility of taxes ("Taxes") or common area expenses ("CAM"). CAM includes any work that is completed in the hospital building's common area on behalf of the hospital and all of its tenants, including the Tenant. CAM includes, but is not limited to, snowplowing of the parking lot and sidewalks, landscaping of the exterior, insurance for the building, or the cleaning of common areas (lobbies, bathrooms, hallways, etc.). Each tenant, including the Tenant, is responsible for such charges, which are passed on by the Landlord.

**Waiver of Rent,
Taxes and CAM**

Landlord and Tenant agree that Tenant will not pay Rent to the Landlord, or its pro-rated portion of Taxes and/or CAM costs, any month during the Term of the Lease in which Loretto Hospital has not fully compensated Tenant for the fair market value of fifteen (15) membership units in Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto. During any such month, Tenant shall credit Loretto Hospital for the full amount of Rent, pro-rated Taxes, and CAM costs, applying such amounts towards payment for the LLC membership units.

Improvements

Landlord will not provide an allowance towards improvements within the Premises. Tenant shall provide those alterations and improvements required such that the Premises comply with codes and regulations necessary for the use by Tenant as a Medicare certified ESRD facility.

**Assignment &
Sublease**

Tenant shall not have the right to assign or sublet all or part of the Premises at any time during the Term of the Lease without first obtaining the Landlord's consent, which shall not be unreasonably withheld or delayed. No consent shall be required for an assignment or sublet to any subsidiary, affiliate, or company related to Tenant.

**Real Estate
Brokers;
Commissions**

It is represented that neither the Tenant nor the Landlord is represented by a real estate broker and no commission will be paid in connection with the Lease.

**Government
Approvals**

Landlord and Tenant acknowledge and agree that the establishment of a Medicare certified ESRD 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, therefore, the Tenant cannot establish an ESRD facility within the Premises or execute a binding real estate Lease in connection therewith, unless the Tenant first obtains a CON permit from the State CON Board. Tenant agrees to proceed using commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application without undue delay in order to obtain a CON permit from the State CON Board as soon as possible.

In light of the foregoing facts, Landlord and Tenant agree that the Lease may only be executed after the Tenant has obtained a CON permit from the State CON Board, or alternatively, execute a Lease prior to CON approval, but such Lease shall include a provision that states the agreement, though executed, shall not be binding on either party unless the State CON Board grants a CON permit to the Tenant. If the Tenant fails to obtain a CON permit from the State CON Board, neither party shall have any further obligation to the other party with regard to the negotiations, Lease, or Premises contemplated by the parties in this Letter of Intent.

**Exclusive
Negotiations**

In consideration of each of the parties entering into this Letter of Intent, each party agrees to deal with the other in good faith while negotiating the terms set forth in this Letter of Intent and the transactions contemplated hereby, and Landlord agrees to negotiate exclusively with the Tenant with respect to these transactions for up to thirty (30) days after either: (1) a final decision is made by the State CON Board in connection with a CON permit application regarding the establishment of an ESRD facility within the Premises; or (2) the parties mutually agree to abandon all efforts to establish the ESRD facility before the State CON Board issues any decision on the matter.

Confidentiality

Subject to mandatory provisions of applicable law, the parties to this Letter of Intent hereby agree to preserve and maintain the confidentiality of any and all information (including, but not limited to, information gathered or exchanged during due diligence, except to the extent such information is already in the public domain) and negotiations relative to the transactions contemplated herein, including the existence of this Letter of Intent, and the fact that negotiations concerning a joint venture are taking place. Neither party hereto shall issue any press releases, nor disclose such information, without the prior written consent of the other party except: (1) where a party is required by applicable law or regulatory requirements to make a disclosure concerning the information or the proposed transactions; or (2) where a party makes disclosure to its employees, legal counsel, accountants, and agents who have a need to know such information in connection with the transactions contemplated hereby.

This Letter of Intent is not intended to be a binding agreement between the Landlord and Tenant; but, shall be the basis for negotiation going forward. There shall be no binding agreement between the Landlord and Tenant until a Lease is fully executed by all of the necessary parties, including, but not necessarily limited to, the Landlord and Tenant. Either party may withdraw from negotiations at any time for any reason, without liability to the other. The terms set forth in this Letter of Intent are being provided with confidentiality and must not be shared with any other parties not specifically identified herein.

If the terms described in this Letter of Intent are consistent with your understanding and approval, please sign and date below and return the executed document to the address provided below. Upon receipt of the signed offer and CON approval, we will prepare an executable Lease for your approval.

We look forward to working with you. Please free to contact me if you have any questions regarding this Letter of Intent.

Sincerely,

George K. Miller, Jr.
President and Chief Executive Officer
Loretto Hospital
o/b/o Landlord

[signatures continue on following page]

AGREED AND ACCEPTED

Please indicate your acceptance of the above terms and conditions by executing below and returning an original signed copy to the address below.

TENANT:

Austin Dialysis Center, LLC d/b/a Austin Dialysis at Loretto

Sameer K. Suhail, M.D.
President and Chief Executive Officer

Date: _____

Please return a signed copy of this Letter of Intent to:

Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60601
Attention: George K. Miller, Jr. President/CEO

ATTACHMENT 38

Safety Net Impact Statement

I. Overview

Pursuant to the Illinois Health Facilities Planning Act, 20 ILCS 3960/5.4 (“Act”), any application related to a “substantive” project must include a Safety Net Impact Statement (“Impact Statement”). Substantive projects include the establishment of a “health care facility.” That term includes in-center hemodialysis facilities. As a result, the applicant submits this Impact Statement as required by the Act.

While outpatient dialysis treatments have not generally been considered “safety net” services, the Applicants welcome the opportunity to discuss Loretto Hospital’s not-for-profit mission, its charity care program that has helped many low income or uninsured patients obtain healthcare services, and its intent to extend its not-for-profit charitable mission to the proposed in-center hemodialysis facility. Upon CON approval, area residents will gain increased access to dialysis care, including, but not limited to, pre-ESRD care and education, dialysis treatments, and assistance with organ transplant requests. The Applicants believe this project will have a positive effect on the community as a whole.

II. Analysis

Section 5.4(c) of the Act provides that each CON applicant presenting a substantive application must include an Impact Statement with its application for permit. The Impact Statement must describe all of the following: (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 and (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. Each of these elements are discussed below.

1. Impact on Essential Safety Net Services in the Community

Section 5.4(c)(1) of the Act requires an applicant to address whether the project will have a material impact on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge. For the following reasons, the Applicant firmly believes that the proposed project will not have an adverse impact on essential safety net services in the Applicant’s proposed geographic service area (“GSA”). In fact, the Applicant firmly believes that the project will expand services to an underserved population that disproportionately needs dialysis care.

- First, dialysis services have not generally been considered safety net services; therefore, the addition of this service line on Loretto Hospital’s campus should not adversely affect the types of providers typically considered safety net providers (e.g., Federally qualified health centers, rural health clinics, school-based health centers,

and local health department clinics). Safety net providers do not provide dialysis services, so the proposed ESRD facility will not harm, in any way, the scope of services such providers presently offer to the communities in the GSA.

- Second, while existing ESRD facilities that are organized as for-profit entities are not required to provide free or reduced-cost care to persons who are low income or uninsured, the Applicants intend to offer charity care services to further Loretto Hospital's not-for-profit mission. Every charitable case that the proposed facility can handle will only improve the dialysis outcomes in the fragile ESRD population.
- Third, the new ESRD facility, being partially-owned and operated by Loretto Hospital (a not-for-profit provider), will increase access to care for vulnerable low-income individuals and provide a stronger safety net for all persons in need of life-saving dialysis care.
- The Applicant will enroll the ESRD facility in the Medicaid program.
- The Applicant will establish a charity care program at the ESRD facility that is consistent with Loretto Hospital's current plan.
- The Applicant will not provide services that will harm, in any way, federally qualified health centers and other safety net providers in the GSA. FQHCs and other safety net providers do not offer dialysis services.

For these reasons, the proposed project will not adversely impact existing providers of safety net services.

2. Impact on the Ability of Other Providers or Health Care Systems to Cross-Subsidize Safety Net Services.

Section 5.4(c)(2) of the Act adds that an applicant must discuss 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. Under this section, cross subsidization is understood to mean the practice of charging higher prices to one group of consumers in order to subsidize lower prices for another group (i.e., cost shifting to paying populations to offset losses incurred from assistance programs like charity care).

As noted above, the Applicant believes that a new ESRD facility, which will be partially owned and operated by a not-for-profit hospital, will only strengthen the safety net in the proposed GSA. The Applicants know of no reason why the proposed facility would impair the ability of other providers or health care systems to cross-subsidize any safety net services they may provide.

3. No Discontinuation of Safety Net Services

Section 5.4(c)(3) of the Act provides that an applicant must describe 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. This permit request is for the establishment of a new health care facility, not a discontinuation; therefore, this part of the Impact Statement is not applicable to this project.

4. Additional Safety Net Impact Statement Information

The Act also declares that the Impact Statement shall include all of the following:

(i) for the three (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 HFSRB),

(ii) for the three (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 Payer Source" and "Inpatient and Outpatient Net Revenue by Payer Source" as required by the HFSRB under Section 13 of the Act and published in the Annual Hospital Profile), and

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

In satisfaction of this requirement, please find attached to this Impact Statement a certification signed by the applicant's primary representative attesting to these provisions.

(a) Charity Care & Medicaid Tables

The primary Applicant is a newly-formed entity and is not an established provider. Consequently, the Applicant cannot provide historical data as it pertains to charity care and Medicaid services. However, the Co-Applicant Loretto Hospital is a Medicaid provider and also has an established charity care program. The hospital data will be used in the following charts.

Furthermore, the Applicant will be establishing a charity care program once the ASTC becomes operational and financially viable. The Applicant will also enroll the ESRD facility as a provider in the Medicaid program to expand the types of care available to the hospital's Medicaid patients.

HISTORICAL CHARITY CARE: LORETTO HOSPITAL			
	Year 2016	Year 2017	Year 2018
Charity Care Patients	130	1,337	1,395
Cost of Charity Care	\$2,147,643	\$2,573,063	\$2,185,933
MEDICAID			
	Year 2016	Year 2017	Year 2018
Medicaid (# of patients)			
Medicaid (revenue) - Inpatient	\$8,428,917	\$3,970,254	\$4,989,703
Medicaid (revenue) – Outpatient	\$3,221,871	\$1,784,328	\$2,433,662
Total	\$11,650,788	\$5,754,582	\$7,423,365

HISTORIC PAYER MIX: LORETTO HOSPITAL			
	Year 2016	Year 2017	Year 2018
Private/Commercial Insurance	9.9%	6.1%	2.2%
Medicare	17.6%	20.7%	26.1%
Medicaid	63.5%	65.5%	61.9%
Self-Pay/Charity Care	9.1%	7.7%	9.8%
TOTAL	100.0%	100.0%	100.0%

FORECASTED PAYER MIX			
	Year 2019	Year 2020	Year 2021
Private/Commercial Insurance	2.5%	2.5%	2.5%
Medicare	30.0%	50.0%	70.0%
Medicaid	62.5%	42.5%	23.0%
Self-Pay	3.0%	2.0%	1.5%
Charity Care	2.0%	3.0%	4.0%
TOTAL	100.0%	100.0%	100.0%

Note: Although the Applicant is committed to participating in Medicaid, and fully intends to offer a charity care program, the numbers provided above are only estimates based on market demographics and anticipated patient mix moving more towards Medicare coverage of dialysis services.

Summary

The establishment of an ESRD facility owned, in part, by a not-for-profit provider will have a positive impact on the community's essential safety net services because additional charity care services will be made available to persons in financial need or who are uninsured and the facility will offer another option to people insured through Medicaid. Although the charity care services provided at ESRD facilities are not "safety net" services per se, the assistance programs offered by or through the proposed ESRD facility will increase access to health care services for vulnerable population groups, strengthen the safety net as a whole, and provide other value added benefits to the community such as patient education programs and wellness training.

May 5, 2019

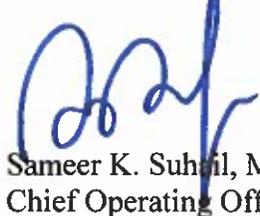
Illinois Health Facilities and Services Review Board
525 West Jefferson St., 2nd Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

Re: Safety Net Impact Statement Certification

Dear Ms. Avery:

Austin Dialysis Center, LLC ("Applicant") is a newly formed business entity created solely for the purpose of owning and operating the in-center hemodialysis facility to be located at 645 South Central Avenue, Suite 100, Chicago, Illinois 60644. Because the entity is new, the Applicant is unable to provide historical Medicaid and charity care data as requested in the certificate of need permit application. Instead, historical data from the co-applicant Loretto Hospital is provided. The Applicant will enroll the proposed facility as a provider in the Illinois Medicaid program and will also extend the hospital's existing charity care program to cover the dialysis facility after it is operational and becomes financially viable. As a result, the proposed healthcare facility will enhance the safety net services available in the proposed geographic service area. Finally, the proposed facility will enhance safety net services because of the Applicants' commitment to serve patients with a history of lacking adequate access to health care services.

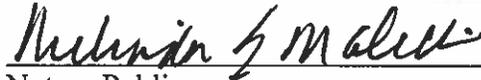
Respectfully Submitted,



Sameer K. Suhril, M.D.
Chief Operating Officer
Austin Dialysis Center, LLC

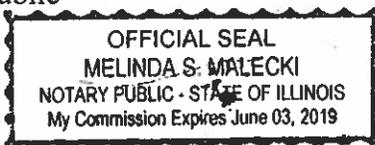
NOTARY:

Subscribed and sworn to me this 9th day of May, 2019



Notary Public

Seal:



May 5, 2019

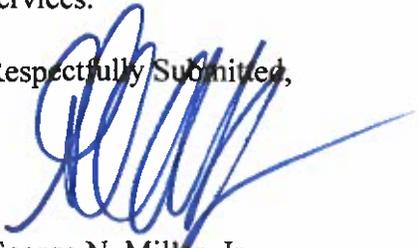
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Respectfully Submitted,



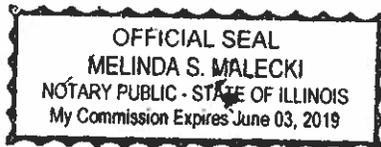
George N. Miller, Jr.
President & Chief Operating Officer
Loretto Hospital

NOTARY:

Subscribed and sworn to me this 9th day of May, 2019

Melinda S Malecki
Notary Public

Seal:



ATTACHMENT 39

Charity Care and Medicaid Participation

The applicant, Austin Dialysis Center, LLC (“Applicant”), is a new business entity formed for the sole purpose of owning and operating the proposed ESRD facility. Consequently, the Applicant entity cannot provide historical data as it pertains to charity care.

The Applicant, however, is partly owned by Loretto Hospital, an Illinois not-for-profit corporation. Therefore, the data below is the hospital’s data, which was also used as a base for future projections.

HISTORICAL CHARITY CARE: LORETTO HOSPITAL			
	Year 2016	Year 2017	Year 2018
Charity Care Patients	130	1,337	1,395
Cost of Charity Care	\$2,147,643	\$2,573,063	\$2,185,933
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Self-Pay/Charity Care	9.1%	7.7%	9.8%
TOTAL	100.0%	100.0%	100.0%

FORECASTED PAYER MIX			
	Year 2019	Year 2020	Year 2021
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Medicare	30.0%	50.0%	70.0%
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Self-Pay	3.0%	2.0%	1.5%
Charity Care	2.0%	3.0%	4.0%
TOTAL	100.0%	100.0%	100.0%

Note: Although the Applicant is committed to participating in Medicaid, and fully intends to offer a charity care program, the numbers provided above are only estimates based on market demographics and anticipated patient mix moving more towards Medicare coverage of dialysis services.

LORETTO HOSPITAL
POLICY

Effective Date:	SECTION: Patient Accounts Policies/Procedures	POLICY NUMBER:
Revisions:	TITLE: Financial Assistance/Charity Care For Uninsured & Underinsured Patients	=====
Reviewed:	AUTHORIZED BY:	PAGE
	<u>Kenneth McGhee</u> <u>03-01-16</u>	
	Kenneth McGhee	Date
	Chief Financial Officer	

FINANCIAL ASSISTANCE/CHARITY CARE FOR UNINSURED & UNDERINSURED PATIENTS

PURPOSE:

This policy identifies the circumstances under which Loretto Hospital will extend medical care free of charge or at a discount commensurate with the patient's ability to pay. The necessity for medical treatment of all patients will be based upon clinical judgment without regard to the financial status of the patient.

DEFINITIONS:

AGB – amounts generally billed for emergency or medically necessary care to individuals who have insurance coverage.

Bad Debt Expense – health care services provided that are expected to result in the generation of payment of services, but due to the patients' unwillingness to meet their financial obligation, resulted in non-collection of those services.

Charity (Free) or Discounted Care – health care services provided that are not expected to result in the generation of payment in full, in accordance with procedures established in this policy. This does not include contractual allowance amounts between hospital gross charges and contracted third party reimbursement rates.

ECAs – extraordinary collection actions are actions taken by Loretto Hospital against an individual related to obtaining payment of a bill for care covered under Loretto Hospital's FAP that require a legal or judicial process or involve selling an individual's debt to another party, or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

FAP – financial assistance policy.

FAP-Eligible Individual – an individual eligible for financial assistance under Loretto Hospital's FAP (without regard to whether the individual has applied for assistance under the FAP).

3. In order to be eligible for charity or discounted care, the patient must be willing to provide verification of income, assets, etc., by filling out the Financial Assistance Application (Attachment B). It is the responsibility of the patient to voluntarily submit any and all documentation in order to be eligible to receive the discount.
4. During the registration and information gathering process, the Financial Counselors will first determine if the patient qualified for medical assistance from other existing financial resources such as Medicare, Medicaid, Kid Care, Family Care or other state or federal programs. If the patient refuses to apply for existing financial resources or to provide information necessary to the application process, charity or discounted care cannot be granted. If the application for existing financial resources is denied or has been previously denied, consideration for charity or discounted care will then be given.
5. Patients will qualify for Presumptive Charity Care assistance based on their individual life circumstances, homeowner status, living address and other measurable socio-economics factors. Assistance provided under Presumptive Charity Care will be the most generous assistance available under the FAP (including free care). Presumptive eligibility may be determined on the basis of individual life circumstances, including, but not limited to, state-funded prescription programs; homeless or received care from a homeless clinic; participation in Women, Infants and Children (WIC) programs; food stamp eligibility; subsidized school lunch program eligibility; eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down); low income/subsidized housing is provided as a valid address; or patient is deceased with no known estate.
6. Once the information on the Financial Assistance Application form is received, the Financial Counselor and the Director of Patient Financial Services (PFS) will determine the eligibility for charity or discount care. Loretto Hospital will suspend any ECA's while the Financial Assistance Application is being reviewed. The only criteria to be considered for financial assistance will be income and family size. Income will be evaluated against the matrix of Federal Poverty Guidelines to determine whether full or partial discount can be approved. Documentation of income can be submitted in the form of paycheck stubs, income tax return, Social Security checks, and other documents that are indicative of income. If the information submitted is not perceived to be accurate or reliable, Loretto Hospital reserves the right to request additional documentation to substantiate income or family size.
7. The insured patient with a large balance due to deductible and/or co-payments may be eligible for charity or discounted care. In order to qualify, the patient must complete the Financial Assistance Application and return it to the Financial Counselor for evaluation and recommendation.
8. Patients requesting to speak with a Financial Counselor or to obtain an application or itemized bill may contact the Financial Counselor at 773-854-5097, or, if coming in person, the address of Loretto Hospital is Patient Account Department, 645 S. Central Ave., Chicago, Illinois 60644.

Determination of Eligibility under the Illinois Uninsured Patient Discount Act:

1. Illinois residents who have a family income that is no more than 600% of the Federal Poverty Guidelines (as determined each year), and who do not have any health insurance (or coverage under workers' compensation, accident liability insurance, or other third party liability) as documented through Loretto Hospital's insurance verification procedures, will receive a discount in accordance with the Illinois Hospital Uninsured Patient Discount Act (Act). Uninsured patients who own assets with a value of more

"You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information contact Loretto Hospital Financial Counselors at 773-854-5097."

3. Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement, in accordance with the Illinois Hospital Uninsured Patient Discount Act, to the effect that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under Loretto Hospital's FAP.
4. The FAP, Financial Assistance Application and plain language summary of the FAP will be available on Loretto Hospital's website at www.lorettohospital.org. The documents will be posted in a format that will allow any individual with access to the Internet to access, download, view, and print a hard copy of the documents without requiring special computer equipment and without the payment of a fee. Loretto Hospital will provide any individual who asks how to obtain online access to a copy of the FAP, Financial Assistance Application form, or plain language summary of the FAP with the direct website address, or URL, of the web page on which these documents are posted.
5. Paper copies of the FAP, Financial Assistance Application and plain language summary of the FAP will be readily available in the admitting department and waiting areas. Patients may also call to obtain a copy and it will be mailed it to them at no cost.
6. The Patient Access Department will also notify those patients with no insurance of the availability of financial assistance and will give a copy of the Financial Assistance Application and plain language summary of the FAP to patients.

Documentation and Recording of Charity or Discounted Care:

In order to quantify the level of charity care, a general ledger report will be available to document the total value of all charity or discounted care. This report will be available for inspection by any government agency requiring levels of charity or discounted care as part of Loretto Hospital maintaining the exemption from federal, state, or local taxes.

Approved by:

CFO: Kenneth M. Lee Date 03-01-16

Director PFS: Carmen Alvarez Date 3-1-16

**ATTACHMENT B
FINANCIAL ASSISTANCE APPLICATION**

Loretto Hospital

LORETTO HOSPITAL Financial Assistance Application

Important: You may be able to receive free or discounted care: Completing this application will help Loretto Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

If you are uninsured, a social security number is not required to qualify for free or discounted care. While a social security number is not required for some public aid programs, including Medicaid, providing a social security number will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Internal Use Only:

Application Date: _____ MRN: _____

Account Number: _____

Approved %: _____ Denied/Reason: _____ Pt's Bal Due: _____

Patient Information:

Patient Name: _____ Phone #: _____

Patient Date of Birth: _____

Patient Address: _____

Patient an Illinois resident at time of service? (circle one) YES NO

Patient involved in an alleged accident? (circle one) YES NO

Patient victim of an alleged crime? (circle one) YES NO

Patient Social Security Number (not required if uninsured): _____

Patient telephone or cell phone number: _____

Patient email address (if applicable): _____

If applicable: Guarantor Information (If patient is a minor or spouse/partner is responsible for patient): _____

Telephone number of employer: _____

Marital status of the patient (please circle one):

Single Married Widowed Separated* Divorced*

*If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order? (circle one) YES NO

Gross monthly family income:

\$	Total household employment income (including self-employed)
\$	Unemployment compensation
\$	Social Security
\$	Social Security Disability
\$	Veterans' pension
\$	Veterans' disability
\$	Private disability
\$	Workers' Compensation
\$	Temporary Assistance for Needy Families
\$	Retirement Income
\$	Child Support, alimony or other spousal support
\$	Other Income
\$	Total gross monthly family income

Please provide documentation of the following:
Paycheck stubs (last 4)
Benefit statements
Award letters
Court orders
Federal tax returns
Other documents in support of income
Ex. Bank Statement

Are you enrolled in any of the following? (circle all that apply)
Women, Infants and Children Nutrition Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)
Illinois Free Lunch and Breakfast Program
Low Income Home Energy Assistance Program (LIHEAP)
Any community-based program that provides access to medical care based on low-income financial status

Insurance/Benefit Information:

Does the patient have medical insurance? (circle one) YES NO

If yes, please specify:

Type of coverage (please circle one):

Health Medicare Medicare Part D Medicare Supplement Medicaid Veterans'

Insured Member Name: _____

Insurance Co. Name: _____

Subscriber ID: _____



January 21, 2019

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
PFS MEMORANDUM 19-01

TO: Committee on Patient Financial Services
FROM: Helena Lefkow, Senior Director, Revenue Cycle & Managed Care
COPY TO: Directors of Access and Registration
SUBJECT: 2019 Federal Poverty Guidelines

The U. S. Department of Health and Human Services recently released the annual updated federal poverty guidelines, which are used to establish financial eligibility for various federal programs. These guidelines are effective January 11, 2019, unless an office administering a program using the guidelines specifies a different effective date for that program. Please note that publication of the guidelines in the *Federal Register* has been delayed due to the government shutdown.

The 2019 poverty guidelines for Illinois are:

family size	poverty guidelines
1	\$12,490
2	\$16,910
3	\$21,330
4	\$25,750
5	\$30,170
6	\$34,590
7	\$39,010
8	\$43,430

For families/households with more than eight people, add \$4,420 for each additional person.

If you have any questions, please contact me at 312-906-6008, hlefkow@team-ihh.org.

This memorandum was prepared for the express use of hospitals participating in the Patient Financial Services program and is not intended for further distribution.

APPENDIX 1

Physician Referral Letters

(see attached)



VIA OVERNIGHT DELIVERY

May 8, 2019

Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761
Attention: Courtney Avery, Administrator

RE: ESRD Facility Proposed by Austin Dialysis at Loretto, Chicago, Illinois

Dear Ms. Avery:

I am a nephrologist practicing in the City of Chicago. I submit this letter in support of the in-center hemodialysis facility ("ESRD Facility") proposed by Austin Dialysis at Loretto ("Applicant"). The Applicant's proposal will enhance access to critical care for end stage renal disease ("ESRD") patients living in Chicago's Austin neighborhood and other at-risk communities near the Loretto Hospital campus.

Based on hospital records, 97 ESRD patients were treated at Loretto Hospital since 2017. I have included with this letter patient origin information for 2017 through the most recent quarter, separated out by zip code, a copy of which is attached to this letter as Exhibit A. I anticipate that these historical patterns will continue for 2019 and beyond. ESRD patient projections are attached hereto as Exhibit B.

Upon review of the hospital's records, Loretto Hospital has historically treated many pre-ESRD patients who currently have Chronic Kidney Disease ("CKD"), Stage 3-5. I estimate that a small number of these patients, approximately 10%, would not continue requiring in-center hemodialysis services due to a change in health status (e.g., the patients received a kidney transplant). This estimate is small because, based on experience at Loretto Hospital, I have found that a significant number of minorities are not approved for kidney transplants and therefore they need to begin and remain on dialysis for the remainder of their lives.

In regard to patients beginning dialysis, based on historical trends, I estimate that at least 36 patients who live within five miles of Loretto Hospital will be treated through the hospital, develop ESRD, require in-center hemodialysis within the proposed ESRD facility's first year of operation, and such patients will choose the proposed ESRD facility for their treatments. I estimate that 60 patients will choose the proposed ESRD facility within the first 24 months of operation. I anticipate referring all 60 of these patients to the proposed ESRD facility within the first two years following project completion. This information is attached as Exhibit B.

Based on foregoing, I certify that: (1) the patients choosing the proposed facility will reside within the Applicant's five-mile geographic service area; (2) the anticipated number of patients does not exceed the hospital's documented historical caseload; (3) I have not used the

aforementioned referrals to support another pending or approved certificate of need permit application; and (4) the information provided in this letter is true and correct to the best of my knowledge.

Respectfully submitted,



Rajani Kosuri, M.D.
Nephrologist
Loretto Hospital
645 South Central Avenue
Chicago, Illinois 60644

NOTARY

Subscribed and sworn to me this 9th day of May, 2019.



Notary Public

Seal:

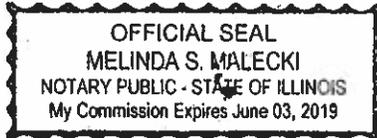


EXHIBIT A

Historical Patient Origin Data

Historical patient information, by zip code, is provided below. The information reflects patient information for the referring physician identified in the letter accompanying this exhibit.

Loretto Hospital Historic ESRD Patients by GSA Zip Code

Zip Code	Population	ESRD Patients 2017	ESRD Patients 2018	ESRD Patients 2019
60153	24,029	0	1	0
60608	78,072	0	2	0
60612	35,559	0	2	0
60622	54,467	0	1	0
60623	88,137	0	5	1
60624	38,134	0	5	1
60632	91,668	0	1	0
60644	49,645	13	47	10
60651	61,759	2	4	1
60804	83,972	0	1	0
TOTAL		15	69	13

The chart above identifies the patients who have received hospital-based dialysis treatments in the past two years at Loretto Hospital (2017 through March 31, 2019). Most notably, most of the patients originated from the same zip code of Loretto Hospital, a zip code that does not currently have an in-center dialysis facility. This also shows that the proposed site will be a very convenient location for most of these patients. Most important, however, is that historical patient data suggests that there are more than enough patients for the proposed ESRD facility to reach the State Board’s target utilization standard of 80% without adversely impacting nearby ESRD providers.

EXHIBIT B

ESRD Projected Referrals

TOTAL POPULATION/TOTAL ESRD PATIENTS IN APPLICANT'S GSA			
** Patients Beginning Dialysis Treatments Within 24 Months **			
Zip Code	Total Population	Pre-ESRD Patients Begin Dialysis < 12 Months	Pre-ESRD Patients Begin Dialysis 12-24 Months
60153	24,029	1	1
60608	78,072	1	1
60612	35,559	1	1
60622	54,467	1	1
60623	88,137	3	3
60624	38,134	3	3
60632	91,668	1	1
60644	49,645	21	15
60651	61,759	3	1
60804	83,972	1	1
TOTAL	1,353,395	36	65

APPENDIX 2

List of Health Care Facilities Within Five (5) Mile Radius of Proposed ESRD Facility

The names and locations of all existing or approved health care facilities (i.e., ESRD facilities) located within the proposed 5-mile radius GSA is provided below.

Existing Health Care Facilities Within Proposed GSA

Facility & City	Miles	Drive Time	Ownership	Stations	Occupancy %	Met Occupancy Standard?
Fresenius Kidney Care Oak Park 733 Madison, Oak Park	2.4	9.0	Fresenius	12	93.06%	Yes
Maple Ave. Kidney Center 610 S. Maple Street, Oak Park	2.6	5.0	Independent	18	N/A	N/A
Fresenius Kidney Care Austin 4800 W. Chicago Ave., Chicago	2.6	9.0	Fresenius	16	67.71%	No
Fresenius Kidney Care Congress 3410 W. Van Buren, Chicago	3.1	6.0	Fresenius	30	56.11%	No
Fresenius Kidney Care Cicero 3000 S. Cicero Ave., Cicero	3.5	9.0	Fresenius	20	80.83%	Yes
Fresenius Kidney Care River For. 103 Forest Ave., River Forest	3.7	9.0	Fresenius	24	69.44%	No
Lawndale Dialysis 3934 W. 24 th Street, Chicago	3.9	13.0	DaVita	16	105.21%	Yes
DaVita Garfield Kidney Center 3250 W. Franklin Blvd., Chicago	4.9	11.0	DaVita	24	61.11%	No
Fresenius Kidney Care Berwyn 2601 Harlem Ave., Berwyn	4.9	11.0	Fresenius	30	76.67%	No
Loyola Center for Dialysis 1201 W. Roosevelt Rd., Maywood	5.0	8.0	Independent	30	N/A	N/A
Fresenius Medical Care Humboldt 3520 W. Grand Ave., Chicago	5.0	14.0	Fresenius	34	70.59%	No

While all of the existing ESRD facilities in the GSA are not at capacity according to the State Board’s 80% utilization standard, the Applicant points out four important facts:

- Two of the facilities have not reported data and therefore cannot be factored into the equation.
- Of the six facilities that are not at capacity, five are owned by Fresenius. When Fresenius comes before the State Board, they always claim that their centers will achieve capacity. Perhaps Fresenius’ inability to achieve the 80% utilization rate is the result to overly aggressive expansion when the State Board’s need data showed over an 80 station need in 2017 or maybe Fresenius simply built centers too large for the particular community (e.g., Fresenius Kidney Care Congress has 30 stations, presently utilized at 56%). The Applicant asks the State Board to hold this against Fresenius and not the Applicant when considering underutilization of existing ESRD facilities in the GSA.

- Of the six facilities not at capacity, two are over 70% utilized and two more have utilization rates in the 60th percentile. Thus, these four centers appear to be approaching the State Board's 80% utilization standard.
- Both DaVita and Fresenius previously asked Loretto Hospital to be a partner in an ESRD facility joint venture.

APPENDIX 3

MapQuest Time & Distance

(see attached)

YOUR TRIP TO:

733 Madison St



9 MIN | 2.4 MI

Est. fuel cost: \$0.28

Trip time based on traffic conditions as of 11:04 PM on August 19, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.70 miles

0.70 total miles



2. Turn **left** onto W Washington Blvd.

If you reach W West End Ave you've gone about 0.1 miles too far.

Then 1.52 miles

2.22 total miles



3. Turn **left** onto S Oak Park Ave.

S Oak Park Ave is just past S Euclid Ave.

If you reach S Grove Ave you've gone a little too far.

Then 0.13 miles

2.35 total miles



4. Turn **left** onto Madison St.

If you reach Adams St you've gone about 0.1 miles too far.

Then 0.04 miles

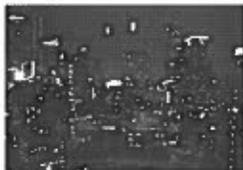
2.38 total miles



5. 733 Madison St, Oak Park, IL 60302-4419, 733 MADISON ST is on the **right**.

If you reach S Euclid Ave you've gone a little too far.

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**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
(1-888-461-3625)

YOUR TRIP TO:

610 S Maple Ave



5 MIN | 2.6 MI

Est. fuel cost: \$0.31

Trip time based on traffic conditions as of 11:07 PM on August 19, 2018. Current Traffic: Moderate



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave.

Then 0.04 miles 0.04 total miles



2. Turn **sharp left**.

Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles 0.06 total miles



3. Turn **sharp right**.

Then 0.03 miles 0.09 total miles



4. Turn **right** onto W Harrison St.

Then 0.02 miles 0.11 total miles



5. Take the 1st **right** onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles 0.18 total miles



6. Merge onto I-290 W.

Then 1.81 miles 1.99 total miles

7. Take the **IL-43/Harlem Ave** exit, EXIT 21B, on the **left**.

Then 0.27 miles 2.25 total miles



8. Turn **right** onto Harlem Ave/IL-43.

If you reach I-290 W you've gone about 0.2 miles too far.

Then 0.31 miles 2.56 total miles



9. Turn **right** onto Monroe St.

Monroe St is just past Adams St.

If you reach Madison St you've gone about 0.1 miles too far.

Then 0.04 miles 2.60 total miles



10. Turn **right** onto S Maple Ave.

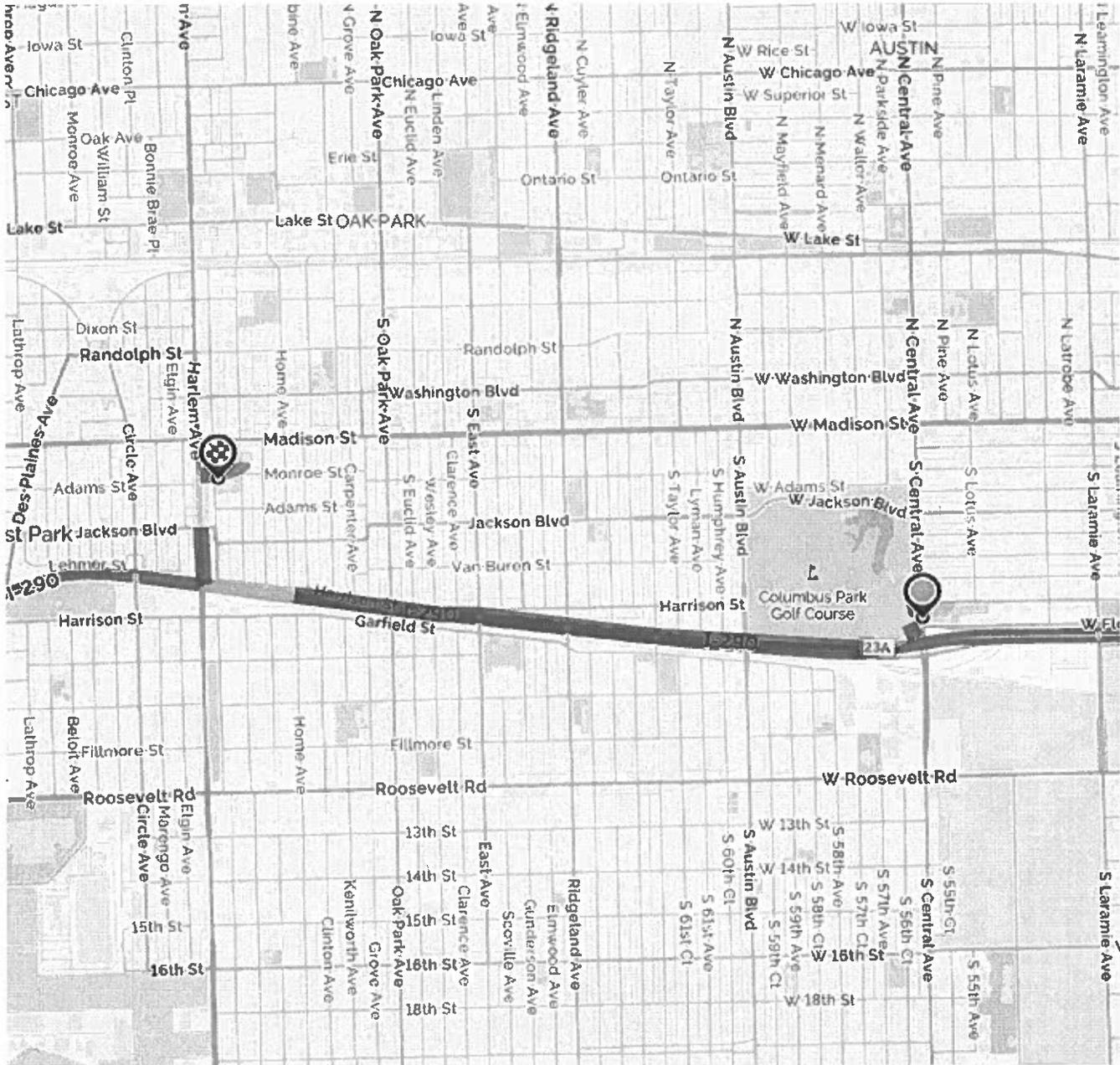
Then 0.02 miles 2.62 total miles



11. 610 S Maple Ave, Oak Park, IL 60304-1003, 610 S MAPLE AVE is on the left.

If you reach Adams St you've gone a little too far.

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Car trouble mid-trip? MapQuest Roadside Assistance is here:

(1-888-461-3625)

YOUR TRIP TO:

4800 W Chicago Ave



9 MIN | 2.6 MI

Est. fuel cost: \$0.30

Trip time based on traffic conditions as of 12:10 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles 0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles 0.55 total miles



3. Turn **left** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 1.52 miles 2.07 total miles



4. Turn **right** onto W Chicago Ave.

W Chicago Ave is 0.1 miles past W Huron St.

If you reach W Iowa St you've gone about 0.1 miles too far.

Then 0.49 miles 2.56 total miles



5. 4800 W Chicago Ave, Chicago, IL 60651-3223, 4800 W CHICAGO AVE is on the **left**.

Your destination is 0.1 miles past N Lamon Ave.

If you reach N Cicero Ave you've gone a little too far.

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YOUR TRIP TO:

3410 W Van Buren St



6 MIN | 3.1 MI

Est. fuel cost: \$0.37

Trip time based on traffic conditions as of 12:04 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles 0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles 0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles 0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flournoy St.

Then 0.08 miles 0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 1.49 miles 2.25 total miles



6. Take EXIT 26A toward **3800 W**.

Then 0.20 miles 2.44 total miles



7. Merge onto W Harrison St.

Then 0.54 miles 2.98 total miles



8. Turn **left** onto S Homan Ave.

S Homan Ave is 0.1 miles past S Saint Louis Ave.

If you reach S Spaulding Ave you've gone about 0.1 miles too far.

Then 0.13 miles 3.11 total miles



9. Turn left onto W Van Buren St.
 W Van Buren St is just past W Congress Pkwy.

If you reach W Gladys Ave you've gone a little too far.

Then 0.03 miles

3.14 total miles



10. 3410 W Van Buren St, Chicago, IL 60624-3358, 3410 W VAN BUREN ST is on the right.

If you reach S Trumbull Ave you've gone a little too far.

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YOUR TRIP TO:

3000 IL Highway 50

aka 3000 S. Cicero Ave.



9 MIN | 3.5 MI

Est. fuel cost: \$0.41

Trip time based on traffic conditions as of 12:11 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.50 miles

1.05 total miles



4. Turn **left** onto W Roosevelt Rd.

W Roosevelt Rd is 0.3 miles past W Lexington St.

If you reach W 13th St you've gone about 0.1 miles too far.

Then 0.51 miles

1.56 total miles



5. Take the 2nd **right** onto S Cicero Ave/IL-50.

S Cicero Ave is just past S 48th Ct.

If you reach S 47th Ave you've gone about 0.1 miles too far.

Then 1.39 miles

2.95 total miles



6. Keep **left** at the fork to continue on S Cicero Ave/IL-50.

Then 0.50 miles

3.45 total miles

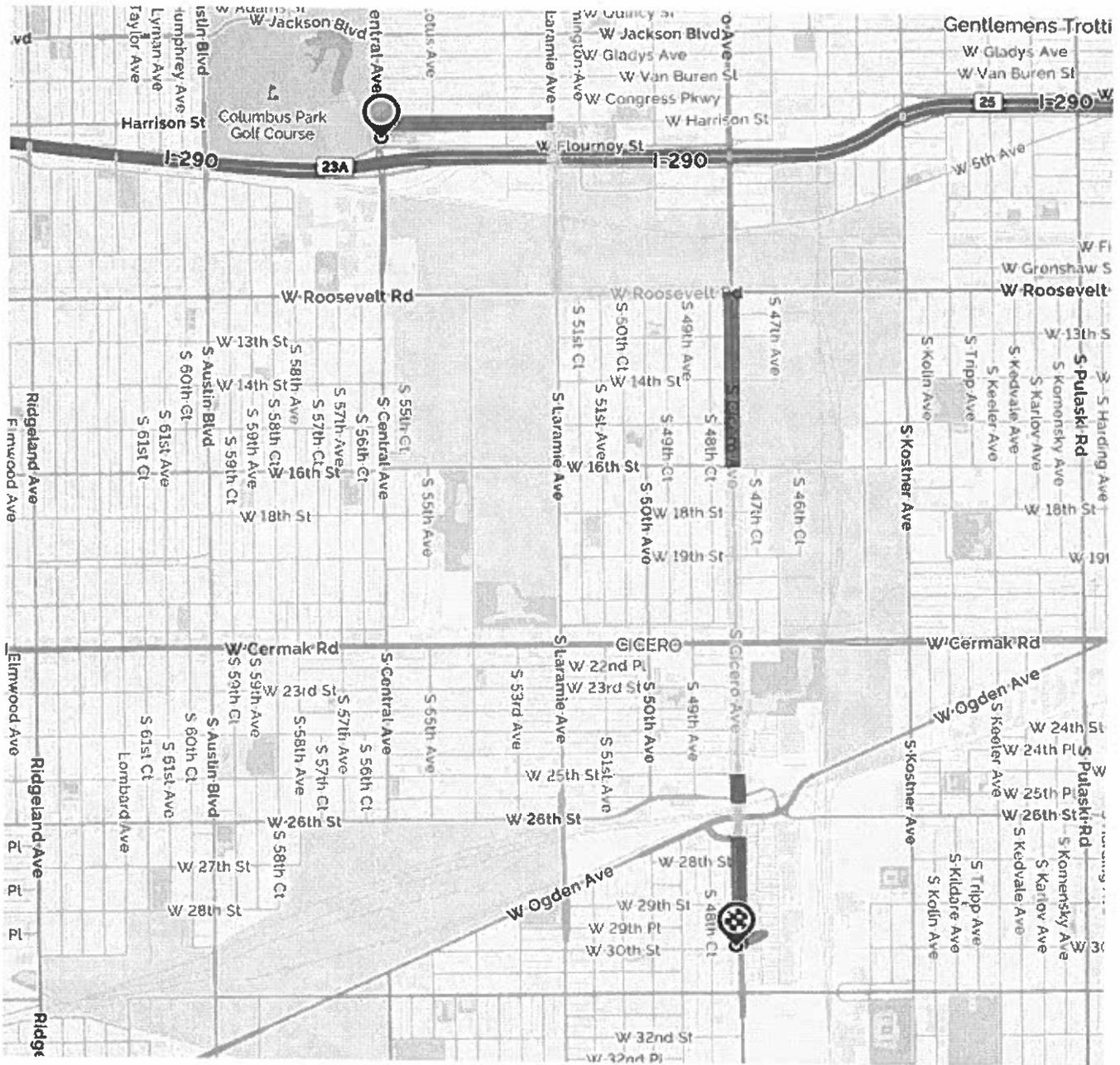


7. 3000 IL Highway 50, Cicero, IL 60804-3638, 3000 IL HIGHWAY 50.

Your destination is 0.1 miles past W 29th St.

If you reach W 31st St you've gone about 0.1 miles too far.

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(1-888-461-3625)

YOUR TRIP TO:

103 Forest Ave



9 MIN | 3.7 MI

Est. fuel cost: \$0.44

Trip time based on traffic conditions as of 11:08 PM on August 19, 2018. Current Traffic: Moderate



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave.

Then 0.04 miles 0.04 total miles



2. Turn **sharp left**.

Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles 0.06 total miles



3. Turn **sharp right**.

Then 0.03 miles 0.09 total miles



4. Turn **right** onto W Harrison St.

Then 0.02 miles 0.11 total miles



5. Take the 1st **right** onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles 0.18 total miles



6. Merge onto I-290 W.

Then 1.81 miles 1.99 total miles

7. Take the **IL-43/Harlem Ave** exit, EXIT 21B, on the **left**.

Then 0.27 miles 2.25 total miles



8. Turn **right** onto Harlem Ave/IL-43.

If you reach I-290 W you've gone about 0.2 miles too far.

Then 0.41 miles 2.67 total miles



9. Turn **left** onto Madison St.

Madison St is 0.1 miles past Monroe St.

If you reach Washington Blvd you've gone about 0.1 miles too far.

Then 0.85 miles 3.52 total miles

➔ **10. Turn right onto Forest Ave.**
Forest Ave is just past Van Buren St.

If you reach Keystone Ave you've gone a little too far.

Then 0.17 miles

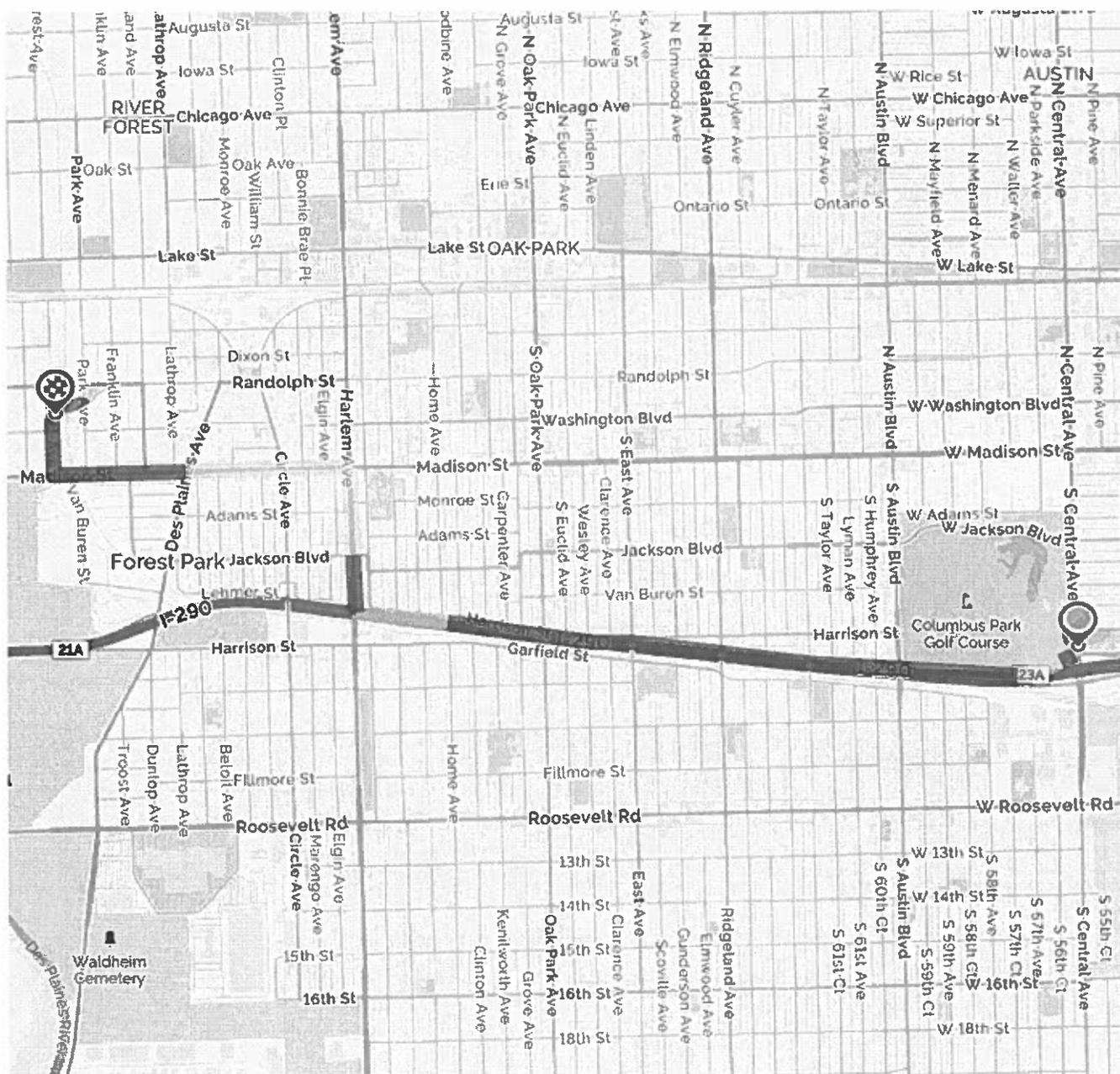
3.68 total miles

📍 **11. 103 Forest Ave, River Forest, IL 60305-2003, 103 FOREST AVE is on the right.**

Your destination is just past Vine St.

If you reach Washington Blvd you've gone a little too far.

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YOUR TRIP TO:

3934 W 24th St



13 MIN | 3.9 MI

Est. fuel cost: \$0.46

Trip time based on traffic conditions as of 12:04 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.50 miles

1.05 total miles



4. Turn **left** onto W Roosevelt Rd.

W Roosevelt Rd is 0.3 miles past W Lexington St.

If you reach W 13th St you've gone about 0.1 miles too far.

Then 1.52 miles

2.57 total miles



5. Turn **right** onto S Pulaski Rd.

S Pulaski Rd is just past S Komensky Ave.

If you reach S Harding Ave you've gone a little too far.

Then 1.26 miles

3.83 total miles



6. Turn **left** onto W 24th St.

W 24th St is 0.2 miles past W Ogden Ave.

If you reach W 24th Pl you've gone a little too far.

Then 0.04 miles

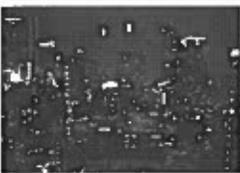
3.87 total miles



7. 3934 W 24th St, Chicago, IL 60623-3073, 3934 W 24TH ST is on the **left**.

If you reach S Harding Ave you've gone a little too far.

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YOUR TRIP TO:

3250 W Franklin Blvd



11 MIN | 4.9 MI

Est. fuel cost: \$0.58

Trip time based on traffic conditions as of 12:05 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 2.54 miles

3.30 total miles



6. Take the **Sacramento Blvd** exit, EXIT 27A, toward **3000 W**.

Then 0.18 miles

3.49 total miles



7. Turn **left** onto S Sacramento Blvd.

If you are on W Congress Pkwy and reach S Francisco Ave you've gone about 0.1 miles too far.

Then 0.67 miles

4.16 total miles



8. Turn **left** onto W Lake St.

W Lake St is just past W Washington Blvd.

If you reach W Walnut St you've gone a little too far.

Then 0.26 miles

4.41 total miles

 **9. Take the 2nd right onto N Kedzie Ave.**
N Kedzie Ave is 0.1 miles past N Albany Ave.

If you reach N Homan Ave you've gone about 0.2 miles too far.

----- Then 0.41 miles ----- 4.82 total miles

 **10. Turn left onto W Franklin Blvd.**
If you reach W Ohio St you've gone about 0.1 miles too far.

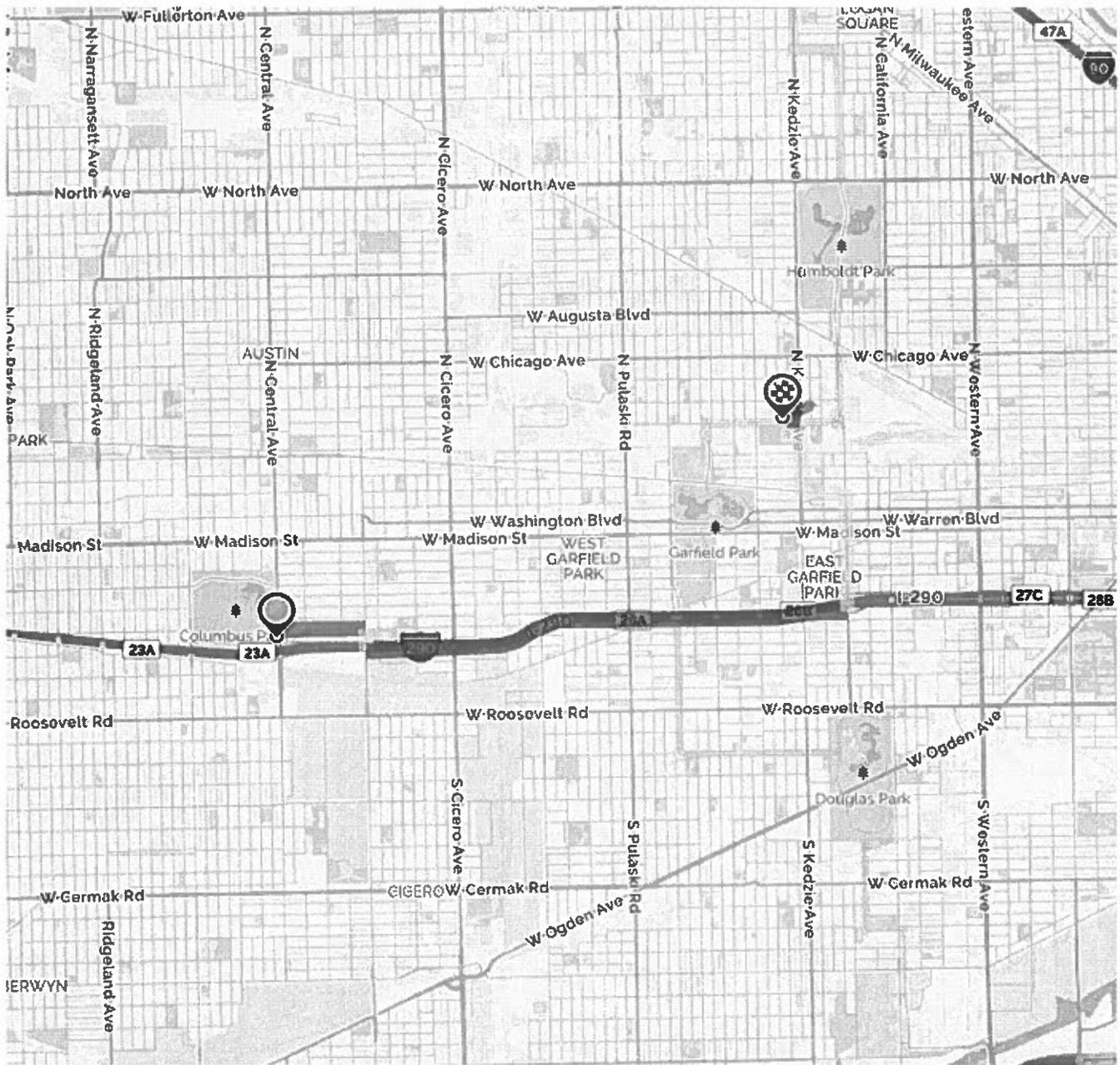
----- Then 0.07 miles ----- 4.90 total miles

 **11. 3250 W Franklin Blvd, Chicago, IL 60624-1509, 3250 W FRANKLIN BLVD is on the right.**

Your destination is just past N Sawyer Ave.

If you reach N Spaulding Ave you've gone a little too far.

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**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
(1-888-461-3625)

YOUR TRIP TO:

2601 Harlem Ave



11 MIN | 4.9 MI

Est. fuel cost: \$0.58

Trip time based on traffic conditions as of 11:56 PM on August 19, 2018. Current Traffic: Moderate



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going north on S Central Ave.

Then 0.04 miles ----- 0.04 total miles



2. Turn sharp left.

Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles ----- 0.06 total miles



3. Turn sharp right.

Then 0.03 miles ----- 0.09 total miles



4. Turn right onto W Harrison St.

Then 0.02 miles ----- 0.11 total miles



5. Take the 1st right onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles ----- 0.18 total miles



6. Merge onto I-290 W.

Then 1.81 miles ----- 1.99 total miles

7. Take the IL-43/Harlem Ave exit, EXIT 21B, on the left.

Then 0.27 miles ----- 2.25 total miles



8. Turn left onto Harlem Ave/IL-43.

Then 2.12 miles ----- 4.38 total miles



9. Turn left onto 26th St.

26th St is 0.2 miles past W 25th St.

If you reach Berkeley Rd you've gone a little too far.

Then 0.15 miles ----- 4.53 total miles

 **10. Turn right** onto Riverside Dr.
Riverside Dr is 0.1 miles past Harlem Ave.

If you reach 26th Pkwy you've gone a little too far.

----- Then 0.21 miles ----- 4.74 total miles

 **11. Take the 1st right** onto Harlem Ave/IL-43.
Harlem Ave is just past Maple Ave.

If you are on Longcommon Rd and reach Byrd Rd you've gone a little too far.

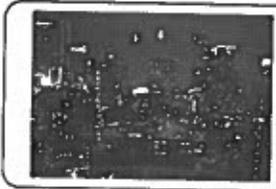
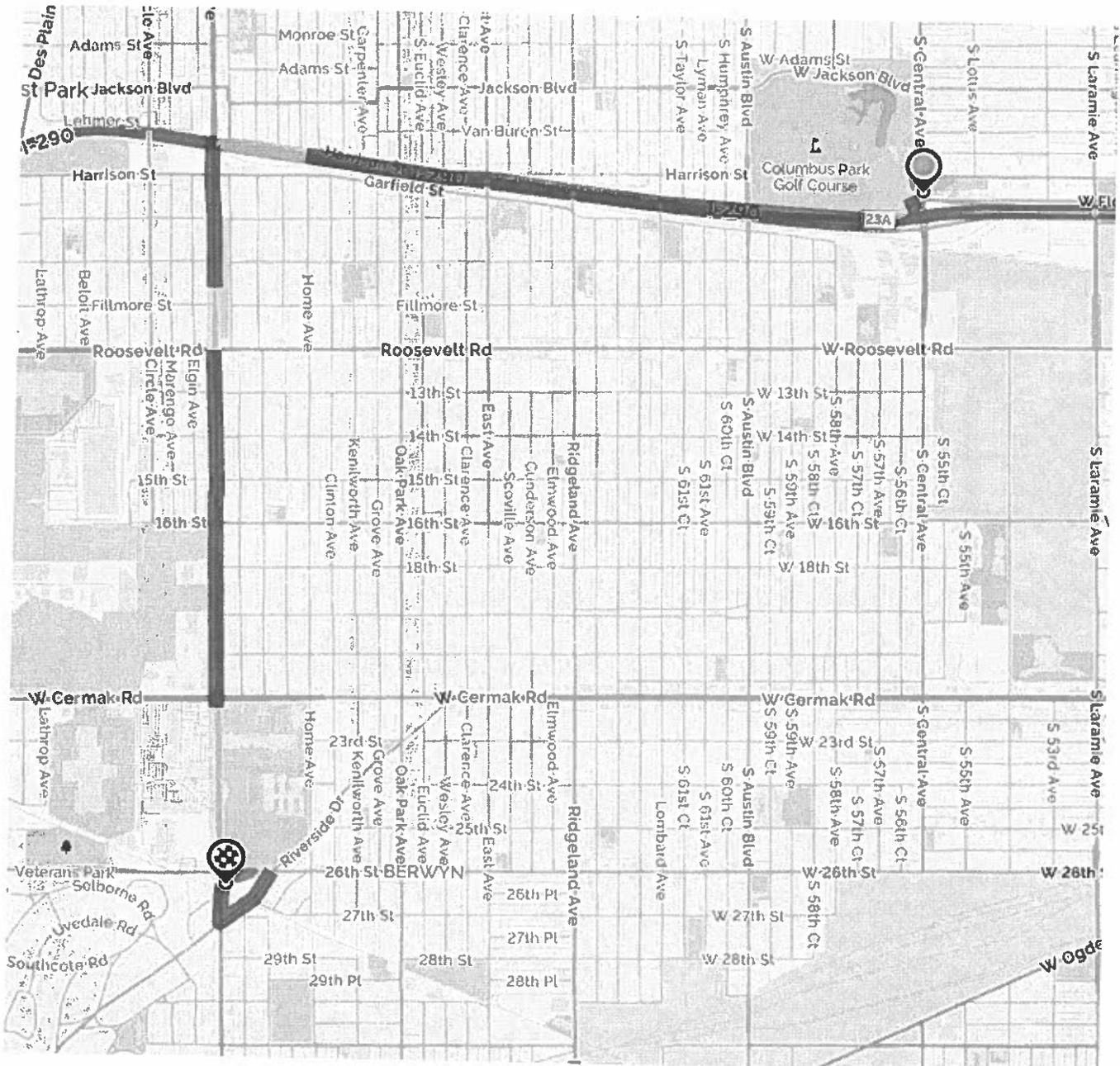
----- Then 0.11 miles ----- 4.85 total miles

 **12. 2601 Harlem Ave, Berwyn, IL 60402-2100, 2601 HARLEM AVE is on the right.**

Your destination is just past Harlem Ave.

If you reach 26th St you've gone a little too far.

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Car trouble mid-trip? MapQuest Roadside Assistance is here:
(1-888-461-3625)

YOUR TRIP TO:

1201 W Roosevelt Rd



8 MIN | 5.0 MI

Est. fuel cost: \$0.59

Trip time based on traffic conditions as of 11:05 PM on August 19, 2018. Current Traffic: Light



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave.

Then 0.04 miles ----- 0.04 total miles



2. Turn **sharp left**.

Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles ----- 0.06 total miles



3. Turn **sharp right**.

Then 0.03 miles ----- 0.09 total miles



4. Turn **right** onto W Harrison St.

Then 0.02 miles ----- 0.11 total miles



5. Take the 1st **right** onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles ----- 0.18 total miles



6. Merge onto I-290 W.

Then 3.93 miles ----- 4.10 total miles



7. Take EXIT 19B toward **9th Ave**.

Then 0.18 miles ----- 4.28 total miles



8. Merge onto Harrison St.

Then 0.01 miles ----- 4.30 total miles



9. Take the 1st **left** onto S 9th Ave.

If you reach S 10th Ave you've gone a little too far.

Then 0.50 miles ----- 4.80 total miles



10. Turn **right** onto W Roosevelt Rd.

W Roosevelt Rd is 0.1 miles past Fillmore St.

If you reach W 13th St you've gone about 0.1 miles too far.

Then 0.22 miles ----- 5.02 total miles

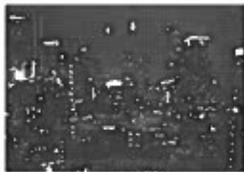
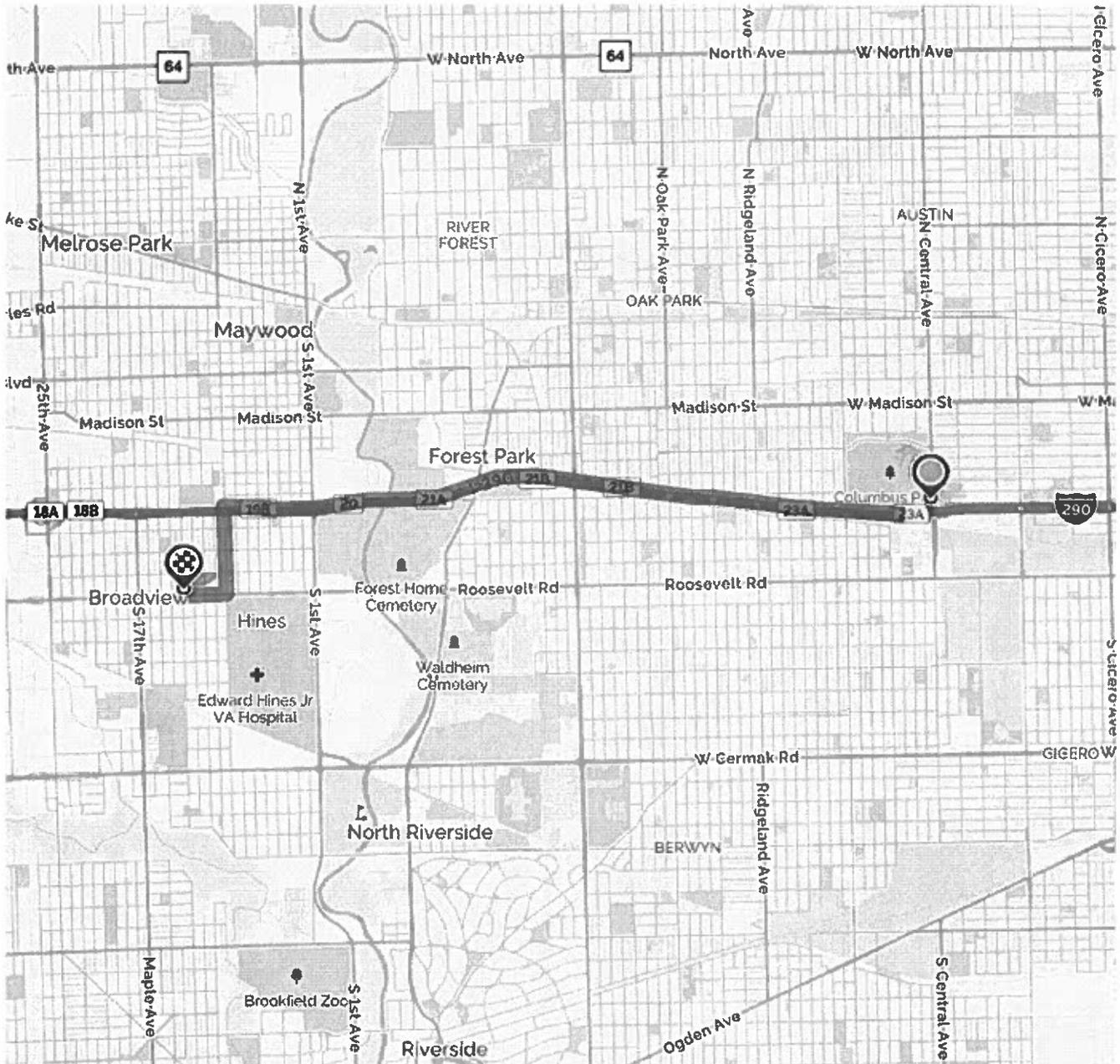


11. 1201 W Roosevelt Rd, Maywood, IL 60153-4046, 1201 W ROOSEVELT RD is on the right.

Your destination is just past S 12th Ave.

If you reach S 13th Ave you've gone a little too far.

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YOUR TRIP TO:

3520 W Grand Ave



14 MIN | 5.0 MI

Est. fuel cost: \$0.59

Trip time based on traffic conditions as of 12:10 AM on August 20, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 1.49 miles

2.25 total miles



6. Take EXIT 26A toward **3800 W**.

Then 0.20 miles

2.44 total miles



7. Merge onto W Harrison St.

Then 0.54 miles

2.98 total miles



8. Turn **left** onto S Homan Ave.

S Homan Ave is 0.1 miles past S Saint Louis Ave.

If you reach S Spaulding Ave you've gone about 0.1 miles too far.

Then 1.82 miles

4.81 total miles



9. S Homan Ave becomes W Grand Ave.

Then 0.16 miles

4.97 total miles

YOUR TRIP TO:

1901 W Harrison St



8 MIN | 5.1 MI

Est. fuel cost: \$0.60

Trip time based on traffic conditions as of 12:01 AM on August 20, 2018. Current Traffic: Moderate



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.
W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.
S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.
W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 3.80 miles

4.56 total miles



6. Take EXIT 28A toward **Damen Ave/2000 W**.

Then 0.16 miles

4.72 total miles



7. Merge onto W Congress Pkwy.

Then 0.03 miles

4.75 total miles



8. Take the 1st **right** onto S Damen Ave.
If you reach S Wolcott Ave you've gone about 0.1 miles too far.

Then 0.16 miles

4.91 total miles



9. Turn **sharp left** onto W Ogden Ave.
W Ogden Ave is just past W Harrison St.

If you reach W Polk St you've gone a little too far.

Then 0.12 miles

5.03 total miles



10. Turn right onto W Harrison St.
W Harrison St is just past S Winchester Ave.

If you reach S Wolcott Ave you've gone a little too far.

Then 0.03 miles

5.06 total miles



11. 1901 W Harrison St, Chicago, IL 60612-3714, 1901 W HARRISON ST is on the right.

If you reach S Wolcott Ave you've gone a little too far.

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YOUR TRIP TO:

820 S Damen Ave



8 MIN | 5.1 MI

Est. fuel cost: \$0.60

Trip time based on traffic conditions as of 12:02 AM on August 20, 2018. Current Traffic: Moderate



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 3.80 miles

4.56 total miles



6. Take EXIT 28A toward **Damen Ave/2000 W**.

Then 0.16 miles

4.72 total miles



7. Merge onto W Congress Pkwy.

Then 0.03 miles

4.75 total miles



8. Take the 1st **right** onto S Damen Ave.

If you reach S Wolcott Ave you've gone about 0.1 miles too far.

Then 0.31 miles

5.06 total miles

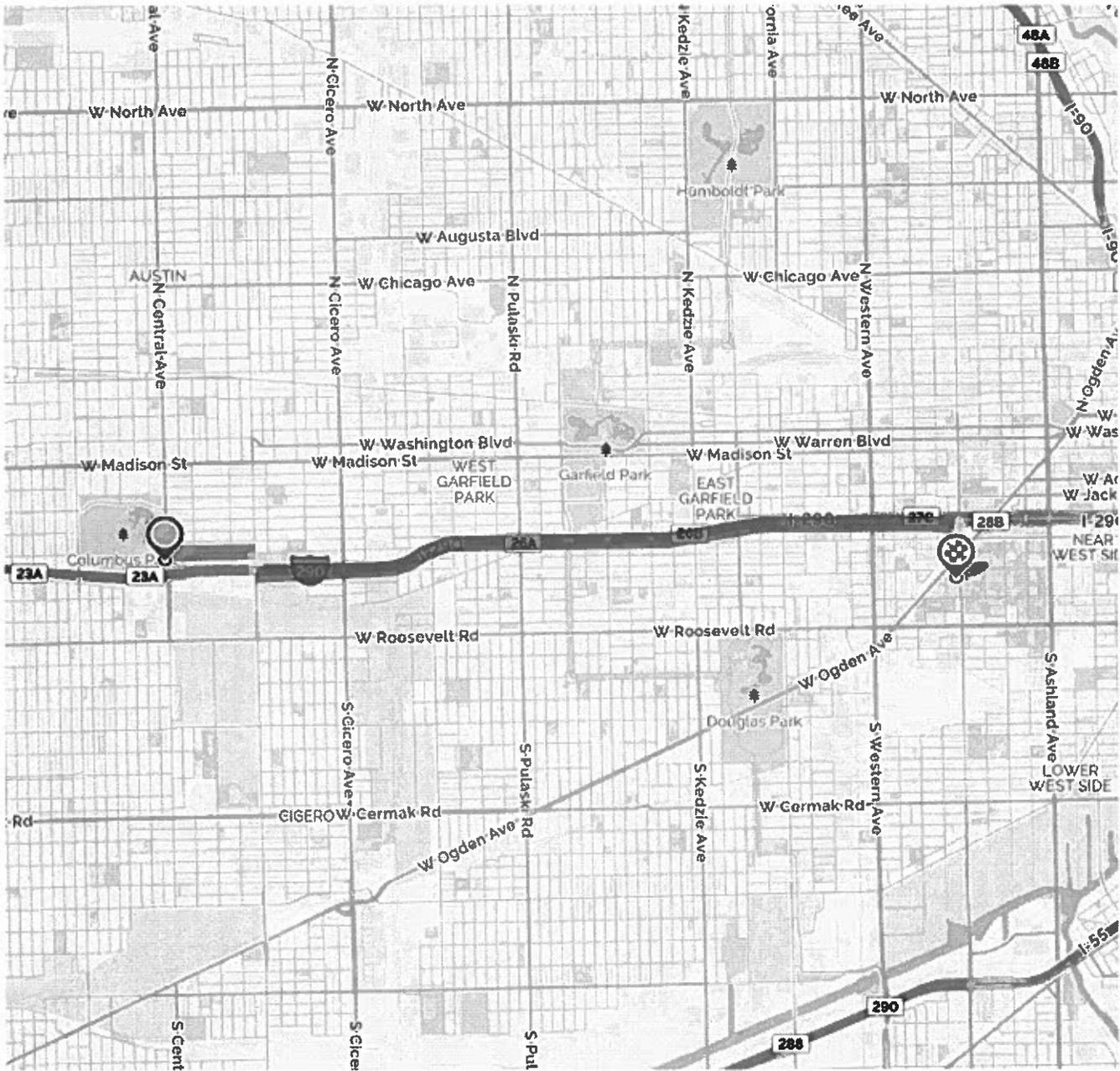


9. 820 S Damen Ave, Chicago, IL 60612-3728, 820 S DAMEN AVE is on the **right**.

Your destination is just past W Polk St.

If you reach W Taylor St you've gone a little too far.

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YOUR TRIP TO:

1653 W Congress Pkwy



7 MIN | 5.2 MI

Est. fuel cost: \$0.61

Trip time based on traffic conditions as of 11:59 PM on August 19, 2018. Current Traffic: Light



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1. Start out going north on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn right onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn right onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st left onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the left.

Then 4.17 miles

4.93 total miles



6. Take EXIT 28B toward Ashland Ave/Paulina St/1600 W/1700 W.

Then 0.17 miles

5.10 total miles



7. Merge onto W Congress Pkwy.

Then 0.07 miles

5.17 total miles



8. 1653 W Congress Pkwy, Chicago, IL 60612, 1653 W CONGRESS PKWY is on the right.

If you reach S Ashland Ave you've gone a little too far.

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**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
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YOUR TRIP TO:

1859 W Taylor St



10 MIN | 5.3 MI

Est. fuel cost: \$0.63

Trip time based on traffic conditions as of 12:01 AM on August 20, 2018. Current Traffic: Moderate



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles 0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles 0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles 0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flournoy St.

Then 0.08 miles 0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 3.80 miles 4.56 total miles



6. Take EXIT 28A toward **Damen Ave/2000 W**.

Then 0.16 miles 4.72 total miles



7. Merge onto W Congress Pkwy.

Then 0.03 miles 4.75 total miles



8. Take the 1st **right** onto S Damen Ave.

If you reach S Wolcott Ave you've gone about 0.1 miles too far.

Then 0.41 miles 5.16 total miles



9. Turn **left** onto W Taylor St.

W Taylor St is 0.1 miles past W Polk St.

If you reach W Greshaw St you've gone a little too far.

Then 0.19 miles 5.35 total miles

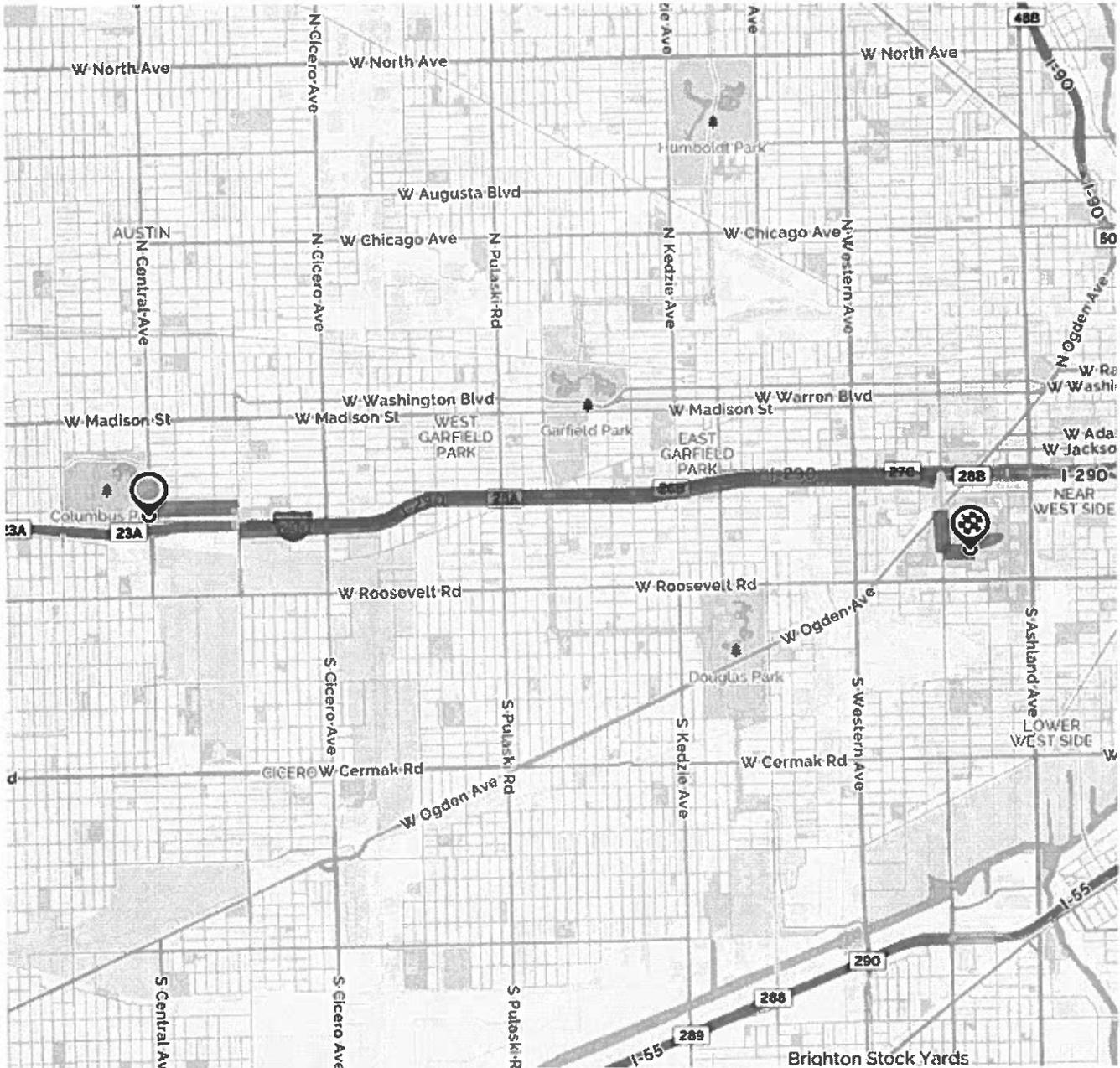


10. 1859 W Taylor St, Chicago, IL 60612-4795, 1859 W TAYLOR ST is on the right.

Your destination is just past S Wolcott Ave.

If you reach S Wood St you've gone a little too far.

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Car trouble mid-trip? MapQuest Roadside Assistance is here:
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YOUR TRIP TO:

1044 N Mozart St



13 MIN | 5.6 MI

Est. fuel cost: \$0.66

Trip time based on traffic conditions as of 12:03 AM on August 20, 2018. Current Traffic: Heavy



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles 0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles 0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles 0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles 0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 2.54 miles 3.30 total miles



6. Take the **Sacramento Blvd** exit, EXIT 27A, toward **3000 W**.

Then 0.18 miles 3.49 total miles



7. Turn **left** onto S Sacramento Blvd.

If you are on W Congress Pkwy and reach S Francisco Ave you've gone about 0.1 miles too far.

Then 1.72 miles 5.21 total miles



8. Turn **right** onto W Augusta Blvd.

W Augusta Blvd is 0.1 miles past W Grand Ave.

If you are on N Humboldt Blvd and reach W Cortez Dr you've gone a little too far.

Then 0.10 miles 5.32 total miles



9. Turn left onto N Richmond St.
N Richmond St is just past N Sacramento Ave.

If you reach N Francisco Ave you've gone a little too far.

Then 0.13 miles

5.44 total miles



10. Take the 1st right onto W Thomas St.
W Thomas St is just past W Cortez St.

If you reach W Division St you've gone about 0.1 miles too far.

Then 0.13 miles

5.57 total miles



11. Turn right onto N Mozart St.
N Mozart St is just past N Francisco Ave.

If you reach N California Ave you've gone a little too far.

Then 0.03 miles

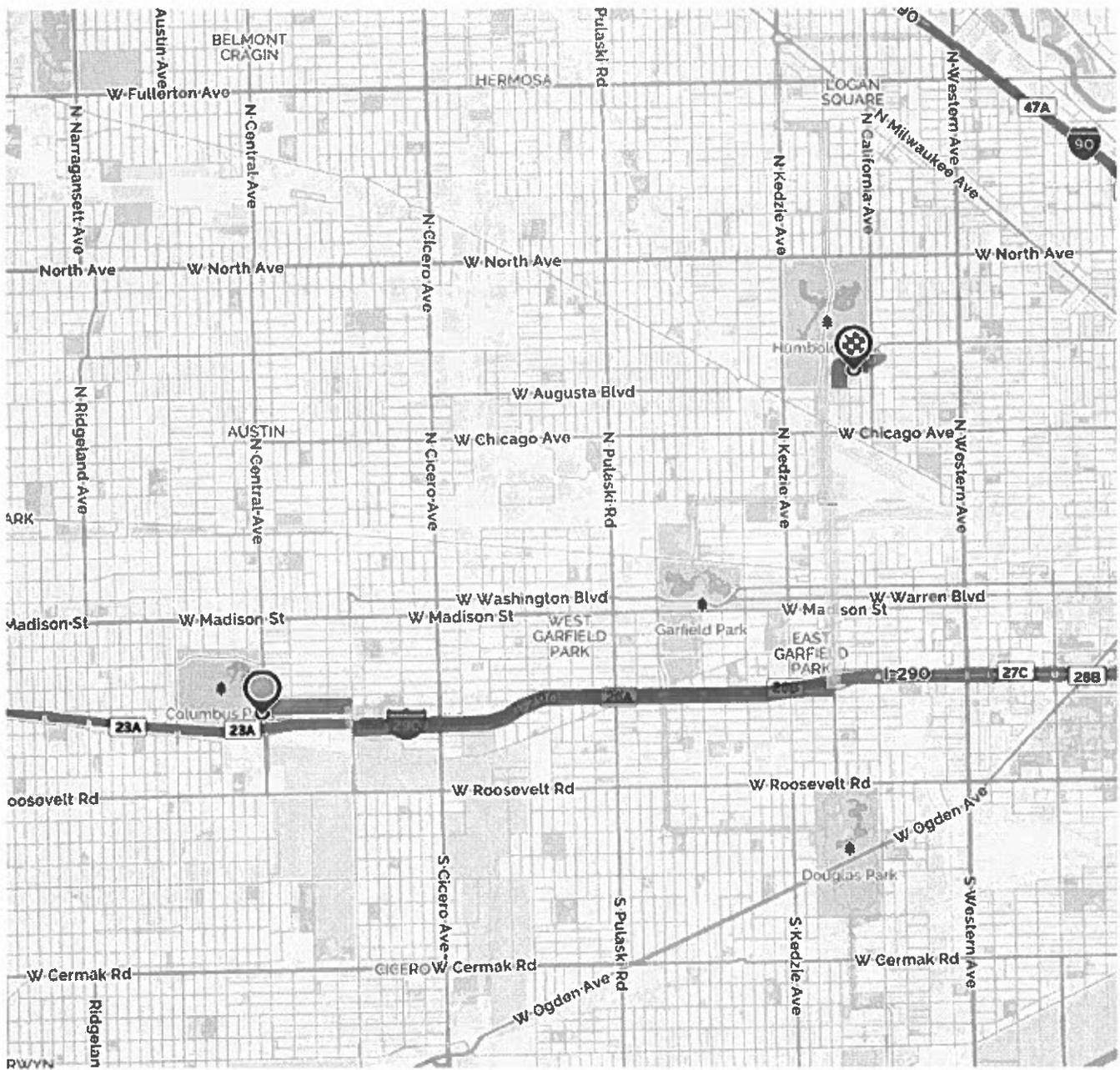
5.60 total miles



12. 1044 N Mozart St, Chicago, IL 60622-2759, 1044 N MOZART ST is on the right.

If you reach W Cortez St you've gone a little too far.

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**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
(1-888-461-3625)

YOUR TRIP TO:

1111 Superior St



11 MIN | 5.8 MI

Est. fuel cost: \$0.68

Trip time based on traffic conditions as of 11:05 PM on August 19, 2018. Current Traffic: Moderate



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1. Start out going **north** on S Central Ave.

Then 0.04 miles ----- 0.04 total miles



2. Turn **sharp left**.

Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles ----- 0.06 total miles



3. Turn **sharp right**.

Then 0.03 miles ----- 0.09 total miles



4. Turn **right** onto W Harrison St.

Then 0.02 miles ----- 0.11 total miles



5. Take the **1st right** onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles ----- 0.18 total miles



6. Merge onto I-290 W.

Then 3.40 miles ----- 3.58 total miles



7. Take **EXIT 20** toward **IL-171/1st Ave**.

Then 0.17 miles ----- 3.75 total miles



8. Merge onto Harrison St.

Then 0.04 miles ----- 3.79 total miles



9. Take the **1st right** onto S 1st Ave/IL-171.

If you reach S 2nd Ave you've gone a little too far.

Then 1.18 miles ----- 4.97 total miles



10. Turn **left** onto Lake St.

Lake St is just past Main St.

If you reach Ohio St you've gone a little too far.

Then 0.67 miles ----- 5.63 total miles

 11. Turn **right** onto N 11th Ave.
N 11th Ave is just past N 10th Ave.

If you reach N 12th Ave you've gone a little too far.

----- Then 0.08 miles ----- 5.72 total miles

 12. Take the 1st **left** onto Superior St.
If you reach Chicago Ave you've gone a little too far.

----- Then 0.04 miles ----- 5.75 total miles

 13. 1111 Superior St, Melrose Park, IL 60160-4100, 1111 SUPERIOR ST is on the
right.

If you reach N 12th Ave you've gone a little too far.

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**Car trouble mid-trip?
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Assistance is here:**
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YOUR TRIP TO:

2335 W Cermak Rd



12 MIN | 5.9 MI

Est. fuel cost: \$0.70

Trip time based on traffic conditions as of 11:57 PM on August 19, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 3.08 miles

3.84 total miles



6. Take EXIT 27C toward **2400 W/Western Ave.**

Then 0.20 miles

4.05 total miles



7. Keep **right** at the fork in the ramp.

Then 0.15 miles

4.20 total miles



8. Merge onto W Congress Pkwy.

Then 0.05 miles

4.25 total miles



9. Take the 1st **right** onto S Western Ave.

If you reach S Claremont Ave you've gone a little too far.

Then 1.59 miles

5.83 total miles



10. Turn **left** onto W Cermak Rd.
W Cermak Rd is just past W 21st Pl.

If you reach W 22nd Pl you've gone a little too far.

Then 0.09 miles

5.93 total miles

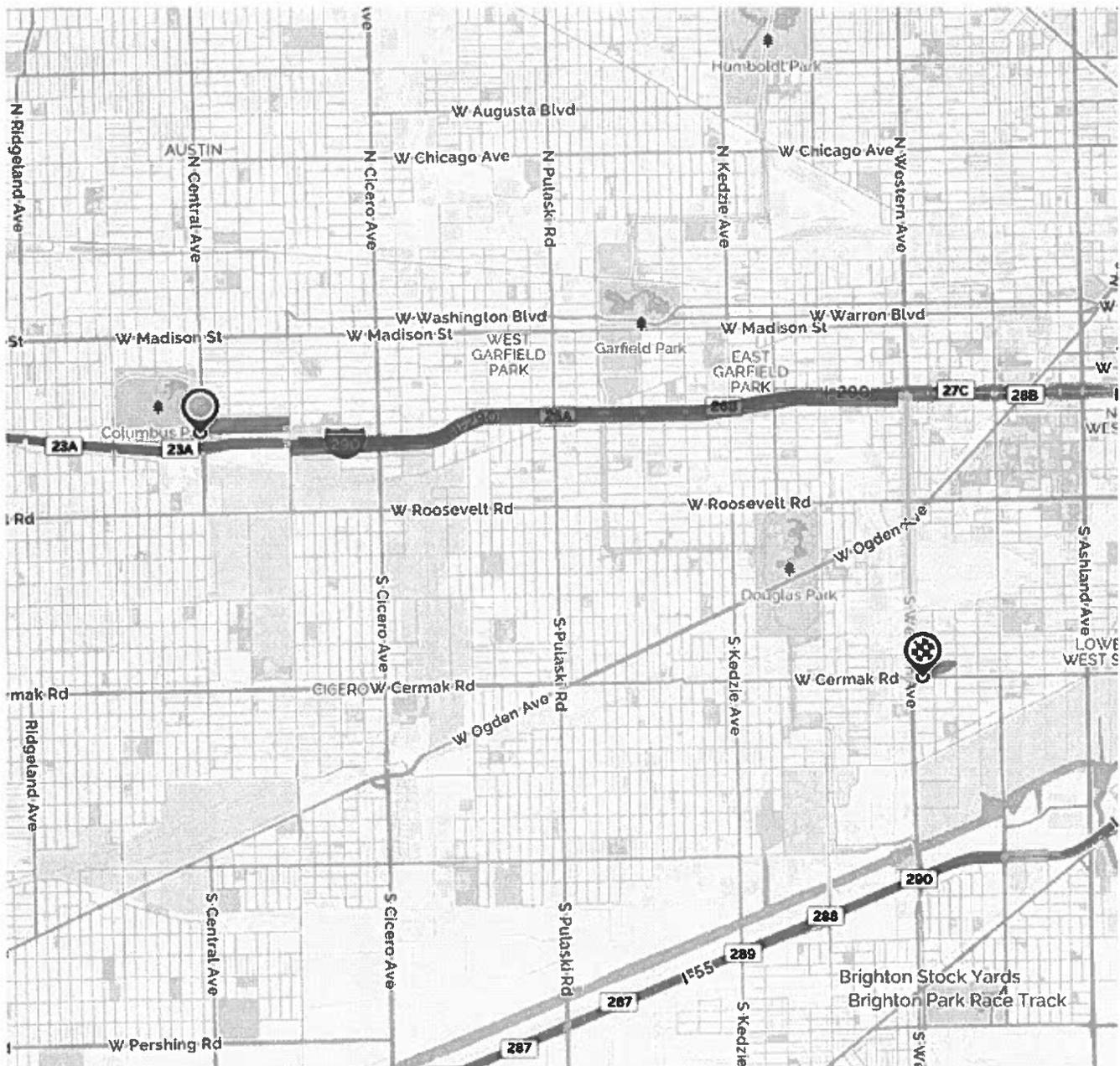


11. 2335 W Cermak Rd, Chicago, IL 60608-3811, 2335 W CERMAK RD is on the **right**.

Your destination is just past S Western Ave.

If you reach S Oakley Ave you've gone a little too far.

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YOUR TRIP TO:

1600 W 13th St



11 MIN | 6.0 MI

Est. fuel cost: \$0.71

Trip time based on traffic conditions as of 12:00 AM on August 20, 2018. Current Traffic: Heavy



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles 0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles 0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles 0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles 0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 4.17 miles 4.93 total miles



6. Take EXIT 28B toward **Ashland Ave/Paulina St/1600 W/1700 W**.

Then 0.17 miles 5.10 total miles



7. Merge onto W Congress Pkwy.

Then 0.16 miles 5.26 total miles



8. Turn **right** onto S Ashland Ave.

If you reach S Loomis St you've gone about 0.2 miles too far.

Then 0.70 miles 5.96 total miles



9. Turn **right** onto W 13th St.

W 13th St is just past W Washburne Ave.

If you reach W Hastings St you've gone a little too far.

Then 0.03 miles 5.99 total miles



10. 1600 W 13th St, Chicago, IL 60608-1304, 1600 W 13TH ST is on the right.

If you reach S Paulina St you've gone about 0.1 miles too far.

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(1-888-461-3625)

YOUR TRIP TO:

719 W North Ave, Melrose Park, IL, 60160-1612



12 MIN | 6.7 MI

Est. fuel cost: \$0.79

Trip time based on traffic conditions as of 11:06 PM on August 19, 2018. Current Traffic: Moderate



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1. Start out going north on S Central Ave.

Then 0.04 miles 0.04 total miles



2. Turn sharp left.
Just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.03 miles 0.06 total miles



3. Turn sharp right.

Then 0.03 miles 0.09 total miles



4. Turn right onto W Harrison St.

Then 0.02 miles 0.11 total miles



5. Take the 1st right onto S Central Ave.

If you reach S Lotus Ave you've gone about 0.1 miles too far.

Then 0.07 miles 0.18 total miles



6. Merge onto I-290 W.

Then 3.40 miles 3.58 total miles



7. Take EXIT 20 toward IL-171/1st Ave.

Then 0.17 miles 3.75 total miles



8. Merge onto Harrison St.

Then 0.04 miles 3.79 total miles



9. Take the 1st right onto S 1st Ave/IL-171.

If you reach S 2nd Ave you've gone a little too far.

Then 2.54 miles 6.33 total miles



10. Turn left onto W north Ave/IL-64.

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

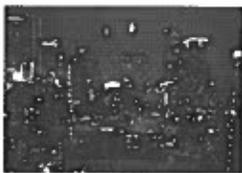
Then 0.32 miles 6.65 total miles



11. 719 W North Ave, Melrose Park, IL 60160-1612, 719 W NORTH AVE is on the right.

If you reach Riverwoods Dr you've gone a little too far.

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Car trouble mid-trip? MapQuest Roadside Assistance is here:
(1-888-461-3625)

YOUR TRIP TO:

1310 W 18th St



11 MIN | 6.8 MI

Est. fuel cost: \$0.81

Trip time based on traffic conditions as of 11:58 PM on August 19, 2018. Current Traffic: Heavy



Print a full health report of your car with HUM vehicle diagnostics (800) 906-2501



1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 4.17 miles

4.93 total miles



6. Take EXIT 28B toward **Ashland Ave/Paulina St/1600 W/1700 W**.

Then 0.17 miles

5.10 total miles



7. Merge onto W Congress Pkwy.

Then 0.16 miles

5.26 total miles



8. Turn **right** onto S Ashland Ave.

If you reach S Loomis St you've gone about 0.2 miles too far.

Then 1.20 miles

6.46 total miles



9. Turn **left** onto W 18th St.

W 18th St is just past W 17th St.

If you reach W 18th Pl you've gone a little too far.

Then 0.36 miles

6.82 total miles



10. 1310 W 18th St, Chicago, IL 60608-3102, 1310 W 18TH ST is on the **left**.

Your destination is just past S Ada St.

If you reach S Throop St you've gone a little too far.

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Car trouble mid-trip? MapQuest Roadside Assistance is here:

(1-888-461-3625)

YOUR TRIP TO:

518 N Austin Blvd



6 MIN | 1.8 MI

Est. fuel cost: \$0.22

Trip time based on traffic conditions as of 11:07 PM on August 19, 2018. Current Traffic: Heavy



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.57 miles

0.57 total miles



2. Turn **left** onto W Madison St.

If you reach W Washington Blvd you've gone about 0.1 miles too far.

Then 0.51 miles

1.07 total miles



3. Take the 3rd **right** onto N Austin Blvd.

N Austin Blvd is just past N Mason Ave.

If you are on Madison St and reach S Humphrey Ave you've gone a little too far.

Then 0.77 miles

1.84 total miles

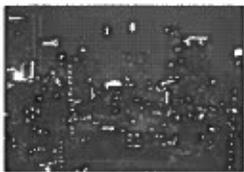


4. 518 N Austin Blvd, Oak Park, IL 60302-2947, 518 N AUSTIN BLVD is on the **left**.

Your destination is just past W Ohio St.

If you reach W Erie St you've gone a little too far.

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**Car trouble mid-trip?
MapQuest Roadside
Assistance is here:**
(1-888-461-3625)

YOUR TRIP TO:

2700 W 15th St



10 MIN | 4.9 MI

Est. fuel cost: \$0.57

Trip time based on traffic conditions as of 11:57 PM on August 19, 2018. Current Traffic: Moderate



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1. Start out going **north** on S Central Ave toward W Harrison St.

Then 0.05 miles

0.05 total miles



2. Turn **right** onto W Harrison St.

W Harrison St is just past S Central Ave.

If you reach W Congress Pkwy you've gone a little too far.

Then 0.50 miles

0.55 total miles



3. Turn **right** onto S Laramie Ave.

S Laramie Ave is 0.1 miles past S Lockwood Ave.

If you reach S Leamington Ave you've gone a little too far.

Then 0.13 miles

0.68 total miles



4. Take the 1st **left** onto W Lexington St.

W Lexington St is just past W Flourney St.

Then 0.08 miles

0.76 total miles



5. Merge onto I-290 E via the ramp on the **left**.

Then 2.54 miles

3.30 total miles



6. Take the **Sacramento Blvd** exit, EXIT 27A, toward **3000 W**.

Then 0.18 miles

3.49 total miles



7. Turn **slight left** onto W Congress Pkwy.

Then 0.26 miles

3.75 total miles



8. Turn **right** onto S California Ave.

S California Ave is 0.1 miles past S Francisco Ave.

If you reach S Washtenaw Ave you've gone about 0.1 miles too far.

Then 0.94 miles

4.69 total miles



9. Turn **left** onto W Ogden Ave.

If you reach W 15th Place Dr you've gone a little too far.

Then 0.07 miles

4.76 total miles

➔ 10. Take the 1st right onto S Fairfield Ave.
If you reach S Washtenaw Ave you've gone a little too far.

Then 0.05 miles

4.81 total miles

⬅ 11. Take the 2nd left onto W 15th St.
W 15th St is just past W Ogden Ave.

Then 0.05 miles

4.85 total miles

📍 12. 2700 W 15th St, Chicago, IL 60608-1610, 2700 W 15TH ST is on the left.
If you reach S Washtenaw Ave you've gone a little too far.

Use of directions and maps is subject to our [Terms of Use](#). We don't guarantee accuracy, route conditions or usability. You assume all risk of use.





**HYLAK-REINHOLTZ
LAW FIRM, LLC**

601 West Monroe Street
Springfield, Illinois 62704

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Attorney at Law
(217) 525-0700 ext. 114
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May 20, 2019

VIA HAND DELIVERY

Illinois Health Facilities & Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761
Attention: Michael Constantino, Supervisor, Project Review Section

Re: Application for Permit – Austin Dialysis Center

Dear Mr. Constantino:

I submit the enclosed certificate of need permit application (“Application”) on behalf of co-applicants Austin Dialysis Center, LLC and Loretto Hospital (“Applicants”) seeking approval for a 12-station dialysis facility in Chicago, Illinois. For your review, please find attached an original copy and a duplicate of the following:

1. Application for CON Permit;
2. All Required Attachments; and
3. Check for \$2,500 payable to the Illinois Department of Public Health to cover the initial portion of the application fee.

The Applicants respectfully request an expedited review of this Application. The proposed dialysis facility will be located in an area of great need. The proposed geographic service area overlaps with a federally-designated medically underserved area, several census tracts in the immediate vicinity of the project site have some of Chicago’s highest mortality rates, a significant share of its residents live below the federal poverty line, and a majority of the service area’s population will be African-American, a community that is disproportionately affected by kidney disease. The proposed dialysis facility will address these needs and enhance access to care for some of Chicago’s most vulnerable residents.

Thank you for your time and consideration. If you have questions, do not hesitate to contact me at (630) 464-4514.

Sincerely yours,

Joseph Hylak-Reinholtz

Enclosure