Original

10-028

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
APR 28 2010
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: *Fresenius Medical Care Spoon River*			
Street Address: *175 S. Main Street*			
City and Zip Code: *Canton 61520*			
County: *Fulton*	Health Service Area	2	Health Planning Area:

**After relocation the facility will change its name to Fresenius Medical Care Elmhurst*

Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: *Dialysis Centers of America – Illinois, Inc. d/b/a Fresenius Medical Care Spoon River*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Rice Powell*
CEO Address: *920 Winter Street, Waltham, MA 02451*
Telephone Number: *800-662-1237*

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

Type of Ownership

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

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

Primary Contact

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

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care-North America*
Address: *One Westbrook Corporate Center, Tower One, Suite 1000, Westchester, IL 60154*
Telephone Number: *708-498-9121*
E-mail Address: *lori.wright@fmc-na.com*
Fax Number: *708-498-9334*

Additional Contact

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

Name: *Richard Stotz*
Title: *Regional Vice President*
Company Name: *Fresenius Medical Care-North America*
Address: *One Westbrook Corporate Center, Tower One, Suite 1000, Westchester, IL 60154*
Telephone Number: *708-498-9165*
E-mail Address: *richard.stotz@fmc-na.com*
Fax Number: *708-498-9283*

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care-North America*
Address: *One Westbrook Corporate Center, Tower One, Suite 1000, Westchester, IL 60154*
Telephone Number: *708-498-9121*
E-mail Address: *lori.wright@fmc-na.com*
Fax Number: *708-498-9334*

Additional Contact

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

Name: *Clare Ranalli*
Title: *Attorney*
Company Name: *Hinshaw & Culbertson, LLP*
Address: *222 N. LaSalle Street, Suite 300, Chicago, IL 60601*
Telephone Number: *312-704-3253*
E-mail Address: *cranalli@hinshawlaw.com*
Fax Number: *312-704-3001*

Additional Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance]

Name: *Clare Ranalli*
Title: *Attorney*
Company Name: *Hinshaw & Culbertson, LLP*
Address: *222 N. LaSalle Street, Chicago, IL 60601*
Telephone Number: *312-704-3253*
E-mail Address: *cranalli@hinshawlaw.com*
Fax Number: *312-704-3001*

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Graham Hospital*

Address of Site Owner: *210 W. Walnut Street, Canton, IL 61520*

Street Address or Legal Description of Site: *175 N. Main Street, Canton, IL 61520*

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

Operating Identity/Licensee

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

Exact Legal Name: *Dialysis Centers of America – Illinois, Inc. d/b/a Fresenius Medical Care Spoon River*

Address: *920 Winter Street, Waltham, MA 02451*

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

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

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person 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-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.] ***NOT APPLICABLE – APPLICANT WILL BE LEASING EXISTING SPACE***

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

APPEND DOCUMENTATION AS ATTACHMENT 4, 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-5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis	8	1		8	9
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

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

3. Narrative Description

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

Dialysis Centers of America – Illinois, Inc. proposes to discontinue its 8-station ESRD facility, Fresenius Medical Care Spoon River, located at 210 W. Walnut, Canton. In conjunction with this discontinuation we will establish a replacement 9-station ESRD facility, Fresenius Medical Care Spoon River, at 175 N. Main Street, Canton. This is essentially a relocation of the existing facility and the addition of one station to be used as an isolation station for Hepatitis B patients only. The Canton facility will be in leased space in the Graham Professional Building with the interior to be built out by the applicant. Both locations are in HSA 2.

This project is "non-substantive" under Planning Board rule 1110.10(b) as it entails the discontinuation and establishment (relocation) of a health care facility that will provide in-center chronic renal dialysis services

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-clinical components that are not related to the provision of health care, complete the second column of the table below. See 20 ILCS 3960 for definition of non-clinical. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Preplanning Costs	N/A	N/A	N/A
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	681,200	N/A	681,200
Contingencies	68,000	N/A	68,000
Architectural/Engineering Fees	70,800	N/A	70,800
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	240,000	N/A	240,000
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space 1,048,637 Equipment 139,150	1,187,787	N/A	1,187,787
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	2,247,787	N/A	2,247,787
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	1,060,000	N/A	1,060,000
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	1,187,787	N/A	1,187,787
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	2,247,787	N/A	2,247,787

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

Related Project Costs

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

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

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

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

Estimated start-up costs and operating deficit cost is $ 53,364.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): December 31, 2012

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

☐ Cancer Registry
☐ APORS
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
■ All reports regarding outstanding permits

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. 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**
CLINICAL	2,247,787	5,200			5,200		
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	2,247,787	5,200			5,200		
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	**2,247,787**	**5,200**			**5,200**		

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

CERTIFICATION

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

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

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

SIGNATURE

Marc Lieberman
PRINTED NAME

Asst. Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____ 2010

Signature of Notary

Seal

SIGNATURE

Mark Fawcett
PRINTED NAME

Vice President & Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of April 2010

C. Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

Marc Lieberman
PRINTED NAME

Asst. Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____2010

Signature of Notary

Seal

SIGNATURE

Mark Fawcett
PRINTED NAME

Vice President & Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 14 day of April 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE

PRINTED NAME Marc Lieberman

PRINTED TITLE Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____2010

Signature of Notary

Seal

SIGNATURE

PRINTED NAME Mark Fawcett

PRINTED TITLE Vice President & Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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

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

Criterion 1110.230 - Project Purpose, Background and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

PURPOSE OF PROJECT

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

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

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

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

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

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

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

NOTE: The description of the "Purpose of the Project" should not exceed one page in length. Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ALTERNATIVES

Document **ALL** of the alternatives to the proposed project:

Examples of alternative options 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

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, 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.

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

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

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

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

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

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

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

PROJECT SERVICES UTILIZATION: ***NOT APPLICABLE – UTILIZATION STANDARDS APPLY***

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.

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

UNFINISHED OR SHELL SPACE: ***NOT APPLICABLE – THERE IS NO UNFINISHED SHELL SPACE***

Provide the following information:

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

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

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

4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data are available; and

b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-15, 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-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. - CATEGORY OF SERVICE - REVIEW CRITERIA

1. This Section is applicable to all projects proposing establishment, expansion or modernization of **ALL categories of service that are subject to CON review**, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960], WITH THE EXCEPTION OF:
   - General Long Term Care;
   - Subacute Care Hospital Model;
   - Postsurgical Recovery Care Center Alternative Health Care Model;
   - Children's Community-Based Health Care Center Alternative Health Care Model; and
   - Community-Based Residential Rehabilitation Center Alternative Health Care Model.

   If the project involves any of the above-referenced categories of service, refer to " SECTION VIII.- Service Specific Review Criteria" for applicable review criteria, and submit all necessary documentation for each service involved..

2. READ THE APPLICABLE REVIEW CRITERIA FOR EACH OF THE CATEGORIES OF SERVICE INVOLVED. **[Refer to SECTION VIII regarding the applicable criteria for EACH action proposed, for EACH category of service involved.]**

3. **After identifying the applicable review criteria for each category of service involved (see the charts in Section VIII), provide the following information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:**

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:**
   Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

   Planning Area HSA 2

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFSRB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
In-center Hemodialysis	9	Need 6	80%
		(see Attachment – 19)	

Using the formatting above:

2. Indicate the number of beds/stations/key rooms proposed for each category of service.

3. Document that the proposed number of beds/stations/key rooms is in conformance with the projected deficit specified in 77 Ill. Adm. Code 1100.

4. Document that the proposed number of beds/stations/key rooms will be in conformance with the applicable occupancy/utilization standard(s) specified in Ill. Adm. Code 1100.

B. Planning Area Need - Service to the Planning Area Residents:

1. If establishing or expanding beds/stations/key rooms, document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

2. If expanding an existing category of service, provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, document that at least 50% of the projected patient volume will be from residents of the

area.

3. If expanding an existing category of service, submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

APPEND DOCUMENTATION AS ATTACHMENT -19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Service Demand - Establishment of Category of Service

Document "Historical Referrals" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Referrals
   If the applicant is an existing facility, document the number of referrals for the last two years for each category of service, as formatted below:

EXAMPLE:

Year	CY or FY	Category of Service	Patient Origin by Zip Code	Name & Specialty of Referring Physician	Name & Location of Recipient Hospital
2008	CY	Medical/Surgical	62761 [Patient Initials]	Dr. Hyde	Wellness Hospital

2. Projected Referrals
   An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in Criterion 1110.530(b)(3)

3. Project Service Demand - Based on Rapid Population Growth ***NOT APPLICABLE***

   If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the Criterion titled "Project Service Demand - Based on Rapid Population Growth".

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Service Demand - Expansion of an Existing Category of Service ***NOT APPLICABLE – ESTABLISHING A CATEGORY OF SERVICE***

Document "Historical Service Demand" and **either** "Projected Referrals" or "Project Service Demand - Based on Rapid Population Growth" :

1. Historical Service Demand

Category of Service	Board Occupancy/Utilzation Standards	Year One Indicate CY or FY	Year Two Indicate CY or FY
	[Indicate standards for the planning area.]		

a. As formatted above, document that the average annual occupancy/utilization rate has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years;

b. If patients have been referred to other facilities in order to receive the subject services, provide documentation of the referrals, including: patient origin by zip code; name and specialty of referring physician; and name and location of the recipient hospital, for each of the latest two years

2. Projected Referrals
An applicant proposing to establish a category of service or establish a new hospital shall submit physician referral letters containing ALL of the information outlined in subsection(b)(4) of the criteria for the subject service(s).

3. Projected Service Demand – Based on Rapid Population Growth ***NOT APPLICABLE***

If a projected demand for service is based upon rapid population growth in the applicant facility's existing market area (as experienced annually within the latest 24-month period), the projected service demand must be determined, as specified in the criterion titled "Projected Service Demand-Based on Rapid Population Growth" of the criteria for the subject service(s).

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Service Accessibility - Service Restrictions

1. The applicant shall document that at least one of the factors listed in subsection (b)(5) of the criteria for subject service(s) exists in the planning area.

2. Provide documentation, as applicable, listed in subsection (b)(5) of the criteria for the subject service(s), concerning existing restrictions to service access:

APPEND DOCUMENTATION AS ATTACHMENT-22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Unnecessary Duplication/Maldistribution

1. Document that the project will not result in an unnecessary duplication, and provide the following information:

a. A list of all zip code areas that are located, in total or in part, within 30 minutes normal travel time of the project's site;

b. The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois); and

c. The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide the categories of bed service that are proposed by the project.

2. Document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, beds and services characterized by such factors as presented in subsection (c)(1) and (2) of the criteria for the subject service(s)..

3. Document that, within 24 months after project completion, the proposed project:

   A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

   B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

APPEND DOCUMENTATION AS ATTACHMENT-23, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Category of Service Modernization ***NOT APPLICABLE - RELOCATION***

1. Document that the inpatient beds areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, citing factors, as listed in subsection (d)(1) of the criteria for the subject service(s), but not limited to the reasons cited in the rule.

2. Provide the following documentation of the need for modernization:

   A. the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports;
   B. the most recent Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports;

3. Include other documentation, as applicable to the factors cited above:

   A. Copies of maintenance reports;
   B. Copies of citations for life safety code violations; and
   C. Other pertinent reports and data.

4. Provide the annual occupancy/utilization for each category of service to be modernized, for each of the last three years.

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

H. Staffing Availability

1. For each category of service, document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met.

2. Provide the following documentation:

   a. The name and qualification of the person currently filling the position, if applicable; and
   b. Letters of interest from potential employees; and
   c. Applications filed for each position; and
   d. Signed contracts with the required staff; or
   e. A narrative explanation of how the proposed staffing will be achieved.

APPEND DOCUMENTATION AS ATTACHMENT-25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE

APPLICATION FORM.

I. Performance Requirements

READ the subsection titled "Performance Requirements" for the subject service(s).

K. Assurances

Submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after project completion, the applicant will achieve and maintain the occupancy/utilization standards specified in 77 Ill. Adm Code 1100 for each category of service involved in the proposal.

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

B. G. Criterion 1110.1430 - In-Center Hemodialysis

1. In addition to addressing the Review Criteria for ALL category of service projects, applicants proposing to establish, expand and/or modernize In-Center Hemodialysis must submit the following information:

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

Category of Service	# Existing Stations	# Proposed Stations	# to Establish	# to Expand	# to Modernize
■ In-Center Hemodialysis	8	9		1	

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

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

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

APPEND DOCUMENTATION for "Support Services", Minimum Number of Stations" and Continuity of Care", AS ATTACHMENT-31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

T. Financial Feasibility

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

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN)

Does the applicant (or the entity that is responsible for financing the project or is responsible for assumin applicant's debt obligations in case of default) have a bond rating of "A" or better?
Yes ☐ No ■.

If yes is indicated, submit proof of the bond rating of "A" or better (that is less than two years old) from Fitch's, Moody's or Standard and Poor's rating agencies and go to Section XXVI. **If no is indicated, submit the most recent three years' audited financial statements including the following:**

1. **Balance sheet**
2. **Income statement**
3. **Change in fund balance**
4. **Change in financial position**

A. Criterion 1120.210(a), Financial Viability

1. Viability Ratios

If proof of an "A" or better bond rating has not been provided, read the criterion and complete the following table providing the viability ratios for the most recent three years for which audited financial statements are available. Category B projects must also provide the viability ratios for the first full fiscal year after project completion or for the first full fiscal year when the project achieves or exceeds target utilization (per Part 1100), whichever is later.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:	*2008*	*2007*	*2006*	*2012*
Current Ratio	*1.2*	*1.0*	*0.7*	*1.1*
Net Margin Percentage	*7.6%*	*7.3%*	*5.8%*	*6.7%*
Percent Debt to Total Capitalization	*39.5%*	*41.9%*	*41.8%*	*34.9%*
Projected Debt Service Coverage	*(.01)*	*0.02*	*0.02*	*0*
Days Cash on Hand	*7.2*	*10*	*6.416*	*6.4*
Cushion Ratio	*.65*	*1.09*	*0.55*	*0.11*

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. Insert the worksheets after this page.

2. Variance

Compare the viability ratios provided to the Part 1120 Appendix A review standards. If any of the standards for the applicant or for any co-applicant are not met, provide documentation that a person or organization will assume the legal responsibility to meet the debt obligations should the applicant default. The person or organization must demonstrate compliance with the ratios in Appendix A when proof of a bond rating of "A" or better has not been provided.

REVIEW CRITERIA RELATING TO FINANCIAL FEASIBILITY (FIN) (continued)

B. Criterion 1120.210(b), Availability of Funds

If proof of an "A" or better bond rating has not been provided, read the criterion and document that sufficient resources are available to fund the project and related costs including operating start-up costs and operating deficits. Indicate the dollar amount to be provided from the following sources:

1,060,000 Cash & Securities
Provide statements as to the amount of cash/securities available for the project. Identify any security, its value and availability of such funds. Interest to be earned or depreciation account funds to be earned on any asset from the date of application submission through project completion are also considered cash.

N/A Pledges
For anticipated pledges, provide a letter or report as to the dollar amount feasible showing the discounted value and any conditions or action the applicant would have to take to accomplish goal. The time period, historical fund raising experience and major contributors also must be specified.

N/A Gifts and Bequests
Provide verification of the dollar amount and identify any conditions of the source and timing of its use.

1,187,787 Debt Financing (indicate type(s)Lease for premises & equipment)
For general obligation bonds, provide amount, terms and conditions, including any anticipated discounting or shrinkage) and proof of passage of the required referendum or evidence of governmental authority to issue such bonds;
For revenue bonds, provide amount, terms and conditions and proof of securing the specified amount;
For mortgages, provide a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated;
For leases, provide a copy of the lease including all terms and conditions of the lease including any purchase options.

N/A Governmental Appropriations
Provide 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, provide a resolution or other action of the governmental unit attesting to such future funding.

N/A Grants
Provide a letter from the granting agency as to the availability of funds in terms of the amount, conditions, and time or receipt.

N/A Other Funds and Sources
Provide verification of the amount, terms and conditions, and type of any other funds that will be used for the project.

$2,247,787 TOTAL FUNDS AVAILABLE

C. Criterion 1120.210(c), Operating Start-up Costs

If proof of an "A" or better bond rating has not been provided, indicate if the project is classified as a Category B project that involves establishing a new facility or a new category of service? Yes ☐ No ☐. If yes is indicated, read the criterion and provide in the space below the amount of operating start-up costs (the same as reported in Section I of this application) and provide a description of the items or components that comprise the costs. Indicate the source and amount of the financial resources available to fund the operating start-up costs (including any initial operating deficit) and reference the documentation that verifies sufficient resources are available.

APPEND DOCUMENTATION AS ATTACHMENT 75, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

U. Economic Feasibility

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

SECTION XXVI. REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON)

A. Criterion 1120.310(a), Reasonableness of Financing Arrangements

Is the project classified as a Category B project? Yes ■ No □. If no is indicated this criterion is not applicable. If yes is indicated, has proof of a bond rating of "A" or better been provided? Yes □ No ■ If yes is indicated this criterion is not applicable, go to item B. If no is indicated, read the criterion and address the following:

Are all available cash and equivalents being used for project funding prior to borrowing? ■ Yes □ No

If no is checked, provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following:

1. a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order that the current ratio does not fall below 2.0 times; or
2. 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. Criterion 1120.310(b), Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

B. Criterion 1120.310(c), Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ESRD		131.00			5,200			681,200	681,200
Contingency		13.08			5,200			68,000	68,000
TOTALS		144.08			5,200			749,200	749,200

* Include the percentage (%) of space for circulation

2. For each piece of major medical equipment included in the proposed project, the applicant must certify one of the following:

REVIEW CRITERIA RELATING TO ECONOMIC FEASIBILITY (ECON) (continued)

a. that the lowest net cost available has been selected; or

b. that the choice of higher cost equipment is justified due to such factors as, but not limited to, maintenance agreements, options to purchase, or greater diagnostic or therapeutic capabilities.

3. List the items and costs included in preplanning, site survey, site preparation, off-site work, consulting, and other costs to be capitalized. If any project line item component includes costs attributable to extraordinary or unusual circumstances, explain the circumstances and provide the associated dollar amount. When fair market value has been provided for any component of project costs, submit documentation of the value in accordance with the requirements of Part 1190.40.

D. Criterion 1120.310(d), Projected Operating Costs

Read the criterion and provide in the space below the facility's projected direct annual operating costs (in current dollars per equivalent patient day or unit of service, as applicable) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. If the project involves a new category of service, also provide the annual operating costs for the service. Direct costs are the fully allocated costs of salaries, benefits, and supplies. Indicate the year for which the projected operating costs are provided.

E. Criterion 1120.310(e), Total Effect of the Project on Capital Costs

Is the project classified as a category B project? Yes ■ No □. If no is indicated, go to item F. If yes is indicated, provide in the space below the facility's total projected annual capital costs as defined in Part 1120.130(f) (in current dollars per equivalent patient day) for the first full fiscal year of operation after project completion or for the first full fiscal year when the project achieves or exceeds target utilization pursuant to 77 Ill. Adm. Code 1100, whichever is later. Indicate the year for which the projected capital costs are provided.

F. Criterion 1120.310(f), Non-patient Related Services *NOT APPLICABLE*

Is the project classified as a category B project and involve non-patient related services? Yes □ No □. If no is indicated, this criterion is not applicable. If yes is indicated, read the criterion and document that the project will be self-supporting and not result in increased charges to patients/residents or that increased charges are justified based upon such factors as, but not limited to, a cost benefit or other analysis that demonstrates the project will improve the applicant's financial viability.

APPEND DOCUMENTATION AS ATTACHMENT -76, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SAFETY NET IMPACT STATEMENT that describes all of the following: ***NOT APPLICABLE***

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

APPEND DOCUMENTATION AS ATTACHMENT-77, 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 attachments included as part of the project's application for permit:

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Co - Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: *Renal Care Group, Inc.*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Rice Powell*
CEO Address: *920 Winter Street, Waltham, MA 02541*
Telephone Number: *781-669-9000*

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

Type of Ownership

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

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

Co - Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: *Fresenius Medical Care Holdings, Inc.*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Rice Powell*
CEO Address: *920 Winter Street, Waltham, MA 02541*
Telephone Number: *781-669-9000*

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

Type of Ownership

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

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

ATTACHMENT – 1

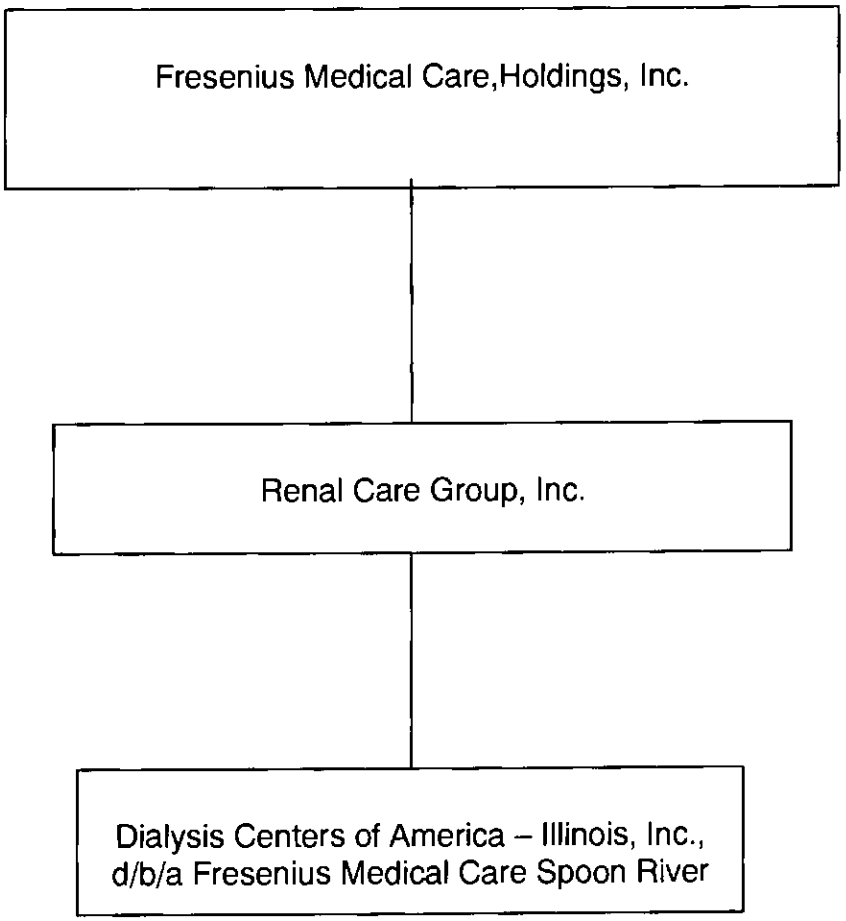
Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Graham Hospital*
Address of Site Owner: *210 W. Walnut Street, Canton, IL 61520*
Street Address or Legal Description of Site: *175 N. Main Street, Canton, IL 61520*

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

Organization Structure For
Dialysis Centers of America – Illinois, Inc.



ATTACHMENT - 3

File Number 5829-168-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

DIALYSIS CENTERS OF AMERICA-ILLINOIS, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 11, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, 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* 22ND *day of* APRIL *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1011201902

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

ATTACHMENT - 3

Illinois Historic Preservation Agency

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Fulton County
Canton
CON - Relocation of Dialysis Clinic
175 S. Main St.
IHPA Log #002032410

April 5, 2010

Lori Wright
Fresenius Medical Care
One Westbrook Corporate Center, Suite 1000
Westchester, IL 60154

Dear Ms. Wright:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

2. Project Outline

In the chart below, indicate the proposed action(s) for each clinical service area involved by writing the number of beds, stations or key rooms involved:

Clinical Service Areas	Establish	Expand	Modernize	Discontinue	No. of Beds, Stations or Key Rooms
Medical/Surgical, Obstetric, Pediatric and Intensive Care					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
Open Heart Surgery					
Cardiac Catheterization					
In-Center Hemodialysis	9	1		8	9
Non-Hospital Based Ambulatory Surgery					
General Long Term Care					
Specialized Long Term Care					
Selected Organ Transplantation					
Kidney Transplantation					
Subacute Care Hospital Model					
Post Surgical Recovery Care Center					
Children's Community-Based Health Care Center					
Community-Based Residential Rehabilitation Center					
Long Term Acute Care Hospital Bed Projects					
Clinical Service Areas Other Than Categories of Service:					
• Surgery					
• Ambulatory Care Services (organized as a service)					
• Diagnostic & Interventional Radiology/Imaging					
• Therapeutic Radiology					
• Laboratory					
• Pharmacy					
• Occupational Therapy					
• Physical Therapy					
• Major Medical Equipment					
Freestanding Emergency Center Medical Services					
Master Design and Related Projects					
Mergers, Consolidations and Acquisitions					

SUMMARY OF PROJECT COSTS

Modernization Contracts

General Conditions	34,060
Temp Facilities, Controls, Cleaning, Waste Management	1,703
Concrete	8,719
Masonry	10,354
Metal Fabrications	5,109
Carpentry	59,877
Thermal, Moisture & Fire Protection	12,125
Doors, Frames, Hardware, Glass & Glazing	46,662
Walls, Ceilings, Floors, Painting	110,014
Specialities	8,515
Casework, Fl Mats & Window Treatments	4,087
Piping, Sanitary Waste, HVAC, Ductwork, Roof Penetrations	217,984
Wiring, Fire Alarm System, Lighting	131,335
Miscelleanous Construction Costs	30,654
Total	**681,200**

Contingencies

Contingencies **$68,000**

Architectural/Engineering

Architecture/Engineering Fees **$70,800**

ATTACHMENT - 7

Movable or Other Equipment

Water Treatment Equipment	55,176
Dialysis Equipment	22,810
Office Furniture & Equipment	76,785
Facility Automation	18,725
TVs & Accessories	46,260
Telephones	6,853
Generator	11,348
Other (Drains, etc.)	2,043
Total	**240,000**

Fair Market Value Leased Space & Equipment

FMV Leased Space (5,200 GSF)		$1,048,637
FMV Leased Dialysis Machines		139,150
FMV Leased Computers		4,900
	Total	**$1,192,687**

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. 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**
CLINICAL	2,247,787	5,200			5,200		
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	2,247,787	5,200			5,200		
NON CLINICAL							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	**2,247,787**	**5,200**			**5,200**		

ATTACHMENT - 8

1110.130 – DISCONTINUATION

General Information Requirements

Dialysis Centers of America – Illinois, Inc. proposes to discontinue its 8-station ESRD facility located at 210 W. Walnut Street, Canton, on the campus of Graham Hospital. In conjunction with this discontinuation we will establish a replacement 9-station ESRD facility at 175 S. Main Street, Canton, which is the Graham Hospital Professional Building. This is essentially a relocation of the existing facility and an addition of one station to be designated as an isolation station.

The discontinuation is expected to occur simultaneously with the opening of the proposed new facility at 175 S. Main Street. The expected date is approximately January 1, 2012. All current patients are expected to transfer to the new facility and therefore all medical records will be transferred to the new site as well. There will be no break in service to the patients involved. The evacuated space at 210 W. Walnut Street is going to be released back to Graham Hospital to be renovated with an expansion of its outpatient services department.

Reasons for Discontinuation

The Spoon River facility is located in an older section of Graham Hospital and the Hospital has plans to renovate this section to expand its growing outpatient services department. The Hospital has offered us space at its Graham Professional Building at 175 Main Street in Canton.

Impact On Access

It is determined that the "relocation" of the Spoon River a few blocks away to another site in Canton, will not have any impact on any area ESRD facility. A written request for an impact statement was not sent to any area ESRD facility considered to be within 45 minutes travel time, because there is only one facility within this travel time, which is Fresenius Medical Care Pekin. The relocation of the Spoon River facility will not have an impact on the Pekin facility.

IMPACT ON ACCESS STATEMENT PER PART 1110.130

The proposed discontinuation of the Fresenius Medical Care – RCG Spoon River 8-station end stage renal disease (ESRD) facility will not have an adverse effect upon access to care for the residents of the healthcare market area in which it is situated. Along with this discontinuation, a replacement 9-station ESRD facility will be established at 175 Main Street, Canton. The Spoon River facility, which is currently located in Canton, is essentially being relocated approximately one block away with one station being added that is to be an isolation station. All current patients are expected to transfer to the replacement facility. There will be no break in service to these patients.

A written request for an impact statement was not sent to the other ESRD providers within 45 minutes travel time due to the fact that there is only one facility within that range, Fresenius Medical Care Pekin. There will be no adverse impact to this facility due to its distance from Canton. The Canton patients do not drive to Pekin for treatment.

Date: 4/9/2010

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 9th DAY
OF April, 2010.

NOTARY PUBLIC

OFFICIAL SEAL
MICHELLE M HOGAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:01/12/13

ATTACHMENT - 9

Certification & Authorization

Dialysis Centers of America - Illinois, Inc.

In accordance with Section III, A (2) of the Illinois Health Facilities Planning Board Application for Certificate of Need; I do hereby certify that no adverse actions have been taken against Dialysis Centers of America - Illinois, Inc. by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
~~Vice President & Treasurer~~

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
MY COMM. EXPIRES AUG. 1, 2014
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

ATTACHMENT - 10

Certification & Authorization

Renal Care Group, Inc.

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

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

By: _____
Mark Fawcett
Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2010

_____
Signature of Notary

Seal

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C. Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

ATTACHMENT - 10

Certification & Authorization

Fresenius Medical Care Holdings, Inc.

In accordance with Section III, A (2) of the Illinois Health Facilities Planning Board Application for Certificate of Need; I do hereby certify that no adverse actions have been taken against Fresenius Medical Care Holdings, Inc. by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
Vice President & Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
MY COMM. EXPIRES AUG. 1, 2014
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

ATTACHMENT - 10

Fresenius Medical Care Holdings, Inc. Clinics in Illinois

Clinic	Provider #	Address	City	Zip
Alsip	14-2630	12250 S. Cicero Ave Ste. #105	Alsip	60803
Antioch	14-2673	311 Depot St., Ste. H	Antioch	60002
Aurora	14-2515	455 Mercy Lane	Aurora	60506
Austin Community	14-2653	4800 W. Chicago Ave., 2nd Fl.	Chicago	60651
Berwyn	14-2533	2601 S. Harlem Avenue, 1st Fl.	Berwyn	60402
Blue Island	14-2539	12200 S. Western Avenue	Blue Island	60406
Bolingbrook	14-2605	538 E. Boughton Road	Boilingbrook	60440
Bridgeport	14-2524	825 W. 35th Street	Chicago	60609
Burbank	14-2641	4811 W. 77th Street	Burbank	60459
Carbondale	14-2514	725 South Lewis Lane	Carbondale	62901
Champaign (managed)	14-2588	1405 W. Park Street	Champaign	61801
Chatham		S. Holland Avenue	Chicago	60633
Chicago Dialysis	14-2506	820 West Jackson Blvd.	Chicago	60607
Chicago Westside	14-2681	1340 S. Damen	Chicago	60608
Congress Parkway	14-2631	3410 W. Van Buren Street	Chicago	60624
Crestwood	14-2538	4861-73 W. Cal Sag Road	Crestwood	60445
Decatur East	14-2503	1830 S. 44th St.	Decatur	62521
Deerfield		405 Lake Cook Road	Deefield	60015
Downers Grove	14-2503	3825 Highland Ave., Ste. 102	Downers Grove	60515
DuPage West	14-2509	450 E. Roosevelt Rd., Ste. 101	West Chicago	60185
DuQuoin	14-2595	#4 West Main Street	DuQuoin	62832
East Belmont	14-2531	1331 W. Belmont	Chicago	60613
East Peoria	14-2562	3300 North Main Street	East Peoria	61611
Elgin		2130 Point Boulevard	Elgin	60123
Elk Grove	14-2507	901 Biesterfield Road	Elk Grove	60007
Evanston	14-2621	2953 Central Street	Evanston	60201
Evergreen Park	14-2545	9730 S. Western Avenue	Evergreen Park	60805
Garfield	14-2555	5401 S. Wentworth Ave.	Chicago	60609
Glendale Heights	14-2617	520 E. North Avenue	Glendale Heights	60139
Glenview	14-2551	4248 Commercial Way	Glenview	60025
Greenwood	14-2601	1111 East 87th St., Ste. 700	Chicago	60619
Gurnee	14-2549	101 Greenleaf	Gurnee	60031
Hazel Crest	14-2607	17524 E. Carriageway Dr.	Hazel Crest	60429
Hoffman Estates	14-2547	3150 W. Higgins, Ste. 190	Hoffman Estates	60195
Jackson Park	14-2516	7531 South Stony Island Ave.	Chicago	60649
Kewanee	14-2578	230 W. South Street	Kewanee	61443
Lake Bluff	14-2669	101 Waukegan Rd., Ste. 700	Lake Bluff	60044
Lakeview	14-2679	4008 N. Broadway, St. 1200	Chicago	60613
Lockport		Thornton Avenue	Lockport	60441
Lombard		1940 Springer Drive	Lombard	60148
Lutheran General	14-2559	8565 West Dempster	Niles	60714
Macomb	14-2591	523 E. Grant Street	Macomb	61455
Marquette Park	14-2566	6515 S. Western	Chicago	60636
McLean Co	14-2563	1505 Eastland Medical Plaza	Bloomington	61704
McHenry	14-2672	4312 W. Elm St.	McHenry	60050
Melrose Park	14-2554	1111 Superior St., Ste. 204	Melrose Park	60160
Merrionette Park	14-2667	11630 S. Kedzie Ave.	Merrionette Park	60803
Metropolis	14-2705	20 Hospital Drive	Metropolis	62960
Midway		6201 W. 63rd Street	Chicago	60638
Mokena	14-2689	8910 W. 192nd Street	Mokena	60448
Morris	14-2596	1401 Lakewood Dr., Ste. B	Morris	60450
Naperville	14-2543	100 Spalding Drive Ste. 108	Naperville	60566
Naperville North	14-2678	516 W. 5th Ave.	Naperville	60563
Niles	14-2500	7332 N. Milwaukee Ave	Niles	60714
Norridge	14-2521	4701 N. Cumberland	Norridge	60656
North Avenue	14-2602	805 W. North Avenue	Melrose Park	60160
North Kilpatrick	14-2501	4800 N. Kilpatrick	Chicago	60630
Northwestern University	14-2597	710 N. Fairbanks Court	Chicago	60611
Oak Park	14-2504	773 W. Madison Street	Oak Park	60302
Orland Park	14-2550	9160 W. 159th St.	Orland Park	60462
Oswego	14-2677	1051 Station Drive	Oswego	60543
Ottawa	14-2576	1601 Mercury Court	Ottawa	61350
Palatine		Dundee Road	Palatine	60074

ATTACHMENT - 10

Pekin	14-2571	600 S. 13th Street	Pekin	61554
Peoria Downtown	14-2574	410 R.B. Garrett Ave.	Peoria	61605
Peoria North	14-2613	10405 N. Juliet Court	Peoria	61615
Plainfield	14-2707	2300 Michas Drive	Plainfield	60544
Polk	14-2502	557 W. Polk St.	Chicago	60607
Pontiac	14-2611	804 W. Madison St.	Pontiac	61764
Prairie	14-2569	1717 S. Wabash	Chicago	60616
Randolph County	14-2589	102 Memorial Drive	Chester	62233
Rockford	14-2615	1302 E. State Street	Rockford	61104
Rogers Park	14-2522	2277 W. Howard St.	Chicago	60645
Rolling Meadows	14-2525	4180 Winnetka Avenue	Rolling Meadows	60008
Roseland	14-2690	135 W. 111th Street	Chicago	60628
Ross-Englewood	14-2670	6333 S. Green Street	Chicago	60621
Round Lake	14-2616	401 Nippersink	Round Lake	60073
Sandwich	14-2700	1310 Main Street	Sandwich	60548
Saline County	14-2573	275 Small Street, Ste. 200	Harrisburg	62946
Skokie	14-2618	9801 Wood Dr.	Skokie	60077
South Chicago	14-2519	9200 S. Chicago Ave.	Chicago	60617
South Holland	14-2542	17225 S. Paxton	South Holland	60473
South Shore	14-2572	2420 E. 79th Street	Chicago	60649
South Side	14-2508	3134 W. 76th St.	Chicago	60652
South Suburban	14-2517	2609 W. Lincoln Highway	Olympia Fields	60461
Southwestern Illinois	14-2535	Illinois Rts 3&143, #7 Eastgate Plz.	East Alton	62024
Spoon River	14-2565	210 W. Walnut Street	Canton	61520
Spring Valley	14-2564	12 Wolfer Industrial Drive	Spring Valley	61362
Steger		34th Street	Steger	60475
Streator	14-2695	2356 N. Bloomington Street	Streator	61364
Uptown	14-2692	4720 N. Marine Dr.	Chicago	60640
Villa Park	14-2612	200 E. North Ave.	Villa Park	60181
West Batavia		Branson Drive	Batavia	60510
West Belmont	14-2523	4848 W. Belmont	Chicago	60641
West Chicago	14-2702	1855-1863 N. Neltnor	West Chicago	60185
West Metro	14-2536	1044 North Mozart Street	Chicago	60622
West Suburban	14-2530	518 N. Austin Blvd., Ste. 5000	Oak Park	60302
Westchester	14-2520	2400 Wolf Road, STE 101A	Westchester	60154
Williamson County	14-2627	900 Skyline Drive, Ste. 200	Marion	62959
Willowbrook	14-2632	6300 S. Kingery Hwy, STE 408	Willowbrook	60527

Criterion 1110.230 – Purpose of Project

The purpose of this project is to keep access available to life-sustaining dialysis services to the Canton market area by relocating the current Fresenius Spoon River dialysis facility to another site also located in Canton at 175 Main Street.

This facility was established approximately twenty years ago in leased space at Graham Hospital in Canton. The facility is located in an older section of the building and the Hospital has plans to renovate this section to expand its growing outpatient services department. The Hospital has offered us space at its Graham Professional Building at 175 Main Street in Canton.

Due to the fact that there are no other dialysis facilities within 30 minutes travel time of Canton, Fresenius Medical Care's goal is to relocate this facility to keep dialysis services accessible to this rural patient population.

The purpose of adding an additional station is to allow this market area access to isolation treatment currently available only in Peoria, almost an hour away. When a hepatitis B positive patient requires dialysis they must, according to CMS Guidelines, be treated in an isolation station. This is a station separated from the other stations to prohibit cross contamination to other patients.

There is no direct empirical evidence relating to this project other than that when chronic care patients have adequate access to services, it tends to reduce overall healthcare costs and results in less complications. The quality outcomes for the Spoon River facility for the past year have been above the State standard:

- 95.45% of patients had a URR $\geq$ 65%
- 95.45% of patients had a Kt/V $\geq$ 1.2

Alternatives

- The alternative of doing nothing was not considered. The landlord at our current site, Graham Hospital, is asking us to vacate our space. The Hospital has plans to renovate the space to enlarge their outpatient services department. They have offered us an alternative space to lease in the Graham Professional Building at 175 Main Street in Canton.

- The alternative of using area facilities was not considered due to the fact that the nearest facility, Fresenius Medical Care Pekin, is 38 minutes away. There are no facilities within 30 minutes of Canton. There is no monetary cost associated with the alternative of using area facilities. The cost to the healthcare system as far as Medicare and Medicaid are concerned remains the same regardless of where the patient dialyzes since the reimbursement does not change.

- Our first alternative was to relocate only the 8 stations and not add the isolation station. The cost for this would only be about $45,000 less than the current project. While this is alternative could be feasible, the issue of needing a station for isolation patients is evident. Any patient that is Hepatitis B positive has to dialyze in an isolation or separation station. This is a station that is separated from the other stations to eliminate cross contamination to other patients. Currently Hepatitis B positive patients have to drive almost an hour away to Peoria for treatment.

- A second alternative would be to relocate the 8 stations and make one of the 8 into an isolation station. However due to the way rural facilities tend to operate their daily schedules; this alternative was determined not to be feasible.

    - Utilization of a dialysis clinic is calculated on a facility running 3 shifts a day, six days a week. Most rural facilities do not operate the 3rd shift of the day. They operate 2 shifts a day, 6 days a week. The reason for this is transportation problems which are unique to rural areas. The 3rd shift begins in the late afternoon and ends after dark except in the summer months. Patients in these areas tend to drive long distances to treatment on desolate, unlit country roads. This in itself is difficult for a dialysis patient who is often elderly and ill. In inclement weather the risk is even greater. As well, county transportation programs do not transport after 4pm. Patients will often forego treatment rather than risk driving at night to dialyze on a 3rd shift.

    - The cost of this alternative would be approximately $25,000 less than the current proposed project. This alternative would not best serve this rural patient population especially those with Hepatitis B.

- The most realistic alternative is to relocate the 8 station Spoon River facility to another site in Canton to keep dialysis accessible for current and future patients and add one station designated to be an isolation station. While according to the Board rules, the Spoon River facility does not meet the utilization standards, per the rules a facility may add 10% or 3 stations every two years without a permit, provided stations have not been added in the previous two years. The Spoon River facility qualifies to add this additional station now, however it seems more prudent to wait and add this station along with the relocation. This alternative will keep dialysis services available in Canton and create access to isolation treatment services. The cost of this project is $2,247,787.

Criterion 1110.234, Size of Project

The total space being leased is 5,200 GSF. The State Standard for a 9 station facility that is being modernized is between 3,240 and 4,680 DGSF. The applicant realizes the size of space being leased is over this amount by 520 GSF. A suitable site for a medical facility was not available in Canton within the State Standard.

While the size may be slightly over, the extra space is needed because a 9 station ESRD facility is relatively small; however the support space (offices, staff areas, storage, waiting room etc.) is virtually the same for a 9 station facility as it would be for a 10 or 12 station facility. As a result, the non-direct patient care space (which constitutes 75-80% of a facility's total) is distributed over fewer stations, resulting in a higher square footage/station ratio.

The Spoon River facility will also include an isolation station, which takes up about 60% more space than a non-isolation station. This space for an isolation station includes walls, door, 2 sinks and 2 cabinets.

Planning Area Need – Service To Planning Area Residents:

A. Planning Area Need - Formula Need Calculation:

1. **Complete the requested information for each category of service involved:** Refer to 77 Ill. Adm. Code 1100 for information concerning planning areas, bed/station/key room deficits and occupancy/utilization standards.

Planning Area *HSA 2*

Category of Service	No. of Beds/Stations/Key Rooms Proposed	HFPB Inventory Need or Excess	Part 1100 Occupancy/Utilization Standard
In-center Hemodialysis	*9**	*Need 6*	*80%*

*8 stations already exist; the applicant is proposing adding one station for a total of 9. This would result in only one station being added to the inventory.

B. Planning Area Need – Service To Planning Area Residents:

1.The primary purpose of this project is to provide in-center hemodialysis services to the residents of East Fulton County in HSA 2. Since it is near the border of the counties and HSAs there will be some patients coming from HSA 3, Mason County as well.

County	HSA	Current Spoon River patients and pre-ESRD	
Fulton	2	55	
Peoria	2	5	94%
Mason	3	4	6%

2. Admissions to Fresenius Medical Care Spoon River for the past 12 months were residents of HSA 2.

Zip Code	HSA	# Patients
61520	2	2
61529	2	1
61531	2	2

C. Service Demand – Establishment of a Category of Service

1. Historical Referrals:

Year	CY or FY	Category of Service	Patient Origin by Zip Code	Name & Specialty of Referring Physician	Name & Location of Recipient Hospital
2008	CY	ESRD	61520	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61553	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	62644	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61520	Dr. Olsson/Nephrologist	Fresenius Spoon River
2008	CY	ESRD	61531	Dr. Olsson/Nephrologist	Fresenius Spoon River
2009	CY	ESRD	61542	Dr. Olsson/Nephrologist	Fresenius Spoon River
2009	CY	ESRD	61561	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2009	CY	ESRD	61529	Dr. Dreyer/Nephrologist	Fresenius Spoon River
2009	CY	ESRD	61531	Dr. Olsson/Nephrologist	Fresenius Spoon River
2009	CY	ESRD	61520	Dr. Dreyer/Nephrologist	Fresenius Spoon River

2. Projected Referrals on following pages.

Illinois Kidney Disease & Hypertension Center

Nephrology Associates
Frederick Horvath, Jr., M.D.
Phillip J. Olsson, M.D., F.A.C.P.
Robert T. Sparrow, M.D.
Benjamin R. Pflederer, M.D.
David C. Rosborough, M.D.
Timothy A. Pflederer, M.D.
Paul T. Dreyer, M.D.
Gordon W. James, M.D.
Andrew C. Bland, M.D., F.A.A.P., F.A.C.P.
Robert Bruha, M.D.
Samer B. Sader, M.D.
Anthony R. Horinek, M.D.
Robert A Pflederer, M.D. - Emeritus
R. Kent Bryan, M.D. - Emeritus

Surgery Associates
Beverley L. Ketel, M.D.
Timothy P. O'Connor, M.D., F.A.C.S.

Physician Assistants
Julie A. DeSutter, P.A.-C.
Holly R. Walker, P.A.-C.

Nurse Practitioners
Tonya K. McDougall, M.S.N., F.N.P.
Karen A. Helfers, M.S.N., F.N.P.
Cheryl M. Wiemer, M.S.N., F.N.P.
Judith A. Dansizen, A.P.R.N.-B.C.

Administrator
Beth A. Shaw, MBA

200 E. Pennsylvania Ave., Suite 212
Peoria, IL 61603
Office 309.676.8123
Fax 309.676.8455

1404 Eastland Drive, Suite 103
Bloomington, IL 61701
Office 309.663.4766
Fax 309.663.7238

2355 Broadway Rd.
Pekin, IL 61554

1100 E. Norris Drive
Ottawa, IL 61350

501 E. Grant St.
Macomb, IL 61455

920 West Street
Medical Office Building, Suite 212
Peru, IL 61354

Perry Memorial Hospital
530 Park Avenue East, Suite 306
Princeton, IL 61356

107 Tremont Street
Hopedale, IL 61741

Graham Hospital
210 W. Walnut
1st Floor, Outpatient Clinic
Canton, IL 61520

1315 Memorial Drive
Outpatient Clinic
Mendota, IL 61342

205 South Park
Streator, IL 61364

April 21, 2010

Mr. Dale Galassie
Acting Chair
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Mr. Galassie:

I am a nephrologist in practice with Renal Care Associates (RCA) and am the Medical Director of the Fresenius Spoon River and Pekin dialysis clinics. Due to the fact that the landlord (Graham Hospital) of the Spoon River ESRD facility has asked us to vacate the current space to make room for Hospital renovations, I am in full support of the relocation of this facility to 175 Main Street, also in Canton. I am also excited at the prospect of having the added isolation station located in the Spoon River facility. Currently my patients who are Hepatitis B positive have to drive a long distance to Peoria for treatment. This trip can be in excess of an hour for patients from the Canton area.

Over the past three years (in those facilities listed below) RCA was treating 631 hemodialysis patients at the end of 2007, 625 patients at the end of 2008 and 633 patients at the end of 2009, as reported to The Renal Network. As of the most recent quarter, RCA was treating 678 hemodialysis patients. As well, over the past twelve months RCA has referred 135 patients for dialysis services to Fresenius Spoon River, Pekin, East Peoria, Peoria Downtown, Peoria North, Macomb, Kewanee, Ottawa, McLean County, Pontiac and Spring Valley. I expect that all 30 current patients of Fresenius Medical Care Spoon River facility will relocate to the new site upon its opening. RCA currently has 73 pre-ESRD patients that live in the zip codes surrounding the Canton area. Of these there are 7 that we expect to begin dialysis at Spoon River by the end of 2010. 27 of the patients are expected to begin dialysis therapy in the next one to two years at the Spoon River facility (see attached lists of patients by zip code). The remaining 39 are expected to begin treatment in approximately 3 years. These patients all have lab values indicative of a patient in active kidney failure.

RenalCare Associates, S.C.

ATTACHMENT - 20

The Spoon River facility treats approximately 40 patients a year and has experienced an approximate 25% death rate due to the aging population of the Canton area. As well, the facility has an approximate 5% transplant rate. It is therefore expected that 10-12 current patients of the facility are not expected to continue to require dialysis services by the time the facility is relocated.

Given the increase of pre-ESRD patients seen in our practice and the loss of our current Canton site, I urge the Board to approve the relocation of Fresenius Medical Care Spoon River in order to keep access available to this rural ESRD patient population. Thank you for your consideration.

I attest to the fact that to the best of my knowledge, all the information contained in this letter is true and correct and that the projected referrals in this document were not used to support any other CON application.

Sincerely,

Phillip J. Olsson MD FACP

Phillip Olsson, M.D.

Notarization:
Subscribed and sworn to before me
this 22nd day of April, 2010

Alice J. Musselman

Signature of Notary

Seal

OFFICIAL SEAL
ALICE J. MUSSELMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6-30-2011

ATTACHMENT - 20

Illinois Kidney Disease & Hypertension Center

Nephrology Associates
Frederick Horvath, Jr., M.D.
Phillip J. Olsson, M.D., F.A.C.P.
Robert T. Sparrow, M.D.
Benjamin R. Pflederer, M.D.
David C. Rosborough, M.D.
Timothy A. Pflederer, M.D.
Paul T. Dreyer, M.D.
Gordon W. James, M.D.
Andrew C. Bland, M.D., F.A.A.P., F.A.C.P.
Robert Bruha, M.D.
Samer B. Sader, M.D.
Anthony R. Horinek, M.D.
Robert A. Pflederer, M.D. - Emeritus
R. Kent Bryan, M.D. - Emerito

Surgery Associates
Beverley L. Ketel, M.D.
Timothy P. O'Connor, M.D., F.A.C.S.

Physician Assistants
Julie A. DeSutter, P.A.-C.
Holly R. Walker, P.A.-C.

Nurse Practitioners
Tonya K. McDougall, M.S.N., F.N.P.
Karen A. Helfers, M.S.N., F.N.P.
Cheryl M. Wiemer, M.S.N., F.N.P.
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1404 Eastland Drive, Suite 103
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2355 Broadway Rd.
Pekin, IL 61554

1100 E. Norris Drive
Ottawa, IL 61350

501 E. Grant St.
Macomb, IL 61455

920 West Street
Medical Office Building, Suite 212
Peru, IL 61354

Perry Memorial Hospital
530 Park Avenue East, Suite 306
Princeton, IL 61356

107 Tremont Street
Hopedale, IL 61741

Graham Hospital
210 W. Walnut
1st Floor, Outpatient Clinic
Canton, IL 61520

1315 Memorial Drive
Outpatient Clinic
Mendota, IL 61342

205 South Park
Streator, IL 61364

April 21, 2010

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Acting Chair
Illinois Health Facilities & Services Review Board
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Springfield, IL 62761

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I attest to the fact that to the best of my knowledge, all the information contained in this letter is true and correct and that the projected referrals in this document were not used to support any other CON application.

Sincerely,

Paul Dreyer MD

Paul Dreyer, M.D.

Notarization:
Subscribed and sworn to before me
this 22nd day of April, 2010

Alice J. Musselman

Signature of Notary

Seal

OFFICIAL SEAL
ALICE J. MUSSELMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6-30-2011

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CURRENT SPOON RIVER PATIENTS THAT WILL TRANSFER TO THE NEW SPOON RIVER LOCATION AT 175 MAIN STREET, CANTON UPON OPENING

Zip Code	2010
61427	1
61520	13
61524	1
61529	1
61531	3
61533	3
61542	2
61543	1
61569	1
62644	4
Total	**30**

PRE-ESRD PATIENTS THAT WILL BEGIN DIALYSIS AT SPOON RIVER BY THE END OF 2010

Stage 5			
City	Zip Code	# Patients	Initials
Canton	61520	5	FD
			HE
			PS
			HW
			NW
Cuba	61427	1	DS
Ipava	61441	1	CK
Total		**7**	

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PRE ESRD PATIENTS RCA EXPECTS TO REFER TO FRESENIUS MEDICAL CARE SPOON RIVER IN THE 1ST 2 YEARS (24 MONTHS) AFTER PROJECT COMPLETION

Stage 4			
City	Zip Code	# Patients	Initials
Canton	61520	21	MB
			BB
			RB
			DD
			BE
			KF
			LG
			PH
			EL
			CO
			DP
			HR
			AR
			GS
			PS
			TS
			JT
			ET
			GV
			MH
			DS
Cuba	61427	1	GH
Lewistown	61542	5	WC
			DT
			JH
			RP
	Total	27	

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NEW REFERRALS OF RCA FOR THE PAST TWELVE MONTHS
APRIL 1, 2009 THROUGH MARCH 31, 2010

Spoon River

Zip Code	Pts
61520	2
61529	1
61531	2
	5

Kewanee

Zip Code	Pts
61434	1
	1

Macomb

Zip Code	Pts
61422	2
61455	2
	4

Ottawa

Zip Code	Pts
60518	1
60549	1
61301	1
61341	2
61350	7
61373	1
	13

Pekin

Zip Code	Pts
61554	4
61564	1
61568	1
61603	1
61734	1
61914	1
	9

McLean Co

Zip Code	Pts
60936	1
61701	7
61704	4
61728	1
61740	1
61745	1
61761	8
61842	2
61940	1
	26

East Peoria

Zip Code	Pts
60614	1
61535	1
61548	3
61550	4
61554	2
61561	1
61571	5
61604	1
61610	1
61611	1
61755	2
61832	1
62367	1
	24

Peoria North

Zip Code	Pts
61364	1
61491	1
61546	1
61552	1
61562	1
61603	1
61604	2
61605	2
61614	2
61615	5
61616	3
	20

Peoria Downtown

Zip Code	Pts
60613	1
61523	1
61554	1
61568	1
61603	2
61604	8
61605	11
61607	2
61612	1
61614	3
61616	1
61637	1
	33

Total 135

ATTACHMENT - 20

PATIENTS OF RCA AT YEAR END 2007, 2008, 2009 & 1ST QUARTER 2010
BY FACILITY AND ZIP CODE

Fresenius Medical Care Spoon River

Zip Code	EOY 2007	Zip Code	EOY 2008	Zip Code	EOY 2009	Zip Code	1st QTR 2010
61427	2	61427	1	61427	1	61427	1
61432	1	61520	18	61520	13	61520	13
61477	1	61524	1	61524	1	61524	1
61520	14	61529	1	61529	1	61529	1
61524	1	61531	1	61531	3	61531	3
61529	1	61533	2	61533	3	61533	3
61531	1	61542	1	61542	2	61542	2
61533	3	61543	1	61543	1	61543	1
61542	3	61546	1	61569	1	61569	1
61543	1	61563	1	62644	3	62644	4
61563	1	61569	1	**Total**	**29**	**Total**	**30**
61569	1	62644	2				
61611	1	**Total**	**31**				
62644	2						
Total	**33**						

Fresenius Medical Care East Peoria

Zip Code	EOY 2007	Zip Code	EOY 2008	Zip Code	EOY 2009	Zip Code	1st QTR 2010
60411	1	60611	1	60604	1	60604	1
60555	1	61440	1	60611	1	60611	1
60611	1	61523	1	61348	1	60614	1
61354	1	61537	1	61491	1	61491	1
61401	1	61540	1	61530	1	61530	2
61520	1	61545	1	61535	1	61535	1
61523	2	61546	1	61537	1	61537	1
61530	1	61548	2	61540	1	61540	1
61537	1	61550	7	61548	3	61548	4
61545	1	61554	10	61550	6	61550	10
61547	1	61555	1	61554	6	61554	7
61548	1	61571	12	61561	1	61561	1
61550	7	61603	4	61564	1	61571	15
61554	5	61604	5	61571	17	61603	3
61571	11	61605	7	61603	3	61604	6
61603	4	61610	4	61604	5	61605	7
61604	9	61611	16	61605	7	61610	4
61605	8	61614	4	61610	4	61611	10
61607	1	61615	1	61611	11	61614	3
61610	4	61616	2	61614	4	61615	3
61611	17	61747	1	61615	2	61616	2
61614	2	61761	1	61616	2	61755	2
61616	2	63031	1	61755	2	61832	1
61704	1	**Total**	**85**	61832	1	62650	1
Total	**84**			65775	1	62884	1
				Total	**84**	65775	1
						Total	**90**

ATTACHMENT - 20

Fresenius Medical Care Mclean County

Zip Code	EOY 2007
60154	1
61520	1
61561	1
61701	29
61702	1
61704	14
61705	1
61721	1
61727	2
61728	1
61732	1
61738	3
61748	1
61752	5
61754	1
61761	26
61856	1
65662	1
Total	**91**

Zip Code	EOY 2008
60154	1
60628	1
61561	1
61615	1
61701	24
61702	2
61704	16
61705	1
61721	1
61723	2
61727	1
61729	1
61732	1
61738	2
61745	1
61748	1
61752	7
61753	2
61754	1
61761	25
61842	1
61856	1
61882	1
65662	1
Total	**95**

Zip Code	EOY 2009
20136	1
60936	1
61364	1
61561	1
61701	26
61702	2
61704	13
61705	1
61721	1
61727	1
61730	1
61738	2
61745	2
61748	1
61752	8
61753	1
61761	20
61777	1
61842	2
61856	1
61940	1
65662	1
Total	**89**

Zip Code	1st QTR 2010
60936	1
61561	1
61701	30
61702	2
61704	16
61705	2
61721	1
61727	1
61728	1
61730	1
61738	2
61745	2
61748	2
61752	8
61753	1
61761	22
61777	1
61801	1
61842	2
61856	1
62706	1
Total	**99**

Fresenius Medical Care Pekin

Zip Code	EOY 2007
61483	1
61535	1
61546	2
61554	32
61567	2
61605	1
61607	1
61611	1
61734	3
61759	1
Total	**45**

Zip Code	EOY 2008
61546	5
61554	34
61555	1
61605	1
61607	1
61734	3
61759	1
72712	1
Total	**47**

Zip Code	EOY 2009
61546	5
61554	27
61555	3
61564	1
61568	1
61603	1
61607	1
61734	3
61747	1
61759	1
Total	**44**

Zip Code	1st QTR 2010
61533	1
61546	5
61554	26
61555	3
61564	1
61568	1
61603	1
61607	1
61734	3
61747	1
61759	1
61914	1
Total	**45**

ATTACHMENT - 20

Fresenius Medical Care Kewanee

Zip Code	EOY 2007
61314	1
61361	1
61379	1
61401	1
61421	1
61443	15
61483	2
61491	2
Total	24

Zip Code	EOY 2008
61314	1
61361	1
61379	1
61401	1
61443	16
61483	3
61491	1
Total	24

Zip Code	EOY 2009
61314	1
61356	1
61361	1
61401	1
61434	12
61443	17
61483	2
Total	35

Zip Code	1st QTR 2010
61314	1
61356	1
61361	1
61401	1
61434	2
61443	17
61483	2
Total	25

Fresenius Medical Care Macomb

Zip Code	EOY 2007
61420	1
61422	4
61445	1
61450	1
61455	6
61470	1
61482	1
62326	1
Total	16

Zip Code	EOY 2008
61420	1
61422	3
61445	1
61450	1
61455	6
61470	1
61482	1
61484	1
62311	1
Total	16

Zip Code	EOY 2009
61420	1
61422	4
61445	1
61450	1
61455	8
61482	1
61484	1
62311	1
Total	18

Zip Code	1st QTR 2010
61319	1
61420	1
61422	5
61445	1
61450	1
61455	8
61482	1
61484	1
62311	1
Total	20

Fresenius Medical Care Ottawa

Zip Code	EOY 2007
60518	3
60551	1
61325	2
61341	8
61350	19
61364	16
61371	2
63141	1
Total	52

Zip Code	EOY 2008
60518	2
60551	1
60628	1
61325	2
61341	9
61350	18
61360	1
61364	5
61373	1
Total	40

Zip Code	EOY 2009
60473	1
60518	2
61301	1
61341	9
61350	16
61360	1
61364	2
61373	2
Total	34

Zip Code	1st QTR 2010
60447	1
60450	2
60473	1
60518	3
60549	1
61301	1
61341	10
61342	1
61350	19
61360	1
61364	3
61373	2
Total	45

Fresenius Medical Care Peoria Downtown

Zip Code	EOY 2007
61528	1
61571	1
61602	2
61603	21
61604	29
61605	41
61606	4
61607	1
61610	1
61612	1
61614	7
61615	8
61616	3
Total	**120**

Zip Code	EOY 2008
61571	1
61602	1
61603	18
61604	28
61605	44
61606	5
61607	2
61610	1
61611	1
61612	1
61614	7
61615	7
61616	1
Total	**117**

Zip Code	EOY 2009
60516	1
60613	1
60625	1
61523	1
61528	1
61534	1
61546	2
61550	1
61554	1
61565	1
61571	2
61602	1
61603	17
61604	26
61605	40
61606	6
61607	5
61610	2
61612	1
61614	9
61615	7
61616	3
61637	1
61755	1
Total	**132**

Zip Code	1st QTR 2010
60516	1
60613	1
61484	1
61523	1
61528	1
61534	1
61546	2
61550	1
61554	1
61565	1
61568	1
61571	2
61602	1
61603	17
61604	29
61605	46
61606	6
61607	5
61610	2
61612	1
61614	9
61615	7
61616	3
61637	1
65355	1
Total	**142**

Fresenius Medical Care Peoria North

Zip Code	EOY 2007
60004	1
61491	1
61517	2
61523	6
61525	2
61528	2
61529	1
61540	1
61554	1
61559	1
61561	1
61565	2
61569	1
61571	1
61603	2
61604	10
61605	3
61606	1
61607	3
61611	1
61614	14
61615	10
61616	2
Total	**69**

Zip Code	EOY 2008
60004	1
61443	1
61455	1
61517	2
61523	7
61525	3
61528	1
61540	1
61554	1
61559	1
61603	1
61604	11
61605	2
61606	1
61607	1
61611	1
61614	17
61615	11
61616	1
Total	**65**

Zip Code	EOY 2009
60004	1
61364	1
61455	1
61517	2
61523	6
61525	3
61540	1
61550	1
61552	1
61562	1
61603	3
61604	8
61605	4
61607	2
61611	1
61614	15
61615	15
61616	3
Total	**69**

Zip Code	1st QTR 2010
61364	1
61455	2
61491	1
61517	2
61523	6
61525	3
61540	1
61546	1
61550	1
61552	1
61562	1
61603	2
61604	8
61605	4
61607	1
61614	17
61615	15
61616	5
Total	**72**

ATTACHMENT - 20

Fresenius Medical Care Pontiac

Zip Code	EOY 2007
60420	2
60470	1
60764	1
60921	2
60934	1
60959	1
61319	3
61358	1
61364	2
61674	1
61728	2
61740	4
61753	1
61760	2
61764	14
Total	**38**

Zip Code	EOY 2008
60420	2
61460	1
60466	1
60764	1
60921	3
60934	1
60952	1
61319	3
61728	1
61730	1
61739	1
61740	2
61753	2
61760	2
61764	15
Total	**37**

Zip Code	EOY 2009
60420	2
60460	3
60764	1
60921	3
60934	1
60952	1
61319	2
61728	1
61730	1
61739	2
61740	1
61753	2
61760	2
61764	14
Total	**36**

Zip Code	1st QTR 2010
60420	3
60460	3
60764	1
60921	2
60934	1
60952	1
61319	2
61728	1
61739	4
61740	1
61753	1
61760	2
61764	15
Total	**37**

Fresenius Medical Care Spring Valley

Zip Code	EOY 2007
60440	1
60603	1
61301	9
61312	1
61317	1
61322	2
61327	1
61329	1
61330	1
61335	1
61336	2
61342	2
61348	6
61349	2
61350	1
61354	6
61356	3
61362	9
61368	2
61369	1
61377	2
61501	1
61537	2
61614	1
Total	**59**

Zip Code	EOY 2008
60440	1
60603	1
61301	11
61312	1
61317	2
61322	3
61327	1
61329	1
61330	1
61335	1
61336	2
61342	4
61348	4
61349	1
61354	12
61356	5
61362	10
61369	1
61501	1
61537	3
61611	1
61614	1
Total	**68**

Zip Code	EOY 2009
60354	1
60440	1
60560	1
61301	11
61312	1
61317	1
61322	6
61327	2
61329	1
61335	1
61336	2
61342	4
61348	3
61349	1
61354	8
61356	7
61358	1
61362	8
61537	2
61603	1
Total	**63**

Zip Code	1st QTR 2010
60354	1
60440	1
60515	1
61301	12
61312	1
61317	1
61320	1
61322	7
61327	2
61329	1
61335	1
61336	3
61342	4
61348	3
61349	1
61354	9
61356	9
61358	1
61362	9
61373	1
61537	3
61603	1
Total	**73**

ATTACHMENT - 20

SUMMARY/TOTALS

Facility	EOY 2007	EOY 2008	EOY 2009	1st QTR 2010
Fresenius Medical Care Spoon River	33	31	29	30
Fresenius Medical Care East Peoria	84	85	84	90
Fresenius Medical Care Kewanee	24	24	35	25
Fresenius Medical Care Ottawa	52	40	34	45
Fresenius Medical Care Macomb	16	16	18	20
Fresenius Medical Care McLean County	91	95	89	99
Fresenius Medical Care Pekin	45	47	44	45
Fresenius Medical Care Peoria Downtown	120	117	132	142
Fresenius Medical Care Peoria North	69	65	69	72
Fresenius Medical Care Pontiac	59	68	63	73
Fresenius Medical Care Spring Valley	38	37	36	37
Totals	**631**	**625**	**633**	**678**

ATTACHMENT - 20

Service Demand – Establishment of a Category of Service

As documented on the previous pages and attested to by the physicians supporting this project, the facility has experienced the following census numbers at the Spoon River Facility:

	Total Patients Treated	Total Admissions	Deaths	Transplant	Patients Referred to Peoria Home Therapies
2007	43	14	12	1	1
2008	40	11	9	0	2
2009	37	5	5	3	2
1st Qtr 2010	33	4	4	0	1

This facility's death rate is higher than the national average. This is due to the demographics of the Canton area and the historic referral patterns. Canton is a farming community in central Illinois that has experienced little or no growth and has little job market to attract or keep younger residents in the community. This creates a patient population that is mostly elderly with multiple chronic health issues. Historically patients were not referred for dialysis until they were close to end stage renal disease. This practice has changed evidenced by the increase in the pre-ESRD patients in the physician's practice. Graham Hospital has recruited a number of young physician's who are making patient referrals earlier to nephrologists. The Renal Care Associates nephrologists in turn now hold a patient clinic twice a month in Canton to see and educate these new kidney disease patients prior to dialysis. The facility is expected to have lower future death rates, with the patients being referred earlier in the disease process.

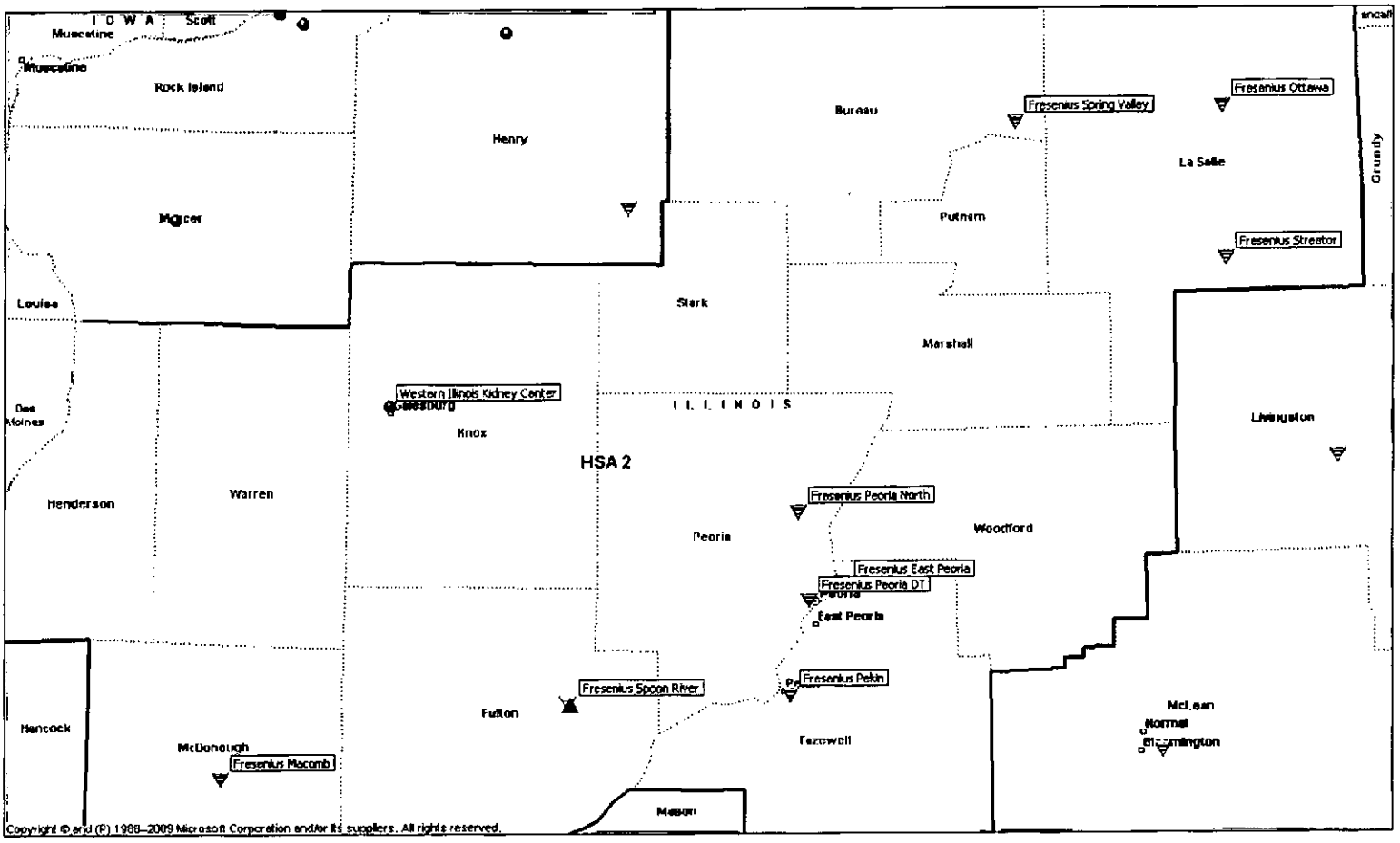
The nephrologists along with St. Francis Hospital in Peoria are aggressively referring patients to be evaluated to be placed on the kidney transplant list. The Spoon River facility has nearly 30% of its patients awaiting transplant compared to the national average of 21%. The nephrologists also refer approximately 1/3 of all new patients to receive home dialysis training in Peoria.

Service Accessibility – Service Restrictions

If the Fresenius Medical Care Spoon River in-center hemodialysis facility in Canton, is discontinued and not re-established at another site, there will be no access to dialysis services within 30 minutes travel time of Canton, which would negatively impact the current Spoon River patients.

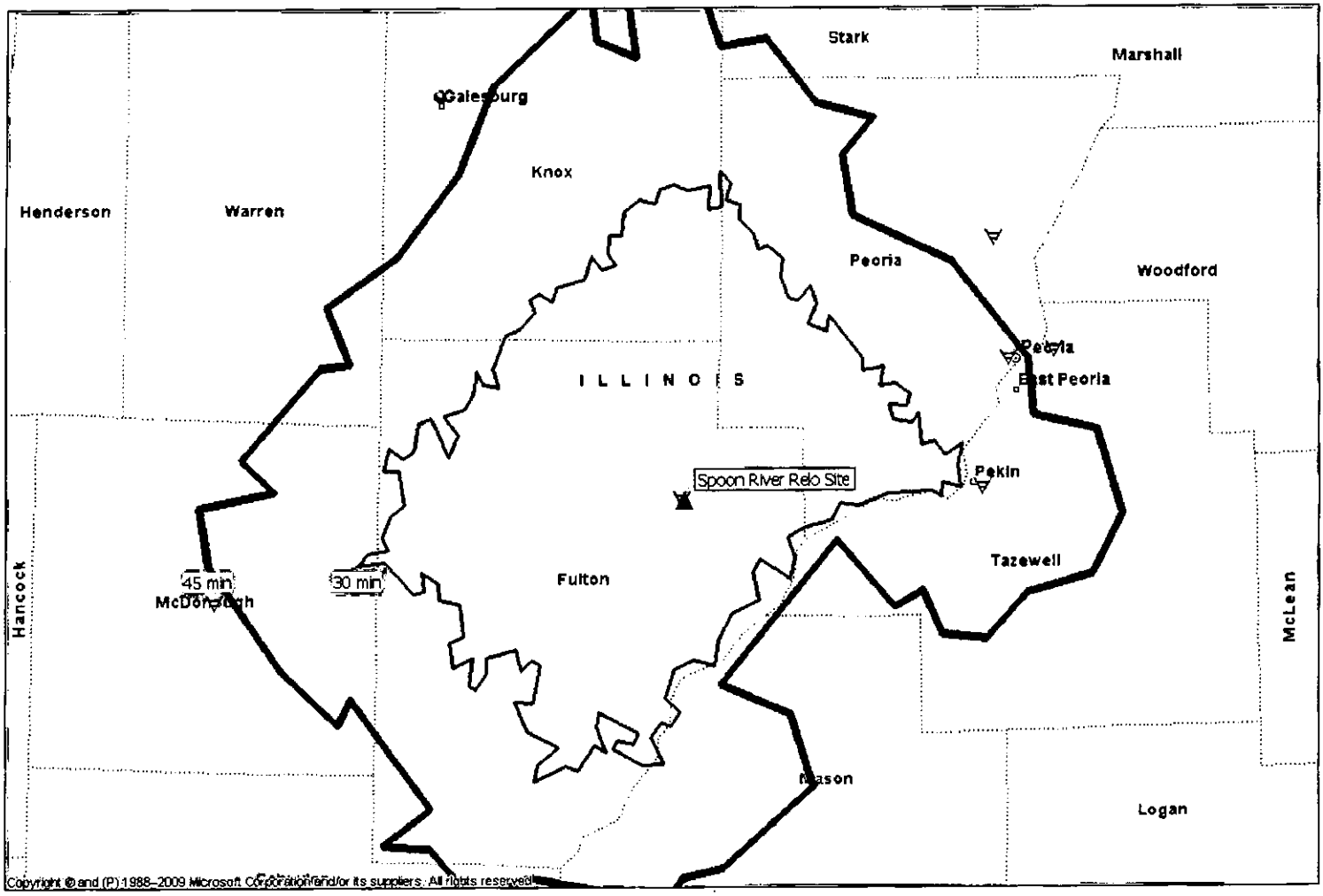
This project meets the service restriction requirement of all facilities within 30 minutes being above the State standard of 80% in that there are no ESRD facilities within 30 minutes of Canton.

HSA 2 ESRD Providers

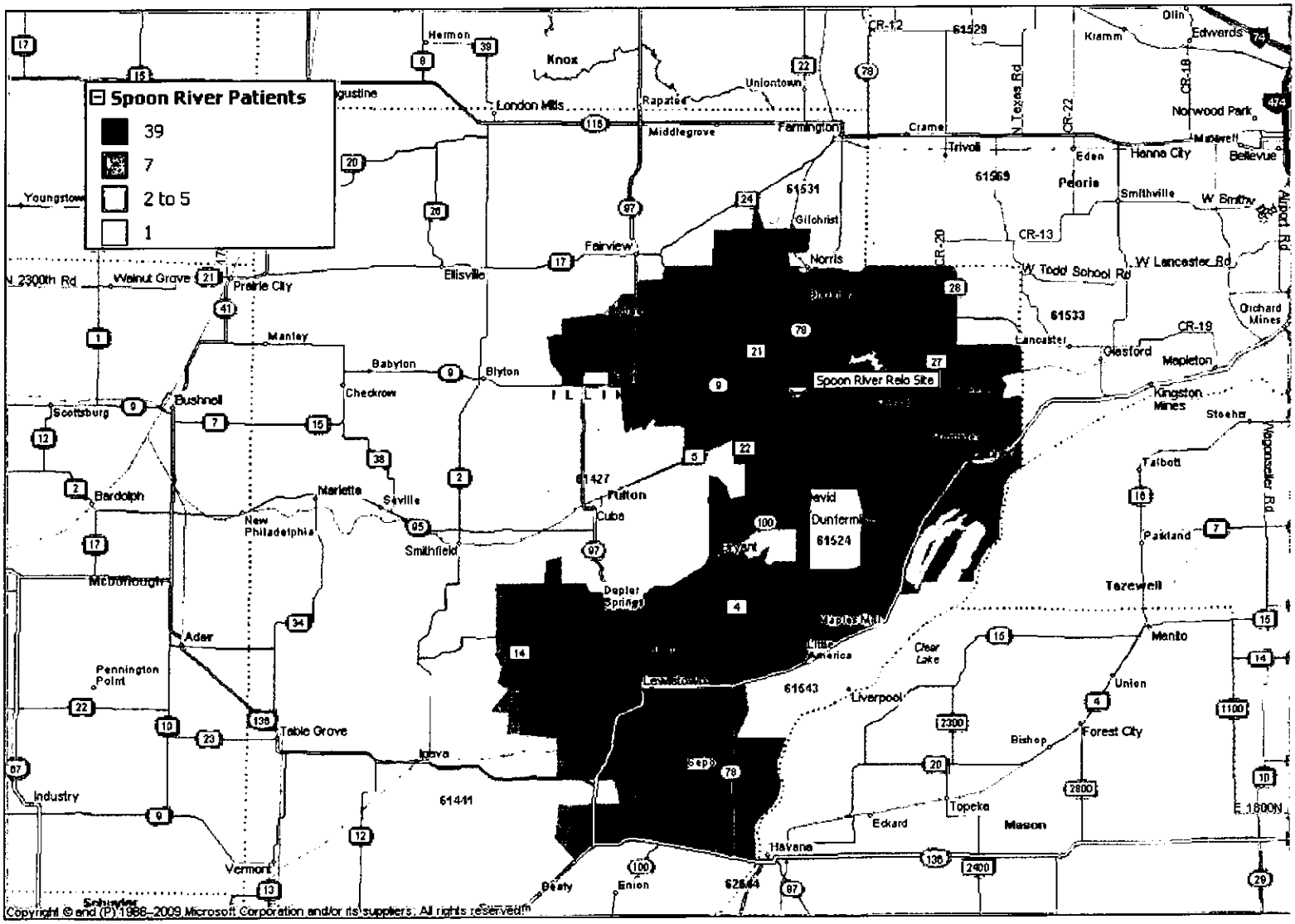


Location of Fresenius Medical Care Spoon River in Relation to The 30 & 45 Minute Drive Time Zone

There are no facilities within 30 minutes travel time of Fresenius Spoon River.



Demographics of the Current 30 Spoon River Patients and the 7 Pre-ESRD Patients who will begin dialysis in 2010 and the 27 Pre-ESRD Patients Identified who will begin dialysis within 24 months after the relocation of the Spoon River Facility



Service Accessibility
ATTACHMENT - 22

MAPQUEST.

Notes

TO FRESENIUS MEDICAL CARE PEKIN

Trip to 600 S 13th St
Pekin, IL 61554-4936
28.78 miles - about 38 minutes

A 175 Main St, Canton, IL 61520

START	1. Start out going **SOUTHEAST** on **MAIN ST** toward **IL-100**.	go 0.0 mi
100	2. Turn **LEFT** onto **IL-100**.	go 1.5 mi
78	3. Turn **LEFT** onto **IL-78 / IL-100**.	go 3.1 mi
9	4. Turn **RIGHT** onto **E LINN ST / IL-9**. Continue to follow **IL-9**.	go 7.4 mi
EAST 24	5. **IL-9** becomes **US-24 E**.	go 13.5 mi
EAST 9	6. Turn **SLIGHT RIGHT** onto **IL-9 E**.	go 3.1 mi
	7. Turn **RIGHT** onto **S 14TH ST**.	go 0.0 mi
	8. Turn **RIGHT** onto **PARK AVE**.	go 0.0 mi
	9. Turn **RIGHT** onto **S 13TH ST**.	go 0.0 mi
END	10. **600 S 13TH ST** is on the **RIGHT**.	go 0.0 mi

B 600 S 13th St, Pekin, IL 61554-4936

Total Travel Estimate : 28.78 miles - about 38 minutes

MAPQUEST.

Trip to 410 W Romeo B Garrett Ave
Peoria, IL 61605-2401
34.51 miles - about 47 minutes

Notes
TO FRESENIUS MEDICAL CARE PEORIA DOWNTOWN

A 175 Main St, Canton, IL 61520

1. Start out going **SOUTHEAST** on **MAIN ST** toward **IL-100**.	go 0.0 mi
2. Turn **LEFT** onto **IL-100**.	go 1.5 mi
3. Turn **LEFT** onto **IL-78 / IL-100**.	go 3.1 mi
4. Turn **RIGHT** onto **E LINN ST / IL-9**. Continue to follow **IL-9**.	go 7.4 mi
5. **IL-9** becomes **US-24 E**.	go 19.7 mi
6. Turn **SLIGHT RIGHT**.	go 0.0 mi
7. Turn **SLIGHT RIGHT** onto **SW WASHINGTON ST / US-24 E**.	go 2.0 mi
8. Turn **LEFT** onto **OAK ST**.	go 0.2 mi
9. **OAK ST** becomes **N HIGHTOWER ST**.	go 0.4 mi
10. Turn **RIGHT** onto **W ROMEO B GARRETT AVE**.	go 0.0 mi
11. **410 W ROMEO B GARRETT AVE** is on the **RIGHT**.	go 0.0 mi

B 410 W Romeo B Garrett Ave, Peoria, IL 61605-2401

MAPQUEST.

Notes

TO FRESENIUS MEDICAL CARE MACOMB

Trip to 523 E Grant St
Macomb, IL 61455-3313
41.81 miles - about 51 minutes

A 175 Main St, Canton, IL 61520

START	1. Start out going **SOUTHEAST** on **MAIN ST** toward **IL-100**.	go 0.0 mi
100	2. Turn **RIGHT** onto **IL-100**.	go 7.8 mi
97	3. Turn **SLIGHT RIGHT** onto **IL-97**.	go 5.3 mi
95	4. Turn **SLIGHT LEFT** onto **IL-95**.	go 17.1 mi
	5. **IL-95** becomes **N 1450TH RD / CR-2 / CR-1450 N**.	go 3.0 mi
	6. Turn **LEFT** onto **HANNA ST / CR-17 / CR-1800 E**. Continue to follow **CR-17 / CR-1800 E**.	go 2.5 mi
136	7. Turn **RIGHT** onto **N 1200TH RD / US-136 / CR-1200 N**.	go 3.0 mi
67	8. Turn **LEFT** onto **E 1500TH ST / US-67 / CR-1500 E**.	go 0.6 mi
	9. Turn **RIGHT** onto **N 1150TH RD / CR-25 / CR-1150**. Continue to follow **CR-25**.	go 2.5 mi
END	10. **523 E GRANT ST** is on the **LEFT**.	go 0.0 mi

B 523 E Grant St, Macomb, IL 61455-3313
Total Travel Estimate : 41.81 miles - about 51 minutes

Unnecessary Duplication/Maldisribution

1 & 2

The ratio of ESRD stations to population in the zip codes within a 30 minute radius of Canton is 0 stations per 61,240 residents according to the 2000 census. If the 9 stations for the proposed Spoon River, Canton relocation are taken into account, the ratio becomes 1 station per 6,804 residents. The State average is 1 station per 3,602 residents. This is more than 1.5 times the State Average. Relocating the Spoon River facility and adding one station will not duplicate services or create a maldistribution of services in HSA 2 or the Canton market.

ZIP Code	Population	Stations	Facility
61415	1,975		
61427	2,427		
61431	328		
61432	691		
61441	1,007		
61458	958		
61459	424		
61477	775		
61482	954		
61519	261		
61520	18,659	9	Fresenius Spoon River
61524	140		
61529	2,665		
61531	3,347		
61533	2,247		
61536	2,892		
61542	4,049		
61543	55		
61544	706		
61547	3,412		
61563	511		
61569	1,215		
61572	1,069		
61607	10,473		
Total	**61,240**	**9**	**1/6,804**

Total population within a 30 minute travel time of Fresenius Spoon River is 61,240 according to the 2000 Census.

Projected census for Illinois for 2006-08 is 12,485,179.

March 2010 ESRD Station Inventory is 3,466.

Without the relocation of Fresenius Medical Care Spoon River there would be no stations within 30 minutes.

3. The proposed discontinuation of the current 8 station Fresenius Medical Care Spoon River site and the subsequent establishment of a 9 station "relocation" facility also in Canton, will not lower the utilization of any other area dialysis providers. There are no facilities within 30 minutes travel time of Canton, and the nearest facilities are between 38 and 51 minutes away. All current patients of the Spoon River facility are expected to transfer to the new location and all pre-ESRD patients identified for the new facility would have been referred to the current site had it been able to remain at its current location.

Criterion 1110.1430 (e)(1) – Staffing

2) A. Medical Director

Phillip J. Olsson, M.D. is currently the Medical Director for Fresenius Medical Care Spoon River and will continue to be the Medical Director after the relocation. Attached is his curriculum vitae.

Paul T. Dreyer, M.D. will also be referring to the Spoon River facility. His curriculum vitae is attached.

B. All Other Personnel

Upon the discontinuation of the current Spoon River facility and the establishment of the new Spoon River facility all staff will transfer to the new location and resume their current position. There will be no break in employment or work schedules as the facility will relocate on a Sunday when there are no patient treatments scheduled. This will include the following staff:

- Clinic Manager who is a Registered Nurse
- Charge Nurse who is a Registered Nurse
- 2 Full-time Patient Care Technicians
- 2 Part-time Patient Care Technicians
- Part-time Registered Dietitian
- Part-time Licensed Master level Social Worker
- Part-time Equipment Technician
- Part-time Ward Clerk

3) All patient care staff and licensed/registered professionals will meet the State of Illinois requirements. Any additional staff hired must also meet these requirements along with completing a 9 week orientation training program through the Fresenius Medical Care staff education department.

Annually all clinical staff must complete OSHA training, Compliance training, CPR Certification, Skills Competency, CVC Competency, Water Quality training and pass the Competency Exam.

4) The above staffing model is required to maintain a 4 to 1 patient-staff ratio at all times on the treatment floor. A RN will be on duty at all times when the facility is in operation.

CURRICULUM VITAE

Phillip J. Olsson, M.D., F.A.C.P.

PERSONAL INFORMATION

Date of Birth:	June 4, 1949
Place of Birth:	Des Plaines, Illinois
Home Telephone:	309/685-5891
Work Address:	RenalCare Associates, S.C. 515 NE Glen Oak Avenue, Ste. 108 Peoria, Illinois, 61603
Work Telephone:	309/676-8123
Work Fax:	309/624-8336

UNDERGRADUATE EDUCATION

B.A., Southern Illinois University, Carbondale, Illinois, 1971

MEDICAL SCHOOL EDUCATION

M.D., University of Health Sciences, The Chicago Medical School, Chicago, Illinois, 1975

POST GRADUATE EDUCATION

Internal Medicine Intern and Residency, University of Illinois School of Medicine, St Francis Medical Center, 1975-1978
Nephrology Fellowship, University of Florida, Gainesville, Florida, 1978-1980

ACADEMIC APPOINTMENTS

1984-present	Clinical Assistant Professor, University of Illinois College of Medicine, Peoria
1980-present	Coordinator, Plasmapheresis Treatment Program, OSF, St. Francis Medical Center, Peoria
1980- present	Medical Teaching Staff, OSF, St. Francis Medical Center, Peoria

CERTIFICATION AND LICENSURE

1976	Illinois Medical License, #036-053986
1978	American Board of Internal Medicine, #66569
1980	American Board of Internal Medicine, Nephrology, #66569

HOSPITAL STAFF APPOINTMENTS

1981 - present St. Francis Medical Center, Peoria, Illinois, active staff
1980 - present Methodist Medical Center, Peoria, Illinois, active staff
1980 - present Proctor Hospital, Peoria, Illinois, courtesy staff
1981 - present BroMenn Health Care, Normal, Illinois, courtesy staff
1981 - present St. Margaret's Hospital, Spring Valley, Illinois, consulting staff
1990 - present St. Joseph's Medical Center, Bloomington, Illinois, consulting staff
1991 - present Graham Hospital, Canton, Illinois, affiliate staff
1995 - present Pekin Hospital, Pekin, Illinois, consulting staff
2004 - present McDonough District Hospital, Macomb, Illinois, consulting staff
2006 - present Kewanee Hospital, Kewanee, Illinois, provisional staff

PROFESSIONAL AFFILIATIONS

American College of Physicians, Fellow
American Society for Diagnostic and Interventional Nephrology
Renal Physicians Association
Peoria Medical Society
American Society of Nephrology

AWARDS AND HONORS

National Honor Society, 1967
President's Scholar, SIU, 1967-1971
Scholastic Honors, SIU, 1970
Life member of National Register of Who's Who published in the 2000 edition, Member # 176360
Fellow American College of Physicians, 1993

PUBLICATIONS/ABSTRACTS

Olsson PJ, Black JR, Gaffney E B.Ch., Alexander RW, Mars DR, Fuller TJ. Reversible Acute Renal Failure Secondary to Acute Pyelonephritis, Southern Medical Journal. 73 (3):374-376; 1980.

Olsson PJ, Horvath F, Bingham R, Mars DR. Continuous Ambulatory Peritoneal Dialysis (CAPD) in the High Risk ESRD Patient. ABSTRACT. Kidney International. 16 (6): 895; December 1979.

Olson PJ. Behcet's Syndrome. LETTER. NEJM. 302 (7):407-408; 1980.

Olsson PJ, Gaffney E B.Ch., Alexander RW, Mars DR, Fuller TJ. Severe Diffuse Proliferative Glomerulonephritis with Crescent Formation in Behcet's Syndrome. Archives of Internal Medicine. 140:713-714; 1980.

Olsson PJ, Horvath F, Bingham R, Carter RL, Peterson JC, Mars DR. Chronic Ambulatory Peritoneal Dialysis (CAPD) in High Risk Patients with Renal Failure. Morbidity and Mortality. ABSTRACT. American Society of Nephrology. 48A; 1980.

Olsson PJ. CAPD in Diabetes Mellitus. LETTER. Archives of Internal Medicine. 141(4):543-544; 1981.

Olsson PJ, Renal Disease in Behect's Syndrome. LETTER. JAMA. 1987; September 1981.

Olsson PJ, Fierer JA, Kelly CE, Wright RW, Blaise D, Anderson KB, Peterson JC, Alexander RW. Renal Carcinoma in "End Stage" Dialysis Kidneys. Southern Medical Journal. Vol 78 (5): 507-512; May 1985.

Olsson PJ, Goergen MH, Masi AT. Plasmapheresis in Botulism. International Society for Artificial Organs. No. 304; 1984. ABSTRACT.

Miller MA, Hjelle T, Olsson PJ, and Peterson D. Distinguishing Bacterial and Kidney Alanyl Aminopeptidase Activity. Kidney International. 25:287, 1984. ABSTRACT.

Tillman, Mars, Olsson. Diet in CAPD Patients. SEDTA. 1980. ABSTRACT.

Miller MA, Hjelle JT, Olsson PJ, Peterson D. Distinguishing Bacterial and Kidney Alanyl Amino Peptidase Activity. ABSTRACT. American Society of Nephrology, 1983.

Hjelle JT, Waters DC, Golinska BT, Steidley KR, Burmeister V, Caughey R, Ketel B, McCarroll DR, Olsson PJ, Prior RB, Miller MA. Autosomal Recessive Polycystic Kidney Disease: Characterization of Human Peritoneal and Cystic Kidney Cells In Vitro. American Journal of Kidney Diseases. Vol XV, No 2:123-136; February 1990.

Hjelle JT, Steidley KR, Pavlina TM, Welch MH, Mockler D, Webb LE, Miller MA, Olsson PJ, Horvath F, Dobbie JV. Choline Loss Into Peritoneal Dialysis Effluent (PDE) and the Effect of a Platelet-Activating Factor (PAF) Agonist on Choline Transport by Mesothelial Cells In Vitro. Peritoneal Dialysis International. Vol. 12, Suppl. 1; 1992. ABSTRACT.

Hjelle JT, Welch MH, Pavlina TM, Webb LE, Mockler D, Miller MA, Steidley KR, Olsson PJ, Horvath F, Mahon L, Olson K, Abel C, and Dobbie JW. Choline Levels in Human Peritoneal Dialysate. Advances in Peritoneal Dialysis. 9:299-302, 1993. ABSTRACT.

Wiser NA, Shane JM, McGuigan AT, Memken JA, Olsson PJ. The Effects of a Group Nutrition Education Program on Nutrition Knowledge, Nutrition Status, and Quality of Life in Hemodialysis Patients. Journal of Renal Nutrition. Vol. 7, No 4:187-193; October 1997.

COMMITTEES

Physicians Health Committee, OSF, St Francis Medical Center
Division of Services for Crippled Children, University of Illinois at Chicago

CURRICULUM VITAE

Paul T. Dreyer, M.D.

PERSONAL INFORMATION

Date of Birth:	June 18, 1965
Place of Birth:	Elmhurst, Illinois
Work Address:	RenalCare Associates, S.C. 515 NE Glen Oak Avenue, Ste. 108 Peoria, Illinois, 61603
Work Telephone:	309/676-8123
Work Fax:	309/676-8455

UNDERGRADUATE EDUCATION

B.A. Chemistry, University of Iowa, 1987

MEDICAL SCHOOL EDUCATION

M.D. University of Illinois, 1991

POST GRADUATE EDUCATION

Internal Medicine Internship, University of Illinois School of Medicine, Peoria, Illinois 1991-1992
Internal Medicine Residency, University of Illinois School of Medicine, Peoria, Illinois 1992-1994

Activities:
- Chief Medical Resident, 11/93-2/94
- Vice President, House Staff
- Resident Representative Blue Alert Committee
- Physical Diagnosis Instructor, UICOMP M-2 Students

Nephrology Fellowship, University of Michigan Medical School, Ann Arbor, Michigan 1994-1996

Activities:
- Teaching house officers and medical students in Renal Clinics on Nephrology Services
- Instructor, Urinalysis Labs, Nephrology section of ICS Clinical Skills
- Physical Diagnosis Instructor, M-2 Students

CERTIFICATION AND LICENSURE

1993	Illinois State License, #036-086961
1994	American Board of Internal Medicine, Certificate #155614
1996	American Board of Internal Medicine, Nephrology

HOSPITAL STAFF APPOINTMENTS

1998 - present St. Francis Medical Center, Peoria, Illinois, active staff
1998 - present Methodist Medical Center, Peoria, Illinois, courtesy staff
1998 - present Proctor Hospital, Peoria, Illinois, courtesy staff
1998 - present Graham Hospital, Canton, Illinois, affiliate staff
1998 - present Pekin Hospital, Pekin, Illinois, consulting staff
1998 - present BroMenn Health Care, Normal, Illinois, courtesy staff
1998 - present St. Joseph's Medical Center, Bloomington, Illinois, courtesy staff
1998 - present St. Margaret's Hospital, Spring Valley, Illinois, consulting staff
1998 - present Kewanee Hospital, Kewanee, Illinois, consulting staff
2004 - present McDonough District Hospital, Macomb, Illinois, consulting staff

PROFESSIONAL AFFILIATIONS

American Society of Nephrology
Renal Physicians' Association

AWARDS AND HONORS

1991 Alpha Omega Alpha, University of Illinois
1991 Charles Spencer Williamson Excellence in Internal Medicine, University of Illinois
1991 Merck Manual "Doctor's Doctor" Award, UICOMP
1993 Resident of the Year, UICOMP
1994 Resident of the Year, UICOMP

PUBLICATIONS

Hoschek JC, Dreyer P, Dahal S, and Walker, PD. Rapidly Progressive Renal Failure in Childhood. American Journal of Kidney Diseases, Vol 40, No 6, December 2002, 1342-1347.

Criterion 1110.1430 (e)(5) Medical Staff

I am the Regional Vice President of the Central Illinois Region of the North Division of Fresenius Medical Care North America. In accordance with 77 Il. Admin Code 1110.1430, and with regards to Fresenius Medical Care Spoon River, I certify the following:

Fresenius Medical Care Spoon River is and will be an "open" unit with regards to medical staff. Any Board Licensed nephrologist may apply for privileges at the Spoon River facility, just as they currently are able to at all Fresenius Medical Care facilities.

Signature

Richard Stotz
Printed Name

Regional Vice President
Title

Subscribed and sworn to before me
this 9th day of April, 2010

Signature of Notary

Seal
OFFICIAL SEAL
MICHELLE M HOGAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:01/12/13

Criterion 1110.1430 (j) – Assurances

I am the Regional Vice President of the Central Illinois Region of the North Division of Fresenius Medical Care North America. In accordance with 77 Il. Admin Code 1110.1430, and with regards to Fresenius Medical Care Spoon River, I certify the following:

1. Due to operational hours that are specific to rural dialysis centers and to lower patient populations in rural areas such as Canton, I cannot certify that the Spoon River facility will, with certainty, reach and/or maintain the utilization standard of 80% as specified in 77 Ill. Adm. Code 1100. This standard suggests that all dialysis facilities operate 3 shifts a day, six days a week. The Spoon River facility generally operates 2 shifts a day, six days a week. (it currently is operating the 3rd shift on Monday/Wednesday/Friday to accommodate a patient who works days) While this is somewhat due to lower patient population, it more attributed to transportation issues. The patients are mostly elderly and ill and unable to travel desolate country roads in the evening and in the dark when the third shift of the day is. This is particularly true in inclement weather. For this reason, it is in the patient's best interest with regards to access to receive treatment on one of the two daytime shifts. Taking this into account, the Spoon River facility expects to achieve and maintain 80% utilization based on 2 shifts a day, six days a week.

   Due to the fact that Graham Hospital has recruited several new young physicians who are referring patients to our nephrologists at an earlier stage in their kidney disease, we expect the census at the facility to rise slightly and for the death rate to decline, however it is too early to ascertain what the utilization outcome of this new trend to be.

2. Fresenius Medical Care Spoon River patients achieved adequacy outcomes of:

   - 95.45% of patients had a URR $\geq$ 65%
   - 95.45% of patients had a Kt/V $\geq$ 1.2

   and same is expected for Fresenius Medical Care Spoon River after relocation.

Signature

Richard Stotz Regional Vice President
Name/Title

OFFICIAL SEAL
CYNTHIA S TURGEON
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:01/12/13

Subscribed and sworn to before me
this 26th day of APRIL, 2010

Cynthia S. Turgeon
Signature of Notary
Seal

ATTACHMENT - 26

Criterion 1110.1430 (f) – Support Services

I am the Regional Vice President of the Central Illinois Region of the North Division of Fresenius Medical Care North America. In accordance with 77 Il. Admin Code 1110.1430, I certify to the following:

- Fresenius Medical Care utilizes the Proton patient data tracking system in all of its facilities.

- These support services are/will be available at Fresenius Medical Care Spoon River during all six shifts:
  - Nutritional Counseling
  - Psychiatric/Social Services
  - Home/self training
  - Clinical Laboratory Services – provided by Spectra Laboratories

- The following services are currently provided to Fresenius Medical Care Spoon River and will continue to be provided after the relocation via referral to OSF St. Francis Medical Center:

  - Blood Bank Services
  - Rehabilitation Services
  - Psychiatric Services

Signature

Richard Stotz/Regional Vice President
Name/Title

Subscribed and sworn to before me
this 9th day of April, 2010

Michelle M. Hogan

Seal

OFFICIAL SEAL
MICHELLE M HOGAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:01/12/13

TRANSFER AGREEMENT
between
OSF HEALTHCARE SYSTEM,
SAINT FRANCIS MEDICAL CENTER
and
DIALYSIS CENTERS OF AMERICA - ILLINOIS

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, by and between OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, having its Corporate Office in Peoria, Illinois, owner and operator of SAINT FRANCIS MEDICAL CENTER, located and doing business in Peoria, Illinois, (such System and Hospital are collectively referred to as "Receiving Hospital") and DIALYSIS CENTERS OF AMERICA – ILLINOIS, which owns and operates renal dialysis facilities, whose locations are set forth in Exhibit A, attached hereto and made a part hereof (all hereinafter referred to as "Transferring Facility").

RECITALS:

A. The Transferring Facility and the Receiving Hospital desire, by means of this Agreement, to assist physicians in the treatment of patients.

B. The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the parties hereto agree as follows:

I. DUTIES AND RESPONSIBILITIES.

1.1 Joint Responsibilities. In accordance with the policies and procedures of the Transferring Facility and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Facility to the Receiving Hospital as long as the Receiving Hospital has bed availability, staff availability, is able to provide the services requested by the Transferring Facility, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Receiving Hospital. In such cases, the Receiving Hospital and the Transferring Facility agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the parties shall comply with all EMTALA requirements with respect to such transfers. Receiving Hospital and Transferring Facility

shall meet periodically to review the transfer process, of policies and procedures in order to improve the process, including efficiency, clinical care and patient safety.

1.2 Receiving Hospital. The Receiving Hospital shall accept patients in need of transfer from the Transferring Facility pursuant to the criteria set forth in Section 1.1. Further, Receiving Hospital shall designate a person to coordinate with Transferring Facility in order to establish acceptable and efficient transfer guidelines.

1.3 Transferring Facility. Transferring Facility shall request transfers of patients to Receiving Hospital pursuant to the criteria set forth in Section 1.1. Further, Transferring Facility shall:

a. Have responsibility for obtaining the patient's informed consent for the potential transfer to Receiving Hospital, if the patient is competent. If the patient is not competent, the consent of the legal guardian, agent with power of attorney for health care, or surrogate decision maker of the patient shall be obtained.

b. Notify Receiving Hospital as far in advance as possible of the impending transfer.

c. Transfer to Receiving Hospital the patient's personal effects, including money and valuables, and information related thereto. A standard form shall be adopted and used by both parties listing such personal effects and appropriate documentation and transfer procedure. Transferring Facility shall be responsible for such personal effects until such standard form has been signed by the Receiving Hospital and Receiving Hospital has received such personal effects.

d. Affect the transfer to Receiving Hospital through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures. Receiving Hospital's responsibility for the patient's care shall begin when the patient is admitted to Receiving Hospital.

e. Transfer, and supplement as necessary, all relevant medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue the patient's treatment without interruption and to provide identifying and other information,

including contact information for referring physician, name of physician(s) at Receiving Hospital contacted with regard to the patient (and to whom the patient is to be transferred), medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical and lab findings, history of the illness or injury, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring Facility, medications administered, known allergies, nursing, dietary information, ambulation status and pertinent administrative, third party billing and social information.

1.4 Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with an handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.

1.5 Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional or advertising material.

1.6 Standards. Receiving Hospital shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of the Joint Commission on Accreditation of Healthcare Organizations, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Hospital. Receiving Hospital shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.

1.7 Exclusion/Debarment. Both parties certify that they have not been debarred, suspended, or excluded from participation in any state or federal healthcare program, including, but not limited to, Medicaid, Medicare and

Tricare. In addition, each party agrees that it will notify the other party immediately if it subsequently becomes debarred, suspended or excluded or proposed for debarment, suspension or exclusion from participation in any state or federal healthcare program.

1.8 Condidentiality. Receiving Hospital agrees to maintain confidentiality. Receiving Hospital acknowledges that certain material, which will come into its possession or knowledge in connection with this Agreement, may include confidential information, disclosure of which to third parties may be damaging to Transferring Facility. Receiving Hospital agrees to hold all such material in confidence, to use it only in connection with performance under this Agreement and to release it only to those persons requiring access thereto for such performance or as may otherwise be required by law and to comply with the Health Insurance Portability and Accountability Act.

1.9 Access to Books and Records. Both parties will maintain records relating to their responsibilities under this Agreement for a period of one (1) year from the date of services. During normal working hours and upon prior written and reasonable notice, each party will allow the other party reasonable access to such records for audit purposes and also the right to make photocopies of such records (at requesting party's expense), subject to all applicable state and federal laws and regulations governing the confidentiality of such records.

II. FINANCIAL ARRANGEMENTS.

2.1 Billing and Collection. The patient is primarily responsible for payment for care provided by Transferring Facility or Receiving Hospital. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Facility nor the Receiving Hospital shall have any liability to the other for billing, collection or other financial matters relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the parties.

2.2 Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate to insure such party and its Board, officers, employees and agents acting

within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

III. TERM AND TERMINATION.

3.1 Term and Automatic Renewal. The promises and obligations contained herein shall commence as of March 1, 2005 for a term of one (1) year therefrom and shall automatically renew pursuant to like terms unless one party shall give the other party a notice of intent not to renew thirty (30) days prior to the expiration of the initial term, or the then-existing term, subject, however, to termination under Section 3.2 herein.

3.2 Termination. This Agreement may be sooner terminated on the first to occur of the following:

a. Written agreement by both parties to terminate this Agreement.

b. In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by either party, such other party may terminate this Agreement immediately with written notice of such termination to the breaching party.

c. In the event either party to this Agreement shall, without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.

d. Debarment, suspension or exclusion, as set forth in Section 1.7.

3.3 Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

IV. MISCELLANEOUS.

4.1 This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Hospital and Transferring

Facility shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.

4.2 This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Hospital or Transferring Facility arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.

4.3 The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Receiving Hospital:	Transferring Facility:
Keith Steffen CEO Saint Francis Medical Center 530 N.E. Glen Oak Avenue Peoria, Illinois 61637	David G. Carter Regional Vice President Dialysis Centers of America - Illinois Central Illinois Region 3300 North Main Street East Peoria, Illinois 61611

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

4.4 It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or

against a third party. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.

4.5 This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same.

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

RECEIVING HOSPITAL:

OSF HEALTHCARE SYSTEM,
an Illinois not-for-profit
corporation, owner and operator of
Saint Francis Medical Center

By: _____
Title: CEO

Dated: 4/18/06

XX 3/08/05

TRANSFERRING FACILITY:

DIALYSIS CENTERS OF AMERICA -
ILLINOIS

By: _____
Title: _____

Dated: _____

EXHIBIT A

FACILITY LOCATIONS

RCG Macomb
523 E. Grant Street
Macomb, IL 61455

RCG Kewanee
511 Pine Street
Kewanee, IL 61443

RCG Spring Valley
12 Wolfer Industrial Park Drive
Spring Valley, IL 61362

RCG Ottawa
1000 E. Norris Drive
Ottawa, IL 61350

RCG Peoria North
3300 N. Main Street
Peoria, IL 61615

RCG East Peoria
3300 N. Main Street
East Peoria, IL 61611

RCG Canton
210 W. Walnut
Canton, IL 61520

RCG East Peoria Home Dialysis
3300 N. Main Street
East Peoria, IL 61611

RCG Peoria North Home Dialysis
10405 N. Juliet Court
Peoria, IL 61615

RCG Pekin
600 S. 13th Street – 3rd Floor
Pekin, IL 61554

RCG Peoria Downtown
410 R.B. Garrett Avenue
Peoria, IL 61605

Transfer Agreement

THIS AGREEMENT made on this 10th day of March, 2005 by and between Dialysis Centers of America - Illinois, with facilities located as shown on Exhibit I ("Facility") and Methodist Medical Center of Illinois, a general acute care hospital duly licensed under the laws of this State with a current provider agreement issued pursuant to Title XVII of the Social Security Act, whose address is 221 NE Glen Oak Ave, Peoria, IL 61636, ("Hospital").

Agreement

1. When a patient's need for transfer from Facility to Hospital determined by the patient's physicians, Hospital agrees to admit the patient as promptly as possible, provided admission requirements are met, and adequate capacity to accommodate the patient is available, in accordance with Federal and State laws and regulations.

2. Facility will complete and send with each patient at the time of transfer, or in the case of emergency, as promptly as possible, the standard transfer and referral forms mutually agreed upon by the parties to this Agreement to provide the medical and administrative information necessary to determine to enable continuing care to the patient.

3. Hospital shall make available its outpatient diagnostic and therapeutic services in accordance with the orders of the attending physician provided customary requirements for such services are met in accordance with Federal and State laws and regulations and a separate agreement or agreements have been established between the parties setting forth the terms for use and reimbursements of any service or services utilized.

4. Facility will be responsible for effecting the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items in its custody. Any personal effects, including medications and patient ID (insurance information, i.e., cards), specifically entrusted to an authorized officer or agent of Facility shall be transferred upon signed receipt from a similarly designated individual of Hospital.

5. The institution in custody of the patient shall be accountable for the recognition of the need of social services and for prompt reporting of such need to the local Welfare Department or other appropriate sources.

6. When indicated by patient's condition, Facility will be responsible for effecting the transfer of the patient, including arranging for appropriate and safe transportation during the transfer in accordance with applicable Federal and State laws and regulations.

7. Facility shall contact and explain reasons for transfer to patient and patient's relatives or other parties responsible for patients.

8. Charges for services performed shall be collected by the institution rendering such services, directly from the patient, third-payer or other sources normally billed by the institution, and

neither party shall have any liability to the other party for such charges. (This provision does not preclude separate agreements between the parties for the sale, purchase, exchange of supplies or services including drugs and diagnostic or therapeutic services.)

9. The transferring facility agrees to make notification to Illinois Department of Public Health and other regulatory organizations as required.

10. It is the parties' intention that the relationship between the parties is that of independent contractors. The Governing Body of each party shall have exclusive control of policies, management, assets and affairs of its respective institution. No institution shall assume any liability by virtue of the Agreement for any debts or other obligations incurred by any other party to this Agreement.

11. Each party will maintain such insurance as will fully protect it from any and all claims of any nature for damage to property from personal injury including death, made by anyone which may arise from operations carried on by either party under this Agreement. It is the intention that the party in custody of the patient will be liable for the injury. Each party agrees, however, to indemnify and hold the other harmless for any and all liability, loss, cost or expenses incurred directly or indirectly from any act of omission by Hospital or Facility arising from or relating to the obligations provided for under this Agreement. Certificates of insurance will be provided upon request.

12. Nothing in this Agreement shall affect or interfere with the rules and regulations of either institution as they relate to medical staff membership or privileges in that institution.

13. No institution shall use the name of any other party to this Agreement in any promotional or advertising material and this Agreement shall not constitute an endorsement by one party of any other party to this Agreement.

14. It is understood that all disputes arising under the Agreement shall first be discussed directly by the institutions that are directly involved.

15. This Agreement shall automatically terminate, without regard to the notice requirements contained in paragraph sixteen (16), upon the date that either party to this Agreement: (1) ceases to have a valid provider agreement with the Secretary of the Department of Health, Education and Welfare, under Title XVII of the Social Security Act, or subsequent statutory authority amending or replacing said Title; or (2) fails to renew, has suspended or has revoked its' license or registration issued by this State to operate as a general acute care hospital.

This Agreement shall be effective on the date written above and shall continue in full force and effect for twelve months. This Agreement shall be automatically be renewed from year to year. This Agreement may be terminated at any time upon 30 day written notice to the other party.

In WITNESS WHEREOF, the parties have executed this Agreement on the day and date first above written to be effective as provided hereinabove.

Methodist Medical Center of Illinois

By: H. Michael Bryant

Title: President & CEO

Dialysis Centers of America – Illinois

By: David G. Carter

David G. Carter, Regional Vice President

Exhibit I
Facility Locations:

RCG Peoria North
10405 N. Juliet Court
Peoria, IL 61615

RCG Canton
210 W. Walnut
Canton, IL 61520

RCG East Peoria
3300 N. Main Street
East Peoria, IL 61611

RCG Pekin
600 S. 13th Street
Pekin, IL 61554

RCG Peoria Downtown
410 R.B. Garrett Avenue
Peoria, IL 61605

RCG East Peoria Home Dialysis
3300 N. Main Street
East Peoria, IL 61611

RCG Peoria North Home Dialysis
10405 N. Juliet Court
Peoria, IL 61615

RCG Morris Home Dialysis
1401 Lakewood Drive, Suite D-1
Morris, IL 61450

Fresenius Medical Care

March 25, 2010

Connie Torrey-Romanus
c/o Fresenius Medical Care Spoon River
175 N. Main Street
Canton, IL 61520

Dear Connie,

Fresenius Medical Care East Peoria will accept end stage renal disease patients from Fresenius Medical Care Spoon River who require peritoneal dialysis services. These services include Continuous Ambulatory Peritoneal Dialysis (CAPD) & Continuous Cycling Peritoneal Dialysis (CCPD) training and support. Through this agreement all necessary training and follow-up services will be provided until one of the parties notifies the other in writing of a change. This notice will be made 30 days prior to termination of the agreement.

Sincerely,

Kathy Olson RN

Kathy Olson
Director of Operations
Fresenius Medical Care East Peoria

Fresenius Medical Services ♦ Dialysis Services
Support Services – Home Training
ATTACHMENT - 31
One Westbrook Corporate Center, Suite 1000 Westchester, IL 60154 708-562-0371 Fax: 708-498-9283

Criterion 1110.1430 (g) – Minimum Number of Stations

Fresenius Medical Care Spoon River is not located in a Metropolitan Statistical Area (MSA). A minimum of four dialysis stations is required to establish an in-center hemodialysis outside of a MSA. Fresenius Medical Care Spoon River will have 9 dialysis stations thereby meeting this requirement.

Fresenius Medical Care

September 30, 2009

Fresenius Medical Care Holdings, Inc (the Company or FMCH) provides the internal financing necessary for all acquisitions and construction for its wholly-owned subsidiaries.

The Financial and Economic Ratios for FMCH are as follows:

	Required	12/07	12/08	12/09	12/10	12/11	12/12	12/13
Net Margin (Last Twelve Months)	3.5%	7.3%	7.6%	6.7%	6.7%	6.7%	6.7%	6.7%
Debt to Total Capitalization	80.0%	41.9%	39.5%	34.9%	34.9%	34.9%	34.9%	34.9%
Days Cash on Hand	45.0	**10.0	**7.2	**6.4	**6.4	**6.4	**6.4	**6.4
Current Ratio	1.5	**1.0	**1.2	**1.1	**1.1	**1.1	**1.1	**1.1
Cushion Ratio	5.0	** 1.09	**.65	**0.64	**0.64	**0.64	**0.64	**0.64
Projected Debt Service Coverage	1.75	.02	(.01)	0	0	0	0	0

**** As discussed with Illinois CON Board on January 23, 2006, these ratios are inappropriate measures of liquidity or measures of ability to meet upcoming required payments. Well managed companies with debt will seek to minimize cash on hand, accelerate accounts receivable collections, and pay payables no sooner than required in order to minimize interest expense and reduce leverage.**

The amounts for 2007/2008 represent actuals from the FMCH, Inc financials. The remainder of 2009 and the projected years are an extension of our most recent performance.

The Company currently has in excess of $500 million of readily available liquidity. In addition, the Company has moderate leverage (currently less than 2.75x Funded Debt/EBITDA) and an S&P credit rating of BBB- on the Senior Secured bank debt. The Company's healthy financial position and abundant liquidity indicate that the Company has the ability to support the acquisition and development of additional dialysis centers. Additionally, the Company has more than adequate capability to meet all of its expected financial obligations over the next twelve months and its long term outlook is strong and stable.

Mark Fawcett
Vice President, Treasurer
Fresenius Medical Care NA

Section V. Review Criteria Relating To Financial Feasibility (FIN)

A. Criterion 1120.210.a, Financial Viability

2. Variance

*Ratios provided are for Fresenius Medical Care, Holdings, Inc. Dialysis Centers of America – Illinois, Inc. and Renal Care Group, Inc. do not maintain audited financial statements. Fresenius Medical Care Holdings, Inc. is willing and able to provide financial support to Renal Care Group, Inc. and hence to Dialysis Centers of America – Illinois, Inc. if necessary.

Fresenius Medical Care

Sent Via Email

April 26, 2010

Attn: Bob Ackerman

RE: Dialysis Centers of America - Illinois, LLC d/b/a Fresenius Medical Care Spoon River

Dear Bob

Below are the terms of the letter of intent:

LANDLORD:	Graham Hospital
TENANT:	Dialysis Centers of America - Illinois, LLC d/b/a Fresenius Medical Care Spoon River
LOCATION:	175 S Main Street Canton, IL 61520
Parcel ID Number:	PIN # 09-08-27-419-002
INITIAL SPACE REQUIREMENTS:	Approximately 5200 of contiguous usable square feet - See attached preliminary plan.
PRIMARY TERM:	An initial lease term of ten (10) years. The Lease and rent would commence One hundred twenty (120) days after Landlord Delivery.
DELIVERY OF PREMISES:	Landlord shall deliver the Premises to the Tenant for completion of the Tenant Improvements the earlier of 30 days after CON Approval
OPTIONS TO RENEW:	Three (3) - Five (5) year options to renew the Lease. Option rental rates shall be based upon 10% increase in the then existing rent.
RENTAL RATE:	$18.00 SF increase each year by 2.5%
USE:	Tenant shall use and occupy the Premises for the purpose of an outpatient dialysis facility and related office uses and for no other purposes except those authorized in writing by Landlord, which

shall not be unreasonably withheld, conditioned or delayed. Tenant may operate on the Premises, at Tenant's option, on a seven (7) days a week, twenty-four (24) hours a day basis, subject to zoning and other regulatory requirements.

DEMISED PREMISES SHELL:

The Demised Premises will be delivered as followed at landlord expense, in vanilla shell condition with building being watertight.

a. Adequate electrical power installed for Tenant's operation (800-amp/208-volt, 3-phase*), terminated inside the building within a main distribution panel dedicated solely for Tenant's use, to be located at location mutually- agreed upon by Tenant and Landlord

b. The presence of gas service* to handle the Tenant's HVAC needs and the use of two 100 gallon water heaters and one 50 gallon water heater to the premises, minimum of 600 MBHat a location to be mutually-agreed upon by Tenant and Landlord.

c. The presence of a sewer service with no less than a 4" line, dedicated to the space, into the leased premises at a location mutually-agreed upon by Tenant and Landlord. Provide sewer invert to meet Tenant's requirements.

d. The presence of a water service** with no less than a 2" dedicated line to thespace, (pressure 60-80 psi) into the leased premises at a location mutually-agreed upon by Tenant and Landlord.

e. Building fully-serviced by automatic fire suppression system to meet requirements and meet all applicable state and local codes, laws, ordinances and regulations.

f. Provide conduit to the building for Cable TV and Telephone service. Conduit shall also be provided to the tenant space and will originate from the building point of demarcation into the tenant space at a location mutually-agreed upon by Tenant and Landlord. If cable is not available Tenant shall have the right to install a satellite system for its use at its own cost.

g. The demising of the premises shall be in conformance with all applicable state and local codes, laws, ordinances and Life Safety / NFPA 101. The demising of tenant space includes removing asbestos join compound (gypsum) and

reinstalling gypsum to retain the fire rating on demised Partitions.

h. Assurances that the front of the building can have a patient drop off area (Porte Cochere) at a location designated by FMC

i. Verification that all asbestos and floor mastic was removed by an approved remediation contractor.

j. Provide a mutually agreeable location to place a concrete pad with enclosure for two 6-8 yard dumpsters.

k. Provide a mutually agreeable location to place a concrete pad with enclosure for a diesel generator.

l. Parking lot resealed and amply parking no less than five (5) spaces per thousand.

m. HVAC units , landlord to provide One(1) 7.5 ton unite and two (2) five ton units.

CONTRACTOR FOR TENANT IMPROVEMENTS: FMC will hire a contractor and/or subcontractors of their choosing to complete their tenant improvements utilizing the tenant allowance. FMC shall be responsible for the implementation and management of the tenant improvement construction and will not be responsible to pay for Landlord's project manager, if any.

LOADING: FMC requires access to the loading dock 24 hours per day, 7 days per week.

SPACE PLANNING/ ARCHITECTURAL AND MECHANICAL DRAWINGS: FMC will provide all space planning and architectural and mechanical drawings required to build out the tenant improvements, including construction drawings stamped by a

licensed architect and submitted for approvals and permits. All building permits shall be the Tenant's responsibility.

PRELIMINARY IMPROVEMENT PLAN: At this time, please provide AutoCAD files that include one-eight inch scale architectural drawings of the proposed demised premises and detailed building specifications.

PARKING: Landlord will provide a parking ratio of 5 per 1,000 RSF with as many of those spaces as possible to be directly in front of the building for patient use. BMA shall require that 10% of the parking be designated handicapped spaces plus one ambulance space (cost to designate parking spaces to be at Landlord's sole cost and expense).

BUILDING CODES: FMC requires that the site, shell and all interior structures constructed or provided by the Landlord to meet all local, State, and Federal building code requirements, including all provisions of ADA.

REAL ESTATE TAXES: FMC will pay their pro-rata share of Real Estate Taxes

ASSIGNMENT/ SUBLETTING: FMC requires the right to assign or sublet all or a portion of the demised premises to any subsidiary or affiliate without Landlord's consent. Any other assignment or subletting will be subject to Landlord's prior consent, which shall not be unreasonably withheld or delayed. Landlord reserves first right of refusal.

MAINTENANCE: Landlord shall, without expense to Tenant, maintain and make all necessary repairs to the exterior portions and structural portions of the Building to keep the building weather and water tight and structurally sound including, without limitation: foundations, structure, load bearing walls, exterior walls, doors and windows, the roof and roof supports, columns, retaining walls, gutters, downspouts, flashings, footings as well as any water mains, gas and sewer lines, sidewalks, private roadways, landscape, parking areas, common areas, and loading docks, if any, on or appurtenant to the Building or the Premises.

Tenant shall maintain and keep the interior of the Premises in good repair, free of refuse and rubbish and shall return the same at the expiration or termination of the Lease in as good condition as received by Tenant, ordinary wear and tear, and damage or destruction by fire, flood, storm, civil commotion or other unavoidable causes excepted. Tenant shall be responsible for maintenance and repair of Tenant's equipment in the Premises.

HVAC Landlord shall provide, at there cost , one (1) 7.5 ton unit and 2 five (5) ton units.

UTILITIES: Tenant shall pay all charges for water, electricity, gas, telephone and other utility services furnished to the Premises. Landlord agrees to bring water, electricity, gas and sanitary sewer to the Premises in sizes and to the location specified by Tenant and pay for the cost of meters to meter their use.

SURRENDER: At any time prior to the expiration or earlier termination of the Lease, Tenant may remove any or all the alterations, additions or installations, installed by or on behalf of Tenant, in such a manner as will not substantially injure the Premises. Tenant agrees to restore the portion of the Premises affected by Tenant's removal of such alterations, additions or installations to the same condition as existed prior to the making of such alterations, additions, or installations. Upon the expiration or earlier termination of the Lease, Tenant shall turn over the Premises to Landlord in good condition, ordinary wear and tear, damage or destruction by fire, flood, storm, civil commotion, or other unavoidable cause excepted. All alterations, additions, or installations not so removed by Tenant shall become the property of Landlord without liability on Landlord's part to pay for the same.

ZONING AND RESTRICTIVE COVENANTS: Landlord before the lease is executed confirms that the current property zoning is acceptable for the proposed use as an outpatient kidney dialysis clinic.

ENVIRONMENTAL: Landlord confirms that there is no asbestos present in the building and that there are no contaminants or environmental hazards in or on the property. A Phase One Environmental

Study has been conducted and has been made available for Tenant's review. Landlord also confirms that no other tenants or there activities present issues as to the generation of hazardous materials.

DRAFT LEASE: FMC propose the use of its Standard Form Lease.

CONFIDENTIAL: The material contained herein is confidential. It is intended for use of Landlord and Tenant solely in determining whether they desire to enter into a Lease, and it is not to be copied or discussed with any other person.

NON-BINDING

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

ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT

We look forward to reaching an agreement with your company. Once you have completed please email it back to my attention at William.Popken@fmc-na.com. Any questions please call me at 781-699-9994

Yours sincerely,

Bill Popken

Bill Popken

EXHIBIT 1

LEASE SCHEDULE NO. 769-0002105-015
(True Lease)

LESSOR: SIEMENS FINANCIAL SERVICES, INC.
("Lessor")

Address: 170 Wood Ave South
Iselin, NJ 08830

LESSEE: NATIONAL MEDICAL CARE, INC.
a Delaware corporation
("Lessee")
Address: 920 Winter Street
Waltham, MA 02451

1. Lessor and Lessee have entered into a Master Equipment Lease Agreement dated as of March 10, 2008 ("Master Lease"), including this Schedule (together, the "Lease"), pursuant to which Lessor and Lessee have agreed to lease the equipment described in Exhibit A hereto (the "Equipment"). Lessee and Lessor each reaffirm all of its respective representations, warranties and covenants set forth in the Master Lease, all of the terms and provisions of which are incorporated herein by reference, as of the date hereof. Lessee further certifies to Lessor that Lessee has selected the Equipment and prior to the execution of this Schedule has received and approved a purchase order, purchase agreement or supply contract under which the Equipment will be acquired for purposes of this Lease.

2. The Acquisition Cost of the Equipment is: $ 3,673,373.64

3. The Equipment will be located at the location specified in Exhibit A hereto, unless the Equipment is of the type normally used at more than one location (such as vehicular equipment, construction machinery or the like), in which case the Equipment will be used in the area specified on Exhibit A hereto.

4. TERM OF LEASE: The term for which the Equipment shall be leased shall be for 72 months (the "Initial Lease Term"), commencing on the Lease Term Commencement Date as set forth in the Acceptance Certificate to this Schedule, and expiring 03/30/2015, unless renewed, extended, or sooner terminated in accordance with the terms of the Lease.

6. RENT: (a) Payable in monthly installments on the 26th day of each month during the Initial Lease Term as follows:

Rental Payment Numbers	Number of Rental Payments	Amount of Each Rental Payment
1-72	72	$53,954.37

Lessor will invoice Lessee for all sales, use and/or personal property taxes as and when due and payable in accordance with applicable law, unless Lessee delivers to Lessor a valid exemption certificate with respect to such taxes. Delivery of such certificate shall constitute Lessee's representation and warranty that no such tax shall become due and payable with respect to the Equipment and Lessee shall indemnify and hold harmless Lessor from and against any and all liability or damages, including late charges and interest which Lessor may incur by reason of the assessment of such tax.

6. OTHER PAYMENTS:

(a) Lessee agrees to pay Rental Payments in advance.

7. EARLY TERMINATION OPTION: So long as no Event of Default under the Lease, nor any event which upon notice or lapse of time or both would constitute such an Event of Default has occurred and is continuing, Lessee shall have the option to terminate the Lease for all, but not less than all, of the Equipment on the rental payment date for the twenty-forth (24th) monthly rental payment (the "Early Termination Date"). Lessee shall notify Lessor in writing of Lessee's intention to exercise such termination option at least ninety (90) days prior to the Early Termination Date of such Lease. Lessee shall pay to Lessor on the Early Termination Date an aggregate amount (the "Termination Amount") equal to: (i) all rental payments, late charges and other amounts due and owing under the Lease, including the rental payment due on the Early Termination Date; plus (ii) any and all taxes, assessments and other charges due in connection with the termination of the Lease; plus (iii) 84% of the original Acquisition Cost of the Equipment as set forth herein.

In addition to the payment of the Termination Amount, Lessee shall return all of the Equipment to Lessor on the Early Termination Date pursuant to and in the condition required by the terms of the Lease.

In the event Lessee shall not pay the Termination Amount on the Early Termination Date and return the Equipment to Lessor pursuant to, and in the condition required by the Lease, then the Lease Term for the Equipment shall continue in full force and effect and this Early Termination Option shall be null and void and of no further force or effect.

8. EARLY PURCHASE OPTION: So long as no Event of Default under the Lease, nor any event which upon notice or lapse of time or both would constitute such an Event of Default has occurred and is continuing, Lessee shall have the option to terminate the Lease and purchase all, but not less than all, of the Equipment on the rental payment date for the sixtieth (60th) monthly rental payment (the "Early Purchase Option Date"). Lessee shall notify Lessor in writing of Lessee's intention to exercise such early purchase option at least ninety (90) days prior to the Early Purchase Option Date of such Lease. Lessee shall pay to Lessor on the Early Purchase Option Date an aggregate amount (the "Purchase Price") equal to: (i) all rental payments, late charges and other amounts due and owing under the Lease, including the rental payment due on the Early Purchase Option Date; plus (ii) any and all taxes, assessments and other charges due in connection with the termination of the Lease and the purchase of the Equipment; plus (iii) **28.02%** of the original Acquisition Cost of the Equipment as set forth herein.

Provided that Lessor shall have received the Purchase Price on the Early Purchase Option Date, Lessor shall convey all of its right, title and interest in and to the Equipment to Lessee on the Early Purchase Option Date, on an "AS-IS", **"WHERE-IS" BASIS WITHOUT REPRESENTATION OR WARRANTY, EXPRESS OR IMPLIED,** and without recourse to Lessor; provided however, that notwithstanding anything else herein to the contrary, Lessor shall warrant that the Equipment is free and clear of all liens, charges and encumbrances created by, through or under Lessor, and that Lessor has good and lawful right, power and authority to sell said Equipment to Lessee.

In the event Lessee shall not pay the Purchase Price on the Early Purchase Option Date then the Initial Lease Term or any renewal term for the Equipment shall continue in full force and effect and this Early Purchase Option shall be null and void and of no further force or effect.

9. PURCHASE OPTION: So long as no Event of Default, nor any event which upon notice or lapse of time or both would constitute and Event of Default, has occurred and is continuing under the Lease, and the Lease has not been earlier terminated, and upon not less than ninety (90) days prior written notice, Lessee shall have the option, upon expiration of the Initial Lease Term, renewal term or Extended Term, to purchase all, but not less than all, of Lessor's right, title and interest in and to the Equipment at the end of the Lease Term for a Purchase Option Price (hereinafter defined), on the last day of the Lease Term, in immediately available funds.

The Purchase Option Price shall be equal to the Fair Market Value of the Equipment (hereinafter defined) plus any sales, use, property or excise taxes on or measured by such sale, any other amounts accrued and unpaid under the Lease and any other expenses of transfer including UCC termination fees.

The "Fair Market Value" of the Equipment, shall be determined on the basis of, and shall be equal in amount to the value which would be obtained in, an arm's-length transaction between an informed and willing buyer-user (other than a lessee currently in possession or a used equipment dealer) and an informed and willing seller under no compulsion to sell and, in such determination, costs of removal from the location of current use shall not be a deduction from such value. For purposes of determining Fair Market Value it will be assumed that as of the date of determination that the Equipment is in at least the condition required by the Lease. If during or after the period of thirty (30) days from Lessor's receipt of the aforesaid written notice from Lessee of Lessee's intention to exercise said purchase option, Lessor and Lessee determine that they cannot agree upon such fair market value, then such value shall be determined in accordance with the foregoing definition by a qualified independent appraiser as selected by mutual agreement between Lessor and Lessee, or failing such agreement, by a panel of three independent appraisers, one of whom shall be selected by Lessor, the second by Lessee and the third designated by the first two selected. If any party refuses or fails to appoint an appraiser or a third appraiser cannot be agreed upon by the other two appraisers, such appraiser or appraisers shall be selected in accordance with the rules for commercial arbitration of the

American Arbitration Association. The appraisers shall be instructed to make such determination within a period of twenty (20) days following appointment, and shall promptly communicate such determination in writing to Lessor and Lessee. The determination of Fair Market Value so made by the sole appraiser or by a majority of the appraisers, if there is more than one, shall be conclusively binding upon both Lessor and Lessee. All appraisal costs, fees and expenses shall be payable by Lessee. The sale of the Equipment by Lessor to Lessee shall be on an AS-IS, WHERE-IS basis, without recourse to, or warranty by, Lessor, provided however, that notwithstanding anything else herein to the contrary, Lessor shall warrant that the Equipment is free and clear of all liens, charges and encumbrances created by, through or under Lessor, and that Lessor has good and lawful right, power and authority to sell said Equipment to Lessee.

Lessee shall be deemed to have waived this Purchase Option unless it provides Lessor written notice of its irrevocable election to exercise this option within fifteen (15) days after Lessee is advised of the Fair Market Value of the Equipment.

Lessee may elect to return all, but not less than all, of the Equipment at the end of the Initial Lease Term or any renewal term, provided that such return will only be permitted if (i) the Lessee provides the Lessor with written notice of its intention to return the Equipment not less than ninety (90) days prior to the end of the Initial Term, and (ii) the return of the Equipment is in accordance with the terms of the Lease and any Schedules, Acceptance Certificate, Riders, Exhibits and Addenda thereto.

If, for any reason whatsoever, the Lessee does not purchase the Equipment at the end of the Initial Lease Term or any renewal term in accordance with the foregoing, or exercise their option to return the Equipment as set forth above, the lease term of the Equipment shall end without further action on the part of Lessee be extended on a month-to-month basis with rentals payable monthly calculated at one hundred five percent (105%) of the highest monthly rental payable during the Initial Lease Term (the "Extended Term"). At the end of such Extended Term, the Lessee shall have the option to either: (i) return the Equipment to the Lessor in accordance with the terms of the Lease; or (ii) purchase the Equipment for its then Fair Market Value as determined in accordance with the provisions set forth above. The Extended Term shall continue until (a) Lessee provides Lessor with not less than ninety (90) days prior written notice of the anticipated date Lessee will return the Equipment and Lessee returns the Equipment in accordance with the return provisions of this Lease, or (b) Lessee provides Lessor with not less than ninety (90) days prior written notice of Lessee's exercise of its Fair Market Value purchase option with respect to the Equipment.

10.STIPULATED LOSS VALUES:

Rental Payment #	Percentage of Acquisition Cost	Rental Payment #	Percentage of Acquisition Cost
1	101.47	37	60.22
2	100.51	38	58.94
3	99.55	39	57.66
4	98.56	40	56.37
5	97.55	41	55.08
6	96.53	42	53.78
7	95.48	43	52.47
8	94.41	44	51.16
9	93.33	45	49.84
10	92.25	46	48.51
11	91.15	47	47.18
12	90.05	48	45.84
13	88.95	49	44.50
14	87.83	50	43.15
15	86.71	51	41.79
16	85.58	52	40.43
17	84.44	53	39.06
18	83.29	54	37.69
19	82.14	55	36.31

Rental Payment #	Percentage of Acquisition Cost	Rental Payment #	Percentage of Acquisition Cost
20	80.97	56	34.92
21	79.81	57	33.53
22	78.63	58	32.13
23	77.46	59	30.72
24	76.26	60	29.31
25	75.06	61	27.89
26	73.86	62	26.47
27	72.65	63	25.04
28	71.44	64	23.61
29	70.22	65	22.17
30	68.99	66	20.72
31	67.76	67	19.27
32	66.52	68	17.82
33	65.27	69	16.35
34	64.01	70	14.88
35	62.75	71	13.40
36	61.49	72	11.92

Stipulated Loss Values are due in addition to the Rental Payment due on the same date.

IN WITNESS WHEREOF, the parties hereto certify that they have read, accepted and caused this Individual Leasing Record to be duly executed by their respective officers thereunto duly authorized.

Dated: 3/30/09

LESSOR:

Siemens Financial Services, Inc.

By: Carol Walters

Name: CAROL WALTERS

Title: VICE PRESIDENT-DOCUMENTATION

Ernest Errigo
Sr. Transaction Coordinator

LESSEE:

National Medical Care, Inc.

By:

Name: MARK FAWCETT

Title: TREASURER

015 Exhibit 12.doc

SIEMENS FINANCIAL SERVICES INC
FUNDING 03/30/2009

Exhibit A

04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134602	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134613	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134549	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134603	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134618	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134606	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134598	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134605	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134619	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134443	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
04060256 Total											$	187,950.00					14										
04060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134425	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864888	2/27/2009	3/16/2009	3/30/2009	3/30/2015
04060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134292	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864888	2/27/2009	3/16/2009	3/30/2009	3/30/2015
04060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134319	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864888	2/27/2009	3/16/2009	3/30/2009	3/30/2015
04060261 Total									$	40,275.00							3										
04060280	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133265	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504890837	3/12/2009	3/16/2009	3/30/2009	3/30/2015
04060280	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133083	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504890837	3/12/2009	3/16/2009	3/30/2009	3/30/2015
04060280 Total									$	20,850.00							2										
04060282	3/24/2009	769-0002105-015	0701	FMS GAINESVILLE	1775 NW 80TH BOULEVARD	GAINESVILLE	FL	32606	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133308	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504781910	1/5/2009	3/10/2009	3/30/2009	3/30/2015
04060282 Total									$	13,425.00							1										
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134147	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134436	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134467	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134513	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134311	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134322	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134497	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$	13,425.00	$	839.06	$	14,264.06	$	215.37	9K0S134415	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
04060283 Total									$	107,400.00							8										
04035046	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134099	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504845586	2/17/2009	2/26/2009	3/30/2009	3/30/2015
04035046 Total									$	13,425.00							1										
04035048	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$	5,000.00	$	-	$	5,000.00	$	75.50	1272343	1	PO MILLENIUM M-750 W/PRESS-SW.8	4504845590			3/30/2009	3/30/2015
04035048 Total									$	5,000.00							1										
04035047	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$	252.00	$	-	$	252.00	$	3.80		1	TANK, CARBON EXCHANGE, 0.25 CUB	4504845590			3/30/2009	3/30/2015
04035047 Total									$	252.00							1										
04035050	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$	252.00	$	-	$	252.00	$	3.80		1	TANK, CARBON EXCHANGE, 0.25 CUB	4504845590			3/30/2009	3/30/2015
04035050 Total									$	252.00							1										
04060307	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133920	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504841841	2/13/2009	3/9/2009	3/30/2009	3/30/2015
04060307	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133950	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504841841	2/13/2009	3/9/2009	3/30/2009	3/30/2015
04060307	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133907	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504841841	2/13/2009	3/9/2009	3/30/2009	3/30/2015
04060307	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133904	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504841841	2/13/2009	3/9/2009	3/30/2009	3/30/2015
04060307	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S133945	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504841841	2/13/2009	3/9/2009	3/30/2009	3/30/2015
04060307 Total									$	67,125.00							5										
04060258	3/27/2009	769-0002105-015	4238	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134126	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504741675	12/19/2008	3/5/2009	3/30/2009	3/30/2015
04060258	3/27/2009	769-0002105-015	4238	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134251	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504741675	12/19/2008	3/5/2009	3/30/2009	3/30/2015
04060258	3/27/2009	769-0002105-015	4238	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$	13,425.00	$	-	$	13,425.00	$	202.70	9K0S134247	1	2008K2 HEMODIALYSIS SYS, OLC/DI	4504741675	12/19/2008	3/5/2009	3/30/2009	3/30/2015

Case

DELL

QUOTATION

QUOTE #: 485293558
Customer #: 84405601
Contract #: 70137
CustomerAgreement #: Dell Std Terms
Quote Date: 4/22/09
Customer Name: FRESENIUS MEDICAL CARE N A

Date: 4/22/09 12:33:14 PM

TOTAL QUOTE AMOUNT:	$975.02		
Product Subtotal:	$864.59		
Tax:	$46.43		
Shipping & Handling:	$64.00		
Shipping Method:	Ground	Total Number of System Groups:	1

GROUP: 1	QUANTITY: 1	SYSTEM PRICE: $584.51	GROUP TOTAL: $584.51
Base Unit:	OptiPlex 760 Small Form FactorBase Standard PSU (224-2219)		
Processor:	OptiPlex 760,Core 2 Duo E7300/2.66GHz,3M,1066FSB (311-9514)		
Memory:	2GB,Non-ECC,800MHz DDR2,2X1GB OptiPlex (311-7374)		
Keyboard:	Dell USB Keyboard,No Hot Keys English,Black,Optiplex (330-1987)		
Monitor:	Dell UltraSharp 1708FP BLK w/AdjStn,17 inch,1x08FPBLK OptiPlex,Precision and Latitude (320-7682)		
Video Card:	Integrated Video,GMA 4500,DellOptiPlex 760 and 960 (320-7407)		
Hard Drive:	80GB SATA 3.0Gb/s and 8MB DataBurst Cache,Dell OptiPlex (341-8006)		
Floppy Disk Drive:	No Floppy Drive with Optical Filler Panel,Dell OptiPlex Small Form Factor (341-4609)		
Operating System:	Windows XP PRO SP3 with Windows Vista Business LicenseEnglish,Dell Optiplex (420-9570)		
Mouse:	Dell USB 2 Button Optical Mouse with Scroll,Black OptiPlex (330-2733)		
NIC:	ASF Basic Hardware Enabled Systems Management (330-2901)		
CD-ROM or DVD-ROM Drive:	24X24 CDRW/DVD Combo,with Cyberlink Power DVD,No Media Media,Dell OptiPlex 960 Small Form Factor (313-7071)		
CD-ROM or DVD-ROM Drive:	Cyberlink Power DVD 8.1,with Media,Dell OptiPlex/Precision (420-9179)		
Sound Card:	Heat Sink, Mainstream, Dell Optiplex Small Form Factor (311-9520)		
Speakers:	Dell AX510 black Sound Bar forUltraSharp Flat Panel DisplaysDell Optiplex/Precision/ Latitude (313-6414)		
Cable:	OptiPlex 760 Small Form FactorStandard Power Supply (330-1984)		
Documentation Diskette:	Documentation,English,Dell OptiPlex (330-1710)		
Documentation Diskette:	Power Cord,125V,2M,C13,Dell OptiPlex (330-1711)		
Factory Installed Software:	No Dell Energy Smart Power Management Settings,OptiPlex (467-3564)		
Feature	Resource DVD contains Diagnostics and Drivers for Dell OptiPlex 760 Vista (330-2019)		
Service:	ProSupport for IT: Next Business Day Parts and Labor Onsite Response Initial Year (991-6370)		
Service:	ProSupport for IT: Next Business Day Parts and Labor Onsite Response 2 Year Extended (991-3642)		
Service:	Dell Hardware Limited Warranty Plus Onsite Service Initial Year (992-6507)		
Service:	Dell Hardware Limited Warranty Plus Onsite Service Extended Year(s) (992-6508)		
Service:	ProSupport for IT: 7x24 Technical Support for certified IT Staff, Initial (984-6640)		
Service:	ProSupport for IT: 7x24 Technical Support for certified IT Staff, 2 Year Extended (984-0002)		
	Thank you choosing Dell ProSupport. For tech support, visit http://support.dell.com/ProSupport		

Service:	or call 1-866-516-31 (989-3449)
Installation:	Standard On-Site Installation Declined (900-9987)
Installation:	Standard On-Site Installation Declined (900-9987)
Misc:	Shipping Material for System Cypher Small Form Factor,Dell OptiPlex (330-2193)
	Vista Premium Downgrade Relationship Desktop (310-9161)
	CFI Routing SKU (365-0257)
	CFI,Rollup,Integration Service,Image Load (366-1416)
	CFI,Rollup,Custom Project,Fee for ESLH (366-1551)
	CFI,Rollup,Integration Services,BIOS Setting (366-1656)
	CFI,Information,Vista To WXP ONLY,Factory Install (372-6272)
	CFI,Software,Image,Quick Image,Titan,Factory Install (372-9740)
	CFI,BIOS,Across Line Of Business,Wakeup-on-lan, Enable,Factory Install (374-4568)
	CFI,Information,Optiplex 760 Only,Factory Install (374-8402)

SOFTWARE & ACCESSORIES

Product	Quantity	Unit Price	Total
Office 2007 Sngl C 021-07777 (A0748570)	1	$259.68	$259.68
Windows Server CAL 2008 Sngl MVL Device CAL C R18-02830 (A1511502)	1	$20.40	$20.40
Number of S & A Items: 2	S&A Total Amount: $280.08		

SALES REP:	PHIL CLINTON	PHONE:	1800-274-3355
Email Address:	Phil_Clinton@Dell.com	Phone Ext:	723-3128

For your convenience, your sales representative, quote number and customer number have been included to provide you with faster service when you are ready to place your order. Orders may be faxed to the attention of your sales representative to 1-866-230-4217. You may also place your order online at www.dell.com/qto

This quote is subject to the terms of the agreement signed by you and Dell, or absent such agreement, to Dell's Terms of Sale.

Prices and tax rates are valid in the U.S. only and are subject to change.

***Sales/use tax is a destination charge, i.e. based on the "ship to" address on your purchase order. Please indicate your taxability status on your PO. If exempt, please fax exemption certificate to Dell Tax Department at 888-863-8778, referencing your customer number. If you have any questions regarding tax please call 800-433-9019 or email Tax_Department@dell.com. ***

All product and pricing information is based on latest information available. Subject to change without notice or obligation.

LCD panels in Dell products contain mercury, please dispose properly. Please contact Dell Financial Services' Asset Recovery Services group for EPA compliant disposal options at US_Dell_ARS_Requests@dell.com. Minimum quantities may apply.

Shipments to California: For certain products, a State Environmental Fee Of Up to $10 per item may be applied to your invoice as early as Jan 1, 2005. Prices in your cart do not reflect this fee. More info: or refer to URL www.dell.com/environmentalfee

2008 Financial Statements for Fresenius Medical Care Holdings, Inc. were submitted previously to the Board with Project #09-028 and are the same financials that pertain to this application. In order to reduce bulk these financials can be referred to if necessary.

Financials
ATTACHMENT - 75

Criterion 1120.210(c), Operating Start-up Costs

Estimated 1-month personnel expense:	$ 28,230
Estimated 2 weeks medical supply expense:	3,120
Estimated 2 weeks rent expense:	3,904
Estimated 1-month other expense:	18,110
Total:	$53,364

It is estimated that $53,364 in start up costs will be incurred. No deficits are anticipated from the operation. Total funding for the project is available from cash and securities.

Criterion 1120.310(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)	
ESRD		131.00			5,200			681,200	681,200
Contingency		13.08			5,200			68,000	68,000
TOTALS		144.08			5,200			749,200	749,200
* Include the percentage (%) of space for circulation									

Criterion 1120.310(b) Conditions of Debt Financing

Dialysis Centers of America - Illinois, Inc.

In accordance with 77 ILL. ADM Code 1120, Subpart D, Section 1120.310, of the Illinois Health Facilities Planning Board Application for Certificate of Need; I do hereby attest to the fact that:

There is no debt financing. The project will be funded with cash and leasing arrangements; and

The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

By: _____

ITS: Marc Lieberman
~~Asst. Treasurer~~

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
~~Vice President & Treasurer~~

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

WYNELLE SCENNA
MY COMM. EXPIRES AUG. 1, 2014
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

Criterion 1120.310(b) Conditions of Debt Financing

Renal Care Group, Inc.

In accordance with 77 ILL. ADM Code 1120, Subpart D, Section 1120.310, of the Illinois Health Facilities Planning Board Application for Certificate of Need; I do hereby attest to the fact that:

There is no debt financing. The project will be funded with cash and leasing arrangements; and

The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

By:_____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2010

_____
Signature of Notary

Seal

By:_____

ITS: Mark Fawcett
Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

_____
Signature of Notary

Seal

WYNELLE SCENNA
MY COMM. EXPIRES AUG. 1, 2014
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

Criterion 1120.310(b) Conditions of Debt Financing

Fresenius Medical Care Holdings, Inc.

In accordance with 77 ILL. ADM Code 1120, Subpart D, Section 1120.310, of the Illinois Health Facilities Planning Board Application for Certificate of Need; I do hereby attest to the fact that:

There is no debt financing. The project will be funded with cash and leasing arrangements; and

The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
Vice President & Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

Criterion 1120.310(a) Reasonableness of Financing Arrangements

Dialysis Centers of America – Illinois, Inc.

The applicant is paying for the project with cash on hand, and not borrowing any funds for the project. However, per the Board's rules the entering of a lease is treated as borrowing. As such, we are attesting that the entering into of a lease (borrowing) is less costly than the liquidation of existing investments which would be required for the applicant to buy the property and build a structure itself to house a dialysis clinic. Further, should the applicant be required to pay off the lease in full, its existing investments and capital retained could be converted to cash or used to retire the outstanding lease obligations within a sixty (60) day period.

By:_____

Title: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2010

_____
Signature of Notary

Seal

By:_____

Title: Mark Fawcett
Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

_____
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

Criterion 1120.310(a) Reasonableness of Financing Arrangements

Renal Care Group, Inc.

The applicant is paying for the project with cash on hand, and not borrowing any funds for the project. However, per the Board's rules the entering of a lease is treated as borrowing. As such, we are attesting that the entering into of a lease (borrowing) is less costly than the liquidation of existing investments which would be required for the applicant to buy the property and build a structure itself to house a dialysis clinic. Further, should the applicant be required to pay off the lease in full, its existing investments and capital retained could be converted to cash or used to retire the outstanding lease obligations within a sixty (60) day period.

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

Criterion 1120.310(a) Reasonableness of Financing Arrangements

Fresenius Medical Care Holdings, Inc.

The applicant is paying for the project with cash on hand, and not borrowing any funds for the project. However, per the Board's rules the entering of a lease is treated as borrowing. As such, we are attesting that the entering into of a lease (borrowing) is less costly than the liquidation of existing investments which would be required for the applicant to buy the property and build a structure itself to house a dialysis clinic. Further, should the applicant be required to pay off the lease in full, its existing investments and capital retained could be converted to cash or used to retire the outstanding lease obligations within a sixty (60) day period.

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2010

_____
Signature of Notary

Seal

By: _____

ITS: Mark Fawcett
Vice President & Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 14 day of April, 2010

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES AUG. 1, 2014

Criterion 1120.310 (d) – Projected Operating Costs

Year 2012

Salaries:	$275,000
Benefits:	68,750
Supplies*:	612,052
Total:	**$955,802**
Treatments:	5,640
Cost Per Treatment:	$169.47

Criterion 1120.310 (e) – Total Effect of the Project on Capital Costs

Year 2012

Depreciation/Amortization	$140,111
Interest	0
CAPITAL COSTS	$140,111
Treatments:	5,640
Capital Cost per treatment	$24.84