ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: *Fresenius Medical Care Roseland*				
Street Address: *132 W 111th Street*				
City and Zip Code: *Chicago 60628*				
County: *Cook*	Health Service Area	*6*	Health Planning Area:	

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

Exact Legal Name: *Fresenius Medical Care Roseland, LLC d/b/a Fresenius Medical Care Roseland*
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*

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care*
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*
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-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care*
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: *Holland & Knight, LLP*
Address: *131 S. Dearborn, 30th Floor, Chicago, IL 60603*
Telephone Number: *312-578-6567*
E-mail Address: *clare.ranalli@hklaw.com*
Fax Number: *312-578-6666*

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Roseland Medical Center, LLC*
Address of Site Owner: *45 W 111th Street, Chicago, IL 60628*
Street Address or Legal Description of Site: *132 W 111th Street, Chicago, IL 60628*
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

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

Operating Identity/Licensee

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

Exact Legal Name: *Fresenius Medical Care Roseland, LLC d/b/a Fresenius Medical Care Roseland*
Address: *920 Winter Street, Waltham, MA 02451*

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.] ***NOT APPLICABLE/ CHANGE OF OWNERSHIP***

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.] ***NOT APPLICABLE/CHANGE OF OWNERSHIP***

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Narrative Description

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

Fresenius Medical Care Roseland (a 12-station ESRD facility) is currently operated by Fresenius Medical Care of Illinois, LLC, a Delaware corporation that is qualified to do business in Illinois. The facility is located at 132 W 111th Street, Chicago, IL 60628. All of the assets specific to Fresenius Medical Care of Illinois, LLC d/b/a Fresenius Medical Care Roseland will be transferred to Fresenius Medical Roseland, LLC, also a Delaware corporation that is qualified to do business in Illinois.

There is no cost associated with this transaction as it entails the transfer of assets only.

This project is "non-substantive" under Planning Board rule 1110.10(b) as it entails the change of ownership of an existing in-center hemodialysis facility.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	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	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
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 or Equipment	N/A	N/A	N/A
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	0	0	0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	N/A	N/A	N/A
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)	N/A	N/A	N/A
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	0	0	0
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 targe utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ _____.

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, 2010

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

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

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements *NOT APPLICABLE – CHANGE OF OWNERSHIP*

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

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

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

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 Roseland, LLC * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application 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

Mark Fawcett
PRINTED NAME

Vice President & Treasurer
PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

Marc Lieberman
PRINTED NAME

Asst. Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of June 2010

Susan H Console
Signature of Notary

Seal

SUSAN H. CONSOLE
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 1, 2013

*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 Mark Fawcett
Vice President & Asst. Treasurer

PRINTED TITLE

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

Signature of Notary

Seal

SIGNATURE

PRINTED NAME Mark Fawcett
Asst. Treasurer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10 day of June 2010

Susan H Console

Signature of Notary

Seal

SUSAN H. CONSOLE
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 1, 2013

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT ***NOT APPLICABLE – THE PROJECT WILL NOT IMPACT PATIENT CARE, QUALITY OR ACCESS TO SERVICES OFFERED BY THE CLINIC. IT IS SIMPLY A CHANGE TO THE BUSINESS STRUCTURE/OWNERSHIP OF THE ENTITY THAT OWNS/OPERATES THE DIALYSIS FACILTY.***

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

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

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

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

ALTERNATIVES ***NOT APPLICABLE – THERE ARE NOT COSTS ASSOCIATED WITH THIS PROJECT/CHANGE OF OWNERSHIP***

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

Alternative options **must** include:

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

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

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

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

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

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

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

SECTION VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP

This Section is applicable to projects involving merger, consolidation or acquisition/change of ownership.

NOTE: For all projects involving a change of ownership THE TRANSACTION DOCUMENT must be submitted with the application for permit. The transaction document must be signed dated and contain the appropriate contingency language.

A. Criterion 1110.240(b), Impact Statement

Read the criterion and provide an impact statement that contains the following information:

1. Any change in the number of beds or services currently offered.
2. Who the operating entity will be.
3. The reason for the transaction.
4. Any anticipated additions or reductions in employees now and for the two years following completion of the transaction.
5. A cost-benefit analysis for the proposed transaction.

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

1. The current admission policies for the facilities involved in the proposed transaction.
2. The proposed admission policies for the facilities.
3. A letter from the CEO certifying that the admission policies of the facilities involved will not become more restrictive.

C. Criterion 1110.240(d), Health Care System ***NOT APPLICABLE – APPLICANT IS NOT A HEALTH CARE SYSTEM***

Read the criterion and address the following:

1. Explain what the impact of the proposed transaction will be on the other area providers.
2. List all of the facilities within the applicant's health care system and provide the following for each facility.
   a. the location (town and street address);
   b. the number of beds;
   c. a list of services; and
   d. the utilization figures for each of those services for the last 12 month period.
3. Provide copies of all present and proposed referral agreements for the facilities involved in this transaction.
4. Provide time and distance information for the proposed referrals within the system.
5. Explain the organization policy regarding the use of the care system providers over area providers.
6. Explain how duplication of services within the care system will be resolved.
7. Indicate what services the proposed project will make available to the community that are not now available.

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

G.

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

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

VIII. - 1120.120 - Availability of Funds

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

N/A	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
N/A	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
N/A	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
N/A	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
N/A	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
N/A	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
N/A	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
N/A	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance ***NOT APPLICABLE***

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements ***NOT APPLICABLE – THERE ARE NO PROJECT COSTS***

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

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

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

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

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

B. Conditions of Debt Financing ***NOT APPLICABLE – THERE ARE NO PROJECT COSTS***

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

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

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

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

C. Reasonableness of Project and Related Costs ***NOT APPLICABLE – THERE ARE NO PROJECT COSTS***

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs ***NOT APPLICABLE***

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

APPEND DOCUMENTATION AS ATTACHMENT -42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS: ***NOT APPLICABLE – PROJECT IS NON-SUBSTANTIVE AND IS NOT A DISCONTINUTAION***

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 Medicaidpatients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

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

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

Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

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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File Number 0298085-1

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

FRESENIUS MEDICAL CARE ROSELAND, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MAY 26, 2010, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 14TH *day of* JUNE *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1016501124

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

Certificate of Good Standing
ATTACHMENT - 1

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 02451*
Telephone Number: *800-662-1237*

Type of Ownership of Applicant/Co-Applicant

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

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Roseland Medical Center, LLC*
Address of Site Owner: *45 W 111th Street, Chicago, IL 60628*
Street Address or Legal Description of Site: *132 W 111th Street, Chicago, IL 60628* **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Site Owner
ATTACHMENT – 2

Operating Identity/Licensee

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

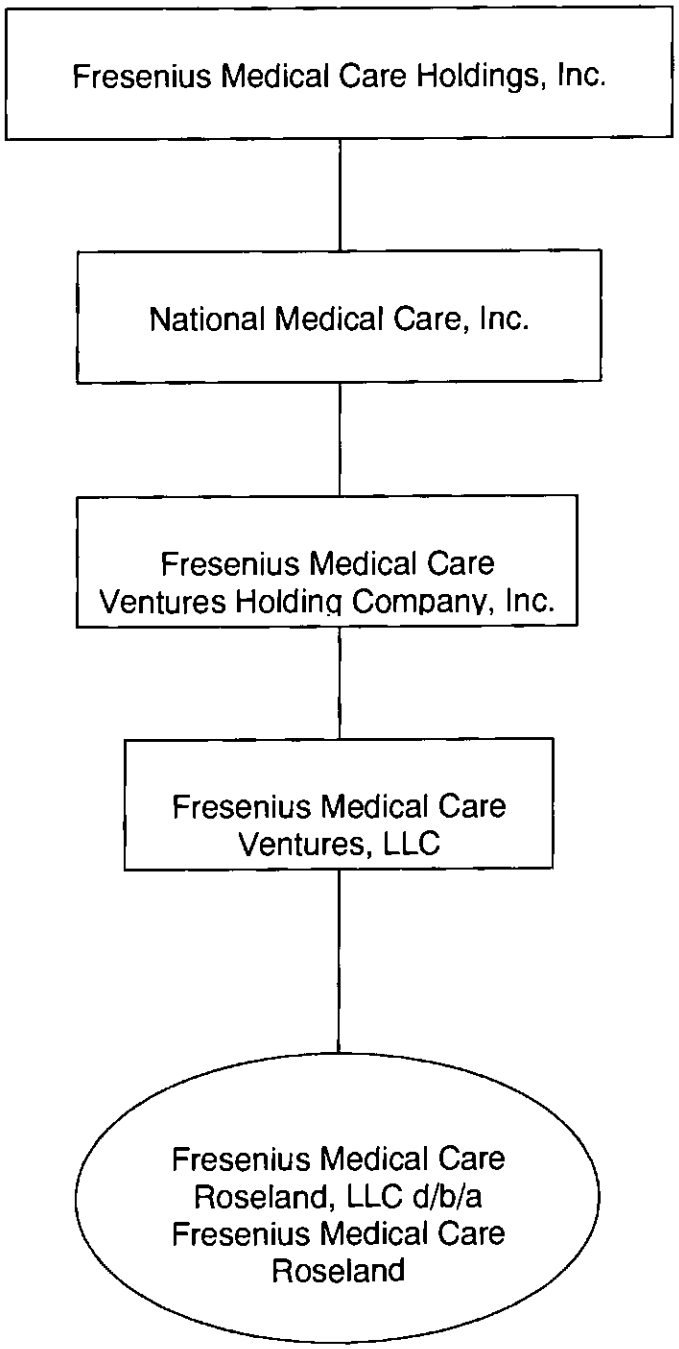
Exact Legal Name: *Fresenius Medical Care Roseland, LLC d/b/a Fresenius Medical Care Roseland*

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

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

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

Certificate of Good Standing at Attachment – 1.



Organizational Chart
ATTACHMENT - 4

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	14-2710	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

Facility List
ATTACHMENT - 11

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
River Forest		103 Forest Avenue	River Forest	60305
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		219 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
West Willow		14404W. Willow	Chicago	60620
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

Certification & Authorization

Fresenius Medical Care Roseland, LLC

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 Roseland, LLC, by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

In regards to section III, A (3) of the Illinois Health Facilities Planning Board Application for Certificate 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: _____
Mark Fawcett
ITS: Vice President & Treasurer

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

_____
Signature of Notary

Seal

By: _____
Marc Lieberman
ITS: Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 6 day of June, 2010

Susan H Console
Signature of Notary

Seal

SUSAN H. CONSOLE
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 1, 2013

ATTACHMENT - 11

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: Mark Fawcett
Vice President & Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 6 day of June, 2010

Susan H Console
Signature of Notary

Seal

SUSAN H. CONSOLE
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
February 1, 2013

ATTACHMENT - 11

BILL OF SALE; ASSIGNMENT AND ASSUMPTION AGREEMENT

This **BILL OF SALE; ASSIGNMENT AND ASSUMPTION AGREEMENT** (this **"Agreement"**), dated June 15, 2010 is made between **Fresenius Medical Care of Illinois, LLC**, a Delaware limited liability company (the **"Initial Transferor"**), Fresenius Medical Care Ventures, LLC, a Delaware limited liability company (the **"Initial Transferee"** and **"Second Transferor"**), and Fresenius Medical Care Roseland , LLC, a Delaware limited liability company (the **"Second Transferee"**).

1. Effective as of 12:00:00 a.m. on the October 1, 2010 (the "**Effective Date**"), for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, (a) the Initial Transferor hereby sells, assigns, transfers and conveys to the Initial Transferee and its successors and assigns all of the Initial Transferor's right, title and interest in and to the Facility Assets (as such term is defined in the Limited Liability Company Agreement for the Second Transferee dated as of the date hereof (the "**LLC Agreement**"), which Facility Assets include without limitation those assets listed on Exhibit A attached hereto, and (b) the Initial Transferee hereby assumes all of the obligations of the Initial Transferor arising under or relating to the Facility Assets.

2. Effective as of 12:00:01 a.m. on the Effective Date, for good and valuable consideration the receipt and sufficiency of which are hereby acknowledged, and subject to the terms of the LLC Agreement, (a) the Second Transferor hereby sells, assigns, transfers and conveys to the Second Transferee and its successors and assigns all of the Second Transferor's right, title and interest in and to the Facility Assets, and (b) the Second Transferee hereby assumes all of the obligations of the Second Transferor arising under or relating to the Facility Assets.

3. Notwithstanding anything herein to the contrary, this Agreement shall not become effective unless and until both of the following events have occurred: (i) the Second Transferee has obtained a Certificate of Need from the Illinois Health Facilities and Services Review Board that permits the transactions contemplated hereby; and (ii) the LLC Agreement, along with all documents ancillary thereto, has been fully executed and delivered.

The parties each shall, without further consideration, execute and deliver to the other such instruments, and take such further action, as the other party may reasonably request to effectuate the assignments contemplated hereby.

[signature page follows]

IN WITNESS WHEREOF, the Initial Transferor, the Initial Transferee and Second Transferor, and the Second Transferee have executed this Bill of Sale; Assignment and Assumption Agreement as of the date first above referenced.

THE INITIAL TRANSFEROR:

FRESENIUS MEDICAL CARE OF ILLINOIS, LLC

By: _____
Name: Joseph J. Ruma
Title: Vice President

THE INITIAL TRANSFEREE and SECOND TRANSFEROR:

FRESENIUS MEDICAL CARE VENTURES, LLC

By: _____
Name: Joseph J. Ruma
Title: Vice President

THE SECOND TRANSFEREE:

FRESENIUS MEDICAL CARE ROSELAND, LLC

By: _____
Name: Joseph J. Ruma
Title: Manager

[Signature Page to Bill of Sale; Assignment and Assumption Agreement]

Fresenius Medical Care Roseland, LLC

IMPACT AND ACCESS STATEMENT PER PART 1110.240

The proposed change of ownership will not result in the reduction or addition of stations at the existing certified dialysis facility. The current owner/operator of the facility is Fresenius Medical Care of Illinois, LLC, (whose ultimate parent entity is Fresenius Medical Care Holdings, Inc.) and will be owned/operated by Fresenius Medical Care Roseland, LLC, (whose ultimate parent entity is also Fresenius Medical Care Holdings, Inc.), after the change of ownership. There will be no reduction in employees at the facility for a period of two years from the date of change of ownership other than in the normal course of business. There is no cost associated with this transaction.

There will be no changes to patient admissions and no reduction in access to dialysis services as a result of the change of ownership. The admission policies of the facility involved will not become more restrictive. Facilities owned and operated by Fresenius Medical Care of Illinois, Inc. accept all patients regardless of ability to pay. They are "open" facilities from the standpoint of granting privileges to any physician who wishes to admit patients to the facility. The facility currently operates under the Fresenius Medical Care Holdings, Inc. Admissions Policies and will remain operating under the Fresenius Medical Care Holdings, Inc. Policies, a copy of which are attached. These policies will not change.

The Fresenius Medical Care Roseland dialysis facility is located in a economically depressed and medically underserved area of Chicago. The physicians who serve this patient population have been doing so for decades and have expressed an interest in investing in the facility. The preferred Fresenius model of ownership is for our facilities to be wholly owned, however we do enter into Joint Ventures on occasion. The Roseland facility will likely be one of those occasions due to the fact that the physicians desire to continue to serve this community as well as investing in the facility. Changing ownership of the Roseland facility from Fresenius Medical Care of Illinois, LLC to Fresenius Medical Care Roseland, LLC will allow for this investment should it occur. Fresenius Medical Care will maintain control of the governance, assets and operations of the facility as if physicians do invest in this facility their investment will be a minority interest only and will not allow them control of the facility.

No health care system is involved in this transaction.

Signature

Richard Stotz, Regional Vice President
Printed Name/Title

Date: 6/4/2010

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

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 4th DAY
OF JUNE, 2010.

Cynthia S. Turgeon
NOTARY PUBLIC

ADMISSION, TRANSFER, AND DISCHARGE POLICY

1. ADMISSION

It is the policy of this dialysis facility to admit and to treat all patients referred by physician members of its Medical Staff without regard to race, creed, color, age, sex, handicap, disability, national origin or social status. All persons and organizations having the occasion to refer patients to physician members of this facility's medical staff for admission to this dialysis facility are advised to do so without regard to the patient's race, creed, color, age, sex, handicap, disability, national origin or social status.

Each patient admitted will be followed by a physician member of the facility's Medical Staff. Prior to admission to this dialysis facility, or with reasonable concurrence thereto, there shall be documented consideration of the most appropriate mode of treatment, including full-maintenance hemodialysis, self-care hemodialysis, home training and home dialysis, renal transplantation, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis and intermittent peritoneal dialysis. The patient shall be made aware and afforded access to all of the above modes of treatment provided by other facilities that are not provided by this dialysis facility.

Patients shall be medically cleared for treatment in this dialysis facility when such treatment is deemed indicated and appropriate according to the clinical judgment of that patient's attending physician. No arbitrary criteria with respect to patient's age or magnitude of complicating medical problems are established. It is intended that appropriateness of dialysis shall be a decision to be made by the patient's attending physician in accordance with his or her best clinical judgment, and in compliance with the ESRD program and the facility's policies.

Prior to admission to this dialysis facility, all appropriate paperwork must be completed as outlined in section 122-040-020 of the FMCNA Financial Procedure Manual. All appropriate medical and financial records must be received prior to the patient's admission to the facility. Upon referral, the Admissions Coordinator collects all demographic and insurance information from the referral source and the prospective patient and forwards it immediately to the designated staff at the billing group office. Within two days, the billing group staff will verify the patient's insurance coverage and identify any

coverage gaps which exist. Billing office staff will then notify the Admissions Coordinator of the results of the insurance verification and will discuss with the Coordinator the facility's plans for obtaining appropriate coverage, as necessary.

Financial approval for admission is based upon the patient's insurance coverage and his/her willingness to pursue enrollment in insurance or assistance programs for which he/she qualities.

The billing office will deny financial clearance to individuals who a) cannot obtain Medicare or other coverage or b) indicate an unwillingness to enroll in programs for which he/she is potentially eligible or c) are uncooperative and refuse to disclose insurance information.

In such an event, the billing office representative will notify the Admissions Coordinator, the Administrator and the Region Manager. The patient's physician should be contacted to obtain his/her assistance. The final decision concerning the admission will be made in such cases by the Region Manager.

Medical clearance and financial approval are required prior to admission. Once admission approval has been granted, the Admissions Coordinator must forward the following items from the Patient Admissions Checklist to the billing group office:

Signed Admission Agreement
Signed Release of Information/Assignment of Benefits
Signed LifeChem Assignment of Benefits Form
Copies of all insurance cards
Dates of application for Medicare and/or other Insurance

For Home Patients only:

Signed ESRD Beneficiary Selection Form
MPD/ERIKA Assignment of Benefits Form

Medical Records, which must be sent to the facility prior to the patient's admission, will contain at least the following:

Long Term Program, Patient Care Plan, History and Physical, Discharge Summary if transferring from hospital unit, Physician's Progress Notes, Social Service Summary, Dietary History, Current Labwork including Chemistries and CBC. **HbsAg**

results within 30 days unless the patient has HBV antibodies, then an HbsAg is not needed, but a documented HbsAb within the past 12 months is required instead, EKG, Chest X-Ray reports **if available or most recent**, and Hemodialysis Sheets.

A Consent for Chronic Hemodialysis (or consent appropriate for modality chosen) must be signed by the patient prior to the patient's first treatment at the facility. The signed consent form is binding until the patient is discharged from the facility, withdraws consent for treatment, or his/her dialysis modality changes at which time a new consent must be signed. Consent forms from other FMCNA facilities or non-FMCNA's shall not be used as consent for treatment at this facility.

Each patient shall be evaluated annually by an interdisciplinary team as to appropriateness and effectiveness of the treatment modality received, and the need for continuation of or change in treatment. This team will consist of at least a physician, transplant surgeon or his/her designee, nurse, social worker, dietitian and patient.

Patients who exhibit inappropriate behavior such that they constitute a danger to themselves or to others, or who do not agree to follow the policies and procedures of this facility, may be denied admission to this dialysis facility or may be discharged for same, at the discretion of the Medical Director.

The Director of Nursing or designee shall be responsible for checking the patient's incoming medical records for completeness, and for opening the patient's medical record. The Director of Nursing or designee shall attempt to obtain missing information, and shall notify the patient's physician and/or the Medical Records Supervisor as to any unobtainable data.

The Director of Nursing or designee shall be responsible for scheduling the patient for dialysis treatments in a manner consistent with the attending physician's dialysis prescription, patient needs, and with regard to available time slots.

The patient and/or his or her family shall designate a person to notify in case of emergency. This dialysis facility shall make every effort to notify the appropriate person of any change in a patient's condition considered significant by the physician.

2. TRANSFER AND DISCHARGE

Patients temporarily admitted to the hospital, or in a transient

status at another out-patient hemodialysis facility, shall not be discharged from this dialysis facility. In these cases, and in the case of a patient being discharged for permanent transfer to another facility, this dialysis facility shall provide the hospital or the receiving facility with appropriate records summarizing the interim medical course and records concerning the patient's dialysis treatments. These include, but are not limited to: Long Term Program and Patient Care Plans, Hemodialysis Sheets, History and Physical, Physician Progress Notes, Social Services Summary, Dietary History, Current Labwork and Physician Order Sheets. Transfer of such records shall occur within one working day after the patient transfers. Should a patient be permanently transferred to another facility, transplanted, discontinue dialysis or expire, the patient's medical record shall be closed by the Medical Records Supervisor within 30 days from the time the patient leaves the facility. The patient's primary physician shall complete a Patient Discharge Summary within 30 days of the patient's discharge. (Exhibit-Discharge Summary). This discharge summary shall be placed at the front of the patient's closed medical record. The billing office should immediately be notified of all temporary/permanent transfers or discharges.

All patients admitted to this dialysis facility are admitted voluntarily. Any patient who insists on terminating a treatment early will be asked to sign an "Against Medical Advice" form. If a patient cancels a scheduled dialysis treatment, either by calling to inform the dialysis facility, or by not showing up for a scheduled treatment, the charge nurse or other licensed nurse shall attempt to inform the patient of the consequences of missing a scheduled treatment. The patient's physician should be notified of the cancellation, and should make the decision as to whether the treatment needs to be rescheduled. (See Early Termination or Cancellation of Treatment Policy).

If a patient chooses to withdraw from dialysis, every effort will be made to ensure the patient has been informed of his/her treatment options and understands the consequences of withdrawing from dialysis. (See Withdrawal From Dialysis Policy).

The Charge Nurse shall be responsible for immediately notifying the attending physician, the Director of Nursing and/or Administrator at any time a patient leaves the Hemodialysis Unit against medical advice.

In cases of patient emergencies occurring at this dialysis facility, the physician responsible for the patient's care at

the time of the emergency shall arrange for the transfer of the patient to the hospital. He or she shall notify the attending physician, if applicable, and this dialysis facility shall promptly provide the hospital with appropriate medical records.

When circumstances warrant, these responsibilities shall be carried out by the Charge Nurse on duty at the time of the emergency.

Personal effects of a patient who is transferred to a hospital and/or expires will be recorded on a "Patient's Personal Effects" check list, placed in an envelope or bag, and stored in a safe location in the facility. The Administrator, Director of Nursing, or Charge Nurse will contact the patient's family and request that they pick up the personal effects. (See Patient's Personal Effects Policy).

In the event of death occurring at the facility, the patient's next of kin or responsible party, as designated, shall be promptly notified. The attending physician shall sign the death certificate, as appropriate. Remains shall be released to the appropriate undertaker only after the persons responsible have signed a release form.

If required by state and/or local law, the Department of Health and/or County Coroner will be notified of a death on-site within the mandated time frame.

Request for and permission for autopsy should be referred to the Administrator. Arrangements for the examination are the responsibility of the attending physician.

EXHIBIT

"DISCHARGE SUMMARY

FMCNA **DISCHARGE SUMMARY**

ADDRESSOGRAPH

Date of Discharge: _____

Discharge to:

1. Transferred to _____ Dialysis Unit

   Address _____

   Reason for transfer _____

   Date records sent _____

2. Transplant Surgery Date _____ Hospital _____

3. Discontinued Dialysis Date _____

   Reason _____

   _____

4. Expired Caused of Death: _____

   Date of Death: _____

   Place of Death: _____

Final Diagnosis: (includes both primary and secondary diagnoses)

1. _____

2. _____

3. _____

Prognosis: _____

_____

_____

Brief Summary: _____

_____

_____

_____ _____

PERSON COMPLETING SUMMARY/TITLE DATE

_____ _____

ATTENDING PHYSICIAN DATE

FMCNA CS-I-112 (1/01

EMERGENCY TRANSFER GUIDELINES

Facilities may experience emergencies caused by severe weather, fire or other serious facility operating problems such as water treatment failure or other unexpected problems. These problems may require construction or repairs that are believed to be short-lived and may necessitate closure of a facility. Inability of facilities to provide services can result in the need for subsequent temporary arrangements for patients to be dialyzed at another FMCNA "host" facility. In addition, patients may require temporary care at another FMCNA facility based on their inability to safely get to their "home" facility.

Emergency Transfer is defined as:

- Not expected to extend beyond **30 days**.
- Patients are expected to return to their "home" facility to continue their treatments when operations are able to resume.

The treating clinic or "host" facility or facilities will provide services for the "home" facility according to the company wide agreement "Dialysis Unit Emergency Back Up Agreement" (established by Corporate Law Department). A fully executed "Dialysis Unit Emergency Back Up Agreement" is included with this policy.

Following the activation of the Emergency Back Up Agreement, the "home" facility patients must be assigned to a physician with privileges at the "host" facility, unless patient's attending physician already maintains privileges at the "host" dialysis facility. Dialysis treatment orders must be obtained from the assigned physician if the patient is assigned to a physician at the "host" facility.

When possible, copies of Medical Records such as Physician Order Sheets, Hemodialysis Treatment Sheets, current Lab Work, History and Physical, Multidisciplinary Progress Notes (including physician, nursing, social worker and dietary notes), Long Term Program and Patient Care Plans, Psychosocial Assessment (most recent), and Dietary Referral Sheet, must be sent to the "host" facility.

- If patient's paper medical records are destroyed due to fire, water or other serious facility damage, information

available in the Proton Information System should be printed from Proton. When the patient returns to their "home" facility, all medical record documentation that was created at the "host" facility should be copied and transferred to the patient's "home" facility medical record.

When a patient or patients require emergency transfer to another facility, the "home" facility (facility experiencing the emergency) must notify Spectra Customer Service of the emergency transfer in order for Spectra to send any laboratory reports to the "host" facility where patient is being treated.

Under normal facility operating procedures, when new patients are initially admitted into a facility, each patient is set up in the Spectra Lab system in their "home" facility so that lab resulting data and information system notification is sent to the facility of record.

Lab tests that are ordered for the patient while they are located in the "host" facility, **should be ordered with the "home" facility number**, so the lab results will be downloaded into Proton and can be used for clinical outcome reporting.

Staff can access the "home" facility Proton information and the patient lab results from **any** Proton facility database. As long as Spectra is notified that the patient is dialyzing in the "host" facility, the printed lab results can be sent directly to the "host" facility printer.

All services performed **must be entered into Proton in the "home" facility database,** as if the "home" facility provided the services. (Application Instructors should provide direction to the facility on performing the following procedures.)

- Patient information can be accessed in Proton from any facility database.
- The treatment sheet can print to the "host" facility.
- The "host" facility name must be written on the top of the treatment sheet and all medical records created at the "host" facility.
- A daily validation must be run on the "home" facility database.

  NOTE: If patients are at several different local facilities, the Clinical Manager or Area Manager must communicate with each "host" facility to ensure treatment information has been entered into the correct Proton "home"

facility information system before validating treatments.

If the facility closure/emergency transfer exceeds **30 days**, the continuation of the "Dialysis Unit Emergency Back Up Agreement" must be reviewed and approved. The Regional Vice President must contact the FMS Vice President of Operations Support and the FMS Vice President of Clinical Services and provide a report on the status of the "home" facility. The need to extend the time of the Emergency Back Up Agreement will be approved on a case-by-case basis depending on the length of time that the "home" facility can return to normal operations.

If the "Dialysis Unit Emergency Back Up Agreement" continues past thirty days, Subpart U documentation requirements (such as Short Term Care Plan, Long Term Program, Progress notes) must be completed at the "host" facility according to the usual schedule.

If it is determined that the "Dialysis Unit Emergency Back Up Agreement" must be discontinued because the "home" facility will not be operational in a reasonable period of time and therefore unable to accept patients, each patient accepted into the "host" facility because of an emergency must be formally transferred to the "host" facility and the appropriate admission, clinical and billing forms (refer to Financial Procedure Manual #122-040-020 for direction on billing forms) must be completed.

DIALYSIS UNIT EMERGENCY BACK UP AGREEMENT

This Agreement is made and entered into July 1, 2004 by and between **Fresenius Medical Care Holdings, Inc.** (hereinafter referred to as "Facility") and **Entities listed on Exhibit A** (collectively hereinafter referred to as "Alternative Dialysis Unit").

I. Duties of the Parties

Subject to available appropriate facilities, staffing and resources at Alternative Dialysis Unit, and applicable policies or procedures of the Alternative Dialysis Unit, in the event that Facility patients are transferred to Alternative Dialysis Unit for dialysis due to an emergency that renders Facility as either inoperable or inaccessible to some or all of its enrolled dialysis patients ("Facility patients"), Alternative Dialysis Unit agrees to provide dialysis treatments ("Services"). These Services would continue until Facility is back in total operation. The Services provided to these Facility patients will continue to be billed through the Facility. In order to receive services, Facility patients first must be assigned to a physician with privileges at Alternative Dialysis Unit, unless patient's attending physician already maintains privileges at Alternative Dialysis Unit. Alternative Dialysis Unit agrees to provide services by directly using its own employees, equipment and supplies or by contracting with an outside vendor to provide services.

In the event a patient is admitted to Alternative Dialysis Unit, Facility shall be responsible for arranging to have Facility patients transported to the Alternative Dialysis Unit and shall send appropriate interim medical records. The Facility will provide for the Alternative Dialysis Unit, within one working day, copies of the Facility patients' Long Term Program and Patient Care Plan, and of medical and other information necessary or useful in the care and treatment of Facility patients referred to the Alternative Dialysis Unit. In the event the Facility patients must be transferred directly from Facility to Alternative Dialysis Unit, Facility shall provide for the security of, and be accountable for, the patients' personal effects during the transfer. Services provided by Alternative Dialysis Unit shall be provided regardless of the Facility patients' race, color, creed, sex, age, disability, or national origin.

Each party agrees to develop, maintain and operate, in all aspects, an outpatient hemodialysis facility, providing all physical facilities, equipment and personnel necessary to treat patients suffering from chronic renal diseases. Each party shall conform to standards not less than those required by the applicable laws and regulations of any local, state or federal regulatory body, as the same may be amended from time to time. In the absence of applicable laws and regulations, each party shall conform to applicable standards of professional practice. Each party shall treat such commitment as its primary responsibility and shall devote such time and effort as may be necessary to attain these objectives. The cost of such facilities, equipment and personnel shall be borne by each party.

Each party shall engage a medical director who shall have the qualifications specified in 42 C.F.R. 405.2102. This individual must be a physician properly licensed in the profession by the state in which such facility is located. In accordance with 42 C.F. R. 405.2162, each party shall employ such duly qualified and licensed nurses, technicians, and other personnel as shall be

necessary to administer treatment at its facility, in accordance with applicable local, state, and federal laws and regulations.

II. Insurance

Each party shall maintain in full force and effect throughout the term of this Agreement, at its own expense, a policy of comprehensive general liability insurance and professional liability insurance covering it and its staff, respectively, each having a combined single limit of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate for bodily injury and property damage to insure against any loss, damage or claim arising out of the performance of each party's respective obligations under this Agreement. Each will provide the other with certificates evidencing said insurance, if and as requested. Both parties further agree to maintain, for a period of not less than three (3) years following the termination of this Agreement, any insurance required hereunder if underwritten on a claims-made basis. Either party may provide for the insurance coverage set forth in this Section through self-insurance.

III. Indemnification

Each party agrees to indemnify and hold harmless the other, their officers, directors, shareholders, agents and employees against all liability, claims, damages, suits, demands, expenses and costs (including but not limited to, court costs and reasonable attorneys' fees) of every kind arising out of or in consequence of the party's breach of this Agreement, and of the negligent errors and omissions or willful misconduct of the indemnifying party, its agents, servants, employees and independent contractors (excluding the other party) in the performance of or conduct related to this Agreement.

IV. HIPAA

The Parties expressly agree to comply with all applicable patient information privacy and security regulations set for in the Health Insurance Portability and Accountability Act ("HIPAA") final regulations for Privacy of Individually Identifiable Health Information, as amended from time to time.

V. Term

Term. The term of this Agreement shall be for a period of one (1) year from the date first written above. This Agreement shall automatically renew, unless either party shall notify the other party of its intention to terminate this Agreement by written notice given at least sixty (60) days in advance of such renewal date. This Agreement may also be terminated by either party for cause by giving thirty (30) days written notice to the other party specifying default by such other party. This Agreement may also be terminated at any time upon the mutual consent of both parties.

VI. General Provisions

If any provisions of this agreement shall, at any time, conflict with any applicable state or federal law, or shall conflict with any regulation or regulatory agency having jurisdiction with respect thereto, this Agreement shall be modified in writing by the parties hereto to conform to such regulation, law, guideline, or standard established by such regulatory agency.

This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all negotiations, prior discussions, agreements or understandings, whether written or oral, with respect to the subject matter hereof, as of the date first written above. This Agreement shall bind and benefit the parties, their respective successors and assigns.

This Agreement shall be governed by and construed and enforced in accordance with the laws of the State where Alternative Dialysis Unit is located, without respect to its conflicts of law rules.

The parties agree to cooperate with each other in the fulfillment of their respective obligations under the terms of this Agreement and to comply with the requirements of the law and with all applicable ordinances, statutes, regulations, directives, orders, or other lawful enactments or pronouncements of any federal, state, municipal, local or other lawful authority.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their respective officers thereunto duly authorized as of the date above written.

Fresenius Medical Care Holdings, Inc.	**Entities listed on Exhibit A**
By: _____	By: _____
Name: Marc S. Lieberman ~~Assistant Treasurer~~	Name: PAUL COLANTONIO ASST TREASURER
Date: 1-1-04	Date: 7/7/04

Criterion 1120.310 Financial Viability

Financial Viability Waiver

This project has no cost and therefore this section is not applicable, however 2009 Financial Statements for Fresenius Medical Care Holdings, Inc. are being submitted to the Board with an application submitted June 16, 2010 for a 12 station ESRD facility to be called Fresenius Medical Care Mundelein and are the same financials that pertain to this application. In order to reduce bulk these financials can be referred to if necessary.

(Fresenius Medical Care funds all of its projects through cash and securities and therefore meets the criteria for the financial waiver)

Criterion 1120.310 (d) – Projected Operating Costs

Year 2011

Salaries	$758,730
Benefits	151,746
Supplies	222,552
Total	$1,133,028

Annual Treatments	9,048
Cost Per Treatment	$125.22

Charity Care Information

From a charity standpoint Fresenius Medical Care accepts any patient regardless of their ability to pay. Most ESRD patients qualify for Medicare coverage or have private insurance and there are some who qualify for Medicaid. For those patients who don't have insurance and for whatever reason don't pursue government payor sources, Fresenius Medical Care will treat and bill the patient even though payment is not expected. These patients are considered "self-pay" patients. These unpaid accounts are then written off as bad debt. This practice does not meet the Board's definition of Charity Care so therefore, Fresenius Medical Care would have no charity care to report.