

Original

70-039

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

RECEIVED**SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**

JUN 17 2010

This Section must be completed for all projects.**Facility/Project Identification**HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name: <i>Fresenius Medical Care Waukegan Harbor</i>			
Street Address: <i>110 N. West Street</i>			
City and Zip Code: <i>Waukegan, IL 60085</i>			
County:	<i>Lake</i>	Health Service Area	<i>8</i>
		Health Planning Area:	

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

Exact Legal Name: <i>Fresenius Medical Care of Illinois, LLC d/b/a Fresenius Medical Care Waukegan Harbor</i>	
Address: <i>920 Winter Street, Waltham, MA 02451</i>	
Name of Registered Agent: <i>CT Systems</i>	
Name of Chief Executive Officer: <i>Rice Powell</i>	
CEO Address: <i>920 Winter Street, Waltham, MA 02451</i>	
Telephone Number: <i>800-662-1237</i>	

Type of Ownership of Applicant/Co-Applicant

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

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.

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

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

Name: <i>Brian Brandenburg</i>
Title: <i>Regional Vice President</i>
Company Name: <i>Fresenius Medical Care</i>
Address: <i>557 W. Polk Street, Chicago, IL 60607</i>
Telephone Number: <i>312-583-9072</i>
E-mail Address: <i>brian.brandenburg@fmc-na.com</i>
Fax Number: <i>312-583-9081</i>

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

Additional Contact

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: <i>Plainfield 550, LLC – Chad Middendorf</i>
Address of Site Owner: <i>10531 Timberwoods Circle, Suite D, Louisville, KY 40223</i>
Street Address or Legal Description of Site: <i>110 N. West Street, Waukegan, IL 60085</i>
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: <i>Fresenius Medical Care of Illinois, LLC d/b/a Fresenius Medical Care Waukegan Harbor</i>
Address: <i>920 Winter Street, Waltham, MA 02451</i>
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each 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 NOT APPLICABLE – PROJECT IS NOT NEW CONSTRUCTION

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

<p>Part 1110 Classification:</p> <p><input type="checkbox"/> Substantive</p> <p><input checked="" type="checkbox"/> Non-substantive</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p> <p><input type="checkbox"/> Part 1120 Not Applicable</p> <p><input type="checkbox"/> Category A Project</p> <p><input checked="" type="checkbox"/> Category B Project</p> <p><input type="checkbox"/> DHS or DVA Project</p>
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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 of Illinois, LLC, proposes to establish a 21 station in-center hemodialysis facility at 110 N. West Street, Waukegan,, Illinois. The facility will be in leased space in a single tenant building. The interior of the leased space will be built out by the applicant.

Fresenius Medical Care Waukegan Harbor will be in HSA 8.

This project is "non-substantive" under Planning Board rule 1110.10(b) as it entails the establishment of a health care facility that will provide 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-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	1,158,240	N/A	1,158,240
Contingencies	115,800	N/A	115,800
Architectural/Engineering Fees	127,400	N/A	127,400
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	560,000	N/A	560,000
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 or Equipment	1,390,800 313,675	1,704,475	N/A 1,704,475
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	3,665,915		3,665,915
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	CLINICAL
Cash and Securities	1,961,440	N/A	1,961,440
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)	1,704,475	N/A	1,704,475
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	3,665,915	N/A	3,665,915
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>95,669</u> .		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>June 30, 2012</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> 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:
<input type="checkbox"/> Cancer Registry
<input type="checkbox"/> APORS
<input type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ESRD	3,665,915		9,120 DGSF		9,120 DGSF		
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	3,665,915		9,120 DGSF		9,120 DGSF		
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	3,665,915		9,120 DGSF		9,120 DGSF		

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:

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

This Application for Permit is filed on the behalf of Fresenius Medical Care of Illinois, 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

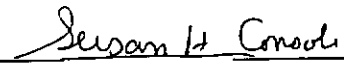

SIGNATURE

Marc Lieberman
PRINTED NAME
Asst. Treasurer

PRINTED TITLE

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

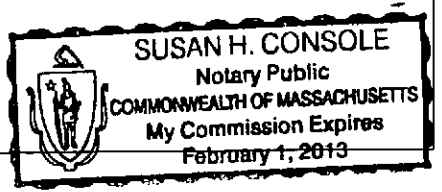
Notarization:
Subscribed and sworn to before me
this 7 day of June 2010


Signature of Notary

Signature of Notary

Seal

Seal




*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:

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

This Application 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

Mark Fawcett
PRINTED NAME President & Asst. Treasurer

PRINTED TITLE

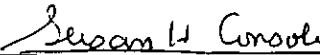

SIGNATURE

Marc Lieberman
PRINTED NAME Asst. Treasurer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7 day of June 2010

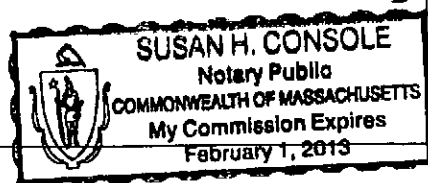
Notarization:
Subscribed and sworn to before me
this 7 day of June 2010


Signature of Notary

Signature of Notary

Seal

Seal



*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

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

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

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

ASSURANCES: NOT APPLICABLE – THERE IS NO UNFINISHED SHELL SPACE

Submit the following:

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

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

G. Criterion 1110.1430 - In-Center Hemodialysis

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

Category of Service	# Existing Stations	# Proposed Stations
<input checked="" type="checkbox"/> In-Center Hemodialysis	0	21

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - Support Services	X	X	X
1110.1430(g) - Minimum Number of Stations	X		
1110.1430(h) - Continuity of Care	X		
1110.1430(j) - Assurances	X	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT-26</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

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

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

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

VIII. - 1120.120 - Availability of Funds

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

<u>1,961,440</u>	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;
<u>N/A</u>	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.
<u>N/A</u>	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
<u>1,704,475</u>	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
<u>N/A</u>	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;
<u>N/A</u>	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
<u>3,665,915</u>	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
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 WAIVER CRITERIA IN THAT ALL OF THE PROJECTS CAPITAL EXPENDITURES ARE COMPLETELY FUNDED THROUGH INTERNAL SOURCES, THEREFORE NO RATIOS ARE PROVIDED.			
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

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -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 Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
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:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Co-applicant Identification including Certificate of Good Standing	21-22
2	Site Ownership	23-27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	228
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	229
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	30
7	Project and Sources of Funds Itemization	31-32
8	Obligation Document if required	
9	Cost Space Requirements	33
10	Discontinuation	
11	Background of the Applicant	34-37
12	Purpose of the Project	38
13	Alternatives to the Project	39-41
14	Size of the Project	42
15	Project Service Utilization	43
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	44-68
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	69-79
40	Financial Waiver	80-81
41	Financial Viability	
42	Economic Feasibility	82-86
43	Safety Net Impact Statement	
44	Charity Care Information	87
	Appendix 1 – MapQuest Travel Times	88-91
	Appendix 2 – Referral Letters	92-95

Co-Applicant Identification

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

Exact Legal Name: <i>Fresenius Medical Care Holdings, Inc.</i>
Address: <i>920 Winter Street, Waltham, MA 02451</i>
Name of Registered Agent: <i>CT Systems</i>
Name of Chief Executive Officer: <i>Rice Powell</i>
CEO Address: <i>920 Winter Street, Waltham, MA 02451</i>
Telephone Number: <i>800-662-1237</i>

Type of Ownership of Applicant/Co-Applicant

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

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



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 OF ILLINOIS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 26, 2004, 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 15TH day of JUNE A.D. 2010 .



Jesse White

Authentication #: 1016601420

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

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Plainfield 550, LLC – Chad Middendorf*

Address of Site Owner: *10531 Timberwoods Circle, Suite D, Louisville, KY 40223*

Street Address or Legal Description of Site: *110 N. West Street, Waukegan, IL 60085*

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.



Cushman & Wakefield of
 Illinois, Inc.
 455 N. Cityfront Plaza Drive
 Suite 2800
 Chicago, IL 60611-5555
 (312) 470-1800 Tel
 (312) 470-3800 Fax
 www.cushwake.com

April 13, 2010

Chad Middendorf
 10531 Timberwood Circle, Suite D
 Louisville, KY 40223

RE: **Fresenius Medical Care Dialysis Center
 Letter Of Intent**

Dear Chad,

Cushman & Wakefield has been exclusively authorized by Fresenius Medical Care (FMC) to secure proposals and assist them in negotiations regarding the acquisition of leased space in the Waukegan area. Of the properties we will analyze, your site has been identified as one that potentially meets the necessary requirements. At this time, we are pleased to provide the following Letter Of Intent.

Fresenius Medical Care is the world's leading provider of dialysis products and services. It manages in excess of over 2,500 kidney dialysis clinics and 50 billing centers and regional offices throughout North America. You can visit their website for financial information and highlights at www.fmcna.com.

Please prepare the proposal to correspond to the following terms and conditions:

OWNERSHIP:

Plainfield 550 LLC

We will need this to submit to the Illinois Health Facilities Planning Board for approval on this site.

LOCATION:

110 N West Street Street
 Waukegan, IL 60085

**INITIAL SPACE
 REQUIREMENTS:**

Approximately 9,120 SF of contiguous usable square feet.

HOURS OF OPERATION:

Please be advised that FMC may have employees and / or patients on site 24 hours per day 6 days per week. FMC is not open on Sundays.

PRIMARY TERM:

Twelve (12) years.

POSSESSION DATE:

FMC will have the right to take possession of the premises upon approval of the Certificate of Need to complete its necessary improvements. FMC will need a minimum of 90 days to build out the premises.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

COMMENCEMENT DATE: 90 days after Possession .

OPTION TO RENEW: FMC desires three (3) five (5) year options to renew the lease. Options based upon pre-established rates. Please identify the terms of any option to renew.

RENTAL RATE: \$15.25 NET NET.

COMMON AREA EXPENSES AND REAL ESTATE TAXES: Operating Expenses and Taxes are estimated to be approximately \$3.00 per square foot.

TENANT IMPROVEMENTS: FMC shall not be required to remove their tenant improvements at the end of the term.

DEMISED PREMISES SHELL: Tenant shall accept the premises in its "as-is" condition.

FIRE SUPPRESSION: At this time only the lower level is sprinklered.

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 one-eighth inch architectural drawings of the proposed demised premises and detailed building specifications. Please email AutoCads to loren.guzik@cushwake.com

PARKING: 33 parking stalls are available exclusively for tenants use.

CORPORATE IDENTIFICATION: FMC will have complete signage rights in accordance with local code.

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.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

ZONING AND RESTRICTIVE COVENANTS:

Please indicate if the current property zoning is acceptable for use as a Dialysis Clinic and if there are any restrictive covenants imposed by the development, owner, and/or municipality.

FINANCING:

FMC will require a non-disturbance agreement.

ENVIRONMENTAL:

Please confirm that there is no asbestos present in the building and that there are no contaminants or environmental hazards in or on the property. Also include a brief narrative of any tenants and their activities as they relate to the generation of hazardous materials.

EXCLUSIVE TERRITORY:

Landlord agrees not to lease space under its control to another dialysis provider within a five mile radius of the proposed location.

CON CONTINGENCY:

Landlord and FMC understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, FMC cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless FMC obtains a Certificate of Need (CON) permit from the Illinois Health Facilities Planning Board (the "Planning Board"). FMC agrees to proceed using its commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application to obtain the CON permit from the Planning Board. Based on the length of the Planning Board review process, FMC does not expect to receive a CON permit prior to September 2010. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit provided, however, the lease shall not be binding on either party prior to the approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective pending CON approval. Assuming CON permit approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the Planning Board does not award FMC a CON permit to establish a dialysis center on the Premises by September 2010, neither party shall have any further obligation to the other party with regard to the negotiations, lease or Premises contemplated by this Letter of Intent.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

SECURITY:

Fresenius Medical Care Holding will fully guarantee the lease.

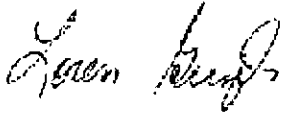
BROKERAGE FEE:

Per separate agreement.

This offer is not intended to be contractual in nature and only an executed lease delivered to both parties can bind the parties to this transaction. It is expressly understood, agreed, and hereby acknowledged, that only upon the proper execution of a fully completed, formal lease contract, with all the lease terms and conditions clearly defined and included therein, will there then be any obligation, of any kind or nature, incurred or created between the herein parties in connection with the referenced property.

You may email the proposal to loren.guzik@cushwake.com. Thank you for your time and cooperation in this matter, should you have any questions please call me at 312.470.1897.

Sincerely,



Loren Guzik
Associate Director
Office Group
Phone: 312-470-1897
Fax: 312-470-3800
e-mail: loren_guzik@cushwake.com

CC: Mr. Bill Popken

AGREED AND ACCEPTED this ____ day of _____, 2007

By: _____

Title: _____

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

Operating Identity/Licensee

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

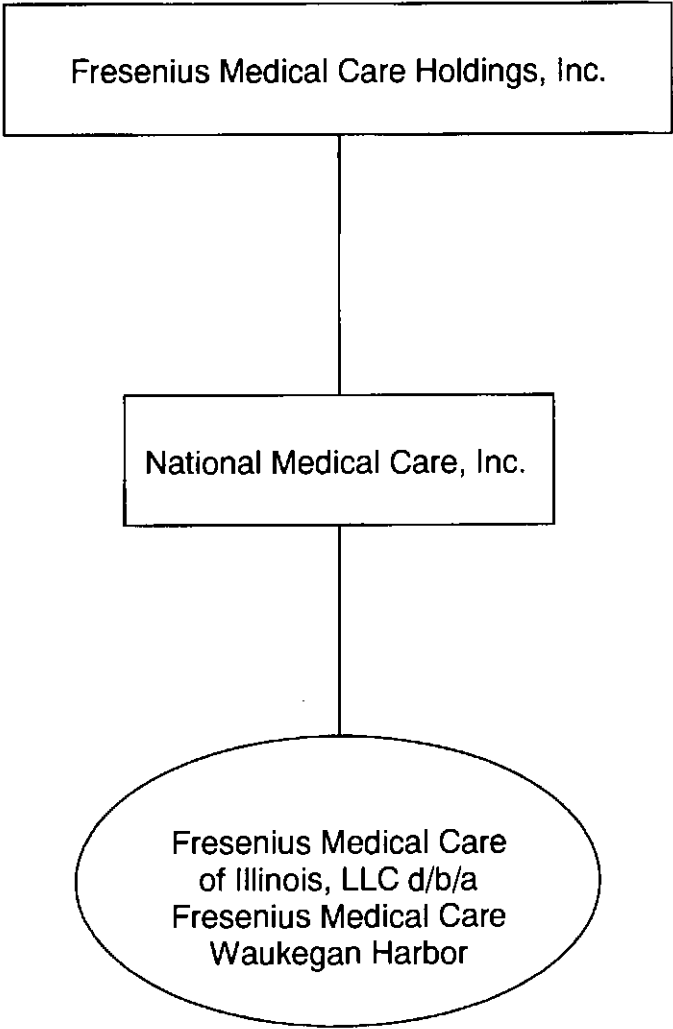
Exact Legal Name: *Fresenius Medical Care of Illinois LLC, d/b/a Fresenius Medical Care Waukegan Harbor*

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

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

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

Certificate of Good Standing at Attachment – 1.





**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

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

Lake County
Waukegan

CON - Establish a 21 Station Dialysis Facility
110 N. West St.
IHPA Log #014052710

June 14, 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

SUMMARY OF PROJECT COSTS

Modernization Contracts

General Conditions	\$57,900
Temp Facilities, Controls, Cleaning, Waste Management	2,890
Concrete	14,800
Masonry	17,600
Metal Fabrications	8,690
Carpentry	101,800
Thermal, Moisture & Fire Protection	20,620
Doors, Frames, Hardware, Glass & Glazing	79,340
Walls, Ceilings, Floors, Painting	187,060
Specialities	14,480
Casework, Fl Mats & Window Treatments	6,950
Piping, Sanitary Waste, HVAC, Ductwork, Roof Penetrations	370,640
Wiring, Fire Alarm System, Lighting	223,310
Miscellaneous Construction Costs	52,120
Total	\$1,158,200

Contingencies

Contingencies **\$115,800**

Architectural/Engineering

Architecture/Engineering Fees **\$127,400**

Movable or Other Equipment

Dialysis Chairs	\$28,400
Misc. Clinical Equipment	28,400
Clinical Furniture & Equipment	39,700
Office Equipment & Other Furniture	56,800
Water Treatment	189,200
TVs & Accessories	94,600
Telephones	22,700
Generator	56,800
Facility Automation	37,800
Other miscellaneous	5,600
Total	\$560,000

Fair Market Value Leased Space & Equipment

FMV Leased Space (9,120 GSF)	\$1,390,800
FMV Leased Dialysis Machines	308,775
FMV Leased Computers	4,900
Total	\$1,704,475

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.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ESRD	3,665,915		9,120 DGSF		9,120 DGSF		
Medical Surgical Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	3,665,915		9,120 DGSF		9,120 DGSF		
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	3,665,915		9,120 DGSF		9,120 DGSF		

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

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	Deerfield	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 of Illinois, 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 of Illinois, 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: Mark Fawcett
Vice President & Treasurer

By: *Marc Lieberman*

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

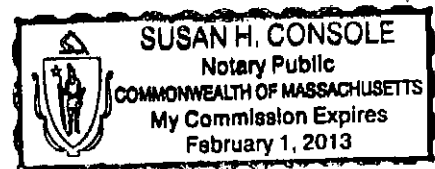
Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

Susan H Console
Signature of Notary

Susan H Console
Signature of Notary

Seal

Seal



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: [Signature]

ITS: Mark Fawcett
Vice President & Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

Signature of Notary

Seal

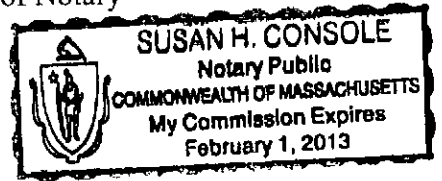
By: [Signature]

ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

Signature of Notary

Seal



Criterion 1110.230 – Purpose of Project

1. The purpose of this project is to keep dialysis services accessible to a growing ESRD population in Lake County (HSA 8) and to alleviate high utilization in the 30-minute travel zone of Waukegan. This will also allow for continued growth.
2. The market area that Fresenius Medical Care Waukegan Harbor will serve is Zion, Beach Park, Park City, North Chicago and Waukegan market.
3. This facility is needed to accommodate the pre-ESRD patients that Dr. Ghantous has identified from this area who will require dialysis services in the next 1-3 years. The facilities within 30-minutes travel time are operating at 79% average utilization. This leaves inadequate options as far as treatment schedule times and also hampers transportation choices since County and Township services do not operate after 4pm. Current utilizations also do not allow for any additional growth of ESRD patients.

If Dr. Ghantous' 122 identified pre-ESRD for Waukegan Harbor were added to the 30-minute average utilization, the region would be at 109%. This would clearly not be an acceptable way to operate and it is more prudent to plan now for these future patients.

4. Utilization of area facilities is obtained from the Renal Network for the 1st Quarter 2010. Pre-ESRD patients for the market area were obtained from Dr. Ghantous.
5. The goal of Fresenius Medical Care is to keep dialysis access available to this patient population as we continue to monitor the growth and provide responsible healthcare planning for this area. 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.
6. It is expected that this facility would have and maintain the same quality outcomes as the other facilities of which Dr. Ghantous is the Medical Director. These are:

Fresenius Medical Care Gurnee

- o 93% of patients had a URR \geq 65%
- o 97% of patients had a Kt/V \geq 1.2

Fresenius Medical Care Round Lake

- o 89% of patients had a URR \geq 65%
- o 94% of patients had a Kt/V \geq 1.2

Alternatives

1) All Alternatives

A. Proposing a project of greater or lesser scope and cost.

There was only one alternative considered that would entail a lesser scope and cost than the project proposed in this application, however it was not determined to be a feasible option. This was the alternative of doing nothing. The facilities in the Waukegan market are all operating either above or near the State 80% target utilization. The number of pre-ESRD patients that Dr. Ghantous has in this market, considering he is only one of many other nephrologists, along with high utilizations, are evidence that proper healthcare planning must be done now to accommodate the ESRD population in the Waukegan market. There is no monetary cost associated with this alternative.

B. Pursuing a joint venture or similar arrangement with one or more providers of 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.

The preferred Fresenius model of ownership is for our facilities to be wholly owned, however we do enter into joint ventures on occasion. Fresenius Medical Care always maintains control of the governance, assets and operations of a facility it enters into a joint venture agreement with. Our healthy financial position and abundant liquidity indicate that that we have the ability to support the development of additional dialysis centers. Fresenius Medical Care has more than adequate capability to meet all of its expected financial obligations and does not require any additional funds to meet expected project costs.

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

The option of sending Dr. Ghantous pre-ESRD patients to underutilized facilities in the area as they require dialysis treatment was not considered a reasonable alternative. There are only three facilities that fall under 80% within 30 minutes of the Waukegan Harbor facility. They are DSI Waukegan, Fresenius Round Lake and Lake Bluff. Combined these facilities can only accommodate 17 more patients before reaching target utilization. Dr. Ghantous alone has identified 122 pre-ESRD from his practice who will need dialysis in the next 1-3 years.

D. As discussed further in this application, the most desirable alternative to keep access to dialysis services available by addressing current high utilization and planning for known future ESRD patients in the market area is to establish Fresenius Medical Care Waukegan Harbor. The cost of this project is \$3,665,915. While this is the most costly alternative, the expense is to Fresenius Medical Care only, while the patients will benefit from continued and improved access.

2) Comparison of Alternatives

	Total Cost	Patient Access	Quality	Financial
Maintain Status Quo	\$0	Patient access in this market would gradually diminish as the facilities utilizations rise due to identified pre-ESRD in the market.	Patient clinical quality in Fresenius Medical Care facilities would remain above standards	No effect on patients
Pursue Joint Venture	\$3,665,915	Same as current proposed project	Patient clinical quality would remain above standards	No effect on patients Fresenius Medical Care is capable of meeting its financial obligations and does not require assistance in meeting its financial obligations. If this were a JV, Freseius Medical Care would maintain control of the facility and therefore ultimate financial responsibilities.
Utilize Area Providers	\$0	Loss of access to treatment schedule times would result in transportation problems as county/township transportation services do not operate after 4pm. Would create ripple effect of raising utilization of area providers to or above capacity	Loss of continuity of care which would lead to lower patient outcomes Unavailability to choose treatment schedule shift could cause transportation problems which leads to missed treatments and lower quality	No financial cost to Fresenius Medical Care Cost of patient's transportation would increase with higher travel times
Establish Fresenius Medical Care Waukegan Harbor	\$3,665,915	Continued access to dialysis treatment as patient numbers continue to grow. Improved access to favored treatment schedule times.	Patient clinical quality would remain above standards Patient satisfaction would improve with facilities closer to patient's home resulting in decreased travel times and less missed treatments	This is an expense to Fresenius Medical Care only who is able to support the development of additional dialysis facilities and is capable of meeting all financial obligations.

3. Empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

There is no direct empirical evidence relating to this project other than that when chronic care patients have adequate access to services, it tends to reduce overall healthcare costs and results in less complications. Fresenius Medical Care facilities where Dr. Ghantous is the Medical Director in the market area have had above standard quality outcomes.

Fresenius Medical Care Round Lake

89% of patients had a URR \geq 65%

94% of patients had a Kt/V \geq 1.2

Fresenius Medical Care Gurnee

93% of patients had a URR \geq 65%

97% of patients had a Kt/V \geq 1.2

Criterion 1110.234, Size of Project

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD IN-CENTER HEMODIALYSIS	9,120 (21 Stations)	360-520 DGSF	NONE	YES

As seen in the chart above, the State Standard for ESRD is between 360-520 DGSF per station. This project is being accomplished in leased space with the interior to be built out by the applicant therefore the standard being applied is expressed in departmental gross square feet. The proposed 9,120 DGSF amounts to 434 DGSF per station and falls within the State Standard.

Criterion 1110.234, Project Services Utilization

UTILIZATION					
	DEPT/SERVICE	HISTORICAL UTILIZATION	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
	IN-CENTER HEMODIALYSIS	Not Applicable New facility		80%	N/A
YEAR 1	IN-CENTER HEMODIALYSIS		48%	80%	Yes
YEAR 2	IN-CENTER HEMODIALYSIS		97%*	80%	Yes

With the 122 pre-ESRD patients that Dr. Ghantous expects to refer to the Waukegan Harbor facility in the first two years of operation, the facility will exceed the State Standard of 80%.

*While Dr. Ghantous has identified 122 pre-ESRD patients who would bring the utilization to 97% by the end of the second year of operation, it is likely that not all patients may choose the Waukegan Harbor facility and/or may no longer require dialysis services due to death or transplant, it is estimated that approximately 12% of these pre-ESRD patients may not begin dialysis at the Waukegan Harbor facility. If this is the case, the utilization will still be above target utilization at 85%.

Planning Area Need – Formula Need Calculation:

A. Planning Area Need - Formula Need Calculation:

The proposed Fresenius Medical Care Waukegan Harbor dialysis facility is located in HSA 8, which is comprised of Lake, Kane and McHenry counties. According to the May 2010 station inventory there is a need for 3 more stations in this HSA.

While this project is requesting more stations than is determined needed in HSA 8, the ratio of stations to population within a 30-minute travel zone of Waukegan Harbor is 1/6,553. This is more than 1½ times the the State average and exhibits a need for additional stations. Also, the average overall utilization of the facilities within the 30-minute travel zone is 79%, only 2 patients away from being at 80%.

Planning Area Need – Service To Planning Area Residents:

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

- A. The primary purpose of this project is to provide in-center hemodialysis services to the residents of Lake County in HSA 8, more specifically the Waukegan, North Chicago, Zion, Park City, Beach Park market area. 100% of the pre-ESRD patients reside in HSA 8.

County	HSA	# Pre-ESRD Patients Who Will Be Referred to Fresenius Medical Care Mundelein
Lake	8	122 – 100%

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

TEL: 847-855-9152
FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

June 11, 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 practicing in Lake County and serve as Medical Director of the Fresenius Medical Care Gurnee and Round Lake dialysis centers. I currently refer patients to Fresenius Medical Care Gurnee, Round Lake, Antioch and to DSI Waukegan. Lake County has seen a constant increase of ESRD patients over the past several years and the facilities I refer patients to are operating at high utilizations. For this reason, I am in full support of the proposed Fresenius Medical Care Waukegan Harbor dialysis clinic.

Over the past three years I was treating 105 hemodialysis patients at the end of 2007, 126 patients at the end of 2008 and 133 patients at the end of 2009, as reported to The Renal Network. At the end of the 1st quarter 2010 I had 141 hemodialysis patients. As well, over the past twelve months, I have referred 59 hemodialysis patients to Fresenius Gurnee, Antioch, Round Lake and DSI Waukegan. I have 122 pre-ESRD patients in my practice that will be referred to the Waukegan Harbor facility within 2 years after completion of the facility (see attached lists of patients).

I therefore urge the Board to approve the establishment of Fresenius Medical Care Waukegan Harbor to keep access to dialysis treatment available to the patients in the Lake County. Thank you for your consideration.

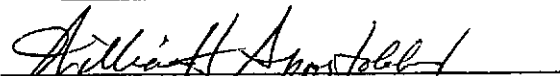
I attest that to the best of my knowledge, all the information contained in this letter is true and correct and that the projected patient referrals listed in this document have not been used to support any other CON application.

Sincerely,

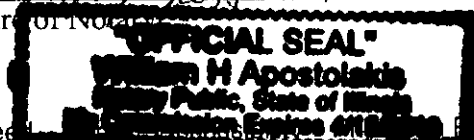

Walid Ghantous, M.D.

Notarization:

Subscribed and sworn to before me
this 14th day of JUNE, 2010


Signature of Notary Public

Seal



Planning Area No.

Referral Letter

ATTACHMENT - 26b - 3

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

TEL: 847-855-9152
FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

**PRE - ESRD PATIENTS DR. GHANTOUS EXPECTS TO REFER TO
FRESENIUS MEDICAL CARE WAUKEGAN HARBOR BY 2 YEARS
AFTER PROJECT COMPLETION**

Zip Code	Patients
60031	11
60060	1
60064	12
60085	58
60087	16
60088	3
60096	6
60099	15
Total	122

**ADMISSIONS OF DR. GHANTOUS FOR THE PREVIOUS TWELVE
MONTHS - 05/01/2009 THROUGH 04/30/2010**

Fresenius Gurnee	
Zip Code	Patients
60031	3
60064	3
60085	7
60087	2
60099	1
Total	16

DSI Waukegan	
Zip Code	Patients
60085	1

Antioch	
Zip Code	Patients
53179	1
53181	1
60020	1
60031	1
60046	1
60073	2
60083	2
60085	2
60099	3
60002	6
Total	20

Fresenius Round Lake	
Zip Code	Patients
60030	1
60031	2
60046	2
60060	1
60061	1
60073	10
60084	2
60085	3
Total	22

TOTAL 59

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

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FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

PATIENTS OF DR. GHANTOUS AT YEAR END 2007 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60031	6
60064	15
60079	1
60083	1
60085	24
60087	6
60096	1
60099	6
Total	60

Antioch	
Zip Code	Patients
53104	1
60020	1
60073	1
60099	3
60002	9
Total	15

Fresenius Round Lake	
Zip Code	Patients
60020	4
60030	3
60046	2
60061	1
60064	1
60073	15
60084	2
60099	2
Total	30

TOTAL 105

PATIENTS OF DR. GHANTOUS AT YEAR END 2008 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60096	1
60099	5
60087	6
60031	7
60064	17
60085	29
Total	65

DSI Waukegan	
Zip Code	Patients
60085	4

Antioch	
Zip Code	Patients
53104	1
60002	14
60020	1
60046	1
60071	1
60073	1
60096	1
60099	4
Total	24

Fresenius Roundlake	
Zip Code	Patients
60020	2
60030	6
60046	1
60051	1
60061	1
60064	1
60073	17
60084	1
60085	2
60087	1
Total	33

TOTAL 126

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

TEL: 847-855-9152
FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

PATIENTS OF DR. GHANTOUS AT YEAR END 2009 BY FACILITY AND ZIP CODE

Fresenius Gurnee		Antioch		Fresenius Round Lake	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60096	1	53179	1	60020	2
60099	4	60002	11	60030	2
60031	5	60020	1	60031	2
60087	7	60046	3	60046	2
60064	14	60071	1	60051	1
60085	33	60073	1	60060	1
Total	64	60083	1	60061	2
		60085	1	60064	1
		60096	1	60073	19
		60099	5	60084	2
		Total	26	60085	4
				60087	1
				Total	39

TOTAL 133

PATIENTS OF DR. GHANTOUS PRACTICE AT END OF 1ST QUARTER 2010 BY FACILITY AND ZIP CODE

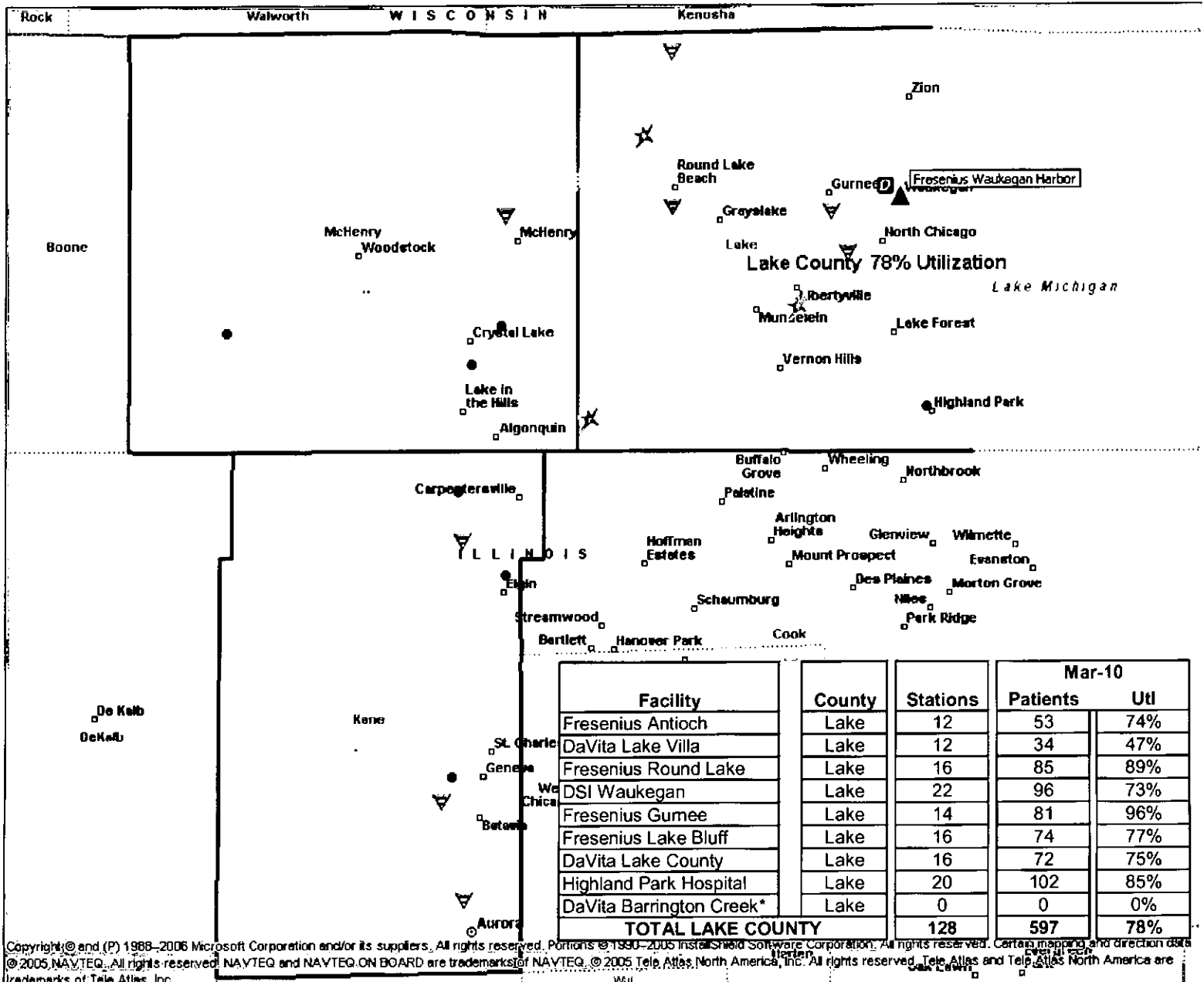
Fresenius Gurnee		Antioch		Fresenius Round Lake	
Zip Code	Patients	Zip Code	Patients	Zip Code	Patients
60031	7	53179	1	60020	3
60064	13	60002	13	60030	3
60085	32	60020	2	60031	1
60087	8	60031	1	60046	1
60096	1	60046	3	60051	1
60099	3	60071	1	60060	1
Total	64	60073	1	60061	1
		60083	1	60064	1
		60085	2	60073	20
		60096	1	60084	3
		60099	6	60085	4
		Total	32	60087	1
				Total	40

TOTAL 141

Service Accessibility – Service Restrictions

Fresenius Waukegan Harbor is located in HSA 8 which consists of Lake, McHenry and Kane Counties. There are 4 ESRD facilities in McHenry County, 7 in Kane County and 9 in Lake County. The current utilization of the combined facilities in Lake County is 78%. It would only take 18 more patients in all of Lake County to reach 80%. While the proposed service, in-center hemodialysis, does exist in the HSA and there is a need for only 3 additional stations, the county is on the verge of a shortage as seen by the growth of pre-ESRD patients as identified in this application and high utilization of county facilities. The ratio of stations to population within 30 minutes of Waukegan is 1/6,553 which is more than 1½ times the State average indicating a need for stations in the immediate area, even though there may not be a determined need across the HSA.

HSA 8/Lake County



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Data from The Renal Network 1st Quarter Census Data

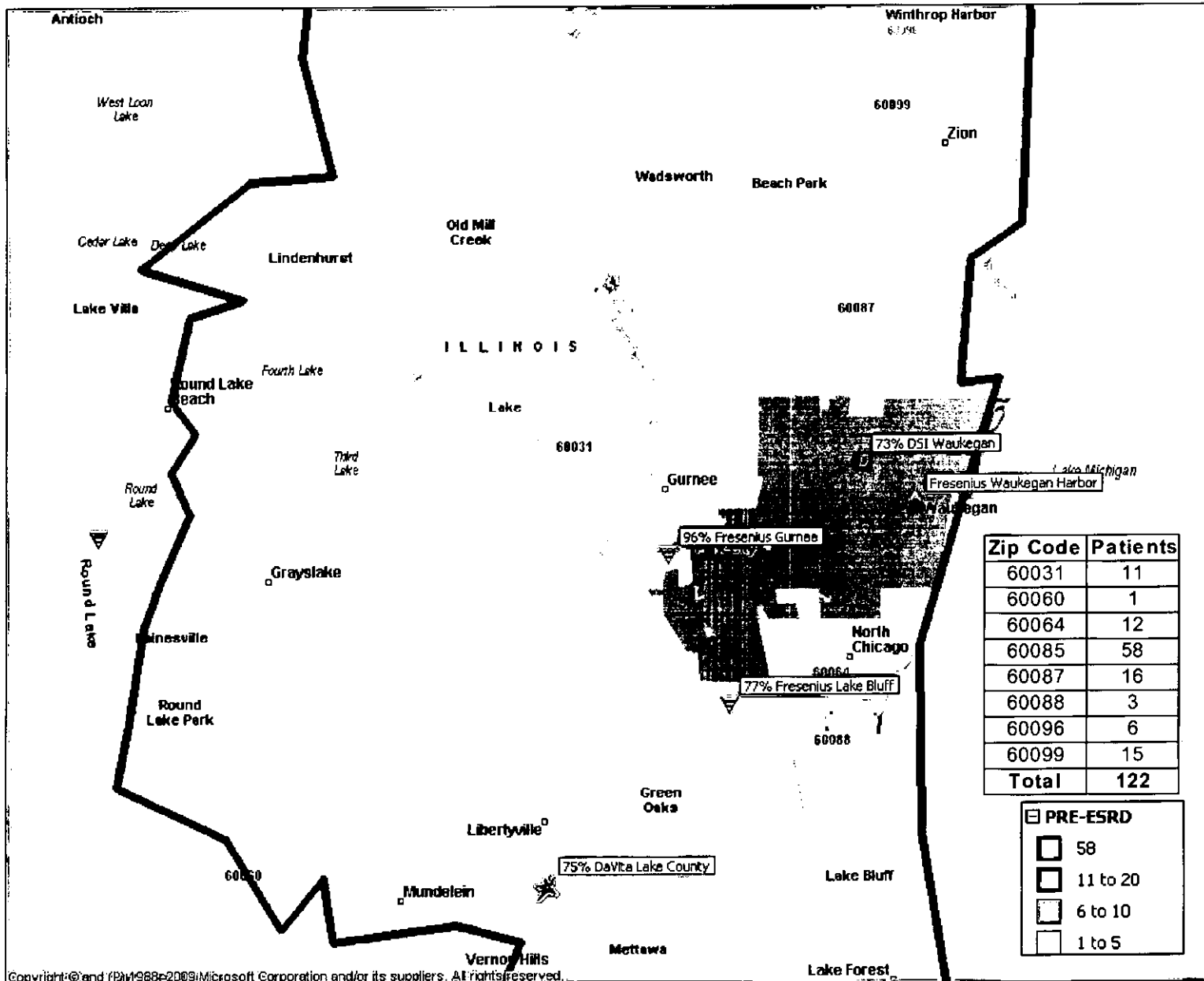
*DaVita Barrington Creek is not yet operational and therefore was not included in the current utilization count.

- As seen below, all facilities are not at the 80% target utilization, however one is almost at capacity and the remaining three are just under target utilization. Overall the facilities combined have a 79% utilization rate. Just 2 patients away from 80%. With all facilities operating at these high utilizations a shortage of treatment schedule choices for patients occurs. Most patients desire the morning or midday shift due to transportation ease and seasonal daylight hour changes. When these shifts are full new patients only option is the late afternoon into evening shift. County and township transportation services do not operate after 4pm disallowing these patients access to this service. New ESRD patients are generally more ill at the onset of dialysis therapy and find it difficult to travel home from treatment in the nighttime.

Name	Address	City	ZIP Code	Miles	Travel Time	Adjusted Time	Stations	1st Qtr Util
DSI Waukegan	1616 Grand Ave	Waukegan	60085	1.18	3	3	22	73%
Fresenius Gurnee	101 N Greenleaf Ave	Gurnee	60031	3.62	9	10	14	96%
Fresenius Lake Bluff	101 Waukegan Rd	Lake Bluff	60044	9.41	18	21	16	77%
DaVita Lake County	918 S Milwaukee Ave	Libertyville	60048	11.82	24	28	16	75%

- The map on the following page shows the relationship of the demographics of the pre-ESRD patients identified for the Waukegan Harbor facility and the utilization of area facilities.

PRE-ESRD PATIENT IDENTIFIED FOR FRESenius MEDICAL CARE WAUKEGAN HARBOR & CLINIC UTILIZATIONS WITHIN A 30 MINUTE DRIVE TIME



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Unnecessary Duplication/Maldistribution

1(A-B-C) The ratio of ESRD stations to population in the zip codes within a 30-minute radius of Fresenius Waukegan Harbor is 1 station per 6,553 residents according to the 2000 census (based on 445,616 residents and 68 stations – see chart below). This is more than 1½ times the State average of 1 station per 3,776 residents.

Zip Code	Population	Stations	Facility
60002	19,442		
60015	27,224		
60030	32,340		
60031	37,461	14	Fresenius Gurnee
60044	15,516	16	Fresenius Lake Bluff
60045	22,248		
60046	30,225		
60048	28,562	16	DaVita Lake County
60060	37,037		
60061	20,328		
60064	16,121		
60069	7,204		
60083	5,387		
60085	72,937	22	DSI Waukegan
60087	23,530		
60088	13,319		
60096	6,853		
60099	29,882		
Total	445,616	68	1/6,553

Although all facilities within thirty minutes travel time are not above the target utilization of 80%, Fresenius Medical Care Waukegan Harbor will not create a maldistribution of services. There is a determined need in Lake County for 3 more ESRD stations. While the number of stations requested exceeds that amount, the ratio of stations to population exhibits that a mal-distribution of stations exists within the 30-minute travel zone of Fresenius Waukegan Harbor. This is according to the 2000 census. The population of the area has increased in the past ten years; therefore, the actual ratio is would be much higher once the 2010 census numbers are revealed.

As well, the overall utilization of facilities within a 30-minute travel zone is 79%. Only two additional patients would put the utilization up to the State Standard of 80%.

Facilities Within 30 Minutes of Fresenius Medical Care Waukegan Harbor

Name	Address	City	ZIP Code	Miles	Travel Time	Adjusted Time	Stations	1st Qtr Util
DSI Waukegan	1616 Grand Ave	Waukegan	60085	1.18	3	3	22	73%
Fresenius Gurnee	101 N Greenleaf Ave	Gurnee	60031	3.62	9	10	14	96%
Fresenius Lake Bluff	101 Waukegan Rd	Lake Bluff	60044	9.41	18	21	16	77%
DaVita Lake County	918 S Milwaukee Ave	Libertyville	60048	11.82	24	28	16	75%

- 3A. Fresenius Medical Care Waukegan Harbor will not have an adverse effect on any other area ESRD provider in that all of the patients identified who will be referred to the Waukegan Harbor facility are pre-ESRD patients currently seeing Dr. Ghantous and no patients will be transferred from any other facility. As well, the facilities within 30 minutes travel time are operating at high utilizations.
- B. Not applicable – applicant is not a hospital, however the utilization will not be lowered at any other ESRD facility due to the establishment of the Waukegan Harbor facility.

Criterion 1110.1430 (e)(1) – Staffing

2) A. Medical Director

Dr. Vohra is currently the Medical Director for Fresenius Medical Care Deerfield. Attached is his curriculum vitae.

B. All Other Personnel

Upon opening the facility will hire a Clinic Manager who is a Registered Nurse (RN) from within the company and will hire one Patient Care Technician (PCT). After we have more than one patient, we will hire another RN and another PCT.

Upon opening we will also employ:

- Part-time Registered Dietitian
- Part-time Licensed Master level Social Worker
- Part-time Equipment Technician
- Part-time Secretary

These positions will go to full time as the clinic census increases. As well, the patient care staff will increase to the following:

- One Clinic Manager – Registered Nurse
- Four Registered Nurses
- Ten Patient Care Technicians

- 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.

Walid N. Ghantous, M.D., MPH

Date of Birth: June 2, 1938

Education: 1964 University of Baghdad, M.B. Ch.B.
ECFMG No. 58394
1997 Loma Linda University, Masters in Public Health

Internship: Norwalk Hospital
Norwalk, Connecticut
1965

Residency/ Fellowship: Resident in Internal Medicine
Northwestern University / Evanston Hospital
1966 - 1969

Fellow in Nephrology
Northwestern University / Evanston Hospital
1969 - 1970

Fellow in Nephrology
Harvard Medical School / Peter Bent Brigham Hospital
1970 - 1971

Appointments: Clinical Associate
Northwestern Medical School
1971 - Present

Hospital Affiliation: Evanston Hospital
2650 Ridge Avenue
Evanston, IL 60201
Senior Attending Internal Medicine, Nephrology
1971 - Present

Advocate Condell Medical Center
801 South Milwaukee Avenue
Libertyville, IL 60048
Attending, Nephrology
1985 - Present

Vista Medical Center East
1324 North Sheridan Road
Waukegan, IL 60085

Walid N. Ghantous, M.D., MPH

Consultant, Nephrology
2003 - Present

Midwestern Regional Medical Center
2520 Elisha Avenue
Zion, IL 60099
Consultant, Nephrology
1987 - Present

Provena St. Therese Medical Center
2615 Washington St.
Waukegan, IL 60085
Consultant, Nephrology
1987 - 2003

Practice: North Suburban Nephrology, LLC
1445 North Hunt Club Road
Suite 201
Gurnee, IL 60031
2006 - Present

Internal Medicine
• 1971 - 1973
• 1984 - 1992

Nephrology
• 1973 - Present

Positions: Medical Director Evanston / DSI
1715 Central Street
Evanston, IL 60201
1974 - Present

Medical Director Gurnee / FMCNA
101 South Greenleaf Street
Gurnee, IL 60031
1998 - Present

Medical Director Round Lake / FMCNA
401 West Nippersink Road
Round Lake, IL 60073
2000 - Present

Walid N. Ghantous, M.D., MPH

Consulting McHenry / FMCNA
4312 West Elm Street
McHenry, IL 60050
2006 - Present

Consulting Antioch / FMCNA
311 West Depot Street
Antioch, IL 60002
2005 - Present

Medical Director West Belmont / FMCNA
4848 West Belmont Avenue
Chicago, IL 60641
1977 - 2000
Consultant West Belmont / FMCNA
2000 - Present

Medical Director Niles / FMCNA
7332 North Milwaukee Avenue
Niles, IL 60714
1974 - 1998

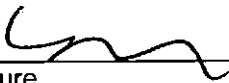
GCP Training

NIH Protecting of Human Research Participants online training
Multiple Investigator Meeting GCP training for various clinical trials.

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 Waukegan Harbor, I certify the following:

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

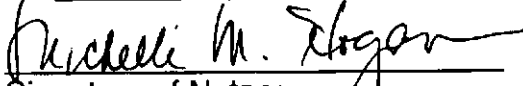


Signature

Brian Brandenburg
Printed Name

Regional Vice President
Title

Subscribed and sworn to before me
this 7th day of June, 2010



Signature of Notary

Seal



Criterion 1110.1430 (f) – Support Services

I am the Regional Vice President of the Northern 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 Waukegan Harbor during all six shifts:
 - Nutritional Counseling
 - Psychiatric/Social Services
 - Home/self training
 - Clinical Laboratory Services – provided by Spectra Laboratories
- The following services will be provided via referral to Vista Medical Center East, Waukegan:
 - Blood Bank Services
 - Rehabilitation Services
 - Psychiatric Services



Signature

Brian Brandenburg/Regional Vice President
Name/Title

Subscribed and sworn to before me
this 7th day of June, 2010

Michelle M. Hogan
Signature of Notary

Seal





Fresenius Medical Care

June 9, 2010

Arlene Catacutan
Area Manager
Fresenius Medical Care Waukegan Harbor
110 N. West Street
Waukegan, IL 60085

Dear Arlene,

Fresenius Medical Care Antioch will accept end stage renal disease patients from Fresenius Medical Care Waukegan Harbor 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,

Brian Brandenburg
Regional Vice President

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Fresenius Medical Services ♦ Dialysis Services

Criterion 1110.1430 (g) – Minimum Number of Stations

Fresenius Medical Care Waukegan Harbor is located in the Chicago-Naperville-Joliet-Gary, IL-IN-WI Metropolitan Statistical Area (MSA). A minimum of eight dialysis stations is required to establish an in-center hemodialysis center in an MSA. Fresenius Medical Care Waukegan Harbor will have twelve dialysis stations thereby meeting this requirement.

AFFILIATION AGREEMENT

This AGREEMENT made as of this 7th day of June, 2010 ("Effective Date"), between **Vista Medical Center East** (hereinafter referred to as "Hospital") and **Fresenius Medical Care of Illinois, LLC d/b/a Fresenius Medical Care Waukegan Harbor** (hereinafter referred to as "Company").

WHEREAS, Company desires to assure the availability of the Hospital's facilities for its patients who are in need of inpatient treatment at a hospital, in compliance with 42 C.F.R. 405.2160, and the Hospital is equipped and qualified to provide hospital care on an inpatient basis for such patients; and

WHEREAS, the Hospital desires to assure the availability of hemodialysis treatment for its patients who are in need of outpatient treatment, and Company is experienced and qualified to administer dialysis treatments and clinically manage patients with chronic renal failure on an outpatient basis;

1. The hospital agrees to make the facilities and personnel of its routine emergency service available for the treatment of acute life-threatening emergencies, which may occur to any of Company's patients. If, in the opinion of a member of Company's medical staff, any patient requires emergency hospitalization, the hospital agrees that it will provide a bed for such a patient (or in the event a bed is not available at the Hospital, to arrange for the transfer of the patient to an affiliated hospital) and furnish all necessary medical services at its facility for such patient at the patient's expense. In the event of an emergency at Company, the responsible physician shall notify the patient's physician of record, as indicated in Company's files, and shall promptly notify the Emergency Room physician of the particular emergency. Company shall be responsible for arranging to have the patient transported to the Hospital and shall send appropriate interim medical records. There will be an interchange, within one working day, of the patient LongTerm Program and Patient Care Plan, and of medical and other information necessary or useful in the care and treatment of patients referred to the Hospital from Company, or in determining whether such patients can be adequately cared for otherwise than in either of the facilities. Admission to Hospital, and the continued treatment by Hospital, shall be provided regardless of the patient's race, color, creed, sex, age, disability, or national origin.
2. In the event the patient must be transferred directly from Company to the Hospital, Company shall provide for the security of, and be accountable for, the patient's personal effects during the transfer.
3. Company shall keep medical records of all treatments rendered to patients by Company. These medical records shall conform to applicable standards of professional practice. If requested by the Hospital, Company shall provide complete copies of all medical records

of a patient treated by Company who is, at the time of the request, an inpatient at the Hospital.

4. The Hospital shall accept any patient of Company referred to the Hospital for elective reasons, subject to the availability of appropriate facilities, after the Company attending physician has arranged for inpatient hospital physician coverage,
5. In addition to the services described above, the Hospital shall make the following services available to patients referred by Company either at the Hospital or at an affiliated hospital:
 - a. Availability of a surgeon capable of vascular access insertion and long-term maintenance;
 - b. Inpatient care for any patient who develops complications or renal disease-related conditions that require hospital admission;
 - c. Kidney transplantation services, where appropriate, including tissue typing and cross-matching, surgical transplant capability, availability of surgeons qualified in the management of pre- and post-transplant patients; and
 - d. Blood Bank services to be performed by the Hospital.
6. Company shall have no responsibility for any inpatient care rendered by the hospital. Once a patient has been referred by Company to the Hospital, Hospital agrees to indemnify Company against, and hold it harmless from any claims, expenses, or liability based upon or arising from anything done or omitted, or allegedly done or omitted, by the Hospital, its agents, or employees, in relation to the treatment or medical care rendered at the Hospital.
7. Company 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. Company 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, Company shall conform to applicable standards of professional practice. Company shall treat such commitment as its primary responsibility and shall devote such time and effort as may be necessary to attain these objectives. Admission to Company, and the continued treatment by Company, shall be provided regardless of the patient's race, color, creed, sex, age, disability, or national origin. The cost of such facilities, equipment and personnel shall be borne by Company.
8. The cost of such facilities, equipment and personnel shall be borne by Company. The location of such facilities shall be selected by Company, but shall be sufficiently close to

the proximity to the Hospital to facilitate the transfer of patients, and communication between the facilities.

9. Company shall engage a medical director of Company's outpatient hemodialysis facility 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, Company 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.

10. The Hospital, acting through its appropriate medical staff members, shall, from time to time, evaluate its patients with chronic renal failure in accordance with its standard operating procedures. With the approval of the patient, the patient's physician shall consult with the Company Medical Director. If outpatient treatment is considered appropriate by the patient's physician and the Company Medical Director, said patient may be referred to Company for outpatient treatment at a facility operated by Company which is most convenient for the patient (or, in the event space is not available, to an affiliated unit). There will be an interchange, within one working day, of the Patient Long-Term Program and Patient Care Plan, and of medical and other information necessary or useful in the care and treatment of patients referred to Company from the Hospital, or in determining whether such patients can be adequately cared for otherwise than in either of the facilities.

11. With respect to all work, duties, and obligations hereunder, it is mutually understood and agreed that the parties shall own and operate their individual facilities wholly independent of each other. All patients treated at the facilities of Hospital or Company shall be patients of that facility. Each party shall have the sole responsibility for the treatment and medical care administered to patients in their respective facilities.

12. Company and Hospital shall each 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 Company's Staff and Hospital staff and physicians, respectively, each having a combined single limit of not less than \$1,000,000 per occurrence, \$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. Company and Hospital 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.

13. 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.
14. 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 by the federal due date for compliance, as amended from time to time.
15. Whenever under the terms of this Agreement, written notice is required or permitted to be given by one party to the other, such notice shall be deemed to have been sufficiently given if delivered in hand or by registered or certified mail, return receipt requested, postage prepaid, to such party at the following address:

To the Hospital:

Barbara J. Martin, President and Chief Executive Officer
Vista Medical Center East ___
1324 N. Sheridan Road _____
Waukegan, IL 60085 _____
 Attn:

To Company:

Fresenius Medical Care
One Westbrook Corporate Center _____
Tower One, Suite 1000 _____
Westchester, IL 60154 _____
 Attn: Lori Wright

With a copy to:

Fresenius Medical Care North America
920 Winter Street
Waltham, MA 02451-1457
 Attn: Corporate Legal Department

16. 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.
17. 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

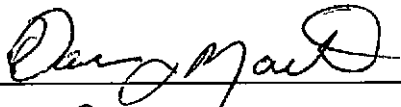
the Effective Date. This Agreement shall bind and benefit the parties, their respective successors and assigns.

18. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State where Company is located, without respect to its conflicts of law rules.
19. The term of this Agreement is for one (1) year, beginning on the Effective Date, and will automatically renew for successive one year periods unless either party gives the other notice prior to an expiration date. Either party may terminate this Agreement, at any time, with or without cause, upon thirty (30) days written notice to the non-terminating party.
20. 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.

Hospital: Vista Medical Center East

**Company: Fresenius Medical Care,
Of Illinois, LLC**

By: 

By: 

Name: Barbara J. Martin

Name: Brian Brandenburg

Title: Barbara J. Martin, CEO


Title: Regional Vice President

Criterion 1110.1430 (j) – Assurances

I am the Regional Vice President of the Northern Illinois Region of the North Division of Fresenius Medical Care North America. In accordance with 77 II. Admin Code 1110.1430, and with regards to Fresenius Medical Care Waukegan Harbor, I certify the following:

1. As supported in this application through expected referrals to Fresenius Medical Care Waukegan Harbor in the first two years of operation, the facility is expected achieve and maintain the utilization standard, specified in 77 Ill. Adm. Code 1100, of 80% and;
2. Fresenius Medical Care hemodialysis patients in Illinois have achieved adequacy outcomes of:
 - o 91% of patients had a URR \geq 65%
 - o 94% of patients had a Kt/V \geq 1.2

and the same is expected for Fresenius Medical Care Waukegan Harbor.

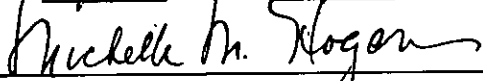


Signature

Brian Brandenburg/Regional Vice President

Name/Title

Subscribed and sworn to before me
this 7th day of June, 2010



Signature of Notary

Seal



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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 02461

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: \$ 3,573,373.64

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 03/30/2016, unless renewed, extended, or sooner terminated in accordance with the terms of the Lease.

5. 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.

015 Exhibits 12.doc

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-fourth (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) 64% 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 an 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

015 Exhibit 12.doc

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 Certificates, 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 and 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	100.61	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

015 Exhibits 12.doc

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	77.45	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	69.00	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 hereunto duly authorized.

Dated: 3/30/09

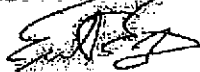
LESSOR:

Siemens Financial Services, Inc.

By: Carol Walters

Name: CAROL WALTERS
VICIPRESIDENT OF SIEMENS

Title: _____



Ernest Enrigo
 Sr. Transaction Coordinator

LESSEE:

National Medical Care, Inc.

By: Mark Fawcett

Name: MARK FAWCETT

Title: TREASURER

015 Exhibits 12.doc

DELL**QUOTATION**

QUOTE #: 485293558

Customer #: 84405601

Contract #: 70137

Customer Agreement #: Dell Std Terms

Quote Date: 4/22/09

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

Customer Name: FRESENIUS MEDICAL CARE N A

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 Factor Base 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, Dell OptiPlex 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 License English, 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 for UltraSharp Flat Panel Displays Dell OptiPlex/Precision/ Latitude (313-6414)		
Cable:	OptiPlex 760 Small Form Factor Standard 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 (984-6540)		
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			

Dell Computer Quote

ATTACHMENT - 39

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 (366-1556)
	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 (374-4558)
	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



Cushman & Wakefield of
Illinois, Inc.
455 N. Cityfront Plaza Drive
Suite 2800
Chicago, IL 60611-5555
(312) 470-1800 Tel
(312) 470-3800 Fax
www.cushwake.com

April 13, 2010

Chad Middendorf
10531 Timberwood Circle, Suite D
Louisville, KY 40223

RE: **Fresenius Medical Care Dialysis Center
Letter Of Intent**

Dear Chad,

Cushman & Wakefield has been exclusively authorized by Fresenius Medical Care (FMC) to secure proposals and assist them in negotiations regarding the acquisition of leased space in the Waukegan area. Of the properties we will analyze, your site has been identified as one that potentially meets the necessary requirements. At this time, we are pleased to provide the following Letter Of Intent.

Fresenius Medical Care is the world's leading provider of dialysis products and services. It manages in excess of over 2,500 kidney dialysis clinics and 50 billing centers and regional offices throughout North America. You can visit their website for financial information and highlights at www.fmcna.com.

Please prepare the proposal to correspond to the following terms and conditions:

OWNERSHIP:

Plainfield 550 LLC

We will need this to submit to the Illinois Health Facilities Planning Board for approval on this site.

LOCATION:

110 N West Street Street
Waukegan, IL 60085

**INITIAL SPACE
REQUIREMENTS:**

Approximately 9,120 SF of contiguous usable square feet.

HOURS OF OPERATION:

Please be advised that FMC may have employees and / or patients on site 24 hours per day 6 days per week. FMC is not open on Sundays.

PRIMARY TERM:

Twelve (12) years.

POSSESSION DATE:

FMC will have the right to take possession of the premises upon approval of the Certificate of Need to complete its necessary improvements. FMC will need a minimum of 90 days to build out the premises.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

Letter of Intent for Leased Space
ATTACHMENT - 39

COMMENCEMENT DATE: 90 days after Possession .

OPTION TO RENEW: FMC desires three (3) five (5) year options to renew the lease. Options based upon pre-established rates. Please identify the terms of any option to renew.

RENTAL RATE: \$15.25 NET NET.

COMMON AREA EXPENSES AND REAL ESTATE TAXES: Operating Expenses and Taxes are estimated to be approximately \$3.00 per square foot.

TENANT IMPROVEMENTS: FMC shall not be required to remove their tenant improvements at the end of the term.

DEMISED PREMISES SHELL: Tenant shall accept the premises in its "as-is" condition.

FIRE SUPPRESSION: At this time only the lower level is sprinklered.

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 one-eighth inch architectural drawings of the proposed demised premises and detailed building specifications. Please email AutoCads to loren.guzik@cushwake.com

PARKING: 33 parking stalls are available exclusively for tenants use.

CORPORATE IDENTIFICATION: FMC will have complete signage rights in accordance with local code.

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.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

Letter of Intent for Leased Space
ATTACHMENT – 39

ZONING AND RESTRICTIVE COVENANTS:

Please indicate if the current property zoning is acceptable for use as a Dialysis Clinic and if there are any restrictive covenants imposed by the development, owner, and/or municipality.

FINANCING:

FMC will require a non-disturbance agreement.

ENVIRONMENTAL:

Please confirm that there is no asbestos present in the building and that there are no contaminants or environmental hazards in or on the property. Also include a brief narrative of any tenants and their activities as they relate to the generation of hazardous materials.

EXCLUSIVE TERRITORY:

Landlord agrees not to lease space under its control to another dialysis provider within a five mile radius of the proposed location.

CON CONTINGENCY:

Landlord and FMC understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, FMC cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless FMC obtains a Certificate of Need (CON) permit from the Illinois Health Facilities Planning Board (the "Planning Board"). FMC agrees to proceed using its commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application to obtain the CON permit from the Planning Board. Based on the length of the Planning Board review process, FMC does not expect to receive a CON permit prior to September 2010. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit provided, however, the lease shall not be binding on either party prior to the approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective pending CON approval. Assuming CON permit approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the Planning Board does not award FMC a CON permit to establish a dialysis center on the Premises by September 2010, neither party shall have any further obligation to the other party with regard to the negotiations, lease or Premises contemplated by this Letter of Intent.

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

Letter of Intent for Leased Space
ATTACHMENT - 39

SECURITY:

Fresenius Medical Care Holding will fully guarantee the lease.

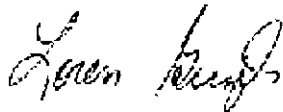
BROKERAGE FEE:

Per separate agreement.

This offer is not intended to be contractual in nature and only an executed lease delivered to both parties can bind the parties to this transaction. It is expressly understood, agreed, and hereby acknowledged, that only upon the proper execution of a fully completed, formal lease contract, with all the lease terms and conditions clearly defined and included therein, will there then be any obligation, of any kind or nature, incurred or created between the herein parties in connection with the referenced property.

You may email the proposal to loren.guzik@cushwake.com. Thank you for your time and cooperation in this matter, should you have any questions please call me at 312.470.1897.

Sincerely,



Loren Guzik
Associate Director
Office Group
Phone: 312-470-1897
Fax: 312-470-3800
e-mail: loren_guzik@cushwake.com

CC: Mr. Bill Popken

AGREED AND ACCEPTED this ____ day of _____, 2007

By: _____

Title: _____

No warranty or representation, express or implied, is made as to the accuracy of the information contained herein, and same is submitted subject to errors, omissions, change of price, rental or other conditions, withdrawal without notice, and to any special listing conditions, imposed by our principals.

Criterion 1120.310 Financial Viability

Financial Viability Waiver

This project is being funded entirely through cash and securities thereby meeting the criteria for the financial waiver.

2009 Financial Statements for Fresenius Medical Care Holdings, Inc. were submitted previously 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.

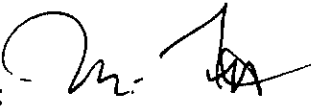
Criterion 1120.310(b) Conditions of Debt Financing

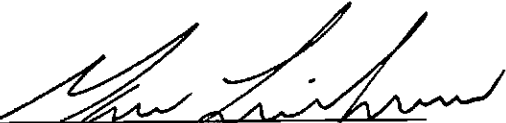
Fresenius Medical Care of Illinois, LLC

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

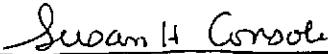
The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

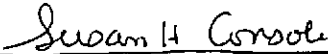
By: 
ITS: Mark Fawcett
Vice President & Treasurer

By: 
ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

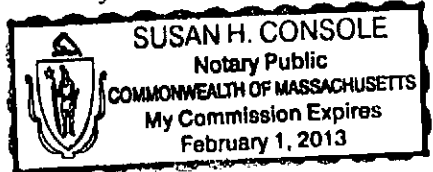
Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010


Signature of Notary


Signature of Notary

Seal

Seal



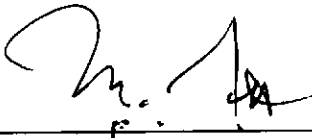
Criterion 1120.310(b) Conditions of Debt Financing

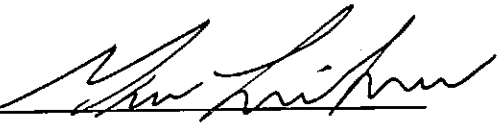
Fresenius Medical Care Holdings, Inc.

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:

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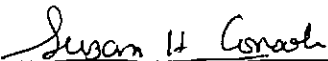
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By: 
ITS: Mark Fawcett
Vice President & Asst. Treasurer

By: 
ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

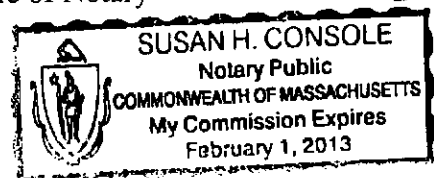
Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010


Signature of Notary

Signature of Notary

Seal

Seal



Criterion 1120.310(a) Reasonableness of Financing Arrangements

Fresenius Medical Care of Illinois, LLC

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: [Signature]

Title: Mark Fawcett
Vice President & Treasurer

By: [Signature]

Title: Marc Lieberman
Asst. Treasurer

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

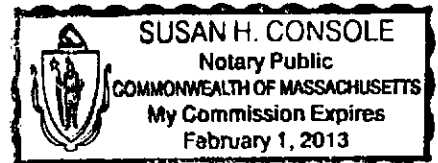
Signature of Notary

Seal

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

Signature of Notary

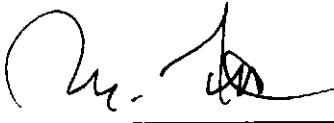
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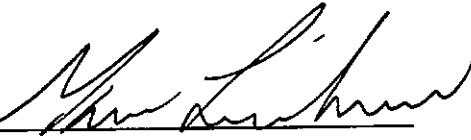


Criterion 1120.310(a) Reasonableness of Financing Arrangements

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: Mark Fawcett
Vice President & Asst. Treasurer

By: 
ITS: Marc Lieberman
Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

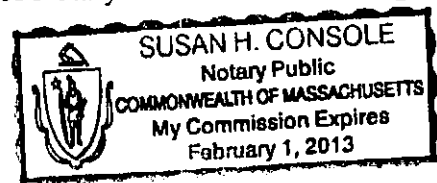
Signature of Notary

Seal

Notarization:
Subscribed and sworn to before me
this 7 day of June, 2010

Signature of Notary

Seal



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		127.00			9,120			1,456,000	1,158,240
Contingency		12.70			9,120			145,000	115,800
TOTALS		139.70			9,120			1,601,000	1,274,040

* Include the percentage (%) of space for circulation

Criterion 1120.310 (d) – Projected Operating Costs

Year 2014

Salaries	\$720,860
Benefits	180,215
Supplies	<u>173,074</u>
Total	\$1,074,149

Annual Treatments 15,725

Cost Per Treatment \$68.00

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

Year 2014

Depreciation/Amortization	\$163,252
Interest	<u>0</u>
CAPITAL COSTS	\$163,252

Treatments: 15,725

Capital Cost per treatment \$10.38

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.



MAPQUEST

Trip to 1616 Grand Ave
Waukegan, IL 60085-3600
1.18 miles - about 3 minutes

Notes

TO:
DSI WAUKEGAN



A 110 N West St, Waukegan, IL 60085-4330



1. Start out going **NORTH** on **N WEST ST** toward **W CLAYTON ST.** go 0.2 mi



2. Turn **LEFT** onto **GRAND AVE.** go 1.0 mi



3. **1616 GRAND AVE** is on the **RIGHT.** go 0.0 mi

B 1616 Grand Ave, Waukegan, IL 60085-3600

Total Travel Estimate : 1.18 miles - about 3 minutes

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MAPQUEST

Trip to 101 N Greenleaf St
Gurnee, IL 60031
3.62 miles - about 9 minutes

Notes

TO:

FRESENIUS MEDICAL CARE GURNEE



A 110 N West St, Waukegan, IL 60085-4330



1. Start out going **SOUTH** on **N WEST ST** toward **W MADISON ST.** go 0.1 mi



2. Turn **RIGHT** onto **WASHINGTON ST.** go 3.4 mi



3. Turn **RIGHT** onto **N GREENLEAF AVE.** go 0.0 mi



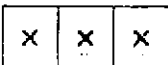
4. **101 N GREENLEAF ST.** go 0.0 mi

B 101 N Greenleaf St, Gurnee, IL 60031
Total Travel Estimate : 3.62 miles - about 9 minutes

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MAPQUEST

Notes

TO:



Trip to 101 Waukegan Road

Lake Bluff, IL 60044

9.41 miles - about 18 minutes

FRESENIUS MEDICAL CARE LAKE BLUFF



110 N West St, Waukegan, IL 60085-4330



1. Start out going **SOUTH** on **N WEST ST** toward **W MADISON ST.** go 0.1 mi



2. Turn **RIGHT** onto **WASHINGTON ST.** go 1.0 mi



3. Turn **LEFT** onto **S LEWIS AVE / CR-W34.** go 0.6 mi



4. Turn **RIGHT** onto **BELVIDERE ST / IL-120.** Continue to follow **IL-120 W.** go 2.0 mi



5. Merge onto **US-41 S / SKOKIE HWY** toward **CHICAGO.** go 5.1 mi



6. Turn **RIGHT** onto **W WASHINGTON AVE.** go 0.0 mi



7. **W WASHINGTON AVE** becomes **SHAGBARK RD.** go 0.1 mi



8. Turn **RIGHT** onto **ROCKLAND RD / IL-176.** go 0.3 mi



9. Turn **LEFT** onto **N WAUKEGAN RD / IL-43 / WAUKEGAN RD.** go 0.0 mi



10. **101 WAUKEGAN ROAD.** go 0.0 mi



101 Waukegan Road, Lake Bluff, IL 60044

Total Travel Estimate : 9.41 miles - about 18 minutes



MAPQUEST

Trip to 918 S Milwaukee Ave
Libertyville, IL 60048-3229
11.82 miles - about 24 minutes

Notes

TO:
DAVITA LAKE COUNTY



A 110 N West St, Waukegan, IL 60085-4330



1. Start out going **SOUTH** on **N WEST ST** toward **W MADISON ST.** go 0.1 mi



2. Turn **RIGHT** onto **WASHINGTON ST.** go 4.9 mi



3. Turn **LEFT** onto **IL-21 / MILWAUKEE AVE / N RIVERSIDE DR.** Continue to follow **IL-21 / MILWAUKEE AVE.** go 6.8 mi



4. **918 S MILWAUKEE AVE.** go 0.0 mi

B 918 S Milwaukee Ave, Libertyville, IL 60048-3229
Total Travel Estimate : 11.82 miles - about 24 minutes

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NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

TEL: 847-855-9152
FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

June 11, 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 practicing in Lake County and serve as Medical Director of the Fresenius Medical Care Gurnee and Round Lake dialysis centers. I currently refer patients to Fresenius Medical Care Gurnee, Round Lake, Antioch and to DSI Waukegan. Lake County has seen a constant increase of ESRD patients over the past several years and the facilities I refer patients to are operating at high utilizations. For this reason, I am in full support of the proposed Fresenius Medical Care Waukegan Harbor dialysis clinic.

Over the past three years I was treating 105 hemodialysis patients at the end of 2007, 126 patients at the end of 2008 and 133 patients at the end of 2009, as reported to The Renal Network. At the end of the 1st quarter 2010 I had 141 hemodialysis patients. As well, over the past twelve months, I have referred 59 hemodialysis patients to Fresenius Gurnee, Antioch, Round Lake and DSI Waukegan. I have 122 pre-ESRD patients in my practice that will be referred to the Waukegan Harbor facility within 2 years after completion of the facility (see attached lists of patients).

I therefore urge the Board to approve the establishment of Fresenius Medical Care Waukegan Harbor to keep access to dialysis treatment available to the patients in the Lake County. Thank you for your consideration.

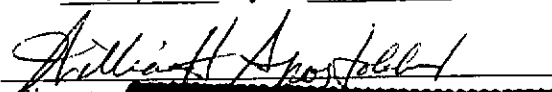
I attest that to the best of my knowledge, all the information contained in this letter is true and correct and that the projected patient referrals listed in this document have not been used to support any other CON application.

Sincerely,

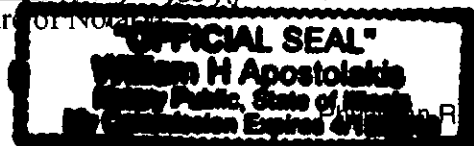

Walid Ghantous, M.D.

Notarization:

Subscribed and sworn to before me
this 14th day of JUNE, 2010


Signature of Notary

Seal



-1-
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NORTH SUBURBAN NEPHROLOGY

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L. ROBERTS, M.S., PA-C

**PRE - ESRD PATIENTS DR. GHANTOUS EXPECTS TO REFER TO
FRESENIUS MEDICAL CARE WAUKEGAN HARBOR BY 2 YEARS
AFTER PROJECT COMPLETION**

Zip Code	Patients
60031	11
60060	1
60064	12
60085	58
60087	16
60088	3
60096	6
60099	15
Total	122

**ADMISSIONS OF DR. GHANTOUS FOR THE PREVIOUS TWELVE
MONTHS - 05/01/2009 THROUGH 04/30/2010**

Fresenius Gurnee	
Zip Code	Patients
60031	3
60064	3
60085	7
60087	2
60099	1
Total	16

DSI Waukegan	
Zip Code	Patients
60085	1

Antioch	
Zip Code	Patients
53179	1
53181	1
60020	1
60031	1
60046	1
60073	2
60083	2
60085	2
60099	3
60002	6
Total	20

Fresenius Round Lake	
Zip Code	Patients
60030	1
60031	2
60046	2
60060	1
60061	1
60073	10
60084	2
60085	3
Total	22

TOTAL 59

9²/₃

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

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W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

PATIENTS OF DR. GHANTOUS AT YEAR END 2007 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60031	6
60064	15
60079	1
60083	1
60085	24
60087	6
60096	1
60099	6
Total	60

Antioch	
Zip Code	Patients
53104	1
60020	1
60073	1
60099	3
60002	9
Total	15

Fresenius Round Lake	
Zip Code	Patients
60020	4
60030	3
60046	2
60061	1
60064	1
60073	15
60084	2
60099	2
Total	30

TOTAL 105

PATIENTS OF DR. GHANTOUS AT YEAR END 2008 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60096	1
60099	5
60087	6
60031	7
60064	17
60085	29
Total	65

DSI Waukegan	
Zip Code	Patients
60085	4

Antioch	
Zip Code	Patients
53104	1
60002	14
60020	1
60046	1
60071	1
60073	1
60096	1
60099	4
Total	24

Fresenius Roundlake	
Zip Code	Patients
60020	2
60030	6
60046	1
60051	1
60061	1
60064	1
60073	17
60084	1
60085	2
60087	1
Total	33

TOTAL 126

9³
4

NORTH SUBURBAN NEPHROLOGY

1445 N. HUNT CLUB RD.
SUITE 201
GURNEE, IL 60031

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FAX: 847-855-5215

W. GHANTOUS, MD, MPH
R. KHANNA, DO
O. DEGANI, MD
L. ROBERTS, M.S., PA-C

PATIENTS OF DR. GHANTOUS AT YEAR END 2009 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60096	1
60099	4
60031	5
60087	7
60064	14
60085	33
Total	64

DSI Waukegan	
Zip Code	Patients
60085	4

Antioch	
Zip Code	Patients
53179	1
60002	11
60020	1
60046	3
60071	1
60073	1
60083	1
60085	1
60096	1
60099	5
Total	26

Fresenius Round Lake	
Zip Code	Patients
60020	2
60030	2
60031	2
60046	2
60051	1
60060	1
60061	2
60064	1
60073	19
60084	2
60085	4
60087	1
Total	39

TOTAL 133

PATIENTS OF DR. GHANTOUS PRACTICE AT END OF 1ST QUARTER 2010 BY FACILITY AND ZIP CODE

Fresenius Gurnee	
Zip Code	Patients
60031	7
60064	13
60085	32
60087	8
60096	1
60099	3
Total	64

DSI Waukegan	
Zip Code	Patients
60085	5

Antioch	
Zip Code	Patients
53179	1
60002	13
60020	2
60031	1
60046	3
60071	1
60073	1
60083	1
60085	2
60096	1
60099	6
Total	32

Fresenius Round Lake	
Zip Code	Patients
60020	3
60030	3
60031	1
60046	1
60051	1
60060	1
60061	1
60064	1
60073	20
60084	3
60085	4
60087	1
Total	40

TOTAL 141

Physician Referral Letter

APPENDIX - 2