Original

10-080

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
DEC 16 2010
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: *Neomedica North Kilpatrick*				
Street Address: *4800 N. Kilpatrick*				
City and Zip Code: *Chicago 60630*				
County: *Cook*	Health Service Area	6	Health Planning Area:	

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

Exact Legal Name: *National Medical Care, Inc. d/b/a Neomedica North Kilpatrick*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Rice Powell*
CEO Address: *920 Winter Street, Waltham, MA 02451*
Telephone Number: *800-662-1237*

Type of Ownership of Applicant/Co-Applicant

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

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

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

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

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

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

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

Post Permit Contact

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

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

Additional Contact

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

Name: *Clare Ranalli*
Title: *Attorney*
Company Name: *Holland & Knight, LLP*
Address: *131 S. Dearborn, 30th Floor, Chicago, IL 60603*
Telephone Number: *312-578-6567*
E-mail Address: *clare.ranalli@hklaw.com*
Fax Number: *312-578-6666*

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Renal Investment Properties, LLC*
Address of Site Owner: *210 S. Des Plaines St., Chicago, IL 60661*
Street Address or Legal Description of Site: *4800 N. Kilpatrick, Chicago, IL 60630* **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: *National Medical Care, Inc. d/b/a Neomedica North Kilpatrick*
Address: *920 Winter Street, Waltham, MA 02451*

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.] ***NOT APPLICABLE – PROJECT IS FOR ADDITION OF STATIONS***

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.] ***NOT APPLICABLE – PROJECT IS FOR ADDITION OF STATIONS***

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

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

2. Narrative Description

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

National Medical Care, Inc. proposes to expand its Neomedica North Kilpatrick in-center hemodialysis facility by 6 stations. The facility is located at 4800 N. Kilpatrick, Chicago, IL in leased space and consists of 22 stations. The result of the expansion will be a 28 station facility.

Neomedica North Kilpatrick is in HSA 6. There is a need for 112 stations in this HSA according to the November 2010 inventory.

This project is "non-substantive" under Planning Board rule 1110.10(b) as it entails the expansion of a health care facility that provides in-center chronic renal dialysis services.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-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	100,000	N/A	100,000
Contingencies	9,500	N/A	9,500
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	124,000	N/A	124,000
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 80,550	80,550	N/A	80,550
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	314,050	N/A	314,050
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**CLINICAL**
Cash and Securities	233,500	N/A	233,500
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)	80,550	N/A	80,550
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	**314,050**	N/A	**314,050**

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): December 1, 2012

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

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

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

Cost Space Requirements

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

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

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

CERTIFICATION

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

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

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

SIGNATURE

Marc Lieberman
PRINTED NAME
Asst. Treasurer
PRINTED TITLE

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

C Wynelle Scanna
Signature of Notary

Seal

SIGNATURE

Mark Fawcett
PRINTED NAME
Vice President & Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 01 day of Dec 2010

Signature of Notary

Seal

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

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE	SIGNATURE
PRINTED NAME: Todd Lieberman	PRINTED NAME: Mark Fawcett
PRINTED TITLE: Asst. Treasurer	PRINTED TITLE: Vice President & Asst. Treasurer
Notarization: Subscribed and sworn to before me this _____ day of _____ 2010	Notarization: Subscribed and sworn to before me this 01 day of Dec. 2010
Signature of Notary	Signature of Notary
Seal	Seal

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

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

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

ASSURANCES: ***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
In-Center Hemodialysis	22	28

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

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

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

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

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

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

VIII. - 1120.120 - Availability of Funds

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

233,500	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
N/A	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
N/A	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
80,550	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
N/A	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
N/A	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
N/A	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
314,050	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio	***APPLICANT MEETS THE FINANCIAL VIABILITY WAVER 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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	24
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18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
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File Number 5928-478-9

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

NATIONAL MEDICAL CARE, INC., INCORPORATED IN DELAWARE AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON FEBRUARY 26, 1997, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED 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* 20TH *day of* SEPTEMBER *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1026301800

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

Certificate of Good Standing
ATTACHMENT - 1

Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Renal Investment Properties, LLC*
Address of Site Owner: *210 S. Des Plaines St., Chicago, IL 60661*
Street Address or Legal Description of Site: *4800 N. Kilpatrick, Chicago, IL 60630* **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.]

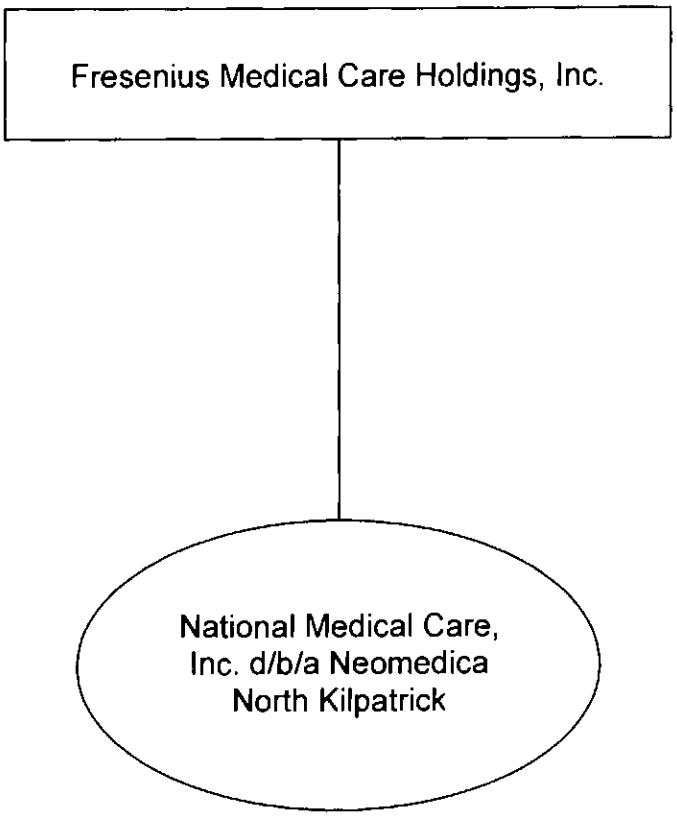
Exact Legal Name: *National Medical Care, Inc. d/b/a Neomedica North Kilpatrick*

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

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

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

Certificate of Good Standing at Attachment – 1.



ATTACHMENT - 4

Itemization of Project Costs and Sources of Funds

Modernization Contracts

Plumb Station Boxes	$100,000

Contingencies $9,500

Movable & Other Equipment

Dialysis Chairs (6)	$15,000
Television (6)	$9,000
Water Treatment	$100,000

FMV Leased Equipment

Dialysis Machines (6)	$80,550

Cost Space Requirements

Provide in the following format, the department/area GSF and cost. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
In-Center Hemodialysis	314,050	11,447			900	900	
Total Clinical	314,050	11,447			900	900	
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	**314,050**	11,447			900	**900**	

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

Certification & Authorization

National Medical Care, Inc.

In accordance with Section III, A (2) of the Illinois Health Facilities & Services Review Board Application for Certificate of Need; I do hereby certify that no adverse actions have been taken against National Medical Care, 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 & Services Review Board; and

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____

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

Notarization:
Subscribed and sworn to before me
this 01 day of Dec, 2010

C Wynelle Scenna
Signature of Notary

Seal

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

ATTACHMENT - 11

Certification & Authorization

Fresenius Medical Care Holdings, Inc.

In accordance with Section III, A (2) of the Illinois Health Facilities & Services Review 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 & Services Review Board; and

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____

Mark Sawcett
Vice President & Asst. Treasurer

ITS: _____

Notarization:
Subscribed and sworn to before me
this 01 day of Dec, 2010

C Wynelle Scenna
Signature of Notary

Seal

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

ATTACHMENT - 11

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
Chicago Dialysis	14-2506	820 West Jackson Blvd.	Chicago	60607
Chicago Westside	14-2681	1340 S. Damen	Chicago	60608
Congress Parkway	14-2631	3410 W. Van Buren Street	Chicago	60624
Crestwood	14-2538	4861-73 W. Cal Sag Road	Crestwood	60445
Decatur East	14-2503	1830 S. 44th St.	Decatur	62521
Deerfield	14-2710	405 Lake Cook Road	Deefield	60015
Downers Grove	14-2503	3825 Highland Ave., Ste. 102	Downers Grove	60515
DuPage West	14-2509	450 E. Roosevelt Rd., Ste. 101	West Chicago	60185
DuQuoin	14-2595	#4 West Main Street	DuQuoin	62832
East Belmont	14-2531	1331 W. Belmont	Chicago	60613
East Peoria	14-2562	3300 North Main Street	East Peoria	61611
Elgin		2130 Point Boulevard	Elgin	60123
Elk Grove	14-2507	901 Biesterfield Road	Elk Grove	60007
Evanston	14-2621	2953 Central Street	Evanston	60201
Evergreen Park	14-2545	9730 S. Western Avenue	Evergreen Park	60805
Garfield	14-2555	5401 S. Wentworth Ave.	Chicago	60609
Glendale Heights	14-2617	520 E. North Avenue	Glendale Heights	60139
Glenview	14-2551	4248 Commercial Way	Glenview	60025
Greenwood	14-2601	1111 East 87th St., Ste. 700	Chicago	60619
Gurnee	14-2549	101 Greenleaf	Gurnee	60031
Hazel Crest	14-2607	17524 E. Carriageway Dr.	Hazel Crest	60429
Hoffman Estates	14-2547	3150 W. Higgins, Ste. 190	Hoffman Estates	60195
Jackson Park	14-2516	7531 South Stony Island Ave.	Chicago	60649
Kewanee	14-2578	230 W. South Street	Kewanee	61443
Lake Bluff	14-2669	101 Waukegan Rd., Ste. 700	Lake Bluff	60044
Lakeview	14-2679	4008 N. Broadway, St. 1200	Chicago	60613
Lockport		Thornton Avenue	Lockport	60441
Lombard		1940 Springer Drive	Lombard	60148
Lutheran General	14-2559	8565 West Dempster	Niles	60714
Macomb	14-2591	523 E. Grant Street	Macomb	61455
Marquette Park	14-2566	6515 S. Western	Chicago	60636
McLean Co	14-2563	1505 Eastland Medical Plaza	Bloomington	61704
McHenry	14-2672	4312 W. Elm St.	McHenry	60050
Melrose Park	14-2554	1111 Superior St., Ste. 204	Melrose Park	60160
Merrionette Park	14-2667	11630 S. Kedzie Ave.	Merrionette Park	60803
Metropolis	14-2705	20 Hospital Drive	Metropolis	62960
Midway	14-2713	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
Mundelein		1400 Townline Road	Mundelein	60060
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
Waukegan Harbor		101 North West Street	Waukegan	60085
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

Criterion 1110.230 – Purpose of Project

1. The purpose of this project is to keep dialysis services accessible to a growing ESRD population in the northwest side of Chicago (HSA 6) and to alleviate the continued high utilization at the Fresenius Medical Care North Kilpatrick dialysis facility.

2. The market area that Fresenius Medical Care North Kilpatrick serves is primarily the area surrounding the intersection of I-90/94. The neighborhoods included are Albany Park, Irving Park, Old Irving Park, Mayfair, Jefferson Park and Portage Park.

3. This facility is needed to alleviate historic high utilizations. The facility is currently at 89%. It is also needed to accommodate the pre-ESRD patients that Dr. Rao has identified from this area who will require dialysis services within the first two years of operation of the 6 additional stations.

4. Clinic utilization is obtained from the Renal Network for the 3rd Quarter 2010. Current counts of pre-ESRD patients for the market area were obtained from Dr. Roa.

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 it has historically as listed below.

   - 97% of patients had a URR $\geq$ 65%
   - 97% 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 North Kilpatrick facility is currently at 89% utilization with 22 stations and has been operating at a high utilization rate for many years. Access to a greater number of dialysis stations is needed in this northwest Chicago area to accommodate current and future ESRD patients. 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. The addition of stations is not a costly project and it would not make sense to form a joint venture solely for that reason.

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 North Kilpatrick area pre-ESRD patients to underutilized facilities in the area as they require dialysis treatment was not considered a reasonable alternative. Those facilities closest to the North Kilpatrick facility are also operating at high utilizations.

Facility	Utilization 09/30/10	Comment
Fresenius West Belmont	98%	Adding 3 stations to alleviate high utilization
Fresenius NorthCenter	96%	Adding 4 stations to alleviate high utilization
DaVita Montclare	83%	
DaVita Logan Square	88%	
Nephron Dialysis	110%	

D. The most desirable alternative is to address the need for more stations in the most timely and cost effective manner and to keep access to dialysis services available by addressing current high utilization and planning for known future ESRD patients in the market area by adding the 6 stations to Fresenius Medical Care North Kilpatrick facility, near where the patients reside. The cost of this project is $314,050.

2) Comparison of Alternatives

	Total Cost	Patient Access	Quality	Financial
Maintain Status Quo	$0	There would be a continual decline in access in the Chicago northwest side market until there was literally no access to dialysis services.	Patients would have to travel outside their market for services. Loss of continuity of care would result. 4th shift would have to be operated causing transportation problems and missed treatments.	For patient - higher transportation costs due to 4th shift, where there is no available county transportation.
Pursue Joint Venture	$314,050	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, Fresenius 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 patient transportation services do not operate after 4pm. Would create ripple effect of raising utilization of area providers which are already over utilized 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
Add 6 stations to Fresenius Medical Care North Kilpatrick	$314,050	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	This is an expense to Fresenius Medical Care only and is a minimal cost compared with other CON projects.

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 Northcenter has had the following quality outcomes:

97% 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	11,447	360-520 DGSF	NONE	YES

As seen in the chart above, the State Standard for ESRD is between 360-520 DGSF per station. 28 stations in 11,447 DGSF of space equals 409 DGSF per station which is within the State standard.

Criterion 1110.234, Project Services Utilization

UTILIZATION					
	DEPT/SERVICE	**HISTORICAL UTILIZATION**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MET STANDARD?**
	IN-CENTER HEMODIALYSIS	89%		80%	Yes
YEAR 1	IN-CENTER HEMODIALYSIS		74%	80%	No
YEAR 2	IN-CENTER HEMODIALYSIS		85%	80%	Yes

This facility is experiencing a 89% utilization rate with 22 stations. It is expected that approximately 11 of the current patients will no longer require dialysis services by the time the 6 stations are in operation due to death/transplant. Dr. Rao has identified 55 pre-ESRD patients that he expects to refer to the North Kilpatrick facility in the two years after the 6 stations become certified. However it is estimated that approximately 17 of these patients will no longer require dialysis services by the time the stations are operational.

The above utilization numbers do not account for any additional patients Dr. Rao may acquire during this time who are new pre-ESRD patients or those who present in the emergency room in kidney failure.

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 Chicago/Cook County in HSA 6. 100% of the pre-ESRD patients reside in HSA 6 and 98% of the current patients also reside in HSA 6.

County	HSA	# Pre-ESRD Patients Who Will Be Referred to Fresenius Medical North Kilpatrick
Chicago/Cook	6	55 - 100%

County	HSA	# Current Fresenius Medical Care West Belmont Patients
Chicago/Cook	6	54 - 98%
Suburban Cook	7	1 - 2%

ASSOCIATES IN NEPHROLOGY, S.C.
NEPHROLOGY AND HYPERTENSION
210 South Des Plaines Street
Chicago, Illinois 60661
(312) 654-2720

PAUL W. CRAWFORD , M.D., F.A.S.N.
AZZA S. SULEIMAN, M.D.
SATYA P. AHUJA, M.D., F.A.S.N.
MARIA I. SOBRERO, M.D.
VINITHA RAGHAVAN, M.D.
DANIEL KNIAZ, M.D., F.A.C.P.
EDGAR V. LERMA, M.D., F.A.S.N.
RAMESH SOUNDARARAJAN, M.D., F.A.S.N.
NEETHA S. DHANANJAYA, M.D.
MARK P. LEISCHNER, M.D.
SREEDEVI CHITTINENI, M.D.
CHIRAG P. PATEL, M.D., F.A.S.N.
MADHAV RAO, M.D.
APRIL KENNEDY, M.D.
RIZWAN MOINUDDIN, D.O.
NIMEET R. BRAHMBHATT, M.D.

SUDESH K. VOHRA, M.D.
VIJAYKUMAR M. RAO, M.D., F.A.S.N.
CLARK MCCLURKIN, JR., M.D.
WADAH ATASSI, M.D., M.B.A.
HAROLD BREGMAN, M.D., F.A.C.P.
CONSTANTINE G. DELIS, D.O.
KAREEN R. SIMPSON, M.D., F.A.S.N.
AMITABHA MITRA, M.D.
JIM JIANLING YAO, M.D.
EDUARDO J. CREMER, M.D.
RICHARD HONG, M.D.
LO-KU CHIANG, M.D.
HARESH MUNI, M.D.
BOGDAN DERYLO, M.D., M.Sc.
NIC I. IIRISTEA, M.D.
DONALD F. CRONIN, M.D.

December 2, 2010

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

Dear Mr. Galassie:

I am a nephrologist practicing with Associates in Nephrology (AIN) in northwest Chicago and am the Medical Director of the Fresenius Medical Care North Kilpatrick dialysis facility. Given the continued high utilization the facility is experiencing, I am in full support of the addition of 6 stations to allow for continued access to dialysis treatment.

I was treating 39 hemodialysis patients at the end of 2007, 36 at the end of 2008 and 56 at the end of 2009, as reported to The Renal Network. As of the most recent quarter, I was treating 58 hemodialysis patients. Over the past twelve months I have referred 20 patients for hemodialysis services to Fresenius North Kilpatrick and Uptown and to DaVita Lincoln Park. There are currently 118 ESRD patients dialyzing at the North Kilpatrick facility. There are 6 other nephrologists who also admit and see patients at the facility. I currently have 55 pre-ESRD patients that live in the zip codes surrounding the North Kilpatrick facility that I expect to begin dialysis at the facility in the two years after the installation of the 6 stations. These patients all have lab values indicative of a patient in active kidney failure (see attached patient list).

The Fresenius North Kilpatrick facility treats approximately 152 patients a year and has experienced a combined death/transplant rate of 9%. It is therefore expected that approximately 11 of the current patients of the facility are not expected to continue to require dialysis services by the time the 6 stations are operational.

I respectfully ask the Board to approve the addition of 6 stations to the North Kilpatrick facility in order to keep access available to this patient population. Thank you for your consideration.

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

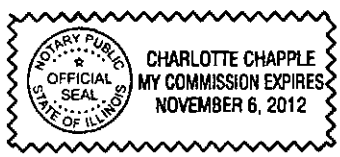
Sincerely,

Madhav Rao, M.D.

Notarization:
Subscribed and sworn to before me
this 8th day of January, 2010

Signature of Notary

Seal



CURRENT FRESENIUS MEDICAL CARE NORTH KILPATRICK PATIENTS

Zip Code	Fresenius North Kilpatrick Patients
60076	2
60610	2
60615	1
60618	13
60619	1
60622	3
60625	25
60626	2
60629	1
60630	25
60634	5
60639	8
60640	3
60641	10
60642	1
60645	2
60646	2
60647	1
60649	1
60651	1
60656	1
60659	5
60660	2
60706	1
Total	**118**

PRE-ESRD PATIENTS OF DR. RAO THAT WILL BEGIN DIALYSIS AT FRESENIUS MEDICAL CARE NORTH KILPATRICK

Zip Code	Pre-ESRD
60618	13
60625	13
60630	12
60639	7
60641	10
Total	**55**

NEW REFERRALS OF DR. RAO FOR THE PAST TWELVE MONTHS

ZIP CODE	DAVITA LINCOLN PARK	FRESENIUS NORTH KILPATRICK	FRESENIUS POLK	FRESENIUS UPTOWN	TOTAL
60131			1		1
60618		1			1
60625		3			3
60630		7			7
60634		1			1
60636				1	1
60641		1			1
60645		1			1
60647		1		1	2
60657	1				1
60706		1			1
TOTAL	1	16	1	2	20

HEMODIALYSIS PATIENTS OF DR. RAO FOR YEAR END 2007

Zip Code	Fresenius North Kilpatrick
60016	1
60062	1
60610	2
60615	1
60618	5
60622	1
60625	3
60629	2
60630	6
60634	1
60639	3
60640	2
60641	5
60647	1
60656	1
60659	1
60660	2
60676	1
Total	39

PATIENTS OF DR. RAO FOR YEAR END 2008

ZIP CODE	FRESENIUS NORTH KILPATRICK	NEPHRON DIALYSIS	TOTAL
60626		1	1
60611	1		1
60618	4		4
60622	2		2
60625	4	2	6
60630	5		5
60634	1		1
60639	6		6
60640	1		1
60641	3		3
60645	1		1
60647	1		1
60659	1	1	2
60660	1	1	2
TOTAL	31	5	36

PATIENTS OF DR. RAO FOR YEAR END 2009

ZIP CODE	FRESENIUS NORTH KILPATRICK	FRESENIUS POLK	FRESENIUS UPTOWN	TOTAL
60062	1			1
60076	1			1
60131		1		1
60610	2			2
60614			2	2
60615	1			1
60618	8			8
60625	8			8
60626	1			1
60629	1			1
60630	9			9
60634	1			1
60639	1			1
60640	1			1
60641	7			7
60645	2			2
60647	4			4
60649	1			1
60656	1			1
60659	2			2
60660	1			1
TOTAL	55	1	2	56

PATIENTS OF DR. RAO AS OF MOST RECENT QUARTER

ZIP CODE	FRESENIUS NORTH KILPATRICK	FRESENIUS UPTOWN	FRESENIUS POLK	TOTAL
60131			1	1
60039	1			1
60076	1			1
60610	2			2
60615	1			1
60618	5			5
60622	1			1
60625	8			8
60629	1			1
60630	12		1	13
60634	2			2
60639	3	1		4
60640	1			1
60641	6			6
60645	2			2
60647	1	1		2
60656	1			1
60659	3			3
60660	2			2
60706	1			1
TOTAL	54	2	2	58

Criterion 1110.1430 (e)(1) – Staffing

2) A. Medical Director

Dr. Madhav Rao is currently the Medical Director for Fresenius Medical Care North Kilpatrick and will continue to be the Medical Director. Attached is his curriculum vitae.

B. All Other Personnel

The North Kilpatrick facility currently employs the following staff:

- Clinic Manager who is a Registered Nurse
- Charge Nurse who is a Registered Nurse
- 4 Full-time Registered Nurse
- 11 Full-time Patient Care Technicians
- Full-time Registered Dietitian
- Full-time Licensed Master level Social Worker
- Full-time Equipment Technician
- Full-time Secretary

4 additional Patient Care Technicians and 1 Registered Nurse will be hired for the 6 station expansion.

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.

Criterion 1110.1430 (f) – Support Services

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

- Fresenius Medical Care utilizes the Proton patient data tracking system in the majority of its facilities and all of its new facilities.
- These support services are available at Fresenius Medical Care North Kilpatrick 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 Swedish Covenant Hospital, Chicago:
  - Blood Bank Services
  - Rehabilitation Services
  - Psychiatric Services

Signature

Richard Stotz/Regional Vice President
Name/Title

Subscribed and sworn to before me
this 22nd day of November 2010

Michelle M. Hogan
Signature of Notary

Seal

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

Criterion 1110.1430 (j) – Assurances

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

1. As supported in this application through existing patients and expected referrals to Fresenius Medical Care - Neomedica North Kilpatrick in the first two years after addition of the 6 stations, the facility is expected to achieve and maintain the utilization standard, specified in 77 Ill. Adm. Code 1100, of 80% and;

2. Fresenius Medical Care - Neomedica North Kilpatrick hemodialysis patients have achieved and will maintain adequacy outcomes of:
   a. $\geq$ 85% of patients with a urea reduction ratio (URR) $\geq$ 65% and;
   b. $\geq$ 85% of patients with a Kt/V Daugirdas II. 1.2.

   For the past twelve months the following quality data was recorded for Fresenius Medical Care - Neomedica North Kilpatrick:

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

Signature

Regional Vice President
Title

Subscribed and sworn to before me
this 22nd day of November, 2010

Michelle M. Hogan
Signature of Notary

Seal

OFFICIAL SEAL
MICHELLE M HOGAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 6/1/2013

EXHIBIT 1

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

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

Address: 170 Wood Ave South
Iselin, NJ 08830

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

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

2. The Acquisition Cost of the Equipment is: $ 3,573,373.64

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.

Dialysis Machine Lease
ATTACHMENT - 39

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

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

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

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

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

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

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

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

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

Dialysis Machine Lease
ATTACHMENT - 39

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

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

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

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

10.STIPULATED LOSS VALUES:

Rental Payment #	Percentage of Acquisition Cost	Rental Payment #	Percentage of Acquisition Cost
1	101.47	37	60.22
2	100.61	38	59.94
3	99.55	39	57.66
4	98.66	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

Dialysis Machine Lease
ATTACHMENT - 39

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	68.99	66	20.72
31	67.76	67	19.27
32	66.52	68	17.82
33	65.27	69	16.35
34	64.01	70	14.88
35	62.75	71	13.40
36	61.49	72	11.92

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

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

Dated: 3/30/09

LESSOR:

Siemens Financial Services, Inc.

By: Carol Walters

Name: CAROL WALTERS

Title: VICE PRESIDENT-DOCUMENTATION

Ernest Errigo
Sr. Transaction Coordinator

LESSEE:

National Medical Care, Inc.

By:

Name: MARK FAWCETT

Title: TREASURER

015 Exhibit 12.doc

Dialysis Machine Lease
ATTACHMENT - 39

SIEMENS FINANCIAL SERVICES INC
FUNDING 03/30/2009

Exhibit A

94060209	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134900	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/10/2009	3/30/2009	3/30/2015
94060250	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134015	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
94060259	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134648	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/10/2009	3/30/2009	3/30/2015
94060254	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134033	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
94060259	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134010	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/11/2009	3/30/2009	3/30/2015
94060258	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134806	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
94060259	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K08134395	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/10/2009	3/30/2009	3/30/2015
94060250	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K07134603	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
94060259	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K07134518	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/16/2009	3/30/2009	3/30/2015
94060259	3/24/2009	769-0002105-015	4565	FMS EAST NASHVILLE	604 GALLATIN ROAD	NASHVILLE	TN	37206	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134440	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504744723	12/22/2008	3/10/2009	3/30/2009	3/30/2015
94060259 Total									$ 107,953.00					14						
94060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134424	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504364896	2/27/2009	3/18/2009	3/30/2009	3/30/2015
94060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134255	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504664865	2/27/2009	3/19/2009	3/30/2009	3/30/2015
94060261	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134316	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504364865	2/27/2009	3/18/2009	3/30/2009	3/30/2015
94060261 Total									$ 40,275.00					3						
94062260	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05135265	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504862807	3/12/2009	3/18/2009	3/30/2009	3/30/2015
94062260	3/24/2009	769-0002105-015	1131	FMS FREDERICKSBURG	230 EXECUTIVE CENTER PKWY	FREDERICKSBURG	VA	22401	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05135060	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504800637	3/12/2009	3/18/2009	3/30/2009	3/30/2015
94062260 Total									$ 26,850.00					2						
94060262	3/24/2009	769-0002105-015	6701	FMS GAINESVILLE	1775 NW 80TH BOULEVARD	GAINESVILLE	FL	32606	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05135204	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504781916	1/5/2009	3/19/2009	3/30/2009	3/30/2015
94060262 Total									$ 13,425.00					1						
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134145	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134475	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134467	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134513	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134011	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134322	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134497	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504854830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263	3/24/2009	769-0002105-015	4309	FMS GARFIELD	5401 SOUTH WENTWORTH AVENUE STE	CHICAGO	IL	60609	$ 13,425.00	$ 839.06	$ 14,264.06	$ 215.37	9K05134415	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504864830	2/27/2009	3/13/2009	3/30/2009	3/30/2015
94060263 Total									$ 107,400.00					8						
94035046	3/5/2009	769-0002105-015	4412	FMS HELENA	100 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134097	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504845366	2/17/2009	2/26/2009	3/30/2009	3/30/2015
94035046 Total									$ 13,425.00					1						
94035048	3/5/2009	769-0002105-015	4412	FMS HELENA	106 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$ 5,000.00	$ -	$ 5,000.00	$ 75.50	127234	1	PO MILLENIUM M-750 W/PROSS SYS	4504845366			3/30/2009	3/30/2015
94035048 Total									$ 5,000.00					1						
94035047	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$ 252.00	$ -	$ 252.00	$ 3.80		1	TANK, CARBON EXCHANGE 0.25 CUB	4504845686			3/30/2009	3/30/2015
94035047 Total									$ 252.00					1						
[illegible]	3/5/2009	769-0002105-015	4412	FMS HELENA	108 D'ANNA PLACE	HELENA-WEST HELENA	AR	72342	$ 252.00	$ -	$ 252.00	$ 3.80		1	TANK, CARBON EXCHANGE 0.25 CUB	4504845686			3/30/2009	3/30/2015
[illegible] Total									$ 252.00					1						
[illegible]	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05133920	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504841641	2/13/2009	3/8/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05133255	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504841641	2/13/2009	3/8/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05133810	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504841641	2/13/2009	3/8/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05133904	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504841641	2/13/2009	3/8/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	1435	FMS JACKSON	381 MEDICAL DRIVE	JACKSON	MS	39216	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05133840	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504841641	2/13/2009	3/8/2009	3/30/2009	3/30/2015
[illegible] Total									$ 67,125.00					5						
[illegible]	3/27/2009	769-0002105-015	4231	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134126	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504741875	12/19/2008	3/5/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	4231	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134231	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504741875	12/19/2008	3/5/2009	3/30/2009	3/30/2015
[illegible]	3/27/2009	769-0002105-015	4231	FMS MANY	100 DEVERA DRIVE	MANY	LA	71449	$ 13,425.00	$ -	$ 13,425.00	$ 202.70	9K05134245	1	2008K2 HEMODIALYSIS SYS. OLC/DI	4504741875	12/19/2008	3/5/2009	3/30/2009	3/30/2015

Dialysis Machine Lease
ATTACHMENT 39

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 #10-036, 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 (c) Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ESRD		111.11			900				100,000
Contingency		10.56			900				9,500
TOTALS		121.67			900				109,500
* Include the percentage (%) of space for circulation									

Criterion 1120.310 (d) – Projected Operating Costs

Year 2013

Salaries	$1,379,583
Benefits	344,896
Supplies	325,728
Total	$2,050,207

Annual Treatments 20,904

Cost Per Treatment $98.08

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

Year 2013

Depreciation/Amortization	$135,151
Interest	0
CAPITAL COSTS	$135,151
Treatments:	20,904
Capital Cost per treatment	$6.47

Criterion 1120.310(a) Reasonableness of Financing Arrangements

National Medical Care, Inc.

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

By: _____

Title: Marc Lieberman
Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____

Mark Fawcett
Title: Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this 01 day of Dec, 2010

C Wynelle Scenna
Signature of Notary

Seal

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

Criterion 1120.310(a) Reasonableness of Financing Arrangements

Fresenius Medical Care Holdings, Inc.

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____

Mark Fawcett
Vice President & Asst. Treasurer

ITS: _____

Notarization:
Subscribed and sworn to before me
this 01 day of Dec, 2010

_____
Signature of Notary

Seal

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

Criterion 1120.310(b) Conditions of Debt Financing

National Medical Care, Inc.

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

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

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

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

_____
Signature of Notary

Seal

By: _____
Mark Hawcett

ITS: Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this 01 day of Dec, 2010

C Wynelle Scenna
Signature of Notary

Seal

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

Criterion 1120.310(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 & Services Review Board Application for Certificate of Need; I do hereby attest to the fact that:

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

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

By: _____

ITS: Marc Lieberman
Asst. Treasurer

By: _____

Mark Fawcett
ITS: Vice President & 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 01 day of Dec, 2010

C Wynelle Scenna
Signature of Notary

Seal

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

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.

ASSOCIATES IN NEPHROLOGY, S.C.
NEPHROLOGY AND HYPERTENSION
210 South Des Plaines Street
Chicago, Illinois 60661
(312) 654-2720

PAUL W. CRAWFORD , M.D., F.A.S.N.
AZZA S. SULEIMAN, M.D.
SATYA P. AHUJA, M.D., F.A.S.N.
MARIA I. SOBRERO, M.D.
VINITHA RAGHAVAN, M.D.
DANIEL KNIAZ, M.D., F.A.C.P.
EDGAR V. LERMA, M.D., F.A.S.N.
RAMESH SOUNDARARAJAN, M.D., F.A.S.N.
NEETHA S. DHANANJAYA, M.D.
MARK P. LEISCHNER, M.D.
SREEDEVI CHITTINENI, M.D.
CHIRAG P. PATEL, M.D., F.A.S.N.
MADHAV RAO, M.D.
APRIL KENNEDY, M.D.
RIZWAN MOINUDDIN, D.O.
NIMEET R. BRAHMBHATT, M.D.

SUDESH K. VOHRA, M.D.
VIJAYKUMAR M. RAO, M.D., F.A.S.N.
CLARK MCCLURKIN, JR., M.D.
WADAH ATASSI, M.D., M.B.A.
HAROLD BREGMAN, M.D., F.A.C.P.
CONSTANTINE G. DELIS, D.O.
KAREEN R. SIMPSON, M.D., F.A.S.N.
AMITABHA MITRA, M.D.
JIM JIANLING YAO, M.D.
EDUARDO J. CREMER, M.D.
RICHARD HONG, M.D.
LO-KU CHIANG, M.D.
HARESH MUNI, M.D.
BOGDAN DERYLO, M.D., M.Sc.
NIC I. HRISTEA, M.D.
DONALD F. CRONIN, M.D.

December 2, 2010

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

Dear Mr. Galassie:

I am a nephrologist practicing with Associates in Nephrology (AIN) in northwest Chicago and am the Medical Director of the Fresenius Medical Care North Kilpatrick dialysis facility. Given the continued high utilization the facility is experiencing, I am in full support of the addition of 6 stations to allow for continued access to dialysis treatment.

I was treating 39 hemodialysis patients at the end of 2007, 36 at the end of 2008 and 56 at the end of 2009, as reported to The Renal Network. As of the most recent quarter, I was treating 58 hemodialysis patients. Over the past twelve months I have referred 20 patients for hemodialysis services to Fresenius North Kilpatrick and Uptown and to DaVita Lincoln Park. There are currently 118 ESRD patients dialyzing at the North Kilpatrick facility. There are 6 other nephrologists who also admit and see patients at the facility. I currently have 55 pre-ESRD patients that live in the zip codes surrounding the North Kilpatrick facility that I expect to begin dialysis at the facility in the two years after the installation of the 6 stations. These patients all have lab values indicative of a patient in active kidney failure (see attached patient list).

The Fresenius North Kilpatrick facility treats approximately 152 patients a year and has experienced a combined death/transplant rate of 9%. It is therefore expected that approximately 11 of the current patients of the facility are not expected to continue to require dialysis services by the time the 6 stations are operational.

I respectfully ask the Board to approve the addition of 6 stations to the North Kilpatrick facility in order to keep access available to this patient population. Thank you for your consideration.

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

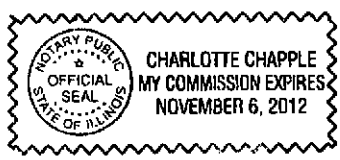
Sincerely,

Madhav Rao, M.D.

Notarization:
Subscribed and sworn to before me
this 21st day of January, 2010

Signature of Notary

Seal



CURRENT FRESENIUS MEDICAL CARE NORTH KILPATRICK PATIENTS

Zip Code	Fresenius North Kilpatrick Patients
60076	2
60610	2
60615	1
60618	13
60619	1
60622	3
60625	25
60626	2
60629	1
60630	25
60634	5
60639	8
60640	3
60641	10
60642	1
60645	2
60646	2
60647	1
60649	1
60651	1
60656	1
60659	5
60660	2
60706	1
Total	**118**

PRE-ESRD PATIENTS OF DR. RAO THAT WILL BEGIN DIALYSIS AT FRESENIUS MEDICAL CARE NORTH KILPATRICK

Zip Code	Pre-ESRD
60618	13
60625	13
60630	12
60639	7
60641	10
Total	**55**

NEW REFERRALS OF DR. RAO FOR THE PAST TWELVE MONTHS

ZIP CODE	DAVITA LINCOLN PARK	FRESENIUS NORTH KILPATRICK	FRESENIUS POLK	FRESENIUS UPTOWN	TOTAL
60131			1		1
60618		1			1
60625		3			3
60630		7			7
60634		1			1
60636				1	1
60641		1			1
60645		1			1
60647		1		1	2
60657	1				1
60706		1			1
TOTAL	1	16	1	2	20

HEMODIALYSIS PATIENTS OF DR. RAO FOR YEAR END 2007

Zip Code	Fresenius North Kilpatrick
60016	1
60062	1
60610	2
60615	1
60618	5
60622	1
60625	3
60629	2
60630	6
60634	1
60639	3
60640	2
60641	5
60647	1
60656	1
60659	1
60660	2
60676	1
Total	39

PATIENTS OF DR. RAO FOR YEAR END 2008

ZIP CODE	FRESENIUS NORTH KILPATRICK	NEPHRON DIALYSIS	TOTAL
60626		1	1
60611	1		1
60618	4		4
60622	2		2
60625	4	2	6
60630	5		5
60634	1		1
60639	6		6
60640	1		1
60641	3		3
60645	1		1
60647	1		1
60659	1	1	2
60660	1	1	2
TOTAL	31	5	36

PATIENTS OF DR. RAO FOR YEAR END 2009

ZIP CODE	FRESENIUS NORTH KILPATRICK	FRESENIUS POLK	FRESENIUS UPTOWN	TOTAL
60062	1			1
60076	1			1
60131		1		1
60610	2			2
60614			2	2
60615	1			1
60618	8			8
60625	8			8
60626	1			1
60629	1			1
60630	9			9
60634	1			1
60639	1			1
60640	1			1
60641	7			7
60645	2			2
60647	4			4
60649	1			1
60656	1			1
60659	2			2
60660	1			1
TOTAL	55	1	2	56

PATIENTS OF DR. RAO AS OF MOST RECENT QUARTER

ZIP CODE	FRESENIUS NORTH KILPATRICK	FRESENIUS UPTOWN	FRESENIUS POLK	TOTAL
60131			1	1
60039	1			1
60076	1			1
60610	2			2
60615	1			1
60618	5			5
60622	1			1
60625	8			8
60629	1			1
60630	12		1	13
60634	2			2
60639	3	1		4
60640	1			1
60641	6			6
60645	2			2
60647	1	1		2
60656	1			1
60659	3			3
60660	2			2
60706	1			1
TOTAL	54	2	2	58