

Original

11-057

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION JUL 14 2011

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: <i>Fresenius Medical Care North Avenue</i>			
Street Address: <i>911 North Avenue</i>			
City and Zip Code: <i>Melrose Park 60160</i>			
County: <i>Cook</i>	Health Service Area: <i>7</i>	Health Planning Area:	

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

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

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

Additional Contact

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

Name: <i>Coleen Muldoon</i>
Title: <i>Regional Vice President</i>
Company Name: <i>Fresenius Medical Care</i>
Address: <i>One Westbrook Corporate Center, Tower One, Suite 1000, Westchester, IL 60154</i>
Telephone Number: <i>708-498-9118</i>
E-mail Address: <i>coleen.muldoon@fmc-na.com</i>
Fax Number: <i>708-498-9283</i>

Post Permit Contact

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

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

Additional Contact

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: <i>Gottlieb Memorial Hospital</i>
Address of Site Owner: <i>701 W. North Avenue, Melrose Park, IL 60160</i>
Street Address or Legal Description of Site: <i>911 North Avenue, Melrose Park, IL 60160</i>
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: <i>WSKC Dialysis Services, Inc. d/b/a Fresenius Medical Care North Avenue</i>
Address: <i>920 Winter Street, Waltham, MA 02451</i>
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

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

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

Flood Plain Requirements

[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:

- Substantive
- Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- Part 1120 Not Applicable
- 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.

WSKC Dialysis Services, Inc. proposes to expand its Fresenius Medical Care North Avenue in-center hemodialysis facility by 2 stations. The facility added 7 stations in 2009 and 2 more stations in April of 2011 but is currently at 92% utilization.

The facility is located at 911 North Avenue, Melrose Park, IL in leased space on the campus of Gottlieb Memorial Hospital and consists of 22 stations. The result of the expansion will be a 24 station facility.

Fresenius Medical Care North Avenue is in HSA 7. There is a need for 8 stations in this HSA according to the June inventory update.

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	7,000	N/A	7,000
Contingencies	500	N/A	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)	10,000	N/A	10,000
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	26,850	N/A	26,850
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	44,350	N/A	44,350
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	17,500	N/A	17,500
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)	26,850	N/A	26,850
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	44,350	N/A	44,350
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

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

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>December 31, 2012</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals

Are the following submittals up to date as applicable:	
<input type="checkbox"/> Cancer Registry	
<input type="checkbox"/> APORS	
<input type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted	
<input checked="" type="checkbox"/> All reports regarding outstanding permits	
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.	

Cost Space Requirements

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

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

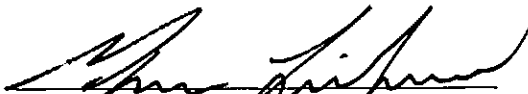
APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.


CERTIFICATION

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

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

This Application for Permit is filed on the behalf of WSKC Dialysis Services, 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

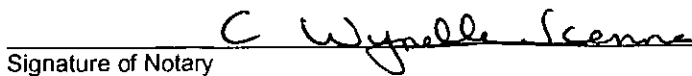

 SIGNATURE

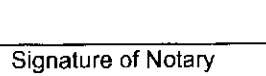
PRINTED NAME
Marc Weberman
 Asst Treasurer
 PRINTED TITLE

PRINTED NAME
Mark Fawcett
 Vice President & Treasurer
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this ____ day of _____ 2011

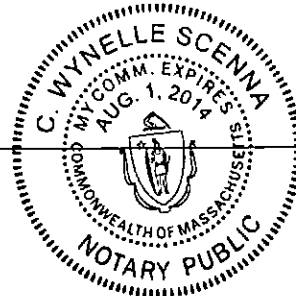
Notarization:
 Subscribed and sworn to before me
 this 13 day of June 2011


 Signature of Notary


 Signature of Notary

Seal

Seal



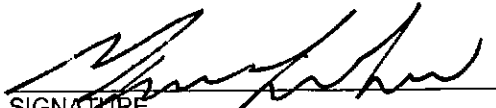
*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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


SIGNATURE

PRINTED NAME **Mark Lieberman**
Asst Treasurer

PRINTED TITLE


SIGNATURE

PRINTED NAME **Mark Fawcett**
Vice President & Asst. Treasurer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this ____ day of _____ 2011

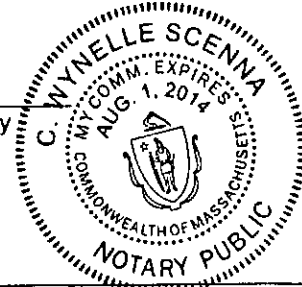
Notarization:
Subscribed and sworn to before me
this 13 day of June 2011

Signature of Notary C Wynelle Scenna

Signature of Notary C Wynelle Scenna

Seal

Seal



*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

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

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF 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
<input checked="" type="checkbox"/> In-Center Hemodialysis	22	24

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:**

<u>17,500</u>	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
<u>N/A</u>	<p>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.</p>
<u>N/A</u>	<p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p>
<u>26,850</u>	<p>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:</p> <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
<u>N/A</u>	<p>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;</p>
<u>N/A</u>	<p>f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;</p>
<u>N/A</u>	<p>g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.</p>
<u>44,350</u>	TOTAL FUNDS AVAILABLE

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio	APPLICANT MEETS THE FINANCIAL VIABILITY WAIVER CRITERIA IN THAT ALL OF THE PROJECTS CAPITAL EXPENDITURES ARE COMPLETELY FUNDED THROUGH INTERNAL SOURCES, THEREFORE NO RATIOS ARE PROVIDED.			
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance **NOT APPLICABLE**

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS: NOT APPLICABLE – PROJECT IS NON-SUBSTANTIVE AND IS NOT A DISCONTINUTAION HOWEVER ONE IS PROVIDED FOR THE BOARD'S INFORMATION

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

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

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

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

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

Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information **MUST** be furnished for ALL projects.

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

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

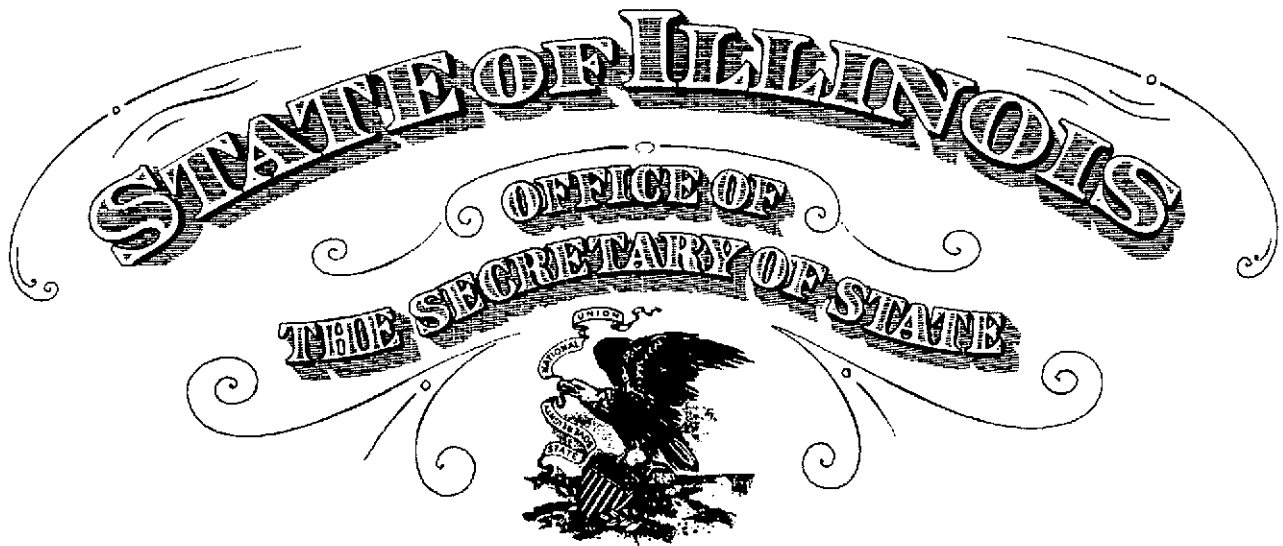
A table in the following format must be provided for all facilities as part of Attachment 44.

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

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

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

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Co-applicant Identification including Certificate of Good Standing	21-22
2	Site Ownership	23
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	24
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	25
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	26
8	Obligation Document if required	27
9	Cost Space Requirements	28
10	Discontinuation	
11	Background of the Applicant	29-32
12	Purpose of the Project	33
13	Alternatives to the Project	34-36
14	Size of the Project	37
15	Project Service Utilization	38
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	39-49
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	50-54
40	Financial Waiver	55-56
41	Financial Viability	
42	Economic Feasibility	57-61
43	Safety Net Impact Statement	62-66
44	Charity Care Information	67
Appendix 1	Physician Referral Letter	68-72



To all to whom these Presents Shall Come, Greeting:

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

WSKC DIALYSIS SERVICES, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 31, 1969, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1117301798

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

In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 22ND
day of JUNE A.D. 2011 .

Jesse White

SECRETARY OF STATE

Co - Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Site Ownership

Exact Legal Name of Site Owner: <i>Gottlieb Memorial Hospital</i>
Address of Site Owner: <i>701 W. North Avenue, Melrose Park, IL 60160</i>
Street Address or Legal Description of Site: <i>911 North Avenue, Melrose Park, IL 60160</i> Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

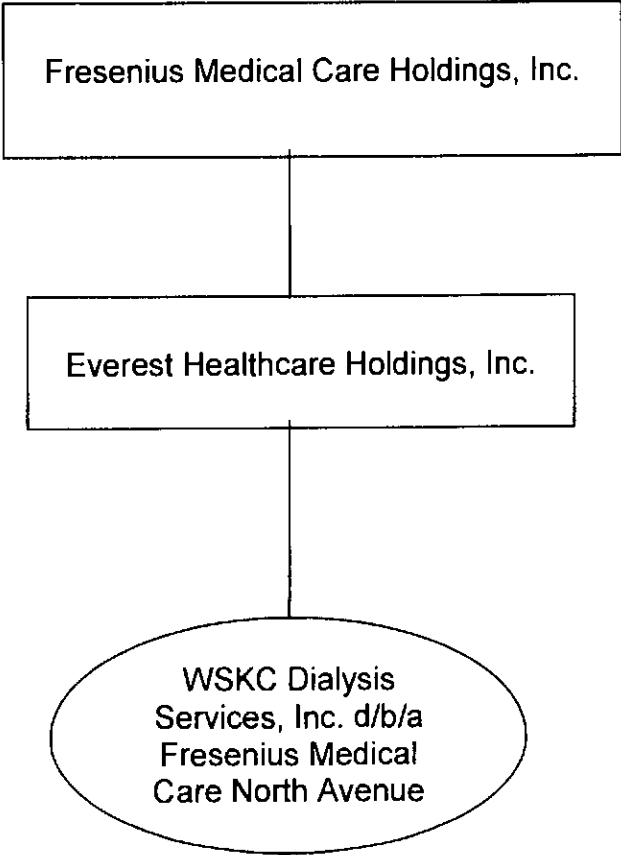
Exact Legal Name: *WSKC Dialysis Services, Inc. d/b/a North Avenue Dialysis Center*

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

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which 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.



Itemization of Project Costs and Sources of Funds

Modernization Contracts

Plumb Station Boxes	\$7,000
---------------------	---------

Contingencies	\$500
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Movable & Other Equipment

Dialysis Chairs (2)	\$6,000
Television (2)	\$4,000

FMV Leased Equipment

Dialysis Machines (2)	\$26,850
-----------------------	----------

Project obligation will occur after permit issuance.

Cost Space Requirements

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
In-Center Hemodialysis	44,350	10,000			300		
Total Clinical	44,350	10,000			300		
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL	44,350	10,000			300		
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Fresenius Medical Care Holdings, Inc. In-center 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	Bolingbrook	60440
Bridgeport	14-2524	825 W. 35th Street	Chicago	60609
Burbank	14-2641	4811 W. 77th Street	Burbank	60459
Carbondale	14-2514	725 South Lewis Lane	Carbondale	62901
Champaign (managed)	14-2588	1405 W. Park Street	Champaign	61801
Chatham		333 W. 87th Street	Chicago	60620
Chicago Dialysis	14-2506	820 West Jackson Blvd.	Chicago	60607
Chicago Westside	14-2681	1340 S. Damen	Chicago	60608
Congress Parkway	14-2631	3410 W. Van Buren Street	Chicago	60624
Crestwood	14-2538	4861-73 W. Cal Sag Road	Crestwood	60445
Decatur East	14-2503	1830 S. 44th St.	Decatur	62521
Deerfield	14-2710	405 Lake Cook Road	Deerfield	60015
Des Plaines		1625 Oakton Place	Des Plaines	60018
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
Joliet		721 E. Jackson Street	Joliet	60432
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

Facility List

ATTACHMENT - 11

Oswego	14-2677	1051 Station Drive	Oswego	60543
Ottawa	14-2576	1601 Mercury Court	Ottawa	61350
Palatine		Dundee Road	Palatine	60074
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		14404 W. Willow	Chicago	60620
Westchester	14-2520	2400 Wolf Road, STE 101A	Westchester	60154
Williamson County	14-2627	900 Skyline Drive, Ste. 200	Marion	62959
Willowbrook	14-2632	6300 S. Kingery Hwy, STE 408	Willowbrook	60527

Certification & Authorization

WSKC Dialysis Services, 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 WSKC Dialysis Services, 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: *Marc Lieberman*

ITS: Marc Lieberman
Asst Treasurer

By: *Mark Fawcett*

ITS: Mark Fawcett
Vice President & Treasurer

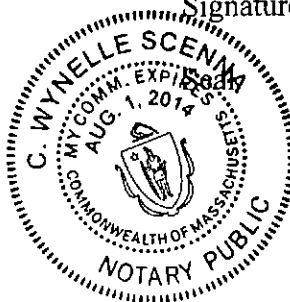
Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011

Signature of Notary *C Wynelle Scenna*

Signature of Notary

Seal

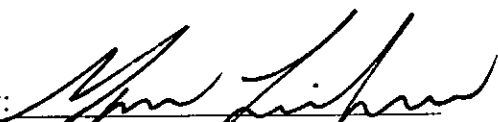


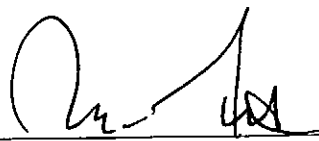
Certification & Authorization

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.

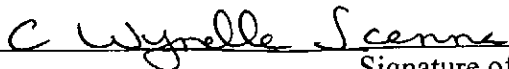
By: 
ITS: Marc Lieberman
Asst Treasurer

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

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011

Signature of Notary


Signature of Notary

Seal



Criterion 1110.230 – Purpose of Project

1. The purpose of this project is to keep dialysis services accessible to a growing ESRD population in the Melrose Park area of suburban Cook County, (HSA 7) and to alleviate the near capacity utilization at the Fresenius North Avenue ESRD facility.
2. The market area that Fresenius Medical Care North Avenue serves is mostly Melrose Park along with the surrounding towns of Northlake, Franklin Park, Bellwood, Maywood, River Grove and Elmwood Park.
3. This expansion of this facility will allow it to accommodate the pre-ESRD patients that Dr. Finn has identified from this area who will require dialysis services in the next 2 years after the stations are operational.
4. Utilization of area facilities is obtained from the Renal Network for the 1st Quarter 2011. Pre-ESRD patients for the North Avenue facility were obtained from Nephrology Associates of Northern Illinois.
5. The goal of Fresenius Medical Care is to keep dialysis access available to this patient population while we continue to monitor the growth of this clinic. The facility added 7 stations in 2009 and 2 in April of this year. Despite these additions the facility is operating at 92%, just 11 patients away from 100% capacity. 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.
 - o 86% of patients had a URR \geq 65%
 - o 91% 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 Avenue facility added 7 stations in 2009 and another 2 in 2011 and still the facility is continually operating above target utilization and is currently near capacity at 92%. Obviously access to a greater number of dialysis stations is needed in the Melrose Park market 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 Melrose Park area pre-ESRD patients to other facilities in the area is already being accomplished. Dr. Finn also refers patients to Fresenius Oak Park and Norridge. There is no monetary cost associated with this alternative.

D. The most desirable alternative is to address the need for more stations in a timely and cost effective manner. This alternative will maintain access to dialysis services by addressing current high utilization at an existing facility and planning for known future ESRD patients in the market area by adding 2 stations. The cost of this project is \$44,350.

2) Comparison of Alternatives

	Total Cost	Patient Access	Quality	Financial
Maintain Status Quo	\$0	There would be no access to dialysis services in Melrose Park. The North Avenue facility is only 11 patients away from capacity.	Patients would have to travel outside their market for services. Loss of continuity of care would result. 4 th shift would have to be operated causing transportation problems and missed treatments.	For patient - higher transportation costs due to 4 th shift, where there is no available county transportation.
Pursue Joint Venture The facility is not a joint venture and has no plans to become one just to add two stations.	\$0	Patient access would remain the same.	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 county/township transportation services do not operate after 4pm. Would create ripple effect of raising utilization of area providers to or above capacity	Loss of continuity of care which would lead to lower patient outcomes Unavailability to choose treatment schedule shift could cause transportation problems which leads to missed treatments and lower quality	No financial cost to Fresenius Medical Care Cost of patient's transportation would increase with higher travel times
Add 2 stations to Fresenius Medical Care North Avenue	\$44,350	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 North Avenue has had the following quality outcomes:

Fresenius Medical Care North Avenue
86% of patients had a URR \geq 65%
91% 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	10,000	360-520 DGSF	NONE	YES

As seen in the chart above, the State Standard for ESRD is between 360-520 DGSF per station. The two station addition will bring the total station count to 24. This amounts to 417 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	92%		80%	Yes
YEAR 1	IN-CENTER HEMODIALYSIS		92%	80%	Yes
YEAR 2	IN-CENTER HEMODIALYSIS		106%*	80%	Yes

This facility is experiencing a 92% (121 patients) utilization rate with 22 stations. Bringing the facility to 24 stations and accounting for patient attrition the facility will be at 92% after the first year when the new stations will be operational and 106% after the second year of operation.

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 HSA 7 specifically, the Melrose Park area. 81% of the pre-ESRD patients reside in HSA 7.

County	HSA	# Pre-ESRD Patients Who Will Be Referred to Fresenius Medical Care North Avenue
Suburban Cook	7	85 – 81%
Chicago/Cook	6	20 - 19%



July 8, 2011

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I am the Medical Director of Fresenius Medical Care North Avenue Dialysis Center. This facility had been operating above capacity for several years requiring the 7 station expansion certified in January 2009. By the end of that year the utilization was still high at 88%. Two additional stations were added and as of March 2011 the utilization is even higher at 92%. I am therefore writing to support of the addition of 2 more stations with the end result being a 24 station facility.

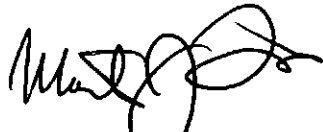
The Fresenius North Avenue facility has experienced average 10% yearly combined mortality and transplant rate. It is therefore expected that approximately 10% of the current patients will no longer require dialysis services by the time the additional stations are in operation.

I was treating 130 hemodialysis patients at the end of 2008, 144 hemodialysis patients at the end of 2009, 133 hemodialysis patients at the end of 2010, and 147 patients at the end of the 2nd quarter 2011, as reported to The Renal Network. Over the past twelve months, I have referred 36 new hemodialysis patients to the Fresenius North Avenue and Oak Park. There are currently 122 ESRD patients at Fresenius Medical Care North Avenue and I have 105 pre-ESRD patients in stage 3 & 4 of kidney failure that I expect will be referred to the North Avenue facility in the first 24 months after project completion.

I respectfully ask the Board to approve the 2 station addition to Fresenius Medical Care North Avenue to alleviate the high utilization. Thank you for your consideration.

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

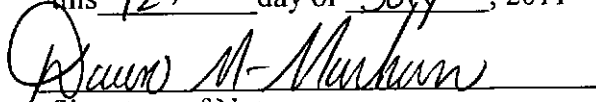
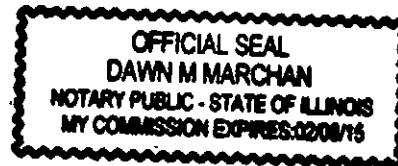
Sincerely,



Martin Finn, M.D.

Notarization:

Subscribed and sworn to before me
this 12th day of July, 2011


Signature of Notary

Seal

**ESRD PATIENTS OF DR. FINN FOR YEAR END 2008, 09, 10
& 2ND QUARTER 2011**

Zip Code	Fresenius Norridge				Fresenius North Avenue				Fresenius Oak Park			
	2008	2009	2010	Jun-11	2008	2009	2010	Jun-11	2008	2009	2010	Jun-11
60018								1				
60101					3	3	3	2				
60104					6	5	5	8	3	3	4	3
60130					1	1			2	4	2	2
60131		1			10	12	12	12				
60133							1					
60138											1	1
60153					6	7	11	12	2	1		
60155					2	1	2	2	1	1	1	
60157						1	1					
60160					8	6	8	9				
60162					2	4	3	3				
60163					1	1	2	2				
60164					8	9	9	11				
60165					3	2	1	1				
60171					2	2	2	2				
60176	1		1	1		2	1	1				
60181						1						
60187						1			1	1		
60188												
60189					1							
60194						1	1	1				
60301										1		
60302			1	1		1			7	8	5	7
60304					1				1		1	1
60305					2	1	2	2				1
60402					1	1			2	2	1	2
60453									1	1		
60455						1	1	1				
60516								1				
60534						1						
60543								1				
60544									1	1	1	1
60546					1	2			1			
60564										1		
60607						2	3	4			1	1
60609									2	1	1	1
60612									2	2	2	2
60613											1	1
60616						1	1	1				
60618	1	1							1			
60620					1	1	1	1				
60623									2	1		
60624									1			
60628					1							
60629							1	1				
60634					1	2	1	2				
60639					2	4	5	5				1
60644					2	1	2	2	9	7	4	4
60647		1		1								
60649					1	1	1	1				
60651					4	6	4	3	2			
60656	1	1										
60701						1	1	1				
60706	1		1	1	1	1	1	1				
60707	1				8	13	14	14				1
60714					1	1	1	1				
60804							1	1	4	5	3	4
Total	5	4	3	4	80	100	102	110	45	40	28	33

Yearly Totals	2008	2009	2010	Jun-11
	130	144	133	147

ADMISSIONS OF DR. FINN FOR THE PREVIOUS TWELVE MONTHS –
07/01/10 THROUGH 06/30/2011

Zip Code	Fresenius North Avenue	Fresenius Oak Park	Total
60104	2		2
60131	3		3
60136	1		1
60153	4		4
60155	1		1
60160	3		3
60162		1	1
60163	1		1
60164	2		2
60189	1		1
60302		2	2
60304		1	1
60305		1	1
60513	1		1
60516	1		1
60548	1		1
60612		1	1
60629	1		1
60634	2		2
60639	1		1
60680		1	1
60707	3		3
60804		1	1
Total	28	8	36

PRE - ESRD PATIENTS DR. FINN EXPECTS TO REFER TO FRESENIUS
MEDICAL CARE NORTH AVENUE IN THE FIRST 24 MONTHS AFTER
PROJECT COMPLETION

Zip Code	Stage 3	Stage 4	Total
60101		1	1
60104	7	3	10
60126		1	1
60131	3	6	9
60153	6	5	11
60155	1		1
60160	3	9	12
60162	2	1	3
60164	4	3	7
60165		1	1
60171	1	1	2
60176	2	3	5
60305	1		1
60634	4	2	6
60639	5	1	6
60651	5	3	8
60706		1	1
60707	10	10	20
Total	54	51	105

Planning Area Need – Service Demand – Physician Referral Letter

ATTACHMENT 26B - 4

CURRENT FRESENIUS NORTH AVENUE ESRD PATIENTS

Zip Code	ESRD
60018	1
60101	2
60104	9
60131	15
60153	13
60155	2
60160	10
60162	3
60163	3
60164	11
60165	1
60171	3
60176	1
60189	1
60194	1
60305	2
60455	1
60516	1
60543	1
60607	4
60609	1
60616	1
60620	1
60623	1
60629	1
60634	2
60639	5
60644	2
60649	1
60651	4
60701	1
60706	1
60707	14
60714	1
60804	1
Total	122

Criterion 1110.1430 (e)(1) – Staffing

2) A. Medical Director

Dr. Finn is currently the Medical Director for Fresenius Medical Care North Avenue Dialysis Center and will continue to be the Medical Director. Attached is his curriculum vitae.

B. All Other Personnel

The North Avenue facility currently employs the following staff:

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

One additional Registered Nurse will be hired for the 2 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.

CURRICULUM VITAE
MARTIN J. FINN, M.D.

PERSONAL:
Birthdate:
Birthplace:
Marital Status:

August 16, 1956
Chicago, Illinois
Married to Kathleen
Four Children

HOME ADDRESS:
Gottlieb Professional Building
675 West North Avenue Suite 510
Melrose Park, IL 60160
(708) 450-4551

West Suburban Kidney Ctr
101 N Scoville
Oak Park, IL 60302
(708) 386-1000

UNDERGRADUATE EDUCATION:
Loyola University of New Orleans
August 1974 to May 1978
Degree: Bachelor of Science - cum laude

GRADUATE EDUCATION:
Loyola University of Chicago-Stritch School of Medicine
July 1978 to June 1982
Degree: Doctor of Medicine

POSTGRADUATE MEDICAL TRAINING:
Loyola University of Chicago-Foster G. McGaw Hospital
June 1982 to June 1985
Internal Medicine

RESIDENCY TRAINING:
Northwestern University Medical Center-Chicago
July 1985 to June 1987
Nephrology

BOARD CERTIFICATION:
Board Certified in Internal Medicine September 11, 1985
Board Certified in Internal Medicine/Nephrology
November 1, 1988

RESEARCH ACTIVITIES:
Under direction of Antonio Quintanilla, M.D.
Presentation at May 1986 APCR/ASCI/AAP meeting on
"Effects of Hydrochlorothiazide on Red Cell Na-K
ATPase Activity"

OCT 21 2004

DR. J. FINN, M.D.
CURRICULUM VITAE - PAGE 2

LICENSES:
State of Illinois No. 036-068656 - Physician & Surgeon

PROFESSIONAL MEMBERSHIPS:
Associate of American College of Physicians
Illinois State Medical Society
American Medical Association
Chicago Medical Society
Renal Physicians Association
National Kidney Foundation of Illinois

HOSPITAL AFFILIATIONS:
Gottlieb Memorial Hospital (Associate Attending)
LaGrange Memorial Hospital (Associate Attending)
Oak Park Hospital (Associate Attending)
Westlake Community Hospital (Associate Attending)
West Suburban Hospital Medical Center (Associate Attending)

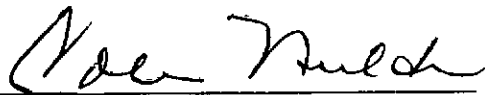
EMPLOYMENT:
Nephrology Associates of Northern Illinois
July 1, 1987 to present

OCT 21 2004

Criterion 1110.1430 (f) – Support Services

I am the Regional Vice President of the Chicago Central 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:

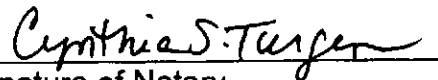
- Fresenius Medical Care North Avenue Dialysis Center utilizes the Proton patient data tracking system.
- These support services are available at Fresenius Medical Care North Avenue Dialysis Center during all six shifts:
 - Nutritional Counseling
 - Psychiatric/Social Services
 - Home/self training
 - Clinical Laboratory Services – provided by Spectra Laboratories
- The following services are provided via referral to Gottlieb Memorial Hospital, Melrose Park:
 - Blood Bank Services
 - Rehabilitation Services
 - Psychiatric Services



Signature

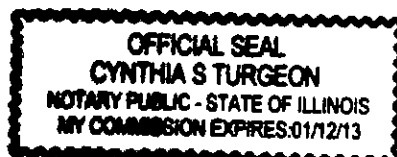
Coleen Muldoon/Regional Vice President
Name/Title

Subscribed and sworn to before me
this 6th day of JUNE, 2011



Signature of Notary

Seal



Support Services
ATTACHMENT – 26f

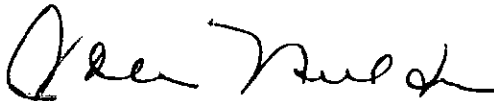
Criterion 1110.1430 (j) – Assurances

I am the Regional Vice President of the Chicago Central Region of the North Division of Fresenius Medical Care North America. In accordance with 77 Ill. Admin Code 1110.1430, and with regards to Fresenius Medical Care North Avenue Dialysis Center, I certify the following:

1. As supported in this application through expected referrals to Fresenius Medical Care North Avenue Dialysis Center in the first two years after addition of the 2 stations, the facility will achieve and maintain the utilization standard, specified in 77 Ill. Adm. Code 1100, of 80% and;
2. Fresenius Medical Care North Avenue Dialysis Center 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 North Avenue Dialysis Center:

- o 86% of patients had a URR $\geq 65\%$
- o 91% of patients had a Kt/V ≥ 1.2

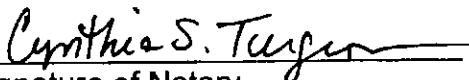


Signature

Regional Vice President

Title

Subscribed and sworn to before me
this 6th day of JUNE, 2011



Signature of Notary

Seal



EXHIBIT 1

LEASE SCHEDULE NO. 769-0002105-016
(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: 320 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: \$ 3,679,373.64.

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

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

5. RENT: (a) Payable in monthly installments on the 28th 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	\$53,854.37

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

6. OTHER PAYMENTS:

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

015 Exhibit 12.doc

7. **EARLY TERMINATION OPTION:** So long as no Event of Default under the Lease, nor any event which upon notice or lapse of time or both would constitute such an Event of Default has occurred and is continuing, Lessee shall have the option to terminate the Lease for all, but not less than all, of the Equipment on the rental payment date for the twenty-fourth (24th) monthly rental payment (the "Early Termination Date"). Lessee shall notify Lessor in writing of Lessee's intention to exercise such termination option at least ninety (90) days prior to the Early Termination Date of such Lease. Lessee shall pay to Lessor on the Early Termination Date an aggregate amount (the "Termination Amount") equal to: (i) all rental payments, late charges and other amounts due and owing under the Lease, including the rental payment due on the Early Termination Date; plus (ii) any and all taxes, assessments and other charges due in connection with the termination of the Lease; plus (iii) 64% of the original Acquisition Cost of the Equipment as set forth herein.

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

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

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

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

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

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

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

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

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

10. STIPULATED LOSS VALUES:

Rental Payment #	Percentage of Acquisition Cost	Rental Payment #	Percentage of Acquisition Cost
1	101.47	37	60.22
2	100.61	38	58.94
3	99.66	39	57.66
4	98.66	40	56.37
5	97.55	41	55.08
6	96.63	42	53.78
7	95.48	43	52.47
8	94.41	44	51.16
9	93.33	45	49.84
10	92.25	46	48.51
11	91.15	47	47.18
12	90.05	48	45.84
13	88.95	49	44.50
14	87.83	50	43.15
15	86.71	51	41.79
16	85.58	52	40.43
17	84.44	53	39.06
18	83.29	54	37.69
19	82.14	55	36.31

015 Exhibit 12.600

Rental Payment #	Percentage of Acquisition Cost	Rental Payment #	Percentage of Acquisition Cost
20	80.97	66	34.92
21	79.81	67	33.53
22	78.63	68	32.13
23	77.45	69	30.72
24	76.26	70	29.31
25	75.06	71	27.89
26	73.86	72	26.47
27	72.65	73	25.04
28	71.44	74	23.61
29	70.22	75	22.17
30	68.99	76	20.72
31	67.76	77	19.27
32	66.52	78	17.82
33	65.27	79	16.35
34	64.01	80	14.88
35	62.75	81	13.40
36	61.49	82	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

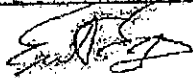
LESSOR:

Siemens Financial Services, Inc.

By: Carol Walters

Name: CAROL WALTERS
VICE PRESIDENT-DOCUMENTATION

Title: _____



Brent Enrigo
Rt. Transaction Coordinator

LESSEE:

National Medical Care, Inc.

By: Mark Fawcett

Name: MARK FAWCETT

Title: TREASURER

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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.

2010 Financial Statements for Fresenius Medical Care Holdings, Inc. were submitted previously to the Board with #11-022, Fresenius Medical Care Lockport 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 Mod.		Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD		23.33			300			7,000	7,000
Contingency		1.67			300			500	500
TOTALS		25.00			300			7,500	7,500
* Include the percentage (%) of space for circulation									

Criterion 1120.310 (d) – Projected Operating Costs

Year 2013

Salaries	\$838,986
Benefits	209,747
Supplies	<u>202,894</u>
Total	\$1,251,627

Annual Treatments 17,971

Cost Per Treatment \$69.65

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

Year 2013

Depreciation/Amortization	\$186,573
Interest	<u>0</u>
CAPITAL COSTS	\$186,573

Treatments: 17,971

Capital Cost per treatment \$10.38

Criterion 1120.310(a) Reasonableness of Financing Arrangements

WSKC Dialysis Services, 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: *Marc Lieberman*
Title: Marc Lieberman
Asst Treasurer

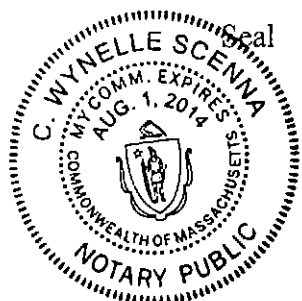
By: *Mark Fawcett*
Title: Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011

Signature of Notary *C. Wynelle Scenna* Signature of Notary

Seal



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: *Marc Lieberman*
ITS: Marc Lieberman
Asst Treasurer

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

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011

C Wynelle Scenna
Signature of Notary

Signature of Notary

Seal



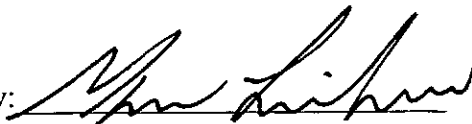
Criterion 1120.310(b) Conditions of Debt Financing

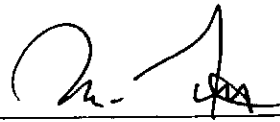
WSKC Dialysis Services, Inc.

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

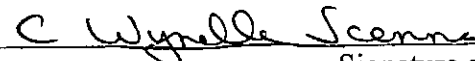
The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

By: 
ITS: Marc Lieberman
Asst Treasurer

By: 
ITS: Mark Fawcett
Vice President & Treasurer

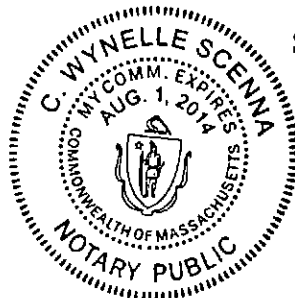
Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011


Signature of Notary

Signature of Notary

Seal



Seal

Criterion 1120.310(b) Conditions of Debt Financing

Fresenius Medical Care Holdings, Inc.

In accordance with 77 ILL. ADM Code 1120, Subpart D, Section 1120.310, of the Illinois Health Facilities & 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: [Signature]
ITS: Marc Lieberman
Asst Treasurer

By: [Signature]
ITS: Mark Fawcett
Vice President & Asst. Treasurer

Notarization:
Subscribed and sworn to before me
this _____ day of _____, 2011

Notarization:
Subscribed and sworn to before me
this 13 day of June, 2011

Signature of Notary C Wynelle Scenna

Signature of Notary

Seal



Seal

Safety Net Impact Statement

The expansion of the Fresenius Medical Care North Avenue dialysis facility will not have any impact on safety net services in the Melrose Park community. Outpatient dialysis services are not typically considered "safety net" services, to the best of our knowledge. However, we do provide care for patients in the community who are economically challenged and/or who are undocumented aliens, who do not qualify for Medicare/Medicaid. We assist patients who do not have insurance in enrolling when possible in Medicaid and/or Medicaid as applicable, and also our social services department assists patients who have issues regarding transportation and/or who are wheel chair bound or have other disabilities which require assistance with respect to dialysis services and transport to and from the unit.

This particular application will not have an impact on any other safety net provider in the area, as no hospital within the area provides dialysis services on an outpatient basis.

Fresenius Medical Care is a for-profit publicly traded company and is not required to provide charity care, nor does it do so according to the Board's definition. However, Fresenius provides care to all patients regardless of their ability to pay. There are a number of patients treated by Fresenius who either do not qualify for or will not seek any type of coverage for dialysis services. These patients are considered "self-pay" patients. These patients are invoiced as all patients are invoiced, however payment is not expected and Fresenius does not initiate any collections activity on these accounts. These unpaid invoices are written off as bad debt. Fresenius notes that as a for profit entity, it does pay sales, real estate and income taxes. It also does provide community benefit by supporting various medical education activities and associations, such as the Renal Network and National Kidney Foundation.

The table below shows the amount of "self-pay" care provided for the 3 fiscal years prior to submission of the application for all Fresenius Medical Care facilities in Illinois and the amount of care provided to Medicaid patients for the three fiscal years prior to submission of the application for all Fresenius Medical Care facilities in Illinois. This includes in-center hemodialysis, peritoneal dialysis, home hemodialysis & sub-acute hemodialysis. (data by facility on next page)

SAFETY NET INFORMATION			
CHARITY CARE			
	2008	2009	2010
Charity (# of self-pay patients)	305	260	146
Charity (self-pay) Cost	3,524,880	362,751	1,307,966
MEDICAID			
	2008	2009	2010
Medicaid (Patients)	1,626	1,783	1,828
Medicaid (Revenue)	37,043,006	40,401,403	44,001,539

There is no other information directly relevant to safety net services.

CHARITY CARE BY FACILITY

CHARITY CARE						
Facility	2008		2009		2010	
	Charity Patients	Charity Cost	Charity Patients	Charity Cost	Charity Patients	Charity Cost
CARBONDALE	2	2,500	2	20,723	0	11,262
NORTHCENTER	1	30,407	2	34,727	3	22,117
BRIDGEPORT	6	99,428	11	118,493	2	10,991
POLK	3	51,467	4	60,738	1	26,376
EVERGREEN PARK	4	23,541	10	140,975	4	52,782
GURNEE	3	67,702	0	29,403	2	8,329
HOFFMAN ESTATES	2	19,789	2	7,418	2	4,037
MELROSE PARK	0	0	1	5,156	0	0
MARQUETTE PARK	3	39,118	3	100,681	0	0
NORRIDGE	0	3,002	2	1,506	1	747
NORTH KILPATRICK	1	11,290	0	0	0	14,200
ROLLING MEADOWS	1	55,625	0	0	5	53,516
SOUTH CHICAGO	3	115,038	8	205,498	4	70,577
SOUTH HOLLAND	4	22,191	4	31,917	1	26,731
SOUTH SHORE	2	20,591	1	30,066	0	2,086
SOUTHWESTERN ILLINOIS	1	242	0	0	0	0
SALINE COUNTY	1	3,645	2	5,583	1	2,952
RANDOLPH COUNTY	0	0	2	1,219	3	8,913
WEST BELMONT	2	26,984	0	51,980	2	18,896
SUB ACUTES-CHICAGO	12	80,452	3	37,748	0	0
DU QUOIN	0	0	1	10,433	0	2,756
WILLIAMSON COUNTY	1	1,812	0	0	1	7,468
HAZEL CREST	3	53,440	1	9,226	1	6,303
ROUNDLAKE	4	57,640	2	44,165	1	255
AURORA	6	67,864	0	18,818	4	21,087
BOLINGBROOK	4	31,451	0	12,317	3	5,081
BLUE ISLAND	2	21,901	4	49,341	3	22,611
DUPAGE WEST	3	43,409	3	18,336	2	9,290
CHICAGO DIALYSIS CENTER	9	66,732	6	89,972	1	14,202
DOWNERS GROVE	3	31,380	1	4,878	2	56,124
ELK GROVE	9	75,105	2	29,711	4	12,642
ELK GROVE HOME	0	0	1	18,394	1	289
GLENVIEW DIALYSIS	4	18,692	1	19,974	1	10,095
GREENWOOD	9	46,374	5	62,205	4	42,481
JACKSON PARK	11	115,160	7	125,578	2	681
WESTCHESTER	3	56,641	0	0	0	0
NAPERVILLE	5	41,182	4	67,077	3	22,565
NORTH AVENUE	0	0	0	23,669	3	18,189
OAK PARK	5	40,346	2	32,752	2	1,487
SOUTHSIDE	9	209,871	8	129,554	3	34,459
WEST METRO	2	54,133	11	187,505	3	49,677
WEST SUBURBAN	4	34,283	5	65,129	3	34,504
ALSIP	2	9,960	0	0	0	0
AUSTIN	3	8,284	3	40,504	0	0
CONGRESS PARKWAY	2	63,900	2	46,511	1	3,760
GLENDALE HEIGHTS	4	81,125	5	35,089	3	3,681
WILLOWBROOK	3	23,477	0	10,815	0	0
BURBANK	3	63,286	5	185,201	2	12,597
OSWEGO	1	25,307	1	3,389	1	305
ANTIOCH	2	21,689	2	28,682	0	0
MCHENRY	3	26,941	4	57,292	1	1,332
LAKE BLUFF	5	54,948	3	17,317	1	1,112
NILES	3	55,817	3	37,442	0	0
CHICAGO WESTSIDE	4	77,512	3	46,548	0	0

NAPERVILLE NORTH	2	18,437	1	48,627	0	0
LAKEVIEW	2	61,074	1	7,377	1	3,217
CHICAGO SUB ACUTE SOUTH	6	15,336	4	53,195	0	0
SOUTH SUBURBAN	10	92,140	15	148,380	8	64,049
ROGERS PARK	2	44,464	3	85,647	3	60,351
BERWYN	19	199,885	13	163,817	5	52,363
CRESTWOOD	9	59,373	3	17,034	4	84,179
ORLAND PARK	4	43,222	1	30,148	0	0
GARFIELD	5	97,761	3	45,903	2	14,915
EAST PEORIA	6	55,285	1	12,238	0	0
MC LEAN COUNTY	2	31,715	2	17,291	2	4,152
SPRING VALLEY	1	236	0	233	1	6,422
SPOON RIVER	3	14,971	1	9,033	1	8,835
PRAIRIE	5	25,383	3	32,357	3	15,634
PEKIN	0	0	0	0	2	4,721
PEORIA DOWNTOWN	2	13,799	1	10,980	2	11,301
OTTAWA	4	32,866	1	2,357	1	454
KEWANEE	0	0	0	0	1	20,619
MORRIS	0	0	1	11,267	0	29,076
NORTHWESTERN UNIVERSITY	12	89,528	9	58,416	3	21,695
DECATUR	0	0	0	0	0	0
DECATUR EAST HOME	1	282	5	18,622	0	0
PONTIAC	3	9,732	3	4,801	0	0
VILLA PARK	2	35,003	3	95,048	2	7,258
PEORIA NORTH	4	27,782	3	13,179	0	3,245
ROCKFORD	0	18,003	2	24,267	2	6,946
SKOKIE	0	0	1	4,508	1	2,698
EVANSTON	4	58,821	5	49,319	3	63,059
MC LEAN COUNTY HOME	1	2,144	1	3,971	2	6,544
FMS OTTAWA HOME	1	4,256	1	9,605	0	0
MERRIONETTE PARK HOME	0	1,792	0	0	0	0
MERRIONETTE PARK	0	0	2	28,882	1	9,936
UPTOWN CHICAGO	2	35,291	3	44,148	1	33,311
MIDWAY	0	0	0	0	0	0
WEST CHICAGO IL	0	0	3	24,152	0	0
MOKENA	1	544	1	16,250	1	1,012
ROSELAND	5	108,043	3	61,632	1	31,345
STREATOR	0	0	0	0	0	0
ROSS DIALYSIS - ENGLEWOOD	3	55,077	7	56,239	1	2,132
DUPAGE PD	2	19,961	2	14,011	1	0
HOME DIALYSIS NETWORK	0	0	0	0	0	0
MACOMB	0	0	0	0	0	0
DEERFIELD	0	0	0	0	0	0
SANDWICH JV	0	0	0	8,161	1	985
PLAINFIELD	0	0	0	0	1	494
JOLIET HOME	0	0	0	0	0	1,382
TOTAL	305	3,524,880	260	3,642,751	146	1,307,966

MEDICAID BY FACILITY

MEDICAID						
Facility	2008		2009		2010	
	Medicaid Patients	Medicaid Revenue	Medicaid Patients	Medicaid Revenue	Medicaid Patients	Medicaid Revenue
CARBONDALE	12	283,148	16	415,952	16	522,725
NORTHCENTER	15	405,569	20	558,533	24	594,242
BRIDGEPORT	40	1,180,753	54	1,248,522	56	1,497,867
POLK	32	925,431	23	834,213	30	931,482
EVERGREEN PARK	33	1,375,747	25	809,312	35	900,105
GURNEE	18	478,528	21	500,856	24	539,340
HOFFMAN ESTATES	15	336,993	18	409,503	27	625,205
MELROSE PARK	12	310,393	12	311,744	16	404,480
MARQUETTE PARK	21	648,670	22	588,349	27	693,007
NORRIDGE	5	89,895	12	233,683	11	280,710
NORTH KILPATRICK	22	545,259	29	584,295	35	628,314
ROLLING MEADOWS	13	262,758	17	413,596	21	565,024
SOUTH CHICAGO	47	1,027,670	46	1,236,396	52	1,409,444
SOUTH HOLLAND	18	422,618	15	365,421	15	453,076
SOUTH SHORE	29	794,571	27	658,469	22	499,015
SOUTHWESTERN ILLINOIS	2	52,064	4	89,559	5	151,753
SALINE COUNTY	9	153,579	14	204,043	8	131,145
RANDOLPH COUNTY	2	71,698	3	82,832	2	71,635
WEST BELMONT	22	664,716	26	661,051	28	863,976
SUB ACUTES-CHICAGO	34	572,566	23	271,619	0	0
DU QUOIN	4	118,815	5	121,331	3	58,717
WILLIAMSON COUNTY	7	155,810	8	101,072	5	96,058
HAZEL CREST	13	241,853	10	287,286	10	214,477
ROUNDLAKE	21	475,824	24	493,893	30	664,115
AURORA	15	282,952	13	340,956	23	409,254
BOLINGBROOK	14	369,776	15	302,564	16	391,443
BLUE ISLAND	18	520,857	19	639,785	20	587,079
DUPAGE WEST	14	340,246	17	478,342	23	619,706
CHICAGO DIALYSIS CENTER	54	1,701,836	52	1,611,952	51	1,527,810
DOWNERS GROVE	11	185,345	12	246,657	15	259,648
ELK GROVE	9	246,004	19	391,391	22	557,917
ELK GROVE HOME	3	65,936	4	56,185	6	86,193
GLENVIEW DIALYSIS	11	296,108	11	253,113	10	236,826
GREENWOOD	31	1,020,091	34	1,104,451	42	1,098,034
JACKSON PARK	60	1,763,376	50	1,611,563	60	1,851,859
WESTCHESTER	8	137,417	7	168,327	9	131,141
NAPERVILLE	6	77,624	8	115,372	6	119,920
NORTH AVENUE	21	391,879	21	458,432	22	506,854
OAK PARK	28	841,810	25	664,166	26	564,587
SOUTHSIDE	61	1,634,898	61	1,681,211	76	1,912,184
WEST METRO	63	1,747,068	67	2,010,301	76	1,962,013
WEST SUBURBAN	65	2,090,809	60	1,846,835	72	1,843,959
ALSIP	9	244,090	7	191,197	9	225,197
AUSTIN	13	332,346	19	528,817	27	671,506
CONGRESS PARKWAY	41	1,083,913	46	1,180,866	47	1,367,495
GLENDALE HEIGHTS	21	465,902	22	482,868	24	565,137
WILLOWBROOK	3	94,728	5	101,999	10	233,802
BURBANK	29	664,960	28	569,628	22	577,991
OSWEGO	7	98,019	7	143,557	5	122,456
ANTIOCH	2	10,824	7	43,266	16	287,398
MCHENRY	2	21,351	10	135,724	8	170,711
LAKE BLUFF	11	255,400	25	512,844	16	338,331

NILES	23	381,191	15	378,443	20	502,907
CHICAGO WESTSIDE	33	666,627	39	1,046,926	57	1,118,766
NAPERVILLE NORTH	4	62,580	10	141,891	11	165,756
LAKEVIEW	15	287,692	16	308,998	15	347,176
CHICAGO SUB ACUTE SOUTH	21	196,373	22	180,149	0	0
SOUTH SUBURBAN	25	354,674	33	394,309	26	507,127
ROGERS PARK	37	641,736	28	449,528	20	512,444
BERWYN	53	968,039	69	949,396	50	1,149,178
CRESTWOOD	19	272,090	19	326,320	14	299,259
ORLAND PARK	10	119,775	14	182,338	11	249,556
GARFIELD	42	784,977	48	844,222	38	974,577
EAST PEORIA	21	171,700	19	165,516	14	272,155
MC LEAN COUNTY	22	323,592	23	379,599	13	315,092
SPRING VALLEY	0	0	1	7,835	5	50,230
SPOON RIVER	0	0	1	3,368	1	14,403
PRAIRIE	24	426,557	19	290,328	20	289,441
PEKIN	2	21,427	1	5,605	2	75,355
PEORIA DOWNTOWN	26	436,300	30	478,951	21	476,682
OTTAWA	5	68,546	4	50,152	3	18,974
KEWANEE	3	24,709	3	52,898	1	55,679
MORRIS	2	10,197	2	36,784	3	71,705
NORTHWESTERN UNIVERSITY	56	896,346	59	1,977,014	34	958,461
DECATUR	1	7,642	1	139	2	26,534
DECATUR EAST HOME	1	6,333	0	0	2	25,777
PONTIAC	2	43,448	4	50,662	5	76,620
VILLA PARK	22	270,734	20	283,318	12	266,218
PEORIA NORTH	6	94,974	8	105,519	6	77,577
ROCKFORD	6	71,682	12	181,373	11	196,457
SKOKIE	15	148,400	14	152,005	10	236,890
EVANSTON	14	260,902	23	414,068	12	391,703
MC LEAN COUNTY HOME	0	0	1	8,184	2	6,038
FMS OTTAWA HOME	0	0	2	28,754	1	25,393
MERRIONETTE PARK HOME	4	31,251	3	32,228	1	24,985
MERRIONETTE PARK	10	121,995	18	303,698	12	226,148
UPTOWN CHICAGO	0	0	13	185,174	19	294,031
MIDWAY	0	0	0	0	1	7,882
WEST CHICAGO IL	0	0	1	2,447	14	95,727
MOKENA	0	0	0	0	1	43,121
ROSELAND	6	33,873	8	247,925	20	621,823
STREATOR	0	0	1	1,918	1	7,690
ROSS DIALYSIS - ENGLEWOOD	17	241,686	22	257,522	32	606,518
DUPAGE PD	2	10,958	2	26,658	5	32,570
HOME DIALYSIS NETWORK	0	0	3	48,741	0	0
MACOMB	1	3,507	4	52,762	2	30,803
DEERFIELD	0	0	0	0	3	92,714
SANDWICH JV	0	0	3	13,838	3	36,284
PLAINFIELD	0	0	0	0	9	102,051
JOLIET HOME	0	0	0	0	2	5,400
TOTAL	1,626	37,043,006	1,783	40,401,403	1,828	44,001,539

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.



July 8, 2011

Ms. Courtney Avery
Administrator
Illinois Health Facilities & Services Review Board
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I am the Medical Director of Fresenius Medical Care North Avenue Dialysis Center. This facility had been operating above capacity for several years requiring the 7 station expansion certified in January 2009. By the end of that year the utilization was still high at 88%. Two additional stations were added and as of March 2011 the utilization is even higher at 92%. I am therefore writing to support of the addition of 2 more stations with the end result being a 24 station facility.

The Fresenius North Avenue facility has experienced average 10% yearly combined mortality and transplant rate. It is therefore expected that approximately 10% of the current patients will no longer require dialysis services by the time the additional stations are in operation.

I was treating 130 hemodialysis patients at the end of 2008, 144 hemodialysis patients at the end of 2009, 133 hemodialysis patients at the end of 2010, and 147 patients at the end of the 2nd quarter 2011, as reported to The Renal Network. Over the past twelve months, I have referred 36 new hemodialysis patients to the Fresenius North Avenue and Oak Park. There are currently 122 ESRD patients at Fresenius Medical Care North Avenue and I have 105 pre-ESRD patients in stage 3 & 4 of kidney failure that I expect will be referred to the North Avenue facility in the first 24 months after project completion.

I respectfully ask the Board to approve the 2 station addition to Fresenius Medical Care North Avenue to alleviate the high utilization. Thank you for your consideration.

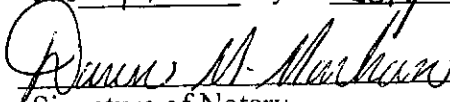
I attest that to the best of my knowledge, all the information contained in this letter is true and correct and that the projected patient referrals listed in this document were not used to support any other CON application.

Sincerely,

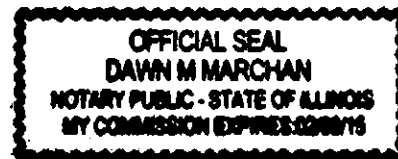
Martin Finn, M.D.

Notarization:

Subscribed and sworn to before me
this 7th day of July, 2011



Signature of Notary



Seal

**ESRD PATIENTS OF DR. FINN FOR YEAR END 2008, 09, 10
& 2ND QUARTER 2011**

Zip Code	Fresenius Norridge				Fresenius North Avenue				Fresenius Oak Park			
	2008	2009	2010	Jun-11	2008	2009	2010	Jun-11	2008	2009	2010	Jun-11
60018								1				
60101					3	3	3	2				
60104					6	5	5	8	3	3	4	3
60130					1	1			2	4	2	2
60131		1			10	12	12	12				
60133							1					
60138											1	1
60153					6	7	11	12	2	1		
60155					2	1	2	2	1	1	1	
60157						1	1					
60160					8	6	8	9				
60162					2	4	3	3				
60163					1	1	2	2				
60164					8	9	9	11				
60165					3	2	1	1				
60171					2	2	2	2				
60176	1		1	1		2	1	1				
60181						1						
60187						1			1	1		
60188												
60189					1							
60194						1	1	1				
60301										1		
60302			1	1		1			7	8	5	7
60304					1				1		1	1
60305					2	1	2	2				1
60402					1	1			2	2	1	2
60453									1	1		
60455						1	1	1				
60516								1				
60534						1						
60543								1				
60544									1	1	1	1
60546					1	2			1			
60564										1		
60607						2	3	4				
60609									2	1	1	1
60612									2	2	2	2
60613											1	1
60616						1	1	1				
60618	1	1							1			
60620					1	1	1	1				
60623									2	1		
60624									1			
60628					1							
60629							1	1				
60634					1	2	1	2				
60639					2	4	5	5				1
60644					2	1	2	2	9	7	4	4
60647		1		1								
60649					1	1	1	1				
60651					4	6	4	3	2			
60656	1	1										
60701						1	1	1				
60706	1		1	1	1	1	1	1				
60707	1				8	13	14	14				1
60714					1	1	1	1				
60804							1	1	4	5	3	4
Total	5	4	3	4	80	100	102	110	45	40	28	33

Yearly Totals	2008	2009	2010	Jun-11
	130	144	133	147

ADMISSIONS OF DR. FINN FOR THE PREVIOUS TWELVE MONTHS -
07/01/10 THROUGH 06/30/2011

Zip Code	Fresenius North Avenue	Fresenius Oak Park	Total
60104	2		2
60131	3		3
60136	1		1
60153	4		4
60155	1		1
60160	3		3
60162		1	1
60163	1		1
60164	2		2
60189	1		1
60302		2	2
60304		1	1
60305		1	1
60513	1		1
60516	1		1
60548	1		1
60612		1	1
60629	1		1
60634	2		2
60639	1		1
60680		1	1
60707	3		3
60804		1	1
Total	28	8	36

PRE - ESRD PATIENTS DR. FINN EXPECTS TO REFER TO FRESENIUS
MEDICAL CARE NORTH AVENUE IN THE FIRST 24 MONTHS AFTER
PROJECT COMPLETION

Zip Code	Stage 3	Stage 4	Total
60101		1	1
60104	7	3	10
60126		1	1
60131	3	6	9
60153	6	5	11
60155	1		1
60160	3	9	12
60162	2	1	3
60164	4	3	7
60165		1	1
60171	1	1	2
60176	2	3	5
60305	1		1
60634	4	2	6
60639	5	1	6
60651	5	3	8
60706		1	1
60707	10	10	20
Total	54	51	105

CURRENT FRESENIUS NORTH AVENUE ESRD PATIENTS

Zip Code	ESRD
60018	1
60101	2
60104	9
60131	15
60153	13
60155	2
60160	10
60162	3
60163	3
60164	11
60165	1
60171	3
60176	1
60189	1
60194	1
60305	2
60455	1
60516	1
60543	1
60607	4
60609	1
60616	1
60620	1
60623	1
60629	1
60634	2
60639	5
60644	2
60649	1
60651	4
60701	1
60706	1
60707	14
60714	1
60804	1
Total	122