Original

15-024

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
JUN 01 2015
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: *Fresenius Medical Care Chicago*				
Street Address *1806 W. Hubbard Street*				
City and Zip Code: *Chicago, 60622*				
County: *Cook*	Health Service Area	*6*	Health Planning Area:	

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

Exact Legal Name: *Fresenius Medical Care Summit, LLC d/b/a Fresenius Medical Care Chicago*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Ron Kuerbitz*
CEO Address: *920 Winter Street, Waltham, MA 02451*
Telephone Number: *800-662-1237*

Type of Ownership of Applicant

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

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

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

Co-Applicant Identification

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

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

Type of Ownership of Co-Applicant

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

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

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

Co-Applicant Identification

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

Exact Legal Name: *WSKC Dialysis Services, Inc.*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Ron Kuerbitz*
CEO Address: *920 Winter Street, Waltham, MA 02451*
Telephone Number: *800-662-1237*

Type of Ownership of Co-Applicant

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

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

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

Primary Contact

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care*
Address: *3500 Lacey Road, Suite 900, Downers Grove, IL 60515*
Telephone Number: *630-960-6807*
E-mail Address: *lori.wright@fmc-na.com*
Fax Number: *630-960-6812*

Additional Contact

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

Name: *Coleen Muldoon*
Title: Regional *Vice President*
Company Name: *Fresenius Medical Care*
Address: *3500 Lacey Road, Suite 900, Downers Grove, IL 60515*
Telephone Number: *630-960-6706*
E-mail Address: *coleen.muldoon@fmc-na.com*
Fax Number: *630-960-6812*

Post Permit Contact

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

Name: *Lori Wright*
Title: *Senior CON Specialist*
Company Name: *Fresenius Medical Care*
Address: *3500 Lacey Road, Suite 900, Downers Grove, IL 60515*
Telephone Number: *630-960-6807*
E-mail Address: *lori.wright@fmc-na.com*
Fax Number: *630-960-6812*

Additional Contact

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

Name: *Clare Ranalli*
Title: *Attorney*
Company Name: *McDermott, Will & Emery*
Address: *227 W. Monroe Street, Suite 4700, Chicago, IL 60606*
Telephone Number: *312-984-3365*
E-mail Address: *cranalli@mwe.com*
Fax Number: *312-984-7500*

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Net3, LLC*
Address of Site Owner: *2803 W. Butterfield Road, Suite 310, Oak Brook, IL 60523*
Street Address or Legal Description of Site: *1806 W. Hubbard Street, Chicago, IL* **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: *Fresenius Medical Care Summit, LLC d/b/a Fresenius Medical Care Chicago*
Address: *920 Winter Street, Waltham, MA 02451*
☐ Non-profit Corporation ☐ Partnership ☐ For-profit Corporation ☐ Governmental ☒ Limited Liability Company ☐ Sole Proprietorship ☐ Other o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. 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 – CHANGE OF OWNERSHIP***

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

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

Historic Resources Preservation Act Requirements

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

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:

☐ Substantive

☒ Non-substantive

2. Narrative Description

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

Fresenius Medical Care Chicago (a 21-station ESRD facility) is currently owned and operated by WSKC Dialysis Services, Inc., a Delaware corporation that is qualified to do business in Illinois. The facility is located at 1806 W. Hubbard Street, Chicago. All of the assets specific to WSKC Dialysis Services, Inc. d/b/a Fresenius Medical Care Chicago will be transferred to Fresenius Medical Care Summit, LLC, also a Delaware corporation that is qualified to do business in Illinois.

There is no cost associated with this transaction as it entails the transfer of assets only, between companies wholly owned by Fresenius Medical Care Holdings, Inc.

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

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	N/A	N/A	N/A
Site Survey and Soil Investigation	N/A	N/A	N/A
Site Preparation	N/A	N/A	N/A
Off Site Work	N/A	N/A	N/A
New Construction Contracts	N/A	N/A	N/A
Modernization Contracts	N/A	N/A	N/A
Contingencies	N/A	N/A	N/A
Architectural/Engineering Fees	N/A	N/A	N/A
Consulting and Other Fees	N/A	N/A	N/A
Movable or Other Equipment (not in construction contracts)	N/A	N/A	N/A
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	N/A	N/A	N/A
Other Costs To Be Capitalized	N/A	N/A	N/A
Acquisition of Building or Other Property (excluding land)	N/A	N/A	N/A
TOTAL USES OF FUNDS	$0	N/A	$0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	N/A	N/A	N/A
Pledges	N/A	N/A	N/A
Gifts and Bequests	N/A	N/A	N/A
Bond Issues (project related)	N/A	N/A	N/A
Mortgages	N/A	N/A	N/A
Leases (fair market value)	N/A	N/A	N/A
Governmental Appropriations	N/A	N/A	N/A
Grants	N/A	N/A	N/A
Other Funds and Sources	N/A	N/A	N/A
TOTAL SOURCES OF FUNDS	$0	N/A	$0

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

Related Project Costs

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

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

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

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

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

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): January 31, 2016

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

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

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

State Agency Submittals

Are the following submittals up to date as applicable:

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

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

Cost Space Requirements *NOT APPLICABLE – CHANGE OF OWNERSHIP*

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

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

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

CERTIFICATION

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

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

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

B Mello

SIGNATURE

Bryan Mello

PRINTED NAME

Assistant Treasurer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21 day of May 2015

C Wynelle Scenna

Signature of Notary

Seal

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

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

SIGNATURE	SIGNATURE
Mark Fawcett	Bryan Mello
PRINTED NAME	PRINTED NAME
Vice President & Treasurer	Assistant Treasurer
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____2015	Notarization: Subscribed and sworn to before me this 23 day of Feb 2015
C Wynelle Scenna	
Signature of Notary	Signature of Notary
Seal	Seal

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

*Insert EXACT legal name of the applicant

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of *WSKC Dialysis Service, 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
Mark Fawcett	Bryan Mello
PRINTED NAME	PRINTED NAME
Vice President & Treasurer	Assistant Treasurer
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this _____ day of _____2015	Notarization: Subscribed and sworn to before me this 23 day of Feb 2015
C Wynelle Scenna	
Signature of Notary	Signature of Notary
Seal	Seal

*Insert EXACT legal name of the applicant

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

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

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

ALTERNATIVES ***NOT APPLICABLE – THERE ARE NO COSTS ASSOCIATED WITH THIS PROJECT/CHANGE OF OWNERSHIP***

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

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

Read the criterion and address the following:

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

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

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

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

VIII. - 1120.120 - Availability of Funds

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

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

APPEND DOCUMENTATION AS ATTACHMENT-36, 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. **"A" Bond rating or better**
2. **All of the projects capital expenditures are completely funded through internal sources**
3. **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**
4. **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-37, 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. THIS PROJECT HAS NO COST.***			
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

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 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

NOT APPLICABLE – THERE ARE NO PROJECT COSTS

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

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

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

APPEND DOCUMENTATION AS ATTACHMENT -39, 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:

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 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Net Revenue	$387,393,758	$398,570,288	$411,981,839
	2012	2013	2014
Charity * (# of self-pay patients)	203	499	251
Charity (cost In dollars)	$1,536,372	$5,346,976	$5,211,664
Ratio Charity Care Cost to Net Patient Revenue	.40%	1.34%	1.27%
MEDICAID			
	2012	2013	2014
Medicaid (# of patients)	1,705	1,660	750
Medicaid (revenue)	$36,254,633	$31,373,534	$22,027,882
Ratio Medicaid to Net Patient Revenue	12.99%	7.87%	5.35%

APPEND DOCUMENTATION AS ATTACHMENT-40, 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			
	2012	**2013**	**2014**
Net Patient Revenue	**$387,393,758**	**$398,570,288**	**$411,981,839**
Amount of Charity Care (charges)	$1,566,380	$5,346,976	$5,211,664
Cost of Charity Care	$1,566,380	$5,346,976	$5,211,664
	.40%	1.34%	1.27%

APPEND DOCUMENTATION AS ATTACHMENT-41, 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	22-24
2	Site Ownership	25
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	26
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	27
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	28
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	29-35
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	36-46
	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	
27	Non-Hospital Based Ambulatory Surgery	
28	Selected Organ Transplantation	
29	Kidney Transplantation	
30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
32	Community-Based Residential Rehabilitation Center	
33	Long Term Acute Care Hospital	
34	Clinical Service Areas Other than Categories of Service	
35	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
36	Availability of Funds	
37	Financial Waiver	47
38	Financial Viability	
39	Economic Feasibility	
40	Safety Net Impact Statement	48-49
41	Charity Care Information	50-52

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

Exact Legal Name:	*Fresenius Medical Care Summit, LLC d/b/a Fresenius Medical Care Chicago**
Address:	*920 Winter Street, Waltham, MA 02451*
Name of Registered Agent:	*CT Systems*
Name of Chief Executive Officer:	*Ron Kuerbitz*
CEO Address:	*920 Winter Street, Waltham, MA 02451*
Telephone Number:	*800-662-1237*

Type of Ownership of Applicant

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

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

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

Certificate of Good Standing for Fresenius Medical Care Summit, LLC on following page.

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

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

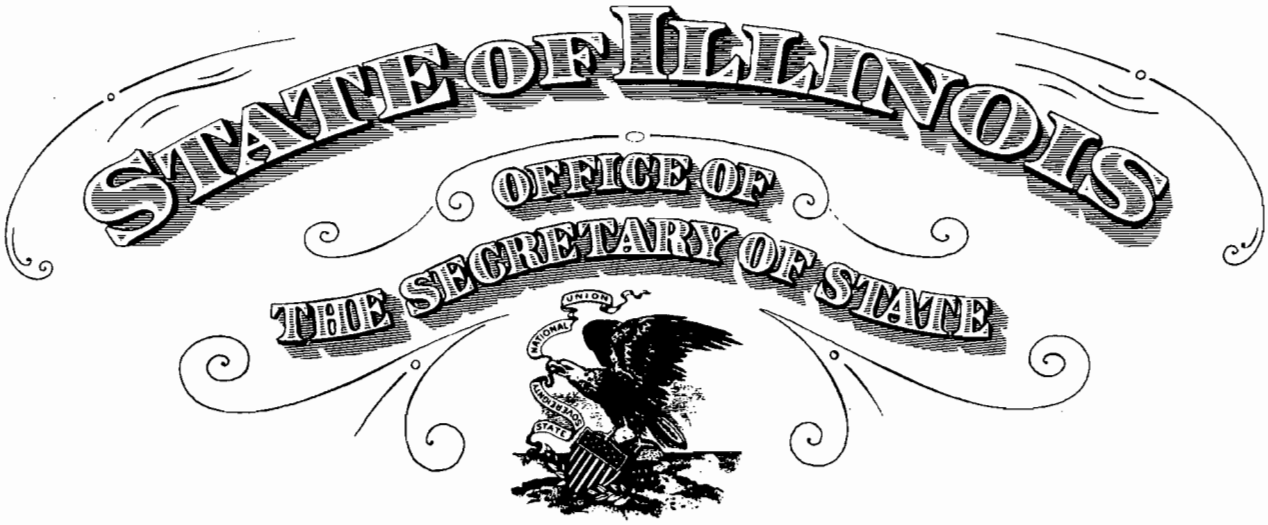
APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Type of Ownership – Co-Applicant

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

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

File Number 0466019-6



To all to whom these Presents Shall Come, Greeting:

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

FRESENIUS MEDICAL CARE SUMMIT, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON MARCH 31, 2014, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 21ST *day of* MAY *A.D.* 2015 .

Authentication #: 1514102174

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

Jesse White

SECRETARY OF STATE

Certificate of Good Standing
ATTACHMENT 1

Co-Applicant Identification

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

Exact Legal Name: *WSKC Dialysis Services, Inc.*
Address: *920 Winter Street, Waltham, MA 02451*
Name of Registered Agent: *CT Systems*
Name of Chief Executive Officer: *Ron Kuerbitz*
CEO Address: *920 Winter Street, Waltham, MA 02451*
Telephone Number: *800-662-1237*

Type of Ownership of Co-Applicant

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

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: *Net3, LLC*
Address of Site Owner: *2803 W. Butterfield Road, Suite 310, Oak Brook, IL 60523*
Street Address or Legal Description of Site: *1806 W. Hubbard Street, Chicago, IL* **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Site Owner
ATTACHMENT – 2

Operating Identity/Licensee

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

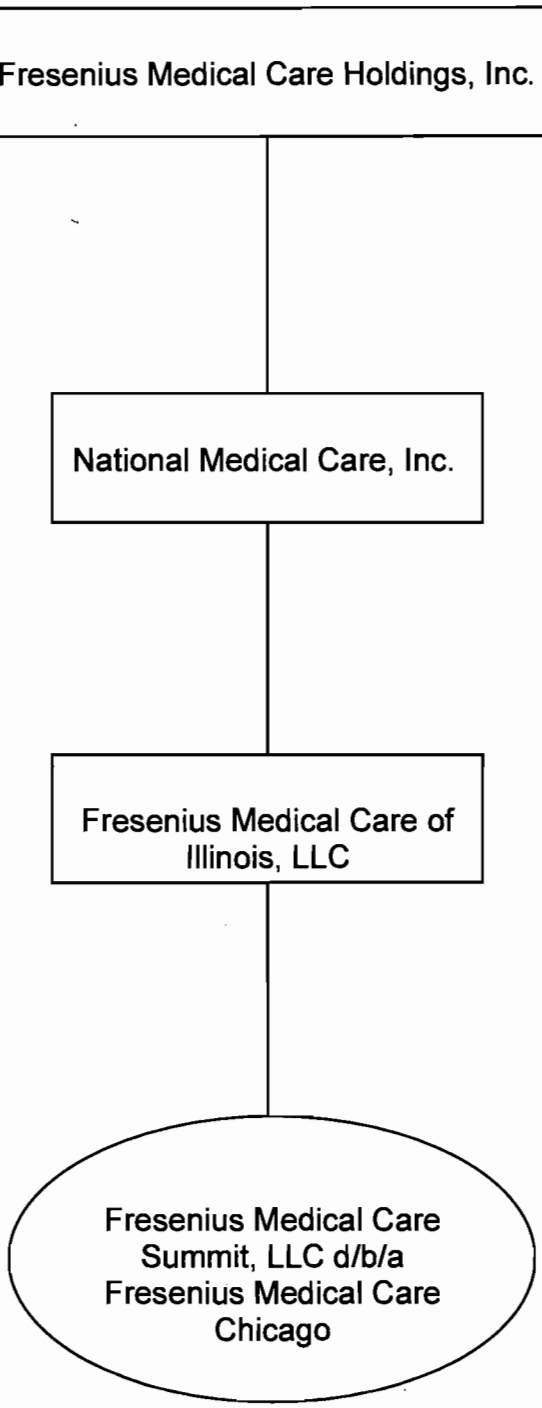
Exact Legal Name: *Fresenius Medical Care Summit, LLC d/b/a Fresenius Medical Care Chicago*
Address: *920 Winter Street, Waltham, MA 02451*

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

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

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

***Certificate of Good Standing at Attachment – 1.**



Org Chart
ATTACHMENT - 4

Project Status and Completion Schedules

- Anticipated completion date is February 28, 2017.
- Project obligation will occur after permit issuance.
- **List of Current CON Permits**

Project Number	Name	Project Type	Completion Date
#12-029	Fresenius SW Illinois	Relocation	05/01/2015
#12-095	Fresenius Waterloo	Establishment	02/28/2015
#12-098	Fresenius Monmouth	Establishment	02/28/2015
#14-010	Fresenius Highland Park	Establishment	11/30/2015
#14-012	Fresenius Gurnee	Relocation/Expansion	12/31/2015
#14-019	Fresenius Summit	Establishment	12/31/2015
#13-040	Fresenius Lemont	Establishment	09/30/2016
#14-041	Fresenius Elgin	Expansion	06/30/2016
#14-026	Fresenius New City	Establishment	06/30/2016
#14-047	Fresenius Medical Care Humboldt Park	Establishment	12/31/2016
#14-065	Fresenius Medical Care Plainfield North	Relocation	12/31/2016
#15-001	Fresenius Medical Care Steger	Expansion	12/31/2016

Fresenius Medical Care

Fresenius Medical Care is the leading provider of dialysis products and services in the world and as such has a long-standing commitment to adhere to high quality standards, to provide compassionate patient centered care, educate patients to become in charge of their health decisions, implement programs to improve clinical outcomes while reducing mortality & hospitalizations and to stay on the cutting edge of technology in development of dialysis related products.

The size of the company and range of services provides healthcare partners/employees and patients with an expansive range of resources from which to draw experience, knowledge and best practices. It has also allowed it to establish an unrivaled emergency preparedness and disaster relief program that's designed to provide life sustaining dialysis care to dialysis patients whose access to clinics are disrupted in areas of the U.S. that are compromised by disaster (e.g. hurricanes, tornadoes, earthquakes). Through this program we also provide clinics, employees and others with essential supplies such as generators, gasoline and water.

Quality Measures – Fresenius Medical Care continually tracks five quality measures on all patients. These are:

- eKdrt/V – tells us if the patient is getting an adequate treatment
- Hemoglobin – monitors patients for anemia
- Albumin – monitors the patient's nutrition intake
- Phosphorus – monitors patient's bone health and mineral metabolism
- Catheters – tracks patients access for treatment, the goal is no catheters which leads to better outcomes

The above measures as well as other clinic operations are discussed each month with the Medical Directors, Clinic Managers, Social Workers, Dietitians, Area Managers and referring nephrologists at each clinic's Quality Assessment Performance Improvement (QAI) meeting to ensure the provision of high quality care, patient safety, and regulatory compliance.

INITIATIVES that Fresenius has implemented to bring about better outcomes and increase the patient's quality of life are the TOPS program, Right Start Program and The Catheter Reduction Program.

TOPs Program (Treatment Options) – This is a company-wide program designed to reach the pre-ESRD patient (also known as CKD – Chronic Kidney Disease) to educate them about available treatment options when they enter end stage renal disease. TOPs programs are held routinely at local hospitals and physician offices. Treatment options include transplantation, in-center hemodialysis, home hemodialysis, peritoneal dialysis and nocturnal dialysis.

Right Start Program – This is an intensive 90-day intervention program for the new dialysis patient centering on education, anemia management, adequate dialysis dose, nutrition, reduction of catheter use, review of medications and logistical and psychosocial support. The Right Start Program results in improved morbidity and mortality in the long term but also notably in the first 90 days of the start of dialysis.

Catheter Reduction Program – This is a key strategic clinical initiative to support nephrologists and clinical staff with increasing the number of patients dialyzed with a permanent access, preferably a venous fistula (AVF) versus a central venous catheter (CVC) venous fistula). Starting dialysis with or converting patients to an AVF can significantly lower serious complications, hospitalizations and mortality rates. Overall adequacy of dialysis treatment also increases with the use of the AVF.

Diabetes Care Partnership - Fresenius Medical Care and Joslin Diabetes Center, the world's preeminent diabetes research, clinical care and education organization, announced an agreement to jointly develop renal care programs in select Joslin Affiliated Centers for patients with diabetic kidney disease (DKD). Fresenius and Joslin will jointly develop clinical guidelines and effective care delivery systems to manage high blood pressure, glucose, and nutrition in patients with DKD. In addition, the organizations will help educate patients as they prepare for the possibility of end stage renal disease (ESRD) and the necessity for dialysis or kidney transplantation. Fresenius Medical Care and Joslin's multidisciplinary and coordinated approach to chronic disease management will seek to improve patient outcomes while reducing unnecessary or lengthy hospitalizations, drug interactions and overall morbidity and mortality associated with uncoordinated care.

Locally, in Illinois, Fresenius Medical Care is a predominant supporter of the National Kidney Foundation of Illinois (NKFI), Kidney Walk in downtown Chicago. Fresenius Medical Care employees in Chicago alone raised almost $15,000 for the foundation. The NKFI is an affiliate of the National Kidney Foundation, which funds medical research improving lives of those with kidney disease, prevention screenings and is a leading educator on kidney disease. Fresenius Medical Care also donates another $25,000 annually to the NKFI and another $5,000 in downstate Illinois.

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	329 Remington	Boilingbrook	60440
Breese	14-2637	160 N. Main Street	Breese	62230
Bridgeport	14-2524	825 W. 35th Street	Chicago	60609
Burbank	14-2641	4811 W. 77th Street	Burbank	60459
Carbondale	14-2514	1425 Main Street	Carbondale	62901
Centre West Springfield	14-2546	1112 Centre West Drive	Springfield	62704
Champaign	14-2588	1405 W. Park Street	Champaign	61801
Chatham	14-2744	333 W. 87th Street	Chicago	60620
Chicago Dialysis	14-2506	1806 W. Hubbard Street	Chicago	60622
Chicago Westside	14-2681	1340 S. Damen	Chicago	60608
Cicero	14-2754	3000 S. Cicero	Chicago	60804
Congress Parkway	14-2631	3410 W. Van Buren Street	Chicago	60624
Crestwood	14-2538	4861W. Cal Sag Road	Crestwood	60445
Decatur East	14-2603	1830 S. 44th St.	Decatur	62521
Deerfield	14-2710	405 Lake Cook Road	Deefield	60015
Des Plaines	14-2774	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	825 Sunset Avenue	DuQuoin	62832
East Peoria	14-2562	3300 North Main Street	East Peoria	61611
Elgin	14-2726	2130 Point Boulevard	Elgin	60123
Elk Grove	14-2507	901 Biesterfield Road, Ste. 400	Elk Grove	60007
Elmhurst	14-2612	133 E. Brush Hill Road, Suite 4	Elmhurst	60126
Evanston	14-2621	2953 Central Street, 1st Floor	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	130 E. Army Trail Road	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
Highland Park	142782	1657 Old Skokie Road	Highland Park	60035
Hoffman Estates	14-2547	3150 W. Higgins, Ste. 190	Hoffman Estates	60195
Humboldt Park	-	3500 W. Grand Avenue	Chicago	60651
Jackson Park	14-2516	7531 South Stony Island Ave.	Chicago	60649
Joliet	14-2739	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
Lemont	-	16177 W. 127th Street	Lemont	60439
Logan Square	14-2766	2721 N. Spalding	Chicago	60647
Lombard	14-2722	1940 Springer Drive	Lombard	60148
Macomb	14-2591	523 E. Grant Street	Macomb	61455
Marquette Park	14-2566	6515 S. Western	Chicago	60636
McHenry	14-2672	4312 W. Elm St.	McHenry	60050
McLean Co	14-2563	1505 Eastland Medical Plaza	Bloomington	61704
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
Maple City		1225 N. Main Street	Monmouth	61462
Morris	14-2596	1401 Lakewood Dr., Ste. B	Morris	60450
Mundelein	14-2731	1400 Townline Road	Mundelein	60060
Naperbrook	14-2765	2451 S Washington	Naperville	60565
Naperville	14-2543	100 Spalding Drive Ste. 108	Naperville	60566

Facility List
ATTACHMENT - 11

Clinic	Provider #	Address	City	Zip
Naperville North	14-2678	516 W. 5th Ave.	Naperville	60563
New City	-	4622 S. Bishop Street	Chicago	60609
Niles	14-2500	7332 N. Milwaukee Ave	Niles	60714
Normal	14-2778	1531 E. College Avenue	Normal	61761
Norridge	14-2521	4701 N. Cumberland	Norridge	60656
North Avenue	14-2602	911 W. North Avenue	Melrose Park	60160
North Kilpatrick	14-2501	4800 N. Kilpatrick	Chicago	60630
Northcenter	14-2531	2620 W. Addison	Chicago	60618
Northfield	14-2771	480 Central Avenue	Northfield	60093
Northwestern University	14-2597	710 N. Fairbanks Court	Chicago	60611
Oak Forest	14-2764	5340A West 159th Street	Oak Forest	60452
Oak Park	14-2504	773 W. Madison Street	Oak Park	60302
Orland Park	14-2550	9160 W. 159th St.	Orland Park	60462
Oswego	14-2677	1051 Station Drive	Oswego	60543
Ottawa	14-2576	1601 Mercury Circle Drive, Ste. 3	Ottawa	61350
Palatine	14-2723	691 E. Dundee Road	Palatine	60074
Pekin	14-2571	3521 Veteran's Drive	Pekin	61554
Peoria Downtown	14-2574	410 W Romeo B. Garrett Ave.	Peoria	61605
Peoria North	14-2613	10405 N. Juliet Court	Peoria	61615
Plainfield	14-2707	2320 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
Regency Park	14-2558	124 Regency Park Dr., Suite 1	O'Fallon	62269
River Forest	14-2735	103 Forest Avenue	River Forest	60305
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
Saline County	14-2573	275 Small Street, Ste. 200	Harrisburg	62946
Sandwich	14-2700	1310 Main Street	Sandwich	60548
Skokie	14-2618	9801 Wood Dr.	Skokie	60077
South Chicago	14-2519	9200 S. Chicago Ave.	Chicago	60617
South Deering	14-2756	10559 S. Torrence Ave.	Chicago	60617
South Holland	14-2542	17225 S. Paxton	South Holland	60473
South Shore	14-2572	2420 E. 79th Street	Chicago	60649
Southside	14-2508	3134 W. 76th St.	Chicago	60652
South Suburban	14-2517	2609 W. Lincoln Highway	Olympia Fields	60461
Southwestern Illinois	14-2535	7 Professional Drive	Alton	62002
Spoon River	14-2565	340 S. Avenue B	Canton	61520
Spring Valley	14-2564	12 Wolfer Industrial Drive	Spring Valley	61362
Steger	14-2725	219 E. 34th Street	Steger	60475
Streator	14-2695	2356 N. Bloomington Street	Streator	61364
Summit	-	7319-7322 Archer Avenue	Summit	60501
Uptown	14-2692	4720 N. Marine Dr.	Chicago	60640
Waterloo	-	624 Voris-Jost Drive	Waterloo	62298
Waukegan Harbor	14-2727	101 North West Street	Waukegan	60085
West Batavia	14-2729	2580 W. Fabyan Parkway	Batavia	60510
West Belmont	14-2523	4943 W. Belmont	Chicago	60641
West Chicago	14-2702	1859 N. Neltnor	West Chicago	60185
West Metro	14-2536	1044 North Mozart Street	Chicago	60622
West Suburban	14-2530	518 N. Austin Blvd., 5th Floor	Oak Park	60302
West Willow	14-2730	1444 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

Fresenius Medical Care Summit, LLC

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 Summit, LLC by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities & 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: Bryan Mello
Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 21 day of May, 2015

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

ATTACHMENT - 11

Certification & Authorization

Fresenius Medical Care Holdings, Inc.

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

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

By:_____

ITS: Mark Fawcett
Vice President & Treasurer

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2015

_____
Signature of Notary

Seal

By:_____

ITS: Bryan Mello
Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this 23 day of Feb, 2015

C Wynelle Scenna
Signature of Notary

Seal

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

ATTACHMENT - 11

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: _____

ITS: Mark Fawcett
Vice President & Treasurer

By: _____

ITS: Bryan Mello
Assistant Treasurer

Notarization:
Subscribed and sworn to before me
this_____ day of _____, 2015

Notarization:
Subscribed and sworn to before me
this 23 day of Feb, 2015

C Wynelle Scenna

Signature of Notary

Signature of Notary

Seal

Seal

C. WYNELLE SCENNA
Notary Public
Massachusetts
Commission Expires Jun 25, 2021

ATTACHMENT - 11

WSKC Dialysis Services, Inc.

IMPACT AND ACCESS STATEMENT PER PART 1110.240

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

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

The preferred Fresenius model of ownership is for our facilities to be wholly owned, however we do enter into Joint Ventures on occasion. The Chicago facility will likely be one of those occasions due to the fact that the physicians desire to serve this community as well as investing in the facility. Changing ownership of the Chicago facility from WSKC Dialysis Services, Inc. to Fresenius Medical Care Summit, LLC will allow for this investment should it occur. Fresenius Medical Care will maintain control of the governance, assets and operations of the facility as if physicians do invest in this facility their investment will be a minority interest only and will not allow them control of the facility.

No health care system is involved in this transaction.

Signature

Coleen Muldoon, Regional Vice President
Printed Name/Title

Date: May 27, 2015

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 27th DAY
OF May, 2015.

NOTARY PUBLIC

OFFICIAL SEAL
CANDACE M TUROSKI
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/09/17

FRESENIUS MEDICAL CARE HOLDINGS, INC.
OFFICER CERTIFICATION

The undersigned, Fresenius Medical Care Holdings, Inc. ("Holdings"), hereby certifies to the Illinois Health Facilities and Services Review Board ("the Board") as follows:

1. WSKC Dialysis Services, Inc. (the "Subsidiary") is a wholly owned, direct or indirect subsidiary of Holdings.

2. Under the transaction for which Board approval is being requested, the Subsidiary proposes to transfer Assets, as defined below, to Fresenius Medical Care Summit, LLC, another wholly owned indirect subsidiary of Holdings, on or before _____, 2015. There is no cost associated with the transfer of assets.

3. The "Assets" comprise the fixed assets, leases and contracts used by the Subsidiary to operate the dialysis facility at the following location:

FACILITY	ADDRESS	CITY/STATE	ZIP
Fresenius Medical Care Chicago	1806 W. Hubbard Street	Chicago, IL	60622

The foregoing certification is made and delivered on February____, 2015.

FRESENIUS MEDICAL CARE HOLDINGS, INC.

By: _____

Name: Bryan Mello
Assistant Treasurer

Title: _____

FRESENIUS MEDICAL CARE

FMS Clinical Services **Policy**

Patient Admission

Purpose

To guide facility management on the admission process for all patients being admitted to an FMS dialysis facility.

Responsibility

Medical Director, Clinical Manager or Registered Nurse , Master's Social Worker, Registered Dietitian and Facility Secretary as defined in this policy, Central Admissions Office, Central Verification Office

General Policy

This policy applies to In-Center, Home and Transient Patients.

Where medically appropriate and consistent with this policy, facilities shall admit and treat patients needing dialysis without regard to race, creed or religion, color, age, sex, disability, national origin, marital status, diagnosis and/or sexual orientation.

Each patient admitted will be followed by an attending physician on the facility's medical staff or physician who has been granted temporary privileges at the facility.

All services provided by the FMCNA facility are available to all patients:

- For whom they are medically suitable,
- Based on the clinical judgment of the physician, and
- The willingness of the responsible party to pay for such services.

In the case where the Medical Director determines the patient is too acutely ill or not appropriate for outpatient dialysis care, the decision for admission to the facility shall be made by the Governing Body pursuant to the *Documentation Required for Medical Clearance* section of this policy.

The Clinical Manager or designee is responsible for scheduling the patient for dialysis treatments in a manner consistent with the attending physician's dialysis prescription, patient needs, and available time slots.

The patient and/or his or her family shall designate a person to be notified in

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

case of emergency.

Patient Referrals

Patients may be referred by their physician, a hospital, another dialysis facility or as a self-referral.

All referrals for permanent admissions are directed to the Central Admissions Office (CAO) which then contacts the dialysis facility for placement. The CAO obtains the minimum necessary information required from the referral source to medically and financially clear the patient for admission.

The CAO forwards this information to the following:

- The facility where the patient is seeking admission for medical clearance and,
- Central Verification Office for financial clearance (see Patient Admissions and Readmissions policy, FMS-AR-040-020A, 122-040-020.)

Patient Change of Modality or Transfer to another FMS Facility

The Clinical Manager or his/her designee must contact the CAO when there is a modality change or the patient transfers to a different FMCNA facility. The CAO will initiate a new admission template packet to be completed with the patient.

Documentation Required for Medical Clearance

A patient shall be medically cleared for treatment when dialysis treatment is deemed indicated and appropriate according to the clinical judgment of the patient's Attending Physician. In the case where the Medical Director determines the patient is too acutely ill or not appropriate for outpatient dialysis care, then the decision for admission to the facility shall be made by the Governing Body.

NOTE: Requests to admit a patient with an external device such as left ventricular assist device (LVAD) or LifeVest Defibrillator requires approval from the corporate medical office.

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

Patient Admission

The following information is necessary prior to a patient's admission and is reviewed by the Medical Director and Clinical Manager or RN designee.

Documentation Required for Medical Clearance, cont.

REQUIRED
• For patients new to dialysis: at a minimum a Hepatitis B surface antigen (HBsAg) result obtained within 30 days prior to the admission date • History and Physical or a hospital or clinic discharge notes or summary • Dialysis Orders • Current Medication List • Last Three (3) Dialysis Flow sheets (from hospital or incenter • treatment (if applicable or available)Admission or Demographic Sheet • Allergy Status Note: For transient or transfer patients: All patients must have a documented hepatitis B antigen (HBsAg) or antibody (HBsAb) result prior to admission to the facility. HBsAg results must have been reported within 30 days of admission. If the patient has hepatitis antibodies (HBsAb), the results must have been report within the past 12 months. Any discrepancies or questions related to admitting a patient and/or a patient's hepatitis results should be reported by the Clinical Manager to their Corporate Clinical Quality Manager.
MOST RECENT AND IF AVAILABLE
• Nursing, Nutrition and Psychosocial assessment or Comprehensive Interdisciplinary Patient Assessment • Care plans or Comprehensive Plan of Care • EKG report • Chest x-ray report • Physician's Progress Note • Current lab results including chemistries and CBC • 2728 Form if transferring from another facility or an ESRD certified hospital

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

Patients with Prior Behavioral Issues

A referred patient who has exhibited behavioral issues in the hospital, another facility or during the admission process, such that they reasonably constitute a danger to themselves or to others, may be denied admission to the dialysis facility.

However, a patient who has been involuntarily discharged from another FMS facility or other provider is not automatically excluded from admission. The decision to admit a patient who has exhibited behavioral issues or was previously discharged from another facility due to behavioral issues shall be made by the facility management in collaboration with the patient's attending physician and the Medical Director.

Patient Unable to Sign Admission Documents Due to Being Deemed Incompetent or Incapable of Health Care Decision Making

The Regional Vice President must be contacted by the Central Admissions Office or facility if questions arise regarding the mental capacity or competency of a patient or the legal authority of another party to sign on the patient's behalf. The RVP is responsible for consulting the Law Department for guidance before the admission process can proceed.

The patient cannot be dialyzed if:

- The patient has been deemed by a physician to be incompetent or to lack mental capacity consistent with state law,
- The patient does not have an appropriate legal guardian or an agent with a valid healthcare power of attorney or healthcare proxy, and
- The law department determines that state law does not permit family members to give consent.

Who is Authorized to Sign Admission Documents?

Patients must have the mental capacity/competency to consent to treatment and sign admission forms in order for treatment to be given in the facility, except as described below.

If a patient has been deemed by a physician to lack the mental capacity/competency to consent to treatment, a Legally Authorized Person may consent to the patient's treatment and may sign the admission forms.

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

NOTE: State laws vary on who may consent to treatment on the patient's behalf if the patient lacks capacity or competency to consent.

In some states, family members or persons permitted by state law may consent to the patient's treatment and sign the admission forms even if such persons do not hold a power of attorney for healthcare or healthcare proxy as the Law Department will determine.

For purposes of this Policy, a 'Legally Authorized Person " is as follows:

(a) The patient's legal guardian or someone who hold a valid power of attorney for healthcare/healthcare proxy or who may sign on behalf of the patient under state law as determine by the Law Department.
(b) A parent or legal guardian if the patient is a minor.

NOTE: If there is any doubt the person is authorized to sign the consent contact the Law Department.

Patient Appears Unable to Consent for Treatment

If a patient comes for their first treatment and does not appear to have the mental capacity/competency, the nurse:

- must notify the patient's attending physician of the patient's perceived incapacity to understand and his/her inability to consent, and
- should seek confirmation whether a medical determination of incompetency or lack of capacity has been made in the medical record consistent with state law, and
- should attempt to contact any emergency contacts listed on the patient's admission paperwork in an attempt to find a family member who can
  - provide proof of guardianship/power of attorney for healthcare or healthcare proxy (which must be provided at the time of admission, prior to treatment being provided), or
  - assist in providing valid consent to treatment, if permitted under state law, or who can obtain legal authority/guardianship to represent the patient.

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

Patient Admission

Required Documents that must be Signed Prior to First Dialysis Treatment

The Clinical Manager or designee will conduct an admission interview with all new patients.

The following documents and any state-specific required documents must be reviewed with and signed by the patient and/or their Legally Authorized Person before or at their first scheduled dialysis treatment:

- Informed Consent for Dialysis (appropriate to modality chosen)
- Admission Agreement (appropriate to modality chosen)
- FMCNA Notice of Privacy Practices and Acknowledgment of Receipt of Notice of Privacy Practices Form (or document such efforts consistent with this policy)
- Facility's Assignment of Benefits
- Medicare Secondary Payor Questionnaire (MSPQ)
- Spectra Assignment of Benefits

Consent to Receive, Use and Disclose Health Information for Treatment Payment and Health Care Operations

Note: Patients or their Legally Authorized Persons not be asked to sign consent forms for services that are not being provided (ex. blood transfusion consent) until the actual service is needed. Blank consents forms should never be signed or used.

Copies of all insurance cards, front and back, including prescription drug plans, should be made at the time of admission.

All required Admission forms are filed in the patient's medical record. In addition, the Clinical Manager should refer to the Admission Form Distribution Guide FMS-CS-IC-I-103-009D1 to determine the appropriate distribution for each of the forms.

FMCNA Notice of Privacy Practice

A copy of the "FMCNA Notice of Privacy Practices (NPP)" must be given to each patient that is receiving direct care from an FMCNA provider prior to the patient's first treatment (see Privacy Notice Procedure COR-COMP-PS-0-001-001C1).

Patients have a right to review this Notice of Privacy Practices prior to

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

signing the "Acknowledgement of Receipt of the NPP" form (See COR-COMP-PS-0-001-001D3). The "Acknowledgement of Receipt of the NPP" form should be signed by the patient or Legally Authorized Person, prior to the patient's first treatment from an FMCNA direct provider of care. This form serves as an acknowledgement of receipt of the FMCNA Notice of Privacy Practices.

NOTE: This form is **not** a condition for treatment. If the patient refuses to sign the acknowledgement form, the FMCNA staff should document the efforts that were made to obtain their signature and document that the FMCNA Notice of Privacy Practices was provided to the patient. This documentation should be made on the acknowledgement form and should be witnessed by another staff member. The acknowledgement form should be kept as part of the permanent active medical record.

A copy of this notice must also be posted in a clear and prominent location readily visible to patients in each FMCNA physical service delivery site. This notice will also be posted on the FMCNA web site. In addition, whenever the notice is revised, the FMCNA direct provider must make the notice available upon request.

Additional Information Provided During Admission and Orientation Process

All new admissions to the facility will receive the following information:

- Patient Rights and Responsibilities within the first six (6) treatments
- Patient Complaints and Grievances information.
- Information about the members of the healthcare team and contact information for the facility and members of the team
- Specific information contained in the Patient Rights and Responsibilities and Patient Complaints and Grievances information that relate to facility policies that affect patients should be reviewed with the patient or Legally Authorized Person by the RN or Master's Social Worker during the patient's subsequent treatments as part of the admission orientation process.
- Facility policy information that should be reviewed includes, but is not limited to: conditions for routine and involuntary discharge, if interruption of treatment to use the restroom is needed, visitor policy, eating and

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

drinking policy and weapons and firearms policy.

Advance Directive/DNR Status

All new admissions to the facility will be asked if they have an Advance Directive and/or a valid state specific Do Not Resuscitate Order. If the patient or Legally Authorized Person indicates that these exist, the facility will ask that a copy be provided to be added to the patient's medical record.

All new admissions will be given the "FMCNA Notice of Do Not Resuscitate (DNR) Practices" information sheet and must sign the "Acknowledgement of Receipt of FMCNA Notice of Do Not Resuscitate Practices". A Registered Nurse or Social Worker also must complete and sign the Acknowledgement and retain it in the patient's medical record.

Until a valid state specific Do Not Resuscitate Order is provided or executed by the patient or Legally Authorized Person, the patient will be considered a full code. For additional information, refer to Do Not Resuscitate Order policy and procedure and Advance Directive Policy.

Information Regarding Modalities and Schedules

The patient shall be made aware of and afforded access, where available, to all treatment modalities provided by the facility as appropriately certified or licensed by the state:

In-center Hemodialysis
Self-care Dialysis
Nocturnal In-center Hemodialysis
Home Hemodialysis (Nocturnal and Daytime)
Continuous Ambulatory Peritoneal Dialysis
Continuous Cycling Peritoneal Dialysis
Referral for Renal Transplantation

Additionally, the patient shall be provided with resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients.

Related

Patient Admissions and Readmissions: In-Center, Home and Transient

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

Policies & Procedures

eCube Procedure for transmitting documents to eCube Document Imaging (If applicable)
Patient Rights and Responsibilities
Patient Complaints and Grievances policy and procedure
Advance Directive policy
Full Resuscitative Measures Policy
Do Not Resuscitate Order policy and procedure
Routine and Involuntary Patient Discharge
Visitor's Policy
Eating and Drinking Policy
Interruption of Treatment
Weapons and Firearms Policy
Records Management Policy, Filing, Storage, Preservation and Destruction of Records
Strong Bones Healthy Heart Program Guidelines Policy

END OF DOCUMENT

©2013, Fresenius Medical Care Holdings, Inc. All Rights Reserved.

Criterion 1120.310 Financial Viability

Financial Viability Waiver

This project has no associated costs.

2014 Financial Statements for Fresenius Medical Care Holdings, Inc. were submitted previously to the Board with #15-022, Fresenius Medical Care Blue Island and are the same financials that pertain to this application. In order to reduce buld these financials can be referred to if necessary.

Likewise, 2013 Financial Statements were submitted with #14-029 and 2013 Financial Statements were submitted with #13-040.

Safety Net Impact Statement

The change of ownership of the Fresenius Medical Care Chicago dialysis facility will not have any impact on safety net services in the city of Chicago. 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 pursuant to an Indigent Waiver policy. 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 Medical Care provides care to patients who do not qualify for any type of coverage for dialysis services. These patients are considered "self-pay" patients. They are billed for services rendered, and after three statement reminders the charges are written off as bad debt. Collection actions are not initiated unless the applicants are aware that the patient has substantial financial resources available and/or the patient has received reimbursement from an insurer for services we have rendered, and has not submitted the payment for same to the applicants. 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 on the following page shows the amount of "self-pay" care and Medicaid services provided for the 3 fiscal years prior to submission of the application for all Fresenius Medical Care facilities in Illinois.

CHARITY CARE			
Net Revenue	$387,393,758	$398,570,288	$411,981,839
	2012	**2013**	**2014**
Charity *			
(# of self-pay patients)	203	499[1]	251[2]
Charity (cost In dollars)	$1,536,372	$5,346,976	$5,211,664
Ratio Charity Care Cost to Net Patient Revenue	0.40%	1.34%	1.27%
MEDICAID			
	2012	**2013**	**2014**
Medicaid (# of patients)[3]	1,705	1,660	750
Medicaid (revenue)	36,254,633	31,373,534	22,027,882
Ratio Medicaid to Net Patient Revenue	9.36%	7.87%	5.35%

Note:

1) A new billing procedure was put into place in late 2012 to reduce the amount of voids and rebilling. Previously patients with Medicaid pending were considered only under Medicaid and after the procedure change, Medicaid pending patients are considered under self-pay. This has resulted in the increase in "charity" (self-pay) patients and costs.

2) Charity (self-pay) patient numbers decreased however treatments were higher per patient resulting in similar costs as 2013.

3) Medicaid number of patients is decreasing due to an effort to assist patients in signing up for health insurance in the Healthcare Marketplace.

Charity Care Information

The applicant(s) do not provide charity care at any of their facilities per the Board's definition of charity care because self-pay patients are billed and their accounts are written off as bad debt. Fresenius takes Medicaid patients without limitations or exception. The applicant(s) are for profit corporations and do not receive the benefits of not for profit entities, such as sales tax and/or real estate exemptions, or charitable donations. The applicants are not required, by any State or Federal law, including the Illinois Healthcare Facilities Planning Act, to provide charity care. The applicant(s) are prohibited by Federal law from advising patients that they will not be invoiced for care, as this type of representation could be an inducement for patients to seek care prior to qualifying for Medicaid, Medicare or other available benefits. Self-pay patients are invoiced and then the accounts written off as bad debt.

Uncompensated care occurs when a patient is not eligible for any type of insurance coverage (whether private or governmental) and receives treatment at our facilities. It is rare in Illinois for patients to have no coverage as patients who are not Medicare eligible are Medicaid eligible. This represents a small number of patients, as Medicare covers all dialysis services as long as an individual is entitled to receive Medicare benefits (i.e. has worked and paid into the social security system as a result) regardless of age. In addition, in Illinois Medicaid covers patients who are undocumented and/or who do not qualify for Medicare, and who otherwise qualify for public assistance. Also, the American Kidney Fund provides low cost insurance coverage for patients who meet the AKF's financial parameters and who suffer from end stage renal disease (see uncompensated care attachment). The applicants work with patients to procure coverage for them as possible whether it be Medicaid, Medicare and/or coverage through the AKF. The applicants donate to the AKF to support its initiatives.

If a patient has no available insurance coverage, they are billed for services rendered, and after three statement reminders the charges are written off as bad debt. Collection actions are not initiated unless the applicants are aware that the patient has substantial financial resources available and/or the patient has received reimbursement from an insurer for services we have rendered, and has not submitted the payment for same to the applicants

Nearly all dialysis patients in Illinois will qualify for some type of coverage and Fresenius works aggressively to obtain insurance coverage for each patient.

Uncompensated Care For All Fresenius Facilities in Illinois

CHARITY CARE			
	2012	**2013**	**2014**
Net Patient Revenue	**$387,393,758**	**$398,570,288**	**$411,981,839**
Amount of Charity Care (charges)	$1,566,380	$5,346,976	$5,211,664
Cost of Charity Care	$1,566,380	$5,346,976	$5,211,664
Ratio Charity Care Cost to Net Patient Revenue	.40%	1.34%	1.27%

Fresenius Medical Care North America - Community Care

Fresenius Medical Care North America (FMCNA) assists all of our patients in securing and maintaining insurance coverage when possible.

American Kidney Fund

FMCNA works with the American Kidney Fund (AKF) to help patients with insurance premiums at no cost to the patient.

Applicants must be dialyzed in the US or its territories and referred to AKF by a renal professional and/or nephrologist The Health Insurance Premium Program is a "last resort" program. It is restricted to patients who have no means of paying health insurance premiums and who would forego coverage without the benefit of HIPP. Alternative programs that pay for primary or secondary health coverage, and for which the patient is eligible, such as Medicaid, state renal programs, etc. must be utilized. Applicants must demonstrate to the AKF that they cannot afford health coverage and related expenses (deductible etc.).

Our team of Financial Coordinators and Social Workers connect patients who cannot afford to pay their insurance premiums, with AKF, which provides financial assistance to the patients for this purpose. The benefit of working with the AKF is that the insurance coverage which AKF facilitates applies to all of the patient's insurance needs, not just coverage for dialysis services.

Indigent Waiver Program

FMCNA has established an indigent waiver program to assist patients who are unable to obtain insurance coverage or who lack the financial resources to pay for medical services.
In order to qualify for an indigent waiver, a patient must satisfy eligibility criteria for both annual income and net worth.

Annual Income: A patient (including immediate family members who reside with, or are legally responsible for, the patient) may not have an annual income in excess of two (2) times the Federal Poverty Standard in effect at the time. Patients whose annual income is greater than two (2) times the Federal Poverty Standard may qualify for a partial indigent waiver based upon a sliding scale schedule approved by the Office of Business Practices and Corporate Compliance.

Net Worth: A patient (including immediate family members who reside with, or are legally responsible for, the patient) may not have a net worth in excess of $75,000 (or such other amount as may be established by the Office of Business Practices and Corporate Compliance based on changes in the Consumer Price Index

The Company recognizes the financial burdens associated with ESRD and wishes to ensure that patients are not denied access to medically necessary care for financial reasons. At the same time, the Company also recognizes the limitations imposed by federal law on offering "free" or "discounted" medical items or services to Medicare and other government supported patients for the purpose of inducing such patients to receive ESRD-related items and services from FMCNA. An indigent waiver excuses a patient's obligation to pay for items and services furnished by FMCNA. Patients may have dual coverage of AKF assistance and an Indigent Waiver if their financial status qualifies them for both programs.

IL Medicaid and Undocumented patients

FMCNA has a bi-lingual Regional Insurance Coordinator who works directly with Illinois Medicaid to assist patients with Medicaid applications. An immigrant who is unable to produce proper documentation will not be eligible for Medicaid unless there is a medical emergency. ESRD is considered a medical

emergency.

The Regional Insurance Coordinator will petition Medicaid if patients are denied and assist undocumented patients through the application process to get them Illinois Medicaid coverage. This role is actively involved with the Medicaid offices and attends appeals to help patients secure and maintain their Medicaid coverage for all of their healthcare needs, including transportation to their appointments.

FMCNA Collection policy

FMCNA's collection policy is designed to comply with federal law while not penalizing patients who are unable to pay for services.

FMCNA does not use a collection agency for patient collections unless the patient receives direct insurance payment and does not forward the payment to FMCNA.

Medicare and Medicaid Eligibility

Medicare: Patients are eligible for Medicare when they meet the following criteria: age 65 or older, under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

There are three insurance programs offered by Medicare, Part A for hospital coverage, Part B for medical coverage and Part D for pharmacy coverage. Most people don't have to pay a monthly premium, for Part A. This is because they or a spouse paid Medicare taxes while working. If a beneficiary doesn't get premium-free Part A, they may be able to buy it if they (or their spouse) aren't entitled to Social Security, because they didn't work or didn't pay enough Medicare taxes while working, are age 65 or older, or are disabled but no longer get free Part A because they returned to work. Part B and Part D both have monthly premiums. Patients must have Part B coverage for dialysis services.

Medicare does allow members to enroll in Health Plans for supplemental coverage. Supplemental coverage (secondary) is any policy that pays balances after the primary pays reducing any out of pocket expenses incurred by the member.

Medicare will pay 80% of what is allowed by a set fee schedule. The patient would be responsible for the remaining 20% not paid by Medicare. The supplemental (secondary) policy covers the cost of co-pays, deductibles and the remaining 20% of charges.

Medicaid: Low-income Illinois residents who can't afford health insurance may be eligible for Medicaid. In addition to meeting federal guidelines, individuals must also meet the state criteria to qualify for Medicaid coverage in Illinois.

Self-Pay

A self-pay patient would not have any type of insurance coverage (un-insured). They may be un-insured because they do not meet the eligibility requirements for Medicare or Medicaid and can not afford a commercial insurance policy.

In addition, a patient balance becomes self-pay after their primary insurance pays, but the patient does not have a supplemental insurance policy to cover the remaining balance. The AKF assistance referenced earlier may or may not be available to these patients, dependent on whether or not they meet AKF eligibility requirements.