

Original

15-057

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD  
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

DEC 04 2015

This Section must be completed for all projects.

HEALTH FACILITIES &  
SERVICES REVIEW BOARD

**Facility/Project Identification**

Facility Name: <i>Fresenius Medical Care Spoon River</i>			
Street Address <i>340 S. Avenue B</i>			
City and Zip Code: <i>Canton 61520</i>			
County: <i>Fulton</i>	Health Service Area <i>2</i>	Health Planning Area:	

**Applicant Identification**

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

Exact Legal Name: <i>Dialysis Centers of America – Illinois, Inc. d/b/a Fresenius Medical Care Spoon River</i>	
Address: <i>920 Winter Street, Waltham, MA 02451</i>	
Name of Registered Agent: <i>CT Systems</i>	
Name of Chief Executive Officer: <i>Ron Kuerbitz</i>	
CEO Address: <i>920 Winter Street, Waltham, MA 02451</i>	
Telephone Number: <i>800-662-1237</i>	

**Type of Ownership of Applicant**

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

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each
- o 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: <i>Fresenius Medical Care Holdings, Inc.</i>
Address: <i>920 Winter Street, Waltham, MA 02451</i>
Name of Registered Agent: <i>CT Systems</i>
Name of Chief Executive Officer: <i>Ron Kuerbitz</i>
CEO Address: <i>920 Winter Street, Waltham, MA 02451</i>
Telephone Number: <i>800-662-1237</i>

**Type of Ownership of Co-Applicant**

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

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

**Additional Contact**

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

Name: <i>Rick Stotz</i>
Title: <i>Regional Vice President</i>
Company Name: <i>Fresenius Medical Care</i>
Address: <i>3500 Lacey Road, Suite 900, Downers Grove, IL 60515</i>
Telephone Number: <i>630-960-6709</i>
E-mail Address: <i>richard.stotz@fmc-na.com</i>
Fax Number: <i>630-960-6812</i>

**Post Permit Contact**

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

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

**Additional Contact**

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

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

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: <i>Graham Hospital</i>
Address of Site Owner: <i>210 W. Walnut Street, Canton, IL 61520</i>
Street Address or Legal Description of Site: <i>340 S. Avenue B, Canton, IL 61520</i>
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
<b>APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>

**Operating Identity/Licensee**

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

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

**Organizational Relationships**

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

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

**Flood Plain Requirements** **NOT APPLICABLE – EXPANSION ONLY**

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at [www.FEMA.gov](http://www.FEMA.gov) or [www.illinoisfloodmaps.org](http://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** **NOT APPLICABLE – EXPANSION ONLY**

[Refer to application instructions.]

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

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

**DESCRIPTION OF PROJECT**

**1. Project Classification**

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

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.

*Dialysis Centers of America – Illinois, Inc. proposes to expand its Spoon River dialysis center, located at 340 S. Avenue B, Canton by 3 stations. The facility currently has 9 stations and the result will be a 12-station facility at the current site. One of these stations is an isolation station. The facility was operating at 83% as of September 30, 2015.*

*Fresenius Medical Care Spoon River is in HSA 2.*

*This project is “non-substantive” under Planning Board rule 1110.10(c) as it entails the addition of stations totaling more than 10% of the clinic’s current station count.*

**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.

<b>Project Costs and Sources of Funds</b>			
<b>USE OF FUNDS</b>	<b>CLINICAL</b>	<b>NONCLINICAL</b>	<b>TOTAL</b>
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	12,000	N/A	12,000
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)	70,000	N/A	70,000
Bond Issuance Expense (project related)	N/A	N/A	N/A
Net Interest Expense During Construction (project related)	N/A	N/A	N/A
Fair Market Value of Leased Space or Equipment	42,975	N/A	42,975
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
<b>TOTAL USES OF FUNDS</b>	<b>\$124,975</b>	<b>N/A</b>	<b>\$124,975</b>
<b>SOURCE OF FUNDS</b>	<b>CLINICAL</b>	<b>NON-CLINICAL</b>	<b>TOTAL</b>
Cash and Securities	82,000	N/A	82,000
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)	42,975	N/A	42,975
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
<b>TOTAL SOURCES OF FUNDS</b>	<b>\$124,975</b>	<b>N/A</b>	<b>\$124,975</b>
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

**Related Project Costs**

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

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

**Project Status and Completion Schedules**

<b>For facilities in which prior permits have been issued please provide the permit numbers.</b>	
Indicate the stage of the project's architectural drawings:	
<input checked="" type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>May 31, 2017</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
<b>APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>	

**State Agency Submittals**

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

**Cost Space Requirements**

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
In-center Hemodialysis	124,975	6,000	6,000		450		
Total Clinical	124,975	6,000	6,000		450		
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>	124,975	6,000	6,000		450		

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

**CERTIFICATION**

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

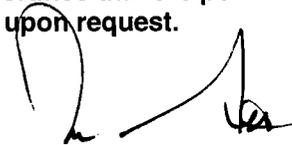
- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of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

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

  
 \_\_\_\_\_  
 SIGNATURE

\_\_\_\_\_  
 PRINTED NAME **Bryan Mello**  
**Assistant Treasurer**

\_\_\_\_\_  
 PRINTED TITLE

  
 \_\_\_\_\_  
 SIGNATURE

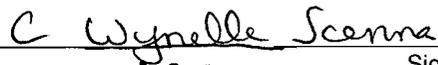
**Mark Fawcett**  
**Senior Vice President & Treasurer**  
 \_\_\_\_\_  
 PRINTED NAME

\_\_\_\_\_  
 PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_ 2015

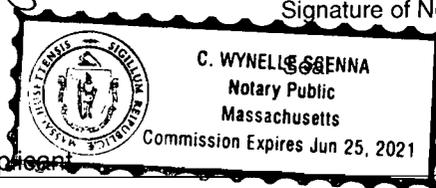
Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct 2015

\_\_\_\_\_  
 Signature of Notary



\_\_\_\_\_  
 Signature of Notary

Seal



\*Insert EXACT legal name of the applicant

**CERTIFICATION**

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

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

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

Bryan Mello  
SIGNATURE

Bryan Mello  
PRINTED NAME  
Assistant Treasurer

PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_ 2015

Mark Fawcett  
SIGNATURE

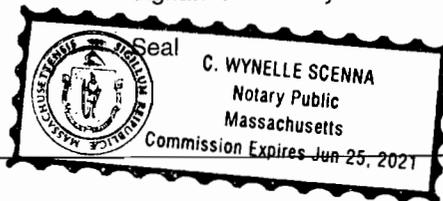
Mark Fawcett  
Senior Vice President & Treasurer  
PRINTED NAME

PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct 2015

C. Wynelle Scenna  
Signature of Notary

Seal



\*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

##### BACKGROUND OF APPLICANT

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

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

##### PURPOSE OF PROJECT

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

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

**NOTE: Information regarding the "Purpose of the Project" will be included in the State 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**

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

Alternative options **must** include:

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

**SIZE OF PROJECT:**

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

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

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

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

**PROJECT SERVICES UTILIZATION:**

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

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

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

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

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

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

Provide the following information:

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

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

**ASSURANCES: NOT APPLICABLE – THERE IS NO UNFINISHED SHELLSPACE**

Submit the following:

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

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

**SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA**

***This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:***

**G. Criterion 1110.1430 - In-Center Hemodialysis**

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

Category of Service	# Existing Stations	# Proposed Stations
<input checked="" type="checkbox"/> In-Center Hemodialysis	9	12

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

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

**APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST**

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

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

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

**VIII. - 1120.120 - Availability of Funds**

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

<u>82,000</u>	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> <li>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</li> <li>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;</li> </ol>
<u>N/A</u>	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
<u>N/A</u>	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
<u>42,975</u>	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> <li>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;</li> <li>2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;</li> <li>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.;</li> <li>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;</li> <li>5) For any option to lease, a copy of the option, including all terms and conditions.</li> </ol>
<u>N/A</u>	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
<u>N/A</u>	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
<u>N/A</u>	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
<b><u>\$124,975</u></b>	<b>TOTAL FUNDS AVAILABLE</b>

**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	<b>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.</b>			
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**

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

**A. Reasonableness of Financing Arrangements**

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

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

**B. Conditions of Debt Financing**

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

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

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

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD		26.67			450			12,000	12,000
Contingency		0			0			0	0
<b>TOTALS</b>		<b>\$26.67</b>			<b>450</b>			<b>\$12,000</b>	<b>\$12,000*</b>

Include the percentage (%) of space for circulation

\*Modernization costs include only plumbing to accommodate the three additional stations.  
Numbers have been rounded.

**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%	1.57%
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 41.

CHARITY CARE			
	2012	2013	2014
<b>Net Patient Revenue</b>	<b>\$387,393,758</b>	<b>\$398,570,288</b>	<b>\$411,981,839</b>
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:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Co-applicant Identification including Certificate of Good Standing	22-23
2	Site Ownership	24
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	25
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	26
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	27
8	Obligation Document if required	28
9	Cost Space Requirements	29
10	Discontinuation	
11	Background of the Applicant	30-35
12	Purpose of the Project	36
13	Alternatives to the Project	37
14	Size of the Project	38
15	Project Service Utilization	39-40
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	<b>Service Specific:</b>	
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	41-53
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	
	<b>Financial and Economic Feasibility:</b>	
36	Availability of Funds	
37	Financial Waiver	54
38	Financial Viability	
39	Economic Feasibility	55-59
40	Safety Net Impact Statement	60-61
41	Charity Care Information	62-64
	Appendix 1 – Physician Referral Letter	65-68

**Applicant Identification**

Exact Legal Name: <i>Dialysis Centers of America – Illinois, Inc. d/b/a Fresenius Medical Care Spoon River</i>
Address: <i>920 Winter Street, Waltham, MA 02451</i>
Name of Registered Agent: <i>CT Systems</i>
Name of Chief Executive Officer: <i>Ron Kuerbitz</i>
CEO Address: <i>920 Winter Street, Waltham, MA 02451</i>
Telephone Number: <i>800-662-1237</i>

**Type of Ownership of Applicant**

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

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

**\*Certificate of Good Standing for Dialysis Centers of America – Illinois, Inc. on following page.**

**Co-Applicant Identification**

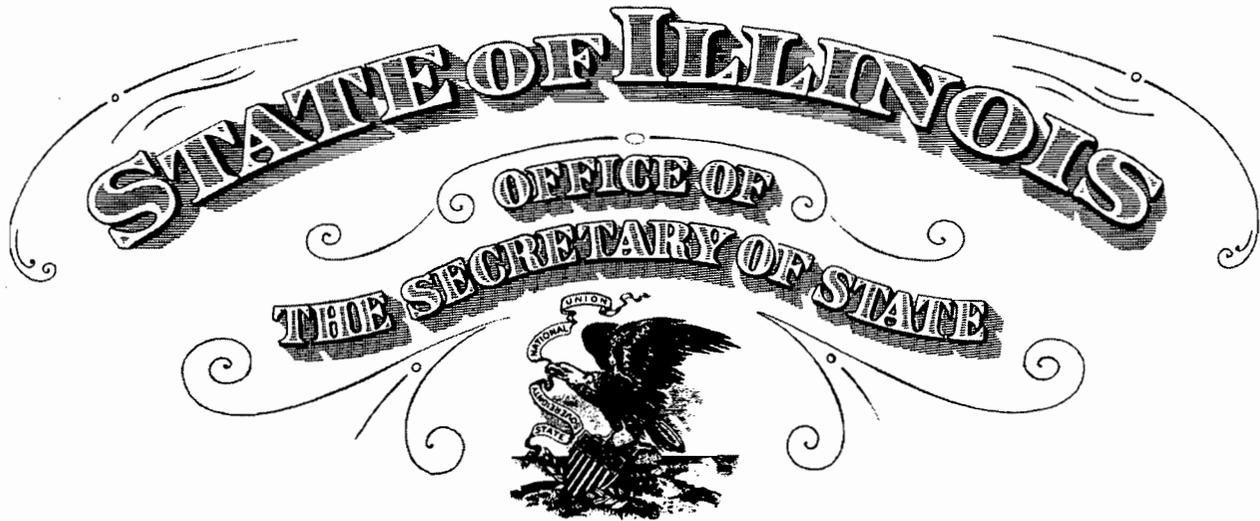
**Provide for each co-applicant [refer to Part 1130.220]**

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

**Type of Ownership of Co-Applicant**

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

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



**To all to whom these Presents Shall Come, Greeting:**

*I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that*

DIALYSIS CENTERS OF AMERICA-ILLINOIS, INC., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 11, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

***In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 19TH day of OCTOBER A.D. 2015 .***



Authentication #: 1529203146 verifiable until 10/19/2016  
Authenticate at: <http://www.cyberdriveillinois.com>

*Jesse White*

SECRETARY OF STATE

Certificate of Good Standing  
ATTACHMENT - 1

## Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: <i>Graham Hospital</i>
Address of Site Owner: <i>210 W. Walnut Street, Canton, IL 61520</i>
Street Address or Legal Description of Site: <i>340 S. Avenue B, Canton, IL 61520</i> <b>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.</b>

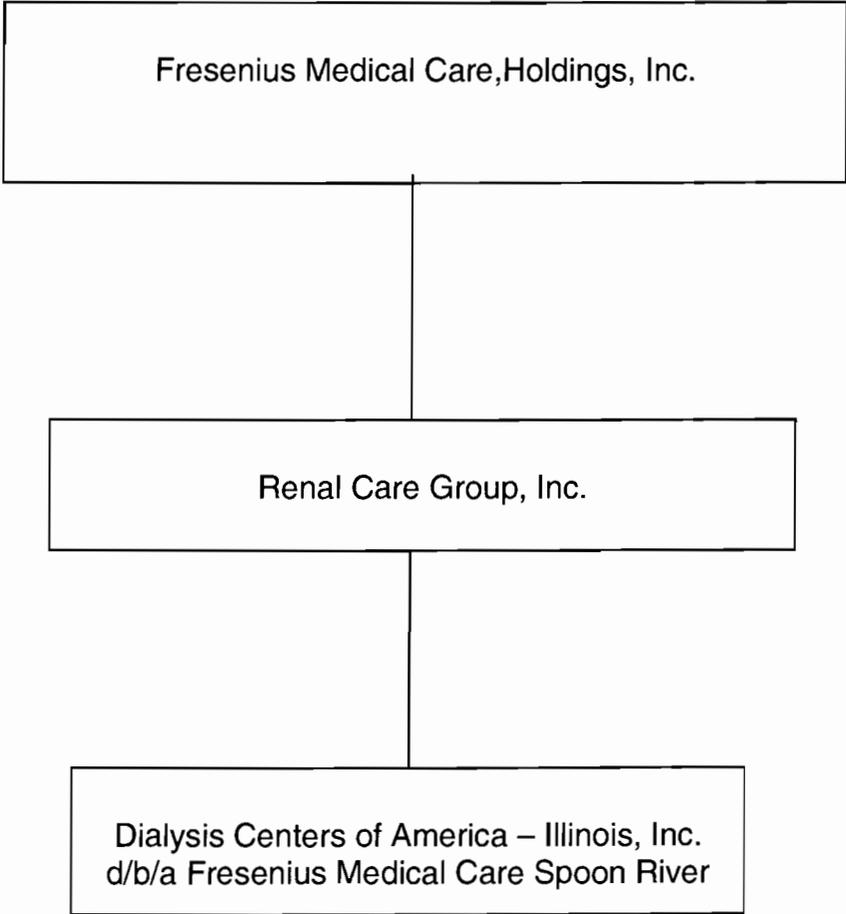
## Operating Identity/Licensee

Exact Legal Name: *Dialysis Centers of America – Illinois, Inc. d/b/a Fresenius Medical Care Spoon River*  
Address: *920 Winter Street, Waltham, MA 02451*

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

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

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



**SUMMARY OF PROJECT COSTS**

<b>Modernization</b>	
Plumbing	12,000
<b>Total</b>	<b>\$12,000</b>
<b>Contingencies</b>	
	<b>\$0</b>
<b>Architecture/Engineering Fees</b>	
	<b>\$0</b>
<b>Moveable or Other Equipment</b>	
Dialysis Chairs	15,000
Clinical Furniture & Equipment	10,000
Office Equipment & Other Furniture	0
Water Treatment	0
TVs & Accessories	40,000
Telephones	0
Generator	0
Facility Automation	0
Other miscellaneous	5,000
	<b>\$70,000</b>
<b>Fair Market Value of Leased Space and Equipment</b>	
FMV Leased Dialysis Machines	42,975
	<b>\$42,975</b>
<b>Grand Total</b>	<b>\$124,975</b>

## Current CON Permits and Status

Project Number	Name	Project Type	Completion Date
#12-098	Fresenius Medical Care Maple City	Establishment	02/28/2015
#14-012	Fresenius Medical Care Gurnee	Relocation/Expansion	12/31/2015
#14-019	Fresenius Medical Care Summit	Establishment	12/31/2015
#13-040	Fresenius Medical Care Lemont	Establishment	09/30/2016
#14-041	Fresenius Medical Care Elgin	Expansion	06/30/2016
#14-026	Fresenius Medical Care 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
#15-022	Fresenius Medical Care Blue Island	Expansion	12/31/2016
#15-024	Fresenius Medical Care Chicago	Change of Ownership	01/31/2016
#15-034	Fresenius Medical Care South Holland	Expansion	12/31/2015
#15-028	Fresenius Medical Care Schaumburg	Establishment	02/28/2017
#15-036	Fresenius Medical Care Zion	Establishment	06/30/2017

**Cost Space Requirements**

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
<b>REVIEWABLE</b>							
In-Center Hemodialysis	\$124,975	6,000	6,000		450		
Total Clinical	\$124,975	6,000	6,000		450		
<b>NON REVIEWABLE</b>							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
<b>TOTAL</b>	\$124,975	6,000	6,000		450		

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

## **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.

Alongside our core business with dialysis products and the treatment of dialysis patients, Fresenius Medical Care maintains a network of additional medical services to better address the full spectrum of our patients' health care needs. These include pharmacy services, vascular, cardiovascular and endovascular surgery services, non-dialysis laboratory testing services, physician services, hospitalist and intensivist services, non-dialysis health plan services and urgent care services. We have a singular focus: improving the quality of life of every patient every day.

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 \$22,000 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.

Certification & Authorization

Dialysis Centers of America - Illinois, 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 Dialysis Centers of America - Illinois, Inc. by either Medicare or Medicaid, or any State or Federal regulatory authority during the 3 years prior to the filing of the Application with the Illinois Health Facilities Planning Board; and

In regards to section III, A (3) of the Illinois Health Facilities & 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: [Signature]  
ITS: Bryan Mello  
Assistant Treasurer

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

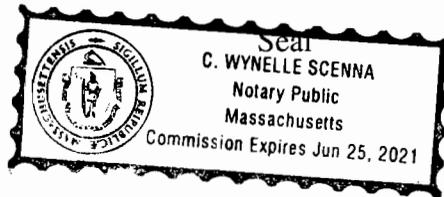
Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 2015

Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct, 2015

Signature of Notary C Wynelle Scenna

Signature of Notary

Seal



Certification & Authorization

Fresenius Medical Care Holdings, Inc.

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

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

By: [Signature]  
ITS: Bryan Mello  
Assistant Treasurer

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

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 2015

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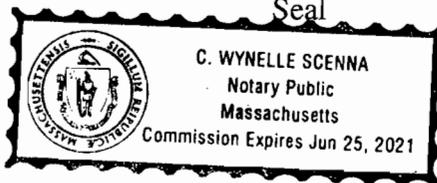
\_\_\_\_\_  
Signature of Notary

C Wynelle Scenna

\_\_\_\_\_  
Signature of Notary

Seal

Seal



**Fresenius Medical Care Holdings, Inc. In-center Clinics in Illinois**

<b>Clinic</b>	<b>Provider #</b>	<b>Address</b>	<b>City</b>	<b>Zip</b>
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	Deerfield	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	14-2782	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

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

## Criterion 1110.230 – Purpose of Project

1. The purpose of this project is to maintain life-sustaining dialysis services, cost effectively, in the Canton area by adding 3 stations in existing space to the Fresenius Spoon River 9-station ESRD facility currently operating at 83% utilization with 45 patients. The addition will raise the total station count at the facility to 12.
2. This facility is located in Canton in Fulton County, which is part of HSA 2.
3. The Spoon River facility is currently operating at 83%. One station was added in 2014, but this station is used only for patients who require isolation from other patients due to infectious disease. If this station is removed from the utilization calculation the facility is operating at 94%. This facility also has seen excessive growth in the past year and a half - from 27 patients to 45 currently.
4. Not Applicable
5. Increasing the station count at the Fresenius Spoon River facility will maintain access to dialysis services in Fulton County where there are no other dialysis clinics within 30 minutes. The Canton area is rural and with the clinic operating at a high utilization rate the unpopular third shift of the day is the only shift that is left available to new patients. Most rural clinics try to dialyze patients on the two daytime shifts, per patient preference, which allows the patients safer daytime hours for travelling country roads and offers them more transportation choices.
6. The goal of Fresenius Medical Care is to keep dialysis access available to this rural patient population. There is no direct empirical evidence relating to this project other than that when chronic care patients have adequate access to services, it tends to reduce overall healthcare costs and results in less complications. It is expected that this facility would continue to have similar quality outcomes after the expansion. Currently the Spoon River patients have exceptional quality outcomes as listed below:
  - 100% of patients had a URR  $\geq$  65%
  - 100% of patients had a Kt/V  $\geq$  1.2

**Alternatives**

**1) All Alternatives**

A-C.

- The alternative to do nothing will not address patient access issues due to the high utilization currently at the Spoon River facility and therefore was not considered. There is no cost to this alternative.
- There are no other facilities within 30 minutes of Spoon River to refer the Canton area patients to so this is not an alternative for the high utilization at Spoon River. There is no cost to referring patients to other area facilities.
- The facility is not currently a joint venture and there is no physician interest in doing so. Even so, it would not make sense to enter into one just to add three stations.

D. The best alternative for addressing the patient's need for additional access in Fulton County while remaining cost effective is to add 3 stations at the current site in existing space. The cost of this project is minimal at \$124,975.

**2) Comparison of Alternatives**

	<b>Total Cost</b>	<b>Patient Access</b>	<b>Quality</b>	<b>Financial</b>
Do Nothing	Rejected – won't address patient access issues.			
Admit patients to other area facilities.	There are no other facilities within 30 minutes of Canton to refer patients to.			
Establish a Joint Venture	There is no interest in joint venture on this facility and it would not make sense to joint venture simply to add three stations.			
Expand Fresenius Spoon River by 3 stations.	\$124,975	Access to dialysis treatment will be maintained in Canton. Patients will have treatment shift options with additional stations.	Fresenius Medical Care Spoon River's quality is exceptional and it is expected to remain so.  With access to treatment patient's transportation problems will decrease and thus missed treatments keeping quality high.	This cost is to Fresenius only.  The patients will benefit by having lower transportation costs.

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

There is no direct empirical evidence relating to this project other than that when chronic care patients have adequate access to services, it tends to reduce overall healthcare costs and results in less complications. Fresenius Spoon River has had above standard quality outcomes as demonstrated below.

- 100% of patients had a URR  $\geq$  65%
- 100% of patients had a Kt/V  $\geq$  1.2

**Criterion 1110.234, Size of Project**

<b>SIZE OF PROJECT</b>				
<b>DEPARTMENT/SERVICE</b>	<b>PROPOSED BGSF/DGSF</b>	<b>STATE STANDARD 450-650 BGSF Per Station</b>	<b>DIFFERENCE</b>	<b>MET STANDARD?</b>
ESRD IN-CENTER HEMODIALYSIS	6,000 (12 Stations)	5,400 – 7,800 BGSF	None	Yes

The facility's 6,000 BGSF meets the State standard for a 12 station facility.

**Criterion 1110.234, Project Services Utilization**

<b>UTILIZATION</b>					
	<b>DEPT/SERVICE</b>	<b>HISTORICAL UTILIZATION</b>	<b>PROJECTED UTILIZATION</b>	<b>STATE STANDARD</b>	<b>MET STANDARD?</b>
	IN-CENTER HEMODIALYSIS	83% 9 Stations 9/30/2015		80%	Yes
<b>YEAR 1</b>	IN-CENTER HEMODIALYSIS	12 Stations	74%	80%	No
<b>YEAR 2</b>	IN-CENTER HEMODIALYSIS	12 Stations	89%	80%	Yes

The Spoon River facility has already met the State standard utilization target of 80%. The facility is currently at 83% utilization with 45 patients. Three additional stations would drop the utilization to 63%; however there were a total of 24 admissions in 2014 according to the Annual ESRD Survey and in the past twelve months the physician supporting this project referred 12 new patients to the Fresenius Spoon River facility. Dr. Horinek has identified an additional 47 pre-ESRD patients who he will potentially refer to the facility in the first two years after the three new stations are in operation. If even the historic referral rate is maintained, utilization will be near 89% by the second year the stations are operating.

# END STAGE RENAL DIALYSIS - FACILITY PROFILE 2014

## Ownership, Management and General Information

<b>Name:</b> Fresenius Medical Care - Spoon River	<b>Legal Entity Operator:</b> Dialysis Centers of America - Illinois, Inc.
<b>Address:</b> 340 S. Avenue B	<b>Legal Entity Owner:</b>
<b>City:</b> Canton	<b>Ownership Type:</b> For Profit Corporation
<b>County:</b> Fulton	<b>Property Owner:</b> Graham Hospital
<b>HSA:</b> 2	<b>Other Ownership:</b>
<b>Medicare ID:</b> 14-2565	<b>Medical Director Name:</b> Anthony Horinek, M.D.
	<b>Provides Incenter Nocturnal Dialysis:</b> <input type="checkbox"/>

### STATION INFORMATION

Authorized Stations as of 12/31/2014:	9
Certified Stations by CMS:	9
Peak Authorized Stations Operated:	9
Authorized Stations Setup and Staffed in Oct 1-7:	9
Isolation Stations Set up in Oct 1-7: (subset of authorized stations)	1
Number of Shifts Operated per day	

### FACILITY STAFFING - FULL TIME EQUIVALENT

Full-Time Work Week:	32
Registered Nurse :	2
Dialysis Technician :	5
Dietician :	0
Social Worker:	0
LPN :	0
Other Health :	0
Other Non-Health:	1

### Dialysis Station Utilization for the Week of Oct 1 - 7

Date of Operation	Oct 1	Oct 2	Oct 3	Oct 4	Oct 5	Oct 6	Oct 7
Hours operated	16	13	16	13	0	16	13
Number of Patients Treated	19	15	19	13	0	21	15

## Facility Utilization Information

### Facility Reported Patient Information

Patients treated as of 1/1/2014: (Beginning patients)	34
Patients treated as of 12/31/2014: (Ending patients)	38
Total Unduplicated patients treated in calendar year:	55

### Facility Reported Treatment Information

In-Center Treatments in calendar year:	5,351
Number of Missed Treatments:	57
Average Daily Treatments:	
Average Treatment Time (min):	300.0

### ADDITIONS to the FACILITY

New Patients:	18
Transient Patients:	3
Patients Re-Started:	1
Post-Transplant Patien	2
Total:	24

### LOSSES to the FACILITY

Recovered patients:	1
Transplant Recipients:	0
Patients transferred out:	7
Patients voluntarily discontinued	6
Patients lost to follow up:	0
Patients deceased:	6
Total:	20

### USE RATE for the FACILITY

Treatment Capacity/year (based on Stations):	8,424
Use Rate (Treatments/Treatment capacity):	64%
Use Rate (including Missed Treatments):	64%
Use Rate (Beginning patients treated):	63%
Use Rate (Year end Patients/Stations*6):	70%

### Patients and Net Revenue by Payor Source

	Medicare	Medicaid	Private Insurance	Private Pay	Other Public	TOTAL	Charity Care
	72.7%	5.5%	21.8%	0.0%	0.0%	100.0%	0.0%
Patient	40	3	12	0	0	55	0
1/1/2013 to 12/31/2013	44.2%	0.5%	55.0%	0.3%	0.0%	100.0%	0.0%
Net Revenue	\$1,015,662	\$11,771	\$1,263,491	\$7,342	\$0	\$2,298,266	\$0

### Patients by Age and Sex

AGE GROUPS	MALE	FEMALE	TOTAL
<14 yrs	0	0	0
15-44 yr	2	1	3
45-64 yr	7	4	11
65-74 yr	7	8	15
75 < yrs	17	9	26
Total	33	22	55

### Patients by Race

Asian Patients:	0
Native American/ Indian:	0
Black/ African American :	2
Hawaiian /Pacific Islande	0
White:	53
Unknown :	0
TOTAL:	55

### Patients by Ethnicity

Hispanic Latino Patients:	0
Non-Hispanic Latino Patien	55
Unknown Ethnicity Patients	0
TOTAL:	55

Fresenius Medical Care does not hold long term debt on any Illinois dialysis location balance sheet. Fresenius Medical Care does not, as a for profit corporation, provide charity care under the Board's definition of same; however, it treats all patients regardless of ability to pay and thus does provide uncompensated care.

Source: Data based on 2014 Annual ESRD Questionnaire administered on behalf of Illinois Department of Public Health, Health Systems Development.

**Planning Area Need – Formula Need Calculation:**

Fresenius Medical Care Spoon River is located in Canton (Fulton County) which is part of HSA 2. HSA 2 is comprised of Bureau, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, Warren, and Woodford Counties. According to the October 2015 Inventory there is an excess of 13 stations in this HSA.

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

- A. The primary purpose of this project is to maintain in-center hemodialysis services to the residents of the Canton area market in HSA 2 in Fulton County. All of the patients currently dialyzing at the Spoon River facility as well as all pre-ESRD patients identified reside in HSA 2 thereby meeting this requirement.

## Service Demand – Expansion of In-center Hemodialysis Service

### A. Historical Service Demand

1. The Spoon River facility is currently operating at 83% despite the addition of one station in 2014. However, this one station was installed to serve a small population of patients who require isolation from other patients due to infectious disease. If the utilization calculation excluded this station the facility would now be at 94% utilization. Although the average utilization rate for the past year was just below 80%, at 77%, the facility has grown excessively during this time from 27 patients to 45 currently.

See physician support/referral letter.



**Illinois  
Kidney Disease &  
Hypertension Center**



**RenalCare**  
Associates, S.C.

Nephrology Associates  
Alexander J. Alonso, M.D.  
Robert Bruha, M.D.  
Sudha Cherukuri, M.D.  
Anthony R. Horinek, M.D.  
Raji Jacob, M.D.  
Gordon W. James, M.D.  
Amit B. Jamnadas, M.D.  
Dinesh K. Kannabhiran, M.D.  
Smitha R. Pamulaparthi, M.D.  
Benjamin R. Pflederer, M.D.  
Timothy A. Pflederer, M.D.  
David C. Rosborough, M.D.  
Samer B. Sader, M.D.  
Kumarpal C. Shrishrimal, M.D.  
Robert T. Sparrow, M.D., FASH  
Parthasarathy Srinivasan, M.D.

December 1, 2015

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

Surgery Associates  
Beverly L. Ketel, M.D.  
Timothy P. O'Connor, M.D., F.A.C.S.

Dear Ms. Avery:

Physician Assistants  
Julie A. DeSutter, P.A.-C.  
Holly R. Walker, P.A.-C.

I am a nephrologist in practice with Renal Care Associates (RCA) and am the Medical Director of the Fresenius Spoon River dialysis clinic. This is a small (9-station) rural clinic operating at 83% utilization. Most of my patients are elderly and travel long distances for treatment. Due to the high utilization I am not able to offer reasonable treatment schedule times. I prefer to accommodate my patients in the morning and afternoon hours to avoid travel at night on the dark and sometimes hazardous county roads.

Nurse Practitioners  
Judith A. Dansizen, A.P.R.N.-B.C.  
Karen A. Helfers, F.N.P.  
Tonya K. McDougall, F.N.P.  
Jill C. Peterson, A.N.P.

The facility recently added one station however this is a station dedicated for patients who require isolation from other patients and cannot be used for the general population of ESRD patients. It is therefore not an option of my new patients.

Administrator  
Beth A. Shaw, MBA

Main Offices  
Peoria  
200 E. Pennsylvania Ave., Suite 212  
(309) 676-8123

Bloomington  
1404 Eastland Drive, Suite 103  
(309) 663-4766

Galesburg  
765 N. Kellogg, Suite 203  
(309) 343-4114

Ottawa  
1050 E. Norris Dr., Suite 2C  
(815) 431-0785

I was treating 30 patients at the end of 2012 and 46 patients at the end of 2013, 58 at the end of 2014, and 62 as of the most recent quarter. I see these patients at the Spoon River clinic and at Fresenius East Peoria. Over the past twelve months I referred 27 new hemodialysis patients for services to these two facilities. There are 192 pre-ESRD patients that live in the zip codes surrounding the Canton area. Of these there are 47 that I expect to begin dialysis at Spoon River in the first two years after the three additional stations are in operation. These patients all have lab values indicative of a patient in active kidney failure.

With the increase of pre-ESRD patients in my practice, I urge the Board to approve the addition of three stations at the Fresenius Medical Care Spoon River facility in order to keep access available to this rural ESRD patient population. Thank you for your consideration.



Illinois  
Kidney Disease &  
Hypertension Center



RenalCare  
Associates, S.C.

Nephrology Associates  
Alexander J. Alonso, M.D.  
Robert Bruha, M.D.  
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Samer B. Sader, M.D.  
Kumarpal C. Shrishrimal, M.D.  
Robert T. Sparrow, M.D., FASH  
Parthasarathy Srinivasan, M.D.

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

Sincerely,

Anthony Horinek, M.D.

Surgery Associates  
Beverly L. Ketel, M.D.  
Timothy P. O'Connor, M.D., F.A.C.S.

Physician Assistants  
Julie A. DeSutter, P.A.-C.  
Holly R. Walker, P.A.-C.

Nurse Practitioners  
Judith A. Dansizen, A.P.R.N.-B.C.  
Karen A. Helfers, F.N.P.  
Tonya K. McDougall, F.N.P.  
Jill C. Peterson, A.N.P.

Administrator  
Beth A. Shaw, MBA

Main Offices  
Peoria  
200 E. Pennsylvania Ave., Suite 212  
(309) 676-8123

Bloomington  
1404 Eastland Drive, Suite 103  
(309) 663-4766

Galesburg  
765 N. Kellogg, Suite 203  
(309) 343-4114

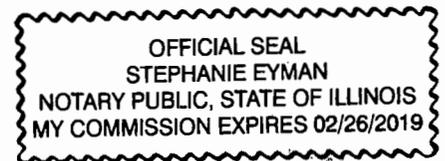
Ottawa  
1050 E. Norris Dr., Suite 2C  
(815) 431-0785

Notarization:

Subscribed and sworn to before me  
this 1<sup>st</sup> day of Dec., 2015

Signature of Notary

Seal



**CURRENT SPOON RIVER PATIENTS****IDENTIFIED PRE-ESRD PATIENTS**

Zip Code	Patients
61520	24
62644	4
61542	4
61529	3
61531	3
61553	1
61441	2
61533	1
61432	1
61427	1
61569	1
<b>Total</b>	<b>45</b>

Zip Code	Patients
61427	2
61431	1
61432	1
61458	1
61477	1
61520	22
61529	2
61531	5
61533	4
61542	5
61544	1
61563	2
61569	2
61572	2
<b>Total</b>	<b>47</b>

**NEW REFERRALS OF DR. HORINEK FOR THE PAST TWELVE MONTHS**

Fresenius E. Peoria	
Zip Code	Patients
61523	1
61545	1
61548	1
61550	1
61554	2
61571	3
61603	1
61605	2
61610	1
61611	1
61614	1
<b>Total</b>	<b>15</b>

Fresenius Spoon River	
Zip Code	Patients
60406	1
61432	1
61441	1
61520	5
61529	1
61542	2
61569	1
<b>Total</b>	<b>12</b>

<b>Grand Total</b>	<b>27</b>
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**HEMODIALYSIS PATIENTS OF DR. HORINEK**

<b>Facility</b>	<b>Zip Code</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
East Peoria	61523		2		1
East Peoria	61530			1	1
East Peoria	61536	1	2	1	
East Peoria	61540		1		
East Peoria	61545			1	2
East Peoria	61548		2	2	1
East Peoria	61550		2	1	2
East Peoria	61554	1	1	1	
East Peoria	61571	4	2	3	4
East Peoria	61603	2	1	3	2
East Peoria	61604				2
East Peoria	61605	2	1		
East Peoria	61607			1	1
East Peoria	61610			2	1
East Peoria	61611	1	1	1	2
East Peoria	61612			1	1
East Peoria	61614		1	1	1
East Peoria	61616			2	1
East Peoria	61650		1		
Spoon River	61432			1	1
Spoon River	61441		1	1	2
Spoon River	61520	9	15	19	19
Spoon River	61524	1	1		
Spoon River	61529	1	1	2	3
Spoon River	61531	2	4	3	3
Spoon River	61533	1		1	1
Spoon River	61542	1	3	5	6
Spoon River	61553			1	1
Spoon River	61569	2	3	1	1
Spoon River	62644	2	1	3	3
	<b>Total</b>	<b>30</b>	<b>46</b>	<b>58</b>	<b>62</b>

Criterion 1110.1430 (e)(1) – Staffing

2) A. Medical Director

Anthony Horinek, M.D. is currently the Medical Director for Fresenius Medical Care Spoon River. Attached is his curriculum vitae.

B. All Other Personnel

The Spoon River facility currently employs the following staff:

- 1 FT Clinic Manager who is a Registered Nurse
- 3 FT Registered Nurses
- 5 FT Patient Care Technicians
- 1 PT Registered Dietitian
- 1 PT Licensed Master level Social Worker
- 1 PT Equipment Technician
- 1 PT Secretary

After the expansion the facility will hire one additional Registered Nurse.

- 3) All patient care staff and licensed/registered professionals will meet the State of Illinois requirements. Any additional staff hired must also meet these requirements along with completing a 9 week orientation training program through the Fresenius Medical Care staff education department.

Annually all clinical staff must complete OSHA training, Compliance training, CPR Certification, Skills Competency, CVC Competency, Water Quality training and pass the Competency Exam.

- 4) The above staffing model is required to maintain a 4 to 1 patient-staff ratio at all times on the treatment floor. A RN will be on duty at all times when the facility is in operation.

## CURRICULUM VITAE

Anthony R. Horinek, M.D.

### PERSONAL INFORMATION x

Date of Birth: October 4, 1970  
Place of Birth: Atwood, Kansas  
Home Telephone: .

Work Address: RenalCare Associates, S.C.  
200 E. Pennsylvania Ave. Suite 212  
Peoria, Illinois, 61603

RenalCare Associates, S.C.  
1404 Eastland Drive, Suite 103  
Bloomington, Illinois 61701

Renal Intervention Center  
430 Maxine Drive  
Morton, Illinois 61550

Work Telephone: 309/676-8123  
Work Fax: 309/676-8455

### UNDERGRADUATE EDUCATION

01/12/90-05/17/90 Fort Hays State University, 600 Park Street  
08/21/90-12/12/90 Hays, KS 67601  
08/22/91-05/15/92

08/20/93-05/12/94 Associate Degree in Biology  
Colby Community College, 1255 South Range,  
Colby, KS 67701

08/15/92-05/12/93 Bachelor of Science Degree in Cellular Biology  
08/15/94-05/15/95 University of Kansas  
1450 Jayhawk Boulevard, Room 121,  
Lawrence, KS 66045

### MEDICAL SCHOOL EDUCATION

08/14/95-05/15/97 University of Kansas School of Medicine-KC Campus  
3901 Rainbow Boulevard, Kansas City, KS 66160

05/28/97-05/15/99 Medical Degree  
University of Kansas School of Medicine-Wichita Campus  
1010 North Kansas, Wichita, KS 67215

## POST GRADUATE EDUCATION

- 07/01/99-06/30/03      Medicine/Pediatrics Residency  
University of Illinois at Peoria, 530 NE Glen Oak Avenue, Peoria, IL  
61637  
Director: Richard Horndash, MD
- 07/01/03-06/30/05      Nephrology Fellowship  
University of Missouri-Columbia, One Hospital Drive, Room MA436,  
Columbia, MO 65212  
Director: Ramesh Khanna, MD

## HONORS AND AWARDS

- 2002              Walter Tunnessen Jr., MD, Award  
2003              Outstanding Pediatric Resident Teacher Award  
2002              Outstanding Pediatric Resident Teacher Award

## SCHOLASTIC TESTING

USMLE Part I	87	220
USMLE Part II	84	210
USMLE Part III	96	236

## CERTIFICATION AND LICENSURE

- 2003              American Board of Internal Medicine, Certificate #222765  
2005              Illinois State Medical License #036-109367  
2008              American Board of Pediatrics, Certification

## PAST EMPLOYMENT

- 2004-2005      Medical Officer of the Day – VA, Columbia, MO  
1996-1997      Kansas University Medical Center  
EKG Technician  
1988-1999      Kansas Army National Guard  
Medical Service Officer  
Combat Medic  
Wheel Vehicle Mechanic  
12/90-06/91    Service in SW Asia

## HOSPITAL STAFF APPOINTMENTS

- 2005-present    St. Francis Medical Center, Peoria, Illinois, temporary staff

2005-present Methodist Medical Center, Peoria, Illinois, courtesy staff  
2005-present Proctor Hospital, Peoria, Illinois, courtesy staff  
2005-present Graham Hospital, Canton, Illinois, temporary staff  
2005-present Pekin Hospital, Pekin, Illinois, pending staff  
2005-present BroMenn Health Care, Normal, Illinois, temporary staff  
2005-present St. Joseph's Medical Center, Bloomington, Illinois, provisional staff  
2005-present St. Margaret's Hospital, Spring Valley, Illinois, consulting staff  
2005-present Kewanee Hospital, Kewanee, Illinois, provisional staff  
2005-present Hopedale Medical Complex, Hopedale, Illinois, courtesy staff

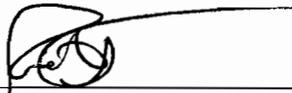
**PROFESSIONAL AFFILIATIONS**

2003-present American Society of Nephrology  
2003-present National Kidney Foundation  
1995-present American Medical Association  
1993-present Phi Theta Kappa  
1999-2003 American Academy of Pediatrics

Criterion 1110.1430 (f) – Support Services

I am the Regional Vice President of the Central Illinois Region of Fresenius Medical Care, which includes the Fresenius Medical Care Spoon River facility. In accordance with 77 Il. Admin Code 1110.1430, I certify to the following:

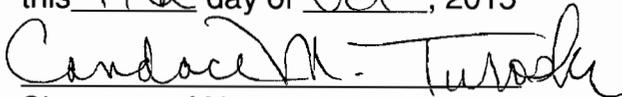
- Fresenius Medical Care utilizes a patient data tracking system in all of its facilities.
- These support services are available at Fresenius Medical Care Spoon River during all six shifts:
  - Nutritional Counseling
  - Psychiatric/Social Services
  - Home/self training
  - Clinical Laboratory Services – provided by Spectra Laboratories
- The following services are provided via referral to Graham Hospital, Canton:
  - Blood Bank Services
  - Rehabilitation Services
  - Psychiatric Services



Signature – Rick Stotz

Regional Vice President/Manager  
Title

Subscribed and sworn to, before me  
this 19~~th~~ day of Oct, 2015



Signature of Notary

Seal



Criterion 1110.1430 (j) – Assurances

I am the Regional Vice President of the Central Illinois Chicago Region of Fresenius Medical Care. In accordance with 77 Il. Admin Code 1110.1430, and with regards to Fresenius Medical Care Spoon River, I certify the following:

1. As supported in this application through expected referrals to Fresenius Medical Care Spoon River in the first two years after the addition of the new stations, the facility is expected to achieve and maintain the utilization standard, specified in 77 Ill. Adm. Code 1100, of 80% and;
2. Fresenius Medical Care hemodialysis patients at Fresenius Medical Care Spoon River have achieved adequacy outcomes of:
  - o 100% of patients had a URR  $\geq$  65%
  - o 100% of patients had a Kt/V  $\geq$  1.2

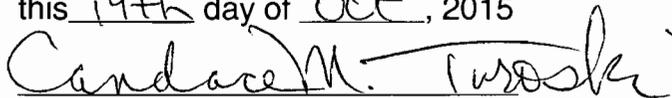
These are expected to remain the same.



Signature – Richard Stotz

Regional Vice President/Manager  
Title

Subscribed and sworn to before me  
this 19th day of Oct, 2015



Signature of Notary

Seal



## **Criterion 1120.310 Financial Viability**

### Financial Viability Waiver

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

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 bulk 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.

**Criterion 1120.310(a) Reasonableness of Financing Arrangements**

Dialysis Centers of America – Illinois, Inc.

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

  
\_\_\_\_\_  
SIGNATURE  
\_\_\_\_\_  
PRINTED NAME **Bryan Mello**  
**Assistant Treasurer**  
\_\_\_\_\_  
PRINTED TITLE

  
\_\_\_\_\_  
SIGNATURE  
\_\_\_\_\_  
PRINTED NAME **Mark Fawcett**  
**Senior Vice President & Treasurer**  
\_\_\_\_\_  
PRINTED TITLE

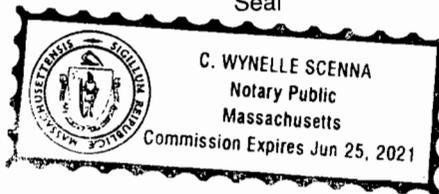
Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_ 2015

Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct 2015

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

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Seal



**Criterion 1120.310(a) Reasonableness of Financing Arrangements**

Fresenius Medical Care Holdings, Inc.

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

By: *B. Mello*  
Title: Bryan Mello  
Assistant Treasurer

By: *[Signature]*  
Title: Mark Fawcett  
Senior Vice President & Treasurer

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 2015

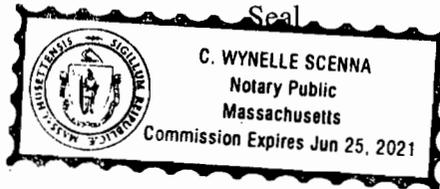
Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct, 2015

\_\_\_\_\_  
Signature of Notary

*C Wynelle Scenna*  
Signature of Notary

Seal

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**Criterion 1120.310(b) Conditions of Debt Financing**

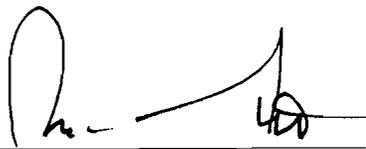
Dialysis Centers of America – Illinois, Inc.

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

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

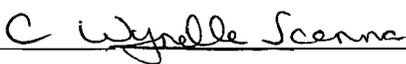
The expenses incurred with leasing the proposed facility and cost of leasing the equipment is less costly than constructing a new facility or purchasing new equipment.

  
\_\_\_\_\_  
SIGNATURE  
\_\_\_\_\_  
PRINTED NAME **Bryan Mello**  
**Assistant Treasurer**  
\_\_\_\_\_  
PRINTED TITLE

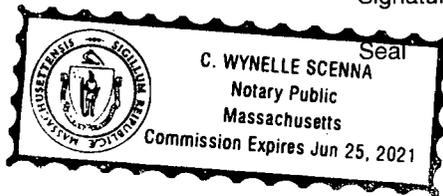
  
\_\_\_\_\_  
SIGNATURE  
**Mark Fawcett**  
**Senior Vice President & Treasurer**  
\_\_\_\_\_  
PRINTED NAME  
\_\_\_\_\_  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_ 2015

Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct 2015

\_\_\_\_\_  
Signature of Notary  Signature of Notary

Seal



**Criterion 1120.310(b) Conditions of Debt Financing**

Fresenius Medical Care Holdings, Inc.

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

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

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

By: *Bryan Mello*  
ITS: Bryan Mello  
Assistant Treasurer

By: *Mark Fawcett*  
ITS: Mark Fawcett  
Senior Vice President & Treasurer

Notarization:  
Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 2015

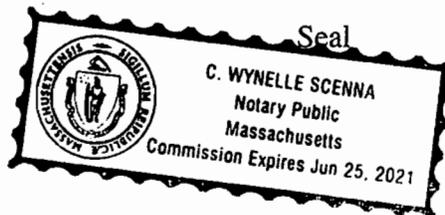
Notarization:  
Subscribed and sworn to before me  
this 27 day of Oct, 2015

\_\_\_\_\_  
Signature of Notary

*C. Wynelle Scenna*  
Signature of Notary

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**Criterion 1120.310 (c) Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

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

<b>COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE</b>									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	
ESRD		26.67			450			12,000	12,000
Contingency		0			0			0	0
<b>TOTALS</b>		<b>\$26.67</b>			<b>450</b>			<b>\$12,000</b>	<b>\$12,000*</b>

Include the percentage (%) of space for circulation

\*Modernization costs include only plumbing to accommodate the three additional stations. Numbers have been rounded.

**Year 2016**

Estimated Personnel Expense:	\$528,000
Estimated Medical Supplies:	\$115,980
Estimated Other Supplies (Exc. Dep/Amort):	\$660,000
	<u>\$1,303,980</u>
Estimated Annual Treatments:	6,000
Cost Per Treatment:	\$217.33

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

**Year 2016**

Depreciation/Amortization:	\$127,000
Interest	<u>\$0</u>
Capital Costs:	\$127,000
Treatments:	6,000
Capital Cost per Treatment	\$21.17

## Safety Net Impact Statement

The expansion of the Fresenius Medical Care Spoon River dialysis facility will not have any impact on safety net services in Fulton County. 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.

<b>CHARITY CARE</b>			
Net Revenue	\$387,393,758	\$398,570,288	\$411,981,839
	<b>2012</b>	<b>2013</b>	<b>2014</b>
Charity *			
(# of self-pay patients)	203	499 <sup>1</sup>	251 <sup>2</sup>
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%
<b>MEDICAID</b>			
	<b>2012</b>	<b>2013</b>	<b>2014</b>
Medicaid (# of patients) <sup>3</sup>	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

<b>CHARITY CARE</b>			
	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Net Patient Revenue</b>	<b>\$387,393,758</b>	<b>\$398,570,288</b>	<b>\$411,981,839</b>
<b>Amount of Charity Care (charges)</b>	\$1,566,380	\$5,346,976	\$5,211,664
<b>Cost of Charity Care</b>	\$1,566,380	\$5,346,976	\$5,211,664
<b>Ratio Charity Care Cost to Net Patient Revenue</b>	.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.

Nephrology Associates

Alexander J. Alonso, M.D.  
Robert Bruha, M.D.  
Sudha Cherkuri, M.D.  
Anthony R. Horinek, M.D.  
Raji Jacob, M.D.  
Gordon W. James, M.D.  
Amit B. Janmadas, M.D.  
Dinesh K. Kannabhiran, M.D.  
Smitha R. Pamulaparthi, M.D.  
Benjamin R. Pflederer, M.D.  
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David C. Rosborough, M.D.  
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Parthasarathy Srinivasan, M.D.

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December 1, 2015

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

Dear Ms. Avery:

I am a nephrologist in practice with Renal Care Associates (RCA) and am the Medical Director of the Fresenius Spoon River dialysis clinic. This is a small (9-station) rural clinic operating at 83% utilization. Most of my patients are elderly and travel long distances for treatment. Due to the high utilization I am not able to offer reasonable treatment schedule times. I prefer to accommodate my patients in the morning and afternoon hours to avoid travel at night on the dark and sometimes hazardous county roads.

The facility recently added one station however this is a station dedicated for patients who require isolation from other patients and cannot be used for the general population of ESRD patients. It is therefore not an option of my new patients.

I was treating 30 patients at the end of 2012 and 46 patients at the end of 2013, 58 at the end of 2014, and 62 as of the most recent quarter. I see these patients at the Spoon River clinic and at Fresenius East Peoria. Over the past twelve months I referred 27 new hemodialysis patients for services to these two facilities. There are 192 pre-ESRD patients that live in the zip codes surrounding the Canton area. Of these there are 47 that I expect to begin dialysis at Spoon River in the first two years after the three additional stations are in operation. These patients all have lab values indicative of a patient in active kidney failure.

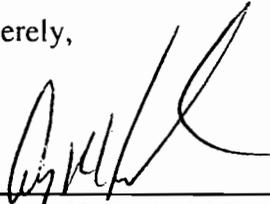
With the increase of pre-ESRD patients in my practice, I urge the Board to approve the addition of three stations at the Fresenius Medical Care Spoon River facility in order to keep access available to this rural ESRD patient population. Thank you for your consideration.

Nephrology Associates

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Robert T. Sparrow, M.D., FASH  
Parthasarathy Srinivasan, M.D.

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

Sincerely,



Anthony Horinek, M.D.

Surgery Associates

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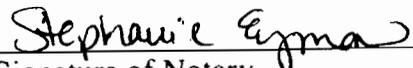
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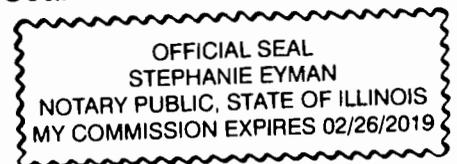
Ottawa  
1050 E. Norris Dr., Suite 2C  
(815) 431-0785

Notarization:

Subscribed and sworn to before me  
this 1<sup>st</sup> day of Dec., 2015

  
Signature of Notary

Seal



**CURRENT SPOON RIVER PATIENTS**

Zip Code	Patients
61520	24
62644	4
61542	4
61529	3
61531	3
61553	1
61441	2
61533	1
61432	1
61427	1
61569	1
<b>Total</b>	<b>45</b>

**IDENTIFIED PRE-ESRD PATIENTS**

Zip Code	Patients
61427	2
61431	1
61432	1
61458	1
61477	1
61520	22
61529	2
61531	5
61533	4
61542	5
61544	1
61563	2
61569	2
61572	2
<b>Total</b>	<b>47</b>

**NEW REFERRALS OF DR. HORINEK FOR THE PAST TWELVE MONTHS**

Fresenius E. Peoria	
Zip Code	Patients
61523	1
61545	1
61548	1
61550	1
61554	2
61571	3
61603	1
61605	2
61610	1
61611	1
61614	1
<b>Total</b>	<b>15</b>

Fresenius Spoon River	
Zip Code	Patients
60406	1
61432	1
61441	1
61520	5
61529	1
61542	2
61569	1
<b>Total</b>	<b>12</b>

<b>Grand Total</b>	<b>27</b>
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**HEMODIALYSIS PATIENTS OF DR. HORINEK**

<b>Facility</b>	<b>Zip Code</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
East Peoria	61523		2		1
East Peoria	61530			1	1
East Peoria	61536	1	2	1	
East Peoria	61540		1		
East Peoria	61545			1	2
East Peoria	61548		2	2	1
East Peoria	61550		2	1	2
East Peoria	61554	1	1	1	
East Peoria	61571	4	2	3	4
East Peoria	61603	2	1	3	2
East Peoria	61604				2
East Peoria	61605	2	1		
East Peoria	61607			1	1
East Peoria	61610			2	1
East Peoria	61611	1	1	1	2
East Peoria	61612			1	1
East Peoria	61614		1	1	1
East Peoria	61616			2	1
East Peoria	61650		1		
Spoon River	61432			1	1
Spoon River	61441		1	1	2
Spoon River	61520	9	15	19	19
Spoon River	61524	1	1		
Spoon River	61529	1	1	2	3
Spoon River	61531	2	4	3	3
Spoon River	61533	1		1	1
Spoon River	61542	1	3	5	6
Spoon River	61553			1	1
Spoon River	61569	2	3	1	1
Spoon River	62644	2	1	3	3
<b>Total</b>		<b>30</b>	<b>46</b>	<b>58</b>	<b>62</b>