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HEALTH FACILITIES &  
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**STATE OF ILLINOIS  
HEALTH FACILITIES AND SERVICES REVIEW BOARD**

**OPEN SESSION**

**JANUARY 10, 2012**

**ORIGINAL**

**NATIONWIDE SCHEDULING**

**OFFICES: MISSOURI Springfield Jefferson City Kansas City Columbia Rolla Cape Girardeau ■ KANSAS Overland Park ■ ILLINOIS Springfield**

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STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

217-782-3516

OPEN SESSION

JANUARY 10, 2012

Open session of the meeting of the State of Illinois Health Facilities and Services Review Board was held on January 10, 2012, at the Bolingbrook Golf Club, 2001 Rodeo Drive, Bolingbrook, Illinois.

1 PRESENT:

John Hayes - Vice-Chairman

2 Ronald Eaker

Alan Greiman

3 Kathy Olson

Richard Sewell

4 Robert Hilgenbrink

David Penn

5

6 ALSO PRESENT:

7 Courtney Avery - Board Administrator

8 Cathy Clarke - Assistant

9 Frank Urso - General Counsel

10 Juan Morado - Assistant Counsel

11 Alexis Kendrick -- HFSRB Staff

12 Michael Constantino - IDPH Staff

13 George Roate - IDPH Staff

14 Bill Dart - IDPH Staff

15 David Carvalho - IDPH Staff

16 Michael C. Jones - IDHFS

17 Michael Pelletier - IDHS

18

19 Reported by:

20 Karen K. Keim

21 CRR, RPR, CSR-IL, CRR-MO

22 Midwest Litigation Services

23 401 N. Michigan Avenue

24 Chicago, IL 60611

1 START TIME: 10:06 a.m.

2

3 VICE-CHAIRMAN HAYES: Welcome to the board  
4 meeting of the Health -- Illinois Health Facilities and  
5 Services Review Board, and I'd like to mention that we do  
6 have outside, with Cathy, a sign-up sheet for public  
7 comment, and if anyone needs -- wants to be able to present  
8 or have a public comment before on any of the projects  
9 today, please go out and talk to Cathy. She's back in the  
10 outer room there, and she'll sign you up for that, and we  
11 certainly appreciate that.

12 And what I'd like to do is we have a new  
13 member of our staff, Alexis Kendrick, and we welcome her,  
14 and she will be working on our Legislative Affairs area,  
15 and we welcome her to our staff.

16 So, I'd like to call this meeting to order,  
17 and the first item on the agenda is a roll call.

18 MR. ROATE: Chairman Galassie is absent. So  
19 is Dr. James Burden.

20 John Hayes?

21 VICE-CHAIRMAN HAYES: Here.

22 MR. ROATE: Ronald Eaker?

23 MR. EAKER: Present.

24 MR. ROATE: Justice Alan Greiman?

1 MR. GREIMAN: Here.

2 MR. ROATE: Mr. Robert Hilgenbrink?

3 MR. HILGENBRINK: Here.

4 MR. ROATE: Ms. Kathy Olson?

5 MS. OLSON: Here.

6 MR. ROATE: Mr. David Penn?

7 MR. PENN: Here.

8 MR. ROATE: Mr. Richard Sewell?

9 MR. SEWELL: Here.

10 MR. ROATE: That is 7.

11 VICE-CHAIRMAN HAYES: Now, the Chairman,  
12 Chairman Dale Galassie, is under the weather today, so  
13 Vice-Chairman John Hayes, myself, will be chairing this  
14 meeting, and then also he hopes to be back in February, and  
15 I'm sure he will be. So, I'm just holding the fort down  
16 here.

17 Approval of the agenda is the next item on our  
18 calendar here. And, Mike, are there any changes to the  
19 agenda?

20 MR. CONSTANTINO: No, Mr. Chairman.

21 VICE-CHAIRMAN HAYES: Thank you. So, I'd  
22 like to have a roll call for the approval of the agenda of  
23 the meeting of January 12, 2012 of the Illinois Health  
24 Facilities and Services Review Board.

1 MR. ROATE: Mr. Eaker?  
2 MR. EAKER: Yes.  
3 MR. ROATE: Justice Greiman?  
4 MR. GREIMAN: Aye.  
5 MR. ROATE: Mr. Hayes?  
6 VICE-CHAIRMAN HAYES: Aye.  
7 MR. ROATE: Mr. Hilgenbrink?  
8 MR. HILGENBRINK: Yes.  
9 MR. ROATE: Ms. Olson?  
10 MS. OLSON: Yes.  
11 MR. ROATE: Mr. Penn?  
12 MR. PENN: Yes.  
13 MR. ROATE: Mr. Sewell?  
14 MR. SEWELL: Yes.  
15 MR. ROATE: That's 7 votes in the affirmative.  
16 VICE-CHAIRMAN HAYES: Thank you.  
17 The next item on our agenda is the approval of  
18 the minutes of the December 6th and 7th, 2011 meeting, and  
19 what I would propose is that we table that approval to the  
20 next meeting. That would allow our Chairman, Dale  
21 Galassie, to be able to look at them and also field any  
22 comments. So, what I'd like to do is have a motion to  
23 table the approval of the minutes of the December 6th and  
24 7th, 2011 meeting.

1 MR. SEWELL: So moved.

2 MR. GREIMAN: Second.

3 MR. ROATE: Motion made by Mr. Sewell,  
4 seconded by Justice Greiman.

5 Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. ROATE: Justice Greiman?

8 MR. GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes?

10 VICE-CHAIRMAN HAYES: Yes.

11 MR. ROATE: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. ROATE: Ms. Olson?

14 MS. OLSON: Yes.

15 MR. ROATE: Mr. Penn?

16 MR. PENN: Yes.

17 MR. ROATE: Mr. Sewell?

18 MR. SEWELL: Yes.

19 MR. ROATE: That's 7 votes in the affirmative.

20 VICE-CHAIRMAN HAYES: Motion approved.

21 The next item is the Post Permit Items  
22 Approved by Chairman, and there are none.

23 The next item is Items for State Board Action,  
24 and the different areas that -- these were items for State

1 Board action that were forwarded to Chairman Dale Galassie.  
2 Permit Renewals, none. Extension Requests, none.  
3 Exemption Requests, none. Alterations, none. Declaratory  
4 Rulings, none. Healthcare Self-Referral Act, none. And  
5 Status Reports on Conditional Permits, none.

6 Let's go into Item H then, which are  
7 Applications Subsequent to Initial Review. Now, our first  
8 item here is a series of items from H-01 to H-21, and this  
9 is a change of ownership from -- a reorganization of  
10 different -- of Neomedica, primarily, and Fresenius Medical  
11 Care. So, what we'll be doing is we'll be having each of  
12 these projects -- we will have them as one. So, basically,  
13 they will be presented as H-1 through H-21. We will  
14 present them as -- they'll come up here and they'll present  
15 them as one project. Each of the Board members then will  
16 have an opportunity to be able to ask questions on any of  
17 the projects.

18 So, is there any problem with proceeding that  
19 way with these items?

20 (Pause)

21 MR. PENN: Just a question. Are we going to  
22 vote item one and item two, or cast one vote for the entire  
23 list?

24 VICE-CHAIRMAN HAYES: We will cast one vote

1 for the entire list.

2 MR. PENN: All right. One motion.

3 MR. GREIMAN: Mr. Chairman, so, if one wanted  
4 to vote against any one of these, how would you do it?

5 VICE-CHAIRMAN HAYES: Well, Justice, if there  
6 is any opposition to any of these projects, we'll have to  
7 take them out of this -- of the motion and be able to vote  
8 on that separately.

9 MR. GREIMAN: Okay. All right. Thank you.

10 MS. OLSON: Mr. Chairman, really, a vote  
11 against one is a vote against all of them. How can it  
12 proceed if one of them can't --

13 VICE-CHAIRMAN HAYES: They would be separate  
14 motions.

15 MS. OLSON: I know, but the company can't  
16 proceed with what they are intending to do if they can't do  
17 it with everybody, right? So, if you're voting against  
18 one, you're in effect voting against all of them. Or is  
19 that not accurate? Bridgeport is going to be left out and  
20 everybody else is in? How does that work? If you're  
21 voting against one you're really voting against the merger,  
22 right, or the entire reorganization?

23 VICE-CHAIRMAN HAYES: Ultimately, the Board  
24 looks at each of these individually. Now, what I propose

1 to do here is be able to group these -- the ones that do  
2 not have opposition and we'd be able to vote on those as a  
3 specific -- as one motion, including that in one motion.  
4 Now, if there is one that -- there are projects that do  
5 have opposition, they will have to be taken out and they  
6 will have to be -- we will have to have a separate motion  
7 for those, and I -- you know, I'm not speaking for the  
8 applicant, but I would believe that if one of them was  
9 rejected or a couple of them were rejected even, they would  
10 still go ahead with the parts of this, for the other ones  
11 that we're accepting.

12 MS. OLSON: Thank you. I appreciate that.

13 VICE-CHAIRMAN HAYES: Kathy, would you like  
14 to be able to go through each of these individually?

15 MS. OLSON: No, no, no. I'm just speaking to  
16 the point of -- I don't know the point of going through  
17 them individually, because my question to the applicant  
18 would be, if we reject one, does that stop the process? I  
19 take your point that we should do them all at once, because  
20 to me, it's one transaction that involves many different  
21 parts. I think that's great.

22 VICE-CHAIRMAN HAYES: Well, this way,  
23 grouping them together, is more for efficiency.

24 MS. OLSON: I agree. I think that's the right

1 way to do it.

2 VICE-CHAIRMAN HAYES: Exactly. So, what I'd  
3 like to do is be able to call H-01 through H-21, and I'd  
4 like to first ask for any public comment that would be  
5 associated with that. And first, could I also ask if we  
6 have any -- Juan, do you have any information that you'd  
7 like to go over for our public comment section?

8 MR. MORADO: Yes. The Open Meeting Act  
9 requires any person shall be permitted an opportunity to  
10 address public officials under the rules established and  
11 recorded by the public body. The following is the  
12 procedure which the Illinois Health Facilities and Services  
13 Review Board will adhere to.

14 If you have previously participated in any  
15 public hearings or submitted written comments related to  
16 projects listed on today's agenda, you will not be allowed  
17 to repeat your previous comments, because each Board member  
18 has already received those materials. Board Staff will be  
19 comparing a speaker's public hearing testimony and/or  
20 previous written comments to ensure that the public  
21 participation testimony is not repetitive. Speakers will  
22 be reminded not to provide repetitive comments.

23 So that the Board is able to accomplish other  
24 agenda items, each speaker will be allowed a maximum of two

1 minutes to provide their comments. Please understand, when  
2 the Chairman signals, you must conclude your comments.

3 Inflammatory or derogatory comments are  
4 prohibited. No more than three persons representing the  
5 same organization are allowed to provide testimony  
6 regarding the same project. Public comment for each  
7 speaker is limited to the testimony for one project or  
8 issue. The Board asks that you please make sure that all  
9 comments are focused and relevant to the specific projects  
10 on the current agenda. Comments should not be repetitive  
11 and not be disruptive to the Board's proceedings.

12 The public is strongly urged to participate in  
13 the long standing opportunities for oral and written  
14 comment provided by the public hearings conducted for CON  
15 projects under review, as well as draft rule making.  
16 Scheduled public hearings are posted on the Health  
17 Facilities and Services Review Board web site.

18 Speakers who do not comply with these  
19 guidelines will not be allowed to provide comment at the  
20 Board's open meeting. And please note, anyone wanting to  
21 provide public participation comments at the Board meeting  
22 must pre-register. As Vice-Chairman Hayes mentioned, Cathy  
23 is outside with the forms. The only times to pre-register  
24 will begin thirty minutes before the scheduled board

1 meeting.

2 Thank you.

3 VICE-CHAIRMAN HAYES: Thank you, Juan.

4 Now, what I will do is I will go through each  
5 of these projects here to announce them, and then we have  
6 one public comment, and when we get to that, I will have  
7 that as well, and then we'll proceed into our normal agenda  
8 item here.

9 H-01, No. 11-070, Neomedica Bridgeport.

10 Agenda Item H-02, FMNCA Dialysis Services,  
11 Burbank, and that's 11-071.

12 Agenda Item H-03, No. 11-072, Neomedica  
13 Evergreen Park.

14 Agenda Item H-04, Item 11-073, Neomedica Hazel  
15 Crest.

16 Agenda Item H-05, No. 11-074, Neomedica  
17 Hoffman Estates.

18 Agenda Item H-06, No. 11-075, FMC Lakeview.

19 Agenda Item H-07, No. 11-076, Neomedica  
20 Marquette Park.

21 Agenda Item H-08, No. 11-077, Neomedica  
22 Melrose Park.

23 Agenda Item H-09, 11-078, FMC Midway.

24 Agenda Item H-10, 11-079, FMC Niles.

1 Agenda Item H-11, 11-080, Neomedica

2 Cumberland.

3 Agenda Item H-12, 11-081, FMC Northcenter.

4 Agenda Item H-11 (sic), 11-082, Neomedica,

5 North Kilpatrick.

6 Agenda Item H-14, 11-083, FMC Polk.

7 Agenda Item H-15, 11-084, Neomedica Rolling

8 Meadows.

9 Agenda Item H-16, 11-085, FMC Roseland.

10 Agenda Item 11-17 (sic), Item 11-086, FMC Ross

11 Dialysis-Englewood.

12 Item 11-H-18, 11-087, FMC South Chicago.

13 Agenda Item H-19, 11-088, Neomedica South

14 Holland.

15 Item H-20, 11-089, Neomedica South Shore. And

16 I understand we have a public comment for this.

17 MS. AVERY: I think they wrote the wrong

18 project number on there. So it's really for 11-098.

19 VICE-CHAIRMAN HAYES: Okay. Agenda Item H-21,

20 No. 11-090, FMC West Belmont.

21 Now, these are all of the projects that we're

22 going to be grouping together. Do I have any public

23 comment on any of these projects here?

24 (Pause)

1                   VICE-CHAIRMAN HAYES:   Well, seeing none,  
2   could I ask the applicants to come forward and to be able  
3   to be sworn in.

4   (Pause)

5   (Oath given)

6                   VICE-CHAIRMAN HAYES:   Could you -- okay.  
7   State Agency Report?

8                   MR. CONSTANTINO:   Thank you, Mr. Chairman.  
9   Fresenius Medical Care is proposing a change of ownership  
10  of 21 facilities in Chicago and suburban Cook County.   This  
11  is a corporate reorganization that is being done to allow  
12  physician investment in the dialysis facilities.   There is  
13  no change in the number of stations, employees or  
14  restriction in the admission of patients or access to care.  
15  There is no cost to these projects.

16                   The State Board Staff notes the following:   No  
17  public hearings were requested, nor did the State Board  
18  Staff receive any letters of support or opposition.   The  
19  applicants have provided all of the necessary information  
20  and have met all of the State Board requirements for a  
21  change of ownership.

22                   Thank you, Mr. Chairman.

23                   VICE-CHAIRMAN HAYES:   Thank you.

24                   Now, could I hear from the -- please identify

1 yourselves, and then could I hear from the applicant?

2 MS. WIEST: Good morning. I'm Michelle Wiest.  
3 I'm the Group Vice-President with Fresenius Medical Care.

4 MS. RANALLI: Good morning. Clare Ranalli,  
5 counsel to the applicant.

6 We'd be happy to answer any of the Board's  
7 questions. This is a corporate reorganization. The  
8 purpose of the reorganization is to allow for physician  
9 investment, should physicians wish to do so in certain of  
10 the clinics that are identified, and you, through the  
11 process, identified each of those clinics.

12 The State Agency Reports are clean. We've met  
13 all of the criteria, and there is no opposition.

14 We'd be happy to answer any questions you  
15 have.

16 VICE-CHAIRMAN HAYES: Okay. Thank you.

17 Can I open up the questions to Board members?

18 MR. GREIMAN: So, is there any kind of --  
19 well, let me ask you, first of all, what percentage of  
20 these stations do you own in Cook County? Do you know?

21 MS. RANALLI: You mean, how many of the  
22 clinics are located in Cook County and then of those how  
23 many stations?

24 MR. GREIMAN: Well, no. What percentage of

1 all of them -- in other words, other people have -- there  
2 are a couple people that must be left in the county that  
3 own these stations besides you. Isn't that right?

4 MS. RANALLI: Yes.

5 MR. GREIMAN: So I want to know what  
6 percentage you own in the county.

7 MS. RANALLI: That, we don't know. I  
8 apologize, Justice Greiman.

9 MR. GREIMAN: It's a significant number, I  
10 assume.

11 MS. RANALLI: I mean, honestly, I couldn't  
12 speak to it.

13 MR. GREIMAN: So, if a doctor now is an  
14 investor and I live at 75th and Colfax and there's a place  
15 around the corner but it isn't part of your group, isn't  
16 the doctor likely to send me to the one that's in Hyde  
17 Park, which he has an interest in?

18 MS. RANALLI: You know, I will be happy to  
19 briefly touch on that, but there is a physician in the  
20 audience who has expressed an interest, and we asked him to  
21 attend, just not certain of the types of questions or  
22 whether there would be any and he may be able to, I think,  
23 really speak more directly to that question. Would it be  
24 acceptable if he were to be sworn in and step up to answer

1 that? He's the Medical Director at two of our clinics.

2 MR. GREIMAN: You're suggesting that a doctor  
3 who has an interest -- is a shareholder wouldn't direct his  
4 customers to the outfit because -- well, for some other  
5 reason? I don't know.

6 MS. RANALLI: I think our physicians generally  
7 dialogue with the patients about where they live, where  
8 they can travel to, what's easiest for them. It also  
9 depends upon where they admit.

10 MR. GREIMAN: Now they're shareholders.

11 MS. RANALLI: Again, I think it might be  
12 helpful, really, if it's acceptable, to have Dr. Crawford  
13 speak to this.

14 MR. GREIMAN: Mr. Chairman?

15 VICE-CHAIRMAN HAYES: I think he could be  
16 sworn in. No problem.

17 (Pause)

18 (Oath given)

19 MR. CRAWFORD: Good morning. To address the  
20 question of referral of patients to --

21 MR. GREIMAN: Speak into the mike.

22 MR. CRAWFORD: Sorry. We have practiced in  
23 the Chicago area for about 32 years. I grew up in the  
24 south side, so I'm familiar with the area of 75th and

1 Colfax and the units in that area, and what we have  
2 practiced is basically, say twenty years ago, most of our  
3 patients we acquired, when they needed end-stage renal  
4 disease care, from the hospital. Currently, when patients  
5 need dialysis services, the majority of those patients come  
6 out of what we call our CKD clinics, the chronic kidney  
7 disease clinics, where we've been working with those  
8 patients for many years and some of them, to keep them off  
9 of dialysis and to prevent the progression of the kidney  
10 disease, and as a result of that, we've established  
11 long-term relationships with the families as well as the  
12 patients. When time -- if a patient progresses to  
13 end-stage renal disease and needs the services of renal  
14 replacement therapy or dialysis or transplant, we refer  
15 them to the areas where they live and in areas where they  
16 can have the convenience and the care that we deem  
17 appropriate and quality care that's necessary for them to  
18 receive.

19 MR. GREIMAN: So, the answer is you don't  
20 think doctors will say, "I want you to go to this one"  
21 because he's a shareholder?

22 MR. CRAWFORD: No. I think the majority of  
23 the time, it's the patient's choice. There's also enough  
24 facilities around, that most of us go to several facilities

1 and accommodate those patients.

2 MR. GREIMAN: There's no question about  
3 Fresenius has one in about every block, so you're right  
4 there.

5 MR. PENN: I have a question. Doctor, are you  
6 speaking for all physicians at every facility today?

7 MR. CRAWFORD: I'm the Vice-President of  
8 Associates in Nephrology, and there are 33 of us spread  
9 throughout all of the Chicago metropolitan area, and if I  
10 get a patient who lives north, I don't go north and follow  
11 that patient. We refer to a unit in their neighborhood and  
12 one of our associates may go there or may not. It's  
13 ultimately always the patient's choice, but informed with  
14 what we consider appropriate for that patient. Actually,  
15 we try to get most of them to go on home dialysis nowadays,  
16 but support services are not always available for everyone  
17 to go to home dialysis. Or, if possible, we get them a  
18 preemptive transplant so they don't need dialysis at all.

19 MR. PENN: I'm just curious. Of all of the  
20 physicians who would have financial investments in this  
21 transaction, there's only one physician here to speak. So  
22 I'm curious if you were chosen by your colleagues today to  
23 speak for all physicians at all of the facilities.

24 MR. CRAWFORD: Right. I'm pretty much,

1 fortunately/unfortunately, the senior physician in the  
2 group and have recruited most of them over time such that  
3 we have a structure that is one single group. We are one  
4 single specialty group, and pretty much our group is pretty  
5 cohesive. Of course, there are different regions, so we  
6 have different physicians working in different regions of  
7 the city, and that prevents some of the travel I have to do  
8 from way north to way south. So we pretty much  
9 regionalized to the area where we want to practice and  
10 participate in that area. It's very collegial. I  
11 haven't -- over the years, as we have some physicians  
12 leave, some come, but, for the most part it's been a  
13 working relationship that we haven't had any major conflict  
14 of interest within the group.

15 MR. PENN: I think I have the same concerns  
16 that Justice Greiman has, the financial investment. It's a  
17 physician investment. It's not a career investment. It's  
18 a financial investment. So, what's going to prevent these  
19 physicians from filling up their stock in this company,  
20 when it's an advantage to them to treat people and drive up  
21 costs? What's going to prevent this from happening if they  
22 have a financial investment in this transaction?

23 MR. CRAWFORD: The cost is pretty well bundled  
24 and capitated, so the cost for doing the treatment, as of

1 January of this year, is what they call a bundle payment.  
2 We actually have been an active recruiter of what we  
3 consider the best physicians we can, some of whom we in the  
4 past were not able to recruit because we were not able to  
5 offer them the opportunities more currently. So that I  
6 think it's important to try and attract quality physicians  
7 to all areas of the inner city and suburbs of Chicago, and  
8 in an effort to do that, we have sought to bring some new  
9 opportunities to those physicians in practice. We haven't  
10 experienced any circumstances where we felt that a patient  
11 was being not given a choice of where they go or the type  
12 of mode of treatment. We try to offer them all of those,  
13 and I think for the majority of that time, there has been  
14 no real conflicts with investment as well as quality of  
15 care. Quality of care always is our main focus for our  
16 patient population.

17 MS. OLSON: I have just a couple questions.  
18 First of all, it would not be unusual in many situations  
19 for a physician to be part owner in a facility that he  
20 was -- is that not true? I mean, whether it be a--

21 MR. CRAWFORD: Right. Most of the --

22 MS. OLSON: -- surgery center or --

23 MR. CRAWFORD: Many of the other facilities  
24 already have this relationship. We have not had that

1 relationship offered until more recently, and, like I said,  
2 we even lost recruitment of some top physicians because we  
3 couldn't offer it. So, in the past we've lost some of the  
4 physicians we wanted, whereas our competitors or other  
5 people in the same industry were able to offer that and  
6 those physicians went to that area.

7 MS. OLSON: And my second question is are the  
8 33 doctors that you talk about in your group -- I think you  
9 said 33 -- are you employees now of Neomedica or Fresenius,  
10 or are you independent?

11 MR. CRAWFORD: No, we're independent.  
12 Associates in Nephrology is an independent,  
13 single-specialty nephrology practice.

14 MS. OLSON: So, at this point, you have no  
15 interest in Neomedica or Fresenius, but with this new  
16 relationship, you would be able to buy into part of --

17 MR. CRAWFORD: Correct.

18 MS. OLSON: Okay. Thank you.

19 MR. CRAWFORD: Let me say, too, that many  
20 times -- for example, you heard Roseland, Englewood. These  
21 areas of the inner city are not so attractive to young  
22 physicians who are looking for a financial basis for their  
23 future and pay for their homes and send their kids to  
24 college, and with our sort of attraction to that community,

1 we tried to deliver that quality of care and stayed in  
2 those communities. We've been able to, I think, deliver  
3 quality care, no matter what the income of those patients  
4 are or what neighborhood they live in and make it  
5 attractive to practice in the inner city of Chicago.

6 MR. GREIMAN: I have another question on  
7 another subject. You have -- your company has had a  
8 reduction in the charitable cases of 62 percent. In the  
9 last three years, it has dropped -- the charitable work  
10 that you do has dropped six percent, at the time when your  
11 number of stations have risen significantly, and I wonder  
12 why your charity contributions would drop six percent.

13 MS. RANALLI: I'll speak to that briefly, and  
14 certainly Ms. Wiest could as well.

15 As we have commented here before on that  
16 particular issue, you see the charity care network going  
17 down and the Medicaid number increasing significantly.  
18 What Fresenius has done, as has other like facilities, has  
19 actively participated in assisting patients who do not  
20 qualify for Medicare coverage, for a period of time to be  
21 enrolled in the Medicaid program. In Illinois --  
22 unfortunately, not all states have this philosophy, but in  
23 Illinois, those residents who are undocumented, who  
24 basically are the population of people who would not be

1 covered or eligible for Medicare benefits and in many  
2 states are not eligible for Medicaid benefits, but in  
3 Illinois they are, Fresenius very actively assists those  
4 patients in obtaining Medicaid coverage. So, our Medicaid  
5 numbers have gone significantly up. The charity care, as a  
6 result, is going down.

7 MR. GREIMAN: But as I look, your Medicaid  
8 numbers have gone up about six or 7 percent. So -- and at  
9 the same time that your charity was going down 6 percent,  
10 your Medicaid was going up 7 or maybe 10 percent.

11 MS. RANALLI: I'm sorry, Justice Greiman. I  
12 haven't analyzed the numbers and percentages. I am  
13 surprised to hear that, because the Medicaid numbers have  
14 increased exponentially. However, again --

15 MR. GREIMAN: I said 7 percent. About 18  
16 percent.

17 MS. RANALLI: That also could speak to the  
18 fact that more of our patients that we are dialyzing are  
19 Medicare recipients. Dialysis is a unique industry,  
20 because many, many years ago, Congress decided they would  
21 cover all patients who required dialysis through Medicare,  
22 regardless of age. The only thing that would prevent  
23 Medicare coverage would be if someone had never worked and  
24 was not able for Medicare benefits.

1 MR. GREIMAN: So, if I'm ineligible for  
2 Medicare or Medicaid, how do I get to you?

3 MS. RANALLI: In Illinois, you would be  
4 eligible for, if not Medicare, Medicaid.

5 MR. GREIMAN: So I just walk in -- you say I  
6 would be. Maybe so. I don't know. There are people that  
7 aren't, I assume.

8 MS. RANALLI: You know, actually there are  
9 some patients who are undocumented residents who are  
10 reluctant to enroll in the Medicaid program because that is  
11 of concern to them.

12 MR. GREIMAN: And they walk in?

13 MS. RANALLI: We treat them.

14 MR. GREIMAN: I'm just looking at your  
15 statistics, and you're six percent less. I can't  
16 understand why exactly, at a time when you rose about 18  
17 percent in the Medicare, you were dropping down 6 percent  
18 in the other.

19 MS. RANALLI: The only explanation is more  
20 patients that we are seeing now have Medicare and Medicaid  
21 coverage. We have over the years again and again repeated  
22 that we accept all patients. If a patient cannot pay for  
23 dialysis and is referred to our facility, that patient will  
24 receive dialysis. That is an absolute. It is -- all we

1 can do is make that representation to you. Dr. Crawford,  
2 who has worked with Fresenius, can probably speak to  
3 whether he's ever had an issue getting a patient into  
4 Fresenius. It does not happen. We treat all patients.

5 MR. CRAWFORD: One of the things you may be  
6 viewing is the rise in increasing number of Baby Boomers  
7 with diabetes, who develop kidney disease as a result of  
8 diabetes. So, our patient population is getting older, and  
9 to a large extent, that's the trend across the country, and  
10 in all of the years that I've practiced, which is 32, since  
11 '79, we've never had a patient whom we did not care for,  
12 regardless of their ability to pay, and have no plans for  
13 changing that in the future. We've had -- none of our  
14 physicians would be allowed to deny care for someone for  
15 that reason. I think we have an obligation to keep to our  
16 communities as well as our patients in the care that we  
17 deliver.

18 MR. GREIMAN: So, would you mind if we  
19 conditioned your acceptance of these 21 things on the fact  
20 that you would develop and continue a program of taking  
21 everybody that walks through the door?

22 MR. CRAWFORD: Just as we always have.

23 MR. GREIMAN: But it would be a condition of  
24 doing this.

1 MS. WIEST: And, Justice, I think certainly  
2 that is our policy, as Dr. Crawford and Ms. Ranalli have  
3 stated, and we would welcome that. That is our mission.  
4 We have done that. We will continue to do that.

5 MR. GREIMAN: Okay. Mr. Chairman, I would  
6 move that we amend the motion to accept the condition that  
7 they continue to serve everybody who walks in the door.

8 VICE-CHAIRMAN HAYES: And this would be from  
9 the applicant itself, as opposed to the Medical Director?

10 MR. GREIMAN: Right.

11 MR. URSO: So, the applicant would have to  
12 agree to this, and there would have to be a reporting back  
13 to the Board requirement within this condition. So, the  
14 Board can say, you know, every six months there would have  
15 to be a report back, saying they're accepting all patients,  
16 or annually, whatever the Board wants.

17 MR. GREIMAN: Yeah, that's fine. That's fine.  
18 Okay?

19 VICE-CHAIRMAN HAYES: Do you have any feel for  
20 six months or a year, every year?

21 MR. GREIMAN: Year is okay.

22 MR. SEWELL: I'll second that, Mr. Chairman.

23 VICE-CHAIRMAN HAYES: Okay.

24 MR. URSO: Does the applicant understand?

1 MS. RANALLI: Yes. We would accept that  
2 condition, and for these clinics we'll report and all of  
3 our clinics in Illinois.

4 MR. PENN: Can you repeat the motion? What's  
5 the motion, please?

6 VICE-CHAIRMAN HAYES: The -- we'll have a  
7 motion to approve, with these provisions in there,  
8 basically asking them to come back to the Board yearly to  
9 specifically request -- to specifically talk about their  
10 policies of not rejecting anyone that comes in to their  
11 facilities, and the applicant will submit a written report.

12 And then the Board may ask you to testify, as  
13 well, to that written report.

14 MR. PENN: How is that policed? How do we  
15 know that everybody was given care? How do we know that no  
16 one was turned away?

17 VICE-CHAIRMAN HAYES: Good faith of the  
18 applicant.

19 MR. PENN: I'm asking the applicant. What's  
20 going to be your policy? How are you going to make your  
21 argument with some type of evidence that no one was turned  
22 away?

23 MS. RANALLI: You bring up a good point. We  
24 can certify, on an annual basis, that this is our policy

1 and this has been our practice. We could have the clinic  
2 managers, who are probably really day-to-day people at each  
3 clinic, make that certification. You know, how do you  
4 police that and verify the accuracy of it? I'm not sure  
5 how that would occur. The Department of Public Health,  
6 through its surveys, gathers information typically on  
7 quality. It doesn't usually look at that particular aspect  
8 of clinic operations. I suppose it could, as part of its  
9 survey process, include a question or analysis of that,  
10 but, once again, I think they would be looking at that day  
11 at the clinic and what the people at the clinic tell them.

12 So, I don't know, short of having someone from  
13 the State there every day, that we could do that, other  
14 than have a certification, a sworn statement from our --  
15 you know, I would suggest our clinic managers as opposed to  
16 somebody in Westchester make that certification to you on  
17 an annual basis.

18 VICE-CHAIRMAN HAYES: Frank?

19 MR. URSO: Mr. Penn, we have -- in the past,  
20 when we needed some verification of information, we have  
21 utilized, as Ms. Ranalli said, the Illinois Department of  
22 Public Health surveyors, who could check for us, for the  
23 Board, and I suppose they can do chart reviews on  
24 admissions and interview people, if the need be. So, there

1 is a mechanism. I'm not saying it's one hundred percent  
2 accurate, and we can't get one hundred percent accuracy on  
3 this, but there are methods we can use to check it, if we  
4 think that we're not getting correct information, if we  
5 just want to verify the information we are getting.

6 MR. PENN: I think that needs to be verified.  
7 It's an administrative nightmare at your end, I would  
8 think, but in support of Judge Greiman's intent, I agree,  
9 we should be watching this charity care as part of this  
10 application. If we're making a motion that has no teeth  
11 and there's no way to follow up on it, it's kind of a  
12 useless motion. We're back to how do we make sure that  
13 people get the charity care or services that they need, and  
14 as we bundle this package together at all of these  
15 stations, I think it is important that there is some type  
16 of reporting that's from Illinois Department of Public  
17 Health, or cross checking. I don't think we should wait a  
18 year. I think that's too long a period of time. I'd be  
19 more comfortable with quarterly reports. The motion takes  
20 in everybody that comes in the door.

21 MR. CRAWFORD: One information that I think  
22 the Board needs to be aware of. Within the last few  
23 years --

24 MR. PENN: Are we back -- we're still talking

1 about our motion.

2 MR. GREIMAN: Why don't we do six months?  
3 That's sort of an in-between. If they're having their  
4 people certify it every six months acceptable to me anyhow.

5 VICE-CHAIRMAN HAYES: Mr. Carvalho?

6 MR. CARVALHO: Thank you.

7 On two different issues. One, on the  
8 certification, if you get a certification, that is good.  
9 And then we don't proactively go out -- "we" meaning the  
10 Department of Public Health, go out to proactively enforce  
11 your regulations. However, end stage renal dialysis  
12 centers, I believe, are subject to licensing. So, in  
13 connection with a licensing survey, if the surveyors are  
14 there for their licensing purposes, this could be something  
15 else that is spot checked.

16 However, I've got a slightly different  
17 question related to this, which is, just as I've often  
18 said, a hospital is not a hotel where people go to check  
19 in. They're admitted by a doctor. I believe an end stage  
20 renal dialysis center is the same thing. People are not  
21 standing on your door, saying, "I think I have kidney  
22 disease. Can I have dialysis?" You're only sent there by  
23 a physician. So, if you have a policy that says you don't  
24 turn anybody away, but your physicians don't take charity

1 cases in the first place, they won't be referring any  
2 charity cases. So, for a facility to say, "We take all  
3 comers" in a way is not really saying anything, unless the  
4 physicians who are referring to the center are referring  
5 patients who don't have coverage.

6 What process -- how can Judge Greiman and  
7 Member Penn's concern about whether you are being available  
8 to everybody come to be if you don't have physicians  
9 referring persons who are uninsured because they don't want  
10 them as their patients in the first place?

11 MR. CRAWFORD: As I was stating earlier, the  
12 units that we have in Ross-Englewood and Roseland are  
13 examples of units that we recently put in those communities  
14 that you would -- maybe if someone were after a large  
15 commercial base, they would not have put a unit in Roseland  
16 or Englewood, because having got those units going, we did  
17 not have an influx of commercial patients at all in either  
18 the Roseland unit or the Englewood unit, and those are  
19 examples, I think, of Fresenius' commitment to the  
20 communities that are under served and where the disease of  
21 end-stage renal disease is very prevalent. We've never  
22 turned any of those patients down in those units, and they  
23 still exist and continue to deliver quality care.

24 MR. CARVALHO: I think you may be missing my

1 point, because I made the same point with ASTC's. ASTC's  
2 sometimes come to us and say, "We will take all payors. We  
3 will treat everybody." But they are owned by physicians,  
4 and the only people that can refer to the ASTC are  
5 physicians who have privileges with the ASTC, and if none  
6 of the physicians take uninsured patients, then they will  
7 have nobody to refer. So, you can say you'll take all  
8 comers, but if there is nobody in your pool of people who  
9 can refer to you, who will send you those uninsured  
10 patients in the first place, how do you get --

11 MR. CRAWFORD: We have large enough referrals  
12 from the Federally-Qualified Health Centers. I think  
13 you're familiar with those, and we turn none of those  
14 patients down, and we see all of the referrals from the  
15 Federally-Qualified Health Centers with no problem, as well  
16 as use them to help us with the patients who don't have  
17 resources to get some of their medicine. So, we work  
18 together very closely with the Federally-Qualified Health  
19 Centers and have had no real difficulties working through  
20 those difficult financial situations.

21 MR. CARVALHO: Let me make sure that -- I  
22 think you may be describing the difference from ASTC's that  
23 may be important. As I understand, an ASTC --

24 MR. CRAWFORD: Tell me what an ASTC --

1 MR. CARVALHO: I'm sorry. ASTC stands for  
2 Ambulatory Surgical Treatment Center. As I understand the  
3 way an ASTC works, if Dr. Burden wanted to do a procedure  
4 at an ASTC, he could not unless he had privileges at that  
5 ASTC. If he wanted to refer a patient to One of your  
6 centers, although he had no other relationship with your  
7 center, could he do that, or does he have to have  
8 equivalent privileges with your center to refer a patient?

9 MR. WIEST: Yes. The answer is that he would  
10 need privileges, but we have open privileges, so any  
11 physician can refer.

12 MR. CARVALHO: So, we still have to  
13 hypothesize. If there's a physician who has the uninsured  
14 patient who he is then interested in referring to you, but  
15 if that hypothetical physician has that hypothetical  
16 uninsured patient, that referral will occur, because you  
17 have an open privilege system, and one source of those  
18 hypothetical doctors are FQHC's, as you noted. Got it.  
19 Thank you.

20 VICE-CHAIRMAN HAYES: Member Sewell?

21 MR. SEWELL: Yes, there's a couple of things.  
22 Maybe the Staff or someone knows. I'm sort of suspecting  
23 that there is a pretty small percentage of uninsured people  
24 when it comes to having been diagnosed for end-stage renal

1 disease because of the Medicare changes that were mentioned  
2 before. This is not like what we always quote, that number  
3 of about 16 percent of the population that's uninsured.  
4 Well, that percentage has to be much lower for patients  
5 diagnosed with end-stage renal disease. Anyone know what  
6 that is? We may be talking about a pretty small problem  
7 here, because Medicare also covers people if they have that  
8 diagnosis, regardless of their age.

9 Now, I think one instance you mentioned is I  
10 guess if you never participated in the work force, then,  
11 you know, you wouldn't be eligible for that. But this  
12 can't be anywhere near the way it is for other diagnoses.

13 MR. CARVALHO: You're correct. Another  
14 category which you may or may not have concerns for would  
15 be medical tourists, persons coming from another country  
16 who do not have access to the care there and come here.  
17 These would be persons who would not be covered by Medicare  
18 or Medicaid, the other reason why they would not have a  
19 connection to the work system.

20 MR. SEWELL: And then the other thing, our  
21 motion may be a little too broad. Aren't we concerned  
22 about them not rejecting anyone for financial reasons? I  
23 think we want to limit that to ability to pay reasons,  
24 rather than just percent, anybody that walks in your door.

1 We're concerned about them not turning away people based on  
2 ability to pay. I think our motion should narrow that to  
3 that issue.

4 VICE-CHAIRMAN HAYES: And that would allow  
5 for medical tourism -- I mean, they would be able to reject  
6 people for medical tourism and if they never participated  
7 in the work force?

8 MS. OLSON: That has something to do with  
9 their ability to pay.

10 MR. SEWELL: That's their ability to pay.

11 MS. WIEST: I think if I can add on to that, I  
12 think there are perhaps some situations where the patient  
13 may be referred to us but may need, for a period of time,  
14 to be in a more structured environment, like a  
15 rehabilitation center, and that may be a more appropriate  
16 place for them to receive dialysis until they are more  
17 stable, because they may have more comorbids that exist  
18 which need to be managed, as well. So, an outpatient  
19 dialysis center may not be appropriate. And I think  
20 Dr. Crawford can speak to that a little more fully.

21 MR. CRAWFORD: We, unfortunately, have an  
22 increase in complexity of illness. When I started 30 years  
23 ago, we had many patients who are just hypertension and  
24 end-stage renal disease, and we would start them on

1 dialysis, get them ready for a transplant. Currently, the  
2 situation is much, much, much different. We have patients  
3 come to the office for the first time and they're in  
4 congestive heart failure, they have diabetes, hypertension,  
5 hyperlipidemia, they've already had coronary by-pass  
6 surgery, they have an amputation of one lower extremity,  
7 and they're blind in both or one eyes and that is,  
8 unfortunately, not an unusual situation that we see in the  
9 office today. So, it's much more complex than just a  
10 simple patient comes in with hypertension and end-stage  
11 renal disease, you put them on dialysis until you get them  
12 a transplant. We're dealing with a complex patient that  
13 requires all of our efforts of social workers, dietitians,  
14 placement, living quarters, what their means are to obtain  
15 their medications, which is why we work with the  
16 Federally-Qualified Health Centers, because many of them  
17 don't have the means to afford some of those medicines.  
18 And so we are practicing a different brand of medicine  
19 today than we did 20 and 30 years or even 10 years ago.  
20 It's not the same environment.

21 MS. OLSON: I think it's, to the doctor's  
22 point, beyond the scope of this Board to dictate the  
23 appropriateness of a referral to any clinic. As a clinic  
24 director, I can tell you that would be a nightmare. You

1 can't tell me that everybody that walks in my door, I have  
2 to treat. You can say, "Cannot be denied treatment based  
3 on the ability to pay."

4 But I would also suggest that perhaps somebody  
5 who works at an FQHC -- perhaps maybe in this report, if  
6 there were perhaps some letter of support from some of the  
7 FQHC's that you work with, because if an FQHC is not  
8 getting the service they need as far as referring their  
9 patients, they are going to tell you. So, that may be a  
10 good way to make sure that they're being honest with what  
11 they're saying.

12 MR. CRAWFORD: As a matter of fact, the  
13 Roseland facility we built next door to a  
14 Federally-Qualified health center. It's adjacent.

15 MR. PENN: I want to go back to a question  
16 that was asked earlier. Mike, George, I don't know if you  
17 know the answer to this, the market share that Fresenius  
18 would have, if this is bundled all together, in Cook County  
19 and the collar county areas.

20 MR. CONSTANTINO: Dave, I wouldn't know. I  
21 can get you that information, but it would take a day or  
22 two. I can send it to you or send it to all of the Board  
23 members.

24 VICE-CHAIRMAN HAYES: Now, would you also, as

1 part of this reporting, basically be able to provide the  
2 Board the agreements between the doctors and Fresenius when  
3 they become owners here, specifically about the charity  
4 care and about their policies of ability to pay and charity  
5 care.

6 MS. WIEST: So, Mr. Hayes, you're asking for  
7 the policy, not only for us as Fresenius, but the  
8 Associates in Nephrology, their policy that they accept  
9 patients regardless? Is that what you're asking for?

10 VICE-CHAIRMAN HAYES: Well, that could be  
11 part of it, but in part of your agreements of ownership, if  
12 they go through and be able to receive an ownership  
13 interest in these facilities, that will -- you will have  
14 some sort of an agreement between your doctors and  
15 Fresenius associated with that.

16 MS. WIEST: well, I think we would need to  
17 take that up with our corporate counsel. Generally those  
18 are privileged documents.

19 MR. PENN: Excuse me. I'm having a hard time  
20 hearing you.

21 MS. RANALLI: All right. The agreements --  
22 I'm not sure -- are you talking about an ongoing agreement,  
23 like operating agreement, that the newly-formed entity  
24 would have in place where it describes the relationship

1 between the physicians and Fresenius, as we indicated in  
2 our application, being the primary owner? Is that the  
3 agreement you're referring to? We just want to make sure,  
4 before we even take it -- we want to make sure we  
5 understand exactly what agreement, because I don't think we  
6 would have an agreement with our physicians, other than the  
7 operating agreement that would reflect their unit interest,  
8 you know, what they invested in based on units. Is that  
9 it?

10 MR. URSO: You've already stated that  
11 Fresenius has a policy about accepting all patients  
12 regardless of their ability to pay. I think what Mr. Hayes  
13 and other Board members is asking is how can we be assured  
14 that the physicians that are now, if this goes through,  
15 going to become owners of these facilities, how do we know  
16 that they are going to abide by that same policy, and is  
17 there some kind of a written document between the  
18 physicians and Fresenius saying, "Yes, we will agree with  
19 this policy"? And perhaps there's a term in the agreement  
20 that spells that all out.

21 MS. RANALLI: Thank you, Mr. Urso. We were  
22 talking about that, and I was asking if that would be  
23 required, and, yes, we will require that, and we can  
24 provide it, yes, that they abide by our policy, yes,

1 absolutely. Thank you for clarification.

2 MS. OLSON: I have a question for point of  
3 clarification. So, we have 21 facilities here, and some of  
4 them are listed as Neomedica and some are listed as  
5 Fresenius. These facilities are all currently owned by  
6 Fresenius. So, when we talk about market share, the market  
7 share is not going to change here, right? The market share  
8 that Fresenius has now is going to remain -- I don't know  
9 what that is, but we're not taking two people that have 20  
10 percent market share and making 40 percent market share.  
11 It's 40 percent, it's 40 percent before and after, whatever  
12 is here today.

13 MS. RANALLI: Right, right. The different  
14 names relate to what the clinics were called years and  
15 years ago, but they are all Fresenius clinics, and the  
16 market share would not change.

17 VICE-CHAIRMAN HAYES: Do you think that in  
18 this -- we're here -- we've gone over a lot of issues and,  
19 you know, basically a couple of questions that I have right  
20 now are some very basic questions, specifically about the  
21 Stark laws and about the Illinois Healthcare Workers  
22 Self-Referral Act. Did you look into those, and how do  
23 they affect this?

24 MS. RANALLI: Yes. Fresenius has a very

1 robust compliance program. Again, given its size, it's  
2 very sensitive to those issues, not just in Illinois but  
3 nationally. All of these arrangements fit into the Safe  
4 Harbor and Stark and fraud and abuse laws. Dialysis,  
5 because of its very nature, is not a treatment which lends  
6 itself to increased physician utilization as a result of a  
7 physician investment, because, unlike some modes of  
8 treatment which may rely somewhat on a physician's  
9 discretion as to whether an MRI is necessary or maybe  
10 diagnostic cardiac catheterization is necessary, dialysis  
11 is only reimbursed by Medicare -- as well as Medicaid or  
12 private pay, for that matter -- if certain, very discreet  
13 and clinical laboratory values are achieved -- is not an  
14 ideal word, but achieved by the patient. So, it is not a  
15 treatment that is subject to a physician's discretion for  
16 referral. As a result of the Stark and fraud and abuse  
17 laws and also the Illinois Healthcare Workers Self-Referral  
18 Act have carved out safe harbors for physician investments  
19 and dialysis clinics, and it's a very common model,  
20 actually, throughout the nation. Fresenius typically has  
21 not joint ventured as frequently as other providers of  
22 dialysis services, but that is changing as a result of the  
23 Medicare bundling and other issues associated with  
24 reimbursement. And, as Dr. Crawford pointed out, it also

1 assists physicians, nephrologists who are looking to  
2 establish a practice to be motivated to serve various  
3 areas, those where there may be a higher private pay  
4 complement as well as where there are not.

5 VICE-CHAIRMAN HAYES: Would you be able to  
6 provide -- as part of your application, did you provide  
7 something from your corporate counsel which talks about the  
8 Safe Harbor provisions for both the federal and state law?

9 MS. RANALLI: We did comment that we met the  
10 fraud and abuse and Stark qualifications. I don't believe  
11 anyone from Fresenius' corporate department that's in  
12 Boston actually signed anything. The Treasurer, Mark  
13 Fawcett, signs off on every application as to its financial  
14 viability and compliance, and he did sign these  
15 applications.

16 VICE-CHAIRMAN HAYES: He did sign these  
17 applications?

18 MS. RANALLI: Yes.

19 VICE-CHAIRMAN HAYES: He signed off on them?

20 MS. RANALLI: Yes.

21 VICE-CHAIRMAN HAYES: Because basically,  
22 Doctor, are you the only group that is -- Neomedica has  
23 been owned by Fresenius for about 15 years, and are you the  
24 only group that is going to benefit by this transaction or

1 are there other groups as well?

2 MR. CRAWFORD: Actually, other groups already  
3 have joint ventures. Our group was in some ways being  
4 penalized in our recruitment efforts, because we weren't  
5 able to offer young physicians -- we weren't able to offer  
6 that to them. So, we lost some of the people we were  
7 trying to recruit to other groups that already have that  
8 structure. I don't know if it's most. I don't know the  
9 numbers, but the majority of units now for young physicians  
10 who are practicing nephrology either have joint ventures or  
11 are in the process of getting joint ventures, and when  
12 they're looking to join a group, they're looking to that as  
13 something that is attractive to them.

14 MR. CARVALHO: Something made me think of  
15 Dr. Burden and one question he might ask if he were here.  
16 It was what you said, Clare, that the -- because of the  
17 nature of end-stage renal dialysis, the decision of whether  
18 to treat or not is not really driven by the doctor but  
19 driven by the clinical result. One of the things that  
20 Dr. Burden has been concerned about is the decision to  
21 provide dialysis in the home versus in a center. Will the  
22 physician ownership in the center influence the decision --  
23 have the potential for influencing the decision based on  
24 financial considerations about whether to seek to have the

1 treatment offered in the home versus having the treatment  
2 offered in a center in which a physician now has a  
3 financial interest?

4 MR. CRAWFORD: One of the things that,  
5 fortunately, happened earlier this year under the bundling  
6 and the changes of Medicare, they have now incentivized  
7 physicians to keep people in the home for the dialysis,  
8 something that I've always practiced but is always a  
9 struggle with the resources that are available in different  
10 patient's homes. But we have a Home Therapies Dialysis  
11 Unit at our Evergreen Park facility, which is growing, and  
12 we're in the process of putting up a peritoneal dialysis  
13 unit in center for the patients who don't have the support  
14 of a family structure at home. But this is something that  
15 is a growing effort. Increasing number of physicians are  
16 utilizing home dialysis for the patient-centered home, and  
17 when we're counseling our patients in our CKD, chronic  
18 kidney disease clinics, we have a nurse educator that meets  
19 with them when they reach stage four kidney disease.  
20 That's anything below 30 percent kidney function. We have  
21 them meet with the dietitians. They sit down with our  
22 physicians and go through a series of classes. The  
23 National Kidney Foundation has a series of classes for the  
24 patient as well as the family, and most of that is to get

1 them to choose home dialysis, whether peritoneal or hemo,  
2 and even now, with the daily home hemo option, many of the  
3 patients are even asking for home dialysis. So, some of  
4 the patients that are in center are going into home. Some  
5 of those that are not on dialysis yet, more will be going  
6 into home dialysis. But it does require some support  
7 services in the home, either a daughter or a spouse or a  
8 caregiver, husband or someone who is willing to assist the  
9 patient with that treatment. But it is becoming more and  
10 more an option, and we are very gratified to see that,  
11 because those patients tend to participate in their care to  
12 a much higher degree than the in-center patients.

13 MR. CARVALHO: And are the financial  
14 incentives the same from Fresenius irrespective of whether  
15 the patient chooses home care versus center care.

16 MS. WIEST: that is correct.

17 VICE-CHAIRMAN HAYES: But in the financial  
18 incentives here, would there be -- if a physician had an  
19 interest, would there be less of an incentive for him to go  
20 and -- have a patient go for transplant as opposed to  
21 staying in dialysis?

22 MR. CRAWFORD: The treatment of choice for  
23 end-stage renal disease is not dialysis. The treatment of  
24 choice is transplant. We don't have the availability for

1 the hundred thousand people that are waiting for -- of that  
2 hundred thousand, eighty thousand are waiting for kidneys.  
3 But we don't have the human kidneys, either cadaver or live  
4 donors. Research is looking at zeno transplants from pigs  
5 or other -- but that's got a long time before it's ready  
6 for prime time, such that the incentive to get a patient a  
7 kidney preemptively, even before they need dialysis, when  
8 their GFR gets below 20, is that those patients have a much  
9 better quality of life, continue to work longer and live  
10 longer. So, we know that that's a better quality, and then  
11 if they go on dialysis, we try to get them on home  
12 peritoneal. They tend to lose less of their residual renal  
13 function more rapidly than on hemo, where they lose  
14 residual renal function faster, plus we avoid catheters.  
15 So, this is why we really, really, really make a major  
16 effort to -- even for young physicians, say, who weren't  
17 trained in peritoneal dialysis, we train them and get them  
18 started, and we're seeing them start to put patients on  
19 home. So, I think we're going to see the trend in the  
20 United States -- which, say, about 10 years ago, we peaked  
21 at about 16, 17 percent, and then we saw a drop down to  
22 about 8 percent of patients on peritoneal, but I think  
23 we're going to see that trend go upwards for many reasons,  
24 some of which are financial. You see that patient once a

1 month typically, and you get the same reimbursement if you  
2 saw that patient on hemodialysis. So, in some ways, it's  
3 less work, those patients tend to do much better and are  
4 more and more involved in their care. So, I think it's the  
5 wave of the future.

6 MR. EAKER: Mr. Chairman, I'd like to move the  
7 previous question to vote.

8 VICE-CHAIRMAN HAYES: Well, I was -- I would  
9 also like to propose a motion that -- is it possible for  
10 you to defer this application to be able to get -- there  
11 seems to be a lot of questions here and --

12 MR. EAKER: No.

13 VICE-CHAIRMAN HAYES: -- from other -- from  
14 Board members that are not here today.

15 MS. WIEST: It certainly would be our  
16 preference not to defer. I think we're more than happy to  
17 answer any questions. We're more than happy to provide an  
18 educational session, as well, to the Board, but because the  
19 State Agency Report was favorable, I think we would like to  
20 not defer at this time.

21 MR. SEWELL: I was just wondering -- maybe  
22 this is your role, but I'm just wondering if people had  
23 more questions and maybe if we asked them now, there's no  
24 need for that. I don't think the call for the question was

1 intended -- I think you were sensitive that there were no  
2 more questions.

3 MR. EAKER: Right.

4 MR. SEWELL: I don't think we should leave  
5 questions unasked. I see no reason to defer.

6 MR. GREIMAN: I agree.

7 VICE-CHAIRMAN HAYES: Well, I don't see any  
8 support to defer this application, so I think we will move  
9 forward. One quick, final question on this. Is Neomedica  
10 North Kilpatrick -- is that correct, that the name sounds  
11 like it's on the north side of Chicago? But this is on  
12 35th Street, on approximately Kilpatrick and 35th Street,  
13 on the south side of Chicago. Is that a misprint or what?

14 MS. WIEST: No, it's not on the south side of  
15 Chicago. It is north. Dr. Crawford said that Bridgeport  
16 is on 35th but this one actually north. It's on  
17 Kilpatrick, and forgive me, because I don't know the cross  
18 street.

19 VICE-CHAIRMAN HAYES: Lawrence.

20 MS. WIEST: Yes, yes, yes.

21 VICE-CHAIRMAN HAYES: Okay. But the  
22 application and the State Agency Report have it on the  
23 other -- have it on the south side, on 35th Street, but  
24 maybe I could be wrong on that.

1 MS. WIEST: You know, I don't have it in front  
2 of me, so I can't comment on that.

3 VICE-CHAIRMAN HAYES: This was a facility  
4 that -- you came in front of the Board just a few months  
5 ago with an addition.

6 MS. WIEST: Yes.

7 MS. RANALLI: I suspect -- because Ms. Wright,  
8 who does all of the applications, and I were working  
9 together, if you did detect that, quite frankly, it would  
10 be just a typo. We had 21 applications. We were very  
11 sensitive in trying to make sure all of the unique clinic  
12 information was inputted correctly. The same could have  
13 happened with the State Agency Report. So that -- if there  
14 was 35th street in here, that may have been a typo from the  
15 Bridgeport application, for which we apologize.

16 MR. URSO: It does say 35th Street on the  
17 State Agency Report.

18 VICE-CHAIRMAN HAYES: Okay. Thank you.

19 Well, is there any more questions from Board  
20 members?

21 (Pause)

22 VICE-CHAIRMAN HAYES: Well, this motion, we'd  
23 like to put a condition on it, basically that the applicant  
24 would come before the Board on a quarterly basis, asking

1 that they provide information on their ability to pay --  
2 coming before the Board on quarterly basis with a written  
3 report, and then also for -- as well be available for -- to  
4 talk to the Board, as well, on that application -- that  
5 report, if necessary.

6 MS. RANALLI: If I may -- and this is  
7 obviously completely up to you, and we will do what you  
8 would like us to do. But I heard quarterly, I heard a  
9 year, and I heard six months. It certainly would be fairly  
10 straightforward for us to provide a quarterly report. I  
11 think it would be valuable and address Mr. Penn's and other  
12 individual's concerns if we actually included a  
13 certification from clinics. As you know and pointed out,  
14 we have a number of clinics. It would be, from an  
15 administrative standpoint, much less burdensome to come in  
16 every six months to a year and provide those  
17 certifications, and I think that would also really more  
18 specifically address your concerns, if the Board would at  
19 all entertain that, instead of a quarterly report.

20 VICE-CHAIRMAN HAYES: Well, I think six months  
21 would be a compromise there, and that would be done on a  
22 written basis, and that would include certifications from  
23 the clinic managers on the ability to pay, and that would  
24 also -- each of those -- you know, if we need to call

1 somebody in, that you would be available to be able to come  
2 in and defend that written report, and that the physician  
3 fees -- we want to be able to understand that your  
4 physicians are complying, that they're taking -- working  
5 with patients no matter their ability to pay.

6 MS. RANALLI: Correct. We will -- what I  
7 would foresee is that if and when physicians invest in any  
8 one of these 21 facilities, you would like to see our  
9 agreement with them requiring them to comply with our  
10 policies, and we will provide that as they invest, yes.

11 MR. PENN: Point of order, so I'm clear on  
12 this. Judge made a motion, and we're amending his motion.  
13 From my understanding, he has to rescind his motion,  
14 because we've added "everybody who walks into the clinic"  
15 to "people who have financial need," whatever, however the  
16 new motion reads. But I think we have two motions on the  
17 floor here. We need to clarify which motion we're going to  
18 vote on and make sure that --

19 MR. GREIMAN: I'm going to rescind it and go  
20 with the other one.

21 VICE-CHAIRMAN HAYES: Okay.

22 MR. PENN: He's going to rescind his original  
23 motion, and so please repeat what we're voting on now.

24 MS. OLSON: Do you want a new motion?

1 MR. PENN: I think the Chairperson was making  
2 a motion.

3 VICE-CHAIRMAN HAYES: I was amending his  
4 original motion.

5 MR. PENN: Okay. So we're amending the  
6 Judge's motion. So, what is our motion now?

7 VICE-CHAIRMAN HAYES: Well, to approve  
8 Projects 11-070 through 11-090, and then we will require  
9 that the applicant provide a written report every six  
10 months for a period of three years. I think that's fair.  
11 And specifically in that report will include information on  
12 a certification from the clinic managers as well as report  
13 from the -- that the physicians themselves are complying  
14 with the ability-to-pay provisions in the operating  
15 agreements. This information will be submitted six months  
16 from the date that the motion is approved today.

17 MR. GREIMAN: So moved.

18 MR. PENN: I have One more question.

19 MR. GREIMAN: Sorry. I'll withdraw my "so  
20 moved".

21 MR. PENN: If you can't meet the criteria of  
22 this motion by the Board today, what's the consequences  
23 going to be?

24 If they report within six months and don't

1 meet the criteria of this amended motion, what happens? Is  
2 it back under review for --

3 VICE-CHAIRMAN HAYES: Well, they could be  
4 sanctioned, if they don't comply with this motion and the  
5 conditions.

6 MR. PENN: Okay.

7 VICE-CHAIRMAN HAYES: So, again, do I have --  
8 I'd like to propose a motion to approve Projects 11-070  
9 through 11-090 and with the amendments that we've  
10 discussed.

11 MS. OLSON: So moved.

12 MR. SEWELL: Second.

13 MR. ROATE: Motion made by Ms. Olson, seconded  
14 by Mr. Sewell.

15 Mr. Eaker?

16 MR. EAKER: Yes.

17 MR. ROATE: Justice Greiman?

18 MR. GREIMAN: Yes.

19 MR. ROATE: Mr. Hayes?

20 VICE-CHAIRMAN HAYES: Yes.

21 MR. ROATE: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Yes.

23 MR. ROATE: Ms. Olson?

24 MS. OLSON: Yes.

1 MR. ROATE: Mr. Penn?

2 MR. PENN: Yes.

3 MR. ROATE: Mr. Sewell?

4 MR. SEWELL: Yes.

5 MR. ROATE: That's 7 votes in the affirmative,  
6 sir.

7 VICE-CHAIRMAN HAYES: Approved.

8 Now, with our agenda here, what I would like  
9 to propose is that we take a 10-minute break, and we'll go  
10 from there then. So, we're recessed until 11:30.

11 (Recess)

12 VICE-CHAIRMAN HAYES: I'd like to be able to  
13 get our meeting back to order here. The next item on our  
14 agenda is H-22, and that's No. 11-091, FMC Duquoin, and  
15 that's been moved or deferred. So, it's off our agenda  
16 now.

17 The next item on our agenda is H-23, 11-092,  
18 RAI North Main, and, again, we'll be looking at these  
19 projects -- Agenda No. H-23 to H-25, we'll be looking at  
20 them as one project. We'll be taking a motion for these  
21 three projects together, to approve or disapprove. Now, if  
22 anyone has -- wants to be able to, we can certainly take  
23 these three projects separately and have separate votes on  
24 that, but our idea is to be able to go forward this way.

1                   So, seeing no objections, we'll look at Agenda  
2 Item H-23, 11-092, RAI North Main; Agenda Item H-24,  
3 11-093, RAI Centre West, Springfield; and Agenda H-25,  
4 11-094, RAI Lincoln Highway. And I don't see -- there's no  
5 public comments associated with that, so, why don't we  
6 basically get -- why don't we swear the applicants in, and  
7 then we'll have the State Report, and then we'll have the  
8 applicants describe.

9   (Oath given)

10                   VICE-CHAIRMAN HAYES:   Mike.

11                   MR. CONSTANTINO: Thank you, Mr. Chairman.  
12 Fresenius Medical Care purchased Liberty Dialysis, Inc.,  
13 which owns and operates approximately 260 end-stage renal  
14 dialysis facilities in 32 states, for approximately \$1.7  
15 billion. Of those 260 facilities, three of the facilities  
16 were located in Illinois. Fresenius is before you today  
17 for approval of this change of ownership of these three  
18 facilities. The anticipated completion date is April 30th,  
19 2012.

20                   The State Board Staff notes the following:  
21 There has been no request for a public hearing, and no  
22 letters of support or opposition have been received, and  
23 the applicants have provided all of the necessary  
24 information and have met all of the requirements of the

1 State Board.

2 Thank you, Mr. Chairman.

3 VICE-CHAIRMAN HAYES: Thank you, Mike.

4 The applicant?

5 MS. JOHNSON: Sarrah Johnson with Liberty

6 Dialysis.

7 VICE-CHAIRMAN HAYES: If you could identify  
8 yourselves?

9 MS. WIEST: Michelle Wiest from Fresenius  
10 Medical Care, Vice-President and the buyer.

11 MS. RANALLI: Clare Ranalli, legal counsel to  
12 Fresenius.

13 VICE-CHAIRMAN HAYES: You may proceed.

14 MS. WIEST: Since the State Agency Report has  
15 no deficiencies, we would certainly be open to any  
16 questions you would have relative to this.

17 VICE-CHAIRMAN HAYES: I'd like to open it up  
18 to questions from the State Board.

19 MR. GREIMAN: Let's see if I can make trouble  
20 again.

21 MS. OLSON: We're never going to get lunch.

22 (Laughter)

23 MR. GREIMAN: So, I sit here sort of month  
24 after month, and every single month you guys are taking

1 over an agency, and I don't know how many agencies are left  
2 that you don't own in Illinois. And my question really is,  
3 my concern is what happens when one company owns all of the  
4 facilities in the state of Illinois or Cook County? Is  
5 that a good thing or is that a bad thing? Because it's  
6 pretty clear to me that you must own a hell of a lot of  
7 them now.

8 MS. RANALLI: I am very, very glad that on the  
9 way in, Ms. Wright, who is our CON Specialist, gave me some  
10 information, because otherwise I wouldn't have been able to  
11 address this as specifically.

12 Fresenius apparently treats, patient-wise,  
13 just under 50 percent of the patients who are on in-center  
14 hemodialysis in Illinois, from a clinic standpoint, not a  
15 station standpoint. Because you had mentioned "stations"  
16 in the previous applications, I want to make clear from a  
17 clinic standpoint, we own just under, again, 50 percent of  
18 the clinics in Illinois. So, we certainly are a  
19 predominant player in the market, and as you said, you see  
20 us every month, but we don't own all of the clinics in  
21 Illinois. We own just under 50 percent, and we treat just  
22 under 50 percent of the dialysis patients in Illinois.

23 As far as speaking to the reason for  
24 acquisition of facilities, I think Ms. Wiest can address

1 that.

2 MS. WIEST: Well, I think that -- and perhaps  
3 my colleague from Liberty can speak a little bit more to  
4 why they decided to sell their business to Fresenius, but  
5 as the State Agency reports, these three small facilities  
6 in Illinois were part of a much larger acquisition across  
7 the country. These are three facilities, smaller  
8 facilities that fall into some of the rural areas  
9 predominantly, where we don't really have a presence at  
10 all. So, this is really quite new to us and Fresenius and  
11 these specific markets.

12 MR. GREIMAN: So you don't have a big  
13 downstate presence?

14 MS. WIEST: We have some facilities but not  
15 certainly to the presence that we probably have for the  
16 north here.

17 I'll let you maybe speak to that.

18 MS. JOHNSON: Yes. Fresenius and Liberty have  
19 similar operating philosophies, from a physician-driven  
20 care perspective. So, because of that perspective, we went  
21 with Fresenius.

22 MS. OLSON: Mr. Chairman?

23 The acquisition nationwide, was that subject  
24 to FTC approval?

1 MS. WIEST: Yes, it was.

2 MS. OLSON: And that's done?

3 MS. WIEST: It's just being completed at this  
4 time.

5 MS. OLSON: So, you do believe you're going to  
6 get that approval?

7 MS. WIEST: We do believe we will for these  
8 three facilities.

9 MS. OLSON: For these three?

10 MS. WIEST: For all of them. I think always  
11 when you acquire a large book of business, with FTC  
12 scrutiny certainly you may see some divestitures as a  
13 result of that, because of the FTC scrutiny. We do not  
14 believe that these three will fall to that.

15 MS. OLSON: Thank you.

16 MR. HILGENBRINK: Mr. Chair, I move approval  
17 of Projects H-23, 24 and 25.

18 MR. SEWELL: Second.

19 MR. ROATE: Motion made by Mr. Hilgenbrink,  
20 seconded by Mr. Sewell.

21 Mr. Eaker?

22 MR. EAKER: Yes.

23 MR. ROATE: Justice Greiman?

24 MR. GREIMAN: I'm going to vote yes now, but

1 when you get over 50 percent, I'm going to think about  
2 voting no.

3 MR. ROATE: Mr. Hayes?

4 VICE-CHAIRMAN HAYES: I'm going to vote no.  
5 Basically, this is a nationwide acquisition. They will  
6 have some discretion with the FTC and the federal laws, and  
7 I'm just -- basically, I'm going to vote no, even though I  
8 don't think this has anything to do with this -- we'll be  
9 able to stop this transaction.

10 MR. ROATE: Mr. Hilgenbrink?

11 MR. HILGENBRINK: Yes.

12 MR. ROATE: Ms. Olson?

13 MS. OLSON: Yes.

14 MR. ROATE: Mr. Penn?

15 MR. PENN: Yes.

16 MR. ROATE: Mr. Sewell?

17 MR. SEWELL: Yes.

18 MR. ROATE: That's six votes in the positive,  
19 one vote in the negative.

20 VICE-CHAIRMAN HAYES: Motion passes. Thank  
21 you.

22 Now, the next item on our agenda is H-26, and  
23 the number is 11-096, FMC Cicero. Now, we have testimony  
24 or public comment, and I'd like to call the three public

1 comments up to the podium here. Silvana Chavez, Diana  
2 Martinez, and Esther Corpuz.

3 (Pause)

4 VICE-CHAIRMAN HAYES: Now, at our public  
5 comment, they'll be restricted to three minutes?

6 MR. MORADO: It's actually two minutes.

7 VICE-CHAIRMAN HAYES: Okay. So, please state  
8 your name, and we'll start out with Silvana Chavez.

9 MS. CHAVEZ: Hello. My name is Silvana  
10 Chavez. I'm a social worker at Fresenius Dialysis Clinic  
11 in Berwyn. I have worked at Fresenius for more than four  
12 years and am one of two social workers at the clinic. It's  
13 quite a traumatic experience when patients learn they must  
14 undergo dialysis. So, we are there to provide one-on-one  
15 counseling to every patient. During our patient meetings  
16 we educate them about the dialysis process and treatment  
17 options. We also give patients room to grieve, so they can  
18 emotionally adjust to their diagnosis in the way they can't  
19 in a group setting.

20 Being available to help all patients includes  
21 those who are undocumented, do not speak English, and need  
22 a lot of assistance in navigating the healthcare system.  
23 In fact, 60 percent of our patients are Hispanic, and, for  
24 many, Spanish is their primary language. We are able to

1 communicate in their language.

2 One of the most rewarding parts of my job is  
3 to help patients get kidney transplants. We are very proud  
4 that we had 12 patients successfully undergo kidney  
5 transplants last year. We talk to patients about the  
6 possibility of a transplant during the first one-to-one  
7 meeting and work with them throughout the process. Many  
8 times patients are part of a large family and can get a  
9 kidney donated from a relative. The best part is when a  
10 former dialysis patient visits the clinic after they get a  
11 transplant.

12 MR. MORADO: Thirty seconds.

13 MS. CHAVEZ: You should see the reaction of  
14 the rest of the patients when they see that one of their  
15 colleagues has received a transplant. They are encouraged  
16 that perhaps they can be next on the list.

17 By -- in closing, I appreciate that you've  
18 given me time to talk about the different ways in which we  
19 serve our patients. We will provide the same care and  
20 treatment for those patients who are currently in physician  
21 treatment for impending end-stage renal disease and will  
22 eventually have dialysis at the imposed Cicero facility.

23 Thank you.

24 VICE-CHAIRMAN HAYES: Thank you.

1                   If you could state your name.

2                   MS. MARTINEZ: Good morning. My name is Diana  
3 Martinez, and I am the Manager at the Berwyn facility.

4                   There are a couple of reasons why a new  
5 facility in Cicero would help us better serve our patients.  
6 First, I'd like to talk about our capacity at Berwyn.  
7 Presently, we are full on all three shifts. Our  
8 utilization has been steadily increasing each year. We do  
9 everything we can to accommodate our patients and  
10 scheduling needs, but it is difficult when utilization is  
11 high. In addition, we want to avoid having to run a fourth  
12 shift.

13                   The Cicero facility will allow us to prepare  
14 for future patient growth at our Berwyn facility, which is  
15 certain to happen, given our historic growth. Right now  
16 one-third of our patients are from Cicero. Most of them  
17 come from generally low-income areas, and a large majority  
18 of them are senior citizens. Because of this, many of our  
19 patients do not own or operate cars and readily -- and rely  
20 on public transportation or rides from friends or families  
21 to get to our facility to receive their treatment. For  
22 example, we have patients who receive treatment until 8:30  
23 p.m. during our third shift. If they want to take  
24 transportation home, it's impossible for them to do so,

1 because it's too late and the buses no longer run. It's  
2 not simply a matter of convenience, but it's a quality of  
3 life and quality of care issue. If patients have  
4 difficulty getting to dialysis, they are more likely to  
5 miss treatments, greatly increasing the chances of  
6 complications and other health problems.

7 Our Berwyn facility is like a community unto  
8 itself.

9 MR. MORADO: Thirty seconds.

10 MS. MARTINEZ: Over the years our managers and  
11 staff have developed strong bonds with our patients during  
12 their visits three times a week. We know that while our  
13 patients appreciate the treatment they receive at our  
14 clinic, many of them will benefit from another high quality  
15 dialysis facility closer to their homes. We also know that  
16 there will be more patients entering Berwyn and requiring  
17 dialysis in the future from the Cicero neighborhood.

18 I respectfully ask that you approve the  
19 Certificate of Need for a new Fresenius dialysis center in  
20 Cicero, and I thank you for your time.

21 VICE-CHAIRMAN HAYES: Thank you.

22 MS. CORPUZ: Good morning. My name is Esther  
23 Corpuz, and I'm the Vice-President for Government and  
24 Community Relations for Vanguard Health Chicago.

1 Vanguard operates 26 acute care hospitals in 7  
2 markets, 4 here in Illinois, Weiss on the lakefront, West  
3 Suburban Westlake and MacNeal. We serve Berwyn and Cicero,  
4 which is where the site would be located. I've spent 6 of  
5 my last 18 years as a member of the leadership team at  
6 MacNeal and last two years as a member of the Corporate  
7 Leadership Team at Vanguard. In addition to my work at  
8 Vanguard, I serve on many civic organizations and boards,  
9 including chairing the National Latino Education Institute  
10 and the vice-chair of the Alivio Medical Center, which is a  
11 Federally-Qualified Health Center. We have referred  
12 patient to Fresenius, and I can assure you, we've never had  
13 any issues with referrals. I also serve on the National  
14 Kidney Foundation Board and also the National Forum for  
15 Latino Healthcare Executives.

16 I grew up in a very traditional Mexican  
17 household. Both my parents have or have had diabetes.  
18 Unfortunately, my dad died at 42 of heart disease. I point  
19 this out because the Hispanic population, as you know, is  
20 more likely to develop diabetes and high blood pressure,  
21 which often ends in kidney failure and other complications.

22 During my tenure at MacNeal, I've been charged  
23 with starting programs that were dedicated to meeting the  
24 needs of the Hispanic population, including a diabetes

1 program for Spanish-speaking patients.

2 I'm here today to support the pending  
3 Certificate of Need application submitted by Fresenius  
4 Medical Care to expand the dialysis center in Cicero. I  
5 have witnessed firsthand the overwhelming need for  
6 increased medical services for families in the Cicero and  
7 Berwyn community. Cicero is a federally-designated  
8 medically under served area and has seen a dramatic growth  
9 in Latino population. Cicero is 87 percent Hispanic, and  
10 Berwyn is 59 percent Hispanic, many of whom are  
11 undocumented and in need of healthcare services.

12 MR. MORADO: Thirty seconds.

13 MS. CORPUZ: I became acquainted with  
14 Fresenius Dialysis Center through my relationship with  
15 Dr. Lohman, who is a Board-certified nephrologist on staff  
16 at MacNeal for more than 30 years. Dr. Lohman is a very  
17 dedicated and loyal physician who cares for his patients  
18 with respect and compassion. He has embraced the cultural  
19 differences and the inherent fears of medical problems  
20 encountered by Hispanic patients.

21 I urge the Board to approve the application  
22 for Fresenius, and I thank you for your time. Thank you.

23 VICE-CHAIRMAN HAYES: Thank you.

24 Now, if we could call the applicant to the --

1 (Pause)

2 (Oath given)

3 VICE-CHAIRMAN HAYES: Now, I'd like to call  
4 for the State Agency Report.

5 MR. CONSTANTINO: Thank you, Mr. Chairman.

6 Fresenius Medical Care Holdings, Inc. and  
7 Fresenius Medical Care Cicero, LLC, the applicants are  
8 proposing the establishment of a 16-station end-stage renal  
9 dialysis facility, located in approximately 8,000 gross  
10 square feet of leased space in Cicero, Illinois. The cost  
11 of the project is approximately \$4 million. The  
12 anticipated project completion date is December 31st, 2013.

13 The State Board Staff notes the following: No  
14 public hearing was requested and no letters of support or  
15 opposition were received. There is a calculated need for  
16 108 dialysis stations in the HSA VII Planning Area, which  
17 is DuPage and suburban Cook County. Finally, there are  
18 existing facilities within a 30-minute travel radius that  
19 are operating below the State Board standard target  
20 utilization of 80 percent.

21 Thank you, Mr. Chairman.

22 VICE-CHAIRMAN HAYES: Thank you, Mike.

23 The applicant, could you introduce yourselves  
24 and proceed?

1 MS. RANALLI: Certainly. In the interest of  
2 efficiency, I will introduce the people here at the table  
3 today. To my far right is Coleen Muldoon, Regional  
4 Vice-President for Fresenius. Lori Wright is next to me,  
5 to my direct right, and she is the CON Specialist for  
6 Fresenius, and to my left is Dr. Lohman, who Ms. Corpus  
7 from MacNeal discussed and she has worked with for many  
8 years and would be the Medical Director at the imposed  
9 clinic and who is also familiar with the Berwyn facility.  
10 I'm going to turn this over to him, but would like to  
11 highlight the point that there is a need in the Service  
12 Area 7 that of the operating clinics within 30 minutes, the  
13 average utilization is 80.6. So, it is above your target  
14 utilization rate. Although there are some that are under  
15 utilized, they are mostly in the high 60's to 70 percent  
16 utilization rate. There are very few clinics within 30  
17 minutes that are at low capacity, although there are a  
18 number that are at zero percent, because they were recently  
19 approved. This is a medically under served area, and the  
20 predominant number of patients who will be seen at this  
21 area are Latino patients, and Dr. Lohman can briefly  
22 discuss his patient population, the capacity at Berwyn, and  
23 the reason there is a need for this clinic, which, again,  
24 your own inventory establishes a need in HSA VII.

1 Thank you.

2 DR. LOHMAN: Dr. Lohman. Thank you.

3 It's been -- I've been many years at MacNeal  
4 and also in the Berwyn-Cicero area. It's been a delight  
5 taking care of the patients there and serving them in the  
6 present facility that we have. It has grown steadily. We  
7 started out with -- in 1985 with about two patient --  
8 actually, 9 patient stations at MacNeal Hospital, and now  
9 we have 28 stations. So, over time, things have grown  
10 progressively, and we are at capacity right now.

11 We serve very much the Hispanic community and  
12 are a very family-oriented community, a delight to work  
13 with. Our needs are to move -- our location presently is  
14 at the west side of Berwyn, and this facility would be at  
15 the very much east side of Cicero and serving an area that  
16 is not served. There's a major gap in that whole area for  
17 dialysis facilities, and this unit would provide  
18 transportation, being very much closer to them as far as  
19 transportation.

20 MS. WRIGHT: Again, I'd just like to point out  
21 that there is a need in this Health Service Area. As  
22 you've heard, it's a federally-designated medically under  
23 served area. The population is Hispanic, and one thing --  
24 the reason why we decided to come in this area is because

1 it's in the patients' best interests to create additional  
2 space where the patients live, rather than diverting them  
3 all over the suburbs or city. It will reduce their travel  
4 times.

5 Another thing that the Cicero facility will  
6 do, if approved, is reduce the utilization at Berwyn. It's  
7 currently at 101 percent. It's going to allow the patients  
8 shift choices. If we have to go to a fourth shift at  
9 Berwyn, what's going to happen is the new patients are  
10 going to have to go on that last shift of the day, and they  
11 are going to be dialyzing until midnight or after. There's  
12 no public transportation, such as Mediacar. They will have  
13 to rely on friends and families. They are often elderly  
14 when they first start dialysis, and this is just not an  
15 optimum way for a patient to have to be treated.

16 There is currently a growing waiting list of  
17 patients wanting to get off third shift of the day to an  
18 earlier shift because of transportation problems, so this  
19 will allow that shift choice. It's also going to allow the  
20 Mediacar service for patients. It stops at four p.m., so  
21 the third shift of the day doesn't have that option of  
22 going home. Currently, 17 percent of the population at the  
23 Berwyn facility rely on public transportation. The new  
24 clinic will also allow 107 previous RD patients that Dr.

1 Lohman has identified, that are going to start dialysis  
2 when this clinic is open, the first two years of operation,  
3 and that's approximately 18 months, two years out from now.  
4 So, in that next 18 months there's going to be even more  
5 patients present at the hospital and the ER on dialysis,  
6 and there's not going to be many places to put them, unless  
7 we start diverting them out.

8           And this is also going to allow these patients  
9 to remain with their current physician. Often times, if  
10 you have to divert patients out to another area, to another  
11 clinic, the physician may not follow that patient at the  
12 clinic, because there's only a limited number of clinics a  
13 physician can go to, and the patient would have to switch  
14 physicians, which is not in the patient's best interests.

15           Just as a side note, there is need in HSA VI  
16 and VII. Cicero sits on the border of HSA VI and VII, and  
17 there are facilities within 30 minutes that are under 80  
18 percent utilization and, literally, there would be no place  
19 in either VI or VII where you could place a clinic  
20 currently that there wouldn't be just one clinic under 80  
21 percent nearby, but this doesn't mean that there are not  
22 pockets of need within these areas, as we have seen in  
23 Cicero.

24           MS. RANALLI: We'd be happy to answer any

1 questions you have.

2 VICE-CHAIRMAN HAYES: Thank you.

3 MR. SEWELL: I wanted to ask the State Staff a  
4 question about these places that were recently approved and  
5 is showing zero percent utilization. Do you have the data  
6 yet?

7 MR. CONSTANTINO: No. The stations are not  
8 operational yet, Mr. Sewell. We haven't been notified by  
9 IDPH that they are operational.

10 MR. SEWELL: Now, the need formula that this  
11 proposal calls for, does it take these facilities into --

12 MR. CONSTANTINO: Yes, sir.

13 MR. SEWELL: So, as they come on line, this  
14 figure -- I think the applicant presented an average figure  
15 of about 80.1 percent. Did I hear that? That's their  
16 average occupancy of the ones that are operational, I  
17 assume. That's going to go down with all of these zero  
18 percent places --

19 MR. CONSTANTINO: Yes, sir.

20 MR. SEWELL: -- as they come on line and start  
21 to contribute.

22 MR. CONSTANTINO: Yes, sir.

23 MR. SEWELL: I'd also ask the applicant, in  
24 terms of the Latino population, are most of the Latino

1 patients in that area being treated at the Berwyn facility?  
2 And you're anticipating that the demographics of your  
3 population will be largely Latino also, Cicero. What does  
4 it look like at the other places within the -- on Table 4  
5 here, within the 20-minute travel time -- I'm sorry, Table  
6 4 in the State Agency Report?

7 MS. RANALLI: Right. The demographics of all  
8 of these facilities on Table 4, it's very different from  
9 facility to facility. I mean, you have locations as  
10 disparate as Jackson part, Logan Square, Westchester. So,  
11 these are all very different demographics. The patients  
12 who are identified by Dr. Lohman in his practice for the  
13 Cicero facility are from the Berwyn and Cicero neighborhood  
14 specifically, and that -- the Cicero neighborhood, as  
15 indicated, a medically under served area,  
16 federally-designated medically under served area, and the  
17 majority of the patients, probably about 61 percent of  
18 them, as spoken to by Dr. Lohman, who will be referred to  
19 the Cicero facility will be Latino. That's important,  
20 because it speaks to the growth. I mean, demographics,  
21 unfortunately, are impacted more by diabetes and  
22 morbidities that cause end-stage renal disease. It also, I  
23 think, speaks to the Clinic Manager and social worker who  
24 were here. There will be continuity, because they are very

1 in tune to the population, the cultural needs. About 20  
2 percent of the patients we anticipate -- sometimes you  
3 don't know until you get into it, but about 20 percent of  
4 the Berwyn patients will probably go to the Cicero  
5 facility, because they currently live in Cicero, and as  
6 mentioned by Ms. Wright, they're dialyzing at Berwyn, but  
7 the shift choice for them is difficult because of  
8 transportation issues, work issues and otherwise.

9           So, there will be continuity, because the  
10 Clinic Manager and social worker will maintain  
11 relationships and also work at the Cicero facility, and,  
12 obviously, continuity of physicians and practice, which is  
13 very important for care. You know, when you look at these  
14 charts, I mean, I would respectfully request the  
15 overdriving issue is the need. Maldistribution is  
16 critically important, maldistribution relating to how many  
17 clinics within 30 minutes are under utilized. But there is  
18 a need in HSA VII and HSA VI, and the patients who go to  
19 Cicero are from those HSA's, primarily HSA VII, where  
20 there's a need for 108 stations. Certainly, this area  
21 where we have chosen is one where there is, as  
22 Ms. Wright said, sort of a pocket of need and where we have  
23 continuity of care and physician practices with patients  
24 who are currently dialyzing in Berwyn. You have spoken how

1     unfortunate it is to have to go to a fourth shift, and if  
2     patients of Dr. Lohman's -- you could say, "Well, why do  
3     you have to do a fourth shift? Why don't you send them to  
4     one of these clinics?" You know, they may say -- and they  
5     usually say -- they don't want to go. We can make that  
6     option available to them. It's clearly available to them,  
7     but they want to remain with the people they know and the  
8     physicians that they've been treating with for years, and  
9     so, they're going to say, "Run the fourth shift. We'll  
10    dialyze then." That's not good for the patients, it's not  
11    good for the staff, quite frankly either, the employees.  
12    So that's why we're here in front of you.

13                   MS. OLSON: Can I just ask a question on this  
14    same line? So, what you're suggesting is this facility in  
15    Oak Park, which is 12 minutes away, the same as Berwyn --  
16    Austin is 12 minutes away, Midway is 13 minutes away,  
17    Congress Parkway is 13 minutes away. But the highest  
18    utilization of that is 67 percent. You're suggesting that  
19    the patients from Berwyn can't go there because they don't  
20    want to and, demographically, it's not going to fit them as  
21    well? Because I want to tell you something. Where I live,  
22    my close friend has to drive 35 miles to the closest  
23    dialysis center, and nobody is complaining. I mean,  
24    there's people from all different ethnic backgrounds at his

1 dialysis center. So, I don't know how we can -- we have 56  
2 facilities within 30 minutes that are not at capacity. So,  
3 what you're suggesting is that we approve this based on  
4 this particular patient population, and I'm very sensitive  
5 to that. I would love to be able to -- I've got to drive  
6 30 minutes to go to any doctor. I'd love to do something  
7 different than that. But I just think that when you have  
8 56 and three of those are yours -- I mean, what percentage  
9 of occupancy does FMC need to break even? Like ten? Is it  
10 that lucrative that you don't need -- I don't understand.

11 MS. RANALLI: I'm going to let Dr. Lohman  
12 speak to the patient demographic. Also, if you have  
13 someone who drives 35 miles for dialysis, maybe you should  
14 speak to Fresenius, if there is a need. You're right, the  
15 facilities in the area are our facilities. Fresenius's  
16 goal and the physicians who refer patients to Fresenius  
17 work to provide the best access to this patient population.  
18 We do that where we believe there is a need and to  
19 physician practices who have growing patients who have  
20 pre-ESRD. So, we know there are so many patients that have  
21 to dialyze. We choose to look at areas and respond to our  
22 physicians to provide the best access to care, because  
23 patients sometimes will not go to clinics if they have to  
24 sever their physician relationship, and there's published

1 information -- we provided it in the past -- about chronic  
2 illness and the need for continuity of care with a primary  
3 treating physician, whether that's an internist, a  
4 cardiologist, or a nephrologist. So, that's very important  
5 for quality of care and for keeping medical care costs low,  
6 not so much at clinic but regarding subsequent  
7 hospitalizations.

8 As far as the patient population and why they  
9 wouldn't travel to Midway or Austin or some of the clinics,  
10 I any Dr. Lohman, who --

11 MS. OLSON: I understand that they don't want  
12 to, but to me, this is part of the problem with healthcare.  
13 I have a very limited choice with my private insurance plan  
14 of where I can go and what I can do. So, I don't  
15 understand the -- I appreciate the fact that you're trying  
16 to be very sensitive to your patient population. That's  
17 very admirable, but at some point -- I mean, there's  
18 physicians I'd like to go to that I can't go to, because  
19 they're not part of my insurance plan. I don't  
20 understand -- we can't just keep increasing capacity  
21 because certain people don't want to go -- that's my  
22 personal opinion, and I understand and appreciate your  
23 sensitivity to your patients. I think that's incredibly  
24 admirable, but I think when you are looking at making a

1 decision, we've got 56 facilities within 30 minutes that  
2 are not at capacity. I can't see the reason for it, I  
3 guess, is my personal opinion.

4 MS. RANALLI: If I can just briefly speak to  
5 that, part of this process that we engage in is planning.  
6 HSA VI and HSA VII, because of the patient population --  
7 and, you know, you go through -- the formula is quite  
8 complex. It does take into account demographics, it looks  
9 at incidents of end-stage renal disease, as well as  
10 population growth. The formula that this Board utilizes  
11 for that purpose has identified a need for additional  
12 stations, looking at a 10-year projection of the patients  
13 who will require dialysis in the future. While there may  
14 be facilities that are at 67 percent currently within 30  
15 minutes, this particular clinic will not be up and running  
16 and treating patients for probably two years, by the time  
17 it's certified for Medicare occupancy. So, we're  
18 anticipating the need and growth. We're not looking at  
19 opening the clinic tomorrow, when there are going to be  
20 facilities within 30 minutes that are at 67 percent. We're  
21 anticipating the growth, just as your own formula has in  
22 HSA VI and VII.

23 I also appreciate what you're saying. The  
24 conundrum we have then is when you -- "you" being the

1 agency, the State. Your formula has identified a need in  
2 HSA VI and VII. There would not be a clinic approved in  
3 those two HSA's for years and years if you were to require  
4 every clinic to be at 80 percent target utilization rate or  
5 even. We frequently confront this in Chicago, HSA VI, and  
6 always have for years and years and years, because HSA  
7 VI -- there has been a need for as long as I can remember  
8 in the past 15 years, and there are always many, many  
9 clinics that are under utilized, not just one or two in HSA  
10 VI, when we go to put a new facility in, such as Roseland,  
11 which Dr. Crawford spoke to, which is a five-year-old  
12 clinic. It is at capacity.

13                   So, we have to look at the need in the  
14 particular area, your formula, and plan for growth, and  
15 understand that for whatever reason -- and, quite frankly,  
16 maybe Fresenius should study this more. We don't know why  
17 there is such disparity in utilization of clinics, where  
18 you see one at 60 percent, one at 100 percent. Like Berwyn  
19 is 101 percent and, like you said, 12 months away, you have  
20 Midway that is under utilized. Those are both our  
21 facilities. Part of our planning process maybe should be  
22 to look at this and figure it out more, so we can get it  
23 right, along with you. But in the meantime, you have 100  
24 pre-ESRD patients right in that neighborhood, and that is

1 what we're trying to plan for.

2 MS. OLSON: Thank you.

3 DR. LOHMAN: I would just make a comment that,  
4 yes, the major practice is located -- our major practice is  
5 located in Berwyn and Cicero, but where we draw from is  
6 definitely east of Cicero and a little bit south. We don't  
7 draw much west of Harlan. So, these are where the patients  
8 are coming from. They're coming from where we are at.  
9 And --

10 MS. OLSON: And all of these other facilities  
11 are west that are under utilized? Is that what you're  
12 saying?

13 DR. LOHMAN: They're north of us and west,  
14 yes.

15 MS. OLSON: Thank you. I understand. Go  
16 ahead. I didn't mean to stop you. I'm a country girl. I  
17 don't know where all of these places are.

18 DR. LOHMAN: The other comment I would make is  
19 transportation is difficult for these people. It would be  
20 nice if they had new cars. And it's a financially poor  
21 individual that is coming to our clinic, because they're  
22 coming from that side, and it would be nice if they had  
23 financial abilities to have nice cars and -- or even had  
24 cars. But transportation is a very important issue for

1 them and I any --

2 MS. OLSON: Did I hear you say that you're  
3 going to provide some transportation?

4 DR. LOHMAN: No.

5 MS. OLSON: Medicaid will pay?

6 MS. RANALLI: Up until four p.m., Medicaid  
7 will provide transportation. Ms. Wright actually can speak  
8 to a couple of the facilities you mentioned. For instance,  
9 Midway has only been open one year, and it's at 66 percent.  
10 I wasn't aware of that. That's pretty high utilization for  
11 a facility open for one year.

12 MS. WRIGHT: Actually, it's 46 percent, and I  
13 guess that's been open a year, and Dr. Lohman and his  
14 partners are sending some patients over there, and that's  
15 why that clinic is growing so quickly. Also, the Oak Park  
16 facility at 68 percent, I don't know how many stations --  
17 that's not the --

18 MS. OLSON: Eighteen.

19 MS. WRIGHT: I'm not sure that that's -- do  
20 you know which Oak Park that is, because that's not our  
21 facility. They just -- that's Maple Avenue. They were  
22 over 100 percent, and they just had an application approved  
23 to expand, I think, by six stations to accommodate growth  
24 in the same area. Also, the Austin clinic, it's been there

1 for probably six years, maybe eight years, and one of the  
2 things that we've seen is it's an area -- the clinic is in  
3 an area of high crime. We have security guards there and  
4 things, but there are a lot of patients from that area,  
5 instead of dialyzing there will come out to the West Sub  
6 clinic to dialyze. We haven't had a lot of control over  
7 that clinic.

8 MS. MULDOON: Just on the Austin, we have not  
9 opened that third shift there only because of the crime in  
10 the area. We're getting very close to opening that third  
11 shift, but the unit has requested, and the staff members,  
12 that we do not do that. We have full security, but the  
13 crime rate is so high there that we have to have that third  
14 shift closed.

15 MR. SEWELL: Here I go with the Staff again.  
16 We have the same situation here that I wrote to you about  
17 last, where we've got this demand-based formula with a  
18 target occupancy rate that uses population projections and  
19 projects demand to the future. That's why they met the  
20 need criteria. Then we want to see everybody hit the  
21 target occupancy for right now.

22 MR. CONSTANTINO: That's correct.

23 MR. SEWELL: That's something that long term  
24 we've got to think about, because I think that it's almost

1 like double counting utilization. It's putting too much  
2 weight on utilization, and we're planning -- the fact that  
3 we're using population projections, saying we're planning  
4 the capacity for the future, based on current demand and  
5 ideal arguments. But then what we want, before we approve  
6 anything, is for everybody to be at the target occupancy,  
7 and I don't know how you -- you're not going to have that.

8 MR. CONSTANTINO: Some of these facilities --  
9 our formula is based on three shifts a day, six days a  
10 week. Some of these facilities are not operating at that  
11 capacity, as this young lady just stated. So, that's why  
12 you'll see some of these facilities under utilized in our  
13 report, because we have to use that three shifts a day  
14 criteria. That's one reason I know of. And then some of  
15 these facilities -- like Lori said, that one facility had  
16 just opened up and has only been open a year, so that's  
17 some of it, too.

18 MR. CARVALHO: Also I think part of it is that  
19 our need formula, population projection formula, is based  
20 on 10 years out. So, we let capacity -- what we're calling  
21 a need today is not a need today. It's a need based on a  
22 10-year projection. In the case of a hospital that may  
23 take four or five years to build, that may make more sense  
24 than the case of an ESRD center that may take six months,

1 eight months, a year to build. It's not going to take five  
2 years to build a ESRD facility.

3 MS. MULDOON: No, but it depends on if it's a  
4 ground up or an existing building. Plus, IDPH inspections  
5 -- an example would be opened up in Batavia August 1st. We  
6 still are waiting. We have one patient now. Almost six  
7 months we've been waiting for the letter. We've been  
8 inspected, but it takes about six months from the day you  
9 open your doors until we can dialyze and open it up to  
10 other patients. It's just a very long --

11 MR. CARVALHO: Sure. But do you see what I'm  
12 getting at in terms of if you let someone build something  
13 based on a need that's 10 years out and you have let the  
14 whole industry build something based on something that's 10  
15 years out and they, in fact, build to need 10 years out,  
16 the utilization today is never going to look anywhere near  
17 our maximum utilization, because we've got all of this  
18 capacity built for a future need.

19 MR. SEWELL: But then the answer to that  
20 dilemma is not have a 10-years-out formula that's  
21 constraining development. Let's just look at whether or  
22 not everybody is at the target occupancy rate. I mean,  
23 that would have still denied this project.

24 MR. CARVALHO: Yeah, the 10-year number --

1 MR. SEWELL: We've got both, though.

2 MR. CARVALHO: The 10-year number did not come  
3 from the analysis of this Board. It was imposed by the  
4 Legislature.

5 MR. SEWELL: I see.

6 MR. CARVALHO: Could I ask a question? I  
7 don't have the information that I should, because the  
8 question only occurred to me when one of your witnesses  
9 testified early about the high incidents of undocumented in  
10 the communities that you're serving. So, following up on  
11 our conversation with the other project, where you noted  
12 that there's very few categories of people who do not have  
13 coverage under either Medicare or Medicaid, I'm assuming  
14 one of them is the undocumented. Are the undocumented  
15 covered under Medicare?

16 MS. RANALLI: They can obtain coverage through  
17 Medicaid, not Medicare, but Medicaid.

18 MR. CARVALHO: So the undocumented are not in  
19 the uninsured?

20 MS. RANALLI: No, although very rarely will a  
21 patient be reluctant to participate because of a concern  
22 about filling out State forms, et cetera, and if that's the  
23 case, we respect that.

24 MR. CARVALHO: Does it also ding them for the

1 provision in the law about government benefit in their path  
2 to citizenship? You know, there's a provision for not  
3 taking government benefit.

4 MS. RANALLI: Right. I don't know.

5 MR. CARVALHO: Okay. Thank you.

6 VICE-CHAIRMAN HAYES: Any other questions  
7 from the Board members?

8 (Pause)

9 VICE-CHAIRMAN HAYES: Seeing none, I'd like to  
10 propose -- I'd like to make a motion to have -- to approve  
11 project 11-096 to establish a 16-station ESRD facility in  
12 Cicero.

13 MS. OLSON: Second.

14 VICE-CHAIRMAN HAYES: Can I have a "so  
15 moved"?

16 MS. OLSON: Oh. So moved.

17 MR. GREIMAN: Second.

18 MR. ROATE: Motion made by Ms. Olson, seconded  
19 by Justice Greiman.

20 Mr. Eaker?

21 MR. EAKER: Yes.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: I'm voting yes but pointing out  
24 that you -- that of the 55 facilities within 30 minutes,

1 you own 33 of them, or 60 percent of them. So, you're  
2 getting close to that 50 percent. So I'll vote aye now.

3 (Laughter)

4 MR. ROATE: Mr. Hayes?

5 VICE-CHAIRMAN HAYES: Yes.

6 MR. ROATE: Mr. Hilgenbrink?

7 MR. HILGENBRINK: Yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: No, based on excess capacity.

10 MR. ROATE: Mr. Penn?

11 MR. PENN: No, based on excess capacity.

12 MR. ROATE: Mr. Sewell?

13 MR. SEWELL: No, excess capacity.

14 MR. ROATE: That's four votes in the positive,  
15 three votes in the negative.

16 VICE-CHAIRMAN HAYES: The motion does not  
17 pass.

18 MR. URSO: You'll receive an Intent to Deny.  
19 You'll have an opportunity to come back before the Board,  
20 as well as submit additional information.

21 MS. RANALLI: Okay. Thank you.

22 VICE-CHAIRMAN HAYES: Now, I'd like to be  
23 able to go to our next project. I've been told that --  
24 anyway, I'd like to break for lunch now. We'll be

1 meeting -- coming back here at ten after one, and I'd like  
2 to be punctual so we can move forward with our agenda.  
3 Thank you very much.

4 (Lunch recess)

5 VICE-CHAIRMAN HAYES: I'd like to call us  
6 back to order. Now, because of our scheduling conflict,  
7 some people aren't here from downstate. I'd like to be  
8 able to go into Executive Session right now, and I'd like  
9 to make a motion to go into an Executive Session pursuant  
10 to Section 2(c)(5) and 2(c)(11) of the Open Meetings Act.

11 MS. OLSON: So moved.

12 MR. SEWELL: Second.

13 VICE-CHAIRMAN HAYES: About 30 minutes, and I  
14 have a motion and a second.

15 MR. ROATE: Mr. Eaker?

16 MR. EAKER: Yes.

17 MR. ROATE: Mr. Greiman?

18 MR. GREIMAN: Yes.

19 MR. ROATE: Mr. Hayes?

20 VICE-CHAIRMAN HAYES: Yes.

21 MR. ROATE: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Yes.

23 MR. ROATE: Ms. Olson?

24 MS. OLSON: Yes.

1 MR. ROATE: Mr. Penn?

2 (No response)

3 MR. ROATE: And Mr. Sewell?

4 MR. SEWELL: Yes.

5 MR. ROATE: Mr. Penn is absent.

6 VICE-CHAIRMAN HAYES: Motion passes. We're in  
7 Executive Session, so if we could clear the room. We'll be  
8 about an hour, and then we'll go into Open Session.

9

10 BOARD ADJOURNS TO EXECUTIVE SESSION.

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1 FOLLOWING EXECUTIVE SESSION, THE FOLLOWING WAS HELD IN OPEN  
2 SESSION:

3

4 VICE-CHAIRMAN HAYES: I'd like to go into  
5 our agenda now, and the next project is Item H-27, 11-097,  
6 Shiloh Dialysis. I don't see any public comment, and why  
7 don't we bring up to applicant.

8 (Pause)

9

(Oath given)

10 VICE-CHAIRMAN HAYES: State Agency Report?

11 MR. CONSTANTINO: Thank you, Mr. Chairman.

12 DaVita Incorporated and Total Renal Care,  
13 Inc., the applicants, are proposing the establishment of a  
14 12 millionstation ESRD station facility, located in  
15 approximately of 6,400 gross square feet of leased space in  
16 Shiloh, Illinois. The cost of the project is approximately  
17 \$2.6 million. The anticipated project completion date is  
18 December 31st, 2013.

19 State Board Staff notes the following: No  
20 public hearing was requested and no letters of opposition  
21 were received by the State Board Staff. Twelve letters of  
22 support were received, however. There is a calculated need  
23 for 17 stations in this ESRD Planning Area. Finally, three  
24 of the five facilities within 30 minutes are not operating

1 at target occupancy.

2 Thank you, Mr. Chairman.

3 VICE-CHAIRMAN HAYES: Thank you, Mike.

4 Now, the applicant, if you could introduce  
5 yourself and give a presentation. Thank you.

6 MS. EMLY: Good afternoon. I'm Cindy Emly,  
7 and I'm the Regional Operations Director for DaVita.

8 MS. BANDAHMAN: Hi. I'm Sarah Bandahman. I  
9 am a Practice Manager for Midwest Nephrology and  
10 Hypertension Associates.

11 MS. COOPER: Anne Cooper, attorney for the  
12 applicant.

13 MS. FRIEDMAN: Hi. Kara Friedman, attorney  
14 for the applicant.

15 VICE-CHAIRMAN HAYES: Go ahead.

16 MS. EMLY: Good afternoon. My name is Cindy  
17 Emly, and I'm a Regional Operations Manager for the Metro  
18 East, St. Louis market in southern Illinois for DaVita.  
19 With me are the attorneys who assisted in the preparation  
20 of the CON application, Kara Friedman and Anne Cooper, from  
21 Polsinelli Shughart. I'd like to thank the Health  
22 Facilities and Services Review Board for the opportunity to  
23 explain why a dialysis facility is needed in Shiloh.

24 Over the past four years, HSA XI, the planning

1 area where the proposed Shiloh facility will be located,  
2 has seen explosive growth in the number of ESRD patients.  
3 In fact, there's been a 15 percent increase in the number  
4 of patients within the last year alone. Currently, there  
5 is a need for 17 stations in HSA XI. As documented in the  
6 physician referral letter submitted with the Shiloh  
7 application, Midwest Nephrology and Hypertension  
8 Associates, the primary referring practice for the proposed  
9 Shiloh facility, has referred an average of 134 patients  
10 for over the past three years in the area dialysis  
11 facilities.

12           Additionally, there has been tremendous growth  
13 in the number of hospital referrals through DaVita's  
14 Patient Pathways program. Patient Pathways provides  
15 hospitals with an unbiased, on-site liaison, who works with  
16 patients to place them in the dialysis facility of their  
17 choice, both DaVita and non-DaVita. Our Patient Pathway  
18 liaison at Belleville Memorial and St. Elizabeth Hospital  
19 in Belleville has reported difficulty in quickly placing  
20 patients and has repeatedly complained that our facilities  
21 are too full. This growth is due to a combination of  
22 factors: The aging population, increase in prevalence of  
23 diabetes and hypertension, and, really, increasing  
24 awareness of chronic kidney disease among the primary care

1 physicians.

2           In addition to increasing number of patients,  
3 the attrition rates of patients on dialysis are decreasing,  
4 due to improved treatment. One of DaVita's great  
5 achievements was the nationwide implementation of our  
6 Impact Program, which focuses on reducing patient mortality  
7 and morbidity during the first 90 days on dialysis, through  
8 our aggressive education and management. It has  
9 accomplished its goals of patients living longer and  
10 healthier lives.

11           While we're proud of the success of our Impact  
12 Program, lower patient attrition rates means we have fewer  
13 stations available for the increasing number of new ESRD  
14 patients. As noted in the State Agency Report, there are  
15 five dialysis facilities within 30 minutes of our proposed  
16 Shiloh dialysis. Utilization of these facilities has  
17 increased four percent within the last 12 months, from 73  
18 to 77 percent. In fact, four of the five facilities are  
19 now operating at or near the State's 80 percent utilization  
20 standard. The only facility operating significantly below  
21 the State's utilization standard is Granite City Dialysis.  
22 However, utilization at this facility has steadily  
23 increased from 63 percent in September up to 66 percent in  
24 December. While we acknowledge there is excess capacity at

1 Granite City, this facility is not easily accessible for  
2 many patients who live in and around Shiloh. Although  
3 MapQuest calculates a distance from the proposed Shiloh  
4 Dialysis to Granite City Dialysis at 30 minutes, the actual  
5 travel time, utilizing the shortest and fastest routes as  
6 determined by MapQuest, is over 30 minutes.

7 Dialysis often leaves patients fatigued, and  
8 it can be a difficult trip home for them. Requiring  
9 patients to travel over 30 minutes for dialysis three times  
10 a week would be a hardship for both patients and their  
11 caregivers, and requiring patients to use an under utilized  
12 facility is not appropriate access.

13 Finally, I wanted to address the existing  
14 capacity in the HSA XI. There are currently 9 dialysis  
15 facilities in this HSA XI. Average utilization of the  
16 existing facility, 71 percent. While we acknowledge there  
17 is capacity in the Planning Area, most of these facilities  
18 are outside the region of the patients in Shiloh and not  
19 viable alternatives to the proposed facility. Moreover, as  
20 previously discussed, there is insufficient capacity within  
21 the HSA XI to accommodate all of MNHA's projected  
22 referrals.

23 We respectfully request the Board approve our  
24 application for permit. Thank you for your consideration

1 and your Staff's assistance throughout this process and for  
2 your time today.

3 At this time I'd like to turn things over to  
4 Sarah Bandahman. She's the Practice Manager for Midwest  
5 Nephrology and Hypertension Associates -- who will provide  
6 specific information about the practice and the patient  
7 population the proposed Shiloh dialysis would serve.

8 MS. BANDAHMAN: Good afternoon. I'm Sarah  
9 Bandahman, and I'm the Practice Manager for Midwest  
10 Nephrology and Hypertension Associates, the primary  
11 referring practice for the proposed Shiloh Dialysis Center.  
12 Dr. Rashid Delal, who will be the Medical Director for the  
13 facility, is not able to be here, due to scheduling  
14 conflicts, and asked me to speak to the Board on his  
15 behalf.

16 I would like to thank the Health Facilities  
17 and Services Review Board for this opportunity to describe  
18 our practice and why a new dialysis facility is needed in  
19 Shiloh. Midwest Nephrology and Hypertension Associates is  
20 a nephrology practice based in Belleville, Illinois. We  
21 currently have three nephrologist serving 3,000 CKD  
22 patients throughout the Metro East area. Our practice has  
23 seen tremendous growth over the past several years. In  
24 fact, our annual growth is approximately 23 percent. Given

1 this growth, we are currently recruiting a fourth  
2 nephrologist and considering adding a mid-level  
3 practitioner.

4 Our practice is currently treating 258 Stage 4  
5 and 5 CKD patients. Assuming attrition rates due to  
6 patient death, transplant, relocation, and return of kidney  
7 function, approximately 165 of these patients will be  
8 referred for in-center hemodialysis within the next 12 to  
9 18 months. This is consistent with our historical  
10 in-center hemodialysis referrals, which has averaged 134  
11 patients annually over the past three years. Our practice  
12 will continue to refer to the existing dialysis facilities  
13 after the completion of the Shiloh Dialysis Center. Given  
14 the high rate of new ESRD patients we have recently  
15 referred for dialysis, it is clear that within several  
16 months, the existing facilities will not be able to  
17 accommodate more patients until more capacity is created.  
18 This is consistent with the need for the stations that the  
19 CON Board Staff has identified. Therefore, a new facility  
20 is necessary to accommodate future need for dialysis in the  
21 Metro East area.

22 We attribute the kidney failure growth in the  
23 Metro East area to several factors: The aging population,  
24 poor nutrition, the high obesity rate, and the increase in

1 addiction to heroin and other opiates. On that last  
2 contributor, some of you who live in the area may have seen  
3 news reports in recent times covering the rise in heroin  
4 addiction and deaths from heroin overdoses in the last  
5 several years. Many people don't know that kidney failure  
6 is one of the problems that addicts, whether recovered or  
7 not, face.

8           Due to the growing obesity epidemic, there is  
9 a higher incidence and prevalence are two of the leading  
10 causes for chronic kidney disease and end-stage renal  
11 disease among younger groups. ESRD patient demographics  
12 seem to vary from one area to the other in different parts  
13 of the country, and here in the Metro East area we are  
14 seeing an increase in the number of young people, those  
15 below the age of 40, initiating dialysis. In fact, over  
16 half of our patients are below the age of 60, and nearly 10  
17 percent are below the age of 40. Unfortunately, without  
18 effective public health, wellness initiatives to combat the  
19 major nutritional problems most people now face, we  
20 anticipate this trend will continue for the foreseeable  
21 future.

22           When patients reach late Stage 4 CKD, dialysis  
23 is eminent. We discuss all treatment options, including  
24 transplant, and develop a care which usually involves some

1 dialysis modality while the patient is simultaneously  
2 enrolled on the transplant wait list. For patients who  
3 have not received a transplant, either because they are  
4 ineligible for because they are wait-listed most of our  
5 patients elect in-center hemodialysis due to a variety of  
6 reasons, include lack of support at home, fear of needles  
7 or self-cannulation, and the belief that they will receive  
8 better care in an in-center environment. Our goal is to  
9 get patients on to the transplant waiting list as early as  
10 possible, because the average wait time for a kidney is  
11 four years. Unfortunately, many of our patients drop off  
12 the waiting list after several months. The waiting time is  
13 extremely long, and patients must have a cytotoxic antibody  
14 screening every month while on the waiting list.

15           Finally, I would like to provide a little  
16 information on the Metro East area for the Board members  
17 who are not familiar with this part of the state. The  
18 Metro East area includes Clinton, Jersey, Madison, Monroe,  
19 St. Clair, and Washington counties, across the Mississippi  
20 River from St. Louis. It is the second-largest urban area  
21 in Illinois after the Chicago metropolitan area, with a  
22 population of over 700,000. Over the past decade, there  
23 has been an eastward shift in the population from the East  
24 St. Louis, Granite City area to the O'Fallon, Shiloh area.

1 As part of this eastward migration, we are seeing more  
2 health services develop in the O'Fallon, Shiloh  
3 communities. As demonstrated by both Belleville Memorial  
4 and St. Elizabeth Hospitals, recent undertakings to  
5 relocate their in-patient facilities is to these locations.  
6 Similarly, we are seeing an eastward shift in our patient  
7 population.

8 Shiloh dialysis will provide much-needed  
9 dialysis services to a growing community in the O'Fallon  
10 and Shiloh area. As Cindy stated in her presentation,  
11 Granite City Dialysis was the only facility in the area  
12 that can accommodate additional patients. However,  
13 patients from the O'Fallon, Shiloh area do not generally  
14 choose to dialyze at Granite City. The facility is 23  
15 miles from Shiloh, and the average travel time is 40 to 45  
16 minutes. Granite City, which is -- which was established  
17 as a company town for the local steel mill, is  
18 geographically isolated from the patient base that this  
19 project is targeted for. It is approximately five miles  
20 from the interstate and hard to navigate for those who are  
21 not familiar with the area.

22 Importantly, most of our patients are relying  
23 upon non-emergency transportation providers to get to and  
24 from their dialysis appointments. Due to the travel time

1 to Granite City, no emergency transportation provider will  
2 transport patients from the O'Fallon, Shiloh area to  
3 Granite City. Therefore, Granite City is not an option for  
4 many of our patients.

5 The Shiloh facility is needed to allow our  
6 physicians to better serve their patients. Thank you for  
7 are time and attention, and I'd be happy to answer any of  
8 your questions regarding our practice.

9 VICE-CHAIRMAN HAYES: Okay. Could I ask if  
10 there are any questions from the Board?

11 (Pause)

12 VICE-CHAIRMAN HAYES: Could I have a motion  
13 then? I'll propose a motion to -- on project -- motion to  
14 approve Project 11-097 to establish a 12-station ESRD  
15 facility in Shiloh.

16 MR. HILGENBRINK: So move.

17 MS. OLSON: Second.

18 MR. ROATE: Motion made by Mr. Hilgenbrink,  
19 seconded by Ms. Olson.

20 Mr. Eaker?

21 MR. EAKER: Yes.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: Yes.

24 MR. ROATE: Mr. Hayes?

1 VICE-CHAIRMAN HAYES: Yes.

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: Yes.

6 MR. ROATE: Mr. Penn?

7 MR. PENN: Yes.

8 MR. ROATE: Mr. Sewell?

9 MR. SEWELL: No.

10 MR. ROATE: That's six votes in the  
11 affirmative, one vote in the negative.

12 VICE-CHAIRMAN HAYES: Motion passes. Thank  
13 you.

14 MR. CONSTANTINO: Mr. Chairman, Item H-28 has  
15 deferred, FMC Prairie Meadows.

16 VICE-CHAIRMAN HAYES: That's deferred, so  
17 let's go to the next item on the agenda.

18 Item H 29, 11-102, Lake Park Dialysis. Is  
19 there any public comment on this?

20 (Pause)

21 VICE-CHAIRMAN HAYES: Can we get the  
22 applicant to be sworn in, and then we'll have the State  
23 report.

24 (Oath given)

1 MR. CONSTANTINO: Thank you, Mr. Chairman.  
2 DaVita Incorporated and Total Renal Care,  
3 Inc., the applicants, are proposing to discontinue a  
4 20-station end-stage renal dialysis facility and establish  
5 a 32-station facility approximately two miles from the  
6 existing facility. The facility will be located in  
7 approximately 12,000 gross square feet of leased space in  
8 Chicago. The cost of the project is approximately \$5.5  
9 million. The anticipated project completion date is  
10 December 31st, 2013.

11 The State Board Staff notes the following: No  
12 public hearing was requested, and no letters of support or  
13 opposition were received by the State Board Staff. HSA VI  
14 currently has a calculated need for 124 ESRD stations.  
15 Finally, 22, or 49 percent, of the facilities within 30  
16 minutes are under utilized.

17 Thank you, Mr. Chairman.

18 VICE-CHAIRMAN HAYES: Thank you.

19 The applicant, if you could introduce  
20 yourselves and then give a presentation.

21 MS. DAVIS: My name is Penny Davis. I'm the  
22 Division Vice-President for DaVita in the Chicagoland area,  
23 and with me is Kara Friedman, our CON attorney, and Anne  
24 Cooper, both from Polsinelli.

1 First, as was the case from our Woodlawn  
2 facility, which we were required to relocate due to the  
3 lease that we had had with the University of Chicago, this  
4 facility needs to be relocated as well. The facility is  
5 operating currently at 105 percent, and in the Planning  
6 Area, as Staff just noted, there's need for 129 dialysis  
7 stations, which is the greatest need anywhere in the state.

8 Specifically with regard to relocation, during  
9 the closing of the acquisition of the University of Chicago  
10 facilities a year and a half ago, we were informed that the  
11 landlord had an intent to not renew the lease for the Lake  
12 Park facility. He is redeveloping that site. As a short  
13 aside, though, he is redeveloping it as a grocery store,  
14 and that is a food desert, that area, which, you know,  
15 obviously, because of the lack of good supermarkets and  
16 grocery stores, allows for the fact that there is more fast  
17 food restaurants. So, a lack of good, healthy nutrition in  
18 a community is probably a factor in the increasing ESRD  
19 rate. So, while it might be serendipity with this  
20 relocation, area residents will not only have a beautiful  
21 new dialysis facility, but they will also have a grocery  
22 store close to home.

23 The physicians that care for the patients at  
24 this and our Woodlawn and Stony Island facilities are

1 academics employed by the University of Chicago. As you  
2 likely well no there is tremendous demand for specialty  
3 care for south side residents by University of Chicago  
4 physicians. Each U of C physician has office space within  
5 their home facility. In this instance, Dr. Ready tends to  
6 dialysis patients exclusively at the Lake Park facility and  
7 puts significant time into one-on-one care for the patients  
8 that she serves during their dialysis treatment.

9           Based on this being a forced relocation, I  
10 don't believe I need the take up your time identifying some  
11 of the problems with the current site, but suffice it to  
12 say that when relocated, the building will be brand new, it  
13 will have adequate parking, and even a non-facility-related  
14 amenity for patients and their families which the developer  
15 is building.

16           One note about our Lake Park facility, and  
17 that is that we offer nocturnal dialysis there. It's  
18 actually the only nocturnal dialysis in that community.  
19 For some patients, nocturnal dialysis is a better option  
20 from both a clinical perspective as well as quality of  
21 life. It works well for certain working patients, for  
22 patients with child care demands, and for patients who just  
23 don't want to be tied to dialysis during their waking  
24 hours. We will be able to retain this program at the new

1 site and with additional stations, open up more slots for  
2 Dr. Reddy's CKD patients.

3 Finally, with regard to community engagement  
4 you know we have faced in the past, prior to filing this  
5 application, we worked with the Fourth Ward Alderman, Will  
6 Burns, and various community groups to ensure that we have  
7 community support for this project. There's been no  
8 community opposition, and Alderman Burns, as a community  
9 representative, fully supports this project and has  
10 provided a support letter.

11 At this point, I would like to thank the Board  
12 and Staff for all of your help and ask if there are any  
13 questions that we might answer.

14 VICE-CHAIRMAN HAYES: Thank you.

15 Board members have any questions?

16 MR. PENN: Just a quick question. Do you  
17 have a policy in place or a written policy about your  
18 charitable care?

19 MS. DAVIS: Actually, when any patient who --  
20 before being admitted to our facility, the facility  
21 administrator is not allowed to deny admission because of  
22 insurance. So, they have to get my approval on any  
23 uninsured patient, and since I've been with DaVita over the  
24 last eight months, I have not refused an uninsured patient.

1 MS. FRIEDMAN: And we have documented in the  
2 application that we admit patients regardless of their  
3 ability to pay.

4 MS. DAVIS: Currently our patients at that  
5 facility are just over 90 percent Medicare or Medicaid.

6 MR. URSO: Mr. Penn, did you ask if they have  
7 a written policy?

8 MR. PENN: Yes.

9 MR. URSO: Do you have a written policy?

10 MS. DAVIS: Yes, it's part of our Admissions  
11 Policy.

12 MR. CONSTANTINO: Yeah.

13 VICE-CHAIRMAN HAYES: You know, as we talked  
14 about this application, obviously, from before, with the  
15 two big, large companies, DaVita was the second largest  
16 ESRD facility or ESRD company in the U.S.

17 MS. DAVIS: Right.

18 VICE-CHAIRMAN HAYES: Do you have any idea on  
19 your market share for both stations and facilities in the  
20 Chicago area, including Chicago and the Cook County?

21 MS. DAVIS: We use the 4 HSA's in terms of --  
22 we use Chicago and Suburban Cook, and in that area,  
23 Fresenius has 62 percent of the stations, and we have 22  
24 percent of the stations.

1 MR. CARVALHO: Just to clarify, I think the  
2 data she just provided you is for all of the collar  
3 counties and Cook County.

4 MS. DAVIS: Right. I don't have it broken  
5 just for HSA VI.

6 VICE-CHAIRMAN HAYES: Because HSA VI was the  
7 City of Chicago.

8 MS. DAVIS: Right.

9 VICE-CHAIRMAN HAYES: Now, in the  
10 application, it points out, the State Agency Report, that  
11 about 49 percent of the facilities are under the State  
12 Board standard of 80 percent.

13 MS. FRIEDMAN: If I could just comment, if you  
14 look at the State Agency Report, I believe that it notes  
15 that over all of the facilities that are in what's  
16 technically considered a 30-minute area, that utilization  
17 is around 78 and a half percent. So, overall, it is very  
18 close to the target utilization, and I think that's why --  
19 with the trending in dialysis that we see, that's why there  
20 is a projected need, because of the level of utilization  
21 being at about target for the area as a whole. There are  
22 deviations from one facility to the next, but in connection  
23 with continuing to provide for Dr. Reddy's patient base, we  
24 primarily considered the area of this patient base.

1 VICE-CHAIRMAN HAYES: So, your utilization at  
2 the Lake Park facility is what?

3 MS. DAVIS: It's over a hundred percent.

4 VICE-CHAIRMAN HAYES: And at the Woodlawn  
5 facility was over a hundred percent, too?

6 MS. DAVIS: Right.

7 VICE-CHAIRMAN HAYES: And these are very close  
8 to each other, essentially?

9 MS. DAVIS: This facility is located at 1531  
10 East Hyde Park Boulevard, and we're moving into 23rd and  
11 Cottage Grove. The Woodlawn facility is moving to 51st and  
12 State, and so, while it would appear to be close, based on  
13 the traffic in those areas it's not necessarily that close.  
14 But the demand is there. They are separate physicians, our  
15 Medical Directors at each of those facilities.

16 VICE-CHAIRMAN HAYES: Thank you.

17 Well, is there any more questions from Board  
18 members?

19 If not, I'd like to propose a motion. May I  
20 have a motion to approve Project 11-102 to discontinue a 32  
21 (sic) station ESRD facility and establish a 32-station ESRD  
22 facility in Chicago?

23 MS. OLSON: So moved. But they're going to  
24 discontinue a 20-station.

1 VICE-CHAIRMAN HAYES: That's correct, yes.

2 MS. OLSON: So moved.

3 MR. GREIMAN: Second.

4 MR. ROATE: Motion made by Ms. Olson, seconded

5 by Justice Greiman.

6 Mr. Eaker?

7 MR. EAKER: Yes.

8 MR. ROATE: Justice Greiman?

9 MR. GREIMAN: Yes.

10 MR. ROATE: Mr. Hayes?

11 VICE-CHAIRMAN HAYES: Yes.

12 MR. ROATE: Mr. Hilgenbrink?

13 MR. HILGENBRINK: Yes.

14 MR. ROATE: Ms. Olson?

15 MS. OLSON: Yes.

16 MR. ROATE: Mr. Penn?

17 MR. PENN: Yes.

18 MR. ROATE: Mr. Sewell?

19 MR. SEWELL: No.

20 MR. ROATE: That's six votes in the

21 affirmative, one vote in the negative.

22 VICE-CHAIRMAN HAYES: Motion approved. Thank

23 you.

24 MS. DAVIS: Thank you.

1 VICE-CHAIRMAN HAYES: The next item on our  
2 agenda is H-39 (sic), Item H-39 (sic), 11-100, Oak Surgical  
3 Institute. Do we have any public testimony?

4 (Pause)

5 VICE-CHAIRMAN HAYES: Could we swear in the  
6 applicant, and then we'll go to the State Agency Report.

7 (Oath given)

8 VICE-CHAIRMAN HAYES: State Agency Report?

9 MR. CONSTANTINO: Thank you, Mr. Chairman.  
10 The applicant, Oak Surgical Institute,  
11 proposes to add podiatry services to an existing Limited  
12 Specialty ASTC, in approximately 7,000 gross square feet of  
13 space. This ASTC currently offers orthopedic and pain  
14 management surgical services in Bradley, Illinois. There  
15 is no cost to this project. The anticipated project  
16 completion date is March 31st, 2012.

17 Should the State Board approve this project,  
18 the facility will be classified as a Multi-Specialty ASTC.  
19 The State Board Staff notes the following: There was no  
20 request for a public hearing and no letters of support or  
21 opposition. And, finally, there are no existing -- there  
22 are existing facilities within the intended geographic  
23 service area that provide the proposed service.

24 Thank you, Mr. Chairman.

1 VICE-CHAIRMAN HAYES: Thank you, Mike.

2 Now the applicant. Could you introduce  
3 yourselves and then go ahead with your presentation?

4 MS. FROGGE: I am Margaret Hansen Frogge, and  
5 I'm a Board Member of Oak Surgical Institute, and with me  
6 is Joy Moore, our Executive Director.

7 Mr. Chairman and Board, thank you for the  
8 opportunity to come before you. Oak Surgical Institute was  
9 opened in 2003. It is a Limited Specialty Surgery Center  
10 with 11 physicians, providing orthopedic and pain  
11 management procedures. The largest group that does the  
12 predominant surgical volume at the center has added a  
13 podiatric surgeon to their practice, and we are here today  
14 to ask you to consider expanding the Oak Surgical Institute  
15 to a multi-specialty center, allowing us to provide  
16 podiatric surgical services there also. I'd be happy to  
17 entertain any questions.

18 VICE-CHAIRMAN HAYES: Thank you.

19 MR. SEWELL: These other facilities that  
20 provide ambulatory surgery in the area, are they offering  
21 podiatry surgery?

22 MS. FROGGE: Of the four that are in the area,  
23 only three are. One is a Limited Specialty, GI center; two  
24 are hospitals; and one is an ambulatory surgery center.

1 MR. SEWELL: And what about the pain  
2 management, are they offering that?

3 MS. FROGGE: Three of the four, not the GI  
4 center.

5 VICE-CHAIRMAN HAYES: Now, your project  
6 basically would allow you to become a multi-specialty  
7 center. Would you accept a provision, amendment basically,  
8 describing that you would come back to the Board if you  
9 were adding another specialty?

10 MS. FROGGE: Yes, we would. In fact, we did  
11 state that in our application, that it is our intention to  
12 keep it an orthopedic-related center, and if we would ever  
13 extend what we've asked for today, we would come back to  
14 you.

15 VICE-CHAIRMAN HAYES: So, basically,  
16 orthopedic services, you're pain management, and now you're  
17 adding podiatry?

18 MS. FROGGE: Correct, yes.  
19 We'd like to thank you.

20 VICE-CHAIRMAN HAYES: Does any other Board  
21 members have any questions?

22 (Pause)

23 VICE-CHAIRMAN HAYES: Okay. I'd like to  
24 approve -- I'd like to have a motion to approve Project

1 11-100 to establish a multi-specialty ASTC.

2 MR. SEWELL: So moved.

3 VICE-CHAIRMAN HAYES: Okay. Second?

4 MS. OLSON: Second.

5 MR. CARVALHO: Mr. Chairman, did you want to  
6 incorporate in your motion the amendment you just discussed  
7 with the applicant?

8 VICE-CHAIRMAN HAYES: Yes. I'd like to  
9 incorporate an amendment, basically describing that if  
10 there was another specialty added beyond the three  
11 specialties that we've already discussed, that you would  
12 come back to the Board and go through an application  
13 process for another -- for that other sub-specialty.

14 MR. SEWELL: I'd agree to that in the motion.

15 MR. HILGENBRINK: Question? Is that not  
16 required to do, that they would have to come back to do  
17 that?

18 VICE-CHAIRMAN HAYES: My understanding is  
19 that they become a multi-specialty. They would be able to  
20 add the specialties without having to come back to the  
21 Board. So, this is requiring that they come back to the  
22 Board.

23 MR. HILGENBRINK: Thank you.

24 MR. ROATE: Motion made by Mr. Sewell,

1 seconded by Ms. Olson.

2 Mr. Eaker.

3 MR. EAKER: I vote no due to the impact of  
4 neighboring facilities.

5 MR. ROATE: Justice Greiman?

6 MR. GREIMAN: Aye.

7 MR. ROATE: Mr. Hayes?

8 VICE-CHAIRMAN HAYES: Yes.

9 MR. ROATE: Mr. Hilgenbrink?

10 MR. HILGENBRINK: Yes.

11 MR. ROATE: Ms. Olson?

12 MS. OLSON: Yes.

13 MR. ROATE: Mr. Penn?

14 MR. PENN: No.

15 MR. ROATE: Mr. Sewell?

16 MR. SEWELL: No, because of the occupancy of  
17 the other facilities.

18 MR. ROATE: Four notes in the positive, three  
19 votes in the negative.

20 VICE-CHAIRMAN HAYES: The motion does not  
21 pass.

22 MR. URSO: You'll receive an Intent to Deny.  
23 You have another opportunity to come before the Board, as  
24 well as to supply additional information.

1 (Pause)

2 VICE-CHAIRMAN HAYES: The next item on our  
3 agenda is H-31, No. 11-095, Palos Hills Surgery Center.  
4 Can we bring up the applicant?

5 (Pause)

6 (Oath given)

7 VICE-CHAIRMAN HAYES: Mike?

8 MR. CONSTANTINO: Thank you, Mr. Chairman.

9 The applicant proposes to establish a Limited  
10 Specialty ASTC, offering orthopedic and pain management  
11 services in two OR's and six recovery stations. The  
12 estimated cost of the project is \$2.4 million. The  
13 anticipated completion date is September 1st, 2012.

14 The State Board Staff notes the following: No  
15 public hearing was requested. Letters of support and  
16 opposition were received by the State Board Staff. Board  
17 Staff also received four Impact Letters. Two Impact  
18 Letters alluded to a negative impact. This was provided by  
19 Silvercross Hospital and Justice Med-Surg, and the two  
20 remaining reported no impact on their existing services.  
21 Board Staff also identified 8 hospitals and 11 ASTC's that  
22 are currently under performing in this current geographic  
23 service area.

24 Thank you, Mr. Chairman.

1 VICE-CHAIRMAN HAYES: Thank you.

2 The applicant, could you introduce yourselves  
3 and then have your presentation?

4 MR. KRONEN: Gary Kronen.

5 MR. FAKHOURI: Anton Fakhouri.

6 MS. MURER: Cherilyn Murer, representing our  
7 client, and I will make an opening statement. Thank you,  
8 Mr. Chairman.

9 The genesis of this application is not from a  
10 quantitative measurement but rather qualitative  
11 measurement. Not all ambulatory surgery centers are  
12 created equally. The focus of this particular surgery  
13 center is that of upper extremity, hand, elbow, wrist.  
14 These two surgeons specialize in this particular area,  
15 which has impacted industry, it has affected work days,  
16 but, in particular, it affects the quality of life of an  
17 individual who isn't able to seek treatment in an  
18 expeditious manner.

19 The focus of this application is to allow  
20 these two surgeons the ability to control their  
21 environment, thereby providing stronger patient care. What  
22 I mean by "control their environment" is to control the  
23 hours available for surgery, to control the equipment that  
24 is being purchased, to control the types of staff that are

1 being retained. What they have found in other facilities  
2 who may have capacity is that this sub-specialization is  
3 not addressed at the level that they wish to see.

4 We have received several letters, that have  
5 been part of our application, in support of this  
6 application and, in particular, these letters of support  
7 are representative of the client population. Letters of  
8 support from Buedel Foods, from Cardell Corporation, from  
9 Navistar, from Tootsie Roll, from Pepperidge Farm, from  
10 Marriott Rosemont, from Central Steel. These are the case  
11 managers that are trying to place their injured workers in  
12 the most expeditious matter possible. Time is of the  
13 essence, in particular with hand injuries. It is not  
14 appropriate for an individual to go to a hospital to then  
15 be triaged, to then see another physician who will send  
16 that patient to a hand surgeon. What these two surgeons  
17 are trying to do is to mitigate that wait time, and that  
18 increases patient care.

19 The intent of this application is to be in  
20 compliance with Health Reform, and that is access to  
21 patients in the most expeditious manner, in the most cost  
22 efficient manner possible. The fact that a patient can be  
23 seen with extended hours that are proposed by this  
24 application, extended much more so than any other facility

1 in the area, means that that patient will have access, that  
2 patient will be treated immediately, and what we're trying  
3 to do is mitigate lost days and productivity.

4 It was interesting that the Mayor of Palos  
5 Hills was exceptionally supportive of this application,  
6 because I think as a representative of the municipality, he  
7 sees the need for individuals to be able to go to a  
8 facility and be treated in a very timely manner.

9 I will end my remarks in this fashion and  
10 would open it to questions, in particular to our two  
11 surgeons.

12 MR. FAKHOURI: Greetings, Mr. Chairman,  
13 members of the Board, Staff.

14 I have been a specialist in the area of hand  
15 surgery for 20 years, and I am honored to be a hand  
16 surgeon, but I also would like to see hand surgery at the  
17 level where it belongs in our community. Hand surgery --  
18 and some of you may have had hand surgery yourselves -- are  
19 very ominous in our society. There are 6 million emergency  
20 visits every year just from hand surgeries alone, 12 office  
21 visits. There is 90 million days of restricted work and 16  
22 million days of missed work just for hand surgery alone.  
23 This costs our society \$10 billion. Much of this is  
24 related to delayed treatment of hand surgery. It's not

1 general orthopedics. It's not dental surgery. It is  
2 specifically hand surgery. Delay in care truly affects the  
3 patient.

4           Imagine a patient, your daughter or your  
5 mother, with a hand fracture that is delayed in treatment  
6 for several days, a cut tendon that takes two weeks, by the  
7 time we get them to the operating room and fix them. It  
8 doesn't make sense for these delays. It increases the  
9 healing time, it increases the risk of complications, the  
10 pain, the stress, the days off work, the days off school,  
11 and we've been seeing this for two decades, and it's about  
12 time that we deal with this accordingly, where a patient  
13 has an injury, they're treated definitively right then and  
14 there, not a week later, not a triage where they're sitting  
15 in the Emergency Room for four to six hours, not to get  
16 four bills from the Emergency Room, from the primary  
17 physician, from the orthopedic surgeon, from the hand  
18 surgeon, and again from the surgery center. It doesn't  
19 make sense. If this is your family this is what you want.

20           Each of us as physicians needs to take  
21 responsibility for the health of our society, and we each  
22 need to do our own part. We're not cardiac surgeons.  
23 We're not general surgeons. But the area we know best, we  
24 know we can take it to the next level. So, obviously, we

1 would like your support. We want to take medicine to that  
2 next level in the area of our specialty.

3 Thank you.

4 MR. KRONEN: I'd just like to point out a  
5 couple of things. One, in the summation of the application  
6 is orthopedic and plastic surgery, not pain management,  
7 because plastic surgery -- hand surgery is under plastic  
8 surgery as well as orthopedics. And just to concur with  
9 what Dr. Fakhouri said, I've been doing this for about 15  
10 years and have been on staff at many ambulatory surgery  
11 centers and hospitals, and I can tell you first hand that  
12 it's extremely difficult to get places to get the equipment  
13 in the facilities that we need to take appropriate care of  
14 our patients. We're constantly battling with the fact that  
15 surgery centers close and the last case is at 2:30 in the  
16 afternoon, because they need to close the doors between  
17 four and five o'clock in the afternoon, and do not allow  
18 for add-on cases.

19 Such a substantial part of hand surgery is  
20 trauma. We have approximately 35 to 40 percent of our  
21 patients now are traumatic injuries, which gets in to us by  
22 clinics, emergency rooms, occupational medicine clinics,  
23 directly from companies, and people who get injured and  
24 call their primary care physicians, and these people need

1 to be taken care of as quickly as possible. If you've had  
2 breakfast, we can do your surgery at five o'clock in the  
3 afternoon because we're open. We don't have to find time  
4 sometimes five to seven days later before we can finally  
5 get the case scheduled.

6 We feel this is very important to taking  
7 medicine to the next level of where it really should be and  
8 where it's very capable of in the United States.

9 VICE-CHAIRMAN HAYES: Thank you.

10 I open it up to questions from Board members.

11 MR. SEWELL: These -- I'm looking at the State  
12 Agency Report, Table 2. It's the ambulatory surgery  
13 treatment centers within the service area. Now, other than  
14 the two obvious ones, there's one here for endoscopy and  
15 one for ophthalmology. Of the others, are any of them  
16 doing hand and upper extremity surgery and plastic surgery  
17 associated with that?

18 MR. FAKHOURI: I have personally visited some  
19 of these. For example, Justice Medical Center objected. I  
20 don't see why they objected. We don't impact them at all.  
21 They don't do it. I cannot see them spending a hundred  
22 thousand dollars for a microscope, hundreds of thousands of  
23 dollars for plates and screws, for all of the intricate  
24 things we need for hand surgery. And to be honest with

1 you, we are interested in having the standard of care that  
2 is optimal. So, we need a place that you would want your  
3 family to visit, and if this is a place that I don't want  
4 my family to visit, I don't want my patients there. So,  
5 we're looking at something much more optimal, as far as  
6 physical structure, as far as equipment.

7 So, to answer you, no, that's not the case.

8 MR. KRONEN: Most of these facilities are  
9 doing general orthopedics, because even in Chicago, with  
10 eight million people, we really are under served in the  
11 area of hand surgery. Most of us are on staff at multiple  
12 hospitals and institutions because there are not a  
13 sufficient number of hand surgeons in the area. Why do the  
14 surgery centers cater to general and not hand surgery? A,  
15 the number of physicians; B, the equipment costs and  
16 everything for hand surgery, and the specific equipment  
17 that we need is very dedicated and cannot have the expense  
18 shared amongst all of the specialties because it only  
19 applies to hand surgery.

20 MS. OLSON: So, this facility would be  
21 physician owned?

22 MR. FAKHOURI: Yes.

23 MS. OLSON: And what would you -- I mean, from  
24 what you're talking about, a very highly specialized

1 facility, and I understand that. So, I would guess -- and  
2 I'm asking you. It looks to me like you're going to be  
3 getting patients, if this goes through, from probably a  
4 hundred miles away. I can't imagine that you're just going  
5 to be in one little area, if you're doing that kind of  
6 specialty care. I would assume that you would get  
7 patients -- you talked about all of the companies. You're  
8 doing a lot of Workers' Comp.

9 MS. KRONEN: May I answer this in a very  
10 honest and sincere way? If that's what it takes for a  
11 patient to be treated the same day, let them come down.  
12 It's all about patient care. If it takes five days to take  
13 care of a patient, that's not acceptable.

14 MS. OLSON: You're misunderstanding my  
15 question, because I -- what I'm -- the point I'm trying to  
16 make is that is a highly specialized field, so I would  
17 think that you would be getting -- I would think that if  
18 other companies outside of this area find out you're -- I  
19 have a friend who had to go to Florida to get a hand  
20 surgery. I mean, I understand what you're.

21 MR. FAKHOURI: We get calls all the time from  
22 various clinics and companies to transport their patients  
23 to us. We treat them now on an elective basis, because  
24 that's all we can offer, but imagine if you had a company

1 that had a hand injury, you could pick up a phone and call  
2 our practice, have them transported there and have  
3 definitive care right then and there. I think it would be  
4 something you would like to take advantage of.

5 MS. OLSON: The point I'm trying to make, and  
6 I'm not doing very well, is for the other Board members. I  
7 think we need to go beyond the HSA, a service that could be  
8 offered to a much larger geographic area perhaps than.

9 MR. KRONEN: As I said, our patients come now  
10 from Wisconsin, we do get some from Iowa, downstate  
11 Illinois, because, again, lack of hand specialization. So,  
12 yes, with respect to hand surgery, this really is something  
13 that could be taken care of on a state-wide and not just  
14 looking at the limited HSA that we're limited to.

15 MS. OLSON: I'm interested, because my  
16 daughter has a hand problem, I swear to God.

17 MS. MURER: One comment, Ms. Olson, in regards  
18 to your question is that as we're describing this, these  
19 physicians are seeing these patients, but that means that  
20 if a patient comes into that facility, to their office, and  
21 they need to be seen in a surgery center, that staff has to  
22 make one call, two calls, three calls, sometimes four calls  
23 to figure out who has an opening. If it's after 2:30,  
24 there is no opening, then it has to get postponed to four

1 o'clock. What this means is great accessibility and great  
2 capability of these physicians to be able to see more  
3 patients because they won't leave their office. They will  
4 have their office at the surgery center, and the continuum  
5 of care, because there's a therapy center also within that  
6 same complex.

7 MS. OLSON: You're preaching to the choir. I  
8 spent 13 years trying to get OR time for a couple of  
9 dentists, so I understand the parameters on the hours too.

10 MR. KRONEN: It's not just the hours. A lot  
11 of it has to do with the fact that most ambulatory surgery  
12 centers are geared towards elective surgeries. So,  
13 therefore, their staff needs as well as their  
14 anesthesiologist needs are set the day before. Most of the  
15 anesthesiologist have university affiliations over other  
16 hospitals. So, when you're calling on Wednesday afternoon  
17 at three o'clock because somebody walked in with a fracture  
18 that you need to take care of tomorrow, the answer is  
19 typically, "Sorry, we don't have staff, we don't have  
20 anesthesia, and the next day we have available for you is  
21 next Tuesday," and that's something we've dealt with now  
22 for 15 to 20 years, and we'd like to change that and stop  
23 it.

24 MR. FAKHOURI: Ms. Olson, we hope this is

1 infectious. We hope that this model we are developing,  
2 hopefully you can approve, God willing, that other clinics  
3 can develop, whether it's Nebraska or California or  
4 Michigan. We have an opportunity to make a real change  
5 here.

6 MR. KRONEN: One last thing I would like to  
7 point out. Tinley Woods Surgery Center, where we currently  
8 do the majority of our outpatient surgeries, actually  
9 supports our project. They recognize that hand surgery is  
10 a specialty unto itself and is a real niche, and they  
11 understand and agree that what we're asking for is  
12 something that the community really needs.

13 VICE-CHAIRMAN HAYES: Mr. Carvalho?

14 MR. CARVALHO: At the last meeting when I  
15 spoke, the applicant said why am I talking? So that gives  
16 me pause. I talk because I'm the Health Policy here. So,  
17 I've got a question or at least a statement or an  
18 observation on this.

19 You said God willing, this becomes a model,  
20 and I'm sitting here thinking God willing it doesn't.  
21 Something doesn't make sense to me about this. I'm trying  
22 to think about what should the healthcare delivery system  
23 look like? And my picture of the healthcare delivery  
24 system doesn't consist of a variety of hospitals and a

1 variety of hand surgery centers. Our whole premise of  
2 hospitals and trauma system and emergency rooms is that  
3 through this process, we carpet the state with the  
4 resources necessary to deal with all of the things that  
5 happen. Everything that happens to people is not a hand  
6 injury. And so to think we should create an exception to  
7 our ordinary system of demonstration of need and look at  
8 the operating capacity available and say, "Well, hand  
9 surgery is uniquely different, so hand surgery centers need  
10 to proliferate" -- I mean, the next person is going to come  
11 in with dental surgery or some other -- I mean, every  
12 category of healthcare could say, "We would be best  
13 addressed through a facility devoted solely to our purpose  
14 and then that should be spread all over across" -- that  
15 just seems like a very strange healthcare delivery system.  
16 Just a general observation.

17                   Then a specific one. If part of the  
18 attractiveness from your perspective is, "Well, all those  
19 other places, people have to wait, but our place, people  
20 won't have to wait," if you're busy, won't they have to  
21 wait? If you're operating on some other patient that you  
22 scheduled for Tuesday and somebody has this problem they  
23 need addressed right away, if your Tuesday is all filled,  
24 they're still going to have to wait, aren't they? You

1 can't double-up people in the emergency room -- I mean,  
2 operation room.

3 MR. FAKHOURI: It is different. The majority  
4 of these hand injuries, as I explained to you, are, for  
5 example, fingertip injuries, work injuries. These injuries  
6 can be treated very swiftly, 10, 15 minutes operative time.  
7 The patient is there already, the staff is there. The  
8 majority of the time and energy and expenditure is just  
9 getting the patient up to the room. Our part is actually  
10 very swift, the surgeon's part. So, no there shouldn't be  
11 any delays, because our staff is there. We're ready to  
12 take care of the patient right then and there. So, it  
13 doesn't make sense for us to bring the patient back the  
14 next day.

15 MR. CARVALHO: Sure, but all of the fingertip  
16 injuries in the state are not all going to come to this  
17 town. So, your model of the healthcare delivery system  
18 would require what, hand surgery centers everywhere? This  
19 is what I'm missing. Why isn't the ordinary hospital  
20 system -- what is -- why is it uniquely unprepared to deal  
21 with this injury, whereas it's expected to deal with every  
22 other injury out there.

23 MS. MURER: I'm going to try a stab at this,  
24 because I've always highly respected Mr. Carvalho's

1 knowledge of healthcare policy. I think what we're looking  
2 at today is not solving the problems of the United States,  
3 a healthcare policy, but decide what's going to be  
4 happening in this community for these patients. What we  
5 have are physicians who are trying to optimize their time  
6 so that they're optimizing access to patients. What  
7 they're trying to do is to optimize the environment in  
8 which they're working, so that the quality of care is at a  
9 higher level, because it's highly specialized.

10 We know that there is need. We know that  
11 there is a need across the country, but we also know there  
12 is a need in this community. Fact of the matter is, every  
13 time that one of the physicians has to go to another site  
14 or to call two or three or four different sites, get in the  
15 car and go to another surgery center that is also owned by  
16 a group of physicians who may not have the same vision that  
17 they have, who then decide in their surgery center they're  
18 not focusing on the equipment or the talent of the  
19 individuals that are focusing on the upper extremity. What  
20 we have is a dilution of efforts in this way. In this  
21 particular case -- and we're not looking to model it across  
22 the United States this afternoon. What we're saying in  
23 this particular case, what we have are two surgeons who,  
24 for the past 15 to 20 years, have been providing services,

1 but they've been providing services in a handicapped  
2 manner. What we're asking for the ability for them to be  
3 able to expand their service capacity within their own  
4 environment, to be able to make their own decisions in  
5 terms of what staff they hire, what hours will they  
6 maintain, what prompt care will they provide, and not be at  
7 the behest of another group of physicians who may not have  
8 that particular interest. We know the need is there. We  
9 know that from the letters of support that we've gotten  
10 from major corporations in the state of Illinois, and we  
11 also know that in the state of Illinois, we are at this  
12 position where retaining industry and optimizing employment  
13 and optimizing productivity and work days is as important  
14 as it could ever be.

15 MR. CARVALHO: Those are important, but here's  
16 my point: Theoretically, almost any surgeon in every  
17 specialty can say the same thing about "It's difficult  
18 getting block time; it's difficult making sure that I can  
19 control the environment in the operating room, because I  
20 don't like some of the nurses that the hospital has hired."  
21 It's -- you know, "I don't like the way the -- I'd rather  
22 have my own receptionist; the patient enrollment process is  
23 better," literally, the vision of a healthcare system that  
24 has a free-standing surgery center for every surgeon in the

1 State of Illinois. There's nothing different in the  
2 complaints that you've just described that they've  
3 encountered in their practice than almost every applicant  
4 that comes before us seeking a surgery center.

5 So, historically, the Board hasn't reacted to  
6 those harrowing stories about why "this would help my  
7 practice" but looked at the healthcare system as a whole.  
8 What is the operating capacity that we need per Planning  
9 Area? Is there adequate hospital base and ASTC base  
10 capacity? And not let anecdotes about individual practices  
11 lead to an over proliferation of operating rooms.

12 MS. MURER: I think what we're saying, though,  
13 is that these patients will get treated eventually. That's  
14 the question. These patients will get treated eventually,  
15 given the capacity of ASTC's that we have in this  
16 community. What we're trying to do is be expeditious. By  
17 being expeditious, it's not only dealing with quality  
18 issues, but it's mitigating any infections that may occur,  
19 it's mitigating any greater injury to that patient. This  
20 is going -- this facility will not have a financial impact  
21 on the State in that this is being funded by the physicians  
22 through their own financing and the patient payor mix is  
23 not going to be altered, given that these are their  
24 patients to begin with. So, it's whether or not these

1 patients are going to be seen at an ASC owned by another  
2 group of surgeons, or will they have the opportunity to be  
3 able to provide those services within a facility that they  
4 will go themselves.

5 MR. KRONEN: I'd like to add a little bit to  
6 that. One of the things about hand surgery that is very  
7 different from other surgeries is that 95 to 97 percent of  
8 our patients can be taken care of on an outpatient basis,  
9 which in general surgery in other areas don't exist. The  
10 full capacity in terms of you look at the hospital -- you  
11 look at Christ Hospital. They are at 102 percent capacity.  
12 Their emergency room is so full up with chronically-ill  
13 patients who have heart conditions, strokes, diabetes, et  
14 cetera, they actually don't want these patients in their  
15 emergency room, and they're not -- with clinical  
16 integration going on, they're actually penalizing the  
17 primary care physicians if their patients winds up in the  
18 emergency room to be triaged, eventually to a specialist,  
19 when the specialist could have been seeing the patient  
20 right away and taking care of the problem on an outpatient  
21 basis, and we're looking to extend that so that we can  
22 provide critical and acute care right away for these  
23 patients.

24 The current model that we have works to a

1 point, but with the amount of capacity that's required to  
2 take care of this, it just doesn't work, and, again, as we  
3 said, the issue -- we acknowledge the fact that if you look  
4 at all of the surgery centers in the area, there is  
5 capacity. We've investigated these other surgery centers,  
6 and this really comes down to the quality of care, the  
7 expedition of the care, and the availability of the care.

8 MR. HILGENBRINK: Where do you currently do  
9 your surgery? Do you have a certain facility you use, or  
10 is there one in particular?

11 MR. FAKHOURI: We do 95 percent of our cases  
12 or more Tinley Woods Surgery Center, which has actually  
13 supported this project, and the Christ Hospital, which has  
14 not objected to this. And as Tinley Woods Surgery said,  
15 whatever cases we do, they're going to replace with other  
16 surgeons. Furthermore, we're adding other doctors in the  
17 future. So, they know very well that whatever cases may  
18 not come there, that they will be replaced by others, and  
19 Christ Hospital is at full capacity, and, furthermore,  
20 whatever cases we do at Christ we will continue doing,  
21 because those are the cases we're presently doing,  
22 generally the sick patients and the patients that require  
23 hospital, we are -- we will continue doing that. That will  
24 not change.

1 MR. HILGENBRINK: So both facilities support  
2 your proposal.

3 MR. FAKHOURI: Tinley Woods Surgery Center  
4 supported. Christ have not objected to it.

5 MR. KRONEN: Christ Hospital is --  
6 Dr. Fakhouri has met with the CEO, and they are very aware  
7 in our discussions our desire to open this up, and they are  
8 looking forward to opening up capacity and things. So,  
9 they are definitely aware and, as Dr. Fakhouri mentioned,  
10 they did not object to this.

11 MR. HILGENBRINK: Thank you.

12 VICE-CHAIRMAN HAYES: Frank?

13 MR. URSO: You spoke a number of times about  
14 the accessibility of this facility and the hours, but in  
15 review of the application, I didn't see any hours. So, are  
16 you going to be open 24/7, and are you going to be  
17 available for anyone who walks through the door,  
18 essentially, or anyone who calls your facility and requires  
19 care?

20 MR. FAKHOURI: Well, initially we are going to  
21 have extended hours from seven in the morning to  
22 approximately eight o'clock at night, including Saturdays  
23 and possibly Sundays. Obviously, we have to do it in  
24 integrated fashion. We'll see what the needs are and we'd

1 adjust it accordingly.

2           The fact of the matter is, if we're in the  
3 office and we get a call that somebody needs to come over  
4 and it's five or six o'clock in the afternoon, the whole  
5 thing is we can have them come over to the office and take  
6 them upstairs to the operating room to provide the  
7 definitive care right there, which if we were dealing with  
8 the standard ambulatory surgery center, we wouldn't be able  
9 to. We would have to temporize the situation and then  
10 determine where we can actually get operating room time.  
11 One of the things we see a lot of are infections. You  
12 know, patient comes in to the office with a hand infection  
13 and need surgery. If they happen to walk in the door at  
14 the wrong time, they will end up getting referred to the  
15 hospital and spending five days in the hospital to get  
16 surgery and get their IV antibiotics, get coordination and  
17 finally get home. If they come in at the wrong time, the  
18 surgery center won't allow us to add it on, because it's  
19 too late. At our facility, we can take care of that  
20 patient right then, even if they have to wait 6 or 7 hours  
21 because of NPO status, because they had eaten, and then  
22 everything can be treated as an outpatient, where they can  
23 have surgery, go see the be given their antibiotics, and go  
24 home and be back at work in a day or two, as opposed to

1 spending four or five days and a huge hospital bill,  
2 sitting in the hospital.

3 MR. URSO: What about the second part of my  
4 question in regards to patient's ability to pay? How do  
5 you do that when and if you're going to accept everyone  
6 that comes into the center?

7 MS. MURER: First, Mr. Urso, we did address  
8 hours in the application, in Chart 1 and Chart 2 and a  
9 comparison of hours and then daily hours of operation, and  
10 so we did indicate that this facility would have hours that  
11 were much more extensive than what exists at this time.

12 As it relates to the ability to pay, in the  
13 application as well, under per forma we have charity care  
14 at two percent and self-pay at one percent, which is three  
15 percent, but also, given the nature of this being primarily  
16 work injury, what we're seeing is that -- we're projecting  
17 is that 59 percent of the payor mix would be commercial or  
18 private, with Workers' Comp at about 18 percent and balance  
19 thereof. It's the nature of the patient population that  
20 really lends itself to a commercial Workers' Comp payor  
21 mix, but we did have three percent, including charity and  
22 self-pay, in the application.

23 MR. KRONEN: I'd like to add to that.  
24 Currently, we get referrals from private physicians for

1 patients who don't have insurance. Unfortunately, once  
2 they're sent out of the emergency room, getting them back  
3 to the same hospital gets very difficult, because they  
4 either have to qualify for charity or the hospital requests  
5 a down payment for them to have their procedure. This  
6 actually allows us to then provide the care that these  
7 individuals need on a charity basis, dealing with the  
8 self-pay, which often times becomes not -- becomes a very  
9 difficult situation once they get sent out of the emergency  
10 room. So, that -- if that answers your question.

11 MR. URSO: Yes, it does.

12 VICE-CHAIRMAN HAYES: Now, many of these  
13 patients that you currently see, you treat them in your  
14 office; is that correct? And perhaps some of them then are  
15 referred out to surgery centers or hospitals.

16 MR. FAKHOURI: Many patients are treated as  
17 outpatient, of course, and they're treated right then and  
18 there, and many of them require surgery. If they do, we  
19 have to find a surgery center that can take them as soon as  
20 possible. A scenario is, for example, a 9-year-old girl  
21 injures herself on Thursday, goes to the emergency room,  
22 they go to the emergency room or see the primary physician.  
23 Now they're sent to us. We see them that day or the next  
24 day. Now it's Friday. Imagine trying to get a surgery

1 center that will take them Friday to do surgery. What is  
2 the next day? Monday, maybe Tuesday, because they're at  
3 capacity. Right now I have a problem because Friday I  
4 can't get a fracture on and they're working on -- as your  
5 daughter is having a hand problem, my staff is trying to  
6 find a place for one of my wrist fractures, because Tinley  
7 Woods has full capacity. These are the issues that we deal  
8 with on a regular basis. Hence why we're here. Our  
9 motivation, I believe, is good. Our hearts are in the  
10 right place, and I believe this would be a good thing for  
11 our community.

12 VICE-CHAIRMAN HAYES: Now, would any of your  
13 payors -- specifically private insurance companies or  
14 Medicare or whatever, or Medicare or Medicaid, would  
15 they -- would you receive -- the surgery center -- would  
16 you receive an extra compensation for that or a facilities  
17 fee when you -- if you had a facility, an AST right at your  
18 office?

19 MR. KRONEN: We'd have to.

20 MS. MURER: The point is that reimbursement to  
21 an ASC would be the same whether it's owned by these  
22 physicians or if the patient is going to another ASC. The  
23 determination of whether that patient is seen in the office  
24 or the ASC depends on the appropriateness of that venue in

1 terms of anesthesiology or the complexity of the surgery.  
2 So, right now, the decision is, when a patient needs a  
3 surgery center on an outpatient basis, that payor source,  
4 whether it's Medicare, Medicaid, private, commercial or  
5 Workers' Comp, will pay the same rate to these physicians  
6 or to Tinley Woods. It's the same thing. The point,  
7 though, is that the physicians won't have to try to  
8 schedule that patient at four o'clock at Tinley Woods,  
9 rather than have that capacity to be able to make those  
10 decisions for themselves.

11 VICE-CHAIRMAN HAYES: I understand that.

12 MR. KRONEN: It's pretty much a rule on a  
13 daily basis where we'll be calling two or three surgery  
14 centers -- the fact is, they may have a slot in the morning  
15 and a slot in the afternoon, or they can't get anything on  
16 for four or five days. So, as we said, we acknowledge the  
17 capacity argument, but this is really about the  
18 availability, which we do not see, and this has been the  
19 same issue for 15 to 20 years.

20 VICE-CHAIRMAN HAYES: Any other questions for  
21 the Board?

22 (Pause)

23 VICE-CHAIRMAN HAYES: May I have a motion to  
24 approve project 11-100, to establish a multi-specialty ASTC

1 in Palos Hills?

2 MR. HILGENBRINK: So moved.

3 MR. SEWELL: Second.

4 MR. ROATE: Motion made by Mr. Hilgenbrink --

5 VICE-CHAIRMAN HAYES: Excuse me. Could we --  
6 I'd like to put -- if the applicant would be interested in  
7 putting on an amendment, basically saying if there was any  
8 other -- if there was any other specialty that you would  
9 add, you would come back to the Board. You would not  
10 become a multi-specialty without coming back to the Board.

11 MR. KRONEN: Yes, we'd have no problem with  
12 that.

13 MR. HILGENBRINK: I'll amend my motion.

14 MR. CARVALHO: Clarification. I think they're  
15 applying to be a single specialty. So, the issue you dealt  
16 with with the prior application was, because they were  
17 adding a third, that would make them a multi. But in the  
18 case of a single specialty, if they choose to add  
19 additional -- how many.

20 MR. KRONEN: Orthopedics and plastics would be  
21 considered limited specialty. So, to come back to add  
22 another specialty, we'd have to submit another application  
23 to become a multi-specialty, if that answers the question.

24 VICE-CHAIRMAN HAYES: Okay. Thank you.

1                   What I'd like to do is basically amend my --  
2   start over with my motion, because, basically, we're  
3   looking at a limited specialty. We're not looking at a  
4   multi-specialty specifically for this. So, may I have a  
5   motion to approve Project 11-100 to establish a limited  
6   specialty ASTC in Palos Hills?

7                   MR. URSO: This is 11-095.

8                   MR. HILGENBRINK: So moved.

9                   MR. SEWELL: Second.

10                  MR. ROATE: Motion made by Mr. Hilgenbrink,  
11   seconded by Mr. Sewell.

12                  VICE-CHAIRMAN HAYES: Excuse me. This is --  
13   I'll have to make this motion again. I'd like to -- may I  
14   propose a motion to approve Project 11-095, Palos Hills  
15   Surgery Center, a limited specialty ASTC in Palos Hills?

16                  MR. HILGENBRINK: So moved.

17                  MR. SEWELL: Seconded.

18                  VICE-CHAIRMAN HAYES: Thank you.

19                  MR. ROATE: Motion made by Mr. Hilgenbrink,  
20   seconded by Mr. Sewell.

21                  Mr. Eaker?

22                  MR. EAKER: I'm going to vote no. It seems to  
23   me that this application is more about maximizing profits  
24   as opposed to lowering overall healthcare costs or

1 improving access to healthcare.

2 MR. ROATE: Justice Greiman?

3 MR. GREIMAN: I'm going to vote aye. I think  
4 they made a fine presentation, explaining how they want to  
5 service patients.

6 MR. ROATE: Mr. Hayes?

7 VICE-CHAIRMAN HAYES: I'm going to vote no.

8 MR. ROATE: Mr. Hilgenbrink?

9 MR. HILGENBRINK: Yes.

10 MR. ROATE: Ms. Olson?

11 MS. OLSON: Yes.

12 MR. ROATE: Mr. Penn?

13 MR. PENN: No, due to under utilization in the  
14 area.

15 MR. ROATE: Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. ROATE: That's four votes in the  
18 affirmative, three votes in the negative.

19 VICE-CHAIRMAN HAYES: The motion does not  
20 pass.

21 MR. URSO: You're going to be receiving an  
22 Intent to Deny. You'll have an opportunity to come back  
23 before the Board, as well as submit additional information.

24 VICE-CHAIRMAN HAYES: I'd like to take a

1 break until 3:10, and we'll reconvene then.

2 (Recess).

3 VICE-CHAIRMAN HAYES: I'd like to call Item  
4 H-32, 11-098, Ritacca Laser Center, Limited. The  
5 applicants are at the table there, and could you swear in  
6 the applicant, and we'll have the State Agency Report then.

7 (Oath given)

8 MR. CONSTANTINO: Thank you, Mr. Chairman.  
9 The applicant, Ritacca Laser Center, Ltd.,  
10 proposes to add pain management services to an existing  
11 limited specialty ASTC in approximately 4,500 gross square  
12 feet of space. This ASTC currently offers ophthalmologic  
13 and plastic surgery. There is no cost to this project.  
14 The anticipated project completion date is August 31st,  
15 2012.

16 The ASTC consists of two operating rooms and  
17 six recovery stations. Should the State Board approve this  
18 project, the facility will be classified as a  
19 multi-specialty ASTC. No public hearing was requested and  
20 no letters of support was received by the State Board  
21 Staff. One Impact Letter was received from Grand Oak  
22 Surgery Center.

23 Finally, there are existing facilities within  
24 the proposed TSA not operating at target occupancy.

1 Thank you, Mr. Chairman.

2 I would like to apologize for the mistake we  
3 made on your agenda for the last project. That was my  
4 mistake. I apologize for that.

5 VICE-CHAIRMAN HAYES: I accept. Thank you,  
6 Mike.

7 The applicants, could they identify themselves  
8 and give a presentation.

9 MR. KNIERY: Thank you, Mr. Vice-Chair. My  
10 name is John Kniery. I'm with Foley and Associates,  
11 healthcare consultants. To my left is Dr. Daniel Ritacca,  
12 and to my right is Dr. Jay Joshi. I'd like to have  
13 Dr. Ritacca make some opening comments about the facility  
14 and what brings us here today, and then I'll address a  
15 couple of the negative findings.

16 MR. RITACCA: Thank you very much for your  
17 time, Mr. Chairman and the Board. I'd like to thank the  
18 Staff for the support for this project.

19 Ritacca Laser Center specializes in eyes and  
20 plastic and reconstructive surgery, and we opened  
21 approximately two years ago. In December of 2008, fire  
22 destroyed our surgery center, which caused us to seek  
23 renewal of our permit. Even though this partially whipped  
24 out my practice, this impact was met with increasing

1 surgical volume and progress over the last two years, and  
2 approximately 2,000 hours are currently taking place in the  
3 two OR system, which I believe 80 percent would be 3,000  
4 hours. Dr. Joshi approached me approximately in the last  
5 year. He's a pain specialist, Board-certified in  
6 anesthesia, with distinguished work in health organizations  
7 in Geneva at the World Health Organization and Fraud and  
8 Waste Reform in America. He's a consultant of pain  
9 management, and I felt with his help, I could get to this  
10 80 percent level, and as I improved the volume my practice  
11 as well. He shares office space with me in the building  
12 where the surgery center is, and because of the 50 percent  
13 rule and the limited specialty, and I am presenting today  
14 to the Board.

15 I have conferred with two area hospitals and  
16 am encouraged and believe that the addition of a pain  
17 facility that accepts Medicaid and Blue Cross in the area  
18 is needed. I asked Condell to write me a letter to that  
19 effect, and they support my endeavors. No public hearing  
20 was requested, and I believe our opposition to the project  
21 does not accept major insurance or Medicaid.

22 I'm going to allow Dr. Joshi to make a  
23 statement.

24 MR. JOSHI: Thank you, Board members, and

1 thank you for hearing us. My name is Jay Joshi. I'm an  
2 anesthesiologist and an ABA, Board-certified interventional  
3 pain physician. Why is that important? Because it's the  
4 only accreditation that is recognized by the American  
5 College of because I think in the future, you're going to  
6 be approached by other people who are going to call  
7 themselves pain physicians. The reality is, the vast  
8 majority of pain physicians in America are not accredited  
9 by an American College of Medical Specialties  
10 accreditation. The reason for that is if you look at the  
11 landscape of pain, you'll find that by the Department of --  
12 the Office of Internal Medicine published a study earlier  
13 this year. The demographics of chronic pain state that  
14 about one-third of America has some kind of chronic pain,  
15 over one hundred million people in America. The amount of  
16 people that just have the accreditation that's recognized  
17 in America is about 4,000. That doesn't mean they're good  
18 or bad or whatever. That just means how many people are  
19 recognized? You understand the deviation. You see, there  
20 is a huge deficiency of people that are actually accredited  
21 that do interventional pain management. How many of those  
22 do comprehensive or multi-modal pain management? That  
23 number is extremely small. It's a topic I've become very,  
24 very passionate about. I even did work on this before I

1 graduated medical school. I did a lot of healthcare policy  
2 and world health organization. I've really put my money  
3 where my mouth is, even before I had money to put in my  
4 mouth, and I've worked on -- met some of our esteemed  
5 Congressmen of Illinois to try and get some reform, as well  
6 to try to increase patient satisfaction, patient care,  
7 decrease the healthcare over utilization, and streamline  
8 care, so especially for our population like Medicare,  
9 Medicaid patients, where we have a major problem in  
10 America. How do we take care of these patients? A lot of  
11 physicians don't even accept those insurance plans. Those  
12 are the things I've tried to work on.

13 I was a Medical Director for Pain at Alexian  
14 Brothers, and it was something -- another topic that I  
15 tried to streamline. At that hospital, just in the last  
16 year, I can tell you that I saw more Medicaid patients than  
17 anyone, any other pain physicians on staff there, and I  
18 think I actually saw more Medicaid patients than all the  
19 pain physicians on staff there combined.

20 We don't have those services. It's a major  
21 problem. Some of the pain physicians on staff at the  
22 hospital and the community don't even take Medicare  
23 anymore. So, it's a major problem, because chronic pain is  
24 more prevalent, obviously, as we all get older. We see it

1 in younger patients, too, from car accidents and things  
2 like that. As we all get older, we're all going to have  
3 it. Arthritis is one major form of chronic pain. We're  
4 all going to have it and management of that is really  
5 important. If you don't manage it, you start seeing the  
6 numbers that we see right now, which include a total cost,  
7 indirect and direct care, of \$635 billion a year. To me  
8 that's insane. It can be lower if we sort of streamline  
9 care and actually take care of patients early on, instead  
10 of allowing them to enter this horrible, disabled sort of  
11 situation.

12 I have an office in the Schaumburg area, and  
13 Lake County is an area that's incredibly under served by  
14 qualified pain physicians, to the point where just the  
15 people who actually have the same credentials I do, in  
16 terms of just education, not in terms of anything else,  
17 just the credentials, I think we're only able to identify  
18 maybe 10 or 15 or something like that, for a population of  
19 over a million people. Obviously, that number is -- if you  
20 sort of look at just the demographics you're seeing maybe  
21 300,000 who have chronic pain and ten people to manage it.  
22 That's insane. Out of those people, again, some of those  
23 people don't take Medicare. Some of those people don't  
24 take Medicaid. I looked very hard to find facilities where

1 I could take patients in Lake County. Of all of the places  
2 I approached and I called, all the surgery centers --  
3 there's a couple, only two even remotely in the area, and I  
4 say "remotely". I'm talking half an hour, 40 minutes away,  
5 that offer pain, and none of them would let me even step  
6 foot on the property, because they don't want me there  
7 because of the competition. They just want to keep their  
8 little thing. So, they wouldn't even allow me. One of  
9 them is up for sale, so they won't -- obviously, they  
10 weren't interested in having anyone there.

11 The only person, the only surgery center that  
12 said, "Hey, we want to actually take care of your patients.  
13 We actually will take Medicare and Medicaid patients," was  
14 Dr. Ritacca. The only problem, obviously, is he didn't  
15 have a pain certification. So, it's taken us about  
16 probably close to a year now to be -- have the opportunity  
17 to be here today, and that's why we're here today. So,  
18 thank you for your time and, obviously, I'm open to  
19 questions.

20 One other point I want to mention. There's a  
21 veteran's hospital up by north Chicago. We've been  
22 approached for a year now to help provide services to the  
23 patients out at the VA up there. The only problem is we  
24 haven't been able to have a facility up in Lake County.

1 Our closest facility is down in Schaumburg. So, those  
2 patients would literally have to drive down an hour each  
3 way to be able to see us, and when you say see someone,  
4 it's not just procedures. There's follow-ups, there's --  
5 sometimes there are medications and medication checks. You  
6 have to make sure that they're actually doing well. So,  
7 all those visits, they would have to drive down an hour to  
8 see us, and it's incredibly inconvenient. A lot of the VA  
9 patients are elderly patients that have a lot of health  
10 issues, and it's really hard for them to drive an hour each  
11 way. So, we've really been waiting for a facility in Lake  
12 County that's only 20 minutes away and something much more  
13 reasonable for those patients.

14 Thank you.

15 VICE-CHAIRMAN HAYES: Excuse me. Could I  
16 take a little break here? I'd like to note that Member  
17 Penn has left the meeting, while we still have a majority  
18 and quorum.

19 Proceed.

20 MR. KNIERY: Thank you. I would just like to  
21 address the findings in the State Agency Report briefly, if  
22 I may. As you review the report, you'll note that there  
23 are basically two issues: Under utilization of existing  
24 facility per population center, and the second is low

1 utilization of the area facilities, namely Granville  
2 Surgery Center.

3           The first issue, Dr. Ritacca and his physician  
4 associates have been rebuilding the utilization rates from  
5 the loss as a result of a facility fire. As reported in  
6 the application -- they will report also in the next annual  
7 questionnaire form -- their utilization has been around  
8 2,000 hours and is growing on an annualized basis. As  
9 previously indicated, also Ritacca Laser Center is now  
10 whole again. So, it is projected that they will be able to  
11 continue improving their utilization rates to near optimal  
12 levels through ongoing operations and with existing case  
13 load. This project also supports the facility's ability to  
14 reach and maintain the optimal utilization by bringing on  
15 additional specialty and by using an existing healthcare  
16 resource.

17           The second issue, the area low utilization.  
18 We think that the focus of the Board and this criteria  
19 specifically is to utilize existing capacity in existing  
20 area surgery centers before establishing a new center and  
21 expending additional healthcare dollars. Although there  
22 appears to be an existing facility with utilization rates  
23 less than the State's optimal targets, Ritacca Laser Center  
24 is such a facility and should be utilized before a new

1 surgery center is established. To that end, we have a  
2 doctor who has approached the 50 percent licensing rule  
3 under ambulatory surgical treatment centers, which limits  
4 his own practice. He will need to be either licensed or  
5 find alternative locations to perform these procedures or a  
6 percent of these procedures. This project fulfills the  
7 Board's intent and rules by utilizing the existing  
8 healthcare resource of Ritacca Laser Center with the lowest  
9 amount of healthcare capital.

10 And it is important to point out that this  
11 project did receive a letter of support from Condell  
12 Medical Center, a local area hospital.

13 If I can direct your attention quickly to the  
14 chart in the State Agency Report on page 13 and 14, Table  
15 2, I believe it is, there appears to be a total of 14  
16 surgery centers, for instance. However, I'd like to point  
17 out that only 8 of those are actually within 30 minutes.  
18 From those, there are only two centers that actually do  
19 pain, pain specialty, Grand Oak Surgical Center, I believe,  
20 and Ravine Way Surgery Center. Ravine Way is nearly 30  
21 minutes away at just over 28 minutes, and Dr. Joshi  
22 referred to Grand Oak Surgery Center, which was approved  
23 two and a half years before Dr. Ritacca's center, is just  
24 recently opened. As you see, don't even have their latest

1 year of utilization. They opened that recently, and they  
2 are already in the process of trying to find a buyer for  
3 that facility.

4 So, I'd like to turn it over -- back over to  
5 Dr. Ritacca for just one brief comment on charity care.

6 MR. SEWELL: Before you do that, not your last  
7 point, but the point before that, I was just totally lost.  
8 I'm sorry.

9 MR. CARVALHO: Why don't you -- you'd rather  
10 explain it than let me do it. So, why don't you explain  
11 that issue about if the physician does a certain amount of  
12 activity in their office that goes beyond 50 percent, then  
13 they have to have a license as a surgery center, not being  
14 able to do it as they have been doing it in just a doctor's  
15 office. Why don't you explain that?

16 MR. KNIERY: I can't say it much better than  
17 that. Let me try. There is a rule --

18 MR. CARVALHO: Okay. I guess I will. Right  
19 now in Illinois there are many things that a doctor is  
20 allowed to do in their office, office procedures, that  
21 might also be done in a surgery center, and so the way  
22 regulation works is we, as the Department of Public Health,  
23 don't regulate that activity if it's just occurring in a  
24 doctor's office, because the medical community doesn't want

1 that type of regulation. But the question became, well, at  
2 some point it's functioning as a surgery center, not as a  
3 doctor's office. What should that point be? And so the  
4 compromise written into the law is that after a certain  
5 amount of activity occurs in a doctor's office that looks  
6 like surgery, it now has to go in and get licensed as a  
7 surgery center, not work under the exception of a doctor's  
8 office exception. And so I think from what John said is  
9 that Dr. Joshi's activity -- the mix of stuff that he's  
10 doing in his office, the stuff that would account for  
11 surgery versus the stuff that doesn't account for surgery,  
12 the mix is approaching the point where he's going to start  
13 to look like a surgical center for our purposes, "our"  
14 being the Department of Health, and so then he's faced with  
15 a choice. He has to start doing the stuff that would look  
16 like surgery someplace else, or he has to himself try to  
17 become a surgical center, and that's when the Department of  
18 Public Health rule kicks in with yours, because he can't  
19 just become a surgical center by calling himself that. He  
20 has to apply to you. So, that's the interplay of our  
21 Department of Public Health law and rules and your law and  
22 rules.

23 MS. OLSON: I didn't understand whose  
24 utilization rate. You're talking about Dr. Joshi's

1 utilization rate?

2 MR. KNIERY: Correct, in his current practice.  
3 If you want me to go into it, I definitely can. The 50  
4 percent rule comes from the Ambulatory Surgery Treatment  
5 Center licensing requirements, and it says -- and I'll  
6 quote -- "Any institution or building devoted primarily to  
7 the maintenance and operation of facilities for the  
8 performance of surgical procedures, as evidenced by use of  
9 the facilities for the performance of surgical procedures,  
10 which constitutes more than 50 percent of the activities at  
11 this location," end quote, should be considered a surgery  
12 center.

13 MS. OLSON: I get it.

14 MR. CARVALHO: Just to keep all the thoughts  
15 together at one point, if you recall, Member Eaker  
16 mentioned in another application the issue of facility fee,  
17 and what he was alluding to, if you, as a physician, are  
18 doing those surgical procedures in your office before your  
19 office has been converted to a surgery center, you are not  
20 eligible for being paid a facility fee. If you're doing  
21 them in an office that has been converted to a surgical  
22 center -- exact same procedures -- you now are eligible or  
23 the facility is eligible for a payment of a facility fee,  
24 and so, sometimes that issue comes up in your discussions

1 about is this saving money or not saving money or -- but  
2 that's the key. The facility fee doesn't go to the same  
3 stuff, just when it's in a doctor's office.

4 MR. KNIERY: The nice thing about this  
5 process, also we have provided those charges from what  
6 Dr. Joshi has projected he will charge, and we also, per  
7 your rules, are holding those constant for at least two  
8 years. So, that's a health saving facet that's built in  
9 your rules that we are applying for But I would like  
10 Dr. Ritacca to make a brief comment about the charity care  
11 policy at Ritacca Health Center.

12 DR. RITACCA: After sitting through the  
13 meeting today, I realized the concern of the Board members  
14 on charity care and public health, and I felt it was  
15 necessary to address that issue on charity care at my  
16 facility. Personally, for the last 15 years, I've helped  
17 establish Lake County's Gang Tattoo Removal Program, where  
18 we laser and surgically remove tattoos from gang members  
19 professionally for free. I helped Mr. John Hernandez  
20 (unintelligible) a gang outreach, as well as gang outreach  
21 programs throughout the state and even through Indiana and  
22 Missouri, because I get gang members all the way from there  
23 to remove their tattoos. I've done this voluntarily. I've  
24 never thought about how important this would be except

1 today at this meeting. There's often times I have feared  
2 for my life -- but I do it anyway -- because I don't know  
3 if I'm offending another gang member by removing his fellow  
4 member's tattoo. I didn't want to bring attention to this,  
5 but now I think it's important.

6 For the last 30 years, I taught at Cook County  
7 Hospital in three departments. For the last 10 years I've  
8 done it voluntarily, without even a mention for gas money  
9 or for parking. I've taught the specialty of dermatology  
10 plastics around the eyes, ophthalmology and maxillofacial  
11 surgery, and in regards to the tattoos, I've probably  
12 removed 1,000 gang-related tattoos, and I've helped these  
13 people return to normal lives.

14 The question may be, why haven't you done it  
15 in the surgery center? That's a good question, and I  
16 probably will do from now on, but I do it mostly for  
17 convenience of the patient and time, and in the surgery  
18 center, it would take me probably over an hour. In the  
19 suite next to the surgery center, it takes me about 15  
20 minutes.

21 On page 99, Dr. Feldman from the John Stroger  
22 Hospital has written a letter to the Board, graciously  
23 praising my efforts in helping his students as well as  
24 addressing the needs of the under served, which I have done

1 up until this moment without boasting.

2 Thank you very much.

3 MR. KNIERY: I think at this time we'd be more  
4 than happy to answer any questions you may have.

5 VICE-CHAIRMAN HAYES: Board member questions?  
6 David?

7 MR. CARVALHO: Two quick questions. You  
8 mention your efforts to find places and you wouldn't find  
9 places that would accept Medicare and Medicaid. Hospitals  
10 accept Medicare and Medicaid. What is the impediment to  
11 doing what you want to do in a hospital.

12 DR. JOSHI: I have taken patients to  
13 hospitals. That's where I take them right now. I take  
14 them to Alexian Brothers in the Schaumburg area. The  
15 distance between there -- I have patients up in Gurnee,  
16 Grayslake. That's like -- I don't know -- an hour, hour  
17 and 15 minutes. That's a huge distance to bring them down.

18 The other issue is hospitals are far more  
19 expensive. I have patients who are Medicare patients,  
20 patients who are Blue Cross, whatever the case may be,  
21 Medicaid patients, patients who have sometimes 20 percent  
22 co-pay, and I have seen the EO's that the hospital charges  
23 for simple 10-minute procedure. They charge them \$5,000.  
24 So that means my patient is stuck with a thousand dollars

1 from the hospital, which to me is an absolutely insane cost  
2 for a 15-minute procedure. I mean, the whole entire  
3 procedure in an office is maybe sometimes one-fifth,  
4 sometimes, of their 20 percent co-pay at the hospital.

5 The hospital -- we all share the procedure  
6 rooms. The patient before me could have been a MRSA  
7 patient, and so now I've got to contend with a perfectly  
8 healthy person, coming in for an elective procedure that  
9 they end up paying \$1,000 for a co-pay, going into a room  
10 that someone has MRSA was in. I have done that. That's  
11 what I do, but, again, it's very far away from Lake County.  
12 Lake County is truly -- you all know where Lake County is.  
13 It's truly a geographic area that has been incredibly under  
14 served by people with my -- in my specialty, with my  
15 credentials, and the whole goal then is to target those  
16 patients in Lake County, those VA patients in Lake County,  
17 the Medicare patients in Lake County, and keep that  
18 population from driving an hour. And local hospitals  
19 support this project, too.

20 MR. CARVALHO: As luck would have it, my  
21 division is the Division of Patient Safety and Quality, and  
22 we're responsible for the issue of healthcare-acquired  
23 infections and dealing with it. The patients you see in  
24 your center, the patient before could also have MRSA.

1 MR. JOSHI: True.

2 MR. CARVALHO: In fact, recent reports from  
3 CMS have suggested that the rate of healthcare-acquired  
4 infections and the risk of infection in surgical centers  
5 has been grossly under estimated, due to lack of collection  
6 of appropriate data. So, I don't think you want to make  
7 the case that hospitals are where people get MRSA and  
8 surgery centers are where they don't, because I don't think  
9 that's an accurate statement.

10 Could I ask a question of Staff? On page 7 of  
11 our SAR, there's a chart that has a bunch of zeroes that  
12 I'm not sure I understand. One shows zero charity patients  
13 and the cost of charity care being \$4,000. Are there typos  
14 in that chart?

15 MR. CONSTANTINO: No. This is what was  
16 provided to us by the applicants, David.

17 MR. CARVALHO: Okay. I guess the question is  
18 for the applicant. This chart shows zero charity patients,  
19 zero Medicaid patients, zero revenue, but the cost of  
20 charity care was 4,000. Could you explain both the -- your  
21 point was that this was a facility that takes Medicaid, but  
22 the chart has zero Medicaid. Just please explain the  
23 chart.

24 DR. RITACCA: Yes. Thank you for asking that.

1 That's a good question.

2 I've taken Medicaid now for as long as I've  
3 been open. We'll say two and a half years. My accounts  
4 receivable for Medicaid is close to \$300,000. I've not  
5 received one penny of it.

6 MR. CARVALHO: This is cash accounting? It's  
7 a fact that you have billed Medicaid, but you haven't  
8 received the money?

9 DR. RITACCA: Correct. I've tried -- and I  
10 probably have scores of pages -- working with Medicaid, and  
11 I can give names to the Medicaid office, why I can't get  
12 paid, and hopefully -- close to three years -- we are  
13 working through this problem. So that's -- hope that  
14 number for Medicaid will no longer be zero, but I continue  
15 to take Medicaid, which I think that shows my good faith  
16 and believing in the system, because I'm not sure how many  
17 other physicians would continue to finance surgery for all  
18 of this time and not get paid and continue to take  
19 Medicaid.

20 MR. KNIERY: If I may elaborate, also, on a  
21 comment that Dr. Ritacca made a little while ago,  
22 Dr. Ritacca -- the charity care that he was mentioning  
23 earlier, this is care he provides personally through his  
24 practice. That's what he was saying, and I told him, I

1 wish you would have been doing this as part of the surgery  
2 center and you could report it as such. But he is -- I  
3 will speak for him. He is very committed to taking care of  
4 this population.

5 VICE-CHAIRMAN HAYES: This is a limited  
6 specialty ambulatory surgery center?

7 MR. KNIERY: It is right now, yes.

8 VICE-CHAIRMAN HAYES: Under our rules, you'll  
9 be going to a multi-specialty with adding this new service.

10 MR. KNIERY: Yes.

11 VICE-CHAIRMAN HAYES: Would you be -- accept  
12 an amendment that basically would require you, if you  
13 wanted to enter a new -- beyond the pain management and  
14 beyond ophthalmology and plastic surgery, if you wanted to  
15 enter another specialty, that you would have to come back  
16 to the Board and do that?

17 MR. RITACCA: Absolutely, Vice-Chairman.

18 I would just like to mention a few things  
19 about plastic and reconstructive surgery. Sometimes we can  
20 enter into another specialty -- and I don't want to  
21 misconstrue. When we move somebody's jaw, I don't want it  
22 to look like we're maxillofacial. When we fix a hernia, I  
23 don't want it to look like we're general surgery. So, I do  
24 not plan to do any of those. I do not have the space nor

1 do I have the time. I'm looking to get to the 80 percent  
2 rule. I'm very content to doing plastic and reconstructive  
3 surgery. So, as Mr. Constantino can tell you, there was at  
4 one point that we do vein surgery. I have a vascular  
5 surgeon that fixed his varicose veins. It was construed as  
6 general surgery. I have no plans on doing any other  
7 specialty, but in the future, if the need arises in my  
8 specialty, plastics and reconstructive, that I feel like  
9 the Board is misinterpreting this as another procedure, I  
10 will come in front of you, yes.

11 MR. KNIERY: Does that answer your question?

12 VICE-CHAIRMAN HAYES: Yes.

13 MR. CARVALHO: Dr. Ritacca, let me just  
14 clarify what we're asking. You may have misunderstood.  
15 Theoretically, under ordinary procedures, by virtue of  
16 adding a third specialty -- if this were approved without  
17 condition, you could add thereafter anything. Not that you  
18 could branch out a little, you could really add anything,  
19 and the Chair has asked would you accept a condition on  
20 this application that you couldn't add -- the things that  
21 you could otherwise add but for this condition? In other  
22 words, you would be restricted to the three specialties  
23 that you would at that point have received approval for.

24 DR. RITACCA: I absolutely agree with this,

1 but I hope you understand as -- the confusion. When we do  
2 an abdominoplasty and we fix a hernia, I'm not doing  
3 general surgery.

4 MR. CARVALHO: That's a slightly different  
5 issue, which is an issue that you currently have authority  
6 to do two categories and what are the boundaries of those  
7 categories. That's an issue that I know you've addressed  
8 with us. The difference -- this is a slightly different  
9 issue that I think you now understand, is that  
10 theoretically, you do do ophthalmology. If this were  
11 approved and you could receive the third category, you  
12 could then start doing ophthalmology and you could start --  
13 I don't want to speculate. And that's the thing that the  
14 Chairman was suggesting. Would you accept the condition  
15 that limits you to the three?

16 DR. RITACCA: Yes.

17 VICE-CHAIRMAN HAYES: Thank you.

18 Seeing no other questions, I'd like to -- may  
19 I have a motion to approve Project 11-098 to establish a  
20 multi-specialty ASTC in Vernon Hills, with a condition that  
21 if there is additional specialties beyond ophthalmology,  
22 plastic surgery, and pain management, that the applicants  
23 would come before the Board for additional specialties?

24 MR. GREIMAN: So moved.

1 MR. SEWELL: Second.

2 MR. ROATE: Motion made by Justice Greiman,  
3 seconded by Mr. Sewell.

4 Mr. Eaker?

5 MR. EAKER: Yes.

6 MR. ROATE: Justice Greiman?

7 MR. GREIMAN: Yes.

8 MR. ROATE: Mr. Hayes?

9 VICE-CHAIRMAN HAYES: Yes.

10 MR. ROATE: Mr. Hilgenbrink?

11 MR. HILGENBRINK: Yes.

12 MR. ROATE: Ms. Olson?

13 MS. OLSON: Yes.

14 MR. ROATE: Mr. Penn? Absent.

15 Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. ROATE: That's six votes in the  
18 affirmative.

19 VICE-CHAIRMAN HAYES: Motion passes. Thank  
20 you.

21 DR. RITACCA: God bless you, and thank you.

22 (Pause)

23 VICE-CHAIRMAN HAYES: Now we'd like to move  
24 to our next item on our agenda, which is I-01. This is

1 under the Applications Subsequent to Intent to Deny. Item  
2 I-01, 11-038, FMC Naperbrook. The applicant may come to  
3 the front here.

4 (Pause)

5 VICE-CHAIRMAN HAYES: State Report?

6 MR. CONSTANTINO: Thank you, Mr. Chairman.

7 Fresenius Care Holdings, Inc. and Fresenius  
8 Medical Care Naperbrook, LLC, the applicants, are proposing  
9 the establishment of a 16-station ESRD facility located in  
10 approximately 10,000 gross square feet of leased space in  
11 Naperville, Illinois. The cost of the project is  
12 approximately \$4.9 million. The anticipated project  
13 completion date is December 31st, 2013.

14 State Board Staff notes that this project  
15 received an Intent to Deny at the October 2011 State Board  
16 meeting. No public hearing was requested, and no letters  
17 of support or opposition were received by the State Board  
18 Staff. Currently HSA IX has a calculated excess of 30 ESRD  
19 stations and 2 of the 11 facilities in a 30-minute drive  
20 radius are operating below the target occupancy of 80  
21 percent.

22 Thank you, Mr. Chairman.

23 VICE-CHAIRMAN HAYES: Thank you.

24 The applicant, if you could identify

1 yourselves again and then go ahead with your presentation.

2 MS. RANALLI: Certainly. Clare Ranalli,  
3 counsel for the applicant.

4 MS. WRIGHT: Lori Wright, CON Specialist for  
5 Fresenius.

6 MS. GURCHIEK: Teri Gurchiek, Director of  
7 Operations for Fresenius.

8 As I said, I'm the Director of Operations for  
9 actually the Naperville, Bolingbrook area, and I do oversee  
10 the operations of those facilities. I have a special  
11 relationship with this particular clinic, because 21 years  
12 ago, when I was in nursing school, I actually worked at  
13 this facility, and when I started working there, it only  
14 had a handful of stations, and today it's operating with 15  
15 stations. I've seen them grow from a very small clinic to  
16 this very busy clinic that has had to operate four shifts  
17 in the past and continues to run on the border of having to  
18 do so.

19 We have two facilities now in Naperville. One  
20 of them was opened five years ago, and we've added stations  
21 to this one since then. Currently, the utilization rates  
22 at both of these facilities are almost 90 percent. We've  
23 seen a steady growth each year, and based on what our  
24 Medical Directors are telling us, we can expect that growth

1 to continue.

2           When this project received an Intent to Deny  
3 in October, due to the excess capacity, and the new  
4 inventory came out, showing the need for 108 stations in  
5 HSA VII, we considered abandoning this project and  
6 reapplying in HSA VII, on that side of Naperville, even  
7 though this particular site is 400 yards from HSA VII.  
8 However, we couldn't find a location that provided the same  
9 access. Many of the other sites that we looked at were too  
10 small or they didn't provide enough parking or it was very  
11 difficult for patients, visitors, and the ambulances to get  
12 in and out, because you could only go one way on that  
13 particular busy stretch of street.

14           We believe that this location is ideal for  
15 mainly three reasons. It is centrally located. It  
16 straddles the county line between Will and DuPage counties,  
17 and it will supply the need for the 108 stations in HSA  
18 VII, which is just 400 yards away from the site that we  
19 have found. It provides excellent transportation access  
20 for patients, as I said earlier. It is just a straight  
21 shot down Washington from our current facility. And  
22 probably the most important issue here is that this  
23 building that's existing can be easily expanded, and as we  
24 mentioned the last time we were here, our lease is up to

1 expire in 2014 with Edward Hospital, and we will have to  
2 leave that location, and what the plan was, to move those  
3 patients from that existing site into this site that we  
4 would want to expand on, to accommodate those patients.

5 So, we know that there's a defined need for  
6 more dialysis care in this area, based on what we know now,  
7 and we're planning to address the need, particularly since  
8 we're going to be moving from Edward Hospital. I  
9 appreciate you listening to me and thank you and encourage  
10 you to vote in favor of our project.

11 VICE-CHAIRMAN HAYES: Thank you.

12 MS. RANALLI: Thank you. First of all, thank  
13 you. I know it's been a long day, and we appreciate your  
14 time. Because this project is pending subsequent to an  
15 Intent to Deny, if you could just indulge us with a few  
16 more minutes of your time, I did want to point out a couple  
17 of things.

18 First, when we were before you previously, we  
19 received an Intent to Deny vote. We had four affirmative  
20 votes then, despite the fact there was an excess in  
21 capacity in both HSA IX and HSA VII. Now there is a need  
22 for 108 stations in HSA VII, which is just 400 yards from  
23 our chosen site. Also -- and I don't usually do this, as  
24 many of you know, but I think a picture speaks a thousand

1 words, and while it's on the chart that you have, Table 5  
2 shows that there are only two facilities within 30 minutes  
3 that are under utilized. One is at 79.86 percent. I would  
4 have rounded up, if I had been doing the State Agency  
5 Report, but I guess I wasn't. So, the other one is a  
6 Lombard facility, and that was just certified about six to  
7 eight months ago. So it's still in the ramp-up mode. It  
8 has not been operating for more than a year and, again, it  
9 was just certified, meaning we could admit Medicare  
10 patients to it just about six to eight months ago.

11 Also, let me know if you can't hear me, but  
12 this map is really, I think, very helpful, if it were not  
13 upside-down.

14 (Laughter)

15 MR. URSO: I was wondering what country we  
16 were in.

17 MS. RANALLI: Mr. Urso, this is in the  
18 application, except we added the 400 yards, after the  
19 inventory showed a need up there.

20 We are actually -- another point you all  
21 brought up when we appeared before you previously, we  
22 mentioned what we were doing is relocating our Edward  
23 Naperville Clinic to here, because we received a letter  
24 from Edward Hospital -- or notice from Edward Hospital,

1 verbal, that we had to move in 2014. You asked us to  
2 provide a letter from Edward Hospital, which we did,  
3 confirming that they want us out of the space we're  
4 currently in on their campus.

5           So, in reality, this is a relocation to here  
6 (indicating). We did not couch it as a relocation in the  
7 application, because under your rules, we cannot. We have  
8 to relocate within the same HSA and, therefore, when we  
9 filed the application, we filed it as what we would call a  
10 de novo, a new clinic. But what is going to happen is this  
11 clinic at 86 percent utilization, which Teri has spoken to,  
12 that has been in existence for more than 21 years, is going  
13 to close. We're going to relocate here (indicating). We  
14 have room for expansion, because the physicians tell us  
15 that there is a need for expansion, but if we expand, we  
16 would come back to you, as we are required to do under your  
17 rules, to receive approval to add stations to this  
18 facility. So in many respects, this is a relocation. It  
19 is within 400 yards of an area where there is a need.  
20 There are a number of clinics within 30 minutes. They're  
21 all at capacity, except for Lombard -- and I'm stretching  
22 when I say "all," because one is at 79.86 percent. But  
23 they're all at capacity and above, except for Lombard,  
24 which has only been operated and certified for six to eight



1 patients to the Naperbrook facility. Then the lease is up.  
2 We will submit another CON application to discontinue that  
3 facility. Those patients will be sent to the Naperbrook  
4 facility, and if we need additional stations at that time,  
5 we will do a CON for an expansion, and we have 2,000 gross  
6 square feet of additional space there that we can modernize  
7 at that time.

8 VICE-CHAIRMAN HAYES: You'll have -- because  
9 at the Edward Hospital, you have 16 right now?

10 MS. RANALLI: Fifteen.

11 VICE-CHAIRMAN HAYES: And how much shelf  
12 space -- how many stations, approximately, would you put at  
13 this Naperbrook facility then when you build that out?

14 MS. RANALLI: We're requesting approval for 12  
15 stations. We have -- 16 stations, I'm sorry. And we have  
16 the opportunity to build out for 15 more. But, obviously,  
17 we need to come back for your approval to do that. So, as  
18 the need occurs, if the need occurs, we would add stations  
19 as is warranted at the new location. But the 16 stations  
20 would accommodate 15 that are currently at Edward Hospital  
21 and then add a station, because, again, as you can see, we  
22 have 86 percent at both of our facilities. So, we went for  
23 16 stations to accommodate that factor.

24 VICE-CHAIRMAN HAYES: Now, basically, you --

1 December 31st of 2013 was the expectation for this facility  
2 to be completed. From there then you would have to build  
3 an additional 15 stations to be able to take over the  
4 Edward Hospital, their facility, to be able to close that  
5 and to put a total of 31 stations at this Naperbrook  
6 facility?

7 MS. RANALLI: No. We're requesting just 16  
8 stations. So, we'll hopefully be complete, pending  
9 certification, at the end of 2013. The Naperville  
10 facility, the lease expires in 2014. I don't recall the  
11 date -- August. So when that facility closes -- and  
12 probably actually before, quite frankly. I think Edward  
13 would like us out sooner rather than later. We will start  
14 transferring those patients from the 15 stations at Edward  
15 to the 16-station facility at Naperbrook, and then if  
16 growth occurs, we would add more stations up to -- and  
17 space for up to 15. I think it would be unlikely we would  
18 add that many, but there's also room for home dialysis  
19 training and peritoneal dialysis.

20 VICE-CHAIRMAN HAYES: Would you be amenable  
21 to defer this project and be able to greater specify your  
22 long-term plans in this area, specifically Edward Hospital  
23 and your facility at Edward and this one and the timing  
24 involved with them?

1 MS. RANALLI: We already have the letter from  
2 Edward, which is in the record, reflecting that it has  
3 asked us to leave. That letter reflects that it's asking  
4 us to vacate the space no later than August of 2014.  
5 That's when our lease is up, and our application says this  
6 facility will be closed at the end of -- we hope to  
7 complete this facility at the end of 2014, again allowing  
8 time for the transfer of patients as we -- we hope to be  
9 certified by 2013, and then we could start the transfer of  
10 patients from Edward right away. I'm not sure how much  
11 more we can clarify, and because we're pending subsequent  
12 to an Intent to Deny, I think the latest we could be  
13 deferred would be the 28th, and, honestly, that's -- to be  
14 truthful, it's going to cost a great deal of money to keep  
15 that space. We've already maintained it for some time at  
16 the Naperbrook site that we have, and it's such an ideal  
17 site -- I mean, we even considered withdrawing the  
18 application and going into HSA VII when the new inventory  
19 came out, but that simply wouldn't be in the best interests  
20 of the patients, based on the sites that we found.

21 MS. WRIGHT: Additionally, as far as timing,  
22 we would likely submit the CON to discontinue the site at  
23 Edward Hospital probably at the end of 2013.

24 MS. RANALLI: Ms. Wright did comment -- and

1 this may be something that you may be interested in,  
2 because it maybe is not as much time line, but a concern  
3 might be the Edward Hospital -- you have a letter that we  
4 have to vacate the space, but we would also accept a  
5 condition that we will discontinue that facility. So, this  
6 truly is a relocation, if that is any concern of yours,  
7 that you'll approve this and then somehow Edward and  
8 Fresenius will somehow renegotiate their lease. That is  
9 not our intent.

10 VICE-CHAIRMAN HAYES: Would you look at a  
11 condition, basically, that you would have to come before  
12 the Board with a discontinuation of your current facility  
13 in Edward Hospital by -- discontinue that hospital by the  
14 end of 2013?

15 MS. RANALLI: Yes.

16 VICE-CHAIRMAN HAYES: And you'd have that  
17 application ready by the September of 2012 meeting?

18 MS. RANALLI: September 2012 or 2013 -- yeah,  
19 2012. I apologize. So you would want an application  
20 submitted by September of 2012?

21 VICE-CHAIRMAN HAYES: Yes.

22 MS. RANALLI: Right, I think that would be  
23 fine. I just want to point this out, in case it matters at  
24 all. It doesn't matter to us, but if we were to file the

1 application in September 2012 and let's say it was heard in  
2 early 2013, then -- and approved, those stations would come  
3 out of your inventory, creating an even greater need. As  
4 long as that's acceptable to you, it's fine for us.

5 MS. AVERY: It should be okay. We probably  
6 wouldn't get to it until the December meeting, if you  
7 submit it by September.

8 MS. RANALLI: I think 2013.

9 MS. AVERY: Submit it in 2012 with completion  
10 date by the August deadline, 2013.

11 VICE-CHAIRMAN HAYES: The deadline is August  
12 of 2014; is that right?

13 MS. AVERY: They're saying there is a parting  
14 of space by August of 2013.

15 MS. RANALLI: 2014.

16 MS. AVERY: I'm sorry. I thought it was 2013.

17 MS. RANALLI: I think if we submitted -- this  
18 project will be complete at the end of 2013. That's our  
19 goal. So, if we submitted an application to discontinue  
20 the Edward facility in, say, mid 2013, that would be  
21 heard -- and then that I think dovetails what you're  
22 reflecting. I think your time frame is correct. It's 2012  
23 versus 2013. And we absolutely will condition this on  
24 discontinuing that project by the end of 2013, submitting

1 the application in time for it to be heard in 2013.

2 VICE-CHAIRMAN HAYES: Okay. Any other Board  
3 questions?

4 (Pause)

5 VICE-CHAIRMAN HAYES: I'd like to -- may I  
6 have a motion to approve Project 11-038 for the  
7 establishment of a 16-station ESRD facility in Naperville,  
8 Illinois, conditional that the applicant will come to the  
9 Board in mid 2013 with an application to discontinue their  
10 facility on the Edward Hospital campus by December 31st of  
11 2013?

12 MR. GREIMAN: So moved.

13 MR. SEWELL: Second.

14 MR. ROATE: Motion made by Justice Greiman,  
15 seconded by Mr. Sewell.

16 Mr. Eaker?

17 MR. EAKER: Yes.

18 MR. ROATE: Justice Greiman?

19 MR. GREIMAN: Yes.

20 MR. ROATE: Mr. Hayes?

21 VICE-CHAIRMAN HAYES: Yes.

22 MR. ROATE: Mr. Hilgenbrink?

23 MR. HILGENBRINK: Yes.

24 MR. ROATE: Ms. Olson?

1 MS. OLSON: Yes.

2 MR. ROATE: Mr. Sewell?

3 MR. SEWELL: Yes.

4 MR. ROATE: That's six votes in the

5 affirmative.

6 VICE-CHAIRMAN HAYES: Motion passes.

7 MS. RANALLI: Thank you very much.

8 (Pause)

9 VICE-CHAIRMAN HAYES: Okay. Now, our next  
10 item on our agenda is Compliance Issues, Settlement  
11 Agreements and Final Orders, and I'd like to turn this over  
12 to Frank Urso, our Legal Counsel.

13 MR. URSO: Thank you, Mr. Hayes.

14 The first action item I have is a request for  
15 approval of Final Order on Timothy Place, doing business as  
16 Park Place Christian Community of Elmhurst and Rest Haven,  
17 Illini Christian Convalescent Home, Docket No. HFSRB 11-05,  
18 Project No. 07-17, requesting a final order.

19 VICE-CHAIRMAN HAYES: So moved.

20 MR. EAKER: Second.

21 MR. ROATE: Motion made by Mr. Hayes, seconded  
22 by Mr. Eaker.

23 Mr. Eaker?

24 MR. EAKER: Yes.

1 MR. ROATE: Justice Greiman?  
2 MR. GREIMAN: Yes.  
3 MR. ROATE: Mr. Hayes?  
4 VICE-CHAIRMAN HAYES: Yes.  
5 MR. ROATE: Mr. Hilgenbrink?  
6 MR. HILGENBRINK: Yes.  
7 MR. ROATE: Ms. Olson?  
8 MS. OLSON: Yes.  
9 MR. ROATE: Mr. Sewell?  
10 MR. SEWELL: Yes.  
11 MR. ROATE: That's six votes in the  
12 affirmative.  
13 VICE-CHAIRMAN HAYES: Motion passes.  
14 MR. URSO: Requesting approval for a final  
15 order on Pershing Convalescent Center, Docket No. HFPB  
16 8-15, AG 2010-8924.  
17 VICE-CHAIRMAN HAYES: May I have a motion to  
18 approve Pershing Convalescent Home, Docket No. Attorney  
19 General 2010-8924, HFPB 8-15?  
20 MR. EAKER: So moved.  
21 MS. OLSON: Second.  
22 MR. ROATE: Motion made by Mr. Eaker, seconded  
23 by Mrs. Olson.  
24 Mr. Eaker?

1 MR. EAKER: Yes.

2 MR. ROATE: Justice Greiman?

3 MR. GREIMAN: Yes.

4 MR. ROATE: Mr. Hayes?

5 VICE-CHAIRMAN HAYES: Yes.

6 MR. ROATE: Mr. Hilgenbrink?

7 MR. HILGENBRINK: Yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: Yes.

10 MR. ROATE: Mr. Sewell?

11 MR. SEWELL: Yes.

12 MR. ROATE: That's six votes in the

13 affirmative.

14 VICE-CHAIRMAN HAYES: Motion passes.

15 MR. URSO: Requesting approval to close the

16 Board versus Northwest Community Hospital, which is

17 docketed as HFPB 07-98 and AG, 11-01 to not pursue any

18 legal action, since the Attorney General has determined

19 that there is no cause of action to be pursued that can

20 result in payment of this facility's debt. Requesting

21 approval to close that case.

22 VICE-CHAIRMAN HAYES: May I propose a motion

23 to be able to close legal action Northwest Community

24 Hospital?

1 MR. SEWELL: So moved.

2 MR. GREIMAN: Second.

3 MR. ROATE: Motion made by Mr. Sewell,  
4 seconded by Justice Greiman.

5 Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. ROATE: Justice Greiman?

8 MR. GREIMAN: Yes.

9 MR. ROATE: Mr. Hayes?

10 VICE-CHAIRMAN HAYES: Yes.

11 MR. ROATE: Mr. Hilgenbrink?

12 MR. HILGENBRINK: Yes.

13 MR. ROATE: Ms. Olson?

14 MS. OLSON: Yes.

15 MR. ROATE: Mr. Sewell?

16 MR. SEWELL: Yes.

17 MR. ROATE: Six votes in the affirmative.

18 VICE-CHAIRMAN HAYES: Motion approved.

19 MR. URSO: I'm also requesting approval to  
20 close Covenant Care of O'Fallon, HFSRB 10-06 and not pursue  
21 any further legal action, since the Attorney General has  
22 determined that there's no chance of any recovery of debt  
23 owed and any further action would be deemed fruitless.

24 VICE-CHAIRMAN HAYES: May I propose an

1 amendment -- may I propose a motion on -- to approve  
2 consent for an order for Covenant Care of O'Fallon?

3 MS. OLSON: So moved.

4 MR. SEWELL: Second.

5 MR. ROATE: Motion made by Ms. Olson, seconded  
6 by Mr. Sewell.

7 Mr. Eaker?

8 MR. EAKER: Yes.

9 MR. ROATE: Justice Greiman?

10 MR. GREIMAN: Yes.

11 MR. ROATE: Mr. Hayes?

12 VICE-CHAIRMAN HAYES: Yes.

13 MR. ROATE: Mr. Hilgenbrink?

14 MR. HILGENBRINK: Yes.

15 MR. ROATE: Ms. Olson?

16 MS. OLSON: Yes.

17 MR. ROATE: Mr. Sewell?

18 MR. SEWELL: Yes.

19 MR. ROATE: Six votes in the affirmative.

20 VICE-CHAIRMAN HAYES: Motion passes.

21 MR. URSO: I'm also requesting approval to  
22 close the Board versus Monroe County Long-Term Care  
23 Facility, based upon the facts and the evidence in this  
24 matter, that there are no violations of the Board's Act or

1 the Board's Rules. Requesting approval to close that file.

2 VICE-CHAIRMAN HAYES: May I have a motion to  
3 close the file on Monroe Long-Term Care?

4 MR. EAKER: So moved.

5 MR. HILGENBRINK: Second.

6 MR. ROATE: Motion made by Mr. Eaker, second  
7 by Mr. Hilgenbrink.

8 Mr. Eaker?

9 MR. EAKER: Yes.

10 MR. ROATE: Justice Greiman?

11 MR. GREIMAN: Yes.

12 MR. ROATE: Mr. Hayes?

13 VICE-CHAIRMAN HAYES: Yes.

14 MR. ROATE: Mr. Hilgenbrink?

15 MR. HILGENBRINK: Yes.

16 MR. ROATE: Ms. Olson?

17 MS. OLSON: Yes.

18 MR. ROATE: Mr. Sewell?

19 MR. SEWELL: Yes.

20 MR. ROATE: That's six votes in the

21 affirmative.

22 VICE-CHAIRMAN HAYES: Motion approved.

23 MR. URSO: That's all I have. Thank you very

24 much.

1 VICE-CHAIRMAN HAYES: Going down our agenda  
2 here, there's nothing in "Other Business". Rules  
3 Development, there is nothing. And New Business, Mike, do  
4 you have something in there?

5 MR. CONSTANTINO: Thank you, Mr. Chairman.

6 We have three facilities that we need to  
7 report to the Board that have been discontinued, Hickory  
8 Estates in Sumner, Illinois discontinued 16-bed ICF/DD  
9 facility. Rockford Nursing and Rehab Center, Rockford,  
10 Illinois discontinued 97-bed nursing facility. And Holy  
11 Family Nursing and Rehab Center in Des Plaines, Illinois  
12 discontinued 251-bed nursing care facility.

13 The next item, Critical Care Access Hospital  
14 Update, we just wanted to inform the Board that the Staff  
15 has been working on -- with the Critical Care Access  
16 Hospital Network in trying to reduce their bed count to the  
17 required 25 beds. We should have that completed within the  
18 next couple of months.

19 And then, the financial reports, we have the  
20 December report for you. George is passing that out now.

21 And then I'll continue while you -- we'd like  
22 to make a hospital profile correction for Anderson  
23 Hospital, regarding the 2010 profile. They had mistakenly  
24 given us gross revenue instead of net revenue. So, we're

1 requesting that we change that information in their 2010  
2 Annual Hospital Profile. The amount of the gross charges  
3 that were reported to us was approximately \$340 million.  
4 The net patient revenue was approximately a \$124 million,  
5 and this will increase the charity care percentage to 1.26  
6 percent, instead of .46 percent. Basically, that's the  
7 main reason they would like to have this changed, so the  
8 charity care is reported as the higher number.

9 VICE-CHAIRMAN HAYES: Do the Board members  
10 have any questions on that?

11 (Pause)

12 MR. CONSTANTINO: I would like to point out  
13 this is the only correction we've received to date on the  
14 2010 information on both the long-term care and the ASTC  
15 and the hospital surveys.

16 VICE-CHAIRMAN HAYES: Any other questions on  
17 any of these discontinuations or the Critical Access  
18 Hospital update?

19 (Pause)

20 MR. CONSTANTINO: We passed out the December  
21 2011 financial report.

22 VICE-CHAIRMAN HAYES: Are there any comments  
23 on that?

24 MR. CONSTANTINO: It was prepared by Bill's

1 staff.

2 VICE-CHAIRMAN HAYES: Why don't I give the  
3 Board members a couple of moments to look at this.

4 (Pause)

5 VICE-CHAIRMAN HAYES: The Board members have  
6 an option to go back and study the financial report, and if  
7 they have any questions, please come back at the next  
8 meeting and be able to ask those.

9 And also, for Item D, Dialysis Information, do  
10 you have any information for that at all?

11 MR. CONSTANTINO: Yes. We'd just like to  
12 report to the Board that DaVita and Fresenius were required  
13 to submit to us their ESRD Cost Report that they submit to  
14 CMS. Both did that. However, the financial information  
15 was not included. So we have undertaken -- we are going to  
16 be undertaking a survey of all ESRD facilities in this  
17 state. It should be going out this month, and we will be  
18 asking each individual ESRD facility what their revenue  
19 figures are, along with additional information.

20 VICE-CHAIRMAN HAYES: And then finally --

21 MR. CONSTANTINO: The training, I think Frank  
22 wanted to speak to that.

23 MR. URSO: This is just for informational  
24 purposes. I wanted to alert the Board members that there's

1 going to be annual ethics training in the very near future,  
2 so look forward to that. In addition, there's been a  
3 revision to the Open Meetings Act, and there's also going  
4 to be training on the Open Meetings Act. There will be  
5 more about this at the next meeting, and if you have any  
6 questions, just feel free to ask me. But those are two  
7 trainings that all of the Board members are going to have  
8 to take in the near future.

9 The final thing I wanted to mention to you is  
10 that the Statement of Economic Interest will be coming out  
11 again this year. It will be going to your home addresses  
12 in March. So, if anybody has any questions, please feel  
13 free to contact me.

14 VICE-CHAIRMAN HAYES: Is there any other  
15 questions from the Board members on any of these other  
16 areas of other business or any of these things for Mike and  
17 Frank or Courtney?

18 (Pause)

19 VICE-CHAIRMAN HAYES: Courtney Avery, Frank  
20 Urso or Mike Constantino?

21 (Pause)

22 VICE-CHAIRMAN HAYES: Well, seeing none, I'd  
23 like to have a motion to adjourn.

24 MR. EAKER: So moved.

1 MR. SEWELL: Second.

2 VICE-CHAIRMAN HAYES: Roll call?

3 MR. ROATE: Motion made by Mr. Eaker, seconded  
4 by Mr. Sewell.

5 Mr. Eaker?

6 MR. EAKER: Yes.

7 MR. ROATE: Justice Greiman. Absent.

8 Mr. Hayes?

9 VICE-CHAIRMAN HAYES: Yes.

10 MR. ROATE: Mr. Hilgenbrink?

11 MR. HILGENBRINK: Yes.

12 MR. ROATE: Ms. Olson?

13 MS. OLSON: Yes.

14 MR. ROATE: And Mr. Sewell?

15 MR. HILGENBRINK: Yes.

16 VICE-CHAIRMAN HAYES: Motion passes. We're  
17 adjourned. The next meeting is February 28th. Please  
18 check the web site for the location and confirm the date.  
19 The location will be here in Bolingbrook. So thank you  
20 very much, and I appreciate it. Thank you.

21

22 END TIME: 4:20 P.M.

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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, RPR, CRR, a Certified Court Reporter, do hereby certify that the proceedings in the above-entitled cause were taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.



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KAREN K. KEIM  
CSR-IL, CCR-MO, RPR, CRR

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