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HEALTH FACILITIES &
SERVICES REVIEW BOARD

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

OPEN SESSION

JULY 21, 2011

DAY 2

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

DAY 2

Regular session of the meeting of the State of Illinois Health Facilities and Services Review Board was held on July 21, 2011, at Holiday Inn Joliet Conference Center, 411 South Larkin, Joliet, Illinois.

1 PRESENT:

Dale Galassie - Chairman

2 Ronald Eaker

John Hayes

3 John Burden

Alan Greiman

4 Kathy Olson

Richard Sewell

5 Rob Hilgenbrink

6 ALSO PRESENT:

Courtney Avery - Administrator

7 Cathy Clarke - Assistant

Frank Urso - Legal Counsel

8 Juan Morado

9

10 Michael Constantino - IDPH Staff

11 Bonnie Hills - IDPH Staff

12 George Roate - IDPH Staff

13 Bill Dart - IDPH Staff

14 Claire Burman - IDPH Staff

15 David Carvalho - Deputy Director, IDPH

16 Michael C. Jones - IDFS

17 Mike 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

State of Illinois
Health Facilities and Services Review Board
 525 West Jefferson Street, 2nd Floor, Springfield, Illinois 62761 (217) 782-3516, (217) 785-4111 (fax)
www.hfsrb@illinois.gov

FINAL A G E N D A
 (M-316) - (per 2 IAC 1925.240)
CONTINUED FROM June 28, 2011
 Final Agenda will be posted no later than
 9:00 A.M. Monday, July 18, 2011 at the
 Health Facilities and Services Review Board's office
 and at the meeting location.
Holiday Inn Joliet
Banquet & Conference Center
411 South Larkin Avenue
Joliet, IL 60436

1. **CALL TO ORDER: Thursday, July 21, 2011, 10:00 A.M.**
2. **APPROVAL OF AGENDA**
3. **PROCEDURES FOR PUBLIC COMMENT**
4. **ITEMS FOR STATE BOARD ACTION**
 - A. **APPLICATIONS SUBSEQUENT TO INITIAL REVIEW**

Item	Class	Opposition	Facility	City	Number	
A-1	Sub	Yes	FMC East Aurora Establish a 12-Station ESRD Facility	Aurora	10-086	_____
A-2	Sub	No	Woodlawn Dialysis Relocate 20 ESRD stations and add 12 stations	Chicago	10-093	_____
A-3	Sub	Yes	Crest Hill Dialysis Establish a 12-Station ESRD Facility	Crest Hill	11-004	_____
A-4	Sub	Yes	Barrington Creek Dialysis Establish a 12-Station ESRD Facility	Lake Barrington	11-010	_____
A-5	Sub	Yes	Apollo Health Center, Ltd. Establish a Multi-Specialty ASTC	Des Plaines	11-002	_____

NOTICE: THIS MEETING WILL BE ACCESSIBLE TO PERSONS WITH SPECIAL NEEDS IN COMPLIANCE WITH PERTINENT STATE AND FEDERAL LAWS UPON NOTIFICATION OF ANTICIPATED ATTENDANCE. PERSONS WITH SPECIAL NEEDS SHOULD CONTACT BONNIE HILLS AT THE HEALTH FACILITIES AND SERVICES REVIEW BOARD OFFICE BY TELEPHONE AT (312) 814-2793 (TTY # 800-547-0466 FOR HEARING IMPAIRED ONLY) OR BY LETTER NO LATER THAN July 18, 2011.

Agenda - Health Facilities and Services Review Board - July 21, 2011 - Page 2

Item	Class	Opposition	Facility	City	Number	
A-6	Sub	No	Sedgebrook Health Ctr. Add 44 Long term care beds	Lincolnshire	11-009	_____
A-7	Sub	Yes	Hart Road Pain and Spine Institute Establish an Limited Specialty ASTC	Barrington	11-014	_____
A-8	Sub	No	Blessing Hospital Discontinuation/Major Modernization	Quincy	11-018	_____

B. APPLICATIONS SUBSEQUENT TO INTENT TO DENY (none)

5. EXECUTIVE SESSION

A. APPLICATIONS PENDING ADMINISTRATIVE HEARING (ADM) / JUDICIAL REVIEW (JUD)

6. COMPLIANCE ISSUES / SETTLEMENT AGREEMENTS / FINAL ORDERS

A. Referrals to Legal Counsel

1. #07-071 Park Place Christian Village
2. Grand Oaks Surgical Center - Change of ownership without State Board approval
3. #10-083 - RAI Lincoln Highway - Failure to file required reports timely
4. # 10-084 - RAI North Main - Failure to file required reports timely
5. # 10-085 - RAI Centre West - Failure to file required reports timely
6. #08-106 - Mendota Community Hospital - Failure to file required reports timely

B. Final Orders

1. HFPB 0903 Clare Oaks Retirement Community

7. UNFINISHED BUSINESS

8. RULES DEVELOPMENT

1. Update on Rules Development

9. NEW BUSINESS

1. Legislative Update
2. Financial Report
3. Meeting Dates and Locations

10. ADJOURNMENT

FOR TRANSCRIPTS OF THIS MEETING CONTACT: *

Midwest Litigation Services
15 South Old State Capitol Plaza
Springfield IL 62701
217-522-2211

11. NEXT MEETING:

NOTICE: THIS MEETING WILL BE ACCESSIBLE TO PERSONS WITH SPECIAL NEEDS IN COMPLIANCE WITH PERTINENT STATE AND FEDERAL LAWS UPON NOTIFICATION OF ANTICIPATED ATTENDANCE. PERSONS WITH SPECIAL NEEDS SHOULD CONTACT BONNIE HILLS AT THE HEALTH FACILITIES AND SERVICES REVIEW BOARD OFFICE BY TELEPHONE AT (312) 814-2793 (TTY # 800-547-0466 FOR HEARING IMPAIRED ONLY) OR BY LETTER NO LATER THAN July 18, 2011.

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August 16, 2011
Holiday Inn Joliet
Banquet & Conference Center
411 South Larkin Avenue
Joliet, IL 60436
10:00 AM

12. FUTURE MEETINGS

Date	City	Location
October 4, 2011	TBA	TBA
November 22, 2011	TBA	TBA

NOTICE: THIS MEETING WILL BE ACCESSIBLE TO PERSONS WITH SPECIAL NEEDS IN COMPLIANCE WITH PERTINENT STATE AND FEDERAL LAWS UPON NOTIFICATION OF ANTICIPATED ATTENDANCE. PERSONS WITH SPECIAL NEEDS SHOULD CONTACT BONNIE HILLS AT THE HEALTH FACILITIES AND SERVICES REVIEW BOARD OFFICE BY TELEPHONE AT (312) 814-2793 (TTY # 800-547-0466 FOR HEARING IMPAIRED ONLY) OR BY LETTER NO LATER THAN July 18, 2011.

1 START TIME: 10:00 a.m.

2

3 CHAIRMAN GALASSIE: Good morning and welcome.

4 Despite the heat, we appreciate everybody being here.

5 Good morning, Board members, and I certainly

6 apologize for the length of our last meeting and respect

7 your endurances for everyone that was involved in that

8 rather long, arduous meeting. That having been said, we

9 have a fairly light agenda today, somewhat by design.

10 For Board members, we passed around a menu for

11 lunch. I've asked Staff to hold the menus. Fill the menu

12 out, give it to Staff -- Mike, I suppose -- and we're going

13 to hold them until about eleven o'clock, to kind of

14 determine where we are. We'll make a determination jointly

15 if we want to go through lunch at that time or not. Let's

16 see how things go. Sound like a plan? Very good. Thank

17 you.

18 I need a motion to call the meeting to order.

19 MR. EAKER: So moved.

20 MR. HILGENBRINK: Second.

21 CHAIRMAN GALASSIE: Second by Hilgenbrink.

22 Roll call?

23 MR. ROATE: Dr. Burden?

24 MR. BURDEN: Here.

1 MR. ROATE: Mr. Eaker?

2 MR. EAKER: Here.

3 MR. ROATE: Justice Greiman?

4 MR. GREIMAN: Here.

5 MR. ROATE: Mr. Hayes?

6 MR. HAYES: Here.

7 MR. ROATE: Mr. Hilgenbrink?

8 MR. HILGENBRINK: Here.

9 MR. ROATE: Ms. Olson?

10 MS. OLSON: Here.

11 MR. ROATE: Mr. Penn? Absent.

12 Mr. Sewell?

13 MR. SEWELL: Here.

14 MR. ROATE: Chairman Galassie?

15 CHAIRMAN GALASSIE: Here. Thank you very

16 much.

17 And I need a motion for the approval of the

18 agenda, please.

19 MR. HAYES: So moved.

20 MR. GREIMAN: Second.

21 CHAIRMAN GALASSIE: Moved and seconded.

22 Thank you very much.

23 Roll call, please?

24 MR. ROATE: Dr. Burden?

1 MR. BURDEN: Yes.

2 MR. ROATE: Mr. Eaker?

3 MR. EAKER: Yes.

4 MR. ROATE: Justice Greiman?

5 MR. GREIMAN: Yes.

6 MR. ROATE: Mr. Hayes?

7 MR. HAYES: Yes.

8 MR. ROATE: Mr. Hilgenbrink?

9 MR. HILGENBRINK: Yes.

10 MR. ROATE: Ms. Olson?

11 MS. OLSON: Yes.

12 MR. ROATE: Mr. Penn? Absent.

13 Mr. Sewell?

14 MR. SEWELL: Yes.

15 MR. ROATE: Chairman Galassie?

16 CHAIRMAN GALASSIE: Yes.

17 Motion passes. Thank you very much.

18 We are now in the Procedures for Public

19 Comment, and we would like our counsel, Mr. Urso, to share

20 some information with us, please.

21 MR. URSO: Thank you, Mr. Chair.

22 What I'm going to explain now are the formal

23 guidelines for public participation at Board meetings. The

24 Open Meetings Act requires that any person shall be

1 permitted an opportunity to address public officials under
2 the rules established and recorded by the public body. The
3 following is the procedure which the Board will adhere to.

4 Number one, if you have previously
5 participated in any public hearings or submitted written
6 comments related to projects listed on today's agenda, you
7 will not be allowed to repeat your previous comments,
8 because each Board member has already received those
9 materials from public hearings, as well as written
10 comments.

11 Board Staff will be comparing a speaker's
12 public hearing testimony and/or previous written comments
13 to ensure that the public participation testimony is not
14 repetitive. Speakers will be reminded not to provide
15 repetitive comments.

16 Number three, so that the Board is able to
17 accomplish other agenda items, each speaker will be
18 allotted a maximum of two minutes to provide their
19 comments. Please understand, when the Chairman or Board
20 Staff signal, you must conclude your comments.

21 Number four, inflammatory or derogatory
22 comments are prohibited.

23 Number five, no more, no more than three
24 persons or three people representing the same organization

1 are allowed to provide testimony regarding the same
2 project.

3 Number six, public comment for each speaker is
4 limited for testimony for one project or issue.

5 Number seven, the Board asks that you please
6 make sure that all your comments are focused and relevant
7 to the specific projects on the current agenda. Comments,
8 once again, should not be repetitive and not be disruptive
9 to the Board's proceedings.

10 Number eight, the public is strongly urged to
11 participate in long-standing opportunities for oral and
12 written comment provided by the public hearings conducted
13 for projects under review by this Board, as well as for
14 draft rule making. Scheduled public hearings are posted on
15 the Board's web site.

16 Number nine, speakers who do not comply with
17 these guidelines will not be allowed to provide comments at
18 the Board's open meeting.

19 Thank you.

20 CHAIRMAN GALASSIE: Thank you, Frank. Any
21 questions on those revised guidelines from Board members?
22 Those are subsequent to some conversations we've had with
23 the AG's office.

24 We'll go ahead and move forward. We're moving

1 into items for State Board Action on the agenda, 4-A,
2 Applications Subsequent to Initial Review, item No. 10-086,
3 Fresenius Medical Care East Aurora. Is there anyone here
4 representing Fresenius Medical Care East Aurora?

5 (Pause)

6 CHAIRMAN GALASSIE: And is there anyone here
7 to speak from a public perspective on this item?

8 (Pause)

9 CHAIRMAN GALASSIE: There is one, so,
10 technically, we'll have to start with you.

11 I apologize I called you up to the table, but
12 if you don't mind, sir, come up to this table on your
13 right, and if you would, introduce yourself and be sworn
14 in.

15 (Pause)

16 CHAIRMAN GALASSIE: You don't need to be
17 sworn in.

18 MR. RUBINSTEIN: Good morning, Mr. Chairman,
19 members of the committee. My name is Harry Rubinstein.
20 I'm a licensed nephrologist in the state of Illinois,
21 President of Fox Valley Medical Associates, Renaissance
22 Management Company, and Fox Valley Dialysis. On behalf of
23 Fox Valley Medical Associates, I want to thank the Board
24 for this opportunity to provide comments to its State

1 Agency Report on the FMC East Aurora project. Foremost, we
2 would like to commend the State Agency and agree that FMC
3 has not met its fundamental legal obligations to comply
4 with the size of the project, Planning Area need, and
5 unnecessary duplication, mal-distribution of service
6 requirements. We also appreciate the State Agency
7 correctly listing the new FMC West Batavia facility as
8 being twenty minutes from the East Aurora project. It is,
9 therefore, viable to serve the needs of patients from
10 Aurora.

11 From our view, FMC West Batavia is not only a
12 viable alternative but also is significantly material to
13 the analysis concerning the viability and need of the East
14 Aurora project. We encourage the Board to withhold its
15 approval of this project until FMC West Batavia becomes
16 operational and fully occupied.

17 As set forth in previous testimony in opposing
18 the project, we believe that there still remain unanswered
19 questions regarding the reliability of the patient demand
20 and the patient referral data tendered in support of the
21 project CON application. Specifically, the applicant
22 attempts to satisfy its legal obligations under the service
23 demands criteria predicated primarily on the referring
24 physicians' letter, wherein he represents that his practice

1 currently supports four facilities in the service area.
2 Yet, two of these four facilities operate below the 80
3 percent occupancy and are owned by the applicant. FMC,
4 Sandwich, has 35 percent occupancy; FMC Aurora, 74 percent
5 occupancy.

6 In addition, the referring physicians'
7 practice also supports a new but-not-yet-operational FMC
8 West Batavia facility, which is only twenty minutes from
9 the proposed site. Most notably, physicians own that and
10 show that the patient base from the Aurora base as
11 dissipated in 2010. Empty stations, recent patient loss in
12 the Aurora area require an explanation. Therefore, we
13 respectfully suggest that the State Agency further analyze
14 the tendered physicians' practice data. It appears as if
15 there is a shifting of information from different zip codes
16 in the Aurora area, which would result in the gross
17 underutilization of FMC West Chicago and FMC Aurora. In
18 addition, these data indicate that the FMC East Aurora
19 project will directly or indirectly materially, adversely
20 affect utilization of the new FMC West Batavia facility.

21 Finally, we know the Board considers each
22 application individually, without taking into account any
23 previous application by a specific applicant. In this
24 particular instance, given the foregoing issues regarding

1 the reliability and accuracy of the physician referral
2 data, we respectfully suggest to the Board, in order to get
3 a complete picture and understanding of the physician
4 referral data, this project application should be reviewed
5 together with the representations made by the same
6 referring physician in support of the FMC West Batavia
7 Certificate of Need, which was approved March 2nd of 2010
8 and is well within the 30-minute travel time of the
9 proposed project.

10 For all of the foregoing reasons, the FMC East
11 Aurora Certificate of Need application should be denied.

12 Thank you.

13 CHAIRMAN GALASSIE: Thank you, sir.

14 Any other public comment on this item?

15 (Pause)

16 MR. CONSTANTINO: Mr. Chairman, we received a
17 comment on the SAR and it essentially reflected what this
18 gentleman has just spoken about. It was essentially the
19 same comments.

20 CHAIRMAN GALASSIE: Okay. Thank you.

21 MR. CONSTANTINO: I've got copies. Do you
22 want me to hand them out?

23 CHAIRMAN GALASSIE: Sure.

24 MR. URSO: You also sent copies in the mail.

1 MS. OLSON: Yes, we have copies.

2 CHAIRMAN GALASSIE: If the individuals
3 representing Fresenius Medical Care would introduce
4 themselves and be sworn in, and then we will have a Staff
5 report.

6 MS. RANALLI: Thank you. My name is Clare
7 Ranalli. I am counsel to the applicant, Fresenius Medical
8 Care. To my left is Lori Wright, CON specialist, and to
9 her left is Jenny Lowe, the area manager for this
10 particular project. Thank you.

11 (Oath given)

12 CHAIRMAN GALASSIE: Staff report?

13 MR. CONSTANTINO: The applicants, Fresenius
14 Medical Care Holdings, Inc. and Fresenius Medical Care
15 Sandwich LLC, are proposing to establish a 12-station ESRD
16 facility in approximately 8,500 gross feet of space at a
17 cost of approximately \$4.4 million. The project is before
18 the State Board because it proposes to establish a
19 healthcare facility as defined by the Act. A public
20 hearing was held February 24th, 2011. Fifteen individuals
21 provided supporting testimony and five individuals provided
22 opposition testimony.

23 The State Agency notes the following: The
24 facility size is in excess of the State Board's standard by

1 11 gross square foot by station, and there is an excess of
2 35 stations in the Planning Area that is HSA 8, and the
3 applicants propose 12 stations, therefore increasing the
4 number of excess stations in the Planning Area to 47
5 stations. Four of the eight facilities within 30 minutes
6 are underutilized.

7 Thank you, Mr. Chairman.

8 CHAIRMAN GALASSIE: Mike, can I just ask --
9 before our presentation, do we have any comments in regards
10 to the allegations that they have not met their legal,
11 fundamental obligation?

12 MR. CONSTANTINO: Yes. Our responsibility,
13 when we review these applications for permit, is to look at
14 the data that is submitted, and we ask for referral letters
15 from the referring physicians. What we received are three
16 years of historical data, the most current one-year data,
17 by facility and zip code, and that physician and Fresenius
18 both certify that that information is true and correct. We
19 rely upon that attestation to make our judgments regarding
20 each individual application.

21 Secondly, our rules require us to review each
22 application separately and on its own merit. So, we cannot
23 go and compare other applications to the current
24 applications.

1 CHAIRMAN GALASSIE: Thank you. And I ask
2 that question for Board members' edification. Thank you
3 very much.

4 Please.

5 MR. CARVALHO: Mike, just to make sure
6 everybody understands your question -- not in this case,
7 but let's assume hypothetically a doctor in one application
8 says, "My practice will generate 3,000 referrals", and then
9 a year later, there's another application, and the same
10 doctor says, "My practice will generate 3,000 referrals."
11 Do we pick up that kind of thing so that we say, "Hey,
12 geez, the same doctor is saying the same thing in two
13 different applications"?

14 MR. CONSTANTINO: The referrals for the
15 Pre-ESRD patients cannot exceed the historical caseload,
16 historical referral case load. Okay? We do not compare
17 applications, David.

18 MR. CARVALHO: I know we don't compare them.

19 MR. CONSTANTINO: Even in past applications,
20 we don't review past applications to the current
21 application and what is submitted.

22 MR. CARVALHO: So, what mechanism would be in
23 place for the Board to know that they weren't being
24 double -- that somebody wasn't being used in two different

1 applications.

2 MR. CONSTANTINO: Essentially, we're relying
3 on self-reported information for all of these applications
4 for permit, and in this case, we're relying upon the
5 attestations of the physicians, as well as Fresenius
6 Medical Care, that tells us this information is true and
7 correct.

8 MR. CARVALHO: Sure. But the attestation
9 could be correct because in the application a year ago, the
10 guy says, "I have 3,000 referrals, and if that opens, I'm
11 going to send them there", and that was his intent a year
12 ago, and then a year moves on and he says, "I'm going to
13 have 3,000 referrals. I'm going to send them there."

14 MR. CONSTANTINO: Well, they also make the
15 statement that the referrals have not been used for any
16 other applications. That's part of the attestation.

17 MR. CARVALHO: So, in the attestation, it says
18 these specific referrals have not been used someplace else,
19 so that's the Board's protection, is that the person is
20 attesting to the fact that they haven't used the same
21 referrals in another application?

22 MR. CONSTANTINO: That's correct, yes.

23 MR. CARVALHO: Okay. Thanks.

24 CHAIRMAN GALASSIE: Thank you very much.

1 Please.

2 MS. RANALLI: Okay. Thank you. You know, I
3 like to be as brief as possible, as Board members know --
4 and welcome to the new Board members, and good morning to
5 everyone, and thank you to Staff for this State Agency
6 Report. But I would like to take just two minutes, because
7 I am somewhat troubled, as is the applicant, by some of the
8 tenor of the recent public comment. We very much value the
9 public comment process. We participate in public comment
10 ourselves on occasion, whether we're supporting an
11 application or opposing one. But we do our best -- as an
12 applicant that appears in front of you almost every month,
13 we're somewhat unique in that regard. We are in front of
14 this Board on almost a monthly basis, and so we are very
15 careful when we provide public comment to do our best to
16 provide comment that helps illuminate for the Board issues
17 that are relevant to its criteria by which it provides
18 applications. We try to not throw allegations out there,
19 such as "This applicant has not met its legal obligations."

20 One of the statements was we didn't meet our
21 legal obligation regarding the size of the facility in this
22 particular situation. We're 11 gross square feet beyond,
23 per station, on size. You know, we really would encourage
24 the Board to try and get past some of the veiled statements

1 of misinformation or misrepresentations, when they are not
2 specifically supported by factual information, because it's
3 very difficult for us as we sit here to try and convince
4 this Board -- when a statement has been made that we
5 provided data that's inaccurate or in error or
6 intentionally misleading, it's difficult for us to sit here
7 and try to have a meaningful dialogue with this Board about
8 the true merits of the application in front of it, when
9 we're instead forced to deal with those sorts of
10 generalizations about the data and information in front of
11 it.

12 CHAIRMAN GALASSIE: I don't think we're
13 asking you to deal with those. We're really asking you to
14 give your presentation on the subject at hand.

15 MS. RANALLI: I appreciate that, and I'll do
16 that as briefly as possible.

17 I do want to also mention, Mr. Carvalho's
18 question, I think, is a good one, and Lori can talk to it,
19 if the Board wishes, but I won't have her address it now.
20 They may have questions or not. I'll try to get to the
21 merits of the application, as suggested, but she can talk
22 to you the way at least Fresenius gathers information from
23 the physicians and, of course, they attest that they don't
24 duplicate individual patients in their practice for, say,

1 West Batavia or East Aurora. They're told not to do that.
2 They attest that they are not doing that, but she can speak
3 with more specificity on exactly how she does her process
4 in providing information to this Board and the application.

5 With respect to East Aurora, the facility is
6 going to be located in downtown East Aurora, serving
7 primarily African and Latino population. It also is
8 serving a medically under served area, and that's something
9 that Dr. Dodhia -- who was present at the last meeting but
10 could not be here today -- feels very strongly about.

11 There is an excess of stations in the Planning Area based
12 upon your criteria and how need is computed in the area.
13 We believe that the need ratios are being redone at this
14 time and believe that probably when that occurs, there will
15 be a reflected need of stations.

16 But one thing we would like to point out is
17 the State's standard for dialysis stations to population is
18 one station to 3,573 residents. In the Aurora, there is
19 one station per 5,089 residents. So that alone reflects a
20 need for more stations in that area to serve the
21 population.

22 And with respect to maldistribution, I think
23 the other sort of relevant criteria by which we did not
24 meet the State standard, there are facilities that are

1 underutilized. However, your State target is 80 percent,
2 and the under utilization is -- as an example, FMC
3 Plainfield -- and this is according to the March Renal
4 Network data -- 79 percent; Central DuPage, 77 percent;
5 Aurora, the FMC Aurora Dialysis, 73 percent. That facility
6 is now at 77 percent and it just added four stations in
7 January, as approved by this Board, in January of 2010,
8 and, yes, it's already grown and is now almost at your
9 target utilization rate. So, while there are underutilized
10 facilities, they're very close to your target utilization
11 rate, and Plainfield also has exceeded the target
12 utilization rate as we sit here today. But as of the March
13 Renal Network data, which is what you utilize, it was at 79
14 percent.

15 The West Batavia facility is not yet
16 operating. Dr. Dodhia, who will be referring patients to
17 this facility in East Aurora, will refer patients to that
18 facility. All I can say is that common sense would dictate
19 that he would have no reason to say, "Well, I want a
20 facility in East Aurora and I want a facility in West
21 Batavia for the same patients." It would only stress him
22 and burden him to travel to two facilities, which he's
23 required to do by the Medicare conditions of participation.
24 I mean, it really would make no sense for him to duplicate

1 patients and have two facilities, one just sitting there
2 not utilized because why? I mean, it's nonsensical.

3 The West Batavia community is a very different
4 community than the East Aurora community, particularly
5 because this facility will be in downtown East Aurora. The
6 travel study we did reflected that it's approximately 25
7 minutes drive time, so it isn't twenty minutes away. It's
8 actually fairly far away from the proposed East Aurora
9 facility, and the patients identified for East Aurora don't
10 live toward West Batavia. They live in the north and on
11 the opposite side of the facility as traveling to West
12 Batavia.

13 Having said that, I'll be happy to answer any
14 of the Board's questions.

15 CHAIRMAN GALASSIE: Thank you very much.

16 Questions on the part of Board members?

17 MR. EAKER: I have a question. I think I
18 asked this once before but I'm not sure. On Table 4, your
19 charity care is listed, and it's pretty much the same table
20 for every one of your facilities. My question specifically
21 is is self-pay the same as charity care? It looks as if
22 you're only listing self-pay. And could you just explain
23 to me in your particular type of care, what is charity
24 care?

1 MS. RANALLI: Well, I'll answer the first
2 question on self-pay and invite Lori or Jenny to step in if
3 they have any more information to add to it.

4 Self-pay patients are patients that are
5 categorized as self-paid because they are not covered by
6 Medicare, which is atypical for dialysis patient. They
7 don't have private insurance and/or they have not enrolled
8 in and qualified for Medicaid, which in Illinois Medicaid
9 does cover dialysis services. So for a period of time,
10 they might be self-pay. Those patients would be charged
11 and the debt would be written off, because patients -- we
12 don't try and obtain payment for those services. We charge
13 the patient and we write off the charges as bad debt, and
14 that's for internal accounting purposes. That would not
15 meet your definition of charity care, because I believe bad
16 debt is not charity care under your definition.

17 MR. EAKER: But it would help me if I knew --
18 does the patient know that ahead of time, that even though
19 they get a bill, they don't have to pay it?

20 MS. RANALLI: The Regional Vice-President is
21 not here today. I'm not sure. I can tell you from
22 listening to her in past dialogue on this issue, a self-pay
23 patient in a dialysis setting is going to be qualified for
24 some form of reimbursement, either through, again, Medicaid

1 or through various organizations that provide assistance to
2 dialysis -- end stage renal disease patients.

3 What Fresenius does, because it's in the
4 patient's best interests and also because it provides a
5 revenue stream for payment for dialysis, is help those
6 patients prepare the paperwork and determine what they can
7 do and what they best qualify for with respect to that
8 window of time before Medicare will cover them, because
9 that's another thing that's important to remember with
10 dialysis patients. Medicare is not just available for
11 people based upon age, 65 or 67. It's available for anyone
12 who has end stage renal disease requiring dialysis. So,
13 after 90 days the patient will qualify for Medicare. In
14 order to make sure that if they don't have private
15 insurance or aren't receiving Medicaid they're either
16 enrolled in Medicaid or obtain other financial assistance,
17 we work with the patient and their families and
18 representatives to get that for them during that window of
19 time. I don't know, though, specifically whether they are
20 told, "If you don't get that, don't worry, we won't put a
21 collection agency after you" or what have you. I don't --
22 I can't answer that question. I don't want to say that we
23 don't, but --

24 MR. EAKER: That's significant for me, the

1 difference between a bill that can't be collected after
2 you've tried all the avenues, or if it's just an assumed
3 thing, until the 90-day process happens, treatments will be
4 written off.

5 MS. RANALLI: I know in our applications we
6 specifically state on charity care that any charges are
7 written off. Dialysis, because of the nature of the costs
8 associated with it, is such that we would not expect a
9 patient to pay -- most patients wouldn't be able to pay for
10 it. Now, if Bill Gates came in and didn't have insurance
11 or something, might we try to collect from him? Possibly.
12 But it's just typically not something -- would almost be
13 more expensive for Fresenius to try and collect that type
14 of debt.

15 MR. EAKER: Thank you.

16 CHAIRMAN GALASSIE: If there was a condition
17 that the Board would want to place on you, asking that
18 those patients as described, during that time period be
19 notified up-front if the bill was being processed, that
20 they are not responsible to pay this, would you
21 logistically be able to do this?

22 MS. LOWE: My name is Jenny Lowe. I'm the
23 area manager for this facility. We wouldn't tell a patient
24 up-front that he wouldn't be liable for the bill, because

1 then it would be considered enticement, that they would
2 come to us as a provider because we would write their bills
3 off. That's why we don't tell patients that we're going to
4 write it off, because then it would be considered to be
5 enticement for treatment. But we -- I mean, we all know
6 that that is what ends up happening, but we don't tell
7 patients that, because we wouldn't want to entice them to
8 come to us because we're going to write treatment off.

9 CHAIRMAN GALASSIE: I don't think that's
10 Member Eaker -- if I'm mistaken, tell me. The point is,
11 when you're notifying me, how do I know I'm not responsible
12 to pay this bill that you sent to me?

13 MS. LOWE: We have financial coordinators as
14 well as social workers that work with the patients, and I
15 think that they tell them that after three times, you know,
16 the bill is submitted to them that it is -- it's written
17 off, but they don't tell them that up-front because of the
18 enticement.

19 CHAIRMAN GALASSIE: Okay.

20 MS. OLSON: I'd like to stay on Table 4, if I
21 could. I note when you spoke, you said that this new
22 facility that you're requesting the CON for will serve
23 under served populations. Yet, if we look at Table 4, from
24 2008 to 2010, your charity is less than half of what it

1 was, and it doesn't seem as though the Medicaid has
2 increased very much in that time frame either, because I'm
3 assuming that there's been more facilities between '08 and
4 2010? So even with more facilities, you're only 200 more
5 Medicaid patients and you're charity is less than half.

6 MS. RANALLI: Right. I asked that question
7 myself, because I anticipated that it might be an issue, so
8 I asked, Coleen Muldoon, the Regional Vice-President, why
9 the charity care numbers were decreasing and the Medicaid
10 numbers were increasing. First of all, a number of
11 patients -- because of the economic situation, a number of
12 patients have enrolled in Medicaid. So, when they come to
13 us, they're already a Medicaid recipient. We don't need to
14 help them with that process. So that's one reason that the
15 Medicaid numbers are just generally higher.

16 Also, the financial coordinators have been
17 given robust training on helping patients to obtain
18 financial assistance through outside organizations that
19 provide same to patients who have end stage renal disease
20 and also in helping patients enroll in Medicaid and helping
21 them understand that they're eligible for Medicaid. Once
22 those patients have the financial assistance or Medicaid
23 reimbursement, they can no longer fall under that charity
24 care number.

1 MS. OLSON: I understand that, but in 2008,
2 how many facilities are included in that 305 number, do you
3 know, as compared to 2010? I'm assuming that there's more
4 facilities in 2010 than there were in 2008. Is that not
5 correct?

6 MS. RANALLI: Definitely there are more
7 facilities that have gone on line, ten maybe.

8 MS. OLSON: So, despite there were ten more
9 facilities, there was still only 200 more Medicaid
10 patients?

11 MS. RANALLI: That would be true, and I think
12 I can speak to this, because, again, I'm here in front of
13 the Board obtaining some approval. I believe -- and this
14 is coming from me -- and Ms. Wright, because she's the CON
15 specialist, could comment on it as well. But in the last
16 couple of years -- we have very, very many cities in
17 Chicago and other areas where you might have a different
18 population and more patients who would be Medicaid
19 recipients. The facilities that have been approved in the
20 last ten years -- excuse me -- last couple of years have
21 been in areas where you might see less Medicaid patients.
22 That's not because we're necessarily going to those areas,
23 and East Aurora is a perfect example of an application that
24 will probably have a relatively high Medicaid patient

1 population. But we have so many facilities in Chicago
2 currently, and we have a couple coming up in the west and
3 north Chicago area, that there really has not been much of
4 a need to grow those facilities more.

5 MS. OLSON: Is there a guess on what
6 percentage of the patients in this new facility would be
7 Medicaid and uninsured or charity care? Do you have any
8 guess.

9 MS. RANALLI: Yes, we have that information.

10 MS. LOWE: We're assuming it would be somewhat
11 similar to the already-established Aurora facility, and it
12 is currently ten percent Medicaid.

13 MS. OLSON: Thank you.

14 CHAIRMAN GALASSIE: Any other questions on
15 the part of Board members?

16 MR. BURDEN: Thank you, Mr. Chairman. My
17 comments are not specifically related to Ms. Ranalli's
18 presentation regarding this particular unit, but it is in
19 general. I just -- this was raised, page 10, which I read
20 previously on the numerous times we've had renal dialysis
21 applications in front of us, is that a for-profit,
22 publicly-traded company is not required to provide charity
23 care nor does it do so.

24 Recently, running through the German

1 countryside -- I just came back -- reading English
2 literature, the Fresenius company is expanding, exploding
3 in China. Return on investments and their overall
4 investments in China has reached the point where they're
5 now the leading German component of German technology, at
6 least one of them. I've got to be careful. This article
7 was very interesting to me to see that this company that
8 presents monthly -- we're talking about another
9 application, another unit -- and I think you know my
10 concern about this in general, not for the patients. I'm
11 concerned obviously for them and their cost. But a company
12 that is doing so well in a climate in Europe which is
13 devastating is interesting to me. This is the same company
14 that owns this and 10 of the 15 or 16 dialysis units
15 mentioned, so I'm always coming to this from a perspective
16 of investment, capital.

17 There's no question there's a lot of money in
18 this and I commented ProPublica before, which is a liberal
19 leading publication that has been very critical about
20 hemodialysis and how they're run in general. So I always
21 come at this probably with a different perspective from my
22 other Board members who are probably more rational about
23 the whole operation.

24 I think we said before, and I still feel it,

1 because there is so much and so much money involved in this
2 entire process, that we should give more time to the whole
3 proposition of how we evaluate renal dialysis units, their
4 need. I know you're prepared to defend it. You've told me
5 such at prior meetings, and I've talked about it, and
6 since, I guess, I'm going to be around for a few more
7 years, I'm going to bring it back to the table, looking
8 forward to hearing people who may not have a particular
9 interest in a company-based dialysis unit but more
10 interested from the patient care and a nephrology point of
11 view and also the number of patients.

12 I think more evidence of transplantation
13 should be demonstrated. As a retired urologist involved
14 with the first kidney transplant done at Children's
15 Hospital -- and that was 50 years ago and that patient is
16 still alive, still sends me a card every Christmas. Okay?
17 So I'm looking around and hearing -- I don't hear enough
18 conversation about the people you treat who go on to some
19 permanent resolution of their problem. That's something
20 that you're not prepared to answer today, and I don't
21 expect it, but I am going to be pushing that we get to that
22 point so that the entire Board members get an opportunity
23 to hear the whole spectrum. I've not meant to lecture but
24 I'm doing it. I apologize.

1 I was sitting in Germany and I saw that
2 headline, Fresenius up 20 percent, growth unlimited, bigger
3 than some of the big companies I get involved with in
4 taking care of kidney stones, so-called extracorporeal
5 treatment of kidney stones, which was borne in Germany and
6 came to this country became a quite wonderful modality to
7 treat conditions that we used to have to operate on.

8 I'm looking forward to hearing where the
9 dialysis conglomerate which, if you bought their stock, I
10 think I'd say, "Hooray, they're doing super." Well,
11 they're doing super at the expense, in my judgment, of
12 unfortunate people who really are stuck. Their options are
13 minimal. If they don't get dialysis regularly, they will
14 not be here longer. I'm trying to find more data that
15 helps me say we're doing a good job -- I know we're not
16 doing as good a job in this state as they are doing in
17 Wisconsin. Maybe that's another thing to hear about.

18 I don't want to go further with it. I'm
19 wasting your time. What you're here for is not to hear me
20 talk about it, but I'm saying it because I've heard it
21 before and hopeful that we will get to a point where
22 everybody on this Board gets a full picture of the whole
23 spectrum, not just do we have too many beds in this
24 location or not enough. Your efforts, your overall

1 approach is based on our wonderful State agency, who I
2 think does a super job, but they're not -- as David
3 Carvalho mentioned a very key point, how do we know that
4 the data is, as you would attest to, factual, honest, of
5 high integrity people? I practiced medicine for 50 years.
6 I can tell you that there's a few people that I
7 encountered, physicians, who didn't have the highest
8 integrity. So I challenge that as an overall statement.

9 I'd like to see more evidence of it. On that,
10 I'm going to turn the table back to the Chairman. I've
11 said enough about it already. You know how I feel,
12 Ms. Ranalli. I've talked about it before, and hopefully
13 we'll get to a point where you can have an opportunity --
14 the whole spectrum, independent of a meeting, where we're
15 taking up everybody's time. I think it's such a big thing.
16 Every meeting there's four or five dialysis units before
17 us. I think it's more than 25 percent of our time,
18 significantly more when you think that we have to
19 investigate, the State agency does to get it to us.

20 I apologize.

21 CHAIRMAN GALASSIE: I'm actually going to
22 move this forward. Any other questions on the part of
23 Board members?

24 MR. SEWELL: I guess this is directed to the

1 Staff. I need to understand a little bit about how we make
2 the estimate for end stage renal disease stations. Are we
3 using an actual utilization based formula with a targeted
4 occupancy rate, like we do with beds?

5 MR. CONSTANTINO: Yes, sir.

6 MR. SEWELL: What's the relevance of the
7 station-to-population ratios that the applicant cited,
8 where they said that in the Aurora area there's one per
9 5,089 population and -- I'm not making the connection
10 between station-to-population and then the
11 utilization-based formula with a targeted occupancy rate.

12 MR. CONSTANTINO: That's information we ask
13 for under that maldistribution of services. We ask the
14 applicants to provide us with that data within that
15 30-minute travel time, and that's what they do. So, in
16 this instance, there was one station per 5,000 and some odd
17 population, and the State average is one station per every
18 3,700.

19 MR. SEWELL: That's a State average? That is
20 not a standard or a rule?

21 MR. CONSTANTINO: That's the State.

22 MR. SEWELL: I see.

23 MR. HAYES: Mr. Chairman?

24 CHAIRMAN GALASSIE: Yes, sir.

1 MR. HAYES: I'd like to comment that I
2 certainly appreciate Dr. Burden's analysis, and my question
3 is along the same lines here, is on Table 5 of the State
4 Agency Report, you essentially have, except for one center,
5 and there's -- I count seven other centers that are within
6 30 minutes that are owned by Fresenius. Am I reading that
7 right?

8 MS. RANALLI: Yes.

9 MR. HAYES: Okay. What about competition in
10 this industry? There seems to be amongst at least the
11 first largest two or even three in Illinois, most of the
12 projects that are coming before our Board are now for
13 either one of these two companies or three companies, and
14 what about -- have you ever addressed the issue of
15 competition in the dialysis centers?

16 MS. RANALLI: We have spoken to that issue in
17 the context of the Board, you know, ruling on our
18 applications, and there are two things that are germane to
19 that. One Dr. Burden touched on with respect to Fresenius
20 and its operations, and this also, I think, applies to the
21 other -- the second largest provider of dialysis services
22 in the United States who is in front of the Board.

23 Dialysis, because of the nature of the
24 services provided, is costly to provide. The two largest

1 companies -- or Fresenius, I'll speak to Fresenius, are
2 involved in pharmaceuticals, research, manufacturing of
3 equipment, and providing services. They provide home
4 dialysis, peritoneal dialysis, acute dialysis for hospital
5 patients. Because they are doing that and because they are
6 large, in fact, they are able to sustain the cost and
7 actually bring delivery to the very patients that so need
8 it.

9 When we testified at the Task Force hearing,
10 Sister Sheila Lynes said -- and this was a quote from her,
11 "God bless you for what you do, because hospitals simply
12 can't do it." You will notice that very few hospitals have
13 outpatient dialysis facilities. It is too costly to do it.
14 There are very few physician practices, and it's great that
15 the physicians such as Fox Valley, the opposition here
16 today, have been able to do it and do it successfully and
17 well. But it's not common. That is just sort of a fact
18 that exists with respect to the dialysis services and why
19 you see Fresenius and other -- a few companies that tend to
20 put most applications in front of you.

21 Also, with respect to competition -- and it
22 goes to the approval this particular facility in front of
23 you -- I will say that it does, again, go to what I argued
24 was somewhat common sense. We would have no reason to

1 compete with ourselves. We do have the majority of the
2 facilities in the area. We have the West Batavia facility.
3 Unless we were working with a physician who saw an actual
4 need of patients who would require dialysis, we would have
5 no reason to invest the \$4 million in this particular
6 facility, because we wouldn't have patients to dialyze
7 there and we wouldn't make money from the clinic. So, the
8 flip side of that competition is, when we are in front of
9 you and we have the other clinics in the area and we're
10 telling you that we want to build another one because there
11 is a need, there most likely is a need as opposed to us
12 trying to muscle our way in to get the market share of
13 patients. There are patients there that need to be served,
14 and that's why we're willing as a company to invest in a
15 facility that will serve those patients. Otherwise they
16 clog up our facilities. We would have to run four shifts,
17 which that would be us doing it, because we're the only
18 ones doing it in the area. We have to dialyze patients
19 until one in the morning. That's not in our best interests
20 and it's not in the patient's best interests.

21 We want to serve the patients. We want to
22 work with the physicians. So, again, common sense would
23 tell you that there is a need for the facility that we're
24 proposing in East Aurora; otherwise, we wouldn't build it,

1 we would just have our patients go to two existing
2 facilities in the area.

3 MR. HAYES: Fresenius is a very large,
4 international corporation; is that correct.

5 MS. RANALLI: Yes.

6 MR. HAYES: And the doctor was mentioning that
7 they seem to be very profitable in some parts of their
8 business internationally, as well as growth in China, but
9 then when we look at your bond ratings here, they,
10 obviously, are, from Standard and Poors, BB, and Bal from
11 Moody's and Fitch is BB. That is a concern. In other
12 words, there seems to be a disconnect with these bond
13 ratings and the profitability and the growth of this
14 company. If this company is such a large company,
15 providing international services and able to do this
16 efficiently, the bond rating agencies at least and the Wall
17 Street in general are very pessimistic about it long-term.
18 They're very concerned about the contingencies for the
19 future.

20 MS. RANALLI: You've asked that question a
21 couple of times, and I'm not trying to punt, but I am not
22 the best person, and I don't think Lori and Jenny are
23 either, to answer the question as to the bond ratings. A
24 number of years ago the Treasurer for Fresenius came from

1 the corporate headquarters in Boston, and I will invite
2 him, because you've asked that a couple of times, and I
3 think you deserve a more specific answer than what maybe
4 even the Regional Vice-Presidents can provide. I will ask
5 him, and I'm sure he'll be happy to attend a meeting and
6 talk to you about it.

7 I do know the bond ratings are what they are
8 because of the significant regulation and compliance
9 issues, speaking to what Jenny said about not telling a
10 patient we can write off bills. Healthcare is so highly
11 regulated and so subject to internal investigations, et
12 cetera, and Fresenius is a large company, and so, believe
13 me, it's looked at all the time, that I know, according to
14 the Treasurer, does impact the bond ratings. But he really
15 could speak much more eloquently to your question, and so I
16 will invite him to come, and my guess is he will, because
17 he's done it before.

18 MR. HAYES: Well, I would appreciate that,
19 because, really, we're looking at the Fresenius corporation
20 as opposed to a specific facility, each facility in
21 Illinois, because the ultimate control and responsibility
22 and financial responsibility is going to be from this
23 international corporation.

24 MS. RANALLI: It goes up to Fresenius

1 Holdings, you're correct, which is a USA national company,
2 but its parent is the ultimate international company, so
3 you're correct.

4 CHAIRMAN GALASSIE: I'm going to encourage to
5 bring this to a motion, if I may. May I have a motion to
6 approve Project No. 10-086 to establish a 12-station end
7 stage renal dialysis facility in Aurora, Illinois, at a
8 cost of \$4,368,990?

9 MR. BURDEN: So moved.

10 MR. HAYES: Second.

11 CHAIRMAN GALASSIE: Moved and seconded. Roll
12 call?

13 MR. ROATE: Motion made by Dr. Burden,
14 seconded by Mr. Hayes.

15 Dr. Burden?

16 DR. BURDEN: I vote no.

17 MR. ROATE: Mr. Eaker?

18 MR. EAKER: I'm going to -- for the reasons
19 stated in SAR and also would very much like to hear the
20 information about the Fresenius company, I'm going to vote
21 no at this time.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: For the reasons stated by my
24 fellow Board members, I'll vote no.

1 MR. ROATE: Mr. Hayes?

2 MR. HAYES: Well, for my concerns that I've
3 expressed and, specifically, I'd certainly like to hear
4 from the Fresenius International or their Fresenius
5 Holdings, the U.S. corporate entity here, I'm voting no.

6 MR. ROATE: Mr. Hilgenbrink?

7 MR. HILGENBRINK: I vote yes.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: I believe that we're being asked
10 to approve this application based on the fact that they are
11 going to serve an under served population, and I don't see
12 proof that that is their commitment, so I vote no.

13 MR. ROATE: Mr. Sewell?

14 MR. SEWELL: For the reasons stated by fellow
15 Board members and that there doesn't appear to be a need
16 for the additional stations, I vote no.

17 MR. ROATE: Chairman Galassie?

18 CHAIRMAN GALASSIE: Yes.

19 MR. ROATE: That's six votes in the negative,
20 two votes in the positive.

21 CHAIRMAN GALASSIE: Motion does not 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 submitting additional information.

1 MS. RANALLI: Okay. We'll do so.

2 CHAIRMAN GALASSIE: Moving on to the next
3 agenda item -- I would encourage you Board members, if you
4 have not filled out your luncheon menus, probably you
5 should do so.

6 (Pause)

7 CHAIRMAN GALASSIE: We are moving on to Item
8 10-093, Woodlawn Dialysis. We have four public comments.
9 Those for public comment I would actually ask to come to
10 the table first.

11 (Pause)

12 CHAIRMAN GALASSIE: So the folks in the room
13 understand, we'll announce what item is on the agenda. If
14 there is public comment, we will offer public comment to
15 come to the table first. Following public comment, we'll
16 invite the organization to the table for your presentation.
17 Thank you.

18 MS. AVERY: Mr. Chair, we have three in
19 opposition, one in support. Julie Tepni, Patricia Abrams,
20 Latrice Williams, and Bernard Loyd.

21 CHAIRMAN GALASSIE: Folks, if I may just
22 reiterate upfront -- and I hope to do so as respectfully as
23 possible -- we are asking that your comments be kept within
24 a two-minute time frame. I'm asking Juan Morado to have

1 the wonderful position of time keeper, and he'll give you a
2 30-second notice when your time is about to evaporate in 30
3 seconds.

4 MS. FRIEDMAN: May I have a moment, Chairman
5 Galassie? I'm Kara Friedman, counsel for Davita. I just
6 want you to know that we do have a public comment
7 previously from Bernard Lloyd, and if I did understand your
8 comments from the beginning, you didn't want to have
9 duplication.

10 CHAIRMAN GALASSIE: If it's a repeat, that's
11 correct, that's not necessary. We have that documentation.
12 If it's different, it's acceptable, but if it's the same --

13 MS. AVERY: Their comment was requesting a
14 public hearing, but the public hearing had already taken
15 place. If I remember correctly, Mike, they were requesting
16 a public hearing?

17 MR. CONSTANTINO: Yes, there was some concern
18 that they didn't receive our notice.

19 CHAIRMAN GALASSIE: Again, two minutes at
20 public hearings. Thank you very much.

21 MS. TEPNI: Good morning. My name is Julie
22 Tepni, and I'm the divisional social worker for Davita. I
23 oversee the social work here in the Chicagoland area.

24 I'm sure some of the CON Board members are

1 already well aware of dialysis service, ESRD, but for the
2 benefit of those who are new and those who don't, I just
3 want to provide some perspective from the clinic personnel
4 that focus on the quality of life and emotional well-being,
5 as well as the limitations, struggles and challenges of
6 people with kidney failure, and we hope you support our
7 application today for our patients.

8 Our social workers work with dialysis patients
9 and their families to help them adjust and manage life
10 while on dialysis. Through my work, I see the strain that
11 kidney disease places on both patients and their families.
12 Kidney disease and dialysis regiment can create emotional,
13 financial, career and lifestyle difficulties. Due to the
14 ongoing nature of dialysis and frequency and length of
15 dialysis treatments, patients often struggle to maintain
16 their employment and independence.

17 Typically, including transportation time, a
18 patient spends 15 to 20 minutes -- 15 to 20 hours a week to
19 dialysis treatment. So it's very important that dialysis
20 facilities are located close to home and have some
21 flexibility and shift availability, to decrease the burden
22 patients have to schedule their lives around dialysis and
23 can have improved quality of life.

24 Although only really one of them is new,

1 Davita has three applications to you today, and I'd like to
2 explain why approval is so important to the patients and
3 families we serve. For the benefit of the new Board
4 members, I'll use the term "ESRD patients". ESRD patients
5 are those who need dialysis or transplant to survive.
6 There's recently been an increase in ESRD incidents.
7 According to government data, utilization state-wide has
8 increased seven percent annually over the past three years,
9 and the increase is due to a combination of factors
10 including, the aging population, increasing prevalence of
11 diabetes and hypertension, early detection, and an
12 increased collaboration between primary care physicians and
13 nephrologists. In addition to the increasing number of
14 ESRD patients, the attrition rates for patients on dialysis
15 are decreasing, due to improved treatment.

16 CHAIRMAN GALASSIE: Thirty seconds, please.

17 MS. TEPNI: For example, the IMPACT program
18 focuses on reducing patient mortality and morbidity during
19 the first 90 days on dialysis, through aggressive education
20 and management. Since its piloting, the IMPACT program has
21 shown to decrease both mortality and morbidity, and while
22 we're very proud of our success in these initiatives,
23 because our patients are living healthier, longer lives, it
24 does present some delivery and planning concerns and

1 challenges, because it's more difficult to accommodate new
2 ESRD patients at our existing facilities.

3 Life on dialysis can be arduous, and it's very
4 difficult for patients to remain independent, employment
5 and a sense of quality of life. Dialysis is scheduled
6 three days a week and lasts between three to five hours.
7 Due to transportation, occupation, socioeconomic, child
8 care and other issues, there's a high demand for the
9 morning, first and second shifts. When there's a limited
10 number of stations available, facilities can't accommodate
11 all of the patients' needs. As a result, many patients are
12 forced to limit their work schedule --

13 CHAIRMAN GALASSIE: Ma'am, I'm going to ask
14 you to come to a closure, please.

15 MS. TEPNI: -- or quit their jobs. I want to
16 respect your time I just really want to get across, our
17 patients have a lot of challenges to get to dialysis, and
18 social workers are trying to overcome those challenges, and
19 having an increased number of facilities will help us do
20 that and accommodate their needs and desires.

21 So, thank you for your time.

22 CHAIRMAN GALASSIE: Thank you. We appreciate
23 your comments.

24 Second, for public comment is --

1 MR. LOYD: Good morning. I'm Bernard Loyd. I
2 am a 20-year resident of Bronzeville and also a business
3 person in Bronzeville, working with many others to develop
4 this historic neighborhood. Bronzeville is the old
5 Blackville. There are many challenges in Bronzeville.
6 What we do have is our rich heritage, and we have our
7 graceful boulevards that present an opportunity for
8 revitalization through creating retail and jobs.

9 I'm here to oppose this. We cannot afford
10 this dialysis center at the location suggested. The
11 location suggested is at one of the most prominent
12 locations in Bronzeville. It would be the equivalent of
13 Michigan and Roosevelt, if you were thinking of downtown,
14 in the sense that on the one hand we have gracious
15 architecture along King Drive, the most prominent boulevard
16 down there, and on the other hand, we have west of the
17 proposed facility emerging retail that needs a boost, and
18 on the east side of the proposed facility some residential,
19 and then a block away Provident Hospital that needs help as
20 well. What is being proposed is underscaled. It is not in
21 keeping with the character of the boulevard, and it will
22 hamper greatly our efforts to redevelop that corridor and
23 that community. We cannot afford that.

24 Secondly, if we are to invest in -- invest

1 precious healthcare capital dollars, we need each dollar to
2 count, and in our community, we need those dollars to be
3 coordinated. Specifically, Provident Hospital, as I
4 mentioned, is one block east of the proposed facility. It
5 would welcome the facility either within its building or
6 right adjacent to it. There is space adjacent to it. It's
7 a wonderful space, looks on the park, and they would
8 welcome that, and there are other places in our community
9 that would welcome it likewise. We cannot afford to
10 separate our healthcare facilities --

11 MR. URSO: Thirty seconds, sir.

12 MR. LOYD: -- and not make full use of that
13 capital.

14 Finally, as you know, more than half of the
15 facilities within 30 minutes of this -- of the original
16 facility are under 80 percent utilization. In fact, there
17 are two within five minutes that could accommodate all of
18 the capacity without any expansion. It is not necessary to
19 have this new facility. We cannot afford it. The State
20 cannot afford it.

21 Thank you.

22 CHAIRMAN GALASSIE: Thank you.

23 MS. WILLIAMS: Good morning. My name is
24 Latrice Williams, and I'm a Bronzeville resident and a

1 member of the Bronzeville Community Garden, which is
2 located across the street from the proposed site, and also
3 a member of a community collaborative for the restoration
4 and preservation of Bronzeville.

5 The Bronzeville area of Chicago is steeped in
6 African American tradition because of its key role in the
7 migration from the southern states. Current redevelopment
8 in the area will reflect this history as an entertainment,
9 culinary and retail destination. In addition to the
10 historic homes lining King Drive, many existing structures
11 are being turned to their former glory.

12 The applicants' proposed design is not in
13 keeping with the direction of this redevelopment, and a key
14 corridor into our community, which is 51st Street. The
15 Woodlawn Dialysis Center would not make the best use of
16 this prominent corner in our neighborhood because of its
17 highly specialized nature. It will limit the sustainable
18 and substantial economic potential of that particular
19 corner. As a mother, sustainability is a primary concern
20 of mine regarding the redevelopment of my community. It
21 not only will lend itself to immediate advantages but for
22 those of my children and my grandchildren.

23 My involvement in this matter -- I ask the
24 Board to consider the applicant's lack of acknowledgement

1 of the plans for redevelopment, the historical heritage of
2 the community and the possibility of a study of economic
3 growth for this area.

4 Thank you.

5 CHAIRMAN GALASSIE: Latrice, pardon me. Can
6 you tell me again the name of your community organization?

7 MS. WILLIAMS: The Bronzeville Community
8 Garden.

9 CHAIRMAN GALASSIE: That's the community
10 organization?

11 MS. WILLIAMS: Yes.

12 CHAIRMAN GALASSIE: Thank you.

13 MS. ABRAMS: Good morning. My name is
14 Patricia Abrams. I am the Executive Director of the
15 Renaissance Collaborative and the sponsoring agency of TRC
16 Senior Village 1, which is located about two blocks from
17 the proposed site.

18 I am addressing the commission this morning
19 for two reasons. One, to sort of reiterate what Bernard
20 Loyd has already said about Provident being a space where
21 this facility should or could be located, in addition to
22 which there is another developer that is developing a
23 medical center. So, we're more concerned about -- we're
24 just as concerned about land use and appropriate land use.

1 planning for the redevelopment of the area, but along with
2 what one of the commission members mentioned earlier, we
3 are looking at quality of life issues, and so as a person
4 who served the very low income senior population, we have a
5 health and wellness center built right into the facility
6 and we're working with those primary care physicians to
7 improve the quality of life of seniors in a different kind
8 of manner, so that hopefully they don't need dialysis. So,
9 where there is the projectory that all seniors as they age
10 will eventually need dialysis, we have a different
11 perspective on that, that improving one's fitness and
12 wellness can keep people healthy and well for the duration
13 of their life. And so that's the perspective that we as an
14 organization is coming from.

15 And because there are alternatives, as well as
16 under utilization of the current sites for dialysis, we're
17 here to ask the Committee to please vote no. Thank you.

18 CHAIRMAN GALASSIE: Thank you for your
19 comments, all four of you. We appreciate it.

20 We would like to invite the representatives
21 from Woodlawn Dialysis to the table. We will ask that you
22 be -- introduce yourselves and be sworn in, and then we'll
23 go to Staff report.

24 (Pause)

1 MR. CONSTANTINO: Mr. Chairman, we received a
2 comment on the State Agency Report -- two comments, in
3 fact, on the State Agency Report. It was in the packet of
4 material that we sent to you.

5 CHAIRMAN GALASSIE: Did you just want to
6 remind Board members generally what those comments were?

7 MR. CONSTANTINO: Concerns were expressed by
8 the Bronzeville community about the location of the
9 proposed facility. The State -- there was some concerns
10 expressed that they were not notified that this facility
11 was coming in to their area. This facility had a Type A
12 modification. We reposted the notice and opportunity for
13 public hearing on April 1st, and, evidently, after the time
14 frame for the public hearing request had passed, they
15 realized that they could not request a public hearing. So,
16 essentially, it's a repeat of the conversation that we just
17 heard here this morning.

18 CHAIRMAN GALASSIE: And remind me what a Type
19 A modification is.

20 MR. CONSTANTINO: Type A modification requires
21 notice of an opportunity for a public hearing. Type B
22 modification does not. Type A modification would include
23 such changes as this one, as a site relocation, increase in
24 the number of stations -- there's four or five different

1 criteria in our Rules that would require a Type A
2 modification, but the significant difference is the notice
3 of an opportunity for a public hearing.

4 CHAIRMAN GALASSIE: Thank you.

5 MS. FRIEDMAN: I'm Kara Friedman.

6 MS. DAVIS: Penny Davis.

7 MS. WOZNIAK: Delia Wozniak.

8 CHAIRMAN GALASSIE: Good morning. State
9 Agency Report, and then we'll come to you.

10 MR. CONSTANTINO: Thank you, Mr. Chairman.
11 The applicants, Davita, Inc. and Total Renal Care, Inc.,
12 are proposing a discontinuation of a 20-station ESRD
13 facility and the establishment of a 32-station facility in
14 approximately 12,000 gross square of space at a cost of
15 approximately \$5 million. The new location is
16 approximately one and a half miles from the existing
17 location.

18 No public hearing was requested, and there was
19 no letters of support or opposition. Like I mentioned,
20 there were two comments on the State Agency Report. The
21 applicants are before the State Board because the
22 applicants are proposing a discontinuation and
23 establishment of a new healthcare facility, as defined by
24 the Act.

1 The State Agency would note there is a
2 calculated need for 53 ESRD stations in Chicago. This
3 project was deferred from the March 22nd, 2011 meeting and
4 was modified on March 25th, 2011. This was a Type A
5 modification because the applicant changed the site. The
6 discontinuation of the 20 stations will increase the number
7 of stations needed in the Planning Area to 73 stations. We
8 would also note 23 of the 44 facilities within 30 minutes
9 are operating less than the 80 percent target occupancy.
10 And that concludes my remarks.

11 CHAIRMAN GALASSIE: Thank you. We appreciate
12 that. And just to reiterate so Board members understand,
13 there actually was a request for public hearing, but it did
14 not meet our time requirements, as mentioned earlier.

15 MR. CONSTANTINO: Right, they didn't.

16 CHAIRMAN GALASSIE: Thank you. Good morning.

17 MS. DAVIS: Good morning. Thank you. My name
18 is Penny Davis. I'm the Divisional Vice-President for
19 Davita in Chicago, and with me today is our legal counsel,
20 Kara Friedman, and CON consultant Delia Wozniak. We
21 appreciate your efforts and are really glad to be at this
22 specially-scheduled meeting.

23 As you know from our counsel's dialogue with
24 you, over the past it's been important for us to relocate

1 this facility. This project is a relocation of an existing
2 ESRD facility. We currently operate this facility as a
3 tenant of the University of Chicago. We have a short-term
4 lease with U of C, which is imminently due to expire. The
5 hospital wants to use this space for amenities that will
6 support their other programs.

7 While the physical plant requirements for
8 operating dialysis facilities don't require nearly the
9 capital that you see for hospital modernization projects,
10 we are faced with many practical issues. Here we are
11 working with the University of Chicago to close the current
12 heavily-utilized facility as promptly as we can. And I say
13 "heavily utilized". We are at a hundred percent occupancy.

14 For the new location, we are working with our
15 broker at through site selection difficulties presented by
16 the stagnant real estate market on the south side of
17 Chicago, as well as strict zoning requirements of the City.
18 Because the facility currently operates at a high
19 utilization rate and we see demand continuing to grow in
20 that market, we are increasing the number of stations in
21 connection with the move. While our internal target for
22 Chicago programs and the State standard is at 80 percent,
23 our current facility, as I said, operates at a hundred
24 percent. By adding stations, we will be better able to

1 manage this group of patients.

2 In this community, we think that the aging
3 population and increased incidents of ESRD comorbidities,
4 particularly in the African American and Hispanic
5 communities, are primary contributors to the increases
6 we're seeing. Renal Network Data from the most recent
7 reported quarter indicates that the average occupancy of
8 facilities in the area is over 80 percent. This high
9 utilization supports this Board's identified need for more
10 stations in Planning Area 6 in the City of Chicago.

11 I'd like to briefly address the concerns
12 raised by the public comment. Those involved in building
13 matters in the City of Chicago know that the zoning and
14 permit laws are onerous and time-consuming. In fact, we
15 had to modify this application back in March with a new
16 address, because the property we identified could not be
17 zoned for healthcare, notwithstanding the fact that the
18 landlord had told us it could be. We have consulted with
19 our legal counsel to ensure the current site is properly
20 zoned for a healthcare facility.

21 Further, in order to ensure that this project
22 does not get held up in building permit phase, I have
23 worked, along with our developer, diligently with the
24 alderman to ensure that she is satisfied that we have

1 addressed the reasonable concerns of the community. We
2 have met with the alderwoman on multiple occasions, along
3 with community members, and it's the alderman who has
4 supported this project and continues to support it as we
5 have made refinements to the building design to fit better
6 into the Bronzeville community. Ultimately, the individual
7 who spoke may have personal biases which brought him here
8 to speak against the building, but we believe that the
9 alderwoman has balanced the needs and interests of her
10 constituents going forward and that this is a great place
11 for a dialysis facility. She's in support of the project,
12 and with your approval, we will immediately move forward
13 with the developer and the City of Chicago to bring this
14 project to completion.

15 We respectfully request the Board approve this
16 application. Thank you for your consideration.

17 CHAIRMAN GALASSIE: Thank you. Do we have
18 that alderwoman's support in writing?

19 MS. DAVIS: I have an e-mail I could print
20 out.

21 CHAIRMAN GALASSIE: Thank you.
22 Mike, have you received anything in writing?

23 MR. CONSTANTINO: No, sir.

24 MR. CARVALHO: Could I just give a little bit

1 of information how the alderman is involved versus zoning,
2 if anyone wants to know?

3 CHAIRMAN GALASSIE: At this point, probably
4 not. We have no written confirmation from the alderman. I
5 respect your comments.

6 Questions from Board members?

7 (Pause)

8 CHAIRMAN GALASSIE: Hearing none --

9 MR. CARVALHO: Two things. I've been on this
10 Board for eight years, and I have regularly jumped down the
11 throats of applicants who are seeking to avoid serving
12 under served communities and moving into more affluent
13 communities. So this is a first for me in eight years
14 where someone has come and said, "Please keep a healthcare
15 facility out of our neighborhood; we don't want them." I
16 mean, we would not give that a moment's thought if it was
17 in Lake Forest or some other community, and I'm not sure
18 why anybody would want to suggest to this Board that we
19 should adopt a nimby approach, "We don't want healthcare
20 serving our community and our neighborhood because we don't
21 like healthcare facilities" .

22 Second, the reference to Provident Hospital,
23 I'm on the Board of Provident Hospital. We've never
24 considered, that I know of, of putting a dialysis center in

1 the hospital, so I'm not sure where that came from either.

2 So I just wanted to make those two points.

3 CHAIRMAN GALASSIE: Thank you, Mr. Carvalho.

4 MS. OLSON: I have a question. This is
5 probably a logistical question. Is it correct that we can
6 ask to have this deferred until everybody can figure out
7 how to play in the sandbox together, because this is
8 ridiculous. These people are trying very hard to
9 revitalize their community, and there's got to be some way
10 everybody can play together.

11 CHAIRMAN GALASSIE: An excellent question, and
12 I appreciate that. I might ask Frank to spend a few
13 minutes sort of reiterating the kind of options we have
14 available to us.

15 MR. URSO: First of all, let me just comment
16 about the public comment periods. There are two public
17 comment periods that the public has to access the Board,
18 and the public comment period for all public officials and
19 public in general ends 20 days prior to the meeting, 20
20 days prior to when this project is going to be considered
21 by the Board. Then the State Agency Report are issued and
22 put on the web site 14 days prior to the meeting and,
23 therefore, comment opens up again for those individuals who
24 want to respond to the State Agency Report, and that

1 comment period opens from the 14th day prior to the meeting
2 to the 10th day. Those are the comments that you see Mike
3 handing you and talking about prior to the consideration of
4 the projects. Those are the comments that are, number one,
5 supposed to be responsive to the State Agency Report. If
6 they're not responsive to the State Agency Report, then we
7 take a different look at those.

8 But the Board then has an opportunity then to
9 do several things once we receive these comments. They're
10 late in the game. Okay? In other words, they come 14
11 days -- between 14 days and 10 days before the Board
12 meeting. The Board can accept those comments and decide to
13 hear the project anyway. They can decide to accept the
14 comments but further analysis is required by Board Staff,
15 and that would key in a deferral. Or they can reject the
16 comments outright, saying basically they're not responsive
17 to the State Agency Report.

18 So, those are the options that this Board has.
19 So, by its action today, for instance, on the first
20 project, the Board received the comments and decided to
21 consider the project anyway. In the second instance now,
22 we've had an opportunity to see these comments and the
23 Board considered the project, but, still, there is some
24 issues that are pending, it sounds like, and the Board then

1 has a right, even at this point in time, to say it wants
2 this project deferred so that the parties could come back
3 before the Board and determine what the community actually
4 wants and how things are -- might be melded together or not
5 melded together. So those are the options.

6 MR. GREIMAN: Question.

7 CHAIRMAN GALASSIE: Sure, Judge.

8 MR. GREIMAN: So, could you give me a brief
9 description of the premises that you plan to use? Are you
10 a single tenant in a building? Is this a single building
11 for your purposes? Is a multi-story. Tell me about it.

12 MS. DAVIS: What we're building is a two-story
13 building where we will be the tenant.

14 MR. GREIMAN: Building a building?

15 MS. DAVIS: Yes, the developer is building a
16 building that we will lease.

17 MR. GREIMAN: And what's on the land now?

18 MS. DAVIS: It's empty space.

19 MR. GREIMAN: It's a vacant lot?

20 MS. DAVIS: Yes.

21 MR. GREIMAN: Okay.

22 MS. DAVIS: And currently what the developer
23 has agreed to, along with the alderman and the community
24 members, is he is also building 5,000 square feet of retail

1 space in a design that was approved by the community groups
2 and the alderwoman.

3 MR. GREIMAN: So that when people walk down
4 the street, they'll see the retail stores and they won't
5 see the ugliness of a dialysis unit?

6 MS. DAVIS: Exactly. What we've done is --
7 and this was in response to the community meetings that
8 we've had, is that on the corner of 51st and King Drive
9 will be a retail space and behind that --

10 MR. GREIMAN: Okay. Is there a -- what do I
11 want to use? Is there a style in the -- on the street of
12 the block?

13 MS. DAVIS: Yes.

14 MR. GREIMAN: Particular style.

15 MS. DAVIS: Right.

16 MR. GREIMAN: Will your facility follow that
17 style?

18 MS. DAVIS: Absolutely. The alderman
19 requested that the architects actually go around the
20 community. She pointed out certain features of the
21 architecture in the community, and they designed the
22 building specific to those requests.

23 JUSTICE GREIMAN: Thank you very much.

24 MS. FRIEDMAN: If I just may, since there's

1 been discussion about whether it's appropriate to continue
2 at this point, this program was acquired, along with two
3 others from the University of Chicago last summer. In
4 connection with that transaction, it was a mandate of the
5 University of Chicago Hospitals that we vacate this space.
6 This has always been a very needy community with respect to
7 the delivery of ESRD services, and these facilities, for as
8 long as I've known them, have always been very full and
9 sometimes difficult to operate. There are 135 existing
10 patients in the facility right now, and the University of
11 Chicago is mandating that we depart and has lease terms
12 requiring it.

13 This building needs to be built, and we need
14 to get it in so these patients don't need to transition
15 away, outside of their community to receive services. In
16 balancing the healthcare needs of this community versus the
17 development needs, I don't really think it's within the
18 purview of this Board to worry about the development needs.
19 The alderman and the City of Chicago, through the zoning
20 processes, are -- have jurisdiction over those matters, and
21 this client -- my client, Davita, has worked very hard.
22 Their site, which was also on a boulevard, fell through,
23 and we have another facility that we also need to relocate.
24 It's extremely difficult to find real estate in this

1 market, and we are working hard for that second site as
2 well, and we're going to have to overcome these issues with
3 the community in the other site.

4 So, I very much urge that you do not defer
5 this project today. We really need to move forward so that
6 these patients don't have a gap in care.

7 CHAIRMAN GALASSIE: Thank you.

8 Mike, do you have the other facilities closest
9 to this, the utilization data? I'm sorry to put you on the
10 spot and if you don't --

11 MR. CONSTANTINO: Yes, give me a minute.

12 (Pause)

13 MR. CONSTANTINO: Page 14.

14 CHAIRMAN GALASSIE: So, members who are
15 interested, on page 14 is a Table 4, talking about the
16 facilities that are closest to this project, and the
17 utilization numbers are in front of you.

18 MR. CONSTANTINO: 23 of the 44 are not
19 operating at 80 percent.

20 CHAIRMAN GALASSIE: 23 of the 44 are not
21 operating at 80 percent.

22 MS. FRIEDMAN: If you see that list, it
23 includes facilities that are in neighborhoods such as
24 Uptown, so I'm not really sure that's within 30 minutes

1 from a practical perspective.

2 CHAIRMAN GALASSIE: I'll ask the Board to
3 adopt this chart in front of them. Thank you for your
4 comment.

5 MR. URSO: Mr. Chair, I would say if the Board
6 wishes to defer on this project or other projects, that
7 they specify the reasons so the applicants can understand
8 why this project or any project is being deferred. Thank
9 you.

10 CHAIRMAN GALASSIE: Any other questions on the
11 part of Board members?

12 (Pause)

13 CHAIRMAN GALASSIE: Hearing none, I would ask
14 for a motion to approve Project 10-093 to relocate a
15 20-station end stage renal dialysis facility and establish
16 32 ESRD stations in Chicago, Illinois at the cost of
17 \$4,983,511.

18 MR. GREIMAN: So moved.

19 MR. SEWELL: Second.

20 CHAIRMAN GALASSIE: Motion and seconded.

21 MR. ROATE: Motion made by Justice Greiman,
22 seconded by Mr. Sewell. Calling for a vote. Dr. Burden?

23 MR. BURDEN: This is the first time in my time
24 where I've seen a situation where there's a significant

1 conflict of interest. I support the concern that's
2 expressed by the applicant regarding providing care for a
3 significant overbooked facility that really has a lot of
4 patients to care for. Also, there's a fair number on this
5 Table 4 that could utilize more business. However, I do
6 recognize that Uptown is not an appropriate place for
7 somebody on the south side of Chicago to go for kidney
8 dialysis. I think that's a big stretch.

9 However, I recognize the community. They have
10 a strong feeling about their community, and although I'm
11 told that -- there's not enough data to really make it
12 comfortable for me to go either way. I have dealt with the
13 alderman politically a lot. I'd like to see a letter. You
14 say you have an e-mail. We haven't seen it, so we have to
15 go on your word.

16 I'm leaning towards voting against it with the
17 idea of deferring it, but I'm very concerned about the
18 patients who are questionably in limbo during a period of
19 time that there is no building in place. How long a period
20 of time? I'm asking a question as I'm about to say my
21 vote. How long -- can I ask this question? How long a
22 period of time would it take for a building to be in place
23 and when are you expected to exit the University of
24 Chicago?

1 CHAIRMAN GALASSIE: We're actually in the
2 process of voting Dr. Burden.

3 MR. BURDEN: I should have asked that question
4 before. I'm going to vote no with Intent to Deny, because
5 I don't have enough data.

6 CHAIRMAN GALASSIE: Just a reminder for
7 members if you are voting in the positive, if you are
8 voting to defer this project, you would be voting in the
9 negative.

10 Thank you, Dr. Burden. I didn't mean to cut
11 you off.

12 MR. ROATE: Mr. Eaker?

13 MR. EAKER: I also am very much concerned that
14 there seems to be a lack of preparation in working with the
15 community. I read in the material somewhere about the
16 community was asking that certain demands be met, and it
17 wasn't until the very end of your presentation that it
18 seems that you addressed that. I'm going to vote no and
19 hope that you'll come back with more of that information
20 and with a revised community support with you this time.
21 No.

22 MR. ROATE: Justice Greiman?

23 MR. GREIMAN: Aye.

24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes?

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: No.

6 MR. ROATE: Mr. Sewell?

7 MR. SEWELL: Yes.

8 MR. ROATE: That's four votes in the positive,
9 three in the negative.

10 CHAIRMAN GALASSIE: Excuse me.

11 MR. ROATE: Mr. Galassie?

12 CHAIRMAN GALASSIE: Chairman votes yes.

13 MR. ROATE: That's five votes in the positive,
14 three votes in the negative.

15 CHAIRMAN GALASSIE: Motion passes.

16 Would Members like to take a 10-minute
17 stretch? My watch says 25 after 11:00. If we could bring
18 it back about 25 to. We'll be breaking for lunch at 12:30.

19 (Recess)

20 CHAIRMAN GALASSIE: Thank you for being
21 timely. We are moving on to 11-004, Crest Hill Dialysis,
22 and I believe we have two individuals interested in making
23 public comments. I would ask those who are interested in
24 making public comments to come up to the table on the left,

1 introduce yourselves, and you have heard us repeatedly ask
2 you to keep timely and focused. You heard Counsel Urso
3 describe the process. While it seems we're being tight to
4 public comment, again, there are numerous steps that
5 precede getting here today. This is a very open process.
6 So at this perhaps final stage, we ask folks to try to keep
7 themselves timely in their comments. Thank you very much.

8 MR. CHAWLA: Thank you, Chairman Galassie and
9 members of the Board. My name is Dr. Bhuvan Chawla. I am
10 a Board-certified nephrologist and have been practicing in
11 Joliet for 29 years. I'm also the owner and operator of
12 Sun Health Dialysis, which has been providing quality
13 dialysis to Joliet for twenty years. I, therefore, bring
14 the perspective of a practicing physician, a practicing
15 nephrologist and a facility owner. I bring the perspective
16 of Main Street versus the perspective of Wall Street.

17 The Board also has a dual mandate to maintain
18 access to care but also to prevent unnecessary duplication.
19 Last month I sat through the Board's entire day of
20 deliberations, and I would like to commend the Board
21 members for the level of engagement you demonstrated at
22 this very location and the thoughtful deliberation you
23 displayed in addressing the various CON applications before
24 you. I would like to ask for the same level of engagement

1 going forward as you review CON application for dialysis
2 units in general and specifically for this application.

3 In 2010, the Board approved 100 percent of the
4 35 ESRD applications it considered. It issued only one
5 Intent to Deny to Project No. 10-066, Fresenius Joliet,
6 only to reverse itself in March of 2011, in spite of an
7 unchange in negative SAR. To me this would suggest that
8 the issue of duplication and maldistribution is not
9 necessarily getting the amount of attention it deserves. I
10 would like the Board to give due consideration to this
11 important mandate and to vote against this project.

12 I am thrilled to see how the Board is
13 addressing applications today.

14 MR. MORADO: Thirty seconds.

15 MR. CHAWLA: It appears that 25 percent of
16 your applications are related to dialysis, and I would be
17 happy to enlighten the Board about issues related to
18 dialysis coming from a small provider versus a large
19 provider, the issue of competition that you've asked
20 questions -- that you've asked Fresenius, that they were
21 unable to answer, but I would have been able to answer.

22 So, in summary, I would like you to stand by
23 your SAR findings and to vote against this application.
24 There is no need. It would cause over duplication and

1 maldistribution, and, as a side note, the issue of
2 nocturnal dialysis has been addressed in my letter, and I
3 would encourage you to read my letter to address the issues
4 that are relevant to the Board.

5 Thank you.

6 CHAIRMAN GALASSIE: Thank you, doctor. We
7 appreciate your comments.

8 MS. AHMED: Good morning. I'm Dr. Naila
9 Ahmed. I'm a nephrologist practicing in Joliet with a
10 group of five other nephrologists. I'm here to support the
11 project today. I strongly believe this project is vitally
12 important to the patients my colleagues and I care for. My
13 practice has provided nephrology care in this area to the
14 expanding population for more than 25 years, irrespective
15 of their ability to pay. My practice has provided
16 consistent, good care, and we are very active in referring
17 patients for transplant, preemptive, and also listing
18 patients who don't have live donors available immediately,
19 and I've been practicing nephrology in Joliet for nearly 9
20 years myself.

21 In that time, the incidents and prevalence of
22 ESRD has dramatically increased in this area. According to
23 the Renal Disease Network data, number of patients on
24 dialysis where this facility will be located has increased

1 58 percent over the past two years and nearly 9 percent
2 within the past 12 months. This increase is likely most
3 attributable to the recent dramatic rise in incidents and
4 prevalence of two types of comorbidity: Type 2 diabetes
5 and hypertension. The area has an expanding population of
6 elderly patients, especially in the assisted living
7 facilities and nursing homes, who carry a huge burden of
8 kidney disease, therefore a risk for ESRD or end stage
9 renal disease. Unfortunately, also some minority
10 populations are disproportionately affected by end stage
11 renal disease and its comorbidity.

12 Crest Hill and surrounding communities include
13 a significant number of African American population. In
14 2010, approximately 22 percent of the population of Crest
15 Hill was African American, compared to state-wide of 14.5
16 percent. Given the higher prevalence of diabetes and high
17 blood pressure, African American population have high risk
18 for ESRD than the general population. Unfortunately, we
19 have seen an increase in the number of patients presenting
20 in the emergency room with late stage kidney failure who
21 have not seen a nephrologist prior. We believe this
22 increase is due to several factors, including lack of
23 insurance, lack of access to preventative care, failure to
24 adequately screen patient, and failure to refer to a

1 nephrologist for seeking management.

2 MR. URSO: Time is up, ma'am.

3 CHAIRMAN GALASSIE: You can bring it to a
4 conclusion please.

5 MS. CHAWLA: This problem is particularly
6 acute among African American community. Given the
7 significant number of undiagnosed end stage patients
8 coupled with stage four and five patients who are
9 currently -- we are treating, there will not be sufficient
10 number of dialysis stations in the area to meet future
11 needs of our patients, especially with the relocation of
12 the Silver Cross unit to New Lennox, which is under way.

13 I'm confident my patients will benefit from
14 the proposed stage, which will ensure ESRD patients having
15 access to life-sustaining dialysis.

16 Thank you for your time and attention today.

17 CHAIRMAN GALASSIE: Thank you. We appreciate
18 your comments.

19 No other public comments, I would ask members
20 representing Crest Hill Dialysis if you would please come
21 to the table, introduce yourselves and be sworn in.
22 Following that I will ask for our Staff report on this
23 item.

24 (Pause)

1 MS. DAVIS: Good morning. My name is Penny
2 Davis, and with me today is Matthew Forsythe, who is the
3 Regional Operations Director for Chicago, and our attorneys
4 who assisted in the preparation of our CON application,
5 Kara Friedman and Anne Cooper from Polsinelli Shughart.

6 CHAIRMAN GALASSIE: Thank you very much.
7 Staff report, please.

8 MR. CONSTANTINO: The applicants, Davita Inc.
9 and Joliet Dialysis, LLC, are proposing the establishment
10 of a 12-station ESRD facility in approximately 6,200 gross
11 square feet of space, at a cost of approximately \$2
12 million. The applicants are before the State Board because
13 the project proposes to establish a healthcare facility.
14 There was no public hearing requested. However, the State
15 Agency did receive letters of support and opposition. We
16 received two opposition letters, one from Kidney Care
17 Center and one from Sun Health, who testified here today.

18 We would like to point out, there is a
19 calculated excess of 53 stations in this Service Area, and
20 1 of the 6 facilities within 30 minutes has achieved target
21 occupancy. Thank you, Mr. Chairman.

22 CHAIRMAN GALASSIE: Could you just repeat
23 that?

24 MR. CONSTANTINO: Okay. We would just like --

1 the State Agency would like to note there is a calculated
2 excess of 53 stations in this Service Area, which is HSA 9,
3 and 1 of the 6 facilities within 30 minutes is not at
4 target occupancy.

5 CHAIRMAN GALASSIE: And that's represented on
6 Table 4 of our packet for Board members.

7 MR. CONSTANTINO: 1 of 6 facilities has
8 achieved target occupancy.

9 CHAIRMAN GALASSIE: I'm not sure I had
10 members sworn.

11 (Pause)

12 (Oath given)

13 CHAIRMAN GALASSIE: Comments for the Board?

14 MS. DAVIS: I'd like, first of all, to thank
15 the Health Facilities and Services Review Board for
16 approving our application for the relocation of Woodlawn.
17 Before I begin my formal comments, I would like to clarify
18 that our three projects before the Board today are in three
19 separate Planning Areas and will serve three very different
20 patient populations.

21 At this time, I'd like to explain why a new
22 facility for end stage renal disease patients is needed in
23 Crest Hill and to address the few negative findings of the
24 State Agency Report. For the benefit of the new Board

1 members -- and you've heard it several times today the
2 acronym ESRD is for end stage renal disease. It means that
3 it is irreversible and permanent. As Julie Tepni discussed
4 in her public comments earlier, we have seen a significant
5 increase in the incidents and prevalence in ESRD over the
6 past several years. In fact, within HSA 9, the area where
7 the proposed Crest Hill facility will be located, the
8 number of patients on dialysis has increased 58 percent
9 over the past three years. That's an average annual
10 increase of nearly 18 percent.

11 While we believe this increase is due in part
12 to the factors that Julie discussed, it is important to
13 understand that Crest Hill has a large minority population
14 and that certain minority populations, including African
15 Americans and Hispanics disproportionately suffer from
16 kidney failure. This factor is also likely driving some of
17 the ESRD incident increases in the area that we're
18 experiencing.

19 In addition to increasing numbers of ESRD
20 patients, the attrition rates for patients on dialysis are
21 decreasing due to improved treatment. As Ms. Tepni
22 explained, Davita's IMPACT program has been successful in
23 reducing patient mortality and morbidity. While we are
24 proud of this success of IMPACT, lower patient attrition

1 rates means it's more difficult to accommodate new ESRD
2 patients in our existing facilities. Fortunately, in some
3 areas of the State, including Crest Hill, it's easier to
4 develop new sites for expansion. As you've heard earlier
5 it's been more of a challenge finding space that is
6 suitable for healthcare in the City of Chicago.

7 There are currently six approved or existing
8 dialysis facilities in the Crest Hill market. Fresenius
9 Joliet was approved at the May Board meeting. That
10 facility is anticipated to be operational in two years.
11 Importantly, the referrals used to support the Fresenius
12 Joliet application were from a physician who is not
13 affiliated with the group which has documented patient
14 referrals for this project, and Dr. Ahmed spoke to that.
15 Moreover, there is no significant overlap in the Planning
16 Service Areas of the two facilities.

17 Based on the patient data provided by Dr.
18 Alausa, that facility, we assume Fresenius Joliet will
19 achieve 80 percent utilization within two years of the
20 project completion and will not be able to alleviate
21 projected need for dialysis patients nor these nephrology
22 consultants. That's Dr. Ahmed's practice. Of the existing
23 facilities, four of the five facilities are above or
24 quickly approaching the State's 80 percent utilization

1 standard. The only facility in the area significantly
2 below 80 percent utilization is Sun Health, which is
3 operating at approximately 53 percent.

4 In his July 6, 2010 objection to the
5 relocation application for Silver Cross Dialysis,
6 Dr. Chawla attributed this low utilization to the exclusion
7 of Sun Health from the major Health Insurers Providers
8 Network. Notwithstanding Sun Health's low utilization,
9 average utilization of the existing facilities is currently
10 82 percent. Assuming 80 percent utilization, the existing
11 facilities can only accommodate 30 additional patients and
12 maintain their 80 percent target occupancy at the current
13 time.

14 Importantly, almost all of the low capacity is
15 at Sun Health, due to insurance limitations this provider
16 cited. It is not an option for certain patients. Given
17 the trending, the few slots available will be filled by
18 other patients before this facility is open. Northeast
19 Nephrology Consultants is currently treating 130 Stage 4
20 and Stage 5 pre-ESRD patients in the Crest Hill area. We
21 acknowledge that due to a variety of factors, not every
22 patient identified as chronic kidney disease patients will
23 initiate dialysis. To achieve 80 percent utilization for a
24 12 station facility, only 58 of those CKD patients, or less

1 than half of the identified patients, would be referred to
2 the proposed facility. We believe this is very
3 conservative.

4 I'd like to also mention something about the
5 Planning Area in question, HSA 9. The State Agency Report
6 shows there are 11 existing facilities in the Planning Area
7 that are operating below the State's 80 percent target
8 rate. The HSA 9 Planning Area, however, is expansive. It
9 encompasses Grundy, Kankakee, Kendall, and Will Counties.
10 Importantly, nearly all of the facilities in the Planning
11 Area that fall below the State's 80 percent utilization
12 standard are located outside of Will County in the more
13 rural, less-populated counties, which together have less
14 than 50 percent of Will County's population. These rural
15 facilities are distant from the Joliet area and are not a
16 realistic option for patients residing in Will County.

17 Kara Friedman would like to make a statement
18 at this point.

19 MS. FRIEDMAN: In looking at the State Agency
20 Report from your perspective, I just wanted to focus you on
21 two different charts that you have that discuss the
22 facilities in the Planning Area. The first one which
23 probably most people look at is on page 4, and it shows all
24 of the facilities in the Planning Area. Further back, on

1 page 16, it discusses facilities which are within the
2 vicinity of this proposed facility, which whittles it down
3 a little bit. But you see an excess of 55 stations in the
4 Planning Area, and you have to think thoughtfully about
5 adding more. But if I could go through this list on page
6 4, I'd like to point out, the lower utilization facilities,
7 what you don't have the benefit of is the time -- the
8 travel time to those other facilities.

9 But to start out, the St. Mary's program in
10 Kankakee is 67 minutes away from this facility. Likewise,
11 both of the facilities in Morris, Illinois, together
12 they're not at 80 percent capacity, and one is at about 39
13 percent capacity, but it is in Morris, which is about 40
14 minutes away from Joliet. Manteno Dialysis an hour away,
15 and it's at 40 percent utilization. Oswego is about 36
16 minutes away; it's actually got a higher utilization rate.
17 And Kankakee Dialysis in Bourbonnais is 63 minutes away and
18 is at 54 percent. So, I think it's probably helpful to
19 understand that most of these facilities are not a good
20 option for patients that are residing in Will County and
21 the Crest Hill, Joliet community where 71 percent of the
22 population of the Planning Area live.

23 CHAIRMAN GALASSIE: Thank you.

24 MS. DAVIS: In addition, I would just like to

1 remind the Board that when we talk about dialysis patients
2 and dialysis and the distance from facilities, these
3 patients come to our facilities three times a week. They
4 spend three to five hours at our facilities, and it's
5 ongoing. It's for the rest of their lives, and many of
6 them rely on either public transportation or their families
7 to help them get to the facilities. So, when you look at
8 travel times of over 30 minutes each way, I am sure that
9 you're considering that.

10 We respectfully request the Board approve this
11 application. We thank you for your consideration, and I'm
12 more than happy to answer any questions at this time.
13 Thank you.

14 CHAIRMAN GALASSIE: Thank you very much.

15 I'd like to turn it over to Board questions,
16 if there are any.

17 MR. HILGENBRINK: Mr. Chair?

18 CHAIRMAN GALASSIE: Yes, sir.

19 MR. HILGENBRINK: I'd like to clarify the
20 travel time calculation with the Staff. My assumption is
21 that includes -- that only includes vehicle transportation,
22 not public transportation.

23 MR. CONSTANTINO: That's correct.

24 MR. HILGENBRINK: And it's done off a map?

1 MR. CONSTANTINO: In this case, travel time
2 study was done and certified by the applicants and we used
3 that information.

4 MR. HILGENBRINK: How does the applicant
5 determine the travel time?

6 MS. FRIEDMAN: We actually engaged someone who
7 is accredited by the Department of Transportation, a third
8 party, to do the travel time study, and we only did that
9 study for the facilities within 30 minutes. So the numbers
10 I just cited are MapQuest numbers for the ones outside of
11 30.

12 MR. HILGENBRINK: So the study they do only
13 includes private vehicles?

14 MS. FRIEDMAN: Right.

15 CHAIRMAN GALASSIE: Other questions from
16 Board members?

17 (Pause)

18 CHAIRMAN GALASSIE: Hearing none, I will move
19 forward. I will ask for a motion to approve Project 11-004
20 to establish a 12-station end stage renal dialysis facility
21 in Crest Hill, Illinois, at a cost of \$1,984.179.

22 MR. HILGENBRINK: So moved.

23 MR. BURDEN: Second.

24 CHAIRMAN GALASSIE: Motion. Second by

1 Dr. Burden.

2 Roll call, please.

3 MR. ROATE: Dr. Burden?

4 MR. BURDEN: I am inclined to disagree with
5 the statement that dialysis should be a lifetime
6 proposition. You heard my enthusiasm for something other
7 than dialysis, being transplantation. I'm going to vote no
8 based on the fact that we have over utilization
9 significantly in the area, even though there is a distance
10 that was pointed out, a distance issue.

11 MR. ROATE: Mr. Eaker?

12 MR. EAKER: Due to the stated over size of
13 beds, I'm going to vote no.

14 MR. ROATE: Justice Greiman?

15 MR. GREIMAN: Aye.

16 MR. ROATE: Mr. Hayes?

17 MR. HAYES: Yes.

18 MR. ROATE: Mr. Hilgenbrink?

19 MR. HILGENBRINK: Yes.

20 MR. ROATE: Ms. Olson?

21 MS. OLSON: No.

22 MR. ROATE: Mr. Sewell?

23 MR. SEWELL: No, due to the excess capacity,
24 and I wasn't convinced on the occupancy presentation.

1 MR. ROATE: Chairman Galassie?

2 CHAIRMAN GALASSIE: Chairman votes no based on
3 excess capacity numbers at this time.

4 MR. ROATE: That's five votes in the
5 negative, three votes in the positive.

6 CHAIRMAN GALASSIE: Motion fails.

7 MR. URSO: You will receive an Intent to Deny.
8 You have a right to come before the Board again, as well as
9 submit additional information.

10 CHAIRMAN GALASSIE: Thank you very much.

11 We'll be moving forward to Item No. 11-010,
12 and I believe we have one person interested in public
13 comment.

14 Before we do, the Chair would just like to ask
15 the gentleman in the back, who is taping us, that just sat
16 down, I was assuming you were a representative from the
17 media, but Staff have not been able to confirm that. Would
18 you please advise us or me who you are representing?

19 AUDIENCE MEMBER: I'm the representing the
20 property owner for the hearing that's this afternoon, the
21 Crest Hill Dialysis.

22 CHAIRMAN GALASSIE: I didn't quite get that.
23 You're representing the property owner for--

24 AUDIENCE MEMBER: Where the proposed Crest

1 Hill Dialysis was supposed to be.

2 CHAIRMAN GALASSIE: The item we just heard?

3 AUDIENCE MEMBER: Yes.

4 CHAIRMAN GALASSIE: Thank you very much. I'd
5 just like the record to show who was in the room taping.

6 I'm sorry. Mr. Martin?

7 MR. MARTIN: Yes, that's me.

8 CHAIRMAN GALASSIE: Good morning.

9 MR. MARTIN: Good morning.

10 Thank you, Chairman, Members of the Board. My
11 name is Chris Martin. I'm the Village Administrator from
12 the Village of Lake Barrington, here to speak in support of
13 the Davita proposal for the Lake Barrington Flint Creek med
14 office building. You have a letter dated June 2nd, 2001
15 (sic) from the Village President, which also represents the
16 Village Board, unanimously supporting Davita's request to
17 locate in Lake Barrington.

18 To add to that, just a couple quick notes.
19 The building they're intending to lease or purchase -- I'm
20 not quite sure which at this point -- just came out of
21 foreclosure. It was in foreclosure for about 24 to 36
22 months. So, with Davita entering that building and
23 becoming a major tenant in that building, it solidifies it
24 is a medical office building, which is what it was built

1 for and which is what it is intended to be used for. So it
2 would be exceptional to get that building back into
3 circulation.

4 Also, on the building itself, it is a Class A,
5 high-quality office building with a significant number of
6 windows, overlooking a 30-acre wetland complex. So the
7 dialysis stations, as far as I understand them -- the
8 patients would have a really nice view while going through
9 what apparently is a fairly rough process. So it is a very
10 nice environment for that.

11 And then just finally in reference to one of
12 the Board members, we are in the sandbox with Davita. We
13 are playing very nicely, so we would appreciate if you
14 would approve the request.

15 Thank you. Those are my remarks.

16 CHAIRMAN GALASSIE: Thank you. We appreciate
17 your comments and appreciate the focus of them.

18 If there are representatives here from the
19 Barrington Creek Dialysis, we would ask you to come to the
20 table, introduce yourselves and if you've not been so,
21 please be sworn in, and then we will go to Staff comment.
22 Introduction and swear in first.

23 (Pause)

24 MS. DAVIS: Good morning. My name is Penny

1 Davis, Divisional Vice-President for Davita in Chicago.
2 With me today is Kelly Ladd, the Regional Operations
3 Director for the north region of Chicago; Kara Friedman,
4 our attorney; and Delia Wozniak, our CON consultant.

5 CHAIRMAN GALASSIE: Welcome.

6 (Oath given)

7 CHAIRMAN GALASSIE: Thank you.

8 Staff report, please.

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

10 The applicants, Davita, Inc. and Total Renal Care, Inc. and
11 Camino Dialysis, LLC are proposing to establish a
12 12-station ESRD facility in approximately 7,000 gross
13 square feet of space, at a cost of approximately \$2.5
14 million. This project was deferred from the May 2011 State
15 Board meeting. The project is before the State Board
16 because the project proposes to establish a healthcare
17 facility.

18 There was no public hearing requested.
19 However, opposition comments were received by the State
20 Agency and were included in your packet of material. The
21 State Agency notes the following: There is a calculated
22 excess of 35 stations in the HSA 7, ESRD Service Area, and
23 7 of the 10 facilities within 30 minutes are not operating
24 at the 80 percent target occupancy.

1 Thank you, Mr. Chairman.

2 CHAIRMAN GALASSIE: Thank you, Mike.

3 Presentation for the Board?

4 MS. DAVIS: Yes, thank you.

5 This project was previously approved by the
6 Board in January of 2010. We're before you today due to
7 circumstances beyond our control, when we had to abandon
8 our original permit because the building went into
9 foreclosure. We had been planning to lease the original
10 site from a third party, and we weren't able to come to
11 terms with the bank on the site and had to find a new site.
12 Because CON permits are site specific, we had to abandon
13 that permit and locate a new site.

14 One of our challenges in recent years in
15 identifying real estate is the impact of the economic down
16 turn on the commercial real estate market. While in
17 certain areas of the country we have attractive options in
18 the market where we need new sites, some of those sites
19 have been more difficult to secure because the site in
20 question may be tied up in foreclosure or development may
21 have been halted because of lack of financing. We've seen
22 some improvement in recent months. In fact, this site that
23 we're asking for today is the original site that we had a
24 CON permit for a year and a half ago. It replaces the site

1 that we attained a CON permit for last year that had
2 similar trouble.

3 We rely on our real estate broker's service to
4 help us with due diligence on properties, but we often get
5 steered up with an owner's financial problems. Again, this
6 is a -- the project was previously approved and there
7 was -- has been a long lead time for us to find a facility.
8 It takes us about two years to get a facility up and
9 running.

10 Importantly, in the time since initial
11 approval of the project, the prevalence of ESRD -- number
12 of ESRD patients in the Geographic Service Area has
13 increased nearly four percent. In fact, according to the
14 data from the Renal Disease Network in Illinois, the number
15 of patients on dialysis increased approximately five
16 percent in the first quarter of 2011. Accordingly, this
17 facility is needed now more than ever.

18 We respectfully request the Board approve this
19 application. We thank you for your time and the Staff's
20 assistance through these processes. Thanks so much. I'm
21 happy to answer any questions.

22 CHAIRMAN GALASSIE: Thank you very much. I
23 would like to open this issue up again to Board members, if
24 there are any questions.

1 (Pause)

2 CHAIRMAN GALASSIE: Hearing none, may I have
3 a motion to approve Project 11-010 for the establishment of
4 a 12-station end stage renal dialysis facility in Lake
5 Barrington, Illinois, at a cost of \$2,494,432?

6 MR. BURDEN: So moved.

7 MR. EAKER: Second.

8 CHAIRMAN GALASSIE: Motion by Dr. Burden.
9 Second by Member Eaker.

10 Roll call, please.

11 MR. ROATE: Dr. Burden?

12 MR. BURDEN: I'm going to vote no based on the
13 excess beds that have been presented. Thank you.

14 MR. ROATE: Mr. Eaker?

15 MR. EAKER: Vote yes.

16 MR. ROATE: Justice Greiman?

17 MR. GREIMAN: Aye.

18 MR. ROATE: Mr. Hayes?

19 MR. HAYES: Yes.

20 MR. ROATE: Mr. Hilgenbrink?

21 MR. HILGENBRINK: Yes.

22 MR. ROATE: Ms. Olson?

23 MS. OLSON: No, based on excess stations.

24 MR. ROATE: Mr. Sewell?

1 MR. SEWELL: No, excess capacity.

2 MR. ROATE: Chairman Galassie?

3 CHAIRMAN GALASSIE: Yes.

4 MR. ROATE: That's five votes in the
5 affirmative, three votes in the negative.

6 CHAIRMAN GALASSIE: Motion passes.

7 MS. DAVIS: Thank you so much.

8 CHAIRMAN GALASSIE: Moving on to Item A-5,
9 11-002, Apollo Health Center, Limited. I believe we have
10 three individuals that have signed up for public comment.
11 Again, we will assume that you have not previously made
12 public comment or submitted written comment. We would ask
13 you to introduce yourself, and you have heard the Chair's
14 request to keep focused and timely in your comments,
15 please.

16 MS. PATEL: Hi. My name is Dr. Nisha Patel
17 and I'm a Board-certified family practice physician in the
18 northwest suburb. Thanks for rescheduling for today
19 instead of a week later, because I probably wouldn't have
20 been able to make it. So I just wanted to thank you.

21 So, I'm here in support of Apollo Health,
22 basically because it could potentially provide services to
23 my patients, many of whom are under insured, uninsured or
24 speak a first language other than English. So, just to

1 give an example. I recently saw a 62-year-old Polish male.
2 He's been in the country 20 years, working, probably making
3 under 15K a year. He works at a job that does not provide
4 insurance for him, and he came to me with abdominal
5 complaints, nausea, vomiting, blood in his stool, and
6 unintentional weight loss, which for any physician is a
7 horrible thing to hear. Being 62, I told him he should
8 have received a screening colonoscopy at the age of 50, but
9 he explained to help that he didn't have insurance and
10 every doctor he tried calling was inaccessible.

11 Having done my residency in the Chicagoland
12 area, I had spent a lot of time at Cook County Hospital,
13 and I knew they offered charity care for uninsured
14 patients. I spent about two hours on the phone and found
15 out that there is approximately a five-year waiting list
16 for a screening colonoscopy and a one-year waiting list if
17 the patient has a history of Crohn's or ulcerative colitis,
18 which he did not have. So this patient would had been put
19 on a five-year waiting list.

20 I have another patient with uterine fibroids,
21 who has been hospitalized for anemia and needed several
22 blood transfusions and unable to get an elective surgery.

23 The other thing, many of these area hospitals,
24 I think, have turned down diagnostic and therapeutic care

1 to many of my patients, especially when it comes to
2 preventative care. So, the thing I took away from the last
3 meeting was a lot of these --

4 MR. MORADO: Thirty seconds.

5 MS. PATEL: A lot of these hospitals talk
6 about charity care, charity care, when the majority of it
7 is done in the form of emergency care visits, not
8 preventative, not mammograms, not elective procedures. So,
9 an ambulatory surgical center that provides a multilingual
10 staff, charity care, especially focusing on preventive care
11 services like routine cystoscopies, breast mass removals,
12 things like that that they are not eligible for at the
13 emergency room, would greatly benefit my patients.

14 So, I am very much in favor of Apollo Health.
15 Thank you.

16 CHAIRMAN GALASSIE: Ms. Stevens?

17 MS. STEVENS: Yes, good morning. My name is
18 Makiseca Stevens. I work and live less than three miles
19 away from the proposed Apollo Health Center. I am a single
20 mother, and although I am currently working full-time, I
21 cannot afford health insurance provided by my job.
22 Therefore, I do not have health insurance.

23 I have been struggling with various health
24 issues for more than a year. My gastroenterologist

1 recommended that I have a diagnostic procedure performed.
2 Since I do not have health insurance, I have been putting
3 it off for over a year now.

4 I heard from my doctor that Apollo Health
5 Center will be offering significantly discounted rates for
6 procedure. Also, because I work Monday through Saturday,
7 the possibility of scheduling an appointment on Sunday is
8 very appealing to me, in addition to the discounted rates.

9 Please consider Apollo Health Center to open
10 in my neighborhood. I personally know of others that are
11 in the same situation as I am and can benefit from the
12 opening of the center.

13 CHAIRMAN GALASSIE: Thank you for your
14 comments.

15 And Ms. Macoch.

16 MS. MACOCH: I'd like to thank the Board for
17 the opportunity to speak today. My name is Aga Macoch, and
18 for more than nine years, I have been working in healthcare
19 managing a variety of administrative functions, but with
20 direct patient contact. I've also volunteered for various
21 non-profit organizations that provide assistance and
22 counseling to low income immigrant populations in Chicago
23 and in suburbs. Moreover, I am an immigrant myself,
24 arrived in the United States at the age of 15. Therefore,

1 I'm well placed to speak for and to understand the needs of
2 patients who deal with an income as well as a language
3 barrier. I'd like to share some of my experiences with
4 you.

5 On a daily basis in my professional as well as
6 community work, I'm presented with patients who have only
7 minimal access to medical care. They are frightened by
8 communication barriers and the overwhelming costs
9 associated with preventive as well as remedy care. Often
10 they choose to stay away until it is too late for them. My
11 father was one of them. He died of a heart disease at the
12 age of 59.

13 Many patients who are in dire need of medical
14 care are unemployed, under employed, or uninsured. These
15 patients have a limited or no ability to pay for these
16 services they desperately need. It has been my experience
17 that the physicians' offices receive calls from people in
18 such circumstances on a daily basis. These patients are
19 looking for guidance, assistance, and sometimes financial
20 help. These are good, hard-working people in need of a
21 helping hand. It's a mother of three children who lives in
22 a shelter for domestic violence. It's a father of two who
23 has been unemployed for four months. It's a young single
24 parent with a minimum wage job and no insurance coverage.

1 We all know someone in such difficult circumstances.

2 Apollo Health Center presents an opportunity
3 to provide accessible, low-cost, quality medical care with
4 fewer communication barriers.

5 MR. MORADO: Thirty seconds.

6 MS. MACOCH: I support it wholeheartedly as
7 the Apollo Health Center will be vital to my community.
8 Please vote in support of it.

9 CHAIRMAN GALASSIE: Thank you very much.
10 Appreciate your comments this morning.

11 And I assume we have members from Apollo
12 Health Center. If you would come up and then introduce
13 yourselves, be sworn in, and then we will ask for a Staff
14 report.

15 (Pause)

16 CHAIRMAN GALASSIE: Just quickly, if you
17 could give your names, please.

18 MS. SCHMIDT: My name is Vera Schmidt. I'm
19 the Chief Executor Officer for Apollo Health Center.

20 MS. GOYAL: Dr. Vijay Goyal. I'm one of the
21 physician and Board of Directors, member of the Board of
22 Directors of Apollo Health Center.

23 MS. FRIEDMAN: Kara Friedman, Polsinelli
24 Shughart, counsel for the applicant.

1 MS. BRIDGEWATER: My name is Jessica
2 Bridgewater. I'm Vice-President for Apollo Health Center.

3 MS. FRIEDMAN: And to her left is Anne Cooper,
4 also from Polsinelli.

5 MS. PURI: Aditi Puri; I'm also with Apollo.

6 CHAIRMAN GALASSIE: Staff report, please?

7 MR. CONSTANTINO: Thank you, Mr. Chairman.
8 The applicant, Apollo Health Center, proposes to establish
9 a multi-specialty ASTC in approximately 5,900 gross square
10 foot of space, at a cost of approximately two and a half
11 million dollars. The project is before you today because
12 it proposes to establish a healthcare facility. There was
13 no public hearing requested. However, we did receive
14 letters of support and opposition.

15 The State Agency notes the following: The
16 project patient referrals do not justify the two operating
17 rooms being requested, because the referrals are from
18 physician practices and are not licensed ASTC's or
19 hospitals. There are 46 facilities within 30 minutes; 33
20 are not at the target occupancy.

21 Thank you, Mr. Chairman.

22 CHAIRMAN GALASSIE: Thank you, Mike.

23 Comments for the Board, please.

24 MS. SCHMIDT: Good morning, Chairman Galassie,

1 Board members and Staff. As I mentioned, I am the Chief
2 Executive Officer for Apollo Health Center, and I'd like to
3 thank you for the opportunity to present our project.

4 As you've heard, Apollo Health Center proposes
5 to establish a multi-specialty surgery center with two
6 operating rooms. Apollo's goal is to increase access to
7 much-needed health services for low income and medically
8 under served populations in this area. There is much talk
9 about nationwide healthcare reform and reducing health
10 disparities in low income, minority, and other populations.
11 It is Apollo's goal to initiate that reform at a very
12 grassroots level by making healthcare more accessible and
13 affordable to those most vulnerable populations, through
14 our hardship criteria, which will provide patients who
15 qualify with an 80 percent discount on surgical procedures.
16 We will commit to provide charity care to patients without
17 means to pay, and work with community service organizations
18 to get our message out to the medically under served
19 populations.

20 It is important to understand Apollo's market
21 area. According to the U.S. Census Bureau, this market
22 area includes 43 medically under served areas and 11
23 medically under served populations. Nearly 850,000
24 individuals residing in Apollo's market area live below the

1 Federal poverty level. Access to free or low cost
2 healthcare is imperative to the overall health of the
3 community we propose to serve. These factors were critical
4 in selecting Apollo's location. Apollo will be unique
5 among ambulatory surgical centers and well positioned to
6 care for the under served populations in the area. Apollo
7 will be staffed by physicians and staff who speak Spanish,
8 Polish and Russian, as well as other languages, which is
9 key in breaking down linguistics barriers and accessing
10 healthcare services.

11 Furthermore, we will offer evening, Saturday
12 and Sunday hours to accommodate patients' work schedules.
13 For our patients' convenience, we will also have an onsite
14 certified laboratory, which will be able to perform pre-op
15 testing on the same day of surgery. And, most importantly,
16 unlike other facilities, we will be able to immediately
17 advise patients of their eligibility for charity care.
18 They will have piece of mind, knowing when they receive
19 medical care that they can afford it, before the treatment
20 takes place.

21 Medicaid and Medicare will be accepted, but we
22 will also provide patients who meet our financial hardship
23 criteria an 80 percent discount on the facility fee. In
24 many cases, these financially-vulnerable patients are

1 employed but do not have insurance. Since they are not
2 candidates for public assistance, they fall through the
3 cracks in the system. In this economy, many of us know
4 someone dealing with an unexpected, extended unemployment
5 situation. There are countless people like this who are
6 weighing the cost of continued medical insurance.

7 To our knowledge, no other surgery center
8 currently offers such discounted rates and up-front charity
9 services. While it may appear that there is capacity in
10 area hospitals, acute care hospitals cannot be considered
11 as viable alternatives. We are all too familiar with
12 hospital wait times due to emergency cases and other
13 priorities. Surgery centers provide low-cost, high-quality
14 alternatives to hospital-based surgery. Apollo has
15 committed that its charges for most procedures performed at
16 its facility will be lower than hospital charges, for both
17 patients and payers.

18 As already stated, patients who satisfy
19 Apollo's criteria will receive an additional 80 percent off
20 of the facility charges, and our referring physicians have
21 committed to providing similar discounts off their charges.
22 As a result, these patients can have the same procedure
23 performed at Apollo for approximately one-fifth of what
24 hospital charges would be. A good example of cost savings

1 a patient could experience at Apollo would be an upper GI
2 endoscopy. According to Illinois Department of Public
3 Health data, the average charge for this procedure in area
4 hospitals is about \$4,406. However, our charge for the
5 procedure being performed at Apollo would be \$3,134, which
6 is -- represents a 37 percent savings for Apollo's
7 patients. In addition to that, if patients qualify for the
8 Apollo's hardship criteria, he or she would receive an
9 additional 80 percent discount and pay only \$826 for that
10 procedure.

11 In summary, Apollo will offer patients
12 significant cost savings, better access to care, and
13 greater convenience in terms of improved location, ability
14 to schedule more quickly, and shorter wait times compared
15 to other hospitals. In addition, we have received support
16 from community organizations, including non-profit
17 organizations such as Rape Advocacy Counseling and
18 Educational Services, Life Span, Compassion Care Network,
19 and Mujeres Latinas, as well as primary care physicians.
20 They all understand that Apollo will provide much needed
21 access to vital services through charity care or discounted
22 pricing, access that is currently lacking in our community.

23 I would like to hand it over to Dr. Vijay
24 Goyal, one of our Board members. She would like to briefly

1 speak to Apollo's commitment to provide safety net services
2 in our community.

3 CHAIRMAN GALASSIE: Thank you. Good morning,
4 Doctor.

5 MS. GOYAL: Good morning, Respected Chairman
6 and Respected Members of the Board. Good morning.

7 As Ms. Schmidt noted, I'm a practicing
8 physician for the last 25 years, and as a physician, I'm
9 thankful for the opportunity to fulfill a community service
10 mission in a diverse community where I serve, where I
11 practice. I do not need to travel abroad to give back. I
12 can give back to the community right here.

13 I treat many patients who cannot obtain needed
14 health services because either lack insurance or they are
15 under insured. I cannot tell you how many times over the
16 years I have difficulty referring patients, the uninsured
17 patients, for diagnostic and (inaudible) services. Acute
18 care hospitals do not generally provide the full range of
19 services, nor necessarily they open their arms for the
20 uninsured patients. Many surgical centers do not accept
21 Medicaid or provide charity care at all.

22 As Dr. Patel noted in her statement, even
23 public hospitals are not a viable option, since screening,
24 the routine screening -- the waiting time could be many

1 years. It's unacceptable. Apollo is committed to serving
2 this wonderful population, and we are willing to stand
3 behind our commitment. While non-profit hospitals are
4 required by law to provide community benefit to justify
5 their tax exempt status, they're not held to any particular
6 standards, and many hospitals do not guarantee charity care
7 or even discounted care until long after the services have
8 been rendered, which we believe is an untenable situation
9 for a patient who may be ultimately financially responsible
10 for a surgical procedure. We, rather, will make such
11 determination in advance.

12 Moreover, tax exempt or not, the hospital
13 business model is a competitive one in which hospitals vie
14 and compete with one another for privately-insured patients
15 and for the business of the most profitable specialist.
16 This is not conducive to serving low-income patients.
17 Apollo will be a safety net provider of health services.
18 We will offer charity care and financial assistance to
19 patients who qualify, and we agree to be accountable to
20 this Board to demonstrate our contributions. Those
21 patients who meet our financial criteria, financial
22 hardship criteria, will receive an 80 percent discount on
23 facility charges. Our referring physicians have also
24 committed to providing similar discounts to the patients

1 who meet Apollo's financial hardship criteria.

2 According to 2009 questionnaire, annual
3 questionnaire completed by ASTC's and hospitals, the
4 State-wide average for surgical centers for charity care is
5 0.3 percent, and it is 4.8 percent for the self-paid
6 patients. We anticipate that in the first year of our
7 operation, approximately 5 percent of our patients will
8 receive the charity care and 55 percent of our patients
9 will receive the financial hardship discount. Apollo's
10 number for charity care and hardship discounts are
11 significantly higher than the State-wide and Planning Area
12 averages for both surgical centers and for the hospitals.

13 As discussed earlier, we would offer
14 affirmative charity care for non-emergency surgical
15 procedures which are not provided by average hospital and
16 surgical centers. Apollo will be a valuable participant in
17 the healthcare safety net. During these hard economic
18 times, when unemployment is at its highest, most people,
19 most patients have no healthcare coverage due to high
20 premiums or no jobs. There is a need for a place like
21 Apollo, to be able to provide services to the wonderful,
22 under privileged, uninsured and medically under served
23 population.

24 Thank you.

1 MS. SCHMIDT: Thank you for your time and
2 attention. We would be happy to answer any questions you
3 may have at this time.

4 CHAIRMAN GALASSIE: We appreciate that.

5 I would open it up to the Board for questions.

6 MR. SEWELL: I need a little help in
7 understanding your business model that enables you to offer
8 these discounts on behalf of a corporation. It sounds like
9 you recruit physicians that have agreed to discount their
10 charges. But say a little something about your business
11 model that enables you to do this.

12 MS. SCHMIDT: Well, we're a smaller
13 organization. We intend to have a very streamline
14 administration with less overhead costs than a hospital or
15 very large surgical center would have. We intend to hire
16 staff that are mission-oriented, as we are, and have the
17 same goals as we do for patients and keep our payroll down
18 with that intention.

19 MS. FRIEDMAN: As you forecast how the
20 facility will perform, you take into account the discounted
21 care that you are going to provide, along with the
22 commercially-insured patients.

23 MR. SEWELL: Related to that, on page 6, Table
24 2, these ambulatory surgery treatment centers within 30

1 minutes, so how many of those offer discounted care.

2 MS. SCHMIDT: Well, we feel that we can't even
3 be compared to many of these facilities. We did our own
4 study and had some staff call different facilities, and
5 many of them don't take Medicaid. Many of them do not
6 provide any discounted rates. Most of them don't, and
7 those that do provide charity care don't really come right
8 out and say they have charity care. They have to find a
9 physician that is going to offer the charity care first,
10 and the frustration that you see that some of our speakers
11 had and the physicians themselves, who try calling around
12 for patients, they're on the phone all day, making phone
13 calls, trying to find a doctor that will take them and then
14 a facility that also will take them. So, we're trying to
15 cut those steps out so they can call one place and we can
16 work with them.

17 MS. FRIEDMAN: One of the things to note about
18 most of the existing surgery centers in the Chicago
19 metropolitan area is that this Board never asked them
20 whether they would accept Medicaid patients or charity
21 care. I've become cognizant that that's part of what it
22 takes to participate in the healthcare system, is that
23 there needs to be a balance of the commercial patients and
24 the charity care, and I've come up on this group of

1 individuals who is very much mission-oriented in that way.
2 So you don't have an ability to monitor the charity care
3 and Medicaid that surgery centers take that you do with
4 most applicants.

5 MS. OLSON: I'm very confused. I really want
6 to support this, but the numbers are really confusing me,
7 and I've never been good at math, but on the Executive
8 Summary, the sentence says, "The applicant does anticipate
9 receiving a payor mix of 10.7 Medicare, 1.5 percent
10 Medicaid, 3.4 percent public insurance, 74.4 percent
11 private insurance, and 10 percent private pay." Now the
12 number I heard today was 5 percent charity care and 55
13 percent discounted care which is 65 percent, but the other
14 number says that 84 percent will be private pay and private
15 insurance. I'm not -- the numbers aren't working for me,
16 and I don't think that 1.5 percent Medicaid is a commitment
17 to under served populations in any way, shape or form.

18 MS. SCHMIDT: The charity care is not listed
19 here.

20 MS. OLSON: If it's 84 percent private
21 insurance and private pay, how can -- that comes out to
22 more than a hundred, even in my terrible month.

23 MS. FRIEDMAN: I think the person behind me is
24 telling me that the number you're looking at is a revenue

1 percentage. I need to look closer to what you're looking
2 at.

3 MS. OLSON: "The applicant does anticipate
4 serving a payor mix of" -- and then it gives the
5 percentages. It doesn't say anything there --

6 CHAIRMAN GALASSIE: Kathy, may I ask for
7 Staff to respond to this?

8 MR. CONSTANTINO: We requested the payor mix
9 from the applicant, and this was the numbers they provided
10 to us. We accepted those numbers --

11 MS. OLSON: That's what I thought.

12 MR. CONSTANTINO: -- as true and correct.

13 MS. COOPER: The dollar amounts or the
14 percentages that were provided were based upon revenue
15 totals. So, with charity care, because you're not getting
16 any revenue, they wouldn't be included in this number.
17 It's kind of difficult because, obviously, you're not
18 taking any money, you're not charging the patients for the
19 services. So, therefore, there is no revenue attributed to
20 it. The rest of it would be -- the actual money that
21 they're actually going to be receiving is actually coming
22 from this payor mix. That's actually money coming in the
23 door.

24 MS. OLSON: So you're guaranteeing this

1 Board -- because I really want to go with this thing, but I
2 feel like I'm not getting -- I feel like I'm getting sold a
3 charity hospital that's going to be 84.4 percent not
4 charity. I can't -- help me get that out of my head. It's
5 not making sense to me.

6 MS. FRIEDMAN: Do you want to look at page 10
7 of the State Agency Report? So, if you look at the
8 projections for services, they did it as Usual and
9 Customary, Hardship, which would be the discounted charity
10 care, and the total.

11 MS. OLSON: Are you looking at Table 5?

12 MS. FRIEDMAN: Yes.

13 MS. OLSON: So 5 percent of the total revenue
14 will be charity, the bottom line?

15 MS. FRIEDMAN: Percentage compared to net
16 revenue.

17 MS. OLSON: So only 5 percent?

18 MS. FRIEDMAN: But we didn't do a percentage
19 here on the discounted, which is a significantly higher
20 number.

21 MS. SCHMIDT: But we are looking at 55 percent
22 of the patients to fall into the hardship category where
23 they would get the highly discounted rate.

24 MS. OLSON: And that's in addition to 1.5

1 Medicaid?

2 MS. SCHMIDT: That's separate from Medicaid.

3 MS. OLSON: So, what actual percentage of
4 Medicaid patients? I understand what you charge and what
5 Medicaid pays you. What percentage of actual patients do
6 you anticipate being Medicaid patients?

7 MS. SCHMIDT: 1.5.

8 MS. OLSON: So, one out of every hundred
9 patients will be a Medicaid patient?

10 MS. SCHMIDT: Yes, and 55 percent are the
11 patients that don't qualify for Medicare or Medicaid, that
12 don't have insurance but can't afford the procedure.

13 MS. OLSON: So, 55 out of every hundred --

14 MS. SCHMIDT: Right, would get this high
15 discounted rate.

16 CHAIRMAN GALASSIE: The 80 percent?

17 MS. SCHMIDT: The 80 percent.

18 CHAIRMAN GALASSIE: Both physician and
19 facility?

20 MS. SCHMIDT: Correct.

21 CHAIRMAN GALASSIE: Dr. Burden.

22 MR. BURDEN: May I? I really am impressed
23 with Ms. Olson's --

24 MS. OLSON: Bad math?

1 MR. BURDEN: No, good math. I have trouble
2 understanding those numbers, too.

3 As a practicing physician, once the onset of
4 Medicare occurred, it made a lot of doctors quite edgy, but
5 it turned out to be a bonanza. However there is a pro
6 forma fee profile attached to every specialist. I being a
7 urologist, I had a fee profile that I had for thirty years.
8 Many of the younger guys came on board, recognized that
9 this fee limited the amount of money I would receive from
10 the government for surgical procedures; i.e.,
11 prostatectomy. I have trouble understanding how you're
12 going to get specialists that are going to either work for
13 nothing, their fee profile is going to be impacted
14 significantly, and if they are consistent with what I
15 heard, I don't know how it's going to be financially
16 feasible, other than volunteerism. The government is not a
17 volunteer organization, as you well know. You have a fee
18 profile attached to you. You have a patient that comes in
19 that has cystostomy, bladder tumors discovered. There's
20 certain number of costs involved or fee attached to both of
21 those for both the facility and the doctor. They're in
22 jeopardy in a way.

23 I can't figure out how you're going to -- I'm
24 impressed with your attempt. That's one question. The

1 other question, I heard someone say we never interrogated
2 ASTC applicants previously about charity care. But I did,
3 and ended with a discussion a couple years ago with an
4 orthopedist who wanted to open up an ambulatory treatment
5 surgery center in Peoria. So we did. That's been my
6 tenure on the Board. We've asked that question -- at least
7 someone has, not necessarily me -- every time. But I agree
8 when I hear you mention that this didn't occur prior to CON
9 applications. I guess you're right, because I don't know.
10 I haven't seen any data, but the failure to allow charity
11 care to treat patients, indigent treatment in this
12 ambulatory treatment center, is a real unfortunate thing,
13 in my judgment. But that's the second question.

14 The first question is I don't know how you're
15 going to work this. It sounds nice, but if you're asking
16 me to come over and my fee profile is in jeopardy, I'll say
17 I'll work for nix, I'll spend a day a week, and then I'll
18 take care of them and we'll call it a freebie, until
19 somebody sues me and says, "You missed a bladder tumor,
20 baby, and I had to go out to Loyola, where I didn't have
21 any money, but I did find it."

22 I see this having a lot of implication as a
23 practitioner that I have some questions. Going to salary
24 the doctors? That's a different story. You going to pick

1 up their malpractice premiums, which is horrendous in most
2 cases.

3 You're talking about a multi-specialty clinic.
4 I see urology is mentioned. I don't know the names of who
5 you've recruited. Maybe you haven't recruited anybody yet.
6 But how is that going to work?

7 MS. GOYAL: If I may answer this question for
8 you, Doctor, just like yourself we -- myself included and
9 many physicians included, we are in that phase of our life
10 where we have practiced for many years and we have come
11 across all kinds of patients who could not afford the
12 services. Through my practice of 25 years, I probably have
13 given -- my standard policy is never, ever to turn any
14 patient to collection. It's been for the last twenty
15 years. And we have partnered with the physicians who have
16 active practices of their own who also want to give back to
17 the community.

18 We have -- I, luckily, am part of a family
19 which is two member only family. We have given to our
20 children. We have done what's best for our family. But
21 we're in that phase of our life where we want to give back
22 to the community. I don't want to travel abroad. This
23 community here, this is where I made my career, and this is
24 where I want to give back. It is with that intention,

1 those intentions, many of the physicians we have partnered
2 with, at least four physicians, who would stick to our
3 policy of hardship criteria and would give those discounts.
4 The center is being opened with intention of giving back to
5 the community.

6 MR. BURDEN: I think that's noble. My own
7 personal reaction to that would be that if we could get
8 evidence subsequent to an application approval -- if it
9 does get approved -- that you are doing such, you
10 represent, shall we say, a step far above what I expect to
11 hear from an ambulatory surgical treatment center
12 application. Most of them are clearly applied for for the
13 purposes of making economic rewards and they are, because
14 there's two -- both a facility fee and a service fee. So,
15 most of them do extremely well. Your approach would be so
16 different that it would be my reaction -- I have trouble
17 understanding how it's going to work. It sounds great. I
18 would be impressed if you're able to do such, and I do
19 agree, everybody on this Board, I presume, feels like you
20 do, giving back is part of what we should be considering
21 doing, but I'd like to see some proof of such to make me a
22 little more content. I think it's a wonderful idea. I'm
23 not objecting to what you're trying to do.

24 I looked at all of the alleged malpractice in

1 the State of Illinois for 25 years. Things happen and all
2 of a sudden there's a problem. How we going to cover that?
3 Who is going to pay for that aspect? The liability of
4 running this institution is going to be substantial. To
5 that degree, there is no charity care. That's what I'm
6 getting to. Your business model -- I think we have alluded
7 to it, but how is it going to work? I think it's great.
8 That's me talking. I'd like to see some evidence that you
9 can do this, practically speaking, and provide the care you
10 so nobly wish to do.

11 CHAIRMAN GALASSIE: I would just like to
12 remind the Board, if we so chose -- Member Sewell has a
13 comment. Sorry.

14 MR. SEWELL: Let's assume we approve this. Is
15 it possible for the local Public Health Department to send
16 us an annual report on what actually happens with your
17 operation with respect to the charity care?

18 MR. CARVALHO: They're going to do it.

19 CHAIRMAN GALASSIE: We could also require a
20 condition that we would want a comment from the community
21 health centers for their referral capability with this
22 organization a year down the road.

23 MR. URSO: Or you can ask the applicant to
24 provide this kind of information back to the Board.

1 MS. OLSON: That's really where I wanted to go
2 but in the event that we request that, what resource is
3 there -- I love this model, and I think if it works, I'll
4 approve every one of them that comes to this Board.

5 So it's not working and they go back to mostly
6 private insurance, what recourse do we have? I don't -- I
7 am just at the point where I don't understand what recourse
8 you would have.

9 MR. URSO: Well, you can specify conditions to
10 the permit, that X number of cases are going to be charity
11 cases, or however you want to express it. The applicants
12 have an opportunity to agree with that, and they must agree
13 to those conditions, and the Board can approve a permit in
14 that regard.

15 CHAIRMAN GALASSIE: It's conditioned upon
16 them meeting those numbers. They come back within a year
17 from now, if they're not meeting those numbers, then it's
18 contingent upon us to continue it or not.

19 MR. URSO: And there's consequences if someone
20 doesn't fulfill the conditions of the permit in terms of
21 compliance with the conditional permit.

22 MS. OLSON: Are you comfortable with that?

23 MS. GOYAL: Very much so.

24 MR. HAYES: For clarification, when we're

1 talking about charity care, they're actually talking about
2 what, discounted patients? Is that correct?

3 MS. FRIEDMAN: We're talking about two things:
4 One, pure, free care, and the other discounted.

5 MR. HAYES: Okay. Now, if you report charity
6 care, do they report these discounted patients? Do they
7 even have to talk about that?

8 CHAIRMAN GALASSIE: We would be -- we could
9 be placing a condition on our approval that they come back
10 a year from now to show us their statistics of did 55
11 percent of your population receive an 80 percent reduction?
12 No, 51 percent did. Okay. If only 10 percent did, then
13 clearly I think there's an issue. 1.5 percent received
14 charity care. If they're close to the 1.5 percent --

15 MS. OLSON: Medicaid.

16 CHAIRMAN GALASSIE: Medicaid. Thank you.

17 MS. FRIEDMAN: And that would be a year from
18 licensure, not from today's date.

19 CHAIRMAN GALASSIE: Thank you.

20 MR. HAYES: Normally, when this data is
21 reported to the Department of Public Health, have they --
22 are they interested in that? Have they ever collected data
23 like that?

24 CHAIRMAN GALASSIE: I'm sorry, John, I missed

1 the first half. I apologize.

2 MR. CARVALHO: Currently we collect
3 information that talks about the revenues, and we do
4 collect the charity care. We don't have something other
5 than implicitly. In other words, if you showed the
6 revenues are a lot lower than one would expect given the
7 volume, that would tell you implicitly that there was
8 discounted care. You can make whatever condition you
9 fashion on this that works for the Board and the applicant.
10 You could require some additional details supplementing the
11 normal report.

12 Could I ask a few questions that will help
13 clarify what that condition should be? Would now be a good
14 time for that?

15 CHAIRMAN GALASSIE: Ask a question.

16 MR. CARVALHO: Yes, and maybe some context,
17 because I think some of you who have been on the Board know
18 this, but others may know about it. But just to clarify,
19 Illinois imposes no obligation on an ASTC to provide any
20 charity care, and as the applicant said, the average in
21 this state is .03 percent. That's not three percent,
22 that's .03 percent. I mean, that's an accident. That's
23 statistically zero. Although there's an obligation on
24 hospitals for charity care, it's not measured -- what I

1 mean, there's not a numerical requirement, and most
2 hospitals fulfill it by persons who come to the emergency
3 room who are indigent and they waive the fee, but they had
4 to see those persons who came to the emergency room,
5 because EMTALA says they have to see those persons.

6 So, the referral of somebody who needs a
7 colonoscopy or something like that, it's totally in the
8 discretion of the hospital whether to grant it, and I'm not
9 familiar with a vast amount of that kind of care being
10 done. Most of the emergency -- most of the charity care is
11 done through what comes through the emergency room, and
12 nobody comes in with an emergency, every-five-year
13 colonoscopy. That's not an emergency. That's just
14 something that's good, primary and preventative care.

15 So, when you intercept that state of the law,
16 naming no obligation for charity care, with your Board's
17 charge, which is to say we only let the number of operating
18 rooms that are required under a Certificate of Need
19 analysis be built and no more, you create a real bad
20 situation that this Board has struggled with for years, as
21 Dr. Burden has alluded to. Namely, let's say that there is
22 a need for ten operating rooms in an area and ten ASTC's
23 at those ten operating rooms, and none of them provide
24 charity care. Basically, nobody in that area is going to

1 get charity care and nobody can come in and ask to build
2 another one, even if they promise that they're going to do
3 charity care, because all of the other ones can complain,
4 saying that the need hasn't been met -- there isn't a need,
5 there's only a need for ten, and you've got ten, so they
6 don't meet the need.

7 So you're presented with this unusual
8 situation where, as Dr. Burden alluded, we've had
9 applicants come in and show they're clearing a
10 million-seven a year profit on the surgery centers. These
11 are money printing machines. So, if someone comes in and
12 says, "I'm styling a business model where I'm only going to
13 clear a third of that, but that's enough for me, because
14 I'm at that stage in any career where I don't need the
15 million 7," you still run into the problem that it's -- the
16 need isn't ten -- you know, this is where -- this is why
17 you hear us say this all the time.

18 CHAIRMAN GALASSIE: We're approaching the
19 lunch hour.

20 MR. CARVALHO: So, I'm saying -- Frank says
21 this to you all the time, why you have discretion, why this
22 isn't an automatic process, why there isn't just a computer
23 that plugs the numbers in and it comes out yes and no. So,
24 the key question, it seems to me, for you is that if their

1 story is persuasive about what they want to do, how do you
2 memorialize that commitment? How do you put in that
3 commitment that gives you the reason why you want to
4 exercise your discretion, gives you an expectation that the
5 commitment will be met? It's a little awkward doing it ad
6 hoc, on the spot, in a way.

7 So, the question I had is how have you
8 memorialized this commitment? Because then the Board can
9 kind of latch on to that, because one of the things
10 Dr. Burden alluded to as well, an ASTC can come here and
11 say, "We're going to give everybody charity care that
12 qualifies", but if no doctors bring the patients there they
13 can make that commitment without any adverse effect to
14 their bottom line -- because a surgery center doesn't do
15 operations, the brick and mortar doesn't do the operations,
16 doctors do. And if the doctors don't bring charity care to
17 the center, there is no charity care done. You've had
18 applicants come in and say, "We promise we'll give
19 everybody that comes in X percent of poverty charity care,"
20 but absent that physician commitment, that promise isn't
21 very useful.

22 So, how have you memorialized the commitment
23 of doctors to do this, because if you've memorialized it
24 and this Board can latch on to it as a condition, that may

1 be persuasive to some Board members.

2 DR. GOYAL: I think I'm not understanding the
3 word "memorialized".

4 MR. CARVALHO: Well, you said that doctors
5 have made a commitment to provide this charity care and to
6 provide it at a discounted bases and to bring patients.
7 Somehow they have to come across these patients, but
8 assuming their practice brings these patients to them, have
9 they signed an agreement with you or are they the owners
10 and so it's the four owners and they've all agreed to this?
11 "Memorialize" is a lawyer's word, but how is it written
12 down?

13 MS. SCHMIDT: As Dr. Goyal mentioned before,
14 these physicians have their own practices, successful
15 practices, independent contracts in some cases, and many of
16 our referring physicians, these are the ones that said,
17 "You know, I have patients who I need to take them
18 somewhere. I would like to provide them some kind of
19 either charity care or I can discount my fee, but it
20 doesn't help if I discount my fee and the facility
21 doesn't". So, that's where our numbers are coming from,
22 the physicians that we have worked with, the ones that are
23 going to be referring their patients to us, and any
24 newcoming physicians that come in, something to discuss

1 with them at that time.

2 MS. FRIEDMAN: I guess I would suggest that if
3 we turn to what the conditions of the permit would be, in
4 this scenario it would be contemplating coming back here a
5 year after licensure, 15 months after we compiled the data,
6 to talk about it, and if we look at the page 10 and the
7 chart, you know, we don't know for sure that that first
8 number is going to be 1,685 cases, but the intent is that
9 the payer mix is substantially the same as this, and maybe
10 there's more charity and less hardship or maybe the volumes
11 weren't exactly what we thought they would be in the total,
12 but it's substantially similar to what we anticipated.

13 MS. OLSON: I think that's all we're asking.

14 MS. FRIEDMAN: And then patients probably
15 wouldn't come there -- I mean, if we have a problem with
16 physicians referring and taking the discounted care, then
17 the patients won't be there in the numbers.

18 MR. URSO: So are you saying there's going to
19 be a discount not only in the physician fees but also the
20 facility fees?

21 DR. GOYAL: Correct. It works both ways. For
22 the physician it works very well, because physicians are
23 faced every day with a patient who are not able to pay for
24 the services. So, if they find a place who is going to

1 give that hardship discount, that their patients can get
2 the colonoscopy for \$600, the doctor is more than willing
3 to give that discount for their services. So, not only it
4 works for the facility, it works for the physician, too.

5 CHAIRMAN GALASSIE: I'm hearing the Board
6 suggest to you that we would like to have you come back to
7 us 12 months from now to share the statistics of what your
8 population has actually been.

9 MR. SEWELL: I think she specified 12 months
10 from license.

11 CHAIRMAN GALASSIE: Correct.

12 MS. FRIEDMAN: Might we suggest a couple
13 months after that so we can submit the data?

14 CHAIRMAN GALASSIE: Fifteen months from
15 licensure?

16 MS. FRIEDMAN: Yes.

17 CHAIRMAN GALASSIE: I would entertain a
18 motion to approve Project 11-002, to establish a
19 multi-specialty ambulatory surgical treatment center in Des
20 Plaines at a cost of \$2,536,751, with the condition that
21 the applicant return to the Board fifteen months following
22 licensure to determine the compliance statistics.

23 MR. BURDEN: So moved.

24 MS. OLSON: I'll second.

1 CHAIRMAN GALASSIE: Motion and second.

2 MR. ROATE: Motion made by Dr. Burden,
3 seconded by Ms. Olson.

4 Dr. Burden?

5 MR. BURDEN: I'm going to vote yes, and I
6 trust that when you come back, it will look -- which we
7 hope it will, that this will be a first.

8 MR. ROATE: Mr. Eaker?

9 MR. EAKER: Yes. I want to commend you on the
10 direction that you're headed and invite you to establish a
11 facility in Champaign County, if you'd like to do so. I
12 vote yes.

13 MR. ROATE: Justice Greiman?

14 MR. GREIMAN: Yes. I notice this is in Des
15 Plaines. They just opened a gambling casino there.

16 MR. SCHMIDT: It's right down the street.

17 MR. GREIMAN: Des Plaines will be desperate.
18 I vote aye.

19 MR. ROATE: Mr. Hayes?

20 MR. HAYES: I'm going to vote no, because I
21 feel that the competition to hospitals and other ASTC's for
22 an unproven model, and I'm going to vote no because of
23 that.

24 MR. ROATE: Mr. Hilgenbrink?

1 MR. HILGENBRINK: Yes.

2 MR. ROATE: Ms. Olson?

3 MS. OLSON: I vote yes and wish you all the
4 luck in the world.

5 MR. ROATE: Mr. Sewell?

6 MR. SEWELL: I vote yes.

7 MR. ROATE: Chairman Galassie?

8 CHAIRMAN GALASSIE: Chair votes yes.

9 MR. ROATE: That's seven votes in the
10 positive, one vote in the negative.

11 CHAIRMAN GALASSIE: Motion passes.

12 Congratulations.

13 Our next item is 11-009. However, we will be
14 breaking for lunch. It's five to 1:00. We're going to try
15 to bring it back in this room at 1:30, which is a quick
16 lunch for Board members, and we'll get the air turned back
17 on and cool things down a little bit.

18 (Lunch recess)

19 CHAIRMAN GALASSIE: We have a quorum. We
20 will come back to order. Appreciate everybody being
21 relatively timely.

22 We are moving into our agenda item 11-009
23 Sedgebrook Health Center. We have no public comments
24 requested. Seeing none, I would ask for the

1 representatives from Sedgebrook Health Center to please
2 come up, introduce yourselves, be sworn in, please, and
3 then we will ask for a Staff report.

4 (Pause)

5 MS. deFIEBRE: Good afternoon. I'm Denise
6 deFiebre. I'm with Senior Care Development, the owner of
7 Sedgebrook.

8 MR. CLANCY: I'm Ed Clancy, an attorney with
9 Ungaretti and Harris, representing Senior Care Development
10 and the applicant.

11 MS. MCGHEE: I'm Valerie McGhee, the Executive
12 Director, who is hired by Life Care Services, a management
13 company for Sedgebrook.

14 MR. FEAUTO: And my name is Mick Feauto. I'm
15 Vice-President of Operations with Life Care Services, the
16 management company.

17 CHAIRMAN GALASSIE: Thank you.

18 (Oath given)

19 CHAIRMAN GALASSIE: Staff report?

20 MR. CONSTANTINO: Thank you, Mr. Chairman.
21 The applicant, Lincolnshire Senior Care, LLC, is proposing
22 to discontinue a 44-bed long-term care facility established
23 under the CCRC variance and is requesting to establish a
24 new facility with a total of 88 long-term care beds with

1 unrestricted access, in Lincolnshire, Illinois. This
2 project is before you today because the project proposes to
3 discontinue and establish a long-term care facility. The
4 total cost of the project is approximately 7 and a half
5 million dollars. No letters of support or opposition were
6 received by the State Agency, and there was no request for
7 a public hearing.

8 You'll to bear with me a minute here. This
9 project has a long history -- or a history. I don't know
10 if it's long or not, but it's a history. This project was
11 originally approved as Permit No. 05-036, Sedgebrook. One
12 of the applicants was Erickson Retired Communities, Inc.
13 This project was approved in October of 2006 as an 88-bed
14 continuum care retirement community with assisted living
15 and independent living units. At the time of approval,
16 there was an excess of 6 long-term cares in the Lake
17 County -- 6 long-term care beds in the Lake County Planning
18 Area. Therefore, they had to address a variance to the
19 calculated need, which, under the long-term care rules
20 presently, we have two variances, the CCRC variance which
21 is the continuum care variance, and the second variance is
22 a defined population variance. They chose to address the
23 continuum care variance, which required them only to admit
24 patients to their long-term care unit from the assisted

1 living units or the independent living units of that
2 facility, of the Sedgebrook facility.

3 Before this project could be completed, the
4 State Agency licensed 44 long-term care beds.
5 Subsequently, Erickson Retirement Communities, Inc.
6 declared bankruptcy and the applicants changed. Well,
7 under our rules, when that happens, the permit is
8 violated -- is determined to be null and void. This
9 project, Project 05-036, was referred to Legal Counsel, I
10 believe in either late 2009 or 2010. Subsequently, it was
11 determined that the Board could take no action on this
12 project, Project 05-036, because the Board no longer has
13 jurisdiction over the discontinuation of a long-term care
14 facility.

15 So, subsequently, the applicants are back here
16 today before you, requesting that you discontinue the 44
17 beds that we consider to be permit beds that are still in
18 our inventory, and asking you to license 44 more beds, for
19 a total of 88.

20 CHAIRMAN GALASSIE: That qualifies as a long
21 history.

22 MR. CONSTANTINO: I apologize. It's
23 convoluted, and I apologize for that.

24 CHAIRMAN GALASSIE: Not convoluted, just

1 long. Thank you.

2 And your comments for the Board, please?

3 MS. deFIEBRE: Thank you very much for your
4 time. We appreciate your patience, and on behalf of the
5 600 residents at Sedgebrook and its staff, we are very
6 appreciative of the time you've taken to review our
7 application.

8 As the report states, there is a 103-bed need
9 in the Lake County Planning Area, and we are requesting the
10 88 beds to both meet that need and to help the financial
11 viability of Sedgebrook be improved as it comes out of
12 bankruptcy and gets on the road to financial viability. My
13 company purchased Sedgebrook in November of 2010. It was
14 an all-cash transaction. There's very little debt on the
15 property at this point in time, and we worked very hard to
16 make certain that the existing residents -- and there's
17 about 400 units of independent living residents on site
18 right now -- make sure that all of their contracted
19 obligations that Erickson promised them would be met under
20 our new ownership. So we've worked very hard to make sure
21 that we live up to the promises that were made to those
22 residents when they signed up and moved in to the
23 community.

24 As part of that, we have maintained a

1 two-physician medical practice at the campus. Those
2 doctors solely treat the residents of the independent
3 living apartments as well as the health center. So, that
4 is a tremendous asset to the residents, and those
5 physicians provide terrific care and have wonderful
6 contacts within the community. Those contacts have, in
7 large part, been major drivers to the requests that we
8 continually get from the outside, for the people from the
9 outside to come to Sedgebrook's Health Center, particularly
10 for short-term rehab, as well as longer-term skilled.

11 We are a little surprised to see the
12 utilization information provided within the Staff Report
13 showed so many of the communities within that 30-mile
14 distance having low utilization. I think from our
15 perspective, both the experience of how many requests that
16 we get, but also our understanding of the competitors, we
17 can only presume that although they're licensed for a
18 certain number of beds, they're not operating those,
19 whether or not it's because they don't want -- the market
20 doesn't really demand anything other than private or
21 semi-private rooms, and many of those communities were
22 built at times when they were higher occupancy units. So,
23 we're really asking for this to meet the need in the
24 Planning Area and also to help us in the short term

1 maintain the financial viability and stability of
2 Sedgebrook.

3 I will let you know that the existing
4 population, independent living apartments as the residents
5 stay in place, will probably -- the industry average is
6 that about 15 to 20 percent of independent living
7 apartments end up using the skilled nursing care. So,
8 ultimately, we're expecting that 70 to 80 units of the
9 skilled nursing beds will be filled by the independent
10 living residents. It simply takes time for the continuum
11 of care to be demanded by those independent living
12 residents. So while I believe Erickson's original plan
13 anticipated the fill-up to be a lot faster, clearly things
14 didn't go according to their plan, because they're
15 bankrupt. It's just taking longer to fill those
16 independent living units and, therefore, those independent
17 living resident are not demanding -- they don't have the
18 healthcare needs at this point in time that they will in
19 the future.

20 So, while we anticipate needing direct
21 entrance in the near future to help run the building -- we
22 purchased this, we've got the 88 beds there, the building
23 is built. We just want to be able to use those for the
24 outside population until our current residents demand the

1 healthcare beds themselves.

2 So, we look forward to answering your
3 questions and thank you for your time.

4 CHAIRMAN GALASSIE: Thank you. We appreciate
5 that.

6 Questions from the Board?

7 (Pause)

8 MR. JONES: I was pleased to hear that you
9 were respecting the contracts of people who entered into
10 the contracts with your predecessor entity. Are those
11 contracts defined under Illinois law as Life Care
12 contracts?

13 MS. deFIEBRE: Yes, they are.

14 MR. JONES: And the preceding entity had a
15 permit to enter into those contracts?

16 MS. deFIEBRE: Yes, they did.

17 MR. JONES: And have you obtained a Life Care
18 permit?

19 MS. deFIEBRE: Yes.

20 MR. JONES: And given your financing, do you
21 have in reserve, funds to cover the Section 7(b) escrow of
22 the Life Care Act?

23 MS. deFIEBRE: I don't know what you're
24 referring to.

1 MR. CLANCY: There's the escrow requirement to
2 pay for six months principal and interest for any long-term
3 debt on the facility. They don't have that escrow, because
4 there really is no long-term debt on the facility. IDPH is
5 aware of that, and we made that point very clear with the
6 folks down in the Life Care section, that it didn't have
7 the debt and didn't require that escrow.

8 MR. JONES: Very good.

9 CHAIRMAN GALASSIE: Any other questions by
10 Board members.

11 Mike, I have to ask you a question. Just
12 because of my past life, I'm very familiar with the
13 facility, very familiar with the community, and I'm in
14 support of this. But I have to verify for my own voting.
15 Their involvement was post June of '08?

16 MR. CONSTANTINO: They became involved after
17 Erickson went into bankruptcy.

18 CHAIRMAN GALASSIE: I served in a regulatory
19 capacity prior to that in Lake County, so I would feel a
20 conflict of interest if they had preceded that.

21 MR. CARVALHO: Just one thing as members vote
22 on this and state their reasons, if you followed what Mike
23 had said, because you haven't seen CCRC's, all of you here,
24 before, normally if somebody wants to build that part of

1 the CCRC community because they want to provide a
2 continuum, they often run into the problem that they're in
3 an area that doesn't have a bed need, and so what we say
4 is, "Okay, we'll let you build it anyway under this
5 exception, because you're building it as part of this
6 closed community. But then you've got to run it as a
7 closed community." So, everybody builds into their
8 finances the recognition that that part of the business is
9 probably going to be unused for a while as people age in,
10 as the applicant said, and so every person who builds a
11 CCRC would love to be able to use the rest of the community
12 coming in while they're doing the build-up to help cover
13 the costs, but they all have to finance it, recognizing
14 that they're not going to get to do that.

15 So, because of the very unusual circumstances
16 of this one, you're probably inclined to support it, but
17 you might want to make note of the fact that there are
18 unusual circumstances, because, trust me, every CCRC would
19 love to open its beds to the community during this interim
20 time, and then your CCRC exception kind of goes out the
21 window.

22 CHAIRMAN GALASSIE: Thank you, Mr. Carvalho.

23 Any other questions?

24 (Pause)

1 CHAIRMAN GALASSIE: Hearing none, I will
2 entertain a motion to approve Project 11-009, for the
3 addition of 44 long-term care beds to an existing 44
4 long-term care facility, Lincolnshire, Illinois at a cost
5 of \$7,474,300.

6 MR. SEWELL: So moved.

7 CHAIRMAN GALASSIE: Motion by Member Sewell.

8 MR. HAYES: Second.

9 CHAIRMAN GALASSIE: Second by Member Hayes.

10 Roll call, please.

11 MR. ROATE: Dr. Burden?

12 MR. BURDEN: Yes.

13 MR. ROATE: Mr. Eaker?

14 MR. EAKER: Yes.

15 MR. ROATE: Justice Greiman?

16 MR. GREIMAN: Yes.

17 MR. ROATE: Mr. Hayes?

18 MR. HAYES: Yes.

19 MR. ROATE: Mr. Hilgenbrink?

20 MR. HILGENBRINK: Yes.

21 MR. ROATE: Ms. Olson?

22 MS. OLSON: Yes.

23 MR. ROATE: Mr. Sewell?

24 MR. SEWELL: Yes.

1 MR. ROATE: Chairman Galassie?

2 CHAIRMAN GALASSIE: Chair votes yes.

3 Motion passes.

4 Moving forward to Item No. 11-014, Hart Road
5 Pain and Spine Institute. We have had no requests for a
6 public comment. Seeing none, if you gentlemen would please
7 introduce yourselves and be sworn in.

8 MR. PRUNSKIS: I'm Dr. John Prunskis.

9 MR. AXEL: Jack Axel, Axel and Associates.

10 CHAIRMAN GALASSIE: Thank you.

11 (Oath given)

12 CHAIRMAN GALASSIE: I'll ask for a Staff
13 report.

14 MR. CONSTANTINO: Thank you, Mr. Chairman.
15 The applicant, Hart Road Pain and Spine Institute, is
16 proposing a single-specialty ASTC for pain management, in
17 approximately 10,000 gross square feet of space. The
18 facility will contain two OR's and eight recovery stations
19 and will cost approximately \$4.4 million. There is no
20 public hearing requests. However, we did receive one
21 letter of comment from the Illinois Hospital Association.

22 This project is before the State Board because
23 the project proposes the establishment of a healthcare
24 facility. The State Agency notes the following: All

1 physician referrals were from an office space setting and
2 could not be accepted in determining projected patient
3 volume and treatment room need assessment. Under the
4 Board's current rules, only physician referrals, from a
5 hospital or an ASTC, can be accepted in determining whether
6 or not the applicant has met these two criteria. We also
7 note 6 of 10 hospitals and 2 of 11 ASTC's are at the State
8 Board's target utilization within the proposed geographic
9 service area.

10 Thank you -- oh, I do have one additional
11 comment. The agenda said this was an opposition letter
12 that we received from the IHA. Subsequently we were told
13 that it was neither a support or opposition letter.

14 Thank you, Mr. Chairman.

15 CHAIRMAN GALASSIE: Thank you, Mike.

16 Good morning -- or good afternoon. Your
17 comments, please.

18 MR. AXEL: Mr. Galassie, with your permission,
19 and because this meeting seems to be a little longer than
20 we originally anticipated, rather than giving a fairly
21 lengthy presentation, I am going to attempt to bullet point
22 what we were going to say and focus on the project itself
23 and the SAR.

24 With me today is Dr. Prunskis. Dr. Prunskis

1 is a Board-certified interventional pain management
2 specialist and President of the Illinois Pain Institute,
3 which is a five-member, single specialty practice,
4 interventional pain management, and he's the president of
5 the applicant entity.

6 This is the fourth ASTC project that this
7 Board has heard for interventional pain management
8 services. The last one was last summer, and the
9 circumstances related to this project are identical to that
10 of that project. These projects, interventional pain
11 management, single-specialty ASTC's, have no impact
12 whatsoever on hospital utilization. Approval of these
13 projects allows the physicians to comply with the Illinois
14 ASTC Act, and the background on that is CMS has now
15 designated interventional pain management as a surgical
16 specialty. As such, these physicians need to move at least
17 50 percent of their caseload out of their office setting.
18 Approval of this project would, therefore, allow the
19 physicians to practice in compliance with the Act.

20 There was no public hearing called on this
21 project, no letters of opposition, and no public comment
22 today. Dr. Prunskis's group maintains privileges at five
23 area hospitals. They take patients to those hospitals only
24 when medically indicated, and that's because the hospitals

1 have a charge structure that's 35 to 45 percent higher than
2 either ASTC's or their office space procedure rooms. The
3 group understands the Board's concern -- and there was
4 lengthy discussion on this issue earlier today -- the
5 Board's concern over services provided to the economically
6 disadvantaged. For that reason, the group approached the
7 County Health Department and entered into a letter of
8 agreement with the County Health Department. That letter
9 is included in your file, and it provides a vehicle through
10 which the County Health Department will refer five patients
11 a month to the practice, and those patients will be treated
12 for the duration of their care with no charge either on the
13 facility side or on the physician side. All facility and
14 all professional fees will be waived.

15 This project has a capital outlay of \$2.9
16 million. The alternatives are, one, to bring patients to
17 the hospitals. As I mentioned that's unfair to the
18 patients because of the significant cost differential. The
19 second alternative is to bring patients to other ASTC's.
20 That's impractical, because of the type and volume of cases
21 that interventional pain management physicians provide and,
22 more specifically, this group. The volume would clog any
23 surgery center that they went to, both procedure rooms and
24 more importantly recovery areas.

1 Turning to the SAR, only two issues were
2 raised. First issue is the under utilization of some area
3 providers, as Mr. Constantino mentioned. Four of the
4 facilities are hospitals with their inherent charge
5 differentials, and all but one of those facilities is
6 located in excess of 30 minutes away. Related to area
7 ASTC's, three are limited specialty surgery centers that
8 could not accept interventional pain management. Two of
9 the facilities, the HealthSouth in Libertyville and Alden
10 in Addison, are over 30 minutes away, and two of the
11 facilities, Algonquin Road and Lake in the Hills and
12 Northwest in Arlington Heights, do not have the capacity
13 for the group's documented caseload. The SAR confirms that
14 the group has documented sufficient caseload to support the
15 project as proposed.

16 Second issue is the one that Mike mentioned,
17 that you heard about earlier this morning with the other
18 ASTC project. That is that your rules require cases come
19 out of an ASTC or hospital to support a new ASTC. Same
20 circumstances earlier today, exact same circumstance as
21 with the other interventional pain management ASTC last
22 year. When the rules for ASTC's were written and last
23 revised in 1999, the rules didn't contemplate
24 interventional pain management being designated by CMS as a

1 surgical specialty. Interventional pain management is
2 different from the other specialties in that these
3 physicians are currently receiving a facility fee for their
4 office-based procedures, and that's due to the significant
5 charge structure at hospitals as compared to the office
6 space practices.

7 In summary, this project will not impact any
8 other provider. There's been no opposition. Approval will
9 allow the physicians to practice in compliance with the
10 Ambulatory Treatment Center Act. This is a limited
11 specialty surgery center, interventional pain management
12 only and only three rooms, and the group has committed to
13 provide charity care, and that is documented in your files.

14 With that, I would like to close. Thank you
15 very much for your attention, and we'll be happy to answer
16 any questions.

17 CHAIRMAN GALASSIE: Thank you.

18 I'd like to open it up now for questions from
19 the Board.

20 MR. BURDEN: I'm interested in knowing more
21 about pain management as a sub-specialty of anesthesia or
22 internal medicine. Am I right or wrong? It's grown up,
23 more or less, since my retirement 11 years ago.

24 MR. PRUNSKIS: That's a great question. The

1 sub specialty of interventional pain management currently
2 requires that after one obtains their M.D. degree, that
3 they then have an internship, which could be surgical,
4 medical, or transitional. The majority of interventional
5 pain management physicians then go on and do a three-year
6 anesthesiology residency followed by a one to two-year
7 interventional pain management practice. There are some
8 physicians who have a similar track where they do a
9 physiatry residency and then they have to do an anesthesia
10 interventional fellowship following that.

11 MR. BURDEN: Is back disorder, complications
12 of disk disorder, et cetera, is that the most common
13 procedure that comes to your attention for management?

14 MR. PRUNSKIS: Yes, doctor. That is probably
15 the majority of our cases, are involved with some problem
16 in the cervical, thoracic or lumbar spine, but also we see
17 headache pain and pains that are elsewhere in the body that
18 have been present for at least two weeks or longer.

19 MR. BURDEN: One last question. I'm intrigued
20 with the letter that you received from the Lake County
21 Health Department, Health Center. Was this your intention,
22 to secure their support for what you wish to do, or was it
23 their -- did they come to you saying, "Listen, you're going
24 to go with this facility. We want you to care of our

1 uninsured"? I think it's a novel thing and a
2 complementary, in my judgment, that you proceeded to do
3 this, but I'm just wondering how the mechanism occurred.
4 Who spoke to you first?

5 MR. PRUNSKIS: Doctor, we approached them.

6 MR. BURDEN: Was there an Axel behind this.

7 MR. AXEL: There was Axel behind it, and I
8 have to tell you that there was a fairly significant level
9 of surprise when I suggested this to the Department.

10 MR. BURDEN: I'm surprised, but I congratulate
11 you. Occasionally, Axel, you do something noble.

12 MR. AXEL: I try to limit that.

13 DR. BURDEN: It's good for me to hear that.

14 (Laughter)

15 CHAIRMAN GALASSIE: Other questions and
16 comments?

17 MR. CARVALHO: You mentioned that there will
18 be five referrals from the Health Department. How many
19 procedures will be done a month in the facility as a whole,
20 just to put it in context.

21 MR. PRUNSKIS: Well, I'm not quite sure if I
22 understand the question, because a referral could generate
23 more than one procedure, especially as the doctor knows.
24 Or maybe some people here know, if you have a herniated

1 disk, sometimes we do two or three epidural, cortisone
2 injections. So, one patient could generate several
3 procedures.

4 MR. CARVALHO: Let me clarify, and the reason
5 for the question is, as I mentioned earlier, there's no
6 obligation on the part of any ASTC to do any sort of
7 charity care or to do Medicaid or even to do Medicare, and
8 so, as Dr. Burden said, this is novel, and if the Board
9 approves this, I imagine future applicants may also seek
10 similar arrangements. So, if the Board is establishing a
11 precedent that this is a useful thing to do, when the need
12 analysis suggests the need might be skimpy, then at least
13 the Board ought to know of the magnitude of what they
14 received from you.

15 So, if there's five referrals a month, you
16 expect, from the Health Department, how many unique
17 patients do you normally deal with in a month?

18 MR. AXEL: David, your math expertise is a lot
19 better than mine. Figure 3,000 patients a year.

20 MR. CARVALHO: Okay. So, that's 250 a month.
21 So that's about 2 percent. Hospital charity care is about
22 2 percent typically in the state.

23 CHAIRMAN GALASSIE: And can I just get -- I
24 assume Lake County was approached because of the location

1 and the Community Health Center. McHenry was not
2 approached because of no.

3 MR. AXEL: We're located in Lake County.
4 That's why we approached Lake County.

5 CHAIRMAN GALASSIE: Okay. Thanks.
6 Any other questions?

7 (Pause)

8 CHAIRMAN GALASSIE: Hearing none, I'll ask
9 for a motion to approve Project 11-014, to establish a
10 limited specialty ambulatory surgical treatment center in
11 Barrington, Illinois at a cost of \$4,385,900.

12 MR. BURDEN: So moved.

13 MR. GREIMAN: Seconded.

14 CHAIRMAN GALASSIE: Moved and seconded.

15 MR. ROATE: Motion made by Dr. Burden,
16 seconded by Justice Greiman.

17 Dr. Burden?

18 MR. BURDEN: Yes.

19 MR. ROATE: Mr. Eaker?

20 MR. EAKER: Yes.

21 MR. ROATE: Justice Greiman?

22 MR. GREIMAN: Yes.

23 MR. ROATE: Mr. Hayes?

24 MR. HAYES: Yes.

1 MR. ROATE: Mr. Hilgenbrink?

2 MR. HILGENBRINK: Yes.

3 MR. ROATE: Ms. Olson?

4 MS. OLSON: Yes.

5 MR. ROATE: Mr. Sewell?

6 MR. SEWELL: Yes.

7 CHAIRMAN GALASSIE: I would first also like to
8 commend you for involving your local Health Department. My
9 vote is yes.

10 MR. ROATE: That's eight votes in the
11 positive.

12 MR. PRUNSKIS: Thank you.

13 CHAIRMAN GALASSIE: Moving on to Item No.
14 11-018, Blessing Hospital. Welcome.

15 We have no public comment requests, and seeing
16 none, please be seated and welcome. Introduce yourselves,
17 if you will, please, and then we'll have you sworn in, and
18 we'll then ask for our sterling staff report.

19 MR. BILLINGS: Mr. Chairman, members of the
20 Board and Staff, thank you for the opportunity to share the
21 latter portion of your agenda today. We've had two times
22 to be with you in the last several days or several weeks,
23 and we appreciate very much the time and commitment that
24 you made to this very positive process.

1 CHAIRMAN GALASSIE: We appreciate your
2 patience as well.

3 MR. BILLINGS: No problem.

4 I'm Brad Billings. I'm the President and CEO
5 of the Blessing Health System, been with the organization
6 for thirty years.

7 MS. KAHN: I'm Maureen Kahn. I'm the
8 President and CEO of Blessing Hospital which is a member of
9 the Blessing Health System, and I've been with the company
10 ten and a half years.

11 MR. GERVELER: I'm Patrick Gerveler. I'm the
12 Chief Financial Officer for the Blessing Health System.
13 I've been with the organization for nineteen years.

14 MR. JACKSON: I'm Jerry Jackson I'm the
15 Vice-President of Engineering and Facility Development for
16 Blessing Corporate Services. I've been with the
17 organization for 26 years.

18 MR. MOORE: I'm Tim Moore. I'm the
19 Vice-President of Finance for Blessing Hospital, and I've
20 been with the organization for 22 years.

21 MS. KASPARIE: Betty Kasparie, Vice-President
22 of Corporate Compliance and Operational Planning, 32 years
23 with the System.

24 CHAIRMAN GALASSIE: You win, Betty.

1 MR. BILLINGS: Not only that, she's got 32
2 years of relationship with your organization.

3 (Oath given)

4 CHAIRMAN GALASSIE: Staff report, please.

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

6 The applicant, Blessing Hospital, currently
7 operates two hospitals in Quincy, Illinois. This project
8 proposes to discontinue the hospital located at 14th
9 Street, which houses 39 med/surg beds and 56 AMI beds, and
10 they are proposing to modernize the hospital located at
11 11th Street in Quincy, Illinois. The modernization will
12 encompass about 85,000 gross square feet of new
13 construction at a cost of approximately \$70.5 million.

14 In addition, the applicant proposes to
15 establish a 41-bed AMI category of service and a
16 discontinuation of 42 med/surg beds at the 11th Street
17 campus.

18 They're here before you today because they're
19 proposing a modernization project in excess of the capital
20 expenditure minimum. There was no public hearing and no
21 letters of opposition or -- I'm sorry. No letters of
22 opposition were received by the State Agency.

23 Thank you, Mr. Chairman.

24 CHAIRMAN GALASSIE: Thank you. Appreciate

1 that.

2 Comments for the Board, please.

3 MR. BILLINGS: We'll be brief. For those of
4 you who don't know where Quincy, Illinois is, it's on the
5 far west side of the state, 110 miles due west of
6 Springfield, right on the Mississippi River. Blessing
7 hospital as two campuses there. We serve approximately
8 150,000 people in our catchment area. We are the largest
9 hospital within 110 miles, so we don't have immediate
10 competition hospital-wise within our area. We've been in
11 the Quincy location for 136 years.

12 We're a not-for-profit hospital and,
13 therefore, charity care is important to us. Approximately
14 3.7 percent of our gross revenues are allocated towards
15 charity care, which does not include community benefits on
16 top of that. We provide charity care to anyone who is at
17 400 percent or less of the Federal poverty guidelines,
18 which is rather generous in today's marketplace.

19 We have been in the psychiatric, mental health
20 business for decades, primarily in two forms: One,
21 St. Mary Hospital, our hospital we purchased, and this
22 Board approved back in 1993 that purchase. We've continued
23 that service. We are the only provider of inpatient
24 psychiatric services within hundreds of miles of Quincy.

1 We serve northeast Missouri, southeast Iowa, much of
2 western Illinois. On any given day, if you look at the
3 people who are served in our unit, you will find people
4 from Chicago, from Springfield, from Decatur and all parts
5 of basically Illinois because of the lack of services
6 available for those patients.

7 I'm going to ask Maureen Kahn to share with
8 you briefly the project and what we're intending to
9 accomplish with this project. When she's finished, we will
10 be happy to respond to any questions you might have.

11 MS. KAHN: Thank you very much. As Staff and
12 as Brad mentioned, our objective is to close our 14th
13 Street campus, which today houses our mental health
14 services and some medical/surgical beds. With the addition
15 of the new patient tower, we will be modernizing our
16 approach to mental healthcare and developing a new mental
17 health service and unit in the new tower. It will also
18 allow us to add some private room beds to the hospital. We
19 will have two floors that will have adult medical/surgical
20 private rooms. Today in our hospital we have 15 private
21 rooms. Our beds are mainly semi-private, and our rooms,
22 which were built about 42 years ago, are about 365 or 366
23 square feet, very tight for us to manage two patients in
24 one room, especially with today's technology. So, our hope

1 is with this modernization we'll be able to meet the number
2 one request from our community, which is private rooms.

3 We will be able to align our mental health
4 services at our main campus, and as those of you who know
5 about providing care, when you have a service that's 24
6 hours a day at another campus, we have duplicate services
7 down at that other campus so we can support the patients, a
8 duplicate pharmacy, we have support staff down there to
9 support our patients, and our caregivers, food and
10 nutritional services that have to be provided. This will
11 enable us to streamline many of our approaches to care and
12 avoid some duplication of those core services.

13 We've received over 27 letters of support for
14 our tower, which we submitted with our application. Our
15 Public Health Department is very supportive of what we want
16 to do. All of our mental health agencies are very
17 supportive of what we want to do.

18 Unfortunately, last week we got notice that
19 the 12-bed unit across the river in Missouri for mental
20 health is closing. So all of a sudden, we took a very
21 conservative approach with where we were going to be with
22 services, but Hannibal Hospital in Hannibal, Missouri has
23 announced the closure of their unit, and so we'll be
24 seeing, we expect, because we're 27 miles away from that

1 hospital, also an increase and influx in business.

2 We're excited about moving in this direction.

3 We also took the responsibility of looking at eliminating
4 some beds, and in our application you'll see that we are
5 eliminating beds.

6 CHAIRMAN GALASSIE: Thank you very much. I'd
7 like to open it up to questions from the Board.

8 (Pause)

9 MR. PELLETIER: Are you extending the
10 single-room capacity to your AMI beds as well?

11 MS. KAHN: Yes.

12 MR. PELLETIER: Thank you.

13 I just want to go on record. For some of the
14 new members, the Department of Mental Health, which I
15 represent on behalf of Dr. Jones, we're always concerned
16 with any application specific to either establishing new
17 beds for AMI services or discontinuing services for AMI
18 services. Obviously, we believe that consumers are best
19 served in the communities where they reside and maintaining
20 as many beds in the community is critically important to
21 us, and, we think, also to the community. We believe that
22 this -- obviously, this application does, in fact,
23 discontinue 15 beds. However, we think that certainly the
24 advantages of modernization of the unit, streamlining it,

1 moving that capacity, I think, also related to their
2 outpatient services certainly would make it more
3 integrative with the general hospital in total, and I just
4 want to make sure that the other Board members know that
5 the Department of Mental Health has had a extraordinarily
6 positive history with Blessing Hospital. They have
7 exceeded and sometimes actually approached us on things
8 that they wanted to do for their community. They are a
9 very critical portion of providing mental health services
10 in that area. We are continually appreciative, despite the
11 fact that we're losing capacity, which I'm sure that to
12 some extent they also both appreciate and perhaps
13 understand that impact, particularly now with the new
14 developments in Missouri, but I just want to make sure that
15 the Board understands that this hospital has been a very
16 esteemed member of the mental health community, and the
17 Department of Mental Health believes that they will
18 continue to provide very needed and very high quality
19 services for the community.

20 CHAIRMAN GALASSIE: Thank you, Mike.

21 Any other questions or comments from Board
22 members?

23 (Pause)

24 CHAIRMAN GALASSIE: Hearing none, may I have

1 a motion to approve Project 11-018?

2 MS. OLSON: So moved.

3 MR. BURDEN: Second.

4 CHAIRMAN GALASSIE: Excellent.

5 MR. CONSTANTINO: Mr. Chairman, I would like
6 to point out that the applicants do have approximately
7 19,000 gross square foot of shell space. So, under our
8 current rules, they would have to make a commitment to come
9 back before you to get approval for any activity in that
10 shell space.

11 CHAIRMAN GALASSIE: So I'd like the motion to
12 include a comment that they will have to come back to the
13 Board prior to any development of the 19,000 square foot of
14 shell space.

15 MR. CONSTANTINO: Right, and they have given
16 us written assurance that they will.

17 CHAIRMAN GALASSIE: Thank you very much, and
18 we will clarify that wording when the minutes are finished.

19 Roll call.

20 MR. ROATE: Motion made by Ms. Olson, seconded
21 by Dr. Burden.

22 Dr. Burden?

23 MR. BURDEN: Yes.

24 MR. ROATE: Mr. Eaker?

1 MR. EAKER: Yes.

2 MR. ROATE: Justice Greiman?

3 MR. GREIMAN: Yes.

4 MR. ROATE: Mr. Hayes?

5 MR. HAYES: Yes.

6 MR. ROATE: Mr. Hilgenbrink?

7 MR. HILGENBRINK: Abstain.

8 MR. ROATE: Ms. Olson?

9 MS. OLSON: Yes.

10 MR. ROATE: Mr. Sewell?

11 MR. SEWELL: Yes.

12 MR. ROATE: Chairman Galassie?

13 CHAIRMAN GALASSIE: Yes.

14 MR. ROATE: That's seven votes in the

15 positive, one vote of abstention.

16 CHAIRMAN GALASSIE: Motion passes. Thank you

17 very much.

18 We will be moving on to Item No. 8, which is

19 Executive Session. I will be asking all non Board members

20 to please leave the room. We're hoping to be in Executive

21 Session no longer than 45 minutes, maybe less, and the

22 minutes shall show that Dr. Burden has had to leave.

23 Ex-officio members can stay in as well.

24 I need to motion to go into Executive Session.

1 CHAIRMAN GALASSIE: And we are going into
2 Executive Session pursuant to Sections 2(c)(1), 2(c)(5),
3 2(c)(11) and 2(c)(21) of the Open Meetings Act.

4

5 (EXECUTIVE SESSION HELD)

6

7 CHAIRMAN GALASSIE: Thank you very much.
8 Calling the meeting back to order. I appreciate your
9 patience.

10 Moving things along -- and the minutes should
11 show that Justice Greiman did have to leave. That having
12 been said, I believe we're moving on to Item No. 9,
13 Compliance Issues, Settlement Agreements, and Final Orders
14 with Counselor Urso.

15 MR. URSO: We'll just do one motion for all of
16 them.

17 CHAIRMAN GALASSIE: Fine. Please do.

18 MR. CONSTANTINO: Thank you, Mr. Chairman. We
19 have six referrals to make to the Board's Legal Counsel
20 today. The first one is Project No. 07-071, Park Place
21 Christian Village, failure to file required reports timely;
22 Grand Oak Surgical Center, change of ownership without
23 State Board approval. The next three are 10-083, 10-084
24 and 10-085, fail to file the required reports timely. This

1 is a final cost report they have not filed. And Project
2 No. 08-106, Mendota Community Hospital, again, failure to
3 file the required reports timely.

4 Thank you, Mr. Chairman.

5 CHAIRMAN GALASSIE: Thank you, Mike.

6 MR. URSO: Mr. Chair, we're going to request a
7 motion to refer these matters to Legal Counsel for review
8 and filing of any notices of non-compliance, which may
9 include sanctions detailed and specified in the Board's Act
10 as well as the Board's rules.

11 MR. EAKER: So moved.

12 MR. SEWELL: Seconded.

13 CHAIRMAN GALASSIE: Motion and seconded.

14 Roll.

15 MR. ROATE: Dr. Burden? Absent.

16 Mr. Eaker?

17 MR. EAKER: Yes.

18 MR. ROATE: Mr. Greiman is absent.

19 Mr. Hayes?

20 MR. HAYES: Yes.

21 MR. ROATE: Mr. Hilgenbrink?

22 MR. HILGENBRINK: Yes.

23 MR. ROATE: Ms. Olson?

24 MS. OLSON: Yes.

1 MR. ROATE: Mr. Sewell?

2 MR. SEWELL: Yes.

3 MR. ROATE: And Chairman Galassie?

4 CHAIRMAN GALASSIE: Chair votes yes.

5 MR. ROATE: Six votes in the affirmative.

6 MR. URSO: Mr. Chair and Board Members, I have
7 a final order that I'm requesting a motion to approve.
8 This has to do with the Clare Oaks Retirement Community,
9 Project No. 05-002, Docket Number HFBP 0903. This is based
10 on said agreement that's been entered into between the
11 parties and approved by the Board. So requesting approval
12 of final order.

13 CHAIRMAN GALASSIE: Do I have a motion to
14 approve?

15 MR. HAYES: So moved.

16 CHAIRMAN GALASSIE: Second?

17 MS. OLSON: Second.

18 CHAIRMAN GALASSIE: Motion and second.

19 Roll call, George?

20 MR. ROATE: Motion made by Mr. Hayes, seconded
21 by Ms. Olson.

22 Mr. Eaker.

23 MR. EAKER: Yes.

24 MR. ROATE: Mr. Hayes?

1 MR. HAYES: Yes.

2 MR. ROATE: Mr. Hilgenbrink?

3 MR. HILGENBRINK: Yes.

4 MR. ROATE: Ms. Olson?

5 MS. OLSON: Yes.

6 MR. ROATE: Mr. Sewell?

7 MR. SEWELL: Yes.

8 MR. ROATE: Chairman Galassie?

9 CHAIRMAN GALASSIE: Yes.

10 MR. ROATE: That's six votes in the
11 affirmative.

12 CHAIRMAN GALASSIE: Motion passes. Thank
13 you.

14 Moving on.

15 MR. URSO: I guess we'll go into Rules
16 Development now.

17 CHAIRMAN GALASSIE: I think so.

18 MR. URSO: Mr. Chair, Board Members, I want to
19 introduce or reintroduce Claire Burman, who is with us
20 today. Maybe some of the Board members have not had an
21 opportunity to formally meet Claire. She's sitting over
22 there between Bonnie and Mike, and she's our rules person,
23 rule coordinator.

24 CHAIRMAN GALASSIE: One of our employees we

1 just discussed, we're fortunate to say.

2 MR. URSO: And she will now give the rules
3 update. Take it away, Claire.

4 MS. BURMAN: Okay. Thank you very much. It's
5 good to be here, good to be back and, believe it or not, I
6 did miss it.

7 This will be very quick. I know that we'd
8 like to wrap things up. If you turn to page 2 of your
9 summary, Rulemaking Status Report, I'd just like to give
10 you an update on the latest rulemakings that came before
11 the Board. If you look at Part 1125, which is for
12 long-term care, this set of rules was approved by the Board
13 on March 22nd of this year. The draft rules were published
14 in Illinois Register on May 13th, and the public hearing
15 was conducted on June 7th of 2011. There was one person
16 who gave testimony for this, and since the 45-day public
17 comment period has ended for this, the Second Notice, the
18 second phase of activity for JCAR is in the process of
19 being completed, so we're moving right along.

20 CHAIRMAN GALASSIE: Is this coming out of our
21 long-term care committee?

22 MS. BURMAN: Yes. We work very closely with
23 the subcommittee.

24 CHAIRMAN GALASSIE: Board establishing -- we

1 established our own subcommittee, long-term care
2 subcommittee, with state-wide representation. Claire has
3 been working with them for the last year.

4 MS. BURMAN: Maybe not that long. So that's
5 making some progress, and in the meantime, we'll be working
6 on other issues that need to be refined and pared down and
7 then maybe we'll have another rulemaking soon.

8 Then under right under long-term care, it says
9 Part 1110, Birth Centers, and this set of rules was looked
10 at and approved by the Board on May 10th of this year.
11 This was statutory in terms of our developing rules for
12 birth centers. There was no new language in there. It all
13 came straight from the Act. And these rules were published
14 in the Illinois Register on July 8th and a public hearing
15 is scheduled for next Thursday, the 28th. So, we'll have
16 something to report on that later.

17 Then we have a couple of other rulemakings
18 that are in the process of being developed. One is for
19 ambulatory surgical treatment centers, which is -- it's
20 wide open for discussion right now. We're trying to seek a
21 lot of input as we go along and we have a tentative draft
22 that we've put together.

23 Then looking down at Part 1130, which are the
24 procedural rules for the Board, and 1110, which is mainly a

1 review criteria for all of the different kinds of projects
2 that you look at, these need to be updated according to the
3 changes to the Act that occurred a couple of years ago now.
4 This got interrupted by a couple of other activities, so
5 we're picking it back up, and we hope to be done with those
6 rulemakings in the next couple of months. So that's --

7 CHAIRMAN GALASSIE: Does that mean through
8 the Legislature or just on our end?

9 MS. BURMAN: Our end.

10 CHAIRMAN GALASSIE: Thank you.

11 MS. BURMAN: Okay. Thank you.

12 CHAIRMAN GALASSIE: Thank you, Claire. We're
13 fortunate to have her, especially when you see the process.
14 It's very tedious or can be.

15 Moving on to new business. Ms. Avery?

16 MS. AVERY: I'm in the process -- first of
17 all, thank you all, Kathy, Mr. Sewell -- Ms. Olson -- I'm
18 sorry -- Dale and Ron who so far have signed up for public
19 hearing, so thank you very much, and Mr. Hayes. We have 15
20 of them coming up, so I'll be calling you. I'm doing a
21 spreadsheet now, trying to figure out who can attend and
22 where and get all of that sent out to you on an e-mail and
23 ask for you to pitch in again.

24 CHAIRMAN GALASSIE: Certainly any member

1 currently not present should be first on that list.

2 (Laughter)

3 MR. EAKER: I second that motion.

4 MS. AVERY: You have the finance reports, and
5 I asked Bill like Monday, I think, for a spreadsheet of
6 month-by-month expenses and then year-to-date and
7 projections, and I asked so late, so we'll have those for
8 the next meeting on the 16th. But you have the summary,
9 and we'll have the projections for FY 12 and everything and
10 looking at what we did last year for the next meeting.

11 As far as the Legislative update, Senate Bill
12 40, our largest bill, that is gone for now. We'll see if
13 it's revived. We've heard some things about it coming back
14 to life on the fall session.

15 MS. OLSON: What bill is that?

16 MS. AVERY: Senate Bill 40. The other issue
17 was the Compliance and Legislative Affairs position. We
18 did make an offer to a young lady, and I'll be sending her
19 bio and everything. We were hoping that she would be
20 started by now, but it's in the Governor's office waiting
21 for approval for the hire. So hopefully we'll get that
22 soon. I think Dale is going to make a couple calls to talk
23 about that.

24 And the next items are for you all to discuss

1 about our next Board meetings, and Mike has a sheet with
2 the dates, and you'll notice that the location and city is
3 blank. So, that's something that you all need to decide
4 on, what we're going to do for FY 12, starting January to
5 December, and then the next two meeting days the locations
6 are to be announced. August 16th is set. It's back here
7 for that meeting, and then we have October the 12th, which
8 we switched, and then November. We had to switch it
9 because the Staff has been invited to go to Michigan for
10 the CON.

11 CHAIRMAN GALASSIE: 2011. What has been
12 handed out is 2012.

13 (Discussion held off the record.)

14 CHAIRMAN GALASSIE: I would ask Board members
15 to e-mail either myself or Courtney. I will just let you
16 know we have bounced -- we have really not done meetings
17 for the last year in Springfield, and that has been more
18 the desire of -- our Board members that are from central or
19 southern Illinois were more interested in Chicago, so the
20 rest of us were happy to hear that. But, truly, we are --
21 we understand completely we're a large and diverse state,
22 so we can mix it up. Many folks have preferred this
23 location to Chicago. So, I guess what I'd be asking you is
24 Joliet, Chicago, or central Illinois? So give us your

1 feedback. We're happy to adjust, and we should adjust.

2 So, I keep pushing Lake County but it hasn't gone very far
3 so far.

4 (Laughter)

5 (Discussion held off the record.)

6 CHAIRMAN GALASSIE: Let me just say the other
7 thing, it really depends on Bonnie's promise on getting
8 us -- this facility we get for next to nothing, which is
9 wonderful. We looked at another one a few more miles from
10 here which is going to be 2500 bucks. So give us your
11 preference in locations and if it doesn't work, we'll tell
12 you why. But I'd say until then, I would anticipate this
13 being our location for the next meeting or two.

14 MS. AVERY: The next meeting definitely,
15 because that's the one we have with Forest Hospital, and
16 we've already publicized that that meeting will be here,
17 during the public hearings and the web site, and we have a
18 signed contract.

19 CHAIRMAN GALASSIE: So Cook County is coming
20 back in August?

21 MS. AVERY: Yes.

22 CHAIRMAN GALASSIE: People should know that.
23 We do have our new rules for public comments. We'll try to
24 utilize those. Any other business.

1 Ms. Avery.

2 MS. AVERY: No.

3 CHAIRMAN GALASSIE: Hearing none, as I
4 predicted, 3:30 on the dot.

5 (Laughter)

6 CHAIRMAN GALASSIE: Thank you very much. I
7 don't think we need a motion.

8

9 END TIME: 3:30 p.m.

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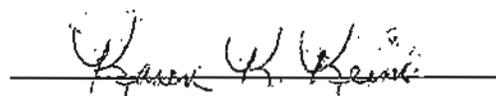
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CERTIFICATE OF REPORTER

I, KAREN K. KEIM, CRR, RPR, a Certified Court Reporter in the States of Illinois and Missouri, 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 writing; 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.



KAREN K. KEIM

CRR, RPR, CSR-IL, CCR-MO

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